Medicare’s Financial Outlook and the Effects of Growing Enrollment in Medicare Advantage

Thursday May 23, 2024
2 to 3:30 p.m. EDT

Academy **Webinar**

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Presenters

Moderator

- Cori Uccello, MAAA, FSA, FCA, MPP
  Senior Health Fellow, American Academy of Actuaries

Panelists

- Paul Spitalnic, MAAA, ASA
  Chief Actuary, Office of the Actuary, Centers for Medicare & Medicaid Services (CMS/OACT)
- Michael E. Chernew, Ph.D.
  Chair, Medicare Payment Advisory Commission (MedPAC)

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Agenda

- Overview of the Medicare Trustees Report findings, including challenges to the program's solvency and sustainability.
- Discussion of how the increase in Medicare Advantage enrollment is affecting Medicare's financial condition, with a focus on MedPAC's analyses of the effects of coding intensity and favorable selection.

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The Financial Status of Medicare

A Summary of the 2024 Trustees Report

May 23, 2024

Paul Spitalnic
CMS Chief Actuary

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Agenda

- Current snapshot and evolution of the program
- Key results of the report
- Additional material
  - Recent changes in HI depletion date
  - Medicare Advantage trends

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Medicare Overview

	HI (Hospital Insurance)	SMI (Supplementary Medical Insurance)	
	Part A	Part B	Part D
Benefits	**Inpatient hospital care Skilled nursing care Home health care (post-institutional) Hospice care**	**Physician services Outpatient hospital services Home health care (general) Other services, e.g. Diagnostic tests Medical equipment Ambulance Physician-administered drugs**	**Prescription drugs**
Enrollment (CY2023)	**66.3 million**	**60.8 million**	**52.9 million**
Financing (CY2024)	**HI tax on covered earnings: • 1.45% payable by employees and employers, each • 2.90% payable by self-employed • Applies to all earnings in covered employment • Additional 0.90% for high-income earners Revenue from income taxation of OASDI benefits (portion between 50% & 85%)**	**Part B premiums: • $174.70 standard monthly premium for 2024 • Income-related premium • Premiums account for about 27% of revenue Government contributions account for about 72% of revenue Fees on Rx manufacturers and importers**	**Part D drug premiums, general revenues, and State transfers: • Base premium in 2024 is $34.70; average premium is $33.21; covers 13.5% of standard benefit costs • (13.4% of total revenue) • Income-related premium • State transfers (13.6% of revenue) • Government contribution (72.7% of revenue)**
Expenditures (CY2023)	**$403.1 billion**	**$502.9 billion**	**$131.1 billion**

Part C: Private plans that provide Part A and Part B coverage (Medicare Advantage)

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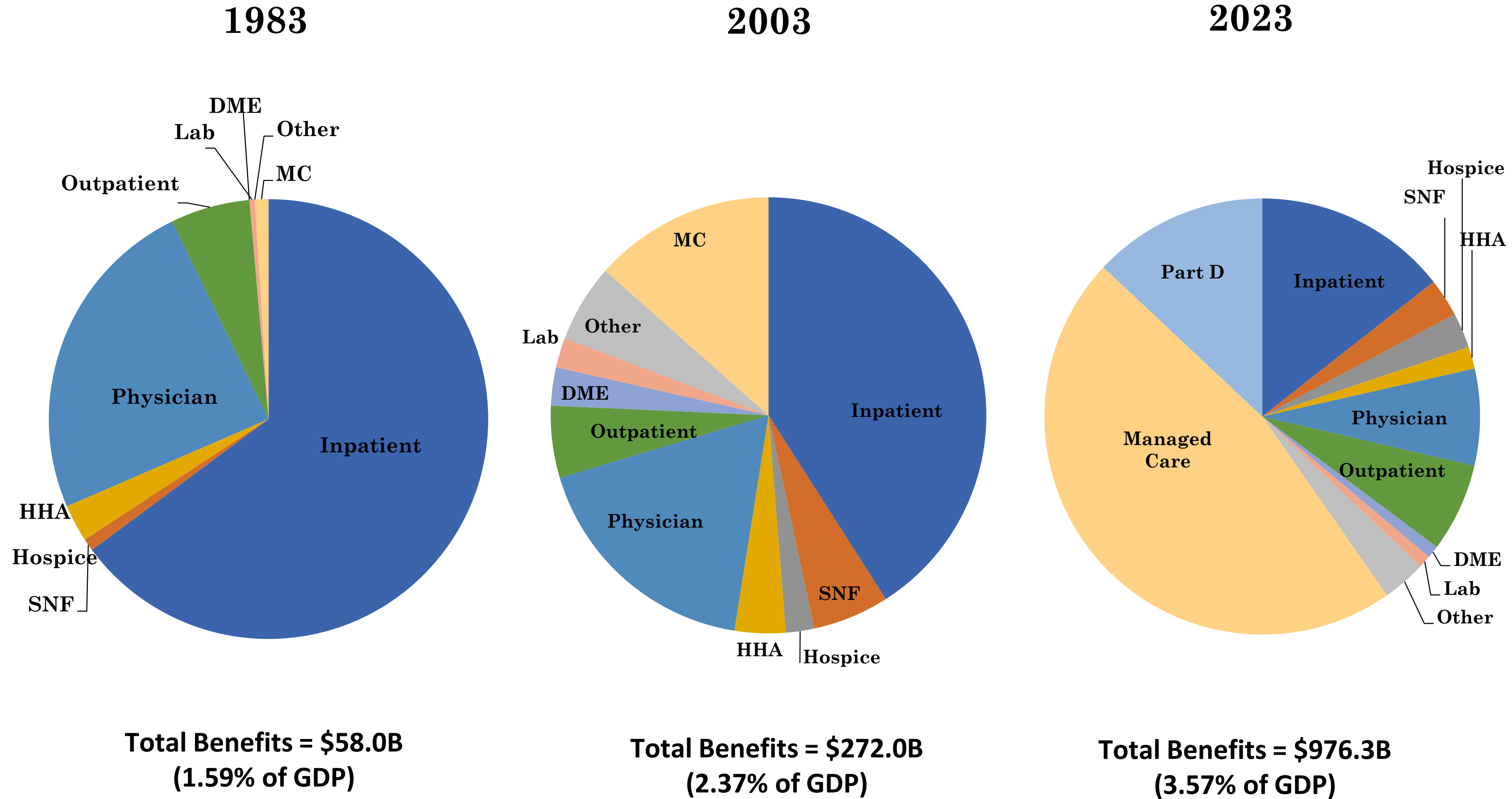
Medicare Benefits by Category



Total Benefits = $58.0B (1.59% of GDP)

Total Benefits = $272.0B (2.37% of GDP)

Total Benefits = $976.3B (3.57% of GDP)

Note: Totals represent incurred benefits only and do not include QIO, Fraud & Abuse, or admin.

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Key Results of the 2024 Trustees Report

- Hospital Insurance trust fund depletion date is 2036
  - 5 years later than estimated in last year's report

- Factors affecting depletion date:
  - Expenditures – 2024-2033 lower than 2023 report by 4.7%
    - Policy change to exclude medical education expenses associated with Medicare Advantage (MA) enrollees from the fee-for-service per capita costs used in the development of MA spending

  - Income – 2024-2033 higher than 2023 report by 3.2%
    - Higher payroll taxes (more covered workers and higher average wages)

Key Modeling Changes

- Post public health emergency, Medicare FFS per capita spending has stabilized
  - Trustees place a greater reliance on recent experience when developing cost projections.
- Remaining FFS trend adjustments
  - Morbidity improvement in the surviving population which is expected to affect spending levels through 2029
  - Ending of the waiver regarding the 3-day inpatient stay requirement to receive SNF services
  - Home health spending that was still, in 2023, significantly lower than estimated prior to the pandemic

