Advising the Congress on Medicare issues

The Medicare Advantage program: Status report

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January 12, 2023

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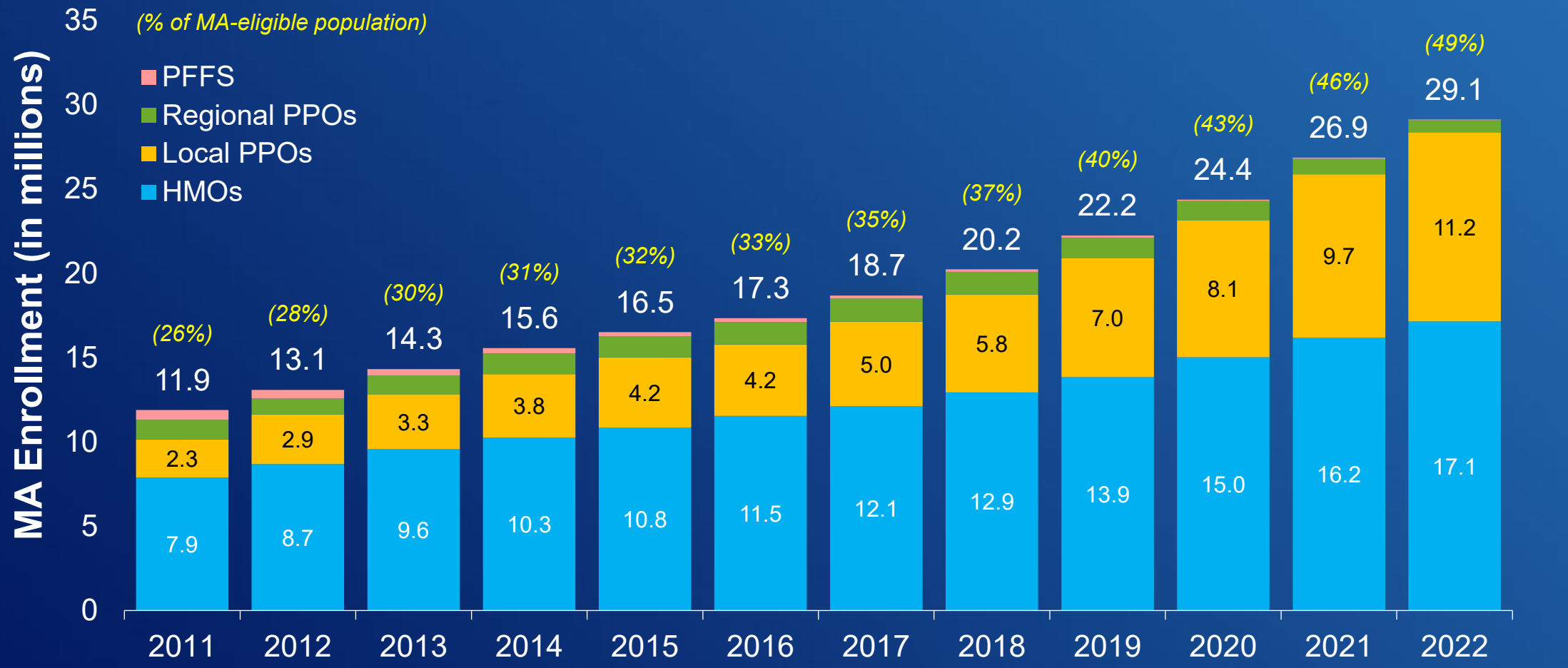
Today's presentation

- Status report on Medicare Advantage (MA) enrollment, availability, benchmarks, bids, and payment
- Congressional request on MA and FFS spending
  - MedPAC's long-standing prospective method
  - New retrospective method
- Update on coding intensity
- Ongoing concerns about MA quality

In 2022, 49% 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 2011-2022

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Estimates preliminary and subject to change

