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“UPCODING” PROBLEM EXACERBATES OVERPAYMENTS TO MEDICARE ADVANTAGE PLANS

Administration Action and House Health Reform Bill Seek to Address Problem

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Private plans were brought into Medicare on the theory that they could deliver Medicare services at lower cost. However, the Medicare Payment Advisory Commission (MedPAC) — Congress’s expert advisory body on Medicare payment policy — has found that Medicare pays private plans 14 percent more than it costs to treat the same beneficiaries in the traditional Medicare program. These overpayments threaten Medicare’s finances and increase the premiums that participants in traditional Medicare pay.

As a result, MedPAC has recommended for a number of years that Congress “level the playing field” by paying private plans no more than it costs to cover the same beneficiaries in traditional Medicare. Another approach, proposed by President Obama in his budget released on February 26, would establish a competitive bidding system by which private plans would submit bids that would be used to determine plan payments. The Obama Administration proposal is intended to have the same effect as the MedPAC recommendation in eliminating the overpayments to Medicare Advantage plans.

It is not widely understood, however, that private plans would likely still be overpaid even if Congress enacted legislation to “level the playing field.” This is because of a phenomenon called “upcoding” (or “coding creep”). Private plans report regularly to Medicare on the health status of

KEY FINDINGS

- Many Medicare beneficiaries receive coverage through private “Medicare Advantage” plans rather than traditional Medicare. In many cases, however, the diagnosis codes that private plans assign to their enrollees to report their health status make the enrollees appear less healthy than they actually are. This problem is known as “upcoding.”
- Because Medicare pays the private plans more to cover sicker enrollees than healthier ones, upcoding causes Medicare to overpay the plans.
- Another, larger source of overpayments is that Medicare pays the private plans more than it would cost traditional Medicare to treat beneficiaries with the same reported health status. But even if Congress addresses that issue, as outside experts and some policymakers favor, overpayments will continue unless upcoding is also addressed, since payments will continue to be based on inaccurate information about enrollees’ health status.
- The Obama Administration has begun addressing upcoding by announcing it will adjust Medicare payments to private plans in 2010 to offset the effects of upcoding. The House health reform bill proposes to address upcoding on an ongoing basis thereafter. These are important steps to improving payment accuracy, reducing unnecessary Medicare spending, and ensuring financial neutrality between traditional Medicare and Medicare Advantage.

their enrollees, by assigning diagnosis codes to the enrollees. “Upcoding” or “coding creep” refers to unexplained changes plans make over time in the diagnosis codes they assign that make their enrollees appear less healthy than they actually are. Upcoding helps private plans financially by inflating the payments that Medicare makes to them.

Medicare “risk adjusts” its monthly capitated payments to private plans to reflect the reported health status — and hence, the expected health care costs — of plan enrollees. (Enrollees in private plans are healthier, on average, and thus less costly to treat than beneficiaries in traditional Medicare.) Upcoding undermines the risk-adjustment process, which depends on an accurate comparison of the relative health of enrollees in private plans and in traditional Medicare. Until upcoding is addressed, private plans will continue to receive overpayments even if Congress enacts MedPAC’s recommendation to equalize payments for comparable beneficiaries, because the private plan beneficiaries’ *actual* health status will be better than their *reported* health status.

In 2006, as part of the Deficit Reduction Act (DRA), Congress sought to address the problem of upcoding by requiring the Centers for Medicare and Medicaid Services (CMS) to take upcoding into account in setting Medicare payments to private plans for the 2008-2010 period. Unfortunately, the Bush Administration failed to implement this provision, despite CMS and Congressional Budget Office (CBO) findings of growing evidence of upcoding.

On April 6, the Obama Administration acted to end this failure to comply with the Deficit Reduction Act by acting administratively to adjust Medicare Advantage payments for upcoding in 2010.¹ The House Tri-Committee health reform bill includes a provision that would require CMS to adjust Medicare Advantage payments for upcoding problems on a permanent basis beyond the limited 2008-2010 period specified in the DRA. These actions constitute sound first steps toward ensuring that the risk adjustment system used for Medicare Advantage accurately reflects the degree to which private plan enrollees are healthier, on average, than those in traditional Medicare, so that unnecessary federal spending can be avoided.

