Medicare Improvements for Patients and Providers Act of 2008 Medicare Advantage payment report

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Chapter summary

Section 169 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) requires a Commission study and report on Medicare Advantage (MA) payments. The Commission is directed to:

- evaluate CMS's measurement of county-level spending.
- study the correlation between MA plan costs (as reflected in plan bids) and county-level spending under fee-for-service (FFS) Medicare.
- examine approaches to MA payment other than "county-level payment area equivalents," and make recommendations as appropriate.

CMS's estimates of spending in traditional FFS Medicare are reasonably accurate and capture the important administrative costs associated with the FFS program. To increase accuracy, we encourage CMS to adjust for services provided by the Department of Veterans Affairs and the Department of Defense at the county payment level where warranted. Another way to enhance the reliability of FFS

estimates is to increase the size of the MA payment areas. An appendix to this chapter includes the Commission's previous recommendation on payment areas and our supporting analysis.

We find that MA plan costs to deliver Part A and Part B benefits and county-level per capita spending under FFS Medicare are highly correlated, which we take into account in our development of new approaches to payment.

The Commission supports private plans in Medicare and the innovative delivery systems and care management techniques they can offer. But plans will innovate only if payment rates encourage them to do so. The current high payments have resulted in some plans that bring no innovation but simply mimic FFS Medicare at a much higher cost to the program. This situation is unfair to taxpayers and beneficiaries not enrolled in MA, who subsidize the higher costs.

In response to the mandate, we have developed a number of options for setting MA "benchmarks" administratively. (A benchmark is the maximum MA payment amount, set by law, for each payment area.) Each option is financially neutral to FFS Medicare in the aggregate in the first year; any one of them will cost the same as traditional Medicare, saving an estimated $12 billion. In later years, spending relative to FFS for each option will vary depending on where enrollment is encouraged or discouraged. Because all the options remove money from the current MA program, each would result in fewer plans and reduced extra benefits in some areas. For each option, we consider the effect on the availability of high-quality plans and plans that can provide care coordination. We discuss a modification that would differentiate payment for extra benefits in high- and low-use areas, balancing extra benefits among areas and helping mitigate concerns about equity.

Another alternative is to set benchmarks through a competitive bidding process. We present the fundamental issues to address when designing a competitive bidding system and outline some possible behavioral responses. The approach could result in approximate financial neutrality with FFS in

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the first year if plans' bids are similar to those made in 2009. However, we expect that plans would alter their bidding practices; thus, we cannot rely on current bidding data to simulate future behavior under this option. Therefore, we do not present a quantitative analysis of the option.

In the commentary section of this chapter, we reflect on how the goals for private plans in Medicare have shifted over time. The shifting of goals has resulted in the MA program of today, with plans available to all beneficiaries in all parts of the country providing enhanced benefits but at a high price to Medicare:

- We estimate that in 2009 Medicare pays about $12 billion more for enrollees of MA plans than it would if they were in FFS Medicare. The Congressional Budget Office estimates the additional 10-year cost at more than $150 billion.

- These excessive payments encourage inefficient plans to enter the program, further raising the costs to Medicare. The program pays on average $1.30 to subsidize each dollar of enhanced benefits. In the case of private FFS plans, Medicare pays more than $3.00 in subsidies for each dollar of enhanced benefits. (By contrast, Medicare subsidizes HMOs $0.97 for each dollar of enhanced benefits.)

- The cost of MA subsidies is borne by taxpayers who finance the Medicare program and by all Medicare beneficiaries via Part B premiums: The Part B premium for all beneficiaries is increased by about $3.00 a month, regardless of whether they receive any of the benefit.

- The additional MA payments hasten the insolvency of the Medicare Part A trust fund by about 18 months.

- Further, although many plans are available (e.g., 1 county has more than 90 plans), only some are of high quality. Only about half of beneficiaries nationwide (and only one-third in rural areas) have access to a plan that CMS rates as above average in overall plan quality.

The MA payment system could be improved by recasting the goals of the program to emphasize financial neutrality, efficiency, equity, and quality. A new framework needs to be achieved that includes care coordination and cost savings (the original goals of the program), realizes greater equity (as intended by later changes to the program), and improves quality. Encouraging plans to be efficient is a key element. Plans that are more efficient than FFS Medicare can provide extra benefits while maintaining financial neutrality with FFS. In a transition to new benchmarks, quality improvements could be promoted by paying more for better quality. After the transition, if plans' quality can be measured relative to FFS, plans providing better quality care than FFS would be paid more than FFS.

In the analytics section of this chapter, we present our findings on each task of the MIPPA mandate. We preface the discussion with a background section on the current MA program, including the mechanics of payment, payment statistics, and plan quality.

In the commentary section of this chapter, we review the goals of the MA program and how those goals can influence the evaluation of various payment options. We also discuss some considerations for the MA program as it transitions to a different system of payment. ∎

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Background

The current Medicare Advantage (MA) payment system has evolved and now presents many complexities and raises many issues. The principal issue is that payment benchmarks are too high, resulting in excessive payments that encourage the entry of inefficient plans and increase Medicare spending. The higher spending hastens the insolvency of the Part A trust fund and increases the burden on taxpayers and beneficiaries—and all beneficiaries face higher Part B premiums to pay for higher spending in MA plans that benefits only a fraction of the Medicare population. Although some of that spending is translated into enhanced benefits, 13 percent goes for overhead expenses (administrative costs and margins).[1] Medicare pays on average $1.30 to subsidize each dollar of enhanced benefits and more than $3.00 in subsidies in the case of private fee-for-service (PFFS) plans. (By contrast, Medicare subsidizes HMOs $0.97 for each dollar of extra benefits.) The problems with the current system will become evident as we review the current status of the MA program.

Current MA program status

The MA program provides Medicare beneficiaries with an alternative to the fee-for-service (FFS) Medicare program. It enables them to choose a private plan for their Medicare benefits. Private plans can use alternative delivery systems and care management techniques, and—if paid appropriately—they have the incentive to innovate and be efficient.

About 22 percent of Medicare beneficiaries were enrolled in MA plans in 2008. All beneficiaries have access to an MA plan in 2009, with an average of 34 plans available in each county. In 2009, 88 percent of Medicare beneficiaries have an HMO or local preferred provider organization (PPO) plan in their county, and all beneficiaries have a PFFS plan available.[2]

MA payment system mechanics

Plan payment rates are determined by the MA plan "bid" (the dollar amount of revenue the plan estimates it needs to cover the Part A and Part B benefit for a beneficiary of average health status) and the "benchmark" in the payment area (the maximum Medicare payment set by law for an MA plan in a payment area). If a plan's bid is above the benchmark, then the plan's payment rate is equal to

the benchmark, and enrollees have to pay an additional premium equal to the difference. If a plan's bid is below the benchmark, the plan's MA payment rate is its bid plus 75 percent of the difference between the plan's bid and its benchmark. Because benchmarks are often set well above what it costs Medicare to provide benefits to similar beneficiaries in the traditional FFS program, MA payment rates usually exceed FFS spending.[3]

In the MA program, an individual county defines a payment area. Each county has a benchmark rate against which MA plans must bid if they want to serve the county. CMS is required to adjust each county's benchmark annually by a "minimum update," defined as the percentage projected change in overall Medicare expenditures over the preceding year.[4] However, CMS is legally required at least every three years to "rebase" the benchmarks by estimating per capita spending in FFS Medicare in each county, which CMS calculates based on a five-year moving average (for description, see text box, pp. 176–177).[5] In rebasing years, the FFS spending becomes the benchmark if it exceeds the amount that results from the minimum update. These adjustments can only increase a county's benchmark; they cannot decrease it. Since the introduction of the rebasing concept, CMS has made rebasing calculations more frequently than the statute requires: in 2004, 2005, 2007, and 2009.

The use of counties as payment areas in conjunction with using county-level FFS spending in setting benchmarks creates two problems. First, many counties have small populations in the FFS program. In these counties, unusually high or low health care use by just a few FFS beneficiaries can cause substantial annual changes in FFS spending. For example, from 2007 to 2009 FFS spending (adjusted for risk) increased by more than 30 percent in Loving County, Texas, which has fewer than 20 FFS beneficiaries. The second problem is that adjacent counties often have very different levels of FFS spending. This difference can be due to one county having an unusually costly year or because adjacent counties have persistently different costs. In either event, basing benchmarks on FFS spending can result in adjacent counties having very different benchmarks. When this situation occurs, plans tend to offer more limited benefits in the county with the lower benchmark—or avoid that county altogether— which creates appearances of inequity between adjacent counties (MedPAC 2001).

To mitigate these problems, the Commission has recommended larger payment areas for the MA program

**TABLE
7–1**

Medicare Advantage payments exceed FFS spending for all plan types in 2009

Plan type	Enrollment November 2008 (in millions)	Percent of FFS spending in 2009		
		Benchmarks	Bids	Payments
All MA plans	9.9	118%	102%	114%
HMO	6.6	118	98	113
Local PPO	0.7	121	108	118
Regional PPO	0.3	114	106	112
PFFS	2.3	120	113	118
Restricted availability plans included in totals above				
SNP*	1.3	122	99	116
Employer group*	1.7	117	109	115

Note: FFS (fee-for-service), MA (Medicare Advantage), PPO (preferred provider organization), PFFS (private fee-for-service), SNP (special needs plan). Benchmarks are the maximum Medicare program payments for MA plans. FFS spending by county is estimated using the 2009 MA rate book. Spending related to the double payment for indirect medical education payments made to teaching hospitals was removed. Data are enrollment weighted.
  *SNPs and employer group plans have restricted availability and their enrollment is included in the statistics by plan type. They are presented separately to provide a more complete picture of the MA program.

Source: MedPAC analysis of data from CMS on plan bids, enrollment, benchmarks, and fee-for-service expenditures.

(MedPAC 2005). Those payment areas would make the estimates of FFS spending more stable and would more closely approximate insurance plan market areas. Our analysis of this issue and detailed recommendations are presented in the appendix to this chapter.

Current benchmarks, bids, and payments

We estimate that, on an enrollment-weighted average basis, 2009 MA benchmarks will be 118 percent of spending in Medicare's traditional FFS program, bids will be 102 percent of FFS spending, and payments will be 114 percent of FFS spending (Table 7-1). In 2009, the Medicare program is paying about $12 billion more for the beneficiaries enrolled in MA plans than it would be spending if they were in FFS Medicare. (We include plans in Puerto Rico in our totals, although its MA market has some unusual characteristics.)[6]

We report benchmarks by plan type in Table 7-1. County benchmarks do not vary by plan type, but different plan types tend to draw their enrollment from counties with different characteristics, which have different benchmarks.[7] Hence, in aggregate, benchmarks vary by plan type as an artifact of their enrollment patterns. By law, certain counties have higher benchmarks to increase plan availability. Those counties, called "floor" counties (there are two types: the large urban floor and a lower floor that applies to all other counties), have

benchmarks that average 120 percent of FFS spending, whereas nonfloor counties' benchmarks average 112 percent of FFS spending.[8] Local PPOs and PFFS plans tend to operate in counties with higher benchmarks than other plan types. Local PPOs draw their enrollment more heavily from urban floor counties and PFFS plans draw more heavily from rural floor counties.

Plan bids also vary by plan type. We estimate that HMO bids were on average 98 percent of FFS spending, which suggests that HMOs can provide Part A and Part B services for less than the cost of FFS. Plan bid averages for other plan types exceeded the overall average. PFFS plan bids average 113 percent of FFS, up from 108 percent in 2008. The presence of plans bidding over FFS in the program means that the current payment system is encouraging inefficient plans to participate. These plans by definition are less efficient than Medicare FFS; their bids indicate that it costs them more than Medicare FFS to provide the basic Part A and Part B benefit. Plans do not have to be efficient to thrive under the current payment system, but they would have to be more efficient if they faced the financial pressure of benchmarks closer to Medicare FFS levels. As the Commission has stated, organizations are more likely to be efficient when they face financial pressure, and the Medicare program needs to exert consistent financial pressure on providers in the FFS program and plans in the MA program.

In 2009, MA plan payments in relation to FFS spending vary by the type of MA plan, but the levels for all plan types are substantially higher than 100 percent. We estimate that 2009 payments to plans overall will average 114 percent of FFS spending. More than 13 percent of those payments are used for overhead (administrative costs and margins) and not for direct medical care for beneficiaries. HMO payments are estimated to average 113 percent of FFS, while payments to PFFS plans are estimated to average 118 percent. Each of these payment levels is a percentage point higher relative to FFS than we estimated for 2008.[9] Because payments are so much higher than FFS spending for similar beneficiaries, the overall cost of the Medicare program is higher, which increases the burden on taxpayers and beneficiaries. All beneficiaries have to pay higher Part B premiums to fund higher payments to MA plans that benefit only some individuals. Higher spending also hastens the insolvency of the Medicare Part A trust fund.

Although higher spending for MA plans may provide extra benefits, Medicare pays a high price for the benefits. Overall, the Medicare subsidy per dollar of enhanced benefit is $1.30 for all plans. In the case of HMOs, because their bids for the Medicare benefit package are below Medicare FFS spending, the program subsidy is $0.97 for each $1.00 of enhanced benefits. HMOs are the only MA plan type that finances any part of enhanced benefits through plan efficiencies: $0.03 of every dollar. Medicare fully subsidizes enhanced benefits in other plan types (MedPAC 2009). At the extreme, Medicare pays a subsidy of $3.26 for each dollar of enhanced benefits a member receives in a PFFS plan.

Distribution of spending and benchmarks

As discussed, a county's benchmark can be well above its FFS spending. Figure 7-1 shows two data series: Light bars show the percent of beneficiaries by FFS spending in their county of residence and dark bars indicate the percent of MA enrollees by the MA benchmarks in their county of residence. More than 60 percent of beneficiaries live in counties with monthly FFS payments per capita less than $741, and only 2 percent of beneficiaries live in counties with monthly FFS payments exceeding $900. By contrast, no MA enrollees live in an area with a benchmark below $741 because that is the lower floor value (applicable almost exclusively in rural counties). (Puerto Rico is not included in this figure because its benchmarks have a different floor rate prescribed by statute.) The large urban floor is $819 a month. About 15 percent of MA enrollees

FIGURE 7–1

Over 60 percent of beneficiaries live in counties with FFS spending below the lower floor
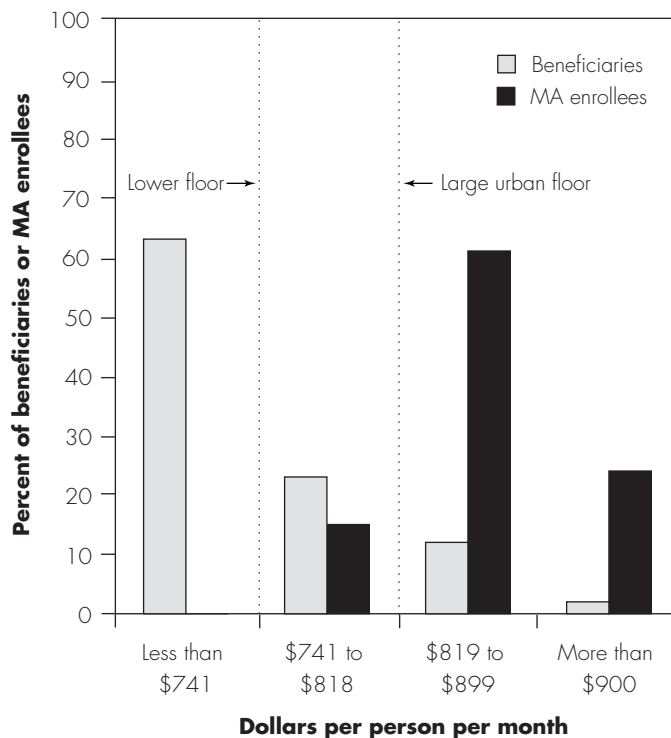
Note: FFS (fee-for-service), MA (Medicare Advantage). For beneficiaries, dollars per person per month is FFS spending in their county of residence; for MA enrollees, it is benchmarks for their county of residence.

Source: MedPAC analysis of CMS enrollment and payment data.

live in areas with benchmarks between these two floors. Most MA enrollees (about 60 percent) live in areas with benchmarks at or above the large urban floor and below $900 a month. Almost 25 percent of MA enrollees live in areas with benchmarks higher than $900 a month. This disparity in the distributions is reflected in the disparity in payments per beneficiary between FFS and MA.

