

Understanding the Medicare Advantage Program

October 2017



KEY HIGHLIGHTS

- Fee-for-service (FFS) Medicare and Medicare Advantage (MA) plans both provide all Medicare benefits, but MA is a notably different model than FFS offering care coordination, disease management, out-of-pocket cost protections, and often additional benefits.
- Unlike FFS, which pays providers based on the services they perform, MA plans receive a capitated payment under which they bear the full risk for providing all Medicare benefits to enrollees, giving plans an incentive to prioritize value of care over volume.
- As MA enrollment continues to increase, there are “spillover” effects onto FFS that lead to improvements in service utilization and lower costs for the Medicare program overall.

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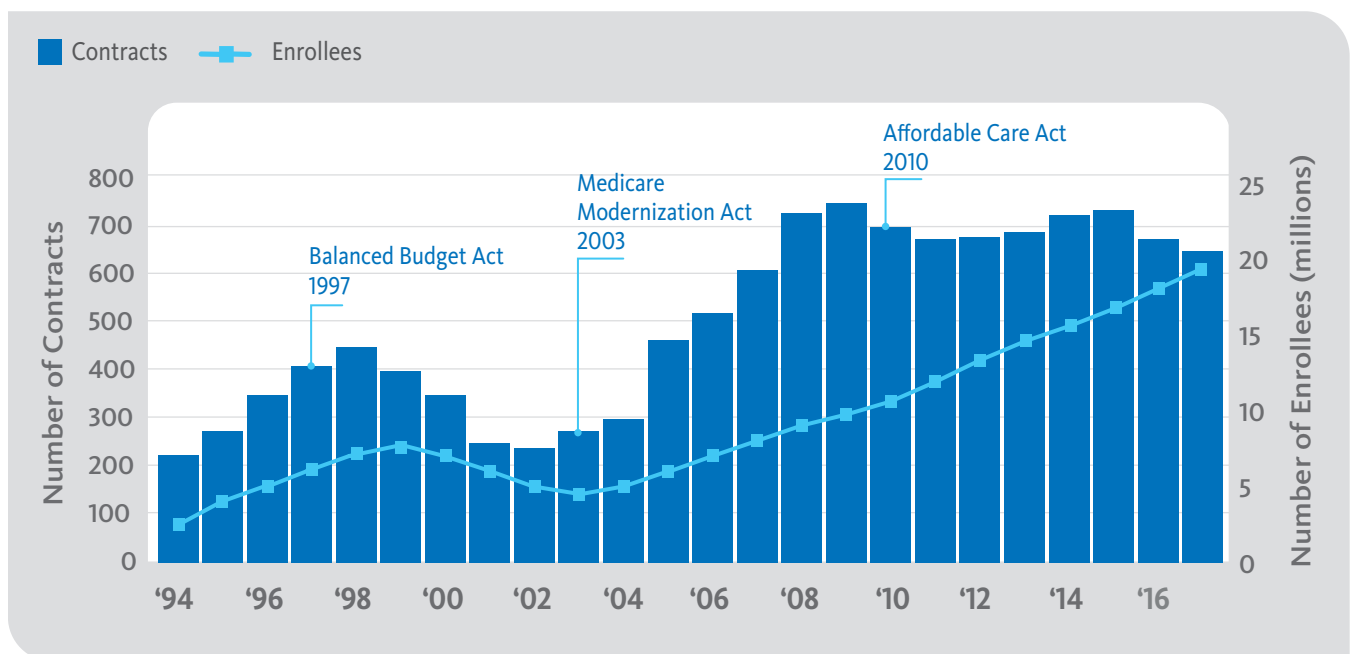
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Overview

Approximately 19 million Medicare beneficiaries, or almost one-third of the Medicare population, receive their benefits through a Medicare Advantage (MA) plan.

MA plans are private plans that provide Medicare benefits as an alternative to traditional Medicare, also known as Medicare fee-for-service (FFS). Unlike FFS, MA plans provide care coordination programs and disease management programs and may offer Medicare beneficiaries additional benefits to supplement their coverage. Most MA plans also provide prescription drug coverage in combination with the medical coverage. MA plans offer a more coordinated approach to care compared to the fragmented coverage generally received through FFS.

