MEDPAC

Advising the Congress on Medicare issues

The Medicare Advantage program: Status report

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Presentation roadmap

1. Overview of Medicare Advantage enrollment, plan availability, and levels of supplemental benefits
2. Market structure, vertical integration, and insurer financial condition
3. Ongoing concerns about the Quality Bonus Program
4. Medicare Advantage plan payments: Update on coding intensity
5. Medicare Advantage plan payments: Update on favorable selection
6. Comparison of Medicare Advantage and fee-for-service spending

MedPAC's MA status report

- The Commission is required by law to report in March of each year on the status of the MA program, including a review of:
  - Payment policies, risk adjustment methods, the impact of risk selection, mechanisms for promoting quality, access to care, and other issues
- We examine MA enrollment trends, plan availability for the coming year, plan generosity, and Medicare spending
- This year's status report is informational only and does not include new recommendations

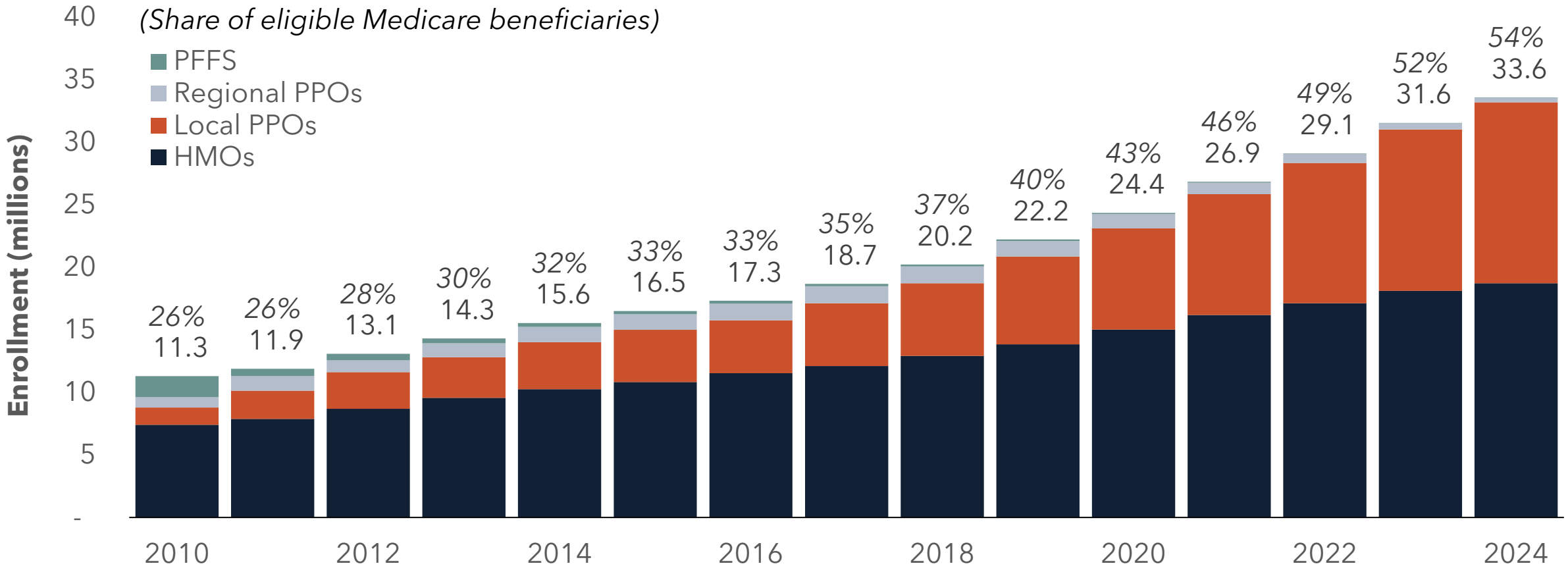
Note: MA (Medicare Advantage).

The Commission supports the inclusion of private plans in Medicare

- The MA program allows Medicare beneficiaries to receive benefits from private plans rather than the FFS program
  - For beneficiaries, the primary trade-off is access to the supplemental benefits MA plans provide versus a broader choice of providers and fewer constraints on utilization in FFS
- The Commission strongly supports including private plans in the Medicare program
  - The Commission has expressed concern about the FFS benefit design and has made recommendations to give beneficiaries better protection against high OOP spending and to create incentives to make better decisions about the use of discretionary care
- The Commission has recommended important reforms to improve Medicare's policies for paying and overseeing MA plans

Note: MA (Medicare Advantage), FFS (fee for service), OOP (out of pocket).
Source: Medicare Payment Advisory Commission. (2012). *Medicare and the health care delivery system*.

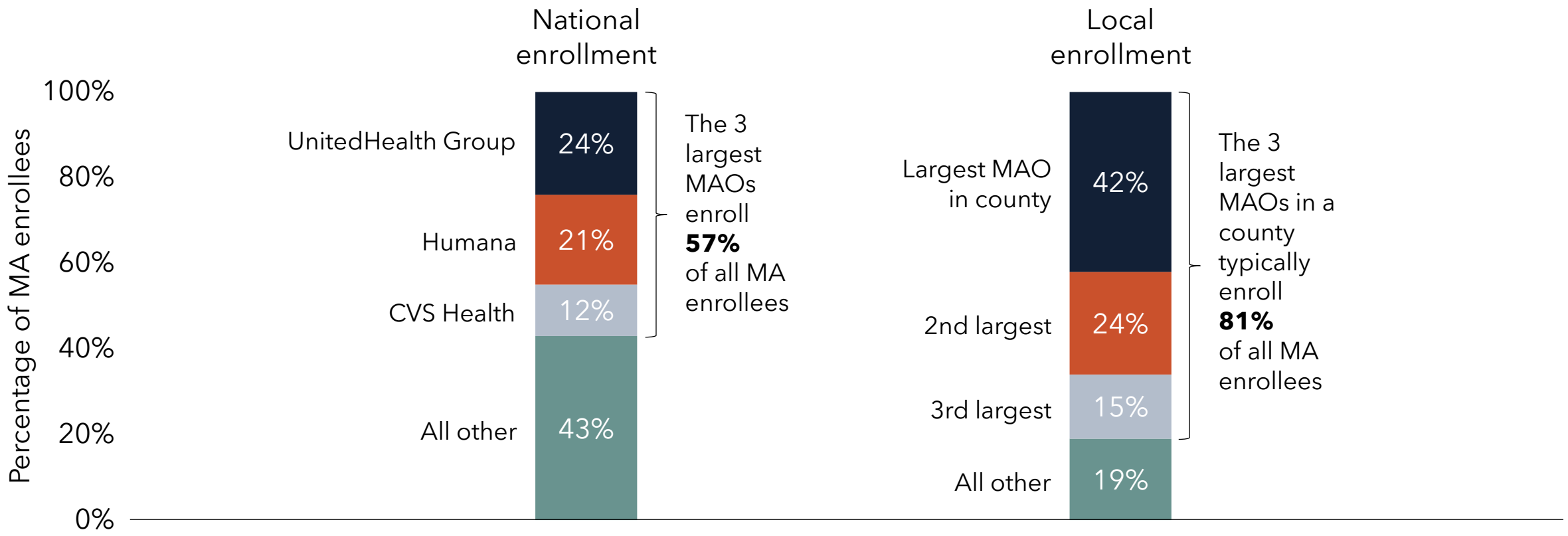
In 2024, 54% of eligible beneficiaries enrolled in MA plans



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.

