Medicare & Medicare Advantage

This Photo by Unknown Author is licensed under CC BY-NC-ND

AGENDA

- Defining Medicare and Medicare Advantage
- A History and the Evolution of Medicare and Private Health Insurance Organizations
- Components of Medicare vs. Medicare Advantage
- Challenges with Medicare Advantage and Medicare
- The future

AzHHA
Arizona Hospital and Healthcare Association

Medicare vs. Medicare Advantage

Original Medicare is a health plan managed by the federal government that has two parts: Part A (hospital insurance) and Part B (Medical insurance). It is the typical Medicare insurance that most are familiar with.

Medicare Advantage - is a health plan called Part C and is offered by private insurance companies as an alternative to Original Medicare. It replaces and cancels your Original Medicare plan if a Medicare-eligible person chooses this option.

A History of Health Plans & Medicare

- Health Maintenance Organizations (HMOs) and their precursors, such as group practice prepayment plans, have been part of the Medicare program since it began in 1965.
- In 1972, Congressional amendments established Medicare HMO enrollment and contracting, rather than just providing a mechanism for reimbursement of services rendered by these organizations.
- The Tax Equity and Fiscal Responsibility Act of 1982 [TEFRA] risk contracting program was authorized in 1982 and began in mid-1985.
- The Balanced Budget Act of 1997 (BBA) significantly changed private plan contracting in Medicare by revising the types of eligible plans, contracting standards, beneficiary enrollment rules, and payment regulations. It also established Part C of Medicare, known as "Medicare+Choice (M+C).“

https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/HealthCareFinancingReview/downloads/00fallpg61.pdf

AzHHA
Arizona Hospital and Healthcare Association

Types of Medicare Advantage Plans

Most Medicare Advantage plans are either:

- Health Maintenance Organizations (HMOs) that typically cover only the care provided by in-network doctors, hospitals, and other health providers.
- Preferred Provider Organizations (PPOs) that offer access to out-of-network providers, although this comes at a higher cost compared to in-network providers.
- PPOs can be classified as local or regional. Local plans serve one or multiple counties, while regional plans cover a single state or a group of states; there are a total of 26 regions.
- Regional plans were established in 2003 to expand the available options, particularly for beneficiaries in rural areas.

https://www.commonwealthfund.org/publications/explainer/2024/jan/medicare-advantage-policy-primer

