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Medicare Advantage: Current Landscape and Future Reform

Robert Saunders, PhD
Senior Research Director, Health Care Transformation
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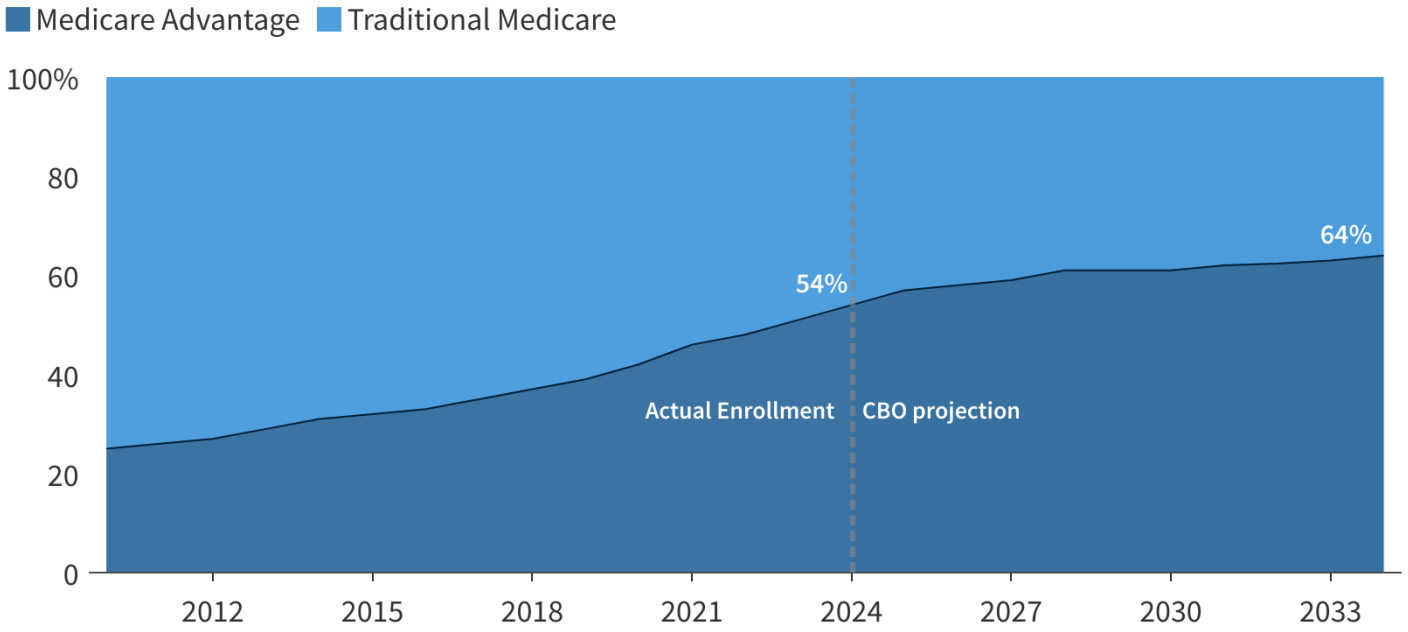
Talk Overview

- **Landscape of the Medicare Advantage Market**
- Current issues in Medicare Advantage
- Looking ahead: Future of Medicare Advantage reforms

Medicare Advantage now serves majority of the Medicare-eligible population

Figure 2

Medicare Advantage and Traditional Medicare Enrollment, Past and Projected



Source: KFF analysis of CMS Medicare Advantage Enrollment Files, 2010-2024; Medicare Chronic Conditions (CCW) Data Warehouse from 5 percent of beneficiaries, 2010-2016; CCW data from 20 percent of beneficiaries, 2017-2020; CCW data from 100 percent of beneficiaries, 2021-2022, and Medicare Enrollment Dashboard 2023-2024. Enrollment numbers from March of the respective year. Projections for 2025 to 2034 are from the June Congressional Budget Office (CBO) Medicare Baseline for 2024.

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- 54% of Medicare eligible beneficiaries are enrolled in a MA plan as of August 2024
- MA Special Needs Plans (SNPs) have more than doubled since 2019, now enrolling 20% of the MA population
- MA is very consolidated--UnitedHealthcare, Humana, BCBS plans, and CVS Health cover about 70% of Medicare Advantage enrollees

Source: https://www.kff.org/medicare/issue-brief/medicare-advantage-2024-spotlight-first-look/

