Understanding Medicare Advantage Payment

How the Program Allows and Obscures Overspending

Robert A. Berenson, Bowen Garrett, and Adele Shartzer

September 2022

Enrollment in Medicare Advantage (MA) will soon be larger than enrollment in traditional Medicare (TM). Rapid enrollment growth demonstrates the popularity of MA among Medicare beneficiaries. MA is also profitable for insurers and has widespread bipartisan political support. MA plans have reduced health care utilization, but although MA was also supposed to generate Medicare program savings, it never has. Policy groups such as the Medicare Payment Advisory Commission (MedPAC) have long understood and explained that MA plans are overpaid relative to TM when viewed on comparable terms. Meanwhile, the Hospital Insurance trust fund that finances Part A of TM (hospital services) is estimated to be exhausted in 2028, leaving Part A insolvent with enough dedicated financing to pay only 90 cents on the dollar for promised services (Medicare Trustees 2022).

The way Medicare pays MA plans is complicated and difficult to describe in simple terms, which can hinder reform efforts. In this brief, we describe the three major components of the MA payment system (bidding benchmarks, quality bonuses, and risk adjustment), how they contribute to overpayment to MA plans, and why the magnitude of overpayment is difficult to directly observe. We also describe reform proposals that would improve MA and generate program savings that could help shore up Medicare's financing or reduce federal budget deficits, as summarized in table 1.

TABLE 1

Summary of Key Issues and Policy Options for Reform in Medicare Advantage Payment

	Summary of issues	Policy options	Estimate of savings impact
Benchmarks and bidding system	Current benchmark system fails to efficiently transfer savings from MA to beneficiaries and the Medicare program	Adopt MedPAC's alternative benchmark policy	More than $10 billion over five years[a]
Quality bonuses	MA's current quality bonus payment system has contributed to excessive and inequitable payment without producing intended improvements in quality performance	Eliminate the "double bonus" for high-performing plans in urban counties where fee-for-service spending is low and MA enrollment is high, which can increase the benchmark by as much as 10 percent	$18.2 billion between 2021 and 2028[b]
		Eliminating QBP benchmark bonus payments altogether	$94 billion between 2021 and 2028[c]
		Replace the current QBP with MedPAC's proposed value incentive program	Budget neutral
Risk adjustment	Patients with similar health conditions and medical needs are coded as being sicker in MA, leading to artificially higher risk scores and overpayment	Replace the current mandatory minimum coding intensity adjustment with set of MedPAC policy recommendations	$198 to $355 billion from 2021 to 2030[d]

Sources: [a] MedPAC (Medicare Payment Advisory Committee), *June 2021 Report to the Congress: Medicare and the Health Care Delivery System* (Washington, DC: MedPAC, 2021).

[b, c] "Options for Reducing the Deficit: 2019 to 2028, Reduce Quality Bonus Payments to Medicare Advantage Plans," Congressional Budget Office, December 13, 2018, https://www.cbo.gov/budget-options/2018/54737.

[d] Committee for a Responsible Federal Budget, "Reducing Medicare Advantage Overpayments" (Washington, DC: Committee for a Responsible Federal Budget, 2021).

Notes: MA = Medicare Advantage. MedPAC = Medicare Payment Advisory Commission. QBP = quality bonus program.

Background

Medicare beneficiaries can choose to receive their benefits through TM (also called fee-for-service Medicare) or through MA plans, which are private health plans offered by insurers that contract with Medicare. The insurers follow rules set by Medicare for MA and receive payments to provide services. MA plans must cover all services under Parts A and B, and often plans combine these benefits with prescription drug benefits under Part D. MA plans are also allowed to offer additional benefits to enrollees, such as eyeglasses or hearing aids, financed either through additional premiums or plan rebates at no cost to the beneficiary. In addition, MA plans may be attractive because they often provide "one-stop shopping" to beneficiaries by providing standard Parts A, B, and D services and an upper limit on out-of-pocket spending through one insurer. In contrast, beneficiaries in TM may face three-stop shopping with different plans: TM providing Parts A and B services, a standalone Part D prescription

drug plan, and a Medigap plan or other supplemental coverage to provide financial protection against high out-of-pocket payments not covered in TM.

In 2022, the average Medicare beneficiary has a choice of 36 MA plans offered by eight organizations, and the average beneficiary has access to nearly $2,000 in extra benefits not available to TM beneficiaries. Medicare payments for MA extra benefits have increased 53 percent just since 2019. From 2018 to 2021, the share of eligible Medicare beneficiaries enrolled in MA rose by 3 percentage points per year, from 37 to 46 percent. Assuming this trend continues, a majority of eligible Medicare beneficiaries will be enrolled in MA by 2023 (MedPAC 2022, chapter 12).

The growth and popularity of the MA program have come at a high cost, largely because of the payment system used for MA plans, as we describe in detail here. The paradox is that MA plans provide Parts A and B services for a much lower cost than TM would spend for the same beneficiaries, but Medicare spends more overall than TM would spend for these same beneficiaries by paying for extra benefits and providing MA plans healthy and growing profit margins. Overall, MA plan bids to provide Parts A and B benefits in 2022 were at record lows—only 88 percent of what TM would pay—but payments were 104 percent of TM (MedPAC 2022, chapter 12). The 2022 data continue the decades-long reality described by MedPAC in which aggregate Medicare payments to MA plans have never been lower than spending in TM, even though spending reduction was a prominent reason for promoting private plan choice in Medicare. This brief explores the explanations for this paradox. We point to some evidence that suggests MedPAC's estimates for the amount of extra payments MA plans receive actually may be low, and further analysis is needed.

Growing enrollment suggests MA is popular among enrollees. It also appears to be popular among participating insurance companies. Richard Gilfillan and Donald Berwick have characterized MA plans as "money machines,"[1] able to game the complex system of payment rules to their own financial benefit. The most recent data available, from 2020, demonstrate that MA plans reported profit margins averaging 6.5 percent, substantially higher than margins in commercial insurance and Medicaid managed-care products.[2] As we will show, the overall quality provided by MA plans is as good as or better than that provided to TM beneficiaries, although it is deficient in specific areas.

Further, Medicare rules permit beneficiaries to move between TM and MA annually and at other times, such as when their coverage status changes (e.g., when entering a skilled nursing facility). That flexibility allows beneficiaries to take advantage of the substantial extra benefits that MA plans provide, yet they can move back to TM if they have a health problem for which they consider unrestricted freedom of provider choice beneficial on the whole. In short, by addressing the gaps in coverage in TM, MA is a particularly good deal for beneficiaries. It is not surprising that the program has strong bipartisan support in Congress. Earlier this year, 346 members of the House of Representatives—80 percent of the chamber—signed on to a letter expressing strong support for the MA program and opposing consideration of long-overdue payment changes.[3]

Over many years, MedPAC has recommended to Congress reforms to address MA plan overpayments while also promoting "level playing field" competition among MA plans and between MA

plans and TM. Congress has either watered down or ignored these recommendations, reflecting the strong political support MA has achieved. Consequently, MedPAC reported to Congress that "a major overhaul of MA policies is…urgently needed" (MedPAC 2021, chapter 1).

This brief provides background on key aspects of MA financing, including benchmarks and bids, risk adjustment, and the way in which MA payments currently account for quality. Further, given that MA costs more than TM, we review the evidence about whether the increased spending is buying higher quality. Following an explanation of the basic MA payment approach, we highlight key policy issues for MA payment, including problems with how payments to plans are determined, the evidence on the quality and services beneficiaries receive, and the continuing problems associated with the failure of current approaches to adequately adjust payments to MA plans for the favorable beneficiary selection MA plans continue to benefit from.

