Humana

January 27, 2024
Paul B. Masi, M.P.P.
Executive Director
Medicare Payment Advisory Commission
425 I Street, NW, Suite 701
Washington, D.C. 20001

Dear Mr. Masi:

Humana Inc., headquartered in Louisville, Kentucky, is a leading health care company that offers a wide range of insurance products and health and wellness services that incorporate an integrated approach to lifelong well-being. Humana currently serves approximately 6.2 million beneficiaries enrolled in our Medicare Advantage (MA) plans and 2.3 million beneficiaries enrolled in our Medicare Part D Prescription Drug Plans (PDPs). As one of the nation's top contractors for MA, we are distinguished by our long-standing, comprehensive commitment to Medicare beneficiaries across the United States. These beneficiaries – a large proportion of whom depend upon the MA program as their safety net – receive integrated, coordinated, quality, and affordable care through our plans. Our perspective is further shaped by the comprehensive medical coverage we provide for Medicaid beneficiaries in seven states.

This letter is in response to content shared in MedPAC's January 2025 public meeting, comparing MA payment to FFS cost, which finds that 2025 MA payments are 20% higher than equivalent FFS cost.[1] We note that the content shared in the January 2025 meeting relies on work that was originally published in the March 2024 Report to the Congress and previous publications. Humana has completed a detailed review of MedPAC's published work on the topic of MA Payments compared to FFS cost, including supporting research on favorable selection and coding intensity, and we would like to take this opportunity to offer constructive feedback on the methodology used in the analysis.[2] Humana shares MedPAC's aim of improving the Medicare program and ensuring payments to MA plans that are sustainable, fair and adequate to provide for the health coverage needs for millions of Medicare beneficiaries. All of Humana's recommendations below are offered with the goal of improving the accuracy of MedPAC's assessment of MA Payments, compared to FFS, and ensure that stakeholders are given the best information with which to make policy decisions.

MedPAC's analysis includes:

- A base comparison of MA payments (prior to any adjustment for coding intensity or favorable selection) of 100% of the expected FFS cost for MA beneficiaries

[1] The Medicare Advantage program: Status Report. January 17, 2025 meeting
[2] Humana recognizes that MedPAC's presentation alludes to methodology changes that will be explained in more detail in the March Report. All recommendations and commentary included here are based on information that MedPAC made public as of the writing of this letter.

- 10% adjustment for coding Intensity[3]
- 11% adjustment for favorable selection.

Humana acknowledges the reasons for assessing coding patterns and beneficiary selection differences between MA and FFS; however, the specific methods that MedPAC uses leave significant room for opportunity, described in more detail below.

The points below outline areas where **Humana recommends methodological changes** to improve the accuracy of MedPAC's study on MA Payments.

1. When estimating coding intensity, MedPAC should explore alternative morbidity measures to the AAPCC, to account for clinical characteristics.
2. Regression-to-the-mean patterns in MA should be estimated based on patterns observed in FFS.
3. Attrition should be measured directly from FFS experience for MA-to-FFS Switchers.
4. Findings from the favorable selection study should not be extrapolated to the full MA population, pending further research justifying the decision to extrapolate.

Coding Intensity

The AAPCC is an inadequate tool for measuring population morbidity.

The Demographic Estimate of Coding Intensity (DECI) method for measuring coding intensity relies on the demographic-based AAPCC (Adjusted Average Per Capita Cost) model to compare "true" morbidity differences. However, the AAPCC model has very low predictive accuracy at measuring beneficiary cost (R^2 less than 1%) and doesn't take conditions into account (only demographics).

Humana notes that MedPAC's application of AAPCC within the context of DECI only requires that the model have predictive accuracy at an aggregate level, and not necessarily at the level of an individual.[4] However, MedPAC has not cited any research showing that the AAPCC attains predictive accuracy for larger groups of beneficiaries generally, or for MA beneficiaries specifically. The AAPCC was abandoned for use in 2004 by CMS in favor of a risk adjustment model that incorporates diagnoses from medical claims. CMS justified their decision, in part, based on the recognition that the AAPCC was unable to measure population health accurately for sicker groups of beneficiaries.[5]

---

[3] Estimate is net of CMS-applied Coding Intensity Factor, which reduces 2025 MA payments by 5.9%

[4] Topic raised in 1/17/2025 meeting discussion by Commissioner Kan, with response by Drs. Johnson and Chernew – January-2025-public-meeting-transcript-SEC.pdf.

