

CHAPTER 12

**The Medicare Advantage
program: Status report**

The Medicare Advantage program: Status report

Chapter summary

Each year, the Commission provides a status report on the Medicare Advantage (MA) program. In 2023, the MA program included 5,635 plan options offered by 184 organizations, enrolled about 31.6 million beneficiaries (52 percent of Medicare beneficiaries with both Part A and Part B coverage), and paid MA plans an estimated \$455 billion (not including Part D drug plan payments). To monitor program performance, we examine MA enrollment trends, plan availability for the coming year, and payments for MA plan enrollees relative to spending for beneficiaries enrolled in traditional fee-for-service (FFS) Medicare. We also provide updates on risk adjustment, risk coding practices, the structure of the MA market, and the current state of quality reporting in MA.

The MA program gives Medicare beneficiaries the option of receiving benefits from private plans rather than from the FFS Medicare program. The Commission strongly supports the inclusion of private plans in the Medicare program. Beneficiaries should be able to choose among Medicare coverage options since some may prefer to avoid the constraints of provider networks and utilization management by enrolling in the traditional FFS Medicare program, while others may prefer the additional benefits and alternative delivery systems that private plans provide. MA plans are required by statute to offer an out-of-pocket spending limit

In this chapter

- Robust MA enrollment, plan availability, and rebates
- Payments to MA plans far exceed FFS spending due to favorable selection into MA plans and higher MA coding intensity
- Industry concentration, integration, and financial condition
- Quality in MA
- Commission recommendations would address many problems with MA payment policies and the quality bonus program

that is not available in FFS Medicare, and plans can provide extra benefits not covered by Medicare, reduce cost-sharing liability, and offer integrated Part D benefits. Because Medicare pays private plans a partially predetermined rate that is risk adjusted for each enrollee rather than a per service rate, plans should have greater incentives than FFS providers to deliver more efficient care.

The MA program is quite robust, with growth in enrollment, increased plan offerings, and a near record-high level of extra benefits financed by payments to plans through Medicare rebates. From 2018 to 2023, the share of eligible Medicare beneficiaries enrolled in MA rose by 3 percentage points per year, from 37 percent to 52 percent. Thus, a majority of eligible Medicare beneficiaries are now enrolled in MA. In 2024, the average Medicare beneficiary has a choice of 43 plans (offered by an average of 8 organizations), and the average enrollee in a conventional MA plan has \$2,142 in extra benefits available from the plan for the year (plans project \$187 in administrative costs and profit for these services for an average plan rebate of \$2,329). These extra benefits are subsidized by Medicare payments to plans for MA enrollees; such benefits are not available to beneficiaries in FFS unless they purchase additional health insurance coverage or pay for the services out of pocket. Projected Medicare payments for MA extra benefits (including plan administrative fees and profit) have more than doubled since 2018 and account for a projected 17 percent of payments to all MA plans in 2024, yet currently there is no reliable information about the extent to which beneficiaries use these benefits.

Medicare spends an estimated 22 percent more for MA enrollees than it would spend if those beneficiaries were enrolled in FFS Medicare, a difference that translates into a projected \$83 billion in 2024. The Commission acknowledges that a portion of these increased payments to MA plans are used to provide more generous supplemental benefits and better financial protection for MA enrollees. Table 12-3 (p. 371) includes a detailed breakdown of those benefits. Nevertheless, the Commission is concerned that the relatively higher payments to MA plans are subsidized by the taxpayers and beneficiaries who fund the program. Higher MA spending increases Part B premiums for all beneficiaries (including those in FFS who do not have access to the supplemental benefits offered by MA plans); the Commission estimates that those premiums will be about \$13 billion higher in 2024 because of higher MA spending. Further, the Commission is concerned that policies leading to higher MA payments also do not adequately address issues that distort the nature of plan competition in MA.

When risk-based payment for private plans was first added to Medicare in 1985, payments to private plans were set at 95 percent of FFS payments because it was expected that plans would share savings from their efficiencies relative to FFS with taxpayers. But private plans in the aggregate have never been paid less than FFS Medicare because of policies that have increased payments to MA above FFS. As examples, MA benchmarks are set above FFS spending in many markets in part to encourage more uniform plan participation across the country, and payments under the quality bonus program further increase MA payments above FFS (without, the Commission has found, producing meaningful information on plan quality for Medicare beneficiaries or the Medicare program). Further, favorable selection of enrollees into MA plans leads to risk-standardized spending of MA enrollees that would be lower than the FFS average (this effect is independent of the effects of any plan utilization management). Moreover, MA plans' diagnostic coding practices increase payments and distort the goal of plans competing to improve quality and reduce health care costs. Currently, the Commission does not quantify the extent to which favorable selection stems from plan behavior, beneficiary preferences, or other reasons, nor the extent to which higher MA coding intensity reflects documenting diagnoses more comprehensively than providers in FFS Medicare, the fraudulent submission of diagnostic data, or other reasons. Regardless of the causes, favorable selection of enrollees in MA and higher MA coding intensity increases payments to plans. Finally, the Commission finds that plan-submitted data about beneficiaries' health care encounters are incomplete—or, in the case of many extra benefits, missing. Without adequate information, policymakers cannot fully understand enrollees' use of services, which limits policymakers' ability to oversee the program.

A major overhaul of MA policies is urgently needed for several reasons. First, beneficiaries lack meaningful quality information when choosing among MA plans. Second, Medicare is paying more for MA than for comparable beneficiaries in FFS Medicare. Third, the disparity between MA and FFS payment disadvantages beneficiaries who—for medical reasons or personal preferences—do not want to enroll in MA plans that use tools like provider networks or utilization management policies and instead want to remain in FFS (which includes care provided through alternative payment models). Fourth, the lack of information about the use and value of many MA supplemental benefits prevents meaningful oversight of the program such that we cannot ensure that enrollees are getting value from those benefits. Finally, the continued growth in MA will increasingly create challenges for benchmark

setting because beneficiaries remaining in FFS may be higher risk (and thus have higher spending) in ways that risk adjustment cannot adequately capture.

Over the past few years, the Commission has made several recommendations to improve the program. These recommendations call for the Congress and CMS to address coding intensity, replace the quality bonus program, establish more equitable benchmarks, and improve the completeness of encounter data. In addition, the growing subsidization of supplemental benefits remains a concern. Because of Medicare's fiscal situation, the subsidization of supplemental benefits, if desired by policymakers, should be considered with attention to their value. In the Commission's view, current policy does not meet that standard. If payments to MA plans were lowered, plans might reduce the supplemental benefits they offer. However, because plans use these benefits to attract enrollees, they might respond instead by modifying other aspects of their bids.

In this chapter, we examine:

Medicare payments to plans—As noted, Medicare payments to MA plans in 2024 (including rebates that finance extra benefits) are projected to total \$83 billion more than if MA enrollees were enrolled in FFS Medicare. Payments to MA plans average an estimated 122 percent of what Medicare would have expected to spend on MA enrollees if they were in FFS Medicare. This estimate reflects higher MA coding intensity, even after the annual CMS coding adjustment; favorable selection of beneficiaries in MA; setting benchmarks—the maximum amount Medicare will pay an MA plan to provide Part A and Part B benefits—above FFS spending in low-FFS-spending counties; and payments associated with benchmark increases under the quality bonus program, which the Commission contends does not effectively promote high-quality care.

Risk adjustment and coding intensity—Medicare payments to MA plans are specific to each enrollee, based on a plan's payment rate and an enrollee's risk score. Risk scores account for differences in expected medical expenditures and are based in part on diagnoses that providers code. In both MA and FFS Medicare, claims include both procedure and diagnosis codes; however, most FFS Medicare claims are paid using only procedure codes, which offers little incentive for providers to record more diagnosis codes than necessary to justify providing a service. In contrast, MA plans have a financial incentive to ensure that their providers record all possible diagnoses because adding new risk-adjustment-eligible diagnoses raises an enrollee's risk score and results in higher payments to the plan. And plans have several mechanisms that do

not exist in FFS Medicare to document diagnoses for their enrollees, including chart reviews (which document diagnoses not captured through the usual means of reporting diagnoses) and health risk assessments (which sometimes rely on unverified enrollee-reported data). Coding differences may reflect MA plans capturing more diagnoses than FFS providers, potentially because MA plans have an incentive to report every diagnosis for an enrollee and FFS providers may be more likely to focus on more significant diagnoses that are a primary reason for a visit. Research has shown that some FFS beneficiaries have chronic conditions that are reported inconsistently from year to year—including conditions like kidney failure or paraplegia—suggesting that not all diagnoses are reported in FFS Medicare. Furthermore, whistleblowers and the Department of Justice allege that some MA plans have submitted fraudulent diagnoses for risk adjustment. There are no data available to parse the share of higher MA coding intensity due to these or other reasons; however, because the risk-adjustment model is calibrated on FFS claims, relatively higher MA coding intensity—regardless of the reason—increases payments to MA plans above FFS spending.

We estimate that in 2022, MA risk scores were about 18 percent higher than scores for similar FFS beneficiaries due to higher coding intensity (the Commission has adopted a new method of estimating the effects of coding intensity; see Chapter 13). We project that in 2024, MA risk scores will be about 20 percent higher than scores for similar FFS beneficiaries (accounting for the phase-in of the V28 risk-adjustment model). By law, CMS reduces all MA risk scores by the same amount to make them more consistent with FFS coding; CMS has the authority to impose a larger reduction than the minimum required by law but has never done so. In 2024, the adjustment will reduce MA risk scores by the minimum amount, 5.9 percent, resulting in MA risk scores that will remain about 13 percent higher than they would have been if MA enrollees had been enrolled in FFS Medicare. In 2024, higher scores will result in a projected \$50 billion in higher payments to MA plans. We continue to find that coding intensity varies significantly across MA plans, with some plans having coding intensity that falls below the 5.9 percent reduction (and even below FFS levels) and other plans coding far above that amount, including 10 MA organizations with average coding intensity that is more than 20 percent higher than FFS levels. Among the eight largest MA organizations, we estimate a 15 percentage point variation in average coding intensity. Higher coding intensity allows some plans to offer more extra benefits—and attract more enrollees—than other plans. That result distorts both the nature of plan competition in MA and plan incentives to improve quality and reduce costs.

The Commission previously recommended changes to MA risk adjustment that would exclude diagnoses collected from health risk assessments, use two years of MA and FFS diagnostic data, and apply an adjustment to MA risk scores to eliminate any residual impact of coding intensity. We find that about half of higher MA coding intensity could result from use of diagnoses from chart reviews and health risk assessments and that these two mechanisms are primary factors driving coding differences among MA plans. Thus, the Commission expects that the recommendation, along with the exclusion of chart reviews from risk adjustment, would improve the heterogeneity in observed coding intensity across MA organizations.

Quality in MA—To make informed choices about enrolling in an MA plan, beneficiaries need good information about the quality and access to care provided by MA plans in their local market. However, the Commission has long been concerned about the ability of the current MA quality bonus program to help beneficiaries meaningfully differentiate across plans and between MA and FFS. Further, the Commission contends that the program does not effectively promote high-quality care and has several other flaws. For instance, it relies on too many measures that do not reflect salient enrollee outcomes or experiences; it distorts improvement incentives with performance thresholds that introduce “cliff effects”; and it evaluates quality for large and sometimes geographically disparate contracts, rather than for plans at the local market level.

In 2024, nearly three-quarters of MA enrollees (23.3 million beneficiaries) were in a plan that received a quality bonus increase to its benchmark, generating about \$15 billion in additional program spending. In its June 2020 report, the Commission recommended replacing the current quality bonus program, which does not achieve its intended purposes and is costly to Medicare, with a new value incentive program for MA. In this report, we focus on the spending implications and other concerns regarding the current quality bonus program. In a future report, we plan to include a more detailed chapter on MA quality and access to care, which will provide more information about the Commission’s approach to these topics, including some empirical analysis of MA plan performance. ■

Background

The Medicare Advantage (MA) program allows Medicare beneficiaries enrolled in both Part A and Part B to receive benefits from private plans rather than from the traditional fee-for-service (FFS) program. The Commission strongly supports including private plans in the Medicare program because they allow beneficiaries to choose between FFS Medicare and the alternative delivery systems that private plans can provide. Unlike traditional FFS Medicare, MA plans typically have flexibility to use alternative payment models, negotiate with individual providers, use care-management techniques that fill potential gaps in care delivery, and provide incentives for beneficiaries to seek care from more efficient providers. By contrast, traditional FFS Medicare has lower administrative costs, but it can lack incentives to coordinate care and is limited in its ability to make care delivery more efficient.¹

For beneficiaries, the primary trade-off in choosing between MA and FFS is access to the additional benefits that plans provide versus a broader choice of providers participating in FFS. MA plans are required by statute to offer an out-of-pocket spending limit that is not available in FFS Medicare. MA plans also can offer integrated Part D benefits, provide supplemental benefits not covered by Medicare, and reduce cost-sharing liability. For 2024, we estimate that conventional MA plans (those available to all MA enrollees) will receive an average rebate from CMS of \$2,329 per enrollee (or \$2,142 after subtracting plan projections for administrative costs and profit for these services) to provide supplemental benefits during the year and that more than half of that will be allocated to reducing beneficiaries' cost sharing or Part B and Part D premiums. In exchange for these benefits, MA plan enrollees accept differences in coverage such as higher cost sharing to access providers out of a plan's network. Because private plans and traditional FFS Medicare have structural aspects that appeal to different segments of the Medicare population, the Commission has supported payment policies that do not unduly favor MA or FFS.

Each year, the Commission provides a status report on the MA program. To monitor program performance, we examine MA enrollment trends, plan availability

for the coming year, and payments for MA enrollees relative to spending for FFS Medicare beneficiaries. We also provide updates on risk adjustment, risk coding practices, and the current state of quality in MA.

Types of MA plans

Our analysis of the MA program uses the most recent data available, and we report our results by plan type. The analysis does not include non-MA private plan options such as cost plans that may be available to some beneficiaries. The primary MA plan types are:²

- **HMOs and local preferred provider organizations (PPOs)**—These plans have provider networks and, if they choose, can use tools such as selective contracting and utilization management to coordinate and manage care and control service use.³ They can choose individual counties to serve and can vary their premiums and benefits across counties. These two plan types are classified as coordinated care plans (CCPs).
- **Regional PPOs**—These plans are required to offer a uniform benefit package and premium across CMS-designated regions made up of one or more states. Regional PPOs have more flexible provider network requirements than local PPOs. Regional PPOs are also classified as CCPs.

Two additional plan classifications cut across plan types: special needs plans (SNPs) and employer group plans. SNPs offer benefit packages tailored to specific populations (beneficiaries who are dually eligible for Medicare and Medicaid, are institutionalized, or have certain chronic conditions). Each SNP must be an HMO or PPO plan. Employer group plans are available only to Medicare beneficiaries who are members of employer or union groups that contract with those plans. SNPs are included in our plan data, with the exception of plan availability figures because these plans are not available to all beneficiaries. Employer plans do not submit bids, so they are not included in our access analyses. In contrast to prior years, we estimate payments for employer group plans and include them in our overall comparison of MA payments relative to FFS spending.⁴ (See the Commission's March 2015 report to the Congress for more detailed information on employer plans.)

How Medicare pays MA plans

In contrast to FFS Medicare's fixed rates per service paid to providers, Medicare pays MA plans a fixed rate for each enrolled beneficiary, which is the product of a base rate and a risk score. Risk scores adjust a plan's base rate to account for differences in expected beneficiary medical costs by increasing a plan's payment rate for beneficiaries who are likely to have higher medical expenses and vice versa.

A plan's base rate is determined by the MA plan's bid and the benchmark for the county in which the beneficiary resides. The bid is intended to represent the dollar amount that the plan estimates will cover the Part A and Part B benefit package for a beneficiary of average health. The benchmark is the maximum amount of Medicare payment set by law for an MA plan to provide Part A and Part B benefits.⁵ (Medicare also pays plans for providing the Part D drug benefit, but those payments are determined through the Part D bidding process, and not all MA plans include the Part D benefit.) Plans with higher quality ratings are rewarded with a higher benchmark (although the increase to the benchmark can be limited by the Affordable Care Act of 2010 (ACA) benchmark caps). If a plan's normalized bid is above the normalized benchmark (after both have been adjusted to reflect 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 usual Part B premium) equal to the difference. For 2024, almost 100 percent of plans bid below their benchmarks. If a plan's normalized bid is below the benchmark, its payment rate is its bid plus a share of the difference between the plan's bid and the benchmark (as low as 50 percent but typically either 65 percent or 70 percent, depending on a plan's quality ratings). For this computation, the comparison is between an individual plan's actual bid for its expected enrolled population and a plan-specific risk-standardized average benchmark, weighted by the plan's projected enrollment from counties in its service area. The beneficiary pays no additional premium to the plan for Part A and Part B benefits (but continues to be responsible for paying the Medicare Part B premium and may pay premiums to the plan for additional benefits). The added payment to the plan, based on the difference between the bid and the benchmark, is

referred to as the rebate. The rebate must be used to provide additional benefits to enrollees in the form of lower cost sharing, lower premiums, or supplemental benefits. Plans also devote some of the rebate to their administrative costs and profit. Plans can choose to include additional supplemental benefits that are not financed by the rebate in their benefit packages and charge premiums to cover those additional benefits.⁶ (A more detailed description of the MA program payment system can be found in our *Payment Basics* series at <https://www.medpac.gov/document-type/payment-basic/>.)

How Medicare calculates MA benchmarks

Under the ACA, each county's benchmark, excluding quality bonuses, equals a certain share (ranging from 95 percent to 115 percent, subject to caps) of the projected average per capita FFS Medicare spending for the county's beneficiaries.⁷ Each county's benchmark is determined by organizing the counties into quartiles based on their FFS spending. Low-FFS-spending counties have benchmarks higher than their county's FFS spending level to help attract plans and enable enrollees to receive extra benefits, and high-FFS-spending counties have benchmarks lower than FFS spending to generate Medicare savings, given the history of very low bids in such counties that reflect high FFS service use. Counties are assigned to quartiles based on average FFS spending; the highest-spending quartile of counties has benchmarks set at 95 percent of local FFS spending. The next-highest-spending quartile of counties has benchmarks set at 100 percent of FFS spending, followed by the third-highest quartile set at 107.5 percent of FFS spending. The lowest-spending quartile has benchmarks set at 115 percent of local FFS spending. U.S. territories are treated like counties in this lowest-spending quartile. Counties that move among quartiles from year to year receive a blended quartile factor. For example, a county that moved from the 100 percent quartile in 2023 to the 107.5 percent quartile in 2024 would have had a blended rate of 103.75 percent in 2024.

By statute, plans awarded quality bonuses have benchmarks that are 5 percent higher than the standard county benchmarks (subject to benchmark growth caps); in certain counties, plans can receive a double bonus, and the benchmarks for plans

awarded quality bonuses are 10 percent higher than the standard benchmarks.⁸ Unlike nearly all of Medicare's FFS quality incentive programs, these quality bonuses are not budget neutral but are instead financed by added program dollars and beneficiary premiums. The Commission's original conception of a quality incentive program for MA plans was a system that would be budget neutral and financed with a small share of plan payments (Medicare Payment Advisory Commission 2012b, Medicare Payment Advisory Commission 2004). A budget-neutral system is consistent with the Commission's principle of providing a level playing field between private MA plans and FFS Medicare and reflects the Commission's recommendation to the Congress in June 2020 (Medicare Payment Advisory Commission 2020a, Medicare Payment Advisory Commission 2019).

How Medicare calculates risk scores

Risk scores are beneficiary-level index values that indicate the expected Medicare costs for an enrollee relative to the national average FFS beneficiary. How well Medicare's payments to MA plans match their enrollees' costliness depends in large part on how well the risk scores predict the expected costs for the plans' enrollees.

CMS calculates risk scores with the CMS hierarchical condition category (CMS-HCC) risk-adjustment model, which uses demographic information (e.g., age, sex, Medicaid enrollment, and disability status) and certain diagnoses grouped into HCCs to calculate a risk score for each enrollee. HCCs are medical conditions or groups of related conditions with similar treatment costs. Some conditions have more than one HCC, which differ by severity of the condition and are arrayed in a hierarchy. For example, the CMS-HCC model has three HCCs for diabetes: without complications, with chronic complications, and with acute complications. The "hierarchical" aspect of HCCs means that if a beneficiary's diagnoses map to more than one HCC in a condition hierarchy, CMS applies only the HCC that has the largest effect on the beneficiary's risk score—the highest-severity HCC.

CMS tracks beneficiary demographic information, but MA plans submit diagnostic information to CMS through encounter records, which contain basic

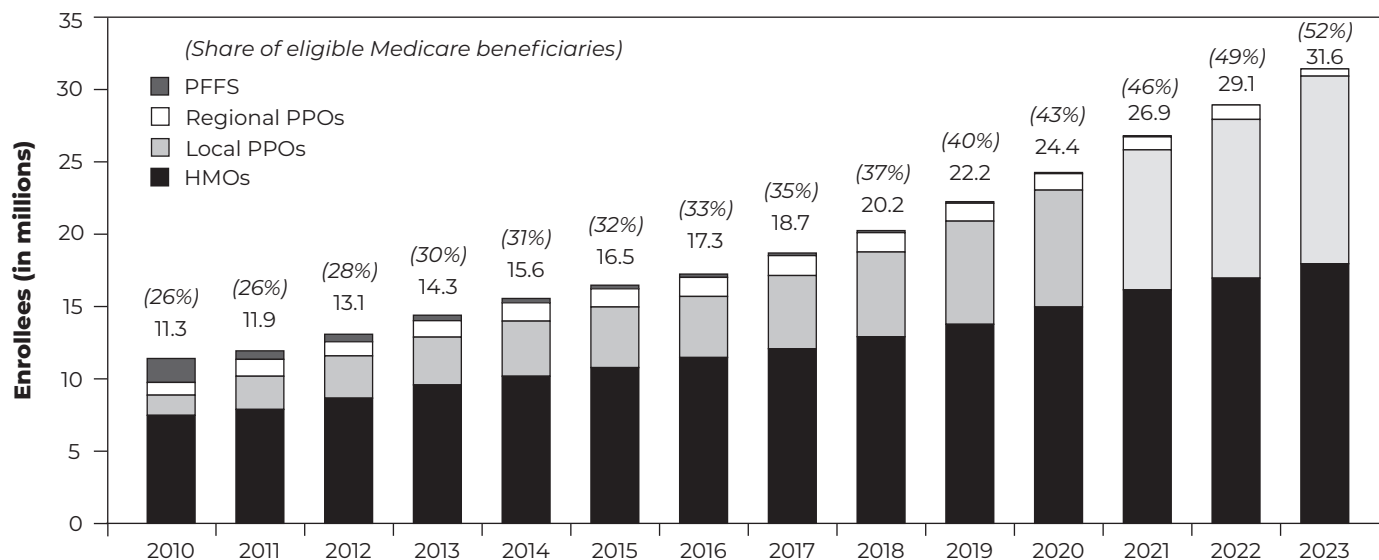
information about each Medicare-covered encounter an enrollee has with a health care provider and each Medicare-covered item provided to the enrollee.⁹ Diagnostic data collected from encounters in one calendar year are used to predict Medicare costs for the following calendar year.

