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The Cost of Privatization: Extra Payments to Medicare Advantage Plans—Updated and Revised

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ABSTRACT: The Medicare Modernization Act of 2003 sharply increased payments to private Medicare Advantage plans. As a result, every plan in every county in the nation was paid more in 2005 than its enrollees would have been expected to cost if they had been enrolled in traditional fee-for-service Medicare. The authors calculate that payments to Medicare Advantage plans averaged 12.4 percent more than costs in traditional Medicare during 2005: a total of more than $5.2 billion, or $922 for each of the 5.6 million Medicare enrollees in managed care. This issue brief updates an earlier analysis of Medicare Advantage payments in 2005 previously published by The Commonwealth Fund; the updated estimates in this report are based on final 2005 enrollment figures that were not available at the time the previous estimates were developed, and they include the effect of policy decisions that were not reflected in the previous estimates.

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Introduction

The Medicare Modernization Act of 2003 (MMA) included a broad set of provisions intended to expand the role of private health plans in Medicare. The increased emphasis on private plans—now referred to as Medicare Advantage (MA) plans—stems from the belief that, with an upfront investment to stabilize plan participation and increase beneficiary enrollment, private plans and competition will help drive down the explosive growth of Medicare spending.[1]

The payments that the MMA policies provide to MA plans, however, substantially exceed comparable costs in traditional fee-for-service Medicare. In estimating the MMA's costs in December 2003, the Congressional Budget Office (CBO) projected that, as a result of these new policies, the MA program would add $14 billion to Medicare costs through 2013. The Medicare Office of the Actuary estimated the additional 10-year costs at $46 billion.[2]

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The analysis described in this paper uses the latest data on enrollment in MA plans in 2005, as well as data on payment rates in that year, to estimate the extra payments made to MA plans relative to what the same enrollees would have cost under traditional fee-for-service Medicare. The results indicate that the CBO and Office of the Actuary projections were correct. Every MA plan in every county in the nation was paid more in 2005 than its enrollees would have been expected to cost had they been enrolled in traditional fee-for-service Medicare.

In 2005, payments to MA plans exceeded average local fee-for-service costs by 12.4 percent, or $922 per MA plan enrollee, for a national total of more than $5.2 billion.[3] These figures are comparable to those cited in other recent reports about MA extra payments.[4]

Background: Medicare and Private Plans

The role of private health plans in Medicare is not new. Prepaid group practice plans, the early form of health maintenance organizations (HMOs), have been part of Medicare since its inception in 1966. The first major set of Medicare amendments in 1972 created the first Medicare prepaid payment program for HMOs.

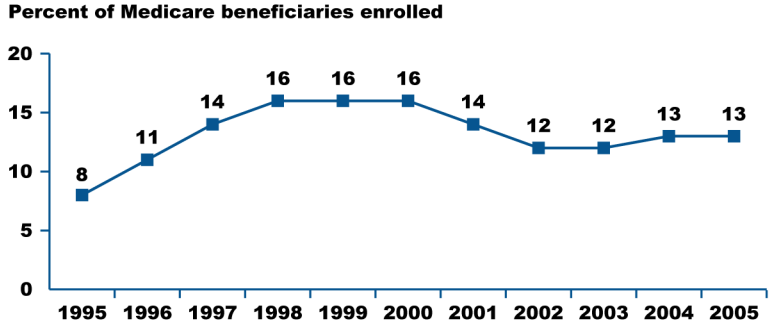
In 1982, the Tax Equity and Fiscal Responsibility Act gave HMOs the opportunity to be paid on a risk basis at 95 percent of the per capita fee-for-service costs in each county. Any excess in the Medicare payment above anticipated plan costs was to be channeled to beneficiaries in the form of extra benefits or reduced cost-sharing, or returned to Medicare. HMOs were expected to be more efficient than the traditional program, saving the government 5 percent for each enrollee while still offering additional benefits.

In general, HMOs participated in the Medicare risk program in regions with a history of managed care, such as California, or in areas where there was a special effort to develop Medicare HMOs, such as southern Florida and Arizona. Studies conducted in the 1990s indicated that beneficiaries who enrolled in HMOs were healthier than those in traditional Medicare, and that Medicare actually paid more for HMO enrollees than for similar beneficiaries in traditional Medicare.[5]

With the expectation that private plans would reduce Medicare costs, the Balanced Budget Act of 1997 expanded the role of such plans when it created the Medicare+Choice (M+C) program. The Act changed the way plans were paid in an effort to encourage private plans to participate in Medicare throughout the nation. It did so by increasing payments to plans in areas with low fee-for-service costs (and, therefore, low payment rates under the previous Medicare risk program), particularly focusing on rural areas. In 2001, this policy was extended to urban areas with low fee-for-service costs by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000.[6]

With the enactment of the Balanced Budget Act, CBO predicted that 27 percent of Medicare beneficiaries would be enrolled in private plans by 2002.[7] But after peaking in 1999 at 16 percent of beneficiaries nationwide, M+C plan enrollment declined to 12 percent in 2003 (Figure 1). This was

Figure 1. Enrollment in Medicare Managed Care/ Medicare+Choice/Medicare Advantage Plans by Beneficiaries, 1995–2005



Sources: Marsha Gold and Lori Achman, *Medicare+Choice 1999–2001: An Analysis of Managed Care Plan Withdrawals and Trends in Benefits and Premiums,* The Commonwealth Fund, Feb. 2002; Centers for Medicare and Medicaid Services (CMS) Medicare Enrollment: National Trends, 1966–2001, 2002, 2003, 2004, 2005. Data for 2003, 2004, and 2005 are for the quarters ending in December of those years.

largely due to the fact that, in addition to changing the way that payment rates were determined, the Balanced Budget Act also sharply reduced the overall level of payments to M+C plans, resulting in the withdrawal of many plans from areas that had become unprofitable and a reduction in the extra benefits offered to enrollees. Some areas of the country were left with no M+C plans.

