

TO: Centers for Medicare and Medicaid Services

FROM: Robert E. Moffit, PhD, Senior Research Fellow, The Heritage Foundation

RE: [CMS-2024-006] Advance Notice of Methodological Changes for Calendar Year (CY) 2025 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies.

Submitted Electronically via <https://www.regulations.gov>

The Center for Medicare and Medicaid Services (CMS) is proposing several technical changes to the Medicare Advantage (MA) payment system. This Advanced Notice is comprehensive and addresses MA growth rates, the risk adjustment model for the payment of private plans, the prescription drug (Part D) risk adjustment system, the “star” quality rating for Medicare Part C and Part D, and the Inflation Reduction Act (IRA) updates for 2025, including the imposition of a \$2000 cap on out-of-pocket drug spending.¹ This Advance Notice complements a proposed rule CMS issued in November 2023 that, according to the agency, “if finalized, would “strengthen protections for the millions of people who rely on MA and Medicare Part D prescription drug coverage.”²

These comments focus exclusively on the MA payment proposals under Part C of the program. The changes are technical ones, consisting of adjustments to the current system previously authorized in statute and confirmed in subsequent regulation over several years. However, it is important for policymakers, both in Congress and the Executive branch, to recognize that the problems burdening MA payment and risk adjustment are unamenable to mere technical adjustments to extant administrative payment formulas. Rather, the problems are structural and will require carefully crafted legislative remedies to secure the objective of providing affordable and high-quality medical care to an ever-larger number of MA enrollees.

The Advanced Notice for 2025 would continue to phase- in previously announced changes to the MA risk adjustment system and update the calculation for growth rates to be applied to the establishment of the MA benchmarks. The agency argues that these changes would “...ensure payments accurately reflect an individual’s costs. These updates not only ensure payment is higher for enrollees with the most complex needs, but they also make Medicare Advantage less susceptible to gaming and protect the long-term stability of the Medicare program.”³

CMS claims the technical changes to the MA payment formulas are projected to slightly increase private health plan payment in 2025. According to CMS, the result will be an “effective growth rate” of 2.44 percent, with technical adjustments to the “Star Rating adjustments for the

¹ Advance Notice of Methodological Changes for Calendar Year (C Y) 2025 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies, Center for Medicare and Medicaid Services, January 31, 2024, <https://www.cms.gov/files/document/2025-advance-notice.pdf> Hereafter cited as Advance Notice,

² CMS Releases Proposed Payment Updates for 2025 Medicare Advantage and Part D Programs,” Press Release, January 31, 2024, <https://www.cms.gov/newsroom/press-releases/cms-releases-proposed-payment-updates-2025-medicare-advantage-and-part-d-programs>

³ Ibid.

quality bonuses, risk model revisions, and FFS payment adjustments. Factoring in these changes, CMS says that there will be an average MA plan payment increase from 2024 to 2025 of 3.7 percent. This will amount to an estimated \$16 billion in revenues, though the impact of these changes will vary among the competing plans.⁴

According to the Agency, the proposed technical changes will stabilize beneficiary premiums and the updated risk adjustment changes will yield more accurate MA payments. The changes will also preserve an accurate payment for dual-eligible (Medicare/Medicaid eligible) individuals with complex or chronic medical conditions, preserve access to persons in need of preventive care among beneficiaries with complex medical conditions, upgrade the diagnostic coding for medical conditions to improve risk scoring, recalibrate the Medicare FFS risk score, and readjust MA payment for changes in medical education costs in calculating health plan payment.⁵

A Word of Caution. While CMS is projecting a 3.7 percent increase in MA payment for 2025, industry and independent experts point out that the totality of technical changes to risk adjustment, more stringent standards for quality bonuses, and updated benchmark calculations are likely to result in MA payment reductions. For example, the Berkely Research Group, a research consulting firm, estimates that monthly MA payment could fall by 1 percent in 2025.⁶ Likewise, health insurers fear that the CMS changes could result in a 0.2 percent reduction, the second such reduction in two years.⁷

