

Payments to Medicare Advantage: The Methodology

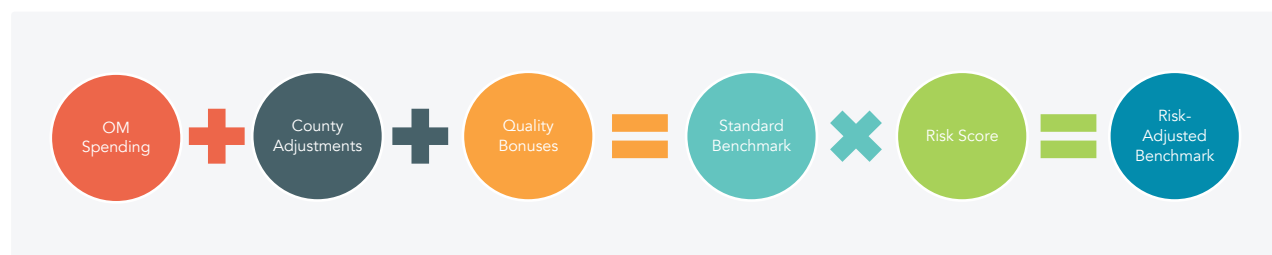


Under Original Medicare (OM), Medicare pays providers a fixed rate for each service rendered to enrollees. Medicare Advantage (MA) has a different structure. Medicare pays MA plans a fixed monthly rate for each enrollee, and the plans pay providers to deliver care. Unlike OM, where payments are service-dependent, MA plans receive the same amount each month, regardless of how much care their enrollees use.

The Centers for Medicare & Medicaid Services (CMS) sets yearly MA payment rates through a complicated series of determinations and adjustments. The process begins with benchmarking, then moves to bidding and applying rebates before arriving at a final payment. As a result of problematic assumptions and calculations along the way, MA plan payments are systemically inflated. In 2023, Medicare will pay MA at least 6% more than OM for similar enrollees, translating to \$27 billion in overpayments.ⁱ

The Benchmarking Process

As part of the rate-setting process, CMS determines the maximum monthly payment a plan could receive for providing OM services. This “benchmark” is based on county-level per enrollee spending in OM and may be adjusted to incorporate additional considerations, such as plan service area, MA Star Ratings, and enrollee health status.



OM Spending  +  +  =  x  = 

To develop MA benchmarks, CMS first calculates how much Medicare spends on OM enrollees in every U.S. county.



Using OM spending as the baseline may inflate MA plan payments. Research suggests people who initially choose OM are sicker and more costly than their MA counterparts,ⁱⁱ and that MA enrollees disproportionately switch to OM when their health needs and expenses grow.ⁱⁱⁱ If these trends persist, MA payments will increasingly be based on inaccurate assessments, inappropriately raising MA payments, Medicare costs, and program misalignments.

County Adjustments



Based on these OM costs, CMS divides the counties into four categories and adjusts the benchmarks for each to encourage plan participation and enrollee access.^{iv} For example, CMS increases benchmarks to make less profitable areas more attractive to plans while dialing back elsewhere to promote efficiency.

County Category	Benchmark Calculation
1st Quartile (lowest OM costs)	OM cost + 15%
2nd Quartile	OM cost + 7.5%
3rd Quartile	OM cost
4th Quartile (highest OM costs)	OM cost - 5%




These add-ons can further inflate payment rates. They definitionally guarantee half of all U.S. counties have MA benchmarks above projected OM spending and that the average benchmark is higher than average OM spending.^v As a result of this approach, about half of MA enrollees live in counties where benchmarks exceed estimated OM costs by 7.5% or 15%.^{vi}

Quality Bonus Payments



The MA Quality Bonus Program (QBP) also raises benchmarks—and thus payments—for certain plans. Under the program, CMS rates plans on a five-star system. The ratings are based on nearly 50 measures that track clinical processes and plan performance.^{vii} Plans that receive at least four stars get a “bonus” in the form of a 5% benchmark increase. In “double bonus” counties (those with low OM spending and high MA enrollment) highly rated plans get a 10% increase.^{viii}

Plan Rating	Bonus Benchmark	Double Bonus (in qualifying counties)
Under 4.0	0%	0%
4.0 to 5.0	5%	10%

 In 2012, quality bonus payments were established to reward plans based on quality and help beneficiaries meaningfully assess plan differences.