This decline in private plan enrollment led to the creation of the MA program, which expanded the private options available for Medicare beneficiaries and further revised the method for determining MA payments.

MA Plan Payments in 2005

Medicare payments to MA plans in 2005 were based on two factors: benchmark payment rates specified by the MMA and an administrative policy implemented by the Centers for Medicare and Medicaid Services (CMS) that is referred to as budget neutral risk adjustment (BNRA).

The combination of MMA payment benchmarks and the BNRA policy resulted in MA plan payments that were more than the corresponding fee-for-service costs in every county. MA benchmarks averaged 8.1 percent more than fee-for-service costs would have been for the same enrollees and BNRA payments increased those payments by an additional 4 percent. Taken together, the total average payments to MA plans exceeded average local fee-for-service costs by 12.4 percent in 2005.[8]

Benchmark payment rates. For 2005, Medicare benchmark payment rates for MA plans were set at the highest of six different reference points. The six benchmark rates are:

- A blended rate; a 50/50 combination of the base MA rate for the county and the national average MA rate.[9]
- A minimum rate (or floor) for large urban areas (areas with populations of more than 250,000); set at $7,850 in 2005.
- A minimum rate (or floor) for rural and smaller urban areas; set at $7,104 in 2005.
- A rate that reflected a minimum increase in the county's 2004 payment level; set at 6.6 percent in 2005.[10,11]
- A payment rate equal to 100 percent of estimated county per capita fee-for-service costs in 2004, updated in 2005.[12]
- A payment rate equal to 100 percent of projected county per capita fee-for-service costs in 2005.[13]

The MMA policy resulted in an average benchmark payment rate for MA plans that exceeded fee-for-service costs by 8.1 percent, or $568 per MA plan enrollee, for a national total of more than $3.2 billion in 2005.[14]

Indirect medical education payments. The MA benchmark payment rates also reflect sums from a provision that requires the inclusion of payments to teaching hospitals for the costs of indirect medical education (IME). Since an earlier Medicare policy enacted in the Balanced Budget Act provides for payment to teaching hospitals directly for the IME costs of MA plan enrollees who are inpatients, Medicare now effectively pays twice for the IME costs of MA plan members.[15]

In total, extra payments due to the double payment for IME accounted for about $1.1 billion in 2005. Because IME payment amounts are included in the benchmark payment rates, these payments are embedded in the extra payment estimates presented above.

Because teaching hospitals are not spread uniformly across geographic areas, IME payments to MA plans vary substantially by area. In New York, which has a high concentration of teaching hospitals, IME extra payments to MA plans exceed 5 percent of total MA payments in some counties. In other states with somewhat lower concentrations of teaching hospitals, such as Florida and Texas, IME extra payments to plans can be less than 1.5 percent of total MA payments. In still other areas with

very few teaching hospitals, particularly in the Midwest and West, IME payments have almost no effect on Medicare spending or MA payments.

As a share of extra payments to MA plans, there is also great variation in terms of which benchmark is used to determine MA payment rates. In counties where MA payment is based on 100 percent of fee-for-service costs, IME accounts for all of the extra payments to MA plans from the benchmark rates and 37 percent of total extra payments to MA plans (including the effect of the BNRA policy, which is described below). In counties where MA payment is based on the floor for large urban areas, IME costs account for 11 percent of total extra payments to MA plans.

Disproportionate share payments. Similar to the IME payments, hospitals that treat a significant number of indigent patients receive a disproportionate share (DSH) payment. Unlike IME payments, Medicare DSH payments are not made directly to hospitals for their MA patients. Instead, they are embedded in the payment rates that plans receive, and the plans determine whether or how much of the DSH amount they pay to hospitals. Medicare DSH payments are not generally related to the costs faced by individual plans, and an argument could be made that the payments should be made directly to eligible hospitals for the MA patients they treat, just as IME payments are. No good estimate is available for the county-level effect of DSH payments on MA payments, so they are not included in the calculations in this analysis. However, DSH payments arguably represent additional overpayments to MA plans.

Budget neutral risk adjustment. Medicare payments to MA plans include payments in addition to benchmark extra payments specified by the MMA, as part of a risk-adjustment system intended to modify each plan's payments for the anticipated costliness of its enrollees.[16]

The new risk-adjustment system—based on retrospective clinical data on each enrollee—is more accurate than the previous system, which was based on only a few broad demographics. The new system was expected to make payments to plans that more closely reflect the anticipated costliness of enrollees, thereby reducing the adverse incentive under the previous system to avoid enrolling beneficiaries expected to have high costs (e.g., older beneficiaries and beneficiaries with chronic conditions) and recruit beneficiaries anticipated to have low costs. As research indicated that plans did tend to enroll beneficiaries with lower risk of high costs, the newly improved risk-adjustment system was expected to reduce plan payments.[17]

To mitigate the effect of this change on plans, CMS phased in the new clinically based system as a blend with the older demographic system; by 2005, the risk adjustment was applied to 50 percent of the MA payment rate, with the proportion rising to 75 percent in 2006 and 100 percent in 2007 and thereafter. Moreover, CMS had made an administrative policy decision to implement the new risk adjustment so that it would not reduce aggregate payments to MA plans.[18] This was done by increasing payments to all MA plans by a uniform percentage—to compensate for the fact that the average MA enrollee has a lower risk score (i.e., is anticipated to be less costly) than the average fee-for-service beneficiary.