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

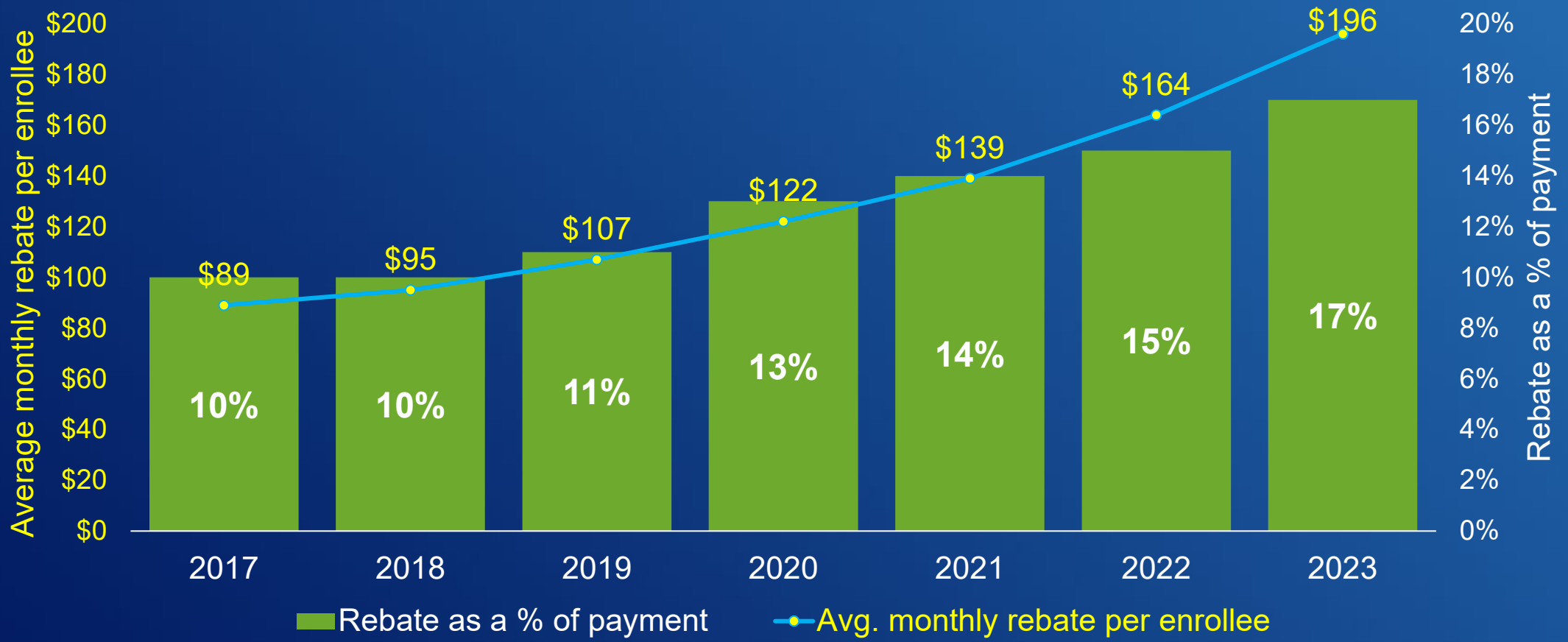
Plan availability*	2018	2019	2020	2021	2022	2023
Any MA plan	99%	99%	99%	99%	99%	>99.5%
Zero-premium plan w/Part D	84	90	93	96	98	99
Avg. number of choices (beneficiary-weighted)	20	23	27	32	36	41

*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 monthly rebates reached historic high in 2023

