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Administrator Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Comment on Request for Information: Medicare Advantage Program - file code CMS-4203-NC

Dear Administrator Brooks-LaSure,

Medicare Advantage is a program offering private health insurance plans as options to replace traditional Medicare. Medicare Advantage plans differ from traditional Medicare in that they are paid with capitation (per member), they are required to limit enrollees' out-of-pocket spending and can offer extra benefits (e.g. gym membership, dental benefits), they almost always offer prescription drug coverage, they use a defined and often restricted network of providers and can require enrollees to pay more for out-of-network care, they can use utilization management techniques such as prior authorization, and they can fund special programs such as rewards for beneficiaries to encourage healthy behaviors. The hope is that these differences will lead to improved care at lower cost compared to traditional Medicare.

However, capitation has serious drawbacks and introduces perverse incentives to skimp on care, game risk pools, and upcode. Payment with unadjusted capitation based on average cost would grossly overpay for the healthy and even more grossly under-pay for the sick. Capitation therefore requires risk adjustment and quality incentives to mitigate its inherent incentives to worsen disparities in care. Risk adjustment and quality incentives in turn require detailed data on diagnoses and treatment, adding administrative costs and burdens that exceed those required by fee-for-service (FFS).[1,2]

Capitation is justified by the common assertion that FFS incentivizes excessive "volume" (over-use) of care and that this can be corrected by shifting insurance risk onto providers of care. However, the four key assumptions – that there is widespread overuse of care due to FFS, that capitation carries improved incentives compared to FFS, that risk adjustment can be done accurately, and that the overhead cost of capitation is worth it to achieve more cost-sensitive care – are all contradicted by the evidence. There is very little evidence for the claim that "volume" of services with FFS payment, as opposed to their price, explains the high cost of health care in the US.[3,4,5] It appears demonization of FFS in health policy is mainly a rationale promoted by the insurance industry to justify a central role for themselves in health care, because unlike FFS, capitation requires their capacity to handle the data demands of risk management. But the overhead required for capitation far exceeds savings from the incentive to reduce care, so patients get less care, Medicare pays more, and intermediary insurers take home large profits.

And risk adjustment cannot be done anywhere near accurately enough to avoid over-paying for the healthy and under-paying for the sick. Gaming of risk pools means capturing a population of members or beneficiaries (risk pool) with lower-than-average health risk while getting paid for an average risk pool, so as to profit from the difference. MA plans use marketing tactics[6] (including variations in coverage and contracting with employers to directly enroll newly Medicare eligible retirees) that attract healthier beneficiaries, and they employ multiple tactics to deny care to the sick, including narrow networks, formulary restrictions, and prior authorization. Sicker enrollees, such as in the last year of life, who have been frustrated by denial or delay of services tend to disenroll and return to the traditional Medicare program.[7] The effect of both marketing tactics ("cherry-picking") and disenrollment of sicker beneficiaries ("lemon-dropping") is to create for Medicare Advantage plans a healthier and less costly than average risk pool.[8,9]

CMS added diagnostic categories to the HCC risk adjustment formula in 2004. This improved its predictive accuracy from 1% to only 12%,[10] but linked payment to diagnosis and introduced a major new opportunity for gaming: up-coding. Up-coding means choosing more specific or severe (and more highly paid) diagnosis codes than would be required for purely patient care purposes, and fraudulently adding irrelevant or non-existent diagnoses. Up-coding has been extensively exploited by Medicare Advantage plans since soon after diagnoses were added to the HCC, apparently often to the point of fraud[11,12]. According to one expert estimate, the cost to Medicare of aggressive diagnostic coding by Medicare Advantage plans and the failure of CMS to correct for it will reach several hundred billion dollars in coming years.[13]

Medicare Advantage plans have achieved profitability largely by gaming their risk pools, up-coding, and blunt restrictions on care including issuing millions of inappropriate denials for care that met Medicare coverage rules,[14] and minimally if at all by improving care. [15,16] Typical administrative costs for Medicare Advantage plans, including profits, have been in the 15-20% range[1,17], compared to around 2% for Traditional Medicare prior to the Affordable Care Act.[2]

It would be far more cost-effective for CMS to improve traditional Medicare by capping out-of-pocket costs and adding improved benefits within the Medicare fee-for-service system than to try to indirectly offer these improvements through private plans that require much higher overhead and introduce profiteers and perverse incentives into Medicare, enabling corporate fraud and abuse, raising cost to the Medicare Trust Fund, and worsening disparities in care.