AzHHA
Arizona Hospital and Healthcare Association

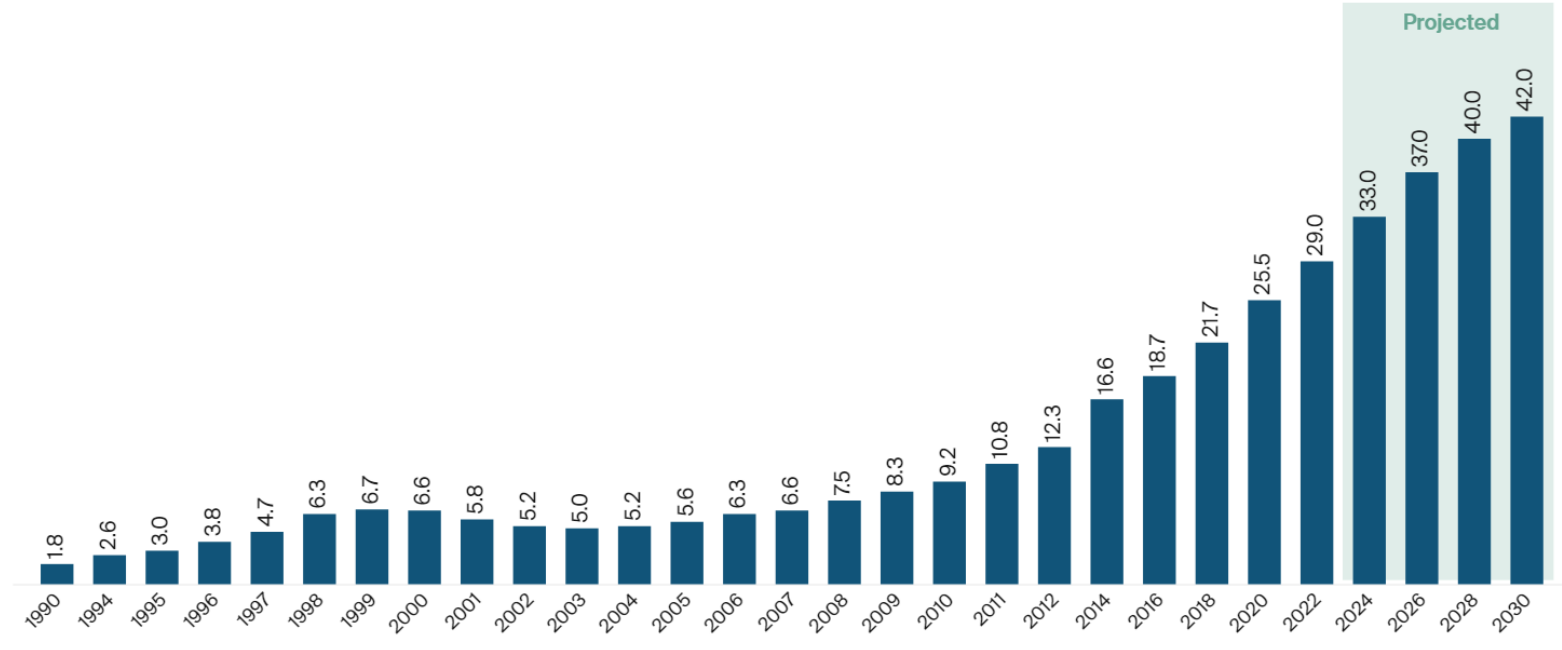
Medicare Advantage Enrollment

Medicare Advantage enrollment is highly concentrated among a small number of firms.

UnitedHealthcare and Humana account for nearly half (47%) of all Medicare Advantage enrollees nationwide.

Medicare Advantage enrollment has grown rapidly in the past decade.

Medicare Advantage enrollment, past and projected (millions)



