MARQUETTE UNIVERSITY
College of Nursing

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DEBATE SERIES

MEDICARE ADVANTAGE

Upon first becoming eligible, a Medicare beneficiary is typically enrolled in Medicare Part A (institutional services, such as hospital coverage) and Part B (office services, such as physician visits) which are commonly referred to as "Original Medicare." On an annual basis, beneficiaries can decide to keep this default benefit structure, or they can opt to sign up for an approved Medicare Advantage (MA) private health insurance plan to help manage their benefits. This debate series examines the pros and cons of electing the MA benefit, and the impact of Medicare Advantage on the Medicare program.

- PRO -

"Medicare Advantage saves enrollees significant money, while giving them critical new benefits that help improve health outcomes."

Typically offering lower annual out-of-pocket costs compared to Original Medicare, Medicare Advantage is increasingly becoming the preferred option for Medicare beneficiaries. By 2023, approximately half of all eligible beneficiaries are expected to be enrolled in MA.[1.1]

MA GIVES MEMBERS MORE BENEFITS FOR LESS MONEY

Even as MA premiums have fallen by approximately 40% over the last decade, plans have expanded benefits, providing a value-oriented option to seniors.[1.2] While most Original Medicare enrollees incur three separate monthly out-of-pocket costs (Part B, prescription drug and Medigap premiums), MA enrollees pay one small monthly premium (average of

[1.1] Analysis of Congressional Budget Office July 2021 Medicare Baseline Data. Congressional Budget Office.
[1.2] Medicare Data Hub. Commonwealth Fund. October 2020.

- CON -

"Medicare Advantage restricts patients' access to care, costs taxpayers more money than the Original Medicare program, and has failed to demonstrate any broad improvements in health outcomes."

Medicare Advantage is a massive, overly subsidized, inconsistent coverage option that benefits a few large insurers. Taxpayers, who are paying more per capita for MA beneficiaries, are footing the bill for more restrictive care that limits patients' access to providers.

MA PLANS RELY ON RESTRICTING ACCESS TO CARE

Although MA plans must offer all Medicare-covered benefits, as many as one-third of MA beneficiaries experienced narrow networks that limit their choice of health care provider.[2.1] Moreover, nearly all MA beneficiaries must obtain prior authorization (PA) for certain services, including mental health (84% of MA plan enrollees in 2021), diabetic care services, physical therapy and preventative health.[2.2]

[2.1] Medicare Advantage. Kaiser Family Foundation. June 6, 2019.
[2.2] Freed, et. al. Medicare Advantage in 2021: Premiums, Cost Sharing, Out-of-Pocket Limits and Supplemental Benefits. Kaiser Family Foundation. June 21, 2021.

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$19 per month) above the standard Part B premium.[1.3] Last year, 59% of MA enrollees had no additional premium.[1.4] MA plans protect beneficiaries against catastrophic care via an annual limit on out-of-pocket costs. In 2018 MA beneficiaries spent $1,640 less out-of-pocket than Original Medicare beneficiaries, resulting in fewer than 12% of MA beneficiaries reporting a health related cost-burden, compared to 20% in Medicare FFS.[1.5]

Even while costing less than Original Medicare, nearly all MA plans include dental, vision, and hearing coverage – benefits that are not covered by Original Medicare.[1.6] In addition, nearly 25% of MA plans offer non-medical supplemental benefits such as transportation, personal care services, and home modifications.[1.7]

MA DELIVERS BETTER OUTCOMES

A recent systematic review of the literature (across 48 different studies) found enrollment in an MA plan is associated with better outcomes including more preventive care visits, fewer hospital admissions, and less emergency department visits.[1.8] During the COVID-19 Public Health Emergency (PHE), 58% of dual-eligible (coverage for Medicare and Medicaid) MA beneficiaries were confident in their ability to get a regular check-up, compared with 45% in Original Medicare.[1.9] Further, MA beneficiaries were less likely to be hospitalized and die from COVID-19 during the PHE.[1.10] In addition, research shows that MA beneficiaries are more likely than those in Original Medicare to have