Relation of bids and FFS spending

The ratio of plan bids to FFS spending in their payment area decreases as FFS spending increases (Figure 7-2, p. 174). For areas with FFS spending below $742 a month, the median bid to provide the Part A and Part B benefit is greater than FFS spending (the ratio is greater than 1.00). For example, in areas with average per capita FFS spending less than $675 per month, the median bid was 1.10 times FFS spending. More than 30 percent of

FIGURE
7–2

Ratio of bids to FFS spending decreases as level of FFS spending increases

Average monthly per capita FFS spending
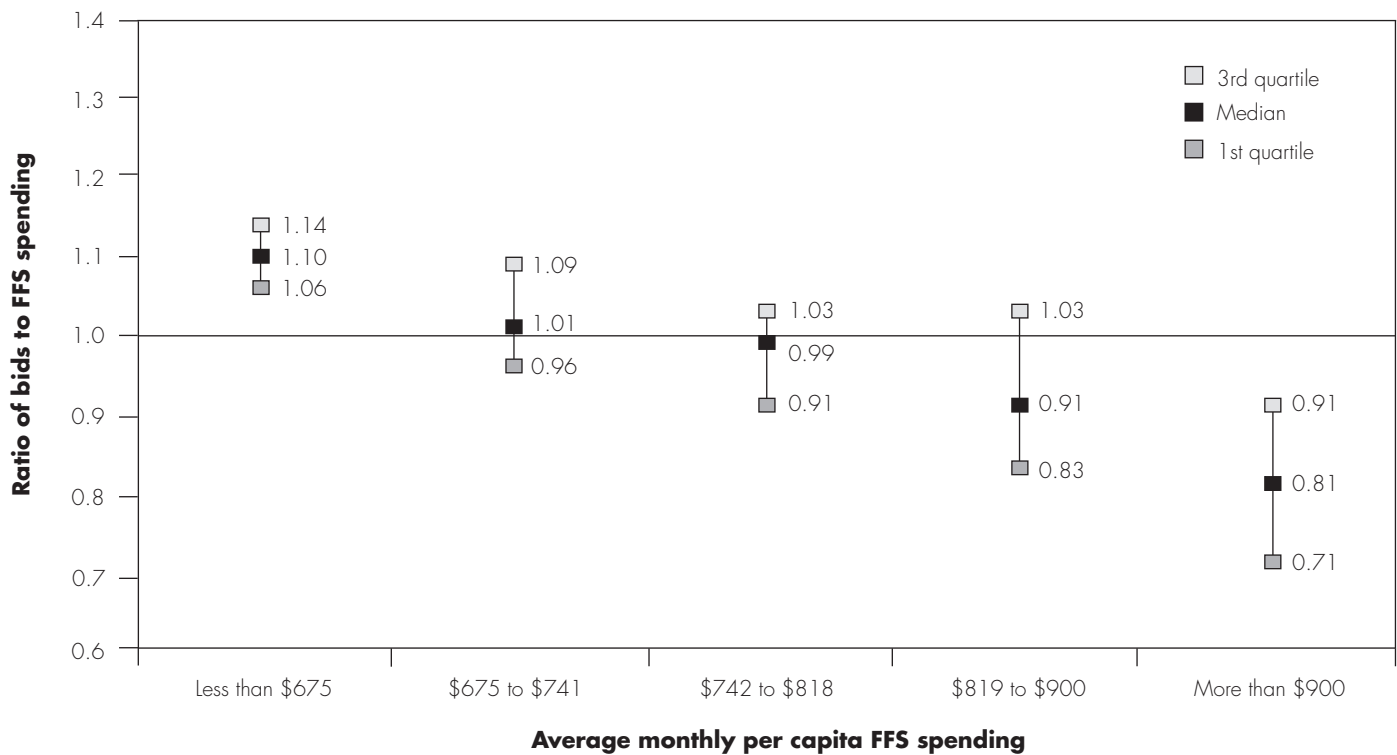
Note: FFS (fee-for-service).

Source: MedPAC analysis of CMS bid data.

beneficiaries live in those areas. Another 30 percent of beneficiaries live in areas with FFS spending between $675 and $741 a month. The median bid in those areas is 1.01 times FFS spending (but 25 percent of plans bid at or below 96 percent of FFS spending). In higher spending areas, with FFS spending at or above $742, median bids are lower than FFS spending. For example, in areas with FFS spending above $900, the median bid was 81 percent of FFS spending. However, only 3 percent of beneficiaries live in those areas. If benchmarks were set equal to median bids, most beneficiaries would live in areas with benchmarks above FFS spending. Conversely, if benchmarks were set to FFS spending, many beneficiaries would live in areas with no bids below the benchmark.

Plan quality

The CMS star rating system is based on plan performance on a combination of quality measures, including Healthcare Effectiveness Data and Information Set® (HEDIS®) (process and outcomes data that plans report to

CMS), Consumer Assessment of Healthcare Providers and Systems® (CAHPS®) (survey-based measures of enrollee perceptions of care), and Health Outcomes Survey (HOS) data (survey-based information on perceived improvement or deterioration in health over time and certain measures of the types of care received), as well as other data on quality and member satisfaction that CMS tracks. CMS uses a five-point scale for its star ratings.[10]

Looking at the current landscape of CMS star ratings among local HMOs and PPOs, we see that some plans perform much better than others and many plans have room for improvement in their quality measures (Figure 7-3). The highest star rating of any plan for overall quality is 4.5, and the lowest is 1.5—with many plans not yet rated. (In this section, we use the term "plan" to mean the Medicare contracting entity because CMS determines plan ratings at the contract level, rather than at the level of the individual plan.) The average plan score for overall health plan quality is 3.0 for the 272 local HMO or PPO plans

FIGURE
7–3

**Some plans have high quality ratings, but many plans
have lower ratings that could be improved**
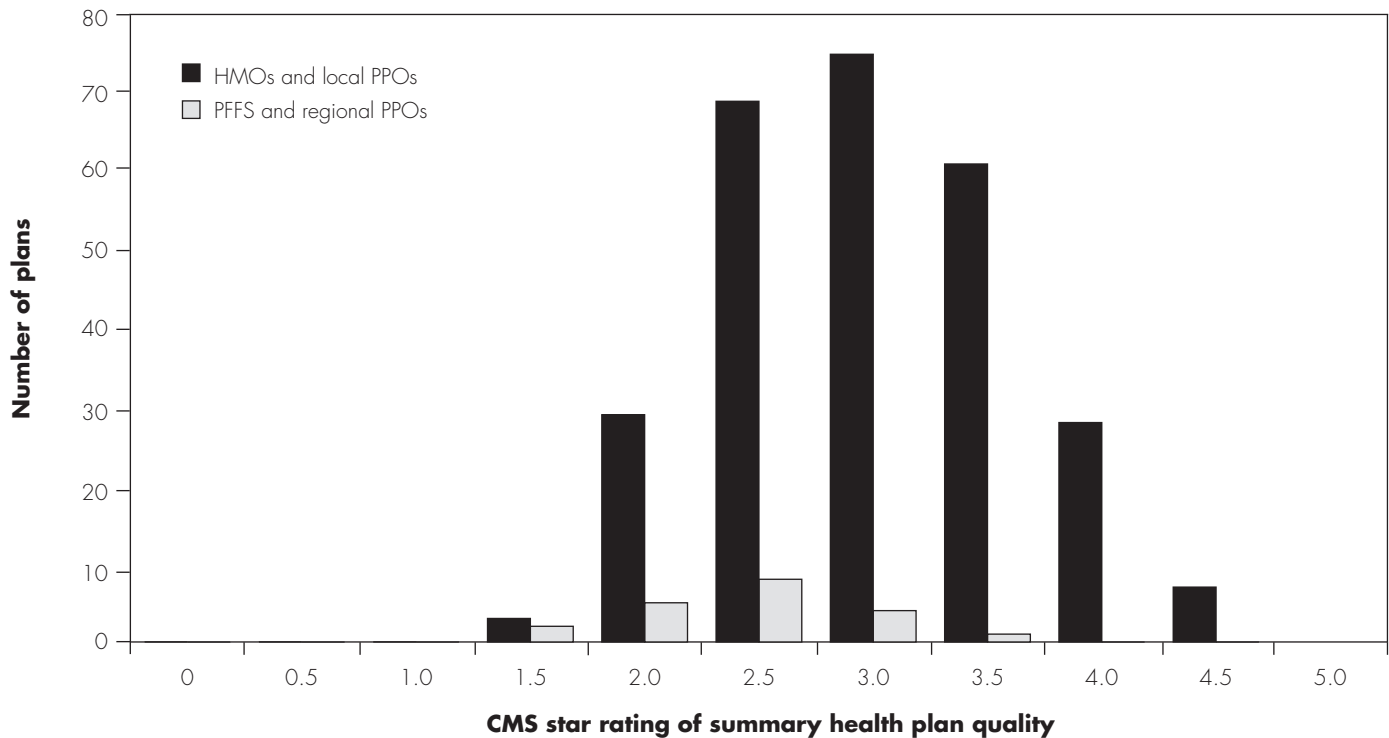
Note: PPO (preferred provider organization), PFFS (private fee-for-service). There are no plans rated below 1.5 or above 4.5. The average plan rating for HMOs and
         local PPOs is 3.0. The averages for PFFS and regional PPOs are, respectively, 2.3 and 2.6.

Source: MedPAC analysis of CMS plan rating data.

with ratings.[11] These 272 plans include 96 percent of the enrollees in HMOs and local PPOs as of March 2008 and 67 percent of overall MA enrollment.[12] Of the 272 plans, 96 (about one-third) have an above-average star rating of 3.5 or higher; 100 plans have a star rating below average (2.5 or lower). Forty-one percent of HMO or local PPO enrollment is in plans that have an above-average star rating of 3.5 or higher. By contrast, the highest star rating among the regional PPOs with ratings is 3.0, and the average is 2.6. Eleven PFFS plans have ratings averaging 2.3, with the highest rating at 3.5 for a plan in Minnesota.

We explored the relationship between plan quality and plan bids and between plan quality and rebates (75 percent of the difference between the benchmarks and a plan bid). In neither case did we find any consistent correlation, indicating an absence of a relationship between quality rankings, on the one hand, and plan payments and extra benefits on the other. A possible explanation for this result is that quality for plans that have broad networks is related

more to the general quality of providers in the area than to specifics of MA payment.

Calculating MA payment rates: Are county-level estimates of per capita spending accurate?

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) mandate asks the Commission to examine "the accuracy and completeness of county-level estimates of per capita spending under … original Medicare." These county-level estimates are the adjusted average per capita costs (AAPCCs)—estimates of each county's FFS spending—adjusted for the risk status of beneficiaries and to exclude direct graduate medical education payments.[13]

Accuracy of the calculation of the AAPCC (the county-level estimate) is important in two ways. First, for every

Process for calculating projected county fee-for-service rates

The first component of the calculation of projected county fee-for-service (FFS) rates is the development of projected national expenditures—the United States per capita cost (USPCC) projections. Six separate USPCC rates are determined: Part A rates and Part B rates for the disabled, the aged, and beneficiaries with end-stage renal disease (ESRD).

The expenditure data used to develop the USPCCs include 100 percent of Medicare's claims costs and administrative costs in each past year for FFS enrollees and MA enrollees. Because the USPCCs are a projection for a coming year based partly on previous years' projections, the statute requires CMS to adjust a forthcoming year's estimate of the rate of growth in expenditures to reflect the preceding years' over- or underestimates of the USPCCs (for years after 2004). That is, the rate of growth between the current (prospective) rate year and the preceding years compares the USPCC for the rate year in question with

the most recent, updated estimates of the USPCC for the preceding years and incorporates an adjustment when earlier years' USPCC estimates are revised. Each yearly rate announcement that CMS publishes includes information about revised USPCCs (prospective versus retrospective) and the effect of any over- or underestimate on the forthcoming year's rates.

To arrive at each county's projected FFS expenditures (the adjusted average per capita cost, or AAPCC), CMS develops an average geographic adjustment (AGA) for each of the USPCCs for each county. For ESRD beneficiaries, the geographic adjustment is statewide because of the small number of beneficiaries involved.

The AGA is the historical relationship (ratio) between a county's past expenditures and the national level of actual past expenditures. The ratio of local-to-national expenditures used for geographic adjustment is a five-year rolling average—meaning that CMS uses the most recent five years for which county-level expenditure

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rebasing year, the newly calculated AAPCC and the minimum update payment rate are compared, and the higher of the two rates becomes the county benchmark. Second, if, as a result of this comparison, a county's rate is the AAPCC, then it is important that the AAPCC reflect the projected FFS costs in the county as accurately as possible.

Although the MIPPA mandate requires the Commission to assess the accuracy of the county-level estimates of per capita spending, accuracy of the national-level calculation of expenditures (the United States per capita cost, or USPCC) is also important because it too affects payments for all MA payment areas. The national estimates are:

• the basis of the national per capita MA growth percentage—which for most counties determines a given year's benchmark, and

• a component of the calculation of the county-level estimates.

Computation of the USPCCs and the AAPCCs is described in the text box.

In assessing the accuracy of the AAPCC calculations, we looked specifically at three issues, as mandated:

• administrative expenses,

• expenditures for Medicare beneficiaries receiving care through facilities of the Department of Veterans Affairs (VA), and

• MA rates in Puerto Rico.

We also considered aspects of the MA payment methodology that might result in inaccurate MA payment rates.

We did not conduct a formal audit of the methodology CMS uses to calculate the USPCCs and AAPCCs. Our evaluation was based on discussions with staff of the Office of the Actuary of CMS, along with a review of the methodology the agency uses to determine the USPCC

data are available to determine the relationship between local (county) expenditures and national expenditures. This approach smooths out variations from year to year in the ratio of county-to-national expenditures.

FFS expenditures are assigned to the county of residence of the Medicare beneficiary. There is a lag period of three years in the inclusion of county expenditure data. That is, for 2009 projected rates, the five-year average is for the period 2002 to 2006. There is also a cutoff for including claims information for the county computations (unlike the USPCC computations, which have 100 percent of the expenditure data). Claims and cost settlements dating from more than six months after the end of the year are not included in the county data.

After the AGA factors are developed, the next step in the process is to remove Medicare expenditures associated with plan enrollees. Because the AAPCC is intended to be a projection of what program costs

would have been for an individual not enrolled in MA, MA expenditures (and expenditures for non-MA Medicare plans, such as cost-reimbursed HMO plans) are removed at the county level. Plan enrollees are also removed from the denominator to arrive at a new average per capita cost for FFS enrollees for each of the per capita rates (Part A aged, Part B aged, etc.), which is then multiplied by the AGA.

The resulting projected FFS per capita rates at the county level (or state level for ESRD) are then standardized for the risk status of the population of each county (or state). The variations in Medicare expenditures that are due to demographic (age, sex, institutional status, and Medicaid status) and health risk factors are established at the national level using the CMS–hierarchical condition category model. Each county's standardized rate is expressed as a monthly dollar amount for a beneficiary residing in the county with a nationally average risk profile (a person with a "risk score" of 1.0). ∎

and AAPCC amounts. We find that CMS's methods for developing projections of the USPCC and AAPCC are reliable and produce results that are as accurate as possible for projections, but we have concerns about two issues that affect specific counties or areas—the exclusion of costs associated with care provided in VA facilities and the calculation of AAPCCs for Puerto Rico. In addition, we find that the distortions in payments introduced by the so-called "ratchet effect" (p. 181) should be addressed.

Administrative costs

The MIPPA mandate asks the Commission to examine whether the county FFS estimates "include all appropriate administrative expenses, including claims processing." The concern, which the industry has raised in the past, is that if MA plans are replacing the FFS system for their enrollees, and the plans are expected to perform administrative functions that CMS would otherwise perform, the plans should be compensated appropriately for these functions. We believe the current method of determining the administrative costs to include in MA payment rates is appropriate.

Under the current methodology, CMS includes the administrative costs specified in the statutory definition of the AAPCC. The statute identifies the includable administrative costs as consisting solely of the costs of carrier and intermediary functions in FFS Medicare ("administrative costs incurred by organizations described in sections 1816 [intermediaries] and 1842 [carriers]," which are the Medicare administrative contractor (MAC) costs). Calculation of the MAC costs is a straightforward calculation of the ratio of cash administrative expenses to cash benefits, and therefore they accurately represent the administrative expenses referred to in the statute.

Some argue that including only MAC administrative costs in the AAPCC calculation shortchanges the plans. The plans assert that additional costs that CMS incurs in administering the FFS Medicare program should be included in plan payments if the intent is to have plans paid for costs that otherwise would have been incurred by CMS in administering the FFS program. However, the amount of administrative expenses over and above the MAC costs that can be attributed exclusively

to administration of the FFS program is negligible and, arguably, should not be included in the AAPCC calculation.

Using budget documents for the Department of Health and Human Services, we calculated that the CMS administrative costs attributable to the Medicare program are about $2.7 billion, with about $1.4 billion attributable to claims processing costs for FFS Medicare (i.e., MAC costs). The remaining administrative costs within CMS—about $1.3 billion—would make up less than 0.5 percent of total FFS spending of about $320 billion in 2009. Even if the entire $1.3 billion were attributable exclusively to CMS administrative functions in the Medicare FFS program that health plans also undertake, including all the additional CMS administrative costs would raise the USPCC (the basis for the AAPCC) by only about 0.4 percent, or $2.40 per month.

However, it is not appropriate to include the entire $1.3 billion in the USPCC calculation. The $1.3 billion represents costs of operations for the entire Medicare program, including Part A, Part B, Part C (MA), and Part D. CMS uses much of this funding for administrative functions for the Medicare program as a whole, such as preventing fraud and abuse. CMS retains these functions even for beneficiaries who have enrolled in MA plans.

In summary, the MAC costs of claims processing accrue solely to FFS and are included in the FFS spending estimates, while other administrative costs are spread across the Medicare program and thus are not added to the FFS estimates. We find this allocation of costs to be appropriate, and even if there were some additional costs that could be attributed solely to FFS, the amount would be negligible.

