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Advising the Congress on Medicare issues

The Medicare Advantage program: Status report

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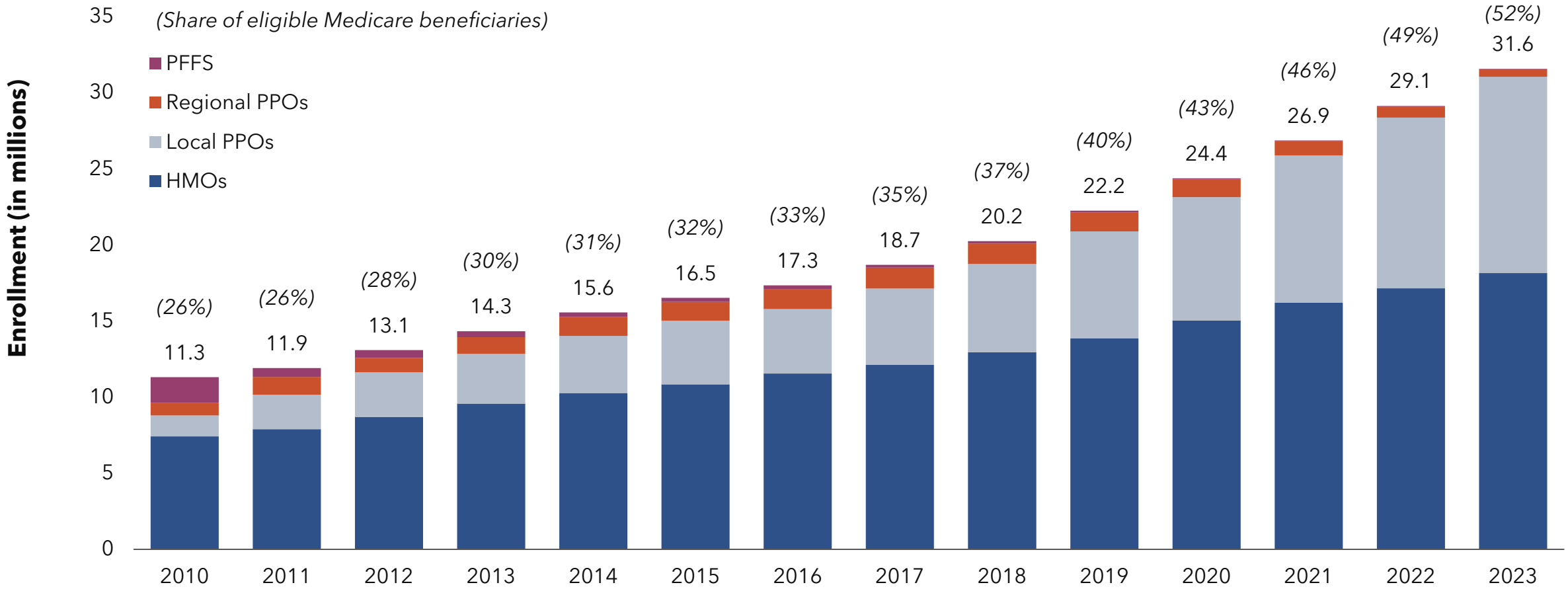
Today's presentation

1. Overview of Medicare Advantage (MA) enrollment, plan availability, and levels of rebates
2. Ongoing concerns about quality
3. Market structure, vertical integration, and insurer financial condition
4. MA plan payments: update on coding intensity
5. MA plan payments: update on favorable selection
6. Comparison of MA and FFS spending

In 2023, 52% of eligible beneficiaries enrolled in MA plans



Note: PFFS (private fee-for-service), PPO (preferred provider organization), HMO (health maintenance organization). Beneficiaries must have both Part A and Part B coverage to enroll in a Medicare Advantage plan; therefore, beneficiaries who have Part A only or Part B only are not included in this figure.

