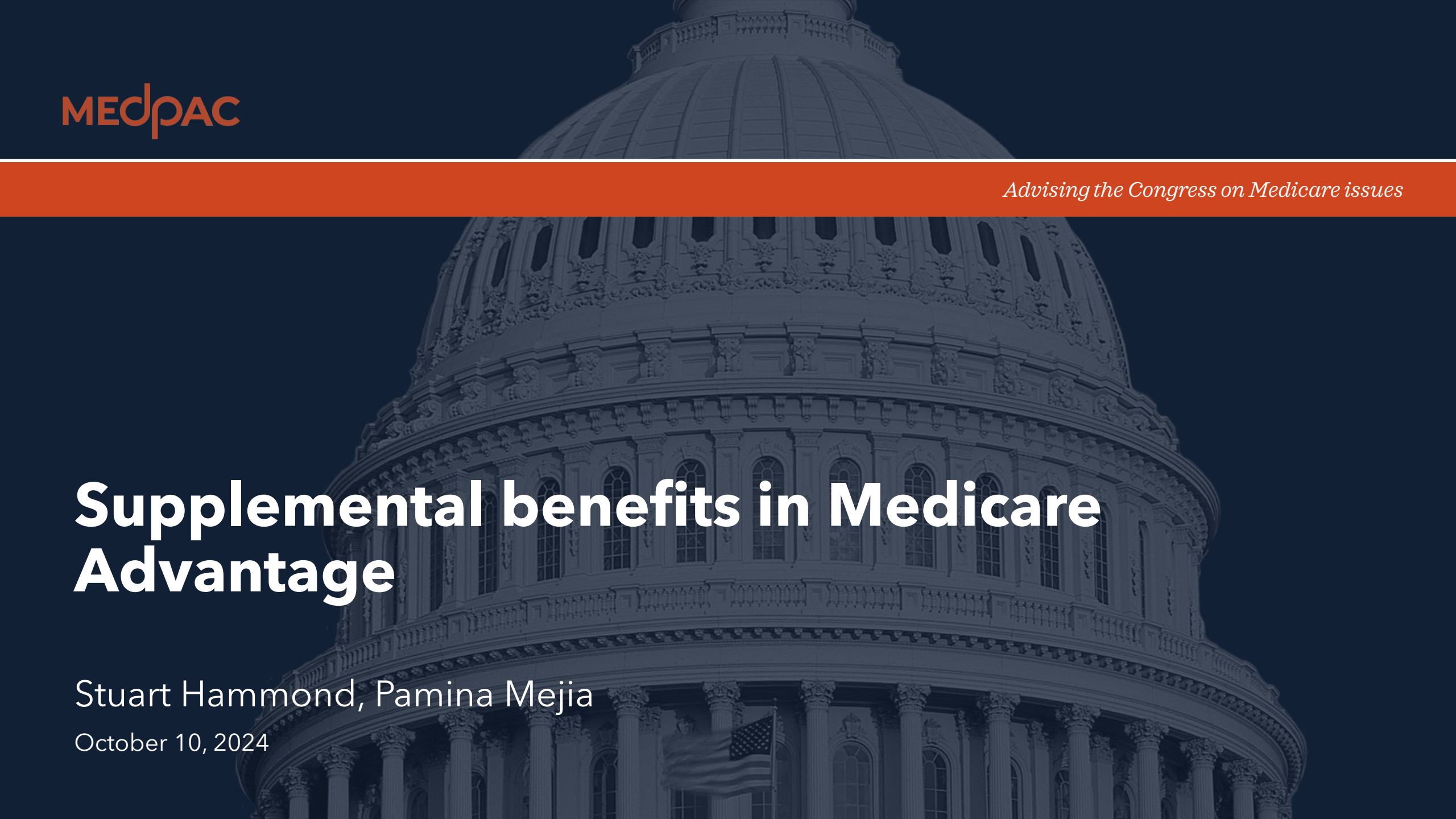
MEDPAC

Advising the Congress on Medicare issues



Supplemental benefits in Medicare Advantage

Stuart Hammond, Pamina Mejia

October 10, 2024

Presentation roadmap

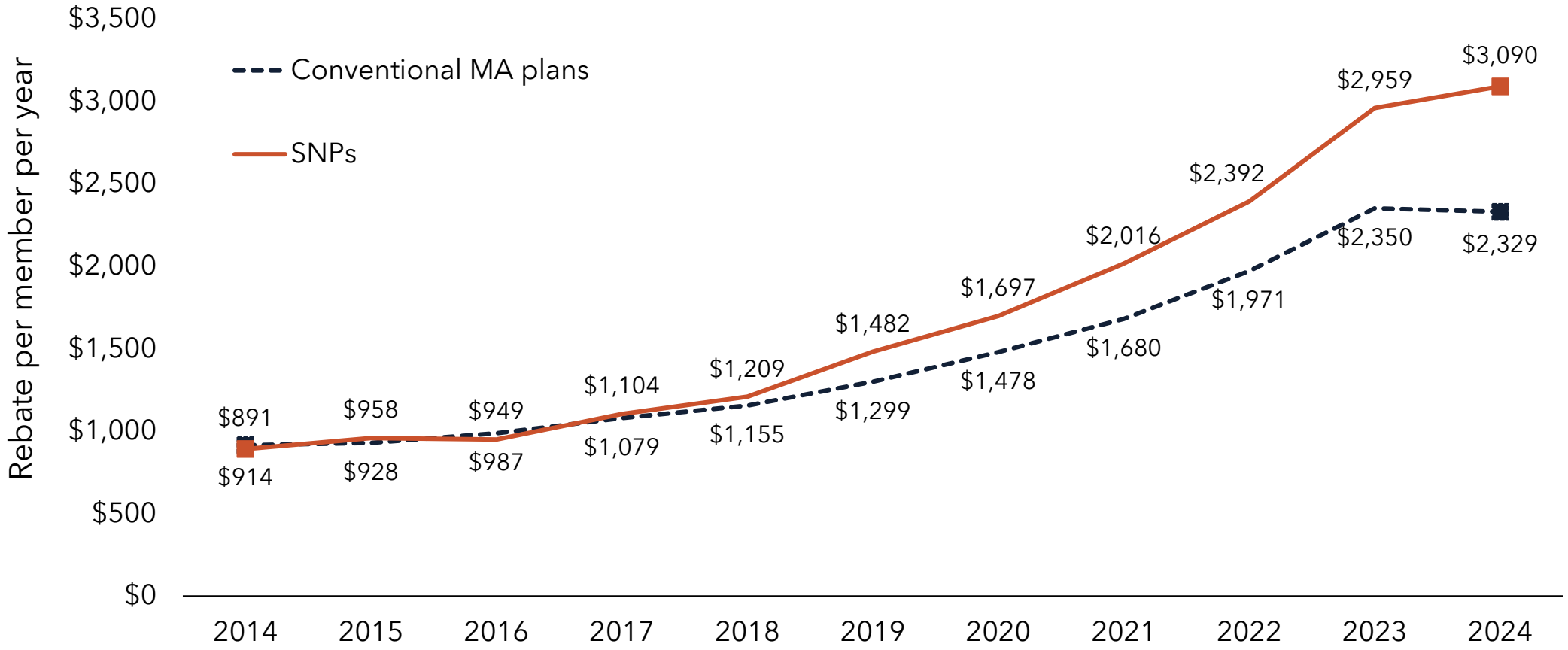
1. Review of MA payment policy
2. What are supplemental benefits?
3. Plan projections of supplemental benefits
4. Data limitations for assessing use of supplemental benefits
5. Discussion

Review of MA payment policy

- More than half of eligible Medicare beneficiaries are enrolled in MA
  - For beneficiaries, a primary trade-off is access to MA's supplemental benefits vs. broader choice of providers and less utilization management in FFS
- Medicare's payments to MA plans are based on bids and benchmarks
  - Bids are the amount each plan expects it will cost to cover Part A and Part B services
  - Benchmarks are based on FFS spending and are the maximum amount Medicare will pay to MA plans in a county
- Nearly all plans bid below their benchmark
  - Plans receive a base payment of their bid plus a "rebate," which is a percentage of the difference between the bid and the benchmark
  - Rebates must be used provide supplemental benefits

Note: MA (Medicare Advantage), FFS (fee-for-service). If a plan's bid is greater than the benchmark, Medicare pays the benchmark and the enrollee pays a premium to make up the difference.
Source: Medicare Payment Advisory Commission 2024.