CMS designed this risk-adjustment model to maximize its ability to predict annual medical expenditures for FFS Medicare beneficiaries while also ensuring that the model's diagnostic categories were clinically meaningful and specific enough to minimize opportunities for gaming or discretionary coding (Pope et al. 2004). CMS has two requirements to ensure the validity and reliability of the diagnostic data used in an enrollee's risk score: Diagnoses must (1) appear on a claim from a hospital inpatient stay, a hospital outpatient visit, or a face-to-face visit with a physician or other health care professional, and (2) be supported by evidence in the patient's medical record.¹⁰ Diagnoses resulting from telehealth services meet the face-to-face requirement when the services are provided using interactive audio and video telecommunication that enables real-time communication with the beneficiary. To ensure that diagnoses are supported by evidence in the patient's medical record, CMS conducts risk-adjustment data validation (RADV) audits. RADV audits have been limited so far, but the available results show significant issues with medical record support for risk-adjustment diagnoses (Schulte and Hacker 2022).^{11,12}

The CMS-HCC model is calibrated using FFS claims data so that each beneficiary's risk score reflects the expected spending that would occur for a beneficiary who represents national average spending in FFS Medicare. Therefore, risk scores do not reflect geographic spending variation, a beneficiary's propensity to seek care, differences between MA and FFS Medicare, including variation in plans' benefit design or initiatives to influence spending, or differences in diagnostic coding practices between MA and FFS Medicare and across MA plans. These factors drive differences between actual spending for MA enrollees and the expected spending based on MA risk scores, some of which are reflected in our estimates of the effects of favorable selection into MA and of higher MA diagnostic coding intensity.

FIGURE 12-1

Enrollment in Medicare Advantage has more than doubled since 2014



Note: PFFS (private fee-for-service), PPO (preferred provider organization), HMO (health maintenance organization). Beneficiaries must have both Part A and Part B coverage to enroll in a Medicare Advantage plan; therefore, beneficiaries who have Part A only or Part B only are not included in this figure.

Source: MedPAC analysis of CMS enrollment files, July 2010–2023.

Robust MA enrollment, plan availability, and rebates

Substantial growth in MA plan enrollment, availability, and rebates indicates a robust MA program. As of 2023, more than half of eligible Medicare beneficiaries were in MA plans. For 2024, the average beneficiary has access to 43 plans sponsored by 8 organizations, and rebates that finance extra benefits are at near record-high levels.

In 2023, 8 percent growth in MA plan enrollment; 52 percent of eligible Medicare beneficiaries enrolled in MA plans

Between July 2022 and July 2023, enrollment in MA plans grew by 8 percent—or 2.4 million enrollees—to 31.6 million enrollees, while the total MA-eligible population (beneficiaries with both Part A and Part B coverage) grew only 2 percent and FFS enrollment

declined about 4 percent. The change in MA enrollment of 2.4 million was the second-highest annual increase over the last five years. Between 2022 and 2023, MA enrollment rose from 49 percent to 52 percent of eligible Medicare beneficiaries (Figure 12-1). Enrollment in MA has more than doubled since 2014. MA has become increasingly attractive to beneficiaries because plans provide cost-sharing reductions and a cap on out-of-pocket expenses at little or no premium. Many beneficiaries with care needs that are met within plan networks will likely have lower financial liability (premiums and cost sharing) compared with beneficiaries who stay in FFS and purchase the most comprehensive supplemental coverage. Some MA enrollees with high care needs do experience greater cost liabilities compared with beneficiaries in FFS (e.g., greater cost sharing for in-network and out-of-network services compared with the premiums for Medigap supplemental coverage), but most of these

**TABLE
12-1**

MA plan enrollment continued rapid growth in 2023

	Enrollment (in millions)		Percent change in enrollment (2022–2023)
	July 2022	July 2023	
Total MA-eligible beneficiaries	59.2	60.4	2%
Total MA	29.1	31.6	8
Plan type			
HMO	17.1	18.1	6
Local PPO	11.2	12.9	15
Regional PPO	0.7	0.5	–32
PFFS	<0.05	<0.05	–22
Restricted-availability plans included in totals above			
SNPs*	4.9	6.1	25
Employer group*	5.2	5.5	6

Note: MA (Medicare Advantage), HMO (health maintenance organization), PPO (preferred provider organization), PFFS (private fee-for-service), SNP (special needs plan). The total Medicare population used to calculate enrollment shares in this table excludes the approximately 8 percent of beneficiaries who are not eligible to enroll in an MA plan because they do not have both Part A and Part B coverage. Totals and calculated values may be affected by rounding.

*SNPs and employer group plans have restricted availability. Their enrollment is included in the statistics by plan type and location. We present them separately to provide a more complete picture of the MA program.

Source: MedPAC analysis of CMS enrollment files.

MA enrollees would likely have difficulty obtaining a Medigap policy if they switched to FFS.¹³

Among plan types, recent growth in MA enrollment has been disproportionately higher among local PPOs. Although HMOs continued to enroll the most beneficiaries (18 million) in 2023, enrollment in local PPOs grew faster (15 percent) than in HMOs (6 percent) (Table 12-1). In addition, between 2022 and 2023, enrollment in local PPOs grew by 1.7 million, accounting for more than two-thirds of the overall increase in MA enrollment. As MA rebates have risen, the resulting increase in extra benefits provided by local PPOs combined with less restrictive networks (relative to HMOs) has likely contributed to the recent enrollment increase among local PPOs.¹⁴ Much of the increase in HMO enrollment resulted from enrollment in SNPs: Increased SNP enrollment accounted for half of all MA enrollment growth between 2022 and 2023. In 2023,

SNP enrollment grew by 25 percent—an acceleration of the rapid growth (above 10 percent per year) observed over the last four years. HMOs accounted for nearly three-quarters of the SNP enrollment growth (data not shown). While enrollment in non-SNP HMOs was essentially unchanged, enrollment in SNP HMOs grew by 23 percent (data not shown). Local PPO SNPs have proliferated since 2018, rising from 4 percent of SNP enrollment to 18 percent in 2023. Altogether, in 2023, Medicare beneficiaries eligible to enroll in SNPs are predominantly enrolled in HMOs, and those without qualifying special needs are primarily enrolled in PPOs (data not shown), but local PPOs are increasingly popular among both groups.

Enrollment patterns differ in urban and rural areas. The majority (54 percent) of eligible urban beneficiaries are enrolled in MA compared with 44 percent of eligible beneficiaries residing in rural counties.¹⁵ However, the

**TABLE
12-2**

Access to Medicare Advantage plans remains high

Share of Medicare beneficiaries with access to at least one MA plan

Type of plan	2020	2021	2022	2023	2024
Any MA plan	99%	99%	99%	>99.5%	>99.5%
Local CCP	98	98	99	99	>99.5
Regional PPO	73	72	74	74	74
PFFS	36	34	35	29	30
Special needs plans					
Dual eligible	90	92	94	94	95
Chronic condition	52	57	59	66	72
Institutional	67	72	74	77	78
Zero-premium plan with drug coverage	93	96	98	99	99
Average number of choices					
County weighted	15	18	22	26	28
Beneficiary weighted	27	32	36	41	43

Note: MA (Medicare Advantage), CCP (coordinated care plan), PPO (preferred provider organization), PFFS (private fee-for-service). "Local CCP" includes HMO and local PPO plans. These figures exclude employer-only plans and Medicare medical savings account plans. Special needs plans are included in the three special needs plan rows but excluded from all other rows. For 2020 and 2021, "share of Medicare beneficiaries" includes beneficiaries who do not have both Part A and Part B coverage (i.e., includes all Medicare beneficiaries). For 2022 through 2024, the share of Medicare beneficiaries includes only beneficiaries with both Part A and Part B coverage (i.e., includes MA-eligible beneficiaries). A "zero-premium plan with drug coverage" includes Part D coverage with no Part D premium (but may include the Part B premium). "County weighted" means that each county is weighted the same and the measure is the average number of choices per county. "Beneficiary weighted" means that each county is weighted by the number of beneficiaries in the county.

Source: MedPAC analysis of CMS bid and enrollment data.

growth of MA plans in rural areas has been much faster in recent years. In 2023, MA enrollment in rural areas grew by 12 percent (compared with 8 percent growth in urban areas). The predominant plan type often differs between urban and rural areas. In 2023, 39 percent of rural MA enrollees were in HMO plans compared with about 61 percent of urban enrollees. By contrast, 57 percent of rural enrollees were in local PPOs compared with 38 percent of urban enrollees.

In many areas of the country, a majority of eligible Medicare beneficiaries are now enrolled in MA. In 28 states (including California, Florida, Michigan, New York, Pennsylvania, and Texas) and Puerto Rico, more than half of the eligible population was enrolled in an MA plan in 2023. In some metropolitan areas (e.g., El

Paso, TX; Grand Rapids, MI; Greensboro, NC; Miami, FL; Pittsburgh, PA; Rochester, NY), more than 70 percent of eligible Medicare beneficiaries were enrolled in MA plans. MA benchmarks are computed at the county level, and in an increasing number of counties, most Medicare beneficiaries are enrolled in MA plans. In all counties in Puerto Rico and an additional 1,170 counties across 39 states, more than half of eligible Medicare beneficiaries were enrolled in MA plans in 2023. The increasing share of MA enrollees in some geographic areas raises questions about whether the local FFS population should continue to be the basis for MA payment benchmarks. Benchmarks can become inaccurate if the FFS population is not representative of Medicare beneficiaries overall. Declining enrollment

in FFS can potentially diminish how well the CMS risk-adjustment model predicts costs for MA enrollees. For example, in some counties, a disproportionate number of FFS beneficiaries have comprehensive supplemental coverage, which is generally unavailable in MA and induces higher demand for health care services.

Access to MA plans remains high in 2024

Every year, we assess plan availability and projected enrollment for the coming year based on the bid data that plans submit to CMS. We find that access to MA plans remains high in 2024, with most Medicare beneficiaries having access to many plans. Some measures of availability have improved for 2024. While almost all beneficiaries have had access to some type of MA plan since 2006, local CCPs have become more widely available in recent years (Table 12-2). In 2024, nearly 100 percent of Medicare beneficiaries have an HMO or local PPO plan (both are considered local CCPs) operating in their county of residence, up from 99 percent in 2023.¹⁶

The availability of SNPs continues to be high across the types of special needs populations served (Table 12-2). In 2024, 95 percent of beneficiaries reside in areas where SNPs serve beneficiaries who are dually eligible for Medicare and Medicaid (up from 94 percent in 2023), 72 percent live where SNPs serve beneficiaries with chronic conditions (up from 66 percent in 2023), and 78 percent live where SNPs serve institutionalized beneficiaries (up from 77 percent in 2023).¹⁷ Overall, 99 percent of beneficiaries reside in counties served by at least one type of SNP (data not shown).

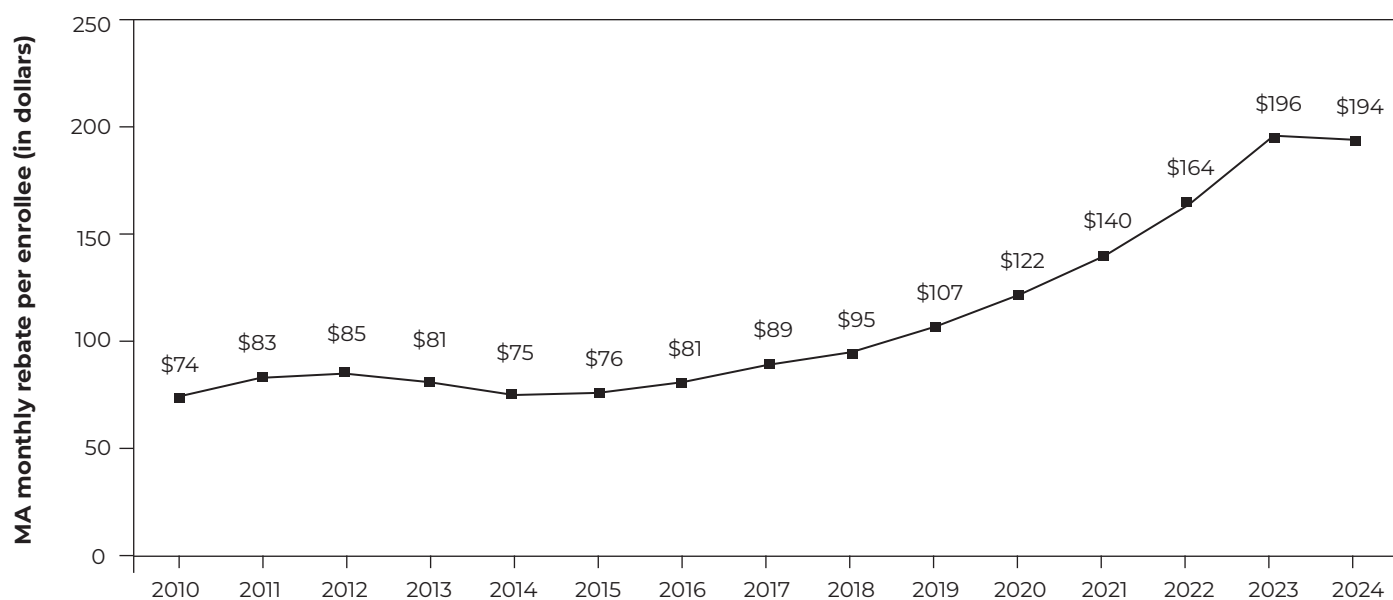
In 2024, nearly 100 percent of eligible Medicare beneficiaries (unchanged from 2023) have access to at least one conventional MA plan (i.e., excluding SNPs and employer group plans) that includes Part D drug coverage and charges no Part C or Part D premium (enrollees still pay the Medicare Part B premium) (Table 12-2).¹⁸ About 75 percent of MA enrollment is projected to be in these zero-premium plans (data not shown). Also in 2024, 99 percent of beneficiaries (unchanged from 2023) have access to plans that offer some reduction in the Part B premium, but only 12 percent of 2024 projected conventional MA enrollment was projected to be in these premium-reduction plans, and the average monthly premium reduction was \$7 (data not shown).

In most counties, beneficiaries have access to a large number of MA plans. In 2024, the average number of plans available in a county increased to 28 plans (from 26 plans in 2023) (Table 12-2). Plan availability can also be evaluated by the number of plan choices available to the average beneficiary. According to that calculation, the average beneficiary in 2024 has 43 available plans, an increase from 41 plans in 2023. An additional measure of plan access is the number of insurers offering products to the average beneficiary. In 2024, the average beneficiary can choose from plans sponsored by 8 organizations (organization data not shown); 98 percent of beneficiaries have access to MA plans sponsored by at least 3 organizations, 95 percent of beneficiaries can choose from plans sponsored by at least 4 organizations, and 91 percent of beneficiaries can choose from plans sponsored by at least 5 organizations. Given the large number of plan choices, beneficiaries may find it difficult to discern differences in plan benefit packages in order to make an optimal choice.

MA rebates in 2024 remain at nearly record levels

MA plans continue to receive nearly record levels of rebates in 2024. Plans must use the rebate to provide extra benefits—such as lower cost sharing, lower premiums, or supplemental benefits not covered by Part A or Part B (such as vision, hearing, dental, and fitness benefits) to attract more enrollees. Plans also use some of the rebate to cover their administrative costs and as profit. Although plans are required to submit encounter data for supplemental benefits, CMS does not have reliable information about enrollees' actual use of these benefits at this time.¹⁹

For 2024, rebates for conventional MA plans—excluding employer plans and SNPs—average \$194 per enrollee per month (\$2,329 annually per enrollee; \$2,142 after subtracting plan projections for administrative costs and profit), a slight decrease from the record high \$196 per enrollee per month in 2023 (Figure 12-2, p. 370). When including SNPs, rebates reached a record high of \$209 per enrollee per month in 2024—a slight increase from \$206 per enrollee per month in 2023 (data not shown). These rebates account for 17 percent of plan payments, unchanged from 2023 (data not shown). The average MA rebate among conventional plans has more than doubled since 2018.

**FIGURE
12-2****MA rebates for conventional plans have more than doubled since 2018**

Note: MA (Medicare Advantage). Employer group plans, special needs plans, and plans that do not offer Part D coverage are not included. The plan rebate is the per beneficiary per month amount that the plan offers as premium-free extra benefits. Rebate dollar amounts are based on the national average and reflect plan risk scores in plan bids but do not reflect payment adjustments for sequestration. We do not have reliable information about beneficiaries' use of these benefits.

Source: MedPAC analysis of data from CMS on plan bids.

We assess plan rebates based on projected rebate allocations included in plans' bids, but we do not have reliable information about enrollees' actual use of extra benefits. In 2024, the share of plan rebates allocated toward cost-sharing reductions is projected to remain about the same as 2023 levels (Table 12-3). Plans project that \$75 per enrollee per month in rebates (39 percent of rebate dollars, unchanged from 2023) will go toward reductions in cost sharing for Medicare services, 1 percent lower relative to 2023.^{20,21} However, plans reported allocating a slightly higher share of plan rebates to non-Medicare-covered supplemental benefits.

In 2024, plans project that 27 percent of rebates (averaging \$53 per enrollee per month) will be used for non-Medicare-covered supplemental benefits.²² The Commission previously reported that while these benefits often include coverage for vision, hearing, or dental services, the non-Medicare supplemental benefits are not necessarily tailored toward populations that have the greatest social or medical

needs (Medicare Payment Advisory Commission 2021a).²³ The lack of information about enrollees' use of supplemental benefits makes it difficult to determine whether the benefits improve beneficiaries' health (Government Accountability Office 2023).

Limited data suggest that use of non-Medicare-covered supplemental benefits is low. A small study by the actuarial firm Milliman analyzed 2018 MA claims for 1.9 million beneficiaries who were 65 or older and enrolled in plans that provided dental coverage (Wix and Fontana 2020). The study found that only 11 percent of enrollees had MA-covered claims for preventive dental care. In addition, multiple studies using survey data have found that beneficiaries with dental coverage in MA are not more likely to receive dental services than other Medicare beneficiaries (Centers for Medicare & Medicaid Services 2020, Simon et al. 2023, Willink et al. 2020). Moreover, one trade association examined data in 2020 for 30,000 MA enrollees in a regional plan who had access to the over-the-counter (OTC) benefit, which provides an allowance for beneficiaries

**TABLE
12-3**

Conventional MA plans project that rebates will be used to reduce cost sharing, reduce Part B and Part D premiums, and offer non-Medicare benefits in 2024

	Rebate (per member per month)			Share of total rebate	
	2023	2024	2024 percent change	2023	2024
Total	\$196	\$194	-1%	100%	100%
Extra benefit type					
Cost sharing	76	75	-1	39	39
Non-Medicare supplemental	50	53	6	26	27
Part D supplemental	38	34	-10	19	18
Part D premium	27	24	-8	14	13
Part B premium	5	7	40	3	4

Note: MA (Medicare Advantage). Employer group plans, special needs plans, and plans that do not offer Part D coverage are not included. Amounts for cost sharing and non-Medicare supplemental benefits include plan costs for administration and profit. Cost-sharing amounts include plan projections of their liability for the beneficiary out-of-pocket expenses cap. Rebate dollar amounts are based on the national average and reflect plan risk scores in plan bids but do not reflect payment adjustments for sequestration. We do not have reliable information about beneficiaries' use these benefits. Values may not sum due to rounding.

Source: MedPAC analysis of data from CMS on plan bids.

to receive specified nonprescription items from pharmacies (Consumer Healthcare Products Association 2021). This study found that only 33 percent of eligible beneficiaries used the OTC benefit during the year. Further, one plan sponsor released a limited summary of the use of their MA supplemental benefits for a sample of about 860,000 MA enrollees in 2022 (Elevance Health 2023). For 6 of the plan's 42 supplemental benefits, the plan did not have the available data to report utilization. For the remaining 36 benefits that the plan covered, most enrollees used 3 or fewer benefits. Although some benefits have restricted availability, the plan did not identify which share of eligible benefits were used. Among the plan's non-dual-eligible enrollees, 25 percent did not use any of the 36 supplemental benefits, the majority (52 percent) used 1 or fewer benefits during the year, and 86 percent used 3 or fewer benefits. Among the plan's dual-eligible enrollees, 17 percent did not use any of the 36 supplemental benefits, 36 percent used 1 or fewer benefits, and 76 percent used 3 or fewer benefits. The plan did not report what share of enrollees used any specific benefit, including benefits that are intended to address social determinants of health. Thus, to the extent that plans' supplemental benefits are intended

to address social determinants of health, it is not clear whether delivering those benefits through MA plans is more effective than other means of financial assistance would be.

Other uses of rebate dollars are for Part D supplemental benefits (18 percent of projected rebates), reductions in Part D premiums (13 percent of projected rebates), and reductions in Part B premiums (4 percent of projected rebates) (Table 12-3). MA plans cannot allocate administrative expenses or margin to Part B premium reductions. Administrative expenses and margin for Part D premium reductions and Part D supplemental benefits may be included in plans' Part D bids.²⁴

Payments to MA plans far exceed FFS spending due to favorable selection into MA plans and higher MA coding intensity

Payments to MA plans are determined using a plan's bid—which is intended to represent the dollar amount that the plan estimates it will need to cover the

**TABLE
12-4**

MA plan payments estimated to be substantially above FFS spending due to the effects of coding intensity and favorable selection

Share of FFS spending in 2024

	Benchmarks	Bids	Payments
Overall estimate	132%*	101%*	122%
Estimated before coding and selection	108*	82*	100
Estimated coding effect	+14	+11	+13
Estimated selection effect	+10	+7	+9

Note: MA (Medicare Advantage), FFS (fee-for-service). Benchmarks are the maximum Medicare program payments for MA plans and incorporate plan quality bonuses. Bids represent the dollar amount that plans estimate will cover the Part A and Part B benefit package for a beneficiary of average health. We estimate FFS spending by county using the 2024 MA rate book. Although MA enrollees must be enrolled in both Part A and Part B, the FFS spending denominator used in the MA rate book includes all Part A and Part B spending (including beneficiaries covered only by Part A). We retrospectively compared MA spending with actual FFS spending for beneficiaries enrolled in both Part A and Part B and found that the results were similar (within 1 percentage point) compared with our prospective analyses that start with CMS’s rate book calculation (Medicare Payment Advisory Commission 2023b). We removed spending related to the remaining double payment for indirect medical education payments made to teaching hospitals. To account for our most recent coding estimate of 13 percent, we estimated overall benchmarks, bids, and payments if coding differences between MA and FFS were fully reflected (i.e., if the risk-adjusted differences between MA and FFS did not include coding differences). The coding effect accounts for CMS’s 5.9 percent coding adjustment. We project coding intensity based on the annual trend from 2017 through 2021, an increase of 1.5 percentage points per year. For 2024, we reduced the annual trend by 0.67 percentage points to account for one-third of an estimated 2 percentage point reduction in coding intensity associated with the introduction of the V28 risk-adjustment model, which will be phased in over three years. Favorable selection accounts for the estimated lower risk-standardized spending that MA enrollees would have without any plan intervention. We assume that the 2024 effect of selection would be the same as our 2019 estimate of selection (before the coronavirus pandemic). More details on our coding and selection analyses are found in Chapter 13. Totals may not sum due to rounding.

