HPAM 7660 – Spring 2024 Case Study

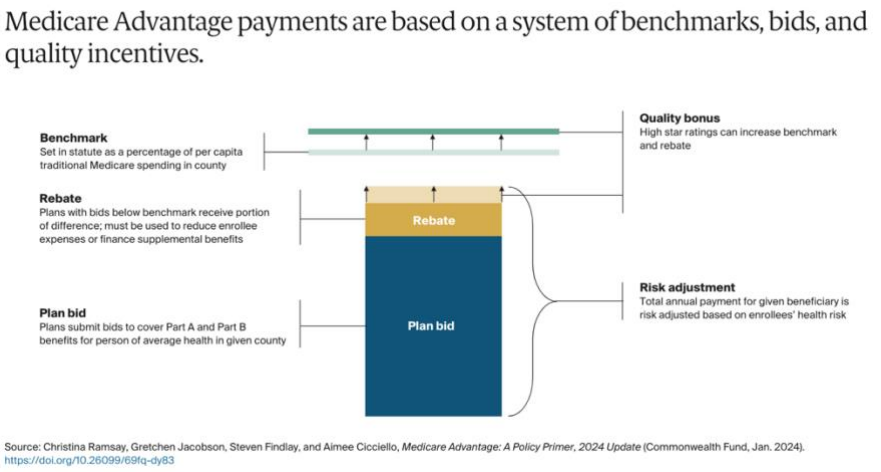
The Road Ahead for Medicare Advantage: Strategies for Sustainable Growth

Background

Medicare Advantage (MA) plans have emerged as a significant component of the Medicare program, offering beneficiaries a range of options and additional benefits compared to traditional fee-for-service Medicare. The popularity of MA plans has soared in recent years, with enrollment numbers rising steadily. However, the growing prominence of MA plans presents several challenges for the Medicare program, including higher costs relative to traditional Medicare, questions about plan quality, and the need for reforms to ensure long-term sustainability.

MA Plan Payment

The government pays Medicare Advantage plans a set rate per person, per year (around $12,000 in 2019, not including Part D–related expenses) under what's known as a risk-based contract. This payment arrangement, called capitation, is also intended to provide plans with flexibility to innovate and improve the delivery of care. But there are layers of complexity built into and on top of that set rate that allow for various adjustments and bonus payments. While those adjustments have proved useful in some ways, they can also be problematic. They are the main reason why Medicare Advantage costs the government more than traditional Medicare for covering the same beneficiary.



Benchmarks:

Plan benchmarks are the maximum amount the federal government will pay a Medicare Advantage plan. Benchmarks are set in statute as a percentage of traditional Medicare spending in a given county, ranging from 115 percent to 95 percent. For counties with relatively low spending, benchmarks are set higher than average spending for traditional Medicare (for example, 115%); for counties with relatively high spending, benchmarks are set lower than average traditional Medicare spending (for example, 95%). Special Needs

Plans and other Medicare Advantage plans are paid in the same manner, with the same benchmarks.

Bids:
Health insurance companies bid every year to enroll Medicare beneficiaries in their Medicare Advantage plans. That bid is based on companies' assessment of their costs to provide Part A and Part B services to the average beneficiary. According to MedPAC, 92 percent of bids in 2022 were below traditional Medicare spending and below the county benchmark.

Rebates:
If a plan's bid is below the local benchmark — as is the case for the majority of plans — then the plan keeps part of the difference between the bid and benchmark. This amount, called the rebate, is equivalent to a shared savings between the federal government and plans. Plans are required to use the rebate to lower patient cost sharing, lower premiums, or provide some coverage for benefits not included in traditional Medicare. Rebate dollars also can be used to pay for administrative expenses and profits associated with providing additional benefits. Rebates, along with the bid amount, are adjusted for enrollees' health status. This means that plans with sicker enrollees, who cost more to treat, receive higher rebates. In 2023, rebates used to provide additional benefits to enrollees reached a historic high of $196 per enrollee per month. If a plan's bid exceeds the benchmark, the plan can charge a premium for coverage of Part A and Part B benefits, in addition to premiums for supplemental benefits and Part D coverage. Plans that receive rebates can also charge premiums for supplemental benefits and Part D coverage.

