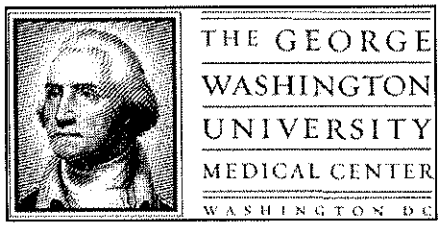

SCHOOL OF PUBLIC HEALTH & HEALTH SERVICES

DEPARTMENT OF HEALTH POLICY
CENTER FOR HEALTH SERVICES RESEARCH & POLICY

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

OPTIONS FOR MEDICARE SAVINGS FROM 2007 THROUGH 2011

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September 15, 2006

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ABSTRACT

The Medicare Modernization Act of 2003 (MMA) and the Deficit Reduction Act (DRA) of 2005 include provisions intended to increase the role of private health plans in Medicare. These provisions set Medicare Advantage plan payment rates at levels higher than average costs would be in traditional fee-for-service Medicare in every county in the nation. The total amount of extra payments to Medicare Advantage plans resulting from these provisions is projected at $5.7 billion in 2007 and nearly $30 billion over the five year period, 2007 to 2011.

This briefing paper outlines the specific MMA and DRA provisions that generate these extra payments and presents opportunities for revised policies that can reduce Medicare spending in excess of fee-for-service costs. The options explored here address the four bases for Medicare Advantage plan extra payments: MMA statutory provisions, including county benchmark extra payment rates and Indirect Medical Education payments that increase the county benchmark rates; budget neutral risk adjustment payments; and payments from a regional PPO stabilization fund.

In view of concerns about the Federal budget deficit of over $250 billion a year and other more short-term concerns facing Medicare, such as the cost savings needed to pay for a modification of the Sustainable Growth Rate (SGR) policies so that Medicare payments to physicians do not decline by 5 percent in 2007, reductions in extra payments to Medicare Advantage plans could provide substantial Medicare savings. Furthermore, reductions in extra payments to Medicare Advantage plans may be seen as appropriate, as these extra payments clearly run counter to the oft-stated purpose of increasing the enrollment of beneficiaries in private plans: to lower total Medicare costs.

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INTRODUCTION

Provisions of the Medicare Modernization Act of 2003 (MMA) are intended to increase the role of private health plans in Medicare. Part of the strategy to accomplish this is 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 anticipated to average 10.9 percent, or $828 per MA plan enrollee, in 2007. The total amount of extra payments to MA plans is projected at $5.7 billion in 2007 and nearly $30 billion during the five years 2007 through 2011.

Extra payments to MA plans occur against the background of a persistent interest in Medicare cost savings.

One immediate difficulty facing the Medicare program is the projected decrease in payments to physicians in 2007 caused by the Sustainable Growth Rate (SGR) policies in the Balanced Budget Act of 1997. The SGR will, if not modified, reduce physician payments by 5 percent in 2007 and subsequent years.[1] Some believe that a reduction in Medicare payments to physicians will reduce the access to physicians by seniors and the disabled.

Recently, proposals have been discussed that would modify the SGR for 2007 by setting the update from 0 to 1.5 percent. These proposals have been estimated to cost, over five years, between $10.8 and $18.4 billion. Given the Federal budget deficit of over $250 billion, there is some pressure to pay for these increased costs by off-setting savings from other parts of the Medicare program. Some SGR proposals have included a reduction in extra payments to MA plans as the pay-for policy.[2]

As a precedent, last year the Deficit Reduction Act (DRA) provided a SGR fix of no decrease in physician fees plus a 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 2007 – 2011 that had been announced by CMS in early 2005 and modified in September 2005.

Beyond the short-term cost savings needed to pay for a solution to the SGR problem, the Federal budget deficit of over $250 billion a year has led to discussions of more significant reductions in future Federal spending in a major budget reconciliation bill similar to the ones adopted in 1990, 1993, and 1997. All of those bills derived substantial savings from reductions in projected Medicare spending. BBA '97 achieved 73 percent of its net savings from Medicare.[3] [4]

In light of the consideration of possible Medicare savings for 2007, this briefing paper describes the specific MMA and DRA policies that provide extra payments to MA plans in 2007 and future years. It reviews a series of options to reduce the extra payments to MA plans and projects the amounts of possible reductions in Medicare spending from 2007 - 2011.

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

- MMA statutory MA county benchmark payment rates that are the basis for the benchmark-based plan bidding system;
- The DRA statutory provisions that continue, with a phase-out, through 2011 to provide additional payments to MA plans to make the new risk adjustment system budget neutral;
- MMA authorized payments from a national stabilization fund to regional PPOs in addition to their basic MA payments from 2007 to 2013.

These three policies provide a projected $30 billion in extra payments to MA plans from 2007 through 2011. The county benchmarks contribute almost $17 billion, the BNRA payments $6 billion and regional stabilization fund payments $6 billion.

Figure 1. Projected Payments to MA Plans in Excess of FFS Costs, 2007 to 2011

	2007	2008	2009	2010	2011	2007-11 5-yr Total
Total MA extra payments	**$5.7 b**	**5.6 b**	**5.5 b**	**5.2 b**	**7.5 b**	**$29.5 b**
MMA statutory/benchmark	$2.7	3.1	3.4	3.7	3.9	$16.8 b
DRA BNRA phase-out[1]	$2.0	1.4	0.9	0.2	2.2	$6.7 b
Regional PPO stabilization fund	$1.0	1.1	1.2	1.3	1.4	$6.0 b