Figure 1
Number of Contracts
and Enrollees by Year,
1994-2017



Source: Centers for Medicare & Medicaid Services. Medicare Advantage/Part D Contract and Enrollment Data.

Types of MA plans

There are a number of different types of MA plans that beneficiaries can choose from when selecting coverage. The most common type of plans are health maintenance organizations (HMOs), which account for almost 70 percent of available MA plans. Other plans include local preferred provider organizations (PPOs) offered in one or more counties, as determined by the plan; regional PPOs offered in an entire state(s), as required by CMS, and private-fee-for-service (PFFS) plans, which are now only offered in rural areas where provider networks are difficult to establish.

Some MA plans, known as special needs plans (SNPs), offer more specialized coverage for beneficiaries. These plans can limit enrollment to certain categories of beneficiaries with particular needs. They include:

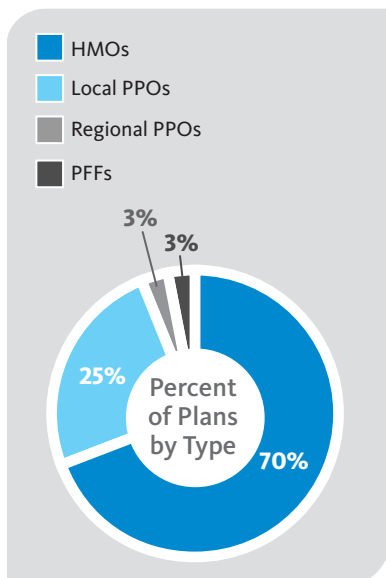
1. **Dual eligible special needs plans (D-SNPs)** for beneficiaries who are dually eligible for Medicare and Medicaid (known as “dual eligibles”);
2. **Institutional SNPs (I-SNPs)** for beneficiaries who live in long-term care institutions or would otherwise require an institutional level of care; and
3. **Chronic condition SNPs (C-SNPs)** for beneficiaries with certain specified chronic or disabling conditions.¹

Finally, MA employer group waiver plans (EGWPs) limit enrollment to the employer group and provide the standard Medicare benefit, but allow employers to supplement those benefits or reduce cost sharing for their retirees.

Access to MA plans

In 2017, 99 percent of Medicare beneficiaries have access to an MA plan option and 95 percent have access to a local coordinated care plan like an HMO or PPO. Further, there is robust participation among MA plans; beneficiaries have an average of 10 plans in their area to choose from when selecting MA coverage.²

Figure 2
Percent of Plans by Type, 2017



Source: Kaiser Family Foundation. Medicare Advantage 2017 Spotlight: Enrollment Market Update.

Medicare Advantage is a different model than FFS Medicare

MA plans are paid in a manner that is significantly different than traditional FFS Medicare.

MA plans receive a capitated payment from the Centers for Medicare & Medicaid Services (CMS), plus any additional required beneficiary premiums, each month for each enrollee for providing the Medicare (Part A and Part B) benefit, as well as a separate capitated payment for the Part D benefit if they provide that as well. MA plans bear the full risk of providing the Medicare benefits within the capitated payment; they do not get paid more if their costs exceed their payments.

The fee-for-service system pays providers based on the number of services they perform, regardless of the relative appropriateness of those services. This creates a system that rewards providers that perform unnecessary tests, and often penalizes those that provide high value, clinically appropriate care. Though FFS Medicare recently began providing a monthly fee that attempts to incentivize FFS providers to deliver care coordination services to their FFS patients, the current system on whole still incentivizes more care over higher value care. Alternatively, the capitated payment model under which MA is administered inherently incentivizes plans to coordinate and effectively manage their enrollees' care, keep members healthy, prevent avoidable complications of chronic disease, and to prioritize value over volume of care and services.



MA plans actively coordinate care and manage chronic conditions, efforts intended to help keep enrollees healthy.

At the same time, plans are held to requirements that govern the amount of their payments that must be spent on medical care and improving quality of care (known as minimum Medical Loss Ratio (MLR) requirements). While plans don't get paid more if costs exceed their payments, if they spend less than their payments, and do not meet the minimum MLR requirements, plans must return a portion of their payments to CMS. If a plan continues to fail to meet the MLR requirements it might be prohibited from enrolling new members and further failure to meet the MLR requirements could result in termination of its MA offerings.