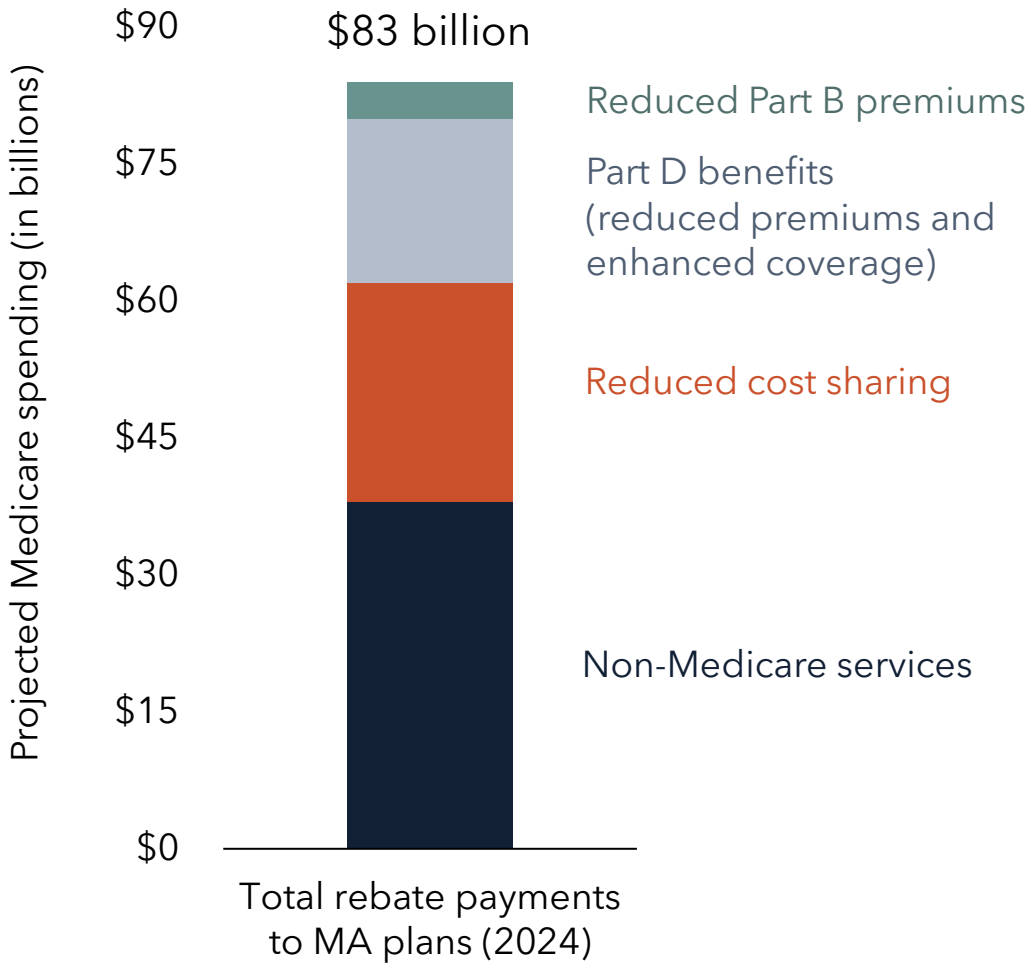
MA rebates have more than doubled since 2018



Note: SNP (special needs plan). "Conventional MA plans" excludes employer group plans and special needs plans. "SNPs" excludes employer group plans and non-SNPs. Figure excludes plans that do not offer a prescription drug benefit. Dollar amounts are nominal figures, not adjusted for inflation.

Source: MedPAC analysis of data from CMS on plan bids, 2014–2024.

Medicare paid MA plans approximately $83 billion in rebates in 2024



- We estimate that Medicare's rebate payments to MA plans will total $83 billion in 2024
- Plan bids include projections of how they expect to allocate the rebates they receive from Medicare
  - Plan projections are prospective and so might not reflect how rebates are actually used
- High spending reflects growth in both MA enrollment and rebates paid per enrollee

Note: MA (Medicare Advantage). Rebates paid to non-employer plans were estimated using rebate amounts from MA bids. Medicare pays employer plans based on the bidding behavior of non-employer plans in the prior year. We estimate the rebate-related portion of Medicare's payments to employer plans as the product of the difference between the benchmark and the plan's base payment rate, a plan-specific rebate percentage (based on the plan's star rating), and the plan's risk score.

Source: MedPAC analysis of data from CMS on plan bids, enrollment, benchmarks, payments to employer plans, and risk scores.