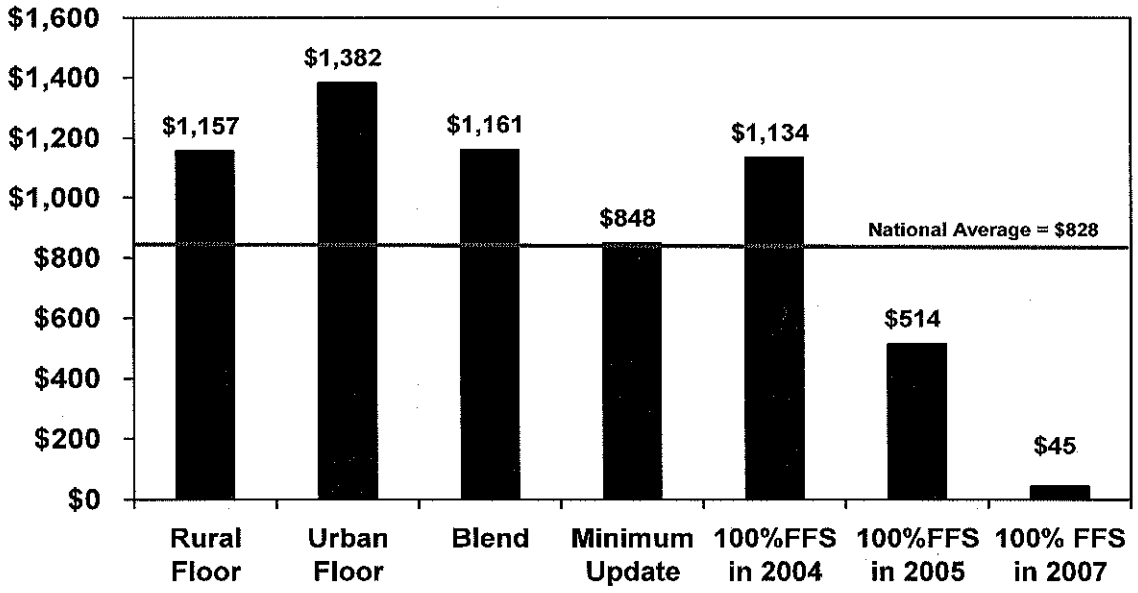
[1] Note: The DRA phase-out of the budget neutral risk adjustment provides a coding intensity adjustment only for 2007 – 10. This DRA provision results in higher projected payments to MA plans in 2011 and subsequent years. [5]

The projected costs presented here are based on our analysis of extra payments to MA plans in 2007. The amount of the extra payments in 2007 are projected to subsequent years based on the Congressional Budget Office's March 2006 estimates of the increase in Medicare Part A and B costs and the enrollment in MA plans to 2011.[6]

As discussed below, the county benchmark system sets MA rates at different levels for seven categories of counties. In Figures 2 and 3, counties are grouped according to the MMA benchmark policy under which MA plans in the counties receive the highest payment rates. Figure 2 presents estimated average extra payments above fee-for-service costs per enrollee for MA plans in these seven categories for 2007. Figure 3 presents the estimated share of total extra payments in 2007 for each of these seven categories of counties.[7]

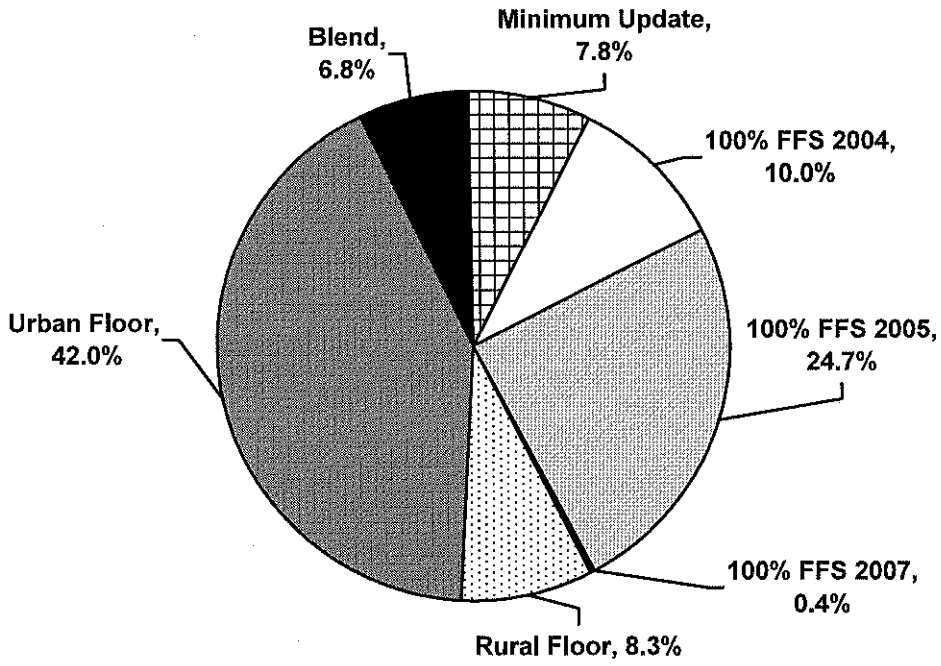
As illustrated in Figure 3, an estimated 42 percent of total MA extra payments will go to plans in urban floor counties in 2007. This is an average of $1,382 in annual extra payments for each of the 1.4 million MA plan enrollees in these counties. Over 24 percent of total extra payments go to plans in the 100 percent of FFS in 2005 counties with $514 per enrollee in extra payments and 2.2 million enrollees.

Figure 2. Estimated Annual Extra Payments to MA Plans per Plan Enrollee, 2007



Source: GWU analysis of Centers for Medicare and Medicaid Services Medicare Managed Care Quarterly State, County, Plan Data File for the quarter ending December 2005 and Medicare Advantage 2007 Ratebook.
Note: Figures above include BNRA and FFS normalization. Assumes plan bids in all counties fall 16% below the benchmark.

