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The Continuing Cost of Privatization: Extra Payments to Medicare Advantage Plans in 2008

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ABSTRACT: The Medicare Modernization Act of 2003 explicitly increased Medicare payments to private Medicare Advantage (MA) plans. As a result, every MA plan in the nation is paid more for its enrollees than they would have been expected to cost in traditional fee-for-service Medicare. The authors calculate that payments to MA plans in 2008 will be 12.4 percent greater than the corresponding costs in traditional Medicare—an average increase of $986 per MA plan enrollee, for a total of more than $8.5 billion. Over the five-year period 2004–2008, extra payments to MA plans are estimated to have totaled nearly $33 billion. Although Congress recently enacted modest reductions in MA plan payments, these changes will not take effect until 2010. Moreover, while the new legislation removes a few factors contributing to the extra payments, a number of other factors remain unaffected.

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OVERVIEW

The Medicare Modernization Act of 2003 (MMA) included a broad set of provisions intended to expand the role of private health plans in Medicare. Included among these were new payment policies that increased payments to private health plans.

The higher level of payments for Medicare Advantage (MA) plans—as these private plans are now called—was based on a belief that, following 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] However, in each of the five years from 2004 through 2008, MMA policies have resulted in payments to MA plans that have substantially exceeded comparable costs in traditional fee-for-service Medicare.

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The analysis in this paper uses the latest (2008) data on actual enrollment in MA plans and on MA benchmark payment rates to estimate the extra payments made to MA plans relative to what the same enrollees would have cost under traditional Medicare.

Based on this information, we calculate that payments to MA plans in 2008 exceed local fee-for-service costs by 12.4 percent, or an average of $986 for each of the 8.7 million Medicare enrollees in managed care,[2] for a national total of more than $8.5 billion.[3] Over the five-year period 2004–2008, extra payments to MA plans are estimated to have totaled nearly $33 billion.[4]

In the recent Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), the Congress made modest reductions in payments to MA plans, which take effect in 2010. If these reductions had been in effect in 2008, MA plan payments still would have exceeded fee-for-service costs by 10.6 percent. This paper focuses on payments in 2008, which were unaffected by the MIPPA legislation.

BACKGROUND: MEDICARE AND PRIVATE PLANS

The participation 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. Moreover, the first major set of Medicare amendments in 1972 created a program under which HMOs would receive prepayment for providing coordinated care to Medicare beneficiaries.

In 1982, the Tax Equity and Fiscal Responsibility Act gave HMOs the opportunity to be paid on a risk basis, at 95 percent of average per capita fee-for-service costs, in each county. HMOs were expected to be more efficient than the traditional program, saving the government 5 percent on expected costs for each enrollee while offering additional benefits—in the form of lower out-of-pocket payments or benefits not covered by traditional Medicare.[5]

During the 1990s, Medicare beneficiary enrollment in these risk plans (called "Medicare+Choice" plans) grew rapidly—from 1.3 million to 5.2 million, or 3.7 percent of beneficiaries to 13.5 percent, between 1990 and 1997.[6] This rapid growth was fueled by the additional benefits that these plans were able to provide: in 1996, risk plans provided an average of $924 per member annually in additional benefits.[7] But the availability of these benefits was not uniform across the country, being highly correlated with the payment rate in each area. The 10 percent of risk plans with the highest payment rates (29 percent higher than the nationwide average, adjusted for local input costs) offered additional benefits worth an average of $1,452 annually, while the 10 percent of plans with the lowest payment rates (25 percent below the nationwide average) offered extra benefits worth only $576 annually.[8]

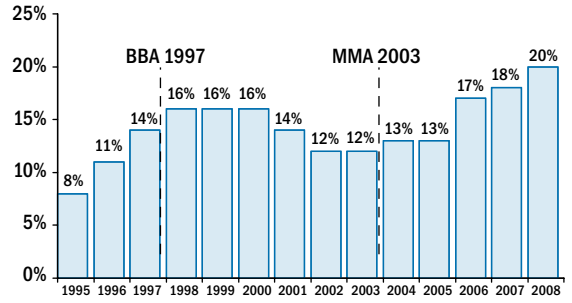
Moreover, because Medicare risk plans—and therefore enrollment in those plans—tended to be concentrated in certain areas, so was the availability of additional benefits. In the era before prescription-drug coverage was available to all Medicare beneficiaries, this distribution caused particular concern. In effect, beneficiaries in some areas with relatively high payment rates and high risk-plan penetration had access to a prescription-drug benefit—funded by Medicare payments—while beneficiaries in other areas (including many rural areas) did not.

Elimination of this inequity was one objective of the Balanced Budget Act of 1997 (BBA), which for the first time set Medicare payments to private plans in some areas at a higher level than average fee-for-service costs. It did this by establishing both a nationwide minimum payment rate, or floor, and a blended rate based on a combination of each area's own average costs and the nationwide average. These provisions benefited plans in rural and other relatively low-cost areas. In 2001, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 expanded the policy of paying private plans more than average fee-for-service costs by setting a new higher floor for private plans in large urban areas.[9]

Following the enactment of the BBA in 1997, the Congressional Budget Office predicted that 27 percent of Medicare beneficiaries would be enrolled in

private plans by 2002.[10] But after peaking in 1999 at 16 percent of beneficiaries nationwide, Medicare Choice (M+C) plan enrollment declined to 12 percent in 2003 (Figure 1). This was largely due to the fact that, in addition to changing the way in which payment rates were determined, the BBA also reduced the overall increase in payments for fee-for-service Medicare and, consequently, to M+C plans. Results included the withdrawal of plans from many areas and a reduction in the benefits offered to private-plan enrollees. This decline helped spur creation of the Medicare Advantage program in 2003, which further increased MA payments and expanded the types of private plans available for Medicare beneficiaries.