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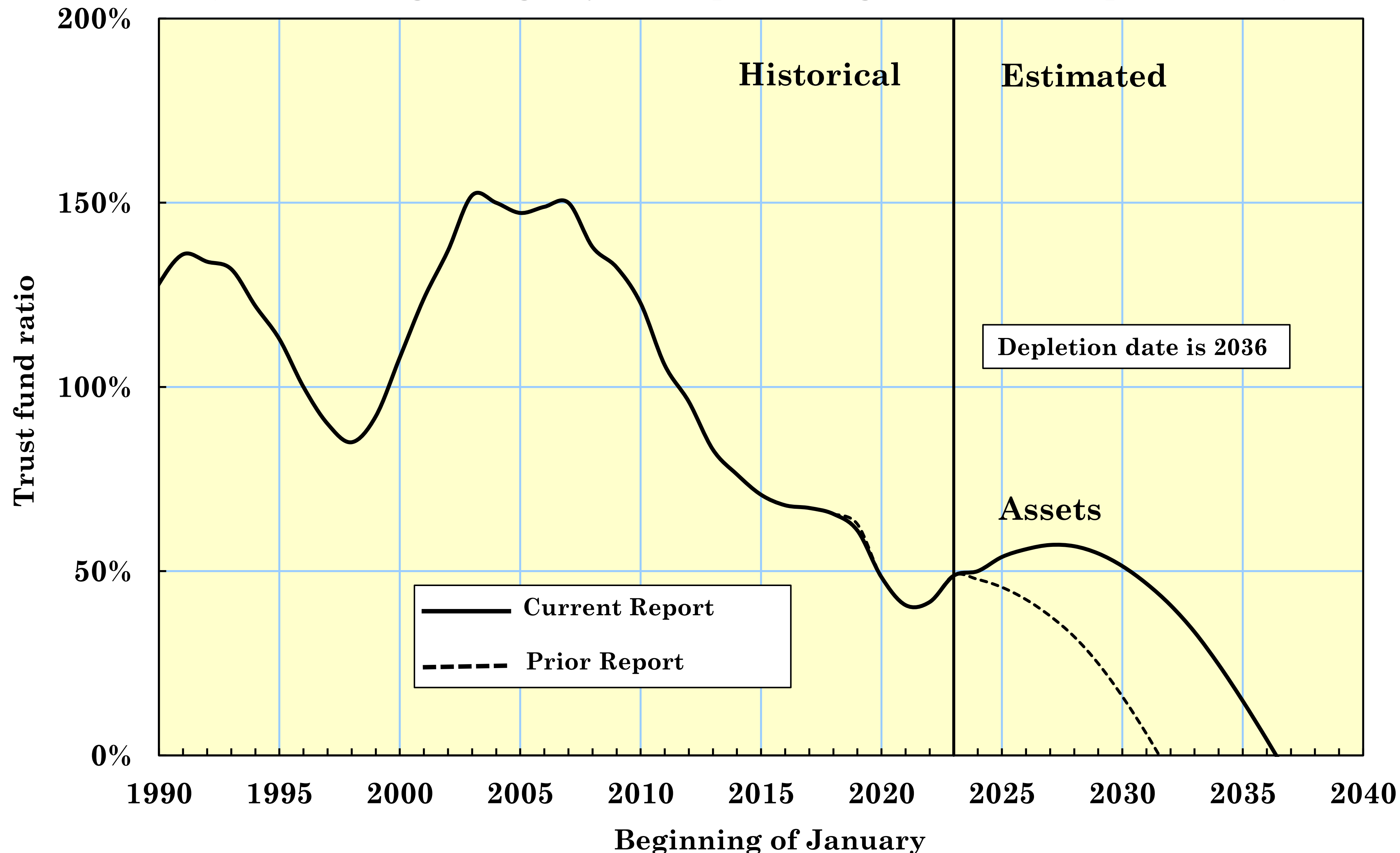
HI fund ratio

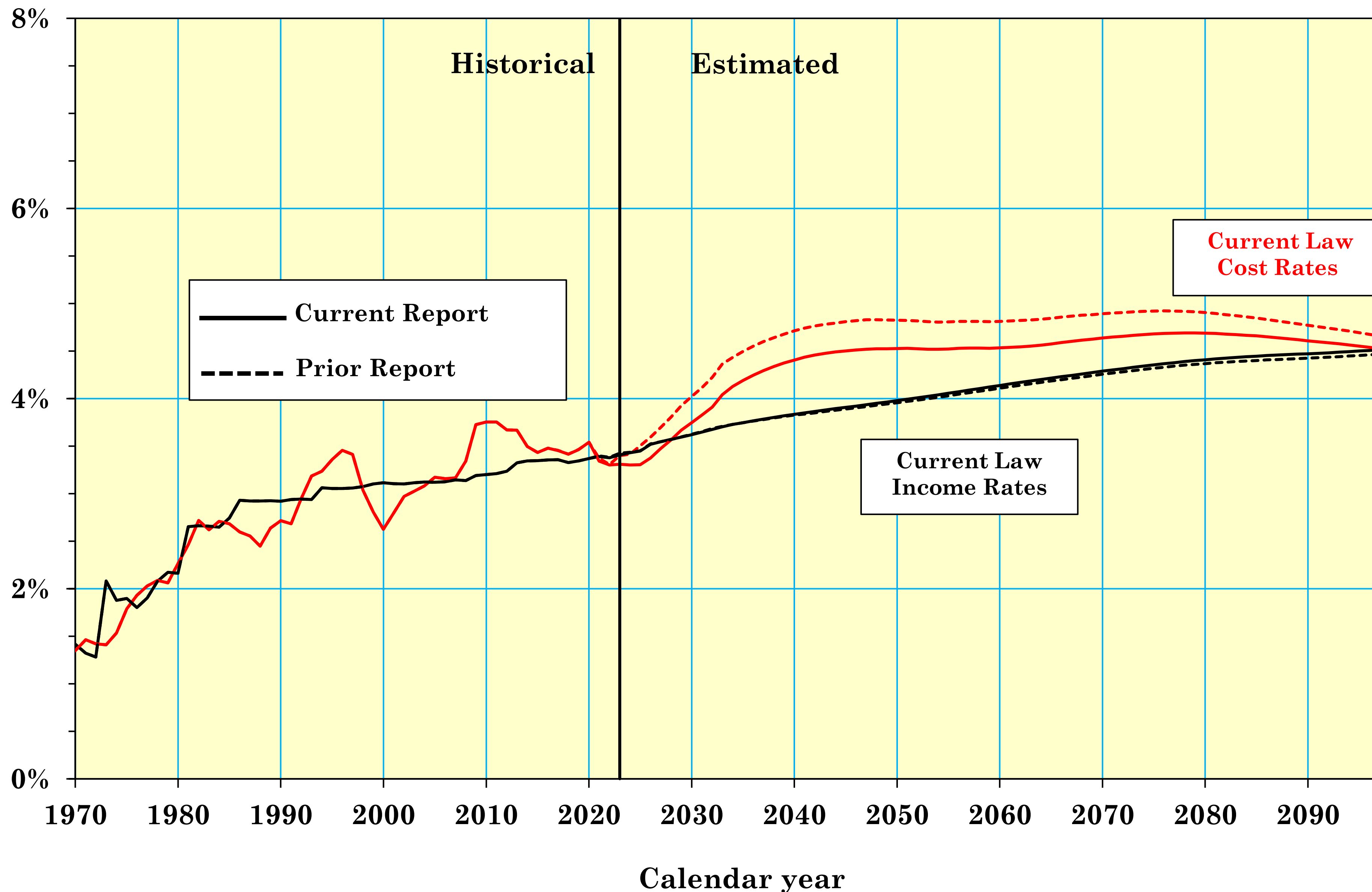
2024 Report compared to 2023 Report

(Assets at beginning of year as percentage of annual expenditures)



Note: Projections are based on the assumptions from the 2024 & 2023 Trustees Reports.

Long-range HI Income and Cost Rates
2024 Report compared to 2023 Report



Note: Projections are based on the assumptions from the 2024 & 2023 Trustees Reports.

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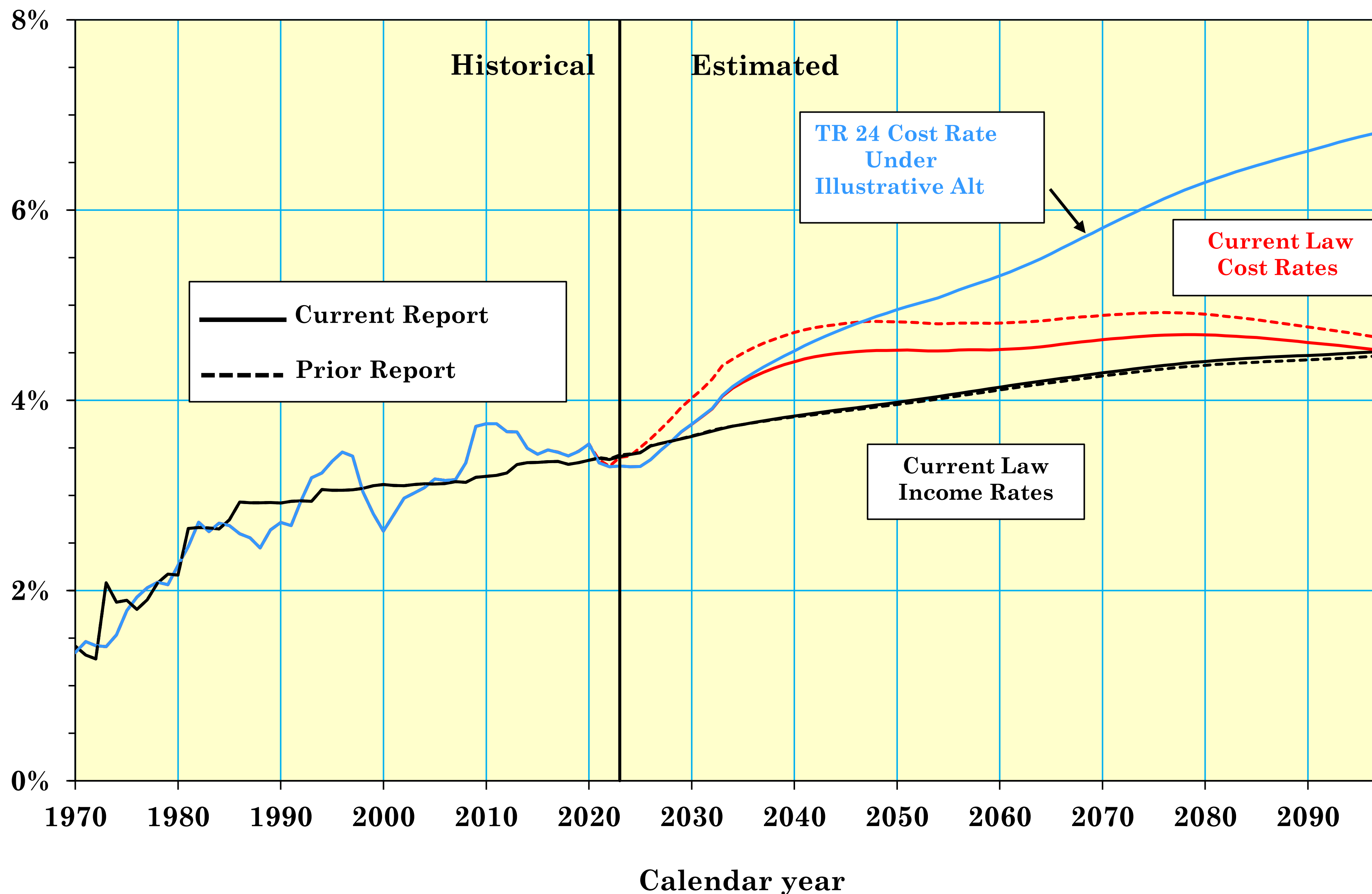
Long-range HI Income and Cost Rates

2024 Report compared to 2023 Report



Note: Projections are based on the assumptions from the 2024 & 2023 Trustees Reports.