Figure 3. Estimated Share of Total $4.7 Billion in Extra Payments to MA Plans by County Payment Category, 2007



Source: George Washington University analysis of Centers for Medicare and Medicaid Services Medicare Managed Care Quarterly State, County Plan Data File for the quarter ending December 2005, Medicare Managed Care Quarterly State County Market Penetration File for the quarter ending December 2005 and Medicare Advantage 2007 Ratebook.

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

EXTRA PAYMENTS TO MA PLANS

In 2005 and earlier years, MA plans were paid at the level of the county benchmark. Beginning in 2006, the MMA specifies that Medicare pay MA plans on a benchmark-based bidding system.

Under this system, CMS calculates a county benchmark each year for each county. This benchmark is then adjusted by a budget neutral risk adjustment factor. The resulting figure is essentially the base rate against which MA plans bid. Every MA plan files a bid each June to provide A and B services for the next calendar year that reflects the costs to the plan of providing Part A and B services in the calendar year.[8]

This section will examine the four factors responsible for the level of extra payments to MA plans in 2007 and future years: MA county benchmark rates; IME payments that increase county benchmarks; budget neutral risk adjustment payments; and MA plan bids.

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

Following MMA policies, the MA county benchmark rates for 2007, posted by CMS in April 2006, are more than the average costs in FFS in every county in the nation.[9] County benchmark rates in 2007 are projected to exceed FFS costs by an average of $1,161 per MA enrollee or 14.9 percent. Benchmark rates vary from $1,693 more than FFS costs in the urban floor counties to just $427 more in the counties paid according to 100 percent of 2007 FFS costs.[10]

MMA provisions specify that the MA benchmark payment rate for each county is set at the highest of seven different amounts for 2007. The seven county payment types are:[11]

- A rural floor rate for rural counties set at, including BNRA, $8,073 in 2007;
- An urban floor rate in urban counties with a population of more than 250,000 set at, including BNRA, $8,992 in 2007;
- 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 2007;

- A minimum increase rate based on the county payment level in 2003 trended forward to 2007;
- 100 percent of average FFS costs in the county in 2004 trended forward to 2007;
- 100 percent of average FFS costs in the county in 2005 trended forward to 2007; and
- 100 percent of average county FFS costs in the county in 2007 [12]

Indirect Medical Education (IME) payments. MMA directs that payments to teaching hospitals for the costs of indirect medical education (IME) be included in the calculation of 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.[13]

In the aggregate, extra payments estimated due to the double payment for IME account for somewhat less than 20 percent of the total MA plan payments in excess of FFS costs, when averaged across the country.

IME payments are estimated at $800 million in 2007 and $5 billion over five years including the reduction of payments to account for MA plan bids.[14]

Because the IME payment amounts are included in the benchmark payment rates, these payments are incorporated in estimates of the amount of extra payments due to the benchmark-based bidding system discussed above.

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 6 percent, or $600 per capita; in other states with lower IME payments for FFS inpatients, such as Florida and Texas, IME extra payments to plans are estimated at under 1 percent, or $90 per capita; in still other areas, IME payments have almost no effect on Medicare spending.

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 all of the benchmark extra payments to MA plans and 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.

Budget Neutral Risk Adjustment (BNRA) payments. The Deficit Reduction Act included provisions that specified that budget neutral payments to MA plans should be continued in 2007 with a phase-out through 2011. This policy provides for MA payments over and above the benchmark extra payments specified by the MMA, as part of the implementation of the new risk adjustment system that is intended to adjust each plan's payments for the anticipated costliness of its enrollees.[15]

The new risk adjustment system, which is based on retrospective clinical data on each enrollee, is more accurate than the previous system, which was based only on a few broad demographic characteristics and was used until 1997. The implementation of the new system was expected to make payments to plans more closely reflect the anticipated costliness of their enrollees, thereby reducing the adverse incentive under the previous system for plans to avoid enrolling beneficiaries expected to have high costs (e.g., older beneficiaries and beneficiaries with chronic conditions) and recruit beneficiaries anticipated to have low costs. Because research indicated that plans did, in fact, tend to enroll beneficiaries with lower risk of high costs, risk adjustment was expected to reduce plan payments.

To mitigate the effect of this change on plans, CMS phased-in the new clinically-based system as a blend with the older demographic system; in 2005, the risk adjuster was applied to 50 percent of the MA payment rate, with the proportion rising to 75 percent in 2006 and 100 percent in 2007 and thereafter.

In an administrative policy decision, CMS implemented the new risk adjustment so that it would not reduce aggregate payments to MA plans beginning in 2000.[16] 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 more than the risk adjustment model indicates it would be expected to pay for the same beneficiaries in FFS.

In January of 2005, CMS indicated, as part of the presentation of Medicare in the budget for FY 2006, that it intended to phase-out the BNRA payments from 2007 through 2011. 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 continues the earlier policy in 2006 by applying the BNRA adjustment to 75 percent of the MA payment rates consistent with the new risk adjuster applying to 75 percent of the MA payment rates. The DRA policy would begin to phase out the BNRA adjustment by applying it to only 55 percent of the MA payment rates in 2007,[17] 40 percent in 2008, 25 percent in 2009, 5 percent in 2010 and 0 percent in 2011.[18] [19]

Extra payments to MA plans are projected to increase in 2011 because the DRA phase-out of the budget neutral risk adjustment specifically provides for a coding intensity adjustment for payments to MA plans only for 2007 – 10. This DRA provision results in higher projected payments to MA plans of $2.2 billion in 2011 and more in subsequent years.[20]

In 2007, the MA plan budget neutral risk adjustment (BNRA) policy will add an estimated 3 percent to MA plan payments and the total cost of the BNRA policy is projected to be about $2 billion.[21] The total amount of extra payments to MA plans in 2007 to 2011 provided by the current BNRA policy is projected at $6.7 billion.

