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Issue Brief

The Cost of Privatization: Extra Payments to Medicare Advantage Plans—2005 Update

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ABSTRACT: This issue brief updates an earlier analysis published by The Commonwealth Fund that examined Medicare payments in 2004 to Medicare Advantage private plans relative to the costs of traditional fee-for-service Medicare. Using data from the 2005 Medicare Advantage Rate Calculation Data spreadsheet, the authors calculate that payments to Medicare Advantage plans in 2005 will average 7.8 percent more than costs in traditional Medicare—or $546 for each of the 5 million Medicare enrollees in managed care—for a total of more than $2.72 billion. These figures are similar to the findings reported for 2004. Although the stated objective of policies to increase the enrollment of beneficiaries in private plans is to lower total Medicare costs, provisions in the 2003 Medicare law explicitly increase Medicare costs in 2005 and for future years through at least 2013.

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Introduction

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) includes a broad set of provisions intended to enlarge the role of private health plans in Medicare. These policies provide higher per-enrollee payments to private plans than costs per beneficiary in traditional fee-for-service Medicare. MMA also makes new types of private plans, including regional preferred provider organizations (PPOs), eligible to participate in Medicare.

The importance that MMA places on private managed care plans—now referred to as Medicare Advantage (MA) plans—stems from the belief that, with an upfront investment to stabilize plan participation and increase beneficiary enrollment, "private plans and competition will help drive down the explosive growth of Medicare spending."[1]

In estimating MMA's costs in December 2003, the Congressional Budget Office (CBO) projected that as a result of the new policies increas-

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ing payments to private plans, the MA program will not reduce Medicare spending but will instead add $14 billion in costs over the next 10 years. The Medicare Office of the Actuary also calculated that the MA program will not produce savings; it estimated the additional costs to the program at $46 billion.[2] According to either projection, MA private plans will raise Medicare expenditures over the next decade.

This issue brief examines the payments that private plans will receive in 2005 relative to costs in traditional fee-for-service Medicare. We find that, in 2005, each of the nation's MA plans will be paid at a rate higher than the level of fee-for-service costs within the same county. Plans will be paid an average of 7.8 percent more—$546 for each of the 5 million Medicare enrollees in managed care, for a total of $2.72 billion more overall.

In our analysis, we do not assume additional enrollment in private plans in 2005; rather, we assume the number of beneficiaries enrolled in MA plans will remain at the level of December 2003.[3] If enrollment in MA plans does increase in 2005 as some predict, the extra costs will be greater than those projected here.

Background: Medicare and Private Plans

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

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

In general, plans participated in those regions with a history of managed care, such as California, or with especially high fee-for-service costs, such as southern Florida. Studies indicate that beneficiaries who enrolled in HMOs were healthier than those in traditional Medicare, and that Medicare actually paid more for HMO enrollees than for similar beneficiaries in traditional Medicare.[4]

Anticipating that private plans would reduce Medicare costs, the Balanced Budget Act of 1997 (BBA '97) expanded the role of such plans when it created the Medicare+Choice program. BBA '97 also made changes to plan payment methods in an effort to entice plans in all regions of the nation to participate. It did so by reducing payment discrepancies between areas with high fee-for-service costs and low-cost, mostly rural areas.

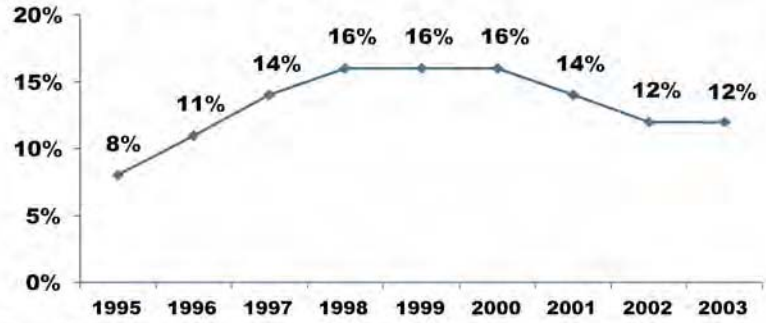
In 1997, CBO predicted that by 2005 up to one-third of Medicare beneficiaries would be enrolled in private plans.[5] But after peaking in 1999 at 16 percent of beneficiaries nationwide, Medicare+Choice plan enrollment declined to 12 percent in 2003. Furthermore, in some areas of the country there were no plans participating in the program (Figure 1).

