

CHAPTER

13

**The Medicare Advantage
program: Status report**

R E C O M M E N D A T I O N S

(The Commission reiterates its March 2014 recommendations on improving the bidding rules in the Medicare Advantage (MA) program and integrating hospice care into the MA benefit package. See text box, pp. 340–341.)

The Medicare Advantage program: Status report

Chapter summary

Each year, the Commission provides a status report on the Medicare Advantage (MA) program. In 2014, the MA program included 3,600 plan options, enrolled more than 15.8 million beneficiaries (30 percent of all beneficiaries), and paid MA plans about \$159 billion to cover Part A and Part B services. To monitor program performance, we examine MA enrollment trends, plan availability for the coming year, and payments for MA plan enrollees relative to spending for fee-for-service (FFS) Medicare beneficiaries. We also provide an update on current quality indicators in MA.

The MA program gives Medicare beneficiaries the option of receiving benefits from private plans rather than the traditional FFS Medicare program. The Commission supports the inclusion of private plans in the Medicare program; beneficiaries should be able to choose between the traditional FFS Medicare program and alternative delivery systems that private plans can provide. Because Medicare pays private plans a per person predetermined rate rather than a per service rate, plans have greater incentives to innovate and use care-management techniques.

The Commission has emphasized the importance of imposing fiscal pressure on all providers of care to improve efficiency and reduce Medicare program costs. For MA, the Commission recommended that benchmarks be brought

In this chapter

- Trends in enrollment, plan availability, payments, and risk coding
- Quality in the Medicare Advantage program

down from previous high levels and be set so that the payment system is neutral and does not favor either MA or the traditional FFS program. Recent legislation has reduced the inequity in Medicare spending between MA and FFS. As a result, over the past few years, plan bids and payments have come down in relation to FFS spending while enrollment in MA continues to grow. The pressure of competitive bidding and lower benchmarks has led to either improved efficiency or lower margins that enable MA plans to continue to increase MA enrollment by offering packages that beneficiaries find attractive.

Previously, the Commission has recommended that pay-for-performance programs be instituted in Medicare to promote quality, with the expected added benefit of improving efficiency by reducing unnecessary program costs. The Congress instituted a quality bonus program for MA in the Patient Protection and Affordable Care Act of 2010, with bonuses available beginning in 2012. The data on quality indicate that plans are responding to the legislation by paying closer attention to the subset of quality measures that are the basis of bonus payments. More plans have achieved quality ratings that would permit bonuses under the statutory provisions.

Enrollment—Between 2013 and 2014, enrollment in MA plans grew by about 9 percent (or 1.3 million enrollees) to 15.8 million enrollees. About 30 percent of all Medicare beneficiaries were enrolled in MA plans in 2014, up from 28 percent in 2013. Among plan types, HMOs continued to enroll the most beneficiaries (10.4 million), with 19 percent of all Medicare beneficiaries in HMOs in 2014. Between 2013 and 2014, enrollment in local preferred provider organizations (PPOs) increased by about 15 percent and in regional PPOs by about 11 percent. As expected, because of legislation effective in 2010, enrollment in private fee-for-service (PFFS) plans continued to decrease from a high of 2.4 million enrollees in 2009 to about 300,000 enrollees in 2014.

Plan availability—Access to MA plans remains high in 2015, with most Medicare beneficiaries having access to a large number of plans. Almost all beneficiaries have had access to some type of MA plan since 2006, and HMOs and local PPOs have become more widely available in the past few years. Ninety-five percent of Medicare beneficiaries have an HMO or local PPO plan operating in their county of residence, the same as in 2014 and up from 67 percent in 2005. Regional PPOs are available to 70 percent of beneficiaries. Access to PFFS plans decreased as expected between 2014 and 2015, from 53 percent to 47 percent of beneficiaries. Overall, 99 percent of all Medicare beneficiaries have access to an MA plan.

Plan payments—For 2015, the base county benchmarks (in nominal dollars and before any quality bonuses are applied) average approximately 5.5 percent

lower than the benchmarks for 2014. However, as part of the benchmark-setting process, the risk scores used to calculate payments were renormalized, resulting in an approximate increase of 5 percent. The average nominal bid did not increase between 2014 and 2015. We estimate that 2015 MA benchmarks (including quality bonuses), bids, and payments will average 107 percent, 94 percent, and 102 percent of FFS spending, respectively.

Risk adjustment and coding intensity—Medicare payments to plans for an enrollee are based on the plan’s payment rate and the enrollee’s risk score. The risk scores are based on diagnoses attributed to the beneficiary during the year before the payment year. To receive the maximum payment they may rightfully claim, plans have an incentive to ensure that providers serving the beneficiary record all diagnoses completely. Analyses have shown that MA plan enrollees have higher risk scores than otherwise similar FFS beneficiaries because of more complete coding. As mandated by the Deficit Reduction Act of 2005, CMS makes an across-the-board adjustment to the scores to make them more consistent with FFS coding practices. We find that if CMS raised the coding adjustment (i.e., lowered risk scores) by about 3 percent, the aggregate level of coding in the FFS and MA programs would be roughly equal.

Quality measures—A comparison of the most current results for MA quality indicators relative to last year shows that there was improvement in many measures, a decline in mental health measures, and no change in a large proportion of measures. MA plans are able to receive bonus payments if they achieve an overall rating of 4 stars or higher on CMS’s 5-star rating system. Although the distribution of plans at different star levels changed between the 2014 star ratings and the 2015 star ratings, there was little change in average star ratings. For plans receiving ratings for both 2014 and 2015, there was virtually no difference between average star ratings for 2014 (3.88) and the ratings for 2015 (3.91). Only a subset of measures is included in determining the overall star rating. For measures included in the star ratings, the majority improved. If including measures in the star ratings makes them more likely to improve, it may be reasonable to include the mental health measures that have been declining for several years.

Responding to an industry concern that the star rating system has a systematic bias against plans that serve low-income beneficiaries, CMS issued a request for information asking plans for data that can show a causal connection between the low-income status of a plan’s enrollees and the plan’s performance in star ratings. In addition to the association with the low-income status of enrollees, our analysis finds an association between a plan’s star ratings and the share of MA enrollees in a plan who are under age 65.

Plan margins—For this annual status report, we include a new element in our analysis of the MA program. To report on plan margins, we use historical data reported by plans in their MA bids. The analysis shows that, on average, companies participating in MA in 2012 had a margin of 4.9 percent. About 91 percent of enrollment was in companies reporting a positive margin. There were differences by plan type: Employer group plans had higher margins than plans for individual Medicare beneficiaries; for-profit plans had higher margins than nonprofit plans; and special needs plans (SNPs) had higher margins than non-SNP plans, except that nonprofit SNP plans reported a slight negative margin.

Plan switching—CMS data show that in 2012, about 10 percent of beneficiaries voluntarily changed their MA plan. Of that number, 80 percent chose another MA plan and the remaining 20 percent went to FFS Medicare—meaning that only 2 percent of MA enrollees left MA for FFS. Among the switchers who faced changes in plan premiums, the large majority switched to a plan with a lower premium.

Plan options and the Medicare website’s display of beneficiary choices—Medicare’s Plan Finder website helps Medicare beneficiaries choose among plans based on cost and quality. For plans offering a reduction in the Part B premium, the manner of displaying premium information can be improved to make beneficiaries more aware of the existence of such an option and its cost. The display should show a beneficiary’s total premium obligation, including the Part B premium. Because plans have different options for providing extra benefits financed by rebate dollars, there should be an examination of the different incentives plans have in choosing among those options. ■

Background

The Medicare Advantage (MA) program allows Medicare beneficiaries to receive benefits from private plans rather than the traditional fee-for-service (FFS) program. In 2014, the MA program included 3,600 plan options, enrolled more than 15.8 million beneficiaries (30 percent of all beneficiaries), and paid MA plans about \$159 billion to cover Part A and Part B services. The Commission supports including private plans in the Medicare program because they allow beneficiaries to choose between FFS Medicare and alternative delivery systems that private plans can provide. Plans often have flexibility in payment methods, including the ability to negotiate with individual providers; care-management techniques that fill potential gaps in care delivery (e.g., programs focused on preventing avoidable hospital readmissions); and robust information systems that provide more timely feedback to providers. Plans can also reward beneficiaries for seeking care from more efficient providers and give beneficiaries more predictable cost sharing, but plans often restrict the choice of providers.

By contrast, traditional FFS Medicare has lower administrative costs and offers beneficiaries an unconstrained choice of health care providers, but it lacks incentives to coordinate care and is limited in its ability to modify care delivery. Because private plans and traditional FFS Medicare have structural aspects that appeal to different segments of the Medicare population, we favor providing a financially neutral choice between private MA plans and traditional FFS Medicare. Medicare's payment systems should not unduly favor one component of the program over the other.

Efficient MA plans may be able to capitalize on their administrative flexibility to provide better value to beneficiaries who enroll in their plans. However, some of the extra benefits that MA plans provide their enrollees result from payments that would have been lower under FFS Medicare for similar beneficiaries. Thus, those benefits are financed by higher government spending and higher beneficiary Part B premiums (including for those who are in traditional FFS Medicare) at a time when Medicare and its beneficiaries are under increasing financial stress. To encourage efficiency and innovation, MA plans need to face some degree of financial pressure, just as the Commission has recommended for providers in the traditional FFS program. One method of achieving financial neutrality is to link private plans' payments more closely to FFS Medicare

costs within the same market. Alternately, neutrality can be achieved by establishing a government contribution that is equally available for enrollment in either FFS Medicare or an MA plan. The Commission will continue to monitor the effect of the changes mandated by the Patient Protection and Affordable Care Act of 2010 (PPACA) on plan payments and performance and to track progress toward financial neutrality.

Each year, the Commission provides a status report on the MA program. To monitor program performance, we examine MA enrollment trends, plan availability for the coming year, and payments for MA plan enrollees relative to spending for FFS Medicare beneficiaries. We also provide an update on current quality indicators in MA.

Trends in enrollment, plan availability, payments, and risk coding

In contrast to traditional FFS Medicare, MA enrolls beneficiaries in several types of private health plans. Medicare pays plans a fixed rate per enrollee rather than a fixed rate per service.

