ISSUE: Rampant Upcoding in Medicare and Medicaid

COST TO TAXPAYERS: $50-$135 Billion Annually

INDUSTRY: Healthcare

POLITICS: Growing Bipartisan Concern

There is a growing fraud problem across government healthcare programs like Medicare and Medicaid. It starts when insurance companies routinely diagnose patients with far worse conditions than they have – known as "upcoding." Doctors still treat the patient, but the providers siphon more money illegally from government healthcare programs. Upcoding has ballooned into a multi-billion dollar swamp of fraud that worsens the quality of care, wastes taxpayer dollars, and undermines our healthcare system.

Backwards Incentives

Hospitals, insurance companies, and state governments all recognize that sicker patients generate more revenue and tax savings when they bill the federal government. Government healthcare programs use risk-adjusted payments, creating incentives to diagnose patients with more severe conditions for higher returns. It turns programs meant to treat vulnerable patients into an arms race to see how much money an insurance company or a hospital can make off of any one patient.

Staggering Fraud

Upcoding has been a growing problem for Medicare and Medicaid over the past two decades, and the total amount of fraud is astonishing. Medicare Advantage plans overbilled insurers by more than $20 billion in 2022. It's worse for Medicaid – improper payments totaled $534 billion between 2015 and 2024, with $50 billion in 2023 alone. However, those numbers are underestimated thanks to incomplete reporting from state governments and other organizations.

Improperly Managed Care

More than ever, managed care organizations (MCOs) are in charge of administering Medicaid plans. But data on upcoding and improper payments only applies to fee-for-service programs, suggesting that the total amount of fraud is exponentially higher. Assuming similar rates of improper payment across MCO and fee-for-service populations, actual improper Medicaid payments could approach $135 billion annually –without taking into account Medicare Advantage.

Potential Solutions

To reduce improper payments and restore integrity to Medicare and Medicaid, policymakers should act now to:

- Mandate full audit authority over all managed care payments to see the full extent of improper payments
- Enforce uniform fraud detection and risk-scoring protocols across all payers
- Impose stiff penalties for upcoding violations and repeat offenders
- Align payment systems with clinical evidence, not billing loopholes that exploit patients