



Education Program

Demystifying Medicare for Patients: Traditional Medicare vs. Medicare Advantage

Friday, November 10 | 4 – 5 pm EST

Moderator

Jenny Boyer, MD, JD, PhD
Officer At-Large, AMA Senior Physicians Section

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A photograph of two medical professionals, a man and a woman, both wearing white lab coats and stethoscopes. They are seated and looking at a clipboard held by the woman. The man is gesturing with his right hand while speaking. The background is a bright, modern office with large windows and a glass partition.

**Sponsored by the
AMA's Senior
Physicians
Section (SPS)**

Learning Objectives

Upon completion of this activity the physician will be able to:

- Review recent trends of seniors enrolled in Traditional Medicare vs. Medicare Advantage programs
- Review factors that assist seniors in recognizing the pros and cons of different coverage plans
- Recognize the current challenges associated with transitioning between plans, like switching from Medicare Advantage to Traditional Medicare.

Speaker

David A. Lipschutz, JD, Associate
Director/Senior Policy Attorney, Center for
Medicare Advocacy

Overview of Medicare

- Part A – hospital, SNF, HH, hospice
- Part B – Physician services, DME, tests, etc.

Together A and B = Original, Traditional, FFS Medicare

- Part C – Medicare Advantage (MA) – private insurance offerings, replaces traditional Medicare (can include Part D coverage)
 - Part D – Prescription Drug Coverage
- Other Coverage – Medicaid, employer, military, Medigap, etc.

Trade-Offs of Medicare Advantage

Pros include: “one-stop shopping”; extra (but not uniform) benefits, including dental, hearing, vision; low or no premium and out-of-pocket cap

Cons include: (usually) limited provider networks; prior authorization; no choice of separate drug plan; limited ability to switch back to trad. Medicare with Medigap

Annual Enrollment

Every year, MA and Part D plans can change benefits, network of providers/pharmacies, formularies, coverage rules, etc.

BUT most people don't analyze or make changes to their coverage (and few use gov't resources that are more objective, unbiased)

Instead – many rely on agents/brokers, MA advertising

Informed Choice?

KFF report (Sept. 2023) – 85% of ads during 2022 annual enrollment period were for MA plans.

“Ads rarely mentioned traditional Medicare, or potential limitations with plan coverage, such as provider networks or prior authorization requirements, leaving beneficiaries with an incomplete view of their coverage options and the tradeoffs among them.”

Agent/broker commission incentives (higher for MA than Part D, Medigap); increased complaints re: marketing misconduct.

Prior Authorization

Nearly all MA enrollees are in plans that use prior auth “most often required for relatively expensive services” ([KFF](#), Aug. 2023)

- See HHS Office of Inspector General (OIG) reports in [2018](#) and [2022](#)
- Increased use of AI/algorithmic tools to make coverage decisions

Provider Networks

- **HMOs** usually have no out-of-network coverage (other than emergency, urgent services)
- **PPOs** usually have out-of-network coverage at a higher cost to the beneficiary
- Growing reports of physician groups, hospitals, health systems refusing to contract with MA plans

MA Enrollee Costs

[Commonwealth Fund](#), 2023: “there doesn’t appear to be much difference between these plans and traditional Medicare with respect to affordability.

MA enrollees can pay more for care than those in traditional Medicare (e.g., about half of all MA enrollees would incur higher costs than beneficiaries in traditional Medicare for a 7-day hospital stay (KFF 2022).

Access to/Choice of Coverage

- One can get in and out of an MA plan on an annual basis (can also make other changes during Jan-March every year – no similar right for stand-alone Part D plans).
- **Medigap rights** limited to certain time periods; no federal rights for individuals under 65.

MA Overpayments

MA plans paid at a higher rate than the Traditional Medicare program spends on a given individual due, in part, to “upcoding” and quality bonus payments.

Estimates vary re: scope of overpayments: [MedPAC](#) says \$27 billion in 2023; [USC/Schaeffer](#) says \$75 billion a year; [Committee for a Responsible Federal Budget](#) says \$180 billion and \$1.6 trillion over the next decade; [PNHP](#) – as much as \$140 billion a year.

Quality Outcomes

[KFF](#) (2022) reviewed 62 studies comparing MA with trad. Medicare re: bene experience, affordability, utilization and quality and “[found few differences between \[MA\] and traditional Medicare that are supported by strong evidence or have been replicated across multiple studies.](#)”

Among the differences – higher rates of switching from MA to TM for dual eligibles, beneficiaries of color, rural enrollees and following the onset of a functional impairment

What is lost if Medicare becomes more privatized?

See, e.g., “[Medicare Advantage Enrollment Growth – Implications for the US Health Care System](#)”

JAMA Viewpoint (May 2022) which “raises questions about how Medicare would work through private plans to achieve the many other public purposes that Medicare has served.”