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75-year HI Actuarial Balance

- Present value of income rate less cost rate
  - Rates compare income or costs to taxable payroll

75-year PV	2023 Report	2024 Report
Income rate	4.05%	4.09%
Cost rate	4.67%	4.44%
Actuarial balance	-0.62%	-0.35%

Note: Projections are based on the intermediate assumptions from the 2023 and 2024 Trustees Reports.

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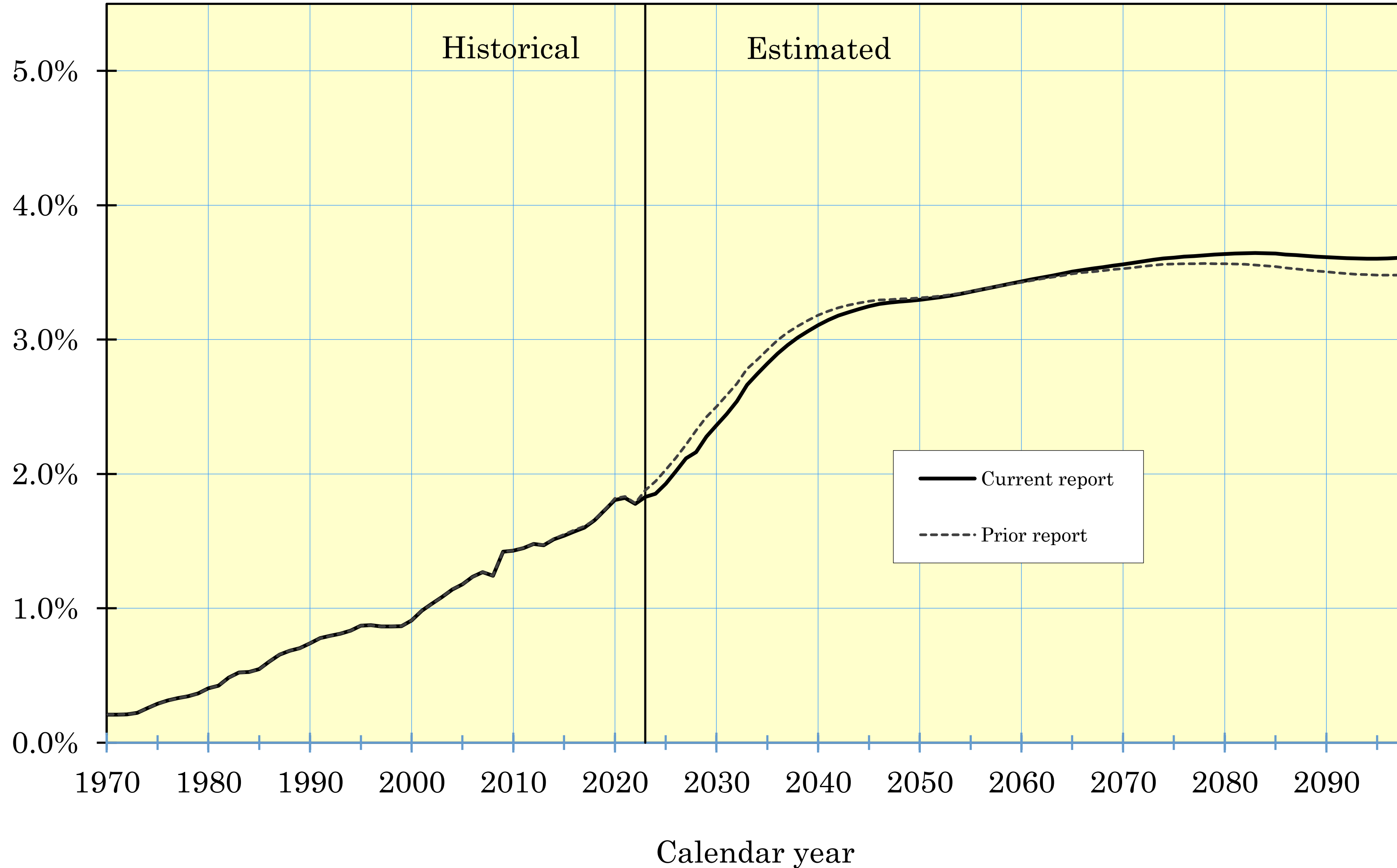
Part B Spending as a Share of GDP

2024 Report compared to 2023 Report



Note: Projections are based on the assumptions from the 2024 & 2023 Trustees Reports.

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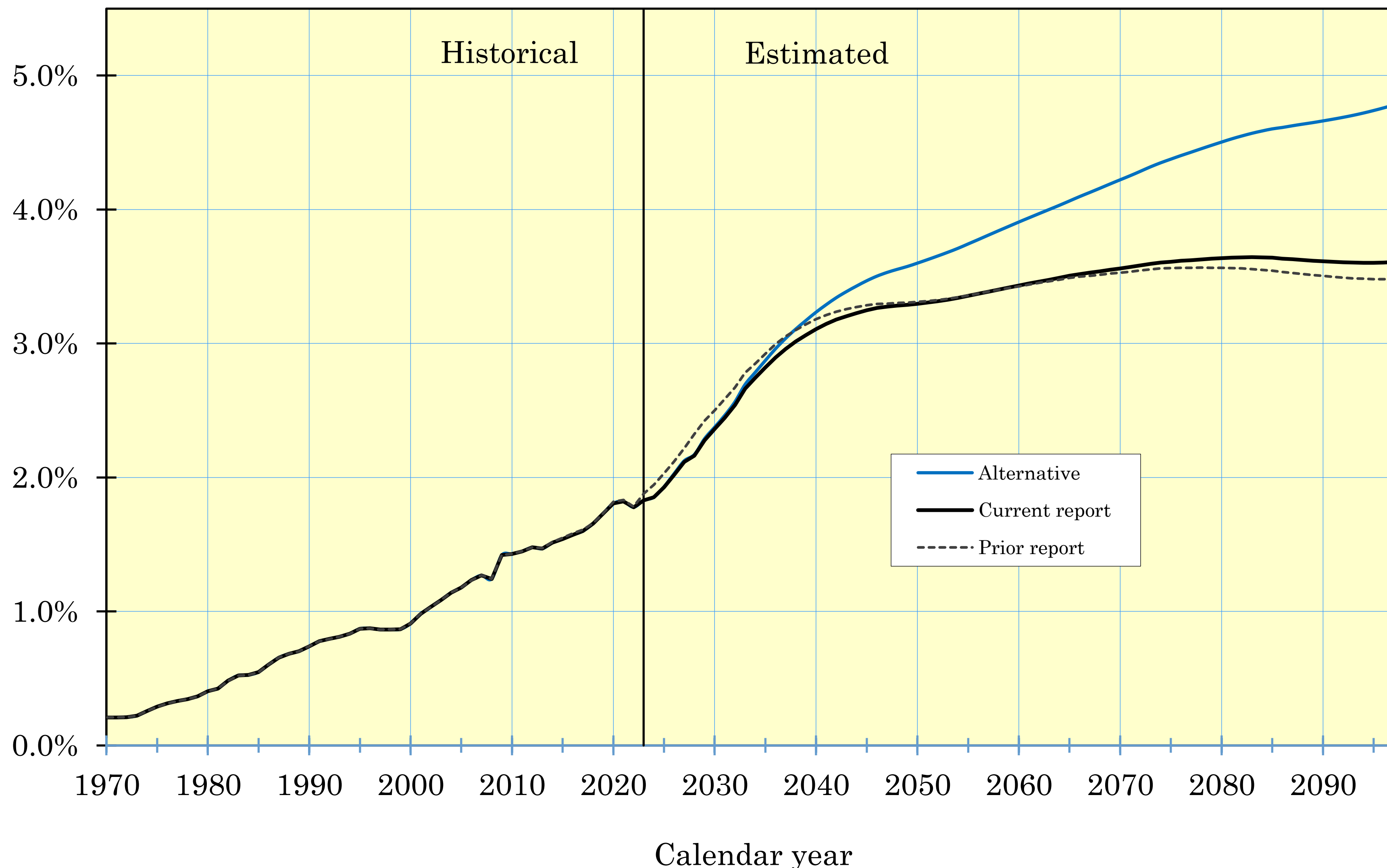
Part B Spending as a Share of GDP

2024 Report compared to 2023 Report



Note: Projections are based on the assumptions from the 2024 & 2023 Trustees Reports.