Download data

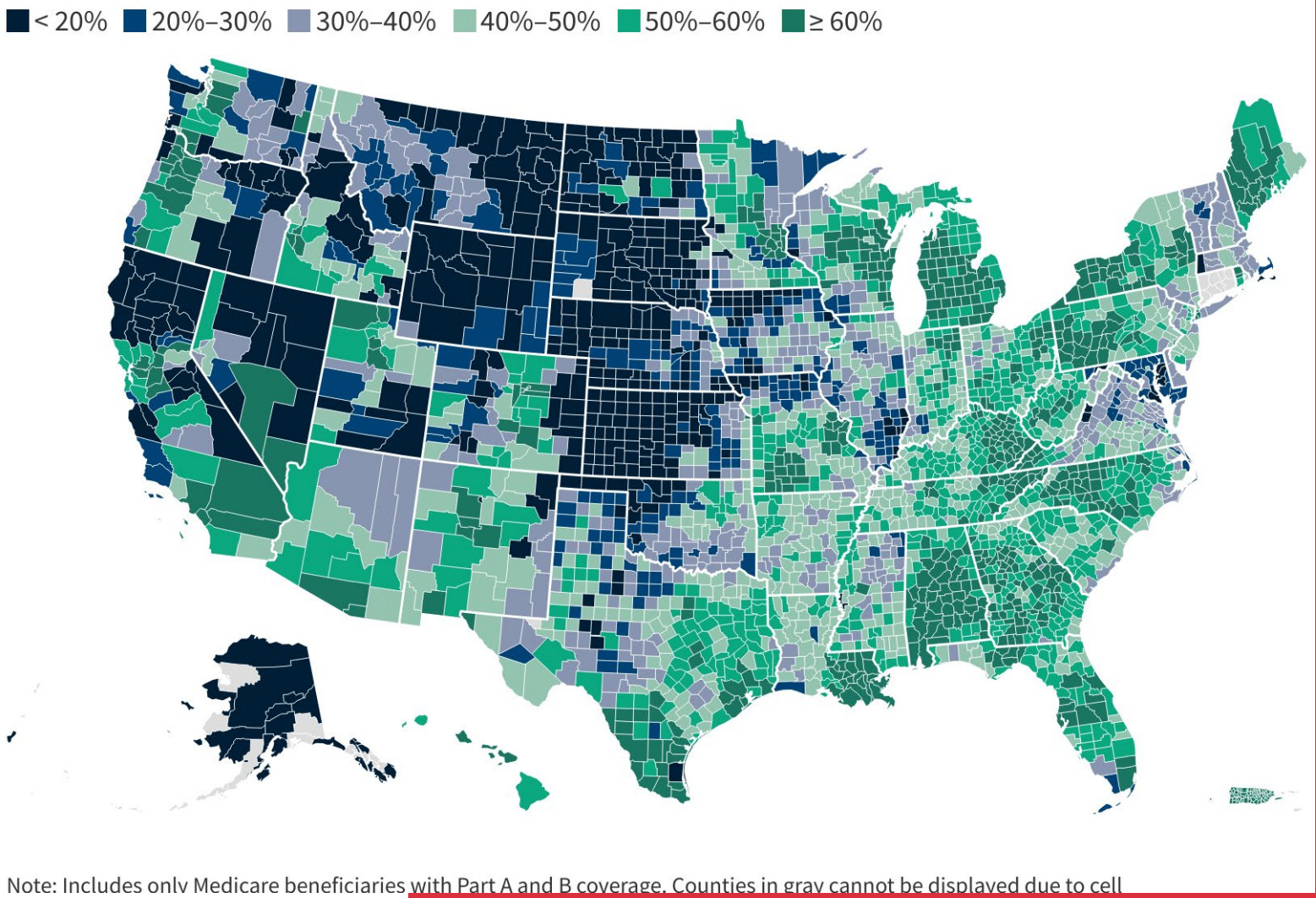
Data: 2013 Edition of Medicare and Medicaid Statistical Supplement, Table 12.1 - Health Maintenance Organization (HMO) and Cost Contract Enrollment Growth: Selected Calendar Years 1990-2012, for years 1990-2012; Centers for Medicare and Medicaid Services, Medicare Advantage State/County Penetration Files, for Dec. 2014, 2016, 2018, and 2020; Congressional Budget Office, Medicare Baseline Projection, May 2023.

Source: Christina Ramsay, Gretchen Jacobson, Steven Findlay, and Aimee Cicciello, *Medicare Advantage: A Policy Primer, 2024 Update* (Commonwealth Fund, Jan. 2024). https://doi.org/10.26099/69fq-dy83

https://www.commonwealthfund.org/publications/explainer/2024/jan/medicare-advantage-policy-primer

MA Enrollment by State and County

Variation in Medicare Advantage enrollment among eligible beneficiaries is influenced by factors such as firm strategies to target specific areas, county and state urbanicity, Medicare payment rate differences, the characteristics of eligible individuals, healthcare use patterns, and past market penetration of Medicare Advantage.



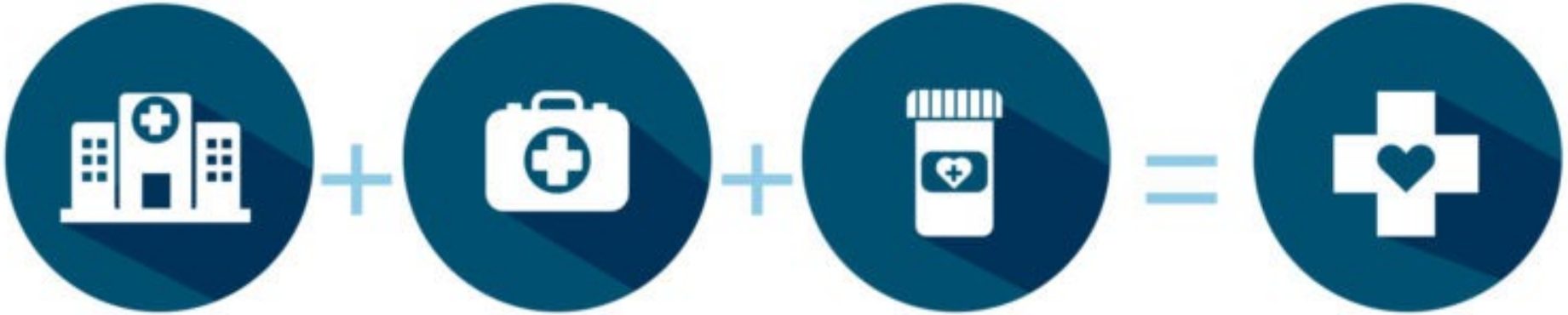
Note: Includes only Medicare beneficiaries with Part A and B coverage. Counties in gray cannot be displayed due to cell

https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2024-enrollment-update-and-key-trends/

