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January 26, 2024

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

Dear Dr. Chernew:

The Blue Cross Blue Shield Association (BCBSA) appreciates the opportunity to submit comments in response to the discussion at MedPAC's January public meeting.

BCBSA is a national federation of independent, community-based and locally operated Blue Cross and Blue Shield (BCBS) companies (Plans) that cover, serve and support 1 in 3 Americans – nearly 118 million people – in every ZIP code across all 50 states, the District of Columbia and Puerto Rico. BCBS Plans contract with 96% of hospitals and 95% of doctors across the country and serve those who are covered through Medicare, Medicaid, an employer, or purchase coverage on their own. We are committed to affordable, equitable coverage and high-quality care for every American.

We are also committed to strengthening Medicare Advantage (MA) — an immensely popular and growing program that provides affordable, coordinated, patient-centered care for seniors and Americans with disabilities. BCBS Plans collectively serve more than 8 million total Medicare beneficiaries, including 4.6 million people in MA, which represents more than 14% of the market, and 1.2 million people in Part D.

Nearly 32 million beneficiaries — over half of Medicare's enrollment — choose MA because it delivers lower costs, better benefits, more choices and access to high-quality care. Beneficiaries utilize expanded supplemental benefits not offered in original Medicare, including vision, dental, hearing, prescription drugs, meals and transportation. The Congressional Budget Office projects that nearly two-thirds all Medicare beneficiaries will choose Medicare Advantage by 2033.

We feel strongly that a stable, sustainable and competitive MA program must protect beneficiaries from higher costs, support providers in delivering whole-person care and allow health plans to strengthen benefits and plan choices. MA also plays an increasingly important role in serving beneficiaries with complex needs, including those who may be covered by both Medicare and Medicaid.

We would like to offer the following recommendations for MedPAC's consideration:

1. **Alternatives to Standardizing MA Products**. BCBSA strongly supports MedPAC's goal of ensuring beneficiaries can make informed decisions about which health plan will best meet their needs. However, we are concerned that standardization of MA products would have significant, unintended consequences:

- All of MA's 32 million enrollees would face changes to their current plans.
- The vast majority (93%) likely needing to switch to new coverage.
- 70% of enrollees would be forced to choose a plan with higher premiums or fewer supplemental benefits.
- The remaining 39% of enrollees would be required to choose a plan with fewer benefits, resulting in higher cost-sharing for these members when they access care.

We recommend that MedPAC perform a more detailed analysis of the potential market impact of standardization before moving forward in recommending MA product standardization, and we offer these alternatives to help ensure consumers can make informed decisions:

- **Improve the Medicare Plan Finder:** We recommend enhancing the Medicare Plan Finder to allow beneficiaries to sort and filter plans based on characteristics that they care about, for example, total estimated out-of-pocket costs based on anticipated health care needs. Consumers should be able to explore their health insurance options in the same way they sort and filter their many product choices on Amazon, for example. Simplifying plan comparisons for users would give them confidence to make important coverage decisions for themselves and their loved ones.

- **Require meaningful difference between plan offerings.** A thoughtful meaningful difference standard would reduce the number of plan choices that are not distinct from one another without harming market innovation or competition. To be effective, the meaningful difference standard should be based on multiple factors that consumers use to differentiate products, for example, network differences, drug formularies, and other cost-sharing differences.

If MedPAC makes a recommendation on consumer navigation, we recommend Commissioners consider these approaches before explicitly recommending standardization or a cap on the number of products that could be offered by an issuer. MedPAC could then evaluate the impact of standardization over time to determine whether beneficiary's ability to make informed choices continues to be a concern.

