Medicare Advantage: Optional or Mandatory?

Discussion Questions

1. Do Medicare Advantage (MA) plans typically outperform traditional Medicare in apples-to-apples comparisons of beneficiary costs and beneficiary outcomes?
2. The data are clear that less is spent on beneficiaries in MA plans than beneficiaries in traditional, FFS Medicare. Is this due to differences in populations, differences in patient management or other factors?
3. Enrollment in MA varies tremendously by state: 43% of Minnesotans are enrolled in MA, compared to 3% of Wyomingites. What is responsible for this profound geographical variance and what, if anything, should be done about it?
4. MA plans often offer supplemental benefits that may help address beneficiaries' social determinants of health. Are these truly effective and fully utilized?
5. Researchers have noted that MA plans, because they are more efficient, could lower premiums to save both their beneficiaries and the taxpayer money. However, the bidding structures between MA plans and CMS incentivize competition based on generosity of benefits rather than significantly lower premiums. Should the bidding structure be changed so that the market is pushing leaner but less generous plans?
6. It seems that, while MA is more efficient than traditional Medicare, the savings do not revert directly to the taxpayer. Instead, these savings go toward supplemental benefits, marketing and administrative costs/profits. Is there a better way to structure the system?
7. Proponents of MA claim that - when compared to traditional, FFS Medicare - MA is more efficient, produces equal or better outcomes and encourages market competition. A lot of the data seem to support this position. This begs the question: Should all Medicare beneficiaries be mandated to enroll in MA plans, spelling the end of traditional Medicare?

Key takeaways

Commonly cited research emphasizes the success and momentum of the Medicare Advantage (MA) program, formally known as Part C of Medicare. This is largely because MA plans are

paid on a risk-adjusted, per-person rate rather than the fee-for-service (FFS) payments of traditional Medicare. Proponents of MA highlight evidence of cost savings as well as its ability to improve the quality and diversity of offerings to its enrollees due to its managed care approach. However, growing research suggests that while MA has the ability to significantly cut costs, these savings are not being drastically passed on to beneficiaries. Additionally, quality metrics for 2019 are incomplete and provide an unreliable comparison of MA and traditional Medicare.

The Debate

Medicare Advantage outperforms traditional, FFS Medicare and should thus fully replace it through mandate.

- Enrollment and accessibility are growing.
- Prioritizing preventative tests and screenings in MA enables significant cost savings related to chronic disease and emergent care.
- Plan offerings and extra benefits are at historically high levels.
- MA has shown to improve quality and reduce costs with greater enrollee choice and satisfaction.

Medicare Advantage already has problems that need to be fixed and universalizing it for beneficiaries through mandate would only make things worse.

- MA is - and always has been - a conservative scheme to undermine a highly-successful and popular entitlement program.
- MA's cost efficiencies do not translate into taxpayer savings or reduced healthcare expenditures due to the way plans bid, compete and receive rebates
- Forced expansion through mandate would destroy choice and lead to new crises

Side A: Medicare Advantage outperforms traditional, FFS Medicare and should thus fully replace it through mandate.

Enrollment and accessibility are growing

Medicare Advantage is an increasingly popular health insurance option for those eligible for the plans – individuals ages 65 and older and some younger people on disability. In 2018, 20.4 million beneficiaries (about one-third of those enrolled in Medicare) took part in MA plans. This was an 8% increase in enrollment in just one year.[1] The Congressional Budget Office (CBO) projects that the share of beneficiaries enrolled in MA plans will rise to about 47% by 2029.[2]

A growing business

In 2018, the MA program included about 3,100 plan options offered by 185 organizations. Medicare paid about $233 billion in payments to the plans (not including Part D drug payments).

[1] Medicare Payment Advisory Commission. The Medicare Advantage program 2019. http://medpac.gov/docs/default-source/reports/mar19_medpac_ch13_sec.pdf

[2] Jacobsen G, Freed M, Damico A and Neuman T. A Dozen Facts About Medicare Advantage in 2019. *KFF.* 6 June 2019. https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage-in-2019/

This is due in part to increasing accessibility geographically. Overall, 99% of Medicare beneficiaries have access to an MA plan.[3] In 2020, the average beneficiary will have access to 28 Medicare Advantage plans, the most available in nearly a decade.[4] The number of special needs plans, which cover the sickest patients, also went up by 19% in 2019 to 855 plans nationwide.[5]

Prioritizing preventative tests and screenings in MA enables significant cost savings related to chronic disease and emergent care

One of the major attractions of MA plans is their potential to provide abundant coverage while simultaneously lowering healthcare costs.

