



# Medicare Advantage Overview: A Primer on Enrollment and Spending

Recent data shows that Medicare Advantage is now about half of the Medicare market, both in terms of beneficiary enrollment and payments.

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## KEY POINTS

- Private health insurance plans have been a part of the Medicare program since the 1980s; they are now called Medicare Advantage (MA).
- Beneficiary enrollment in MA plans has increased rapidly in recent years. The share of eligible Medicare beneficiaries enrolled in MA rose from 25% in 2010 to 47% in 2021 (27.6 million enrollees).
- Payments to MA plans more than doubled between 2015 and 2021 (from \$175 to \$361 billion), taking the share of total Medicare Parts A & B spending on MA from 38% to 54%. Over the next 10 years, CMS is expected to pay MA health insurance companies over \$7 trillion.
- Evidence from independent analyses suggests that federal spending per person in MA exceeds spending for comparable FFS Medicare beneficiaries, with estimates ranging from 4 to 10 percent higher spending in MA in 2021. This differential is projected to grow over time, in large part from differences in diagnostic coding intensity – the number and type of diagnosis codes submitted by plans, which can increase federal payment due to MA risk adjustment practices.
- In recent years, margins are higher in MA than other markets. Gross margins per member per month were higher in MA than in commercial group insurance, individual insurance, and Medicaid managed care markets between 2018 and 2021.

## INTRODUCTION

Since the 1980's, the Centers for Medicare & Medicaid Services (CMS) has contracted with private insurance companies to offer Medicare benefits as an option for seniors and people with disabilities; this option is known as Medicare Advantage (MA). In the early years of the MA program, plan payment was set at 95% of average per beneficiary costs based on the principle that these plans could provide better coordinated, higher quality care and additional benefits at a lower cost than could be obtained in the fee-for-service (FFS) Medicare program.

Program changes over time have resulted in MA plans being paid by the federal government through a complex system that factors in:

- Annual bids submitted by health insurers;
- A “benchmark” derived from county-level costs in FFS Medicare program; and
- Risk adjustment based on beneficiary demographics and diagnoses.

This report provides an overview of MA enrollment and payment, highlighting historical trends and current projections for the near future.

## MA ENROLLMENT

### MA Enrollment Trends and History of Congressional Action

Over the past 40 years, there have been iterative legislative and regulatory changes to the payment model for private plans in Medicare, which have impacted payment and enrollment. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) established a capitated payment system to Medicare-contracted private plans with prospectively set payment rates (95% of average per beneficiary FFS Medicare costs) and risk adjustment based on demographics. According to historical data reported by the 2022 Medicare Trustees Report,<sup>1</sup> enrollment in Medicare’s private plan program increased from 1.3 million in 1985 to 6.9 million in 2000 (See Figure 1). The Balanced Budget Act of 1997 (BBA) limited the annual payment increases in Medicare private plan capitation rates.<sup>2</sup> In addition, both the BBA and the Benefits Improvement and Protection Act of 2000 (BIPA) required the implementation of risk adjustment methods in determining payments in order to reduce the incentives for MA plans to target the enrollment of healthier beneficiaries, also referred to as favorable selection or “cherry picking,” and avoid more complex enrollees.<sup>3</sup> After these changes, Medicare private plan enrollment decreased from 6.3 million in 2000 to 5.8 million by 2005.

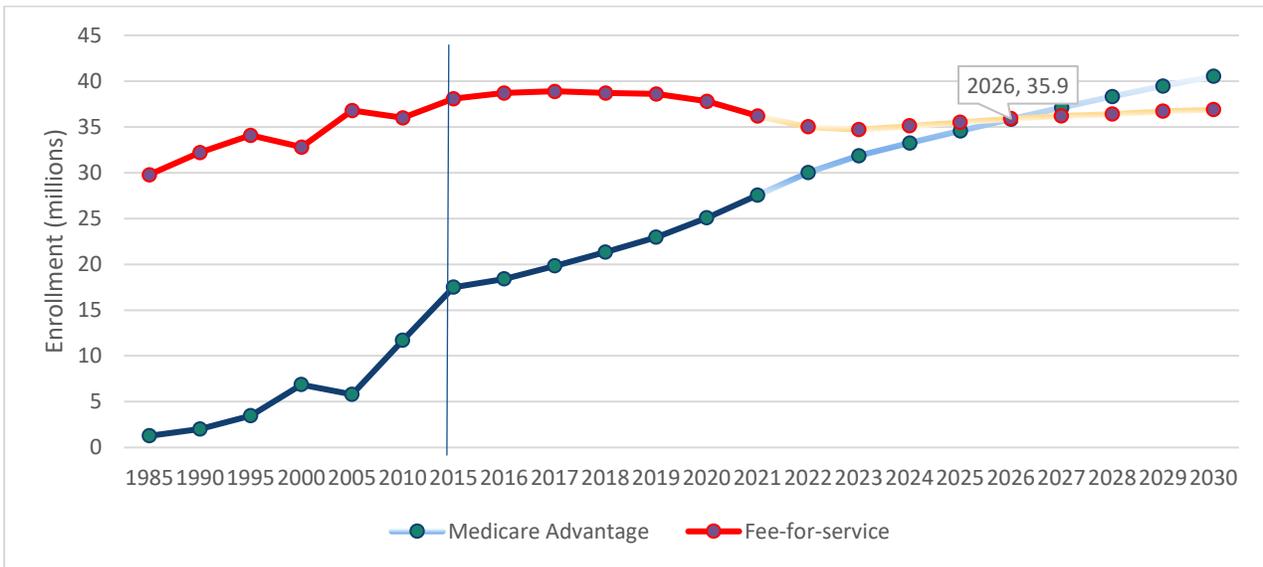
To address declining enrollment, legislative changes were made to enhance insurer participation and beneficiary enrollment in private plans in Medicare. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) authorized the current MA program. This new iteration of the private Medicare program included a new bidding process in which MA plans were required to submit bids against a fixed benchmark to provide services to Medicare beneficiaries at the local or regional level, beginning with the 2006 contract year.\* The MMA also provided immediate increases to MA plan payment rates and other program changes that were designed to encourage plan participation and reverse the downward trend in MA enrollment. The Affordable Care Act (ACA) also made major changes to MA payment, as described below.

As Figure 1 shows, since the increased payment rates under the MMA took effect, MA enrollment more than doubled between 2005 and 2010 (increasing from 5.8 million to 11.7 million, or from 14% to 25% of Medicare enrollment) and has been growing rapidly since.

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\* Specifically, plans whose bids are below the county benchmark receive their per capita bid risk adjusted for each enrollee, plus a rebate equal to 50 to 75 percent of the difference between the bid and the benchmark. Plans bidding above the benchmark amount receive a risk adjusted per capita payment equal to the benchmark and must charge a premium to beneficiaries.

