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Paying Medicare Private Plans By Competitive Bidding: Not The Same As Costs In Regular Medicare

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ABSTRACT: Medicare Advantage plans are now paid $11 billion a year, and $150 billion over 10 years, more than costs in regular fee-for-service (FFS) Medicare. In the past two years there have been discussions about reducing MA payments to the level of 100 percent of average costs in FFS and using the savings to offset the costs of new Federal health initiatives such as health care reform. Earlier this year, OMB proposed "reducing Medicare overpayments to private insurers through competitive payments." Under this proposal, MA plan "payments would be based on an average of plans' bids submitted to Medicare." This issue brief analyzes the new proposal using data on MA plan benchmarks, bids and rebates, and enrollment for 2009.

Analysis of MA plan bids indicates that, while the national average of MA plan bids in the 3,140 counties in the US is 101 percent of FFS costs, the actual level of bids by plans in individual counties varies greatly. Under a bid-based MA payment system, plans would receive under payments - payments less than 100 percent of FFS – of $3.2 billion in approximately 800 counties. These under payments would be balanced with continued extra payments – payments greater than 100 percent of FFS - of $3.8 billion to plans in approximately 2,300 counties.

Bid-based payments in eight states would average less than 100 percent FFS while in the other 42, the average would be greater than FFS costs. Most notably, bid-based payments in Florida would average 21 percent less than FFS costs, $2,200 per enrollee per year and a total of almost $2 billion a year. Bid-based payments in 11 states would continue to average more than $1,000 per enrollee per year over fee-for-service costs. Extra payments in both Oregon and Washington State would average 18 percent more than FFS costs and total $320 million a year in Oregon and $290 million in Washington.

OVERVIEW

As a Presidential candidate, Barack Obama consistently indicated that he supported paying Medicare private plans the same amount as fee-for-service Medicare. In the fall of 2008, for example, the Obama campaign stated in a summary of its health care policy: "We need to eliminate the excessive subsidies to Medicare Advantage plans and pay them the same amount it would cost to treat the same patients under regular Medicare."[1] This policy position was

generally understood to mean that an Obama Administration would propose to eliminate extra payments to Medicare Advantage private plans that average approximately 13% or $1,000 per enrollee per year in 2009.[2]

In December 2008, the Congressional Budget Office in *Budget Options Volume 1: Health Care* published the projected savings and costs of 115 options to reform Federal health care policy. In Option 63 in this volume, CBO projected that a policy that would "Set the Benchmark for Private Plans in Medicare Equal to Local Per Capita Fee-for-Service Spending" would reduce Medicare spending by $157 billion from 2010 to 2019.[3]

In late February of this year, the Obama administration's Office of Management and Budget issued a report *A New Era of Responsibility* that, among a wide range of Federal policy changes, described a number of polices for financing health care reform. One of the polices included was "Reducing Medicare Overpayments to Private Insurers Through Competitive Payments." This policy would "replace the current mechanism to establish payments (to MA plans) with a competitive system in which payments would be based upon an average of plans' bids submitted to Medicare Advantage. This would allow the market, not Medicare, to set the reimbursement limits, and save taxpayers more than $175 billion over 10 years, as well as reduce Part B premiums."[4]

Though the specific details of this OMB proposal are not described in *A New Era of Responsibility*, the CBO *Budget Options Volume 1: Health Care*, describes a model for MA competitive bidding in Option 65 "Establishing Benchmarks for the Medicare Advantage Program Through Competitive Bidding".[5, 6]

Under the Medicare Advantage competitive bidding payment system described by CBO "the benchmark for each county would be the average bid of the plans that served the county, with each plan's bid weighted by its enrollment the previous year. However, benchmarks would be constrained so they did not exceed the benchmarks that would have existed under current law."[7]

CBO explains that the argument for a competitive bidding based payment system is "that it would reduce the per capita amount paid for benefits for enrollees in Medicare Advantage plans to levels determined by the plans' bids. The option might also encourage private plans to compete more strongly on the basis of price."[8] CBO estimates that the described competitive bidding based system would reduce Medicare spending by $158 billion over 10 years.

The analysis in this paper will examine the impact on payments to MA plans using the data on the level of MA plan bids and rebates reported by the Medicare Payment Advisory Commission together with data on Medicare fee-for-service (FFS) costs in 2009 and on MA enrollment in February 2009 reported by the Centers for Medicare and Medicaid Services (CMS).

