Reviewing Methodological Issues in MedPAC's Analysis of Favorable Selection in Medicare Advantage

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FTI Consulting, Inc. assessed the findings contained in recent reports by the Medicare Payment Advisory Commission ("MedPAC") as well as the June 2023 report "Overpayments to Medicare Advantage Plans Could Exceed $75 Billion in 2023" issued by the USC Schaeffer Center for Health Policy and Economics ("Schaeffer Center").[1,2,3]

Executive Summary

The MedPAC report is a counterfactual exercise which seeks to estimate what Medicare beneficiaries in Medicare Advantage ("MA") plans would have cost if they remained in FFS. MedPAC's top line conclusion is that MA plans were paid 22% more in 2021 than what Medicare would have paid for those individuals under FFS.[4] A key element of the analysis is MedPAC's conclusion that MA plans attracted, on average, lower cost beneficiaries, resulting in substantial favorable selection into MA.[5] The Schaeffer Center report uses a similar analysis to find favorable selection into MA.[6]

However, both reports base conclusions on insufficient data to draw the reported conclusions, overlook significant countervailing facts, suffer from methodological deficiencies, and misconstrue findings.

MedPAC Assumptions Based on FFS Data, Not MA Data, May Be Invalid

— The reports' estimates that beneficiaries in MA are lower cost are not based on comparing the experiences of MA beneficiaries while enrolled in MA to the experiences of people enrolled in FFS. Rather, the reports create a proxy for the costs of MA beneficiaries using only fee-for-service data – specifically, comparing the Medicare expenditures for people in FFS in the year before they switch into MA to expenditures for people who remain in FFS. They assume that the expenditures of FFS Medicare beneficiaries who eventually switch to MA are indicative of their costs while in MA, and that expenditures of those who remain in FFS Medicare are an appropriate counterfactual comparison for those who switched to an MA plan.

— These assumptions may be invalid for various reasons. For example, a single calendar year of expenditures is unlikely to be an accurate predictor of future experience. Beneficiaries' healthcare costs and conditions vary unpredictably from year to year. As another example, health care costs of people switching into MA may appear lower than the beneficiaries who stay in FFS because these "switchers" delayed healthcare consumption in anticipation of switching to an MA plan and incurring those costs when coverage is more favorable plan (such as lower cost sharing).

The Reports Assume the Results Apply to All Beneficiaries Even Though the Analyses Exclude Medicare Advantage Beneficiaries Who Enrolled Directly in MA at Retirement

— In 2015, approximately 950,000 people enrolled directly into MA without participating in FFS Medicare, representing 27% of enrollees.[7] Those figures have grown. In 2022, 1.6 million people enrolled directly into MA representing 44% of all new beneficiaries.[8] Since MedPAC's analysis focuses on people who switch from FFS, these "direct enrollment" beneficiaries' experiences are not incorporated.

— Beneficiaries who first enroll in MA (and subsequently stay in MA) may have a different health care cost profile than MA beneficiaries who switch from FFS Medicare.

— Conclusions should not be drawn without understanding the healthcare expenses of a significant group of MA beneficiaries never included in the analysis.

MedPAC's Analysis Ignores Other Important Groups and Issues that Could Impact Estimates

— MedPAC's exclusion of certain other groups from the analyses may lead to inaccurate conclusions.

— Part A-only FFS Medicare beneficiaries, whose costs are much lower than people enrolled in Parts A and B, are excluded from the MedPAC reports even though they are included in the methodology to determine MA costs and therefore are effectively incorporated into the favorable selection estimate.[9]

— Beneficiaries who do not live in the same county in a given year are also excluded, which removes people who could materially impact cost estimates such as those who are housing-insecure (e.g., a low-income dual population) and those who are more affluent and migrate between homes seasonally.[10]

— The MedPAC reports also ignore implications of material changes in the FFS Medicare and MA member populations over the study period, such as the proportional increase in MA population and shifts in dual-eligible beneficiaries to MA. Given these population shifts, the compositions of the cohorts being studied are not in equilibrium. MedPAC itself notes in its reports that higher levels of MA penetration may be correlated with less favorable selection.

The Exclusion of MA Bid Data May Overestimate Potential Impacts

— The MedPAC reports do not account for bids in their analyses, even though bid rates, not benchmarks derived from FFS Medicare costs, comprise most of the basis for MA payments.

— Estimates of favorable selection based exclusively on benchmarks will likely overstate the true costs to taxpayers.

Introduction

Medicare Advantage benchmarks are designed to pay plans based on the average cost of the beneficiaries in FFS Medicare. Because of concerns this could create incentives for MA plans to enroll only the lowest cost seniors from the FFS Medicare program, policymakers developed a system to adjust payments based on risk factors that account for the cost variation. These factors included demographic dimensions such as gender and age and clinical aspects based on the beneficiary's diagnoses. Before 2000, only demographic factors were used to adjust costs of beneficiaries, and those factors could only predict around 1% of spending. By 2004, the current system was implemented, which accounts for demographic characteristics, inpatient care, and outpatient care.[11] A history highlighting the evolution of the MA program is in the Appendix.

Recent reports by MedPAC claim that despite the risk-adjustment methods, MA still attracts, on average, lower cost beneficiaries. According to MedPAC, payments to plans are determined by the average costs of the higher cost beneficiaries that remain in FFS Medicare; this "favorable selection" results in plans being overpaid.[12] Since the plans are paid in part according to the average cost of beneficiaries in FFS Medicare, and the lowest cost seniors' departures have left FFS Medicare with beneficiaries whose costs are higher than average, this artificially pushes up average FFS Medicare costs which pushes up the benchmark, and results in higher payments to MA plans.[13]

Currently, CMS sets a baseline benchmark rate for each county across the country. Benchmarks are based on recent FFS claims data and a projection of FFS Medicare beneficiary spending data for the following year to calculate the estimated average spending per beneficiary.

