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Improving Medicare through Medicare Advantage

February 22, 2024

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Agenda

- Introductions
- Context of Medicare Advantage
- Key Issues & Solutions
- Q&A

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Context of MA

- Established 2006 under Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (previously Medicare+Choice)
- Private plans receive capitated payments based on “bid” relative to county benchmark
- Must cover Part A and B benefits (except hospice). May cover Part D and supplemental benefits
- Receive extra payment from high star ratings and risk adjustment

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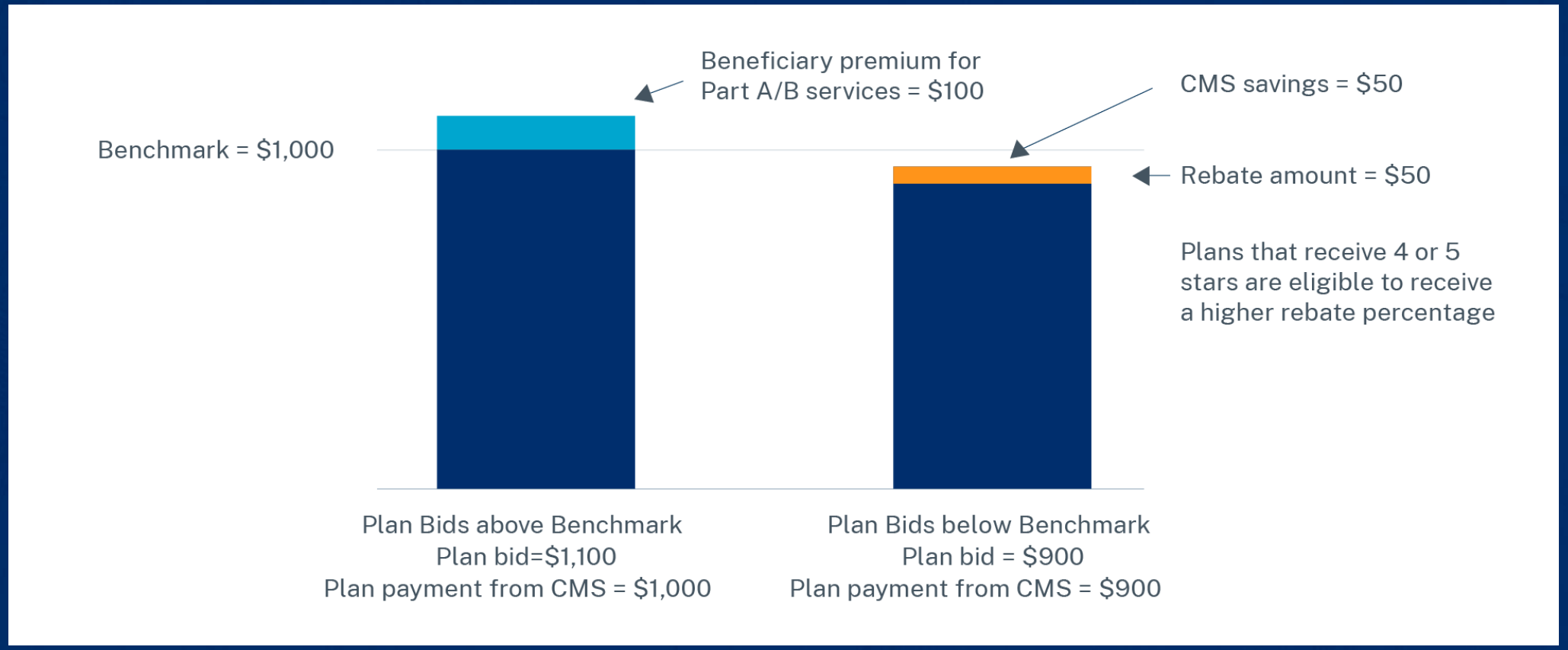
Context of MA



