

Memo to MedPAC

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Thank you very much for the opportunity to provide comments. As someone who has been a CFO/Chief Actuary of MCO's from 1988-2015 and remained active in healthcare policy ever since, I listened with great interest to your discussion of Medicare Advantage at your meeting last Friday morning.

Once again I have heard laments about the higher risk scores by MA plans and unfavorable selection between Traditional Medicare [TM] and MA. The projection for 2026 is that payments to MA members will be 14% greater than if they were in TM. That's down from 21% in 2023, but MedPAC's data show that payments have historically always been greater. For reasons that I give below, I agree with those of you who said that these problems are not solvable given the current structure of the Medicare program. A radical revision is necessary.

I also agree with those of you who feel that MA has the potential to provide quality care at a lower cost. Indeed, on average, MCO's are bidding 17% below the benchmarks for providing TM benefits. That means the most cost-effective plans are providing TM benefits at an even lower cost. The spread between what the plans are capable of doing and what they are being paid can finance the solution I propose below.

In my experience, most provider organizations and most MCO's want to do the right thing: lower costs and increase quality. It is a matter of aligning incentives between both organizations, providing timely data, and having committed leaders of both organizations. Unfortunately, too much time and cost is spent on maximizing risk scores.

Also, In my experience, MCO's and their provider partners are capable of providing quality at least as good as TM in nearly every measure. I know that MedPAC considers the literature to be inconclusive, but I suggest to you a study by Bruce Landon et.al. in *Health Affairs* April 2023 that clearly shows the overall superiority of managed care.

Solution

I propose a solution that creates a combined Medicare program that solves the risk and selection issues as well as the issue you raise about the unfair taxes TM beneficiaries are pay for lesser benefits. In addition, my proposal saves administrative expenses for both plans and providers, which will help lower costs and finance the proposal Michael Chernow and Kenny Kan have heard me speak about this idea.

Most articles and discussions on this topic ask the wrong question. The question should not be "How can we change the rules so that the government pays no more for MA than TM?" Rather,

the question should be “How can society provide the robust benefits of MA to all Medicare beneficiaries for less than it currently costs the government and Medicare members?” I contend that this can be accomplished by combining the strengths of the TM and MA systems into one New Medicare Program.

Risk Scores

First, as noted by at least one of you, it is no longer credible to base risk scores solely on TM members as they are now a minority of the Medicare beneficiaries, and in some densely populated counties, they represent fewer than 20% of the members. Second, in contrast to how providers are paid under TM, the MCO’s have an incentive to make sure that all the diagnoses are coded, and, yes, they should be coded accurately with any mistakes being corrected. However, whatever the rules are, the MCO’s, whether they be for profit or not-for-profit, will and should maximize the rules to their benefit. Providers do the same thing under whatever fee schedule is negotiated with the MCO’s or dictated by CMS.

Selection

Whenever there is plan choice in healthcare, there will be selection. It is a well-documented issue in healthcare insurance. Medicare beneficiaries are voting with their known health conditions and their pocketbooks. A majority have now chosen MA. And why not? MA provides more robust benefits for both medical and prescription drugs with a zero- premium option for most beneficiaries. Members have maximum out-of-pocket protection, no need to purchase a Medicare supplement plan or a separate prescription drug plan, and they obtain needed non-Medicare benefits such as dental, vision or fitness.

Traditional Medicare-strengths and weaknesses

In contrast to MA, the TM benefit structure is archaic and would not be approved today by any insurance department, nor would any employer offer it. TM has only limited hospital coverage. It has separate deductibles for Parts A, B, and D and complicated benefit-period rules for inpatient care. Most glaringly, there is no out-of-pocket maximum. Thus, most TM members without employer coverage are forced to purchase an expensive Medicare Supplement plan and a Prescription Drug Plan to obtain adequate protection.

On the other hand, a strength of TM is that nearly all providers participate while members in MA face a more limited network. Another strength of TM is a universal fee schedule that makes it inexpensive to administer. However,, low administrative costs come at a price due to TM’s lack medical management. This is a weakness because it leaves the government only one option to control costs; namely, to modify the fee schedule.

New Medicare Program

I suggest a New Medicare Program that has the following features:

- 1) A robust MA-like benefit plan for all Medicare beneficiaries that combines medical and pharmacy benefits with out-of-pocket protection
- 2) A universal fee schedule with the government as the sole insurer
- 3) Contracts awarded to the best MCO's on a regional basis based on bids to administer and coordinate care and create incentive systems for beneficiaries and providers
- 4) Payments to MCO's on a fixed fee per beneficiary based on their bids, with possible bonuses based on cost and quality targets.

Discussion

The government does not want to be in the position of managing care. The best MCO's employ physicians, nurses, and pharmacists, and have the know-how. They can nudge members and providers in ways that the government cannot. Bidding would be conducted in several large geographical regions.

Most studies of TM vs. MA are, in my opinion, flawed because they are too general. It is not the case that every MA plan is better than TM everywhere, nor is TM quality and utilization the same everywhere. MA differs by type of plan, by carrier, and by a carrier's network in a specific region. For example, studies showing the superiority of MA usually conclude that HMO plans generate a greater share of the difference than PPO plans. At the same time, almost certainly, one carrier is not the best in every region of the country. In my proposal, a bidder's historical quality and utilization performance would be a criterion along with their requested fee per beneficiary.

For the fee, selected organizations will provide services directly to beneficiaries and providers to:

- coordinate care, especially for those with complex conditions
- encourage preventive care
- monitor drug utilization
- reduce unnecessary hospital stays and duplicate tests.

Since all Medicare beneficiaries in the region will be covered under one plan, there is no need to adjust for risk, and the selection issue also disappears. Since fees are fixed, the MCO's margins are limited.

The program can be funded by a combination of current payments and savings:

(1) the spread between what the plans are being paid compared to what they need to provide TM benefits; i.e., using the money the government is already spending but more efficiently

(2) savings to MCO's who no longer need to develop networks, negotiate fee schedules with every provider, nor maintain large departments to oversee coding and maximize risk scores

(3) savings to providers who no longer need negotiate fee schedules and follow different rules with every MCO

(4) savings to members who no longer need a PDP or a comprehensive Medicare Supplement