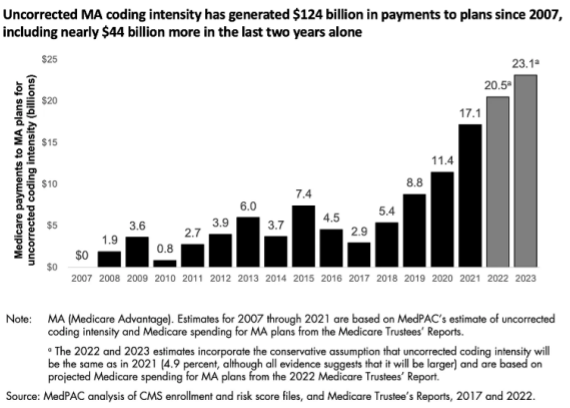
Quality adjustments:
Quality ratings affect benchmarks as well as rebate size. Benchmarks are raised by 5 percent for plans with four or more stars and, in certain counties, are increased by 10 percent for plans with high ratings. However, the ACA required that benchmarks (including quality bonuses) cannot be higher than they would have been prior to the ACA. This can constrain the quality bonus percentages and result in lower adjustments. For the rebate, plans with three stars or fewer receive 50 percent of the difference between the bid and the benchmark; plans with three-and-a-half or four stars receive 65 percent of the difference; and plans with four-and-a-half or five stars receive 70 percent of the difference.

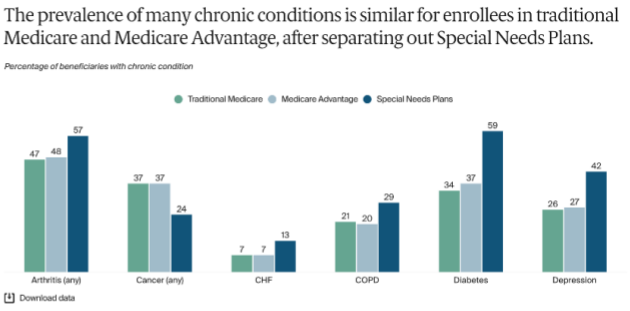
Risk adjustment:
Both the rebate and the bid amount are "risk adjusted" to account for enrollees' health status. Without risk adjustment, Medicare Advantage plans would have an incentive to select the healthiest, lowest-cost beneficiaries and avoid enrolling the sickest, highest-cost beneficiaries. Payment is affected by each beneficiary's risk score, which represents the expected cost of each enrollee relative to the cost of the average Medicare beneficiary. Thus, the average enrollee has a risk score of 1.0. An older person with multiple chronic conditions would have a risk score above 1.0, whereas a younger person with no health issues would have a risk score below 1.0. In general, it's a good thing that private insurers are given strong

incentives to collect data on Medicare Advantage enrollees' health status and medical diagnoses. Such information helps insurers identify people's health care needs and can spur innovation in delivering care more efficiently to sicker patients. There are no similar incentives in traditional Medicare, where about one-third of beneficiaries each year do not have a doctor's visit during which this information could be collected.

Upcoding

In addition to more complete coding, patients may be coded for conditions that have no bearing on their health expenditures. Critics have also asserted that many Medicare Advantage plans have been "upcoding"— that is, systematically assessing enrollees as having more health conditions and being sicker on average than is actually the case. This inappropriately raises total payments to plans. Medicare Advantage insurers counter that their coding is more accurate and complete. In response to the upcoding debate, Congress required CMS to adjust risk scores down 3.4 percent beginning in 2010 and 5.9 percent in 2018 and future years. The CMS administrator has the authority to increase the adjustment, but no administrator has chosen to do so. Some experts argue that a fundamental redesign of Medicare Advantage risk-adjustment methods is needed, with recent studies suggesting that enrollees are no sicker than those in traditional Medicare. According to one estimate, fixing Medicare Advantage overpayments could save $600 billion between 2023 and 2031.

