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Medicare Advantage Payment Provisions: Health Care and Education Affordability Reconciliation Act of 2010 H.R. 4872

Brian Biles
George Washington University

Grace Arnold

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SCHOOL OF PUBLIC HEALTH AND HEALTH SERVICES
THE DEPARTMENT OF HEALTH POLICY
CENTER FOR HEALTH POLICY RESEARCH

MEDICARE ADVANTAGE PAYMENT PROVISIONS:
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ABSTRACT
The Health Care and Education Affordability Reconciliation Act of 2010 makes major changes to Medicare Advantage (MA) payment policies. Overall, payments to MA plans will be reduced from the current national average of 113 percent of local fee-for-service (FFS) costs to a new average of 101 percent of FFS costs. The Congressional Budget Office (CBO) has estimated that the new polices will reduce Medicare spending by $132 billion over 10 years. The new policies will set county payment benchmarks for MA plans at 115 percent, 107.5 percent, 100 percent, and 95 percent of local FFS costs depending of the relative level of FFS costs in the county. The MA plan rebate policy will be reduced from the current level of 75 percent. A new program of plan performance-based payments will be available to certain plans and will increase benchmarks and rebates to plans with high performance scores. This issue brief presents analysis, using data from 2009, of the impact of these new policies on payments to private plans across the nation.

For more information about this study, please contact:
Brian Biles, MD, MPH
Department of Health Policy
School of Public Health and Health Services
The George Washington University
E-mail: bbiles@gwu.edu

BACKGROUND
The Medicare Advantage (MA) program, under which Medicare beneficiaries have the option of enrolling in private plans available in their area, has been extensively discussed and debated since its creation in the Medicare Modernization Act (MMA) of 2003. Medicare's current policy pays MA plans more than the same beneficiaries would be expected to cost in the original fee-for-service (FFS) Medicare program in many areas. These extra payments averaged 13 percent — or $1,138 per plan enrollee — in 2009, totaling $11.4 billion.[1]

As a presidential candidate in 2008, President Obama asserted that Medicare Advantage payment policy should be changed to "pay [MA plans] the same amount it would cost to treat the same patients under regular Medicare".[2] In addition to rectifying an inequity in payment and the resulting distortion of incentives, savings from reducing these

extra payments were cited as a potential source of Federal costs savings that could be used to help offset the cost of health care reform. The Medicare Payment Advisory Commission (MedPAC) similarly has recommended that the Medicare policy be revised to pay plans at average FFS costs. In its annual Medicare payment policy reports since 2005, MedPAC has recommended that MA payment be brought in line with FFS costs. Specifically, they "[have] maintained that 100 percent of [Medicare] FFS [costs] is the correct target for [the] benchmarks [used to determine MA payment rates in each county] because it would encourage plans that are more efficient than Medicare FFS."[3]

In 2009, the initial health care reform bills passed by both the House of Representatives on November 7 and the Senate on December 24 included substantial reductions in payments to MA plans. The House bill would have set benchmarks at 100 percent of FFS costs in each county; the House provisions were credited by the Congressional Budget Office (CBO) with 10-year savings of $154 billion.[4] The Senate bill would have set the benchmarks based on "plan costs as reflected in their bids" at the county level and provide additional payments to plans based on their scores on measures of plan performance on quality and enrollee satisfaction; the Senate provisions were scored by CBO as saving $118 billion over 10 years.[5,6]

This issue brief analyzes the MA payment provisions included in the Health Care and Education Affordability Reconciliation Act of 2010 (HCEARA) passed by the House and Senate on March 25, 2010 and signed into law on March 30, 2010. This bill amends the Patient Protection and Affordable Care Act, signed into law by President Obama on March 23, 2010, with a set of compromise proposals regarding MA payment policies that begin to take effect in 2011.

The analysis presented here utilizes CMS data on Medicare FFS costs, enrollment, and county-level benchmarks. It also uses MedPAC data on MA plan bids in relation to FFS costs and Kaiser Family Foundation analysis of MA plan performance ratings.[7] The data are the latest available from 2009, so the analysis should be interpreted as representing the impact of the new policies as if they had been fully implemented in 2009. Enrollment in MA plans in February 2009 was 10.1 million, and total Medicare payments to MA plans in 2009 are projected to have been $98.9 billion. If the new payment policy had been fully implemented in 2009, we estimate that MA payments would have been $88.2 billion.[8]

OVERVIEW OF NEW MA PAYMENT POLICY

The MA payment policy included in HCEARA makes significant changes to the MA program's method of paying plans.[9] The total effect of this new MA payment policy will be to reduce payments to MA plans from a national average of 113 percent of FFS costs in 2009 to an average of 101 percent of FFS costs when fully phased-in in 2016.

