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Issue Brief

Medicare Advantage's Private Fee-for-Service Plans: Paying for Coordinated Care Without the Coordination

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ABSTRACT: Like the private managed care plans offered under Medicare Advantage, private fee-for-service (PFFS) plans are paid more per beneficiary than those individuals would be expected to cost if they were enrolled in traditional fee-for-service Medicare. However, PFFS plans are not required to provide the same type of coordinated care required of Medicare Advantage plans. Payments to PFFS plans in 2008 average 16.6 percent more than costs in traditional Medicare, or $1,248 for each of the 2 million enrollees in PFFS plans—a total of nearly $2.5 billion in extra payments. Recently, Congress has made significant revisions to policies that will affect how PFFS plans will operate in 2011 and thereafter, as well as their prospects for continued growth. This issue brief examines the development of PFFS plans, the policies underlying the rapid increase in the plans and their enrollment, the payments they receive, and the potential impact of the new legislation.

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BACKGROUND: PRIVATE FEE-FOR-SERVICE PLANS VS. OTHER MEDICARE PLANS

Rapid growth in enrollment and rising costs have in the past few years made Medicare Advantage private fee-for-service (PFFS) plans a prominent part of the Medicare program. Created by the Balanced Budget Act of 1997 (BBA) and given a major boost by the Medicare Modernization Act of 2003 (MMA), these plans are endowed with a number of unique characteristics that distinguish them from other types of Medicare Advantage plans. Unlike other Medicare Advantage plans, PFFS plans are not required to have a contract or other network arrangement with physicians, hospitals, and other providers. Instead, PFFS plans are allowed to pay providers with which they have no contracts at Medicare fee-for-service rates—a provision referred to as "deeming" authority.

Health care providers are required by law to accept these rates for PFFS plan patients, unless providers object before the services are delivered.[1]

In a May 2008 letter to Senator Chuck Grassley, Secretary of Health and Human Services Michael O. Leavitt wrote: "The ability to operate without having to establish networks is important to the continued availability of PFFS plans. Some argue that the so-called 'deeming' requirement advantages PFFS. [But] without deeming, PFFS plans would have difficulty establishing provider networks, especially in rural areas. Weakening these plans will hurt beneficiaries in rural areas."[2]

In addition to the deeming policy, other specific statutory requirements have allowed PFFS plans to operate differently from other private plans under the Medicare Advantage program:

1. They are exempt from the quality reporting and disclosure requirements to which other plans are subject.
2. They are not subject to bid review or negotiation with Medicare.
3. Providers, including hospitals, treating PFFS plan enrollees may directly charge those patients coinsurance of up to 15 percent more than the plan payment amount.

As is the case for all Medicare Advantage plans, PFFS plans receive payment rates that are substantially greater than fee-for-service costs in traditional Medicare, which gives them a competitive advantage over that program.[3] Moreover, the lack of a requirement to contract with the physicians used by their enrollees means that PFFS plans essentially are exempt from having to establish a network in the areas they serve; this has enabled them to choose to locate in areas with particularly favorable payment rates—areas in which other Medicare Advantage plans cannot operate because they cannot establish provider networks there. As a result, PFFS plans have a competitive advantage over other Medicare private plans, as well.

PFFS plans are thought of as helping bring private plan options to Medicare beneficiaries in areas where such options would not otherwise be available, and providing much broader access to providers than do the managed care plans that most of the Medicare Advantage program comprises.[4] In particular, managed care has never taken root in rural areas because rural providers—who frequently do not face much competition in their areas—have no compelling reason to sign contracts with managed care plans; given that PFFS plans are not required to have contracts with their providers, they can establish operations in those areas more easily.

However, PFFS plans fail to offer several of the perceived advantages of managed care plans, including coordinated care and integrated health care delivery. Moreover, because of the high payments that PFFS plans receive, combined with the steep increase in PFFS enrollment, they generate substantial additional costs to Medicare, which increasingly have become a cause for concern.[5]

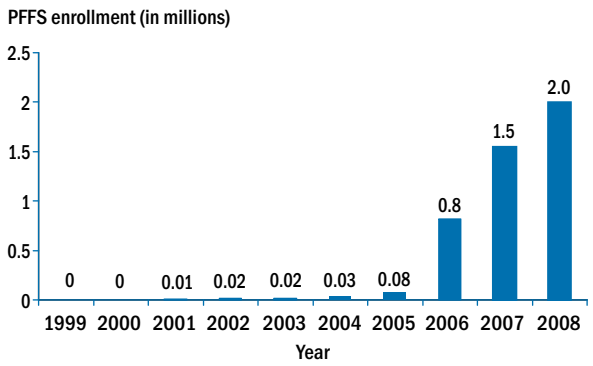
RAPID GROWTH IN PFFS ENROLLMENT

In the years immediately following their authorization, PFFS plans received little attention. Few plans participated in Medicare, enrolling only a small number of beneficiaries. After the MMA was enacted in 2003, PFFS plan enrollment began to grow exponentially—from 220,000 by December 2005 to nearly 2 million in February 2008 (Figure 1). The number of health insurance firms offering Medicare PFFS plans also grew rapidly—from just four firms with Medicare Advantage PFFS contracts in 2004 to 70 with such contracts in 2008.[6]