2. **Clarifying spending comparisons between MA and Fee-for-Service Medicare.** We recommend that MedPAC provide additional information on the new methodology that MedPAC proposes to use in comparing costs between MA and fee-for-service (FFS) Medicare, including its demographic estimate of coding intensity (DECI) methodology, selection analysis, and the derived modeling and assumptions on MA with proper time for industry stakeholders to peer review and replicate MedPAC's results. Specifically, we request additional information on:

- **Benchmarks and Payment:** BCBSA recommends that MedPAC provide clarity on the relationship of MA bids to benchmarks and how estimates from the DECI methodology are reconciled with other elements of bidding and payment that are based on plan's claims experience and administrative costs.

- **Favorable Selection:** We recommend that MedPAC consider additional analysis and adjustments to its methodology to appropriately account for its MA data limitations as well as potential issues surrounding survivorship bias (i.e., attrition).
- **Coding Intensity:** BCBSA recommends that MedPAC provide additional information on the methodologies used to produce its 2024 and unified estimates, with explanation on the appropriateness of not trending the v28 model to project future coding intensity impacts.

In addition to our questions and concerns regarding the new methodology, we have noted that some in the media are mischaracterizing MedPAC's finding that MA plans are paid 23% more than FFS Medicare as an "overpayment." That is wrong. MA provides a comprehensive benefit package that delivers significantly more value to beneficiaries than original Medicare in terms of affordability, financial protection, enhanced benefits and better outcomes. We would encourage MedPAC to include information on the value that MA provides to help ensure that these differences are not mischaracterized as an overpayment. We would also encourage MedPAC to look at the potential consequences of changes, rather than simply illustrating the difference in payment between the two programs.

We appreciate your consideration of these recommendations. Our detailed comments on these topics are included below.

DETAILED DISCUSSION OF MA STANDARDIZATION AND OF SPENDING COMPARISONS

Standardization of MA Benefits

We would like to submit an analysis of how standardization of A/B plan designs could impact choices currently available to beneficiaries, using the three illustrative packages with standardized MA cost-sharing for Part A/B services presented at the September and January MedPAC meetings[1].

Comparing these standardized cost-sharing levels to those in the MA benefit plans in the market in 2023 (limited to members in local HMO & PPO non-SNP plans), we observed the following potential member impacts of standardization:

- 13.5 million (69.8%) beneficiaries are in a product that is, for at least one benefit category, less generous than Package 1. If forced to buy up to Package 1, this would result in higher premiums or fewer supplemental benefits for many of these members.
- 7.4 million members (38.6%) are in a product that is, for at least one benefit category, more generous than package 3. If forced to buy down to Package 3, this would likely result in net higher A & B cost-sharing for many of these members.
- Overall, 18 million members (93.2%) are in a product that is, for one or more benefit categories, either less generous than Package 1 or more generous than Package 3. Forcing these consumers into a standardized package will result in significant disruption.
- 100% of members would experience a plan benefit change to move to one of the three standardized packages, as none of these members had an exact match in benefits to the standardized packages.

		MedPAC Illustrative Packages[2]			
Service Category	**2023 Members[1] with Less Generous Benefits than Package 1**	**Package 1** (Lower Generosity)	**Package 2** (Medium Generosity)	**Package 3** (Higher Generosity)	**2023 Members with More Generous Benefits than Package 3**
Maximum out-of-pocket limit	**4.3M (22.3%)**	$6,200	$4,900	$3,400	**4.0M (20.5%)**
Inpatient Acute (days 1-5 of stay)	**3.0M (15.4%)**	$335	$300	$225	**4.9M (25.3%)**
Outpatient Hospital	**5.9M (30.4%)**	$300	$295	$200	**4.6M (24.0%)**
Specialist Visit	**11.2M (57.9%)**	$40	$35	$20	**4.2M (21.6%)**
One or more of these services	**13.5M (69.8%)**				**7.4M (38.6%)**

[1] The analysis used CMS 2023 MA benefit plan data and CPSC enrollment data as of May 2023, limited to members enrolled in local HMO/PPO non-SNP plans. Packages evaluated were from MedPAC's example standardized benefit packages 1, 2, and 3 from slide 10 of : https://www.medpac.gov/wp-content/uploads/2023/03/Tab-D-Standardized-MA-Sept-2023.pdf

