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Issue Brief

Medicare Advantage in the Era of Health Reform: Progress in Leveling the Playing Field

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ABSTRACT: Payments to private Medicare Advantage (MA) plans have exceeded Medicare fee-for-service (FFS) costs since those payments were increased by the Medicare Modernization Act of 2003 (MMA). Payments to MA plans in 2010 exceeded average costs in FFS Medicare nationally by 8.9 percent, a total of $8.9 billion. While these extra payments are substantial, they represent a decrease relative to 2009, when MA payments were 13.0 percent, or $11.4 billion, greater than FFS costs. The decrease in MA payments relative to FFS costs, while mostly resulting from policy decisions and other factors not directly related to the health reform law, begins to shift MA payments toward levels mandated in the provisions that are set to go into effect in 2012.

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OVERVIEW

A goal of the Medicare private plan program since its inception in 1982 has been to provide a more-efficient model of care to beneficiaries than the unorganized fee-for-service (FFS) payment system used by traditional Medicare. Expecting that private plans had the potential to be more flexible and efficient than FFS Medicare in meeting the needs of their enrollees, Medicare originally set payment rates for these plans, by county, at 95 percent of per beneficiary FFS costs.[1]

The Balanced Budget Act of 1997 (BBA) loosened the relationship between private plan payments and county-specific FFS costs. The Act also caused Medicare spending growth to slow across the board, and many private plans consequently withdrew from Medicare altogether, or from geographical areas that they found to be less profitable than they would have liked.

Policies to offset this trend culminated in the Medicare Modernization Act of 2003 (MMA). Medicare increased payments so that private plans in virtually every county in the nation were paid more per enrollee than the average cost per beneficiary in FFS Medicare in the same county. In 2009, Medicare paid an average of 13.0 percent more, an extra $11.4 billion, for enrollees in private plans

(now known as Medicare Advantage, or MA, plans) than if those beneficiaries had been in FFS Medicare.

Although these changes were intended to encourage private plan participation in Medicare, it has been argued that policies that pay MA plans more than FFS Medicare are contrary to the longtime goal of the Medicare private plan program, because they diminish plans' incentive to provide care more efficiently.

The Medicare Payment Advisory Commission (MedPAC) restated this goal in 2009 and recommended that MA plan payments be set equal to Medicare FFS costs throughout the country:

The Commission has maintained that 100 percent of FFS is the correct target for benchmarks because it would encourage plans that are more efficient than Medicare FFS. An MA plan that is more efficient than Medicare FFS could provide the traditional benefit at a lower cost and would be able to provide additional benefits to beneficiaries, who would be encouraged to enroll in the plan. An MA plan that is not more efficient than FFS Medicare would likely not enter the program.[2]

Following this approach, the health reform legislation (the Patient Protection and Affordable Care Act, as revised by the Health Care and Education Affordability Reconciliation Act) enacted in March 2010 reduces payments to MA plans to amounts more closely related to the level of average costs in FFS Medicare. The Congressional Budget Office (CBO) projected that this policy would yield Medicare savings of $132 billion over the period from 2010 through 2019.

The CBO also projects that MA payment policies in the final health reform law[3] will set payments to MA plans at a national average of 101 percent of FFS costs.[4] The implementation of the new payment system for MA plans begins in 2012 and will be phased in through 2017.

One important feature of the new payment system is that it will, for the first time, provide additional payments to MA plans with higher scores on the Centers for Medicare and Medicare Services (CMS) plan performance rating system. This change will put more emphasis on plan performance; moreover, as a result of this new emphasis, CMS is reviewing ways to improve the way MA plan performance is measured.

A previous working paper, "Medicare Advantage Provisions: The Health Care and Education Affordability Reconciliation Act H.R. 4872," gives a description and analysis of the impact of the new MA payment system.[5] This issue brief examines the amount and distribution of payments to MA plans in 2010, statistics that will serve as a baseline for studying the impact of MA payment policies, because 2010 was the final year of payments to MA plans under the pre-health reform policies.

For this analysis, we have available for the first time data on MA plan payments net of rebate at the county level, which permit more accurate calculation of the distribution of MA payments relative to FFS costs than previous analyses.[6] This analysis also uses the most recent county-level data on MA benchmarks in 2010 and the distribution of enrollment in MA plans in April 2010.

FACTORS AFFECTING MEDICARE ADVANTAGE PLAN PAYMENTS IN 2010

We estimate that in 2010, MA payments per enrollee exceeded average costs in FFS Medicare nationally by 8.9 percent ($8.9 billion), or $814 per enrollee. While these amounts are substantial, they are less than in 2009, when MA payments per enrollee exceeded average costs in FFS Medicare by a national average of 13.0 percent ($11.4 billion), or $1,138 per enrollee (Exhibit 1).[7]

This reduction in payments to MA plans relative to FFS costs is the first since the enactment of the MMA in December 2003. While the reduction is consistent with the aims embodied in the provisions of the health reform law, it is not related to those provisions; the new policies do not begin to take effect until 2012. Rather, this change is the result, mainly, of the following five factors:

- A delay in the resolution of Medicare physician payment reductions for 2010 that were mandated

by law but, in the end, overridden by Congress. This raised FFS costs in 2010, but was too late to affect the setting of MA payments for that year. The ratio of MA payments to Medicare FFS costs was reduced by an average of roughly 4 percentage points.

