Favorable selection and future directions for Medicare Advantage payment policy

Luis Serna, Eric Rollins, and Andy Johnson

March 3, 2023

MEDPAC

Today's presentation

- How Medicare uses FFS spending for MA benchmarks

- Current benchmarks create a favorable bias for MA plans

- Concerns about effects of declining FFS enrollment on MA benchmarks

- Alternative approaches:

  1. Use plan bids to calculate benchmarks (competitive bidding)

  2. Use both FFS and MA data to calculate benchmarks

  3. Update benchmarks using a fixed growth rate

- Discussion

Note: FFS (fee-for-service), MA (Medicare Advantage).

How Medicare pays MA plans

- Payments based on plan bids, county benchmarks, and quality scores
- Bids are plans' estimates of cost to cover Part A and Part B benefits
- Benchmarks range from 115% of FFS in lowest-FFS spending counties to 95% of FFS in highest-spending counties
- Benchmarks are increased for plans with a quality rating of 4+ stars
- If bid < benchmark, Medicare pays the bid plus a percentage (varies by plan quality score) of the difference as a "rebate"; Medicare keeps the rest of the difference
- If bid > benchmark, Medicare pays benchmark, enrollee pays premium to make up the difference

Note: FFS (fee-for-service), MA (Medicare Advantage).

MA benchmarks assume risk adjustment corrects for FFS and MA population differences

- County benchmarks are based on average FFS spending for a beneficiary with average health status (i.e., a risk score of 1.0)
- Risk scores increase payment for MA enrollees with higher expected costs associated with their demographics and medical conditions
- Risk scores predict costs accurately on average but will underpredict or overpredict costs for each beneficiary
  - Underpredicted costs = actual costs above the predicted cost
  - Overpredicted costs = actual costs below the predicted cost
- MA benchmarks assume that, on average, the accuracy of the risk adjustment model will be the same for FFS and MA enrollees

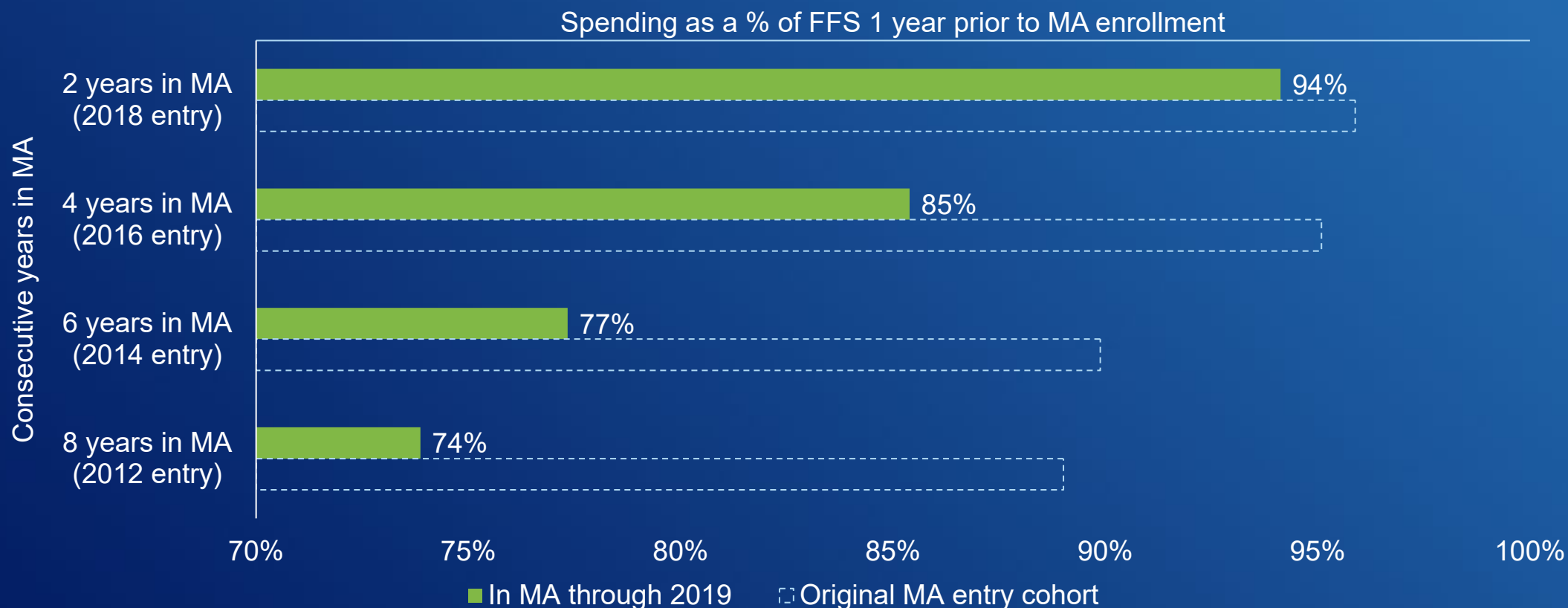Note: FFS (fee-for-service), MA (Medicare Advantage).