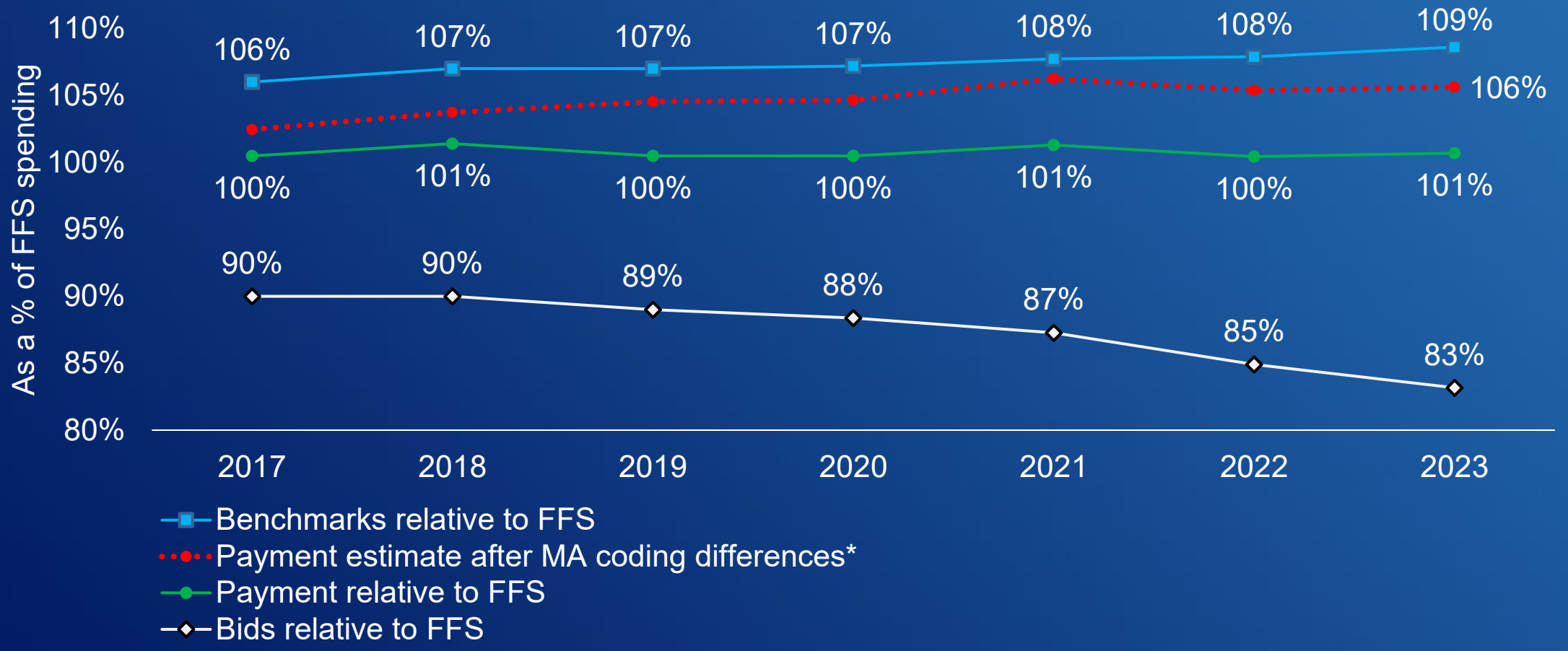


Source: MedPAC analysis of MA bid data.
Estimates are preliminary and subject to change

Prospective comparison of MA to FFS spending

- MedPAC's method since the introduction of MA bids and benchmarks
  - Calculate county-level MA and FFS spending
    - MA spending: Plans' projection of average spending from their bids
    - FFS spending: CMS' projection of average risk-standardized FFS spending (which is the basis for plan benchmarks) multiplied by plans' projection of average MA risk score
  - County-level MA to FFS spending ratios are aggregated using county enrollment projections from plans' bids
  - Add MedPAC's estimate of MA and FFS diagnostic coding differences
- Overall comparison accounts for differences in health status, geographic enrollment patterns, services covered in each program, and diagnostic coding differences

MA bids at historic low relative to FFS, but MA payments continue to be above FFS in 2023



*Coding differences in 2022 and 2023 reflect 2021 levels (the most recent available data). Includes estimate of MA employer plan payments.
Note: MA (Medicare Advantage), FFS (fee-for-service). Benchmark and payment percentages include quality bonuses. Benchmark, payment, and bid percentages reflect our estimates at the time they were published in our March chapter and are not adjusted for coding differences (unless indicated) or underlying differences in risk-adjusted spending between the MA and FFS populations that are not captured by risk scores. Estimates preliminary and subject to change.
Source: Analysis of MA bid and rate data.

