2026 -- H 7430

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S T A T E O F R H O D E I S L A N D

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2026

H O U S E R E S O L U T I O N

RESPECTFULLY URGING THE UNITED STATES CONGRESS TO PROTECT PATIENTS AND TRADITIONAL MEDICARE FROM MEDICARE ADVANTAGE

Introduced By: Representatives Stewart, Fogarty, Cotter, Tanzi, Ajello, Carson, Giraldo, Cruz, Speakman, and Boylan
Date Introduced: January 30, 2026

Referred To: House Health & Human Services

WHEREAS, In 1965, the federal Social Security Amendments Act was passed, establishing healthcare insurance programs for those over age 65 (Medicare) and those with limited incomes (Medicaid); and

WHEREAS, Original Medicare coverage had gaps and un-capped co-insurance costs, but instead of simply and directly improving original Medicare, private corporations were invited to sell various supplemental and replacement plans for enrollee payments and guaranteed federal subsidies; and

WHEREAS, Medicare today consists of a piecemeal program of federal and private programs, namely: Part A (inpatient/hospital coverage), Part B (outpatient/medical coverage), "Medigap" coverage (co-pays/deductibles), Part C (Medicare Advantage plans), and Part D (prescription drug plans), and generally, enrollees can either choose Traditional Medicare (TM), with federally run Parts A and B, and privately run Medigap and Part D plans, or choose Medicare Advantage (MA) Part C private plans to completely replace TM; and

WHEREAS, Insurance companies selling MA plans aggressively market to Medicare eligible people without full disclosure of TM costs and benefits compared to MA; and

WHEREAS, In 2024, fifty-four percent of all eligible beneficiaries in Medicare are enrolled in private MA insurance plans which cover mainly those over age 65, as well as others with certain medical conditions; and

WHEREAS, States may only regulate MA plans in very limited ways because of federal

preemption and generally cannot regulate how MA plans market to potential enrollees; and

WHEREAS, The data show that privatized Medicare has not once yielded savings for the program; conservative estimates by the Medicare Payment Advisory Commission (MedPAC), an independent agency created to advise Congress on the Medicare program, show that payments to MA plans over the past two decades have always been higher than they would have been for patients in TM; and

WHEREAS, MA plans may offer low or no monthly premiums and cap out-of-pocket expenses, but MA plans have been found to cost enrollees more than TM when enrollees become seriously ill, such as when they get cancer or have extended hospital stays; and

WHEREAS, Although MA plans attract enrollees with extra benefits, like coverage for dental, vision, or hearing, enrollees who use these benefits often end up paying for most of these costs out-of-pocket; and

WHEREAS, Despite higher payments, MA plans generally spend less per patient and provide worse coverage than TM; and

WHEREAS, Unlike TM, which gives enrollees freedom to go to virtually any doctor or hospital in the country, MA provider networks are significantly narrower and geographically limited; and

WHEREAS, Unlike TM, which covers physician's orders without requiring third-party approval, MA plans require prior authorizations and have been found to improperly deny about 13 percent of prior authorization requests; and

WHEREAS, Beginning in 1965, original Medicare became the primary driver for greater healthcare equality because the government required hospitals to desegregate before receiving any Medicare funds; and

WHEREAS, Today, MA has exacerbated healthcare inequality by enrolling disproportionately high numbers of disadvantaged populations (e.g., racial minorities, disabled individuals, lower income individuals) into plans that often offer worse coverage and care than TM; and

WHEREAS, Retirees are forced into MA plans because about 53 percent of large employers (200+ employees) require their retirees to accept a MA plan or lose their retirement health benefits; and

WHEREAS, Barriers to switching to Traditional Medicare, including lack of "guaranteed issue" protections, waits for "open enrollment," insurers denying or charging steep prices for Medigap Part D drug plans, etc., keep MA enrollees trapped in MA plans; and

WHEREAS, Medicare Advantage plans have achieved higher revenues by taking actions

that do not benefit enrollees, including:

