Medicare Advantage 101

The Overpayment Cycle: Payments to Medicare Advantage

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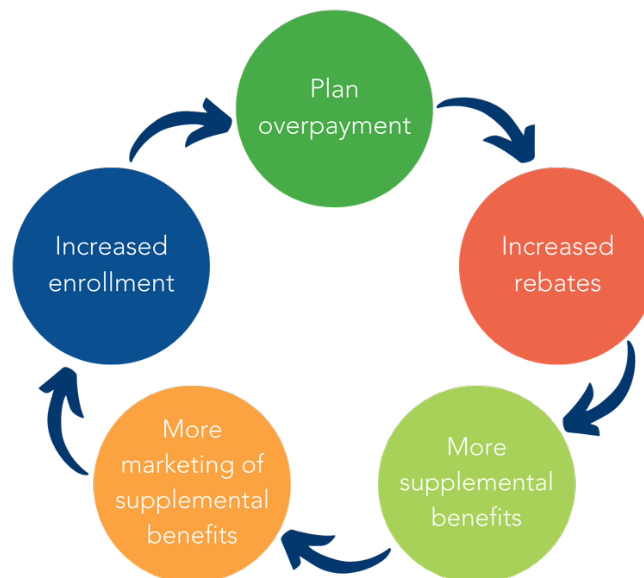
The Medicare Advantage (MA) rate-setting process builds overpayments into the system and incentivizes plans to increase Medicare solvency pressures. Specifically, flaws in the MA methodology yield inflated payments, which are tied to and grow with MA enrollment. MA plans use these additional dollars to offer services Original Medicare (OM) does not cover. They heavily and successfully market these "supplemental benefits," which boosts enrollment and triggers more overpayments. Plans invest those funds to attract more enrollees, and the cycle begins again.[i]



Plan Overpayment

MA overpayments are significant and well-documented. For example, the Government Accountability Office (GAO) found that in 2013, MA plans received an extra $14 billion,[ii] and the Medicare Payment Advisory Commission (MedPAC) has cataloged $140 billion in MA overpayments over the past 12 years.[iii] Between 2007 and 2023, MA coding intensity—the rate at which plans aggressively identify and document enrollee diagnoses—generated $124 billion in additional dollars[iv] and could cost $600 billion over the next decade.[v] Of that amount, $85 billion would be paid by beneficiaries in both MA and OM through higher Part B premiums.[vi]

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The Centers for Medicare & Medicaid Services (CMS) recently identified $650 million in overpayments to 90 plans from 2011 through 2013; some analysts calculated at least twice that much.[vii] CMS estimates that in 2021 alone, plans were improperly overpaid by $23 billion.[viii] This is expected to reach $27 billion in 2023.[ix]

Rebates

MA's benchmark overestimates trigger rising Medicare rebates, which have grown by 53% since 2019 and now account for 17% of total Medicare payments to plans.[x] Rebates are built into the MA payment formula. Plans receive these dollars from Medicare for bidding below the benchmark amount—essentially, for accepting a monthly rate below the maximum Medicare will pay in exchange for a share of the difference—with add-ons for quality as defined by the Star Ratings system.

In 2023, rebates for MA plans average $196 per enrollee per month ($2,350 annually).[xi] They are the highest in the program's history for the seventh consecutive year.[xii] Plans generally must use rebate dollars to lower enrollee costs or provide additional benefits but can internally absorb those from quality bonus payments, including to cover administrative costs and as profit.

Historically, plans' most considerable benefit-related rebate expenditure was reduced cost sharing. This trend appears to be shifting, with plans investing more in supplemental benefits. In 2023, plans dedicated 39% of rebate dollars to lowering enrollee cost sharing, compared to 52% in 2018.[xiii] At the same time, plans have been spending more on benefits not available to OM enrollees. In 2023, 26% of rebate dollars went to non-Medicare-covered supplemental benefits,[xiv] up from 22% in 2022.[xv]

Supplemental Benefits and Marketing

Supplemental benefits are items or services available to MA enrollees but not to people with OM. This can include some dental, vision, or hearing care as well as perks like gym memberships that typically appeal to healthier enrollees.[xvi] Although most supplemental benefits must be primarily health-related, recent policy changes have given MA plans more flexibility. They may now cover a wider array of services in certain instances, including for enrollees with chronic illnesses.[xvii]

Inadequate data and transparency have long made it difficult to evaluate supplemental benefit use and value. Policymakers did not correct for this when expanding their availability and to date, plans are unwilling to voluntarily share their data. Therefore, we currently "have no data about [supplemental benefit] use nor information about their value,"[xviii] including how much MA plans spend on specific benefits, how they market them, who is eligible for them, who is

actually receiving them, and what the enrollee experience has been. Without these and other data points, it is impossible to know how well MA and these benefits are working for people with Medicare, including those from underserved communities. Although this opacity makes it impossible for beneficiaries to make fully informed enrollment choices, supplemental benefits remain appealing. In 2022, 24% of those who chose MA did so because of these uncertain "extras."[xix]

Plan Enrollment

MA enrollment has more than doubled over the last decade.[xx] Approximately half of all people with Medicare are now in MA;[xxi] projections indicate 61% may be by 2032.[xxii]

Plan Payments

Medicare payments to MA plans are also climbing. As a share of total Medicare spending on Parts A and B, MA grew from 26% in 2010 to 45% in 2020 and may reach 54% by 2030.[xxiii] This increase corresponds to per-enrollee spending trends: "Medicare spending is higher and growing faster per person for beneficiaries in Medicare Advantage than in [Original] Medicare."[xxiv] Consequently, MA enrollment growth will continue to drive up Medicare spending, which will raise Part B premiums for everyone and contribute to Medicare solvency challenges.[xxv]