There are three elements of the new MA payment policy:

(1) The basic benchmark policy will rank all 3,140 counties in the nation from lowest to highest by average FFS costs and divide them into four cohorts of 785 counties. New county benchmarks will be set at fixed percentages of county FFS costs: 115%, 107.5%, 100%[10] and 95%[11] for the lowest to highest FFS cost cohorts.[12]

(2) A second element of the policy will increase county benchmarks by 5 percent for plans with four or more stars on the CMS measures of health plan performance, commonly referred to as quality stars (See Box 1).[13]

(3) The third element of the new policy will reduce the rebates to plans (i.e., the

payments that a plan receives based on the amount that its bid is less than the county benchmark). Under current law, rebates are set at 75 percent of the difference between the county benchmark and any plan bid that is lower than the benchmark. The rebate will be reduced to 50 percent for most plan, to 65 percent for plans with 3.5 and 4 stars and to 70 percent for plans with 4.5 or 5 stars on the CMS measures of health plan performance.[14]

Box 1. Health Plan Performance: Quality Stars

The performance-based benchmarks and rebates in the compromise proposal are available to plans that score well on CMS' star-based quality rating system. This system rates plan performance on the following measures:

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

According to the Kaiser Family Foundation, 11 percent of plans achieve 4 or 5 stars. Approximately 23% of MA enrollees are in 4 or 5 star plans.[14] The national average rating for plans, weighted by 2009 enrollment, is 3.27 stars.

The rationale for this payment methodology is first and foremost to reduce the national average of payments to MA plan to an amount near 100 percent of FFS costs. Our analysis indicates that the new system will pay plans a nationwide average of 101 percent of FFS costs, with total extra payments reduced from the estimated level of $11.4 billion in 2009 to $0.7 billion. CBO has estimated that the new policy will reduce Medicare costs by $132 billion over 10 years.[15]

The rationale for setting different levels of payment for counties based on their FFS costs is to reward areas who have low FFS costs. By setting benchmarks higher than FFS costs in low FFS cost areas, the legislation directs additional Medicare funds to these low-cost areas. While this rationale would appear to reward low-cost areas, it must be remembered that these rewards will primarily benefit plans and MA enrollees for the low costs achieved by area doctors — who may benefit to some extent from higher fees paid by MA plans — and FFS beneficiaries — who will not derive any benefit at all from this component of the new policy.

Although the new policy will substantially reduce the amount of extra payments to MA plans, payments would still exceed FFS costs by as much as 17 percent for some, particularly high-performing, plans in counties with low FFS costs. These include counties in Oregon, New Mexico, upstate New York, and Hawaii, many of which have the

Exhibit 1. Overview of Medicare Advantage Payment Benchmark Cohorts in Compromise Proposal

Compromise Proposal Benchmark Compared to FFS Cost Cohort	Current Medicare Advantage Enrollees[1]	Share of Medicare Advantage Enrollees	Share of Cohort Enrollees in Rural Counties[2]	Share of Cohort Enrollees in Counties with Average Plan Rating of 4 Stars or Higher[3]
115%	1,535,171	15%	40%	33%
107.5%	1,782,865	18%	30%	15%
100%	2,462,703	25%	18%	17%
95%	4,233,541	42%	7%	8%
National	**10,014,280**	**100%**	**19%**	**15%**

[1] Medicare Advantage enrollees in plans in Puerto Rico, American Samoa and Guam are excluded. Enrollees in "cost" plans are also excluded.
[2] Based on county classification in the 2005 American Community Survey.
[3] Based on county level enrollee-weighted plan quality average. See previous work by the Kaiser Family Foundation.

highest level of extra payments under current policy. We estimate the total costs of these extra payments to plans in the cohorts of counties with benchmarks set at 115 and 107.5 percent of FFS costs will be approximately $3.0 billion a year more than FFS costs.

These continued extra payments will be balanced by payments that are less than FFS costs to plans in counties where FFS costs are high. Many of these counties now have limited extra payments under current policy. Payments to plans in the cohort of counties with benchmarks set at 95 percent of FFS costs are estimated to be approximately $2.5 billion a year less than FFS costs.

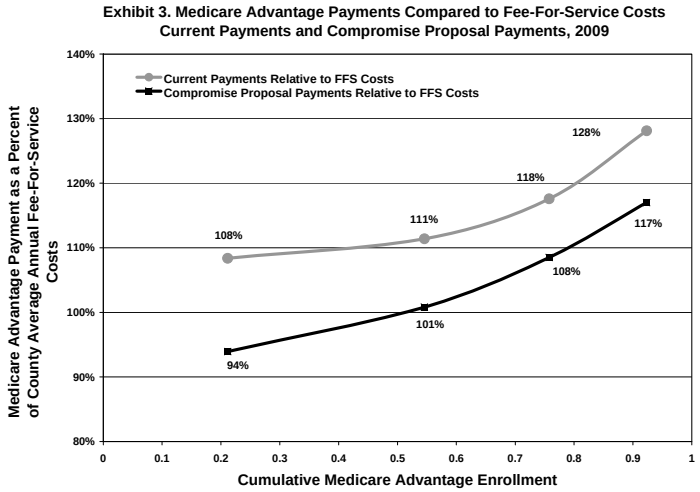
A reduction of rebates to plans from 75 percent under current policy to a new base level of 50 percent will also reduce payments to MA plans and provide Federal budget savings. The total savings due to the reduction in the rebate level, after the benchmarks have been reduced by the new four cohort policy, is estimated at $0.3 billion a year.

