THE BROOKINGS INSTITUTION

WEBINAR

REVISING PAYMENT TO MEDICARE ADVANTAGE PLANS
TO REFLECT THE RAPID GROWTH IN ENROLLMENT

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Panel Discussion:

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P R O C E E D I N G S

MR. GINSBURG: Good morning and welcome to Brookings. The context for today's event on Medicare Advantage is this, enrollment in private Medicare plans has grown very rapidly over the last decade and that by next year is likely to serve a majority of those beneficiaries who are eligible to enroll. Whereas private plans in Medicare were originally conceived as a way for the program to save money, MedPAC has concluded that payments to plans has consistently exceeded costs in the traditional Medicare program throughout the years. High payments may be contributing to the growth in this enrollment. The fiscal burden to the federal government and to beneficiaries who choose to remain in traditional Medicare is now substantial and growing rapidly. Here's the plan for this event.

We'll begin with Erin Trish presenting research on growth in Medicare Advantage enrollment in recent years. Then Meena Seshamani, our keynote speaker, will outline perspectives of the Centers for Medicare and Medicaid Services, or CMS, which administers the Medicare Advantage program. After her remarks, I will interview her to go into greater depth on some of the issues she discusses. Finally, a panel of three highly insightful individuals will participate with me in a discussion of these issues. That will include Matt Fiedler from the USC-Brookings Schaeffer Initiative on Health Policy, Clive Fields from VillageMD, and Gail Wilensky from Project HOPE.

There are some big picture questions for this event that I hope we can address. To help, I've got three questions, or four questions, that will help. One, are Medicare Advantage plans overall overpaid by Medicare? If so, what would be the best way to rectify that? Would competitive bidding be better than approaches to set Medicare Advantage rates administratively? With enrollment having such a large stake in MA payment with enrollees having such a large stake in Medicare Advantage payment rates, so what advantage are the political -- to what extent are the political dynamics making it difficult for CMS to exercise fiscal prudence in this area? Are there reasons to continue the overpayments such as encouraging coordinated care, or assisting lower income individuals or underserved minorities who disproportionately enroll in Medicare Advantage? And are there more equitable or more efficient ways to help these beneficiaries?

And finally, given the rapid growth in Medicare Advantage and concerns that some of it is being driven by overpayments, perhaps this may be a good time to consider ways of improving traditional

Medicare. Improvements to be considered could include updating the benefit structure in traditional Medicare, many of whose elements remain from 1965. For example, by adding an out-of-pocket maximum and unifying the deductible. We could encourage value by providing more generous terms for accountable care organizations, bundle payment arrangements, or partially capitated approaches for primary care to attract more participation. Or we could incorporate cost-effectiveness in coverage decisions and increasing utilization review.

Let me introduce Erin Trish. Erin is deputy director of the USC-Schaeffer Center for Health Policy and Economics, an associate professor of the USC Pharmacy School, and an nonresident fellow with the USC-Brookings Schaeffer Initiative for Health Policy at Brookings. She has been my colleague at the Schaeffer Center since I joined eight years ago. Erin, let me turn to you.

MS. TRISH: Okay. Well, thank you very much, Paul, for the introduction and thank you all for being with us here today. Let me just get my screen share going. And if someone can confirm, are you able to see the screen, the slides, and is it full screen? Paul, can you give me a thumbs up if you can?

MR. GINSBURG: Oh, yeah. Yeah, yeah, I can see it.

MS. TRISH: And is it the full screen version?

MR. GINSBURG: I think so.

MS. TRISH: Okay, excellent. Thank you so much. Well, thank you all for being --

MR. GINSBURG: Oh, no, no, no. You see it's presenter mode.

MS. TRISH: How about now?

MR. GINSBURG: Now, it's full screen. Yes.

MS. TRISH: Okay, excellent. So, thank you all for being here today. As Paul mentioned, there is a number of important and pretty notable trends that have been going on in the Medicare program over the last decade or two. And one of those in terms of Medicare Advantage has actually been a remarkable reduction in the rate that plans say they need, that Medicare Advantage plans tell CMS, you know, what is it going to cost them to provide the traditional Medicare benefit to these Medicare Advantage enrollees?

We've seen those bids come down pretty significantly from about 100 percent of

Medicare spending back in 2008, to now 87 percent of traditional Medicare spending. So, what that means is that plans are telling CMS that they can cover those beneficiaries for about 87 cents on the dollar. If you take a step back for just a second, that's pretty remarkable, right? It's very rare that in the context of healthcare we find effective interventions that are able to reduce the cost of care on the order of about 13 percent. So, kind of remarkable in and of itself that we actually have that intervention by enrolling these beneficiaries in a private plan.

But what's happening is that we're not actually paying plans that 87 cents on the dollar. Instead, when you look at what we're paying plans, as Paul mentioned, that's consistently been about the same or more than what it would have cost to cover those beneficiaries in the traditional Medicare program.