This is made possible because Medicare Advantage spends more than traditional, FFS Medicare preventive services that can prevent the development of more costly chronic diseases. A report from Avalere in 2018 found that MA spent 21% more than Medicare on these preventative services and tests, $3,811 versus $3,139, respectively. In turn, traditional Medicare paid 17% more on inpatient hospital care than MA and also incurred higher emergent care costs.

Overall, Medicare Advantage beneficiaries had 23 percent fewer inpatient stays and 33 percent fewer emergency room visits than Medicare FFS beneficiaries during 2015. Inpatient spending was 17 percent lower in Medicare Advantage than Medicare FFS ($2898 in MA versus $3477 in FFS), and outpatient spending was 5 percent lower in MA.

The cost savings are particularly apparent among more clinically complex patients and low-income populations eligible for both Medicare and Medicaid (known as dual-eligible patients). The cost of care for dual-eligible beneficiaries was 16% higher in traditional Medicare than in MA plans, at $13,398 versus $11,159. MA plans spent 21% less on average per person than traditional Medicare for complex, dual-eligible beneficiaries with diabetes. Complex MA patients with diabetes costs were $11,635, 6% lower on average than in FFS Medicare, which paid $12,438.[6]

While early critics alleged that MA plans could not provide adequate coverage or flexibility for sicker Medicare beneficiaries - such as those requiring specialist doctors or high-price drugs - and would thus lead to significant difference in the program populations, these concerns have dissipated over time.

Plan offerings and extra benefits are at historically high levels

According to recent data from the Kaiser Family Foundation, 90% of beneficiaries had access to a plan including prescription drug coverage in 2020, nearly half of which were offered with no

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[3] http://medpac.gov/docs/default-source/reports/mar19_medpac_ch13_sec.pdf

[4] Jacobsen G, Freed M, Damico A and Neumann T. Medicare Advantage 2020 Spotlight: First Look. 24 October 2019. https://www.kff.org/report-section/medicare-advantage-2020-spotlight-first-look-data-note/

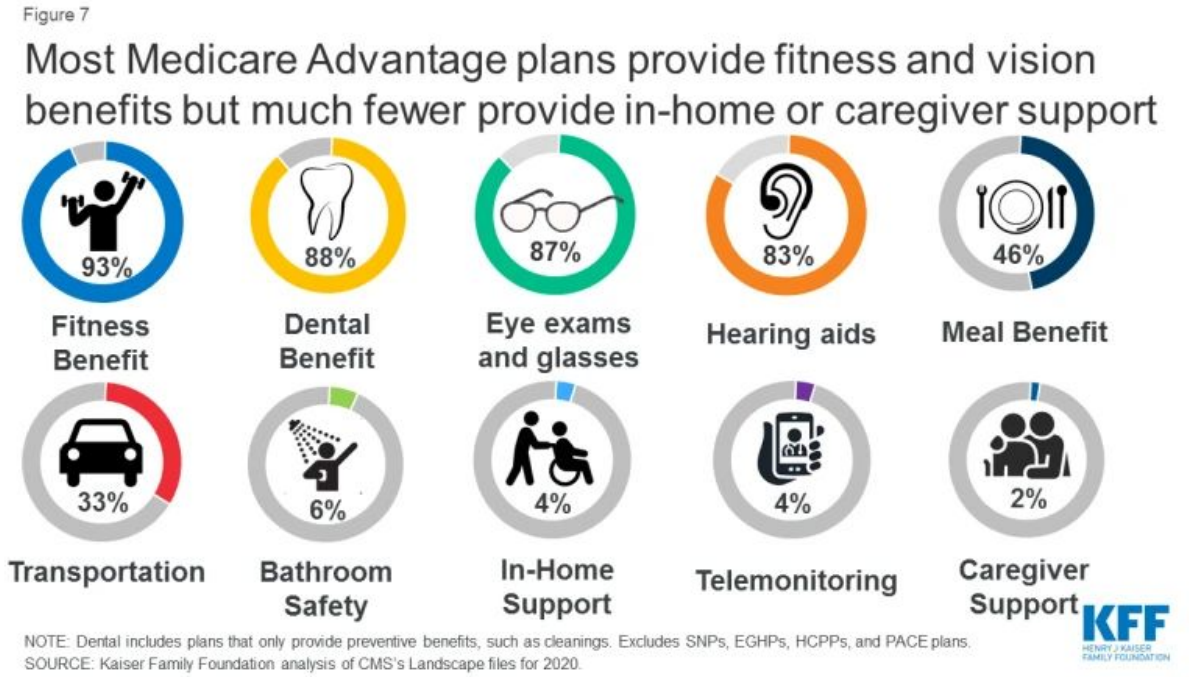
[5] https://www.kff.org/report-section/medicare-advantage-2020-spotlight-first-look-data-note/