Various adjustments are then made to these amounts. Geographic adjustment factors are applied to each county to account for differences in spending in that county, standardized by the risk score.[14] This geographic adjustment factor accounts for each county's relative spending compared to the national FFS Medicare cost on a rolling 5-year basis. Another adjustment accounts for historical Medicare spending levels in each county, ranging from 95% to 115%, which adjusts payments higher for counties with historically lower spending and lowers payments for counties with historically higher spending.[15] This adjusted number is then further adjusted for a plan's quality (star) rating.[16]

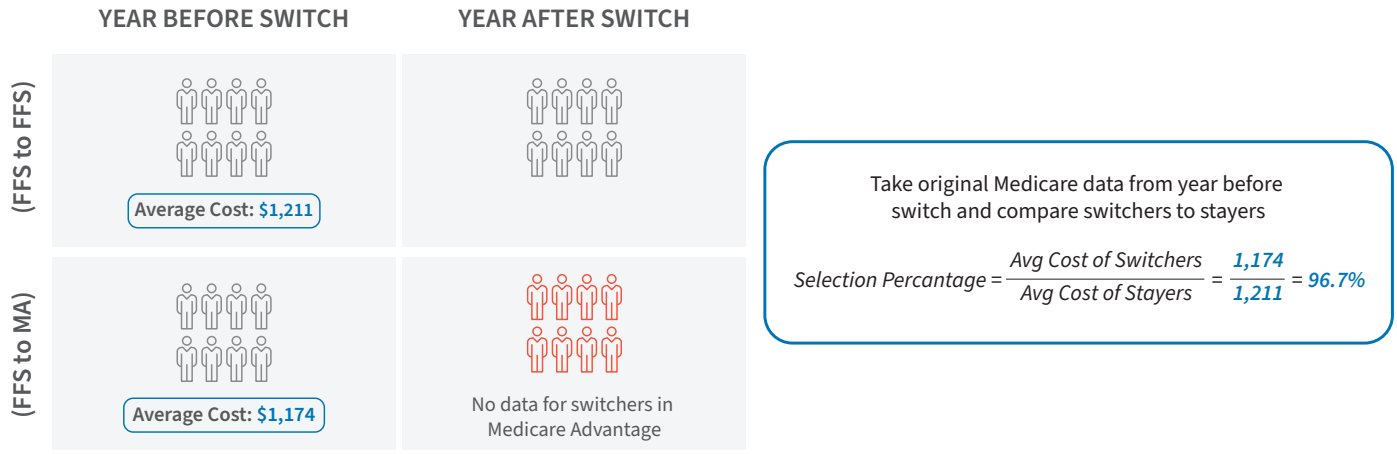
The analyses of favorable selection make several strong and unverifiable assumptions, that, due to the lack of available data should call into question their conclusions until a more detailed and thorough review is completed. Further, MedPAC's estimate of favorable selection does not fully account for the impact on payments. These concerns are explained in detail below.

Description of Methodologies

In June 2023, MedPAC published a report to Congress outlining its methodology for estimating the magnitude of potential overpayments in the MA program. In its March 2024 updated status report to Congress on Medicare Payment Policy, the Commission provided an update that included revisions in the methodology used in the analysis.

A primary analysis conducted in the MedPAC report compares the prior year expenditures between the members remaining in FFS Medicare and the members switching to MA in a given calendar year (see Figure 1).[17] To illustrate, consider the following - in Year 1 of the analysis, the Year 0 FFS Medicare expenditures for enrollees that switched to MA were compared with Year 0 FFS Medicare expenditures of a subset of members that remained in FFS. The ratio of these expenditures is referred to by MedPAC as the "selection percentage" for the MA cohort. MedPAC conducted this calculation for all cohorts entering MA from 2008 through 2020. These ratios represent the initial favorable selection in the year members entered the MA program.

Figure 1: Illustration of MedPAC Favorable Selection Methodology



In constructing the cohorts, the March 2024 MedPAC report excludes the following sets of beneficiaries from the analysis:

— Beneficiaries with ESRD

— Beneficiaries who don't maintain the same residence for all 12 months of the measurement year

— Beneficiaries with Medicare as a secondary payer

— Beneficiaries who enroll directly into a Medicare Advantage plan upon reaching the age of eligibility

The MedPAC analysis then adjusts the initial favorable selection estimates for two additional factors: 1) subsequent favorable selection due to attrition of sicker patients out of MA and 2) regression to the mean effects.[18]

To explore how attrition affects its estimates, MedPAC calculates the selection percentage for the subset of MA members who were continuously enrolled in MA instead of the full complement of switchers in one year. For example, MedPAC compared 2015 FFS Medicare spending for the seniors who switched to MA in 2016 and stayed through 2021 to the spending of the seniors who stayed in FFS Medicare in 2016.[19] These switchers are a subset of all the 2015 FFS Medicare enrollees who switched to MA in 2016; it excludes all the switchers who either passed away or returned to FFS Medicare before 2021.[20] Thus, a beneficiary that switches out of MA or dies in 2019 would not be included in the cohort.[21]

"Regression to the Mean" reflects the tendency of a population who may initially depart from the average (in this case, whose costs are lower than average) to, over time, trend back toward the average of everyone else.

MedPAC quantifies this by estimating how favorable selection changes within a cohort of MA entrants in the years preceding their switch. For beneficiaries who joined MA in 2022 but were in FFS Medicare continuously from 2015-2021, MedPAC measured their FFS Medicare expenditures prior to enrolling in MA.[22] This group of eventual switchers is used as a proxy group to represent what MedPAC expected would happen to costs for the beneficiaries who switched to MA in 2016.[23] Since MedPAC does not have data for the beneficiaries after they switched to MA, the idea is to assume the proxy group that eventually switches to MA reflects the experiences of the people who are enrolled in an MA plan.