The rationale for the new policies to add 5 or 10 percent to plan benchmarks and to set the level of rebates at 65 and 70 percent for plans with high scores on CMS measures of health plan performance is to reward MA plans that perform well on plan quality measures. Plans with high current plan performance scores tend to be located in California, Pennsylvania, Massachusetts, Oregon and Hawaii. Staff and group model HMOs also tend to score well on these measures.[16] The total increase in payments to MA plans due to these plan quality-

Exhibit 2. Effect of Combined Medicare Advantage Payment Policies in Compromise Proposal
Compromise Payment Compared to Current Payments

Compromise Proposal Benchmark Compared to FFS Cost Cohort	Current Average Annual Medicare Advantage Payment	Estimated Compromise Proposal Payment	Current Medicare Advantage Payments Relative to FFS Costs[1]	Estimated Compromise Proposal Payments Relative to FFS Costs	Compromise Proposal Reduction in Payments From Current Levels	Share of Payment Reductions	Compromise Proposal Payments Relative to Current Payments (In Billions)
115%	$9,071	$8,284	128%	117%	-11%	11%	-$1.2
107.5%	$9,209	$8,497	118%	108%	-10%	12%	-$1.3
100%	$9,416	$8,521	111%	101%	-10%	21%	-$2.2
95%	$10,722	$9,292	108%	94%	-14%	56%	-$6.0
National	**$9,878**	**$8,807**	**113%**	**101%**	**-12%**	**100%**	**-$10.7**

[1] See author's previous work.



based policies is projected at $0.7 billion a year.

Overall, the new policies will reduce MA payments, as indicated in Exhibit 2, from current levels by a similar percentage for plans across the range of county FFS costs. The combined effect of the three policies is displayed in Exhibits 1, 2, 3 and 4.

IMPACT OF SPECIFIC COMPONENTS OF THE NEW POLICIES

Analysis of the three components of the new MA payment policies indicates that the four cohort benchmark policy is by far the most significant in the determination of the amount of payments to specific MA plans.

The increase in the benchmarks to 4 or greater star plans has a minimal effect on overall payments, as only 15 percent of enrollees live in counties with plans average ratings of four stars or more on the CMS plan performance measures.

The reduction in the plan rebate from 75 percent to 50 percent, 65 percent, or 70 percent also has only a limited impact on total plan payments. Analysis indicates that under the new four cohort benchmark policy, about 65 percent of MA enrollees will be in plans with bids above the county benchmark and so not eligible for any rebate.[17] Forty-six percent of enrollees live in counties where the average plan performance rating is 3.5 or 4 stars and will be eligible for a 65 percent rebate. Approximately 3 percent of enrollees live in counties where the average plan performance rating is 4.5 or 5 stars so could be eligible for a 70 percent rebate (Exhibit 8).

Four cohort county benchmark policy. The most significant aspect of the new policies in terms of the level of payments to MA plans is the MA payment benchmark policy. Under this policy, all 3,140 of the counties in the nation will be ranked in order from lowest to highest county average FFS costs. CMS will use the same methodology it currently does to calculate average FFS costs. Counties will then be placed in one of four cohorts of 785 counties from low to high FFS costs. These four cohorts are:

Exhibit 4. Effect of Medicare Advantage Payment Policies in Compromise Proposal
Compromise Payment Compared to Fee-For-Service Costs

Compromise Proposal Benchmark Compared to FFS Cost Cohort	Current Average Annual FFS Costs	Estimated Compromise Proposal Payment	Estimated Compromise Proposal Payments Relative to FFS Costs	Compromise Proposal Payments Relative to FFS Costs (In Billions)
115%	$7,080	$8,284	117%	$1.8
107.5%	$7,832	$8,497	108%	$1.2
100%	$8,452	$8,521	101%	$0.2
95%	$9,893	$9,292	94%	-$2.5
National	**$8,740**	**$8,807**	**101%**	**$0.7**

Exhibit 5. Effect of Medicare Advantage Payment Policies in Compromise Proposal
Four-Cohort Benchmarks

Compromise Proposal Benchmark Compared to FFS Cost Cohort	Current Medicare Advantage Enrollees[1]	Reduction in Current Payment as Percent of FFS Costs	Annual Payment Due to Benchmark	Compromise Proposal Benchmark Payments Relative to Current Payments (In Billions)[2]	Compromise Proposal Benchmark Payments Relative to FFS Costs (In Billions)
115%	1,535,171	-13%	$8,141	-$1.4	$1.6
107.5%	1,782,865	-11%	$8,418	-$1.4	$1.0
100%	2,462,703	-11%	$8,442	-$2.4	$0.0
95%	4,233,541	-13%	$9,323	-$5.9	-$2.4
National	**10,014,280**	**-12%**	**$8,764**	**-$10.8**	**$0.2**

[1] Medicare Advantage enrollees in plans in Puerto Rico, American Samoa and Guam are excluded. Enrollees in "cost" plans are also excluded.
[2] See previous work by the authors.

- **Benchmarks set at 115% of FFS costs.** Plans in the 785 counties with the lowest FFS costs in the nation will be paid based on benchmarks set at 115 percent of county FFS costs. These counties include 15 percent of total MA enrollees and 55 percent of the enrollees in the cohort reside in rural counties.

- **Benchmarks set at 107.5% of FFS costs.** Plans in the next 785 counties with FFS costs just above the lowest counties will be paid based on benchmarks set at 107.5 percent of county FFS costs. This group of counties includes 18 percent of MA enrollees and 44 percent of enrollees live in rural areas.

