Favorable Selection in Medicare Advantage?

What the Evidence Tells Us

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There is growing recognition that Medicare Advantage (MA) plans are overpaid. Overpayments arise from three main sources: (1) differentials in diagnostic coding between MA and traditional Medicare (TM) resulting in inflated MA risk scores (and thereby payments), (2) quality bonus payments (QBPs)[1] that are not budget neutral, and (3) selection of enrollees into MA who are less costly than would be expected given comparable risk scores ("favorable selection").[2] With around half of Medicare's 67.2 million enrollees now in MA plans,[3] overpayment to MA plans exacerbates the serious short- and long-term financial pressures the Medicare program faces.[4] As policymakers consider options for improving the financial standing of the Medicare program—including revenue increases and spending reductions—and Medicare program integrity, reducing overpayments to MA plans needs to be on the table. Accordingly, policy analysts are increasingly focused on quantifying the magnitude of each source of MA overpayment to better inform payment policy and design policy responses. In this brief, we focus on the evidence of favorable selection in MA, including several recent studies. Overall, consistent and convincing evidence shows that favorable selection, after accounting for risk adjustment, is a key contributor to MA overpayment. MedPAC (2024) estimates that favorable selection led to 13 percent higher payments to MA plans in 2021 than the same enrollees would have cost in TM.

Different studies focus on different aspects of selection in MA (favorable or otherwise), leaving some potential for confusion in policy discussions. Policy debates can get bogged down when analysts mean different things by the term "favorable selection." In addition, though the literature is broadly consistent, estimates differ across studies focusing on the same aspects of selection into MA and can reach different conclusions. We aim to clarify what the various types of studies tell us about the type and degree of selection in MA and how the findings relate to the appropriateness of Medicare payments to MA plans. Key takeaways emerged from our review of these studies:

- Studies may estimate overall (gross) selection in MA or net selection in MA that remains after adjustment for risk. Studies often provide evidence on both types of selection.
  - » Gross selection refers to how the composition of the MA and TM populations differ, particularly for factors associated with expected health care spending. Evidence on gross selection can help interpret differences in risk scores across groups due to differences in diagnostic coding and their implication for payment.
  - » Net selection refers to differences between MA and TM populations that remain after adjusting for risk, where risk is measured in a manner considered comparable for the two groups. Studies of net selection tell us by how much a group of enrollees has costs or other outcomes that are higher or lower than expected based on observed enrollee characteristics. Estimates of net selection are necessary for evaluating whether risk-adjusted payments are too high or too low, on average, for a group of enrollees due to selection effects.
- Studies based on data up to 2014 generally found favorable gross selection in MA, but that pattern has shifted in recent years. Evidence from 2015 and after shows MA enrollment to be demographically similar to TM enrollment (by age and sex), and rates of dual Medicare/Medicaid eligibility (associated with higher expected spending) are now higher in MA than in TM, consistent with growth in enrollment in special needs plans.
- Studies of selection in MA net of applicable risk adjustment have generally found evidence of selection favorable to MA. The magnitude of favorable net selection varies somewhat across studies and time periods.
- Recent studies of net selection in MA that addressed limitations of earlier work and focused squarely on implications for MA payment appropriateness (MedPAC 2023, 2024; Lieberman, Valdez, and Ginsberg 2023) found substantial degrees of net favorable selection into MA and estimated its sizable contribution to overpayment of MA plans.
- In sum, after several years of rapid growth, the composition of MA enrollees relative to TM is older and more costly than in prior years. Based on demographics, dual Medicaid enrollment status, and institutional status, MA enrollees may be expected to cost slightly more (if enrolled in TM) than TM enrollees. This qualitatively important shift can explain a small portion of the rapid rise in risk scores of MA enrollees. It does not, however, contradict or undermine findings of favorable selection in MA, net of risk adjustment, confirmed in recent studies that address

the limitations of earlier studies. Recent study findings point to favorable selection as an important source of overpayment to MA plans. MedPAC (2024) projects MA payments will be 22 percent higher than what payments would be in TM for the same enrollees in 2024 due to favorable selection and coding differences combined, at an estimated cost of $83 billion.

How Favorable Selection Can Lead to Overpayment of MA Plans

Policy discussions around MA payment and practices in recent years have often focused on overpayment resulting from differential coding of diagnoses in MA relative to TM and problems with the quality bonus program.

Concern about favorable selection in MA, another potential source of overpayment, went relatively quiet for several years as it was overshadowed by other issues, and some influential studies viewed improved risk adjustment in MA using the Centers for Medicare & Medicaid Services-Hierarchical Condition Categories (CMS-HCC) model, starting in 2004 and fully phased-in in 2007, to have largely addressed long-standing concerns about favorable selection (Newhouse et al. 2012). Before 2000, payments were adjusted for age, sex, dual Medicaid/Medicare enrollment, and institutional status (CMS 2021). In 2000, diagnoses from inpatient stays were added to MA risk adjustment, with the addition of diagnoses from outpatient services starting in 2004 with the introduction of CMS-HCC risk adjustment.

With increased scrutiny on MA payment and practices, there is renewed policy interest and updated research on the degree of favorable selection in MA and its implications for MA payment. Favorable selection can result from the active behavior of MA plans through their marketing and how they design their provider networks and care management systems. Favorable selection can also result from consumer behavior, e.g., if certain enrollees are understandably attracted to extra benefits provided in many MA plans, including potentially lower cost sharing, and enrollees' comfort in dealing with MA plans' utilization review processes and limitations on choice of health care provider.[5]

In Medicare's payment system for MA, plans submit bids for the level of payments they would accept to cover Part A and Part B services for Medicare beneficiaries of average risk. Plans make bids relative to a benchmark amount based on the risk-standardized cost of providing those same services to TM enrollees in a geographic area. Plans bidding at or above the benchmark receive a payment for an average risk enrollee equal to the benchmark. Plans bidding below the benchmark plans are paid the bid amount for an average-risk enrollee plus a portion of the difference between the benchmark and bid (called a rebate) that can be used to provide additional benefits to enrollees, reduce required cost sharing, or lower premiums. The base payment amount (bid plus rebate or benchmark) is then adjusted for enrollee risk by multiplying it by a risk factor. The risk factor varies according to patient demographics and recorded diagnoses and is computed to have a mean of 1 for the average TM enrollee. Medicare's complex payment system for MA plans is summarized in further detail in a "Payment Basics" document produced by MedPAC.[6]

Implementation of CMS-HCC risk adjustment altered selection incentives. It discouraged plans from actively seeking enrollees with fewer or less severe diagnoses, as such enrollees would result in lower payments than before. Plans with sicker enrollees, as predicted by risk scores, would receive higher payments and be financially rewarded if they could effectively manage the health problems and costs of those enrollees. Plans would also be more profitable under the new risk adjustment if they could attract enrollees who cost less than predicted by their CMS-HCC risk score, even without doing anything to manage the care of such enrollees.

