MEDPAC | Medicare Payment Advisory Commission

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MEDICARE PAYMENT ADVISORY COMMISSION RELEASES REPORT TO CONGRESS ON MEDICARE PAYMENT POLICY

Washington, DC, March 15, 2023—Today, the Medicare Payment Advisory Commission (MedPAC) releases its March 2023 *Report to the Congress: Medicare Payment Policy*. The report presents MedPAC's recommendations for how provider payment rates in traditional fee-for-service (FFS) Medicare should be updated for 2024 and for providing additional resources to acute care hospitals and clinicians who furnish care to Medicare beneficiaries with low incomes, and reviews the status of Medicare Advantage (MA) and the prescription drug benefit (Part D). This report also satisfies an additional legislative mandate comparing per enrollee spending in MA and FFS Medicare.

Three years into the coronavirus pandemic, Medicare beneficiaries, health care workers, and providers continue to experience the effects of the COVID-19 pandemic. Though the coronavirus public health emergency will end in May of this year, COVID-19 variants continue to evolve, and the future effects of coronavirus transmission on the demand for health care services remains uncertain. In this report, we discuss some of the effects of the pandemic on beneficiaries' access to care and on providers' revenues and costs. However, a fuller discussion of the pandemic's effects on beneficiaries and providers is beyond the scope of this report.

The Commission is acutely aware of how providers' financial status and patterns of Medicare spending varied in 2020 and 2021 from historical trends, as well as the higher and more volatile increases in input costs for several health care sectors that occurred during 2022. Still, our statutory charge is to evaluate available data to assess whether Medicare payments, in aggregate, are sufficient to support the efficient delivery of care and ensure access to care for Medicare's beneficiaries. In this report, we make recommendations aimed at giving providers incentives to constrain their cost growth and thus help control program spending.

| Fee-for-service payment rate update recommendations. MedPAC's payment update recommendations, which we are required by law to submit each year, are based on an assessment of payment adequacy for each provider type that examines beneficiaries' access to and use of care, the quality of the care they receive, the supply of providers and their access to capital, and providers' costs and Medicare's payments.

MedPAC recommends a higher-than-current law FFS payment update in 2024 for acute care hospitals; positive payment updates for clinicians paid under the physician fee schedule and outpatient dialysis facilities; and negative updates (reductions in base payment rates) for skilled nursing facilities, home health agencies, and inpatient rehabilitation facilities. We recommend a positive payment update in 2024 for hospice providers concurrent with wage adjusting and reducing the hospice aggregate Medicare payment cap by 20 percent.

To promote adequate access to care for all Medicare beneficiaries, we also recommend providing additional resources to acute care hospitals and clinicians who furnish care to Medicare beneficiaries with low incomes. For acute care hospitals paid under the inpatient prospective payment system, the Commission recommends adding $2 billion to current disproportionate share and uncompensated care payments and distributing the entire amount using a Commission-developed "Medicare Safety-Net Index" to direct funding to those hospitals that provide care to large shares of low-income Medicare beneficiaries. For clinicians, the Commission recommends that Medicare make targeted add-on payments of 15 percent to primary care clinicians and 5 percent to all other clinicians for physician fee schedule services provided to low-income Medicare beneficiaries.

Previously, the Commission also considered an annual update recommendation for ambulatory surgical centers (ASCs). However, because Medicare does not require ASCs to submit data on the cost of treating beneficiaries, we have no new significant data to inform an ASC update recommendation for 2024. In this report, therefore, we have provided a status report on ASCs. The Commission also previously considered an annual update recommendation for long-term care hospitals (LTCHs). But as the number of cases that qualify for payment under Medicare's prospective payment system for LTCHs has fallen, we have become increasingly concerned about small sample sizes in our analyses of this sector. As a result, we will no longer provide an annual payment adequacy analysis for LTCHs but will continue to monitor that sector and provide periodic status reports.

| Medicare Advantage. Overall, indicators point to an increasingly robust MA program. In 2022, the MA program included over 5,200 plan options, enrolled about 29 million Medicare beneficiaries (49 percent of eligible beneficiaries), and paid MA plans $403 billion (not including Part D drug plan payments). In 2023, the average Medicare beneficiary has a choice of 41 plans offered by an average of 8 organizations. Further, the level of rebates that fund extra benefits reached a record high of about $2,350 per enrollee, on average, in 2023. Medicare payments for these extra benefits—which are not covered for beneficiaries in FFS—have more than doubled since 2018.

