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APPELLATE DIVISION—FIRST DEPARTMENT

ROBERT BENTKOWSKI, KAREN ENGEL, MICHELLE FEINMAN, NANCY LOSINNO, JOHN MIHOVICS, KAREN MILLER, ERICA RHINE, ELLEN RIESER, and BEVERLY ZIMMERMAN, on behalf of themselves and all others similarly situated, and THE NEW YORK CITY ORGANIZATION OF PUBLIC SERVICE RETIREES, INC.,

Petitioners-Plaintiffs-Respondents,

—against—

THE CITY OF NEW YORK; ERIC ADAMS, Mayor of the City of New York; THE CITY OF NEW YORK OFFICE OF LABOR RELATIONS; RENEE CAMPION, Commissioner of the Office of Labor Relations; THE NEW YORK CITY DEPARTMENT OF EDUCATION (a/k/a the Board of Education of The City School District of the City of New York); and DAVID C. BANKS, Chancellor of the New York City Department of Education,

Respondents-Defendants-Appellants.

CASE NO. 2023-04716

BRIEF OF *AMICUS CURIAE* ON BEHALF OF PHYSICIANS FOR A NATIONAL HEALTH PROGRAM—NEW YORK METRO IN SUPPORT OF PETITIONERS-PLAINTIFFS-RESPONDENTS

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INTEREST OF *AMICUS CURIAE*

Physicians for a National Health Program ("PNHP") is a membership organization of more than 25,000 physician members nationwide dedicated to implementing a single-payer national health program to promote better health for all. PNHP—New York Metro is a local chapter of the nationwide organization, which is a non-profit, 501(c)(3) organization with no parent, subsidiary, or affiliates. PNHP's physician members in the New York City metropolitan area treat patients who receive their health insurance through the City's current insurance plans as well as patients who receive treatment through Medicare Advantage. *Amicus* is therefore uniquely positioned to explain how the City's changes to health insurance for retirees would operate in practice, and how those changes would harm retirees, harm physicians, and ultimately undermine the provision of healthcare services in New York City.

PRELIMINARY STATEMENT

This case is about a decision by the City of New York that breaks a promise and imperils retirees' health. For decades, the City promised to fund high-quality insurance for its retirees who had dedicated their careers to public service. Now, the City wants to cut off its spending and force retirees onto the proposed, inferior Aetna Medicare Advantage PPO plan ("Aetna MAP"). This proposal flouts decades of legally binding promises reasonably relied upon by the City's retirees. It also

violates the City's obligation in Administrative Code § 12-126 to "pay the entire cost of health insurance coverage for city employees, city retirees, and their dependents."

In defending its switch to Aetna MAP, the City asserts that retirees will somehow receive better healthcare with only a fraction of the funding. *See, e.g.*, Br. for Appellants at 14, NYSCEF 14 ("City's Br."). That is incorrect. With less money for patient care comes worse health outcomes for patients; the only true beneficiaries are the City (which pays less) and Aetna shareholders (who pocket some of the profits). Simply put, the City is breaking its promise to retirees—public servants who dedicated their careers to serving the City—by forcing them into an objectively inferior healthcare plan.

Overwhelming historical evidence indicates that Aetna MAP, like all Medicare Advantage ("MA") plans, will deny retirees necessary medical care that they would receive under their current Senior Care plans. First, it will push the patients most in need of healthcare services off Aetna MAP by raising copays on the most necessary (but expensive) healthcare services; second, it will impose prior authorization requirements and deny payment for needed medical treatments; and third, it will limit the network of medical providers available to retirees. These tactics are standard fare for programs like Aetna MAP, and the City offers no good reason to doubt they will recur.

The result will be worse outcomes for patients—outcomes that will fall disproportionately onto historically disadvantaged groups. Compounding that harm, MA plans like Aetna MAP impose a severe administrative and mental toll on providers, including PNHP's members. There is growing evidence that the strains attributable to plans like Aetna MAP are exacerbating the supply of physicians by transforming the job into an endless fight against insurance bureaucrats.

Arguments raised in defense of Aetna MAP rest on little more than unsupported assertions by City officials or incomplete assurances by Aetna executives. These claims—made by parties with a political or financial stake in pushing Aetna MAP through—should not be accepted at face value. Nonpartisan investigations by government watchdogs and independent academic research debunk the claims offered in support of MA plans. The lesson from Medicare Advantage's record is clear: If the City cuts costs by replacing retirees' current full-payment healthcare plan with cut-rate Aetna MAP, it is New York City's retirees and medical providers who will pay the price.

ARGUMENT

The City seeks to radically transform its retirees' healthcare for the worse. For years, the vast majority of the City's retirees have chosen to enroll in Traditional Medicare ("TM" or "Original Medicare"), paid for by the federal government, supplemented by the GHI Senior Care plan. Record on Appeal ("R") 2. Senior Care

is a Medicare Supplemental Policy, often referred to as a "Medigap" plan because it fills "gaps" in the coverage offered by Traditional Medicare. R-275; *see* Michelle L. Malloy, CRS, R47552, *Medigap: Background and Statistics* (May 12, 2023). Currently, the City pays the full premium for retirees' Senior Care, which (per retiree) is approximately $191 each month and totals just under $2,300 each year. R-25, 54.