[5] Evaluation of the CMS-HCC Risk Adjustment Model, Final Report (p7) – *"… [the AAPCC] payment methodology was not appropriately compensating plans enrolling sicker beneficiaries or plans specializing in treating high-cost populations, such as beneficiaries with particular chronic diseases or high levels of functional impairment."*

Humana recommends *MedPAC explore alternative approaches to measuring morbidity that account for clinical characteristics, not just demographics. Improvements to the DECI should also include a more refined demographic matching between MA and FFS (e.g. for geographic footprint, disability status, other factors beyond the sex and dual status currently used) and should incorporate clinical data into the morbidity model that are demonstrated to predict beneficiary-level cost more accurately. Additionally, Humana asks that MedPAC cite any studies, or publish their own internal research, indicating that the AAPCC improves its predictive accuracy when used to predict population health in aggregate.*

Favorable Selection

The study's method for estimating regression-to-the-mean (RTM) introduces unnecessary bias.

The study's estimate of regression-to-the-mean relies heavily on the assumption that we can use experience in the years *prior to* enrolling in MA to infer patterns for MA beneficiaries in the years *after* enrolling in the MA plan. However, several factors suggest that the years after enrolling in MA differ meaningfully from the years prior to enrolling in MA. For example, the years after enrolling in MA are necessarily going to reflect a more aged population than the years prior to enrolling in MA; where aged beneficiaries tend to be higher utilizers, with higher mortality rates, and therefore likely to not exhibit the same claims trend patterns as beneficiaries in the pre-MA period. These differences in age and mortality, between eventual MA enrollees and current MA enrollees, makes the years prior to enrolling in MA unsuitable for estimating RTM patterns in the years after enrolling in MA, and likely introduces bias into the analysis.

One method to avoid the bias that comes from using earlier years' MA experience to estimate RTM patterns, would be to model MA RTM patterns off RTM patterns observed in FFS data. We note that the longitudinal beneficiary-level enrollment and FFS claims needed for this analysis are readily available. The FFS population is likely to be far more representative of the MA population, in terms of mortality patterns, than the earlier years' experience of eventual MA enrollees, and various statistical methods could be employed to account for any relevant differences between the FFS and MA populations.

Humana recommends *MedPAC discard their current analytical framework for quantifying RTM and instead consider adopting a methodology based on examining RTM patterns within FFS to infer RTM patterns within MA.*

The attrition portion of the study is biased due to survivorship and uses unsuitably old data to infer attrition-related favorable selection.

The study's estimate of favorable selection due to attrition suffers from two concerns:

1. The cost comparison removes high-cost decedents from the MA population, but not the FFS comparison population, thus biasing the study findings to make MA beneficiaries artificially look healthier than they are[6].
2. The study estimates costs for beneficiaries leaving MA by examining those same beneficiaries' costs prior to joining MA. However, large time gaps (sometimes as much as ten years or more) between the point of joining MA and leaving MA make the pre-MA time period an unsuitable basis for estimating cost patterns at the point of attrition from MA.

Humana recommends *both concerns should be mitigated by measuring attrition based on actual excess FFS risk-adjusted cost for MA-to-FFS switchers. This mitigates the survivorship bias because neither the MA nor FFS populations have any implicit or explicit survivorship requirements imposed. Moreover, this method directly examines cost patterns at the point of attrition, avoiding any need to make inferences based on pre-MA-enrollment claims experience*.[7]

Extrapolation from the study population to the full MA population likely overstates MEDPAC's favorable selection estimate.

The study was conducted on less than half of the MA population, but the study findings are used to draw conclusions about the entire MA population. This assumption effectively doubles the favorable selection estimate, increasing the 2024 favorable selection estimate by nearly 5 percentage points. We note that MedPAC provided references to other studies in support of this methodological decision. However, when considering the magnitude of this assumption, Humana finds that the weight of the evidence provided is inadequate.

Given the manifest differences between the study populations and those excluded from the study, **Humana recommends** *that the study's findings should not be extrapolated to the full MA population, pending further research justifying the decision to extrapolate.*

We appreciate the efforts of MedPAC to provide fair analysis, insights and perspectives which help to improve the Medicare program, as well as MedPAC's willingness to take Humana's feedback into consideration.

[6] Survivorship requirements are implicitly applied to the MA cohort because any decedent MA beneficiaries are deemed to be part of the attrition cohort. No such implicit requirement is placed on the comparator FFS cohort.

[7] For an example of how to apply Humana's recommendation, we note one recent study by KFF that studies favorable selection due to attrition by examining risk-adjusted FFS costs for recent MA-to-TM switchers.

Sincerely,

Chris Chappelear
Senior Vice President, Chief Insurance Actuary

Mike Hoak
Vice President, Public Policy, Corporate Affairs