Favorable selection and future directions for Medicare Advantage payment policy

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Chapter summary

Medicare pays Medicare Advantage (MA) plans a capitated rate that is the product of a base payment rate and a risk score. A plan's base rate is determined by its bid and a county benchmark. The bid is intended to represent the dollar amount that the plan estimates it will need to cover the Part A and Part B benefit package for a beneficiary of average health status; the benchmark is the maximum amount Medicare will pay for an MA plan to provide Part A and Part B benefits and is set for each county based on Medicare spending for the county's beneficiaries enrolled in Medicare's traditional fee-for-service (FFS) program, standardized to represent a beneficiary with average health status.[1]

Risk scores increase payments for plan enrollees whose expected health care costs, based on their demographics and medical conditions, are higher than the costs for the FFS beneficiary of average health status and decrease payment for enrollees whose expected costs are lower. The accuracy of Medicare's payments to MA plans—that is, how well payments match the cost of covering Medicare services for plan enrollees—depends in large part on how well the risk-adjustment model (i.e., risk scores) predicts the expected costs for the plans' enrollees. The purpose of risk adjustment is not to accurately predict costs for a particular person, but rather to accurately predict the average costs for a group of people with

In this chapter

similar attributes. For beneficiaries with the same risk score, the average cost of covering Medicare services will equal the cost predicted by the risk score, but actual costs will exceed the predicted cost (an underprediction) for some beneficiaries and will be below predicted costs (an overprediction) for others.

Medicare's payments for MA plans assume that, after risk adjustment, average spending for MA enrollees is equal to average spending for FFS beneficiaries. However, MA enrollees' risk scores consistently overpredict MA enrollees' actual spending in part because of favorable selection of beneficiaries who choose to enroll in an MA plan rather than FFS Medicare. Favorable selection into MA causes payments to plans to be systemically greater than plans' spending for their enrollees. Consistent with other research, the Commission estimates that prior to the effects of any utilization management from MA plans, MA enrollees' spending in 2019 was about 11 percent lower than the spending of FFS beneficiaries with the same risk scores. The benefits of favorable selection for MA plans are separate from the effects of MA plans' higher diagnostic coding intensity relative to coding in FFS (which we estimated, in our March 2023 report to the Congress, resulted in overpayments to MA plans of about 6 percent), and the effects of the two phenomena are additive.

As a result of this favorable selection, the FFS spending estimates that are the basis for MA benchmarks do not align well with plans' costs of providing the Medicare benefit package, since the spending estimates reflect the higher level of costs associated with beneficiaries enrolled in traditional FFS Medicare. In a county with a benchmark set at 100 percent of FFS spending, the costs of providing Medicare services to the average MA enrollee equal an estimated 89 percent of FFS spending due to the effects of favorable selection alone. (The effects of plan benefit design, cost containment efforts, and diagnostic coding could push that percentage down even further.) Favorable selection thus results in overpayments to MA plans, which are made at the expense of taxpayers and beneficiaries (through higher Part B premiums). In addition, favorable selection distorts efforts to assess how MA plan bids, benchmarks, and payments compare with FFS spending because these comparisons are made on a risk-standardized basis. For example, a plan that submits a bid equal to 89 percent of FFS spending will appear more efficient than FFS (and receive MA rebates) without having produced any efficiencies in care delivery.

These findings raise major concerns about the appropriateness of continuing to base MA benchmarks exclusively on Medicare FFS spending data. Those

concerns are heightened as more beneficiaries enroll in MA and the share of Medicare beneficiaries enrolled in FFS declines. If the number of FFS beneficiaries in a county becomes too small, Medicare's estimates of FFS spending for the county could become unstable, as small changes in enrollment or health service delivery can cause large shifts in average spending. Further, certain population characteristics—such as whether a beneficiary is eligible for Medicaid or qualified for Medicare due to disability—become skewed if those characteristics are associated with a preference for MA or FFS Medicare coverage.

Policymakers could take an approach to setting MA benchmarks that would be less reliant on FFS spending. Possible approaches include (1) a competitive bidding system that relies entirely on MA bids to determine benchmarks, (2) basing benchmarks on both FFS and MA spending instead of just FFS spending, and (3) establishing benchmarks at a point in time and updating them using an administratively set growth rate. Any of these approaches would help address the problems associated with a declining FFS population, but the extent to which they would address the favorable selection of enrollees in MA would vary.

Setting benchmarks using competitive bidding

Under competitive bidding, each county's benchmark (the maximum amount Medicare will pay for an MA plan to provide Part A and Part B benefits, including administrative costs and plan profits) would be set based on MA plan bids rather than on the spending for FFS beneficiaries in the county. (Most competitive bidding proposals have suggested using the enrollment-weighted average bid as the benchmark; the Part D program uses this approach to calculate its national average bid.) As with the current system, a plan that bid above the benchmark would charge their enrollees a premium equal to the difference between the plan's bid and the average bid, while a plan that bid below the benchmark would receive rebates that would be used to lower enrollee premiums or provide extra benefits or both. If desired, policymakers could change the rebate formula so that plans could receive the full difference between the benchmark and the bid (instead of just part of the difference, as under current policy) to give them stronger incentives to lower their bids. (Note that under this form of competitive bidding, the FFS program would not be treated like a competing plan in the bidding system; the benchmark would have no bearing on Medicare payments for FFS beneficiaries.)

One advantage of competitive bidding is that it would reduce the impact of favorable selection and coding intensity on program spending. However, the use of competitive bidding in MA would reduce the rebates that plans receive and plans' ability to offer extra benefits, which could make MA less attractive relative to traditional Medicare than it is now. This challenge could be addressed by requiring plans to include a certain amount of extra benefits in their bids. But it is unclear how plans' behavior would change under a competitive bidding system. Plans with more market power could face less pressure to submit bids that reflect their true costs. Indeed, in highly concentrated markets, plans might submit bids that are actually higher than their current bids, resulting in relatively low program savings and, at least in some areas, potentially higher program spending. Even with changes in bidding behavior, plans that now have relatively high bids would be more likely to charge premiums under competitive bidding and could find themselves at a disadvantage. (For example, if the benchmark equaled the enrollment-weighted average bid, roughly half of plans would charge premiums.) One potential consequence is that enrollment in HMOs could increase at the expense of preferred provider organizations, which have grown more rapidly than HMOs in recent years but also tend to have higher bids.

Basing benchmarks on both FFS and MA spending

A second approach to setting benchmarks would be to base them on spending for the entire Medicare population in each market, including those enrolled in MA. A benchmark alternative that blends average local area FFS and MA spending would strive to closely reflect the market average spending for providing Part A and Part B services for all Medicare beneficiaries. This approach would keep the same bidding and benchmark infrastructure that exists under current policy with little added administrative burden for CMS or for MA plans. CMS would need to calculate an FFS rate and an MA rate for each local area. Spending for the FFS population would be calculated for those with both Part A and Part B coverage (the MA-eligible population). In the absence of sufficient encounter data, spending for the MA population could be calculated using the weighted average of each local area bid. (In the longer term, more complete MA encounter data could be used to estimate spending on Part A and Part B services for plan enrollees, and MA bids could be used to estimate plan administrative expenses and profits.)

The Commission's simulations of this approach suggest that MA plans would continue to bid below their benchmarks, which would preserve MA as an affordable option for beneficiaries, relative to FFS Medicare. We simulated

benchmarks that blend average local area FFS and MA spending and estimate that benchmarks would have been 100 percent of projected FFS spending in 2022, which is 8 percentage points lower than the actual 2022 benchmarks. Because the extra benefits offered in MA rely on the plans' ability to bid below benchmarks, we measured actual 2022 plan bids as a percentage of our simulated benchmarks. Nationally, plan bids were 86 percent of simulated benchmarks on average (compared with an average 79 percent of benchmarks under current policy). In nearly all MA markets, the enrollment-weighted average plan bid was more than 5 percent below their simulated benchmark. These results indicate that benchmarks based on all Medicare spending would likely allow plans to continue to provide some level of extra benefits, including reduced premiums and cost-sharing liability, to enrollees while reducing Medicare spending. Further, while our simulations assume no change in bidding behavior relative to 2022 levels, at least some plans would likely respond to lower benchmarks with lower bids, which could allow some plans to maintain their current levels of extra benefits.

A benchmark approach that uses all Medicare spending could be desirable if policymakers seek to move away from FFS-based benchmarks but want to keep the current MA bidding and benchmark infrastructure. Benchmarks based on all Medicare spending would more closely reflect Medicare's per capita spending in a local market area. As the FFS population in a local area decreased, the benchmark would more closely reflect spending for the area's MA population. One concern with this approach is that, to the extent that it relies on the FFS population, it would continue incorporating some of the effects of favorable selection into MA benchmarks. A second potential concern about basing benchmarks on all Medicare spending, as with competitive bidding, is the high level of market concentration in the MA market. For example, if a majority of a market's Medicare population is enrolled in plans offered by one MA organization, that organization could potentially have a large influence on a market's benchmark. This concern could be addressed by capping the weight of individual MA organizations in a county's benchmark calculation or by capping benchmarks at what they would be under a blended approach (50/50 local/national FFS), as described in the Commission's June 2021 report to the Congress.

Updating established MA benchmarks with an administratively set growth rate

A third approach to benchmark setting would be to establish baseline benchmarks and then apply a fixed growth rate that is set in advance. The fixed

growth rate could be based on CMS Office of the Actuary projected changes in Medicare prices, volume and intensity, and beneficiary demographic mix. Because MA plans have had success in constraining growth in volume and intensity, policymakers could apply a discount factor to those components of the growth rate; without such a discount factor, the growth rate would likely be too high. Another option would be to determine the fixed growth rate using U.S. gross domestic product (GDP), which is the total value of all final goods and services produced in the country over a specified time period, and couple that rate with a factor tied to policy goals. However, because GDP is not closely linked to Medicare spending, it might not always provide a reasonable basis for updating payments to MA plans.

Although choosing the basis for the fixed growth rate could be fairly straightforward, other elements of this approach would not be. Policymakers would need to ensure that the base benchmarks were not set too low or too high. If the base benchmarks were tied to base-year FFS spending, all of the effects of favorable selection would persist (and would require an adjustment to be removed). Any errors in setting the base benchmarks could be carried forward in perpetuity. In addition, because the fixed growth rate would be independent from current Medicare spending and any spending shocks that could arise, policymakers would need to regularly assess whether payments to MA plans are adequate and, if not, determine how to adjust the fixed growth rate. However, assessing the adequacy of MA payments and identifying a trigger for when to override the existing fixed growth rate would be a complex undertaking. ■

Introduction

The Medicare Advantage (MA) program allows Medicare beneficiaries enrolled in both Part A and Part B to receive benefits from private plans rather than the traditional fee-for-service (FFS) program. The MA program is quite robust: In 2022, it included 5,261 plan options offered by 182 organizations, enrolled about 29 million beneficiaries, and paid MA plans $403 billion (not including Part D drug plan payments). The Commission has long acknowledged that the MA program gives beneficiaries more coverage options and has the potential to reduce overall Medicare spending. However, over Medicare's nearly 40-year history of making risk-based payments to private plans, the program has always paid more to private plans than it would have spent to cover the same beneficiaries through FFS. We previously estimated that, in 2023, Medicare will pay MA plans about $27 billion more than it would have spent to cover the same beneficiaries through FFS, largely due to the effects of coding intensity that is greater in MA than in FFS (Medicare Payment Advisory Commission 2023).

The Commission has made a series of recommendations that address diagnostic coding intensity and the quality bonus program (Medicare Payment Advisory Commission 2022a, Medicare Payment Advisory Commission 2020a). In addition, in 2021, the Commission recommended replacing MA's current payment benchmarks with a system that (1) bases benchmarks on a 50/50 blend of a local area's FFS spending and national FFS spending and then (2) lowers all benchmarks by a discount rate of at least 2 percent. Under this recommendation, the local areas used for payment would be larger than the current county-based system (e.g., counties that are located in the same state and the same metropolitan area would be part of the same local area, as would counties that are not part of a metropolitan area but belong to the same health service area). This approach would maintain benchmarks that are lower than FFS spending in high-FFS-spending areas and benchmarks that are higher than FFS spending in low-FFS-spending areas, but it would allocate differences between plan bids and benchmarks more equitably among MA plans, MA enrollees, and the taxpayers who fund the Medicare program.

Although the Commission's recommendation would improve upon the current benchmark system, both approaches rely on FFS spending data. However, MA enrollment has grown substantially in recent years. Among Medicare beneficiaries who are eligible to enroll in MA plans (those with both Part A and Part B), the share enrolled in MA between 2011 and 2022 grew from 26 percent to 49 percent (Figure 4-1, p. 160). If recent trends continue, in 2023, MA's share of Medicare beneficiaries will surpass 50 percent.

Although overall Medicare enrollment is currently split about equally between MA and FFS, the figures for individual counties vary substantially (Figure 4-2, p. 161). Enrollment by county is significant because Medicare spending by a county's FFS beneficiaries is the basis for determining that county's MA payment rates.

As of February 2022, MA represented more than half of eligible beneficiaries in 28 percent of counties in the 50 states and the District of Columbia. In Puerto Rico, MA enrollment represents about 95 percent of all eligible beneficiaries and at least 85 percent of each county's enrollment.[2]

In this chapter, we examine two challenges with using FFS-based payment benchmarks: favorable selection in MA plans and the possibility that declining FFS enrollment makes benchmarks unreliable in some areas. Potential alternatives would establish benchmarks without relying solely on FFS spending.

Medicare pays MA plans based on FFS spending

Medicare pays MA plans a monthly capitated amount per enrollee to provide all Part A and Part B services except hospice; plans must also include a limit on enrollees' out-of-pocket spending. The capitated payment is calculated by multiplying a plan-specific base rate by an enrollee-specific risk score. CMS determines a plan's base rate using the plan's bid and the county-level benchmarks for the plan's service area. CMS standardizes the base rates using the health status of the national average FFS beneficiary. CMS then uses a risk score to adjust the standardized base rate for an MA plan up or down for each enrollee, depending on the enrollee's health status relative to

FIGURE
4–1

Share of beneficiaries with both Part A and Part B who enrolled in FFS versus MA, 2011–2022
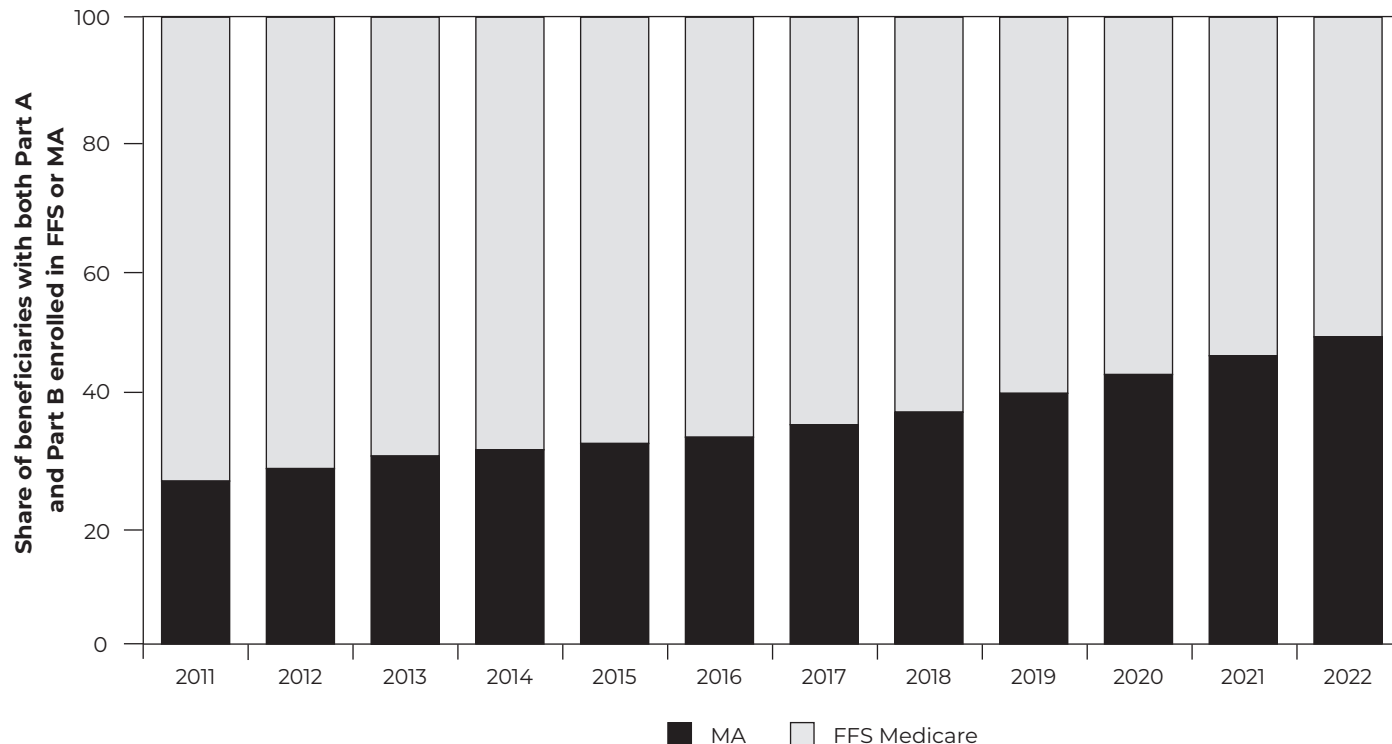
Note: FFS (fee-for-service), MA (Medicare Advantage), ACS (ambulatory care sensitive).

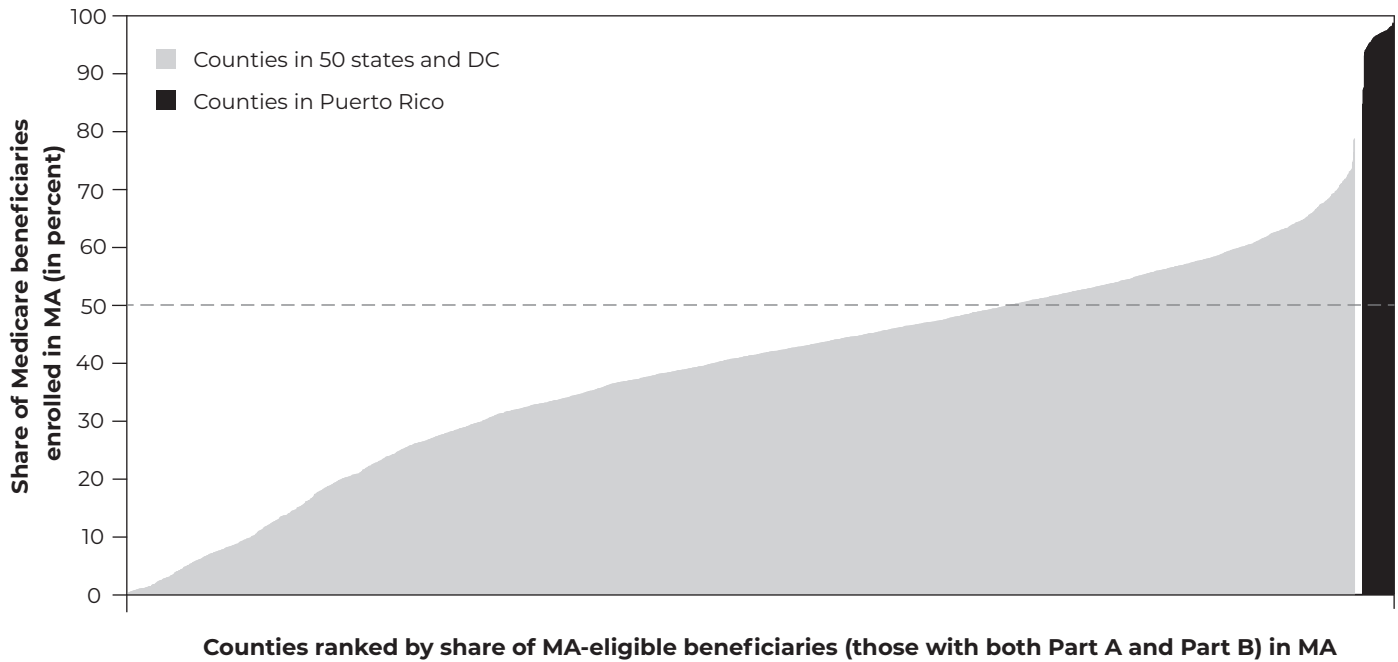Source: MedPAC analysis of CMS enrollment files, 2011–2022.

the national average. The risk scores are beneficiary-level indexes that indicate the expected Medicare costs for an enrollee relative to the national average for FFS beneficiaries.