State Impact of Standardization

We have included an appendix that describes the disruption that would be faced by beneficiaries in states with high or low average cost-sharing relative to MedPAC's standardized packages. Consumers living in states without "average" cost-sharing today would face the sharpest increases in cost-sharing or premiums, or reductions in benefits or plan choices were state cost-sharing variability to be eliminated. Enrollment-weighted averages of these cost-sharing levels (by state) in the market in 2023 reveal the following:

- There is high variability between states' average cost-sharing levels, which would lead to larger impacts of standardization for beneficiaries in some states.
- Beneficiaries' plan choices would be severely limited in states with the highest average MOOPs (i.e., NJ, MD, NY, VT, WV), as Package 3 (Higher Generosity) would likely be difficult for plans to offer.
- Under the illustrative standards, beneficiaries in states like LA, CA and FL would face significant increases in copays for inpatient acute care as the current average inpatient copays in these states are much lower than the lowest standardized inpatient copay.
- Standardizing outpatient hospital copays may induce utilization in states with outpatient hospital copays that are currently higher than the highest outpatient hospital copays.
- Reducing specialist copays would be costly for states with the highest copays, which may lead to fewer Package 2 and Package 3 plans in those states, further reducing member choice.

Experience in the ACA Exchanges: Potential Consequences of Standardizing MA

At the January meeting, MedPAC staff were asked to consider the experience in standardizing plans in the Affordable Care Act (ACA) exchanges. Below, we share our perspectives on CMS' efforts to standardize Qualified Health Plans (QHPs) in federally facilitated marketplaces (FFM). BCBS Plans serve more than 7.4 million members and offer QHP products in counties representing 97% of the U.S. population.

The current QHP standardization model used by CMS is most similar to Package 2 in the options presented at the MedPAC meeting. CMS required Healthcare.gov issuers to offer a standardized QHP at every product network type (e.g., HMO, PPO, etc.) and metal level throughout each service area where they offer non-standardized QHP options. However, the ACA model provides for more flexibility than the options MedPAC considered due to the permutations created by metal levels, product types and service areas. Moreover, CMS proposed an exceptions process in the NBPP for 2025 to allow additional non-standard options recognizing the model's potential to eliminate QHPs aimed at reducing health disparities and other important benefit designs.

Based on BCBS Plans' experience with standardized QHPs in the ACA, we share the following cautions for MedPAC's consideration in the MA market:

- **Standardization will require consumers to switch coverage.** In the economic impact analysis for the NBPP for 2025, CMS estimated 27% of consumers would see their coverage disrupted and

need to find a new plan due to the rule's proposed limitations.[2] For 2024 we are starting to see the number of products available on the exchanges contract. Standardization in the MA market would be more disruptive because MA plans are not currently tiered by actuarial value, limiting the coverage levels from which Medicare beneficiaries could choose.

- **Standard plans are not popular.** CMS data on standardized plan enrollment in 2023 show that across all issuers, standardized plans represented only 20% of enrollment.[3] The majority of enrollment remains in non-standardized products today (69%), underlining that they better meet individual consumers' needs.
- **Standardization can stifle value-based care.** Value-based arrangements generally have cost-sharing structures that are tailored to the providers who are sharing risk. They may not be viable if standardized cost-sharing does not align with incentives.
- **Standardization could reduce the availability of plans with broader networks.** With the current limitation on offering non-standard QHP options in the exchanges, we expect further changes to the types of health plans that QHP issuers bring to market. To be competitive, issuers will likely move towards only the most popular plan designs, such as those with narrow networks, and will close products with broad networks or value-based care arrangements. As a result, issuers will be discouraged from offering broader networks that benefit consumers with greater health care needs.