Figure 1. Enrollment in Medicare Managed Care Plans as a Percentage of Total Medicare Beneficiaries, 1995–2008



Source: Centers for Medicare and Medicaid Services managed care enrollment data—data for 1995–2002 are as of December 1 of each year; data for 2003–2007 are for the quarter ending in December of each year; data for 2008 are as of February 2008.

MA PLAN PAYMENTS IN 2008

Medicare payments to MA plans in 2008 are based on four factors: (1) county benchmark rates specified by the MMA; (2) a budget-neutral risk-adjustment (BNRA) policy that increases the benchmarks by 1.7 percent in 2008; (3) the inclusion of the fee-for-service payment adjustment for indirect medical education (IME) costs in the benchmark rates; and (4) a plan-bidding mechanism (described below) that reduces payments by an average of 4.3 percent in 2008. Taken together, these four policies result in extra payments to MA plans that average $986 per MA plan enrollee per year, for a national total of more than $8.5 billion in 2008.

County Benchmark Rates. For 2008, Medicare benchmark rates for MA plans in each county are set at the highest of seven different reference rates. The first four of these are based on payment levels established in March 2004, trended forward each year through 2008; the other three are based on fee-for-service costs in a base year, trended forward to 2008.

The seven types of county benchmark rates are:

- A minimum rate (or floor) for large urban areas (areas with populations of more than 250,000), which in 2008 is set at $9,499 per enrollee annually.
- A minimum rate (or floor) for rural and smaller urban areas**,** which in 2008 is set at $8,595 annually.
- A blended rate, which is a 50/50 combination of the base Medicare Advantage rate for the county in 2004 and the national average Medicare Advantage rate in that year, updated to 2008.[11]
- A rate that reflects a minimum increase from the county's 2004 payment level, updated to 2008.[12,13]
- A payment rate equal to 100 percent of estimated county per capita fee-for-service costs in 2004, updated to 2008.[14]
- A payment rate equal to 100 percent of projected county per capita fee-for-service costs in 2005, updated to 2008.[15]
- A payment rate equal to 100 percent of projected county per capita fee-for-service costs in 2007, updated to 2008.[16]

On average, county benchmarks exceed average fee-for-service costs in 2008 by 16.7 percent.

Budget-Neutral Risk-Adjustment (BNRA) Policy. The BNRA policy, in effect since 2003, has increased MA plan payments across-the-board so that aggregate MA plan payments are less affected by the implementation of an improved risk-adjustment mechanism that adjusts benchmark rates to account for variation in enrollees' health status and clinical conditions. The Deficit Reduction Act of 2005 provided for a phase-out of this increase in MA benchmark rates from 2006 through 2010. In 2008, the BNRA policy increases all county benchmarks by 1.7 percent, adding approximately $1.3 billion to MA payments.[17]

Payment for Indirect Medicare Education Included in the Benchmarks. An explicit policy included in the MMA provides that the MA benchmark payment rate for each county includes an amount that reflects Medicare payments to teaching hospitals for their indirect medical education (IME) costs. This sum is included in the MA county benchmarks, despite the fact that Medicare makes IME payments directly to teaching hospitals for MA enrollees admitted to these hospitals. Medicare therefore effectively pays twice for the IME costs of MA plan members.[18] This double payment raises the MA benchmark rates by about 2.3 percent, and MA payments by an estimated $1.7 billion. The recent MIPPA legislation removes this component of MA payment rates beginning in 2010.

In an arrangement similar to the additional payments that teaching hospitals receive from Medicare for their IME costs, hospitals that treat a disproportionate share of indigent patients receive a disproportionate share hospital (DSH) payment for patients in traditional fee-for-service Medicare. Unlike IME payments, however, Medicare DSH payments are included in the monthly capitation payment rates that plans receive, but not made directly to hospitals; it is left to each plan to determine how much of the DSH amount, if any, it will pay to each institution. Medicare DSH payments are not in general related to the costs faced by individual plans, and an argument could be made that they, like IME payments, should be paid directly to eligible hospitals for the MA patients they treat. Because a good estimate is not available for the county-level effect of DSH payments on MA payments, they are not included in the calculations in this analysis. But they could be considered as representing additional overpayments to MA plans.

MA Plan Bidding System. Under the bidding mechanism established by the MMA, all MA plans submit bids for the provision of traditional Medicare benefits to their enrollees. MA plans then receive payments equal to the applicable benchmark rate for the county in which each enrollee resides minus 25 percent of the difference between the county benchmark and each individual plan's bid. Plan bids for 2008 were an average of 17 percent below their county benchmarks, according to Medicare Payment Advisory Commission staff analysis.[19] This implies that MA plan payments are, on average, 4.3 percent (25 percent of 17 percent) below their corresponding benchmarks; since the benchmarks themselves are 16.7 percent above fee-for-service costs, on average, MA plan payments are 12.4 percent (16.7 percent minus 4.3 percent) above fee-for-service costs.

