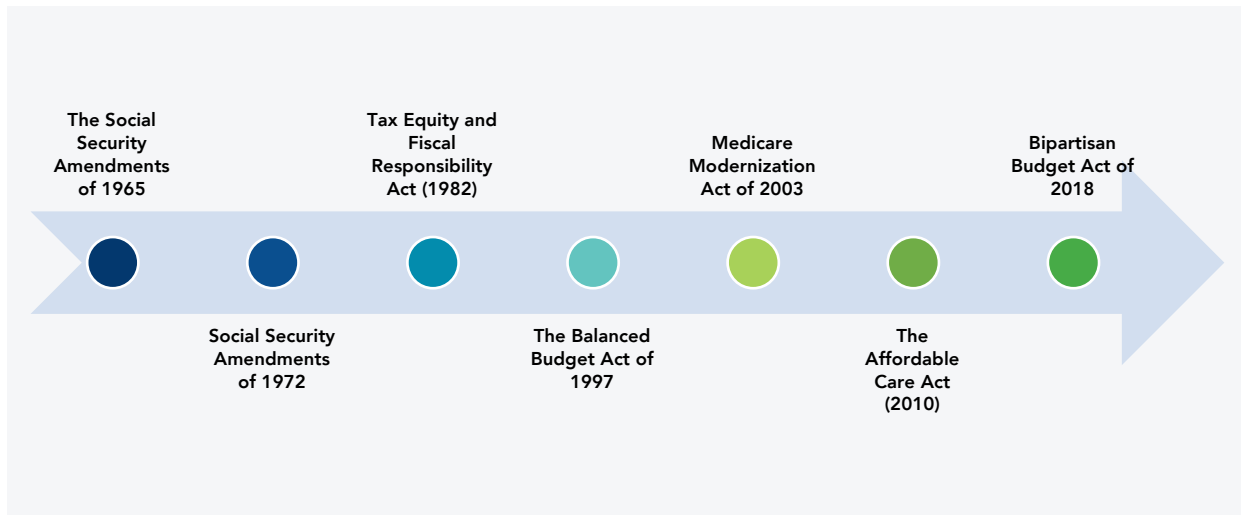


# Medicare Advantage History: Legislative Milestones

Medicare is the federal government program that provides health care coverage to over 60 million people who are over 65, under 65 and receiving Social Security Disability Insurance for a certain amount of time, or under 65 and living with End-Stage Renal Disease. <sup>i</sup>

People with Medicare can choose to receive their core benefits—Part A (inpatient/hospital coverage) and Part B (outpatient/medical coverage)—from Original Medicare, which is the traditional fee-for-service program offered directly through the federal government that was enacted in 1965, or through Medicare Advantage. Also known as Part C, Medicare Advantage allows enrollees to receive their Medicare benefits from a private insurance plan that contracts with the federal government. This option was added in 1996, but health plans have long played an important role in Medicare. Below, we examine this evolution.



## The Social Security Amendments of 1965

Created in 1965, Medicare was originally limited to people ages 65 and older and included Part A, hospital insurance, and Part B, medical insurance. Together, these two parts are known as Original Medicare (OM). Initially, Medicare paid providers exclusively on a fee-for-service (FFS) basis.

## Social Security Amendments of 1972

The Social Security Amendments of 1972 expanded the program to cover people with disabilities and End-Stage Renal Disease (ESRD) regardless of age. They also authorized Medicare to contract with health maintenance organizations (HMOs) to provide plan members with Part A and Part B benefits. Medicare paid the HMOs on a capitated basis—a monthly, per member fee based on Medicare’s estimate of what the plan’s costs would be during the contract period. There was a “risk-based” option in which HMOs that agreed to absorb costs above the capitated amount could keep some of the difference if costs fell below it. A non-risk sharing option was also available: HMOs were reimbursed for their additional expenses at the end of the contract period.<sup>ii</sup> The ensuing years saw several rounds of capitation demonstrations, with mixed success.