Plans are also held to rigorous quality standards which assess member experience, how well plans keep members healthy and manage members' chronic conditions, and compliance with CMS standards such as call center wait times, among other factors. Plans' scores are available on the Medicare plan shopping website, to help encourage beneficiaries to compare and select plans based on quality. Plans that fail to achieve and maintain minimum levels of performance on these quality metrics are at risk of termination from the MA program. Notably, CMS does not measure or report on FFS quality scores the way it does for MA plans. As a result, Medicare enrollees have no way of comparing the quality of traditional FFS to available MA plan options.

As described above, because of the capitated payment structure, MA plans bear full risk for the cost of providing Medicare benefits to their members. As a result, the incentives for plans are different than those of FFS providers. MA plans are successful if they identify conditions earlier, ensure that members' chronic conditions are well managed, and generally keep members healthy. To do this, plans use various tools such as care coordination programs, medication management that is integrated with the medical benefit, and new services and health technologies like remote monitoring systems and telehealth. In other words, MA plans fare better than FFS by engaging members in their health and wellbeing and proactively managing chronic conditions in order to avoid more unnecessary resource-intensive provider encounters—all of which benefits the MA patients.

MA plans provide significant value and benefits to members

While MA plans must offer at least the traditional Medicare benefits, there are a number of ways that MA plans offer beneficiaries a more valuable option for Medicare coverage.

MA plans offer a coordinated approach to care, unlike FFS Medicare

Fundamentally, MA plans offer an approach to health coverage that is better for beneficiaries and for the long-term sustainability of Medicare. MA plans focus on coordinating care so that members get the care they need and avoid harmful or duplicative care. They also take a holistic view of members' healthcare needs, and can connect members to care managers and disease management programs which can help them navigate the healthcare system and better manage chronic conditions. As a result, recent studies document that MA plans can reduce inappropriate use of services and can improve the quality and outcomes for members.³

MA plans provide additional benefits and out-of-pocket cost protections

Beneficiaries also choose MA plans because they provide meaningful extra benefits that enhance their Medicare coverage, as well as cost-sharing reductions and other out-of-pocket (OOP) protections.

- **Extra Benefits:** One of the key features of the MA program is the ability to offer benefits that traditional Medicare doesn't cover. These benefits may include vision, dental, or hearing benefits, programs like Silver Sneakers Fitness Programs, and 24-hour nurse help hotlines.

- **Reductions in Cost Sharing:** Most MA plans reduce cost sharing for beneficiaries and offer an easier-to-understand benefit structure (e.g., copays in place of coinsurance, single deductible) relative to FFS.
- **Maximum OOP Cost Protections:** MA plans are required to have a maximum OOP limit that protects members from incurring high OOP costs for needed care. Many MA plans voluntarily have even lower limits to further protect members. FFS Medicare does not include this protection.
- **Integrated Drug Benefit:** Most MA plans offer the Medicare prescription drug benefit with their MA benefit (known as MA-PD plans). This allows greater coordination of medical and drug coverage and allows plans to more effectively promote medication adherence.



