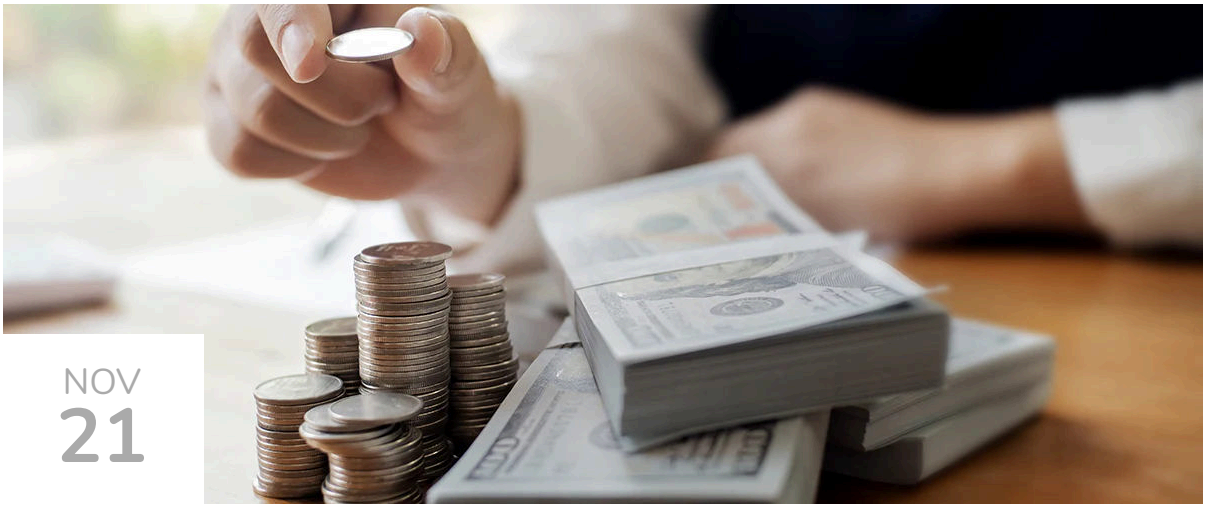
Radar on Medicare Advantage

With ‘Waste’ on Trump Agenda, Could MA Rebate Overhaul Be on the Table?



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Rebates paid to Medicare Advantage plans that bid below the benchmark reached $65.8 billion in 2024 and are projected to total $1.1 trillion over the next decade, according to the 2024 Medicare Board of Trustees Report. While those rebates must be used to lower premiums, reduce cost sharing or enhance benefits for MA enrollees, what if such resources were reallocated to fund extra benefits such as healthy foods and dental care for all Medicare beneficiaries?

That’s a central question posed by researchers in a new article, “The Opportunity Costs of Medicare Advantage Plan Rebates,” published Oct. 24 in the New England Journal of Medicine (NEJM). Comparing the total projected rebate dollars for 2024 from the Trustees report, with the

projected costs of funding extra benefits for all Medicare beneficiaries, the article's authors estimated that a "package of expanded benefits could be made available to all Medicare beneficiaries for less" than what would be spent on rebates in 2029.

That theoretical package would include Part D premium reductions, out-of-pocket cost caps for traditional Medicare beneficiaries, and new basic benefits such as dental care, grocery benefits and over-the-counter medication allowances. At an overall projected price tag of $108.1 billion, it would generate $2.1 billion in annual savings when compared to the $110.2 billion in rebates plans are expected to receive in 2029.

The latter estimate, which came from the Trustees report, assumes no changes to the current benchmark system that is used to pay MA plans — one that the Medicare Payment Advisory Commission (MedPAC) continues to argue is ripe for reform. Despite plans continually bidding below the benchmark, the government is spending billions of dollars more on MA than it would if those enrollees were in traditional fee-for-service (FFS) Medicare, according to MedPAC. In its March 2024 report to the Congress, the independent congressional agency estimated that the federal government this year will spend approximately $83 billion more on MA enrollees than it would if they were enrolled in FFS Medicare.

About $35 billion of that higher projected spending is due to favorable selection, or the disproportionate enrollment of beneficiaries with lower Medicare spending into the MA program, even after adjusting for their health status. As a result, "payment benchmarks are high relative to the needs of the Medicare Advantage population," wrote the NEJM article's authors, who are from the American Academy of Actuaries, The Commonwealth Fund and Johns Hopkins University. "When benchmarks are higher, the difference between the bid and the benchmark, which is used to calculate the rebate, is also higher." The authors contend — echoing MedPAC's previous assertions — that instead of saving the federal government money, MA plans are increasing Medicare spending overall.

"Our paper looks at what else could be funded with the same amount of money that is used for providing supplemental benefits," says Gretchen Jacobson, vice president of Medicare at The Commonwealth Fund and one of the article's authors. She points out that the article is not a proposal per se and declined to speculate on the likelihood of such an idea being pursued under under President-elect Donald Trump.

"We would expect that any Congress or Administration would be interested in ensuring that the Medicare program is effective and efficient and providing the care that the program's beneficiaries need," she tells AIS Health, a division of MMIT.