Because of this policy, Medicare pays MA plans more than the risk-adjustment model indicates it would be expected to pay for the same beneficiaries in traditional fee-for-service Medicare.[19] In 2005, the BNRA policy increased payments for every MA plan across the nation by 4 percent.[20,21]

Variation in extra payments in 2005. There are four key points in the pattern of Medicare extra payments to MA plans in 2005 (Tables 1 and 2):

- *Large urban floor counties.* The largest amount of extra payments went to MA plans in the counties where the large urban floor benchmark determined the MA payment rates because the

per capita fee-for-service costs in those counties are relatively low. The extra payments received by MA plans in these counties amounted to $2.1 billion—40 percent of the total extra payments in 2005. MA payments in those counties averaged 21.5 percent and $1,394 per plan enrollee more than the same enrollees would have been expected to cost in traditional Medicare fee-for-service plans.

Several of the counties paid at the large urban floor benchmark have long histories of managed care, both in Medicare and in the commercial market. However, in spite of the $2.1 billion per year in extra payments to plans in these counties, their MA enrollment rate as of December 2005 was 12.8 percent, less than the national average of 13.2 percent.

- *100 percent of fee-for-service counties.* In the counties where MA payments were determined by the 100 percent of fee-for-service benchmark, extra payments were $1.9 billion, accounting for 36 percent of total extra payments nationwide. This seemingly anomalous finding—how can payments based on fee-for-service costs exceed those costs?—is the result of two policies that actually overstate MA payments relative to "true" fee-for-service costs. First, the double payment for IME for MA plan members added 2.4 percent ($600 million) to MA payments that already are reflected in fee-for-service costs; and second, the BNRA policy added another 4 percent (over $1 billion) to MA payments.

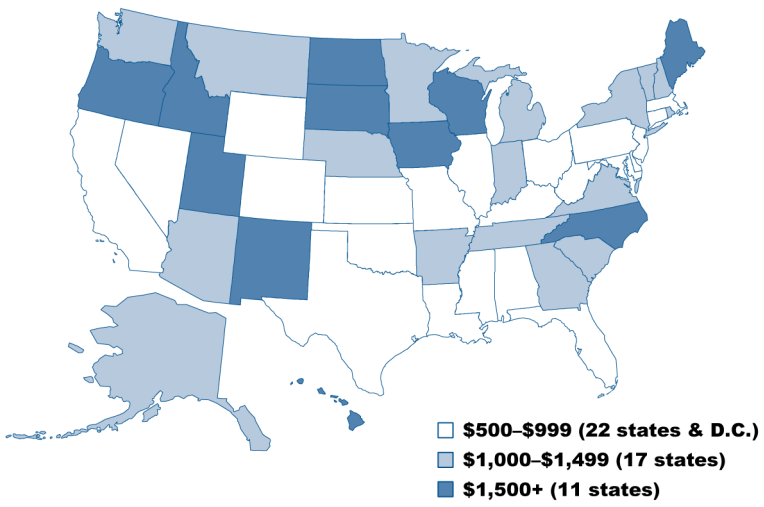
- *Rural and other urban floor counties.* MA extra payments do not in any significant way flow to Medicare plans and beneficiaries in rural areas. While 28 percent of Medicare beneficiaries—mostly rural—live in counties where MA payment rates are determined by the rural and other urban floor benchmark, only 7 percent of MA extra payments, $357 million of the $5.2 billion total, went to plans in those counties in 2005.

  Private managed care plans have generally attracted enrollees in urban areas. This pattern is evident in both employment-based health insurance and Medicare. Fewer than 4 percent of Medicare beneficiaries in rural counties were enrolled in MA plans, compared with 17 percent of beneficiaries in urban counties in 2005.

- *BNRA payment policy.* The BNRA payment policy added a total of $1.8 billion to extra payments, or roughly one-third of the total, in 2005. As noted earlier, BNRA payments are now scheduled to be phased out through 2011, according to a schedule enacted in the Deficit Reduction Act of 2005.

The amount of extra payments also varied greatly by state (Figure 2). Extra payments per enrollee ranged from almost $2,400 in Hawaii to about $500 in Nevada (Table 3). Notably, the states with the greatest extra payments per MA enrollee are generally the ones with the lowest per capita

Figure 2. Medicare Advantage Extra Payments per MA Plan Enrollee by State, 2005



Source: GWU Analysis of the CMS Medicare Managed Care Quarterly State County and CMS Medicare Managed Care Quarterly State, County, Plan data files for the quarter ending December 2005 and Medicare Advantage Revised 2005 Ratebook.

fee-for-service costs. Hawaii, with the greatest amount of extra payments per MA enrollee, has per capita fee-for-service costs that are 25 percent below the national average; Nevada, with the lowest amount of extra payments per MA enrollee, has per capita fee-for-service costs that are 15 percent above the national average.

