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Issue Brief

The Continuing Cost of Privatization: Extra Payments to Medicare Advantage Plans Jump to $11.4 Billion in 2009

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ABSTRACT: The Medicare Modernization Act of 2003 explicitly increased Medicare payments to private Medicare Advantage (MA) plans. As a result, MA plans have, for the past six years, been paid more for their enrollees than they would be expected to cost in traditional fee-for-service Medicare. Payments to MA plans in 2009 are projected to be 13 percent greater than the corresponding costs in traditional Medicare—an average of $1,138 per MA plan enrollee, for a total of $11.4 billion. Although the extra payments are used to provide enrollees additional benefits, those benefits are not available to all beneficiaries—but they are financed by general program funds. If payments to MA plans were instead equal to the spending level under traditional Medicare, the more than $150 billion in savings over 10 years could be used to finance improved benefits for the low-income elderly and disabled, or for expanding health-insurance coverage.

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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 increased payments to private health plans.

The higher level of payments for Medicare Advantage (MA) private plans 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, since 2004, the MMA policies have resulted in substantial extra payments—that is, payments that exceed comparable costs in traditional fee-for-service Medicare.

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As estimates began to indicate the magnitude of the extra payments to MA plans, Congress's perspective on these payment polices shifted.[2] The Deficit Reduction Act of 2005 used savings from phasing out MA budget-neutral risk adjustment (see discussion below) to offset the costs of deferring a scheduled reduction in Medicare payments to physicians. The Children's Health and Medicare Protection Act passed by the House of Representatives in 2007 contained provisions (which did not become law) that would have used a complete phaseout of MA extra payments to finance improved benefits for low-income Medicare beneficiaries, to defer additional physician payment cuts, and to improve benefits for low-income children in the State Children's Health Insurance Program.

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), enacted in July 2008, used savings from a phaseout of double payments to MA plans for indirect medical education costs (see below) to finance the deferral of additional scheduled reductions in physician payments. MIPPA also provided that, for the first time, most Private Fee-for-Service MA plans must, by January 2011, have contracts with physicians and other providers (i.e., establish provider networks).

As the Obama administration and the 111th Congress prepared to take office, more attention focused on MA overpayments. In fall 2008, the Obama campaign said: "We need to eliminate the excessive subsidies to Medicare Advantage plans and pay them the same amount it would cost to treat the same patients under regular Medicare."[3] More recently, the president said: "We are spending a lot of money subsidizing the insurance companies around something called Medicare Advantage, a program that gives them subsidies to accept Medicare recipients but doesn't necessarily make people on Medicare healthier."[4] In November 2008, Senator Max Baucus, chair of the Senate Finance Committee, also called for the elimination of extra payments to MA plans: "Congress must act to level the playing field between traditional Medicare and Medicare Advantage payments and the Baucus plan would do so."[5]

The analysis in this paper updates our previous work on this issue[6] by using the latest data from February 2009 on actual enrollment in MA plans and on MA county benchmark payment rates for 2009 to estimate the extra payments made to MA plans in that year relative to what the same enrollees would have cost under traditional fee-for-service Medicare.[7] Based on those data, we calculate that payments to MA plans in 2009 exceed local fee-for-service costs by 13 percent, or an average of $1,138 for each of the 10 million Medicare enrollees in managed care,[8] for a national total of $11.4 billion.[9] This represents a 34 percent increase in MA extra payments from 2008 to 2009.[10]

In the six years since the MMA was enacted, from 2004 to 2009, extra payments to MA plans are estimated to total nearly $44 billion.[11]

MA PLAN PAYMENTS IN 2009

Medicare payments to MA plans in 2009 are based on four factors:

1. The setting of county-level benchmark rates according to rules specified in the MMA and subsequent legislation;
2. The inclusion of the fee-for-service payment adjustment for indirect medical education (IME) costs in the benchmark rates;
3. A budget-neutral risk-adjustment (BNRA) policy that was put in place to offset the impact of risk adjustment on MA payments; and
4. The submission of bids that represent the payment each plan would require to provide traditional Medicare benefits to its enrollees.

Medicare's payments to each plan are determined by comparing the bid submitted by the plan with the benchmark rate in each county it serves, as described below.

County Benchmark Rates. For 2009, the benchmark value used to establish payment rates for MA plans in each county is set at the highest of eight reference rates. The first four are based on payment levels

established in March 2004, trended forward to 2009; the other four are based on per capita fee-for-service spending in a base year, trended forward to 2009. The eight reference rates used to set the MA benchmark rate for each county are:

- A minimum rate, or floor, for large urban areas (areas with populations of more than 250,000), which in 2009 is set at $9,738 per enrollee annually.
- A floor for rural and smaller urban areas, which in 2009 is set at $8,811 per enrollee annually.
- A blended rate, which is a 50–50 combination of the base MA plan payment rate for the county in 2004 and the national average MA plan payment rate in that year, updated to 2009.[12]
- A rate that reflects a minimum increase from the county's MA plan payment level in 2004, updated to 2009.[13,14]
- A payment rate equal to 100 percent of estimated county per capita spending under traditional fee-for-service Medicare in 2004, updated to 2009.[15]
- A payment rate equal to 100 percent of estimated county per capita spending under traditional Medicare in 2005, updated to 2009.[16]
- A payment rate equal to 100 percent of estimated county per capita spending under traditional Medicare in 2007, updated to 2009. [16]
- A payment rate equal to 100 percent of projected county per capita spending under traditional Medicare in 2009. [16]

Because the benchmark rate for each county is the highest of these eight reference rates—which includes 100 percent of projected fee-for-service spending in 2009—that benchmark rate is, by definition, at least as high as what spending would have been expected to be for its enrollees had they been enrolled in traditional Medicare. On average, the county benchmark rates exceed projected fee-for-service spending by 16.7 percent in 2009.