FACTORS ENCOURAGING THE DEVELOPMENT AND GROWTH OF PFFS PLANS

The creation of PFFS plans by the BBA in 1997 was a response to specific policy concerns. At that time, it was not anticipated that these plans would grow to today's national enrollment level of 2 million members. The current situation stems from the combined effect of five developments in Medicare private-plan policies over the past decade:

Figure 1. Total Enrollment in Medicare Advantage PFFS Plans, 1999–2008



Note: Data are from March of each year.
Source: Henry J. Kaiser Family Foundation, *Medicare Health and Prescription Drug Plan Tracker,* available at: www.kff.org.

- *Interest in an increasing role for private plans in Medicare.* In the late 1990s, many congressional leaders discussed shifting Medicare beneficiaries to a system of managed care plans, generally referred to as the "premium support" model, as a way of limiting Medicare cost increases. Some believed with certainty that all Medicare beneficiaries would soon be enrolled in private plans.[7]
- *Concerns about Medicare utilization review.* Certain groups responded to the private plan-based prospect of Medicare's future with great concern. Because HMO managed care plans have traditionally managed health care costs through utilization review, there was some concern that *all* Medicare private plans would inevitably employ utilization review. It was argued that this would lead to the rationing of health care and a reduction in end-of-life care, which some regarded as "involuntary euthanasia."[8] Given such fears, it was proposed that Medicare should permit private plans other than managed care plans to participate in an "un-managed care" plan model, which became the basis for what is now private fee-for-service.
- *Payment polices to attract private plans.* In response to the concerns of senators from rural states about the failure of managed care plans to develop there, the BBA included for the first time a policy that would pay private Medicare plans more than 100 percent of average costs in traditional fee-for-service Medicare—specifically in rural counties with low fee-for-service costs—with a portion of the extra payments allotted for additional benefits to enrollees.[9] In 2001, that policy was extended to urban counties with low fee-for-service costs, and in 2003, the MMA ensured that Medicare payments to private plans under the Medicare Advantage program exceed average costs under traditional Medicare in every county in the nation—though this differential is greater in some areas than others.[10,11,12]
- *Attraction of extra payments and low start-up costs to national for-profit health insurance firms.* The combination of the higher payment rates set by the MMA and the relative ease of market entry for PFFS plans enacted in the BBA attracted several major health insurance firms to exploit these opportunities by greatly expanding their efforts to establish PFFS plans—especially in counties with high levels of extra payments—and to enroll beneficiaries. In September 2007, the CIBC World Markets equity-analysis firm reported in its analysis of data from Humana, one of the country's largest health insurers: "The most surprising find is that the PFFS/PPO MLR [Medical Loss Ratio] in 2006 was 150 basis points better than Humana, Inc.'s HMO book, defying conventional wisdom. This has implications in Washington, since it supports the view that not all of the additional funding received by PFFS plans is used for extra benefits.[13]
- *Substantial commissions offered to local insurance agents for PFFS plan enrollment.* As loosely organized entities, PFFS plans often have used local insurance agents rather than plan employees for marketing efforts and the enrollment of new members. These local agents have played a major role in the increase in PFFS membership simply by responding to market incentives. Commissions are much

larger for the enrollment of new Medicare Advantage plan members—about $400 to $500 per enrollee in 2007, in comparison with new members in Medicare's private prescription drug plans (PDPs), which are $60 to $80 per enrollee—because annual Medicare payments to Medicare Advantage plans are significantly larger than those made to PDPs.[14,15] The extreme interest of local agents in marketing PFFS plans was documented in the summer of 2007 when, through an agreement with the Centers for Medicare and Medicaid Services, the seven major national PFFS plans suspended enrollment—in part because of complaints about misleading marketing practices by local plan agents.[16]

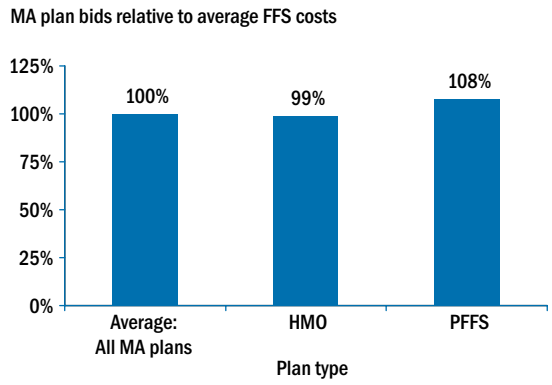
Some of these factors have been at least partially addressed by the Congress in the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), as discussed below. These provisions, however, will not take effect until 2011, and are expected to slow, but not reverse, the impact of PFFS plans.