The key question is how the CMS technical changes to MA rate setting will impact Medicare beneficiaries. The Berkeley Research Group (BRG) analysts say that the proposed MA payment level collides with a projected medical inflation of between 4 to 6 percent in 2025, resulting in a reduction in the value of MA's supplemental benefits and a negative impact on beneficiaries' cost sharing and premiums. In their brief report, the BRG analysts say, "The value of supplemental benefits or reductions to premiums and cost sharing could fall by \$33 per beneficiary per month, on average, which beneficiaries would experience as an increase in health care costs. The impact on those fully eligible for Medicare and Medicaid could be reduced by \$50 per beneficiary per month, on average."⁸

Of course, it remains to be seen. Nonetheless, the CMS capacity to affect the welfare of more than 32 million Medicare beneficiaries through technical changes, once again, highlights

⁴ "2025 Medicare Advantage and Part D Advance Notice Fact Sheet,: CMS, January 31, 2024, <https://www.cms.gov/newsroom/press-releases/cms-releases-proposed-payment-updates-2025-medicare-advantage-and-part-d-programs>

⁵ Ibid.

⁶ The Berkeley Research Group, "MA Advance Notice Does Not Offset Rising Medical Costs and Could Lead to Reduced Healthcare Value for Beneficiaries," (February 2024), p.1. <https://www.thinkbrg.com/insights/publications/ma-advance-notice-does-not-offset-rising-medical-costs/> Hereafter cited as BRG, "MA Advance Notice."

⁷ Noah Tong, "Payers Up Against Slight decline in 2025 Medicare Advantage Payments," *Fierce HealthCare* January 31, 2024, [CMS proposes decline in 2025 Medicare Advantage payments \(fiercehealthcare.com\)](https://www.fiercehealthcare.com/news/cms-proposes-decline-in-2025-medicare-advantage-payments/)

⁸ BRG, "MA Advance Notice".

the persistent problem of permitting administrative agencies to exercise such vast power over the lives of ordinary Americans.

THE CURRENT MA PAYMENT SYSTEM.

The complexity of the current MA payment system is nothing less than astonishing. To determine the government contribution to health plans on behalf of the beneficiaries, the CMS must first establish a benchmark payment based on its estimate of the cost of providing Part A (hospital) and Part B (outpatient) benefits and services. This benchmark payment is then applied to each of the 3142 counties in the United States, reflecting the costs of providing Part A and Part B benefits and services in each county. The CMS benchmark is, of course, based on the FFS program's combination of administrative payments and price caps for hospitals and physicians and other medical professionals, not on market forces.

As a matter of administration, this is an extraordinary regulatory exercise. Beyond hospital payment, the CMS reimburses medical professionals for more than 10,000 medical services and procedures.⁹ These administrative payments, in turn, are based on the various formulas, created by statute, and updated by regulation, to set provider reimbursement. Given the vast differences in health care costs across the country, the CMS benchmark payments are obviously not the same for each county, but, by law, they may range from 115 percent of Medicare FFS spending in the lowest spending counties to 95 percent of FFS spending in the highest spending counties.

Private insurers offer county-wide bids based on their estimates of what it would cost for their health plans to provide the standard Part A and Part B benefits and services. If health plans bid above the CMS benchmark, they are free to charge a premium that covers the difference between their bids and the benchmark. If the plan offers a bid that is below the CMS benchmark, by law the plan gets a rebate that must be provided to the beneficiary. By law, the rebate amount ranges between 50 percent of the difference between the plan bid and the CMS benchmark and 70 percent of that difference; the size of the rebate- whether 50, 65 or 70 percent- is determined by how strong the health plan performance on the CMS "Star Rating" system. If a plan ranks at 3.5 Stars and below, the rebate is 50 percent; if the plan achieves a 4 Star rating, the rebate is 65 percent; and if the health plan gets a rating of 4.5 to 5 Stars, the rebate is 70 percent. By law, a portion of the rebate – between 30 And 50 percent- is thus returned to the federal government and none is returned directly to the beneficiary in the form of a cash rebate. Based on recent experience, health plans distribute the rebates primarily in the form of increased benefits and reduced cost-sharing, followed by Part B and Part D premium reductions.¹⁰