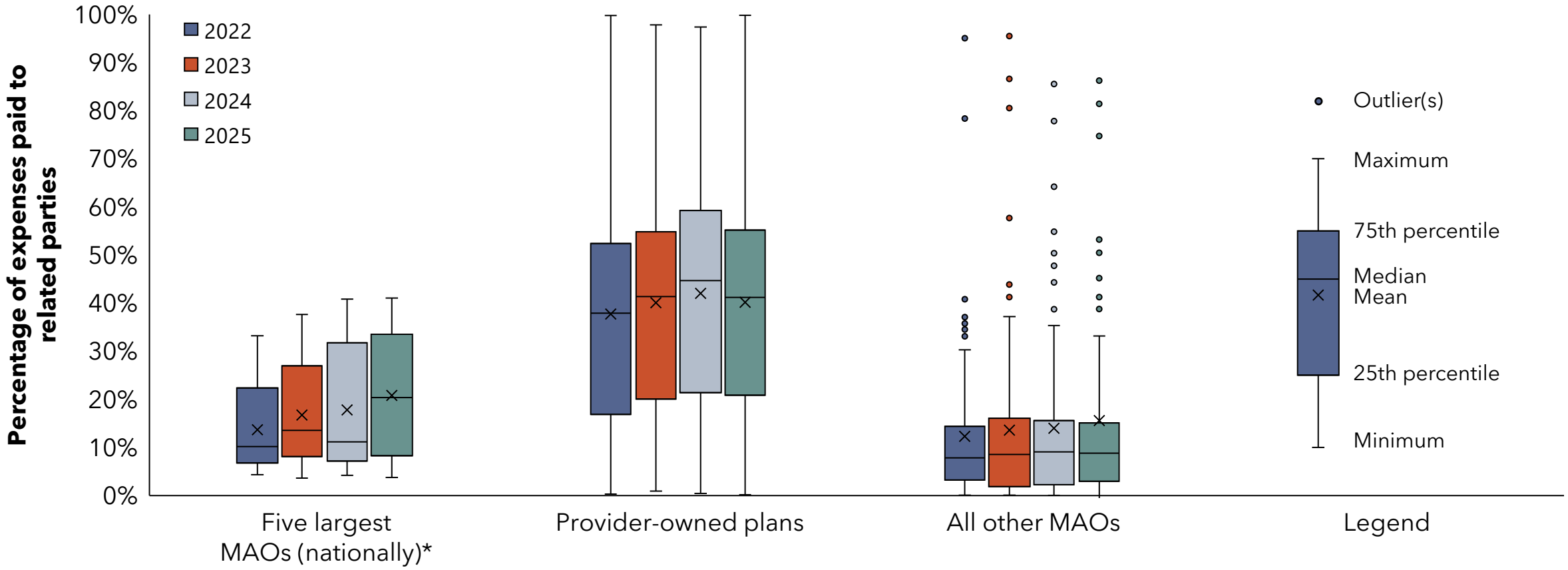
Source: MedPAC analysis of CMS enrollment files, July 2010–2024.

MA enrollment is highly concentrated at the national and local level



Note: MAO (Medicare Advantage organization). Employer plans and special-needs plans are excluded.
Source: MedPAC analysis of CMS July 2024 enrollment data.

MA organizations are increasingly vertically integrated



Note: MAO (Medicare Advantage organization).
* Five largest non-provider-owned MAOs 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. "Outliers" are values greater than 1.5 times the difference between the values at the 75th percentile and 25th percentile. "Maximum" and "minimum" are the values for the category when outliers are excluded.

Source: MedPAC analysis of CMS enrollment data, MMIT Directory of Health Plans.

MA plans available to nearly all Medicare beneficiaries; number of plan choices stable

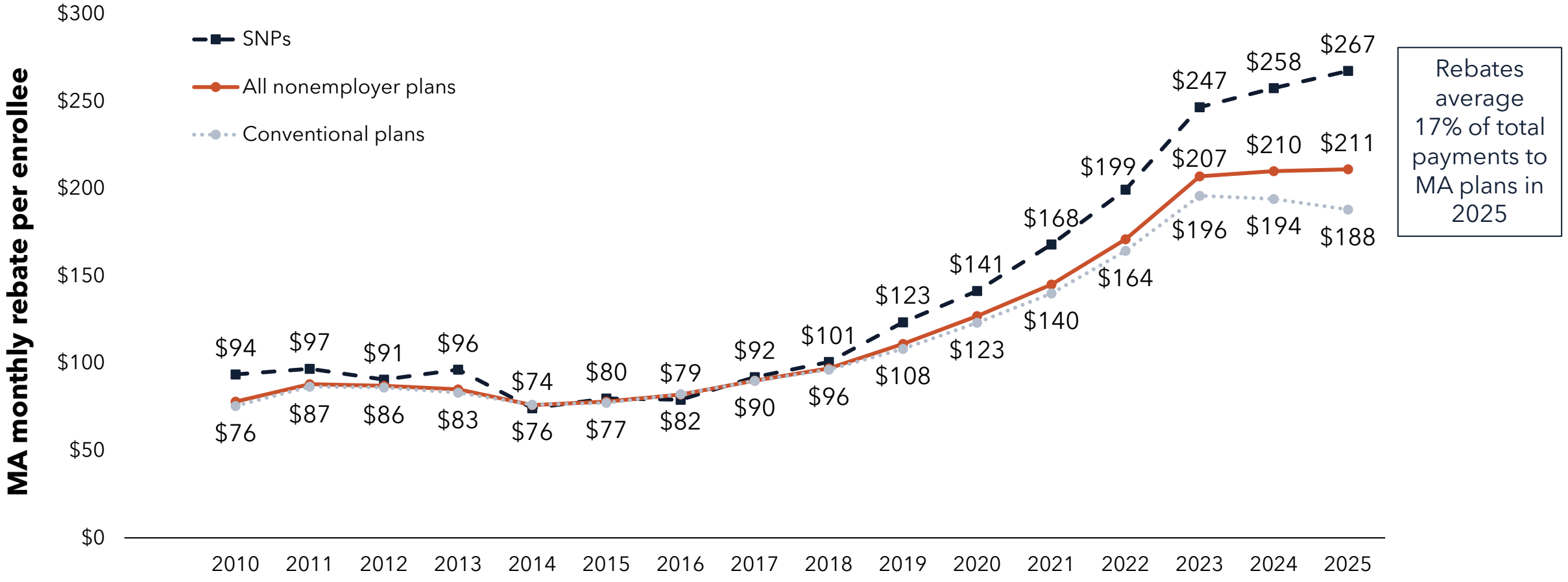
Plan Availability	2024	2025
Share of beneficiaries with access to:		
Any MA plan	>99.5%	>99.5%
$0 premium plan with Part D	99	99
Avg. number of choices (beneficiary weighted)	43	42
Avg. number of insurers (beneficiary weighted)	8	8

- Beneficiaries continue to have many plans available to them in 2025
- More than 95% of beneficiaries have a D–SNP in their county
- Number of plan choices and insurers are similar to 2024

Note: MA (Medicare Advantage), D–SNP (dual-eligible special-needs plan). Plan availability does not include special-needs plans and employer plans.