Adjustment for use of Department of Veterans Affairs facilities

The MIPPA mandate asks the Commission to examine whether the AAPCC calculation includes "expenditures with respect to Medicare beneficiaries at facilities of the Department of Veterans Affairs" (reflecting a provision of the current statute requiring inclusion of such expenditures). We have determined that this is a county-specific issue that does not have a material effect on rates in the aggregate but may affect the calculation of AAPCCs in some counties.

The concern is that in counties where many Medicare beneficiaries use VA facilities, projections of Medicare per capita costs to determine MA payments would be

incorrect. If Medicare beneficiaries receive Medicare-covered services at facilities that are not paid by Medicare and do not submit claims to Medicare, the projections of per capita spending for Medicare-covered services may be understated or overstated. If the VA is providing Medicare-covered services to individuals in lieu of care they would have received through providers billing Medicare, total Medicare program expenditures for them will be less than they would otherwise be. However, the absence of claims associated with Medicare-covered services could also lower the risk scores of beneficiaries using VA services, because risk scores use diagnosis information from claims. Whether underreporting of expenditures has a greater effect than undercalculation of risk scores would determine whether the result is an underpayment or an overpayment.

CMS is investigating the extent to which beneficiaries' use of VA facilities affects MA payments. The method that CMS uses to determine whether an adjustment is appropriate is to compare risk-adjusted Medicare reimbursements for the two populations—those with VA coverage and those without such coverage. If the VA coverage group has risk-adjusted Medicare reimbursements significantly different from what other Medicare beneficiaries receive, CMS will make the necessary adjustment by removing the VA coverage group when determining projected per capita FFS expenditures for purposes of MA payment. That is, if for the VA coverage group there is a significant mismatch between expenditures and risk scores—resulting in an understatement or an overstatement of expenditures for a person with average risk—then an adjustment is warranted. As CMS noted in its February 22, 2008, advance notice of possible methodologic changes for MA rates in 2009, an adjustment could result in higher or lower MA payments depending on the outcome of the CMS analysis (CMS 2008). The CMS approach is described in the text box (pp. 180–181).

CMS announced the results of its analysis of VA data in the announcement of MA payment rates for 2010 (CMS 2009a). CMS found that an adjustment to MA rates was not called for at this time, concluding that "the differences observed between [VA beneficiaries and the total population] … appear to be normal, random variations and not indicative of true underlying differences of the FFS costs between the two populations." In an earlier notice about a possible adjustment, CMS found that if a VA adjustment were warranted, about half the counties would receive an increase and half would receive a decrease,

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with most counties close to the overall average effect of a decrease of 56 cents per beneficiary per month and with "most of the values … tightly clustered about the mean" (CMS 2009b). CMS found that 54 counties would have an increase of more than $12.50 per beneficiary per month. However, CMS will not make adjustments even in those 54 counties because it has concluded that the expenditure differences reflect "random, normal" variations in FFS expenditures that are not attributable to the use of VA facilities.

CMS will continue to study the VA issue. CMS is also in the process of evaluating the effect of health care services received through the Department of Defense (DoD) as required by the statute. The addition of DoD data should help address the question of whether the effects are random rather than systematic differences. If counties have substantial, nonrandom differences when the VA and DoD data are analyzed, CMS should adjust the county rates.

MA rate calculations for Puerto Rico

The MIPPA mandate specifically mentions the rate calculation for Puerto Rico as a potential concern. The small proportion of FFS beneficiaries in Puerto Rico with Part B coverage could compromise the accuracy of both calculated AAPCCs and risk scores.[14] Because only one *municipio* (the equivalent of a county) with a very small population has its benchmark set at an AAPCC rate, the Commission concludes that these are primarily theoretical issues that will come into play in the calculation of MA rates only in future years.[15]

All MA enrollees must have both Part A and Part B coverage. Historically, however, comparatively few beneficiaries in Puerto Rico have opted to enroll in Part B due to the high cost of the Part B premium relative to the cost of medical care in Puerto Rico and the income of the population. As a result, it is common for MA plans in Puerto Rico to attract enrollees by buying down some, or all, of a person's Part B premium.[16] This type of enhanced benefit has attracted large numbers of beneficiaries in Puerto Rico to MA plans; as of 2009, 60 percent of the Medicare population is enrolled in MA.

Of the remaining Medicare beneficiaries in FFS in Puerto Rico, only a small share—30 percent in 2007, compared with a national average of 97 percent—have Part B coverage. Part B AAPCCs calculated on such a small population may be extremely volatile, with large changes from year to year. In addition, there may be an issue for Part A estimates, because expenditures under

Part A are likely to be different for individuals who have only Part A coverage compared with those who have both Part A and Part B. The risk scores of individual Medicare beneficiaries in Puerto Rico could be affected as well. If beneficiaries do not have Part B coverage, there are no physician claims that can be used (together with hospital claims) as a source of diagnosis codes for establishing an individual's risk score. Risk scores for such a population could be systematically understated compared with a population in which nearly all beneficiaries have Part B coverage. That understatement of risk could affect the geographic adjustment component of the AAPCC.

Currently, only one *municipio* with a very small population has its benchmark set at an AAPCC rate that would be affected by these issues. All other *municipios* are paid at the statutory floor rate for Puerto Rico, which is now about 180 percent of local FFS. Thus, these issues will come into play only in the calculation of future rates. Should an adjustment be necessary in the future, the statute provides CMS with relatively broad authority to use actuarial methods to address situations in which the usual method of determining the AAPCC would yield an anomalous or potentially inaccurate result. In the case of Puerto Rico, CMS should expeditiously use its authority to employ an alternative calculation method to determine AAPCC rates if CMS finds that the current calculations are anomalous or potentially inaccurate, though we recognize that an alternative calculation may be difficult with the currently available data.

The usual AAPCC methodology relies on actual claims experience over five years in a given county to determine the geographic adjuster, along with adjustments to normalize the population for purposes of risk adjustment.[17] If an alternative is necessary for Puerto Rico, a difficult analytic problem would arise. CMS might have to base the rates on an examination of use and spending patterns among a similar set of beneficiaries. It is unlikely, however, that there is a geographic area with a similar distribution of beneficiaries who do not have Part B coverage. Therefore, national-level data may have to be used to determine how the absence of Part B coverage affects Part A expenditures. CMS would also have to be able to adjust for the demographic characteristics of the Puerto Rico population. Given that most Medicare beneficiaries in Puerto Rico are in MA plans, CMS might need to require Puerto Rico MA plans to submit expenditure and utilization data to help CMS accurately estimate county-level FFS expenditures for Puerto Rico.

CMS approach to adjustment for use of Department of Veterans Affairs facilities

CMS's approach to determine whether an adjustment for use of Department of Veterans Affairs (VA) facilities is warranted is illustrated in Table 7-2, using a simplified example of two beneficiaries with different risk scores and illustrating how a payment level is computed for a person of average (1.0) risk. Scenario 1 illustrates how per capita costs for a person of average risk are determined based on the expenditures of two individuals with different risk scores and different levels of expenditures

associated with those risk scores. In Scenario 1, there is no VA involvement, and the computation is a straightforward computation that "normalizes" (to a 1.0 level) the expenditures of the healthier person who has a risk score of less than 1.0 and then averages the expenditures for the two individuals.

Scenario 2 shows what happens when fee-for-service (FFS) claims data produce an accurate risk score for a person, but the use of VA services reduces FFS

TABLE 7–2	Comparing risk-adjusted expenditures to evaluate the need for a VA adjustment to MA rates			
	Beneficiary total Medicare expenditures	Beneficiary risk score	Risk-adjusted expenditures (total expenditures divided by risk score)	Is VA adjustment necessary?
Scenario 1: No VA involvement; computation of per capita expenditures for a person with average risk				
Beneficiary A	$10,000	1.0	$10,000	
Beneficiary B	8,000	0.8	10,000	
Total risk-adjusted expenditures			20,000	
FFS expenditures per person for a person of average risk			10,000	
Scenario 2: VA involvement; missing expenditures but correct beneficiary risk scores; material effect				
Beneficiary A, with no VA involvement	10,000	1.0	10,000	Yes,
Beneficiary B, receiving $1,000 in services at VA	7,000	0.8	8,750	otherwise
Total risk-adjusted expenditures			18,750	plans
FFS expenditures per person for a person of average risk, unadjusted			9,375	underpaid
Scenario 3: VA involvement; missing expenditures also resulting in lower risk score; no effect				
Beneficiary A, with no VA involvement	10,000	1.0	10,000	No
Beneficiary B, receiving $1,000 in services at VA	7,000	0.7	10,000	
Total risk-adjusted expenditures			20,000	
FFS expenditures per person for a person of average risk			10,000	
Scenario 4: VA involvement; missing expenditures also resulting in lower risk score; material effect				
Beneficiary A, with no VA involvement	10,000	1.0	10,000	Yes,
Beneficiary B, receiving $1,000 in services at VA	7,000	0.6	11,667	otherwise
Total risk-adjusted expenditures			21,667	plans
FFS expenditures per person for a person of average risk, unadjusted			10,833	overpaid

Note: VA (Department of Veterans Affairs), MA (Medicare Advantage), FFS (fee-for-service). A person with average risk has a risk score of 1.0.

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expenditures. In such a case, average expenditures for a person with a risk score of 1.0 are understated and an adjustment would be warranted. Removing the VA population from the calculation—as CMS proposes—would give the accurate expected level of expenditures for Medicare-covered services for a beneficiary with a risk score of 1.0 ($10,000), based on the per capita expenditures of the one remaining person in this scenario.

Scenario 3 is the case in which there is VA involvement but no adjustment is necessary because, at the same time that Medicare FFS expenditures for a VA user are declining, the person's risk score is also declining in a parallel manner (i.e., the risk score accurately represents the level of expected Medicare FFS expenditures). Scenario 3 is analogous to the first scenario of the table—the claims data and risk scores of FFS for the two beneficiaries accurately determine the expected FFS costs of a beneficiary with a risk score of 1.0.

Scenario 4 shows the case in which the absence of diagnostic data from VA services results in a lower risk score, but FFS expenditures are relatively higher than the risk score would indicate. In that case, removing the VA population from the calculation would produce an accurate estimate of FFS expenditures for a person with a risk score of 1.0 ($10,000), while failing to remove the VA population would overestimate average expenditures as $10,833 for a person with a risk score of 1.0.

The CMS approach also addresses the issue of the pattern of use of VA services by VA eligibles when they enroll in Medicare Advantage (MA). If, for example, the VA-eligible person continued to use the same level of VA services as before MA enrollment, the person's risk score—which is now determined by claims and services within the MA plan—would be the same as the person would have had in FFS Medicare. If the person stops using VA services, the person's risk score would match that of an individual with no VA coverage. ∎

The "ratchet" effect in MA benchmarks

One reason that MA benchmarks are higher than FFS spending in some counties has to do with the rebasing provision of the law and the frequency of rebasing—causing an effect known as the "ratchet." (MA benchmarks are also high in relation to FFS because of various statutory provisions, such as the introduction of payment floors.) The ratchet results in persistently high benchmarks in a county even as FFS spending there decreases. Consequently, payments to MA plans will be higher than warranted by the underlying FFS spending.

In most years, a county's benchmark is established by adjusting the preceding year's benchmark by the national rate of growth in Medicare expenditures. In a rebasing year, CMS compares this adjusted benchmark with the projected FFS rate for each county (the AAPCC). The higher of the two becomes the benchmark for the rebasing year. Benchmarks are rebased to the FFS level only when a county's projected per capita FFS expenditures are growing. In counties where projected per capita FFS expenditures have declined, the benchmark remains at

the previous year's higher rate, adjusted by the national growth rate. Thus, the county's benchmark will be above its current FFS rate as a result of this one-sided approach to rebasing payment rates to equal FFS only if the rebasing yields a higher rate for the county.

This ratchet effect is illustrated by the case of West Baton Rouge Parish in Louisiana (Table 7-3, p. 182). The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 introduced the rebasing concept as of March of 2004. The 2004 rate for West Baton Rouge was set at $813, the estimated FFS rate for the parish for 2004. Since then, FFS expenditures in the parish have not increased appreciably. As a result, in each subsequent rebasing year, West Baton Rouge's benchmark has been set at the preceding year's rate, adjusted for the national rate of growth in Medicare expenditures, because that adjusted rate is higher than the projected FFS rate in the parish. Because of the ratchet effect of continuing minimum updates to the West Baton Rouge MA benchmark, by 2009 the difference between the MA benchmark and estimated FFS expenditures widened to

TABLE
7–3

Example of ratchet effect: West Baton Rouge Parish, Louisiana, has MA benchmarks that are now 54 percent over local FFS

	2004	2005	2008	2009
County FFS estimate	$813	$690	Not rebasing year	$727
MA benchmark rate	$813	$866	$1,075	$1,122
Rate basis	FFS	Minimum update	Minimum update	Minimum update
Percent by which benchmark exceeds FFS	0%	25%	Unknown	54%

Note: MA (Medicare Advantage), FFS (fee-for-service). MA benchmark shown is before budget-neutrality adjustment that raises benchmark. Percent benchmark over FFS does not include effect of budget-neutrality adjustment or duplicate indirect medical education payments, which would raise the percent by which the benchmark exceeds FFS.

Source: MedPAC analysis of Medicare Advantage benchmark rates.

the point where the benchmark is now 54 percent higher than estimated FFS expenditures for the parish.

Overall, in 2009, 818 counties (representing 3.8 million MA enrollees) had benchmarks higher than warranted by their FFS spending, due to the ratchet effect. On average, benchmarks exceeded FFS spending in those counties by 15 percent. The Congressional Budget Office (CBO) has estimated that if all counties that had benchmarks set at FFS rates in a rebasing year had their rates set at FFS in all following years, the resulting savings would be $21 billion over five years (2010–2014), or $61 billion over 10 years (2010–2019) (CBO 2008).

This effect, and the past effect of the ratchet provision, could be remedied by doing two things. First, rates would need to be rebased every year.[18] For counties with benchmarks newly set at projected FFS rates in a given year, this action avoids the situation of a benchmark exceeding FFS rates in later years because of minimum updates. Second, for each county that in the past had its payment rate set at FFS, the basis of payment would need to be reset at the current county FFS rate. Then, only counties with rates above FFS because they were historically floor counties—rather than because of the ratchet effect—would continue to have rates above FFS. Alternatively, the past effects of the ratchet and anticipated future effects (i.e., volatility in rates between years because of volatility in projected FFS expenditures between years) can be remedied in part by limiting both increases and decreases in rates from year to year when rebasing is an issue. For example, increases or decreases in rates could be limited to 5 percent each year. If a county that had its MA benchmark set at FFS in one year had an

increase of 7 percent over the preceding year, that increase would be limited to 5 percent in the first year, followed by a 2 percent increase, and similarly for counties facing reductions. Another alternative to dampen the effect of a large decline from one year to another is to not apply the minimum update when FFS spending declines in a county. This action would leave the county's benchmark at the previous year's level (CBO 2008).

If more comprehensive changes are made to the MA payment system, such as larger payment areas or other options we discuss in later sections of the chapter, the ratchet issue may diminish in importance or even cease to exist. Until that time, the distortions that the ratchet effect introduces should be addressed.

Correlation analysis

The Congress asked us to study the correlation between plan costs to deliver Medicare Part A and Part B benefits and the Medicare program's expected spending in FFS Medicare. The mandate asks us to use the plan bids as the measurement of plan costs and CMS estimates of per capita county-level spending as the measurement of FFS Medicare spending.

Plan costs and FFS spending

Each year, plans submit bids to offer Part A and Part B coverage to Medicare beneficiaries within a service area. A plan defines its own service area as one or more counties where it chooses to offer coverage (the exception is regional plans, which must serve entire CMS-defined

regions). The bid is the plan's estimate of its cost to cover an average beneficiary's (average with respect to health risk) Part A and Part B benefit and includes plan administrative cost and margins. Included in the plan's bid submission are the expected enrollments from each county in the service area as well as the expected health risk scores in each county. The bids do not include separate bids for each county within a service area.

Bids are made in response to county-level benchmarks computed by CMS. The benchmarks are bidding targets for the Part A and Part B benefits. CMS publishes estimates of expected county-level Medicare FFS spending periodically to help set the MA benchmarks. As with the bids, the CMS estimates are standardized to represent the spending of an average beneficiary with respect to health risk.

While the MIPPA mandate (text box, p. 203) asks us to examine how the bids in a county are correlated with FFS spending in the county, the data do not allow us to do that in a straightforward manner. As we stated above, plans do not submit bids for counties, they submit bids for multicounty service areas. The bids, however, do contain county-level estimates of enrollment and the average risk of that enrollment. Therefore, we took the plans' enrollment and risk assumptions and estimated the FFS spending that would be expected for a population with the same health status located proportionately in the same counties for which the plan submitted its bid. In that way, we can measure the correlation between the plan bid and the expected FFS spending for the enrollee population in its service area.

Bids and spending are highly correlated

We find a strong correlation between plan bids for 2009 and expected FFS spending.[19] Overall, the correlation was 0.88, which means that plans serving areas with high FFS spending were very likely to have high bids, and plans serving areas with low FFS spending were very likely to have low bids. It does not mean that plan bids equal FFS spending. For example, if plan bids were exactly twice FFS spending in all counties, they would still be perfectly correlated.

