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Evaluating Medicare Advantage Benchmark Setting Methodology on Rural Counties

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Purpose

Current benchmark setting methods for Medicare Advantage (MA) plans provide incentives based on geography and quality. Plans have used these incentives to offer supplemental benefits (benefits not covered under traditional Medicare including prescription drugs, dental services, vision and hearing services, among others), or reduce cost-sharing (e.g. reduce or eliminate enrollee premiums, deductibles, and/or co-payments for services), thereby making their plans more attractive to potential beneficiaries. However, the current methodology results in incentives that can vary widely among regions and counties. Supplemental benefits, for example, are not uniformly available across all counties.[1] In recent years, the Medicare Payment Advisory Commission (MedPAC) has consistently recommended that the Centers for Medicare & Medicaid Services (CMS) adjust the benchmark setting methodology, in part to reduce the geographic variability.[2] The purpose of this brief is to understand how the current benchmark setting process affects rural counties compared to urban counties.

Key Findings:

- Rural counties are less likely to rank in the lower Medicare Fee for Service (FFS) spending quartiles that receive a higher percentage of the county benchmark: 41 percent of rural counties are categorized in combined quartiles 1 and 2 versus 59 percent for urban counties.
- Global caps (maximum benchmark payments based on pre-Affordable Care Act (ACA) county FFS spending) on benchmark payments are much more likely in rural counties, particularly those in the lower-spending quartiles, reducing incentives for supplemental benefits or reduced cost sharing

Background

Benchmarks are the annual maximum payment amount that CMS sets at the county level as targets for health plans to bid against to provide coverage to MA beneficiaries. Benchmarks are determined under statutory formulas. They differ depending on historic Medicare FFS spending in a county compared to all other counties (please refer to Appendix A for a detailed primer on the benchmark process).

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Per statute, CMS categorizes counties into quartiles based on historic FFS spending and adjusts benchmarks based on each county's FFS spending quartile.

The highest-spending counties receive 95 percent of the county MA benchmark, while the lowest-spending counties receive 115 percent of the MA benchmark. Most MA plans bid below the benchmark (averaging 83 percent of FFS spending).[3] Even in the counties that rank in the lowest quartile of FFS spending, bids tend to be below the benchmark (averaging 89 percent of FFS).[4] MA plans that bid below the benchmark are rebated a portion of the difference between their bid and the benchmark – 50 to 70 percent of the difference, depending on quality rating.[4] Those rebate funds must be spent on reduced cost sharing for enrollees or supplemental benefits. Plans with bids below benchmark in lower FFS-spending counties would have more rebate funds available for cost sharing reductions or supplemental benefits compared to higher FFS-spending counties. CMS by statute also imposes caps on benchmarks so they do not exceed pre-Affordable Care Act of 2010 (ACA) levels (with growth updates), also potentially affecting the availability of supplemental benefits in such counties.

Data and Methods

Public county-level data for 2024 on Medicare FFS spending[5] and benchmark MA payments[6] were downloaded from CMS websites. Urban Influence Codes (2013)[7] were used to categorize counties as urban (metropolitan: 1-2) or rural (nonmetropolitan: 3-12).

Results

Table 1 shows the distribution of metropolitan and nonmetropolitan counties within the FFS spending quartiles established by CMS in 2024. A notably smaller percentage of nonmetropolitan counties are in the combined lowest-spending first and second quartiles. Only 41 percent of nonmetropolitan counties are in quartiles 1 and 2 compared to 59 percent of metropolitan counties. Those lowest-spending quartiles receive more than 100 percent of the county benchmark, creating more opportunities for supplemental benefits or reduced cost-sharing. Further, the largest percentage of nonmetropolitan counties are in the highest-spending quartile where plans receive only 95 percent of the benchmark. This distribution of nonmetropolitan counties in the FFS quartile rankings suggest that, all else being equal, rebate incentives favor more metropolitan counties than nonmetropolitan counties, particularly as the vast majority of plans bid below benchmark regardless of FFS quartile.

Table 1: Medicare FFS Spending Quartiles by Geographic Classification

		Metropolitan		Non-Metropolitan	
Quartile	MA Payment as % of FFS Benchmark	# of Counties	% of Counties	# of Counties	% of Counties
1	115%	322	28%	372	19%
2	107.5%	360	31%	435	22%
3	100%	310	27%	509	26%
4	95%	174	15%	659	33%

Table 2 shows the effects of caps on benchmark payments by geography. One of the ways caps can affect plans is by eliminating or reducing quality bonuses. For example, a plan with a quality rating of four stars or higher stands to receive a 5 percent increase to their benchmark payment (see Appendix A for more details on the payment process). Any part of the additional payment that exceeds that cap is not paid to plans. As Table 2 demonstrates, nonmetropolitan counties were much more likely to face caps on benchmark payments. The proportion of nonmetropolitan counties with a cap on at least one bonus level (5 percent, 3.5

percent or 0 percent) is 50 percent compared to 29 percent of metropolitan counties. Nonmetropolitan counties are also far more likely to face caps across all bonus levels (26 percent vs. 11 percent). With respect to the FFS quartiles, counties in the lower-spending quartiles that would receive 115 percent of the benchmark are also more likely to be capped. These caps reduce incentives for rebates far more in nonmetropolitan counties than metropolitan counties and particularly hit nonmetropolitan counties in the lowest FFS quartile that would receive the highest percentage of the county benchmark.