While the demonstrations “provided some of the first evidence of managed care's potential savings” by reducing hospitalizations, the projects also showed early warning signs about the potential for favorable selection into managed care plans.<sup>iii</sup> Compared to people in OM, the HMO enrollees were more likely to be younger and report being in excellent health; demographic payment adjustments further indicated HMO enrollees were healthier than their OM counterparts.<sup>iv</sup> But Medicare savings were elusive. The HMO enrollees cost “at least 15 percent more” than “demographically similar beneficiaries in traditional Medicare.”<sup>v</sup> Other evaluations estimated these overpayment rates to be as high as 33%.<sup>vi</sup>

## Tax Equity and Fiscal Responsibility Act (1982)

The next legislative breakthrough came in 1982 with passage of the Tax Equity and Fiscal Responsibility Act (TEFRA). The law shifted managed care from a Medicare demonstration project to a formal part of the program. The regulations implementing TEFRA’s risk-based contracting system were completed in 1985. The new rules set payments to private plans five percent below the average OM payments in the county where the plan was operating, under the assumption plans would generate efficiencies and share those savings with Medicare.<sup>vii</sup>



The flaws in TEFRA's payment formula included an inadequate "risk adjustment" system: a method for predicting enrollee health costs and updating plan payments accordingly. Risk adjustment is intended to cover plan expenses more accurately and neutralize the financial incentives for plans to avoid sicker, more expensive enrollees. But TEFRA's formula contemplated only basic demographic factors that did not meaningfully represent enrollee health status. This approach, coupled with plans' propensity for favorable selection and a disenrollment policy that allowed beneficiaries to leave for OM with only a month's notice, led to a disproportionate number of HMO enrollees with lower-than-average costs.<sup>viii</sup> As a result, despite being set at 95% of OM levels, Medicare payments to the HMOs were 5 to 7% too high and no savings accrued to the program.<sup>ix</sup>

Plans that were paid in excess of their projected and actual costs were required to use that surplus to offer additional benefits, an arrangement that would become a key feature of Medicare-private plan contracting.<sup>x</sup> The more generous benefit packages that ensued created "a major inducement to join an HMO" but as a reinvestment strategy and benefit design principle, further ensured Medicare "did not get the 5 percent savings it sought."<sup>xi</sup>



In addition, the TEFRA-era overpayments compounded policymaker worries about Medicare solvency. Program spending was "growing around 10% annually at the time, and the entry of the baby boomers loomed."<sup>xii</sup>

## The Balanced Budget Act of 1997

The Balanced Budget Act of 1997 (BBA 97) created Medicare Part C—originally called Medicare+Choice and now known as Medicare Advantage—and made significant changes to Medicare's interactions with managed care plans.

Responding to concerns about solvency, overpayments, and favorable selection, the BBA 97 reworked TEFRA's payment formula, established new risk-adjustment measures that focused on health status, and created an annual enrollment period to limit frequent mid-year changes. It also authorized new types of private plans to participate: Preferred-provider organizations (PPOs), provider-sponsored organizations (PSOs), and private fee-for-service (PFFS) plans.

Although the reforms were expected to increase enrollment 15% by 2005, plan market participation contracted, enrollment numbers fell, and benefit packages shrank.<sup>xiii</sup> Subsequent analysis attributes these shifts to several factors, including "natural market evolution and

shakeout after a period of rapid growth...Medicare policy changes, the backlash against managed care, and growth projections that were probably always unrealistic."<sup>xiv</sup>

The BBA 97's reimbursement changes did temporarily slow Medicare spending, which fell in nominal dollars from 1997 to 1999.<sup>xv</sup> Notably, this "had never happened before—and has not happened since."<sup>xvi</sup>



Even with demonstrable cuts and payment formula changes, Medicare+Choice did not achieve savings relative to OM.<sup>xvii</sup> Favorable selection concerns continued as well. Several studies found Part C enrollees were healthier than those who remained in OM.<sup>xviii</sup>

## Medicare Modernization Act of 2003

The Medicare Modernization Act of 2003 (MMA) sought to counter the "downward trends in the plans' participation and enrollment," largely by paying plans more.<sup>xix</sup> It modified risk adjustments and reimbursements, setting minimum plan payments at 100% of FFS. The reforms quickly and considerably raised plan payments, boosting them by 11%, on average, between 2003 and 2004.<sup>xx</sup> The MMA also established the Medicare Part D prescription drug program and created two more Part C plan types: Regional Preferred Provider Organizations (RPPOs) and Special Needs Plans (SNPs).