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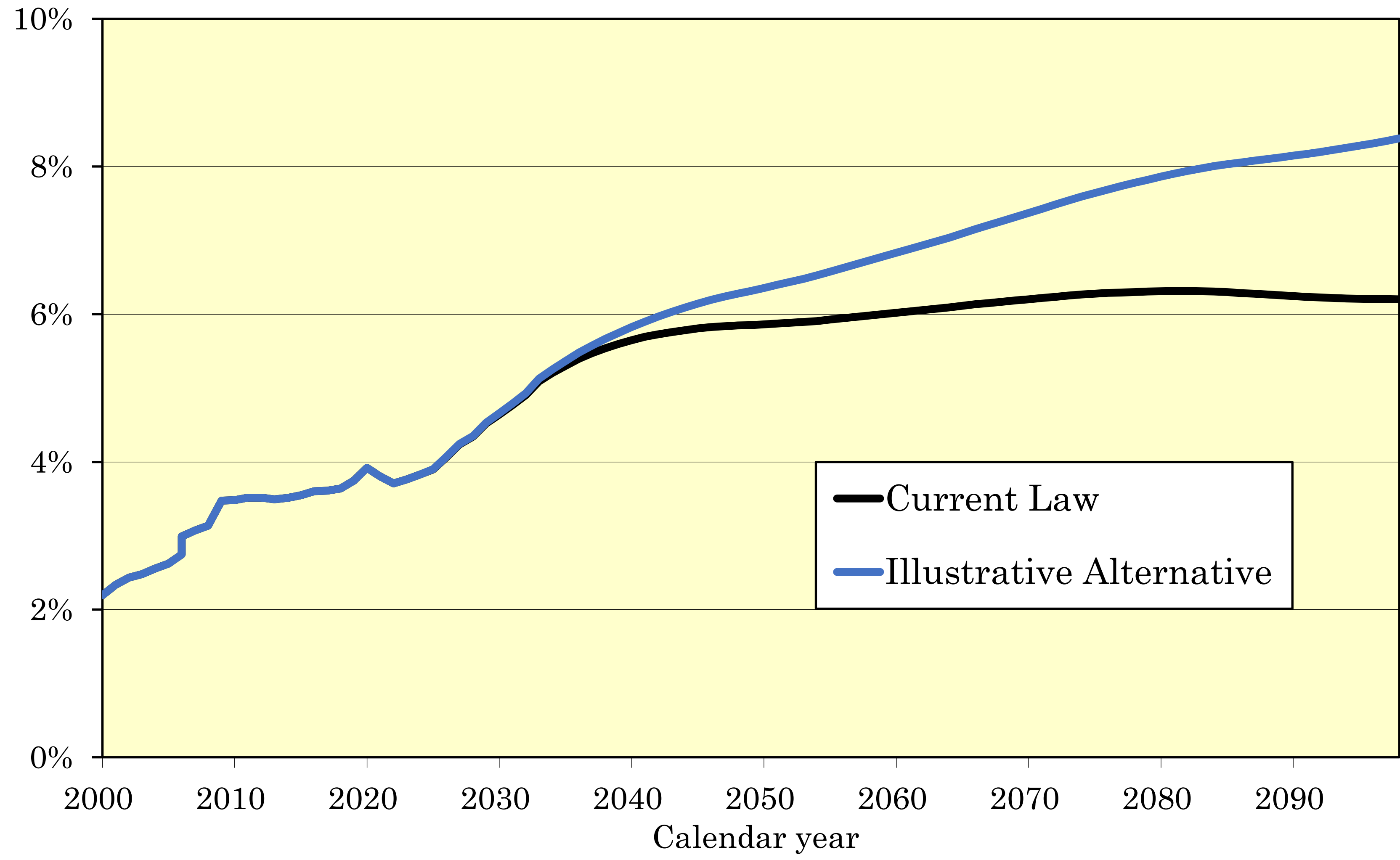
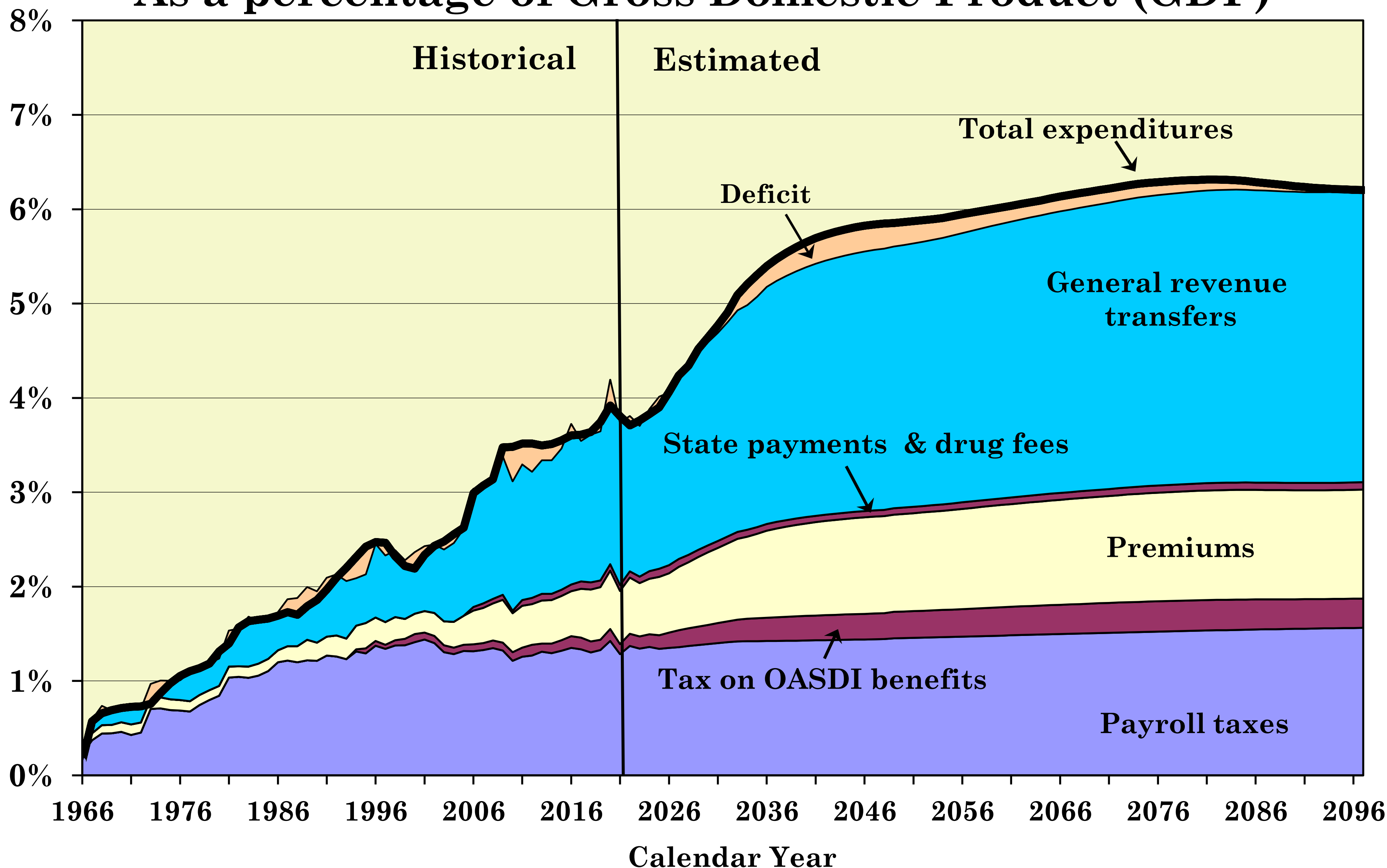
Medicare Spending as a Share of GDP
2024 Report compared to 2023 Report



Note: Projections are based on the assumptions from the 2024 Trustees Reports.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Medicare Sources of non-interest income and expenditures
As a percentage of Gross Domestic Product (GDP)
8%
7%
6%
5%
4%
3%
2%
1%
0%
Historical
Estimated
Total expenditures
Deficit
General revenue transfers
State payments & drug fees
Premiums
Tax on OASDI benefits
Payroll taxes
1966
1976
1986
1996
2006
2016
2026
2036
2046
2056
2066
2076
2086
2096
Calendar Year
Note: Projections are based on the intermediate assumptions from the 2024 Trustees Report.

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Additional Material

Recent HI Depletion Dates

Report	2018	2019	2020	2021	2022	2023	2024
Depletion	2026	2026	2026	2026	2028	2031	2036