PFFS PLANS AND PAYMENT RATES IN THE AREAS THEY SERVE

PFFS plans appear to aim their marketing at counties with very high levels of Medicare Advantage payments relative to what traditional fee-for-service Medicare spends. Overall, payments to the PFFS plans average 16.6 percent more than average costs in traditional fee-for-service Medicare—that is, PFFS plans receive on average 16.6 percent more than their own enrollees would be expected to cost if they had remained in traditional Medicare; this differential, which has been referred to as 'extra payments,' is 11.6 percent for all other types of Medicare Advantage plans.[17]

Evidence that PFFS plans are dependent on high Medicare extra payments is provided by the pattern of bids that all MA plans are required to submit. Since 2006, Medicare Advantage plans have been required to submit bids to Medicare that represent the payment they would be willing to accept for providing to their enrollees the same benefits offered by traditional Medicare. The amount that each plan receives for each enrollee is a function of the difference between the plan's bid and a benchmark rate set for each county.[18] The average bids submitted by Medicare Advantage health maintenance organizations (HMOs)—which, unlike PFFS plans, are required to have contracts with local providers—was 99 percent of corresponding costs in traditional fee-for-service Medicare in the areas they serve (Figure 2).[19] PFFS plans, however, submitted bids that were 108 percent of fee-for-service Medicare costs in the areas they serve—implying that their costs are 8 percent more than Medicare would be expected to spend on the same beneficiaries in the same areas. In addition, because they operate in areas that have benchmark rates that are considerably higher than average, PFFS plans receive a sizeable rebate—for a total payment that averages 16.6 percent more than spending would be in traditional fee-for-service Medicare.

Figure 2. Medicare Advantage Plan Bids by Plan Type



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

The availability of these extra payments beyond the costs of traditional fee-for-service Medicare, together with the provisions of Medicare law that enable easy market entry for firms wishing to establish PFFS plans, have enabled health insurance companies to capture substantial revenues with little investment or risk, and without the coordinated care that has been the historical argument for the role of private plans in Medicare.

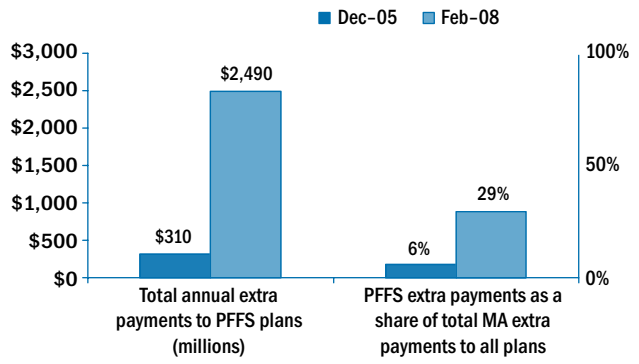
MEDICARE ADVANTAGE PRIVATE FEE-FOR-SERVICE PLAN EXTRA PAYMENTS IN 2008

Medicare Advantage extra payments in general, combined with policies specific to PFFS plans, have led to

PFFS plan payments that are greater than average fee-for-service and other MA plan costs. Total extra payments to PFFS plans are projected to total almost $2.5 billion in 2008. In fact, payments to PFFS plans average 5 percent more than payments to other Medicare Advantage plans, equivalent to $310 more per enrollee.

Between December 2005 and February 2008, the total amount of extra payments going to PFFS plans grew eightfold. In 2005, extra payments to PFFS plans represented just 6 percent of the total extra payments going to all MA plans. In 2008, however, the share of extra payments going to PFFS plans has grown to an estimated 29 percent (Figure 3).[20] Extra payments to PFFS plans in 2008 vary by county payment category, by state, and by urban/rural designation (Appendix Table 1).

Figure 3. Growth in Extra Payments to PFFS Plans, December 2005–February 2008



Source: George Washington University analysis of Centers for Medicare and Medicaid Services Medicare Managed Care State/County/Contract data file released February 2008; Medicare Managed Care Quarterly State County data file for December 2005 and the Medicare Advantage 2005 and 2008 Rate Calculation Data spreadsheets.

