

# Medicare Advantage insurers

Nov 10, 2024

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Elevance. After seeing the success of that lawsuit, other organizations are "jumping on board," said Betsy Seals, the chief executive of the Medicare Advantage consulting firm Rebellis Group.

Critics see the changes as a necessary correction to a system that has overrated — and thus overpaid — insurers for several years. About 40 percent of Medicare Advantage contracts had at least four stars in 2015, leading to \$3.8 billion in bonus payments, according to federal data and the health research group KFF. Nearly 70 percent of contracts — covering more than 80 percent of all enrollees — did by 2022, resulting in bonus payments of \$12.8 billion.

The nonpartisan Medicare Payment Advisory Commission has said the bonus payments are costly, don't promote high-quality care and need to be revised. With more than half of people eligible for Medicare now enrolled in privately administered Advantage plans — up from 19 percent in 2007, according to KFF — there's an "urgent need for a major overhaul," a commission report said.

The dispute between the insurers and the Department of Health and Human Services, which houses the Centers for Medicare and Medicaid Services, also reflects the fragility of the Medicare Advantage rankings system, said David Meyers, a Brown University health policy professor. If a handful of customer service calls can determine whether a company gets millions or billions of dollars in bonus payments, "it's a sign that the larger system is just very broken," Meyers said.

Regulatory changes, including the end of certain pandemic rules that boosted ratings, are bringing down the number of high-ranked contracts. About 40 percent are set to receive four or five stars in 2025, according to rankings re-

leased in October.

The Humana lawsuit alleged that the star rating calculations are "dizzily complex" and that ratings have dropped precipitously even though there has been no indication that plans' quality has gotten worse. Under the 2024 ratings, 94 percent of Humana's Medicare Advantage enrollees were in a plan rated four stars or higher, but that figure will drop to 25 percent under the 2025 rankings, the lawsuit said. That could lead to a nearly \$3 billion loss in bonus funds, according to Cantor Fitzgerald analyst Sarah James.

Combined, UnitedHealthcare and Humana in 2024 have more than 15 million Medicare Advantage enrollees, nearly half of all people in Advantage plans, according to KFF. Centene has about 1.1 million enrollees, KFF estimates.

UnitedHealthcare and Cen-

## Medicare Advantage insurers sue, saying lower ratings could cost them millions

BY SHANNON NAJMARADI

November 10, 2024

As the biggest Medicare Advantage insurers see it, something as minor as a dropped phone call can now cost them hundreds of millions of dollars.

Around the time Medicare open enrollment started last month, the insurance giants Humana and Centene and subsidiaries of UnitedHealthcare filed lawsuits alleging they stand to lose substantial revenue because a tiny number of unsuccessful customer service phone calls hurt their 2025 Medicare Advantage scores — costing them customers or multimillion-dollar bonuses they otherwise stood to get from the federal government.

"These are staggering consequences for a single call," Centene said in its lawsuit, which claims the company and its subsidiaries will lose \$73 million in gross revenue.

Federal regulators use a five-star system to rate Medicare Advantage plans, which are private-sector offerings that cover the majority of the more than 67.5 million people eligible for Medicare, the U.S. government's health-care program for people 65 and older or with disabilities. The scores from the Centers for Medicare and Medicaid Services draw from numerous metrics such as breast cancer screenings and call center assistance.

The U.S. government pays a set rate for each person enrolled in an Advantage plan regardless of its rating, but high scores trigger bonuses and rebates.

Elevance Health and Scan Health Plan previously sued over changes to the ranking process, leading the federal government to recalculate all plans' ratings this year and yielding an expected \$190 million gain for

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# fear losing millions over just a few phone calls

tene did not respond to questions from The Washington Post.

Humana said it repeatedly asked regulators to provide more transparency into its policies and how it calculated some of the company's star ratings. "We believe this litigation is in the best interest of Humana members and is necessary to ensure Star Ratings are accurate, trustworthy and representative of plan quality," the company said in a statement.

A spokesperson for the Centers for Medicare and Medicaid Services said the agency doesn't comment on pending litigation.

Ratings fell on at least a dozen of Humana's largest plans because of three anonymous phone calls meant to test whether the insurer provides language interpreters, according to the company's lawsuit, which was filed in federal court in Texas.

Humana alleged two of the

calls were disconnected because of third-party internet problems. During the third call, neither the Humana representative nor the government caller spoke. After an extended silence, the call was disconnected, the lawsuit said.

Similar phone calls were at issue in the UnitedHealthcare, Centene, Elevance and Scan lawsuits. Centene lawyers said the disputed call never reached the call center and blamed software the contractor used. UnitedHealthcare's lawsuit alleged the government caller did not ask a required introductory question.

Seals, the consultant, said it's healthy for insurers concerned about flaws in the system to question regulators, including through the most recent lawsuits.

"The industry is pushing back, like, wait a minute, some of these measures don't make sense. Some of them are arbitrary," Seals said.

Compared with traditional

Medicare, Advantage plans generally have lower monthly costs and offer additional services such as dental care, optometrist visits and gym memberships. They also typically require more pre-approvals from insurers and have smaller provider networks that can limit options for very sick patients.

Medicare Advantage and insurers' compensation has come under fire in recent years.

Many of the big Medicare Advantage insurers have been sued by the Justice Department or investigated by the Department of Health and Human Services' Office of Inspector General over allegations of fraudulent overbilling.

Furthermore, the number of Medicare Advantage plans rated above average is still disproportionate, said Meyers, the Brown professor.

While other government-ranked health services — such as nursing homes, hospitals and home health agencies — follow a normal bell-curve-shaped distribution, the Medicare Advantage ratings "are the only ones where basically everybody is in the really high-star-rating category," said Meyers, who has extensively researched the Medicare Advantage program.

Critics of Medicare Advantage say reform is needed, especially as the youngest baby boomers reach retirement age in the next few years. Medicare makes up about one-fifth of all health spending in the United States each year.

Research is mixed on whether a plan's star rating correlates with patients' experiences or their health outcomes.

Few people consult the rankings when picking a plan, according to a KFF analysis based on focus group responses. And the ranking of contracts that can cover multiple states gives consumers limited insight into the quality of care available in their area,

some critics have said.

People who work with older adults or brokers said most people avoid one- or two-star-rated plans but make little distinction between those rated three stars and above.

More often, people want to know if the brand of insulin they prefer is on the plan's drug formulary or if a specialist they've seen for years is in-network, information that can't be gleaned just from a star rating, said Chalen Jackson with Senior Marketing Specialists, an agent brokerage based in Missouri.

"A five-star plan that doesn't cover your drugs and doctors doesn't do you any good," Jackson said.

Jackie Boschok, the president of the Washington State Alliance for Retired Americans, said she's faced numerous issues while helping manage care for her ex-husband, who has a traumatic brain injury and an Advantage plan. They have had few options and difficulties finding in-network specialists, despite their community's relatively robust medical network.

In fact, star rankings weren't even a consideration when her ex-husband was looking for an Advantage plan that covered his primary care clinic, she said.

"He had literally zero choices," Boschok said.

But the cost-effectiveness and convenience of getting all coverage in one package is a draw for some people who choose Advantage plans, such as Lielani Charley, 46, who said she has chronic conditions that make her eligible for Medicare.

"You don't get a separate card for vision. You don't get a separate card for dental," said Charley, who works as a clerk with Tennessee's State Health Insurance Assistance Program, helping people sign up for traditional Medicare and Advantage plans. "You get one card and you're good to go."

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