Balancing financial pressure and equity in Medicare Advantage benchmark policy

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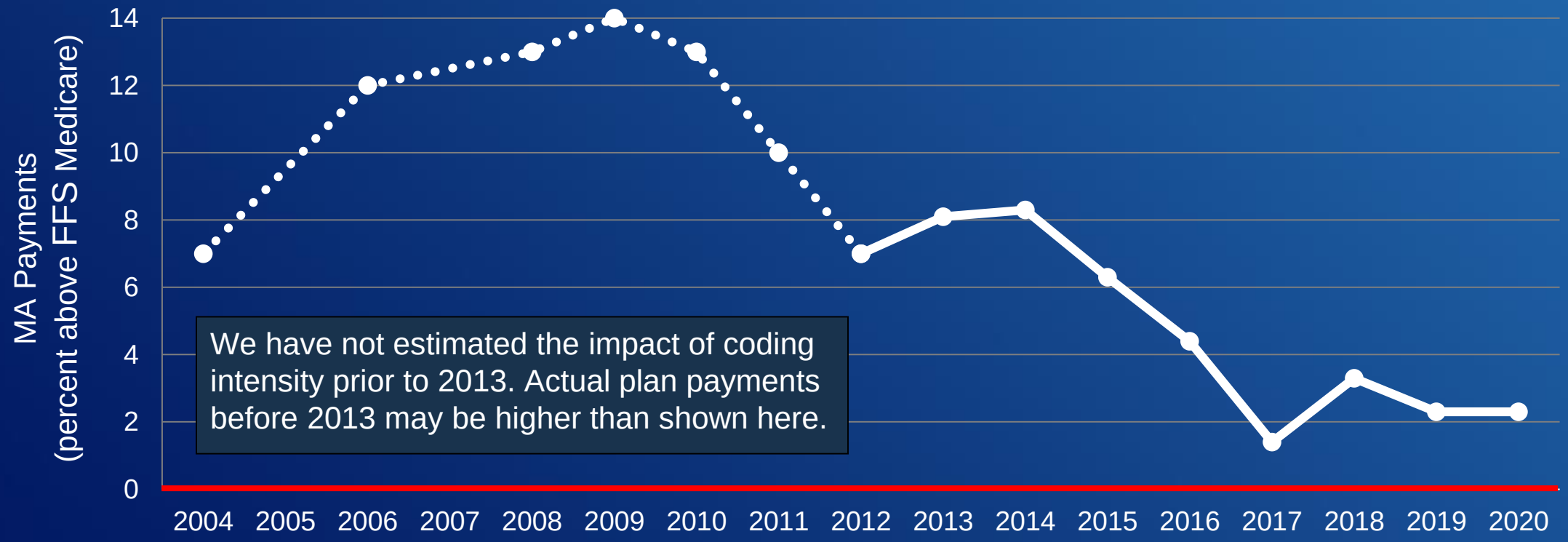
MEDPAC

Today's presentation

- Consider how Medicare polices treat the Medicare Advantage (MA) and Original Medicare (FFS) programs
  - Financial pressure: historical and current MA and FFS payments
  - Benefits: extra benefits in MA, use of Medigap in FFS
- Current MA payment basics
- Issues with MA benchmark and rebate policies
- Alternative approach for establishing benchmarks

Private plans have *never* yielded aggregate savings to Medicare

- Payments to private plans before 2004 suffered from risk selection
- Since 2004, payments to MA plans continue to be above FFS:



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Source: MedPAC reports 2006 through 2020 and analysis of risk score files.
Estimates are preliminary and subject to change.

The MA program is robust and growing

- Despite ACA payment reductions, from 2016 to 2020:
  - MA share of Medicare enrollment: 32 to 39 percent
  - Average number of plan choices: 18 to 27 plans
  - Share of beneficiaries with $0 premium plan option available: 81 to 93 percent
  - Value of extra benefits per enrollee: $972 to $1,464 annually
    - Reduced cost sharing
    - Reduced Part B and Part D premiums
    - Health-related benefits (e.g., vision, dental, gym memberships)

ACA (Affordable Care Act of 2010).
Estimates are preliminary and subject to change.