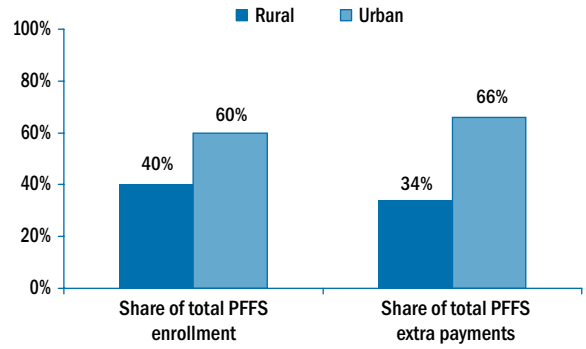
Patterns in extra payments by state. There is distinct variation across states in the amount of extra payments going to PFFS plans. In Wisconsin, where there are high levels of extra payments per enrollee for all Medicare Advantage plans, PFFS plans are paid an average of 122 percent of traditional fee-for-service Medicare costs, or $1,564 in extra payments per PFFS plan enrollee. Enrollment in PFFS plans in Wisconsin accounts for 64 percent of total MA plan enrollment in the state. The total of annual extra payments that went to PFFS plans in Wisconsin in 2008 was approximately $182 million (Appendix Table 2).

Similar patterns of extra payments and enrollment can be found in Indiana, where 83 percent of all Medicare Advantage enrollees are in PFFS plans. These plans are paid an average of 118 percent of traditional FFS Medicare costs—nearly five percentage points higher than the rate paid to other Medicare Advantage plans in the state. PFFS plans in Indiana receive $1,343 in extra payments per PFFS enrollee annually, and over $100 million in annual extra payments statewide.

There is significant variation within each state between the average extra payments to PFFS plans and to all other Medicare Advantage plans in the state. In some states—including California, Pennsylvania, and New York—the average extra payment to PFFS plans is dramatically higher than the average extra payment amount to all other Medicare Advantage plans. In New York, extra payments to PFFS plans average 26.3 percent, compared with a 13.2 percent average for other Medicare Advantage plans in the state.

Patterns in extra payments by urban/rural designation. Despite the promotion of PFFS plans as a way to bring private plans to rural areas, the majority of PFFS plan enrollment and extra payments are in fact in urban areas, with 60 percent of PFFS enrollment in urban areas in 2008, and 66 percent of PFFS extra payments going to urban PFFS plans (Figure 4). If extra payments can be seen as providing extra incentives to private plans to enter the Medicare

Figure 4. Share of PFFS Enrollment and Extra Payments in Urban Versus Rural Areas, 2008



Source: George Washington University analysis of Centers for Medicare and Medicaid Services Medicare Managed Care State/County/Contract data file released February 2008; Medicare Managed Care Quarterly State County data file for December 2005 and the Medicare Advantage 2008 Rate Calculation Data spreadsheets.

program, that incentive appears to be stronger in urban than in rural areas: the average extra payment to PFFS plans in urban areas is 18 percent, compared with 14.5 percent in rural areas.

CHANGES AFFECTING PRIVATE FEE-FOR-SERVICE PLANS IN THE MEDICARE IMPROVEMENTS FOR PATIENTS AND PROVIDERS ACT OF 2008

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) contained a number of provisions to improve Medicare benefits and provider payments. In order to make the legislation budget neutral as a whole—in other words, so that it would not increase the projected federal deficit—MIPPA included some provisions that would reduce total extra payments to MA plans. Among those were changes that affect the organization and operation of PFFS plans. One new policy removes the deeming authority for PFFS plans and requires PFFS plans in certain areas to establish networks of contracted providers beginning in 2011.[21] Another requires that PFFS plans implement quality improvement programs and establishes data collection and reporting requirements beginning in 2011 similar to those already in place for local PPO plans.

The Congressional Budget Office (CBO) has projected these new policies will noticeably reduce PFFS enrollment in 2011 and future years. CBO estimates that the changes to PFFS policies will significantly slow the growth in PFFS plan enrollment by 2013, but still project that about 40 percent more beneficiaries will be enrolled in these plans in 2013 than in 2008.[22]

CONCLUSION

As insurers actively take advantage of Medicare policies that explicitly pay all MA plans more than traditional fee-for-service Medicare and provide exceptions that make PFFS plans particularly attractive, these plans will add $2.5 billion to Medicare spending this year. Payments to PFFS plans in 2008 average $1,248 per year for each of the 2 million Medicare beneficiaries enrolled in PFFS plans, or 16.6 percent more than their costs would be in traditional fee-for-service Medicare.