Potential Policy Solutions

- *Rein in wasteful MA overpayments*, use to shore up Medicare finances and expand benefits in traditional Medicare
- *Strengthen traditional Medicare* by adding vision hearing, dental, other benefits, add out-of-pocket cap, expand Medigap rights
- *Strengthen oversight and enforcement* re: MA plans
- *Strengthen informed decision-making* by standardizing MA plan benefits and limiting plan offerings, more support for SHIPs

Thank you!

For further information, to receive the Center's free weekly electronic newsletter, ***CMA Alert***, update emails and webinar announcements, contact:

Communications@MedicareAdvocacy.org

Or visit

MedicareAdvocacy.org



Speaker

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Governmental Affairs and Public Policy

American College of Physicians

Disclosures

Full-time employee of the
American College of Physicians

Medicare vs. MA enrollees are largely similar, 2021

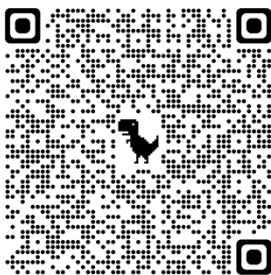
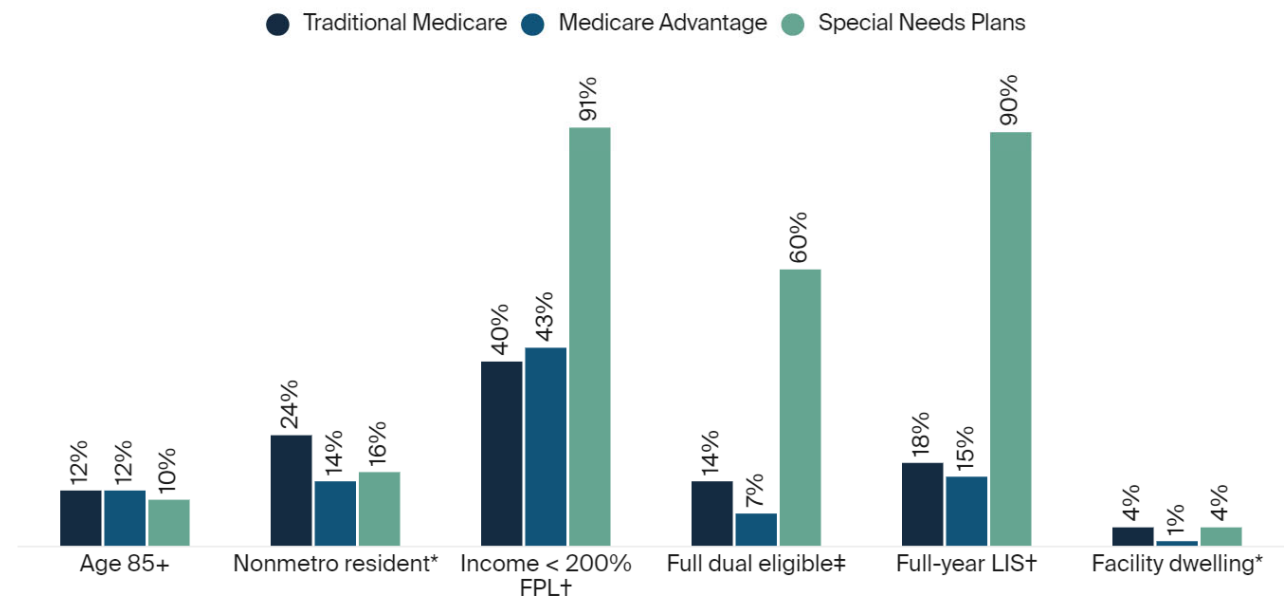


EXHIBIT 1

Beneficiaries in traditional Medicare are similar to Medicare Advantage enrollees across age and income, after separating Special Needs Plans.



