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Issue Brief

Making Sense of the Change in How Medicare Advantage Plans Are Paid

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Abstract: The Affordable Care Act has altered payment policy for private Medicare Advantage (MA) plans, with the goal of lowering costs closer to the level in traditional Medicare. Using newly available information on 2009 MA plan costs, this analysis compares plans' estimates of per capita costs for providing Parts A and B benefits to their enrollees, on a risk-adjusted basis, against what government data show to be the same costs for traditional Medicare program beneficiaries residing in the same county. It finds that on average, risk-adjusted MA plan costs were 4 percent higher than traditional Medicare costs (104%). Among plan types, only HMOs had lower average costs than traditional Medicare. Among local PPOs and private fee-for service plans, over 75 percent had costs exceeding those in traditional Medicare. The wide variation seen in MA plan costs relative to traditional Medicare suggests there is room for greater efficiency in care delivery.

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OVERVIEW

From at least the mid-2000s, health insurance plans participating in Medicare Advantage (MA)—the Medicare program's private coverage option—have been paid considerably more to provide Parts A and B coverage of hospital and physician services than what the government spends to deliver the same benefits to beneficiaries enrolled in the traditional Medicare program. According to the federal Medicare Payment Advisory Commission, average estimated Medicare Advantage payments in 2009 were 114 percent of spending in traditional Medicare.[1]

This payment discrepancy has been a longstanding point of contention among policymakers.[2] While MA enrollees gain from these overpayments—because MA plans are required to use the extra money to enhance benefits or reduce out-of-pocket costs—such payments add to the Medicare program's costs. Moreover, there is the question of equity: beneficiaries in traditional Medicare

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are not offered special benefits or lower costs, since the program is not allowed to compete with private MA plans. Because MA plans are reimbursed for the administrative costs of providing such benefits and realize profits on them (known as the "load"), Medicare spent an estimated $1.30 for each dollar in enhanced benefits.[3]

The Affordable Care Act aims to shrink the difference in payments between Medicare Advantage and traditional Medicare over time. To achieve this goal, Congress divided U.S. counties into four quartiles based on average per-beneficiary spending in traditional Medicare, recognizing that cost savings are probably easier to achieve for health plans in high-payment areas compared with plans in low-payment areas. Thus, plans in counties in the highest-spending quartile ultimately will have their payments reduced to a maximum of 95 percent of traditional Medicare; plans in the lowest-spending quartile will have their payments capped at 115 percent of traditional Medicare (i.e., 15 percent higher); and the middle two quartiles are reduced to a maximum of 100 percent and 107.5 percent, respectively. Payments were frozen in 2011 at their 2010 levels. Starting in 2012, the payment change will be phased in gradually over a two-to-six-year period to give MA plans that are the most affected time to adapt. Plans have the opportunity, however, to receive bonus payments based on their clinical quality and patient experience "star ratings."[4]

UNDERSTANDING THE BASELINE

To establish a baseline for understanding the future impact of the change in Medicare Advantage payment policy, we analyzed newly available data on MA plan costs for 2009, prior to enactment of the new policy. These costs were found in the bids that plans submitted to the Centers for Medicare and Medicaid Services (CMS). We compared plans' estimates of their per capita, risk-adjusted costs of providing enrollees with Part A and Part B benefits against what CMS data show to be the same costs for a traditional Medicare program beneficiary residing in the same county.[5] (See box on page 4 for information on the complete study and methodology.)

To standardize the comparison as much as possible, we limited our analysis to those MA plans offering a prescription drug benefit and open to general enrollment (MA-PDs). This is the type of plan most commonly selected by Medicare beneficiaries in the individual insurance market.[6]

Our analysis found that in 2009, there were 2,315 MA-PD plans, with a combined enrollment of 7.4 million Medicare beneficiaries (Exhibit 1). On average, risk-adjusted costs for MA plans were 104 percent of costs in the traditional Medicare program, or 4 percent higher. Among the various types of MA plans, only health maintenance organizations (HMOs) had costs lower, on average, than those for traditional Medicare. There was considerable variation in costs both within and across plan types: for example, among