The relative ease of market entry for PFFS plans has meant that organizations wishing to offer these plans in counties with high Medicare payment rates relative to costs in traditional Medicare have been able to selectively establish themselves in such areas without having to offer the coordinated care that historically has been expected of private plans in Medicare. Indeed, the analysis presented here indicates that PFFS plans have concentrated their focus on counties with especially high levels of extra payments.

It is important to note that PFFS enrollment and payments are heavily focused in urban areas, despite their perceived role as bringing Medicare private plans and their promise of extra benefits to rural beneficiaries. Of the total of $2.5 billion in extra payments to PFFS plans in 2008, only 34 percent goes to rural counties. Incentives actually favor the urban counties; extra payments to PFFS plans in urban areas average 18 percent, or $1,387 per enrollee annually, compared with 14.5 percent, or $846, to PFFS plans in rural areas.

While the legislation enacted in July 2008 made significant changes to the requirements facing PFFS plans, these changes will not take effect until 2011. This suggests that current patterns of increasing PFFS plan enrollment and extra payments may continue to be present over the next two years, then slow (but not necessarily stop) after that. Although CBO has projected that PFFS enrollment growth will decline compared with what it would have been under current law, these plans will continue to compose a large proportion of Medicare Advantage enrollment. Moreover, the current location of PFFS plans and their enrollees in counties with very high levels of extra payments by Medicare may provide more than adequate compensation to health insurance firms to cover the additional costs incurred by the newly enacted requirement to form physician networks. If this is the case, we will continue to see an unequal geographic distribution of PFFS plan enrollment and percentage of extra payments, with the majority centered in urban rather than rural areas.

Notes

1 P. C. Morgan, H. Chaikind, and H. Stockdale, *Private Fee-for-Service (PFFS) Plans: How They Differ from Other Medicare Advantage Plans,* CRS Report RL34151 (Washington, D.C.: Congressional Research Service, Aug. 28, 2007).

2 M. O. Leavitt, "Secretary Leavitt Letter to Congress on the Administration's Medicare Advantage Policies" (Washington, D.C.: U.S. Department of Health and Human Services, May 22, 2008).

3 B. Biles, E. Adrion, and S. Guterman, *The Continuing Cost of Privatization: Extra Payments to Medicare Advantage Plans in 2008* (New York: The Commonwealth Fund, Sept. 2008).

4 J. Blum, R. Brown., and M. Frieder, *An Examination of Medicare Private Fee-for-Service Plans* (Washington, D.C.: Henry J. Kaiser Family Foundation, Mar. 2007).

5 M. E. Miller, "Private Fee-for-Service Plans in Medicare Advantage," testimony before the U.S. Senate Committee on Finance, Jan. 30, 2008.

6 Henry J. Kaiser Family Foundation, *Medicare Health and Prescription Drug Plan Tracker.* Available at: www.kff.org.

7 National Bipartisan Commission on the Future of Medicare, *Building a Better Medicare for Today and Tomorrow* (final Breaux–Thomas Medicare reform proposal), Mar. 16, 1999. Available at: http://medicare.commission.gov/medicare/index.html.

8 B. J. Balch, "How Medicare Was Saved from Rationing—and Why It's Now in Danger" *National Right to Life News,* Mar. 2007 34(3).

9 The new benchmark-based bidding system determined payments to Medicare Advantage plans in the following way: Each year, the Centers for Medicare and Medicaid Services (CMS) calculate a "benchmark" rate—essentially a base rate against which MA plans bid—for every U.S. county. These rates vary widely by county type and locale, but in every county in the nation they are set at levels higher than average local costs in traditional FFS Medicare. Every MA plan files a bid each June that represents their costs of providing Medicare Part A and B services. They are then paid at rates equal to their bid plus 75 percent of the difference between their bid and the benchmark rate in the county where each enrollee resides.

10 H.R. 5661, Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000. See Section 601, "Increase in Minimum Payment Amount."

11 Biles, Adrion, and Guterman, *Continuing Cost of Privatization,* 2006.

12 In some counties, extra payments are only marginally higher than Medicare fee-for-service costs, while in others the extra payments are 135 percent or more of those costs. Analysts at MedPAC who have studied Medicare private-plan payments and costs have found that the average MA plan bid (for all plan types) is about 17 percent less than the county benchmark and that the average MA private fee-for-service (PFFS) plan bid falls below the county benchmark by about 12 percent—figures that are accounted for in the present analysis. The result is a 4.25 percent reduction in benchmark extra-payment rates on average to all MA plans and a 3 percent reduction to MA PFFS plans. Medicare Payment Advisory Commission, "Special Needs Plans and an Update on the Medicare Advantage Program," MedPAC Public Meeting, Dec. 6, 2007.

