OCTOBER 2012

Realizing Health Reform's Potential

The Impact of Health Reform on the Medicare Advantage Program: Realigning Payment with Performance

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Commonwealth Fund pub. 1637
Vol. 27

Abstract: The Affordable Care Act enacts a new payment system for private health plans available to Medicare beneficiaries through the Medicare Advantage (MA) program. The system, which is being phased in through 2017, aims to 1) reduce the excess payments received by private plans relative to per capita spending in traditional Medicare, and 2) reward plans that earn high performance ratings. Using 2009 data, this issue brief presents analysis of the distributional impact on MA plan payments of these new policies as if they had been fully implemented in that year. We find that, when the polices are in place, they will bring overall MA plan payments nationwide down from 114 percent to 102 percent of what spending would have been for the same enrollees if they had been enrolled in traditional Medicare. While payments will vary across the nation, high-performing MA plans stand to benefit from this new arrangement.

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OVERVIEW

The Medicare Advantage (MA) program, which gives Medicare beneficiaries the option of enrolling in private plans, has been extensively discussed and debated since its creation by the Medicare Modernization Act of 2003. It was built on an earlier program under which Medicare paid prospectively set capitation-based payments to private plans to provide benefits to enrollees. That program originally was called the Medicare Risk Program, enacted as part of the Tax Equity and Fiscal Responsibility Act of 1982, and then became the Medicare+Choice program with enactment of the Balanced Budget Act of 1997.

Medicare's current policies pay private MA plans in most areas more than what Medicare would expect to pay for the same beneficiaries in the traditional Medicare program. In 2009, payments to MA plans exceeded projected spending for the same enrollees in traditional Medicare by an average of 14.2 percent, or $1,236 per enrollee, for a total of $12.7 billion in excess payments nationwide. In 2010 this discrepancy was reduced to an average of 8.9 percent, or $814 per enrollee and $8.9 billion nationwide, by other policy changes, mostly from those enacted in the Medicare Improvements for Patients and Providers Act of 2008.

This issue brief analyzes the impact of the MA payment provisions enacted as part of the Affordable Care Act on the distribution of payments across MA plans in different areas. These new polices began to take effect in 2011 and are being phased in through 2017. The analysis utilizes data on county-level MA benchmark payment rates, traditional Medicare costs, and MA enrollment from the Centers for Medicare and Medicaid Services (CMS). It also uses data on the county-level average of MA plan costs provided by CMS and on MA plan performance ratings from analysis by the Kaiser Family Foundation.[1] All of these data are from 2009, which as the last full year in which the Medicare Modernization Act rules were in place provide an appropriate baseline for assessing the impacts of the new legislation. The analysis therefore explores the impact of the new policies as if they had been fully implemented in that year.

This brief presents the patterns of overall payments to MA plans under the new payment policies when fully implemented, as well as the relative contribution of each of the three major components of the new payment policy to the changes in plan payments.

THREE FACTORS DETERMINING MEDICARE ADVANTAGE PLAN PAYMENTS

Private plans participating in Medicare through the MA program are paid according to a methodology that depends essentially on three factors: the plan's bid, the MA plan benchmark rate set for each county, and the rebate percentage. Each plan's bid, which represents its estimated costs (including administrative costs and profit) of providing the traditional Medicare hospital and medical benefits (Parts A and B) to the average beneficiary, is submitted to CMS in June, prior to the upcoming coverage year.

Before the Affordable Care Act, the benchmark payment rate for each county was set at the highest of the amounts produced by eight different formulas. The lowest of the eight formulas set MA plan benchmarks at 100 percent of the costs in traditional Medicare in the county, while the other formulas set MA plan benchmarks at higher amounts.[2] On average, the county benchmark rates exceeded estimated per-enrollee spending in traditional Medicare by 18 percent in 2009, varying across the eight groups of counties from 2 percent to 26 percent more than costs in traditional Medicare (Exhibit 1). The method for determining county benchmark rates was modified in the health reform law, as described below.