Source: MedPAC analysis of CMS bid and enrollment data.

Level of monthly rebates near historic high



Rebates average 17% of total payments to MA plans in 2025

Note: SNP (special-needs plan), MA (Medicare Advantage). Excludes employer plans and plans that do not offer a prescription drug benefit.
Source: MedPAC analysis of data from CMS on plan bids, 2016–2025.

MA plans offer reduced cost-sharing, lower premiums, and additional services

Supplemental benefit	Share of rebate	
	2024	2025
Cost sharing	39%	43%
Non-Medicare services	27	28
Part D supplemental	18	15
Part D premium	13	8
Part B premium	4	6

- Plans project allocating the largest share of rebates to reducing cost sharing for basic Medicare services
- The share of rebates allocated to non-Medicare services has grown in recent years
- We do not have reliable data about MA enrollees' use of non-Medicare services (e.g., dental, vision, or hearing services)

Note: MA (Medicare Advantage). Employer group plans, special-needs plans, and plans that do not offer Part D coverage are not included. Components may not sum to 100% due to rounding.

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

MedPAC recommendation on the MA quality-bonus program *(June 2020)*

- The QBP has serious flaws
  - Assesses quality for large contracts with geographically dispersed enrollment
  - Uses too many measures
  - Is funded with additional program dollars (unlike FFS quality programs)
- Accounts for at least $15 billion in MA payments annually

- The QBP should be replaced with a value incentive program that would address many flaws, by:
  - Focusing on local markets
  - Using a smaller number of measures
  - Distributing plan-financed rewards

Note: MA (Medicare Advantage), QBP (quality-bonus program), FFS (fee-for-service).

Source: Medicare Payment Advisory Commission. (2020). *Medicare and the health care delivery system.* Chapter 3.

Medicare's payments to MA plans

- Payment to plan = base rate × average risk score
- Base rate is based on plan bids, benchmarks, and quality scores
  - A bid is the amount each plan expects it will cost to cover Part A and Part B services
  - Benchmarks range from 115% of FFS in lowest-FFS-spending counties to 95% of FFS in highest-spending counties (4 quartiles of counties)
    - Can be increased by 5% or 10% as a quality bonus for plans achieving 4 or more stars
- Nearly all plans bid below their benchmark
  - Plans receive a base payment of their bid plus a "rebate," which is a percentage (varying by quality score) of the difference between bid and benchmark

Note: MA (Medicare Advantage), FFS (fee-for-service). If a bid is greater than the benchmark, Medicare pays the benchmark and the enrollee pays a premium to make up the difference. However, this scenario is rare.

MA plan payment policy: Risk adjustment

- Risk scores are a beneficiary-specific index of predicted spending relative to national average spending (a 1.0 risk score)
  - Based on beneficiary demographic characteristics and diagnoses
  - Risk scores increase MA plans' base payment rates for enrollees expected to have higher spending and decrease rates for enrollees expected to have lower spending
  - Risk scores are used to standardize the FFS spending estimates used for county benchmarks
- The risk-adjustment model is developed using data for FFS beneficiaries; spending predictions are distorted when MA enrollee tendencies differ from FFS
  - Coding intensity results from MA diagnostic coding patterns that differ from FFS's
  - Favorable selection results from MA enrollees having spending tendencies that differ from the average FFS beneficiary, independent of coding intensity

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

Comparing spending on MA and FFS Medicare

- Account for differences in health status, including favorable selection, diagnostic coding differences, geographic distribution, and Medicare service coverage (e.g., hospice)
- Relative to FFS, spending on MA varies due to:
  - Payment policies unrelated to risk adjustment
  - Intensity of MA coding relative to FFS
  - Favorable selection of beneficiaries into MA

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

Base comparison accounts for payment policies unrelated to risk adjustment

- Base comparison of MA and FFS spending captures the effects of:
  - Accuracy of projected FFS spending used for plan benchmarks
  - Distribution of MA enrollment among county quartiles
  - Share of MA enrollment in plans receiving a quality bonus benchmark increase
- Compare MA payments and FFS spending adjusted to have MA risk profile
  - Years with historical data available: Use actual payments (including nonclaims FFS spending), risk scores, and enrollment for beneficiaries with both Part A and Part B
  - Other years: Use estimates based on MA bid data and CMS's projections of local-area risk-standardized FFS spending
  - Estimates from these two methods are within 1 percentage point (nonpandemic years)
- MA payments are similar to FFS spending for most recent years before accounting for coding intensity and favorable selection

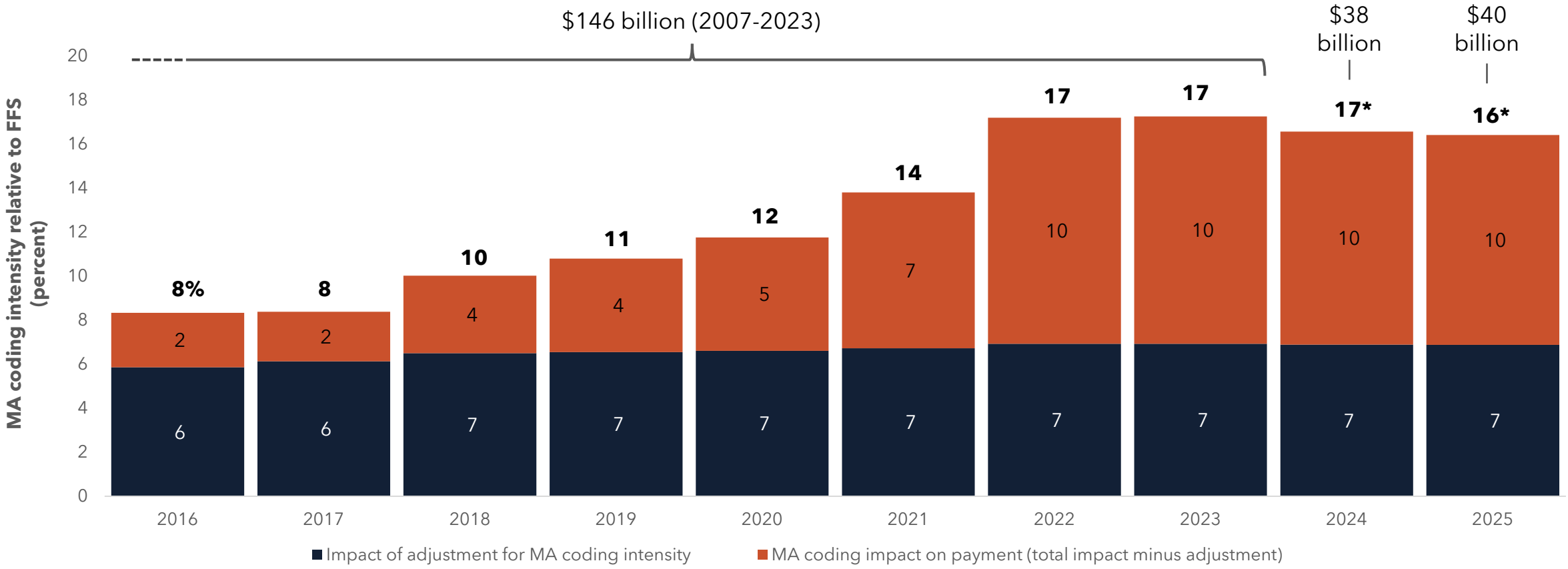
Note: MA (Medicare Advantage), FFS (fee-for-service).