13 CIBC World Markets, Equity Research Earnings Update: Humana, Inc., Sept. 17, 2007.

14 California Health Advocates/Medicare Rights Center, After the Goldrush: The Marketing of Medicare Advantage and Part D Plans, Issue Brief No. 4, Jan. 2007, p. 5. Available at: http://www.medicarerights.org/CHA-MRC-brief_goldrush.pdf.

15 Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (Washington, D.C.: MedPAC, Mar. 2008).

16 Centers for Medicare and Medicaid Services, "Plans Suspend PFFS Marketing: Plans Adopt Strict Guidelines in Response to Deceptive Marketing Practices," press release (Washington, D.C.: CMS Office of Public Affairs, June 15, 2007).

17 For a discussion of extra payments to Medicare Advantage plans, see Biles, Adrion, and Guterman, *Continuing Cost of Privatization,* 2006.

18 Ibid.

19 MedPAC, *Report to the Congress: Medicare Payment Policy,* 2008.

[20] Figures based on George Washington University analysis of Centers for Medicare and Medicaid Services Medicare Managed Care State/County/Contract data file released June 2007; Medicare Managed Care Quarterly State, County Data File for the quarter ending December 2005; and the Medicare Advantage 2007 Rate Calculation Data Spreadsheet.

[21] Non-employer-sponsored PFFS plans in areas where there are at least two other Medicare Advantage plans with contracted networks of providers are required to establish networks. Plans in areas with less than two plans with established networks retain "deeming" authority. See: Congressional Research Service, Report for Congress, *P.L. 110-275: The Medicare Improvements for Patients and Providers Act of 2008* (Washington, D.C.: CRS, July 23, 2008).

[22] Congressional Budget Office, "Letter to the Honorable Judd Gregg, Regarding the Effect of H.R. 6331, the Medicare Improvements for Patients and Providers Act of 2008" (Washington, D.C.: CBO, July 8, 2008)

Appendix Table 1. Extra Payments in 2008, by County Payment Type, to MA Private Fee-for-Service Plans Compared with Average Fee-for-Service Costs[1]

County Payment Type	Medicare Beneficiaries[5]	PFFS Plan Enrollees[6]	PFFS Plan Enrollment Rate	Average Payment Beyond FFS Costs[2,3,4]			
				Average Extra Amount per PFFS Plan Enrollee	Total Annual Extra Payments to PFFS Plans (millions)	Average Extra Payment to PFFS Plans Beyond FFS Costs	Average Extra Payment to All Other (non-PFFS) MA Plans Beyond FFS Costs
National	42,986,173	1,995,372	4.6%	$1,248	$2,490.0	16.6%	11.6%
Rural Floor	7,677,075	582,162	7.6	1,196	696.5	17.1	17.3
Urban Floor	11,346,652	815,692	7.2	1,595	1,301.2	21.4	19.9
Blend	1,404,844	29,401	2.1	1,039	30.6	13.4	15.1
Minimum Update	2,495,260	82,881	3.3	1,145	94.9	13.9	10.5
100% FFS 2004[7]	3,246,396	98,611	3.0	1,247	122.9	14.2	14.3
100% FFS 2005[7]	14,037,766	348,739	2.5	685	238.8	7.9	6.7
100% FFS 2007[7]	2,778,180	37,886	1.4	124	4.7	1.4	1.7

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

[2] Calculations at the county level, weighted by MA enrollment. Excludes MA enrollees in cost plans. Calculations include budget-neutral risk adjustment of 1.0169.

[3] In 2006 and future years, the MMA provides that payments to MA plans change from a system based entirely on county benchmarks to one that combines county benchmarks with a bid by each individual MA plan. The new benchmark-based bidding system allocates 75% of the difference between the county benchmark and the MA plan bid to the plan and 25% to the federal government. Analysts at MedPAC who have studied Medicare private-plan payments and costs have found that the average MA plan bid is approximately 17% less than the county benchmark and the average MA Private Fee-for-Service (PFFS) plan bid falls approximately 12% less than the county benchmark. This would result in a 4.25% reduction in benchmark extra-payment rates to all MA plans and a 3% reduction in benchmark extra payment rates to MA PFFS plans. The above calculations account for average MA plan bids 17% below the 2007 MA benchmark rates and PFFS plan bids 12% below the 2007 MA benchmark rates. See: Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (Washington, D.C.: MedPAC, Mar. 2008).

[4] For these calculations, 2007 FFS rates have been adjusted by 5.71% in accordance with the updated national estimates for 2008 on per capita MA growth percentage, released by CMS on April 2, 2007. See: Centers for Medicare and Medicaid Services, "Announcement of Calendar Year (CY) 2008 Medicare Advantage (MA) Capitation Rates and Payment Policies" (Washington, D.C.: CMS, Apr. 2, 2007), Available at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2008.pdf.

