MEDPAC

Advising the Congress on Medicare issues

Favorable selection in Medicare Advantage

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Presentation overview

1. How Medicare uses FFS spending for MA risk scores and benchmarks
2. How coding and favorable selection create higher MA payments
3. MedPAC's framework for estimating favorable selection
4. Updated analysis of favorable selection
5. Implications of updated favorable selection and coding estimates
6. Discussion

MA payments are directly tied to FFS spending

- MA benchmarks are set relative to FFS spending—ranging from 115% of FFS in lowest-FFS-spending counties to 95% of FFS in highest-spending counties
- A risk-adjustment model is developed using FFS beneficiaries; this model is the basis for risk-adjusting benchmarks and calculating risk scores for MA enrollees
  - 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 submitted medical conditions

Note: MA (Medicare Advantage). FFS (fee-for-service). If bid is greater than the benchmark, Medicare pays the benchmark, and the enrollee pays a premium to make up the difference. However, this scenario is rare.

The goal of risk adjustment is to account for FFS and MA population differences

- Risk scores accurately predict costs for MA enrollees when there are similar coding patterns between FFS providers and MA plans
- Risk scores predict costs accurately for the FFS population 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
- Prior to any coding differences, MA payments assume that the average accuracy of the risk-adjustment model would be the same for FFS and MA enrollees

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

MA diagnostic coding generates higher payments to plans

- Differences in coding between FFS and MA lead to greater MA risk scores for equivalent health status
- CMS currently lowers MA risk scores by 5.9 percent because MA coding is more intense
- In September, MedPAC estimated that coding differences alone led to more than 8 percent higher MA payments than FFS in 2021, after accounting for CMS's 5.9 percent adjustment

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

Favorable selection would also generate higher payments to plans

- Absent any intervention from plans, selection occurs if risk-standardized MA spending would have been lower than the local area FFS average
  - Occurs if spending for MA enrollees would have been systemically lower than their risk scores predict (i.e., risk scores overpredict MA spending), which would lead to higher payments for MA plans
- The effects of selection are difficult to measure directly
- MedPAC has been examining the effects of favorable selection
  - June 2012 report to the Congress
  - March 2023 public presentation
  - June 2023 report to the Congress
- We continue to make refinements to our analysis and are open to feedback
- Coding is separate from favorable selection, and the effects are additive

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

MA plan and beneficiary incentives may produce favorable selection

- Influence of plan incentives on favorable selection
  - Plan networks and prior authorization
  - Higher 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 by certain beneficiaries
  - Beneficiaries who expect to use more medical services may prefer to stay in FFS and purchase supplemental insurance to cover out-of-pocket spending
- Other factors may also contribute to favorable selection (e.g., MA enrollees may have a lower propensity to seek care)

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

MedPAC analysis suggests MA plans experience favorable selection

- In June, MedPAC estimated that favorable selection alone led to 11 percent higher payments than FFS in 2019
- Because MA benchmarks rely on risk-standardized FFS Medicare spending, they reflect the higher level of costs associated with the local area FFS-enrolled population rather than a plan's enrollees
- Favorable selection allows many plans to bid lower than FFS spending before producing any efficiencies in care delivery

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

A substantial body of research also suggests MA plans experience favorable selection

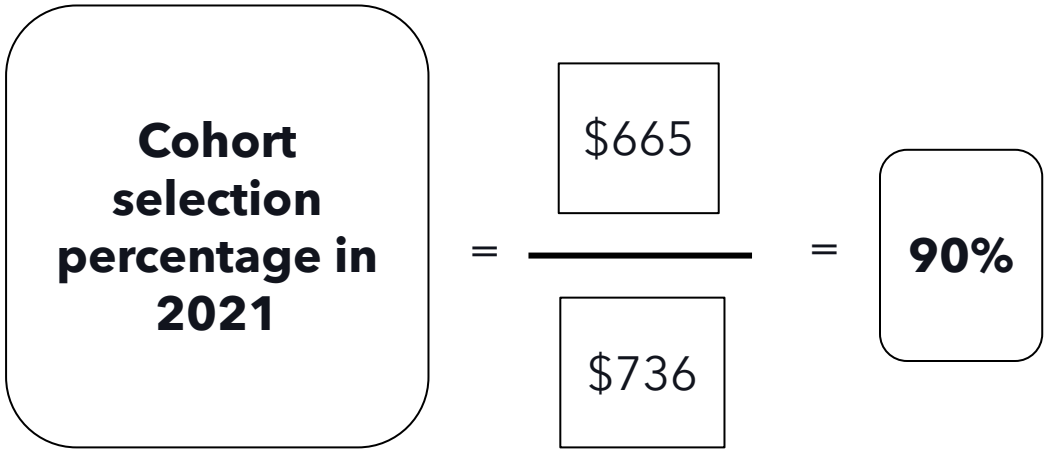
- Indirect selection: Some studies have found selection using indirect measures
  - Mortality (Curto et al. 2019, Newhouse et al. 2019)
  - Part D event data (Jacobs and Kronick 2018)
  - Disproportionate MA enrollment increases in counties where CMS overpredicts spending for all FFS enrollees (Ryan et al. 2023)
- Direct selection: Some studies have found evidence of direct favorable selection
  - These studies examine risk scores and spending in the year before beneficiaries switch to MA (Jacobson et al. 2019, Lieberman et al. 2023, MedPAC 2012, Newhouse et al. 2015, Teigland et al. 2023)

