When Medicare was facing an impossible $13 trillion funding gap, Congress opted for a bold fix: It handed over part of the program to insurance companies, expecting them to provide better care at a lower cost. The new program was named Medicare Advantage.

Nearly 15 years later, a third of all Americans who receive some form of Medicare have chosen the insurer-provided version, which, by most accounts, has been a success.

But now a whistle-blower, a former well-placed official at UnitedHealth Group, asserts that the big insurance companies have been systematically bilking Medicare Advantage for years, reaping billions of taxpayer dollars from the program by gaming the payment system.

The Justice Department takes the whistle-blower’s claims so seriously that it has said it intends to sue the whistle-blower’s former employer, UnitedHealth Group, even as it investigates other Medicare Advantage participants. The agency has until the end of Tuesday to take action against UnitedHealth.

In the first interview since his allegations were made public, the whistle-blower, Benjamin Poehling of Bloomington, Minn., described in detail how his company and others like it — in his view — gamed the system: Finance directors like him
monitored projects that UnitedHealth had designed to make patients look sicker than they were, by scouring patients’ health records electronically and finding ways to goose the diagnosis codes.

The sicker the patient, the more UnitedHealth was paid by Medicare Advantage — and the bigger the bonuses people earned, including Mr. Poehling.

In February, a federal judge unsealed the lawsuit that Mr. Poehling filed against UnitedHealth and 14 other companies involved in Medicare Advantage.

“They’ve set up a perfect scheme here,” Mr. Poehling said in an interview. “It was rigged so there was no way they could lose.”

A spokesman for UnitedHealth, Matthew A. Burns, said the company rejected Mr. Poehling’s allegations and would contest them vigorously.

“We are confident our company and our employees complied with the government’s Medicare Advantage program rules, and we have been transparent with C.M.S. about our approach under its murky policies,” he said, referring to the Centers for Medicare and Medicaid Services, which administers Medicare Advantage.

Mr. Burns also said Mr. Poehling’s complaints and similar ones held UnitedHealth and other Medicare Advantage participants to higher standards than the ones used by the original Medicare program.

Mr. Poehling’s suit, filed under the False Claims Act, seeks to recover excess payments, and big penalties, for the Centers for Medicare and Medicaid Services. (Mr. Poehling would earn a percentage of any money recovered.) The amounts in question industrywide are mind-boggling: Some analysts estimate improper Medicare Advantage payments at $10 billion a year or more.

At the heart of the dispute: The government pays insurers extra to enroll people with more serious medical problems, to discourage them from cherry-picking healthy people for their Medicare Advantage plans. The higher payments are determined by a complicated risk scoring system, which has nothing to do with the treatments people get from their doctors; rather, it is all about diagnoses.
Diabetes, for example, can raise risk scores by varying amounts, depending on a patient’s complications. So UnitedHealth gave people with diabetes intensive scrutiny, to see if they had any other conditions that the diabetes might have caused.

As Mr. Poehling’s lawyer, Mary Inman, described it, the government would pay UnitedHealth $9,580 a year for enrolling a 76-year-old woman with diabetes and kidney failure, for instance, but if the company claimed that her diabetes had actually caused her kidney failure, the payment rose to $12,902 — an additional $3,322. Ms. Inman is with the law firm of Constantine Cannon in San Francisco.

Mr. Poehling said the data-mining projects that he had monitored could raise the government’s payments to UnitedHealth by nearly $3,000 per new diagnosis found. The company, he said, did not bother looking for conditions like high blood pressure, which, though dangerous, do not raise risk scores.

He included in his complaint an email message from Jerry J. Knutson, the chief financial officer of his division, in which Mr. Knutson urged Mr. Poehling’s team “to really go after the potential risk scoring you have consistently indicated is out there.”

“You mentioned vasculatory disease opportunities, screening opportunities, etc., with huge $ opportunities,” Mr. Knutson wrote. “Let’s turn on the gas!”

There were bonuses when Mr. Poehling and his team hit their revenue targets, Mr. Poehling said, but no bonuses for better health outcomes or for more accurate patients’ charts.

“You or I or the average person is probably appalled by this,” Mr. Poehling said. “But the scheme here was not about delivering better care to members — the thing you would expect from a health care company. It was about increasing the bottom line.”

He went to work for UnitedHealth in 2002, filed his lawsuit in 2011 and left the company at the end of 2012, while the case was still under seal.

Mr. Poehling’s allegations, if true, could help explain why insurers are staying in the Medicare Advantage program even as they pull out of the Affordable Care Act.
exchanges in some states: Medicare Advantage offers a way to get extra money from the federal government.

