The Medicare Advantage program: Status report and a benchmark policy option

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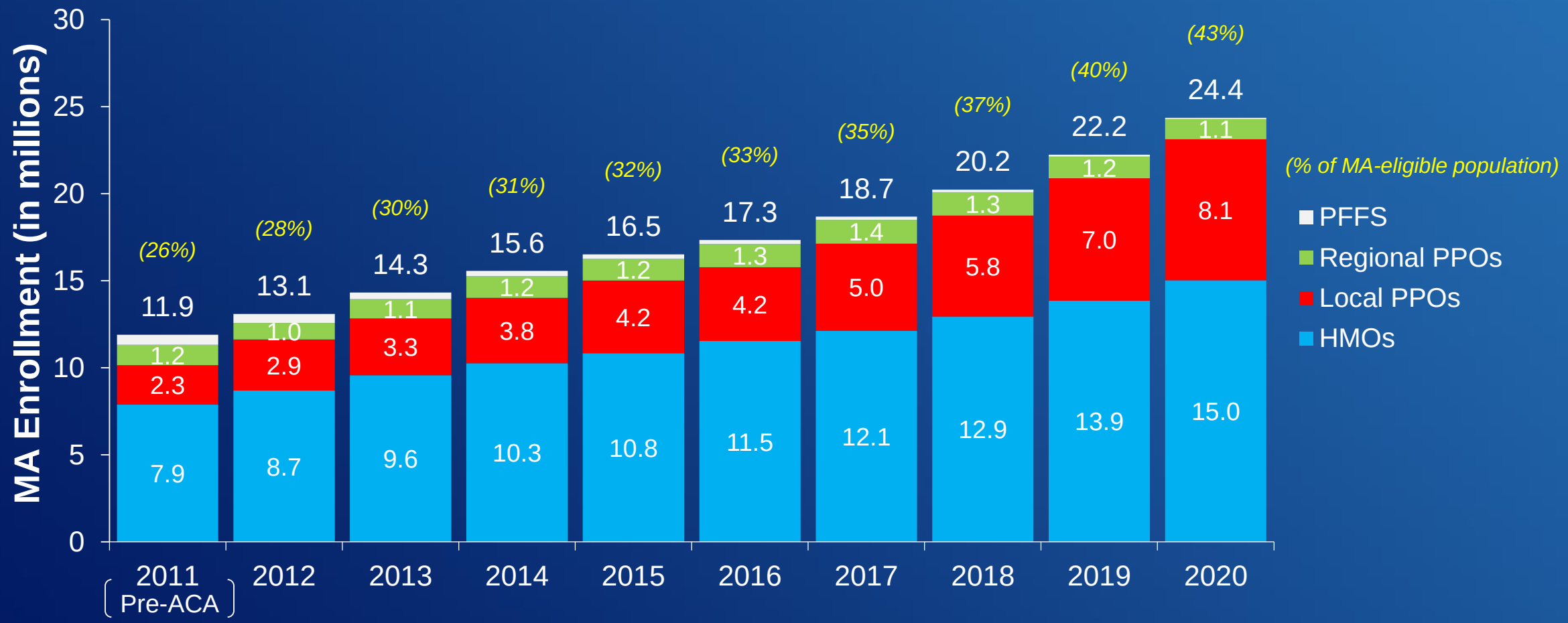
Today's presentation

- Status report on Medicare Advantage (MA) enrollment, availability, benchmarks, bids, and payment
- Update on coding intensity
- Alternative approach for establishing benchmarks

In 2020, 43% of eligible beneficiaries enrolled in MA plans



Notes: MA (Medicare Advantage), ACA (Affordable Care Act of 2010), PFFS (private fee-for-service), PPO (preferred provider organization), HMO (health maintenance organization). MA-eligible beneficiaries have both Part A and Part B coverage. PFFS plans enrolled less than 1 million beneficiaries in each year. ACA benchmark reductions began in 2012 and were fully implemented in 2017.
Source: CMS enrollment data, July 2011-2020