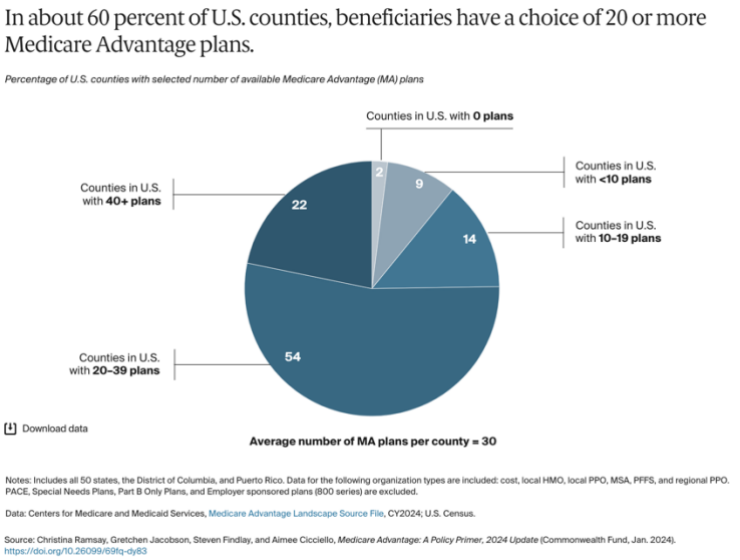




Plan Choice

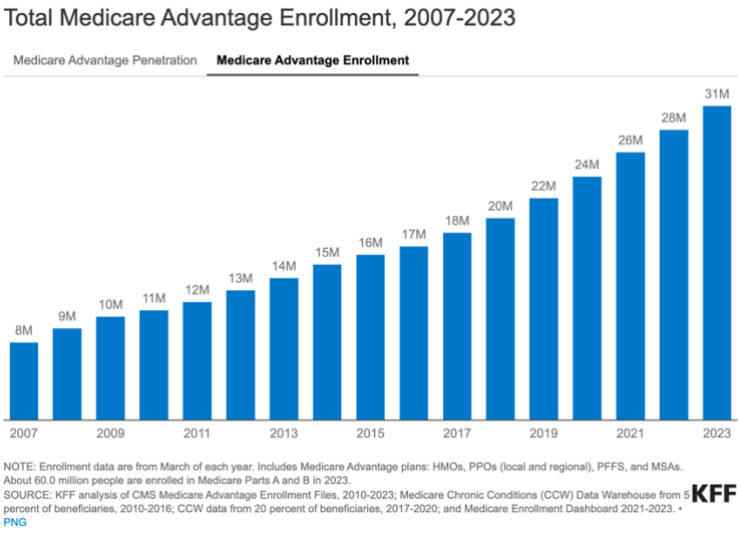
Medicare beneficiaries have a lot of Medicare Advantage plans to choose from each year. The average beneficiary had access to 43 plans in 2023, more than double the number in 2017. For Medicare beneficiaries, the choice between traditional Medicare and a Medicare Advantage plan, or between individual Medicare Advantage plans, can be frustrating, complex, and confusing. Many beneficiaries seek advice from their doctor, a broker, a State Health Insurance Assistance Program (SHIP), or other experts. To complicate matters, brokers are not required to offer plans that best meet the needs of beneficiaries; they may steer clients to plans with the highest commissions or to plans for which they have existing contracts. On Medicare.gov, beneficiaries can compare prices and benefits among plans using the Medicare Plan Finder tool. But according to a study by Georgetown University's Center on Health Insurance Reforms, some beneficiaries find the tool overwhelming,

difficult to use, or unhelpful. In a 2020 survey, 1 out of 3 Medicare beneficiaries described their experience using the tool as "somewhat" or "very" difficult. The tool has since been updated and improved. Since 2021, Medicare beneficiaries with certain health conditions have been able to enroll in Chronic Condition Special Needs Plans with support from a broker without needing to meet other enrollment criteria. In 2021, there were 4.4 million beneficiaries in Special Needs Plans, a decrease of 190,000 from 2020. Total enrollment in Medicare Advantage reached 29.4 million in 2022, or 54 percent of the 54.4 million Medicare beneficiaries. More than one-third (37%) of all Medicare beneficiaries were enrolled in a Medicare Advantage plan with a Medicare-Medicaid dual-eligible Special Needs Plan (34%), a chronic-condition Special Needs Plan (2%), or a institutional Special Needs Plan (1%).