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New retrospective comparison of MA to FFS spending

- MedPAC consistently notes that our prospective method has some limitations:
  - Estimates are based on CMS and plan projections
  - CMS' FFS spending estimates include beneficiaries who are not eligible for MA enrollment
  - MA coding intensity estimate is from two years prior
- As part of a congressional request, we retrospectively compared actual MA plan payments and actual FFS spending from 2017 through 2019
- Similar to prospective method, account for differences in health status, geographic enrollment patterns, services covered in each program, and diagnostic coding differences

Both prospective and retrospective comparisons show MA payments higher than FFS spending

	MA payments as percent of FFS spending		
	2017	2018	2019
Before accounting for coding differences			
Prospective (as originally published)	100%	101%	100%
Retrospective (MA-eligible beneficiaries)	101%	100%	101%
After accounting for coding differences			
Prospective (as originally published with 2-year lag)	104%	103%	102%
Retrospective (MA-eligible beneficiaries)	103%	102%	104%

Note: MA (Medicare Advantage), FFS (fee-for-service). The prospective estimates do not include employer plans because, as of 2017, these plans stopped submitting bids. Employer plans are not included in the retrospective results in the table. Including employer plans would increase MA payments relative to FFS spending by 1 percentage point in each year. Prospective estimates of coding use our most recent estimate at the time of publication of the Commission's March report to the Congress. Retrospective estimates of coding differences reflect the actual coding estimate for each given year. Neither set of estimates accounts for favorable selection into MA plans, which would increase MA payments relative to FFS spending.

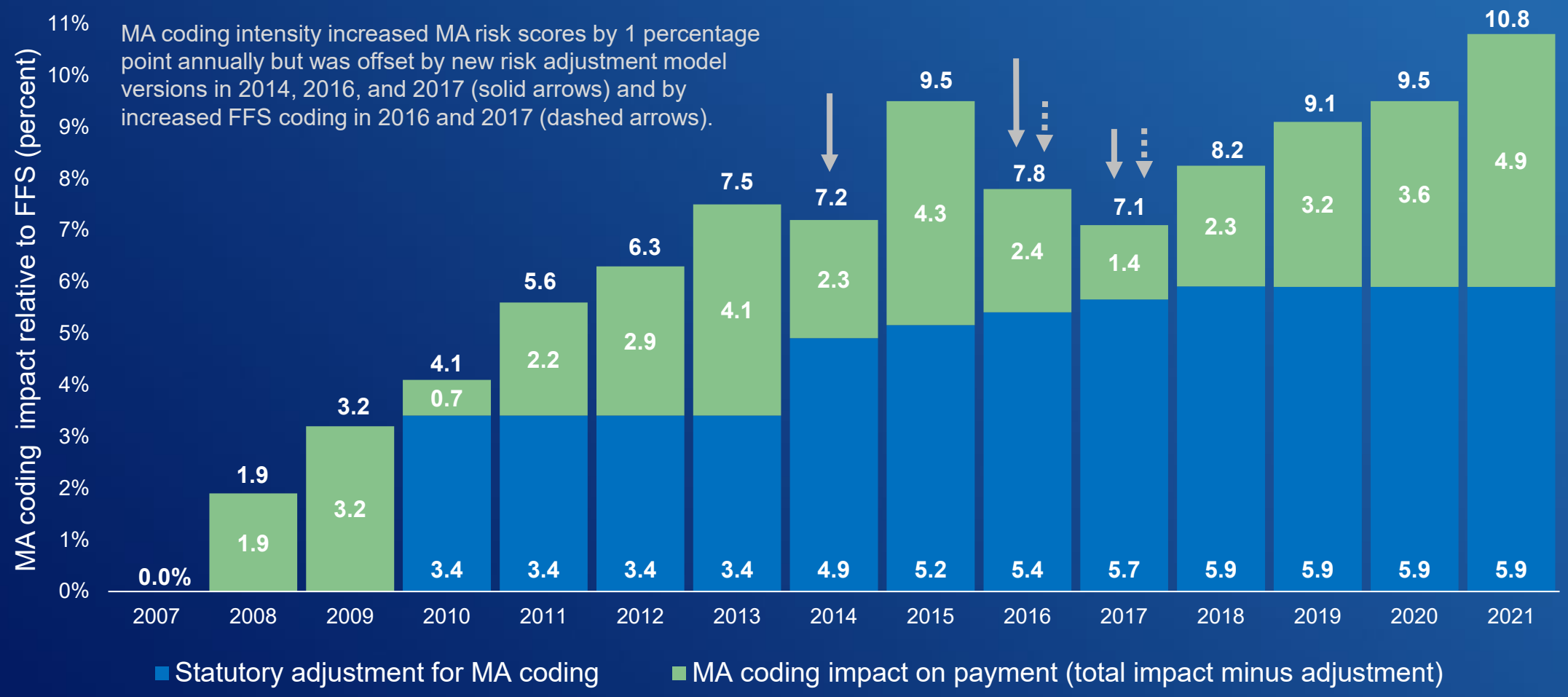
Source: Analysis of MA bid and rate data, MA payment data, and FFS spending data.