- **Benchmarks set at 100% of FFS costs.** Plans in the next 785 counties with higher FFS costs will be paid based on benchmarks set at 100 percent of county FFS costs. Enrollees in these counties mirror the national average of Medicare beneficiaries -- 70 percent live in urban areas and 30 percent live in rural areas. They include 25 percent of MA enrollees.
- **Benchmarks set at 95% of FFS costs.** The 785 counties with the highest FFS costs in the nation will be paid based on benchmarks set at 95 percent of county FFS costs. These counties include 42 percent of MA enrollees and 85 percent of enrollees live in urban areas. This cohort includes the core counties of many of the nation's largest cities.

Exhibit 6. Effect of Medicare Advantage Payment Policies in Compromise Proposal
Performance-Based Benchmark Adjustment

Performance Adjustment Category[1]	Increase in Payment Benchmark	Medicare Advantage Enrollees[2]	Share of Enrollees in Plans With Benchmark Greater than FFS Costs	Total Value of Performance Based Benchmark Adjustment (In Billions)
Less than 4.0 stars	0%	8,488,304	30%	$0.0
4.0 – 5.0 stars	5%	783,608	31%	$0.3
Four-Factor Double Adjustment[3]	10%	742,368	70%	$0.3
National	**0%**	**10,014,280**	**33%**	**$0.5**

[1] Based on county level enrollee-weighted plan quality average. To account for averaging, counties with star averages of 3.75 or more are included. See previous work by the Kaiser Family Foundation.
[2] Medicare Advantage enrollees in plans in Puerto Rico, American Samoa and Guam are excluded. Enrollees in "cost" plans are also excluded.
[3] See Box 2: Four-Factor Double Benchmark Adjustment

Overall, the four cohort benchmark policy, independent of the other two polices, will reduce MA payments to 100 percent of FFS costs and account for essentially all of the Medicare savings in the new policy (Exhibit 5).

Increase in plan payment benchmarks based on plan performance measures. This new policy will provide a 5 percent increase in the county benchmark for all plans with 4, 4.5 or 5 plan performance stars.

There are 147 counties, with a total of 15 percent of all MA enrollees, where MA plans average 4 or more stars. Increasing payment benchmarks to MA plans with high plan performance ratings will increase total MA payments by $0.7 billion annually, or less than 1 percent of total payments to MA plans (Exhibits 6 and 7).

An additional, four-factor double benchmark adjustment is available to plans in counties meeting certain criteria. A more detailed analysis

Box 2. Four-Factor Benchmark Double Increase

The compromise proposal also includes a targeted four-factor benchmark increase. This increase applies to plans: (1) with 4 or more plan performance stars; (2) in counties with plan enrollment rate of 25% or more; (3) in counties that were designated "urban floor" benchmark counties in 2004; and (4) in counties with lower than national average FFS costs.

We estimate that 37 counties will have plans eligible for this bonus. These counties include 715,021 enrollees or about 7% of nation-wide MA enrollees. About 25% of all counties and 49% of enrollees eligible for the national performance-based benchmark adjustment of 5 percent are eligible for this four-factor adjustment to 10 percent.

The total value of this policy is approximately $294 million or 0.3% of the total $88 billion projected to be spent through the MA program under the compromise proposal each year. These include:

State	Number of Medicare Advantage Enrollees	Share of Enrollees in State Receiving Double Adjustment	Share of Total Policy Value	Total Value of Policy (In Millions)
8 State Total	715,021		100%	$294
California	124,914	2%	3%	$10
Colorado	62,113	36%	9%	$26
Florida	11.468	1%	2%	$5
Massachusetts	44,226	23%	6%	$19
New York	247,147	30%	34%	$100
Oregon	147,400	60%	20%	$59
Pennsylvania	89,456	11%	13%	$37
Washington	117,616	54%	17%	$50

Exhibit 7. Effect of Medicare Advantage Payment Policies in Compromise Proposal
Performance-Based Benchmark Adjustment

Compromise Proposal Benchmark Compared to FFS Cost Cohort	Current Medicare Advantage Enrollees[1]	Share of Enrollees in Plans Receiving 5% Benchmark Adjustment[2]	Share of Enrollees in Plans Receiving 10% Benchmark Adjustment	Cohort Share of Performance Based Benchmark Adjustment[2]	Total Value of Performance Based Benchmark Adjustment (In Billions)
115%	1,535,171	11%	22%	32%	$0.2
107.5%	1,782,865	4%	11%	17%	$0.1
100%	2,462,703	8%	9%	28%	$0.2
95%	4,233,541	8%	0%	23%	$0.1
National	**10,014,280**	**15%**	**7%**	**100%**	**$0.6**

[1] Based on county level enrollee-weighted plan quality average. See methods and previous work by the Kaiser Family Foundation.
[2] Medicare Advantage enrollees in plans in Puerto Rico, American Samoa and Guam are excluded. Enrollees in "cost" plans are also excluded.

of this provision can be found in Box 2.

Reduction in plan rebates with higher rebates based on plan performance quality stars. Under the new policy, MA plan rebates will be reduced from the current level of 75 percent to 50 percent for most MA plans eligible for rebates. Rebates under the new policy will be set at 65 percent for plans with 3.5 or 4 plan performance stars and 70 percent for plans with 4.5 or 5 plan performance stars.