Medicare Advantage Extra Benefits

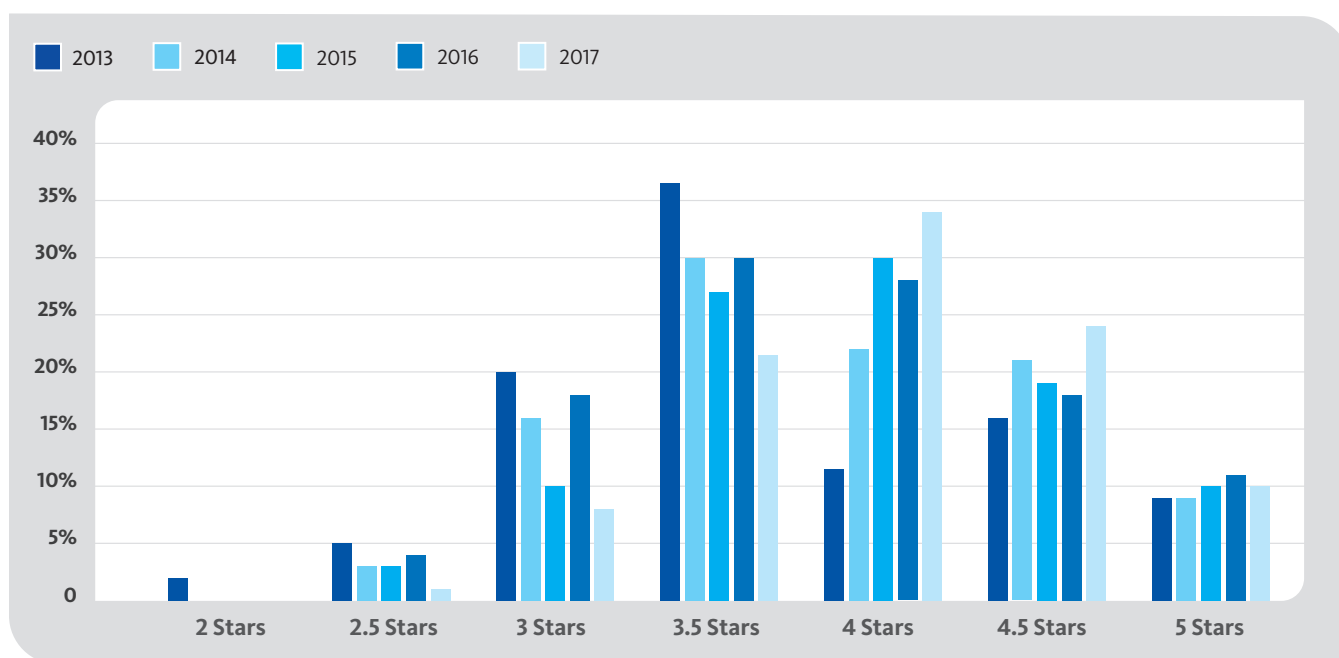
- 24-Hour Nurse Help Hotline
- Acupuncture
- Annual Wellness Exams
- Care Coordination with Medical and Social Supports
- Dental
- Enhanced Mental Health or Substance Use Disorder Services
- Hearing
- Over-the-Counter Prescription Drugs
- Personal Emergency Response System
- Silver Sneakers Fitness Program
- Telehealth
- Transportation
- Vision
- Weight Watchers

MA plans provide high-quality care

MA plans are evaluated on quality across a variety of performance measures—including measures on prescription drug coverage for plans that provide the Part D benefit. The quality measure scores are combined into an overall score known as the MA Star Rating. The overall scores range from 1 to 5 stars with 4 or 5 stars representing higher quality plans. The MA payment system (described in more detail below) incorporates quality performance and rewards higher performing plans with increased payments.

Most MA enrollees are in high performing plans; close to 68 percent of MA-PD enrollees are in plans with quality ratings of four or more stars (out of five) in 2017. Approximately 49 percent of MA-PDs earned four stars or higher for their 2017 overall rating.⁴ In general, plans' quality scores continue to improve, with an increasing share of plans receiving four or more stars since 2013.

Figure 3
Distribution of MA-PD Enrollees
by Contract Quality Score,*
2013-2017



Source: Centers for Medicare & Medicaid Services. 2017 Star Ratings.

*These ratings summarize all Part C and Part D measures combined. Does not include contracts that were too new to be measured or did not have enough data to calculate a rating.

Members are highly satisfied with MA plans

Numerous studies demonstrate the value of MA plans to enrollees. A recent study found that 91 percent of seniors in MA are satisfied with their coverage, with 69 percent saying they are highly satisfied. Among seniors who switched to MA from FFS Medicare, 58 percent say MA is better while just 2 percent say FFS is better. Another survey found 90 percent of MA members are satisfied with their plans, 94 percent are satisfied with the quality of care they receive, and 90 percent are satisfied with the benefits received from their MA plan.⁵

MA plans positively impact the traditional Medicare Program

MA plans' efforts to improve care, such as through improved coordination and focus on value, influence the way in which providers deliver care to all of their patients—in both MA plans and traditional FFS Medicare. The positive “spillover effects” have contributed to improvements in healthcare service utilization and, importantly, a slowdown in overall Medicare spending.⁶

