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PAYMENTS TO MEDICARE ADVANTAGE PLANS EXCEED FEE-FOR-SERVICE COSTS:

OPTIONS FOR MEDICARE SAVINGS FROM 2008 THROUGH 2012

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SUMMARY

The Medicare Modernization Act of 2003 (MMA) and the Deficit Reduction Act (DRA) of 2005 include provisions intended to increase the role of private health plans in Medicare. These provisions set Medicare Advantage plan benchmark rates at levels higher than average costs would be in traditional fee-for-service Medicare in every county in the nation. The total amount of extra payments to Medicare Advantage plans resulting from these provisions is projected to total over \$8 billion in 2008 and \$70 billion over the five year period, 2008 to 2012.

This briefing paper outlines the specific MMA and DRA provisions that generate these extra payments and presents opportunities for revised policies that can reduce Medicare spending in excess of fee-for-service costs. The options explored here address the three basic factors that contribute to Medicare Advantage plan extra payments: MMA statutory county benchmark rates; Indirect Medical Education payments that increase the county benchmark rates; and payments from a regional PPO stabilization fund.

In view of the recent Congressional adoption of a pay-as-you-go rule (PAYGO) that requires all legislation that increases Federal spending to include provisions that reduce Federal spending by an equivalent amount, the amount of extra payments to MA plans may be important in 2007.

In particular, these funds may be a source of the cost savings needed to pay for an extension of the State Children's Health Insurance Program (SCHIP), a modification of the Sustainable Growth Rate (SGR) policies so that Medicare payments to physicians do not decline by 10 percent in 2008, or a reduction in out-of-pocket Medicare costs for the elderly and disabled. Five year costs for the extension of the SCHIP program are estimated at \$50 billion, a two year SGR fix is estimated at \$30 to \$40 billion, and reductions in out-of-pocket costs for low-income Medicare beneficiaries is estimated at \$10 billion or more.

Furthermore, reductions in extra payments to Medicare Advantage plans may be seen as appropriate, as these extra payments clearly run counter to the oft-stated purpose of increasing the enrollment of Medicare beneficiaries in private plans: to lower total Medicare costs.

PAYMENTS TO MEDICARE ADVANTAGE PLANS EXCEED FEE-FOR-SERVICE COSTS: OPTIONS FOR MEDICARE SAVINGS FROM 2008 THROUGH 2012

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INTRODUCTION

Provisions of the Medicare Modernization Act of 2003 (MMA) are intended to increase the role of private health plans in Medicare. Part of the strategy to accomplish this was an increase in payments to Medicare Advantage (MA) plans.

Under these policies, Medicare now pays private MA plans more per enrollee than average costs would be in traditional fee-for-service (FFS) Medicare. This difference – here referred to as extra payments – is estimated to average 13.3 percent, or \$1,008 per MA plan enrollee, for a total of \$7.5 billion in 2007.¹ The total amount of extra payments to MA plans in 2008 has been projected at \$8.8 billion and extra payments are projected to amount to as much as \$71 billion during the five years 2008 through 2012.²

Extra payments to MA plans occur against the background of a persistent interest in Medicare cost savings. This is an especially important issue in 2007 as the Congress has adopted a pay-as-you-go rule (PAYGO) for the 110th Congress. This rule requires all legislation with provisions that increase Federal spending to include provisions that reduce Federal spending by an equivalent amount.

Major health proposals under consideration in 2007 with costs that must be met by PAYGO savings have been estimated to total as much as \$100 billion over five years. These proposals are led by the scheduled extension of the State Children's Health Insurance Program (SCHIP) with projected five year costs of \$50 billion.

A second proposal under consideration in 2007 is a fix of at least two years for the projected decrease in payments to physicians in 2008 caused by the Sustainable Growth Rate (SGR) policies of the Balanced Budget Act of 1997. The SGR will, if not

modified, reduce physician payments by 10 percent in 2008 and by 5 percent a year in subsequent years.^{3,4} Some believe that a reduction in Medicare payments to physicians of this magnitude would reduce access to physicians for seniors and the disabled. Precluding a decrease in Medicare physician payments for two years is projected to cost over \$30 billion.

An additional proposal that may be considered in 2007 is a reduction in out-of-pocket costs for low-income Medicare beneficiaries. An increase in the income eligibility levels similar to those adopted for low-income children and parents would cost \$10 billion or more over five years.

Using extra payments to MA plans in 2007 as a source of savings to support other health spending would be consistent with policies adopted over the past two years.

The Tax Relief and Health Care Act of 2006 (TRHCA) provided a SGR fix so that physician payments in 2008 would not be reduced by five percent but would be maintained at 2006 rates. This provision cost about \$5 billion from 2008-2010. The offsetting savings were provided by a reduction in funding for the MA regional preferred provider organization (PPO) stabilization fund of \$6.5 billion from 2008-2011.⁵

In 2005, the Deficit Reduction Act (DRA) provided a SGR fix of no decrease in physician fees together with net five year reduction of Medicare spending of \$6.4 billion. The DRA achieved its net Medicare savings from a reduction in projected payments to MA plans of \$6.5 billion in FYs 07 through 10. This MA payment provision codified in statute a reduction in MA plan budget neutral risk adjustment payments in 2008 – 2012 that had been announced by CMS in early 2005 and modified in September 2005.

In light of the consideration of possible Medicare savings in 2007, this briefing paper describes the specific MMA and DRA policies that provide extra payments to MA plans in 2008 and future years and reviews a series of options to reduce the extra payments to MA plans and projects the amounts of possible reductions in Medicare spending from 2008 - 2012.

This analysis focuses on MA extra payments related to three policies:

- MMA statutory MA county benchmark rates that are the basis for the benchmark-based plan bidding system;
- MMA policies that provide for double payment of the cost of Indirect Medical Education (IME) for MA enrollees who are hospitalized in teaching hospitals;

- MMA authorized payments from a national stabilization fund to regional PPOs in addition to their basic MA payments, in 2012 and 2013.

These three policies provide a projected \$71 billion in extra payments to MA plans from 2008 through 2012. The county benchmarks contribute almost \$65 billion, the IME double payments \$5 billion and the regional stabilization fund payments \$1.6 billion.