MA plan bids. Beginning in 2006, the MMA provides that payments to MA plans change from a system that pays plans at the level of the county benchmarks plus BNRA payments to one that combines county benchmarks plus BNRA payments with a bid by each individual MA plan.[22] For the remainder of this section, the term 'county benchmark' will include BNRA payments. In 2007, the BNRA will add 3.9 percent to every county benchmark.

The new benchmark-based bidding system 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 who have studied Medicare private plan payments and costs have estimated that the average MA plan bid is approximately 16 percent less than the county benchmark in 2006.[23]

If the bids continue to average 16 percent less than the benchmarks, there would be an average reduction in MA plan payments of 4 percentage points, which would reduce the average level of MMA statutory extra payments from 14.9 percent to 10.9 percent in 2007.

With bids at this level, MMA statutory extra payments are estimated at $4.7 billion in 2007 and $24 billion over the five years 2007 through 2011.

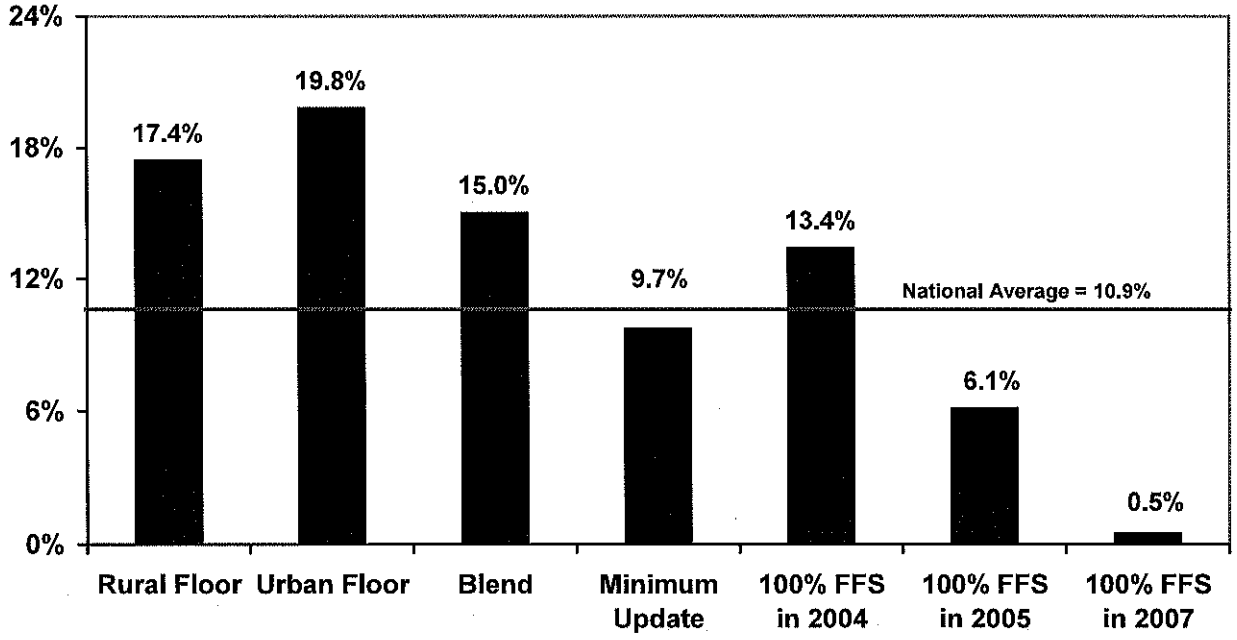
The impact of the bid process will likely vary by individual MA plan and by location. Even if the national average difference between the benchmark rates and the plan bids nationwide is 16 percent, there will be wide variation by plans around this average, depending on the county benchmark payment rate, 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.

If an MA plan bid is 4 percent less than the benchmark, the Medicare payment would be reduced by 1 percentage point while a bid that is 20 percent less than the benchmark would reduce the Medicare payment by 5 percentage points.

The impact of the new bidding system on extra payments to MA plans will, of course, vary by the extra payments available to plans in each type of county.

For example, a 16 percentage point difference between plan bids and the county benchmark still would leave payments to MA plans in rural floor, urban floor, blend and 100 percent of 2004 FFS cost counties more than 10 percent above average FFS costs. Approximately 60 percent of MA extra payments in 2007 go to plans in these counties. In contrast, a 16 percentage point difference between plan bids and the county benchmark in counties in the 100 percent of 2007 FFS costs category would leave plan payments less than 1 percent above average FFS costs. (Figure 4).

Figure 4. Estimated Extra Payments to MA Plans Following 4% Reduction Due to Bids 16% Below Benchmarks, 2007



Source: George Washington University analysis of Centers for Medicare and Medicaid Services Medicare Managed Care Quarterly State, County Plan Data File for the quarter ending December 2005, Medicare Managed Care Quarterly State County Market Penetration File for the quarter ending December 2005 and Medicare Advantage 2007 Ratebook; Transcript of Public Meeting, Medicare Payment Advisory Commission, April 21, 2005.
Note: Figures above include BNRA and FFS normalization. Assumes plan bids in all counties fall 16% below the benchmark.

Extra payments through the regional PPO stabilization fund. In addition to the statutory provisions that provide specific extra payments to all MA plans, the MMA also provides CMS with the authority to make extra payments to new regional PPOs from a stabilization fund between 2007 and 2013. Payments from the fund during this period may total up to $10 billion.[24]

CMS designated 28 state and multi-state regions for the regional PPOs that began operation in 2006.

CMS may use the regional PPO stabilization fund 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.

The pattern of regional PPOs means that CMS may make payments to regional PPOs under each of these three conditions. In 2006, there is no sponsor of regional PPOs in every region; there are five regions without any regional PPO plans; and there are no regions with more than two regional PPO plans.