Estimates preliminary and subject to change

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MA plans available to nearly all Medicare beneficiaries; number of plan choices increasing

Plan availability*	2017	2018	2019	2020	2021
Any MA plan	99%	99%	99%	99%	**99%**
Zero-premium plan w/Part D	81	84	90	93	**96**
Avg. number of choices (beneficiary-weighted)	18	20	23	27	**32**

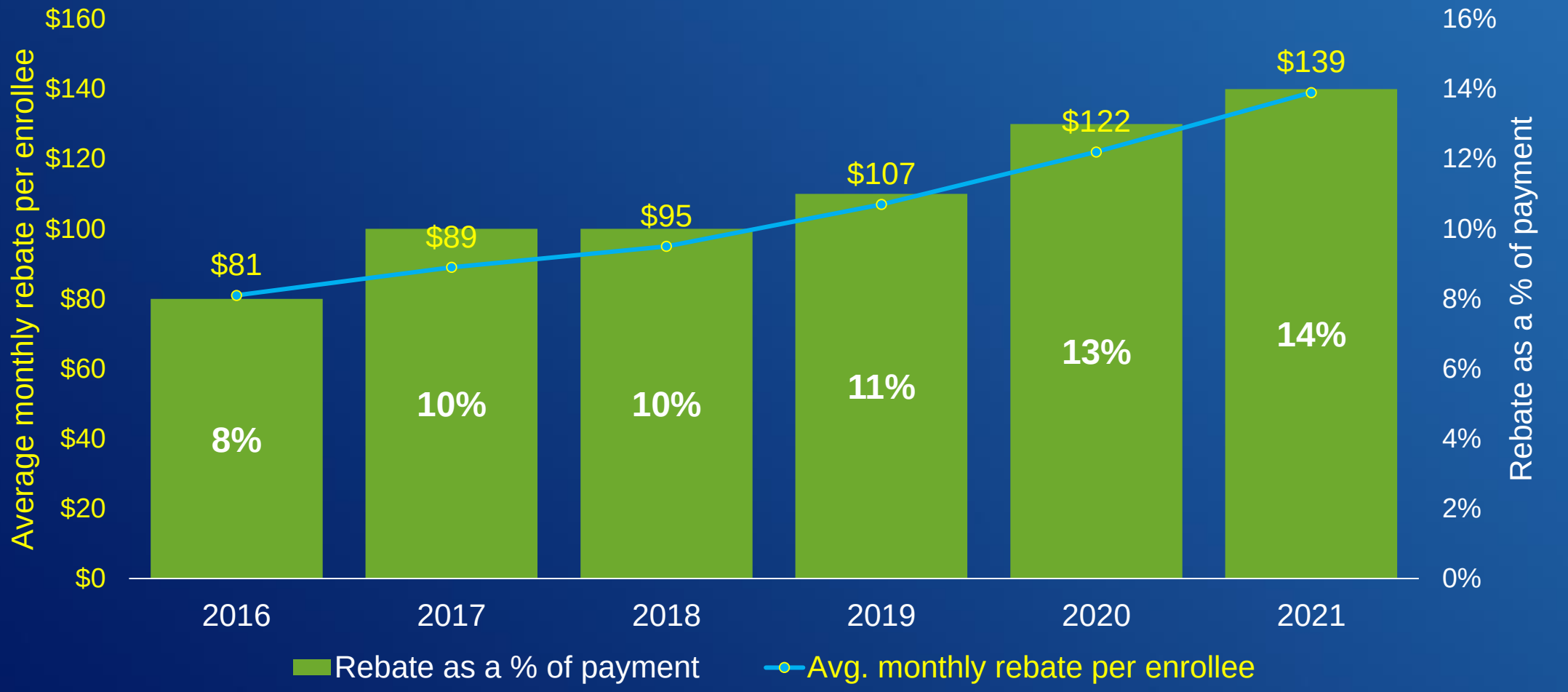
*Medicare beneficiaries with a non-employer, non-Special Needs MA plan available

Source: CMS enrollment data and plan bid submissions.