Plan rebates are payments to plans that reflect the difference between the county MA benchmark and a plan's costs for providing the Medicare benefit package as reflected in the plan's bid. For a plan to receive a rebate, its bid must be less than the local county payment benchmark. Analysis indicates that only about 30 percent of MA enrollees will be in plans with bids less than the new county benchmark and so will receive a rebate.

The new policy will also provide increases in plan rebates from the new 50 percent base rate to 65 percent for plans with 3.5 or 4 stars and to 70 percent for plans with 4.5 or 5 stars.

Exhibit 8. Effect of Medicare Advantage Payment Policies in Compromise Proposal
Quality-Based Rebate Adjustment

Plan Quality-Based Rebate Category[1]	Rebate Amount	Current Medicare Advantage Enrollees[2]	Share of Enrollees in Category	Marginal Increase in Plan Payment from 50% Rebate Due to Quality-Based Rebate Adjustments (In Millions)	Percent Increase in Plan Payment Due to Quality-Based Rebates	Total Value of Rebates (In Millions)
No Rebate	0%	6,786,534	68%	$0.0	0.0%	$0.0
0-3.5 Stars	50%	1,148,271	11%	$0.0	3.8%	$431.7
3.5-4.5 Stars	65%	1,802,220	18%	$77.6	5.6%	$336.2
4.5-5 Stars	70%	277,255	3%	$0.1	3.7%	$2.3
National		**10,014,280**	**100%**	**$77.7**	**0.9%**	**$770.3**

[1] Based on county level enrollee-weighted plan quality average. See methods and previous work by the Kaiser Family Foundation.
[2] Medicare Advantage enrollees in plans in Puerto Rico, American Samoa and Guam are excluded. Enrollees in "cost" plans are also excluded

Exhibit 9. Effect of Medicare Advantage Payment Policies in Compromise Proposal
Quality-Based Rebate Adjustment

Compromise Proposal Benchmark Compared to FFS Cost Cohort	Current Medicare Advantage Enrollees[1]	Share of Cohort Enrollees in Plans Receiving a Rebate[2]	Rebate Payments as a Percent of Total Cohort Payments	Total Value of Rebate Policy (In Millions)
115%	1,535,171	29%	0.0%	$2.9
107.5%	1,782,865	16%	0.0%	$5.4
100%	2,462,703	33%	0.2%	$52.7
95%	4,233,541	40%	1.8%	$709.4
National	**10,014,280**	**32%**	**0.9%**	**$770.3**

[1] Medicare Advantage enrollees in plans in Puerto Rico, American Samoa and Guam are excluded. Enrollees in "cost" plans are also excluded.
[2] Based on county level enrollee-weighted plan bid, benchmark and quality levels. See Methods for details.

Analysis indicates that the 65 percent rebate will be paid to plans in counties that enroll 18 percent of MA enrollees. The 15 percent increase from the 50 percent base level will increase payments by 0.8 percent and $77 million nationwide. The 70 percent rebate will be paid to plans in counties with 3 percent of plan enrollees and the increase in payments from the 50 percent level will total less than $1 million nationwide (Exhibits 8 and 9).

Taken together, the net reduction in MA payments due to the new lower rebate percentages is projected at less than one-half of one percent of total MA payments. This modest combined impact of the new rebate policies is primarily because just over 30 percent of MA enrollees are in plans that will receive any rebate due to the level of their bid relative to the local benchmark. Only 21 percent of enrollees are in counties with plans that average 3.5 stars or more.

CONCLUSION

The new Medicare Advantage provisions will significantly change Federal policies regarding Medicare private plans. Overall, this change will shift from a policy that favors private plans relative to original FFS Medicare by providing subsidies of over $11 billion a year to one that treats private plans neutrally by paying plans nationwide at rates similar to average costs in the Medicare FFS program.

The new policy will, however, continue payments in excess of local FFS costs to MA plans in counties in which approximately one third of current MA enrollees live. These payments will be directed toward low FFS cost areas, often rural areas, and plans with high ratings on CMS' plan performance measures. The new MA payment policy also will pay plans in high-cost areas less than local FFS costs. These counties are predominately urban: 85 percent of these MA enrollees are in urban counties, many of which are the core counties of major metropolitan areas.

Overall, the new benchmark policy will explicitly produce a differential in payments of 20 percent relative to local FFS costs between counties in the 115 percent benchmark county cohort and those in the 95 percent benchmark cohort.

In addition to the reduction in average plan payment benchmarks, the new MA policy will reduce the basic plan rebate level from 75 to 50 percent while setting rebates at 65 and 70 percent for plans with 3.5 or more plan performance quality stars. Since only 30 percent of MA enrollees are in plans projected to receive rebates and the value of rebates is limited, the total reduction in MA payments due to the new rebate polices is projected to be modest at less than one-half of one percent of total MA payments.

New MA payment polices to increase plan benchmarks and rebates based on plan performance measures will be a significant new development in the approach to MA payments. Analysis of the payment increases due to these new policies, however, indicates that the overall impact will again be modest. The plan performance-based increases in the benchmarks and rebates taken together are projected to add less than one percent to overall payments to MA plans.