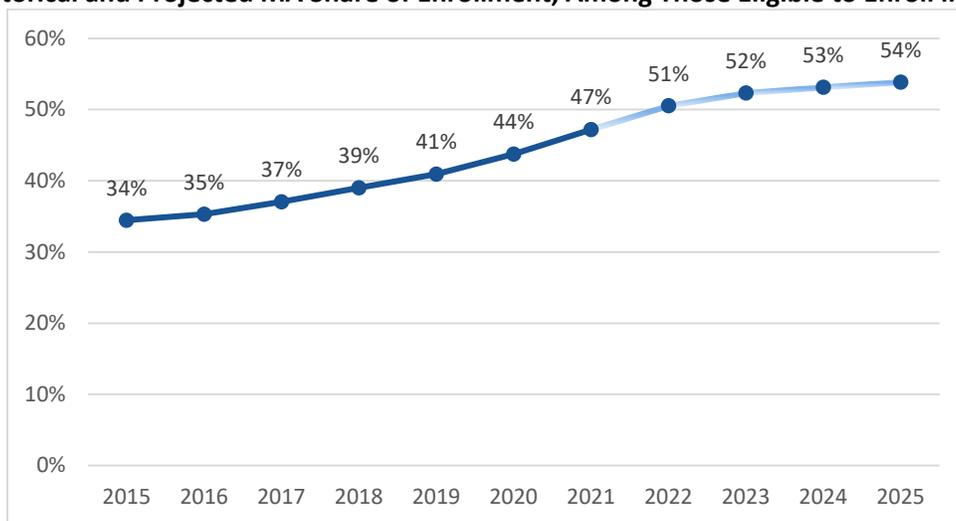
**Figure 1. Historical and Projected Enrollment Growth in MA and FFS Medicare, 1985-2030**



Source: Medicare Trustees Report, 2022. Table V.B3 or IV.C1. Fee-for-service includes enrollment in Part D.  
 Note: Between 1985 and 2015, enrollment was reported for every 5 years. Yearly data was reported after 2015. 2022 and later are projected numbers.

Figure 2 shows historical and projected MA share of Medicare enrollment between 2015 and 2025, as a percentage of Medicare beneficiaries eligible to enroll in MA (defined as having both Medicare Parts A & B).<sup>4</sup> The share of eligible Medicare beneficiaries enrolled in MA rose from 34.5% in 2015 (17.5 million enrollees) to 47% in 2021 (27.6 million enrollees). The growth in MA enrollment is expected to continue, reaching over 30 million in 2022, accounting for roughly 50% of Medicare beneficiaries with Parts A & B. Note that some Medicare beneficiaries are only enrolled in Part A (7.5% of total enrollees in 2019) while others are only enrolled in Part B (0.4% of total enrollees in 2019); these beneficiaries are not eligible to enroll in MA. Starting in 2027, the number of MA enrollees is expected to exceed the number of FFS Medicare enrollees.

**Figure 2. Historical and Projected MA Share of Enrollment, Among Those Eligible to Enroll in MA, 2015-25**

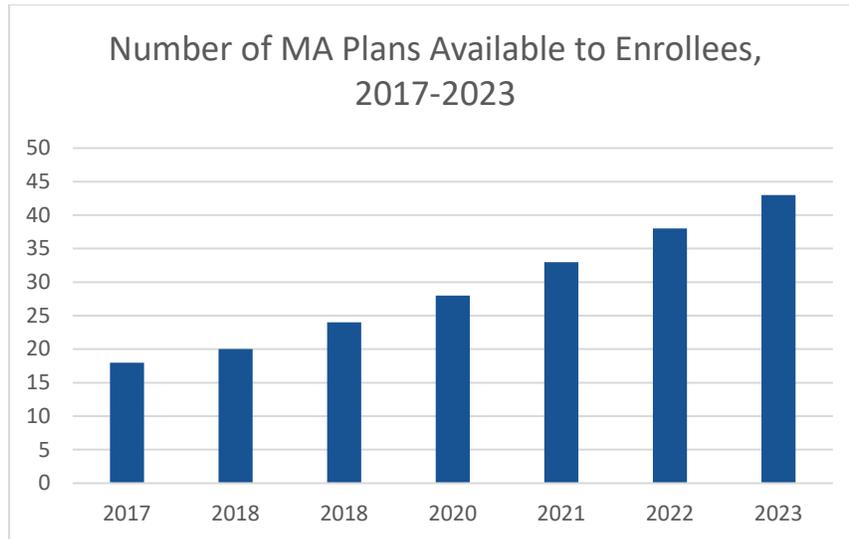


Source: Medicare Trustees Report, 2022. Table V.B3 or IV.C1.  
 Note: To be eligible to enroll in MA beneficiaries must be enrolled in \*both\* Medicare Part A and Part B. Total Medicare population includes those enrolled in both Medicare Part A and B, as well as those only enrolled in Medicare Part A or Medicare Part B.

## MA Market Trends and Plan Choice

Over the past decade, Medicare enrollment and plan choice have grown rapidly. As Figure 3 shows, the average Medicare beneficiary has access to 43 MA plans in 2023, more than double the number of options available only 5 years ago.

**Figure 3. Number of MA Plans Available to Enrollees, 2017-2023**



Source: KFF, “The Typical Medicare Beneficiary Has Close to 70 Different Medicare Advantage and Medicare Part D Stand-Alone Plan Options for 2023,” November 2022.

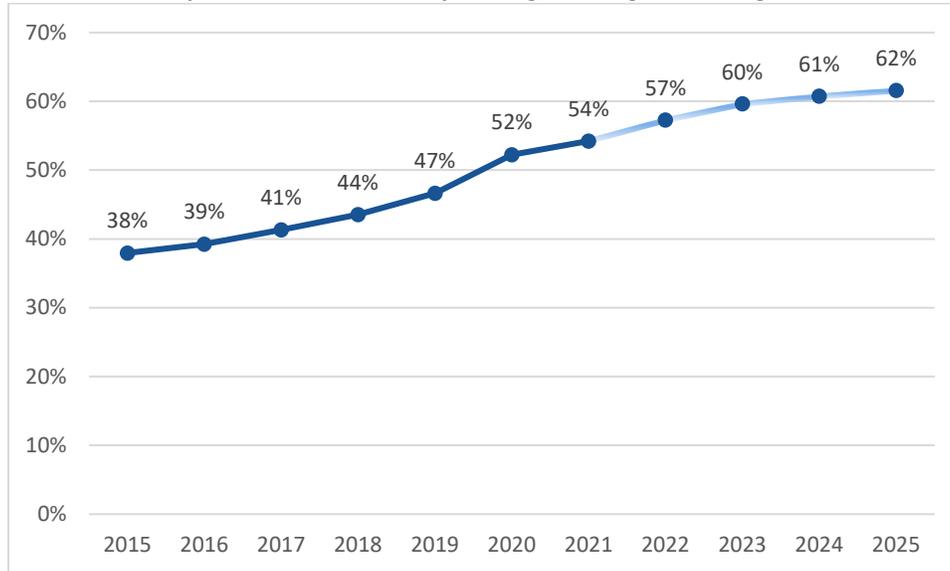
Overall, these trends show that the MA market continues to expand steadily, and that MA plans have successfully grown – even as the policy environment has changed.