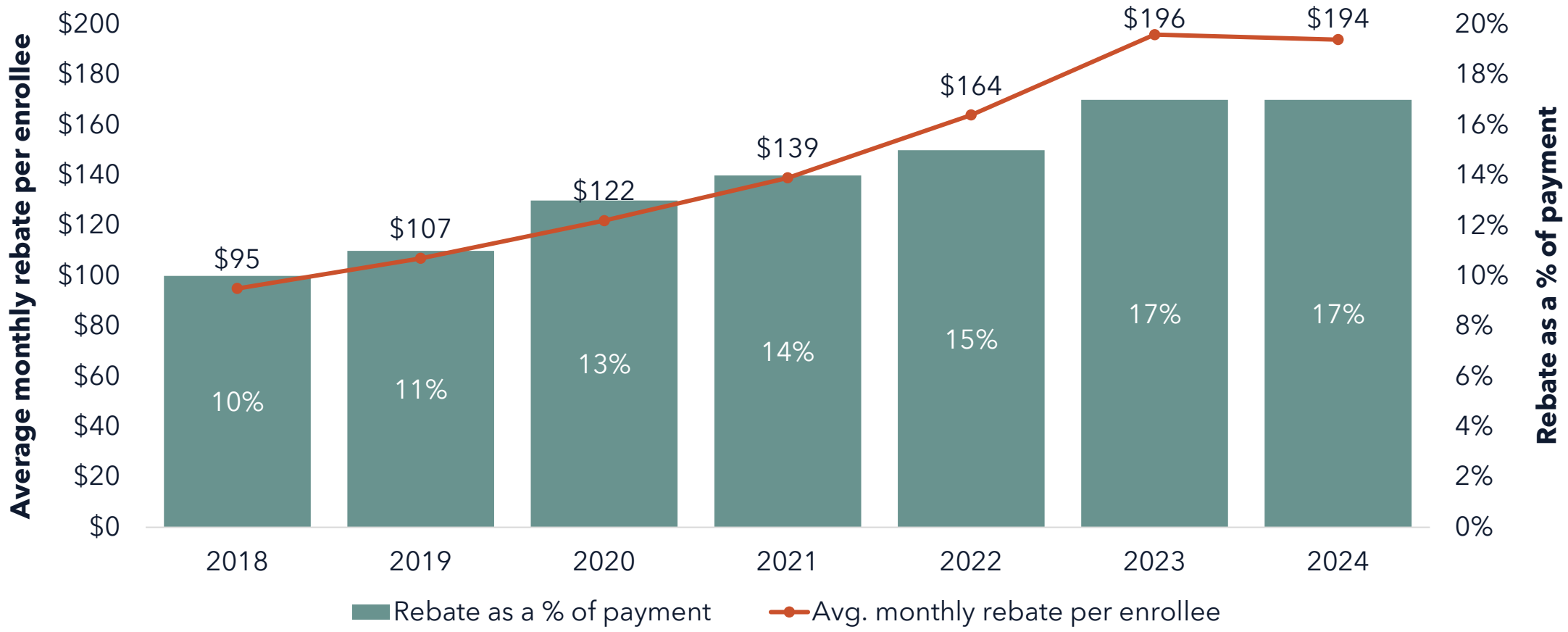
Source: MedPAC analysis of CMS enrollment files, July 2010–2023.

MA plans available to nearly all Medicare beneficiaries; number of plan choices increasing

Plan Availability	2020	2021	2022	2023	2024
Share of beneficiaries with access to:					
Any MA plan	99%	99%	99%	>99.5%	>99.5%
$0-premium plan w/ Part D	93	96	98	99	99
Avg. number of choices (beneficiary-weighted)	27	32	36	41	43

Note: MA (Medicare Advantage). Plan availability does not include plans without a prescription drug benefit, special needs plans, and employer plans.
Source: MedPAC analysis of CMS bid and enrollment data.

Level of monthly rebates near historic high in 2024



Note: Excludes plans that do not offer a prescription drug benefit, employer plans, and special needs plans.

Source: MedPAC analysis of data from CMS on plan bids, 2018–2024.

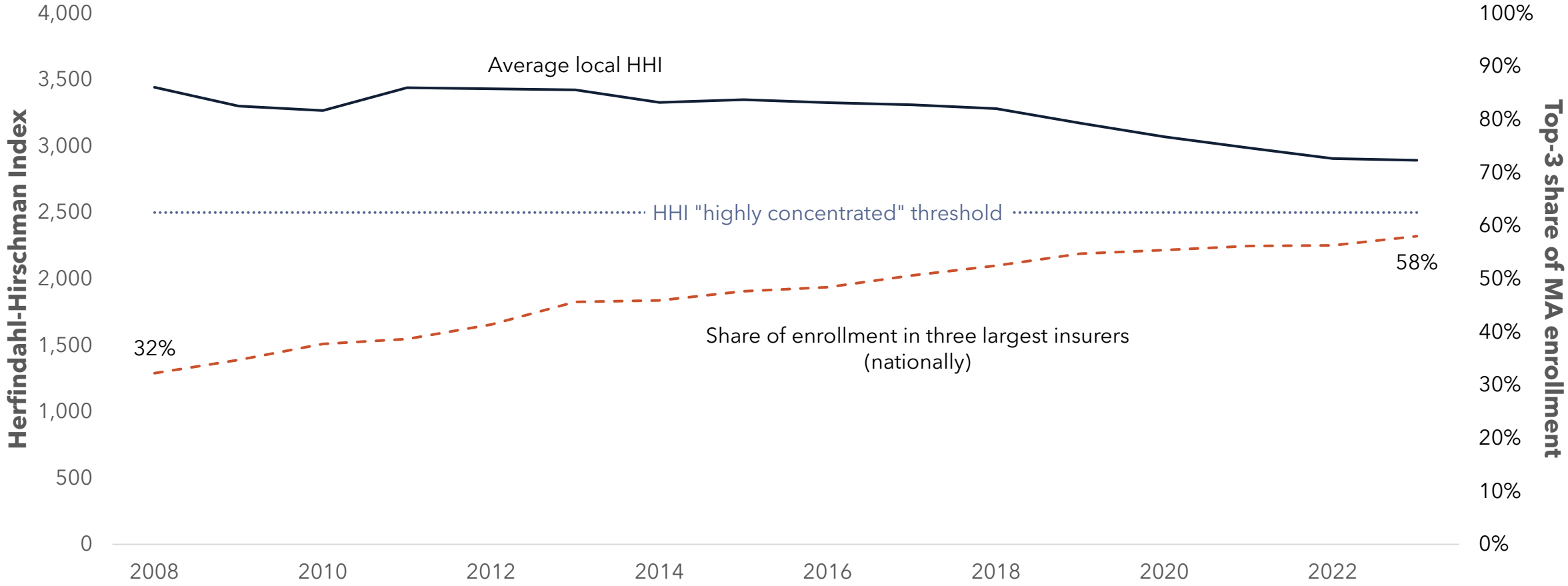
MA quality bonus program costly, not a good basis for judging quality