MedPAC determines the one-year favorable selection for the proxy group at the beginning of the period (2015) and the end of the period (2021).[24] The difference in favorable selection between these two years is assumed to be regression to the mean.[25]

In addition to the MedPAC reports, the Schaeffer Center issued its own analysis in a June 2023 report, "Overpayments to Medicare Advantage Plans Could Exceed $75 Billion in 2023".[26] The authors of the Schaeffer Center report use a different methodology to estimate the extent of initial favorable selection. The report evaluates cohorts of FFS Medicare beneficiaries who switch to an MA plan, like the MedPAC analysis, however, the Schaeffer Center analysis estimates a logistic regression to calculate the association between a beneficiary's likelihood of switching to MA and their risk-score-adjusted expenditures.[27] Finally, the report finds that those with low risk-score-adjusted expenditures were more likely to switch relative to median-expenditure beneficiaries, while beneficiaries with high risk-score-adjusted expenditures were less likely to switch.[28] They use this as evidence of a large initial favorable selection effect.

Methodology Issues

Both the MedPAC and Schaeffer Center reports base their conclusions on insufficient data, overlook significant countervailing facts, suffer from methodological deficiencies, and misconstrue findings. A key limitation in their analyses is the lack of MA claims or encounter data. Instead, the reports create a proxy for the costs of MA beneficiaries using only fee-for-service data.[29,30] This is problematic for several reasons, which are detailed below. The reports also conflate separate and distinct arguments.

The first argument is that FFS Medicare beneficiaries who switch to MA are lower cost than those who stay. From this, both reports infer that all MA beneficiaries, including those that never participated in FFS Medicare, are lower cost than those who remain in FFS Medicare, despite having no MA claims or encounter data and despite excluding beneficiaries who never participated in FFS Medicare from their analysis.[31]

In addition, MedPAC also implies that the gap between the costs of the FFS Medicare beneficiaries who stayed in FFS Medicare and those who switched to MA is equivalent to an overpayment to MA plans.[32] This is also erroneous. Because MA plans are paid based on their bids and not the government's benchmarks, which are derived from FFS Medicare costs, bids must be included in the analysis to determine the magnitude of any overpayment. An estimate of favorable selection for the beneficiaries who switch, even if correct, would only reflect differences in the beneficiaries' costs to their respective payers, but the cost to CMS and to taxpayers is dependent on the bids submitted by those payers.

1. Med PAC Methodology May Not Accurately Estimate Favorable Selection

a. Estimating Effects Based Entirely on FFS Medicare Data Can Lead to Inaccurate Results

The MedPAC reports do not utilize claims or encounter data for MA beneficiaries, which makes a direct comparison of costs between the FFS Medicare and MA programs problematic.[33] Instead of using actual cost data on members who switch to MA plans, the reports rely exclusively on FFS Medicare expenditures and compare those expenditures between beneficiaries who later switched to MA and beneficiaries who remained in FFS Medicare.[34] The MedPAC report assumes that the expenditures of FFS Medicare beneficiaries who eventually switch to MA are indicative of the health care costs of members while they are enrolled in MA.[35] Furthermore, it assumes that the expenditures of the members that remain in FFS Medicare are an appropriate counterfactual comparison for the members who switch to an MA plan.[36]

There are several reasons why these assumptions may not be valid. First, a single calendar year of expenditures is unlikely to be an accurate predictor of costs for the following year. In fact, research has shown that costs vary from year to year, and, importantly, while a person or group may have a single low-cost or high-cost year, that year may be an aberration and costs revert to the mean across everyone over time. This "regression to the mean"[37,38] is examined below.

In addition, while some spikes and valleys in health care costs are random, others are tied directly to product design and a beneficiary's decision to switch. Both sources of variations in year-to-year costs – random or intentional – undermine the conclusions from these reports.

Medicare Advantage plans can offer lower out-of-pocket costs than FFS Medicare.[39] MA plans often provide more comprehensive coverage (*e.g.*, typical MA plans include prescription drug coverage and supplemental benefits such as vision and dental), and they also cap a beneficiary's annual out-of-pocket costs.[40] For some treatments, copays in MA are legally required to be no greater than FFS Medicare.[41] We believe that it is difficult to accurately compare costs from a segment of people who explicitly chose an alternative to FFS Medicare, may dislike FFS Medicare's structure or believe the out-of-pocket costs will be lower in an MA plan and, as a result, may defer care with a group of people who choose to remain in FFS Medicare and may be more motivated by the flexibility to receive care immediately by the provider of their choice despite potentially paying more out-of-pocket. This could result in the switchers' health care costs appearing lower than the beneficiaries who remain but only because these beneficiaries are delaying healthcare consumption in anticipation of switching to an MA plan and incurring those costs when on a more favorable plan.