## MA SPENDING

### MA Payment Trends

Payments to MA plans more than doubled between 2015 and 2021 (from \$175 to \$361 billion), taking the MA spending share of Medicare Parts A & B from 38% to 54% (Figure 4). Medicare Trustees projected the MA spending share will continue growing to about 62% of Medicare Parts A & B spending in 2025. Over the next 10 years, CMS is expected to pay MA health insurance companies over \$7 trillion.

**Figure 4. Historical and Projected MA Share of Spending, Among Those Eligible to Enroll in MA, 2015-25**

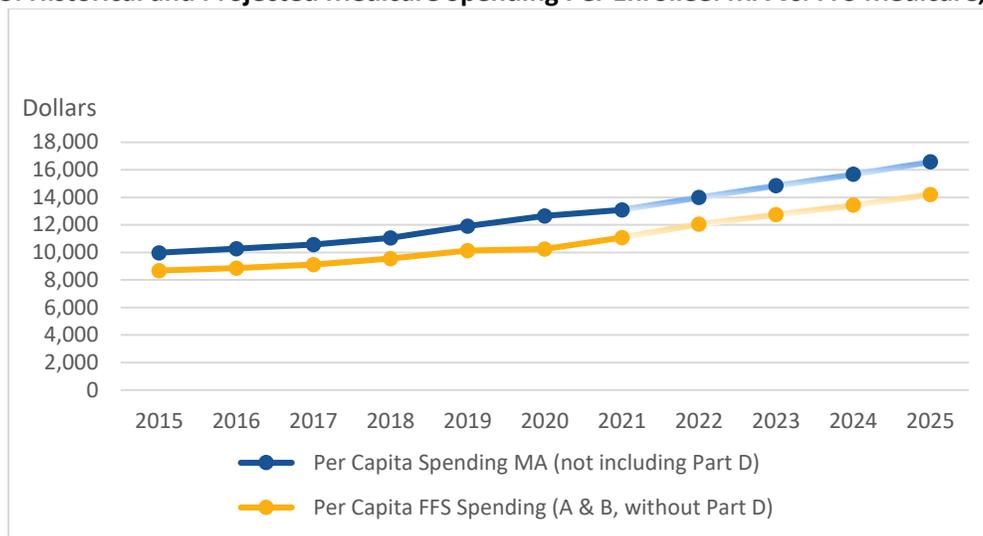


Source: Medicare Trustees Report, 2022. Tables IV.C2, IV.A3, IV.B6, and IV.B10.

Note: Benefits spending are calculated based on MA plans bid in terms of providing A & B benefits (not inclusive of Part D benefits or hospice). 2022 and later are projected numbers.

The growth in MA spending was not only due to steady enrollment growth in MA plans, but also due to higher per person spending in MA than in FFS Medicare, as explained below. Figure 5 shows that federal spending per person in MA has consistently exceeded per capita FFS Medicare spending since 2015 (\$9,981 vs. \$8,683 in 2015 and \$13,099 vs. \$11,083 in 2021). The differential has been growing and is projected to continue growing over time.

**Figure 5. Historical and Projected Medicare Spending Per Enrollee: MA vs. FFS Medicare, 2015-25**



Source: Medicare Trustees Report, 2022. Tables IV.C2, IV.A3, IV.B6, and IV.B10.

Note: Medicare Advantage spending (including rebates) are calculated based on MA plan bids and rebates to provide Parts A & B benefits (not inclusive of Part D benefits or hospice). 2022 and later are projected numbers.

## How are Payments to MA Plans Currently Determined?

Under the MMA, payments to MA plans are based on plan bids to cover all Medicare core benefits, meaning Medicare Part A (hospital) and Medicare Part B (outpatient) services, but excluding hospice and certain other Medicare-covered benefits. MA plans submit these bids in response to county-based benchmarks set by CMS based on FFS Medicare data. Currently, after additional changes to MA payment by the Affordable Care Act (ACA), the MA benchmarks are a bidding target established for each county based on a statutory formula that is based on what would be paid for core Medicare-covered health care services (i.e., Part A and Part B) under FFS Medicare. It represents the maximum payment (after risk adjustment) that the Medicare program will make to an MA plan on behalf of a beneficiary. To develop the benchmark, there are other adjustments that account for variation in FFS Medicare spending. To make this adjustment, each county is ranked according to its per capita FFS Medicare costs in a recent year to determine an applicable percentage that ranges from 95% to 115%. The percentage is then multiplied by the county's estimated per capita FFS Medicare costs for the payment year in order to determine the benchmark. The ACA also requires Medicare to make quality bonus payments to MA plans if they achieve 4-star or above ratings in a 5-star quality rating system.

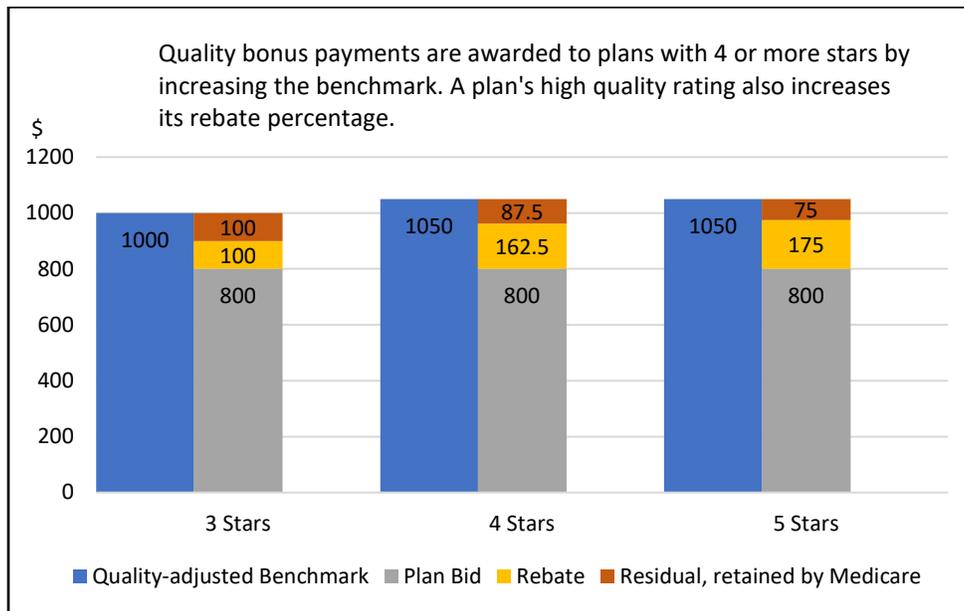
Payments to plans are determined by comparing the bids submitted by plans in response to these quality-adjusted benchmarks. Each year, health insurers that contract with Medicare to participate in MA submit a bid that represents the plans' projected revenue needs for providing the covered Part A and Part B benefits to the average beneficiary in each county. Thus, the bid includes the estimated costs of paying providers for expected use of health care items and services (or the claims cost component), administrative costs, and a financial or profit margin. The claims cost component is based on the prices the plan has agreed upon with providers and expected utilization patterns.