Note: MA (Medicare Advantage), FFS (fee-for-service).
Source: Curto et al. 2019. Health care spending and utilization in public and private Medicare. *American Economic Journal: Applied Economics* 11, no. 2 (April): 302-332. Jacobs, P. D., and R. Kronick. 2018. *Getting what we pay for: How do risk-based payments to Medicare Advantage plans compare with alternative measures of beneficiary health risk?* Health Services Research (May 22). Jacobson et al. 2019. *Do people who sign up for Medicare Advantage plans have lower Medicare spending?* Washington, DC: Kaiser Family Foundation. Lieberman, S. M., et. al 2023. *Medicare Advantage enrolls lower-spending people, leading to large overpayments.* White Paper. June. Medicare Payment Advisory Commission. 2012. Report to the Congress: *Medicare and the health care delivery system.* Washington, DC: MedPAC. Newhouse, J. P., et al. 2015. *How much favorable selection is left in Medicare Advantage?* American Journal of Health Economics 1, no. 1 (Winter): 1-26. Newhouse, J. P., et al. 2019. *Adjusted mortality rates are lower for Medicare Advantage than traditional Medicare, but the rates converge over time.* Health Affairs 38, no. 4 (April): 554-560. Ryan, A. M., et al. 2023. *Favorable selection in Medicare Advantage is linked to inflated benchmarks and billions in overpayments to plans.* Health Affairs 42, no. 9 (September): 1190-1197. Teigland, C. et al. 2023a. Harvard-Inovalon Medicare study: *Utilization and efficiency under Medicare Advantage vs. Medicare fee-for-service.* White Paper. September.

Estimates of favorable selection rely on FFS spending prior to MA enrollment

Illustrative example of estimating the favorable selection percentage for MA entrants in 2022

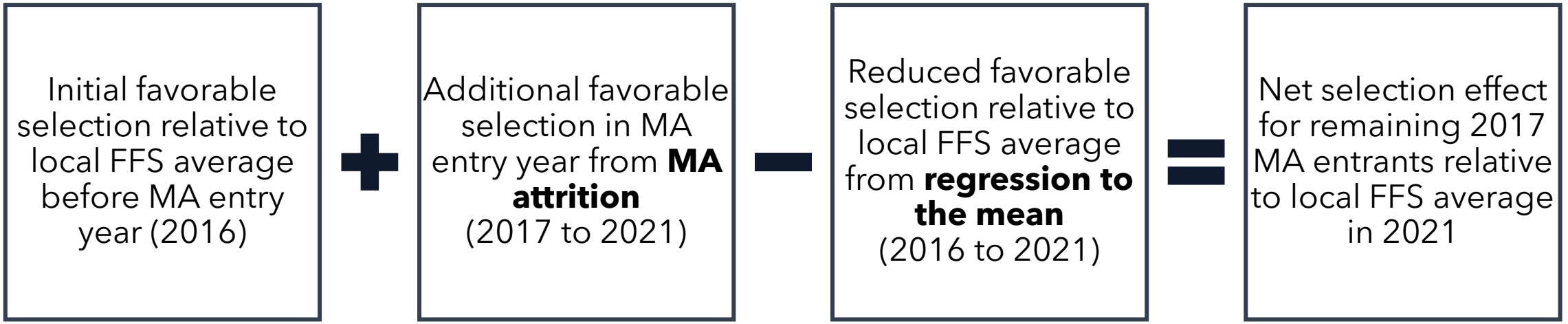
	Inclusion Criteria	2021 FFS Spending
Cohort	2021 FFS enrollment & 2022 MA entry	$665 per member per month
Comparator	Continuous FFS enrollment in 2021 & 2022	$736 per member per month



Note: FFS (fee-for-service), MA (Medicare Advantage). The analysis excludes beneficiaries without at least two full years of enrollment in FFS Part A and Part B prior to the year of MA entry as well as those who joined a non-MA private plan (e.g., cost plan), had end-stage renal disease, had Medicare as a secondary payer, resided in multiple counties during the year, or resided in Puerto Rico.
Source: MedPAC analysis of Medicare enrollment, Medicare claims spending, and risk-adjustment files, 2020–2022.

