Comments for the Record

Comment to CMS on Request for Information for Medicare Advantage

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Dear Administrator Brooks-LaSure,

I thank you for the opportunity to comment on the August 1, 2022, Request for Information (CMS-4203-NC) seeking information on various aspects of the Medicare Advantage (MA) program.

Concerns have been raised that changes to the MA program's payment model would result in fewer plan options for MA beneficiaries at greater amounts of cost-sharing. Below, I address the benefits of the current MA program as well as how those benefits apply to the topics covered by the Centers for Medicare and Medicaid Services (CMS) in this Request for Information.

Background

Medicare Advantage provides anyone eligible for Medicare the option of enrolling in a private health insurance plan, as opposed to receiving benefits through the traditional fee-for-service (FFS) option. While Medicare beneficiaries have had some alternative options for receiving benefits since shortly after Medicare's creation in 1965, the availability, design, and cost of such plans has changed dramatically over time. Medicare Part C was formally created through the Balanced Budget Act of 1997 and was known at the time as Medicare+Choice (M+C). This legislation provided CMS the authority to contract with organizations to provide beneficiaries a variety of health plan options that would cover, at a minimum, all the services covered by Medicare Parts A and B. The Medicare Modernization Act of 2003 (MMA) renamed the program Medicare Advantage (MA), added new plan options (including regional plans), and changed the way plans are paid. Payments are currently based on benchmark rates, plan bids, quality ratings, and enrollee risk scores, but the formulas are slightly different for local plans and regional plans.[1]

The MA program is one of the federal government's most successful health insurance programs to date and has become increasingly popular since its inception as Medicare Part C in the Balanced Budget Act of 1997. As of August 2022, CMS estimates that 29.3 million beneficiaries are enrolled in MA, or 45.4 percent of the total Medicare beneficiary population.[2] This popularity is the result of MA's ability to offer a wide range of benefit designs to suit individual needs at reasonable costs to beneficiaries that are often lower than Medicare FFS. MA can offer these advantages because of the stability and predictability of the program, which allows for plan sponsors to implement new benefits and plans and adjust over time as necessary.

Response to CMS Areas of Interest

MA's popularity has been buttressed by its accessibility as well as its affordability for beneficiaries. On the accessibility front, major strides were made when regional plans were created in 2006 with the intention of expanding access to MA plans for Medicare beneficiaries living in areas local plans were not sufficiently

serving, particularly those in rural areas. In 2005, only 84 percent of Medicare beneficiaries had access to an MA plan; by 2006, the first year regional plans were offered, 100 percent of beneficiaries had access to an MA plan, and that percentage remained at 100 until 2015 when it dropped to 99 percent, where it has remained through 2020.[3],[4]

On the affordability side, MA has advantages for both beneficiaries and the federal government. In 2021, MA's per-member, per-month (PMPM) cost to the federal government was $943, versus $949 for traditional Medicare FFS for Parts A and B. Broken down, Medicare FFS spends $936 PMPM on standard Parts A and B benefits and $14 on administrative costs. MA, on the other hand, spends $710 PMPM on the standard Parts A and B benefits, $110 on margins and administrative costs, and the remaining $123 for extra benefits and lower cost sharing for beneficiaries.[5] MA beneficiaries spent on average $113 PMPM on health care as part of their MA plan, while FFS beneficiaries spent $253 as part of FFS, resulting in an average yearly savings of $1,680. In 2020, 46 percent of MA beneficiaries paid $0 in premiums, compared to the standard FFS monthly premium of $144.60 in Part B alone in 2020.[6] Combination MA and Part D (MA-PD) plans had an average monthly premium of $23.70.[7] Analysis of 2019 Medicare data found that MA beneficiaries spent $1,965 less than FFS beneficiaries annually.[8] In total, MA plans are roughly 12 percent cheaper on average than FFS when factoring in both government and beneficiary spending, while offering significantly more options than FFS that include vision, dental, and hearing coverage.

While a 2021 Medicare Payment Advisory Commission (MedPAC) report put the cost of MA at 104 percent of FFS spending, this was largely due to MedPAC factoring in "uncorrected coding intensity" as an additional 3 percent of MA spending, based on a decades-old comparison of risk scores unadjusted for health status. Appropriately compared with claim administrative costs included, MA plans are 99–100 percent of FFS costs.[9]

It is likely these cost savings for beneficiaries are responsible for the greater health equity outcomes seen in MA. Dual-eligible beneficiaries, who are eligible for both Medicare and Medicaid services due to low incomes, reported greater access to a usual source of care in MA plans than FFS plans. For dual eligibles in MA Special Needs Plans (SNPs), 91 percent reported having a usual source of care, while 93 percent of dual eligibles in MA but not in SNPs reported having a usual source of care.[10] These numbers compare favorably to the 86 percent of FFS dual eligibles who report having a usual source of care. Dual-eligible beneficiaries in MA also attend 12 percent more office visits than FFS dual eligibles but had 33 percent fewer hospitalizations and 42 percent fewer emergency room visits compared with FFS dual eligibles. Additionally, Black and Hispanic MA beneficiaries spent significantly less than their FFS counterparts. In 2019, Black MA beneficiaries spent $1,104 less than Black FFS beneficiaries, while Hispanic MA beneficiaries spent $1,421 less than Hispanic FFS beneficiaries.[11]