Generally, this analysis finds that in most counties a competitive bid-based payment system would not pay plans the same as 100 percent of fee-for-service (FFS) costs in the county. While the national average of payments to plans would be 101 percent of FFS, plans in most counties would be paid significantly more or less that 100 of FFS costs.

Under a bid-based MA payment system, plans would receive under payments — payments less than 100 percent of FFS – of $3.2 billion in approximately 800 of the 3,140 counties in the US. These under payments would be balanced with continued extra payments – payments greater than 100 percent of FFS – of $3.8 billion to plans in approximately 2,300 counties.

In eight states, plans would, on average, be paid less than FFS costs, while in the other 42 states plans would continue to be paid more than FFS costs.

At the state level, payments to plans would

average $2,200 per MA enrollee less than FFS costs in Florida and $1,300 less in Nevada. In 11 states – Oregon, Washington, Virginia, New Mexico, Rhode Island, Hawaii, Iowa, Maine, Vermont, Wisconsin and Alaska – extra payments would continue to average more than $1,000 per enrollee per year.

EXPERIENCE WITH MEDICARE COMPETITIVE BIDDING BASED PAYMENTS TO PRIVATE PLANS

The proposal to establish a competitive bidding based payment system for Medicare private plans is not new.[9]

In 1996, the Health Care Financing Administration[10] developed a Medicare plan competitive bidding demonstration program under its general demonstration authority, and Baltimore, MD was chosen as the first site for the demonstration.[11] However, health plans in the area opposed the proposed program, citing issues including: their inability to calculate an accurate bid since the bid would be only a share of the local payment benchmark; the incentive for plans to reduce their bid by increasing enrollee out-of-pocket costs; and, the use of third-party contractors to provide beneficiaries with plan information. Under this pressure, the plan was abandoned.

In 1997, a similar demonstration was proposed in Denver, CO. However, like its predecessor, the plan was killed before being implemented; this time through legal action.

Later in 1997, the Balanced Budget Act (BBA) provided explicit authority to the Secretary of Health and Human Services (HHS) to establish competitive bidding demonstrations, which would be designed by a national Competitive Pricing Authority Committee (CPAC). The two sites chosen for this demonstration were Kansas City and Phoenix. Despite new elements to the proposed system, including setting the government payment rate at the enrollment-weighted average of plan bids, opposition grew quickly in Arizonia and soon arose in Kansas City. In November 1999, the Consolidated Appropriations Act of 2000 included a provision proposed by Senator Kyl of Arizona that prohibited further spending on the demonstrations in fiscal year 2000.

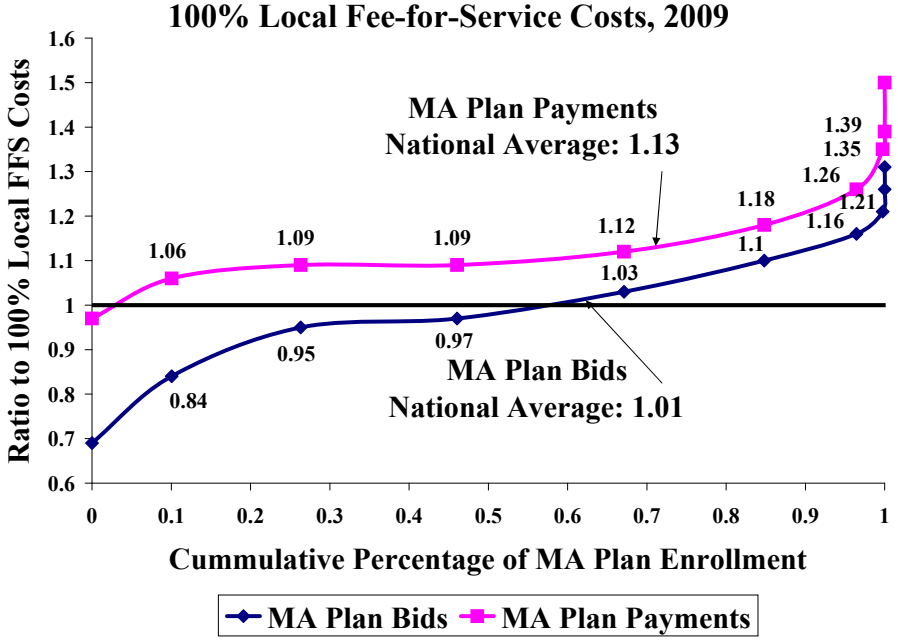
Following the experience with the Medicare private plan demonstrations, authority for a demonstration of a broader premium support approach in both traditional fee-for-service Medicare and Medicare Advantage was included in the Medicare Modernization Act in 2003. This authority required the federal government to conduct a six-year "comparative cost adjustment program" demonstration in up to six metropolitan areas beginning in 2010.[12] The House of Representatives passed a proposal to repeal this authority in the 2007 as part of the CHAMP Act to extend the SCHIP program, but the repeal provision was not included in the final version of the enacted legislation.

