

CHAPTER

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**Rebalancing Medicare  
Advantage benchmark policy**

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## R E C O M M E N D A T I O N

- 1** The Congress should replace the current Medicare Advantage (MA) benchmark policy with a new MA benchmark policy that applies:
- a relatively equal blend of per capita local area fee-for-service (FFS) spending with price-standardized per capita national FFS spending;
  - a rebate of at least 75 percent;
  - a discount rate of at least 2 percent; and
  - the Commission’s prior MA benchmark recommendations—using geographic markets as payment areas, using the FFS population with both Part A and Part B in benchmarks, and eliminating the current pre-Affordable Care Act cap on benchmarks.

**COMMISSIONER VOTES: YES 16 • NO 0 • NOT VOTING 0 • ABSENT 1**

# Rebalancing Medicare Advantage benchmark policy

## Chapter summary

Over the 35-year history of private plan contracting in Medicare, benchmark policy has not attained an appropriate balance of benefits for enrollees, payment adequacy for plans, and responsible use of taxpayer dollars that fund the program. The current benchmarks that determine payments to Medicare Advantage (MA) plans have resulted in a very robust MA program with respect to plan participation, beneficiary enrollment, and the value of extra benefits provided to enrollees. But, in spite of the apparent relative efficiency of MA, no iteration of private plan contracting has yielded net aggregate savings for the Medicare program. The Commission estimates that Medicare currently spends 4 percent more for beneficiaries enrolled in MA than it spends for similar enrollees in traditional fee-for-service (FFS) Medicare.

Current MA benchmark policy uses a quartile system that generates geographic variation in plan payments, including plan subsidies of varying size in most geographic areas, that are not necessary for maintaining affordable supplemental coverage and that fail to capture savings for the Medicare program. The quartile-based benchmarks support higher payments to MA plans in areas where FFS spending is low; despite most plans bidding below FFS spending in these areas, payments are 9 percent higher than the areas' FFS spending, and MA enrollment is disproportionately higher than in many other areas. At the same time, the quartile system insufficiently

## In this chapter

- Background
- Problems with the current benchmark policy
- Simulating an alternative benchmark policy
- Recommendation

leverages plan efficiency in areas where FFS spending is high; plans in these areas bid lower relative to their benchmarks and thus receive disproportionately more rebate dollars—the amount of which equals a share of the difference between a plan’s bid and its benchmark. Because the rebate dollars must be used to provide extra benefits, large rebates result in plans offering a disproportionate level of extra benefits. Moreover, as MA rebates increase, a smaller share of those rebates is used for cost-sharing and premium reductions—benefits that have more transparent value and provide an affordable alternative to Medigap coverage. In addition, current policy can create discontinuities in payment when counties have similar FFS spending but are assigned to a different payment quartile category (e.g., 100 percent of FFS spending vs. 107.5 percent of FFS spending) when the ranking of county spending changes from year to year.

The general decline in plan bids to levels well below FFS spending indicates that the Medicare program could share in plan efficiencies by making appropriate reductions in payment benchmarks. A better MA benchmark policy would rebalance benchmarks by allowing the Medicare program to capture some MA efficiencies—of particular importance given the projections of Medicare’s trust fund solvency and revenue issues—while mitigating possible deleterious impacts on plan participation and benefits. Since November 2019, the Commission has discussed the need for an alternative approach to setting MA benchmarks that would (1) bring benchmarks in the two lowest spending quartiles (those at 115 and 107.5 percent of FFS spending) closer to FFS spending now that most plans in those areas bid below FFS spending, (2) reduce benchmarks in some of the areas with the highest spending (those at 95 percent of FFS spending) that produce the highest share of rebates, and (3) not be overly disruptive to supplemental benefits. In this chapter, we recommend that the Congress implement a new MA benchmark policy that does the following:

- ***Uses a relatively equal blend of per capita local area FFS spending and standardized national FFS spending.*** The use of local area FFS spending in a portion of the blend sets the size of benchmarks on a continuous scale of local FFS spending. The use of standardized national spending reduces variation in local benchmarks to accommodate the availability of MA plans both in areas where FFS spending is high and in areas where it is low. Relative to current policy, benchmarks in low FFS spending areas would be aligned more closely with FFS spending but would remain above local FFS spending. On average, benchmarks in areas with high FFS spending would modestly decrease relative to current policy, allowing the program to capture additional efficiencies in areas where plan bids are lowest relative to their benchmarks.

- ***Uses a rebate of at least 75 percent.*** The rebate percentage (i.e., the share of the difference between the plan bid and benchmark) that is paid to plans for funding extra benefits would be decoupled from the MA quality bonus program and would increase for all plans, thereby creating greater incentives for plan efficiency. Under current policy, a plan’s rebate percentage (typically 65 or 70 percent) is dependent on its star rating, but quality incentives are weak. The average plan rebate is currently 65 percent; this alternative would ensure overall rebates of at least 75 percent.
- ***Integrates a discount rate of at least 2 percent.*** A discount rate would reduce the local–national blended spending amounts, explicitly integrating the efficiency of MA into the benchmark calculation. A discount rate of at least 2 percent would help ensure that the Medicare program shares in the efficiencies generated by MA.
- ***Applies the Commission’s prior MA benchmark recommendations—using geographic markets as payment areas, using the FFS population with both Part A and Part B in benchmarks, and eliminating the current pre–Affordable Care Act cap on benchmarks.*** The Commission has previously recommended improvements to MA benchmarks that would also help ensure consistency and predictability of benchmarks. The Commission’s recommended approach would use geographic markets (e.g., multicounty areas) as payment areas to help ensure stability in benchmarks, calculate benchmarks using the FFS population with both Part A and Part B coverage to ensure comparability with the MA-eligible population, and eliminate caps on benchmarks that disproportionately affect areas where FFS spending is low.

We conducted simulations of our recommended benchmark policy, comparing it with existing policy. The simulations, using 2020 MA bid and FFS benchmark data, demonstrate that CMS could feasibly implement our recommended policy with likely little impact on plan participation. In our simulations, the 50/50 blend of local and national FFS spending reduced benchmarks in the two lowest spending quartiles by an average of 4 percentage points to 5 percentage points while reducing benchmarks by an average of 1 percentage point in the highest spending quartiles where plans have disproportionately higher rebates. The vast majority of MA markets had an average bid far below their blended benchmark level. Our simulations indicate that applying a 2 percent discount rate and a 75 percent rebate would generate about 2 percentage points in savings to the Medicare program relative to current policy (i.e., relative to current base benchmarks both with and without quality bonus payments). Our simulations also indicate that, under a benchmark policy that includes a 2 percent discount rate and assumes no quality

bonus payments to plans, the relative disruption to beneficiary access to MA plans that offer lower cost sharing and reduced premiums would likely be modest.

The Commission's recommendation would immediately address problems created by the current MA benchmarks and produce savings for the Medicare program. In the future, the Commission may compare quality between MA and FFS Medicare and examine the potential for a substantial overhaul of the MA payment system, such as using alternative methods to set payments to plans and standardizing MA plan options. ■

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## Background

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Medicare beneficiaries have the option to receive benefits from private plans rather than from the traditional fee-for-service (FFS) program. In 2020, the Medicare Advantage (MA) program included 4,234 plan options offered by 185 organizations, enrolled over 24 million beneficiaries (43 percent of all Medicare beneficiaries with Part A and Part B coverage), and paid participating plans an estimated \$317 billion (not including Part D drug plan payments). The Commission has long supported the inclusion of private plans in the Medicare program because they are thought to be more efficient than traditional Medicare, and—along with alternative payment models—could help improve the efficiency of the entire Medicare program. Plans often have flexibility in care-management techniques and payment methods, including the ability to negotiate with individual providers, and can steer beneficiaries to more efficient providers by limiting provider networks. By contrast, traditional FFS Medicare has lower administrative costs and offers beneficiaries an unconstrained choice of health care providers, but it often lacks incentives to coordinate care and is limited in its ability to make care delivery more efficient. However, over the 35-year history of private plan contracting in Medicare, although risk adjustment has improved payment accuracy, benchmark policy has not attained an appropriate balance of benefits for enrollees, payment adequacy for plans, or responsible use of taxpayer dollars that fund the program (see text box on the history of MA payment policy, pp. 8–9).

### How Medicare pays MA plans

In contrast to traditional FFS Medicare’s fixed rates per service paid to providers, Medicare pays MA plans a fixed rate for each enrolled beneficiary. Plan payment rates are determined by the MA plan bid—which represents the dollar amount that the plan estimates will cover the Part A and Part B benefit package for a beneficiary of average health status—and the benchmark for the county in which the beneficiary resides, which is the maximum amount of Medicare payment set by law for an MA plan to provide Part A and Part B benefits. If a plan’s normalized bid is above the normalized benchmark (that is, the benchmark for a person of average risk), the plan’s MA base payment rate is set at the benchmark and enrollees have to pay a premium (in addition to the required Part B premium) equal to the difference. If a plan’s bid is below the benchmark, its payment rate is its bid plus a share (between 50 percent and 70 percent, depending on a plan’s

quality rating) of the difference between the plan’s bid and the benchmark. For this computation, the comparison is between an individual plan’s actual bid for its expected enrolled population (which can span multiple counties) and a plan-specific risk-adjusted benchmark (weighted by the plan’s projected county-level enrollment in its service area). The added payment based on the difference between the bid and the benchmark is referred to as the rebate. Plans must use the rebate to provide additional benefits to enrollees in the form of lower cost sharing, lower premiums, or supplemental benefits. Plans can also devote some of the rebate to administration costs and margins. Plans may also choose to include additional supplemental benefits not financed by the rebate and charge premiums to cover those additional benefits.

### Determining MA payment rates

Under the Affordable Care Act of 2010 (ACA), each county’s benchmark, excluding quality bonuses, equals a certain share of the projected average per capita FFS Medicare spending for the county’s beneficiaries. County benchmarks are established by ranking counties based on a county’s level of per capita FFS spending. Benchmarks are set at 115 percent of county FFS spending for the quartile of counties with the lowest FFS spending, 107.5 percent and 100 percent for counties in the next two quartiles of FFS spending, and 95 percent for counties in the quartile with the highest FFS spending.

Under the quality bonus program, benchmarks are increased by 5 percentage points (or 10 percentage points for qualifying counties, known as a “double bonus”) for plans with a star rating of 4 or more stars, or by 3.5 percentage points for new plans.<sup>1,2</sup> For plans bidding below the benchmark, between 50 percent and 70 percent of the difference (depending on the plan’s star rating) must be used to provide extra benefits to plan enrollees.

The ACA established a cap on each county’s benchmark based on either the county’s FFS spending or its historical spending trend, whichever is greater.<sup>3</sup> In 2016, benchmark caps limited quality bonus increases in 45 percent of counties (representing 19 percent of MA enrollment) and limited the base benchmark (applied for plans not entitled to a quality bonus increase) in 24 percent of counties (representing 6 percent of MA enrollment) (Medicare Payment Advisory Commission 2016).

Medicare payments to MA plans are adjusted using an enrollee’s risk score, which accounts for differences in

## A brief history of Medicare Advantage payment policy

The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) introduced the option of allowing private plans to contract with Medicare on a full-risk basis and established a payment ceiling at 95 percent of the amount the federal government would have paid for the enrollees under fee-for-service (FFS) Medicare, which is estimated by the adjusted average per capita cost (AAPCC) (Langwell and Hadley 1986).<sup>4,5</sup> All plans were required to cover the full Medicare benefit. Cost sharing for the Medicare benefit package remained the responsibility of enrollees (an amount equal to the national average value of Medicare cost sharing for each plan), but plans could charge a premium in lieu of cost sharing at the point of service to obtain the cost-sharing revenue. If plans calculated an expected cost of providing the Medicare benefit that was less than 95 percent of the AAPCC, they were required to convert this difference into additional benefits or reduced cost sharing for beneficiaries, defer use of the surplus amount to a future year, or accept a payment lower than 95 percent of the AAPCC (or any combination of the three options).<sup>6</sup> Payments were set at 95 percent of FFS Medicare because the expectation was that private plans (specifically, the HMO model) would yield savings of 5 percent or more for the Medicare program compared with the amount the program would have spent under FFS Medicare.

Although the program increased coverage options for beneficiaries, with plans offering more generous

benefits and reduced cost sharing, private plans did not realize savings for the Medicare program because there was no adjustment for health status in AAPCC payments (McGuire et al. 2011, Zarabozo 2000). Research evaluating the program's early years demonstrated that favorable selection of enrollees (caused by plans avoiding counties with high hospital spending and marketing to healthy beneficiaries and by beneficiaries choosing monthly to enroll in or disenroll from a plan, with sicker beneficiaries preferring FFS Medicare, among other reasons) led to Medicare spending on private plans in 1989 that was 5.7 percent higher than spending would have been under FFS Medicare (Brown et al. 1993, Medicare Payment Advisory Commission 1998, Newhouse 2002). As the program grew, favorable selection persisted; a study in the mid-1990s found that payments to private plans were 7 percent above the amount FFS Medicare would have spent for comparable beneficiaries (Riley et al. 1996). This and other studies led to the conclusion that proper risk adjustment was needed to pay plans more appropriately (Medicare Payment Advisory Commission 2000, Newhouse et al. 1989).

The Balanced Budget Act (BBA) of 1997 required Medicare to improve risk adjustment for payments to private plans and mandated the collection of diagnoses from inpatient claims.<sup>7</sup> Initially, a small share of payment to plans was based on a new risk adjustment model using principal inpatient diagnoses. The

*(continued next page)*

expected medical expenditures based on demographic information (e.g., age, sex, Medicaid enrollment, and disability status) and certain diagnoses. Higher risk scores generate higher payments because beneficiaries with high risk scores are expected to have higher expenditures and vice versa.<sup>8</sup> Risk adjustment, coupled with policies establishing a uniform single annual election period for all plans and eligible beneficiaries and locking in MA enrollees for the calendar year (with limited exceptions), has generally reduced favorable selection for MA plans.

However, favorable selection is not entirely addressed by enrollee risk scores. For example, preferences against narrow provider networks among the most costly Medicare beneficiaries may result in healthier beneficiaries electing to enroll in MA and some MA enrollees switching to FFS Medicare when their health significantly declines (Jacobson et al. 2019b, McWilliams et al. 2012, Newhouse et al. 2012). After beneficiaries experience health declines, the switch from MA to FFS Medicare disproportionately occurs despite these beneficiaries likely



## A brief history of Medicare Advantage payment policy (cont.)

Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) expanded risk adjustment to include the use of diagnoses from ambulatory settings, and Medicare began phasing in a risk adjustment model using diagnoses collected from the claims submitted by hospitals (inpatient and outpatient) and physician office visits in 2004.

Although the BBA of 1997 initiated improvements in risk adjustment, the law also delinked payments to private plans from FFS Medicare spending by establishing a national floor payment amount (generally an increase in payment for rural counties) that increased annually and a 2 percent annual increase in each non-floor county's payment rate.<sup>9</sup> The modest 2 percent increase for non-floor counties was generally smaller than increases in prior years and put pressure on plans' finances, leading to fewer extra benefits, higher cost sharing, and a reduction in overall private plan enrollment between 1999 and 2002 from 6.3 million to 4.9 million as plans left the program. Payment reforms in 1999 and 2000 increased payments for all plans (and created a higher floor payment for urban counties), but only slowed the decline of private plan participation and enrollment in non-floor counties.

The Medicare Modernization Act of 2003 (MMA) established a new system of paying private plans (under the name Medicare Advantage (MA)) based on plan bids and county benchmarks, and the legislation required that plans provide extra benefits financed by

a share (75 percent) of the difference for plans that bid below their benchmark. The Medicare program's payment to each plan was either equal to the plan's bid plus the extra benefit amount for plans bidding below the benchmark or equal to the benchmark for plans bidding above the benchmark (and plans were required to charge beneficiaries a premium to finance the full cost of the Medicare benefit package).<sup>10</sup> Under this framework, the MMA substantially increased payments to MA plans by setting initial benchmarks at 100 percent of FFS spending or higher and establishing annual benchmark increases equal to or greater than FFS Medicare's national growth rate.<sup>11</sup> The ratchet effect of this policy increased payments to MA plans to 14 percent above FFS in 2009 (benchmarks were 18 percent above FFS), the level at which payments roughly remained until the Affordable Care Act of 2010 (ACA) benchmark policy began implementation in 2012 (Medicare Payment Advisory Commission 2009).