Exhibit 1. Distribution of Medicare Advantage Payments Under Policy in Effect in 2009, by County Benchmark Policy

County benchmark group	2009 Medicare Advantage enrollees (in millions)[1]	Average traditional Medicare costs	2009 benchmark rate	2009 benchmark rate relative to average traditional Medicare costs	Average plan cost	Average plan cost relative to average traditional Medicare costs	Average 2009 plan payment	Average 2009 plan payment relative to average traditional Medicare costs
100% FFS 2004	2.9	$9,458	$10,898	115%	$9,182	97%	$10,454	111%
100% FFS 2005	0.4	$9,587	$10,855	113%	$9,690	101%	$10,573	110%
100% FFS 2007	0.4	$9,985	$11,238	113%	$9,547	96%	$10,873	109%
100% FFS 2009	0.3	$12,766	$13,006	102%	$9,343	73%	$11,967	94%
Blend	0.1	$8,238	$10,361	126%	$9,486	115%	$10,158	123%
Minimum update	0.2	$9,963	$12,296	123%	$10,305	103%	$11,700	117%
Rural floor	1.3	$7,502	$8,901	119%	$8,157	109%	$8,826	118%
Urban floor	4.5	$8,078	$9,833	122%	$8,749	108%	$9,600	119%
National	**10.3**	**$8,731**	**$10,281**	**118%**	**$8,933**	**102%**	**$9,967**	**114%**

[1] Medicare beneficiaries in Puerto Rico, American Samoa, Guam, and the Virgin Islands are excluded. Enrollees in "cost" plans also are excluded.
Note: FFS = fee-for-service.

Medicare's payments to each plan are determined by a comparison of the bid submitted by the plan with the benchmark rates in the counties it serves. Prior to health reform, if the plan's bid was less than the benchmark rate, the plan received from Medicare an amount equal to its bid plus a rebate of 75 percent of the difference between the benchmark rate and its bid (which was risk-adjusted to reflect the anticipated costliness of each enrollee). If the plan's bid was greater than the benchmark rate, it received a payment rate equal to the benchmark rate (also risk-adjusted), and Medicare beneficiaries would have to pay the difference between the bid and the benchmark to enroll in the plan. Under the Affordable Care Act, the rebate percentage will be reduced from 75 percent to 50 percent.

Since MA plans with bids less than the benchmark were paid more than their projected cost of providing traditional Medicare benefits to their enrollees, these plans were required to provide additional benefits to their enrollees, either by reducing enrollees' out-of-pocket costs for Medicare covered services, or by covering additional services that are not covered by traditional Medicare. The total value of the reduced out-of-pocket costs and additional covered services was required to be equal in actuarial value to the amount of the rebate payment. The reduced out-of-pocket costs or additional benefits—financed by from the Medicare Trust Funds into which all Medicare beneficiaries contribute—could be used by the plans to attract new enrollees.

In 2009, the average MA plan bid was 102 percent of the corresponding per capita spending in traditional Medicare in their service area. These bids varied by MA plan type. For health maintenance organizations (HMOs), the average bid was 98 percent of local per capita spending in traditional Medicare, while for local and regional preferred provider organizations (PPOs), private fee-for-service plans (PFFS) and other types of MA plans, the average bid was higher than per capita spending in traditional Medicare.[3]

THE NEW MEDICARE ADVANTAGE PAYMENT POLICY: THREE MAJOR CHANGES

The new MA payment policy includes three significant changes: the process of setting the benchmark rates in each county will be extensively altered; the proportion of the difference between the benchmark rates and the plan bids that is paid to plans as "rebates" will be significantly reduced; and each plan's performance on quality measures will be used for the first time to adjust the benchmarks that determine its payment rate.[4] These changes are intended to increase the incentives for MA plans to be more efficient and to improve the quality of care for their enrollees. The Congressional Budget Office (CBO) has estimated that the new MA payment policy will save Medicare $132 billion over 10 years.[5]

Formula for Calculating County Benchmark Rates

The most important component of the health reform law's new MA payment policy is the change in how the county benchmark payment rates are set. Under the new policy, the 3,140 counties in the nation are ranked according to their estimated per capita spending in traditional Medicare and placed in one of four cohorts of 785 counties each. Counties in these four cohorts are assigned benchmark rates according to the following process:

- The 785 counties with the highest per capita spending will be assigned benchmark rates equal to 95 percent of their county's estimated per capita spending in traditional Medicare. In 2009, these counties included 42 percent of all MA enrollees, with 93 percent of those enrollees living in urban areas (Exhibit 2). This cohort includes the core counties of many of the nation's largest cities.