The intent of the MA payment structure is to (1) pay no more than the benchmark amount (tied to the cost of an average-risk enrollee in TM before risk adjustment) and (2) make proportionally higher or lower payments to recognize expected differences in spending depending on patient demographics and diagnoses. Favorable selection and differences in the coding of diagnoses between MA and TM cause actual MA payments to deviate from the intended amounts. If MA enrollees are net favorably selected, that is, they would systematically cost less in TM than TM enrollees with the same risk score (for whatever reason), then Medicare would pay MA plans more than the intended amount. If identical Medicare enrollees (same age, health conditions, etc.) would have more diagnoses coded in MA than in TM (again, for whatever reason), then their risk scores would be inflated in MA relative to TM even though they should be the same, and Medicare would pay MA plans more than the intended amount.

Data Limitations Obscure MA Overpayment and Impede Ability to Test for Net Selection

In a simplified world, we can imagine testing for net favorable selection in MA in a straightforward way. We could just compare the spending of MA enrollees and TM enrollees with similar demographics and diagnoses, summarized via the risk score, and infer the direction and degree of net selection by examining differences in spending, holding the risk score fixed (e.g., via regression). Reality makes this approach infeasible. First, comparable spending data in MA and TM are not generally available, though it may be possible to construct comparable data from health care utilization or encounter data using a set of fixed prices (or weights) for each service (Skopec et al. 2019). Second, even if comparable spending data were available, the point of MA is that it should be able to coordinate care and use care management tools to treat patients more efficiently. We should expect a treatment effect of MA that reduces health care spending if MA works as hoped. Thus, we would not be able to separate what portion of any difference in spending between observably similar enrollees in MA and TM is because of selection rather than a treatment effect of MA. The treatment effect could be the desired one of lower cost at the same or better quality or an undesired one of lower cost at lower quality. Third, in the presence of differential coding (higher coding intensity in MA), the normally computed risk scores are not comparable across MA and TM, with the result that controlling for risk score does not hold actual risk fixed.

Given the difficulties that the complex reality of MA presents, researchers have devised various approaches to make inferences about relative spending, relative risk, and selection effects across MA

and TM. First, studies may employ alternative measures of risk based on enrollee characteristics that are considered comparably measured in MA and TM, such as predicted spending based on demographic characteristics and self-reported health status. Predicted spending based on prescription drug use may also be used under the assumption that it is measured comparably in MA and TM settings (not subject to coding intensity differences like diagnoses are) and assuming any treatment effect of MA on prescription is small. Studies have also used mortality rates as a proxy for risk because they are not subject to measurement differences between MA and TM. Interpreting differences in mortality rates between groups as resulting from group differences in underlying risk between MA and TM requires assuming little or no treatment effect of MA on mortality. Evidence on the quality of care in MA compared with TM overall is mixed, and evidence on the effect of MA on mortality is scant and inconclusive (Agarwal et al. 2021).

Second, switcher-stayer studies compare TM spending and risk scores of Medicare enrollees who switch to MA the following year versus those who stay in TM. Differences (or adjusted differences) in spending can be attributed to selection effects for that group of enrollees switching to MA at that time. Simple extrapolation from such evidence to make inferences about the degree of overall selection in MA has been criticized because (1) switchers from MA to TM may be different from MA enrollees who joined when they first became eligible for Medicare and, more importantly, the overall stock of MA enrollees, and (2) any differences in spending present at the time of switching, relative to TM enrollees, may dissipate as outcomes for both groups (switchers and stayers) converge over time—a dynamic referred to as regression to the mean (Newhouse et al. 2015, 2019).

In the following sections, we describe a range of studies of favorable selection in MA, focusing on studies since 2011. The evidence they provide falls roughly into two types: what we classify as evidence on gross favorable selection and net favorable selection. Many findings fall cleanly into one or the other category. But some findings are in the form of adjusted differences that control for specified factors for analytic purposes, say for age and sex, but do not control for CMS-HSS risk score. Because such findings tell us about the composition of MA enrollees as compared with TM but are not net of risk adjustment applicable for payment purposes (and therefore not suitable for assessing the appropriateness of payments), we include such findings, along with their unadjusted counterparts, with evidence on gross selection.[7]

Overall Compositional Differences between MA and TM Enrollees Have Shifted over Time

Table 1 presents evidence on gross selection in MA. Comparing MA and TM enrollees in 2001–03 (before the phase-in of the CMS-HCC risk adjustment system beginning in 2004), MA enrollees overall had lower health care utilization and better health than TM enrollees, as reported by McWilliams, Hsu, and Newhouse (2012), indicating favorable gross selection in MA. The study found, for example, that MA enrollees had fewer inpatient stays and were less likely to be in fair or poor health. Differences in these measures were substantially reduced by 2006–07, showing that the degree of favorable gross

selection was reduced, but not eliminated, under CMS-HCC risk adjustment, which changed incentives by increasing payments for enrollees with health conditions associated with higher spending.

Kronick and Welch (2014) found that the predicted cost of MA enrollees, based on age, sex, Medicaid status, institutional status, and several self-reported health status and chronic health conditions, relative to TM enrollees, ranged between 95 to 97 percent through the 2006–11 period. This points to a modest and fairly stable degree of gross favorable selection in MA over the period. Jacobs and Kronick (2018) measured the relative health risk of MA and TM enrollees using prescription drug utilization data as an alternative to diagnoses (given the latter are subject to upcoding). MA enrollees had 10.3 percent lower risk than TM enrollees in 2008 and 6.9 percent lower risk in 2015 using their prescription drug-based risk measure. This finding suggests that the degree of gross favorable selection in MA declined over the period.

TABLE 1

Evidence on Gross Selection in MA

Study	Data source, year(s), and approach	Overall conclusion on gross selection in MA	Key findings
Brown, Jason, Mark Duggan, Ilyana Kuziemko, and William Woolston. 2011. "How Does Risk Selection Respond to Risk Adjustment? Evidence from the Medicare Advantage Program." Working Paper 16977. Cambridge, MA: NBER. ———. 2014. "How Does Risk Selection Respond to Risk Adjustment? New Evidence from the Medicare Advantage Program." *American Economic Review* 104 (10): 3335–64.	Compared TM spending and risk scores of switchers from MA to TM to those of enrollees who remain in TM, using MCBS data before and after introduction of CMS-HCC risk adjustment (1994–2006).	Favorable	▪ TM spending was $2,847 lower for enrollees who switched to MA compared with those who stayed in TM before introduction of CMS-HCC risk adjustment (1994 to 2003). There was no meaningful or statistically significant change in the difference after implementation of CMS-HCC risk adjustment (2004–06). ▪ Risk scores were 0.31 points lower for enrollees switching to MA than for those who remained in TM before CMS-HCC risk adjustment (1994–2003 data). ▪ After implementation, risk scores were 0.20 points lower for enrollees switching to MA compared with those who remained in TM (2004–06).