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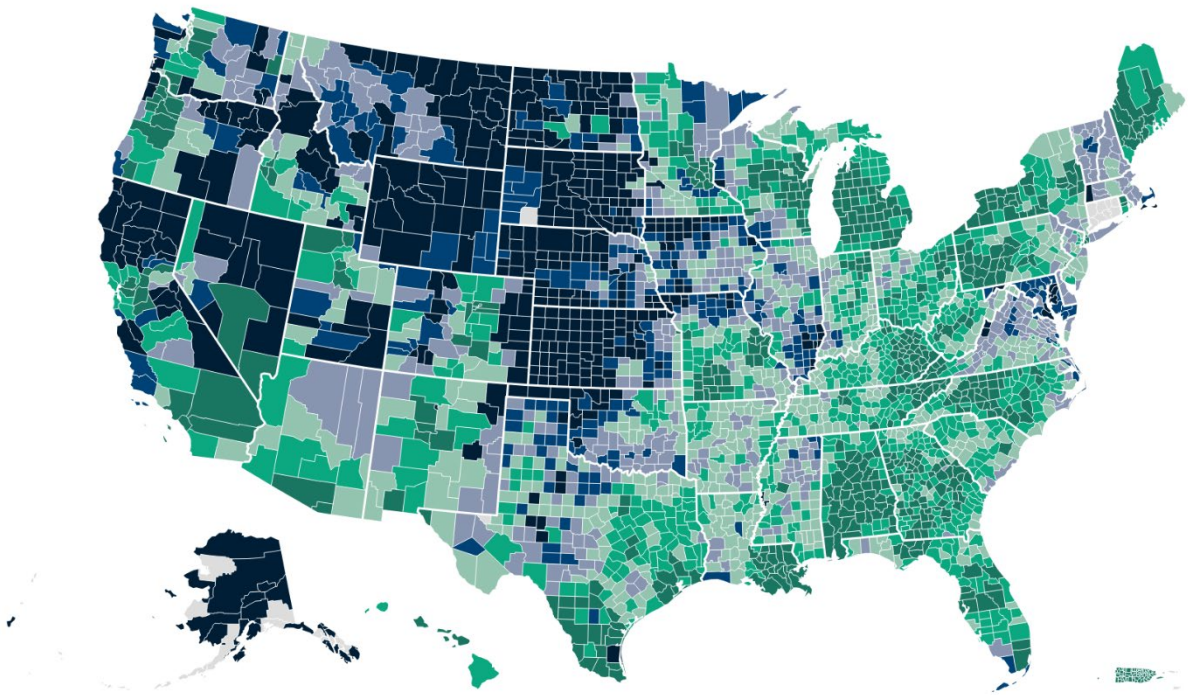
Medicare Advantage access differs across the country and populations

Figure 7

Medicare Advantage Penetration, by County, 2024



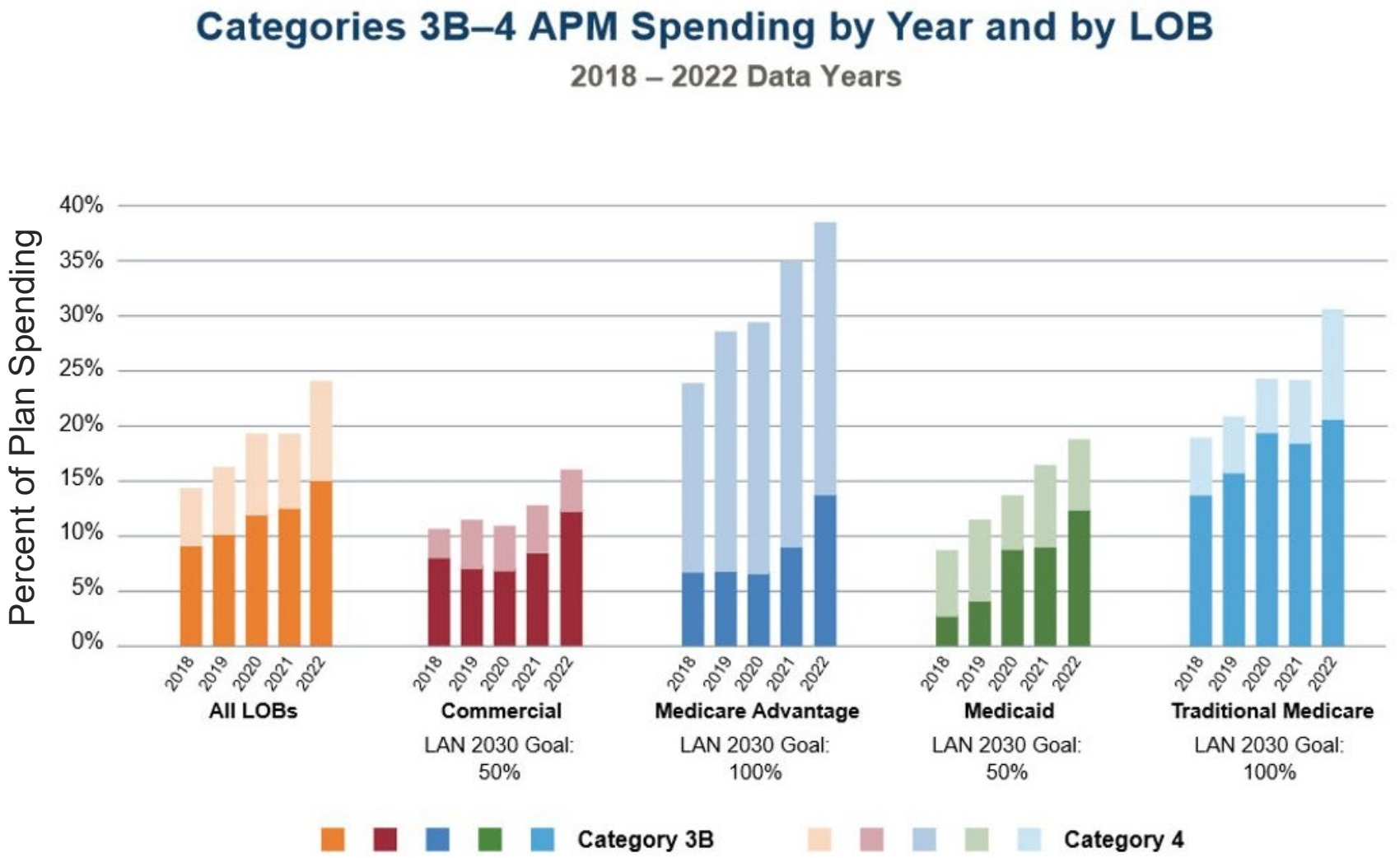
Note: Includes only Medicare beneficiaries with Part A and B coverage. Counties in gray cannot be displayed due to cell suppression standards - see methods for more details. Data on Connecticut is not included due to differences in FIPS codes in the CMS Medicare Advantage Enrollment Files and CMS Medicare Enrollment Dashboard.