PAYMENT TO MA PLANS BASED ON PLAN BIDS

The goal of a MA plan bid-based payment system would be to reduce payments to MA plans from the current average of 113 percent of fee-for-service and "pay them the same amount it would cost to treat the same patients under regular Medicare."[13] This reduction in future Federal spending, estimated by CBO at $150 billion over 10 years, has been proposed to be used in the development of health care reform legislation to off-set the budget costs of expanding health insurance coverage to the 47 million uninsured or for other initiatives including improvements to Medicare.

This analysis examines the impact of a bid-based MA plan payment system relative to the payments of all plans in the nation at 100 percent of fee-for-service in the county by comparing current MA bid levels with the 100 percent of fee-for-service costs.

Figure 1. Medicare Advantage Plan Bids and Payments vs. 100% Local Fee-for-Service Costs, 2009



Sources:
GW analysis of Centers for Medicare and Medicaid Services Medicare Advantage enrollment and payment data for February 2009, and Medicare Payment Advisory Commission analysis of MA plan bids for 2009.

Overview of the effect a plan bid-based payment system. Paying MA plans at the enrollee weighted average of plan bids in each county in the nation would produce Federal savings of more than $158 billion over the next 10 years according to CBO.[14] This CBO estimate of savings is very close to the $157 billion savings estimated for setting payments MA plans at 100 percent of fee-for-service costs in each county.[15]

The bid-based approach would not, however, actually pay MA plans with the substantial majority of enrollees the same as 100 percent of fee-for-service costs in their individual county. While the national average of a plan bid-based payment system would be close to 100 percent of fee-for-service nationwide, this approach would create a wide variation in payments to plans relative to fee-for-service in individual counties. [16]

As Figure 1 illustrates, the bid-based payment approach would continue the current pattern of plans in many counties now being paid more than others. The major change would be that the national average MA plan payment would decrease from the 113 percent of average local fee-for-service costs to roughly 101 percent of costs.

The major change in the pattern for a bid-based system would be that the national average would decrease from 113 percent of average fee-for service costs to roughly 101 percent of average fee-for-service costs.

The way that a bid-based MA payment approach eliminates the national average of 13 percent extra payments to MA plans and saves $150 billion over ten years is by balancing the continuation of extra payments of more than 100 percent of FFS costs to plans in some counties with equivalent amounts of payments at less than 100 percent of FFS in other counties.

Figure 2. Medicare Advantage Plan Bids vs. 100% Local Fee-for-Service Costs by MedPAC Cohorts, 2009[1]

MedPAC Cohort[2]	Medicare Beneficiaries	MA Plan Enrollees[3]	Average Annual FFS Costs per Enrollee[4]	Average Annual MA Plan Bid per Enrollee[5]	FFS to Bids, Annual Plan Gain/Loss		
					Average Percentage	Average Per Enrollee	Total (millions)
National	44,575,208	10,014,280	$8,740	$8,800	1%	$59	$593
1	2,871,645	1,007,159	$11,438	$9,608	-16%	-$1,830	-$1,843
2	8,030,865	1,630,261	$9,788	$9,299	-5%	-$489	-$798
3	8,280,382	1,975,720	$8,969	$8,699	-3%	-$269	-$532
4	10,365,711	2,107,705	$8,397	$8,649	3%	$252	$531
5	8,490,620	1,772,708	$7,826	$8,608	10%	$783	$1,387
6	5,046,265	1,164,380	$7,205	$8,357	16%	$1,153	$1,342
7	1,377,200	331,355	$6,689	$8,094	21%	$1,405	$465
8	112,520	24,992	$6,188	$7,797	26%	$1,609	$40

Sources:
The George Washington University analysis of Centers for Medicare and Medicaid Services Medicare Managed Care State/County/Contract Data File, released February 2009; Medicare Managed Care State/County Penetration Data File, released February 2009; and the Medicare Advantage 2009 Rate Calculation Data Spreadsheet. Medicare Payment Advisory Commission (MedPAC) analysis of MA plan bids for 2009.

