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:

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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

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.

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

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.