But now, the City wants to shirk its promise to support retirees' healthcare costs by replacing Traditional Medicare plus Senior Care with Aetna MAP, a Medicare Advantage plan.[1] Medicare Advantage (or "Medicare Part C") is a

[1] The City pretends it is not walking back its promise to retirees by suggesting that the City never promised retirees a Medigap plan like Senior Care, suggesting that the City's summary plan descriptions ("SPDs") could just as easily be read to describe an MA plan. *See, e.g.*, City's Br. 28, 31-32. But there is no ambiguity on the fact that the descriptions of coverage for retirees in the City's SPDs refer to Medigap plan coverage. Namely, the SPD language the City quotes entitles retirees to "a second level of benefits intended to fill certain gaps in Medicare coverage" that "supplements Medicare but does not duplicate benefits available under Medicare." *Id.* at 28 (quoting R-2113). That language unambiguously refers to Medigap plan coverage, mirroring the descriptions of Medigap plans used in federal regulations and in guidance from the Centers for Medicare and Medicaid Services, the federal agency that oversees Medicare. *See, e.g.*, 42 C.F.R. §§ 403.205(a)(2), (c)(4) (defining a Medigap policy as one designed to cover services and items not reimbursed by Traditional Medicare "that supplements Medicare benefits"); *Learn How Medigap Works*, Ctrs. for Medicare & Medicaid Servs., https://www.medicare.gov/health-drug-plans/medigap/basics/how-medigap-works (accessed Jan. 19, 2024) ("A Medicare Advantage Plan is another way to get your Medicare coverage besides Original Medicare. A Medigap policy is a supplement to Original Medicare coverage."). A patient with Medigap coverage must also have Traditional Medicare coverage for the Medigap plan to supplement. Malloy, *supra*, at 2. In contrast, Medicare Advantage does not "supplement" or "fill certain gaps in Medicare," R-2113—it "offers an *alternative* to Original Medicare." *Understanding Medicare Advantage Plans*, Ctrs. for Medicare & Medicaid Servs. at 5 (July 2022), https://www.medicare.gov/Pubs/pdf/12026-Understanding-Medicare-Advantage-Plans.pdf (emphasis added). No one familiar with the structure of Medicare would use the "parlance" of "supplement[ing]" Traditional Medicare, City's Br. 31, to describe MA plans, *see, e.g.*, *How Are Medigap and Medicare Advantage Different?*,

program created in 2003 under which a for-profit insurance company steps in for the federal government as the primary provider of all of a patient's healthcare services through a plan that replaces Traditional Medicare. *See* 42 U.S.C. § 1395w-21; Patricia A. Davis et al., CRS, R40425, *Medicare Primer* at 4, 22-23 (May 21, 2020).

That switch from Traditional Medicare plus Senior Care to Aetna MAP will fundamentally transform and worsen retirees' healthcare. The City cannot dispute that less funding will be available for retirees' healthcare after the switch. *See* Part I.A. As a result, Aetna MAP will have to make up for the funding deficit—*e.g.*, by pushing needy patients off the plan through higher copays, refusing to pay for medical procedures prescribed by patients' licensed physicians, and restricting patients' network of providers. *See* Part II.B. Aetna MAP's fallback pitch regarding the extra benefits often found in marketing for MA plans—like a generic fitness rewards program and meals—comes nowhere close to making up for the lack of necessary medical care. *See* Part I.C.

Those cost-cutting mechanisms will have real consequences for the retirees forced to join Aetna MAP. Study after study has found that patients on MA plans receive less necessary healthcare and suffer more medical emergencies. *See* Part II.A. Those harms fall most heavily on patients from historically disadvantaged

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AARP (Jan. 24, 2023), https://www.aarp.org/health/medicare-qa-tool/medigap-vs-advantage.html ("Medigap coverage supplements original Medicare, while Medicare Advantage is a private insurance alternative to federally run Medicare.").

backgrounds. And those harms are also experienced by patients' physicians, who cannot properly perform their professional duties and therefore suffer frustration and become more likely to leave the profession. *See* Part II.B. Thus, Aetna MAP will place further stress on our fragile healthcare system. *See* Part II.C.

I. AETNA MAP IS INFERIOR TO RETIREES' CURRENT INSURANCE

A. Aetna MAP Will Reduce Funding for Retirees' Healthcare

The switch from Traditional Medicare plus Senior Care to Aetna MAP will mean less money for retirees' healthcare: Not only will Aetna MAP receive less money from the start because the City will not pay for the Supplement, but, as we explain below, Aetna will then take a significant portion of that limited funding to generate a profit for its shareholders and to employ a large administrative staff to review (and often deny) requests for treatment. The result is roughly 25 percent less money available for retirees' healthcare, a funding deficit that Aetna MAP does not (and could not) remedy by promoting "efficiency." The City is thus not only breaking its promise to retirees that it would pay for Senior Care premiums—it is also seeking to force its retirees onto an inferior healthcare plan while pretending that better care will be offered.

1. Aetna MAP Will Siphon Funding Away to Corporate Profit Margins and Administrative Overhead

The City asserts that its proposal to force retirees into Aetna MAP will provide additional resources for retirees' healthcare because—even as the City stops

paying—Aetna MAP will "tap into federal funding," City's Br. 1, 14, and "leverag[e] substantial Medicare subsidies," *id.* at 17. But this claim is wrong on multiple counts.

First, the amount of additional federal funding that Medicare Advantage receives relative to Traditional Medicare (which the City labels a "subsidy"), falls far short of making up for the loss of funding from the City. In 2022, Medicare Advantage cost federal taxpayers approximately 4 percent more per patient than if that same patient was enrolled in Traditional Medicare; in effect, that works out to a few hundred dollars more per year per patient. *See* Robert A. Berenson et al., *Understanding Medicare Advantage Payment*, Urban Inst. at 3 (Sept. 2022); *see also* Jeannie Fuglesten Biniek et al., *Higher and Faster Growing Spending Per Medicare Advantage Enrollee Adds to Medicare's Solvency and Affordability Challenges*, Kaiser Fam. Found. (Aug. 17, 2021).[2] In this sense, an MA plan gets slightly more federal funding. But under the current plan (Traditional Medicare and Senior Care), healthcare costs are covered by both federal funding *and* City funding. The combination of those two funding sources is greater than the federal funding alone that would support an MA plan. In fact, the City currently covers roughly 20 percent of the total annual costs currently attributed to City retirees' healthcare plans through