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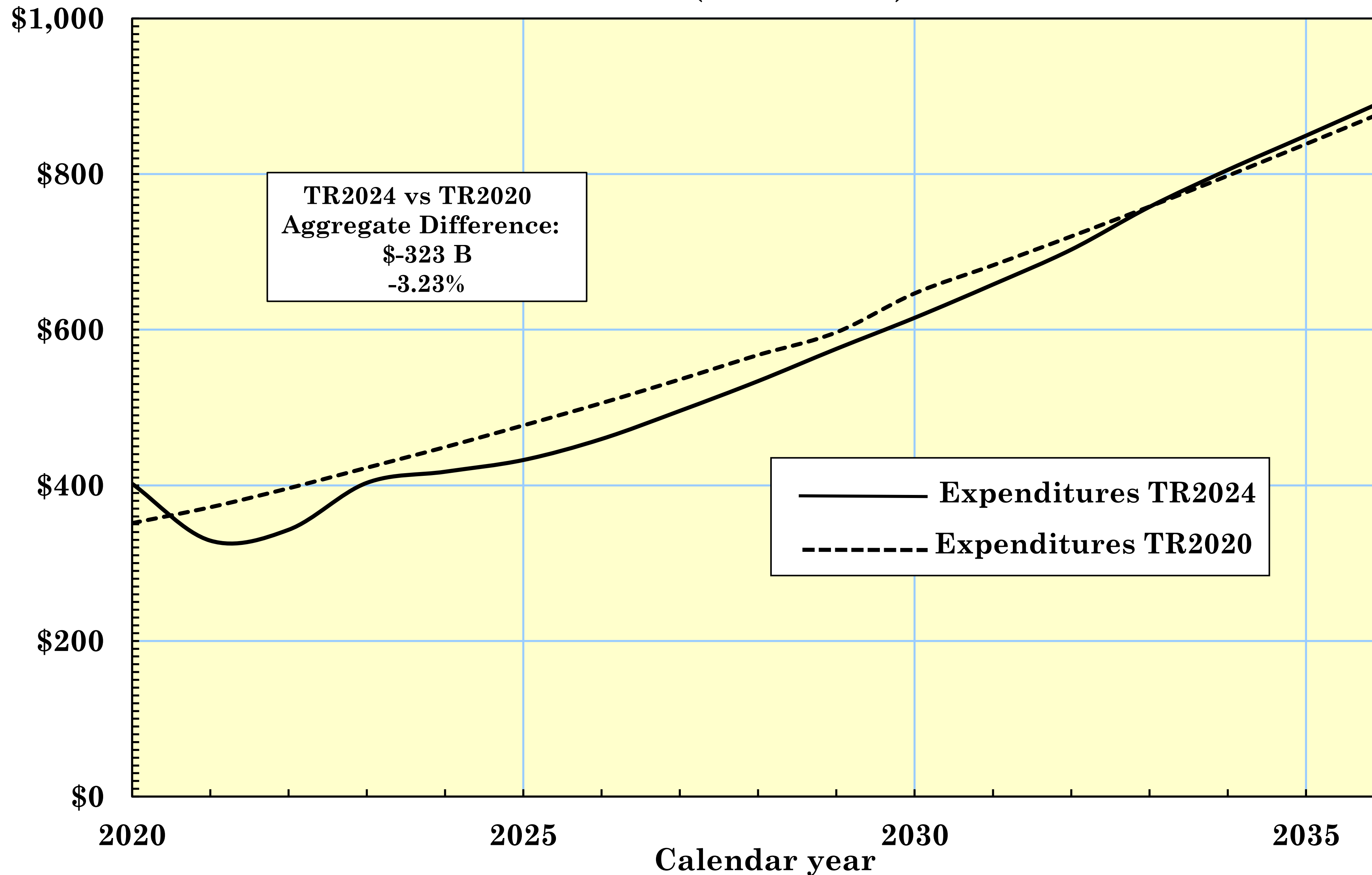
HI Expenditure Projections (Cash) TR2024 vs TR2020 (In billions)



Note: Projections are based on the intermediate assumptions from the 2020 and 2024 Trustees Reports.

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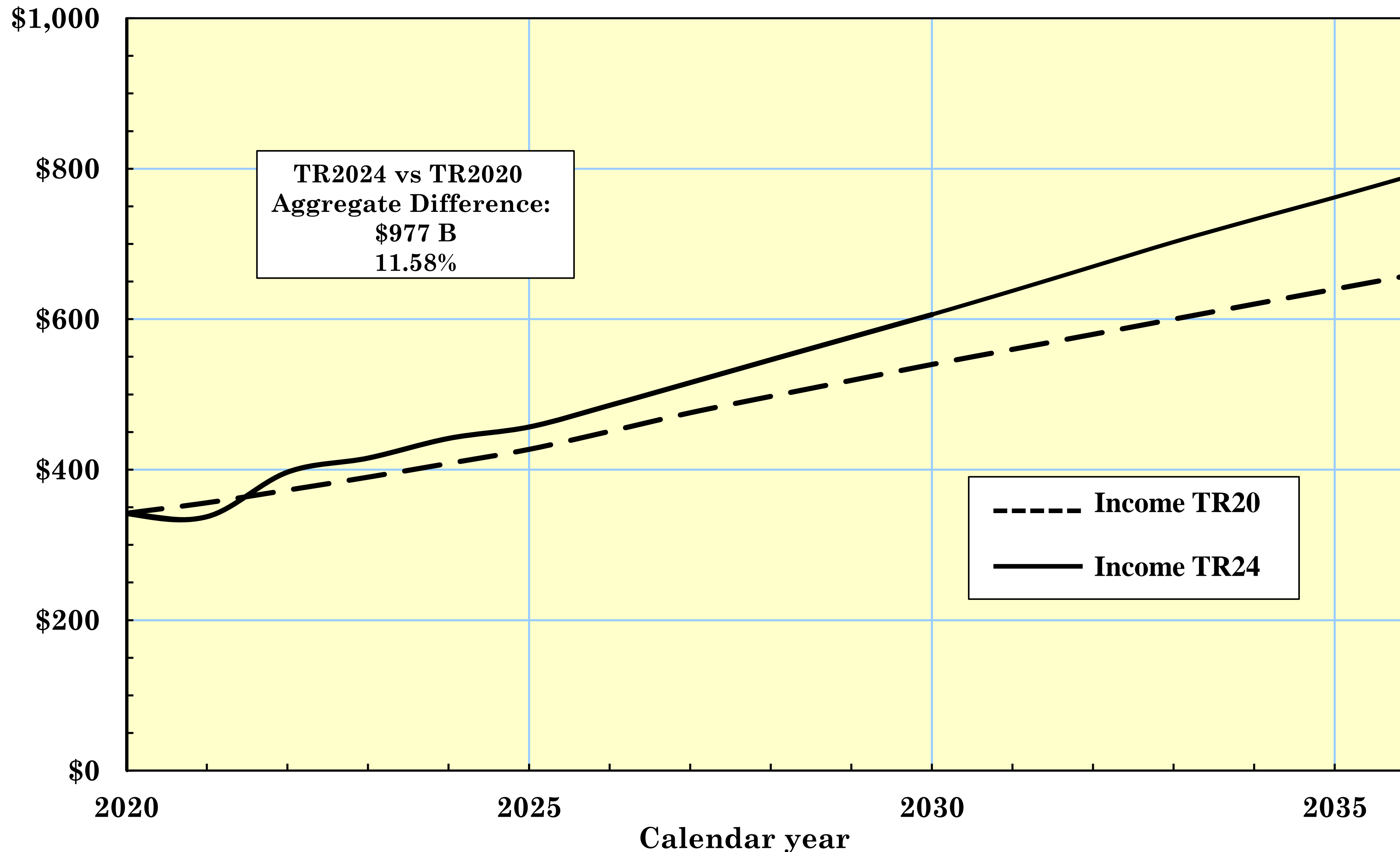
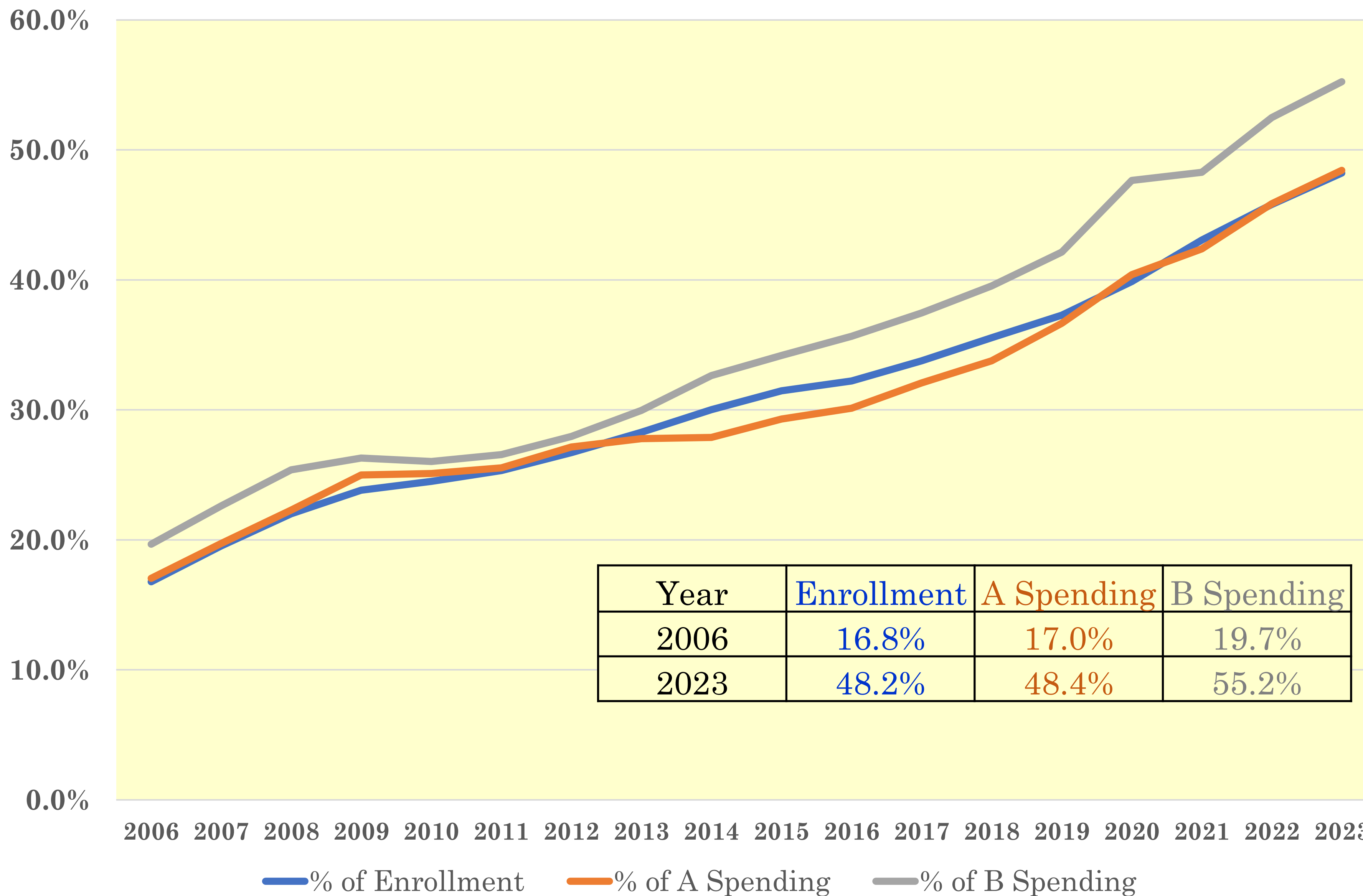
HI Income Projections (Cash)
TR2024 vs TR2020
(In billions)



Note: Projections are based on the current law intermediate assumptions from the 2020 and 2024 Trustees Reports.

