The Importance of Medicare Advantage Plan Design and Impact on Health Equity

HPR140

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Background

- Medicare beneficiaries can choose between two models of insurance coverage: private Medicare Advantage (MA) plans and traditional Fee-for-Service (FFS) Medicare.
- Despite the 40-year history of MA and growth to more than 54% of Medicare in 2024, there is little information on who choses which types of MA plans and how outcomes differ as a function of varying plan features such as coverage design and out-of-pocket costs.
- Careful analysis of real-world data can be leveraged to help plans benchmark performance at a high level of granularity to maximize actionability, including in terms of specific markets, subpopulations, and design elements such as premiums.
- Data on plan selection and performance can also inform policymakers about how to achieve the best outcomes possible for every Medicare enrollee under the most efficient and cost-effective models of care (health equity).

Objectives

- How do different MA plan designs affect who enrolls, and how do certain features address socioeconomic-related health disparities, healthcare utilization, and costs?
- How do plan features affect how members use medical care?
- Does MA deliver superior quality of care compared to FFS?

Methods

Study Design and Data

- A retrospective cohort analysis utilizing Inovalon's MORE^2 Registry® and the 100% Medicare Fee-for-Service dataset from 2015 to 2021.
- Social drivers of health (SDOH) characteristics were linked at the "near-neighborhood" level using members' address at the 9-digit ZIP code level.
- We constructed a sample of beneficiaries who turned age 65 between 2015 and 2019 and who enrolled in MA or FFS Medicare after enrollment in an employer-sponsored commercial insurance plan pre-65.
- Difference-in-difference modeling was used to compare outcomes for those enrolled in MA vs. FFS while controlling for pre-existing characteristics.
- Members were compared on healthcare utilization and quality outcomes, including rehospitalization, hospitalization for potentially preventable complications, medication adherence, and use of alcohol and drug treatment.

Sample

- The eligible population included in the denominators met each of the following inclusion criteria:
  - Enrollment in MA or FFS within 3 months of turning 65
  - Pre-65 enrollment in a commercial plan
  - Membership in the same plan in the 24 months before and the 24 months after Medicare enrollment at age 65
- Members were excluded from the eligible population if they had dual Medicare-Medicaid eligibility or had commercial insurance coverage while in Medicare.
- The final population comprised **10,043 MA** and **117,059 FFS** enrollees who entered Medicare between 2015-2019.

Choice of Medicare Advantage Plan Type is Influenced by Member Characteristics and Type of Pre-Medicare Commercial Coverage

Figure 1: Race/Ethnicity and Plan Selection

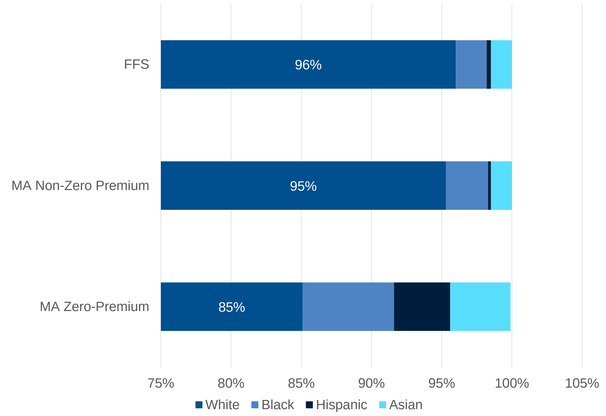


Figure 2: Socioeconomic Characteristics and Plan Selection

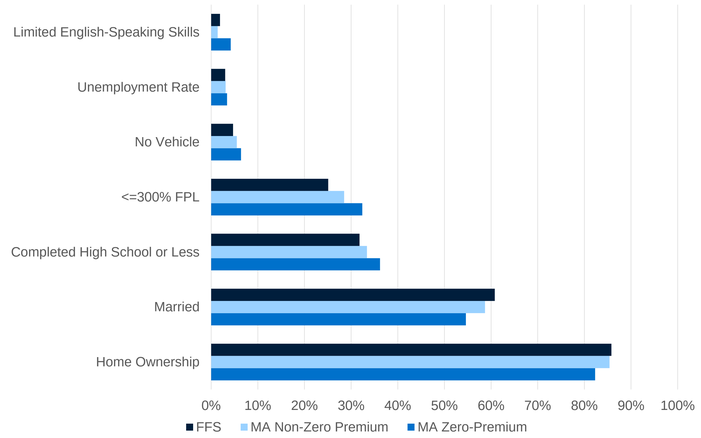


Table 1: Plan Type Before and After Medicare Enrollment

		MA HMO	MA PPO	FFS
Pre-65 Commercial Plan Type	HMO	**59.3%**	22.2%	24.4%
	PPO	29.8%	**63.2%**	60.8%
	POS	3.0%	3.0%	4.9%
	EPO	6.4%	2.1%	7.7%
	Other	1.6%	9.6%	2.2%
	Total	100.0%	100.0%	100.0%