In sum, the new Medicare Advantage payment policies proposed by the HCEARA will reduce payments to MA plans to a national average of approximately 101 percent of FFS costs nationwide. The new MA payment polices have been scored by CBO as reducing Medicare costs by $132 billion over the decade from 2010 to 2019. This is the second largest source, after reductions in payments to hospitals, of Medicare savings in the proposed health care reform legislative package.

NOTES

[1] B. Biles, J. Pozen, and S. Guterman, The Continuing Cost of Privatization: Extra Payments to Medicare Advantage Plans Jump to $11.4 Billion in 2009, The Commonwealth Fund, May 2009

[2] Barack Obama and Joe Biden's Healthcare Plan. 2008. Available at www.barackobama.com.

[3] Medicare Payment Advisory Commission. *Report to the Congress: Medicare Payment Policy.* "Chapter 4: The Medicare Advantage Program." Washington, DC: March, 2010.

[4] Letter from CBO Director Doug Elmendorf to Rep. John Dingell. November 20, 2009. Available at: http://www.cbo.gov/doc.cfm?index=10741&type=1

[5] MA plans are required to submit bids that represent their estimated costs of providing the basic benefit package available under original FFS Medicare, and their payments are based on the difference between those bids and the benchmark rates in the counties they serve. See note 1 for more detail.

[6] Letter from CBO Director Doug Elmendorf to Sen. Harry Reid. March 11, 2009. Available at: http://www.cbo.gov/doc.cfm?index=11307&type=1

[7] The MedPAC bid data was extrapolated from a presentation report on the effects of the Medicare Improvement and Patient Protection Act of 2008 given March 14, 2009. Further detail can be found in the methods sections and note 10. The meeting notes are available at: www.medpac.gov/meetings. The Kaiser Family Foundation's report was based on plan performance star ratings. These are available at the Medicare Compare website, www.medicare.gov.

[8] See Study Methods section for further details.

[9] Health Care and Education Affordability Reconciliation Act of 2010. H.R. 4872. Available at: http://docs.house.gov/rules/hr4872/111_hr4872_amndsub.pdf

[10] The basic MA benchmark policy set forth in the 2003 Medicare Modernization Act was 100% of local county FFS costs.

[11] The basic MA payment policy from 1983 to 2003 was 95 percent of local county FFS costs.

[12] This policy will be phased in gradually depending on the difference between the current benchmark and the new benchmark. Ninety-two percent of enrollees will have a six year benchmark phase-in, fully implemented in 2016. Five percent of enrollees will have a four-year phase-in which will be complete in 2014 and 3 percent will have a two year phase-in complete in 2012.

[13] Quality-based payments to plans will be introduced gradually. Plans will be eligible for 1.5 percent benchmark increases in 2012 and 3 percent benchmark increases in 2013. The policy will be fully implemented in 2014. See Box 1 for further explanation of CMS' health plan performance measures, or stars.

[14] This policy will be phased in over four years.

[15] Letter from CBO Director Doug Elmendorf to Hon. Nancy Pelosi. March 18, 2010. Available at: http://www.cbo.gov/doc.cfm?index=11355&type=1. This cost estimate includes an extension of the Secretary of Health and Human Services' authority to adjust MA payments to account for coding intensity. Coding intensity adjustments are not included in this analysis because they are a part of the risk-adjustment dimension of MA payment. Our data are risk-adjusted to a score of 1.

[16] "What's in the Stars? Quality Ratings of Medicare Advantage Plans in 2010." Kaiser Family Foundation. December 2009. Washington, DC. Available at: www.kff.org/medicare/upload/8025.pdf

[17] At this time, bid information by county is not available. This analysis estimates the county-level bid using data presented by MedPAC on March 14, 2009 (see Note 7). MedPAC presented an average bid-to-FFS comparison for eight cohorts based on local FFS costs. We applied the appropriate eight cohort average bid-to-FFS amount to each county's FFS costs to find an estimated bid for the county. Because we are relying on an average to estimate bids, some plan and county average bids may fall above or below the estimate and therefore may be eligible (or counted as eligible when they are not) for rebate and benchmark adjustments.

Appendix 1. Medicare Advantage Payment Policies in Compromise Proposal Alphabetically by State, 2009