Now, it is the case that plans are using some of those additional dollars to provide extra benefits to beneficiaries, things that they value. So, things like reduced premiums or out-of-pocket spending and extra benefits that aren't covered in the traditional Medicare program. But nonetheless, what that also means is that the federal government, or the federal budget, is not benefiting from the savings that these plans are able to generate. And that's because these plans are paid according to a very complicated payment formula that involves these benchmarks.

And these benchmarks are essentially in and of themselves kind of set to reflect the level of spending among traditional Medicare beneficiaries in the area with a number of complicated adjustments for things like quality bonuses and other things that are going on. But these benchmarks have received a lot of policy attention over the last few years or even more over the last decade or two. And in and of themselves they really though are at the crux kind of tying payment to Medicare Advantage plans back to what it cost to cover traditional Medicare beneficiaries through the traditional Medicare program in the area.

And so, that policy attention that's being focused on reforming or discussions around reforming these benchmarks are somewhat missing a kind of broader bigger picture trend that's going on in the Medicare program. And that is this remarkable increase in Medicare Advantage penetration that we've seen, particularly over the last decade where we're now at the fact where -- or we're now at the point where about half of Medicare beneficiaries are enrolled in a private Medicare Advantage plan. In

fact, when you compare enrollment in the traditional Medicare program, you see that we actually have fewer beneficiaries enrolled in traditional Medicare today than we did back in 2006. That's despite remarkable increase in enrollment in Medicare overall, but essentially all of that growth over the last decade has come through higher enrollment in the Medicare Advantage program, really exploding over this time period.

If you look at the county level, you see these considerable shifts as well. Back in 2006, about three in five Medicare beneficiaries lived in a county that had less than 15 percent Medicare Advantage penetration, with very small shares of beneficiaries enrolled in highly -- or living in highly penetrated counties. We've seen this kind of considerable shift over time even picking up in the last couple of years where we're now at the point where about 1/4 of all beneficiaries, Medicare beneficiaries, live in a county that has over 60 percent Medicare Advantage penetration.

And so, when you think back to this discussion of these benchmarks and the way that we pay plans being based on levels of spending among traditional Medicare beneficiaries in the area, when you put that in context where 1/4 of beneficiaries live in a county where traditional Medicare beneficiaries are the minority of beneficiaries, it gives pause to think about, you know, is this really the right way to be setting payments to plans? Is this at some point not even going to be a statistically viable measure of kind of what Medicare spending should look like in the county as the number of beneficiaries going into those benchmark constructions continues to fall.

And so, with that context I'll turn it back to Paul to continue the discussion about ways to think about the future of Medicare Advantage payment and what these trends mean for the way that we should be having those discussions. So, thank you very much.

MR. GINSBURG: Thank you very much, Erin. I'd like to introduce to you now Dr. Meena Seshamani. She is an economist and a surgeon and is Deputy Director of CMS and Director of its Center for Medicare. Prior to joining CMS in July 2021, she was Vice President for Clinical Transformation at MedStar Health. She also serves as an assistant professor of otolaryngology head and surgery at Georgetown University Medical School. She served as a director of the Office of Health Reform at HHS, where she led implementation of the ACA across the department. It's wonderful to have you, Meena, and we're all looking forward to your remarks.

MS. SESHAMANI: Thank you so much for having me, Paul. It's great to be here with all of you. So, you know, I'll start with what we put out earlier this year. I laid out in Health Affairs the strategic vision for Medicare with Administrator Brooks-LaSure and Innovation Center Director Liz Fowler. And this vision puts the person at the center of care and drives across five key buckets: advancing health equity, expanding access to affordable coverage and care, driving high quality person-centered care, promoting affordability and the sustainability of the Medicare program, and importantly, engaging all stakeholders in an ongoing dialog to continuously improve Medicare.

Now, as we drive towards this vision in Medicare, Medicare Advantage is a crucial piece in achieving our goals, especially as enrollment in MA reaches half of all enrollment in Medicare. So, our work at CMS is focused on ensuring MA is delivering on its promise to beneficiaries, delivering high quality care, driving innovation, and supporting stewardship of the program. We see a huge opportunity for partnership with Medicare Advantage plans and other MA stakeholders and interested parties to better understand how care innovations are changing outcomes and costs, how to ensure MA is working for enrollees, and how to further drive value of the Medicare dollar and the health of people in Medicare and in MA.

So, with that overview, I'm going to circle back to these strategic pillars that I started with. First, equity. Running through all our work is a focus on how we can advance health equity including in MA. CMS defines health equity as the attainment of the highest level of health for all people. Where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, language, and a myriad of other factors that affect access to care and health outcomes.

We're looking across Medicare to make sure that our policies and operations are advancing health equity. We published a piece on this in *JAMA* recently. An importantly, this includes looking at MA. So, for example, we've solicited comments on a health equity index in Medicare Advantage star ratings that would reward excellent care for underserved populations. And we finalized a requirement that special needs plans have to screen for certain social risk factors such as food insecurity, housing insecurity, or transportation problems.

