December 11, 2023

Dear MedPAC Chairman Chernew and Commissioners,

We reviewed the interesting discussion on favorable selection in Medicare Advantage (MA) from the meeting on November 3, 2023. We have a few questions that, based on our experience and past studies, may be useful in communicating these findings to Congress or clarifying information for other researchers.

The questions fall into two groups, technical issues and policy:

Technical questions

- What is the degree of uncertainty in the analysis on the percent of favorable selection, given the amount of unexplained variation for beneficiaries (not covered in slide 3)? (For example, the 2019 MedPAC analysis included a confidence interval to the assessment).

- During the meeting, staff said the increasing enrollment into MA from FFS meant that the remaining FFS population has a higher risk standardized spending. But, the 2023 Medicare Trustees report stated Medicare FFS spending per beneficiary has declined in part due to the movement of dual eligible to Medicare Advantage. At the same time, other data reports that in 2020 FFS duals had an average HCC score (prior to normalization) of 1.26, which mean that a dual patient was expected to cost about 48% more than a non-dual patient at .85.[1]

  Could the Commission clarify this stated issue of the increasing risk-standardized spending of FFS enrollees in contrast to the Medicare Trustees report of declining FFS spending per beneficiary? Technically, for the HCC risk adjustment increase to result in decreased spending, the FFS risk adjustment would have to increase faster than spending, is that correct? Can that scenario be explained?

- MedPAC reports that estimated attrition from MA reinforced favorable selection for those in MA in slide 11. Studies from Newhouse[2] to Xu[3] stated that[4]only a small percentage of beneficiaries switch from MA to TM each year.

    - When comparing the much larger proportion of those that remain in plans over the years compared to leavers, mathematically/proportionately does that reduce the effect of leavers on the unknown risk of remaining individuals in MA?

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[1] CareJourney https://carejourney.com/accounting-for-risk-among-dual-eligible-beneficiaries/ - :~:text=If we look at all,cost 126%25 of average).

[2] Newhouse et al, How Much Favorable Selection is left in Medicare Advantage?, American Journal of Health Economics. 2015 Winter:1-26

[3] Xu et al, Medicare Switching: Patterns of Enrollment Growth in Medicare Advantage, 2006-22https://www.healthaffairs.org/doi/10.1377/hlthaff.2023.00224, Health Affairs, September 2023

[4] Vilsa Curto, Liran Einav, Jonathan Levin, and Jay Bhattacharya Can Health Insurance Competition Work? Evidence from Medicare Advantage, Journal of Political Economy 129, no.22 (Jan 2021): 570–606. 10.1162/AJHE_a_00001

- What is the differences in long term/stay MA enrollee spending from FFS? For example given that minorities are more like to enrollee in MA, if their spending was less in FFS what would you expect in subsequent years?

- Other detailed questions:
    a. What is the treatment of decedents in the observed populations and their effect on the analysis of favorable selection?
    b. Slide 18 constructs and sums entry-year cohorts with durational impacts by year since entry into MA. Given the "average" is more heavily weighted to the most recent entry cohort, does this give the highest weight to the cohort with the least regression to the mean?
    c. On slide 19, given a greater proportion of duals enrolling into MA, why is favorable selection increasing?
    d. Slide 9 on studies cites to the Liberman 2023 study which looked at the lower risk categories of those who move into MA. Is the spending level prior to MA low; if so how does that fit with the work of Puckrein, Cleary and Shapiro, NMQF (2010) that found those with chronic disease who are low consumers of benefits tend to cost Medicare significantly more in the near term?

Policy questions

1. In the study, staff reported the additional costs in MA were dependent upon the favorable selection of the new entrants + the additional increment from the higher cost individuals leaving MA + coding intensity.

   Can MedPAC contextualize these findings within the sum total of CMS policy changes:
   - Use of encounter data for the HCC model,
   - the ACA coding offset (but offset by risk adjustor changes),
   - the new 2024 v.28 planned HCC risk adjustor (that has certain adjustments to remove coding intensity for diabetes and other conditions),
   - estimated impact of CMS permitting greater utilization management in MA,
   - and the literature on the impact of regulatory restrictions on marketing and plan switching?

Thank you for all you do to advance the field of health policy.

Sincerely,

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Note: We have no conflicts to report