State	Medicare Advantage Enrollees[1]	Medicare Advantage Plan Penetration	Percent of Enrollees in Counties with Plan Quality Averages of 4.0 or More[2]	Current Average Annual Fee-For-Service Costs	Current Average Annual Medicare Advantage Payment[3]	Compromise Proposal Payment Per Enrollee	Current Medicare Advantage Payments Relative to FFS Costs	Compromise Proposal Payments Relative to FFS Costs	Payment Reduction Relative to Current Payments Under Compromise Proposal	Compromise Proposal Payments Relative to FFS Costs
National	**10,014,280**	**22%**	**15%**	**$8,740**	**$9,878**	**$8,796**	**113%**	**101%**	**-12%**	**1%**
Alabama	170,929	21%	0%	$8,579	$9,420	$8,523	110%	99%	-11%	-1%
Alaska	640	1%	0%	$8,859	$10,078	$8,701	114%	98%	-16%	-2%
Arizona	323,823	37%	0%	$8,490	$9,346	$8,590	110%	101%	-9%	1%
Arkansas	67,808	13%	0%	$7,894	$9,000	$8,374	114%	106%	-8%	6%
California	1,570,931	35%	4%	$9,246	$10,353	$8,984	112%	97%	-15%	-3%
Colorado	173,014	30%	74%	$8,470	$9,444	$8,714	111%	104%	-7%	4%
Connecticut	87,916	16%	0%	$8,991	$9,596	$8,718	107%	97%	-10%	-3%
Delaware	6,627	5%	0%	$8,364	$9,083	$8,364	109%	100%	-9%	0%
Florida	922,369	29%	1%	$10,331	$10,641	$9,701	103%	94%	-9%	-6%
Georgia	169,945	15%	0%	$8,154	$9,281	$8,378	114%	103%	-11%	3%
Hawaii	37,902	19%	87%	$6,673	$9,194	$7,716	138%	116%	-22%	16%
Idaho	57,219	26%	0%	$7,511	$9,027	$8,398	120%	112%	-8%	12%
Illinois	168,079	9%	6%	$8,750	$9,446	$8,806	108%	101%	-7%	1%
Indiana	132,303	14%	0%	$7,850	$9,131	$8,363	116%	107%	-9%	7%
Iowa	56,193	11%	0%	$7,156	$8,818	$8,051	123%	113%	-10%	13%
Kansas	40,914	10%	0%	$8,170	$9,380	$8,358	115%	102%	-13%	2%
Kentucky	103,977	14%	0%	$8,155	$9,129	$8,413	112%	103%	-9%	3%
Louisiana	146,528	22%	0%	$9,934	$11,634	$9,396	117%	95%	-22%	-5%
Maine	23,921	9%	39%	$7,312	$8,886	$8,463	122%	116%	-6%	16%
Maryland	36,215	5%	1%	$9,919	$10,344	$9,279	104%	94%	-10%	-6%
Massachusetts	195,785	19%	100%	$8,907	$10,037	$8,992	113%	102%	-11%	2%
Michigan	380,956	24%	4%	$8,563	$9,395	$8,560	110%	100%	-10%	0%
Minnesota	175,517	23%	47%	$8,377	$9,115	$8,667	109%	103%	-6%	3%
Mississippi	43,827	9%	0%	$8,922	$9,667	$8,706	108%	98%	-10%	-2%
Missouri	190,434	20%	0%	$8,069	$9,413	$8,329	117%	103%	-14%	3%
Montana	27,046	17%	0%	$7,410	$8,563	$8,309	116%	112%	-4%	12%
Nebraska	29,612	11%	0%	$7,966	$9,054	$8,262	114%	104%	-10%	4%
Nevada	102,927	31%	0%	$9,743	$9,902	$9,322	102%	96%	-6%	-4%
New Hampshire	12,229	6%	0%	$8,002	$9,214	$8,478	115%	106%	-9%	6%
New Jersey	152,989	12%	0%	$9,298	$10,108	$8,888	109%	96%	-13%	-4%
New Mexico	71,462	24%	0%	$6,962	$9,173	$7,993	132%	115%	-17%	15%
New York	822,535	28%	35%	$8,978	$10,660	$9,105	119%	102%	-17%	2%
North Carolina	244,055	17%	0%	$7,800	$9,236	$8,390	118%	108%	-10%	8%
North Dakota	6,984	7%	0%	$7,231	$8,558	$8,162	118%	113%	-5%	13%
Ohio	471,989	26%	2%	$8,159	$9,325	$8,403	114%	103%	-11%	3%
Oklahoma	83,262	14%	0%	$9,128	$9,642	$8,761	106%	96%	-10%	-4%
Oregon	244,823	42%	87%	$7,444	$9,212	$8,599	124%	116%	-8%	16%
Pennsylvania	842,648	38%	30%	$8,500	$9,667	$8,596	114%	101%	-13%	1%
Rhode Island	64,713	36%	0%	$7,823	$9,432	$8,442	121%	108%	-13%	8%
South Carolina	105,515	15%	0%	$8,001	$9,190	$8,336	115%	104%	-11%	4%
South Dakota	9,424	7%	0%	$7,238	$8,558	$8,201	118%	113%	-5%	13%
Tennessee	221,207	22%	0%	$8,254	$9,301	$8,457	113%	102%	-11%	2%

State	Medicare Advantage Enrollees[1]	Medicare Advantage Plan Penetration	Percent of Enrollees in Counties with Plan Quality Averages of 4.0 or More[2]	Current Average Annual Fee-For-Service Costs	Current Average Annual Medicare Advantage Payment[3]	Compromise Proposal Payment Per Enrollee	Current Medicare Advantage Payments Relative to FFS Costs	Compromise Proposal Payments Relative to FFS Costs	Payment Reduction Relative to Current Payments Under Compromise Proposal	Compromise Proposal Payments Relative to FFS Costs
National	**10,014,280**	**22%**	**15%**	**$8,740**	**$9,878**	**$8,796**	**113%**	**101%**	**-12%**	**1%**
Texas	488,491	17%	0%	$9,612	$11,162	$9,059	116%	94%	-22%	-6%
Utah	79,422	30%	0%	$7,908	$9,228	$8,324	117%	105%	-12%	5%
Vermont	3,800	4%	0%	$7,290	$8,534	$8,224	117%	113%	-4%	13%
Virginia	132,793	12%	0%	$7,350	$9,114	$8,177	124%	111%	-13%	11%
Washington	215,825	24%	78%	$7,622	$9,222	$8,647	121%	115%	-6%	15%
Washington D.C.	3,244	4%	0%	$9,144	$10,890	$8,687	119%	95%	-24%	-5%
West Virginia	73,546	20%	14%	$7,798	$9,047	$8,428	116%	108%	-8%	8%
Wisconsin	216,329	25%	15%	$7,440	$8,991	$8,222	121%	111%	-10%	11%
Wyoming	3,638	5%	0%	$7,995	$8,779	$8,280	110%	104%	-6%	4%