We're also thinking about how to improve enrollment in programs that are already in

place to support people with Medicare. For example, we have the Medicare Savings Program, which provides financial assistance to those with lower income or resources. And when I started in my role, I learned that only half of people eligible for the program were enrolled. And so, we have made a concerted effort to engage in outreach so that people know what opportunities and supports are available to them so that these programs can achieve what we want in terms of reducing disparities and improving access for underserved populations.

So, our second pillar that I mentioned is focused on strengthening access to care for people with Medicare and with MA and ensuring that people with Medicare have the information they need to be able to make care choices that best meet their needs. So, this means we continue to explore ways to ensure that plans support access to medically necessary services, especially during emergencies and disasters. We are strengthening oversight of predatory third-party marketing behavior by holding plans accountable and requiring disclaimers that this marketing does not present all plan options to beneficiaries. And we're requiring compliance with provider network adequacy standards in the MA application process. Specifically, we want to make sure that we are expanding access to the information that people need to be able to navigate benefits so they can have access to the care that they need.

Our third pillar is that we remain committed to supporting innovation and accountable care to ensure that the Medicare program is responsive to the needs of each person. A key part of this pillar is our value-based care strategy and making sure that our value-based care strategy is aligned and coordinated between traditional Medicare and Medicare Advantage. We want to ensure that all people with Medicare have access to these holistic care models where people are aligned in providing high quality care, avoiding illness, unnecessary utilization. And we're working with providers and plans to streamline care and remove barriers that would take focus away from improving patient care.

Our next pillar is being a responsible steward of the Medicare program and ensuring there's competition and sustainability. We have efforts underway to get more granularity in how money is being spent to drive towards outcomes that lead to smarter spending. We're increasing transparency in MA, including new reporting on spending on supplemental benefits, such as dental, vision, hearing, transportation, meal support. And importantly, we encourage thoughtful conversations on Medicare Advantage, including the session today. We really welcome the opportunity to hear from a wide array of

stakeholders and interested parties on ways to strengthen all of our collective work to support beneficiaries and be a good steward of the Medicare program, including discussions of how the MA program should look in the long term. We hope that our work will ultimately support a competitive marketplace that protects the integrity and long-term sustainability of the MA program.

And finally, underlying all of this work is to increase engagement with stakeholders and create a more collaborative relationship between CMS and all of you. You know, we know that the goals of Medicare can only be achieved through partnerships and an ongoing dialog between the program, the people that it serves, and the people involved in that healthcare ecosystem. And so, for MA this involves generating greater dialog and feedback to continuously improve the program. We don't want to enact policies that sound good on paper but aren't impactful for the people we're serving. We want to engage early and often to drive towards our vision for Medicare that puts the person at the center of care in front of mind in all that we do.

So, Paul, thank you again for including me and for allowing us to hear what I'm sure will be a spirited discussion by the experts in the room. And I'm looking forward to hearing more about the research and your thoughts on how to strengthen MA. Members of my team are here to listen, and we welcome any ideas and learnings you have to share to strengthen our collective work.

MR. GINSBURG: Thank you very much, Meena, for those remarks. Let me begin with the vision that you were telling us about at the beginning. It gave a lot of emphasis to increasing the importance of value-based delivery in Medicare. So, I want to ask you what sense do you have about whether Medicare Advantage plans are pulling in that same direction? Are most Medicare Advantage plans using approaches to value-based payments extensively that are consistent with what is being pursued in traditional Medicare through alternative payment approaches? Or are too many using traditional fee for service payments and little beyond that?

MS. SESHAMANI: You know, Paul, it's a very good question. And there is a lot that we don’t fully know about how Medicare Advantage plans are contracting with their providers in terms of the relative amount of value-based, you know, arrangements compared to fee for service. The best data we have right now to go off of is from the Healthcare Payment Learning and Action Network, which says that between 30 and 40 percent of spend is done in what is termed level 3 or 4 arrangements, which are some

of these alternative payment arrangements.

Now, this is based on a survey with a 50 percent response rate. You know, anecdotally, I recently had the pleasure of visiting a local MA plan in New Mexico. And this plan serves a very diverse population throughout New Mexico, and they spoke with me about how they connect their members to care, including through their innovative partnerships with providers and how these partnerships can be an important tool to achieving better outcomes for people who are enrolled in the plan.

So, I think all toll, we would like to better understand the landscape in Medicare Advantage going forward. What is working? What isn't working? How can we collectively think about applying the lessons learned across both Medicare Advantage and traditional Medicare? And I say this also as a provider who until recently was leading these care transformation models on the ground. I know the power and opportunities of aligning models so that you're really leveraging momentum on the ground for positive change in how we care for people.

MR. GINSBURG: Thank you. You know, I head so much the analogy of one foot on the dock and one foot in the canoe talking about the challenges that providers face when, you know, some of their patients are in value-based arrangements and others are in traditional volume-oriented fee for service. You had mentioned in your opening remarks that CMS supports a competitive marketplace that protects the integrity and long-term sustainability of the Medicare Advantage program. Can you elaborate? How do you achieve long-term sustainability?