Discussion

MedPAC has long cautioned MA financing is worsening Medicare spending and long-term sustainability:[xxvi]

> The Commission has found that payments to MA plans are inflated as a result of plans maximizing the diagnoses they report for their enrollees in order to gain higher payments, while the underlying risk adjustment model relies on diagnoses collected from claims from fee-for-service (FFS) providers, who lack the same incentives to code diagnoses. MA plans also receive quality bonuses that increase Medicare spending for the majority of MA enrollees, yet the MA quality rating system does not provide meaningful information about plans' quality of care. MA spending is also driven up by plan benchmarks that are set so high that the Medicare program ends up subsidizing the substantial extra benefits that MA plans offer to their enrollees—benefits that are not available to FFS enrollees.[xxvii]

The overpayment cycle and trends described above add to these concerns. Rising rebates ensure plans will have more money to fund supplemental benefits. This may draw more people to MA, increasing enrollment, costs, and long-term financing concerns.[xxviii] If MA enrollment gains continue as projected, this harmful pattern—in which more MA benefits and enrollees lead to higher Medicare spending, which leads to more MA benefits and enrollees—will only accelerate.

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[i] 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.

[ii] U.S. Government Accountability Office, "Medicare Advantage: Fundamental Improvements Needed in CMS's Effort to Recover Substantial Amounts of Improper Payments" (April 2016), https://www.gao.gov/assets/gao-16-76.pdf.

[iii] Richard Gilfillan and Donald M. Berwick, "Medicare Advantage, Direct Contracting, And the Medicare 'Money Machine,' Part 1: The Risk-Score Game" (September 29, 2021), https://www.healthaffairs.org/do/10.1377/forefront.20210927.6239/.

[iv] Medicare Payment Advisory Commission, "The Medicare Advantage Program: Status Report" (January 12, 2023), https://www.medpac.gov/wp-content/uploads/2023/01/MedPAC-MA-status-report-Jan-2023.pdf.

[v] Richard Kronick, et al., "Industry-Wide and Sponsor-Specific Estimates of Medicare Advantage Coding Intensity" (November 17, 2021), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3959446.

[vi] Id.

[vii] Fred Schulte, "Government Lets Health Plans That Ripped Off Medicare Keep the Money" (January 30, 2023), https://khn.org/news/article/cms-audits-medicare-advantage-plans-can-keep-hundreds-of-millions-in-federal-overpayments-maybe-more/.

[viii] U.S. Government Accountability Office, "Medicare Advantage: Continued Monitoring and Implementing GAO Recommendations Could Improve Oversight, Statement of Leslie V. Gordon, Acting Director, Health Care" (June 28, 2022), https://www.gao.gov/assets/gao-22-106026.pdf.

[ix] 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.

[x] See, e.g., 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; 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.

[xi] Id.

[xii] Id.

[xiii] Id.

[xiv] 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.

[xv] Medicare Payment Advisory Commission, "Chapter 12: The Medicare Advantage program: Status report and mandated report on dual-eligible special needs plans" (March 2022), https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_Ch12_SEC.pdf.

[xvi] Shefali S. Kulkarni, "Gym Memberships In Medicare Advantage Plans Cater To Healthy Seniors" (January 11, 2012), https://kffhealthnews.org/news/gym-memberships-in-medicare-advantage-plans-cater-to-healthy-seniors/.

[xvii] Anne Tumlinson, et al., "The CHRONIC Care Act of 2018: Advancing Care for Adults with Complex Needs" (March 2018), http://www.thescanfoundation.org/sites/default/files/chronic_care_act_brief_030718_final.pdf.

[xviii] Id.
[xix] 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.
[xx] Meredith Freed, et al., "Medicare Advantage in 2022: Enrollment Update and Key Trends" (August 25, 2022), https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-enrollment-update-and-key-trends/.
[xxi] See, e.g., Jeannie Fuglesten Biniek, et al., "Half of All Eligible Medicare Beneficiaries Are Now Enrolled in Private Medicare Advantage Plans" (May 1, 2023), https://www.kff.org/policy-watch/half-of-all-eligible-medicare-beneficiaries-are-now-enrolled-in-private-medicare-advantage-plans/; Centers for Medicare & Medicaid Services, "Medicare Monthly Enrollment" (last visited May 23, 2023), https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/medicare-and-medicaid-reports/medicare-monthly-enrollment; Centers for Medicare & Medicaid Services, "Program Enrollment Information" (last visited June 27, 2023), https://www.cms.gov/pillar/expand-access showing "Fee-For-Service: Nearly 34 million" and "Medicare Advantage plans: More than 31.7 million."
[xxii] Id.
[xxiii] Jeannie Fugelsten Biniek, et al., "The Growth in Share of Medicare Advantage Spending" (April 7, 2022), https://www.kff.org/medicare/slide/the-growth-in-share-of-medicare-advantage-spending/.
[xxiv] 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-medicares-solvency-and-affordability-challenges/.
[xxv] Id.
[xxvi] Medicare Payment Access Commission, "For the Record: MedPAC's Response to AHIP's Recent "Correcting the Record" Blog Post" (March 3, 2021), https://www.medpac.gov/for-the-record-medpacs-response-to-ahips-recent-correcting-the-record-blog-post/.
[xxvii] 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.
[xxviii] Id.