Study shows how UnitedHealth uses coding to rake in extra cash from Medicare Advantage

The insurer uses several strategies to make its members seem sicker and collect more payments, the study found

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Health insurers in the private Medicare business have a big incentive to diagnose their members with lots of health conditions: The government pays them more money.

A new study shows the extent to which the biggest player in that business, UnitedHealth Group, stands out from the rest for its prowess at raking in extra cash from that program.

Medicare Advantage insurers pulled in an estimated $33 billion in additional payment from the government in 2021 as a result of these extra diagnoses, or codes, that made their members seem sicker, relative to people in the traditional Medicare program. Almost $14 billion of that, or 42%, went to a single company: UnitedHealth, according to the research, published Monday in the Annals of Internal Medicine. Other insurers, like Humana and Aetna, comprised much smaller shares: 19% and 6%, respectively.

“United is just coding a lot more than the other largest insurers,” said Richard Kronick, the study’s lead author and a professor in the Herbert Wertheim School of Public Health at the University of California, San Diego.

To be fair, UnitedHealth also covered more members in 2021 than anyone else: 7.5 million people or 27% of all members in the program. But that's still a smaller share than its cut of the coding proceeds.

The study is the first to comprehensively compare the extra revenue from Medicare Advantage coding among individual insurers. It did so by quantifying the differences in coding between private Medicare, the program run by private insurers, and traditional Medicare, in which the government pays providers directly and there's no financial incentive to apply certain diagnosis codes.

Kronick said the coding differences are mainly driven by companies' business practices, and whether or not they place a heavy emphasis on identifying more diagnoses for their Medicare Advantage patients. The study bolsters that conclusion with its finding that virtually all of the coding differences between Medicare Advantage and traditional Medicare are contained within just 10 diagnostic groups. With few exceptions, the researchers didn't find differences in other diagnostic groups that affected similar body systems.

The diagnostic groups that accounted for the coding differences include vascular disease, major depressive disorder, and drug and alcohol dependence. The common theme among them is they're more open to interpretation than other conditions with respect to whether patients have them or not, Kronick said. They're all also relatively common, especially among older adults, he said.

Not all of the coding differences between Medicare Advantage and traditional Medicare are the result of upcoding, or applying inappropriate codes just to get paid more. At least some of the disparity could be because of genuine differences in members' health statuses. Research has also found that doctors in some cases don't fully code patients' health conditions if they have traditional Medicare, and that's less often the case in Medicare Advantage.

But even if that's true, Kronick said that shouldn't affect how much money insurers get from the government.

“What we see is that the risk score magically changes as people go into Medicare Advantage,” he said. “The risk score for a person in Medicare Advantage is a lot higher than it would be if she were in traditional Medicare, and in particular, a lot different at United than at Kaiser.”

The Better Medicare Alliance, a group that lobbies on behalf of the Medicare Advantage industry, contested the findings. In a statement, Kaitlyn Saal-Ridpath, the group’s vice president of policy and research, called the study a “flawed apples-to-oranges analysis” because it doesn’t account for under-coding in traditional Medicare and differences in health status between members in the programs. She also noted that the study does not account for recent risk adjustment changes made under the Biden administration.

“We welcome serious analyses to help drive policy conversations around Medicare Advantage, but this study misses the mark,” Saal-Ridpath said.

The study also examined how the codes got added to Medicare Advantage members’ records. It found that roughly half of them came from chart reviews, where insurers direct staffers to mine members’ records for more diagnoses, and health risk assessments, where insurers send clinicians into members’ homes to perform tests that could yield more diagnoses. Of that 50%, the study found that two-thirds came from chart reviews and the rest from health risk assessments.

In particular, the study showed that UnitedHealth got much more money from in-home health risk assessments than other insurers. UnitedHealth also led the pack with respect to chart reviews. UnitedHealth did not comment on the study’s findings.

Coding differences between Medicare Advantage and traditional Medicare are also driven by financially incentivizing doctors to add the codes. In addition to being the biggest private insurer, UnitedHealth also employs or affiliates with almost 1 in 10 U.S. doctors. STAT’s Health Care’s Colossus series examined how the company uses its influence over them to tack more diagnosis codes onto its Medicare Advantage members. STAT interviewed doctors who described intense pressure from UnitedHealth to apply lucrative, yet dubious, codes to their

patients. Doctors said the company offered bonuses of up to $10,000 and managers sent emails ranking them and their peers.

Not all companies make coding such a big part of their Medicare Advantage strategy. Some insurers, like Kaiser Permanente, code in a manner that's much closer to traditional Medicare, in which there's no incentive to upcode. In 2021, the study found Kaiser drew $500 million from coding, or just 1% of its Medicare Advantage revenue.

The study's findings, particularly the dramatic variation in coded disease, are striking because nobody would expect to see such wide differences in disease prevalence among Medicare Advantage and traditional Medicare members, J. Michael McWilliams, a health care policy professor at Harvard Medical School, wrote in an accompanying editorial.

The results also make it clear that an across-the-board pay cut to insurers is not the right way to address the issue, because it would put the smaller ones out of business, McWilliams wrote. Instead, he said reforms should be directed at the risk adjustment system itself, including by stripping out diagnoses that are more easily manipulated.

The Biden administration has phased in changes designed to do just that: weed out the most abused diagnosis codes. Instead of implementing the reforms all at once, they've been phased in over three years, and are scheduled to fully take effect in 2026.

Mehmet Oz, who was confirmed last week as the new head of the Centers for Medicare and Medicaid Services, pledged to crack down on Medicare Advantage upcoding, referring to himself as the "new sheriff in town.