COMPONENTS OF MEDICARE & MEDICARE ADVANTAGE

Know your Medicare basics

Medicare Advantage Insurance Plans



PART A:
Hospital

Medicare Part A is Hospital insurance and helps cover cost if you are staying in a hospital, skilled nursing facility or hospice care.

PART B:
Medical

Medicare Part B is Medical insurance and helps cover cost for doctor servcis, outpatient care, durable medical equiptment and other medical services. If you enroll in a Medicare Advantage Plan you must continue to pay your Part B premium.

PART D:
Prescriptions

Medicare Part D is Prescription Drug coverage, and helps cover the cost of many outpatient prescription drugs. If you enroll in a Medicare Advantage Plan this drug coverage is usually included into the plan, otherwise it is offered through insurance companies as a separate plan.

PART C:
Medicare Advantage

Part C, also know as Medicare Advantage, includes Part A, Part B, and comtimes Part D. It is all in one plan.

COMPONENTS OF ORIGINAL MEDICARE

Medicare Part	Description	Costs
Part A (Hospital)	Helps cover inpatient care in hospitals, skilled nursing care, hospice care, and home health care	$0 Monthly Premium $1,632 Annual Deductible (subject to change)
Part B (Medical)	Helps cover family practice clinic, specialty clinic, outpatient care, durable medical equipment, preventative services	Monthly premium $175 (or higher depending on income) $240 Annual Deductible 20% co-payment (subject to change)
Part D (Drug)	Helps cover the cost of prescription drugs including many recommended shots or vaccines	Varies by plan
Medigap (Supplemental)	Extra insurance you can buy to help pay for your share in costs in Original Medicare	Varies by plan

To get the full array of services, you will likely need to enroll in all four elements

COMPONENTS OF MEDICARE ADVANTAGE

Medicare Part	Description	Costs
Part C (Medicare Advantage) ** Note, this replaces Part A, Part B, Medigap and sometimes Part D	Medicare approved plan from a private insurance company that offers an alternative to Original Medicare for health and drug coverage	Varies by plan
Part D (Drug)	Helps cover the cost of prescription drugs including many recommended shots or vaccines	Varies by plan

What are the differences between Medicare & Medicare Advantage?

AzHHA
Arizona Hospital and Healthcare Association

Access to Providers

- People with traditional Medicare have access to any doctor or hospital that accepts Medicare, anywhere in the United States. That's most doctors and almost all hospitals.
- Medicare Advantage enrollees can access providers only through more limited provider networks.
  - All Medicare Advantage plans are required to have such networks for doctors, hospitals, and other providers (network adequacy).
  - MA plans are required to attest to compliance with network adequacy standards during the application process for a new or expanded service area but are not required to demonstrate compliance
  - Provider participation in MA networks varies greatly. A 2017 analysis found that Medicare Advantage networks included fewer than half (46%) of all Medicare physicians in a given county, on average

AzHHA
Arizona Hospital and Healthcare Association

Prior Authorization

Prior authorization is the process of obtaining health insurance approval before providing a medical service or prescription. It is also called preauthorization or precertification.

- Nearly all Medicare Advantage enrollees are required to obtain prior approval, or authorization, for coverage of some treatments or services.
  - MA plans that require prior authorization can approve or deny care based on medical research and standards of care.
  - When services are not subject to prior authorization, plans can deny coverage for care they deem unnecessary after the service is received, if they follow Medicare coverage rules and guidelines.
- Traditional Medicare generally, does not require prior authorization.