[1.3] CMS Releases 2022 Premiums and Cost-Sharing Information for Medicare Advantage and Prescription Drug Plans. Centers for Medicare & Medicare Services. September 30, 2021.
[1.4] Freed, et. al. Medicare Advantage 2022 Spotlight: First Look. Kaiser Family Foundation. September 2, 2021.
[1.5] Medicare Advantage Outperforms Traditional Medicare on Cost Protections for Low and Modest Income Populations. ATI Advisory. March 2021.
[1.6] Freed, et. al. Medicare Advantage 2022 Spotlight: First Look. Kaiser Family Foundation. September 2, 2021.
[1.7] Delivering on the Promise of the CHRONIC Care Act. ATI Advisory. Viewed on December 8, 2021.
[1.8] Agarwal, et. al. Comparing Medicare Advantage and Traditional Medicare: A Systematic Review. Health Affairs. 40(6) June 2021.
[1.9] Medicare Advantage See Fewer COVID-19 Hospitalizations in Beneficiaries and Offers Greater Access to In-Person and Telehealth Non-COVID Care During Pandemic. ATI Advisory. October 2021.
[1.10] Ibid.

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These aggressive coverage restrictions have led the U.S. government to conclude that the PA tactics MA plans use have led to inappropriately excessive denials of care.[2.3] These overly restrictive PA rules have likely contributed to higher rates of disenrollment in MA.[2.4] Concerns about PA have resonated within the U.S. Congress. Representative DelBene introduced H.R. 3173 (246 bipartisan co-sponsors) and Senator Marshall introduced S. 3018 (7 bipartisan co-sponsors)—two companion bills that aim to increase transparency, provide oversight, and streamline the PA process.

Due to limited MA encounter data, not much is known about how PA requirements and other utilization management requirements impact beneficiary care. However, the COVID-19 Public Health Emergency (PHE) has provided some added perspective because many MA plans suspended PA restrictions during the initial phase of the PHE.[2.5] This temporarily evened the utilization playing field between Original Medicare and MA. One study examining the utilization of long term care hospitals and inpatient rehabilitation hospitals during this period provides important insights.

Suspension of PA facilitated faster transitions of care between short-term acute care hospitals and these post-acute hospitals.[2.6] Similarly, MA beneficiaries were admitted to inpatient rehabilitation hospitals at rates similar to traditional Medicare, even as patient characteristics for these admissions remained consistent with pre-pandemic levels.[2.7] This suggests that MA plan PA policies are overly

[2.3] Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials. Health and Human Services Office of Inspector General. September 25, 2018.
[2.4] Jacobson, G and Neuman, T. Prior Authorization in Medicare Advantage Plans: How Often is it Used? Kaiser Family Foundation. October 24, 2018.
[2.5] COVID-19 Flexibilities Reminder. Centers for Medicare & Medicaid Services Memo to Medicare Advantage Organization and Medicare-Medicaid Plan. August 20, 2021.
[2.6] Role of LTAC Hospitals in COVID-19 Pandemic. ATI Advisory.
[2.7] Comparison of Traditional Medicare and Medicare Advantage Discharges Before and During the COVID-19 Public Health Emergency. American Medical Rehabilitation Providers Association. July 2022.

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a treatment plan, someone who reviews their prescriptions, and a regular doctor or place of care.[1.11]

MA IMPROVES HEALTH CARE ACCESS FOR VULNERABLE POPULATIONS

The Medicare Advantage benefit has also helped reduce inequities in health care access by providing expanded benefits and lower cost health care options to an ever growing and increasingly diverse patient population. Over time, this has included greater proportions of racial and ethnic minorities, as well as low-income beneficiaries.[1.12] MA beneficiaries face more socioeconomic risk factors and are more financially vulnerable compared to the Original Medicare population.[1.13]

Recent research sponsored by the Better Medicare Coalition confirms this trend. Compared to Original Medicare, MA serves a greater proportion of both lower income beneficiaries and those eligible for both Medicare and Medicaid.[1.14] The continued growth of MA Special Need Plans, care models designed for patients with specific clinical conditions and social characteristics, has the potential to deliver further value to the nation's most vulnerable and underserved populations.

MA LEADS THE DEVELOPMENT OF INNOVATIVE CARE MODELS FOR MEDICARE

As capitated health insurers responsible for the total cost of care for their enrollees, MA plans are motivated to invest in new care models that can improve care while reducing costs. Their experience, honed from delivering these models at scale to their broad plan

[1.11] Medicare Advantage vs. Traditional Medicare: How do Beneficiaries' Characteristics and Experiences Differ? Commonwealth Fund. October 14, 2021.
[1.12] As It Grows, Medicare Advantage Is Enrolling More Low-Income and Medically Complex Beneficiaries. Commonwealth Fund. May 13, 2020.
[1.13] Beerman, L. 2022 Medicare Advantage Plan Overview, Part Three: Social Determinants. Healthleaders. October 25, 2021.
[1.14] Medicare Advantage Outperforms Traditional Medicare on Cost Protections for Low and Modest Income Populations. ATI Advisory. March 2021.