MMA Policies for MA Plan Payments

MMA made important changes to plan payments. For 2004, MMA set payments to MA plans at the highest of five different categories, all of which were higher than traditional fee-for-service Medicare spending. These policies were implemented at the county level. For 2005, Medicare payments to MA plans will be set at the highest of six different categories—the five 2004 county payment categories, which will increase in 2005 by 6.6 percent (the specified minimum update), plus a new, sixth county category. The six payment types for 2005 include:

- **A rural floor,** which in 2005 will pay plans an annual minimum of $7,104 for Medicare Advantage enrollees in rural counties. The rural floor in 2004 was $6,665.

Figure 1. Enrollment in Medicare Managed Care/ Medicare+Choice Plans by Beneficiaries, 1995–2003



Sources: Marsha Gold and Lori Achman, *Medicare+Choice 1999–2001: An Analysis of Managed Care Plan Withdrawals and Trends in Benefits and Premiums*, The Commonwealth Fund, February 2002; Centers for Medicare and Medicaid Services (CMS) Medicare Managed Care Contract Report; CMS 2002 Data Compendium, 2003; and CMS Medicare Enrollment: National Trends, 1966–2001, 2002. 2003 data are for December.

- **An urban floor,** which in 2005 will pay plans an annual minimum of $7,850 for Medicare Advantage enrollees in urban counties with a population of more than 250,000. The urban floor in 2004 was $7,366.

- **A blended rate,** which combines a local rate and the national average rate. BBA '97 stipulated that blended payment rates be phased in over six years until a 50% local/50% national rate is achieved. However, this transition was subject in each year to a budget neutrality test, and the increase in the blend occurred in one year only.[6] MMA eliminated the BBA '97 budget neutrality test and fully implemented the blend for 2004 payments.

- **A minimum increase in payments from the previous year's level.**[7] The minimum increase for 2004 was set at 6.3 percent more than the 2003 payment level. The national growth rate will be 6.6 percent for 2005.[8]

- **A payment level equal to 100 percent of average county fee-for-service costs in 2004.** The MA rate in these counties will actually exceed 100 percent of fee-for-service costs by an average of 2.3 percent in 2005. This is because MMA provides for MA plan payments to include the costs of indirect medical education—even though Medicare makes payments directly to teaching hospitals to help cover these costs.

- **A new payment level for "rebased" counties, to be set at 100 percent of average county fee-for-service costs in 2005.** This new category is result of a decision by CMS to update, or "rebase," the calculation of county fee-for-service spending amounts for 2005.[9] To rebase plan payments, CMS recalculated the average per capita fee-for-service costs in each of the nation's counties.

Under MMA, all 2005 payments to MA plans will equal their 2004 amounts increased by the national-average fee-for-service cost increase, unless payments are rebased.[10] If they are rebased, then payments to MA plans in 2005 will be set at the higher of: (1) 100 percent of the rebased county average fee-for-service costs; or (2) the county-payment amount in the previous year (based on the 2004 five-category payment system) increased by the Medicare national growth rate in fee-for-service expenditures (6.6 percent).

For 2005, MA plans in 660 counties, where just under half of all MA enrollees reside, will receive the rebased, 100-percent-of-fee-for-service-costs rate.[11] On average, MA plans in these counties will receive increases of 7.7 percent for calendar year 2005. MA plans in the remaining 2,562 counties will receive payment increases of the national minimum update of 6.6 percent above their 2004 rate.

The MA rate in the rebased counties will exceed 100 percent of fee-for-service costs by an average of 2.5 percent, due to the inclusion of indirect medical education costs in plan payments.

Beginning in 2006, plan payments will be determined through a bidding process based on a county benchmark that is set at the level of the

2005 MA payment level increased by the Medicare national growth rate percentage in fee-for-service expenditures.[12]

Extra Payments to Private Plans in 2005

Although the stated objective of efforts to increase enrollment in private health plans is to lower Medicare costs, the policies of MMA regarding private plans explicitly increase Medicare costs in 2004, 2005, and in future years through 2013. During 2005, every Medicare plan in every county in the nation, for every Medicare plan enrollee, will be paid more than the average of fee-for-service costs.