Exhibit 1. Distribution of Medicare Advantage Relative Costs by Plan Type, 2009

Plan type	Number of plans	Number of enrollees	MA bid costs as a percentage of local FFS costs			
			Mean	25th percentile	Median	75th percentile
All	**2,315**	**7,377,845**	**104%**	**87%**	**104%**	**121%**
HMO	1,492	5,361,080	97	81	97	113
LPPO	437	710,186	119	103	119	134
PFFS	331	971,669	119	110	119	129
RPPO*	55	334,910	100	70	108	122

Notes: FFS = fee-for-service; HMO = health maintenance organization; LPPO = local preferred provider organization; PFFS = private fee-for-service; RPPO = regional preferred provider organization.
* Because RPPO bids are handled differently than local MA plan bids and because there are only 55 RPPOs, the RPPO figures should be interpreted with caution.
Source: Mathematica analysis of publicly available Medicare Advantage data.

local preferred provider organizations (PPOs) and private fee-for-service plans, where much of the recent growth in enrollment has been concentrated, more than 75 percent had costs that exceeded those of traditional Medicare.

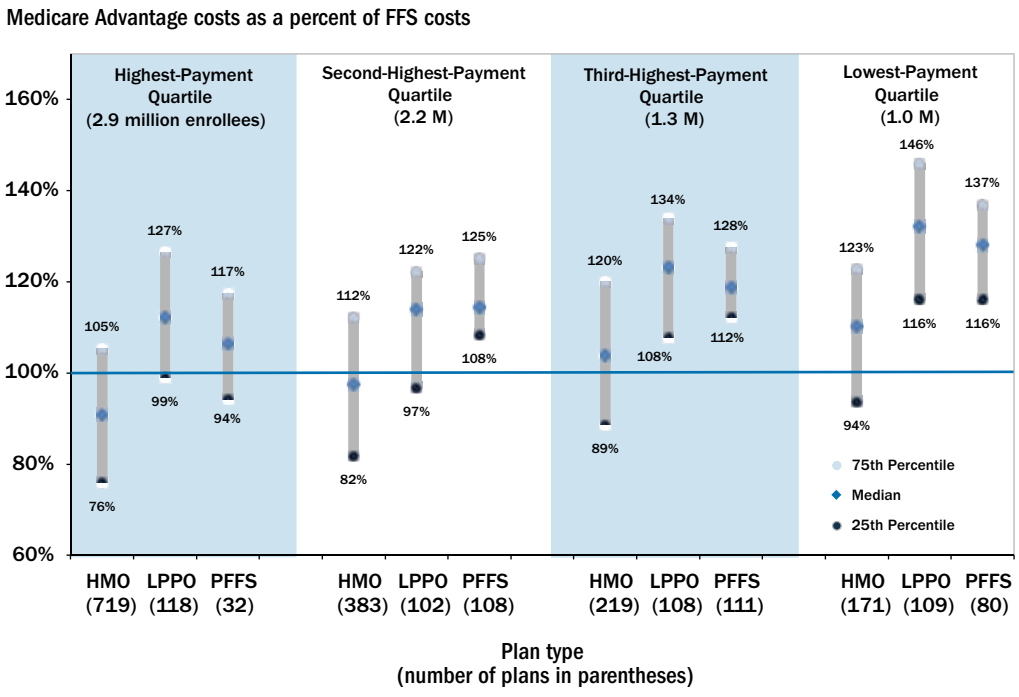
For a more complete understanding of how the MA payment changes would affect plans of different types, we examined the relationship between plan costs and traditional Medicare payment levels, on a risk-adjusted basis, within each payment quartile (Exhibit 2). Plans in the highest quartile generally operate in the highest-cost counties, and those in the lowest quartile operate in the lowest-cost counties. Relative to traditional Medicare enrollees, Medicare Advantage enrollees are disproportionately located in higher-cost counties, reflecting the MA program's largely urban, HMO-dominant base.

However, no plan type, other than HMOs, has lower costs than the traditional Medicare program in any quartile, even the highest-payment areas. HMOs, on average, are about 90 percent as expensive as traditional Medicare in the highest-payment quartile. Local PPOs cost the most in relative terms—in the highest-payment quartiles, 13 percent more. (Regional PPOs are omitted from the analysis because there are so few of them, and only a few are in the top and bottom quartiles.)

