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Michael Chernew, Ph.D.
Chairman
Medicare Payment Advisory Commission
425 I Street, NW, Suite 701
Washington, D.C. 20001

Dear Dr. Chernew:

AHIP appreciates the opportunity to share our comments on the information presented during the Medicare Payment Advisory Commission's (MedPAC) January 12, 2024 public meeting on *The Medicare Advantage Program: Status Report*. The discussion of MedPAC's analysis of projected 2024 spending in the Medicare Advantage (MA) and fee-for-service (FFS) programs raised serious questions about the validity of the conclusions drawn from that analysis. In addition, it is essential that future discussions of recommended policy changes relating to MA payments consider the impacts on MA beneficiaries.

The estimates of relative MA and FFS spending included various assumptions about differences between MA and FFS enrollees, and projections of future changes in costs. However, the discussion at the meeting did not convey the limits of those estimates and assumptions. For example:

- The "favorable selection" analysis did not quantify the extent to which prior FFS spending for those who switch into MA may reflect barriers to access and thus do not translate into lower MA spending, or other reasons that actual MA spending may change over time after people enroll (e.g., "regression to the mean"). Further, the discussion failed to explain how the conclusion on favorable selection is consistent with CMS demographic data. MA serves a disproportionately diverse population (including 60% of the dually eligible Medicare population, and higher percentages of people of color), with poorer health status and lower average incomes. Further, the Medicare Trustees have observed that increased enrollment of dual-eligibles in MA has been one driver of lower-than-expected FFS spending in recent years.

- Certain methodological choices in the analysis may skew the comparative data. For example, the favorable selection analysis excludes people who enrolled in MA and died in the data review period, which has the potential to bias estimates of spending. A problem MedPAC acknowledges but cannot quantify. In addition, the benchmark analysis made MA costs appear higher because it used costs for all FFS enrollees. This included nearly 15% of the FFS population enrolled only in Medicare Part A in 2021 who are not eligible to enroll in MA, even though their average Part A costs ($71.99 in 2021)

are much lower than the Part A costs for those eligible to enroll in MA ($411.43). One recent analysis found that limiting FFS cost estimates to those enrolled in both Parts A and B would increase average FFS spending in 2021 by 6%.[1]

- The meeting discussion clarified that there was no detailed analysis to support MedPAC's assumptions about future coding practices under the new MA risk adjustment model given the changes went into effect this month. In addition, MedPAC asserted that favorable selection is separate from coding so that the effects are additive, but it does not provide any explanation or justification, including any analysis of potential interactions for people who had lower spending in FFS due to the inability to access care rather than better health.

Furthermore, reducing program payments could adversely affect MA enrollees, particularly low-income, older, and racial and ethnic minority enrollees who increasingly choose MA. The MA program offers reduced cost sharing for Part A and Part B benefits, out-of-pocket limits, and access to supplemental benefits not available in FFS, such as dental, vision, hearing, transportation, nutrition and home support services, and care management programs. These benefits are critical for making health care more affordable and accessible for seniors and individuals with disabilities.

We urge MedPAC to consider these concerns before finalizing its assessment of the MA program in its March Report to the Congress. Stakeholders should have full awareness and understand the uncertainties inherent in MedPAC's analyses. Moreover, MedPAC should ensure that MA program analyses, particularly those that reference recommendations that can result in funding cuts to the program, also assess the extent to which such cuts could result in higher costs and/or loss of critical benefits for 32 million Americans.

With a clearer understanding of these issues, we look forward to working with stakeholders to explore ways to build on the strengths of the MA program for seniors, people with disabilities, and taxpayers.

Sincerely,

Jeanette Thornton
Executive Vice President, Policy and Strategy

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[1] See https://www.ahip.org/resources/value-of-medicare-advantage-compared-with-fee-for-service-medicare.