- The next 785 counties ranked by per capita spending will be assigned benchmark rates equal to 100 percent of their county's estimated per capita spending in traditional Medicare. In 2009, this cohort included 25 percent of all MA enrollees; the urban/rural distribution of MA enrollees in this

Exhibit 2. Overview of Affordable Care Act County Benchmark Groups

Benchmark cohort: as a percent of FFS costs	2009 Medicare beneficiaries (in millions)[1]	Share of Medicare beneficiaries	2009 Medicare Advantage enrollees (in millions)[1]	Share of Medicare Advantage enrollees	Share of Medicare Advantage enrollees living in urban counties
95%	18.3	41%	4.3	42%	93%
100%	11.4	25%	2.5	25%	81%
107.5%	8.7	19%	1.8	18%	70%
115%	6.7	15%	1.6	15%	59%
National	**45.2**	**100%**	**10.3**	**100%**	**81%**

[1] Medicare beneficiaries in Puerto Rico, American Samoa, Guam, and the Virgin Islands are excluded. Enrollees in "cost" plans also are excluded.
Note: FFS = fee-for-service.

group mirrors the national pattern for Medicare beneficiaries: 81 percent live in urban areas and 19 percent live in rural areas.

- The next 785 counties ranked by per capita spending will be assigned benchmark rates equal to 107.5 percent of their county's estimated per capita spending in traditional Medicare. In 2009, these counties included 18 percent of all MA enrollees in 2009, with 70 percent living in urban areas and 30 percent in rural areas.
- The 785 counties with the lowest per capita spending will be assigned benchmark rates equal to 115 percent of their estimated per capita spending in traditional Medicare. In 2009, these counties included 15 percent of all MA enrollees in 2009, with 59 percent of the enrollees in this cohort residing in urban areas and 41 percent in rural areas.

Overall, if plans had been paid using the new benchmarks in 2009, without rebates or quality bonus payments (see below), average MA payments nationwide would have been equal to per capita spending in traditional Medicare—producing Medicare savings of $12.7 billion relative to actual payments to MA plans in that year (Exhibits 3 and 4).

The new policy was the result of intense debate over whether and how to account for geographic variation in local health care spending. In particular, it was argued that MA plans in areas with low spending in traditional Medicare could not provide basic Medicare benefits at costs below those already low levels, and that MA plan enrollees in those areas would have access to

Exhibit 3. Projected Medicare Advantage Payments in 2009 with Affordable Care Act County Benchmarks in Effect

Affordable Care Act benchmark cohort: as a percent of FFS costs	Average traditional Medicare costs	Affordable Care Act benchmark[1]	Affordable Care Act benchmark relative to average traditional Medicare costs	2009 plan cost	2009 plan cost relative to average traditional Medicare costs	Affordable Care Act plan payment[2]	Affordable Care Act plan payment relative to average traditional Medicare costs
95%	$9,887	$9,393	95%	$9,314	94%	$9,274	94%
100%	$8,451	$8,451	100%	$8,759	104%	$8,428	100%
107.5%	$7,831	$8,419	108%	$8,689	111%	$8,399	107%
115%	$7,079	$8,141	115%	$8,458	119%	$8,120	115%
National	**$8,731**	**$8,793**	**101%**	**$8,933**	**102%**	**$8,731**	**100%**

[1] Affordable Care Act benchmark calculated excluding performance-based bonuses.
[2] Affordable Care Act plan payment calculated including four-cohort benchmark policy but excluding reduction to rebate payments from 75 percent to 50 percent; excluding all benchmark and rebate performance-based bonuses.
Note: FFS = fee-for-service.