- Quality bonus program (QBP) accounts for at least $15 billion in MA payments annually, and has serious flaws:
  - Large and geographically dispersed contracts
  - Too many measures, some based on small sample
  - Cannot be compared to FFS in local market
- QBP does not promote the use of high-value care, nor provide beneficiaries with meaningful information about local plan quality
- Commission recommended replacing the QBP with a value incentive program that would address its many flaws *(June 2020)*

Structure of MA markets

- MA enrollment nationwide is increasingly concentrated in a few large firms offering plans in a majority of counties
- High enrollment concentration is a concern because it can limit the extent to which beneficiaries benefit from competition between insurers
  - Local market concentration has decreased in recent years

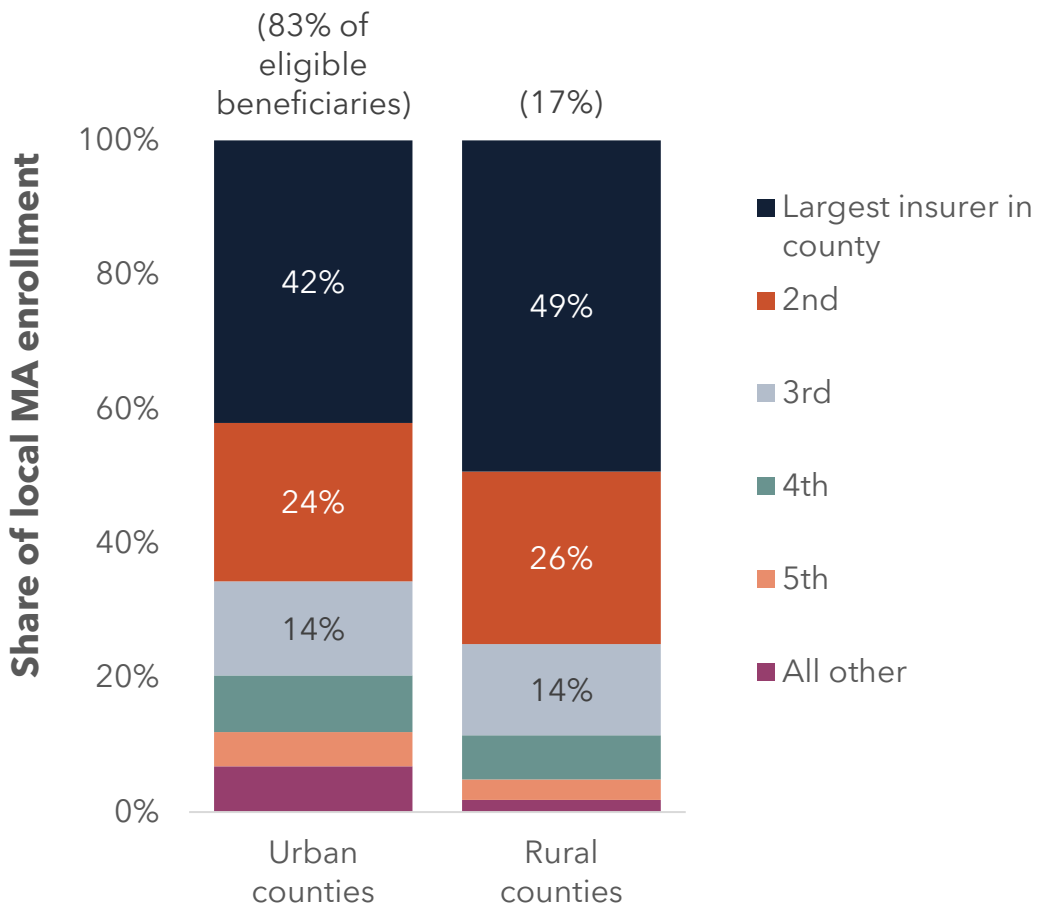
Local concentration has fallen as national concentration has increased, but remains high



Note: HHI (Herfindahl–Hirschman Index), MA (Medicare Advantage). Includes only Medicare Advantage. The threshold for highly concentrated markets is that described in the Department of Justice and the Federal Trade Commission Horizontal merger guidelines.

Source: MedPAC analysis of CMS July 2008–2023 enrollment data.

The largest three insurers in a market typically enroll roughly 80 percent of enrollees