The MMA's shift away from cost containment profoundly impacted Medicare spending and solvency. From 2004 to 2009, plan payments were nearly 14% above OM rates, costing Medicare billions of additional dollars annually.<sup>xxi</sup> The Centers for Medicare & Medicaid Services (CMS) actuary later estimated that during this time, MA benchmarks—the annually established maximum amount that Medicare will pay a plan to cover Part A and Part B services—ranged from 100 to 140% of OM costs.<sup>xxii</sup>

## The Affordable Care Act (2010)

The Patient Protection and Affordable Care Act (ACA), enacted in 2010, brought MA payments closer to OM spending levels and reduced rates overall.<sup>xxiii</sup> The ACA reforms included new quality-based payments, benchmark updates, limits on administrative spending, and changes to certain risk-adjustment measures. Despite widespread predictions of plan and enrollee market withdrawals,<sup>xxiv</sup> MA enrollment increased more than 80% from 2009 to 2017, with 33% of all beneficiaries enrolled in a private plan by the end of that year.<sup>xxv</sup>



The ACA's impact on MA was notable in the short term, as aggregate plan payments relative to OM fell from 114% in 2009 to 100% percent in 2017.<sup>xxvi</sup> But payment neutrality between OM and MA was still not achieved. The risk adjustment process did not offset "coding intensity" differences between MA and OM; this inequity is estimated to have inflated MA plan payments by 2 to 4% per year from 2010-2017, and continues today.<sup>xxvii</sup>

CMS adjusts MA payments to reflect enrollees' expected costs as represented in their "risk scores." An individual's risk score reflects diagnoses their providers document through a process known as "coding." Because higher risk scores translate into higher payments, MA plans have a strong incentive to identify all possible enrollee diagnoses. No similar incentives exist in OM, where clinicians generally only record diagnoses relevant to the real-time treatment. This creates a coding intensity difference between OM and MA that can generate significant plan overpayments.

To address this, the Deficit Reduction Act of 2005 directed CMS to adjust MA risk scores before calculating risk-based payments.<sup>xxviii</sup> CMS finally did so in 2010, reducing risk scores by 3.41%.<sup>xxix</sup> The ACA subsequently established minimum annual coding intensity adjustment levels, which the American Taxpayer Relief Act of 2012 slightly increased.<sup>xxx</sup>

The minimum adjustment has been statutorily set at 5.9% since 2018 and is falling ever behind MA coding practices. Though CMS can make a more accurate correction, the agency has never done so. Due to this and other factors, the current risk adjustment model is an ineffective counterweight to favorable selection, and plans continue to be financially rewarded for artificially high risk scores.<sup>xxxi</sup> In 2020, risk scores for MA enrollees were 9.5% higher than OM, funneling an extra \$12 billion to plans.<sup>26</sup> By 2021, the scores and payments had jumped to 11% and \$17 billion, respectively.<sup>xxxii</sup>



The ACA-established quality bonus program (QBP) increases payments to MA plans based on a five-star rating system, with the goal of promoting plan quality and informed decision-making. However, since its inception, "the QBP has been characterized by excess payments unrelated to quality."<sup>xxxiii</sup> Bonuses now regularly exceed \$10 billion annually, increasing MA payments by 2% to 3% over OM levels.<sup>xxxiv</sup> Yet, information about plan quality is still lacking.<sup>xxxv</sup> With most enrollees (75%) now in plans receiving bonuses, concerns about the meaningfulness of the ratings continue.<sup>xxxvi</sup>



The ACA gradually lowered the average MA benchmark from around 112% of OM in 2010 to 103% (108% after including quality bonuses) in 2017, when the changes were fully phased in.<sup>xxxvii</sup> As benchmarks decreased, plans found ways to “bid” below them, but overall savings to Medicare still failed to materialize.

As part of the annual MA rate-setting process, plans submit “bids” to CMS estimating how much it will cost to provide coverage in the coming year and indicating the payment rate they will accept to do so. CMS measures plan bids against the benchmark amount. If a plan’s bid is lower, it receives a portion of the difference in the form of a “rebate.” The bigger the gap, the bigger the rebate. Plans must use these dollars to improve costs and coverage, investments that can draw beneficiaries to the plan, thereby increasing enrollment and profits.