MA Shares



Year	Enrollment	A Spending	B Spending
2006	16.8%	17.0%	19.7%
2023	48.2%	48.4%	55.2%

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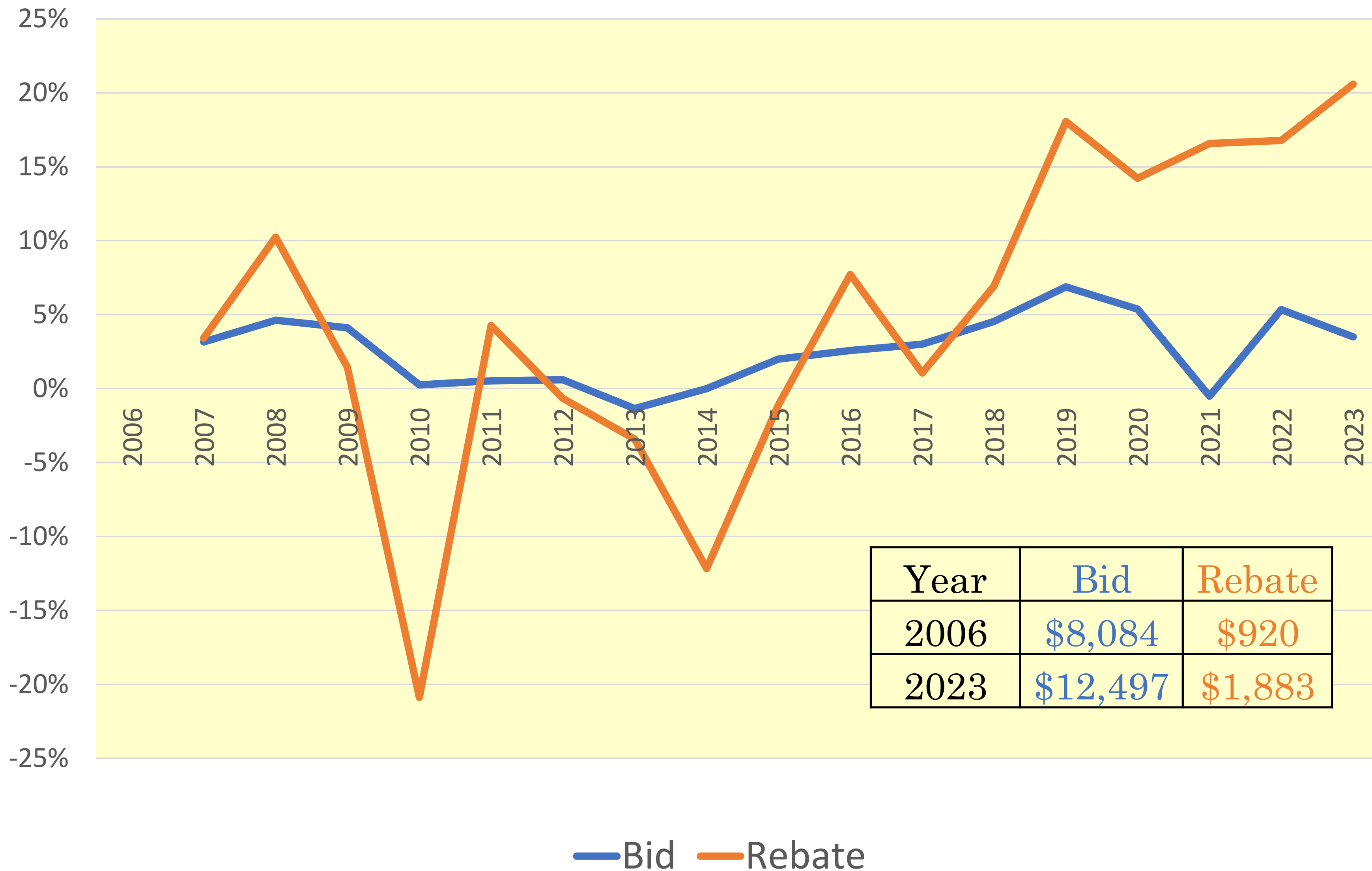
MA Annual Bid and Rebate Growth



Year	Bid	Rebate
2006	$8,084	$920
2023	$12,497	$1,883

MEDPAC

Advising the Congress on Medicare issues

MedPAC's comparison of spending on Medicare Advantage and fee-for-service Medicare

Michael E. Chernew, Ph.D.

May 23, 2024

Today's discussion

- Overview of MedPAC
- MedPAC's MA analyses comparing spending in MA and FFS
  - Payments to MA plans
  - Estimating coding intensity
  - Estimating favorable selection
- Questions/discussion

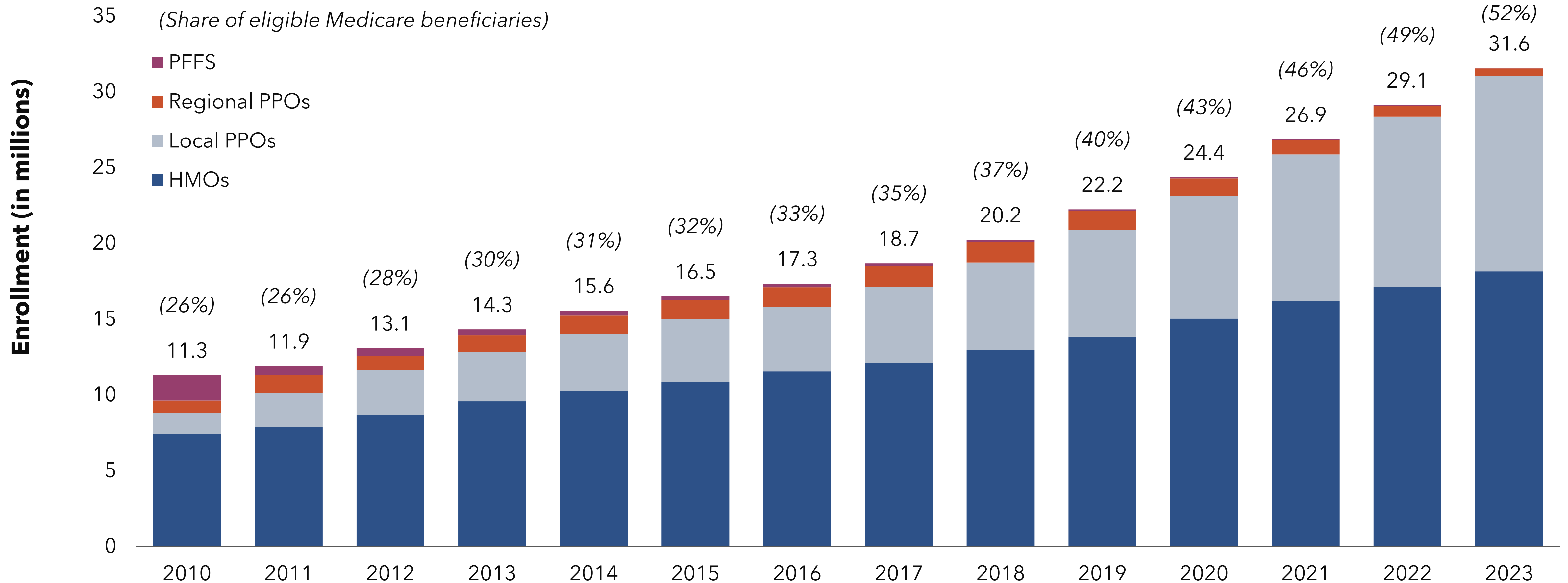
MedPAC's mission and structure

- Provide independent, nonpartisan policy and technical advice to the Congress on issues affecting the Medicare program
- 17 Commissioners selected by the Comptroller General of the Government Accountability Office (GAO) for experience and subject matter expertise
  - Include providers, payers, researchers, beneficiary-focused individuals
  - Serve 3-year terms, can be reappointed
- Commissioners supported by 25-30 analysts; most staff analysts are experts in their fields
- Seven public meetings during the year
  - Staff present analyses informed by site visits, focus groups with beneficiaries and providers, expert panels, input from stakeholders, quantitative analyses

Transparency in MedPAC’s work

- Commission meetings are open to the public and webcast
- Full meeting transcript publicly available on MedPAC’s website
- Presentations are available through webcast and MedPAC’s website
- Public comments are disseminated to commissioners and available on MedPAC’s website
- Other publications on MedPAC’s website include reports, comment letters, testimony, press releases, data books, payment basics, contractor reports, and recommendations
- Publish analytic agenda for the upcoming year

In 2023, 52% of eligible beneficiaries enrolled in MA plans



Note: PFFS (private fee-for-service), PPO (preferred provider organization), HMO (health maintenance organization). Beneficiaries must have both Part A and Part B coverage to enroll in a Medicare Advantage plan; therefore, beneficiaries who have Part A only or Part B only are not included in this figure.