Plans' base payment rates are determined by the MA plan bid and the benchmark for the county in which the beneficiary resides. The benchmark is the maximum amount that Medicare will pay the plan.[3] If a plan's standardized bid (i.e., adjusted to reflect average risk) is above the standardized benchmark, the plan's base payment rate is set at the benchmark and its enrollees have to pay a premium equal to the difference (in addition to the usual Part B premium). If a plan's bid is below the benchmark (as is the case for over 99 percent of plans), its payment rate equals

its bid plus a share (as low as 50 percent but typically either 65 percent or 70 percent, depending on a plan's quality rating) of the difference between the bid and the benchmark. This additional amount is referred to as the rebate. The beneficiary pays no additional premium to the plan for Part A and Part B benefits (but continues to pay the Part B premium and may pay a premium for additional benefits). Plans must use their rebates to provide additional benefits to enrollees in the form of lower cost sharing, lower Part B or Part D premiums, or supplemental benefits. Plans can also keep some of the rebate for administrative costs and profits.[4] (A more detailed description of the MA payment system can be found in our MA program *Payment Basics* document, available at http://www.medpac.gov.)

**FIGURE
4–2**

Share of Medicare beneficiaries enrolled in MA varies by county, February 2022

Note: MA (Medicare Advantage), DC (District of Columbia).

Source: Centers for Medicare & Medicaid Services enrollment data, February 2022.

How Medicare calculates risk scores

Risk scores are beneficiary-level index values that indicate the expected Medicare costs for an enrollee relative to the national average FFS beneficiary. How well Medicare's payments to MA plans match their enrollees' costliness depends in large part on how well the risk scores predict the expected costs for the plans' enrollees.

Medicare spending varies widely among beneficiaries. Some of this variation is predictable because it depends on beneficiary characteristics that can be observed, such as age, chronic medical conditions, or historical health care use. The rest of the variation is generally not predictable from information that CMS has available because the variation is due to random medical events, such as a heart attack or hip fracture. The demographic characteristics included

in risk adjustment therefore reflect the costs of these unpredictable medical events.

Risk-adjustment models strive to address predictable spending variation; otherwise, MA plans could use beneficiaries' observable characteristics to their advantage through favorable selection—avoiding beneficiaries with certain (unprofitable) attributes and attracting those with favorable (profitable) attributes. The general purpose of risk adjustment is to accurately predict costs not for a particular person but on average for a group of people with the same attributes that affect health care costs (Newhouse et al. 2012). For enrollees who have the same risk score, payments will be below actual costs for some (that is, the risk model will underpredict costs for some) and above actual costs for others (that is, the risk model will overpredict costs for others) but will be accurate on average. This result is a feature of all models that use patients' conditions to predict costs.

CMS calculates risk scores with the CMS hierarchical condition category (CMS–HCC) risk-adjustment model, which uses demographic information (e.g., age, sex, Medicaid enrollment, and disability status) and certain diagnoses grouped into HCCs to calculate a risk score for each enrollee. HCCs are categories of medical conditions or groups of related conditions with similar treatment costs. Each demographic component and HCC in the risk-adjustment model has a coefficient based on the expected spending associated with that characteristic or condition. A risk score is the sum of all coefficients for a beneficiary.

How Medicare calculates MA benchmarks

Each county's benchmark—the maximum base payment rate for the county's MA plans—equals a certain percentage (95 percent, 100 percent, 107.5 percent) of the projected average per capita FFS spending for the county's beneficiaries. The percentage specified for each county is determined by grouping all counties into quartiles based on their FFS spending. In counties where FFS spending is low, benchmarks are set above the county's FFS spending level to help attract plans to the area; in counties where FFS spending is high, benchmarks are set below the county's FFS spending level to generate Medicare savings. Plans with a 4-star rating or higher are awarded quality bonuses that can increase benchmarks by 5 percentage points (or 10 percentage points in some counties) relative to the standard county benchmarks.

Favorable selection results in higher-than-warranted benchmarks and payments for MA plans

Because MA benchmarks are based on risk-standardized county-level FFS spending, CMS relies on enrollee risk scores to help ensure comparability between the MA and FFS populations. The risk score indicates a beneficiary's expected cost relative to the cost of the national average FFS beneficiary (e.g., a beneficiary with a risk score of 1.65 has expected costs that are 65 percent higher than the national average). The accuracy of Medicare's payments to MA plans (how well payments match the cost of covering Medicare services for plan enrollees) depends in large part on how well the risk scores predict the expected costs

for the plans' enrollees, given their demographics and medical conditions. When setting MA benchmarks, CMS assumes that if MA enrollees were in FFS, their average Medicare spending would be equal to that of current FFS enrollees after adjusting for differences in risk scores (prior to the effects of differences in coding practices between MA and FFS).

However, a substantial body of research suggests that risk scores do not fully account for spending differences between the FFS and MA populations because of favorable selection into MA (Brown et al. 2014, Curto et al. 2021, Curto et al. 2019, Goldberg et al. 2017, Government Accountability Office 2021, Jacobs and Kronick 2018, Jacobson et al. 2019, Medicare Payment Advisory Commission 2012, Meyers et al. 2019, Newhouse et al. 2015, Rahman et al. 2015, Riley 2012). (See text box describing the plan and beneficiary incentives that may lead to favorable MA selection, pp. 164–165.) Our analysis examining favorable selection in MA finds that, on average, MA enrollees have lower spending than FFS beneficiaries with the same risk scores—resulting in higher-than-warranted benchmarks and payment rates for MA plans. We found that:

- MA entrants nationally over the period from 2008 to 2020 had lower risk-standardized spending prior to joining an MA plan;

- beneficiaries who subsequently stayed in MA for longer periods of time tended to have lower risk-standardized spending than enrollees who disenrolled earlier; and

- for beneficiaries who remained in MA, the effects of favorable selection—lower risk-standardized spending—persisted for years after they entered MA.

We estimate that favorable selection across all MA enrollees resulted in spending in 2019 that was approximately 11 percent lower than for FFS beneficiaries with the same risk score. These findings raise concerns about the appropriateness of basing MA benchmarks exclusively on FFS spending data. Favorable selection into MA causes risk scores to systemically overpredict spending for MA enrollees. Thus, the average MA enrollee is healthier relative to their risk score and more profitable than the average beneficiary in FFS. This lower-than-predicted spending

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FIGURE
4-3

Illustrative example of estimating the favorable selection percentage for MA entrants in 2016

	Inclusion criteria	2015 FFS spending
MA cohort	2015 FFS enrollment and 2016 MA entry	**$561** per member per month
FFS comparator	Continuous FFS enrollment in 2015 and 2016	**$601** per member per month

$$\text{MA cohort selection percentage in 2016} = \frac{\$561}{\$601} = 93\%$$

Note: FFS (fee-for-service), MA (Medicare Advantage). Both the MA cohort and FFS comparator groups had FFS enrollment in 2014. The analysis excludes beneficiaries without at least two full years of enrollment in FFS Part A and Part B prior to the year of MA entry as well as those who joined an employer plan or non-MA private plan (e.g., cost plan), elected hospice, had end-stage renal disease, had Medicare as a secondary payer, resided in multiple counties during the year, or resided in Puerto Rico (due to the relatively small number of FFS beneficiaries in that territory). Spending for the FFS comparator group reflects the county-level average, adjusted by the geographic and risk score distribution of the MA cohort. The selection percentage reflects the risk-standardized spending below the local FFS average prior to any MA efficiencies or coding differences. The selection percentage reflects 2015 spending and CMS–HCC risk scores.

Source: MedPAC analysis of Medicare enrollment, Medicare claims spending, and risk-adjustment files, 2014–2016.

is evident in the years prior to a beneficiary enrolling in an MA plan, and thus this overprediction by a beneficiary's risk score is not attributable to any plan activity (such as utilization management). Because plan benchmarks rely on risk-standardized FFS Medicare spending estimates, they reflect the higher level of costs associated with the FFS-enrolled population rather than the costs associated with a plan's enrollees. For example, in a county with a benchmark set at 100 percent of FFS spending, favorable selection allows plans to submit bids that are lower than FFS spending without producing any efficiencies in care delivery (that is, before accounting for the added effects of plan benefit design and cost containment efforts). Note that the favorable selection that MA plans experience is separate from the effects of higher MA coding intensity, but the effects of the two phenomena are additive.

The amount of favorable selection that MA plans experience in payment benchmarks can be quantified as a selection percentage, which represents the risk-standardized payments for MA enrollees as a percentage of the local FFS spending average. Some

prior research (Jacobson et al. 2019, Newhouse et al. 2015, Medicare Payment Advisory Commission 2012) estimated the effect of favorable selection in the year prior to MA entry for beneficiaries who switch from FFS to MA; this approach has some advantages because it eliminates the effects of MA plan benefit design, utilization management, and coding differences on spending. Our analysis uses this method for several cohorts of beneficiaries who switched from FFS to MA (see text box describing prior research measuring MA favorable selection, pp. 164–165).

Measuring favorable selection when beneficiaries first enroll in MA

As an initial step to understand favorable selection, we built upon our previous method of analyzing FFS spending in the year prior to MA enrollment by analyzing a much longer period (2006 through 2020). We compared the FFS spending for beneficiaries who had FFS coverage before enrolling in MA with the spending for FFS beneficiaries who did not switch to MA (Figure 4-3). For example, we calculated the ratio of 2015 FFS spending for beneficiaries who switched to

MA plan and beneficiary incentives may produce a favorable selection of enrollees

Even after risk standardization, the beneficiaries who choose to enroll in a Medicare Advantage (MA) plan systemically incur lower costs than those who stay in the fee-for-service (FFS) program (or switch from MA to FFS), implying a correlation between a beneficiary choosing to join an MA plan and having lower risk-standardized spending. When the risk-adjustment model overpredicts spending for MA enrollees on net, this leads to overpayments for MA plans and distorts the comparison of risk-standardized spending of MA and FFS enrollees (Curto et al. 2021).

MA plans have a financial incentive to enroll beneficiaries with actual costs that are below Medicare's payment for that beneficiary, as adjusted by the beneficiary's risk score. This incentive does not result in a strict preference for healthy enrollees but, rather, an incentive to enroll beneficiaries who will incur lower costs than others with a similar risk profile (Brown et al. 2014).[5] Plans can develop offerings designed to attract such enrollees— and discourage the enrollment of beneficiaries with higher expected costs relative to their risk scores—using strategies such as care management restrictions, extra benefits, and favorable cost-sharing arrangements.

Beneficiaries tend to enroll in a plan when the plan's benefit package matches their own self-assessed preferences and needs. Because health needs, appetite for health care service use, and financial priorities vary across the Medicare population, plans that are attractive to some beneficiaries will be unattractive to others. Risk scores account for some, but not all, of the variation in cost for MA beneficiaries (Brown et al. 2014, Jacobson et al. 2019). Likewise, beneficiaries' health needs and financial situations change over time, and beneficiaries may find that a plan that worked well for them in the past no longer meets their needs. A growing literature has found that a disproportionate share of the beneficiaries who leave MA for FFS are chronically ill, costly, or nearing the end of life (Goldberg et al. 2017, Government Accountability Office 2021, Meyers et al. 2019, Rahman et al. 2015, Riley 2012).

Plan networks and care management restrictions

MA plans can influence which beneficiaries enroll in their plan by maintaining narrow provider networks. Narrow networks can potentially lead to higher-quality care by ensuring that only high-quality providers are in the network. However, a more limited network can also contribute to favorable selection by discouraging beneficiaries with certain health conditions from enrolling in MA plans. For instance, MA plan networks typically do not include cancer centers and include only a relatively small share of psychiatrists (Jacobson et al. 2017,

(continued next page)

MA in 2016 to the 2015 FFS spending for beneficiaries who remained in FFS in 2016, and then we converted the result to a percentage that we call the "selection percentage." (When calculating benchmarks, CMS adjusts for geographic distribution of beneficiaries and differences in risk scores. Similarly, we adjusted the spending of beneficiaries who remained in FFS to have the same geographic distribution and risk scores as the beneficiaries who switched to MA.) We calculated an initial selection percentage for each cohort that entered MA in 2008 through 2020.

Study and comparison populations

We included beneficiaries in our study population if they (1) enrolled in MA between 2008 and 2020 and (2) had been enrolled in FFS and had both Part A and Part B coverage for at least two full calendar years prior to enrolling in MA. We required beneficiaries to have at

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Jacobson et al. 2016). A plan's network design can also contribute to favorable selection by including clinicians whose practice patterns and patient populations tend to have lower overall medical spending, or by dropping clinicians whose practice patterns and patient populations have higher overall medical spending.

Plans also use other techniques, like prior authorization or claims denials, to encourage the use of high-value care and discourage the use of low-value services.[6] However, beneficiaries with complex care needs may view these techniques as barriers to obtaining medically necessary care, which lead some enrollees with complex care needs to disenroll (Meyers et al. 2019). In addition, these techniques may influence some skilled nursing facilities to either encourage beneficiary MA disenrollment or even disenroll beneficiaries from MA plans without the beneficiaries' consent (Centers for Medicare & Medicaid Services 2021, Centers for Medicare & Medicaid Services 2015).

Cost sharing

MA plans may be attractive to some beneficiaries because they often have a different cost-sharing structure than FFS Medicare. Although plans require cost sharing for most services, they can use different cost-sharing arrangements to steer beneficiaries to less costly sites of care. Beneficiaries who expect to use more medical services than average may prefer more comprehensive coverage of their cost sharing and therefore remain in FFS and purchase supplemental Medigap insurance to cover their out-of-pocket spending (Direct Research 2014). Plans are required to have an overall limit on out-of-pocket spending and may also offer a variety of extra benefits for no additional premium.

As described above, actual health care spending does not perfectly correlate with the spending predicted by risk scores. For a number of reasons (including personal attitudes toward health care use, provider treatment decisions, and interactions between health conditions), beneficiaries with the same risk scores can have higher or lower actual costs. The typical MA cost-sharing rules, which pair cost sharing for many services with an out-of-pocket maximum, likely attract beneficiaries who are not inclined to use many health services while discouraging beneficiaries who use more services from enrolling. ∎

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least two full calendar years of FFS enrollment because the CMS–HCC risk-adjustment model calculates risk scores using diagnoses from the prior year's claims, so we needed data on MA beneficiaries with two years of prior FFS enrollment to calculate risk scores for their last year of FFS enrollment. In 2019, nearly half of MA entrants (47 percent) met these criteria; for the remaining entrants, 10 percent had between one and two years of prior FFS enrollment, 13 percent had less than one year of prior FFS enrollment, and 31 percent had no prior FFS enrollment (meaning they enrolled directly in MA when they first became eligible for Medicare).[7] We then divided the study population into 13 annual cohorts based on the year they enrolled in MA (2008 through 2020).

We excluded beneficiaries from our study population if they were enrolled in employer-sponsored MA plans. Those plans have different enrollment processes than other MA plans because employers often require all former employees to enroll in the same plan, similar to the commercial group market. Since the beneficiaries in employer-sponsored plans have limited control over their decision to join or leave MA, we assumed no favorable selection for those plans. We tested this assumption by examining spending for beneficiaries who joined employer-sponsored plans in 2019 and found that their average FFS spending in the prior year was nearly the same as the average spending for beneficiaries who stayed in FFS (i.e., there was little to no evidence of favorable selection). We also excluded

An overview of prior research measuring favorable selection in Medicare Advantage

Medicare Advantage (MA) plans benefit from favorable selection of enrollees if their spending on Part A and Part B benefits is, on average, consistently lower than the amount predicted by their enrollees' risk scores. (Conversely, plans would be adversely affected by unfavorable selection if their spending is, on average, consistently higher than the amount predicted by their enrollees' risk scores.) In measuring the effects of favorable selection, it is necessary to control for other important factors that can affect spending on MA enrollees, such as plan benefit designs, cost containment efforts, and diagnostic coding practices.

Measuring the impact of favorable selection in MA is challenging because plans do not submit beneficiary-level spending data, and plans' diagnostic coding practices increase their risk scores relative to fee-for-service (FFS), preventing an apples-to-apples comparison of actual and projected spending amounts for beneficiaries enrolled in MA plans. Some studies have found evidence of favorable selection using indirect measures, such as mortality (Curto et al. 2019, Newhouse et al. 2019) and Part D event data (Jacobs and Kronick 2018). Other studies have examined the risk scores and spending in the year before a sample of beneficiaries switch from FFS to MA (Jacobson et al. 2019, Newhouse et al. 2015). The prior-year spending and risk scores published in one study indicated that the risk-standardized spending of beneficiaries who switched from FFS to MA in 2010 was 13 percent lower than that of beneficiaries who remained in FFS (Newhouse et al. 2015). A more recent study found that risk-standardized spending

was 16 percent lower for beneficiaries in the year before switching to MA in 2016 compared with beneficiaries who stayed in FFS (Jacobson et al. 2019).

In 2012, the Commission also used the method of examining spending in the year before MA entry and found favorable selection both within CMS hierarchical condition categories (CMS–HCCs) and among one year of MA entrants overall (Medicare Payment Advisory Commission 2012). The Commission found MA favorable selection within 68 of 70 CMS–HCCs and found that MA entrants had risk-standardized spending that was 15 percent lower overall than that of beneficiaries who remained in FFS. In addition, the Commission found that MA plans benefited from beneficiaries who switched from MA to FFS. The spending for these beneficiaries was 16 percent higher than for beneficiaries who were continuously enrolled in FFS.

Despite results that suggest favorable selection for MA enrollees, examining spending in the year prior to MA entry has its limitations. In 2012, the Commission noted that using only one year of data on MA enrollees to measure favorable selection captures the effect of selection during the MA enrollment period, including when beneficiaries switch between FFS and MA, but does not provide direct information about the persistence of the effects of favorable selection throughout the duration of MA enrollment. Researchers who used indirect measures of selection (e.g., mortality) have also acknowledged this limitation (Newhouse et al. 2019). ∎

beneficiaries who enrolled in Medicare plans that are not part of the MA program, such as cost plans.