Balancing financial pressure and equity between MA and FFS Medicare

- Differences in benefits:
  - FFS enrollees are not restricted by provider networks, but often purchase Medigap policies to reduce cost-sharing or for extra benefits
- Should we expect efficiency from the MA program?
  - Currently, efficiency relies on reductions in FFS spending
- Does current MA spending provide sufficient value?
  - 13 percent of MA payments go to extra benefits (including some administration costs and profit)
  - Availability of extra benefits varies across benchmark levels
  - Plan quality is not meaningfully measured
  - Limited encounter data hinders our ability to understand plan efficiency

How Medicare pays MA plans

- Each plan submits a bid: Estimated revenue needed to cover the basic Medicare benefit (Parts A and B)
- Bids are compared with benchmark to determine base payment
- If bid < benchmark (almost all plans)
  - Base payment is the plan bid + a “rebate”
  - Rebate is a share (50 to 70 percent, 65 percent on average) of the bid and benchmark difference, must be used to cover extra benefits
  - Medicare keeps the remainder of the bid and benchmark difference
- If bid > benchmark (rarely)
  - Base payment is benchmark, enrollee pays difference as premium

MA benchmarks are set based on quartiles of fee-for-service (FFS) spending

Quartiles (786 counties each)	Current Benchmark
Lowest FFS spending	115% FFS
2nd lowest spending	107.5% FFS
2nd highest spending	100% FFS
Highest spending	95% FFS

- Counties ranked by FFS spending and divided into quartiles
- Benchmarks set as a percentage of county FFS spending for each quartile
- For 2020, the average benchmark is 103 percent of FFS spending

Issues with MA benchmarks

- Benchmarks 15 percent above FFS spending have attracted a disproportionate share of MA enrollment
  - Plans are paid 10 percent above FFS, have highest share of MA enrollment
- Quartile system creates benchmark "cliffs" across counties
  - $1 difference in FFS spending can result in $54 difference in benchmark
- Despite plan bids averaging 88 percent of FFS, current benchmark and rebate system has not yielded aggregate savings to Medicare

Alternative benchmark structure

- Over the long-term, the Commission could discuss benchmark and rebate alternatives that would require a major overhaul, such as benefit uniformity across FFS and MA
- In the short-term, the Commission could consider a benchmark alternative that:
  - Could be implemented immediately
  - Would apply fiscal pressure on MA plans and support wide availability of plans without paying excessive rates

Benchmarks that blend local area and national spending align with Commissioner preferences

- During November 2019 meeting, Commissioners coalesced around certain preferences:
  - Eliminating the benchmark cliffs between payment quartiles
  - Benchmarks above local FFS spending should be brought much closer to local FFS spending
  - Benchmarks in some high-spending areas (in the 95% quartile) are inappropriately high and could be reduced
  - An immediate change in benchmarks should try to avoid being overly disruptive to basic supplemental coverage (e.g., cost sharing reductions)
- Benchmarks that blend local and national FFS spending and apply a discount factor conform to Commissioner preferences

Assumptions underlying blended benchmark alternative simulations

- Compare with current base benchmarks (prior to quality bonus), which are 103% of FFS spending
- Includes MedPAC recommendations:
  - Adjust FFS spending for population with both Part A and Part B
  - Remove benchmark caps
  - Remove quality bonus from benchmarks
- Simulations use a 75% rebate—an increase from current 65% rebate average—to align with pre-ACA quality bonus rebates
  - An alternative structure for MA supplemental benefits will require a longer-term discussion for the Commission to address in the future

Three aspects to consider with a blended benchmark alternative

- *Weight applied to local and national spending:* We simulate a 50/50 blend to meet Commissioners' preferences for additional financial pressure on both the highest and lowest spending areas
- *Floor and ceiling relative to local FFS spending:* We simulate two scenarios: (1) a ceiling of 115% of FFS and floor of 95% of FFS, and (2) a ceiling of 115% of FFS and floor of 90% of FFS
- *Level of savings incorporated into benchmarks through a discount rate:* We incorporate a discount rate of 2%

Weighting: 50/50 blend of local and national FFS spending decreases benchmarks in both low and high spending areas