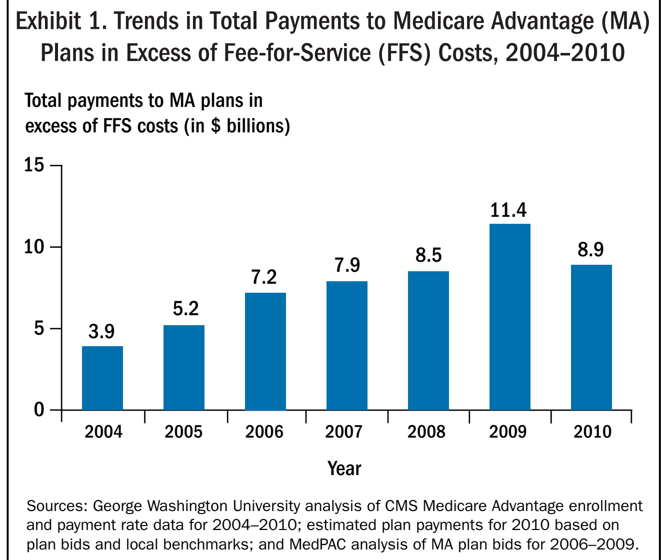
- The beginning of a phaseout of the double payment for indirect medical education (IME), which reduced MA payments relative to what they would have been by an average of 0.5 percentage points.
- The continuation of a phaseout of the budget-neutral risk adjustment (BNRA), which had been implemented to prevent a reduction in aggregate payments to all MA plans when there was an improvement in the methodology used to adjust payments to MA plans to reflect enrollees' health status. The phaseout reduced MA payments in 2010 relative to what they would have been by 0.8 percentage points.
- An increase in the amount of plan bids (which represent the payments that plans say they would need to cover the costs of providing the traditional Medicare benefit package to their enrollees) relative to the benchmark rates set in each county, which increased MA payments relative to Medicare FFS costs by an average of 1.0 percent.[8]
- A payment correction for the estimated effects of changes in coding practices by MA plans, which reduced MA payments by 3.4 percent.[9]

Although MA plan payment rates per enrollee decreased relative to Medicare FFS costs in 2010, a continued increase in MA enrollment raised the total amount of payments received by those plans. MA enrollment rose from 10.0 million in February 2009 to 10.9 million in April 2010—an increase of 9 percent.

VARIATIONS IN PLAN PAYMENTS IN 2010

While MA payments in 2010 averaged 8.9 percent more than FFS costs nationwide, MA payments relative to FFS costs in counties varied substantially across the nation.

Exhibit 1. Trends in Total Payments to Medicare Advantage (MA) Plans in Excess of Fee-for-Service (FFS) Costs, 2004–2010



Sources: George Washington University analysis of CMS Medicare Advantage enrollment and payment rate data for 2004–2010; estimated plan payments for 2010 based on plan bids and local benchmarks; and MedPAC analysis of MA plan bids for 2006–2009.

This brief illustrates the pattern of payments to MA plans in 2010 by focusing on plan payments in counties grouped as follows: 1) range of Medicare FFS costs; 2) the health reform law payment policy cohorts (also related to the level of Medicare FFS costs) that will begin to go into effect in 2012; 3) the 100 counties in the United States with the largest number of Medicare beneficiaries; and 4) by state.

Counties Grouped by Medicare Fee-for-Service Costs

Although MA payments were closer to Medicare FFS costs than in previous years, MA payment policies in 2010 continued to result in wide variations. To analyze in more detail the relationship between Medicare FFS costs and MA payments across the nation, we ranked the 3,140 counties in the United States by Medicare FFS costs from lowest to highest and then divided them into 10 groups with approximately 1.1 million enrollees each.

Nationally, county FFS costs ranged from a low of less than $6,000 a year in a number of small rural counties in Montana, New Mexico, and Iowa, to a high of over $15,000 in Miami, Florida—a variation of more than 250 percent across individual counties.