Overpayments Raise Medicare Premiums and Weaken Medicare’s Finances

Medicare Advantage provides health care coverage to Medicare beneficiaries through private health plans as an alternative to the traditional Medicare fee-for-service program. Private plans were brought into Medicare to introduce competition and reduce costs, but MedPAC’s findings show they have actually cost the program much more money. MedPAC recently estimated that in 2009, Medicare will pay the private plans 14 percent more per beneficiary than it would cost to cover these beneficiaries in traditional Medicare.² The Commonwealth Fund estimates that the overpayments average over \$1,100 for each beneficiary enrolled in a private plan.³

By increasing Medicare costs, the overpayments drive up premiums for beneficiaries in traditional Medicare even though these beneficiaries receive no extra coverage in return. The chief actuary at

¹ Centers for Medicare and Medicaid Services (CMS), “Announcement of Calendar Year (CY) 2010 for Medicare Advantage (MA) Capitation Rates and Medicare Advantage and Part D Payment Policies,” April 6, 2009.

² Medicare Payment Advisory Commission, “Report to the Congress: Medicare Payment Policy,” March 2009.

³ Brian Biles, Jonah Pozen, and Stuart Guterman, “The Continuing Cost of Privatization: Extra Payments to Medicare Advantage Plans Jump to \$11.4 Billion in 2009,” The Commonwealth Fund, May 4, 2009.

the Centers for Medicare and Medicaid Services (CMS) has reported that the overpayments now raise premiums by \$3.60 per month per person (or \$86 a year for a couple).⁴

The overpayments also weaken Medicare's long-term finances. They advance by 17 months the date when the Medicare Hospital Insurance Trust Fund will become insolvent,⁵ and they ultimately will require larger benefit cuts and/or tax increases than otherwise would be needed to restore long-term solvency to the program.

For a number of years, MedPAC has called on Congress to rein in the excessive payments to private plans and has recommended several specific reforms. In 2008, Congress adopted one of these recommendations, phasing out double payments to Medicare Advantage for the costs of indirect medical education.⁶ This, along with other provisions that would slow the rate of enrollment growth in private fee-for-service plans (the type of Medicare Advantage plan with some of the largest overpayments), will save an estimated \$12.5 billion over five years (2009-2013) and \$47.5 billion over ten years (2009-2018), according to the Congressional Budget Office (CBO).

But Congress has yet to adopt the largest of MedPAC's proposed reforms, which would equalize payments between private plans and traditional Medicare for covering comparable beneficiaries. The House Tri-Committee health reform bill includes a provision that would "level the playing field" over three years, which CBO has estimated would save \$156 billion over ten years (2010-2019).⁷ The "competitive bidding" proposal that President Obama has included in his budget is intended to have a similar effect, by requiring plans to submit competitive bids, with plan payments based on the average bid, weighted by enrollment.⁸ CBO estimates that competitive bidding would save more than \$176 billion over ten years (2010-2019).⁹

These proposals represent important reforms. But to truly create a level playing field between traditional Medicare and private plans, Medicare must also be able to take beneficiaries' health status and expected health costs into account *accurately* in computing its payment levels to private plans. And as explained below, if the "upcoding" problem is not properly addressed, overpayments to private plans are likely to continue.

⁴ Rick Foster, "Letter to Pete Stark on Medicare Advantage and the Hospital Insurance Trust Fund Solvency," Centers for Medicare and Medicaid Services, Office of the Actuary, June 25, 2009.

⁵ See Foster, *op cit*.