Source: KFF analysis of CMS Medicare Advantage Enrollment Files, 2024 and March Medicare Enrollment Dashboard, 2024.

KFF

- Access to MA differs significantly across states and even across counties
- 1/3 of Medicare beneficiaries live in a county with > 50 MA plan options; some parts of the country have little or no MA penetration
- MA growth not just for high-resourced populations; substantial growth for populations with high social needs (although 5 Star plans aren't uniformly available)

MA plans have tended to report highest use of value-based payment models



Source: https://hcp-lan.org/workproducts/apm-infographic-2023.pdf

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Several policy challenges occur when MA is most of the Medicare program.

- MA plan payment benchmarks and risk adjustment use spending data from Traditional Medicare
- Medicare program can directly implement policy with Traditional Medicare
- MA fee schedule generally negotiated at Traditional Medicare fee schedule rates (although somewhat changing)
    - Commercial plans also often negotiate rates as multiples of Traditional Medicare fee schedule
- Most evidence about health care delivery derived from Traditional Medicare claims (much less data available from MA)

Substantial growth in supplemental benefit offerings, however actual benefit use remains limited

- MA plans can offer benefits not covered by Traditional Medicare:
  - Special Supplemental Benefits for the Chronically Ill (SSBCI) such as food and produce supports, transportation, and general supports for living.
  - Expanded primarily health-related benefits such as in-home support services, caregiver supports, and home-based palliative care.
  - CMMI VBID pilot also offers benefit flexibility
- Notable increases in supplemental benefit offerings across plans for CY 2024
  - Uptake of these services remains low—challenges include payment, regulatory, operational, data-based, and workforce barriers.

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With continued growth in MA enrollment, there are concerns regarding federal budget impact

MedPAC expresses concern over greater MA costs per enrollee in Medicare

MedPAC calculations are that Medicare spends 22% more for MA enrollees compared to Traditional Medicare

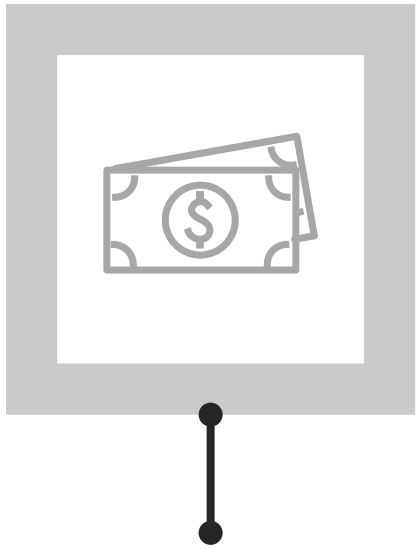
This difference translates to about **$83 billion** in 2024

Medicare Payment Advisory Commission. 2024. Report to the Congress: Medicare payment policy. Washington, DC: MedPAC.

