**OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES**

**Resolution No. 34 – 2025**

**Introduced by:** Medical Student Section

**Subject:** Oversight of Medicare Advantage Plan

**Referred to:** Resolutions Committee No. 2

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**WHEREAS**, the original Medicare option established in 1965, hereafter referred to as "traditional Medicare" (TM) decreases healthcare spending and increases access to care for seniors and persons with disabilities[1]; and

**WHEREAS**, the newer Medicare Advantage (MA) program, established in 1999, allows private health insurance companies, hereafter referred to as "MA Organizations" (MAOs), to "manage" Medicare plans[2]; and

**WHEREAS**, in Ohio, 2.4 million residents are enrolled in Medicare, and the proportion of MA enrollees to total Medicare beneficiaries in Ohio is 54% as of April 2023[3]; and

**WHEREAS**, MA plans offer more limited healthcare provider networks compared to TM, with average coverage limited to 46% of physicians in a respective county compared to over 98% of physicians who accept TM[4]; and

**WHEREAS**, MA enrollees require prior authorization for a significantly greater number of services than those enrolled in TM, with 99% of MA enrollees requiring prior authorization for necessary services such as hospital admissions and skilled nursing facilities which starkly contrasts to the limited services requiring prior authorization in TM such as select outpatient services, repetitive ambulance transport, and durable medical equipment[5,6]; and

**WHEREAS**, 13% of total prior authorization denials and 18% of denied payment claims issued by MA organizations (MAOs) would have been approved under the coverage rules of Traditional Medicare[5,7,8]; and

**WHEREAS**, Repeated claims denials by MAOs have subjected patients to delays in medical care, put community and rural hospitals at risk of closure, and due to claims denials and care delays, some hospitals have terminated contracts with MAOs, further compromising patients' provider networks under MA plans[9,10]; and

**WHEREAS**, federal payments to MA plan enrollees are high, and annual costs were found to be $321 higher per MA enrollee than if the same enrollee had been covered by TM[11,12]; and

**WHEREAS**, MA insurance plans have higher rates of overhead or administrative costs (13% to 18.5%) compared to Traditional Medicare (2%) and have a higher overhead and profit margins than even the individual market (12.3%)[13,14]; and

**WHEREAS**, the federal government pays MAOs a fixed rate per enrollee plus risk-adjusted rebates that are calculated as the difference between a) the benchmark of spending on TM adjusted for a given county and b) a bid, or the cost that an MAO estimates it will take to provide healthcare services to the average enrollee[15]; and

**WHEREAS**, the Medicare Payment Advisory Commission (MedPAC) estimates that the current system of benchmarks and risk-adjustments has led to increased spending of 6% more for each MA enrollee than if the same enrollee had been covered by TM, a difference that is estimated to be $27 billion in 2023 alone[16],

**WHEREAS**, MedPAC has recommended that the Centers for Medicare & Medicaid Services (CMS) reform the current benchmark payment system to more closely align with spending within TM17 and changes based on MedPAC recommendations are projected to reduce total Medicare spending by an estimated $82 billion dollars by 2029[11]; and

**WHEREAS**, MAOs charge taxpayers a minimum of $88 billion per year, for supplementary benefits which often attract enrollees however, a Congressional Budget Office analysis completed in 2019 found that adding dental, hearing, and vision benefits to TM and Medicaid would only cost a combined $84 billion in the most expensive year of its implementation[18]; and

**WHEREAS**, the American Medical Association (AMA) has adopted Medicare Advantage Policies D-285.959 and H-330.867 to prevent access to care limitations and improve risk-adjustment for MA enrollees[17,18]; and

**WHEREAS**, our OSMA recognizes the need for universal access to healthcare (Policy 13-2024) and supports increased access to comprehensive high quality care (Policy 6 - 2023) while providing oversight of health insurance plans (Policy 21 - 2024); and therefore be it

**RESOLVED**, that our OSMA supports equivalence in treatment and prior-authorization guidelines between Medicare Advantage plans and Traditional Medicare; and be it further