MA coding generates increased payments in 2025

- Differences in diagnostic coding between FFS and MA
  - FFS: Little incentive to code diagnoses
  - MA: Financial incentive and infrastructure to code more diagnoses
- MedPAC's estimates of coding intensity
  - Uses the DECI method, accounting for Medicaid eligibility and institutional status
  - Projects estimates for 2024 and 2025 based on 2019 through 2023 trend and an updated estimate of the impact of the V28 risk model
    - We estimate coding intensity to be about 8 percentage points lower under V28 (when fully phased in) before accounting for plan behavior and higher expected coding trend
- 2025 MA risk scores are projected to be 16% higher than scores would be if MA enrollees were instead enrolled in FFS Medicare

Note: MA (Medicare Advantage), FFS (fee-for-service), DECI (demographic estimate of coding-intensity).

Impact of MA coding intensity remains high

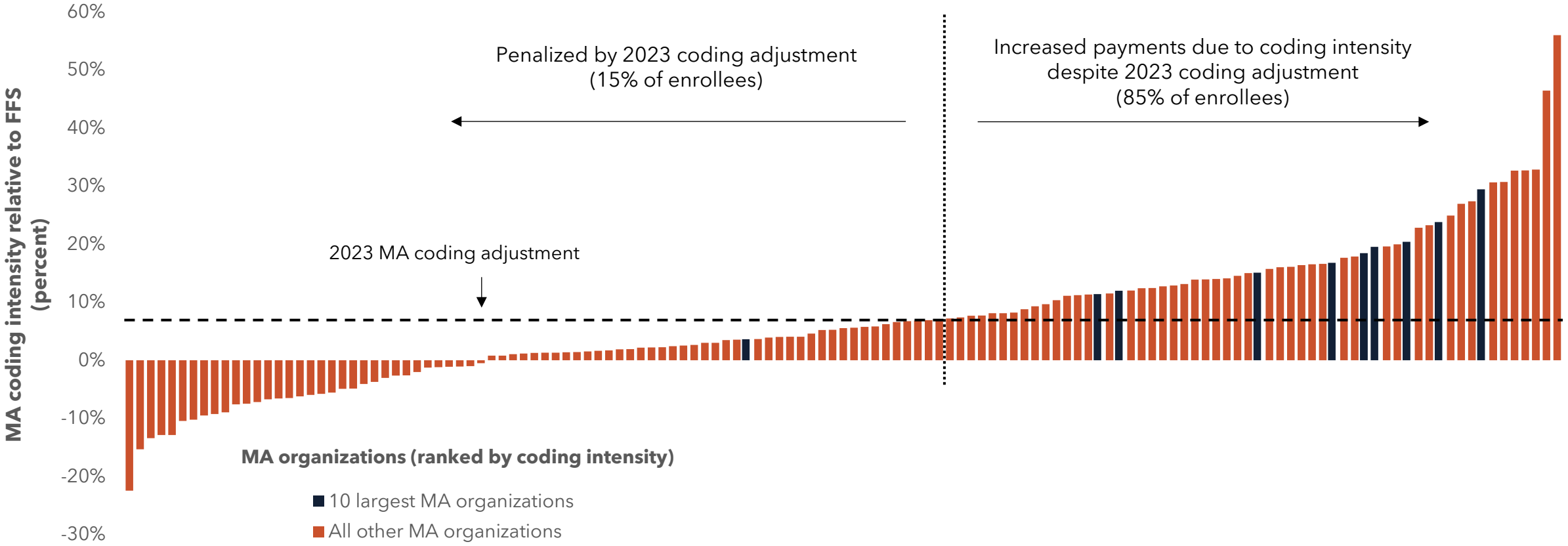


Note: MA (Medicare Advantage), FFS (fee-for-service). Estimates account for differences between MA and FFS populations in age, sex, Medicaid eligibility, and institutional status. New enrollees are constrained to have no coding intensity. Increases in MA coding intensity were offset by new versions of the risk-adjustment model and by increased FFS coding in 2016 and 2017. Components may not sum to totals due to rounding.

* For 2024 and 2025, we projected coding intensity based on the annual trend from 2019 through 2023 and then reduced that trend to account for the phase-in of the V28 risk-adjustment model.

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

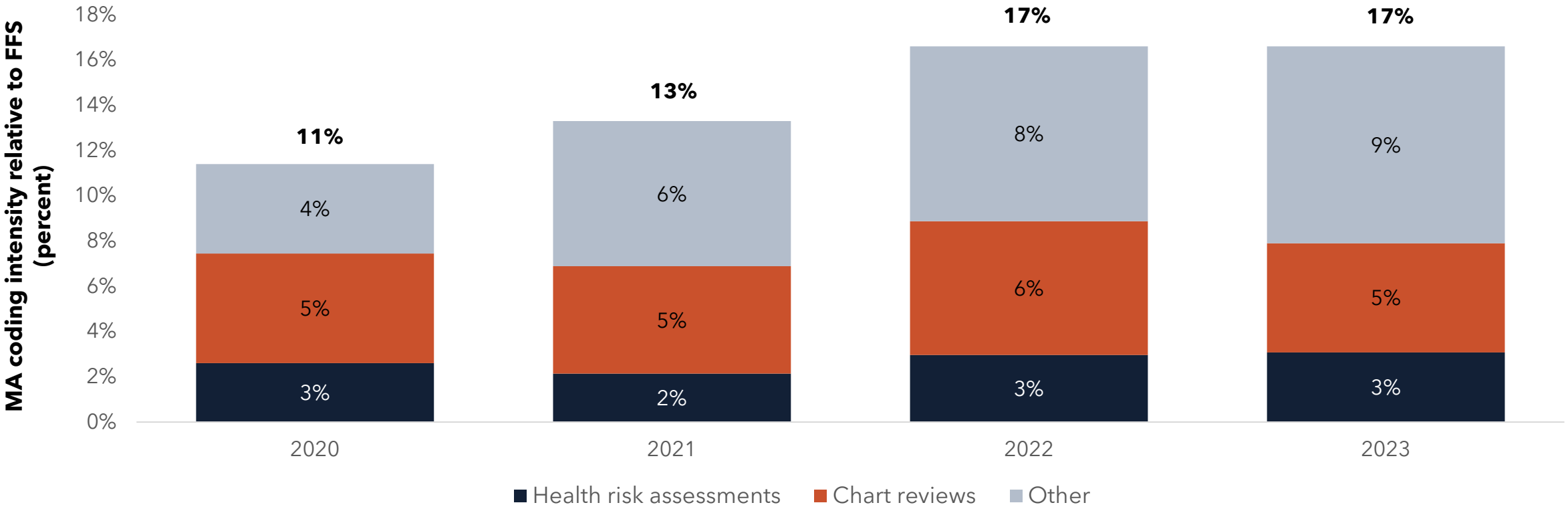
Coding intensity generates payment differences across MA organizations