Study	Data source, year(s), and approach	Overall conclusion on gross selection in MA	Key findings
McWilliams, J. Michael, John Hsu, and Joseph P. Newhouse. 2012. "New Risk-Adjustment System Was Associated with Reduced Favorable Selection in Medicare Advantage." *Health Affairs* 31 (12): 2630–40. https://doi.org/10.1377/hlthaff.2011.1344.	Compared utilization and health indicators of MA and TM groups before and after introduction of CMS-HCC risk adjustment using MCBS data (2001–07).	Favorable	▪ MA enrollees overall had lower utilization and better health than TM enrollees in 2001–03 (various measures). ▪ Most of these differences were substantially reduced by 2006–07, showing a reduction in the degree (but not elimination) of favorable selection. ▪ Relative utilization of switchers to MA compared with TM stayers increased from 0.60 in 2001–03 to 0.93 in 2006–07. ▪ Utilization of switchers out of MA relative to MA stayers increased from 1.15 in 2001–03 to 1.64 in 2006–07.
Newhouse, Joseph P., Mary Price, Jie Huang, J. Michael McWilliams, and John Hsu. 2012. "Steps To Reduce Favorable Risk Selection in Medicare Advantage Largely Succeeded, Boding Well for Health Insurance Exchanges." *Health Affairs* 31 (12): 2618–28. https://doi.org/10.1377/hlthaff.2012.0345.	Compared CMS-HCC average risk scores for those who switched from TM to MA to those who remained in TM. Also compared those who switched from MA to TM to those who stayed in TM. Used a 20 percent sample of TM claims from 2003 to 2008.	Favorable	▪ Adjusted differences in risk scores for beneficiaries switching from TM to MA compared with TM stayers were -0.113 in 2004 and narrowed to -0.037 in 2008. Adjustment was for age, sex, county MA penetration rate, and whether beneficiary moved zip code. ▪ Adjusted differences in risk scores for beneficiaries switching from MA to TM compared with TM stayers were -0.004 in 2004 and widened to 0.093 in 2008. ▪ Adjusted for age, sex, and Medicaid status, differences in mortality rates narrowed by a factor of 2 between 1998 and 2008, with mortality among beneficiaries in MA as a percentage of mortality among beneficiaries in TM increasing from 85 to 93 percent. ▪ Adjusted mortality rates in 2008 were almost equal between persons enrolled in MA for five or more years and those enrolled in TM.

Study	Data source, year(s), and approach	Overall conclusion on gross selection in MA	Key findings
Kronick, Richard, and W. Pete Welch. 2014. "Measuring Coding Intensity in the Medicare Advantage Program: Supplement." *Medicare & Medicaid Research Review* 4 (2).	Estimated relative costs (in TM) of MA and TM enrollees using MCBS data (2006–11). Compared mortality rates of MA and TM enrollees using Medicare administrative data (2004–12).	Favorable	▪ Predicted cost of MA enrollees, based on age, sex, Medicaid status, institutional status, and certain self-reported health status and chronic health conditions, relative to the cost of TM enrollees, ranged between 95 and 97 percent through the 2006 to 2011 period. ▪ From 2004 to 2012, mortality rates declined for both MA and TM enrollees, but somewhat faster for MA enrollees. The mortality rate of MA enrollees relative to TM enrollees fell from 87 percent in 2004 to 81 percent in 2012; adjusting for age and sex, mortality in MA and TM declined at about the same rate over the period.
Newhouse, Joseph P., Mary Price, J. Michael McWilliams, John Hsu, and Thomas G. McGuire. 2015. "How Much Favorable Selection Is Left in Medicare Advantage?." *American Journal of Health Economics* 1 (1): 1–26.	Estimates selection effects using an approach similar to that in Brown et al. 2011 with a larger but more restricted sample (2001–10) that excludes institutionalized and dual Medicaid/Medicare eligible enrollees, and enrollees who switched into cost MA plans or special needs plans. Computed risk scores using the 2007 CMS-HCC model.	Favorable	▪ In each year from 2001 to 2010, spending and risk scores of TM enrollees switching to MA were less than those of enrollees staying in TM. ▪ Risk scores ranged from 0.788 to 0.947 for switchers to MA and from 0.922 to 1.023 in the stayer group. ▪ Risk scores for switchers to MA were 0.121 lower than for TM stayers in 2010. ▪ TM enrollees who switched to MA had average spending in TM in the year before they switched, which was 17 percent to 34 percent less than among the much larger group that remained in TM over the years 2001 to 2010. ▪ TM spending for switchers to MA was $5,590 and was $7,343 for TM stayers.

Study	Data source, year(s), and approach	Overall conclusion on gross selection in MA	Key findings
Beveridge, Roy A., Sean M. Mendes, Arial Caplan, Teresa L. Rogstad, Vanessa Olson, Meredith C. Williams, Jacquelyn M. McRae, and Stefan Vargas. 2017. "Mortality Differences Between Traditional Medicare and Medicare Advantage: A Risk-Adjusted Assessment Using Claims Data." *INQUIRY: A Journal of Medical Care Organization, Provision and Financing* 54.	Compared mortality between the MA population covered by Humana, Inc. and 5 percent Limited Dataset samples from CMS for years 2010-12. Conducted an indirect comparison of mortality by estimating a predictive model of mortality on a traditional fee-for-service (FFS) Medicare dataset using diagnoses and demographics, applying the model to an MA dataset, and then evaluating the ratio of actual-to-predicted mortality in the MA dataset.	Favorable	▪ Predicted mortality was lower in the MA population than in TM (3.7 versus 4.3 percent), indicating favorable gross selection in MA. ▪ The ratio of actual-to-predicted mortality (0.80 = 2.9%/3.7%) in the MA dataset suggested that the individuals in MA dataset were less likely to die than would be predicted had those individuals been enrolled in FFS Medicare. ▪ The gap between actual and predicted mortality in MA could reflect favorable selection (net of the factors in the prediction model, which excludes risk score but includes HCC count and selected health conditions) or a beneficial treatment effect of MA.
Park, Sungchul, Anirban Basu, Norma Coe, and Fahad Khalil. 2017. "Service-Level Selection: Strategic Risk Selection in Medicare Advantage in Response to Risk Adjustment." Working Paper 24038. Cambridge, MA: NBER.	Examined how differences in risk scores and expenditures between MA and TM groups changed after implementation of CMS-HCC risk adjustment using 2001–09 MCBS data.	Favorable	▪ Differences in risk scores between TM-to-MA switchers and TM stayers reduced by around a factor of three, from -0.14 in 2001–02 to -0.05 in 2007–09. ▪ Differences in risk scores between MA-to-TM switchers and MA stayers increased from -0.01 in 2001–02 to 0.17 in 2007–09.