MA plans are far more economically efficient in delivering standard Medicare benefits than traditional Medicare itself. Today, almost all health plans offer bids *below* the CMS benchmark, meaning that virtually all Medicare beneficiaries get the benefits of the MA rebate

⁹ Center for Medicare and Medicaid Services, "Overview: Medicare Physician Fee Schedule," September 8, 2023, <https://www.cms.gov/medicare/physician-fee-schedule/search/overview>

¹⁰ See Joe Albanese, "Improving Medicare Through Medicare Advantage," The Paragon Health Institute, February 2024, p.13., <https://paragoninstitute.org/medicare/improving-medicare-through-medicare-advantage/>

program. According to the staff of the Medicare Payment Advisory Commission (MedPAC), the dollar value of the average monthly rebate per enrollees, has grown from \$95 in 2018 to \$196 in 2023, or \$2,352 annually.¹¹ The current system then is not designed to stimulate intense price competition among plans or providers and thus control health care costs. Rather, the government’s economic incentives encourage benefit expansions and discourage the maximization of price competition.

Beyond the basic CMS benchmark payment, health plan payment is further adjusted by a “Quality Bonus Program,” which awards higher payments to health plans that achieve four or more stars on the aforementioned “Five Star” quality rating system. According to MedPAC staff, this program adds an additional \$15 billion a year to the government contribution to MA plans.¹²

How CMS Plans to Address MA Payment for 2025.

In setting the FFS benchmarks, the CMS relies on various data to make projections including the historical and projected Medicare enrollment, the historical and projected expenditures, and adjustments to the baselines based on direct and indirect medical education costs.

The projected growth in the CMS benchmark payments is the primary basis for calculating the annual MA plan payments; the growth rate estimate is, in turn, reflective of the estimated per capita costs of Medicare FFS program in delivering the standard Medicare Part A and Part B benefits and services. This FFS per capita cost estimate must also be adjusted for geographical factors that influence the cost of providing care.

The Medicare statute requires CMS to use the base FFS amount from the previous year increased by the national per capita growth percentage. The statute also requires CMS to “rebase” the county FFS rates not less than once every three years. According to the Advanced Notice: ‘When the rates are rebased, CMS updates its updates of Each county’s FFS costs using more current FFS claims information. CMS intends to rebase the county rates for 2025 using FFS claims data from 2018 through 2022. “CMS has rebased the rates every year since 2012 and has discussed in previous Rate Announcements that we anticipate rebasing rates each year. Given that MA rates are based on FFS costs, CMS believes it is important to update the FFS per capita cost estimates using the most current FFS data available.”¹³

The Medicare statute, as noted, also requires CMS to vary county MA benchmark payments based on the level of FFS spending at the county level. For the highest spending quartile, the MA payment is to be set at 95 percent of the FFS spending; for the third quartile, it

¹¹ Stuart Hammond, Andy Johnson, and Louis Serna, “The Medicare Advantage Program: Status Report,” presentation to the Medicare Payment Advisory Commission, January 12, 2024, <https://www.medpac.gov/wp-content/uploads/2023/10/MedPAC-MA-status-report-Jan-2024.pdf>

According to MedPAC staff, these estimates do not include MA plans that do not offer drug coverage, nor do they include employer-sponsored plans or “special needs” plans that serve low-income, high-risk Medicare enrollees. Hereafter cited as MedPAC Status Report.

¹² Ibid.