MA plan and beneficiary incentives may produce favorable selection

- MA favorable selection is when average MA costs are lower than their risk scores predict (i.e., risk scores overpredict MA spending) and is separate from MA coding

- Influence of plan incentives on favorable selection
  - Plan networks and prior authorization
  - Cost sharing for most services (compared with Medigap)

- Beneficiary self-selection in reaction to plan incentives
  - Plan networks and perceived delays in care from prior authorization may discourage enrollment from beneficiaries with certain health conditions
  - Beneficiaries who expect to use more medical services may prefer to stay in FFS and purchase supplemental insurance to cover out-of-pocket spending

Note: FFS (fee-for-service), MA (Medicare Advantage).

MEDPAC

FFS-based benchmarks create a favorable bias for MA plans

- A substantial body of research suggests that risk scores, on average, overpredict spending for the MA population, before considering any coding differences between FFS and MA

- Because MA benchmarks rely on risk-standardized FFS Medicare spending, they reflect the higher level of costs associated with the FFS-enrolled population rather than a plan's enrollees

- Favorable selection allows plans to bid lower than FFS spending before producing any efficiencies in care delivery
  - Creates overpayments for MA plans
  - Introduces bias in risk-standardized comparisons with FFS

Note: FFS (fee-for-service), MA (Medicare Advantage).

Beneficiaries that remain in MA tended to have greater initial favorable selection

Spending as a % of FFS 1 year prior to MA enrollment

Note: MA (Medicare Advantage), FFS (fee-for-service). MA entrants are beneficiaries that switched to from FFS to MA during the year of entry. MA entrants who stayed in MA through 2019 are those with at least one month of MA enrollment in 2019. Beneficiaries who left MA after the entrant year are those who either returned to FFS or died during the period. Spending reflects the year prior to MA entry, is risk-adjusted, and excludes beneficiaries without at least two full years of enrollment in FFS Parts A and B prior to the year of MA entry. Results are preliminary and subject to change.

Source: MedPAC analysis of Medicare enrollment, beneficiary spending, and risk adjustment files, 2009-2019.

Favorable selection of MA enrollees results in higher-than-warranted MA benchmarks and payments

- 2008-2019 FFS experience of 2020 MA entrants suggests that favorable selection persists after beneficiaries enter MA
- Overall, we estimate 11 percentage points of MA favorable selection in 2019 (separate from any coding differences between MA and FFS)
- These findings raise concerns about the appropriateness of basing MA benchmarks exclusively on FFS spending data

Note: FFS (fee-for-service), MA (Medicare Advantage). Results are preliminary and subject to change.

Declining FFS enrollment may pose challenges for setting MA benchmarks

- Counties with fewer than 1,000 FFS beneficiaries may have unstable FFS spending estimates and require a credibility adjustment