MA Benchmarks and Bids

The current MA bidding system and setting of MA benchmarks have contributed to MA's inability to generate Medicare program savings.

Although TM has low administrative costs and pays health care providers rates typically lower than what commercial health insurance plans have been able to negotiate (McMorrow, Berenson, and Holahan 2021), TM enrollees' choices of providers are not constrained. This leads to care that can be uncoordinated and leaves few limited mechanisms to promote efficient use of health care services. By allowing MA plans to compete with TM and among each other to attract enrollees, MA plans were initially intended to be more efficient than TM and to save the Medicare program money. However, at times, such as with passage of the Medicare Modernization Act of 2003, Congress has focused more on expanding access to MA to provide extra benefits not available in TM, substantially raising spending (Patel and Guterman 2017). MA plans compete by submitting bids to the Centers for Medicare & Medicaid Services (CMS) to provide services to enrollees. Lower plan bids can result in lower premiums and enhanced services for enrollees. By competing to offer lower bids, plans can attract a higher market share and potentially be more profitable.

Payments to MA plans are largely based on the bids plans submit. Bids are made relative to a benchmark amount based on the cost of providing Parts A and B services in TM in a geographic area. Payments cannot exceed the benchmark amounts, but if bids fall under the benchmark amounts, plans are paid a portion of the difference (i.e., a rebate percentage), which they can then use to provide additional services to enrollees, thereby attracting more enrollment.

Issues Arising from the Benchmark Methodology

The benchmark system allows MA plans in many geographic areas to be paid more than what it would cost to serve similar enrollees in TM.

Initially, MA benchmark amounts were set to 95 percent of spending under TM, an approach that would produce savings to the Medicare program to the extent enrollees were willing to sign up for MA plans. Because relatively few insurers offered MA plans in counties with lower TM spending early on, the Medicare Modernization Act changed the MA program to set benchmarks above TM costs in many areas. As the program now stands, county benchmarks are set according to a quartile system (established in the Affordable Care Act), whereby counties are ranked according to their levels of per capita TM spending. Before considering quality bonuses (discussed below), benchmarks for counties in the lowest quartile are set at 115 percent of a county's fee-for-service (FFS) spending. Benchmarks are set at 107.5 and 100 percent of FFS spending for counties in the next two quartiles and at 95 percent of FFS spending for counties in the most-expensive quartile of FFS spending per capita. The Affordable Care Act also imposed caps on benchmarks that affect plans in some counties, based on a county's TM spending or its spending trend (using the higher of the caps implied by each method). In 2016, the caps limited benchmarks in 69 percent of counties, representing 25 percent of MA enrollment (MedPAC 2016).

A plan quality rating system can raise payments even further above what TM would cost and can pass through to plans as profits.

Plan benchmarks may be adjusted and rebate percentages are set according to how many stars a plan receives in a five-star plan quality rating system (described below). MA plan contracts (which can cover multiple MA plans offered under the same insurer contract with CMS) that have four or more stars receive a 5 to 10 percent increase in their benchmarks. MA contracts also receive rebates on the basis of star rating when their bids are below the benchmark. Plans with four-and-a-half and five stars receive 70 percent of the difference between the benchmark and the bid as a rebate, plans with three-and-a-half and four stars receive 65 percent of the difference, and plans with fewer than three-and-a-half stars receive 50 percent of the difference. MA contracts must spend their rebates on supplemental benefits or reduced cost sharing for enrollees, but revenues from higher benchmarks due to star ratings can be absorbed as profit or administrative expenses and are not required to pass through to enrollees. A rule requiring plans to have a minimum medical loss ratio of 85 percent is intended to prevent plans from receiving excessive profits. The medical loss ratio summarizes the share of plan revenue spent on medical expenses (and other allowable expenses, such as quality improvement and fraud reduction activities) as opposed to administrative expenses and profits (McDermott et al. 2021). However, some have argued that the medical loss ratio rule may not be binding; in a recent article, Richard G. Frank and Conrad Milhaupt described how pricing practices within a parent firm can shield profits from the terms of medical-loss-ratio regulations.[4]

MedPAC has recommended overhauling MA's benchmarking system to retain many of the program's beneficial aspects while incentivizing greater program efficiency and generating savings to the Medicare program.

On the basis of considerable analysis conducted over many years, MedPAC has identified several problems with the current benchmarking system; among them is the system's failure to appropriately transfer savings resulting from MA plans' efficiency to beneficiaries and the Medicare program. Benchmarks in areas with low FFS spending (the lowest and second-lowest quartiles at 115 and 107.5

percent of FFS) increase costs for the Medicare program, creating an unnecessary drain on the Hospital Insurance trust fund and the program in general while producing unnecessarily wide variation in plan payments (MedPAC 2021, chapter 1).

In the past, a rationale for setting the benchmark in the lowest spending quartile at 115 percent of TM spending was the need to induce MA insurers to participate in those areas. That is not the case now. For example, the median bid for areas in this quartile declined from 111 percent (only 4 percent below the benchmark) to 92 percent of the TM level between 2013 and 2022. Yet, Medicare is still paying an average of 109 percent of TM spending in these areas because the benchmarks actually average 118 percent of TM when quality bonuses are included (MedPAC 2022, 429). In light of the efficiencies that MA plans have produced—evidenced by robust program growth, a proliferation of plan offerings, new market entrants, and historically high rebates from overly generous benchmarks against which the plans bid—MedPAC has concluded that MA plans could share savings resulting from the efficiencies they achieve with the Medicare program with little adverse effect.

Accordingly, MedPAC has proposed and simulated the effects of an alternative MA payment system that would

- keep the overall benchmark structure while aiming to support equal access to extra benefits across geographic areas, maintain wide availability of MA plans, and allocate savings from MA plan efficiency to beneficiaries and the Medicare program (MedPAC 2021);
- continue to have higher benchmarks in low-spending areas and lower benchmarks in high-spending areas (which, overall, would result in lower benchmarks in most areas); and
- increase the rebate percentage to a fixed 75 percent, which would increase the rebate percentage overall and reward plans more highly for efficiency gains.

The Congressional Budget Office estimated that MedPAC's recommended new benchmark policy would reduce Medicare program spending relative to current policy by more than $2 billion in a single year and more than $10 billion over five years (MedPAC 2021). More recently, MedPAC estimated the impact of the new benchmark policy to be approximately a 2 percent reduction in MA spending (MedPAC 2022). With estimated MA spending in 2021 of $350 billion, this would translate to $7 billion in savings.

Quality and Medicare Advantage

MA's current quality bonus program has contributed to excessive and inequitable payment without producing intended improvements in quality performance.

Medicare payments to plans account for quality through the quality bonus program (QBP), which awards MA plan contracts with star ratings and bonus payments. The Affordable Care Act established the QBP in 2012. The program uses the five-star rating system that existed before the Affordable Care Act to inform beneficiaries of MA plan quality. As described above, MA plans' star ratings affect their

benchmarks, bids, and rebate amounts; MA contracts must spend their rebate on supplemental benefits or reduced cost sharing for enrollees, but when a benchmark increases because of bonus payments, plans are not required to use the bonus dollars to finance extra benefits and instead can absorb the money as profit or administrative expenses (MedPAC 2019, 247). During the COVID-19 public health emergency, CMS changed the rules regarding the calculation of star ratings in light of difficulties obtaining the data needed to calculate star ratings during the pandemic; in the calendar year 2023 MA final rule, CMS has proposed to walk back some of the pandemic-era patches for star-rating calculations.