MA plans are reporting higher medical utilization while MA plan rates have tightened

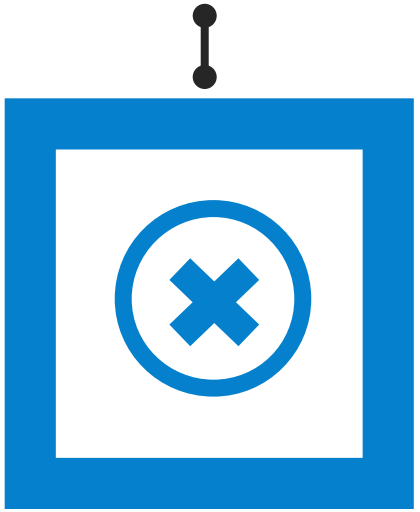
- Several plans are reporting higher medical utilization recently (potentially utilization bounce back from COVID-19 era)
  - Impact on plan profitability
  - This week, Humana reported cutting 10% of its MA lives
- Plans are pushing back on CMS' small decrease in benchmark rate
  - Overall payment depends on benchmark and risk adjustment
- Plan profitability affected by plan company structure
  - Plans providing more health care delivery in-house tend to have higher profits
  - Plans also provide services through MA start-up ecosystem

Additional MA considerations may impact providers and patients



Does MA plan payment changes lead to increased premiums, cost sharing, and/or fewer supplemental benefits.

Utilization management and prior authorization (with associated delays/ denials/access concerns)



Limited data and transparency

Open question on how Medicare Advantage fits into CMS' value strategy

- **Risk adjustment:** Data for MA risk adjustment comes from Traditional Medicare claims, which not necessarily representative of MA population
  - Unlimited risk adjustment factor (RAF) for MA, while CMS VBP programs generally cap risk adjustment growth. VBP orgs (inc ACOs) may be at financial disadvantage
  - Concern about risk adjustment "arms race" with coding-focused home visits and other coding techniques

- **VBP/measures alignment:** Each MA plan uses different VBP approaches with different model design and measures
  - Concerns from providers on administrative burden in quality measure reporting and aligning other aspects (eg, attribution)

Some MA challenges are visible to Medicare beneficiaries

- **Limited ability to leave MA program:** Seriously ill beneficiaries may not be able to switch from MA to Traditional Medicare (given guaranteed issue time period for Medigap).
  - CMMI MA VBID pilot challenged in offering hospice services; will not continue in 2025.
- **Prior auth/denials felt by patients**: In 2022, MA plans denied 7.4% of prior auth requests; prior auth requests and denials more common for some plans.
- **Health systems indicating willingess to drop some MA contracts**: Examples of high-profile systems dropping some MA contracts; HFMA survey suggests ~1/6 of systems planning to drop 1 or more contract.

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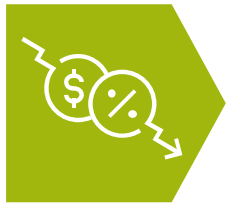
Prior MA policy actions focused on transparency and quality

- **Congress:** Consolidated Appropriations Act of 2023 included provisions to enhance transparency and quality
  - Introduced requirements for MA plans to provide clearer information on OOP costs and covered services
  - Mandated improved oversight and reporting mechanisms to ensure that MA plans adhere to quality standards.
- **CMS**:
  - Substantial health equity focused actions (e.g., health equity index in Star Ratings)

Future MA policy reforms may focus on prior authorization and modest initiatives

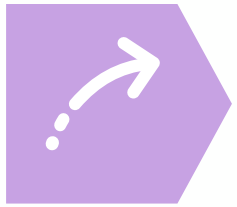
- **Emerging bipartisan agreement on prior auth reforms:** Potential legislative activity:
  - Require electronic prior authorization
  - Use of AI in prior auth
  - Require reporting on prior auth (e.g., rejections, appeals, time to respond, effect on populations with social risk factors)
- **Potential pay-for:** Continuing tight federal fiscal environment, which requires pay-fors for any other legislation
- **Unclear impact of election**: Traditional partisan dividing lines are less clear on MA
- **State efforts on D-SNPs:** Increasing state interest in more integrated D-SNPs, which may be place for action among MA plans

Summary of potential future MA policy actions



Tightening fiscal environment at plan and federal level (e.g., MA plans focusing on certain markets or beneficiary populations, potential pay-for in future legislation)

Addressing care denials from utilization management tools like prior authorization



Increased transparency (e.g., care utilization, supplemental benefit offerings)

Aligned VBP reforms in performance measures and other administrative burden reduction

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1201 Pennsylvania Avenue, NW,
Suite 500 • Washington, DC 20004

DC office: 202-621-2800
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