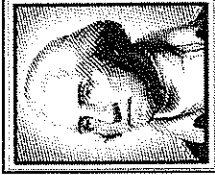


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# PRIMER ON MEDICARE ADVANTAGE PAYMENTS IN 2008

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June 2008

The authors would like to acknowledge the Commonwealth Fund for its support of the analysis of Medicare Advantage payments.

**PRIMER ON MEDICARE ADVANTAGE PAYMENTS IN 2008**  
**PAYMENTS TO MEDICARE ADVANTAGE PLANS EXCEED FEE-FOR-SERVICE COSTS**

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## SUMMARY

The Medicare Modernization Act of 2003 (MMA 03) included provisions intended to increase the role of private health plans in Medicare. These provisions, building on policies adopted earlier in 1997 and 2000, set Medicare Advantage (MA) plan benchmark rates at levels higher than average costs 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 policies will total over \$8.5 billion in 2008 and over \$82 billion over the five year period from 2009 through 2013.

This briefing paper describes the three major Medicare policies that generate these extra payments to Medicare Advantage plans:

- MMA 03 statutory county benchmark rates and the MA plan bidding process;
- Indirect Medical Education double payments that increase the county benchmark rates; and
- Potential payments from the regional PPO stabilization fund.

This briefing paper presents the amount of MA extra payments in 2008 that result from each of these policies and projects extra payment amounts through the years 2009 to 2013.

In view of the current Congressional 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, extra payments to MA plans may be important in 2008 and 2009. In particular, changes to MA payment policies to reduce extra payments to private plans by more than \$8 billion a year may be a source of the cost savings needed to pay for a modification of Medicare's Sustainable Growth Rate (SGR) policies so that Medicare payments to physicians do not decline by 10 percent in July 2008, for a reduction in specific out-of-pocket Medicare costs for the elderly and disabled, or for an extension of the State Children's Health Insurance Program (SCHIP). The five year costs for a two year SGR fix are estimated at \$20 billion or more, reductions in out-of-pocket costs for low-income Medicare beneficiaries are estimated at \$10 billion or more, and the extension of the SCHIP program at over \$35 billion.



# PRIMER ON MEDICARE ADVANTAGE PAYMENTS IN 2008

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## INTRODUCTION

Provisions included in the Medicare Modernization Act of 2003 (MMA 03) sought 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 12.4 percent, or \$986 per MA plan enrollee, for a total of \$8.5 billion in 2008.<sup>1</sup> The total amount of extra payments to MA plans is projected to amount to as much as \$82 billion during the five years 2009 through 2013.<sup>2</sup>

These MA extra payments are the result of three policies included in the MMA 03:

- MMA 03 statutory county benchmark rates that are the basis for the benchmark-based MA plan bidding system;
- MMA 03 policies that provide for double payment of the cost of Indirect Medical Education (IME) for MA enrollees who are hospitalized in teaching hospitals;
- MMA 03 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 \$8.5 billion in extra payments to MA plans in 2008.



The projected costs of extra payments to MA plans of \$82 billion for 2009 to 2013 is more than 2.5 times as much as we reported two years ago for 2007 to 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 8.7 million as of February 2008 and is now projected by CBO to total 14.5 million in 2013.<sup>3</sup> The increased costs are to some extent due to the increased enrollment of beneficiaries in Private Fee-For-Service (PFFS) plans. These PFFS plans are heavily located in urban and rural floor counties where extra payments average over 16 percent more than FFS costs.<sup>4</sup>

The projected costs presented here are based on our analysis of extra payments to MA plans in 2008 and 2009 to 2013 derived from data from the Centers for Medicare and Medicaid Services and from five- and ten-year projections of Medicare Advantage-related expenditures released by the Congressional Budget Office.<sup>5, 6</sup>

Extra payments to MA plans occur against the background of a persistent interest in Medicare cost savings. This is an especially important issue in 2008 as the 110<sup>th</sup> Congress has adopted a pay-as-you-go rule (PAYGO). This rule requires all legislation with provisions that increase Federal spending to include provisions that reduce Federal spending by an equivalent amount.

The major Medicare proposal under consideration in 2008 is a fix for the projected decrease in payments to physicians in July 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 about 10 percent in July 2008.<sup>7,8</sup> 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 as much as \$20 billion over five years.

