

Comparing Spending Across Medicare Programs

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Designed in 1965 as an old-age entitlement benefit at a time when the average life expectancy was 70.2 years,¹ Medicare—in its multiple modern forms—is very different today. The average life expectancy is now 78.7 years and Medicare, with more than 64 million beneficiaries, now consists of 2 competing programs: traditional fee-for-service (FFS) Medicare and Medicare Advantage (MA). In contrast to FFS Medicare, MA is a publicly financed program with privately organized and administered benefits. As MA market penetration nationally exceeds 50% by some measures and in some counties has become the dominant form of Medicare, comparative programmatic cost has resurfaced as a source of debate. Long a substantial policy issue, a pragmatic program-level framework for meaningful comparison remains elusive. In this article, we review recent challenges in comparing the cost of the 2 Medicare operating models and suggest multiple comparison frameworks to improve the transparency of trade-offs for beneficiaries and policy makers around choice, value, and cost.

Recent History of Programmatic Comparisons

FFS Medicare comprises Part A and “voluntary” Part B, covering hospital care and physician and other services, respectively, with most beneficiaries paying an additional premium for prescription drug coverage through the voluntary Part D program. In part because FFS Medicare has beneficiary cost sharing without a catastrophic annual out-of-pocket limit, most beneficiaries purchase or receive supplemental coverage that functions as a “wrap plan.” Supplemental coverage is typically procured through either a Medigap plan or employer-sponsored retiree coverage for an additional premium, or through Medicaid at no cost to the beneficiary—albeit at great costs to states and the federal government—if the beneficiary meets the programmatic qualifications. In contrast, MA covers Part A and Part B and has an agency-determined annual maximum out-of-pocket limit (MOOP) of \$7550 for in-network services, with the average enrollee seeing their expenses capped at \$5091.² Further, 89% of MA beneficiaries are enrolled in plans with prescription drug coverage (MA-PD plans), and 60% select a zero-premium plan and thus incur no additional cost beyond the standard Part B premium.³

ABSTRACT

As Medicare Advantage increasingly becomes the dominant form of Medicare, meaningful and accurate comparisons with traditional fee-for-service Medicare will be increasingly important for both beneficiaries and policy makers. Recent debate among policy experts, government advisory bodies, and health plans highlights the need to create standardized comparison between the 2 Medicare programs. Supplemental benefits, Part B cost-sharing differences, and prescription drug benefits should be valued with a series of structured comparisons. Making this information transparent to beneficiaries through the plan finder would improve beneficiary decision-making. Finally, pragmatic comparisons would support policy makers in making improvements to Medicare Advantage program policy, undertaking comparative program evaluation, and engaging in Medigap plan oversight.

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TAKEAWAY POINTS

As Medicare Advantage (MA) increasingly becomes the dominant form of Medicare coverage, meaningful and accurate comparison with traditional fee-for-service (FFS) Medicare will be increasingly important for both beneficiaries and policy makers:

- ▶ The comparative population should include FFS beneficiaries who are eligible for MA.
- ▶ Beneficiary cost-sharing differences and supplemental benefits should be explicitly, transparently valued and integrated into the Medicare plan finder to empower beneficiary choice.
- ▶ A series of structured comparisons between MA and FFS Medicare would promote comparative program evaluation, facilitating future improvements in MA benchmark policy and Medigap plan oversight.

In the setting of 2 diverging operating models for Medicare, prior research efforts have targeted granular clinical and economic comparisons. Economic research has suggested that MA achieves price reductions for hospitals⁴ and physician services and successfully deploys utilization review to reduce costs.⁵ Additionally, health services research has suggested positive clinical outcomes with beneficiary enrollment in MA such as increased rates of bypass surgery for patients with cardiac disease⁶ and greater utilization of clinical preventive and screening services⁷ in addition to potential decreases in mortality.⁸ At the same time, other policy experts argue that inaccurate risk adjustment coupled with increased intensity of health plan diagnosis coding results in CMS overpaying MA plans.⁹ The Medicare Payment Advisory Commission (MedPAC) stated that total payments to MA plans were approximately 102% to 104% of FFS spending during recent years, with potential modifications to risk adjustment and comparator populations reducing that to 101% to 103% of spending, a figure close to equivalence that raises the question of whether such small differences could be due to underlying assumptions.

Despite robust research regarding targeted outcomes and populations in Medicare, program-level comparisons useful to both beneficiaries and policy makers remain elusive. Simultaneously, the appropriate choice of population and health benefits packages remains fraught with debate. The health plan industry noted that MedPAC program analyses included beneficiaries with only Part A in the total population used for the Part A and Part B spending computations, positing that the inclusion of beneficiaries with only Part A biased FFS expenditures downward due to the healthier nature of these beneficiaries, in addition to denoting unaccounted-for differences in the MA and FFS Medicare benefit packages.¹⁰

In contrast, MedPAC noted that the application of CMS' comparison methodology of risk-standardized Part A and Part B spending would still result in MA program spending being more expensive than FFS Medicare, citing programmatic divergence in coding intensity and beneficiary health status.¹¹ Although undoubtedly significant challenges were present with health plan risk adjustment, the recent transition to encounter-based risk adjustment is a significant step forward in addressing this concern.¹²⁻¹⁴ However, other challenges remain, as MedPAC analyses did not account for programmatic differences in the beneficiary annual MOOP liability. Simultaneously, MedPAC's 2022 annual report to Congress demonstrated that MA

plan bids for Part A and Part B benefits were only 85% of FFS spending, an improvement from 2014 when bids were 98% of FFS costs. These contradictory yet congruent views highlight the need for clarity.