MA plan payment policy

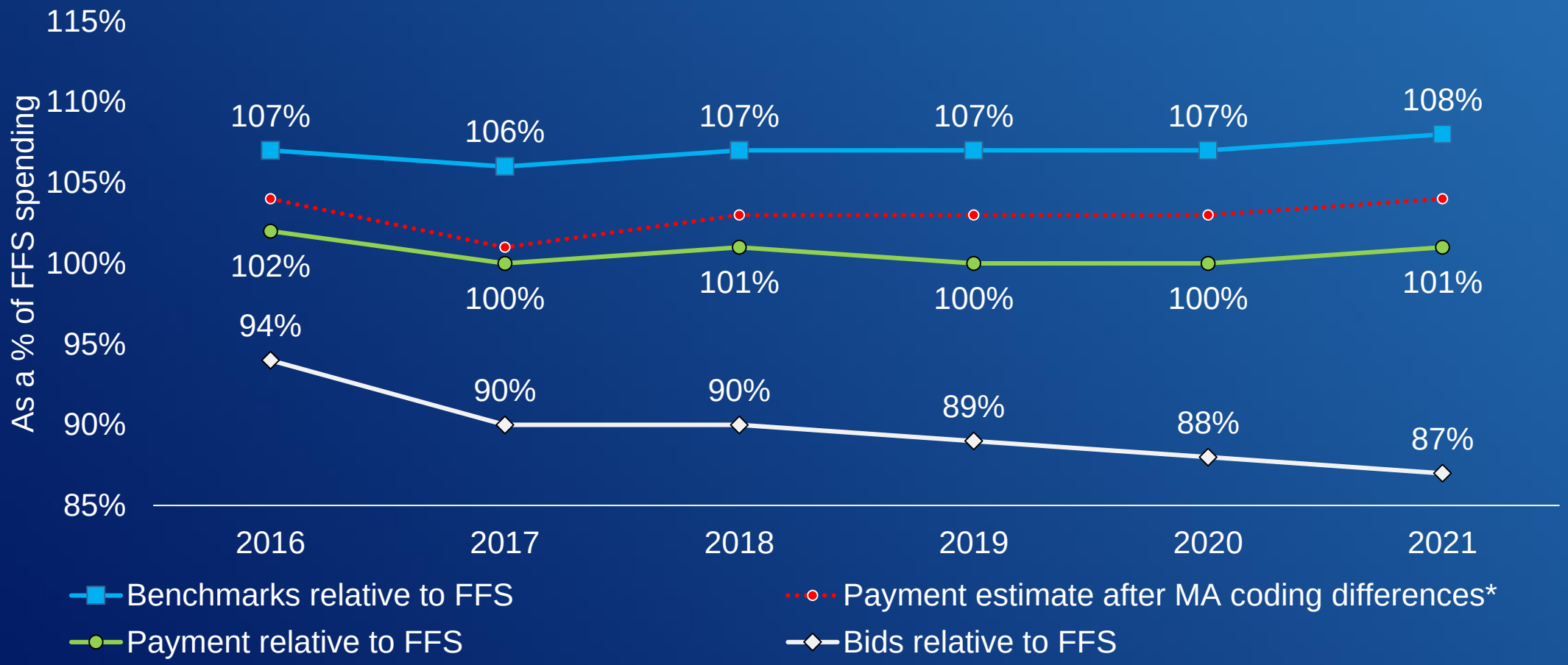
- Payments based on plan bids, benchmarks (county-based and risk-adjusted), and quality scores
- Benchmarks range from 115% of FFS in lowest-FFS spending counties to 95% of FFS in highest-spending counties
- Benchmarks are increased for plans based on overall quality scores
- If bid < benchmark, plans get a percentage (varies by plan quality score) of the difference as a “rebate”; Medicare keeps the rest of the difference
- If bid > benchmark, program pays benchmark, enrollee pays premium

Level of rebates reached historic high in 2021



Source: MedPAC analysis of MA bid data.
Estimates are preliminary and subject to change

MA bids at historic low relative to FFS, but MA payments continue to be above FFS in 2021



*Coding differences in 2020 and 2021 reflect 2019 levels (the most recent available data).
Note: FFS (fee-for-service). Benchmark and payment percentages include quality bonuses. Estimates preliminary and subject to change.
Source: Analysis of MA bid and rate data.