[5] Medicare beneficiary totals as of December 2005.

[6] Medicare Advantage PFFS enrollment data as of February 2008.

[7] CMS decided to rebase the 100% of FFS rate at the county level in 2005 and 2007. Rebasing the FFS rates means that CMS retabulated the per capita FFS expenditures for each county so that the FFS rates reflected more recent county growth trends in FFS expenditures. The MMA provided that the county-level payment rate for MA plans in 2005 be the higher of the 2005 rebased 100% of FFS rate or the 2004 rate increased by 6.6%. See: Centers for Medicare and Medicaid Services, "Note to Medicare Advantage Organizations and Other Interested Parties: Advance Notice of Methodological Changes for Calendar Year (CY) 2005 Medicare Advantage Payment Rates" (Washington, D.C.: CMS, Mar. 26, 2004). Available at: http://www.cms.hhs.gov/healthplans/rates/2005/45day.pdf. Accessed September 15, 2004. For 2007, the county-level payment rate for MA plans was the higher of the 2007 rebased 100% of FFS rate or the 2006 rate increased by 7.1%. See: Centers for Medicare and Medicaid Services, "Announcement of Calendar Year (CY) 2007 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies Fact Sheet" (Washington, D.C.: CMS, Apr. 3, 2006). Available at: http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/factsheet2007.pdf. Accessed May 30, 2006.

Note: Calculations exclude Medicare beneficiaries and MA enrollees in Puerto Rico, Guam, and the U.S. Virgin Islands. Also, because of HIPAA concerns, CMS does not include enrollment data in the State/County/Contract Data Files for plans with 10 or fewer enrollees in a county. For 2008, this exclusion pertains to approximately 230,000 enrollees nationwide.

Source: George Washington University analysis of Centers for Medicare and Medicaid Services 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.

Appendix Table 2. Extra Payments in 2008, by State, to MA Private Fee-for-Service Plans Compared with Average Fee-for-Service Costs[1]

State	Medicare Beneficiaries[5]	PFFS Plan Enrollees[6]	PFFS Plan Enrollment Rate	Average Payment Beyond FFS Costs[2,3,4]			
				Average Extra Amount per PFFS Plan Enrollee	Total Annual Extra Payments to PFFS Plans (millions)	Average Extra Payment to PFFS Plans Beyond FFS Costs	Average Extra Payment to All Other (non-PFFS) MA Plans Beyond FFS Costs
National	42,986,173	1,995,372	4.6%	$1,248	$2,490.0	16.6%	11.6%
Rural	12,692,302	810,772	6.4	1,044	846.0	14.5	11.0
Urban	30,293,871	1,184,600	3.9	1,387	1,643.0	18.0	11.7
Alabama	781,601	19,035	2.4	875	16.7	11.3	9.9
Alaska	45,701	88	0.2	715	0.1	8.3	—
Arizona	818,639	34,347	4.2	1,015	34.9	13.2	13.9
Arkansas	489,388	35,272	7.2	1,160	40.9	15.9	9.6
California	4,386,037	45,076	1.0	1,444	65.1	18.9	10.5
Colorado	542,294	22,547	4.2	769	17.3	10.2	11.2
Connecticut	540,699	5,971	1.1	634	3.8	7.5	5.1
Delaware	132,269	2,516	1.9	585	1.5	7.0	7.4
Dist. Columbia	77,597	724	0.9	1,466	1.1	16.1	16.1
Florida	3,129,832	48,069	1.5	486	23.4	5.8	3.3
Georgia	1,076,986	76,016	7.1	1,127	85.7	14.7	13.3
Hawaii	189,271	2,423	1.3	2,255	5.5	34.2	34.1
Idaho	198,714	20,679	10.4	1,112	23.0	15.3	19.4
Illinois	1,749,064	49,132	2.8	878	43.1	11.6	8.1
Indiana	934,910	75,183	8.0	1,343	100.9	18.3	13.5
Iowa	502,547	35,501	7.1	1,588	56.4	23.5	20.2
Kansas	412,026	13,548	3.3	1,076	14.6	14.0	11.1
Kentucky	704,727	51,928	7.4	936	48.6	12.4	11.1
Louisiana	642,618	23,570	3.7	1,167	27.5	12.7	12.9
Maine	243,190	7,104	2.9	1,421	10.1	20.0	25.2
Maryland	718,389	4,440	0.6	560	2.5	6.6	3.8
Massachusetts	1,007,212	24,604	2.4	933	23.0	10.3	9.9
Michigan	1,537,840	251,702	16.4	793	199.6	10.0	7.8
Minnesota	721,521	67,793	9.4	952	64.5	13.1	9.3
Mississippi	471,940	27,265	5.8	972	26.5	11.8	8.4
Missouri	942,794	34,587	3.7	1,167	40.4	16.0	12.8
Montana	153,286	18,785	12.3	954	17.9	13.3	15.3
Nebraska	267,836	14,036	5.2	973	13.7	13.2	11.4
Nevada	308,802	5,709	1.8	386	2.2	4.6	2.5
New Hampshire	194,363	6,787	3.5	1,106	7.5	14.1	12.7
New Jersey	1,270,110	3,454	0.3	410	1.4	4.5	3.9
New Mexico	277,591	8,500	3.1	1,757	14.9	26.5	36.3
New York	2,879,429	40,621	1.4	1,801	73.2	26.3	13.2