Inclusion of Indirect Medical Education Payments in Benchmark Rates. The MMA in 2003 explicitly provided that the calculation of the MA benchmark rate for each county should include an amount that reflects payments made under traditional Medicare to teaching hospitals for their indirect medical education costs, despite the fact that Medicare separately makes IME payments directly to teaching hospitals for MA enrollees admitted to those hospitals, under a policy enacted in the Balanced Budget Act of 1997.

Medicare therefore effectively pays twice for IME costs related to MA plan members.[17] What's more, while the direct payment goes to the teaching hospitals for which it is intended, the amount included in the calculation of the benchmark rate goes only to the plan. Whether that amount is, in the end, passed on to the teaching hospitals that serve the plan's enrollees depends on the payment rates negotiated between each of those hospitals and the plan; but in any case, it is a double payment, because IME payments are made directly to the hospital. This double payment raises MA plan payments by about 2.2 percent in 2009.

The MIPPA legislation gradually phases out this component of MA payment rates beginning in 2010. This policy provides that the amount of IME payments to plans in each county will be reduced by 0.6 percentage points a year until it is eliminated. This provision, of course, will have no effect on MA payments in 2009. But even if the full effect of eliminating the double payment for IME were in place in 2009, MA plan payments would still exceed corresponding fee-for-service costs by 10.8 percent.

It should also be noted that, 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) adjustment to their fee-for-service Medicare payments. While DSH payments are included in the payment rates for MA plans, no DSH payments are

made directly to hospitals for MA patients; it is left to each plan to determine how much of the DSH amount, if any, it will pay to the hospitals that its enrollees use. Medicare DSH payments are generally not related to the costs that individual plans face, and an argument could be made that they, like IME payments, should be removed from the MA payment rates and instead 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 payment rates, they are not included in the calculations in this analysis. However, they could be considered as representing additional overpayments to MA plans.

Budget-Neutral Risk-Adjustment (BNRA) Policy. Medicare adjusts its payments to MA plans for each beneficiary who enrolls by a risk-adjustment factor that accounts for variation in beneficiaries' health status and other determinants of the expected cost of providing care to different enrollees. Because the risk-adjustment factor reflects variation in expected costs across the entire Medicare population, and because enrollees in MA plans tend to be healthier than the average Medicare beneficiary, risk adjustment has the effect of reducing total MA plan payments. Improvements in the risk-adjustment mechanism to provide more accurate adjustments, mandated in the Balanced Budget Act of 1997, were phased in beginning in 2000. To counteract the potential adverse effect on MA plan payments, the BNRA policy was implemented in 2003. This policy applied an across-the-board increase to MA payment rates in every county to offset reductions resulting from improved risk adjustment. With the application of the BNRA, the risk-adjustment mechanism could affect the distribution of MA payments across beneficiaries and plans, but aggregate MA payments would be unaffected. In 2005, the BNRA policy increased MA payments in every county by 4 percent.[18]

The Deficit Reduction Act of 2005 provided for a phaseout of this increase in MA benchmark rates, with only 55 percent of the BNRA applied in 2007, 40 percent in 2008, 25 percent in 2009, and 5 percent in 2010. By 2011, MA payment rates will no longer be adjusted by this factor.[19] In 2009, the BNRA policy will add approximately $900 million to MA payments.[20]

MA Plan Bidding Mechanism. Under the bidding mechanism established by the MMA, each MA plan submits a bid to represent the payment amount it would require for providing traditional Medicare benefits to its enrollees. The bid submitted by each plan is compared with the benchmark rate in each county it serves, and each plan receives from Medicare a payment rate equal to the benchmark rate (if its bid is equal to or greater than the benchmark rate), or its bid plus a "rebate" of 75 percent of the difference between the benchmark rate and the bid (if its bid is less than the benchmark rate). For plans with bids greater than the benchmark rate, Medicare beneficiaries must pay the difference between the bid and the benchmark to enroll in the plan. Plans with bids less than the benchmark rate must either provide benefits beyond what is covered by traditional Medicare or provide for a reduction in enrollees' out-of-pocket payments equal in actuarial value to the amount of the "rebate" payment. However, while these additional benefits may be attractive to MA plan enrollees—and, in fact, are thought to be the primary factor in spurring the sharp increase in MA enrollment over the past few years—they are available only to those enrollees and not to other beneficiaries, even though they are funded out of general program funds.

It should be noted that while "bid" is the term the MMA uses for the amount submitted by each MA plan, it may not be just any amount the plan prefers but must be calculated by following the detailed "Instructions for Completing the Medicare Advantage Bid Pricing Tool."[21] The bid may thus be viewed as a kind of Medicare cost report for MA plans, and it is auditable by the Centers for Medicare and Medicaid Services.

