What Will Cuts to Medicare Advantage Payments Do to Enrollment?

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Half of US Medicare beneficiaries are now enrolled in Medicare Advantage (MA)—a share that is expected to exceed 60% by 2032.1 Despite the increasing importance of MA for policy makers and the delivery system, the effect of payment policy on plans and beneficiaries remains relatively understudied. More evidence is needed to better understand the effects of potential federal efforts to slow MA payments, such as recent regulations to curtail incentives for MA coding intensity, which tend to generate substantial controversy.2 This type of controversy will likely intensify, as efforts to slow Medicare spending increasingly consider or involve MA.

MA Payment System

Medicare Advantage is a publicly financed, privately administered arm of the Medicare program. Key policy issues in MA can be contextualized within a 4-step process (Figure). First, the Centers for Medicare & Medicaid Services (CMS) publishes a benchmark payment rate for each county—an amount that CMS is willing to pay a private plan for enrolling a beneficiary of average risk. This key element of plan payments can be thought of as an offer, an upper limit on the government’s defined contribution, reflecting what the government estimates a private plan would need to take care of a beneficiary of average risk. Second, each MA plan chooses the counties it would like to offer coverage in and submits a plan-level bid to CMS for those counties. This bid is a counteroffer—the amount that the plan thinks it needs to take care of a beneficiary of average risk across those counties.

Third, CMS compares the plan’s bid to the benchmarks in those counties and determines the final plan payment. If the bid exceeds the benchmark, CMS pays the benchmark, and plans would need to ask for the difference from beneficiaries through a monthly premium. But if the bid is below the benchmark, CMS pays plans their bid along with a rebate—a bonus that plans can use to offer additional benefits (eg, vision, dental, hearing coverage) or buy down a beneficiary’s cost sharing or premiums. This rebate, boosting plan generosity, is a proportion of the difference between the bid and the benchmark, with the exact percentage (50%-70%) determined by the plan’s quality (star) rating. Thus, for a given plan, the lower its bid, the larger its rebate. The larger its rebate, the more attractive it can be for enrollees. Finally, in step 4, Medicare beneficiaries make enrollment decisions among plans in their county and the traditional Medicare option.

Figure. The Medicare Advantage Program and Recent Evidence

Key policy issues in Medicare Advantage can be contextualized within this 4-step process, from benchmark payment rates to beneficiary enrollment. The recent studies noted provide newer evidence on the associations between these steps in the process.
Newer Evidence

In this 4-step schematic, an overarching policy question is how changes in MA payment (step 1) will affect MA enrollment (step 4). Why is this question important? For policy, if lowering federal spending does not reduce MA enrollment, it suggests that savings are possible without diminishing the value of the MA program to beneficiaries—at least relative to alternatives. Early in the Affordable Care Act (ACA), which lowered MA benchmarks (to partly finance coverage expansion), enrollment was projected to decline in response to the benchmark cuts. Yet, while benchmarks did go down, albeit gradually, in about a quarter of counties, the enrollment losses never materialized. Instead, enrollment grew. In this issue of JAMA Health Forum, Schwartz and colleagues provide rigorous new evidence on the association between these ACA-related benchmark cuts and enrollment.3

Using data from 2008 to 2019, the authors found that not only were ACA-related benchmark cuts not associated with lower MA enrollment, but also that enrollment grew in a way seemingly unrelated to the ACA cuts.3 They assessed a natural experiment in benchmark changes, where some counties were affected more than others because of how the law was written, not because of benchmark changes possibly associated with factors more susceptible to confounding. Using a difference-in-differences strategy, they showed that counties with larger payment cuts did not exhibit differential changes in enrollment relative to counties with smaller payment cuts. Their finding that enrollment was not sensitive to these payment cuts contrasted prior studies, which generally found a positive association between changes in payment and changes in enrollment.6-10 Of note, however, prior studies largely examined payment increases, rather than cuts. Reconciling this difference, the authors theorized that MA plans may respond differently to payment increases and decreases—perhaps passing through higher payments to enrollees but shielding enrollees from payment cuts.3

Why was MA enrollment not sensitive to ACA-related payment cuts? For one, MA plans do not fully pass through cuts to enrollees.6,11 By lowering their bids in response to lower benchmarks, plans can shield their rebates from the benchmark cut, thus maintaining their plan generosity for beneficiaries. Second, new ACA-related quality bonuses,12 which included a doubling of the quality bonus program bonuses in certain counties, were strong buffers against the benchmark cuts.