- One recent study examined the impact of the rate of MA enrollment on the treatment for FFS beneficiaries with a diagnosis of Acute Myocardial Infarction (AMI). Areas with rates of higher MA enrollment were associated with a reduction in both the costs and the treatment intensity of FFS AMI patients. Specifically, a one percent increase in MA market penetration was associated with a 0.94 percent reduction in hospital costs for FFS AMI patients, a 2.2 percent reduction in the number of inpatient procedures, a 2.4 percent reduction in the probability of receiving an angioplasty, a 2.4 percent reduction in the probability of ventilator utilization, and a 1.8 percent increase in the probability of mortality.⁷
- Another recent study found that when more beneficiaries enroll in MA plans, hospital costs decline for all Medicare beneficiaries and for commercially insured younger populations.⁸
- A 2015 study found that greater MA enrollment led to FFS beneficiaries with fewer days in the hospital but more outpatient visits, consistent with a substitution of less expensive outpatient care for more expensive inpatient care, particularly at high levels of managed care.⁹
- In another study, researchers found that as rates of MA enrollment increased in a county, avoidable hospitalizations—compared with expected hospitalizations—decreased for both MA and FFS beneficiaries.¹⁰
- Recent studies show that MA plan practices can also lead to more effective use of hospital services including lower hospitalization costs and shorter lengths of stay. One study found that a 10 percent increase in MA penetration is associated with a 2.4 percent to 4.7 percent reduction in hospital costs for patients not enrolled in the MA program.¹¹

Understanding MA plan payment

As described above, plans receive a capitated payment to cover all Medicare services for their enrollees. In turn, plans contract with physicians, hospitals, pharmacies, and a range of other providers to ensure that their members have access to all Medicare-covered health-care services, as well as supplemental benefits.

Plans also use payments for important activities such as case management and disease management programs, customer service, quality improvement programs and efforts to deter fraud, waste, and abuse. Plan payments are established through a process that is based on administratively set benchmarks that plans bid against; plan quality performance also factors into plan payments.

Determining plans' payments

MA plans' payments are based on administratively set, county-specific payment rates (known as "benchmarks"). MA benchmarks are aligned with FFS costs in each county. Counties are divided into quartiles based on the level of their FFS costs, and the benchmarks are calculated as a percent of the county FFS costs based on the quartile assignment (see table below). Higher performing plans—those with 4 or more stars—are eligible for higher county benchmarks.

Table 1

MA Benchmark Quartile Values

County Quartile Assignment	Benchmark Amount
1 st Quartile (Lowest FFS)	115.0% FFS
2 nd Quartile	107.5% FFS
3 rd Quartile	100.0% FFS
4 th Quartile (Highest FFS)	95.0% FFS



MA plans use their payments to provide all Medicare services for enrollees and offer supplemental benefits.

MA plans determine in which counties to offer coverage and then submit bids representing their estimated costs for providing the Medicare Parts A and B benefits. The MA plan bids are compared to the benchmarks for those counties. If a plan bids below the benchmark, it retains a portion of the difference between its bid and the benchmark, which is known as a "rebate." Rebates can be used to provide extra benefits for enrollees such as reduced cost sharing or enhancing the Part D benefit if the plan offers prescription drug coverage. If a plan bids above the benchmark, it must charge a premium to the enrollee for the amount above the benchmark.

Finally, plans' payments are adjusted to account for the health status, or "risk level" of each enrollee. Risk adjustment helps ensure that plans are paid appropriately for the health status of the beneficiaries that enroll in their particular plan (more below).

The current approach to determining the county benchmarks was set by the Affordable Care Act (ACA) with the intent of better aligning plan payments with FFS costs. While benchmarks range from 95 percent to 115 percent of FFS costs, on average, MA plans’ payments are equal to FFS costs (i.e., MA payments equal 100 percent of FFS).¹² The higher benchmarks in the lowest quartiles help promote plan participation in rural areas, but are offset by lower benchmarks in the higher spending areas, such that on average, across the entire program, MA plans are paid on par with FFS.¹³ While the current payment structure does not cost the government any more, on average, for an MA enrollee compared to FFS, there is evidence that quality and outcomes may be better in MA.¹⁴

Incentives for quality

There are also payment incentives for high quality performance by MA plans. Plans are rewarded based on their quality scores, known as Star Ratings.