Source: MedPAC analysis of CMS enrollment files, July 2010–2023.

Medicare's payments to MA plans

- Payment is based on plan benchmarks, quality, bids, and risk scores
  - Benchmarks range from 115% of FFS in lowest-FFS spending counties to 95% of FFS in highest-spending counties (4 quartiles of counties)
  - Benchmarks can be increased by 5 or 10 percent as a quality bonus for plans achieving 4 or more stars
  - A bid is the amount each plan expects it will cost to cover Part A and B
  - Risk scores increase or decrease MA plans' base payment rates to account for enrollee health status
- Nearly all plans bid below their benchmark
  - Plans receive a base payment of their bid plus a "rebate," which is a percentage (varying by quality score) of the difference between bid and benchmark

Note: MA (Medicare Advantage), FFS (fee-for-service). If bid is greater than the benchmark, Medicare pays the benchmark, and the enrollee pays a premium to make up the difference. However, this scenario is rare.

MA payment policy: Risk adjustment

- Risk scores are a beneficiary-specific index of expected spending relative to national average spending (a 1.0 risk score)
  - Based on beneficiary demographic characteristics and diagnoses
  - Used to standardize the FFS spending estimates that county benchmarks are based on, reflecting spending for a beneficiary of average health status
- The risk adjustment model is developed using data for FFS beneficiaries and reflects:
  - Expected spending for a beneficiary enrolled in FFS
  - The diagnostic coding patterns in FFS

Note: MA (Medicare Advantage), FFS (fee-for-service).

Comparing spending on MA and FFS Medicare

- Account for differences in health status, geography, etc.
- Relative to FFS, spending on MA varies due to:
  - Plan benchmarks
  - Quality scores
  - Plan bidding
  - Intensity of MA coding relative to FFS
  - Favorable selection of beneficiaries into MA
- Other comparisons might also be important for policymakers to consider, but this analysis focuses on Medicare spending

Note: FFS (fee-for-service), MA (Medicare Advantage).

MedPAC's comparison of MA payments relative to what FFS spending would have been for MA enrollees

- Base comparison: MA payments compared with local area FFS spending that is adjusted to have the same risk score profile as MA enrollees
- Adjust base comparison for unaccounted differences in risk scores: Coding intensity and favorable selection
- These are challenging analytic issues and we continue to refine our work

Share of FFS payment in 2024	
Overall	≈122%
Estimated before coding and selection	≈100
Estimated coding effect	≈+13
Estimated selection effect	≈+9

Note: MA (Medicare Advantage), FFS (fee-for-service).
Source: MedPAC analysis of data from CMS on plan bids, enrollment, benchmarks, FFS expenditures, and risk scores.

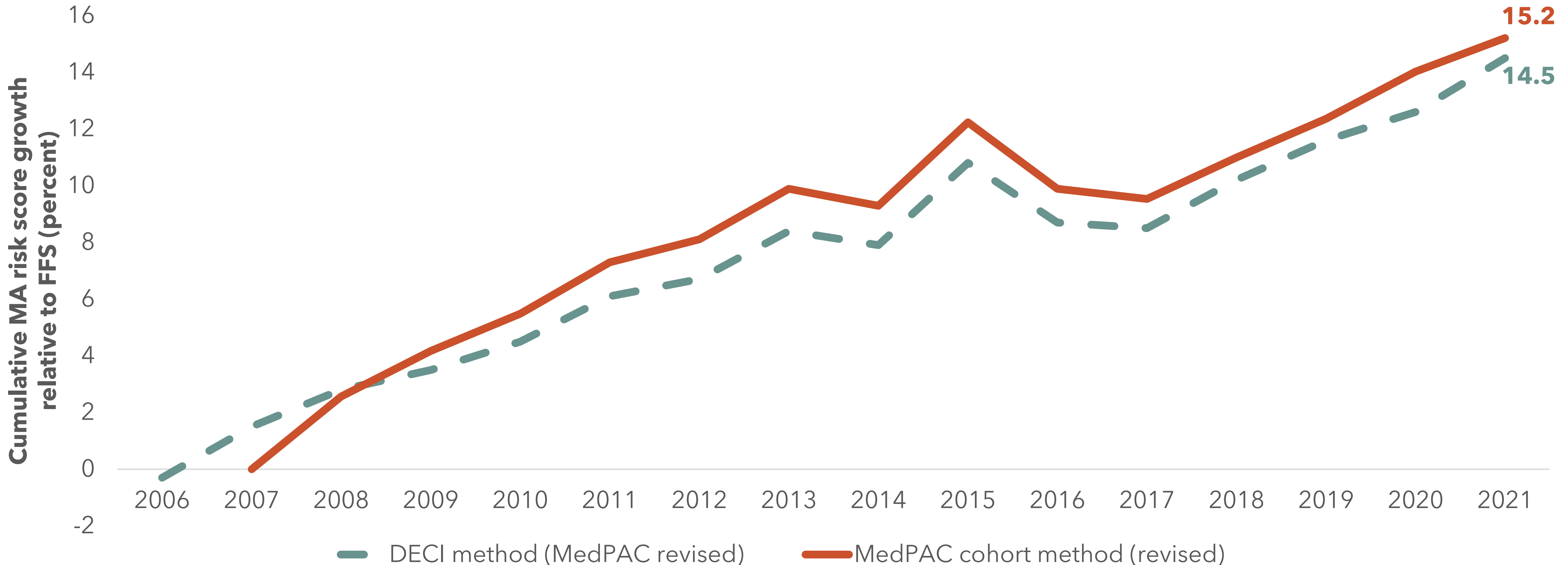
Incentives encourage differences in diagnostic coding

- FFS: Weak incentive to code diagnoses
- MA: Financial incentive and infrastructure to code more diagnoses through health risk assessments and chart reviews
  - Leads to greater MA risk scores for equivalent health status
- MedPAC's estimates of coding intensity
  - MedPAC refined two separate methods for estimating coding intensity
  - The two methods produced similar results with less than 1.5 percentage points difference each year from 2008 through 2022
  - MedPAC's findings are consistent with estimates published by CBO and GAO and in academic literature

Note: MA (Medicare Advantage), FFS (fee-for-service).

Source: Geruso, M., and T. Layton. 2020. Upcoding: Evidence from Medicare on squishy risk adjustment. *Journal of Political Economy* 12, no. 3 (March): 984–1026. Hayford, T. B., and A. L. Burns. 2018. Medicare Advantage enrollment and beneficiary risk scores: Difference-in-differences analyses show increases for all enrollees on account of marketwide changes. *Inquiry* 55 (January-December). Jacobs, P. D., and R. Kronick. 2018. Getting what we pay for: How do risk-based payments to Medicare Advantage plans compare with alternative measures of beneficiary health risk? *Health Services Research* (May 22). Kronick, R., and F. M. Chua, Department of Health and Human Services. 2021b. *Industry-wide and sponsor-specific estimates of Medicare Advantage coding intensity*. Kronick, R., and W. P. Welch. 2014. Measuring coding intensity in the Medicare Advantage program. *Medicare & Medicaid Research Review* 4, no. 2.

Estimates from MedPAC's revised DECI method and revised cohort method closely align, 2006 – 2021



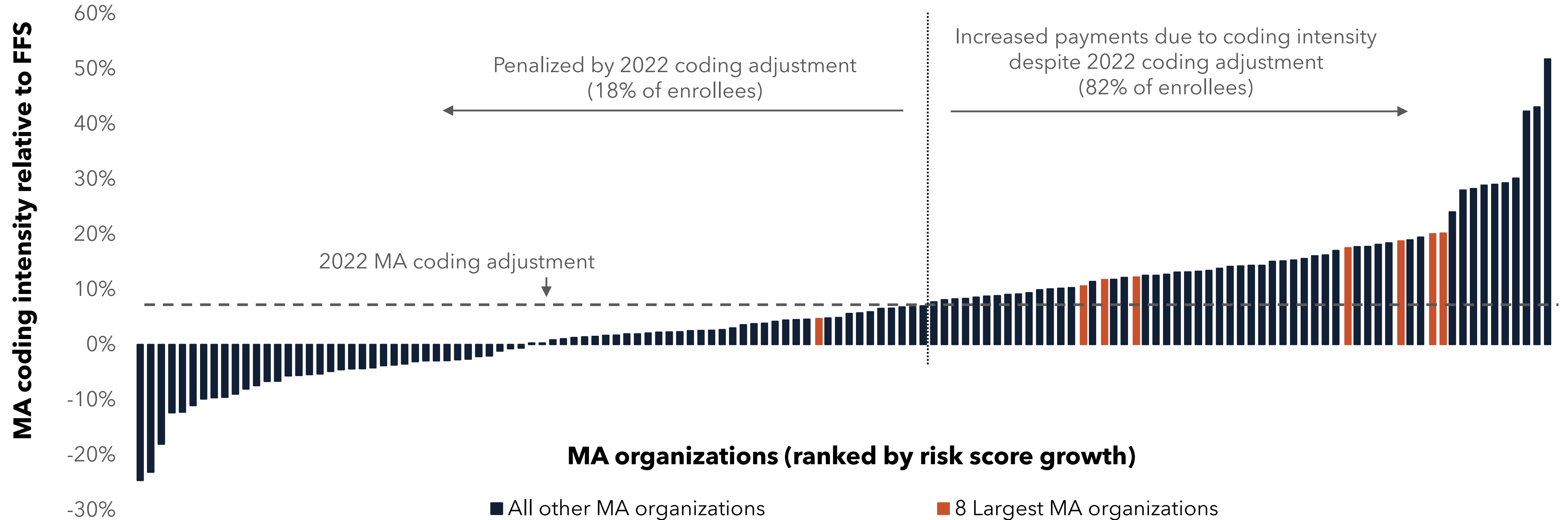
Notes: DECI (Demographic estimate of coding intensity). MA (Medicare Advantage). FFS (fee-for-service).
Source: MedPAC analysis of Medicare enrollment, risk score, and master beneficiary summary files, 2006 through 2021.