VARIATION IN EXTRA PAYMENTS IN 2008

The overall pattern of Medicare extra payments to MA plans in 2008 may be described by focusing on plans located in three types of areas.

- *"Large urban floor" counties.* The largest aggregate amount of extra payments goes to MA plans in the counties in which the large urban floor benchmark determines the MA payment rates. The extra payments received by MA plans in these counties amount to approximately $3.8 billion, or 44 percent of the $8.5 billion in total extra payments in 2008. Extra payments to plans in these counties are estimated to average $1,478 (or 20 percent) more per plan enrollee than the same person would be expected to cost under traditional Medicare fee-for-service.

- *"100 percent of fee-for-service" counties.* In the counties where MA payments are determined by the 100 percent of fee-for-service benchmark, total extra payments are estimated at over $2.6 billion, accounting for 30.6 percent of total extra payments nationwide.

  This seemingly anomalous finding—payments based on 100 percent of fee-for-service costs actually exceeding fee-for-service costs—is the result of the three policies described above, which actually overstate MA payments relative to patient care costs under traditional Medicare. First, the BNRA policy adds 1.7 percent to the MA benchmarks in every county in 2008. Second, the inclusion of the IME payment in the MA benchmarks adds 2.3 percent, on average, to those benchmarks. Third, because the MA rebasing policy sets new county benchmarks only higher than, and never less than, a county's previous year MA benchmark updated to the current year, many plans paid at 100 percent of fee-for-service in an earlier year updated to 2008 are paid more than the current average of fee-for-service costs in the county in 2008.

- *Rural counties*. Despite the initial concern over low MA payment rates in rural counties, it should be noted that MA extra payments do not flow disproportionately to Medicare plans in rural areas. While 17.9 percent of Medicare beneficiaries live in counties where MA payment rates are determined by the rural floor benchmark, only $1.1 billion (13 percent) of MA extra payments will go to plans in these counties in 2008.

Thirty-five years of national experience with HMOs and managed care plans indicates that private managed care plans have generally located and attracted enrollees in urban areas. This pattern is evident both in commercial health insurance and Medicare. After 10 years of rural floor payments in excess of 100 percent of average fee-for-service costs, fewer than 11 percent of Medicare beneficiaries in rural counties are enrolled in MA plans in 2008, compared with 24 percent of beneficiaries in urban counties.

The distribution of MA extra payments and enrollees by payment category is displayed in Appendix Tables 1 and 2.

VARIATION IN EXTRA PAYMENTS BY STATE IN 2008

The amount of extra payments to MA plans in 2008 varies greatly by state (see Appendix Table 3). Extra payments per enrollee in 2008 range from a maximum of over $2,200 in New Mexico and Hawaii to a minimum of just $228 in Nevada. Notably, the states with the greatest extra payments per MA enrollee are generally the ones with the lowest per capita fee-for-service costs. While New Mexico's are 20 percent below the national average, Nevada's are 6 percent above.

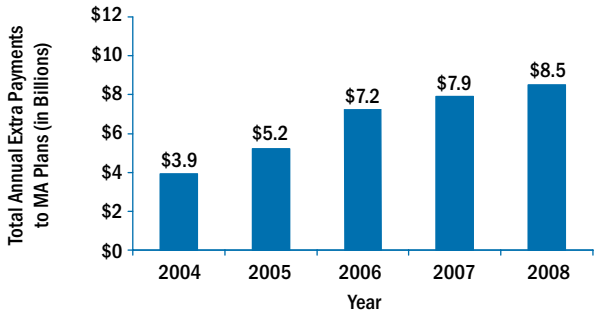
However, although this relationship might appear to reduce the discrepancy between high- and low-cost states, it actually provides a perverse incentive for beneficiaries in states with low fee-for-service costs to leave traditional Medicare while failing to provide the same attractive alternative for beneficiaries in states with high fee-for-service costs. Plans in states where costs are already low thus are disproportionately rewarded by these extra payments, compared with plans in high-cost states—where more competition might be expected to bring those high costs down.

Moreover, the total amount of extra payments to MA plans is highly concentrated among a relatively small number of states. In 2005, California and New York alone accounted for about one-fourth of total extra payments, and more than half went to plans in six states. By contrast, the 30 states with the lowest total extra payments together accounted for just 15 percent of those payments.

MA PLAN PAYMENTS SINCE 2003

MA payment rates were increased by the MMA beginning in March 2004. Since that time, MA payment benchmarks—and Medicare payments generally—have exceeded costs of fee-for-service Medicare for every plan in every county in the nation. The effect of these provisions has been to increase total extra payments from $3.9 billion in 2004 to $8.5 billion in 2008 (Figure 2), with a cumulative five-year cost of nearly $33 billion.

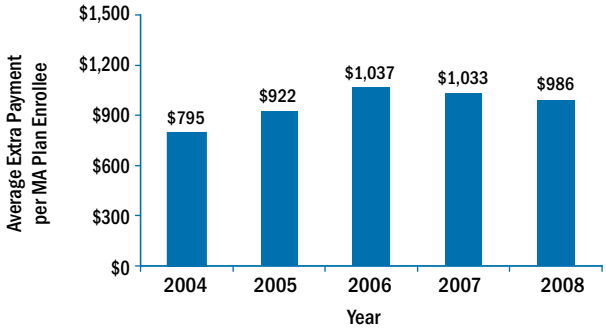
Figure 2. Trends in Total Extra Payments to MA Plans, 2004–2008



Source: GWU analysis of CMS Medicare Advantage enrollment and payment rate data for 2004-2006 and MedPAC analysis of MA plan bids for 2006, 2007, and 2008.