These problems are not correctable within the competitive insurance business model, and the Medicare Advantage program should be terminated.

Sincerely,

Susan Rogers, M.D.
President, Physicians for a National Health Program

References:

[1] McDermott D, Stolyar, L, Hinton E, et. al. Health Insurer Financial Performance in 2020. *Kaiser Family Foundation* May 3, 2021. https://www.kff.org/private-insurance/issue-brief/health-insurer-financial-performance-in-2020/

[2] 2012 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. April 23, 2012.

[3] Health at a Glance 2019. OECD Indicators: Number of doctor consultations per person. Hospital discharge rates, 2000 and 2017.

[4] Deborah Korenstein et al., Overuse of health care services in the United States: an understudied problem, *Archives of Internal Med* 2012 doi:10.1001/archinternmed.2011.772).

[5] Katz MH. Overuse of health care: Where are the data? 2012;172:178. doi:10.1001/archinternmed.2011.1253)

[6] Gilfillan R, Berwick DM. Medicare Advantage, Direct Contracting, and The Medicare 'Money Machine,' Part 1: The Risk-Score Game. *Health Affairs Blog*. Sept. 29, 2021 10.1377/forefront.20210927.6239

[7] Meyers DJ, Belanger E, Joyce N, McHugh J, Rahman M, Mor V, Analysis of drivers of disenrollment and plan switching among Medicare Advantage beneficiaries, *JAMA Intern Med.* 2019;179(4):524–532. doi:10.1001/jamainternmed.2018.7639

[8] Brown, J., M. Duggan, I. Kuziemko, et al. 2011. How does risk selection respond to risk adjustment? Evidence from the Medicare Advantage program. *NBER working paper 16977*. Cambridge, MA: National Bureau of Economic Research. DOI 10.3386/w16977.

[9] Neuman P, Jacobson GA, Medicare Advantage Checkup, *N Engl J Med* 2018; 379:2163-2172 DOI: 10.1056/NEJMhpr1804089

[10] June 2014 Report to the Congress: Medicare and the Health Care Delivery System. *MedPAC* June 13, 2014.

[11] Schulte F. Researcher: Medicare Advantage Plans Costing Billions More Than They Should. *Kaiser Health News*. Nov. 11, 2021.

[12] Hiltzik M. The government lawsuit against Kaiser points to a massive fraud problem in Medicare. *Los Angeles Times*. August 4, 2021.

[13] Kronick R. Projected Coding Intensity In Medicare Advantage Could Increase Medicare Spending By $200 Billion Over Ten Years *Health Affairs* 36, no.2 (2017):320-327 doi: 10.1377/hlthaff.2016.0768

[14] Grimm, Christi A, Inspector General. Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care. OIG Report OEI-09-18-00260 https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf

[15] Park S, Jung J. Burke RE et al. Trends in Use of Low-Value Care in Traditional Fee-for-Service Medicare and Medicare Advantage. *JAMA Network Open.* 2021;4(3):e211762. doi:10.1001/jamanetworkopen.2021.1762

[16] Figueroa JF, Wadhera RK, Frakt AB, et al. Quality of Care and Outcomes Among Medicare Advantage vs Fee-for-Service Medicare Patients Hospitalized With Heart Failure. *JAMA Cardiol.* Published online September 02, 2020. doi:10.1001/jamacardio.2020.3638

[17] Day B, Himmelstein DU, Broder M, Woolhandler S. The Affordable Care Act and Medical Loss Ratios: No Impact in First Three Years. *Int J Health Svcs* 2015:45(1);127-131. http://org.salsalabs.com/o/307/images/JOH45_1_DayArticle(1).pdf