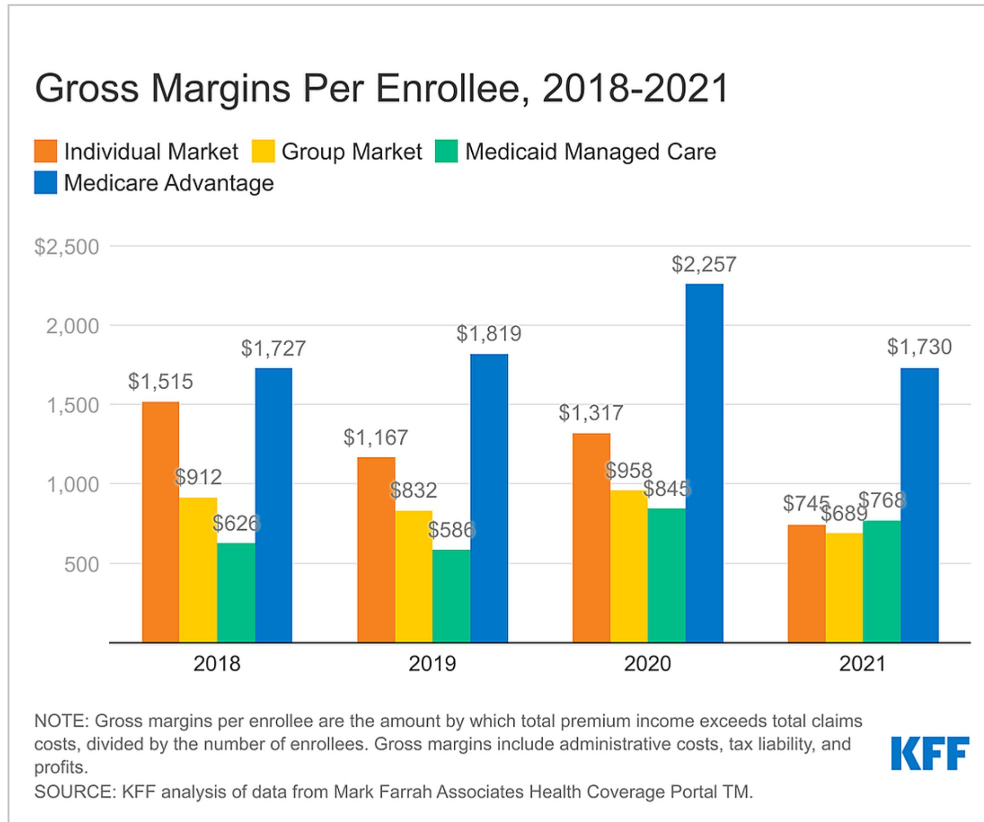
[2] https://www.kff.org/medicare/issue-brief/higher-and-faster-growing-spending-per-medicare-advantage-enrollee-adds-to-medicares-solvency-and-affordability-challenges/.

the monthly $191 premium. If that City payment is eliminated, as the City proposes, marginally higher federal funding for MA plans cannot make up the difference. *See* Leonard Rodberg, *Medicare Dis-Advantage: Shortchanging the Patients While Enriching the Insurer*, Common Dreams (Aug. 30, 2022).[3] In other words, removing City funding will result in less total healthcare funding on a per retiree basis.

Second, from that smaller pie of funding for retirees' healthcare, Aetna would take a meaningful slice of profit to pay its shareholders. MA plans have become highly profitable "money machines" for private insurers. *See* Richard Gilfillan & Donald M. Berwick, *Medicare Advantage, Direct Contracting, and the Medicare 'Money Machine,' Part 1: The Risk-Score Game*, Health Affs. (Sept. 29, 2021).[4] Private insurers' profit margins on Medicare Advantage are higher than *every other type* of health insurance, even exceeding the profits earned on plans for private-sector employers and the individual market. Lanlan Xu et al., Dep't of Health & Human Servs. Off. of Health Pol'y, No. HP-2023-06, *Medicare Advantage Overview: A Primer on Enrollment and Spending* at 13 (May 25, 2023). This is demonstrated by the following graphic:

[3] https://www.commondreams.org/views/2022/08/30/medicare-dis-advantage-shortchanging-patients-while-enriching-insurer.

[4] https://healthaffairs.org/content/forefront/medicare-advantage-direct-contracting-and-medicare-money-machine-part-1-risk-score-game.



Craig Palosky, *Medicare Advantage Insurers Report Much Higher Gross Margins Per Enrollee Than Insurers in Other Markets*, Kaiser Fam. Found. (Feb. 28, 2023).[5]

These high profit margins to private insurers in MA plans are a direct result of the "subsidies" that the City lauds in its briefing—instead of flowing to patient care, those subsidies feed corporate profits. *See* Richard Gilfillan & Donald M. Berwick, *Born on Third Base: Medicare Advantage Thrives on Subsidies, Not Better Care*, Health Affs. (Mar. 27, 2023).[6] And on top of these high profit margins, Aetna

[5] https://www.kff.org/medicare/press-release/medicare-advantage-insurers-report-much-higher-gross-margins-per-enrollee-than-insurers-in-other-markets/.

[6] https://www.healthaffairs.org/content/forefront/born-third-base-medicare-advantage-thrives-subsidies-not-better-care.

would then take *another* slice of funding to employ an expansive bureaucracy to issue prior authorizations, review payment requests, and administer its network.

Together, corporate profits and administrative overhead reduce funds available for healthcare under MA plans by an average of 17 percent. Diane Archer, *Medicare Is More Efficient Than Private Insurance*, Health Affs. (Sept. 20, 2011).[7] As one study found, because of Medicare Advantage's higher administrative costs and the need to generate a profit, MA plans' revenues are 30 percent above the amount of money actually spent on enrollees' healthcare—meaning that a large percentage of federal "subsidies" to Medicare Advantage goes to private insurers, not to patients or their treating physicians. *See* Vilsa Curto et al., *Health Care Spending and Utilization in Public and Private Medicare*, 11 Am. Econ. J. 302, 330 (Apr. 2019).[8]

At bottom, the City is attempting to put a positive spin on a well-known failure of Medicare Advantage. Although the original purpose of Medicare Advantage was to reduce costs to federal taxpayers by providing care at a lower price than Traditional Medicare, Medicare Advantage has cost more every year since its creation. *See* Berenson et al., *supra*, at 3. Notably, the City provides no basis at all to conclude that the higher cost of MA plans means more money is flowing to patient

[7] https://www.healthaffairs.org/do/10.1377/forefront.20110920.013390/.