AzHHA
Arizona Hospital and Healthcare Association

U.S. Department of Health and Human Services

Office of Inspector General

Report in Brief

April 2022, OEI-09-18-00260

Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care

Why OIG Did This Review

A central concern about the capitated payment model used in Medicare Advantage is the potential incentive for Medicare Advantage Organizations (MAOs) to deny beneficiary access to services and deny payments to providers in an attempt to increase profits. Although MAOs approve the vast majority of requests for services and payment, they issue millions of denials each year, and CMS's annual audits of MAOs have highlighted widespread and persistent problems related to inappropriate denials of services and payment. As enrollment in Medicare Advantage continues to grow, MAOs play an increasingly critical role in ensuring that Medicare beneficiaries have access to medically necessary covered services and that providers are reimbursed appropriately.

How OIG Did This Review

We selected a stratified random sample of 250 denials of prior

Key Takeaway

MAOs denied prior authorization and payment requests that met Medicare coverage rules by:

- using MAO clinical criteria that are not contained in Medicare coverage rules;
- requesting unnecessary documentation; and
- making manual review errors and system errors.

What OIG Found

Our case file reviews determined that MAOs sometimes delayed or denied Medicare Advantage beneficiaries' access to services, even though the requests met Medicare coverage rules. MAOs also denied payments to providers for some services that met both Medicare coverage rules and MAO billing rules. Denying requests that meet Medicare coverage rules may prevent or delay beneficiaries from receiving medically necessary care and can burden providers. Although some of the denials that we reviewed were ultimately reversed by the MAOs, avoidable delays and extra steps create friction in the program and may create an administrative burden for beneficiaries, providers, and MAOs. Examples of health care services involved in denials that met Medicare coverage rules included advanced imaging services (e.g., MRIs) and stays in post-acute facilities (e.g., inpatient rehabilitation facilities).

Covered Benefits

- MA plans must cover all services covered by traditional Medicare under Part A (hospital services, some home health, hospice care, skilled nursing care) and Part B (physician services, durable medical equipment, outpatient drugs, mental health, ambulance services).
- Most MA plans (89% in 2024) cover Part D prescription drug benefits.
- Most MA plans offer additional benefits such as eyeglasses, hearing aids, and some coverage of dental care.
- Traditional Medicare has notable gaps in coverage, and it requires cost sharing for most services.
- Traditional Medicare does not have prescription drug coverage, and beneficiaries must choose a separate “stand-alone” Part D plan if they want drug coverage.

AzHHA
Arizona Hospital and Healthcare Association

Out of Pocket Costs

Many factors influence whether a beneficiary would pay more with traditional Medicare or with a Medicare Advantage plan including:

- Health status and healthcare use
- Supplemental coverage and premiums for that coverage
- Medicare Advantage plan benefits and cost-sharing
- MA plan provider networks.

Since 2011 MA plans are required to limit enrollees' out-of-pocket expenses for services covered by Parts A and B. *Traditional Medicare has no limit, which is why people need a MediGap plan.*

AzHHA
Arizona Hospital and Healthcare Association

The Challenges with Medicare Advantage vs. Traditional Medicare

Medicare Advantage Costs Taxpayers More Money

Studies have largely found that Medicare Advantage plans cost the government and taxpayers more than traditional Medicare on a per beneficiary basis.

- In 2023, that additional cost was about 6 percent, down from a peak of 17 percent in 2009.