We calculated the correlations separately for four plan types (HMOs, local PPOs, regional PPOs, and PFFS plans) and found a high correlation within each (Table 7-4). HMOs had a correlation of 0.89, PFFS had a correlation of 0.93, and the correlation for PPOs was even higher. The correlations were higher for plan types that tend not to have relatively tight networks of providers (all

TABLE 7–4	Strong correlation between MA plan bids and FFS spending		
Plan type	**All areas**	**Urban areas**	**Rural areas**
All MA plans	0.88	0.85	0.91
HMO	0.89	0.86	0.94
Local PPOs	0.94	0.92	N/A
Regional PPOs	0.95	N/A	N/A
PFFS	0.93	0.92	N/A

Note: MA (Medicare Advantage), FFS (fee-for-service), PPO (preferred provider organization), PFFS (private fee-for-service), N/A (not available). Correlations near 1.0 show high correlation and correlations near zero show low correlation. Data are noted as N/A if insufficient data are available to determine correlation.

Source: MedPAC analysis of plan bid data from CMS.

but HMOs), which means that the bids of plans that are more likely to pay providers based on Medicare rates are more closely correlated to the level of FFS spending in their service areas.

Although our mandate asks us to look at differences by geographic area, we are limited because we do not have county-level bids. However, we were able to explore differences between urban and rural plans. We selected a group of 1,500 plans that drew their entire enrollment from urban counties and designated them as urban plans. Rural-only plans were rarer, but we found 125 plans that expect to receive 90 percent or more of their enrollment from rural counties. We designated these 125 plans as rural plans.

We found a high correlation of plan bids and FFS spending within both urban and rural areas; however, the correlation was somewhat stronger in rural areas (0.91) than in urban areas (0.85). As with the plan type differences, this finding suggests that plans that are more likely to have to pay providers based on FFS Medicare rates (rural plans) are more likely to have bids that are highly correlated with FFS spending.

Although bids and FFS spending are highly correlated, as shown in Figure 7-2 (p. 174), the ratio of plan bids to FFS spending is much higher in areas with low levels of FFS spending than in areas with high FFS spending. For example, as noted previously the median bid for areas with FFS spending below $675 per person per month is 110 percent of the FFS spending level, but in areas with FFS spending above $900 per person per month,

the median bid is only 81 percent of FFS spending. This situation illustrates how certain plans in certain areas (such as HMOs in high-use areas) can use mechanisms to bring down the level of utilization and costs, but such mechanisms may not be available in lower cost areas (e.g., plans may have limited negotiating ability vis-à-vis providers, and the FFS system in certain areas may be relatively efficient).

Alternative approaches to MA payment

The Congress asked the Commission to examine approaches to MA payment other than "county-level payment area equivalents." We previously recommended payment areas larger than the county level, as we discuss in the appendix to this chapter. In this section, we examine other approaches for setting payment benchmarks for the MA program.

The Commission supports private plans in the Medicare program and the innovative delivery systems and care management techniques they potentially can bring to beneficiaries. But plans will be encouraged to innovate only if payment rates are set correctly. Paying too much is unfair to taxpayers and other beneficiaries and can result in plans that bring no innovation but simply mimic FFS Medicare at a much higher cost to the program. It now costs the Medicare program more for beneficiaries in MA than it would if the same beneficiaries were in traditional FFS. CBO estimates this additional cost over 10 years at more than $150 billion. Setting payment levels that are financially neutral to FFS Medicare could save that $150 billion, while creating incentives for private plans to innovate and prove themselves in the marketplace and still providing beneficiaries with a desirable alternative to the traditional FFS program.

The Commission has maintained that 100 percent of FFS is the correct target for benchmarks because it would encourage plans that are more efficient than Medicare FFS. An MA plan that is more efficient than Medicare FFS could provide the traditional benefit at a lower cost and would be able to provide additional benefits to beneficiaries, who would be encouraged to enroll in the plan. An MA plan that is not more efficient than FFS Medicare would likely not enter the program.

Therefore, we have created and analyzed a number of options the Congress might consider for setting MA payment benchmarks. All these options are financially neutral to FFS Medicare in the aggregate—any one of them would cost the program the same as traditional Medicare in the first year, saving $12 billion. However, the savings over 10 years may vary for some of the options from the $150 billion CBO estimated for the 100 percent of FFS option, because all the options are based on the presumption of lower MA program spending; consequently, they all will result in fewer plans being available in some payment areas and in reduced extra benefits. We show those results for each option. We also show the availability of plans of particular value to beneficiaries: those that can provide care coordination and innovative delivery systems and those that demonstrate high quality.

Options for setting benchmark rates

There are two broad alternatives for setting benchmarks in the MA program: using competitive bidding to set the rates or setting the rates administratively. The current system uses administratively set rates.

Setting benchmarks through competitive bids

Using competitive bids from MA plans to set the benchmarks in an area is a potentially attractive concept. The theoretical argument for setting benchmarks through bids is that a competitive market would provide the best price information, and getting bids on a set benefit package (such as the Medicare Part A and Part B benefit) is as close as we can come to a competitive market. We present the fundamental decisions that would have to be made when designing a competitive bidding system and outline some possible behavioral responses. We also review a previous demonstration of bidding for private plans (see text box, pp. 186–187).

However, there is a practical problem for quantitative simulation of a competitive bidding option: Plans do not make county-level bids; they make one bid for an entire service area, which usually includes multiple counties. If bids determine benchmarks, plans will face pressure to vary their bidding by county across a service area. The current bidding data thus will not be a good proxy for their resulting bids. (The existing bids can be useful as a proxy for bids under different options for setting administrative benchmarks because the benchmarks would not be changed by plan bids, and no disaggregation by county level is necessary to simulate the results of options.) For this technical reason, and because the results of the simulations would be very sensitive to the assumptions made, we do not present a quantitative analysis of setting benchmarks through competitive bidding.

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Basic design features of competitive bidding A specific bid design would have to decide about features such as:

- What would be the minimum number of plans required for a competitive bidding system to work?

- Should there be an upper limit on benchmarks?

- If the benchmark is based on bids, what point in the distribution would determine the new benchmark—the lowest bid, the median bid, the second highest bid?

- How would quality enter into the bidding process?

- Should Medicare FFS "bid" alongside MA plans?[20]

We explore certain of these design decisions below.

Number of competitors. Competitive bidding requires multiple competitors to participate in the bidding process. With an average of 34 plans in a county, the MA program would probably have no dearth of bidders. However, the number of insurers in an area is often significantly fewer than the number of plans because a single insurer may offer multiple plans. For example, Cook County, Illinois (Chicago), has 30 MA plans available to beneficiaries there, but only 6 insurance companies offer these 30 products, and 1 of those companies offers only PFFS products. Thus, under a competitive bidding model involving only coordinated care plans, Chicago would have 5 organizations submitting bids, not 30.

If only one Medicare health plan were to bid in an area, there would be no competition to establish a benchmark. Several options are possible under this circumstance: (1) An administered pricing system could set the benchmark (e.g., using 100 percent of local FFS or one of the other options we discuss later). (2) The single plan's bid could be the benchmark for the area (which could exceed 100 percent of FFS if the benchmark amount is not capped). (3) Medicare would not have any private plans in the area because of the lack of a sufficient number of competitors to establish a benchmark. The rule for what to do when only one plan bids would have to be specified in advance of bidding.

Upper limit on benchmarks. Competitive bidding might attract plans to certain areas if a pure competitive bidding approach were used and there were no upper limit on the benchmarks. For example, as shown in Figure 7-2 (p. 174), in areas with FFS spending below $675 a month, median plan bids exceed FFS Medicare expenditures by 10 percent. Whether there should be an upper limit

on benchmarks is a design feature policymakers would have to consider. If benchmarks are allowed to be well above FFS Medicare, two questions arise: What product is Medicare buying with the additional expenditures, and is the product worth the cost difference? Related to this question is whether savings achieved through competitive bidding in one area (because expenditures are brought below FFS rates) should be used to finance a competitive bidding approach in areas where the bid-based benchmarks would exceed FFS.

Choosing what point in the distribution to set the benchmark. Deciding how bids are used to set the benchmark has implications for the availability of enhanced benefits. If the low bid for the Medicare Part A and Part B benefit is set as the benchmark, no enhanced benefits are financed by the government contribution to the premium. The plan with the lowest bid offers the Medicare Part A and Part B benefit package at no premium. All other plans charge a premium for the package, and all plans, including the one with the lowest bid, charge an additional premium for enhanced benefits.

If the benchmark is the median bid, weighted average, or otherwise set at some higher point, then the difference between the benchmark and the bid can be used to finance extra benefits (as is the case now). Another alternative for ensuring the provision of enhanced benefits is to set the benchmark at the lowest bid but have plans bid on an enriched benefit package beyond the Medicare Part A and Part B package.

Quality as a factor in payment. The competitive bidding model, like the administered pricing options, can include quality as a factor in plan payments. For example, once a benchmark is established based on the bids of competing plans, higher quality plans can receive add-on payments that reward those plans with demonstrably higher quality.

Long-run issue Some have raised concerns about the long-term effect of competitive bidding. They worry that, after several rounds of competition, extra benefits would erode, leading to lower enrollment in plans and less interest among plans in participating in the program.

In each round of bidding, the plan with the lowest bid in relation to the benchmark will have the highest level of extra benefits. It is therefore in a plan's interest to bid as low as possible. However, low bids bring down the benchmark for all plans, resulting in less money to finance enhanced benefits, which are funded by the difference between the bid and the benchmark. Over

Lessons learned from previous demonstrations of competitive bidding for Part C

In previous demonstrations of competitive bidding in Part C, certain themes became evident:

• Stakeholders were united in opposing the demonstrations.

• Plans wanted to have benchmarks set in advance.

• Plans resisted being judged on the level of their premiums rather than on the benefits they offered.

• Plans objected to third-party marketing.

• Some thought Medicare fee-for-service (FFS) should be included as a plan for bidding purposes.

In 1996, the Health Care Financing Administration (HCFA, now CMS) began developing a demonstration of competitive pricing. Baltimore was selected as the site for the demonstration because of the large number of available plans, the small number of beneficiaries enrolled in the plans at the time, and the relatively high adjusted average per capita cost rates that allowed plans to offer a substantial level of enhanced benefits. The latter feature of the Baltimore market was important because the demonstration had to be budget neutral, and no additional Medicare dollars could be used to finance extra benefits that would attract enrollment.

The design of the bidding process called for plans to bid on a standard benefit package that HCFA specified. On receiving the bids, HCFA would determine the level of the government contribution, and plans with bids above that level would charge a premium. HCFA did not specify the level of the government contribution in advance but stated that it would not be set at the lowest bid for the standard benefit package. Marketing and enrollment would be through a third party, not through the health plans.

The demonstration ended before implementation because of unified opposition from stakeholders. The industry objected to certain design features, including not knowing the government contribution in advance, using member premiums as the basis for distinguishing among bidding plans in the market, and using a third party for marketing and enrollment. Dowd and colleagues state that "plans repeatedly asked HCFA to forgo the competitive bidding process and simply to announce an administrative price that achieved whatever cut in payments the agency sought. HCFA rejected this approach as just another variant of administrative pricing, which would not produce information on the efficient price of the standard benefit package" (Dowd et al. 2000).

HCFA then chose Denver as the demonstration site. The Denver market was similar to Baltimore in the number of plans, enrollees, and benefits offered. One design feature was changed: Plans that had to charge premiums when their bids exceeded the government contribution were allowed to waive all or some of the

(continued next page)

the years, as plans seek to be the lowest bidder, only the lowest bidding plans remain viable, and they could be bidding at extremely low levels. As the difference in the financial benefit of being in MA versus FFS narrows, more beneficiaries may decide to remain in the FFS option. This decision has a consequence for the Medicare program if a decline in MA enrollment occurs in areas where FFS is the more expensive option. In such areas, competitive bidding will have resulted in increased program expenditures because the bidding process has brought MA benchmarks to levels that do not permit plans to offer a rich benefit package.

This scenario may not transpire. Plan bidding behavior may result in an equilibrium for a given area, with most plan bids clustering around a level where they can do a good job of providing the Part A and Part B benefit. They may also be able to provide supplemental coverage for less than medigap because they have better control over service use. Beneficiaries may want to enroll in plans because of the less expensive supplemental coverage or because plans have brand recognition for better quality or other features beneficiaries find attractive, such as the ability to obtain the full range of Medicare coverage (Part A and Part B as well as Part D drug coverage) through one entity. In some market areas, beneficiaries have been willing to pay

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premium if they also accepted a payment reduction equal to the waived amount. Plans opposed the Denver demonstration for the same reasons as in Baltimore, with the added concern that FFS Medicare was not being considered a bidding plan. As they did in Baltimore, plans also asked HCFA to set administered pricing rates if the goal was to reduce plan payments. Some of the Denver HMOs initiated a lawsuit that resulted in a temporary restraining order just as plan bids were being submitted, and opposition led to the end of the demonstration before full implementation.

One thing HCFA learned from the Denver demonstration is the range of plan bids for the enriched standard benefit package (which included drug coverage) and the Medicare Part A and Part B benefit package. According to Dowd, "HCFA … made it known that the … bids they examined in Denver for the standard benefit package (the 'market norm' benefit package that included prescription drugs) were 5 percent to 17 percent below the published Balanced Budget Act (BBA) payment rates, which reflect the cost of entitlement benefits (that is, no drugs) in FFS Medicare. The … bids for the entitlement benefit package [Medicare Part A and Part B] were 25 percent to 38 percent below the BBA rates" (Dowd 2001).

The Balanced Budget Act of 1997 (BBA) mandated competitive pricing demonstrations at various sites, with the design of the demonstrations to be determined by a national Competitive Pricing Advisory Committee (CPAC) with additional input from Area Advisory Committees (AACs). Under the CPAC design, FFS Medicare was excluded as a bidding plan because no statutory authority allowed its inclusion, but CPAC urged the Congress to consider including FFS. CPAC established a national standard enhanced benefit package that included drug coverage, but each AAC could further enhance the benefit if the local standard was to have a more generous benefit package in Medicare plans. CPAC specified that the government contribution should be at the median bid (adjusted for plan capacity) or at the enrollment-weighted average bid. At each of the two demonstration sites (Kansas City and Phoenix), the AACs chose the amount resulting in a higher government contribution. Plans bidding above the contribution level would charge a premium; plans bidding below that amount could retain the difference or provide extra benefits. CPAC also considered ways to have financial incentives to promote quality of care. In addition to decisions about the standard benefit package and the level of the government contribution, the AACs would determine whether plans would bid on a county-by-county basis (separate bids for each county) or on a "reference" county, with ratios established for payments in each county.

After a number of delays, the Kansas City and Phoenix demonstrations ended before implementation because of mounting stakeholder opposition. ∎

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premiums to enroll in Medicare HMOs not offering rich extra benefits (Brown and Gold 1999).

This erosion effect could be mitigated partly by stating benchmarks in advance (based on the previous year's bids). Doing so could mitigate the possible effect as plans adjust their bids based on a specific target. The specific target (the known benchmark) enables the plan to establish in advance its level of enhanced benefits rather than relying entirely on a "blind" process that would lead it to bid in such a way as to ensure that it was the lowest bidder.

Another way to mitigate the erosion effect is for plans to bid on a package consisting of Medicare Part A and Part B benefits plus a specified set of benefit enhancements. The strategy would still create pressure to lower bids through competition, but they would not be so low as to eliminate enhanced benefits. This alternative would be along the lines of the approach of the Competitive Pricing Advisory Committee to enhanced benefits (see text box). A benchmark is established based on bids for the entire benefit package—meaning that the benchmark incorporates payment for enhanced benefits. All plans would provide the Medicare benefit plus at least the specified set of extra benefits. The Medicare payment could be capped at 100 percent of FFS.

Behavioral responses to setting benchmarks through competitive bids Any design would also have to take into account plan behavior in response to the incentives inherent in the specific design. For example:

- Would plans bid strategically to eliminate a competitor? Some plans might bid low to stay in the program and eliminate other plans and then expect to make up the difference in following years.

- What level of extra benefits would plans perceive as necessary to attract members? Might they think other aspects of the plan such as provider network would be enough to retain members?

- Would all plans participate if they had to charge a premium? There are examples now of plans that charge a premium coexisting in markets with plans that do not.

- How would plans react to larger payment areas? If plans were required to serve all areas, would they bid some average cost across areas or assume they could market selectively and hence gain enrollment in only some locations?

Comparison of administered pricing and competitive bidding as the basis for setting MA benchmarks

Before we look at options for administered pricing, we compare the features of using administered pricing versus competitive bidding to determine MA benchmarks (Table 7-5).

Options for setting benchmark rates administratively: Assumptions in modeling

We designed four options for setting benchmarks administratively. The first two options—local FFS benchmarks and hybrid benchmarks—link benchmarks closely to 100 percent of FFS spending in the local payment area. The last two options are blends that link to expected plan costs. All four options are designed to reduce the average MA benchmark from the current 118 percent of average FFS Medicare spending to 100 percent of FFS spending nationally. However, each option could produce different results for different areas. We simulate some of these effects and compare the different options.

