
PHYSICIANS FOR A NATIONAL HEALTH PROGRAM

OUR
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Quantifying Overpayments in the Medicare Advantage Program

Published October 4, 2023

OVERPAID BY BILLIONS

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By our estimate, and based on 2022 spending, **Medicare Advantage overcharges taxpayers by a minimum of 22% or \$88 billion per year, and potentially by up to 35% or \$140 billion. By comparison, Part B premiums in 2022 totaled approximately \$131 billion, and overall federal spending on Part D drug benefits cost approximately \$126 billion.** Either of these—or other crucial aspects of Medicare—could be funded entirely by eliminating overcharges in the Medicare Advantage program.

Medicare Advantage, also known as MA or Medicare Part C, is a privately administered insurance program that uses a capitated payment structure, as opposed to the fee-for-service (FFS) structure of Traditional Medicare or TM. Instead of paying directly for the health care of beneficiaries, the federal government gives a lump sum of money to a third party (generally a commercial insurer) to “manage” patient care.

Although private insurers have been involved in one form or another since the early days of Medicare, it is only since the establishment of Medicare Advantage in the Medicare Modernization Act of 2003 that such participation has grown significantly. **Since 2007, the share of beneficiaries enrolled in MA has nearly tripled, and the program now manages the care of more than half of all eligible beneficiaries.** (1)

Proponents of managed care have long maintained that programs like MA reduce expenditures, improve quality of care, and enable consumer choice. **The reality is just the opposite.** 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 Traditional Medicare. (2) Despite this additional spending, MedPAC could not say conclusively whether care outcomes fared better under MA. (3) And while patients in Traditional Medicare have access to nearly all doctors and hospitals across the country (4), those in MA must contend with heavily limited networks (5) and arcane prior authorization procedures, calling into question which “choices” consumers are ultimately able to make.

These are all serious issues, but this report will deal chiefly with the first problem: overcharging in Medicare Advantage. Various elements of MA, either by design or by consequence, result in a much higher level of government spending than is necessary to provide Medicare benefits, with much of this money going toward corporate profits. Instead of creating a more efficient system of care, large corporations have used MA as their cash cow, taking billions in taxpayer dollars while using a plethora of tactics to delay or deny treatment for patients.

In this paper, we will discuss the various methods by which MA is grossly overpaid for the care and services it provides to beneficiaries. We will attempt to estimate at least in a preliminary manner the magnitude of these overpayments in each case. It is worth noting that much of this is shrouded in mystery because the relevant data is unavailable to researchers or difficult to measure. (6) What is clear, however, is that the privatization of Medicare is for the benefit of private insurers. Patients, the government, and the American taxpayer are simply left to pick up the tab.

FAVORABLE SELECTION

MA enrollees have less expensive health needs than their TM counterparts, but MA insurers are paid as though all Medicare enrollee health needs are the same.

Payments to MA plans rely heavily on comparisons made to beneficiaries in Traditional Medicare. In this system, Medicare sets a “benchmark,” which equals a certain percentage of the average level of spending for a beneficiary in Traditional Medicare within a given county. This benchmark can vary from 95% of the average in counties with the highest spending, to 115% in counties with the lowest spending. (7) MA plans then submit a “bid” that represents their estimation of total costs to cover all Medicare benefits for an average beneficiary in the county (this includes money allocated to administrative overhead and profit for the insurer). These bids are multiplied by a risk adjustment score based on a combination of demographic and diagnostic factors. If MA plans bid below the benchmark, they are allowed to keep approximately two-thirds of the difference, which is used to reduce cost-sharing for enrollees or improve benefits. (8)