Note: MA (Medicare Advantage), FFS (fee-for-service). All estimates are for 2023 and account for any differences between MA and FFS populations in age, sex, Medicaid eligibility, and institutional status. New enrollees are constrained to have no coding intensity because their risk scores are not based on diagnostic coding. Beneficiaries residing in Puerto Rico or enrolled in a chronic-condition special-needs plan are excluded from the analysis, as well as organizations with fewer than 2,500 enrollees.

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

Chart reviews and health risk assessments account for about half of overall MA coding intensity, 2020–2023



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 2023. The underlying diagnoses were reported during health care encounters in the previous years, 2019 through 2022, respectively. "Other" sources of coding intensity can result from pay-for-coding programs, patient-assessment forms, transferring coding incentives from plans to providers via subcapitation, and other mechanisms. Components may not sum to totals due to rounding.

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

MA coding intensity: Results from several studies consistent with MedPAC's estimates

- MA risk-score growth 1% faster than FFS using Part D data to control for health status
- CBO's difference-in-difference approach found 1.2% faster MA risk score growth
- MA coding intensity at least 6% through 2011 (compared to MedPAC's 5%)
- GAO's 2010-2012 estimates (4% to 6%) match MedPAC's estimates
- Estimates of the impact of health risk assessments (two studies) and chart reviews (one study) are also consistent with MedPAC's estimates
- Implemented MedPAC's method of estimating coding intensity and found similar estimates, rates of growth, and impact of health risk assessments and chart reviews

Note: MA (Medicare Advantage), FFS (fee-for-service), CBBO (Congressional Budget Office), GAO (Government Accountability Office).

Sources: Jacobs P. D., and R. Kronick. 2018. Getting what we pay for: How do risk-based payments to MA plans compare with alternative measures of beneficiary health risk? *Health Services Research*. 53(6): 4997–5015.

Hayford T. B., and A. L. Burns. 2018. MA enrollment and beneficiary risk scores: Difference-in-differences analyses show increases for all enrollees on account of market-wide changes. *Inquiry* 55 (January–December): 46958018788640.

Geruso, M., and T. Layton. 2020. Upcoding: Evidence from Medicare on squishy risk adjustment. *Journal of Political Economy* 12, no. 3 (March): 984–1026

Government Accountability Office. 2013. *MA: Substantial excess payments underscore need for CMS to improve accuracy of risk score adjustments*. GAO–13–206. Washington, DC: GAO.

Jacobs, P. D. 2024. In-home health risk assessments and chart reviews contribute to coding intensity in MA. *Health Affairs* 43, no. 7 (July): 942–949.

James, H. O., B. A. Dana, M. Rahman, et al. 2024. MA health risk assessments contribute up to $12 billion per year to risk-adjusted payments. *Health Affairs* 43, no. 5 (May): 614–622.

Kronick, R., F. M. Chua, R. Krauss, et al. 2025. Are fewer diagnoses better? Assessing a proposal to improve the MA payment system. *Health Affairs* 44, no. 1 (Jan): 66–74.

Differences in MA and FFS coding

- Different incentives in MA and FFS contribute to different relative rates of diagnostic coding and associated affects on payment
  - We estimated rates of follow-up coding for chronic conditions in MA and FFS, the best available measure to assess the impact of differing incentives
  - Follow-up coding rates: Share of beneficiaries coded in 2022 who were then coded with the same condition or a related higher-severity condition in 2023
  - For chronic conditions with differing MA and FFS rates, we considered the influence of relative coding intensity, relative severity among related conditions, and prevalence
- The House Committee on Appropriations requested that the Commission report on differential coding in MA and FFS

Note: MedPAC's staff physician reviewed the diagnosis codes associated with each hierarchical condition category (HCC) and those that represent chronic conditions such that if these conditions were coded in one year, we would expect the condition to persist to the following year for nearly all beneficiaries. Related HCCs are ranked into hierarchies based on severity, and only the highest-severity HCC counts toward a risk score when more than one HCC in the hierarchy is identified for a beneficiary.

Differences in MA and FFS coding, continued

- Follow-up coding rates were higher in MA for most, but not all, of the 52 chronic conditions we identified
  - 12 had rates that were more than 5 percentage points higher in MA
  - 2 had rates that were more than 5 percentage points higher in FFS
- Diagnoses are coded incompletely in both MA and FFS
  - Neither MA nor FFS coding practices likely produce "accurate diagnostic coding"
- Risk model is calibrated on FFS spending and diagnoses; higher MA coding intensity for any reason increases payments to MA plans
  - Overall MA coding intensity raises payments to plans by $40 billion in 2025

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

Addressing MA coding intensity

- The Commission's recommendation addresses underlying causes of coding intensity *(March 2016):*
  - Remove health risk assessments (HRAs) from risk adjustment
  - Use two years of MA and FFS Medicare diagnostic data
- Chart reviews and HRAs are key drivers of coding intensity
  - We estimate that chart reviews and HRAs account for about half of higher payments to MA plans that are due to coding intensity
  - Use of chart reviews and HRAs varies substantially within MA, contributing to coding intensity variation across plans

Note: MA (Medicare Advantage).

