MILLIMAN REPORT

Value to the federal government of Medicare Advantage

Commissioned by Better Medicare Alliance's Center for Innovation in Medicare Advantage

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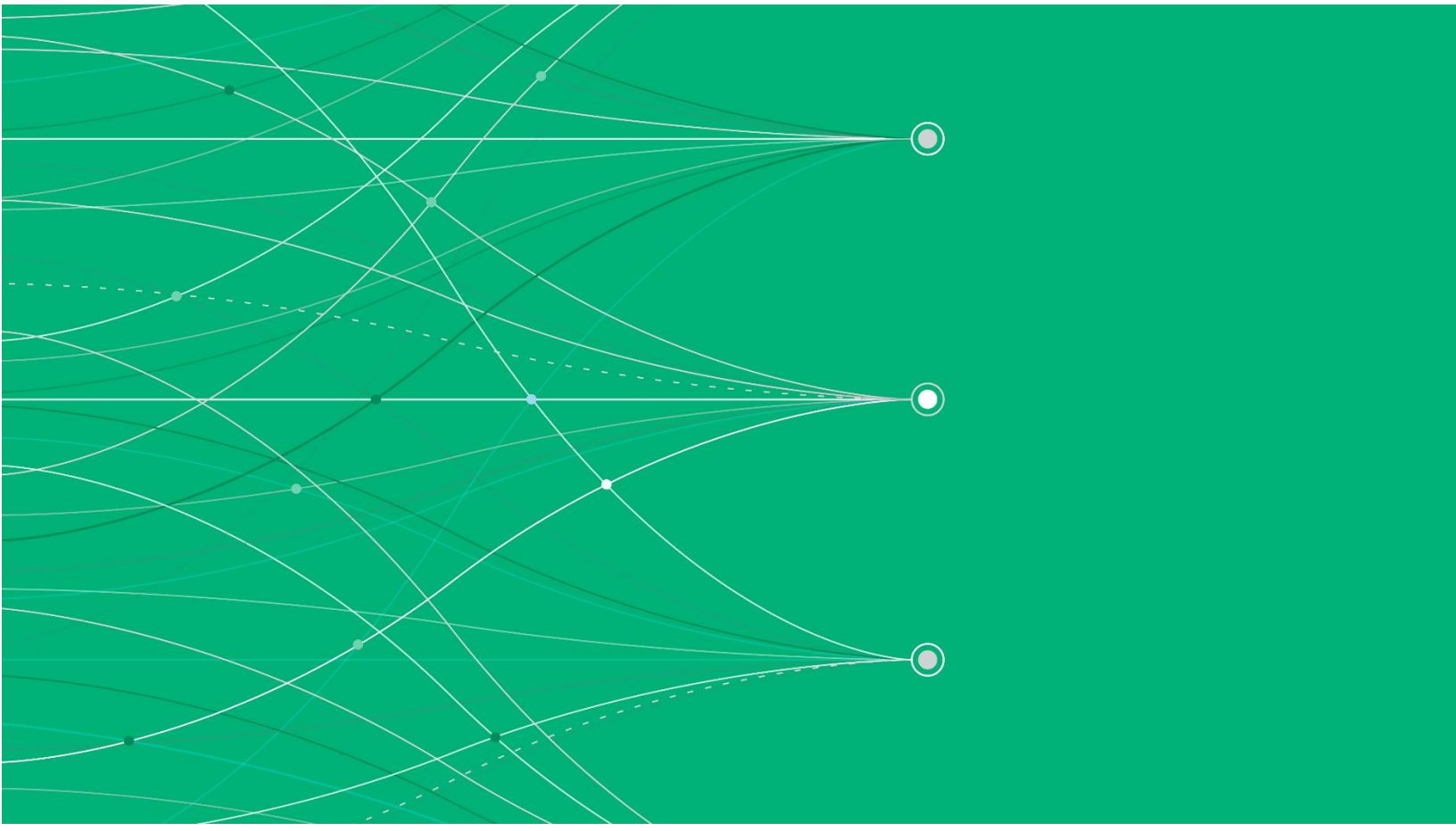

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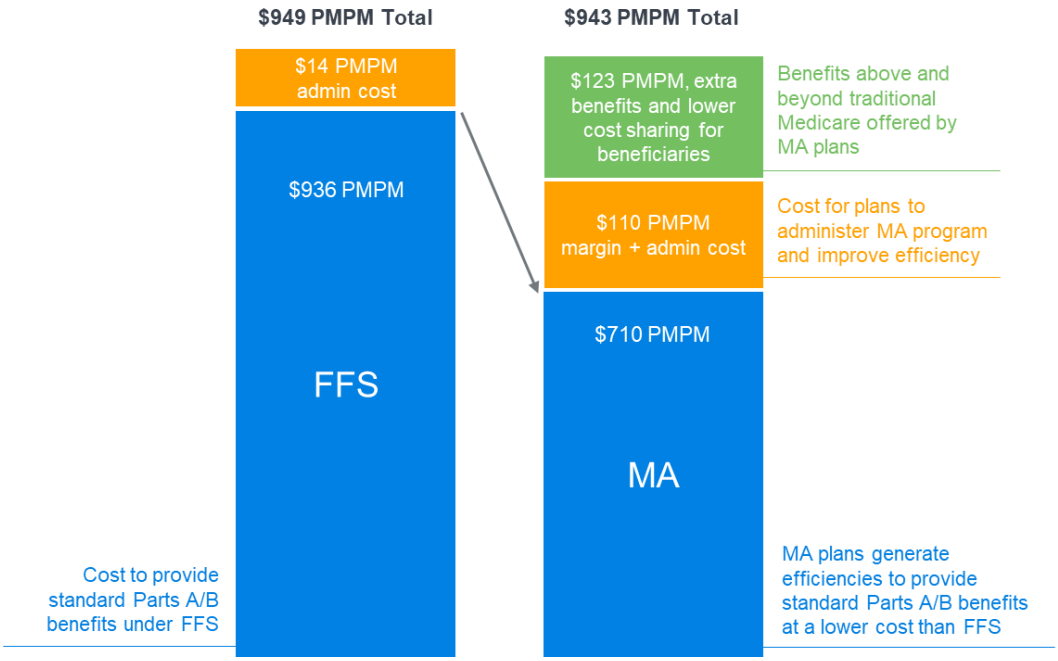
I. Executive summary

Better Medicare Alliance's Center for Innovation in Medicare Advantage commissioned Milliman to analyze the value to the federal government, and indirectly to the "taxpayer," of the Medicare Advantage (MA) program relative to fee-for-service (FFS) Medicare. Our analysis focused on estimating the value of the MA program by quantifying the value of the government's dollar (i.e., what can be provided for that dollar) paid to MA plans for providing services to MA beneficiaries as compared to the same dollar spent by the government to pay for services provided under FFS Medicare.

Our analysis determined that each dollar spent by the federal government on MA provides beneficiaries with additional benefits and lower cost sharing than they would otherwise receive under FFS Medicare. MA beneficiaries spend less in out-of-pocket costs for Medicare-covered services, and they also receive additional benefits not available under FFS. We estimate the value of reduced cost sharing and additional benefits at $123 per member per month (PMPM): $48 for the reduction in cost sharing for Medicare-covered services and $76 for the value of additional benefits not covered by traditional Medicare.[1] Extrapolated to the approximately 22 million beneficiaries enrolled in individual Medicare Advantage plans, this equates to $32.5 billion annually in additional benefits.

For beneficiaries in FFS Medicare, almost 99% of the government payments go toward expenses in Part A (hospital services) and Part B (physician services). In contrast, just over 75% of the comparable payments to MA plans are spent on Part A and Part B expenses. The remaining 25% of the payments fund enhanced coverage for MA beneficiaries through additional benefits, lower cost sharing, and reduced premiums for Part B and Part D (drug coverage) while still covering plan administrative expenses and a profit margin. The allocations of the government's spending for beneficiaries in FFS and MA, respectively, are shown in Figure 1.

FIGURE 1: FFS MEDICARE VS. MEDICARE ADVANTAGE GOVERNMENT PAYMENTS (2021), $ PMPM



Government payments for Medicare Advantage attributed to extra benefits in this figure include allocations to buy down Part D premium for beneficiaries. Part D is otherwise excluded from government payments in this figure. More detail on allocation of government payments to Part D premiums in Figure 3. Totals may not equal sum of components due to rounding.

[1] Values do not include retention amounts for administrative cost and profit margin.

Under statute, services covered and cost sharing for Parts A and B services for MA beneficiaries, in aggregate, must be at least as generous as the coverage and cost sharing under FFS Medicare. MA plans reduce their costs while providing the same Parts A and B coverage and lower cost sharing than FFS through provider networks and utilization management programs, including care coordination.

In addition to covering the same hospital and physician services (Parts A and B) covered by FFS, most MA plans include subsidized prescription drug coverage (Part D), whereas FFS beneficiaries must purchase drug coverage separately. MA plans also offer a wide variety of additional benefits to their members, like lower cost sharing for medical services; dental, vision, and/or hearing coverage; and meals, nonemergency transportation, and other such additional services.