Evidence suggests the program is meeting neither objective. Ten years ago, 38% of MA enrollees were in plans with four or five stars. After years of plan gaming, including through contract consolidations that boosted bonus payments and masked underperformance, as well as generous policy choices by CMS, most recently in reaction to the COVID-19 emergency, this number reached a high of 90% in 2022^x before settling at 72% in 2023.^x However, it is unclear if the surge in highly rated—and highly paid—plans is due to meaningful quality improvements or a Star Ratings system that is inaccurate, ineffective, and easily manipulated.^{xi}

Although the QBP’s relationship to plan quality is questionable, its effect on Medicare costs is not. Over the last seven years, the program has paid out nearly \$50 billion in bonuses. These payments have increased exponentially, from \$3 billion in 2015 to \$12 billion in 2021.^{xii} Since unlike other quality programs the QBP is not required to be budget-neutral, its potential to generate extra plan dollars, and Medicare costs, is limitless.^{xiii}

Standard Benchmark



After making these adjustments, CMS arrives at the standard benchmark for every county.

 According to the Medicare Payment Advisory Commission (MedPAC), MA standard benchmarks in 2023 averaged 109% of projected OM spending.^{xiv}

Risk Score



CMS then upwardly adjusts the benchmark calculation based on health risk, paying plans more for higher-cost enrollees.



Intended to predict and cover plan expenses more accurately and mitigate plan incentives to enroll only healthy beneficiaries, risk adjustment instead encourages plans to maximize documentation of sicker, older enrollees. If a plan can increase its risk score, it can increase its Medicare payment. This practice is called “upcoding” and it regularly leads to substantial MA overpayments, potentially costing Medicare an extra \$600 billion over the next decade.^{xv} Although CMS is statutorily required to lower plan risk scores by a minimum amount each year, this base rate (5.9%) has been unchanged since 2018 and is not keeping pace with MA coding practices.^{xvi} MedPAC estimates that in 2021, risk scores for MA enrollees were 11% higher than they should have been, inflating MA payments by \$17 billion and clearly exposing the inadequacy of a 5.9% adjustment.^{xvii}

Risk-Adjusted Benchmark (RAB)



After all these factors—OM costs, county adjustments, quality bonuses, and risk scores—are combined, CMS finally arrives at a plan-specific risk-adjusted benchmark (RAB). This is the maximum payment an MA plan can receive.



Because of the inflationary flaws within each of its components, the benchmark sharply diverges from the OM costs it is meant to reflect; it sets the MA payment floor too high. The upshot is that Medicare has overpaid MA plans relative to OM every year since 2003, when the current payment system was established.^{xviii}

Using the Benchmark to Determine Plan Payment

Bidding

With the benchmark in mind, MA plans then submit bids to CMS. The bid is meant to represent how much money the plan estimates it will need to cover Part A and B benefits for the average enrollee in the coming year, including administrative costs and profits. The relationship between the bid and the relevant RAB largely determines the plan’s monthly payment:

- A plan bidding at or above the RAB receives a per-enrollee payment equal to the benchmark. Enrollees must make up the difference, if any, through higher premiums.
- When a plan bids below the RAB, it receives the bid amount plus a share of the difference in the form of a rebate. Plans must generally use these dollars to provide additional services or lower enrollee costs.

Plan Bid	Base Payment	Rebate (% of difference)	MA Premium?
Above the RAB	RAB	0%	Required
At the RAB	RAB	0%	Not required
Under the RAB	Bid	50-70% (average 65%)	Not required

Rebates

The cost and coverage enhancements that MA plans must spend their rebates on can include lower cost sharing, reduced premiums, and supplemental benefits like dental coverage. However, plans may keep some rebates from quality bonus payments to cover administrative expenses and as profit.^{xx} Historically, plans invested most of their enrollee-facing rebate dollars in lowering member costs. But allocations for additional benefits are growing.^{xx}



Since the MA payment methodology yields inflated benchmarks, most plans can and do comfortably bid significantly below these targets and receive unnecessarily generous rebates in return, dollars they use to fund attractive supplemental benefits that drive enrollment and overpayment.

MA bids are historically low relative to OM spending, but benchmarks remain well above the OM threshold. This gap is widening each year: In 2017, benchmarks were 106% of OM spending and the average plan bid was 90%. By 2023, OM payments had grown to 109% while bids had fallen to 83%.^{xxi}



Rebate amounts range from 50% to 70% of the difference between the plan's bid and the RAB, depending on the plan's Star Rating—higher stars result in higher rebates. In 2021, as in prior years, the average rebate was near the top of this range, around 65%.^{xxii}

Under this approach, Star Ratings increase already inflated plan rebates, worsening the problem of MA overpayment. Further, allowing Star Ratings to affect both QBP and rebate payments gives the program disproportionate influence, adding to plan gaming incentives and questions about the system's quality measurement capabilities.

Star Rating	Rebate percentage
Under 3.5	50%
3.5 to under 4.5	65%
4.5 to 5.0	70%

Conclusion

The plan payments that emerge from the benchmark and bidding processes are meant to reflect OM spending and lower Medicare costs, but the payments fall short on both counts.^{xxiii} As shown above, much of this is by design.

This methodology has consequences. Per person, Medicare spending is higher and growing faster for MA beneficiaries than for those with OM.^{xxiv} The resulting overpayments reward insurers with greater profits but penalize all beneficiaries through higher Part B premiums and taxpayers through increased costs. Absent correction, these impacts will only deepen.