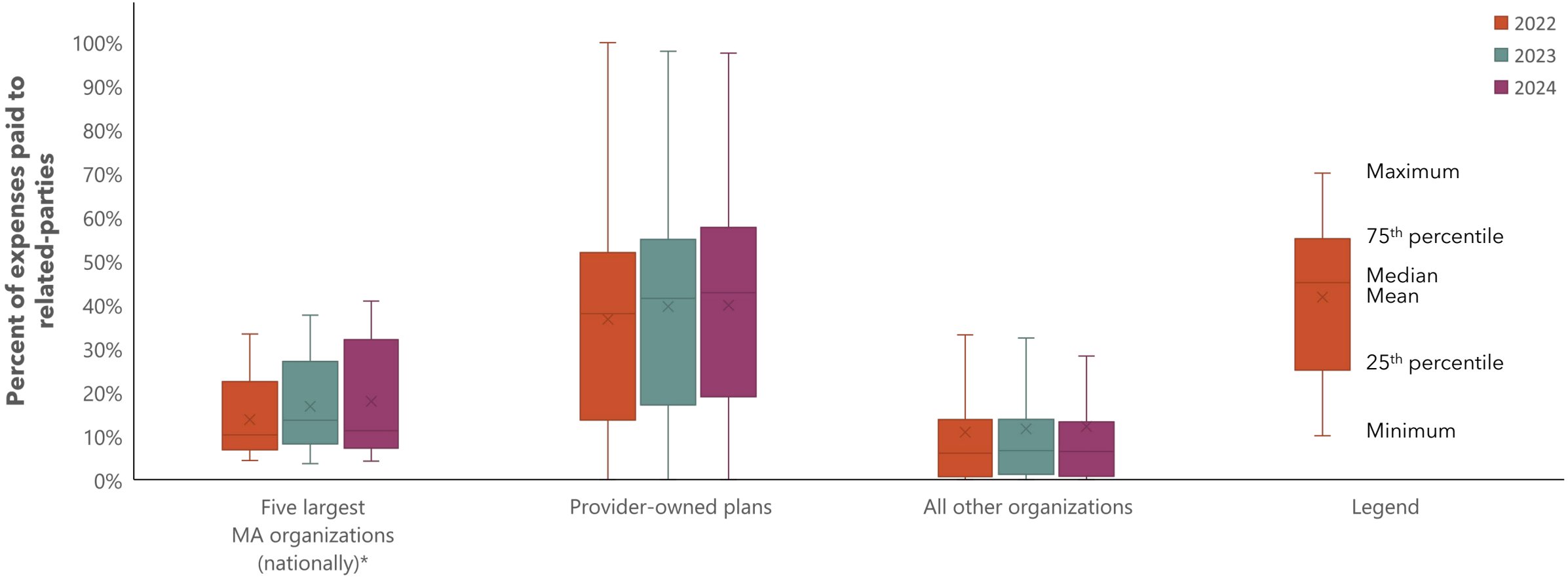
- The typical MA market has plans offered by roughly 8 insurers
- Local enrollment is generally highly concentrated in the top three insurers
- The largest insurers nationally also frequently cover the largest share of enrollees at the local level

Source: MedPAC analysis of CMS 2023 enrollment data.

Limitations in assessing the financial condition of MA organizations

- Growth in enrollment and plan availability signals strong financial health in the MA sector
- We have historically reported the margins that MA plans report in their bids
- Declining confidence in the usefulness of the data
  - Margins might not be the most relevant metric of financial health
  - Plan-specific margins might not sufficiently characterize the financial health of organizations offering MA plans

MA organizations are increasingly vertically integrated



Note: MA (Medicare Advantage). *Five largest non-provider owned plans are UnitedHealth Group, Humana, CVS Health, Elevance Health, and Centene. Kaiser Foundation Health Plan enrolls more beneficiaries than Centene but is categorized as a provider-owned plan in the figure.

Source: MedPAC analysis of CMS enrollment data, MMIT Directory of Health Plans.

Medicare's payments to MA plans

- Payment to plan = base rate × average risk score
- Payment is based on plan bids, benchmarks, and quality scores
  - A bid is the amount each plan expects it will cost to cover Part A and B
  - Benchmarks range from 115% of FFS in lowest-FFS spending counties to 95% of FFS in highest-spending counties (4 quartiles of counties)
    - Can be increased by 5 or 10 percent as a quality bonus for plans achieving 4 or more stars
- Nearly all plans bid below their benchmark
  - Plans receive a base payment of their bid plus a "rebate," which is a percentage (varying by quality score) of the difference between bid and benchmark

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.

MA plan payment policy: Risk adjustment

- Risk scores are a beneficiary-specific index of expected spending relative to national average spending (a 1.0 risk score)
  - Based on beneficiary demographic characteristics and diagnoses
  - Risk scores increase or decrease MA plans' base payment rates to account for enrollee health status
  - Risk scores are used to standardize the FFS spending estimates that county benchmarks are based on, reflecting spending for a beneficiary of average health status
- The risk adjustment model is developed using data for FFS beneficiaries
  - Risk scores reflect expected spending for a beneficiary enrolled in FFS
  - Risk scores reflect the diagnostic coding patterns in FFS

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

Comparing spending on MA and FFS Medicare

- Account for differences in health status, including favorable selection; diagnostic coding differences; geographic distribution; and coverage (e.g., hospice)
- Relative to FFS, spending on MA varies due to
  - Plan benchmarks
    - Accuracy of projected FFS spending used for plan benchmarks
    - Distribution of MA enrollment among county quartiles
    - Share of MA enrollment in plans receiving a quality bonus benchmark increase
  - Intensity of MA coding relative to FFS
  - Favorable selection of beneficiaries into MA