In 2005, average payments to MA plans will exceed average local fee-for-service costs by 7.8 percent, or $546 per MA plan enrollee, for a national total of more than $2.72 billion.[13] These figures are comparable to those cited in other recent reports about MA extra payments,[14] and similar to the findings of our previous analysis for 2004 (8.4 percent higher payments to MA plans, which amounts to $552 for each enrollee, for a total of $2.75 billion).

It should be noted that this projection of extra payments to MA plans for 2005 is conservative, since it does not include either the additional costs resulting from plans enrolling healthier, lower-cost beneficiaries ("favorable selection") or additional costs related to any increase in enrollment in MA plans in 2005. (See Methodology on page 10 to learn how we calculated our projections.)

Extra payments to MA plans may be used to provide additional benefits, which may attract more enrollees. According to the Centers for Medicare and Medicaid Services (CMS), plans used the increase in the amount they were originally projected to receive in 2004 as follows: 31 percent to reduce enrollee premiums; 17 percent to enhance existing benefits; 42 percent to raise payments to providers; and 5 percent to increase stabilization funds.[15]

Variation in Extra Payments

Medicare's annual extra payments to MA plans in 2005 are the sum of the six distinct MMA payment policies implemented at the county level (Figure 2; Tables 2 and 3).

County variation. The largest extra payments relative to fee-for-service costs will continue to be made to plans in the rural floor counties. Plans in these counties will receive 27 percent more than fee-for-service costs, or $1,296 more annually for each plan enrollee. Total extra payments is modest, however, because the share of Medicare beneficiaries in these counties who are enrolled in private plans is the smallest of any of the five payment types. Although over 50 percent of U.S. counties are rural floor counties, they have only 19 percent of Medicare beneficiaries and less than 4 percent of MA plan enrollees.

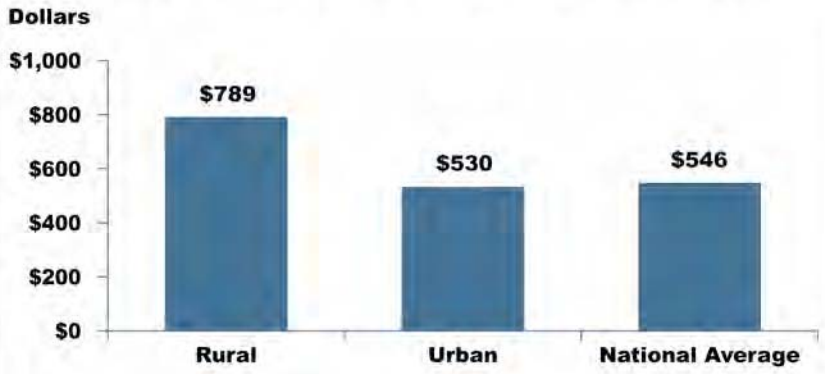
Providing incentives for private health plans to locate and enroll beneficiaries in rural areas has been a major policy objective—as well as a major challenge—since 1997. Thirty years of national experience with managed care plans indicates that private plans will generally choose to locate in urban areas. This pattern is evident in both employment-based health insurance and Medicare.

Figure 2. Payments to Medicare Advantage Plans Exceed Average Annual Fee-for-Service Costs

Source: GWU analysis of Centers for Medicare and Medicaid Services Medicare Managed Care Quarterly State, County Plan Data File for the quarter ending December 2003 and Medicare Advantage Revised 2005 Ratebook.

Across all rural counties, payments above fee-for-service costs per MA plan enrollee average $789 per year, $259 more than the extra amount paid for each urban MA enrollee (Figure 3). Nevertheless, total extra payments in rural areas represent less than 10 percent of all the extra funds going to private MA plans.

Figure 3. Extra Payments to Medicare Advantage Plans per MA Enrollee, by Rural and Urban Location, 2005



Source: GWU analysis of Centers for Medicare and Medicaid Services Medicare Managed Care Quarterly State, County Plan Data File for the quarter ending December 2003 and Medicare Advantage Revised 2005 Ratebook.