It should be noted that the projected savings from reductions in extra payments to MA plans reported here for 2008 to 2012 are more than twice as high as we reported last year for 2007-2011. This increase is primarily due to the current and projected increase in total enrollment in MA plans. MA enrollment grew from 5.7 million in December 2005 to 7.8 million as of May 2007.⁶ The increased costs are especially a product of the increased enrollment in Private Fee-For-Service plans in rural floor counties where extra payments average 18 percent more than FFS costs.

Figure 1. Projected Payments to MA Plans in Excess of FFS Costs, 2008 to 2012

	2008	2008	2009	2010	2012	2008-11 5-yr Total
Total MA extra payments	\$8.8 b	13.2 b	14.8 b	17.5 b	17.3 b	\$71.6 b
MMA statutory benchmark¹	\$8.1	12.2	13.7	16.2	14.6	\$64.8b
MMA double payment for IME	\$0.7	1.0	1.1	1.3	1.1	\$5.2
Regional PPO stabilization fund	\$0	0	0	0	1.6	\$1.6 b

¹ Note: Payments for the DRA BNRA phase-out are also included in the figures for the MMA statutory benchmark.

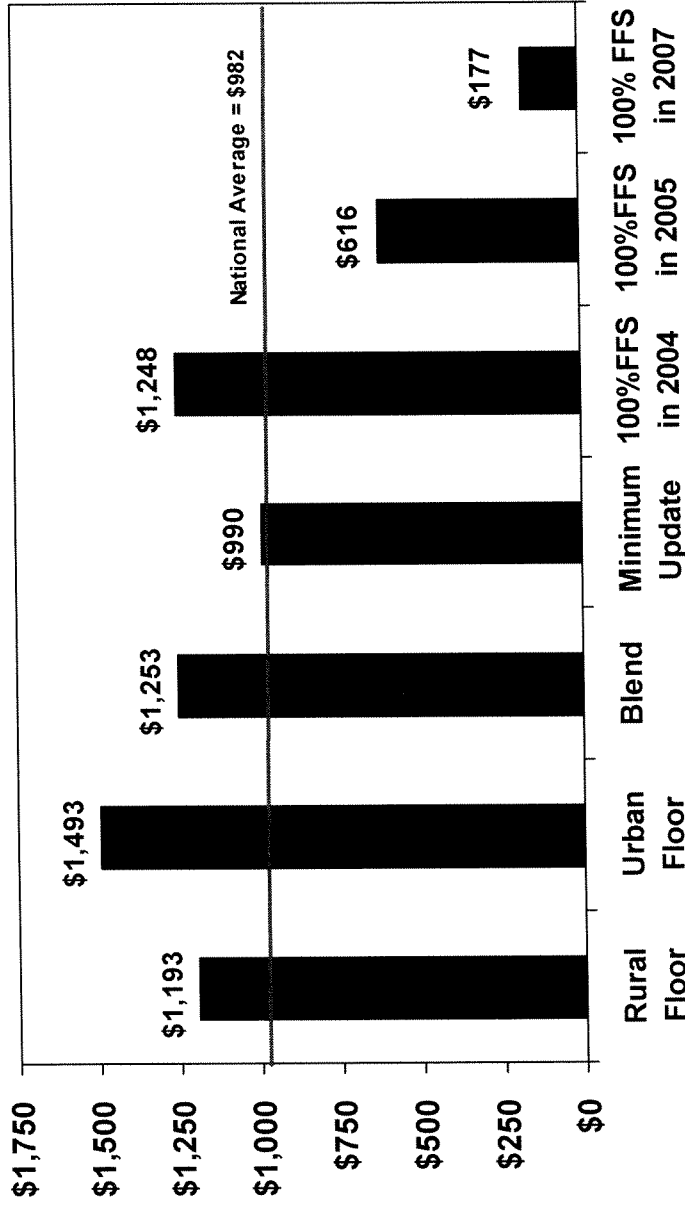
The projected costs presented here are based on five- and ten-year projections of Medicare Advantage-related expenditures released by the Congressional Budget Office,⁷ in addition to our own analysis of extra payments to MA plans in 2007 and 2008 based on data from the Centers for Medicare and Medicaid Services.⁸

The extra payments to MA plans are primarily the product of the county benchmark system, discussed in greater detail below, which sets MA rates at different levels for seven categories of counties.

In Figures 2 and 3, counties are grouped according to the MMA benchmark policy under which MA plans in the counties are paid. Figure 2 presents estimated average extra payments above fee-for-service costs per enrollee for MA plans in these seven county payments types for 2008. Figure 3 presents the estimated share of total extra payments in 2008 for each of these seven types of counties.

As illustrated in Figure 3, an estimated 43 percent of total MA extra payments will go to plans in urban floor counties in 2008. This is an average of \$1,493 in annual extra payments for each of the 2.1 million MA plan enrollees in these counties. Over 22 percent of total extra payments go to plans in the 100 percent of FFS in 2005 counties with \$616 per enrollee in extra payments and 2.7 million enrollees.

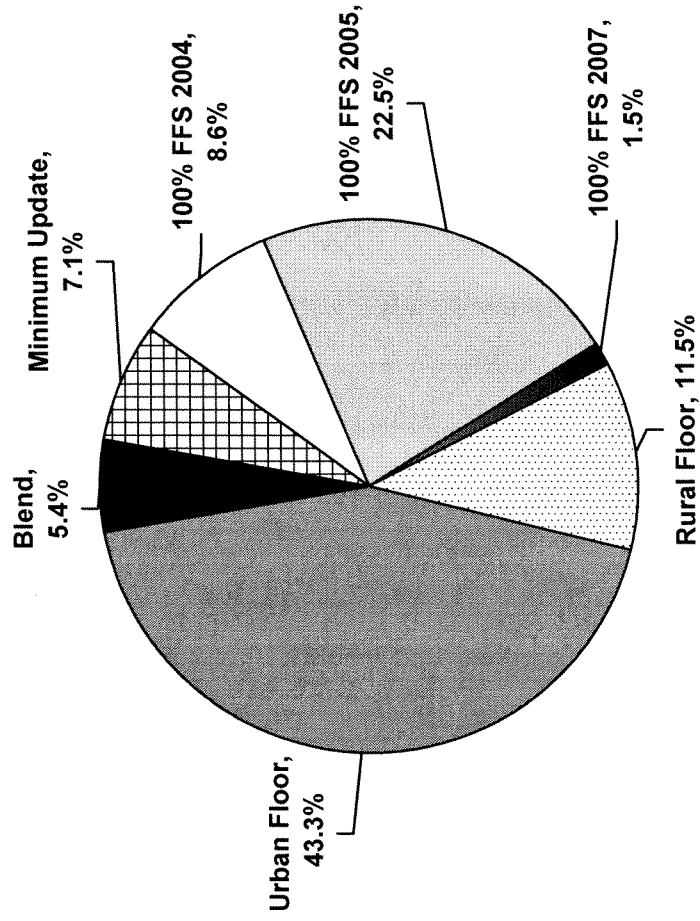
Figure 2. Estimated Annual Extra Payments to MA Plans per Plan Enrollee, 2008



Source: GWU analysis of Centers for Medicare and Medicaid Services Medicare Managed Care State/County/Contract Data File released February 2007, the Medicare Managed Care State County data file for December 2005 and the Medicare Advantage 2008 Rate Calculation Data spreadsheet.