An additional proposal that may be considered in 2008 or 2009 is a reduction in out-of-pocket costs for low-income Medicare beneficiaries. An increase in the income eligibility levels and expanded benefits could cost \$10 billion or more over five years. The State Children's Health Insurance Program (SCHIP) is scheduled to be extended in March of 2009 with projected five year costs of \$35 billion or more.

Using extra payments to MA plans in 2008 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 January 2007 would not be reduced by five percent but would be maintained at 2006 rates. This provision would cost about \$5 billion from 2008-2011. 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.<sup>9</sup>

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 2008, this briefing paper describes the specific Medicare policies that provide extra payments to MA plans in 2008 and future years.

## EXTRA PAYMENTS TO MA PLANS IN 2008

In 2005 and earlier years, MA plans were paid at the level of the county benchmark. However, the MMA 03 specified that, beginning in 2006, Medicare pay MA plans by means of a county benchmark-based bidding system.

Under this system, CMS calculates and posts on its website a county benchmark each year for each of the over 3,000 counties in the US. This benchmark is then increased by a budget neutral risk adjustment factor. The resulting figure is the base rate against which MA plans bid. Every MA plan files a bid each June that reflects the costs to the plan of providing Medicare Part A and B services in the following calendar year.<sup>10</sup>

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

### MA County Benchmark Rates

The MMA 03 provides specific instructions for CMS to follow each year when it posts MA county level benchmarks as the basis for the calculation of Medicare payments to MA plans. Following MMA 03 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.<sup>11</sup>

County benchmark rates in 2008 are projected to exceed FFS costs by an average of \$1,344 per MA enrollee or 16.6 percent. Benchmark rates differ by county and vary from \$1,820 more than FFS costs in urban floor counties to \$578 more in counties paid according to 100 percent of FFS costs in the county in 2007.<sup>12</sup>

**Seven county payment types.** MMA 03 provisions specify that the MA benchmark payment rate for each county is set at the highest of seven different amounts in 2008.

The seven county payment types are the product of multiple MA plan payment policies adopted between 1997 and 2003 and include:

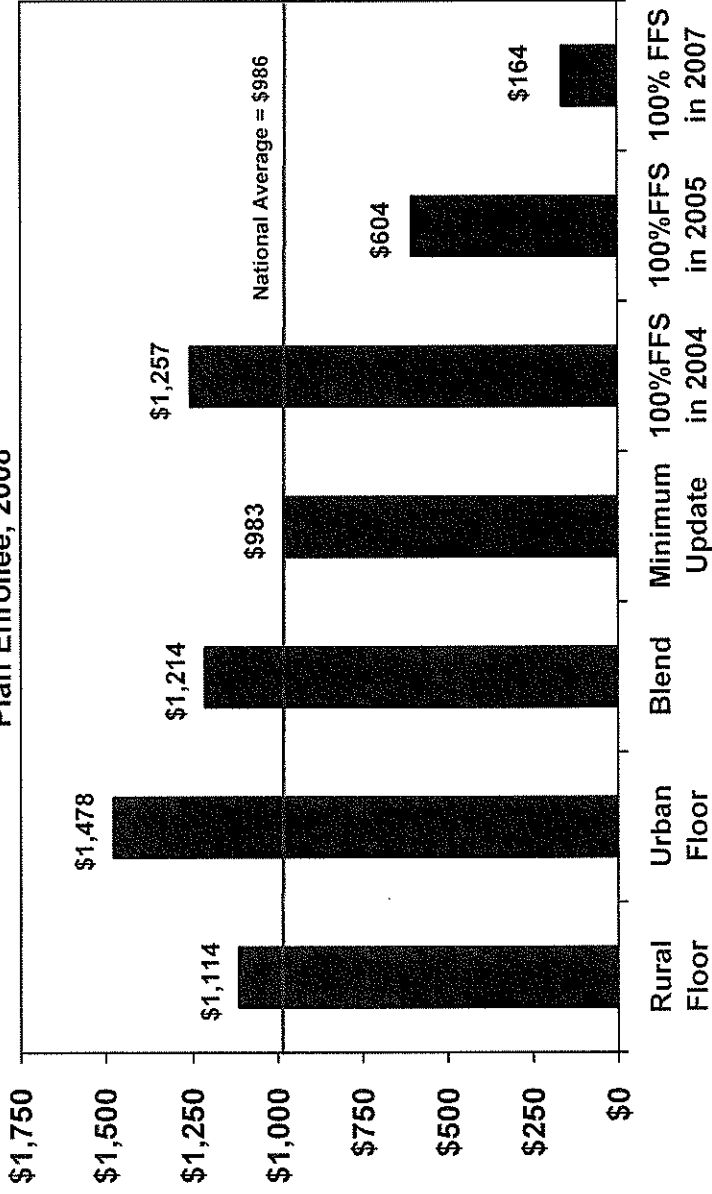
- A rural floor rate for rural counties set at, including BNRA, \$8,595 in 2008;