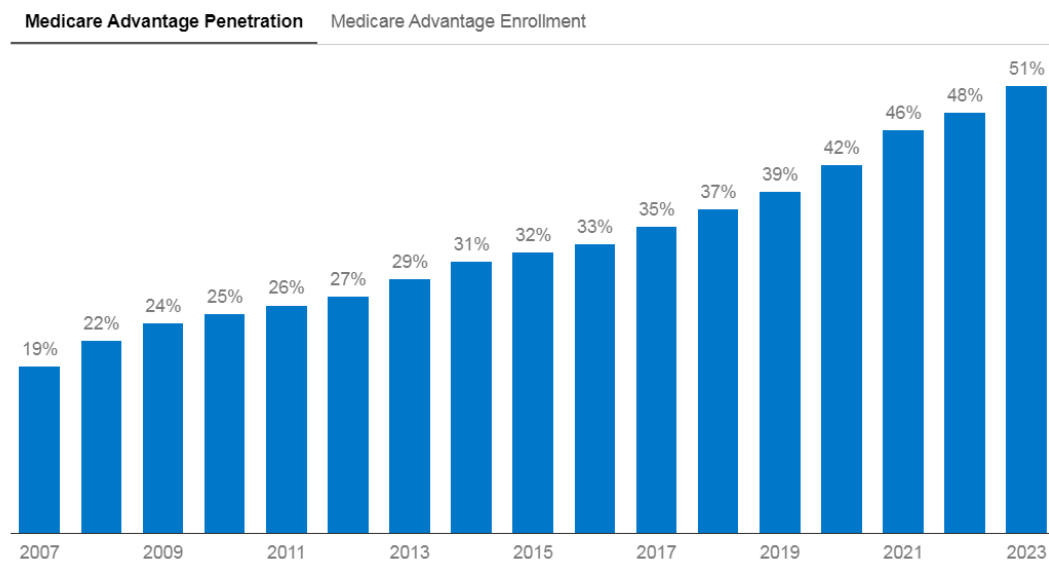


Overall, MA enrollment is increasing

- In 2023, 30.8 million people are enrolled in a MA plan.
- Accounting for \$454 billion (or 54%) of total federal Medicare spending
- The average Medicare beneficiary in 2023 has access to 43 MA plans, the largest number of options ever.

Figure 1

Total Medicare Advantage Enrollment, 2007-2023



NOTE: Enrollment data are from March of each year. Includes Medicare Advantage plans: HMOs, PPOs (local and regional), PFFS, and MSAs. About 60.0 million people are enrolled in Medicare Parts A and B in 2023.

SOURCE: KFF analysis of CMS Medicare Advantage Enrollment Files, 2010-2023; Medicare Chronic Conditions (CCW) Data Warehouse from 5 percent of beneficiaries, 2010-2016; CCW data from 20 percent of beneficiaries, 2017-2020; and Medicare Enrollment Dashboard 2021-2023. •

PNG

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Senate Finance Hearing on Medicare Advantage – Transparency and Fraud

- MA plans should provide beneficiaries with a clear and understandable means to compare benefits and options when deciding between an MA plan and traditional Medicare.
 - The process of “seamless conversion” into these plans should be stopped entirely and reevaluated so that newly eligible Medicare beneficiaries are not automatically enrolled in their commercial insurer’s MA plan without their knowledge or understanding that they may opt out of the plan.
- Congress, CMS, Office of Inspector General (OIG), and external independent bodies need to investigate potentially fraudulent activity and the misuse of risk stratification by MA plans.
 - CMS must also address issues of fraud and abuse in the MA Program.



Key findings:

- Federal officials have made billions in “improper” payments to Medicare Advantage plans traced to risk score errors.
- Medicare Advantage risk scores rose much faster than the national average in hundreds of counties nationwide between 2007 and 2011. That rise in risk scores cost taxpayers more than \$36 billion; critics attribute that more to aggressive billing than sicker patients.
- Though federal health officials have recently disclosed some Medicare billing data, key financial records of Medicare Advantage plans have been kept under wraps.
- The failure to crack down on health plans that overbill doesn’t bode well for the Affordable Care Act, which relies on a similar risk scoring system.

Risk score:

Since 2004, CMS has paid Medicare Advantage plans based on a risk score that is supposed to assess the overall health of each patient. Medicare pays higher rates for sicker patients that are likely to require more costly medical services and less for healthy people. Medicare Advantage plans on average received about \$9,900 per person in 2011.



Marketing Issues with MA Plans

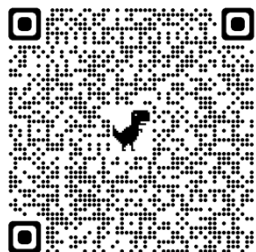
- KFF focus group participants of Medicare beneficiaries ages 65 and older and younger adults with disabilities who make health coverage decisions for themselves and/or their spouse or family member.
 - Many participants reported experiencing aggressive marketing tactics pushing Medicare plans, including unsolicited phone calls.
 - Nearly all participants have seen TV advertisements that are marketing Medicare, most frequently Medicare Advantage plans. Participants reported they were often confused about who was sponsoring the ads.
 - Participants did not trust the content of the ads, particularly the ones that marketed a slew of “free” benefits. In general, many thought TV advertisements were misleading.
 - Most participants found the process of selecting their coverage to be confusing, difficult and overwhelming. As a result, many participants relied on a broker to assist them when choosing their coverage and valued their expertise.

CMS is starting to respond to these concerns

- CMS has proposed to increase the transparency of MA plans and their respective marketing policies.
- The Agency has expressed a goal of ensuring that MA enrollees receive the same access to medically necessary care they would receive in TM.
- CMS would require agents to explain the effect of a beneficiary's enrollment choice on their current coverage whenever the beneficiary makes an enrollment decision.
- The Agency is tightening MA marketing rules to protect beneficiaries from misleading advertisements and pressure campaigns.
 - Prohibiting advertisements that do not mention a specific plan name and that use words, imagery, and logos in a confusing way.