*Estimates of benchmarks and bids relative to FFS spending do not include employer plans.

Source: MedPAC analysis of data from CMS on plan bids, enrollment, benchmarks, FFS expenditures, and risk scores.

Medicare benefit package for a beneficiary—and the benchmark for the county in which the beneficiary resides. The benchmark is based on CMS’s projection of risk-standardized local FFS spending and is the maximum Medicare payment amount set by law for an MA plan to provide Part A and Part B benefits for beneficiaries in that county.

In recent years, we have reported on payments to MA plans relative to what FFS spending would have been for comparable beneficiaries, highlighting that coding differences substantially contributed to MA payments above FFS spending. This year, in addition to coding differences, we include the effects of favorable selection, which the Commission discussed in prior reports (Medicare Payment Advisory Commission 2023a, Medicare Payment Advisory Commission 2012a).²⁵ Selection may reflect beneficiaries who are healthier than predicted or beneficiaries who use

less care than predicted for nonhealth reasons (e.g., preferences about seeking care).²⁶ More details on the coding and selection analyses that informed this chapter are provided in Chapter 13.

In 2024, we project that MA plan payments (including rebates that finance extra benefits) remain far above what Medicare would have paid for similar beneficiaries in FFS, continuing the trend of higher levels of payment throughout the history of Medicare managed care. We estimate that Medicare spends 22 percent more for MA enrollees than it would spend if those beneficiaries were enrolled in FFS Medicare, a difference that translates into a projected \$83 billion in 2024.

Our estimate reflects the impact of higher MA coding intensity, even after the CMS coding adjustment; favorable selection of beneficiaries in MA; setting of benchmarks—the maximum amount Medicare will pay an MA plan to provide Part A and Part B benefits—

above FFS spending in low-FFS-spending counties; and payments associated with benchmark increases under the quality bonus program. The Commission acknowledges that a portion of these increased payments to MA plans are used to provide more generous supplemental benefits and better financial protection for MA enrollees.

Payments to MA plans are an estimated 22 percent higher than FFS spending for 2024

Because CMS's FFS projections do not fully account for coding differences (i.e., MA coding intensity in excess of what is expected when paying plans) and favorable selection (i.e., the extent to which risk-standardized spending of MA enrollees would be lower than the FFS average without any intervention from MA plans), the projections do not accurately reflect what an MA enrollee would have cost the Medicare program if instead enrolled in FFS.²⁷ We only show how MA benchmarks, bids, and payment compare with CMS's projected FFS spending because that spending is the amount that CMS assumes for purposes of creating benchmarks.²⁸ Benchmarks are based on CMS's projection of risk-standardized FFS spending, and the underlying MA payment rates assume that standardized spending is equal between MA and FFS enrollees. However, these benchmarks and the risk-adjustment model do not account for favorable selection and coding intensity, so payment rates to MA plans are inflated and CMS's FFS spending projections that are used for payment do not represent what FFS Medicare would have spent on MA enrollees.

We include uncorrected coding intensity and favorable selection in our analysis so that the MA and FFS populations are comparable. Because benchmarks do not account for these adjustments, it is also unlikely that plan bids assume the effects of uncorrected coding and favorable selection. With these adjustments, we project that benchmarks in 2024 are 132 percent of FFS spending (i.e., the amount that would have been spent on MA enrollees if they were in FFS). Overall, plan bids—14 percent of which are projected to be nonmedical expenses for administration and profit—in 2024 are an estimated 101 percent of FFS spending. Thus, though MA plans have lower medical costs than FFS, these projected efficiencies are offset by plans' projected administration costs and profits. In total, we project

that plans will offer the standard Medicare benefit at about the same cost as FFS in 2024, which implies that the majority of extra benefits for MA enrollees are not financed by plans offering the benefit at lower costs than FFS, but rather by the taxpayers and beneficiaries who fund the program. Overall, we estimate that coding and selection cause MA payments to be 22 percentage points above FFS spending in 2024.²⁹ That difference translates into MA payments that are a projected \$83 billion above FFS spending in 2024.

Before accounting for the effects of diagnostic coding practices (MA coding intensity in excess of the adjustment) and favorable selection (risk-standardized spending of MA enrollees would be lower than the FFS average without any intervention from MA plans) between MA and FFS, MA benchmarks in 2024 are estimated to average 108 percent of CMS's projected FFS spending (Table 12-4), down 1 percentage point from 2023.³⁰ Before accounting for coding intensity and favorable selection, in 2024, overall plan bids average an estimated 82 percent of CMS's projection of FFS spending, a record low relative to CMS's projected FFS amount (down from 83 percent in 2023). When a plan bids below the benchmark, its payment rate is its bid plus a share of the difference between its bid and the benchmark. Overall, we estimate that—without any adjustments for coding intensity or favorable selection—Medicare payments to MA plans in 2024 would average 100 percent of projected FFS spending. We estimate that quality bonuses accounted for 3.2 percent (an estimated \$15 billion) of MA payment in 2024. (Thus, the absence of these payments would have reduced payments relative to FFS spending by 3.2 percent.) However, because these estimates do not adjust for the effects of coding and selection, they only serve as a measure of how current policy directly pays MA plans relative to FFS spending.

Aggregate Medicare payments to MA plans have always been substantially higher than what estimated spending would have been in FFS Medicare

Our review of private plan payments suggests that over a 39-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 than it would have paid if

beneficiaries had been in FFS Medicare. Evaluations of private plan payment rates under Medicare demonstrations occurring before 1985 found that payment rates were 15 percent to 33 percent higher than FFS Medicare spending (Langwell and Hadley 1990). Between 1985 and 2004, risk adjustment was inadequate and researchers estimated that private plan payments were 5 percent to 7 percent higher than FFS Medicare spending in the late 1980s and through the mid-1990s (Brown et al. 1993, Medicare Payment Advisory Commission 1998, Newhouse 2002, Riley et al. 1996). Since the introduction of bids and benchmarks in MA payment policy, the Commission started using a prospective method to compare plan benchmarks, plan bids, and the resulting payments to MA plans relative to CMS's projected FFS spending (standardizing differences in risk scores). From 2004 through 2006, the Commission found that payments to MA plans were 7 percent to 12 percent higher than FFS Medicare spending. However, these estimates used FFS projections that included beneficiaries who were not eligible for MA, did not account for differences in diagnostic coding, and did not account for the favorable selection that plans experience with beneficiaries who choose to enroll in MA (see Chapter 13, text box on "MA plan and beneficiary incentives may produce a favorable selection of enrollees," for more detail on why plans may experience favorable selection). To account for these differences, the Commission now applies three adjustments on an ongoing basis:

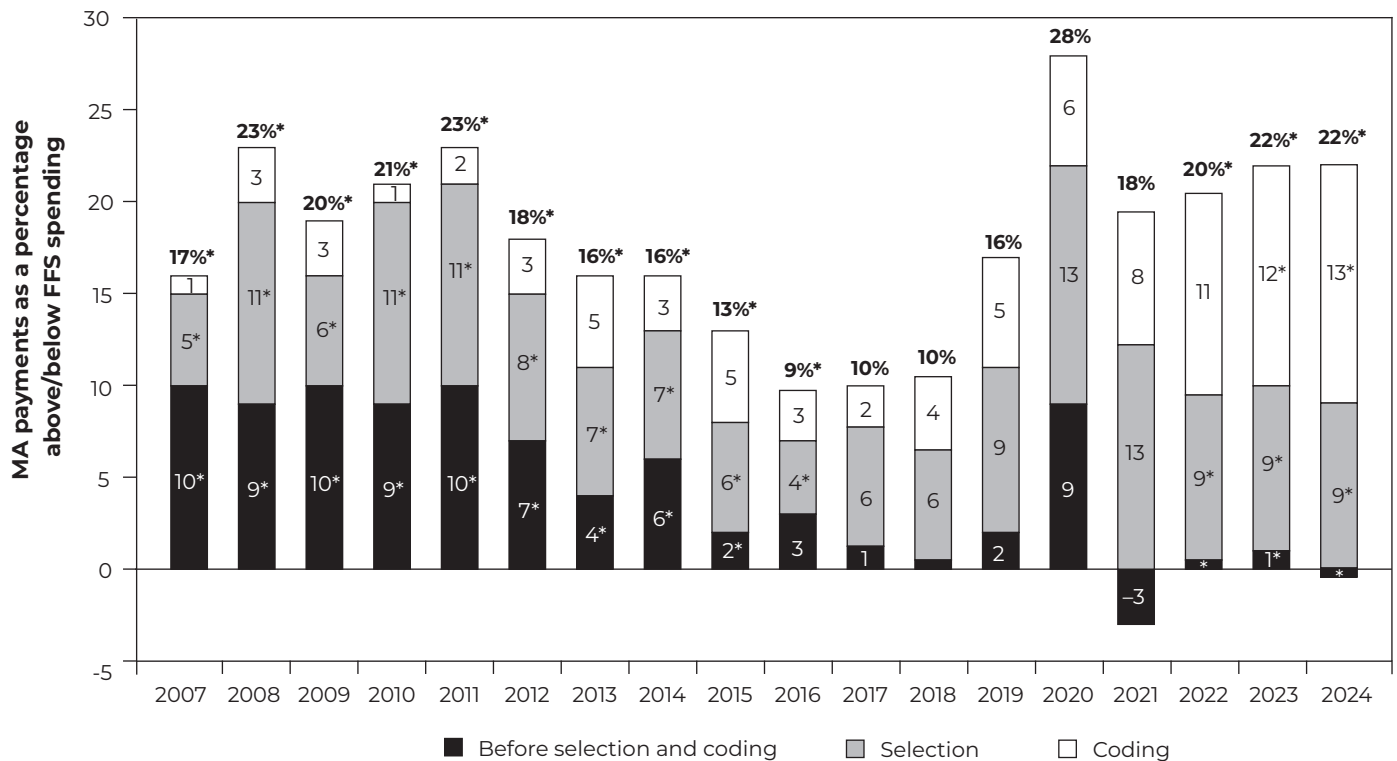
- First, starting with 2016 data, the Commission retrospectively compares actual MA payments with actual FFS spending for beneficiaries who are eligible to enroll in an MA plan (i.e., beneficiaries with both Part A and Part B coverage). Our analysis from 2016 to 2019 showed that our prospective and retrospective comparisons consistently produced similar results. Thus, our prospective estimates prior to the coronavirus pandemic were reasonable (at least partially due to risk adjustment and adjustments for Medicare as a secondary payer that helped account for population differences). We have now updated our retrospective analysis to estimate MA payments as a percentage of FFS spending in 2020 and 2021 (the most recent year of available data). These years were directly affected by the coronavirus pandemic and produced a relatively larger difference between our prospective

and retrospective estimates, which were driven by large differences between projected and actual FFS risk-standardized spending. We will continue to update our retrospective analysis as data become available. Because of data availability, we continue to show our prospective analyses from 2007 through 2015 and 2022 through 2024. In addition, consistent with an adjustment the Commission made that assumed an override of the sustainable growth rate in 2010, we have now made a similar adjustment to our 2007 through 2009 prospective estimates of MA payments relative to FFS spending.

- Second, we have updated our method for estimating coding intensity and have retrospectively applied our estimate beginning in 2007. More details on our updated method are found in Chapter 13. From 2023 through 2024, we project coding intensity based on the annual trend from 2017 through 2021, an increase of 1.5 percentage points per year. For 2024, we reduced the annual trend by 0.67 percentage points to account for one-third of an estimated 2 percentage point reduction in coding intensity associated with the introduction of the V28 risk-adjustment model, which will be phased in over three years (from 2024 to 2026). There is uncertainty about the impact of moving to the V28 on MA coding intensity. We will continue to monitor those effects and will update our analysis as we are able.
- Third, we now account for favorable selection of beneficiaries into MA whereby the risk-standardized spending of MA enrollees would be lower than the local FFS average without any intervention from MA plans. We estimated the cumulative annual effect of selection, including the effects of attrition and regression to the mean from 2017 through 2021 (the most recent year of available data).³¹ For 2022 through 2024, we apply our 2019 estimate of selection (about 9 percent) to avoid any effect from the coronavirus pandemic on our projections. For 2007 to 2016, we apply the selection estimate for MA entrants in the subsequent year (i.e., beneficiaries who switched from FFS to MA in each year from 2008 to 2017). Our analysis from 2017 through 2021 showed that the overall selection effect was only slightly higher than the selection effect for entrants in the

FIGURE 12-3

Higher MA payments relative to what estimated spending would have been in FFS, 2007-2024



Note: MA (Medicare Advantage), FFS (fee-for-service). Estimates of MA payments before selection and coding relative to what spending would have been in FFS are less than 0.5 percent for 2018, 2022, and 2024. We exclude MA payments for beneficiaries with end-stage renal disease. Components may not sum to totals due to rounding. Our estimates before selection and coding reflect CMS's projection of FFS spending from 2007 through 2015 (including adjustments that assume an override of the sustainable growth rate during the applicable years) and 2022 through 2024. Estimates from 2016 through 2021 reflect our retrospective comparison of actual payments (including nonclaims spending) for beneficiaries who had both Part A and Part B coverage, had Medicare as their primary payer, did not have end-stage renal disease, and resided in the 50 states and the District of Columbia. Thus, estimates in 2020 and 2021 reflect the effects of the coronavirus pandemic. Estimates of actual MA payments in 2020 include remittances related to plan medical loss ratios. Favorable selection accounts for the estimated lower risk-standardized spending that MA enrollees would have incurred without any plan intervention. Estimates of the effect of selection from 2007 through 2016 are based on beneficiaries who switched from FFS to MA in the following year (2008 to 2017). These estimates do not account for attrition and regression to the mean, but our comprehensive estimates of selection annually from 2017 through 2021 suggest that these factors would, on net, increase the effect of selection. We assume that the 2022 through 2024 annual effect of selection would be the same as our 2019 estimate of selection (before the coronavirus pandemic). Coding estimates are net of CMS's adjustment to MA risk scores. From 2023 through 2024, we project coding intensity based on the annual trend from 2017 through 2021, an increase of 1.5 percentage points per year. For 2024, we reduced the annual trend by 0.67 percentage points to account for one-third of an estimated 2 percentage point reduction in coding intensity associated with the introduction of the V28 risk-adjustment model, which will be phased in over three years. *Specified values used projected data.

Source: MedPAC analysis of Medicare enrollment, Medicare claims spending, and risk-adjustment files.

subsequent year (from 2018 to 2022). More details on our updated selection analysis are found in Chapter 13.

Figure 12-3 shows that since 2007, payments to MA plans have been substantially above the amount FFS

Medicare would have spent for the same beneficiaries. Throughout the 18-year period from 2007 through 2024, we estimate that MA payments were at least 9 percent more than FFS spending for comparable beneficiaries in each year. Between 2011 and 2017, relative MA payments decreased from 23 percent above

FFS spending to 10 percent above FFS spending. This change is largely explained by (1) declining benchmarks resulting from ACA policies and (2) declining favorable selection—coinciding with an increasing share of MA enrollees who were dually eligible for Medicaid and were found to have less favorable spending for plans in the risk-adjustment model that CMS applied prior to 2017. However, after changes to CMS’s risk-adjustment model were fully implemented in 2017 (including the segmentation of the model for dual-eligible beneficiaries, which makes them no longer unfavorable on a risk-standardized basis), MA payments increased relative to FFS spending through 2024—driven by the combined effects of coding intensity and selection. We estimate that MA payments are 22 percent above FFS spending in both 2023 and 2024. Given the increasing share of Medicare beneficiaries enrolled in an MA plan, these differences translate to a substantial amount of MA payments above FFS spending.

Figure 12-4 shows the higher payments to MA relative to what spending would have been in dollar terms if enrollees were in FFS. In estimating the payment amount above FFS spending, we removed MA payments for beneficiaries with end-stage renal disease, whom we exclude from all of our analyses and for whom there is no evidence of selection or coding intensity. Since 2007, we estimate that Medicare has paid \$507 billion and will pay \$83 billion more for MA enrollees in 2024 than if those beneficiaries had instead been in FFS—a total of \$591 billion. Over half (an estimated \$338 billion) of the MA payments above FFS spending will have occurred in the last five years—from 2020 through 2024. These higher payments are increasingly driven by coding intensity, which we estimate accounted for the largest share of payments above FFS spending from 2022 through 2024.

Coding differences increase payments to MA plans in 2024 by \$50 billion and continue to generate inequity across plans

Payments to MA plans are risk adjusted to account for differences in health status. Higher risk scores increase payments to plans for enrollees with higher expected Medicare spending. Risk scores are based on demographic information and diagnoses that plans submit to CMS. Documenting additional diagnosis codes raises plan enrollees’ risk scores, generating two distinct benefits for MA plans: (1) increasing the

monthly payments MA plans receive from Medicare and (2) increasing the rebates plans use to provide extra benefits to enrollees. Plans that document relatively more diagnosis codes have a competitive advantage over other plans.

Documenting more diagnosis codes increases payments to plans

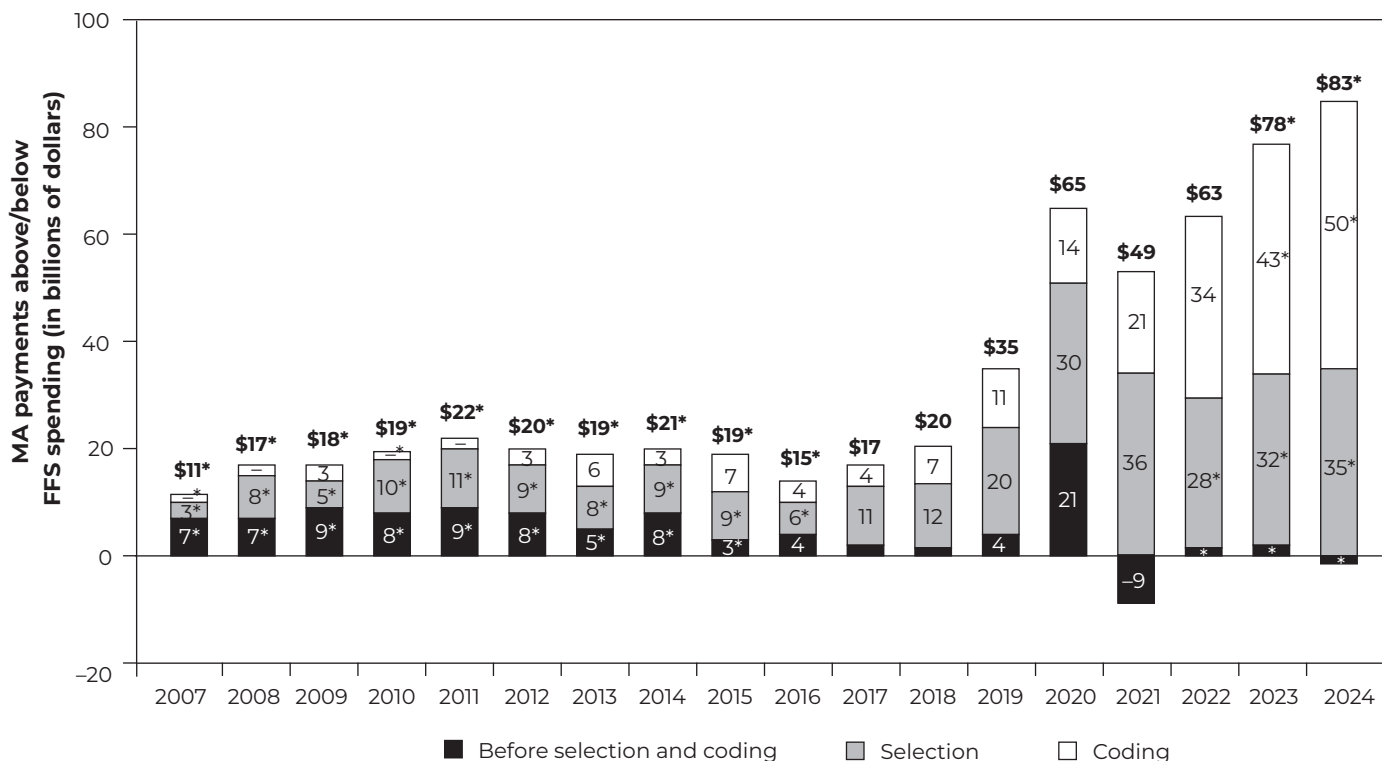
Among the 20 most common HCCs in MA—which have reimbursement amounts ranging from roughly \$1,000 to \$5,500—the average additional payment per HCC is about \$3,400 per year. Documenting each additional HCC for an enrollee can thus significantly increase Medicare payment to a plan. We can illustrate how coding additional HCCs increases payment to a plan using average FFS Medicare spending.³² For example, in 2022, the annual Medicare payment to an MA organization for a non-Medicaid-eligible 80-year-old male (where the demographic component of the risk score is valued at \$6,726) with diabetes without complication (HCC 19, valued at \$1,284) would have been \$8,010. If the same 80-year-old male with diabetes were also found to have vascular disease (HCC 108, valued at \$3,620), the Medicare annual payment to the MA organization would increase to \$11,630.