For the comparison population, we used FFS beneficiaries who did not switch to MA. We included any FFS beneficiaries who met our inclusion criteria

for sufficient data and would have been part of CMS's MA benchmark calculation. These beneficiaries had to have both Part A and Part B coverage for at least two full years by the end of the reference year (the study population's last year of FFS enrollment). For both our MA and FFS comparison populations, we required

that beneficiaries live in the same county during the reference year because we used county-level figures in our spending calculations.

We excluded beneficiaries from either population if they had end-stage renal disease (ESRD) or if they had another source of health coverage for which Medicare acted as a secondary payer during the reference year. CMS excludes beneficiaries with ESRD from benchmark calculations and adjusts benchmarks and payments for those with Medicare as a secondary payer to remove the secondary-payer effect. In addition, we excluded beneficiaries who received hospice care during either the reference year or the subsequent year. While beneficiaries who receive hospice care are included in MA benchmarks, their spending can be unusually high and thus can reduce the comparability of the two populations.

Calculation of average FFS spending per capita

We calculated the average FFS spending per capita for the study and comparison populations using beneficiary-level spending to calculate average spending in each county. We then aggregated the county-level figures into an overall national average:

- We divided each beneficiary's actual FFS spending in the reference year by their CMS–HCC risk score for that year to generate their risk-standardized annual spending; we then divided that figure by 12 to produce the beneficiary's average risk-standardized monthly spending amount.

- We then calculated the average risk-standardized monthly spending in each county for the study and comparison populations. We did this by multiplying the beneficiary-level figures by the number of months in the following year that beneficiaries were enrolled in MA (for the study population) or FFS (for the comparison population) and dividing those amounts by the total number of MA or FFS enrollment months in the county. For beneficiaries who had some MA enrollment and some FFS enrollment during the year, we allocated their spending based on the number of months enrolled in each program. When a county's study or comparison population had fewer than 1,000 beneficiaries, we blended its average spending figure with the corresponding figures for neighboring counties, similar to the credibility

adjustment that CMS makes to MA benchmarks to ensure that they are reliable.

- We then calculated a national figure for average risk-standardized monthly spending for the study and comparison populations. We did this by summing the FFS and MA county-level spending figures weighted by the number of MA enrollment months and the average MA risk score for each county and then dividing by the national total of MA enrollment months. This approach ensured that the figure for the comparison population (FFS stayers) had the same geographic distribution and risk scores as the figure for the study population (new MA entrants).

We performed separate calculations for each annual cohort of MA entrants and its corresponding comparison population.

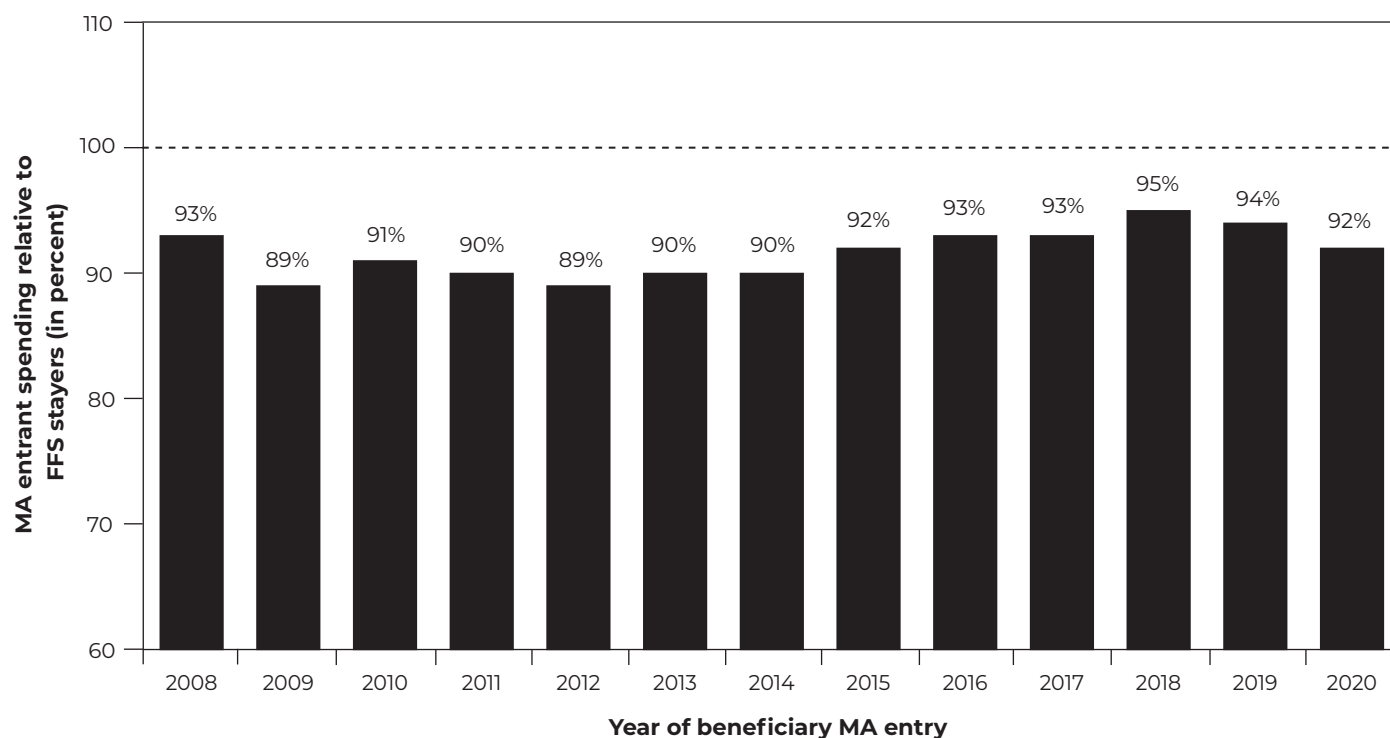**Calculation of effect of favorable selection on benchmarks**

We calculated the effect of favorable selection for each cohort by dividing the national figure for average risk-standardized monthly spending for the study population (new MA entrants) by the corresponding figure for the comparison population (FFS stayers) and converting the result into a percentage, called the selection percentage. There was favorable selection in MA if the selection percentage was less than 100 percent and unfavorable selection if the percentage was more than 100 percent. For example, a figure of 95 percent means that the prior-year FFS spending for new MA entrants was 5 percent less than the prior-year spending for beneficiaries who remained in FFS, even after adjusting for differences in the risk scores and geographic distribution of the two groups.

Beneficiaries enrolling in MA throughout the period between 2008 and 2020 showed evidence of favorable selection at the time of MA entry

We examined the prior-year spending of MA entrants nationally and found evidence of favorable selection among new MA enrollees between 2008 and 2020 (Figure 4-4, p. 168). MA entrants in 2008 had risk-standardized FFS spending in the prior year that was 93 percent of the spending for beneficiaries who stayed in FFS. In 2009, MA entrants had FFS spending in the year before enrollment that was just 89 percent of FFS stayers. The increase in favorable selection between

FIGURE
4–4

Beneficiary FFS spending in the year before MA enrollment shows evidence of favorable selection from 2008 to 2020

MA entrant spending relative to FFS stayers (in percent)

Year	%
2008	93%
2009	89%
2010	91%
2011	90%
2012	89%
2013	90%
2014	90%
2015	92%
2016	93%
2017	93%
2018	95%
2019	94%
2020	92%

Year of beneficiary MA entry

Note: FFS (fee-for-service), MA (Medicare Advantage). "MA entrants" are beneficiaries who switched from FFS to MA. "FFS stayers" are beneficiaries who remained in FFS. Spending reflects the year prior to MA entry and is risk standardized. The analysis excludes beneficiaries without at least two full years of enrollment in FFS Part A and Part B prior to the year of MA entry as well as those who joined an employer plan or non-MA private plan (e.g., cost plan), elected hospice, had end-stage renal disease, had Medicare as a secondary payer, resided in multiple counties during the year, or resided in Puerto Rico (due to the relatively small number of FFS beneficiaries in that territory).

Source: MedPAC analysis of Medicare enrollment, Medicare claims spending, and risk-adjustment files, 2006–2020.
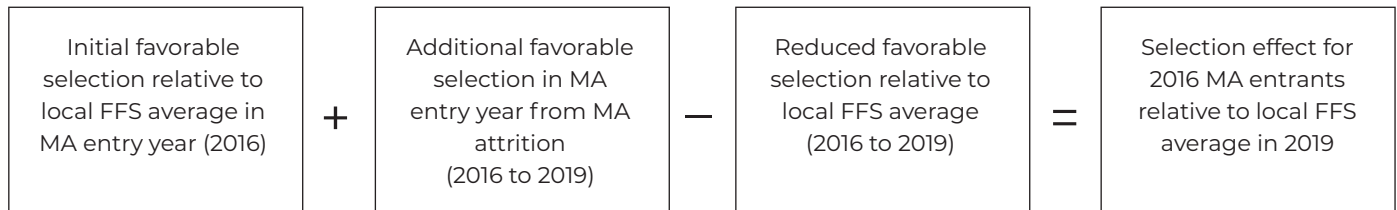
2008 and 2009 coincides with the requirement that private fee-for-service (PFFS) plans—which in 2008 enrolled nearly 40 percent of MA entrants—establish a network if two other network-based plans have enrollees in a county. Prior to this point, PFFS plans were not required to have contracted networks, and thus they likely benefited from relatively little (if any) selection. After the network requirement was implemented, enrollment in PFFS plans declined sharply, while enrollment in HMOs and preferred provider organizations (PPOs) grew.[8] After 2009, favorable selection among MA entrants remained steady for several years but in 2014 began to steadily

decline. (Given the method we used to measure favorable selection, a decline in selection would mean that the selection percentages shown in Figure 4-4 began to rise.) From 2014 through 2018, the favorable selection among MA entrants fell, as shown by the 5 percentage point increase in the selection percentage over this period. Between 2018 and 2020, the favorable selection for all MA entrants rebounded, and 2020 MA entrants had spending in the year before enrollment that was 92 percent of FFS stayers.

The effects of favorable selection among MA entrants were not explained by risk score differences with the comparison population. For example, the prior-year

FIGURE
4-5

Illustration of the components that determine the amount of favorable selection in 2019 for MA entrants in 2016

Initial favorable selection relative to local FFS average in MA entry year (2016)	**+**	Additional favorable selection in MA entry year from MA attrition (2016 to 2019)	**−**	Reduced favorable selection relative to local FFS average (2016 to 2019)	**=**	Selection effect for 2016 MA entrants relative to local FFS average in 2019

Note: MA (Medicare Advantage), FFS (fee-for-service). "Favorable selection" is the percentage of risk-standardized spending below the local FFS average prior to any MA efficiencies or coding. "Attrition of MA" enrollment reflects the beneficiaries who were not continuously enrolled in MA from 2016 through at least the first month of 2019.

Source: MedPAC.

average risk score of 2017 MA entrants was only 2 percent lower than the prior-year average risk score of 2017 FFS stayers (data not shown). We observed similarly small differences in prior-year average risk scores between MA entrants and FFS stayers in 2018, 2019, and 2020, a period during which the effects of favorable selection far exceeded these risk score differences (data not shown).

We found that favorable selection in 2020 was somewhat correlated with county-level MA penetration (i.e., a county's share of beneficiaries enrolled in MA).[9] While favorable selection among new MA entrants persisted in areas with high MA penetration, the largest effects of favorable selection among new entrants tended to be in areas where MA had a smaller share of the market (data not shown). Thus, the effects of favorable selection among new MA entrants could decrease as the share of FFS beneficiaries becomes smaller.

Estimating the overall effect of favorable MA selection

While the conventional approach of examining FFS spending prior to MA entry provides clear evidence of favorable selection when beneficiaries first enroll in MA, it does not provide an estimate of the overall impact of favorable selection on the FFS spending estimates used for MA benchmarks in any given year. The conventional approach is limited because it does

not account for subsequent changes that can either increase or reduce favorable selection. Figure 4-5 shows how the estimate of favorable selection for the 2016 cohort of MA entrants could change between 2016 and 2019.

The effect of favorable selection for a cohort of MA enrollees is affected by both attrition out of MA over time and the convergence of risk-standardized spending for the beneficiaries who remain in the MA cohort toward the annual average risk-standardized spending for all FFS beneficiaries that is used for benchmarks. Estimates of the overall effects of favorable selection need to account for both factors.

- After the initial year of MA entry, some enrollees will either return to FFS or die. Because beneficiaries who leave MA or die are likely to have high utilization of services in that year, the attrition in MA enrollment likely increases favorable selection for MA plans. Thus, the selection percentage that we calculated for the initial year of MA entry (shown in Figure 4-4) must be adjusted to reflect the population that is still enrolled in MA in later years.

- While a cohort of MA enrollees may have favorable risk-adjusted spending relative to the local FFS population when they first enter MA, the effect of favorable selection may become smaller in

later years. This concept is often referred to as "regression to the mean," but previous studies have largely assumed it occurs rather than measured it directly.[10] Regression to the mean presupposes that the effects of favorable selection will decline over a period of time because the growth in spending for MA enrollees will exceed their growth in risk scores during their enrollment (independent from the effects of coding differences and any plan interventions). To the extent that risk scores of MA entrants grow at the same rate as their spending, the effect of favorable selection of MA entrants will not decline (i.e., there will be no regression to the mean).

These two factors work in opposite directions: Attrition due to beneficiaries leaving MA or dying tends to increase favorable selection, while regression to the mean tends to reduce favorable selection. On net, however, the effects of favorable selection may remain roughly constant, or even increase over time for a given cohort of MA entrants.

We built upon our previous method of analyzing FFS spending in the year prior to MA enrollment by estimating the overall effect of favorable selection on MA benchmarks in 2019. To accomplish this, we largely aligned our approach for estimating favorable selection with CMS's method for calculating FFS spending for purposes of constructing MA benchmarks, which are based on risk-standardized county-level averages of FFS spending.

Our approach for measuring overall favorable selection accounts for both the subsequent attrition of MA enrollees and the tendency of spending for the remaining MA enrollees to converge toward the local FFS average.

- First, we accounted for beneficiaries who either died or switched back to FFS by calculating the selection percentages for each MA entry cohort who were continuously enrolled in MA through 2019. For example, we compared the 2015 FFS spending of beneficiaries who switched to MA in 2016 and remained in MA through 2019 with the 2015 FFS spending of beneficiaries who remained in FFS in 2016.

- Second, we estimated the change in the selection percentage during MA enrollment by using

the spending history of a proxy cohort of FFS beneficiaries who entered MA in 2020. For example, we compared the 2015 FFS spending of beneficiaries who were in FFS from 2014 through 2019 and enrolled in MA in 2020 with the 2015 FFS spending of all other beneficiaries who were in FFS from 2014 through 2015 (and did not enter MA in 2016). For the same set of beneficiaries who were in FFS from 2014 through 2019 and enrolled in MA in 2020, we compared their FFS spending in 2019 with that of beneficiaries who were in FFS from 2018 through 2019 (and did not enter MA in 2020). The change in relative FFS spending from 2009 to 2019 was used to estimate the change in the selection percentage during the 2016 to 2019 period. We add this change in selection percentage to the initial selection percentage estimated for 2016 MA entrants who were continuously in MA.

Favorable selection in MA is reinforced by lower-spending enrollees remaining in MA longer and higher-spending enrollees leaving MA

An examination of favorable selection solely among MA entrants is limited because it does not account for differences between the beneficiaries who subsequently leave MA (either through FFS enrollment or death) and those who remain enrolled. The initial selection percentage of a cohort of MA entrants in Figure 4-4 (p. 168) cannot be used to estimate the amount of favorable selection in a future year. For example, the MA entry cohort in 2016 may have changed substantially by 2019. Thus, the initial favorable selection for 2016 MA entrants (i.e., the selection percentage "starting point") would have to be recalculated using only the MA entrants who were continuously in MA through 2019.

While some MA enrollees die while being continuously enrolled in MA, a notable share disenroll from MA and enroll (or reenroll) in FFS. Studies following the same cohort of beneficiaries over several years show that over time, a larger share of beneficiaries switch from MA to FFS than would be apparent from a one-year snapshot of switching across all cohorts (Dong et al. 2022, Meyers and Trivedi 2022, Newhouse et al. 2019). One study examined the rate of switching for beneficiaries who were newly eligible for Medicare in 2008 and elected MA in that year; after five years, 19 percent of enrollees had switched to FFS at some

point during the period, and the switching rate was somewhat higher (23 percent) among enrollees who initially switched from FFS to MA (Newhouse et al. 2019). Another study followed all MA entrants who had switched from FFS during the 2011 through 2019 period; this study similarly found that 23 percent of these beneficiaries switched back to FFS at some point within five years of MA enrollment (Meyers and Trivedi 2022). We identified all beneficiaries who entered MA in 2010 and followed their enrollment for a nine-year period. By 2019, 51 percent of MA entrants in 2010 remained continuously enrolled in MA, 31 percent switched to FFS at some point between 2011 and 2019, and an additional 18 percent died while enrolled in MA (data not shown).

Studies have shown that beneficiaries with full Medicaid benefits or who have nursing home use or high costs in their final year of life are disproportionately more likely to leave MA (Goldberg et al. 2017, Government Accountability Office 2021, Medicare Payment Advisory Commission 2018, Meyers et al. 2019, Rahman et al. 2015). Thus, we should expect the effects of favorable selection to increase at least somewhat when beneficiaries either leave MA for FFS or die (and thus are no longer compared with the local FFS average for benchmark purposes). If the beneficiaries who leave an MA cohort have higher risk-standardized spending, over time, it could reinforce the effects of favorable selection and may even exacerbate those effects for several years after the cohort initially joined an MA plan.