Exhibit 4. Projected Medicare Advantage Payments in 2009 if Affordable Care Act County Benchmarks Had Been in Effect

Affordable Care Act benchmark cohort: as a percent of FFS costs	2009 benchmark	Affordable Care Act benchmark[1]	Percent difference between 2009 benchmark and Affordable Care Act benchmark	2009 plan payment	Affordable Care Act plan payment[2]	Total Affordable Care Act plan payments (in billions)	Difference of total plan payments (in billions)	Percent difference of total plan payments
95%	$11,162	$9,393	–16%	$10,678	$9,274	$40.0	–$6.1	–13%
100%	$9,806	$8,451	–14%	$9,597	$8,428	$21.2	–$2.9	–12%
107.5%	$9,591	$8,419	–12%	$9,417	$8,399	$15.5	–$1.9	–11%
115%	$9,446	$8,141	–14%	$9,261	$8,120	$12.9	–$1.8	–12%
National	**$10,281**	**$8,793**	**–14%**	**$9,967**	**$8,731**	**$89.6**	**–$12.7**	**–12%**

[1] Affordable Care Act benchmark calculated excluding performance-based bonuses.
[2] Affordable Care Act plan payment calculated including four-cohort benchmark policy but excluding reduction to rebate payments from 75 percent to 50 percent; excluding all benchmark and rebate performance-based bonuses.
Note: FFS = fee-for-service.

fewer additional benefits than do those in areas with higher traditional Medicare spending levels.

If the new policy had been in effect in 2009, the MA plans in counties with the lowest levels of spending in traditional Medicare would have received payment rates exceeding traditional Medicare spending in those areas by an average of 15 percent. While the new Affordable Care Act payments would have been substantially higher than traditional Medicare costs in those areas, those payment rates would, on average, have corresponded to actual MA plan costs in those counties (Exhibit 3).[6] Plans in the highest-spending areas would have received payment rates that, on average, were lower than per capita spending in traditional Medicare, but those payments also would, on average, have corresponded to their actual costs.

It should be noted that both the benchmark rates and the payment rates in the lowest-cost areas are substantially lower than the benchmark rates and the payment rates in areas with high levels of spending in traditional Medicare. For example, the new benchmark rates in the counties with the lowest per capita spending in traditional Medicare would average $8,141 and their payment rates would average $8,120, while in the counties with the highest spending the benchmarks would average $9,393 and the plan payment rates would average $9,274 (Exhibit 3). Of course, an MA payment system could place more pressure on private plans to operate more efficiently in both high-cost and low-cost areas.[7] In any case, these observations indicate the difficulty of setting rates across a very large nation with geographic areas with different patterns of medical practice, utilization of heath care, and total spending on health services.

Reduction in Plan Rebate Payments

The current system of plan bidding and rebate payments was established by the Medicare Modernization Act and implemented in 2006. Each MA plan's rebate payment is based on the difference between the benchmark rate for each county in the plan's service area and the plan's bid (which, again, reflects its costs of providing the traditional Medicare benefit package, including its administrative costs and profit). As described above, the Medicare Modernization Act set the rebate payment at 75 percent of the difference between the benchmark rate and the plan's bid if the bid is below the benchmark rate and zero if the bid exceeds the benchmark rate.[8]

The new MA payment policy not only changes how the benchmark rates are set but also reduces the amount of the rebate payment from 75 percent to 50 percent of the difference between the benchmark and the plan's bid. Under this policy, payments to plans can be understood as a 50/50 blend of the county benchmark and the plan's own projected costs of providing traditional Medicare benefits, up to the level of the county benchmark.

Exhibit 5. Projected Impact on Medicare Advantage Payments in 2009 of Affordable Care Act County Benchmarks and Reductions in Plan Rebate Percentages

Affordable Care Act benchmark cohort: as a percent of FFS costs	2009 plan payment	Total 2009 plan payments (in billions)	Affordable Care Act plan payment[1]	Total Affordable Care Act plan payments (in billions)	Difference of total plan payments (in billions)	Percent difference of total plan payments
95%	$10,678	$46.1	$9,156	$39.5	–$6.6	–13%
100%	$9,597	$24.1	$8,405	$21.1	–$3.0	–12%
107.5%	$9,417	$17.4	$8,379	$15.4	–$1.9	–11%
115%	$9,261	$14.7	$8,099	$12.9	–$1.8	–12%
National	**$9,967**	**$102.3**	**$8,668**	**$88.9**	**–$13.3**	**–12%**

[1] Affordable Care Act plan payment calculated including four-cohort benchmark policy but excluding reduction to rebate payments from 75 percent to 50 percent; excluding all benchmark and rebate performance-based bonuses.
Note: FFS = fee-for-service.