[8] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6532061/.

care. The truth is that, despite more taxpayer money flowing *in* to MA plans, less money is flowing *out* to patients. Without the City's premium payments, and with a new need to fuel corporate profits and employ an expansive private bureaucracy, Aetna MAP will spend less on necessary care.

2. Aetna MAP Is Less Efficient than Retirees' Current Medicare

The City suggests that Aetna MAP's lower spending on patients' healthcare is justified because it will be more efficient than Traditional Medicare. City's Br. 13. Not so. *First*, as just explained, MA plans like Aetna MAP have enormous profit margins and high overhead costs that come directly out of the funds available to treat patients. By contrast, Traditional Medicare's administrative overhead is funded separately and so does not affect payments to providers for retirees' healthcare, and (in any event) averages below 2 percent compared to MA plans' average of 17 percent. *See 2023 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplemental Medicare Insurance Trust Funds* at 13.[9]

Second, Aetna has represented that Aetna MAP would pay medical providers the same price for healthcare services as Traditional Medicare pays. *See* R-685-86. This means that for any medical service that a retiree receives under Aetna MAP, the cost will be the exact same as that service currently costs under Traditional

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[9] https://www.cms.gov/oact/tr/2023.

Medicare plus Senior Care. *See* City's Br. 16; *see also* Curto et al., *supra*, at 304 ("Lower healthcare spending in MA than in TM primarily reflects lower utilization of services rather than lower payments for the same services."). Nor is Aetna MAP saving money by somehow cutting out wasteful medical spending. Rather, research demonstrates that MA plans are just as likely as Traditional Medicare to pay for low-value services that have relatively little benefit for patients. *E.g.*, Sungchul Park et al., *Trends in Use of Low-Value Care in Traditional Fee-for-Service Medicare and Medicare Advantage*, JAMA Network Open at 10 (Mar. 17, 2021).

In related litigation, the City supports its claim of MA plans' supposed efficiency by citing a March 2022 report to Congress by the Medicare Payment Advisory Commission ("MedPAC"). *See* Br. for Appellants at 7-8, No. APL-2023-00086 (N.Y. Nov. 6, 2023). But this report does not support the City's position. Instead, it raises serious concerns about the cost, administration, and treatment quality of Medicare Advantage when compared to Traditional Medicare. Among other concerns, that report concludes as follows:

- Data provided by insurers about MA plans is of such poor quality that it "prevent[s] policymakers from understanding plan efficiencies or implementing program oversight," such that a "major overhaul of MA policies is therefore urgently needed." MedPAC, *The Medicare Advantage Program: Status Report and Mandated Report on Dual-Eligible Special Needs Plans*, in *Report to the Congress: Medicare Payment Policy* at 411, 416-17 (Mar. 2022).

- The high cost of MA plans compared to Traditional Medicare "will further worsen Medicare's fiscal sustainability," making reforms "imperative." *Id.* at 411-12, 416-17.
- Traditional Medicare has "lower administrative costs" than MA. *Id.* at 415.

At bottom, the truth is that MA plans like Aetna MAP excel at generating corporate profits, not at efficiently providing healthcare to patients who need it.

B. Because Aetna MAP Has Fewer Resources, It Will Inevitably Provide Less Healthcare to Retirees

The only way that the City can save money while Aetna generates big profits is if retirees receive fewer, and lower quality, healthcare services. Aetna MAP will shortchange retirees' healthcare in at least three ways. *First*, it will incentivize the neediest patients to disenroll by imposing costly copays. *Second*, it will impose burdensome prior authorization requirements and deny payment even after a patient receives treatment. And *third*, it will limit the network of physicians available to retirees, often excluding the highest-quality providers.

1. Aetna MAP Will Push Off the Patients Most in Need of Healthcare

One way that Aetna MAP will cut its costs is by using copays to incentivize patients most in need of healthcare services (and who therefore most threaten Aetna's profits) to make the difficult choice to leave for Traditional Medicare. City retirees have not had copays to access healthcare services under Senior Care. *See Bianculli v. City of New York Off. of Lab. Rels.*, 216 A.D.3d 560, 561 (1st Dep't 2023) (affirming injunction of an unprecedented $15 copay for Senior Care). And

since retirees would need to pay copays under Aetna MAP to access certain healthcare, they will ration their healthcare and forgo treatment. That is because, as an "extensive body of evidence" demonstrates, copays especially "deter[] the use of effective, but often underused, preventive health care." Amal N. Trivedi et al., *Elimination of Cost Sharing for Screening Mammography in Medicare Advantage Plans*, 378 New Eng. J. Med. 262, 263 (Jan. 18, 2018). Consequently, studies have found that even small copays measurably increase patients' mortality rates. Amitabh Chandra et al., *The Health Costs of Cost-Sharing* at 4-6 (Nat'l Bureau of Econ. Res., Working Paper No. 28439, Apr. 2023).

MA plans like Aetna MAP understand that they can discourage patients from receiving treatment through copays. MA plans therefore disproportionately impose (and eventually raise) copays on more expensive healthcare services used by the neediest patients with the intent that those patients eventually choose to leave the plan. *See* Sungchul Park et al., *Service-Level Selection: Strategic Risk Selection in Medicare Advantage in Response to Risk Adjustment* at 27, 30-31 (Nat'l Bureau of Econ. Res., Working Paper No. 24038, Nov. 2017).

That Aetna MAP will seek to push the neediest patients off its plan is not mere speculation. The Government Accountability Office ("GAO"), a nonpartisan watchdog agency, has for years sounded the alarm that even as overall enrollment in Medicare Advantage is increasing (often, because employers like the City leave

patients no other choice), patients *disenroll* from their MA plans when they are most in need of medical care because Traditional Medicare is more affordable to patients with serious medical conditions and does not delay or deny their necessary care. *See* GAO-22-106026, *Medicare Advantage: Continued Monitoring and Implementing GAO Recommendations Could Improve Oversight* at 4, 6-7 (June 2022); GAO-17-393, *Medicare Advantage: CMS Should Use Data on Disenrollment and Beneficiary Health Status to Strengthen Oversight* at 11 (Apr. 2017) (finding that "beneficiaries in poor health were substantially more likely to leave their [MA] contracts than those in better health"). Independent researchers have repeatedly identified the same trend, including in studies on cancer patients and on patients that require dialysis. Brett Lissenden, *The Effect of Cancer Diagnosis on Switching Health Insurance in Medicare*, 28 Health Econs. 339 (2019) (cancer patients); Qijuan Li et al., *Medicare Advantage Ratings and Voluntary Disenrollment Among Patients with End-Stage Renal Disease*, Health Affs., Jan. 2018, at 70 (dialysis patients).