It is important to note that CMS reported there were approximately 50,000 enrollees in Regional PPOs nationwide as of May 25, 2006.[25]

The discretionary nature of the PPO stabilization fund and the length of the time period involved – 2007 to 2013 – makes it difficult to project the costs of the fund in specific years. One reasonable assumption is that CMS may use these funds at roughly equal amounts of $1 - $1.4 billion in each of the seven years of the fund's availability. Under this assumption, the total amount of extra payments to MA plans in 2007 to 2011 provided by the regional PPO stabilization fund policy is projected at $6.0 billion.

OPTIONS FOR MEDICARE SAVINGS IN 2007 THROUGH 2011

Extra payments to MA plans are projected to total more than $5 billion in 2007 and as much as $30 billion in the five year period from 2007 through 2011.

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

Depending on the extent and the timing of any new policies, the amount of savings from 2007 to 2011 could total from a few to tens of billions of dollars.

Medicare savings from the benchmark extra payments. Medicare savings may be achieved by changing the MMA polices that explicitly set county benchmarks at levels above average FFS costs. Possible five year savings of up to $16 billion are possible from setting MA payment county benchmarks closer to FFS costs.

Option 1a. The greatest savings from revising the MMA extra payment provisions would be generated by eliminating all benchmark extra payments as of January 2007. The new policy could specify that the MA plan benchmarks would be set at 100 percent of the costs of FFS at the county level. Any Federal savings from plan bids below the new benchmarks would contribute toward pay-for-performance payments to MA plans.

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

This option is projected to reduce Medicare spending by $2.7 billion in 2007 and over $16 billion over five years.

Option 1a: Set MA Plan Statutory/Benchmark Payments at 100% of County FFS Costs in 2007 and Future Years

	2007	2008	2009	2010	2011	2007-11 5-yr Total
Current baseline: MMA statutory/benchmark extra payments	$2.7	3.1	3.4	3.7	3.9	$16.8 b
Residual Medicare costs: benchmark at 100% of FFS	-0-	-0-	-0-	-0-	-0-	-0-
Medicare savings	**$2.7**	**3.1**	**3.4**	**3.7**	**3.9**	**$16.8 b**

Note: Assumes MA plan benchmark is set at 100% of county FFS costs in 2007 and subsequent years. Assumes that all funds that result from MA plan bids at less than the benchmark are returned to MA plans as pay-for-performance payments.

Source: George Washington University analysis of Centers for Medicare and Medicaid Services Medicare Managed Care Quarterly State, County, Plan Data File for the quarter ending December 2005, Medicare Managed Care Quarterly State County Market Penetration File for the quarter ending December 2005 and Medicare Advantage Revised 2007 Ratebook; Medicare Payment Advisory Commission, *Medicare Advantage Benchmarks and Payments Compared with Average Fee-For-Service Spending* (Washington, D.C.: MedPAC, June 2006).

Option 1b. An approach to the gradual reduction of the MMA extra payments would be to phase-down the benchmark extra payments over a number of years. A reduction of MMA benchmark extra payments could begin in 2007 and run over four years at 25 percent per year. Under this approach, benchmark extra payments in every county would decline from the 2006 levels to 75 percent in 2007, 50 percent in 2008, and 25 percent in 2009, with payments at 100 percent of average county FFS costs in 2010 and subsequent years.

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

This option is projected to reduce Medicare spending by around $12 billion over five years.

Option 1b: Phase-out MA Plan Statutory/Benchmark Extra Payments at 25% per year from 2007 to 2010

	2007	2008	2009	2010	2011	2007-11 5-yr Total
Current baseline: MMA statutory/benchmark extra payments	$2.7	3.1	3.4	3.7	3.9	$16.8 b
Residual Medicare costs: benchmark phase-down at 25%	2.0	1.5	0.9	-0-	-0-	$4.5 b
Medicare savings	**$0.7**	**1.5**	**2.5**	**3.7**	**3.9**	**$12.3 b**

Note: Assumes MA benchmark rates are phased-down at the county level from 100% MMA statutory levels to 100% of county FFS costs at the pace of 75% of difference in 2007, 50% of difference in 08, 25% in 09, 0% in 10 and 11. Assumes that all funds that result from MA plan bids at less than the benchmark are returned to MA plans as pay-for-performance payments.

Source: George Washington University analysis of Centers for Medicare and Medicaid Services Medicare Managed Care Quarterly State, County, Plan Data File for the quarter ending December 2005, Medicare Managed Care Quarterly State County Market Penetration File for the quarter ending December 2005 and Medicare Advantage Revised 2007 Ratebook; Medicare Payment Advisory Commission, *Medicare Advantage Benchmarks and Payments Compared with Average Fee-For-Service Spending* (Washington, D.C.: MedPAC, June 2006).

Option 1c. Another approach to the gradual reduction of the MMA extra payments would be to set a declining ceiling on county benchmark rates over a number of years. A declining ceiling on benchmark county rates in excess of FFS costs could begin at 15 percent in 2007 and decline to 10 percent in 2008, 5 percent in 2009, and zero in 2010 and subsequent years.

This approach would provide substantial Medicare savings while giving plans until 2011 to plan for county rates at the level of fee-for-service costs in the county.

Under this approach, plans in the counties with benchmark rates the greatest excess of rates -- mostly urban floor counties -- would have a gradual three year phase-out from 2007 to 2010 of their extra payments that are now estimated to average over 15 percent more than FFS costs before BNRA. Plans in the 100 percent of 2005 fee-for-service costs counties, with county benchmark rates that are estimated to average around 2 percent more than FFS costs in 2007 before BNRA, would not be affected until 2011.