⁶ The double payments occurred because Medicare Advantage rates included medical education (IME) payments, even though Medicare was already making separate payments for indirect medical education to teaching hospitals treating Medicare enrollees, including those in Medicare Advantage. Most of the cost savings cited in this paragraph can be attributed to the IME provision. See Congressional Budget Office, "Cost Estimate for H.R. 6331, Medicare Improvements for Patients and Providers Act of 2008," July 23, 2008.

⁷ Congressional Budget Office, "Preliminary Analysis of the America's Affordable Health Choices Act of 2009," July 17, 2009.

⁸ For an analysis of whether competitive bidding would be as effective in lowering Medicare Advantage payments as a proposal to set payments as 100 percent of traditional Medicare costs, see Brian Biles, Jonah Pozen, and Stuart Guterman, "Paying Medicare Advantage by Competitive Bidding: How Much Competition is There?," The Commonwealth Fund, August 12, 2009.

⁹ Congressional Budget Office, "CBO Estimate of Spending Provisions in the President's Budget Proposal for a Health Reform Reserve Fund," March 24, 2009.

The Medicare Advantage Risk Adjustment System

Medicare pays private plans a monthly capitated fee for each member enrolled, regardless of the amount or type of health care services the member actually uses. Medicare adjusts these payments through a mechanism known as risk adjustment, which is supposed to factor in enrollees' relative health status (as well as other characteristics) and thus their expected health costs. Plans receive larger payments for enrollee groups that, on average, are in poorer health and thus are more costly to treat; the plans receive smaller payments for healthier, less costly enrollees.

In theory, risk adjustment ensures that plans are paid fairly and do not benefit from “cherry picking,” or disproportionately enrolling the healthiest individuals. In practice, it is an imperfect tool. As CBO has explained, “current risk-adjustment systems tend to overpredict the costs of beneficiaries who end up with low health care spending and to underpredict the costs of those who end up with high spending.”¹⁰ Nevertheless, an effective system of risk adjustment is critically important for Medicare, given the rapid growth in enrollment in private plans and their continued tendency to attract healthier beneficiaries.¹¹

When private plans were first introduced into Medicare, the program's risk-adjustment process was rudimentary: payments were adjusted based only on demographic factors such as age and sex, which alone are poor predictors of individuals' health care costs. Consequently, private plans — which attracted healthier-than-average enrollees — were paid as if they were serving the *average* Medicare beneficiary of a given age and sex. This resulted in overpayments to private plans of as much as 16 percent, even though Medicare's payments to the plans were officially fixed at 95 percent of the cost of traditional Medicare.¹²

In 2000, CMS gradually began implementing a more accurate risk-adjustment system that also incorporated enrollees' predicted health status. Under this new system, each enrollee is assigned a “risk score” — a measure of health status based on the diagnosis codes that providers assign to their patients, as reported in Medicare claims. (The lower the risk score, the healthier the beneficiary.) The risk score is used to adjust the payment that plans receive, so that plans are paid more for beneficiaries with higher risk scores and less for those with lower risk scores.

The new risk adjustment system was phased in over a seven-year period, becoming fully effective in 2007.¹³ Although this system is a vast improvement over the previous system and is considered the state of the art in risk adjustment, researchers from the Commonwealth Fund have concluded

¹⁰ Congressional Budget Office, “Designing a Premium Support System for Medicare,” December 2006.

¹¹ See, for example, Medicare Payment Advisory Commission, “Report to the Congress: Promoting Greater Efficiency in Medicare,” June 2007.

¹² General Accounting Office, “Medicare Managed Care: Better Risk Adjustment Expected to Reduce Excess Payments Overall While Making Them Fairer to Individual Plans,” February 1999. See also June Gibbs Brown, “Adequacy of Medicare's Managed Care Payments After the Balanced Budget Act of 1997,” Office of Inspector General, U.S. Department of Health and Human Services, September 18, 2000; General Accounting Office, “Medicare Managed Care: HMO Rates, Other Factors Create Uneven Availability of Benefits, May 1997; and General Accounting Office, “Medicare Managed Care: Growing Enrollment Adds Urgency to Fixing HMO Payment Problem,” November 1995.