Note: Figures above include BNRA and FFS growth adjustment. Assumes plan bids in all counties fall 16% below the benchmark.

Figure 3. Estimated Share of Total Extra Payments to MA Plans by County Payment Category, 2008



Source: GWU analysis of Centers for Medicare and Medicaid Services Medicare Managed Care State/County/Contract Data File released February 2007, the Medicare Managed Care State County data file for December 2005 and the Medicare Advantage 2008 Rate Calculation Data spreadsheet.

Note: Figures above include BNRA. Assumes plan bids in all counties fall 16% below the benchmark.

EXTRA PAYMENTS TO MA PLANS

In 2005 and earlier years, MA plans were paid at the level of the county benchmark. However, the MMA specified that beginning in 2006 Medicare pay MA plans by means of a benchmark-based bidding system.

Under this system, CMS calculates and posts on its website a county benchmark each year for each county. This benchmark is then adjusted by the budget neutral risk adjustment factor. The resulting figure is essentially the base rate against which MA plans bid. Every MA plan files a bid each June to provide A and B services for the next calendar year that reflects the costs to the plan of providing Part A and B services in the calendar year.¹⁰

This section will examine the factors that together are responsible for the level of extra payments to MA plans in 2008 and future years: MA county benchmark rates; IME payments that increase county benchmarks; MA plan bids; and finally, the extra payments provided through the regional PPO stabilization fund.

MA county benchmark rates. The MMA provides specific instructions for CMS to follow each year when it posts MA county level benchmarks as the foundation for the calculation of Medicare payments to MA plans.

Following MMA policies, the MA county benchmark rates for 2008, posted by CMS in April 2007, are more than the average costs in FFS Medicare in every county in the nation.¹¹

County benchmark rates in 2008 are projected to exceed FFS costs by an average of \$1,331 per MA enrollee or 16.4 percent. Benchmark rates vary from \$1,824 more than FFS costs in the urban floor counties to \$581 more in the counties paid according to 100 percent of 2007 FFS costs.¹²

MMA provisions specify that the MA benchmark payment rate for each county is set at the highest of seven different amounts for 2008. The seven county payment types are:

- A rural floor rate for rural counties set at, including BNRA, \$8,595 in 2008;
- An urban floor rate in urban counties with a population of more than 250,000 set at, including BNRA, \$9,499 in 2008;

- A blended rate for the county calculated as the average of 50 percent of local FFS costs and 50 percent of national FFS in 2004 trended forward to 2008;
- A minimum increase rate based on the county payment level in 2003 trended forward to 2008;
- 100 percent of average FFS costs in the county in 2004 trended forward to 2008;
- 100 percent of average FFS costs in the county in 2005 trended forward to 2008; and
- 100 percent of average county FFS costs in the county in 2008.¹³

Included in the county benchmark rates are additional payments associated with the enactment of budget neutral risk adjustment (BNRA). This policy provides for MA payments over and above the benchmark extra payments specified by the MMA, as part of the implementation of the new MA payment risk adjustment system that adjusts each plan's payments for the estimated costliness of its enrollees.¹⁴

The new MA risk adjustment system, termed the CMS-HCC model, is based on retrospective clinical data on each enrollee and is more accurate than the previous system, which was based only on a few broad demographic characteristics. The implementation of the new system was expected to make payments to plans more closely reflect the anticipated costliness of their enrollees. Because research indicated that plans tended to enroll beneficiaries with lower risk of high costs, risk adjustment was expected to reduce plan payments.

In an administrative policy decision, CMS implemented the new risk adjustment beginning in 2000 so that it would not reduce aggregate payments to MA plans.¹⁵ This was done by increasing payments to all MA plans by a uniform percentage — the BNRA payment — to compensate for the fact that the average MA enrollee has a lower risk score (is anticipated to be less costly) than the average FFS beneficiary.

Because of the BNRA payments, Medicare pays MA plans in total more than the risk adjustment model indicates Medicare would be expected to pay for the same beneficiaries in FFS.

In January of 2005, CMS indicated that it intended to phase-out the BNRA payments from 2007 through 2012. This phase-out policy was revised in September of 2005 by CMS to a slightly more rapid phase-out. The Deficit Reduction Act (DRA) enacted in February 2006 codified in statute the September 2005 CMS BNRA policy.

The DRA mandated phase-out applied the BNRA adjustment to 75 percent of the MA payment rates in 2006, consistent with the new risk adjuster applying to 75 percent, adding 7.6 percentage points to the MA payment rates in 2006. The DRA policy began to phase out the BNRA adjustment by applying it to 55 percent of the MA payment rates in 2007, adding 3.9 percentage points; 40 percent in 2008, adding 1.7 percentage points;¹⁶ 25 percent in 2009, adding an estimated 1.1 percentage points; 5 percent in 2010, adding an estimated 0.2 percentage points; and 0 percent in 2011.^{17, 18}

In 2008, the MA plan budget neutral risk adjustment (BNRA) policy will add an estimated 1.7 percent to MA plan payments. The total cost of the BNRA policy in 2008 is projected to be about \$1.2 billion.¹⁹ The total amount of extra payments to MA plans from 2008 to 2012 resulting from the current BNRA policy is projected at \$2.1 billion.

Indirect Medical Education (IME) payments. MMA directs that payments to teaching hospitals for the costs of indirect medical education (IME) be included in the calculation of the county per capita FFS costs for setting the MA plan county benchmark rates. However, an earlier Medicare policy enacted in 1997 provides for Medicare to pay teaching hospitals directly for the IME costs of MA plan enrollees who are inpatients, rather than leaving the determination of those payments to the MA plans. As a result, Medicare now effectively pays twice for the IME costs of MA plan members.²⁰

In the aggregate, extra payments estimated due to the double payment for IME account for somewhat less than 8 percent of the total MA plan payments in excess of FFS costs, when averaged across the country.