For 2023, the average MA plan bid to provide Medicare Part A and Part B benefits was 17 percent less than FFS Medicare would be projected to spend for those enrollees. However, the benefits from MA's lower cost relative to FFS spending are shared exclusively by the companies sponsoring MA plans and MA enrollees (in the form of extra benefits). The taxpayers and FFS Medicare beneficiaries (who help fund the MA program through Part B premiums) do not realize any savings from MA plan efficiencies. Instead, we estimate that Medicare spends 6 percent more for MA enrollees than it would spend if those enrollees remained in FFS Medicare, a difference that translates into a projected $27 billion in excess payments in 2023 alone. This amount would be even larger if the favorable selection of beneficiaries in MA plans were taken into account, because beneficiaries who switch to an MA plan tend to have substantially fewer health care costs than the amount predicted by their risk score while they are in FFS Medicare and are thus likely to be profitable to MA plans.

The Commission remains committed to including private plans in the Medicare program and allowing beneficiaries to choose among Medicare coverage options, including the alternative delivery systems that private plans can provide. However, Medicare should not continue to overpay MA plans. Indeed, under current policies, doing so will further worsen Medicare's fiscal sustainability as MA enrollment continues to grow. Over the past few years, the Commission has made recommendations to address coding intensity, replace the quality bonus program, and establish more equitable benchmarks, which are used to set plan payments, all of which will stem Medicare's excess payments to MA plans, helping to preserve Medicare's solvency and sustainability while maintaining beneficiary access to MA plans and the extra benefits they can provide.

| Part D. Over 77 percent of Medicare beneficiaries (about 50 million beneficiaries) participated in private Medicare drug plans in 2022. Beneficiaries continue to have broad choice among plans in 2023. Beneficiaries' options range from 19 to 28 prescription drug plans (PDPs) depending on where they live, in addition to dozens of MA plans in most areas that also offer prescription drug benefits (MA–PDs). In 2021, total Part D spending was $110.8 billion. Plan enrollees paid about $14.9 billion of that amount in plan premiums for basic benefits. Beyond program spending, enrollees also paid $17.9 billion in cost sharing and $7.5 billion in premiums for enhanced benefits.

Since its inception in 2006, Part D has changed in important ways. Generic drugs now account for nearly 90 percent of the prescriptions filled, while a relatively small share of prescriptions for high-cost biological products and specialty medications accounts for a mounting share of spending. In 2021, about 464,000 enrollees filled a prescription for which a single claim was sufficient to put them into the catastrophic phase of the Part D benefit, up from just 33,000 enrollees in 2010. Medicare's cost-based reinsurance continues to be the largest and fastest growing component of Part D spending, totaling $52.4 billion, or about 55 percent of the total. As a result, the financial risk that plans bear, as well as their incentives to control costs, has declined markedly. The value of the average basic benefit that is paid to plans through the capitated direct subsidy has plummeted in recent years. In 2023, direct subsidy payments average less than $2 per member per month, compared with payments of nearly $94 per member per month for reinsurance.

To help address these issues, in 2020 the Commission recommended substantial changes to Part D's benefit design to limit enrollee out-of-pocket spending; realign plan and manufacturer incentives to help restore the role of risk-based, capitated payments; and eliminate features of the current program that distort market incentives. In 2022, the Congress passed the Inflation Reduction Act (IRA), which included numerous policies related to prescription drugs; one such provision is a redesign of the Part D benefit with many similarities to the Commission's recommended changes. The changes adopted in the IRA will be implemented over the next several years and are likely to alter the drug-pricing landscape.

| Mandated report: Historical comparison of Medicare Advantage payments to fee-for-service spending. The Consolidated Appropriations Act, 2023, mandated that the Commission compare MA and FFS per enrollee spending for at least the last five years for which data are available. The Act requests that the Commission's analysis compare MA payments to FFS spending as calculated for MA benchmarks and as calculated using beneficiaries enrolled in both Part A and Part B.

For this analysis, we use our long-standing prospective method of comparing MA payments with FFS spending (as calculated for MA benchmarks) from 2004 through 2023. We also supplement this analysis with a new retrospective method using available data from 2016 to 2019 for beneficiaries enrolled in both Part A and Part B that uses actual FFS and MA spending, avoiding the uncertainties intrinsic to projecting FFS spending and plan bids. Our prospective and retrospective methods yielded very similar results: Both found that MA payments were higher than what Medicare would have spent had MA enrollees remained in FFS Medicare over these periods of time. This finding is consistent with previous Commission analyses that have found that private plans have never yielded aggregate savings for the Medicare program.

The full report is available at MedPAC's website (http://www.medpac.gov).

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The Medicare Payment Advisory Commission is an independent, nonpartisan Congressional agency that provides policy and technical advice to the Congress on issues affecting the Medicare program. The Commission's goal is to achieve a Medicare program that ensures beneficiary access to high-quality care, pays health care providers and health plans fairly, rewards efficiency and quality, and spends tax dollars responsibly.