We accounted for the effects of attrition by identifying the subset of beneficiaries in each cohort who remained in MA for a specific period of time. For example, in the 2016 cohort of MA entrants, we identified the beneficiaries who were still enrolled in MA at the beginning of 2017, at the beginning of 2018, and at the beginning of 2019. Thus, a beneficiary in that cohort who switched to FFS or died before 2019 would be excluded from the subset that was still enrolled in MA in 2019. We then recalculated the initial selection percentage for each subset of beneficiaries. Because favorable selection in MA benchmarks would always be relative to the local FFS average, we used a 2016 FFS comparison group in our recalculations.
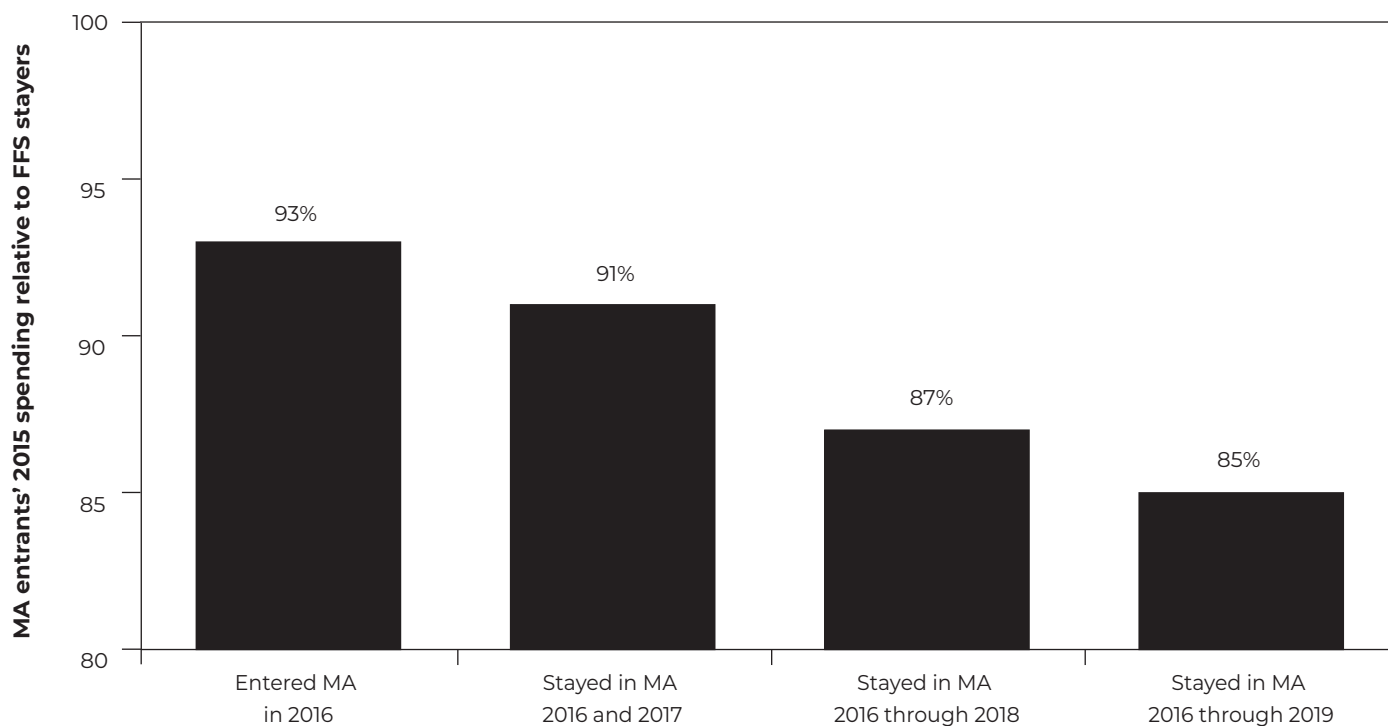
We found that beneficiaries who remained in MA for longer periods of time had lower risk-standardized

FFS spending prior to their enrollment in MA than the beneficiaries who left MA (Figure 4-6, p. 172). We analyzed sub-cohorts of the 2016 MA entry cohort based on the duration of their MA enrollment. While the overall cohort of 2016 MA entrants had prior-year FFS spending that equaled 93 percent of the 2015 FFS average, the sub-cohort of 2016 MA entrants who remained in MA through 2019 had prior-year FFS spending that equaled 85 percent of the 2015 FFS average, while beneficiaries who left MA between 2016 and 2019 (and either returned to FFS or died) were substantially unfavorable to MA plans in 2015. These MA "leavers" had prior-year FFS spending that equaled 121 percent of the 2015 FFS average (data not shown). These analyses suggest that favorable selection for MA plans increases over time, as favorable (lower-spending) beneficiaries tend to remain in MA while relatively unfavorable (higher-spending) beneficiaries tend to leave MA. This phenomenon effectively redefines the selection percentage "starting point" for an MA entrant cohort in future years.

Across all cohorts, more favorable MA enrollees remained in MA longer Similar to the analysis shown in Figure 4-6 (p. 172), we examined the effects of favorable selection within each cohort of MA entrants by examining the subset of enrollees who were still in MA in 2019. Across all cohorts, we found that MA entrants who remained enrolled in MA for longer periods tended to be beneficiaries who had lower risk-standardized spending in the year prior to joining MA (Figure 4-7, p. 173), well below the levels observed for all MA entrants shown in Figure 4-4 (p. 168). These higher levels of favorable selection among enrollees who remain in MA for longer periods are likely influenced by MA enrollees with high risk-standardized spending either leaving MA or dying during this period—those enrollees had average spending either near or above the FFS local average in the year prior to joining an MA plan (data not shown). Nearly all enrollees in the 2017 and 2018 MA entrant cohorts were still in MA in 2019, which means that the effects of favorable selection for the sub-cohorts of enrollees who remained through 2019 are similar to the estimates for the overall cohort. For the cohorts of MA entrants in 2008 through 2016, the share of enrollees who left MA prior to 2019 is larger, as are the differences in the favorable selection effect between all MA entrants in a cohort and the subset who stayed in MA through 2019. The differences in

FIGURE
4-6

2016 MA entrants who remained in MA through 2019 had lower pre-enrollment spending than 2016 MA entrants who left MA or died

Note: MA (Medicare Advantage), FFS (fee-for-service). "MA entrants" are beneficiaries who switched from FFS to MA. "FFS stayers" are beneficiaries who remained in FFS. MA entrants who stayed in MA through 2019 are those with at least one month of MA enrollment in 2019. Spending reflects the year prior to MA entry and is risk standardized. This criterion excludes beneficiaries without at least two full years of enrollment in FFS Part A and Part B prior to the year of MA entry as well as those who joined an employer plan or non-MA private plan (e.g., cost plan), elected hospice, had end-stage renal disease, had Medicare as a secondary payer, resided in multiple counties during the year, or resided in Puerto Rico (due to the relatively small number of FFS beneficiaries in that territory).

Source: MedPAC analysis of Medicare enrollment, Medicare claims spending, and risk-adjustment files, 2014–2019.

the favorable selection effect at the time of MA entry is most striking for beneficiaries who entered MA between 2008 and 2012.

A separate question is whether the effects of favorable selection observed at the time of MA entry were evident for several years before the initial year of MA entry (i.e., is there evidence of lower risk-standardized spending among MA entrants in the years prior to joining MA?). We examined the FFS spending of beneficiaries who had at least five consecutive years in FFS prior to joining MA and who were still in an MA plan through at least one month in 2019. We found that

the longer beneficiaries were in MA, the more likely they were to maintain the same selection percentage across all years prior to joining MA (data not shown).

Approximating changes in favorable selection for beneficiaries who remain enrolled in MA

One limitation of the conventional approach of measuring favorable selection based on prior FFS spending is that it focuses on selection at the time of MA entry. This initial favorable selection effect may change while beneficiaries are enrolled in MA, but we cannot directly measure those changes due to the lack of beneficiary-level spending data for MA

**FIGURE
4–7**

Beneficiary spending in the year before MA enrollment shows evidence of much greater favorable selection for enrollees who stayed in MA through 2019
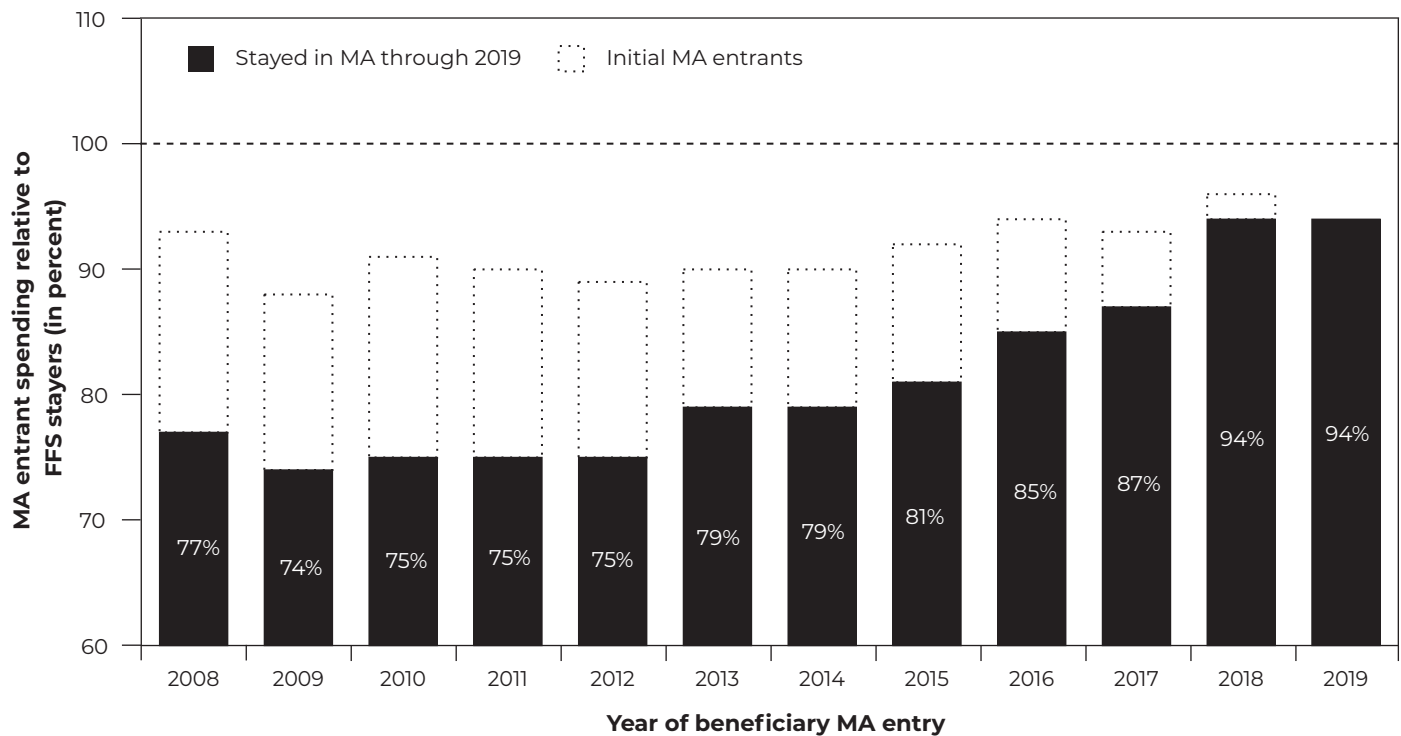
Note: MA (Medicare Advantage), FFS (fee-for-service). "MA entrants" are beneficiaries who switched from FFS to MA. MA entrants who stayed in MA through 2019 are those with at least one month of MA enrollment in 2019. Beneficiaries who left MA after the entry year either returned to FFS or died during the period. Spending reflects the year prior to MA entry and is risk adjusted. The analysis excludes beneficiaries without at least two full years of enrollment in FFS Part A and Part B prior to the year of MA entry as well as those who joined an employer plan or non-MA private plan (e.g., cost plan), elected hospice, had end-stage renal disease, had Medicare as a secondary payer, resided in multiple counties during the year, or resided in Puerto Rico (due to the relatively small number of FFS beneficiaries in that territory).

Source: MedPAC analysis of Medicare enrollment, Medicare claims spending, and risk-adjustment files, 2006–2020.

enrollees. Even if that data were available, the analysis would be limited because MA enrollee risk scores would be affected by plans' benefit design, utilization management, and diagnostic coding practices. Prior research implies that the effects of favorable selection will "regress to the mean" such that favorable selection essentially fades away; however, the "regression to the mean" assumption has never been tested.

We therefore approximated the change in favorable selection effect for the 2008–2019 cohorts of MA entrants *while they were enrolled in MA* by looking at the experience of a proxy group of beneficiaries who

were in the 2020 cohort of MA entrants but had FFS coverage for many years before that. Simply put, we calculated the change in the selection percentage for those beneficiaries during those prior years of FFS enrollment and assumed that the selection percentage for beneficiaries who were in MA during the same period changed by the same amount. This approach evaluates the degree of "regression to the mean" for enrollees in MA by using a proxy population that likely had similar coverage preferences as other MA cohorts and for which we have complete spending data. Although we cannot directly measure the effects

of favorable selection during MA enrollment, using this proxy population has several advantages:

- It prevents MA plan efficiencies and coding from influencing our estimate of favorable selection.

- It reflects the observation that MA entrants have favorable risk-adjusted spending in the years prior to joining an MA plan, as shown in Figure 4-4 (p. 168).

- It measures the actual change in favorable selection for the proxy group of future MA entrants who had favorable risk-standardized spending prior to MA entry.

- It measures the relative change in selection percentage over the same period of time that the cohort of earlier MA entrants remained in MA.

- It reflects the same FFS spending, risk score, and MA entrant eligibility criteria for both the proxy group of future MA entrants and the actual cohort of earlier MA entrants; these criteria are applied to both the MA entry year and the measurement year (2019).

- Because the change in favorable selection percentage is indexed to a change in selection percentage and risk scores account for differences in demographic characteristics (e.g., age, sex, Medicaid eligibility), it serves as a reasonable proxy for the change in favorable selection for each additional year of MA enrollment.

- It uses a proxy group of future MA entrants who, when faced with similar incentives for choosing to enroll in MA or FFS, ultimately selected an MA plan—indicating that they likely had preferences that were similar to the beneficiaries in the earlier MA entry cohorts. (See text box describing the plan and beneficiary incentives that may lead to favorable MA selection, pp. 164–165.)

Figure 4-8 illustrates how we approximated the change in selection percentage for the 2016 cohort of MA entrants:

- We identified a proxy group of beneficiaries in the 2020 cohort of MA entrants who had both Part A and Part B and were enrolled in FFS from 2014 to 2019. As a result, this subset met the same criteria

as the 2016 cohort of MA entrants, except they remained in FFS through 2019.

- We estimated the selection percentage for this subset of 2020 MA entrants in 2016 (using spending in 2015—the reference year for the 2016 cohort of MA entrants) and 2019 (90 percent and 95 percent, respectively).

- We calculated the change in selection percentage for this subset of 2020 MA entrants over the period from 2016 through 2019 (+4%). If the selection percentage increased, the effect of favorable selection decreased during the period; if the selection percentage decreased, the reverse was true.

- We then estimated the effect of favorable selection in 2019 for the 2016 cohort of MA entrants who remained in MA through 2019 by adding the initial selection percentage for the cohort (85%) to the change in the selection percentage from 2016 to 2019 that we calculated for the subset (i.e., proxy group) of 2020 MA entrants (+4%).

We repeated the steps above for each of the 2008–2018 cohorts of MA entrants. The subsets of beneficiaries from the 2020 cohort of MA entrants that we used to calculate the change in the selection percentage were not mutually exclusive. For example, a beneficiary in the 2020 cohort of MA entrants who was in FFS from 2010 to 2019 would be in the subsets of beneficiaries that we used to estimate the change in favorable selection for both the 2012 and 2018 cohorts of MA entrants.

After we calculated the initial selection percentages for the 2008–2019 cohorts of MA entrants and then trended those figures forward to 2019 using the methodology illustrated in Figure 4-8, we estimated the overall effect of favorable selection in MA in 2019 by calculating the enrollment-weighted average of the trended selection percentages for each cohort. In our calculation, we assumed that the effect of favorable selection for MA enrollees who joined prior to 2008 (which we did not estimate) was the same as the amount for the 2008 cohort. When we calculated the enrollment weights for each cohort, we excluded any beneficiaries who had at least one month during which they had end-stage renal disease or Medicare acted as a secondary payer. We also assumed that there was no favorable selection for enrollees in employer-sponsored MA plans, who represented about 21 percent of MA enrollment in 2019.

FIGURE
4-8

Illustrative example estimating cumulative favorable selection in 2019 for the 2016 cohort of MA entrants

Step 1: For the 2016 cohort in MA through 2019, estimate initial selection percentage in the MA entry year.

| MA cohort selection percentage in 2016 | = | $\dfrac{\$462}{\$545}$ | = | 85% |

Step 2: Using the historical FFS spending of 2020 MA entrants as a proxy, estimate the change in selection percentage from 2016 to 2019.

	Inclusion criteria	T_1 (2015) FFS spending	T_2 (2019) FFS spending
Proxy cohort	2015–2019 FFS enrollment and 2020 MA entry	$518	$744
T_1 comparator	2015–2016 FFS enrollment	$573	—
T_2 comparator	2019–2020 FFS enrollment	—	$786

| Proxy selection percentage in T_1 | = | $\dfrac{\$518}{\$573}$ | = | 90% |

| Proxy selection percentage in T_2 | = | $\dfrac{\$744}{\$786}$ | = | 95% |

△ = T_2 selection percentage – T_1 selection percentage = +4% (rounded difference)

Step 3: Estimate cumulative favorable selection in 2019 for the 2016 MA cohort.

| Step 1 result 2016 initial selection percentage (85%) | + | Step 2 result 2016–2019 change in selection percentage for 2020 proxy cohort (+4%) | = | Estimated 2019 selection percentage for 2016 cohort (89%) |

Note: FFS (fee-for-service), MA (Medicare Advantage), T_1 (time period 1 = 2015), T_2 (time period 2 = 2019). Analyses exclude beneficiaries without at least two full years of enrollment in FFS Part A and Part B prior to the years of MA entry (2016 and 2020) as well as those who joined an employer plan or non-MA private plan (e.g., cost plan), elected hospice, had end-stage renal disease, had Medicare as a secondary payer, resided in multiple counties during the year, or resided in Puerto Rico (due to the relatively small number of FFS beneficiaries in that territory). The 2020 MA entrants (proxy cohort) are mutually exclusive from the comparator groups of FFS enrollees. Comparator spending reflects the county-level average, adjusted by the geographic and risk score distribution of the MA cohort in step 1 and the proxy cohort in step 2. The selection percentage reflects the risk-standardized spending below the local FFS average prior to any MA efficiencies or coding differences. Totals and differences may not sum due to rounding.

Source: MedPAC analysis of Medicare enrollment, Medicare claims spending, and risk-adjustment files, 2014–2020.

TABLE
4–1

For 2020 MA entrants, the effects of favorable selection were persistent across all prior years of FFS enrollment

MA 2020 entrants' historical spending relative to:	(Consecutive years of prior FFS enrollment) Initial spending year											
	(13+) 2008	(12+) 2009	(11+) 2010	(10+) 2011	(9+) 2012	(8+) 2013	(7+) 2014	(6+) 2015	(5+) 2016	(4+) 2017	(3+) 2018	(2+) 2019
FFS stayers in the initial spending year	88%	89%	89%	89%	88%	91%	90%	91%	90%	90%	92%	94%
FFS stayers in 2019	95%	95%	94%	94%	94%	95%	95%	94%	95%	95%	95%	94%
Change in selection percentage	+6%	+6%	+5%	+5%	+6%	+4%	+5%	+3%	+4%	+4%	+3%	0%
Average risk score in 2019	1.25	1.24	1.22	1.21	1.19	1.17	1.15	1.14	1.10	1.08	1.06	0.99

Note: MA (Medicare Advantage), FFS (fee-for-service). "MA entrants" are beneficiaries who switched from FFS to MA. "FFS stayers" are beneficiaries who remained in FFS. Spending is risk standardized. The analysis excludes beneficiaries without at least two full years of enrollment in FFS Part A and Part B prior to the year of MA entry as well as those who joined an employer plan or non-MA private plan (e.g., cost plan), elected hospice, had end-stage renal disease, had Medicare as a secondary payer, resided in multiple counties during the year, or resided in Puerto Rico (due to the relatively small number of FFS beneficiaries in that territory). CMS hierarchical condition category risk scores are normalized to 1.0. Differences may not sum due to rounding.

Source: MedPAC analysis of Medicare enrollment, Medicare claims spending, and risk-adjustment files, 2006–2020.

Effects of favorable selection likely persist throughout the duration of MA enrollment The extent to which favorable selection for 2019 MA enrollees persists depends largely on how much the selection percentage changes after MA enrollment.[11] For 2020 MA entrants, we examined several prior years of their FFS spending to assess whether lower risk-standardized spending is persistent over time. If lower risk-standardized spending is persistent, then favorable selection among MA enrollees is likely to be found across all years of their MA enrollment.

