HEALTH MANAGEMENT ASSOCIATES

ISSUE BRIEF #4

Options for Adjusting Medicare Advantage Benchmarks and Quality Bonuses to Achieve Program Savings

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Executive Summary

The Medicare Part A Trust Fund is projected to become insolvent by 2028. The Medicare Supplementary Medical Insurance Trust Fund, which includes Part B and Part D, has been and is projected to continue to experience spending growth in excess of Gross Domestic Product growth. One option for addressing excessive spending under both the HI and SMI Trust Funds, in part, is suggested by potential modifications to Medicare Advantage (MA) payment policy, including modifying the MA benchmarks that determine plan payments. MA is likely to be considered in any Medicare savings proposals as it will soon cover more than half of all beneficiaries and, as currently designed, costs both the HI and SMI Trust Funds more than the traditional fee-for-service benefit. Congress could direct the Medicare program to:

- calculate MA benchmarks using spending only for beneficiaries enrolled in both Part A and Part B,
- base MA benchmarks on a blend of local market and national spending, adjusted for local wage differences, and
- choose to **either**:
    - reward plan quality exclusively through rebates
    - **or** reduce MA benchmarks.

Together these policies could reduce Medicare program spending by $51 billion over 10 years if the quality option is chosen or $23 billion over 10 years if the MA benchmarks option is chosen.

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Issue

The Medicare Trustees expect that Medicare's Hospital Insurance (HI) Trust Fund, which covers Part A, will become insolvent by 2028, due to income from dedicated payroll taxes not keeping pace with expenditure growth.[1] While the impending insolvency of the Medicare Part A Trust Fund receives more attention, the Supplementary Medical Insurance (SMI) Trust Fund that covers Part B and Part D is also experiencing high expenditure growth. The SMI Trust Fund will not become insolvent as by design income increases to meet expenditures. Yet this automatic increase in income through increases in general revenue taxes, federal borrowing, and premiums is a growing strain on taxpayers and beneficiaries.

One option for addressing excessive spending under both the HI and SMI Trust Funds, in part, is suggested by refining the way that Medicare pays Medicare Advantage (MA) plans. MA represents a large and growing share of the Medicare program. In 2021, 43% of Medicare beneficiaries were enrolled in an MA plan, and half of beneficiaries are expected to be enrolled by 2025.[2] Due to its significant share of enrollees, MA accounts for a significant share of total

[1] 2022 annual report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, Boards of Trustees (June 2022)
[2] Medicare Advantage: A Policy Primer, The Commonwealth Fund (May 2022)

Medicare spending financed by both the HI and SMI trust funds. Therefore, any plans to reduce spending under either trust fund that exclude MA to focus on the traditional fee-for-service (FFS) side of Medicare, would either need to call for steeper cuts or result in less total savings.

Medicare beneficiaries have been able to enroll in private plans since the 1970s.[3] The Medicare program's method for setting payments for MA (and predecessor) plans has evolved over time—to increase or decrease the appeal of plans relative to the traditional FFS program and to support new goals like paying for quality—but has consistently linked payment per enrollee in MA to spending per beneficiary in FFS. Yet, FFS spending per person varies widely from county to county for reasons that can be grouped into differences across three categories:

1. Population characteristics, including factors such as age and health status, which is affected by social determinants of health among other aspects,
2. Wage costs and other healthcare input costs, and
3. Provider practice patterns.

By linking payment per enrollee in MA to spending per beneficiary in FFS, Medicare's method for determining payments to MA plans carries these three categories of FFS county-level variation into MA payment. It then explicitly addresses variation in population characteristics through risk adjusting plan payment for individual enrollees.

To maintain the linked foundation between spending per person in both MA and traditional FFS, MA payment methodology begins with a "ratebook" that projects what the Medicare program expects to spend per beneficiary in FFS in each county in the country. Given geographic variation in beneficiaries' needs and providers' practice patterns, these amounts vary substantially county to county. The ratebook is used to set a "benchmark" spending amount per person for each county for MA plans to bid against. The nation's counties are grouped into quartiles so that the benchmark is 95%, 100%, 107.5%, or 115% of the projected FFS spending for a county, depending on the amount of local FFS spending per person.[4] To encourage broad MA plan participation across the country, Congress designed benchmark quartiles to be inverse to counties' FFS spending levels. In other words, counties with higher FFS spending per person are assigned lower benchmarks. This system expects that MA plans in high-FFS-spending counties can implement practice patterns that are more efficient than FFS practice patterns in the same area and supports higher payments to plans in areas with already efficient FFS practice patterns. MA plans have responded to this system with bids that are mostly below the county benchmark; in 2022 the average MA plan bid was 85% of FFS spending.