¹³ Advance Notice, p. 22.

would be 100 percent; for the second quartile, it would be 107.5 percent; and for the fourth quartile (the lowest spending counties) the payment would be 115 percent.¹⁴

For 2025, CMS is continuing its plan to discount the costs of graduate medical education as a component of MA payment. For 2024 and 2025, CMS decided to remove direct and indirect medical education costs (associated with services delivered to MA enrollees) from the calculation of the MA payment, phased out over a three- year period.¹⁵ In short, CMS would end payments to MA plans for graduate medical education costs. When fully implemented, this change would result in a Part A reduction for MA medical education by \$12.5 billion.¹⁶

Our Assessment. This change in the role of graduate medical education costs as a component of the growth rate and in the benchmark MA payment is a positive step in the right direction. Technical change, however welcome, does not and cannot go far enough. The problem invites a legislative solution. In fact, it is past time to retire the FFS calculation of direct and indirect costs of direct medical education costs for the medical treatments and procedures altogether.¹⁷ Instead of being programmatically tied to Medicare and generating an additional stream of Medicare costs, it would be far better if the program were re-established as a separate and far more flexible program and financed directly through congressional appropriations for the education of medical professionals. This could be done, as Heritage Foundation has long suggested, with a view toward increasing the number of physicians the nation desperately needs with a flexible funding arrangement where the funding follows the residents.¹⁸

How CMS is Updating FFS Payment.

In setting MA payment, CMS must annually project FFS spending for medical treatments and procedures under Medicare Part A and Part B. Annually, therefore, CMS updates its FFS estimates based on variety of data sources, including recent cost reports, payment adjustments, payments made through the “shared savings program (the accountable care organizations or ACOs) payment modifications or adjustments authorized by law or regulation.

These administrative FFS payments are, of course, the basis for the Medicare benchmarks that determine the MA plan payments. In contrast to the rapid adaptability of pricing in a normal market, with a system of administrative pricing the only option is to rely on previous data. So, as CMS explains, for 2025, the agency’s projections of FFS costs, the “base year” for expenditures is CY 2022.¹⁹

Our Assessment. Today, MA enrolls more than 52 percent of total Medicare population, and that enrollment is likely to expand rapidly in the next few years. Conceptually, the rationale for tying Medicare Advantage payment to the traditional Medicare fee-for-service (FFS) program

¹⁴ Advance Notice, p. 24.

¹⁵ Ibid., p. 12.

¹⁶ Ibid., p. 13.

¹⁷ Ibid.

¹⁸ For a detailed discussion of how to reform graduate medical education, see John O’Shea, MD, “Reforming Graduate Medical Education in the U.S.” Heritage Foundation *Backgrounder* No.2983, December 29, 2014, https://thf_media.s3.amazonaws.com/2014/pdf/BG2983.pdf

¹⁹ Advance Notice, p. 10.

is rapidly becoming outdated. As a research team from the University of California recently concluded, “Basing MA payment benchmarks on FFS expenditures is increasingly problematic as FFS enrollment continues to decline—underscoring the need for reforming how MA payments are set such as decoupling MA payments from FFS benchmarks or instituting competitive bidding.”²⁰

So, improving the benchmark requires a legislative solution. For that reason, Congress must address a first order question. Why should one assume the inherent validity of any system of administrative payment as the basis for reimbursement for any good or service in any market, let alone as the foundation of reimbursement for what should be competitive private health plans? As Professor Michael Porter of Harvard University and Professor Elizabeth Teisberg of the University of Virginia observe: “The top-down prices in the current system are not well calibrated with value...Some are too high (so every hospital wants to provide those services), and others are too low to be attractive to providers. In the current system, there is also no incentive for an excellent provider to offer the well-reimbursed services at lower rates. The methodology for top-down price setting can be improved, but never perfected. Administered prices will never really work. Hence, preserving the current Medicare pricing structure will only perpetuate the system’s problems.”²¹

Once again, the MA payment problem cannot be effectively resolved through periodic, piecemeal administrative or regulatory changes. It requires a legislative solution. Congress should replace the current system with a simpler process of straight market-based bidding among competing health plans to offer the traditional Medicare benefits, and government payment to plans would reflect the actual market price of care and coverage and thus drive more intense competition among health plans and medical professionals. Also, instead of the narrow county-based bidding, such competitive bidding should be undertaken regionally, broadening the competition, smoothing out the sharp pricing differences that exist among localities and recognizing the fact that modern care delivery is itself increasingly more regionally based.²²