Study	Data source, year(s), and approach	Overall conclusion on gross selection in MA	Key findings
Jacobs, Paul D., and Richard Kronick. 2018. "Getting What We Pay For: How Do Risk-Based Payments to Medicare Advantage Plans Compare with Alternative Measures of Beneficiary Health Risk?" *Health Services Research* 53, (6): 4997–5015. https://doi.org/10.1111/1475-6773.12977.	Examined enrollee health risk as measured using prescription drug utilization as compared with using coded diagnoses. Used Medicare claims and enrollment data for the sample of beneficiaries enrolled in Part D between 2008 and 2015.	Favorable	▪ Based on prescription drug utilization data, beneficiaries enrolled in MA had 10.3 percent lower health risk in 2008 and 6.9 percent lower health risk in 2015 than beneficiaries in TM. ▪ Differences in risk based on coded diagnoses suggested risk of MA enrollees was 6.2 percent higher than enrollees in TM, pointing to significantly higher coding intensity in MA. ▪ Based on drug usage, the health risk of MA beneficiaries relative to those in TM increased by 3.4 percentage points from 2008 to 2015, while the relative risk using diagnoses increased by 9.8 percentage points, suggesting increasing coding intensity differences.
Curto, Vilsa, Liran Einav, Amy Finkelstein, Jonathan Levin, and Jay Bhattacharya. 2019. "Health Care Spending and Utilization in Public and Private Medicare." *American Economic Journal: Applied Economics* 11 (2): 302–32. https://doi.org/10.1257/app.20170295.	Used mortality rates, which are comparably measured for both MA and TM enrollees, as a proxy for health risk to evaluate selection. Uses Health Care Cost Institute (HCCI) and CMS data for Medicare enrollees ages 65 and over in 2010.	Favorable	▪ Mortality rates for MA enrollees are lower than for TM enrollees (3.9 versus 5.0 percent), which suggests favorable selection in MA under the assumption of no treatment effect of MA on mortality.

Study	Data source, year(s), and approach	Overall conclusion on gross selection in MA	Key findings
Newhouse, Joseph P., Mary Price, J. Michael McWilliams, John Hsu, Jeffrey Souza, and Bruce E. Landon. 2019. "Adjusted Mortality Rates Are Lower for Medicare Advantage than Traditional Medicare, but the Rates Converge over Time." *Health Affairs* 38 (4): 554–60. https://doi.org/10.1377/hlthaff.2018.05390.	Examined mortality experience over five years of two cohorts choosing Medicare Advantage compared with corresponding cohorts choosing TM. Compared mortality rates adjusted for age, sex, and Medicaid status over the subsequent five-year period using MBSF data from 2007 to 2017.	Favorable	▪ In cohorts of those newly enrolling in Medicare (over the 2008 to 2012 period), the mean mortality rate of those choosing MA was 70 percent of that of those choosing TM in the first year of enrollment and converged to 87 percent of that of TM enrollees after five years. ▪ For established TM enrollees switching to MA, the mean mortality rate was 80 percent of that of TM enrollees in the first year and converged to 93 percent that of TM enrollees after five years. ▪ Not clear if convergence would continue after five years and to what degree.
Kronick, Richard, and F. Michael Chua. 2021. "Estimating the Magnitude of Medicare Advantage Coding Intensity and of the Budgetary Effects of Fully Adjusting for Differential MA Coding." *SSRN*. https://doi.org/10.2139/ssrn.3792038.	Computed risk scores for MA and TM enrollees using age, sex, and Medicaid status using CMS MBSF data from 2009 to 2019, and similarly using MCBS data from 2011 to 2018 (without and with institutional status as a risk factor).	Favorable in earlier years, then turning unfavorable around 2015 based on age, sex, and Medicaid status. Favorable based on adjusted mortality rates.	▪ Ratio of MA to TM risk scores increased from 0.97 in 2009 to 1.01 in 2019 (MBSF). ▪ The share of MA enrollees who are dually Medicare/Medicaid enrolled increased from around 13 percent to more than 18 percent from 2009 to 2019, while the share of dually enrolled TM enrollees fell somewhat from around 19 percent to around 17 percent. ▪ Ratio of MA to TM risk scores increased from 0.97 in 2011 to 1.04 in 2018 (MCBS, using age, sex, and Medicaid status). ▪ Ratio of MA to TM risk scores increased from 0.93 in 2011 to 1.01 in 2018 (MCBS, using age, sex, Medicaid, and institutional status). ▪ Controlling for age, sex, and Medicaid status, the mortality rate of MA enrollees was about 88 percent of that of TM enrollees over the entire 2009–19 period.

Source: Author's review of cited studies.

Notes: TM = traditional Medicare; MA = Medicare Advantage; MCBS = Medicare Current Beneficiary Survey; MBSF = Master Beneficiary Summary File; CMS-HCC = Centers for Medicare & Medicaid Services-Hierarchical Condition Categories.

Kronick and Chua (2021) examined changes in the relative composition of MA and TM enrollees using risk scores based on age, sex, and Medicaid status. Using Master Beneficiary Summary File data from 2009 to 2019, the study found the ratio of MA to TM risk scores increased from 0.97 in 2009 to 1.01 in 2019. The pattern switched from a small degree of favorable selection on the risk score to gross adverse selection, that is, higher risk in MA based on demographics and Medicaid status. The ratio of risk scores moved from below 1 to above one from 2016 to 2017. An increased share of MA enrollees who are dually eligible for Medicare and Medicaid, from around 13 percent in 2009 to 18 percent in 2019, contributed to this switch. The share of dually enrolled TM enrollees fell from around 19 to 17 percent over the same period. This growth coincided with a significant enrollment increase in dual-eligible special needs plans.[8] The study obtained a similar result using Medicare Current Beneficiary Survey data, with the ratio of MA to TM demographic risk scores increasing from 0.97 in 2011 to 1.04 in 2018 and the switch from below 1 to above 1 happening between 2013 and 2015 (2014 data were not released). With institutional status added as a risk factor in the MCBS data, the ratio of risk scores increased from 0.93 in 2011 to 1.01 in 2018.

As predicted by age, sex, Medicaid, and institutional status, the overall MA population is no longer expected to cost less than the TM population (though MA enrollees may be expected to cost less based on other factors). This qualitatively important shift can muddy current discussions about favorable selection in MA.