Patient outcomes are also better in MA despite having a higher proportion of beneficiaries with clinical and social risk factors. In 2018, MA beneficiaries with chronic conditions had 23 percent fewer inpatient stays and 33 percent fewer emergency room visits compared to FFS beneficiaries with chronic conditions.[12] MA beneficiaries with chronic conditions also had a 29 percent lower rate of potentially avoidable hospitalizations, 41 percent fewer avoidable hospitalizations, and 18 percent fewer avoidable hospitalizations.[13] MA beneficiaries with diabetes had a 52 percent lower rate of any complication and a 73 percent lower rate of serious complications than FFS beneficiaries. As expected, this has led to lower overall per-beneficiary costs in MA: In the clinically complex diabetes cohort, spending was 6 percent lower for all beneficiaries and 21 percent lower for dual eligible beneficiaries compared to FFS.[14]

When it comes to patient-centered care, MA is tailor-made for patients. In 2020, 98 percent of MA-PD plans covered vision care, 93 percent provided hearing benefits, and 87 percent covered dental services. Additionally,

95 percent of MA-PD plans offered fitness benefits such as gym memberships, and 68 percent offered coverage for over-the-counter items such as sunscreen and first aid supplies. MA also fosters competition and provides beneficiaries with choices of coverage and benefits. The average MA enrollee chooses among 33 plans offered by eight different issuers in their geographic area, and there is even some evidence that MA enrollment leads to better health outcomes: MA enrollees have 33 percent fewer emergency department visits and 23 percent fewer hospital visits than those in FFS Medicare.[15]

Additionally, MA's Star Rating System gives beneficiaries a method to inform themselves on plan options and creates competition through comparison. On average, higher ratings are correlated with a longer length of time operating an MA contract, possibly suggesting that over time plan sponsors learn how to best achieve the results desired by CMS. Generally, average scores have been increasing along with the number of plans with higher ratings.[16] While the Star Rating System needs to be improved, it provides a tool for beneficiaries to choose the plan most suitable for them and incentives for plan sponsors to continually innovate their offerings.

Conclusion

The above statistics indicate that, compared to FFS, MA plans produce better health outcomes, reduce health inequities, and significantly reduce costs for MA beneficiaries for roughly the same cost to the federal government as FFS. This is made possible by the stability of the MA payment structure, which allows for greater planning, experimentation, and refinement by plan sponsors. Calls by some to make MA more like FFS disregard the strong advantages that the current MA structure has produced. Any potential changes made to the existing payment structure should keep in mind these advantages, as well as the cost of losing them.

[1] https://www.americanactionforum.org/research/primer-medicare-advantage-employer-group-waiver-plans-2/

[2] https://www.cms.gov/research-statistics-data-and-systemsstatistics-trends-and-reportsmcradvpartdenroldatamonthly/contract-summary-2022-08

[3] https://www.americanactionforum.org/research/primer-medicare-advantage-employer-group-waiver-plans-2/

[4] https://www.bettermedicarealliance.org/wp-content/uploads/2020/07/State-of-MA-Report-Final.pdf

[5] https://www.milliman.com/-/media/milliman/pdfs/2021-articles/10-20-21-value-federal-government-of-medicare-advantage.ashx

[6] https://www.bettermedicarealliance.org/wp-content/uploads/2020/07/State-of-MA-Report-Final.pdf

[7] https://www.milliman.com/-/media/milliman/pdfs/2021-articles/10-20-21-value-federal-government-of-medicare-advantage.ashx

[8] https://bettermedicarealliance.org/wp-content/uploads/2022/04/BMA-Medicare-Advantage-Cost-Protections-Data-Brief_FINv2.pdf

[9] https://www.milliman.com/-/media/milliman/pdfs/2021-articles/10-20-21-value-federal-government-of-medicare-advantage.ashx

[10] https://bettermedicarealliance.org/publication/dual-eligible-beneficiaries-receive-better-access-to-care-and-cost-protections-when-enrolled-in-medicare-advantage/

[11] https://bettermedicarealliance.org/wp-content/uploads/2022/04/BMA-Medicare-Advantage-Cost-Protections-Data-Brief_FINv2.pdf

[12] https://www.bettermedicarealliance.org/wp-content/uploads/2020/02/BMA_Avalere_MA_vs_FFS_Medicare_Report_0.pdf

[13] https://www.bettermedicarealliance.org/wp-content/uploads/2020/02/BMA_Avalere_MA_vs_FFS_Medicare_Report_0.pdf

[14] https://www.bettermedicarealliance.org/wp-content/uploads/2020/02/BMA_Avalere_MA_vs_FFS_Medicare_Report_0.pdf

[15] https://www.americanactionforum.org/weekly-checkup/medicare-already-offers-coverage-for-dental-vision-and-hearing-its-called-medicare-advantage/

[16] https://www.americanactionforum.org/research/primer-the-medicare-advantage-star-rating-system/