Types of MA supplemental benefits

Enhanced Part D benefits

- Reduced basic Part D premiums
- Lower cost sharing
- Coverage of additional drugs

Reduced cost sharing

- Lower cost sharing for Part A and Part B services
- Maximum out-of-pocket limit*

Non-Medicare services

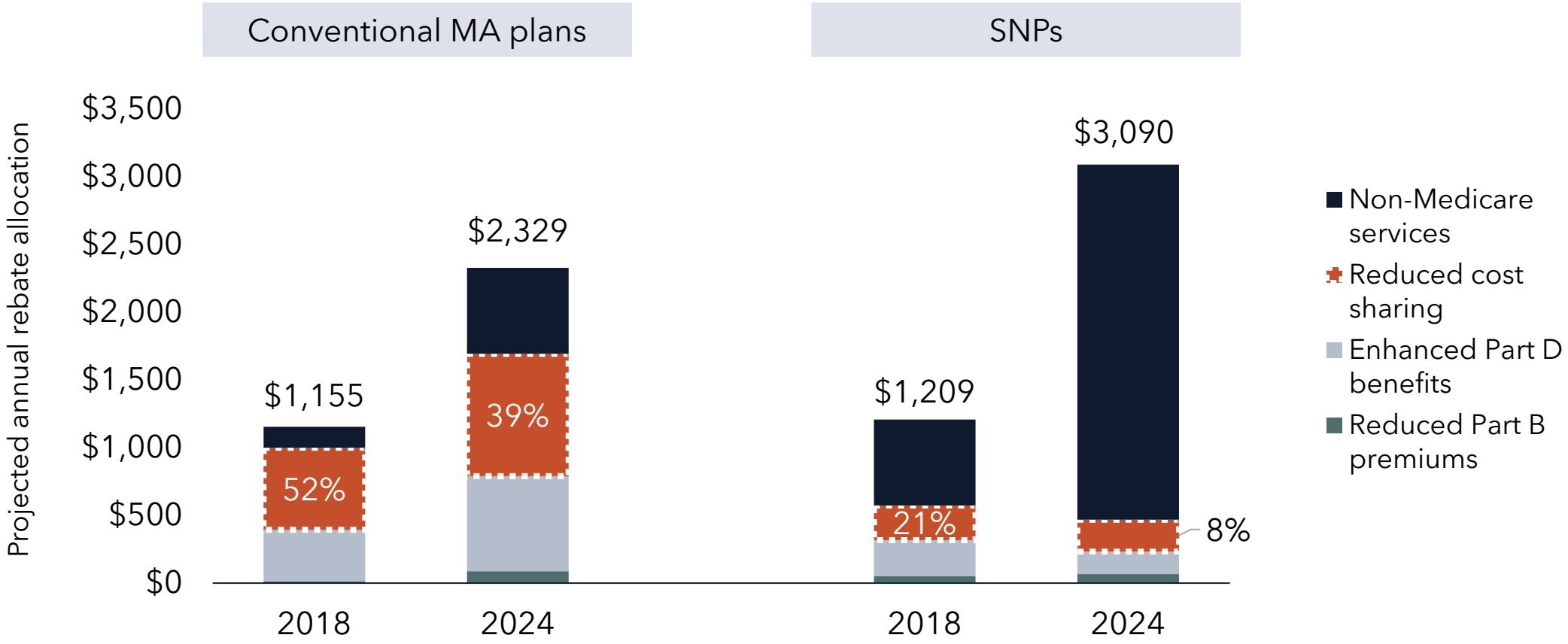
- Coverage of services such as dental, vision, or hearing benefits

Reduced Part B premium

- Reduced Part B premiums
- It is relatively rare for plans to provide significant premium reductions

Note: MA (Medicare Advantage).
* MA plans are required to provide the maximum out-of-pocket limit but can use rebates to finance the benefit.