- 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 as rebased for 2008.<sup>13</sup>

As a result of the county benchmark system which sets benchmark rates at different levels for the seven categories of counties, actual payment rates to MA plans also vary widely. In Figures 1 and 2, counties are grouped according to the MMA benchmark policy under which MA plans in the counties are paid. Figure 1 presents estimated average extra payments above fee-for-service costs per enrollee for MA plans in these seven county types for 2008. Figure 2 presents the estimated share of total extra payments for each of these seven types of counties in 2008.<sup>14</sup>

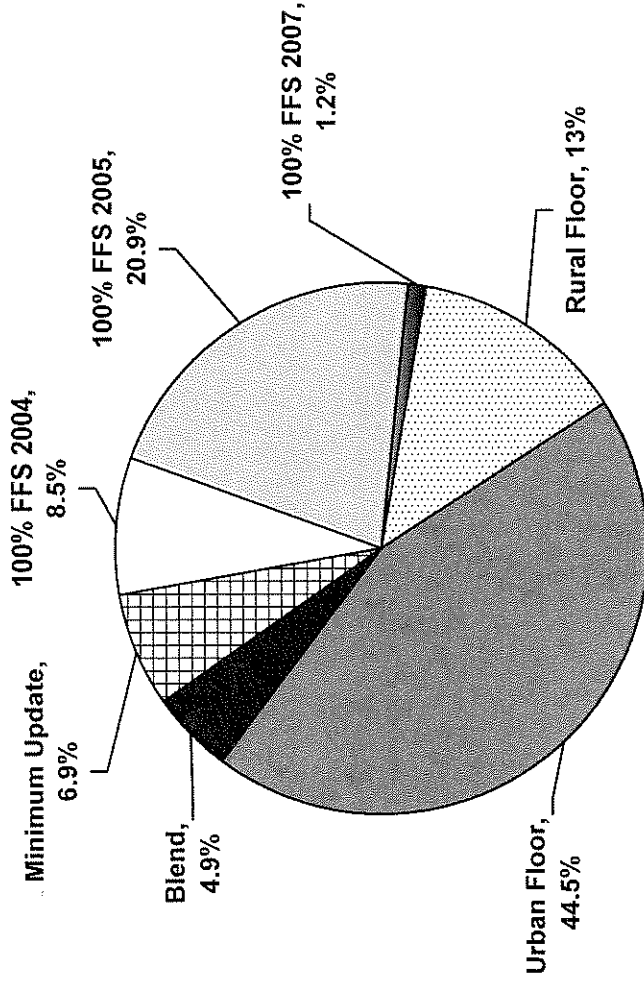
As illustrated in Figure 2, an estimated 44.5 percent of total MA extra payments will go to plans in urban floor counties in 2008. This is an average of \$1,478 in annual extra payments for each of the 2.6 million MA plan enrollees in these counties. Over 20 percent of total extra payments go to plans in the 100 percent of FFS in 2005 counties with \$604 per enrollee in extra payments and 3 million enrollees.

**Figure 1. 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 2008, 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 17% below the benchmark.

**Figure 2. 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 2008, 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 17% below the benchmark.

A number of factors play a part in determining the county benchmark rate in a specific county for a given year. These factors include the urban and rural county payment floor policies, the Per Capita National Growth Percentage, the rebasing policy for the 100 percent of average FFS cost counties, and the Budget Neutral Risk Adjustment policies.

**Urban and rural county payment floors.** The first, and precedent-setting extra payment policy, was the rural floor set by the Balanced Budget Act of 1997. This policy set a minimum plan payment amount that exceeded the average fee-for-service (FFS) costs in county. This was the first policy to be enacted that paid Medicare private plans more than average FFS costs at the county level.