Types of MA plans

Our analysis of the MA program uses the most recent data available and reports results by plan type. The plan types are:

- **HMOs and local preferred provider organizations (PPOs)**—These plans have provider networks and can use tools such as selective contracting and utilization management to coordinate and manage care and control service use. They can choose individual counties to serve and can vary their premiums and benefits across counties. These two plan types are classified as coordinated care plans (CCPs).
- **Regional PPOs**—These plans are required to offer a uniform benefit package and premium across designated regions made up of one or more states. Regional PPOs have more flexible network requirements than local PPOs. Regional PPOs are also classified as CCPs.
- **Private FFS (PFFS) plans**—PFFS plans are not classified as CCPs. Before 2011, PFFS plans typically did not have provider networks, making them less able than other plan types to coordinate care. They usually paid providers Medicare's FFS payment rates (instead of negotiated rates) and had fewer quality

**TABLE
13-1**

Medicare Advantage plan enrollment continued to grow faster than total Medicare beneficiary growth in 2014

	MA enrollment (in millions)		Percent change in enrollment	2014 MA enrollment as a share of total Medicare
	November 2013	November 2014		
Total	14.5	15.8	9%	30%
Plan type				
CCP	14.2	15.5	11	29
HMO	9.7	10.4	7	19
Local PPO	3.3	3.8	15	7
Regional PPO	1.1	1.3	11	2
PFFS	0.4	0.3	-21	1
Restricted availability plans included in totals above				
SNPs*	1.9	2.1	12	4
Employer group*	2.7	3.1	16	6
Urban/rural				Share of Medicare population in MA
Urban	12.8	13.9	8	32
Rural	1.7	1.9	11	20

Note: MA (Medicare Advantage), CCP (coordinated care plan), PPO (preferred provider organization), PFFS (private fee-for-service), SNPs (special needs plans). CCP includes HMO, local PPO, and regional PPO plans. The sum of column components may not equal the stated total due to rounding.
* SNPs and employer group plans have restricted availability. Their enrollment is included in the statistics by plan type and location. We present them separately to provide a more complete picture of the MA program.

Source: MedPAC analysis of CMS enrollment files.

reporting requirements. Because PFFS plans generally lacked care coordination, had lower quality measures than CCPs on the measures they reported, paid Medicare FFS rates, and had higher administrative costs than traditional FFS Medicare, they were viewed as providing little value. In response, the Medicare Improvements for Patients and Providers Act of 2008 required that, in areas with two or more network MA plans, PFFS plans can be offered only if they have provider networks. PFFS plans are also now required to participate in quality reporting. Existing PFFS plans had to either locate in areas with fewer than two network plans or develop provider networks themselves, which in effect would change them into PPOs or HMOs, or they would operate as network-based PFFS plans.

Two additional plan classifications cut across plan types. Special needs plans (SNPs) are one of these classifications; they offer benefit packages tailored to specific populations (those beneficiaries who are dually

eligible for Medicare and Medicaid, are institutionalized, or have certain chronic conditions). SNPs must be CCPs. The second classification is employer group plans, which are available only to Medicare beneficiaries who are members of employer or union groups that contract with those plans. Employer group plans are all CCPs. Both SNPs and employer group plans are included in our plan data, with the exception of plan availability figures because these plans are not available to all beneficiaries. (See the Commission’s March 2013 report to the Congress for a full chapter on SNPs.)

How Medicare pays MA plans

Plan payment rates are determined by the MA plan bid (the dollar amount the plan estimates will cover the Part A and Part B benefit package for a beneficiary of average health status) and the payment area’s benchmark (the maximum amount of Medicare payment set by law for an MA plan to provide Part A and Part B benefits). Plans with higher quality ratings are rewarded with a higher

benchmark. If a plan's bid is above the benchmark, its MA payment rate is equal to the benchmark and enrollees have to pay a premium equal to the difference. If a plan's bid is below the benchmark, its payment rate is its bid plus a percentage (between 50 percent and 70 percent in 2014 and thereafter, depending on a plan's quality ratings) of the difference between the plan's bid and the benchmark; the beneficiary pays no premium to the plan for the Part A and Part B benefits (but continues to be responsible for payment of the Medicare Part B premium and may pay premiums to the plan for additional benefits). The payment amount above the bid is referred to as the rebate. The rebate must be used by the plan to provide additional benefits to the enrollees in the form of lower cost sharing, lower premiums, or supplemental benefits. (A more detailed description of the MA program payment system can be found at <http://medpac.gov/documents/payment-basics/medicare-advantage-program-payment-system-14.pdf?sfvrsn=0>.)

Because benchmarks are often set well above what it costs Medicare to provide benefits to similar beneficiaries in the FFS program, MA payment rates usually exceed FFS spending. In past reports, we examined why benchmarks are above FFS spending and what the ramifications are for the Medicare program. In 2014, Part A and Part B payments to MA plans totaled approximately \$159 billion.

MA plan enrollment growth

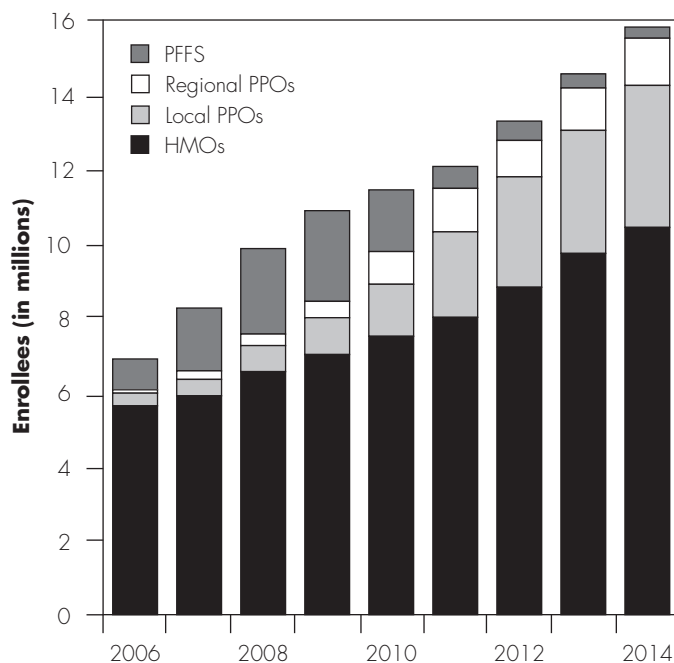
Between November 2013 and November 2014, enrollment in MA plans grew by about 9 percent—or 1.3 million enrollees—to 15.8 million enrollees (compared with growth of about 3 percent in the same period for the total Medicare population). About 30 percent of all Medicare beneficiaries were enrolled in MA plans in 2014, up from 28 percent in 2013 (Table 13-1).

Among plan types, HMOs continued to enroll the most beneficiaries (10.4 million), with 19 percent of all Medicare beneficiaries in HMOs in 2014. Between 2013 and 2014, enrollment in local PPOs continued to grow, by about 15 percent. Regional PPO enrollment increased by about 11 percent. As expected because of legislation effective in 2010, PFFS enrollment continued to decrease from a high of 2.4 million enrollees in 2009 to about 300,000 enrollees in 2014 (Figure 13-1). In 2014, SNP enrollment grew by 12 percent and employer group enrollment grew by 16 percent.

Enrollment patterns differ in urban and rural areas. A larger share of urban beneficiaries are enrolled in MA

FIGURE 13-1

Medicare Advantage enrollment, 2006–2014



Note: PFFS (private fee-for-service), PPO (preferred provider organization).

Source: MedPAC analysis of CMS enrollment files.

(about 32 percent) compared with beneficiaries residing in rural counties (about 20 percent). About one-third of rural MA enrollees were in HMO plans (not shown in Table 13-1) compared with about 70 percent of urban enrollees. By contrast, 7 percent of rural enrollees were in PFFS plans compared with 1 percent of urban enrollees.

The percentage of Medicare beneficiaries enrolled in MA plans in 2014 varied widely by geography. In some metropolitan areas, less than 1 percent of Medicare beneficiaries were enrolled in MA plans (Anchorage, AK), whereas in other areas, enrollment was 60 percent or more (Miami, FL; Pittsburgh, PA; Rochester, NY; and several areas in Puerto Rico).

Growth in MA enrollment in 2014 continued a trend begun in 2003. Since 2003, enrollment has more than tripled. We did not have final 2015 enrollment information as of this report's publication, but plans project overall enrollment growth of 3 percent to 5 percent for 2015. Plan bids for 2014 projected similar growth, but actual growth was 9 percent. Trends vary by plan type. HMOs have grown steadily each year since 2003, but their market

New enrollees in Medicare Advantage and plan switching among Medicare Advantage enrollees

New Medicare beneficiaries do not account for most enrollment growth

Some observers have suggested that half of beneficiaries immediately join Medicare Advantage (MA) plans upon becoming eligible for Medicare. However, our analysis finds that instead, beneficiaries often wait until they are in their late 60s and early 70s, have experienced one or more MA open enrollment periods, and then switch out of fee-for-service (FFS) Medicare. For example, of the 2.5 million beneficiaries new to Medicare in 2012, only 600,000, or 24 percent, enrolled in MA.

The fact that many individuals do not enroll in MA immediately upon their eligibility for Medicare suggests that beneficiaries may not focus on that choice until they have some experience with cost sharing in FFS Medicare or with the widespread marketing that occurs during an MA open enrollment period. These experiences may be important for beneficiaries to understand fully the options between traditional Medicare and MA plans. Medicare may wish to ensure that marketing materials for new entrants to Medicare explain these options more clearly.

Plan switching among Medicare Advantage enrollees

In 2012, CMS data show that 10 percent of beneficiaries in MA voluntarily chose to leave their MA plan to enroll in another MA plan or elected FFS Medicare (excluding those who moved from their plan's service area and beneficiaries enrolled in employer group MA plans). The Commission's analysis of these data shows

that, within that 10 percent, only a small fraction (2 percent of total MA enrollment) moved to traditional FFS Medicare; the rest left one MA plan to join a different MA plan. That is, among the nearly 14 million MA enrollees in 2012, 98 percent remained in MA in their same plan or in another MA plan. Beneficiaries who voluntarily leave MA do not have a right of guaranteed issue of a medigap plan (except in limited circumstances); for beneficiaries who wish to have supplemental coverage, this risk may make FFS less attractive than changing to another MA plan.

We found that when there is plan switching within MA, enrollees generally changed plans to obtain a lower premium or because their current plan increased its premiums. Of the 1.4 million beneficiaries who voluntarily changed their MA status in 2012, 762,000 beneficiaries with no low-income subsidy (LIS) did so during the annual election period (a change effective December 31, 2012). We remove LIS beneficiaries from consideration because the subsidization of the Part D premium in certain plans is a complicating factor. We also remove from the 762,000 number those beneficiaries:

- whose election was a move from MA to FFS,
- who changed their Part D status (e.g., moved from an MA-only plan, with no drug coverage, to a Medicare Advantage–Prescription Drug [plan] (MA–PD)), or
- for whom we do not have premium data in both years.

(continued next page)

share declined between 2006 and 2008, when PFFS plans grew rapidly (Figure 13-1, p. 321). PFFS enrollment plateaued in 2008 and 2009 and then declined as legislated requirements for PFFS plans began to take effect. While enrollment in PFFS declined, enrollment in both local and regional PPOs began to grow.

We have also examined enrollment trends among new beneficiaries and the switching behavior of MA enrollees (see text box).

Plan availability for 2015

Every year, we assess plan availability and projected enrollment for the coming year based on the bid data that plans submit to CMS. We find that access to MA plans remains high in 2015, with most Medicare beneficiaries having access to a large number of plans. While almost all beneficiaries have had access to some type of MA plan since 2006, local CCPs have become more widely available in the past few years (Table 13-3, p. 324). In

New enrollees in Medicare Advantage and plan switching among Medicare Advantage enrollees (cont.)