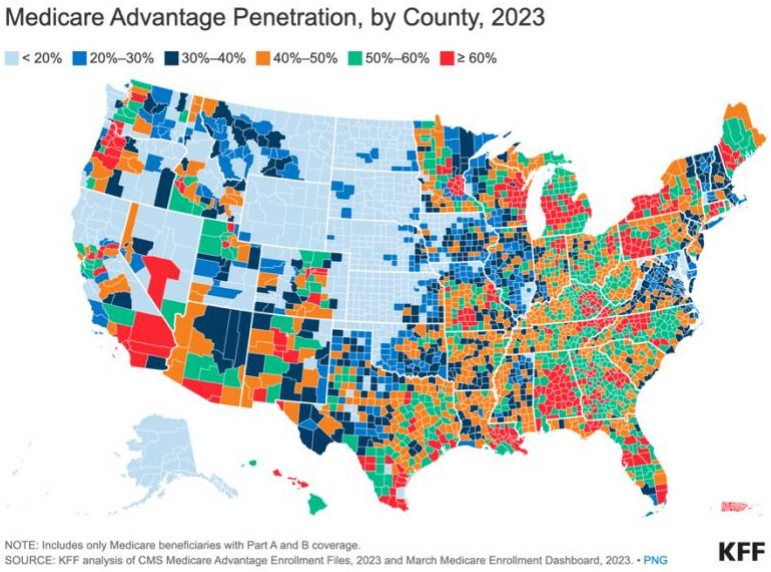


Trends in Medicare Advantage Enrollment

Enrollment in Medicare Advantage plans has steadily increased over the past decade, driven by factors such as demographic trends, changes in plan offerings, and policy initiatives to expand access to MA plans. As of 2022, nearly 30 million Medicare beneficiaries, or about 48 percent of the Medicare population, were enrolled in Medicare Advantage plans. Enrollment has grown significantly in recent years, with an average annual growth rate of 7 percent since 2010. Experts attribute this growth to several factors, including the aging population, increased availability of MA plan options, and marketing efforts by insurers. In addition, policy changes implemented under the Affordable Care Act (ACA) and subsequent legislation have expanded access to MA plans and enhanced plan benefits.



Geographic Variation in Enrollment



The proportion of Medicare beneficiaries enrolled in Medicare Advantage varies across the country, with higher enrollment in some states than others. For example, 62 percent of beneficiaries in Florida were enrolled in Medicare Advantage in 2022, while 41 percent of beneficiaries in California were. In contrast, 18 percent of beneficiaries in Alaska were enrolled in Medicare Advantage. Some beneficiaries are required to switch between traditional Medicare and a Medicare Advantage plan, and others lose access to their plan if it withdraws from the market or loses its contract with Medicare. Each year, an average of 10 percent of Medicare Advantage plans withdraw from the market, and an average of 19 percent lose their contracts with Medicare, leaving beneficiaries with an average of 35 plans to choose from. Though plan withdrawals can be frustrating for beneficiaries, they also signal market competition. Indeed, studies show that counties with fewer plans or less competition tend to have higher premiums. Experts at the Kaiser Family Foundation have suggested that the federal government can better regulate the market by more closely scrutinizing plan consolidations, setting higher quality standards for plans, and updating payments to plans.