State	Medicare Beneficiaries[5]	PFFS Plan Enrollees[6]	PFFS Plan Enrollment Rate	Average Payment Beyond FFS Costs[2,3,4]			
				Average Extra Amount per PFFS Plan Enrollee	Total Annual Extra Payments to PFFS Plans (millions)	Average Extra Payment to PFFS Plans Beyond FFS Costs	Average Extra Payment to All Other (non-PFFS) MA Plans Beyond FFS Costs
North Carolina	1,318,782	113,409	8.6%	$1,448	$164.3	19.8%	21.5%
North Dakota	106,313	5,794	5.4	1,185	6.9	16.9	16.0
Ohio	1,811,669	175,147	9.7	1,045	183.0	13.4	14.0
Oklahoma	559,862	16,809	3.0	720	12.1	8.7	7.9
Oregon	557,661	20,902	3.7	1,643	34.3	24.3	25.4
Pennsylvania	2,189,492	68,051	3.1	1,358	92.4	18.8	9.2
Rhode Island	177,579	1,462	0.8	1,423	2.1	18.4	18.9
South Carolina	673,878	58,059	8.6	1,117	64.8	14.5	12.2
South Dakota	128,623	5,111	4.0	1,203	6.1	17.3	17.7
Tennessee	955,071	50,738	5.3	1,058	53.7	13.7	13.1
Texas	2,641,789	73,082	2.8	1,192	87.1	13.0	16.3
Utah	245,106	24,816	10.1	1,289	32.0	17.5	20.2
Vermont	100,351	2,167	2.2	1,169	2.5	16.6	13.7
Virginia	1,023,393	87,446	8.5	1,625	142.1	22.9	23.1
Washington	851,609	45,071	5.3	1,222	55.1	16.5	21.1
West Virginia	367,440	51,840	14.1	1,071	55.5	14.4	12.3
Wisconsin	854,772	116,380	13.6	1,564	182.0	22.4	20.5
Wyoming	73,560	2,076	2.8	649	1.3	8.7	8.8

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

[2] Calculations at the county level, weighted by MA enrollment. Excludes MA enrollees in cost plans. Calculations include budget neutral risk adjustment of 1.0169.

[3] In 2006 and future years, the MMA provides that payments to MA plans change from a system based entirely on county benchmarks to one that combines county benchmarks with a bid by each individual MA plan. The new benchmark-based bidding system allocates 75% of the difference between the county benchmark and the MA plan bid to the plan and 25% to the federal government. Analysts at MedPAC who have studied Medicare private-plan payments and costs have found that the average MA plan bid is approximately 17% less than the county benchmark and the average MA Private Fee-for-Service (PFFS) plan bid falls approximately 12% less than the county benchmark. This would result in a 4.25% reduction in benchmark extra payment rates to all MA plans and a 3% reduction in benchmark extra payment rates to MA PFFS plans. The above calculations account for average MA plan bids 17% below the 2007 MA benchmark rates and PFFS plan bids 12% below the 2007 MA benchmark rates. See: Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (Washington, D.C.: MedPAC, Mar. 2008).

[4] For these calculations, 2007 FFS rates have been adjusted by 5.71% in accordance with the updated national estimates for 2008 on per capita MA growth percentage released by CMS on April 2, 2007. See: Centers for Medicare and Medicaid Services (April 2, 2007). "Announcement of Calendar Year (CY) 2008 Medicare Advantage (MA) Capitation Rates and Payment Policies." Washington, D.C.: CMS. Available at: http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2008.pdf.

[5] Medicare beneficiary totals as of December 2005.

[6] Medicare Advantage PFFS enrollment data as of February 2008.

Note: Because of HIPAA concerns, CMS does not include enrollment data in the State/County/Contract Data Files for plans with 10 or fewer enrollees in a county. For 2008, this exclusion amounts to approximately 230,000 enrollees nationwide.

Source: George Washington University analysis of Centers for Medicare and Medicaid Services 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.

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