In 2022, most MA enrollees (90 percent) are in plans with four or more stars, and 10 percent of MA are in plans with five stars (Biniek et al. 2021). The trend toward enrollment in plans with high star ratings predates the COVID-19 public health emergency. Medicare spending on bonus payments to MA plans has grown from $3 billion in 2015 to $11.6 billion in 2021. In 2022, quality bonus payments account for about 3 percent of MA payments relative to FFS spending for benefits under Parts A and B (MedPAC 2022, 428).

The star ratings are based on a large number (46) of measures of clinical quality, patient experience, and administrative performance using four data sources. Examples of these measures include adult body mass index assessment, which simply indicates that body mass index is noted in the medical record, or process measures such as the availability of call center foreign language interpreters and teletypewriters. The plan receives a score from 1 to 5 on different measures; for most measures, performance is assessed relative to other plans, which can shift thresholds for ratings over time. Each measure has a weight based on the measure category (e.g., process versus outcomes measures). The overall star rating is the weighted average of all the measures a plan can report. Some plans do not have star ratings, either because they are new or because enrollment is too low.

Issues in Quality Bonus Payments for MA Plans

The star-rating system underlying MA quality measurement has shortcomings that mask variations in plan performance relevant to patient outcomes.

In its June 2019 report to Congress, MedPAC focused on redesigning the MA QBP to address several concerns with the star-rating system (MedPAC 2019, chapter 8). In prior reports, MedPAC had noted flaws in the QBP, specifically "its complexity, inequity in distributing financial rewards, and opportunities for organizations to obtain unwarranted bonuses by consolidating contracts" (MedPAC 2019, chapter 8). MedPAC noted that the star ratings are based on a large number of "quality" measures, including process and administrative measures and true clinical outcome measures. For example, plans that perform well on administrative and insurance process measures can still achieve high star ratings even if their performance on health outcomes is mediocre. In addition, performance is assessed at the MA contract level, but contracts can span large and sometimes incongruous geographic areas, making it difficult for beneficiaries to assess MA plan performance in a local area. MA plan performance is assessed relative to other plans instead of against predetermined performance targets, which MedPAC thinks hinders plans' performance improvement efforts.

Another MedPAC concern is that the risk-adjustment method in QBP (a version of peer grouping) may not fully account for variations in quality across Medicare subgroups, such as beneficiaries with low incomes and those with disabilities. Finally, the QBP is not budget neutral; it was financed with $11.6 billion in additional program dollars in 2021 (Biniek et al. 2021). This creates an uneven playing field between TM and MA.

In June 2020, MedPAC recommended replacing the current QBP with a new value incentive program. Academic research on the impact of the QBP on health outcomes is mixed and suggests the substantial investments in the program have not clearly led to improvements in MA quality performance (Markovitz et al. 2021).

An assessment of MA CAHPS (Consumer Assessment of Healthcare Providers and Systems) survey data found differences between men and women enrollees' patient experiences; nationally, women reported better experiences with administrative staff and timely access to care but worse experiences on measures that may reflect negotiation with physicians (Burkhart et al. 2020). The gender gaps in patient experience varied across plans by as much as 5 to 6 percentage points for some measures.

MA star ratings do not reflect concerns about network adequacy or inappropriate denials of care.

Analyses of patient experience in MA plans using other data sources, such as appeal outcomes and audit findings, have raised concerns about network adequacy, the validity of network information for enrollees, and inappropriate denials of care. Whereas beneficiaries in TM can visit any participating provider, MA enrollees are limited to the providers in the plan's network without incurring additional costs. For example, a 2018 report by the US Department of Health and Human Services' Office of the Inspector General found that when beneficiaries or providers appealed preauthorization and payment denials, MA plans overturned 75 percent of their initial denials (Office of the Inspector General 2018). This represents about 216,000 denials overturned through appeals each year from 2014 to 2016. A 2022 Office of the Inspector General report continued to find inappropriate denials of prior authorizations and payment requests for services that met Medicare coverage rules and MA billing rules (Office of the Inspector General 2022). A CMS audit found that nearly half of MA plan directories included inaccurate information for participating providers, which can impede access to care.[5] A 2021 analysis found a positive correlation between narrow provider networks and star ratings (Sen, Meisilbach, and Anderson 2021), consistent with research finding that MA plans create narrow networks primarily to garner higher star ratings (Skopec, Berenson, and Feder 2018).

Paying more in MA than TM might be justified if MA provides better-quality care for similar patients, but evidence of this is elusive.

Overall, findings comparing quality in MA with that in TM show that MA has been better for some outcomes and the same as TM for others. However, some limitations exist. Comparisons between MA and TM may not fully account for unobserved differences in social determinants of health, or risk-adjustment challenges, partly because of data quality differences (Agarwal et al. 2021). Studies including a 2021 systematic review comparing TM with MA have found that MA is typically associated with more preventive care visits, fewer hospital admissions and emergency department visits, shorter

hospital and postacute lengths of stay, and lower health care spending (Feyman et al. 2019; Park, Figueroa, et al. 2020; Park et al. 2021). Further, studies have found MA plans deliver care more efficiently by increasing the use of primary care visits and decreasing care intensity or the use of unnecessary care (Curto et al. 2019; Duggan, Gruber, and Vabson 2018; Huckfeldt et al. 2017; Park, Larson, et al. 2020; Park, White, et al. 2020). Assessments of patient experience, mortality, and racial or ethnic disparities did not demonstrate better performance in MA. TM and MA beneficiaries report similar levels of patient satisfaction and access to care (Jacobson et al. 2021). Further, a recent study found a similar prevalence of low-value care in both TM and MA (Park et al. 2021). The study also found no decreases in prevalence of low-value care over time.

Consistent with these findings, the Kaiser Family Foundation recently published a review of 62 studies published since 2016 that compare MA and TM based on measures of beneficiary experience, affordability, service utilization, and quality. The review "found few differences between MA and TM that are supported by strong evidence or have been replicated across multiple studies" (Ochieng and Biniek 2022). MA outperformed on use of preventive services, having a usual source of care, and having lower hospital readmission rates. TM outperformed on whether patients received care in the highest-rated hospitals for cancer care and the highest-quality skilled nursing facilities and home health agencies. Overall, the differences detected were relatively small.

Comparing quality in MA and TM is difficult because of data differences.

One challenge in comparing TM and MA is the lack of a comparable data source for analysis. Medicare claims often form the basis for quality assessments, but MA encounter data detailing service provision have generally been limited. Patient survey data can be useful for making comparisons for large areas (i.e., nationally), but the sample sizes are not large enough to make local comparisons or to use methodologies that account for local market and demographic factors.

Proposed Reforms to the MA QBP

Recent proposals to reform the QBP and the estimated savings associated with these proposals are as follows:

- **Eliminating the "double bonus" for high-performing plans in urban counties where FFS spending is low and MA enrollment is high.** This bonus can increase the benchmark by as much as 10 percent. The Congressional Budget Office estimated this proposal would save $18.2 billion between 2021 and 2028.[6]
- **Eliminating QBP benchmark bonus payments altogether.** The Congressional Budget Office estimates this would save approximately $94 billion between 2021 and 2028.
- **Replacing the current QBP with a value incentive program, as proposed by MedPAC.** This would move the program toward budget neutrality.
- **Modifying the current star-rating system to address shortcomings.** A more modest reform, this could include placing greater weight in the star-ratings calculation on clinical measures

rather than customer service metrics, setting absolute performance targets, and rewarding progress toward those targets.[7]

Medicare Advantage and Risk Adjustment

The methodology to account for differences in MA enrollee risk across plans and relative to TM beneficiaries incentivizes "upcoding" and has led to overpayments.

