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INSIGHTS

MedPAC Discusses Growth and Costs of Medicare Advantage Plans

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On November 3, 2023, the Medicare Payment Advisory Commission (MedPAC) held the final day of its November meetings. Two sessions were held regarding issues related to Medicare Advantage (MA) plans: coding and favorable selection and network management and prior authorization (PA). MedPAC staff presented findings related to these topics and the Commissioners had a robust discussion about these issues.

CODING AND FAVORABLE SELECTION

In this session, MedPAC staff shared they had found differences in coding in Medicare fee-for-service (FFS) Plans versus MA Plans. Staff shared that these differences contribute to higher risk scores for MA Plans. Because of this, the Centers for Medicare and Medicaid Services (CMS) lowers MA risk scores to account for the differences. In September, MedPAC estimated that these coding differences led to more than 8 percent higher payments to MA Plans compared to FFS Plans in 2021. In June of 2023, MedPAC estimated that favorable selection led to 11 percent higher payments for MA plans compared to FFS Plans in 2019. MedPAC staff also shared that a large collection of research points to MA plans experiencing favorable selection, both indirectly and directly. Staff also shared updates they made to the analysis from the 2023 MedPAC June Report to Congress. Two of these updates increased the selection effect by less than one percent and one of them decreased the selection effect by two to three percent. The estimated cumulative selection effect in this analysis went from 5.9 percent in 2017 to 12.8 percent in 2021. Based on this analysis, MedPAC staff estimates the combined effects of selection and coding to have caused $50.8 billion in increased payments to MA Plans in 2021. MedPAC plans to continue looking at the effects of selection into MA and will include estimates in the annual March MA status report.

Overall, the Commissioners were very supportive of the ongoing discussions involving how benchmarks are determined, and there was widespread support and interest in how the data should inform MA policy. Commissioners asked questions about certain choices made by MedPAC staff in producing the analysis. These included questions about what factors MedPAC used, how MedPAC determined which spending to include, and how the analysis was segmented (disease type, geography, plan type). Another topic of discussion was how MA Plans use rebates that they receive. Additionally, concerns were raised about states where beneficiaries do not have guaranteed issue rights. A couple of Commissioners discussed the need to make sure MedPAC arguments were bullet proof against industry arguments that they suspect will be made in response to policy proposals.

NETWORK MANAGEMENT AND PRIOR AUTHORIZATION

In this session, MedPAC staff noted that MA Plans use network management and PA to manage beneficiary access to providers and services to affect quality and cost. These can raise value, but stakeholders have concerns about the burden these tools put on providers and potential barriers for beneficiaries to access care. When it comes to networks in MA, MedPAC staff has found that choice of provider is important for beneficiaries and that many beneficiaries are willing to trade choice for reduced cost sharing, out-of-pocket spending caps, and additional benefits. When it comes to PA in MA plans, MedPAC has found most MA PA determinations and reconsiderations were eventually approved. Stakeholders have also raised concerns about inappropriate denial of care. Staff also noted recent CMS guidance on PA in MA and that CMS has proposed additional requirements that have not been finalized.

During the discussion portion of the session, there was an acknowledgment among a few Commissioners that PA can be a useful tool to control costs and prevent patients from getting unnecessary care. However, there were also concerns raised about the burden of PA requirements on providers and the potential barriers to access of care for patients. Although some Commissioners acknowledged the difficulty of making sure networks are accurate, there was widespread frustration with reports among directories being inaccurate. One commissioner brought up tying the STAR ratings to factors such as network adequacy and access denials in order to incentivize plans to improve in those areas.

We trust you found this summary useful. Please reach out to us with any questions.