MedPAC's estimate of favorable selection tries to account for enrollment attrition and regression to the mean

Net amount of favorable selection in 2021 for enrollees who entered MA in 2017: Illustration of components



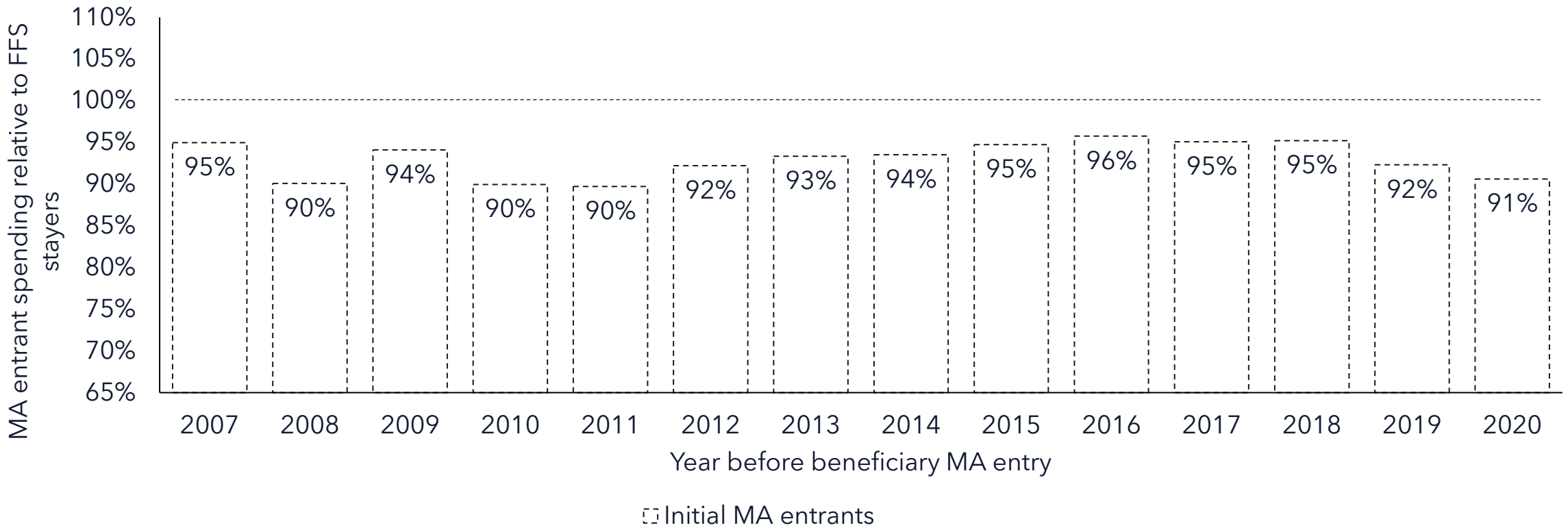
Note: MA (Medicare Advantage), FFS (fee-for-service).

Updates to MedPAC's favorable selection estimate

June 2023 report	Update
1. Cumulative selection estimate: 2019	1. Cumulative selection annual estimate: 2017–2021
2. Employer plan enrollees: Exclude from analysis and incorporate as having no selection effect Hospice users: Exclude from analysis	2. Include both employer plan enrollees and hospice users in analysis. *[Increases selection effect: <1%]*
3. Using the historical FFS spending of 2020 MA entrants as a *proxy* (for regression to the mean during MA enrollment), apply the favorable selection trends from 2008-2019 to cohorts of 2019 MA enrollees based on the year of MA entry (2008-2018)	3. Prior to applying the trend of the *proxy* group to an MA enrollee cohort, account for the initial magnitude in favorable selection *[Decreases selection effect: 2% to 3%]*
4. Assume no change in favorable selection for 2019 MA entrants (based on prior year spending)	4. Trend forward the favorable selection estimate of the most recent MA entrants using the *proxy* group *[Increases selection effect: <1%]*