The ACA policy revisions kept the basic structure of plan bids, benchmarks, and extra benefits, but significantly revised how benchmarks were established. The ACA benchmark policy phase-in began in 2012 and reduced the average benchmark over several years to about 103 percent of FFS spending in the aggregate (108 percent after including benchmark increases resulting from quality bonuses), the level at which benchmarks have remained in recent years. ■

facing substantially higher Medigap premiums relative to beneficiaries who have never enrolled in MA. Because only four states require guaranteed issue for Medigap policies, most beneficiaries who switch from MA to FFS are subject to medical underwriting and can be denied a Medigap policy (Boccuti et al. 2018). In addition, the risk adjustment model's reliance on diagnosis codes creates a financial incentive for providers in MA plans to document diagnosis codes more thoroughly than do providers in FFS Medicare. Because the risk adjustment model is based on

FFS Medicare data, more thorough diagnostic coding in MA (greater "coding intensity") generates greater payment for MA plans than FFS Medicare would have spent for the same beneficiary (3 percentage points more payment than FFS in 2019).<sup>12</sup> Overall, policies under the ACA improved payment accuracy and addressed a significant share of the payment excesses generated under prior laws; however, with the ACA policies fully phased in, MA payments continue to be above expected FFS spending (see text box on aggregate Medicare payments to MA plans, p. 10).

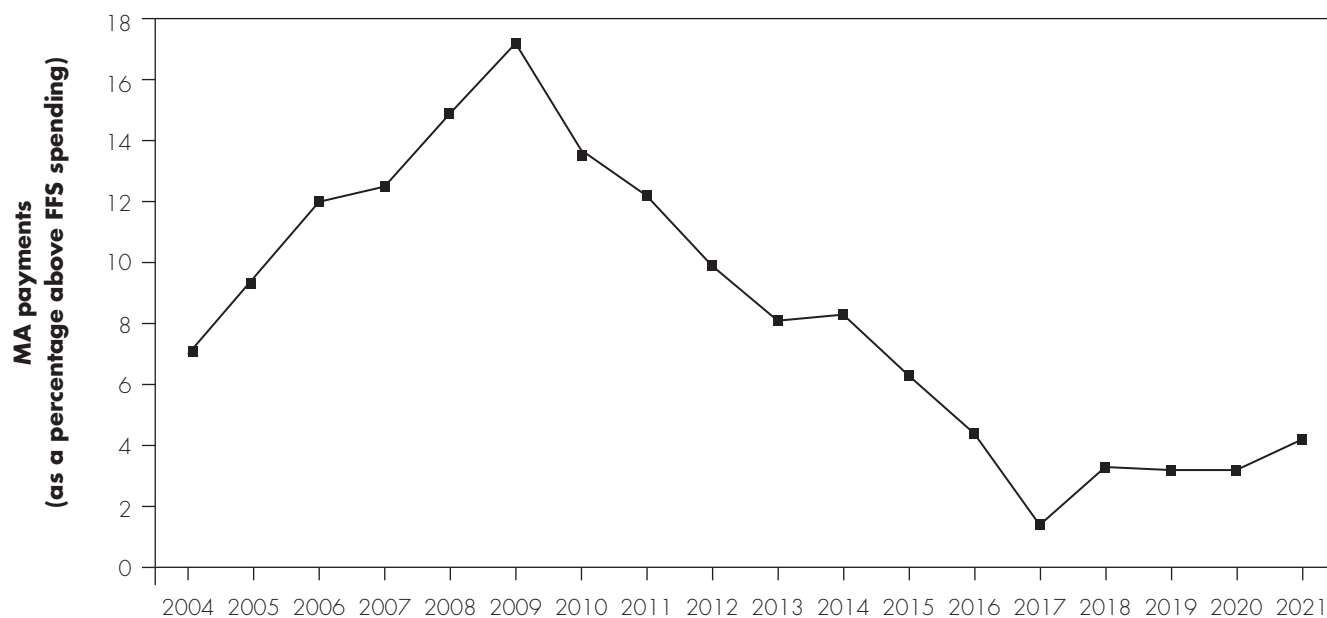
## Aggregate Medicare payments to Medicare Advantage plans have never been lower than fee-for-service Medicare spending

The Commission's review of payments to private plans suggests that over a 35-year history, the many iterations of full-risk contracting with private plans have never yielded aggregate savings for the Medicare program. Throughout the history of Medicare managed care, the program has paid more—sometimes much more—than it would have paid for beneficiaries to have remained in fee-for-service (FFS) Medicare. Evaluations of payment rates to private plans under Medicare demonstrations occurring before

1985 found that payment rates were 15 percent to 33 percent higher than FFS Medicare (Langwell and Hadley 1990). Between 1985 and 2004, risk adjustment was inadequate and led to overall payments to private plans that were higher than comparable FFS Medicare spending (5 percent to 7 percent higher in the late 1980s and through the mid-1990s). Figure 1-1 shows that since 2004, aggregate payments to Medicare Advantage plans have been above the amount FFS Medicare would have spent for similar beneficiaries. ■

**FIGURE 1-1**

**MA plans have not realized aggregate savings for Medicare, 2004–2021**



Note: MA (Medicare Advantage), FFS (fee-for-service). Benchmark increases under the quality bonus demonstration applied from 2012 through 2014 and under the quality bonus program applied starting in 2015. The figure reflects the Commission's estimates of the impact of coding intensity, beginning in 2007. We assume, conservatively, that the coding intensity impact for 2020 and 2021 was the same as for 2019 (the most recent year of data available). The Commission uses the figures for FFS per beneficiary spending that CMS's Office of the Actuary generates to determine the MA benchmarks that plans use when submitting bids. Those FFS spending figures are calculated by summing (1) risk-standardized Part A FFS monthly spending for all Part A enrollees and (2) risk-standardized Part B FFS monthly spending for all Part B enrollees. This method for calculating FFS spending includes all FFS beneficiaries, including those who are enrolled only in Part A or only in Part B, and thus is not perfectly comparable with the MA population, who have both Part A and Part B. We estimated that calculating 2017 FFS spending only for enrollees with both Part A and Part B would yield a result that is about 1 percent higher than the estimate of spending for all FFS enrollees. Assuming that an increase to FFS spending (and benchmarks) would not increase plan bids, comparing MA payments with spending for FFS enrollees with both Part A and Part B would lower the spending estimate about 1 percentage point.

Source: MedPAC reports to the Congress 2006 through 2021.

## **MA plan availability, enrollment, and extra benefit availability continue to increase**

As the ACA changes were phased in, many predicted that the MA program would suffer a major contraction because reductions in plan payments would lead to fewer benefits for enrollees, lower MA enrollment, and lower levels of plan participation. Instead, plans found ways to reduce costs and lower bids by more than enough to keep pace with decreasing benchmarks, leading to increases in plan offerings, higher levels of extra benefits provided to enrollees, and substantial MA enrollment growth in recent years.

Since 2017, with the ACA's changes fully implemented, the share of eligible Medicare beneficiaries (those with Part A and Part B coverage) in MA has grown from 35 percent to 43 percent in 2020.<sup>13</sup> Between 2016 and 2021, the average number of plan choices grew from 18 to 32; the share of Medicare beneficiaries with a zero-premium plan option grew from 81 percent to 96 percent; and the annual value of extra benefits for each enrollee grew by approximately 75 percent, from \$972 to \$1,700 per enrollee.

Our estimates of plan payments do not take into account the impact of the coronavirus pandemic, but given the prospective nature of MA payments, we do not anticipate the pandemic having a substantial effect on our estimates. For our simulations, we use CMS's estimate of 2020 FFS spending, which uses data through 2018 as the basis for 2020 MA benchmarks, bids, and payments. This estimate also represents the FFS spending levels assumed by plans when they submitted bids for 2020 in June of 2019. We do not yet know the full effect of the pandemic on beneficiary spending and risk scores. However, the 2021 record low bid levels relative to FFS spending, record high plan rebates, and wider availability of zero-premium plans indicate that plans anticipate continued ability to offer bids far below payment benchmarks.

For 2021, we estimate that payments to MA plans are about 104 percent of what FFS Medicare would have spent to cover the same enrollees.<sup>14</sup> Despite the higher average payment relative to FFS Medicare, the average plan bid is 87 percent of FFS Medicare spending; moreover, about 91 percent of MA plans, accounting for 87 percent of MA enrollment, have bids below the amount FFS Medicare would spend for similar beneficiaries. These figures demonstrate that MA plans have the ability to provide the Medicare benefit more efficiently than FFS Medicare; however, Medicare continues to pay more for MA beneficiaries because of payment policies and other

aspects of the MA program. The Commission has made recommendations to improve several of these policies (see text box on prior recommendations, pp. 30–32), but additional improvements to the current benchmark system are needed.

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## **Problems with the current benchmark policy**

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Current MA benchmark policy uses a quartile system that generates variation in payments to plans and extra benefits offered to enrollees, but it is out of balance with intended policy goals to maintain wide availability of plans, establish predictable and stable payment rates, support access to valuable extra benefits across geographic areas, and appropriately allocate savings from MA plan efficiency to beneficiaries and the Medicare program.

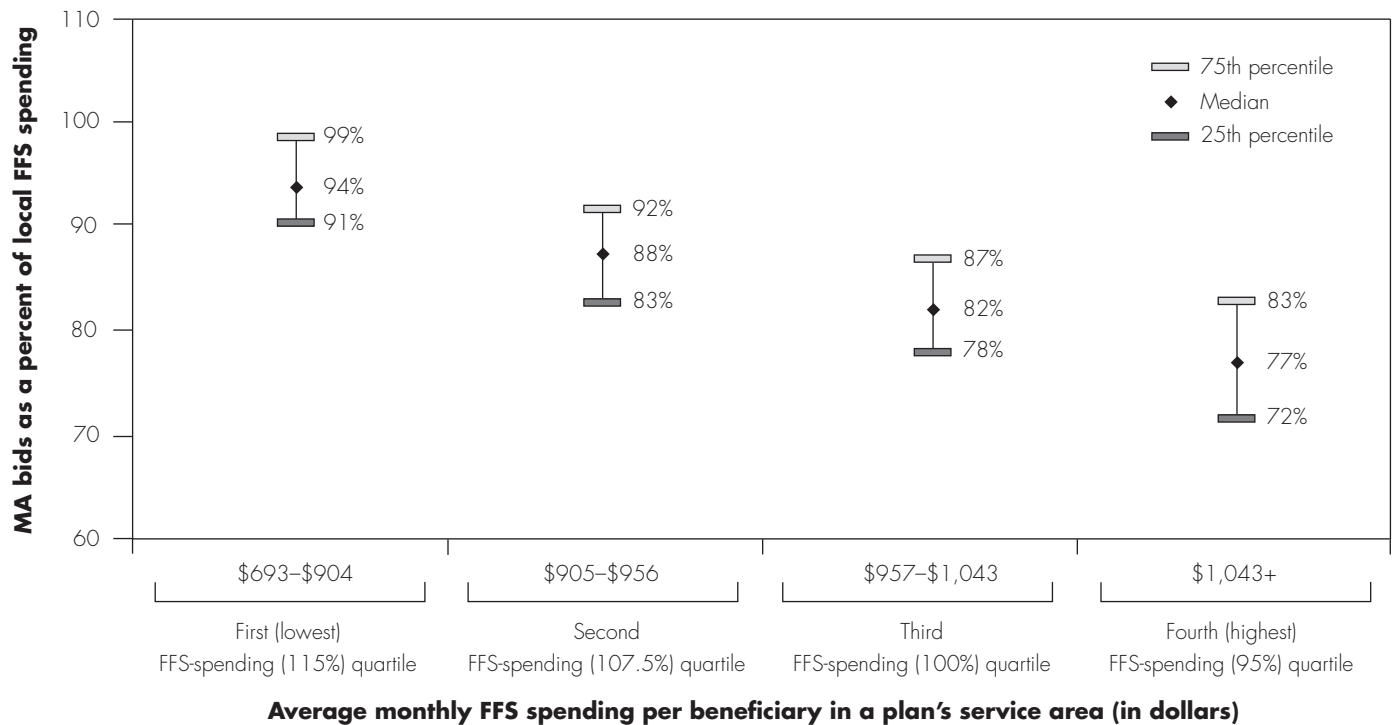
### **Higher benchmarks and payments in areas with low FFS spending attract a disproportionate share of MA enrollees**

The benchmark policy seeks to create similar incentives to enroll beneficiaries across all areas by setting higher benchmarks in areas with low FFS spending to encourage plan offerings and enrollment and setting lower benchmarks in high FFS spending areas to offset higher Medicare payments. However, despite most plans bidding below FFS, current benchmarks support payments (including quality bonuses) that are 9 percent higher than FFS spending in the areas with the lowest FFS spending, which has attracted a disproportionately high share of MA enrollees.

Currently, MA enrollment in areas in the lowest FFS spending quartile (and to a lesser extent in the second-lowest quartile) increases costs for the Medicare program, which both weakens the Hospital Insurance Trust Fund and produces taxpayer, state, and beneficiary costs under Part B (which is financed by general revenues and Part B premiums that all Medicare beneficiaries are responsible for paying). The quartile system enacted by the ACA set higher benchmarks in low-spending areas to ensure broad access to MA plans. But the benchmark level in the areas with the lowest FFS spending (115 percent of FFS) is likely higher than needed to induce plan participation in most areas in this quartile. On average, MA bids in the lowest spending quartile have decreased in recent years relative to FFS spending, declining between 2018

**FIGURE 1-2**

**Most plans in the lowest spending areas bid below estimated FFS spending, 2021**



Note: FFS (fee-for-service), MA (Medicare Advantage). This figure is based on 3,797 plan bids and excludes employer group plans, special needs plans, and plans in the territories. Benchmark percentages within each quartile indicate benchmark quartile factors that are applied to local FFS spending (e.g., counties in the 115 percent quartile have base benchmarks 15 percent higher than local FFS spending). Estimated FFS spending levels in the figure are not affected by the quality bonus payments to plans. FFS spending uses the entire Medicare population (including those who are enrolled only in Part A or only in Part B), standardizes for average risk, geographically aligns with MA plan enrollment, and risk adjusts using MA plan risk scores. However, percentages do not account for unaddressed coding intensity differences, which increased overall MA payments by 3 percentage points in 2019. In addition, the FFS spending denominator used in the figure includes all Part A and Part B spending, but MA enrollees must be enrolled in both Part A and Part B. Comparing plan bids with spending for FFS enrollees with both Part A and Part B would likely decrease the percentages in the figure.

Source: MedPAC analysis of MA bid and rate data, 2021.

and 2021 from 101 percent of FFS to 95 percent of FFS. Most plans in the lowest spending areas now bid below 100 percent of FFS spending (Figure 1-2). In 2021, payments to plans (excluding plans in Puerto Rico) whose enrollment was mainly in counties in the lowest spending quartile were paid about 105 percent of average FFS spending in the plans’ service areas before quality bonuses and paid 109 percent of FFS after benchmarks were increased for quality bonuses (data not shown).

In recent years, the distribution of MA enrollment by quartile has shifted toward the lowest spending quartile where payment benchmarks tend to be far above local FFS spending (Table 1-1). Among nonemployer plans in

2021, plan bids project that 28 percent of MA enrollees will reside in the quartile areas with the lowest spending, up from 26 percent in 2020.<sup>15</sup> In contrast, 22 percent of projected MA enrollees now reside in the quartile areas with the highest spending (down from 24 percent in 2020), where payments tend to be below local FFS spending. As the Commission noted in 2018, the larger share of Medicare beneficiaries residing in the quartile areas with the lowest spending at least partially explains the shift in enrollment toward these areas (Medicare Payment Advisory Commission 2018). In 2018, after the counties were reranked by FFS spending to create quartiles, the share of Medicare beneficiaries living in the 786 lowest spending counties was 22 percent,

**TABLE  
1-1**

**The share of MA enrollment in the lowest FFS spending quartile has increased**

**Share of projected MA enrollment, by quartile**

<b>Quartile of FFS spending</b>	<b>2020</b>	<b>2021</b>
Lowest (benchmark 115% of FFS spending)	26%	28%
Second (benchmark 107.5% of FFS spending)	23	22
Third (benchmark 100% of FFS spending)	27	28
Highest (benchmark 95% of FFS spending)	24	22

Note: MA (Medicare Advantage), FFS (fee-for-service). Each percentage represents MA quartile enrollment (as projected in plan bid data) as a share of MA enrollment among plans that submitted bids. Data exclude employer group waiver plans, which do not submit bids. Actual payment factors in each quartile use an average of the two most recent quartiles (e.g., a county that moves from the 95 percent quartile to the 100 percent quartile will have a payment factor of 97.5).