Not all payment incentives are provided to rural areas or areas with low MA plan enrollment. Plans located in relatively low-cost urban areas—so-called urban floor counties—also receive substantial payment bonuses, despite having managed care enrollment rates close to the national average. Plans in urban floor counties will receive 16 percent more than local fee-for-service costs, with these extra payments amounting to more than $1,000 for each plan enrollee. Extra payments to plans in urban floor counties total over $1.3 billion, or 48 percent of all extra MA plan payments nationwide. Urban floor counties include a number of counties with a long history of HMOs and Medicare managed care, including Portland, Oregon, and Phoenix, Arizona.

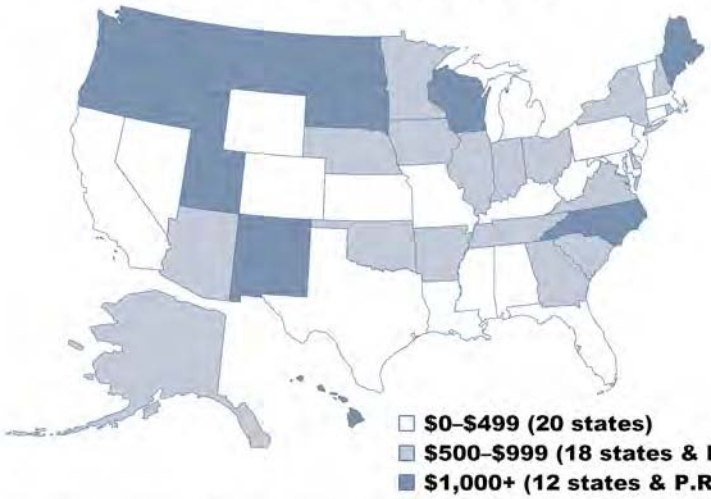
Due to the rebasing of MA plan payments for 2005, only 7.1 percent of plan enrollees live in those counties where plans are paid based on 100 percent of fee-for-service costs in 2004. Total extra payments in these counties will be $72 million, an average of $203 per enrollee.

Plans in counties where payment rates are rebased according to 2005 fee-for-service costs enroll 50 percent of all MA plan members. Extra payments to these plans will total more than $500 million and average $230 per enrollee.

State variation. The amount by which payments per plan enrollee exceed fee-for-service costs varies greatly by state, depending on the state enrollment patterns in each payment category (Figure 4; Table 4).

Extra payments per enrollee range from more than $1,500 in Hawaii, New Mexico, North Carolina, North Dakota, Oregon, and Wisconsin to less than $200 in Florida, Nevada, and Texas. One-third of all the extra payments go to plans in California and New York and another

Figure 4. Medicare Average Extra Payment Amount per MA Plan Enrollee, 2005



Source: GWU analysis of CMS Medicare Managed Care Quarterly State, County Plan Data File for the quarter ending December 2003 and Medicare Advantage Revised 2005 Ratebook.

one-quarter go to plans in Arizona, Oregon, Pennsylvania, and Washington.

CONCLUSION

Despite decades of experimentation with different payment methods, private plans will not reduce Medicare costs in 2005 or over the next decade.

MMA explicitly pays private plans more than traditional fee-for-service Medicare. Both the CBO and the Medicare Office of the Actuary predict that payments to MA private plans will increase Medicare costs for at least the next 10 years.

The analysis presented here examines the extra funds paid to MA private managed care plans in 2005. For each of the 5 million Medicare enrollees in managed care, Medicare will spend an average of $546 more than it does for an average beneficiary in traditional fee-for-service Medicare. In some parts of the country, extra payments by Medicare are more than three times this amount. The total extra payments to MA plans in 2005 are projected at $2.72 billion.

A portion of this $2.72 billion will result in additional benefits for elderly and disabled beneficiaries enrolled in MA plans. But these additional benefits are not uniformly distributed: more than 40 percent of Medicare beneficiaries, particularly those living in rural areas, do not have access to a MA plan, nor do all Medicare beneficiaries in urban areas have their physicians in MA plan networks.