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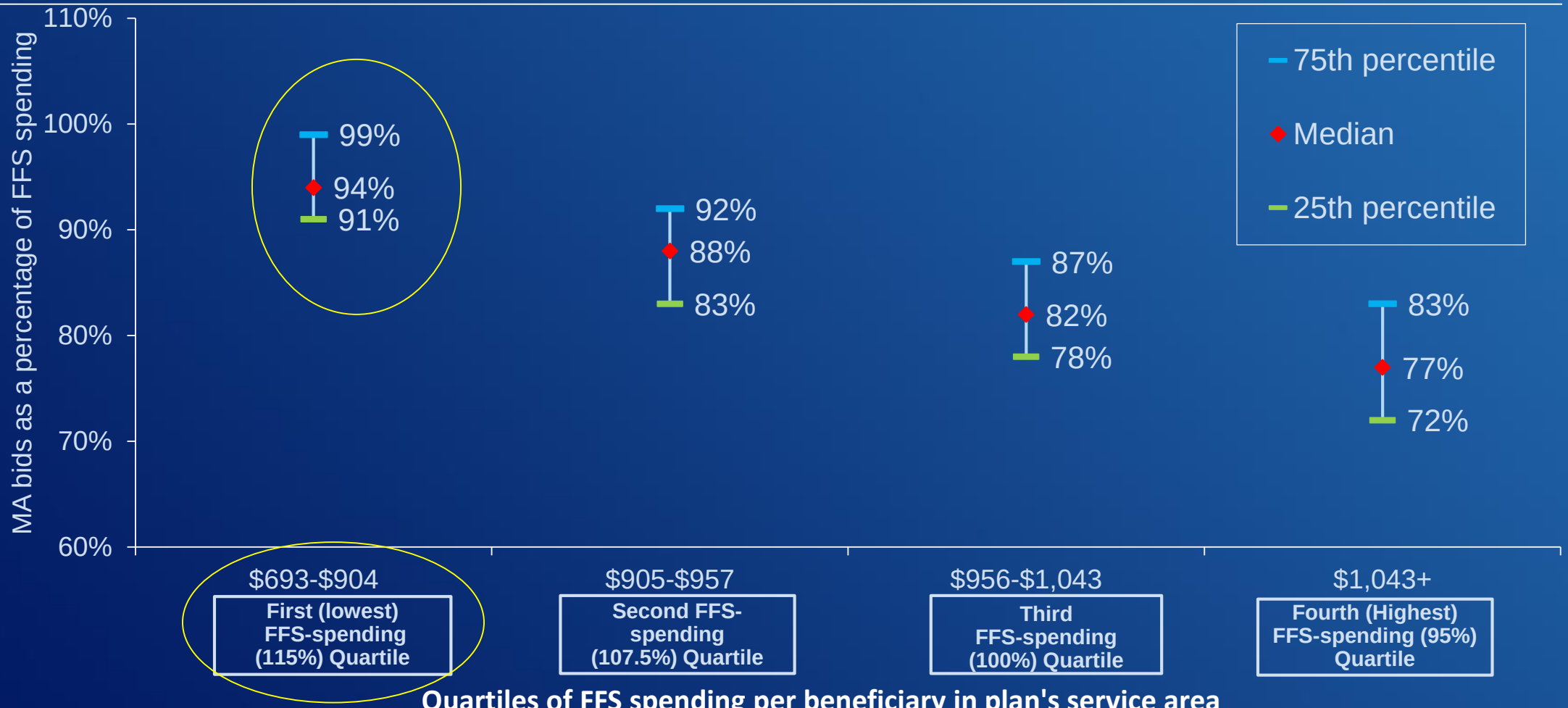
Even in the lowest-spending areas, most MA plans bid below local FFS spending



Note: FFS (fee-for-service). Benchmark and payment averages within each quartile include quality bonuses and are shown as a percentage of local FFS spending. Estimates preliminary and subject to change.
Source: Analysis of MA bid and rate data.