Total extra payments have increased both because of growth in the amount of extra payments per MA plan enrollee and growth in the total number of enrollees. Extra payments per enrollee were $795 (11.9 percent) above fee-for-service costs in 2004, rising to a high of $1,037 (14.1 percent) above fee-for-service costs in 2006, and then hitting $986 (12.4 percent) above fee-for-service costs in 2008 (Figure 3). The peak in 2006 mainly reflects the level of BNRA payments at 7.7 percent in 2006, 3.9 percent in 2007, and 1.7 percent in 2008. Meanwhile, the number of Medicare beneficiaries enrolled in MA plans has increased from 4.8 million to 8.6 million.

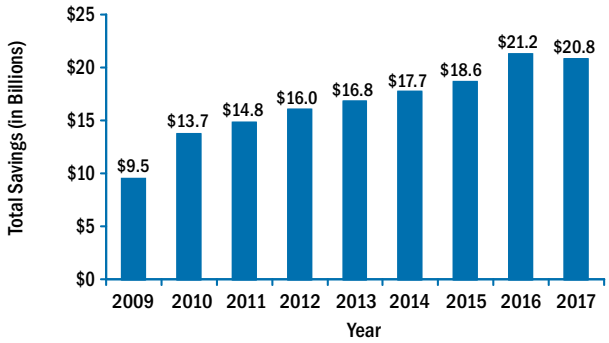
Figure 3. Trends in Average Extra Payment per MA Plan Enrollee, 2004–2008



Source: GWU analysis of CMS Medicare Advantage enrollment and payment rate data for 2004-2006 and MedPAC analysis of MA plan bids for 2006, 2007, and 2008.

The Congressional Budget Office (CBO) has attributed the increase in MA enrollment to the extra payments received by MA plans. In 2007, prior to the passage of MIPPA, CBO projected that a policy of paying MA plans at 100 percent of fee-for-service costs at the county level—that is, of eliminating the extra payments—would reduce projected MA enrollment in 2012 from 12.5 million to 6.2 million Medicare beneficiaries, a number only slightly higher than MA enrollment in 2005.[20] CBO also estimated that the resulting reduction in Medicare spending would total $54 billion over the four years from 2009 through 2012 and $149 billion over the nine years from 2009 through 2017 (Figure 4).

Figure 4. Estimated Savings from the Implementation of a Policy to Reduce Payments to MA Plans to 100 Percent of Fee-for-Service Costs, 2009–2017



Source: Congressional Budget Office, June 2007.

CONCLUSION

The MMA-driven policies that raised Medicare payments to private plans have spurred greater enrollment in those plans, but have substantially increased Medicare costs. This is primarily due to extra payments—payments in excess of fee-for-service costs—paid to private plans by Medicare. In 2008, for each of the 8.6 million Medicare enrollees in managed care, Medicare will spend an average of $986, or 12.4 percent, more than it would for comparable beneficiaries in traditional fee-for-service Medicare, with total extra payments to MA plans exceeding $8.5 billion.

There is wide variation in these extra payments across geographic areas: the average amount per MA enrollee by state ranges from $228 (2.6 percent above average fee-for-service costs) in Nevada to $2,305 (35 percent above average fee-for-service costs) in New Mexico. This variation indicates that the availability of additional benefits—which was a major objective of the policy changes in the MMA—is concentrated in some regions while remaining absent from others. Moreover, the impact of these extra payments on beneficiaries in many areas is questionable. For example, counties where the rural floor applies contain 17.9 percent of total Medicare beneficiaries, but they receive only 13 percent of extra payments because the vast majority of their beneficiaries—87.4 percent—remain in traditional Medicare.

Extra payments to MA private plans have increased Medicare costs by nearly $33 billion in the five years since 2004. Prior to the enactment of MIPPA in July 2008, MA extra payments were projected to add almost $150 billion to Medicare costs over the next nine years. Moreover, overpayment of private plans presents a threat to Medicare's efficiency—contravening the original reason for including a private plan option in Medicare.

These extra payments, which represent a drain on the federal budget, could otherwise be used to reduce the nation's deficit or to offset the costs of Medicare policy improvements. The latter could involve, say, reducing Part B premiums, increasing eligibility for low-income subsidies in Medicare Part D, or reducing Part D copayments. All of these alternatives represent broader or better-targeted benefits for the Medicare dollars spent.

While MIPPA reduced the extra payments to private plans, a substantial amount of those extra payments remain. The substantial cost of those extra payments, along with the potential distortion of incentives in a program intended to improve efficiency, and the large number of pressing needs to which those resources might alternatively be applied all suggest that current Medicare policies deserve continued 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 The total number of Medicare Advantage enrollees excludes those in cost plans and in Puerto Rico, Guam, and the U.S. Virgin Islands.

3 This figure is comparable to recent analyses of extra payments performed by the Medicare Payment Advisory Commission (MedPAC), which released a report in March 2008 that estimated 2008 payments to MA plans would be 113 percent of fee-for-service costs. See: Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (Washington, D.C.: MedPAC, Mar. 2008).