Although this relationship may appear to reduce the discrepancy between high- and low-cost states, it actually provides an adverse incentive for beneficiaries in low-cost states to leave the fee-for-service program, while failing to provide the same attractive alternative for beneficiaries in states with high fee-for-service costs. Plans in states where costs are already low are disproportionately rewarded by these extra payments, compared with plans in high-cost states, where there is presumably greater opportunity for private plans to lower costs.

The total amount of extra payments is highly concentrated among a relatively small number of states. California and New York alone accounted for about one-third of the national total of extra payments to MA plans in 2005, and more than half of the total extra payments went to plans in five states. In contrast, the 30 states that received the lowest amounts of extra payments accounted for only 10 percent of the total extra payments nationwide.

Conclusion

Private plans did not reduce Medicare costs in 2005 because MMA policies explicitly pay private plans more than traditional fee-for-service Medicare.

The analysis presented here examines the extra funds paid to MA private managed care plans in 2005. For each of the 5.6 million Medicare enrollees in managed care, Medicare spent an average of $922 more than it would have for comparable beneficiaries in traditional fee-for-service Medicare. In some parts of the country, extra payments by Medicare were more than twice the fee-for-service amount. Total extra payments to MA plans in 2005 exceeded $5.2 billion.

MMA policies will continue to pay MA plans more than the corresponding fee-for-service costs in future years. As a result of the implementation of the benchmark-based bidding system in 2006, extra payments now average an estimated 11 percent.[22] Following the phase-out of the BNRA payments, extra payments are projected to average at least 7 percent in 2010. Both the CBO and Medicare Office of the Actuary predict that payments to MA private plans will increase Medicare costs for at least the next 10 years.

Current discussions include proposals to return to the "pay-as-you-go" budget policy that was in effect during the 1990s. This would require that the costs of any change in Medicare policies be balanced by a reduction in Medicare or other federal spending. In any case, the extra payments documented here represent a potential source of funds to at least partially offset the costs of improved benefits for all Medicare beneficiaries. These improvements could include filling in the coverage gap in the Medicare drug benefit or making other needed changes, such as finding a viable alternative to the ineffective sustainable growth rate mechanism currently used to determine the default physician payment update. The $30 billion in extra payments projected over the next five years would also be sufficient to reduce the increase in the Part B premium in 2007 by approximately $10 per month for every Medicare beneficiary.[23]

The extra payments provided to Medicare Advantage plans distort the policy intent of the program, which was to provide an option for Medicare beneficiaries to enroll in private plans that could operate more efficiently than traditional Medicare fee-for-service plans. Moreover, the substantial cost of these extra payments, as well as the large number of pressing needs to which those resources might alternatively be applied, indicates that the current policy would bear careful re-examination.

Notes

[1] E. M. Kennedy and B. Thomas, "Dramatic Improvement or Death Spiral—Two Members of Congress Assess the Medicare Bill," *New England Journal of Medicine,* Feb. 19, 2004 350(8):747–51.

[2] Congressional Budget Office, Letter to Congressman Jim Nussle, Feb. 2, 2004. Available at http://www.cbo.gov. Accessed Apr. 1, 2004.

[3] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (Washington, D.C.: MedPAC, Mar. 2004).

[4] The Medicare Payment Advisory Commission released a report in June 2006 that estimates 2006 payments to MA plans at 108 percent of fee-for-service costs before the budget neutral risk adjustment (BNRA). This figure is comparable to our 2005 findings of 108 percent before BNRA. See: Medicare Payment Advisory Commission, *Medicare Advantage Benchmarks and Payments Compared with Average Fee-for-Service Spending* (Washington, D.C.: MedPAC, June 2006).

Other recent reports estimated payments to managed care plans in 2004 at 107 percent of fee-for-service costs. These include: Medicare Payment Advisory Commission, *Medicare+Choice Rates Compared with County Medicare per Capita Fee-for-Service Spending* (Revised) (Washington, D.C.: MedPAC, 2004); and L. Achman and M. Gold, *Medicare Advantage 2004 Payment Increases Resulting from the Medicare Modernization Act* (Washington, D.C.: Mathematica Policy Research, Inc., 2004).

Our 2005 estimate of 112.4 percent of average fee-for-service costs differs from others primarily because this analysis accounts for the budget neutral risk adjustment of 1.04. Furthermore, it uses more recent and adjusted data than the 2004 figures mentioned above. This analysis uses December 2005 enrollment data and excludes enrollees paid on the basis of costs, for which plans do not receive additional payments, from the total number of MA enrollees.

[5] U.S. Government Accountability Office, *Medicare+ Choice: Payments Exceed Cost of Fee-for-Service Benefits, Adding Billions to Spending* (Washington, D.C.: GAO, 2000).

[6] H.R. 5661, Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000. See Sec. 601, "Increase in Minimum Payment Amount."

[7] Congressional Budget Office, "CBO Memorandum: Budgetary Implications of the Balanced Budget Act of 1997" (Washington, D.C.: CBO, Dec. 1997).

[8] MedPAC, *Medicare Payment Policy,* 2004.

[9] The base Medicare Advantage rate for the county is the county's 1997 risk plan rate, updated to the current payment year; the national average base Medicare Advantage rate is the average rate across all counties, weighted by Medicare enrollment.