CMS is also starting to address health equity in MA plans

- CMS has proposed to clarify the marginalized groups that MA plans must accommodate, including those:
 - with limited English proficiency or reading skills;
 - of ethnic, cultural, racial, or religious minorities;
 - with disabilities;
 - who identify as lesbian, gay, bisexual, or other diverse sexual orientations;
 - who identify as transgender, nonbinary, and other diverse gender identities, or people who were born intersex;
 - who live in rural areas and other areas with high levels of deprivation; and
 - otherwise adversely affected by persistent poverty or inequality



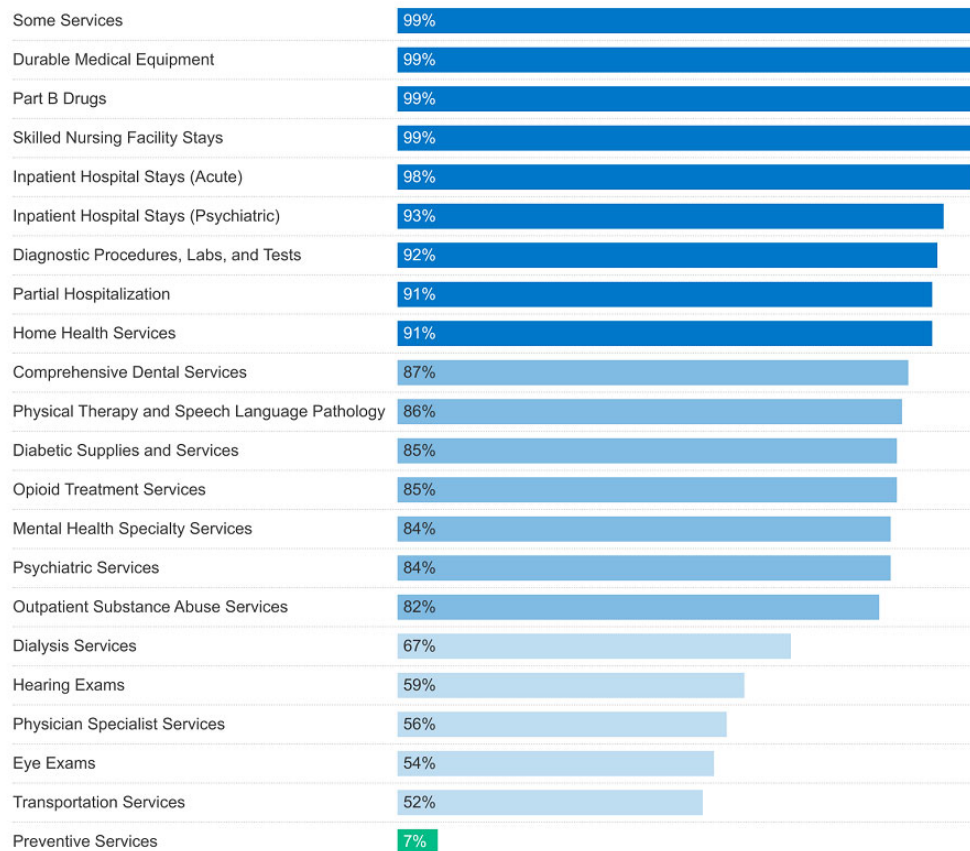
Biggest challenge with MA plans: Prior Authorizations

- In 2023, more than 7 in 10 (73%) enrollees in individual Medicare Advantage plans with prescription drug coverage pay no premium other than the Medicare Part B premium
- Most Medicare Advantage enrollees have access to benefits that are not covered by traditional Medicare, such as vision, hearing and dental.
- BUT...Nearly all Medicare Advantage enrollees (99%) are in plans that require prior authorization for some services, which is generally not used in traditional Medicare.

Figure 6

Share of Medicare Advantage Enrollees Required to Receive Prior Authorization, by Service, 2023

Most enrollees are required to receive prior authorization for the **highest cost services** and fewer enrollees need to receive it for **preventive services**

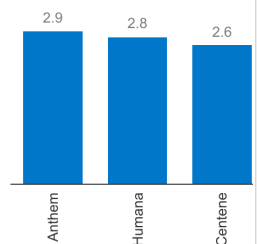


NOTE: Excludes employer group health plans and special needs plans. Preventive services are Medicare-covered zero-dollar cost-sharing preventive services. For supplemental benefits, including dental, hearing, vision, and transportation, the share of enrollees required to receive prior authorization are based on the enrollees in plans that offer those benefits.

SOURCE: KFF analysis of CMS Medicare Enrollment and Dashboard Files, 2023.