4 The $33-billion figure is based on George Washington University analysis of enrollment and payments to MA plans in 2004 through 2008.

Note: In estimating (in December 2003) the MMA's future costs, the Congressional Budget Office projected that the new MA payment policies would add just $5.2 billion to Medicare costs from 2004 to 2008 and $14.2 billion from 2004 to 2013. The Medicare Office of the Actuary estimated the additional 10-year costs due to the MA program at $46 billion. These estimates would have applied only to the new MMA MA payment policies and not to the continuation of the rural and urban floor policies adopted in 1997 and 2000. See: Congressional Budget Office, "Letter to Congressman Jim Nussle" (Washington, D.C.: CBO, Feb. 2, 2004), available at www.cbo.gov, accessed Apr. 1, 2004.

5 Each risk plan was required to offer additional benefits if its payment rate was greater than its estimated cost of providing the traditional Medicare benefit package, and those additional benefits were required to be equal in actuarial value to the difference between the payment rate and the estimated cost.

6 L. Achman and M. Gold, *Medicare+Choice 1999–2001: An Analysis of Managed Care Plan Withdrawals and Trends in Benefits and Premiums* (New York: The Commonwealth Fund, Feb. 2002).

7 Prospective Payment Assessment Commission, *Medicare and the American Health Care System: Report to the Congress* (Washington, D.C.: ProPAC, 1997).

8 Ibid.

9 H.R. 5661: Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000. See Sec. 601, Increase in Minimum Payment Amount.

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

11 The base Medicare Advantage rate for the county is its 1997 risk plan rate, updated to the base year; the national average base Medicare Advantage rate is the average rate across all counties, weighted by Medicare enrollment.

12 Centers for Medicare and Medicaid Services, "Note to Medicare Advantage Organizations and Other Interested Parties. Subject: Announcement of Calendar Year 2008 Medicare Advantage Capitation Rates and Payment Policies" (Washington, D.C.: CMS, Apr. 2007), available at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2008.pdf.

13 The MMA provides for the annual minimum increase to be either 2 percent or the Medicare national growth-rate percentage in fee-for-service expenditures, whichever is higher. Because the projected national growth rate for 2008 was 5.71 percent, payments in all counties were increased by at least that amount.

14 This payment rate includes Medicare payments for IME costs, even though Medicare makes such payments to teaching hospitals directly for MA enrollees; the effect of this double counting was to set rates an average of 2.3 percent higher than actual Medicare fee-for-service costs.

15 The MMA requires that the estimates of per capita fee-for-service costs used as benchmark MA rates be rebased (updated) a minimum of every three years. Those estimates were rebased in 2005 and 2007. Note that counties for which rebasing would result in a decrease in the benchmark rate from their previous levels continue to use the old benchmark updated to the current payment year (that is to say, rebasing can only raise benchmark rates, not lower them). See: Centers for Medicare and Medicaid Services, "Note to Medicare Advantage Organizations and Other Parties. Subject: Announcement of Calendar Year 2005 Medicare Payment Rates" (Washington, D.C.: CMS, 2004), available at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Advance2005.pdf.

16 Ibid.

[17] The BNRA payment policy, originally implemented administratively but codified in the Deficit Reduction Act (DRA) of 2005, adds about $1.3 billion to total extra payments in 2008. This amount is less than the $1.8 billion that BNRA contributed to extra payments in 2005 (or roughly one-third of total extra payments in 2005). When BNRA payment policy was formally recognized in statute through the DRA, it included a schedule to phase out the BNRA from 2006 through 2010.

[18] To calculate the effect of these double payments on the level of payments to MA plans, MedPAC and other analysts reduce the per capita fee-for-service costs in a county by the per capita IME costs in the county. This is done by deflating the county fee-for-service average by a factor of 1–(0.65 x GME), where GME is the county graduate medical education carve-out and 0.65 represents the national average percentage of GME payments that goes to indirect medical education (county-specific data are unavailable). Because Medicare makes IME payments directly to teaching hospitals for patients who are enrolled in Medicare Advantage, MA 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).

[19] CMS does not make the actual amount of payments to individual plans, or the amount of the bids, available for analysis by nongovernmental organizations.

[20] Congressional Budget Office, "Statement of Peter R. Orszag, Director, on the Medicare Advantage Program before the Committee on the Budget, U.S. House of Representatives" (Washington, D.C.: CBO, June 28, 2007).

Appendix Table 1. Extra Payments in 2008, by County Payment Category, to Medicare Advantage Plans Relative to Average Fee-for-Service Costs[1]

				Average Extra Payment for MA Plans[2,3,7]	
County Payment Type	Medicare Beneficiaries[5]	MA Plan Enrollees[4]	Total Annual Extra Payments to MA Plans (millions)	Average Extra Amount per MA Plan Enrollee	Average Extra Payment to MA Plans Greater than FFS Costs
National	42,986,173	8,666,615	$8,541	$986	12.4%
Rural Floor	7,677,075	968,106	1,114	1,151	16.4%
Urban Floor	11,346,652	2,572,212	3,802	1,478	20.0%
Blend	1,404,844	343,146	416	1,214	14.8%
Minimum Update	2,495,260	598,826	588	983	10.8%
100% FFS 2004[6]	3,246,396	578,946	728	1,257	14.1%
100% FFS 2005[6]	14,037,766	2,958,146	1,788	604	6.7%
100% FFS 2007[6]	2,778,180	647,233	106	164	1.6%

[1] Calculations exclude payments to teaching hospitals for the IME expenses both of MA and fee-for-service (FFS) beneficiaries. Calculations include budget-neutral risk adjustment of 1.0169.