Benchmark policy	MA benchmark as a % of local FFS spending				
	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
Current base benchmark	*113%*	*107%*	*100%*	*97%*	*94%*
Local/national FFS weight:					
50/50	106%	103%	100%	96%	92%
70/30	103%	102%	100%	98%	95%
90/10	101%	101%	100%	99%	98%

Note: FFS (fee-for-service), MA (Medicare Advantage). We used CMS's estimate of FFS spending for 2020 benchmark calculations and made adjustments to better reflect spending for the FFS population with both Part A and Part B coverage. Current base benchmark includes the cap on benchmarks. National spending reflects the median per capita value across all local areas. Results are preliminary and subject to change.

Source: MedPAC analysis of 2020 MA rate data

Ceiling and floor: Should benchmark limits be set relative to local FFS spending?

- Under blended benchmarks:
  - 3 counties would be above the current 115% quartile factor
  - 529 counties would be below the current 95% quartile factor
- Most areas with a blended benchmark below 95% of FFS spending had average MA bids below 80% of FFS
- Most areas with a blended benchmark below 90% of FFS were rural with a low share of MA enrollment
- We simulated two scenarios:
  - 95% floor/115% ceiling relative to FFS
  - 90% floor/115% ceiling relative to FFS

Level of savings: 2% discount in blended benchmarks would help Medicare share in plan efficiencies

Blended benchmark	Overall	Quartiles of FFS spending			
		Lowest	Second	Third	Highest
Simulated MA payment relative to current MA base payments:					
115% Ceiling; 95% Floor	**-1%**	-4%	-3%	0%	+3%
115% Ceiling; 90% Floor	**-2%**	-4%	-3%	0%	-1%

Note: FFS (fee-for-service), MA (Medicare Advantage). We used CMS's estimate of FFS spending for 2020 benchmark calculations and made adjustments to better reflect spending for the FFS population with both Part A and Part B coverage. Current base benchmark includes the cap on benchmarks. National spending reflects the median per capita value across all local areas. Results are preliminary and subject to change.

Source: MedPAC analysis of 2020 MA rate and bid data

- Savings are not ensured without a discount rate applied to benchmarks
- Reducing benchmarks by 2% discount rate achieves 1-2% savings, depending on level of benchmark floor

Access to MA plans with rebates covering current levels of cost sharing would be high under this approach

	Quartiles of FFS spending			
	Lowest	Second	Third	Highest
Share of Medicare beneficiaries with at least 1 available plan	99%	99%	99%	95%
Avg. number of available plan sponsors	5	6	7	8
Avg. number of available plans	12	13	21	24

Note: FFS (fee-for-service), MA (Medicare Advantage). Available MA plans do not include employer plans, specials needs plans, and plans that did not offer cost sharing reductions in 2020. Payments for alternative benchmarks reflect rebate values at 75 percent of the difference between benchmarks and bids for plans that bid below the benchmark. Simulated rebate values for blended benchmarks assume no change in plan bidding behavior. Current base benchmarks and payment rates reflect current policy without quality bonus payments. Blended benchmarks reflect a 50/50 weight of local area FFS spending and the median spending across all local areas. Blended benchmarks also include a 2 percent reduction through a discount rate. Plan sponsors represent the number of distinct parent organizations. Results are preliminary and subject to change.

Source: MedPAC analysis of 2020 MA rate data

Blended benchmarks help Medicare realize MA's potential

- The growth in Medicare program spending poses a significant challenge for the federal government
- MA has the potential to serve as a vehicle to address that challenge
- MA has not realized its potential for the Medicare program largely because of its benchmark structure
- Applying appropriate financial pressure to MA through a blended benchmark structure could help the Medicare program realize savings and broaden the use of value-based payment

Discussion

- Does the alternative benchmark blend appropriately balance financial pressure with geographic equity?
- Should additional financial pressure be phased-in for areas where benchmarks would still be above FFS spending?
- Is it appropriate to have a benchmark floor and ceiling relative to FFS spending in each local area?
- Is 2% the appropriate level of savings for the Medicare program to share in MA efficiencies?