As of the fall of 2021, of the 62 million beneficiaries enrolled in Medicare, 26 million (42%) were enrolled in Medicare Advantage (MA), which are plans offered by private companies that have been approved by the Centers for Medicare & Medicaid Services (CMS) to serve Medicare beneficiaries. More than 5 million of the MA enrollees are retirees in employer-sponsored plans. Medicare Advantage will likely enroll the majority of beneficiaries by 2030, making it the dominant delivery system used in Medicare.

Medicare Advantage plans are required to offer the benefits in traditional Medicare (ie, Medicare Parts A and B), which include inpatient and outpatient hospital care, physician care inside and outside the hospital, laboratory care, durable medical equipment, and a limited amount of home care. Most MA plans (89%) also offer Part D prescription drug coverage. According to the Kaiser Family Foundation, most MA plans (59%) do not charge beneficiaries any additional premium beyond what they would pay for Part B—a minimum of $170 per month in 2022, a figure that rises with income.

The large and growing share of beneficiaries in MA and the diminishing share of those enrolled in traditional Medicare is consistent with the philosophy underlying the structure of Medicare when the program was established in 1965. Specifically, when older Americans retire, they should have health insurance that is similar to the type of insurance they had while working. For the first 20 years of Medicare that meant fee-for-service plans similar to the high-option Blue Cross Blue Shield plans—what we now label traditional Medicare. However, by the late 1980s and into the 1990s, the use of health maintenance organizations (HMOs) grew substantially as did preferred provider organizations (PPOs) in employer-sponsored plans. This trend meant that traditional Medicare was no longer the type of insurance that individuals who were reaching retirement age had while they were in the workplace.

There are ongoing debates about the similarities between individuals who enroll in MA plans and the general population of Medicare beneficiaries and also about whether MA is more or less costly than traditional Medicare for the federal government. The characteristics of people enrolling in MA are straightforward to assess. Whether MA costs the government more than would be spent if these individuals had enrolled in traditional Medicare depends on whether there is “favorable selection” (for people who are systematically healthier) of enrollees in MA and whether it is appropriately addressed by the risk-adjustment measures that CMS uses to deal with differences in beneficiary health levels. It is more complex to determine the appropriate response for people who choose to stay in MA and whether they are healthier (or sicker) than those who choose traditional Medicare because it is unclear whether the MA plans are responsible for any difference in health outcomes over time.

Beneficiaries who are enrolled in traditional Medicare have characteristics that are similar to those in MA plans if the 4 million beneficiaries who are in special needs plans (or SNPs) are excluded. The SNPs are limited to people who either have specific medical conditions or who are dually eligible for Medicare and Medicaid. When the SNP population is excluded, MA enrollees and traditional Medicare enrollees look similar in terms of age, race, income, and chronic conditions. If the MA enrollees in SNPs are included, MA enrollees are more likely to be Black or Hispanic and to have chronic health conditions such as diabetes. A recent systematic review found that MA enrollees report more preventive care visits, fewer hospitalizations and emergency department visits, shorter
hospitalizations, and lower spending compared with those in traditional Medicare—but found that readmission rates or mortality rates did not differ. Because these findings represent a compilation of studies and most studies exclude people in SNPs, they primarily reflect people who are not in such plans.3

Some payments to MA plans are deliberately set higher, in a non-budget-neutral manner, to reward for higher quality as determined by the star rating program. Medicare uses information from satisfaction surveys, the plans, and the physicians who provide care to determine member access to preventive services, care for chronic diseases, as well as overall satisfaction with the service provided. For most counties, receiving 4 or 5 stars means that the CMS will pay plans a 5% bonus. In some urban counties (known as double-bonus counties), health plans with 4 or 5 stars receive a 10% bonus.

Aside from these explicit nonneutral payments to MA plans, several analysts have raised concerns about whether and how much more MA plans spend for enrollees relative to what traditional Medicare spends for comparable beneficiaries.4,5 Most of the debate has centered around the risk adjustment system used by the CMS and whether it may be exploited so that MA plans can offer extra benefits to attract beneficiaries. Initially, the argument had focused on whether plan administrators had been reporting enrollee diagnoses more comprehensively compared with physicians billing traditional Medicare, making MA plan beneficiaries appear sicker than they are relative to enrollees in traditional Medicare and leading to higher payments from the CMS.

However, starting in 2022, the CMS uses only encounter data to calculate its risk adjustment for both MA and Part D plans. Questions have already been raised about the accuracy of encounter data,6 although in my experience as a former administrator of the Health Care Financing Administration (renamed the CMS in 2001), we regarded encounter data as the most accurate data available to the agency. It may be desirable to validate information from encounter data to bring clarity to this issue.

Medicare was created with the intent of providing retirees with health insurance coverage comparable with the coverage they received while working, but few people retiring into Medicare now have had experience with an indemnity plan similar to traditional Medicare. Continuing the philosophy underlying the creation of Medicare means that MA, with its offerings of HMO and PPO network plans, will and should become the dominant form of Medicare for future generations of retirees. This will pose challenges for policy makers because the impending dominance of MA makes its reliance on traditional Medicare for calculating capitation payments an anachronism that needs to be replaced, perhaps with a competitive bidding process. Replacing the pricing system is among the thornier issues that policy makers will need to address, along with safeguards such as network adequacy and appropriate quality metrics that need to be in place to protect future beneficiaries.

ARTICLE INFORMATION
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REFERENCES