¹³ At the same time that CMS began to implement the new risk-adjustment system, it instituted a “hold harmless” policy that increased aggregate payments to private plans to offset the downward payment that resulted from risk adjustment. Thus, aggregate payments to plans were not affected by the phased implementation of the new health-based risk adjustment system. The hold harmless payments will be fully phased out after 2010.

that “risk adjustment is difficult and imperfect.”¹⁴ CBO and leading experts in the field also have acknowledged that no risk adjustment system has yet been developed that fully captures all differences in health status.¹⁵

Upcoding Undermines Risk Adjustment

The Medicare risk adjustment system’s ability to correct for the better overall health status of Medicare Advantage enrollees is further weakened by the fact that enrollees’ health status may not be measured accurately. This problem is known as “upcoding” or “coding creep” — a common phenomenon whereby Medicare Advantage enrollees may be intentionally or unintentionally assigned diagnosis codes that make them appear less healthy than they actually are. If it occurs, upcoding can undermine risk adjustment by allowing private plans to receive higher payments than is warranted for enrolling beneficiaries who, on average, are healthier than beneficiaries in traditional fee-for-service Medicare.

The risk that upcoding poses is not unique to Medicare Advantage. It has been a common occurrence among payments to providers in the traditional Medicare program. Diagnosis codes are associated with different levels of payment for hospitals; for example, in traditional Medicare, hospitals are reimbursed more than twice as much per admission for cases of “respiratory infections and inflammations” as for “pneumonia without complications.” In one example of upcoding in traditional fee-for-service Medicare, when Medicare implemented a new way of paying for inpatient hospital care called the Prospective Payment System, the number of patients assigned diagnosis codes that yield higher payments increased significantly.¹⁶ A RAND study found that much of this increase reflected changes in documentation and coding practices that were *not* related to changes in patients’ health status or care needs.¹⁷ As a result, payments to hospitals increased more than was warranted.¹⁸

Upcoding has similarly been an issue in traditional Medicare’s home health benefit as well. In reviewing data from 2000-2003, CMS found an increase in patients being categorized as needing higher levels of care, but did *not* find a corresponding change in patients’ underlying health status or in the average amount of home health care resources used to treat them. CMS concluded that some of the changes in how patients were categorized likely reflected upcoding. Further analyses revealed

¹⁴ Cathy Schoen, Karen Davis and Sara Collins, “Building Blocks for Reform: Achieving Universal Coverage with Private and Public Group Health Insurance,” *Health Affairs*, May/June 2008

¹⁵ See Thomas Rice and Katherine Desmond, “The Distributional Consequences of a Medicare Premium Support Proposal,” *Journal of Health Politics, Policy, and Law*, December 2004; and Congressional Budget Office, “Designing a Premium Support System for Medicare,” *op cit*.

¹⁶ In the Prospective Payment System, which applies to hospital payments in the traditional Medicare program, each case is assigned a code that has a payment amount associated with it. This amount is generally based on the expected relative costs of treating patients with particular diagnoses during a hospital stay, and does not change based on the number or type of services that are actually provided (though hospitals may be eligible for additional “outlier” payments in certain cases). Therefore, hospitals are generally paid a predetermined amount for each patient admission based on the patient’s diagnosis.

¹⁷ Grace Carter and Paul Ginsberg, “The Medicare Case-Mix Index Increase: Medical Practice Changes, Aging and DRG Creep,” RAND Corporation, June 1985.

¹⁸ To some extent, the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services) had already anticipated changes in coding that would lead to patients being assigned higher paying diagnosis codes, but the degree of upcoding was much greater than anticipated.

that since 2000, the observed case mix — an indicator of the characteristics of the beneficiaries being served by home health agencies, such as age, gender, and health status — increased by roughly 13 percent. However, more than 90 percent of this increase was a result of changes in documentation and coding practices rather than changes in patients' medical needs.¹⁹

Government Studies Find Evidence of Upcoding in Medicare Advantage

There is increasing evidence that upcoding is now undermining the risk adjustment system used to determine Medicare Advantage payments.