Benefits

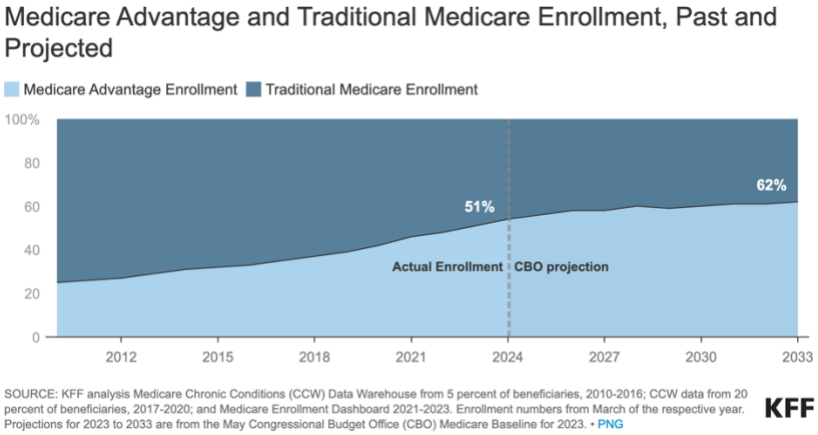
Medicare Advantage beneficiaries, like other Medicare beneficiaries, are eligible for benefits under the Medicare program, including hospital and physician services. Medicare Advantage plans are required to cover everything that traditional Medicare covers, except for hospice care, which is covered by traditional Medicare. Most Medicare Advantage plans also offer additional benefits not covered by traditional Medicare, such as dental, vision, hearing, and fitness benefits, as well as transportation to medical appointments. Most Medicare Advantage plans also offer Part D prescription drug coverage. In 2022, 71 percent of plans offered drug coverage with no premium, 11 percent with a premium of less than $25, and 16 percent with a premium of $25 or more. Medicare Advantage plans must also have a maximum out-of-pocket limit to protect beneficiaries from catastrophic health care expenses. In 2022, the limit was $7,550, up from $7,400 in 2021. Some plans offer lower out-of-pocket limits, sometimes as low as $0. Despite these protections, beneficiaries may still face high out-of-pocket costs, particularly if they require frequent medical care or expensive drugs.

Networks

Medicare Advantage plans are also required to have a provider network of doctors, hospitals, and other health care providers that agree to provide services to plan enrollees. Some plans use managed care networks, which require enrollees to choose a primary care doctor and obtain referrals to see specialists. Other plans use preferred provider networks, which allow enrollees to see any provider in the network without a referral. Some plans offer out-of-network coverage, but beneficiaries typically pay more for out-of-network services. Most Medicare Advantage plans have closed networks, meaning they do not cover services provided by providers outside the plan's network. According to the Kaiser Family Foundation, the average Medicare Advantage plan network includes 59 percent of physicians and 74 percent of hospitals in a given area. Critics argue that narrow networks can limit beneficiaries' access to care, particularly if they live in rural areas or require specialized services. However, supporters of Medicare Advantage argue that narrow networks can help plans negotiate lower prices with providers, which can result in lower premiums and cost sharing for beneficiaries. According to a 2019 analysis by Avalere Health, 92 percent of Medicare Advantage beneficiaries were enrolled in plans with hospital networks rated as average or better.

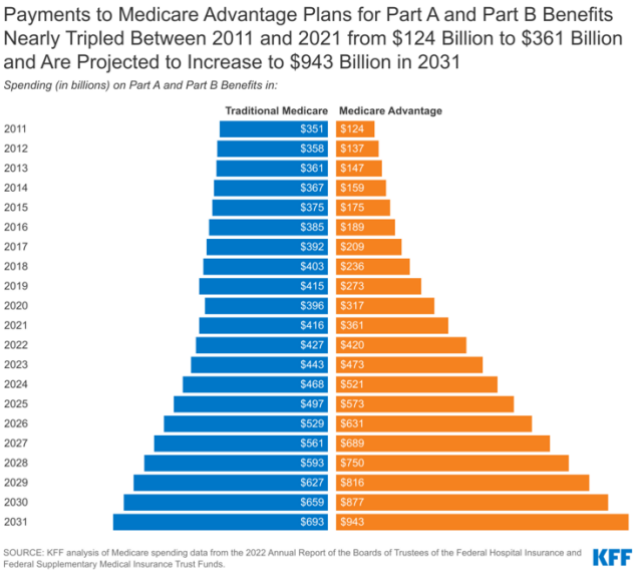
The Future of Medicare Advantage

The ACA implemented several reforms aimed at strengthening the Medicare Advantage program, including payment reforms, quality improvement initiatives, and expanded supplemental benefits. These reforms have incentivized insurers to offer high-quality, value-based care and provide additional benefits to enrollees. As a result, Medicare Advantage plans have become increasingly attractive to Medicare beneficiaries seeking comprehensive coverage and enhanced benefits, and projections indicate that Medicare Advantage enrollment will continue to grow.