One of the most important features of MA for beneficiaries is the maximum out-of-pocket spending limit (MOOP)—a feature not found in FFS Medicare. This limits an MA member's medical out-of-pocket spending to a specified maximum amount with the plan covering the cost of all amounts above that threshold. In 2021, the average MOOP for MA members was $5,091.[2] Most FFS enrollees obtain supplemental coverage in the form of a Medigap plan, employer-sponsored coverage, or Medicaid to cover out-of-pocket costs, including those costs that would otherwise be capped by a MOOP under an MA plan. Of these supplemental options, only Medigap plans are available as a voluntary election. However, Medigap does not offer coverage for services not traditionally covered by FFS Medicare, such as pharmacy drugs, vision, and dental.

In order to provide coverage at a lower cost and to be able to offer significant additional benefits, Medicare Advantage organizations (MAOs) design their plans with additional structure for members. This structure includes provider networks and care management, which require members to use providers specified by the plan and may require prior authorization or other prerequisites before obtaining certain medical services. FFS Medicare includes some prior authorization requirements,[3] though these requirements impact a much smaller selection of services than in MA plans. Despite this structure, MA continues to be very popular. As of March 2021, 43.3% (27 million) of Medicare-eligibles are enrolled in an MA plan.[4]

In addition to Medicare-covered services, MA beneficiaries also receive additional benefits that lower out-of-pocket (OOP) costs under MA from FFS levels.[5,6] As a result, both the federal government and beneficiaries spend less for Parts A and B coverage under MA than FFS. Figure 2 outlines our estimates of total program cost (for the government and the beneficiary) for MA and FFS Medicare coverage.[7,8,9]

[2] Milliman analysis of publicly available Medicare Advantage benefit and enrollment information.

[3] CMS. Prior Authorization and Pre-Claim Review Initiatives. Retrieved August 13, 2021, from https://www.cms.gov/research-statistics-data-systems/medicare-fee-service-compliance-programs/prior-authorization-and-pre-claim-review-initiatives.

[4] Milliman analysis of CMS enrollment files. See https://www.cms.gov/research-statistics-data-and-systemsstatistics-trends-and-reportsmcradvpartdenroldatama-state-county/ma-statecounty-penetration-2021-03.

[5] Mike, D. & Yilmaz, G. (January 2021). Average Annual Beneficiary Healthcare Costs for Various Medicare Coverage Options. Milliman Client Report. Retrieved August 13, 2021, from http://www.milliman.com/en/insight/Average-annual-beneficiary-health-care-costs-for-various-Medicare-coverage-options-2021.

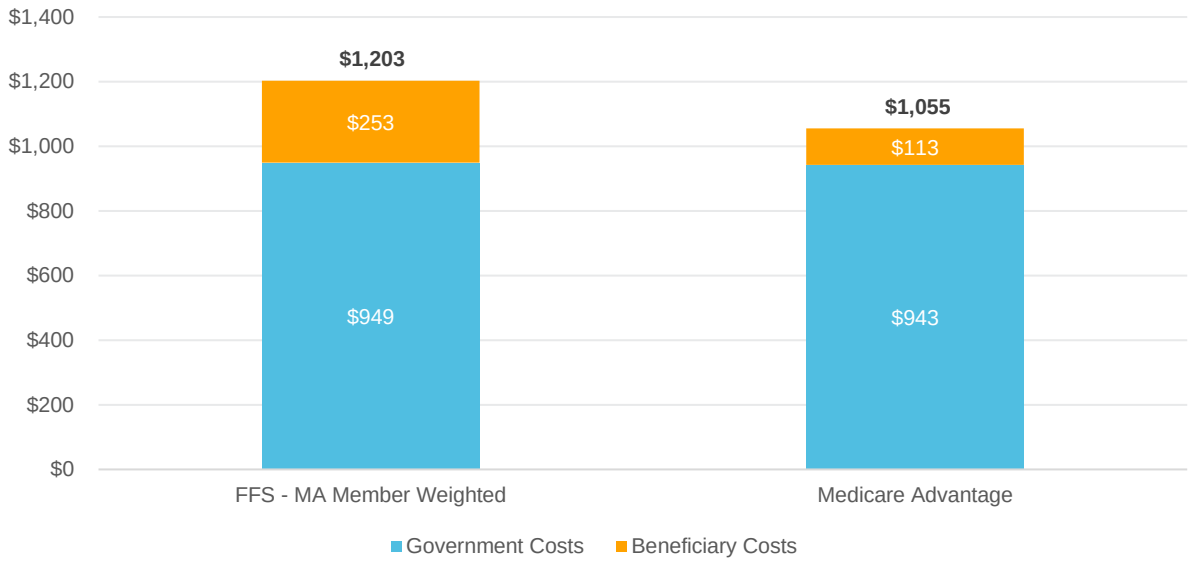
[6] In our previous analysis, we estimated a Medicare beneficiary's out-of-pocket spending on premiums and cost sharing was approximately $1,803 (34%) less annually under MA than under FFS Medicare, and about $2,434 (41%) less under MA than under the most popular Medigap plan option currently available to new enrollees, Plan G. These numbers include Medicare Part D premiums and estimated out-of-pocket spending for prescription drugs, in contrast to this analysis, which excludes prescription drug spending.

[7] The government costs are for only Parts A and B coverage. The beneficiary costs consist of Parts B, C, and D premiums and any cost sharing for Parts A and B services.

[8] The beneficiary's share of Medicare-covered services differs from our previous analysis in the 2021 report "Average Annual Beneficiary Health Care Costs for Various Medicare Coverage Options" (available at http://www.milliman.com/en/insight/Average-annual-beneficiary-health-care-costs-for-various-Medicare-coverage-options-2021) because the actuarial value analysis in this paper is limited to Part A and Part B covered services and does not include the drug benefit in the beneficiary out-of-pocket cost analysis.

[9] Some beneficiaries have additional coverage such as Medicaid coverage, employer-sponsored coverage, or a Medigap plan. In these cases, the beneficiary's supplemental coverage may pay for some or all of the cost sharing.

FIGURE 2: GOVERNMENT AND BENEFICIARY COST IN FEE-FOR-SERVICE AND MEDICARE ADVANTAGE, $ PMPM



Beneficiary costs include premiums and out-of-pocket costs for medical coverage as well as Part D premiums but exclude pharmacy-related out-of-pocket costs. Government costs only include the portion of Part D premiums funded by government payments to MA plans. No other government costs for Part D are included. Totals may not equal sum of components due to rounding.

The Medicare Payment Advisory Commission (MedPAC) recently estimated that 2021 government payments to MA plans are, on average, 104% of FFS spending.[10] This includes three percentage points of "uncorrected coding intensity." Our analysis did not address uncorrected coding intensity because data to support a robust analysis was not available to us. Instead, we addressed potential discrepancies between the two populations through sensitivity testing.

To account for the possibility that government payments for MA and FFS are not directly comparable due to risk adjustment differences between MA and FFS and other differences, like population samples used to compare FFS costs to MA costs, we performed a sensitivity analysis by adjusting FFS Medicare costs by +/-5%. The sensitivity analysis shows that even with 5% lower FFS Medicare costs for Medicare-covered services, MA is still less expensive in total program costs than FFS.

These findings suggest that overall MA offers significant value for the government. MA provides not just a choice between a government option and a private option but also choices among various plans within the private option, each offering a varying set of additional benefits that may suit a beneficiary's needs more adequately than a one-size-fits-all solution. MA plans cover the same services offered by FFS Medicare at lower costs than FFS, lowering government spending on Parts A and B services and enabling the savings to be deployed toward additional benefits and lower out-of-pocket costs for MA beneficiaries.

[10] MedPAC (March 2021). Report to the Congress: Medicare Payment Policy. Retrieved August 13, 2021, from http://www.medpac.gov/docs/default-source/reports/mar21_medpac_report_to_the_congress_sec.pdf.

II. Background

Better Medicare Alliance's Center for Innovation in Medicare Advantage commissioned Milliman to analyze the value to the federal government and indirectly to the "taxpayer" of the Medicare Advantage (MA) program relative to fee-for-service (FFS) Medicare. Our analysis focused on estimating the value of the MA program by quantifying the value of services provided by MA plans and comparing this overall value to that of services provided under FFS Medicare. Additional sources of value, such as care coordination and case management programs, as well as better healthcare quality, are identified and generate implicit cost differences in our estimates but are not directly quantified in our analysis.

GENERAL BACKGROUND ON MEDICARE

Medicare is healthcare coverage provided by the federal government, generally, to people over the age of 65 and those who meet other specific criteria related to disease burden and disability status. Medicare was enacted with the signing of the Social Security Amendments Act of 1965 and consists of two parts: Part A, the hospital benefit entitlement, and Part B, coverage for supplemental medical care, typically physician services. Expenses for Part A are paid from the Medicare Hospital Insurance (HI) Trust Fund, which is financed primarily by payroll taxes.[11] In comparison, expenses for Part B are paid out of the Medicare Supplemental Medical Insurance (SMI) Trust Fund (along with Medicare Part D), which is funded primarily through beneficiary premiums and general revenues.