The reduction of rebates to plans from 75 percent to 50 percent provides $0.6 billion in additional Medicare savings on top of the $12.7 billion impact of the revised benchmark policy alone (Exhibit 5).

Increased Payments for High-Performing Plans

The new policy that ties payments to plan performance ratings raises the benchmark payment rates by 5 percent for plans with a rating of 4 or more stars (out of a maximum of 5) and rebates from 50 percent to 65 percent or 70 percent for plans with 3.5 or more stars. The rationale for this policy is to reward MA plans that score well on performance measures (see box below); it is a shift away from determining payments solely on geographic location and toward performance-based incentives. Rewards for MA plans will provide a total of $2.1 billion in additional payments each year to plans with high performance ratings (Exhibit 6).[9]

This new policy of higher benchmarks and rebates for plans with high performance scores will provide strong incentives for plans to perform well—it will increase total payments to MA plans, but also substantially redistribute those payments toward the highest-performing plans.[10]

CMS's Quality-Based Rating System for Medicare Advantage Plans

As part of the Affordable Care Act's new payment policy, performance-based benchmarks and rebates are available to Medicare Advantage (MA) plans that score well on the star-based quality rating system used by the Centers for Medicare and Medicaid Services (CMS). This system rates plan performance on the following measures:

- Staying healthy: screenings, tests, and vaccines. Includes how often members got various screening tests, vaccines, and other check-ups that help them stay healthy.
- Managing chronic (long-term) conditions. Includes how often members with different conditions got certain tests and treatments that help them manage their conditions.
- Ratings of health plan responsiveness and care. Includes ratings of member satisfaction with the plan and the quality of physician communication.
- Health plan member complaints, appeals, and decisions to disenroll. Includes how quickly appeals are handled, how often members have made complaints against the plan, and how often members choose to leave the plan.
- Health plan telephone customer service. Includes how well the plan handles calls from members.

According to the Kaiser Family Foundation, 14 percent of plans achieve four or five stars (out of a maximum of five). Approximately 25 percent of MA enrollees are in four- or five-star plans. The national average rating for plans, weighted by 2010 enrollment, is 3.32 stars.

Exhibit 6. Projected Impact on Medicare Advantage Payments in 2009 of Affordable Care Act Policies with County Benchmarks and Plan Rebate Percentages Based on Plan Performance Ratings

Performance-based category	Affordable Care Act plan payment, *excluding* performance-based payments[1]	Total Affordable Care Act plan payments, *excluding* performance-based payments (in billions)[1]	Affordable Care Act plan payment, *including* performance-based payments[2]	Total Affordable Care Act plan payments, *including* performance-based payments (in billions)[2]	Difference of total payments (in billions)	Percent difference of total payments
0–3.5 stars	$8,664	$27.5	$8,664	$27.5	$0.0	0%
3.5–4.5 stars	$8,688	$57.9	$8,964	$59.8	$1.8	3%
4.5–5 stars	$8,383	$3.5	$8,901	$3.7	$0.2	6%
National	**$8,668**	**$88.9**	**$8,869**	**$91.0**	**$2.1**	**2%**

[1] Affordable Care Act plan payment calculated including four-cohort benchmark policy and including reduction to rebate payments from 75 percent to 50 percent; excluding all benchmark and rebate performance-based bonuses.

[2] Affordable Care Act plan payment calculated including four-cohort benchmark policy and including reduction to rebate payments from 75 percent to 50 percent; including all benchmark and rebate performance-based bonuses.