The idea of using straight market-based bidding to set the government contribution to MA plans is neither new nor partisan. In his 2009 address to the American Medical Association, President Barack Obama argued that MA plans were overpaid, and that the existing financing arrangement was incompatible with “free market principles”: “That is why we need to introduce

²⁰ Steven M. Lieberman, Paul Ginsburg, PhD, and Samuel Valdez, PhD, “Medicare Advantage Enrolls Lower-Spending People, Leading to Large Overpayments,” the USC Leonard D. Shaeffer Center for Health Policy and Economics, *White Paper*, June 13, 2023, <https://healthpolicy.usc.edu/research/ma-enrolls-lower-spending-people-leading-to-large-overpayments/>

²¹ Michael E. Porter and Elizabeth Olmsted Teisberg, *Redefining Health Care: Creating Value Based Competition on Results*, (Boston: Harvard Business School Press, 2006), p. 371.

²² For a detailed discussion of the payment reform proposal, see Robert E. Moffit PhD, “Preparing Medicare Advantage for Comprehensive Medicare Reform,” Heritage Foundation *Special Report* no. 267, February 23, 2023, especially pp.10-14, and 18-20., <https://www.heritage.org/sites/default/files/2023-02/SR267.pdf>

See also, Walton J. Francis, “Reforming Medicare: Lessons from Premium Support’s Long Bipartisan History,” in Robert Emmet Moffit and Marie Fishpaw, *Modernizing Medicare: Harnessing the Power of Consumer Choice and Competition* (Baltimore: Johns Hopkins University Press, 2023), pp. 187-200. Hereafter cited as Moffit and Fishpaw (eds.) *Modernizing Medicare*.

competitive bidding into the Medicare Advantage program, a program under which private insurance companies are offering Medicare coverage. That alone will save \$177 billion over the next decade, just that one step.”²³

President Obama was then championing the same market-based policy previously proposed by President Bill Clinton. In 1999 the Clinton Administration proposed straight competitive bidding, providing a direct government contribution to Medicare’s private health plans, separate and apart from the FFS payment system: “Such price competition would make it easier for beneficiaries to make informed choices about their health plan options. It would also provide incentives for beneficiaries to choose private plans offering high quality health care while also saving them money by reducing their Part B premium costs. This saves the government money as well.”²⁴

There are several model formulas for setting the government contribution in a system of straight, market-based competitive bidding. Policymakers could adopt the use of an average weighted bid among competing health plans, as is done today in the FEHBP, or the use of the second lowest-cost health plan, as is done in the health insurance exchanges created by the Affordable Care Act of 2010 (ACA). Alternatively, policymakers could set the government contribution in a competitive region based on the average of the three lowest cost plans, as initially proposed by The Heritage Foundation.²⁵

MA’s CURRENT RISK ADJUSTMENT SYSTEM

The government contribution to private plans is not only based on the benchmark payment, the insurers’ bidding process, and the quality bonus system, but also the “risk scores” of Medicare beneficiaries. The risk scores not only include the basic demographic characteristics, but also the beneficiaries’ health status, as reflected in the diagnostic codes for their medical conditions.

The conditions for risk, ranging from diabetes to heart failure, are registered in the CMS’s hierarchical conditions categories (HCC). For physicians practicing in traditional FFS Medicare, as MedPAC staff observe, there is “little incentive to code diagnoses.”²⁶ For private plans participating in MA, however, the economic incentive for coding for health risk is enormous: the higher the health risk of beneficiaries, registered through diagnostic coding, the higher the risk adjustment for Medicare plan payment. To cope with this “coding intensity”, by law CMS must reduce risk-adjustment payments by 5.9 percent. Nonetheless, MedPAC staff report that the MA

²³ The White House, “Remarks by the President to the Annual Conference of the American Medical Association,” June 15, 2009, <https://obamawhitehouse.archives.gov/the-press-office/remarks-president-annual-conference-american-medical-association>