THE BASICS OF MEDICARE COVERAGE OPTIONS

People eligible for Medicare can choose to receive their Medicare benefits either through traditional FFS Medicare or through enrolling in an MA plan.

- **Medicare Advantage:** Medicare Advantage organizations (MAOs) contract with the Centers for Medicare and Medicaid Services (CMS) to offer privately managed insurance plans covering Part A, Part B, and frequently Part D (prescription drug) services—they are known as Medicare Advantage and Prescription Drug (MA-PD) plans. The MA program is an alternative to FFS, and beneficiary premiums for MA-PD coverage vary from $0 to over $350 per month in 2021, with an average of $23.70, in addition to the standard Medicare Part B premium ($148.50 per month in 2021). In many cases, additional healthcare services not covered by FFS are offered by MAOs, known as ancillary or supplemental benefits. These types of services vary widely and include items such as hearing, vision, dental, over-the-counter (OTC) benefit cards, and nonemergency medical transportation (NEMT) benefits. MAOs, through capitated payments from CMS, are incentivized to manage and coordinate the care of the beneficiaries enrolling in their plans.
- **Traditional FFS Medicare:** Those who are enrolled in traditional FFS Medicare can go to any doctor or hospital that accepts Medicare. Only Part A facility services and Part B ambulatory services are covered under FFS, so beneficiaries opting for FFS must select a prescription drug plan (PDP) or have some alternative drug coverage, such as Veterans Administration (VA) benefits or employer-provided insurance. All beneficiaries pay a premium for Part B services, which in 2021 is $148.50 per month. Higher-income beneficiaries may pay higher premiums than the standard monthly amount.
- **Prescription drug plans:** While Part D benefits are typically bundled with MA-PD coverage, PDP organizations contract with CMS to provide Part D plans that cover only prescription drug benefits—mainly for FFS beneficiaries (including those who enroll in Medigap plans). Premiums for PDP plans in 2021 range from just under $6 to just over $205 per month, with an average of about $38.30 per month. If a beneficiary is not enrolled in an MA-PD plan that provides both medical and drug coverage, then they must enroll in a PDP plan to avoid facing future penalties from CMS.

[11] Additional funding for Part A comes from taxation of benefits, railroad retirement account transfers, reimbursements for uncompensated care, premiums for voluntary enrollees who are not entitled to the full benefit, payments for military wage credits, and interest income on trust fund balances.

- **Medigap:** Those beneficiaries in FFS can purchase private supplemental "wraparound" insurance known as Medigap[12] for a monthly premium, in addition to the standard Part B premium paid by Medicare beneficiaries. Medigap plans, such as Plan G,[13] are purchased from private insurance companies. Plan G is currently the most comprehensive and most popular Medigap plan actively sold on the market. The average Plan G premium was $183.83 per month in 2020.[14] Prior to 2020, Plan F was the most popular Medigap coverage option, but is no longer actively available to new Medicare beneficiaries. The premiums are exchanged for certainty in out-of-pocket (OOP) costs; Plan G covers out-of-pocket costs for all Medicare-covered services other than the Part B deductible. The high premiums are driven by the need for an administrative cost and profit load, as well as what some argue to be moral hazard due to lack of cost sharing (i.e., first dollar coverage),[15] and the lack of tools to control underlying cost and utilization of medical services.[16,17] Less generous Medigap plans are available, with lower premiums that reflect leaner benefits. Medigap plans do not offer coverage for services not otherwise covered by FFS, including prescription drug coverage, so any coverage for services not covered by FFS must be obtained separately. Beneficiaries who choose MA are not eligible to purchase Medigap plans.

A PRIMER ON MA PAYMENTS AND DIFFERENCES BETWEEN FFS COSTS AND MA PAYMENTS

Medicare Advantage, also known as Medicare Part C, is an alternative to FFS Medicare whereby private health plans offer managed care plans as a beneficiary's source of Medicare benefits. One of the main goals of the MA program is to expand Medicare beneficiaries' choices by including private plans with coordinated care and more comprehensive benefits than those provided through traditional Medicare.[18]

MA plans are paid using a benchmark that is intended to align MA payments with the regional costs of care for FFS Medicare. Private MA plans submit a "bid" that is an estimate of their costs to cover FFS Medicare-covered services. The federal government will pay the plan the bid amount up to the benchmark for FFS-covered benefits plus associated administrative costs and profit margin. If the bid amount is less than the benchmark, the federal government retains a share (in 2021, approximately 34.4%) of the difference between the bid and the benchmark, and the plans use the remainder of the difference (called the "rebate") to fund additional benefits beyond what FFS covers. The design of the program creates an incentive for MAOs to manage down the costs of providing Medicare-covered services so that their plans have rebate dollars to fund additional benefits that make those plans more attractive to potential beneficiaries and this delivers more value for every dollar spent by the government on MA than in FFS. Our analysis finds that, in 2021, the average difference between the benchmark and plan bid was $205.29 per member per month (PMPM); the government retained on average $70.57 PMPM of this difference and the MA plan received the remaining $134.72 PMPM as the rebate to offer additional benefits and reduce beneficiary cost sharing.

[12] Medigap is also known as Medicare Supplement.

[13] There are 10 standardized Medigap plan designs, designated by letters A through N. Three states, Massachusetts, Minnesota, and Wisconsin, have different standardized plans through federal waivers.

[14] Mike, D. & Yilmaz, G. (January 2021), op cit.

[15] *Moral hazard* is the lack of incentive to guard against risk where one is protected from its consequences, e.g., by insurance.

[16] Medigap plans lack the traditional tools used by health insurers to contain costs, such as care management and negotiation with providers.

[17] As of 2020, Plan F will no longer be offered to beneficiaries newly eligible to Medicare, therefore Plan G will be the most generous coverage option beginning in 2020.

[18] MedPAC. Report to the Congress: Medicare in Rural America. Washington, DC: 2001.

Plans that submit a bid above the benchmark cover the excess cost by charging members a premium when they enroll in the plan. In this manner, the payment for MA made by the federal government is capped at the benchmark amount. The bid and the benchmark are adjusted for the health status of the enrollees in the plan. Benchmarks for higher-quality plans, as determined by Medicare's star rating system, are higher and result in larger rebates for plans, enabling them to offer more benefits, which can make the plan more attractive to prospective enrollees.

There are two differences between government payments for MA and FFS that have recently received increased attention from Medicare experts. The first relates to risk adjustment, which, it is argued, increases payments to MAOs. The second relates to the population used for setting the benchmark rates, which, it is argued, reduces payments to MAOs.

- MAOs receive payments from the federal government reflecting projected costs for medical care in their service areas, adjusted for the health status of the population they insure. Risk scores serve as a proxy for health status and function as payment adjustment factors. In FFS Medicare, providers are paid largely based on the services they perform (i.e., fee-for-service) and not on the diagnosis a beneficiary has. As such, providers have incentive for procedure codes submitted on a claim to be accurate but limited incentive to ensure that the proper diagnosis code is submitted on that claim. These same providers serve MA beneficiaries as well, but MA plans have an incentive to ensure the proper diagnosis code is submitted, as diagnosis codes impact the adjustment to the payment MA plans receive for their members and, ultimately, MA plan revenue.

  Risk scores are based on diagnosis codes. At a very basic level, the more diagnosis codes recorded for a member and the more intensive those diagnosis codes are (e.g., with complications vs. without complications), the higher the risk score a member receives and, correspondingly, the higher the payment the plan receives from the government for bearing risk for that member. MA plans make a concerted effort to ensure diagnoses for their members are properly recorded. This effort to code fully and accurately results in higher risk scores for MA members when compared to similar FFS enrollees with similar health status. CMS adjusts for this difference by reducing MA risk scores by 5.9% through an "MA coding pattern adjustment." Some studies suggest the actual coding pattern difference exceeds the 5.9% adjustment.[19,20] If the actual coding pattern difference exceeds the 5.9% adjustment and other factors are not considered, payments to MA plans may exceed payments for FFS for enrollees of similar health status. MedPAC estimates that there is a higher payment of about 3%.[21] We account for this potential difference in payment through our sensitivity testing using 5% lower FFS costs.
- CMS uses estimated FFS payments as the basis for setting benchmark rates for MA plans. Importantly, all members enrolled in FFS are included in the calculation of these benchmark rates, including those with only Part A or only Part B coverage. In contrast, beneficiaries must be enrolled in both Part A and Part B to qualify for an MA plan. The concern of some is that Part A-only beneficiaries in FFS tend to be younger and healthier than the average Medicare beneficiary, so their claims experience is generally lower than the Part A claims costs of beneficiaries enrolled in both Part A and Part B. Their inclusion in the calculation of the benchmarks lowers the estimated spending on FFS beneficiaries and ultimately results in lower payments to MA plans. Exacerbating this concern is that risk score adjustments for the benchmark calculation are completed using risk scores for only members with both Part A and Part B, creating a difference between the FFS claims experience and the MA plan risk adjustment, further reducing MA plan payment.

[19] MedPAC (March 2021), op cit., p. 355.