This rural floor policy, which has not resulted in a substantial increase in Medicare costs, was followed by the establishment of an urban floor policy included in the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000. Provisions of BIPA established a payment floor for plans in counties with populations of more than 250,000 which was higher than average FFS costs in those counties.<sup>15</sup>

In 2008, the urban floor is responsible for extra payments to MA plans totaling \$3.8 billion. Extra payments to urban floor counties constitute 44.5 percent of total extra payments to MA plans nationwide. In comparison, the rural floor policy is estimated to contribute just \$1.1 billion or 13 percent of total extra payments to MA plans in 2008.

Base year payment trended forward to 2008. The MMA 03 provides that the benchmark rates for MA plans in many counties in 2008 are based on payment amounts set in some earlier year and trended forward to 2008. The current urban and rural floor rates, together with a local-national average blend rate, are based on rates established in an earlier year, for example 2003, that have been updated annually by a growth rate referred to as the Per Capita National Growth Percentage. The Per Capita National Growth Percentage for the previous years has increased benchmark rates in these counties by: 6.6 percent for 2005; 5.5 percent for 2006; 4.8 for percent 2007; and 5.71 percent for 2008.<sup>16</sup>

Rebasing the 100 Percent Average FFS Costs Counties. It should be noted that the reason that there are three different groups of so-called '100 percent of average FFS costs' counties is that MA payment policies provide for CMS to rebase, or recalculate, the average FFS costs in each county in the nation at least every three years. Since the MMA 03, CMS has rebased the average FFS costs in each county in 2004, 2005 and 2007.

The MA payment rebasing policy acts in only one direction – to increase payments to plans in counties with FFS costs that have increased more rapidly than the national average. In other words, in counties for which average FFS costs in the rebased year are *higher* than the prior county benchmark rate trended forward would be, the benchmarks are reset at the level of average FFS costs in the county. Because of this, plans in counties where benchmarks were set at 100 percent of FFS costs in 2004, for

example, are paid in future years at the rebased benchmark for 2004 trended forward in each year by the Per Capital National Growth Percentage.

This approach to rebasing is sometimes referred to as the “ratchet up” policy since MA plan payments can only increase from the national trend and never decrease when county FFS costs are rebased.

**Budget Neutral Risk Adjustment Payments.** Included in the county benchmark rates are additional payments associated with the budget neutral risk adjustment (BNRA) policy. This policy provides for MA payments over and above the benchmark extra payments specified by the MMA, as part of the implementation beginning in 2000 of a newer MA payment risk adjustment system that adjusts each plan’s payments for the estimated costliness of its enrollees.<sup>17</sup>

The newer 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.<sup>18</sup> 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;<sup>19</sup> 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.<sup>20,21</sup>



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 \$1.3 billion.<sup>22</sup> The total amount of extra payments to MA plans from 2009 to 2013 resulting from the current BNRA policy is projected at \$1.2 billion.

### **Indirect Medical Education 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.<sup>23</sup>

In the aggregate, extra payments estimated due to the double payment for IME account for somewhat less than 15 percent of the total MA plan payments in excess of FFS costs, when averaged across the country.

IME payments are estimated at \$1.6 million in 2008 and \$12.3 billion over five years.<sup>24</sup>

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 around \$600 per enrollee. In other northeastern states with heavily academic medical center-based health care systems, IME payments add an estimated 5 percent to extra payments on average in 2008. In other states with lower IME payments for FFS inpatients, such as Florida, IME extra payments to plans are estimated at less than 1 percent, or about \$90 per capita.<sup>25</sup>

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 03 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.<sup>26</sup> For this section, the term ‘county benchmark’ will include BNRA payments. In 2008, the BNRA will add 1.69 percent to every county benchmark.

The MMA 03 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.