If the plan bid is less than the benchmark, the plan receives their risk-adjusted bid as well as receiving additional rebate dollars, which are a percentage of the difference between the risk-adjusted bid and the risk-adjusted benchmark. The percentage difference (between 50% and 70%) is based on the plan's star ratings. Figure 6 depicts the impact of star ratings on payment to MA plans. The higher the star rating bonus, the more revenue a plan has to increase benefits or reduce cost sharing without charging or increasing a supplemental premium, paid by the beneficiary. The portion of the difference not given to the plans in rebates (the residual) is retained by the Medicare program. If the bid is greater than the benchmark described above, the plan is paid the risk-adjusted benchmark<sup>†</sup> rate by Medicare and then must charge an MA premium to beneficiaries who choose the plan in order to cover the additional costs reflected in the bid.

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<sup>†</sup> The per person amount – either the bid amount or the applicable regional or county rate – is adjusted to account for differences in health status between enrolled beneficiaries in order to determine the monthly payment. This adjustment is referred to as “risk adjustment” and is based on the CMS-HCC risk adjustment model. The model is prospective – it uses a profile of major medical conditions in the base year, along with demographic information (age, sex, Medicaid dual eligibility, disability status), to predict Medicare expenditures in the next year. It is calibrated on a population of FFS beneficiaries entitled to Part A and enrolled in Part B because CMS has complete Medicare expenditure and diagnoses data for this population.

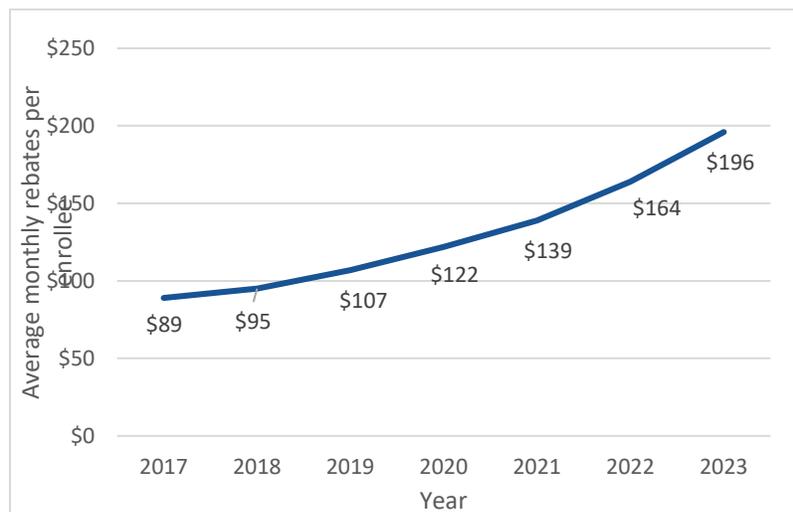
**Figure 6. Illustrative Example of the Impact of Star Ratings on Medicare Advantage Payments**



Note: This example illustrates difference in payments to three hypothetical plans that are in the same county (county benchmark=\$1,000) and submitted the same bids (\$800) but received different star ratings. Plans with 4 stars or above get a 5% quality bonus payment, which increases their benchmark (adjusted for both risk and star rating) to \$1,050. In addition, plans receive a proportion of the difference between the adjusted benchmark and the bid as a rebate (50% for plans with fewer than 3.5 stars, 65% for plans with 3.5 and 4 stars, and 70% for plans with 4.5 and 5 stars).

Figure 7 shows that MA plan rebates per enrollee have increased significantly, more than doubling between 2017 and 2023. Plans can use rebate dollars to pay the premiums for supplemental benefits made available to all enrollees in the plan, such as dental, vision, and reduced cost sharing or to pay all or part of the enrollee’s Part B or Part D premium. According to a recent GAO report, about a third of MA plans offered at least one type of supplemental benefits in 2022 – yet little is known about their use due to incomplete plan reporting.<sup>5</sup>

**Figure 7. Average Monthly Rebates per MA Enrollee, 2017-2023**



Source: MedPAC analysis of MA bid data. <https://www.medpac.gov/wp-content/uploads/2023/01/MedPAC-MA-status-report-Jan-2023.pdf>

## Medicare Payment Differences Between MA and FFS Medicare: Magnitude and Causes

Based on the payment methods described in the previous section, there are several ways in which payments to an MA plan for a beneficiary could differ from the cost to the Medicare program for that same beneficiary in FFS Medicare. In other words, there are features in the formula for the MA payment benchmarks – like star bonus payments and adjustments for geographic variation – that lead to higher payment. Additionally, as described below, there are also coding patterns in MA that lead to higher per capita payment in MA as part of risk adjustment.<sup>‡</sup>

As described above, legislative provisions designed to grow MA enrollment and other market changes in early 2000s resulted in higher MA payments than FFS Medicare payments. The MMA of 2003 increased payments to MA plans by setting initial benchmarks at 100 percent of FFS spending or higher and establishing annual benchmark increases equal to or greater than FFS Medicare’s national growth rate, until the ACA benchmark policy began implementation in 2012.<sup>6</sup> Table 1 displays estimates from the Medicare Payment Advisory Commission (MedPAC) of the ratio of MA to FFS Medicare spending per beneficiary over time. Between 2008 and 2011, the per capita MA payments ranged from 109% to 114% of payment for comparable beneficiaries in the traditional or FFS Medicare program.

**Table 1. Medicare Advantage (MA) Benchmarks, Bids, and Program Payments as a Percentage of Fee-For-Service Expenditures (2008-2021) Excluding Coding Intensity Effects**

Year	MA Benchmarks as a % of FFS Medicare Expenditures (includes local and regional benchmarks)	MA Bids as a % of FFS Medicare Expenditures (represents bids for Medicare Part A and Part B benefits)	MA Program Payments as a % of FFS Medicare Expenditures (bids plus rebates)
2008	118%	101%	113%
2009	118%	102%	114%
2010 <sup>b</sup>	112%	100%	109%
2011	113%	100%	110%
2012	112%	98%	107%
2013	110%	96%	104%
2014 <sup>c</sup>	112%	98%	106%
2015	107%	94%	102%
2016	107%	94%	102%
2017 <sup>d</sup>	106%	90%	100%
2018 <sup>d</sup>	107%	90%	101%
2019 <sup>d</sup>	107%	89%	100%
2020 <sup>d</sup>	107%	88%	100%
2021 <sup>d,e</sup>	108%	87%	101%