In one study, CBO found that between 2003 and 2004, the average risk score for enrollees in private plans increased significantly relative to the traditional Medicare program. In 2003, risk scores for private plan enrollees were 12 percent lower than risk scores for fee-for-service beneficiaries; in 2004, this difference was reduced by half — to 6 percent — despite no apparent change in the makeup of Medicare Advantage enrollees.

While CBO could not directly attribute this change to upcoding, it warned that the change could be evidence that private plans are now conducting diagnosis coding in a substantially different way than traditional Medicare does. This would prevent Medicare from accurately measuring the relative health status of enrollees for purposes of determining risk-adjusted payments to private plans.²⁰

CMS, too, has found evidence of upcoding in Medicare Advantage. In 2001 and 2002, it reviewed the medical records of 171 enrollees in private plans and examined whether the medical documentation supported the diagnosis codes they had been assigned. CMS found that *one-third* of the diagnosis codes were inappropriately assigned; a significant proportion of these were upcoded.²¹

In a later study, CMS analyzed data from 2004-2006 to determine whether there were any differences in coding between enrollees in private plans and in traditional Medicare. CMS focused on beneficiaries who were consistently enrolled in either FFS or Medicare Advantage (a group known as “stayers”). It found that among this population, risk scores for the enrollees in private plans increased *more than twice as much* over this period as risk scores for enrollees in traditional Medicare did.²² CMS found that about half of the difference in risk score growth was unexplained and thus could be attributed to upcoding, rather than to normal variations in enrollment or demographic characteristics between Medicare Advantage beneficiaries and those in traditional Medicare. CMS noted that while it was conceivable that private plan beneficiaries were simply getting sicker at a much faster rate than beneficiaries in traditional Medicare, with that causing the differential growth in risk scores, it would be “unreasonable” to believe this was, in fact, occurring

¹⁹ See Federal Register Vol. 72, No. 86, pages 25356-25481, May 4, 2007, and Federal Register, Vol. 72, No. 167, pages 49763-49945, August 29, 2007.

²⁰ Congressional Budget Office, “Designing a Premium Support System for Medicare,” *op cit*.

²¹ Centers for Medicare and Medicaid Services, “Medicare Advantage Risk Adjustment Data Validation CMS-HCC Pilot Study: Report to Medicare Advantage Organizations,” July 24, 2004.

²² Medicare Advantage risk scores rose 4.5 percent per year as compared to two percent per year in FFS. See Centers for Medicare and Medicaid Services, “Announcement of Calendar Year 2008 Medicare Advantage Capitation Rates and Payment Policies,” April 2, 2007.

and driving the large differences in risk-score growth.²³

CMS continued to analyze this issue in 2008, incorporating data from 2007. The newer data are consistent with the earlier findings: disease scores — the component of the risk score that is affected by which diagnosis codes are used — were rising faster among stayers in the private plans than among stayers in traditional Medicare. After comparing coding patterns between these two groups of beneficiaries, CMS recently announced that “based on ... careful consideration of this data ... there exists a difference in coding patterns” between Medicare Advantage and traditional Medicare.²⁴

Upcoding Has Been Previously Addressed in Traditional Medicare, But Not in Medicare Advantage

As noted, upcoding is not unique to Medicare Advantage and has occurred in the traditional Medicare program. As a result, Medicare has had to periodically adjust payments to providers in the traditional fee-for-service program to account for unexplained changes in beneficiaries’ reported health status that resulted in inflated payments.

When the Prospective Payment System for inpatient hospital care was first implemented in 1984, for example, CMS reduced hospital payments by 3.38 percent in 1984 and another 1.05 percent in 1985 to offset the effects of upcoding.²⁵ The Prospective Payment Assessment Commission (a predecessor of MedPAC) recommended annual adjustments for upcoding for ten consecutive years, from 1986 to 1995.

