



September 21, 2022

Lynn Nonnemaker
Vice President
America's Health Insurance Plans
Innonemaker@ahip.org

via email

Re: Value of Medicare Advantage Compared with Fee for Service

Dear Lynn:

America's Health Insurance Plans (AHIP) has retained Wakely Consulting Group, an HMA company (Wakely) to provide a targeted analysis on Medicare fee-for-service (FFS) data to assist with providing a response to Chapter 12 of the March 2022 Medicare Payment Advisory Commission (MedPAC) report to Congress. This document contains the results, assumptions, and methods used in our analysis, and satisfies the ASOP 41 reporting requirements. Reliance on this report is at AHIP's discretion. This information has been prepared for the sole use of the management of AHIP and cannot be distributed to or relied on by any third party without the prior written permission of Wakely. This information is confidential and proprietary.

Sincerely,

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Executive Summary

The overall theme in Chapter 12 of the MedPAC March 2022 Report to the Congress: Medicare Payment Policy¹ is that the Medicare Advantage (MA) program is not producing savings for the Centers for Medicare & Medicaid Services (CMS). The report specifically states the following:

- “...nearly all plan bids are below the cost of FFS Medicare. However, these efficiencies are shared exclusively by the companies sponsoring MA plans and MA enrollees, in the form of extra benefits. The taxpayers and FFS Medicare beneficiaries who help fund the MA program do not realize any savings from MA plan efficiencies.”
- “...private plans in the aggregate have never produced savings for Medicare, due to policies governing payment rates to MA plans that the Commission has found to be deeply flawed.”

To assist AHIP in assessing the validity of these MedPAC conclusions, Wakely reviewed the following specific aspects of the FFS and MA programs:

- The impact on these conclusions if the mandatory maximum out-of-pocket (MOOP) provision required under MA applied under traditional Medicare.
- The impact on cost comparisons of establishing MA benchmarks based only on beneficiaries eligible for both Part A and Part B of Medicare (i.e., same eligibility criterion for MA enrollment)

In summary, our findings for these analyses are as follows:

1. If the traditional FFS program were required to implement a maximum out-of-pocket (MOOP) provision equivalent to the mandatory amount required under Medicare Advantage, the net liability to CMS would increase by 3.5% nationally. The impact of a MOOP provision generally increases as the expenses of a given classification of beneficiaries change, although not in all cases. In particular, we estimate that FFS costs for beneficiaries with ESRD status would increase by 9.1% with a \$6,700 MOOP in place.
2. Costs associated with non-ESRD FFS beneficiaries who are enrolled in both Parts A and B are about 5.9% higher than the total non-ESRD FFS population.

In its analysis of the impact of basing benchmarks on only those with both Parts A and B instead of counting beneficiaries with either Part A or B, MedPac concludes current benchmarks are understated by about 1%; however, this includes an adjustment for risk scores. Adjusting for risk scores is not appropriate for this comparison. Furthermore, we are not aware of any risk adjustment model that uses only diagnoses from only Part A or only Part B services to predict both Part A and B expenses. The CMS HCC risk

¹ https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_Ch12_SEC.pdf

adjustment model is intended only to predict both Part A and B expenses based on diagnoses from all Medicare Part A and B covered services; therefore, it is not appropriate to assign a risk score using this model for beneficiaries with only diagnoses derived from Part A only or Part B only covered services. Without more information on the risk score methodology, we can only assume this comparison is using the current HCC methodology, which, for reasons stated above, would be in error.

Table 1 summarizes the results of these analyses. These adjustments should be considered when comparing MA payments to FFS costs.

Table 1 - FFS Cost Estimates Under Alternative Conditions

Condition	Cost Difference vs. Current FFS
MOOP Applies to FFS	3.5%
Non-ESRD beneficiaries with A and B Enrollment	5.9%
All Combined	9.4%

Analysis and Results

Impact of a Maximum Out-of-Pocket Provision in FFS

Currently, the traditional FFS Medicare benefit does not include a provision to cap beneficiary out-of-pocket expenses. CMS regulations require that all Medicare Advantage Organizations (MAOs) offer a maximum out-of-pocket benefit provision for medical (i.e. Part C) services. Historically, CMS has defined a “mandatory” MOOP amount and a lower, “voluntary” amount. Plans that offered the voluntary MOOP were allowed increased flexibility with respect to cost sharing provisions for certain key services.

While MAOs must offer a MOOP provision at the mandatory level or less, the increased costs created by this requirement are classified as a Mandatory Supplemental benefit in the bid pricing tool (BPT).