The primary problem here is that this process assumes that after risk adjustment, average spending for patients in MA is more or less the same as average spending for patients in Traditional Medicare. **This is not the case.** MA plans benefit from “favorable selection,” where the beneficiaries who join MA plans are generally healthier and therefore less costly. A 2019 study by KFF compared the spending levels of two groups of beneficiaries who both started in Traditional Medicare. One group stayed in the program, and the other moved to MA. Compared to the group that stayed, the group that moved to MA cost on average \$1,253 per year less while in Traditional Medicare, a 13% difference in spending. Even beneficiaries with chronic conditions requiring additional care, if they moved to MA, were found to have cost over \$1,000 less than their counterparts who remained in Traditional Medicare. Most concerning, these figures were found *after* using a risk adjustment model very similar to Medicare’s own, making clear that the adjustment process inadequately addresses this issue. (9)

Many other studies have come to a similar conclusion. MedPAC’s June 2023 report to Congress estimated that favorable selection across the entire MA population resulted in a level of spending approximately 11% lower than for Traditional Medicare beneficiaries with the same risk score in 2019. (10) MA beneficiaries were found to have had lower levels of spending for multiple years prior to entering their MA plan, and the effects of favorable selection persisted for years after they joined one. (11) Another study by the USC Schaeffer Center estimated overpayments from favorable selection to be even higher at 14%, an effect which again was apparent even after the application of risk adjustment. (12)

There are several factors that potentially contribute to this phenomenon. Patients who are sicker and thus have more complicated care needs may be turned off by limited networks, the use of prior authorizations, and other care denial strategies in MA plans. (13) By contrast, healthier patients may feel less concerned about restrictions on care and more attracted to common features of MA plans like \$0 premiums and additional benefits (e.g. dental and vision coverage,

gym memberships, etc.). Insurers can also use strategies such as targeted advertising to reach the patients most favorable to their profit margins. Risk adjustment in MA as it stands is not capable of fixing these issues. In fact, one study published in the *American Economic Review* suggested that insurers respond to risk adjustment simply by switching from seeking out the cheapest patients overall to seeking out the cheapest patients who have conditions included in the adjustment model. (14)

Whatever the reasons for the difference in spending, the problem is that MA plans are paid as though their enrollees have the same health needs and require the same levels of spending as their Traditional Medicare counterparts when this is very clearly untrue. This results in a level of overpayment that is **anywhere from 11-14%, or about \$44-56 billion per year** based on total MA spending for 2022.

FAVORABLE DESELECTION

Both high-need patients and dual-eligible patients switched from MA to TM at higher rates compared to other patients.

As mentioned previously, there is evidence that besides healthier and less costly individuals moving into MA, less healthy and more costly individuals are moving out of MA. We could term this “favorable deselection,” which would have the same type of effect on payments. A 2019 study in JAMA Internal Medicine found that both high-need patients (those with several chronic conditions) as well as dual-eligible patients (those who qualify for both Medicare and Medicaid due to lower income) switched from MA to Traditional Medicare at higher rates compared to other patients. (15) These findings were echoed in an earlier study conducted in 2015, which found that patients in high-cost services like nursing homes and home health care tended to switch from MA to Traditional Medicare at higher rates than the reverse. (16)

MedPAC has no official estimate of the overall effects of favorable deselection on overpayment, nor does any study we are currently aware of. It is likely to be much smaller in magnitude than the effect of favorable selection, but without firmer data it is difficult to quantify and is therefore not included in our summary analysis.

UPCODING

Risk scores create an incentive for insurers to game patient diagnoses for profit; the average risk score in MA was 20% higher than it would have been in TM.

Upcoding refers to the adding of diagnoses to patient charts that are either false or, more commonly, irrelevant to treatment. It is probably the best known of the issues with Medicare Advantage payments: Congress has mandated since 2010 that Medicare reduce risk scores to account for overpayments caused by differences in coding intensity between MA and Traditional Medicare. (17) More recently, upcoding was the subject of a bombshell article in *The New York Times* which examined the methods by which various insurers allegedly recorded spurious diagnoses to collect more money from Medicare. (18) Bipartisan legislation has been proposed in Congress to fix the issue, and the Biden administration recently instituted new rules designed to strengthen audits of MA plans and recover overpayments when they occur. (19)

How exactly does upcoding work? Patients in MA are given a risk score related to their diagnosed conditions, which is used as a multiplier for the amount of money Medicare capitates to the MA insurer to manage their care. The more diagnosed conditions and the more severe each condition that appears on a patient's chart, the more money the insurer will receive from Medicare, creating an incentive for insurers to add diagnoses or inflate their severity regardless of their relevance or current status.

