Saving Medicare Enrollees from Deceptive Insurers and Creating Ample Resources for Everyone (Saving MEDICARE) Act

Endorsements: Public Citizen, Center for Medicare Advocacy, Medicare Rights Center, National Committee to Protect Social Security and Medicare, Justice in Aging, Center for Health and Democracy, Social Security Works, Healthcare NOW

The Saving MEDICARE Act seeks to strengthen and improve Medicare by reducing the unjustified, costly advantage private Medicare Advantage insurers are receiving. Taxpayers are continuously paying more while consumers receive less. This bill includes many complex provisions with a consistent goal of leveling the playing field so that Traditional Medicare does not remain at a disadvantage to giant private insurance companies.

Based on findings from the Brown University Center for Advancing Health Policy through Research, this legislation is estimated to save at least $2.5 trillion over the next decade—providing critical resources to extend Medicare solvency and to improve Medicare for all consumers through enhancements such as establishing dental, vision, and hearing benefit coverage, an out-of-pocket cap for Parts A and B, premium support, long-term care benefit coverage, lowering the eligibility age, or other measures.

Twenty-three years ago, in the same legislation with which they arm-twisted through the night to ban Medicare from negotiating prescription drug prices, Republicans also established the Medicare Advantage program—the private insurance alternative to Traditional Medicare. Though initially claiming that they would be more efficient and cost less than Traditional Medicare, MA private insurers have never saved a penny and have actually cost taxpayers more every year.

In 2026, the nonpartisan Medicare Payment Advisory Commission (MedPAC) estimates that MA will cost $2,660 more per beneficiary than if they had Traditional Medicare, resulting in $76 billion in overpayments to MA private insurers this year alone. Private insurers earn higher gross margins from MA than any other type of insurance, nearly double what they receive from selling individual insurance policies, which is their second highest grossing.

MA insurers use a variety of tactics to secure additional payments, including upcoding, where plans add diagnoses codes to make a consumer appear sicker, thereby securing higher payments even though the consumer was not treated for all of the conditions the plan is claiming. Some insurers offer bonuses and other incentives to pressure physicians to add unnecessary codes.

In a shocking loophole, MA plans are even profiting off our Nation's veterans. Plans collect benchmark payments and premiums from dually enrolled veterans, who seek all or most of their care through the VA and at the VA's expense—leaving all of the payments to MA insurers as profit.

Plans also work to steer healthier consumers into MA while using care delays, denials, narrow networks, and other tactics to push sicker consumers into Traditional Medicare. This practice of favorable selection ensures MA enrollees seek fewer services, leaving plans with higher profits.

Meanwhile, MA plans dodge any meaningful accountability for these abusive practices since state insurance commissioners have no enforcement authority over MA plans, and CMS is asleep at the wheel as it stalls on auditing these plans—with audits from 2020 just now beginning and overpayment recoveries from payments made as early as 2011 still not completed.

While MA plans have been widely criticized for limiting consumers' access to care, they receive billions in additional quality bonus payments. Unlike similar quality bonus programs for nursing homes, hospital value-

based programs, and end-state renal disease quality incentives, the MA quality program is not budget neutral—yet the program has deeply flawed quality metrics and poor data quality control. And the use of a county quartile system in benchmark payments has been found to inflate payments without incentivizing plans to invest in less-profitable markets.

Medicare Advantage is draining valuable resources, threatening the long-term solvency of Medicare, and increasing Medicare Part B premiums. The long-held promise was that Medicare Advantage would save taxpayer dollars. It's time to at least level the playing field and ensure it does not cost more than Traditional Medicare. This legislation is part of showing Americans what a Democratic Congress could accomplish. Better Medicare for more Americans.

The Saving MEDICARE Act would:

- Prevent upcoding by:
  - Excluding diagnosis codes collected from chart reviews and health risk assessments. This policy is recommended by MedPAC.
  - Requiring CMS to review diagnosis codes annually as part of the Medicare Advantage payment rulemaking, and eliminate or adjust codes that are most likely to be abused.
  - Prohibiting percentage of premium contracts and other financial incentives for providers to add unnecessary diagnosis codes. This policy is recommended by the Center for American Progress.
  - Requiring a MedPAC study on establishing an alternative risk adjusted payment system based on consumer survey data. This policy is recommended by the Center for American Progress.
- Improve benchmark payments by:
  - Establishing a favorable selection payment adjustment. This policy is recommended by the Center for American Progress.
  - Eliminating the county quartile system. This policy is recommended by MedPAC.
- Eliminate frivolous payments by:
  - Ending the failed Quality Bonus Program. This policy is recommended by the Medicare Rights Center.
  - Permitting the VA to collect reimbursement from MA plans for care delivered to dually-enrolled veterans, just as the VA already does with other commercial insurance. This policy is supported by the American Legion, Veterans of Foreign Wars, Paralyzed Veterans of America, and other consumer groups.
- Enhance oversight by:
  - Establishing timelines for completion of Risk Adjustment Data Validation (RADV) audits. Contract audits must be completed within one year. For plans that appeal the outcome of an audit, each stage of appeals must be completed within 90 days. This policy is recommended by the Center for American Progress.
  - Permitting state insurance commissioners to enter into agreements with CMS to share enforcement authority over Medicare Advantage plans. This policy is recommended by the National Association of Insurance Commissioners.