Because the CMS–HCC model uses FFS Medicare claims data to estimate the size of the model coefficients, the model calculates an expected spending amount based on FFS Medicare costs and diagnostic coding patterns. Most diagnoses are reported on physician and outpatient claims, which in FFS Medicare tend to be paid based on procedure codes, thus providing little financial incentive to document diagnoses for FFS beneficiaries. If certain diagnoses are not reported on FFS claims, the cost of treating those conditions is attributed to other components in the model, causing the coefficients overall to be inflated above the value they would have been if the diagnoses had been reported. For MA payments to be accurate, diagnoses must be coded with the same intensity in FFS Medicare and MA. When MA plans submit more diagnoses for a beneficiary than would have been documented in FFS Medicare, the program spends more for that beneficiary in MA than it would have if the beneficiary were in FFS.

Because of the increased financial incentives for MA plans to code more diagnoses and the additional tools

FIGURE 12-4

Estimated coding and selection have increased MA payments above what spending would have been in FFS



Note: MA (Medicare Advantage), FFS (fee-for-service). Estimates of MA payments before selection and coding relative to what spending would have been in FFS are less than \$3 billion for 2017, 2018, 2022, 2023, and 2024. We exclude MA payments for beneficiaries with end-stage renal disease. Components may not sum to totals due to rounding. Our estimates before selection and coding reflect CMS's projection of FFS spending from 2007 through 2015 (including adjustments that assume an override of the sustainable growth rate during the applicable years) and 2022 through 2024. Estimates from 2016 through 2021 reflect our retrospective comparison of actual payments (including nonclaims spending) for beneficiaries who had both Part A and Part B coverage, had Medicare as their primary payer, did not have end-stage renal disease, and resided in the 50 states and the District of Columbia. Thus, estimates in 2020 and 2021 reflect the effects of the coronavirus pandemic. Estimates of actual MA payments in 2020 include remittances related to plan medical loss ratios. Favorable selection accounts for the estimated lower risk-standardized spending that MA enrollees would have incurred without any plan intervention. Estimates of the effect of selection from 2007 through 2016 are based on beneficiaries who switched from FFS to MA in the following year (2008 to 2017). These estimates do not account for attrition and regression to the mean, but our comprehensive estimates of selection annually from 2017 through 2021 suggest that these factors would, on net, increase the effect of selection. We assume that the 2022 through 2024 annual effect of selection would be the same as our 2019 estimate of selection (before the coronavirus pandemic). Coding estimates are net of CMS's adjustment to MA risk scores. From 2023 through 2024, we project coding intensity based on the annual trend from 2017 through 2021, an increase of 1.5 percentage points per year. For 2024, we reduced the annual trend by 0.67 percentage points to account for one-third of an estimated 2 percentage point reduction in coding intensity associated with the introduction of the V28 risk-adjustment model, which will be phased in over three years. *Specified values used projected data.

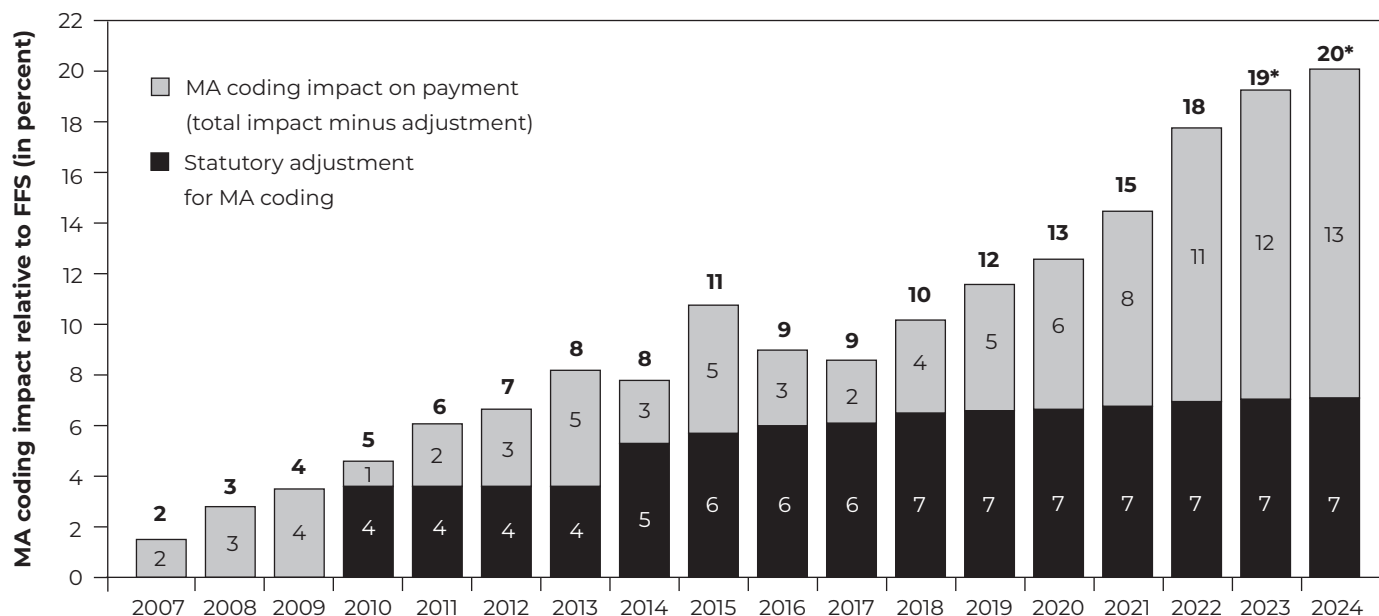
Source: MedPAC analysis of Medicare enrollment, Medicare claims spending, and risk-adjustment files.

that MA plans use to capture diagnoses—which are not features of FFS Medicare—coding intensity is higher in MA than in FFS and payments to MA plans are higher than intended. Although Medicare’s accountable care organization (ACO) programs and some other

alternative payment models (APMs) offer incentives to increase diagnostic coding intensity in FFS Medicare, we continue to see higher coding intensity in MA, and that difference continues to increase. The tools that ACOs and APMs have available result in less coding

**FIGURE
12-5**

Estimated impact of coding intensity on MA risk scores was larger than coding adjustment, 2007-2024



Note: MA (Medicare Advantage), FFS (fee-for-service). All estimates account for any differences in age, sex, Medicaid eligibility, and institutional status between MA and FFS populations. New enrollees are constrained to have no coding intensity as their risk scores are not based on diagnostic coding. The annual adjustment for MA coding began in 2010. MA coding intensity has increased MA risk scores annually, but increases were offset by new versions of the risk-adjustment model in 2014, 2016, and 2017 and by increased FFS coding in 2016 and 2017. The impact of the coding adjustment is calculated as the MA coding intensity estimate relative to FFS, multiplied by the coding adjustment. For 2024, we calculate $1.20 \times 5.9\% = 0.071$ or 7.1%. Components may not sum to totals due to rounding.
 *For 2023 and 2024, we project coding intensity based on the annual trend from 2017 through 2021, an increase of 1.5 percentage points per year. For 2024, we reduced the annual trend by 0.67 percentage points to account for one-third of an estimated 2 percentage point reduction in coding intensity associated with the introduction of the V28 risk-adjustment model, which will be phased in over three years.

Source: MedPAC analysis of CMS enrollment and risk-score files.

intensity than those available to MA plans; notably, chart reviews, in-home health risk assessments, and subcapitation to medical groups are used only in MA. Furthermore, CMS limits annual risk-score growth for ACO enrollees when calculating shared savings or losses. Thus, we expect that FFS coding will continue to identify fewer diagnosis codes than MA coding does.

Coding differences may reflect MA plans capturing more diagnoses than FFS providers because plans have an incentive to report every diagnosis for an enrollee whereas FFS providers may be more likely to focus on more significant diagnoses that are primary reasons for a visit. Research has shown that some FFS

beneficiaries have chronic conditions that are reported inconsistently year to year—including conditions like kidney failure or paraplegia—suggesting that not all diagnoses are reported in FFS Medicare (Frogner et al. 2011, Medicare Payment Advisory Commission 2012a). Furthermore, whistleblowers and the Department of Justice allege that some MA plans have submitted fraudulent diagnoses for risk adjustment (Department of Justice 2022, United States of America ex rel. Benjamin Poehling v. UnitedHealth Group 2016, United States of America ex rel. James M. Swoben v. Secure Horizons 2017). There are no data available to parse the share of higher MA coding intensity due to these or other reasons; however, because the risk-adjustment

model is calibrated on FFS claims, relatively higher MA coding intensity—regardless of the reason—increases payments to MA plans above FFS spending.

Higher MA payments due to coding differences have been under scrutiny for more than a decade. Research has consistently found that the impact of coding differences on MA risk scores produces higher payments for MA plans (Congressional Budget Office 2017, Geruso and Layton 2015, Government Accountability Office 2013, Hayford and Burns 2018, Jacobs and Kronick 2018, Kronick and Chua 2021, Kronick and Welch 2014). One study found that when controlling for differences in health status using Part D prescription drug data, from 2008 to 2015, MA risk scores grew by about 1 percent more per year than FFS risk scores (Jacobs and Kronick 2018). A second study used a difference-in-difference approach on risk-adjustment data for 2008 to 2013 to estimate that risk scores for enrollees remaining in MA grew about 1.2 percent faster per year than for beneficiaries in FFS Medicare (Hayford and Burns 2018). A third study, using county-level data, found that the first year after MA enrollment, risk scores increased about 6 percent faster than FFS, and about 2 percent faster in the second year (Geruso and Layton 2020). Finally, the Government Accountability Office used a risk-score prediction model to estimate coding intensity for 2010 through 2012, and those estimates align very closely with the Commission's estimates over that same time period (Government Accountability Office 2013).

Starting in 2010, a series of congressional mandates required CMS to reduce MA risk scores to address the impact of MA and FFS coding differences on payments to MA plans. Because of these mandates, CMS reduced MA risk scores by 3.41 percent in each year from 2010 through 2013. Starting in 2014, legislation specified a minimum reduction of about 4.9 percent, which rose gradually to about 5.9 percent in 2018, where it will remain until the Secretary of Health and Human Services implements risk adjustment using MA diagnostic, cost, and use data. Although larger reductions are allowed under the legislation, CMS reduced MA risk scores by only the minimum amount required by law for 2014 through 2024.³³

This chapter reflects revisions to our method of estimating coding intensity. Chapter 13 describes those revisions, the research leading to them, and the impact

of estimating coding intensity using the revised method relative to the method used in prior MA status reports. Figure 12-5 shows the impact, for 2007 through 2022, of differences in coding intensity on MA risk scores relative to FFS and the size of the coding intensity adjustment (the amount by which CMS reduced MA risk scores to account for coding intensity).

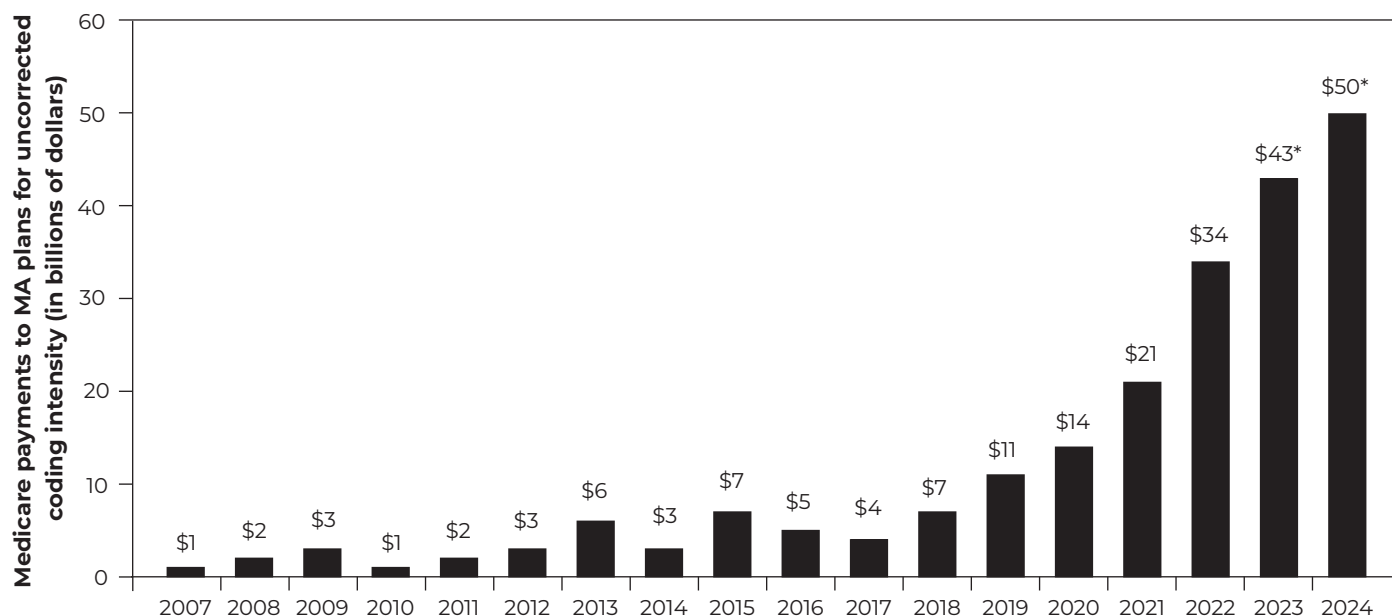
From 2007 through 2013, MA coding intensity increased MA risk scores by 1.15 percentage points per year more than the FFS risk-score trend, and by 1.5 percentage points more per year for 2017 through 2021. Deviations from the typical trend occurred in 2014, 2016, and 2017, which we attribute to two factors: (1) new versions of the risk-adjustment model that were introduced in 2014, 2016, and 2017 reduced the gap in MA and FFS diagnostic coding differences; and (2) FFS risk scores grew faster (matching or nearly matching MA risk-score growth rates) in 2016 and 2017 than in the previous or subsequent years, likely due to Medicare's transition from using International Classification of Diseases (ICD)-9 to ICD-10 diagnosis codes in October 2015. See our March 2021 report's MA chapter for a more detailed explanation of these factors (Medicare Payment Advisory Commission 2021b).

In 2021, overall MA risk scores (based on diagnoses on claims from services provided in 2020) decreased from 2020 (data not shown), which is associated with the reduction in service use in 2020 during the pandemic. However, the reduction in MA risk scores in 2021 was less than the reduction in risk scores for comparable FFS beneficiaries, so estimated MA coding intensity continued to increase in 2021. For 2022, we estimate a 3.3 percentage point increase from 2021, likely due to an increased effort to raise MA risk scores, in part through the use of health risk assessments and chart reviews as described below, after MA risk scores had fallen in the prior year.³⁴

For 2023 and 2024, we project coding intensity based on the annual trend from 2017 through 2021, an increase of 1.5 percentage points per year. For 2024, we reduced the annual trend by 0.67 percentage points to account for one-third of an estimated 2 percentage point reduction in coding intensity associated with the introduction of a new risk-adjustment model (V28), which will be phased in over three years.³⁵ There is uncertainty about the impact of moving to the V28 on

**FIGURE
12-6**

Uncorrected MA coding intensity has increased payments to plans by an estimated \$124 billion through 2022 and is projected to generate nearly \$94 billion more in 2023 and 2024



Note: MA (Medicare Advantage). Estimates for 2007 through 2022 are based on the Commission's estimate of uncorrected coding intensity. In all years, Medicare spending for MA plans is based on the Medicare Trustees' reports and excludes spending for end-stage renal disease beneficiaries. *For 2023 and 2024, we project coding intensity based on the annual trend from 2017 through 2021, an increase of 1.5 percentage points per year. For 2024, we reduced the annual trend by 0.67 percentage points to account for one-third of an estimated 2 percentage point reduction in coding intensity associated with the introduction of the V28 risk-adjustment model, which will be phased in over three years.

Source: MedPAC analysis of CMS enrollment and risk-score files, and Medicare Trustees' reports.

MA coding intensity. We will continue to monitor those effects and will update our analysis as we are able.

For 2024, we project that MA risk scores will be about 20 percent above risk scores for comparable FFS beneficiaries. This difference is only partially offset by the coding intensity adjustment that reduced MA risk scores by 5.9 percent. The net effect is a 13 percent increase in MA risk scores due to coding intensity, leading to \$50 billion in higher payments to MA plans.

Between 2007 and 2024, we estimate that MA coding intensity will have generated \$217 billion in aggregate higher payments to MA plans (Figure 12-6). Between 2007 and 2022, MA coding intensity resulted in \$124 billion in increased payments to MA plans. Using our

projection of MA coding intensity, we estimate that uncorrected coding intensity in 2023 and 2024 will increase program spending by another \$43 billion and \$50 billion, respectively.

Documenting additional diagnosis codes increases plan rebates and can distort the nature of competition among plans

Documenting additional diagnostic codes increases the size of MA plans' rebates, which in turn allows plans to offer their enrollees more extra benefits than plans that document fewer additional diagnoses. For a plan submitting a bid below its benchmark (nearly all plans in 2024), the plan's rebate is based on the difference between the plan's bid for its expected enrollee population and the plan's risk-adjusted benchmark,

**TABLE
12-5**

Illustrative example: A plan that codes diagnoses more aggressively can offer its enrollees more extra benefits

Plan	Bid: Monthly cost of care for expected population	Risk score of expected population	Monthly MA benchmark for the county for an average-risk population (+5% for bonus plan)	Risk-adjusted monthly benchmark (benchmark multiplied by risk score)	Difference in risk-adjusted benchmark and plan bid	Monthly value of extra benefits (rebate amount)*
Nonbonus plans						
Plan A (3.5 stars)	\$900	0.97	\$952	\$923	\$23	\$15
Plan B (3.5 stars)	900	1.03	952	981	81	52
Bonus plan						
Plan Z (5 stars)	900	0.97	1,000	970	70	49

Note: MA (Medicare Advantage). An average-risk population has a risk score of 1.0. This example assumes that the actual cost of care for the expected population is \$900 monthly for each of the three plans and that the plans serve the same beneficiaries. Plan B's risk score of 1.03 is inflated due to greater diagnostic coding effort.

*Plans A and B at 3.5 stars have a rebate percentage of 65 percent. Plan Z at 5 stars has a rebate percentage of 70 percent.

which is the standard benchmark (for a beneficiary of average risk, with a 1.0 risk score) multiplied by the plan's expected average risk score. Raising a plan's average risk score raises the plan's risk-adjusted benchmark and widens the difference between the plan's bid and the risk-adjusted benchmark, thereby increasing the plan's rebate amount and ability to offer more extra benefits. In sum, plans can translate greater coding effort into the ability to offer more extra benefits than their competitors and can gain a competitive advantage in attracting enrollees.

MA payment policies aim to give plans an incentive to lower spending and improve quality by allowing them to offer more extra benefits. By reducing health care costs, plans can reduce their bids, increasing their rebate and extra benefit value. By improving quality scores, plans can be rewarded with a 5 percent or 10 percent increase in their benchmark or with an increase in the rebate percentage (the percentage of the bid and benchmark difference that determines the rebate amount).³⁶ These policies are intended to benefit beneficiaries through improved quality, more extra benefits, and reduced premiums, as well as lower taxpayer funding for the Medicare program. Greater

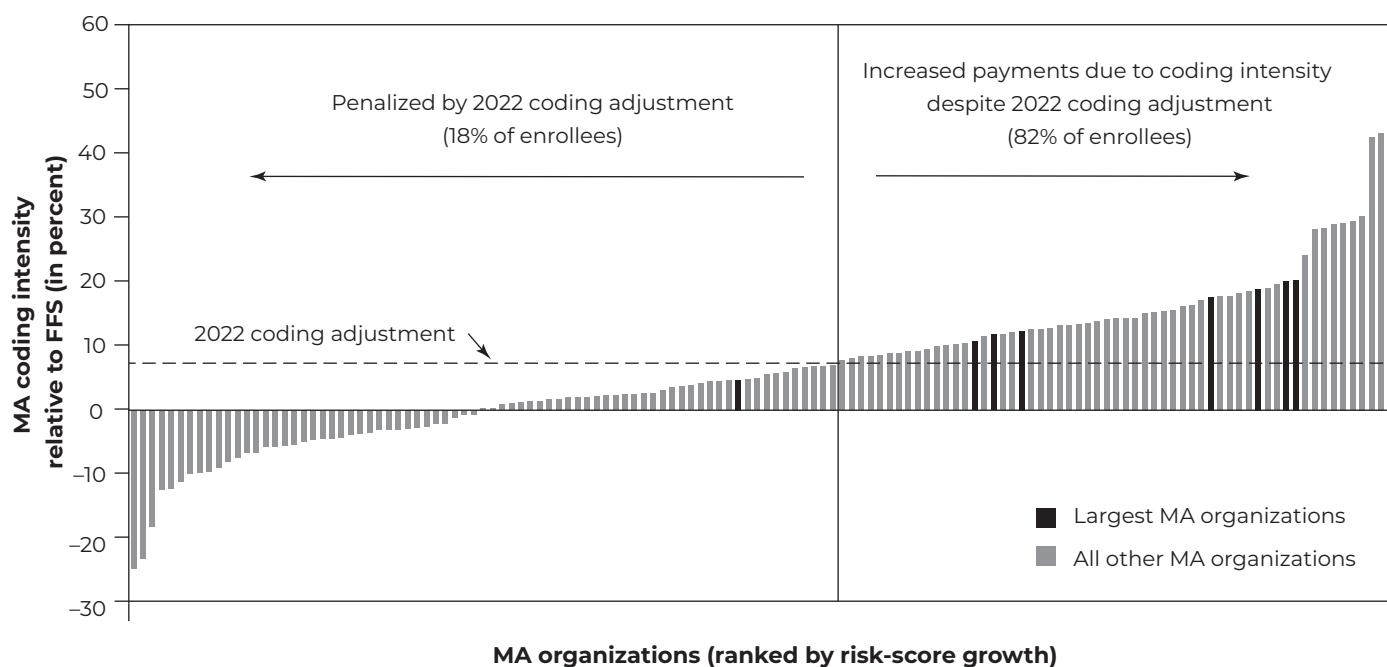
MA coding intensity, however, distorts these incentives by allowing plans to offer more extra benefits regardless of whether they reduce costs or improve quality.

Table 12-5 illustrates the relationship between coding intensity and rebate amounts using a hypothetical example of three plans covering the same set of enrollees for whom the expected cost of care is the same, at \$900 per member per month. Plans A and Z have an expected risk score of 0.97, and Plan B has an expected risk score of 1.03 due to more aggressive diagnostic coding. All three plans have bids below the risk-adjusted benchmark and provide extra benefits funded by rebates. However, because Plan B has a higher risk score, its rebate is larger than Plan A's rebate (\$52 per month vs. \$15 per month), so it can offer enrollees more extra benefits. Plan B's aggressive diagnostic coding effort has therefore given it an unfair competitive advantage over Plan A.