[20] CRFB. Reducing Medicare Advantage Overpayments. Retrieved August 13, 2021, from https://www.crfb.org/sites/default/files/HSI_MAOverpayments.pdf.

[21] MedPAC (March 2021), op cit.

Other sources of payment differences between MA and FFS are embedded in the structure of the MA program itself. They include county quartiles, quality bonus payments (QBPs), counties eligible for bonuses, and benchmark payment caps.

- Benchmark payments are adjusted based on the quartile into which a given county falls. Every year, CMS ranks counties based on total FFS expenditures by beneficiary. CMS then splits the counties into quartiles based on this ranking. CMS applies a multiplier to the county-level benchmark payments based on the quartile in which the given county falls. These multipliers range from 0.95 to 1.15, averaging 1.08 in 2021.
- The government pays QBPs to MAOs based on the MAO's performance and the quality of services they provide to their beneficiaries as defined by Medicare's star rating criteria. Data on quality, such as medication adherence, health outcomes, and health plan member satisfaction, are collected and measured each year, and MAOs are awarded star ratings based on the results. These star ratings translate into bonus payments in the form of an increase to benchmarks and the share of difference between the benchmark and the bid a plan retains. MAOs achieving star ratings of 4.0 or above (out of 5.0) will receive a 5% increase to benchmarks as well as retain between 65% and 70% of the difference between the benchmark and the bid. Recent MedPAC research suggests that quality bonus payments make up two to three percentage points of the difference between MA payments and FFS costs.[22]
- Some plans will receive a multiplier on the QBPs if they operate in so-called "double bonus" counties. To be a double bonus county, the county must meet certain requirements but generally that it is highly populated, has high MA enrollment, and has lower-than-average cost.
- While QBPs and double bonus counties increase payments to some MA plans, benchmark payments (including bonuses) are capped at the "applicable amount." The "applicable amount" is the greater of a county's FFS costs and the prior year's applicable amount increased by trend. This cap methodology prevents payments to MA plans, that would otherwise be based on FFS costs, from increasing above payment amounts based on applicable rates existing before the Patient Protection and Affordable Care Act (ACA).

The above factors are used in determining the benchmark. After accounting for the difference between the bid and the benchmark, and the cost of additional benefits for beneficiaries funded by a portion of this difference (the rebate), then total net payments to MA plans are expected to be 101% of FFS payments.[23] If claim administration costs are included in FFS Medicare estimated costs, total net payments to MA plans are expected to be 99% to 100% of FFS payments.[24] This estimate assumes that risk scores are consistent between benchmark payments and FFS payments (after normalizing for the 5.9% coding pattern adjustment) and MA enrollment weights by county.

[22] Ibid, p. 355.

[23] Ibid, p. 368.

[24] Milliman analysis of Medicare FFS and Medicare Advantage costs. Medicare FFS administrative costs of 1.47% of benefit costs from 2019 Annual Report of the Boards of Trustees of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund (2019 Medicare Trustees Report). Retrieved August 13, 2021, from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2019.pdf.

III. Estimating government value: Funding, benefits, and delegated services

Using reports from MedPAC, CMS, and Milliman's Medicare bid modeling suite of tools, we connected publicly available aggregate totals to plan and region-specific costs in order to estimate components of Medicare program payments, both for MA and FFS. Specifically, we estimate the following:

- The cost for MA plans to provide traditional FFS Medicare-covered benefits
- The difference between FFS Medicare and MA costs for these services
- Rebates earned by MA plans based on this difference and how these rebates are allocated to supplemental benefits
- The overall value of the MA benefit to the government and MA beneficiaries
- Average beneficiary premiums and cost sharing for both programs

Our estimates focus on comparing total payments made by the government for Medicare beneficiaries between those in FFS and those in MA. For those in FFS, payments are limited to those for Part A and Part B services and the amount the government spends to administer the program. For those in MA, the payments include the bid payment, which covers all of those same Part A and Part B expenses, as well as the rebate payment, which covers the cost of the additional benefits provided by MA plans.

Our estimates assume that risk profiles and county distributions are consistent between MA and FFS. Additionally, the estimates reflect coding intensity differences captured by the 5.9% MA coding pattern adjustment set by CMS between beneficiaries enrolled in MA and beneficiaries covered by FFS, but do not reflect any differences in coding intensity that may not be captured by this adjustment.

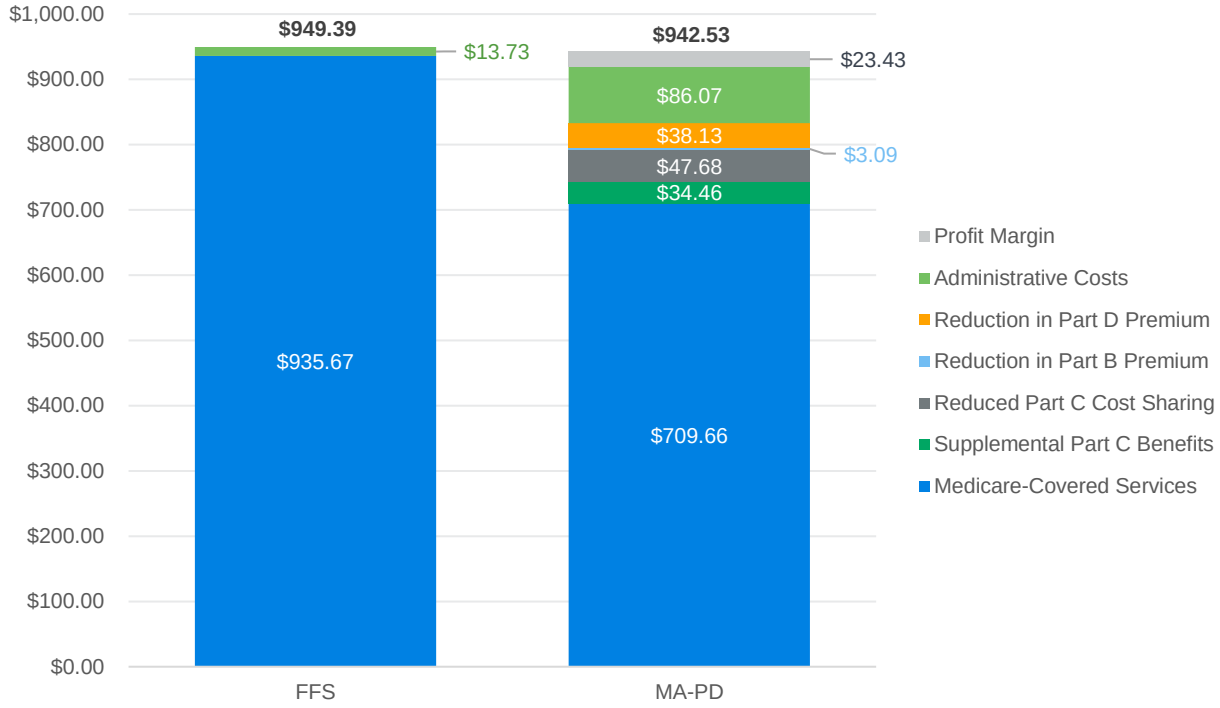
Figure 3 shows a breakdown of the components of the MA and FFS payments by the government. While the government payments are quite similar between Medicare coverage options, each dollar spent by the federal government on MA provides Part A and Part B covered services as covered by FFS and also includes additional benefits and lower cost sharing for beneficiaries than is provided by FFS.[25,26]

[25] Friedman, J. and Yeh, M. (December 2020). Prevalence of Supplemental Benefits in the General Enrollment Medicare Advantage Marketplace: 2017 to 2021. Milliman White Paper. Retrieved August 13, 2021, from https://us.milliman.com/-/media/milliman/pdfs/2020-articles/articles/12-14-20-prevalence_of_supplemental_benefits_general_enrollment-v1.ashx.

[26] Friedman, J. and Yeh, M. (December 2020). Prevalence of Supplemental Benefits in the D-SNP Medicare Advantage Marketplace: 2017 to 2021. Milliman White Paper. Retrieved August 13, 2021, from https://www.milliman.com/en/insight/prevalence-of-supplemental-benefits-in-the-d-snp-medicare-advantage-marketplace.

GOVERNMENT PAYMENTS PMPM TO MA VS. FFS

FIGURE 3: FFS MEDICARE VS. MEDICARE ADVANTAGE GOVERNMENT PAYMENTS, $ PMPM



In some other analyses,[27] costs to administer claims are excluded from FFS payments. In our analysis, we include FFS administrative costs for comparability, as MA plans must fund claim administrative expenses through their capitated payments. This results in total FFS payments slightly higher than total MA payments ($949.39 vs. $942.43) for beneficiaries of a similar health status. Without including claim administrative expenses for FFS, FFS payments are slightly lower than MA payments ($935.67 vs. $942.53). We include more information on the impact of potential differences that may not be fully accounted for in the data sources used for this analysis in the "Sensitivity Testing" section below.