MA coding generated excess payments in 2021

- Differences in diagnostic coding between FFS and MA
  - FFS: Little incentive to code diagnoses
  - MA: Financial incentive and infrastructure to code more diagnoses
  - Leads to greater MA risk scores for equivalent health status
- 2021 MA risk scores were about 10.8 percent higher than FFS
- After accounting for CMS coding adjustment of 5.9 percent:
  - 2021 MA risk scores were 4.9 percent higher than FFS due to coding differences, generating $17 billion in excess payments to MA plans

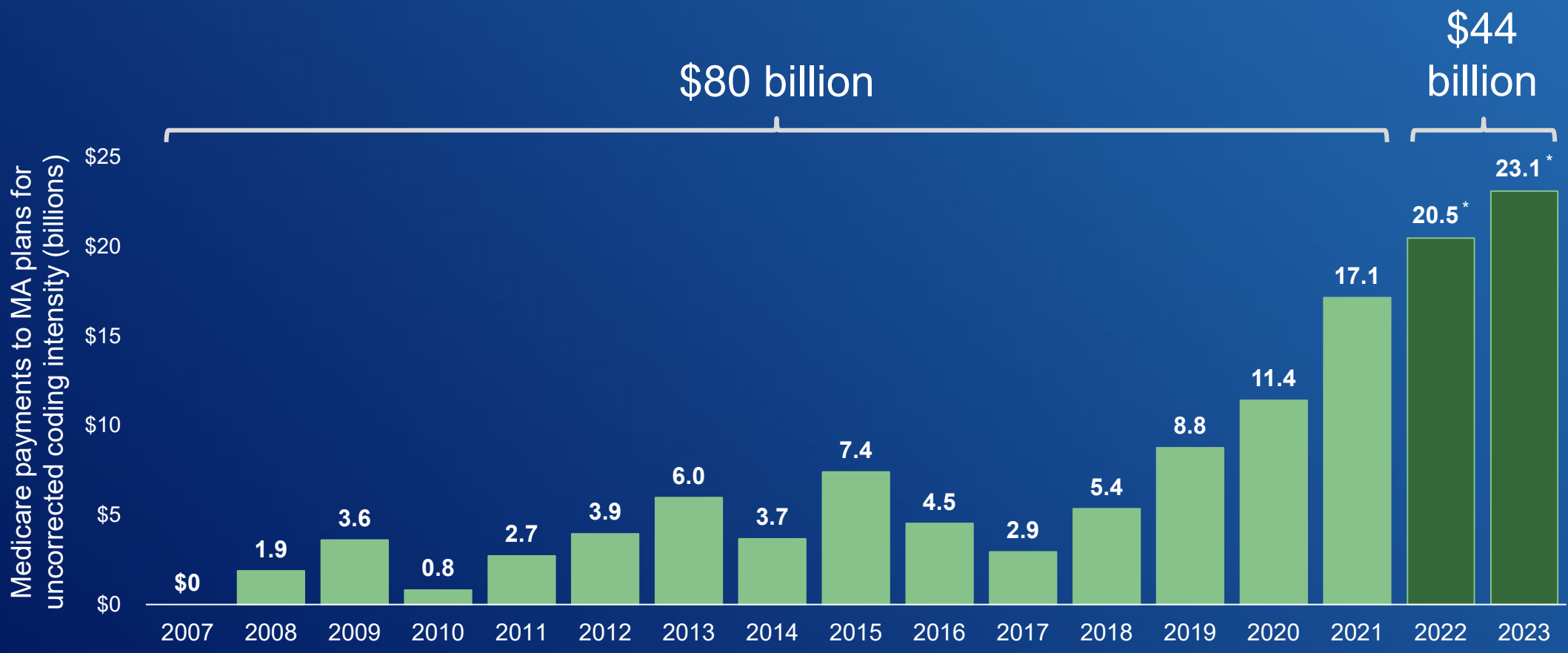
Source: MedPAC analysis of enrollment and risk score files.
Estimates are preliminary and subject to change.

Impact of MA coding intensity continues to grow



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

Between 2007 and 2023, MA coding intensity generated nearly $124 billion in excess payments



* 2022 and 2023 estimates assume that uncorrected coding intensity will be the same as in 2021 (4.9 percent, although all evidence suggests that it will be larger) and are based on projected Medicare spending for MA plans from the 2022 Medicare Trustees' Report.
Source: MedPAC analysis of enrollment and risk score files, and the Medicare's Trustee's Reports for 2017 and 2022.
Estimates are preliminary and subject to change.