The remaining number is 436,000 beneficiaries for whom we could determine whether their move from one MA plan to another resulted in a lower premium. Among those 436,000 beneficiaries, 35 percent (151,000) who voluntarily disenrolled from an MA plan in December 2012 moved from a plan that had a zero premium in 2013 to a different plan that also had a zero premium in 2013 (Table 13-2). For each of the remaining categories of beneficiaries, in the majority of cases, the beneficiary's change of plan resulted in a lower premium. For example, the largest category of beneficiaries in the data we examined consisted of

220,000 beneficiaries who were in a plan that raised its premium in 2013. For this group, 90 percent of the beneficiaries who disenrolled from a plan moved to a different plan with a lower premium than they would have paid if they had they remained in their original plan. However, our analysis includes only beneficiaries who decided to make a plan change. The majority of beneficiaries remained in their MA plans, and many of those beneficiaries faced premium increases but decided to remain in their plan even when a lower priced option was available. ■

**TABLE
13-2**

Beneficiaries who switch plans during open enrollment generally do so to have lower premiums

	Beneficiaries (in thousands)	Within group, percent of beneficiaries moving to lower premium plan
Zero-premium and Part B–premium-reduction plans		
Changed from zero-premium plan to new zero-premium plan	151	N/A
Change involved Part B–premium-reduction plans	40	71%
Plans charging a premium		
Original plan premium did not change	14	85
Original plan premium decreased in 2013	11	71
Original plan premium increased in 2013	220	90

Note: N/A (not applicable). A Part B–premium-reduction plan has no Medicare Advantage plan premium and reduces all or part of an enrollee's Part B premium. Changes involving a Part B–premium-reduction plan include a plan's discontinuance of the option, a plan's introduction of the option, and a beneficiary changing to or from a Part B–premium-reduction plan. Data are for a subset of beneficiaries choosing a different option during the annual election period.

Source: MedPAC analysis of CMS voluntary disenrollment data for 2012.

2015, 95 percent of Medicare beneficiaries have an HMO or local PPO plan operating in their county of residence, the same as in 2014 and up from 67 percent in 2005. Regional PPOs are available to 70 percent of beneficiaries. As expected, access to PFFS plans decreased between 2014 and 2015, from 53 percent to 47 percent of beneficiaries. Overall, 99 percent of all Medicare beneficiaries have access to an MA plan, and 98 percent have access to a CCP (not shown in Table 13-3, p. 324).

In 2015, 78 percent of Medicare beneficiaries have access to at least one MA plan that includes Part D drug coverage

and charges no premium (beyond the Medicare Part B premium) compared with 84 percent in 2014. Many beneficiaries have access to plans that offer a reduction in the Part B premium, though they may not be aware of the option (see text box about Part B–premium-reduction plans, pp. 326–327).

We had been using the “zero-premium plan with drugs” measure as an indication of the availability of very generous plans. However, the measure is subject to relatively wide swings based on the yearly pricing strategies of a few plan sponsors. Plan sponsors may

**TABLE
13-3****Access to Medicare Advantage plans remains high****Percent of beneficiaries with access to MA plans by type**

Type of plan	2005	2010	2011	2012	2013	2014	2015
Any MA plan	84%	100%	100%	100%	100%	100%	99%
Local CCP	67	91	92	93	95	95	95
Regional PPO	N/A	86	86	76	71	71	70
PFFS	45	100	63	60	59	53	47
Zero-premium plan with drugs	N/A	85	90	88	86	84	78
Average number of choices	5	21	12	12	12	10	9
Average rebate for nonemployer, non-SNP plans	N/A	\$74	\$83	\$85	\$81	\$75	\$76

Note: MA (Medicare Advantage), CCP (coordinated care plan), PPO (preferred provider organization), N/A (not applicable), PFFS (private fee-for-service), SNP (special needs plan). CCPs include HMO, local PPO, and regional PPO plans. These figures exclude special needs plans and employer-only plans. A zero-premium plan with drugs includes Part D coverage and has no premium beyond the Part B premium. Regional PPOs were created in 2006. Rebates began in 2006. Part D began in 2006.

Source: MedPAC analysis of CMS bid data and population reports.

believe that beneficiaries are more willing to pay a premium to enroll in higher value plans than previously thought. In any event, perhaps the best summary measure of plan generosity is the average rebate, which plans receive to provide additional benefits. The last row of Table 13-3 shows the average rebates for nonemployer, non-SNP plans. For 2015, rebates (which can include allocations to plan administration and profit) for nonemployer, non-SNP plans average \$76 per enrollee per month. The rebates were at roughly the same level as 2014 and 2010 but were lower than the peak years around 2012.

The availability of SNPs has changed slightly and varies by the type of special needs population served (not shown in Table 13-3). In 2015, 82 percent of beneficiaries reside in areas where SNPs serve beneficiaries who are dually eligible for Medicare and Medicaid (the same as in 2014), 47 percent live where SNPs serve institutionalized beneficiaries (also the same as in 2014), and 55 percent live where SNPs serve beneficiaries with chronic conditions (up from 51 percent in 2014). Overall, 86 percent of beneficiaries reside in counties served by at least one type of SNP.

In most counties, a large number of MA plans are available to beneficiaries. For example, beneficiaries in New York City can choose from more than 40 plans in 2015. At the other end of the spectrum, over 200 counties, representing 1 percent of beneficiaries, have no MA plans available; however, many of these beneficiaries have

the option of joining cost plans (another managed care option under Medicare).¹ On average, 9 plans, including 8 CCPs, are offered in each county in 2015, down from 10 plans and 8 CCPs in 2014 (Table 13-3 does not break out CCPs). Plan availability could also be calculated using weights based on the number of beneficiaries living in the county, thus framing the measure as the number of plan choices available to the average beneficiary. According to that calculation, the average beneficiary has 17 plans—including 16 CCPs—available in 2015, down from 18 plans—including 16 CCPs—in 2014. Regardless of the approach to calculating plan availability, the decrease in plan choices from 2010 to 2015 was due to the reduction in PFFS and regional PPO plan choices.

2015 benchmarks, bids, and payments relative to FFS spending

Using plans' bid projections, we compare the Medicare program's projected MA spending with projected FFS spending on a like set of FFS beneficiaries. We calculate and present three sets of percentages: the benchmarks relative to projected FFS spending, the bids relative to projected FFS spending, and the resulting payments to MA plans relative to projected FFS spending. Benchmarks are set each April for the following calendar year. Plans submit their bids in June, incorporating the recently released benchmarks. Benchmarks reflect FFS spending estimates for 2015 made by the CMS actuaries at the time the benchmarks were published in April 2014.

**TABLE
13-4**

Projected payments are at or above FFS spending for all plan types in 2015

Percent of FFS spending in 2015

Plan type	Benchmarks*	Bids	Payments
All MA plans	107%	94%	102%
HMO	106	90	101
Local PPO	109	107	107
Regional PPO	102	97	100
PFFS	111	108	111
Restricted availability plans included in totals above			
SNP**	106	93	101
Employer groups**	108	105	106

Note: FFS (fee-for-service), MA (Medicare Advantage), PPO (preferred provider organization), PFFS (private fee-for-service), SNP (special needs plan). Benchmarks are the maximum Medicare program payments for MA plans and incorporate plan quality bonuses. We estimate FFS spending by county using the 2015 MA rate book. We removed spending related to the remaining double payment for indirect medical education payments made to teaching hospitals.

* Benchmarks include quality bonuses.

** SNPs and employer group plans have restricted availability, and their enrollment is included in the statistics by plan type. We have broken them out separately to provide a more complete picture of the MA program.

Source: MedPAC analysis of data from CMS on plan bids, enrollment, benchmarks, and fee-for-service expenditures.

We estimate that 2015 MA benchmarks (including quality bonuses), bids, and payments will average 107 percent, 94 percent, and 102 percent of FFS spending, respectively (Table 13-4). Last year, we estimated that for 2014, these figures would be 112 percent, 98 percent, and 106 percent, respectively. The primary reason for this movement in the ratios is the 5.5 percent decline in the base benchmarks (that is, benchmarks before adding in quality bonuses). These effects, however, are partly (or may be fully) offset by changes in the risk-adjustment calculations and risk-coding intensity.

MA benchmarks

Under PPACA, county benchmarks in 2015 are transitioning to a system in which each county’s benchmark in 2017, excluding quality bonuses, will be a certain percentage (ranging from 95 percent to 115 percent) of the average per capita FFS Medicare spending for the county’s residents. Counties are ranked by average FFS spending; the highest spending quartile of counties would have benchmarks set at 95 percent of local FFS spending, and the lowest spending quartile would have benchmarks set at 115 percent of local FFS spending. The transition from old benchmarks will be complete by 2017. (See the Commission’s March 2011 report for more details on PPACA benchmark changes.) In 2015, more than three-quarters of all counties have base benchmarks

(not including quality payments in the base) that have fully transitioned to the final PPACA levels. These counties include 67 percent of all Medicare beneficiaries and 62 percent of all MA enrollees. Overall, more than three-quarters of the base benchmark transition has occurred:

- In 2011, plan base benchmarks averaged 113 percent of FFS spending.
- In 2015, plan base benchmarks averaged 104 percent of FFS spending.
- In 2017, fully transitioned base benchmarks are expected to average about 101.5 percent of FFS spending.

For 2015, the base county benchmarks (in nominal dollars and before any quality bonuses are applied) average approximately 5.5 percent less than the benchmarks for 2014. However, as part of the benchmark-setting process, the risk-score normalization factor was lowered significantly, resulting in an approximate increase in payment risk scores of 5 percent. (These changes raise the standardized spending for both FFS Medicare and MA. The effect of this restandardization of payments is to raise payments for MA enrollees by 5 percent but leave the ratio with FFS Medicare unchanged.) Also, for 2015, 59 percent of MA enrollees are projected to be in plans that will

Displaying information about Part B–premium-reduction plans in Medicare Advantage

When plans bid below Medicare Advantage (MA) benchmarks and have rebate dollars to provide extra benefits, one of the options a plan has is to reduce the monthly Part B premium for an enrollee. In 2014, Part B premium reductions of \$10 or more per month were available in 162 counties in 12 states, representing 23 percent of the Medicare population (excluding dual-eligible special needs plans (D–SNPs) for beneficiaries dually eligible for Medicare and Medicaid and plans in Puerto Rico, where special circumstances exist). Of the 250,000 beneficiaries enrolled in such plans, 89 percent were enrolled in Florida plans, where half of the Part B–premium-reduction plan enrollees had reductions of \$80 or more per month. In 2015, a Part B–premium-reduction option will be available in 346 counties in 11 states, representing 27 percent of the Medicare population (excluding beneficiaries in Puerto Rico and D–SNPs). In 2015, plan options in which the entire (standard) Part B premium has been reduced to zero are available in 20 counties in the country, all of which are in Florida. For 10 of the 20 counties, only 1 of the 3 to 11 companies operating in the county offers a Part B–premium reduction of more than \$25, and the distribution was similar in the preceding year, suggesting that plans do not feel competitive pressure to offer a significant Part B premium reduction if another plan in the area is doing so.