Under this bidding mechanism, plans generally receive payments in excess of their estimated cost of providing traditional Medicare benefits to their enrollees. Because of this, the average bid submitted by

plans has tended to drift upward over time. In 2009, the average MA plan bid was approximately 102 percent of the corresponding Medicare fee-for-service costs in the plan's service areas, although these bids varied considerably across types of plans: for health maintenance organizations (HMOs), the average bid was 98 percent of local fee-for-service costs; for private fee-for-service plans, the average bid was 113 percent of local fee-for-service costs.[22]

VARIATION IN EXTRA PAYMENTS IN 2009

The overall pattern of Medicare extra payments to MA plans in 2009 can be discerned by focusing on plans located in counties with three types of MA plan payments.

"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 $6 billion, or 53 percent of the $11.4 billion in total extra payments in 2009. Extra payments to plans in these counties are estimated to average $1,361, or 17 percent, more per plan enrollee than the same person would be expected to cost under traditional fee-for-service Medicare.

"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 $3.4 billion, accounting for 30 percent of total extra payments nationwide. This seemingly anomalous finding—payments based on 100 percent of fee-for-service costs exceeding fee-for-service costs—is the result of three of the policies described above, which add to MA payments relative to patient care costs under traditional Medicare:

- First, the BNRA policy adds 0.9 percent to the MA benchmarks in every county in 2009.
- Second, the inclusion of the IME payment to MA plans adds 2.2 percent, on average, to those benchmarks.
- Third, and most important in this context, the MA rebasing policy (the addition of new base years for determining 100 percent of fee-for-service costs) has a "ratchet up but never down" component. This means that the addition of new base years may increase rates in some counties, but it never reduces them. Under this policy, plans in counties in which fee-for-service costs are increasing at a slower rate that the national average are paid at 100 percent of their local fee-for-service costs in an earlier base year, with that rate updated to 2009 using the higher national rate of increase. The MA county benchmarks have been rebased in 2004, 2005, 2007, and 2009. The Congressional Budget Office (CBO) has estimated that eliminating the one-sided rebasing process for MA benchmarks would reduce Medicare spending by $61 billion over 10 years.[23]

Rural Counties. Despite the initial concern in 1997 over low MA payment rates in rural counties—which led to the implementation of the rural floor policy—MA extra payments do not flow disproportionately to Medicare plans in rural areas. While 18.9 percent of Medicare beneficiaries live in counties where MA payment rates are determined by the rural floor benchmark, in 2009 only $1.3 billion, or 11 percent, of MA extra payments go to plans in these counties. (The distribution of MA extra payments and enrollees by payment category is displayed in Appendix Tables 1 and 2.)

Extra payments to MA plans in 2009 vary greatly by state (see Appendix Table 3). Three patterns of MA extra payments across states are particularly important:

- First, the states with the greatest extra payments per MA enrollee are, due to the urban floor policy, generally the ones with the lowest per capita fee-for-service costs. While Virginia's Medicare fee-for-service costs are 14 percent below the national average, Florida's are 12 percent above.[24]

  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 bonus for beneficiaries to enroll in plans in states with high fee-for-service costs. Plans in states where fee-for-service costs are already low thus are disproportionately rewarded by these extra payments, compared with plans in high-cost states. In fact, many of the states with low fee-for-service costs already have a high managed-care presence. Hawaii and Oregon, for example, are states where Kaiser Permanente has been a major presence for the 60 years since the formation of the insurance plan after World War II.

- Second, the total amount of extra payments to MA plans is highly concentrated among a relatively small number of states. In 2009, California and New York accounted for over 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.
- Third, after 11 years of MA rural floor payments in excess of 100 percent of average fee-for-service costs, fewer than 15 percent of Medicare beneficiaries in rural counties are enrolled in MA plans in 2009, compared with nearly 25 percent of beneficiaries in urban counties. 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 in commercial health insurance and Medicare. Moreover, MA plans that do operate in rural areas tend to be more expensive to Medicare than the fee-for-service program.[25]

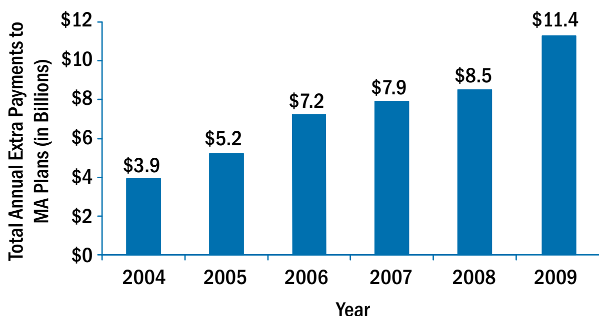
MA PLAN EXTRA PAYMENTS SINCE 2003

The MMA increased MA payment rates beginning in March 2004. Since then, MA payment benchmarks have exceeded costs in traditional fee-for-service Medicare for every plan in every county in the nation. The annual amount of these extra payments has increased from $3.9 billion in 2004 to $11.4 billion in 2009 (Figure 1), with a cumulative six-year cost of $44 billion.