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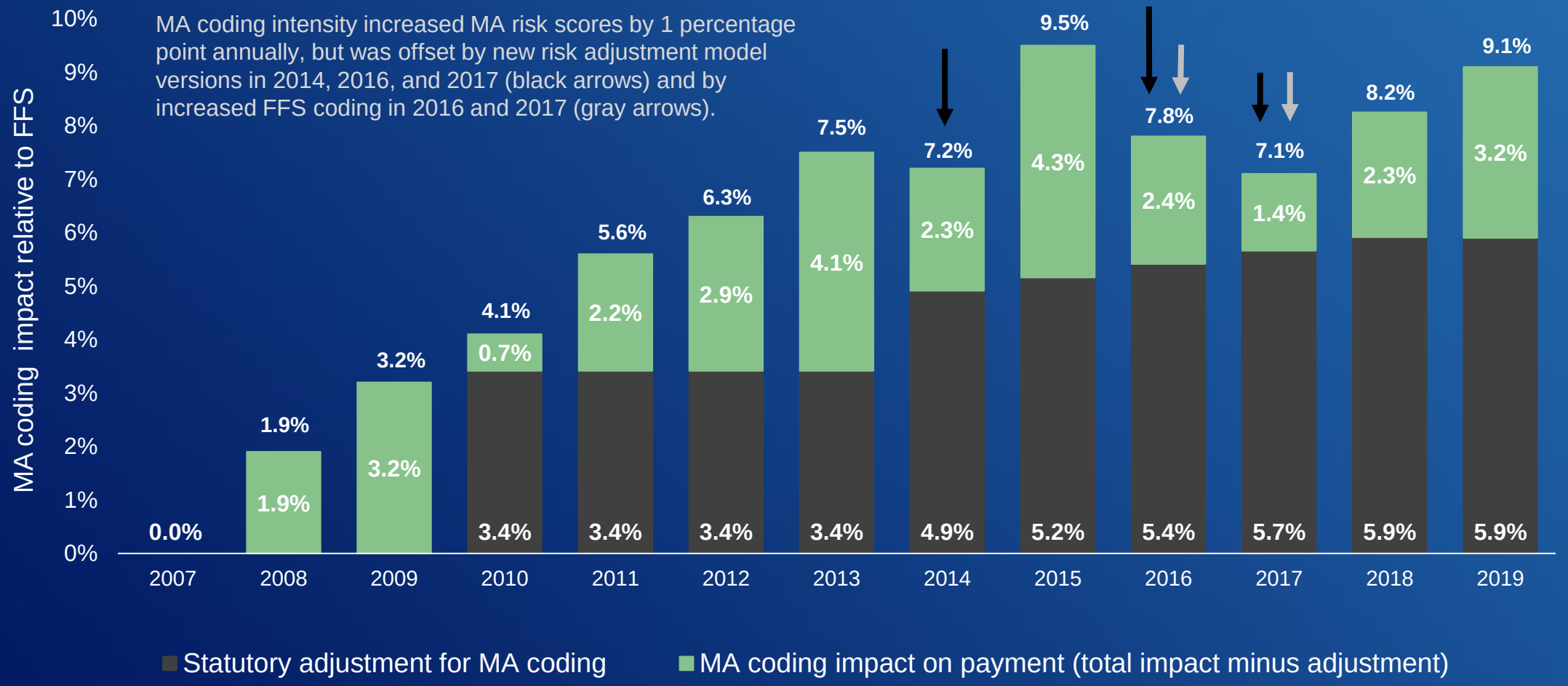
MA coding generated excess payments in 2019