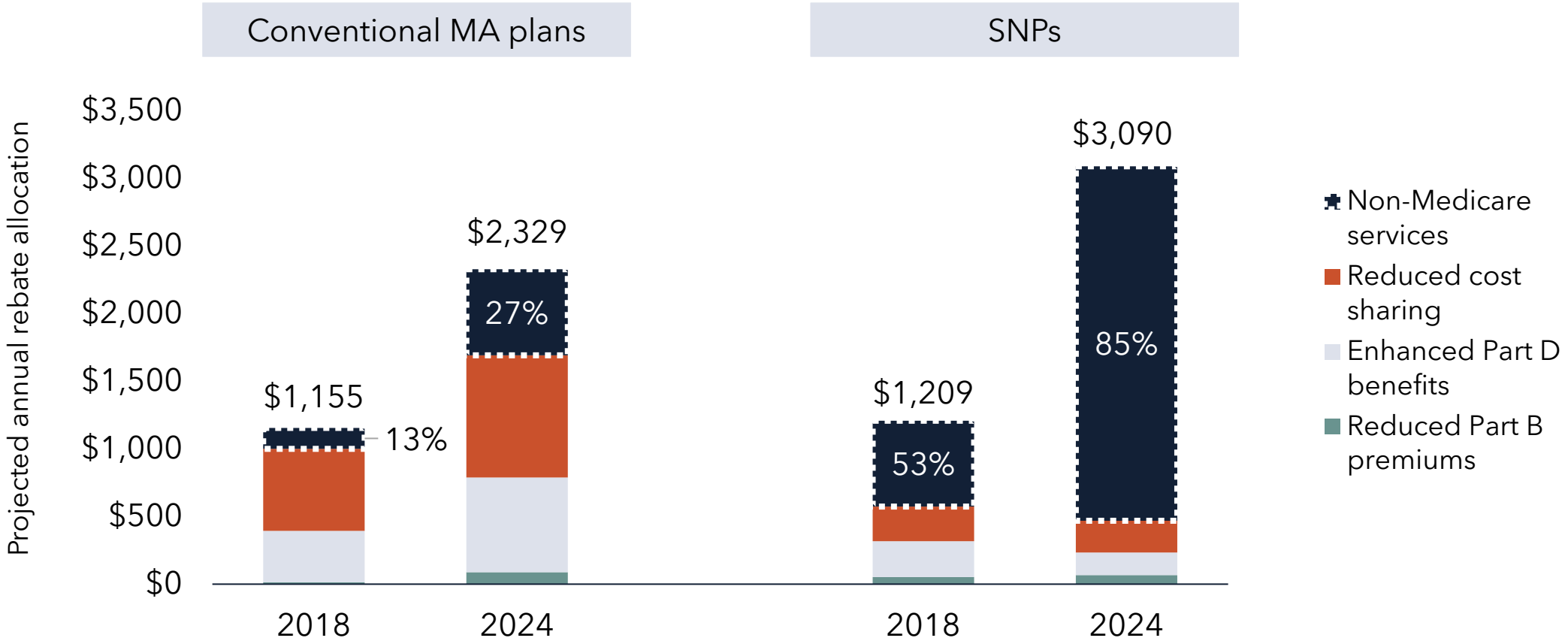
MA plans project using a smaller share of rebates to reduce cost sharing in 2024



Note: MA (Medicare Advantage), SNP (special needs plan). "Conventional MA plans" excludes employer group plans and SNPs. "SNPs" excludes employer group plans and non-SNPs. Excludes plans that do not offer a prescription drug benefit. Dollar amounts are nominal figures, not adjusted for inflation. Plan projections are prospective and so might not reflect how rebates are actually used.

Source: MedPAC analysis of MA bid data, 2018–2024.

MA plans project using a growing share of rebates to finance coverage of non-Medicare services in 2024



Note: MA (Medicare Advantage), SNP (special needs plan). "Conventional MA plans" excludes employer group plans and SNPs. "SNPs" excludes employer group plans and non-SNPs. Excludes plans that do not offer a prescription drug benefit. Dollar amounts are nominal figures, not adjusted for inflation. Plan projections are prospective and so might not reflect how rebates are actually used.

Source: MedPAC analysis of MA bid data, 2018–2024.

Little is known about MA enrollees' use of supplemental benefits

- As Medicare spending for MA supplemental benefits grows, it is increasingly important for policymakers to have reliable information about enrollees' use of the services
- The data that Medicare has collected thus far are significantly limited
- The lack of reliable data makes it impossible to answer many important questions about supplemental benefits:
  - Which enrollees use each benefit
  - Whether service use differs by age, sex, race, disability status, geography, etc.
  - How much plans spend on each type of benefit
- Better information could be used to generate new policy ideas that could be applied across the entire Medicare program
- Without better information, it is difficult to assess the potential value of supplemental benefits to MA enrollees and taxpayers

Note: MA (Medicare Advantage).

Currently available data tell us little about MA enrollees' use of supplemental benefits

- Available data are insufficient for examining enrollees' use of supplemental benefits
- We can gain some understanding from information that plans report as part of the annual bidding process

	Bid data	Plan benefit data
What the data include	Plan bids contain information about spending and utilization, aggregated to the plan- and service-category level	Plans submit information about the benefits they cover and the structure of that coverage
Limitations	Information about supplemental benefits is highly aggregated. Data for non-Medicare services is grouped into broad categories: dental, vision, hearing, transportation, and other	The data do not include information about MA enrollees' use of benefits

Note: MA (Medicare Advantage).