Total extra payments have increased because of growth in the amount of extra payments per MA plan enrollee and growth in the total number of enrollees:

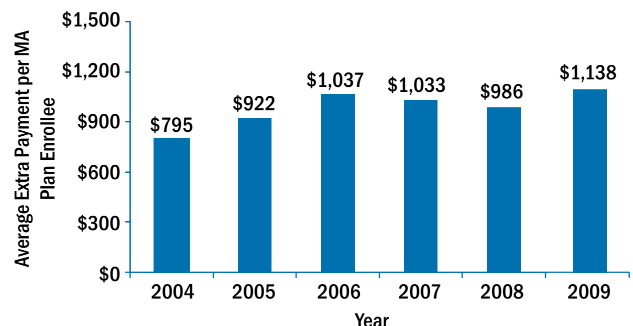
- Extra payments per enrollee were $795, or 11.9 percent above fee-for-service costs in 2004, rose to $1,037, or 14.1 percent above fee-for-service costs in 2006, and are at $1,138, or 13 percent above fee-for-service costs in 2009 (Figure 2).

Figure 1. Trends in Total Extra Payments to Medicare Advantage (MA) Plans, 2004–2009



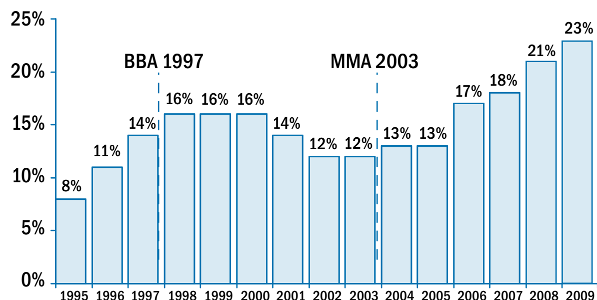
Sources: George Washington University analysis of Centers for Medicare and Medicaid Services (CMS) Medicare Advantage enrollment and payment rate data for 2004–2009, and Medicare Payment Advisory Commission analysis of MA plan bids for 2006–2009.

Figure 2. Trends in Average Extra Payment per Medicare Advantage (MA) Plan Enrollee, 2004–2009



Source: George Washington University analysis of Centers for Medicare and Medicaid Services (CMS) MA enrollment and payment rate data for 2004–2009, and Medicare Payment Advisory Commission analysis of MA plan bids for 2006–2009.

Figure 3. Enrollment in Medicare Managed Care Plans as Percentage of Total Medicare Beneficiaries, 1995–2009



Source: Centers for Medicare and Medicaid Services (CMS) Medicare and Medicare managed care enrollment data 1966-2001, 2002-2009. Data for 2003, 2004, 2005, and 2008 are for the quarters ending in December of those years. Data for 2009 are as of February 2009.

Figure 4. Estimated Savings from Implementation of Policy to Reduce Payments to Medicare Advantage (MA) Plans to 100 Percent of Fee-for-Service Costs, 2010–2019

Source: George Washington University estimates, based on Congressional Budget Office, *Budget Options, Volume 1: Health Care* (CBO, Dec. 2008), p.119.

- Meanwhile, the number of Medicare beneficiaries enrolled in MA plans has increased from 4.8 million in 2004, or 13 percent of Medicare beneficiaries, to over 10 million in February 2009, or 23 percent of Medicare beneficiaries (Figure 3).

The CBO has attributed the increase in MA enrollment to the extra payments received by MA plans. They projected in 2007 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.[26] The CBO also estimated in December 2008 that the resulting reduction in Medicare spending would total $55 billion over the five years from 2010 through 2014, and $157 billion over the 10 years from 2010 through 2019 (Figure 4).[27]

CONCLUSIONS

Current MA payment policies, enacted beginning with the MMA in 2003, have spurred greater enrollment in Medicare private plans at substantially higher costs to Medicare. This is primarily due to extra payments—payments in excess of Medicare fee-for-service costs—going to private plans. In 2009, for each of the 10 million Medicare enrollees in managed care, Medicare will spend an average of $1,138, or 13 percent, more than it would for comparable beneficiaries in traditional fee-for-service Medicare, with extra payments to MA plans totaling $11.4 billion.

These extra payments vary widely across geographic areas: the average annual amount per MA enrollee by state ranges from $2,521, or 38 percent above average fee-for-service costs, in Hawaii, to $159, or 2 percent above average fee-for-service costs, in Nevada.

Overall, extra payments to MA private plans have increased Medicare costs by $44 billion in the six years since the MMA was implemented. Even with the changes enacted in 2008 as part of MIPPA, the CBO projects that MA extra payments will add more than $150 billion to Medicare costs over the next 10 years.

The initial rationale for paying Medicare more than costs in fee-for-service—to bring plans to rural areas and benefits to rural beneficiaries—has not been borne out. Ten years after the rural payment floor was established by the Balanced Budget Act of 1997, payments of 14 percent above average fee-for-services costs have resulted in the enrollment of only 15 percent of rural beneficiaries in MA plans. Counties where the rural floor applies contain 19 percent of total Medicare beneficiaries but receive only 11 percent of extra payments, because the vast majority of their beneficiaries, 85 percent, remain in traditional Medicare. Moreover, the MA plans in those areas tend to be more expensive than traditional fee-for-service Medicare. If the goal of special policies for rural areas

is to improve health services to the elderly and disabled who live in those areas, redirecting the $1.3 billion a year in extra payments away from rural MA plans to increase payments to rural physicians and hospitals would be a more effective—and far more equitable—approach.