Estimates of Gross Favorable Selection Can Be Used to Evaluate Differential Coding Intensity

Although the studies by Kronick and colleagues provide useful information on trends in the degree of gross favorable selection in MA, their estimates of selection were made to evaluate the degree to which risk scores based on reported diagnoses are inflated in MA relative to TM (Jacobs and Kronick 2018; Kronick and Chua 2021; Kronick and Welch 2014). They compared risk measures based on factors not subject to measurement differences or upcoding (demographics, Medicaid status, institutional status, mortality, drug utilization) to diagnosis-based risk measures and evaluated the degree of upcoding by how the risk measures differed. Based on drug usage, for example, Jacobs and Kronick (2018) found that the health risk of MA beneficiaries relative to those in TM increased by 3.4 percentage points from 2008 to 2015, while the relative risk using diagnoses increased 9.8 percentage points. It is reasonable to infer that the differential in growth rates is because of relatively inflated diagnosis-based risk scores in MA and that actual relative health risk for MA increased more in line with the prescription drug-based risk measure.

Mortality Rates Are Persistently Lower in MA than in TM, Consistent with Gross Favorable Selection in MA

Studies have also assessed the relative health risks of the overall MA and TM population using mortality rates, which have the benefit of being comparably measured for both MA and TM enrollees. Newhouse et al. (2012) found that the relative mortality rate of MA to TM enrollees, adjusted for age, sex, and Medicaid status, rose from 85 to 93 percent from 1998 to 2008. Kronick and Welch (2014) compared the trends in mortality rates for MA and TM enrollees from 2004 to 2012, finding lower mortality rates for MA than TM each year. The rates declined steadily for both groups over the period but declined somewhat faster for MA enrollees. Adjusting for age and sex, mortality in MA and TM declined at about the same rate over the period. Using Health Care Cost Institute (HCCI) data for Medicare enrollees in 2010 aged 65 and over, Curto et al. (2019) found mortality rates are lower for MA enrollees than for TM enrollees (3.9 versus 5.0 percent), which suggests gross favorable selection in MA. Controlling for age, sex, and Medicaid status, Kronick and Chua (2021) found that the mortality rate of MA enrollees was about 88 percent of that of TM enrollees over the entire 2009–19 period.

Beveridge et al. (2017) estimated a predictive model of mortality using data on TM enrollees, including as predictors age, sex, race, Medicaid and disability status, number of HCCs, and indicator variables for many individual HCCs and then applied that model to data on an MA population from a single large insurer. Predicted mortality was lower in the MA population than in TM (3.7 versus 4.3 percent), indicating favorable gross selection in MA. The ratio of actual-to-predicted mortality for a group of MA enrollees was 0.8, suggesting that MA enrollees were favorably selected (net of factors in the prediction model), assuming no sizable beneficial treatment effect of MA. But the gap between actual-to-predicted mortality for MA enrollees could at least partly be an artifact of higher coding intensity in MA. The study excluded the CMS-HCC risk score from the mortality prediction model because of concern about coding intensity differences but then still included the number of HCCs and several health conditions in the prediction model, which we would assume are also subject to measurement differences related to coding intensity.

Newhouse et al. (2019) examined the mortality experience over five years of two cohorts choosing MA compared with corresponding cohorts choosing TM. The study found lower mortality rates in both MA cohorts compared with their respective TM cohorts in the first year. But the difference in mortality rates diminished as relative rates converged over time, though still showed favorable selection in MA after five years. By showing how initial group differences in risk can diminish, this study provides evidence on regression to the mean that has implications for what we can infer about MA overpayment from stayer/leaver studies, an issue also raised by Newhouse et al. (2015). It is not clear whether the convergence in mortality rates would continue after the five years studied and to what degree. If the observed convergence in mortality rates carries over to convergence in spending, it could mitigate but still not be enough to neutralize effects of favorable selection that accrue to MA.

Switcher-Stayer Studies Predominantly Find Gross Favorable Selection into MA, with Variation over Time

Another form of evidence on gross selection effects in MA, also described in table 1, comes from studies comparing the composition of Medicare enrollees who switch into MA from TM or switch out of MA to TM to those who remain in TM or MA. These studies show that TM enrollees moving to MA are lower-risk or lower-cost (before adjusting for risk scores) than enrollees staying in TM (Brown et al. 2011, 2014; McWilliams, Hsu, and Newhouse 2012; Newhouse et al. 2015, and Park et al. 2017). Each of these studies shows that the degree of gross favorable selection into MA, gauged by risk scores, fell after the introduction of CMS-HCC risk adjustment. For spending, Brown et al. (2011, 2014) found that TM spending was $2,847 lower for enrollees who switched to TM from MA compared with those who stayed in TM before 2004 and that the difference was not significantly changed in the 2004–06 period. With a larger but more restricted sample, Newhouse et al. 2015 found that the difference in TM spending between switchers into MA and TM stayers narrowed in the 2004–10 period. The studies that compare enrollees leaving MA for TM to enrollees staying in MA generally found that MA leavers are higher-risk and/or higher-cost than MA stayers (McWilliams, Hsu, and Newhouse 2012; Park et al. 2017), again pointing to selection that favors MA.

Newhouse et al. (2012) examined differences in CMS-HCC risk scores, net of enrollee demographic characteristics, and other selected factors between switchers from TM to MA and TM stayers. Differences in risk scores, with lower-risk beneficiaries moving to MA, were reduced after the introduction of CMS-HCC risk adjustment. This finding suggests that the new risk adjustment was successful in encouraging MA plans to enroll more patients with diagnoses associated with higher spending, though the study also showed the difference in risk between MA enrollees switching to TM and MA stayers widened, leading to increased selection favorable to MA among those disenrolling from MA.

Evidence on Selection Net of Risk Adjustment Points to Substantial Favorable Selection in MA

Selection net of risk adjustment is the type of selection more directly relevant to evaluating the effects of selection in MA on payment adequacy. Table 2 summarizes evidence on net favorable selection in MA. Studies of net selection in MA generally focus on differences in spending, net of that predicted by risk scores, between switchers into (and sometimes out of) MA compared with stayers in TM or MA. These studies, including recent ones, overwhelmingly find evidence of net favorable selection in MA, with a few exceptions depending on study and time period. Ideally, we would be able to compare all MA enrollees to all TM enrollees, but that is precluded because spending is not measured comparably, and diagnoses (and thereby risk scores) are not measured comparably. In switcher-stayer studies, TM spending and diagnoses are measured comparably for both groups, though the problem of extrapolating to the full MA population remains because of the limitations described above.