Total Impact of the New Medicare Advantage Policies

The total impact of the new policies enacted in the Affordable Care Act will be to reduce MA payments relative to the level of payments under the rules in effect in 2009 (Exhibit 7). Overall, the new MA payments will be much closer to costs in traditional Medicare, with higher payments for high-performing plans. These changes are consistent with the principle of more equitable payment between payments to private Medicare plans and costs in traditional Medicare.

CONCLUSION

The Medicare Advantage provisions in the health reform law significantly change federal policies regarding Medicare private plan payments. The new payment system consists of three new components: 1) benchmarks set for four cohorts of counties based on costs in traditional Medicare; 2) a reduction in plan rebates from 75 percent to 50 percent; and 3) an increase in both county benchmark rates and rebates to plans that score well on the CMS performance quality rating system.

Analysis of the new MA payment system suggests four key points regarding its impact on MA plans. First, the new policy shifts from the previous payment mechanism that provided virtually all MA private plans extra payments relative to costs in traditional Medicare—which totaled $12.7 billion in 2009—to one that reduces the amount of extra payments to an estimated $1.4 billion a year. Private MA plans will still, in the aggregate, continue to receive

Exhibit 7. Projected Impact on Medicare Advantage Payments in 2009 of All Affordable Care Act Payment Policies Combined

Affordable Care Act benchmark cohort: as a percent of FFS costs	2009 plan payment	Total 2009 plan payments (in billions)	Affordable Care Act plan payment[1]	Total Affordable Care Act plan payments (in billions)	Difference of total plan payments (in billions)	Percent difference of total plan payments
95%	$10,678	$46.1	$9,339	$40.3	–$5.8	–13%
100%	$9,597	$24.1	$8,558	$21.5	–$2.6	–11%
107.5%	$9,417	$17.4	$8,599	$15.9	–$1.5	–9%
115%	$9,261	$14.7	$8,396	$13.3	–$1.4	–9%
National	**$9,967**	**$102.3**	**$8,869**	**$91.0**	**–$11.3**	**–11%**

[1] Affordable Care Act plan payment calculated including four-cohort benchmark policy and including reduction to rebate payments from 75 percent to 50 percent; including all benchmark and rebate performance-based bonuses.

Note: FFS = fee-for-service.

higher payments than their enrollees would have been expected to cost in traditional Medicare.

Second, the new payment system will change the way private plans are paid in three ways:

- the change in the way benchmark rates are set will eliminate an estimated $12.7 billion in Medicare overpayments to private plans;
- the reduction in plan rebate payments will reduce Medicare overpayments to private plans by an estimated $640 million; and
- the increase in both benchmarks and rebates to plans with high scores on the Medicare plan performance rating system will provide an estimated $2.1 billion in additional payments to high-performing plans.

Third, while the new system will pay private plans an average of 102 percent of spending in traditional Medicare nationwide, MA plan payments at the local level will continue to vary widely, both relative to traditional Medicare spending and in absolute dollars. County benchmark rates used to set payments will vary relative to local per capita spending in traditional Medicare by 20 percentage points—from 5 percent less to 15 percent more than local fee-for-service costs. On a dollar basis, the range of payments is from $548 a year less than local per capita spending in traditional Medicare spending to $1,317 more than such spending.

Finally, while the dollar impact of the performance-based increases in benchmark rates and rebates is limited in comparison to the impact of the other new payment policies, this is the first time that private plan payments will be based in part on performance. As a result, plans are likely to place greater emphasis on tracking and improving their performance as they strive to qualify for the bonus payments.[11]

Taken together, the new Medicare Advantage payment policies in the health care reform law will bring significant changes to the program and the incentives presented to private plans. The performance-based payments will focus plans' attention on quality improvement. Overall, the new incentives should make participation in Medicare attractive for plans that provide well-coordinated, responsive care for beneficiaries.

Notes

1 Further detail can be found in the About This Study box on page 11. See the Kaiser Family Foundation report based on plan performance star ratings, *Medicare Advantage Plan Star Ratings and Bonus Payments in 2012* (Washington, D.C.: Henry J. Kaiser Family Foundation, Nov. 2011), available at http://www.kff.org/medicare/upload/8257.pdf.