[10] Centers for Medicare and Medicaid Services, "Note to Medicare Advantage Organizations and Other Parties, Subject: Announcement of Calendar Year 2005 Medicare Payment Rates" (Baltimore, Md.: CMS, 2004). Available at http://cms.hhs.gov/healthplans/rates/2005/cover.asp.

[11] The MMA provides for the annual minimum increase to be the higher of: (1) the Medicare national growth rate percentage in fee-for-service expenditures; or (2) 2 percent. Since the projected national growth rate for 2005 was 6.6 percent, payments in all counties were increased by at least that amount.

[12] This payment rate includes Medicare payments for indirect medical education costs, even though Medicare makes these payments to teaching hospitals directly for Medicare Advantage enrollees; the effect of this double counting was to set these rates an average of 2.3 percent higher than actual Medicare fee-for-service costs.

[13] The MMA requires that the estimates of per capita fee-for-service costs used as to benchmark Medicare Advantage rates be rebased a minimum of every three years. Those estimates were updated for 2005, but counties where the rebased estimates decreased from their previous levels continued to use the 2004 benchmark. In 2005, MA plans in 660 counties, where just under half of all MA enrollees resided, received payments based on the rebased rate; on average, MA plans in these counties received payment increases of 7.7 percent in 2005. MA plans in the remaining 2,562 counties received payment increases equal to the national minimum update of 6.6 percent. See CMS, "CY 2005 Rates," 2004. Available at http://cms.hhs.gov/healthplans/rates/2005/cover.asp.

[14] MedPAC, *Medicare Payment Policy,* 2004.

[15] To calculate the effect of these double payments on the level of payments to MA plans, MedPAC and other analysts reduce the per capita FFS costs in a county by the per capita IME costs in the county. This analysis follows a methodological convention developed by MedPAC in addressing the Medicare policy of making direct payments to teaching hospitals for the costs of indirect medical education (IME) for Medicare Advantage enrollees. It adjusts fee-for-service costs at the county level by removing the average IME expense. This is done by deflating the county fee-for-service average by a factor of 1 – (0.65 * GME), where GME is the county graduate medical education carve-out. A national average of 65 percent of graduate medical education payments goes to indirect medical education; county-specific data are unavailable. Because Medicare makes indirect medical education payments directly to teaching hospitals for patients who are enrolled in Medicare Advantage, Medicare Advantage plan-payment rates are most appropriately compared with fee-for-service costs adjusted in this manner. Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (Washington, D.C.: MedPAC, Mar. 2002).

[16] Risk adjustment of Medicare private plan payments is important because the cost of care for Medicare beneficiaries varies greatly. The most expensive 5 percent of Medicare beneficiaries accounted for 43 percent of total spending at an average cost of $63,000 in 2001 while the least expensive 50 percent of beneficiaries accounted for only 4 percent of total spending at an average cost of $550. In the absence of effective risk adjustment of payments, plans that enroll sicker beneficiaries can be subject to large losses and those that enroll healthier beneficiaries can gain substantial surpluses. Congressional Budget Office, *High Cost Medicare Beneficiaries* (Washington, D.C.:CBO, May 2005).

While the development and implementation of an improved system to adjust payments to individual Medicare plans was mandated by the Balanced Budget Act of 1997 and subsequent legislation, the decision to make extra payments to MA plans associated with the new risk adjustment system was made by CMS officials following language in the conference report for the Balanced Budget Refinement Act of 1999 that urged HHS to implement the risk adjustment "without reducing overall Medicare+ Choice payments."

[17] See R. Brown, J. Bergeron, D. Clement et al., *The Medicare Risk Program for HMOs: Final Summary Report on Findings from the Evaluation Report to the Health Care Financing Administration* (Princeton, N.J.: Mathematica Policy Research, Inc., Feb. 1993).

[18] R. A. Berenson, "Medicare Disadvantaged and the Search for the Elusive 'Level Playing Field,'" *Health Affairs* Web Exclusive (Dec. 15, 2004):w4-572–w4-585.

[19] The total amount of the risk differential between MA plan enrollees and fee-for-service beneficiaries was estimated by CMS at 8 percent for 2005. See Berenson, "Medicare Disadvantaged," 2004.

[20] Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy.(Washington, D.C.: MedPAC, Mar. 2004).

[21] The Deficit Reduction Act, enacted in February 2006, formalized a schedule to phase out the BNRA from a level of 3.9 percent in 2007 to 0 percent by 2011.

[22] MedPAC, *Benchmarks and Payments,* 2006.

[23] Congressional Budget Office, "Medicare's Physician Payment Rates and the Sustainable Growth Rate," testimony before the Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives, July 25, 2006. Available at http://www.cbo.gov. Accessed August 3, 2006.

Table 1. Extra Payments to Medicare Advantage Plans Compared with Average Fee-for-Service Costs, by County Payment Category, 2005[a]

County Payment Category	Medicare Beneficiaries[d]	MA Plan Enrollees[d]	Total Extra Payments to MA Plans (millions)	Average MA Plan Payment Greater than FFS Costs[b,c]	
				Average Extra Amount per MA Plan Enrollee	Average Extra Payment to MA Plans Greater than FFS Costs
National	42,985,118	5,659,802	$5,220	$922	12.4%
Blend	1,569,853	334,565	435	1,301	18.0
Large Urban Floor	11,765,208	1,503,677	2,096	1,394	21.5
Rural and Other Urban Floor	7,294,360	247,297	357	1,445	25.6
Minimum Update	2,555,913	440,688	442	1,003	11.5
100% FFS 2004[e]	3,285,395	419,090	233	555	6.4
100% FFS 2005[e]	16,491,985	2,714,485	1,657	610	6.5

[a] Calculations of fee-for-service costs exclude payments to teaching hospitals for the IME expenses of both MA and fee-for-service beneficiaries.