TRADITIONAL MEDICARE DOESN'T COVER EYES AND EARS

"If Medicare was being built from scratch today, it would cover services like dental, vision and hearing that are important to a person's overall health," remarks Michael Adelberg. Adelberg is a former CMS official who monitored the explosion of supplemental benefits while principal at Faegre Drinker Consulting and is now executive director of the National Association of Dental Plans. "So, we should be open-minded to any research that suggests ways to modernize Medicare in a cost-effective manner. But we should also make sure we're comparing apples to apples when hypothesizing savings."

While most MA plans offer some type of dental, vision and/or hearing benefit, various pieces of legislation have failed to add such benefits to Medicare. Bills introduced in the House by Rep. Lloyd Doggett (D-Texas) never "made meaningful headway, even under the Democratic trifecta of 2021 and 2022," observes Jason Karcher, actuary and health policy consultant with Milliman. Prior to that, the Elijah E. Cummings Lower Drug Costs Now Act of 2019 proposed including all three benefits in Medicare, which the Congressional Budget Office estimated would increase spending by $358 billion between 2020 and 2029 ($238 billion toward dental, $30 billion for vision, and $89 billion for hearing services), he points out. The bill was later reintroduced without that provision.

"Based on these recent efforts, there has been interest in the past to include benefits that are core to the Medicare Advantage program and which are offered nearly ubiquitously across all MA plan offerings," says Karcher. "However, there has been political opposition from Republicans about funding this fairly significant change given the ever-increasing national debt, and there would need to be significant Republican support to pass a bill in the House. In 2025, the Congress will be narrowly controlled by Republicans, so this seems unlikely. However, the Trump campaign at points put forth the idea of expanding Medicare benefits, so it is hard to rule expansion out entirely."

It is also unclear what Trump's respective picks for HHS secretary and CMS administrator — environmental lawyer and known vaccine skeptic Robert F. Kennedy, Jr. and television personality Mehmet Oz, M.D., aka Dr. Oz — will mean for Medicare if confirmed by the Senate. But Kennedy, who campaigned for president on the concept of "making America healthy again," appears to be more focused on getting Americans to exercise and eat healthy foods, which could surface as non-medical benefits in Medicare or Medicaid. In his Nov. 19 statement on the announcement of Oz, Trump highlighted disease prevention and budget management as areas of focus, vowing that Oz would "cut waste and fraud within our country's most expensive government agency."

In its March report, MedPAC estimated that higher MA spending drove an estimated $13 billion increase in Part B premiums in 2024. And according to a presentation at MedPAC's October public meeting, MA rebates have more than doubled since 2018, averaging $3,090 per member per year for Special Needs Plans and $2,329 for members in conventional, non-SNP MA plans. Of the approximately $83 billion in rebates MedPAC estimated plans will receive, a fraction of those payments will be used to reduce Part B premiums for enrollees, while a growing share will be used to finance coverage of non-Medicare services, MedPAC observed.

"By using rebates to fund extra benefits in only Medicare Advantage plans, policymakers are making an implicit trade-off," wrote the NEJM paper's authors. With higher MA plan payments driving premiums and deductibles in FFS Medicare, the authors advocated for Congress to "actively review" the way MA plans are paid and the "methods of providing extra benefits." And regardless of whether those benefits are provided solely in MA or extended across the program, "benefits that improve health outcomes should be prioritized."

WHAT WOULD PROPOSAL MEAN FOR MA BIDS?

If the new Congress passed legislation adding extra Medicare benefits as early as 2025, "benefits could not reasonably be reflected in bids until 2027, and it is nearly certain that MAOs would ask for more time to ensure their systems and approach were aligned with those of the federal government," cautions Julia Friedman, principal and consulting actuary for Milliman.

"If it did pass, this would mean that MA plans have less ability to differentiate their plan designs than they do now. Differentiating your plans from the competition via benefit design is critical for enrollment growth — and I believe this would have meaningful impact on the way this differentiation occurs in the MA marketplace," she adds.

Potential scenarios could include organizations continuing to add benefits "above and beyond what would be offered under the revised traditional Medicare coverage," she continues. "For example, if traditional Medicare only covered $200 annually for frames (eyewear), an MA plan could cover an additional $100 for frames each year for a total of $300 of coverage annually." That would still require, however, additional rebate dollars, and current Medicare managed care regulations state that supplemental benefits beyond traditional Medicare benefits should be taken into consideration if the additional benefit is medically necessary, points out Friedman.

“Additionally, dual eligible members typically have higher health needs than non-dual eligible members, so a standard set of original Medicare benefits applicable to all beneficiaries might not be sufficiently generous for [dual eligible] SNPs, which tend to have richer limits for items like dental and vision hardware.”

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Lauren has been covering health business issues since the early 2000s and specializes in in-depth reporting on Medicare Advantage, managed Medicaid and Medicare Part D. She also possesses a deep understanding of the complex world of pharmacy benefit management, having written AIS Health’s Radar on Drug Benefits from 2004 to 2005 and again from 2011 to 2016. In addition to her role as managing editor of Radar on Medicare Advantage, she oversees AIS Health’s publications and manages the health editorial staff. She graduated from Vassar College with a B.A. in English.