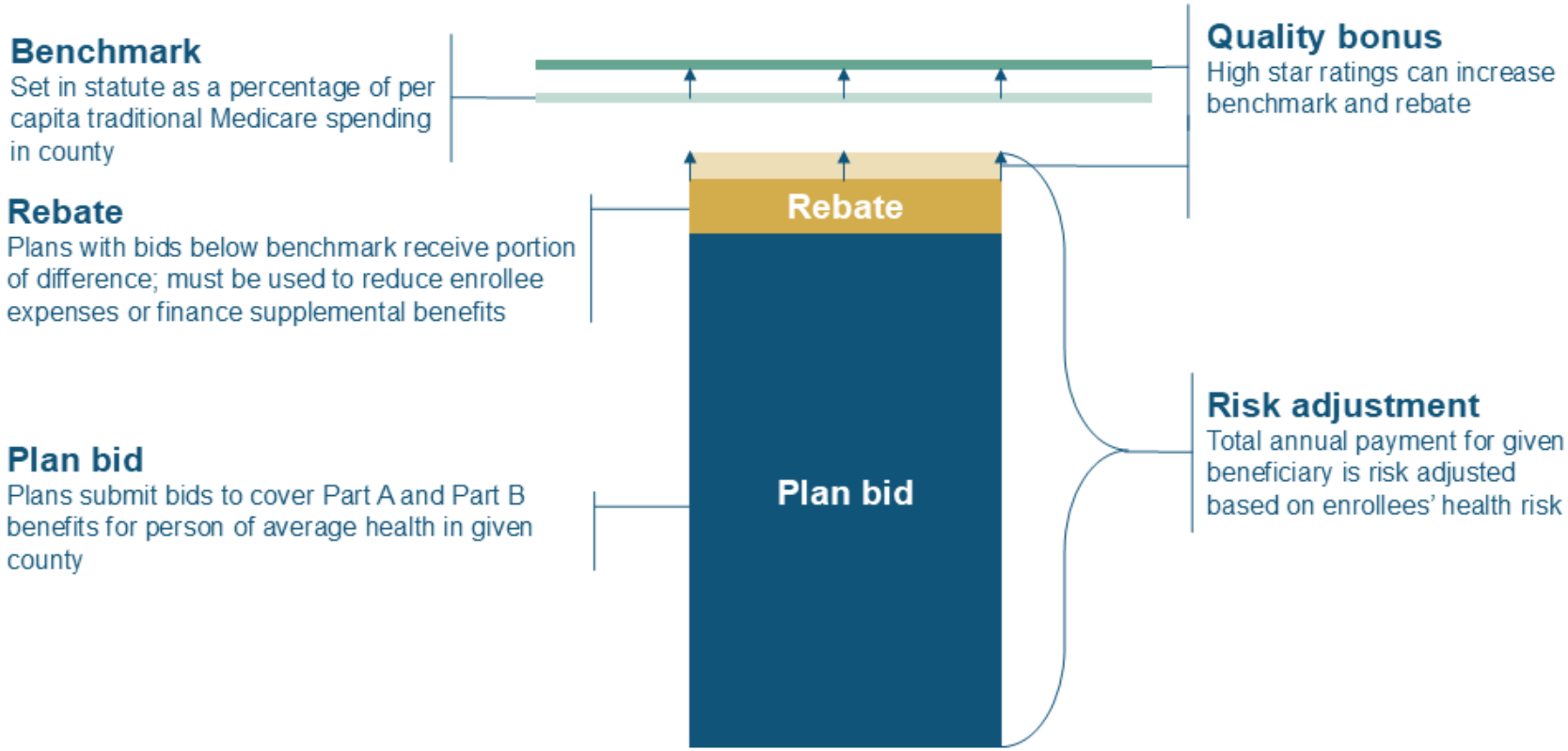
Higher costs can be attributed to:

- Overpayments
- Rebates
- Quality bonuses

AzHHA
Arizona Hospital and Healthcare Association

EXHIBIT 2

Medicare Advantage payments are based on a system of benchmarks, bids, and quality incentives.



Source: Christina Ramsay, Gretchen Jacobson, Steven Findlay, and Aimee Cicciello, *Medicare Advantage: A Policy Primer, 2024 Update* (Commonwealth Fund, Jan. 2024). https://doi.org/10.26099/69fq-dy83

