Welcome to *Washington Update*, the weekly e-newsletter on the latest health care happenings in the nation's capital that affect APG's members.

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Medicare Advantage Plan Star Ratings Dip Slightly, Intensifying Pressure On Some Plans And Provider Groups

Changes that the Centers for Medicare & Medicaid Services (CMS) made to Medicare Advantage Star Ratings last year continue to ripple through the marketplace, data released this week by the agency show. In 2025, 40 percent of MA and Part D prescription drug plans score four stars or higher; as of this year, 62 percent of MA enrollees belong to such highly scored plans. These measures constitute a slight decline from 2024, when 42 percent of plans earned four stars or higher, and 74 percent of enrollees were in these top-rated plans.

As reported in last week's *Washington Update*, large Medicare Advantage Organizations (MAOs) including Humana and UnitedHealthcare are among those that lost ground when the "cut points" used in calculating the ratings shifted upward. It remains to be seen what impact the somewhat lower share of four- and five-

star plans will have on MA open enrollment, which begins Oct. 15. But since higher Star Ratings translate into substantial marketplace and financial benefits to MAOs, the now-sinking ratings could have the opposite effect on plans. Meanwhile, APG's member groups could see the effects in terms of downward pressure on their MAO payments as contract negotiations play out in 2025.

UnitedHealth Group Proposals For Reforming Medicare Advantage Raise Questions About Potential Impact On APG Groups

Amid the many headwinds facing Medicare Advantage, major MA organizations (MAOs) are teeing up sweeping proposals to reform and expand the program and strengthen their marketplace position and likely profitability.

One is UnitedHealth Group, which recently published "A Path Forward to a Modern, High-Performing Health System." A central premise of the report is that MA should be a key mechanism for driving greater value in health care – but the organization's recommendations could produce uncertain impact on other health system players and government finances.

Among the report's ambitious recommendations are these:

- The medical loss ratio requirements applied to MA and other government health programs should be revamped to count as medical expenses spending on social services, such as for housing, nutrition, and transportation, and provider practice capabilities such as electronic health record systems. Such a change would turn spending in these categories into the equivalent of a medical claim as opposed to an administrative expense born by health plans. Depending on how it is structured, such a change could constitute a massive transfer of costs from plans to provider organizations, such as many APG groups operating in "delegated" relationships with MAOs.
- The Medicare spending benchmarks that constitute the starting point for calculating payments to MA plans should be adjusted for "rising health costs and increases in utilization." MAOs bid against these benchmarks to establish their government payment rates, so adjusting them upward would help plans' finances, enable higher payments to providers, and potentially enable expand benefits for enrollees.
- Approximately 99 percent of MAOs already provide such supplemental benefits as dental, hearing, and vision care, but

the report recommends that they be "required to provide coordinated and managed supplemental benefits," which could be construed as a way of leveling the playing field among plans.

- The traditional Medicare program should cover such home-based services as home infusion, remote monitoring, and hospital-at-home services, presumably as a way of continuing to shift care from highest cost settings. At the same time, "in-home care models" in MA should be protected, which could be a reference to maintaining the ability of MAOs to conduct health-risk assessments in beneficiaries' homes.

APG will continue to garner insight into the details behind these proposals, which could produce healthy debate – even as they arguably stand little chance of being enacted soon, either by CMS or Congress.

More Transparency Needed On Use And Impact Of Medicare Advantage Supplemental Benefits, MedPAC Says

The staff of the Medicare Payment Advisory Commission (MedPAC) this week joined a growing chorus calling for more transparency about enrollees' use of supplemental benefits in Medicare Advantage.

Some $83 billion in "rebates" paid to MA plans this year helped to finance the supplemental benefits that they offered in 2024, MedPAC said. Rebates are MA plans' share of the difference between the Medicare spending benchmarks and the plans' bids for what they will spend offering Medicare Parts A and B benefits to enrollees. Plans are required to return the rebates to enrollees in the form of lower premiums or supplemental benefits.

As these rebate amounts have risen sharply in recent years, the dollars available for supplemental benefits have grown. At the same time, CMS and Congress have allowed more flexibility in the types of benefits that can be offered – so they now extend beyond the conventional dental, hearing, and vision benefits, to such areas as transportation assistance and even "cash cards" covering a broad array of purchases.

But "the available data are insufficient for examining enrollees' use of supplemental benefits." MedPAC's staff says, echoing similar conclusions reached by other government entities. Although plans spent an average of $721 in 2024 on dental, vision, and hearing

benefits, it isn't known how enrollees used the benefits. Better encounter data – detailed records of the care provided to MA beneficiaries, including diagnoses, care, and treatments – would yield far greater insight into use of the benefits, and should be explored to assess that use.

All in on data: APG supports enhanced data collection and analysis around supplemental benefits. As noted in a January 5 comment letter to CMS on proposed policy changes to Medicare Advantage and Medicare Part D, APG recommended that CMS collect and analyze data on enrollees' use of supplemental benefits as well as the impact of MA supplemental benefit utilization on enrollees' quality of care outcomes and out-of-pocket costs.

In Case You Missed It

- **Medicare coverage of GLP-1 drugs to combat obesity would raise net federal spending by about $35 billion from 2026 to 2034**, the Congressional Budget Office finds. What's more, compared to the direct costs of the drugs, savings in improved health for beneficiaries would be small, amounting to just $1 billion in 2034. Currently, Medicare covers the drugs only for treatment of diabetes and reducing cardiovascular risk. Although lower than some previous estimates, the CBO's downbeat analysis seems unlikely to spark enactment of the Treat and Reduce Obesity Act (TROA) adopted by the House Ways & Means Committee in June.

- **Vice President Kamala Harris proposed expanding Medicare to cover in-home long-term care services** for older adults and the disabled. Details are sparse, but the new benefits would be paid for in part with savings from Medicare drug price negotiations, with costs also partly borne by enrollees on a sliding income scale. The proposal is one of the first of its kind to be floated since a voluntary long-term care insurance program established under the Affordable Care Act was repealed by Congress in 2013, due to concerns about its lack of financial viability.

APG Announcements And Offerings

- REGISTER NOW! - **APG Fall Conference 2024 - Health Care Strong: Embracing Change and Thriving in Uncertain Times - will be held November 11 – 13 in Washington, DC.** Don't miss our superb lineup of speakers and

unparalleled networking opportunities. Our special rate at the Grand Hyatt Washington hotel expires **next Friday, October 18**. Reserve your room and access other travel deals here.

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Valinda Rutledge, EVP, Advocacy and Education .... vrutledge@apg.org
Jennifer Podulka, Senior Vice President, Federal Policy .... jpodulka@apg.org
Jennifer Salopek, Vice President, Communications .... jsalopek@apg.org