Source: Better Medicare Alliance

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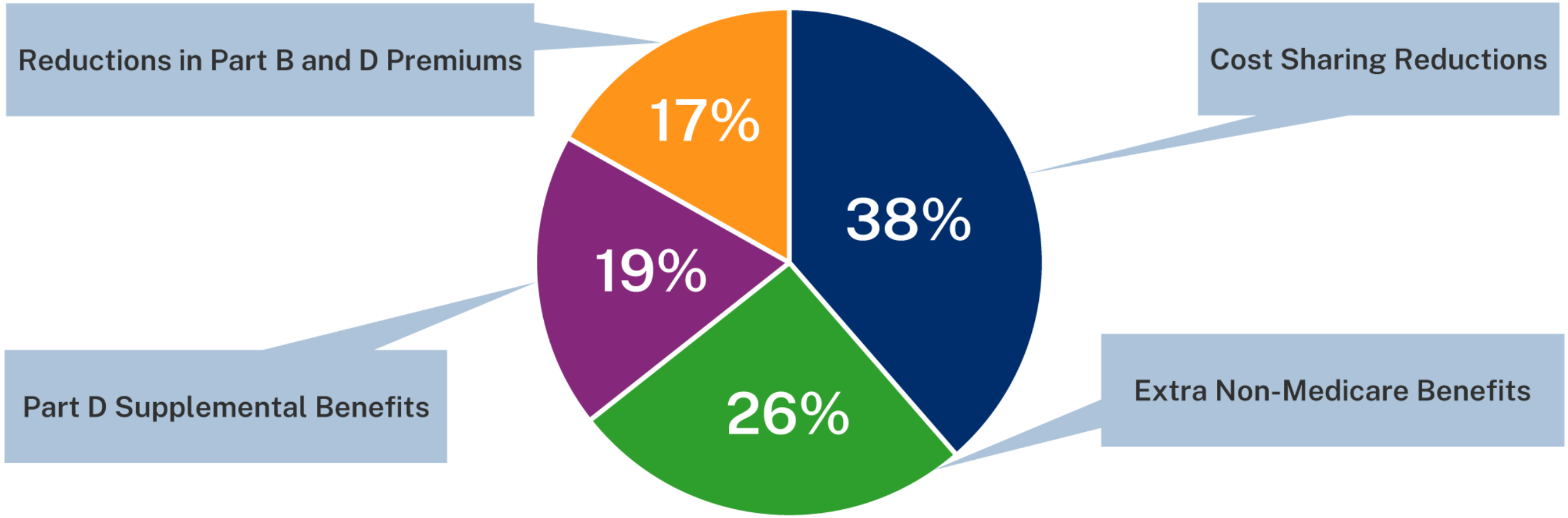
Figure 1: Rebate Use Breakdown (2023)



Source: MedPAC, "The Medicare Advantage Program: Status Report," in Report to the Congress: Medicare Payment Policy, March 2023, https://www.medpac.gov/document/chapter-11-the-medicare-advantage-program-status-report-march-2023-report.
Note: Values do not add up to 100% due to rounding.

MA vs. FFS

- FFS has serious flaws
  - Government price-setting distorts the market
  - Payment and other policies are politicized
  - Bad incentives hinder quality improvement
  - Top-down solutions reflect paternalistic outlook
- MA's design solves many of these problems
  - Capitation and reg flexibilities encourage value
  - Plans compete and seniors choose coverage
  - Better outcomes, lower OOP costs, extra benefits

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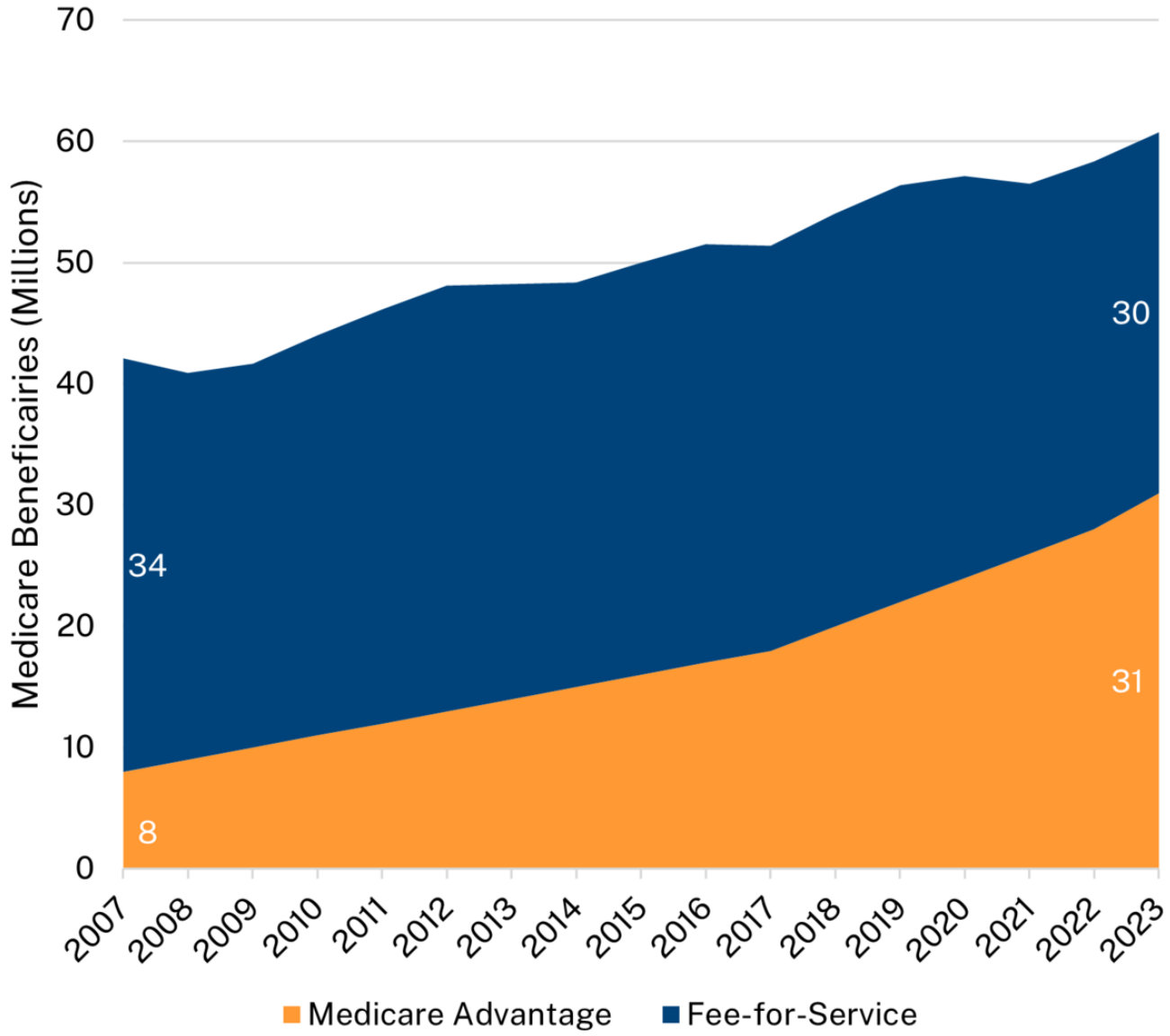
Medicare Enrollment by Program