The Commonwealth Fund

AzHHA Arizona Hospital and Healthcare Association

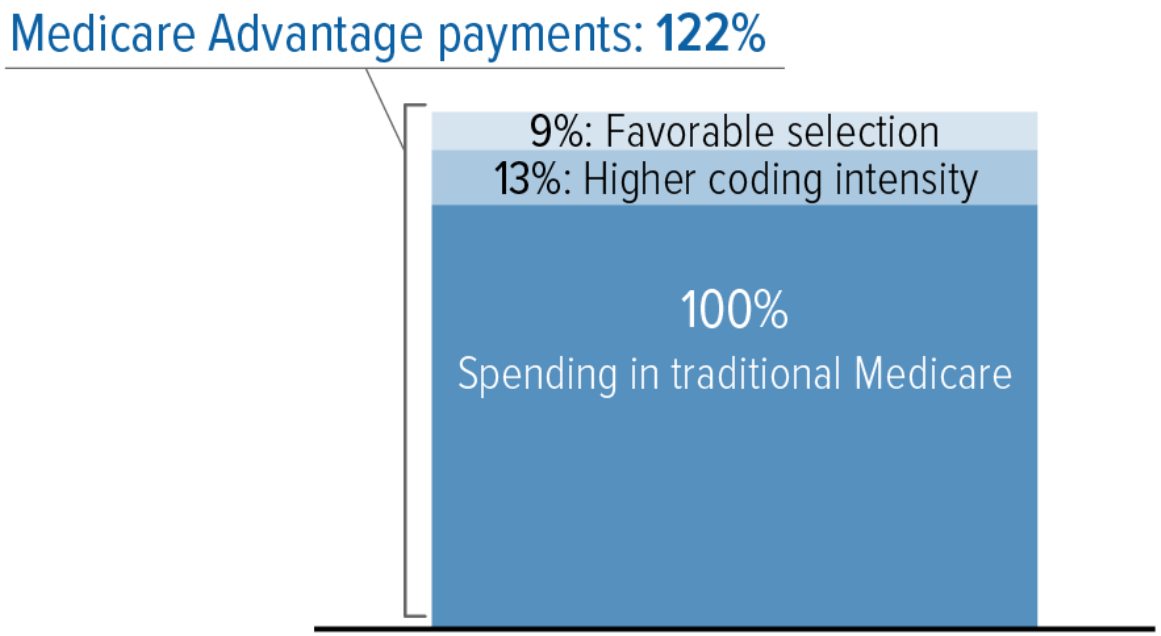
Medicare Advantage Overpayments

Overpayments arise for three main reasons:

- Higher coding intensity
- Favorable selection
- Quality bonuses.

Taking additional factors into account, other researchers have estimated that MA overpayments could be as high as 39 percent.

Medicare Advantage Plans Are Substantially Overpaid



Note: "Favorable selection" is the extent to which Medicare Advantage enrollees have lower health spending than those in traditional Medicare with the same risk scores. "Coding intensity" is a difference in diagnostic coding practices that makes Medicare Advantage enrollees look sicker than similar enrollees in traditional Medicare.

Source: Medicare Payment Advisory Commission, 2024

Coding Intensity in MA Plans vs. Traditional Medicare

- The Medicare Payment Advisory Commission (MedPAC) has long found evidence that Medicare Advantage plans have a higher diagnostic “coding intensity” than traditional Medicare.
- Medicare’s payments to MA plans are higher for less-healthy enrollees. MA plans have an incentive to identify as many diagnoses as possible for each enrollee.
- Payments to health care providers in traditional Medicare depend on the services they provide, not the number of diagnoses.

AzHHA
Arizona Hospital and Healthcare Association

Switching between MA Plans and Traditional Medicare

Switching between MA and Traditional Medicare is uncommon.

People who switch to traditional Medicare are:

- Disproportionately dually eligible for Medicare and Medicaid
- More likely to live in rural areas,
- In poor health
- Need more help with activities of daily living
- Using more health care services than people who do not switch.

It isn't easy to switch from an MA plan after the first year.

AzHHA
Arizona Hospital and Healthcare Association

The Future of Medicare Advantage

Medicare Advantage's increasing enrollment presents challenges.

- MA plans can be more expensive than traditional Medicare, which may raise federal costs and strain the Hospital Insurance (Part A) trust fund.
- Growing enrollment could require changes to the payment system for these plans.
- Ongoing concerns about the quality of care compared to traditional Medicare.

This Photo by Unknown Author is licensed under CC BY-NC-ND

Questions? Contact Helena Whitney at hwhitney@azhha.org

AzHHA
Arizona Hospital and Healthcare Association

2800 N. Central Ave., #1450 | Phoenix, AZ 85004