Discussions about the federal budget for 2005 have included proposals to return to the pay-as-you-go budget policy that was in effect during the 1990s. If adopted, pay-as-you-go would require that the costs of any increase in Medicare benefits be balanced by a reduction in Medicare or other federal spending. In this context, $2.72 billion per year might be viewed as a possible source of funds for improved benefits to all Medicare beneficiaries. This amount would, for example, be sufficient to reduce the increase in the Part B premium for 2005 for every Medicare beneficiary, from $11.60 per month, the largest increase in Medicare history, to $6.30 per month.

In the future, the $400 billion annual federal deficit may lead to a budget reconciliation bill similar to the ones adopted in 1990, 1993, and 1997. All of those bills derived substantial savings from reductions in projected Medicare spending. BBA '97 achieved 73 percent of its savings from Medicare.[16] If there is a deficit reduction bill in 2005 or in a subsequent year, $2.72 billion a year might be viewed as a significant part of a deficit reduction package that would not adversely affect the large majority of elderly and disabled Medicare beneficiaries.

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* 350 (Feb. 19, 2004): 747–51.

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

3 Overall MA and Medicare enrollment has increased slightly between December 2003 and June 2004, reflecting increases in the elderly population. However, the Medicare Managed Care penetration rate has remained stable in the wake of MMA—12.6 percent of beneficiaries were enrolled in Medicare+Choice plans as of December 2003 and 12.6 percent were enrolled in MA plans as of June 2004 (including cost plan enrollees).

4 U.S. General Accounting Office, *Medicare+Choice: Payments Exceed Cost of Fee-for-Service Benefits, Adding Billions to Spending* (Washington, D.C.: GAO, 2000).

5 Congressional Budget Office.

6 This MMA policy eliminates the BBA '97 Medicare+Choice requirement that the policy be implemented annually only on a budget-neutral basis.

7 MMA provides for the annual minimum increase to be the higher of: (1) the Medicare national growth rate percentage in fee-for-service expenditures; or (2) 2 percent. Since the national growth rate for 2005 of 6.6 percent is greater than 2 percent, payments in all counties will increase by at least that amount.

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

[9] Ibid.

[10] Ibid.

[11] 660 counties qualify for the 100-percent-of-fee-for-service-cost payment rate in 2005; 260 of these counties have zero MA enrollees, however.

[12] The county benchmark would be higher in rebased counties in years that CMS decides to rebase county fee-for-service spending amounts. CMS is required to rebase the county amount at least once every three years.

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

[14] Other recent reports that estimate payments to managed care plans in 2004 at 107 percent of fee-for-service costs include: Medicare Payment Advisory Commission, *Medicare+Choice Rates Compared with County Medicare per Capita Fee-for-Service Spending* (Revised) (Washington, D.C.: MedPAC, 2004); and L. Achman and M. Gold. *Medicare Advantage 2004 Payment Increases Resulting from the Medicare Modernization Act* (Washington, D.C.: Mathematica Policy Research, 2004). This 2005 estimate of 107.8 percent of average fee-for-service costs differs from others because it uses more recent and adjusted data. This analysis uses December 2003 enrollment data and excludes enrollees paid on the basis of costs, for which plans do not receive additional payments, from the total number of MA enrollees.

[15] Centers for Medicare and Medicaid Services, "Review Shows Beneficiaries in Medicare Advantage Plans Will See Better Benefits, Lower Costs," *CMS News,* Feb. 27, 2004 (Washington, D.C.: CMS, 2004).

[16] M. Moon, B. Gage, and A. Evans, *An Examination of Key Medicare Provisions in the Balanced Budget Act of 1997* (New York: The Commonwealth Fund, Sept. 1997).

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

County Payment Type	Medicare Beneficiaries[3]	MA Plan Enrollees[3]	Total Extra Payments to MA Plans (millions)	Average MA Plan Payment Greater than FFS Costs[2]	
				Average Extra Amount per MA Plan Enrollee	Average Extra Payment to MA Plans Greater than FFS Costs
National	42,229,268	4,984,898	$2,720	$546	7.8%
Rural Floor	7,666,052	163,459	$212	$1,296	27.2%
Urban Floor	11,261,638	1,251,018	$1,314	$1,050	16.3%
Blend	1,543,739	327,756	$308	$941	13.1%
Minimum Update	2,474,827	410,563	$246	$598	6.8%
100% FFS 2004[4]	3,207,816	355,172	$72	$203	2.3%
100% FFS 2005[4]	16,075,196	2,476,930	$569	$230	2.5%

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

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

[3] Medicare and Medicare Advantage (then Medicare+Choice) enrollment data as of December 2003.