Plans' bid projections show how they expect to allocate cost-sharing reductions

Service category	Average plan-estimated cost-sharing reduction (PMPM)
Professional	$25.02
Outpatient, surgery	8.04
Part B drugs	4.76
Inpatient facility	4.65
Outpatient, emergency	3.99
Outpatient, other	3.67
Skilled nursing facility	2.60
Part B, other	1.40
DME	1.23
Home health	(0.16)
Ambulance	(1.03)

- Nearly all MA plans allocate a portion of the rebate to reducing what enrollees' out-of-pocket costs
- In their bids, plans estimate the amount that they anticipate their enrollees will pay in cost sharing for Medicare-covered services in the upcoming year
- We can gain a rough sense of the service categories for which plans expect to use relatively more of the rebate to reduce enrollees' cost sharing

Note: MA (Medicare Advantage), PMPM (per member per month), DME (durable medical equipment). "DME" includes DME, prosthetics, and certain diabetes-related products. Positive numbers indicate that estimated cost sharing in MA will be lower than estimated cost sharing in fee-for-service (FFS) Medicare without other coverage, while negative numbers indicate that MA cost sharing will be higher. The reductions reflect the combined effects of the required maximum out-of-pocket limit in MA and plans' benefit design decisions and use of rebates. Plan projections are prospective and so might not reflect actual spending.

Source: MedPAC analysis of MA 2024 bid data.

An increasing share of enrollees are in MA plans offering dental, vision, hearing, and transportation coverage

- The share of enrollees in conventional MA plans offering such coverage has increased significantly since 2014
- Coverage of these services varies across MA plans
- Numerous studies point to low utilization of dental services, though several of these studies use data from earlier years
  - Knowledge of utilization of other non-Medicare services is limited

Note: MA (Medicare Advantage).

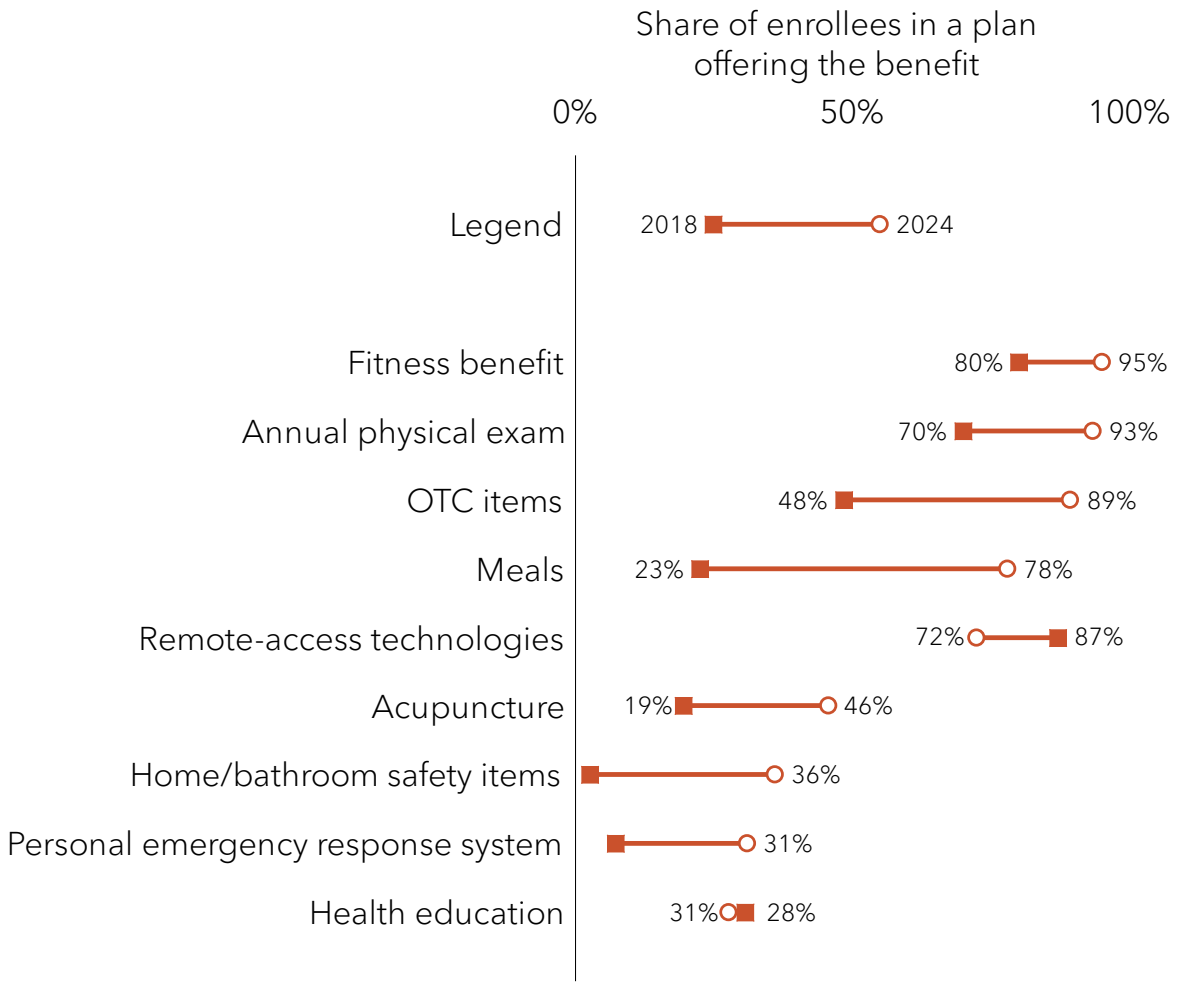
Sources: MedPAC analysis of MA bid data, 2014–2024; Willink et al. 2020; Wix & Fontana 2024; Wix & Fontana 2020.