[6] Medicare Advantage Achieves Cost-Effective Care and Better Outcomes for Beneficiaries with Chronic Conditions Relative to Fee-for-Service Medicare. July 2018. https://img04.en25.com/Web/AvalereHealth/%7B914072d2-41c3-4645-84e0-2ac8f761be2e%7D_BMA_Report.pdf

monthly premium.[7] Even among plans with premiums, many plans worked to keep patients' costs low: the average monthly premium is $36 per month this year, down slightly from 2019.[8] Plans are also legally required to limit out-of-pocket costs to $6,700 a year.[9] Original FFS Medicare, on the other hand, does not place limits on out-of-pocket costs.

MA plans also offer a wide range of benefits to plan participants that are not available in FFS Medicare. Almost all plans include prescription drug coverage and more than half will offer dental, vision, hearing and fitness benefits in 2020.

Figure 7



Furthermore, the Bipartisan Budget Act of 2018 allowed the Centers for Medicare and Medicaid Services (CMS) to expand the offerings in Medicare Advantage plans to include supplemental benefits. Supplemental benefits that provide a "reasonable expectation of improving or maintaining the health or overall function of enrollees" were rolled out in 2019 and more are set to be released in 2020. These benefits are not included under Medicare Part A, Part B or Part D. A recent Avalere report found that the key supplemental benefits that were increasingly offered by plans from 2018 to 2020 include meals, transportation, acupuncture, and over-the-counter (OTC) benefits, among others.

These supplemental benefits are continuing to expand and and address underlying social determinants of health. 2020 will be the first year that MA plans are allowed to offer non-primary health-related special supplemental benefits for those with chronic illness. Such

[7] https://www.kff.org/report-section/medicare-advantage-2020-spotlight-first-look-data-note/
[8] https://www.healthaffairs.org/do/10.1377/hblog20180122.210298/full/
[9] https://www.healthaffairs.org/do/10.1377/hblog20180122.210298/full/

benefits may include home-delivered meals (beyond a limited basis), pest control, and more.[10] These offerings align with a move towards value-based care and support the implementation of more innovative health measures. The expansion and utilization of telehealth is another example of MA's push to include and spur innovation in the healthcare space.

MA has shown to improve quality and reduce costs with greater enrollee choice and satisfaction

Just because costs are lower in MA plans does not mean quality is suffering. Medicare Advantage plans use tools including selective contracting, care management and care coordination, information systems shared across providers, and utilization management, wellness and prevention efforts to improve quality. According to KFF, 81% of enrollees are in plans receiving either four or five stars in CMS' quality ratings.[11] A study of 9.9 million beneficiaries in California, New York and Florida found that MA contracts outperformed traditional Medicare on 16 clinical quality measures including breast and colorectal cancer screenings, and management of rheumatoid arthritis and high cholesterol.[12]

A national poll released by Morning Consult in November 2019 found that 94 percent of enrollees are satisfied with their Medicare Advantage coverage and 62 percent call it a "better choice" when compared to traditional FFS. In addition, the turnover rate of beneficiaries returning from MA back to FFS has remained consistently low. KFF found that: "Among 9.4 million Medicare Advantage prescription drug (MA-PD) enrollees without low-income subsidies, 7.6 percent voluntarily switched to another MA-PD during the 2016 open enrollment period for 2017, and another 0.9 percent switched from an MA-PD to traditional Medicare (with a prescription drug plan). These low switching rates are indicative of high beneficiary satisfaction.

Medicare Advantage outperforms traditional, FFS Medicare and should thus fully replace it through mandate.

The above evidence demonstrates that MA is not only working, it is outperforming traditional, FFS Medicare on virtually every measure. Fee-for-service and inefficient government bureaucracies should go the way of the dinosaur. The full privatization of the Medicare program through a mandate to participate in MA will increase beneficiary value, quality, experience, and choice. MA has already achieved so much with only one-third market share; imagine what is possible with the additional enrollment volume that would accompany a mandate. MA is successful, scalable and replicable. It is time to make the transition to Medicare Advantage for every American 65 and older.

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[10] Young J, Creighton S, Kornfield T and Donthi S. Medicare Advantage Beneficiaries Will Again See a Jump in Supplemental Benefit Offerings in 2020. 19 November 2019. https://avalere.com/insights/medicare-advantage-beneficiaries-will-again-see-a-jump-in-supplemental-benefit-offerings-in-2020

[11] https://www.kff.org/report-section/medicare-advantage-2020-spotlight-first-look-data-note/

[12] Timbie J, Bogart A, Paddock S et al. Medicare Advantage Performance on Clinical Quality and Patient Experience Measures: Comparisons from Three Large States. *Health Services Research.* Dec 2017: 52(6). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5682140/#!po=43.1818

Side B: MA already has problems that need to be fixed and mandating would only make things worse.