Notes:
1. Calculations at the county level, weighted by MA enrollment
2. Medicare Payment Advisory Commission (MedPAC) *MIPPA Medicare Advantage Payment Report,* March 12, 2009. Available at http://www.medpac.gov/meetings.cfm
3. Exclude MA plan enrollees in Cost plans, Puerto Rico, Guam, Virgin Islands and American Samoa
4. Include a reduction for Indirect Medical Education costs
5. Calculated in relation to fee-for-service costs using MedPAC analysis of 2009 county bids

Under the bid-based approach, plans in counties that would be paid less than 100 percent of local FFS costs would be paid an estimated $3.2 billion less than FFS costs while plans that would be paid more than 100 percent of local FFS costs would be paid an estimated $3.7 billion more than FFS costs.

Overall impact of a bid-based MA plan payment system. The overall impact of a MA bid-based payment system on payments to plans at the county level are analyzed here using eight cohorts of counties with each individual county assigned to a cohort by the amount of fee-for-service costs in the county. (Figure 2)

This analysis indicates that MA plans in counties with higher than the national average of FFS costs of $8,740 per year would generally be paid appreciably less than 100 percent of FFS costs in the county. MA plans in counties with lower than the national average of FFS costs would be continue to receive extra payments significantly more than 100 percent of FFS costs in the county.

Overall, MA plans in the approximately 70 counties in Cohort 1 with the highest FFS costs in the nation – over $10,500 per year (with aver-

age costs of $11,438) – would be paid over $1.8 billion a year less than 100 percent of FFS costs in their counties. The average payment to plans in these counties would be at 84 percent of FFS costs or $1,800 less per enrollee than FFS costs in the county. The counties have over 1 million MA enrollees.

In contrast, MA plans in the approximately 770 counties in the three Cohorts 6, 7 and 8 with the lowest FFS costs in the nation – under $7,500 per year (with average costs of $7,205 or less) would be paid over $1.8 billion dollars a year more than average FFS costs in their counties. The average payment to plans in these counties would be over 116 percent of FFS costs and $1,150 more per enrollee than average FFS costs in the county. These counties have over 1.5 million MA enrollees.

Overall, a bid-based MA payment system would achieve a national average of payments to MA plans of 101 percent of FFS costs by balancing savings from new under payments to plans in some counties with the costs of continued extra payments to plans other counties. In general terms, plans in the counties that would lose the most would be paid an average of 16 percent less than local FFS costs while plans in the counties that would gain the most would be paid an average of 16 percent or more than local FFS costs.

Effect of a plan bid-based payment system on payments in states. At the state level, the bid-based payment system would shift billions of dollars among states compared with payment at 100 percent of FFS costs by county. (Appendix I)

The states with largest total losses compared to 100 percent of FFS costs would be, consistent with the analysis just discussed, those states with counties with high costs in FFS Medicare.

Overall, the most notable impact would be on Florida which would lose $2,160 per enrollee relative to FFS costs and nearly $2.0 billion a year. Plans in Florida would be paid at an average of 79 percent of FFS costs in the county. California, with nearly 1.6 million enrollees, would be paid a total of $320 million less than FFS costs, and Nevada would be paid at $1,270 less than FFS costs and a total of $131 million a year. Other notable losses include Louisiana at almost $100 million a year less than FFS costs and Alabama and Texas at about $50 million a year less.

As a percent of payments, the states with the lowest average payments in a bid-based system compared to 100 percent of FFS costs would be Florida at 79 percent, Nevada at 87 percent and Louisiana at 93 percent.

The states that would gain the most with a bid-based payment system compared to 100 percent FFS costs would be Pennsylvania with $650 million a year, Oregon with $320 million and Washington with $290 million. The states that would have payments the most in excess of 100 percent of FFS costs would be Hawaii at 27 percent, Oregon and Washington State at 18 percent and Virginia at 16 percent.

CONCLUSION

In recent years, there has been extensive discussion about eliminating extra payments to MA plans. In 2008, the Obama campaign indicated that MA plans should be paid "...the same amount it costs to treat the same patient under regular Medicare." This position was consistent with a proposal passed by the House of Representatives in 2007, but not enacted, that would have, after a four year transition, paid MA plans at 100 percent of the average FFS costs in each county in the nation.