This diagnosis-based risk adjustment formula, known as the Hierarchical Condition Categories (HCC), was ironically created to solve the previously described issue of favorable selection. However, it only accounts for 11-13% of the variability in spending on individuals, so it cannot meaningfully prevent favorable selection, and its presence creates the opportunity to profit from upcoding. (20) When providers are paid via FFS as in Traditional Medicare, there is no need for risk adjustment or tying payment to diagnosis, and thus no ability to profit from upcoding.

The magnitude of difference between the risk score of patients in MA and Traditional Medicare is astounding. Although CMS uses a 5.9% coding intensity adjustment across the board, in 2019, **the average risk score in MA was 20% higher than it would have been in Traditional Medicare.** (21) In addition, average MA risk scores are growing by roughly 2% each year, making this adjustment more and more worthless as time passes. (22) According to MedPAC, the cumulative effect of an uncorrected difference in risk scores of 4.9% accounted for \$17 billion in excess payments to MA in 2021, **which is close to 5% of total payments for that year.** (23) As a percentage of MA spending in 2022, this would be about \$20 billion.

BENCHMARKS & BONUSES

County Benchmarks and Quality Bonuses generate excess payments to MA plans that are largely unconnected to any measurable need, or to any improvements in care.

These two policies were introduced to MA as part of the Affordable Care Act. The first policy, county benchmarks, was described earlier in this report; benchmarks in counties are set at 4 quartiles that can vary from 95% to 115% of the average level of spending for a Traditional Medicare beneficiary in that county. The counties with the lowest Traditional Medicare spending get the highest benchmark adjustments, and the counties with the highest spending get the lowest benchmark adjustments. This is done so that counties with low spending attract plans with the promise of a higher rebate, while counties with high spending have some of that spending offset. (24)

The main issue with the county benchmark system is that the level set for the areas with the lowest spending is higher than necessary to attract plans. Bids from MA insurers have decreased in these areas such that most plans now bid below 100% of Traditional Medicare spending, but still enjoy a benchmark set at 115%. (25) With higher and higher shares of MA enrollees living in areas with higher county benchmarks, the net effect of this policy is to increase MA overpayment with no difference in care or savings.

Quality bonuses are based on the star-rating system used ostensibly to measure the quality of MA plan care. Benchmarks are increased by 5% or even 10% for plans that have a rating of 4 or more stars. New plans receive an automatic 3.5% bonus to their benchmark as well. (26) Unfortunately, the star-rating system is highly flawed, as quality in MA is difficult to measure and the methods used to do so suffer from limited data, flawed sampling, and score inflation. (27) As a result, the average rating of plans in MA in 2023 is 4.15, and more than half of contracts are rated 4 stars or higher. (28) The effect of this is, yet again, a large sum of excess payments to MA that is largely unconnected to any measurable improvements in care. (29)

MedPAC estimates that the cumulative effect of these policies amounts to an extra 7-8% in overall benchmarks for MA. (30) While we cannot translate benchmarks directly to payments because of the bidding system, another MedPAC analysis from January 2023 stated that quality bonuses accounted for at least \$15 billion in MA payments. In 2022, payments to MA totaled \$403 billion, which would mean that at least 4% of payments came from the quality bonus program. If we assume that with rebates the extra 7-8% in benchmarks resulted in an extra 6-7% in overall payments, and 4% of that was from quality bonuses, then 2-3% came from the county benchmark system. **Quality bonuses and county benchmarks together thus constitute 6-7% in excess payments to MA**, which for 2022 spending amounts to \$24-28 billion.