In addition, aggressive coding can result in greater extra benefits than the effect of MA quality bonuses. The higher risk score of Plan B, which has only 3.5 stars, gives it an advantage over bonus-level Plan Z,

**FIGURE
12-7**

Coding intensity varied across MA organizations relative to FFS, 2022



Note: MA (Medicare Advantage), FFS (fee-for-service). Excludes special needs plans, contracts for the Program of All-Inclusive Care for the Elderly, and organizations with fewer than 2,500 enrollees in the analysis. All estimates account for any differences in age, sex, Medicaid eligibility, and institutional status between MA and FFS populations. New enrollees are constrained to have no coding intensity because their risk scores are not based on diagnostic coding.

Source: MedPAC analysis of CMS enrollment and risk-score files.

which has 5 stars: Plan B's rebate amount is higher than Plan Z's (\$52 per month vs. \$49 per month). Thus, by inflating its risk score from 0.97 to 1.03, Plan B can offer more extra benefits than are provided through quality bonuses.

The plans illustrated in Table 12-5 (p. 381) have a risk-score difference of 6 percentage points, reflecting different coding practices. We estimated coding intensity for MA organizations and found much greater variation in coding for 2022.³⁷ Figure 12-7 shows coding intensity relative to FFS coding by MA parent organization, excluding contracts in the Program of All-Inclusive Care for the Elderly, special needs plans, and organizations with fewer than 2,500 enrollees.

Consistent with prior years, coding intensity varies significantly across MA organizations. We find that

about half of organizations (covering 18 percent of MA enrollees) have coding intensity below the 2022 coding adjustment, and are thereby penalized by the adjustment, while the other half of organizations (covering 82 percent of MA enrollees) have coding intensity that increases their payment after accounting for the 2022 coding adjustment. These differences demonstrate that CMS's across-the-board adjustment for coding intensity, which reduces all MA risk scores by the same amount, generates inequity across contracts by reducing net revenue for plans with lower coding intensity and allowing other plans to retain a significant amount of revenue from higher coding intensity.

We also find significant variation in coding intensity across the largest eight MA organizations (covering 77 percent of MA enrollees), from 4.7 percent to 20.2

percent above FFS levels. Seven of the eight largest MA organizations had greater coding intensity than the 2022 coding adjustment and therefore received a net increase in payment due to aggressive coding practices. These differences are large enough to give MA organizations with higher coding intensity a significant competitive advantage by increasing the size of plan rebates and helping them to attract more enrollees. Our finding that coding intensity varies across MA organizations is consistent with other research assessing variation in coding intensity across or in the use of health risk assessments and chart review, which are key drivers of MA coding intensity (Geruso and Layton 2015, Kronick and Welch 2014, Office of Inspector General 2021).

MA plans have several tools that are unavailable in FFS to code more diagnoses

MA plans use several mechanisms that do not exist in FFS Medicare to document diagnoses for their enrollees. They can identify enrollees likely to have an HCC that has not yet been documented using data the plan already has: an enrollee's historical claims, risk-score data, and prescription drug data (e.g., a prescription for insulin likely indicates a diabetes diagnosis). Of all the mechanisms to document more diagnosis codes, evidence continues to highlight MA plans' use of health risk assessments and chart reviews as major sources of plan revenue from coding intensity.

Pay-for-coding programs and patient assessment forms

Some plans try to ensure that providers submit all possible diagnoses for their enrollees through pay-for-coding programs in which plans send physicians a patient assessment form that includes diagnosis codes that the plan has identified for a beneficiary. Plans ask physicians to confirm the existence of plan-identified diagnoses on the form and document those diagnoses on subsequent claims. Plans pay physicians based on completing the form or as a dollar amount per diagnosis code submitted, and some plans include a bonus payment for submitting every code that the plan identifies for a beneficiary.

Capitated arrangements in California and Florida may exacerbate coding intensity In the course of reviewing our coding intensity estimates by MA organization, we found that several organizations with the highest diagnostic coding relative to FFS are located in California and Florida. Of the 23 MA organizations

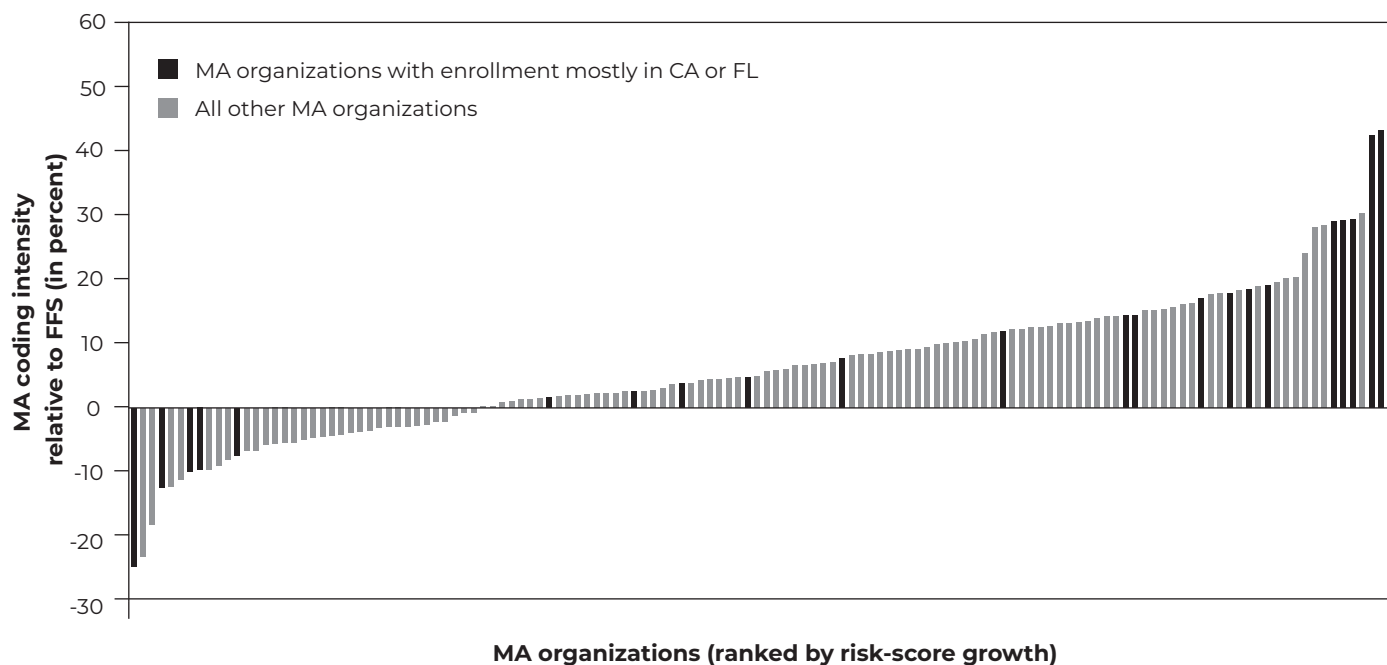
offering plans primarily in California and Florida (i.e., organizations with a majority of their enrollment in California or Florida, excluding the 8 largest MA organizations), 10 were among the 21 organizations with the highest coding intensity, including 6 of the top 7 highest coding organizations (Figure 12-8, p. 384). These six organizations had MA risk scores that ranged from 29 percent higher to 52 percent higher than scores for comparable FFS beneficiaries.

To address why these California- and Florida-focused organizations account for so many of the highest-coding organizations, we considered that health plans in California and (to a somewhat lesser extent) Florida have long participated in a form of capitated payment for providers known as the “delegated model.” Under the delegated model, the responsibility for health care delivery and associated financial risk are delegated by the plan to a medical group or independent physician association. Typically, a plan pays a medical group a risk-adjusted sum per enrollee, which is often calculated as a share of a plan's total Medicare revenue. Because a plan's revenue increases when more diagnoses are documented, the capitated payments to providers (determined as a percentage of the plan's revenue) increase proportionately. In these arrangements, the financial incentive to document more diagnoses is passed on to the medical group, which has direct access to an enrollee's medical records and diagnostic information.

Although we could not confirm that the plans offered by the highest-coding California and Florida organizations use the delegated model, we reviewed the share of 2021 provider payments that were capitated for 9 of the top 10 such organizations (one organization did not have 2021 data). Of these nine organizations, the share of provider payments that were capitated was above the national average (33 percent in 2021) for six organizations, including two organizations with provider payments that were almost entirely capitated. Two other organizations had some capitated provider payments but a lower share than the national average, and one organization reported no capitated provider payments. We note that the alignment of clinical and financial accountability under the delegated model may provide a number of beneficial incentives to constrain costs, avoid low-value care, and coordinate care. However, these potential benefits do not justify increased payments due to

**FIGURE
12-8**

MA organizations offering plans primarily in California or Florida account for many of the organizations with the highest estimated coding intensity



Note: MA (Medicare Advantage), FFS (fee-for-service). Excludes special needs plans, contracts for the Program of All-Inclusive Care for the Elderly, and parent organizations with fewer than 2,500 enrollees in the analysis. All estimates account for any differences in age, sex, Medicaid eligibility, and institutional status between MA and FFS populations. New enrollees are constrained to have no coding intensity since their risk scores are not based on diagnostic coding. The eight largest MA organizations were excluded from the highlighted organizations indicating enrollment mostly in CA or FL.

Source: MedPAC analysis of CMS enrollment and risk-score files.

coding intensity, and such payments are not necessary to sustain the model's incentives.

MA plans' use of health risk assessments to increase diagnosis coding Health risk assessments are provided to Medicare beneficiaries as part of an annual wellness visit, and, for MA enrollees, health risk assessments are often provided during a plan-initiated home visit.³⁸ Health risk assessments sometimes rely on patient self-reporting of medical conditions, which may result in HCCs based on inaccurate diagnoses, diagnoses that are no longer active (and therefore not eligible for risk adjustment), or diagnoses without sufficient evidence to conform to ICD coding guidelines (Department of Justice 2022). (More information about these concerns is in our March 2023 report chapter on Medicare Advantage.)

We analyzed 2021 encounter records to identify HCCs that were supported only by a health risk assessment, meaning that there was no physician or hospital service provided to treat a beneficiary for a specific health condition during the same calendar year.³⁹ In 2021, about 6.9 million MA enrollees had a health risk assessment that identified at least one HCC, and a total of 15.0 million unique HCCs were identified through health risk assessments. Of those, 3.2 million beneficiaries had a health risk assessment that was the only source for at least one of the HCCs identified, and a total of 5.0 million HCCs (one-third of all HCCs identified on health risk assessments) were identified only on a health risk assessment. Seven HCCs each generated more than \$500 million in payments from

these assessments, accounting for nearly 60 percent of all payments generated by health risk assessments.⁴⁰ We found that in 2022, diagnostic coding that was associated with only health risk assessments accounted for \$13 billion in payments to MA plans, or a little more than 3 percent of all payments to MA plans. About 60 percent of these payments were from health risk assessments conducted as part of an annual wellness visit or initial preventive physical examination, while the rest of these payments were from in-home health risk assessments.⁴¹

MA plans' use of chart reviews to increase diagnosis coding Some MA plans devote significant effort to conducting chart reviews to increase MA payments. Because chart reviews are not used in FFS Medicare, all diagnoses newly documented through chart reviews contribute to differences in FFS and MA diagnostic coding and contribute to increased payments to MA plans. Chart reviews allowable for risk adjustment document the diagnoses made during hospital and physician encounters in which medical services were provided. MA plans use chart reviews to identify diagnoses not captured through the usual means of reporting diagnoses (e.g., claims data and encounter data): diagnoses that are not reported on the provider's claim sent to the MA plan, diagnoses made during an encounter in which the MA plan does not submit a record of the encounter to CMS, or diagnoses made during an encounter in which the total number of diagnoses from that encounter exceeds the number of diagnosis fields on the encounter record. Because Medicare requires each HCC to be supported by diagnostic evidence in a patient's medical record (chart), chart reviews are one way for plans to identify diagnoses not captured through provider claims or on plan encounter data. However, chart review programs are used exclusively in MA (there is no incentive to undertake chart reviews in FFS Medicare) and thereby exacerbate Medicare's failure to sufficiently account for differences in MA and FFS diagnostic coding.

Like health risk assessments, some MA plans treat chart review programs as an independent revenue stream that yields a positive return on investment because the additional Medicare payments from newly documented diagnoses far exceed the costs of paying nurses and medical assistants to review medical charts.⁴² Several lawsuits allege that MA plans

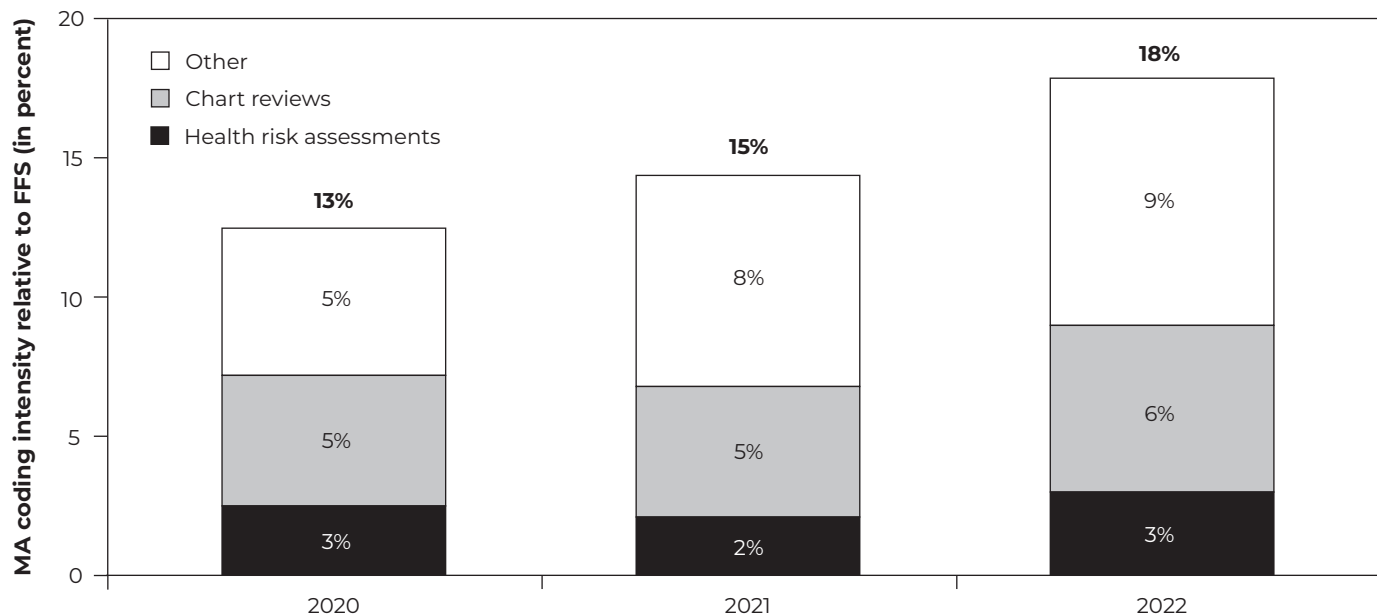
use chart reviews to identify new diagnosis codes, but not to verify the accuracy of already submitted codes. Some lawsuits allege that an MA organization is aware that diagnoses submitted to CMS are not supported by the medical chart and therefore violated Medicare's rules governing the reporting of diagnoses (United States of America ex rel. Benjamin Poehling v. UnitedHealth Group 2016, United States of America ex rel. James M. Swoben v. Secure Horizons 2017, United States of America v. Anthem 2020). Some plans and vendors appear to selectively review charts with a higher likelihood of increasing revenue and use artificial intelligence to more accurately identify likely revenue-producing charts (Blue Health Intelligence 2020, Optum 2020). While the financial return is worth plan sponsors' effort and financial investment, chart review programs increase the financial burden for the taxpayers and beneficiaries who fund the Medicare program.

We analyzed 2021 encounter records to identify HCCs that were supported by a chart review but not through any other record of a physician or hospital encounter during the same calendar year. In 2021, about 11.6 million MA enrollees had a chart review that identified at least one HCC, and a total of 32.7 million unique HCCs were identified on chart reviews. Of enrollees with a chart review, 5.9 million beneficiaries had a chart review that was the only source of an HCC, and a total of 9.6 million HCCs (about 30 percent of all HCCs identified on chart reviews) were identified only through a chart review. Eight HCCs each generated more than \$1 billion in Medicare payments from chart reviews, accounting for more than half of all chart review-based payments.⁴³ We found that in 2022, chart reviews alone accounted for about \$25 billion in payments to MA plans, or about 7 percent of all payments to MA plans.⁴⁴

We estimate that chart reviews and health risk assessments together accounted for about \$33 billion in payments to MA plans, or about 9 percent of all payments to MA plans in 2022.⁴⁵ Combined with our finding that all sources of coding intensity resulted in MA risk scores that were about 18 percent higher than risk scores for comparable FFS beneficiaries in 2022, we conclude that health risk assessments and chart reviews together accounted for about 50 percent of all MA coding intensity (Figure 12-9, p. 386).

**FIGURE
12-9**

Chart reviews and health risk assessments accounted for about half of overall MA coding intensity, 2020–2022



Note: MA (Medicare Advantage), FFS (fee-for-service). Figure shows the impact of coding intensity on payments to MA plans for the years 2020 through 2022. The underlying diagnoses were reported during health care encounters in the prior year, 2019 through 2021, respectively.

Source: MedPAC analysis of CMS enrollment and risk-score files, and Medicare Trustees' reports.

The Commission's prior recommendation on coding intensity

In our March 2016 report to the Congress, the Commission recommended a multipronged approach that would fully account for the impact of coding differences, improve the equity of the adjustment across MA contracts, and increase incentives to reduce costs and improve quality. The Commission's approach to reduce the impact of MA coding intensity has been to address the underlying causes first (e.g., remove health risk assessments and reduce year-to-year coding variations by using two years of diagnostic data) and then address remaining differences with either an across-the-board or tiered adjustment. The Commission's 2016 recommendation did not address the use of chart reviews because data were not available at that time, but eliminating chart reviews as

a source of diagnoses for risk adjustment is consistent with the Commission's approach.

The recommendation, which would replace the existing mandatory minimum coding intensity adjustment (which has reduced MA risk scores by 5.9 percent since 2018), has three parts:

- develop a risk-adjustment model that uses two years of FFS and MA diagnostic data,
- exclude diagnoses that are documented only on 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.

Implementing the first two policies—using two years of diagnostic data and excluding diagnoses documented through health risk assessments alone—and excluding chart review data from risk adjustment (consistent with the Commission’s approach) would result in a more equitable, targeted adjustment to MA contracts than the current across-the-board adjustment. As noted earlier, health risk assessments and chart reviews alone account for roughly half of MA coding intensity. The Commission carefully considered options for addressing coding intensity and supports this approach because it balances implementation feasibility, administrative burden, and effectiveness.

Part of the cause of coding intensity is that providers do not report all possible diagnosis codes for the FFS beneficiaries. We note that using two years of diagnostic data would help address the under-reporting of chronic conditions for FFS beneficiaries by helping to capture conditions that are not reported consistently year to year. Theoretically, conducting chart reviews for FFS beneficiaries could also reduce differences in MA and FFS coding; however, such a strategy would need to carefully consider the number of chart reviews necessary to have a meaningful impact, the administrative effort involved in reviewing the charts to identify diagnoses allowable for risk adjustment, and the disruption to providers when assisting the collection of FFS beneficiary charts. Alternatively, chart reviews could be eliminated from risk adjustment altogether, thereby aligning the data sources used as sources of diagnoses for risk adjustment.

Adjusting for any remaining coding intensity differences could also improve equity across MA contracts. Under one approach, contracts would be grouped into tiers of high, medium, and low coding intensity, and a coding intensity adjustment would be applied based on each tier’s average level of coding intensity (Medicare Payment Advisory Commission 2016a). CMS has used a similar approach to select MA contracts for risk-adjustment data validation audits.⁴⁶ This policy would improve the overall equity of the coding intensity adjustment relative to the single, across-the-board adjustment used today. Finally, we note that in 2016, when the Commission voted on this recommendation, estimates of MA coding intensity net of CMS’s coding adjustment were much

smaller than they are for 2024. Given that the impact of the Commission’s recommendation, which would fully account for the effects of higher MA coding intensity, has grown substantially, policymakers could contemplate phasing in the Commission’s recommendation.

Industry concentration, integration, and financial condition

In 2023, the MA program included 5,635 plan options offered by 184 organizations. However, enrollment is highly concentrated at the local level and increasingly concentrated at the national level: The largest organization in a county typically enrolls between 40 percent and 50 percent of the market, and just three organizations enrolled more than half of all MA enrollees nationally in 2023. The continued growth in MA enrollment, the substantial number of plans offered by several organizations, and plans’ ability to provide generous extra benefits point to continued strong financial health in the MA sector. The Commission has historically analyzed the margins that MA plans report in their bids. However, we have become increasingly concerned about the appropriateness of focusing on plan margins (instead of other metrics of financial health) and about whether the margins reported in bids are sufficient for characterizing insurers’ financial condition.

MA market heavily concentrated, but slightly less concentrated in 2023

Enrollment in MA is highly concentrated at the local level and increasingly concentrated at the national level. High enrollment concentration—particularly at the local level—can be a cause for concern if it dampens the competitive pressures that might otherwise drive insurers to maintain or improve quality, make care delivery more efficient, lower premiums, or provide supplemental benefits. Researchers have studied MA market concentration by examining the results of legislated changes to MA payment policy that created natural experiments through which the effects of insurer market power were revealed. Two studies analyzing experience from the early 2000s investigated how insurers responded to payment cuts and increases (Cabral et al. 2018, Pizer and Frakt

**TABLE
12-6**

Medicare Advantage enrollment share by top three parent organizations increased nationally and locally, July 2019–2023

Top 3 parent organizations, by type of MA plan	Share of MA-eligible beneficiaries living in counties in which insurer offers an MA plan			Percentage point change in share	
	2019	2022	2023	2019–2023	2022–2023
Conventional plans					
UnitedHealth Group Inc.	80%	90%	94%	+14%	+4%
Humana Inc.	85	89	92	+7	+3
CVS Health Corporation	73	83	84	+11	+1
	Share of enrollment			Percentage point change in share	
	2019	2022	2023	2019–2023	2022–2023
All MA plans					
Top 3 nationwide	55%	57%	58%	+3%	+1%
UnitedHealth Group Inc.	27	28	29	+2	+1
Humana Inc.	18	18	18	0	0
CVS Health Corporation	10	11	11	+1	0
Conventional plans					
Top 3 nationwide	53	54	56	+3	+2
UnitedHealth Group Inc.	23	24	25	+2	+1
Humana Inc.	22	20	22	0	+2
CVS Health Corporation	9	10	9	0	-1
County level (weighted average)*					
Top organization	47	43	43	-4	0
Top 2 organizations	71	67	67	-4	0
Top 3 organizations	84	81	81	-3	0

Note: MA (Medicare Advantage). Includes only MA plans (coordinated care, private fee-for-service, and medical savings account plans). Excluded are cost-reimbursed plans and Medicare–Medicaid demonstration plans. Conventional plans exclude special needs plans and employer group plans, which have restricted availability. Totals, differences, and market shares may not sum due to rounding.