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

MA coding intensity: Several studies find consistent estimates

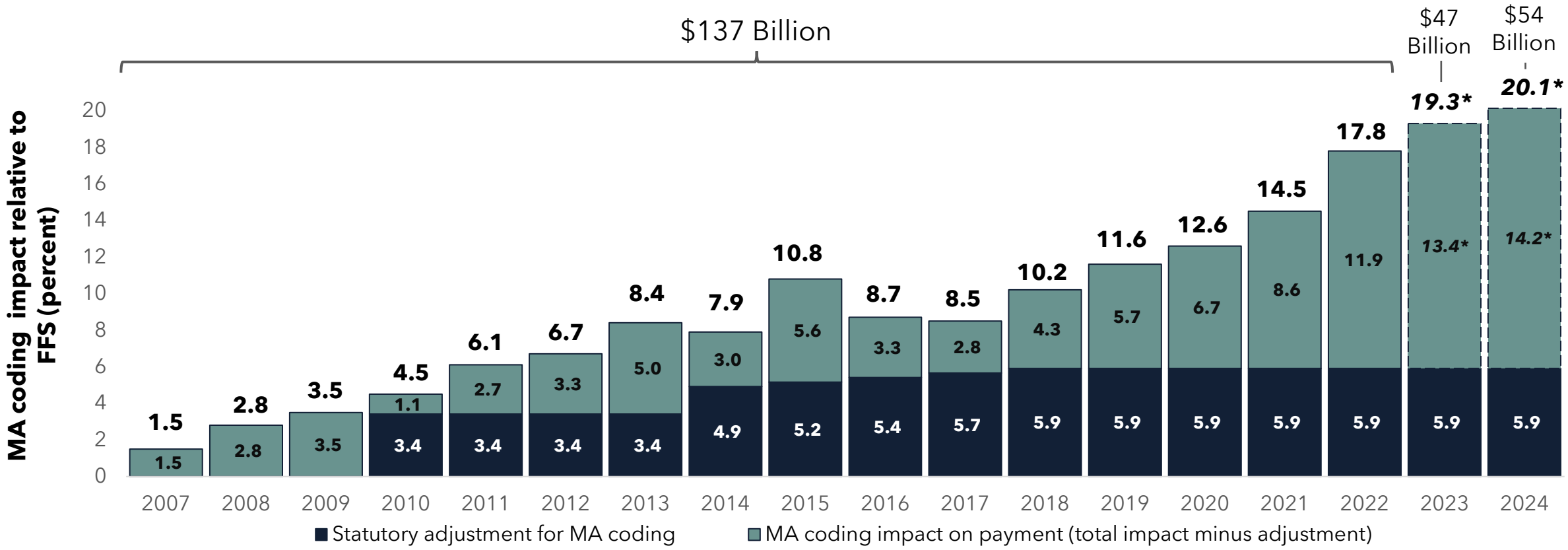
- Differences in diagnostic coding between FFS and MA
  - FFS: Little incentive to code diagnoses
  - MA: Financial incentive and infrastructure to code more diagnoses
- Other coding intensity analyses consistent with MedPAC estimates
  - Analyses of 2013 and earlier found 1 percent faster annual MA risk score growth relative to FFS
  - In the first year after MA enrollment, risk scores grew about 6 percent faster than FFS, and grew about 2 percent faster in second year
  - GAO estimates of coding intensity for 2010 through 2012 are very similar to MedPAC's estimates

Sources: 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*. 53(6): 4997–5015. Hayford T. B., and A. L. Burns. 2018. Medicare Advantage enrollment and beneficiary risk scores: Difference-indifferences analyses show increases for all enrollees on account of market-wide changes. *Inquiry* 55 (January– December): 46958018788640. Geruso, M., and T. Layton. 2015. *Upcoding: Evidence from Medicare on squishy risk adjustment*. NBER working paper no. 21222. Cambridge, MA: National Bureau of Economic Research. Government Accountability Office. 2013. *Medicare Advantage: Substantial excess payments underscore need for CMS to improve accuracy of risk score adjustments*. GAO–13–206. Washington, DC: GAO.

MA coding generates excess payments in 2024

- In September, we reconciled differences in estimates from the demographic estimate of coding intensity (DECI) and MedPAC's prior cohort method
- MedPAC's estimates of coding intensity
  - Based on MedPAC's revisions to DECI method
  - Project estimates for 2023 and 2024 based on 2017 through 2021 trend
- 2024 MA risk scores are about 20.1% higher than scores would be if MA enrollees were instead enrolled in FFS Medicare

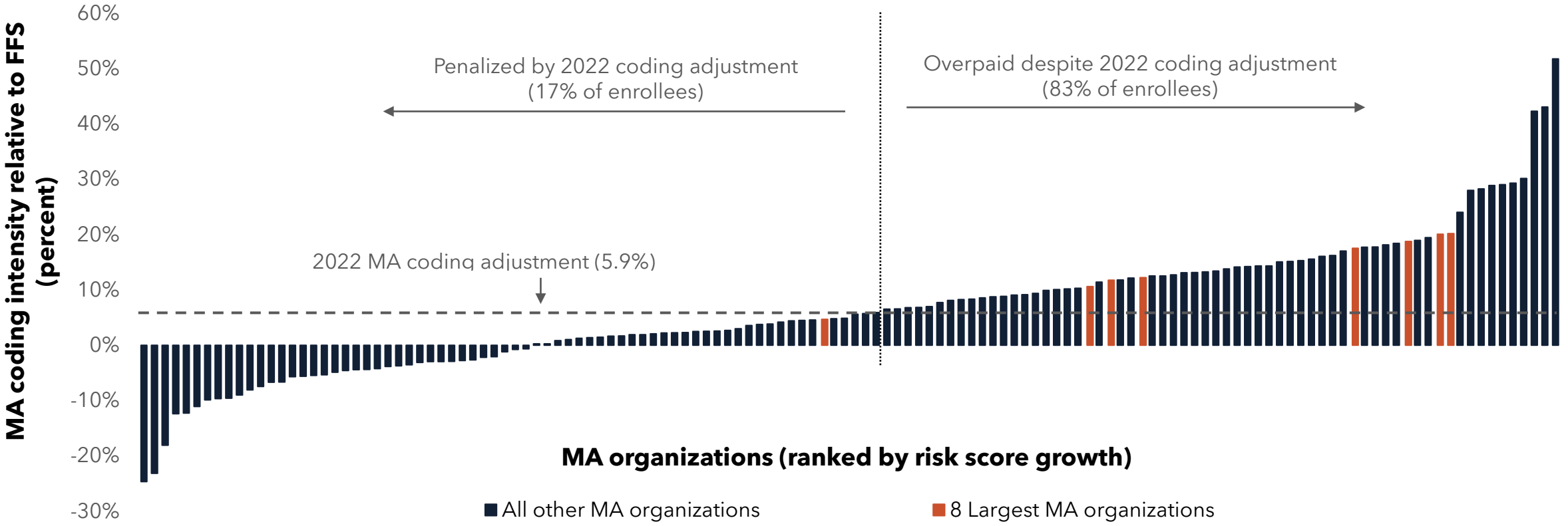
Impact of coding intensity continues to grow