IME payments are estimated at \$700 million in 2008 and \$5.2 billion over five years.

Since teaching hospitals are not spread evenly across geographic areas, IME payments and, consequently, the contribution of IME payment amounts to extra payments to MA plans, vary substantially by area. In New York, IME extra payments to MA plans in some counties are estimated at greater than 6 percent, or over \$600 per enrollee; in other states with lower IME payments for FFS inpatients, such as Florida and Texas, IME extra payments to plans are estimated at less than 1 percent, or about \$90 per capita.²¹

As a share of extra payments to MA plans, there is also great variation by county payment type. In the 100 percent of FFS counties, IME costs account for approximately 59 percent of total extra payment rates. In urban floor counties, IME costs are estimated to account for less than 10 percent of total extra payment rates to MA plans.

MA plan bids. Beginning in 2006, the MMA provides that payments to MA plans change from a system that pays plans at the level of the county benchmarks plus BNRA payments to one that combines county benchmarks plus BNRA payments with a bid by each individual MA plan.²² For the remainder of this section, the term ‘county benchmark’ will include BNRA payments. In 2008, the BNRA will add 1.0169 percent to every county benchmark.

The new benchmark-based bidding system introduced in 2006 allocates 75 percent of the difference between the county benchmark and the MA plan bid to the plan and 25 percent to the Federal government. MA plans must use their 75 percent share to provide additional benefits to MA plan enrollees.

Analysts at the Medicare Payment Advisory Commission (MedPAC) who have studied Medicare private plan payments and costs have estimated that the average MA plan bid was approximately 16 percent less than the county benchmark in 2006.²³

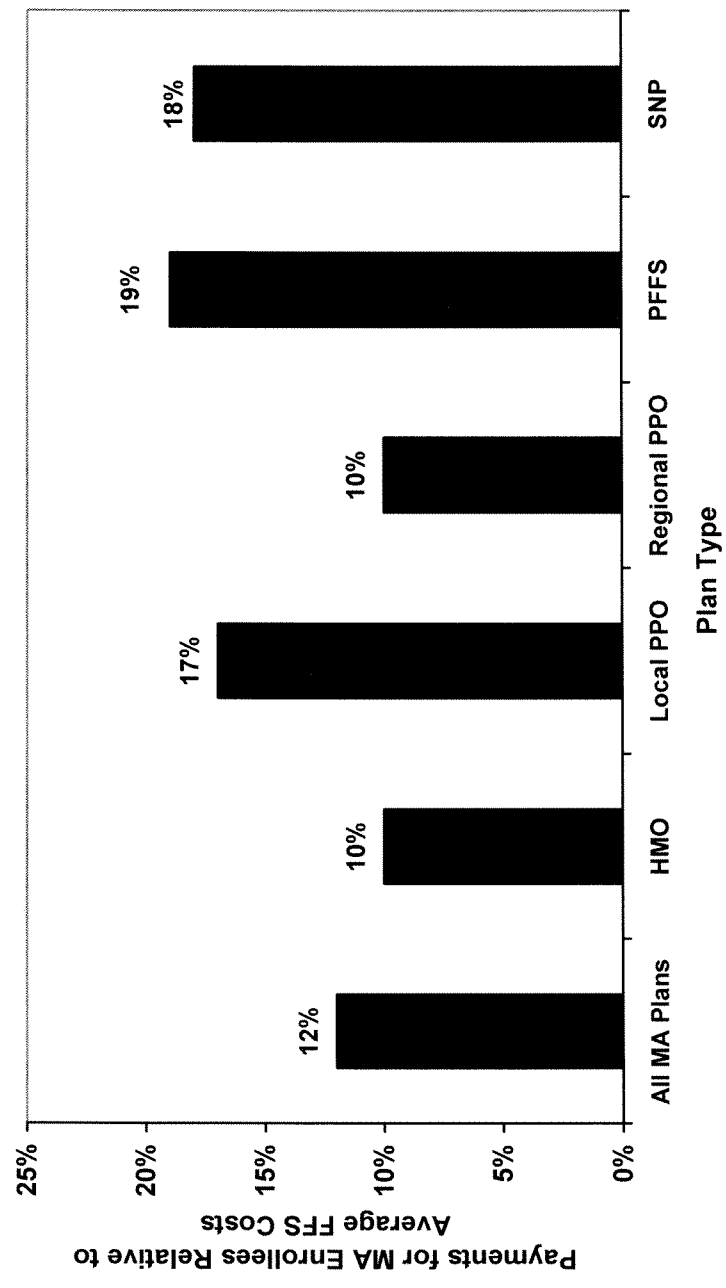
If the bids continue to average 16 percent less than the benchmarks, there would be an average reduction in MA plan payments of 4 percentage points, which would reduce the average level of MMA statutory extra payments from 16.4 percent to 12.3 percent in 2008.

With bids at this level, MMA statutory benchmark extra payments, not including IME, are estimated at \$8.1 billion in 2008 and \$65 billion over the five years 2008 through 2012.²⁴

However, the impact of the bid process likely varies by individual MA plan and by location. Even if the national average difference between the benchmark rates and the plan bids nationwide is 16 percent, wide variation by plans around this average is expected, depending on the county benchmark payment rate, the amount by which the county benchmark exceeds FFS costs, the MA plan’s management of health prices and utilization, and the amount of competition among MA plans in each market.

Analysis by MedPAC staff has also indicated that there was significant variation in the levels of bids and extra payments across plan types in 2006 [Figure 4]. On average, HMOs were found to receive the lowest levels of extra payments of any plan type – about 10 percent more than average FFS costs. Private Fee-for-Service plans, in contrast, were found to receive the highest percentage of extra payments above FFS costs, with extra payments averaging 19 percent above FFS costs nationally.²⁵

Figure 4. MA Extra Payments by Plan Type



Source: Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy, (Washington, D.C.: MedPAC, March 2007).

Extra payments through the regional PPO stabilization fund. In addition to the statutory provisions that provide specific extra payments to all MA plans, the MMA also provided CMS with the authority to make extra payments to new regional PPOs from a stabilization fund between 2007 and 2013. CMS has designated 28 state and multi-state regions for the regional PPOs.