[b] Calculations at the county level, weighted by MA enrollment. Excludes MA enrollees in cost plans.

[c] Calculations include budget neutral risk adjustment of 1.04. For more on risk adjustment and budget neutrality in 2005, see R. A. Berenson, "Medicare Disadvantaged and the Search for the Elusive 'Level Playing Field,'" *Health Affairs* Web Exclusive (Dec. 15, 2004):w4-572–w4-585.

[d] Medicare and Medicare Advantage enrollment data as of December 2005.

[e] CMS rebased the estimates of county-level per capita fee-for-service costs for 2005. Rebasing means that the estimates of per capita FFS expenditures for each county were recalculated so that they reflected more recent county trends. The MMA provides that the county level payment rate for MA plans in 2005 was the higher of the 2005 rebased 100 percent of FFS rate or the 2004 rate increased by 6.6 percent. See Centers for Medicare and Medicaid Services, "Note to Medicare Advantage Organizations and Other Interested Parties: Advance Notice of Methodological Changes for Calendar Year (CY) 2005 Medicare Advantage Payment Rates" (Baltimore, Md.: CMS, Mar. 26, 2004). Available at http://www.cms.hhs.gov/healthplans/rates/2005/45day.pdf. Accessed Sept. 15, 2004.

Source: George Washington University analysis of Centers for Medicare and Medicaid Services Medicare Managed Care Quarterly State, County Plan Data File for the quarter ending December 2005, Medicare Managed Care Quarterly State County Market Penetration File for the quarter ending December 2005 and Medicare Advantage Revised 2005 Ratebook.

Table 2. Distribution of Medicare Beneficiaries and Medicare Advantage Plan Enrollees, Compared with Extra Payments to Medicare Advantage Plans, by County Payment Category, 2005

County Payment Category	Distribution of Medicare Beneficiaries	Distribution of MA Plan Enrollees	MA Plan Enrollment Rate	Distribution of MA Plan Extra Payments
National	100.0%	100.0%	13.2%	100.0%
Blend	3.7	5.9	21.3	8.3
Large Urban Floor	27.4	26.5	12.8	40.2
Rural and Other Urban Floor	17.0	4.4	3.4	6.9
Minimum Update	5.9	7.8	17.2	8.5
100% FFS 2004[a]	7.6	7.4	12.8	4.3
100% FFS 2005[a]	38.4	48.0	16.5	31.7

[a] CMS rebased the estimates of county-level per capita fee-for-service costs for 2005. Rebasing means that the estimates of per capita FFS expenditures for each county were recalculated so that they reflected more recent county trends. The MMA provides that the county level payment rate for MA plans in 2005 was the higher of the 2005 rebased 100 percent of FFS rate or the 2004 rate increased by 6.6 percent. See Centers for Medicare and Medicaid Services, "Note to Medicare Advantage Organizations and Other Interested Parties: Advance Notice of Methodological Changes for Calendar Year (CY) 2005 Medicare Advantage Payment Rates" (Baltimore, Md.: CMS, Mar. 26, 2004). Available at http://www.cms.hhs.gov/healthplans/rates/2005/45day.pdf. Accessed Sept. 15, 2004.

Source: George Washington University analysis of Centers for Medicare and Medicaid Services Medicare Managed Care Quarterly State, County Plan Data File for the quarter ending December 2005, Medicare Managed Care Quarterly State County Market Penetration File for the quarter ending December 2005 and Medicare Advantage Revised 2005 Ratebook.

Table 3. Extra Payments to Medicare Advantage Plans Compared with Average Fee-for-Service Costs by State, 2005[a]

State	Medicare Beneficiaries[d]	MA Plan Enrollees[d]	MA Plan Enrollment Rate	Average MA Plan Payment Greater than FFS Costs[b,c]: Average Extra Payment to MA Plans Greater than FFS Costs	Average MA Plan Payment Greater than FFS Costs[b,c]: Average Extra Amount per MA Plan Enrollee	Average MA Plan Payment Greater than FFS Costs[b,c]: Total Extra Payments to MA Plans (millions)
National	42,985,118	5,659,802	13.2%	12.4%	$922	$5,220
Rural	12,347,163	428,768	3.5	17.6	1,061	455
Urban	30,637,955	5,231,034	17.0	12.0	911	4,765
Alabama	781,601	77,998	9.9	8.5	670	52
Alaska	45,844	46	0.1	13.6	1,050	⋆
Arizona	818,639	227,234	27.8	15.5	1,069	243
Arkansas	489,388	3,042	0.6	21.7	1,357	4
California	4,386,037	1,367,717	31.2	9.3	735	1,005
Colorado	541,096	119,144	22.0	10.7	782	93
Connecticut	540,699	17,279	3.2	10.6	808	14
Delaware	132,269	1,040	0.8	9.9	733	1
D.C.	77,597	881	1.1	10.5	927	1
Florida	3,129,832	635,347	20.3	5.3	514	327
Georgia	1,076,986	32,273	3.0	14.7	1,039	34
Hawaii	189,271	22,424	11.8	43.0	2,386	54
Idaho	198,714	19,645	9.9	26.7	1,661	33
Illinois	1,749,064	90,135	5.1	14.4	995	90
Indiana	934,910	11,071	1.2	23.3	1,450	16
Iowa	502,547	14,468	2.9	28.0	1,624	23
Kansas	412,026	16,155	3.9	9.4	676	11
Kentucky	704,727	20,615	2.9	9.5	691	14
Louisiana	642,618	75,186	11.7	6.1	611	46
Maine	243,190	469	0.2	25.2	1,554	1
Maryland	718,389	15,310	2.1	7.3	690	11
Massachusetts	1,007,212	162,405	16.1	9.3	778	126
Michigan	1,537,840	30,403	2.0	12.6	1,003	30
Minnesota	721,521	70,861	9.8	22.0	1,334	95
Mississippi	471,940	3,624	0.8	11.8	821	3
Missouri	942,794	117,698	12.5	12.3	840	99
Montana	153,268	2,595	1.7	22.4	1,318	3