<sup>‡</sup> Another mechanism that has payment impacts is “favorable selection,” which means that MA plans might disproportionately enroll beneficiaries who are less expensive to treat than predicted by their risk scores. Favorable selection allows plans to bid lower than FFS Medicare spending before producing any efficiencies in care delivery, thus creating overpayments for MA plans. MedPAC recently estimated 11 percentage points of MA favorable selection in 2019 (separate from any coding differences between MA and FFS Medicare). For more information, see Serna, L., Rollins, E, & Johnson, A. Medicare Payment Advisory Commission. “Favorable selection and future directions for Medicare Advantage Payment Policy,” slides 7-8, presented on March 3, 2023. Accessed at: <https://www.medpac.gov/wp-content/uploads/2022/07/MA-benchmarks-March-2023-SEC.pdf>

Source: Medicare Payment Advisory Commission (MedPAC) Reports to Congress, March 2006-March 2021

Notes: (a) This analysis is based on MedPAC analysis of MA plans' bid submissions, and does not include any assumptions regarding coding intensity, nor are the figures adjusted to reflect actual MA and FFS Medicare experience. These data represent national averages.

(b) MedPAC changed its methodology for estimating FFS Medicare expenditures in 2010. Data for years 2006 – 2009 reflect projection of FFS Medicare experience under current law, which includes expected cut in physician fee schedule due to the Sustainable Growth Rate (SGR) system. For 2010 – 2014, the FFS Medicare projection is based on a scenario of a 0 percent physician update.

(c) MedPAC assumes that plans in 2014 bid would be paid about the same relative to fee-for-service as they were in 2013.

(d) Beginning in 2017, MedPAC indicates that all numbers have been risk adjusted and reflect quality bonuses, but they have not been adjusted for coding intensity differences between MA and FFS Medicare that exceed the statutory minimum adjustment. MedPAC estimates that all values would be increased by the following amounts in each year if coding differences were fully reflected: increased by 4% in 2017 (i.e., payments for all MA plans would average 104% of FFS Medicare spending if coding differences were fully reflected); increased by 2% in 2018; increased by 1% to 2% in 2019; increased by 2% to 3% in 2020; and increased by about 3% in 2021.

(e) MedPAC changed its methodology for estimating FFS Medicare expenditures in 2021, indicating that the FFS Medicare denominator used in the table includes all Part A and Part B spending. MedPAC also indicated that MA enrollees must be enrolled in both Part A and Part B for purposes of these estimates, and stated that comparing benchmarks, bids and payments with spending for FFS Medicare enrollees with both Part A and Part B would decrease the overall values for all MA plans in 2021 by about 1 percentage point.

The Affordable Care Act (ACA) attempted to reduce this overall payment differential by lowering benchmarks beginning in 2012. Plans responded by reducing their bids as a percent of FFS Medicare spending from 102% in 2009 to 87% in 2021. In 2019 and 2020, MA and FFS Medicare payments were estimated to be equivalent – that is, per beneficiary payments would have been the same if not for differences in risk scores related to diagnostic coding for health conditions (an issue called “coding intensity,” discussed at more length below). This ratio grew in 2021 to 101%.

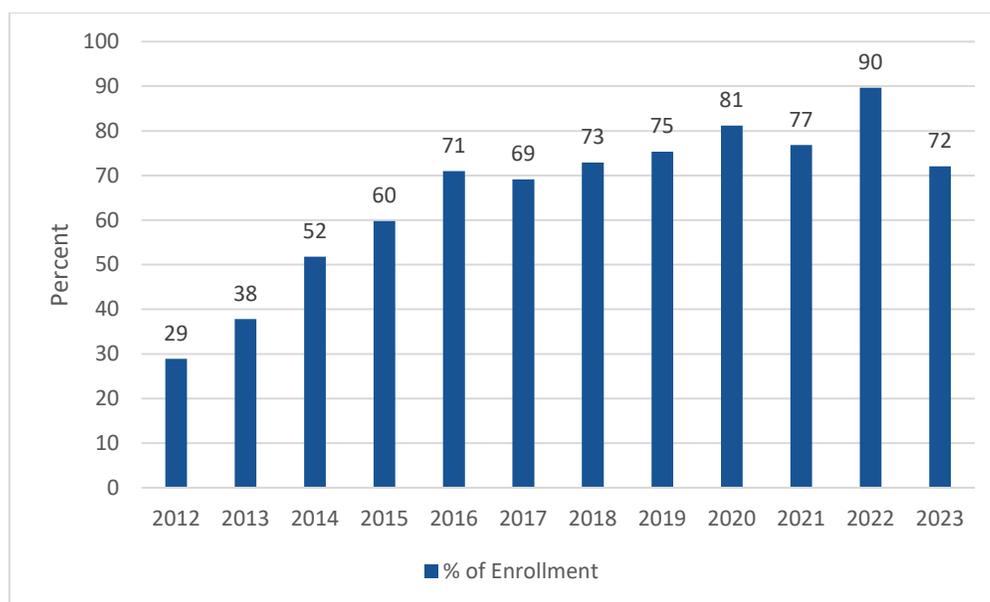
An additional factor for the increase in payments to MA plans is the increased percentage of MA enrollees in plans with star ratings sufficient to increase their benchmark via the quality bonus payment described above.<sup>5</sup> Figure 8 shows that 72% of enrollees in MA contracts offering prescription drug coverage (MA-PD) are currently in contracts with 4 or more stars, as of 2023. This is more than double the share of enrollees in 4 star plans compared to 2012 (29%), the first year that star ratings were used to adjust payments to MA plans. In 2022, 90% of MA enrollees were in plans with at least 4 stars and thus eligible for quality bonus payments; this record high percentage was largely due to a temporary change to the star ratings methodology due to the COVID-19 public health emergency.

While a considerable narrowing of the payment differential has occurred since before the ACA, MA per capita payment levels remain higher than FFS Medicare, resulting in higher spending for the Medicare program overall. Without further policy changes, projections indicate this differential will grow substantially in the coming decade.

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<sup>5</sup> Certain urban counties with low FFS costs receive a double bonus of 10%.

**Figure 8. Percent of Medicare Advantage Enrollees in Plans with 4 or More Stars, 2012-2023**



Source: CMS Star Ratings Fact Sheet from various years. Accessed at: <https://www.cms.gov/medicare/prescription-drug-coverage/prescriptiondrugcovgenin/performance/data>

### MA Plans' Coding Intensity

The estimates in Table 1 do not include the spending impact of changes in plans' coding intensity. Coding intensity relates to the fact that Medicare payments to MA plans are based on a plan's payment rate and an enrollee's risk score. Risk scores are designed to account for differences in expected medical expenditures and are based in part on diagnoses that plans submit to CMS based on providers' diagnoses and support in medical records. Additionally, many MA plans do retrospective chart reviews and hire coding vendors to ensure they maximize all codes based on the medical records. In general, most payments in FFS Medicare do not increase as a result of recording more diagnosis codes, so providers have little incentive to report more diagnosis codes than required. In contrast, MA plans have a financial incentive to ensure that their providers record all possible diagnoses, because higher enrollee risk scores result in higher payments to the plan; this phenomenon is known as "coding intensity."