When considering a Part B–premium-reduction plan, a beneficiary often must make a choice between a fixed amount of monthly savings because of a reduced premium and a variable or uncertain amount in possible out-of-pocket costs. MA organizations offering Part B–premium-reduction plans frequently offer plans in the same service area without a Part B premium reduction but with lower cost sharing for covered services. Beneficiaries can evaluate these choices using Medicare’s Medicare.gov Plan Finder website. The website provides certain tools that help the beneficiary, but the tools provided can be improved.

The default sorting in Plan Finder ranks plans from least costly to most costly, taking into account any Medicare Part B premium reduction, any plan premium, and other expected out-of-pocket costs. A beneficiary can specify his or her health status, which will change the expected out-of-pocket costs. When the initial set of plan options is displayed, it is not immediately evident whether a Part B–premium-reduction plan is available. The display shows the Part B premium for Medicare FFS and premiums for plans—without also showing that the total premium obligation for plans is the plan premium plus the Part B premium. A beneficiary wishing to choose between a lower Part B premium, on the one hand, and lower cost sharing, on the other, would have to take an additional

(continued next page)

receive add-ons to their benchmarks through the PPACA quality bonus provisions. These quality bonus add-ons range from 5 percent to 10 percent. On average, the quality bonuses added 3 percent to the benchmarks in 2015.

Benchmarks for regional plans are based on a weighted average of benchmarks for counties in the region and bids submitted by the regional PPOs. For 2015, regional plans submitted bids in 17 of 26 regions. In 15 of the 17 regions, the average bids were below the region’s average benchmark, so benchmarks for those regions were reduced. As a result, the average regional PPO benchmark (weighted by projected enrollment) was 102 percent of

FFS spending compared with the overall average of 107 percent of FFS spending.

MA bids and payments for different plan types

The modest growth in benchmarks over the past few years may have exerted fiscal pressure on MA plans and encouraged them to better control costs and restrain growth in their bids. The average bid did not increase between 2014 and 2015. The average bid for 2015 is 94 percent of the projected FFS spending for similar beneficiaries. About 62 percent of nonemployer plans bid to provide Part A and Part B benefits for less than what the FFS Medicare program would spend to provide these

Displaying information about Part B–premium-reduction plans in Medicare Advantage (cont.)

step to determine that a reduced Part B premium is one of the factors contributing to the overall expected costs displayed for a given plan. In addition, the beneficiary is not able to search specifically for a Part B–premium-reduction plan. When a beneficiary does arrive at the second level of the display of plan features, the Part B premium for a Part B–premium-reduction plan is shown as an amount less than the standard Part B premium, and the plan premium (if other than zero) is also shown. The plan premium for an MA plan with Part D prescription drug coverage is shown as a total plan premium along with two amounts also shown, the drug component (Part D) and the “health” component (Part C). There are thus three possible pieces of premium information that a beneficiary sees, but not a statement of the total premium obligation (total Part B premium plus any plan premiums). (These issues, and the tendency for plans to add extra benefits rather than reduce the Part B premium, are discussed in a recent article by Stockley and colleagues (Stockley et al. 2014).)

In our interviews with insurance brokers, the brokers noted that Part B–premium-reduction plans were important in some parts of the country and were most attractive to low-income beneficiaries. However, when plans have rebate dollars to provide extra benefits,

the type of benefit that a plan chooses to offer may be affected by whether there is a “load” on the benefit. If plans provide a Part B premium reduction with rebate dollars, there is no load on the benefit—that is, unlike benefits such as reduced cost sharing or added non-Medicare benefits, the plan’s bid for the extra benefit cannot have any administrative costs or margin amount included. The lack of load may help explain why Part B–premium-reduction plans are not more widely available.

Even where Part B–premium-reduction plans are available, beneficiary enrollment in such plans is limited. In counties with the option available, 7 percent of MA enrollees choose this option. Enrollment might be limited because beneficiaries are able to weigh this option against other options better suited to their needs (such as a plan with lower cost sharing for medical services) or because the presentation of this option lacks transparency. To address the transparency problem, CMS should revise the Medicare.gov display to provide clearer information about total expected cost sharing and the total monthly premium for each MA plan, including the net Part B premium. There should also be an examination of the different incentives that plans have in choosing among the options for providing extra benefits financed by rebate dollars. ■

benefits. These plans are projected to enroll 66 percent of nonemployer MA enrollees in 2015. About 1 million beneficiaries, excluding those enrolled in employer group MA plans, are projected to enroll in plans that bid lower than 75 percent of FFS spending, while a similar number of beneficiaries are projected to enroll in plans that bid at least 110 percent of FFS spending.

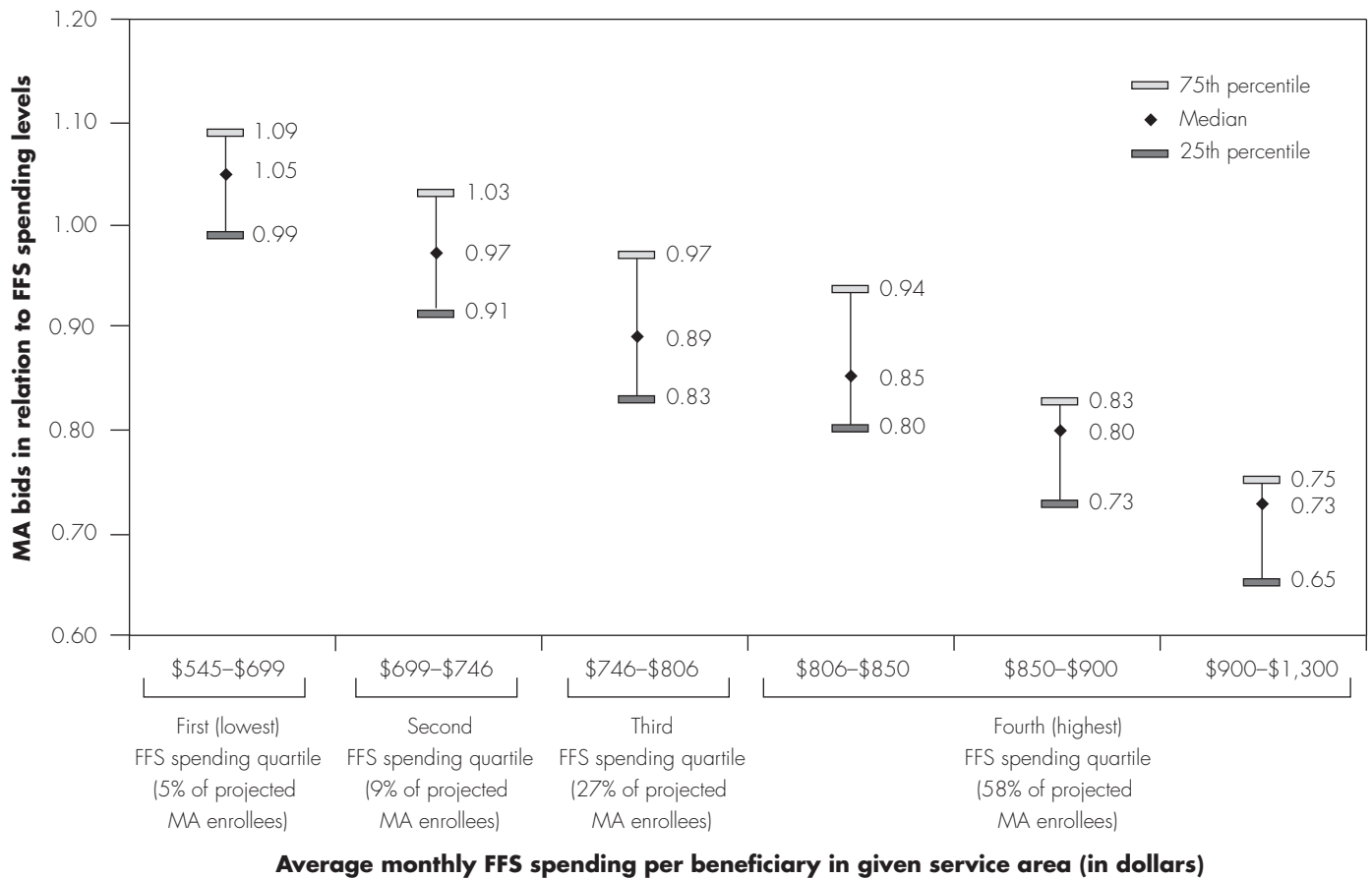
Figure 13-2 (p. 328), illustrating over 2,000 plan bids (employer plans, SNPs, and plans in the territories were excluded), shows how plans bid relative to FFS for service areas with different ranges of FFS spending. The first three FFS spending ranges roughly correspond to the FFS ranges in the first three rate quartiles in the PPACA payment rules for 2015. We broke the fourth quartile into three FFS spending ranges because a substantial share of Medicare beneficiaries—about 36 percent—live in

counties in the highest spending quartile. Each FFS range covers the bids of at least 140 plans and 500,000 projected enrollees, with 72 percent of the plans and 76 percent of projected enrollment falling in the three groups between \$746 and \$900 of FFS spending per month.

Plans bid high (relative to FFS) in areas with relatively low FFS spending. When plans bid for service areas that average less than \$699 in monthly FFS spending, they are likely to bid more than FFS (Figure 13-2, p. 328). However, when plan service areas average more than \$699 per month in FFS spending, plans are likely to bid below (sometimes far below) the FFS level. This finding suggests that, geographically, plan costs do not vary as much as FFS spending. Ninety-six percent of beneficiaries live in a county served by at least one plan that bid below the average FFS spending of its service area. However, plans

FIGURE 13-2

Medicare Advantage bids in relation to FFS spending levels, 2015



Note: FFS (fee-for-service), MA (Medicare Advantage). Excludes employer group plans, special needs plans, and plans in the territories.

Source: MedPAC analysis of MA bid and FFS expenditure data from CMS.

with large service areas and a geographically dispersed membership are probably not considering exactly how their costs will vary in each county they serve.² While the bidding and payment patterns are reported here as averages, clearly there is much variation within these averages (Table 13-3, p. 324; Figure 13-2).

Although the plan bids average less than FFS spending, payments for enrollees in these plans usually exceed such spending because the benchmarks (including the quality bonuses) are high relative to FFS spending. Overall, plan bids average 94 percent of expected FFS spending for similar beneficiaries in 2015, but because the benchmarks average 107 percent of FFS spending, Medicare pays an average of 102 percent of FFS for beneficiaries enrolled in MA.

The ratio of MA plan payments to FFS spending varies by plan type, but the ratios for all plan types are at or higher

than 100 percent of FFS. For example, HMOs as a group bid an average of 90 percent of FFS spending, yet 2015 payments for HMO enrollees are estimated to average 101 percent of FFS spending because the benchmarks average 106 percent of FFS spending. Local PPOs and PFFS plans have average bids above FFS spending. As a result, payments for local PPO and PFFS enrollees are estimated to be 107 percent and 111 percent, respectively, of FFS spending (Table 13-4, p. 325). Payments for beneficiaries enrolled in regional PPOs averaged 100 percent of FFS because of the relatively low benchmarks for the regional PPOs.