More recently, CMS proposed to reduce hospital payments by 1.2 percent in 2008 and by 1.8 percent in both 2009 and 2010.²⁶ These payment reductions were intended to account for the upcoding CMS anticipated would result from the switch to a modified coding system in 2008. Congress reduced these prospective adjustments but permitted CMS to make additional retroactive adjustments if upcoding was found to have occurred in 2008 and 2009.²⁷

For payments to home health agencies, CMS reduced the payment rate by 2.75 percent each year from 2008 to 2010 and by 2.71 percent for 2011 to recover overpayments due to upcoding since 2000.²⁸ Other types of facilities, such as inpatient rehabilitation facilities and long-term acute care hospitals, have been subject to similar adjustments.

²³ Centers for Medicare and Medicaid Services, “Advance Notice of Methodological Changes for Calendar Year 2009 for Medicare Advantage Capitation Rates and Part D Payment Policies,” February 22, 2008

²⁴ Centers for Medicare and Medicaid Services, “Advance Notice of Methodological Changes for Calendar Year (CY) 2010 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies,” February 20, 2009.

²⁵ See Federal Register, Vol. 48, No. 171, September 1, 1983, and Federal Register, Vol. 49, No. 171, August 31, 1984.

²⁶ See Federal Register, Vol. 72, No. 195, October 10, 2007.

²⁷ In 2008, CMS adopted a new method of classifying patients into diagnosis codes that results in more accurate payments. The new classification system, the Medicare Severity Adjusted Diagnosis Related Groups (MS-DRGs), more accurately reflects the severity of patients’ illnesses and also provides financial incentives for hospitals to improve medical documentation and coding.

²⁸ See Federal Register, Vol. 72, No. 167, pages 49763-49945, August 29, 2007.

MedPAC has supported these actions, arguing that because the increase in the reported severity of patients' health care needs does not reflect *real* change in their health status or the cost of care for the patients being treated, "offsetting adjustments to the payment rates [to compensate for upcoding] are needed to protect the Medicare program."²⁹

In sum, payments to hospitals, home health agencies, and other providers in traditional Medicare have been reduced to offset the effects of upcoding. But private plans have been the notable exception. CMS was required by the Deficit Reduction Act of 2005 to modify the Medicare Advantage risk adjustment system to take into account unexplained coding differences between Medicare Advantage and traditional Medicare for the 2008-2010 period.³⁰ Despite this statutory requirement — and the fact that the three CMS analyses discussed above all found patterns of upcoding — CMS under the Bush Administration did not address the issue.

CMS failed to adjust for upcoding in setting payment levels to private plans for 2008, claiming that it could not conclusively attribute to upcoding the differences in risk scores between private plans and traditional Medicare. For the 2009 payments, CMS (under the Bush Administration) did propose to apply a coding adjustment to private plans that have significant coding-pattern differences from traditional Medicare. (The adjustment would have been limited to plans in operation after 2005 whose increases in risk scores exceeded *twice* the industry average.) Strong opposition from the insurance industry, however, led CMS to hold off on this change.³¹

Obama Administration Provision for 2010 Payments and House Health Reform Proposal to Adjust for Upcoding on an Ongoing Basis Would Reduce Unnecessary Spending

On April 6, CMS took an important step by adjusting upcoding the payments it will make to private plans for 2010. CMS will adjust these payments to reflect differences between 2007 and 2010 in disease-score growth (as shown in the diagnosis codes) between beneficiaries in Medicare Advantage and beneficiaries in traditional Medicare.³² MedPAC endorsed this action, stating that the proposed adjustment would "improve payment accuracy, ... reduce unnecessary Medicare expenditures, ... [and] better assure financial neutrality between [traditional Medicare and Medicare

²⁹ Medicare Payment Advisory Commission, "Comments on CMS's Proposed Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2008 Rates," June 11, 2007.

