CHAMBER HILL

INSIGHTS

MedPAC April Meeting Day 1 Summary

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On April 10, 2025, the Medicare Payment Advisory Commission (MedPAC) met to discuss work for their June 2025 report and beyond. The June report contains recommendations and research on the future of Medicare and is usually filled with new ideas and/or innovations. Today's sessions focused on proposed reforms to the physician fee schedule (PFS), a comparison of stand-alone Medicare prescription drug plans (PDPs) and Medicare Advantage-Prescription Drug (MA-PD) Plans, discussions about MA supplemental benefits, and a look at the impact of MA plans on rural areas.

PHYSICIAN PAYMENT FORMULA

The first session of the day focused on reforming updates to and ensuring the accuracy of the Medicare PFS. Staff reviewed data presented in March regarding the inadequacy of physician payment updates and the accuracy of the fee schedule Relative Value Units (RVUs). They then voted on two recommendations for the June report.

The first recommendation is: "The Congress should replace the current-law updates to the PFS with an annual update based on a portion of the growth in the Medicare Economic Index (MEI) (Such as MEI minus 1 percentage point." Commissioners voted unanimously in favor (17-0). Discussion centered around the fact that Commissioners would have liked to have set an actual number (i.e., MEI minus 1) and a minimum or maximum limit on the amount of the payment update. The Chairman pointed out, however, that they wanted to keep things general to give Congress flexibility to implement this recommendation.

For the second recommendation, the staff again presented three examples of potential areas of inaccuracy in RVUs, focusing on concerns that the MEI used to update RVUs is outdated; the need to update global surgical codes to truly address care practices; and inaccuracy in practice expense (PE) RVUs. In the PE RVUs, staff showed that a significant number of physicians no longer have offices outside of the hospital, so indirect PE payments might need to be suspended for these types of physicians.

The second recommendation, which passed unanimously, is: "The Congress should direct the Secretary to improve the accuracy of Medicare's relative payment rates for clinical services by collecting and using timely data that reflect the costs of delivering care. Again, this was a very general recommendation. The Commissioners' discussion centered around the fact that they think RVUs are misvalued (some said due to the American Medical Association's RVS Update Committee RUC process, others said that it is a function of data over time).

This will be a chapter in MedPAC's June Report to Congress.

STRUCTURAL DIFFERENCES BETWEEN THE PDP AND MA–PD MARKETS

The second session focused on the differences between stand-alone PDPs for fee-for-service (FFS) beneficiaries and the MA–PDs for beneficiaries who choose to enroll in MA. Staff presented additional data explaining the two different systems, how rates were set, payment mechanisms, etc. They also focused on structural issues between the two plan types and discussed changes coming in 2025 from the Centers for Medicare and Medicaid Services (CMS).

Staff showed more data showing that plan offerings and enrollment are continuing to shift away from standalone PDPs. This time, they dug into not just overall numbers, but also into data on low-income subsidy (LIS) beneficiaries.

Staff found four trends. First, the average premiums charged by PDPs exceed those of MA-PDs. Second, fewer PDPs qualify as premium-free to beneficiaries with LIS. Third, PDPs have higher average gross costs but lower risk scores than MA-PDs. Fourth, PDPs are more likely to incur losses compared with MA-PDs.

Staff also looked at the structural reasons for differences between the plans, including MA rebates, the fact that MA-PDPs can adjust premiums after CMS published average amounts, the fact that MA PDs can segment the market by LIS status, and the fact that MA PDs can document additional diagnoses, which enables them to have higher risk scores.

The Commissioners again expressed concerns that stand-alone PDPs might disappear altogether due to unfair competition with MA-PDs, which Commissioners said was unfair to beneficiaries in Medicare FFS because these are the plans those beneficiaries use. Commissioners are concerned that without stand-alone PDPs, traditional FFS will be erased or will be used only for high-income beneficiaries who can afford higher out-of-pocket costs.

Commissioners pointed out that having MA PDPs is not a negative thing, as they can lead to more coordination on beneficiary care and maybe more innovation. A few Commissioners stressed that they would not want to have any recommendations in this area until they see the effects of new risk stabilization payments being rolled out by CMS this year.

As for the next steps, Commissioners also want to investigate the impacts on pharmacy viability from these two types of plans and research into biosimilars.

While there were no recommendations on this topic, this will be a chapter in the June Report to Congress.

ASSESSING THE UTILIZATION AND DELIVERY OF MEDICARE ADVANTAGE SUPPLEMENTAL BENEFITS

In the third session, staff reviewed work on MA supplemental benefits, which are extra benefits delivered by MA plans to beneficiaries as part of their enrollment, like dentistry or vision care. Staff went through a background on the benefits, discussed how MA plans administer these benefits, and what data they do and do not have on these benefits.

Staff reviewed what shares of MA plan rebates are being used on non-Medicare services. For conventional MA plans, dental benefits account for the largest share of non-Medicare supplemental benefits. Special needs plans (SNPs) are using a large amount of their rebates for "other" services like home modifications or home-delivered meals. Commissioners pointed out that this was not surprising, given that Duals are covered under Medicare and Medicaid, so Medicaid is wrapping around traditional benefits; hence, they have a larger amount of capital to use on non-transitional benefits.

Staff outlined the data, or lack thereof, showing that very few claims are available to measure usage or efficacy of these supplemental benefits.

Commissioners had a lot of questions about benefit utilization, how to measure efficacy/outcomes, and beneficiary knowledge about these benefits. Commissioners also discuss standardizing some supplemental benefits and how to create a parallel supplemental benefit in FFS Medicare. Commissioners even threw out the idea of creating an HSA for beneficiaries and letting them choose what supplemental benefits they want to use. The Chairman said they need a lot more data in this area and need to look at the cost of acquiring the data.

This will be a chapter in the June Report to Congress.

EXPLORING THE EFFECT OF MEDICARE ADVANTAGE ON RURAL HOSPITALS

Staff presented a new analysis examining the effect of Medicare Advantage penetration on rural hospitals in their markets. The Commission has been hearing from rural providers for years that MA plans are negatively affecting their profitability through prior authorization, steering patients away from their facilities, and lowering payment rates.

First, staff examined MA growth in rural areas. In addition to growing enrollment volumes, staff found that three insurers control 60% of the rural enrollee market.

After examining financial and volume effects through various calculations, the staff found:

- There is some evidence that MA expansion results in fewer inpatient admissions at CAHs.
- No statistically significant effect of MA expansion on revenue, costs, or profits
- Price for FFS and potentially MA patients increases when volume declines and, in the face of prospective payment system (PPS) hospitals, when volume shifts from FFS to MA.

Commissioners had 45 minutes worth of questions on the analysis and a robust debate about the true impact of MA on rural providers. Some Commissioners said the market was working as it should, and this was a political ploy since some people don't like MA. Others said this was a true problem and that MA plans use their large market leverage to handicap hospitals through prior authorization and denials.

At the end, the Chairman pointed out that the session combined rural care and MA, and that they started here because MedPAC wanted to answer claims being made. He said that there would be no recommendations, and they would continue to dig into these issues throughout the next cycle.

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