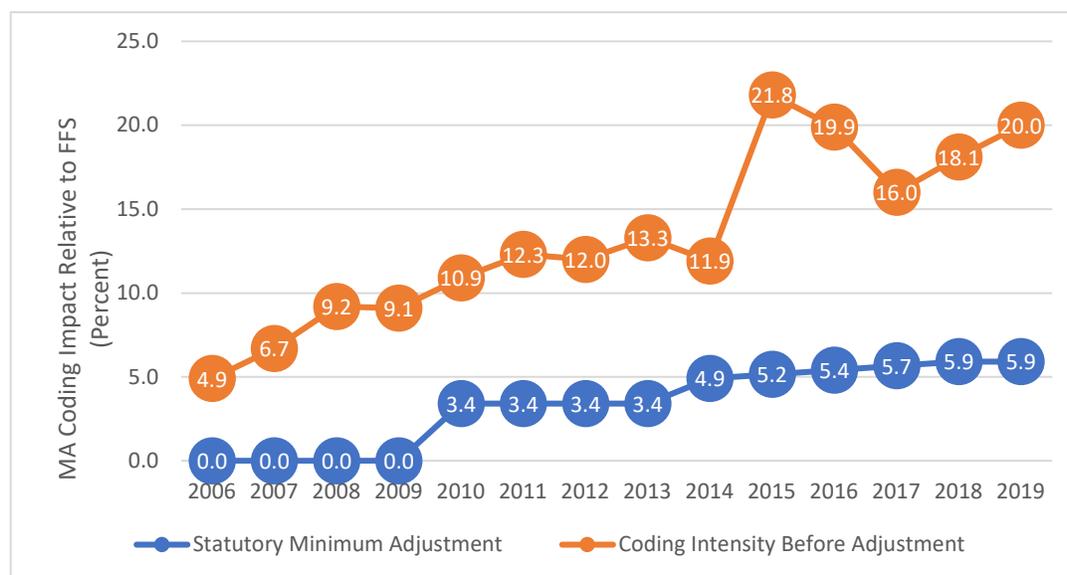
The Deficit Reduction Act of 2005 created a requirement to address coding intensity in MA by reducing MA payments to account for the additional coding in MA as compared to FFS Medicare. Later legislation introduced minimums, with the ACA creating a coding intensity adjustment factor. The statutory minimum was phased in from 3.4% between 2010-2013 to 4.9% in 2014 and has remained at the statutory minimum of 5.9% since 2018.<sup>7</sup>

Experts in and outside the federal government have concluded that coding intensity plays an important role in driving the payment differences between MA and FFS Medicare. According to the Medicare Payment Advisory Commission (MedPAC),<sup>8</sup> MA plans are paid more relative to FFS Medicare spending in part because MA enrollees have higher risk scores than FFS Medicare beneficiaries, which MedPAC describes as reflective of MA coding intensity as opposed to higher actual underlying risk of enrollees. Due to this phenomenon, MedPAC estimates that coding intensity that exceeds the statutory minimum adjustment has led to excess payments to MA plans of more than \$91 billion between 2007 and 2022. MedPAC has found that the statutory minimum adjustment has fallen short of the full payment impact.<sup>9</sup> For 2021, coding intensity was estimated to be 10.8%, compared to the 5.9% statutory minimum adjustment factor; that is, due to coding

intensity payments to MA plans were 104.9% of payments (10.8% - 5.9%) for a comparable beneficiary in the FFS Medicare program. This is in addition to the 101% reported on Table 1. In other words, MedPAC concluded that MA plans were paid 5.9% (1.0% + 4.9%) higher than in FFS Medicare in 2021, a sizable increase from the estimated 4.6% in 2020.

Using a different methodological approach, Kronick and Chua obtained even higher coding intensity estimates than MedPAC's. Figure 9 shows those estimates by Kronick & Chua.<sup>10</sup> Estimated coding intensity before adjustment fluctuated over the years but was generally on an upward trajectory. It was at 4.9% in 2006 and reached 20% in 2019, when the coding intensity after adjustment was 12.9%.\*\* Given the lack of evidence that coding intensity is hitting a plateau, the problem is likely to worsen without some policy change.

**Figure 9. Estimated Coding Intensity Before Statutory Minimum Adjustment, 2006-19**



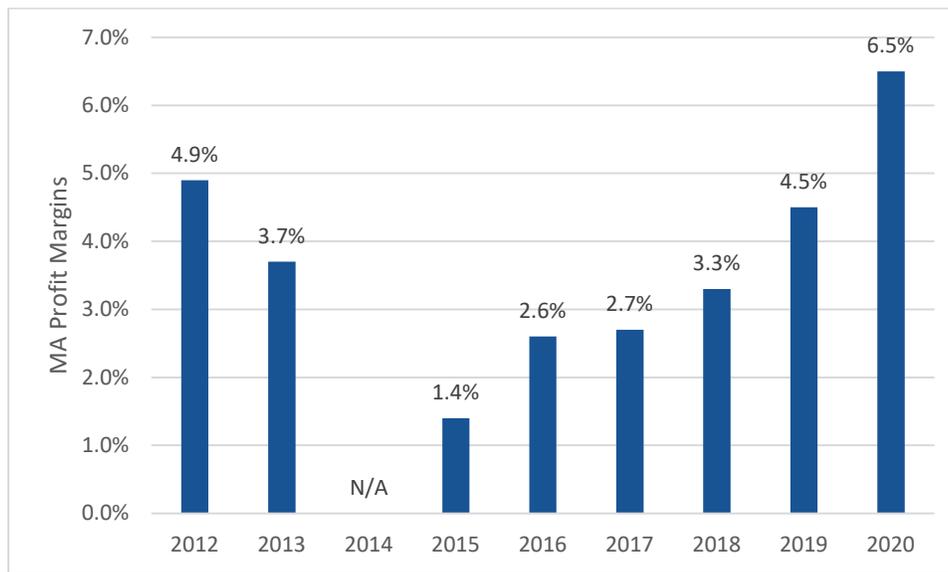
Source: Richard Kronick & F. Michael Chua. Industry-Wide and Sponsor-Specific Estimates of Medicare Advantage Coding Intensity, Nov. 11, 2021. Accessed at: [https://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=3959446](https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3959446).