Source: MedPAC analysis of MA bid and rate data, 2020–2021.

compared with 16 percent of Medicare beneficiaries living in the 786 lowest spending counties in 2012 (data not shown). MA penetration in the lowest spending quartile is also relatively high. In 2020, 44 percent of Medicare beneficiaries living in the lowest spending quartile of counties chose to enroll in MA plans, compared with a national average of 39 percent.<sup>16</sup> At the same time, MA spending in areas with high FFS spending (the 95 percent quartile) has been restrained without any adverse effect on MA enrollment (or the number of plans available to beneficiaries). In 2020, plans whose enrollment was mainly in counties in the highest spending quartile were paid just over 92 percent of the average FFS spending in the plans’ service areas. Even though the Medicare program achieves net savings from MA at the 95 percent quartile, payments to plans were high enough in 2020 for plans to offer benefits that attracted 37 percent of Medicare beneficiaries living in those areas.

**Quartile structure can create large differences in benchmarks despite small differences in county FFS spending**

The quartile structure creates discontinuities in benchmarks, contributing to changes in MA payment rates that can be unpredictable or lack stability over time. The quartile factor applied to local FFS spending jumps by 7.5 percent or 5 percent at three points in the distribution of all counties, ranked by local FFS spending. Notwithstanding policies that mitigate discontinuities directly (e.g., the quartile factor is an average of the last

two years) and indirectly (e.g., the benchmarks that exceed pre-ACA levels of spending are capped), large differences in the quartile factors—despite small differences in FFS spending—can contribute to large differences in benchmarks. Table 1-2 (p. 14) illustrates an example of this inconsistency. County A has an average FFS spending of \$847.98 and County B averages \$847.99. Because neither of them switched quartiles in the last year, County A’s benchmark is set at 115 percent of FFS spending and County B’s benchmark is set at 107.5 percent of the almost identical FFS spending.<sup>17</sup> Despite only a one-percent difference in FFS spending, the quartiles produce a \$63.59 difference in benchmarks. In fact, County A’s \$975.18 benchmark is among the highest within the 115 percent quartile. Examples of similar discontinuities can occur between each quartile. Such discontinuities, and the resulting instability in payment rates over time, could be eliminated by using a continuous function to translate local FFS spending in benchmarks.

**The current benchmark policy creates variation in the availability of extra benefits for beneficiaries**

The large difference between bids and benchmarks has led to total rebate dollars that are the highest in the program’s history—increasing between 2016 and 2021 from 8 percent to 14 percent of MA payment—but beneficiaries’ access to rebate-funded extra benefits varies across the country. In the highest FFS spending areas, plan bids, on



**TABLE  
1-2**

**Illustrative example of how quartile factors create discontinuities in MA benchmarks relative to FFS spending, 2020**

County	FFS spending	Quartile factor	MA benchmark
A	\$847.98	115%	\$975.18
B	\$847.99	107.5	\$911.59

Note: MA (Medicare Advantage), FFS (fee-for-service). MA benchmarks (excluding quality bonuses) are the product of FFS spending and the quartile factor. Current law requires quartile factors to be calculated based on a ranking of projected FFS spending in the prior year (in this case, 2019).

Source: MedPAC analysis of MA rate data, 2020.

average, are lower relative to benchmarks than among plans in lower FFS spending areas (Table 1-3). Because the difference between a plan’s bid and its benchmark tends to be greater in high FFS spending areas, plans in those areas must offer more extra benefits (or benefits of greater value) relative to plans in low FFS spending areas. This relatively large difference between plan bids and benchmarks suggests that benchmarks in the highest spending quartile could be reduced, making access to extra benefits more similar for beneficiaries in all geographic areas, while still allowing plans to provide substantial extra benefits to beneficiaries.

**Under current benchmark policy, Medicare finances MA supplemental benefits at levels that eliminate potential program savings**

As benchmarks decreased under the ACA, plans found ways to reduce costs and lower their bids, but overall savings to the Medicare program have been elusive. In 2021, MA plans bid an average of 87 percent of FFS spending—an all-time low—demonstrating that MA plans can provide the Medicare benefit more efficiently than FFS Medicare. Benchmark and rebate policies determine how these plan efficiencies are allocated to enrollees in the form of extra benefits or to the Medicare program as savings relative to expected Medicare FFS spending. However, the current policy is unbalanced. Because the average benchmark is well above FFS spending, rebates that plans receive result in overall spending above expected FFS spending. The rebate dollars that plans receive from the Medicare program are used to finance extra benefits. While plan enrollees are the recipients of these substantial extra benefits, plans also benefit from additional administrative fees and profit that they load onto most extra benefits.

Benchmark policy largely determines the imbalance of plan efficiency, rebates, and lack of overall program savings. After the current (ACA) benchmark policy was fully phased in, plans continued to lower their bids, yet overall benchmarks have remained at 107 percent to 108 percent of FFS spending for the last four years. Unsurprisingly, the value of extra benefits has reached a record high in each of the last five years. In 2021, extra benefits account for 14 percent of all payments to MA plans. However, the high level of MA benchmarks continues to prevent plan efficiency from translating into aggregate Medicare program savings. Changes to the current benchmark structure are necessary to enable the program to share in savings from MA efficiencies.

As the dollar value of extra benefits has grown, a related concern is the limited ability to assess the value of the increasing level of Medicare program spending on extra benefits. The value to beneficiaries of reductions in cost sharing and premiums is clear because these benefits are akin to discounts for service users (cost-sharing reductions) or cash savings (premium reductions). However, the share of rebates allocated to these extra benefits has declined overall—leaving a greater share of rebates for other supplemental benefits where there is more uncertainty about utilization or efficacy.

Historically, the greatest amount of extra benefit funding has gone toward cost-sharing reductions, where plans reduce coinsurance, copayments, and deductibles from FFS levels. Medicare beneficiaries, who are often on fixed incomes, may find this benefit attractive as MA plans often have lower out-of-pocket expenses (cost sharing plus premiums) than Medigap coverage (Mike et al. 2019).<sup>18</sup> (Some beneficiaries may receive reduced cost

**TABLE  
1-3****Plans in the areas with highest spending bid lower relative to their benchmarks, creating geographic differences in rebate dollars****MA bids as a share of benchmarks, by quartile**

<b>Quartile of FFS spending</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>
Lowest (benchmark 115% of FFS spending)	86%	85%	83%	82%
Second (benchmark 107.5% of FFS spending)	86	85	83	81
Third (benchmark 100% of FFS spending)	84	83	82	80
Highest (benchmark 95% of FFS spending)	80	79	79	78

Note: MA (Medicare Advantage), FFS (fee-for-service). CMS assigns quartiles at the county level, but a plan's service area includes one or more counties. Therefore, quartiles in the table are assigned using the average monthly FFS spending per beneficiary in a plan's entire service area. Plans that bid lower relative to their benchmarks offer more extra benefits (or benefits of greater value) than plans that bid higher relative to their benchmarks. Data exclude employer group waiver plans and special needs plans.

Source: MedPAC analysis of MA bid and rate data, 2018–2021.

sharing through an employer-sponsored plan or through Medicaid.) However, as MA rebate levels have increased, plans have allocated smaller shares of rebate dollars toward reducing beneficiary cost sharing (Table 1-4). In 2021, MA plans allocated 46 percent of MA rebate dollars toward cost sharing—down from 52 percent in 2018. This trend suggests that many MA plans do not need or want to allocate additional rebate dollars for this benefit out of concern that reductions in cost sharing that are too generous may induce demand for additional, potentially unnecessary services. Such induced demand has been found to occur in FFS when beneficiaries have

first-dollar Medigap coverage (i.e., no cost sharing for any Medicare services) (Medicare Payment Advisory Commission 2012). If a plan has allocated the maximum amount to reduced cost sharing that the plan is willing to allocate, the plan needs only to allocate additional rebate funding to keep up with medical inflation. From 2020 to 2021, the growth rate in per member cost-sharing rebate dollars (5 percent) was nearly identical to the expected per capita growth rate in FFS spending (5.7 percent; data not shown). This leveling off of cost-sharing rebate dollars suggests that, on average, plans are no longer increasing the actuarial value of cost-sharing reductions.

**TABLE  
1-4****MA plans have used a decreasing share of rebate dollars on beneficiary cost-sharing and premium reductions****Share of rebate dollars allocated by MA plans**

<b>MA extra benefit</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>
Cost-sharing reductions	52%	51%	49%	46%
Part D premium buydown	16	15	13	15
Part B premium buydown	1	1	2	2
Other supplemental benefits	30	33	36	38

Note: MA (Medicare Advantage). Each percentage represents the share of MA rebate dollars allocated toward each type of extra benefit in plan bids. Data exclude employer group waiver plans, special needs plans, and plans that serve U.S. territories. Totals may not sum due to rounding. Between 2018 and 2021, average rebates per month increased from \$95 to \$140.

Source: MedPAC analysis of MA bid and rate data, 2018–2021.

In addition, MA plans have not devoted a larger share of rebate dollars to direct premium reductions for MA enrollees. Between 2018 and 2021, the plan share of rebate dollars for premium reductions has remained roughly constant, from 16 percent to 15 percent for Part D and from 1 percent to 2 percent during the same period for Part B. Rebates are rarely used to lower Part B premiums, which provides a financial benefit to all enrollees in a given plan (as compared with benefits that only some enrollees use, such as in-network dental care or a foreign travel benefit). Because a premium-reduction benefit is given—not just offered—to all enrollees, it generally costs plans more per enrollee to provide. In addition, MA plans are not permitted to allocate administrative costs and profit toward premium reduction.<sup>19,20</sup> Plans therefore have a financial disincentive to offer this benefit. Only 4 percent of 2021 MA general enrollment was projected to be in these premium-reduction plans (Figure 1-3).<sup>21</sup>

MA plans have allocated an increasing share of rebate dollars toward coverage of other MA supplemental benefits, and these benefits could be used to address issues related to health equity. However, the benefits that plans most commonly offer focus on the broader MA population rather than populations that have the greatest social or medical needs (Figure 1-3). We examined the 10 supplemental benefits offered most often for general enrollment MA plans (i.e., excluding special needs plans (SNPs) and employer plans). Many of the most commonly offered supplemental benefits appear to be tailored toward relatively healthy beneficiaries. Four of the top five most common supplemental benefits addressed coverage for international travel, fitness benefits that typically consist of a gym membership, or coverage for an annual physical exam, the efficacy of which has been questioned (Prochazka and Caverly 2013, Society of General Internal Medicine 2017).<sup>22</sup>

Common supplemental benefits with more obvious health value to beneficiaries were discounts on dental, vision, and hearing services.<sup>23</sup> These benefits may be of particular value to low-income, non-dual-eligible beneficiaries, who may view MA plans that offer these benefits as financially attractive. However, we do not have reliable data about the use of these benefits and cannot determine their value relative to the amount Medicare spends on them.<sup>24,25</sup> Limited evidence on MA dental claims suggests that—though oral health is important—relatively few enrollees with embedded dental coverage utilize these benefits, and users are disproportionately those in better

health (Wix and Fontana 2020).<sup>26</sup> Similarly, one study of claims data from a large private payer found that—though hearing loss is associated with declines in mental health and cognition—relatively few aged enrollees received any hearing aid services after being diagnosed with hearing loss, and hearing aid use was disproportionately higher among white enrollees (Mahmoudi et al. 2019).<sup>27,28</sup> In addition, benefits for dental, vision, and hearing are not standardized, and plans offer a vast array of benefits for the same service.<sup>29</sup> For example, among the 2,400 MA plans with a hearing aid benefit in 2016, there were 123 unique variations of hearing aid coverage—by in-network or out-of-network providers; by type of hearing aid; by type of cost sharing (copayments or coinsurance); and, most commonly, by a dollar limit on the amount of coverage (Medicare Payment Advisory Commission 2017). Beneficiaries are likely to find it difficult to choose the best plan for coverage of supplemental benefits, raising concerns about whether these benefits are being administered efficiently for both beneficiaries and the Medicare program.<sup>30</sup>

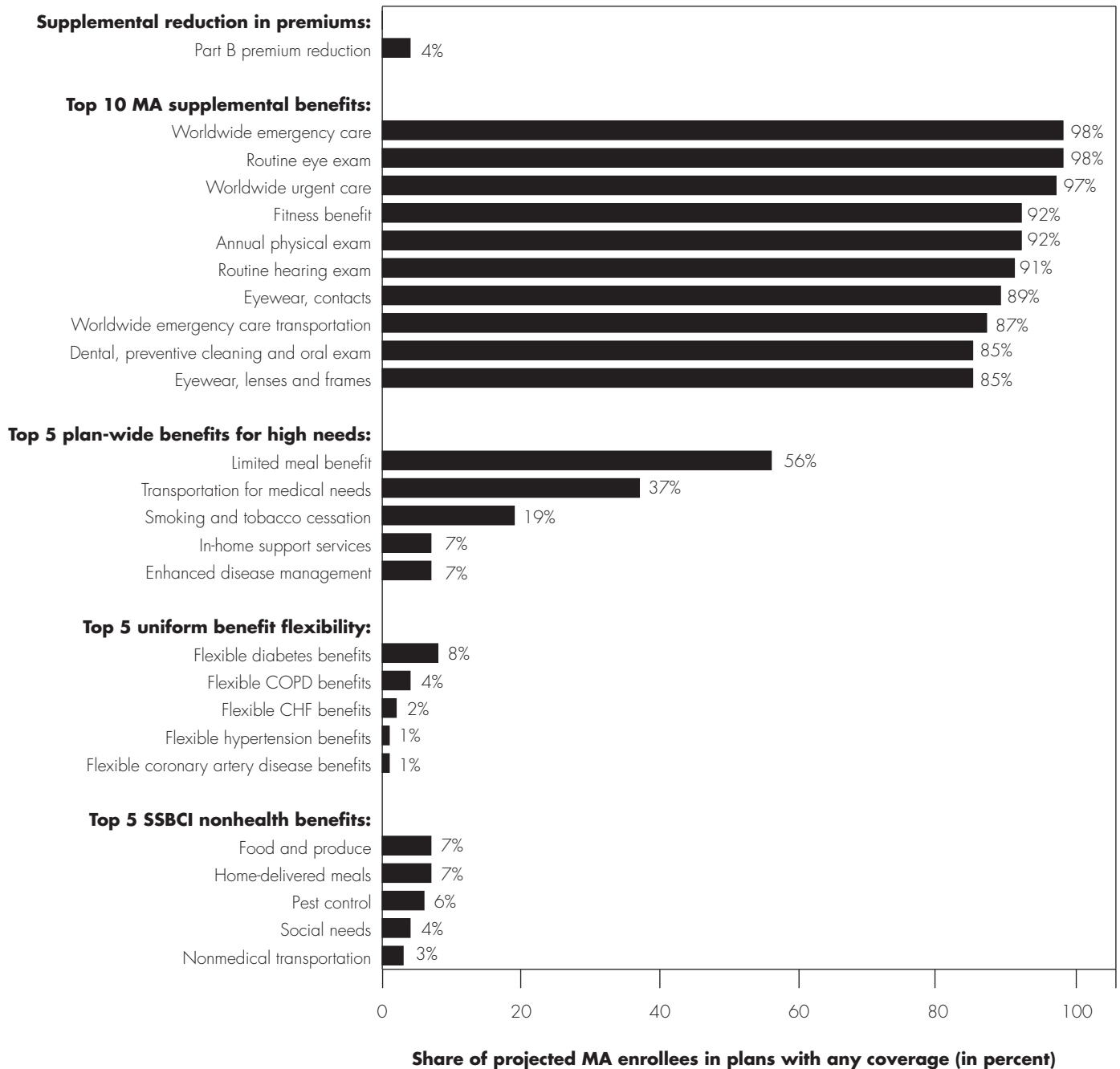
Further, while MA coverage of dental, vision, and hearing services provides essential access for some beneficiaries, it is not clear that these benefits drive beneficiary choice of plans. Evidence suggests that cost sharing and premiums drive beneficiary plan selection (Jacobson et al. 2014). Studies have found that beneficiaries entering MA were highly likely to choose the lowest premium plan option (Jacobson et al. 2014, Meyers et al. 2019, Skopec et al. 2019). These studies did not include the influence of any Part B premium reductions. While relatively few MA enrollees voluntarily switch MA plans, premiums are a dominant factor when plan switching does occur (Jacobson et al. 2016, Medicare Payment Advisory Commission 2015, Meyers et al. 2019). Additionally, in interviews, insurance brokers noted that Part B premium reductions were important in some parts of the country and were most attractive to low-income beneficiaries (Medicare Payment Advisory Commission 2015).