In order to better understand how traditional Medicare FFS costs compare with those under Medicare Advantage, we analyzed how traditional FFS costs would change if the mandatory MOOP provision was applied.

Specifically, we looked at 2019 FFS costs from the 100% claim files and re-priced claims by beneficiary based on an assumption that out-of-pocket expenses could be no greater than \$6,700. The use of a \$6,700 MOOP is based on the mandatory MOOP amount in effect for MAOs in contract year 2019.

Based on our analysis, we found that 2019 FFS costs would be 3.5% higher if a MOOP of \$6,700 was implemented under traditional FFS.

We further analyzed how costs would increase if a MOOP were in place according to different status markers such as dual, ESRD, institutionalized status and age group.

Table 2 summarizes the results of the different analyses.

Table 2 – Impact of \$6,700 MOOP on 2019 FFS Costs by Population Type

Population Group	MOOP Impact
Total FFS	3.5%
Total Dual	4.1%
Total Non-Dual	3.4%
Total non-ESRD	3.0%
Total ESRD	9.1%
<65	5.0%
65-69	3.4%
70-74	3.3%
75-79	3.3%
80-84	3.2%
85+	2.8%
Institutionalized	6.9%
Non-Institutionalized	3.1%

Generally the MOOP impact increases as the level of claims by beneficiary increases; although, this was not the case for age groupings, where we saw lower MOOP impact for beneficiaries in older age groups even though claims are higher than average. We believe this dynamic is caused by members in higher age groups having a larger proportion of spend in Part A (vs. Part B) than those in the lower age groups. Part B services average 20% coinsurance for all service categories, whereas the Part A deductible and other cost sharing provisions equate to about 9% to 10% coinsurance.

Notably, the impact of MOOP is much higher than average for ESRD and Institutionalized beneficiaries. For ESRD beneficiaries, many of whom require regular dialysis treatment at 20% coinsurance, a \$6,700 MOOP would increase costs 9.1% for the Medicare program. This finding is particularly important when comparing the programs, because it is easy to ignore ESRD beneficiaries since MA bids are submitted on a non-ESRD basis. Plans are still required to make coverage available to ESRD members (members could proactively join MA plans beginning in 2021), so liabilities associated with these members impact MA plans. Any comparison of the MA program and FFS should include consideration for ESRD beneficiaries.

It is also worth noting that there are payment differences for ESRD vs. non-ESRD beneficiaries. Because there is no bid for ESRD beneficiaries, there is no rebate paid for these members, nor is there any quality bonus adjustment for qualifying plans. Instead, MA organizations are paid the full risk adjusted benchmark and are required to fund the MOOP along with any supplemental benefits offered by the plan.

Similar to the ESRD population, we found that the impact of a MOOP for institutionalized beneficiaries would also be well above the overall average. For these beneficiaries, whose medical needs are associated with high acute care costs, a \$6,700 MOOP would result in 6.9% higher FFS costs.

It is important to note that our analysis did not consider potential beneficiary behavioral changes as a result of a MOOP. It is likely that utilization of services would increase for beneficiaries after a MOOP was reached, so our estimate impact of the MOOP in Table 1 should be viewed as a minimum amount.

Benchmark Development – Limiting to Beneficiaries Enrolled in Part A and Part B

Although MA beneficiaries are required to be enrolled in both Part A and Part B, the benchmarks (the primary source of MA revenue) are calculated using FFS costs from the total population, which includes beneficiaries enrolled in Part A only, Part B only or both Part A and Part B. In the March 2017 report titled “Report to the Congress: Medicare Payment Policy”, MedPAC made a recommendation for CMS to calculate benchmarks using only the FFS spending of beneficiaries enrolled in both Part A and Part B. In the most recent report from March 2022, they source the prior analysis stating that the risk adjusted FFS spending for beneficiaries with both Part A and Part B was about 1 percent higher than the risk adjusted spending for all FFS enrollees.

While we agree with the recommendation to develop benchmarks using only the population eligible for MA, we believe the appropriate measure of the impact of changing the benchmark calculation is to only look at the cost difference. The risk score adjustment is not needed since it is a nation-wide calculation, and risk scores calculated for beneficiaries with Part A only or Part B only coverage are not comparable to scores for those enrolled in both Part A and B.

For purposes of calculating the benchmark, FFS spending is developed by taking the sum of Part A per capita spending and Part B per capita spending. In the analysis used to support the 1% difference in the March 2017 recommendation, MedPAC takes the following steps:

1. Calculate Part A spending and risk scores for beneficiaries enrolled in Part A and Part B vs. beneficiaries enrolled only in Part A. For beneficiaries enrolled in both, FFS spend was 8% higher and risk scores were 6% higher than those enrolled in Part A only. The risk-adjusted Part A difference in spending between the two programs was 2% higher for those in both Part A and Part B.