[1] Medicare Advantage enrollees in plans in Puerto Rico, American Samoa and Guam are excluded. Enrollees in “cost” plans are also excluded.
[2] Based on county level enrollee-weighted plan quality average. See previous work by the Kaiser Family Foundation.
[3] See authors’ previous work.

STUDY METHODS

This report analyzes Medicare Advantage payment, FFS cost, enrollment, plan quality and bid data from 2009. This analysis applies the new payment policies to 2009 payment and enrollment levels.

Current, or 2009, Medicare Advantage payment rates and fee-for-service expenditure averages posted by county in the 2009 CMS Medicare Advantage Rate Calculation Data spreadsheet.[1] The number of Medicare beneficiaries and Medicare Advantage enrollees by county is taken from the CMS State/County Penetration data file and the CMS State/County/Contract data file for February 2009. These data are posted on the Website of the Centers for Medicare and Medicaid Services, http://www.cms.hhs.gov.[2]

Using 2009 FFS data, all counties in the country were rank ordered by FFS costs. Following the reconciliation bill policy, the 3,140 counties were divided into 4 cohorts of 785 counties. The reconciliation bill sets county-level benchmarks in relation to FFS costs, so we have applied the appropriate benchmark cohort percentage (95 percent, 100 percent, 107.5 percent or 115 percent) to the appropriate cohort to determine the county-level payment benchmark.

An estimate for the county average plan costs as reflected in bids was derived from data presented by MedPAC. MedPAC grouped all counties in the country into one of eight cohorts, determined by their respective 2009 annual FFS costs, and provided aggregated bid-to-FFS ratios for each cohort. The authors used these average bid-to-FFS ratios to derive an estimated annual bid value for each county.

County-level plan performance stars are enrollee-weighted 2009 averages based on previous work by the Kaiser Family Foundation. These were used to determine the average quality-based benchmark and rebate adjustments. Our previous work on plan market concentration suggests that this average reflects the quality of the plan in which most enrollees participate.[3]

The new policy provides that 4, 4.5 and 5 star plans will receive benchmark adjustments. We included counties with star averages of 3.75 or more in the quality-based benchmark adjustment group. In addition, plans with 3 stars or fewer are eligible to receive a 50 percent rebate, 3-4.5 star plans can receive a 65 percent rebate and 4.5-5 star plans can receive a 70 percent rebate. We set rebate levels at 50 percent for counties with plan averages up to 3.25; rebate levels were set at 65 percent counties with star averages equal to 3.25 up to 4.25 and rebates were set at 70 percent in counties with star averages of 4.25 to 5. These more generous rebate and benchmark levels account for the fact that our data reflect county average plan quality.

Rebates were calculated by comparing this county-level bid estimate to the benchmark under the reconciliation bill (50 percent, 65 percent or 70 percent, determined by statute in the reconciliation bill). The final payment is the benchmark for counties where the average bid is higher than the benchmark. In counties where the bid is lower than the benchmark, payment is the bid plus the rebate amount times the difference between the bid and the benchmark.

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

Over 300,000 MA enrollees are in Medicare "cost" plans, paid on the basis of costs. Although these beneficiaries (identified through the CMS Medicare Advantage State/County/Contract data file for February 2009) receive Medicare benefits through managed care plans, they do not generate extra payments based on MA plan payment rates.[4] Cost beneficiaries were removed from the Medicare Advantage enrollee totals by county but are included in the number of overall Medicare beneficiaries.

This analysis follows a methodological convention developed by the Medicare Payment Advisory Commission (MedPAC) in addressing the Medicare policy of making direct payments to teaching hospitals for the costs of indirect medical education (IME) for MA enrollees. MedPAC adjusts 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 x GME), where GME is the county graduate medical education carve-out and 0.65 represents the national average percentage of GME payments that goes to IME; county-specific data are unavailable. Because Medicare makes IME payments directly to teaching hospitals for patients who are enrolled in Medicare Advantage, MA plan payment rates are most appropriately compared with fee-for-service costs adjusted in this manner.[5]

Budget-neutral risk adjustments to 2009 payments to Medicare Advantage plans provide additional extra payments to MA plans. This analysis of extra payments includes a budget-neutral risk adjustment of 1.009 for 2009.[6]

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[1] Centers for Medicare and Medicaid Services, Rate Calculation Data Risk 2009 spreadsheet (Baltimore, Md.: CMS, Apr. 2008), available at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/

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

[3] B. Biles, J. Pozen, and S. Guterman, "Paying Medicare Advantage by Competitive Bidding: How Much Competition Is There?" The Commonwealth Fund, August 2009

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

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

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