This approach is projected to reduce Medicare spending by nearly $10 billion over five years.

Option 1c: Declining Ceiling on Extra Payments from 2007 to 2010

	2007	2008	2009	2010	2011	2007-11 5-yr Total
Current baseline: MMA statutory/benchmark extra payments	$2.7	3.1	3.4	3.7	3.9	$16.8 b
Residual Medicare costs: ceiling on extra payments	2.7	2.4	1.8	-0-	-0-	$6.9 b
Medicare savings	**$0.03**	**0.7**	**1.6**	**3.7**	**3.9**	**$9.9 b**

Note: Assumes MA plan benchmark is phased-down at the county level from 100% MMA statutory levels to 100% of county FFS costs with a ceiling set at 115% of FFS costs in 2007, 110% in 08, 105% in 2009 and 100% in 2010. Assumes that all funds that result from MA plan bids at less than the benchmark are returned to MA plans as pay-for-performance payments. Assumes plan bids in all counties fall 16% below the benchmark. Figures do not include BNRA.

Source: George Washington University analysis of Centers for Medicare and Medicaid Services Medicare Managed Care Quarterly State, County, Plan Data File for the quarter ending December 2005, Medicare Managed Care Quarterly State County Market Penetration File for the quarter ending December 2005 and Medicare Advantage Revised 2007 Ratebook; Medicare Payment Advisory Commission, *Medicare Advantage Benchmarks and Payments Compared with Average Fee-For-Service Spending* (Washington, D.C.: MedPAC, June 2006).

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

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

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

The short-term impact of this policy might be mitigated by limiting the reduction in an individual MA county benchmark rates to 2 percent in any one year. This would phase-down payments over two or more years to MA plans in the small number of counties with higher amounts of extra payments related to IME costs.

The elimination of IME double payments would reduce Medicare spending by an estimated $800 million in 2006 and $5 billion over five years.

Option 2: Remove IME Extra Payments from MA Benchmarks in 2007 and Future Years

	2007	2008	2009	2010	2011	2007-11 5-yr Total
Current baseline: IME Payments	$0.8	0.9	1.0	1.1	1.2	$5.0 b
Residual Medicare costs: Remove IME from benchmarks	-0-	-0-	-0-	-0-	-0-	-0-
Medicare savings	**$0.8**	**0.9**	**1.0**	**1.1**	**1.2**	**$5.0 b**

Note: Assumes that MA plan payments in urban and rural floor counties are reduced by IME costs in the specific county. Assumes plan bids in all counties fall 16% below the benchmark.

Source: George Washington University analysis of Centers for Medicare and Medicaid Services Medicare Managed Care Quarterly State, County, Plan Data File for the quarter ending December 2005, Medicare Managed Care Quarterly State County Market Penetration File for the quarter ending December 2005 and Medicare Advantage Revised 2007 Ratebook.

Medicare savings from DRA budget neutral risk adjustment extra payments. Medicare savings were included in the DRA by providing that BNRA extra payments would be phased-out over the next five years. DRA provides that the schedule for the phase-out of the BNRA payments is 55 percent in 2007, 40 percent in 2008, 25 percent in 2009, 5 percent in 2010 and zero percent in 2011.

A more rapid phase-out of BNRA payments would provide Medicare savings of over $5 billion in 2007 – 2011. These savings would include over $2 billion in 2011 that would result from the extension of the DRA coding intensity adjustment policy.

Option 3a. The greatest savings from revising the DRA BNRA provisions would be generated by the elimination of all BNRA extra payments as of January 2007. The new policy could specify that no MA BNRA extra payments would be paid in 2007 or subsequent years and the DRA coding intensity adjustment policy would be extended to 2011. Any savings from plan bids below the new benchmarks would be returned to plans as pay-for-performance payments.

Option 3a: Eliminate BNRA Payments in 2007 and Future Years

	2007	2008	2009	2010	2011	2007-11 5-yr Total
Current Baseline: DRA BNRA phase-out payments[1]	$2.0	1.4	0.9	0.2	2.2	$6.7 b
Residual Medicare costs: eliminate BNRA payments	-0-	-0-	-0-	-0-	-0-	-0-
Medicare savings	**$2.0**	**1.4**	**0.9**	**0.2**	**2.2**	**$6.7 b**

[1]The DRA phase-out of the budget neutral risk adjustment provides a coding intensity adjustment only for 2007 – 10. This DRA provision results in higher projected payments to MA plans in 2011 and subsequent years.

Note: Assumes baseline for calculation of savings is DRA payments at 75% of full BNRA costs in 2006, 55% in 07, 40% in 08, 25% in 09, and 5% in 2010 and 0% in 11; option assumes elimination of BNRA payments in January of 2007 and future years and the extension of the MA coding intensity adjustment for 2011.

Source: George Washington University analysis of Centers for Medicare and Medicaid Services Medicare Managed Care Quarterly State, County, Plan Data File for the quarter ending December 2005, Medicare Managed Care Quarterly State County Market Penetration File for the quarter ending December 2005 and Medicare Advantage Revised 2007 Ratebook.

Option 3b. The schedule for the phase-in of BNRA extra payment was, in recent years, set at an increase of 25 percent per year: 25 percent in 2004, 50 percent in 2005 and 75 percent in 2006. A parallel phase-out of BNRA extra payments would be at the rate of 25 percent per year. This would be set BNRA payments at 75 percent in 2006, 50 percent in 2007, 25 percent in 2008, and zero percent in 2009 and subsequent years. The DRA MA coding intensity adjustment policy would be extended to 2011.

Medicare savings would begin in 2007 and would be $3.2 billion through 2010 with the extension of the DRA coding intensity adjustment policy 2011 contributing $2.2 billion in 2011 for a total of $5.4 billion.