Notes: MA is Medicare Advantage; FFS is fee-for-service.

[a] Calculations exclude payments to teaching hospitals for the IME expenses of both MA and FFS beneficiaries.

[b] Calculations at the county level, weighted by MA enrollment. Excludes MA enrollees in cost plans.

[c] Calculations include budget neutral risk adjustment of 1.04. For more on risk adjustment and budget neutrality in 2005, see R. A. Berenson, "Medicare Disadvantaged and the Search for the Elusive 'Level Playing Field,'" *Health Affairs* Web Exclusive (Dec. 15, 2004):w4-572–w4-585.

[d] Medicare and Medicare Advantage enrollment data as of December 2005.

⋆ < $0.5 million.

Source: George Washington University analysis of Centers for Medicare and Medicaid Services Medicare Managed Care Quarterly State, County Plan Data File for the quarter ending December 2005, Medicare Managed Care Quarterly State County Market Penetration File for the quarter ending December 2005 and Medicare Advantage Revised 2005 Ratebook.

Table 3. Extra Payments to Medicare Advantage Plans Compared with Average Fee-for-Service Costs by State, 2005 (cont.)[a]

State	Medicare Beneficiaries[d]	MA Plan Enrollees[d]	MA Plan Enrollment Rate	Average MA Plan Payment Greater than FFS Costs[b,c]: Average Extra Payment to MA Plans Greater than FFS Costs	Average MA Plan Payment Greater than FFS Costs[b,c]: Average Extra Amount per MA Plan Enrollee	Average MA Plan Payment Greater than FFS Costs[b,c]: Total Extra Payments to MA Plans (millions)
Nebraska	267,836	13,321	4.9%	15.3%	$1,320	$18
Nevada	308,802	87,598	28.4	5.9	506	44
New Hampshire	194,363	1,528	0.8	16.8	1,162	2
New Jersey	1,270,110	103,430	8.1	7.2	675	70
New Mexico	277,591	45,815	16.5	39.2	2,269	104
New York	2,879,429	553,302	19.2	15.8	1,310	725
North Carolina	1,318,782	91,688	6.9	29.8	1,832	168
North Dakota	106,313	690	0.6	31.3	1,732	1
Ohio	1,811,699	214,430	11.8	12.8	932	200
Oklahoma	559,862	47,673	8.5	11.2	810	39
Oregon	557,661	149,172	26.7	30.9	1,849	276
Pennsylvania	2,189,492	547,619	25.0	8.9	778	426
Rhode Island	177,579	58,817	33.1	17.5	1,196	70
South Carolina	673,878	17,990	2.7	21.4	1,399	25
South Dakota	128,623	793	0.6	32.8	1,802	1
Tennessee	955,071	98,429	10.3	18.5	1,233	121
Texas	2,641,789	212,505	8.0	6.6	561	119
Utah	245,106	18,341	7.5	26.4	1,650	30
Vermont	100,351	88	0.1	25.9	1,497	⋆
Virginia	1,023,393	16,145	1.6	21.3	1,329	21
Washington	851,609	130,846	15.4	21.4	1,399	183
West Virginia	367,440	21,785	5.9	7.7	621	14
Wisconsin	854,772	71,694	8.4	34.8	1,918	138
Wyoming	73,560	1,038	1.4	9.8	656	1

Notes: MA is Medicare Advantage; FFS is fee-for-service.

[a] Calculations exclude payments to teaching hospitals for the IME expenses of both MA and FFS beneficiaries.

[b] Calculations at the county level, weighted by MA enrollment. Excludes MA enrollees in cost plans.

[c] Calculations include budget neutral risk adjustment of 1.04. For more on risk adjustment and budget neutrality in 2005, see R. A. Berenson, "Medicare Disadvantaged and the Search for the Elusive 'Level Playing Field,'" *Health Affairs* Web Exclusive (Dec. 15, 2004):w4-572–w4-585.

[d] Medicare and Medicare Advantage enrollment data as of December 2005.

⋆ < $0.5 million.

Source: George Washington University analysis of Centers for Medicare and Medicaid Services Medicare Managed Care Quarterly State, County Plan Data File for the quarter ending December 2005, Medicare Managed Care Quarterly State County Market Penetration File for the quarter ending December 2005 and Medicare Advantage Revised 2005 Ratebook.