As described above, MA plans receive a payment referred to as "capitation" (payment per capita) for each month an MA beneficiary is enrolled. In theory, capitation provides stronger incentives than FFS payment for plans to better manage costs by allowing them to deploy resources to accomplish quality, access, and spending objectives without the constraints inherent in FFS coding and payment. Plans are paid monthly for the average patient enrolled, in effect providing them a budget to manage.

However, four decades of studies have found that MA plans enroll beneficiaries who require lower spending than the average beneficiary, called "favorable selection," whether intentionally through how they market and advertise, design their benefits, and configure their provider networks or simply as a reflection of the segment of the Medicare beneficiary population attracted to MA as an alternative to TM.

In response to the evidence that MA plans have historically benefited financially through favorable selection—at a large cost to the Hospital Insurance trust fund and the US Department of the Treasury—Congress and CMS have incrementally adopted over many years various approaches to reduce the effect of favorable selection on health plan payments. The most prominent of the approaches is risk adjusting payments on the basis of each enrollee's health status. Risk-adjusted payments are intended both to make fairer payments in relation to plan costs and to reduce insurers' incentives to selectively enroll beneficiaries on the basis of their expected spending.

Clinical diagnoses underlie the MA risk-adjustment methodology.

CMS modifies the payments to MA plans upward or downward according to the risk scores of a plan's enrollees. Risk scores are constructed to reflect variation in enrollees' expected health care costs and are calculated for all Medicare beneficiaries on the basis of their diagnoses and other characteristics, such as age and disability status. Those scores are standardized so that a score of 1.0 reflects the health care spending of the average beneficiary in TM. A plan is paid more for enrollees with higher risk scores and less for enrollees with lower risk scores, given their higher or lower expected health care spending.

To generate the risk scores, CMS groups risk-adjustment-eligible diagnoses into Hierarchical Condition Categories (HCCs), which are categories of clinically related diagnoses based on ICD-10 codes. Each HCC has a relative numerical value representing the expected cost associated with treating the medical conditions in that category in the following year, using spending in the TM program. Because the risk scores are used to predict subsequent-year spending, the risk-adjustment approach is a prospective model, thereby giving the MA plans clear spending targets on which to manage care

delivery. A beneficiary's risk score equals the sum of the relative factors that correspond with a beneficiary's HCCs and demographic characteristics. The total risk-adjusted payment to an MA plan for an enrollee equals the risk score multiplied by the MA plan's base payment rate (see the above section on bids).

In diagnosis-based risk adjustment, more thorough documentation of beneficiaries' diagnoses increases risk scores, giving plans strong financial incentives to identify and record all diagnoses for their enrollees. In contrast, clinicians serving TM patients lack financial incentives to code all of a beneficiary's diagnoses because their payments are not tied to the specific diagnoses coded. The growing divergence in risk scores between MA and TM enrollees reflects more thorough diagnosis coding by MA plans, rather than differences in enrollees' health (Hayford and Burns 2018). The HCC method has been in place since 2007, although occasional small tweaks have been made to the technical requirements. The HCC method raised the percentage of explained variance in spending from 1 percent to 11 to 12 percent.[8]

The selection of enrollees with lower-than-expected costs into MA has historically contributed to overpayment, but this pattern may have changed, necessitating further study.

The extent to which MA plans receive favorable selection and inappropriate payment for the beneficiaries they enroll has been hard to measure, largely because of a lack of comparable data. Policy analysts have used two different but related approaches to estimating both the level of favorable selection in MA plans and the success of risk adjustment in accounting for favorable selection.

Many studies of selection patterns have used a method that did not depend on MA plan coding or even MA plans' management activities that affect the care beneficiaries receive. In this methodology, the requisite data come from spending only in TM, not MA. The data divide beneficiaries who were in TM in a base year into two groups: those who enrolled in MA plans in the subsequent year and those who stayed in TM in the subsequent year. The latter is a much larger number. For each group, researchers calculated the mean spending in each HCC or HCC equivalent they assigned to the TM beneficiaries and then used the beneficiaries' risk scores to measure the spending differences by health status. The basic assumption underlying the approach is that for each HCC, if the risk-adjusted mean for beneficiaries who joined MA was below that of the beneficiaries who stayed in TM, then lower-cost beneficiaries are more likely to enroll in the MA program (Brown et al. 2011; MedPAC 2012, chapter 4).[9]

Various studies using this method to estimate the effects of favorable selection have shown spending differences of between about 5 and 15 percent due to plans' enrollment of healthier beneficiaries; differences to some extent reflect the different time periods studied, during which the risk-adjustment method was evolving (Brown et al. 2011; MedPAC 2012, chapter 4; Morrissey et al. 2013; Newhouse et al. 2015). The most recent study using this method for 2015 spending among beneficiaries who switched into an MA plan in 2016 found that those who switched spent $1,250 less (a 13 percent difference) than those who stayed in TM that year, after adjusting for health risk. When Part D prescription drug spending was included in the calculations, the difference was 15 percent. Of note,

by 2015 the CMS HCC model of risk adjustment had been in place for more than five years (Jacobson, Neuman, and Damico 2019).

Newhouse and colleagues have raised substantive concerns about the generalizability and usefulness of this research method, emphasizing that the relatively small number of people who leave TM or MA may not be representative of the much larger number of people who stay in either plan (Newhouse et al. 2015). Rather, they argue there is a natural regression to the mean of health status, wherein individuals who may have been healthier when they joined MA become less healthy as they stay in their plan for years, thereby substantially reducing the impact of any favorable selection initially evident (Newhouse et al. 2015).

Other methods have also found favorable selection into MA.

Nevertheless, other, less quantitative but still compelling findings support the likelihood that MA plans receive substantial favorable selection not fully captured in the current CMS HCC risk adjustment. Perhaps the most compelling is that standardized mortality rates for MA changed little from 2009 to 2019 and were about 85 to 90 percent of the TM mortality rate in those years (Committee for a Responsible Federal Budget 2021; Curto et al. 2019).[10] These differences in mortality suggest MA beneficiaries are significantly healthier than TM beneficiaries. (As noted earlier, no evidence shows that MA achieves lower mortality rates.) Curto and colleagues showed that MA plans reduce service use substantially and estimated that there was substantial difference in "unobserved health not captured by the risk score" (Curto et al. 2011), that is, healthier patients *within* HCCs in ways unrelated to MA plan upcoding (Brown et al. 2011), which is discussed more below.

Similarly, pharmaceutical data for nondiscretionary prescription drugs show that MA patients are prescribed fewer medications and are likely healthier. However, the data show a trend toward comparable prescription drug usage between MA and TM in recent years (Jacobs and Kronick 2020).