First, plans with 4 and 5 stars receive an increase in their county benchmarks equal to 5 percent of the county’s underlying FFS costs (e.g., a 4-star plan in a county with a benchmark set at 95 percent of FFS costs would have a benchmark set at 100 percent of FFS costs). This means that plans bid against a higher amount, giving them greater rebate opportunity if they bid below the benchmark. In some counties, known as “double bonus counties,” the benchmark is increased by 10 percent of underlying FFS costs. However, because the ACA limited benchmarks to no more than they would have been prior to the ACA, in some counties where the “benchmark cap” limits the quality bonus amount, it prevents plans from receiving the full amount of the quality bonus they earned.

Second, MA Star Ratings determine the rebates that plans receive when they bid below the benchmarks. The ACA created a tiered system for rebate amounts based on the Star Ratings as shown below, with the highest performing plans retaining the largest portion of the difference.

Table 2

MA Plan Rebate Percentages Based on Star Rating

Plan Star Rating*	Benchmark Increase	Rebate Percentage
4.5-5 Stars	5% of county FFS (10% in double bonus counties)	70%
4 Stars	5% of county FFS (10% in double bonus counties)	65%
3.5 Stars	NA	65%
3 or Less Stars	NA	50%

*New plans from parent organizations receive a benchmark increase equal to 3.5% of county FFS costs and 65% rebate amount.

How MA plans use payments

Plans use the payments they receive in a variety of ways to provide quality care for enrollees. Further, as described earlier, plans are required to use a minimum amount of their payments on providing direct care to enrollees. A substantial portion of the MA plan payment is used to pay providers that plans contract with such as physicians, hospitals, and pharmacies.

MA plans hold providers accountable for the quality of care they deliver to Medicare beneficiaries and seek to partner with providers to improve quality and delivery of care.

MA plans may contract with providers to pay for services in a variety of ways:



MA plans hold providers accountable for the quality of care they deliver to Medicare beneficiaries and seek to partner with providers to improve quality and delivery of care.

- **Pay Claims on a FFS Basis:** While MA plans are paid a capitation amount, MA plans may choose to pay claims from providers as they deliver services, often at rates that are similar to those that the provider would receive from traditional Medicare.¹⁵ Even in these circumstances where plans pay providers based on volume of services, plans may still use contracting strategies to require the providers to meet quality standards or demonstrate quality improvements.
- **Value-Based Payment Arrangements:** Plans may engage providers in value-based payment arrangements. These arrangements often center on collaborations with providers designed to support them in providing more personalized, coordinated care that emphasizes the value of care over the volume of care delivered. These arrangements can include medical homes, bundled payments, and/or accountable care organizations with shared savings opportunities. In designing value-based payment arrangements, plans may:
 - > Redesign payments to align financial incentives with quality and cost goals;
 - > Provide compensation for important clinical interventions that occur outside of traditional patient encounters (e.g., email, remote monitoring);
 - > Support care management efforts through data sharing, reporting, and technology;
 - > Share meaningful information regarding patients that goes beyond the information captured in the physicians' medical record (e.g., hospitalizations, prescription drug fills); and
 - > Provide physicians with the information and tools to succeed under new payment models, along with support services and information exchange to transform the way they deliver care.
- **Capitated Payments:** Plans may pay a provider, such as a primary care provider or multi-specialty physician group practice, a capitated amount (i.e., per member per month amount) to be responsible for most or all costs associated with care for an enrollee. Plans generally hold providers responsible for meeting set quality benchmarks as well to ensure that they are appropriately coordinating care for enrollees and not limiting access to needed benefits.

MA plan payments are risk adjusted

Risk adjustment helps ensure robust participation among MA plans by mitigating the effects of adverse selection in the market. Adverse selection occurs when the sickest patients, or those patients likely to be most costly, disproportionately enroll in certain plans, such as those with more generous benefits or more robust coverage of certain providers or drugs to treat chronic conditions.

If plans are not paid accurately for costs associated with higher risk enrollees, then plans may try to avoid enrolling sicker patients. That is, concerns about adverse selection could lead plans to compete based on risk avoidance rather than on the value of the benefits offered to enrollees. In contrast, if plans are paid accurately for the risk profile of their enrollees, they can invest in innovative benefit designs and care management that address their needs.