Frameworks for a Meaningful Comparison

Program-level comparisons should help both beneficiaries and policy makers determine cost, benefits, and value. Any single comparison alone is likely incomplete.

A comparator population should be carefully chosen. Because beneficiaries can elect to enroll in MA only if they have Part A and Part B, this beneficiary population represents the salient comparator population. Beneficiaries enrolled in special needs plans should be included. Despite specific distinguishing characteristics, these beneficiaries are present in both MA plans and FFS Medicare. Risk adjustment, coding intensity, and spillover effects all represent further challenges for ensuring that any comparison has similar populations. MedPAC analyses have highlighted coding intensity in MA based on risk scores while failing to fully consider an equally likely corollary: undercoding in the FFS population. These challenges underscore the need for the uniform application of risk adjustment in analyses across programs, and the transition from plan-submitted diagnoses driving coding to an encounter-based risk-adjustment system should ameliorate these concerns.¹¹ This transition offers policy makers another benefit, as it supports the future application of risk adjustment to FFS Medicare.

Comparing benefits packages and their cost requires multiple frameworks to evaluate impacts on choice, program cost and beneficiary expense, and value. To facilitate comparison, health benefits packages should be broken down component by component.

First, programs should be evaluated on the comparative cost to deliver standard Part A and Part B benefits, highlighting for beneficiaries the direct financial trade-offs, both advantages and disadvantages, resulting from the managed care setting (ie, acceptance of a network and utilization review practices). Policy makers would gain clarity of trade-offs between managed competition and administrative pricing.

Second, analysts should break out other components of MA, including beneficiary cost sharing, supplemental benefits, and prescription drug benefits, and compare the component and summative value between the 2 Medicare programs. For example, analysts should compare the reduced cost sharing in MA inclusive of reductions in Part B/D premiums or cost sharing in addition to the differing annual MOOP vs beneficiary cost sharing in FFS Medicare. This would require analysts to construct a standard Medigap comparison metric for FFS beneficiaries. Prescription drug plans (PDPs) would require similar transparency, valuing the Part D component of MA-PD plans—inclusive of any premium or cost-sharing reduction—against a standard PDP plan for FFS beneficiaries. Finally,

the actuarial value of MA supplemental benefits should be made transparent, noting that health plans and CMS jointly determine their actuarial value as part of the MA rate-setting process.

Creation of benchmarks for Medigap plans and PDPs for FFS Medicare beneficiaries, along with transparency of the actuarial value of supplemental benefits, would promote meaningful programmatic comparisons. Policy makers could explore both the cost and clinical value of the 2 programs in delivering not only Part A and Part B benefits but also other combinations of benefits, making clear to policy makers how costs shift between taxpayers and beneficiaries.

Integration of the cost of all components of Medicare health benefits into the plan finder would promote transparency of the increased beneficiary financial protections in MA, relative costs of prescription drug coverage across programs, and the value (or lack thereof) of supplemental benefits. Building off previously suggested improvements in the Medicare plan finder,¹⁵ beneficiaries and their proxies could then select the form of Medicare benefits that works best for them. Transparency would enable clarity regarding the total monthly and annual cost of a complete health benefits package, allowing beneficiaries and their proxies to better value trade-offs regarding cost, network breadth, and benefits.

For policy makers, facilitating clear component cost comparisons would make plain the total cost to society for seniors' health benefits, whereas a subsequent breakdown of private and public costs could inform future policy. Transparency and pragmatic comparisons would also highlight opportunities for reform, such as the need for reforms in the Medicare supplemental plan market or changes in MA benchmark policy.

A third and final comparison is critical primarily for policy makers: a programmatic cost comparison from the perspective of statutory spending. In this context, MA provides a better benefits package at a cost marginally above the cost of FFS Medicare providing the standard Part A and Part B benefits package.

In conclusion, multiple programmatic comparisons are needed and should include measures of total cost from the perspectives of both taxpayers (statutory spending) and beneficiaries. Policy solutions must take into account both fiscal solvency for the nation and the health needs of the individual, along with differences in public and private financing of benefits. As the Medicare Hospital Insurance Trust Fund faces insolvency in 2028, bipartisan programmatic adjustments are a national imperative. With the 2 operating models for the Medicare program representing diverging paths, policy makers can thread the needle and improve Medicare program policy through the creation of benchmarks to drive meaningful comparisons. ■

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