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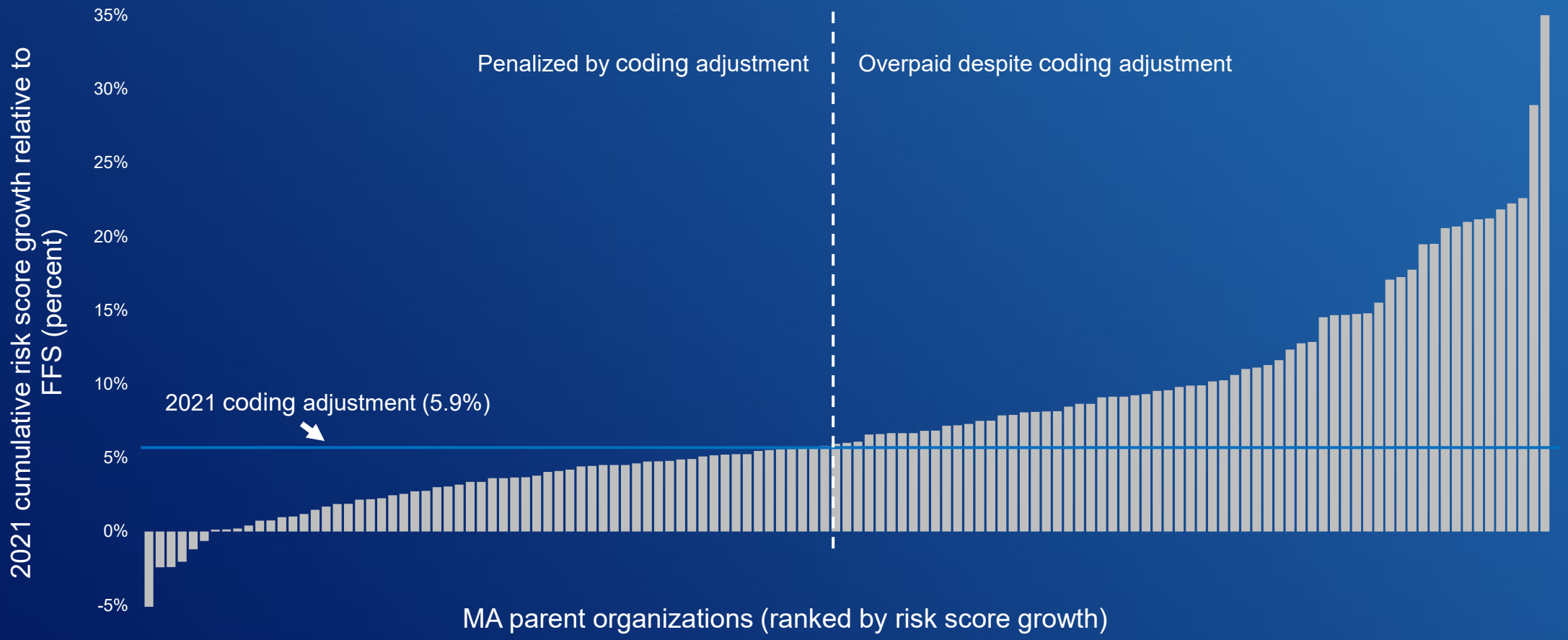
Coding intensity generates payment inequity