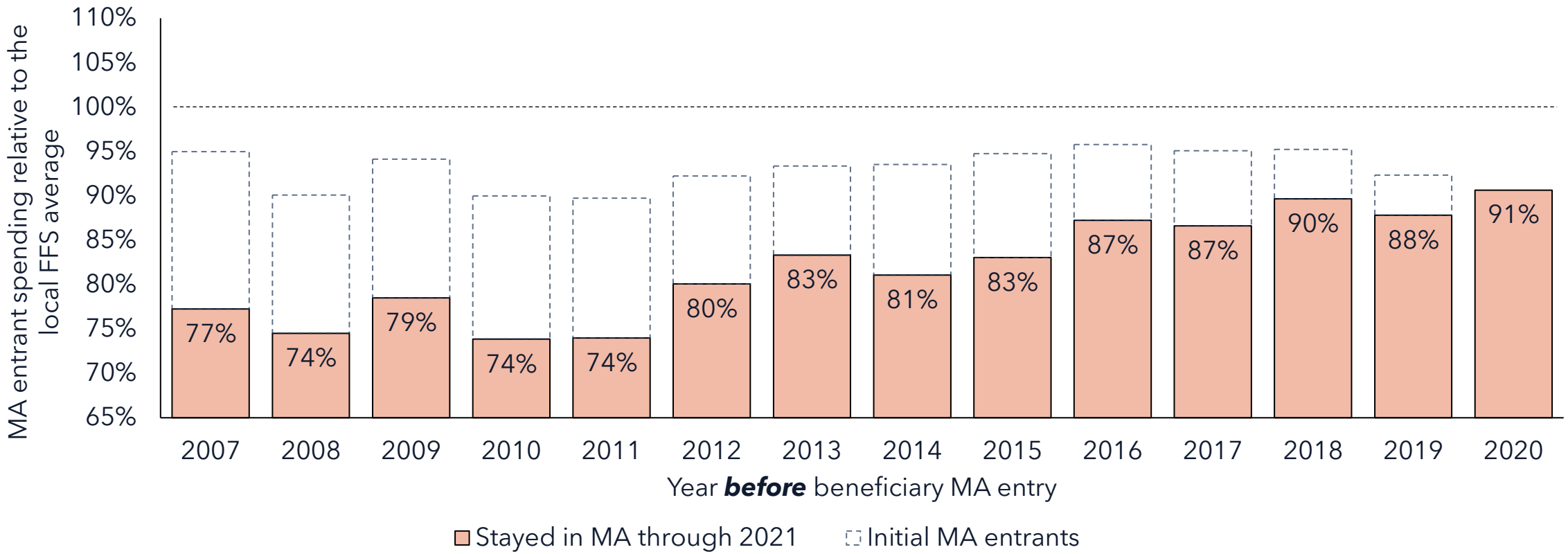
Note: MA (Medicare Advantage), FFS (fee-for-service).
Source: Medicare Payment Advisory Commission. 2023. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

Estimated attrition reinforced favorable selection for enrollees who stayed in MA through 2021



Note: MA (Medicare Advantage), FFS (fee-for-service). The analysis excludes beneficiaries without at least two full years of enrollment in FFS Part A and Part B prior to the year of MA entry as well as those who joined a non-MA private plan (e.g., cost plan), had end-stage renal disease, had Medicare as a secondary payer, resided in multiple counties during the year, or resided in Puerto Rico. Spending reflects the year prior to MA entry and is risk adjusted. Lower MA entrant spending relative to the local area FFS average reflects a greater effect of favorable selection.
Source: MedPAC analysis of Medicare enrollment, Medicare claims spending, and risk-adjustment files, 2006–2022.

Estimated attrition reinforced favorable selection for enrollees who stayed in MA through 2021