MS. SESHAMANI: Yes. So, Paul, my last answer I spoke to, you know, my experience as a provider, and here I'll speak to my expertise as an economist. You know, being a responsible steward of our programs is one of the CMS pillars and we can do this by supporting competition in Medicare, both within the Medicare Advantage market and across Medicare. We want to ensure we are getting good value for the Medicare dollar for beneficiaries. And a lot of this is with data and transparency.

So, for example, we recently finalized new requirements that increased transparency of plan costs and revenue by medical loss ratio reporting where now there will be reporting of MA spending on supplemental benefits not available under traditional Medicare. As I mentioned, dental, vision, hearing, food, transportation. We also recognized that as MA approaches half of Medicare enrollment,

there are new data and methodological questions that we must consider.

So, we continue to explore short and long-term approaches to ensure MA is sustainable, to ensure that we have the competition, that we have transparency, that people are able to navigate the program most effectively for what they need. And so, we also welcome any feedback from the esteemed researchers here today and in the future.

MR. GINSBURG: Yes, you know, MedPAC each year puts out a pretty comprehensive, you know, discussion of Medicare Advantage issues and they have come back, you know, time and time again to problems with coding and the quality bonus program not really delivering much value for the money it costs. Can you give us any thoughts you have on those issues?

MS. SESHAMANI: I mean, I think overall I would say that we really are looking at how we can strengthen the Medicare Advantage program to drive the strategic pillars for Medicare. How are the dollars in Medicare being used to advance health equity to drive innovation in a way that achieves better care, healthier populations, and spending money in a smarter way.

And so, where can we all partner together and engage as we think about continuous learning. Again from, you know, from the various hats that I've worn in my career working as a provider, being an economist, I think one underlying theme is continuous learning, data. Being able to see where are there opportunities for improvement? What interventions, what initiatives can we try to try to achieve those improvements? And then learning from it. Is it working, is it not?

And again, coming back to one of the things that I mentioned before is the importance of thinking about Medicare Advantage as part of the overall Medicare program where you have traditional Medicare Parts A and B, you have Medicare Advantage, you have Part D prescription drug coverage, and you have supplemental insurance, Medigap coverage. And really being to think about how we can strengthen Medicare across all of those platforms and do so in a way that enables people to pick what works best for them.

MR. GINSBURG: Okay, thank you. How are you and your team incorporating social determinants of health into the Medicare Advantage program to improve care for individual enrollees?

MS. SESHAMANI: Yeah, I mean, this piggybacks off of what we were just talking about as well. You know, building a healthcare system that addresses the social determinants of health for

people with Medicare really is key to our pillar of providing whole person care, our pillar of advancing health equity, you know, since so many health disparities are tied to underlying social factors.

So, we are first trying to ensure that where it makes sense, we are requiring screening for social needs, which is the first step to building a healthcare system that regularly addresses the social determinants of health. As I mentioned, we are now requiring that special needs plans screen as part of their health risk assessments for food, housing, and transportation concerns. We've also solicited comments on a measure related to social needs screening and follow-up as part of the MA star ratings program.

And again, more broadly, we are thinking about rewarding plans when they provide high quality care to underserved populations, which is partly why we've solicited comments on a health equity index. And importantly where we're looking at this across our programs. You know, we recently proposed in the Medicare Shared Savings program, the largest accountable care organization program, similarly a health equity adjustment where we can, again, reward good care for underserved populations.

MR. GINSBURG: Thank you. And I've got one final question, and this is about extra benefits. As the amounts that are available to plans to fund extra benefits are growing rapidly, there are concerns that those benefits that are highly valued by enrollees, such as zero premiums, prescription drug coverage, lower deductibles, are already being so extensively provided that in a sense the opportunity has topped out. And now, there's more focus on benefits with possibly much less value to enrollees and they're being expanded. Any perspectives on this?

MS. SESHAMANI: Yeah, I will say that one of my goals, again, as someone who has taken care of people with Medicare and seen the confusion as they try to navigate, you know, really one of my goals as Medicare director is to make the program more navigable so that people with Medicare better understand the choices available to them. So, for example, for enrolling in Medicare, we recently unveiled a series of updates to the Medicare.gov website to make it easier to use and more helpful for people seeking to understand their Medicare coverage. You know, these updates use simpler language to answer complex questions that people have about their coverage. And provides step by step guidance for people who are new to Medicare to understand their coverage options and when they need to sign up.

CMS has also added more detailed pricing information about Medicare supplemental

insurance, Medigap policies, to help individuals compare Medigap plan costs and their coverage options as they're thinking about this fuller picture. So, again where we have that opportunity to really enable people to figure out what is right for them.

I think it also comes back to the data and the transparency that I was talking about. We really want to engage in a thoughtful way in thinking about how the Medicare dollar is supporting our goals of advancing equity, of whole person care, of access to care, and of good fiscal stewardship of the program.

And so, where we have those opportunities to engage to really see where we can make sure that the MA program is driving on these pillars and that, you know, the funds are being used in a way that really is promoting the most effective care possible to advance our goals of better care, smarter spending, and healthier populations, and improved outcomes.