While MMA authorized payments from the fund during this period of \$10 billion,²⁶ the Tax Relief and Health Care Act of 2006 (TRHCA) adopted in 2006 provided that payments from the MA regional preferred provider organization (PPO) stabilization fund could only be made in 2012 and 2013 and limited the total amount to \$3.5 billion.^{27, 28}

The MMA provides that the regional PPO stabilization fund may be used to make extra payments to regional PPOs in three instances:

- The first sponsor of regional PPOs in every region in the nation would receive a bonus of 3 percent of the benchmark in each region;
- Regional PPOs that would be the first to serve a region may be provided extra payments; and
- Regional PPOs that indicate they plan to leave a region resulting in fewer than two regional PPOs plans in the region may be provided extra payments.

It is obviously impossible to project what the pattern of regional PPO plans may be in 2011 and 2012. In 2007, there is no sponsor of regional PPOs in every region; there are seven regions without any regional PPO plans; and there are no regions with more than two regional PPO plans.²⁹

CMS reported there were just 125,883 enrollees in Regional PPOs nationwide as of March 2007.³⁰

The discretionary nature of the PPO stabilization fund years involved – 2012 to 2013 – makes it difficult to project the costs of the fund in specific years. CBO has projected the total amount of extra payments to MA plans in 2012 from the regional PPO stabilization fund policy to be \$1.6 billion.³¹

OPTIONS FOR MEDICARE SAVINGS IN 2008 THROUGH 2012

Extra payments to MA plans are projected to total more than \$8 billion in 2008 and as much as \$71 billion in the five year period from 2008 through 2012.

The specific MMA and DRA provisions that generate these extra payments present opportunities for revised policies that can reduce this Medicare spending in excess of FFS costs. The options described here are grouped according to the three bases for MA plan extra payments: MMA statutory provisions; IME double payments; and the regional PPO stabilization fund.

The savings options presented here do not include any savings in 2008 since any legislation adopted in 2007 would be enacted so late in the year that the MA plan bidding process for FY 2008 would be already completed. This suggests that the first year that MA payment changes adopted in 2007 could be effective would be FY 2009.

Depending on the extent and the timing of any new policies, the amount of savings from the four years 2009 to 2012 could total nearly \$63 billion.

Medicare savings from the benchmark extra payments. Medicare savings may be achieved by changing the MMA polices that explicitly set county benchmarks at levels above average FFS costs. Five year savings of up to \$56 billion are possible from setting MA plan benchmark payments at FFS costs.

Option 1a. The greatest savings from revising the MMA extra payment provisions would be generated by eliminating all benchmark extra payments as of January 2009. The new policy could specify that the MA plan benchmarks would be set at 100 percent of the costs of FFS at the county level. Any Federal savings from plan bids below the new benchmarks would contribute toward pay-for-performance payments to MA plans.

Savings would be most significant in the urban floor counties where annual Medicare MA payments above FFS costs would be reduced by an average of well over \$1,000 per enrollee.

This option is projected to reduce Medicare spending by \$12.2 billion in 2009 and over \$56 billion over five years.

Option 1a: Set MA Plan Statutory/Benchmark Payments at 100% of County FFS Costs in 2009 and Future Years

	2008	2009	2010	2011	2012	2008-12 5-yr Total
Current baseline: MMA statutory/benchmark extra payments	\$8.1	12.2	13.7	16.2	14.6	\$64.8 b
Residual Medicare costs: benchmark at 100% of FFS	8.1	-0-	-0-	-0-	-0-	\$8.1 b
Medicare savings	\$0	12.2	13.7	16.2	14.6	\$56.7b

Note: Assumes MA plan benchmark is set at 100% of county FFS costs in 2009 and subsequent years. Assumes that all funds that result from MA plan bids at less than the benchmark are returned to MA plans as pay-for-performance payments. Figures exclude IME double payment expenses.

Source: Congressional Budget Office, *Budget Options*, (Washington, DC: CBO, February 2007).

Option 1b. An approach to the gradual reduction of the MMA extra payments would be to implement a freeze on extra payments. This would maintain payments to plans at their 2008 levels, but there would be no increase in the national per capita MA growth percentages for payments to MA plans in 2009 and future years. Given that the growth rate for payments is about 5 percent each year, this would lead to a gradual reduction in the gap between average fee-for-service costs and MA payments in each county. Under this method, the only increase in total costs each year would come from growth in MA program enrollment.

Option 1b: Freeze on Extra Payments, 2009 to 2012

	2008	2009	2010	2011	2012	2008-12 5-yr Total
Current baseline: MMA statutory/benchmark extra payments	\$8.1	12.2	13.7	16.2	14.6	\$64.8 b
Residual Medicare costs: freeze on extra payments	8.1	9.0	9.7	10.2	10.6	\$47.6 b
Medicare savings	\$0	3.2	4.0	6.0	4.0	\$17.2 b

Source: Congressional Budget Office, *Budget Options*, (Washington, DC: CBO, February 2007) and Congressional Budget Office, *Fact Sheet for CBO's March 2007 Baseline: Medicare*, (Washington, DC: CBO, March 2007)

Option 1c. Another approach to the gradual reduction of the MMA extra payments would be to set a declining ceiling on county benchmark rates over a number of years. A declining ceiling on benchmark county rates in excess of FFS costs could begin at 12 percent in 2009 and decline to 8 percent in 2010, 4 percent in 2011, and zero in 2012. This approach would provide substantial Medicare savings while giving plans until 2012 to plan for MA payments at the level of fee-for-service costs in the county.

Under this approach, plans in the counties with benchmark rates the greatest excess of rates -- mostly urban floor counties -- would have a gradual three year phase-out of their extra payments from 2009 to 2011. A number of the new PFFS plans that first enrolled appreciable numbers of members in 2007 would also fall into this three year phase-out group.

Plans in some of the lower extra payment counties, however, would not be affected until 2012.

This approach is projected to reduce Medicare spending by nearly \$34 billion over five years.

Option 1c: Declining Ceiling on Extra Payments from 2008 to 2010

	2008	2009	2010	2011	2012	2008-12 5-yr Total
Current baseline: MMA statutory/benchmark extra payments	\$8.1	12.2	13.7	16.2	14.6	\$64.8 b
Residual Medicare costs: ceiling on extra payments	8.1	9.3	8.2	5.2	-0-	\$30.8 b
Medicare savings	\$0	2.9	5.5	11.0	14.6	\$34 b

Note: Assumes MA plan benchmark is phased-down at the county level from 100% MMA statutory levels to 100% of county FFS costs with a ceiling set at 112% of FFS costs in 2009, 108% in 2010, 104% in 2011 and 100% in 2012 and subsequent years. Assumes that all funds that result from MA plan bids at less than the benchmark are returned to MA plans as pay-for-performance payments. Assumes plan bids in all counties fall 16% below the benchmark.