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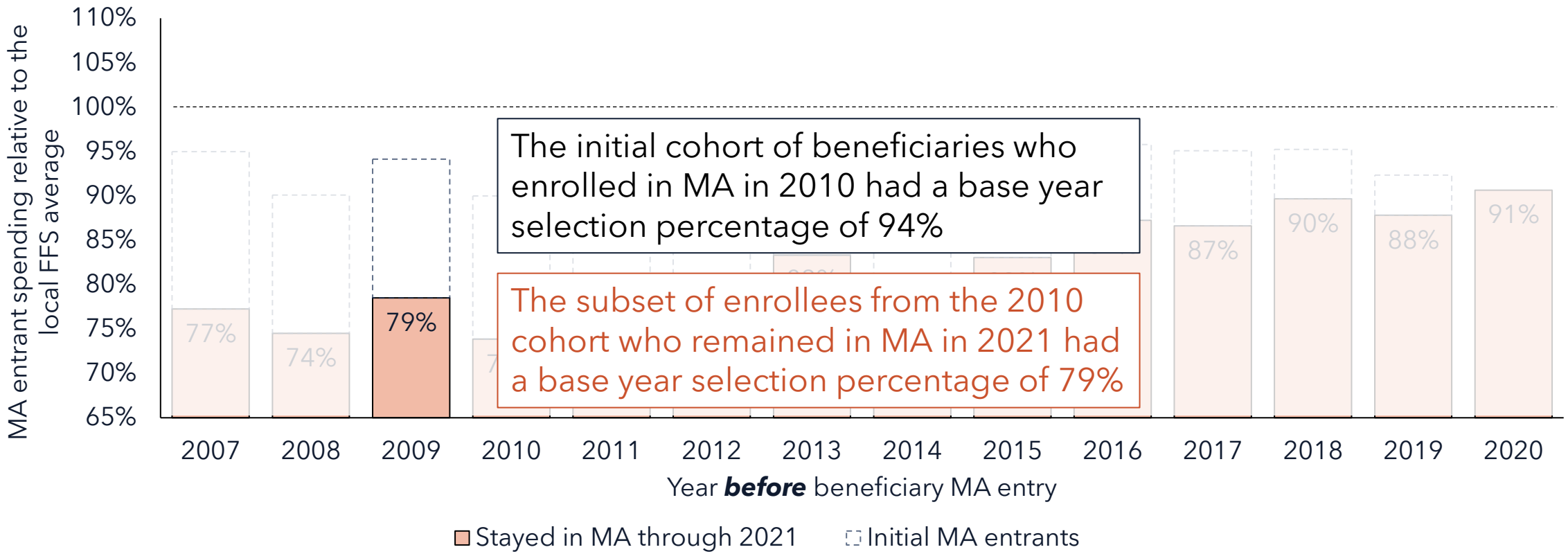

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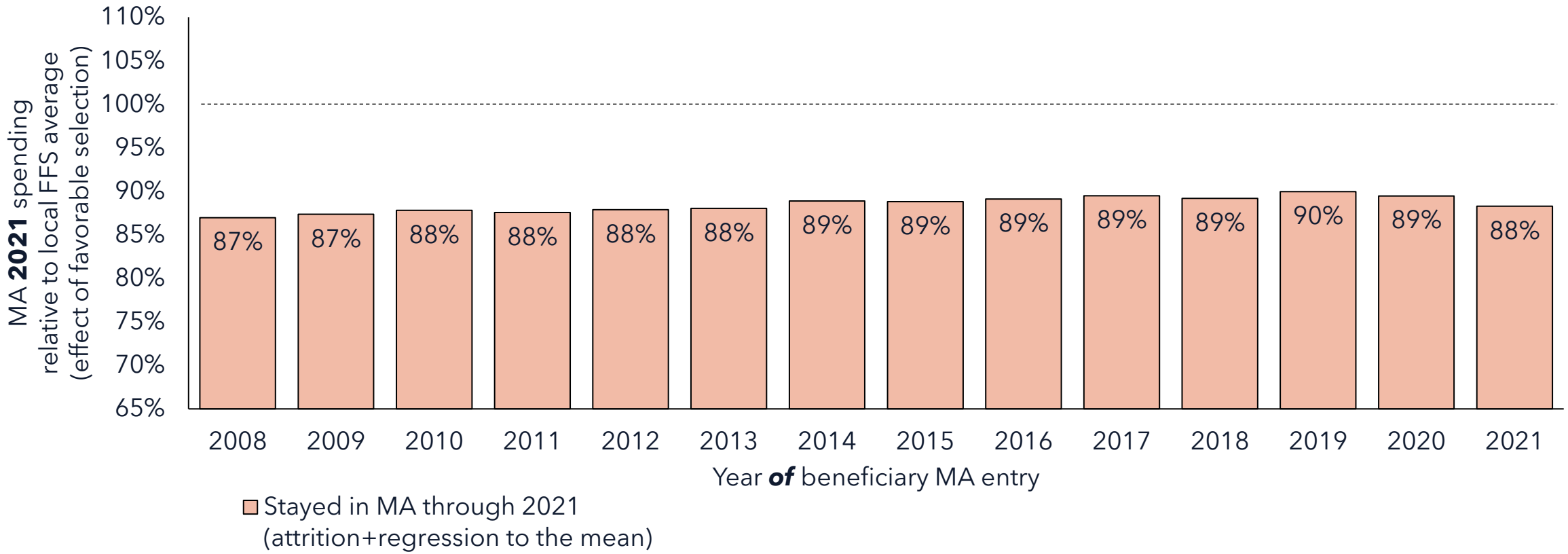
Source: MedPAC analysis of Medicare enrollment, Medicare claims spending, and risk-adjustment files, 2006–2022.