Background on favorable selection

- Every beneficiary (FFS and MA) has a risk score that predicts what their spending will be in the next year based on demographics and diagnoses (hierarchical condition categories, or HCCs)
- Risk models are imperfect; there is a distribution of actual spending for individuals with each risk score
- Some beneficiaries have spending that is lower than expected, others have spending that is higher than expected
- Favorable selection can occur if beneficiaries with lower-than-expected spending on average choose MA over FFS
  - Favorable selection can occur at any risk score because it is the difference between expected spending and actual spending

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

MA plan and beneficiary incentives may produce favorable selection

- Absent any intervention from plans, favorable selection in MA occurs if spending for MA enrollees is systematically lower than their risk scores predict
- MA plan features may contribute to favorable selection
  - Plan networks and prior authorization
  - Higher cost sharing for most services compared with Medigap
- Beneficiary preferences may contribute to favorable selection
  - Perception of MA networks and prior authorization may influence choice of coverage
  - Beneficiaries who seek more care may prefer FFS with supplemental insurance
  - Beneficiaries who seek less care and extra benefits may prefer MA

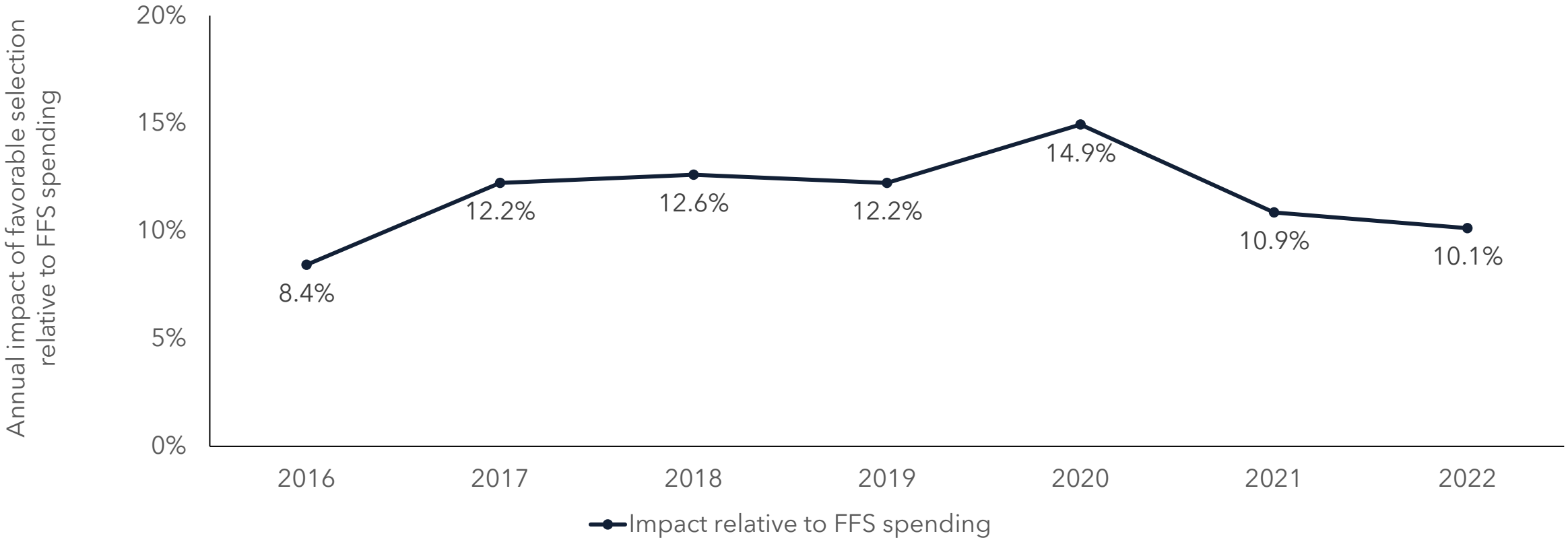
Note: MA (Medicare Advantage), FFS (fee-for-service).

MedPAC analysis indicates MA plans experience favorable selection

- MedPAC recently (March 2024) estimated that favorable selection alone led to higher payments than FFS annually
- Updates to methodology
  - Use the broader FFS population to estimate changes in selection effects during MA enrollment, including during the year of death
  - Account for the differences in mortality rates between MA and FFS

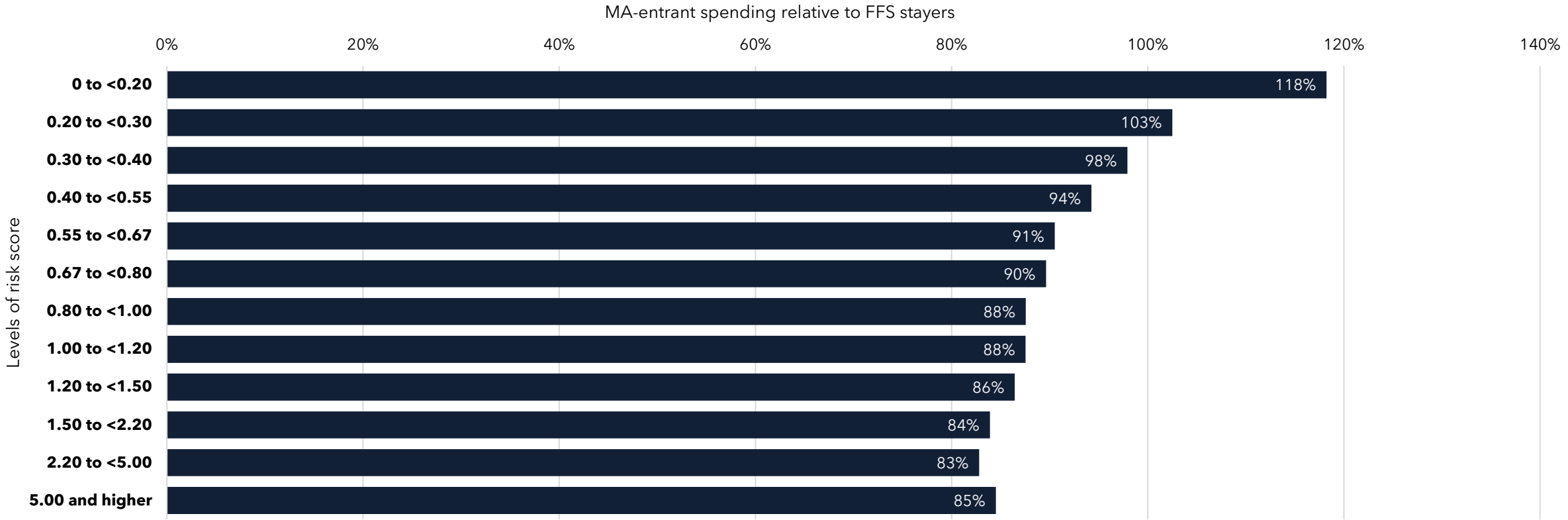
Note: MA (Medicare Advantage), FFS (fee-for-service).

Estimated impact of favorable selection, 2016–2022



Note: MA (Medicare Advantage), FFS (fee-for-service).
Source: MedPAC analysis of Medicare enrollment, Medicare claims spending, and risk-adjustment files.