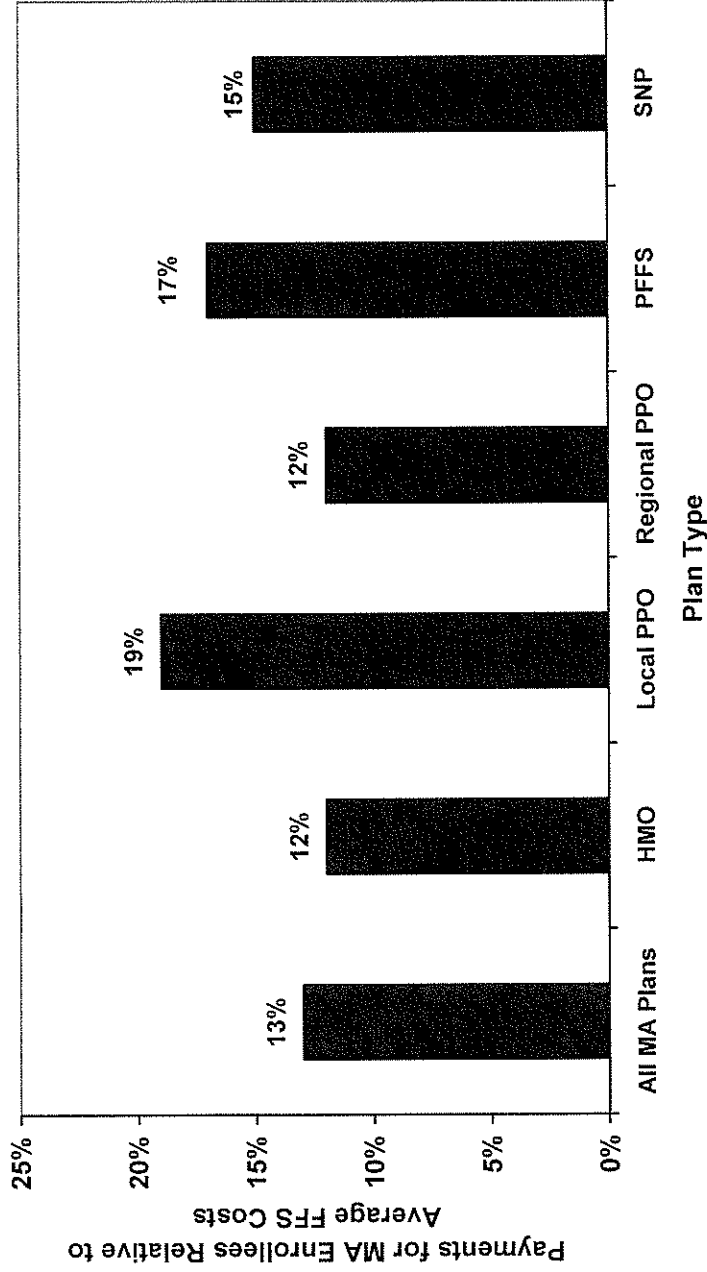
Analysts at the Medicare Payment Advisory Commission (MedPAC), who have access to the data on MA plan payments including plan bids, have studied Medicare private plan payments and costs. MedPAC has estimated that the average MA plan bid was approximately 17 percent less than the county benchmark in 2008.<sup>27</sup>

If the bids continue to average 17 percent less than the benchmarks, there would be an average reduction in MA plan payments of 4.25 percentage points, which would set the average level of MMA statutory extra payments at 12.4 percent in 2008. With bids at this level, MMA statutory benchmark extra payments, including IME, are estimated at \$8.5 billion in 2008.

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 17 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 for 2008 [Figure 3]. On average, HMOs were found to receive the lowest levels of extra payments of any plan type – about 12 percent more than average FFS costs. Private Fee-for-Service plans and PPOs, in contrast, were found to receive the highest percentage of extra payments above FFS costs, with extra payments averaging 17 and 19 percent respectively above FFS costs.<sup>28</sup>

Figure 3. MA Extra Payments by Plan Type



Source: Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy, (Washington, D.C.: MedPAC, March 2008).

### **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 03 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.

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 may be noted that CMS data indicates there were just 253,214 enrollees in regional PPOs nationwide as of February 2008.<sup>29</sup>

While MMA 03 authorized payments from the stabilization fund during this period of \$10 billion,<sup>30</sup> the Medicare, Medicaid and SCHIP Extension Act of 2007 adopted in 2007 and 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 2013 and limited the total amount to \$1.6 billion.<sup>31,32</sup>

Given the use by the Congress in 2006 and 2007 of the reduction in funds authorized for the regional PPO stabilization fund as PAYGO savings to support new Medicare spending, it may be unlikely that any funds will remain authorized for this fund by 2013.