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restrictive and are inappropriately limiting access to needed care, at least for certain services.

MA COSTS MORE PER BENEFICIARY

The Medicare program pays MA nearly 4% more, per beneficiary, than Original Medicare.[2.8] These higher payments are generated in part from, questionable, carefully managed diagnostic risk scoring.[2.9] In 2019, MA costs increased 6.3% versus 2.4% for Original Medicare.[2.10] Although individual studies have demonstrated select improvements in some outcomes in MA, findings are not broad-based. Policymakers have long argued that the increased cost of MA, compared to Original Medicare, is not justified because there is no ability to directly compare quality between the two benefits. This quality comparison is needed to determine the true value provided by MA.[2.11]

MA VARIATION PERPETUATES INEQUITIES IN MEDICARE

MA enrollment varies significantly from state to state, and is driven by many factors, including wildly different monthly payment rates to MA plans, which can vary more than 50% across the continental U.S. states.[2.12] The number of MA plans available to beneficiaries ranges from two in Alaska to 369 in Florida.[2.13] In turn, the number and type of additional benefits available to beneficiaries varies significantly too – exacerbating inequities in the value of the MA benefit, particularly in rural areas. Urban-rural differences across MA plans are linked

[2.8] Rebalancing Medicare Advantage Benchmark Policy. June 2021 Report to Congress. Chapter 1. Medicare Payment Advisory Commission.
[2.9] Some Medicare Advantage Companies Leverage Chart Reviews and Health Risk Assessments to Disproportionately Drive Payments. Health and Human Services Office of the Inspector General. September 20, 2021.
[2.10] Terry, K and Muhlestein, D. Medicare Advantage for All? Not so Fast. Health Affairs. March 11, 2021.
[2.11] The Medicare Advantage Program: Status Report. March 2019 Report to Congress. Chaptaer 13. Medicare Payment Advisory Commission.
[2.12] Analysis of the Centers for Medicare and Medicaid Services 2022 Medicare Advantage Ratebook. Reviewed on December 5, 2021.
[2.13] Freed, et. al. Medicare Advantage 2022 Spotlight: First Look. Kaiser Family Foundation. September 2, 2021.

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populations, has spurred many creative delivery initiatives. For example, Humana has been investing in community-based interventions, including diagnosis-specific educational and community-focused nutritional programs, that have helped reduce "mean unhealthy days" for their members.[1.15] The largest MA plan in Minnesota recently invested in Lifespark, a technology-enabled holistic healthcare platform for seniors that offers proactive care solutions to plan enrollees, including nutrition counseling and transport services that enable more healthy living. Lifesparks' creative "life manager" approach has led to significant reductions in emergency room visits and hospital readmissions for its members.[1.16]

CONCLUSION

Enrollment in Medicare Advantage is growing across the country for a reason. The MA program offers Medicare beneficiaries access to important additional benefits at little to no additional costs. In turn, these additional benefits and MA plans' innovative approaches to care management are working to both improve health outcomes and expand access to care, particularly for vulnerable Medicare beneficiary groups.

[1.15] Cordier, et. Al. A Bold Goal: More Healthy Days through Improved Community Health. Population Health Management. June 2018 21(3). 202-208.
[1.16] Why Minnesota's Largest Medicare Advantage Provider Is Investing in Lifespark. Home Healthcare News. October 12, 2021.

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to beneficiary dissatisfaction with access and are driven by limited provider networks.[2.14] This rural disparity is further exacerbated for beneficiaries with multiple chronic conditions, especially among those with at least one annual hospitalization, who experienced 2-times the rate of switching from MA to Original Medicare compared to urban beneficiaries.[2.15]

CONCLUSION

The MA program restricts beneficiary access to care, costs taxpayers more compared to Original Medicare, and exacerbates inequities in the health care system. Policymakers should reexamine the appropriateness of MA payment policies and advance more beneficiary protections to coincide with the growth of MA.

[2.14] Langellier, et. al. Rural Enrollees in Medicare Advantage Have Substantial Rates of Switching to Traditional Medicare. Health Affairs. 40(3). March 2021.
[2.15] Ibid.

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