2 For more detail on the determination of benchmarks prior to the Affordable Care Act, see 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).

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

4 Health Care and Education Affordability Reconciliation Act of 2010, H.R. 4872, available at http://docs.house.gov/rules/hr4872/111_hr4872_amndsub.pdf.

5 Letter from CBO Director Douglas Elmendorf to Hon. Nancy Pelosi, March 18, 2010, available at http://www.cbo.gov/sites/default/files/cbofiles/attachments/hr4872_0.pdf. This cost estimate includes an extension of the Secretary of Health and Human Services' authority to adjust MA payments to account for coding intensity. Coding intensity adjustments are not included in this analysis because they are a part of the risk-adjustment dimension of MA payment. Our data are risk-adjusted to a score of 1.

6 Plans in most areas would be under pressure to constrain their costs relative to their 2009 levels under the new policy.

7 Remember that, prior to the Balanced Budget Act of 1997, private plans in what was then known as the Medicare Risk Program were paid at 95 percent of local per capita spending in traditional Medicare.

8 Prior to the implementation of the Medicare Modernization Act policy, MA plans were paid a fixed county-specific rate for enrollees in each county. Plans were not required to submit bids, but they were required to report to CMS their estimate of the costs of providing traditional Medicare benefits to their enrollees; each plan was required to provide additional benefits to enrollees equal in value to the difference between their payment rate and those estimated costs.

9 An additional policy for plans with performance ratings of four or more stars and located in counties with low levels of traditional Medicare spending and high MA plan enrollment that were designated as urban floor payment counties as of 2004 (see box on page 10) provides an additional $923 million in payments to high-performing MA plans in those 75 counties, but the impact of that policy is not reflected in the estimates presented in this paper.

10 A CMS demonstration related to increased payments to MA plans based on plan performance ratings that was announced in November 2010 is not reflected in this analysis because it ends in 2014, prior to full implementation of the new MA payment system. This demonstration provides plans with bonuses for 3.0 and 3.5 stars, up to 3 percent of the benchmark between 2012 and 2014.

11 The new payments related to plan performance have also focused attention on the way CMS evaluates plan performance and prompted the agency to review its methodology.

The Four-Factor Double Benchmark Adjustment

The Affordable Care Act also includes a targeted four-factor benchmark payment rate increase for Medicare Advantage (MA) plans. This increase applies to plans in counties that: 1) have lower than national average fee-for-service costs; 2) have plan penetration of 25 percent or more; 3) have been designated "urban floor" benchmark counties in 2004; and 4) qualify for the 5 percent performance-based benchmark adjustment.

We estimate that plans in 75 counties will be eligible for this bonus. These counties include approximately 1.33 million enrollees, or about 13 percent of nationwide MA enrollees. About 7 percent of all counties and 28 percent of enrollees in the nation are eligible for the 5 percent plan performance-based benchmark adjustment.

The total value of this four-factor double benchmark adjustment policy will be approximately $1.76 billion, or 2 percent of the total $91 billion projected to be paid to MA plans under the Affordable Care Act. The distribution of these additional payments is displayed below.

Four-Factor Double Bonus Policy: Fully Implemented ACA Policies Using 2009 Data

State	Number of counties receiving double bonus	2009 Medicare Advantage enrollees	Share of MA enrollees receiving a double bonus adjustment	Share of four-factor double bonus payments	Share of policy value	Total value of double bonus
California	12	1,580,106	23%	27%	35%	$569
New York	12	840,773	30%	19%	11%	$171
Oregon	8	247,686	71%	13%	9%	$143
Pennsylvania	11	850,823	15%	10%	16%	$259
Washington	4	225,243	54%	9%	7%	$119
Michigan	9	403,356	20%	6%	9%	$150
Colorado	6	173,892	55%	7%	4%	$72
North Carolina	3	252,775	12%	2%	2%	$26
Hawaii	1	42,558	73%	2%	2%	$27
Rhode Island	1	64,620	6%	0%	0%	$4
Wisconsin	3	224,744	11%	2%	3%	$41
Florida	4	943,981	1%	1%	1%	$17
Tennessee	1	232,901	2%	0%	1%	$9
13 states	**75**	**6,083,458**	**22%**	**100%**	**100%**	**$1,608**

About This Study

This issue brief analyzes Medicare Advantage (MA) payments, per capita spending in traditional Medicare, enrollment, plan quality, and bid data from 2009. The analysis applies the new MA payment policies in the Affordable Care Act to 2009 payment and enrollment levels, using 2009 as a baseline for evaluating the potential impacts of the policies, which are being phased in through 2017.

