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Federal Audit Finds Three Insurers Overcharged the Medicare Program

In separate audit reports of three health plans owned by Humana, Aetna and EmblemHealth, the federal Department of Health and Human Services' (HHS) Office of Inspector General (OIG) has found the insurance companies overcharged the Medicare program in order to receive higher payments under the Medicare Advantage (MA) risk adjustment program.

While the total amount of overpayments across all three companies is estimated at approximately $145 million, HHS regulations limit the amount the agency can recoup. Thus, OIG recommends refunds of just $11.6 million.

The audits are a part of an OIG strategy released a year ago, which is intended to better hold Medicare Advantage plans accountable for their practices. At the time, OIG expressed its concern about risk adjustment payments and that plans might game the system by making enrollees appear sicker than they are to receive a higher risk adjustment payment, a practice commonly known as "upcoding."

Under the risk adjustment program, the Centers for Medicare & Medicaid Services (CMS) makes higher payments for enrollees who receive a diagnosis that maps to certain condition categories. To determine if a higher payment is warranted, CMS relies on the Medicare Advantage organizations to submit diagnosis codes to CMS. CMS makes higher payments for enrollees who receive diagnoses that map to certain condition categories.

In its audits, OIG found that risk scores for 67% of the sampled enrollees for EmblemHealth were incorrect, the majority of which were invalid because the medical records did not support the diagnosis code submitted for the risk adjustment payment. For Humana, medical records did not support the diagnosis, or the company could not locate the medical record for 84% of the OIG sample, and for HealthAssurance, in 83% of the instances reviewed by OIG, the diagnoses were not supported by the medical records.

In its March 2024 report to Congress, the Medicare Payment Advisory Commission (MedPAC) projected that Medicare Advantage risk scores would be about 20% higher than scores for similar fee-for-service (FFS) beneficiaries. By law, CMS reduces all MA risk scores by the same amount to make them more consistent with traditional FFS Medicare coding. Even after this adjustment, MA risk scores are projected to remain about 13% higher than they would have been if MA enrollees had been enrolled in traditional FFS Medicare. In 2024, MedPAC indicates that higher scores will result in a projected $50 billion in higher payments to MA plans.

Also in its 2024 report, MedPAC indicated that Medicare spends an estimated 22%, or $83 billion, more for MA enrollees than it would spend if those beneficiaries were enrolled in FFS Medicare. Although MedPAC suggests that a portion of these increased payments to MA plans may be due to more generous supplemental benefits and better financial protection for MA enrollees, the Commission expressed concern that the higher payments to MA plans result in higher premiums for all beneficiaries.

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