Exhibit 2 shows that MA payments in 2010 relative to FFS costs were substantially higher in areas with low FFS costs than areas with high FFS costs—but, in nine of the 10 county groups (all but the group

Exhibit 2. Medicare Advantage (MA) Enrollment and Payments Relative to Medicare Fee-for-Service (FFS) Costs for Counties Grouped by per Beneficiary Fee-for-Service Costs, 2010

Counties grouped by per beneficiary FFS costs	MA enrollment	MA enrollment as a percent of all Medicare beneficiaries	Percent of MA enrollees living in rural counties	FFS costs per beneficiary	MA payments per enrollee relative to FFS costs per beneficiary	MA payments per enrollee in excess of FFS costs per beneficiary	Total MA payments in excess of FFS costs (in millions)
1 (lowest)	1,090,251	27%	48%	$7,251	127%	$1,930	$2,104
2	1,091,964	21%	42%	$7,843	118%	$1,397	$1,525
3	1,081,609	23%	27%	$8,236	114%	$1,176	$1,271
4	1,091,501	22%	23%	$8,529	111%	$976	$1,065
5	1,080,565	21%	26%	$8,830	109%	$793	$857
6	1,085,294	29%	9%	$9,114	106%	$558	$606
7	1,093,076	22%	11%	$9,428	107%	$619	$676
8	1,133,574	22%	12%	$9,818	105%	$518	$587
9	1,050,058	21%	4%	$10,499	103%	$329	$346
10 (highest)	1,089,712	37%	1%	$12,023	99%	–$166	–$181
National	**10,887,604**	**24%**	**19%**	**$9,156**	**109%**	**$814**	**$8,857**

with the highest FFS costs), MA plans received payments substantially in excess of what their enrollees would have expected under traditional FFS Medicare. Payments to MA plans in the counties with the lowest FFS costs exceeded FFS costs by $1,930 per enrollee, for a total $2.1 billion in "extra payments." Payments to the plans in the group with the second-to-highest FFS costs exceeded FFS costs by $329 per enrollee, for a total of $346 million. Payments in the county group with highest FFS costs averaged $166 less than FFS costs, with total Medicare savings of $181 million. Note, however, that the absolute level of MA plan payments in counties with the highest Medicare FFS costs was much higher in the high FFS cost counties than in the counties with lower costs—$11,857 per enrollee, compared with $9,970 nationwide and $9,181 for the group of counties with the lowest costs.

The counties in the groups with low FFS costs tend to have a higher proportion of rural enrollees while those with higher FFS costs are more urban. The county group with the lowest FFS costs was 48 percent rural, while the group with the highest FFS costs was only 1 percent rural.

Counties Grouped According to the Payment Cohorts in the Health Reform Law

The health reform law creates four new MA county payment cohorts. Counties will be rank-ordered by average FFS costs and then divided into four cohorts containing 785 counties each. Plans in the counties with the lowest FFS costs will have their benchmark rates set at 115 percent of county FFS costs; plans in the next-lowest county FFS cost quartile will have their benchmarks set at 107.5 percent of FFS costs; benchmark rates for plans in the next quartile of counties will be set at 100 percent of FFS costs; and plans in the quartile of counties with the highest FFS costs will have county-level benchmarks set at 95 percent of FFS costs.

Exhibit 3 displays the MA payments in 2010 for the new health reform law county payment cohorts and indicates that payments relative to FFS costs varied

substantially among plans in these four cohorts. In the lowest-cost counties (where the new health reform law payment benchmarks will be set at 115 percent of FFS costs), plans were paid 124 percent of local FFS costs, on average, in 2010; in the highest-cost counties (where the new benchmarks will be set at 95 percent of local FFS costs), plans were paid 103 percent of local FFS costs.

On a dollar basis, MA payments per MA enrollee in 2010 in the low-cost county cohort exceeded FFS costs by $1,766 per enrollee, while that difference was only $332 per enrollee in the high-cost county cohort—but, as pointed out above, the absolute payment amounts for plans in the higher-cost counties are substantially higher.

Also note that, although the payments that MA plans will receive once the new law takes effect will depend not only on the benchmark rates but also on the plan bids and their quality rating, the impact of the new law will be felt across all of the new cost cohorts. This impact is much more favorable to the low-cost areas than the alternative of an across-the-board reduction in MA payment rates to 100 percent of FFS costs.

Counties with Large Numbers of Medicare Beneficiaries

Analysis of MA payments in the 100 counties with the largest numbers of Medicare beneficiaries also indicates substantial variation. For plans in the four counties in this group with the lowest FFS costs, MA plan payments exceeded FFS costs by 26 percent, while in the four counties with the highest FFS costs, MA payments averaged 6 percent below FFS costs.[10] Again, though, it must be noted that the plans in the highest-cost counties have substantially higher absolute payment rates.

Among the 100 counties with the most Medicare beneficiaries, Exhibit 4 illustrates how MA plan payments exceed FFS costs in the four counties with the lowest, middle, and highest Medicare FFS costs, respectively. Payments ranged from 30 percent above local FFS costs in Bernalillo County, New Mexico (with an absolute average MA payment of $9,487 per enrollee) to 10 percent below local FFS costs in Dade County, Florida (with an average MA payment of $13,684 per enrollee). Note that each category contains

Exhibit 3. Medicare Advantage (MA) Enrollment and Payments Relative to Medicare Fee-for-Service (FFS) Costs for Counties Grouped by Payment Cohort (Quartiles According to FFS Costs) According to the Health Reform Law, 2010