This experience, in reverse, has been documented in private plans. As plans periodically adjust their structures and benefits, beneficiaries react by accelerating their utilization to incur any treatment costs while benefits are more generous. This then causes a decline in healthcare once the new benefits package goes into effect.[42,43]

b. Material Growth in MA Makes Cohort Comparisons Less Reliable

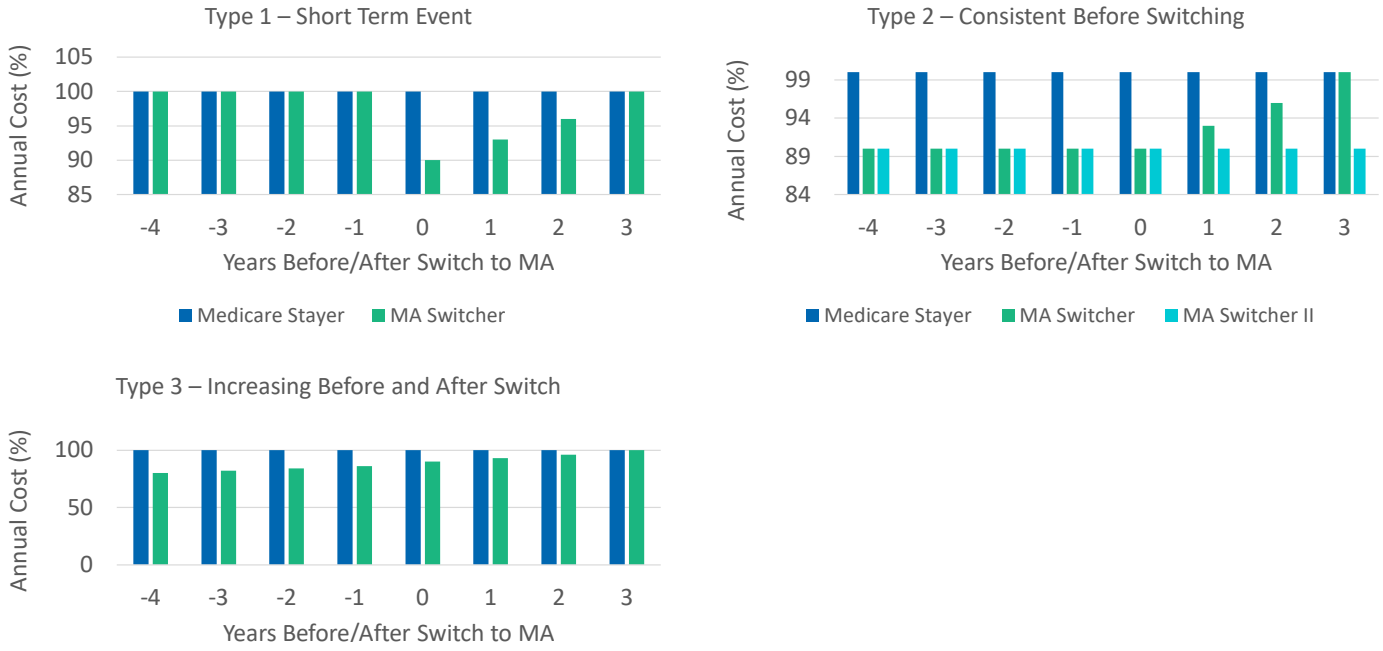
The composition of Medicare member population has changed over the period studied, falling from over 75% enrolled in FFS Medicare in 2010 to fewer than 50% in 2024.[44] This makes MedPAC's conclusions drawn from year to year less comparable because the compositions of the cohorts being studied are not in equilibrium.

Cohort comparisons are more effective when the population under analysis is in equilibrium. Equilibrium would mean the same number and/or proportion of people were turning 65 each year, with the same proportions choosing FFS Medicare, the same proportion switching to MA, and these cohorts having similar health profiles from year-to-year. But because populations are shifting materially from FFS Medicare to MA, equilibrium does not exist. The populations from year to year are not proportionally the same in the dimensions that would allow such analysis. In addition, annual programmatic changes in FFS Medicare and the MA program make it infeasible to reach an equilibrium in which a static set of beneficiaries are comparable year over year. In fact, MedPAC itself notes in its reports that higher levels of MA penetration may be correlated with less favorable selection.[45]

2. Excluding or Ignoring Certain Data Can Distort Estimates of Favorable Selection

Figure 2 highlights three potential causes of favorable selection. In the first hypothesis, there could be a short-term event making members appear at a lower cost for a brief time. In subsequent years, after members switch to MA, their costs would revert to the mean. A second hypothesis is that a cohort of members were *consistently lower* cost before switching to MA. The third hypothesis is that people who are inclined to switch to MA are *always* lower cost than those who never switch, but their costs relative to FFS Medicare are increasing over time.

Figure 2: Three Potential Causes of Favorable Selection in MA



We do not believe MedPAC addresses the first hypothesis, since the report has no data to evaluate costs after switching. Nor does MedPAC's analysis prove that the second hypothesis is correct. Instead, MedPAC's analysis attempts to address the third hypothesis – the cohort that leaves FFS Medicare exhibited lower costs before the beneficiaries switched to MA. However, MedPAC's report does not prove this hypothesis either. As noted, the MedPAC report does not evaluate actual MA data for the cohort that switches to MA. In addition, MedPAC notes that the magnitude of any gap between this cohort's costs before switching diminished significantly as the beneficiary approached the year they switched.

In its analyses, MedPAC excludes or ignores important facts that could, if included, impact the conclusions in their analyses. Examples of data not included by MedPAC that could impact results include:

— Costs associated with developing, implementing, and operating a Special Needs Plan.
— Ignoring the potential implications of variability in a person's annual health care expense and consumer behavior on health care utilization; and
— Excluding material populations of beneficiaries from the analysis, such as those who enroll directly in MA, those without two full years of eligibility, and beneficiaries enrolled only in Medicare Part A.

The potential impacts of excluding or ignoring data is detailed below.

a. Methodology May Not Fully Realize Costs Associated with Special Needs Plans ("SNP")

The Medicare dual-eligible population has grown from 8.6 million beneficiaries in 2006 to 12.5 million in 2023.[46] Concurrently, the Urban Institute reported that dual-eligible members have migrated away from FFS Medicare and that MA and other Special Needs Plans (SNPs) have grown in popularity, with dual-eligible SNPs ("D-SNPs") being the predominant type of SNP.[47] For example, in January 2013, 23.6% of dual eligibles were enrolled in an MA plan.[48] By December 2021, that figure had more than doubled to over 50%.[49]

In its analysis, MedPAC's methodology assumes dual-eligible beneficiaries can be assessed in the same manner as other Medicare-eligible beneficiaries. Dual eligibles are included in the MedPAC risk cohorts, which categorizes beneficiaries according to their characteristics such as risk score, age, gender, etc. This approach may not accurately reflect the administrative costs to MA plans associated with developing and operating a D-SNP.