We also examined plan-wide supplemental benefits that target populations with high needs; coverage for these benefits was generally not common.<sup>31</sup> A limited meals benefit related to temporary medical needs was the most common among these benefits (56 percent of projected MA enrollees covered), but all others were far less common. Nonemergency medical transportation covered 37 percent of projected MA enrollees, and less than 10 percent of projected enrollees were covered by in-home



**FIGURE  
1-3**

**The MA supplemental benefits currently offered to most enrollees do not focus on high-needs populations, 2021**



Note: MA (Medicare Advantage), COPD (chronic obstructive pulmonary disease), CHF (congestive heart failure), SSBCI (special supplemental benefits for the chronically ill). This figure is based on 3,821 plan benefit packages and plan projected enrollment in bid data; the figure excludes plans with enrollment restrictions, such as employer group plans and special needs plans. The figure does not include Part D extra benefits or MA optional supplemental benefits (benefits beneficiaries can opt into and pay a separate premium for to cover the cost). Limited meal benefits are of limited duration and either follow an inpatient stay or are part of an established medical treatment. Uniform benefit flexibility allows MA plans to design disease-specific benefits; the figure includes plan flexibilities offered under the value-based insurance design model that also allows benefit design specific to socioeconomic status. SSBCI are supplemental benefits that are not primarily health related and may be offered non-uniformly to eligible chronically ill enrollees who are at risk of adverse health outcomes and require intensive care coordination.

Source: MedPAC analysis of MA bid and plan benefit package data for general enrollment plans, 2021.

support services and enhanced disease management (Figure 1-3, p. 17). Among dual-eligible SNPs (D-SNPs), nonemergency medical transportation (86 percent of projected enrollees covered) and limited meals (74 percent of projected enrollees covered) were commonly offered, but most MA enrollees are not eligible for D-SNP enrollment (data not shown).

In addition, most plans in 2021 did not choose to offer special supplemental benefits that are targeted exclusively for enrollees with specific medical or social needs (Figure 1-3, p. 17). Plans have two general options for targeting benefits to specific groups of enrollees: flexibility of the uniform benefit requirement (starting in 2019) and special supplemental benefits for the chronically ill (SSBCI) (starting in 2020). Most plans did not offer supplemental benefits that target enrollees with high needs through either uniform benefit flexibility or CMS's Center for Medicare and Medicaid Innovation value-based insurance design model. These flexibilities allow MA plans to offer additional benefits or cost-sharing reductions based on specific diseases or socioeconomic status. However, the most commonly targeted group was beneficiaries with diabetes, and only 8 percent of projected MA enrollees were in a plan that used this flexibility.<sup>32</sup> Among D-SNPs, the most commonly targeted group was beneficiaries of low socioeconomic status, and 40 percent of projected MA enrollees were in a plan that used this flexibility (data not shown).<sup>33</sup> Additionally, SSBCI were only sparsely covered among general enrollment MA plans. These supplemental benefits are not primarily health related and may be offered nonuniformly to eligible chronically ill enrollees who are at risk of adverse health outcomes and require intensive care coordination. The most common of the SSBCI were food and produce, which was available only to 7 percent of projected MA enrollees. SSBCI were more common among D-SNPs (data not shown), but coverage of SSBCI was relatively low given the needs of the population that D-SNPs serve.<sup>34</sup> As plans become accustomed to administering SSBCI, these benefits may become more common, but we currently do not have utilization data for these (or any) supplemental benefits and are unable to assess their efficacy or their value to beneficiaries.

Finally, the supplemental benefit policy provides an incentive for plans to allocate rebates to cost-sharing reductions (although this incentive is limited by the potential for induced utilization) and supplemental benefits. Plans can apply administrative costs and profit to these extra benefits. For supplemental benefits in 2021,

15 percent of rebate dollars was devoted to administrative costs and profits. In contrast, MA plans are not allowed to apply any administrative cost or profit to rebate dollars allocated to reducing premiums. Overall, standardizing some types of supplemental benefits could potentially help beneficiaries choose a plan with higher value for their needs. Improved availability of supplement benefit utilization data would help policymakers assess the value of supplemental benefits and help ensure that Medicare beneficiaries and the program receive good value for these services, which represent a growing share of payments to MA plans.

### **Current benchmark policy does not leverage plan efficiencies**

Consistent with the original incorporation of full-risk private plans in Medicare, we expect plans to be more efficient than FFS Medicare, and the Medicare program should be able to capitalize on such efficiency as a means of improving the fiscal outlook of the Medicare program. MA plans have more tools to control costs relative to FFS, such as narrower provider networks and prior authorization. To entice enrollees to accept the constraints of these cost controls, plans must have an out-of-pocket cap on cost sharing for the basic Medicare benefit, and plans increase enrollment by offering beneficiaries extra benefits. Improved plan efficiencies have led to more competitive bids that enable plans to offer greater coverage of extra benefits. However, these taxpayer-subsidized extra benefits are at an all-time high level, accounting for 14 percent of Medicare's payments to MA plans. In addition, Medicare Part B premiums—which are paid by beneficiaries in both FFS and MA—are used in part to finance extra benefits that only MA beneficiaries receive. Furthermore, nearly all Medicare beneficiaries (99 percent) have access to an MA plan that bid below FFS spending, and—on a per member dollar basis—MA is far more profitable for insurers relative to the individual and group markets (Jacobson et al. 2019a, McDermott et al. 2020). Plan efficiency could be more directly leveraged through revisions to the benchmark policy.

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### **Simulating an alternative benchmark policy**

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Over time, improvements in plan efficiency have led to higher rebates, more extra benefits offered to beneficiaries, and higher MA enrollment. The Commission contends

that the Medicare program should share in the efficiencies obtained through the MA program. Thus, we consider an alternative to the current benchmark policy for the near term that generally maintains the current bidding processes and structure but rebalances the allocation of MA efficiency and geographic subsidies for extra benefits.

A revised benchmark policy should have four attributes: maintain wide availability of plans, establish predictable and stable payment rates, support equal access to extra benefits across geographic areas, and appropriately allocate MA plan efficiency to beneficiaries and the Medicare program. A number of alternatives to the current benchmark policy could accomplish one or two of these goals. Our preferred approach to satisfying all four goals is one that would continue to set a range of benchmarks, with higher benchmarks in low-spending areas (to ensure plan participation) and lower benchmarks in high-spending areas (to encourage efficient delivery of care), but would reduce benchmarks for most areas. Benchmarks in the two lowest spending quartiles (those currently set at 115 and 107.5 percent of FFS spending) would be brought much closer to FFS spending now that most plans in those areas bid below FFS spending, while benchmarks in the highest spending quartile (those currently set at 95 percent of FFS spending) would be further reduced. Reducing benchmarks would provide a more balanced approach that reduces subsidies in low-spending FFS areas while modestly increasing financial pressure on high-spending FFS areas where plans bid the lowest relative to their benchmarks and thus generate disproportionately more rebate dollars in the extra benefits plans can offer. The new benchmarks can maintain existing levels of reduced cost sharing for beneficiaries who enroll in MA plans. To improve continuity and stability, benchmarks would be set on a continuous scale of local FFS spending. To improve incentives for plan efficiency, rebates would be set at a level more reflective of the level of financial risk plans are taking. Overall, program savings would be integrated into benchmarks to ensure that the Medicare program receives at least a small share of plan efficiencies.

Under this policy option, the current quartile structure would be replaced with a system blending local area and national per capita FFS spending and applying a discount factor.<sup>35</sup> This alternative benchmark approach would address the problems with current benchmarks discussed in the preceding section and would incorporate the Commission's current set of recommendations on MA benchmarks:

- Calculate estimates of county FFS spending using beneficiaries enrolled in both Part A and Part B. Current policy calculates county FFS spending based on all beneficiaries, including those with Part A only or Part B only. Calculating benchmarks using only beneficiaries with Part A and Part B increases benchmarks relative to current policy.<sup>36</sup>
- Eliminate the ACA's benchmark caps, which cap any county's benchmark at the higher of (1) its pre-ACA level, projected into the future with a legislatively modified national growth factor and (2) 100 percent of its estimated FFS spending in the current year. The cap disproportionately affects counties in the areas with lowest spending. Eliminating benchmark caps increases benchmarks relative to current policy.
- Decouple star ratings from rebates by removing differential rebate percentages based on star ratings. In June 2020, the Commission recommended eliminating quality bonus increases to benchmarks and replacing that system with a plan-financed MA value incentive program (MA-VIP) that distributes higher payments to plans that perform well within geographically defined areas. That recommendation did not address the MA rebate policy. Our alternative benchmark approach is separate from that recommendation and would replace the current rebate policy—that depends on star ratings—with a 75 percent rebate for all plans, the rebate percentage that was used before the implementation of the MA quality bonus program. Increasing the rebate percentage provides a greater incentive for plan efficiency and directly helps maintain basic supplemental benefits for MA enrollees. In addition, a 75 percent rebate aligns with the highest shared savings rate (75 percent) in the Medicare Shared Savings Program for accountable care organizations that take on the highest risk. If the alternative benchmark approach were implemented, incentives for plan quality would largely continue unabated through the MA quality bonus program or those incentives could be substantially improved through the Commission's prior recommendation on the MA-VIP.
- Use local market areas, rather than counties, as the payment areas for benchmarks (consistent with prior Commission recommendations to establish geographic areas for payment to MA plans). The alternative benchmarks would be based on payment areas that aggregate counties within each state according to

metropolitan statistical areas for urban counties and health service areas (as defined by the National Center for Health Statistics) for nonurban counties. However, because plan bids and benchmarks are currently based on counties, we use county-level plan payments and rebates to compare benchmark alternatives with current policy.

To test the feasibility of our alternative benchmark policy, we conducted simulations comparing benchmarks and payments under our alternative approach to current base benchmarks (i.e., benchmarks without any quality bonus increase) using 2020 bid and spending data. We conducted these simulations and comparisons on base benchmarks to isolate the effect of replacing the current benchmark policy with the alternative approach, independent of the Commission’s recommendation to replace the current quality bonus program with the MA–VIP (Medicare Payment Advisory Commission 2020). In 2020, base benchmarks under current policy are an estimated 103 percent of FFS spending and would be 102 percent of FFS spending if benchmarks were calculated using the FFS population with both Part A and Part B coverage, as the Commission recommended in 2017.<sup>37</sup> Simulations (assuming no quality bonus payments) show that our alternative policy for formulating benchmarks could lower Medicare spending with little disruption to plan availability. Simulations also show how our alternative benchmark policy can be calibrated over time by adjusting the weighting of local and national spending amounts or the discount factor.

Our estimate of MA payments relative to FFS spending does not directly account for coding differences or other potential factors with more measurement uncertainty, such as the potential for a favorable selection of beneficiaries enrolling in an MA plan or for enrollees who choose to exit MA for FFS. Our estimates also do not incorporate various forms of potential “spillover” (e.g., changes in FFS provider practice patterns that may occur in areas with high MA market shares that reflect providers’ adaptation to MA utilization management techniques, or potential spillover into MA from FFS alternative payment models), or any effect of retrospective MA and FFS improper payment remittances.<sup>38</sup> Although these factors may affect some estimates in this chapter, their net effect does not affect the merit of replacing the current benchmark policy with the proposed alternative policy.

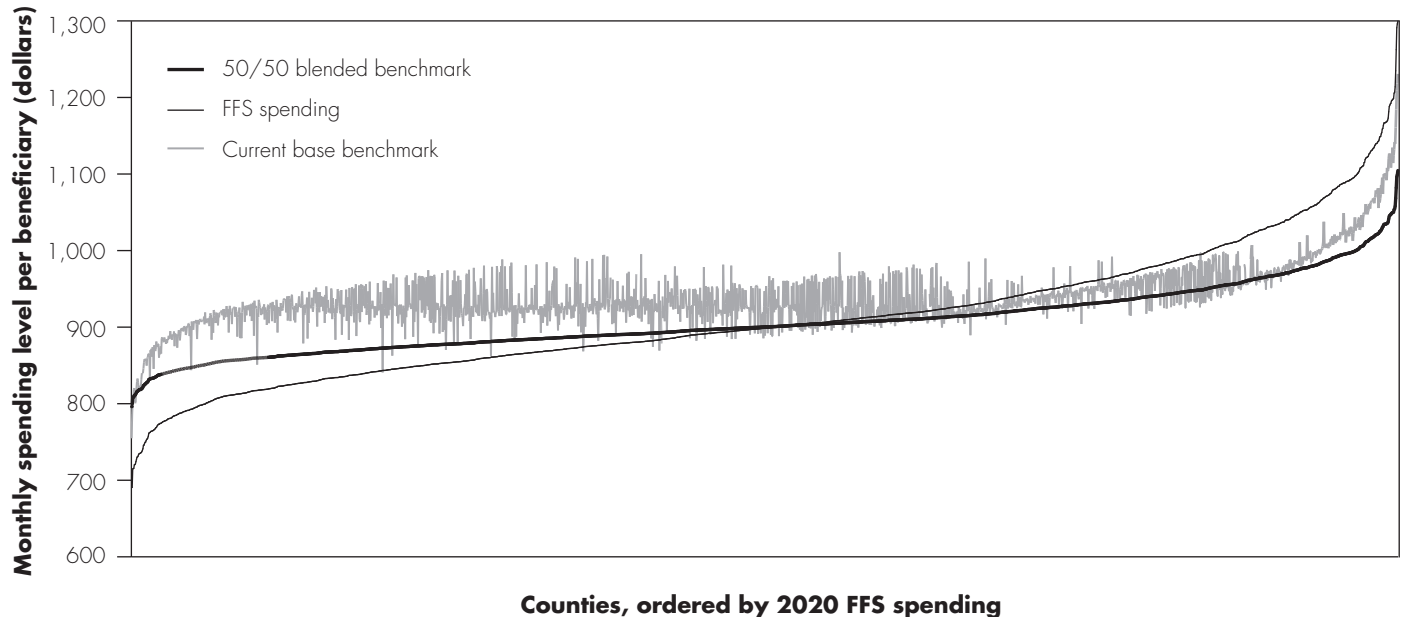
In developing our alternative benchmark policy option, we considered the following parameters:

- ***The weight of local and national spending in the blend.*** A 50/50 blend meets the Commission’s preferences for additional financial pressure on both the highest and lowest spending areas. Increasing the local area weight (e.g., 90 percent local area spending and 10 percent national spending) would move all benchmarks closer to FFS spending. Decreasing the local weight (e.g., 10 percent local area spending and 90 percent national spending) would increase benchmarks in low-spending areas further above FFS and decrease benchmarks in high-spending areas further below FFS spending.
- ***Whether benchmarks should have a floor and ceiling relative to local FFS spending.*** Depending on the weight given to local FFS spending, blending local and national FFS spending could result in benchmarks that are (1) lower than the current quartile factor of 95 percent of FFS for the highest spending areas and (2) higher than the current quartile factor of 115 percent of FFS for the areas with lowest spending. Using local market areas instead of counties and using a local area weight of at least 50 percent mitigates the extreme values that would necessitate the establishment of a floor and ceiling. In our simulations that equally blended local and national FFS spending, we examined the average bid within each MA market and determined that a floor and ceiling were not likely necessary.<sup>39</sup>
- ***Applying a 75 percent rebate.*** The existing rebate percentage policy varies from 50 percent to 70 percent based on star ratings from the quality bonus program. Under our estimates, a flat 75 percent rebate for all MA contracts decouples rebates from the MA star ratings, aligns incentives with other alternative payment models, and helps efficient plans maintain basic supplemental coverage for enrollees by offsetting reductions in benchmarks from applying the 50/50 blend.
- ***Applying a 2 percent discount rate to ensure Medicare program savings.*** While we estimate the effect of our alternative benchmark policy relative to plan payments without quality bonus dollars (equivalent to 103 percent of FFS spending), our benchmark alternative also makes adjustments that increase MA payments (i.e., adjusting our FFS spending to include only the population with both Part A and Part B coverage, removing benchmark caps, and increasing the rebate percentage). Therefore,



**FIGURE  
1-4**

**A blended approach would keep benchmarks above local FFS in low-spending areas and below local FFS in high-spending areas, 2020**



Note: FFS (fee-for-service). We used CMS’s estimate of FFS spending for 2020 benchmark calculations and made adjustments to better reflect spending for the FFS population with both Part A and Part B coverage. Base benchmark includes the cap on benchmarks. The 50/50 blended benchmark is 50 percent weighted with local area spending per capita and 50 percent weighted with standardized national FFS spending per capita. National FFS spending uses standardized wages and eliminates adjustments made to FFS payments for graduate medical education and indirect medical education.