MAKING SENSE OF THE CHANGE IN POLICY

Our analysis has inevitable limitations. In reality, plans compete against others within their local market, rather than against the universe of plans, even within a given payment quartile. Although the methods we used in our analysis to adjust for plan risk mirror those used by Medicare, it is possible that critical differences are unaccounted for across plans, or between Medicare Advantage and traditional Medicare. Also, while we have attempted to control for differences in plan types (HMOs, PPOs, etc.), the quartiles are necessarily broad and are likely to cover areas with diverse payment levels and characteristics.

Exhibit 2. Comparison of Medicare Advantage Plan Bid Costs to Medicare Fee-for-Service Costs, by Geographic Payment Quartiles, High to Low, 2009



Notes: FFS = fee-for-service; HMO = health maintenance organization; LPPO = local preferred provider organization; PFFS = private fee-for-service.
Source: Mathematica analysis of publicly available Medicare Advantage data.

Notwithstanding these limitations, the findings from the analysis are relevant to the current policy environment. The Affordable Care Act's MA plan payment changes will increase pressure on plans to be more efficient—that is, to provide higher-quality care at lower cost. The wide variation in MA costs relative to traditional Medicare suggests that there is room for greater efficiency, though perhaps there were limited incentives to seek it under historical payment methods. While payments will be reduced most (relative to traditional Medicare) in the highest-cost U.S. counties, our analysis shows there are many plans operating within these counties, including many HMOs, that should be well positioned to be compensated for their costs, even under the new payment system.

The situation is more complicated in the lowest-cost counties, where most plans have a harder time competing on a cost basis with the traditional program. Under the health reform law, MA plans in these areas will continue to be eligible to receive as much as 15 percent more than it costs the traditional Medicare program to enhance choice in lower-cost areas. Presumably, policymakers have decided that, in a tight budget environment, plans that cannot provide benefits within that cost target do not provide sufficient value to the Medicare program to warrant greater subsidy.

About This Study

This brief is based on the report *Analysis of the Variation in Efficiency of Medicare Advantage Plans,* by Marsha Gold and Maria Cupples Hudson, which can be downloaded at http://www.mathematica-mpr.com/publications/redirect_pubsdb.asp?strSite=pdfs/health/variation_efficiency_ma_plans.pdf. For their analysis, the authors drew from public data on 2009 Medicare Advantage plan bids (http://www.cms.gov/Plan-Payment/PPData/list.asp) made available through a Freedom of Information Act request, as well as on public files describing the distribution of Medicare beneficiaries, enrollees, plans, and traditional program spending by county. The results are for MA-PD plans, which include prescription drug benefits; excluded from the analysis are plans available only to selected beneficiaries (so-called Special Needs Plans), those offered by group accounts, or those excluding pharmacy benefits (MA-only plans).

Notes

[1] Medicare Payment Advisory Commission, "Chapter 3. The Medicare Advantage Program," in *Report to Congress: Medicare Payment Policy* (Washington, D.C.: MedPAC, March 2009).

[2] M. Gold, "Perspectives: Medicare Advantage: Lessons for Medicare's Future," *New England Journal of Medicine,* March 29, 2012 366(13):1174–77.

[3] MedPAC, "Chapter 3," 2009.

[4] Medicare Payment Advisory Commission, *Medicare Advantage Payment Basics* (Washington, D.C.: MedPAC, Nov. 2012).

[5] By "risk-adjusted," we mean that the relative health status and medical care needs of each plan's enrolled beneficiaries were taken into account. We used the same metrics as Medicare uses for this purpose.

[6] Our unit of analysis was the "plan" as defined in the bids MA companies file with CMS. Since a plan often spans more than one county, we developed the traditional program comparison data to reflect Medicare program costs for beneficiaries residing in the same geographical mix of counties.

About the Author

Marsha Gold, Sc.D., is a senior fellow at Mathematica Policy Research in Washington, D.C. She is a nationally known expert on health care delivery and financing, especially in managed care and public programs such as Medicare and Medicaid. Her expertise covers trends in the organization and financing of medical care and its implications for access to care. Current studies include the Medicare Advantage Monitoring Program, which has been tracking the use of private plans in Medicare, the Global Assessment of HITECH for the Office of the National Coordinator for Health Information Technology, and several studies that aim to monitor emerging models (e.g., accountable care) and support policymakers (e.g., the Medicaid Access and Payment Commission). She has an Sc.D. in health services/evaluation research from the Harvard University School of Public Health.

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