Selection several years prior to MA entry suggests sustained selection during MA enrollment

- Risk-standardized spending may increase as beneficiaries age
- We examined the historical FFS experience of 2018-2022 MA entrants going back to continuous FFS enrollment starting in 2007
- MA entrants consistently regressed toward the MA mean rather than the FFS mean—even after more than a decade of aging
- We estimated the regression to the mean effect using proxy cohorts who entered MA immediately after the measurement year (e.g., cohorts of 2022 MA entrants used to estimate the 2021 regression to the mean of MA entry cohorts from 2008-2021)

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

Estimated net effects of attrition and regression to the mean resulted in substantial MA favorable selection in 2021



Note: MA (Medicare Advantage). FFS (fee-for-service). The analysis excludes beneficiaries without at least two full years of enrollment in FFS Part A and Part B prior to the year of MA entry as well as those who joined a non-MA private plan (e.g., cost plan), had end-stage renal disease, had Medicare as a secondary payer, resided in multiple counties during the year, or resided in Puerto Rico.
Source: MedPAC analysis of Medicare enrollment, Medicare claims spending, and risk-adjustment files, 2006–2022.

Estimating cumulative selection effect in 2021: Illustration of components

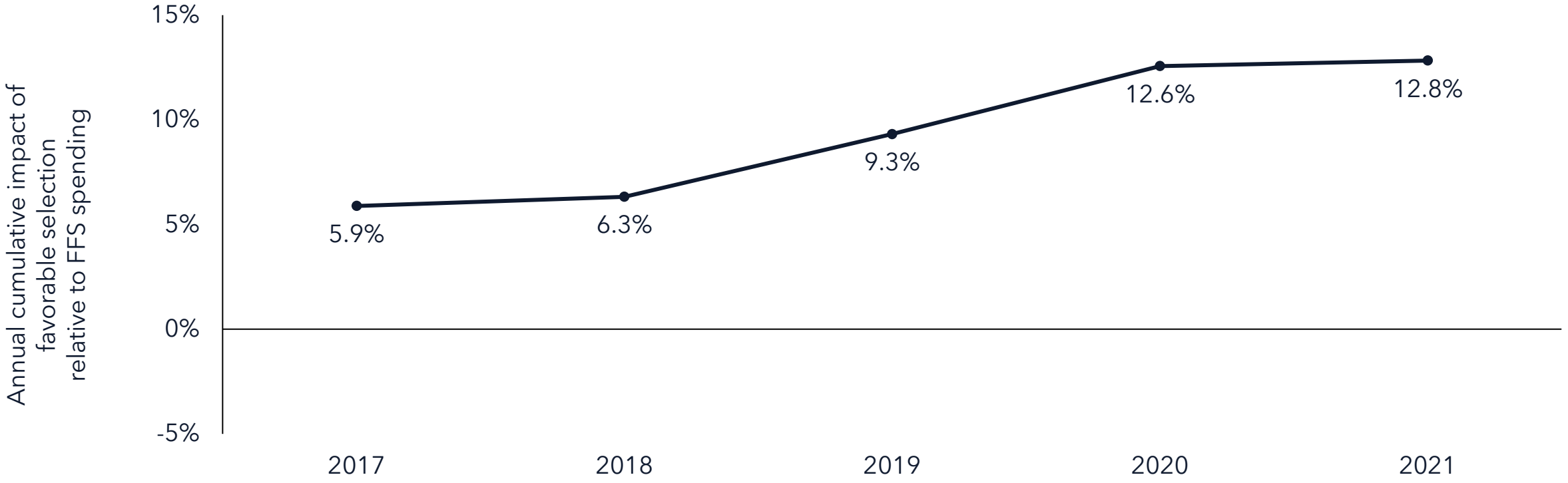
Net selection effect of 14 MA entry cohorts: 2008-2021

Weight each of 14 cohorts by 2021 enrollees in each MA entry year: 2008-2021

Cumulative selection in 2021: Weighted average of 14 cohorts (2008-2021)