We analyzed cohorts of 2020 MA entrants based on the number of consecutive years of FFS enrollment prior to joining MA and compared them with FFS beneficiaries who remained in FFS. Across all cohorts, 2020 MA entrants systemically exhibited favorable risk-standardized spending in the years prior to joining MA (Table 4-1). These results indicate that MA entrants not only show evidence of favorable selection in the year

prior to joining MA, they have a history of lower risk-standardized spending several years before entering MA. Cohorts with more consecutive years in FFS before joining MA in 2020 had lower initial risk-standardized spending relative to FFS stayers than cohorts with fewer years of prior FFS enrollment. All cohorts had similar risk-standardized spending (94 percent or 95 percent of spending for FFS stayers) in the year prior to joining MA, including cohorts with several consecutive years of FFS enrollment and relatively high risk scores (e.g., 2020 MA entrants with 13 years of prior FFS enrollment who had an average risk score of 1.25). Hence the change in risk-standardized spending relative to FFS stayers between the initial year and 2019 was generally correlated with the number of consecutive years in FFS. For example, the 2020 MA entrants with 13 years of prior FFS enrollment had a 6 percentage point increase in risk-standardized spending relative to FFS stayers, and entrants with 3 years of prior MA enrollment had

| | (Consecutive years in MA) MA entrant year | | | | | | | | | | | |
MA entrant	**(12+)** **2008**	**(11)** **2009**	**(10)** **2010**	**(9)** **2011**	**(8)** **2012**	**(7)** **2013**	**(6)** **2014**	**(5)** **2015**	**(4)** **2016**	**(3)** **2017**	**(2)** **2018**	**(1)** **2019**
Spending relative to FFS stayers	77%	74%	75%	75%	75%	79%	79%	81%	85%	87%	94%	94%
Approximate change in selection percentage while in MA	+6%	+6%	+5%	+5%	+6%	+4%	+5%	+3%	+4%	+4%	+3%	0%
Selection percentage trended forward to 2019	83%	80%	80%	80%	81%	83%	84%	84%	89%	91%	97%	94%
Overall nonemployer plan spending relative to 2019 average (enrollment weighted)												86%
Overall MA plan spending relative to 2019 average (enrollment weighted)												89%

Note: MA (Medicare Advantage), FFS (fee-for-service). "MA entrants" are beneficiaries who switched from FFS to MA. "FFS stayers" are beneficiaries who remained in FFS. MA entrants who stayed in MA through 2019 are those with at least one month of MA enrollment in 2019. Spending reflects the year prior to MA entry and is risk adjusted. The analysis excludes beneficiaries without at least two full years of enrollment in FFS Part A and Part B prior to the year of MA entry as well as those who joined an employer plan or non-MA private plan (e.g., cost plan), elected hospice, had end-stage renal disease, had Medicare as a secondary payer, resided in multiple counties during the year, or resided in Puerto Rico (due to the relatively small number of FFS beneficiaries in that territory). The approximate change in relative risk-standardized spending is based on the historical experience of beneficiaries with continuous years of FFS enrollment before entering MA in 2020. This historical experience is used to trend forward the selection percentage of each MA entry cohort. The MA plan total includes employer plans and assumes that enrollment in those plans did not reflect any favorable selection. Estimates for 2008 are used for enrollees who entered MA prior to 2008. Totals may not sum due to rounding.

Source: MedPAC analysis of Medicare enrollment, Medicare claims spending, and risk-adjustment files, 2006–2020.

an increase of 3 percentage points (Table 4-1). These analyses show that the effects of favorable selection persist in the absence of any intervention from MA plans.

In 2019, favorable selection led to MA enrollees having 11 percent lower spending than FFS beneficiaries

To estimate the overall impact of favorable selection on spending for MA enrollees in 2019, we combined our estimates of favorable selection in the year prior to joining MA with estimates of the change in the level of favorable selection over time. Figure 4-7 (p. 173)

shows the estimates of risk-standardized spending relative to risk-standardized spending for FFS stayers in the year prior to joining MA for the 12 MA entry cohorts (2008 through 2019). These cohorts were continuously enrolled in MA through 2019. We trended these estimates of favorable selection using the cohorts of 2020 MA entrants' change in risk-standardized spending relative to FFS stayers in Table 4-1. We matched initial favorable selection estimates by MA entry year cohort with the cohort of 2020 MA entrants based on years of consecutive FFS enrollment (Table 4-2). This matching uses the change in risk-adjusted FFS spending for 2020 MA entrants relative to FFS

Sensitivity analyses to address unobservable data and outliers

Our approach assumed that the effect of favorable selection for the Medicare Advantage (MA) entrants who were not in our study population—those with less than two full calendar years of prior fee-for-service (FFS) coverage—was the same as for the MA entrants who were in our study population. In our view, this assumption is conservative (i.e., it understates the degree of favorable selection effect for MA plans in payment benchmarks), for three reasons:

- We contend that MA entrants with less than two years of prior FFS coverage have *lower* risk-standardized spending, on average, than the beneficiaries in the study population. As a sensitivity analysis, we examined beneficiaries who joined MA in 2019 and had between one and two years of prior FFS enrollment (and thus had a full year of FFS spending in 2018). These beneficiaries did not have 2018 risk scores that included diagnostic information, so we instead calculated their risk-standardized spending in 2018 using their 2019 risk scores, which reflect diagnoses from 2018 and demographic information from 2019. We found that the effect of favorable selection was substantially greater for these beneficiaries than those who had at least two years of FFS enrollment before joining MA in 2019.[12] This finding is consistent with a study that used mortality as a proxy for MA favorable selection and found substantially more favorable selection among enrollees who elected MA during their first year of Medicare eligibility—differences that somewhat diminished but persisted after five years without considering the length of MA

enrollment (Newhouse et al. 2019). These results suggest that the effect of favorable selection for MA entrants who had less than one year of prior FFS coverage, or none at all, may also be larger than what we observed in our study population.

- We contend that FFS stayers with less than two years of prior FFS coverage have higher risk-standardized spending, on average, than the beneficiaries in the comparison population. As a sensitivity analysis, we examined beneficiaries who had between one and two years of FFS coverage at the end of 2018 (and thus had a full year of FFS spending in 2018). We calculated their risk-standardized spending in 2018 using their 2019 risk scores—similar to the sensitivity analysis described above—and found that the average per capita spending was 7 percent higher for beneficiaries with only one full year of Medicare eligibility and FFS enrollment. This difference in risk-standardized spending occurred despite an average risk score that was 33 percent lower for FFS beneficiaries with only one full year of Medicare Part A and Part B coverage (indicating that their risk scores substantially underpredicted their actual costs). We used the same approach to analyze the spending of beneficiaries who were in FFS in 2018 but had been in MA in 2017 and found that those beneficiaries had average spending per capita that was 19 percent higher than our FFS comparison population.

- We contend that including beneficiaries who died (i.e., decedents) in 2019 would not markedly change our overall results and may slightly increase the effect of favorable selection. As a

(continued next page)

stayers as a proxy for the change in favorable selection for MA enrollees that would have occurred during their MA enrollment.

By taking the enrollment-weighted sum across all cohorts, we estimate that beneficiaries in nonemployer

MA plans have spending that is approximately 14 percent lower than the spending of beneficiaries in FFS with the same risk scores (i.e., their risk-standardized spending was 86 percent of the FFS stayer comparison population). In addition, our sensitivity analyses of the population which did not meet our inclusion criteria

sensitivity analysis, we compared the share of beneficiaries who died in FFS and MA in 2019.[13] We found that the share of beneficiaries who died in FFS (3.8 percent) was slightly higher than in MA (3.2 percent). Thus, to the extent that beneficiaries who died have higher risk-standardized spending, including decedents in our analysis would have added a greater share of beneficiaries with high risk-standardized spending to the FFS comparator population than to the MA population—potentially increasing the effect of favorable selection in MA. In addition, research shows that high-spending beneficiaries disproportionately disenroll from MA plans back to FFS (especially during the last year of life) (Goldberg et al. 2017, Government Accountability Office 2021, Medicare Payment Advisory Commission 2018, Meyers et al. 2019, Rahman et al. 2015), which suggests that it is unlikely that MA decedents have higher risk-standardized spending than FFS decedents. We examined switching from 2018 to 2019 among decedents, and we found that decedents in MA had twice the rate of switching to FFS (6.2 percent) compared with FFS decedents who switched to MA (3.1 percent).[14] Our sensitivity analyses on beneficiaries who died in 2019 suggest that including these beneficiaries in our analysis would not have had a marked impact on our overall results, but could have slightly increased our estimate of favorable selection in MA.

Further, we tested whether the change in favorable selection that was due to the length of MA enrollment (i.e., MA enrollment attrition) was driven exclusively by beneficiaries who died. We compared the cohort of 2016 MA entrants who stayed in MA through 2019 with FFS beneficiaries who remained

in FFS from 2016 through 2019 and found an increase in the initial effect of favorable selection (a selection percentage of 88 percent compared with 93 percent for the original 2016 cohort of MA entrants). This pattern persisted when comparing the subset of enrollees who remained in MA from 2010 through 2019 with a cohort of beneficiaries who remained in FFS from 2010 through 2019 (a selection percentage of 83 percent compared with 91 percent for the original 2010 cohort of MA entrants).[15] These results indicate that the effect of length of MA enrollment on favorable selection was not driven exclusively by the exclusion of decedents from our analysis.

Moreover, we further tested our results for outliers by excluding long-term institutionalized (LTI) residents from both the reference year and the subsequent year. We found that the effect of favorable selection during the MA entry year was generally similar (no more than 2 percentage points higher in a given year; data not shown). When examining the non-LTI population of 2020 MA entrants, we found almost no change in risk-standardized spending during their prior years of FFS enrollment relative to non-LTI FFS stayers. For example, the 2020 non-LTI MA entrants with at least 13 consecutive years in FFS had a selection percentage that went from 89 percent to 90 percent during the 2008 to 2019 period. These results provide further evidence that the subsets of the FFS population who eventually join MA persistently have lower risk-standardized spending than beneficiaries remaining in FFS (even in the absence of any intervention from MA plans)—particularly for beneficiaries who are relatively healthy and reside in their community rather than in an institution. ∎

(i.e., two prior years of FFS spending) indicate that including this population would not decrease our estimate of favorable selection. (See text box on our sensitivity analysis of unobservable data and outliers.) After including enrollees in employer plans, whose spending we assume does not reflect any favorable

selection because of the enrollment process of employer plans, we estimate that beneficiaries in MA plans have spending that is approximately 11 percent lower than the spending of beneficiaries in FFS with the same risk scores (i.e., their risk-standardized spending was 89 percent of the FFS stayer comparison

population). Thus, because beneficiary risk scores do not fully account for the differences between the FFS and MA populations, we estimate that MA benchmarks in 2019 were inflated by approximately 11 percent due to favorable selection alone.

Implications of substantial favorable selection in MA

Prior research has shown evidence of favorable selection in MA. Despite differences in analytic method and years evaluated, our analysis finds a generally similar magnitude of impact as in prior studies. However, our analysis provides new evidence that favorable selection in MA is likely to persist rather than fade to zero or "regress to the mean," as has been posited by other researchers. First, our analysis of the prior FFS spending for 2020 MA entrants shows that lower risk-standardized spending is persistent over time in the years prior to MA entry. Although the effects of favorable selection are reduced over time, the rate of decline is slow, such that at the time of joining MA, beneficiaries still have lower risk-standardized spending than beneficiaries remaining in FFS. Second, enrollees who remain in MA longer have lower risk-standardized spending at the time of MA entry compared with those who leave MA. Enrollees who have more unfavorable (or less favorable) spending at the time of MA entry are likely to leave MA sooner, thereby bolstering the effects of favorable selection among remaining MA enrollees relative to FFS enrollees who never joined MA or previously left MA. Third, our analysis studied spending patterns over a much longer time period than other studies and found consistent evidence of favorable selection among MA entrants and consistent evidence that this effect was bolstered by MA leavers over the 12-year period of analysis. Given these consistent results, we conclude that the impact of favorable selection on MA spending relative to FFS is unlikely to change meaningfully in future years.

Finally, favorable selection among MA enrollees has implications for comparisons of MA to FFS spending. The Commission recently estimated that MA payments in 2023 will be 6 percent higher than FFS spending, primarily due to higher diagnostic coding intensity relative to coding in FFS (Medicare Payment Advisory Commission 2023). That estimate of MA overpayments would be substantially higher if we had accounted for favorable selection into MA. As we noted in our March

2023 report to the Congress, these overpayments to plans are financed by taxpayers and by all Medicare beneficiaries (including those in FFS) who help fund the MA program through Part B premiums. Our findings here underscore the need for a major overhaul of MA policies. Over the past few years, the Commission has made several recommendations to improve the program, including calling for the Congress to establish more equitable MA payment benchmarks. However, the level of favorable selection among MA enrollees reported here should raise concerns about the appropriateness of continuing to base MA benchmarks exclusively on Medicare FFS spending data. Alternative options for setting MA benchmarks should take into account the extent to which those options address favorable selection.

Declining FFS enrollment potentially compromises the accuracy of MA benchmarks

One benefit of the current MA payment system is that benchmarks are based on observed FFS spending and thus automatically adjust for many factors that affect Medicare spending, including new technologies and coverage decisions, changes in standards of care, and fluctuations in care-seeking behavior (e.g., reductions in the use of most services during the early months of the coronavirus pandemic).

However, with the growth in MA enrollment, there is increasing concern about whether the FFS population in each county continues to provide a reasonable basis for the MA benchmarks. To be clear, apart from favorable selection, we have not identified a problem with the way that FFS spending data are used to calculate MA benchmarks at this time, but problems could arise in the future if FFS enrollment continues to decline, such as if a county's FFS population were not sufficient to provide reliable spending estimates.

Many counties now have very low FFS enrollment

The number of beneficiaries enrolled in FFS reached its peak in 2017 at 37.8 million (including those with only Part A or only Part B) and has been declining ever since—even as the overall number of Medicare

TABLE
4–3

Most counties have declining FFS enrollment, and many have relatively few FFS enrollees, May 2021 to May 2022

County FFS Medicare enrollment, May 2022	Share of counties in U.S.	Share of counties with declining FFS enrollment, 2021–2022	Share of overall FFS enrollment lost, 2021–2022
Less than 1,000	14%	82%	6%
1,001 to 2,000	16	93	6
2,001 to 3,000	15	94	6
3,001 or more	56	94	3

Note: FFS (fee-for-service). Table includes the 50 states and the District of Columbia but excludes Puerto Rico. Enrollment figures are limited to beneficiaries with both Part A and Part B coverage. To produce reliable estimates of FFS spending in counties with fewer than 1,000 FFS beneficiaries, CMS applies a "credibility adjustment" by blending FFS spending in those counties with FFS spending from other counties in the market area.

Source: MedPAC analysis of MA penetration files, May 2021 and May 2022.

beneficiaries increases. As of March 2023, there were 33.4 million FFS enrollees. As FFS enrollment declines, the number of FFS enrollees in some counties may not be large enough to produce accurate and stable spending estimates. To limit the influence of random variation and produce more stable FFS spending estimates, CMS averages county-level FFS spending using the most recent five years of available data and applies a "credibility adjustment" to counties with fewer than 1,000 FFS enrollees by blending FFS spending in those counties with FFS spending from other counties in the market area.[16] For 2023, 436 counties, or about 14 percent of counties in the U.S., required a credibility adjustment. The number of counties requiring a credibility adjustment has increased in recent years, and we expect the number to grow, given the large number of counties with relatively low FFS enrollment and the loss of FFS enrollees between May 2021 and May 2022 for a vast majority of these counties. Table 4-3 shows that, as of May 2022, 14 percent of counties had fewer than 1,000 FFS enrollees, 16 percent had between 1,000 and 2,000 FFS enrollees, and 15 percent had between 2,000 and 3,000 FFS enrollees. Most of the counties with fewer than 3,000 FFS enrollees had declining FFS enrollment between May 2021 and May 2022, losing about 6 percent of FFS enrollment overall.

The credibility adjustment may effectively stabilize FFS spending in counties with few FFS enrollees, but the growing need for credibility adjustments indicates that a different method for establishing benchmarks may be needed in the future.
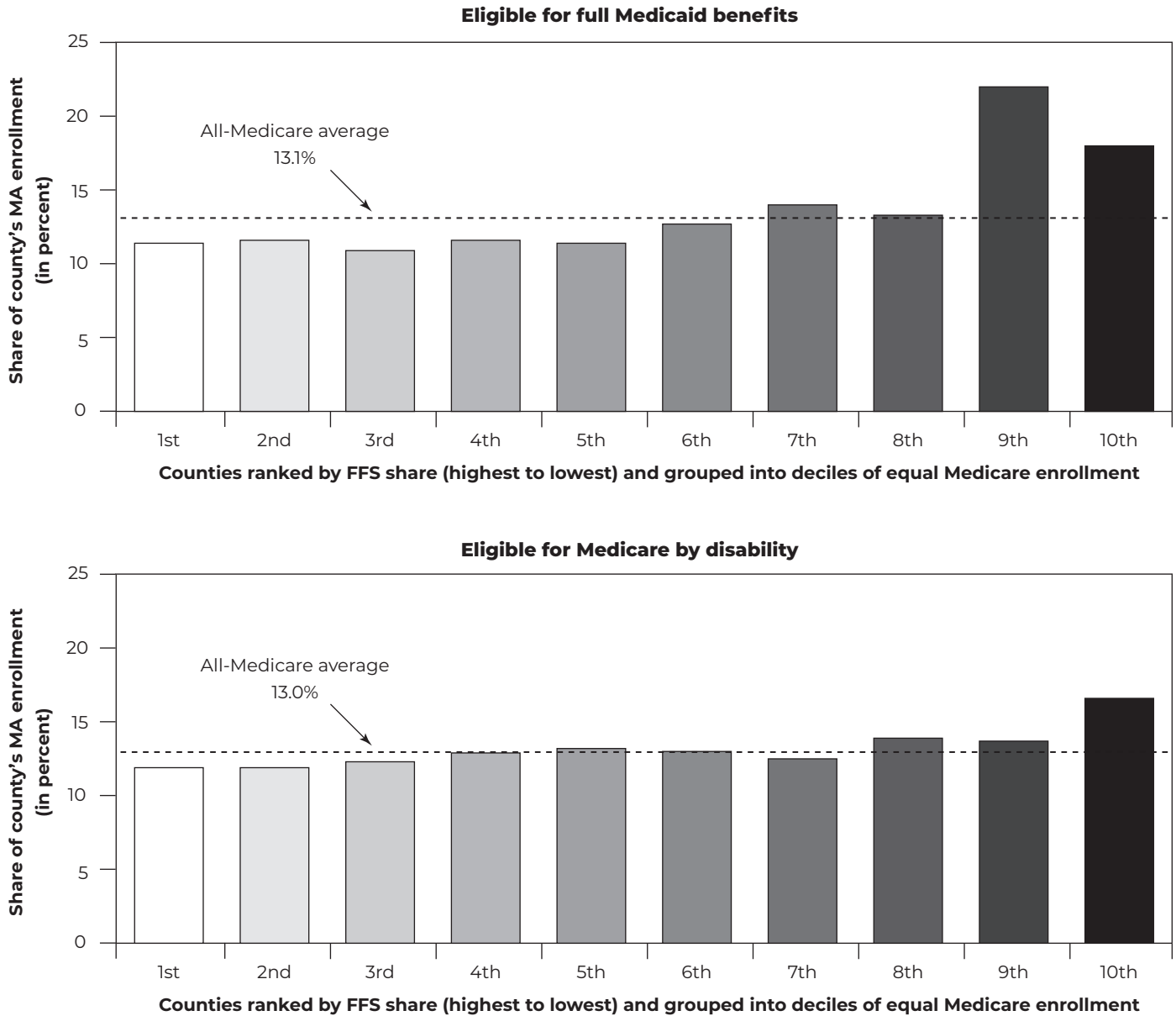
Changing FFS population characteristics

A second potential issue caused by declining FFS enrollment is the possibility that a county's FFS population will no longer be representative of overall Medicare enrollment (including MA). Figure 4-9 (p. 182) shows how the FFS population varies in counties with different levels of MA participation, specifically for two groups of beneficiaries: those who are eligible for full Medicaid benefits and those who have a disability (ages 64 and younger). Counties are ranked by the share of beneficiaries enrolled in MA and then grouped into deciles with roughly equal numbers of beneficiaries. The lighter bars have lower shares of beneficiaries enrolled in MA (i.e., have lower MA penetration), while the darker bars have higher shares of beneficiaries enrolled in MA (i.e., have higher MA penetration).