Post ACA implementation, plans have continued to lower their bids while benchmarks and payments remain well above OM spending levels.<sup>xxxviii</sup>

## Bipartisan Budget Act of 2018

MA plans have long been able to offer supplemental benefits not covered by OM. In general, these benefits have had to be primarily health related and available to all plan members. In 2018, Congress and CMS loosened these rules.<sup>xxxix</sup> Plans may now use rebate and premium dollars to offer more and more targeted supplemental benefits.



Plan ability to offer supplemental benefits has increased dramatically. So too has funding for these enhancements. Rebates grew by 53% between 2019 and 2022 and account for 15% of total Medicare payments to plans.<sup>xl</sup> However, there has been no corresponding increase in transparency or accountability. Little data is available about supplemental benefit design, marketing, access, utilization, impact on health, or value. Despite this opacity, nearly one in four beneficiaries who chose MA are drawn to the extra benefits that plans market.<sup>xli</sup>

## Discussion

Initially created to improve choice, enhance quality, and reduce costs, the evolution of private Medicare plans has not always aligned with these objectives.

On choice, the number of MA plans continues to skyrocket, with the average Medicare beneficiary in 2023 having access to 43 plans, more than twice as many as in 2018.<sup>xlii</sup> This has

led to a cluttered plan landscape, which can be difficult to navigate.<sup>xliii</sup> Few MA enrollees review their coverage annually,<sup>xliiv</sup> and an even smaller share switch plans from one year to the next.<sup>xlv</sup>

Although plan numbers are burgeoning, the data are unclear when it comes to MA quality, and much of the information we do have raises questions about the value of MA to enrollees and taxpayers.<sup>xlvi</sup> A recent JAMA analysis found “little evidence” MA plans “provide meaningful improvements in access, affordability, or preventive care compared with [Original Medicare] for adults with low income.” The authors note this suggests “MA may not meaningfully advance health equity in the Medicare program” and that while “Medicare Advantage is widely thought to cost the federal government more than [Original Medicare] per beneficiary” MA may not “provide benefits commensurate with the increased costs, specifically among adults with low income.”<sup>xlvii</sup>

MA’s higher costs are also problematic. The evidence is clear that Medicare consistently overpays MA plans. As the Medicare Payment Advisory Commission (MedPAC) notes, “...private plans have never yielded aggregate savings for the Medicare program. Throughout the history of Medicare managed care, the program has paid more—sometimes much more—than it would have paid for beneficiaries to have remained in fee-for-service (FFS) Medicare.”<sup>xlviii</sup> As MA enrollment continues to grow, higher plan payments will further threaten Medicare solvency, placing greater financial burdens on beneficiaries, taxpayers, and the government.

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<sup>i</sup> Centers for Medicare & Medicaid Services, “CMS Program Statistics – Medicare Total Enrollment” (last visited May 23, 2023), <https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/medicare-and-medicare-reports/cms-program-statistics-medicare-total-enrollment>.

<sup>ii</sup> See, e.g., Robert M. Ball, “Social Security Amendments of 1972: Summary and Legislative History” (March 1973), <https://www.ssa.gov/policy/docs/ssb/v36n3/v36n3p3.pdf>; Kathryn M. Langwell, et al., “Capitation and the Medicare program: History, issues, and evidence” (December 1986), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4195086/>.

<sup>iii</sup> Thomas G. McGuire, et al., “An Economic History of Medicare Part C” (June 2011), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3117270/>.

<sup>iv</sup> Yash M. Patel & Stuart Guterman, “The Evolution of Private Plans in Medicare” (December 8, 2017), <https://www.commonwealthfund.org/publications/issue-briefs/2017/dec/evolution-private-plans-medicare>.

<sup>v</sup> Id.

<sup>vi</sup> Medicare Payment Advisory Commission, “Medicare Payment Policy: Report to the Congress” (March 2022), [https://www.medpac.gov/wp-content/uploads/2022/03/Mar22\\_MedPAC\\_ReportToCongress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_SEC.pdf).

<sup>vii</sup> Medicare Payment Advisory Commission, “Medicare Payment Policy: Report to the Congress” (March 2023), [https://www.medpac.gov/wp-content/uploads/2023/03/Ch11\\_Mar23\\_MedPAC\\_Report\\_To\\_Congress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2023/03/Ch11_Mar23_MedPAC_Report_To_Congress_SEC.pdf).