Note: MA (Medicare Advantage), FFS (fee-for-service). Estimates account for differences in age, sex, Medicaid eligibility, and institutional status between MA and FFS populations. New enrollees are constrained to have no coding intensity. Increases in MA coding intensity were offset by new versions of the risk-adjustment model in 2014, 2016, and 2017 and by increased FFS coding in 2016 and 2017. *For 2023 and 2024, we project coding intensity based on the annual trend from 2017 through 2021. For 2024, we reduced that annual trend by 0.67 percentage points to account for the introduction of the v28 risk adjustment model.

Source: MedPAC analysis of CMS enrollment and risk score files.

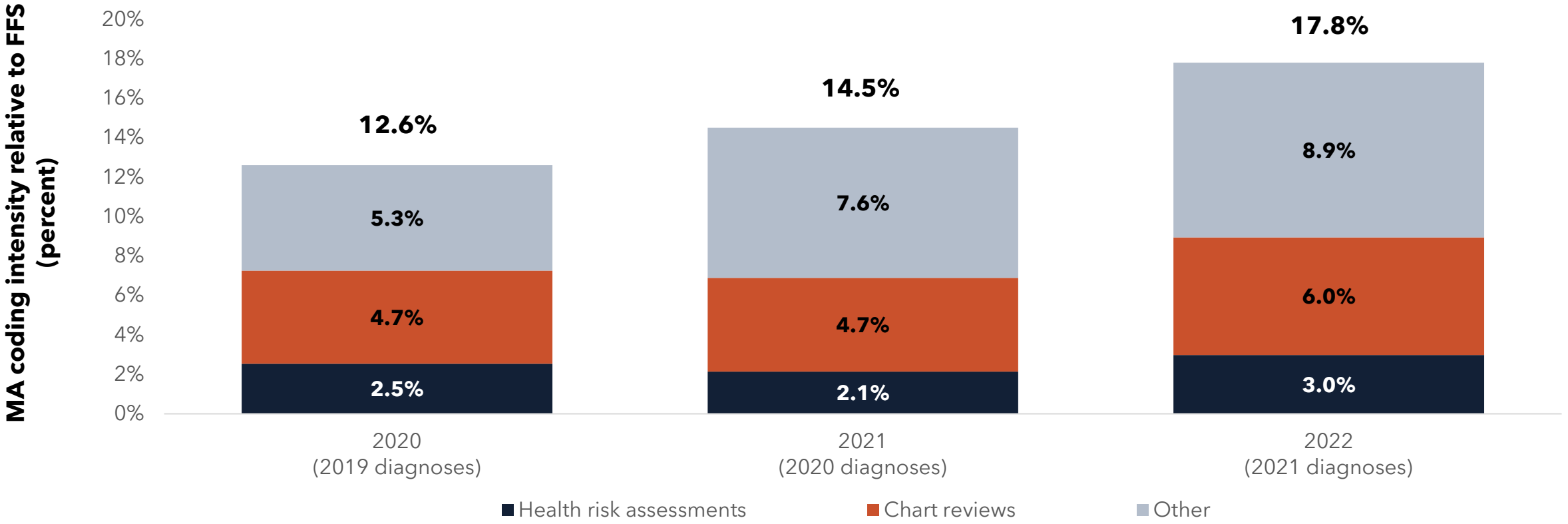
Coding intensity generates payment inequity across MA organizations



Note: MA (Medicare Advantage), FFS (fee-for-service). Estimates are for 2022 and exclude special needs plans, contracts for the Program of All-Inclusive Care for the Elderly, and organizations with fewer than 2,500 enrollees in the analysis. All estimates account for any differences in age, sex, Medicaid eligibility, and institutional status between MA and FFS populations. New enrollees are constrained to have no coding intensity as their risk scores are not based on diagnostic coding.

Source: MedPAC analysis of CMS enrollment and risk score files.

Chart reviews and health risk assessments account for about half of overall MA coding intensity, 2020-2022



Note: MA (Medicare Advantage), FFS (fee-for-service). The figure shows the impact of coding intensity on payments to MA plans for the years 2020 through 2022. The underlying diagnoses were reported during health care encounters in the prior year, 2019 through 2021, respectively. Health risk assessments are provided to Medicare beneficiaries as part of an annual wellness visit, and, for MA enrollees, health risk assessments are often provided during a plan-initiated home visit. Chart reviews are plan-initiated reviews of medical charts for health care encounters that are allowable for risk adjustment.

Source: MedPAC analysis of CMS enrollment and risk score files.