MA is - and always has been - a conservative scheme to undermine a highly-successful and popular entitlement program

> "One of these days you and I are going to spend our sunset years telling our children and our children's children what it once was like in America when men were free."
>
> -Ronald Reagan, 1961
> Ronald Reagan Speaks Out Against Socialized Medicine,
> The American Medical Association

Conservative opposition to Medicare is older than the program itself. The above quote from future President Ronald Reagan describes the dystopian world that he and the American Medical Association predicted Americans would live in should the Medicare program be adopted in the United States. Of course, Medicare was implemented in 1965 and is currently one of the most popular programs in America.

Yet conservative ideological opposition to Medicare remains a constant. If the program cannot be wholly destroyed, it must be undermined, adulterated or dismembered through privatization. As Speaker of the House Newt Gingrich, another conservative politician, said of Medicare in 1996:

> "It's a centralized command bureaucracy. It's everything we're telling Boris Yeltsin to get rid of. Now we don't get rid of it in round one because we don't think that's politically smart and we don't think that's the right way to go through a transition. But we believe it's going to wither on the vine because we think people are going to voluntarily leave it. Voluntarily."

The mechanism by which beneficiaries would "voluntarily" leave Medicare, causing it to "wither on the vine," was - of course - the expansion of Medicare Advantage. The above proposal to universalize MA through mandate would put radical conservative ideology above good policymaking.

MA's cost efficiencies do not translate into taxpayer savings or reduced healthcare expenditures due to the way plans bid, compete and receive rebates

MA's cheerleaders enjoy touting the program's efficiencies. Leaving aside the legitimacy of these claims for the moment, the untold story is that these potential cost savings are squandered on bloated plans, marketing and administrative expenditures and profits anyway.

This is not due simply to avarice, but rather to a poor bidding structure between Medicare Advantage Organizations and CMS that incentivizes inefficient high plan bids. As researchers at USC-Brookings Schaeffer Initiative for Health Policy describe:

> "Each Medicare Advantage Organization (MAO) submits a bid intended to reflect its estimated price for offering the Traditional Medicare benefit package, but MAOs are discouraged from competing on price because the government collects 30-50 cents on the dollar when it reduces a plan's bid below the local administratively-set payment "benchmark." As a result, MAOs face weakened incentives to become more efficient or accept lower markups and compete to attract enrollees largely based on the generosity of the benefits they offer over and above standard Medicare benefits without requiring an additional premium."

Put another way, MA plans are not the lean, competitive products that their proponents describe, but equally expensive options that compete on their abundance of benefits rather than cost.

Furthermore, it is important to note that MA plans overstate the severity of their beneficiaries' health conditions in order to receive rebates. If you artificially inflate the number of conditions that you are treating, your care per condition will seem more efficient. And the MA marketplace itself encourages precisely this type of manipulation. Risk adjustment for MA plans is based upon diagnoses; MA plans receive a rebate for serving beneficiaries with greater needs. The result, predictably, is that there is significantly higher coding within MA than within traditional, FFS Medicare. Despite Congressional efforts to study and address this incongruence, MA risk scores for 2017 were about 7 percent higher than for a comparable FFS population. And once you adjust for risk, remarkably, it turns out that MA is actually costing more per beneficiary than traditional, FFS Medicare.

Finally, MA plans generate larger margins than other private market plans. The average gross margins for MA plans was $1,608 per person per year from 2016 to 2018. Individual and group markets were $779 and $855, respectively.[13] There are also concerns, raised by a recent MedPac report, that MA plans may be using a consolidation strategy to increase bonus payments on their contracts.[14]

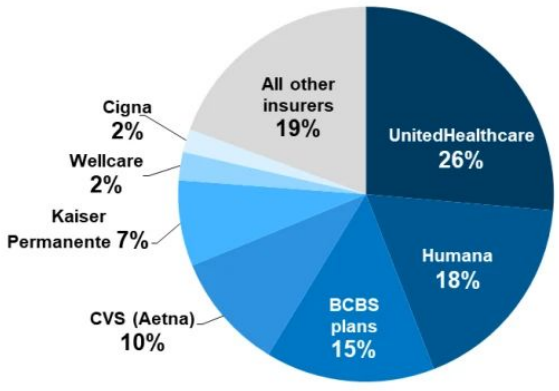
Simply put, any efficiencies found in MA may not be real at all, and in any case do not result in cost savings for beneficiaries, savings for the taxpayers or reduced overall healthcare expenditures.