And I think the last point is, again, where we have the opportunity to make sure that, you know, all of this information comes together in a way that people can understand. And I mentioned before about looking at third-party marketing behavior and making sure that people are getting information that they need, that they can understand so that they can make these kinds of decisions. You know, I did virtual media tours for open enrollment, you know, talking about how to think about the different options that are available and where you can go to get information through Plan Finder on Medicare.gov and by calling 1-800-Medicare. And we really want to make sure that we have compliance with third-party marketing, that we have compliance with provider network adequacy standards. You know, making sure that we have standards so that people with Medicare can get the care that they need.

MR. GINSBURG: Thank you very much, Meena. It's been terrific having you and I think we've learned a lot from your kind of big picture perspectives on Medicare Advantage and the rest of the Medicare program. I'd like to introduce --

MS. SESHAMANI: Thank you again so much for having me.

MR. GINSBURG: Okay. I'd like to introduce our panel now and we've got three people. Matt Fiedler, an economist, is a senior fellow with the USC-Brookings Schaeffer Initiative on Health Policy at Brookings and my colleague there since 2017. Before that he served as chief economist at the Council of Economic Advisors under President Obama.

Clive Fields, a family physician, is cofounder of VillageMD, a national primary care provider, which partners with physician-led practices across the United States to help them transition to a value-driven model of care. He is president of its subsidiary, Village Medical, which provides primary care for patients at traditional freestanding practices. Village Medical at Walgreen clinics at home and via virtual visits.

Gail Wilensky, an economist and senior fellow at Project HOPE, an international health foundation, has played a highly influential role in federal health policy for decades. She served as the director of the predecessor agency to CMS and served as a senior advisor on health and welfare policies to President George W. Bush. She was the first chair of MedPAC and now chairs the bipartisan -- now cochairs the Bipartisan Policy Center's program on the future of healthcare.

Let me turn to you first, Matt, and here's the question I have. In the aggregate, are Medicare Advantage plans overpaid? And if you believe they are, or even if you don't, if policy makers want to reduce Medicare Advantage payments, how should they go about doing that? Should they make incremental reforms to the existing administered payment system or implement more radical reforms like competitive bidding?

MR. FIEDLER: Well, thanks for the question, Paul, and thanks for having me. I'm really looking forward to the conversation with my fellow panelists. So, on the first question of whether plans are overpaid. My view is that they are, and I think that's true from sort of two different perspectives of looking at the problem.

One way to look at the problem is from the perspective of the federal budget, which is the perspective you alluded to at the outset and that Erin talked about. And I think it's pretty clear that we are spending more to cover enrollees in MA than we would spend to cover the same enrollees in traditional Medicare. And in fact, I think the extent of those overpayments may actually be even somewhat larger than some of the numbers Erin presented after we account for coding intensity differences and differences in health status beyond what's being captured in the risk adjustment system.

I think another perspective you can use to look at this question is, you know, what are we really getting for the marginal dollar that we pay to an MA plan. And in some ways, I think this sort of more holistic perspective is the way I often kind of prefer to look at this problem. And I think, you know,

when you look the research literature on that what you conclude that is a big chunk of that marginal dollar is being captured by the plans as profits, dissipated by increases in plans costs, or being allocated as supplemental benefits that may not be especially high value. That's not to say that beneficiaries are getting no value from that marginal dollar, but it does seem like there are probably opportunities to spend that marginal dollar better.

So, the question then is what do we do about it? As a theoretical matter, I think there's a lot to like in bidding approaches. In principle, a well-designed bidding system can cause plans to reveal what it actually costs them to cover Medicare enrollees and so, we can then set benchmarks accordingly based on that information. I think that's a real advantage of bidding approaches. But I do think there are some risks that plans could start to bid strategically in ways that are designed to manipulate the payment benchmarks. And so, this system might not work quite as well as it might initially appear.

I also think that in practice you can get to a fairly similar place with a sort of well-designed package of incremental reforms drawn from the sort of usual menu. You know, larger coding intensity adjustments, other tweaks to risk adjustment, reforms to the quality bonus program, direct benchmark changes, either nationwide or in certain markets.

And, you know, while I don't think either a bidding approach or these types of reforms would be anything resembling politically easy, I do think the incremental reform path might be a little bit easier than a bidding path. And I think there are a couple reasons for that. You know, I think the incremental reform path is a little bit less disruptive and gives policy makers a little bit more control over how the pain is going to be shared. I think it's also amenable to piecemeal implementation rather than having to be done all at once.

And then the last thing I'll say is I actually I don't think the choice between these two paths has as much to do as we might think with rising MA penetration. And that I think you can achieve big improvements over the status quo even if MA penetration is quite a bit higher than it is today. And in particular, there's often a concern that sort of rising MA penetration is going to make TM, traditional Medicare enrollees even less representative and that the risk adjustment system is not going to be able to grapple with those risk mix differences.