Figure 1
Prior Authorization Requests for Medicare Advantage

Requests for prior authorization of services

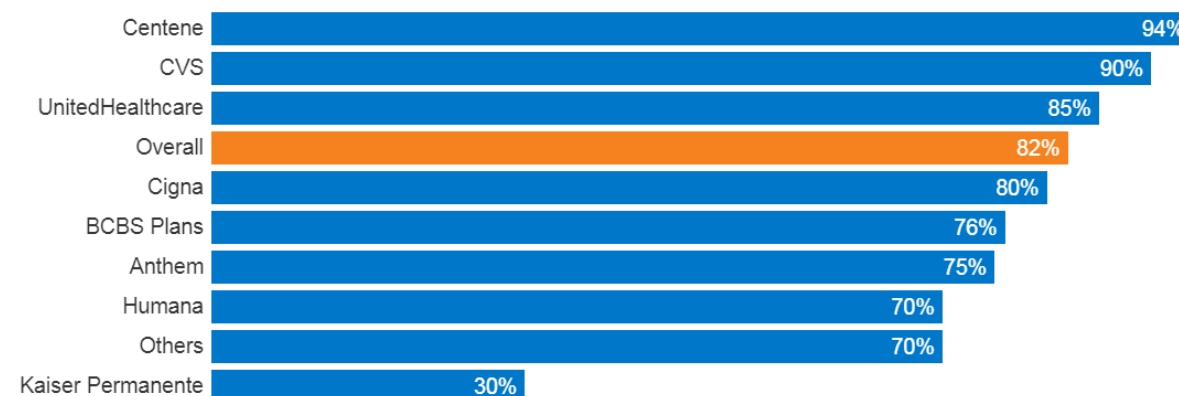


NOTE: Excludes requests that were withdrawn.
SOURCE: Technical Specifications Public Use File of Contract Year 2021 Part C and D Reporting Requirements Data • PNG

Figure 4

Across Most Firms, the Vast Majority of Prior Authorization Request Denials that Were Appealed Were Overturned

Share of reconsiderations that were fully or partially favorable in 2021



NOTE: Includes reconsiderations that were fully or partially favorable. Anthem BCBS plans are not included due to data quality issues.
SOURCE: Technical Specifications Public Use File of Contract Year 2021 Part C and D Reporting Requirements Data • PNG

Prior Authorization Requests

Denials in 2021

not included in the analysis

Denials Data

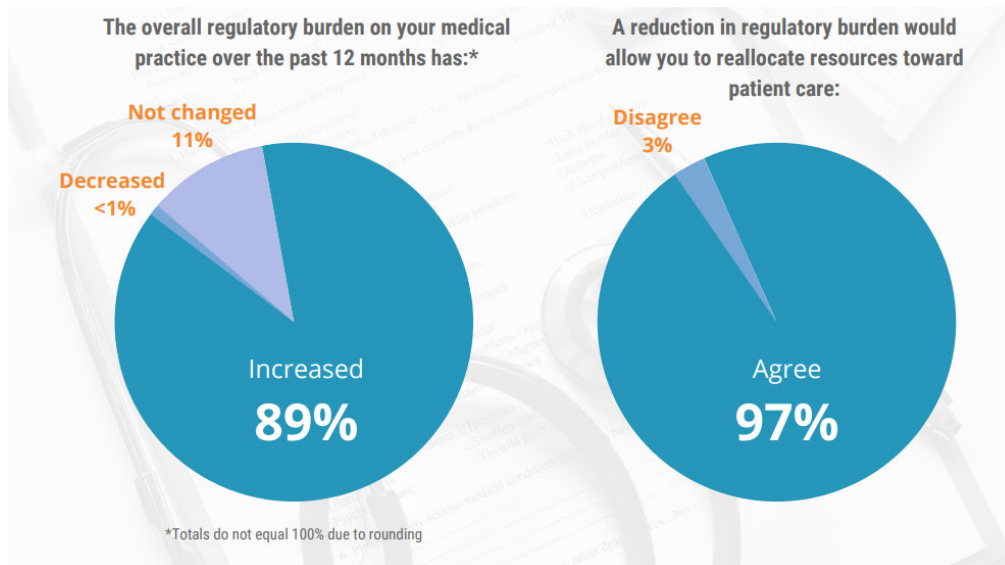
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Prior Authorization is Variable Across Payers



The impact of prior authorizations on physicians is significant – and likely translates to issues for their patients



BURDEN LEVEL BY REGULATORY ISSUE

How burdensome would you rate each of the following regulatory issues?

	Not burdensome	Slightly burdensome	Moderately burdensome	Very or extremely burdensome
Prior Authorization	2.20%	4.41%	11.45%	81.93%
Surprise billing & good faith estimate requirements	2.67%	8.67%	18.42%	70.45%
Medicare Quality Payment Program (MIPS/APMs)	7.00%	7.66%	20.79%	64.56%
Audits and appeals	2.34%	6.49%	27.27%	63.90%
Medicare Advantage chart audits	7.28%	11.04%	20.75%	60.93%
Translation and interpretation requirements	7.96%	17.42%	23.87%	50.75%
Lack of EHR interoperability	8.30%	14.85%	26.42%	50.44%
COVID-19 Provider Relief Fund reporting requirements	10.60%	13.02%	34.00%	42.38%
Medicare & Medicaid credentialing	7.33%	18.97%	32.54%	41.17%

What can be done to address prior authorization in MA plans? – Additional CMS proposals