Medicare has expanded the types of services plans can offer and how they can be targeted

- Originally, supplemental benefits were required to be "primarily health related" and offered "uniformly" to all enrollees
- Plans have been granted more flexibility in recent years
  - Expanded definition of "primarily health related"
  - Expanded definition of "uniformity" to target a particular "health status or disease state"
  - Special supplemental benefits for the chronically ill (SSBCI)
    - Coverage of services such as meals, food and produce, nonmedical transportation, and pest control services
  - MA–VBID model allows plans to target services based on socioeconomic status

Note: MA (Medicare Advantage), VBID (value-based insurance design).

The share of MA enrollees in plans offering other 'primarily health-related' benefits has risen

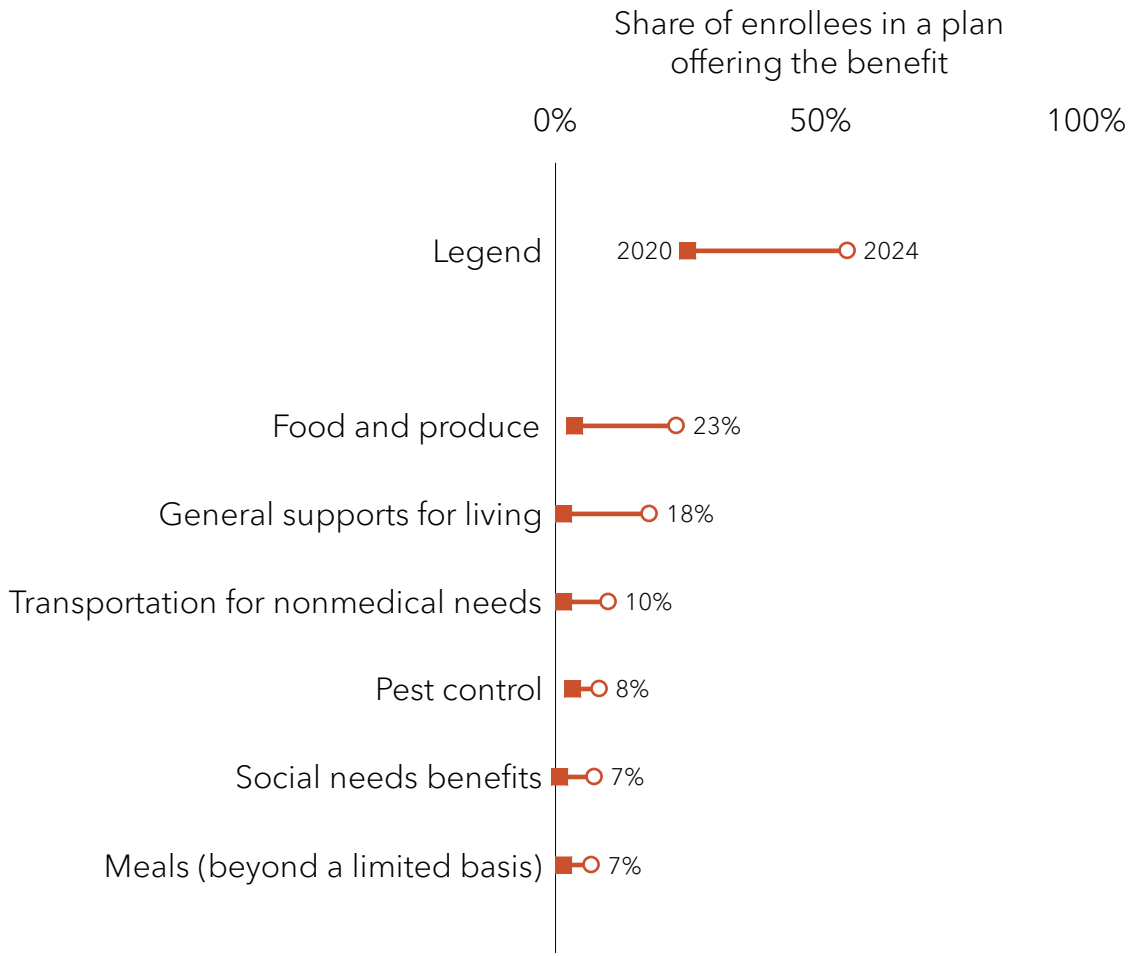


- A large share of MA enrollees are in plans offering coverage of other "primarily health-related" non-Medicare services
- In 2024, fitness benefits, annual physical exams, and coverage of OTC items were most common

Note: MA (Medicare Advantage), OTC (over-the-counter). Includes conventional MA plans and special needs plans; excludes employer group plans.

Source: MedPAC analysis of MA bid data.

An increasing share of MA enrollees are in plans offering SSBCI



- SSBCI are nonmedical benefits that can be targeted to chronically ill enrollees
- In 2024, food and produce and "general supports for living" were most common
- The share of MA enrollees in plans offering SSBCI has risen but remains relatively low

Note: MA (Medicare Advantage), SSBCI (special supplemental benefits for the chronically ill). Includes conventional MA plans and special needs plans; excludes employer group plans.

Source: MedPAC analysis of MA bid data.

MA plans increasingly deliver benefits using "combined" benefit arrangements

	2021	2024
Share of enrollees in plan offering a combined benefit		
Conventional MA plans	4%	45%
SNPs	6	86
Average annualized spending limit in combined benefit plans		
Available benefits: only dental, vision, and hearing	$350	$721
Available benefits: OTC and SSBCI	447	1,507
Conventional plans	*55*	*452*
SNPs	*513*	*1,798*