In counties with lower MA penetration (the first five deciles), a slightly smaller-than-average share of the FFS population is eligible for full Medicaid benefits; by contrast, counties with the highest MA penetration have a larger-than-average share of FFS beneficiaries

FIGURE
4–9

Share of FFS beneficiaries who are eligible for full Medicaid benefits and the share who have a disability somewhat correlate with share of a county's MA enrollment, 2020

Eligible for full Medicaid benefits

All-Medicare average
13.1%

Counties ranked by FFS share (highest to lowest) and grouped into deciles of equal Medicare enrollment

Eligible for Medicare by disability

All-Medicare average
13.0%

Counties ranked by FFS share (highest to lowest) and grouped into deciles of equal Medicare enrollment

Note: FFS (fee-for-service), MA (Medicare Advantage). Figures include the 50 states and the District of Columbia but exclude Puerto Rico. The national average rates of each characteristic for all Medicare beneficiaries are shown by the dashed line.

Source: MedPAC analysis of Medicare enrollment and risk score files, 2020.

who are eligible for full Medicaid benefits. In these high MA-penetration counties, benchmarks used to set payments for plans are based on a higher-than-average share of FFS beneficiaries who are eligible for full Medicaid benefits. A similar, though less strong,

tendency is seen with FFS beneficiaries who are eligible due to disability.[17]

The MA risk-adjustment system is designed to account for differing characteristics among Medicare populations, but risk adjustment may not account

for all relevant characteristics, allowing for biased FFS spending estimates. The potential for bias due to population characteristics may increase if MA and FFS Medicare enrollment patterns become more divergent.

Alternatives for determining MA payment rates

We have considered three options for determining MA payment rates that would be less reliant on FFS spending data. The first would use competitive bidding to determine MA benchmarks and payment rates. The other two would modify the current bid-and-benchmark framework to determine payment rates: One would base benchmarks on all Medicare spending in an area by combining FFS and MA spending data on an ongoing basis, and the other would set benchmarks at a point in time and then use a long-term spending forecast to establish an update factor for benchmarks.

Competitive bidding

The MA program currently sets plan payment rates using a combination of plan bids and benchmarks that are determined administratively and are based on FFS spending. If policymakers conclude that factors such as declining FFS enrollment and favorable selection in MA plans have made those benchmarks unreliable, an alternative approach would be to set plan payment rates using a competitive bidding system that does not use FFS-based benchmarks and instead relies entirely on plan bids (as is the case in Part D). The underlying assumption is that competitive bidding would generate more accurate payment rates (relative to MA costs) and have more potential to generate program savings.

Over the years, numerous proposals to use competitive bidding in MA have been offered from several sources: the USC-Brookings Schaeffer Initiative for Health Policy, the President's 2017 budget proposal, and the Bipartisan Policy Center (Bipartisan Policy Center 2013, Department of Health and Human Services 2016, Lieberman et al. 2018).

The concept also received serious consideration during the development of the Affordable Care Act (ACA) in 2009 and 2010; the original Senate version of the legislation included a competitive bidding system for MA, but the final version of the ACA dropped

the provision in favor of the current benchmark system. In the late 1990s, CMS (then known as the Health Care Financing Administration) made several attempts to conduct a demonstration that used competitive bidding, but it abandoned those efforts due to opposition from plans and other stakeholders (Medicare Payment Advisory Commission 2013).

The use of competitive bidding would be limited to MA plans and would not have any direct effect on the FFS program.[18] As we use the term, competitive bidding is thus distinct from premium support, where the FFS program would be treated like a competing plan in the bidding system and the benchmark would determine the government's contribution toward the cost of both FFS and MA coverage.[19]

Figure 4-10 (p. 184) provides an illustrative example of how MA plan payments could change under competitive bidding. Under the current payment system shown on the left in the figure, CMS calculates the county's benchmark before plans submit their bids. Under this example:

- Local FFS spending is $1,000 per month, which places the county in the 107.5 percent quartile, so its MA benchmark equals $1,075.

- Three plans submit bids that range from $900 to $800, and each plan receives a rebate equal to 65 percent of the difference between the plan's bid and the benchmark. (Plans use these rebates to offer extra benefits and attract enrollment.)

- Once those rebates are taken into account, total Medicare payments to the plans range from $1,014 for Plan A to $979 for Plan C. Plans with higher bids have higher payment rates.

With competitive bidding, shown on the right in the figure, the benchmark would be determined by plan bids (similar to Part D) and would not be tied to the county's FFS costs. In our illustrative example, the benchmark would equal the enrollment-weighted average bid, or $850. Like the current system, plans that bid above the benchmark would charge their enrollees a premium equal to the difference between the two, so Plan A's enrollees would pay a $50 monthly premium. Plans that bid below the benchmark would receive rebates that, depending on the proposal, would be used to either lower enrollee premiums or

FIGURE
4–10

Illustrative example of how MA plan payments would change under a competitive bidding system
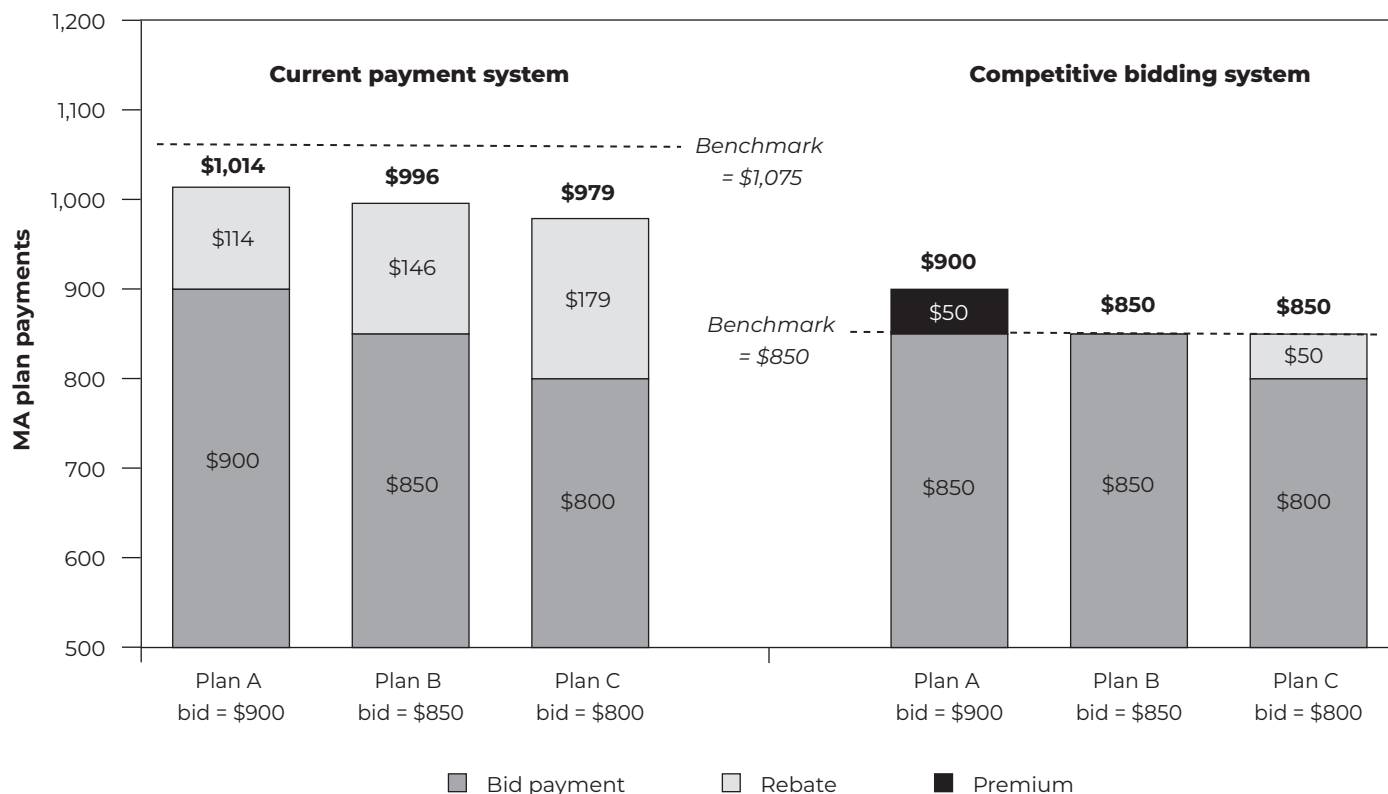
Note: MA (Medicare Advantage). All bids and benchmarks are risk adjusted to reflect a beneficiary of average health. Figure assumes that (1) rebates under the current benchmark system equal 65 percent of the difference between the benchmark and the bid (about the national average) and (2) rebates under competitive bidding equal 100 percent of the difference between the benchmark and the bid. Figure does not include any quality bonuses. Note that the vertical axis on the figure has been truncated to show greater detail.

provide extra benefits. In many proposals, the rebate formula would be changed so that plans receive the full difference between the benchmark and the bid (instead of just part of the difference) to give them stronger incentives to reduce their bids; under such a policy, Plan C would receive $50 in rebates. Since Plan B's bid happens to equal the benchmark, the plan would not charge a premium or receive rebates. As a result, unlike under the current system, Medicare would pay each plan the same amount—the $850 benchmark amount.

Most competitive bidding proposals have suggested using the enrollment-weighted average bid as the benchmark; the Part D program uses this approach

to calculate its national average bid. Other methods are also possible, such as using the lowest bid, the second-lowest bid (the approach used in the ACA's insurance exchanges), or the median bid. Compared with other methods, using the enrollment-weighted average would probably result in higher benchmarks and generate less program savings, but benchmarks would also be more stable—since they would reflect the experience of all plans in the market and enrollment patterns tend to change slowly—and thus would be less disruptive to beneficiaries and plans. The benchmarks would also tend to be similar to the bids by a market's large insurers, since their bids would be weighted more

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heavily in the calculation. In contrast, using the lowest or second-lowest bid could allow a smaller insurer, such as a new entrant, to determine the benchmark.

One thing to note about competitive bidding is that, as with the current payment system, each MA plan is paid the full amount of its bid, which represents the plan's estimate of the revenue needed to provide the Part A and Part B benefit package and includes administrative costs and profits. (For plans that bid at or below the benchmark, the bid is paid entirely by Medicare; for plans that bid above the benchmark, the bid is paid partly by Medicare and partly by enrollee premiums.) As a result, while competitive bidding might reduce MA benchmarks and plan payment rates, those reductions would have little, if any, effect on enrollees' access to Part A and Part B benefits.

One advantage of competitive bidding is that it would lessen the impact of favorable selection and coding intensity on program spending. Under the current system, favorable selection and coding intensity both increase the risk-adjusted benchmarks for plans (since their risk scores are higher than they should be), which results in higher rebates and higher overall payments for MA plans. With competitive bidding, payments to plans would still be risk adjusted, but the starting point for those payments—the benchmarks—would be based on standardized bids (the plan's bid divided by its projected risk score). Under this approach, favorable selection and coding intensity would put downward pressure on benchmarks and plan payment rates because the standardized bids would decrease.

Challenges to using competitive bidding to set MA payment rates

The use of competitive bidding would pose some challenges. The bidding process would reduce the rebates that plans receive and plans' ability to offer extra benefits, which could make MA less attractive relative to traditional Medicare than it is now. In addition, under the current system, in which plans bid against a predetermined benchmark, plans know what their rebates will be when they submit their bid, so their bid can include information on the extra benefits they will offer. Much of this information is later used in plan marketing materials and on the Medicare Plan Finder website. With competitive bidding, plans would not know what their rebates would be until after CMS

had calculated the benchmark, so plan bids could not include much (if any) information about their extra benefits. Once the benchmark was set, plans would need to submit revised bids that indicated how they would use their rebates, an extra step that would make the MA bidding process more complex.[20]

Many competitive bidding proposals address these challenges by requiring MA plans to be standardized in some fashion. For example, the USC-Brookings proposal would require all MA plans to offer a benefit package that has an actuarial value equal to 105 percent of FFS spending (i.e., the MA benefit package would be 5 percent richer than the FFS benefit package and plans would include this amount of extra benefits in their bids) (Lieberman et al. 2018). This type of standardization would make competitive bidding more workable administratively because plans would include a specific amount of extra benefits in their bids, thus avoiding the need for plans to submit revised bids after benchmarks have been set. In addition, requiring the standard MA benefit package to be richer than FFS would guard against the possibility that competitive bidding generates limited Medicare savings by reducing the extra benefits that MA plans offer to the point at which MA enrollees switch to FFS coverage.

In Chapter 3 of this report, we examine the possibility of standardizing benefits in MA plans using a framework under which plans use one of a limited number of benefit packages for Part A and Part B cost sharing, have a limited number of options for covering certain supplemental benefits (such as dental, vision, and hearing benefits), and have flexibility to determine their coverage of other benefits. This framework could potentially be used in a competitive bidding system, albeit with some adjustments. For example, the options for Part A and Part B cost sharing could reflect a certain level of actuarial value (with each option being more generous than FFS coverage) and an overall limit could be placed on the actuarial value of each plan's supplemental benefits (with plans having flexibility to decide which benefits to offer).

If plans submitted bids for a standard benefit package, the bidding process would determine each plan's premium. Plans that bid above the benchmark would charge an additional premium above the Part B premium, while plans that bid below the benchmark would provide a discount on the Part B premium.

The use of standardization in a competitive bidding system would thus offer a way to promote price competition because beneficiaries could compare plans on an apples-to-apples basis (since each plan would offer a similar benefit package) and any differences in plans' relative efficiency would be reflected in their premiums.[21] Since a certain amount of extra benefits would be built into the standard MA package, all plans that bid at or below the benchmark would offer extra benefits that beneficiaries would receive without paying any additional premium, which would help ensure that MA plans remained an attractive option relative to FFS. Some plans that bid above the benchmark could also be attractive to beneficiaries if their premiums were reasonable compared with the value of the extra benefits and lower than the premiums for other forms of supplemental coverage, such as Medigap policies.

Another challenge is uncertainty about how plans would react under a competitive bidding system. Several studies, which examined how MA plans responded to previous changes to their benchmarks (Cabral et al. 2018, Pelech and Song 2018, Song et al. 2013), have found that:

- Plans have some degree of market power and do not submit bids that reflect the true cost of providing the Part A and Part B benefit package. As a result, plans raised their bids when benchmarks were increased and lowered them when benchmarks were decreased. The change in plan bids equaled about 50 percent of the change in benchmarks—that is, increasing benchmarks by $1 led plans to raise their bids by about 50 cents, and decreasing benchmarks by $1 led plans to lower their bids by about 50 cents.

- Only a portion of earlier changes in MA benchmarks was ultimately passed through to plan enrollees in the form of higher or lower levels of extra benefits. For example, if benchmarks were increased by $1 and a plan with a 4-star rating raised its bid by 50 cents (but still bid below the benchmark), then the plan's rebates would increase by only 35 cents.

- Plans in more competitive markets are forced to bid closer to the true costs of providing the Part A and Part B benefit package; as a result, their bids

changed less in response to benchmark changes. Thus, the effects of payment changes in more competitive markets were more likely to be passed through to MA enrollees.

A major limitation of these studies is that they examined payment changes in settings where MA plans bid against predetermined benchmarks; plans might respond differently under a competitive bidding system in which benchmarks were a function of plan bids. Nonetheless, it seems reasonable to conclude that plan bids would change under competitive bidding and that efforts to use existing bids to model the effects of competitive bidding would need to be viewed with caution. (In this sense, the illustrative example in Figure 4-10, p. 184, which holds plan bids constant, is unrealistic.) The changes in plan bids could also be larger in less competitive markets, where plans have more market power and face less pressure to submit bids that reflect their true costs.

Even with changes in bidding behavior, many plans that now have relatively high bids would be more likely to charge premiums under competitive bidding and could find themselves at a disadvantage. (For example, if the benchmark equaled the enrollment-weighted average bid, roughly half of plans would charge premiums.) One potential consequence is that enrollment in HMOs could increase at the expense of PPOs, which have grown more rapidly than HMOs in recent years but also tend to have higher bids.

One particular concern about using competitive bidding is the MA market's high level of concentration. In highly concentrated markets, plans face less competition and might submit bids that are actually higher than their current bids, resulting in relatively low program savings and, at least in some areas, potentially higher spending. These outcomes could become more likely if the MA market became more consolidated in the future—for example, through mergers and acquisitions. However, since 2018, the average market shares for the largest MA organizations (measured at the county level) have declined modestly, indicating that the market has become somewhat less concentrated. In addition, the vast majority of beneficiaries (95 percent) now live in counties served by four or more MA organizations, which appears large enough to ensure a sufficient level of competition. Nonetheless, policymakers could address these

concerns by requiring benchmarks under competitive bidding to be lower than a predetermined ceiling amount that is based on current benchmarks or plan payment rates.

Another concern about competitive bidding is beneficiaries' willingness to compare and switch plans. The process of comparing plans is complex because plans differ in many dimensions, such as premiums, extra benefits, provider networks, and drug formularies. One consequence is that the share of beneficiaries who switch plans in a given year is relatively low (although, as noted earlier, the share of beneficiaries who switch plans over longer periods of time is much higher). If relatively few beneficiaries are willing to switch to plans with lower premiums, plans will have weaker incentives to bid competitively. The use of standardized benefits could make it easier for beneficiaries to compare plans and lead to more price competition, but the process of comparing plans would remain challenging and (as with the current system) there would likely be a significant number of beneficiaries who would not be enrolled in the plan that best met their needs.

Benchmarks based on all Medicare spending

A second approach to setting benchmarks would be to base them on spending for the entire Medicare population, including those enrolled in MA. A benchmark alternative that blends average local area FFS and MA spending would strive to closely reflect the market average spending for providing Part A and Part B services for all Medicare beneficiaries. This approach would keep the same bidding and benchmark infrastructure that exists under current policy with little added administrative burden for CMS or for MA plans. This approach would require the calculation of an FFS rate and an MA rate in each local area—both of which would use existing data and processes.

Spending for the FFS population would continue to be estimated as it is now. MA encounter data would be used to estimate spending on Part A and Part B services for plan enrollees (encounter data contain similar information as FFS claims, but the records are not adjudicated for payment), and MA bids would be used to estimate plan administrative expenses and profits. Currently, encounter data do not contain complete cost information (plans are not required to

submit information about payments to providers for encounters occurring under a capitated arrangement), and we have found that plans do not submit encounter data for all items and services as required.[22] However, FFS payment rates could be applied to all MA records to approximate cost information for all MA enrollees, although this would involve a considerable amount of effort. Although our analysis shows that encounter data completeness is improving slowly, using encounter data to establish MA benchmarks would provide a significantly better incentive than existing ones for plans to improve the completeness of encounter data submitted to CMS.