[4] CMS has decided to rebase the 100% of FFS rate at the county level for 2005. Rebasing the FFS rates means that CMS retabulated the per capita FFS expenditures for each county so that the FFS rates reflect more recent county growth trends in FFS expenditures. The MMA provides that the county level payment rate for MA plans in 2005 will be the higher of the 2005 rebased 100% of FFS rate or the 2004 rate increased by 6.6%. See Centers for Medicare and Medicaid Services (CMS), "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/healthplans/rates/2005/45day.pdf. Accessed September 15, 2004

Source: George Washington University analysis of Centers for Medicare and Medicaid Services Medicare Managed Care Quarterly State, County Plan Data File for the quarter ending December 2003 and Medicare Advantage Revised 2005 Ratebook.

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

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%	11.8%	100.0%
Rural Floor	18.2%	3.3%	2.1%	7.8%
Urban Floor	26.6%	25.1%	11.1%	48.3%
Blend	3.7%	6.6%	21.2%	11.3%
Minimum Update	5.9%	8.2%	16.6%	9.0%
100% FFS 2004[1]	7.6%	7.1%	11.0%	2.6%
100% FFS 2005[1]	38.0%	49.7%	15.4%	21.0%

[1] CMS has decided to rebase the 100% of FFS rate at the county level for 2005. Rebasing the FFS rates means that CMS retabulated the per capita FFS expenditures for each county so that the FFS rates reflect more recent county growth trends in FFS expenditures. The MMA provides that the county level payment rate for MA plans in 2005 will be the higher of the 2005 rebased 100% of FFS rate or the 2004 rate increased by 6.6%. See Centers for Medicare and Medicaid Services (CMS), "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/healthplans/rates/2005/45day.pdf. Accessed September 15, 2004.

Source: George Washington University analysis of Centers for Medicare and Medicaid Services Medicare Managed Care Quarterly State, County Plan Data File for the quarter ending December 2003 and Medicare Advantage Revised 2005 Ratebook.

Table 3. Extra Payments to Medicare Advantage Plans Compared with Average Fee-for-Service Costs by State, 2005[1]

				Average MA Plan Payment Greater than FFS Costs[2]		
State	Medicare Beneficiaries[3]	MA Plan Enrollees[3]	MA Plan Enrollment Rate	Average Extra Payment to MA Plans Greater than FFS Costs	Average Extra Amount per MA Plan Enrollee	Total Extra Payments to MA Plans (millions)
National	42,229,268	4,984,898	11.8%	7.8%	$546	$2,720
Rural	12,557,499	304,067	2.4%	15.8%	$789	$240
Urban	29,671,769	4,680,831	15.8%	7.3%	$530	$2,480
Alabama	747,954	48,166	6.4%	3.7%	$299	$14
Alaska	50,237	110	0.2%	10.3%	$761	$0.08
Arizona	762,655	207,539	27.2%	10.9%	$749	$155
Arkansas	469,750	1,885	0.4%	11.9%	$762	$1
California	4,245,740	1,327,773	31.3%	5.0%	$372	$493
Colorado	513,655	114,497	22.3%	6.3%	$458	$52
Connecticut	536,341	29,259	5.5%	5.4%	$419	$12
Delaware	124,386	533	0.4%	6.8%	$500	$0.3
D.C.	77,348	122	0.2%	6.3%	$553	$0.7
Florida	3,022,501	541,408	17.9%	1.2%	$112	$61
Georgia	1,016,266	35,390	3.5%	8.5%	$637	$23
Hawaii	181,933	20,708	11.4%	37.4%	$2,076	$43

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

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

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

[3] Medicare and Medicare Advantage (then Medicare+Choice) enrollment data as of December 2003.

Source: George Washington University analysis of Centers for Medicare and Medicaid Services Medicare Managed Care Quarterly State, County Plan Data File for the quarter ending December 2003 and Medicare Advantage Revised 2004 Ratebook.