*County-level shares of MA enrollment reflect the beneficiary-weighted average of the top organizations in each county.

Source: MedPAC analysis of July 2018–2023 enrollment data and CMS Landscape files.

2002). In both, researchers found evidence that market power affects the generosity of plan offerings: Greater competition was associated with increases in benefit generosity and reductions in premiums, and higher payments to plans were passed through

to beneficiaries more completely in areas with higher competition in the wake of payment increases. In the late aughts and early 2010s, additional policy changes created a second opportunity to examine insurers’ market power. Two studies, examining

two distinct policy changes, found further evidence that MA concentration affects whether competition works to the benefit of MA enrollees. One study again found that increases in MA payment in concentrated markets were incompletely passed through to beneficiaries, and the second found that insurer exit (decreased competition) was associated with declines in benefit generosity among plans that remained active, particularly in areas with higher concentration (Pelech 2018, Song et al. 2013).

In extreme cases, dominance by a single firm (or small set of firms) may make it difficult for competitors to enter or remain active in a market, particularly if economies of scale are a necessary feature of the business model. One study looking at the effect of competition on insurers' decisions to enter or exit a market demonstrated that insurers with higher market shares were less likely to exit a market following a regulatory shock, and that insurers with less market power relative to local providers were more likely to exit (Pelech 2017). Another study found that insurers were less likely to enter markets in which an incumbent had higher market power (Frakt et al. 2012).⁴⁷ While the studies described above all cover earlier periods in the history of the MA program (during which local markets were more highly concentrated than they are today), they illustrate the potential downsides of a highly concentrated market.

Over the last decade, enrollment has become increasingly concentrated at the national level in plans owned by a small set of large insurers that serve a majority of markets in the country. Between 2008 and 2023, the share of total MA enrollment in the three largest firms rose from 32 percent to 58 percent. Much of the growth of these firms has been driven by their expansion into new markets. For example, UnitedHealth Group expanded from offering plans in 48 percent of counties (a service area covering 70 percent of MA-eligible beneficiaries) in 2013, to 53 percent of counties (covering 80 percent of eligible enrollees) in 2019, to 82 percent of counties (covering 94 percent of eligible enrollees) in 2023. Humana and CVS Health Corporation have also expanded their service areas, and all three organizations now offer plans in counties that are home to more than 80 percent of MA-eligible beneficiaries (Table 12-6).

Between 2022 and 2023, the share of enrollees covered by these top three organizations rose by 1 percentage point to 58 percent (5 percentage points higher than in 2019) (Table 12-6).⁴⁸ Among conventional plans (plans available to all Medicare beneficiaries, i.e., excluding SNPs and employer plans), the top three organizations nationwide had 56 percent of enrollment in 2023—an increase from 54 percent in 2022.⁴⁹

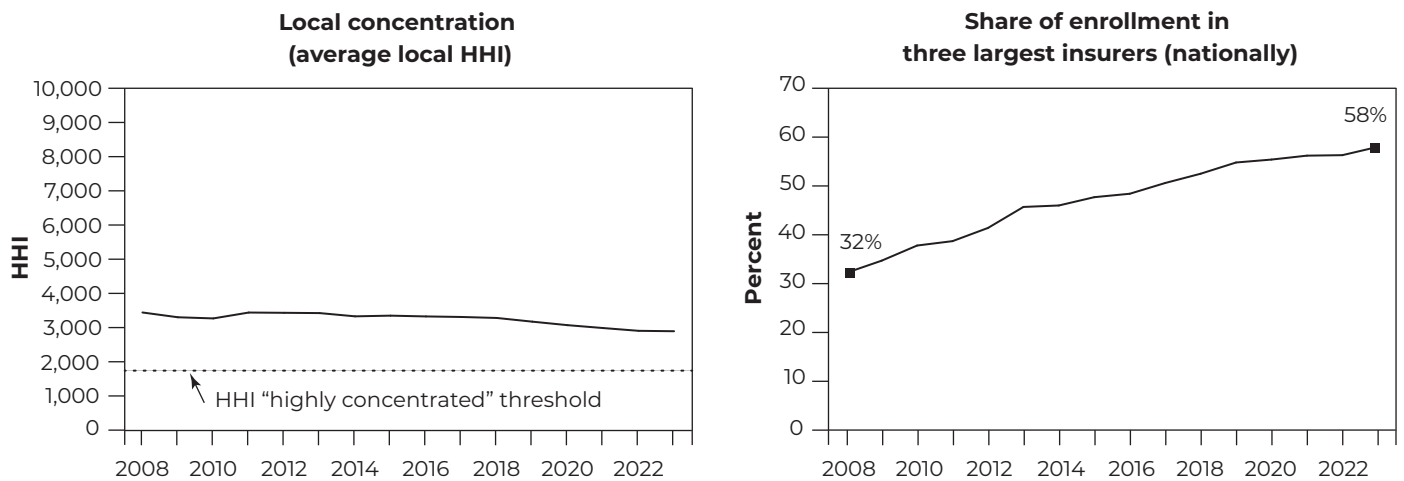
Given the relevance of local competition for MA enrollees, we place greater importance on examining competition at the county level (Table 12-6). Excluding employer plans and SNPs, in 2023, enrollment in the largest organization in each county accounted for 43 percent, on average, of all MA enrollment in the county (unchanged from 2022). Enrollment in the top three organizations in each county accounted for 81 percent, on average, of all MA enrollment (unchanged from 2022 but lower than the 84 percent observed in 2019). However, the share of MA enrollees living in counties with highly concentrated markets (as measured using the Herfindahl–Hirschman Index (HHI), a common measure of market concentration) increased from 89 percent in 2022 to 94 percent in 2023 (data not shown).⁵⁰

The geographic expansion of large national insurers has contributed to decreasing concentration in local markets. When measured using the HHI, average county-level enrollment concentration has fallen over the last decade, despite the rising share of enrollees covered by the three largest firms nationally (Figure 12-10, p. 390).

Although the local concentration of MA enrollment varies somewhat throughout the country, in the typical county, the top organization enrolls between 40 percent and 50 percent of MA enrollees in the county; the next largest enrolls roughly one-quarter of enrollees; the third largest enrolls 10 percent to 15 percent; and the remaining enrollment is shared among other organizations. This pattern is present in both urban and rural areas, though rural areas are slightly more concentrated than urban areas in 2023 (Figure 12-11, p. 391). Concentration—particularly the enrollment share of the largest organization in a county—is unusually high in areas with very low and very high MA penetration. However, a relatively small share of beneficiaries live in such counties. In 2023,

**FIGURE
12-10**

Local concentration has fallen as a small number of insurers enroll a growing share of total MA enrollees



Note: MA (Medicare Advantage), HHI (Herfindahl–Hirschman Index). Includes only Medicare Advantage plans (coordinated care, private fee-for-service, and medical savings account plans). Excluded are cost-reimbursed plans and Medicare–Medicaid demonstration plans. The threshold for highly concentrated markets is described in the Department of Justice and the 2023 Federal Trade Commission *Merger Guidelines*.

Source: MedPAC analysis of CMS July 2008–2023 enrollment data.

approximately 3 percent of MA-eligible beneficiaries live in counties with less than 20 percent or more than 80 percent penetration, while nearly half (48 percent) live in counties with penetration between 40 percent and 60 percent.

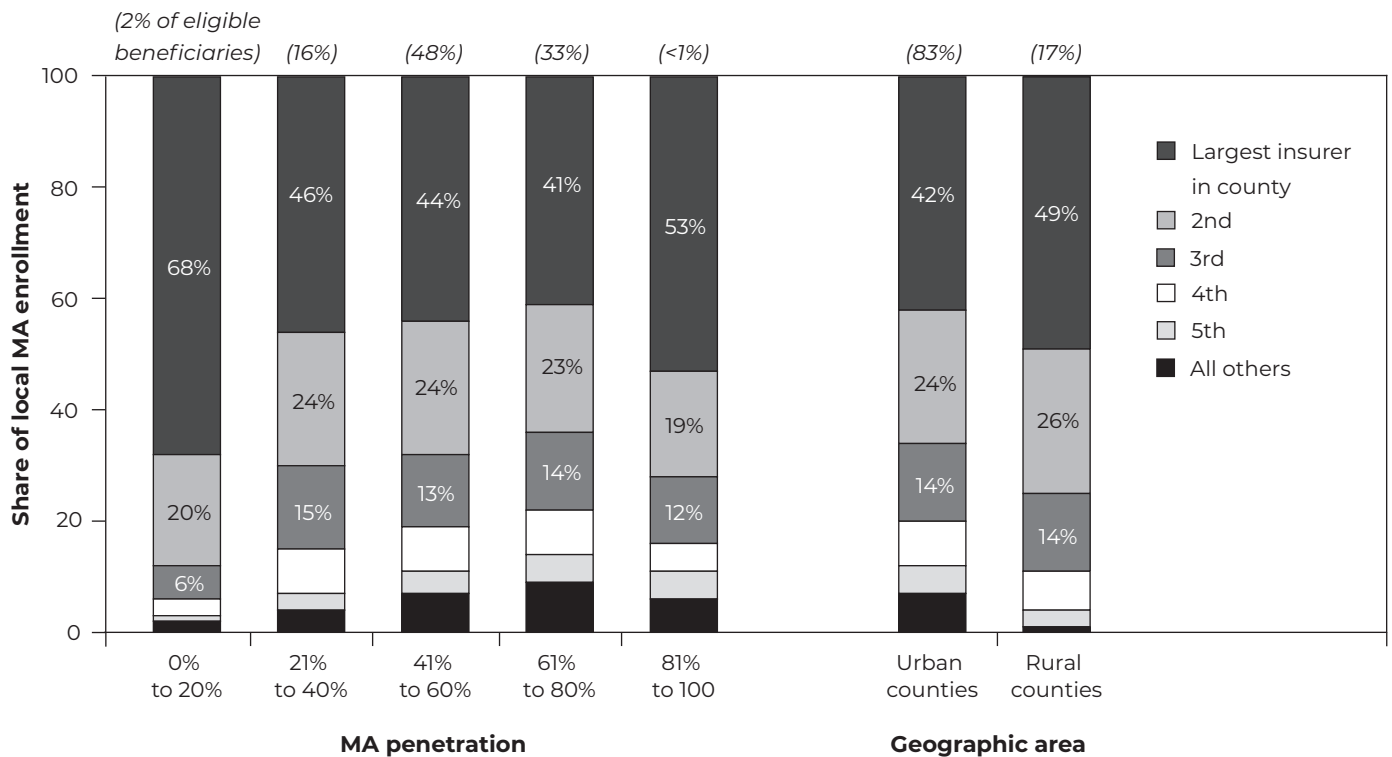
In addition to enrolling a dominant share of all MA enrollees nationally, large national insurers are also frequently the largest insurers in local markets. In 2023, 141 parent organizations offered an MA plan that was open to all enrollees (excluding SNPs and employer plans), and the typical enrollee had access to such plans offered by 8 insurers. Nevertheless, more than 60 percent of MA enrollees lived in a county in which the top insurer was one of the three largest insurers nationally. Large national insurers were similarly dominant in both urban and rural areas, enrolling the largest share of MA enrollees in 67 percent of the country’s urban counties (home to 60 percent of urban-dwelling MA enrollees) and nearly three-quarters of rural counties (home to 65 percent

of enrollees in rural areas). Areas in which the largest insurer was one of the top three largest organizations nationally were typically more concentrated than other areas: The average HHI in counties led by a top-three national insurer was roughly 5 percent higher than in counties with a non-top-three leader. For the roughly 40 percent of MA enrollees living in a county in which the largest insurer was not among the national top three, the top insurer in their area was frequently a Blue Cross Blue Shield–affiliated plan (roughly 60 percent of counties with a non-top-three insurer as the largest insurer, home to 40 percent of MA enrollees in such counties), or a health plan for which the parent organization was a vertically integrated health system (25 percent of such counties, 50 percent of MA enrollees in such counties).⁵¹

Overall, local MA markets tend to be highly concentrated, although the level of concentration has trended downward in recent years. This trend coincides with insurers entering new markets and

FIGURE 12-11

Rural counties and those with unusually low or high MA penetration are more concentrated



Note: MA (Medicare Advantage). Excluded are cost-reimbursed plans and Medicare–Medicaid demonstration plans. Excludes special needs plans and employer group plans, which have restricted availability. U.S. territories are also excluded.

Source: MedPAC analysis of CMS enrollment data.

steadily gaining market share in areas that have historically been very concentrated. In addition, as illustrated earlier in this chapter, estimates for 2024 indicate that the average beneficiary will have access to many MA plans offered by a substantial number of organizations. However, large national insurers, and some regional or local insurers, frequently enroll a large fraction of MA enrollees in an area. Such concentration may dampen competition, a topic the Commission will continue to explore and monitor.

MA margins

The continued growth in MA enrollment, the substantial number of plans offered by several organizations, and plans’ ability to provide generous

extra benefits point to continued strong financial health in the MA sector. We have historically analyzed the margins that MA plans report in their bids. We have consistently reported that the data do not include plans’ expected costs and revenues for providing Part D (which nearly all MA plans offer) and do not include employer plans (17 percent of MA enrollment in 2022). However, we have become increasingly concerned about the appropriateness of focusing on plan margins (instead of other metrics financial health) and about whether the margins reported in bids are sufficient for characterizing insurers’ financial condition.

One concern is that MA margins may not be comparable with the margins of other health insurance lines of business. For example, MA gross profits

(measured in total MA revenue dollars per enrollee after subtracting MA expenses) tend to be much higher than other lines of health insurance businesses (Ortaliza et al. 2023). While Medicare beneficiaries have higher costs, the remaining revenues after covering those costs tend to be higher per enrollee relative to individuals covered under other lines of business. Thus, an organization that has the same profit margin (measured as the share of remaining revenue after subtracting medical expenses) across its various insurance lines of business will likely have higher gross profits (measured in dollars per enrollee) in MA, particularly if the organization's fixed costs (e.g., rent, utilities, information technology infrastructure, and base salaries and benefits) are similar across lines of business. Thus, gross profits per MA enrollee may be a more salient indicator than margin because high gross profits would enable a plan to increase the amount of revenue allocated toward employee and broker compensation, investments, advertising, lobbying, and infrastructure.

A second concern with the margins reported in MA bids is whether the margin data collected through the bidding process appropriately characterize insurers' profits. This concern is particularly acute for vertically integrated firms—those in which plans and providers are owned by the same organization. For a vertically integrated organization, the margin for the insurance line of business might not reflect the margin for the parent organization. For example, payments from a plan to a provider owned by the same parent organization would count as medical expenses for the plan (putting downward pressure on plan margin) but contribute positively to the margin of the parent organization. Because plan bids include margin information only for the plan, they may understate insurers' financial health. The degree to which provider revenues are shared with plans under these arrangements is unclear, but limited financial data suggest a substantial shifting of revenues and expenses for at least one large health plan (Frank and Milhaupt 2022, Milhaupt 2023). In addition, we have observed some provider-sponsored plans that consistently report negative MA margins despite consistent growth in MA enrollment. These reported margins have become difficult for us to reconcile with CMS's requirement that MA plans with negative margins must submit a business plan to achieve profitability and

CMS's stated expectation that MA plans meet or exceed the year-by-year margin targets in the business plan. Because plan bid data do not necessarily reflect the expenses and margins of their affiliated providers, we have diminishing confidence in the margins reported in plan bids. This problem is likely to grow as vertical integration increases (see the text box on consolidation and vertical integration in MA, pp. 394–397, for more detail). Given our declining confidence in the salience and accuracy of plan-reported margins, we will consider omitting these data in future cycles and focus on more reliable indicators of the financial health of the MA program, such as plan availability and enrollment.

While analyses of MA margins are not indicative of the financial health of the MA sector (as discussed above), we analyzed plan-reported margins for 2022 to the limited extent that they can be used as a partial indicator of MA financial health. Using the most recent data available, in 2022, MA plans reported margins that averaged 3.6 percent, an increase from 2.2 percent in 2021.^{52,53} Plan-reported margins vary by a plan's tax status and whether a plan is a SNP. In the 2022 data, nonprofit plans reported a margin of 0.1 percent; for-profit entities reported a pretax margin of 4.3 percent, both increases relative to 2021. In 2022, all categories of SNPs reported overall positive margins. D-SNPs, for beneficiaries dually eligible for Medicare and Medicaid benefits, reported margins of 7.5 percent. SNPs for enrollees with certain chronic conditions (C-SNPs) reported margins of 7.4 percent. Institutional SNPs reported margins of 4.0 percent.

Quality in MA

The Commission has long held that MA presents opportunities for innovation to achieve higher-quality care at lower cost. To make informed choices about enrolling in an MA plan, beneficiaries need good information about the quality and access to care provided by MA plans in their local market. However, the Commission has determined that the current system for MA quality reporting and measurement is flawed and does not provide a reliable basis for evaluating quality across MA plans. Nonetheless, these measures are the basis for the MA quality bonus program (QBP), which uses trust fund and taxpayer dollars to increase MA payments by about \$15 billion

annually. It is unclear how responsive MA plan quality is to these incentives.

Here, we provide a brief overview of the current MA QBP and the Commission's standing recommendations to improve MA quality assessment. We continue to evaluate MA quality and access and are working to expand our assessment to include network adequacy, prior authorization, literature on MA quality, and some empirical analyses.

CMS assessment of MA quality

In 2006, CMS introduced the MA star rating system to give beneficiaries information about the clinical quality, administrative capability, and patient experience an enrollee can expect in an MA plan.⁵⁴ Medicare currently collects close to 100 MA quality measures, 40 of which are used to determine a star rating from 1 to 5 for each MA contract (Centers for Medicare & Medicaid Services 2022).^{55,56} These ratings are made available through the medicare.gov Plan Finder website to enable beneficiaries to compare across plans. As required by the ACA, since 2012 the star rating system has been the basis of the QBP, which increases benchmarks for MA contracts rated 4 stars or higher.⁵⁷ Contracts with a 5-star rating are able to enroll beneficiaries during every month of the year, rather than being limited to the annual election period from October to December. The star rating also contributes to the level of rebate payments. Plans with higher star ratings retain a higher share of the difference between a plan bid and the benchmark when bids are below the benchmark.

The share of MA contracts receiving quality bonuses is consistently high. Forty-two percent of all MA contracts are in bonus status for 2024, a decrease from recent years (Centers for Medicare & Medicaid Services 2023a). Under the coronavirus public health emergency (PHE), CMS relaxed quality reporting rules, boosting the average star rating from 4.04 in 2021 to 4.37 in 2022. The share of enrollees in plans achieving 5 stars was 27 percent in 2022 and 22 percent in 2023, compared with 5 percent in 2021 (before the PHE rule change) and 7 percent in 2024 (after the rules reverted back). The average star rating declined in 2024, but it remains above 4 stars. Roughly three-quarters of MA enrollees are enrolled in contracts with a 4-star rating or higher for 2024.

Unlike other Medicare quality programs, the QBP is financed with additional program dollars; it increases MA payments (and program spending) by about \$15 billion annually. Our prior work has indicated that plans have significant incentives to engage in activities that increase their star ratings, and our analyses raised questions about whether the extra dollars from quality bonus payments have been used to provide benefits to MA enrollees (Medicare Payment Advisory Commission 2020a, Medicare Payment Advisory Commission 2020b).

Previously, the Commission would monitor a subset of measures used in the QBP as part of the status report (Medicare Payment Advisory Commission 2017, Medicare Payment Advisory Commission 2016b). The Commission observed some variability but generally found it difficult to assess whether MA plan quality of care was changing over time. For the last several years, the Commission has concluded that the current state of quality reporting is such that we cannot provide an accurate description of the quality of care across MA plans with this information (Medicare Payment Advisory Commission 2019). Instead, the Commission has made recommendations to improve MA quality reporting and quality payment programs, including a recommendation to assess MA quality at the local market area (Medicare Payment Advisory Commission 2018). The next section details the Commission's recommendations to address these and other flaws in MA payment policies.

Commission recommendations would address many problems with MA payment policies and the quality bonus program

When risk-based payments for private plans were first incorporated in the Medicare program, policymakers expected that they would help to reduce Medicare spending. Indeed, under the original incorporation of private plans in Medicare in 1985, payments to private plans were set at 95 percent of FFS payments.⁵⁸ However, under current policy, Medicare pays rates higher than FFS in some areas, including quality bonuses that apply to the vast majority of payments to MA plans, and policy does not adjust for the full effect

Vertical integration of Medicare Advantage plans and providers

Medicare Advantage (MA) organizations are increasingly integrating vertically, with provider and insurer lines of business having common ownership (or other financially aligned arrangements). Vertical integration is highest in organizations in which a provider-based organization owns and operates a health plan, though insurer-led integration has accelerated in recent years, with the three largest MA organizations investing significantly in the acquisition of provider businesses. MA payment policy—though not the only factor influencing firms’ decisions to integrate—likely promotes such arrangements.

MA organizations are increasingly vertically integrated

Recent acquisitions of provider businesses by insurers have been widely reported and suggest that insurers see significant advantages to owning a greater share of the health care supply chain. For example, UnitedHealth Group has pursued a strategy of acquiring physician groups and practices, and it reports having approximately 130,000 employed or affiliated physicians and advanced practice clinicians as of the end of 2023 (UnitedHealth Group 2023). Both Humana and CVS have followed suit, investing resources in acquiring clinics and primary care practices (CVS Health 2023, Humana 2022, Humana 2020). The three largest MA organizations (MAOs) have each also acquired their own home health businesses, purchasing several of the largest home health providers in the country. Humana bought Kindred at Home in 2021, UnitedHealth Group bought the LHC Group in 2022, and CVS Health Corporation acquired Signify Health in 2022 (Humana 2021, Signify Health 2023, UnitedHealth Group 2022).