- Differences in diagnostic coding between FFS and MA
  - FFS: Little incentive to code diagnoses
  - MA: Financial incentive to code more diagnoses
  - Leads to greater MA risk scores for equivalent health status
- 2019 MA risk scores were about 9 percent higher than FFS
- After accounting for CMS coding adjustment of 5.9 percent:
  - 2019 MA risk scores were more than 3 percent higher than FFS due to coding differences, generating about $9 billion in excess payments to MA plans

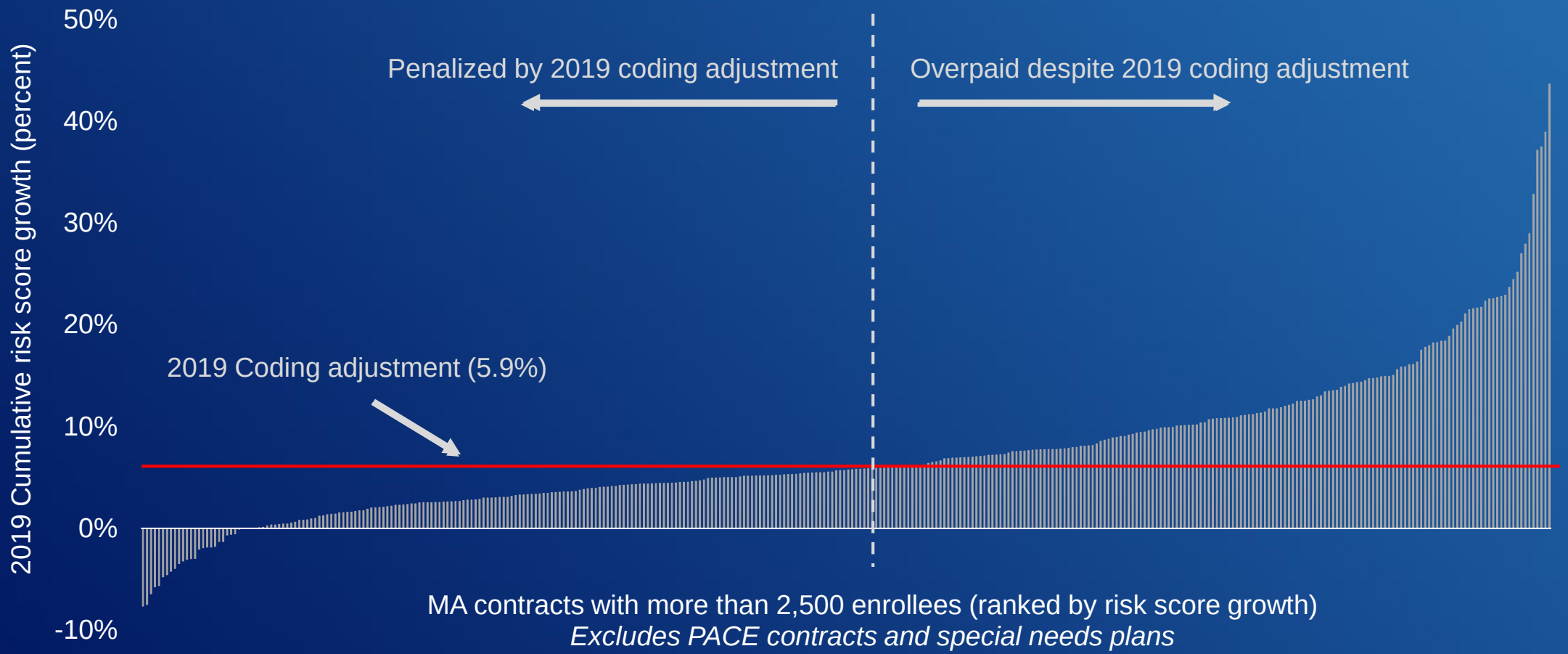
Source: MedPAC analysis of enrollment and risks score files.
Estimates are preliminary and subject to change.