Although MA was intended to reduce Medicare expenditures through competition and efficiencies, its formula—premised on flawed assumptions and misalignments that fuel inaccurate overpayments at every turn—prevents any savings from accruing.

ⁱ 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>.

ⁱⁱ See, e.g., Medicare Payment Advisory Commission, “Chapter 4: Favorable selection and future directions for Medicare Advantage payment policy” (June 2023), https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch4_MedPAC_Report_To_Congress_SEC.pdf; Steven Lieberman, et al., “Medicare Advantage Enrolls Lower-Spending People, Leading to Large Overpayments” (June 13, 2023), <https://healthpolicy.usc.edu/research/ma-enrolls-lower-spending-people-leading-to-large-overpayments/>; Gretchen Jacobson, et al., “Do People Who Sign Up for Medicare Advantage Plans Have Lower Medicare Spending?” (May 07, 2019), <https://www.kff.org/medicare/issue-brief/do-people-who-sign-up-for-medicare-advantage-plans-have-lower-medicare-spending/>.

ⁱⁱⁱ See, e.g., U.S. Government Accountability Office, “Medicare Advantage: CMS Should Use Data on Disenrollment and Beneficiary Health Status to Strengthen Oversight: GAO-17-393” (April 28, 2017), <https://www.gao.gov/products/gao-17-393>; Medicare Rights Center, “Medicare Advantage Disenrollment in Final Year of Life Continues Troubling Pattern” (August 5, 2021), <https://www.medicarerights.org/medicare-watch/2021/08/05/medicare-advantage-disenrollment-in-final-year-of-life-continues-troubling-pattern>.

^{iv} Medicare Payment Advisory Commission, “Chapter 1: 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.

^v Congressional Budget Office, “Options for Reducing the Deficit, 2023 to 2032—Volume 1: Larger Reductions: Reduce Medicare Advantage Benchmarks” (December 7, 2022), <https://www.cbo.gov/budget-options/58626>.

^{vi} Id.

^{vii} Medicare Payment Advisory Commission, “Chapter 8: Redesigning the Medicare Advantage Quality Rating System” (June 2019), https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun19_ch8_medpac_reporttocongress_sec.pdf

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- ^{viii} Adam Markovitz, et al., “Medicare Advantage Plan Double Bonuses Drive Racial Disparity In Payments, Yield No Quality Or Enrollment Improvements” (September 2021), <https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.00349>.
- ^{ix} Bob Herman, “The Lake Wobegon effect in Medicare Advantage” (October 11, 2021), <https://www.axios.com/2021/10/11/medicare-advantage-star-ratings-2022>.
- ^x Centers for Medicare & Medicaid Services, “2023 Medicare Advantage and Part D Star Ratings: Fact Sheet” (October 6, 2022), <https://www.cms.gov/files/document/2023-medicare-star-ratings-fact-sheet.pdf>.
- ^{xi} 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 (“The current state of quality reporting is such that the Commission’s yearly updates can no longer provide an accurate description of the quality of care across MA plans.”).
- ^{xii} See, e.g., Jeannie Fuglesten Biniek, et al., “Spending on Medicare Advantage Quality Bonus Program Payment Reached \$10 Billion in 2022” (August 25, 2022), <https://www.kff.org/medicare/issue-brief/spending-on-medicare-advantage-quality-bonus-program-payment-reached-10-billion-in-2022/>; Sarah Klein and Martha Hostetter, “Taking Stock of Medicare Advantage: Quality Reporting and Quality Bonus” (March 3, 2022), <https://www.commonwealthfund.org/blog/2022/taking-stock-medicare-advantage-quality-reporting-and-quality-bonuses>.
- ^{xiii} Medicare Payment Advisory Commission, “Chapter 3: Replacing the Medicare Advantage quality bonus program” (June 2020), https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun20_ch3_reporttocongress_sec.pdf.
- ^{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} 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>.
- ^{xvi} See, e.g., Section 1853 (a)(1)(C)(ii) of the Social Security Act [42 U.S.C. 1395w–23(a)(1)(C)(ii)]; 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>.
- ^{xvii} 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.
- ^{xviii} Medicare Payment Advisory Commission, “Chapter 1: 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.
- ^{xix} Robert A. Berenson, et al., “Understanding Medicare Advantage Payment: How the Program Allows and Obscures Overspending” (September 2022), <https://www.urban.org/sites/default/files/2022-09/Understanding%20Medicare%20Advantage%20Payment.pdf>.
- ^{xx} Id.
- ^{xxi} 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>.
- ^{xxii} Medicare Payment Advisory Commission, “Chapter 1: 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.
- ^{xxiii} 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.
- ^{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-medicare-solvency-and-affordability-challenges/>.