Forced expansion through mandate would destroy choice and lead to new crises

By definition, MA plans have narrower provider networks than traditional FFS Medicare.

Figure 4

Medicare Advantage Enrollment by Firm or Affiliate, 2019



Total Medicare Advantage Enrollment, 2019 = 22 Million

NOTE: All other insurers includes firms with less than 2% of total enrollment. BCBS are BlueCross and BlueShield affiliates and includes Anthem BCBS plans. Anthem non-BCBS plans is less than 2% of total enrollment.
Percentages may not sum to 100% due to rounding.
SOURCE: Kaiser Family Foundation analysis of CMS Medicare Advantage Enrollment Files, 2019.

KFF

[13] Jacobson G, Fehr R, Cox C and N
and Group Health Insurance Markets
http://files.kff.org/attachment/Issue-B
oup-Health-Insurance-Markets

[14] http://www.medpac.gov/docs/defa

Mandating enrollment in an MA plan will eliminate choice by forcing beneficiaries to access care from providers in-network.

Furthermore, there is the issue of plan accessibility and competition. There are currently many rural areas throughout the United States where there are few MA plans to choose from. While the number of plans might be expected to expand should participation in MA reach 100 percent of beneficiaries, there is no guarantee that this would lead to greater diversification and market-based competition. In other words, Medicare beneficiaries in rural parts of the United States would find themselves mandated to enroll in plans that have a monopoly, leaving them at the mercy of the plan's benefit design and cost structure.

There are also concerns that the wholesale elimination of traditional, FFS Medicare would remove the very benchmark that currently keeps MA premiums lower than premiums in the private employer market, for example. Gutting traditional Medicare as we know it through privatization removes choice, encourages market consolidation and sets a very popular and successful program on a course collision with reality.

Sources

1. Moffit R, Numerof R and Buseman C. Let The Market Compete: Learning From Medicare Advantage To Move Toward Value-Based Care. *Health Affairs.* 25 January 2018. https://www.healthaffairs.org/do/10.1377/hblog20180122.210298/full/
2. Medicare Payment Advisory Commission. The Medicare Advantage program: Status report. March 2019. http://medpac.gov/docs/default-source/reports/mar19_medpac_ch13_sec.pdf
3. Jacobsen G, Freed M, Damico A and Neuman T. A Dozen Facts About Medicare Advantage in 2019. *KFF.* 6 June 2019. https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage-in-2019/
4. Jacobsen G, Freed M, Damico A and Neumann T. Medicare Advantage 2020 Spotlight: First Look. 24 October 2019. https://www.kff.org/report-section/medicare-advantage-2020-spotlight-first-look-data-note/
5. Jacobsen G, Freed M, Damico A and Neumann T. Medicare Advantage 2020 Spotlight: First Look. 24 October 2019. https://www.kff.org/report-section/medicare-advantage-2020-spotlight-first-look-data-note/
6. Medicare Advantage Achieves Cost-Effective Care and Better Outcomes for Beneficiaries with Chronic Conditions Relative to Fee-for-Service Medicare. July 2018. https://img04.en25.com/Web/AvalereHealth/%7B914072d2-41c3-4645-84e0-2ac8f761be2e%7D_BMA_Report.pdf
7. Young J, Creighton S, Kornfield T and Donthi S. Medicare Advantage Beneficiaries Will Again See a Jump in Supplemental Benefit Offerings in 2020. 19 November 2019. https://avalere.com/insights/medicare-advantage-beneficiaries-will-again-see-a-jump-in-supplemental-benefit-offerings-in-2020
8. Timbie J, Bogart A, Paddock S et al. Medicare Advantage Performance on Clinical Quality and Patient Experience Measures: Comparisons from Three Large States. *Health Services Research.* Dec 2017: 52(6). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5682140/#!po=43.1818
9. Jacobson G, Fehr R, Cox C and Neuman T. Financial Performance of Medicare Advantage, Individual, and Group Health Insurance Markets. *KFF.* August 2019. http://files.kff.org/attachment/Issue-Brief-Financial-Performance-of-Medicare-Advantage-Individual-and-Group-Health-Insurance-Markets
10. Jacobson G, Neuman T and Damico A. Do People Who Sign Up for Medicare Advantage Plans Have Lower Medicare Spending? KFF. 7 May 2019. https://www.kff.org/report-section/do-people-who-sign-up-for-medicare-advantage-plans-have-lower-medicare-spending-issue-brief/