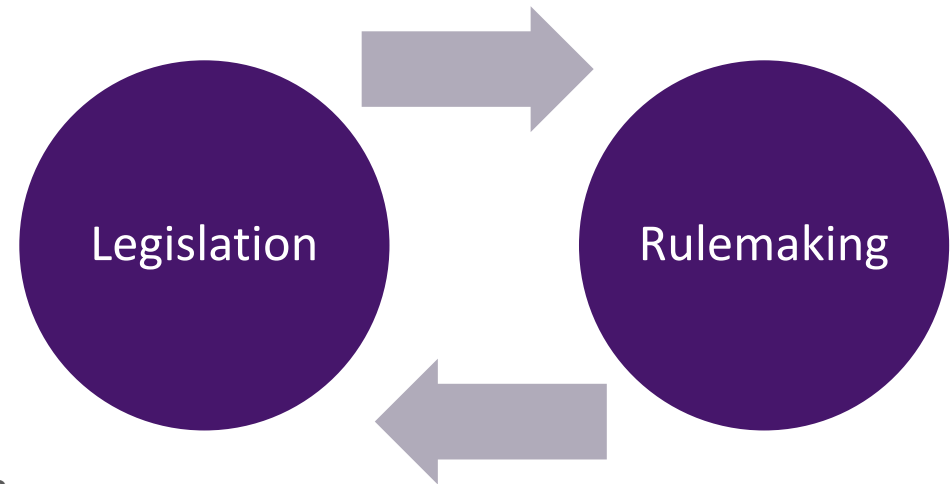
- prior authorization policies for coordinated care plans may only be used to confirm the presence of diagnoses or other medical criteria and/or ensure that an item or service is medically necessary;
- an approval granted through prior authorization processes be valid for the duration of the approved course of treatment and that plans provide a minimum 90-day transition period when an enrollee who is currently undergoing treatment switches to a new MA plan;
- MA plans must comply with national coverage determinations (NCD), local coverage determinations (LCD), and general coverage and benefit conditions included in the TM statutes and regulations;
- MA plans cannot deny coverage of a Medicare covered item or service based on internal, proprietary, or external clinical criteria not found in TM coverage policies; and
- all MA plans establish a Utilization Management Committee (“Committee”) to review all utilization management, including prior authorization, and ensure they are consistent with current TM national and local coverage decisions and guidelines.

What can be done to address prior authorization in MA plans? – Additional CMS proposals

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Capitol Hill is also listening...

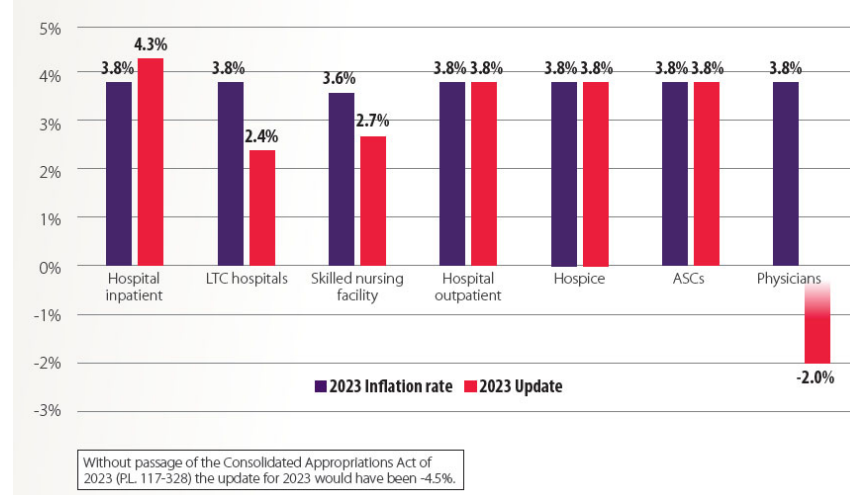
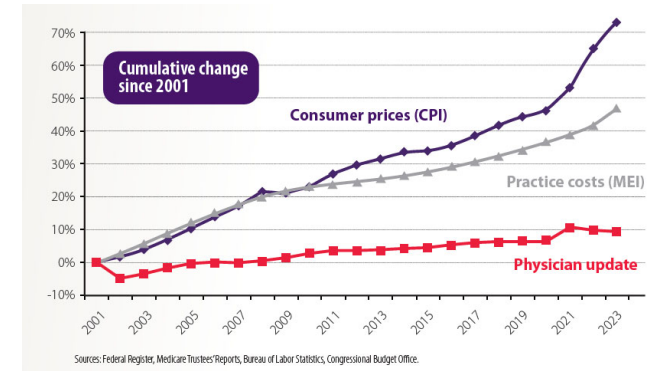
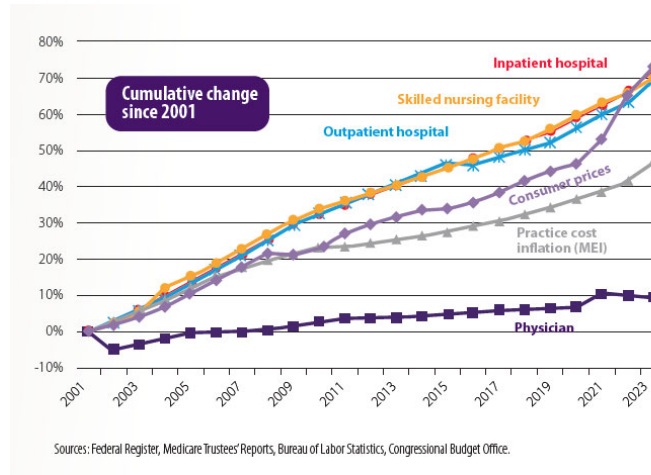
- Improving Seniors Timely Access to Care Act would reduce burdens associated with prior authorization in Medicare Advantage (MA) by:
 - Protecting beneficiaries from any disruptions in care due to prior authorization requirements as they transition between MA plans.
 - Requiring all MA plans adopt electronic prior authorization capabilities to streamline the process for prior authorization approval.
 - Standardizing the process and procedures for reporting electronic prior authorization criteria to MA plans.