The $150 billion in funds to be saved from Medicare by paying MA plans the same as FFS costs would be used in health care reform legislation to help offset the new Federal costs of expanding coverage to the uninsured and for Medicare improvements and other initiatives.

Early in 2009, Obama administration Office of Management and Budget proposed that Medicare private plans, rather than being paid 100 percent of costs in regular FFS Medicare should instead in the future be paid based on "competitive payments." Under this approach, payments to MA plans would be based on the amount of the bids that the plans submit each year to Medicare. Medicare MA plans have been submitting bids to Medicare since 2006 and, before that, similar calculations that were termed the "adjusted community rate" or ACR.

This approach would, for the first time, since President Reagan proposed risk based capitation payments to Health Maintenance Organizations in 1982, shift the payment of Medicare private plans from an approach based on FFS costs in the local county to one based on the private plans' own internal costs.

Analysis of MA plans' enrollment and bids in 2009 indicates two key features of the impact of such an approach to payment of to MA private plans.

First, a bid-based payment approach would allow private health insurance firms in some generally low-cost counties, by submitting bids that average more than the costs of FFS Medicare in an area, to continue to be paid more – in some cases much more – than "the same amount it cost to treat the same patient under regular Medicare" in the counties where they operate. MA plan bids in 2009 indicate that this approach would continue extra payments – payments in excess of FFS costs – to plans in counties with 54 percent of MA enrollees.

Of these plans, those in the lowest cost counties with 15 percent of total MA enrollees would continue to be paid an average of 17 percent and $1,200 per enrollee per year more than FFS costs. Extra payments to MA plans in these counties would total over $1.8 billion a year.

Second, plans in other generally high-cost counties would be paid less—in some cases much less—than FFS costs in the same county. This would be the first time in the history of Medicare that risk plans would be paid less than 95 percent of FFS costs in their county.

Under payments – payments less than FFS costs – to plans in the highest FFS cost counties, with 10 percent of total MA enrollees, would be paid an average of 16 percent or $1,800 per year below FFS costs in the same county. Under payments in those counties would total $1.8 billion a year.

The real impact of the loss from plan payments below FFS costs would not be on the MA plans themselves – their costs and profits are included in the bids - but on the MA plan enrollees in these areas whose extra benefits are dependent on amounts that plan bids are less than Medicare payments.

Notes

1 Barack Obama and Joe Biden's Health Care Plan, available at www.barackobama.com, September 2008.

2 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.

3 Congressional Budget Office, *Budget Options Volume 1: Health Care*, p. 119 (Washington, D.C.: CBO Dec. 2008) available at http://www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf.

4 Office of Management and Budget, *A New Era of Responsibility: Renewing America's Promise*, p. 28 (Washington, DC OMB February 2009) available at http://www.whitehouse.gov/omb/assets/fy2010_new_era/a_new_era_of_responsibility2.pdf.

5 Congressional Budget Office, *Budget Options Volume 1: Health Care*, p. 122 (Washington, D.C.: CBO Dec. 2008) available at http://www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf.

6 Peter Orszag, who is now the Director of the Office of Management and Budget (OMB), was the Director of CBO prior to December when the *Budget Options Volume 1* report was prepared and published.

7 Under the CBO option 65, unlike the current MA payment system, plans that bid below the county bid-based benchmark would receive 100% of the difference between their specific bid and the benchmark instead of the current policy of 75% of the difference between the bid and the benchmark. As with the current MA payment system, plans that bid in excess of the benchmark must charge enrollees the difference between their bid and the benchmark as an out-of-pocket premium.

8 Congressional Budget Office, *Budget Options Volume 1: Health Care*, p. 122 (Washington, D.C.: CBO Dec. 2008) available at http://www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf.

9 Medicare Payment Advisory Commission, *Report to Congress: Improving Incentives in the Medicare Program,* p. 186 (Washington, D.C. MedPAC June 2009) available at http://www.medpac.gov/documents/Jun09_EntireReport.pdf.

10 The previous name for the Center for Medicare and Medicaid Services.

11 B. Dowd, R. Coulam, and R. Feldman, A Tale of Four Cities: Medicare Reform and Competitive Pricing, Health Affairs, September/October 2000.