The reduction in Part D premium, reduction in Part B premium, reduction in Part C cost sharing, additional Part C supplemental benefits, and a portion of administrative costs and profit are paid for by Part C rebates achieved by MA plans that bid below the benchmark. A portion of these benefits may also be funded by an additional Part C member premium, which is not included in the graph. Based on the distribution of government payment to MAOs across Parts A and B and the additional benefits in Figure 3, we estimate that, in 2021, the average plan Part C bids are 86% to 87% of payments made for traditional FFS. This means that MAOs are able to offer Medicare-covered services at FFS levels and cover their administrative costs and profits at 13% to 14% lower cost than FFS Medicare.

[27] MedPAC (March 2021), op cit., p. 355.

ALLOCATION OF GOVERNMENT PAYMENTS TO MA VS. FFS

MAOs can offer beneficiaries additional benefits and cost sharing reductions because the cost of traditional Medicare-covered services (Parts A and B) is lower in MA than in FFS. This does not mean MAOs cover fewer Part A and Part B services than FFS, but rather that they find ways to reduce the cost of providing those same services, typically through requiring beneficiaries receive services from designated providers or through their care management programs. The cost differences can be seen in Figure 4.

FIGURE 4: ALLOCATION OF FFS MEDICARE AND MEDICARE ADVANTAGE PAYMENTS

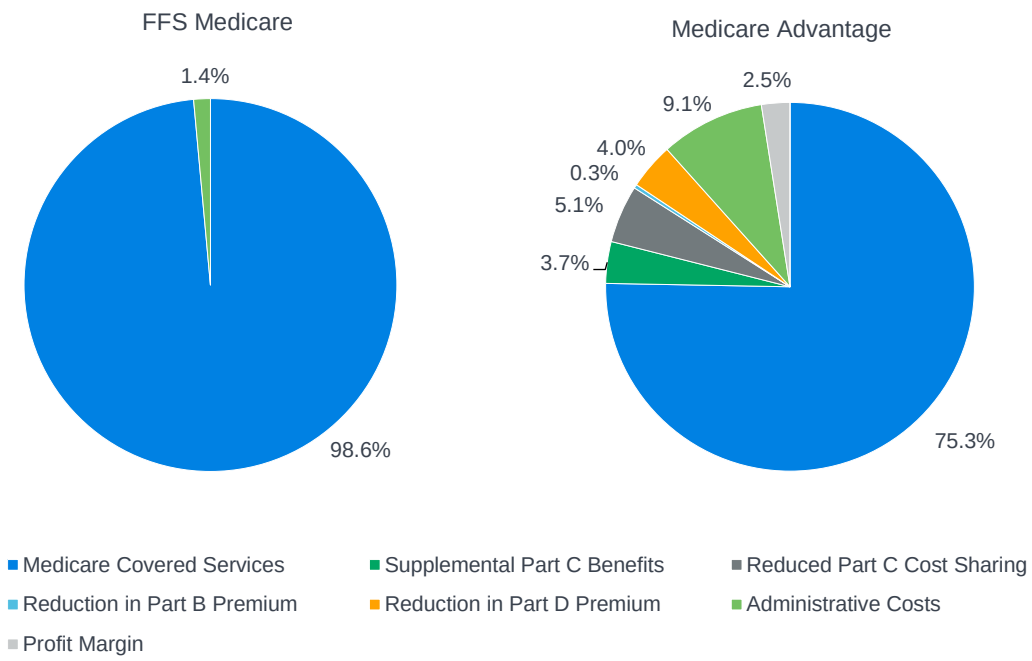
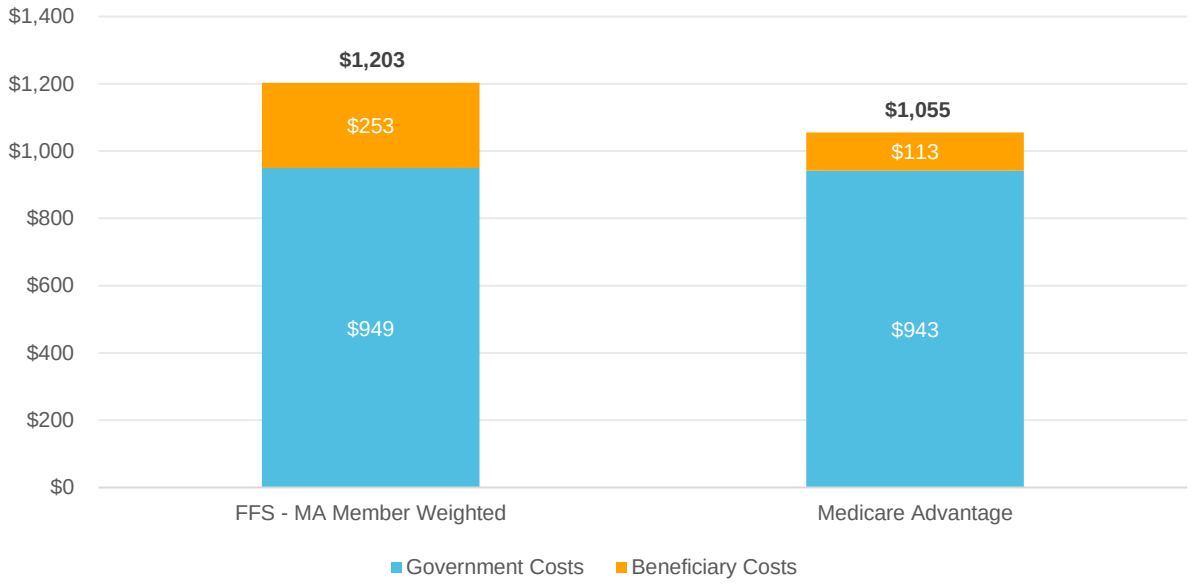


Figure 4 shows how the government payments for Part A and Part B expenses are allocated among various categories by MA and FFS. For beneficiaries in FFS, almost 99% of the government payment is spent on covering Part A and Part B expenses. In contrast, Part A and Part B expenses account for just over 75% of that similar government payment to MA plans. The remaining 25% of the government payment to MA plans provides enhanced coverage for MA beneficiaries through additional benefits, lower cost sharing, and reduced premiums for Part B and Part D in addition to covering plan administrative expenses and a profit margin.

TOTAL GOVERNMENT AND BENEFICIARY SPEND FOR MA VS. FFS COVERAGE

Figure 5 details the costs for the federal government and beneficiary for FFS and MA coverage. The government costs are for only Parts A and B coverage. The beneficiary costs consist of Parts B, C, and D premiums and any cost sharing for Parts A and B services. Cost sharing is the portion of the cost of a service (e.g., an inpatient visit) for which the member is responsible. Under statute, Parts A and B cost sharing for MA beneficiaries, in aggregate, must be the same as or lower than the cost sharing under FFS Medicare (i.e., benefits must be the same or better under MA than FFS). As shown here, the combined average spending by the federal government for Parts A and B coverage and the beneficiary for Parts B, C, and D premiums and any cost sharing for Parts A and B services is lower under MA than in FFS. This demonstrates that MA plans are not shifting the spending from the government to the beneficiary to pay for Parts A and B services but rather that these plans provide the beneficiary additional benefits at a lower total cost than the cost of FFS coverage for only Part A and Part B services.

FIGURE 5: GOVERNMENT AND BENEFICIARY COST IN FEE-FOR-SERVICE AND MEDICARE ADVANTAGE, $ PMPM



Beneficiary costs include premiums and out-of-pocket costs for medical coverage as well as Part D premiums but exclude pharmacy-related out-of-pocket costs. Government costs only include the portion of Part D premiums funded by government payments to MA plans. No other government costs for Part D are included. Totals may not equal sum of components due to rounding.

Beyond the additional benefits and lower cost sharing that beneficiaries receive in MA, one of the most important features of MA is the maximum out-of-pocket spending limit (MOOP)—a financial protection not provided by FFS Medicare. This limits an MA beneficiary's medical cost exposure to a specified amount, with the plan covering the cost of all amounts above that threshold. In 2021, the average MA MOOP was $5,091.[28] FFS does not offer such spending limits for its beneficiaries; in 2018, 4.8% of FFS beneficiaries would have exceeded the 2018 mandatory MA MOOP of $6,700[29] and had average annual out-of-pocket costs exceeding $12,600.[30]

ADDITIONAL BENEFITS

As noted above, MAOs offer significant additional benefits to their members that are not covered under the traditional Medicare benefit. These benefits have been an important differentiator (both from FFS Medicare and other MA plans) since the program's inception but today have become so prevalent that plans may have difficulty gaining enrollment if they do not offer them. The most popular benefits offered are dental, vision, and hearing. In 2021, 84% of beneficiaries are enrolled in plans offering dental benefits, 97% are enrolled in plans offering vision exams, with 90% offering vision hardware, and 89% have hearing benefits, including exams and hardware.[31] Benefits in the "Other" category include (but are not limited to) meal delivery, nonemergency transportation to physician visits, fitness benefits, and OTC benefit cards. Prevalence of all these benefits has increased significantly from 2017 to 2021.[32] These additional benefits are paid for with a combination of Part C rebates and member premium. Figure 6 shows a breakdown of the additional benefits provided by MA plans, funded through Part C rebates. This breakdown does not include the portion paid for by member premium.

[28] Milliman analysis of publicly available Medicare Advantage benefit and enrollment data.