I'd say for one, I think we already have some of those problems today. And it's not

actually clear that it makes those problems worse. There's good reason to believe that the enrollee that's sort of on the margin between traditional Medicare and Medicare Advantage today is actually sicker than the typical Medicare Advantage enrollee, but healthier than the typical traditional Medicare enrollee. And so, both Medicare Advantage and traditional Medicare are likely to get sicker as an enrollment falls. It's not clear that the sort of total strain on the risk adjustment system rises as MA penetration rises.

But the biggest thing I would say I think in the face of rising MA penetration is that it increases the importance of doing something. With more people in MA, the longstanding problems we have in the MA payment system becoming more important simply because they affect more people. And so, I think we can do a lot better by traveling down either of these reform paths. Either the sort of bidding type reform path or the sort of incremental reform path than by staying where we are.

MR. GINSBURG: Yeah, you know, Matt, when you were talking about that issue of the incremental administered versus bidding approaches, it reminds me of our history with hospital, in-patient hospital payments. Where in the early 1980's, the hospitals got so frustrated with the incremental additional constraints put on the cost reimbursement system that they were ready to take the plunge into in-patient perspective payments of the DRG system.

I'd like to turn now to Clive Fields and ask him is strong primary care essential to Medicare Advantage? If you could explain this.

MR. FIELDS: Yeah, Paul, thanks for the invitation to participate today. I think sometimes we've got to step back and realize that this is not just an economic issue, or a regulatory issue, or a political issue, but this is a patient issue. And ultimately, what Medicare either in its traditional forms or in Medicare Advantage delivers to patients is truly what's important. And when we look at Medicare spend and we look at the overwhelming majority of that spend that is spent on chronic disease, I think it's clear that only through the management of chronic illness prevention and wellness will we ever have the ability to actually talk about payment reform.

Across the country, the primary care base has been underinvested in for years and continues to be underinvested in. I think that became self-evident through the recent COVID pandemic and the ongoing COVID pandemic. But our position at Village and I think with most of the institutions that we work with that are focused on primary care is that payment reform that actually focuses on where

Medicare spend is and where the opportunity for improved outcomes exists, which is in the management of chronic medical conditions, is really where that payment reform needs to be focused.

As a physician, it's not complicated to understand that congestive heart failure, COPD, and diabetes continue to actually drive, not just the cost, but the morbidity and mortality that Medicare patients experience, again, either in traditional Medicare or in Medicare Advantage. So, we really believe and again, institutions that are focused on primary care, that payment reform that drives resources to where they actually make the greatest impact on outcomes, quality, health equity, and overall cost, are the ones that will ultimately be the ones that -- be the ones that pay off in the greatest way.

MR. GINSBURG: Thank you. Clive, you come from an environment of large primary care group practices. But many Medicare Advantage plans do not include the close relationships with either large primary care or multi-specialty groups that, you know, is the norm in your world. So, indeed, you know, they look much more like what we see in so much of the private insurance market for the non-Medicare population, you know, with a fragmented delivery of care. So, the question is can those organizations, you know, the others that are in Medicare Advantage, deliver a high value Medicare Advantage product to seniors?

MR. FIELDS: Yeah, it's a really good question and I think the analogy you drew between payment reform at hospitals and what's happening on the physician provider side is accurate. That it is really challenging as a small independent physician group to have access to the types of teams or technology or analytics that are really necessary to manage patients outside of the exam room as opposed to just inside the exam room.

When you think about managing a Medicare patient, if you think it can be done in three or four 30-minute visits across a 12-month period, I think everybody on this call knows that you're kind of kidding yourself. So, those resources are really available or more readily available inside large groups.

What we're seeing across the primary care landscape are primary care doctors coming together either in groups of independent physicians or affiliated or associated with other larger organizations that can provide those tools. So, to be completely blunt, I think it will be harder for small organizations and small groups to deliver high quality care because of just the inherent financial technology and analytic needs that many times can only be driven by the aggregation of physicians and

patients.

MR. GINSBURG: Thank you. That's very interesting because also a reason why in a sense the, you know, the continued change in the delivery system towards larger organizations may be a critical thing to ultimately improve care for those chronic conditions more broadly.

One follow-up question to this is at a time of consistent overpayment of Medicare Advantage plans, should we be concerned that it is too easy to earn money in Medicare Advantage without delivery value-based care?

MR. FIELDS: So, I wish I could tell you that in my career we had found it easy to earn money without delivering value-based care. But in organizations that really experience outcome-based reimbursement, reimbursement that's tied to higher quality, lower readmissions, the management of chronic illness, prevention, and wellness guidelines, that feels like the way that economics should flow. So, I have not run into the easy way to actually make money in value-based care. If someone on this call would like to email me how to do that, that would be awesome. But I suspect the emails will be few and far between.

MR. GINSBURG: I think you misunderstood my question. The question was really about concern that perhaps it's too easy to earn money in Medicare Advantage in plans that are not delivering value-based care in the sense that are just doing traditional fragmented fee for service.