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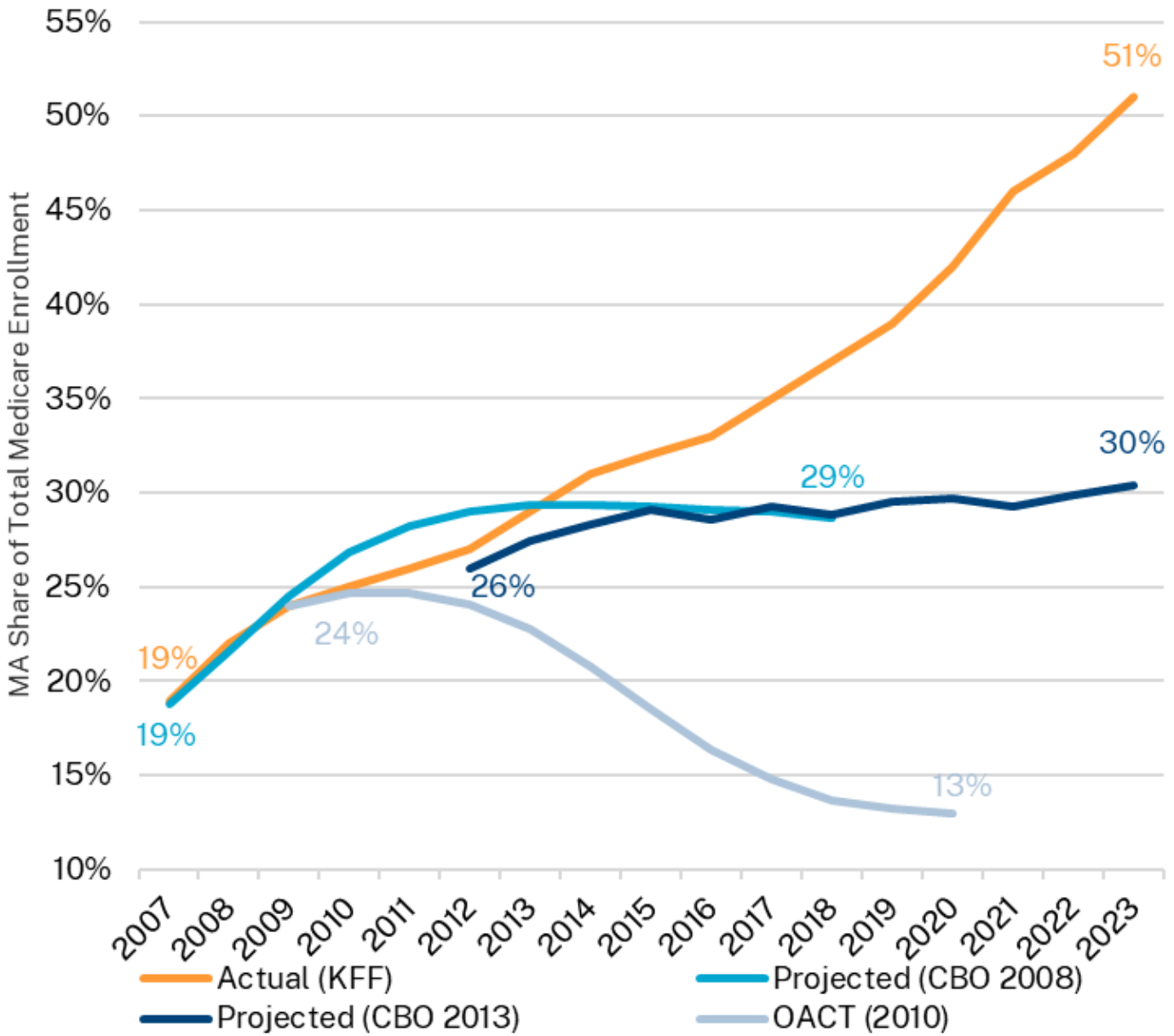
Medicare Advantage Beats Projections



Sources: CBO March 2007 and May 2013 Medicare baselines, 2010 Medicare Trustees Report, and Kaiser Family Foundation "Medicare Advantage in 2023 Enrollment Update and Key

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How to Improve MA?