Brown et al. (2011) found that before introduction of CMS-HCC-based risk adjustment, TM spending was similar for switchers to MA and TM stayers after controlling for CMS-HCC risk scores. But after implementation, TM enrollees switching to MA were about $1,200 less costly than expected, holding risk scores fixed. From this finding, the authors infer that, with risk of more costly diagnoses now receiving higher payment, MA plans began enrolling enrollees with lower "residual risk," i.e., enrollees who cost less than predicted by the risk adjustment who are, thereby, more profitable under the new risk adjustment. Using similar methods but with a larger sample that excluded institutionalized and dual Medicare/Medicaid enrollees and those who switched into special needs plans, and with later years of data, Newhouse et al. (2015) found TM enrollees who switched to MA had $406 (or 5.5 percent) lower spending than enrollees who stayed in TM in 2010 after adjusting for CMS-HCC risk score. Thus, the study still found favorable selection benefiting MA, but to a lesser degree, though sample differences mean the result is not directly comparable to Brown et al. (2011). Park et al. (2017) found that differences in total expenditures, adjusting for CMS-HCC risk scores, between switchers to MA and TM stayers decreased in magnitude from -$2,400 before implementation of CMS-HCC risk adjustment to -$84 after full implementation. The authors note the latter point estimate is imprecisely estimated. Thus, the study found substantial favorable selection into MA before CMS-HCC risk adjustment is introduced but is fairly uninformative on whether or not there is favorable selection after implementation. Park et al. (2017) also found that MA enrollees who disenrolled and moved to TM had estimated spending $1,418 higher (adjusting for CMS-HCC risk scores) than those who stayed in MA before implementation of CMS-HCC risk adjustment and nearly $5,000 higher than those who stayed in MA after full phase-in of CMS-HCC risk adjustment. Thus, selection was also favorable to MA plans as more costly-than-expected enrollees left for TM.[9]

TABLE 2

Evidence on Net Selection in MA after Adjusting for CMS-HCC Risk Score

Study	Approach	Overall conclusion on net selection in MA	Key findings
Brown, Jason, Mark Duggan, Ilyana Kuziemko, and William Woolston. 2011. "How Does Risk Selection Respond to Risk Adjustment? Evidence from the Medicare Advantage Program." Working Paper 16977. Cambridge, MA: NBER. ———. 2014. "How Does Risk Selection Respond to Risk Adjustment? New Evidence from the Medicare Advantage Program." *American Economic Review* 104 (10): 3335–64.	Compared total Medicare expenditures of switchers from MA to TM to those of enrollees who remain in TM, using MCBS data before and after introduction of CMS-HCC risk adjustment (1994–2006).	Favorable after implementation of CMS-HCC risk adjustment	▪ Controlling for CMS-HCC risk scores, total Medicare expenditures for TM enrollees who then switched to MA were similar before implementation of CMS-HCC risk adjustment (1994–2002 data). ▪ After implementation, the difference fell by about $1,200, indicating TM enrollees switching to MA were less costly than predicted by their risk score.
Newhouse, Joseph P., Mary Price, J. Michael McWilliams, John Hsu, and Thomas G. McGuire. 2015. "How Much Favorable Selection Is Left in Medicare Advantage?" *American Journal of Health Economics* 1 (1): 1–26. https://doi.org/10.1162/ajhe_a_00001.	Estimated selection effects using an approach similar to that in Brown et al. 2011, with a larger but more restricted sample (2001–10) that excludes institutionalized and dual Medicaid/Medicare eligible enrollees and enrollees who switched into cost MA plans or special needs plans. Computed risk scores using the 2007 CMS-HCC model.	Favorable	▪ Adjusting for CMS-HCC risk score, TM enrollees who switched to MA had $174 lower spending than enrollees who stayed in TM in 2001 (mean spending = $5,325). ▪ Adjusting for CMS-HCC risk score, TM enrollees who switched to MA had $406 lower spending than enrollees who stayed in TM in 2010 (mean spending = $7,343).

Study	Approach	Overall conclusion on net selection in MA	Key findings
Park, Sungchul, Anirban Basu, Norma Coe, and Fahad Khalil. 2017. "Service-Level Selection: Strategic Risk Selection in Medicare Advantage in Response to Risk Adjustment." Working Paper 24038. Cambridge, MA: NBER.	Examined how differences in risk scores and expenditures between MA and TM groups changed after implementation of CMS-HCC risk adjustment using 2001–09 MCBS data.	Favorable	▪ Adjusting for risk score, differences in total Medicare expenditures between switcher to MA and stayer in TM groups decreased in magnitude from -$2,400 before implementation (2001–02) to -$84 (imprecisely estimated) after full phase-in of CMS-HCC risk adjustment (2006–09). ▪ Adjusting for risk score, MA enrollees who disenrolled and moved to TM had an estimated expenditure of $1,418 more than those who stayed in MA before implementation of CMS-HCC risk adjustment and $4,996 more than those who stayed in MA after full phase-in of CMS-HCC risk adjustment.

Study	Approach	Overall conclusion on net selection in MA	Key findings
Curto, Vilsa, Liran Einav, Amy Finkelstein, Jonathan Levin, and Jay Bhattacharya. 2019. "Health Care Spending and Utilization in Public and Private Medicare." *American Economic Journal: Applied Economics* 11 (2): 302–32. https://doi.org/10.1257/app.20170295.	Compared mortality rates, which are comparably measured for both MA and TM enrollees, to proxy for selection. Used Health Care Cost Institute (HCCI) and CMS data for Medicare enrollees ages 65 and over in 2010. Adjusted MA risk scores downward by 3.41 percent (the coding intensity adjustment CMS applied in 2010) to make MA risk scores more comparable to those in TM.	Favorable	▪ Spending in MA is 25 percent lower than in TM ($642 versus $855 per enrollee month) after reweighting TM population to have same county and adjusted CMS-HCC risk score distribution as MA. ▪ Mortality rates in MA are lower than in TM after adjusting for county and risk score (adjusted difference not reported). ▪ Expected spending for TM enrollees falls to $706 per month after TM enrollees are reweighted to have the same predicted mortality rate as MA enrollees (predicted by county, risk score, and MA status), thus mortality rate differences can explain at most (70 percent) of the MA-TM spending gap (-$149 of the -$213 gap) ▪ Assuming mortality differences are because of net selection rather than treatment effects of MA, net selection results in spending for MA enrollees being 17.5 percent (0.70*25%) lower than what would be predicted for TM enrollees with the same risk score and county, which can be viewed as an upper bound on the degree of net selection.