Addressing MA coding intensity

- The Commission's recommendation addresses underlying causes of coding intensity *(March 2016)*
  - Remove health risk assessments (HRAs) from risk adjustment
  - Use two years of MA and FFS Medicare diagnostic data
- Chart reviews and HRAs are key drivers of coding intensity
  - We estimate that chart reviews and HRAs account for about half of excess payments to MA plans
  - Use of chart reviews and HRAs varies substantially within MA, contributing to coding intensity variation across plans

Source: MedPAC analysis. Office of Inspector General, Department of Health and Human Services. 2021. *Some Medicare Advantage companies leveraged chart reviews and health risk assessments to disproportionately drive payments*. OEI-03-17-00474. Washington, DC: OIG.

Favorable selection would also generate excess payments to plans

- Absent any intervention from plans, favorable selection in MA occurs if spending for MA enrollees is systematically lower than their risk scores predict
- Favorable selection would result in excess payments for MA plans but is 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
  - November 2023 public presentation
- Favorable selection is separate from coding, and the effects are additive

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

MA plan and beneficiary incentives may produce favorable selection

- MA plans use tools to manage utilization
  - Plan networks and prior authorization
  - Higher cost sharing for most services compared with Medigap
- Beneficiaries may respond to these tools by self-selecting into or out of MA
  - Perception of limited networks and delays in care
  - Beneficiaries who seek more care may find FFS with supplemental insurance to be less costly
  - Beneficiaries who seek less care may find MA to be less costly

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

MedPAC analysis suggests MA plans experience favorable selection

- In November, MedPAC estimated that favorable selection alone led to 6 to 13 percent higher payments than FFS annually from 2017-2021
  - These estimates are largely consistent with other researchers who have measured favorable selection
- Because CMS's estimates of FFS spending 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).

MedPAC's comparison of MA payments relative to what FFS spending would have been for MA enrollees

- We incorporate two types of estimates:
  - Retrospective: Use actual payments (including non-claims FFS spending), risk scores, and enrollment when available
  - Prospective: Use retrospective comparisons, MA bid data, and CMS's projections of local area risk-standardized FFS spending
- Base comparison: MA payments compared with local area FFS spending and adjusted to have the same risk score profile as MA enrollees
- Adjust risk-standardized FFS spending for unaccounted differences in risk scores: Coding intensity and favorable selection

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

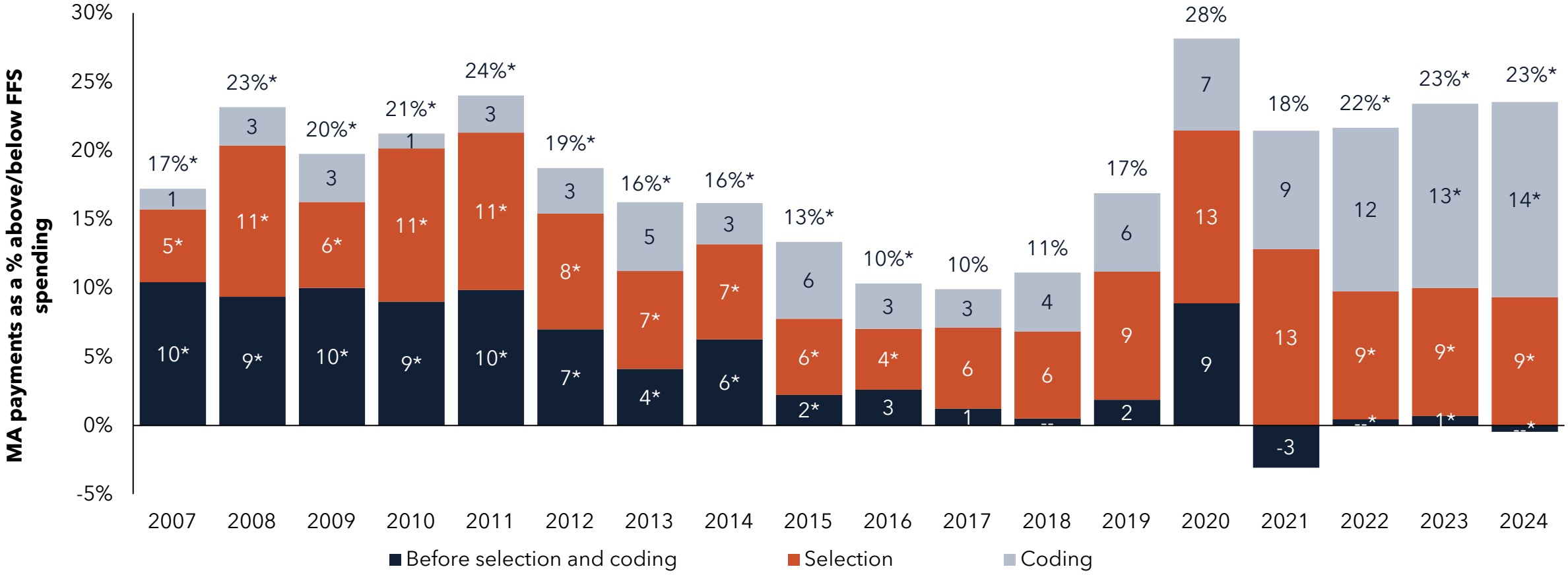
Estimated effects of coding and selection push MA benchmarks, bids, and payments higher relative to FFS

	Share of FFS spending in 2024		
	Benchmarks	**Bids**	**Payments**
Overall	132%	106%	123%
Estimated before coding and selection	108	82	100
Estimated coding effect	+14	+14	+14
Estimated selection effect	+9	+9	+9