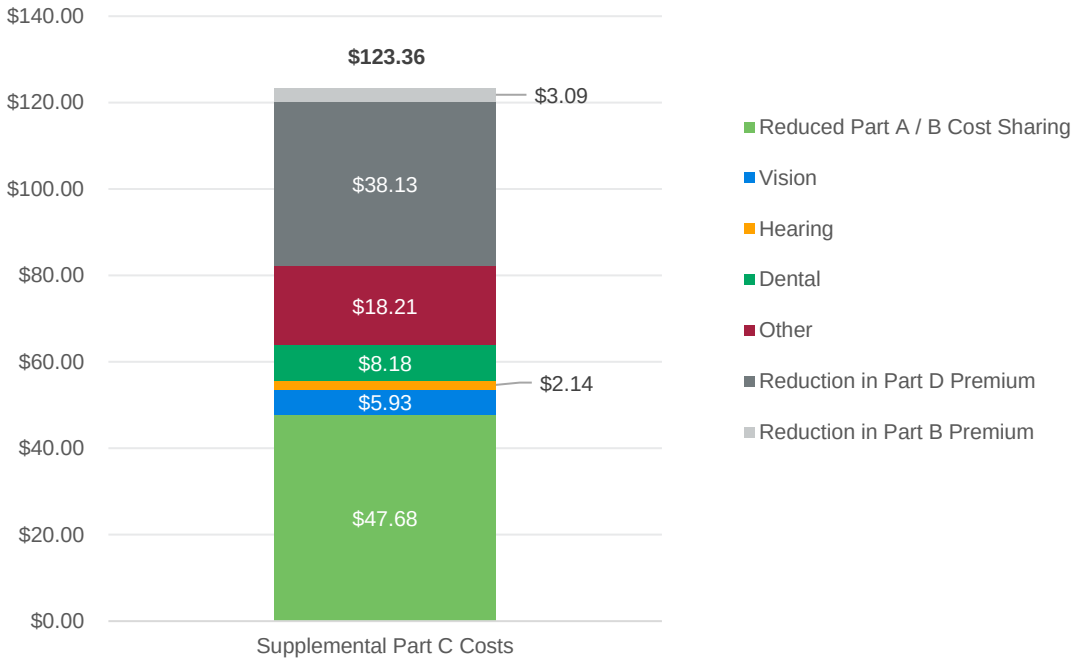
[29] In 2021, CMS increased the mandatory MA MOOP limit to $7,550 due to end-stage renal disease (ESRD) beneficiaries being able to actively enroll in MA beginning in 2021.

[30] Milliman analysis of 2018 Medicare 5% sample data

[31] Barnhart, A. (December 16, 2020). An Analysis of Supplemental Benefit Prevalence in Medicare Advantage Plans. Milliman Report. Retrieved August 13, 2021, from https://www.milliman.com/-/media/milliman/pdfs/2021-articles/1-26-21-analysis-supplemental-benefit-prevalence-medicare-advantage-plans.ashx.

[32] Ibid.

FIGURE 6: BREAKOUT OF NON-MEDICARE-COVERED PART C COSTS, $ PMPM



While additional benefits like dental, vision, and hearing coverage are a popular way to spend Part C rebates, comprising 28% ($34.46 PMPM) of rebate allocation, MA plans use rebate dollars in many other ways, including:

- Reducing member cost sharing for Part A and B covered services (39% of the rebate or $47.68 PMPM)
- Buying down Part B premiums (3% of the rebate or $3.09 PMPM)
- Buying down Part D premiums (31% of the rebate or $38.13 PMPM)

Figure 7 outlines prevalence in 2021 of several of the most common additional benefits offered by MA plans, weighted by enrollment.

FIGURE 7: ADDITIONAL MA BENEFIT PREVALENCE, 2021 (ENROLLMENT WEIGHTED)[33]

Comprehensive Dental	70%	Transportation	45%
Preventative Dental	84%	OTC	81%
Vision Exams	97%	Acupuncture	27%
Vision Hardware	90%	Chiropractic Services	22%
Hearing Exams	89%	Podiatry Services	48%
Hearing Hardware	89%	Visitor/Travel	23%
Meals	59%		

[33] Ibid.

CHOICE AND POPULARITY

MA plans are able to offer additional benefits, lower average out-of-pocket costs, and lower up-front premiums relative to FFS Medicare through cost savings achieved in managing the cost of covering medical benefits. In exchange for the broader coverage and lower average costs, MA beneficiaries accept certain plan requirements, including seeking care within the plan's provider network and under the plan's care management programs. MA plans leverage care coordination and other programs to reduce use of certain services deemed unnecessary or duplicative by the plan and to steer beneficiaries to less costly sites of care, reducing spending. MA plans establish provider networks based on the provider's cost and willingness to engage in the care management protocols established by the plan. These requirements subject beneficiaries to additional structure, yet they significantly lower cost of coverage for MA beneficiaries. In 2019, half of Medicare beneficiaries had annual incomes below $29,650[34] and so the lower cost of coverage in MA, supplemented by additional benefits, makes it a popular choice. In fact, in 2020 a greater percentage of MA members were low-income (51%) than FFS members (44%).[35]

In contrast, it appears FFS Medicare alone may not provide enough coverage in the eyes of most seniors. In fact, 89% of noninstitutionalized Medicare beneficiaries augment their FFS coverage with some form of supplemental medical coverage.[36,37] While many Medicare beneficiaries supplement FFS coverage with either employer-sponsored coverage or Medicaid, those not eligible for such coverage can voluntarily purchase supplemental coverage through a Medigap plan (augmenting with a standalone Part D plan for prescription drug coverage), or they can enroll in an MA plan rather than FFS Medicare.

MA maintains continued and increasing popularity, as well as a very competitive market, offering a variety of plan choices for beneficiaries.[38] In addition to providing a choice between a government option and a private option, MA also offers choices among various plans within the private option. Each MA plan offers a varying set of additional benefits that may suit a beneficiary's needs more adequately than a one-size-fits-all solution.

In addition to varied options for costs, coverage levels, and additional benefits, the average out-of-pocket cost is lower than the cost of FFS Medicare with Medigap and Part D coverage. In 2020, out-of-pocket spending on premiums and cost sharing for a Medicare beneficiary not receiving subsidies due to income was estimated to be $3,558 under MA-PD, $5,361 (34% more than under MA-PD) for FFS Medicare and PDP coverage, and $5,992 (41% more than under MA-PD) for FFS Medicare with PDP and Medigap (Plan G).[39] With the significant cost difference among Medicare coverage options, for many beneficiaries, MA may be the only affordable coverage option providing adequate financial protection for healthcare costs.

Despite provider networks and care management programs that help direct beneficiary care but may be perceived to be restrictive, enrollment in MA has grown significantly, from about 1 million beneficiaries in 1986[40] to 27 million beneficiaries in 2021, increasing from 4% of overall Medicare enrollment to the 43.3% share of 2021 enrollment.[41] This demonstrates that MA beneficiaries value the additional benefits and lower cost sharing offered by MA and actively select MA along with its provider networks and care management programs.

[34] Koma, W. et al. (April 24, 2020). Medicare Beneficiaries' Financial Security Before the Coronavirus Pandemic. Kaiser Family Foundation. Retrieved August 13, 2021, from https://www.kff.org/medicare/issue-brief/medicare-beneficiaries-financial-security-before-the-coronavirus-pandemic/.

[35] Mike, D., Friedman, J., & Yilmaz, G. (October 2019). Average Annual Beneficiary Healthcare Costs for Various Medicare Coverage Options. Milliman Client Report. Retrieved August 13, 2021, from https://www.milliman.com/en/insight/Average-annual-beneficiary-health-care-costs-for-various-Medicare-coverage-options-2021.

[36] MedPAC (July 2020). A Data Book: Healthcare Spending and the Medicare Program, Chart 3-2. Retrieved August 13, 2021, from http://www.medpac.gov/docs/default-source/data-book/july2020_databook_entirereport_sec.pdf?sfvrsn=0.

[37] Supplemental medical coverage only, excluding supplemental pharmacy coverage. Approximately 12% of beneficiaries are without some form of creditable pharmacy coverage. Source: MedPAC 2021 Databook Table 10-7. Retrieved August 13, 2021, from http://medpac.gov/docs/default-source/data-book/july2021_medpac_databook_sec.pdf?sfvrsn=0.

[38] Friedman, J., Swanson, B., Yeh, M., and Cates, J. (February 2020). State of the 2020 Medicare Advantage Industry: As Strong as Ever. Milliman Research Report. Retrieved August 13, 2021, from https://us.milliman.com/-/media/milliman/pdfs/articles/state_of_the_2020_medicare_advantage_industry.ashx.

[39] Mike, D. & Yilmaz, G. (January 2021), op cit.

[40] Mcguire, T.G., Newhouse, J.P., & Sinaiko, A.D. (June 2011). An economic history of Medicare Part C. *Milbank Q*. Retrieved August 13, 2021, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3117270/.

[41] Milliman analysis of CMS-published March 2021 MA State/County Penetration data from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/MA-State-County-Penetration.