We modeled each of the benchmark options with data from 2009 plan bids. We included all plan types but excluded special needs plans and employer group plans because they are available only to subgroups of Medicare

beneficiaries. We also excluded Puerto Rico, both because of data comparability questions and because benchmarks in Puerto Rico have been treated differently under Medicare statute (e.g., floors set at 180 percent of FFS spending).

For the most part, the results assume that plan bids and service areas do not change. We expect that any overhaul of the benchmarks would cause plans to change their bidding strategies. Our simulations examine first-year static effects and may not be informative over time as we did not model any behavioral changes.

A plan's bid—based on service area data rather than on individual county data—includes calculations of a plan-level benchmark based on the area's county benchmarks and the plan's expected enrollment and average risk score from each county. Our simulations work the same way. We assume that the plan's bid and projected enrollment are the same and we use the new county benchmarks that would result from each of the options to build a new plan-level benchmark to compare against the bid and then calculate the payment from Medicare. In this way, a plan is calculated to be either under or over the benchmarks across its service area.

Local FFS

One of the most straightforward ways to set benchmarks at 100 percent of average FFS spending is to set each county's benchmark at 100 percent of local FFS spending. We have examined this approach frequently in the past. The mandate specifies that we need to examine alternatives to this option, but we include it (along with the current benchmarks) as a good basis of comparison for the other options. Figure 7-4 (p. 190) displays a simplified representation of the current benchmarks and local FFS rates. As mentioned earlier, average FFS spending in a county is as low as $453, but the benchmarks can be no lower than the floor of $741. Above the floor (for this illustration, we ignore the large urban floor of $819), the benchmarks are based on, and are above, local FFS spending.

Hybrid: Floor, ceiling, and local FFS

One criticism of the local FFS approach is that some counties have very high FFS spending because of very high service volume per capita. Some policymakers may consider it inequitable that these counties receive high MA benchmarks based on their FFS spending. The high benchmarks in some markets enable plans to offer significantly more generous benefits than in other markets. Similarly, some counties, where providers and

**TABLE
7–5**

Features of administered pricing versus competitive bidding as the basis for setting MA benchmarks

	Administered pricing/current MA	Competitive bidding
Description	The contribution toward a health plan benefit package is a fixed amount set by the government and known to plans in advance. For local MA plans, this is the local county benchmark as determined by statute. Bids below the benchmark allow plans to provide higher levels of extra benefits and thus attract enrollment.	Plan bids are the basis for determining the benchmark amount. Plans bid against each other to offer their best price for the product the buyer (Medicare) seeks to purchase. Low bidders are rewarded for their low bids (through higher enrollment), and the plan bid should reflect the plan's costs of providing the product in the most efficient manner possible. The bidding process establishes a market-based price for the product in a given area.
Treatment of bids below or above benchmark	Bids above the benchmark require the enrollee to pay a premium to join the plan. Bids below the benchmark require plans to provide enhanced benefits.	Same.
Preconditions (plan participation)	No minimum number of plans. (There can be areas with only one Medicare plan participating.)	More than one competitor (probably three or more) necessary for competitive bidding. If fewer plans are in an area, or there is only one plan, an alternative approach to setting the benchmark would be necessary (e.g., administered pricing).
Geographic area issues	In MA, local plans can serve a single county or multiple counties. Regional plans are required to serve the entire region. (The Commission has recommended forming larger geographic areas for MA and requiring plans to serve the entire area.)	All bidding plans could be required to bid for the entire defined geographic area (larger than a plan's current area in some cases). The bidding process occurs at a local market area level. That is, benchmarks are set within competitive areas for just those areas.
CMS role and administrative burden/cost	Setting benchmarks is a more mechanical process based on payment formulas and calculations.	Managing a competitive bidding process in many geographic areas requires resources. For areas with an insufficient number of bidders, administered pricing might have to continue in order to have plans available. (CMS might have to administer two different systems for setting benchmarks, depending on local market conditions.)
Plan availability after bidding process and over multiyear period	All plans meeting contracting standards (including an evaluation of plan capacity) are allowed to participate each year. Multiyear participation prospects for a particular plan depend on future benchmark levels as determined by legislation and administrative changes, trends in health care costs, and the competitive environment. Plan availability may erode over time.	Generally, in the Medicare competitive pricing models, all plans are allowed to participate regardless of the level of their bid. However, it is especially important to ensure that a low-bid plan has the capacity to serve the expected number of enrollees at the submitted bid level, particularly if the plan might be expected to have a large increase in enrollment as a result of its bid. Plan availability may erode over time.
Plan quality	Can be made a factor in payment (through a legislative change).	Can be made a factor in payment.

Note: MA (Medicare Advantage).

FIGURE
7–4

Current benchmarks and 100 percent of local FFS spending alternative benchmark
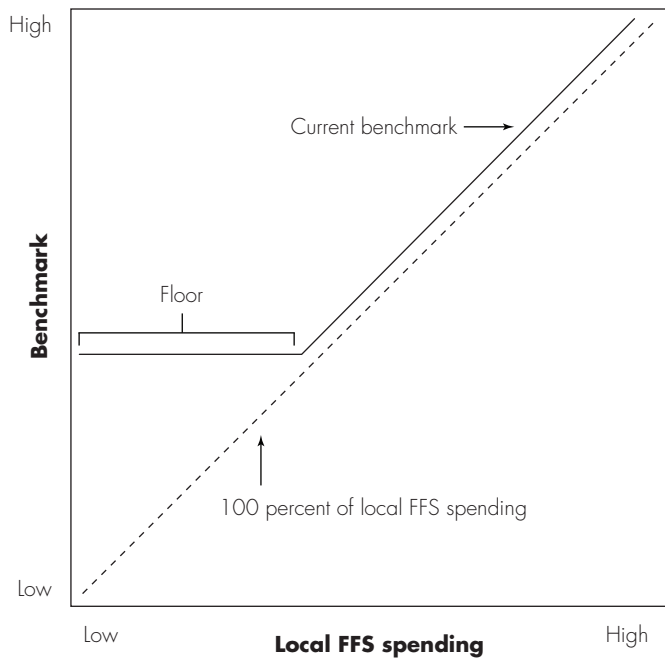
beneficiaries have used fewer services, have low FFS spending, and MA benchmarks based on these counties' FFS spending would result in rates too low for plans to survive and provide extra benefits. One option to help address these equity concerns is to set a floor at the low end, use FFS spending rates in the middle, and set a ceiling at the high end (Figure 7-5).

The floor and ceiling could be set in a number of ways. For the simulations, a floor and ceiling should combine to produce benchmarks that average 100 percent of FFS spending, so that the option is comparable to the other options. A hybrid system with a floor at $618 and a ceiling at $926 results in benchmarks that average 100 percent of FFS spending; thus, we used that floor and that ceiling for the simulations.[21]

Blend of local FFS spending and national spending

Another option is to set benchmarks that take into account expected plan costs as well as expected FFS spending. That is, areas where MA costs were expected to be higher than

FFS spending (these areas tend to be rural or low-spending urban counties) would have benchmarks exceeding 100 percent of FFS spending, and areas where MA costs were expected to be lower than FFS spending (these areas tend to be urban markets with high FFS spending) would have benchmarks below 100 percent of FFS spending. In addition, we interpret MIPPA as asking for an examination of an option where the benchmarks would be set by using a blend of local FFS spending and national average FFS spending so as to reflect expected plan costs.

As a result of the correlation analysis and a regression analysis that predicted plan bids based on local FFS spending (we found that bids tended to rise about $0.75 for each $1.00 increase in FFS spending), we simulate an option using a blend of 75 percent of the county's local FFS spending and 25 percent of the national average FFS spending (Figure 7-6). This particular blend of national and local FFS spending best approximates plan costs (as represented by the plans' bids). Under this option the benchmarks would range from $524 to $1,147.
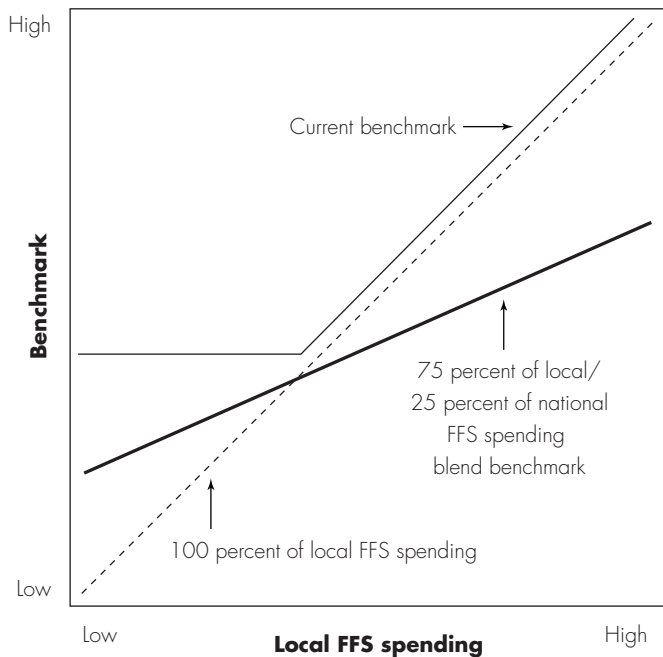
FIGURE
7–5

Current benchmarks, 100 percent of local FFS spending, and a hybrid alternative benchmark

MEDPAC

**FIGURE
7–6**

**Current benchmarks,
100 percent of local FFS spending,
and a 75 percent of local/25 percent
of national average FFS spending
blend alternative benchmark**
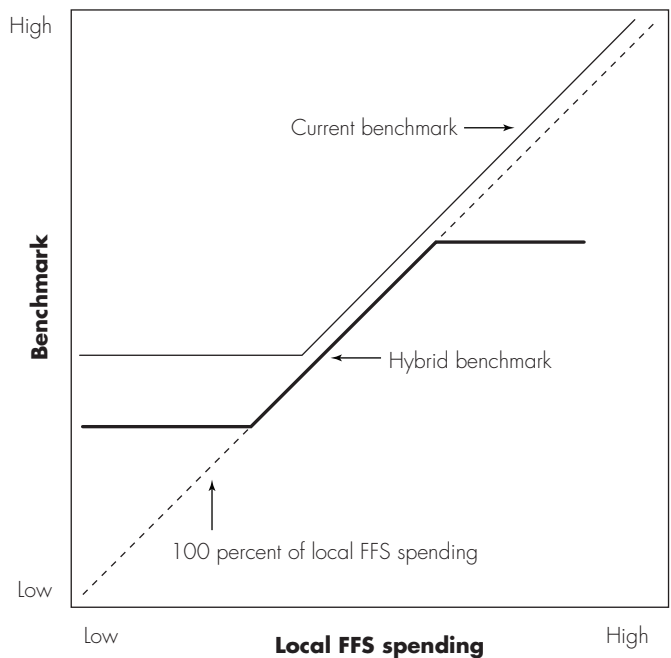
Note: FFS (fee-for-service). The simplified illustration of the current benchmark
          presented in this figure includes only one floor and ignores the fact that
          individual benchmarks may be significantly above FFS for a variety of
          reasons.

National FFS spending adjusted for local input prices

We examine another option for setting benchmarks that takes expected plan costs into account. Benchmarks that are based on local FFS spending adjust for both local service use and local input prices. However, in theory, managed care plans can manage utilization so there would be less variation in plan costs across the country. In this option, we take the national average FFS spending and adjust it by local input prices to set benchmarks.

This option would set benchmarks higher in areas where plans might be expected to have to pay providers more, but it would not set higher benchmarks based on higher service utilization. That is, we have created a normative standard for utilization. We would be saying that plans should be able to provide the Medicare benefit using no more than average utilization.

We computed the national average FFS spending rate as the average expected Medicare FFS spending for beneficiaries projected to be enrolled in MA plans. This national average is $734 per member per month for an enrollee with average health risk. We used the two primary Medicare price indices—the hospital wage index and the geographic adjuster that is used for the physician fee schedule—as our price indicators. We then regressed the bids on the national rate adjusted for local prices and found that a blend of 85 percent of the national price-adjusted rate and 15 percent of the unadjusted national rate was the best predictor of the bids. This input-price-adjusted blend option produced benchmarks that were more predictive of the bids than the benchmarks based on the blend of national and local FFS spending, particularly for HMOs.

Under this option, the benchmarks would range from $618 to $926. Counties with very high use would see their benchmarks fall from current levels; counties with low use (particularly those in low price areas) would see less of an effect. Unlike the other options, some benchmarks would rise from current levels. The range in benchmarks would be much narrower than under current law or under the local FFS option.

Figure 7-7 (p. 192) shows the national average FFS spending as a horizontal line slightly below the floor and illustrates the range in benchmarks that would result from this option. Our analysis suggests that most of the variation in county-level FFS spending is caused by variation in service use rather than by price differences. Counties with very different levels of FFS spending— caused by differences in the volume of services used rather than by prices—could have very similar benchmarks under this option. For example, Minneapolis would have a slightly higher benchmark than Miami under this option, although FFS spending in Miami is significantly higher than it is in Minneapolis.

Results of simulations

Each option, by design, reduces average benchmarks to about 100 percent of FFS spending from the current average benchmark that equals 118 percent of FFS spending. This reduction would cause substantial changes in plan availability, extra benefits, and cost to the program. We estimate that in 2009 this benchmark reduction would save the program $12 billion. CBO estimates that such a reduction would save approximately $150 billion over its 10-year budget window. However, CBO has scored only the 100 percent of local FFS option. Other options might produce similar savings in

FIGURE
7–7

Current benchmarks, 100 percent of local FFS spending, and an input-price-adjusted blend alternative benchmark
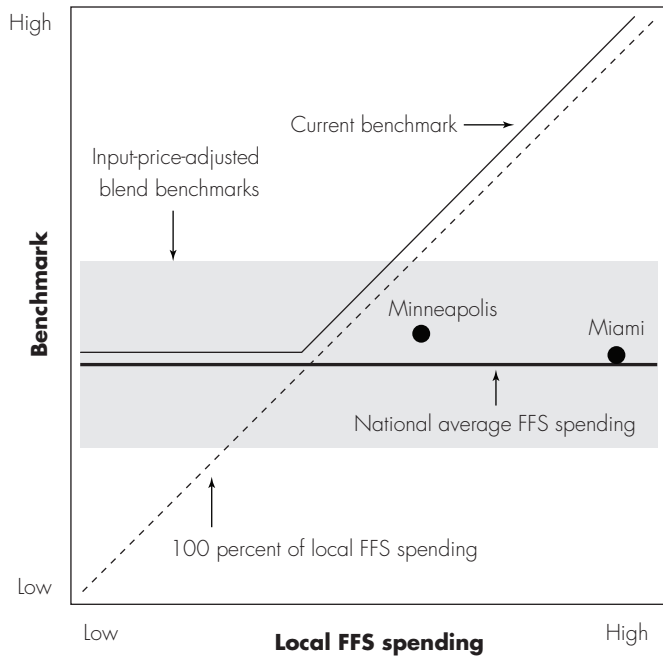
Note: FFS (fee-for-service). The input-price-adjusted blend benchmark is the national average level of FFS expenditures adjusted for local prices and would vary across areas, as illustrated by the two examples—Minneapolis and Miami. The simplified illustration of the current benchmark presented in this figure includes only one floor and ignores the fact that individual benchmarks may be significantly above FFS for a variety of reasons.

the first year, but shifts in enrollment patterns over time could reduce the savings.

Although all four options would likely produce similar first-year cost savings, they would also produce different benchmarks in different areas. The 100 percent of local FFS option would produce the largest benchmark differences between high- and low-spending counties, but each county would have its benchmark equal to local FFS (Table 7-6). The input-price-adjusted blend (along with the hybrid option) would produce the narrowest range of benchmarks but would have benchmarks in some counties about 50 percent above and in others 50 percent below local FFS spending.

We examined several additional metrics for each option:

- plan availability by plan type and quality ranking, with separate analyses for urban and rural areas;

- level of extra benefits; and

- cost to the Medicare program.

Availability of plans by plan type and quality rankings and by urban and rural areas

Policymakers want to know whether plans will be available if the benchmarks change. The simulations measure plan availability by whether the current plan bids are above or below the simulated new benchmarks. We assume that plans that bid below the simulated

TABLE
7–6

MA benchmark characteristics vary by option

Benchmark type	Benchmark		Ratio of benchmark to FFS spending	
	Minimum	Maximum	Minimum	Maximum
Current benchmarks (118% of FFS)	$ 741	$1,366	1.01	1.83
Alternative benchmarks (100% of FFS; *potentially saves $150 billion over 10 years*):				
100% of local FFS	$453	$1,285	1.00	1.00
Hybrid	618	926	0.72	1.36
75% of local/25% of national FFS blend	524	1,147	0.89	1.15
Input-price-adjusted blend	618	926	0.54	1.56

Note: MA (Medicare Advantage), FFS (fee-for-service). The hybrid alternative benchmark is 100% of local FFS with specified minimum and maximum benchmark amounts. The input-price-adjusted blend alternative benchmark is the national average level of FFS expenditures adjusted for local prices. The Congressional Budget Office has scored only the 100% of local FFS alternative. Other options might start at similar savings, but shifts in enrollment patterns over time could reduce the savings.