Despite the growth and popularity of Medicare Advantage, the program faces several challenges and uncertainties that could impact its future trajectory. These challenges include concerns about the long-term sustainability of Medicare Advantage, rising costs and premiums, and potential changes to federal policies and regulations affecting the program. In addition, ongoing debates about the role of private insurers in Medicare and the appropriate balance between traditional Medicare and Medicare Advantage could shape the future landscape of the program. Policymakers, stakeholders, and researchers continue to monitor and evaluate trends in Medicare Advantage enrollment, plan offerings, and

beneficiary experiences to inform policy decisions and ensure the program's effectiveness and affordability for current and future beneficiaries.



Your Task

In the case scenario, your team will serve as committee staff advising the Republican chairman of the Ways & Means committee, who is an advocate for managed care but also seeks to address concerns regarding rising Medicare spending. The chairman is committed to exploring policies that promote the efficiency and effectiveness of Medicare Advantage while ensuring fiscal responsibility and equitable access to healthcare services for beneficiaries. The chairman has also expressed a desire that reform proposals at least have the potential to garner bipartisan support.

Areas of Focus

Your analysis should provide strategic guidance on the future of Medicare Advantage, considering the program's growth trajectory, payment mechanisms, quality of care, equitable access, and long-term sustainability. Given the chairman's interest in managed care and cost containment, your recommendations should focus on reforms and innovations that enhance the value proposition of MA plans while addressing the following issues:

1. **Rising Costs**: The increasing costs associated with Medicare Advantage relative to traditional Medicare pose a significant fiscal challenge for the Medicare program. Higher payments to MA plans raise concerns about the sustainability of federal spending and the solvency of the Hospital Insurance (Part A) trust fund. Policymakers must explore strategies to contain costs while preserving the value and effectiveness of MA plans for beneficiaries.
2. **Payment Reform**: The current payment system for Medicare Advantage plans relies on a complex set of mechanisms, including risk-based contracts, benchmarks, rebates, quality adjustments, and risk adjustment. While these mechanisms aim to promote efficiency and quality of care, they also raise questions about fairness, transparency, and accountability. Policymakers should consider reforms to payment methodologies that align incentives with desired outcomes and promote value-based care delivery.
3. **Quality of Care**: Ensuring high-quality care delivery is essential to the success and sustainability of Medicare Advantage. While MA plans often tout their ability to offer additional benefits and enhanced services compared to traditional Medicare, questions remain about the overall quality and outcomes of care provided by MA

plans. Policymakers must prioritize initiatives to measure, monitor, and improve the quality of care in MA plans, including robust quality reporting requirements, performance incentives, and oversight mechanisms.

4. **Equitable Access**: As Medicare Advantage enrollment grows, concerns arise about equitable access to healthcare services for all beneficiaries, particularly those with complex medical needs, low-income individuals, and residents of rural areas. Policymakers should explore strategies to promote access and equity in MA plans, such as network adequacy standards, targeted outreach and education efforts, and incentives for plans to serve underserved populations.
5. **Sustainability and Innovation**: The long-term sustainability of Medicare Advantage hinges on its ability to adapt to evolving healthcare trends, technological advancements, and demographic changes. Policymakers should encourage innovation and experimentation within the MA program, including initiatives to promote care coordination, chronic disease management, telehealth services, and preventive care. By fostering a culture of innovation and continuous improvement, policymakers can help ensure that Medicare Advantage remains a viable and valuable option for beneficiaries.

Case Presentation Logistics:

- The date for the case presentations is Tuesday, April 30th.
- A Zoom link will be sent out prior to this date. Please be sure to log in to Zoom a few minutes before your scheduled start time.
- You will have 20 minutes to deliver your proposal.
- There will be a 10 minute question and answer period with the judges.
- It is not necessary that everyone on your team speak during the presentation or Q&A. All team members will receive the same grade for the case competition regardless of their role on the project. However, you will have the opportunity to evaluate the contributions of each of your team members individually.
- All team members should have their cameras turned on for the presentation and Q&A.

Sources:

- Commonwealth Fund – Medicare Advantage: A Policy Primer
- Kaiser Family Foundation – Medicare Advantage 2024 Spotlight: First Look
- Kaiser Family Foundation – Medicare Advantage in 2023: Enrollment Update and Key Trends
- MedPAC – The Medicare Advantage Program: Status Report
- MedPAC Medicare Advantage Reports