<sup>viii</sup> Medicare Payment Advisory Commission, “Medicare Payment Policy: Report to the Congress” (March 2022), [https://www.medpac.gov/wp-content/uploads/2022/03/Mar22\\_MedPAC\\_ReportToCongress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_SEC.pdf).

<sup>ix</sup> Yash M. Patel & Stuart Guterman, “The Evolution of Private Plans in Medicare” (December 8, 2017), <https://www.commonwealthfund.org/publications/issue-briefs/2017/dec/evolution-private-plans-medicare>.

<sup>x</sup> Marsha Gold, “Can Managed Care And Competition Control Medicare Costs?” (2003), <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.W3.176>.

<sup>xi</sup> Id.

<sup>xii</sup> Thomas G. McGuire, et al., “An Economic History of Medicare Part C” (June 2011), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3117270/>.

<sup>xiii</sup> Congressional Budget Office, “Medicare+Choice Provisions in the Balanced Budget Act of 1997” (November 12, 1997), [https://www.cbo.gov/sites/default/files/105th-congress-1997-1998/reports/1997\\_11\\_12\\_choice.pdf](https://www.cbo.gov/sites/default/files/105th-congress-1997-1998/reports/1997_11_12_choice.pdf).

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- <sup>xiv</sup> Marsha Gold, "Can Managed Care And Competition Control Medicare Costs?" (2003), <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.W3.176>
- <sup>xv</sup> See, e.g., Thomas G. McGuire, et al., "An Economic History of Medicare Part C" (June 2011), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3117270/>; Robert Pear, "With Budget Cutting, Medicare Spending Fell Unexpectedly" (May 4, 1999), <https://www.nytimes.com/1999/05/04/us/with-budget-cutting-medicare-spending-fell-unexpectedly.html> ("mainly because of large cuts in T[raditional] M[edicare] reimbursement to home health agencies and skilled nursing facilities").
- <sup>xvi</sup> Thomas G. McGuire, et al., "An Economic History of Medicare Part C" (June 2011), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3117270/>.
- <sup>xvii</sup> Yash M. Patel & Stuart Guterman, "The Evolution of Private Plans in Medicare" (December 8, 2017), <https://www.commonwealthfund.org/publications/issue-briefs/2017/dec/evolution-private-plans-medicare>.
- <sup>xviii</sup> Thomas G. McGuire, et al., "An Economic History of Medicare Part C" (June 2011), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3117270/>.
- <sup>xix</sup> Id.
- <sup>xx</sup> Lori Achman & Marsha Gold, "Medicare Advantage 2004 Payment Increases Resulting from the Medicare Modernization Act" (February 2004), <https://www.mathematica-mpr.com/-/media/publications/pdfs/medavpayrates.pdf>.
- <sup>xxi</sup> Thomas G. McGuire, et al., "An Economic History of Medicare Part C" (June 2011), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3117270/>.
- <sup>xxii</sup> Centers for Medicare & Medicaid Services Actuary, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended" (April 22, 2010), [https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/PPACA\\_2010-04-22.pdf](https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf).
- <sup>xxiii</sup> Yash M. Patel & Stuart Guterman, "The Evolution of Private Plans in Medicare" (December 8, 2017), <https://www.commonwealthfund.org/publications/issue-briefs/2017/dec/evolution-private-plans-medicare>.
- <sup>xxiv</sup> See, e.g. Congressional Record, "HOUSE H2883" (April 27, 2010), <https://www.govinfo.gov/content/pkg/CREC-2010-04-27/pdf/CREC-2010-04-27.pdf> ("Even care for our seniors is jeopardized. The CMS report warns that Medicare cuts may trigger a flight of hospitals and other health care providers from participation in Medicare. It also states that 50 percent of the seniors participating in Medicare Advantage are set to lose their coverage." Eric Cantor (R-VA)).