³⁰ The Senate-passed version of the Deficit Reduction Act contained much stronger safeguards against upcoding than the final legislation, as it would have required *permanent* adjustments for upcoding. After intense industry opposition, the Senate provision was altered in conference so that after 2010, the Secretary of Health and Human Services would have no obligation to take upcoding patterns into account.

³¹ In a response to an inquiry by Congressman Charles Rangel, CMS's Chief Actuary indicated that if implemented immediately, applying even this modest upcoding adjustment would have yielded \$334 million in savings for calendar year 2009.

³² The upcoding adjustment comprises two elements: the average annual difference in disease-score growth between stayers in Medicare Advantage and stayers in traditional Medicare, and the average length of time that beneficiaries have been enrolled in Medicare Advantage. These would be combined to derive a "Medicare Advantage coding difference factor," which would be adjusted by the percentage of stayers in Medicare Advantage. For more details on the methodology for deriving the upcoding adjustment, see Centers for Medicare and Medicaid Services, "Announcement of Calendar Year (CY) 2010 Medicare Advantage (MA) Capitation Rates and Medicare Advantage and D Payment Policies," April 6, 2009.

Advantage].³³ The Chairmen of the House Ways and Means Committee, the House Energy and Commerce Committee, and the Senate Finance Committee, which have jurisdiction over Medicare Advantage, also expressed support for the adjustment.³⁴

More importantly, CMS signaled that it will address upcoding on an ongoing basis by using actual encounter data from private plans to fine-tune the current risk adjustment process each year. In addition, section 1163 of the House Tri-Committee health reform bill proposes to require CMS to adjust for upcoding for each year past 2010. It would also require CMS to periodically analyze the upcoding issue and incorporate its findings on a timely basis into the upcoding adjustments that it makes. If combined with enactment of the MedPAC recommendation to level the playing field or another payment reform designed to have similar effects, action to address upcoding over the long term would end the excessive payments to private plans — even if such plans continue to enroll beneficiaries who are healthier on average than those in traditional Medicare.

CBO estimates that the House Tri-Committee bill's provision to address upcoding on a permanent basis would save \$15.5 billion over ten years, which would be used to help offset the cost of various Medicare improvements in the bill and of the overall health reform legislation.³⁵

Conclusion

Upcoding in Medicare Advantage is a little-known problem with a significant budgetary impact. By undermining the effectiveness of the Medicare risk adjustment system, it exacerbates overpayments to private plans that enroll healthier Medicare beneficiaries, diverting resources that could otherwise be used to strengthen Medicare or help pay for broader health care reform. Unless measures are taken to address upcoding, the adoption of various recommendations to level the playing field between private plans and traditional Medicare will fall short of eliminating wasteful overpayments to private plans.

The Obama Administration's action to address upcoding for Medicare Advantage payments in 2010 is a sound first step in dealing with upcoding. The next step, to which the Administration also has committed itself and which the House Tri-Committee health reform bill proposes to address, is to strengthen risk adjustment by making action to account for upcoding an ongoing part of the risk-adjustment system.

³³ Medicare Payment Advisory Commission, "Comments on CMS' Advance Notice of Methodological Changes for Calendar Year (CY) 2010 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies," March 5, 2009.

³⁴ See Letter to Acting CMS Administrator and Chief Operating Officer Charlene Frizzera (regarding the Advance Notice of Methodological Changes to 2010 Medicare Advantage Rates and Payment Policies) from Congressmen Henry Waxman, Charles Rangel, John Dingell, Frank Pallone, Jr., and Pete Stark, March 6, 2009; and Letter to Acting CMS Administrator and Chief Operating Officer Charlene Frizzera (regarding the Advance Notice of Methodological Changes to 2010 Medicare Advantage Rates and Payment Policies) from Senator Max Baucus, March 6, 2009.

³⁵ Congressional Budget Office, "Preliminary Analysis of the America's Affordable Health Choices Act of 2009," July 17, 2009.