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

[3] In 2006 and future years, the MMA provides that payments to MA plans change from a system based entirely on county benchmarks to one that combines county benchmarks with a bid by each individual MA plan. The new benchmark-based bidding system allocates 75% of the difference between the county benchmark and the MA plan bid to the plan and 25% to the federal government. Analysts at MedPAC who have studied Medicare private-plan payments and costs have found that the average MA plan bid is approximately 17% less than the county benchmark. This would result in a 4.25% reduction in benchmark extra payment rates to MA plans. The above calculations account for the fact that average MA plan bids fall 17% below the 2007 MA benchmark rates. See: Medicare Payment Advisory Commission, "Special Needs Plans and an Update on the Medicare Advantage Program," MedPAC Public Meeting, Dec. 6, 2007 (Washington, D.C.: MedPAC, 2007).

[4] Medicare Advantage enrollment data as of February 2008.

[5] Medicare beneficiary totals as of December 2005.

[6] CMS decided to rebase the 100% of FFS rate at the county level in 2005 and 2007. Rebasing the FFS rates means that CMS retabulated the per capita FFS expenditures for each county so that the FFS rates reflected more recent county growth trends in FFS expenditures. The MMA provided that the county-level payment rate for MA plans in 2005 be the higher of the 2005 rebased 100% of FFS rate or the 2004 rate increased by 6.6%. 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" (Washington, D.C.: CMS, Mar. 26, 2004), available at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Advance2005.pdf, accessed Sept. 15, 2004.

For 2007, the county-level payment rate for MA plans was the higher of the 2007 rebased 100% of FFS rate or the 2006 rate increased by 7.1%. See: Centers for Medicare and Medicaid Services, "Announcement of Calendar Year (CY) 2007 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies Fact Sheet" (Washington, D.C.: CMS, Apr. 3, 2006), available at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/factsheet2007.pdf, accessed May 30, 2006.

[7] For these calculations, 2007 FFS rates have been adjusted by 5.71% in accordance with the updated national estimates for 2008 on per capita MA growth percentage, released by CMS on April 2, 2007. See: Centers for Medicare and Medicaid Services, "Announcement of Calendar Year (CY) 2008 Medicare Advantage (MA) Capitation Rates and Payment Policies" (Washington, D.C.: CMS, Apr. 2, 2007), available at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2008.pdf.

Note: Calculations exclude Medicare beneficiaries and MA enrollees in Puerto Rico, Guam, and the U.S. Virgin Islands.

Source: George Washington University analysis of Centers for Medicare and Medicaid Services Medicare Managed Care State/County/Contract Data File, released February 2008; Medicare Managed Care Quarterly State, County Data File for the quarter ending December 2005; and the Medicare Advantage 2008 Rate Calculation Data Spreadsheet.

Appendix Table 2. 2008 Distributions, by County Payment Category, of Medicare Beneficiaries, Medicare Advantage Plan Enrollees, MA Enrollment Rates, and Extra Payments to MA Plans

County Payment Type	Distribution of Medicare Beneficiaries	Distribution of MA Plan Enrollees	MA Plan Enrollment Rate	Distribution of MA Plan Extra Payments
National	100.0%	100.0%	20.2%	100.0%
Rural Floor	17.9%	11.2%	12.6%	13.0%
Urban Floor	26.4%	29.7%	22.7%	44.5%
Blend	3.3%	4.0%	24.4%	4.9%
Minimum Update	5.8%	6.9%	24.2%	6.9%
100% FFS 2004[1]	7.6%	6.7%	17.8%	8.5%
100% FFS 2005[1]	32.7%	34.1%	21.1%	20.9%
100% FFS 2007[1]	6.5%	7.5%	23.3%	1.2%

[1] CMS decided to rebase the 100 percent of FFS rate at the county level in 2005 and 2007. Rebasing the FFS rates means that CMS retabulated the per capita FFS expenditures for each county so that the FFS rates reflected more recent county growth trends in FFS expenditures. The MMA provided that the county-level payment rate for MA plans in 2005 be the higher of the 2005 rebased 100% of FFS rate or the 2004 rate increased by 6.6%. 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" (Washington, D.C.: CMS, Mar. 26, 2004), available at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Advance2005.pdf, accessed Sept. 15, 2004.

For 2007, the county level payment rate for MA plans was the higher of the 2007 rebased 100% of FFS rate or the 2006 rate increased by 7.1%. See: Centers for Medicare and Medicaid Services, "Announcement of Calendar Year (CY) 2007 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies Fact Sheet" (Washington, D.C.: CMS, Apr. 3, 2006), available at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/factsheet2007.pdf, accessed May 30, 2006.

Source: George Washington University analysis of Centers for Medicare and Medicaid Services Medicare Managed Care State/County/Contract data file released February 2008; Medicare Managed Care Quarterly State, County Data File for the quarter ending December 2005; and the Medicare Advantage 2008 Rate Calculation Data Spreadsheet.