Despite this apparently strong evidence of unobserved favorable selection, other researchers have asserted that little or no difference in underlying health status exists between beneficiaries in MA and those in TM. Kronick and various colleagues, who have done much of the research demonstrating that MA's upcoding (also known as "increased coding intensity" and "code creep") of diagnoses has produced inappropriately high risk scores for and payments to MA plans (even higher than MedPAC estimates), have found that "there is strong evidence that MA members are no healthier, and may be somewhat sicker, than [TM] beneficiaries of similar age, gender, Medicaid and institutional status" (Kronick and Chua 2021).[11] In fact, Kronick and Chua have developed an approach for offsetting MA plan upcoding using a method that assumes that after controlling for demographics, MA members are no healthier and no sicker than demographically similar TM beneficiaries (Kronick and Chua 2021). In short, experts do not agree about whether MA plans receive substantial additional payments from favorable selection that would not be captured by proper application of the current risk-adjustment approach.

Patients with similar health conditions and medical needs are coded as being sicker in MA, leading to artificially higher risk scores and overpayment.

Since 2015, risk-adjustment policy and studies, except for Jacobson, Neuman, and Damico (2019) mentioned above, have focused not on estimating the patterns of selection plans experience but rather on estimating the CMS HCC risk adjustment's success in reducing the payment impact of favorable selection. MA plans can remain overpaid even with a reasonably effective risk-adjustment model by inflating the diagnoses provided to CMS that are used to generate risk scores. Risk scores are vulnerable to upcoding, where risk scores that MA plans submit increase without actual changes in enrollees' health. Plans have incentives to find additional diagnoses that will raise the risk score. And in some cases, different codes representing variations of the same disease are mapped to different HCCs. In short, the opportunities for increasing coding intensity are plentiful (MedPAC 2019).

As noted above, MA plans have stronger incentives to find and document conditions than do providers in TM. Plans argue that the tools they use to find additional diagnoses to supplement routine claims that clinicians submit are a reasonable and proper response to the payment incentives inherent in risk-adjustment coding. MA plans use various approaches, including chart reviews and health risk assessments that they generate, to identify missing diagnoses that they then bring to patients' clinicians so that the codes can be included in claims, as is required for including those diagnoses in risk-score calculations (Office of the Inspector General 2021). Further, under some forms of value-based payment, such as capitation, plans can pass the coding incentives to include additional diagnoses on to physicians with direct access to medical records. However, the same incentives that may lead MA plans to code more completely and accurately can also lead to abusive practices that exaggerate the presence or severity of health conditions. To try to mitigate such incentives, current policy holds that Medicare should not pay MA plans for medical conditions that are not treated. The additional approaches MA plans use to surveil for more conditions or add incentives for clinicians to list more conditions may often produce conditions that violate this requirement.

Upcoding produces overpayment to MA plans.

MA plans assert that their supplemental efforts to search for diagnoses improve patient care while also raising their risk scores. However, the Office of the Inspector General, CMS, the US Department of Justice, and the Government Accountability Office have identified payment vulnerabilities related to MA companies inflating their beneficiaries' risk scores through these and related techniques. The Office of the Inspector General, citing two of its earlier studies published in 2019 and 2020, found that the diagnoses MA companies reported only on chart reviews or health risk assessments (i.e., not on any other service records) resulted in many billions in risk-adjusted payments for 2017 (Office of the Inspector General 2021). The Office of the Inspector General found that 20 of the 162 MA companies drove a disproportionate share of the $9.2 billion in payments from diagnoses reported only on chart reviews and health risk assessments. One company had 40 percent of the risk-adjusted payments from these two tools yet enrolled only 22 percent of MA beneficiaries. Recently, the Department of Justice reviewed its 2021 settlements and judgments for fraud under the False Claims Act and observed that the MA program was a priority, leading the department to investigate and litigate a growing number of matters related to the program.[12]

In a comprehensive national study, Kronick and Chua found that differential coding in MA caused the MA risk scores to be an estimated 4.5 percent higher in 2007 than they would have been if coding had been identical in MA and TM. This gap had grown to 15.4 percent by 2017 (Kronick and Chua 2021). That pattern of differential coding caused MA risk scores to increase by approximately 1 percent per year from 2007 to 2017, similar to MedPAC's findings (MedPAC 2022). In a review of studies of upcoding, Jacobs and Kronick found that the size of the coding-intensity effect caused risk scores for MA enrollees to range from 7 to 10 percent higher than would be expected if the same beneficiaries were in TM (Jacobs and Kronick 2020). However, the analyses by Kronick and Chua and by MedPAC have apparently diverged in recent years. For example, MedPAC estimates that differential coding resulted in MA risk scores that were, on average, 7 percent higher in 2017 than they would have been if coding were the same in MA and TM, a smaller estimate than Kronick and Chua's 15.4 percent (Committee for a Responsible Federal Budget 2021). As the Committee for a Responsible Federal Budget suggests, further work is needed to understand why estimates produced by MedPAC's and Kronick and Chua's methods diverge; the difference represents billions of dollars.

CMS has reduced a portion of the total excess payment related to upcoding by applying an across-the-board discount factor to risk scores, but more targeted and comprehensive solutions are needed.

A series of congressional mandates has required CMS to reduce MA risk scores to address the impact of coding differences between MA and TM. For 2010 through 2013, risk scores were reduced across the board by 3.4 percent. The reduction then increased incrementally by established minimum adjustments, reaching 5.9 percent for 2018 and subsequent years (MedPAC 2022, chapter 12). (For 2023, CMS has again chosen to adopt the required minimum reduction of 5.9 percent, saying it would maintain that level until risk adjustment incorporates MA diagnostic, cost, and use data.) But that means the required coding-intensity adjustment has never accounted for the full impact of coding intensity that some plans excel at.[13] For example, MedPAC estimates that MA risk scores were 9.5 percent above what they would have been in TM in 2020, but the adjustment was only 5.9 percent, resulting in a net effect of a 3.6 percent overpayment based on the upcoding. That 3.6 percent translated to $12 billion in excess payment to MA plans.

Although the risk-score adjustment represents a partial recouping for MA upcoding, the aggressiveness of MA plans' coding varies dramatically. In that way, CMS's across-the-board adjustment that reduces all MA risk scores by the same percentage produces inequity across MA contracts, disadvantaging plans engaging in more accurate coding while providing underserved rewards to plans that aggressively game the system. MedPAC has found that several health plan contracts have inflated risk scores of 15 to 20 percent above TM levels solely because of coding practices (MedPAC 2021). In short, the across-the-board adjustment is a short-term approach to reduce some excessive payments to MA plans as a group, but it is ultimately inequitable and negatively compromises desired competition among MA plans and between MA and TM.

For a few years, MedPAC proposed policies that would replace the current mandatory minimum coding-intensity adjustment with three components:

- the development of a risk-adjustment model that uses two years of TM and MA diagnosis data to improve the predictive accuracy of the model
- the exclusion of diagnoses documented only on health risk assessments from both TM and MA
- the application of a coding adjustment that fully accounts for the remaining differences in coding between MA and TM

In 2021, MedPAC suggested supplementing these recommendations by eliminating chart reviews as a source of diagnoses for risk adjustment. It estimated that adopting these policies would reduce MA payments by 2 percent (MedPAC 2022), which would translate to $7 billion in annual savings when applying MedPAC's estimated percent reduction to MA spending in 2021. The Committee for a Responsible Federal budget found that adopting these coding-intensity policies would reduce net Medicare spending by $198 to $355 billion from 2021 to 2030 (Committee for a Responsible Federal Budget 2021). Finally, CMS is pursuing the active application of data validation audits to ensure diagnoses are supported by medical records. Audits of MA plan data have been limited so far but have confirmed that average overpayment rates have been well over 10 percent for most contracts audited.[14]

In conclusion, the earlier studies comparing enrollees who either leave or stay in TM or MA and recent qualitative findings related to mortality and prescription drug use suggest that favorable selection into MA is (or at least was) substantial, independent of upcoding. Other experts disagree, but some then assert that upcoding is substantially greater than CMS and MedPAC have calculated. To carry out MedPAC's call for a major overhaul of MA policies, these views need to be reconciled to provide a consensus estimate of the level of overpayment attributable to favorable selection and coding intensity.