- Policy goals
  - Allow MA to continue provide coverage options for beneficiaries and transform Medicare
  - Address concerns about MA spending parity with FFS
  - Advance parity between MA and FFS options
  - Enable more innovation and better coverage in MA
- Other considerations
  - Policy feasibility (avoid benefit cuts, major restructuring, and retain bipartisan appeal)
  - Address efforts to restrict beneficiary access to MA options

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MA Spending

- Some estimate higher MA spending than FFS
- MA has lower health care costs, but other policies increase payments
- Unaddressed/Unsettled factors: benchmark population, spillover effects, unique MA rules (e.g., MOOP limits)

Key Issues & Solutions

- Benchmarks
- Quality Bonuses
- Coding Intensity
- Parity between MA and FFS

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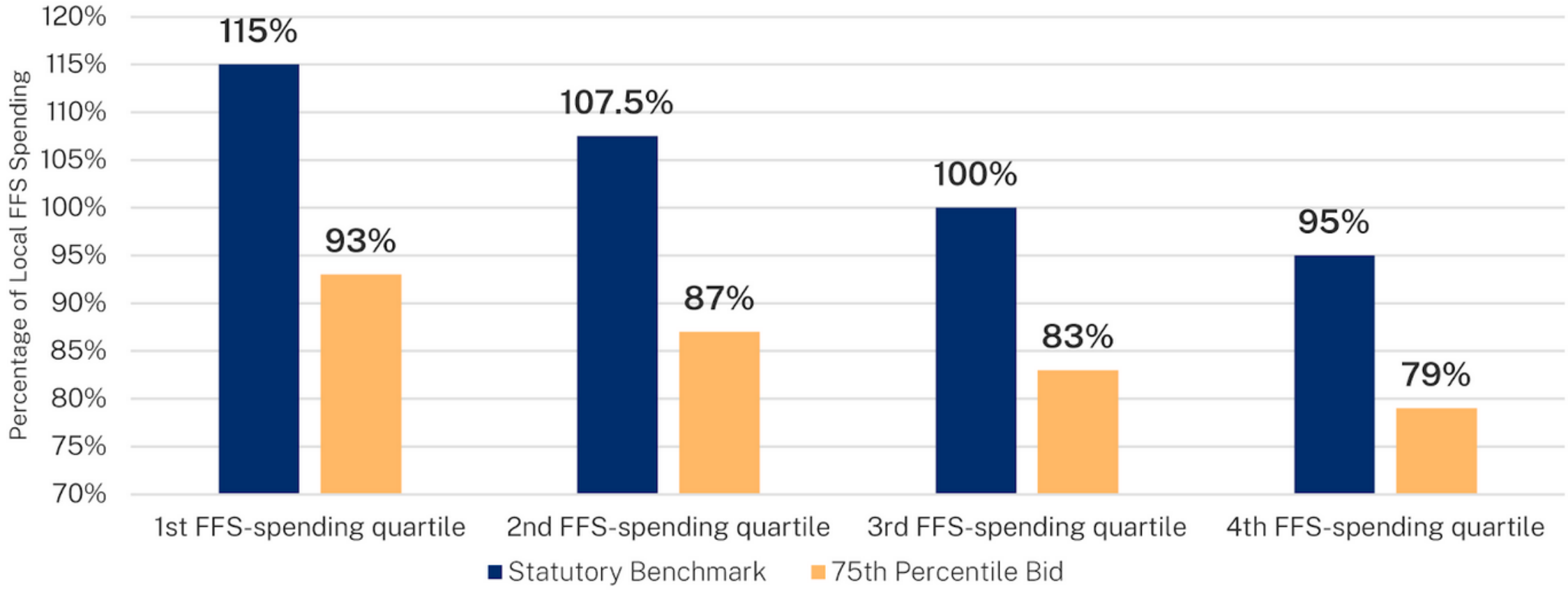
Benchmarks

- MA benchmarks are set at four levels based on local FFS spending
- Lower FFS costs lead to higher benchmarks (to preserve access) and higher costs lead to lower benchmarks (to control spending)
- Half of county benchmarks exceed FFS costs
- FFS costs are currently calculated using those with Part A or Part B rather than both

Figure 3: Most MA Bids Are Below FFS Spending (2023)



Source: https://www.medpac.gov/document/chapter-11-the-medicare-advantage-program-status-report-march-2023-report/.