2. Calculate Part B spending and risk scores for beneficiaries enrolled in Part A and Part B vs. beneficiaries enrolled only in Part B. MedPAC found no difference in spend or risk scores for the two groups.
3. Blend, the Part A and B FFS risk-adjusted spending for beneficiaries enrolled in both Part A and Part B. The result was that beneficiaries enrolled in both Part A and B experienced risk-adjusted costs about 1% higher than the total FFS population. Note, we are unclear how MedPAC blended the two impacts to arrive at the 1%.

It is not necessary to adjust for a difference in risk scores because the CMS HCC risk model is developed using only beneficiaries enrolled in both Part A and Part B², and thus already reflects for the higher average risk of those with both Part A and B. Therefore, it would be inappropriate to use risk scores produced by the model for beneficiaries who are only enrolled in Part A or only Part B since diagnoses will only be based on a subset of claims as compared with beneficiaries enrolled in both A and B. It is also inappropriate to apply a risk adjustment to estimated costs since only the cost difference would flow through to nationwide benchmark rates now based on only those enrolled in both A and B.

Wakely independently calculated the cost difference with the 2019 100% FFS data. We found that Part A spending was 13.4% higher for beneficiaries that were enrolled in Part A and B compared to those only enrolled in Part A. This compares to the 8% in MedPAC's study. We believe one cause of the cost differential increasing is that MA penetration has been increasing over time, leaving fewer beneficiaries in FFS. Since beneficiaries must be eligible for both Part A and B, those with Part A only enrollment comprise a greater percentage of the total remaining in FFS.

For Part B spend, we also found there was no material difference between the two populations. Combining the impact based on overall cost, the total non-ESRD FFS spend is 5.9% higher for those enrolled in Part A and Part B vs those enrolled in Part A and/or Part B.

Data and Methodology

The analyses in this report are based on 2019 FFS costs and membership from the 100% claims and enrollment files. We used logic consistent with CMS's definition of dual, institutional and ESRD members. Age was calculated as of January 2019. Our analysis excludes Hospice members.

² <https://www.cms.gov/files/document/report-congress-risk-adjustment-medicare-advantage-december-2021.pdf>, page 9.

Members may switch dual, institutional, or ESRD status throughout the year. For purposes of classifying beneficiaries into appropriate categories, we took the most recent status and assumed it applied for the entire year.

The impact of the MOOP was calculated at a member level. The revised paid amounts equal the original allowed amount minus the minimum of the member's annual cost share and \$6,700. Our analysis is limited to members who were enrolled in both Parts A and Part B.

MA membership and risk score information was sourced from the Virtual Research Data Center (VRDC). This data represents nationwide 2019 MA beneficiaries.

The benchmark analysis comparing FFS spending for beneficiaries enrolled in Part A and Part B vs Part A and/or Part B relied on the 2019 100% FFS cost and membership files. We separately calculated the Part A PMPM and the Part B PMPM consistent with how CMS calculates Medicare Advantage benchmarks.

Limitations

The assumptions and resulting estimates included in this report and produced by the model are inherently uncertain. Users of the results should be qualified to use it and understand the results and the inherent uncertainty. Actual results may vary, potentially materially, from our estimates. Wakely based this analysis primarily on CMS published data, which are subject to revision over time. It is the responsibility of AHIP to review the assumptions carefully and notify Wakely of any potential concerns.

Responsible Actuaries

We, Rachel Stewart, and Tim Courtney are the actuaries responsible for this communication. We are Members of the American Academy of Actuaries. Rachel is an Associate of the Society of Actuaries, and Tim is a Fellow in the Society of Actuaries. We meet the Qualification Standards of the American Academy of Actuaries to issue this report.

Conflict of Interest

Wakely provides actuarial services to a variety of clients throughout the health industry. Our clients include commercial, Medicare, and Medicaid health plans, the federal government and state governments, medical providers, and other entities that operate in the domestic and international health insurance markets. Wakely has implemented various internal practices to reduce or eliminate conflict of interest risk in serving our various clients. Except as noted here, we, Rachel Stewart and Tim Courtney, are financially independent and free from conflict concerning all matters related to performing the actuarial services underlying this analysis. In addition, Wakely is organizationally and financially independent to AHIP.

Subsequent Events

There are no known relevant events subsequent to the date of information received that would impact the results of this report.

Contents of Actuarial Report

This document and the supporting exhibits/files constitute the entirety of the actuarial report and supersede any previous communications on the project.