**CMS SHOULD IMPROVE THE FAIRNESS OF MEDICARE ADVANTAGE PREMIUMS FOR ENROLLEES BY BASING BENCHMARKS ON FEE-FOR-SERVICE BENEFICIARIES WITH BOTH PART A AND PART B COVERAGE, AS MedPAC RECOMMENDED**

Basing benchmark rates on the per capita cost of care for fee-for-service beneficiaries in each county obligates CMS to ensure that its measure accurately reflects the full per capita cost of care. But CMS’s measure is distorted by including data from beneficiaries lacking Part B coverage, who have much lower-than-average Part A costs. This has led to Medicare Advantage (MA) enrollees in Hawaii and other areas paying higher premiums than they should.

The key reason for the low costs of beneficiaries without Part B is that many are working and have coverage provided by their employer. In this situation, Medicare is usually the secondary payer and is then only obligated to cover the person’s copays—about 20 percent of the total cost of care. This means that the 80 percent of costs paid for by the commercial carrier is left out of the benchmark calculation.

While this distortion biases benchmarks downward in all parts of the country, it also creates major geographic inequities. Hundreds of thousands of MA enrollees in some counties and states—including all Hawaii counties—are paying much more than they should in premiums.

The Medicare Payment Advisory Commission (MedPAC) recognized this problem and recommended that CMS address it by basing the benchmark calculation on data for beneficiaries who have both Part A and Part B coverage.

The Hawai‘i Medical Service Association (Blue Cross Blue Shield of Hawai’i) and the Hawai’i division of Kaiser Permanente sponsored a comprehensive study to document the impact on CMS’s per capita cost calculation of following MedPAC’s recommendation—that is, dropping beneficiaries lacking Part B from the calculation. To make sure the analysis was comprehensive, the study also looked at a second group of beneficiaries who bias the measure in the same way—those who are still working and have employer coverage but have elected to retain Part B. The study used the 2015 Medicare claims files, as processed by JEN Associates of Cambridge, MA.

Exhibit 1 below shows the impact on the six most affected and six least affected states. The wide variation in impact is striking. Dropping both groups of beneficiaries biasing CMS’s measure raises per capita costs by 22 percent in Hawai’i, compared with only 7 percent in several states.

On average, about three quarters of the improvement in equity (the lower, blue portion of the bars in our graph) is accomplished by following MedPAC’s approach—omitting beneficiaries lacking Part B.

We strongly urge CMS to adopt MedPAC’s recommendation because this approach would be relatively straightforward to implement and provides most of the needed improvement. Note that the resulting increase in MA payment to health plans would be less than the increase in costs shown in the graph, due to the effects of risk adjustment.

**Exhibit 1: Impact on Medicare fee-for-service per capita costs of omitting beneficiaries causing downward bias, by state, 2015**



*Source: Hawaii Health Information Corporation and JEN Associates*

We recognize that time and financial resources would be required to implement this policy change nationally. But as MedPAC also advised, CMS could introduce an interim adjustment targeting the most affected counties—those with the very highest shares of fee-for-service beneficiaries lacking Part B. This would be the most practical way to begin addressing the severe bias caused by working aged with employer coverage in CY 2019.

In October of 2017, HMSA representatives presented our recommendation that CMS base its benchmarks on beneficiaries with both Part A and Part B coverage in a meeting with Cheri Rice, Deputy Director of CMS’s Center for Medicare, and Richard Coyle, Director of the Parts C and D section of CMS’s Office of the Actuary.

Thank you for your consideration, and if you have any questions regarding our comment, please contact David Herndon, HMSA’s Executive Vice President and Chief Member Services Officer, at (808) 948-5099 or david\_herndon@hmsa.com.