Therefore, risk adjustment is used to determine the expected costliness of individuals based on their risk scores, and payments are adjusted up or down in accordance with those risk levels, relative to an “average” Medicare beneficiary. This ensures that plans with higher risk enrollees who are expected to cost more receive higher payments than plans with lower risk enrollees who aren’t expected to be as costly.

The amount by which payments are adjusted is based on information about the member’s health conditions and their demographics (e.g., age and gender). Health plans capture information about members’ health conditions through claims submissions, medical charts, and health risk assessments with members. Plans historically submitted to CMS only the diagnosis information from these sources to be used for risk score calculations. CMS now extracts the diagnosis information from the “encounter data” that plans submit, and has begun to use this information for risk score calculations (see text box on page 15).

CMS uses a risk adjustment model to predict the expected relative costliness of certain conditions and demographic characteristics compared to others. These relative values are used to assign an MA risk score to each member. The risk score is the total of all the relative values associated with the condition and demographic factors applicable to the individual.

As an illustrative example, below we calculate the risk score for a female who is 84 years old and is morbidly obese and has both diabetes without complications and chronic obstructive pulmonary disease (COPD). The sum of the coefficients (or relative values) associated with each of these factors



Risk adjustment serves an important role in ensuring that MA plans are paid accurately based on the health status of their enrollees.

is the risk score for this beneficiary. Her risk score of 1.242 is just above the average risk score for Medicare beneficiaries, which is set at 1.0, thereby increasing the plan payment to cover the costs associated with the enrollee’s demographic profile and known health status.

Table 3

Example Risk Score Calculation

Category	Risk Model Coefficient*
Female 80-84	0.537
Condition: Diabetes without Complications	0.104
Condition: Morbid Obesity	0.273
Condition: COPD	0.328
Total Risk Score	1.242

*Based on the community, non-dual, aged segment of the 2017 CMS-HCC model

Coding intensity and other adjustments

In calculating plans’ risk scores, CMS makes some adjustments to the scores. One such adjustment, required by law, is known as the coding intensity adjustment, which accounts for what is called “coding pattern differences” between FFS and MA. This adjustment reduces MA plans’ risk-adjusted payments.

The coding intensity adjustment is made because the risk adjustment model that CMS uses for MA plans is calibrated with Medicare FFS data, and as a result, the model reflects the relative costs for conditions under the FFS program, but not necessarily those under MA. The adjustment is intended to make up for greater growth in risk scores in MA relative to those in FFS (i.e., “coding intensity”).

These differences are driven by the fact that inclusion of diagnosis codes on FFS Medicare claims has historically been less complete than coding in MA due to the fact that procedure codes, rather than diagnoses, form the basis for how providers are reimbursed in FFS Medicare. Therefore, FFS providers have less incentive to capture all diagnoses that might be present or that were addressed in a visit. In contrast, MA plans’ risk adjustment—as well as their ability to appropriately manage members’ chronic conditions and other health needs—relies on the complete and accurate capture of diagnoses for their members. Thus, MA plans work with providers to improve the accuracy of their coding practices and also engage in their own efforts to ensure that members’ conditions are identified and treated.

Under current law, the coding intensity adjustment for 2017 is a 5.66 percent reduction to risk scores; it will be 5.91 percent for 2018. This is also the minimum amount required beyond 2018, though CMS has the ability to increase the adjustment amount without further action by Congress. The same adjustment applies to all MA plans, regardless of the level of care they provide or the severity of health conditions of the populations they serve.

Additionally, since CMS only calibrates the model every few years, CMS also adjusts plan risk scores for changes in FFS risk level over time, to keep the average risk score at 1.0 in between the model recalibrations. This adjustment is known as the fee-for-service normalization factor. Usually this adjustment reduces plan risk scores because of changes in FFS risk levels.

What is “encounter data”?

CMS is currently collecting encounter data from MA plans. Encounter data is detailed data generated by healthcare providers, such as doctors and hospitals, that documents both the clinical conditions they diagnose as well as the services and items delivered to beneficiaries to treat those conditions.

CMS began collecting encounter data from MA plans in 2012 and began using encounter data to impact plan payments in 2016.

What will CMS do with encounter data?