Comparison of MA and FFS Medicare Spending

At the January meeting, as part of the MA Status Report, MedPAC staff presented a new methodology for comparing MA and FFS Medicare costs. This was the first time that the public had seen many of the elements of this new methodology, such as the proposed adjustment for favorable selection and how MedPAC plans to account for the significant changes CMS made in the MA Rate Notice last year. We request that MedPAC share additional details on this new approach to ensure that it is credible and reliable. Specific areas include DECI methodology, selection analysis, and the derived modeling and assumptions on MA. We encourage MedPAC to provide this additional detail before finalizing this analysis. We also request additional time to properly peer review and replicate MedPAC's results. Our specific requests are below:

1. **Benchmarks and Payment:** BCBSA requests that MedPAC clarify that MA payments are based on Part A/B costs incurred by the plan (risk adjusted for the plan's population) and on rebates. The MedPAC study addresses theoretical factors that may inflate the MA benchmarks, but higher benchmarks cannot be equated directly with payment. BCBSA recommends that MedPAC clarify the relationship of the MA bids to benchmarks and how its estimates can be reconciled with other elements of bidding and payment, which are based on plan's claims experience and administrative costs as approved and audited by the CMS Office of Chief Actuary (OACT).

[2] https://www.federalregister.gov/documents/2022/12/21/2022-27206/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2024
[3] https://www.cms.gov/files/zip/2014-2023-oep-plan-design-public-use-file.zip

2. **MA Margin:** MedPAC's margin analysis is consistent with data provided to the CMS Office of the Chief Actuary as part of the annual bidding process. BCBSA notes that these margins are not consistent with assertions that MA plans are being overpaid; instead, the modest margins reflect health plan efforts to lower Medicare costs and provide extra benefits to enrollees. Our questions on MedPAC's margin analysis include:

    - What are the ranges of underwriting margins shown for MA plans in the historical NAIC reports?
    - In assessing margins, what considerations are made toward current margin requirements and the significant administrative costs felt by MA plans?
    - Do Medical Loss Ratio (MLR) rebates protect the consumer in the case of excess margin?

3. **Favorable Selection Study:** BCBSA requests that MedPAC consider additional analysis to fill the gaps in its methodology. Notably, MedPAC does not have data prior to MA enrollment for approximately 50% of the MA enrollees, and thus the generalizability of the favorable selection results can be questioned. At a minimum, MedPAC should consider adjusting its estimate to appropriately account for the limited data.

    In addition, the selection study methodology makes large assumptions in concluding that MA enrollee expenditures will not regress to the FFS mean. It is an implicit assumption that data collected in the years *before* enrolling in MA give valid evidence for understanding experience *after* enrolling in MA. There are a number of reasons to question this assumption, including but not limited to the issue of survivorship, meaning not all enrollees will survive to enroll in MA, and removing them lowers the FFS cost basis against which MA is evaluated.

    BCBSA requests that MedPAC address the issue of survivorship bias (i.e., attrition), a well-established phenomenon whereby, because any cohort of beneficiaries that have survived a certain number of years will exclude all beneficiaries who died over that time, the cohort looks initially healthier. MedPAC does not appear to fully address this issue in its study, raising questions about the generalizability of the results. BCBSA requests that MedPAC share more information about how it addressed survivorship bias and consider updating its study.

    Other aspects of selection to be clarified in MedPAC's modelling include:

    - How does the model account for factors such as mandatory maximum out-of-pocket caps in MA and SNPs in influencing plan selection, given the attraction for sicker and poorer beneficiaries?
    - How does MedPAC's analysis take into account the transition of duals from FFS to MA over time and their impact on their health status of each pool?

4. **Coding Intensity:** MedPAC's most recent estimate of the impact of coding intensity appears to be based on summing estimates calculated using two different methodologies. We would appreciate a more detailed description of the methodologies used to produce the 2024 estimate and an explanation of how the methodologies have been combined to produce a unified estimate. We also ask that MedPAC address the appropriateness of not trending the V28 model to determine what the coding intensity adjuster would have been under the model that will be fully in effect in 2026. At a

minimum, the trended model estimates under v24 and v28 should have been combined to produce a weighted estimate rather than an adjustment to the final year of the v24 estimate.