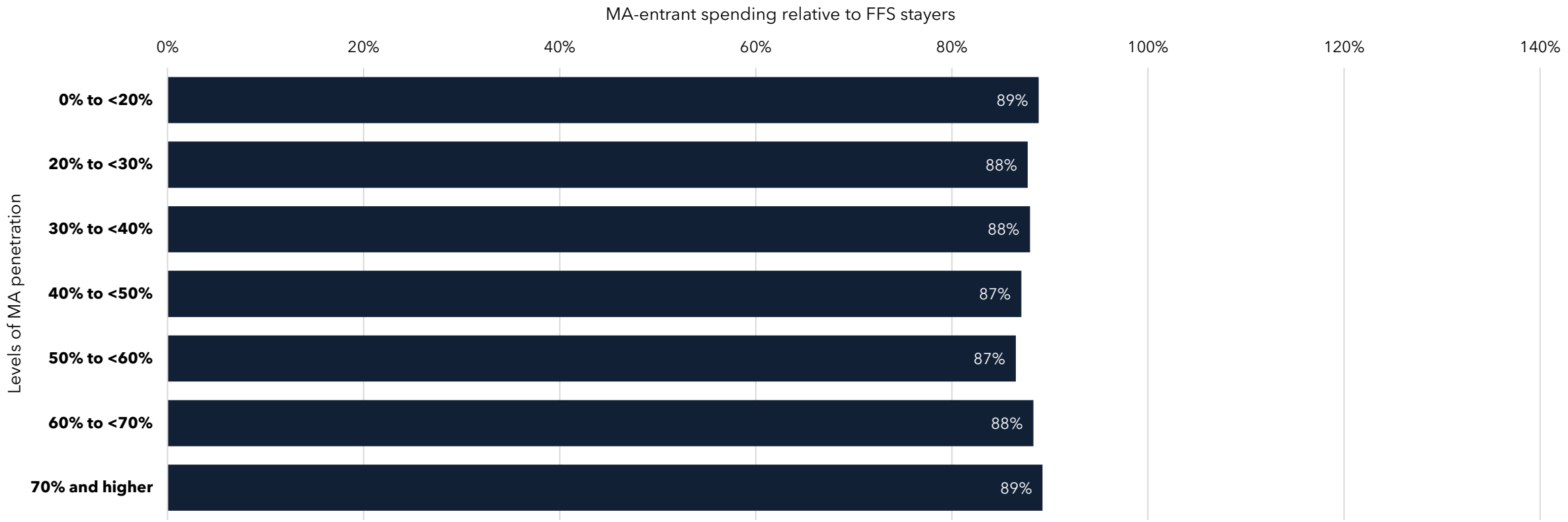
Beneficiaries with high risk scores before MA entry had the most favorable selection in 2022



Note: MA (Medicare Advantage), FFS (fee-for-service). Risk-score levels reflect the pre-entry risk scores for MA enrollees. "MA entrants" are beneficiaries who switched from FFS to MA in the following year. "FFS stayers" are beneficiaries who remained in FFS in the following year. Lower MA-entrant spending relative to FFS stayers' risk-adjusted spending reflects a greater effect of favorable selection.

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

Favorable selection of recent MA entrants was similar in counties with high and low MA penetration



Note: MA (Medicare Advantage), FFS (fee-for-service). MA penetration levels reflect the pre-entry county-level for MA enrollees. "MA entrants" are beneficiaries who switched from FFS to MA in the following year. "FFS stayers" are beneficiaries who remained in FFS in the following year. Lower MA entrant spending relative to FFS stayers' risk-adjusted spending reflects a greater effect of favorable selection.

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

MedPAC's estimates of favorable selection are largely consistent with other researchers'

- Studies vary widely in the way they measure selection, in their sample populations, and in the years of data used
  - Other researchers have found estimates ranging from about 7% to 16%
- Indirect selection: Some studies have found selection using indirect measures
  - Mortality (Curto et al. 2019, Newhouse et al. 2019)
  - Part D event data (Jacobs and Kronick 2018)
  - Disproportionate MA enrollment increases in counties where CMS overpredicts spending for all FFS enrollees (Ryan et al. 2023)
- Direct selection: Some studies have found evidence of direct favorable selection
  - Studies examine risk scores and spending in the year before beneficiaries switch to MA (Jacobson et al. 2019, Lieberman et al. 2023, MedPAC 2012, Newhouse et al. 2015, Teigland et al. 2023)
  - One recent study found Medicare spending was 27% higher for beneficiaries who switched from MA to FFS (Fuglesten Biniek et al. 2024)

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

Source: Curto et al. 2019. Health care spending and utilization in public and private Medicare. *American Economic Journal: Applied Economics* 11, no. 2 (April): 302-332. Jacobs, P. D., and R. Kronick. 2018. *Getting what we pay for: How do risk-based payments to Medicare Advantage plans compare with alternative measures of beneficiary health risk?* Health Services Research (May 22). Jacobson et al. 2019. *Do people who sign up for Medicare Advantage plans have lower Medicare spending?* Washington, DC: Kaiser Family Foundation. Lieberman, S. M., et. al 2023. *Medicare Advantage enrolls lower-spending people, leading to large overpayments.* White Paper. June. Medicare Payment Advisory Commission. 2012. Report to the Congress: *Medicare and the health care delivery system*. Washington, DC: MedPAC. Newhouse, J. P., et al. 2015. *How much favorable selection is left in Medicare Advantage?* American Journal of Health Economics 1, no. 1 (Winter): 1-26. Newhouse, J. P., et al. 2019. *Adjusted mortality rates are lower for Medicare Advantage than traditional Medicare, but the rates converge over time.* Health Affairs 38, no. 4 (April): 554-560. Ryan, A. M., et al. 2023. *Favorable selection in Medicare Advantage is linked to inflated benchmarks and billions in overpayments to plans.* Health Affairs 42, no. 9 (September): 1190-1197. Teigland, C. et al. 2023a. Harvard-Inovalon Medicare study: *Utilization and efficiency under Medicare Advantage vs. Medicare fee-for-service.* White Paper. September. Fuglesten Biniek, J., A. Cottrill, N. Sroczynski, et al. 2024. Medicare Spending was 27% More for People who Disenrolled from Medicare Advantage than for Similar People in Traditional Medicare. Washington, DC: Kaiser Family Foundation. December 6.