Source: George Washington University analysis of Centers for Medicare and Medicaid Services (CMS) Medicare Managed Care Quarterly State/County/Contract data file for February 2007, the CMS Medicare Managed Care Quarterly State County data file for the quarter ending December 2005; the CMS Medicare Advantage 2008 Rate Calculation Data spreadsheet; Medicare Payment Advisory Commission, *Medicare Advantage Benchmarks and Payments Compared with Average Fee-For-Service Spending* (Washington, D.C.: MedPAC, June 2006); Congressional Budget Office, *Budget Options*, (Washington, DC: CBO, February 2007).

Option 1d. Another method to gradually reduce payments to Medicare Advantage plans would be to phase-down the benchmark extra payments over a number of years. A reduction of MMA benchmark extra payments could begin in 2009 and run over four years at 25 percent per year. Under this approach, benchmark extra payments in every county would decline from the 2008 levels to 75 percent in 2009, 50 percent in 2010, and 25 percent in 2011 with payments at 100 percent of average county FFS costs in 2012 and subsequent years.

This approach would provide substantial Medicare savings while giving plans in the counties with the greatest extra payments four years to gradually tighten management practices and revise their provider payments and benefit packages.

This option is projected to reduce Medicare spending by \$36.6 billion through 2012.

Option 1d: Phase out MA Plan Statutory/Benchmark Extra Payments at 25% per Year from 2009 to 2011

	2008	2009	2010	2011	2012	2008-12 5-yr Total
Current baseline: MMA statutory/benchmark extra payments	\$8.1	12.2	13.7	16.2	14.6	\$64.8 b
Residual Medicare costs: benchmark phase-down at 25%	8.1	9.2	6.8	4.0	-0-	\$28.1 b
Medicare savings	\$0	3.0	6.8	12.2	14.6	\$36.6 b

Note: Assumes MA benchmark rates are phased-down at the county level from 100% MMA statutory levels to 100% of county FFS costs at the pace of 75% of difference in 2009, 50% of difference in 2010, 25% in 2011, and 0% in 2012. Assumes that all funds that result from MA plan bids at less than the benchmark are returned to MA plans as pay-for-performance payments.

Source: Congressional Budget Office, *Budget Options*, (Washington, DC: CBO, February 2007).

Medicare savings from IME extra payments. A more focused approach to the reduction of MMA extra payments would revise the current policy that provides double payment for Indirect Medical Education costs at teaching hospitals for MA plan enrollees.

Option 2. IME costs could be eliminated from the calculation of MA county benchmark rates, since Medicare already pays teaching hospitals directly for the costs of Medicare inpatients that belong to MA plans.

This IME policy would reduce payments to MA plans by about 2 percent nationwide. Payments in a few counties would be reduced by more than 6 percent. The counties with the greatest reduction in rates would be in New York, Boston and other areas with high concentrations of Medicare IME payments to teaching hospitals.

The short-term impact of this policy might be mitigated by limiting the reduction in individual MA county benchmark rates to 5 percentage points in any one year. This would phase-down payments over two or more years to MA plans in the small number of counties with higher amounts of extra payments related to IME costs.

The elimination of IME double payments would reduce Medicare spending by an estimated \$1 billion in 2009 and \$4.5 billion over five years.

Option 2: Remove IME Extra Payments from MA Benchmarks in 2009 and Future Years

	2008	2009	2010	2011	2012	2008-11 5-yr Total
Current baseline: IME Payments	\$0.7	1.0	1.1	1.3	1.1	\$5.2 b
Residual Medicare costs: Remove IME from benchmarks	0.7	-0-	-0-	-0-	-0-	\$0.7 b
Medicare savings	\$0	1.0	1.1	1.3	1.1	\$4.5 b

Note: Assumes that MA plan payments in all counties including urban and rural floor counties are reduced by IME costs in the specific county.

Source: Congressional Budget Office, *Budget Options*, (Washington, DC: CBO, February 2007).

Medicare savings from the regional PPO stabilization fund. Medicare savings from the \$3.5 billion remaining in the regional PPO stabilization fund may be generated by eliminating the current authority for spending from the fund in 2012 and 2013. The elimination of the fund would save \$3.5 billion in 2012 through 2013.

Option 3. The elimination of the legislative authority for the fund would provide the spending reductions of \$3.5 billion in 2012 through 2013. Under this policy, regional PPOs would continue to receive extra payments by county at the same level as other MA plans.

To the extent that PPOs emphasize service to beneficiaries in rural areas, the PPOs would still benefit from MA extra payments in rural floor counties that are estimated at 17 percent and \$1,193 per enrollee annually in 2008. This new policy would provide for PPOs to compete with local PPOs and other MA plans on a level playing field.

The possible 2008 to 2012 Medicare savings for the elimination of authority for the PPO stabilization fund would be \$1.6 billion for the spending in 2012 with an additional \$1.9 billion of savings in 2013.

Option 3: Eliminate MMA Regional PPO Stabilization Fund

	2008	2009	2010	2011	2012	2008-11 5-yr Total
Current baseline: regional stabilization fund	\$0	-0-	-0-	-0-	1.6	\$1.6 b
Residual Medicare costs: eliminate stabilization fund	-0-	-0-	-0-	-0-	-0-	\$0 b
Medicare savings	\$0	-0-	-0-	-0-	1.6	\$1.6 b

Source: Congressional Budget Office, *Budget Options*, (Washington, DC: CBO, February 2007).

CONCLUSION

Medicare policies included in the MMA and DRA now set MA payment rates at levels higher than average FFS costs in every county in the nation. As a result of these provisions, Medicare now pays Medicare Advantage plans over \$8 billion a year more than costs in traditional fee-for-service Medicare.³² Extra payments to MA plans in 2008 are projected to amount to a differential of \$982 per plan enrollee.³³ Total MA extra payments are projected at \$71 billion from 2008 through 2012.³⁴

At this time, there are efforts to identify sources of savings in the Medicare program to off-set the costs of new policies that increase spending. These efforts focus on sums to off-set the costs of extending the State Children's Health Insurance Program and of modifying the physician payment Sustainable Growth Rate (SGR) so that Medicare payments to physicians do not decline by 10 percent in 2008.