2. Aetna MAP Denies Payment for Necessary Care and Imposes Prior Authorization Requirements

To further cut costs, Aetna MAP, like all MA plans, will predictably require that patients (and their physicians) obtain prior authorizations for certain treatments or will outright deny payment for treatment already rendered.[10] Such denials—which

[10] The City argues that Aetna agreed to waive "approximately 85% of procedures to which Aetna had applied this requirement." City's Br. 17. But that does not remedy the issue. First, this

by definition involve an insurer (typically, by an employee who is not a physician[11]) evaluating and at times overruling the professional judgment of a licensed physician—result in the systematic denial of necessary medical care to patients. That is the conclusion reached in reports issued by two Inspectors General at the Department of Health and Human Services. Their review of MA plans' decisions to deny prior authorizations found that 13 percent of all denials were incorrect under applicable coverage rules, and that the same patients would have received the requested medical services under Traditional Medicare. Christi A. Grimm, HHS OIG Report OEI-09-18-00260, *Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to*

waiver does not address the systemic problem of improper denials of payment catalogued by the Inspector General separate from the prior authorization requirements. Grimm, *infra*, at 12. Second, notwithstanding that waiver, which could be revoked in two years when Aetna's contract with the City is next up, the City admits that prior authorizations will still be required for a wide variety of medical services, including "non-emergency inpatient hospital stays, rehabilitation facility stays or long-term acute facility stays, and skilled nursing facility care, as well as certain services/items, like cosmetic procedures; certain Part B and Part D drugs, new drugs, therapies, and technologies; and experimental and investigational procedures." Memorandum of Law in Opposition to Petitioners' Motion for a Preliminary Injunction at 31-32, *Bentkowski v. City of New York*, Index No. 154962/2023, NYSCEF 90 (Sup. Ct. June 16, 2023). And Aetna fails to describe exactly which services would be subject to prior authorization and what criteria would guide decisions to deny authorizations and payment.

[11] *See* Ani Turner et al., *Impacts of Prior Authorization on Health Care Costs and Quality*, Nat'l Inst. for Health Care Reform at 5 (Nov. 2019), https://www.nihcr.org/wp-content/uploads/Altarum-Prior-Authorization-Review-November-2019.pdf; Sara Berg, *What Doctors Wish Patients Knew About Prior Authorization*, Am. Med. Ass'n (Sept. 11, 2023), https://www.ama-assn.org/practice-management/prior-authorization/what-doctors-wish-patients-knew-about-prior-authorization ("Oftentimes, the person evaluating the prior authorization requests at the health plan is not a physician and hasn't even heard of the disease the patient has or the treatment the physician is recommending[.]").

Medically Necessary Care at 9 (Apr. 2022). The Inspector General concluded that the rate at which MA plans unlawfully and outright deny payment for services is even higher—18 percent of all payment denials are erroneous, which, over the course of a year, adds up to millions of wrongfully denied payments across all MA plans. *Id.* at 12. The high rate at which insurers erroneously deny patients care is further demonstrated by the fact that when patients and physicians appeal a denial of a prior authorization or of a payment, the insurer loses the appeal *75 percent of the time*. Daniel R. Levinson, HHS OIG Report OEI-09-16-00410, *Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials* at 7 (Sept. 2018). But because only a small fraction of patients know about their right to appeal a denial and use that right, MA plans continue to wrongfully deny care. *See id.*

These wrongful denials of care pose a "'serious threat' to the health and safety of Medicare beneficiaries." *Id.* at 13. The data shows that patients with prior authorization requirements receive much less necessary healthcare. *See* Michael Anne Kyle & Nancy L. Keating, *Prior Authorization and Association with Delayed or Discontinued Prescription Fills*, J. Clinical Oncology (Dec. 12, 2023). But Aetna MAP, like all MA plans, will surely continue to deny care because the basic structure of Medicare Advantage gives "an incentive to deny preauthorization of services for beneficiaries, and payments to providers, in order to increase profits." Levinson,

supra, at 17; *see also* Grimm, *supra*, at 2, 20 (similarly concluding that the capitation model, i.e., paying a flat fee for each patient, creates an "incentive for insurers to deny access to services and payment in an attempt to increase profits").

The City asserts that Aetna MAP's prior authorization requirements are not burdensome because Traditional Medicare implemented a limited set of prior authorization requirements in 2020. City's Br. 17 (citing R-2618, 4388-89). This is a false equivalence. Starting in 2020, Traditional Medicare for the first time subjected a very small list of procedures that are typically only cosmetic in nature (but which can, in some circumstances, have a therapeutic benefit) to a prior authorization requirement, such as blepharoplasty (which improves the appearance of eyelids), Botox, and rhinoplasty. Ctrs. for Medicare & Medicaid Servs., *Final List of Outpatient Department Services That Require Prior Authorization*.[12] There is no comparison between these limited requirements and the vast prior authorization requirements under Aetna MAP. And there is no evidence of a similarly systemic problem under Traditional Medicare. *See* R-2618 ("Senior Care . . . has virtually no prior authorization hurdles."); Alex Cottrill, *What to Know about the Medicare Open Enrollment Period and Medicare Coverage Options*, Kaiser Fam. Found. (Sept. 18,

[12] https://www.cms.gov/files/document/opd-services-require-prior-authorization.pdf.

2023) ("[P]rior authorization is rarely required in traditional Medicare and only applies to a limited set of services.").[13]

Fundamentally, Aetna MAP will impose prior authorization requirements because they achieve their intended effect—costs go down, profits go up, and patients receive less healthcare.