Source: MedPAC analysis of CMS bid and payment data.

benchmarks would continue to do so and therefore would be "available," although the extra benefits they offer would probably be reduced. We also assume that plans bidding above the benchmarks would not stay in the program because they would not be able to offer attractive benefits.

These two assumptions would not hold in all cases. For example, some plans may bid above their benchmarks and remain in the program. Some plans might bid lower than they currently do to stay in the program and attract or retain market share. In contrast, some plans that bid slightly below the new benchmarks could decide to pull out if they thought they could not offer benefits attractive enough to draw or retain members. On balance, the assumptions we use should produce reasonable approximations.

All options presented here would likely result in much lower Medicare spending and in reduced plan availability. We report plan availability separately for urban and rural areas because the difference between those areas can be large. (We define urban areas as counties in metropolitan statistical areas (MSAs) and rural areas as counties not in MSAs.)

Currently, 100 percent of beneficiaries live in counties with plans bidding below the benchmark. Of the four options presented, the one setting benchmarks at 100 percent of local FFS spending would reduce availability the most

(Table 7-7). Under the local FFS option, 80 percent of beneficiaries, and 67 percent of rural beneficiaries, would have a plan available. The option basing benchmarks on the input-price-adjusted blend would reduce availability the least, largely because benchmarks in this option are designed to reflect plan costs. Plan bids tended to track the input-price-adjusted blend closer than the other options. Ninety-four percent of all beneficiaries and 88 percent of beneficiaries in rural counties would have a plan available under that option. Each option would result in lower availability in rural areas than in urban areas.

We also examine the likely effects of benchmark changes by simulating plan availability for current MA enrollees. Although plans may be available in all areas, enrollment penetration varies. Thus, if plans left low penetration areas, proportionately fewer MA enrollees than Medicare beneficiaries would be affected. Plan availability would be higher under all options if it were measured for current (February 2009) MA enrollees rather than for all Medicare beneficiaries (Table 7-8). Under the 100 percent of local FFS option, for example, 83 percent of current MA enrollees would have a plan available, compared with 80 percent of all Medicare beneficiaries (shown in Table 7-7). Availability would reach 98 percent of all MA enrollees and 94 percent of rural enrollees under the price-adjusted blend option. For the remainder of the tables in this section, we present

**TABLE
7–9**

**Percent of beneficiaries with
any MA plan available
using 2011 PFFS rules
under different alternatives**

Benchmark type	All areas	Urban areas	Rural areas
Current benchmarks (118% of FFS)	99%	100%	96%
Alternative benchmarks (100% of FFS; *potentially saves $150 billion over 10 years*):			
100% of local FFS	77	82	61
Hybrid	79	83	62
75% of local/25% of national FFS blend	85	89	69
Input-price-adjusted blend	85	89	70

Note: MA (Medicare Advantage), PFFS (private fee-for-service), FFS (fee-for-service). The hybrid alternative benchmark is 100% of local FFS with specified minimum and maximum benchmark amounts. The input-price-adjusted blend alternative benchmark is the national average level of FFS expenditures adjusted for local prices. The Congressional Budget Office has scored only the 100% of local FFS alternative. Other options might start at similar savings, but shifts in enrollment patterns over time could reduce the savings. As of 2011, network requirements will apply to PFFS plans in certain circumstances.

Source: MedPAC analysis of CMS bid and payment data.

availability in terms of all Medicare beneficiaries, but availability for current enrollees is likely to be higher.

The simulations all assume the 2009 bidding rules, but MIPPA requires that PFFS plans have provider networks where two other network plans are available starting in 2011. CMS recently published the list of counties where PFFS plans would need a network in 2011. To address this impending change, we simulated plan availability assuming that PFFS plans would not be available in the listed counties. It is possible that the PFFS plans could develop networks in these counties, but we did not assume any behavioral change. Plan availability would drop under the base case and all options when the 2011 PFFS rules are included. The general pattern among the options remains the same as under the 2009 rules, except that the two blends are more comparable (Table 7-9).

We also simulated overall plan availability using the MSA–health service area (HSA) definition of payment areas (see the appendix to this chapter). We assumed that if a plan (at the contract level) served more than 50 percent of the Medicare beneficiaries in the area it would serve the entire payment area; otherwise, it would not serve any of the service area. The findings (Table 7-10) show the

same patterns of lower availability in rural areas, lowest availability under the 100 percent of FFS spending option, and highest availability under the input-price-adjusted blend option. Compared with the same simulations using county-level payment areas, these simulations show slightly lower or the same level of availability. Because we found little difference and we need to make more assumptions about plan behavior, we do not show any other results with the larger payment areas. Instead, we present all the other results based on county-level payment areas.

Table 7-11 shows availability for local coordinated care plans (CCPs), which include HMOs and local PPOs only. We report separately on the local CCPs because the Commission has raised concerns about the need to design programs that support plans committed to coordinating care. The plans with the most potential to coordinate care are the local CCPs, so we look at how widely available they might be under different payment alternatives (Table 7-11). Despite currently high benchmarks, local CCPs are not widely available in rural areas. Only 60 percent of rural Medicare beneficiaries have a local CCP available. As before, the 100 percent of local FFS benchmarks would reduce availability the most, and the input-price-adjusted blend would reduce it the least.

**TABLE
7–10**

**Percent of beneficiaries with
any MA plan available using
MSA–HSA payment areas
under different alternatives**

Benchmark type	All areas	Urban areas	Rural areas
Current benchmarks (118% of FFS)	100%	100%	100%
Alternative benchmarks (100% of FFS; *potentially saves $150 billion over 10 years*):			
100% of local FFS	79	82	65
Hybrid	81	85	67
75% of local/25% of national FFS blend	87	90	76
Input-price-adjusted blend	93	95	85

Note: MA (Medicare Advantage), MSA (metropolitan statistical area), HSA (health service area), FFS (fee-for-service). The hybrid alternative benchmark is 100% of local FFS with specified minimum and maximum benchmark amounts. The input-price-adjusted blend alternative benchmark is the national average level of FFS expenditures adjusted for local prices. The Congressional Budget Office has scored only the 100% of local FFS alternative. Other options might start at similar savings, but shifts in enrollment patterns over time could reduce the savings.

Source: MedPAC analysis of CMS bid and payment data.

TABLE
7–11

Percent of beneficiaries with a local CCP available varies under different alternatives

Benchmark type	All areas	Urban areas	Rural areas
Current benchmarks (118% of FFS)	87%	95%	60%
Alternative benchmarks (100% of FFS; *potentially saves $150 billion over 10 years*):			
100% of local FFS	66	76	31
Hybrid	68	77	33
75% of local/25% of national FFS blend	73	82	40
Input-price-adjusted blend	75	83	46

Note: CCP (coordinated care plan), FFS (fee-for-service). The hybrid alternative benchmark is 100% of local FFS with specified minimum and maximum benchmark amounts. The input-price-adjusted blend alternative benchmark is the national average level of FFS expenditures adjusted for local prices. The Congressional Budget Office has scored only the 100% of local FFS alternative. Other options might start at similar savings, but shifts in enrollment patterns over time could reduce the savings.

Source: MedPAC analysis of CMS bid and payment data.

The Commission is also interested in ensuring beneficiary access to high-quality plans. Thus, we also conducted simulations to observe the effect of each option on the availability of plans that have demonstrated high quality, defined as those that achieved a score of at least 3.5 stars in CMS's quality ranking (Table 7-12). By identifying the plans with high quality that would likely have bids below the new benchmarks, we determined the share of beneficiaries who would have high-quality plans available under each option.

Currently, 55 percent of all beneficiaries, and 34 percent of rural beneficiaries, live in counties where they could enroll in a high-quality plan, compared with lower proportions under our four options. (The current share of beneficiaries for whom quality plans are available may be understated, as we counted only those plans that have a CMS star rating, which would exclude newer plans.) For the input-price-adjusted blend option, the drop in availability is not steep. Overall availability drops from 55 percent to 49 percent and availability in rural areas drops only 3 percentage points.

Level of extra benefits

Policymakers have also been concerned about the level of extra benefits plans may offer. To estimate that level under the four options, we calculated the extent to which plans would receive rebates for submitting bids below the alternative benchmarks.

The rebate dollars paid to the plans when their bids are below the benchmark are used to finance the extra benefits; plans offer the extra benefits to attract beneficiaries. In the group of plans we used in our benchmark-setting simulations, the average rebate paid by Medicare is $96 per member per month for those in plans that bid below the benchmark (about 98 percent of all plan enrollees). Plans use the rebate dollars primarily to reduce cost sharing for Medicare Part A and Part B services (MedPAC 2009). The average rebate is $101 for urban plan enrollees and $59 for rural enrollees (Table 7-13, p. 196).

Of the four options, the 100 percent of local FFS spending option had the highest level of rebates. The next two highest rebate options incorporate local FFS spending: the 75 percent of local/25 percent of national FFS spending blend and the hybrid. These options provide the largest rebates because they lower the benchmarks in the highest spending areas the least. The input-price-adjusted blend provides the lowest level of rebates.

Currently, Medicare retains 25 percent of the difference between the benchmark and the bid and provides the remaining 75 percent to the plans as the rebate, as shown in Table 7-13. Under the options we present, with benchmarks set at 100 percent of FFS, financial neutrality

TABLE
7–12

Beneficiaries with a high-quality MA plan available under different alternatives

Benchmark type	All areas	Urban areas	Rural areas
Current benchmarks (118% of FFS)	55%	60%	34%
Alternative benchmarks (100% of FFS; *potentially saves $150 billion over 10 years*):			
100% of local FFS	33	38	15
Hybrid	34	39	15
75% of local/25% of national FFS blend	39	44	21
Input-price-adjusted blend	49	54	31

Note: MA (Medicare Advantage), FFS (fee-for-service). A high-quality plan is a plan that received an overall quality rating of 3.5 stars or greater in the CMS star ranking system. The hybrid alternative benchmark is 100% of local FFS with specified minimum and maximum benchmark amounts. The input-price-adjusted blend alternative benchmark is the national average level of FFS expenditures adjusted for local prices. The Congressional Budget Office has scored only the 100% of local FFS alternative. Other options might start at similar savings, but shifts in enrollment patterns over time could reduce the savings.

Source: MedPAC analysis of CMS bid and payment data.

TABLE
7–13

Average rebate dollars per member per month for projected membership in MA plans bidding below benchmarks under different alternatives

Benchmark type	All areas	Urban areas	Rural areas
Current benchmarks (118% of FFS)	$96	$101	$59
Alternative benchmarks (100% of FFS; *potentially saves $150 billion over 10 years*):			
100% of local FFS	75	76	35
Hybrid	59	59	29
75% of local/25% of national			
FFS blend	62	63	34
Input-price-adjusted blend	38	40	20

Note: MA (Medicare Advantage), FFS (fee-for-service). The hybrid alternative benchmark is 100% of local FFS with specified minimum and maximum benchmark amounts. The input-price-adjusted blend alternative benchmark is the national average level of FFS expenditures adjusted for local prices. The Congressional Budget Office has scored only the 100% of local FFS alternative. Other options might start at similar savings, but shifts in enrollment patterns over time could reduce the savings.

Source: MedPAC analysis of CMS bid and payment data.

would be maintained without Medicare retaining the 25 percent. Rather than being retained, the 25 percent could be put in a quality incentive pool and returned to high-quality plans through a pay-for-performance program, as we have recommended in the past. Alternatively, the 25 percent could go toward extra benefits. Both policies would effectively increase by one-third the rebate dollar amounts shown for the options.

Cost of alternatives

In the first year, these administrative options are financially neutral to FFS Medicare in the aggregate—any one of them would cost the program the same as traditional Medicare, saving $12 billion by our estimate. This savings translates to a 15 percent reduction in the benchmarks. Under these options all beneficiaries would no longer see their Part B premium increasing to subsidize extra benefits for the minority of beneficiaries enrolled in certain plans, and taxpayers would not have to subsidize the costs of the additional benefits out of general revenues. In later years, the level of spending for a given option relative to FFS spending will vary as it is influenced by where enrollment is encouraged and where it is discouraged. For the 100 percent of local FFS option CBO estimates savings to be worth $150 billion over 10 years.

Commentary

To put the options we have presented into context, we first review them and their implications, discuss a modification that would help balance extra benefits across geographic areas, and present a transition strategy that would limit disruption for beneficiaries and encourage high-quality plans. We then reflect on how the goals for private plans in Medicare have shifted and how the current MA payment system could be improved by recasting the goals of the program to emphasize financial neutrality, efficiency, equity, and quality.

Alternative approaches to MA payment

The Commission believes there should be overall financial neutrality between traditional FFS and private plans, with differential payment for higher quality. Achieving overall financial neutrality should be a design goal for establishing benchmarks; quality should be a factor in plan payments. For example, once a benchmark is established, either through bidding or administratively, higher quality plans should be rewarded with add-on payments. The Commission has also recommended that larger payment areas be used for the MA payment system to lessen year-to-year volatility in benchmarks and payment rates and to decrease differences between neighboring areas (see the appendix to this chapter). Either of the alternatives we have discussed—setting benchmarks through competitive bidding or any of the administrative options—could be designed to use larger payment areas.

Defining a preferred option depends on one's perspective and the program goals one considers most important. The administrative options other than 100 percent of local FFS, as well as competitive bidding, would introduce differences between local FFS payments and plan benchmarks. Therefore, in some areas benchmarks will be above FFS payments, introducing the possibility of paying plans more than FFS and increasing overall Medicare payments. At the same time, those differences can make it less likely that plans will enter areas where they might save Medicare money. Administratively setting benchmarks for private plans at 100 percent of local FFS is the only alternative that ensures neither of those situations occurs. It would also create an incentive for plans to be more efficient than Medicare FFS by managing care—that is, reducing costs and improving quality. With the resulting savings, plans could offer additional benefits to beneficiaries and in turn attract enrollment, provide incentives for efficiency, and

TABLE
7-14

Key parameters of current and alternative MA benchmark options

Benchmark type	Benchmark		Ratio of benchmark to FFS spending		Availability (any plan)	Average extra benefits
	Minimum	Maximum	Minimum	Maximum		
Current benchmarks (118% of FFS)	$ 741	$1,366	1.01	1.83	100%	$96
Alternative benchmarks (100% of FFS; *potentially saves $150 billion over 10 years*):						
100% of local FFS	$453	$1,285	1.00	1.00	80	75
Hybrid	618	926	0.72	1.36	82	59
75% of local/25% of national FFS blend	524	1,147	0.89	1.15	88	62
Input-price-adjusted blend	618	926	0.54	1.56	94	38

Note: MA (Medicare Advantage), FFS (fee-for-service). The hybrid alternative benchmark is 100% of local FFS with specified minimum and maximum benchmark amounts. The input-price-adjusted blend alternative benchmark is the national average level of FFS expenditures adjusted for local prices. The Congressional Budget Office has scored only the 100% of local FFS alternative. Other options might start at similar savings, but shifts in enrollment patterns over time could reduce the savings.

Source: MedPAC analysis of CMS bid and payment data.

keep average extra benefits relatively high. But those extra benefits will be concentrated in very few areas and plans; plans in general, and high-quality plans, would not be as widely available as in other options—particularly in areas with low FFS payments. This situation would lead to additional concerns about inequities.

Setting benchmarks through bids

Competitive bidding can be used to set benchmarks for MA plans. We outlined some decisions that would have to be made to set benchmarks through competitive bidding—for example, where to set the benchmark in relation to the distribution of bids and whether bids should be limited at some point above or below local FFS spending. With no modifications, a competitive strategy cannot guarantee that a sufficient number of bids will be made in all areas or that the level of extra benefits in a competitive system will be sufficient to attract beneficiaries.

It is also not clear at what point a bidding system will reach an equilibrium and whether that equilibrium will approximate payment neutrality of 100 percent of FFS spending in the long term. Because plans' benefits and characteristics are sensitive to the rules and design of the bidding process, our evaluation of this alternative is limited. A quantitative simulation of this alternative is particularly difficult because county-level bids are not available. Under the current system, plans submit one bid for an entire service area, which may contain multiple counties. If county-level benchmarks are set by bids, then

plans will likely vary their bids by county within a service area. As a result, county-level bids will be essential to model plan behavior under competitive bidding.

Options for setting benchmarks administratively

We described four options for setting benchmarks administratively (Table 7-14). Each could be designed to use larger payment areas. We set each option equal to 100 percent of FFS spending overall in the first year to attempt to create financial neutrality between MA and FFS. As our analysis of the 100 percent of local FFS option shows, setting benchmarks at 100 percent of local FFS will by definition be financially neutral in all years. However, that will not necessarily be true for the other options.

Each administrative option other than 100 percent of local FFS would lower benchmarks in very high FFS areas and redistribute some of the payments that finance extra benefits in those areas to other areas where benchmarks can increase (relative to the 100 percent of local FFS option), which increases the availability of plans and makes extra benefits available in more areas and to more people, although it lowers the average extra benefit nationwide. (The average of extra benefits is computed only in areas where extra benefits exceed zero.) Because these options also increase the difference between local FFS and the benchmarks (the maximum and minimum ratio of benchmarks to FFS spending shown in Table 7-14), plans will react and change where they offer services. Although we have set the options equal to 100

percent of FFS overall in the first year, we cannot tell how long the other options will maintain financial neutrality because of the dynamics of the process.