When a whistle-blower succeeds in recovering money for the government, the False Claims Act calls for him or her to receive a percentage. Many whistle-blower cases fail to reach that point, but when the Justice Department joins a case, in general, the odds of a recovery go up.

Already the Justice Department has declined to intervene in some smaller whistle-blower cases with similar allegations. But in March, it did say it would join a whistle-blower suit filed by James Swoben, a former data manager of SCAN Health Plan, accusing UnitedHealth and several other companies of cheating Medicare Advantage by looking improperly for ways to raise people’s risk scores.

In 2016, the United States Court of Appeals for the Ninth Circuit vacated a lower court’s decision to throw out Mr. Swoben’s case. After reviewing the allegations, Judge Raymond C. Fisher wrote, “We do not see how a Medicare Advantage contractor who has engaged in such conduct can in good faith certify” that the diagnosis codes it reports to the Centers for Medicare and Medicaid Services “are accurate, complete and truthful.”

That ruling did not decide Mr. Swoben’s case, but merely sent it back to a district court to be adjudicated. His case and Mr. Poehling’s case are both now being handled by the United States District Court in Los Angeles.

Meanwhile, UnitedHealth has sued the Centers for Medicare and Medicaid Services, seeking to vacate a 2014 rule that requires insurers to make sure the diagnoses they report to the government are borne out by what is in people’s charts, and imposing penalties for overstatements. UnitedHealth argues that this rule unlawfully departs from the program’s statutory mandates requiring “actuarial equivalence” with the traditional Medicare program.

“That case could provide further clarity on the program rules,” Mr. Burns of UnitedHealth said. He added that the government seemed to be trying to delay so that the two whistle-blower lawsuits could go first.
The Justice Department has said it is investigating four other Medicare Advantage insurers: Aetna, Humana, Health Net and Cigna’s Bravo Health. That suggests that there are more whistle-blowers in the wings, potentially snarling more insurers in litigation and ultimately forcing a rethinking of the entire program.

“C.M.S. could do a lot to change the rules so it’s not so easy to get away with this stuff,” said Timothy Layton, an assistant professor at Harvard Medical School who researches insurer behavior in health-insurance markets. He is not involved in Mr. Poehling’s lawsuit.

“It’s a huge waste of money,” Professor Layton said of the quest for higher risk scores. “What the insurers are doing is not socially valuable at all.”

The Centers for Medicare and Medicaid Services declined to comment for this article.

Auditors and analysts have warned for at least a decade that Medicare Advantage has been vulnerable to cheating since risk scoring was phased in, from 2004 to 2008. The inspector general of the Department of Health and Human Services, where the centers reside, audited a small sample of Medicare Advantage plans early on and found overpayments of up to $650 million in 2007. It predicted even more in 2008, but then came budget cuts and those audits stopped.

The Government Accountability Office reported last year that the Centers for Medicare and Medicaid Services had identified $14.1 billion of overpayments to insurers in 2013 and did not have a clear plan for recovering the money. It also faulted the agency’s auditing methods.

“I recall a feeling of frustration verging on outrage,” said Ted Doolittle, the deputy director of the Medicare and Medicaid agency’s Center for Program Integrity at that time.

In 2014 the Center for Public Integrity, a nonprofit research group, analyzed the only available Medicare Advantage data and reported that insurers had reaped about $70 billion in overpayments from 2008 to 2013.
Fred Schulte, who led the center’s research and now works for Kaiser Health News, also sued the Centers for Medicare and Medicaid Services to get more data. In January, he reported getting confidential documents showing that the agency had tried to recover $128 million of overpayments to five insurers in 2007 but, “under intense pressure from the health insurance industry,” settled for just $3.4 million in 2012.

Last month, Senator Charles E. Grassley wrote to the agency’s administrator, Seema Verma, complaining that it had trumpeted the $3.4 million recovery to him as a sign of good fiscal oversight, without mentioning that it could have gone after $128 million.

“The difference between the assessment and the actual recovery is striking and demands an explanation,” Mr. Grassley, an Iowa Republican, wrote.

As lawmakers and others try to get their arms around the issue, few insurance insiders have come forward with firsthand accounts. Mr. Poehling said he had done so reluctantly.

“I came to the point where I just couldn’t participate in what they were asking me to do anymore,” he said.

A version of this article appears in print on May 16, 2017, on Page A1 of the New York edition with the headline: Ex-Insurer Says ‘Perfect Scheme’ Bilks Medicare.