We appreciate the efforts of MedPAC to provide fair analysis, insights and perspectives which help to improve the Medicare program, as well as MedPAC's willingness to take public feedback into consideration. We ask that MedPAC delay any formal recommendations to Congress until additional analysis has been completed on its payment comparisons between the MA and FFS programs, with greater methodological transparency and additional dialogue with industry partners. Further, we encourage the Commission to appropriately label any findings to date on these topics as "preliminary and subject to change," given the ongoing analysis and continued consideration of industry feedback.

Thank you again for the opportunity to provide feedback and for considering these recommendations.

Sincerely,

David Merritt

Senior Vice President, Policy and Advocacy

CC: Paul Masi, Executive Director, Medicare Payment Advisory Commission

Appendix: Impact of MA Standardization by State

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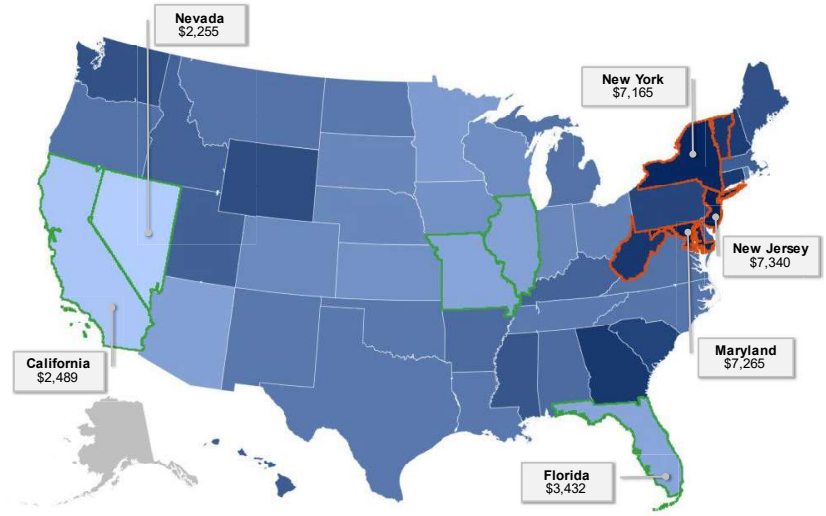
MAXIMUM OUT-OF-POCKET LIMIT BY STATE
HIGH VARIABILITY BETWEEN STATES



Source: CMS 2023 MA benefit plan data and CPSC enrollment as of May 2023; limited to members in local HMO/PPO non-SNP plans

TOP- AND BOTTOM-FIVE STATES
BY AVERAGE MOOP

#	State	MOOP
1	Nevada	$2,255
2	California	$2,489
3	Florida	$3,432
4	Missouri	$3,450
5	Illinois	$3,534
…	…	…
46	West Virginia	$6,688
47	Vermont	$6,690
48	New York	$7,165
49	Maryland	$7,265
50	New Jersey	$7,340

- High variability between states would lead to larger impacts of standardization for states at the extreme ends.
- Plan variation would be severely limited in the states with the highest MOOPs, if the "higher generosity" plan options are unaffordable.

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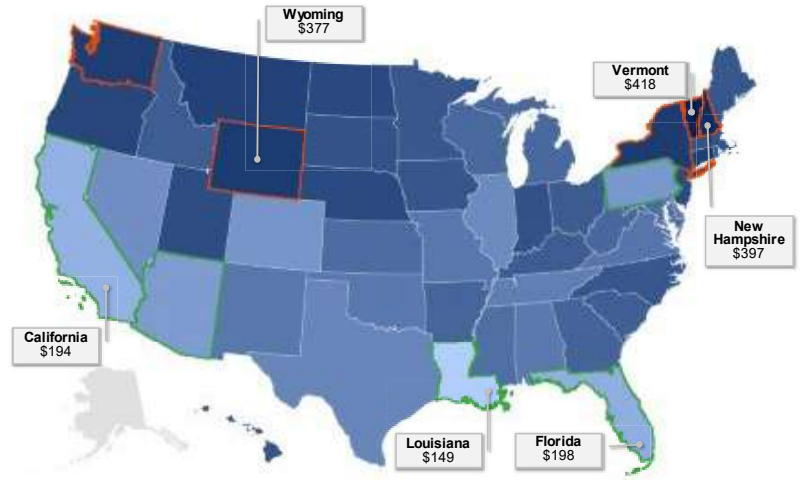
INPATIENT HOSPITAL COST SHARING BY LOCATION
HIGH VARIABILITY BETWEEN STATES