Key Policy Takeaways for Medicare Advantage Payment

In 1995, Newt Gingrich, then Republican speaker of the House, delivered a speech to Blue Cross Blue Shield seeking the demise of Medicare as it has functioned since 1965. He said, "Now, we don't get rid of [Medicare] in round one because we don't think that that's politically smart, and we don't think that's the right way to go through a transition. But we believe it's going to wither on the vine because we think people are going to voluntarily leave it—voluntarily."[15] Twenty-five years later, the withering has occurred, and the future of TM and, indeed, the fiscal sustainability of Medicare are in doubt.

In many parts of the country, TM will soon be unable to provide statistically accurate data on which to base the inflated benchmarks (MedPAC 2022).[16] Some have argued that MA will eventually overtake TM. Eventually is upon us now.

MedPAC's 2022 report to Congress and this brief have focused on how substantial and growing overpayments to MA plans arising from the payment structure described in this brief are driving beneficiaries to enroll in MA, but the demise of TM can be expected for other reasons, too. TM's outdated benefit structure provides a major advantage to MA plans in recruiting Medicare

beneficiaries. Further, a new generation of Medicare beneficiaries is now accustomed to navigating managed care, unlike earlier beneficiaries, so they more naturally seek the convenience of a single plan. This provides MA beneficiaries substantial additional benefits not provided to TM beneficiaries without the extra costs for supplemental insurance.

In addition, Congress and CMS have not allowed TM to use managed-care tools that MA plans use successfully (sometimes to excess) to restrain spending and improve certain aspects of quality (Berenson 2003). Within TM, accountable care organization development has shown modest promise at reducing spending increases, but it is likely too little, too late. Accountable care organizations can do nothing about the need to upgrade Medicare benefits. And, as this brief demonstrates, CMS's oversight of MA performance has been weak, contributing to some plans' abuse of program rules. Altogether, Medicare is privatizing through the voluntary movement of beneficiaries without public discussion and debate, just as Gingrich promised.

Many Organization for Economic Co-operation and Development countries, including France and Germany, provide universal coverage at much lower cost than the US in a social insurance structure and without a public plan akin to Medicare. They are successful because they have strong government regulation of the insurance companies that administer benefits and regulate or negotiate provider prices. Indeed, even in Medicare, MA plans are successful primarily because the Medicare statute effectively regulates the prices that insurers pay hospitals and other providers to near TM payment levels (Berenson et al. 2015; CBO 2017). Stronger regulatory oversight of MA is needed now and will be even more necessary as MA overtakes TM, given the current trajectory of MA enrollment.

MA has broad bipartisan support, as we have noted and is reflected in the recent Better Medicare Alliance letter cited in the introduction.[17] Indeed, Democratic Caucus members have denounced the Center for Medicare & Medicaid Innovation's recent direct contracting initiative, because they asserted it would extend the MA payment model to providers often owned by private equity firms and insurers and to MA plans directly.[18] However, they have not acted on MedPAC's repeated recommendations for MA policy changes. Fifteen of the 54 signatories of a letter to the secretary of the Department of Health and Human Services calling for an end to direct contracting also signed the MA support letter, demonstrating MA's political influence.

Any policy reform must initially focus on the massive overpayments to MA, which, as we emphasize here, result from markedly inflated benchmarks against which MA plans bid, extra funding from quality bonuses from a flawed star-rating program, and, most importantly, problems with the risk-adjustment payments for Medicare beneficiaries enrolled in MA plans. Together these factors provide about $2,000 in extra funding per beneficiary per year for MA plans to use to entice beneficiaries to enroll.

For years, MedPAC has been documenting these problems, and it raised the urgency of MA overpayment in its report to Congress this year. More work is needed not only to achieve an accurate estimate of overpayments but, more importantly, to raise awareness of these issues so that policymakers urgently consider adopting MedPAC's current proposals to begin a major overhaul of the MA program.

Notes

[1] Richard Gilfillan and Donald M. Berwick, "Medicare Advantage, Direct Contracting, and the Medicare 'Money Machine,' Part 1: The Risk-Score Game," *Health Affairs Forefront*, September 29, 2021, https://www.healthaffairs.org/do/10.1377/hblog20210927.6239/full/; and Richard Gilfillan and Donald M. Berwick, "Medicare Advantage, Direct Contracting, and the Medicare 'Money Machine,' Part 2: Building on the ACO Model," *Health Affairs Forefront*, September 30, 2021, https://www.healthaffairs.org/do/10.1377/hblog20210928.795755/full/.

[2] See notes 28 and 29 in chapter 12 of MedPAC (2022).

[3] Better Medicare Alliance, "U.S. House Sets New, Bipartisan Record for Medicare Advantage Support," news release, January 28, 2022, https://bettermedicarealliance.org/news/u-s-house-sets-new-bipartisan-record-for-medicare-advantage-support/.

[4] Richard G. Frank and Conrad Milhaupt, "Profits, Medical Loss Ratios, and the Ownership Structure of Medicare Advantage Plans," USC-Brookings Schaeffer on Health Policy blog, July 13, 2022, https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2022/07/13/profits-medical-loss-ratios-and-the-ownership-structure-of-medicare-advantage-plans/.

[5] "CMS: Inaccurate MA Provider Directories Raise Network Adequacy Issues," Inside Health Policy, April 3, 2019, https://insidehealthpolicy.com/share/109003.

[6] "Options for Reducing the Deficit: 2019 to 2028, Reduce Quality Bonus Payments to Medicare Advantage Plans," Congressional Budget Office, December 13, 2018, https://www.cbo.gov/budget-options/2018/54737.

[7] Sarah Klein and Martha Hostetter, "Taking Stock of Medicare Advantage: Quality Reporting and Quality Bonuses," Commonwealth Fund blog, March 3, 2022, https://www.commonwealthfund.org/blog/2022/taking-stock-medicare-advantage-quality-reporting-and-quality-bonuses.

[8] Although 11 to 12 percent still seems poorly predictive, policymakers accept that only about 25 percent of subsequent years' costs are predictable; the other spending reflects new health problems not apparent in the base year. See Newhouse (1998).

[9] A similar study design can track beneficiaries who left an MA plan to rejoin TM by comparing TM spending in the second year for matched beneficiaries. However, the numbers of beneficiaries involved are much smaller, casting even more doubt on the representativeness of the findings that also show that MA beneficiaries are much healthier than TM beneficiaries.

[10] Studies show that MA plans do not achieve better outcomes, such as reduced mortality rates, than TM does.

[11] For more research demonstrating that MA upcoding of diagnoses has produced inappropriately high risk scores in and payments to MA plans, see the sources cited in Kronick and Chua (2021).

[12] Department of Justice, Office of Public Affairs, "Justice Department's False Claims Settlements and Judgments Exceed $5.6 Billion in Fiscal Year 2021," news release, February 1, 2022, https://www.justice.gov/opa/pr/justice-department-s-false-claims-act-settlements-and-judgments-exceed-56-billion-fiscal-year.