12 Congressional Budget Office, *Designing a Premium Support System for Medicare*, (Washington, DC, CBO December 2006) available at http://www.cbo.gov/ftpdocs/76xx/doc7697/12-08-Medicare.pdf.

13 Barack Obama and Joe Biden's Health Care Plan, available at www.barackobama.com, September 2008.

14 Congressional Budget Office, *Budget Options Volume 1: Health Care*, p. 122 (Washington, D.C.: CBO Dec. 2008) available at http://www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf.

15 Congressional Budget Office, *Budget Options Volume 1: Health Care*, p. 119 (Washington, D.C.: CBO Dec. 2008) available at http://www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf.

16 MedPAC reports that plan bids averaged nationally actually equal 102 percent of 100 percent of fee-for-service costs in the same county. The discrepancy is due to slight methodological differences.

Appendix I.
Medicare Advantage Plan Bids vs. 100% Local Fee-for-Service Costs by State, 2009[1]

State	Medicare Beneficiaries	MA Plan Enrollees[2]	Annual FFS Costs per Enrollee[3]	Annual MA Plan Bid per Enrollee[4]	FFS to Bids, Annual Plan Gain/Loss		
					Percentage	Per Enrollee	Total (millions)
National	44,575,208	10,014,280	$8,740	$8,854	1.3%	$113	$1,136
Alabama	813,023	170,929	$8,579	$8,277	-3.5%	-$302	-$52
Alaska	60,873	640	$8,859	$9,985	12.7%	$1,126	$1
Arizona	867,756	323,823	$8,490	$8,583	1.1%	$93	$30
Arkansas	511,579	67,808	$7,894	$8,447	7.0%	$553	$38
California	4,525,318	1,570,931	$9,246	$9,041	-2.2%	-$206	-$323
Colorado	585,428	173,014	$8,470	$8,717	2.9%	$247	$43
Connecticut	550,451	87,916	$8,991	$9,116	1.4%	$125	$11
D.C.	75,319	3,244	$9,144	$9,743	6.5%	$599	$2
Delaware	141,605	6,627	$8,364	$8,725	4.3%	$361	$2
Florida	3,212,467	922,369	$10,331	$8,172	-20.9%	-$2,158	-$1,991
Georgia	1,165,463	169,945	$8,154	$8,692	6.6%	$538	$91
Hawaii	195,957	37,902	$6,673	$8,473	27.0%	$1,800	$68
Idaho	216,060	57,219	$7,511	$8,252	9.9%	$740	$42
Illinois	1,781,296	168,079	$8,750	$8,800	0.6%	$49	$8
Indiana	967,014	132,303	$7,850	$8,711	11.0%	$861	$114
Iowa	506,375	56,193	$7,156	$8,241	15.2%	$1,085	$61
Kansas	419,188	40,914	$8,170	$8,619	5.5%	$449	$18
Kentucky	730,912	103,977	$8,155	$8,854	8.6%	$699	$73
Louisiana	660,112	146,528	$9,934	$9,254	-6.8%	-$680	-$100
Maine	254,799	23,921	$7,312	$8,488	16.1%	$1,176	$28
Maryland	748,874	36,215	$9,919	$9,575	-3.5%	-$344	-$12
Massachusetts	1,022,639	195,785	$8,907	$9,495	6.6%	$588	$115
Michigan	1,586,025	380,956	$8,563	$9,019	5.3%	$455	$173
Minnesota	753,622	175,517	$8,377	$8,694	3.8%	$317	$56
Mississippi	480,440	43,827	$8,922	$8,950	0.3%	$28	$1
Missouri	969,943	190,434	$8,069	$8,413	4.3%	$344	$66
Montana	161,564	27,046	$7,410	$8,216	10.9%	$806	$22
Nebraska	272,073	29,612	$7,966	$8,712	9.4%	$746	$22
Nevada	333,012	102,927	$9,743	$8,475	-13.0%	-$1,268	-$131
New Hampshire	206,279	12,229	$8,002	$8,910	11.4%	$908	$11
New Jersey	1,286,842	152,989	$9,298	$9,729	4.6%	$431	$66
New Mexico	296,720	71,462	$6,962	$7,988	14.7%	$1,025	$73
New York	2,893,663	822,535	$8,978	$9,168	2.1%	$190	$156
North Carolina	1,412,465	244,055	$7,800	$8,581	10.0%	$780	$190
North Dakota	106,489	6,984	$7,231	$8,211	13.6%	$980	$7
Ohio	1,842,490	471,989	$8,159	$8,754	7.3%	$595	$281
Oklahoma	581,736	83,262	$9,128	$8,875	-2.8%	-$253	-$21
Oregon	588,151	244,823	$7,444	$8,764	17.7%	$1,319	$323
Pennsylvania	2,222,492	842,648	$8,500	$9,270	9.1%	$770	$649
Rhode Island	178,068	64,713	$7,823	$8,897	13.7%	$1,074	$69
South Carolina	727,451	105,515	$8,001	$8,645	8.0%	$643	$68
South Dakota	132,581	9,424	$7,238	$8,211	13.4%	$972	$9
Tennessee	1,007,924	221,207	$8,254	$8,392	1.7%	$138	$31