Source: CMS 2023 MA benefit plan data and CPSC enrollment as of May 2023; limited to members in local HMO/PPO non-SNP plans

TOP- AND BOTTOM -FIVE STATES
BY AVERAGE DAILY INPATIENT COPAY

#	State	IP Per Day
1	Louisiana	$149
2	California	$194
3	Florida	$198
4	Arizona	$227
5	Pennsylvania	$234
…	…	…
46	Washington	$373
47	New York	$376
48	Wyoming	$377
49	New Hampshire	$397
50	Vermont	$418

- The average daily Inpatient copays vary widely by state.
- Standardizing at copay levels higher than the green-highlighted states would result in hundreds of dollars per stay in increased member cost sharing.

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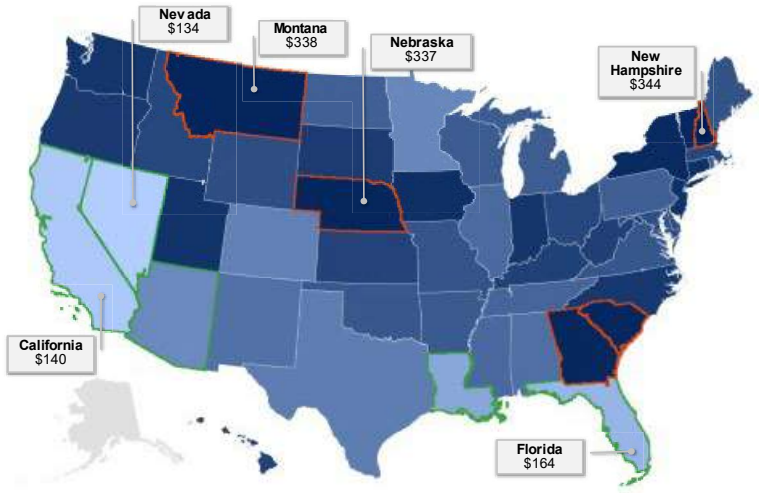
OUTPATIENT HOSPITAL COST SHARING BY LOCATION

HIGH VARIABILITY BETWEEN STATES



Source: CMS 2023 MA benefit plan data and CPSC enrollment as of May 2023; limited to members in local HMO/PPO non -SNP plans

TOP- AND BOTTOM -FIVE STATES
BY AVERAGE OP HOSPITAL COPAY

#	State	OP Hospital
1	Nevada	$134
2	California	$140
3	Florida	$164
4	Louisiana	$182
5	Arizona	$216
…	…	…
46	Georgia	$336
47	South Carolina	$336
48	Nebraska	$337
49	Montana	$338
50	New Hampshire	$344

- The average OP Hospital copays in states with the highest copays are more than double those in states with the lowest copays.
- Benefit standardization may cause induced utilization in states with the highest copays.