Third, benchmark cuts may have been offset, or even exceeded, by additional plan revenue from coding intensity, gaming bonuses, selection behavior, and other plan responses. Evidence shows that the revenue from coding intensity mostly supports plan profits, though a small share passes through to beneficiary rebates and lower premiums.13 An insurer could, until recently, boost quality-related earnings by consolidating lower-star contracts into higher-star contracts, after which it received the higher-star bonus for all beneficiaries in those consolidated plans. In a given year, these extra revenues may amass faster than a slow benchmark cut phased in over 2 to 6 years.3

Additionally, there may be structural reasons for MA enrollment to be “sticky.” Medicare Advantage plans in some counties face little competition, reducing viable alternatives for beneficiaries.14 Medicare Advantage insurers in the ACA-targeted counties (larger counties that tended to have higher traditional Medicare spending) may have been uniquely positioned to weather the cuts, as Schwartz et al noted.3 As a competitor, traditional Medicare, while free of network and utilization constraints, has long struggled to match the otherwise appeal of a zero-premium MA plan with vision, dental, and hearing coverage on top of cost-sharing reductions, even with Medicare supplemental coverage. Beneficiary demand for MA may be sustained through direct-to-consumer advertising, and “seamless conversion” allows insurers to default new beneficiaries into MA unless the beneficiary actively opts out.

Two additional recent studies provide further evidence, particularly around plan behavior (steps 2 and 3). Chernew and colleagues, using data from 2012 to 2019, found that changes in benchmarks had a quite modest effect on rebates.4 They estimated that a reduction of $1000 in the benchmark would only raise the premium by $60 and the deductible by $27 on an annual basis, with what little effect on additional benefits largely reflected through vision, dental, and hearing coverage, rather
than meals or transportation. Similar to Schwartz et al, the authors concluded that should benchmark cuts materialize, effects on plan generosity would be modest.4

Pelech and Song, using data from 2006 to 2019, found largely symmetrical pass-through behavior via strategic bidding in response to benchmark increases and cuts—plans passed 25% of benchmark increases through to beneficiary rebates and passed 26% of benchmark cuts through to beneficiary rebates.5 However, plans responded to reduced benchmarks by cutting the less salient parts of the rebate (additional services and cost-sharing benefits) more so than the more salient parts (premiums). This points to an additional strategy for softening the apparent blow that benchmark cuts could have on plan appeal. The study concluded that lower plan bids, along with quality bonuses and risk score growth after the ACA, shielded plan rebates and helped explain the robust growth in MA enrollment.

Implications for Future Policy
The fact that MA enrollment surged in the face of ACA-related benchmark reforms—and that the growth of MA plan sponsors was similarly undeterred (notably among physician organizations and privately funded primary care groups)—suggests that MA plans were effective in absorbing, or overcoming, the ACA-related benchmark cuts. In the end, due to the offsets and phase in, these cuts were, on average, not large (though they were more substantial in some counties). Consistent with Schwartz et al and Chernew et al, this offers policy makers some reassurance that modest cuts to MA payments would likely not lead to substantial disruptions in enrollment. One such payment cut recently emerged in the form of CMS regulation to reduce the profitability of coding intensity, which will be phased in over 3 years in the final rule. Though lively debate about the potential effects on beneficiaries ensued, on balance the evidence suggests its effect will likely be minimal.

At the same time, the key to any future payment cut remains how large the cut will be—and what counties are targeted. How it gets implemented and what other reforms to MA come along with it would also matter. In the simplest of terms, there is a range by which MA subsides could be cut without disrupting plan generosity enough to affect enrollment, as the ACA experience showed. In this range, MA would likely remain, on average, sufficiently profitable for continued growth. Next, there is a range by which MA subsidies could be cut to levels below plan costs, portending plan losses, after which plans would need to lower their cost structure (eg, reduce benefits), add revenue (eg, raise premiums), or pursue other means (eg, coding, selection) to retain their profitability. This could more meaningfully affect enrollment. Finally, beyond that, there would be amounts by which MA subsidies could be cut to make MA no longer viable for insurers.

Of course, the goal of MA payment policy is not to eliminate the MA program. Medicare Advantage is popular in large part because of its additional benefits and lower out-of-pocket costs relative to traditional Medicare, and beneficiaries have voted for MA with their feet despite the restrictions on network choice and health care utilization. Rather, the goal is to reduce that portion of subsidies that is truly the overpayment while maintaining the parts of subsidies that—while costly to society—are worth it, including those that help improve equity.15 Unfortunately, discerning the true size of subsidies is intrinsically difficult due to the methodological challenges of separating true patient risk from coding intensity.16 Further distinguishing overpayment is thus even trickier.

Given this reality, designing an optimal benchmark cut is difficult, with political constraints likely more binding. Optimal policy should support an MA marketplace that is sustained by the value these plans create for beneficiaries, not by excess spending that could be just as valuable if spent in traditional Medicare or by arbitrage or gaming behavior. Different stakeholders have different normative views about the magnitude of such a cut. The Medicare Payment Advisory Commission recently recommended a minimum 2% cut.17 Other analysts would likely argue for more.2 For the immediate future, cuts of any meaningful magnitude face a challenging legislative path, given MA's popularity and its conceptual compromise as a left-of-center social benefit (health insurance)
delivered via a right-of-center vehicle (markets). In this environment, MA policy will likely need to proceed along a test-and-learn approach, with each effort to improve program efficiency both a contentious policy battle and an invaluable learning experience.

**ARTICLE INFORMATION**

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**REFERENCES**