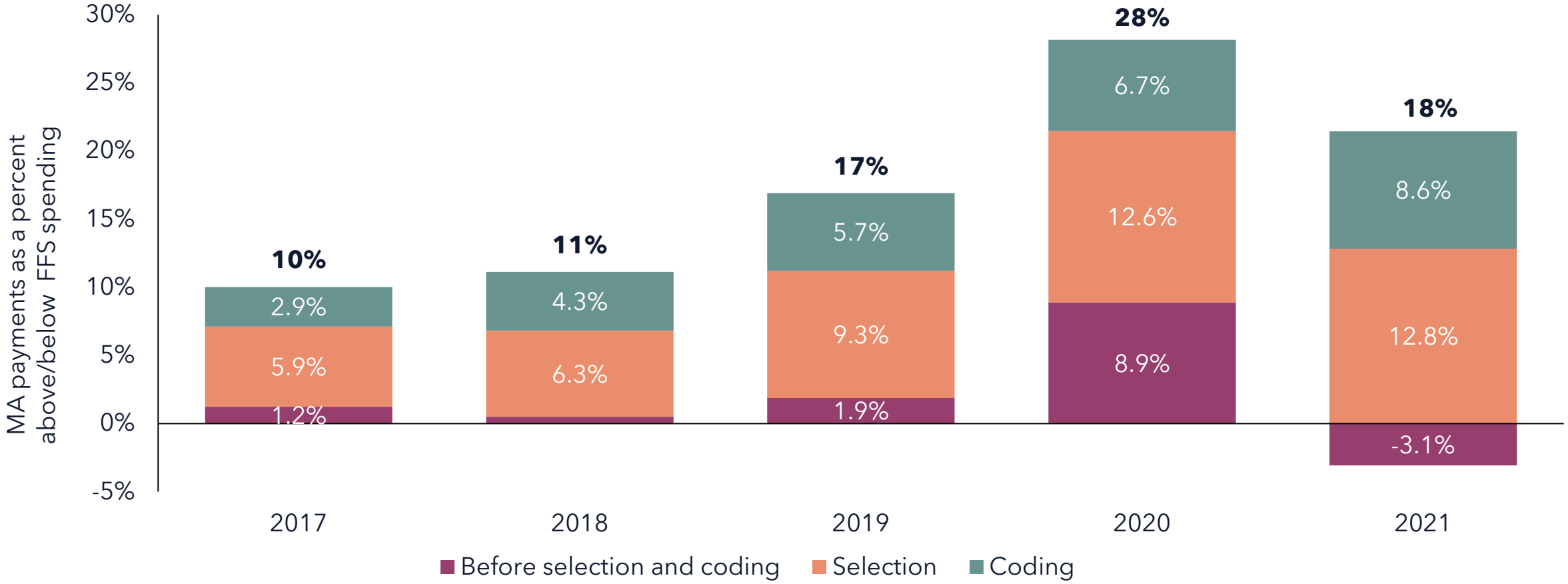
Note: MA (Medicare Advantage). All MA cohorts are mutually exclusive and based on continuous MA enrollment. We assigned cohorts that entered MA prior to 2008 the same selection effect as the 2008 MA entry cohort. We weighted the 2008 MA entry cohort by 2021 MA enrollees who entered MA prior to 2009. The net selection effect and weighting of cohorts excludes beneficiaries who joined a non-MA private plan (e.g., cost plan), had end-stage renal disease, or had Medicare as a secondary payer.

Increasing estimated cumulative effect of favorable selection annually from 2017 to 2021