3. Aetna MAP Limits the Network of Providers

The final way Aetna MAP will foreseeably cut costs is by requiring retirees to obtain care only from a restricted network of physicians. Under Traditional Medicare, the City's retirees currently enjoy the broadest network of providers available in the country, accepted by 99 percent of non-pediatric physicians. Nancy Ochieng & Gabrielle Clerveau, *How Many Physicians Have Opted Out of the Medicare Program?*, Kaiser Fam. Found. (Sept. 11, 2023).[14] But the network available under MA plans like Aetna MAP is more restrictive. *See* R-2617 ("More than a few major hospitals will not participate in the MAP causing further disruption in care."). With fewer providers to choose from, retirees will visit a physician less often and may pay out-of-pocket to see a higher quality provider. Alicia Atwood & Anthony T. Lo Sasso, *The Effect of Narrow Provider Networks on Health Care Use*,

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[13] https://www.kff.org/medicare/issue-brief/what-to-know-about-the-medicare-open-enrollment-period-and-medicare-coverage-options/.

[14] https://www.kff.org/medicare/issue-brief/how-many-physicians-have-opted-out-of-the-medicare-program/.

50 J. Health Econs. 86, 93 (2016); David J. Meyers et al., *Narrow Primary Care Networks in Medicare Advantage*, 37 J. Gen. Internal Med. 488, 488 (2022) ("While setting narrow networks may help a plan control costs, MA enrollees are more likely to receive care from lower quality providers compared to TM, which may be driven in part by network design.").

In particular, a peer-reviewed study of coverage in New York State found significant restrictions on MA plans' networks and that plans fared especially poorly in covering services by the "highest quality providers" who achieved the best results for patients. Simon F. Haeder, *A Tale of Two Programs: Access to High Quality Providers for Medicare Advantage and Affordable Care Act Beneficiaries in New York State*, 11 World Med. & Health Pol'y 212, 221, 226 (2019). Insurers' representations of their MA plans' networks are often deceptive. For example, an investigation by the Senate Finance Committee concluded that MA plans create the appearance of robust provider networks by listing in their directory providers who are not actually in-network for that patient or who are not currently taking new patients. U.S. Senate Finance Committee, *Deceptive Marketing Practices Flourish in Medicare Advantage* at 9 (Nov. 2022).

C. Aetna MAP's "Extra Benefits" Are a Red Herring

The City cannot explain how retirees will get the same care with only a fraction of the funding under Aetna MAP, so it instead claims that Aetna MAP

includes benefits not covered by Traditional Medicare. City's Br. 16. Aetna and the City have been notably vague as to the exact benefits that will be offered, referring usually to "transportation, fitness programs, and wellness incentives" (but not dental care). R-141; *see* Br. for *Amicus Curiae* Aetna Life Insurance Co. at 8, NYSCEF 21. This decision to market Aetna MAP based on vague extra benefits like transportation and gym membership comes right out of the widely criticized MA playbook. Eleanor J. Bader, *Medicare Advantage Plans Disadvantage Many Elderly and Disabled People*, Truthout (Dec. 4, 2023).[15]

Pursuant to that playbook, MA plans (which are objectively worse in the respects noted above) repeatedly emphasize these supposed perks, which are "tailored toward relatively healthy beneficiaries" who use less healthcare. MedPAC, *supra*, at 426. But after patients lock themselves into an MA plan, they often realize (too late) that the reality of their extra benefits does not match what they were promised—for example, routine eye exams but not lenses or coverage for vision treatments. *See* Meredith Freed et al., *Medicare Advantage 2023 Spotlight: First Look*, Kaiser Fam. Found. (Nov. 10, 2022) ("Plans are not required to report data

[15] https://truthout.org/articles/medicare-advantage-plans-disadvantage-many-elderly-and-disabled-people/.

about utilization of these benefits or associated costs, so it is not clear the extent to which supplemental benefits are used by enrollees.").[16]

Moreover, when MA plans offer extra benefits—whether Aetna's fitness program or more traditional vision or dental care—they are almost universally meager and come nowhere close to making up for other deficiencies of MA plans. A study by the GAO of nearly 4,000 MA plans found that the median MA plan spent only $27 per month on all extra benefits combined, with $11 of that spent on dental benefits (which Aetna MAP apparently will not offer City retirees), $3 spent on vision care, and just $1 spent on hearing care. GAO-23-105527, *Medicare Advantage: Plans Generally Offered Some Supplemental Benefits, But CMS Has Limited Data on Utilization* at 18-19 (Jan. 2023). And MA plans spent just $2 per month on transportation (some form of which Aetna MAP will offer) and $10 on all other extra benefits combined (including fitness and wellness programs of the type that Aetna MAP will offer). *Id.* at 19.

Whatever the details of the extra benefits that Aetna MAP will offer here, they would not be offered out of Aetna's generosity. Nor would Aetna receive additional federal funding to offer them. *See* David J. Meyers et al., *Addressing Social Needs Through Medicare Advantage Plans' Supplemental Benefits—A Potential Not Yet*

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[16] https://www.kff.org/medicare/issue-brief/medicare-advantage-2023-spotlight-first-look/.

Realized, JAMA Network Open (Oct. 2022). Instead, the spending on those extra benefits would directly trade off with spending on the most needed healthcare services, and that trade-off would be especially hard felt for the City's retirees because, as explained, the pie of funding under Aetna MAP is already much smaller than what retirees currently enjoy under Traditional Medicare plus Senior Care. *See* Grace McCormack & Erin Trish, *Trends in the Level and Composition of Supplemental Benefits in Medicare Advantage*, 1 Health Affs. Scholar 1, 3-4 (2023) ("MA plans are spending fewer dollars relative to traditional Medicare on medical benefits covered by Parts A and B and are, instead, funneling increasing dollars into supplemental benefits and beneficiary cost reductions that are not covered by traditional Medicare. . . . MA plans have become less generous in terms of important financial protection benefits—out-of-pocket spending maximums, inpatient costsharing, and Part D deductibles.").