State	Medicare Beneficiaries	MA Plan Enrollees[2]	Annual FFS Costs per Enrollee[3]	Annual MA Plan Bid per Enrollee[4]	FFS to Bids, Annual Plan Gain/Loss		
					Percentage	Per Enrollee	Total (millions)
Texas	2,826,361	488,491	$9,612	$9,515	-1.0%	-$97	-$47
Utah	266,648	79,422	$7,908	$8,445	6.8%	$537	$43
Vermont	105,682	3,800	$7,290	$8,314	14.0%	$1,024	$4
Virginia	1,085,920	132,793	$7,350	$8,549	16.3%	$1,200	$159
Washington	910,436	215,825	$7,622	$8,982	17.8%	$1,360	$293
West Virginia	373,403	73,546	$7,798	$8,672	11.2%	$875	$64
Wisconsin	877,674	216,329	$7,440	$8,486	14.1%	$1,046	$226
Wyoming	76,546	3,638	$7,995	$8,728	9.2%	$734	$3

Sources:
The George Washington University analysis of Centers for Medicare and Medicaid Services Medicare Managed Care State/County/Contract Data File, released February 2009; Medicare Managed Care State/County Penetration Data File, released February 2009; and the Medicare Advantage 2009 Rate Calculation Data Spreadsheet. Medicare Payment Advisory Commission (MedPAC) analysis of MA plan rebates by state for 2009.

Notes:
1. Calculations at the state level, weighted by MA enrollment
2. Excludes MA plan enrollees in Cost plans, Puerto Rico, Guam, Virgin Islands and American Samoa
3. Includes a reduction for Indirect Medical Education costs
4. Bids are calculated by subtracting four-thirds the value of the state-wide rebate from enrollee-weighted state-wide average MA benchmarks for 2009.

Study Methods

This report's 2009 analysis is based on data on the level of Medicare Advantage (MA) plan bids and rebates provided by the Medicare Payment Advisory Commission (MedPAC) for 2009, and MA plan benchmarks and fee-for-service (FFS) 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]

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.[3] Cost beneficiaries were removed from the Medicare Advantage enrollee totals by county but are included in the number of overall Medicare beneficiaries. 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.

For analysis at the national level, MedPAC grouped all counties into one of eight cohorts, determined by their respective 2009 annual FFS costs, and provided aggregated bid-to-FFS ratios for each cohort. This information was originally reported on March 12, 2009 in the *MIPPA Medicare Advantage*

Payment Report. Briefs, presentations and transcripts are available at http://www.medpac.gov/meetings.cfm. The authors used these average bid-to-FFS ratios to derive an annual bid value for each county. Using the MA plan enrollment for each county used by MedPAC for the original calculations, the authors re-aggregated the counties into their respective cohorts to determine overall gains and losses.

MedPAC also provided state average plan rebates, weighted by plan enrollment. In this analysis, the authors calculated the enrollee-weighted state-wide average MA plan benchmarks, including a budget-neutral risk adjustment of 0.9 percent, and then lessed four thirds the value of the rebate from the benchmark to obtain the state-wide average plan bids. This convention follows from the bidding mechanism established by the MMA, in which each MA plan submits a bid equal to the payment it would require for providing traditional Medicare benefits to its enrollees. The bid submitted by each plan is compared with the benchmark rate in each county it serves, and each plan receives from Medicare a payment rate equal to the benchmark rate (if its bid is equal to or greater than the benchmark rate) or (if its bid is less than the benchmark rate) its bid plus a 'rebate' of 75 percent of the difference between the benchmark rate and the bid.

Notes:

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. 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/

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