The Daily Dish

Behind the MA Headlines

DOUGLAS HOLTZ-EAKIN | JULY 10, 2024

The Wall Street Journal ran an eyebrow-raising story about overpayments to Medicare Advantage (MA) plans under the headline "Insurers Pocketed $50 Billion From Medicare for Diseases No Doctor Treated." At the heart of the story is the claim that "Private insurers involved in the government's Medicare Advantage program made hundreds of thousands of questionable diagnoses that triggered extra taxpayer-funded payments from 2018 to 2021."

MA was born from the 2003 law that created the Part D prescription drug program. It is an alternative to the traditional fee-for-service program and offers a comprehensive insurance policy – including Part D if desired – for beneficiaries. It has grown increasingly popular and now covers more than one-half of all Medicare beneficiaries. Mechanically, the MA plan gets a fixed amount – the senior's premium plus a federal subsidy – and must cover all the medical expenses. If a beneficiary has extensive medical needs, those costs can be quite high, so there is an incentive to avoid expensive patients, not something you want in a health insurance program.

To avoid this incentive, the subsidies are "risk-adjusted." Sicker patients get bigger subsidies, so MA plans have no reason to avoid covering them. Risk adjustment is quite technical, tedious, data-intensive, and absolutely essential to the operation of the Medicare program. To do it, however, requires knowing the medical needs of beneficiaries. One strategy is to wait until problems arise, the beneficiary sees a provider, and the condition becomes known. But this raises the possibility that the person was not adequately risk-rated at the start of the year. Alternatively, the individual could be given an examination, his or her needs documented, and the risk-adjustment put in place. This has the advantage of providing an incentive for the MA plan to undertake preventive efforts – because they have the funds – and avoid the more expensive acute care.

All of this is utterly non-controversial. The essence of the article's claim is that some of the diagnoses were wrong or even flatly fraudulent. It is impossible for Eakinomics to know and

evaluate this claim. But the implication is that insurers were paid too much for certain patients. As it turns out, the phenomenon has a name – the improper payment rate – and the Centers for Medicare and Medicaid Services (CMS) has an extensive program to measure improper payments. In 2023, the MA gross improper payment rate was 6.01 percent, while the net (of underpayments) improper payment rate was 4.6 percent. The upshot was $12.8 billion in overpayments for MA.

That sounds bad. But what's the alternative? Actually, the alternative is literally the traditional fee-for-service Medicare system and in 2023 it had an improper payment rate of 7.4 percent, leading to $31.2 billion in overpayments. When viewed from that perspective, MA continues to look like an improvement to the Medicare system.

Improper payments are only one dimension where the fee-for-service system gets a free pass from examination and MA gets a microscope. MA has a quality measurement program; no attempt is made to judge the quality of outcomes in traditional Medicare. MA plans face competitive pressure from a bidding system; fee-for-service gets its prices fixed by CMS.

Medicare reforms are an essential part of putting the federal fiscal house in order. The balance between fee-for-service and MA will be central to those reforms. Going forward, it is past due to stop the free pass for traditional Medicare and put both programs on the same regime for administrative efficiency, quality of outcomes, and competitive pressures.