METHODOLOGY

This analysis is based on Medicare Advantage payment rates and fee-for-service expenditure averages posted by county in the 2005 CMS Medicare Advantage Rate Calculation Data spreadsheet.[i]

The number of Medicare beneficiaries and Medicare Advantage enrollees by county is taken from the Medicare Managed Care Quarterly State County data file for the quarter ending December 2005. These data are posted on the Web site of the Centers for Medicare and Medicaid Services, http://www.cms.hhs.gov.[ii] These data do not differentiate between aged, disabled, and end-stage renal disease Medicare beneficiaries, so this analysis treats all beneficiaries as aged.

The county is the basic unit of analysis for the Medicare Advantage program as Medicare sets plan payment rates at the county level. In 2004, Medicare Advantage plans received the highest of five payment types: a blended rate (consisting of 50% of the county-specific base payment rate and 50% of the national average base payment rate), a floor rate for counties in large urban areas, a floor rate for other counties, a minimum update over the previous year's payment rate, or 100 percent of projected per capita fee-for-service costs in the county. The payments to plans in 2005 were the higher of: 1) the county payment level in 2004 increased by the national per capita Medicare Advantage growth percentage for 2005, which was 6.6 percent; or 2) a rebased projection of per capita fee-for-service costs in the county for 2005. This rebasing of fee-for-service costs resulted in an increase in Medicare Advantage payments by more than the national average of 6.6 percent for those counties.

Plan payment and enrollment data were provided at the county level. All 2005 payment data were taken from the Centers for Medicare and Medicaid Services 2005 Medicare Advantage aged rate book. The rate book reports data on per-enrollee monthly payments to Medicare Advantage plans, average per-beneficiary fee-for-service costs, and a carve-out factor for graduate medical education by county.

Extra payments to Medicare Advantage plans are calculated for 3,146 counties in the United States in 2005. Puerto Rico, Guam, and the Virgin Islands are not included in the analysis. For illustrative purposes, counties are aggregated by state or payment category when presented in tables.

The Medicare Advantage payment rate can be accurately compared with the fee-for-service costs at the county level. This analysis presents both the percentage and dollar amounts above fee-for-service Medicare.

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[i] Centers for Medicare and Medicaid Services, *Rate Calculation Data* (Baltimore, Md.: CMS, Dec. 2005). Available at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/.

[ii] Centers for Medicare and Medicaid Services, *Medicare Managed Care Quarterly State County Data* (Baltimore, Md.: CMS, Dec. 2005). Available at http://www.cms.hhs.gov/HealthPlanRepFileData/.

Methodology (cont.)

Some 320,000 Medicare Advantage enrollees are in Medicare plans paid on the basis of costs and which do not receive Medicare Advantage plan payment rates. These beneficiaries were identified from the CMS Medicare Managed Care Quarterly State, County, Plan data file for the quarter ending December 2005.[iii] Cost beneficiaries were removed from the Medicare Advantage enrollee totals by county, but are included in the number of overall Medicare beneficiaries. Although these beneficiaries receive Medicare benefits through managed care plans, they do not generate extra payments.

This analysis follows a methodological convention developed by MedPAC in addressing the Medicare policy of making direct payments to teaching hospitals for the costs of indirect medical education for Medicare Advantage enrollees. It adjusts fee-for-service costs at the county level by removing the average indirect medical education expense. This is done by deflating the county fee-for-service average by a factor of 1 – (0.65 * GME), where GME is the county graduate medical education carve-out. A national average of 65 percent of graduate medical education payments goes to indirect medical education; county-specific data are unavailable. Because Medicare makes indirect medical education payments directly to teaching hospitals for patients who are enrolled in Medicare Advantage, Medicare Advantage plan payment rates are most appropriately compared with fee-for-service costs adjusted in this manner.[iv]

Budget neutral risk adjustments to MMA 2005 payments to Medicare Advantage plans provide additional extra payments to MA plans. In 2005, the BNRA adjustment was applied to 50 percent of the MA payment rates to account for the fact that 50 percent of payments to Medicare Advantage plans were risk-adjusted using the CMS–HCC model to account for beneficiary health characteristics.[v] This analysis of extra payments includes a budget neutral risk adjustment of 1.04 for 2005.[vi]

[iii] Centers for Medicare and Medicaid Services, *Medicare Managed Care Quarterly State, County, Plan Data* (Baltimore, Md.: CMS, Dec. 2005). Available at http://www.cms.hhs.gov/HealthPlanRepFileData/.

[iv] Alternately, indirect medical education amounts may be added to Medicare Advantage payment rates and these adjusted rates can be directly compared with published fee-for-service spending averages. The two methods have extremely similar results.

[v] Centers for Medicare and Medicaid Services, "Note to Medicare Advantage Organizations and Other Interested Parties: Advance Notice of Methodological Changes for Calendar Year (CY) 2005" (Baltimore, Md.: CMS, 2004). Available at http://www.cms.hhs.gov/healthplans/rates/2005/45day.pdf. Accessed Sept. 6, 2004.

[vi] R. A. Berenson, "Medicare Disadvantaged and the Search for the Elusive 'Level Playing Field,'" *Health Affairs* Web Exclusive (Dec. 15, 2004):w4-572–w4-585.

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