Reviewing the results of our simulations as shown in Table 7-14:

- The 100 percent of local FFS option has the widest dollar range of benchmarks, no differences between local FFS and the benchmarks (by definition), estimated first-year plan availability of about 80 percent, and the highest level of extra benefits. (But the highest level of extra benefits will be concentrated in few areas and plans, which has created concerns about inequities.)

- The hybrid option limits the dollar range among benchmarks but has differences between benchmarks and local FFS payments of around 30 percent above or below, little difference in plan availability (82 percent) relative to 100 percent of local FFS, and lowers the average extra benefit relative to 100 percent of local FFS (but makes them available to more beneficiaries in more areas).

- The blend of 75 percent of local and 25 percent of national FFS plan decreases benchmarks in areas with the highest levels of FFS payment and increases benchmarks in areas with low levels of FFS spending but still has a fairly wide dollar range of benchmarks. It allows differences between local FFS spending and benchmarks, setting benchmarks 15 percent higher than FFS in lower FFS payment areas. It increases plan availability (88 percent) and lowers average extra benefits ($62) relative to 100 percent of local FFS (but makes them available to more beneficiaries in more areas).

- The input-price-adjusted blend option is a different option encompassing plan costs. It decreases the dollar range in benchmarks and has the largest percentage differences between local FFS and benchmarks, with benchmarks in some areas 50 percent more and in others 50 percent less than FFS spending. It increases the availability of extra benefits (94 percent) and decreases their average dollar value ($38) relative to 100 percent of local FFS.

Whichever option is chosen, in some markets private plans will find it difficult to contract with providers because there may be monopoly providers in areas with low population density, there may not be providers with efficient practice patterns, or plans may face other barriers. In those markets, Medicare's low administrative costs and the ability to set prices will mean private plans cannot compete with Medicare successfully. However, there may be providers who are willing to organize in those markets to improve care coordination and increase quality but who cannot take on full insurance risk as MA plans do. The Commission will be discussing the viability of possible options in future work.

A modification to balance extra benefits across geographic areas

There is a modification that could mitigate some of the concerns about the equity of extra benefits in the 100 percent of local FFS option and the 75 percent of local/25 percent of national FFS spending blend option. In those options, greater extra benefits would probably be available in areas with very high FFS spending than in other areas.

FFS Medicare is more efficient in some areas than in others. In areas with very high service use and many providers, MA plans have scope for efficiency gains because private plans have the latitude to coordinate care and to select providers with efficient practice patterns. In low-use areas, FFS Medicare may be a reasonable proxy for an efficient plan because of judicious practice patterns and the fact that Medicare has low administrative costs and the ability to set prices.

Medicare could differentiate payment for extra benefits between high- and low-use areas. For example, Medicare's share of the difference between the bid and the benchmark could vary according to an area's service use. Currently, Medicare retains 25 percent of the difference between the bid and the benchmark, and the remaining 75 percent goes to enhanced benefits. This share could be varied, with Medicare retaining a larger share as service use increases above the national average and a smaller share where service use is low, which would tend to balance extra benefits across geographic areas and promote equity. This adjustment could be made prospectively each year and could be designed to be budget neutral.

Table 7-15 illustrates that under the new policy the share Medicare retains is higher (60 percent) in the higher-service-use area and lower (0 percent) in the lower-service-use area. (The numbers in the table are illustrative and were chosen to simplify explication.) In the higher-service-use area, the bid in the example is 70 percent of

the benchmark. Under current rules, Medicare retains 25 percent of the difference and extra benefits (rebate) are 22.5 percent. If Medicare instead were to retain a larger share (60 percent) of the difference, extra benefits would decrease to 12 percent under the new policy. Conversely, in the lower-service-use area the extra benefits would increase from 7.5 percent to 10 percent. The result would be less of a difference between the extra benefits available in the higher- and lower-service-use areas.

Considerations during transition

Under any of the options we have analyzed, benchmarks will decrease. As benchmarks decrease, plans will change their benefit packages and possibly their provider networks; in some cases, they may leave the program. All these steps will be disruptive for beneficiaries enrolled in MA plans. They may have to switch plans, return to FFS Medicare, or adjust to changes in their benefits and cost sharing.

At the same time, other changes already in law or regulation will be changing the MA marketplace. For example, MIPPA requires that PFFS plans have provider networks where two other network plans are available starting in 2011. The likely result will be PFFS plans either becoming network plans or in some cases withdrawing from the program. (See text box, p. 200, for a discussion of previous periods of changing health plan participation.)

To reduce disruption to beneficiaries, it may be advisable to have a transition period during which benchmark rates will decrease to the proposed rates over a period of time rather than all at once. If we define as the desired endpoint an MA program that encourages high-quality plans that are financially neutral to FFS, then a key objective of the transition should be to preserve high-quality plans in the program. During the transition, as the program continues to pay plans more than it would have cost to provide care in FFS Medicare for the plan's enrollees, a condition for a plan to receive extra payments should be that it has demonstrated good performance on quality indicators. As benchmarks are lowered to attain financial neutrality, high-quality plans' payments would not decrease as fast, and low-quality plans would either improve or their payments would decrease and they would exit the program.

At the end of the transition, under any benchmark alternative (competitive or administrative), high-quality plans could be paid more than FFS if their quality were higher than FFS. Payments would be in essence a quality-adjusted 100 percent of FFS. Plans would be free to use

TABLE 7–15	Beneficiaries in areas with lower service use would benefit under alternative formula for extra benefits		
		Higher-service-use area	Lower-service-use area
Bid as percent of benchmark		70%	90%
Difference		30	10
Extra benefits current formula			
Percentage of difference Medicare retains		25	25
Percentage of difference for extra benefits		75	75
Extra benefits (75% of difference)		22.5	7.5
Extra benefits alternative formula			
Percentage of difference Medicare retains		60	0
Percentage of difference for extra benefits		40	100
Extra benefits		12	10

Note: "Extra benefits" is the rebate amount that the plan has to use to provide extra benefits to enrollees; the actual amount of extra benefits the enrollee receives will be reduced by the plan's load factor.

the extra payments to provide extra benefits. It is not now possible to make a direct, broad-based comparison of quality in MA plans versus FFS. The methodology CMS might use to compare the two sectors is the subject of a separate Commission report mandated in MIPPA.

For example, if benchmarks move from 118 percent of FFS to 100 percent of FFS over a three-year transition period, the average rate of decrease would be about 6 percent a year. For a high-quality plan the decrease could be buffered by an additional payment known in advance of bidding based on the previous year's quality performance. In effect, payments could change at a slower rate than benchmarks if plan quality were high. For a low-quality plan, payments could decrease more than 6 percent per year if low quality were directly penalized by a payment decrease. The intent would be to retain high-quality plans in the MA program. After the transition, if plan quality can be measured relative to FFS, MA payments could be set to quality-adjusted financial neutrality with Medicare FFS. That is, if MA plans provide better quality care than FFS, they would be paid more than FFS.

The last major round of health plan withdrawals from Medicare occurred from 1998 through 2003. Plan participation started to decline in 1998 and enrollment started to decline the next year. The number of Medicare plans dropped from 346 in 1998 to 151 in 2003. Plan enrollment dropped from its then-historic high of 6.3 million in 1999 to 5 million in 2003. (The rapid decline in enrollment was preceded by a rapid increase; plans added 2.2 million Medicare enrollees during the years 1997 through 1999.) The percent of beneficiaries with access to at least one managed care plan in their county declined from 74 percent in 1998 to 59 percent in 2003 (CMS 2007).

In terms of the types of benefits offered, access to plans with no premium declined from 61 percent in 1999 to 29 percent in 2003. Premiums and cost sharing for enrollees increased, and drug coverage—the principal extra benefit that attracted Medicare enrollment— became much less generous.

The cause of plan departures and reduced benefits

It is commonly thought that payment changes made in the Balanced Budget Act of 1997 (BBA) led to Medicare plan withdrawals and declines in enrollment. The story is more complicated. The Center for Studying Health System Change (HSC) noted that "While the BBA often is blamed for this turnabout … private market forces also played a key role in [Medicare+Choice's] growing instability."

As Grossman and colleagues of HSC stated in their analysis, "Positive market conditions before the BBA's passage helped to spur Medicare managed care's growth, while declining market conditions, especially rising health care costs, intensified the impact of BBA policy changes. This collision of public policy and private market forces, rather than policy changes alone, brought … growth to a halt" (Grossman et al. 2002). They mention three market factors influencing both the rapid growth and the decline in Medicare health plans: "health care cost trends … the commercial insurance underwriting cycle … [and] plans' ability to negotiate discounts from providers." The latter has been commonly referred to as the "managed care backlash" that forced plans to have wider networks and loosen utilization management practices.

The rise and decline of Medicare managed care roughly matched the rise and decline of managed care in the commercial sector. The market conditions that allowed health plans to bring health care costs down (or slow the rate of the growth in costs) applied in both the commercial market and the Medicare market. The market conditions that led to increases in health care costs applied in both market sectors as well.

How the current situation differs from the 1990s

One difference between the period of enrollment growth in the 1990s and the current period of Medicare enrollment growth is that the new growth in plans is primarily the result of what HSC would call "policy changes alone" in Medicare. The prime example is the growth of Medicare private fee-for-service plans, an exclusively Medicare product introduced by the BBA and whose growth is attributable to the establishment of floor payments in Medicare Advantage. Similarly, the BBA opened the door to Medicare-only health plans or plans that have only Medicare and Medicaid enrollees, which would not have been possible before the BBA (because of what was known as the 50/50 rule governing the composition of enrollment in Medicare plans, which had to have at least 50 percent of their enrollment in non-Medicare, non-Medicaid products).

These changes have allowed companies to enter new areas without the need to compete in the commercial market or without "having roots" in a particular community. Although the BBA introduced these new options, it was primarily payment policy changes after the BBA that allowed their rapid growth. Plans entered new geographic areas because of benchmarks well above Medicare fee-for-service expenditure levels. If the sole reason for plan entry was a change in payment rates, a change in rates in the other direction could lead to rapid plan departures. ∎

Understanding the goals of the Medicare Advantage program

The decision of which alternative for setting benchmarks in the MA program is preferable depends on one's perception of the program's goals. Those goals have shifted.

Original goals of the program

Private plans were included in Medicare to provide a mechanism for introducing innovation into the program while saving money for Medicare (the plans were paid 95 percent of FFS between 1982 and 1997).[22] Private plans were expected to achieve efficiencies by, for example, negotiating lower payment rates with providers, selectively contracting with efficient providers, managing the provision of services, and coordinating care—payment and delivery strategies that were not possible in traditional FFS Medicare. In addition, there was the possibility that more efficient MA practice patterns might "spill over" into the FFS program, leading to greater efficiency there as well. The original goals were thus to import innovation through efficient private plans using care coordination and to save money for Medicare.

Perceptions of geographic inequity spurred change

As the Medicare private plan option evolved, some areas of the country had many private plans available to beneficiaries that offered benefits beyond those included in Medicare Part A and Part B—often at a lower cost to beneficiaries. For example, some plans included, at no additional cost, coverage for prescription drugs, which at the time was not available in the regular Medicare program. At the same time, there were areas of the country where no private plans were available to beneficiaries. Representatives of the latter areas pointed out that their beneficiaries paid the same Part B premium as beneficiaries in other parts of the country yet had no choice of private plans and no access to additional benefits; in their eyes, the system was inequitable.

Private plans tended to enter geographic areas where conditions were favorable—that is, areas where the prevailing level of service use was high, and health care market conditions allowed for negotiation of favorable rates. Efficient private plans could take advantage of those conditions and provide the Part A and Part B benefit package for less than FFS Medicare. They could then provide enhanced benefits to the extent Medicare payments exceeded their cost of providing the Medicare Part A and Part B benefit package.

In geographic areas with high levels of service use in FFS Medicare, plans are able to provide a substantial level of extra benefits because they are able to reduce service use among their enrollees. In other areas, where FFS service use is lower, plans have not been able to provide rich benefit packages because it is more difficult to reduce service use below the prevailing level. The differences in extra benefits across different geographic areas were in part a manifestation of differences in FFS service use across areas. However, they led to the problem of perceived geographic inequities in the private plan options because beneficiaries in areas where FFS service use has been more judicious were less likely to have plans offering the extra benefits found in the areas with highest service use.

Market conditions differ among areas as well. In some areas, there may be a monopoly provider and private plans are not able to negotiate favorable payment rates; hence, they do not enter the market. In contrast, in areas with many providers who are willing to accept lower rates to gain market share, private plans are more willing to enter. This situation led to some areas not having private plans and to further concerns about inequity.

In a discussion of inequities, it is also important to consider differences in the situation of beneficiaries in the FFS program in the two kinds of areas. First, consider FFS beneficiaries in the higher-service-use areas; they have higher out-of-pocket expenses—either directly, related to their higher use of services, or indirectly through higher cost for supplemental plans. This higher use does not result in higher quality. In fact at the state level the opposite is true: Higher use is correlated with lower quality (Baicker and Chandra 2004, MedPAC 2003). Considering the FFS beneficiaries in lower-service-use areas, their out-of-pocket spending is less and supplemental premiums are lower than in higher-service-use areas. At the state level, quality is higher in lower-service-use areas. In terms of equity, although beneficiaries do not have access to extra benefits through private plans, they do have access to providers that produce high-quality care from fewer services, which translates to higher quality at less cost to beneficiaries. In some sense, the inequities in the FFS program are the opposite of those in the private plans.

Changes in program shifted goals

In response to the issue of geographic inequity, beginning with the BBA in 1997, the goals of the program shifted to:

- making private plans of some type available to all beneficiaries even in areas where they had not been

economically viable because of low service use or market conditions, and

- providing benefits beyond those in traditional Medicare through private plans to all beneficiaries.

To meet these goals, benchmarks for plan payment were raised. As we described earlier, legislation established floors for benchmarks. The update mechanism was also changed and benchmarks in many areas increased—in some cases beyond the expected level—because of the ratchet mechanism that allows county benchmarks to only increase and never decrease. New types of plans were created that did not require contracted provider networks, and enrollment in those plans increased rapidly under higher payment rates.

The goals of enhanced benefits and availability for all have been met, although certain areas still have more benefits available than others. However, the other result is that the Medicare program now pays much more for beneficiaries who join MA plans than for similar beneficiaries in FFS.

Current MA system encourages inefficiency Successive changes have resulted in today's MA program and the current situation in which:

- excessive payments encourage inefficient plans and increase Medicare spending.

- higher spending hastens the insolvency of the Part A trust fund.

- the burden on taxpayers is increased.

- all beneficiaries pay higher Part B premiums.

- new inequities are created.

Instead of encouraging innovative plans, the current MA payment system encourages inefficient plans, because the benchmarks used as bidding targets are set too high, and plan payments are not linked to performance.[23] Current benchmarks are on average 118 percent of what Medicare would spend for similar beneficiaries in FFS, and payments are 114 percent of that amount; more than 13 percent of those payments are used to pay for plans' overhead (administrative costs and margins) and not for direct medical care for beneficiaries. The high payment benchmarks increase payments and distort incentives. Plans do not have to be efficient to thrive under the current payment system.

Higher payments in MA than in FFS for similar beneficiaries hasten the insolvency of the Medicare Part A trust fund. The CMS Office of the Actuary estimates that the trust fund will become insolvent 18 months earlier than it otherwise would have if current MA payment and enrollment trends continue (U.S. House 2008). The burden on taxpayers to pay for the system is also increasing as part of the cost of Medicare is funded with general tax revenues.

All beneficiaries have to pay higher Part B premiums ($3 more per month) to subsidize the MA plans and extra benefits for the minority of beneficiaries who are in those plans, creating a new form of inequity. The MA plans with the highest level of extra benefits tend to be in the areas where use of services in FFS is very high. One approach to address the perceived inequity is to reduce Part B premiums in lower-service-use areas. Note, however, that this would result in lower Part B revenues, which would have to be offset by higher premiums for beneficiaries in high-cost areas (by law 25 percent of the cost of Part B has to come from beneficiary premiums).

Although MA plans may provide extra benefits, Medicare pays a high price for them to do so. Overall, the Medicare subsidy per dollar of enhanced benefit is $1.30 for all plans. In the case of HMOs, because their bids for the Medicare benefit package are below Medicare FFS spending, the program subsidy is $0.97 for each $1.00 of enhanced benefits. HMOs are the only MA plan type that finances any part of enhanced benefits through plan efficiencies: $0.03 of every $1.00. Medicare subsidizes enhanced benefits in other plan types (MedPAC 2009). At the extreme, Medicare pays a subsidy of $3.26 for each $1.00 of enhanced benefits a member receives in a PFFS plan.

Although plans are being paid more, the extra payments do not necessarily result in higher quality of care. The National Committee for Quality Assurance found that the most recent results for MA plans show the "second year in a row of relatively flat performance" among MA plans on HEDIS quality measures (NCQA 2008). Although an MA plan is available to every beneficiary, plans with above-average quality rankings are available to only about half of beneficiaries.