The Centers for Medicare & Medicaid Services ("CMS") require all SNPs to establish rigorous processes around a Model of Care that clearly defines the unique health requirements associated with what are often a plan's most vulnerable enrollees, such as creating integrated care plans for each beneficiary, developing specialized networks targeted at the disease states present in the population, and building quality programs that monitor a plan's success in serving the population's care requirements. This level of intense care coordination can create better outcomes for beneficiaries and result in lower long-term costs of care. However, it requires that plans incur additional administrative expenses, which are not accounted for in MedPAC's analysis.

b. MedPAC's Approach Excludes a Large Proportion of MA Beneficiaries

MedPAC's reports focus on a narrow subset of the Medicare beneficiary population that excludes some material segments of beneficiaries:

- Beneficiaries with ESRD,
- Beneficiaries who don't maintain the same residence for 12 months of the measurement-year,
- Beneficiaries with Medicare as a secondary payer,
- Beneficiaries who enroll directly into a MA plan upon reaching the age of eligibility, and
- Beneficiaries only enrolled in Medicare Part A.[50]

Beneficiaries who first enrolled in MA (and subsequently stayed in MA) may have a different health care cost profile than MA beneficiaries who started in FFS Medicare. This represents a material, and growing segment of membership. In 2015, approximately 950,000 people enrolled directly into MA without participating in FFS Medicare, representing 27% of enrollees.[51] Those figures have grown. In 2022, 3.8 million people became eligible for Medicare, and 1.6 million of these (44%) directly enrolled in MA.[52] Thus, many beneficiaries who never enrolled in FFS Medicare were entirely omitted from this analysis. MedPAC's methodology similarly omits millions of direct enrollees from previous years. Any conclusions made by the MedPAC reports are incomplete without understanding the healthcare expense trends of a significant group of MA beneficiaries who were never included in the analysis. Without further analysis of this population, one cannot draw definitive conclusions.

Another population not included in the MedPAC analyses are Part A-only FFS Medicare beneficiaries. They are excluded even though their cost data is used to determine the benchmark.[53] These beneficiaries typically have other sources of insurance, and as a result, the amount that Medicare pays is reduced, which would result in lower benchmarks than what would have been calculated if their total payments were included in the calculation. In a January 2024 study, Wakely independently calculated that Part A spending was 14.2% higher for beneficiaries who were enrolled in Part A and B compared to all beneficiaries (including those enrolled in only Part A).[54] This actuarial study illustrates the potential overstatement created by not including these costs in the FFS Medicare data. In summary, when CMS calculates the benchmarks which are used to determine payments for MA plans, it includes FFS beneficiaries who are enrolled only in Part A, whose costs are lower than those FFS beneficiaries enrolled in both A and B. This leads the benchmarks to be lower than they would be if they were calculated based on who is eligible for MA. Conversely, the MedPAC report calculates its costs per beneficiary only for people eligible for MA and so estimates costs that are higher than what goes into benchmarks and incorporates this difference into its estimate of favorable selection.

In addition, the MedPAC analyses also require beneficiaries to live in the same county during the reference year.[55] This requirement may exclude many beneficiaries who could be housing-insecure (*e.g.*, a low-income dual population), are more affluent and migrate between homes seasonally, or move because of health needs to be near caregivers or providers. Exclusion of these members may be another example where the methodology used in the MedPAC report could produce inaccurate results.

3. Analysis of MA Plan Payments Should Account for Bids, Not Only Benchmarks

a. Plan Bids Must Be Included in Analysis to Determine Potential Overpayment

In the executive summary of the MedPAC report, it states, "MA enrollees' spending in 2019 was about 11 percent lower than the spending of FFS Medicare beneficiaries with the same risk scores".[56] While MedPAC implies that the difference in average costs for switchers is equivalent to an overpayment to MA plans, MedPAC is disregarding the essential role of bids. The 11 percent figure, however, is not the difference in spending between MA and FFS Medicare, but the difference in spending between beneficiaries who left and those who stayed *within FFS Medicare* only. Though the difference is subtle, it is a crucial difference in the context of determining what policies, if any, need to be modified.

Plans are not paid the benchmark amount unless the plan's bid is equal to or greater than the benchmark. Most MA plans bid below their benchmark.[57] For nearly all beneficiaries, the cost to taxpayers to care for members in MA is reduced below the benchmark and estimates of cost differences resulting from favorable selection must be discounted.