Impact of MA coding intensity likely to increase; has been limited by model revisions



Source: MedPAC analysis of enrollment and risks score files.
Estimates are preliminary and subject to change.

Coding intensity varies across MA contracts



Source: MedPAC analysis of enrollment and risks score files.
Estimates are preliminary and subject to change.

Addressing MA coding intensity

- The Commission's recommendation addresses underlying causes of coding intensity *(March 2016)*
  - Remove health risk assessments (HRAs) from risk adjustment
  - Use two years of MA and FFS Medicare diagnostic data
- Removing chart reviews from risk adjustment would eliminate another underlying cause of coding intensity
  - OIG found that 2017 MA payments were inflated by $6.7 billion due to chart reviews and by $2.7 billion due to HRAs
  - We conclude that chart reviews and HRAs accounted for more than 60 percent of coding intensity in 2017

Source: MedPAC analysis of OIG report findings and CMS enrollment and risks score files. Estimates are preliminary and subject to change.

Office of Inspector General, Department of Health and Human Services. 2020. *Billions in Estimated Medicare Advantage Payments from Diagnoses Reported Only on Health Risk Assessments Raise Concerns.* OEI-03-17-00471. Washington, DC: OIG. Office of Inspector General, Department of Health and Human Services. 2019. *Billions in Estimated Medicare Advantage Payments from Chart Reviews Raise Concerns.* OEI-03-17-00470. Washington, DC: OIG.

Quality in MA cannot be meaningfully evaluated

- Quality bonus program (QBP) is not a good basis of judging quality for the more than 40 percent of Medicare beneficiaries in MA
  - Large and dispersed contracts, exacerbated by consolidations
  - Too many measures, some based on small sample
  - Cannot be compared to FFS in local market
- QBP accounts for about $9 billion annually in MA payments
- Commission recommended replacing the QBP with an improved value incentive program *(June 2020)*

Impact of COVID pandemic on MA

- Tragic effects on beneficiaries and the health care workforce and material effects on providers
- Reduced 2020 utilization resulted in lower plan medical expenses, while plan revenues remain at normal levels
  - Uncertainty about future expenses continues
  - In mid-year benefit changes, many plans lowered premiums, further reduced cost sharing, and expanded telehealth benefits

Summary of status of MA

- MA sector is extremely robust
  - Continued growth in enrollment, plan offerings, and extra benefits (now accounting for 14 percent of plan payments)
- The Commission has recommended improvements to the coding intensity adjustment and the quality system
- The MA benchmark system is flawed
  - For 2021, plan bids declined 1 percentage point, yet payments to plans rose 1 to 2 percentage points
  - MA plans now cost Medicare 4 percent more than FFS