Appendix Table 3. Extra Payments to Medicare Advantage Plans in 2008 Compared with Average Fee-for-Service Costs, by State[1]

State	Medicare Beneficiaries[5]	MA Plan Enrollees[4]	MA Plan Enrollment Rate	Average MA Plan Payment Greater than FFS Costs[2,3,6]: Average Extra Amount per MA Plan Enrollee	Total Extra Payments to MA Plans (millions)	Average Extra Payment to MA Plans Greater than FFS Costs
National	42,986,173	8,666,615	20.2%	$986	$8,541	12.4%
Rural	12,692,302	1,399,716	11.0%	889	1,244	12.3%
Urban	30,293,871	7,266,899	24.0%	1,004	7,297	12.5%
Alabama	781,601	126,308	16.2%	841	106	10.1%
Alaska	45,701	88	0.2%	715	0.1	8.3%
Arizona	818,639	300,985	36.8%	1,090	328	13.8%
Arkansas	489,388	53,296	10.9%	1,017	54	13.7%
California	4,386,037	1,458,679	33.3%	902	1,315	10.8%
Colorado	542,294	153,331	28.3%	891	137	11.1%
Connecticut	540,699	67,423	12.5%	459	31	5.3%
Delaware	132,269	4,106	3.1%	596	2	7.1%
D.C.	77,597	2,034	2.6%	1,466	3	16.1%
Florida	3,129,832	819,793	26.2%	279	229	3.4%
Georgia	1,076,986	128,138	11.9%	1,096	140	14.1%
Hawaii	189,271	31,247	16.5%	2,265	71	34.1%
Idaho	198,714	45,573	22.9%	1,289	59	17.5%
Illinois	1,749,064	143,742	8.2%	721	104	9.3%
Indiana	934,910	91,109	9.7%	1,290	118	17.4%
Iowa	502,547	46,763	9.3%	1,548	72	22.7%
Kansas	412,026	30,900	7.5%	993	31	12.4%
Kentucky	704,727	82,838	11.8%	917	76	11.9%
Louisiana	642,618	123,277	19.2%	1,275	157	12.9%
Maine	243,190	10,499	4.3%	1,540	16	21.7%
Maryland	718,389	30,002	4.2%	398	12	4.2%
Massachusetts	1,007,212	180,488	17.9%	877	158	9.9%
Michigan	1,537,840	311,878	20.3%	763	238	9.6%
Minnesota	721,521	161,166	22.3%	814	131	10.9%
Mississippi	471,940	33,977	7.2%	919	31	11.1%
Missouri	942,794	162,321	17.2%	1,059	172	13.5%
Montana	153,286	20,596	13.4%	966	20	13.4%
Nebraska	267,836	24,611	9.2%	950	23	12.4%
Nevada	308,802	97,351	31.5%	228	22	2.6%
New Hampshire	194,363	6,851	3.5%	1,105	8	14.1%
New Jersey	1,270,110	119,500	9.4%	361	43	3.9%
New Mexico	277,591	62,588	22.5%	2,305	144	35.0%
New York	2,879,429	726,156	25.2%	1,123	816	14.0%

State	Medicare Beneficiaries[5]	MA Plan Enrollees[4]	MA Plan Enrollment Rate	Average MA Plan Payment Greater than FFS Costs[2,3,6]		
				Average Extra Amount per MA Plan Enrollee	Total Extra Payments to MA Plans (millions)	Average Extra Payment to MA Plans Greater than FFS Costs
North Carolina	1,318,782	206,710	15.7%	1,510	312	20.6%
North Dakota	106,313	5,902	5.6%	1,184	7	16.9%
Ohio	1,811,669	419,685	23.2%	1,084	455	13.8%
Oklahoma	559,862	71,050	12.7%	691	49	8.1%
Oregon	557,661	221,939	39.8%	1,708	379	25.3%
Pennsylvania	2,189,492	735,739	33.6%	831	612	10.1%
Rhode Island	177,579	62,121	35.0%	1,449	90	18.9%
South Carolina	673,878	82,596	12.3%	1,065	88	13.8%
South Dakota	128,623	10,122	7.9%	1,207	12	17.5%
Tennessee	955,071	186,123	19.5%	1,031	192	13.3%
Texas	2,641,789	409,991	15.5%	1,482	607	15.7%
Utah	245,106	62,275	25.4%	1,416	88	19.1%
Vermont	100,351	2,189	2.2%	1,167	3	16.5%
Virginia	1,023,393	98,115	9.6%	1,628	160	23.0%
Washington	851,609	184,789	21.7%	1,477	273	20.0%
West Virginia	367,440	64,604	17.6%	1,045	68	14.0%
Wisconsin	854,772	182,931	21.4%	1,520	278	21.7%
Wyoming	73,560	2,120	2.9%	649	1	8.7%

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

[2] Calculations at the county level, weighted by MA enrollment. Excludes MA enrollees in cost plans. Calculations include budget neutral risk adjustment of 1.0169.

[3] In 2006 and future years, the MMA provides that payments to MA plans change from a system based entirely on county benchmarks to one that combines county benchmarks with a bid by each individual MA plan. The new benchmark-based bidding system allocates 75% of the difference between the county benchmark and the MA plan bid to the plan and 25% to the federal government. Analysts at MedPAC who have studied Medicare private-plan payments and costs have found that the average MA plan bid is approximately 17% less than the county benchmark. This would result in a 4.25% reduction in benchmark extra payment rates to MA plans. The above calculations account for the fact that average MA plan bids fall 17% below the 2007 MA benchmark rates. See: Medicare Payment Advisory Commission, "Special Needs Plans and an Update on the Medicare Advantage Program," MedPAC Public Meeting, Dec. 6, 2007 (Washington, D.C.: MedPAC, 2007).