We also analyzed bids and payments to SNPs and employer plans separately because the plans are available only to subpopulations of Medicare beneficiaries and bidding behavior may differ from that of other plan types. In the past, payments to SNPs and their bids tended to

be slightly higher relative to FFS spending than general MA plans. This year, however, SNP bids and payments look much like the average HMO plan (87 percent of SNP enrollees are in HMOs).

Employer group plans consistently bid higher than plans that are open to all Medicare beneficiaries. Employer groups bid an average of 105 percent of FFS compared with 92 percent of FFS for nonemployer plans (not shown in Table 13-4, p. 325). Medicare pays 106 percent of FFS for employer plan enrollees. In the past, the Commission has recommended that CMS evaluate employer plan bids differently. (For more details on employer plans and our recommendation, see the text box (pp. 340–341) and our March 2014 report to the Congress.)

MA risk adjustment and coding-intensity adjustment

Medicare calculates its payment to plans separately for each beneficiary, multiplying the plan's payment rate by the beneficiary's risk score. The risk scores are based on diagnoses that providers coded during the year before the payment year. The diagnoses are reported to Medicare through claims for Medicare FFS beneficiaries or by the plans for MA enrollees. To receive the maximum payment they may rightfully claim, plans have an incentive to ensure that the providers serving the beneficiary record all diagnoses completely.

Recent research has found that risk scores for MA plan members have been growing more rapidly than risk scores for FFS beneficiaries (Kronick and Welch 2014). Thus, as mandated by the Deficit Reduction Act of 2005, CMS has been making an across-the-board adjustment to the scores. Taking into account multiple years of coding differences, CMS reduced risk scores by 3.41 percent from 2010 through 2013. PPACA specifies minimum reductions for 2014 and all future years, although CMS has discretion to make larger reductions. The Government Accountability Office found that CMS should make larger reductions to fully account for the coding differences (Government Accountability Office 2012). The American Taxpayer Relief Act of 2013 increased the minimum reductions that CMS must make in the scores. The mandated reductions will end once CMS begins risk modeling based on MA diagnoses and expenditures rather than on the FFS diagnoses and expenditures supporting the current model. For 2015, CMS has chosen to reduce risk scores by 5.16 percent, the minimum reduction under current law. The law specifies that the minimum reduction rises by 0.25

percentage point each year until 2018, when it would reach 5.9 percent. The minimum reduction would remain 5.9 percent for 2019 and each subsequent year.

The Commission has begun its own analysis of coding differences between beneficiaries in FFS Medicare and those enrolled in MA plans. We used beneficiary risk scores and enrollment data from 2006 through 2013. In one analysis, we built cohorts of beneficiaries whose first full calendar year was spent in FFS and whose second and all subsequent full calendar years (through 2013) were spent entirely in either FFS or MA. For example, one cohort consisted of those beneficiaries whose first full year in Medicare was 2006, who were in FFS for all of 2006, and who either remained exclusively in FFS through 2013 or switched into MA in January 2007 and remained in MA through 2013. We examined the 2006 cohort and all the cohorts whose first full years were in 2007 through 2011. From this approach, analysis shows that all beneficiaries had an initial risk score that reflected their year in the FFS program and that the differences in the growth of their risk scores can be attributed primarily to the program in which they were coded. In this analysis we found:

- Beneficiaries who spent their first calendar year in FFS and then switched to MA had entry risk scores that were 84 percent to 87 percent of those who remained in FFS, for each MA entry year from 2007 to 2012. In other words, beneficiaries enrolling in MA start out with lower risk scores than the average risk scores of beneficiaries remaining in FFS Medicare.
- The ratio of the average MA risk score to the average FFS Medicare risk score grew for every additional year of enrollment.
- The ratio of the average MA risk score to the average FFS Medicare risk score during the first year of enrollment in MA increased from 6 percent for beneficiaries who entered MA in 2007 to 7.5 percent for those who entered MA in 2011. It then jumped to 11 percent for beneficiaries entering MA in 2012, the last year of data we have for this measure.
- After the first year, the ratio of the average MA risk score to the average FFS Medicare risk score tends to increase by about 2 percent for each year the beneficiaries remain in MA.

While this analysis shows compelling evidence that a coding difference exists between beneficiaries in FFS Medicare and MA and that the difference is still growing,

it does not tell us the level of the overall difference, which we would need to evaluate whether the statutory coding adjustment seems adequate. To address this issue, we built cohorts of 2013 MA enrollees based on how long they had been continuously enrolled. We then compared the MA enrollees with FFS Medicare beneficiaries who had spent the same amount of continuous time in FFS. In this analysis we found:

- The cohorts who had remained in MA longer had higher growth in risk scores than their contemporaries who had remained in FFS.
- The MA enrollees who had been enrolled exclusively in MA in 2011, 2012, and 2013 had risk-score growth about 4 percent higher than beneficiaries who exclusively had FFS Medicare coverage for those three years, while the difference for those enrolled continuously during the eight years from 2006 to 2013 was about 13 percent.
- When weighted by the duration of continuous enrollment, the risk scores grew about 8 percent more among the MA population than among the FFS population.

Together these analyses show that because of coding practices, beneficiaries in MA plans will have higher risk scores than they would have had if they had remained in FFS. Further, those differences in coding are larger than the current 5.16 percent coding adjustment mandated by law. If CMS raised the coding adjustment by about 3 percentage points, the aggregate level of coding in the FFS and MA programs would be roughly equal.

CMS could change how it calculates risk scores so that the diagnosis codes used to calculate the scores come from the same sources as those that were used to calibrate the model. For example, beneficiaries in FFS Medicare would rarely, if ever, receive in-home risk assessments. Plans are increasingly submitting diagnoses from these assessments for risk-scoring of their enrollees. In its Advance Notice for MA payment policies for 2015, CMS proposed to discontinue the use of the codes from these assessments in the calculation of risk scores. In the Final Notice, however, CMS withdrew the proposal for 2015. Some might argue home assessments can improve quality. However, the HCC risk model used to adjust payment is based on FFS coding practices, and home assessment scores are not consistent with that model. The National Committee for Quality Assurance (NCQA) has pointed out the same problem in regard to using home assessment diagnosis codes for

risk adjusting quality (readmission) measures (National Committee for Quality Assurance 2012).

Perspective on MA payments

The benchmarks, bids, and payments continue the decline relative to FFS spending begun in 2011. Plan enrollees in 2015 would receive about 102 percent of the funding that Medicare spends on similar FFS Medicare beneficiaries. However, there are issues with coding intensity, and while the Commission has supported paying more for higher quality services, there also may be issues with the star rating system, which is the basis for quality bonuses in MA.

In 2015, the Medicare program is paying about 105 percent (102 percent plus 3 percent because of increased coding) of the expected FFS cost for the Part A and Part B benefits for MA enrollees. In other words, in 2015, the Medicare program is paying about \$8 billion more toward the care for MA enrollees than it would have spent had the beneficiaries remained in FFS Medicare. For that cost, beneficiaries receive an average of \$76 per month (including administrative load and profit) in extra benefits. That \$76 rebate for nonemployer, non-SNP plans is unchanged from 2014. Previous studies found that the extra benefits funded by the rebates were a relatively small portion of the extra Medicare payments and that the extra benefits were funded almost entirely through extra Medicare payments and not by plan efficiencies (Curto et al. 2014, Medicare Payment Advisory Commission 2009, Song et al. 2012).

However, the recent benchmark reductions have put pressure on plans to lower bids and have led to lower Medicare MA payments relative to FFS Medicare. In 2015, MA enrollees will receive an estimated \$11 billion in extra benefits after discounting the administrative costs and profits attached to those benefits. On average nationally, those extra benefits were financed by \$8 billion in Medicare subsidies (payments above FFS costs) and \$3 billion in plan efficiencies. The relative mix of Medicare subsidies and plan efficiencies vary by county. Extra benefits in the lowest spending quartile (the 1.15 quartile) are most likely funded exclusively by Medicare subsidies. In the highest spending quartile (the 0.95 quartile), the extra benefits are funded exclusively by plan efficiencies.

These results, combined with our analysis of margins (see text box), suggest that despite benchmark reductions, plans are doing well on average and continue to be able to offer extra benefits to attract enrollment.

Medicare Advantage plan-reported margins in 2012

One component of Medicare Advantage (MA) bids is the statement of a plan's historical data from the previous year (referred to as the base year) that forms the basis of its bid for the coming year. In the bids submitted for the 2014 contract year, organizations included such data for 2012. We used these plan-reported historical data to determine margin levels in MA in 2012 and analyzed data for plans representing 90 percent of MA enrollment in 2012. In general, our methodology for determining which data to include is similar to that used by the Government Accountability Office (GAO) in its reports on plan margins based on 2013 bid data, which contain 2011 historical information (Government Accountability Office 2013a, Government Accountability Office 2013b). Our results are similar to those of GAO. GAO found, for example, that special needs plans (SNPs) had very high margins and that employer group plans had higher margins than plans for individual Medicare beneficiaries. GAO also found that on average overall, the margins that plans reported as actual results for 2011

were consistent with the projected margins in plan bids submitted in 2010 for the 2011 contract year. However, while that finding was true overall for MA, reported margins differed from projected margins within categories of MA plans (for example, SNP plans and employer group plans had each projected lower 2011 margins in the 2011 bid data than the 2011 margins shown in the historical data included in the 2013 bids).

In 2012, the average margin reported by MA plans, weighted by revenue, was 4.9 percent. Examined at the level of the company or parent organization, more companies had positive margins than negative margins (Table 13-5). As a group, MA plans performed well financially in 2012. Companies accounting for 91 percent of enrollment had positive margins. (This analysis does not include Part D margins for MA prescription drug (MA-PD) plans.) Part D is about 12 percent of revenue for MA-PD plans. Note also that margins for years after 2012 may be lower because of factors such as the program-wide sequester

**TABLE
13-5**

Medicare Advantage company-level margin ranges, weighted by revenue, 2012

Margin categories	Range of margins	Number of companies	Revenue-weighted average margin for group	Percent of total MA revenue in this group	Percent of total enrollment in this group
All companies	-5.6 to 16.1	122	4.9%	100%	100%
Companies with negative margins, totals		43	-3.0	8	9
< -5%	-5.6 to -17.9	17	-8.0	2	2
< -2.5%, ≥ -5%	-2.6 to -4.9	10	-3.5	1	2
< 0, ≥ -2.5%	-0.1 to -2.3	16	-1.2	5	5
Companies with positive margins, totals		79	5.5	92	91
> 0, < 2.5%	0.3 to 2.1	23	1.7	27	25
≥ 2.5%, < 5%	2.6 to 4.9	21	3.4	7	7
≥ 5%, < 7.5%	5.0 to 7.1	8	6.0	25	25
≥ 7.5%, < 10%	7.5 to 9.9	17	7.9	30	30
≥ 10%	10.3 to 16.1	10	13.1	4	5

Note: Enrollment numbers are from the plan-reported member months in the bid historical data. The sum of column components may not equal stated totals due to rounding.