A three-year phase-out schedule would provide Medicare savings from the DRA five year schedule while continuing to give MA plans until 2009 to fully accommodate to the changes first announced in 2005.

Option 3b: Phase-out of BNRA Payments at 25% per year from 2007 to 2009

	2007	2008	2009	2010	2011	2007-11 5-yr Total
Current baseline: DRA BNRA phase-out payments[1]	$2.0	1.4	0.9	0.2	2.2	$6.7 b
Residual Medicare costs: BNRA phase-out at 25%	1.0	0.3	-0-	-0-	-0-	$1.3 b
Medicare savings	**$1.0**	**1.1**	**0.9**	**0.2**	**2.2**	**$5.4 b**

[1]The DRA phase-out of the budget neutral risk adjustment provides a coding intensity adjustment only for 2007 – 10. This DRA provision results in higher projected payments to MA plans in 2011 and subsequent years.

Note: Assumes baseline for calculation of savings is DRA payments at 75% of full BNRA costs in 2006, 55% in 07, 40% in 08, 25% in 09, and 0% in 2010 and 11; option assumes phase-out of BNRA payments at rate of 75% in 06, 50% in 07, 25% in 08, 0% in 09, 2010, and 11.

Source: George Washington University analysis of Centers for Medicare and Medicaid Services Medicare Managed Care Quarterly State, County, Plan Data File for the quarter ending December 2005, Medicare Managed Care Quarterly State County Market Penetration File for the quarter ending December 2005 and Medicare Advantage Revised 2007 Ratebook.

Medicare savings from the regional PPO stabilization fund. Medicare savings from the $10 billion regional PPO stabilization fund may be generated by eliminating one or more of the three purposes for which the fund may be used. Savings of approximately $5 billion may be possible in this area.

Option 4. The elimination of all three purposes for support from the fund – nationwide regional PPO, PPO plans entering regions, and PPO plans threatening to leave regions – would provide the largest spending reduction. Under this policy, regional PPOs would continue to receive extra payments by county at the same level as other MA plans.

To the extent that PPOs emphasize service to beneficiaries in rural areas, the PPOs would still benefit from MA extra payments in rural floor counties that are estimated at 17 percent and $1,100 annually in 2007. This new policy would provide for PPOs to compete with local PPOs and other MA plans on a level playing field.

The possible 2007 to 2011 Medicare savings for the elimination of authority for the PPO stabilization fund could be $6 billion, or just under two-thirds of the $10 billion authorized to be expended between 2007 and 2013.

A more focused approach to savings from regional PPO stabilization would retain CMS authority to make extra payments to regional PPOs that were the first to serve a region while eliminating the extra payments to the first nationwide regional PPO and to regional PPOs that indicate they plan to leave a region. This approach might result in potential Medicare savings of over $4 billion between 2007 and 2011.

Option 4: Eliminate MMA Regional PPO Stabilization Fund

	2007	2008	2009	2010	2011	2007-11 5-yr Total
Current baseline: regional stabilization fund	$1.0	1.1	1.2	1.3	1.4	$6.0 b
Residual Medicare costs: eliminate stabilization fund	-0-	-0-	-0-	-0-	-0-	-0-
Medicare savings	**$1.0**	**1.1**	**1.2**	**1.3**	**1.4**	**$6.0 b**

Source: George Washington University

Note: For more information on the regional PPO stabilization fund, see: Medicare Payment Advisory Commission, *Report to the Congress: Issues in a Modernized Medicare Program.* (Washington, D.C.: MedPAC, June 2005).

CONCLUSION

Three broad sets of Medicare policies, included in the MMA and DRA, now set MA payment rates at levels higher than FFS costs in every county in the nation. As a result of these provisions, Medicare now pays Medicare Advantage plans over $5 billion a year more than costs in traditional fee-for-service Medicare. Extra payments to MA plans in 2007 are projected to amount to a differential of $828 per plan enrollee. MA extra payments are projected at nearly $30 billion from 2007 through 2011.

At this time, there are efforts to identify sources of savings in the Medicare program. In the short-run, these efforts focus on sums to off-set the costs of modifying the physician payment Sustainable Growth Rate (SGR) so that Medicare payments to physicians do not decline by 5 percent in 2007. In the long-run, there are concerns about Federal deficits in excess of $250 billion a year.

In 2005, overall deficit concerns led to the Deficit Reduction Act of 2005 that reduced Medicare spending by $6.4 billion and Federal Medicaid spending by $4.7 billion from 2006 to 2010. President Bush's budget for FY 2007 continued this effort by proposing $36 billion in Medicare spending reductions between 2007 and 2011.

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. Representative Michael Burgess, a member of the House Energy and Commerce Committee, included provisions to reduce spending from MA payments associated with IME payments and the Regional PPO stabilization fund as the pay-for in HR 5866, a bill to address the SGR physician payment decrease for 2007.[26]

Senator Charles Grassley, the Chair of the Senate Finance Committee, mentioned possible reductions in extra payments to MA plans in his statement in response to the President's FY 2007 budget: "Congress just finished reducing the growth of Medicare and Medicaid by $11.1 billion over the next five years, and it wasn't an easy legislative accomplishment. Any more reductions of a significant scope could be difficult this year. If Medicare reductions do end up on the table, the Medicare Advantage regional stabilization fund has to be front and center."[27]

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."[28] 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."[29]

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, as MedPAC has 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 2007 and later years could reduce Medicare spending by over $16.8 billion from 2007 to 2011. Advancing the phase-out of the budget neutral risk adjustment payments provided by the DRA and eliminating the stabilization fund authority for extra payments for regional PPOs could save Medicare $12.7 billion over five years. The total savings of $29.5 billion from MA plan extra payments could amount to more than the total of Medicare 2007 – 11 savings proposed by the Bush budget.

