VIEWPOINT

Less Care at Higher Cost—The Medicare Advantage Paradox

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Invited Commentary

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Celebrating a Medicare Advantage (MA) milestone—enrollment in those private plans surpassed 30 million—the health insurance industry's trade group proclaimed MA "a good deal for members and taxpayers."[1] The first part of that claim is debatable, while the second part is false. Medicare Payment Advisory Commission (MedPAC), the nonpartisan agency reporting to Congress, recently estimated that MA overpayments added $82 billion to taxpayers' costs for Medicare in 2023 and $612 billion between 2007 and 2024.[2]

Two insurer strategies drive MA overpayments: diagnosis upcoding and avoiding enrollees who are ill and do not contribute to profits. The Centers for Medicare & Medicaid Services (CMS) pays MA plans using a complex risk-adjustment formula incorporating the diagnoses plans report. Hence, insurers can boost revenues by inflating the number and severity of each enrollee's diagnoses. A wave of MA upcoding after CMS introduced risk-adjusted payments in 2004 triggered Congress to instruct the agency to apply an automatic deflator, currently 5.9%. Yet according to MedPAC, upcoding (relative to the diagnoses coded for comparable fee-for-service [FFS] Medicare beneficiaries) is far larger, generating net overpayments of 13% last year.[2]

Before MA payments were adjusted for diagnoses, MA insurers used a cruder profit-boosting strategy: avoid the expensively ill, so-called favorable selection. In that era, private plans cherry-picked healthier than average older adults and managed to chase away ("lemon drop") those requiring expensive care.

Many assumed that paying plans more for enrollees with more serious illnesses would curtail cherry-picking and lemon-dropping. But in its 2012 report, MedPAC voiced concern that plans could game diagnosis-based risk adjustment by recruiting enrollees who were inexpensive for their risk score, noting that among Medicare enrollees diagnosed with congestive heart failure, costs for the 5% of enrollees with the most severe illness were 322-fold higher than for the healthiest 5%—providing fertile ground for cherry-picking conditional on diagnosis and thus risk score. Early analyses confirmed that MA plans were selectively enrolling beneficiaries who used less health care services than their diagnosis list implied—insurers had shifted from preferring any healthy older adult to preferring older adults likely to be inexpensive for their risk score.[3]

Although some experts held out hope that refinements to risk adjustments instituted in 2007 largely eliminated such gaming, a June 2023 MedPAC analysis confirmed that MA insurers have been soundly beating CMS in the cat-and-mouse game over cherry-picking.[4] That analysis focused on prior-year costs and risk scores of beneficiaries switching from FFS Medicare to MA compared with those staying in FFS Medicare. Before switching, new MA enrollees had incurred below-average Medicare costs (after adjustment for their risk scores), a pattern consistently present since 2008, ie, MA plans were selectively enrolling Medicare beneficiaries who were inexpensive for their risk scores. Moreover, among those who had switched to MA, enrollees associated with higher costs were more likely to switch back to FFS Medicare. This depleted the pool of patients who were expensive for their risk score and remained in MA—plans were lemon-dropping.

Some mechanisms underlying favorable selection are obvious; others remain trade secrets. Although MA insurers must accept all applicants in counties where they offer a plan, they are also free to withdraw from counties where they are accumulating unprofitable enrollees. Offering free fitness club memberships attracts healthier beneficiaries who are less expensive. Tailoring health care networks to exclude clinicians and health care centers (eg, psychiatrists and specialized cancer centers) needed by patients associated with high costs encourages them to avoid MA, or to "voluntarily" switch to FFS Medicare, in which almost all clinicians and health care centers are in network. Similarly, placing expensive medications into drug tiers with high copayments (or coinsurance) repels MA enrollees who are potentially unprofitable. Prior authorization requirements, which are rare in FFS Medicare, serve 2 functions: constraining the use of expensive care and hassling patients (and their physicians) who most need it.

Whatever the mechanisms that MA plans use to implement favorable selection, they generate large overpayments, which, according to MedPAC, are "separate" from and "additive"[4] to the overpayments due to upcoding. Together, upcoding and favorable selection created MA overpayments of 23%.[2]

Paradoxically, despite those overpayments, MA plans spend 9% less on medical services than FFS Medicare spends for comparable enrollees.[5] Most MA plans offer helpful supplementary benefits, for example, eyeglasses, some dental coverage, and reduced Part D (and occasionally Part B) premiums and out-of-pocket costs. But their savings from managed-care techniques, including network restrictions, prior authorization requirements, and financial incentives for health care centers and clinicians to curtail expensive care, more than offset MA plans' extra spending for supplementary benefits. Unfortunately, MA's managed-care techniques reduce both high-value and low-value services, that is, MA is a "blunt instrument for reducing health care utilization."[5] But even blunt instruments can inflict harm, especially on vulnerable patients. Although, according to MedPAC's 2023 annual report, data limitations preclude drawing conclusions about MA's effect on overall quality of care, MA enrollees requiring complex cancer surgeries are less likely to be treated at specialized cen-

ters, experience longer delays and higher mortality than beneficiaries in FFS Medicare.[6]

If MA plans pay for less care, where do the overpayments go? Some pay for supplementary benefits, although plans do not disclose how much they spend on them, and MA enrollees do not get significantly more dental care or incur lower out-of-pocket dental costs than those in FFS Medicare.[7] Instead, overhead and profit eats up the lion's share.

Only 2% of FFS Medicare expenditures go for overhead. But MA insurers incur extra expenses for television advertisements, health care network management, benefit design, executive salaries, health care utilization review, prior authorization, and shareholder profits, driving their overhead up to 14% (just below the limit set by the Affordable Care Act) according to a report from Milliman on financial results for 2022.[8] Based on annual CMS payments to MA plans, the Government Accountability Office estimates of overhead's share in 2006 and 2011 (applied to CMS' 2007-2010 and 2011-2014 payments, respectively), and Milliman estimates applied to subsequent years' payments, MA overhead for 2007 to 2024 totals $592 billion—equivalent to 97% of taxpayers' $612 billion overpayments to them during that period.

MA's overhead is mostly the price of their profits. A minority goes for profit; most funds the bureaucracy needed to upcode, cherry-pick, and erect barriers to high-value care.

Could MA be reformed to make it a better deal for taxpayers? The failure of past efforts to rein in MA gaming and overpayment does not bode well for incremental reforms like tweaking the payment formula. Moreover, payment reductions would not curtail administrative waste or administrative burdens on physicians, or ease access for patients.

We think the time has come to declare MA a failed experiment and abolish it. That would allow redeploying the $88 billion taxpayers will overpay MA this year to upgrade benefits for all Medicare beneficiaries.[2] But we recognize that even with that infusion of funds, constraints on low-value (and particularly no-value) care in Medicare might still be needed, and appropriate; no insurer should pay for harmful or useless treatments. And Medicare should have a preferred formulary covering all beneficiaries; when multiple equally safe and effective drugs are available, the least expensive should be the default option, with opportunities for off-formulary coverage when clinical needs (eg, allergies) dictate. However, coverage decisions should be driven by science, not corporate bottom lines, and they should be implemented fairly, consistently, and transparently—something that, by nearly all accounts, MA plans fail to do. Moreover, health care network limitations are not necessary; free choice of hospital and physician is something all Canadians already have. Medicare beneficiaries should too.

A smarter, thriftier way to expand benefits and lower out-of-pocket costs is possible for all Medicare beneficiaries, but first, we must eliminate MA and double down on traditional Medicare, covering all enrollees in an expanded and improved Medicare program. That would be a good deal for patients and taxpayers.

ARTICLE INFORMATION

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