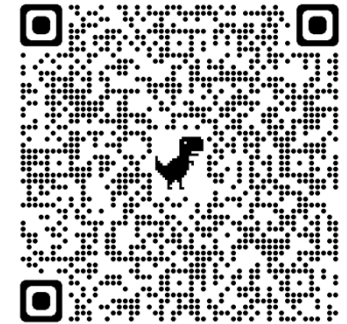


More information on MA prior authorizations and its impact on patients:

- In conjunction with Medicine Forward, ACP has hosted two webinars addressing problems and workflow solutions to address the burdens of prior authorization, and we welcome the opportunity to inform CMS' ongoing work.
 - [Breaking Bad! Prior Authorization Harms the Physician-Patient Relationship](#) (Recorded 5/31/2022)
 - [Breaking Bad Part II: ACP and Medicine Forward Advance Solutions for Prior Authorization](#) (Recorded 10/3/2022)

Traditional Medicare also Faces Issues...





New Budget Neutrality Draft Bill

GOP Doctors Caucus Co-Chairs released a discussion draft of legislation seeking to reform the Medicare Physician Fee Schedule (MPFS).

- 1. Updates Budget Neutrality Threshold:** Increases the budget neutrality threshold, which has not changed since 1992, from \$20 million to \$53 million (for 2025-2029). After 2030, the budget neutrality threshold would be determined by the cumulative increase in Medicare Economic Index (MEI) every 5 years.
- 2. Supports Budget Neutrality Corrections:** Establishes a lookback period to reconcile overestimates and underestimates of pricing adjustments for individual services, allowing the Medicare conversion factor to be calculated with more accuracy based on actual utilization data and claims.
- 3. Updates to Direct Cost Inputs for Practice Expenses:** Requires the HHS Secretary to update prices and rates for direct cost inputs for practice expense (PE) relative value units (RVUs), including clinical wage rates, prices of medical supplies, and prices of equipment no less than every 5 years.
- 4. Limits Conversion Factor Variance:** Starting in 2025, the HHS Secretary would be required to limit positive or negative increases in the conversion factor to no greater than 2.5% each year.

Traditional Medicare has undergone changes recently – Inflation Reduction Act

Health Insurance Affordability:

- Extends the premium subsidies for three years until the end of 2025

Lowers Out-of-Pocket Prescription Drug Costs:

- Allows for the Secretary of HHS to negotiate a set number of drugs per year, rather than a range “up to” a certain amount starting with Medicare drug negotiations beginning in 2023
- Caps out-of-pocket costs at \$2,000 a year for Plan D members
- Provides free vaccines to Medicare seniors
- Expands co-pay assistance for some low-income individuals beginning in January 2023
- Provides monthly caps on cost sharing payments under prescription drug plans in Medicare Advantage and Part D plans starting Jan. 1, 2025
- Caps the cost of insulin at \$35 per month for people on Medicare