The projected $150 billion-plus in extra payments nationwide over the next 10 years could similarly be better used. In Medicare, these funds could help offset the costs of benefit improvements for low-income beneficiaries, such as reducing Part B premiums, increasing eligibility for low-income subsidies in Medicare Part D, or reducing Part D copayments. The $150 billion could also offset part of the more than $1.2 trillion projected 10-year cost of expanding health insurance to 47 million uninsured Americans.

Given the positions taken by the Obama campaign and comments by the president since the election—that Medicare private plans should be paid the same as costs in traditional fee-for-service Medicare—future analysis of MA plan payments may focus on the most equitable way to make those payments more comparable to Medicare fee-for-service costs. While Medicare plan payments have been based on fee-for-service costs at the county level since 1992, there has been discussion of new rates based on a blend of national and local county fee-for-service costs, or on broad metropolitan area and state average costs. These payment policies would result in some plans continuing to be paid more than local fee-for-service costs, while others would be paid less than costs in the county. Such a policy could be used to provide increased incentives for private plans to reduce costs in high-cost areas. But it would have to be structured in a way that allows private plans to better accomplish their intended role—to develop innovations in quality, efficiency, and patient service; to spur traditional Medicare to better performance; and to offer beneficiaries a choice of the best of both worlds.

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. For an early estimate, see B. Biles, L. H. Nicholas, and B. S. Cooper, *The Cost of Privatization: Extra Payments to Medicare Advantage Plans* (New York: The Commonwealth Fund, Dec. 2004).

3. Barack Obama and Joe Biden's Health Care Plan, Sept. 2008. Accessed at www.barackobama.com.

4. Barack Obama on *This Week with George Stephanopoulos,* ABC News, Jan. 11, 2009.

5. M. Baucus, *Call to Action: Health Reform 2009,* Nov. 12, 2008. Accessed at: http://finance.senate.gov/healthreform2009/home.html.

6. B. Biles, E. Adrion, and S. Guterman, *The Continuing Cost of Privatization: Extra Payments to Medicare Advantage* (New York: The Commonwealth Fund, Sept. 2008).

7. In this analysis, payments to MA plans in each area are set at the national average of 4 percentage points less than benchmarks for 2009, following the calculation reported by Medicare Payment Advisory Commission (MedPAC) staff. MedPAC receives MA plan bid and payment information from the Centers for Medicare and Medicaid Services (CMS), but these data were unavailable to the authors because CMS does not make the actual amount of payments to individual plans available for analysis by nongovernmental organizations.

8. The total number of Medicare Advantage enrollees reported here excludes those in cost plans and in Puerto Rico, Guam, American Samoa, and the U.S. Virgin Islands.

9. This figure is comparable to recent analyses of extra payments performed by MedPAC, which released a report in 2009 that estimated 2009 payments to MA plans would be 114 percent of fee-for-service costs. See Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (Washington, D.C.: MedPAC, March 2009).

10. Between May 2008 and February 2009, extra payments to MA plans increased by 34 percent, from $8.5 billion to $11.4 billion. To explain this relatively high percentage increase, a variety of factors must be considered. The increase in extra payments is in large part due to the more rapid growth in MA plan payments than fee-for-service costs across the country. The national per capita MA growth percentage for 2009 is 4.24 percent from 2008. The growth in MA payments is reduced by a decrease in the budget-neutral risk adjustment (BNRA), which dropped from 1.7 percent in 2008 to 0.9 percent in 2009. However, fee-for-service costs increased by only 1.7 percent, less than half of the overall increase in MA plan payments. To isolate the overall impact of this unbalanced growth, if MA plan enrollment remained the same in 2009 as in 2008, extra payments to MA plans would have been $10.5 billion—a 23 percent increase from the $8.5 billion in extra payments for 2008. In addition, during this period, MA enrollment increased from 9.2 million to 10 million, or 8.5 percent. These 800,000 new MA plan enrollees account for $9.1 million, or 8 percent, of the 2009 extra payments.

11. The $44 billion figure is based on George Washington University analysis of enrollment and payments to MA plans in 2004 through 2009. Note: In estimating (in December 2003) the future costs of the Medicare Modernization Act of 2003 (MMA), 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 April 1, 2004.

12. The base Medicare Advantage rate for 2004 for each county is its 1997 risk plan rate, updated to 2004; the national average base Medicare Advantage rate for 2004 is the average base rate for 2004 across all counties, weighted by Medicare enrollment.

[13] Centers for Medicare and Medicaid Services, *Note to Medicare Advantage Organizations, Prescription Drug Plan Sponsors, and Other Interested Parties. Subject: Announcement of Calendar Year 2009 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies* (Washington, D.C.: CMS, April 2008), available at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2009.pdf.

[14] 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 2009 was 4.24 percent, payments in all counties were increased by at least that amount.

[15] This payment rate includes Medicare payments for indirect medical education 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 2.2 percent higher than actual Medicare fee-for-service costs.

[16] 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, 2007, and 2009. 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 Interested Parties. Subject: Advance Notice of Methodological Changes for Calendar Year (CY) 2005 Medicare Advantage (MA) Payment Rates* (Washington, D.C.: CMS, 2004); available at: http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Advance2005.pdf.

[17] 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 × 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, March 2002).

