Rein in Medicaid, Medicare spending

Independent review of actuarial data will lower health insurance premiums

BY BARRY BITZER

FORMER DEPUTY SECRETARY, NM HUMAN SERVICES DEPARTMENT; CORRALES RESIDENT

Back in 2010, the Affordable Care Act promised universal, affordable health care, and with only 8% now uninsured, it is on its way to deliver on half its promise. Yet affordability seems increasingly out of reach and will soon be more so as the feds end their extra subsidies.

In June, a U.S. House Energy and Commerce subcommittee empaneled a group of experts to explain why Medicare Advantage is becoming so expensive. The experts had no explanation.

But at the annual National Fraud and Forensic Conference, my friend and neighbor, Dr. Jacob Kuriyan — a scientist and health care executive I met 20 years ago while Deputy Secretary of NM Human Services (HSD) — offered a solid answer: overpayments to insurers.

Details of his analysis of 2014 Medicaid claims data, using a patented forecasting model he devised that discovered $250 million in overpayments to insurers, appeared in January's Journal of Forensic and Investigative Accounting as "Anatomy of a Medicaid Fraud."

The three key lessons learned in N.M.'s Medicaid managed care program apply to Medicare Advantage plans as well.

First, actuaries use statistics and probability and last year's medical costs to estimate a person's future medical needs and calculate a premium. But actuaries treat details of their calculations as "trade secrets" and so they must be independently verified.

Second, to help verify, the feds require insurers to include in the claims the prevailing market costs for the medical services provided. If the total of medical market costs in all the claims is less than 85% of total premiums — also known as MLR or Medical Loss Ratio — then there is overpayment.

As Kuriyan explains in the paper, the N.M. Medicaid actuary, instead of following the federal suggestion, chose to use consolidated costs presented in the annual financial statements submitted to the state's insurance commission and guess the "medical" and "other nonmedical" costs. Not surprisingly, they were wrong.

The third lesson is actually a call to action. When overpayments are detected, premiums must be recalculated and lowered so as not to "bake" the excesses into future premiums.

N.M. initially disputed but later discovered overpayments for subsequent years as well and recovered a total of $660 million for 2014-2017, as stated in the May 2019 report from the Legislative Financial Committee.

After the recovery of $660 million, New Mexico inexplicably decided to change the rules and stop recovery of overpayments after 2017. While the feds allow this practice for Medicaid, recalculation is critical to

prevent rise in subsequent insurance premiums.

The cumulative impact of undetected overpayments helps explain the nationwide rise in managed care premiums for both Medicare and Medicaid. In the case of New Mexico, a $250 million overpayment in 2014, if uncorrected, can balloon into a billion dollars of excess insurer payments by 2022.

New Mexico using the same actuary who calculated the increased premiums to review and lower them is a case of the wolf guarding the ranch. Independent forensic accountants and actuaries with no conflicts must be recruited to do these recalculations.

These checks and balances are sorely needed to tether premiums. Otherwise, the Sept. 21 request by HSD for an additional $164 million for New Mexico Medicaid is only a down payment.