Source: MedPAC analysis of Medicare Advantage bid data.

(continued next page)

Medicare Advantage plan-reported margins in 2012 (cont.)

that reduced Medicare payments, and because of the medical loss ratio requirement introduced in the Patient Protection and Affordable Care Act of 2010 and effective in 2014 for MA plans. However, our analysis of the 2015 bid data indicates that the projected average all-plan margin for the 2015 contract year is similar to the all-plan margin that plans reported for 2012.

One company can have different types of products for which there are individual bids. For example, a company can offer both HMOs and preferred provider organizations, which require separate bids and therefore can have different margins. We also analyzed the bids at the product level and found that margins varied by certain plan characteristics (Table 13-6):

- HMOs had higher margins than other plan types.
- For-profit plans had higher margins than nonprofit plans.
- Looking at a subset of HMOs not offered by employer group plans and the duration of their Medicare contracts, older plans had higher margins than newer plans.
- Employer group plans had higher margins than plans offered to individual Medicare beneficiaries. In the latter category, nonprofit plans reported negative margins.
- In general, SNPs had higher margins than other plans, but nonprofit SNPs had negative margins on average.
- Plans with a majority of enrollment consisting of beneficiaries with full Medicare–Medicaid dual eligibility (that is, full Medicaid coverage) had lower margins than plans with a majority of enrollment consisting of beneficiaries with partial dual eligibility (coverage of the Part B premium only or coverage of cost sharing for some of the partial group).

In the aggregate, the higher margin (2.8 percentage points) for employer plans compared with that for the nongroup plans is close to the difference in administrative costs between the two plan types

TABLE 13-6 Medicare Advantage margins vary by certain plan characteristics

Category	2012 margin	Share of enrollment
Plan type		
HMOs	5.4%	68%
Local PPOs	3.1	21
Regional PPOs	4.9	8
PFFS	2.8	3
Profit status		
Nonprofit plans	1.9	30
For-profit plans (before taxes)	6.3	70
Group/nongroup		
Employer group plans	7.2	16
Plans sold to individual Medicare beneficiaries	4.4	84
Plan age		
Older plans	5.1	N/A
Newer plans	3.1	N/A
SNP status		
SNPs	8.6	11
Non-SNPs	4.3	89
SNPs, nonprofit	-0.6	2
SNPs, for profit	11.5	8
Non-SNPs, nonprofit	2.2	28
Non-SNPs, for profit	5.3	61
Type of Medicare–Medicaid dual-eligible enrollment		
Over 50 percent partial dual	12.9	1
Over 50 percent full dual	5.7	6

Note: PPO (preferred provider organization), PFFS (private fee-for-service), N/A (not applicable), SNP (special needs plan). The older and newer plan comparison is for a subset of plans comprised of non-employer group HMOs with 2010 historical data in their 2012 bids, which also appear in the 2014 bid data. Enrollment numbers are from the plan-reported member months in the bid historical data. Figures may not sum due to rounding.

Source: MedPAC analysis of Medicare Advantage bid data.

(6.3 percent and 9.4 percent administrative costs for employer plans and nongroup plans, respectively (data not shown in table)). A major factor is that employer group plans do not incur the high marketing costs

(continued next page)

Medicare Advantage plan-reported margins in 2012 (cont.)

associated with either marketing to individual Medicare beneficiaries or paying commissions to brokers who enroll individual Medicare beneficiaries.

With regard to SNPs, one-third of the enrollment in nonprofit plans was in plans reporting a negative margin when examined at the plan level. Within the group of nonprofit SNP plans, however, 67 percent of the enrollment was in plans with a positive margin (at 5.3 percent), but the overall margin among nonprofit SNPs was pulled down by the high negative margins of plans with 33 percent of the enrollment (data not shown in table).

We also found the following:

- Plans drawing their enrollment from areas with relatively high per capita spending in fee-for-service Medicare had higher margins than other plans.
- Plans with higher average risk scores and plans with greater numbers of enrollees who have multiple conditions had higher average margins. This difference may partly reflect higher coding intensity among certain plans. Kronick and Welch (2014) note that certain plans code more intensively than others. ■

Quality in the Medicare Advantage program

The indicators that we track to evaluate quality in MA come from various sources described more fully in an online appendix to the March 2010 report to the Congress (http://medpac.gov/documents/reports/mar10_ch06_appendix.pdf?sfvrsn=0) and in technical notes from CMS. We generally report results separately by plan type and compare HMOs with local PPOs. In determining whether there has been statistically significant improvement in measures over the last year, and in comparing the two plan types, we include only plans that reported a result for a measure in both reporting years (a “same store” approach). Table 13-7 (p. 334) summarizes HMO and local PPO performance for the most current year compared with the previous year on the major measures we track. For plan types other than HMOs and local PPOs—cost-reimbursed HMOs, regional PPOs, and PFFS—because of the small number of plans involved, we make general statements about their performance.

For HMOs and local PPOs, Table 13-7 (p. 334) shows that performance improved on a number of measures, declined for a small number, and was unchanged for a large proportion of measures.

Healthcare Effectiveness Data and Information Set® (HEDIS®) results

From HEDIS, we tracked 39 measures to compare between 2013 and 2014, as well as 5 SNP-only measures

and results for hospital readmissions. The quality measures derived from HEDIS encompass both clinical process measures and intermediate outcome measures. The most current HEDIS data (reported in June 2014) reflect care provided in 2013.

Among HMOs, about 40 percent of HEDIS measures (19 of 45) showed improvement; PPOs improved on a little more than one-fourth of the measures (13 of 45). For both HMOs and local PPOs, five measures declined—all in the realm of mental health care and substance abuse treatment, for which HEDIS has six measures. NCQA has called attention to the poor performance of plans on these measures, which has been declining over the past three years.

There was no statistically significant difference in performance between HMOs and local PPOs for 25 of the 39 HEDIS measures we track that are comparable between 2013 and 2014. The 25 measures included 6 of HEDIS’s 7 intermediate outcome measures, which is noteworthy in that the intermediate outcome measures are “hybrid” measures involving extraction of data from a sample of medical records. Until 2012, PPOs could use only administrative data, such as claims data, to report results on these measures. The most recent data show that PPOs have caught up with HMOs in their ability to report these measures and in their performance on these measures.

For the hospital readmission measure, all plan types showed improvement in the observed-to-expected ratios, with those ratios declining by an admission-weighted

**TABLE
13-7**

Over the last year a number of MA quality measures improved, a small number declined, and a large proportion were unchanged

Major quality indicators	Total measures tracked	Number improved		Number declined	
		HMO	Local PPO	HMO	Local PPO
HEDIS® measure categories					
Process	32	10	3	5	5
Intermediate outcome	7	3	4	0	0
SNP-only measures	5	5	5	0	0
Readmission rates	1	1	1	0	0
HEDIS subtotals	45	19	13	5	5
CAHPS®-MA					
Patient experience	6	0	0	1	1
HOS					
Health status changes	2	2	2	0	0
Other					
Part D clinical measures	4	4	3	0	0
Total, all	57	25	18	6	6

Note: MA (Medicare Advantage), HEDIS® (Healthcare Effectiveness Data and Information Set®), SNP (special needs plan), CAHPS®-MA (Consumer Assessment of Healthcare Providers and Systems® for MA), HOS (Health Outcomes Survey). Data exclude cost-reimbursed HMO plans and measures that cannot be compared between the two years because of changes in the measure specification.

Source: MedPAC analysis of CMS HEDIS public use files and star ratings data.

average of 0.5 percent for PFFS plans, 6.9 percent for regional PPOs, 3.9 percent for local PPOs, and 5.7 percent for HMOs. Improvements occurred in all five HEDIS measures reported by SNPs only—advance care planning, medication review, functional status assessment, pain assessment, and medication reconciliation postdischarge. Between 2013 and 2014, percentage point increases greater than 10 occurred for medication reconciliation postdischarge (from 27.2 percent to 37.5 percent) and for pain assessment (from 70 percent to 84.6 percent). With respect to other plan types, we found that historical patterns held in 2014. Cost-reimbursed HMOs generally perform better than MA HMOs on HEDIS measures, and regional PPOs and PFFS plans have the lowest rates on HEDIS measures.

The Consumer Assessment of Healthcare Providers and Systems for MA and Health Outcomes Survey results

For patient experience measures, we use the Consumer Assessment of Healthcare Providers and Systems® for MA (CAHPS®-MA) data that CMS reports in its plan

performance indicators for star rating purposes. Between 2013 and 2014, no change occurred in plan performance on six CAHPS-MA measures of beneficiaries' perceptions of their access to care and rating of their health plan and providers, but the measure of beneficiaries' perception of their ability to get care when it was needed declined for both HMOs and local PPOs.

The Health Outcomes Survey (HOS) is the source of some of the survey-based measures that are included in HEDIS measures (such as whether a physician advised a person to undertake physical activity). The HOS is also the source of two outcome measures in the CMS star system that track whether a plan's enrollees report improvement or decline in physical health status or mental health status. Both of these measures showed improvement among MA plans between the most recent reporting period and the prior reporting period. CMS also uses the HOS to determine whether health status changes in a given plan are markedly different from the average across all plans. As in past years, for the most recent two-year period of tracking changes in health status (2011 to 2013), only a

small number of plans (fewer than 6 percent) had changes in their enrollees' mental or physical health status that differed significantly from the average across all plans (<http://www.hosonline.org/Content/SurveyResults.aspx>).

Part D measures and contract performance measures

CMS gathers data from both MA and Part D to monitor aspects of these programs and administer the star rating system. Part D measures in the overall star rating for Medicare Advantage–Prescription Drug (MA–PD) plans include three medication adherence measures (medications for diabetes, hypertension, and cholesterol). Plans improved their scores on each of these measures, and HMOs improved on the measure of appropriate blood pressure medication prescribed for people with diabetes. Other measures in the star system include contract performance measures focusing on plans' customer service, appeals processing, and disenrollment, among others. Most of these measures showed improvement over the past year.

The star system and the quality bonus program

Since 2012, the MA program has included a pay-for-performance system that gives bonuses to higher performing plans. The bonuses take the form of an increase in plan benchmarks; higher rated plans are able to use a higher percentage of the difference between bids and benchmarks for rebates, which finance extra benefits. Bonuses are based on a plan's overall rating, with a maximum of five stars. Part D measures are included for plans that have Part D coverage (most MA plans). Performance on SNP-specific measures is a component of the star rating for sponsors of SNPs. Each element of the star rating is assigned a weight of 1 for process measures, 1.5 for patient experience and access measures, and 3 for outcome measures. An improvement measure that CMS calculates for MA and Part D has a weight of 5, which is an increase from a weight of 3 last year.