²⁴ National Economic and Domestic Policy Councils, “The President’s Plan to Modernize and Strengthen Medicare for the 21st Century,” detailed description, July 2, 1999, p. 8, <https://clintonwhitehouse5.archives.gov/WH/New/html/Medicare/toc.html> ; see also, Robert E. Moffit, PhD, and Alyene Senger, “Real Medicare Reform: Why Seniors Will Fare Better,” Heritage Foundation *Backgrounder* No. 2800, May 13, 2013, https://thf_media.s3.amazonaws.com/2013/pdf/bg2800.pdf

²⁵ See, Robert Emmet Moffit, “Medicare Advantage: The Platform for a Comprehensive Premium Support Program,” in Moffit and Fishpaw (eds.) *Modernizing Medicare*, pp. 120-121.

²⁶ MedPAC Status Report.

plans, based on the health risk assessments of their enrollees, have been coding more diagnoses among more beneficiaries, thus identifying them at higher risk. And they project that this higher “intensity” of coding will drive per capita MA spending about 14 percent higher than Medicare FFS in 2024.²⁷

A related issue with Medicare payment is “favorable selection”, meaning that MA is attracting a healthier population overall. The enrollee switching that has occurred over the last two decades has generally seen a relatively healthier Medicare population switching from FFS to MA. The current system “overpays” MA plans because the existing standard for plan payment is “average health risk” but the enrollees in these plans are generally *below* average health risk. In a recent University of California study covering 14 years of data on enrollee switching, analysts concluded, “This persistent effect pays average MA rates for millions of beneficiaries with below-average, risk score adjusted expenditures, and overstated per beneficiary FFS expenditures translate into higher county benchmarks and MA rates. Studies have shown that higher MA rates result in higher plan profit margins along with enrollees receiving additional extra benefits.”²⁸ Between 2017 and 2021 alone, MedPAC staff estimate that this “favorable selection” has led to MA plan payment between 6 and 13 percent higher than Medicare FFS.²⁹

How CMS Plans to Address Risk Adjustment.

The Medicare risk scores are based on demographic and diagnostic factors. Factors that determine beneficiary risk include demographic factors such as age, sex, Medicaid status, institutional status, as well as health status. Under current law and regulation, the CMS risk adjustment model projects risks for beneficiaries prospectively, and these projections are based on expectations of demographic-related spending and health status. Health status is determined by diagnostic coding. As MedPAC analysts have noted, there is “little incentive” to code diagnoses in the FFS program, but there is a strong financial incentive for MA plans “to code more diagnoses.”³⁰

It is MA health status assessments, driven by increasingly intense diagnostic coding of beneficiaries’ health conditions, that has driven higher risk scores and thus unnecessarily higher reimbursement for Medicare plans.

Today, the basic mechanism for assessing beneficiary health risks is the Hierarchical Condition Category (HCC); this measures common medical conditions among seniors such as atrial fibrillation, depression, and various forms of heart disease. These conditions have specific diagnostic codes included in the International Classification of Diseases (ICD-10) classification system.

²⁷ Ibid.

²⁸ Steven M. Lieberman, Paul, Ginsburg, PhD., and Samuel Valdez, PhD., “Medicare Advantage Enrolls Lower-Spending People, Leading to Large Overpayments,” University of California, USC Leonard D. Schaeffer Center for Health Policy and Economics, *White Paper*, June 13, 2023, <https://healthpolicy.usc.edu/research/ma-enrolls-lower-spending-people-leading-to-large-overpayments/>

²⁹ MedPAC Status Report.

³⁰ Ibid.