County payment cohort	MA enrollment	MA enrollment as a percent of all Medicare beneficiaries	MA payment per enrollee relative to FFS costs per beneficiary	MA payments per enrollee in excess of FFS costs per beneficiary	Total MA payments in excess of FFS costs (in millions)
Lowest-cost quartile of counties (payment benchmarks set at 115% of FFS costs)	1,686,373	25%	124%	$1,766	$2,978
Second quartile (payment benchmarks set at 107.5% of FFS costs)	1,970,462	22%	114%	$1,181	$2,328
Third quartile (payment benchmarks set at 100% of FFS costs)	2,685,042	23%	109%	$760	$2,041
Highest-cost quartile of counties (payment benchmarks set at 95% of FFS costs)	4,545,727	25%	103%	$332	$1,511
National total	**10,887,604**	**24%**	**109%**	**$814**	**$8,857**

Note: The Health Reform Law will begin to take effect in 2012.

Exhibit 4. Medicare Advantage (MA) Enrollment and Payments Relative to Medicare Fee-for-Service (FFS) Costs in Selected High, Middle, and Low FFS Cost Counties, 2010[a]

	County	State	MA enrollment	MA enrollment as a percent of all Medicare beneficiaries	FFS costs per beneficiary	MA payments per enrollee	MA payments per enrollee relative to FFS costs per beneficiary	MA payments per enrollee in excess of FFS costs per beneficiary
Selected low-cost counties	Bernalillo	New Mexico	39,224	43%	$7,312	$9,487	130%	$2,175
	Erie	New York	89,338	52%	$7,367	$9,441	128%	$2,075
	Multnomah	Oregon	48,624	53%	$7,429	$9,480	128%	$2,051
	Salt Lake	Utah	37,612	37%	$8,105	$9,584	118%	$1,479
Selected middle-cost counties	Hillsborough	Florida	66,465	40%	$9,450	$9,723	103%	$272
	Ventura	California	28,667	27%	$9,458	$10,168	108%	$710
	Delaware	Pennsylvania	26,942	30%	$9,491	$10,368	109%	$876
	Montgomery	Maryland	2,983	3%	$9,529	$9,702	102%	$173
Selected high-cost counties	Bronx	New York	70,205	43%	$11,461	$12,261	107%	$799
	Baltimore City	Maryland	11,296	13%	$11,486	$11,281	98%	–$205
	Broward	Florida	118,508	48%	$11,865	$11,084	93%	–$781
	Dade	Florida	193,717	53%	$15,264	$13,684	90%	–$1,580

[a] The 100 counties with the largest number of Medicare beneficiaries were ranked by average FFS costs; counties for which 2008 county-level payments net of rebate data were not available were excluded. The highest, middle, and lowest FFS cost counties are displayed here.

counties with a range of beneficiary populations and from a variety of geographic areas.

Appendix A presents detailed information on payments in 2010 to MA plans in the 100 counties with the most Medicare beneficiaries.

States

The range of payments to MA plans may also be displayed at the state level. As in the county-level analyses, MA payments were higher than Medicare FFS costs in states with low costs. For example, payments to MA plans in Hawaii averaged 32 percent, or $2,210 per enrollee, greater than FFS costs. In New Mexico, payments were 27 percent, or $1,961 per enrollee, greater than FFS costs. Average payments to MA plans in 2010 were actually lower than FFS costs in Florida, by $120 per enrollee, for a total of $127 million. Plan payments in Nevada were also lower (99%) than FFS costs, or a total of $8.5 million less than the same enrollees would have been expected to cost in traditional FFS Medicare. As previously noted, however, MA plans in the highest-cost states had higher absolute payment rates: $10,664 per enrollee in Florida, compared with $9,197 in Hawaii. Exhibit 5 displays MA payments and FFS costs in nine high-, medium-, and low-cost states. Appendix B presents MA payments in 2010 to plans in all states.

CONCLUSION

Medicare Advantage plan payments in 2010 declined from 13.0 percent above Medicare FFS costs in 2009 to 8.9 percent above in 2010. The lower number still substantially exceeds what enrollees would have been expected to cost in traditional FFS Medicare, but this decline in payments relative to FFS costs was the first since the enactment of the MMA in 2003.

The reduction of the discrepancy between MA payments and local FFS costs in 2010 was, as discussed above, the result of a combination of various policies intended to increase the correspondence

Exhibit 5. Medicare Advantage (MA) Enrollment and Payments Relative to Medicare Fee-for-Service (FFS) Costs in Selected High, Middle, and Low FFS Cost States, 2010

	State	MA enrollment	MA enrollment as a percent of all Medicare beneficiaries	FFS costs per beneficiary	MA payments per enrollee	MA payments per enrollee relative to FFS costs per beneficiary	MA payments per enrollee in excess of FFS costs per beneficiary	Total MA payments in excess of FFS costs (in millions)
Selected low-cost states	Iowa	59,887	12%	$7,499	$8,990	120%	$1,491	$89
	New Mexico	77,221	25%	$7,300	$9,262	127%	$1,961	$151
	Hawaii	50,840	25%	$6,986	$9,197	132%	$2,210	$112
Selected middle-cost states	Tennessee	253,198	24%	$8,661	$9,508	110%	$847	$215
	Kansas	44,849	10%	$8,574	$9,527	111%	$953	$43
	Kentucky	116,018	15%	$8,570	$9,357	109%	$786	$91
Selected high-cost states	Florida	1,058,707	32%	$10,785	$10,664	99%	–$120	–$127
	Louisiana	161,764	24%	$10,432	$11,402	109%	$970	$157
	Maryland	39,606	5%	$10,357	$10,467	101%	$110	$4

between MA plan payments and the costs that they face, as well as other factors that were unrelated to that purpose.