- <sup>xxv</sup> Yash M. Patel & Stuart Guterman, "The Evolution of Private Plans in Medicare" (December 8, 2017), <https://www.commonwealthfund.org/publications/issue-briefs/2017/dec/evolution-private-plans-medicare>.
- <sup>xxvi</sup> Jeannie Fuglesten Biniek, et al., "Higher and Faster Growing Spending Per Medicare Advantage Enrollee Adds to Medicare's Solvency and Affordability Challenges" (August 17, 2021), <https://www.kff.org/medicare/issue-brief/higher-and-faster-growing-spending-per-medicare-advantage-enrollee-adds-to-medicare-solvency-and-affordability-challenges/>.
- <sup>xxvii</sup> See, e.g., Yash M. Patel & Stuart Guterman, "The Evolution of Private Plans in Medicare" (December 8, 2017), <https://www.commonwealthfund.org/publications/issue-briefs/2017/dec/evolution-private-plans-medicare>; Medicare Payment Advisory Commission, "Status report on the Medicare Advantage program" (March 2017), [https://www.medpac.gov/wp-content/uploads/import\\_data/scrape\\_files/docs/default-source/reports/mar17\\_medpac\\_ch13.pdf](https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar17_medpac_ch13.pdf).
- <sup>xxviii</sup> Tamara Beth Hayford & Alice Levy Burns, "Medicare Advantage Enrollment and Beneficiary Risk Scores: Difference-in-Differences Analyses Show Increases for All Enrollees On Account of Market-Wide Changes" (July 27, 2018), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6077888/>.
- <sup>xxix</sup> Richard Kronick, "Projected Coding Intensity In Medicare Advantage Could Increase Medicare Spending By \$200 Billion Over Ten Years" (February 2017), <https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0768>.
- <sup>xxx</sup> Richard Kronick & W. Pete Welch, "Measuring Coding Intensity in the Medicare Advantage Program" (2014), [https://www.cms.gov/mmrr/downloads/mmrr2014\\_004\\_02\\_a06.pdf](https://www.cms.gov/mmrr/downloads/mmrr2014_004_02_a06.pdf).
- <sup>xxxi</sup> See, e.g., Andrew M. Ryan, et al., "Medicare Advantage Audit Changes Let Plans Keep Billions In Overpayments" (February 27, 2023), <https://www.healthaffairs.org/content/forefront/medicare-advantage-audit-changes-let-plans-keep-billions-overpayments>; Fred Schute, "Medicare Advantage's Cost to Taxpayers has Soared in Recent Years, Research Finds" (November 11, 2021), <https://www.npr.org/sections/health-shots/2021/11/11/1054281885/medicare-advantage-overcharges-exploding>.
- <sup>xxxii</sup> Medicare Payment Advisory Commission, "Chapter 11: The Medicare Advantage program: Status report" (March 2023), [https://www.medpac.gov/wp-content/uploads/2023/03/Ch11\\_Mar23\\_MedPAC\\_Report\\_To\\_Congress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2023/03/Ch11_Mar23_MedPAC_Report_To_Congress_SEC.pdf).
- <sup>xxxiii</sup> Medicare Payment Advisory Commission, "Medicare Payment Policy: Report to the Congress," (June 2020) [https://www.medpac.gov/wp-content/uploads/import\\_data/scrape\\_files/docs/default-source/reports/jun20\\_ch3\\_reporttocongress\\_sec.pdf](https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun20_ch3_reporttocongress_sec.pdf)
- <sup>xxxiv</sup> Id.
- <sup>xxxv</sup> Medicare Payment Advisory Commission, "Medicare Payment Policy: Report to the Congress" (March 2022), [https://www.medpac.gov/wp-content/uploads/2022/03/Mar22\\_MedPAC\\_ReportToCongress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_SEC.pdf).