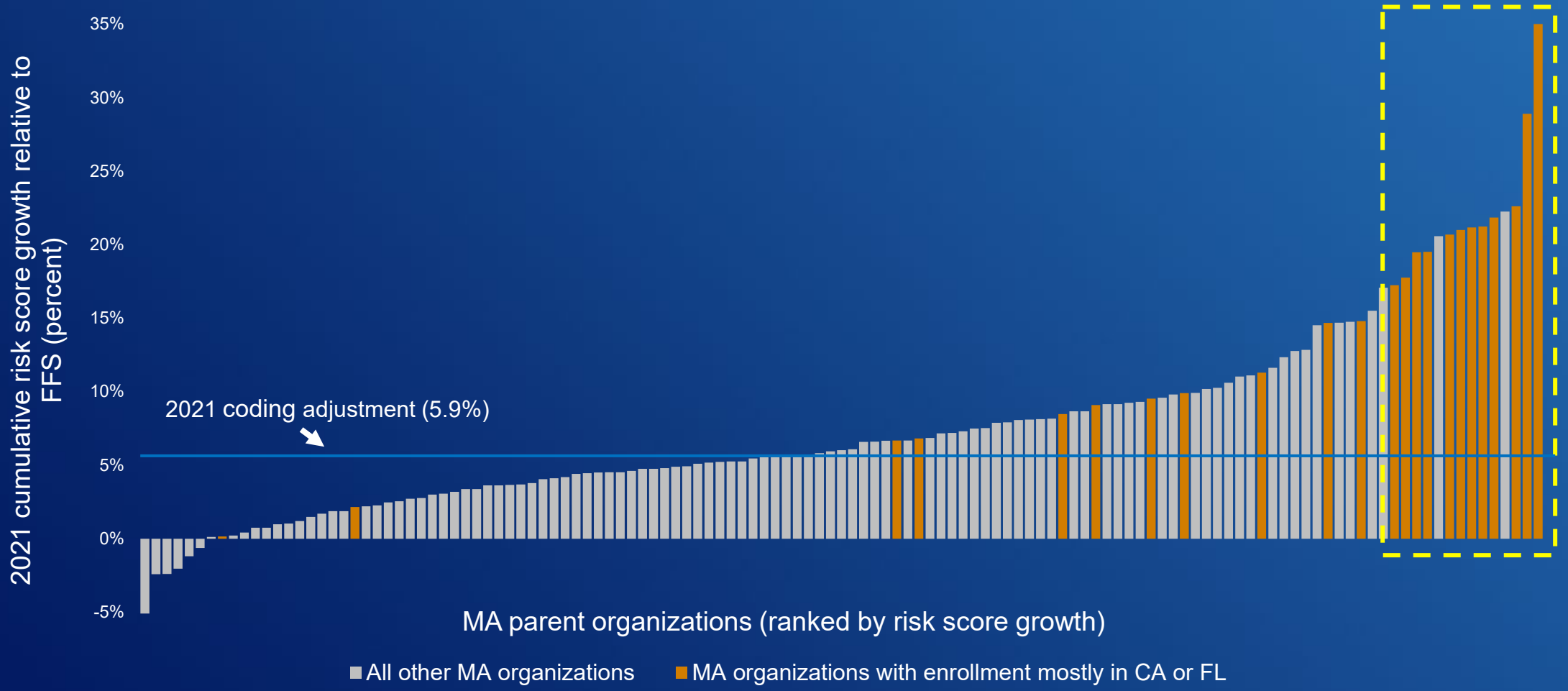


MA (Medicare Advantage), FFS (fee-for-service). Excludes special needs plans, Program of All-Inclusive Care for the Elderly contracts, and parent organizations with enrollment below 2,500. Source: MedPAC analysis of enrollment and risk score files. Estimates are preliminary and subject to change.

Coding intensity varies by 9 percentage points across the 8 largest MA organizations

MA (Medicare Advantage), FFS (fee-for-service).
Analysis excludes special needs plans, Program of All-Inclusive Care for the Elderly contracts, and parent organizations with enrollment below 2,500.
Source: MedPAC analysis of enrollment and risk score files. Estimates are preliminary and subject to change.

Highest coding intensity concentrated among MA organizations primarily in California or Florida



MA (Medicare Advantage), FFS (fee-for-service).
Analysis excludes special needs plans, Program of All-Inclusive Care for the Elderly contracts, and parent organizations with enrollment below 2,500.
Source: MedPAC analysis of enrollment and risk 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
- Chart reviews and HRAs are key drivers of coding intensity
  - Based on OIG findings, we estimate that chart reviews and HRAs account for nearly two-thirds of excess payments to MA plans
  - Use of chart reviews and HRAs varies substantially within MA, contributing to coding intensity variation across plans

Office of Inspector General (OIG). Source: MedPAC analysis of OIG report findings. Estimates are preliminary and subject to change.
Office of Inspector General, Department of Health and Human Services. 2021. *Some Medicare Advantage companies leveraged chart reviews and health risk assessments to disproportionately drive payments*. OEI-03-17-00474. Washington, DC: OIG.

Quality in MA cannot be meaningfully evaluated

- Quality bonus program (QBP) is not a good basis of judging quality for the 49 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 at least $15 billion annually in MA payments
- Commission recommended replacing the QBP with an improved value incentive program *(June 2020)*

Summary: MA program is extremely robust, but policy reforms are urgently needed

- The majority of Medicare beneficiaries with Part A & B will be enrolled in MA in 2023 if current trends continue
- The average beneficiary has a choice of 41 plans, and the average MA enrollee has access to $2,350 in annual extra benefits, more than double the level extra benefits 5 years ago
- However, Medicare is paying MA plans 6 percent more than FFS Medicare for similar enrollees, an estimated $27 billion in 2023
- The Commission has recommended addressing flaws in coding intensity, the quality system, benchmarks, and MA encounter data completeness (not discussed today)

Next Steps

- Publish chapter in March 2023 report
- Commissioner questions