Note: FFS (fee-for-service), MA (Medicare Advantage. Benchmarks are the maximum Medicare program payments for MA plans and incorporate plan quality bonuses. We estimate FFS spending by county using the 2024 MA rate book. Although MA enrollees must be enrolled in both Part A and Part B, the FFS spending denominator used in the MA rate book includes all Part A and Part B spending. We retrospectively compared MA spending with actual FFS spending for beneficiaries enrolled in both Part A and Part B and found that the results were similar (within 1 percentage point) compared with our prospective analyses that start with CMS's rate book calculation. To account for our most recent coding estimate of 14.2 percent, we estimated overall benchmarks, bids, and payments if coding differences between MA and FFS were fully reflected (i.e., if the risk-adjusted differences between MA and FFS did not include coding differences). The coding effect accounts for CMS's 5.9 percent coding adjustment. We project coding intensity based on the annual trend from 2017 through 2021, an increase of 1.5 percentage points per year. For 2024, we reduced the annual trend by 0.67 percentage points to account for one-third of an estimated 2 percentage point reduction in coding intensity associated with the introduction of the v28 risk adjustment model, which will be phased in over 3 years. Favorable selection accounts for the estimated lower risk-standardized spending that MA enrollees would have without any plan intervention. We assume that the 2024 effect of selection would be the same as our 2019 estimate of selection (before the coronavirus pandemic). Totals may not sum due to rounding.

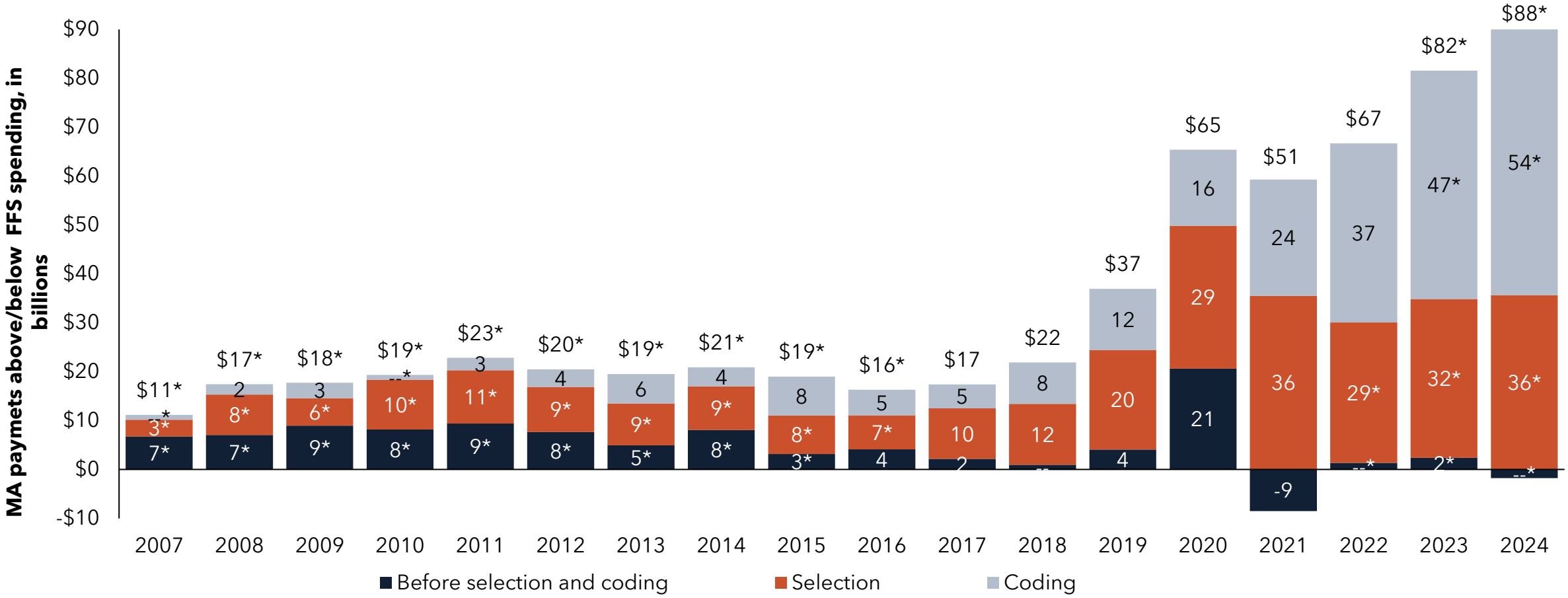
Source: MedPAC analysis of data from CMS on plan bids, enrollment, benchmarks, FFS expenditures, and risk scores.

Coding and selection have driven MA payments substantially above FFS spending



Note: MA (Medicare Advantage), FFS (fee-for-service). Totals may not sum due to rounding. Estimates from 2017 through 2021 use actual MA and FFS data.
* Specified values used projected data.
--Unidentified values indicate less than 0.5 percent.
Source: MedPAC analysis of Medicare enrollment, Medicare claims spending, and risk-adjustment files.

Coding and selection have driven substantial MA payments above what spending would have been in FFS



Note: MA (Medicare Advantage), FFS (fee-for-service). Totals may not sum due to rounding. Estimates from 2017 through 2021 use actual MA and FFS data.
* Specified values used projected data.
--Unidentified values indicate less than $2 billion.
Source: MedPAC analysis of Medicare enrollment, Medicare claims spending, and risk-adjustment files.

Next steps

- Commissioner questions
- March 2024 report to Congress:
  - MA status report
  - Estimating MA coding intensity and favorable selection

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