Despite the fact that none of the factors that affected MA payments in 2010 were directly related to the health reform law, the change in payments described here may be thought of as the first stage of the changes that will follow when that legislation takes effect beginning in 2012. Those policies will further narrow the discrepancy to an average of 101 percent by 2017; beginning in 2012, at the county level MA payments will be set from 115 percent to 95 percent of local FFS costs and MA plan payment rebates reduced from 75 percent to 50 percent. The analysis presented here is intended to provide a baseline for examining the payment impact of the new law.

The health reform law policies will also award higher benchmarks and rebates to MA plans with higher scores on the rating system that, for a number of years, has been used to measure plan performance. (Heretofore those scores had no impact on plan payment rates.) As a result, more emphasis will be put on plan performance, which should improve the care available to Medicare beneficiaries who enroll in private plans and reward plans that achieve the kind of coordinated care envisioned when the private plan option was added to the Medicare program. Future work in this area will examine that potential, and the degree to which it is being achieved.

NOTES

[1] Though payment benchmarks were set below fee-for-service costs, in reality plans were paid more because of an imperfect risk adjustment system. See: Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (Washington, D.C.: MedPAC, 2001).

[2] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (Washington, D.C.: MedPAC, 2009).

[3] During consideration of the health care reform legislation in 2009 and through the enactment of the legislation in March 2010, the House and Senate took substantially different approaches to MA payment policies. In the end, the House and Senate agreed on a compromise, which was included in the health care reform reconciliation bill enacted in March 2010.

[4] Congressional Budget Office, Letter to the Hon. Nancy Pelosi, March 20, 2010, available at http://www.cbo.gov/publications/collections/health.cfm.

[5] B. Biles and G. Arnold, *Medicare Advantage Provisions: The Health Care and Education Affordability Reconciliation Act H.R. 4872* (Washington, D.C.: The George Washington University, March 2010).

[6] B. Biles, J. Pozen, and S. Guterman, *The Continuing Cost of Privatization: Extra Payments to Medicare Advantage Plans Jump to $11.4 Billion in 2009* (New York: The Commonwealth Fund, May 2009). Earlier analyses assumed, following reports by MedPAC, that all plan rebates were equal to the national average of 12 percent of FFS costs. This analysis, while consistent with the MedPAC report that the national average rebate in 2010 is 9 percent of FFS costs, applies a county-specific rebate rate to payments in individual counties.

[7] Biles, Pozen, and Guterman, *Continuing Cost of Privatization,* 2009.

[8] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (Washington, D.C.: MedPAC, 2010), Chapter 4, available at http://medpac.gov/documents/Mar10_EntireReport.pdf.

[9] Center for Medicare and Medicaid Services, 2010 Medicare Advantage Call Letter (Washington, D.C.: CMS, Feb. 29, 2010).

[10] This analysis includes only counties for which county-level data were provided by CMS. See the Methodology for further details.

Appendix A. Medicare Advantage (MA) Enrollment and Payments Relative to Medicare Fee-for-Service (FFS) Costs in the 100 Counties with the Highest Numbers of Medicare Beneficiaries, 2010