In addition to insurer acquisition of providers, many MAOs are vertically integrated as a result of being owned and operated by a hospital system. We reviewed the websites of major

health systems and identified 56 MA parent organizations (of 184 offering plans in 2023) that had some degree of ownership by a health system. In addition to these, many health systems have partnered with an insurer to offer a co-branded insurance product. This review understates the extent of vertical integration in MA because it is limited to plans owned by health systems and is not a comprehensive review of all MA parent organizations and their financial arrangements with providers. There are no public data that provide a systematic accounting of ownership relationships between MA plans and health care providers—a significant barrier to studying the effects of vertical integration. Previous research on the prevalence of vertically integrated plans found that the share of MA enrollees in vertically integrated contracts (defined by the researchers as local coordinated care plans that are not special needs plans and are owned by a provider organization such as a hospital, physician group, or other integrated delivery system) fell from roughly 24 percent to 22 percent between 2011 and 2015 (Johnson et al. 2017). Earlier research found that vertical integration of MA plans was associated with higher premiums but could not establish that this relationship was causal (Frakt et al. 2013).

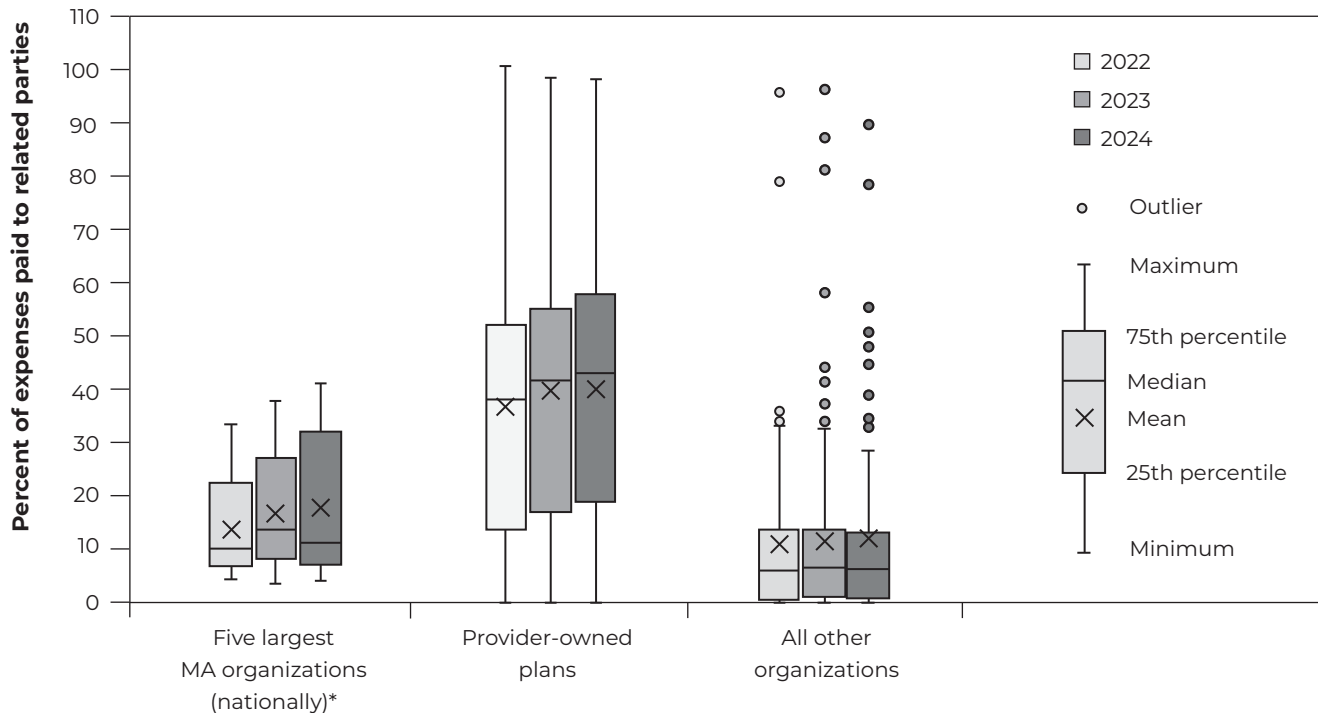
CMS requires MAOs to submit information about the extent of their financial relationships with providers and other entities as part of the bidding process. Specifically, plans submitting bids are required to report the amount (including medical costs and nonbenefit expenses) per member per month that they expect their members to receive from a related party, defined as any entity that “has a different tax identification number than that of the MAO but is associated with the MAO by any form of common, privately held ownership, control, or investment, including any arrangement in which the MAO does business with a related party through one or more unrelated parties” (Centers for Medicare & Medicaid Services 2023c). While the submitted data are projections and not a

(continued next page)

Vertical integration of Medicare Advantage plans and providers (cont.)

FIGURE 12-12

Vertical integration is increasing and is highest in plans owned by provider organizations



Note: MA (Medicare Advantage). Excluded are cost-reimbursed plans, Medicare–Medicaid demonstration plans, and employer group plans.
 *The five largest non-provider-owned plans are UnitedHealth Group, Humana, CVS Health, Elevance Health, and Centene. Kaiser Foundation Health Plan enrolls more beneficiaries than Centene but is categorized as a provider-owned plan in the figure.

Source: MedPAC analysis of data from CMS on plan bids, MMIT Directory of Health Plans.

report of actual utilization in a completed year, they provide insight as to the MAO’s own assessment of its integration with other entities. Figure 12-12 illustrates that the degree of vertical integration in MA varies widely across parent organizations and is highest in provider-owned plans. Among these, the share is highest in plans owned by health systems (data not shown).⁵⁹

Despite the attention paid to recent trends in insurer-led integration, the data show that large national insurers remain significantly less vertically

integrated than their provider-owned competitors. It is nevertheless important to consider that the large national organizations insure a significant share of MA enrollees nationwide, so trends in the organization of the businesses can affect millions of beneficiaries. The information presented here is reported at the parent organization level. However, health care markets operate primarily at a local level, and national statistics do not necessarily describe the markets in which most beneficiaries live.

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Vertical integration of Medicare Advantage plans and providers (cont.)

Interaction between MA payment policy and vertical integration of plans and providers

Several features of MA payment may reward firms that vertically integrate insurer and provider businesses. Incentives for integration are not confined to Medicare and are influenced by trends in other sectors of the health care system, as well as by the actions of regulatory agencies—particularly the Department of Justice and Federal Trade Commission.

Promoting efficient care delivery

Because Medicare pays private plans a predetermined rate that is risk adjusted for each enrollee rather than a per service rate, plans should have greater incentives than fee-for-service providers to deliver more efficient care. Some commentators have hypothesized that MA organizations may view vertical integration as a means of more directly promoting care that is more efficient, higher quality, and more clinically integrated. Evidence is limited regarding the effects of plan-provider integration on quality and efficiency in MA. Most studies that have analyzed these topics use data from plans owned by vertically integrated health systems or integrated provider groups (Frakt et al. 2013, Johnson et al. 2017, Meyers et al. 2020, Parikh et al. 2022, Park et al. 2023). As such, it is difficult to interpret whether the findings stem from the vertical integration of the plan with the provider or from other features of the organizations included in the studies. Additionally, results from studies of provider-owned health systems may not be generalizable to other forms of

plan-provider integration, such as insurer ownership of primary care businesses or home health organizations, and comparatively little research is available on these forms of integration. Regardless of whether the effects of plan-provider integration on quality and efficiency are yet evident to researchers, MAOs may view integration as a way to achieve the efficiencies incentivized under MA's capitated payment structure.

Risk adjustment

Payments to MA plans are risk adjusted to account for differences in health status. Risk scores are based on demographic information and diagnoses that plans submit to CMS (see section on how Medicare calculates risk scores, p. 365). Documenting additional diagnosis codes raises plan enrollees' risk scores, which increases plans' monthly payments from CMS, including the rebates used to offer extra benefits to enrollees. The higher payments garnered through more intensive risk coding may be easier to achieve in vertically integrated organizations that can increase the number of recorded diagnoses by (1) passing the same diagnosis-based incentives along to providers through risk-adjusted payment arrangements and (2) working directly with their employed or affiliated providers to code more thoroughly. Researchers have found that vertically integrated MA organizations tend to identify higher numbers of diagnoses and that coding intensity is higher for integrated plans (Geruso and Layton 2020, Meyers et al. 2020). Some researchers have suggested that the potential for additional revenue through higher risk coding is a key driver of such acquisitions (Gilfillan and Berwick 2021). If vertical

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of diagnostic coding intensity or account for favorable selection of enrollees into MA.

Overall, we estimate in 2024 that Medicare pays MA plans 22 percent, or \$83 billion, more than it would spend if those enrollees were covered under FFS Medicare, which increases financial burden on the

taxpayers and beneficiaries who fund the MA program (including those in FFS Medicare, who help finance MA through their Part B premiums). We estimate that aggregate Part B premiums will be about \$13 billion higher in 2024 because of payments above FFS spending.⁶⁰

Vertical integration of Medicare Advantage plans and providers (cont.)

integration enables MAOs to generate higher payments through greater coding intensity, it may also increase enrollment concentration as higher rebate payments allow plans to offer more generous extra benefits and attract more enrollees.

Quality bonus program

Medicare uses a quality bonus program (QBP) that rates MA plans based on a 5-star system and provides bonuses to plans rated 4 stars or higher (see the “Quality in MA” section, p. 392). The QBP rewards documentation of process measures, creating an incentive for MAOs to integrate with providers so the organization has more direct influence on providers’ performance on the measures that affect payment.

Medical loss ratio requirements

MA organizations are subject to a medical loss ratio (MLR) requirement of 85 percent—meaning that they are required to spend at least 85 percent of their revenue on care for their enrollees (42 CFR 422.2410).⁶¹ When a plan and provider are vertically integrated, a single organization determines contracted payment rates that the plan will pay the provider. Researchers have suggested that payments to related businesses offer an opportunity to avoid the constraints on profits posed by MLR regulations and asserted that insurers may pay higher rates to providers owned by the same parent organization in an effort to increase profits (Frank and Milhaupt 2023, Frank and Milhaupt 2022). To guard against such practices, CMS requires that MA organizations report related-party arrangements and provide documentation regarding the effect of the arrangement on the prices paid for the services

(e.g., by comparing to an estimate of what prices would have been in the absence of the arrangement, or to actual costs) (Centers for Medicare & Medicaid Services 2023c). Even at fair-market rates, however, payments to owned-providers may include a margin and enable a company to retain a higher share of profits within the parent organization while complying with MLR requirements.

Negotiations with providers

MA plans use networks and tiered cost sharing to influence where their members receive care. In designing networks, MA organizations must demonstrate that their network provides adequate access to a range of provider types. Networks are influenced by the outcome of negotiations between providers and insurers. Negotiated contract rates, which generally reflect the balance of market power between a provider and insurer, are heavily influenced by the level of consolidation in the market. Researchers have previously investigated the role of market power in the negotiations between MA plans and providers and found that an insurer’s market power was an important determinant of whether it continued to operate in a market—an effect that was particularly pronounced in more highly concentrated hospital markets (Pelech 2017).

Altogether, we find that the MA industry is increasingly vertically integrated and that such integration may enable MAOs to achieve higher profitability under current MA payment policy. The Commission plans to continue monitoring trends in integration in MA and evaluating their effects on enrollees and the function of the program. ■

In particular, the Commission has found that CMS’s coding intensity adjustment is inadequate to address the higher level of MA diagnostic coding we estimate for 2024 and the resulting higher payments to MA plans. At the same time, the quality bonus program boosts plan payments for 74 percent of MA enrollees

but does not effectively promote high-quality care. Further, we estimate that on average in 2024, after accounting for the effects of uncorrected coding intensity and favorable selection, MA plan bids exceed the costs of covering the Medicare benefit under FFS. Thus, a majority of the supplemental benefits

for MA enrollees are financed by increased program spending and not by MA plan efficiencies. For some enrollees, the extra benefits fill gaps in the Medicare benefit by adding coverage for services that are not included in traditional Medicare.⁶² The generosity of the additional benefits is appealing to beneficiaries, particularly for those who are unable to afford a Medigap policy that would reduce cost sharing in FFS. But these policies distort the goal of plans competing to improve quality and reduce health care costs; instead, the policies increase program spending and Part B beneficiaries' premiums. Moreover, the Commission has found that plan-submitted data about beneficiaries' health care encounters are incomplete. If these data were complete and accurate, they could be used to identify MA plan efficiencies, improve quality measurement, and provide more robust oversight of the MA program.

The Commission remains committed to including private plans in the Medicare program and allowing beneficiaries to choose among Medicare coverage options, including the alternative delivery systems that private plans can provide. But the rapid growth of MA enrollment and spending elevates the urgent need for a major overhaul of MA policies. As MA enrollment continues to grow, higher payments to plans will worsen Medicare's fiscal sustainability.

Paying MA plans more than FFS for beneficiary care also creates inequities among beneficiaries since in FFS Medicare, beneficiaries help finance the higher payments that MA plans use to provide extra benefits for their enrollees (benefits that FFS beneficiaries must pay for through supplemental insurance or out of pocket). Further, paying MA plans more than the program pays for FFS beneficiaries undermines incentives for efficient delivery of care. To encourage efficiency and promote value for taxpayers and beneficiaries, an overhaul of MA payment policy should include reducing the level of Medicare payments to MA plans. Past experience with reductions in MA payments under the ACA has demonstrated that plans can adjust their bidding behavior and lessen the effects on plan participation and beneficiary enrollment.

Over the past few years, the Commission has developed four recommendations (some that incorporate and update prior recommendations)

that would improve the MA program for both beneficiaries and taxpayers. Table 12-7 summarizes the Commission's standing recommendations to (1) account for continued coding differences between MA and FFS and address those differences in a complete and equitable way (Medicare Payment Advisory Commission 2016b); (2) ensure the completeness and accuracy of encounter data to improve the MA payment system, serve as a source of quality data, and facilitate comparisons with FFS Medicare (Medicare Payment Advisory Commission 2019); (3) replace the QBP with a market area-based, plan-financed reward program (Medicare Payment Advisory Commission 2020a); and (4) establish more equitable MA benchmarks for the Medicare program (Medicare Payment Advisory Commission 2021a). Through reforms to the MA payment system, the Commission aims to improve the program for the beneficiaries it serves and to harness plan efficiency to strengthen Medicare's long-term financial sustainability.

If payments to MA plans were lowered, plans might reduce the supplemental benefits they offer. However, because plans use these benefits to attract enrollees, they might respond instead by modifying other aspects of their bids (Cabral et al. 2018, Chernew et al. 2023, Congressional Budget Office 2022, Song et al. 2013).

The inability of the MA quality bonus program to meaningfully characterize the quality of care that MA enrollees receive makes it difficult for beneficiaries to make informed choices and for policymakers to assess the value that private plans bring to the Medicare program. In the June 2020 report to the Congress, the Commission recommended replacing the QBP with a value incentive program that addresses the flaws of the QBP. First, focusing on a small set of population-based outcome and patient/enrollee experience measures would facilitate comparisons across MA plans, enabling beneficiaries to choose based on factors that are most meaningful to their experience. A continuous scale of performance, rather than one with "cliff effects," would provide MA plans with the incentive to improve quality at every level. Performance evaluation at the local market level, rather than the contract level as is currently done, would similarly improve the information that beneficiaries can use for decision-making and would

Recommendation

Fully account for MA coding intensity—*March 2016*

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.

Improve encounter data accuracy and completeness—*June 2019*

The Congress should direct the Secretary to establish thresholds for the completeness and accuracy of MA encounter data and rigorously evaluate MA organizations' submitted data and provide robust feedback; concurrently apply a payment withhold and provide refunds to MA organizations that meet thresholds; and 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.

Replace the quality bonus program—*June 2020**

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.

Establish more equitable benchmarks—*June 2021***

The Congress should replace the current MA benchmark policy with a new MA benchmark policy that applies a relatively equal blend of per capita local area 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.

Note: MA (Medicare Advantage), FFS (fee-for-service).

*The June 2020 quality recommendation incorporates the Commission's prior recommendations to eliminate the doubling of the quality increases in specified counties (recommended in March 2016) and to establish a geographic basis for MA quality reporting that reflects health care market areas (June 2005, March 2010, and March 2018).

**The June 2021 benchmark recommendation incorporates the Commission's prior recommendations to eliminate the cap on benchmark amounts implemented by the ACA (recommended in March 2016), base benchmarks on FFS spending data only for beneficiaries with both Part A and Part B (recommended in March 2017), and establish a geographic basis for MA payments that reflects health care market areas (recommended in June 2005, March 2010, and March 2018).

Source: Medicare Payment Advisory Commission (2021a), Medicare Payment Advisory Commission (2020a), Medicare Payment Advisory Commission (2019), Medicare Payment Advisory Commission (2016b).

correct MA plan incentives to improve quality in every geographic area.

The Commission also recommended that the value incentive program address the variation in the demographics of MA enrollees across plans. By accounting for differences in enrollees' social risk factors by stratifying plan enrollment into groups of

beneficiaries with similar social risk profiles, plans with higher shares of these enrollees would not be disadvantaged in their ability to receive quality-based payments, while actual differences in the quality of care would not be masked. Finally, the Commission believes strongly that MA quality bonus payments should not be financed with additional program dollars, especially given that Medicare pays MA plans

more than would have been spent on FFS for the same beneficiaries. Application of budget-neutral financing would ensure that the MA quality system is more consistent with Medicare's FFS quality payment

programs, which are either budget neutral (financed by reducing payments per unit of service) or produce program savings because they involve penalties (Medicare Payment Advisory Commission 2020a). ■

Endnotes

- 1 CMS includes FFS-claim administrative costs in MA benchmarks, which account for about 0.20 percent of FFS spending (Centers for Medicare & Medicaid Services 2023b, Centers for Medicare & Medicaid Services 2021). Expenses for FFS-claim administration are included in our comparison of FFS spending with MA payments and differ from the expenses found in Medicare's Trustees' report, which include the administration and oversight of the MA program and the enrollment of all Medicare providers (which is required for contracting with MA plans). The Medicare Trustees reported that administrative expenses (including those for MA enrollees) accounted for 1.04 percent of CMS's total Medicare benefit costs in 2020 (Boards of Trustees 2021).
- 2 Private FFS plans that operate without a network are limited to a small share of counties where fewer than 2 network-based plans offered; by the end of 2023, private FFS plans covered about 33,000 beneficiaries. Medical savings account plans combine a high deductible and a medical savings account, and by the end of 2023 they covered about 8,000 beneficiaries.
- 3 HMOs generally do not reimburse care provided by out-of-network (OON) providers. They often require that enrollees select a named primary care provider (PCP), who manages referrals to specialists. PPOs provide more flexibility for enrollees by not requiring a named PCP and by allowing enrollees to see both in- and out-of-network specialists without a referral. However, these plans generally have both higher premiums than HMOs and higher cost sharing for OON providers compared with in-network providers. HMO point-of-service (HMO-POS) is a subset of the HMO plan type that allows members to seek out-of-network care for certain types of services or in certain cases (such as travel). These plans offer less flexibility to seek care OON than PPOs but more than standard HMOs.
- 4 In 2017 and 2018, CMS began paying employer plans based on a blend of the 2016 bidding behavior of employer plans and the other MA plans. Starting in 2019, CMS began paying employer plans based on the prior year's bidding behavior of nonemployer plans by plan type and payment quartile. Because employer plans are mostly PPOs, their payment in 2024 largely reflects the average bidding behavior of nonemployer PPOs in 2023. We apply 2024 employer plan payment rates and recent employer plan enrollment and risk-score trends when estimating overall MA payments relative to FFS spending. Consistent with our prior analyses, we assumed employer plan enrollment growth of 3.5 percent from 2023 to 2024, which is lower than the enrollment growth of employer plans in most recent years. In addition, we calculated the overall risk-score ratio of employer plans to other MA plans in 2020 (reflecting diagnoses documented in 2019), and we applied this ratio to the average risk score in 2024 MA bids. Employer plans are also included in our estimates of coding intensity and favorable selection.
- 5 Payments described here do not apply to the relatively small number of enrollees with end-stage renal disease (ESRD). How Medicare pays MA plans for enrollees with ESRD is described in the Commission's March 2021 report under "Medicare payments to MA plans differ for ESRD and non-ESRD enrollees" (Medicare Payment Advisory Commission 2021b).
- 6 Plans' benefits may include a premium for mandatory supplemental benefits that cover all enrollees. Additionally, plans may offer optional supplemental benefits. Plans are not permitted to apply rebate dollars toward optional supplemental benefits. In addition, optional supplemental benefits cannot include reduced cost sharing for Medicare Part A and Part B services.
- 7 Benchmarks are calculated using FFS spending for all Medicare beneficiaries, including those with both Part A and Part B coverage and those with only Part A or Part B. In our March 2017 report to the Congress, we recommended that CMS change the calculation to include FFS spending for only those beneficiaries with both Part A and Part B coverage (that is, expenditures for only those beneficiaries eligible to enroll in MA plans) (Medicare Payment Advisory Commission 2017). This change would make the assumptions about FFS spending in the calculation of MA benchmarks and payments more reflective of the MA-eligible population.
- 8 The ACA caps any county's benchmark at the higher of (1) its pre-ACA level, projected into the future with a legislatively modified national growth factor, or (2) 100 percent of its estimated FFS spending in the current year. Our March 2016 report to the Congress provides more detail on double-bonus counties and benchmark growth caps. In that report, we recommended eliminating the double bonuses as well as the benchmark growth caps, which limited the benchmarks in many counties (Medicare Payment Advisory Commission 2016b).
- 9 Before 2022, MA plans also submitted diagnostic information through the Risk Adjustment Processing System (RAPS). The use of RAPS data was phased out from 2016 through 2021, except for contracts in the Program of All-Inclusive Care for the Elderly, which continue to use pooled RAPS and encounter data as the source of diagnostic data for risk scores.