[4] Medicare Advantage enrollment data as of February 2008.

[5] Medicare beneficiary totals as of December 2005.

[6] For these calculations, 2007 FFS rates have been adjusted by 5.71% in accordance with the updated national estimates for 2008 on per capita MA growth percentage estimates for 2008, released by CMS on April 2, 2007. See: Centers for Medicare and Medicaid Services, "Announcement of Calendar Year (CY) 2008 Medicare Advantage (MA) Capitation Rates and Payment Policies" (Washington, D.C.: CMS, Apr. 2, 2007), available at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2008.pdf.

Source: George Washington University analysis of Centers for Medicare and Medicaid Services Medicare Managed Care State/County/Contract Data File released February 2008; Medicare Managed Care Quarterly State, County Data File for the quarter ending December 2005; and the Medicare Advantage 2008 Rate Calculation Data Spreadsheet.

STUDY METHODS

This report's 2008 analysis is based on Medicare Advantage payment rates and fee-for-service expenditure averages posted by county in the 2008 CMS Medicare Advantage Rate Calculation Data spreadsheet.[i] The number of Medicare Advantage enrollees by county is taken from the CMS State/County/Contract data file for February 2008. The number of Medicare beneficiaries 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 Website of the Centers for Medicare and Medicaid Services, http://www.cms.hhs.gov.[ii]

The county is the basic unit of analysis, as Medicare sets MA plan payment rates at the county level. For 2008, Medicare benchmark rates for MA plans in each county are set at the highest of seven different reference points: a floor rate for counties in large urban areas; a floor rate for other counties; a blended rate (consisting of 50 percent of the county-specific base MA payment rate and 50 percent of the national average base MA payment rate); a minimum update over the previous year's payment rate; a payment rate equal to 100 percent of per capita fee-for-service costs in the county in 2004, trended forward to 2008; a payment rate equal to 100 percent of per capita fee-for-service costs in the county in 2005, trended forward to 2008; or a payment rate equal to 100 percent of per capita fee-for-service costs in the county in 2007, trended forward to 2008. The MMA provides for the annual minimum increase in MA plan payments to be the higher of: 1) the Medicare national growth-rate percentage in fee-for-service expenditures; or 2) 2 percent. Given that the projected national growth rate for 2008 was 5.71 percent, payments in all counties were thus increased by at least that amount.

Extra payments to Medicare Advantage plans are calculated for each of the more than 3,000 counties in the United States in 2008. Puerto Rico, Guam, and the Virgin Islands are not included in the analysis. All calculations are MA plan enrollee-weighted to reflect variations in enrollment and payment rates.

Over 300,000 MA enrollees are in Medicare "cost" plans, paid on the basis of costs. Although these beneficiaries (identified through the CMS Medicare Advantage State/County/Contract data file for February 2008) receive Medicare benefits through managed care plans, they do not generate extra payments based on MA plan payment rates.[iii] Cost beneficiaries were removed from the Medicare Advantage enrollee totals by county but are included in the number of overall Medicare beneficiaries.

This analysis follows a methodological convention developed by the Medicare Payment Advisory Commission (MedPAC) in addressing the Medicare policy of making direct payments to teaching hospitals for the costs of indirect medical education (IME) for MA enrollees. MedPAC 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 x GME), where GME is the county graduate medical education carve-out and 0.65 represents the national average percentage of GME payments that goes to IME; county-specific data are unavailable. Because Medicare makes IME payments directly to teaching hospitals for patients who are enrolled in Medicare Advantage, MA plan payment rates are most appropriately compared with fee-for-service costs adjusted in this manner.[iv]

Budget-neutral risk adjustments to 2008 payments to Medicare Advantage plans provide additional extra payments to MA plans. This analysis of extra payments includes a budget-neutral risk adjustment of 1.0169 for 2008.[v]

Notes to Study Methods

[i] Centers for Medicare and Medicaid Services, Rate Calculation Data Risk 2008 spreadsheet (Baltimore, Md.: CMS, Apr. 2007), available at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/.

[ii] Centers for Medicare and Medicaid Services, Medicare Advantage State/County/Contract Data (Baltimore, Md.: CMS, Feb. 2008), available at http://www.cms.hhs.gov/MCRAdvPartDEnrolData/; 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/.

[iii] Centers for Medicare and Medicaid Services, Medicare Advantage State/County/Contract Data (Baltimore, Md.: CMS, Feb. 2008), available at http://www.cms.hhs.gov/MCRAdvPartDEnrolData/.

[iv] Alternatively, indirect medical education amounts may be added to Medicare Advantage payment rates, and these adjusted rates are 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: All Medicare Advantage Organizations and Other Interested Parties: Announcement of Calendar Year (CY) 2008 Medicare Advantage Capitation Rates and Payment Policies" (Baltimore, Md.: CMS, Apr. 2007), available at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/.

Note: This brief's analysis for the years 2004–2007 utilizes the same methods described above. Enrollment and beneficiary totals are from December of each year.

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