Table 2: Percent of Counties with Capped Bonus Levels by Geographic Classification and Medicare FFS Spending Quartile

	At Least 1 Bonus Capped		All Bonuses Capped	
Quartile	**Metro**	**Non-Metro**	**Metro**	**Non-Metro**
1	38%	75%	16%	44%
2	40%	83%	14%	47%
3	18%	64%	8%	30%
4	5%	4%	0%	0%
Overall	29%	50%	11%	26%

Discussion

The benchmark setting methodology creates uneven opportunities for MA plans in metropolitan and nonmetropolitan counties. Nonmetropolitan counties are less likely to rank in the lower Medicare FFS spending quartiles 1 and 2, so these counties are less likely to receive the higher 115 (or 107.5) percent of the MA county benchmark payment. Further, the highest proportion of nonmetropolitan counties are in the highest spending quartile where plans receive only 95 percent of MA benchmark payments. This is in sharp contrast to metropolitan counties where the smallest proportion of counties are in the highest FFS quartile and the largest proportion of counties are in the lowest (higher paying) quartiles. The result is a benchmark setting process that creates relatively less incentive for supplemental benefits or reduced cost sharing in nonmetropolitan counties. We also found nonmetropolitan counties are more likely to have their quality bonus payments capped compared to metropolitan counties. Caps on quality bonus payments for MA plans servicing nonmetropolitan beneficiaries mean plans may not receive all benchmark adjustments for a high-quality rating or rebates if bids are below the benchmark.

The benchmark setting process (and overall MA reimbursement) is a controversial topic. MedPAC, for example, has consistently argued that CMS overpays MA plans and that taxpayers do not reap the benefits from the efficiencies of MA plans compared to traditional Medicare FFS. Part of the evidence for this argument is the overwhelming fraction of plans that bid below the benchmark, even in counties that receive only 95 percent of the county benchmark. In contrast, MA plans may argue that the additional incentives included in the current methodology are necessary to offer supplemental benefits or reduced cost-sharing. Our work shows the uneven incentives across rural and urban counties within the current benchmark process and thus, the need to consider the geographic effects in both the current benchmark setting methodology and when contemplating reforms to the benchmark setting process.

Understanding how benchmarks, in addition to other factors such as risk adjustments, affect MA plan offerings in nonmetropolitan counties is a task for future research. Particularly worthy of attention is identifying whether the notably higher incidence of benchmark caps in nonmetropolitan counties and the unfavorable Medicare FFS quartile mix affects plan participation, including availability of additional cost sharing and/or supplemental benefits.

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Appendix A: Primer on Medicare Advantage Payment Process[8,9,10]

Part 1: Calculating Benchmarks

Benchmarks are the annual maximum payment amount that CMS sets for health plans to bid against to provide coverage to MA beneficiaries. CMS calculates a separate benchmark for each U.S. county, first projecting per capita Medicare FFS spending for the next year and then using a county-level geographic index to adjust that projected FFS number for each county. Each county level per capita FFS spending estimate is adjusted based on the historical per capita FFS spending, with benchmarks set based on a percentage of per capita FFS spending number as follows:

FFS Spending Quartile	Percent of County Projected FFS Spending
1 (lowest-spending)	115%
2	107.5%
3	100%
4 (highest-spending)	95%

Other adjustments

Benchmarks for MA plans are also adjusted based on the star quality rating. Plans with ratings of 4, 4.5, or 5 stars receive a 5 percent increase in their benchmark. New plans receive a 3.5 percent increase in their benchmark payment. Plans with quality ratings below 4 do not qualify for a benchmark bonus. These benchmark quality adjustments double in certain qualifying counties (all urban). For plans that span counties (e.g., regional Preferred provider Organization (PPO) plans), CMS uses enrollment to calculate a weighted-average benchmark. For plans that span regions, CMS uses a more complex weighting formula based on Medicare enrollees, the national percentage of FFS beneficiaries, and average enrollment weighted plan bids.

Part 2: Plan bids

With benchmarks determined, plans submit bids to cover Medicare Part A and Part B costs (Part D is part of a separate bidding process). All plans abide by the 85 percent minimum loss ratio (MLR), limiting administrative expenses and profits to 15 percent of plan revenue.

Rebates/Premiums

If a plan bids above the benchmark, the enrollee pays a premium that equals the difference between bid and benchmark. If a plan bid is below the benchmark, it receives a percentage of the difference between bid and benchmark as a rebate depending on plan quality. Rebates are also referred to as Quality Bonus Payments (QBPs):

Plan Quality Star Rating	% of Bid-Benchmark Difference Paid as Rebate
3 Stars or below	50%
3.5 – 4 Stars	65%
4.5 – 5 Stars	70%

Rebates/QBPs must be used to provide supplemental benefits, to reduce cost sharing, or to provide innovations in care delivery (e.g., telemedicine).

Benchmark Caps

Per statute, benchmarks are capped, restricting the total quality-adjusted benchmark to a maximum based on the pre-ACA benchmark methodology, adjusted for growth. Essentially, after adjusting for average growth, benchmark payments cannot be higher than they would have been pre-ACA. Plans may not receive all (or any) benchmark adjustments for QBPs in

these cases, potentially limiting opportunities for supplemental benefits and reduced cost-sharing in those counties.

Part 3: Payments to Plans

A Medicare Advantage plan's base payment rate is the lower of the plan's bid and the county benchmark. After that base rate is determined, CMS modifies payments at the enrollee level using an algorithm based on Hierarchical Condition Categories (HCC, essentially an enrollee's risk factor score based on the individual's health conditions, age, sex, and other factors).