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Policy Solutions

- Cap MA benchmarks at 100% of FFS costs
- Exempt areas with low MA penetration
- Calculate benchmarks using population with both Part A and Part B
- Budget impact: -$385 billion (benchmark cap) and +$440 billion (benchmark population)

Quality Bonuses

- Plans receive a star rating from 1-5 based on their performance on quality metrics
- Plans with higher star ratings receive a bonus in their benchmark and get a bigger rebate
- Very few quality metrics focus on health outcomes; stars are not be useful indicator of plan quality

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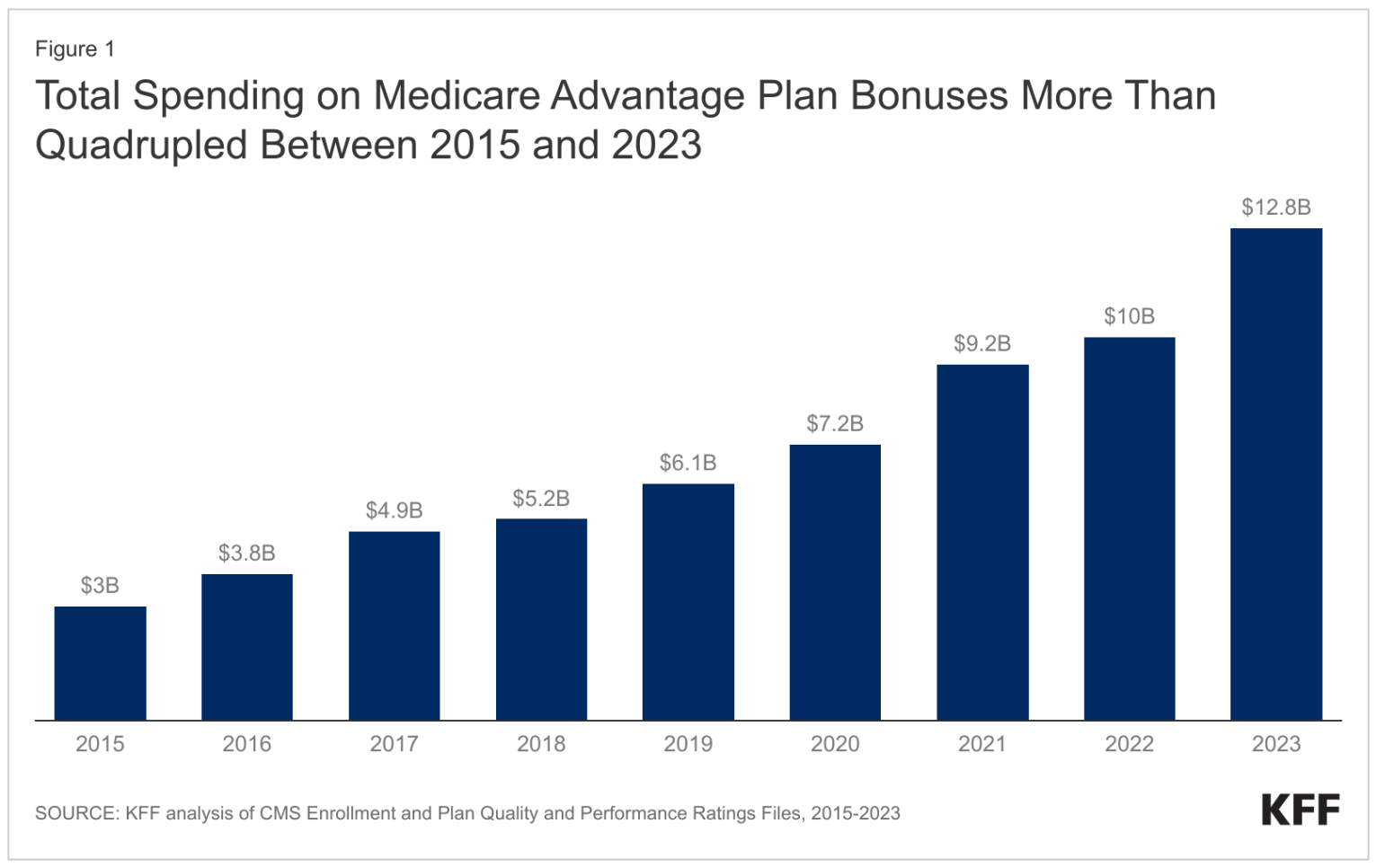
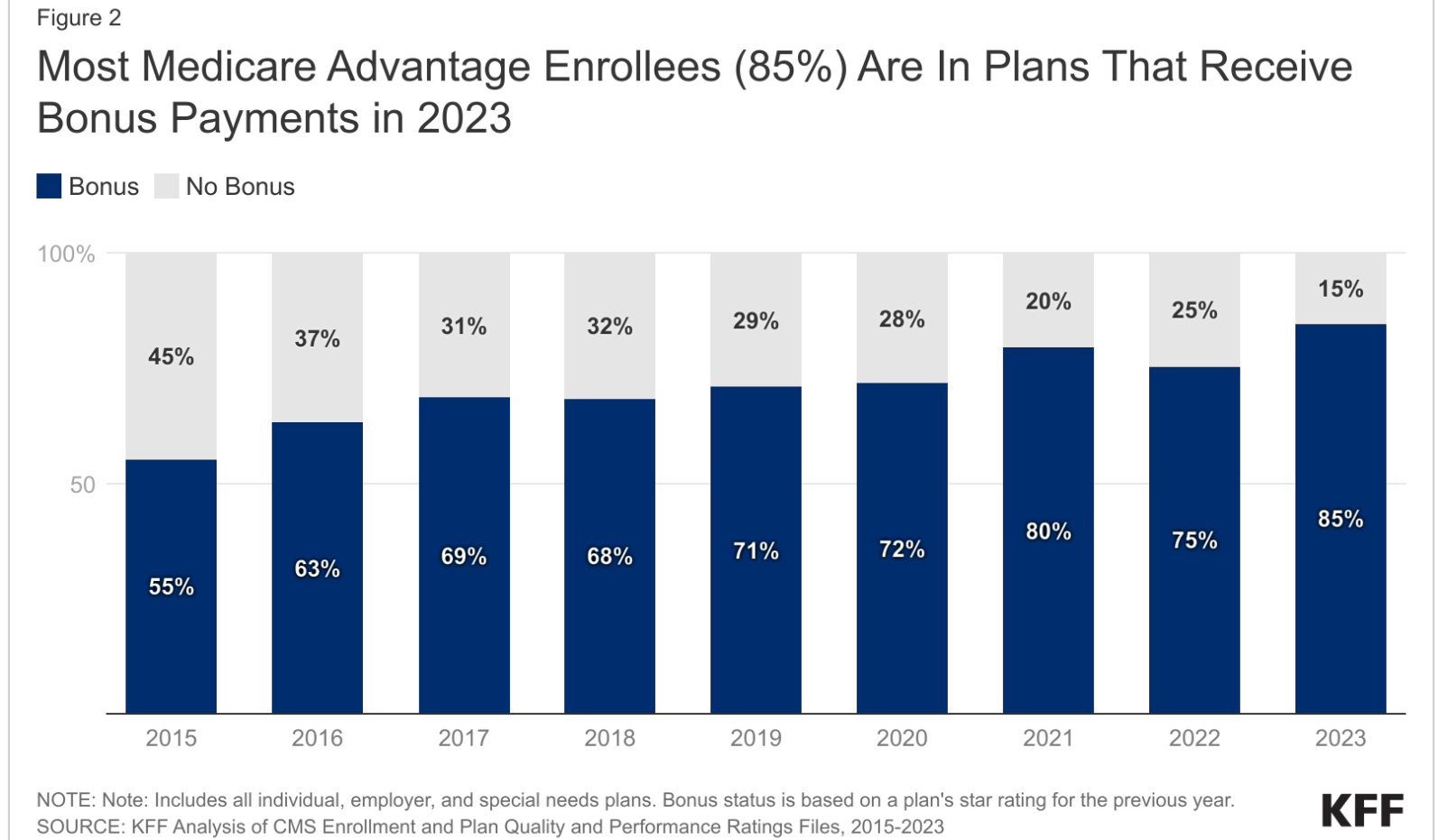
Key Issues & Solutions