[18] B. Biles, L.H. Nicholas, B.S. Cooper, E. Adrion, and S. Guterman, *The Cost of Privatization: Extra Payments to Medicare Advantage Plans—Updated and Revised* (New York: The Commonwealth Fund, Nov. 2006).

[19] 2010 estimate based on Centers for Medicare and Medicaid Services, *Note to Medicare Advantage Organizations, Prescription Drug Plan Sponsors, and Other Interested Parties. Subject: Advance Notice of Methodological Changes for Calendar Year (CY) 2010 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies* (Washington, D.C.: CMS, Feb. 20, 2009), available at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Advance2010.pdf.

[20] The BNRA payment policy, originally implemented administratively but codified in the Deficit Reduction Act of 2005 (DRA), adds about $900,000 million to total extra payments in 2009. This is less than the $1.8 billion 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.

[21] Centers for Medicare and Medicaid Services, *Instructions for Completing the Medicare Advantage Bid Pricing Tool and Medical Savings Account Bid Pricing Tool for Contract Year 2009* (Washington, D.C.: CMS April 7, 2008) available at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/09_Bid_Forms_and_Instructions.asp.

[22] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, chapter 3.

[23] Congressional Budget Office, *Budget Options Volume 1: Health Care*, p. 123 (Washington, D.C.: CBO Dec. 2008) available at http://www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf.

[24] George Washington University analysis of Centers for Medicare and Medicaid Services Medicare Managed Care State/County/Contract Data File, released February 2009; Medicare Managed Care State/County Penetration Data File, released Feb. 2009; and the Medicare Advantage 2009 Rate Calculation Data Spreadsheet.

[25] See B. Biles, E. Adrion, and S. Guterman, *Medicare Advantage's Private Fee-for-Service Plans: Paying for Coordinated Care Without the Coordination* (New York: The Commonwealth Fund, Oct. 2008).

[26] 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).

[27] Congressional Budget Office, Budget Options Volume 1: Health Care," p.119.

Appendix Table 1. Estimated Extra Payments in 2009, by County Payment Category, to Medicare Advantage (MA) Plans Relative to Average Fee-for-Service (FFS) Costs[1]

				Average MA Plan Payment Greater than FFS Costs[2,3]	
County Payment Type	Medicare Beneficiaries[4]	MA Plan Enrollees[5]	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	44,575,208	10,014,280	$11,396	$1,138	13.0%
Rural Floor	8,402,542	1,230,122	1,282	1,042	13.9%
Urban Floor	17,801,463	4,412,726	6,004	1,361	16.8%
Blend	419,735	138,824	238	1,714	20.8%
Minimum Update	886,265	228,259	422	1,850	18.5%
100% FFS 2004[6]	11,579,729	2,869,501	2,873	1,001	10.6%
100% FFS 2005 [6]	2,467,028	432,088	364	842	8.8%
100% FFS 2007[6]	1,870,204	374,959	305	813	8.1%
100% FFS 2009[6]	1,148,242	327,801	-92	-281	-2.2%

Source: George Washington University analysis of Centers for Medicare and Medicaid Services (CMS) Medicare Managed Care State/County/Contract Data File, released February 2009; Medicare Managed Care State/County Penetration Data File, released February 2009; and the Medicare Advantage 2009 Rate Calculation Data Spreadsheet.

[1] Payments to MA plans include the cost of indirect medical education payments and a budget-neutral risk adjustment of 1.009.

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

[3] In 2006 and future years, the Medicare Modernization Act of 2003 (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 percent of the difference between the county benchmark and the MA plan bid to the plan and 25 percent to the federal government if the plan's bid falls below the benchmark. If the plan's bid lies above the benchmark, the plan is paid the benchmark, and plan enrollees pay the difference between the benchmark and the plan bid in the form of premiums. Analysts at the Medicare Payment Advisory Commission (MedPAC) who have studied Medicare private-plan payments and costs have found that, for 2009, the average MA plan bid is approximately 16 percent less than the county benchmark. This would result in average MA plan payments equal to a 4 percent reduction from the county benchmark. The above calculations account for the fact that average MA plan bids fall 16 percent below the 2009 MA benchmark rates. See: Medicare Payment Advisory Commission, "Medicare Advantage Program," MedPAC Public Meeting, Dec. 5, 2008 (Washington, D.C.: MedPAC, 2008).

[4] Medicare beneficiary totals as of February 2009. Calculations exclude Medicare beneficiaries in Puerto Rico, Guam, American Samoa, and the U.S. Virgin Islands.

[5] Medicare Advantage enrollment data as of February 2009. Calculations exclude MA enrollees in Puerto Rico, Guam, American Samoa, and the U.S. Virgin Islands.

[6] CMS decided to rebase the 100 percent of FFS rate at the county level in 2005, 2007, and 2009. 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 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 (Washington, D.C.: CMS, March 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 percent of FFS rate or the 2006 rate increased by 7.1 percent. 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, April 3, 2006), available at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/factsheet2007.pdf, accessed May 30, 2006.

For 2009, the county-level payment rate for MA plans was the higher of the 2009 rebased 100 percent of FFS rate or the 2008 rate increased by 4.24 percent. See: Centers for Medicare and Medicaid Services, *Note to Medicare Advantage Organizations, Prescription Drug Plan Sponsors, and Other Interested Parties. Subject: Announcement of Calendar Year 2009 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies* (Washington, D.C.: CMS, April 2008), available at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2009.pdf.