Study	Approach	Overall conclusion on net selection in MA	Key findings
Jacobson, Gretchen, Tricia Neuman, and Anthony Damico. 2019. "Do People Who Sign Up for Medicare Advantage Plans Have Lower Medicare Spending?" San Francisco: KFF.	Compared risk-adjusted TM spending (Parts A and B) of TM enrollees who switched to MA to spending of TM enrollees who did not switch using Chronic Conditions Warehouse Data 5 percent sample of claims, 2013–16. Estimated adjusted differences using a risk adjustment model similar to the CMS-HCC model.	Favorable	▪ Risk-adjusted TM spending was $1,253 (13 percent) lower in 2015 for TM enrollees who switched to MA in 2016 compared with those who stayed in TM. ▪ Similar differences were found within a range of subgroups with different chronic conditions.
Lieberman, Steven M., Samuel Valdez, and Paul Ginsburg. 2023. "Medicare Advantage Enrolls Lower-Spending People, Leading to Large Overpayments." Los Angeles: USC Schaeffer.	Estimated favorable selection by comparing risk-score-adjusted expenditures of beneficiaries switching from TM to MA from 2006–19. Estimated implications for government costs if beneficiaries switching to MA have below-average, risk-score-adjusted expenditures. Analysis made adjustment to account for regression to the mean. Used 100 percent MBSF data from 2006 to 2019.	Favorable	▪ After adjusting for risk score, TM enrollees who switched to MA had 21.5 percent lower spending ($9,094) than enrollees who stayed in TM ($11,589). ▪ Nearly half of MA beneficiaries in 2020 switched from TM over the 2006-2019 period. ▪ Favorable selection led to MA overpayments on the order of 14.4 percent, adding to MedPAC's estimate of overpayment to MA because of differences in coding intensity and quality bonuses of 6 percent, leading to total MA overpayment of about 20 percent ($75 billion in 2020).
MedPAC (Medicare Payment Advisory Commission). 2023. *Report to Congress: Chapter 4: Favorable Selection and Future Directions for Medicare Advantage Payment Policy*. Washington, DC: MedPAC.	Estimated favorable selection by comparing risk-score-adjusted expenditures of beneficiaries when they originally switched from TM to MA, plus additional favorable selection because of attrition from MA, minus an adjustment to account for regression to the mean. Used Medicare enrollment, Medicaid claims spending, and risk-adjustment file data from 2006 to 2020.	Favorable	▪ Favorable selection alone led to 11 percent higher payments to MA plans in 2019 than the same enrollees would have cost in TM.

Study	Approach	Overall conclusion on net selection in MA	Key findings
Ryan, Andrew M., Zoey Chopra, David J. Meyers, Erin C. Fuse Brown, Roslyn C. Murray, and Travis C. Williams. 2023. "Favorable Selection in Medicare Advantage Is Linked to Inflated Benchmarks and Billions in Overpayments to Plans." *Health Affairs* 42 (9): 1190–97. https://doi.org/10.1377/hlthaff.2022.01525.	Estimated the relationship between price-adjusted TM spending and CMS-HCC risk scores across counties in a regression model that allows the effect of risk score to vary by county MA penetration using county-level data from 2010 to 2020. Interprets variation in the association between TM spending and risk as an indication of selection effects not accounted for by risk adjustment. Observed that net adverse selection in TM (net favorable selection in MA) would inflate MA benchmarks as they are set based on county-level risk-adjusted spending in TM. Estimates MA overpayment resulting from favorable selection in MA and inflated benchmarks.	Links net favorable selection to MA overpayment	▪ Found that unobserved favorable selection in MA led to underpayment to counties with lower MA penetration and overpayment to counties with higher MA penetration. ▪ Estimates that plans were overpaid by an average of $9.3 billion per year from 2017 to 2020, owing to the distribution of MA penetration shifting toward overpaid counties.
MedPAC. 2024. *Report to Congress: Chapter 12: The Medicare Advantage Program: Status Report*. Washington, DC: MedPAC.	Made technical revisions to the framework described in the June 2023 chapter. Accounts for selective enrollment into MA, attrition from MA, and an effect of regression to the mean.	Favorable	▪ Favorable selection led to 9 percent higher payments to MA plans in 2019 and 13 percent higher payments in 2021 than the same enrollees would have cost in TM. ▪ MA payments are projected to be 22 percent higher than what payments would be in TM for the same enrollees in 2024 due to favorable selection and coding differences combined, at an estimated cost of $83 billion in 2024.

Source: Author's review of cited studies.
Notes: TM = traditional Medicare; MA = Medicare Advantage; MCBS = Medicare Current Beneficiary Survey; MBSF = Master Beneficiary Summary File; CMS-HCC = Centers for Medicare & Medicaid Services-Hierarchical Condition Categories.

Recent studies comparing switchers to MA to those staying in TM provide consistent evidence of net favorable selection into MA. Jacobson, Neuman, and Damico (2019) found that risk-adjusted TM spending was $1,253 (13 percent) lower in 2015 for TM enrollees who switched to MA in 2016 compared with those who stayed in TM. Further, the study found these differences were similar across a range of enrollee subgroups with different chronic conditions. Lieberman, Valdez, and Ginsberg

(2023) found that TM enrollees who switched to MA had 21.5 percent lower spending than enrollees who stayed in TM after adjusting for risk score.

Unique in using measures of spending for MA and TM enrollees constructed to be comparable (not just switchers), Curto et al. (2019) found that spending in MA is 25 percent lower than in TM in 2010 ($642-$855 = -$213 per enrollee month) after adjusting for county and risk scores. Adjustment was made by reweighting the TM population to have the same county and risk score distribution as the MA population. MA risk scores were adjusted downward by 3.41 percent (the coding intensity adjustment CMS applied in 2010) to make MA risk scores more comparable to those in TM. To estimate how much of the payment difference could be attributable to net favorable selection, the study uses mortality rates as a proxy measure for unobservable differences in risk. Mortality rates in MA remain lower than in TM after controlling for county and risk score (adjusted difference not reported), consistent with net favorable selection. After reweighting the TM population to have the same predicted mortality rate as the MA population (by county, risk score, and MA status), the spending gap between MA and TM fell from -$213 to -$64 ($642–$706). Thus, mortality rate differences can explain 70 percent of the MA-TM spending gap ($149/$213*100%). Assuming mortality differences are because of net selection rather than a treatment effect of MA, net selection results in spending for MA enrollees being 17.5 percent (0.70*25%) lower than what would be predicted for TM enrollees with the same risk score and county, which can be viewed as an upper bound on the degree of net selection.

Recent Work Found Net Favorable Selection Contributes Substantially to MA Overpayments

MedPAC (2023) developed a framework for estimating the degree of net favorable selection in MA and its contribution to overpayment of MA plans. Its framework starts with estimating the initial degree of net favorable selection in a cohort of enrollees switching from MA to TM compared with TM stayers, similar to what other studies have calculated. It also accounts for selective attrition out of MA and estimated effects of regression to the mean. In its initial estimates, MedPAC calculated that favorable selection led to 11 percent higher payments in 2019 than the same enrollees would have cost in TM. MedPAC (2024) reapplied its framework with some technical revisions, calculating that net favorable selection led to 9 percent higher payments in 2019 and 13 percent higher payments in 2021 than the same enrollees would have cost in TM. Similarly, Lieberman, Valdez, and Ginsberg (2023) incorporate an effect of regression to the mean in their MA overpayment estimate. Thus, this recent work substantially moved the ball forward by addressing the critique of the switcher-stayer approach raised in prior studies (Newhouse et al. 2015, 2019). The recent studies concluded that favorable selection in MA, net of risk adjustment, is a large contributor to current MA overpayment.