Source: MedPAC analysis of 2020 MA rate data and FFS spending.

in order for the Medicare program to achieve overall savings, the Commission’s alternative approach claims a modest share of plan efficiencies—2 percent savings.

**Base all benchmarks on a blend of local and national FFS spending**

In our alternative benchmark policy, each area’s benchmark is based on a 50/50 blend of per capita local FFS spending and price-standardized national per capita FFS spending (measured by service use at standardized wages). A 50/50 local and national weight aims to help plans move from the current quartile payment system to benchmark levels that allow for both plan availability and overall program savings. The benchmark blend ensures a continuous scale of local spending (ordered lowest to highest) but reduces the overall variation by adjusting spending estimates toward a central, national spending estimate. The blend accommodates the availability of

MA plans both in areas where FFS spending is high and in areas where it is low (Figure 1-4). A 50/50 blend of local and national FFS spending would keep benchmarks above local FFS in low-spending areas and below local FFS in high-spending areas. In addition, the blended approach would eliminate the pervasive variation in current base benchmarks relative to local FFS spending (i.e., the numerous peaks and valleys in Figure 1-4), which are created by quartile payment factors (based on the prior two years’ estimates of local area FFS spending), benchmark caps, and FFS spending estimates that include beneficiaries who do not have both Part A and Part B coverage.<sup>40</sup> In conjunction with a local and national blend, policymakers could use a phase-in approach to increase the weight of the local spending in the blend for low-spending areas (where MA payments are currently above FFS spending), which would gradually reduce benchmarks in those areas closer to local FFS spending.

**TABLE  
1-5**

**MA benchmarks based on a 50/50 blend of local and national FFS spending would decrease benchmarks in both low-spending and high-spending areas**

**MA benchmark as a share of FFS spending (ordered by local area FFS spending)**

<b>Benchmark policy</b>	<b>1st percentile</b>	<b>10th percentile</b>	<b>25th percentile</b>	<b>50th percentile</b>	<b>75th percentile</b>	<b>90th percentile</b>	<b>99th percentile</b>
Current base benchmark	114%	113%	107%	100%	97%	94%	93%
Local FFS weight/national FFS weight:							
10/90	119	109	105	99	92	85	73
30/70	115	107	104	100	94	88	79
<b>50/50</b>	<b>110</b>	<b>105</b>	<b>103</b>	<b>100</b>	<b>96</b>	<b>92</b>	<b>85</b>
70/30	106	103	102	100	97	95	91
90/10	102	101	101	100	99	98	97

Note: MA (Medicare Advantage), FFS (fee-for-service). We used CMS’s estimate of FFS spending in 2020 for benchmark calculations and adjusted that estimate to better reflect spending for the FFS population with both Part A and Part B coverage. The current base benchmark includes the cap on benchmarks. National FFS spending standardizes the spending for per capita service use and eliminates adjustments made to FFS payments by hospital wage indexes, geographic practice cost indexes, graduate medical education, and indirect medical education.

Source: MedPAC analysis of 2020 MA rate data and FFS spending.

**How to weight local FFS and national FFS spending in a blended benchmark**

To simulate our alternative benchmark structure, we use a balanced approach of a 50/50 blend of local FFS and national FFS spending. We compare the distribution of alternative benchmarks relative to current base benchmarks (Table 1-5). The current base benchmarks listed in Table 1-5 are not equivalent to the current quartile factors relative to FFS (115 percent, 107.5 percent, 100 percent, or 95 percent) because they include the current benchmark cap policy and are compared with FFS spending after adjusting for the population with both Part A and Part B coverage. Relative to current base benchmarks, a 50/50 blend decreases benchmarks in both the areas with lowest spending and the areas with highest spending.

We found the 50/50 blend reasonably balances the allocation of plan efficiency to enrollee extra benefits and the Medicare program. In contrast, blends that were not of relatively equal weight would not adequately address the Commission’s concerns about current benchmark policy. Starting with a local FFS weight far above 50 percent could put excessive financial pressure on plans in the lowest spending areas—potentially putting basic supplemental coverage for cost sharing at risk for

many MA enrollees in these areas—while applying insufficient pressure on plans in the areas with highest spending, where MA bids are already lowest relative to their benchmarks. For example, when applying a higher local weight in each area equivalent to a 90/10 blend, the lowest spending areas would be closer to parity with local area FFS spending, but the highest spending areas would have increased benchmarks relative to current base benchmarks. Conversely, decreasing the local weight far below 50 percent would not adequately address one of the primary problems with benchmarks—driving MA enrollment toward areas where Medicare pays more for MA enrollees than for FFS beneficiaries. In addition, weighting local FFS far below 50 percent could add excessive financial pressure in the areas with the highest spending, which could discourage enrollment in some areas where MA is achieving Medicare savings.

One related consideration for policymakers is whether Medicare should permanently allow some benchmarks to be above FFS spending in the areas with lowest spending or gradually decrease benchmarks closer to 100 percent of local area FFS spending in these areas. One option would be to start with a 50/50 blend in all areas and gradually reduce benchmarks only in areas that have benchmarks above FFS spending (generally

low-spending areas). This approach would keep a 50/50 blend in high-spending areas (where local FFS spending is above national standardized spending) and gradually transition from a 50/50 blend to a higher local FFS weight (e.g., 90/10) in the low-spending areas. Given the already disproportionate impact on low-spending areas from a 50/50 blend, we did not simulate this approach.

### **Market-level plan bids were lower than blended benchmarks, mitigating the need for a benchmark ceiling and floor**

As shown in Table 1-5, our alternative benchmark structure with a 50/50 blend of local and national FFS spending results in benchmarks below the current base benchmark of 95 percent of FFS. Establishing a benchmark floor would prevent benchmarks in high-spending areas from deviating too far from local FFS spending. Given the propensity of MA plans in high-spending areas to bid further below FFS spending (Figure 1-2, p. 12), some financial pressure below 95 percent of FFS could be appropriate (e.g., 90 percent of FFS spending), and a floor of 95 percent could reduce the program savings resulting from a blended benchmark proposal. We simulated blended benchmarks using MedPAC market areas and found only 5 benchmark areas (out of 856 total MA benchmark areas) with a blended benchmark less than 90 percent of local FFS spending.<sup>41</sup> The average bid (weighted by enrollment) in these areas ranged from 83 percent to 88 percent of FFS spending. Across all market areas nationally, nearly all (99 percent) had an average MA bid below the 50/50 blended benchmark (Figure 1-5, p. 24). Ninety percent of market areas had an average bid more than 5 percent below the 50/50 blended benchmark. Thus, while it may be worthwhile to have a floor relative to FFS spending to protect plans that currently produce savings for Medicare, it is not essential in the vast majority of markets. Therefore, we did not incorporate a floor or ceiling in our simulations. Moreover, plans in most markets would bid far below their benchmark—opening the possibility for further financial pressure.

### **The rationale for a rebate of at least 75 percent**

The rebate percentage (i.e., the share of the difference between the plan bid and benchmark) determines the amount that plans bidding below the benchmark are paid to fund extra benefits. Under current policy, a plan's rebate percentage is typically 65 percent or 70 percent. While these rebate percentages are dependent on a plan's star rating, incentives are weak and do not align with the

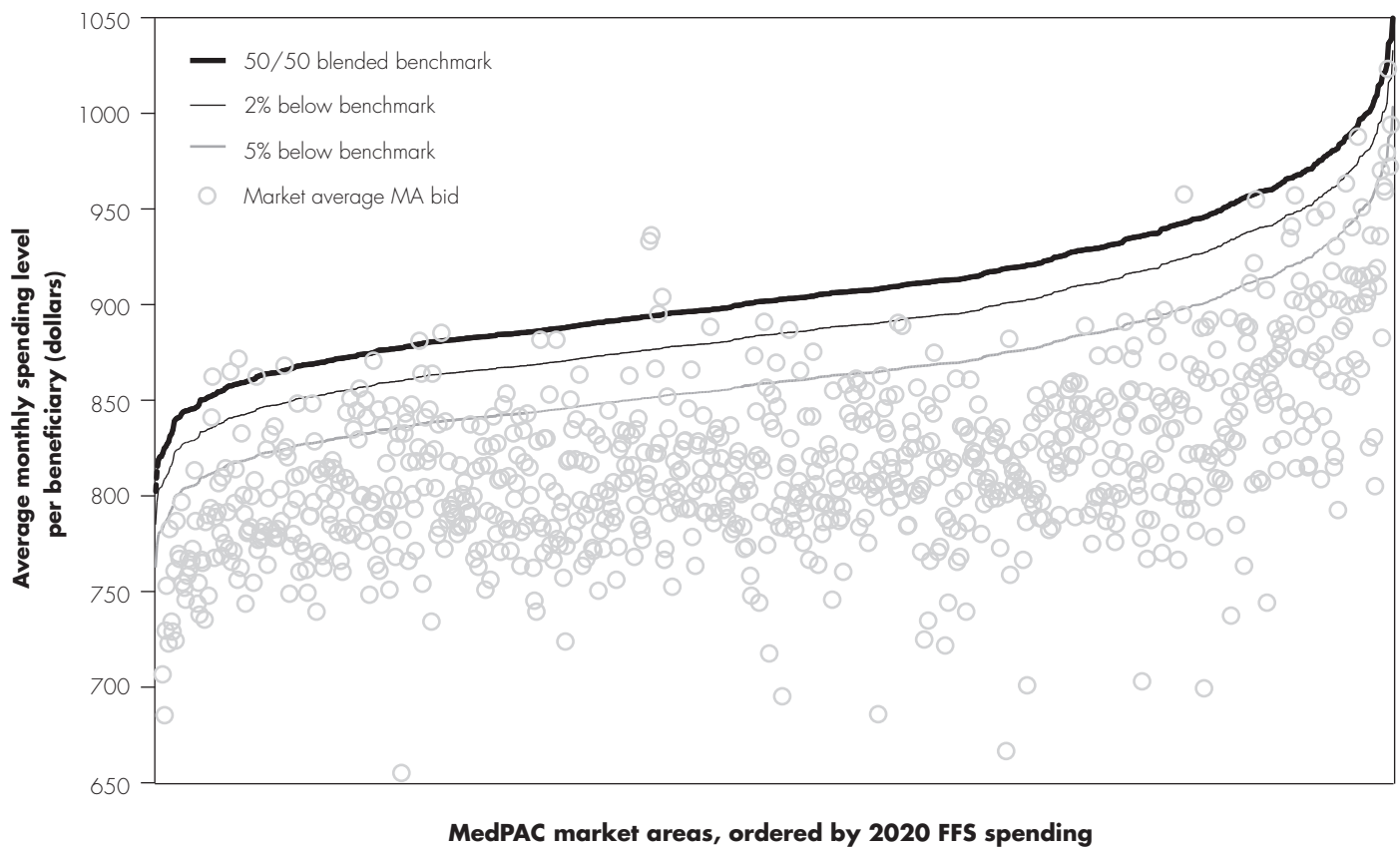
current MA quality bonus program. For example, quality bonus increases to benchmarks require at least 4 stars, but 3.5-star and 4-star plans both receive a 65 percent rebate (accounting for most MA enrollees in 2021). Across all plans, the average rebate is about 65 percent, and enrollees are rarely in plans receiving rebates below that level (fewer than 5 percent of MA enrollees were in a plan receiving less than a 65 percent rebate in 2021). In June 2020, the Commission recommended replacing the quality bonus program, which applies a bonus increase to benchmarks for plans with a star rating of 4 or greater, with an MA–VIP that distributes higher payments to plans that perform well within geographically defined areas. The MA–VIP recommendation did not address the current rebate policy. Our alternative benchmark approach is independent of that recommendation and would do little to alter current quality incentives, which are weakly tied to rebates but driven by benchmark bonus increases (and could be strengthened by implementing the Commission's MA–VIP). For the alternative benchmark approach, we eliminate star ratings from the calculation of rebate payments—allowing quality to be more consistently applied through either the current MA quality bonus program or the Commission's MA–VIP. Our alternative benchmark policy sets the rebate at 75 percent or more for all plans. The overall increase in rebate percentage creates greater rewards for plan efficiency and offsets the potential for reduced rebate amounts due to lower benchmarks under the alternative benchmark policy. A 75 percent rebate policy is consistent with an earlier rebate policy established under the Medicare Modernization Act of 2003 and used until it was replaced by the ACA rebate policy. A 75 percent rebate also aligns with the highest shared savings rate in the Medicare Shared Savings Program for accountable care organizations that take on the highest level of risk. Finally, a rebate of 75 percent would allow efficient plans to maintain a robust level of supplemental coverage for enrollees.

### **Achieving program savings through a discount rate**

The Commission's June 2020 report contends that growth in Medicare program spending poses a significant challenge, and MA has the potential to serve as a vehicle for addressing that challenge. To achieve program savings relative to current base benchmarks (excluding quality bonus increases), the alternative benchmark structure must include a discount factor. Indeed, when simulating blended benchmarks with 50/50 local and national weighting,

**FIGURE  
1-5**

**Average MA bids in nearly all market areas were lower than a 50/50 blended benchmark, 2020**



Note: MA (Medicare Advantage), FFS (fee-for-service). Metropolitan counties are grouped into a MedPAC market area if they are located in the same state and the same metropolitan statistical area. Nonmetropolitan counties are grouped into a MedPAC market area if they are located in the same state and the same health service area as defined by the National Center for Health Statistics. Analysis includes 856 market areas with at least 10 percent of Medicare beneficiaries (covered by both Part A and Part B) enrolled in MA. Data excludes employer group waiver plans, regional preferred provider organizations, and plans in the territories. We used CMS's estimate of FFS spending in 2020 for benchmark calculations and made adjustments to better reflect spending for the FFS population with both Part A and Part B coverage. The 50/50 blended benchmark is 50 percent weighted with local area spending per capita and 50 percent weighted with standardized national FFS spending per capita. National FFS spending standardizes the spending for per capita service use and eliminates adjustments made to FFS payments by hospital wage indexes, geographic practice cost indexes, graduate medical education, and indirect medical education. Average MA bids by market area are weighted by projected plan enrollment in the market. While plans bid at a service area level that often includes multiple counties, MA bid data contained an imputed bid value at the county level that we aggregated to the market level.

Source: MedPAC analysis of 2020 MA rate data and FFS spending.

we estimate no savings when no discount rate is applied (Table 1-6). While the alternative benchmarks were nearly 3 percent lower than current base benchmarks, much of that savings was eliminated because our simulations increased the rebate from an average of 65 percent under current policy to 75 percent (reflecting the MA rebate percentage before the implementation of the MA quality bonus program). Our alternative blended benchmark would remove the quartile benchmark structure, but we examined the change in MA payments by FFS spending

quartile to illustrate how a blended benchmark compares with current base benchmarks. Under a blended approach with no discount factor, plans in the highest quartile of FFS spending would see a decrease in benchmarks of 1 percent and an increase in payments of 1 percent relative to current base benchmarks (Table 1-6). For SNPs, payment differences relative to current base benchmarks were nearly identical to the results for all MA plans (data not shown).



