The US health care system relies more heavily on market mechanisms than the health care systems in most other high-income countries. For this reason, many scholars studying the US system examine aspects of how well the market system works. One strand of this research explores the associations between price and quality, and the study by Haviland and colleagues in this issue of JAMA Health Forum exemplifies this research. Specifically, the authors analyze the associations between premiums and quality in the Medicare Advantage market, which is composed of private health plans that served almost half of eligible Medicare beneficiaries in 2021. Although this study found a positive association between premiums and plan quality, the authors characterized its magnitude as “slight” and noted the wide variation in health plan quality within premium categories. As a result, the authors recommended more resources be devoted to providing more and better quality information to Medicare beneficiaries and their advocates. The authors’ interpretation of the findings—that beneficiaries may not be making optimal plan choices—was reasonable. However, it was less clear whether providing more or better information will address the problem.

Although improving beneficiary plan choices could be valuable, a more pressing and more controversial policy issue is how much Medicare Advantage plans should be paid. There is reasonable evidence that Medicare Advantage plans can provide the Medicare benefit package at a lower cost than traditional fee-for-service (FFS) Medicare, which can help finance expanded benefits to Medicare beneficiaries, and the related spillover effect can reduce FFS spending. Moreover, Medicare Advantage plans can be associated with improved outcomes, and, in some cases, Medicare Advantage plans may be overly strict with prior authorization. Given the general demographic characteristics of Medicare Advantage enrollees, many of its benefits accrue to disadvantaged populations. On balance, this evidence broadly implies that Medicare Advantage has been associated with notable positive benefits.

Yet Medicare Advantage plans can be simultaneously efficient and overpaid, and there is ample evidence that these plans are paid more than what the same enrollees would cost in FFS Medicare. In part, the payments higher than FFS payments reflect how the Medicare Advantage quality bonus program, which is related to the Star Rating Program, works; it also reflects the more complete and, in some cases, excessive documentation of disease by Medicare Advantage plans. High Medicare Advantage spending also reflects deliberate policy decisions, included in statute, to pay more than FFS Medicare in counties with below-average FFS spending, counties where the more generous benefits of Medicare Advantage enrollees in higher FFS-spending counties would otherwise not be likely. In essence, regardless of why Medicare Advantage spending exceeds FFS spending, the high spending supports greater benefits. Thus, it is not surprising that many stakeholders view Medicare Advantage as a mechanism for enhancing the generosity of benefits packages available to Medicare beneficiaries enrolled in Medicare Advantage.

Despite the added benefits associated with paying Medicare Advantage more than FFS Medicare, doing so is problematic for several reasons. First, much of the added payment, whether because of higher benchmarks, quality payment, or risk adjustment payments, may not reach beneficiaries. Research suggests that Medicare Advantage bids rise when benchmark payments...
increase and thus, only approximately half of added payments (less by some estimates) get passed along to beneficiaries. Second, the value of the added benefits is unclear, particularly for those benefits about which little utilization data are available (eg, transportation, meals) and little is understood about how they affect beneficiaries’ health and well-being. Third, because payments for the Medicare Advantage program are based on FFS Medicare spending, continued growth in the share of beneficiaries in Medicare Advantage (and thus shrinkage of the FFS share) makes setting payment benchmarks challenging. Hypothetically, were 100% of beneficiaries to be covered by Medicare Advantage, the existing system for setting its payment benchmarks would collapse. However, even before such an extreme is reached, concerns about representativeness and variability in spending of those remaining in FFS Medicare is a problem. Fourth, the growth in Medicare Advantage undermines efforts to transform the Medicare FFS system, particularly value-based payment reform. This concern arises because alternative payment models (APMs), such as accountable care organizations, and episode payment models require a sufficient number of beneficiaries to pool the risk that alternative payment models impose. As Medicare Advantage siphons beneficiaries away, APMs will become less viable for many practitioners and facilities. Finally, because a portion of Medicare Advantage payments are drawn from the Medicare Part A trust fund, high Medicare Advantage payments exacerbate Medicare’s fiscal challenges and sustainability.

Several broad policy approaches could address high Medicare Advantage payments. First, Medicare Advantage payments could be reduced by cutting its payment benchmarks or raising the adjustment for increased coding intensity in Medicare Advantage. These cuts would undoubtedly be associated with diminished Medicare Advantage plan generosity, which has grown by approximately 50% since 2019. Moreover, cuts could be made gradually, starting with a modest cut (eg, 2%) and tracking its effect, and then making adjustments. Second, the FFS benefit package could be expanded. This change might exacerbate Medicare’s growing fiscal challenge, but if the goal is to expand benefits, doing so in a symmetric way may slow the demise of the traditional Medicare program.

As the findings of Haviland and colleagues suggest, the Medicare Advantage program could be improved by helping beneficiaries to choose better plans for themselves. Broader strategic reforms will likely be needed as well. The exact nature of these reforms may require substantial redesign and policy tradeoffs, such as how to balance the fiscal saving and benefit enhancement features of the Medicare Advantage program. Nevertheless, given the complexity of these tasks, making the needed policy decisions sooner rather than later would be wise.