Ryan et al. (2023) focused on relationships between the amount of net favorable selection, benchmarks, and payments to MA plans, finding that net favorable selection resulted in higher benchmarks leading to overall overpayment to MA plans, but with variation by county depending on the level of MA enrollment. The study estimated that net favorable selection's effect on benchmarks led to

an average of $9.3 billion per year in overpayments to MA plans from 2017 to 2020, which were viewed as being incremental to the overpayments estimated by Lieberman, Valdez, and Ginsberg (2023) and MedPAC (2023).

Discussion

Two statements about MA, perhaps seemingly at odds on the surface, are simultaneously true according to numerous studies on favorable selection in MA described here. First, the MA population has grown older and sicker relative to TM by some measures and is now expected to cost slightly more than TM enrollees based on demographic characteristics, Medicaid enrollment, and institutional status; and second, MA enrollees cost less than would be predicted based on comparably measured diagnosis-based risk scores and this contributes substantially to overpayment of MA plans. Although the first statement is consistent with MA enrollees no longer exhibiting gross favorable selection on certain characteristics as they had historically, the second statement is consistent with net favorable selection in MA (net of risk adjustment that determines payment to MA plans). Although gross favorable selection is easier to see and may be more salient to many observers (e.g., the rate of dual Medicare/Medicaid enrollment is now higher in MA than TM), net favorable selection is hard to see, requires indirect techniques to estimate, and is the proper quantity of interest for evaluating implications of favorable selection for MA payment adequacy.

Recent studies continue to find evidence of substantial net favorable selection in MA, as numerous prior studies overwhelmingly did. However, they have gone further in considering selective disenrollment from MA, incorporating regression-to-the-mean effects into their estimates, and bringing this together to estimate the degree of MA overpayment due to favorable selection. MedPAC (2024) estimates that in 2021, payments to MA plans were 13 percent higher than they would have been in TM due to favorable selection and an additional 8 percent higher than they would have been in TM due to coding differences, i.e., the coding effect that remains after CMS makes a 5.9 percent downward adjustment. Given the substantial contribution of net favorable selection to MA overpayment, MedPAC now incorporates the effect of net favorable selection into its payment adequacy estimates and projects MA payments will be 22 percent higher than what payments would be in TM for the same enrollees in 2024 due to favorable selection and coding differences combined, at an estimated cost of $83 billion in 2024. Similarly, Lieberman, Valdez, and Ginsberg (2023) estimated $75 billion in overpayment to MA plans in 2020 due to favorable selection and coding differences combined.

Overpayment, defined as paying more than necessary to induce MA plans to provide covered services for Medicare beneficiaries at acceptably high quality, is harmful to the Medicare program. Any Medicare overpayment unnecessarily burdens the Medicare Part A trust fund, which is now expected to be depleted by 2036 (CMS 2024). Overpaying for Medicare Part B services in MA needlessly inflates Part B premiums for both MA enrollees and TM enrollees, with TM enrollees receiving no benefit from the increased premium cost. Overpaying also burdens current and future taxpayers who finance the bulk of Part B services each year. Although a portion of MA overpayment is used to finance additional benefits and lower cost sharing for MA enrollees, and reducing MA payments could slightly reduce

these benefits (Chernew et al. 2023), policymakers need to consider the broader costs of providing these benefits through excessively generous payments and the disparity in benefits current policy creates with TM.

Fortunately, a range of ideas have been proposed to reform risk adjustment in MA and reduce MA overpayment more broadly. A panel of experts in MA and risk adjustment convened by the Urban Institute explored existing proposals and potential novel approaches to reforming risk adjustment in MA that could involve significant restructuring, such as transitioning MA to a competitive contracting system similar to Medicaid or TriCare (Skopec, Garrett, and Gangopadhyaya 2023).[10] Short-term incremental solutions included increasing the coding intensity adjustment above the statutory minimum of 5.9 percent where it is now set, as CMS has the authority to do, and excluding diagnoses gathered only from health risk assessments and chart reviews from risk adjustment. Many panelists also supported some larger policy changes, including adding a reinsurance-type program to MA (similar to outlier policies already in place for some services in TM), reforming the risk-adjustment system to be budget-neutral within MA, using the Consumer Assessment of Health care Providers and Systems or other survey data in risk adjustment, either as a supplement to or a replacement for diagnostic data, and other ways to improve the predictability of risk adjustment. Another proposed approach would directly target overpayments related to net favorable selection by adjusting payments for enrollees switching to MA by amounts related to their spending in TM relative to the mean spending of all TM enrollees with the same risk score.[11]

Notes

[1] Quality bonus payments, which can only increase payment as there are no penalties for poor performance, can be viewed as contributing to MA overpayment because plans with more quality stars get higher payments without any clear benefit for enrollees or the Medicare program (Skopec and Berenson 2023).

[2] For a primer on MA payment issues and sources of overpayment see Berenson, Garrett, and Shartzer (2022).

[3] Enrollment statistics for March 2024 are available at "Medicare Monthly Enrollment," Data.CMS.gov, accessed July 24, 2024, https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/medicare-and-medicaid-reports/medicare-monthly-enrollment.

[4] For discussion of Medicare financing issues including sources of revenues and spending trends, see Steuerle and Garrett (2022).

[5] See the box on pages 164–65 of MedPAC (2023) for a discussion on how the MA plan and beneficiary incentives may produce favorable selection.

[6] "Payment Basics: Medicare Advantage Program Payment System," Washington, DC: MedPAC, accessed July 10, 2024.

[7] Kronick and Welch (2014) and Morrisey et al. (2013) summarize earlier studies.

[8] See chart 9-10 of "Section 9: Medicare Advantage," Washington, DC: MedPAC, accessed July 10, 2024.

[9] See also Meyers et al. 2019 on patterns of selective disenrollment from MA.

[10] See also Laura Skopec and Bowen Garrett, "The Value of Small Changes to the Medicare Advantage Risk-Adjustment System," *Health Affairs Forefront* (blog), June 30, 2023, https://www.healthaffairs.org/do/10.1377/forefront.20230621.32417.

[11] Steven M. Lieberman, Paul B. Ginsburg, and Eugene Lin, "Lowering Medicare Advantage Overpayments from Favorable Selection by Reforming Risk Adjustment," *Health Affairs Forefront* (blog), July 13, 2023, https://www.healthaffairs.org/do/10.1377/forefront.20230712.603114.

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