Plans that receive 5-star ratings can enroll beneficiaries outside of the annual election period.³ In the 2015 star ratings, 11 MA–PD plans and 2 MA-only contracts received 5-star ratings. Their status as high-rated plans is displayed at Medicare.gov. The lowest rated plans are also flagged, and beneficiaries are cautioned about choosing to enroll in a low-rated plan. This year (contract year 2015) would have been the first year in which CMS could have invoked a provision to terminate the contract of a plan that

**TABLE
13-8**

Distribution of enrollment by plan star ratings, 2014–2015

Star rating	Percent of total enrollment	
	2014	2015
5.0	10%	10%
4.5	21	19
4.0	22	31
3.5	31	27
3.0	15	11
2.5	1	2

Note: Enrollment is for September 2014. Data exclude cost-reimbursed HMO plans, which are not eligible for bonuses. Figures have been rounded; the unrounded figure for plans at 4.0 stars or above in 2015 is 59 percent.

Source: MedPAC analysis of CMS star ratings and enrollment data.

had three consecutive years of performance at or below the 2.5 star level in either Part C or Part D. However, CMS did not exercise its authority to do so.

Star ratings and changes in the ratings

The 2014 and 2015 star ratings components and methodology are similar in the elements included, but many of the “cut points,” or minimum levels, for a 4-star rating are higher in 2015. Among all plans with any star rating in 2015 (excluding certain plan types not in the quality bonus program), 59 percent of enrollees are in plans with a star rating of 4 or higher based on the 2015 ratings compared with 53 percent for the same set of enrollees if the 2014 star ratings had been used. For plans rated in both 2014 and 2015, even with the improvement in a number of measures included in the star ratings, there was virtually no difference between the 2014 enrollment-weighted average star ratings (3.88) and the 2015 ratings (3.91), which reflects shifts in star ratings and the decline in 4.5-star plan enrollment in particular (Table 13-8). Between 2013 and 2014, the comparable change was a 12 percent increase in the weighted average star ratings (3.41 vs. 3.81, using year 2013 enrollment; data not in table).

Only a subset of HEDIS measures is included in determining a plan's overall star rating. For HEDIS measures included in the star ratings, the majority improved—10 of 19 for HMOs and 10 of 13 for local PPOs (Table 13-9, p. 336). These data suggest that plans may be giving special attention to measures in the star ratings and that HEDIS mental health measures, which

**TABLE
13-9**

The majority of HEDIS® measures with improved results are measures used in the star rating system

Major measure categories	Total measures tracked	Number used in star ratings	Weighting in star ratings	Across all measures in category, number improved		Of measures improving, number in star ratings		Measures that declined		For measures declining, number in star ratings
				HMO	Local PPO	HMO	Local PPO	HMO	Local PPO	
HEDIS measure categories										
Process	32	8	10%	10	3	4	3	5	5	0
Intermediate outcome	7	3	11	3	4	2	3	0	0	0
SNP-only measures	5	3	4	5	5	3	3	0	0	0
Readmission rates	1	1	4	1	1	1	1	0	0	0
HEDIS subtotals	45	15	29	19	13	10	10	5	5	0
CAHPS®-MA										
Patient experience	6	6	13	0	0	0	0	1	1	1
HOS										
Health status changes	2	2	8	2	2	2	2	0	0	0
Other										
Part D clinical measures	4	4	32	4	3	4	3	0	0	0
Health plan improvement	1	1	6	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Drug plan improvement	1	1	6	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Note: HEDIS® (Healthcare Effectiveness Data and Information Set®), PPO (preferred provider organization), SNP (special needs plan), CAHPS®-MA (Consumer Assessment of Healthcare Providers and Systems® for MA), HOS (Health Outcomes Survey), N/A (not applicable). Measures included comprise 94 percent of the weight of measures used in the star rating system. Data exclude cost-reimbursed HMO plans and measures that cannot be compared between the two years because of changes in the measure specification.

Source: MedPAC analysis of CMS HEDIS public use files and star ratings data.

have been declining for several years, should be added to the star rating system as a means of focusing on plan performance on those measures. (However, one issue with the current mental health measures reported in HEDIS is that many plans are unable to report results for some of the measures because of the small number of beneficiaries to whom the measures apply. For example, 30 percent of plans (representing 5 percent of MA enrollment) did not report a result for the measures of follow-up care after hospitalization for a mental illness.)

Moving enrollees to bonus plans

With regard to changes in star ratings, CMS has permitted plans to move enrollees from a contract with a low star rating to a contract with a higher star rating by “cross-walking” members from one contract to another. At the end of 2013, 11 contracts were terminated and their

156,000 enrollees cross-walked to a new contract. Of that number, 122,000 enrollees in 8 contracts (all with the same parent organization) were moved from a contract with a rating below 4 stars to one with 4 or more stars, resulting in additional program expenditures through bonus payments to plans for the 122,000 enrollees who had not been enrolled in bonus-level plans previously. Cross-walking also occurred at the end of 2014, involving 3 companies and 387,000 beneficiaries. In a similar vein, CMS informed plans at risk of termination because of three continuous years of low-star performance that “organizations and sponsors could explore whether it is allowable to consolidate membership currently enrolled in plans offered under low-performing contracts into other plans that will be offered during 2015 in the same service area under a different contract rated at three stars or better” (Centers for Medicare & Medicaid Services 2014b). At the

end of 2014, a total of 84,000 enrollees were moved from plans that were at risk of termination to other plans.

Variation in star ratings by plan type; the performance of dual-eligible SNPs

As noted in CMS’s 2015 star ratings fact sheet, plans with the highest star ratings have certain characteristics (Centers for Medicare & Medicaid Services 2014a). Higher rated plans have been in the MA program longer and are more likely to be nonprofit. Our analysis also shows that plans with a high proportion of enrollees who are in an employer-sponsored plan have higher average star ratings. Plan star ratings also vary by plan type, with HMOs (at 3.97 in 2015) having higher enrollment-weighted star ratings than local PPOs (3.88), PFFS plans (3.76), and regional PPOs (3.53).

Contracts whose majority of enrollment is beneficiaries who are Medicare–Medicaid dually eligible beneficiaries have low star ratings. Across all plans, 59 percent of enrollees in plans with a 2015 star rating are in plans that have bonus-level star rating (4 stars or above); however, the corresponding figure among contracts that primarily serve dually eligible beneficiaries is 14 percent (for contracts with 50 percent or more dual-eligible special needs plan (D–SNP) enrollment). Excluding these majority D–SNP contracts, 63 percent of enrollees are in bonus-level plans. Some D–SNPs and their representatives argue that this wide difference between the two categories is due to the special characteristics of the population served by D–SNPs.

To examine whether the design of the star rating system is biased against D–SNPs and plans serving a high proportion of low-income beneficiaries, CMS issued a request for information in September 2014, inviting interested parties to submit data analyses that could illuminate the causes of the difference in star ratings between these and other plans. While acknowledging an association between D–SNP status and low star ratings, CMS asked plans to demonstrate causality or, alternately, to show “that high quality performance in MA or Part D plans can be achieved in plans serving dual eligible beneficiaries and how that performance level is obtained” (Centers for Medicare & Medicaid Services 2014c).

In past work, the Commission has noted that not all D–SNP plans perform poorly in the star rating system. In the 2015 star ratings, as in earlier years, some contracts with 4-star or 4.5-star ratings have enrollment consisting exclusively of dual-eligible beneficiaries. CMS has used a similar

TABLE 13-10 Average overall 2014 star ratings by level of enrollment of beneficiaries under age 65 and D–SNP status in 2012

Type of contract	Average overall star rating
Non-majority D–SNPs*	
With under-65 enrollment ≤ 30%	3.74
With under-65 enrollment > 30%	2.94
Majority D–SNPs**	
With under-65 enrollment ≤ 30%	3.52
With under-65 enrollment > 30%	3.16

Note: D–SNP (dual-eligible special needs plan). Data exclude cost-reimbursed HMO plans, which are not eligible for bonuses, and plans in Puerto Rico, which have very low star ratings. Star ratings released in the fall of 2013 are used, reflecting care rendered in 2012. Plan demographic data are as of December 2012. Non-majority D–SNPs with under-65 enrollment ≤ 30% number of contracts $n = 337$; non-majority D–SNPs with under-65 enrollment > 30% $n = 18$; majority D–SNPs with under-65 enrollment ≤ 30% $n = 19$; and majority D–SNPs with under-65 enrollment > 30% $n = 39$. * Non-majority D–SNPs have less than 50 percent D–SNP enrollment in contract. **Majority D–SNPs have 50 percent or more D–SNP enrollment in contract.

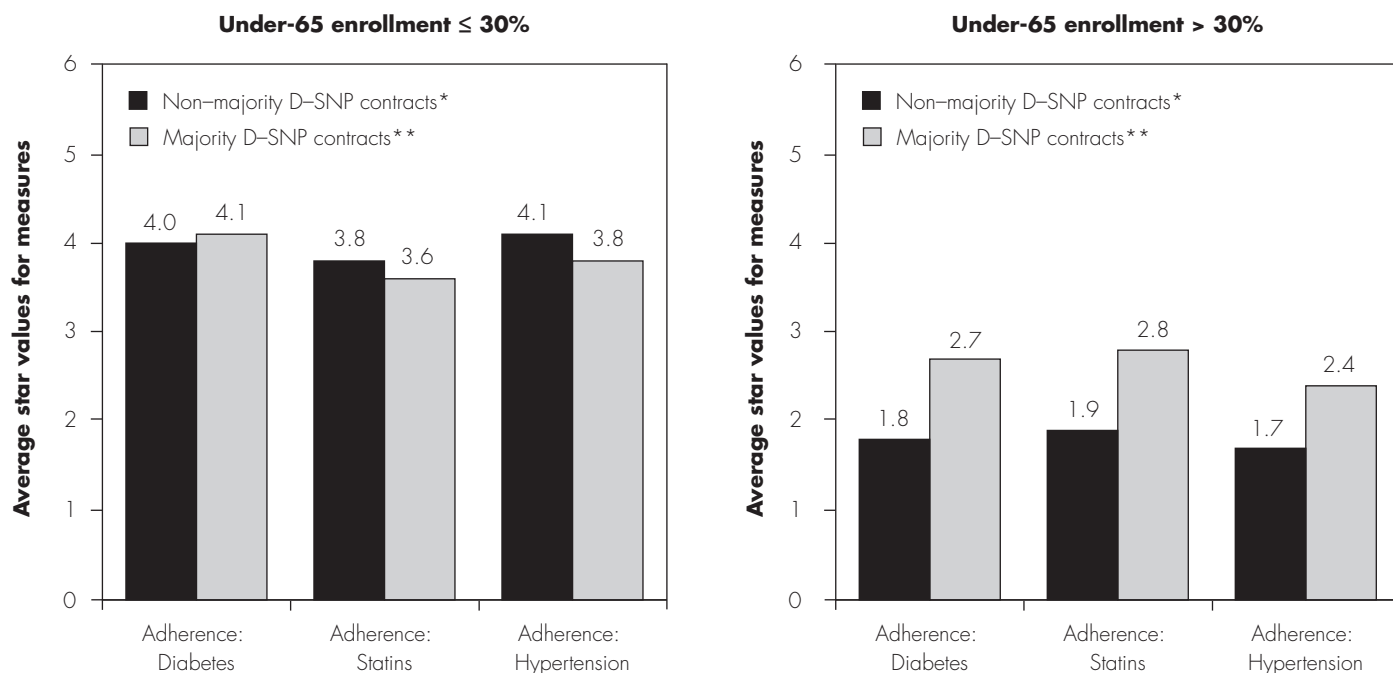
Source: MedPAC analysis of CMS star data, plan reports, and demographic data from the denominator file.

argument—the existence of high-performing D–SNPs—to conclude that the star rating system does not have a systematic bias against D–SNPs. However, in discussions with Commission staff, a plan representative from one of the high-performing D–SNP plans pointed out that part of the reason for the better performance among some D–SNPs is that they serve only beneficiaries age 65 or over (which CMS has permitted in certain circumstances).