In the absence of complete MA encounter data, we developed a simulation of benchmarks based on all Medicare spending using Part A and Part B service spending from MA plan bids, as MA bids are based on actual plan experience from the prior year and are projected forward to the payment year.[23] This approach, shown in Figure 4-11 (p. 188), uses data that are currently available, allowing us to simulate benchmarks based on all Medicare spending.
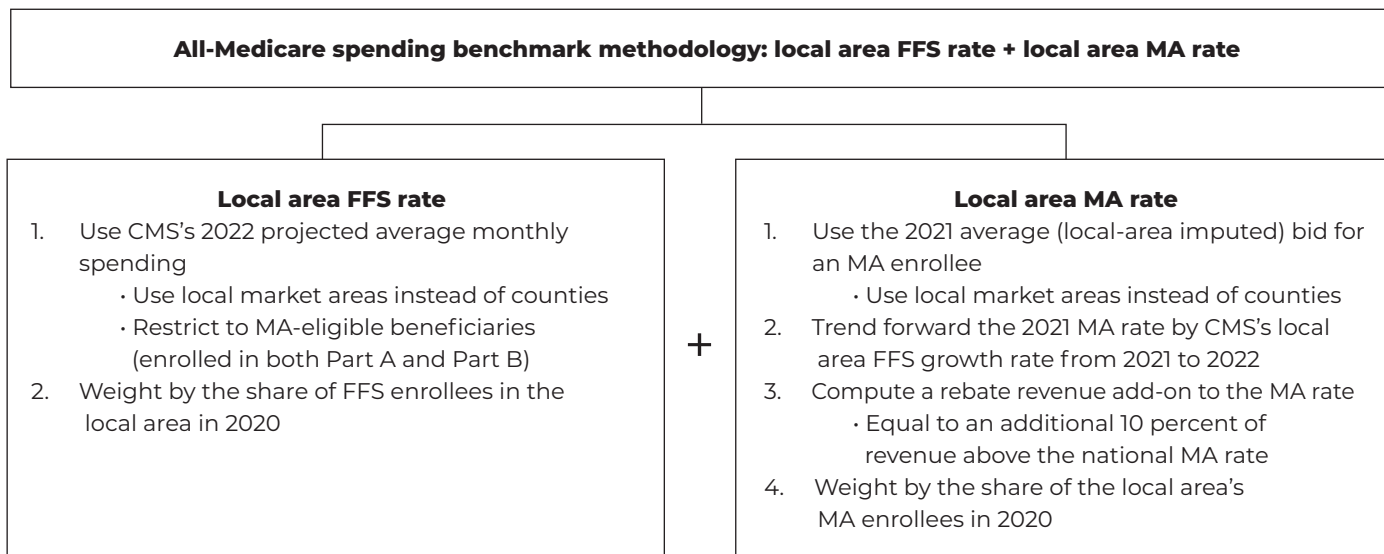
Simulating benchmarks based on all Medicare spending

The key components of an all–Medicare spending benchmark would be:

- local area FFS spending,

- the local area average MA bid,

- a local area FFS growth factor to trend the bids forward,

- a rebate revenue add-on for the MA bids, and

- weights for MA and FFS spending in the local area.[24]

Local area FFS spending As shown in Figure 4-11 (p. 188), in our illustrative methodology, the calculation of local area FFS spending is nearly the same as CMS's current calculation of FFS spending. One key difference would be that—consistent with the Commission's prior recommendations—only the MA-eligible population (those enrolled in both Part A and Part B) is used in the calculation of FFS spending. A second key difference is that local market areas, rather than counties, are used as the payment areas for benchmarks (consistent

FIGURE
4-11

Illustrative methodology for calculating 2022 benchmarks that are based on all Medicare spending

All-Medicare spending benchmark methodology: local area FFS rate + local area MA rate

Local area FFS rate
1. Use CMS's 2022 projected average monthly spending
   · Use local market areas instead of counties
   · Restrict to MA-eligible beneficiaries (enrolled in both Part A and Part B)
2. Weight by the share of FFS enrollees in the local area in 2020

+

Local area MA rate
1. Use the 2021 average (local-area imputed) bid for an MA enrollee
   · Use local market areas instead of counties
2. Trend forward the 2021 MA rate by CMS's local area FFS growth rate from 2021 to 2022
3. Compute a rebate revenue add-on to the MA rate
   · Equal to an additional 10 percent of revenue above the national MA rate
4. Weight by the share of the local area's MA enrollees in 2020

Note: FFS (fee-for-service), MA (Medicare Advantage). This alternative benchmark approach would use MA encounter data to estimate spending on Part A and Part B services for plan enrollees and MA bids to estimate plan administrative expenses and profits. However, in the absence of complete MA encounter data, we simulated the benchmark option by using MA bid information to estimate spending on Part A and Part B services, plan administrative expenses, and profits.

Source: MedPAC.

with the Commission's prior recommendations to establish larger geographic areas for payment to MA plans). These local market areas aggregate counties within each state according to metropolitan statistical areas for urban counties and health service areas (as defined by the National Center for Health Statistics) for nonurban counties. To simulate benchmarks based on all Medicare spending for 2022, we adjusted CMS's 2022 county rates by a local factor that accounts for spending differences for the population with both Part A and Part B coverage. We aggregated this spending to the market level.

Local area average MA bid While MA plans bid on service areas that often include more than one county, each plan bid includes an imputed county-level bid based on the difference in county rates and the enrollment assumptions in the bid. These data allow CMS to calculate the risk-standardized bid in each county for that county's average MA enrollee. These county-level bid data are used to prospectively

calculate county-level payment rates in the subsequent year for employer plans. In our simulation of all-Medicare spending benchmarks, we used county-level bid data in 2021 and aggregated county-level averages to the local market level.

Local area FFS growth factor We trended forward the 2021 local area average bid by CMS's projected growth rate in local area FFS spending from 2021 to 2022. Using prior-year bids and trending forward with the FFS spending growth rate would enable plans to be rewarded for having lower spending growth than FFS spending trends. However, the closer that the trend factor is tied to FFS growth, the more likely it is to include favorable selection for MA plans. One way to account for favorable selection would be to intentionally set the trend factor lower than FFS spending growth. Another way would be to use a two-year rather than one-year lag in bids. A two-year lag would generate benchmarks that are less reflective of actual Medicare spending but would give MA plans

additional opportunities to be rewarded for efficiency gains relative to FFS spending growth trends.

Rebate revenue add-on As with competitive bidding, basing benchmarks on MA bids—even in part—could significantly reduce the rebates that plans use to provide extra benefits for their enrollees. MA plans rely on some level of funding above their bids to attract beneficiaries who otherwise would be covered under FFS and who typically purchase supplemental Medigap coverage. Thus, a key policy decision would be to determine the amount of rebate revenue to be added to the MA portion of the benchmark. Between 2016 and 2022, rebates have dramatically increased, from an average of 9 percent to 18 percent of plan bids.[25] We simulated all-Medicare benchmarks using the amount of rebate revenue that would have provided an additional 10 percent of revenue above the national MA bid.[26] However, given the substantial level of MA favorable selection and coding intensity, policymakers could consider a lower percentage of additional revenue. In addition, rather than applying a specific percentage add-on to each local area, we applied a revenue dollar amount add-on using the national bid average to increase rebate revenues in low-spending areas (where Medicare premiums do not typically reflect the lower wages).

Local area spending weights for FFS and MA After the FFS and MA rates are computed for each local area, weights must be given to each rate that reflect the share of beneficiaries in each program within the area. A downside of this approach is that it retains some degree of favorable selection in MA, depending on the share of FFS enrollees in Medicare. To calculate the share of beneficiaries in each program for our simulation weights, we used 2020 enrollment data because 2021 enrollment data were incomplete at the time when 2022 MA rates were set. We excluded beneficiaries in private plans that do not submit bids (employer plans, cost plans, PACE plans, and Medicare-Medicaid plans). We also excluded beneficiaries who did not have both Part A and Part B coverage.

Simulations of benchmarks based on all Medicare spending show an overall reduction in benchmarks, with plan bids remaining below the (lower) simulated benchmarks

After simulating 2022 plan benchmarks using an all-Medicare spending approach, we compared simulated benchmarks with CMS's 2022 projection of FFS spending and 2022 actual plan bids. We measured simulated benchmarks as a percentage of CMS's projected local area FFS spending. On average nationally, simulated benchmark levels were 100 percent of projected FFS spending in 2022—8 percentage points lower than the actual 2022 benchmarks, which were 108 percent of projected FFS spending. In addition, we found that simulated benchmarks were largely clustered around their projected local FFS spending but were somewhat higher relative to FFS in low-spending areas (Figure 4-12, p. 190). Half of MA markets had benchmarks between 99 percent and 101 percent of projected FFS spending. The lowest benchmark was 85 percent of its projected local area FFS spending, and the highest benchmark was 113 percent of its projected local area FFS spending.

Because the MA program relies on plans' ability to bid below benchmarks, we measured actual 2022 plan bids as a percentage of our simulated benchmarks. On average nationally, plan bids were 86 percent of simulated benchmarks (compared with 79 percent of benchmarks under current policy). In all MA markets, the enrollment-weighted average plan bid was lower than the simulated benchmark (Figure 4-13, p. 191). In nearly all markets, the enrollment-weighted average plan bid was more than 5 percent below their simulated benchmark. These results indicate that benchmarks based on all Medicare spending would likely provide a viable alternative for MA plans while reducing Medicare spending at current bid levels (through a reduction in plan rebates). Further, while our simulations assume no change in bidding behavior relative to 2022 levels, at least some plans would likely respond to lower benchmarks with lower bids (Congressional Budget Office 2018, Song et al. 2013).[27,28,29]

Advantages and disadvantages of basing benchmarks on all Medicare spending

In contrast to competitive bidding, the benchmark approach using all Medicare spending would incorporate MA spending information while still giving plans a prospectively set benchmark to bid against. In addition, since most plans bid below their local area FFS spending level, they would likely bid below their benchmark under this approach as well—even for those somewhat less efficient plans relative to other plans. Further, using prior-year average bids and

FIGURE
4–12

Simulated MA benchmarks using an all-Medicare approach were clustered around their projected local area FFS spending
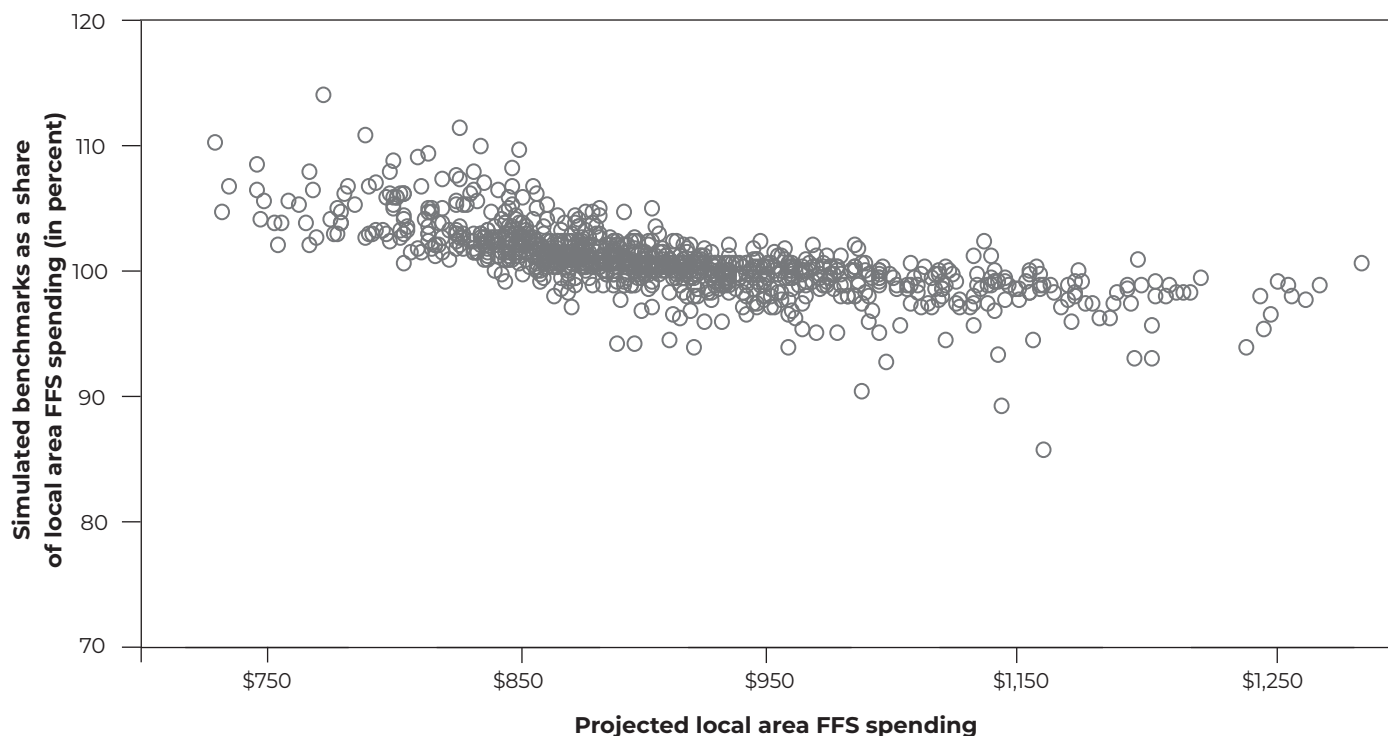
Note: MA (Medicare Advantage), FFS (fee-for-service). Each circle in the figure reflects a local market area. Metropolitan counties are grouped into a local market area if they are located in the same state and the same metropolitan statistical area. Nonmetropolitan counties are grouped into a local market area if they are located in the same state and the same health service area as defined by the National Center for Health Statistics. The figure includes 941 markets and excludes markets that did not have at least 1,000 MA enrollees and 10 percent of all beneficiaries enrolled in MA in 2020. Average MA bids by market area are weighted by projected plan enrollment in the market. While plans bid at a service area level that often includes multiple counties, MA bid data contained an imputed bid value at the county level that we aggregated to the market level.

Source: MedPAC analysis of Medicare enrollment and MA bid data, 2020–2022.

trending them forward by the projected increase in FFS spending allows plans to be rewarded for keeping their spending growth lower than FFS trends.

A benchmark approach that uses all Medicare spending could be desirable if policymakers wanted to move away from FFS-based benchmarks but keep the current MA bidding and benchmark infrastructure. Simulations of this approach suggest that MA plans would continue to bid below their benchmarks, which would preserve MA as an affordable option for beneficiaries compared with FFS Medicare. In addition, benchmarks would more closely reflect Medicare's per capita spending in a local market area. As the FFS population in a local area decreased, the benchmark would more closely rely on

spending for the area's MA population. Further, if FFS spending increasingly diverged from an area's average plan bid, policymakers could lower the rebate add-on from the MA portion of the benchmark.

One concern with this approach is that, to the extent that it relies on the FFS population, it would continue incorporating the effects of favorable selection into MA benchmarks. A second potential concern about basing benchmarks on all Medicare spending, as with competitive bidding, is the high level of concentration in the MA market. For example, if a majority of a market's Medicare population is enrolled in plans offered by one MA organization, that organization (or a small number of MA organizations) could have

FIGURE
4–13

2022 plan bids were generally much lower than simulated MA benchmarks using an all-Medicare approach

Note: MA (Medicare Advantage), FFS (fee-for-service). Each circle in the figure reflects a local market area. Metropolitan counties are grouped into a local market area if they are located in the same state and the same metropolitan statistical area. Nonmetropolitan counties are grouped into a local market area if they are located in the same state and the same health service area as defined by the National Center for Health Statistics. The figure includes 941 markets and excludes markets that did not have at least 1,000 MA enrollees and 10 percent MA share of enrollees in 2020. Average MA bids by market area are weighted by projected plan enrollment in the market. While plans bid at a service area level that often includes multiple counties, MA bid data contained an imputed bid value at the county level that we aggregated to the market level.

Source: MedPAC analysis of Medicare enrollment and MA bid data, 2020–2022.

a large influence on a market's MA benchmark. This concern could be addressed by capping the weight of any individual MA organization in a market (e.g., cap at 50 percent) or capping the weight of the two largest MA organizations (e.g., cap at 75 percent). An alternative approach would be to cap benchmarks at what they would be under a blended approach (50/50 local/national FFS), as described in the Commission's June 2021 recommendation to rebalance MA benchmarks. The calculation of this cap would not add administrative burden because it would use the FFS projections that CMS relies on to calculate benchmarks under current policy. In addition, relative to local FFS spending, this cap would allow benchmarks to be

higher in low-FFS-spending areas (where plan bids are relatively higher) and lower in high-FFS-spending areas (where plan bids are relatively lower).

A benchmark approach that used all Medicare spending could be preferable if policymakers wanted to move away from FFS-based benchmarks but keep the current MA bidding and benchmark infrastructure. Simulations of this approach suggest that MA plans would continue to bid below their benchmarks, which would continue to make MA an affordable option for beneficiaries compared with FFS Medicare. In addition, benchmarks would more closely reflect a local market area's Medicare per capita spending. As the FFS population

FIGURE
4–14

USPCC growth percentages used for MA benchmarks, payment years 2016–2023
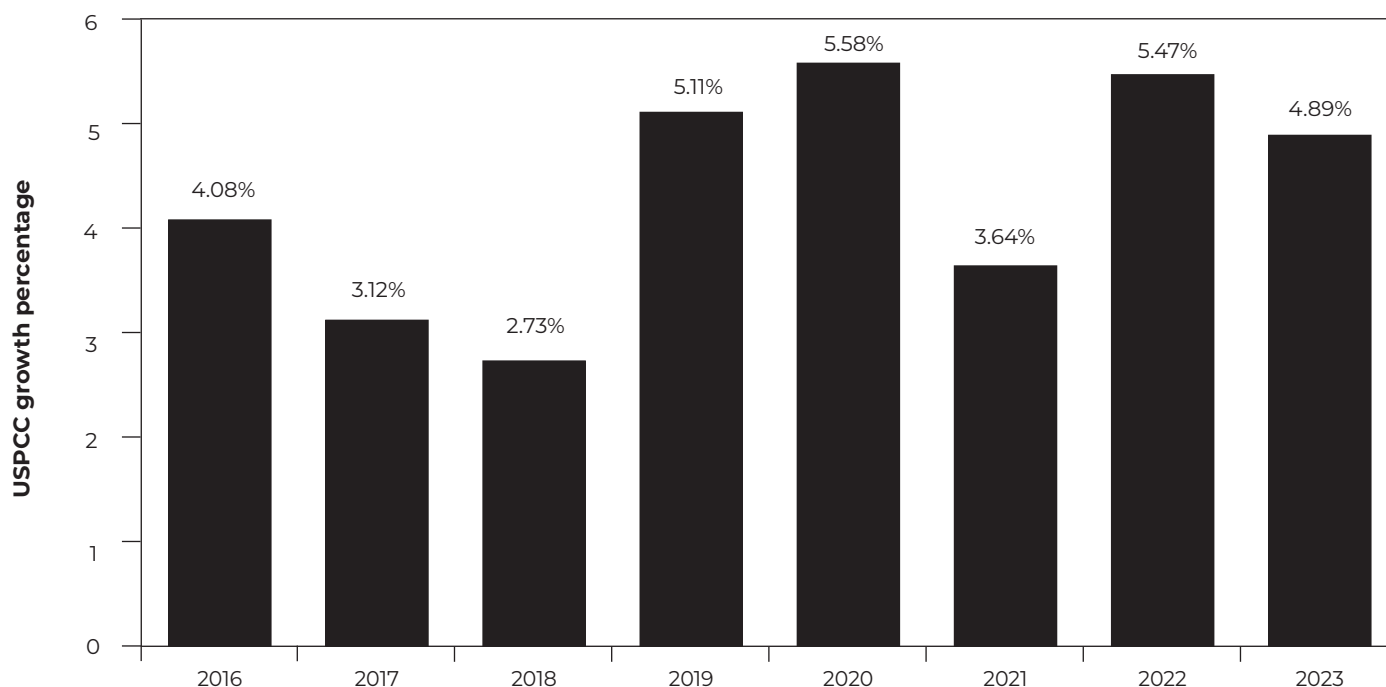
Note: USPCC (U.S. per capita cost), MA (Medicare Advantage). The USPCC is the national average non–end-stage renal disease fee-for-service cost projected for each payment year. The growth percentage is the increase in the projected USPCC for a payment year relative to the projected USPCC for the prior payment year.