As part of its MA risk-adjustment update, in 2024 CMS dropped many of the diagnostic codes that were in its 2020 model. The transition of coding from the older ICD-9 to ICD-10 accounts for “roughly 97 percent” of the codes not included in the 2024 risk adjustment model. As the agency explains, “While all roughly 74,000 diagnoses codes are mapped to an HCC, only a subset of HCCs are included in the model for payment following well established principles to determine which HCCs best predict Medicare costs. CMS developed the HCCs using empirical evidence on the frequencies and predictive power; clinical input and relatedness, specificity, and severity of diagnosis; and professional judgment on incentives and diagnostic patterns relative to the classification system.”³¹

So, the basic change is this. With reduced coding, CMS is undertaking a three-year phase-in of its updated risk adjustment model: the 2024 CMS-HCC model. For 2025, the agency will blend 67 percent of the risk score calculated using the 2024 MA risk adjustment model with 33 percent of the risk score calculated using the older 2020 risk adjustment model: “In the finalized 2024 model, there were 115 HCCs in the payment model and 151 HCC that were not in the payment model.”³²

The CMS says that the technical modifications of its MA risk adjustment system will continue to protect the most vulnerable beneficiaries, such as the dual-eligible beneficiaries with complex and chronic conditions. These changes will also produce more accurate results: “The CY 2024 MA risk adjustment model changes...will support accurate MA payments in Cy 2025. This CMS HCC risk adjustment model improves payment accuracy by incorporating more recent utilization, coding, and expenditures patterns in the relative weights of HCCs in the model and reclassifying HCC to reflect clinical cost patterns associated with ICD-10 codes.”³³

According to McDermott Consulting, the CMS proposed changes to the risk scoring would, if implemented, result in a net savings to the Medicare trust fund of \$11 billion.³⁴

Our Assessment. CMS’s reliance on prospective risk adjustment based on demographic data does not appear to be a problem. The problem is the persistent difficulty in accurately assessing health risk. The updated Medicare MA risk adjustment system, to be phased in over three years, is designed to project and account for future health risks. Projecting forward by looking backward is an inherently difficult, if not insurmountable, task. While *prospectively* using past medical claims data can produce reasonably accurate cost projections for a class of beneficiaries with well-understood chronic conditions, it cannot predict unexpected costs or sudden changes in beneficiary health status. For example, as a class, diabetics are at much higher risk for medical events than non-diabetics, but it is impossible to know, year by year, which patient, or subset of patients, within a large class of diabetics will incur exorbitant medical costs.

³¹ Ibid.

³² Ibid.

³³ CMS “2025 Medicare Advantage and Part D Advance Notice Fact Sheet,”

³⁴ Kristen O’Brien, “CMS Releases CY2025 Advance Notice for Medicare Advantage and Part D,” McDermott Consulting, February 15, 2024, <https://www.mcdermottplus.com/insights/cms-releases-cy-2025-advance-notice-for-medicare-advantage-and-part-d/>

The resolution of this problem goes well beyond trying to recalibrate extant risk adjustment formulas, but, as with MA payment changes, requires a legislative solution. Congress should secure major taxpayer savings and take the guesswork out of health plans' costs attributed to health status by adding a *retrospective* (look-back) system to reimburse plans for the *actual* costs of enrolling a disproportionate number of beneficiaries with higher medical costs.

Such reimbursements could come from a common pool. MA plans would contribute to the pool based on their own actuarial analyses of their beneficiaries' health risk, and then share the yearly costs of expensive enrollees. Such retrospective risk transfer pools could be organized on a state or regional basis, with funding from all participating MA plans, and designed and managed by the health plans themselves under state insurance regulators' supervision. Such a retrospective system would not only be more accurate but would also reduce or eliminate the real problem of intensive coding or insurer gaming of the current MA payment system at the expense of the taxpayer.³⁵

THE MA QUALITY BONUS SYSTEM

Beyond the benchmark and risk adjustment payments, the Medicare statute requires CMS to make a quality bonus payment (QBP) to an MA plan on the basis of the plan's performance on the program's "Five Star" rating system. The star ratings also determine, as noted, the level of rebates that a plan may provide to beneficiaries, ranging from a low of 50 percent to a high of 70 percent of the difference between the benchmark and the plan's bid.