MA plans can choose to submit bids that are above or below the county benchmark. When a plan submits a bid that is higher than the benchmark, Medicare pays the plan the benchmark amount (with adjustments for enrollees' risk scores), and enrollees pay the difference between the benchmark amount and the bid as a monthly premium. When a plan submits a bid that is

[3] 2022 annual report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, Boards of Trustees (June 2022)
[4] Medicare Advantage Program Payment System, MedPAC (November 2021)

lower than the benchmark, Medicare pays the plan their bid amount (with adjustments for enrollees' risk scores) and a portion of the difference between the benchmark amount and the bid as a "rebate." The portion is determined by the plan's quality score and can be 50%, 65%, or 70% of the difference.[5] MA plans must use the rebates to provide additional benefits not covered under traditional FFS Medicare, reduce cost sharing, or reduce Part B or Part D premiums. Plans' quality scores not only determine the portion of the rebate that is paid to plans, they also can raise the benchmark that plans bid against and thus the payments that plans receive. By statute, benchmarks are raised 5% for plans with at least a 4-star rating, and this bonus is doubled in selected counties.[6] Unlike the requirement to use the rebate to benefit enrollees, when the quality mechanism increases the benchmarks, MA plans do not have to pass along these additional dollars to enrollees. Benchmarks, including bonuses, are capped at benchmark levels that were in effect prior to the Affordable Care Act's reform that went into effect in 2012. Including both mechanisms to reward MA plans for quality creates a potential adverse incentive for high-quality plans to opt to increase their bids as plans are eligible to receive 100% of their bid amounts but only 50–70% of the savings for lower bids via the rebate. It is also not clear that raising benchmarks due to a quality score has encouraged higher quality by distinguishing better-performing MA plans from others. Nearly all MA plans (about 90% in 2022) attained the 4-star rating threshold.[7] Despite this lack of evidence, MA's quality payment system increases program spending because it was not designed to be budget neutral or to yield cost savings, as are the quality systems implemented in FFS Medicare.

As noted earlier, MA plans are able to provide services efficiently enough that they submit bids that are mostly below the county benchmark. MedPAC found that in 2022 the average MA plan bid was 85% of FFS spending and that about 92% of plans submitted bids to provide Part A and Part B services for less than the cost of providing these services in FFS Medicare.[8] It is the current level of benchmarks (along with quality bonuses and risk adjustment) that results in program payments to MA plans that are greater than the plans' bids and exceed what the program would pay for beneficiaries enrolled in the traditional FFS benefit. In other words, while most MA plans can provide care at a lower cost than FFS Medicare, the Medicare program does not realize any savings from the MA program as a result of the way plan payments are determined. The current approach also creates inequities. MedPAC reported that plans in the lowest FFS spending quartile (with a 115% benchmark) bid 92% of FFS while those in the highest FFS spending quartile (with a 95% benchmark) were able to bid 76% of FFS.[9] As a result, plans in the highest FFS spending areas of the country receive the largest rebates. This variation in rebates leads to substantial geographic variation in the supplemental benefits that are available to Medicare beneficiaries who choose to enroll in MA.

Finally, the bids that MA plans submit are designed to cover all Part A and Part B Medicare services. Medicare beneficiaries must have both Part A and Part B to enroll in an MA plan. But a number of Medicare beneficiaries have chosen to only sign up for Part A only (about 9%) or

[5] Ibid.
[6] 2022 annual report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, Boards of Trustees (June 2022)
[7] Report to the Congress: Medicare Payment Policy, MedPAC (March 2022)
[8] Ibid.
[9] Ibid.