## MA Profit Margins

To track how MA plans are performing financially, MedPAC has calculated MA profit margins using plan-reported bid data since 2015, which is reported in their annual March Reports to the Congress. Figure 10 shows the industry-wide margin for Part C (MA revenue and expenditures excluding Part D) between 2012 and 2020. The average MA profit margin has increased almost five-fold since then, from 1.4% in 2015 to 6.5% in 2020. The COVID-19 pandemic led to decreased health care utilization among fee-for-service beneficiaries in 2020; similar patterns among MA enrollees may have contributed to the increase in plan margins in 2020 (since plans received their usual payment from Medicare, even as enrollees health care utilization fell).<sup>11</sup> As shown in Figure 12 below, Individual Market, Group Market and Medicaid Managed Care plans also saw increased margins in 2020 consistent with a broad decrease in health care utilization that year due to the COVID-19 pandemic.

\*\* After adjustment coding intensity is calculated using this formula: (before adjustment CI + 1) \* (-.059 + 1).

**Figure 10. Medicare Advantage Profit Margins, 2012-2020**



Source: March MedPAC Report to Congress, each year between 2015 and 2022.

Notes: MA profit margin is defined as industry-wide margin for Part C (MA revenue and expenditures excluding Part D). Calculated based on bid data from various years.

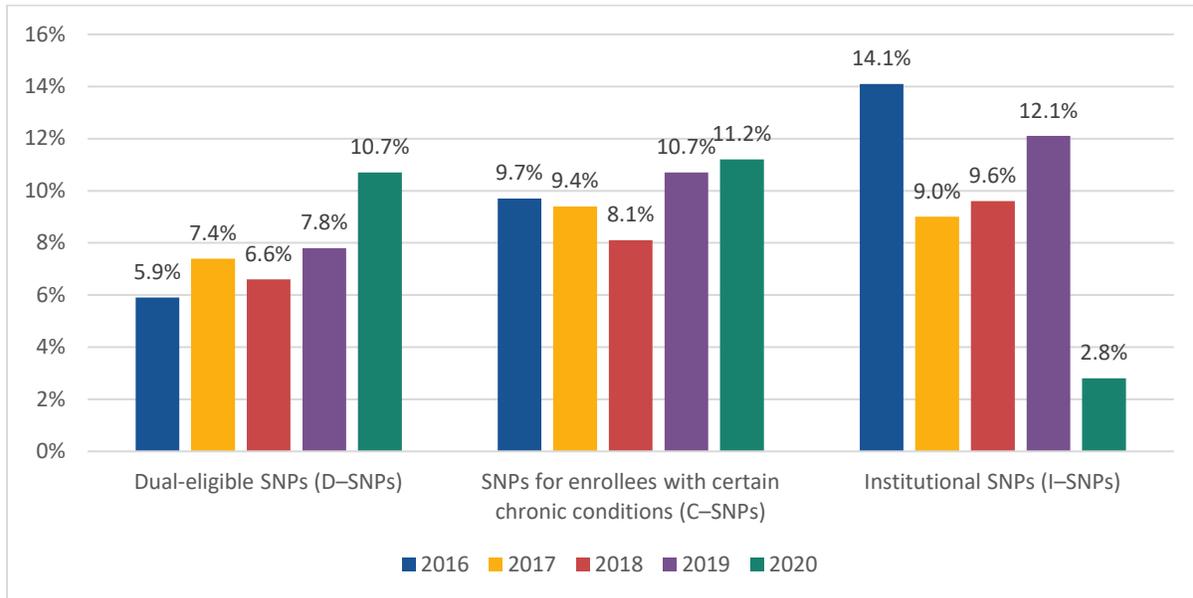
There are 2 years of data lag. For example, 2012 profit margin was reported in the 2015 March MedPAC Report. 2014 data is missing.

The profit margin was 4.9% in 2012. It decreased to 3.7% in 2013 because of the sequestration that went into effect as of April 2013 and because plans were preparing to meet a medical loss ratio requirement as of 2014<sup>12</sup>. No 2014 data was reported by MedPAC.

Special needs plans (SNPs) offer benefit packages tailored to beneficiaries who are dually eligible for Medicare and Medicaid, are institutionalized, or have certain severe or disabling chronic conditions. More than 4.6 million Medicare beneficiaries were enrolled in SNPs in 2022.<sup>13</sup> The majority of SNP enrollees (89%) were in plans for beneficiaries dually enrolled in both Medicare and Medicaid (D-SNPs), with 9 percent of SNP enrollees in plans for people with severe chronic or disabling conditions (C-SNPs) and 2 percent in plans for beneficiaries requiring a nursing home or institutional level of care (I-SNPs).<sup>14</sup>

According to MedPAC, SNPs are among the fastest growing segments of the MA market in recent years (14% growth in 2020).<sup>15</sup> Figure 11 displays SNP plan profit margins estimated by MedPAC based on bid data between 2016-2020. All categories of SNPs had higher profit margins during this period than the overall MA average, except for the I-SNPs, which had margins of 2.8 percent in 2020, notably lower than the 12.1 percent margins of I-SNPs in 2019 (which may have resulted from the pandemic's disproportionate impact on institutionalized beneficiaries).<sup>16</sup> In 2020, D-SNPs had margins of 10.7 percent, while C-SNPs had margins of 11.2 percent.

**Figure 11. Special Needs Plan Profit Margins, 2016-2020**

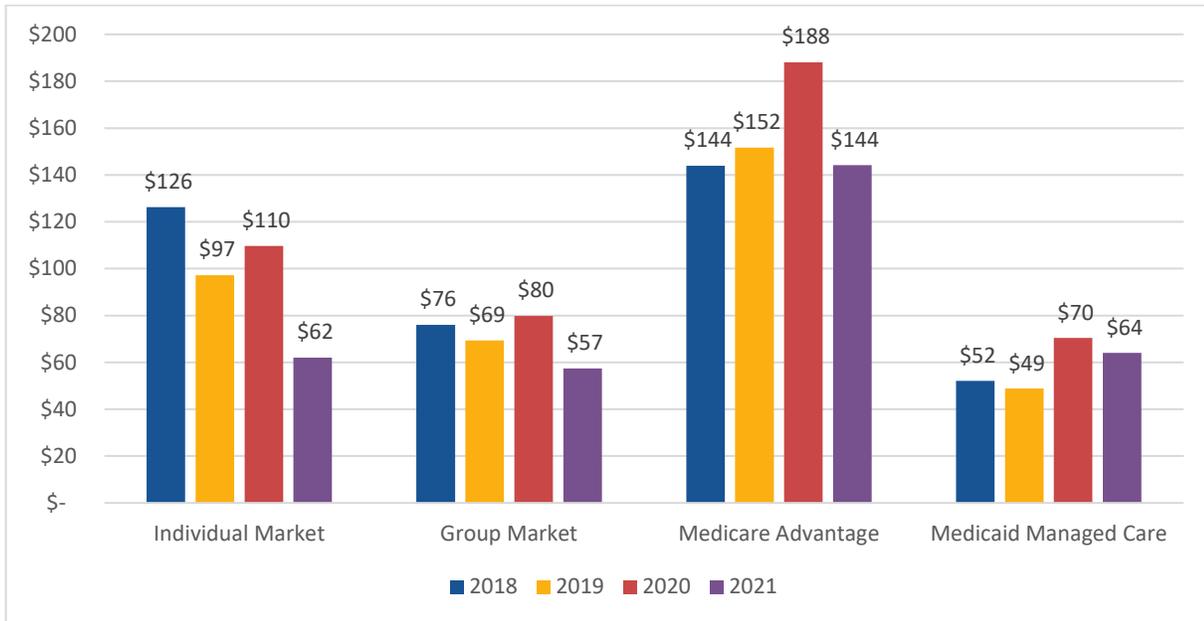


Source: March MedPAC Report to Congress, each year between 2018 and 2022.