Table 3. Extra Payments to Medicare Advantage Plans Compared with Average Fee-for-Service Costs by State, 2005 (cont.)[1]

State	Medicare Beneficiaries[3]	MA Plan Enrollees[3]	MA Plan Enrollment Rate	Average MA Plan Payment Greater than FFS Costs[2]: Average Extra Payment to MA Plans Greater than FFS Costs	Average MA Plan Payment Greater than FFS Costs[2]: Average Extra Amount per MA Plan Enrollee	Average MA Plan Payment Greater than FFS Costs[2]: Total Extra Payments to MA Plans (millions)
Idaho	185,630	12,161	6.6%	23.6%	$1,468	$18
Illinois	1,718,454	78,864	4.6%	8.6%	$590	$47
Indiana	909,172	1,872	0.2%	12.1%	$764	$1
Iowa	496,179	3,735	0.8%	15.6%	$988	$4
Kansas	405,737	13,323	3.3%	3.7%	$259	$3
Kentucky	675,598	18,473	2.7%	4.0%	$290	$5
Louisiana	648,813	68,523	10.6%	2.2%	$222	$15
Maine	235,196	76	0.0%	19.8%	$1,239	$0.09
Maryland	697,315	9,398	1.3%	3.2%	$302	$3
Massachusetts	996,887	170,541	17.1%	5.1%	$423	$72
Michigan	1,498,155	23,104	1.5%	4.5%	$427	$10
Minnesota	700,176	47,093	6.7%	10.5%	$716	$34
Mississippi	455,426	1,854	0.4%	3.4%	$253	$0.5
Missouri	915,996	110,669	12.1%	7.5%	$494	$55
Montana	147,874	249	0.2%	17.5%	$1,031	$0.3
North Carolina	1,252,361	48,752	3.9%	25.3%	$1,553	$76
North Dakota	105,907	144	0.1%	31.4%	$1,672	$0.2
Nebraska	264,524	9,688	3.7%	8.2%	$578	$6
Nevada	288,654	82,097	28.4%	1.8%	$144	$12
New Hampshire	185,978	1,320	0.7%	12.4%	$856	$1
New Jersey	1,256,249	91,776	7.3%	3.1%	$285	$26
New Mexico	260,916	39,257	15.0%	34.2%	$1,977	$78
New York	2,846,008	452,769	15.9%	11.1%	$909	$412
Ohio	1,783,694	204,530	11.5%	8.3%	$602	$123
Oklahoma	539,746	40,091	7.4%	7.7%	$546	$22
Oregon	533,242	129,784	24.3%	28.3%	$1,676	$217
Pennsylvania	2,168,944	511,248	23.6%	4.7%	$407	$208
Puerto Rico	598,682	34,394	5.7%	60.1%	$2,236	$77
Rhode Island	176,959	57,572	32.5%	13.0%	$885	$51
South Carolina	632,828	1,158	0.2%	12.8%	$862	$1
South Dakota	125,432	77	0.1%	22.2%	$1,287	$0.9
Tennessee	908,486	62,218	6.8%	14.5%	$952	$59
Texas	2,490,561	135,206	5.4%	2.1%	$181	$24
Utah	229,430	7,113	3.1%	19.4%	$1,226	$9
Vermont	96,255	0	0	0	0	0
Virginia	978,023	9,287	0.9%	12.4%	$776	$7
West Virginia	359,367	22,417	6.2%	3.4%	$264	$6
Washington	807,287	131,138	16.2%	16.6%	$1,084	$142
Wisconsin	833,298	24,458	2.9%	30.0%	$1,600	$39
Wyoming	71,063	1,079	1.5%	5.1%	$336	$0.4

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

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

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

[3] Medicare and Medicare Advantage (then Medicare+Choice) enrollment data as of December 2003.

Source: George Washington University analysis of Centers for Medicare and Medicaid Services Medicare Managed Care Quarterly State, County Plan Data File for the quarter ending December 2003 and Medicare Advantage Revised 2004 Ratebook.

METHODOLOGY

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

The number of Medicare beneficiaries and Medicare Advantage enrollees by county is taken from the Medicare Managed Care Quarterly State and County data files for the quarter ending December 31, 2003. These data are posted on the Web site of the Centers for Medicare and Medicaid Services, http://www.cms.hhs.gov.[1] The December enrollment data was used so that the 2004 and 2005 estimates can be directly compared. These data do not differentiate between aged, disabled, and end-stage renal disease Medicare beneficiaries, so this analysis treats all beneficiaries as aged.