- Counties with the lowest shares of FFS enrollees tend to have more FFS enrollees who are eligible for full Medicaid benefits or qualified for Medicare due to disability
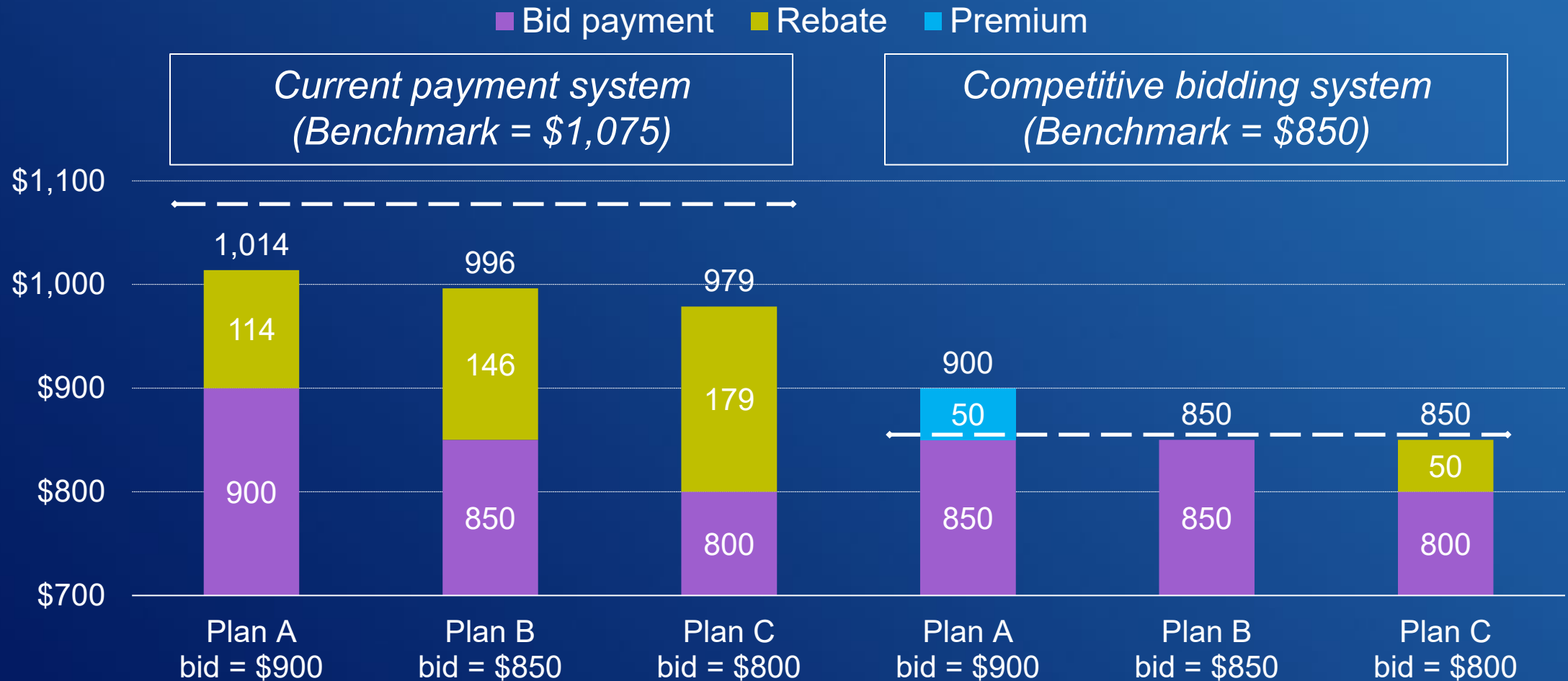
Three alternative options for setting MA benchmarks

1. Use plan bids to calculate benchmarks (competitive bidding)

2. Use both FFS and MA spending data to calculate benchmarks

3. Set benchmarks and update them using a fixed growth rate instead of FFS spending growth rates

1. Competitive bidding

- Benchmarks would be based on MA plan bids instead of FFS spending data
- Competitive bidding would differ from premium support because it would only be used for MA payments and have no direct effect on FFS
- The use of bidding could potentially generate more accurate MA payment rates and more program savings

1. Illustrative example of how MA plan payments could change under competitive bidding

Legend: ■ Bid payment ■ Rebate ■ Premium

Current payment system (Benchmark = $1,075)

	Plan A bid = $900	Plan B bid = $850	Plan C bid = $800
Total	1,014	996	979
Rebate	114	146	179
Bid payment	900	850	800

Competitive bidding system (Benchmark = $850)

	Plan A bid = $900	Plan B bid = $850	Plan C bid = $800
Total	900	850	850
Premium	50		
Rebate			50
Bid payment	850	850	800

Note: In this example, $850 is enrollment-weighted average bid for the county. The relationship between the enrollment-weighted average bid and the current benchmark would vary depending on plan bids and the number of enrollees in each plan.