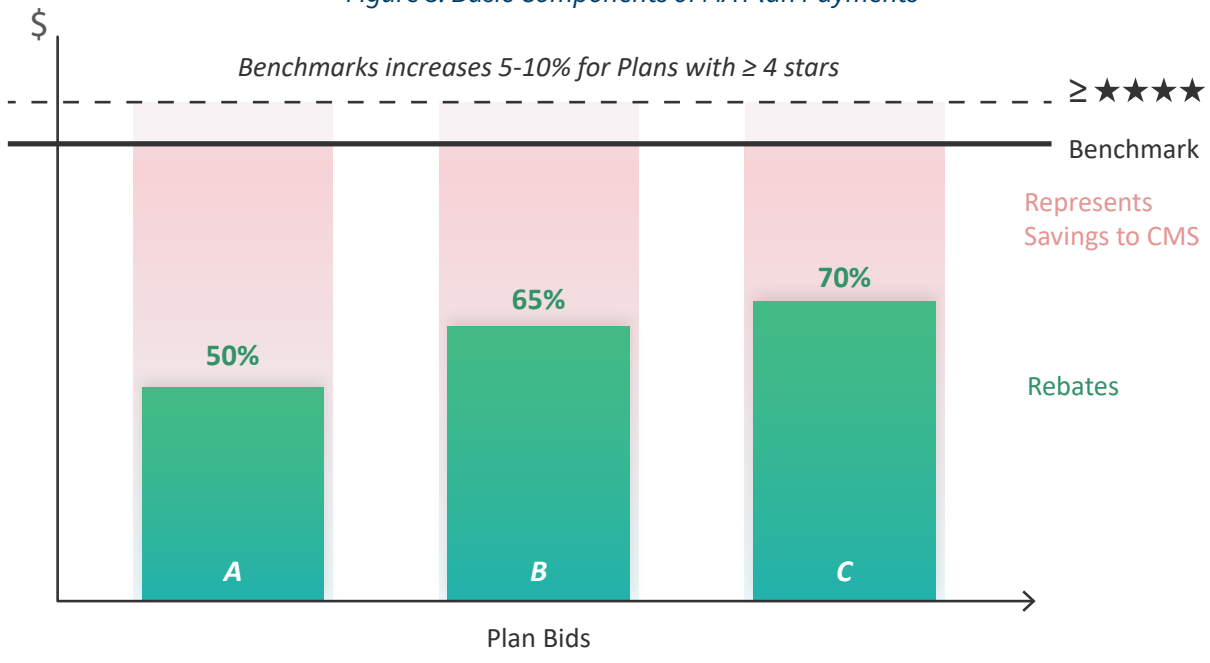
It is important to note that CMS actuaries review and approve MA rates, ensuring they are considered "actuarially sound," meaning the rates are calculated to be sufficient to cover the expected costs of providing healthcare to the enrolled population based on their health risk profile.

Given competition to attract consumers, plans incorporate savings they can generate into lowering their bids to make these plans more attractive to members. This is particularly true in highly competitive markets. Previous research cited in the MedPAC report acknowledges this point.[58]

b. Accounting for Rebates

Medicare Advantage plans are paid according to a formula that accounts for beneficiaries' age, gender, geography, and health care claims history, in addition to average cost of beneficiaries in FFS Medicare and the quality of the plan. The process calculates the average cost of beneficiaries in FFS Medicare (which is called the benchmark), and has plans submit their own expected costs for beneficiaries who enroll ("bids"). Both the benchmark and the bid are risk-adjusted. That is, they are normalized to the average Medicare beneficiary's cost based on age, gender, county, inpatient, and outpatient utilization. The plan's bid is adjusted upward or downward based on the expected cost of its enrollees, and plans that bid below the benchmarks also receive a portion of the differences as a rebate to put toward cost sharing reductions, premium offsets, and enhanced benefit offerings. The size of the rebate depends on the difference between the bid and the benchmark and the quality rating of the health plan, with plans earning 4.5 or more stars being eligible for a rebate of 70%.

Figure 3: Basic Components of MA Plan Payments



The risk adjustment process described above is meant to ensure MA organizations are paid for the expected costs of caring for their beneficiaries. If plans enroll beneficiaries that are healthier and less costly to cover, they receive lower payments from CMS. Note in Figure 3, plans that bid below the benchmarks also receive a rebate, the size of which depends on the difference between the bid and the benchmark and the quality rating of the health plan.[59]

There are important points to note regarding rebates. The plans receive a portion of the savings between bids and benchmarks in the form of a rebate – the remainder which is highlighted in the pink area on Figure 3 represents savings for CMS. Also, plans are required to use the rebate to lower patient cost sharing, lower premiums, or provide some coverage for benefits not included in traditional Medicare.

Other Important Factors

1. Schaeffer Center Approach is Statistically Unsound

The analysis of favorable selection in the Schaeffer Center report is also flawed. The logistic regression used in the Schaeffer Center Report is mis-specified and, consequently, the estimates are biased. Specifically, they use panel data on beneficiaries over a 14-year period to track the set of beneficiaries who decide to switch to MA each year.[60] The regression model aggregates the choices of these beneficiaries over this period and assumes that these are independent observations every year.[61] However, the observations for the same beneficiary over multiple years must be correlated because their individual preferences for choosing an MA plan are not accounted for, year by year.[62] As a result, the Schaeffer Center's estimate of switching to an MA plan for the lowest risk-score-adjusted cost group is likely misestimated. In any regression-based analysis, the investigators must omit a multitude of factors that are relevant but are not measured. For instance, in this case, such variables might be acquaintances' experience with MA, or cost sharing elements of plans, or even plan availability. These factors surely contribute to the decision to switch but are not included in the analysis explicitly. For accurate regressions, these factors must have certain relationships to each other from year to year, and if this requirement isn't satisfied, then the estimated effects of the factors that are included are incorrect.