Plans are to be rated between 1 and 5 stars, with five being the highest rating, on quality performance measures based on clinical process measures, medical outcomes, and patient experience. Plans with a rating of less than 4 Stars, get a 3.5 percent quality bonus increase as part of their MA payment; plans with ratings of 4 stars and above get a 5 percent quality bonus payment.

How CMS Plans to Address the MA Bonus System.

For 2025, MA plans with 4, 4.5 and 5 stars will get a 5 percent increase under the quality bonus program. According to the Advance Notice: "Plans with fewer than four stars will not receive a QBP percentage increase to the county rates."³⁶ CMS observes that any new MA plans will still qualify for a 3.5 percent increase to the county benchmark payments, but low enrollment plans will not qualify because of insufficient enrollment to make a valid assessment of their quality performance, though the agency reserves the right to make an independent determination of their performance and a possible bonus.³⁷

Our Assessment. The CMS projects that its change in the Star Ratings and bonus program will reduce MA payment by 0.15 percent. Whether or not this is an accurate projection,

³⁵ For a detailed description of this proposal, see Edmund F. Haislmaier, "Medicare Risk Adjustment: Stabilizing the Market in a Premium Support Program," in Robert Emmet Moffit and Marie Fishpaw (eds.), *Modernizing Medicare: Harnessing the Power of Consumer Choice and Market Competition* (Baltimore, Johns Hopkins University Press, 2023), pp. 161-173.

³⁶ Advance Notice, p., 24.

³⁷ Advance Notice, p. 26.

there is clearly a need to reform the Star Rating system and the quality bonus payments that flow from it. As MedPAC analysts have recently noted, there are far too many quality measures and they do not promote the use of “high value” medical care.³⁸

Policymakers could pursue a more effective alternative: refocus quality measures on medical outcomes and patient experience, as recommended by the Paragon Health Institute, and reduce or eliminate the quality bonus program altogether.³⁹ If the Congress eliminated the QBPs altogether, according to Paragon, it would reduce MA spending by \$170 billion over ten years.⁴⁰

The tacit assumption behind the current quality bonus system is that government rating health care quality is somehow superior to rating by private sector organizations, including professional medical or health organizations. In fact, however, there are several outstanding quality rating organizations in the private sector, such as The Leapfrog Group, which rates the quality performance of American hospitals. Large seniors’ organizations, such as the American Association of Retired Persons (AARP) or the Association of Mature American Citizens (AMAC) can also rate plans for the quality of care they deliver to their members.

Note also that the Federal Employees Health Benefits Program (FEHBP), which has been functioning effectively for over six decades, has nothing like the current Medicare Advantage bonus system, but the program is intensely monitored by private sector consumer organizations, federal employees’ organizations and retiree associations, rating health plans for their performance in providing quality benefits and service to more than 8 million federal employees and retirees and their families.

Conclusion

CMS will doubtless receive a large number of comments on their Advance Notice. Before finalizing changes to the MA payment and risk adjustment systems on April 1, 2024, the agency will have a great deal to digest and analyze.

Central planning and administrative price-setting and regulation are particularly difficult in a sector of the economy as complex and dynamic as healthcare, where the responses of millions of patients, thousands of plans, and tens of thousands of providers are highly uncertain. On a large scale, for example, the Medicare Boards of Trustees and the Congressional Budget Office (CBO) have often underestimated the rapidity of MA enrollment growth, which now exceeds well over half of the entire Medicare population. Hopefully, the emerging difficulties inherent in this latest MA rate setting episode will stimulate Congressional interest in making structural changes that will secure long-term improvements to the program.

Congress can create a better MA payment system driven by market price competition. It could be far more flexible and nimbler in its response to the health needs of seniors, and would help to mollify taxpayers’ concerns over accelerating federal entitlement spending.

³⁸ MedPAC Status Report.

³⁹ Joe Albanese, “Improving Medicare Through Medicare Advantage,” The Paragon Health Institute, (2024), pp. 40-41., <https://paragoninstitute.org/medicare/improving-medicare-through-medicare-advantage/>

⁴⁰ Ibid, p. 41.