Note: MA (Medicare Advantage), SNP (special needs plan), OTC (over-the-counter), SSBCI (special supplemental benefits for the chronically ill). "Conventional MA plans" excludes employer group plans and SNPs. "SNPs" excludes employer group plans and non-special needs plans. "Combined benefit plans" excludes "dental-only" plans in which the plan offers only dental services under the combination benefit. Dollar amounts are not adjusted for inflation. We estimate the annualized limit for each plan by scaling the value of the benefit according to the time and dollar limits applied by each plan. For example, for a plan using a limit of $100 per quarter, we would calculate an annualized limit of $400.

Source: MedPAC analysis of MA plan benefits data.

CMS is implementing new policies to collect and improve data on MA enrollees' use of non-Medicare services

- New encounter-data submission requirements will provide more information about non–Medicare services (e.g., dental services) at the claims level
- New reporting requirements will provide plan-level information about enrollees' use of non-Medicare services and plans' spending on these services

Note: MA (Medicare Advantage), SSBCI (special supplemental benefits for the chronically ill).
Source: Centers for Medicare and Medicaid Services, 2024.

Until better data are available, it is difficult to assess the value provided by the $83 billion Medicare spends on MA supplemental benefits

- We estimate that Medicare will pay MA plans about $83 billion in rebates to provide supplemental benefits in 2024
- Medicare does not have good data about how MA's cost-sharing reductions and coverage of non-Medicare services affect enrollees
- Recent actions by CMS may address some shortcomings of the current data, but new data will not be available until next year (at the earliest)
- As a next step, we plan to explore the extent to which MA encounter data can be used to assess enrollees' use of vision, hearing, and transportation services

Note: MA (Medicare Advantage), CMS (Centers for Medicare & Medicaid Services)

Discussion

- Questions
- Feedback on materials
- This material will be included in our June 2025 report to the Congress

MEDPAC

Advising the Congress on Medicare issues

Medicare Payment Advisory Commission

www.medpac.gov

@medicarepayment