FFS Medicare has long been the de facto choice for seniors (FFS is the default plan for beneficiaries who do not enroll in MA), but MA is growing in popularity—in 2015, 85% of enrollees in FFS Medicare were satisfied with their care, while 88% of MA enrollees reported the same.[42] This pattern of consumer satisfaction with MA has increased—98% of MA enrollees reported satisfaction with their coverage in 2020.[43] Increasing adoption of MA suggests that members are satisfied with the value they receive from MA plans, and this value—in the form of customized plan offerings and wider benefits for lower costs than FFS—is quite significant.[44]

ADMINISTRATIVE COSTS

MA plans have higher administrative costs compared to FFS Medicare. MA plans allocate approximately 9.1% of government payments to administrative costs, while FFS Medicare allocates approximately 1.4%[45] primarily on basic claim administration activities. In addition to the cost of providing Medicare-covered services themselves, MAOs must factor in the cost of administering the plan (also called non-benefit expense, or NBE). Examples of these costs are expenses to run care management and utilization management programs, claim adjudication costs, enrollment costs, costs to set up and administer provider networks, expenses associated with administering and reporting on quality programs that are not required under FFS Medicare, administrative fees paid to vendors, marketing and sales staff salaries, and commissions to brokers. A portion of administrative costs funds quality improvement activities (used to improve health plan star ratings) as well as care management services for beneficiaries. While data is not readily available for MA plans, a study estimated commercial health plans spend approximately 5% of administrative costs on quality improvement activities and approximately 16% on cost containment activities.[46] All these administrative costs are included in the MA plan's bid and subsequently in the government's PMPM payment to MA plans for Medicare beneficiaries they enroll. Despite higher administrative costs in MA, the total government payment PMPM is similar for MA and FFS Medicare beneficiaries because MA plans have lower costs than FFS for Medicare-covered services. In short, MA plans leverage a portion of their higher administrative expenses to reduce benefit expense, compared to FFS Medicare, which does not actively engage in cost management activities like provider network contracting and care management programs.

THE FEDERAL GOVERNMENT PAYS LESS AND GETS MORE FOR ITS DOLLAR IN MA THAN IN FFS

The managed care models operated within MA plans provide care coordination and help to reduce duplicate and unnecessary services, which, in turn, allows the plans to provide the same services at a lower cost. As a result, the government's dollar goes further with MA plans providing Medicare-covered benefits at least as generous as FFS Medicare for less than what the same benefits cost under FFS Medicare. Specifically, our analysis shows that for every dollar of costs for Medicare-covered services, the government's payment covers 89.5 cents of the costs for MA beneficiaries but only 85.2 cents of the costs for FFS Medicare beneficiaries, with the MA and FFS beneficiary paying for the remaining 10.5 cents and 14.8 cents, respectively.

Further, as demonstrated above, because the savings from bidding below the FFS cost (i.e., the benchmark) are used to fund the provision of additional benefits, each dollar spent by the federal government on MA goes further, as it provides beneficiaries with additional benefits and lower cost sharing than is provided by FFS Medicare. The savings from lower costs to provide Medicare-covered benefits are used by MA plans to reduce member premiums and cost sharing and to provide additional benefits to their enrollees. The additional benefits such as hearing, vision, and dental coverage can help beneficiaries maintain their health by providing coverage for items and exams that a beneficiary may otherwise have skipped or delayed until something more acute needs to be addressed. Increasingly, MA plans are also addressing nonmedical needs that impact beneficiary health by providing benefits like meals,

[42] McCarthy, M. (March 30, 2015), Seniors Love Their Medicare (Advantage). Morning Consult. Retrieved August 13, 2021, from https://morningconsult.com/2015/03/30/seniors-love-their-medicare-advantage/.

[43] Morning Consult (January 2021), Survey Results: Annual Seniors on Medicare Survey. Retrieved August 13, 2021, from https://bettermedicarealliance.org/wp-content/uploads/2021/01/BMA_Seniors-on-Medicare-Memo_.pdf.

[44] Mike, D., Friedman, J., & Yilmaz, G. (October 2019), op cit.

[45] CMS discloses approximately 1.4% in administrative expense for FFS for administering claims.

[46] AHIP (2021). Where Does Your Health Care Dollar Go? Retrieved September 2, 2021, from https://www.ahip.org/wp-content/uploads/AHIP_HealthCareDollar-2021.pdf.

transportation services, and home modifications.[47] None of these additional benefits are available through the government for FFS Medicare beneficiaries. As a result, the government receives more value for every dollar spent on MA than on FFS Medicare.

MA also provides an option for beneficiaries to receive more comprehensive coverage for no additional premium. In fact, 96% of Medicare beneficiaries have access to at least one MA-PD plan for zero premium.[48] For many beneficiaries, MA may represent the only affordable option for obtaining comprehensive coverage, as Medigap plans can be costly, and many beneficiaries are not eligible for other supplemental coverage such as employer-sponsored commercial insurance or Medicaid benefits. In the absence of MA, many beneficiaries would need to spend significantly more to purchase Medigap coverage, and some studies indicate this would ultimately drive up total healthcare spending for the government and beneficiaries.[49]

Finally, MA's lower total cost of coverage in spite of providing more benefits than FFS Medicare lowers total program costs (i.e., government payment and beneficiary spending on premiums and out-of-pocket costs) and increases the value for every healthcare dollar spent by the government and the beneficiary more in MA than in FFS Medicare.

Additionally, there may be other indirect sources of savings to the government driven by MA plans. Indirect savings may come from several sources:

- Spillover savings in FFS Medicare resulting from the presence of MA. Studies have shown that in areas with greater MA penetration, FFS Medicare beneficiaries have fewer days in the hospital but more outpatient visits, consistent with a substitution of less expensive outpatient care for more expensive inpatient care; however, there was no evidence that such lower-cost care was of lower quality.[50] Other studies have also shown that MA growth was associated with decreased FFS Medicare spending and emergency department visits among beneficiaries with multiple chronic conditions.[51] In essence, markets with high MA penetration may exhibit a spillover effect, reducing costs for FFS Medicare beneficiaries and driving savings for the government.
- Savings to Medicaid, which is funded by a combination of state and federal dollars, may accrue for dual-eligible beneficiaries in special needs plans (SNPs) and other MA plans. These plans offer, at minimum, a maximum out-of-pocket cost, transferring claim costs beyond the MOOP from Medicaid to the MA plan. In 2018, 5.2% of dual-eligible FFS Medicare beneficiaries would have exceeded the mandatory MA MOOP of $6,700 and had average annual out-of-pocket costs exceeding $12,700.[52] In 2021, the average MA MOOP for dual-eligible SNPs, which focus on dual-eligible beneficiaries, was $5,555.[53] Taken together, this means the Medicaid program could have saved an average of $7,110 annually under an average MA plan for those dual-eligible beneficiaries with high spending enrolled in FFS Medicare.[54]

[47] Kornfield, T. et al. (February 10, 2021). Medicare Advantage Plans Offering Expanded Supplemental Benefits: A Look at Availability and Enrollment. Commonwealth Fund. Retrieved August 13, 2021, from https://www.commonwealthfund.org/publications/issue-briefs/2021/feb/medicare-advantage-plans-supplemental-benefits.

[48] MedPAC (March 2021), op cit,, p. 355.

[49] Hogan, C. (August 2014). Exploring the Effects of Secondary Coverage on Medicare Spending for the Elderly. Direct Research. Retrieved August 13, 2021, from http://www.medpac.gov/docs/default-source/contractor-reports/august2014_secondaryinsurance_contractor.pdf?sfvrsn=0.

[50] Balcker, K. & Robbin, J.A. (2015). Medicare Payments and System-Level Healthcare Use: The Spillover Effects of Medicare Managed Care. University of Chicago Press Journals. Retrieved August 13, 2021, from https://www.journals.uchicago.edu/doi/full/10.1162/AJHE_a_00024.

[51] Park, S. et al. (August 26, 2020). Association of Medicare Advantage Penetration With Per Capita Spending, Emergency Department Visits, and Readmission Rates Among Fee-for-Service Medicare Beneficiaries With High Comorbidity Burden. Retrieved August 13, 2021, from https://journals.sagepub.com/doi/10.1177/1077558720952582 (requires registration).

[52] Milliman analysis of 2018 Medicare 5% sample data.

[53] Milliman analysis of publicly available Medicare Advantage benefit and enrollment data.

[54] To simplify this analysis, we ignore inflation trends in medical costs from 2018 to 2021. If claims were trended, savings may be greater.

IV. Sensitivity testing

This analysis assumes, for a comparable set of beneficiaries, that MA costs for the federal government are approximately 101% of pure Part A and Part B FFS costs (excluding FFS administrative costs). These results are consistent with recent MedPAC research. However, as discussed in the background section above on payment discrepancies, there are arguments for why the beneficiaries underlying published FFS Medicare costs and those enrolled in MA plans are not comparable, even after normalizing for health differences using risk scores.