Adapted from original figure by KFF

Key Issues & Solutions



Adapted from original figure by KFF

Policy Solutions

- Eliminate quality bonuses for benchmarks
- Budget impact: -$170 billion

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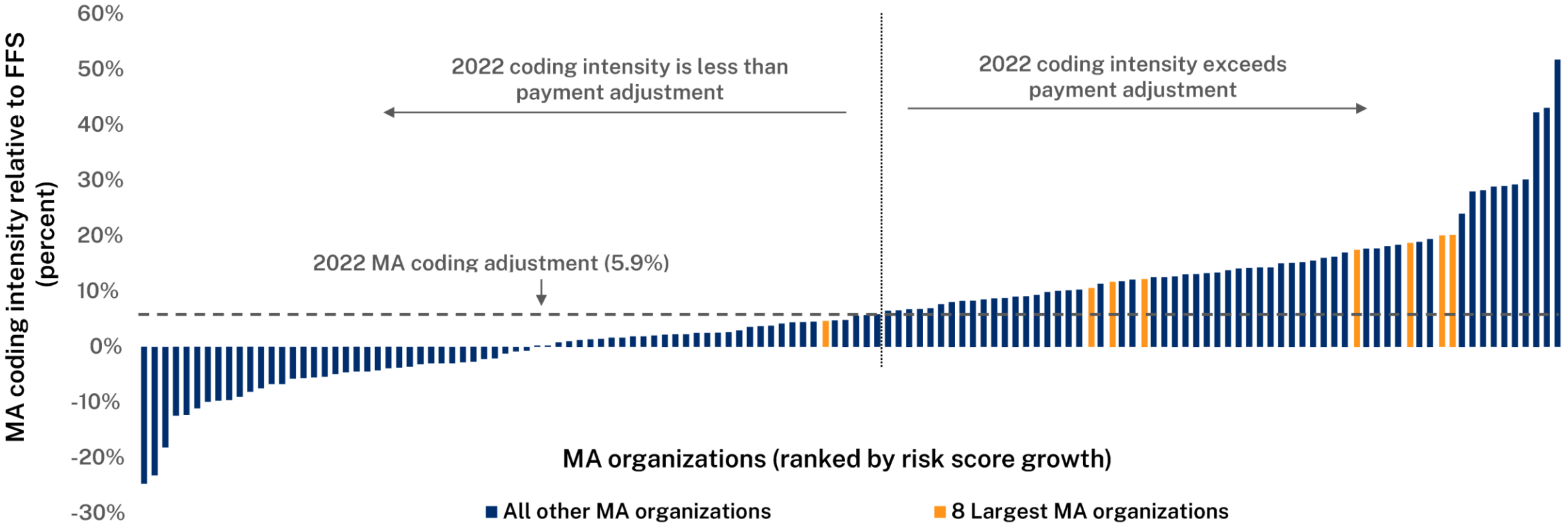
Coding Intensity

- Risk adjustment means plans get higher payments for sicker patients
- This combats a potential negative incentive for plans to avoid these enrollees
- However, it also incentivizes much more diagnostic coding in MA compared to FFS, called “coding intensity”

Coding intensity generates payment inequity across MA organizations



Note: MA (Medicare Advantage), FFS (fee-for-service). Estimates are for 2022 and exclude special needs plans, contracts for the Program of All Inclusive Care for the Elderly, and organizations with fewer than 2,500 enrollees in the analysis. All estimates account for any differences in age, sex, Medicaid eligibility, and institutional status between MA and FFS populations. New enrollees are constrained to have no coding intensity as their risk scores are not based on diagnostic coding.

Source: MedPAC analysis of CMS enrollment and risk score files.

Policy Solutions

- Scale coding intensity adjustment by plan based on risk score trend or diagnostic practices
- Raise average coding intensity adjustment and apply statutory maximum
- Expand use of RADV audits
- Strengthen transparency and notice-and-comment rules for administrative changes to risk score
- Budget impact: -$85 billion from changes to the coding intensity adjustment

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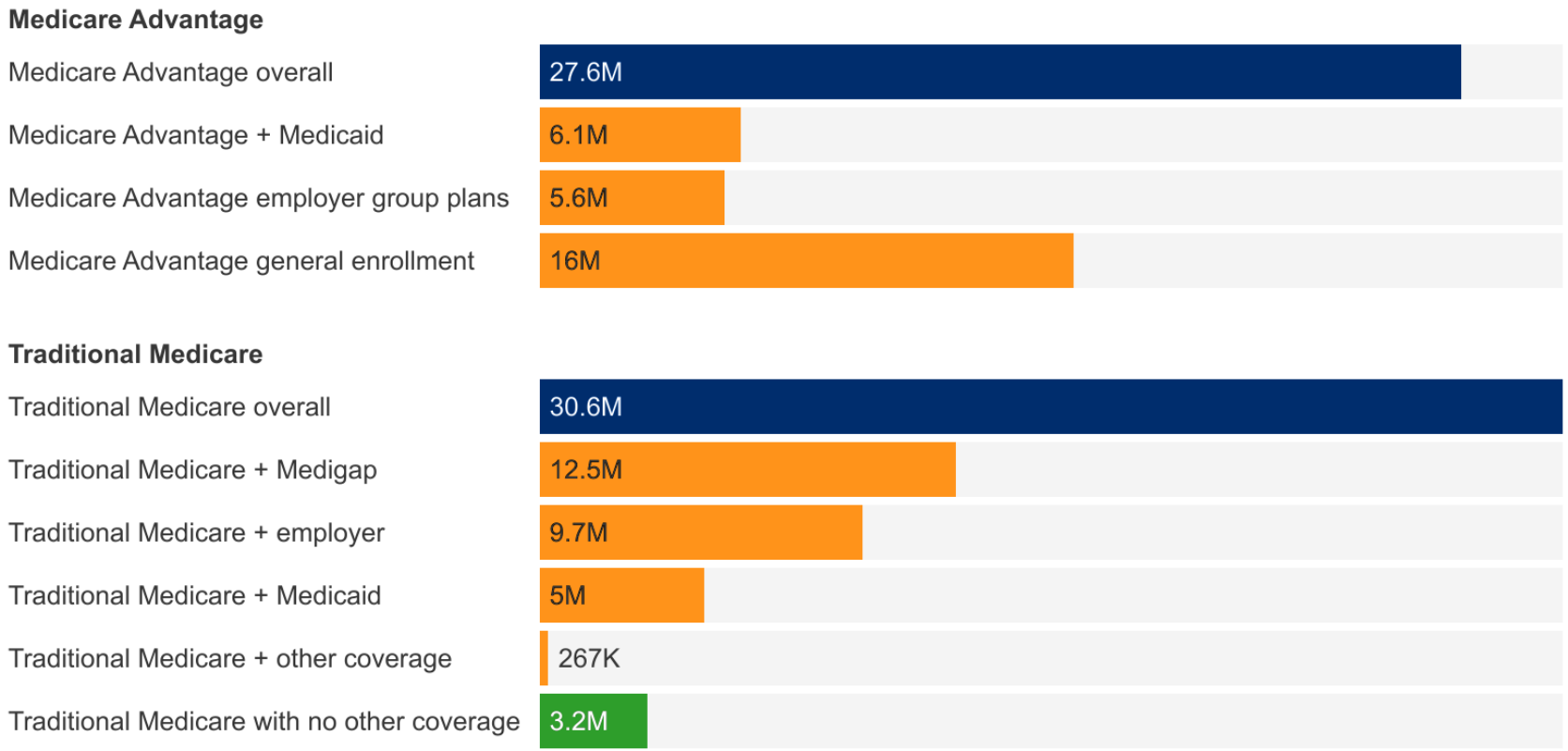
MA and FFS Parity