MR. FIELDS: Yeah, no, I actually have not found that it is -- that that actually is a possibility that the coordination of care, the risk stratification of patients for reactive -- or excuse me -- for proactive outreach. I mean, it's really the only way to actually drive value. And that those organizations that are not doing that are not actually earning money inside Medicare Advantage. So, I actually think to earn money inside an outcome-based reimbursement system does require a proactive and risk stratified model. That is not easy, but I believe is actually the best model to deliver care for Medicare recipients.

MR. GINSBURG: Okay. Thanks for clarifying that. Let me turn to Gail Wilensky. And, you know, Gail, you've been involved in Medicare policy for much of the time that Medicare has offered a private plan alternative to the traditional program. And, you know, to what do you attribute the accelerated growth in enrollment in Medicare Advantage over the last 10 or so years? You know, with the concerns about overpayments and Medicare Advantage becoming such a large part of the Medicare

program, what alternative approaches to payment would be promising to consider?

MS. WILENSKY: Let me just continue Clive's comment for one second and then I'll answer the question you just spoken to me. It is only economists like us and policy people who think that it's so easy to make money on what has been labeled as overpayments. I wasn't surprised at all with regard to Clive's statements about the challenge of actually delivering care. I have heard that for years from the people at Optum and United Health Group who are actually providing care as part of MA. Sometimes I think it would do us economists well to actually follow some of these people around looking over their shoulders and see if it's as easy to claim all this extra money we talk about as we sometimes act as though it is.

Having said that, I think it would be very useful to go to a competitive bidding system rather than trying to resolve this problem through administrative pricing. Partly that reflects my position as a limited government person even though I had the privilege of running Medicare for 2-1/2 years. That almost sounds like an oxymoron. But it has always made me a little uneasy that the government or other payers think that it can come out with all of the right pricing that it needs in order to have this function be undertaken.

However, at the end of the day, whether this can be done well all hinges on risk adjustment. That really is what all of this is about. We know what the actual payments are. They're tied to each other. But the question is whether or not the adjustments made for the different populations that tend to choose Medicare Advantage versus traditional Medicare is appropriate. And at the end of the day, that would be an issue in competitive bidding as well. You still need to make either some assumptions that it doesn't matter if you adjust for the risks in different populations. Or you have to find a way to make those adjustments, and that has been very difficult.

But a movement to competitive bidding rather than relying on administrative pricing as long as traditional Medicare is part of the competitive bid, this notion of having only the MA plans bid against each other, basically see whether they can beat each other enough into submission and leave the traditional Medicare plan out in its own, is absolutely unacceptable to me at least as an analyst and economist. But if it's included that, would I think be more acceptable than what we have now.

Making the transition will require some time and some care. This is both a lot of money

and more importantly, the care of older people in our population. We do not want to do anything as disruptive as happened after 1997, with the introduction of the Balanced Budget Amendment and then the follow on BBRA Act, Balanced Budge Refinement Act, to try and clean up the messes of the first one. So, I believe this would be an improvement. But again, at the end of the day, accounting for the different risks in each of the populations is something that we will have to do if we are going to make this successful.

The notion that government can spend the money better, which is what I discerned in some of the comments from Matt Fiedler, again, makes me very uneasy as someone who is fundamentally a limited government person.

MR. GINSBURG: Yeah. You said a lot of interesting things. You know, the notion of competitive bidding just among Medicare Advantage plans, you know, probably was a reaction to the, you know, the real intense political resistance to what we used to call premium supports, which is including the traditional program as --

MS. WILENSKY: Right.

MR. GINSBURG: -- one of the bidders. But what you're saying --

MS. WILENSKY: A bad word.

MR. GINSBURG: Go ahead.

MS. WILENSKY: I was just saying that we need to find another term. That particular word carries so much baggage. But, yes, that is what I was referencing.

MR. GINSBURG: Yeah, yeah. So, you're saying that, yeah, it might be easier but it's not a path we should go down, the Medicare Advantage only bidding approach. Which I guess is perhaps something Matt agrees with. Matt, your thoughts on that?

MR. FIEDLER: Well, so, two thoughts. I think first with the question of just, you know, do I necessarily think, you know, the government can spend it better? I think, you know, if you think in MA plans, we're not getting much value for the marginal dollar payments, you might well think there are other things the government could do with that money that would be better, but you might also think that, you know, taxes could be lower than they otherwise would be. So, I don't think this has to be a question about, you know, the size of government. I think it's really the question about are we getting value for the

marginal dollar of MA payment or not?

To the question of, you know, various forms of bidding. I'll say that I'm not, you know, strongly opposed to bidding systems. I think they do have some -- they do have a theoretical appeal. I do think the systems where traditional Medicare is involved in the system, so the sort of premium support style systems, to Gail's point, put a lot more strain on the risk adjustment system. And I'm not sure with the sort of ability we have to do risk adjustment at the moment that it's really up to it.

Risk adjustment is going to be important in any type of bidding system or even in the system we have now, particularly in structuring, you know, it plays a different role in the system we have now. But even in an MA only bidding system, it structures the competition between the plans to ensure that the plans that are most successful aren't the ones who can select the healthiest risk but the ones that are actually delivering the greatest value.