Source: CMS annual announcement of MA payment rates, 2016–2023.

in a local area decreased, the benchmark would more closely rely on spending for the area's MA population. Further, if FFS spending increasingly diverged from an area's MA spending, policymakers could lower the rebate add-on from the MA portion of the benchmark.

Establishing MA benchmarks with a fixed growth rate

A third approach to benchmark setting would be to set benchmarks using a fixed growth rate. Currently, MA benchmarks are established in the April prior to a given payment year so that MA plan sponsors have the information to prepare bids. Therefore, the county-level FFS spending estimates used in MA benchmarks are projections of what FFS spending will be in each county for the payment year.[30] For example, MA benchmarks for 2023 (based on projected spending for

that year) were published in April 2022. The current method of calculating county-level FFS spending for MA benchmarks is the product of two factors: the national FFS per capita cost, also called the U.S. per capita cost (USPCC), and a county-level geographic index called the average geographic adjustment (AGA).

The USPCC includes FFS spending on all Part A and Part B services (except hospice services and kidney acquisition costs) as well as all shared savings and losses paid to FFS providers through the Medicare Shared Savings Program, Innovation Center models, and demonstration programs. The USPCC is projected for the payment year based on the most recent program experience and accounts for various trends, including unit cost changes, utilization and intensity of services, changes in population mix, and changes in Medicare coverage due to legislation, regulation, or

TABLE
4–4

Components of per beneficiary annual percentage change in projected Medicare spending

	Medicare prices	Volume and intensity	Beneficiary demographic mix	Per beneficiary total change
2022–2031	1.8%	3.6%	–0.1%	5.3%
2032–2046	2.3	2.1	0.2	4.6
2047–2096	2.2	1.4	–0.1	3.5

Note: Percentage change values combine the CMS Office of the Actuary's (OACT's) Part A and Part B projections by assuming the current distribution of about 45 percent Part A and 55 percent Part B spending. OACT's projection for Medicare spending growth related to an increase in the number of beneficiaries has been excluded from the total to generate a per beneficiary growth rate. The total change is defined as the sum of the following three components as reported in the Trustees report: Medicare prices, volume and intensity, and beneficiary demographic mix. Totals may not sum due to rounding.

Source: MedPAC analysis of Medicare Trustees report, 2022.

national coverage decisions. CMS reports the annual "growth percentage," which is the increase in the projected USPCC relative to the prior year's projection. The growth percentage is like an "update factor" for payments to MA plans.[31] Figure 4-14 shows the USPCC growth percentages for 2016 through 2023.

To calculate the AGA, CMS uses each county's average FFS spending based on five years of historical claims data, which have been price standardized by applying the most recent FFS pricing policies to all five years of historical claims data. Then the average FFS spending for each county is divided by the national average FFS spending to create an index. Each county's AGA is the average index across the five years. Each year, CMS updates the five-year basis for the AGA by one year. For 2023, CMS used claims from 2016 to 2020 to estimate the AGA. Finally, AGA factors are adjusted to remove payments for indirect medical education, graduate medical education, and kidney acquisition costs, which are carved out of MA benchmarks, and to account for services covered by the Department of Veterans Affairs or the Department of Defense.

Setting a base benchmark

Before a fixed growth rate can be applied, a base benchmark amount must be determined. The Commission's analysis shows that existing benchmarks are too high overall and vary considerably across the

country (Medicare Payment Advisory Commission 2021a). One way to avoid this problem would be to use the Commission's recommendation for revised benchmarks, which blends county and national FFS spending and incorporates a discount factor to establish initial benchmarks under this approach. Determining the appropriate discount factor would be important because if the base benchmarks are too high or too low, an optimally set fixed growth rate would carry forward those errors in perpetuity.

Determining the fixed growth rate

The alternative benchmark options discussed in this section would replace the USPCC projection with another growth rate. The AGA would continue to function as it currently operates.

One option for an alternative growth rate would base its rate on projections by the CMS Office of the Actuary (OACT). OACT projects Part A and Part B Medicare spending growth based on four component trends: volume and intensity, beneficiary demographic mix, prices, and number of beneficiaries. For our purposes, we combined OACT's Part A and Part B projections into one overall growth rate using the current distribution of about 45 percent Part A and 55 percent Part B spending. Table 4-4 shows OACT's projections for 2022 to 2031, 2032 to 2046, and 2047 to 2096.

For MA benchmarks, one alternative growth rate could be the combination of changes in Medicare prices, volume and intensity, and beneficiary demographic mix.[32] Although MA plans negotiate prices with providers, for most services MA plans pay approximately FFS Medicare rates on average.[33] Because out-of-network payments to providers are capped at the FFS Medicare rate, a strong link between provider payment rates from MA plans (on average) and from FFS Medicare would likely be maintained for many services. Volume and intensity, on the other hand, is a component for which MA plans have had success in constraining costs overall. To convert OACT's projections into a fixed growth rate, policymakers could apply a discount factor to either Medicare prices, volume and intensity, or both. As an example, policymakers could set a fixed growth rate using a 50 percent discount on volume and intensity:

Medicare prices + (50% × volume and intensity) + beneficiary demographic mix

Using this discount factor, over the periods from 2022 to 2031 and 2023 to 2046, the fixed annual growth rate would be about 3.5 percent, after which it would decline to 2.8 percent for 2047 through 2096.

The use of discount factors is a necessary component of this approach. Without a discount factor, the growth rate from 2022 through 2031 would be 5.3 percent, which is among the larger annual increases resulting from the current USPCC method shown in Figure 4-14 (p. 192). One concern about relying on OACT's projections is that the actual (in contrast to the projected) FFS Medicare volume and intensity trend is about 1 percent per year, considerably lower than OACT's projections. Using the Commission's estimate of a 1 percent annual increase in FFS volume and intensity with a 50 percent discount factor, the MA benchmark growth rate would be about 2.2 percent (that is, 1.8 + (0.5 × 1.0) − 0.1).

A second option would be to determine the fixed growth rate using U.S. gross domestic product (GDP), which is the total value of all final goods and services produced in the country over a specified time period. The Congressional Budget Office projects that U.S. real GDP (GDP adjusted for changes in prices) will increase by 1.2 percent annually from 2024 to 2025 and by 1.6 percent annually from 2026 to 2031 (Congressional Budget Office 2021). To use real GDP in a fixed growth

rate for MA benchmarks, the easiest approach would be to start with growth in Medicare prices and add the projected real GDP growth rate plus or minus an adjustment factor. For example, Medicare price growth of 1.8 percent plus 1.1 percent (1.6 percent real GDP growth rate minus 0.5 percent adjustment factor) would produce a 2.9 percent fixed growth rate. Picking a rate relative to GDP is relatively simple, but because GDP is not closely linked to Medicare spending, there is no guarantee that a GDP-based fixed rate will continue to be a reasonable rate in the future, thus creating greater potential for the need to adjust the fixed growth rate.

Adjusting the fixed growth rate

Replacing the USPCC growth percentage with a fixed growth rate would be relatively simple to implement. However, switching from an empirically based benchmark to one with annual updates that are independent from Medicare spending creates a new problem: how to adjust for unanticipated factors that influence medical spending. By setting payment rates relative to FFS-based parameters, payments to MA plans are insulated from shocks to Medicare spending as benchmarks automatically adjust for new technologies and coverage decisions, changes in standards of care, and fluctuations in care-seeking behavior.[34]

In contrast, the defining features of a fixed growth rate system are that the growth rate is set in advance and is independent of current Medicare spending. Without a connection to Medicare spending and the spending shocks that could arise, policymakers must (1) regularly assess whether payments to MA plans are adequate and, if not, (2) determine how to adjust the fixed growth rate. If payments are too high or too low, adjusting the fixed growth rate would be relatively easy, but more thought would be needed to identify an appropriate trigger for overriding the existing fixed growth rate.

In FFS Medicare, annual payment rate updates are empirically based and generally defined in law. The Commission annually assesses payment adequacy in each FFS sector through a consistent framework and set of metrics, but the decision to recommend a payment rate update that is different from the empirically determined update is based on the judgment of the Commission. In examining FFS Medicare, the Commission considers provider

financial performance (e.g., margins), the number of providers participating in Medicare, providers' access to capital, and other factors. Applying these metrics to MA is possible, but judgment would still be required. Policymakers could assess MA plan margins from bid data, but these margins are becoming less informative as plan sponsors employ more physician groups and generate contracting relationships through their venture capital projects. The number of plan sponsors operating or the number of plans available in a market is easily known, but how would policymakers define an adequate number of sponsors and plan options in each market? Other criteria could include the generosity of extra benefits. A final key difference with the Commission's assessment of payment adequacy in FFS Medicare is that the default rate updates are empirically justified. The annual update for FFS payment systems is calculated based on updating spending for a defined market basket, calculating a productivity adjustment, and making other adjustments based on quantitative estimation. In contrast, a fixed growth rate system, without an empirical basis, is likely to be more vulnerable to political influence.

Vulnerability to favorable selection

Whether favorable selection in MA would continue under this approach depends on how the base benchmarks would be determined. If they were based on FFS spending, adjusting the spending estimates to remove favorable selection would be important before establishing the base benchmarks. As noted earlier, if the base benchmarks were set too high or too low, a fixed growth rate would carry these errors forward in perpetuity. ∎

Endnotes

1   MA plans are also required to offer a limit on out-of-pocket costs, and the coverage for that benefit is included in plans' bids.

2   The MA program in Puerto Rico differs from the rest of the U.S. in a number of ways. For example, MA benchmarks in Puerto Rico are based on FFS beneficiaries with Part A and Part B, are adjusted for a higher share of FFS beneficiaries with no Medicare spending, and are inflated by Medicare's method of distributing disproportionate share hospital payments in FFS Medicare. In addition, the vast majority of counties in Puerto Rico have benchmarks that are based on FFS spending data that have been blended with FFS spending data from surrounding counties because the number of FFS beneficiaries in the county is below 1,000.

3   Plans with higher quality ratings (a rating of 4 or more stars) are rewarded with a higher benchmark.

4   Plans may also choose to include additional supplemental benefits that are not financed by the rebate in their benefit packages and charge premiums to cover those additional benefits.

5   Because plans are paid based on the risk profile of individual enrollees, plans are still incentivized to enroll beneficiaries who have above-average spending such as beneficiaries who are dually eligible for Medicaid. In fact, plans that exclusively enroll dual-eligible beneficiaries (i.e., dual-eligible special needs plans) consistently report higher profit margins relative to conventional MA plans (Medicare Payment Advisory Commission 2023, Medicare Payment Advisory Commission 2022b, Medicare Payment Advisory Commission 2021b, Medicare Payment Advisory Commission 2020b).

6   MA plans can also encourage enrollment by offering extra benefits beyond the standard Medicare benefit package. Popular benefits include integrated Part D coverage for no additional premium, gym memberships, and worldwide emergency and urgent care coverage. However, some supplemental benefits (e.g., worldwide emergency and urgent care coverage) are only or disproportionately attractive to relatively healthy beneficiaries, which may contribute to favorable selection in MA plans. These benefits can serve as a signaling mechanism to indicate the type of beneficiary the plan is trying to attract.

7   MA entrants do not include beneficiaries with either ESRD or Medicare as a secondary payer.

8   In 2009, 16 percent of MA enrollment growth was in PFFS plans. The number of enrollees in PFFS plans has decreased in every subsequent year.

9   Restricting our analysis to counties with at least 1,000 MA entrants, we found that counties in the highest quintile of MA penetration had a median favorable selection of 7 percentage points; counties in the lowest quintile of MA penetration had a median favorable selection of 9 percentage points. In addition, the coefficient of correlation between MA market penetration and the estimated effect of favorable selection for 2020 MA entrants was statistically significant.

10 One study approximated regression to the mean of mortality rates after the initial year in MA, but the authors noted that this method could not account for the effect of continuous enrollment in MA (Newhouse et al. 2019).

11 If the FFS population used for county benchmarks changes only incrementally from year to year (e.g., some beneficiaries die while other individuals become newly eligible), the cohort of MA entrants in a particular year would get older and develop more chronic conditions over time (i.e., the constant MA entry cohort in a particular year would not gain new entrants).

12 MA entrants who had only one full year of eligibility and one prior year in FFS (i.e., nearly newly eligible) had risk-standardized spending that was 85 percent of those who stayed in FFS. In comparison, all 2019 MA entrants had spending that was 95 percent of FFS stayers' spending. The relatively higher favorable selection for MA entrants with only one full year of FFS enrollment was of similar magnitude in 2017 and 2018.

13 Our sensitivity analysis of beneficiaries who died applied similar exclusions to our main analysis of favorable selection (i.e., end-stage renal disease, Medicare as a secondary payer, employer plans, and non-MA private plans). The results of our sensitivity analyses were similar even after adjusting for the geographic distribution of MA enrollees.

14 Our sensitivity analysis of switching from 2018 to 2019 among decedents measured whether each beneficiary had a majority of their 2018 enrollment in MA or FFS and whether they had any months of switching in 2019.

15 To stay consistent with the methodology for MA benchmarks, our FFS comparator in our main analysis was the local FFS average in the reference year rather than the cohort of FFS enrollees who survived from the reference year through 2019.

16 The credibility adjustment blends county FFS data with other counties from the applicable Medicare core-based statistical area (CBSA) or, for counties outside a CBSA, with other counties in the state. Counties with low FFS enrollment tend to have few Medicare beneficiaries overall. Therefore, the credibility adjustment affects the administration of the program for a growing share of counties with low FFS enrollment.

17 We also assessed whether there is a relationship between the share of MA enrollees in a county and beneficiaries who have partial Medicaid benefits or beneficiaries who are long-stay nursing home residents, but there was not a strong correlation.

18 Competitive bidding would have an indirect effect on FFS enrollees through the Part B premium, which covers 25 percent of expected spending on all Part B benefits, across both FFS and MA. If competitive bidding reduced payments to MA plans, some of those savings would be allocated to Part B spending and the Part B premium would be commensurately lower. The reverse is also true: FFS enrollees would pay higher Part B premiums if competitive bidding ended up increasing payments to MA plans.

19 However, policymakers could consider a competitive bidding system that would treat FFS as a "bid" in the benchmark calculation but have no effect on FFS premiums. Since FFS costs are typically higher than costs estimated in plan bids, treating FFS as a bid in a system that sets the benchmark equal to the enrollment-weighted average bid would likely result in higher benchmarks in most areas.

20 Because actual Part D premiums are not known at the time of MA bid submissions, MA plans often resubmit their rebate allocations to reflect needed changes to Part D premium buy-downs. In addition, because regional PPO benchmarks are partially based on an average of regional PPO plans' bids, these plans must resubmit their rebate allocations after their benchmarks are set.

21 Although premiums would become more important under this approach, plans would continue to compete along other dimensions, such as their provider networks, drug formularies, and quality.

22 We compared encounter data with other sources of information about MA utilization and found encounter data that were incomplete in each comparison: Medicare Payment and Review data for inpatient hospital stays, Minimum Data Set for skilled nursing services, Outcome and Assessment Information Set for home health services, and risk score indicators for dialysis services. There are no sources of MA utilization for many Part B services. See Chapter 13 of our

March 2020 report to the Congress for our most recent comparisons (Medicare Payment Advisory Commission 2020b).

23 Because an MA plan's required cost of providing Part A and Part B benefits includes administrative costs and profit, these amounts are included in the bid.

24 Benchmarks for regional PPO plans are currently set in a similar way. Regional PPO benchmarks combine the current-year regional PPO bids with local MA benchmarks. Compared with HMOs and local PPOs, average regional PPO bids and benchmarks are lower relative to their local FFS spending. However, given differences in the regional PPO market and the benchmark methodology used for those plans, caution should be taken in extrapolating from their experience. Key differences are that (1) regional PPO benchmarks use the share of national FFS and MA enrollment as the benchmark weights, (2) there are substantially fewer regional PPOs than other MA plans in a market, and (3) regional PPOs bid before knowing their benchmark (i.e., the previous year's average bid is not trended forward by one year).

25 During this period, the share of rebate dollars used to reduce beneficiary cost sharing and premiums decreased from 72 percent to 60 percent, while the share used for supplemental benefits grew. The most commonly offered benefits in 2021 were worldwide emergency care, urgent care, and emergency care transportation; routine eye exam; fitness benefit; annual physical exam; routine hearing exam; eyewear including contacts and glasses; and preventive dental cleaning and oral exam. CMS has not collected utilization data on these benefits, and the efficacy of these benefits is unclear.

26 This amount of rebate revenue is equivalent to average MA plan rebates between 2016 and 2017, when rebates were 9 percent of plan bids and 11 percent of plan bids, respectively. Rebate revenue hit a historic high in 2017 and has increased in every subsequent year through 2023.

27 Plans that lose their benchmark bonus status tend to respond by lowering their bids, thereby maintaining rebate levels for beneficiaries. See Chapter 3 of our June 2020 report to the Congress (Medicare Payment Advisory Commission 2020a).

28 Song and colleagues found that plans would reduce bids by half of the decrease in plan benchmarks (Song et al. 2013).

29 In its estimates of MA costs, CBO has used Song and colleagues' findings that plans would reduce bids by half the decrease in benchmarks (Congressional Budget Office 2018).

30 Benchmarks for regional plans and payment rates for MA enrollees with ESRD are established through different

processes. All FFS spending estimates for county-level benchmarks exclude beneficiaries with ESRD.

31 Payments to regional MA plans and payments for enrollees with ESRD—a relatively small share of all payments to MA plans—have a different update factor.

32 Note that OACT also projects the effect of an increasing number of Medicare beneficiaries on total Medicare spending growth, but because benchmarks are based on per beneficiary spending, we excluded this component from our discussion and focus on a per beneficiary annual percentage change in Medicare spending.

33 Two exceptions are dialysis services, where MA plans pay more on average, and skilled nursing services, where MA plans pay less on average.

34 The Commission has identified several issues with mechanisms for setting benchmarks in relation to FFS spending, and these issues are addressed in our June 2021 recommendation. In this discussion, we are focused on the use of FFS spending or some other basis for setting MA benchmarks.

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