MA coding generates increased payments relative to FFS in 2024

- After accounting for CMS's coding adjustment, MedPAC projects 2024 MA risk scores will be about 13 percent higher relative to FFS
- MedPAC estimates $50 billion in increased payments to MA plans
  - MedPAC estimated the effects of higher MA coding intensity for 2007 through 2022
  - Projected estimates for 2023 and 2024 based on 2017 through 2021 trend (accounting for V28 risk model in 2024)

Note: MA (Medicare Advantage), FFS (fee-for-service).
Source: MedPAC analysis of data from CMS on plan bids, enrollment, benchmarks, FFS expenditures, and risk scores.

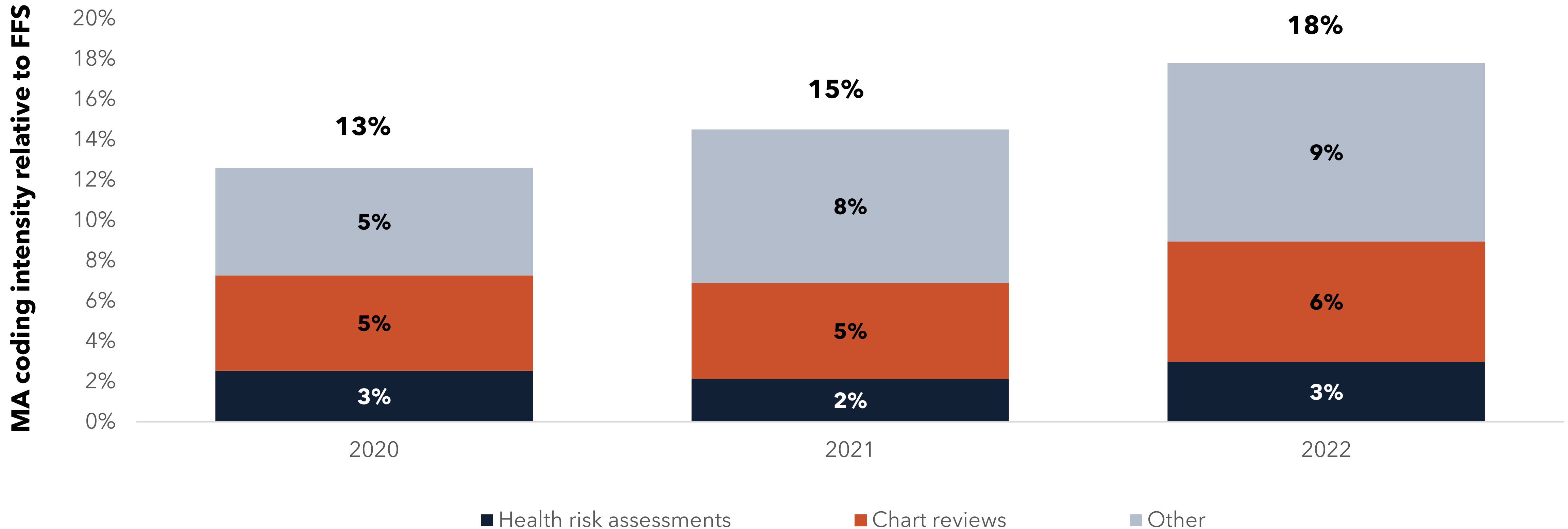
Coding intensity generates payment inequity across MA organizations



Note: MA (Medicare Advantage), FFS (fee-for-service). Estimates are for 2022 and exclude special needs plans, contracts for the Program of All-Inclusive Care for the Elderly, and organizations with fewer than 2,500 enrollees in the analysis. All estimates account for any differences in age, sex, Medicaid eligibility, and institutional status between MA and FFS populations. New enrollees are constrained to have no coding intensity as their risk scores are not based on diagnostic coding.

Source: MedPAC analysis of CMS enrollment and risk score files.

Chart reviews and health risk assessments account for about half of overall MA coding intensity, 2020-2022



Note: MA (Medicare Advantage), FFS (fee-for-service). The figure shows the impact of coding intensity on payments to MA plans for the years 2020 through 2022. The underlying diagnoses were reported during health care encounters in the prior year, 2019 through 2021, respectively. Health risk assessments are provided to Medicare beneficiaries as part of an annual wellness visit, and, for MA enrollees, health risk assessments are often provided during a plan-initiated home visit. Chart reviews are plan-initiated reviews of medical charts for health care encounters that are allowable for risk adjustment.

Source: MedPAC analysis of CMS enrollment and risk score files.

Background on favorable selection

- There is a distribution of actual spending for individuals with each risk score
- Favorable selection can occur if beneficiaries with lower-than-expected spending on average choose MA over FFS
  - Can occur at any risk score because it is the difference between expected spending and actual spending
- MedPAC initially published on this concept in June 2012; presented analyses in March 2023; published a chapter in June 2023; presented analyses in November 2023 and January 2024; and published analyses in March 2024

Note: MA (Medicare Advantage), FFS (fee-for-service).

MA plan and beneficiary incentives may produce favorable selection

- Favorable selection in MA occurs if spending for MA enrollees is systematically lower than their risk scores predict
- MA plan features may induce to favorable selection
  - Plan networks and prior authorization
  - Higher cost sharing for most services compared with Medigap
- Beneficiary preferences may contribute to favorable selection
  - Perception of MA networks and prior authorization
  - Beneficiaries who prefer more care may prefer FFS with supplemental insurance
  - Beneficiaries who prefer less care and extra benefits may prefer MA

Note: MA (Medicare Advantage), FFS (fee-for-service).

MedPAC analysis suggests that MA plans experience favorable selection

- We start by analyzing FFS spending in the year prior to MA enrollment, which allows us to measure selection before any plan intervention
- Adjust for changes that occur over time, which allows us to account for selective attrition and regression to the mean
- MedPAC estimates of favorable selection suggest:
  - 9% higher payments than for comparable beneficiaries in FFS in 2019 (March 2024 report to the Congress)
  - Estimates of favorable selection and coding are additive

Note: MA (Medicare Advantage), FFS (fee-for-service).

MedPAC's estimates of favorable selection are largely consistent with other researchers

- Even though studies vary widely in the way they measure selection, their sample populations, and the years of data used
  - Other researchers have found estimates ranging from about 7 to 16 percent
- We conducted several sensitivity analyses and found our results to be robust
  - Beneficiaries with less than two years of prior FFS coverage
  - Death among hospice and non-hospice users

Note: MA (Medicare Advantage), FFS (fee-for-service).

Source: Curto, V., L. Einav, A. Finkelstein, et al. 2019. Health care spending and utilization in public and private Medicare. *American Economic Journal: Applied Economics* 11, no. 2 (April): 302–332. Newhouse, J. P., M. Price, J. M. McWilliams, et al. 2019. Adjusted mortality rates are lower for Medicare Advantage than traditional Medicare, but the rates converge over time. *Health Affairs* 38, no. 4 (April): 554–560. Jacobs, P. D., and R. Kronick. 2018. Getting what we pay for: How do risk-based payments to Medicare Advantage plans compare with alternative measures of beneficiary health risk? *Health Services Research* (May 22). Jacobson, G., T. Neuman, and A. Damico. 2019. *Do people who sign up for Medicare Advantage plans have lower Medicare spending?* Washington, DC: Kaiser Family Foundation. Lieberman, S. M., S. Valdez, and P. B. Ginsburg. 2023. *Medicare Advantage enrolls lower-spending people, leading to large overpayments.* White Paper. June. Xu, L., W. P. Welch, S. Sheingold, et al. 2023. Medicare switching: Patterns of enrollment growth in Medicare Advantage, 2006-22. *Health Affairs* 42, no. 9 (September): 1203–1211.

Common types of questions about MedPAC's analysis

- Those that ask whether the estimate of the MA/FFS spending gap accurate
  - E.g., Does analysis accurately account for regression to the mean and selective attrition?
- Those that seek to understand how the estimates are consistent with other known facts
  - E.g., How could the effect of favorable selection increase as enrollment of high-spending beneficiaries (including dually eligible beneficiaries) in MA increases?
- Those that accept the estimate but ask if it is justified
  - E.g., Is the estimate of coding intensity driven by under coding in FFS, and should the comparison be adjusted to account for that?

Note: MA (Medicare Advantage), FFS (fee-for-service).
Source: Chernew, M. and P. Masi. Parsing the debate around the Medicare Advantage/Traditional Medicare Payment Gap. *Health Affairs Forefront*. March 15, 2024.

MEDPAC

Advising the Congress on Medicare issues

Questions/Discussion

Stephanie Cameron, Assistant Director, scameron@medpac.gov

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Questions and Answers

Please enter your question(s) in the “Ask Question” box on your screen.

The presenters will answer as many questions as time allows.

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Resources

2024 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds

March 2024 Report to the Congress: Medicare Payment Policy

Medicare's Financial Condition: Beyond Actuarial Balance

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