BACKGROUND

ANNUAL INCREASE IN MEDICARE A+B COSTS PER CAPITA

	2005	2006	2007	2008	2009	2010	2011
Total A+B costs	$328 b	$356.9	$381.7	$401.2	$425	$450.1	$469.5 b
Increase in A+B costs		8.8%	6.9%	5.1%	5.9%	5.9%	4.1%
Increase in beneficiaries		1.4%	1.7%	1.8%	1.8%	1.9%	2.2%
Increase in Per capita A+B costs		7.3%	5.1%	3.2%	4.1%	3.9%	1.9%

Source: *Fact Sheet for CBO's March 2006 Baseline: MEDICARE*, Congressional Budget Office, March 2006

ANNUAL INCREASE IN MEDICARE PAYMENTS TO MA PLANS

	2006	2007	2008	2009	2010	2011
Increase in per capita A+B costs	7.3%	5.1%	3.2%	4.1%	3.9%	1.9%
Increase in MA plan enrollment	6.0%	10.9%	10.2%	5.8%	4.0%	4.1%
Increase in total payments to MA plans	13.7%	16.6%	13.8%	10.1%	8.1%	6.1%

Source: *Fact Sheet for CBO's March 2006 Baseline: MEDICARE*, Congressional Budget Office, March 2006

Notes

[1] CBO Testimony July 25, 2006 Subcommittee on Health, Committee on Energy and Commerce

[2] H.R.5866: Medicare Physician Payment Reform and Quality Improvement Act of 2006. Introduced 7/24/2006. Sponsor: Rep. Michael Burgess [TX-26]. Available at: http://thomas.loc.gov/

[3] M. Moon, B. Gage, and A. Evans, An Examination of Key Medicare Provisions in the Balanced Budget Act of 1997 (New York: The Commonwealth Fund, Sept. 1997).

[4] President Bush's FY 07 budget proposed new Medicare spending reductions in Medicare totaling $36 billion for the years 2007 – 2011. The major cost saving Medicare proposals would reduce the annual inflation increase in payments to hospitals, nursing homes and home health agencies.

[5] S. 1932: Deficit Reduction Act of 2005 Conference Agreement as passed by the Senate, Cost Estimate. Congressional Budget Office, Washington, DC, January 27, 2006. Note that we have reduced CBO's 2011 figure of $2.9 billion by 25% to account for the reduction for the bids.

[6] Congressional Budget Office. Fact Sheet for CBO's March 2005 Baseline: Medicare. Available at http://www.cbo.gov/factsheets/2005/Medicare.pdf Accessed July 25, 2005.

[7] The extra rates in these tables include the benchmark, BNRA payments, the fee-for-service normalization adjustment and a 4% reduction to account for the bidding system.

[8] 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.

[9] Centers for Medicare and Medicaid Services (CMS). Rate Calculation Data (Baltimore, M.D.: CMS, December 2005). Available at: http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/

[10] These rates represent benchmark payment rates with FFS normalization and BNRA of 3.9 percent.

[11] Centers for Medicare and Medicaid Services (CMS). Rate Calculation Data (Baltimore, M.D.: CMS, December 2005). Available at: http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/

[12] For 2007, the benchmarks are, except for the 177 100 percent of FFS counties that were rebased for 2007, the amount of the 2006 benchmark increased by 4.8 percent. (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, 2006). Available at: http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/)

County rates trended forward from 2003 were increased by 6.3 percent in 2004, 6.6 percent in 2005, 5.5 percent in 2006 and 4.8 percent in 2007 for a total compounded increase from to 2003 to 2007 of 25.3 percent.

[13] 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).

[14] The projected costs of MA plan extra payments for IME costs are calculated as part of the county benchmark rates and this projection assumes that the IME costs included in the county benchmark rates are then reduced by 25 percent to account for plan bids as described above.

[15] 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".

[16] 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.

[17] The risk adjuster first applies to 100 percent of the MA rates in 2007

[18] Centers for Medicare and Medicaid Services, "Note to Medicare Advantage Organizations, Prescription Drug Plan Sponsors and Other Interested Parties. Subject: Advance Notice of Methodological Changes for Calendar Year (CY) 2006 Medicare Advantage (MA) Payment Rates" (Washington, D.C.: CMS, 2005). Available at http://www.cms.hhs.gov/healthplans/rates/2006/45-day.pdf. 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). Available at http://www.cms.hhs.gov/healthplans/rates/2006/cover.asp

[19] *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.

[20] S. 1932: Deficit Reduction Act of 2005 Conference Agreement as passed by the Senate, Cost Estimate. Congressional Budget Office, Washington, DC, January 27, 2006. Note that we have reduced CBO's 2011 figure of $2.9 billion by 25% to account for the reduction for the bids.

[21] The 3 percent and $1.7 billion figures presented here represent the estimated amount of BNRA extra payments after MA plan bids. According to CMS, in 2007, BNRA adds 3.9 percent to the benchmark rate before the bid. 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, 2006). Available at: http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/

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

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

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

[25] "MA Enrollment Climbs 12% Since December, with PFFS Accounting for 52% of Gain." *Medicare Advantage News* Volume 12, Number 10. (May 25, 2006): 7.

[26] H.R.5866: Medicare Physician Payment Reform and Quality Improvement Act of 2006. Introduced 7/24/2006. Sponsor: Rep. Michael Burgess [TX-26]. Available at: http://thomas.loc.gov/

[27] Senator Chuck Grassley. "Press Release: President's Budget Proposal" February 6, 2006. Available at: http://grassley.senate.gov/index.cfm?FuseAction=PressReleases.View&PressRelease_id=5001.

[28] 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.

[29] Department of Health, Education and Welfare, *Towards a Comprehensive Health Policy for the 1970s: A White Paper.* (Washington, D.C.: HHS, May 1971).