Appendix Table 2. 2009 Distributions, by County Payment Category, of Medicare Beneficiaries, Medicare Advantage (MA) Plan Enrollees, MA Enrollment Rates, and Estimated 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%	22.5%	100.0%
Rural Floor	18.9%	12.3%	14.6%	11.3%
Urban Floor	39.9%	44.1%	24.8%	52.7%
Blend	0.9%	1.4%	33.1%	2.1%
Minimum Update	2.0%	2.3%	25.8%	3.7%
100% FFS 2004[1]	26.0%	28.7%	24.8%	25.2%
100% FFS 2005[1]	5.5%	4.3%	17.5%	3.2%
100% FFS 2007[1]	4.2%	3.7%	20.0%	2.7%
100% FFS 2009[1]	2.6%	3.3%	28.5%	-0.8%

Source: George Washington University analysis of Centers for Medicare and Medicaid Services (CMS) Medicare Managed Care State/County/Contract Data File, released February 2009; Medicare Managed Care State/County Penetration Data File, released February 2009; and the Medicare Advantage 2009 Rate Calculation Data Spreadsheet.

[1] CMS decided to rebase the 100 percent of fee-for-service (FFS) rate at the county level in 2005, 2007, and 2009. 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 Medicare Modernization Act of 2003 (MMA) provided that the county-level payment rate for MA plans in 2005 be 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* (Washington, D.C.: CMS, March 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 percent of FFS rate or the 2006 rate increased by 7.1 percent. 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, April 3, 2006), available at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/factsheet2007.pdf, accessed May 30, 2006.

For 2009, the county level payment rate for MA plans was the higher of the 2009 rebased 100 percent of FFS rate or the 2008 rate increased by 4.24 percent. See: Centers for Medicare and Medicaid Services, *Note to Medicare Advantage Organizations, Prescription Drug Plan Sponsors, and Other Interested Parties. Subject: Announcement of Calendar Year 2009 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies* (Washington, D.C.: CMS, April 2008), available at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2009.pdf.

Appendix Table 3. Estimated Extra Payments to Medicare Advantage (MA) Plans in 2009 Compared with Average Fee-for-Service (FFS) Costs, by State[1]

State	Medicare Beneficiaries[4]	MA Plan Enrollees[5]	MA Plan Enrollment Rate	Average MA Plan Payment Greater than FFS Costs[2,3]		
				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	44,575,208	10,014,280	22.5%	$1,138	$11,396	13.0%
Rural[6]	13,413,831	1,887,657	14.1%	969	1,828	12.2%
Urban[6]	31,151,025	8,126,490	26.1%	1,177	9,567	13.2%
Alabama	813,060	170,929	21.0%	842	144	9.8%
Alaska	60,875	640	1.1%	1,218	1	13.7%
Arizona	876,576	323,823	36.9%	856	277	10.1%
Arkansas	511,604	67,808	13.3%	1,106	75	14.0%
California	4,528,527	1,570,931	34.7%	1,107	1,739	12.0%
Colorado	585,726	173,014	29.5%	974	168	11.5%
Connecticut	550,462	87,916	16.0%	605	53	6.7%
Delaware	141,606	6,627	4.7%	719	5	8.6%
D.C.	75,338	3,244	4.3%	1,745	6	19.1%
Florida	3,226,443	922,369	28.6%	310	286	3.0%
Georgia	1,165,638	169,945	14.6%	1,127	192	13.8%
Hawaii	195,961	37,902	19.3%	2,521	96	37.8%
Idaho	216,070	57,219	26.5%	1,516	87	20.2%
Illinois	1,781,355	168,079	9.4%	696	117	7.9%
Indiana	967,042	132,303	13.7%	1,281	169	16.3%
Iowa	506,384	56,193	11.1%	1,662	93	23.2%
Kansas	419,221	40,914	9.8%	1,210	49	14.8%
Kentucky	731,038	103,977	14.2%	975	101	12.0%
Louisiana	660,165	146,528	22.2%	1,699	249	17.1%
Maine	254,820	23,921	9.4%	1,574	38	21.5%
Maryland	748,964	36,215	4.8%	425	15	4.3%
Massachusetts	1,022,653	195,785	19.1%	1,130	221	12.7%
Michigan	1,586,269	380,956	24.0%	832	317	9.7%
Minnesota	753,649	175,517	23.3%	737	129	8.8%
Mississippi	480,458	43,827	9.1%	745	33	8.3%
Missouri	969,993	190,434	19.6%	1,344	256	16.7%
Montana	161,569	27,046	16.7%	1,153	31	15.6%
Nebraska	272,077	29,612	10.9%	1,088	32	13.7%
Nevada	333,754	102,927	30.8%	159	16	1.6%
New Hampshire	206,719	12,229	5.9%	1,212	15	15.2%
New Jersey	1,286,869	152,989	11.9%	810	124	8.7%
New Mexico	296,739	71,462	24.1%	2,211	158	31.8%
New York	2,901,918	822,535	28.3%	1,682	1,383	18.7%