Using financial data reported by insurance companies to the National Association of Insurance Commissioners (NAIC) and compiled by Mark Farrah Associates, the Kaiser Family Foundation (KFF) compared gross margins in the MA, Medicaid managed care, commercial individual (non-group), and commercial group (employer) insurance markets. Figure 12 shows that gross margins<sup>††</sup> per member per month (defined as the amount by which premium income exceeds claims costs per enrollee per month) across these four markets were higher in MA than other insurance markets between 2018 and 2020. Although positive margins do not necessarily translate directly into profitability since they do not account for administrative expenses or tax liabilities, sharp increases in margins from 2019 to 2020 suggest that these health insurance markets have become more profitable during the pandemic.<sup>17</sup> Overall, Figure 12 shows that margins per member have risen and fallen somewhat over recent years, but in every year, MA margins were the highest of the four markets -- and generally by a substantial amount.

<sup>††</sup> Gross margins account for the costs of good sold, the direct costs of creating and selling a product and exclude non-operating expenses. Net profit margins, referenced earlier in this brief, account for all expenses. These differences can impact the comparability of the two measures.

**Figure 12. Health Insurer Gross Margins by Market Sector, Per Member Per Month, 2018-2021**



Source:

KFF, "Health Insurer Financial Performance in 2021," February 2023. Accessed at <https://www.kff.org/medicare/issue-brief/health-insurer-financial-performance/>

## CONCLUSION

Medicare Advantage is a rapidly growing sector of the Medicare program, already enrolling half of Medicare beneficiaries who are eligible to enroll and with a growing share of total program spending. One of the main goals of the MA program is to reduce health care costs while providing high quality care. However, evidence shows that plan payments have consistently exceeded what would be paid for the same beneficiaries in FFS Medicare. In recent years, MA plan gross margins have remained higher than other markets, while enrollment in MA has continued to increase and the number of MA plans available to Medicare beneficiaries has grown. These trends can inform policymaking in this area.

## REFERENCES

- <sup>1</sup> 2022 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, accessed at <https://www.cms.gov/files/document/2022-medicare-trustees-report.pdf>
- <sup>2</sup> The BBA reduced the national payment update for private plans in 1998 and 1999. Medicare Payment Advisory Commission, “Medicare+Choice: Trends Since the Balanced Budget Act,” Report to the Congress: Medicare Payment Policy, March 2000, accessed at [http://www.medpac.gov/document\\_TOC.cfm?id=150](http://www.medpac.gov/document_TOC.cfm?id=150)
- <sup>3</sup> Greenwald, L. M., Levy, J. M., & Ingber, M. J. (2000). Favorable selection in the Medicare+ Choice program: new evidence. *Health care financing review*, 21(3), 127.
- <sup>4</sup> Medicare beneficiaries are not eligible for MA if they lack either Part A or Part B. Beneficiaries with Part A only account for 7.5% of total Medicare enrollees and those with Part B only account for 0.4% of total enrollees. For more discussions about Medicare eligibility and demographics for enrollees in Parts A, B, C and D, see Tarazi, W., Welch, W. P., Nguyen, N., Bosworth, A., Sheingold, S., Lew, N. D., & Sommers, B. D. (2022). Medicare beneficiary enrollment trends and demographic characteristics. *US Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, Office of Health Policy Issue Brief*, 5.
- <sup>5</sup> U.S. Government Accountability Office. Medicare Advantage: Plans Generally Offered Some Supplemental Benefits, but CMS Has Limited Data on Utilization. Washington, DC: GAO; 2023. Accessed at <https://www.gao.gov/products/gao-23-105527>
- <sup>6</sup> For a more detailed description of the changes in legislative provisions that affect benchmarks and payments to MA plans, see “Chapter 1. Rebalancing Medicare Advantage benchmark policy” in Medicare Payment Advisory Commission. Report to the Congress: Medicare and the health care delivery system. Washington, DC: MedPAC; 2021. Accessed at [https://www.medpac.gov/wp-content/uploads/import\\_data/scrape\\_files/docs/default-source/reports/jun21\\_ch1\\_medpac\\_report\\_to\\_congress\\_sec.pdf](https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun21_ch1_medpac_report_to_congress_sec.pdf)
- <sup>7</sup> Advance Notice of Methodological Changes for Calendar Year (CY) 2023 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies, accessed at <https://www.cms.gov/files/document/2023-advance-notice.pdf>
- <sup>8</sup> Medicare Payment Advisory Commission. Report to the Congress: Medicare and the health care delivery system. Washington, DC: MedPAC; 2022.
- <sup>9</sup> See slide 12 in <https://www.medpac.gov/wp-content/uploads/2023/01/MedPAC-MA-status-report-Jan-2023.pdf>
- <sup>10</sup> Kronick, R., & Chua, F. M. (2021). Industry-Wide and Sponsor-Specific Estimates of Medicare Advantage Coding Intensity. Available at SSRN 3959446. [https://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=3959446](https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3959446), accessed 2-17-23.
- <sup>11</sup> Tarazi W, Ruhter J, Bosworth A, Sheingold S, and De Lew N. The Impact of the COVID-19 Pandemic on Medicare FFS Beneficiary Utilization and Provider Payments: FFS Data for 2020] (Issue Brief No. HP-2021-13). Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. June 2021.
- <sup>12</sup> Medicare Payment Advisory Commission. Report to the Congress: Medicare and the health care delivery system. Washington, DC: MedPAC; 2015.
- <sup>13</sup> Kaiser Family Foundation. Medicare Advantage in 2022: Enrollment Update and Key Trends, 2022. Accessed at <https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-enrollment-update-and-key-trends/>
- <sup>14</sup> Id.
- <sup>15</sup> Medicare Payment Advisory Commission. Report to the Congress: Medicare and the health care delivery system. Washington, DC: MedPAC; 2021.
- <sup>16</sup> Medicare Payment Advisory Commission. Report to the Congress: Medicare and the health care delivery system. Washington, DC: MedPAC; 2022.
- <sup>17</sup> Kaiser Family Foundation. Health Insurer Financial Performance in 2020, May 2021. Accessed at <https://www.kff.org/medicare/issue-brief/health-insurer-financial-performance/>

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