Our analysis confirms that in addition to the association between D–SNP status and low star ratings (an association others have documented for a variety of measures, for example, Weiss and Pescatello (2014)), there is also an association between low star ratings and the proportion of enrollment in a plan that consists of beneficiaries under age 65 (beneficiaries entitled to Medicare on the basis of disability or end-stage renal disease). This association is also true for other plan types, with D–SNPs outperforming non-D–SNPs in average star ratings for contracts whose enrollment is at least 30 percent beneficiaries under age 65. Both D–SNPs and non-D–SNPs that serve a large proportion of beneficiaries under 65 have star ratings below the ratings of other plans, but the D–SNPs in the group outperform the non-D–SNPs (Table 13-10).

**FIGURE
13-3**

Average 2014 stars for Part D adherence measures, by level of 2012 enrollment of those under age 65 and by majority D-SNP status



Note: D-SNP (dual-eligible special needs plan). Data exclude cost-reimbursed HMO plans, which are not eligible for bonuses, and Puerto Rico plans, which have very low star ratings. Star ratings released in the fall of 2013 are used, reflecting care rendered in 2012. Plan demographic data are as of December 2012.
 * Non-majority D-SNPs have less than 50 percent D-SNP enrollment in contract.
 **Majority D-SNPs have 50 percent or more D-SNP enrollment in contract.

Source: MedPAC analysis of CMS star data, plan reports, and demographic data from the denominator file.

In the 2015 star ratings, of the 64 contracts whose enrollment of beneficiaries under age 65 was more than 30 percent as of December 2012, there are no contracts with a star rating higher than 3.5. One contract with a high share of under-65 enrollment that had 4-star status in the 2014 ratings left the MA program at the end of 2014; another has a star rating of 3.5 for 2015. Both the contracts were 100 percent D-SNP plans. The plan whose overall star rating declined registered declines in several measures, including Part D drug adherence measures.

D-SNP plans have difficulty achieving good results on the Part D drug adherence measures (three of the Part D clinical measures, which are heavily weighted in the star system) (Table 13-9, p. 336). Across all plans, under-65 status is a major factor in plan performance on these measures (Figure 13-3).

Compared with the variation in adherence measures, plan types vary less in outcome measures linked to

levels of adherence. In Table 13-11, two adherence measures and their corresponding outcomes illustrate that adherence measures are not highly correlated with intermediate outcome measures, but the adherence measures have a higher correlation with each other as shown by a correlation coefficient closer to 1.0 (the same is true for the statin-adherence and cholesterol-control measures, which are not included in the table). There is also less variation across plans in the stars associated with outcome measures. While the data show parallel results for the four plan-enrollment categories on the two adherence measures, the data show a different pattern of variation in the intermediate outcome measures, with smaller differences in the star ratings across plans and no systematic relationship between adherence and outcomes. These patterns suggest that any bias affecting D-SNPs in the star system could be limited to only certain measures within the star system—such as the adherence measures—and that the measures themselves (and their weighting) should be examined.

**TABLE
13-11**

Number of stars for adherence measures and corresponding outcome measures, and their correlation, 2012

Plan category by enrollment distribution	Control of blood pressure			Control of blood sugar among diabetics			Correlation between the two adherence measures
	Average number of stars			Average number of stars			
	Medication adherence measure	Outcome measure	Correlation coefficient	Medication adherence measure	Outcome measure	Correlation coefficient	
Non-majority D-SNPs*							
With under-65 enrollment ≤ 30%	4.08	3.55	0.44	4.02	3.50	0.36	0.85
With under-65 enrollment > 30%	1.72	3.06	0.19	1.83	2.83	0.30	0.71
Majority D-SNPs**							
With under-65 enrollment ≤ 30%	3.79	3.74	0.26	4.05	3.05	0.08	0.81
With under-65 enrollment > 30%	2.44	3.36	0.14	2.67	2.69	0.17	0.85

Note: D-SNP (dual-eligible special needs plan). Data exclude cost-reimbursed HMO plans, which are not eligible for bonuses, and plans in Puerto Rico, which have very low star ratings. Star ratings released in the fall of 2013 are used, reflecting care rendered in 2012. Plan demographic data are as of December 2012.

*Non-majority D-SNPs have less than 50 percent D-SNP enrollment in contract.

**Majority D-SNPs have 50 percent or more D-SNP enrollment in contract.

Source: MedPAC analysis of CMS star data, plan reports, and demographic data from the denominator file.

Perspective on MA quality

Broadly, over the past year, many MA quality measures have improved, a few have declined, and a large number have remained stable. The subset of measures included in the star rating system have generally improved, though average star ratings have remained virtually unchanged, in part because of changes in the thresholds for achieving a high star rating. It may be advisable to include in the star system those measures that have declined over the last several years—which are the few mental health measures that plans report.

CMS is examining whether there is a systematic bias in the star rating system that disadvantages plans specializing in caring for dual-eligible beneficiaries. While the discussion to date has focused on D-SNPs, we find poorer performance in the star ratings among plans that serve a large share of beneficiaries who are under age 65. For this age group, we find lower star ratings among both D-SNP and non-D-SNP plans, but relatively better performance among D-SNPs.

The text box (pp. 340–341) reiterates the Commission’s two most recent MA recommendations for the MA program. ■

The Commission reiterates its March 2014 recommendations on Medicare Advantage

The Commission reiterates two recommendations it has recently made to improve the bidding rules in the Medicare Advantage (MA) program and to integrate hospice care into the MA benefit package. The effects on spending were estimated at the time the Commission made these recommendations (and we believe the magnitude and the direction of these effects have not substantially changed in the last year).

Recommendation 13-1, March 2014 report

The Congress should direct the Secretary to determine payments for employer group Medicare Advantage plans in a manner more consistent with the determination of payments for comparable nonemployer plans.

The implementation of this recommendation could use the national average bid-to-benchmark ratio for nonemployer plans and apply that ratio to employer group plans. However, alternatives to this approach are also possible.

Implications 13-1

Spending

- We would expect Medicare program spending to decrease. Under the specific option we discussed, spending would decrease between \$250 million and \$750 million over one year and between \$1 billion and \$5 billion over five years.

Plans

- Most employer group plans would be paid less by Medicare because of the lowering of Medicare subsidies. In response, plans could charge

employers more, offer fewer supplemental benefits, make lower profits, or lower their costs.

Beneficiaries

- Some employer group plan enrollees might choose plans in the nonemployer market or move to FFS Medicare if employers dropped plans or increased charges to plan enrollees.

Recommendation 13-2, March 2014 report

The Congress should include the Medicare hospice benefit in the Medicare Advantage benefits package beginning in 2016.

The carve-out of hospice from MA fragments financial responsibility and accountability for care for MA enrollees who elect hospice. Including hospice in the MA benefits package would give plans responsibility for the full continuum of care, which would promote integrated, coordinated care, consistent with the goals of the MA program. With the inclusion of hospice in the MA benefits package, plans would have greater incentive to use the flexibility inherent in the MA program to develop and test innovative programs designed to improve end-of-life care and to improve care for patients with advanced illnesses more broadly. In addition, giving MA plans responsibility for hospice would be a step toward synchronizing accountability for hospice across Medicare platforms (MA, accountable care organizations (ACOs), and fee-for-service (FFS) Medicare). Because the Commission believes it is important to include hospice in the MA benefits package as soon as possible, we have recommended this change be made by 2016. We

(continued next page)

The Commission reiterates its March 2014 recommendations on Medicare Advantage (cont.)

recognize that implementing this change, if it were enacted by the Congress, would require actions by CMS (to recalculate capitation rates and risk scores) and by plans and providers (to negotiate contracts), but we believe this change could be accomplished by 2016 under a tight time line.

Implications 13-2

Spending

- The effect on Medicare program spending is expected to be negligible, with the policy potentially resulting in a small cost or small savings. The estimated one-year and five-year effects on Medicare program spending fall into our smallest budget categories: cost or savings of less than \$50 million over one year and less than \$1 billion over five years.

Beneficiaries and providers

- MA enrollees could benefit from a more integrated, coordinated MA benefits package. Some plans may choose to provide concurrent hospice and conventional care or offer other supplemental benefits designed to improve care for patients with advanced illnesses, which could expand options available to beneficiaries. We would not expect an adverse impact on beneficiaries' access to hospice care. As with other types of Medicare services, beneficiaries might be required to obtain services from a network provider, so they might have fewer hospice providers to choose from than they do under FFS Medicare. MA plans would have the option to charge nominal beneficiary cost sharing for hospice services, whereas under FFS Medicare, there is no cost sharing (with minor exceptions).

If the experience with home health is any guide, MA plans may be unlikely to charge hospice cost sharing. Few MA plans require cost sharing for home health services from network providers.

MA plans would be better positioned to manage and coordinate care for patients with advanced illnesses. If including hospice in MA led some plans to experiment with concurrent care or other approaches that seek to improve care for patients with advanced illnesses, hospice providers could have opportunities to participate in new models of care. Plans and hospices currently engage in private contracting for commercially insured individuals and incur administrative costs associated with that contracting. If hospice were included in MA, the breadth of those contracting activities would increase and plans and hospice providers would incur additional administrative costs associated with them.

Quality

- Including hospice in MA would reduce fragmentation of coverage, which would promote integrated, coordinated care. Furthermore, broadening MA plans' bundle of services to include the full continuum of end-of-life care could incentivize plans to focus more on efforts to improve quality and satisfaction with this care.

Delivery system reform

- Hospice is an area in which Medicare policy differs across delivery systems. Including hospice in MA would be a step toward synchronizing policies across the Medicare system (MA, ACOs, and FFS). ■

Endnotes

- 1 Cost plans are technically not MA plans. They do not submit bids but are paid their reasonable costs under provisions of section 1876 of the Social Security Act.
- 2 If a policy were to force plans to bid their costs for each county separately, then in many instances, bids for distinct counties would be different from those we observe in the data.
- 3 Star ratings are released to coincide with the October–December annual election period. The star ratings released in October 2014 are referred to as the 2015 star ratings (for

enrollments effective in 2015). However, the level of any bonus payments and rebate percentages for each year are determined as part of the bidding process. For the 2015 contract year, bids submitted in June of 2014 used 2014 star ratings, released in October 2013, to determine bonus levels for the 2015 benefit packages. Thus, beneficiaries will be using more current (2015) quality ratings to see differences in quality across plans, but the variation in benefit packages that is due to star ratings and their effect on rebate dollars is based on an earlier period's star ratings (2014 star ratings).

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