Counties Ranked by FFS Costs per Beneficiary

State	County	MA enrollment	MA enrollment as a percent of all Medicare beneficiaries	FFS costs per beneficiary	MA payment per enrollee	MA payment per enrollee relative to FFS costs per beneficiary	MA payments per enrollee in excess of/less than FFS costs per beneficiary
Florida	Dade	193,717	53%	$15,264	$13,684	90%	–$1,580
Florida	Broward	118,508	48%	$11,865	$11,084	93%	–$781
Maryland	Baltimore City	11,296	13%	$11,486	$11,281	98%	–$205
New York	Bronx	70,205	43%	$11,461	$12,261	107%	$799
New York	Kings	103,204	34%	$11,357	$11,766	104%	$409
Texas	Harris	104,756	28%	$11,192	$12,263	110%	$1,071
California	Los Angeles	432,218	38%	$11,113	$11,084	100%	–$29
New York	New York	65,164	27%	$10,768	$12,083	112%	$1,316
New York	Nassau	43,838	20%	$10,694	$10,808	101%	$114
New York	Queens	104,504	36%	$10,662	$11,079	104%	$416
Florida	Palm Beach	80,641	32%	$10,612	$10,399	98%	–$214
Maryland	Prince Georges	3,406	4%	$10,552	$11,065	105%	$513
California	Orange	155,542	42%	$10,546	$10,525	100%	–$20
Nevada	Clark	85,646	37%	$10,503	$10,236	97%	–$268
Texas	Dallas	49,104	20%	$10,490	$11,674	111%	$1,184
New Jersey	Essex	15,250	15%	$10,420	$10,902	105%	$482
New York	Westchester	25,883	18%	$10,416	$10,531	101%	$116
Illinois	Cook	62,812	9%	$10,321	$10,223	99%	–$98
Maryland	Baltimore	8,802	7%	$10,283	$10,185	99%	–$99
New York	Suffolk	39,294	17%	$10,254	$10,300	100%	$46
California	Contra Costa	62,740	44%	$10,210	$11,282	110%	$1,072
Texas	Tarrant	54,997	30%	$10,094	$10,875	108%	$781
Michigan	Wayne	46,006	16%	$10,008	$10,087	101%	$79
Oklahoma	Oklahoma	20,453	20%	$10,007	$10,329	103%	$322
New Jersey	Bergen	15,151	11%	$9,988	$10,138	102%	$150
Pennsylvania	Philadelphia	97,012	43%	$9,953	$11,029	111%	$1,076
California	Alameda	74,338	41%	$9,944	$10,807	109%	$862
Florida	Duval	25,088	22%	$9,879	$10,015	101%	$136
Connecticut	Fairfield	24,634	19%	$9,837	$9,859	100%	$23
Connecticut	New Haven	29,420	21%	$9,816	$9,962	101%	$146
New Jersey	Ocean	19,082	14%	$9,803	$10,563	108%	$760
New Jersey	Middlesex	12,639	12%	$9,798	$10,127	103%	$330
Florida	Brevard	35,952	31%	$9,796	$9,757	100%	–$40
Massachusetts	Norfolk	20,268	19%	$9,793	$10,464	107%	$672
Minnesota	Hennepin	36,214	24%	$9,734	$9,984	103%	$250
Illinois	Du Page	6,147	5%	$9,734	$9,690	100%	–$43
Texas	Travis	9,874	11%	$9,722	$9,758	100%	$36
Florida	Orange	40,609	33%	$9,706	$10,067	104%	$361
Florida	Pinellas	75,335	39%	$9,685	$9,878	102%	$193
Massachusetts	Essex	20,962	17%	$9,639	$10,189	106%	$550
New Jersey	Monmouth	10,868	11%	$9,611	$9,872	103%	$261
California	San Bernardino	100,317	48%	$9,595	$10,383	108%	$788
California	Riverside	127,767	48%	$9,554	$10,403	109%	$850
Massachusetts	Middlesex	50,410	23%	$9,547	$10,425	109%	$879
Maryland	Montgomery	2,983	3%	$9,529	$9,702	102%	$173
Massachusetts	Suffolk	12,433	14%	$9,529	$11,020	116%	$1,491
Pennsylvania	Delaware	26,942	30%	$9,491	$10,368	109%	$876
Texas	Bexar	69,932	33%	$9,478	$10,960	116%	$1,481
Michigan	Oakland	27,400	15%	$9,476	$9,869	104%	$393
Michigan	Macomb	20,072	15%	$9,473	$9,728	103%	$255
California	Ventura	28,667	27%	$9,458	$10,168	108%	$710