**TABLE  
1-6**

**Without a discount rate, MA payments resulting from benchmarks based on a blend of local and national FFS spending would achieve no overall program savings**

Blended benchmark alternative of 50/50 local and national FFS spending	Quartiles of FFS spending				
	Overall	Lowest	Second	Third	Highest
<b>Simulated MA benchmarks relative to current MA base benchmarks:</b>					
0% discount	-2%	-5%	-4%	-1%	-1%
2% discount	-5	-7	-6	-3	-3
5% discount	-7	-10	-9	-6	-6
<b>Simulated MA payments relative to current MA base payments:</b>					
0% discount	0%	-3%	-2%	1%	1%
2% discount	-2	-4	-3	-1	-1
5% discount	-4	-7	-6	-3	-3

Note: MA (Medicare Advantage), FFS (fee-for-service). Data exclude employer group waiver plans, regional preferred provider organizations, and plans in the territories. Spending quartiles are based on the FFS spending values of plan service areas. National FFS spending standardizes the spending for per capita service use and eliminates adjustments made to FFS payments by hospital wage indexes, geographic practice cost indexes, graduate medical education, and indirect medical education. We used CMS's estimate of FFS spending for 2020 benchmark calculations and made adjustments to better reflect spending for the FFS population with both Part A and Part B coverage. Blended benchmarks reflect (1) a 50/50 weight of local area FFS spending and standardized national FFS spending per capita and (2) rebate values at 75 percent of the difference between benchmarks and bids for plans that bid below the benchmark. Blended benchmarks do not include payment quartiles. Current base benchmarks and payment rates reflect current policy without quality bonus payments. The average rebate under current policy is 65 percent.

Source: MedPAC analysis of 2020 MA bid and rate data and FFS spending.

To ensure overall program savings, then, a discount rate must be applied to benchmarks. We simulated discount rates of 2 percent (i.e., 98 percent of local area blended benchmarks) and 5 percent (i.e., 95 percent of local area blended benchmarks). Table 1-6 shows that a 2 percent discount rate would yield program savings of 2 percent, while a 5 percent discount rate would yield program savings of 4 percent. The magnitude of savings would be similar if MA quality bonuses were included. A discount rate would put some additional financial pressure on plans in the highest FFS spending quartiles. Implementing an alternative benchmark policy that starts with a 2 percent discount rate would allow policymakers to retrospectively examine the MA market before seeking larger program savings.

One concern with applying a discount rate is that it could restrict the availability of plans that can provide sufficient supplemental cost-sharing reductions because MA enrollees rely on this benefit in lieu of supplemental Medigap coverage. To examine this possibility, we analyzed the availability of plans that could provide the same level of cost-sharing reductions under a simulation that applies a 2 percent discount rate and excluded quality

bonus increases to benchmarks and associated quality bonus payments. We excluded special needs plans, employer group plans, and MA plans that did not offer any cost-sharing reductions in 2020. We examined the share of Medicare beneficiaries with access to an MA plan that used rebate dollars for either cost-sharing or premium reductions. We recognize the potential value of other extra benefits, and our alternative benchmark policy would not preclude plans from offering other benefits. We chose cost-sharing reductions because they are most analogous to Medigap supplemental coverage, and we chose premium reductions because they have been most clearly associated with beneficiary plan selection.<sup>42</sup>

Under our alternative benchmark policy with a 2 percent discount rate (excluding quality bonus increases to benchmarks and associated payments), nearly all beneficiaries would continue to have an MA plan available with enough rebate dollars to cover cost-sharing and premium reductions (Table 1-7, p. 26). (There is, however, no requirement or guarantee that plans would spend rebate dollars on these types of supplemental benefits.) In addition, the number of plan sponsors offering a plan that

**TABLE  
1-7**

**Access to MA plans with current levels of cost-sharing and premium reductions would be high under a blended benchmark with a 2 percent discount rate**

Supplemental coverage	Quartiles of FFS spending			
	Lowest	Second	Third	Highest
Share of Medicare beneficiaries with access to at least one MA plan with:				
<i>Current policy:</i> 2020 cost-sharing or premium reduction	>99.5%	>99.5%	99%	97%
<i>Simulated rebate:</i> sufficient to cover 2020 cost-sharing reduction levels	>99.5	>99.5	99	97
<i>Simulated rebate:</i> sufficient to cover 2020 cost-sharing and premium reduction levels	>99.5	>99.5	98	96
Average number of plan sponsor choices per beneficiary with:				
<i>Current policy:</i> 2020 cost-sharing or premium reduction	6	6	7	8
<i>Simulated rebate:</i> sufficient to cover 2020 cost-sharing reduction levels	6	6	7	8
<i>Simulated rebate:</i> sufficient to cover 2020 cost-sharing and premium reduction levels	5	5	7	8
Average number of plan choices per beneficiary with:				
<i>Current policy:</i> 2020 cost-sharing or premium reduction	22	22	27	27
<i>Simulated rebate:</i> sufficient to cover 2020 cost-sharing reduction levels	15	16	22	24
<i>Simulated rebate:</i> sufficient to cover 2020 cost-sharing and premium reduction levels	12	11	19	22

Note: MA (Medicare Advantage), FFS (fee-for-service). Data exclude employer group waiver plans and regional preferred provider organizations. Spending quartiles are based on the FFS spending values of plan service areas. Payments for alternative benchmarks exclude quality bonus increases to benchmarks and associated payments and reflect rebate values at 75 percent of the difference between benchmarks and bids for plans that bid below the benchmark. Simulated rebate values for blended benchmarks assume no change in plan bidding behavior. Simulated rebates result from blended benchmarks that reflect (1) a 50/50 weight of local area FFS per capita spending and standardized national FFS spending and (2) rebate values at 75 percent of the difference between benchmarks and bids for plans that bid below the benchmark. Unlike current policy, blended benchmarks do not include quartile payment adjustments. The average rebate under current policy is 65 percent. Supplemental coverage for premiums may reflect premium buydown for either Part D or Part B. “Plan sponsors” represent the number of distinct parent organizations.

Source: MedPAC analysis of 2020 MA bid and rate data, CMS 2020 enrollment, and FFS spending.

could cover cost-sharing and premium reductions would be nearly the same under a blended benchmark, indicating that the average beneficiary could remain with the same plan sponsor and maintain the same level of cost-sharing and premium reductions. For beneficiaries in the quartile areas with the lowest spending, the number of available plans that could offer such levels of benefits (without any bid reduction) would be reduced, but these beneficiaries would still have access to a reasonably robust number of plans and plan sponsors that could offer 2020 levels of cost-sharing and premium reductions—an average of 12 such plans sponsored by 5 different organizations.<sup>43</sup> Taking these measures of plan availability together, the relative disruption to beneficiary access to MA cost-sharing and premium reduction supplemental coverage would likely be modest under our alternative benchmark policy that includes a 2 percent discount rate.

While our simulations assume no change in bidding behavior relative to 2020 levels, at least some plans would likely respond to lower benchmarks with lower bids, thereby maintaining the same level of extra benefits (relative to current policy). In the Commission’s June 2020 report to the Congress, we reported that plans that lost their benchmark bonus status tended to respond by lowering their bids, thereby maintaining rebate levels for beneficiaries (Medicare Payment Advisory Commission 2020). In addition, the MA cost estimates from the Congressional Budget Office (CBO) have assumed that plans would reduce bids by half of the decrease in benchmarks (Congressional Budget Office 2018, Song et al. 2013, Song et al. 2012). We simulated benchmarks produced by our alternative policy under the CBO assumption and found that nearly all plans would have enough rebate dollars to cover 2020 levels of cost-sharing and premium reductions. Further, our March 2021 report

## Medicare Advantage payments for beneficiaries who are eligible for both Medicare and Medicaid

**M**edicare Advantage (MA) payments account for Medicaid eligibility status through the risk adjustment system and the quality bonus program. Since 2017, the risk adjustment system has distinctly predicted spending (and risk score disease coefficients) for six separate categories of enrollment based on whether beneficiaries qualify for full or partial Medicaid benefits or do not qualify for Medicaid benefits (along with Medicare eligibility due to age or disability). As a result, the relative cost of a condition is specific to each subgroup of beneficiaries, meaning that, on average, Medicare pays more accurately than previously for those groups of beneficiaries. The 2017 risk adjustment system eliminated overpayments for Medicare beneficiaries who qualify for partial Medicaid and underpayments for those who qualify for full Medicaid benefits. In addition, fully integrated dual-eligible special needs plans (i.e., those that administer both Medicare and Medicaid benefits) are also eligible to receive a frailty adjuster that increases all plan payments if plan enrollees have difficulty with activities

of daily living. Furthermore, since 2017, the quality bonus program has included a categorical adjustment index that adjusts the overall star rating (which is the basis of bonus payments) for MA contracts with higher shares of beneficiaries who are eligible for Medicaid or Part D's low-income subsidy (LIS).

Because of these adjustments within the risk adjustment system and quality program, the MA benchmarks do not have to address eligibility for Medicaid or Part D's LIS. Neither the current policy of MA benchmarks (implemented under the Affordable Care Act of 2010) nor our proposed benchmark option directly address low-income status. Furthermore, MA special needs plans can tailor their benefit package by not allocating their rebate to benefits that are covered by other payers (e.g., Part A and Part B cost sharing and Part B premium coverage by Medicaid and Part D premium coverage up to the LIS benchmark through Part D) and instead allocate more rebate funding to other extra benefits. ■

to the Congress showed that plans decreased their bids (relative to FFS) from 2020 to 2021—suggesting that plans have found efficiencies beyond their 2020 bidding levels.<sup>44</sup>

Our simulations on access to MA plans do not include SNPs because those plans do not generally include cost sharing, are far less likely to include premium reductions, and are not available to all Medicare beneficiaries. SNPs offer benefit packages tailored to specific populations, which most often pertain to beneficiaries who are dually eligible for Medicare and Medicaid (see text box on how MA payments account for dual-eligible beneficiaries). In 2020, SNP bids averaged 88 percent of base benchmarks. We simulated a 50/50 blended benchmark with a 2 percent discount rate for SNPs and found that 2020 SNP bids would average 92 percent of alternative benchmarks (data not shown). In the highest spending quartile, SNP bids would average 91 percent of benchmarks. In the lowest spending quartiles, SNP bids would average 96 percent

of alternative benchmarks, which suggests that under a benchmark alternative with a 2 percent discount rate, SNPs would still be able to provide enough extra benefits to be a viable choice for dual-eligible beneficiaries and other beneficiaries with special needs. In addition, under CBO's assumption that plan bids would decrease by half of the decrease in benchmarks, overall SNP bids would average 88 percent of alternative benchmarks. Furthermore, SNPs have consistently been shown, in the Commission's work on MA margins, to have higher margins than other MA plans—suggesting that additional efficiencies are possible for SNPs to maintain the current level of extra benefits offered.

### Longer term examination of bids and rebates

Over the long term, using FFS spending as the basis for benchmarks will result in biased benchmarks if the share of FFS enrollees in a county becomes too small. Forty-six percent of Medicare beneficiaries with Part A and Part B

are currently enrolled in MA. Further, the MA share continues to grow and is much higher in some counties. For example, in Miami-Dade county, the share of MA enrollment is now 75 percent. In counties with a small share of Medicare beneficiaries in FFS, benchmarks would become biased if:

- beneficiaries electing FFS Medicare in a county are not representative of Medicare beneficiaries overall (for example, about 90 percent of Medicare FFS beneficiaries have Medigap coverage or employer-sponsored supplemental coverage that can disproportionately reduce cost sharing and induce higher demand), and if the risk adjustment model is biased for this group of enrollees, or
- providers that do not contract with MA plans (or with a small share of MA patients) are overrepresented in a county (e.g., if MA plans avoid volume-inducing providers, such providers could furnish a majority of Medicare FFS care in the area).<sup>45</sup>

In areas with a small share of FFS beneficiaries, modifying benchmarks so that they do not rely on FFS spending could be done by setting benchmarks through one of three general competitive bidding approaches. First, benchmarks could be based on the distribution of MA bids (e.g., the average bid or second-lowest bid). Second, benchmarks could be set through a premium support model in which Medicare would contribute a premium amount covering at least some Medicare coverage options (local FFS Medicare or MA plan options). This model would require beneficiaries to pay an additional premium if they chose an option that was more expensive than Medicare's contribution. The Commission has previously evaluated important considerations for a premium support model (Medicare Payment Advisory Commission 2017). Third, benchmarks could be set as a blend of local area MA bids and FFS spending. Such a benchmark structure would remove the need for some of the considerations discussed earlier (e.g., setting a discount rate), but implementing such a structure immediately could have substantive effects on cost-sharing and premium reductions.<sup>46</sup> Any competitive bidding approach would need to consider that MA plans may rely on some level of funding above their bids to entice enrollment among beneficiaries who have Medicare FFS with supplemental coverage (Medigap or employer-sponsored coverage).

Over the long term, the Commission may examine the potential for a substantial overhaul of the MA payment

system (e.g., establishing benchmarks through competitive bidding). As noted in the Commission's earlier work, several other aspects of the Medicare program are worth considering in conjunction with such an overhaul, such as redesigning the Medicare benefit, standardizing MA plan options, and comparing quality between MA and FFS Medicare (Medicare Payment Advisory Commission 2017). The approach discussed in this chapter would not preclude such longer term changes to the MA program, but would more immediately address current problems created by MA benchmarks and produce savings to Medicare.

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## Recommendation

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Current benchmark policy has resulted in a robust MA program with plans that are more efficient than local FFS spending, but MA benchmarks have been set at a level that produces unnecessarily wide variation in plan payments and requires Medicare to provide additional funding to MA rather than share in the savings that plans generate. Moving to an alternative benchmarking approach is increasingly important as MA encompasses a growing share of Medicare expenditures and enrollment. In 2020, MA spending was \$317 billion, and 43 percent of MA-eligible beneficiaries were enrolled in an MA plan. Historically high rebates and an increasing number of plan offerings indicate that plans could share some efficiencies with the Medicare program with little adverse effect. Sharing in plan efficiencies is important, particularly given the trust fund solvency and revenue issues that Medicare is projected to encounter in the near future.

Overall, our simulations demonstrate that CMS could feasibly implement an alternative MA benchmark policy that addresses the Commission's concerns about the current system, with little impact on plan participation. Our 50/50 blend of local and national FFS spending sets benchmarks on a continuous scale of local FFS spending while accommodating the availability of MA plans in areas with both high FFS spending and low FFS spending. The vast majority of MA markets had an average bid far below the benchmark calculated under our alternative benchmark policy, suggesting that additional financial pressure could be applied to benchmarks through a 2 percent discount rate. After applying a 2 percent discount rate and a 75 percent rebate, the relative disruption to beneficiary access to MA cost-sharing and premium reduction supplemental coverage would likely be modest.



## RECOMMENDATION 1

**The Congress should replace the current Medicare Advantage (MA) benchmark policy with a new MA benchmark policy that applies:**

- **a relatively equal blend of per capita local area fee-for-service (FFS) spending with price-standardized per capita national FFS spending;**
- **a rebate of at least 75 percent;**
- **a discount rate of at least 2 percent; and**
- **the Commission’s prior MA benchmark recommendations—using geographic markets as payment areas, using the FFS population with both Part A and Part B in benchmarks, and eliminating the current pre-Affordable Care Act cap on benchmarks.**

Under this recommendation, MA benchmarks would be an equal weight of local FFS spending and national FFS spending, allowing benchmarks to vary by their local area characteristics but reducing the overall variation in benchmarks relative to current policy. Rebates paid to plans (as a share of the difference between the plan bid and benchmark) for funding extra benefits would be decoupled from the MA quality bonus program and would increase to 75 percent (compared with the current average of 65 percent) for all plans, to create greater incentives for plan efficiency. This recommendation would have no effect on the current quality bonus that is added on to plan benchmarks. A discount rate would reduce the local–national blended spending amounts, explicitly integrating plan efficiency into the benchmark calculation and helping ensure overall program savings. If policymakers decided to apply a discount rate of more than 2 percent, they would also have the option of simultaneously increasing the plan rebate percentage. Benchmarks would be calculated at a local market level (e.g., multicounty areas) instead of at the county level to improve the stability of local area spending calculations. Benchmark calculations would use the FFS population with both Part A and Part B coverage to ensure comparability with the MA-eligible population. Reductions in benchmark subsidies in the lowest spending areas would largely mitigate the current effect of pre-ACA caps on benchmarks, but this recommendation eliminates any effect from those benchmark caps and provides greater consistency and predictability of benchmarks in all low-spending areas.