## EXTRA PAYMENTS TO MA PLANS IN 2009 – 2013

The \$8.5 billion in extra payments to MA plans in 2008 can be projected to a total of \$82 billion during the period of 2009 to 2013. This amount is based on an analysis of Centers for Medicare and Medicaid Services Medicare Advantage payment and enrollment data and CBO projections of the increase in Medicare costs and enrollment in MA plans during this period.

This cost growth is largely due to the projected increase in MA plan enrollment from 8.6 million in 2008 to 14.5 million in 2013.

**Figure 4. Projected Payments to MA Plans in Excess of FFS Costs, 2009 to 2013**

	2009	2010	2011	2012	2013	2009-13 5-yr Total
<b>Total MA extra payments</b>	<b>\$13.5b</b>	<b>14.6 b</b>	<b>15.9 b</b>	<b>17.6 b</b>	<b>20.5 b</b>	<b>\$82.2 b</b>
<b>MMA statutory benchmark<sup>1</sup></b>	\$11.6	12.4	13.4	14.9	16.0	\$68.3 b
<b>MMA double payment for IME</b>	\$1.9	2.2	2.5	2.7	2.9	\$12.3 b
<b>Regional PPO stabilization fund</b>	\$0	0	0	0	1.6	\$1.6 b

<sup>1</sup> Note: Payments for the DRA BNRA phase-out through 2011 are included in the figures for the MMA statutory benchmark.

## 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 \$8.5 billion a year more than costs in traditional fee-for-service Medicare.

Extra payments to MA plans in 2008 are projected to amount to a differential of \$986 per plan enrollee.<sup>33</sup> Total MA extra payments are projected at \$82 billion from 2009 through 2013.<sup>34</sup>

At this time, there are efforts to identify sources in the Medicare program as PAYGO saving to off-set the costs of new policies that increase spending. These efforts focus on sums necessary to modify the physician payment Sustainable Growth Rate (SGR) so that Medicare payments to physicians do not decline by 10 percent in July 2008, to reduce specific out-of-pocket costs for in Medicare for the elderly and disabled, and to off-set the costs of extending the State Children's Health Insurance Program in March 2009 if not sooner.

Among the areas that may be identified for potential Medicare savings are the current polices 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."<sup>35</sup> 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."<sup>36</sup>

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<sup>37</sup> consistently recommended that MA plans be paid amounts consistent with average costs in the fee-for-service system.

Setting MA county benchmarks at 100 percent of average FFS costs in 2009 and later years could reduce Medicare spending by over \$68 billion through 2013. Limited reductions in MA extra payments such as a phase-out of the IME double payments could save over \$12 b over five years. Eliminating the stabilization fund authority for extra payments for regional PPOs could save Medicare \$1.6 billion in 2013.

## BACKGROUND

### ANNUAL INCREASE IN MEDICARE A+B COSTS PER CAPITA

	2008	2009	2010	2011	2012	2013
Total A+B costs	\$408.8	\$432.1	\$454.3	\$475.4	\$517.8	\$552.1 b
Increase in A+B costs		5.7%	5.1%	4.6%	8.2%	6.2%
Increase in beneficiaries		1.9%	1.9%	2.1%	2.7%	3.0%
Increase in per capita A+B costs		3.7%	3.2%	2.5%	5.3%	3.1%

Source: Fact Sheet for CBO's March 2008 Baseline: MEDICARE, Congressional Budget Office, March 2008

### ANNUAL INCREASE IN MEDICARE PAYMENTS TO MA PLANS

	2009	2010	2011	2012	2013
Increase in per capita A+B costs	3.7%	3.2%	2.5%	5.3%	3.1%
Increase in MA plan enrollment	15.4%	11.6%	7.8%	5.4%	3.4%
Increase in total payments to MA plans	19.7%	15.1%	10.4%	11.0%	7.1%

Source: Fact Sheet for CBO's March 2008 Baseline: MEDICARE, Congressional Budget Office, March 2008