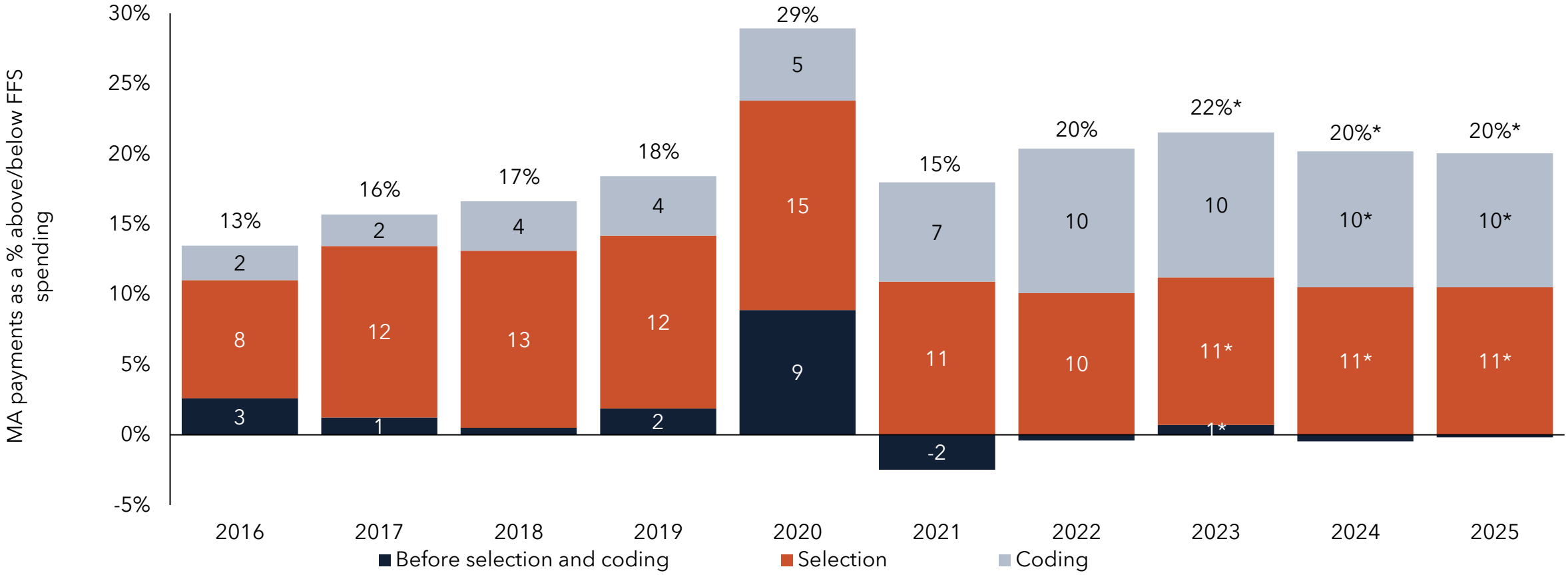
Estimated effects of coding and selection push MA benchmarks, bids, and payments higher relative to what spending would have been in FFS

	Share of FFS spending in 2025		
	Benchmarks	**Bids**	**Payments**
Overall	130%	100%	120%
Estimated before coding and selection	108	83	100
Estimated coding effect (net of CMS coding adjustment)	+10	+8	+10
Estimated selection effect	+11	+9	+11

Note: MA (Medicare Advantage), FFS (fee-for-service). The "overall" estimate of benchmarks, bids, and payments as a share of FFS spending incorporates all three components of the Commission's methodology for comparing payments: (1) a base comparison of MA payments to FFS spending that standardizes for differences in risk scores and geography but does not account for the effects of coding intensity and favorable selection; (2) an adjustment to that base comparison for favorable selection; and (3) an adjustment for coding intensity. The values in the "estimated before coding and selection" row reflect estimates using only the base comparison, without adjusting for the effects of coding intensity and favorable selection. The values in the third and fourth rows are the additive adjustments to the base comparison for the effects of coding and selection. Estimates do not include beneficiaries with end-stage renal disease. More details on our methodology can be found later in this chapter and in the technical appendix. Components may not sum to totals due to rounding.

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

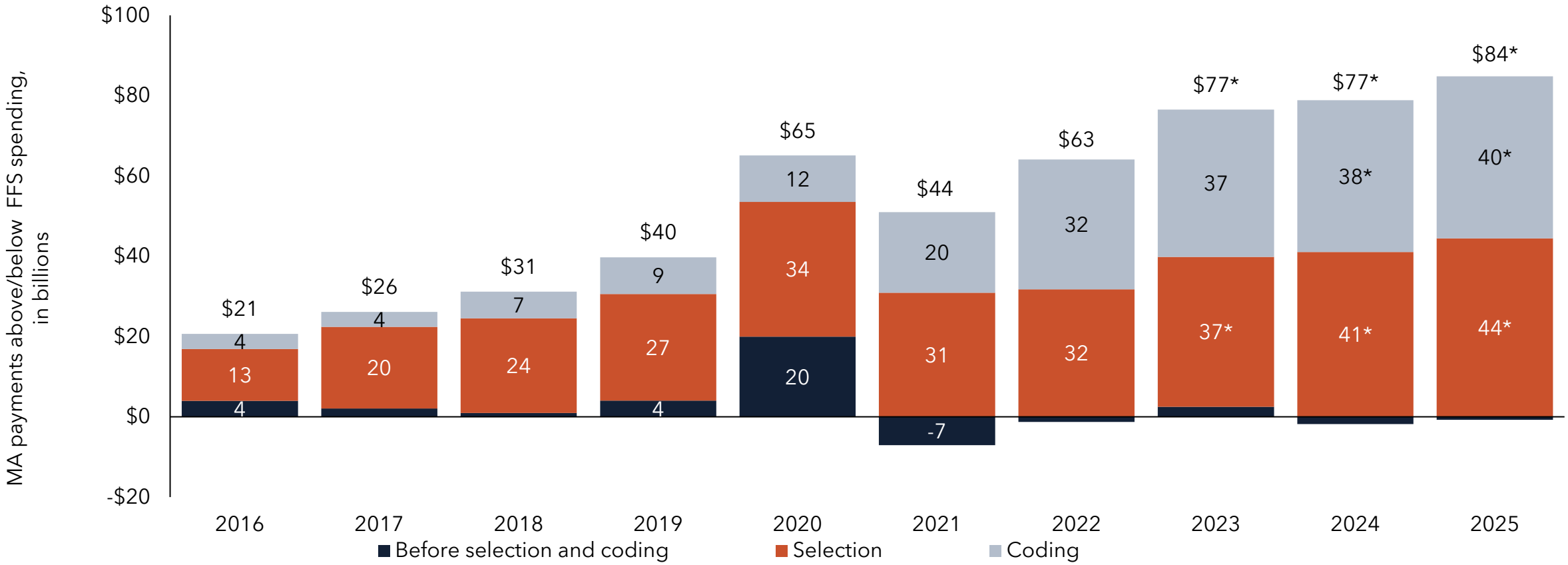
Coding and selection have driven MA payments substantially above what spending would have been in FFS



Note: MA (Medicare Advantage), FFS (fee-for-service). Components may not sum to totals due to rounding. Estimates from 2016 through 2022 use actual MA and FFS data. Unidentified values indicate less than 0.5%.
* Specified values used projected data.

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

Coding and selection have driven MA payments substantially above what spending would have been in FFS



Note: MA (Medicare Advantage), FFS (fee-for-service). Components may not sum to totals due to rounding. Estimates from 2016 through 2022 use actual MA and FFS data. Unidentified values indicate less than $3 billion.
* Specified values used projected data.

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

Next steps

- Commissioner questions
- March 2025 report to the Congress
  - MA status report
  - Technical appendix

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