- 10 Other possible sources of diagnostic information—such as encounters for home health services, skilled nursing, ambulatory surgery, durable medical equipment, lab and imaging tests, and hospice services—are not used to determine payment through the risk-adjustment model for several reasons: (1) adding diagnoses from these sources does not improve the model's ability to predict medical expenditures; (2) concerns exist about the reliability of diagnoses from providers with less clinical training (e.g., home health and durable medical equipment providers); and (3) a high proportion of reported diagnoses from certain settings (e.g., lab and imaging tests) are used to rule out having a diagnosis.
- 11 To date, RADV audits have been initiated for plan years 2016 and earlier and have been completed for only a few years. Information about payment recoveries based on RADV audits has only been made public for 2007. Given the limited nature of RADV audits, we do not yet know whether a “sentinel effect” will have a meaningful impact on higher MA coding intensity.
- 12 The Department of Health and Human Services Office of Inspector General has conducted RADV-like audits of high-risk diagnoses for at least 30 MA contracts and found that 70 percent of all diagnosis codes audited were not supported by medical records and that some diagnoses were not supported over 90 percent of the time (Office of Inspector General 2023).
- 13 Beneficiaries are guaranteed access to a Medigap supplemental insurance policy with no underwriting, even if they have a preexisting condition, if they purchase it during the 6-month Medigap open-enrollment period that begins on the first day a beneficiary is both 65 years old and enrolled in Medicare Part B. Beneficiaries have only one Medigap open enrollment period. Except for in limited circumstances (e.g., a beneficiary moves outside of their MA plan's service area), access to a Medigap policy is not guaranteed in most states after the Medigap open-enrollment period ends. Only four states require guaranteed-issue protections for aged (65 and over) beneficiaries in traditional Medicare, regardless of medical history. Under these protections, insurers cannot deny a Medigap policy to applicants based on preexisting conditions (Boccuti et al. 2018). In certain circumstances, beneficiaries who choose to enter MA and who subsequently disenroll to FFS within a 12 month trial period may also have guaranteed access Medigap coverage with no underwriting (42 USC 1395ss).
- 14 The availability of zero-premium local PPOs may have contributed to the increase in local PPO enrollment in 2023. For example, 96 percent of Medicare beneficiaries had a zero-premium local PPO available in 2023, up from 87 percent in 2022.
- 15 In 2023, 15 percent of MA enrollees and 20 percent of FFS enrollees resided in rural areas.
- 16 Our measurement of beneficiary access to plans uses 2024 plan bids and July 2023 county-level enrollment for the Medicare population with both Part A and Part B coverage. Plans are only included in a county if they project enrolling at least one beneficiary in the county.
- 17 Our measure of SNP availability reflects only the share of MA-eligible beneficiaries residing in a county served by a SNP. However, individuals must meet additional coverage criteria to be eligible to enroll in a SNP; for example, to enroll in an I-SNP, a beneficiary would typically reside in a skilled nursing facility that has a relationship with the plan.
- 18 All beneficiaries enrolling in Medicare Part B, regardless of their decision to receive benefits through FFS or MA, are required to pay the Medicare Part B premium. Some MA plans use rebate dollars to pay a portion of their members' Part B premium as a supplemental benefit. Beneficiaries enrolling in Part D may pay a separate Part D premium, although MA-PD plans may use rebate dollars to reduce the amount the beneficiary pays for drug coverage under the plan. Plans bidding above the local benchmark or offering more extra benefits than can be financed by the plan rebate charge enrollees an additional plan premium. We refer to plans that do not charge a separate plan premium (including any Part D premium) as “zero-premium” plans. The increasing availability of zero-premium plans in recent years has largely been driven by the availability of zero-premium local PPOs. Between 2019 and 2023, the availability of zero-premium local PPOs increased from 69 percent of Medicare beneficiaries to 96 percent, and the availability of zero-premium HMOs increased from 86 percent to 98 percent.
- 19 Federal regulations require MA plans to submit encounter records for all items and services provided to enrollees (42 CFR § 422.310(b)), including items and services provided through supplemental benefits; however, CMS's Encounter Data Submission and Processing guidance limits that requirement to supplemental services for which the plan has sufficient data to populate an encounter record. In addition, CMS systems are able to accept “professional” and “institutional” claim formats, which allow for the collection of some supplemental services, but CMS is not equipped to accept dental claims. Further, reimbursement for many supplemental benefits does not use any claim format (e.g., fitness, meals, transportation, pest control), meaning there is no standard way for plans to submit information about the use of such benefits. For 2024, CMS will require MA organizations to submit plan-level information (not through beneficiary-level encounter records) for a wide range of supplemental benefit categories, including data on the number of enrollees who are eligible for each benefit,

- number of enrollees who utilized each benefit, total and median instances of utilizations among eligible enrollees, the net amount incurred by the plan to offer each benefit, the type of payment arrangement, how the plan accounts for the cost of the benefit including administrative expenses, and the total out-of-pocket cost per utilization for enrollees (Centers for Medicare & Medicaid Services 2024).
- 20 In 2024, conventional plans project that 12 percent of the rebate dollars used for cost-sharing reductions will be allocated for plan administrative costs and profit. Among dual-eligible SNPs, 16 percent of the plan-projected rebate dollars used for cost-sharing reductions is projected to be allocated for plan administrative costs and profit.
 - 21 CMS generally expects MA plans to use their rebate dollars to cover the beneficiary cap on out-of-pocket (OOP) expenses. Thus, the plan liability for the OOP cap would be part of the cost-sharing reductions category. In 2024, plans project that their liability for the OOP cap will be \$14 per enrollee per month—equivalent to 7 percent of rebates and 1 percent of projected plan payments. The plan liability for the OOP cap is generally not comparable with FFS spending because most beneficiaries in FFS have supplemental insurance and are unlikely to have cost-sharing expenses that exceed the OOP cap for MA enrollees. In addition, MA enrollees are prohibited from purchasing Medigap coverage, and MA plans are expected to provide supplemental benefits in lieu of Medigap coverage.
 - 22 In 2023, conventional MA plans (excluding employer plans and SNPs) project that 13 percent of the rebate dollars used for non-Medicare-covered supplemental benefits will be allocated for plan administrative costs and profit. Among D-SNPs, 16 percent of the plan-projected rebate dollars used for non-Medicare-covered supplemental benefits is projected to be allocated for plan administrative costs and profit.
 - 23 Beginning in 2019, CMS relaxed one of the criteria for eligible supplemental benefits—that the benefit be primarily health related—to include items and services that are used to diagnose, compensate for physical impairments, ameliorate the functional and psychological impact of injuries or health conditions, and reduce avoidable emergency and health care utilization. A supplemental benefit is not primarily health related if it is an item or service that is solely or primarily used for cosmetic, comfort, or general-use purposes or to address social determinants of health. The amount of projected spending for new types of supplemental benefits is not available in plan bid data.
 - 24 MA plans do not allocate administrative expenses or margins for Part D premium buydowns or Part D supplemental benefits when submitting Part C bids.
 - 25 We note that our 2024 estimate of spending on MA relative to the amount Medicare would have spent for comparable FFS beneficiaries (122 percent) reflects several changes from the method used for the Commission’s 2023 comparison (reported to be 106 percent in our March 2023 report) (Medicare Payment Advisory Commission 2023). First, in 2023 we did not account for the effects of favorable selection, which, for 2024, we estimate accounts for about 9 percentage points of the difference in spending. Second, we revised our method of estimating coding intensity, adding about 2 percentage points to the difference in spending. Also, we now project the effects of coding intensity from the most recent analytic year (2022) to the next payment year (2024) using a recent trend (1.5 percentage points per year from 2017 to 2021, and accounting for the phase-in of the V28 model in 2024), which adds a little more than 2 percentage points to the spending difference (we previously assumed coding intensity in 2023 was the same as it was in 2021). In addition, MA and FFS coding differences grew by about 3 percentage points between 2021 and 2022 (the largest one-year increase, which reflects the effects of the pandemic on MA risk scores and coding practices). Finally, all other factors (e.g., changes in the share of enrollees in plans receiving a quality bonus increase to their benchmark, changes in MA enrollment share across benchmark quartiles) reduced the difference in our MA and FFS spending comparison by about 1 percentage point. The net of these factors accounts for the 16 percentage point difference in our 2024 and 2023 estimates of MA spending relative to comparable FFS beneficiaries. See Chapter 13 for more information about our revised methods for estimating the effects of coding intensity and favorable selection.
 - 26 We measure selection into MA using risk-standardized spending (i.e., by comparing enrollees’ actual spending with the amount predicted by their risk score). Because actual spending can differ from predicted spending at all levels of spending, the level of selection does not appear to be dependent on the share of Medicare beneficiaries enrolled in MA. More information is available in Chapter 13.
 - 27 In the Medicare program, the overall effect of coding intensity and favorable selection is not budget neutral because risk scores are calibrated on the non-MA population. Because the prediction of MA risk is based on the FFS population, unintended differences in risk-standardized spending can occur through coding intensity and favorable selection. In contrast, other insurance markets (e.g., Medicaid managed care markets) base risk on the managed care population rather than an external population. Thus, the effects of coding and selection are budget neutral in markets where the entire population is in managed care.

- 28 Prior to each payment year, CMS publishes plan benchmarks in April, and plans submit their bids in June. Benchmarks reflect projected FFS spending estimates using data available at the time the benchmarks were published (e.g., estimates of projected 2024 FFS spending use data available just prior to the release of benchmarks in April 2023). We use plans' projected enrollment, spending, and risk scores from their bids to estimate projected MA payments and compare those amounts with CMS's projected FFS spending for a like set of FFS beneficiaries (by applying the MA enrollment and risk profile to CMS's projected spending of FFS beneficiaries in each county).
- 29 Our estimate of 2024 MA payments relative to FFS spending does not account for other potential factors that are more difficult to measure with certainty, including how benchmark quartiles and plan bids and payments would have changed if calculating FFS spending using only beneficiaries with both Part A and Part B. In addition, our analysis does not include secondary effects that can be measured with far less certainty, such as the potential spillover of provider behavior that can occur from large increases in MA market share into FFS or potential spillover from FFS alternative payment models into MA, and any effect of MA and FFS improper payments found retrospectively.
- 30 The 1 percentage point decrease in benchmarks relative to FFS spending in 2024 is at least somewhat attributable to a decrease in the share of MA enrollees in a quality bonus plan, after a record high in 2023.
- 31 We estimate that including employer plans increased our estimate of favorable selection by less than 1 percentage point annually. For more information on the inclusion of employer plan enrollees in this analysis, see Chapter 13.
- 32 The actual dollar amount a plan will receive for coding a new HCC depends on several additional factors, including the version of the HCC model applied to a beneficiary and factors that affect a plan's base rate. Dollar-value coefficients are standardized relative to average FFS spending before being applied to each plan's base rate. CMS maintains separate HCC models for enrollees who lack a full calendar year of diagnostic data or have end-stage renal disease. A plan's base rate varies according to the plan's bid and the local area's benchmark.
- 33 CMS has modified the risk-adjustment model to better align FFS and MA risk scores. Between 2014 and 2016, CMS phased in a new risk-adjustment model that reduced the gap in coding intensity by about 2 percentage points to 2.5 percentage points relative to FFS by removing some diagnoses that were found to be coded more aggressively in MA. In 2017, CMS began accounting for Medicaid benefit eligibility more accurately (full, partial, or no benefits status by month), which reduced the gap in MA and FFS risk scores by about 1 percentage point, eliminating the amount that MA risk scores were unduly higher than FFS due to differing shares of beneficiaries by Medicaid eligibility status. Starting in 2024, CMS will phase-in a new risk model that, similar to the model introduced in 2014, is expected to reduce the gap in coding intensity relative to FFS by removing or constraining the coefficient of some diagnoses that were found to be coded more aggressively in MA.
- 34 We also found a large increase in coding intensity between 2021 and 2022 using our prior method of estimating coding intensity. The "revised MedPAC cohort method" (see Chapter 13 for a description of this method) found an increase of 3.9 percentage points between 2021 and 2022.
- 35 The new risk-adjustment model (V28) introduced in 2024 is expected to reduce MA risk scores relative to FFS because it removes HCCs or constrains the coefficients of HCCs that have much higher rates of MA coding relative to FFS. We believe a 2 percent reduction in risk scores under the V28 model relative to the previous V24 model is a reasonable expectation based on a combination of factors. In 2014, CMS implemented a model that similarly removed HCCs or constrained HCC coefficients with higher MA coding rates, which reduced MA risk scores by roughly 2.0 percentage points or 2.5 percentage points, depending on the year. Also, in the 2024 advance notice, CMS reported that the combined effect of changing from the V24 to the V28 model and of the normalization factor for 2024 would reduce payments to MA plans by -3.12 percentage points. We note that the average annual effect of the normalization factor over the past five years is -2.1 percentage points, with somewhat smaller effects in more recent years. There is uncertainty about the impact of moving to the V28 on MA coding intensity. We will continue to monitor those effects and will update our analysis as we are able.
- 36 In some counties, the full 5 or 10 percent quality bonus increase to a plan's benchmark is limited by the ACA benchmark caps.
- 37 This organization-level analysis, like our national estimate of coding differences, uses the same method of estimating coding intensity as described in Chapter 13, except that the MA risk scores are calculated separately for each MA organization.
- 38 Recent reporting shows that agents and brokers are often paid by plans to conduct health risk assessments of new enrollees, but such assessments are not allowable for risk adjustment because agents and brokers are not clinicians.
- 39 The general steps we followed were to identify physician and hospital encounter records allowable for risk adjustment;

identify each record as a health risk assessment (using procedure codes for annual wellness visit or initial preventive physical exam, or an evaluation and management visit provided in the home), chart review (using chart review indicator), or other service; map diagnoses from those records to HCCs; apply HCC hierarchies; compare the HCCs we identified from encounter records with the HCCs in CMS's risk-score file and exclude HCCs not identified in both sources; apply HCC coefficients for the appropriate risk model; and apply Part A and Part B payment rates specific to each plan. We then identified the number of HCCs and associated dollar amounts that were supported through a health risk assessment, chart review, or both.

- 40 The seven HCCs that each generated more than \$500 million in payments from health risk assessments and the percentage of the time that a health risk assessment was the only source of the HCC were vascular disease, 47 percent; major depressive, bipolar, and paranoid disorders, 46 percent; morbid obesity, 38 percent; chronic obstructive pulmonary disorder, 25 percent; diabetes with chronic complications, 15 percent; coagulation defects and other specified hematological disorders, 60 percent; and congestive heart failure, 23 percent. We note that diabetes with chronic complications and congestive heart failure are among the HCCs that have a constrained coefficient in the V28 risk model, meaning that differences in the level of severity (e.g., diabetes without complications, with chronic complications, or with acute complications) for these conditions are not reflected in the V28 risk-adjustment model coefficients, which may contribute to an expected reduction in overall MA and FFS coding differences.
- 41 The impact of health risk assessments on payments to MA plans has grown. For 2017, the Office of Inspector General (OIG) found that HCCs supported only by a health risk assessment accounted for \$2.6 billion, or about 1.3 percent of payments to MA plans in 2017 (Office of Inspector General 2020). OIG excluded beneficiaries with more than one health risk assessment during the year. Our analysis assessed all health risk assessments. For 2020, we found that HCCs supported only by a health risk assessment accounted for \$8.6 billion, or about 2.9 percent of all payments to MA plans.
- 42 The legal complaints cited in this section support this statement. One complaint includes exhibits of plan documents that detail the financial performance of the plan's chart review program (United States of America v. Anthem 2020).
- 43 The eight HCCs that each generated more than \$1 billion in payments from chart reviews and the percentage of the time that a chart review was the only source of the HCC were vascular disease, 36 percent; chronic obstructive pulmonary disorder, 29 percent; major depressive, bipolar, and paranoid disorders, 36 percent; diabetes with chronic complications, 19 percent; congestive heart failure, 26 percent; morbid obesity, 37 percent; disorders of immunity, 45 percent; and rheumatoid arthritis and inflammatory connective tissue disease, 32 percent. We note that diabetes with chronic complications and congestive heart failure are among the HCCs that have a constrained coefficient in the V28 risk model, meaning that differences in the level of severity (e.g., diabetes without complications, with chronic complications, or with acute complications) for these conditions are not reflected in the V28 risk-adjustment model coefficients, which may contribute to an expected reduction in overall MA and FFS coding differences.
- 44 The impact of chart reviews on payments to MA plans has grown substantially in recent years. OIG found that HCCs supported only by a chart review accounted for \$6.7 billion in payments to MA plans, or about 3.2 percent of payments to MA in 2017 (Office of Inspector General 2020). For 2020, we found that HCCs supported only by a chart review accounted for \$12.7 billion, or about 3.4 percent of all payments to MA plans.
- 45 About \$4.7 billion in payments to MA plans were from HCCs identified on a health risk assessment and a chart review but not during any record of a physician or hospital encounter during the same calendar year.
- 46 For risk-adjustment data validation audits in 2011, CMS grouped all contracts into high, medium, and low levels of coding intensity and selected 20 high-level, 5 medium-level, and 5 low-level contracts at random.
- 47 Other factors may also influence insurers' decisions to enter new markets. Examples include state and federal regulatory and financial requirements (including licensure requirements), the size of the market, the local MA penetration rate, the number of competitors, benchmark payment rates for the market relative to the health care needs of the population, availability and quality of providers, and the estimated likelihood of achieving a sustainable risk profile after accounting for CMS's coding intensity adjustment (Buzby et al. 2022, Killian and Swenson 2016).
- 48 The top three organizations nationally also had the highest share of enrollees in both urban and rural areas in 2023. In urban areas, the top three organizations covered 60 percent of MA enrollees (up from 55 percent in 2022). In rural areas, the top three organizations accounted for 65 percent of the MA enrollees (up from 64 percent in 2022).
- 49 In 2023, 17 percent of MA enrollees were eligible for Medicaid and enrolled in dual-eligible SNPs (D-SNPs). While national D-SNP enrollment is more concentrated than

- overall MA enrollment (the three largest D-SNPs had 64 percent of enrollment), only two of the three largest national MA organizations were also among the top three D-SNP organizations. Enrollment in D-SNPs has been getting more concentrated nationally: The largest three organizations nationally had 57 percent of total enrollment in D-SNPs in 2023, an increase from 54 percent in 2022.
- 50 The Herfindahl-Hirschman Index is calculated by squaring the market share of each entity competing in the market and summing the results. The index approaches zero when a market is occupied by a large number of firms of relatively equal size; the index reaches its maximum of 10,000 points when a market is controlled by a single firm. The index rises both as the number of firms in the market drops and as the disparity in size among those firms increases. Under Department of Justice and Federal Trade Commission guidelines, markets with an index above 1,800 are considered highly concentrated (Department of Justice and Federal Trade Commission 2023).
- 51 We used the 2021 Compendium of U.S. Health Systems developed by the Agency for Healthcare Research and Quality to identify health systems (<https://www.ahrq.gov/chsp/data-resources/compendium-2021.html>). We reviewed the websites of systems that were indicated as offering an insurance product to identify whether the system is the parent organization for, or has any other ownership arrangement with, an MA plan. We excluded cases in which the health system offered a co-branded MA product but for which no ownership relationship could be identified. The compendium defines a health system as one that includes at least one hospital and at least one group of physicians who provide comprehensive care and are connected with each other and with the hospital through common ownership or joint management.
- 52 Margins are calculated as the remainder of payments to the plan after accounting for all other costs, including all medical expenses, salaries, bonuses, beneficiary incentive payments, and all administrative costs. As in prior years, we removed contracts that reported medical expenses equal to or greater than their stated plan revenues for that year (i.e., contracts reporting insufficient revenue to cover benefits and any administrative expenses). We excluded plans at the contract level to account for plans that other MA plans could be subsidizing (i.e., product pairing) within the same service area.
- 53 MA plans annually report their medical loss ratios (MLRs) to CMS and are subject to financial and other penalties for failure to meet the statutory requirement that they have an MLR of at least 85 percent. For contract year 2022, plans submitted MLRs to CMS in December 2023, and CMS will begin subtracting amounts from regular monthly plan payments in July 2024 to recoup any revenue difference between a plan's actual MLR and the 85 percent minimum MLR.
- 54 Star rating is a framework that CMS uses across MA and FFS. On its Care Compare website, CMS publishes star ratings on different types of Medicare providers (like physicians, hospitals, nursing homes, and others) so that beneficiaries can see how providers perform for FFS beneficiaries in their local area. However, there is no single quality evaluation for Medicare FFS in its entirety; star ratings of providers in FFS reflect their individual performance. The performance of a set of providers in a local area is not directly comparable to an MA star rating, which reflects the joint performance of an MA organization and its network of contracted providers, at the contract level.
- 55 This count includes measures for Medicare Advantage-Prescription Drug plan (MA-PD) contracts. MA-only contracts and PDPs are measured on subsets of measures.
- 56 Measures are assigned unique weights, and the overall score is a weighted average. The other roughly 60 measures that Medicare collects are display measures that CMS publicly reports on the [medicare.gov](https://www.medicare.gov) website (not the Medicare Plan Finder website). Some display measures were previously incorporated into the star ratings but have been transitioned out. Others may be new measures being tested before inclusion in the star ratings or that are otherwise reported for informational purposes only.
- 57 Currently, quality results for MA are reported on a contract-wide basis, and those results are used to determine the star rating for all plans under the contract's offerings.
- 58 Although Medicare has contracted with private plans since 1966, prior to 1985 nearly all contracts used cost-based payment rates or used risk-based payment but were administered through a demonstration project. We identify 1985 as the year when the Tax Equity and Fiscal Responsibility Act of 1982 effectively initiated private plan contracting in Medicare with payment rates set on a full risk basis (Zarabozo 2000).
- 59 Some parent organizations that are neither provider owned nor among the top five largest nationally report high rates of payments to related parties (shown under the "All other" category in Figure 12-4, p. 377). Most of these organizations are recent entrants to the MA market with venture capital financing. We did not find evidence that these companies were owners of health care provider organizations, and the high rates being reported may reflect the structure of the business venture rather than the degree of vertical integration with providers.

60 Part B spending represents about 60 percent of all Medicare FFS spending (which is assumed to be the same share of spending on Part B services by MA plans). Twenty-five percent of Part B spending is financed through premiums paid by all Medicare Part B enrollees. The estimate does not account for the reduction in Part B premiums that is offered by some MA plans as a supplemental benefit.

61 Medical loss ratio requirements are monitored at the contract level. The numerator of the MLR includes incurred claims for all enrollees, amounts used to buy down enrollees' Part B premiums, expenditures for activities that improve health care quality, and—for Medicare Savings Account contracts—the amount deposited into medical savings accounts. Incurred claims costs include, but are not limited to, amounts that the MA organization pays (including under capitation contracts) for covered services and the amount of incentive and bonus payments made to providers. Activities that improve health care quality may include those designed to improve health outcomes through quality reporting,

case management, care coordination, chronic disease management, and medication and care compliance initiatives; activities to prevent hospital readmissions; activities to improve patient safety and reduce medical errors; activities to promote health and wellness; activities to enhance the use of health care data to improve quality and support meaningful use of health information technology; medication therapy management programs (for MA-PDs); or activities to reduce fraud. The numerator excludes amounts paid to third-party vendors for network development, administrative fees, claims processing, and utilization management. The denominator of the MLR must equal the total revenue under the contract, which includes CMS's payments to the MA organization less licensing and regulatory fees, state and federal taxes, and certain community benefit expenditures.

62 One study found that additional benefits and limits on out-of-pocket spending were the two leading reasons that MA enrollees chose an MA plan (Leonard et al. 2022).

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