CMS is currently using encounter data to develop plan risk scores and has proposed to use the data to calibrate a new risk adjustment model for MA plans in the future.

- **MA Risk Scores Using Encounter Data:**

While health plans have historically submitted diagnosis information to CMS for risk score calculation, CMS has begun phasing in the use of encounter data to determine plans' risk scores. There continues to be a number of technical issues challenging this transition to encounter data, including issues with the methodology for capturing diagnoses from the data.

- **Using Encounter Data for the Risk Adjustment Model:**

CMS has also proposed using encounter data as the basis of the MA risk adjustment model so that plans' costs for caring for certain conditions are more accurately reflected in the model. While this proposal would alleviate the need for the coding intensity adjustment, the details of how this model would work are not yet known and further study will be required before it can be put into use.

Oversight of MA plans and payment

CMS monitors plans' compliance with program requirements as well as the accuracy of plan payments, including the data submissions and processes that support risk adjustment.

For instance, CMS conducts very detailed audits of plan program practices and monitors plan quality performance. CMS also monitors plans' risk adjustment data through a process known as Risk Adjustment Data Validation (RADV) audits.

RADV audits review enrollees' medical records to confirm that they support the diagnoses submitted by plans for risk adjustment purposes. CMS currently reviews a sample of enrollees from approximately 30 MA contracts each year.

If CMS does not find evidence in the medical record to support a risk score, the plan's payments for that enrollee are adjusted accordingly. CMS has been considering how to extrapolate a plan's error rate, calculated via the RADV audit, in order to adjust a plan's payment for all enrollees and not just those in the RADV sample. However, the agency has not moved forward with this approach yet due to methodological concerns raised by plans and other stakeholders.

Conclusion

The MA program provides an increasingly important option for health-care coverage for Medicare beneficiaries.

MA plans offer beneficiaries a valuable alternative to the more fragmented care found in traditional FFS as well as providing OOP cost protections and often offering additional benefits. MA plans also support the long term viability of the Medicare program overall. MA plans use strategies for care management and coordination that are increasingly being tested in traditional Medicare to lower costs and improve care. There are also important "spillover" effects of increased MA enrollment onto traditional Medicare that lead to improvements in service utilization and lower costs for the program overall.

Endnotes

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- ¹⁴ See for example Huckfeldt, P. J., Escarce, J. J., Rabideau, B., Karaca-Mandic, P., & Sood, N. (2017). Less Intense Postacute Care, Better Outcomes for Enrollees in Medicare Advantage than Those in Fee-for-Service. *Health Affairs*, 36(1), 91-100; and Ayanian J.Z., Landon BE, Zaslovsky AM, Saunders R, Pawlson L.G., & Newhouse JP. (2013). Quality of Ambulatory Care in Medicare Advantage HMOs and Traditional Medicare. *Health Affairs* 32 (7): 1228-1235; and Curto, V., Einav, L., Finkelstein, A., Levin, J.D., & Bhattacharya, J. (2017). Healthcare Spending and Utilization in Public and Private Medicare. NBER Working Paper No. 23090. Retrieved from <http://www.nber.org/papers/w23090> (accessed October 6, 2017); and Beveridge, R. A., Mendes, S. M., Caplan, A., Rogstad, T.L., Olson, V., Williams, M.C., McRae, J. M., & Varga, S. (2017). Mortality Differences Between Traditional Medicare and Medicare Advantage: A Risk-Adjusted Assessment Using Claims Data. College of Population Health Faculty Papers. Paper 77. Retrieved from <http://jdc.jefferson.edu/cgi/viewcontent.cgi?article=1082&context=healthpolicyfaculty&sei-redir=1&referer=http%3A%2F%2Fwww.bing.com%2Fsearch%3Fq%3Dmortality%2Bmedicare%2Badvantage%26src%3DIE-TopResult%26FORM%3DIETRo2%26conversationid%3D#search=%22mortality%20medicare%20advantage%22> (accessed October 6, 2017).
- ¹⁵ Trish, E., Ginsburg, P., Gascue, L., & Joyce, G. (2017). Physician Reimbursement in Medicare Advantage Compared With Traditional Medicare and Commercial Health Insurance. *JAMA Intern Med*. Retrieved from <https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2643349> (accessed October 6, 2017).

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