So, you know, I, again, my inclination is that the sort of feasible path forward here is more administered pricing systems. But I think, you know, certain types of competitive bidding approaches strike me as very reasonable paths forward too.

MR. GINSBURG: Yeah. And let me add one more thing that's really an answer to something Gail said about, you know, the role of government. Because it seems to me that if you have an administered system of setting rates in Medicare Advantage, yes, the government's deciding what the rate should be as opposed to allowing a market process to determine what the rate should be. But, you know, beyond determining what the rate should be, just like hospital perspective payment, the government isn't telling plans, you know, how they should deliver care. You know, how they should seek efficiency or quality. They're just setting a price. So, you know, I don't think it's all the way into a, you know, a type of micromanagement approach.

Let me actually mention one other thing. When Gail and Clive were talking about the difficulty of making money in Medicare Advantage without providing value. It reminds me of a conversation I had a few years back with the CEO of a major insurer, not that one that Gail is on the board of. Who actually mentioned that when the ACA reduced Medicare Advantage payments, that person indicated that that was actually the spark that got them to be more serious about delivering value.

So, it may have been the case that, you know, 15 years ago it was easier to make money

in Medicare Advantage. But it became harder because we did lower the payment rates and perhaps now, we do have the situation that both of you mentioned that, you know, you really have to deliver something of value to be viable in this marketplace.

Let me turn to our --

MS. WILENSKY: Yeah, when you look back at that, Paul, --

MR. GINSBURG: Yeah, go ahead, Gail.

MS. WILENSKY: -- again, excuse me for interrupting you. It's not just that it was very disruptive for the plans. Almost of all of them literally, almost all of them exited what was then called Medicare Plus Choice, if my memory serves me correctly. But we need to think what we did to a whole group of seniors who were in these plans who were all of a sudden confronted with having to make an abrupt change in who was providing services to them because of the completely unexpected largeness of the response that occurred after the 1997 Balanced Budget Act. The actual change in payments turned out to be much greater than the legislative groups had predicted would result in 1998 and 1999.

I think ultimately the responses by government were appropriate with the two pieces of legislation that passed. But it's easy for us either as house analysts, including myself in this group, or as others, to think, well, oh, well, that, you know, took two years, two pieces of legislation and all was well in terms of putting it back on a better path. But both the people providing care in these plans, the physicians, and the hospitals, and even more importantly, maybe, the seniors themselves who were receiving care had enormous disruptions in their care. And that is something that does happen, but the rest of us ought to feel really badly and embarrassed and a bit ashamed when we cause that to happen.

MR. GINSBURG: Yeah. Gail, I was talking about the Affordable Care Act, not the BBA.

MS. WILENSKY: Yeah.

MR. GINSBURG: To that --

MS. WILENSKY: Yeah.

MR. GINSBURG: -- slam, which I think was came in a, you know, in a sense has shown that, you know, of course it led to, you know, an acceleration in the growth of Medicare Advantage and, you know, terrific expansions of extra benefits. So, maybe it's a lesson about, you know, magnitudes. If the cuts are too large, that's going to be traumatic and disruptive. If the cuts are well modulated, they

could be very useful as I -- that was the perspective about how the ACA cuts actually may even have been a tonic that helped propel the program forward.

So, we are getting late on time now. And we just have another minute or two. Actually, I did have one more question for Gail that, you know, what's your perspective about so many seniors, especially low income, and minority seniors, choosing Medicare Advantage rather than traditional Medicare?

MS. WILENSKY: We need to remember that when Medicare was first set up, it reflected the insurance that the working population knew as workers. And so, of course, that seemed comfortable. Now, almost no one who is retiring or has retired in the last 10, 15 years did so with the experience of what is traditional Medicare that is an a la carte fee for service system. MA, Medicare Advantage, is what people have experienced any time in the last two to three decades as workers.

And so, we shouldn't be surprised that MA is going to be the dominant form of Medicare going forward, assuming people want to continue with something that looks like what they knew as workers, albeit with more benefits, and in a slightly relaxed form. It would be bizarre if they were to pick traditional Medicare, an indemnity fee for service plan that they've had no experience with and isn't very easy to use.

MR. GINSBURG: Yeah, good point. Well, we have run out of time now. And I want to thank the panel for a really terrific discussion we've had. I regret that we couldn't get to any questions from the audience, but you know, I think this was a very informative thing. I want to thank the conference, the meeting staff at Brookings for a flawless production of this and thank the audience for your time and your attention.

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I, Carleton J. Anderson, III do hereby certify that the forgoing electronic file when originally transmitted was reduced to text at my direction; that said transcript is a true record of the proceedings therein referenced; that I am neither counsel for, related to, nor employed by any of the parties to the action in which these proceedings were taken; and, furthermore, that I am neither a relative or employee of any attorney or counsel employed by the parties hereto, nor financially or otherwise interested in the outcome of this action.

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