If policymakers deem a phase-in of the new benchmark policy to be necessary, there are several options that could incorporate new benchmarks immediately in many areas. One option would identify areas with large changes to

benchmarks and give them a three-year phase-in during which two benchmark systems would be maintained, with the new benchmarks incrementally given more weight. A second option would be to fully apply the new benchmarks, but place a limit on year-to-year changes in each payment area (e.g., no more than a 5 percentage point change in any one year). A third option would immediately apply the new benchmarks but phase in the discount rate over a limited time period, such as three years. Once the recommendation is fully implemented, policymakers could consider applying additional financial pressure by gradually applying a benchmark ceiling at 100 percent of local FFS spending.

## RATIONALE 1

While the current MA benchmark approach has led to record low bid levels and record high rebates, it has failed to capture program savings and generates imbalances in plan subsidies and the availability of extra benefits across regions. Our recommended MA benchmark policy adheres to the Commission’s desire to rebalance MA benchmarks by creating more consistent payment rates geographically, allowing the Medicare program to capture additional MA efficiencies, and maintaining access to MA plans. It would allow Medicare to capture modest savings of at least 2 percent, limit larger subsidies for plans in areas of low FFS spending, and leverage additional savings in areas where plans are most efficient relative to current benchmarks. Beneficiaries would continue to have access to substantial extra benefits, although plans may not necessarily choose to offer current levels of cost-sharing and premium reductions.

## IMPLICATIONS 1

### Spending

- CBO estimates that this recommendation would reduce program spending relative to current policy by more than \$2 billion over one year and by more than \$10 billion over five years.

### Beneficiary and provider

- We do not expect this recommendation to have adverse effects on beneficiaries’ access to plans. MA would continue to be a viable alternative for beneficiaries seeking supplemental coverage of cost sharing and lower premiums.
- Some beneficiaries could see modest reduced coverage of extra benefits because some plans will receive lower payments. However, the magnitude of

## Prior recommendations by the Commission regarding Medicare Advantage

The recommendation in this chapter incorporates some prior Commission recommendations related to how Medicare Advantage (MA) benchmarks are calculated: eliminating the cap on benchmark amounts implemented by the Affordable Care Act of 2010 (ACA) (March 2016), basing benchmarks on fee-for-service (FFS) spending data only for beneficiaries with both Part A and Part B (March 2017), and establishing a geographic basis for MA payments that reflect health care market areas (initially June 2005). The current recommendation does not incorporate the prior Commission recommendation to eliminate the quality double bonuses, which was recommended concurrently with eliminating benchmark caps. The June 2020 recommendation to replace the quality bonus program did not address the influence of star ratings on rebate payments. (That recommendation addressed only payments associated with the 5 percent and 10 percent bonus increases to benchmarks.) The recommendation in this chapter would replace the current rebate policy under which rebates range from 50 percent to 70 percent of the difference between the plan bid and benchmark (for plans bidding below the benchmark), depending on a plan's star rating, with a rebate equal to 75 percent of the difference between the plan bid and benchmark (for plans bidding below the benchmark).

**Benchmark recommendations**—The first recommendation in Table 1-8 addresses inequity in the current benchmark system. Benchmark caps generate inequity by limiting benchmarks in certain counties based on pre-ACA spending and thus perpetuate any inequities that existed in pre-ACA benchmarks (Medicare Payment Advisory Commission 2016). Double quality bonuses (a 10 percentage point benchmark increase rather than a 5 percentage point increase) generate inequity given that the differential in payment is not based on differences in quality between qualifying (double-bonus) counties and other counties. The Commission recommended eliminating both policies.

The second recommendation in Table 1-8 addresses a miscalculation in estimating each county's FFS spending. MA enrollees must be enrolled in both Part A and Part B; however, the current benchmark calculation incorporates Part A spending for beneficiaries enrolled only in Medicare Part A, which is significantly lower than for beneficiaries enrolled in both Part A and Part B (and a similar issue exists for beneficiaries enrolled only in Part B). As a result, benchmarks are based on FFS spending estimates that are too low relative to the MA-eligible population. The Commission recommended using FFS beneficiaries enrolled in both

*(continued next page)*

change in extra benefits depends on plan responses to lower benchmarks. Some plans could choose to reduce profits or otherwise lower their cost of providing the Medicare benefit—that is, they could become more efficient. The Commission has previously found that plans that experience lower benchmarks respond with lower bids to maintain extra benefits for enrollees.

- We expect a small effect on plan participation in MA, with little or no constraint on the plan options currently available. Without any change in bidding behavior, nearly all plan sponsors would be able to offer plans with enough rebate revenue to maintain the same level of cost-sharing and premium reductions as currently exists.

This recommendation incorporates several prior Commission recommendations regarding the MA benchmark, as specified, but is distinct from others (e.g., our 2020 recommendation to revise the MA quality bonus program), which policymakers should consider independently. Interactive effects could alter the estimated payment impact on plans if policymakers consider implementing a combination of recommendations. The text box clarifies which prior recommendations are incorporated into this recommendation and which are independent of this recommendation. ■

## Prior recommendations by the Commission regarding Medicare Advantage (cont.)

**TABLE  
1-8**

### Commission recommendations for changes to current MA payment policy that have not been implemented and the approximate impact on MA payments

Commission recommendation	Approximate impact on MA payments
<p><b>Eliminate benchmark caps and quality double bonuses</b>—<i>March 2016<sup>a,b</sup></i></p> <p>The Congress should eliminate the cap on benchmark amounts and the doubling of the quality increases in specified counties.</p>	0% (policies offset one another)
<p><b>Base benchmarks on Part A and Part B</b>—<i>March 2017<sup>a</sup></i></p> <p>The Secretary should calculate MA benchmarks using FFS spending data only for beneficiaries enrolled in both Part A and Part B.</p>	+1%
<p><b>Fully account for MA coding intensity</b>—<i>March 2016</i></p> <p>The Congress should direct the Secretary to develop a risk adjustment model that uses two years of FFS and MA diagnostic data and does not include diagnoses from health risk assessments from either FFS or MA, and then apply a coding adjustment that fully accounts for the remaining differences in coding between FFS Medicare and MA plans.</p>	-2%
<p><b>Improve encounter data accuracy and completeness</b>—<i>June 2019</i></p> <p>The Congress should direct the Secretary to establish thresholds for the completeness and accuracy of MA encounter data and:</p> <ul style="list-style-type: none"> <li>• rigorously evaluate MA organizations' submitted data and provide robust feedback;</li> <li>• concurrently apply a payment withhold and provide refunds to MA organizations that meet thresholds; and</li> <li>• institute a mechanism for direct submission of provider claims to Medicare administrative contractors as a voluntary option for all MA organizations that prefer this method, starting in 2024, for MA organizations that fail to meet thresholds, or for all MA organizations if program-wide thresholds are not achieved.</li> </ul>	0%
<p><b>Replace the quality bonus program</b>—<i>June 2020<sup>b</sup></i></p> <p>The Congress should replace the current MA quality bonus program with a new MA value incentive program that scores a small set of population-based measures, evaluates quality at the local market level, uses a peer-grouping mechanism to account for differences in enrollees' social risk factors, establishes a system for distributing rewards with no "cliff" effects, and distributes plan-financed rewards and penalties at a local market level.</p>	-2%
<p><b>Establish geographic basis for payment and quality assessment</b>—<i>June 2005, March 2010, March 2018, June 2020<sup>a</sup></i></p> <p>The Secretary should establish geographic areas for MA quality reporting that accurately reflect health care market areas and should calculate star ratings for each contract at that geographic level for public reporting and for determining quality bonuses.</p>	0%

Note: MA (Medicare Advantage), FFS (fee-for-service). The approximate impact is estimated at the time of the recommendation and may be subject to behavioral responses.

<sup>a</sup>The recommendation in this chapter incorporates the following prior recommendations: eliminating the cap on benchmark amounts implemented by the Affordable Care Act of 2010 (does not incorporate the concurrent recommendation to eliminate quality double bonuses), basing benchmarks on FFS spending data only for beneficiaries with both Part A and Part B, and establishing a geographic basis for MA payments that reflect health care market areas.

<sup>b</sup>The elimination of double bonuses and its impact on MA payments (-0.6 percent in 2016) is included in two recommendations: eliminate quality double bonuses (March 2016) and replace the quality bonus program (June 2020).

(continued next page)

## Prior recommendations by the Commission regarding Medicare Advantage (cont.)

Part A and Part B to estimate FFS spending for MA benchmarks.

**Coding intensity recommendation**—The CMS hierarchical condition category model’s reliance on diagnosis codes creates a financial incentive for MA plans to document diagnosis codes more thoroughly than in FFS Medicare. Because the risk adjustment model is based on FFS Medicare data, more thorough diagnostic coding in MA generates greater payment for MA plans than FFS Medicare would have spent for the same beneficiary. After applying a statutory coding intensity adjustment that accounts for a portion of the coding intensity impact, MA plans in 2018 were paid an average of about 2 percentage points to 3 percentage points more than FFS due to diagnostic coding. While the statutory coding intensity adjustment applies equally to all beneficiaries, our analysis found that coding intensity varies significantly across MA contracts: Some contracts were paid greater than 10 percentage points more than FFS spending, and other contracts were underpaid relative to FFS spending. In the third recommendation in Table 1-8 (p. 31), the Commission recommended two policies intended to improve the equity of the coding intensity adjustment and to subsequently apply an adjustment that fully accounts for any remaining coding intensity impact.

**Encounter data recommendation**—MA plans are required to submit claim-like information about all items and services provided to plan enrollees, and CMS has been collecting the data since 2012. However, our comparisons of encounter data and MA utilization information collected from providers found the encounter data to be incomplete. Complete and accurate encounter data could be used for program oversight and comparisons with FFS to inform Medicare policy. In the fourth recommendation in Table 1-8 (p. 31), the Commission recommended improving encounter data

accuracy and completeness; applying incentives for submitting complete encounter data; and if necessary, establishing an alternative method of collecting MA encounter data directly from providers through Medicare administrative contractors.

**Quality- and geographic-based recommendations**—The MA quality bonus program is deeply flawed in its evaluation of quality (using too many measures, evaluating at the contract level, and inadequately accounting for social risk factors) and its application to MA payment (applying an all-or-none bonus and adding substantial extra payments for MA plans). In the fifth recommendation in Table 1-8 (p. 31), the Commission recommended replacing the quality bonus program with a value incentive program (VIP) that scores a small set of population-based measures, evaluates quality at the local market level, stratifies enrollees into peer groups with similar social risk factors, distributes rewards or penalties on a continuous scale (with no all-or-none cliffs), and finances rewards and penalties by redistributing plan payments (rather than through additional Medicare spending).

A component of the Commission’s MA–VIP is the use of local markets as the basis for assessing quality. As noted in the last recommendation in Table 1-8 (p. 31), several times since the incorporation of plans bidding in the MA program, the Commission has recommended using a health care market–based geographic unit as the basis for quality assessment and payment. In modeling the MA–VIP, the Commission defined geographic units as metropolitan statistical areas (MSAs) divided at state lines and health service areas (defined by the National Center for Health Statistics) in non-MSA areas for a total of roughly 1,200 geographic areas. Future analysis of MA benchmark policy will use the same geographic areas. ■



## Endnotes

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- 1 The current MA quality program assesses quality at the contract level, which can span many counties and different quartiles. Therefore, we are unable to provide an accurate assessment of whether MA quality is associated with relative benchmark levels. We have found that 5-star plans bid lower relative to FFS compared with other plans.
- 2 Qualifying counties are those that were in a metropolitan statistical area with a population of 250,000 in 2004, had at least 25 percent of MA-eligible beneficiaries enrolled in an MA plan in December 2009, and have FFS spending that is less than the national average FFS spending in the payment year.
- 3 The applicable amount is the rate established under Section 1853(k)(1) of the Act. For 2022, CMS intends to rebase the rates, making the applicable amount for 2022 the greater of (1) the county's 2022 FFS cost or (2) the 2021 applicable amount increased by the 2022 National Per Capita Medicare Advantage Growth Percentage. Section 1853(n)(4) of the Act requires that the benchmark (determined taking into account the quality bonus percentage increase) for each county must be capped at the county's applicable amount.
- 4 Private plan contracting existed in Medicare before the implementation of TEFRA, but was limited to less-than-full-risk-bearing arrangements or demonstration projects using full-risk contracting (Zarabozo 2000).
- 5 The AAPCC included adjustments for age, sex, disability status, Medicaid status, institutional status, and county of residence.
- 6 Plans were also allowed to provide additional benefits and charge a premium for those benefits (such as preventive care not covered by Medicare, which HMOs traditionally provided).
- 7 In addition to the risk adjustment changes, the BBA provided that plan payments for a county would be set at the highest of three payment "prongs," consisting of a minimum update from the previous year, a floor amount, and a national–local blended amount. The blended payment used a Part A and Part B input-price-adjusted national FFS amount, with the national share phased in until reaching 30 percent in 2002. In 2004, with the elimination of a budget neutrality requirement affecting the blended rate, during the last year in which the blended rate was applicable, 322 counties had a national–local blended rate as the basis of their plan payment rates. The blended rates could still have had an effect on Medicare Advantage (MA) benchmarks through 2010 (the year of the Affordable Care Act of 2010 (ACA) changes) because, beginning in 2005, benchmarks were set at the higher of 100 percent of FFS or a minimum percentage increase over the preceding year's rate, which could have been based on a 2004 blended rate. Similarly, the blended rates can have an effect on the pre-ACA benchmark caps that are currently in place.
- 8 The Balanced Budget Act of 1997 and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 required improvements to the risk-adjustment model used for MA payments. Revisions to the risk-adjustment model incorporated demographic information and diagnoses from hospitals (inpatient and outpatient) and physician office visits to account for differences in the expected cost of MA enrollees.
- 9 In addition, the BBA of 1997 allowed preferred provider organizations, provider-sponsored organizations, and private fee-for-service (PFFS) plans to have Medicare risk contracts. PFFS plans were not expected to be more efficient than traditional FFS and were the only plan type allowed to charge Medicare enrollees an additional premium to cover the plans' cost of providing the Medicare benefit package. To the extent that the principle of paying at 95 percent had been based on an expectation that HMOs could be more efficient than traditional FFS, the BBA of 1997 retreated from the original expectations for efficiency by allowing other types of private plans to contract with the Medicare program and establishing a defined Medicare contribution for PFFS plans.
- 10 The MMA expanded the application of a defined Medicare contribution (with a beneficiary premium covering costs above the contribution amount) to all plan types; previously, it was applicable only to PFFS plans.
- 11 Payments to MA plans in 2004 would have been 3 percent above FFS under pre-MMA policy, but were 7 percent above FFS under MMA policy (Medicare Payment Advisory Commission 2006).
- 12 CMS applies a statutory coding adjustment to MA payments. After accounting for this adjustment, we estimate that MA plans in 2019 were paid an average of about 3 percentage points more than FFS due to diagnostic coding.
- 13 As of February 2021, 46 percent of all Medicare beneficiaries with both Part A and Part B coverage were enrolled in MA plans.
- 14 This estimate assumes, conservatively, that the impact of coding intensity in 2021 is the same as in 2019 (the most recent year for which we analyzed coding intensity). The coding intensity trend from 2017 to 2019 suggests that the impact in 2021 is higher than in 2019.