State	County	MA enrollment	MA enrollment as a percent of all Medicare beneficiaries	FFS costs per beneficiary	MA payment per enrollee	MA payment per enrollee relative to FFS costs per beneficiary	MA payments per enrollee in excess of/less than FFS costs per beneficiary
Florida	Hillsborough	66,465	40%	$9,450	$9,723	103%	$272
Oklahoma	Tulsa	26,602	31%	$9,417	$9,758	104%	$341
Florida	Lee	29,852	24%	$9,295	$9,715	105%	$420
Tennessee	Shelby	20,042	17%	$9,278	$9,684	104%	$406
Pennsylvania	Allegheny	139,886	60%	$9,188	$9,639	105%	$452
California	San Mateo	42,461	42%	$9,174	$9,704	106%	$530
Arizona	Maricopa	204,719	43%	$9,170	$9,742	106%	$572
Florida	Pasco	45,330	46%	$9,145	$9,652	106%	$507
Alabama	Jefferson	43,524	39%	$9,135	$9,665	106%	$530
California	Kern	31,829	35%	$9,107	$9,672	106%	$566
California	San Diego	156,751	40%	$9,063	$9,850	109%	$787
Florida	Polk	39,551	35%	$9,052	$9,683	107%	$631
Florida	Sarasota	16,950	16%	$9,002	$9,654	107%	$652
Massachusetts	Worcester	44,064	36%	$8,995	$9,631	107%	$637
Kentucky	Jefferson	27,456	23%	$8,955	$9,630	108%	$675
Massachusetts	Bristol	12,672	13%	$8,927	$9,644	108%	$717
Ohio	Cuyahoga	64,344	29%	$8,909	$9,648	108%	$739
Indiana	Marion	20,026	17%	$8,880	$9,633	108%	$753
Connecticut	Hartford	28,366	19%	$8,860	$9,623	109%	$763
Pennsylvania	Bucks	35,610	34%	$8,854	$10,101	114%	$1,247
Pennsylvania	Montgomery	41,079	32%	$8,838	$9,605	109%	$767
California	Santa Clara	75,543	36%	$8,812	$9,989	113%	$1,178
Wisconsin	Milwaukee	35,765	27%	$8,740	$9,621	110%	$882
Missouri	Jackson	30,731	30%	$8,704	$9,787	112%	$1,083
Missouri	St. Louis	46,464	28%	$8,667	$9,593	111%	$926
Florida	Marion	24,174	27%	$8,640	$9,597	111%	$957
Florida	Volusia	43,559	40%	$8,610	$9,640	112%	$1,030
Ohio	Franklin	51,896	38%	$8,608	$9,632	112%	$1,024
Ohio	Hamilton	41,869	33%	$8,569	$9,635	112%	$1,065
Georgia	Fulton	22,502	24%	$8,563	$9,722	114%	$1,159
Texas	El Paso	30,406	31%	$8,506	$9,588	113%	$1,082
Virginia	Fairfax	3,451	3%	$8,502	$9,620	113%	$1,119
North Carolina	Mecklenburg	16,603	18%	$8,421	$9,611	114%	$1,190
Arizona	Pima	69,300	45%	$8,416	$9,637	115%	$1,221
Ohio	Summit	34,400	38%	$8,412	$9,587	114%	$1,175
North Carolina	Wake	16,632	19%	$8,409	$9,625	114%	$1,216
Ohio	Montgomery	38,648	41%	$8,398	$9,598	114%	$1,199
California	San Francisco	42,390	35%	$8,343	$10,070	121%	$1,727
New York	Monroe	74,339	60%	$8,252	$9,449	115%	$1,197
Rhode Island	Providence	37,669	37%	$8,170	$9,557	117%	$1,388
Washington	King	60,653	26%	$8,146	$9,542	117%	$1,396
Washington	Pierce	23,750	23%	$8,131	$9,545	117%	$1,414
Utah	Salt Lake	37,612	37%	$8,105	$9,584	118%	$1,479
California	Fresno	29,080	27%	$7,983	$9,602	120%	$1,619
California	Sacramento	78,088	42%	$7,621	$9,493	125%	$1,872
Oregon	Multnomah	48,624	53%	$7,429	$9,480	128%	$2,051
New York	Erie	89,338	52%	$7,367	$9,441	128%	$2,075
New Mexico	Bernalillo	39,224	43%	$7,312	$9,487	130%	$2,175
Hawaii	Honolulu	36,677	25%	$6,986	$9,384	134%	$2,398

Appendix B. Medicare Advantage (MA) Enrollment and Payments Relative to Medicare Fee-for-Service (FFS) Costs by State, 2010

State	MA enrollment	MA enrollment as a percent of all Medicare beneficiaries	MA payment per enrollee relative to FFS costs per beneficiary	MA payments per enrollee in excess of FFS costs per beneficiary	Total MA payments per enrollee in excess of FFS costs (in millions)
National	**10,887,604**	**24%**	**109%**	**$814**	**$8,857**
Alabama	176,555	21%	107%	$641	$113
Alaska	369	1%	107%	$606	$224
Arizona	334,290	39%	108%	$728	$244
Arkansas	77,838	15%	111%	$926	$72
California	1,668,080	36%	107%	$679	$1,133
Colorado	189,832	31%	109%	$799	$152
Connecticut	101,257	18%	104%	$387	$39
Delaware	5,274	4%	107%	$591	$3
District of Columbia	2,650	3%	113%	$1,220	$3
Florida	1,058,707	32%	99%	–$120	–$127
Georgia	253,260	21%	111%	$919	$233
Hawaii	50,840	25%	132%	$2,210	$112
Idaho	64,605	29%	116%	$1,298	$84
Illinois	171,287	9%	105%	$489	$84
Indiana	155,566	16%	113%	$1,090	$170
Iowa	59,887	12%	120%	$1,491	$89
Kansas	44,849	10%	111%	$953	$43
Kentucky	116,018	15%	109%	$786	$91
Louisiana	161,764	24%	109%	$970	$157
Maine	31,657	12%	118%	$1,398	$44
Maryland	39,606	5%	101%	$110	$4
Massachusetts	201,088	19%	108%	$784	$158
Michigan	255,923	16%	107%	$643	$165
Minnesota	183,202	24%	107%	$577	$106
Mississippi	45,995	9%	105%	$484	$22
Missouri	208,963	21%	113%	$1,081	$226
Montana	29,882	18%	114%	$1,060	$32
Nebraska	31,233	11%	111%	$911	$28
Nevada	111,476	32%	99%	–$77	–$9
New Hampshire	14,739	7%	112%	$1,015	$15
New Jersey	166,130	13%	104%	$409	$68
New Mexico	77,221	25%	127%	$1,961	$151
New York	895,476	30%	112%	$1,100	$985
North Carolina	284,240	19%	115%	$1,231	$350
North Dakota	6,582	6%	116%	$1,188	$8
Ohio	603,344	32%	111%	$957	$577
Oklahoma	90,575	15%	103%	$317	$29
Oregon	255,558	43%	120%	$1,538	$393
Pennsylvania	862,722	38%	110%	$878	$758
Rhode Island	63,212	35%	117%	$1,361	$86
South Carolina	119,352	16%	112%	$985	$118
South Dakota	10,491	8%	116%	$1,214	$13
Tennessee	253,198	24%	110%	$847	$215
Texas	551,818	19%	110%	$986	$544
Utah	92,006	33%	114%	$1,156	$106
Vermont	4,504	4%	115%	$1,142	$5
Virginia	146,144	13%	120%	$1,534	$224
Washington	238,482	25%	117%	$1,383	$330
West Virginia	73,897	19%	113%	$1,055	$78
Wisconsin	241,495	27%	118%	$1,374	$332
Wyoming	4,465	6%	108%	$639	$3