Estimated per capita spending in traditional Medicare for 2009 is posted by county in the 2009 Centers for Medicare and Medicaid Services' MA rate calculation data spreadsheet.[a] The number of Medicare beneficiaries and MA enrollees by county are taken from the CMS State/County Penetration data file and the CMS Contract/Plan/State/County data file for July 2009.[b] MA plan payments net of rebate (plan costs) and rebate amounts for 2009 averaged at the plan type at the county level were provided by CMS in April 2011 in response to a Freedom of Information Act request.

Using adjusted 2009 data, all counties in the country were rank-ordered by per capita spending in traditional Medicare. Following Affordable Care Act policy, the 3,140 counties were divided into four cohorts of 785 counties. The law sets county-level benchmarks in relation to per capita spending in traditional Medicare, so we applied the appropriate benchmark cohort percentage (95%, 100%, 107.5%, or 115%) on that basis to determine the county-level payment benchmark for each county.

Data on plan performance ratings are based on ratings posted by CMS.[c] To compute county-level impacts (Exhibit 6), we used enrollee-weighted averages for the plans in each county. Our previous work on plan-market concentration suggests that this average reflects the quality of the plan in which most enrollees participate.[d] The new policy provides that 4-, 4.5-, and 5-star plans will receive benchmark adjustments. We included counties with star averages of 3.75 or more in the quality-based benchmark adjustment group. In addition, while plans with 3 stars or fewer receive the basic 50 percent rebate, 3.5-to-4.5-star plans can receive a 65 percent rebate, and 4.5-to-5-star plans can receive a 70 percent rebate. We set rebate levels at 50 percent for counties with star averages up to 3.25; at 65 percent for counties with star averages equal to 3.25 to 4.25; and at 70 percent for counties with star averages of 4.25 to 5.

Rebates were calculated by comparing MA plan costs with the county benchmark at 50 percent, 65 percent, or 70 percent. The final payment is the county benchmark for counties where the average plan costs are higher than the benchmark. In counties where the bid is lower than the benchmark, the payment is equal to plan costs plus the rebate amount adjusted by its appropriate rebate percentage.

Payments to MA plans are calculated for each of the more than 3,000 U.S. counties in 2009. Puerto Rico, Guam, American Samoa, and the Virgin Islands are not included in the analysis. All calculations are MA plan enrollee-weighted at the county level to reflect variations in enrollment and payment rates.

Over 300,000 MA enrollees are in Medicare "cost plans," which are paid on the basis of their own costs. Although these beneficiaries receive Medicare benefits through managed care plans, they do not generate extra payments based on MA plan payment rates.[e] Cost beneficiaries were removed from the MA 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 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 traditional Medicare 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 (reflecting the total of Medicare's direct payments to hospitals for the costs of GME programs and the payments for the indirect effects of GME on the costs of providing hospital care) 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 MA patients, plan payment rates are most appropriately compared with traditional Medicare costs adjusted in this manner.[f]

Budget-neutral risk adjustments to 2009 MA payments provide additional extra payments to MA plans. This analysis of extra payments includes a budget-neutral risk adjustment of 0.9 for 2009.[g]

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a 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/.

b 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/.

c Centers for Medicare and Medicaid Services, Part C & Part D Performance Data (Baltimore, Md.: CMS, 2009), available at http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html.

d B. Biles, J. Pozen, and S. Guterman, *Paying Medicare Advantage by Competitive Bidding: How Much Competition Is There?* (New York: The Commonwealth Fund, Aug. 2009).

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

f 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.

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

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Editorial support was provided by Martha Hostetter.