II. AETNA MAP WILL IMPERIL RETIREES' HEALTH, HARM PHYSICIANS, AND UNDERMINE THE PROVISION OF HEALTHCARE IN NEW YORK

The difference between retirees' current healthcare coverage under Traditional Medicare plus Senior Care and Aetna MAP is not merely an economic dispute. Rather, the City's switch to Aetna MAP will also be borne out in worse health outcomes for retirees who devoted their careers to the City—many of whom

are cared for by PNHP's physician members. The burdens of forcing Aetna MAP on retirees will also extend beyond individual patients to their physicians.

A. Aetna MAP Will Harm Retirees' Health and Impose Racially and Economically Disparate Effects

Decades of experience with MA plans make clear that Aetna MAP's restrictions on care have real stakes for patients' health. The Inspector General's report on erroneous denials of care by MA plans contains example after example of how prior authorization requirements and denials of payment harm patients. In one case, a 74-year-old cancer patient's radiation therapy was delayed because the MA plan refused to pay for care until after the patient's physician appealed the denial and submitted a screenshot showing that the physician had already requested and received a prior authorization. Grimm, *supra*, at 14. In another case, an MA plan refused to pay $112 for a walker that a patient needed to move around, citing the (legally improper) basis that the patient had received a walking cane several years earlier. *Id.* at 10. And in yet more cases, MA plans delayed patients' treatments by overriding physicians' professional judgment and imposing arbitrary prerequisites, such as requiring an x-ray before paying for an MRI (potentially endangering the patient's use of their hand), *id.* at 15, or requiring that a patient with an adrenal lesion wait an entire year before receiving an MRI (even as the lesion was potentially malignant), *id.* at 10.

Even when a patient or physician successfully appeals a denial of care, patients can "suffer negative health consequences" during the delay in treatment caused by insurers' bureaucracy. *Id.* at 9. These delays impose mental anguish on patients and their loved ones. One City resident with Medicare Advantage publicly recounted the last six months of his wife's life as she simultaneously battled brain cancer and her insurer's repeated denials of care prescribed by her physician. David Newman, *Reject the Cruelty of Medicare Advantage, NYC*, N.Y. Daily News (June 16, 2022).[17] Even as her condition worsened, the MA plan concluded that a rehabilitation facility was "medically unjustified" (a decision that it eventually reversed), and later determined that she was not yet ill enough to justify paying for hospice care, a decision that was reversed only after the direct intervention of a member of Congress. *Id.*

Because MA plans are more likely to deny care on the front-end, patients on MA plan are also more likely to let medical conditions fester until they become serious problems that require admittance to the emergency room. For example, compared to patients on Traditional Medicare, MA patients on average are admitted to the emergency room in worse health, require more expensive treatment when admitted, and are more often discharged home rather than to post-acute care. Curto

[17] https://www.nydailynews.com/opinion/ny-oped-cruelty-medicare-advantage-20220616-dzlccpynvbhl3mofkprbsm3kza-story.html.

et al., *supra*, at 329 (finding evidence that MA plans' cost-saving mechanisms "constrain patient entry into care, particularly expensive care, so that the average person using that care in MA is in worse health, and has higher cost than the average person using that care in TM").

That research is corroborated by the experiences of physicians: In a 2022 survey, nearly all physicians (94 percent) reported that prior authorization requirements lead to care delays, four out of five reported that medical treatments had been abandoned because of prior authorization requirements, one in three reported that prior authorizations had led to a serious adverse event for a patient, and a staggering one in four physicians reported that a patient's hospitalization had been caused by prior authorization requirements. Am. Med. Ass'n, *2022 AMA Prior Authorization (PA) Physician Survey* (2023).[18]

These harms stemming from the switch to Aetna MAP would fall disproportionately on the economically vulnerable and people of color.[19] Denials of treatment are felt most acutely by patients that do not otherwise have the means to pay for their treatment. *See* Grimm, *supra*, at 9. Because economic vulnerability often falls along racial and ethnic lines, it is "well established that Black, Hispanic,

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[18] https://www.ama-assn.org/system/files/prior-authorization-survey.pdf.

[19] These groups make up the majority of New York City's retiree population. *Aging with Dignity: A Blueprint for Serving NYC's Growing Senior Population*, N.Y.C. Comptroller (Mar. 21, 2017), https://comptroller.nyc.gov/reports/aging-with-dignity-a-blueprint-for-serving-nycs-growing-senior-population/.

and Asian enrollees experience poorer outcomes in the MA program than white enrollees" experience. Meyers et al., *supra*, at 489. Studies that compare Black and Hispanic patients on Medicare Advantage to those on Traditional Medicare find that the patients on Medicare Advantage have higher rates of hospitalizations and report more problems affording medical care. Sungchul Park et al., *Racial Disparities in Avoidable Hospitalizations in Traditional Medicare and Medicare Advantage*, 59 Med. Care 989 (2021); Jenna Pelly, *Medicare Advantage Shortcomings Threaten Access to Quality and Timely Healthcare for Beneficiaries*, Geo. Pub. Pol'y Rev. (Apr. 6, 2023).[20]

B. Aetna MAP Will Harm Physicians

The additional requirements imposed by Aetna MAP will burden not only patients but also physicians, for whom prior authorization requirements and payment denials mean large amounts of paperwork, extended back-and-forth communications with insurers, and repeated justifications for the medical care they have prescribed to their patients. Independent investigations have found that satisfying Aetna MAP's prior authorization requirements and payment requirements create "avoidable delays and extra steps create friction in the program and may create an administrative burden for beneficiaries, providers, and [Medicare Advantage Organizations]."

[20] https://gppreview.com/2023/04/06/medicare-advantage-shortcomings-threaten-access-to-quality-and-timely-healthcare-for-beneficiaries/.