State	Medicare Beneficiaries[4]	MA Plan Enrollees[5]	MA Plan Enrollment Rate	Average MA Plan Payment Greater than FFS Costs[2,3]		
				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	1,412,487	244,055	17.3%	1,436	350	18.4%
North Dakota	106,505	6,984	6.6%	1,328	9	18.4%
Ohio	1,842,533	471,989	25.6%	1,166	551	14.3%
Oklahoma	581,751	83,262	14.3%	513	43	5.6%
Oregon	588,158	244,823	41.6%	1,767	433	23.7%
Pennsylvania	2,226,572	842,648	37.8%	1,167	984	13.7%
Rhode Island	178,103	64,713	36.3%	1,609	104	20.6%
South Carolina	727,532	105,515	14.5%	1,189	125	14.9%
South Dakota	132,589	9,424	7.1%	1,320	12	18.2%
Tennessee	1,007,941	221,207	21.9%	1,046	231	12.7%
Texas	2,831,789	488,491	17.3%	1,550	757	16.1%
Utah	266,656	79,422	29.8%	1,320	105	16.7%
Vermont	105,684	3,800	3.6%	1,244	5	17.1%
Virginia	1,087,696	132,793	12.2%	1,764	234	24.0%
Washington	910,452	215,825	23.7%	1,600	345	21.0%
West Virginia	373,490	73,546	19.7%	1,250	92	16.0%
Wisconsin	877,725	216,329	24.6%	1,551	336	20.8%
Wyoming	76,549	3,638	4.8%	784	3	9.8%

Source: George Washington University analysis of Centers for Medicare and Medicaid Services (CMS) Medicare Managed Care State/County/Contract Data File, released February 2009; Medicare Managed Care State/County Penetration Data File, released February 2009; and the Medicare Advantage 2009 Rate Calculation Data Spreadsheet.

[1] Payments to MA plans include the cost of indirect medical education payments and a budget-neutral risk adjustment of 1.009.

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

[3] In 2006 and future years, the Medicare Modernization Act of 2003 (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 percent of the difference between the county benchmark and the MA plan bid to the plan and 25 percent to the federal government if the plan's bid falls below the benchmark. If the plan's bid lies above the benchmark, the plan is paid the benchmark, and plan enrollees pay the difference between the benchmark and the plan bid in the form of premiums. Analysts at the Medicare Payment Advisory Commission (MedPAC) who have studied Medicare private-plan payments and costs have found that, for 2009, the average MA plan bid is approximately 16 percent less than the county benchmark. This would result in MA plan payments equal to a 4 percent reduction from the county benchmark. The above calculations account for the fact that average MA plan bids fall 16 percent below the 2009 MA benchmark rates.

See: Medicare Payment Advisory Commission, "Medicare Advantage Program," MedPAC Public Meeting, Dec. 5, 2008 (Washington, D.C.: MedPAC, 2008).

[4] Medicare beneficiary totals as of February 2009. Calculations exclude Medicare beneficiaries in Puerto Rico, Guam, American Samoa, and the U.S. Virgin Islands.

[5] Medicare Advantage enrollment data as of February 2009. Calculations exclude MA enrollees in Puerto Rico, Guam, American Samoa, and the U.S. Virgin Islands.

[6] County designations from the 2005 American Community Survey.

Study Methods

This report's 2009 analysis is based on Medicare Advantage payment rates and fee-for-service expenditure averages posted by county in the 2009 Medicare Advantage Rate Calculation Data spreadsheet of the Centers for Medicare and Medicaid Services (CMS).[i] The number of Medicare beneficiaries and Medicare Advantage enrollees by county is taken from the CMS State/County Penetration Data file and the CMS State/County/Contract Data file for February 2009. These data are posted on the CMS Website, 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 2009, Medicare benchmark rates for MA plans in each county are set at the highest of eight 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 2009; a payment rate equal to 100 percent of per capita fee-for-service costs in the county in 2005, trended forward to 2009; a payment rate equal to 100 percent of per capita fee-for-service costs in the county in 2007, trended forward to 2009; or a payment rate equal to 100 percent of per capita fee-for-service costs in the county in 2009. The MMA provides for the annual minimum increase in MA plan payments to be the Medicare national growth-rate percentage in fee-for-service expenditures, which is 4.24 percent for 2009.

Extra payments to Medicare Advantage plans are calculated for each of the more than 3,000 counties in the United States in 2009. Puerto Rico, Guam, American Samoa, 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 2009) 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 2009 payments to Medicare Advantage plans provide additional extra payments to MA plans. This analysis of extra payments includes a budget-neutral risk adjustment of 1.009 for 2009.[v]

Notes to Study Methods

[i] Centers for Medicare and Medicaid Services, *Rate Calculation Data Risk 2009 spreadsheet* (Baltimore, Md.: CMS, April 2008), available at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/.

[ii] Centers for Medicare and Medicaid Services, *Monthly Medicare Advantage State/County/Contract Data and Monthly Medicare Advantage State/County Penetration Data* (Baltimore, Md.: CMS, Feb. 2009), available at http://www.cms.hhs.gov/MCRAdvPartDEnrolData/.

[iii] Centers for Medicare and Medicaid Services, *Monthly Medicare Advantage State/County/Contract Data.*

[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 Medicare Advantage Organizations, Prescription Drug Plan Sponsors, and Other Interested Parties. Subject: Announcement of Calendar Year 2009 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies.*

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