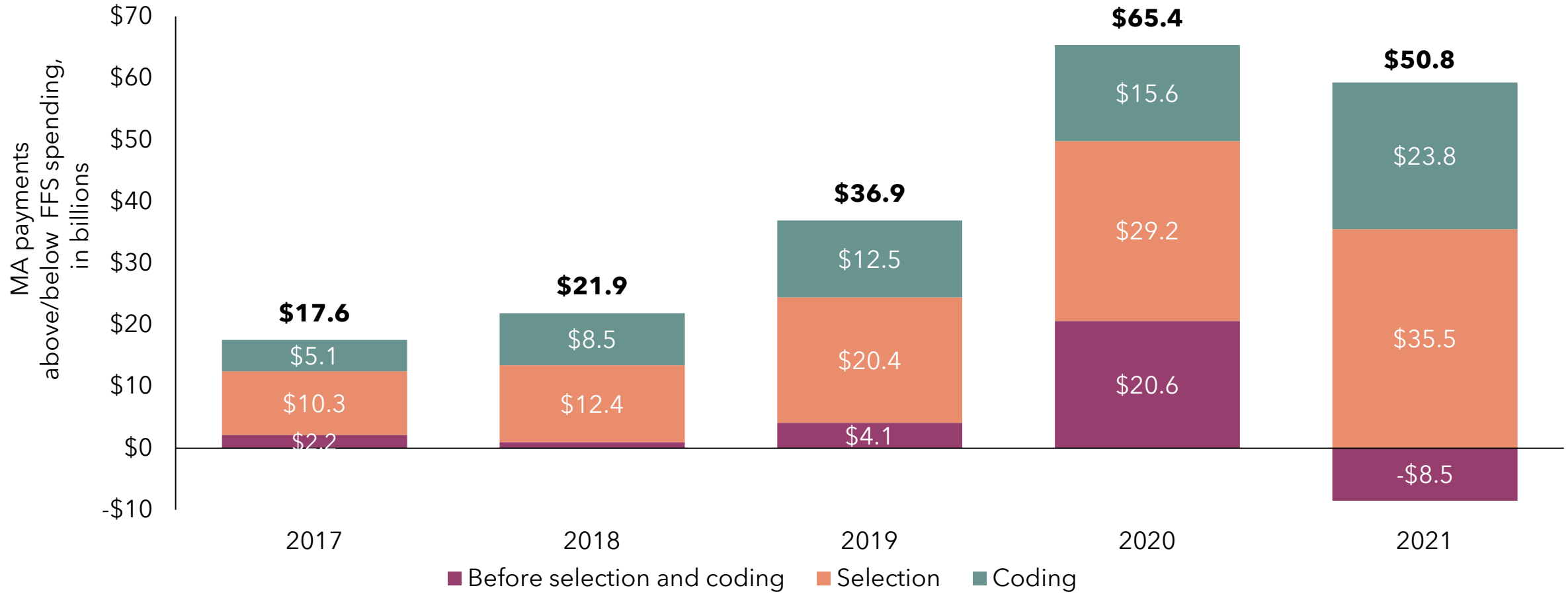
Note: MA (Medicare Advantage). FFS (fee-for-service). The analysis excludes beneficiaries without at least two full years of enrollment in FFS Part A and Part B prior to the year of MA entry as well as those who joined a non-MA private plan (e.g., cost plan), had end-stage renal disease, had Medicare as a secondary payer, resided in multiple counties during the year, or resided in Puerto Rico. The cumulative percent impact is based on the factor necessary to inflate MA spending to FFS levels (and thus remove favorable selection).
Source: MedPAC analysis of Medicare enrollment, Medicare claims spending, and risk-adjustment files, 2006–2022.

Favorable selection and coding imply higher MA payments relative to FFS from 2017 to 2021



Note: MA (Medicare Advantage), FFS (fee-for-service). We exclude MA payments for beneficiaries with end-stage renal disease and those who do not have both Part A and Part B coverage. Totals may not sum due to rounding. Unspecified values indicate less than 0.5 percent. Estimates in 2020 and 2021 include the effects from the coronavirus pandemic. Coding estimates reflect the updated methodology discussed in September 2023 and include CMS's 5.9 percent adjustment to MA risk scores.
Source: MedPAC analysis of Medicare enrollment, Medicare claims spending, and risk-adjustment files, 2006–2022.

Favorable selection and coding imply higher MA payments relative to FFS from 2017 to 2021



Note: MA (Medicare Advantage), FFS (fee-for-service). We exclude MA payments for beneficiaries with end-stage renal disease and those who do not have both Part A and Part B coverage. Totals may not sum due to rounding. Unspecified values indicate less than $1 billion. Estimates in 2020 and 2021 include the effects from the coronavirus pandemic. Coding estimates reflect the updated methodology discussed in September 2023 and include CMS's 5.9 percent adjustment to MA risk scores.
Source: MedPAC analysis of Medicare enrollment, Medicare claims spending, and risk-adjustment files, 2006–2022.

MedPAC's estimates of favorable selection

- We estimate that MA enrollees were consistently favorable relative to local FFS average before entering MA from 2007 to 2021
- After accounting for the estimated effects of MA attrition and regression to the mean, the annual cumulative effects of selection increased from 2017 to 2021
- The combined estimated effects of selection and coding led to MA payments far above FFS levels, an estimated $50.8 billion in 2021
- We plan to continue monitoring the effects of selection into MA and include estimates in our annual March MA status report

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

Discussion

- Feedback on our analytic approach for estimating favorable selection
- Guidance on future work

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