- 15 MA projected enrollment in plan bids is generally consistent with actual enrollment. Among all MA enrollees in 2020 (including employer plans), 26 percent resided in the areas within the lowest quartile of FFS spending.
- 16 Beneficiary eligibility to join an MA plan requires enrollment in both Part A and Part B. Because 9 percent of Medicare beneficiaries do not meet this requirement, MA enrollment as a share of the Medicare population would be higher if the 9 percent were not included in the denominator. In 2020, 43 percent of all Medicare beneficiaries with Part A and Part B coverage enrolled in an MA plan.
- 17 In this example, neither county's rate is limited by the ACA benchmark caps.
- 18 Beneficiaries with high medical costs may experience higher liability for those costs in MA (assuming they have not exceeded their out-of-pocket limit) than Medicare FFS (without Medigap coverage). In 2020, nearly two-thirds of MA enrollees were in a plan that required higher cost sharing than the Part A hospital deductible in Medicare FFS for a 7-day inpatient stay, and 72 percent of enrollees were in a plan that required higher cost sharing than FFS for a 10-day inpatient stay (Freed et al. 2020).
- 19 Historically, Part B premium reductions have not been as transparent through Medicare's plan finder tool compared with Part D premiums (Medicare Payment Advisory Commission 2015, Stockley et al. 2014).
- 20 When submitting Part D bids, plans may allocate administrative expenses and margin toward the Part D revenue that results from projected Part C rebates.
- 21 The share of MA enrollees in plans that reduce Part B spending does not include employer plans and special needs plans, which have restrictions on enrollment and do not have the same incentives to reduce Part B premiums.
- 22 Medicare does not cover annual physical exams. However, unlike other MA supplemental benefits, diagnoses from annual physical exams are eligible for increases to beneficiary risk scores. In addition, coverage for annual physical exams may satisfy the desires of beneficiaries who seek a more thorough examination than an annual wellness visit.
- 23 The most commonly offered hearing benefit was for a routine hearing exam. However, the U.S. Preventive Services Task Force recently concluded that the benefits and harms of screening for hearing loss in asymptomatic older adults are uncertain and that the balance of benefits and harms cannot be determined due to lack of evidence (U.S. Preventive Services Task Force 2021).
- 24 Some beneficiaries may have at least limited Medicare or Medicaid coverage for these benefits. For example, beneficiaries with diabetes have some exam and eyewear coverage; beneficiaries with Medicaid coverage may receive some dental coverage.
- 25 Self-reported results from the 2016 Medicare Current Beneficiary Survey indicate that coverage for these benefits did not result in substantially different use of dental, vision, or hearing services among non-dual-eligible MA beneficiaries with and without the coverage (Willink et al. 2020).
- 26 This study examined 2018 dental claims for MA plans covering 1.9 million beneficiaries and found that only 12 percent of plan enrollees with embedded dental coverage used the benefit (Wix and Fontana 2020). The higher share of self-reported dental usage in the Medicare Current Beneficiary Survey (Willink et al. 2020) suggests some beneficiaries are using out-of-network dental services.
- 27 This study examined claims from 2008 to 2016 for 114,862 adults ages 66 and older who were continuously enrolled in the same private plan for at least 3 years following an initial diagnosis of hearing loss. Only 12 percent of these enrollees received any services related to a hearing aid. Similarly, self-reported results from the 2016 Medicare Current Beneficiary Survey indicate that only 12 percent of Medicare beneficiaries with hearing problems visited an audiologist, and only 8 percent of non-dual-eligible MA beneficiaries had a hearing-related visit (Willink et al. 2020). Self-reported longitudinal results from the National Health Aging and Trends Study indicate that between 2011 and 2018, hearing aid use among participants rose from 15.0 percent to 18.5 percent (Reed et al. 2021).
- 28 In 2021, 84 percent of projected MA enrollees in general enrollment plans had some type of hearing aid coverage.
- 29 Self-reported results from the 2016 Medicare Current Beneficiary Survey indicate that MA beneficiaries with supplemental coverage for dental, vision, and hearing services were liable for most of the cost of these services through out-of-pocket spending (Willink et al. 2020).
- 30 It is unclear whether beneficiaries are aware of all the extra benefits available to them or whether they are choosing to use services outside of plan networks. For example, membership warehouses and some retail stores offer discounted vision and hearing services and hardware (e.g., lenses, frames, and hearing aids).
- 31 Our category of supplemental benefits that target high-needs beneficiaries are those specific to beneficiaries with high medical or social needs. For example, while plan supplemental benefits for some over-the-counter items (e.g., cold medicine and adhesive bandages) and remote access

- technologies (e.g., web- or phone-based access to a nurse that does not supplant services by a beneficiary’s provider) are useful to high-needs beneficiaries, they are benefits that are likely to be used by any enrollee.
- 32 Among general MA plans, 13 percent of projected enrollees were in a plan that used at least one benefit flexibility.
  - 33 Nearly half (48 percent) of projected D–SNP enrollees were in a plan that used at least one benefit flexibility.
  - 34 Among general MA plans, 13 percent of projected MA enrollees were in a plan that offered any SSBCI. In contrast, 30 percent of projected D–SNP enrollees were in a plan that offered any SSBCI. The most common of the SSBCI among D–SNPs was food and produce, with 22 percent of projected D–SNP enrollees in a plan that offered this benefit.
  - 35 Local area spending is the mean per capita FFS spending in each area; national spending represents national service use at standardized wages. To estimate national spending, we used CMS’s U.S. per capita cost (USPCC) estimate for 2020 and adjusted this number to standardize prices (i.e., eliminate adjustments made to FFS payments by hospital wage indexes and geographic practice cost indexes) and to remove extra payments to hospitals that are carved out of the current county-level MA benchmarks (i.e., graduate medical education and indirect medical education). Alternatively, policymakers could define national spending as the median of local area per capita FFS spending, which would similarly establish a single national spending estimate that would be blended with local FFS spending. Using median local area FFS spending rather than the national mean per capita spending would better align with overall MA payments when per capita county-level spending is not normally distributed.
  - 36 To estimate FFS spending for beneficiaries with both Part A and Part B, we apply a factor to FFS spending in each county that accounts for the difference in risk-standardized spending between all FFS beneficiaries and beneficiaries enrolled in both Part A and Part B. We calculated this factor based on 2016 and 2017 claims data.
  - 37 Our analysis excludes employer group plans and regional preferred provider organizations (PPOs). The Commission’s alternative benchmark approach would not affect the current method for employer group plan payment. These payments are based on the bids of all MA plans and adjusted for the weight of employer group enrollment by plan type (HMO, PPO). Thus, we would expect the payment impact of this alternative benchmark approach to be similar between employer plans and other MA plans. An alternative benchmark approach would not affect regional PPOs. Benchmarks for these plans are set through an entirely different structure. Regional PPO benchmarks are a blend between regional PPO bids and FFS spending within a region (encompassing one or more states). Weighting of the blend is based on the national MA market share.
  - 38 Many health services researchers acknowledge some degree of “spillover” from different payers or alternative payment models, although the magnitude of such spillover is difficult to quantify and subject to debate.
  - 39 One exception for a floor and ceiling could be in U.S. territories, such as Puerto Rico. Because the Medicare coverage in Puerto Rico is atypical of the mainland, our simulations used a ceiling of 115 percent of local FFS spending for Puerto Rico.
  - 40 The national portion of the blended benchmarks adjusts the local spending estimates toward a predictable central point. Altering the national portion of the blend to incorporate local (nonstandardized) wages would create peaks and valleys relative to local FFS spending that are similar to current benchmark policy, but would, in many cases, be larger than the discontinuities in current policy. In addition, incorporating a local wage adjustment into the national spending estimate, even with a ceiling at the U.S. per capita cost, would cause benchmarks to rise. On average, high-wage areas have higher per capita service use than low-wage areas. Thus, allowing the national spending estimate to fully reflect local wages would increase overall benchmarks above current base benchmarks.
  - 41 Metropolitan counties are grouped into a MedPAC market area if they are located in the same state and the same metropolitan statistical area. Nonmetropolitan counties are grouped into a MedPAC market area if they are located in the same state and the same health service area as defined by the National Center for Health Statistics. States can have multiple nonmetropolitan MedPAC market areas.
  - 42 These choices are not to diminish the value of other types of supplemental benefits (e.g., hearing aids, vision benefits) for those beneficiaries who need and use them. Rather, the choices reflect the fact that cost-sharing and premium reductions are made available to and used by all enrollees in the plans that offer these benefits, and they are relatively readily quantifiable.
  - 43 On a per county basis, an average of three plan sponsors in the lowest spending quartile offered plans that would have sufficient rebate dollars to cover cost-sharing and premium reductions under an alternative benchmark structure that includes a 2 percent discount rate.
  - 44 Our simulation of plan access indicates that plan competition would continue to be robust under the alternative benchmark structure. In conjunction with the Commission’s prior MA recommendations on quality and risk adjustment, we would expect ample opportunities for locally or regionally based MA plans to compete with national MA plans. To the extent that

local MA plans provide better quality in their market, the Commission's recommendation on the MA-VIP results in a more equitable approach for these plans relative to current policy. In addition, the Commission's recommendations to calibrate the risk adjustment model using two years of data and limit the application of health risk assessments in risk scores would provide a more equitable approach for plans that have limited resources to capture additional revenue through coding.

45 For example, the Commission has found that the risk adjustment model tends to underpredict spending for beneficiaries with no medical conditions (Medicare Payment

Advisory Commission 2020). If a disproportionate share of FFS beneficiaries in a county had no medical conditions, the risk-adjusted average FFS spending estimate would be too high.

46 We simulated a blend of 2020 county-level MA bids and FFS spending and found that such a benchmark structure would save 5 percent relative to current base benchmarks (assuming no change in plan bidding behavior). When capping the MA blend at 50 percent, savings were 4 percent relative to current base benchmarks.

## References

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- Boccuti, C., G. Jacobson, K. Orgera, et al. 2018. *Medigap enrollment and consumer protections vary across states*. Washington, DC: Kaiser Family Foundation. <https://www.kff.org/medicare/issue-brief/medigap-enrollment-and-consumer-protections-vary-across-states/>.
- Brown, R. S., J. W. Bergeron, D. G. Clement, et al. 1993. *The Medicare risk program for HMOs—Final summary report on findings from the evaluation*. Princeton, NJ: Mathematica Policy Research Inc.
- Congressional Budget Office. 2018. *Options for reducing the deficit: 2019 to 2028*. Washington, DC: CBO.
- Freed, M., A. Damico, and T. Neuman. 2020. *A dozen facts about Medicare Advantage in 2020*. Washington, DC: Kaiser Family Foundation. <https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage-in-2020/>.
- Jacobson, G., R. Fehr, C. Cox, et al. 2019a. *Financial performance of Medicare Advantage, individual, and group health insurance markets*. Washington, DC: Kaiser Family Foundation.
- Jacobson, G., T. Neuman, and A. Damico. 2019b. *Do people who sign up for Medicare Advantage plans have lower Medicare spending?* Washington, DC: Kaiser Family Foundation.
- Jacobson, G., T. Neuman, and A. Damico. 2016. *Medicare Advantage plan switching: Exception or norm?* Washington, DC: Kaiser Family Foundation.
- Jacobson, G., C. Swoope, M. Perry, et al. 2014. *How are seniors choosing and changing health insurance plans? Findings from focus groups with Medicare beneficiaries*. Washington, DC: Kaiser Family Foundation.
- Langwell, K. M., and J. P. Hadley. 1990. Insights from the Medicare HMO demonstrations. *Health Affairs* 9, no. 1 (Spring): 74–84.
- Langwell, K. M., and J. P. Hadley. 1986. Capitation and the Medicare program: History, issues, and evidence. *Health Care Financing Review*, annual supplement: 9–20.
- Mahmoudi, E., T. Basu, K. Langa, et al. 2019. Can hearing aids delay time to diagnosis of dementia, depression, or falls in older adults? *Journal of the American Geriatrics Society* 67, no. 11 (November): 2362–2369.
- McDermott, D., L. Stolyar, C. Cox, et al. 2020. *Health insurer financial performance through September 2020*. Washington, DC: Kaiser Family Foundation.
- McGuire, T. G., J. P. Newhouse, and A. D. Sinaiko. 2011. An economic history of Medicare Part C. *Milbank Quarterly* 89, no. 2 (June): 289–332.
- McWilliams, J. M., J. Hsu, and J. P. Newhouse. 2012. New risk-adjustment system was associated with reduced favorable selection in Medicare Advantage. *Health Affairs* 31, no. 12 (December): 2630–2640.
- Medicare Payment Advisory Commission. 2020. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.
- Medicare Payment Advisory Commission. 2018. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.
- Medicare Payment Advisory Commission. 2017. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.
- Medicare Payment Advisory Commission. 2016. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.
- Medicare Payment Advisory Commission. 2015. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.
- Medicare Payment Advisory Commission. 2012. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.
- Medicare Payment Advisory Commission. 2010. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.
- Medicare Payment Advisory Commission. 2009. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.
- Medicare Payment Advisory Commission. 2006. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.
- Medicare Payment Advisory Commission. 2005. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.
- Medicare Payment Advisory Commission. 2000. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.
- Medicare Payment Advisory Commission. 1998. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.
- Meyers, D. J., E. Belanger, N. Joyce, et al. 2019. Analysis of drivers of disenrollment and plan switching among Medicare Advantage beneficiaries. *JAMA Internal Medicine* 179, no. 4 (April 1): 524–532.



- Mike, D., J. Friedman, and G. Yilmaz. 2019. *Average annual beneficiary health care costs for various Medicare coverage options*. Seattle, WA: Milliman.
- Newhouse, J. P. 2002. *Pricing the priceless: A health care conundrum*. Cambridge, MA: MIT Press.
- Newhouse, J. P., W. G. Manning, E. B. Keeler, et al. 1989. Adjusting capitation rates using objective health measures and prior utilization. *Health Care Financing Review* 10, no. 3 (Spring): 41–54.
- Newhouse, J. P., M. Price, J. Huang, et al. 2012. Steps to reduce favorable risk selection in Medicare Advantage largely succeeded, boding well for health insurance exchanges. *Health Affairs* 31, no. 12 (Dec): 2618–2628.
- Prochazka, A. V., and T. Caverly. 2013. General health checks in adults for reducing morbidity and mortality from disease: Summary review of primary findings and conclusions. *JAMA Internal Medicine* 173, no. 5 (March 11): 371–372.
- Reed, N. S., E. Garcia-Morales, and A. Willink. 2021. Trends in hearing aid ownership among older adults in the United States from 2011 to 2018. *JAMA Internal Medicine* 181, no. 3 (March 1): 383–385.
- Riley, G., C. Tudor, Y. P. Chiang, et al. 1996. Health status of Medicare enrollees in HMOs and fee-for-service in 1994. *Health Care Financing Review* 17, no. 4 (Summer): 65–76.
- Skopec, L., S. Zuckerman, E. Allen, et al. 2019. *Why did Medicare Advantage enrollment grow as payment pressure increased?* Washington, DC: Urban Institute.
- Society of General Internal Medicine. 2017. SGIM—General health checks for asymptomatic adults. <https://www.choosingwisely.org/clinician-lists/society-general-internal-medicine-general-health-checks-for-asymptomatic-adults/>.
- Song, Z., M. B. Landrum, and M. E. Chernew. 2013. Competitive bidding in Medicare Advantage: Effect of benchmark changes on plan bids. *Journal of Health Economics* 32, no. 6 (December): 1301–1312.
- Song, Z., M. B. Landrum, and M. E. Chernew. 2012. Competitive bidding in Medicare: Who benefits from competition? *American Journal of Managed Care* 18, no. 9 (September): 546–552.
- Stockley, K., T. McGuire, C. Afendulis, et al. 2014. *Premium transparency in the Medicare Advantage market: Implications for premiums, benefits, and efficiency*. NBER working paper no. 20208. Cambridge, MA: National Bureau of Economic Research.
- U.S. Preventive Services Task Force. 2021. Screening for hearing loss in older adults. <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hearing-loss-in-older-adults-screening#fullrecommendationstart>.
- Willink, A., N. S. Reed, B. Swenor, et al. 2020. Dental, vision, and hearing services: Access, spending, and coverage for Medicare beneficiaries. *Health Affairs* 39, no. 2 (February): 297–304.
- Wix, D., and J. E. Fontana. 2020. *Understanding dental costs and utilization in the Medicare Advantage population*. Seattle, WA: Milliman.
- Zarabozo, C. 2000. Milestones in Medicare managed care. *Health Care Financing Review* 22, no. 1 (Fall): 61–67.