Among the areas that may be identified for potential Medicare savings are the current policies that pay MA plans more than costs in FFS Medicare.

Reduction in payments to MA plans in excess of fee-for-service costs may be seen as appropriate since extra payments to private MA plans clearly contrast with the often stated goal that "...private plans and competition will help drive down the explosive growth of Medicare spending."³⁵ The earliest proposal to develop HMOs by the Nixon Administration in 1971 reported that "...HMOs are saving as much as 15 percent on their elderly enrollees, in comparison with costs under traditional modes of practice."³⁶

Reductions in extra payments to MA plans would be consistent with the Bush Administration's citation of the recommendations of the Medicare Payment Advisory Commission as a basis for Medicare savings. MedPAC has for a number of years consistently recommended that MA plans be paid amounts consistent with average costs in the fee-for-service system.³⁷

Setting MA county benchmarks at 100 percent of average FFS costs in 2009 and later years could reduce Medicare spending by over \$56 billion through 2012. Eliminating the stabilization fund authority for extra payments for regional PPOs could save Medicare \$1.6 billion through 2012. The total savings from the elimination of all MA plan extra payments could amount to more than \$62 billion over the four years from 2009 to 2012.

BACKGROUND

ANNUAL INCREASE IN MEDICARE A+B COSTS PER CAPITA						
	2007	2008	2009	2010	2011	2012
Total A+B costs	\$375.9	\$398.8	\$422.9	\$447.3	\$468	\$511.1 b
Increase in A+B costs	6.1%	6.0%	6.0%	5.8%	4.6%	9.2%
Increase in beneficiaries	1.7%	1.7%	1.8%	1.9%	2.1%	2.6%
Increase in Per capita A+B costs	4.3%	4.3%	4.2%	3.8%	2.3%	5.7%

Source: Fact Sheet for CBO's March 2007 Baseline: MEDICARE, Congressional Budget Office, March 2007

ANNUAL INCREASE IN MEDICARE PAYMENTS TO MA PLANS					
	2008	2009	2010	2011	2012
Increase in per capita A+B costs	4.3%	4.2%	3.8%	2.3%	5.7%
Increase in MA plan enrollment	14.0%	11.4%	7.3%	5.3%	4.4%
Increase in total payments to MA plans	18.9%	16.0%	11.4%	7.7%	10.3%

Source: Fact Sheet for CBO's March 2007 Baseline: MEDICARE, Congressional Budget Office, March 2007

Notes

- ¹ Figures are based on George Washington University analysis of Centers for Medicare and Medicaid Services (CMS) Medicare Managed Care State/County/Contract data file released February 2007; Medicare Managed Care Quarterly State County data file for the quarter ending December 2005; and the Medicare Advantage 2007 Rate Calculation Data spreadsheet. All are available at: <http://www.cms.hhs.gov/>
- ² Congressional Budget Office (CBO), *Budget Options*, (Washington, DC: CBO, February 2007). Available at: <http://www.cbo.gov/ftpdocs/78xx/doc7821/02-23-BudgetOptions.pdf>
- ³ CBO Testimony July 25, 2006 Subcommittee on Health, Committee on Energy and Commerce
- ⁴ Congressional Budget Office (CBO), *Congressional Budget Office Cost Estimate: H.R. 6111 Tax Relief and Health Care Act of 2006*, Washington, DC, December 28, 2006, p.12. Available at: <http://www.cbo.gov/ftpdocs/77xx/doc7714/hr6111lppo.pdf>
- ⁵ Congressional Budget Office (CBO), *Congressional Budget Office Cost Estimate: H.R. 6111 Tax Relief and Health Care Act of 2006*, Washington, DC, December 28, 2006, p.10. Available at: <http://www.cbo.gov/ftpdocs/77xx/doc7714/hr6111lppo.pdf>
- ⁶ Kaiser Family Foundation, *Medicare Health and Prescription Drug Plans Monthly Tracking Report, May 2007*. Available at: http://www.kff.org/medicare/advantagetrackingreport_current.cfm
- ⁷ Congressional Budget Office (CBO), *Budget Options*, (Washington, DC: CBO, February 2007). Available at: <http://www.cbo.gov/ftpdocs/78xx/doc7821/02-23-BudgetOptions.pdf>; and Congressional Budget Office. Fact Sheet for CBO's March 2007 Baseline: Medicare. Available at: http://www.cbo.gov/ftpdocs/78xx/doc7861/m_m_schip.pdf Accessed April 2007.
- ⁸ Centers for Medicare and Medicaid Services (CMS). 2008 Rate Calculation Data spreadsheet (Baltimore, M.D.: CMS, April 2007). Available at: <http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/>; Centers for Medicare and Medicaid Services (CMS) Medicare Managed Care State/County/Contract data file (Baltimore, M.D.: CMS, February 2007). Available at: <http://www.cms.hhs.gov/MCRAdvPartD/Data/MMAFESC/list.asp#TopOfPage>; and Centers for Medicare and Medicaid Services (CMS) Medicare Managed Care Quarterly State, County data file for the quarter ending December 2005 (Baltimore, M.D.: CMS, December 2005). Available at: http://www.cms.hhs.gov/HealthPlanRepFileData/02_SC.asp#TopOfPage
- ⁹ The extra rates in these figures include the benchmark, BNRA payments, FFS growth adjustment and a 4% reduction to account for the bidding system.
- ¹⁰ MA plans that offer prescription drug coverage (MA-PD plans) also file a bid to provide Part D coverage. Since Part D payments are not related to costs in FFS Medicare, these payments are not included in this analysis.

¹¹ Centers for Medicare and Medicaid Services (CMS). Rate Calculation Data (Baltimore, M.D.: CMS, April 2007). Available at: <http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/>

¹² These rates represent benchmark payment rates with BNRA.

¹³ For 2008, the benchmarks are the amount of the 2007 benchmark increased by 5.71 percent. (See: Centers for Medicare and Medicaid Services, “Announcement of Calendar Year (CY) 2008 Medicare Advantage Capitation Rates and Payment Policies Fact Sheet” (Washington, D.C.: CMS, April 2007). Available at: <http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/>

¹⁴ Risk adjustment of Medicare private plan payments is important because the cost of care for Medicare beneficiaries varies greatly. The most expensive 5 percent of Medicare beneficiaries accounted for 43 percent of total spending at an average cost of \$63,000 in 2001 while the least expensive 50 percent of beneficiaries accounted for only 4 percent of total spending at an average cost of \$550. In the absence of effective risk adjustment of payments, plans that enroll healthier beneficiaries can gain substantial surpluses. Congressional Budget Office, High Cost Medicare Beneficiaries, (Washington, D.C.:CBO, May 2005).