**RESOLVED**, that our OSMA supports that proprietary criteria shall not supersede the professional judgment of the patient's physician when determining Medicare and Medicare Advantage patient eligibility for procedures and admissions; and be it further

**RESOLVED**, that our OSMA support that Medicare Advantage risk adjustment formulas be revised so that claims data is based on the actual cost of providing care; and be it further

**RESOLVED**, that our OSMA ask our AMA to lobby in support of MedPAC recommendations to develop an improved risk adjustment model and change the current benchmark policy to one that bases federal payments to Medicare Advantage organizations and Medicare Advantage payments to physicians/healthcare centers on more accurate Fee-For-Service-derived benchmarks; and be it further

**RESOLVED**, that our OSMA ask our AMA to study how financial savings generated through enactment of MedPAC recommendations and AMA policies for reform of the Medicare Advantage program can be used to improve Traditional Medicare.

**Fiscal Note:** $ (Sponsor)
$ 50,000+(Staff)

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**Relevant OSMA Policy:**
**Policy 21 – 2024 - Oversight of Health Insurance Companies**

1. OSMA supports proactive oversight of health insurance carrier policies and practices by the ODI by encouraging the ODI to develop a panel, with physician participation, to provide oversight of health insurance carrier policies and practices.
2. OSMA actively encourages, educates and supports physicians, patients, and hospitals regarding the process for reporting inappropriate and unfair practices by health insurance carriers directly to the Department of Insurance.
3. OSMA will create a structure to which physicians can report concerns and submit gathered information, regarding inappropriate, unsafe, or unfair health insurance carrier policies to be compiled, evaluated for merit, and, if validated, reported to the ODI, with appropriate supporting information from the OSMA.

**Policy 18 – 2024 - "Guarantee Issue" Protections for Traditional Medicare**

1. The Ohio State Medical Association (OSMA) will take all necessary steps to require guaranteed issue protections allowing access to Medigap Insurance coverage for beneficiaries switching from Medicare Advantage to traditional Medicare during the annual open enrollment period.
2. The OSMA delegation to AMA will take this resolution to AMA seeking all necessary actions (legislative or administrative) to allow Medicare beneficiaries the freedom to change back to Traditional Medicare with federal guaranteed issue protection to obtain Medigap insurance once they have disenrolled from Medicare Advantage Plans.

**Policy 20 – 2019 - Establishing Fair Medicare Payor Rates**

1. The OSMA Delegation to the AMA ask the AMA to pursue CMS intervention and direction to prevent commercial Medicare payors from compensating physicians at rates below Medicare's established rates.

**Policy 20 – 2018 - Compensation for Pre-Authorization Requests**

1. The OSMA supports the ability for all Ohio physicians to be compensated for time dedicated to the pre-authorization process.
2. The OSMA requests that payors provide an explanation of their appeals review processes.
3. The OSMA-AMA representatives carry a resolution to the AMA asking the AMA to petition the Centers for Medicare and Medicaid services that CPT code 99080 be reimbursed by Medicare.

**Relevant AMA and AMA-MSS Policy:**

**AMA Policy D-285.959 - Prevent Medicare Advantage Plans from Limiting Care**

1. Our American Medical Association will ask the Centers for Medicare and Medicaid Services to further regulate Medicare Advantage Plans so that the same treatment and authorization guidelines are followed for both fee-for-service Medicare and Medicare Advantage patients, including admission to inpatient rehabilitation facilities.
2. Our AMA will advocate that proprietary criteria shall not supersede the professional judgment of the patient's physician when determining Medicare and Medicare Advantage patient eligibility for procedures and admissions."

**AMA Policy H-330.867 - Medicare Advantage Plans**

1. Our American Medical Association encourages that Medicare Advantage risk adjustment formulas be revised so that claims data is based on the actual cost of providing care.

2. Our AMA will provide or create educational materials such as an infographic to compare Traditional Medicare and Medicare Advantage plans so that patients are able to make informed choices that best meet their health care needs.”; and be it further