INDUCED UTILIZATION

Higher benchmarks from induced utilization creates a situation where taxpayers are subsidizing supplemental coverage for MA.

One more potential source of Medicare overpayment results from differences in spending for those with Medigap and other supplemental coverage policies, and how these differences affect the benchmark setting process. While Medicare covers a large percentage of health care costs, it doesn't cover everything. For the payments that are left to beneficiaries, many purchase what is called a Medigap policy which provides supplemental coverage. Other beneficiaries may receive supplemental coverage through their employer or because they are dually eligible for Medicaid.

The term "Induced utilization" from an article by Richard Gilfillan and Donald Berwick refers to the idea that people with supplemental coverage are likely to use more health care because their insurance pays for more of their cost, removing some of the financial barriers to accessing health services. (31) This is borne out by research from MedPAC that shows that Traditional Medicare spending was higher for beneficiaries with Medigap or employer-sponsored supplemental coverage. (32) Follow-up studies have shown similar results.

As has been explained previously, MA benchmarks are set based on the average spending for beneficiaries in Traditional Medicare. The problem here is that this average spending figure is derived from both beneficiaries with and without supplemental coverage. Why is this an issue? Consider this: If benchmarks took into account only the spending of those without supplemental coverage, then benchmarks across the board would be lower. Thus, the difference between benchmarks and bids would decrease, and MA would not appear to save as much money. But because those with supplemental coverage are included, a substantial portion of the difference between the bid and the benchmark comes not from any additional cost savings (as the bid hasn't changed), but simply because some beneficiaries in the benchmark population have supplemental coverage that allows them to spend greater amounts.

Whether or not this is an issue or a true case of overpayment comes down to whether or not it is appropriate to include the spending levels of beneficiaries with supplemental coverage in the benchmark calculation. To the extent that the benchmark measures the cost to Medicare if the MA beneficiary were in Traditional Medicare, including those with supplemental coverage provides a realistic picture of that population, as many beneficiaries do indeed have such coverage. However, this effectively creates a situation where **taxpayers are subsidizing supplemental coverage for MA**. One could consider this an unfair advantage for MA over Traditional Medicare, and thus consider the higher benchmarks from induced utilization to be a source of overpayments. In this case, given the difference described in Gilfillan and Berwick's article, the average rebate amount from induced utilization would be approximately \$108 per beneficiary per month. Applying that rate to all beneficiaries in MA in 2022 would result in an overpayment of approximately \$36 billion, or approximately 9% of total payments in that year.

CONCLUSION

The deep structural problems with our health care system will only be fixed when we achieve improved Medicare for All.

All told, the percentage of excess payments in MA accounting for all of the discussed factors excluding induced utilization amounts to anywhere from 22-26%. In 2022, this would be \$88-104 billion. With induced utilization, the overpayment amount increases to 31-35%, or \$124-\$140 billion in 2022. It's worth noting that these estimates are also compounded by the money MA insurers save by consistently delaying and denying necessary medical care. Insurers have been found to inappropriately deny claims that would have been covered under Traditional Medicare, and even use algorithms to determine the exact point at which payment for care can be cut off for a patient regardless of their needs. (33) Medical loss ratio requirements also do little to stop profiteering, as insurers can simply game these regulations by misrepresenting business expenses and even profit as clinical spending. These practices may not result in extra charges, but they nonetheless represent another of the many ways that MA puts profits over patients.

To put the sheer magnitude of overcharging in MA in perspective, a CBO analysis of a 2019 bill proposing to add dental, hearing, and vision benefits to Medicare estimated that in the most expensive year of its implementation, these benefits would cost a combined \$84 billion. (34) **Even by our minimum estimate, private insurers receive more than enough surplus money to provide critically needed benefits to all Medicare beneficiaries.** This is unconscionable, unsustainable, and in our current health care system, unremarkable.