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- <sup>xxxvi</sup> See, e.g., Laura Skopec & Robert A. Berenson, “The Medicare Advantage Quality Bonus Program” (June 26, 2023), <https://www.urban.org/research/publication/medicare-advantage-quality-bonus-program>; Jeannie Fuglesten Biniek, et al “Spending on Medicare Advantage Quality Bonus Program Payment Reached \$10 Billion in 2022” Kaiser Family Foundation (August 25, 2022), <https://www.kff.org/medicare/issue-brief/spending-on-medicare-advantage-quality-bonus-program-payment-reached-10-billion-in-2022/>.
- <sup>xxxvii</sup> Medicare Payment Advisory Commission, “Rebalancing Medicare Advantage benchmark policy” (June 2021), [https://www.medpac.gov/wp-content/uploads/import\\_data/scrape\\_files/docs/default-source/reports/jun21\\_ch1\\_medpac\\_report\\_to\\_congress\\_sec.pdf](https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun21_ch1_medpac_report_to_congress_sec.pdf).
- <sup>xxxviii</sup> Medicare Payment Advisory Commission, “Medicare Payment Policy: Report to the Congress” (March 2022), [https://www.medpac.gov/wp-content/uploads/2022/03/Mar22\\_MedPAC\\_ReportToCongress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_SEC.pdf) (“In 2022, MA benchmarks averaged an estimated 108 percent of FFS spending (including quality bonuses), about the same level as in 2021.”).
- <sup>xxxix</sup> U.S. Department of Health & Human Services, Assistant Secretary for Planning and Evaluation, Office of Behavioral Health, Disability, and Aging Policy, “Comparing New Flexibilities in Medicare Advantage with Medicaid Long-Term Services and Supports: Final Report” (January 2022), <https://aspe.hhs.gov/sites/default/files/documents/03390244d012ecbbe80e81d5c972bf39/medicare-advantage-medicaid-ltss.pdf>.
- <sup>xl</sup> Medicare Payment Advisory Commission, “Medicare Payment Policy: Report to the Congress” (March 2022), [https://www.medpac.gov/wp-content/uploads/2022/03/Mar22\\_MedPAC\\_ReportToCongress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_SEC.pdf).
- <sup>xli</sup> Faith Leonard, et al., “Traditional Medicare or Medicare Advantage: How Older Americans Choose and Why” (October 17, 2022), <https://www.commonwealthfund.org/publications/issue-briefs/2022/oct/traditional-medicare-or-advantage-how-older-americans-choose>.
- <sup>xlii</sup> Meredith Freed, et al., “Medicare Advantage 2023 Spotlight: First Look” (November 10, 2022), <https://www.kff.org/medicare/issue-brief/medicare-advantage-2023-spotlight-first-look/>.
- <sup>xliii</sup> See, e.g. Nancy Ochieng, et al., “A Relatively Small Share of Medicare Beneficiaries Compared Plans During a Recent Open Enrollment Period” (November 1, 2022), <https://www.kff.org/medicare/issue-brief/a-relatively-small-share-of-medicare-beneficiaries-compared-plans-during-a-recent-open-enrollment-period/>; Jeannie Fuglesten Biniek, et al., “Medicare Beneficiaries Rarely Change Their Coverage During Open Enrollment” (November 1, 2022), <https://www.kff.org/medicare/issue-brief/medicare-beneficiaries-rarely-change-their-coverage-during-open-enrollment/>.
- <sup>xliv</sup> See, e.g., Meredith Freed, et al., “More Than Half of All People on Medicare Do Not Compare Their Coverage Options Annually” Kaiser Family Foundation (October 29, 2020), <https://www.kff.org/medicare/issue-brief/more-than-half-of-all-people-on-medicare-do-not-compare-their-coverage-options-annually/>; Wyatt Korma, et al., “Seven in Ten Medicare Beneficiaries Did Not Compare Plans Past Open Enrollment Period” Kaiser Family Foundation (October 13, 2021), <https://www.kff.org/medicare/issue-brief/seven-in-ten-medicare-beneficiaries-did-not-compare-plans-during-past-open-enrollment-period/>.
- <sup>xlv</sup> Jeannie Fuglesten Biniek, et al., “Medicare Beneficiaries Rarely Change Their Coverage During Open Enrollment” (November 1, 2022), <https://www.kff.org/medicare/issue-brief/medicare-beneficiaries-rarely-change-their-coverage-during-open-enrollment/>.
- <sup>xlvi</sup> Medicare Payment Advisory Commission, “Medicare Payment Policy: Report to the Congress” (March 2022), [https://www.medpac.gov/wp-content/uploads/2022/03/Mar22\\_MedPAC\\_ReportToCongress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_SEC.pdf).
- <sup>xlvii</sup> Rahul Aggarwal, et al., “Comparison of Medicare Advantage vs. Traditional Medicare for Health Care Access, Affordability, and Use of Preventive Services Among Adults With Low Income” (June 7, 2022), <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2793106>.
- <sup>xlviii</sup> Id.