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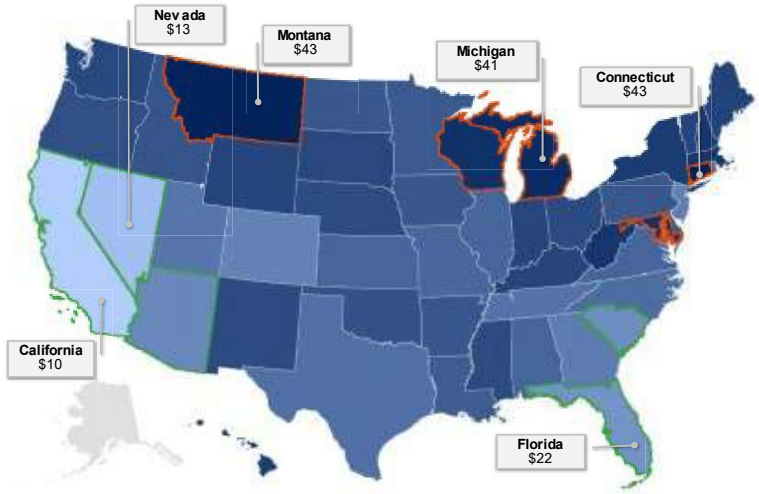
SPECIALIST PHYSICIAN COST SHARING BY LOCATION

HIGH VARIABILITY BETWEEN STATES



Source: CMS 2023 MA benefit plan data and CPSC enrollment as of May 2023; limited to members in local HMO/PPO non -SNP plans

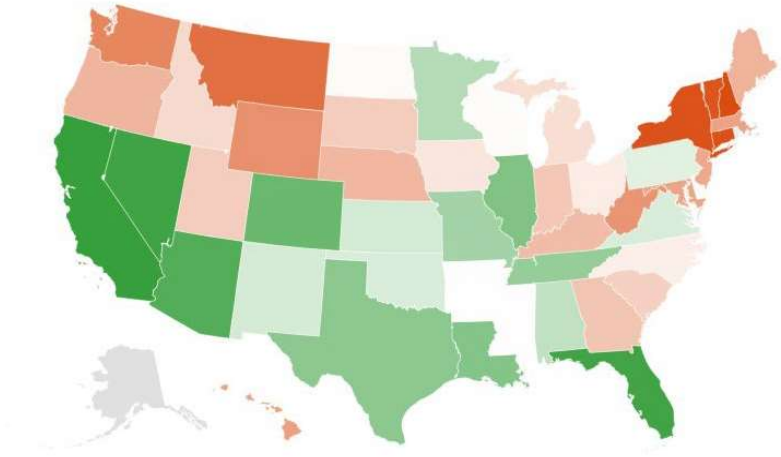
TOP- AND BOTTOM -FIVE STATES
BY AVERAGE SPECIALIST COPAY

#	State	Specialist
1	California	$10
2	Nevada	$13
3	Florida	$22
4	South Carolina	$23
5	Arizona	$24
…	…	…
46	Maryland	$40
47	Wisconsin	$40
48	Michigan	$41
49	Montana	$43
50	Connecticut	$43

- The average specialist copays vary widely by state.
- Reducing specialist copays would be costly for states with the highest copays. This may lead to fewer Package 2 and Package 3 plans in those states, further reducing member choice.

COMPOSITE IMPACT OF STANDARDIZED COST SHARING BY STATE

COMBINED MOOP, INPATIENT, OUTPATIENT, AND SPECIALIST COST SHARE IMPACTS



Source: CMS 2023 MA benefit plan data and CPSC enrollment as of May 2023; limited to members in local HMO/PPO non -SNP plans

STATES WITH GREATEST AGGREGATE IMPACT FROM STANDARDIZATION

#	State	#	State
1	California	41	Massachusetts
2	Nevada	42	Hawaii
3	Florida	43	West Virginia
4	Arizona	44	Wyoming
5	Colorado	45	Washington
6	Illinois	46	Montana
7	Louisiana	47	Vermont
8	Texas	48	Connecticut
9	Tennessee	49	New York
10	Missouri	50	New Hampshire

- The left table shows the 10 states with the lowest average cost sharing. Members would likely see increased cost sharing due to standardization.
- The right table shows the 10 states with the highest average cost sharing. Members would likely see supplemental benefit degradation and/or premium increases to cover the costs of standardization.