Medicare Advantage is just another example of the endless greed of the insurance industry poisoning American health care, siphoning money from vulnerable patients while delaying and denying necessary and often life-saving treatment. While there is obvious reason to fix these issues in MA and to expand Traditional Medicare for the sake of all beneficiaries, the deep structural problems with our health care system will only be fixed when we achieve improved Medicare for All.

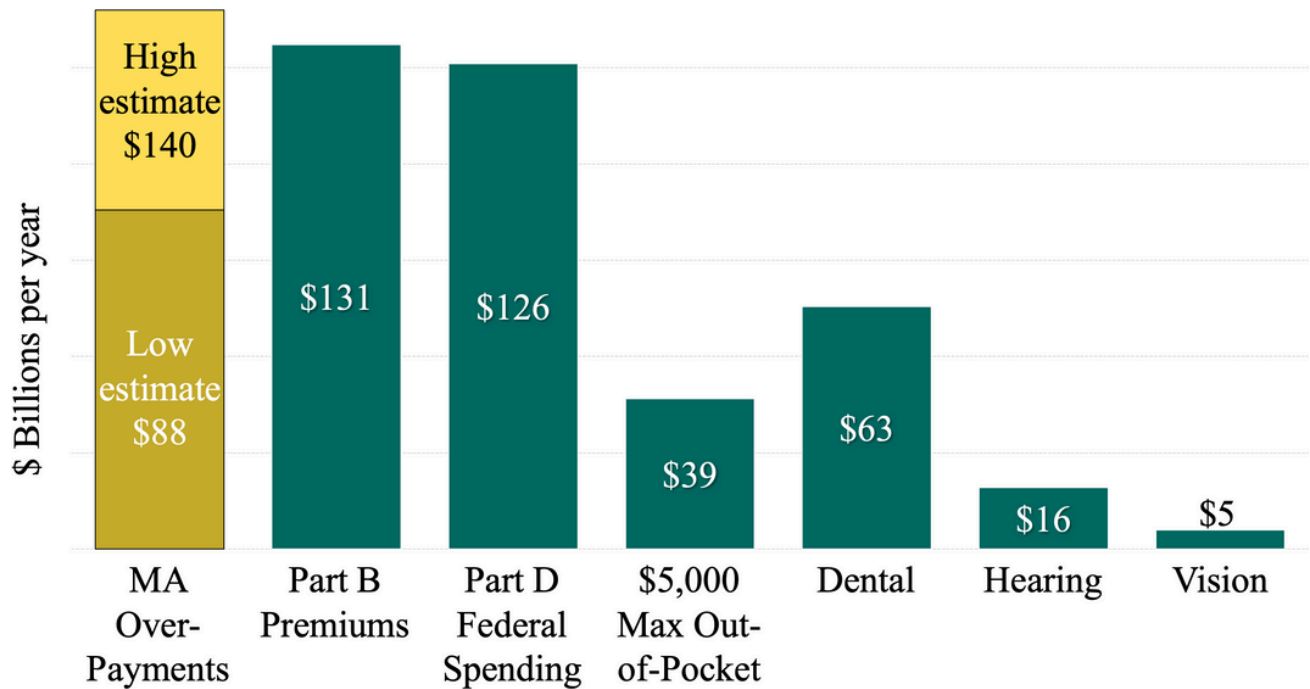
APPENDIX

Fig. 1 - Summary Table of Overpayment Sources

Source	Percentage of Overpayment	Amount in \$ per year (based on 2022 MA spending)
Favorable Selection	11-14%	44-56 billion
Upcoding	5%	20 billion
County Benchmarks and Quality Bonuses	6-7%	24-28 billion
Subtotal	22-26%	88-104 billion
Induced Utilization	9%	36 billion
Total (Including Induced Utilization)	31-35%	124-140 billion

APPENDIX

Fig. 2 - Medicare Advantage overpayments contrasted with the cost of improvements to the Traditional Medicare program (34-36)



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