- FFS does not face the same requirements to operate efficiently as MA does
- One example: Medigap plans
  - Private plans that can cover FFS cost sharing
  - Mostly purchased by healthier, wealthier seniors
  - Increase FFS spending by up to 27%
- FFS is the default enrollment option for newly eligible beneficiaries
- High spending in FFS increase MA benchmarks

Figure 1

Nearly all People with Medicare Had Coverage Either Through Medicare Advantage Plans or Traditional Medicare Coupled with Some Other Type of Coverage in 2021

Three Million Medicare Beneficiaries in Traditional Medicare Had No Additional Coverage in 2021



NOTE: Total excludes beneficiaries with Part A only or Part B only for most of the year (n=5.0 million) or Medicare as a Secondary Payer (n=1.6 million).
SOURCE: KFF analysis of CMS Medicare Current Beneficiary Survey, 2021 Survey File.

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Adapted from original figure by KFF

Policy Solutions

- Restrict Medigap plans from “first-dollar” coverage of FFS cost-sharing
- Require Medigap plans to follow same insurance rules as MA plans (i.e., community rating, guaranteed issue)
- Direct new beneficiaries to choose FFS or MA
- Align other policies across FFS and MA
- Budget impact: -$50 billion from first-dollar limits

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Table 1: Budgetary Impact of Policy Recommendations

Policy	Description	10-Year Score ($ Billions)	10-Year Score (% MA Spending)
Benchmark Calculation	Calculate MA benchmarks based on FFS beneficiaries with both Part A and Part B enrollment, not A or B	+$440	+5.9%
Benchmark Cap	Cap MA benchmarks at 100% of FFS costs except for lower penetration areas	-$385	-5.1%
Eliminate Quality Bonuses	End benchmark increases from star ratings	-$170	-2.3%
Risk Adjustment	Raise coding intensity adjustment and scale by plan, expand RADV audits, authorize transparent changes to risk model	-$85	-1.1%
Medigap Restrictions	Restrict first-dollar Medigap coverage of FFS cost-sharing, extend MA guaranteed issue and community rating protections	-$50	-0.7%
Default Enrollment	Direct new beneficiaries to affirmatively choose between MA and FFS	N/A	N/A
Regulatory Flexibility	Provide more flexibility in MA benefit offerings and contract terms and remove excessive regulations	N/A	N/A
Total		-$250	-3.3%

SOURCES: Conversions between dollar and percentage figures are based on projected Medicare expenditures for group plans and are subject to rounding. See CBO, "Baseline Projections: Medicare," May 2023, https://www.cbo.gov/system/files/2023-05/51302-2023-05-medicare.pdf; Wakely, "Value of Medicare Advantage Compared with Fee for Service," September 21, 2022, https://www.ahip.org/documents/Value-of-MA-_Response-to-MedPAC_09.21.2022.pdf. Author's calculations of MA-specific savings based on CBO, "Reduce Quality Bonus Payments to Medicare Advantage Plans," "Modify Payments to Medicare Advantage Plans for Health Risk," and "Change the Cost-Sharing Rules for Medicare and Restrict Medigap Insurance," in *Options for Reducing the Deficit, 2019 to 2028*, December 13, 2018, https://www.cbo.gov/budget-options/2018/54736.

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