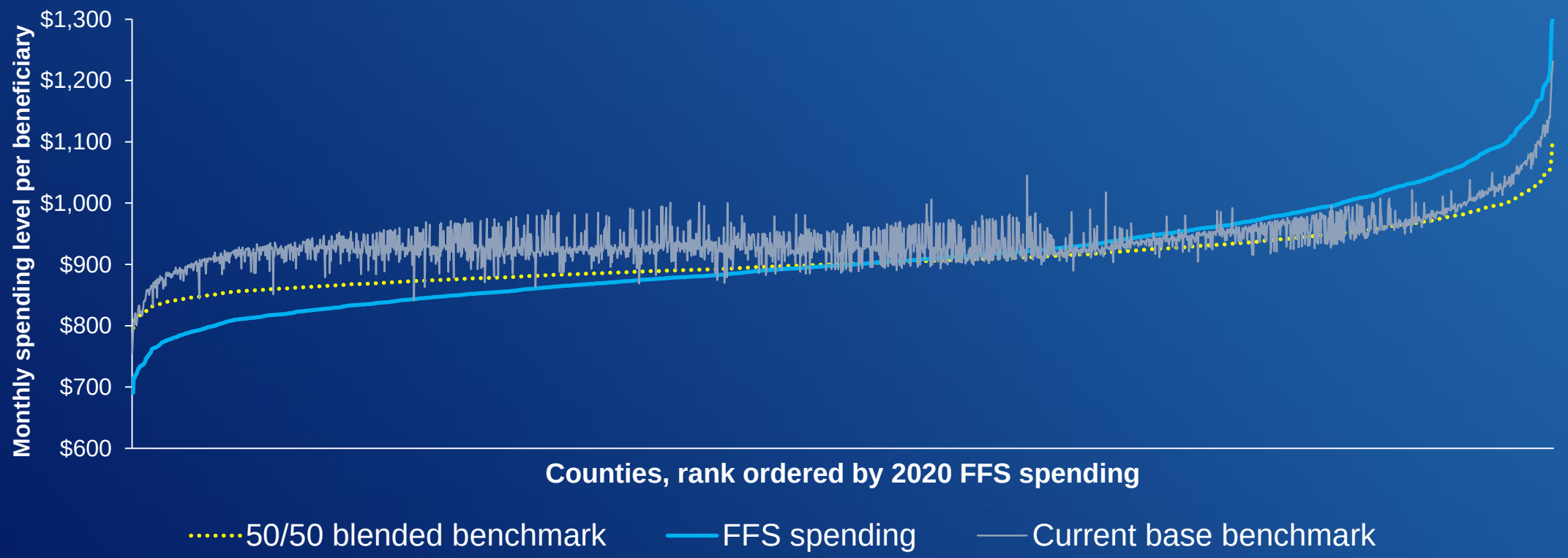
October meeting discussion: Benchmarks that blend local area and national spending

- Discussion centered around improvements for MA benchmarks:
  - 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 these improvements

Assumptions underlying blended benchmark alternative simulations

- Compare 2020 base benchmarks (prior to quality bonus), which are 103% of FFS spending
- Include 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
  - 75% equivalent to the highest shared savings for ACOs in the Medicare Shared Savings Program
  - An alternative structure for MA supplemental benefits will require a longer-term discussion for the Commission to address in the future

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



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. Blended benchmarks are equally weighted between mean local FFS spending and mean price-standardized national spending. Results are preliminary and subject to change.

Source: MedPAC analysis of 2020 MA rate data

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

50/50 Blended benchmark	Overall	Quartiles of FFS spending			
		Lowest	Second	Third	Highest
Simulated MA payment relative to current MA base payments:					
0% discount	**0%**	-3%	-2%	+1%	+1%
2% discount	**-2%**	-5%	-4%	-1%	-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. Blended benchmarks are equally weighted between mean local FFS spending and mean price-standardized national spending. 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 a 2% discount rate:
  - Achieves 2% overall savings
  - Maintains beneficiary access to an MA plan with enough rebate dollars to cover cost sharing

Four elements of an alternative benchmark policy

- During October 2020 meeting, Commissioners coalesced around a benchmark alternative that:
  - Uses a 50/50 blend of per capita local area FFS spending with price-standardized per capita national FFS spending
  - Uses a rebate of at least 75 percent
  - Integrates a discount rate of at least 2 percent, and
  - Applies prior MedPAC MA recommendations:
    - using geographic markets as payment areas
    - using the FFS population with Part A and B coverage
    - eliminating the pre-ACA cap on benchmarks

Two additional elements for Commission consideration

- Remaining questions:
  - Does an alternative benchmark structure warrant a phase-in, and if so, how long?
  - How should additional financial pressure be applied over time?
- We welcome feedback on two additional elements of an alternative benchmark policy:
  - a three-year phase-in
  - gradual application of a benchmark ceiling of 100 percent of local FFS spending

Discussion

- Reaction to basic alternative benchmark structure
- Guidance on open questions
- Elements of a benchmark alternative
  - From October:
    - 50/50 of blend local FFS spending and national price-standardized spending
    - Rebate of at least 75 percent
    - Discount rate of at least 2 percent
    - Applies prior MedPAC recommendations
  - 2 potential elements:
    - 3-year phase-in
    - Gradual benchmark ceiling of 100 percent of local FFS spending