One hypothesis suggests that using similar risk scores to determine comparable beneficiaries between FFS Medicare and MA may be problematic because MA risk scores are higher than FFS beyond what is adjusted for in the coding intensity adjustments. Studies estimate excess coding impacts to range from 3% to 9% of the MA bid payment. MedPAC believes excess coding is worth 3%, and the Committee for a Responsible Federal Budget (CRFB) believes excess coding is worth approximately 9%.[55,56] Accounting for these coding differences would result in higher MA payments relative to FFS Medicare.

Another hypothesis suggests FFS Medicare costs are more than MA payments. In baseline FFS costs used for comparison to MA costs, there are a number of beneficiaries that are not comparable to those in MA. Specifically, CMS sets its benchmark payments to MA plans based on FFS claim data that includes beneficiaries with coverage for only Part A (14% of beneficiaries, who are typically healthier) or only Part B (1% of beneficiaries).[57] To be eligible to enroll in an MA plan a member must have both Part A and Part B coverage. Estimates of difference in payment between MA and FFS Medicare driven by this issue range from 1% to 16%.[58,59]

To address these different hypotheses and their impacts, we include a high-level sensitivity test on our above analysis and results. Figure 8 demonstrates what happens to total costs assuming a 5% increase in FFS costs and a 5% decrease in FFS costs. The 5% increase and 5% decrease scenarios simulate potential differences in health status and eligibility between MA and FFS that may not be accounted for in our analysis due to lack of data. We break out costs between government and beneficiary costs.

Under both scenarios, total costs for FFS Medicare beneficiaries are higher than they are for MA beneficiaries. In the 5% increase in FFS cost scenario, which represents the hypothesis that FFS costs used as comparison for MA payments are too low because the FFS comparison cohort includes only Part A and only Part B beneficiaries, government costs are higher in FFS than in MA. In the 5% decrease in FFS cost scenario, which represents the hypothesis that the FFS costs used to set MA payments are too high due to differences in coding that are not adequately adjusted by CMS, the government costs for FFS are lower than in MA. However, FFS Medicare beneficiaries would still spend materially more out-of-pocket than MA beneficiaries, on average, under this scenario.

[55] MedPAC (March 2021), op cit,

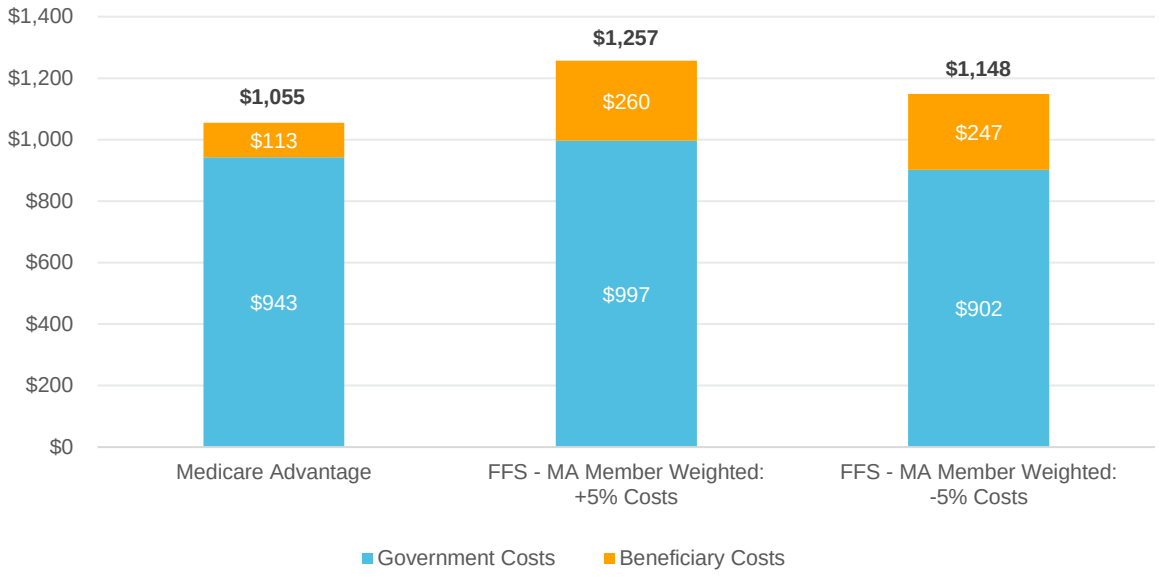
[56] CRFB, Reducing Medicare Advantage Overpayments, op cit.

[57] CMS. Medicare Enrollment Section. Retrieved August 13, 2021, from https://www.cms.gov/research-statistics-data-systems/cms-program-statistics/2019-medicare-enrollment-section.

[58] MedPAC (March 3, 2021). For the record: MedPAC's response to AHIP's recent "Correcting the Record" blog post. MedPAC Blog. Retrieved August 13, 2021, from http://medpac.gov/-blog-/for-the-record-medpac-s-response-to-ahip-s-recent-correcting-the-record-blog-post/2021/03/03/for-the-record-medpac-s-response-to-ahip-s-recent-correcting-the-record-blog-post.

[59] Nonnemaker, L. & Hamelburg, M. (February 24, 2021). Correcting the Record: Medicare Advantage Costs Far Less Than Fee-for-Service Medicare. Retrieved August 13, 2021, from https://www.ahip.org/correcting-the-record-medicare-advantage-costs-far-less-than-fee-for-service-medicare/.

FIGURE 8: GOVERNMENT AND BENEFICIARY COST IN MEDICARE ADVANTAGE VS. FEE-FOR-SERVICE IN +/- 5% OF FFS COST SCENARIOS



V. Methodology and data sources

We estimated traditional FFS Medicare payments using cost and enrollment information published by CMS. We assumed FFS Medicare and MA plans in a given bidding area were funded at the same level (similar risk profiles and member weighting), consistent with the previously referenced MedPAC reports. We set beneficiaries in FFS Medicare consistent with those in MA. We assume no difference in risk profiles between the two populations and assume county-level enrollment for FFS Medicare is the same as for MA. We based enrollment by county on September 2020 CMS enrollment information.

We estimate traditional FFS Medicare administrative expenses using information published in the 2020 Medicare Trustee's report.

We use detailed publicly available benefit design, premium, star rating, and county-level enrollment information for all MA plans provided by CMS. We used this information, along with proprietary Milliman pricing tools, to calculate imputed bids for all contract-year (CY) 2021 MA plans under the current MA payment methodology. We used these imputed bids and FFS Medicare cost estimates published by CMS as the basis for calculating the estimated MA costs.

To calculate imputed bids, we used a plan's benefit design and expected cost for its service area to estimate the plan's net medical cost using proprietary Milliman pricing tools. The estimated medical cost and other assumptions for each plan are combined with the plan's star rating and benchmark revenue rates released by CMS to calculate the MA cost breakdown, including each plan's imputed rebate. Plan type and geography were factors in developing the medical cost estimates and other assumptions. Other assumptions include plan risk scores, administrative expenses, and profit margins.

The analysis excludes all employer group waiver plans (EGWPs), Program of All-inclusive Care for the Elderly (PACE) organizations, Medical Savings Account (MSA) plans, Medicare cost plans (1876 and 1833), and Medicare-Medicaid Plans (MMPs).

VI. Caveats and limitations

The authors of this report are employees of Milliman, Inc. David Mike is a member of the American Academy of Actuaries and meets the qualification standards of the American Academy of Actuaries to perform the analysis supporting this report.

Milliman does not intend to benefit and assumes no duty of liability to parties that receive this work product. Any third party recipient of this work product that desires professional guidance should not rely upon Milliman's work product but should engage qualified professionals for advice appropriate to their own specific needs. Milliman is not advocating for, or endorsing, any specific policy changes to the FFS Medicare or Medicare Advantage programs in this report.

Milliman has developed certain models to estimate the values included in this report. The intent of the models was to illustrate cost differences between Medicare Advantage and traditional FFS Medicare. We have reviewed the models, including their inputs, calculations, and outputs, for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP).

The models rely on data and information as input to the models. We have relied upon certain data and information from CMS and MedPAC for this purpose and accepted it without audit. There is no single comprehensive source that estimates the value of various benefits provided by MA plans, and limited granularity is available in terms of the various funding streams that MA plans receive and how that funding is used. As such, we connected these publicly available aggregate totals to plan and region-specific costs in order to estimate the cost for MA plans to provide traditional Medicare benefits, the difference between FFS Medicare and MA costs for these services, rebates earned by MA plans for these savings, how these rebates are allocated to supplemental benefits, and the value of the MA benefit. To the extent that the data and information relied upon is not accurate, or is not complete, the values provided in this report may likewise be inaccurate or incomplete.

The figures presented in this report are designed to provide information regarding the estimated relative value of the Medicare Advantage and traditional FFS Medicare programs for 2021 based on publicly available benefit, premium, and enrollment data as well as our estimates of Medicare-covered service costs, drug costs, risk scores, supplemental benefit costs, and other related items. Future healthcare costs are highly uncertain and will likely vary from our current estimates and will depend on the demographic characteristics and health statuses of enrolled beneficiaries, a plan’s geography, and other factors.

The models, including all input, calculations, output, and this report, may not be appropriate and should not be used for any other purpose.

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