[13] Meena Seshamani (director, Center for Medicare), note to Medicare Advantage organizations, prescription drug plan sponsors, and other interested parties, regarding "Announcement of Calendar Year (CY) 2023 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies," April 4, 2022, https://www.cms.gov/files/document/2023-announcement.pdf.

[14] Fred Schulte, "Audits of Some Medicare Advantage Plans Reveal Pervasive Overcharging," NPR, August 29, 2016, https://www.npr.org/sections/health-shots/2016/08/29/491543167/audits-of-some-medicare-advantage-plans-reveal-pervasive-overcharging.

[15] "POLITICS; Gingrich on Medicare," *New York Times*, July 20, 1996, https://www.nytimes.com/1996/07/20/us/politics-gingrich-on-medicare.html.

[16] J. Michael McWilliams, "Don't Look Up? Medicare Advantage's Trajectory and the Future of Medicare," *Health Affairs Forefront*, March 24, 2022, https://www.healthaffairs.org/do/10.1377/forefront.20220323.773602.

[17] Better Medicare Alliance, "House Sets New, Bipartisan Record for Medicare Advantage Support."

[18] Congressmember Pramila Jayapal, letter to US Department of Health and Human Services Secretary Xavier Becerra and Centers for Medicare & Medicaid Services Administrator Chiquita Brooks-LaSure, regarding permanently ending the Direct Contracting Model and the Global and Professional Direct Contracting Model and transitioning traditional Medicare beneficiaries in both programs back to traditional Medicare, January 5, 2022, https://jayapal.house.gov/wp-content/uploads/2022/01/Medicare-DCE-Letter.pdf.

References

Agarwal, Rajender, John Connolly, Shweta Gupta, and Amol S. Navathe. 2021. "Comparing Medicare Advantage and Traditional Medicare: A Systematic Review." *Health Affairs* 40 (6). https://doi.org/10.1377/hlthaff.2020.02149.

Berenson, Robert A. 2003. "Getting Serious about Excessive Medicare Spending: A Purchasing Model for CMS." *Health Affairs* 22 (Suppl. 1). https://doi.org/10.1377/hlthaff.W3.586.

Berenson, Robert A., Jonathan H. Sunshine, David Helms, and Emily Lawton. 2015. "Why Medicare Advantage Plans Pay Hospitals Traditional Medicare Prices." *Health Affairs* 34 (8): 1289–95. https://doi.org/10.1377/hlthaff.2014.1427.

Biniek, Jeannie Fuglesten, Meredith Freed, Anthony Damico, and Tricia Neuman. 2021. "Medicare Advantage in 2021: Star Ratings and Bonuses." San Francisco: Kaiser Family Foundation.

Brown, Jason, Mark Duggan, Ilyana Kuziemko, and William Woolston. 2011. "How Does Risk Selection Respond to Risk Adjustment? Evidence from the Medicare Advantage Program." NBER Working Paper 16977. Cambridge, MA: National Bureau of Economic Research. https://doi.org/10.3386/w16977.

Burkhart, Q., Marc N. Elliott, Amelia M. Haviland, Robert Weech-Maldonado, Shondelle M. Wilson-Frederick, Sarah Gaillot, Jacob W. Dembosky, Carol A. Edwards, and Sarah MacCarthy. 2020. "Gender Differences in Patient Experience across Medicare Advantage Plans." *Women's Health Issues* 30 (6): 477–83. https://doi.org/10.1016/j.whi.2020.08.009.

CBO (Congressional Budget Office). 2017. *A Premium Support System for Medicare: An Updated Analysis of Illustrative Options*. Washington, DC: CBO.

Committee for a Responsible Federal Budget. 2021. "Reducing Medicare Advantage Overpayments." Washington, DC: Committee for a Responsible Federal Budget.

Curto, Vilsa, Liran Einav, Amy Finkelstein, Jonathan Levin, and Jay Bhattacharya. 2019. "Health Care Spending and Utilization in Public and Private Medicare." *American Economic Journal: Applied Economics* 11 (2): 302–32. https://doi.org/10.1257/app.20170295.

Duggan, Mark, Jonathan Gruber, and Boris Vabson. 2018. "The Consequences of Health Care Privatization: Evidence from Medicare Advantage Exits." *American Economic Journal: Economic Policy* 10 (1): 153–86. https://doi.org/10.1257/pol.20160068.

Feyman, Yevgeniy, José F. Figueroa, Daniel E. Polsky, Michael Adelberg, and Austin Frakt. 2019. "Primary Care Physician Networks in Medicare Advantage." *Health Affairs* 38 (4): 537–44. https://doi.org/10.1377/hlthaff.2018.05501.

Hayford, Tamara Beth, and Alice Levy Burns. 2018. "Medicare Advantage Enrollment and Beneficiary Risk Scores: Difference-in-Differences Analyses Show Increases for All Enrollees on Account of Market-Wide Changes." *Inquiry* 55 (1): 1–11. https://doi.org/10.1177/0046958018788640.

Huckfeldt, Peter J., José J. Escarce, Brendan Rabideau, Pinar Karaca-Mandic, and Neeraj Sood. 2017. "Less Intense Postacute Care, Better Outcomes for Enrollees in Medicare Advantage Than Those in Fee-for-Service." *Health Affairs* 36 (1): 91–100. https://doi.org/10.1377/hlthaff.2016.1027.

Jacobs, Paul D., and Richard Kronick. 2020. "The Effects of Coding Intensity in Medicare Advantage on Plan Benefits and Finances." *Health Services Research* 56 (2): 178–87. https://doi.org/10.1111%2F1475-6773.13591.

Jacobson, Gretchen, Aimee Cicchiello, Janet P. Sutton, and Arnav Shah. 2021. "Medicare Advantage vs. Traditional Medicare: How Do Beneficiaries' Characteristics and Experiences Differ?" New York: Commonwealth Fund.

Jacobson, Gretchen, Tricia Neuman, and Anthony Damico. 2019. "Do People Who Sign Up for Medicare Advantage Plans Have Lower Spending?" San Francisco: Kaiser Family Foundation.

Kronick, Richard, and F. Michael Chua. 2021. "Estimating the Magnitude of Medicare Advantage Coding Intensity and of the Budgetary Effects of Fully Adjusting for Differential MA Coding." SSRN Scholarly Paper ID 3792038. Rochester, NY: Social Science Research Network.

Markovitz, Adam A., John Z. Ayanian, Devraj Sukul, and Andrew M. Ryan. 2021. "The Medicare Advantage Quality Bonus Program Has Not Improved Plan Quality." *Health Affairs* 40 (12). https://doi.org/10.1377/hlthaff.2021.00606.

McDermott, Daniel, Lina Stolyar , Elizabeth Hinton , Giorlando Ramirez , Cynthia Cox, Jeannie Fuglesten Biniek, Tricia Neuman, and Robin Rudowitz. 2021. "Health Insurer Financial Performance in 2020." San Francisco: Kaiser Family Foundation.

McMorrow, Stacey, Robert A. Berenson, and John Holahan. 2021. "Commercial Health Insurance Markups over Medicare Prices for Physician Services Vary Widely by Specialty." Washington, DC: Urban Institute.

Medicare Trustees (Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds). 2022. *2022 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*. Washington, DC: Medicare Trustees.

MedPAC (Medicare Payment Advisory Commission). 2012. *June 2012 Report to the Congress: Medicare and the Health Care Delivery System*. Washington, DC: MedPAC.

———. 2016. *March 2016 Report to the Congress: Medicare Payment Policy*. Washington, DC: MedPAC.