2. Competition

Robust competition among MA plans should mitigate cost implications of favorable selection. This is because, as discussed, payments to MA are derived through a plan's bids which represent the cost to care for members. Because the plans have an incentive to submit lower bids to attract beneficiaries, they have incentive to deliver care more efficiently, which leads to lower bids.[63] The National Library of Medicine published studies confirming that competition gives plans an incentive to bid low in order to attract consumers.[64] Low bids attract beneficiaries through higher rebates, which are channeled to the beneficiary.[65]

There is also considerable evidence that MA is currently highly competitive. One recent MedPAC report indicates that 95% of beneficiaries live in counties with at least four MA organizations, "which appears large enough to ensure a sufficient level of competition".[66]

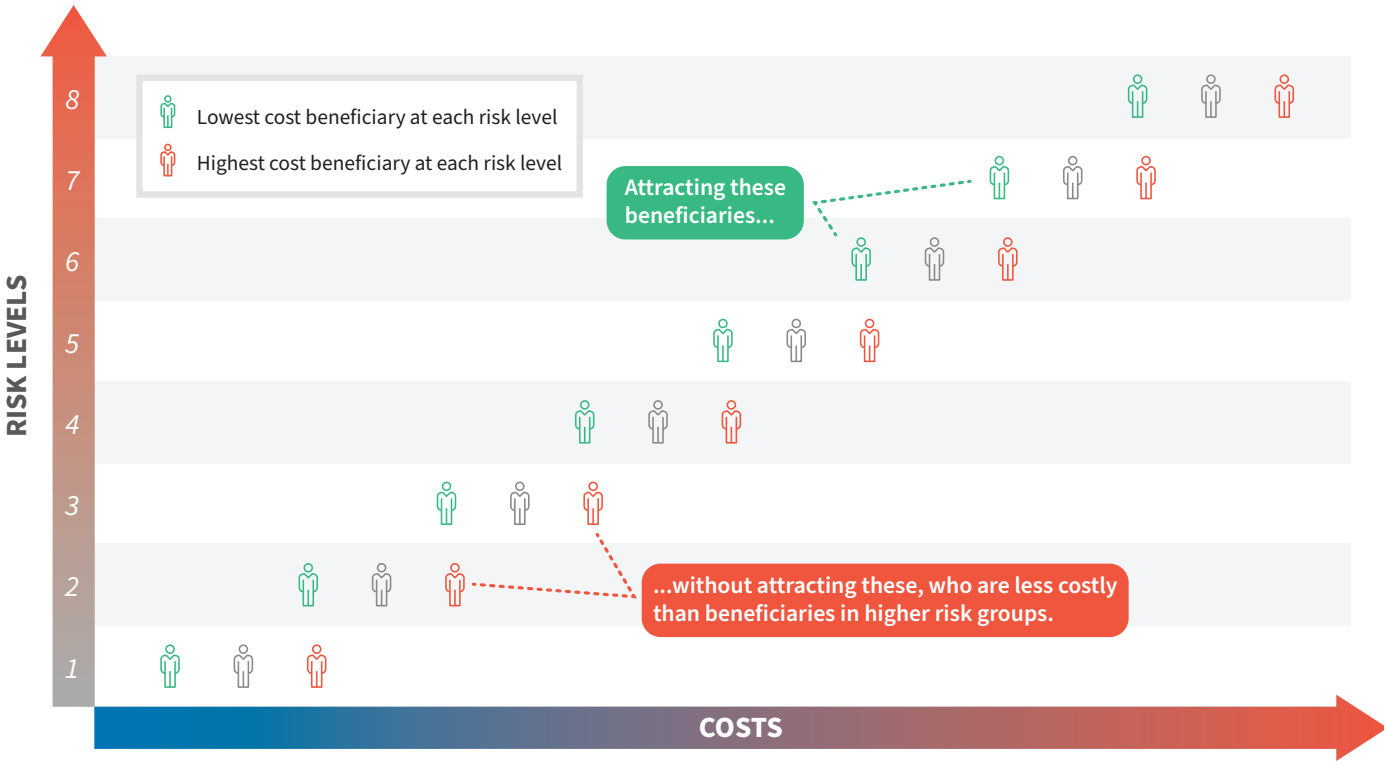
Competition among plans provides Medicare beneficiaries with more choices than FFS Medicare and drives health plans to tailor insurance benefits that meet the demands of some seniors more effectively than FFS Medicare's approach. A highly competitive market that is more responsive to consumers produces lower cost, higher quality, and more adaptive products.

3. Deliberateness of Favorable Selection

Accurately targeting the lowest cost beneficiaries at each risk-level seems extraordinarily difficult, and to date, no study has demonstrated how or that it is being done. Consider that, to deliberately target these beneficiaries, plan designers at the private insurance companies must have data and models that more accurately predict seniors' health care costs than CMS.

Since risk adjustment is based on a beneficiary's underlying diagnoses, plans cannot simply identify and target lower cost beneficiaries within a specific risk group. It is not enough to just identify the healthiest people among all seniors 65 and older, the plans would need to systematically choose the healthiest beneficiaries at each age, in each diagnostic category while not attracting the relatively higher cost people with those same profiles.

Figure 4: Illustration of Risk-Adjusted Favorable Selection



Further, researchers have been claiming different levels of favorable selection for the past 25 years throughout every era of the MA program despite all attempts to address it. Analyses show that from 2003 to 2009, private plans were paid more than FFS Medicare practically by design, to attract more competition.[67] The payment difference peaked at 114% in 2009 before the ACA reduced payments to private plans.[68]

In 2017, according to MedPAC, FFS Medicare and MA were at parity.[69] Now, 7 years later, despite no changes in legislation or how the program is administered, MedPAC is claiming that private plans are paid more.[70] Over the past 25 years, despite multiple changes to the MA reimbursement formula, including a more comprehensive method to categorize beneficiaries, risk adjustment model changes, and annual adjustments to the reimbursement formulas, structural payment reductions, MedPAC is now, with a relatively new approach, claiming to have identified a higher level of overpayment than at any time before.

Conclusion

In this review, FTI identified several potential issues where the MedPAC reports present either incomplete or incorrect analyses or make conclusions based upon incomplete data. The MedPAC report lacks sufficient data to support its conclusions and relies exclusively on FFS Medicare data while never testing their predictions using actual experience. In addition, MedPAC fails to recognize basic principles of consumer choice and cost avoidance, most notably, situations in which a beneficiary with a pending high-cost medical procedure delays the procedure until after switching to a MA plan with lower out-of-pocket costs.