While the development and implementation of an improved system to adjust payments to individual Medicare plans was mandated by the Balanced Budget Act of 1997 and subsequent legislation, the decision to make extra payments to MA plans associated with the new risk adjustment system was made by CMS officials following language in the conference report for the Balanced Budget Refinement Act of 1999 that urged HHS to implement the risk adjustment “without reducing overall Medicare+Choice payments”.

¹⁵ Robert A. Berenson. “Medicare Disadvantaged and the Search For the Elusive ‘Level Playing Field’: What the changes to Medicare really mean for competition and the future of the program.” *Health Affairs, WebExclusive* (Dec. 15, 2005): W4-572.

¹⁶ The risk adjuster first applies to 100 percent of the MA rates in 2008

¹⁷ Centers for Medicare and Medicaid Services, “Note to Medicare Advantage Organizations and Other Interested Parties. Subject: Announcement of Calendar Year (CY) 2006 Medicare Advantage Payment Rates” (Washington, D.C.: CMS, 2005).
Centers for Medicare and Medicaid Services, “Note to Medicare Advantage Organizations and Other Interested Parties. Subject: Announcement of Calendar Year (CY) 2007 Medicare Advantage Payment Rates” (Washington, D.C.: CMS, 2006).
Centers for Medicare and Medicaid Services, “Note to Medicare Advantage Organizations and Other Interested Parties. Subject: Announcement of Calendar Year (CY) 2008 Medicare Advantage Payment Rates” (Washington, D.C.: CMS, 2007).

All the above CMS documents are available at: <http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/>

¹⁸ *Side-by-Side Comparison of Medicare, Medicaid and SCHIP Provisions in the Deficit Reduction Act of 2005*, Domestic Social Policy Division, Congressional Research Service, Library of Congress, Washington, DC January 27, 2006.

¹⁹ The \$1.2 billion figure presented here represents the estimated amount of BNRA extra payments after MA plan bids. According to CMS, in 2008, BNRA adds 1.69 percent to the benchmark rate before the bid. See: Centers for Medicare and Medicaid Services, “Announcement of Calendar Year (CY)

2008 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies Fact Sheet” (Washington, D.C.: CMS, 2008). Available at: <http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/>

²⁰ To calculate the effect of these double payments on the level of payments to MA plans, MedPAC and other analysts reduce the per capita FFS costs in a county by the per capita IME costs in the county. 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. Medicare Payment Advisory Commission. *Report to the Congress: Medicare Payment Policy* (Washington, D.C.: MedPAC, Mar. 2002).

²¹ Figures are based on George Washington University analysis of Centers for Medicare and Medicaid Services (CMS) Medicare Managed Care State/County/Contract data file released February 2007; Medicare Managed Care Quarterly State County data file for the quarter ending December 2005; and the Medicare Advantage 2007 Rate Calculation Data spreadsheet. All are available at: <http://www.cms.hhs.gov/>

²² Medicare Payment Advisory Commission, *Report to Congress: Issues in a Modernized Medicare Program*. (Washington, DC.: MedPAC, June 2005).

²³ Medicare Payment Advisory Commission, “Medicare Advantage Benchmarks and Payments Compared with Average Fee-For-Service Spending” (Washington, D.C.: MedPAC, June 2006).

²⁴ Congressional Budget Office (CBO), *Budget Options*, (Washington, DC: CBO, February 2007). Available at: <http://www.cbo.gov/ftpdocs/78xx/doc7821/02-23-BudgetOptions.pdf>. Note that these figures exclude IME payments.

²⁵ Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, (Washington, DC: MedPAC, March 2007).

²⁶ Medicare Payment Advisory Commission, *Report to the Congress: Issues in a Modernized Medicare Program*. (Washington, D.C.: MedPAC, June 2005).

²⁷ Congressional Budget Office (CBO), *Congressional Budget Office Cost Estimate: H.R. 6111 Tax Relief and Health Care Act of 2006*, Washington, DC, December 28, 2006, p.10. Available at: <http://www.cbo.gov/ftpdocs/77xx/doc7714/hr6111pgo.pdf>

²⁸ Congressional Budget Office (CBO), *Budget Options*, (Washington, DC: CBO, February 2007). Available at: <http://www.cbo.gov/ftpdocs/78xx/doc7821/02-23-BudgetOptions.pdf>

²⁹ Marsha Gold, *Private Plans in Medicare: A 2007 Update*, The Henry J. Kaiser Family Foundation, March 2007.

³⁰ Kaiser Family Foundation, *Medicare Health and Prescription Drug Plans Monthly Tracking Report, Monthly Report for March 2007*, Available at: http://www.kff.org/medicare/advantage/trackingreport_current.cfm

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- ³¹ Congressional Budget Office (CBO), *Budget Options*, (Washington, DC: CBO, February 2007). Available at: <http://www.cbo.gov/ftpdocs/78xx/doc7821/02-23-BudgetOptions.pdf>
- ³² Congressional Budget Office (CBO), *Budget Options*, (Washington, DC: CBO, February 2007). Available at: <http://www.cbo.gov/ftpdocs/78xx/doc7821/02-23-BudgetOptions.pdf>
- ³³ George Washington University analysis of Centers for Medicare and Medicaid Services (CMS) Medicare Managed Care State/County/Contract data file released February 2007; Medicare Managed Care Quarterly State County data file for the quarter ending December 2005; and the Medicare Advantage 2008 Rate Calculation Data spreadsheet. All are available at: <http://www.cms.hhs.gov/>
- ³⁴ Congressional Budget Office (CBO), *Budget Options*, (Washington, DC: CBO, February 2007). Available at: <http://www.cbo.gov/ftpdocs/78xx/doc7821/02-23-BudgetOptions.pdf>
- ³⁵ 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.
- ³⁶ Department of Health, Education and Welfare, *Towards a Comprehensive Health Policy for the 1970s: A White Paper*. (Washington, D.C.: HHS, May 1971).
- ³⁷ Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, (Washington, DC: MedPAC, March 2007).