The county is the basic unit of analysis for the Medicare Advantage program since Medicare sets plan payment rates at the county level. The payments to MA plans in 2005 will be the higher of: (1) the county payment level in 2004 increased by the Medicare national growth rate percentage in fee-for-service expenditures, 6.6 percent; or, (2) a recalculated base of 100 percent of average county fee-for-service costs. This rebasing of fee-for-service costs will result in an increase in MA payments by more the national average of 6.6 percent in 660 counties. In 2004 plans received the highest of five payments: the national rural floor, the national urban floor, the 50/50 national/local blend rate, a minimum update over the previous year's rate, or 100 percent of the average fee-for-service costs in the county.

Plan payment and enrollment data is provided at the county level. All payment data is taken from the Centers for Medicare and Medicaid Services 2005 Medicare Advantage aged rate book.

The aged rate book reports data on per enrollee monthly payments to Medicare Advantage plans, average per-beneficiary fee-for-service costs, and a carve-out factor for graduate medical education by county.

Extra payments to Medicare Advantage plans are calculated for 3,223 counties in the United States and then, for illustrative purposes, aggregated by state or payment category. Puerto Rico is included in the analysis; Guam and the Virgin Islands are not.

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

All calculations are Medicare Advantage plan enrollee weighted to reflect variations in enrollment and payment rates. It is important to note that direct comparisons between fee-for-service costs and payments to plans can only be made at the county level because of these variations. For example, the higher average payment to Medicare Advantage plans relative to fee-for-service costs in a particular state simultaneously reflects the extra payments to Medicare Advantage plans and the tendency of plans to be located in urban areas. Urban areas have higher fee-for-service health care costs (on average) than more rural parts of a state, where managed care networks are more difficult to establish. Medicare Advantage plan enrollee-weighted analysis at the county level captures the portion that is driven by extra payment to plans.

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[1] Centers for Medicare and Medicaid Services. *Rate Calculation Data* (Washington, D.C.: CMS, 2004). Available at http://www.cms.hhs.gov/healthplans/rates/. Accessed Feb. 1, 2004. Centers for Medicare and Medicaid Services. *Medicare Managed Care Market Penetration for All Medicare Plan Contractors—Quarterly State/County Data Files* (Washington, D.C.: CMS, 2004). Available at http://www.cms.hhs.gov/healthplans/statistics/mpsct/. Accessed Feb. 1, 2004.

Methodology (cont.)

Some 330,000 Medicare+Choice enrollees are in Medicare plans paid on the basis of costs and which do not receive Medicare Advantage plan payment rates. These beneficiaries were removed from the Medicare Advantage enrollee totals by county, but are included in the number of overall Medicare beneficiaries. Although these beneficiaries receive Medicare benefits through managed care plans, they do not generate extra payments.

This analysis follows a methodological convention developed by MedPAC in addressing the Medicare policy of making direct payments to teaching hospitals for the costs of indirect medical education (IME) for Medicare Advantage enrollees. It adjusts fee-for-service costs at the county level by removing the average IME expense. This is done by deflating the county fee-for-service average by a factor of 1 – (0.65 * GME), where GME is the county graduate medical education carve-out. A national average of 65 percent of graduate medical education payments goes to indirect medical education; county-specific data are unavailable. Because Medicare makes indirect medical education payments directly to teaching hospitals for patients who are enrolled in Medicare Advantage, Medicare Advantage plan payment rates are most appropriately compared with fee-for-service costs adjusted in this manner.[2]

Budget-neutrality adjustments to MMA 2005 payments to Medicare Advantage plans for risk adjustment provide additional extra payments to MA plans. These are not included in this analysis. In 2005, 50 percent of payments to Medicare Advantage plans will be risk-adjusted using the CMS–HCC model to account for beneficiary health characteristics.[3]

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

[3] 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" (Washington, D.C.: CMS, 2004). Available at http://www.cms.hhs.gov/healthplans/rates/2005/45day.pdf. Accessed September 6, 2004.

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