The MedPAC reports exclude or ignore key sets of beneficiaries. Beneficiaries that enroll in MA when first eligible for Medicare are not represented in the reports, a significant data gap and limitation, as these beneficiaries made up a significant and growing portion of MA beneficiaries.

The MedPAC reports' complete exclusion of plan bids limit the validity and implication of the conclusions. In a competitive market, which MedPAC stipulates exists, MA plan bids will incorporate the lower costs of beneficiaries into their bids and negate potential overpayment.

Other factors the MedPAC report fails to adequately address directly influence MA plan revenue. First, MA plans must meet a minimum Medical Loss Ratio ("MLR") threshold of 85%. Additionally, MA plans deploy programs such as population health, utilization management and provider network design that increase quality and lower cost in relation to traditional FFS Medicare.

Further investigation that accounts for these issues should be pursued before any conclusions about the level or effect of selection into MA are drawn, or any changes to Medicare are pursued. Modifying a system that is poorly understood can lead to a range of unintended consequences that could adversely impact millions of American seniors who currently rely on the program.

Appendix

Background on MA

a. History

Private plans have played a role in the Medicare program for much its existence. They were included originally as a convenience for beneficiaries who had a pre-existing private plan in their retirement provided by their employer. Advocates argued that private plans could provide competition and choice to Medicare beneficiaries, lower costs for taxpayers and offer more innovation than FFS Medicare.[71]

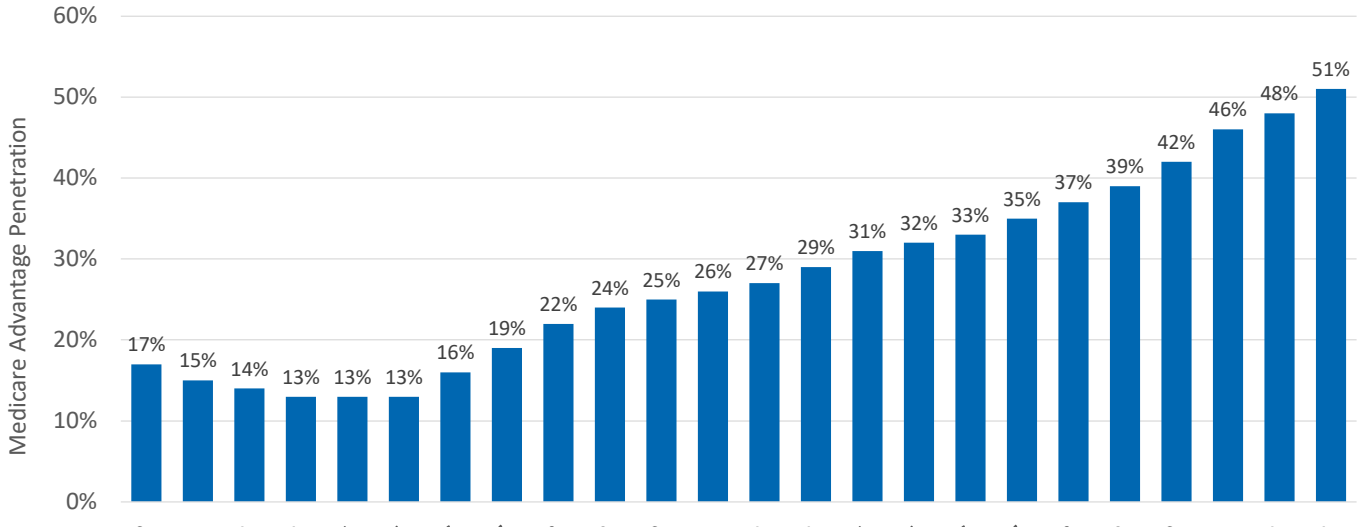
The history of MA can be characterized by a legislative push and pull that reduced payments when they were thought to be too high and increased them when they were considered too low. From 1982-1997, private plans were an official component of Medicare and were paid a flat 95% of the cost of the average beneficiary in FFS Medicare in the same age and gender group. Studies concluded that private plans were paid between 5% and 15% more than FFS would have paid.[72,73]

In 1997, responding to concerns about solvency, overpayments, and favorable selection, the Balanced Budget Act of 1997 reworked payment formulas, established new risk-adjustment measures that focused on health status, and created an annual enrollment period to limit frequent mid-year changes.[74] The private plan element of Medicare was dubbed Medicare + Choice. After these changes were implemented, Medicare spending shrank, and private plans' popularity fell.[75]

The 2003 Medicare Prescription Drug, Improvement, and Modernization Act instituted several reforms, including renaming the program to Medicare Advantage, when it also modified risk adjustments and reimbursements, setting minimum plan payments at 100% of FFS.[76] The reforms raised plan payments. The MMA also established the Medicare Part D prescription drug program and created two more Part C plan types: Regional Preferred Provider Organizations (RPPOs) and Special Needs Plans (SNPs).[77]

The Affordable Care Act (2010) reduced payments to MA plans by modifying benchmarks based on the patient costs for each county and added quality bonuses.[78] Since then, payments have fallen, but, contrary to expectations, enrollment has grown considerably.[79]

Figure A1: MA Enrollment, as a Percentage of Total Medicare Enrollment 2000-2023[80]



Medicare Advantage has grown from accounting for just over 5% of Medicare beneficiaries in 1992 to just over 50% in 2024.[81] Growth was significant between 1992 and 1997, stalled after the passage of the Balanced Budget Act in 1997, and then grew consistently after the Medicare Modernization Act despite the cuts implemented by the ACA, and as of July 2024, 33.6 million people were enrolled in a MA Plan.[82]

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