Part B only (about 0.5%), not both.[10] Beneficiaries who opt to enroll in only one part tend to be healthier than their peers who enroll in both Part A and Part B. To address this issue, the Centers for Medicare & Medicaid Services (CMS) measures FFS spending to create benchmarks by including all beneficiaries in their calculation, adding together spending for Part A-only beneficiaries with that for Part B-only beneficiaries, and risk adjusting the sum for the healthier characteristics of these beneficiaries. However, MedPAC has found that this method does not fully account for the health status of these beneficiaries and has recommended that CMS instead calculate benchmarks using FFS spending of beneficiaries enrolled in both Part A and Part B.[11]

Proposed Policy

Congress could direct CMS to implement a number of modifications to MA payment policy. Following is an illustrative proposal that includes a group of policies that would put MA on a more level playing field with FFS, address geographic variation, and encourage plan bids focused on rebates. The illustrative proposal is comprised of a choice between two policy options that would reduce program spending on MA combined with two companion policies that would redistribute spending across counties while increasing MA spending on average. The latter two policies are included to mitigate the effects of either of the two spending reduction options, in one case to address an existing issue with the way benchmarks are calculated that makes them less reflective of spending in MA, and in the other to control for differences in county-level FFS spending that policymakers may wish to directly reflect in benchmark calculations. The net effect of the illustrative proposal is an overall reduction in MA spending.

Choice between two policy options that will reduce spending on MA:

- **Reward higher quality through one mechanism**—eliminate the quality bonus applied to benchmarks but retain the higher rebate percentage paid to high quality MA plans**.**
- **Reduce county benchmarks by 2.5%**—cut all counties' benchmarks equally.

Included companion policies that will shift county benchmarks and increase spending on MA on average:

- **Align MA benchmark calculations with MA enrollment criteria**—base MA benchmarks on FFS spending per person for Medicare beneficiaries enrolled in both Part A and Part B.

[10] Medicare Total Enrollment, CMS (February 2022)
[11] Report to the Congress: Medicare Payment Policy, MedPAC (March 2017)

- **Modify the MA benchmarks to reduce the impact of geographic variation in practice patterns, while continuing to recognize geographic differences in clinicians' wage costs** —adjust MA benchmarks by implementing a blend of 50% of county-level FFS spending and 50% of the national average standardized FFS spending, adjusted for local wage differences.

Proposed Policy

*Medicare could calculate FFS spending for MA benchmarks using beneficiaries enrolled in both Part A and Part B; base MA benchmarks on a blend of 50% of local market FFS spending and 50% of the national average standardized FFS spending, adjusted for local wage differences; and **either** 1) reward plan quality exclusively through rebates **or** 2) reduce county benchmarks by 2.5%.*

If Congress were to choose to eliminate the quality bonus applied to benchmarks but retain the higher rebate percentage paid to high quality MA plans, then the MA quality payment program would be better aligned with the quality payment program for providers in traditional Medicare and would retain the method that will continue to reward plans via higher rebates, which must be used to provide MA enrollees with enhanced benefits. Alternatively, Congress could opt to reduce current benchmarks by 2.5% across the board. This simple method would harness the savings potential of MA plans' bids that are generally already less than existing benchmarks.

Regardless of which of the two policy options Congress might select, if implemented, the illustrative proposal would more accurately link MA benchmarks to the spending associated with beneficiaries who are enrolled in both Part A and Part B and thus eligible to enroll in MA. It would also introduce a blend of local and national FFS spending to benchmark calculations. As noted above, MA payment policy is designed to reflect geographic and other differences in the cost of providing care to enrollees. MA payments are explicitly adjusted for one of the three categories of geographic variation in FFS spending—beneficiary characteristics—through risk adjustment. Policymakers could modify benchmarks to include a blend of 50% of county-level FFS spending and 50% of the national average standardized FFS spending, adjusted for local wage differences. Wage differences are already reflected in variation in FFS spending, but by explicitly incorporating an adjustment for it in benchmark calculations, policymakers would signal that the remaining category of variation—provider practice patterns—is one that should not be controlled for or accepted as the status quo but instead MA plans should be asked to work to address unwarranted practice patterns. Adjusting for local wage differences would ensure that plans operating in markets with higher labor costs could receive higher payments, in much the same way that hospitals operating in those same high labor cost markets receive higher payments from the Medicare FFS program. Including national FFS spending in the blend would generally reduce the effect geographic variation in provider practice patterns has on MA benchmarks and ask MA plans to play a larger role in addressing this variation through managed care activities, such as building networks of providers who embrace value-based care and implementing care management and utilization management techniques.