Methodology

This issue brief's 2010 analysis is based on Medicare Advantage (MA) payment rates and fee-for-service (FFS) expenditure averages posted by county in the 2010 Centers for Medicare and Medicaid Services (CMS) Medicare Advantage Rate Calculation Data spreadsheet and data on payment net of rebate (PNR) by county provided to the authors by 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 April 2010. These data are posted on the CMS Web site, 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 2010, 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 FFS costs in the county in 2004, trended forward to 2010; a payment rate equal to 100 percent of per capita FFS costs in the county in 2005, trended forward to 2010; a payment rate equal to 100 percent of per capita FFS costs in the county in 2007, trended forward to 2010; or a payment rate equal to 100 percent of per capita FFS costs in the county in 2009, trended forward to 2010. The Medicare Modernization Act of 2003 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 0.81 percent for 2010.

County-level payments were determined using the county average PNR for 2008, trended forward to 2010. CMS provided the authors with county-level PNRs, which we assume to be roughly equivalent to plan bids reflecting their costs. These data excluded cost plans and counties in which one plan enrolled more than 50 percent of the MA enrollees were aggregated at the state level. CMS provided average PNR data for the remaining counties (about 65% of 2008 enrollees lived in counties for which county-level data were available). Using the FFS costs published in the 2008 Medicare Advantage Rate Calculation Data, adjusted for indirect medical education (IME) in the manner described below, we determined a PNR to FFS ratio for each county. We performed a simple linear regression to determine an approximate PNR to FFS ratio for counties for which county-level data were not available. This PNR to FFS ratio was then applied to 2010 FFS costs (adjusted upward 4%) published in the Medicare Advantage Rate Calculation spreadsheet to determine a county-average approximate bid/cost.

Payments were determined by comparing the estimated county average bid/cost to the benchmark. For counties in which the average bid/cost exceeded the benchmark, payment was set at the benchmark. For counties in which the average bid/cost was less than the benchmark, payments were the average bid/cost plus 75 percent of the difference between the bid/cost and the benchmark. Extra payments to MA plans are calculated for each of the 3,140 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.

More than 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 IME costs 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 2010 payments to MA plans provide extra payments to MA plans. This analysis of extra payments includes a budget-neutral risk adjustment of 1.001 for 2010.[v]

County-level FFS costs were adjusted upward by 4 percent to account for a Medicare physician fee schedule "fix." The Congress had not enacted legislation that delayed or averted FFS payment cuts under Medicare Part B by the time MA payment rates were set in April 2009. Legislation delaying the cuts has since been enacted so our analysis reflects FFS costs after a sustainable growth rate fix, following the adjustments made in President Obama's 2010 budget.[vi]

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[i] Centers for Medicare and Medicaid Services, Rate Calculation Data Risk 2010 spreadsheet (Baltimore, Md.: CMS, April 2010), 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, April 2010), available at http://www.cms.hhs.gov/MCRAdvPartDEnrolData/.

[iii] Centers for Medicare and Medicaid Services, Monthly Medicare Advantage State/County/Contract Data (Baltimore, Md.: CMS, Apr. 2010), available at http://www.cms.hhs.gov/MCRAdvPartDEnrolData/.

[iv] Alternatively, indirect medical education amounts may be added to MA 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 2010 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies" (Washington, D.C.: CMS, April 2010), available at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2009.pdf.

[vi] Office of Management and Budget, A New Era of Responsibility: Renewing America's Promise (Washington, D.C.: OMB, Feb. 2010), Summary Tables 1 and 5, available at http://www.whitehouse.gov/omb/assets/fy2010_new_era/A_New_Era_of_Responsibility2.pdf.

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