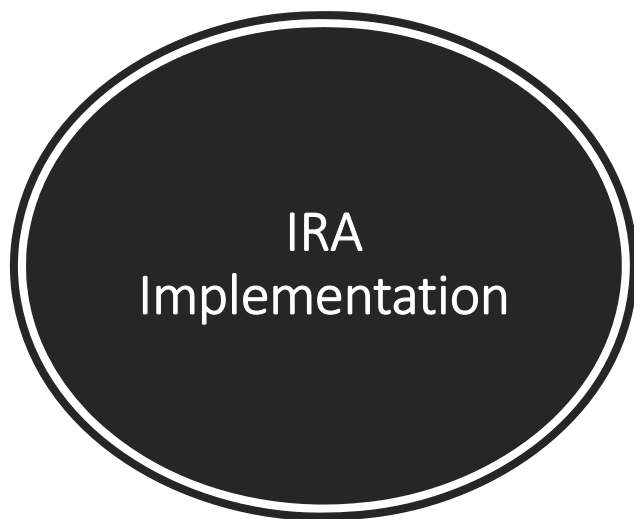
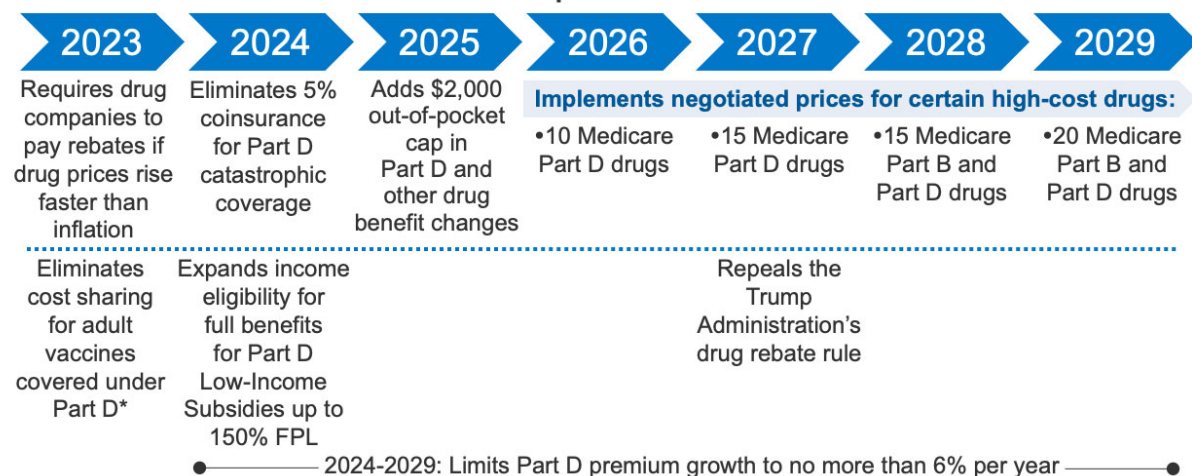


Figure 1

Implementation Timeline of the Prescription Drug Provisions in the Senate Reconciliation Proposal



NOTE: *Effective date of Medicaid and CHIP vaccine provision depends on year of enactment.

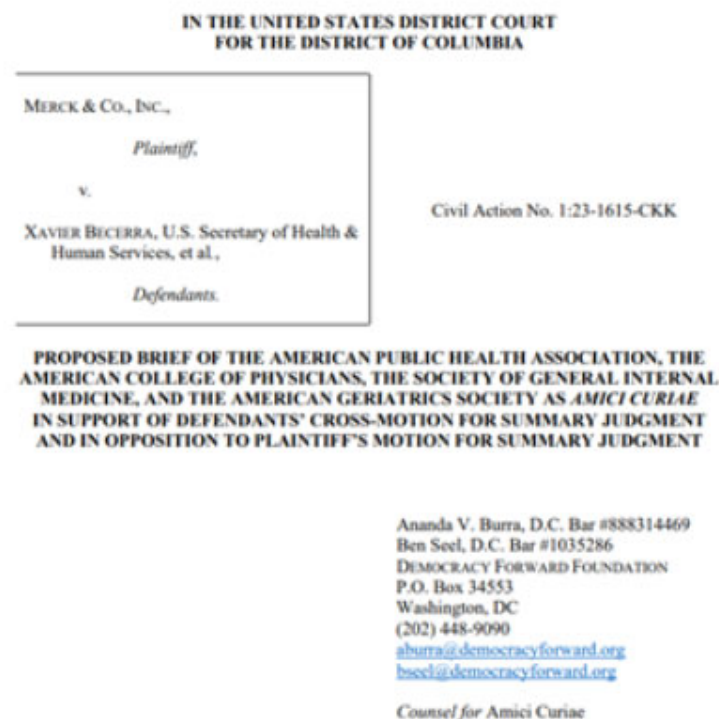
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What Impact will the IRA have?

- CMS has announced the first 10 drugs selected for negotiations
- White House report: Medicare beneficiaries are projected to save approximately \$400 per year on average in prescription drug costs because of the IRA out-of-pocket spending cap of \$4000/year.



Case 1:23-cv-01615-CKK Document 34-1 Filed 09/18/23 Page 2 of 34



Additional TM changes – focus on health equity

- Finalized separate coding and payment for community health integration services, which include person-centered planning, health system coordination, promoting patient self-advocacy, and facilitating access to community-based resources to address unmet social needs that interfere with the practitioner's diagnosis and treatment of the patient.
 - These are the first Physician Fee Schedule services designed to specifically include care involving community health workers, who link underserved communities with critical health care and social services in the community, and expand equitable access to care, improving outcomes for the Medicare population.
- Finalized coding and payment for social determinants of health risk assessments, which can be furnished as an add-on to an annual wellness visit or in conjunction with an evaluation and management or behavioral health visit.

Questions from Audience Members

**If you have questions, contact
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alice.reed@ama-assn.org



Physicians' powerful ally in patient care