Based on my analysis of Medicare data, I estimate that implementing the MA policies included in the illustrative proposal beginning in 2025 could yield $51 billion in savings over 10 years if policymakers opt to reward plan quality exclusively through rebates or $23 billion in savings over 10 years if policymakers opt to reduce county benchmarks by 2.5%.

Potential Savings

Implementing the MA policies of calculating FFS spending for MA benchmarks using beneficiaries enrolled in both Part A and Part B; basing MA benchmarks on a blend of 50% of local market FFS spending and 50% of the national average standardized FFS spending, adjusted for local wage differences; and rewarding plan quality exclusively through rebates could yield savings to the Medicare program of $51 billion over 10 years.

Alternatively, implementing the MA policies of calculating FFS spending for MA benchmarks using beneficiaries enrolled in both Part A and Part B; basing MA benchmarks on a blend of 50% of local market FFS spending and 50% of the national average standardized FFS spending, adjusted for local wage differences; and reducing county benchmarks by 2.5% could yield savings to the Medicare program of $23 billion over 10 years.

While the impact the proposed policies would have on quality of care and additional benefits is unclear, existing evidence suggests that the effects are likely to be minimal. The policies are designed to reduce benchmarks and spending on MA plans, but the current level of MA benchmarks and spending have not been shown to result in higher quality for beneficiaries who choose to enroll in MA. The current level of benchmarks and MA spending do support additional benefits for the beneficiaries who choose to enroll in MA, but this is not a one-to-one relationship (i.e., each additional dollar spent on MA does not have to be passed along to enrollees in the form of a dollar's worth of additional benefits or reduced premiums or cost sharing.) To the extent that MA plans choose to respond to the illustrative proposal policies by offering fewer additional benefits, it is not clear that this reduction would have an effect on quality as MA's additional benefits appeal to some beneficiaries and serve to encourage them to enroll in plans but have not been shown to improve the performance of these plans' quality of care. Furthermore, as noted earlier, MA plans already bid significantly below current benchmarks and have demonstrated the ability to reduce their bids in response to lower benchmarks. Because MA plans have flexibility in their bidding strategy and would continue to be rewarded for quality of care, it is likely that MA plans could respond to the illustrative proposal policies in a manner that, even if it included some reduction in additional benefits, would not affect patients' health outcomes and overall experience of care.

Methodology and Assumptions

I first recalculated MA benchmarks in every county to estimate spending based on individuals with both Part A and Part B enrollment. I relied on the MA county landscape and used a combination of data published in the Medicare Geographic Variation public use file (which only contains spending for beneficiaries with both Part A and Part B coverage) as well as a proprietary analysis of the Medicare 100% claims data.

I then estimated the national average standardized FFS spending, again relying on the Medicare Geographic Variation public use file. This file provides both the standardization factor as well as the geographic adjustment factor for each county in the US. I calculated a wage-adjusted local market standardized FFS rate for each county and blended it with the local market actual FFS spending.

I next applied these new MA benchmarks to each county and recalculated each plan's enrollment-weighted benchmark, both with and without a 2.5% reduction in benchmarks and with and without the quality bonus applied to benchmarks. I estimated the new rebate that each plan would receive with any of these adjusted benchmarks.

CBO has previously demonstrated that MA plans adjust their bids to minimize changes to rebates. I followed this process and assumed that any plan with a reduction in rebates due to revised benchmarks would lower its bids in order to preserve up to 50% of the lost rebate amounts.

CBO has also generally applied upward or downward adjustments to MA enrollment based on the generosity of a plan's rebate, since rebate dollars are the primary mechanism that plans can use to enhance benefits and attract enrollment. For each plan in the analysis, I increased or decreased expected enrollment based on the changes in rebates, with larger changes in rebates associated with larger changes in enrollment.

I also accounted for the expected change in average FFS spending due to the changes in MA enrollment. In general, the revised benchmarks reduce payments to MA plans in areas that currently have lower-than-average FFS spending. Some Medicare beneficiaries affected by these changes are likely to shift to the traditional FFS program, which results in an overall decrease in the weighted average FFS spending. Note that in some scenarios, the remaining MA enrollment has a slightly higher average spending per enrollee as well, due to compositional changes in enrollment as well as changes in actual payment levels.