(1) Gaming risk pools by marketing to younger, healthier enrollees ("cherry-picking") and incentivizing older, sicker beneficiaries to leave ("lemon-dropping");

(2) "Upcoding" to make patients seem sicker than they really are to increase reimbursements from the federal government;

(3) Using "utilization management" tools such as prior authorizations, step therapy protocols and artificial intelligence (AI) algorithms to delay or prevent medically necessary care;

(4) Delaying or refusing payments to hospitals so that they are increasingly not accepting Medicare Advantage patients; and

(5) Gaming contract construction to maximize quality payments under the star rating system; and

WHEREAS, Most MA plans are sold by large insurers that have multiple related businesses, such as pharmacy benefit managers, and those related businesses can account for about 20 percent to 70 percent of spending, parent companies can circumvent Medicare limits on profits; and

WHEREAS, Dozens of fraud lawsuits, inspector general audits and investigations by watchdog groups have shown that major health insurers have exploited the program to inflate their profits by billions of dollars; and

WHEREAS, Insurers typically earn twice as much gross profit from their MA plans than from other types of insurance and private MA insurers have more than doubled their profit margins per enrollee; and

WHEREAS, Estimated amounts overpaid to MA (between $83 billion and $127 billion in 2024) are more than the amounts needed to totally eliminate Medicare Part B premiums, or fund the entire Medicare Part D prescription drug program, or establish dental, hearing, and vision coverage for Medicare and Medicaid enrollees; and

WHEREAS, United Health Care abruptly ended coverage for Medicare Advantage enrollees at Rhode Island's four largest teaching and community hospitals, Rhode Island Hospital, Hasbro Children's Hospital, The Miriam Hospital, and Newport Hospital, in July of 2025, a decision that disrupted care for more than ten thousand (10,000) patients, forced medically fragile seniors to switch providers mid-treatment, and highlighted the risks of allowing corporate insurers to control access to essential healthcare institutions in pursuit of greater bargaining leverage; and

WHEREAS, There is a growing bi-partisan effort by federal legislators and the Centers for Medicare and Medicaid Services (CMS) to protect patients from the kind of MA problems

noted above; now, therefore be it

RESOLVED, That this House of Representatives of the State of Rhode Island hereby recognizes the need for the United States government to prioritize patients over corporate profits and protect and expand traditional Medicare and hereby respectfully urges Senator Jack Reed, Senator Sheldon Whitehouse, Congressman Seth Magaziner, and Congressman Gabe Amo to support and pass legislation, and ask the U.S. Department of Health and Human Services Secretary and Centers for Medicare and the Medicaid Services Administrator to take immediate administrative actions, including to:

(1) Require MA plans to retain and provide information, contracts, documents, and financial data that allows transparency for and accountability to taxpayers and enrollees;

(2) Conduct more MA plan audits to identify overpayments and fraud;

(3) Strictly regulate MA marketing to require full disclosure to potential enrollees of risks, disadvantages, and possible future costs;

(4) Reduce incentives or requirements for historically disadvantaged groups to accept an inferior MA plan over TM;

(5) Prohibit MA plans from taking actions that increase their profits without increasing healthcare services, including upcoding, risk pool "cherry-picking" and "lemon-dropping", and using utilization management that improperly denies or delays medically necessary care and timely payments to providers;

(6) Prohibit MA plans from limiting coverage for beneficiaries seeking expert specialty care by imposing overly narrow provider networks;

(7) Require employers that offer retirement benefits to give employees the option to enroll in TM;

(8) Work with the Justice Department to prosecute and recover improper payments; and

(9) Redirect funds that currently go towards enriching MA plans to instead go towards protecting and expanding traditional Medicare; and be it further

RESOLVED, That the Secretary of State be and hereby is authorized and directed to transmit duly certified copies of this resolution to the Clerk of the United States House of Representatives, the Clerk of the United States Senate, and to members of the Rhode Island Delegation to the United States Congress.

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