Grimm, *supra*, at 18, 20. In part because of MA plans' growing list of requirements, physicians on average complete 45 prior authorizations per week, which occupies almost two weekdays every week. *2022 AMA Prior Authorization (PA) Physician Survey*, *supra*. Consequently, 88 percent of physicians report "high" or "extremely high" burdens imposed by prior authorizations. *Id.*

A growing body of research links these administrative burdens imposed by MA plans like Aetna MAP—and the repeated experience of watching insurers override expert medical opinion and deny patients necessary medical care—to intensifying burnout among physicians. *See, e.g.*, Wendy Dean et al., *Reframing Clinician Distress: Moral Injury Not Burnout*, 36 Fed. Prac. 400, 401 (2019); Off. of the Surgeon Gen., *Addressing Health Worker Burnout* at 8, 39-40 (2022); Sandhya K. Rao et al., *The Impact of Administrative Burden on Academic Physicians: Results of a Hospital-Wide Physician Survey*, 92 Acad. Med. 237, 239-40 (2017). Many physicians now use the term "moral injury" to describe "the challenge of simultaneously knowing what care patients need but being unable to provide it due to constraints that are beyond our control." Dean et al., *supra*, at 401.

PNHP's physician members have experienced these dynamics first-hand and they have spoken publicly about it for years. Three cofounders and members of PNHP explained in the American Journal of Medicine that key features of MA plans—including prior authorization and network restrictions—are "important

contributors to burnout" and lead to "more medical errors and physicians leaving practice." Nancy C. Greep et al., *Physician Burnout: Fix the Doctor or Fix the System?*, 135 Am. J. Med. 416, 416 (2022). Another PNHP member wrote from experience in attributing the crisis of moral injury among physicians to "the extra hours of unpaid work required to fight insurance company denials so that their patients can get the care they prescribe." Peter Gann, *Guest Essay*, Evanston Round Table (Oct. 30, 2023);[21] *see also* Tanya Albert Henry, *Want to Help Physicians Battle Burnout? Fix Prior Authorization*, Am. Med. Ass'n (Nov. 27, 2023) ("'The lack of transparency, the process itself, its overutilization, and often being denied by someone without the expertise of the patient's physician—those are really important aspects that lead to burnout,' Dr. [Marilyn] Heine said. 'It feels like Sisyphus every day.'").[22]

It is clear, therefore, that "[a] major contributor to [this] burnout is the subversion of physician independence"—as explained by yet another PNHP physician—and employers' transitions to MA plans "can only exacerbate current trends leading to burnout." Don McCanne, *Comment: Physician Burnout Is a Public*

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[21] https://evanstonroundtable.com/2023/10/30/guest-essay-its-halloween-season-and-medicare-advantage-is-coming-as-a-vampire/.

[22] https://www.ama-assn.org/practice-management/prior-authorization/want-help-physicians-battle-burnout-fix-prior-authorization.

Health Crisis, Ethicist Says, Physicians for a Nat'l Health Program (Mar. 4, 2016).[23] Because, in the end, money will win out; MA plans' "profit-driven corporations will likely never put the interests of the public above those of their shareholders." Cheryl Kunis, *'Medicarelessness' Revisited After 50 Years*, MedPage Today (Nov. 27, 2023).[24] Physicians, and their patients, are left to pay the consequences of the City's decision to force its retirees to Aetna MAP.

C. The Effects of Aetna MAP Will Undermine the City's Healthcare System

The fallout of physicians' growing feelings of moral injury does not end when individual doctors leave the profession as a result of the burnout. The consequences are much broader—these feelings of burnout risk exacerbating a looming shortage of physicians and, as a consequence, the reliable provision of healthcare in New York City. *See* Eyal Press, *The Moral Crisis of America's Doctors*, N.Y. Times (June 15, 2023);[25] Ass'n of Am. Med. Colls., *The Complexities of Physician Supply and Demand: Projections From 2019 to 2034* at 1 (June 2021).[26] As one study found, the number of physicians lost to burnout alone between 2011 and 2014 equated to losing the entire graduating class of seven medical schools combined. Tait D.

[23] https://pnhp.org/news/macra-and-the-ethics-of-physician-burnout/.

[24] https://www.medpagetoday.com/opinion/second-opinions/107537.

[25] https://www.nytimes.com/2023/06/15/magazine/doctors-moral-crises.html.

[26] https://www.aamc.org/media/54681/download.

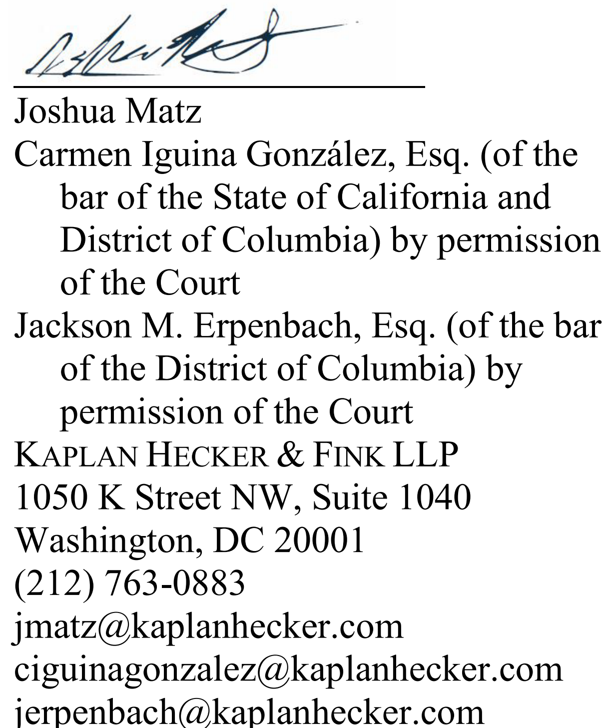
Shanafelt et al., *Potential Impact of Burnout on the US Physician Workforce*, 91 Mayo Clinic Proc. 1667, 1668 (2016). Rather than help to address this "societal imperative," *id.*, the City's switch to Aeta MAP threatens only to exacerbate a healthcare crisis in New York.

CONCLUSION

For the above reasons, *amicus curiae* PNHP supports Plaintiffs-Respondents' request that the Court affirm the order of the Supreme Court, New York County.

Dated: January 24, 2024
Washington, DC

Respectfully submitted,



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