MEDPAC

1. Competitive bidding: Design considerations

- Plans could be standardized to promote price competition
- Specific method used to calculate benchmarks
- Benchmarks could be capped to help ensure that bidding generates program savings
- Bidding would reduce the impact of favorable selection and coding intensity on program spending
- Uncertainty about how plans would change their bidding behavior under a new system

MEDPAC

2. Use all Medicare spending (local area FFS + MA) to set benchmarks

- In each local area, FFS and MA spending would be blended based on the share of FFS and MA enrollment
  - Use current bidding and benchmark structure, but with different benchmarks
  - If the FFS population declines, the benchmark would rely more on spending for MA enrollees
- Empirically-based benchmarks adjust for changes in prices, technologies, coverage, and behavior
- Influence of favorable selection would be reduced

2. Simulating benchmarks using FFS and MA spending estimates

- FFS spending estimated as under current policy, but updated for MedPAC recommendations
- MA spending estimated using encounter data (in the future) or plan bids (in today's presentation)
  - Includes a rebate add-on amount (e.g., 10 percent of plan bids)
- In each local area, FFS and MA spending projected to the payment year and weighted by the share of FFS and MA enrollment

2. Simulated benchmarks clustered around local FFS spending, bids below simulated benchmarks

Simulated MA benchmarks as a percent of local area FFS spending (vertical axis, 90% to 110%) vs. Local area FFS spending (horizontal axis, $750 to $1,250)

Average local area bid as a percent of simulated benchmarks (vertical axis, 70% to 100%) vs. Local area FFS spending (horizontal axis, $750 to $1,250)

Notes: MA (Medicare Advantage), FFS (fee-for-service). Each circle in the figure reflects a local market area. The figure includes 941 markets and excludes markets that did not have at least 1,000 MA enrollees and 10 percent MA share of enrollees in 2020. Average MA bids by market area are weighted by projected plan enrollment in the market. While plans bid at a service area level that often includes multiple counties, MA bid data contained an imputed bid value at the county level that we aggregated to the market level. Simulated benchmarks do not include quality bonuses. *Estimates are preliminary and subject to change.*
Source: MedPAC analysis of Medicare enrollment and MA bid data, 2020-2022

MedPAC

16

2. Setting benchmarks based on all Medicare spending: Design considerations

- Benchmarks reflect some favorable selection in MA
  - Adjust FFS spending for differential selection
- A dominant MA organization could influence the benchmark
  - Limit the weight of the largest MA organization or create a minimum weight for FFS spending
  - Cap benchmarks at a blend of local area/national FFS spending discounted by 2 percent
- Rebate add-on as a policy tool
  - Adjust rebate add-on to balance policy goals of access to MA plans and program savings

3. Use a fixed growth rate to set benchmarks

- Current empirically-based benchmarks are updated each year based on a national FFS spending growth rate
  - Rate varied between 2.7 and 5.6 percent over past six years
- Option 3 would replace current rate with a fixed rate
  - Establish benchmarks for initial year
    - Eliminate the effect of favorable selection in initial benchmarks
  - Define a fixed growth rate
- Fixed rate establishes predictability for plan payment rates

3. Fixed growth rate: Two potential methods

- **Method 1: Use CMS's projected growth rates for Medicare prices, volume & intensity (discounted), demographic mix**
  - Medicare prices + (50% volume and intensity) + demographic mix = 3.5%

- **Method 2: Use CMS's projected growth rate for Medicare prices plus projected growth rate in real U.S. GDP (adjusted)**
  - CBO projects real GDP growth of 1.6 percent annually from 2026 to 2031
  - Medicare prices + (U.S. real GDP – 0.5 percentage points) = 2.9%

MEDPAC

3. Adjusting a fixed growth rate

- A fixed growth rate may require periodic adjustments
  - Empirically-based benchmarks adjust to Medicare spending fluctuations, but a fixed rate may not

- Policymakers will need to assess the adequacy of MA payments and determine the size of any adjustments
  - Challenges in assessing MA rates using a MedPAC-like framework for assessing FFS Medicare's updates
  - MA rate adequacy and adjustments could be vulnerable to stakeholder influence

Discussion

- Implications of favorable selection in MA
- Feedback on the three alternative options for setting MA benchmarks
    - Competitive bidding
    - Benchmarks based on both FFS and MA spending data
    - Update benchmarks using a fixed growth rate
- Other ideas for setting benchmarks
- Next steps: Informational chapter in June

MEDPAC