HMO: Health Maintenance Organization
PPO: Preferred Provider Organization
POS: Point of Service Plan
EPO: Exclusive Provider Organization

Medicare Advantage Plans Manage Utilization and Produce Better Outcomes on Important Measures of Care Quality Relative to FFS Medicare

Figure 3: Utilization by Quarter

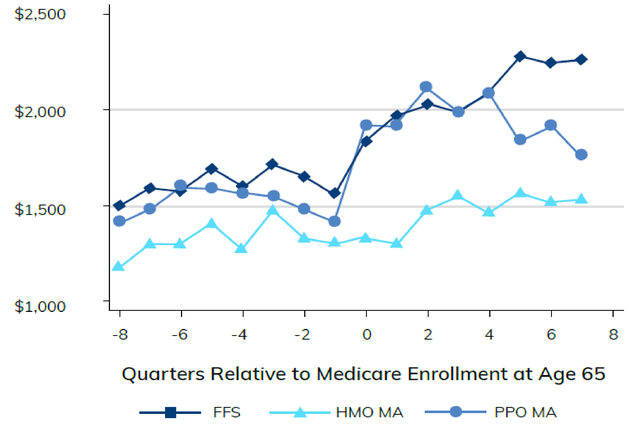
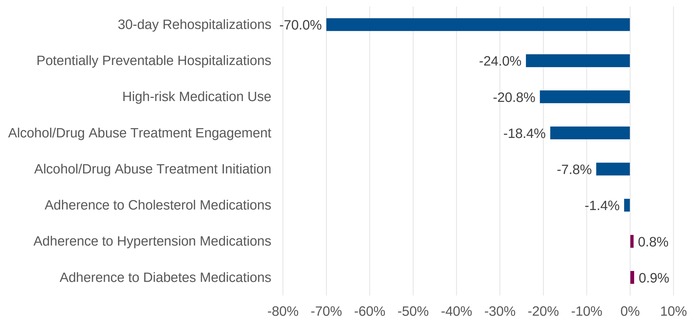


Figure 4: Quality Outcomes – MA as a Percentage of FFS



Summary of Results

- Zero-premium plans tend to attract non-white members **(Figure 1)** and those with fewer social and economic resources **(Figure 2)**.
- New Medicare enrollees tend to select plan types like those they had previously with employer-sponsored insurance **(Table 1)** .
  - Those selecting MA HMO plans tend to come from HMO commercial plans.
  - Those selecting MA PPO plans tend to come from PPO commercial plans.

Summary of Results

- A dramatic increase in healthcare utilization is seen upon enrollment in FFS Medicare and MA PPO plans, but not as much among new MA HMO enrollees **(Figure 3)**.
- The post-enrollment increase among MA PPO beneficiaries reverses a few months after enrollment, but utilization in HMOs remains consistently lower, as it was before Medicare enrollment **(Figure 3)**.
- Modeled post-65 utilization under MA HMOs is 29% lower relative to a comparable population in MA PPOs - $615 lower utilization on a person-quarter basis.
- Analysis of matched MA-FFS cohorts found that MA performs better than FFS on measures concerned with unnecessary hospitalizations **(Figure 4)**.
- MA is better at getting members with substance abuse into treatment and maintaining engagement in care **(Figure 4)**.

Implications

- Results from this real-world study can help MA plans predict and understand utilization and quality outcomes, and how they compare to their peers.
- Findings can help plans navigate different MA design and feature options and understand expected performance for current and future Medicare age-ins.
- They can also help plans select an optimal design mix that appeals to their target markets.
- For policymakers, the results of this study shed new light on the quality MA delivers relative to FFS and underscores the role that care management and coordination can play in promoting quality within the Medicare program.
- Results can help policymakers potentially reduce costs to maintain the financial viability of Medicare by enabling and incentivizing the right mix of plan offerings.

Conclusions

- Plan design has consequences for who enrolls and the challenges members bring with them into Medicare.
- New Medicare beneficiaries tend to stick with plan types they're familiar with from their employer-sponsored years.
- Utilization among FFS and Medicare PPO members increases sharply after enrollment, while HMOs contain utilization consistently, and PPO utilization moderates.
- Important measures of quality demonstrate that MA does a better job of preventing disruptive and costly hospitalizations.

Limitations

- The populations included in this study were required to remain in the same employer-sponsored and Medicare plan for 24 months before and after Medicare enrollment, excluding a potentially important group of members who switch plans.
- Dual-eligible Medicare beneficiaries, a disadvantaged and high-cost subset of those entering Medicare, were not included in this analysis.

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