## Notes

- <sup>1</sup> 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 2008; 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/>
- <sup>2</sup> Figures are based on George Washington University analysis of Centers for Medicare and Medicaid Services (CMS) data and CBO estimates. See: CMS Medicare Managed Care State/County/Contract data file released February 2008; 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/>; Congressional Budget Office (CBO), *Budget Options*, (Washington, DC: CBO, February 2007); and Congressional Budget Office, *Fact Sheet for CBO's March 2008 Baseline: Medicare* (Washington, DC: CBO, March 2008).
- <sup>3</sup> Congressional Budget Office. Fact Sheet for CBO's March 2008 Baseline: Medicare.
- <sup>4</sup> Medicare Payment Advisory Commission (MedPAC), *Report to the Congress: Medicare Payment Policy*, (Washington, D.C.: MedPAC, March 2007).
- <sup>5</sup> 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/MedicareAdvlgSpecRateStats/>; Centers for Medicare and Medicaid Services (CMS) Medicare Managed Care State/County/Contract data file (Baltimore, M.D.: CMS, February 2008). Available at: <http://www.cms.hhs.gov/MCRAdvPartD/enr/Data/MMAESCC/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](http://www.cms.hhs.gov/HealthPlanRepFileData/02_SC.asp#TopOfPage)
- <sup>6</sup> 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 2008 Baseline: Medicare.
- <sup>7</sup> CBO Testimony July 25, 2006 Subcommittee on Health, Committee on Energy and Commerce
- <sup>8</sup> 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/hr6111lpgo.pdf>
- <sup>9</sup> 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/hr6111lpgo.pdf>
- <sup>10</sup> 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.



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

<sup>12</sup> These rates represent benchmark payment rates with BNRA.

<sup>13</sup> 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/MedicareAdvntgSpecRateStats/>

<sup>14</sup> The extra rates in these figures include the benchmark, BNRA payments and a 4.25% reduction to account for the bidding system.

<sup>15</sup> H.R. 5661, Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000. See Sec. 601, “Increase in the Minimum Payment Amount.”

<sup>16</sup> Centers for Medicare and Medicaid Services.

<sup>17</sup> 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”.

<sup>18</sup> 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.

<sup>19</sup> The risk adjuster first applies to 100 percent of the MA rates in 2008

<sup>20</sup> 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/>

<sup>21</sup> *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.

<sup>22</sup> The \$1.3 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/>

<sup>23</sup> 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).

<sup>24</sup> Figures are based on George Washington University analysis of Centers for Medicare and Medicaid Services (CMS) data and CBO estimates.

<sup>25</sup> 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 2008; 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/>

<sup>26</sup> Medicare Payment Advisory Commission, *Report to Congress: Issues in a Modernized Medicare Program*. (Washington, DC.: MedPAC, June 2005).

<sup>27</sup> Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, (Washington, D.C.: MedPAC, March, 2008).

<sup>28</sup> Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, (Washington, D.C.: MedPAC, March, 2008).

<sup>29</sup> Centers for Medicare and Medicaid Services (CMS) Medicare Managed Care State/County/Contract data file released February 2008.

<sup>30</sup> Medicare Payment Advisory Commission, *Report to the Congress: Issues in a Modernized Medicare Program*. (Washington, D.C.: MedPAC, June 2005).

<sup>31</sup> 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>

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<sup>32</sup> Congressional Budget Office (CBO), *Budget Options*, (Washington, DC: CBO, February 2007). Available at: <http://www.cbo.gov/ftpdocs/78xx/doc7821/02-23-BudgetOptions.pdf>

<sup>33</sup> George Washington University analysis of Centers for Medicare and Medicaid Services (CMS) Medicare Managed Care State/County/Contract data file released February 2008; 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/>

<sup>34</sup> George Washington University analysis of Centers for Medicare and Medicaid Services (CMS) data and CBO estimates.

See: CMS Medicare Managed Care State/County/Contract data file released February 2008; 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/>; Congressional Budget Office (CBO), *Budget Options*, (Washington, DC: CBO, February 2007); and Congressional Budget Office, *Fact Sheet for CBO's March 2008 Baseline: Medicare* (Washington, DC: CBO, March 2008).

<sup>35</sup> 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.

<sup>36</sup> Department of Health, Education and Welfare, *Towards a Comprehensive Health Policy for the 1970s: A White Paper*. (Washington, D.C.: HHS, May 1971).

<sup>37</sup> Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, (Washington, DC: MedPAC, March 2007).