———. 2019. *June 2019 Report to Congress: Medicare and the Health Care Delivery System*. Washington, DC: MedPAC.

———. 2021. *June 2021 Report to the Congress: Medicare and the Health Care Delivery System*. Washington, DC: MedPAC.

———. 2022. *March 2022 Report to the Congress: Medicare Payment Policy*. Washington, DC: MedPAC.

Morrissey, Michael A., Meredith L. Kilgore, David J. Becker, Wilson Smith, and Elizabeth Delzell. 2013. "Favorable Selection, Risk Adjustment, and the Medicare Advantage Program." *Health Services Research* 48 (3): 1039–56. https://doi.org/10.1111/1475-6773.12006.

Newhouse, Joseph P. 1998. "Risk Adjustment: Where Are We Now?" *Inquiry* 35 (2): 122–31.

Newhouse, Joseph P., Mary Price, J. Michael McWilliams, John Hsu, and Thomas G. McGuire. 2015. "How Much Favorable Selection Is Left in Medicare Advantage?" *American Journal of Health Economics* 1 (1). https://doi.org/10.1162/ajhe_a_00001.

Ochieng, Nancy, and Jeannie Fuglesten Biniek. 2022. *Beneficiary Experience, Affordability, Utilization, and Quality in Medicare Advantage and Traditional Medicare: A Review of the Literature*. San Francisco: Kaiser Family Foundation.

Office of the Inspector General (US Department of Health and Human Services, Office of the Inspector General). 2018. *Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns about Service and Payment Denials*. Washington, DC: Office of the Inspector General.

———. 2021. *Some Medicare Advantage Companies Leveraged Chart Reviews and Health Risk Assessments to Disproportionately Drive Payments*. Washington, DC: Office of the Inspector General.

———. 2022. *Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns about Beneficiary Access to Medically Necessary Care*. Washington, DC: Office of the Inspector General.

Park, Sungchul, José F. Figueroa, Paul Fishman, and Norma B. Coe. 2020. "Primary Care Utilization and Expenditures in Traditional Medicare and Medicare Advantage, 2007-2016." *Journal of General Internal Medicine* 35 (8): 2480–81. https://doi:10.1007/s11606-020-05826-x.

Park, Sungchul, Jeah Jung, Robert E. Burke, and Eric B. Larson. 2021. "Trends in Use of Low-Value Care in Traditional Fee-for-Service Medicare and Medicare Advantage." *JAMA Network Open* 4 (3): e211762. https://doi.org/10.1001/jamanetworkopen.2021.1762.

Park, Sungchul, Eric B. Larson, Paul Fishman, Lindsay White, and Norma B. Coe. "Differences in Health Care Utilization, Process of Diabetes Care, Care Satisfaction, and Health Status in Patients with Diabetes in Medicare Advantage vs Traditional Medicare." *Medical Care* 58 (11): 1004–12. https://doi.org/10.1097/MLR.0000000000001390.

Park, Sungchul, Lindsay White, Paul Fishman, Eric B. Larson, and Norma B. Coe. 2020. "Health Care Utilization, Care Satisfaction, and Health Status for Medicare Advantage and Traditional Medicare Beneficiaries with and without Alzheimer Disease and Related Dementias." *JAMA Network Open* 3 (3): e201809. https://doi.org/10.1001/jamanetworkopen.2020.1809.

Patel, Yash M., and Stuart Guterman. 2017. "The Evolution of Private Plans in Medicare." New York: Commonwealth Fund.

Sen, Aditi P., Mark K. Meisilbach, and Kelly E. Anderson. 2021. "Physician Network Breadth and Plan Quality Ratings in Medicare Advantage." *JAMA Health Forum* 2 (7): e211816. https://doi.org/10.1001/jamahealthforum.2021.1816.

Skopec, Laura, Robert A. Berenson, and Judith Feder. 2018. "Why Do Medicare Advantage Plans Have Narrow Networks?" Washington, DC: Urban Institute.

About the Authors

Robert A. Berenson joined Urban as an Institute fellow in 2003. In this position he conducts research and provides policy analysis primarily on health care delivery issues, particularly related to Medicare payment policy, pricing power in commercial insurance markets, and new forms of health delivery based on reinvigorated primary care practices. In 2012, Berenson completed a three-year term on the Medicare Payment Advisory Commission, the last two years as vice chair. From 1998 to 2000, he was in charge of Medicare payment policy and private health plan contracting in the Centers for Medicare & Medicaid Services. Previously, he served as an assistant director of the White House Domestic Policy Staff under President Carter. Berenson is a board-certified internist who practiced for 20 years, the last 12 years in a Washington, DC, group practice. While practicing he helped organize and manage a successful preferred provider organization serving the Washington, DC, metropolitan area. He is coauthor of *The Managed Care Blues & How to Cure Them*, with Walter Zelman, and *Medicare Payment Policy and the Shaping of U.S. Health Care*, with Rick Mayes. He publishes frequently in numerous publications, including the *New England Journal of Medicine*, *Health Affairs*, *New York Times*, and *New Republic*. Berenson is a graduate of the Mount Sinai School of Medicine, a fellow of the American College of Physicians, and on the faculty at the George Washington University School of Public Health.

Bowen Garrett is an economist and senior fellow in the Health Policy Center. His research focuses on health reform and health policy topics, including health insurance and labor markets, Medicare's prospective payment systems, and Medicare financing. He leads the development of the Urban Institute's Medicare policy simulation model (MCARE-SIM). Previously, Garrett was chief economist of the Center for US Health System Reform and McKinsey Advanced Health Analytics at McKinsey and Company. Garrett received his PhD in economics from Columbia University in 1996 and was a

postdoctoral research fellow in the Robert Wood Johnson Foundation's Scholars in Health Policy Research Program at the University of California, Berkeley, from 1996 to 1998.

Adele Shartzer is a research associate in the Health Policy Center, where her work focuses on health coverage, access to care, and the health care delivery system; her research has been published in notable health policy journals. Before joining Urban, she worked as a program analyst in the Office of Health Policy in the Office of the Assistant Secretary of Planning and Evaluation at the US Department of Health and Human Services. She has also worked in health policy at several nonprofits in the Washington, DC, area. Shartzer holds a bachelor's degree in bioethics from the University of Virginia and an MPH in health policy from George Washington University. She received her PhD in health services research from the Johns Hopkins Bloomberg School of Public Health. While there, she received a doctoral dissertation award in patient-reported outcomes and was a National Research Service Award trainee.

Acknowledgments

This brief was funded by Arnold Ventures. We are grateful to them and to all our funders, who make it possible for Urban to advance its mission.

The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, or its funders. Funders do not determine research findings or the insights and recommendations of Urban experts. Further information on the Urban Institute's funding principles is available at urban.org/fundingprinciples.

The authors thank Amber Burkhart, Lee-Lee Ellis, John Holahan, Laura Skopec, Erica Socker, and Stephen Zuckerman for helpful feedback and Rachel Kenney for editing.

500 L'Enfant Plaza SW
Washington, DC 20024

www.urban.org

ABOUT THE URBAN INSTITUTE

The nonprofit Urban Institute is a leading research organization dedicated to developing evidence-based insights that improve people's lives and strengthen communities. For 50 years, Urban has been the trusted source for rigorous analysis of complex social and economic issues; strategic advice to policymakers, philanthropists, and practitioners; and new, promising ideas that expand opportunities for all. Our work inspires effective decisions that advance fairness and enhance the well-being of people and places.