The growth in less efficient plans heightens our concerns about equity issues that arise with MA relative to the traditional Medicare program, about equity for beneficiaries and taxpayers, and about ensuring a level playing field among the different MA plan types. The

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equity and efficiency issues are of particular concern when Medicare is not financially sustainable in the long run.

Current MA system could threaten access to care for FFS beneficiaries In the attempt to reach the goal of MA plans everywhere, very high rates must be paid in areas with low FFS use and markets that do not support low negotiated rates for MA plans. MA plans that enter such markets may actually have to pay rates to physicians, for example, that are higher than Medicare rates and they can afford to do so because benchmarks are set too high. If this trend is allowed to continue, Medicare could face

a situation in which physicians accept only the higher MA plan rates, making it difficult for FFS beneficiaries to find physicians who accept Medicare FFS rates. This "hollowing out" of FFS may already have started in certain areas. For example, a large medical group in Oregon is not accepting new patients enrolled in traditional Medicare or Medicare PFFS plans but continues to accept Medicare patients enrolled in all of the MA CCPs operating in its county (Oregon Medical Group 2009). The concern here is that those CCPs may be paying rates that are higher than traditional FFS rates.

Recasting the goals for MA

Reconciling the original efficiency goals of the program with the goal of alleviating perceived geographic inequities is essential for the MA program going forward. The geographic inequities that resulted from including private plans in Medicare were a reflection of geographic differences in the use of Medicare FFS. In areas where the use of services was inordinately high in FFS, private plans could offer very high levels of extra benefits. Beneficiaries in lower-service-use areas perceived that they were paying higher premiums in FFS to support high FFS use in other areas and were also supporting higher benefits from private plans in other areas. The current MA program, while providing private plans in all areas, continues to fund higher extra benefits in higher-service-use areas and also encourages inefficient plans at a time when maintaining Medicare sustainability should be the overriding goal. But MA cannot be the vehicle for addressing the underlying problem of some areas having very high FFS use and poor quality; Medicare must develop and implement separate policies to ensure the efficient and appropriate delivery of high-quality care under the FFS benefit.

The goal of the MA program ought to be to enlist private plans in the task of improving efficiency and quality, thereby reducing Medicare expenditures. This goal is in some sense a return to the original goals of the program, with the important addition of encouraging high quality of care. Ideally, one wants efficient, high-quality plans with innovative delivery systems and care management techniques available in every area where FFS use levels and market conditions allow. Plans that can provide the basic Medicare benefit more efficiently than FFS Medicare by definition can provide extra benefits yet be financially neutral to FFS Medicare. Balancing extra benefits across geographic areas can then be addressed directly as we have described, removing inequity arising from the MA program itself. More plans then could compete with each other on quality and benefits, providing meaningful choices for beneficiaries. ∎

Endnotes

1 Administrative costs include items such as member service activities, provider contracting, provider relations, medical management, quality improvement activities, information systems, claims processing, marketing, and other nonmedical costs. These costs vary among plans. Private fee-for-service plans are likely to have high administrative costs associated with claims processing but few costs associated with provider contracting. Generally, an HMO with salaried physicians that owns its own hospitals has little in the way of claims processing costs, while a preferred provider organization has both claims processing and provider contracting costs. Plans that serve employer-group enrollees exclusively generally have much lower marketing costs than plans that enroll Medicare beneficiaries individually.

2 The plan types in MA are:

• HMOs and local PPOs. These plans have provider networks and can use tools such as selective contracting and utilization management to coordinate and manage care. They can choose to serve individual counties and can vary their premiums and benefits across counties.

• Regional PPOs. Regional PPOs are required to serve and offer a uniform benefit package and premium across designated regions made up of one or more states. They are the only plan type required to have limits, or caps, on out-of-pocket expenditures. Regional PPOs have less extensive network requirements than local PPOs.

• PFFS plans (and plans tied to medical savings accounts). These plans typically do not have provider networks. They use Medicare FFS payment rates, have fewer quality reporting requirements, and have less ability to coordinate care than other types of plans.

• Coordinated care plans (CCPs). CCP is a larger grouping that includes all HMOs, local PPOs, and regional PPOs.

3 Actual plan payments, as opposed to payment rates, are risk adjusted. A more detailed description of the MA program payment system can be found at http://www.medpac.gov/documents/MedPAC_Payment_Basics_08_MA.pdf.

4 The update is based on the statutory requirement of subsection 1853(k)(1)(B) of the Social Security Act, which is the national per capita MA growth percentage, adjusted for past over- or underestimates. As of 2007, there is no longer a minimum percentage increase for MA payments (as had been provided for under subsection 1853(c)(1)(C) of the Social Security Act).

5 For example, CMS estimated per capita FFS spending for each county in 2009. To obtain these estimates, CMS calculated per capita FFS spending in each county over five years, 2002 through 2006. The estimated FFS spending is equal to an average for these five years.

6 The statute set benchmarks in Puerto Rico effectively at 180 percent of FFS expenditures. Excluding Puerto Rico from the overall statistics in the updated analysis results in benchmarks of 117 percent (rather than 118 percent) of FFS and puts MA payments at 113 percent (rather than 114 percent) of FFS.

7 Regional PPO plans have different benchmarks than local plans. The uniform region-wide benchmark for such plans is based on county MA payment rates along with a component based on plan bids. See the description in the payment basics document at http://www.medpac.gov/documents/MedPAC_Payment_Basics_08_MA.pdf.

8 The Balanced Budget Act of 1997 set a floor for all counties, which we refer to as the lower floor. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 then created a second floor for counties in urban areas with 250,000 or more residents, which is referred to as the "large urban" floor. In 2009, the lower floor is $741 and the large urban floor is $819.

9 The figures shown in Table 7-1 are based on CMS's estimates of payments in relation to FFS expenditures for 2009. In the rate announcement for 2010 (CMS 2009b), CMS compared the published estimates and updated estimates of per capita Medicare expenditures for 2009. For Part A and Part B of Medicare, for the aged and disabled combined, the ratio of the published estimate to the current estimate was 0.989; that is, FFS expenditures at the U.S. per capita level were underestimated in the published estimate by 1.1 percentage points. This underestimate would mean the ratios of Table 7-1 are overstated. At the same time, however, MA payments in relation to percent of FFS shown in Table 7-1 may be understated because of the differences CMS has observed in coding of diagnoses between MA and the FFS sector. For 2010, CMS will make a downward adjustment to plan risk scores of 3.41 percentage points to reflect the coding differences. (We do not know what adjustment would be applicable to the single year of 2009.) The figures of Table 7-1 are based on values for a person of average risk in each sector—that is, a person with a risk score of 1.0. More extensive coding in the MA sector would understate the level of plan payments when adjusted to a risk score of 1.0. The two adjustments—for the revised estimate of FFS expenditures and an adjustment for risk-coding differences—would therefore work in opposite directions.

Another factor to consider is that there is some interaction between FFS and MA that can affect the comparisons. The MA program can reduce expenditures in the Part D program. Since bids for both stand-alone prescription drug plans and MA drug plan bids make up the overall national average Part D bid and affect Medicare's payments to drug plan sponsors, lower average bids by MA plans somewhat reduce federal program spending for Part D.

10 In past reports, we noted that some of the low HEDIS scores plans reported may reflect poor reporting practices rather than poor quality of care. Poor reporting may occur because payments are not tied to quality and quality ratings may not be important in competition among Medicare plans. In addition, much of the quality data reported by CMS is at the Medicare plan contract level (or "H number" level), including the plan star ratings. As we will discuss in more detail in a separate MIPPA report on quality reporting for MA, contract-level reporting results in some plans having a single score reported for a very wide geographic area. Despite these limitations, the star rating system is a useful indicator of the availability of high-quality plans.

11 Under some circumstances, newer plans or plans with small enrollment may have insufficient information for a star rating to be assigned. For example, they may not have enough members to meet thresholds for HEDIS reporting (MedPAC 2008).

12 We use enrollment numbers for early 2008 because the plan ratings are based on 2007 quality indicators.

13 The statutory basis for the AAPCC is subsection 1876(e)(4) of the Social Security Act, a provision that predates the MA program. Under the MA payment provisions of subsection 1853(c)(1)(D) of the Social Security Act, the AAPCC is to be used as a basis of payment "adjusted as appropriate for the purpose of risk adjustment, for the MA payment area for individuals who are not enrolled in an MA plan under this part for the year, but adjusted to exclude costs attributable to payments under section 1886(h)" (i.e., excluding graduate medical education payments).

14 Part of the reason fewer beneficiaries enroll in Part B in Puerto Rico is the high cost of the Part B premium in relation to the cost of medical care in the Commonwealth and the income of the population. For example, in 1997, when the monthly Part B premium was $43.80, the published AAPCC rates for Cabo Rojo *municipio* show that per capita Medicare program expenditures averaged $148 per month, consisting of $58 in Part A expenditures and $90 in Part B expenditures. The higher per capita Part B expenditures (expenditures per Part B enrollee compared with Part A expenditures over a larger count of beneficiaries) may indicate that beneficiaries electing Part B are sicker and have higher costs. Outside of Puerto Rico, only one county in the United States had a 1997 per capita Part B expenditure exceeding the Part A level (Banner, Nebraska, with 92 beneficiaries).

15 All other *municipios* are paid based on updates from the floors for Puerto Rico established in the Balanced Budget Act of 1997 (BBA) and revised in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). The BBA established the Puerto Rico floors as 150 percent of the 1997 AAPCC amounts for each *municipio*, and BIPA established a new floor for Puerto Rico (and other areas outside the United States) at 120 percent of the payment rate for the year 2000. The only nonfloor area in Puerto Rico is Culebra *municipio* (an island off the main island), which in 2005 and 2007 had its benchmark set at FFS rates.

16 Most dual eligibles have their Part B premium paid by the Medicaid program. The Commonwealth of Puerto Rico does not have such a "buy in" program for the Part B premium for Medicare–Medicaid duals. Most MA enrollees in Puerto Rico are in special needs plans (SNPs) for dual eligibles—53 percent as of February 2009 (with another 7 percent in chronic care SNPs, many of which have dual eligibles as enrollees). Each organization offering dual SNPs in Puerto Rico has at least one option in which the enhanced benefit (financed by MA rebate dollars) includes a reduction of some or all of the Part B premium.

17 The Congress did, in one instance, provide CMS with very broad authority to establish an alternative payment rate in subsection 1853(c)(3)(D) of the Social Security Act: "Treatment of areas with highly variable payment rates.—In the case of a … payment area for which the annual per capita rate of payment … for 1997 varies by more than 20 percent from such rate for 1996, for purposes of this subsection the Secretary may substitute for such rate for 1997 a rate that is more representative of the costs of the enrollees in the area."

18 However, this solution may lead to more year-to-year variation in MA benchmarks for smaller counties if geographic areas are not reconfigured (as we discuss in the appendix to this chapter).

19 Correlation measures how two variables move in relation to each other. If one variable is relatively high, is the other one relatively high or relatively low? The correlation coefficient (known as r) measures the degree to which two variables move together. It can vary between +1.0 and –1.0. If two variables were perfectly positively correlated, the coefficient would be +1.0, which means the two variables are always high and low together. A coefficient of –1.0 means that when one variable is high, the other variable is always low and vice versa. A coefficient of 0 means they do not vary together at all (no correlation); if one variable were high the other variable would be equally likely to be high or low. Coefficients near 1.0 show high correlation and those near 0 show low correlation.

20 Including FFS as a bidding plan would involve a number of additional design decisions, such as the possible effect on the premiums for the FFS option in a given competitive area.

21 Another option that we describe later, the input-price-adjusted blend option, produces benchmarks that are always between $618 per month and $926 per month. To increase the comparability of the options, we used the minimum from one option as the floor for this option, and the maximum as the ceiling.

22 The original Medicare risk program set payments at 95 percent of FFS. Plans were expected to be more efficient than traditional FFS and to have money left over to provide extra benefits to attract enrollees. Payments were not adjusted to take into account enrollees' health status, so there was some concern about plans selecting healthier than average enrollees and essentially receiving higher payment than the 95 percent number suggests. Although the Medicare risk

contracting program was authorized in 1982 legislation (the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)), no "TEFRA risk" plans were able to operate until the payment system was put in place through regulations promulgated in 1985. Predecessors to the MA program are discussed further elsewhere (MedPAC 2001).

23 By design, the statutorily set benchmarks in some localities exceeded FFS spending to encourage plans to enter the MA program in areas they had not traditionally served. The process for setting benchmarks is rooted in a payment system for Medicare's private plan option established in 1997 legislation and modified through later legislation. As a result, MA payment rates in the vast majority of counties are now higher than local per capita spending in the FFS program. CMS is required to make two adjustments to county benchmarks—updates and rebasing—which exacerbates the problem. These adjustments can only raise county benchmarks but never lower them.

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Medicare Advantage payment areas

In the Medicare Advantage (MA) program, an individual county defines a payment area. Each county has a benchmark rate against which MA plans must bid if they want to serve the county. Each year CMS is required to adjust each county's benchmark by a "minimum update" defined as the percentage projected change in overall Medicare expenditures over the preceding year. However, CMS is legally required at least every three years to estimate per capita spending in fee-for-service (FFS) Medicare in each county, which CMS calculates based on a five-year moving average (see text box, pp. 176–177, for description).[1] In the rebasing years when CMS calculates counties' FFS spending, that spending becomes the benchmark if it exceeds the amount that results from the minimum update.

Using counties as payment areas in conjunction with using county-level FFS spending in setting benchmarks creates two problems. First, many counties have small populations in the FFS program. Among these counties, unusually high or low levels of health care use by just a few FFS beneficiaries can cause substantial annual changes in FFS spending. For example, from 2007 to 2009 FFS spending (adjusted for risk) increased by more than 30 percent in Loving County, Texas, which has fewer than 20 FFS beneficiaries.

Large annual changes in county-level FFS spending are a problem because benchmarks based on counties' FFS spending can be either too high or too low. For example, if CMS calculates FFS spending by using data from a year when a county experienced unusually high FFS spending, the county could have a benchmark much higher than its "true" FFS spending. Moreover, the large annual changes that can occur with benchmarks based on FFS spending can make it difficult for plans to formulate long-term business strategies.

Large annual changes in FFS spending are more common in counties with small Medicare populations. For example,

2004 was one of the years when CMS used counties' FFS spending to set county benchmarks. From 2004 to 2005, the average change in county FFS spending was 10.1 percent among the counties with the 10 percent smallest Medicare populations and 5.1 percent among the counties with the 10 percent largest Medicare populations. Relatively unstable payment rates in small counties may make them less attractive to plans than larger, more stable counties.

The second problem that using counties as payment areas presents is that adjacent counties often have very different levels of FFS spending. This situation can be due to one county having an unusually costly year or it can happen because adjacent counties have persistently different costs. In either event, basing benchmarks on FFS spending can result in adjacent counties having very different benchmarks. When that occurs, plans tend to offer more limited benefits in the county with the lower benchmark—or avoid that county altogether—which creates appearances of inequity between adjacent counties (MedPAC 2001).

These two problems are not unique to the current method for setting benchmarks. Any method of setting county benchmarks that bases them on counties' FFS spending has the potential to result in benchmarks with large annual fluctuations and benchmarks for adjacent counties that are substantially different.

The problems can be addressed by any payment area definition that groups contiguous counties into larger geographic units. Such a definition would increase the number of Medicare beneficiaries within payment areas, making FFS spending more stable over time. In addition, grouping contiguous counties would reduce the frequency of having large differences in FFS spending among adjacent counties. Although plans often create service areas that consist of clusters of contiguous counties, these clusters do not address the problems presented by the

county definition of payment areas. Instead, payment areas should be defined groups of contiguous counties and plans should, in general, be required to cover the entire payment area. The Secretary could make exceptions when plans have difficulty maintaining a provider network throughout a payment area.

Developing an appropriate payment area involves more than simply grouping counties, however. When we consider alternative payment areas, we must be attentive to two issues:

- Although we advocate larger payment areas, they must not be so large that the cost of serving beneficiaries varies widely within payment areas.

- Payment areas should closely match the market areas that plans serve.

If a payment area definition fails to address either of these issues, plans may find that their payments exceed their costs in some parts of a payment area and fall short of their costs in other parts. Plans would have an incentive to serve the parts of the payment area where they are profitable and avoid the parts where they are not. However, if Medicare required plans to serve the entire payment area, they could not act on that incentive. In that situation, the potential for financial losses in some parts of a payment area may cause plans to avoid that area altogether, and any definition of payment areas should be mindful of that issue.

Alternative to the county definition of payment areas

In our June 2005 report, the Commission made the following recommendation to address the issues presented by the county definition of payment areas (MedPAC 2005):

The Congress should establish payment areas for MA local plans that have the following characteristics:

- Among counties in metropolitan statistical areas (MSAs), payment areas should be collections of counties located in the same state and the same MSA.

- Among counties outside MSAs, payment areas should be collections of counties in the same state that are accurate reflections of health care market areas, such as health service areas (HSAs).

We refer to this combined use of MSAs and HSAs as the MSA–HSA definition (see text box, p. 213, for a description of HSAs).

In our June 2005 report, the Commission considered several alternatives for combining counties into larger payment areas. The Commission recommended the MSA–HSA definition because it not only addressed the problems presented by the county definition but it was the best match to the market areas served by private-sector plans, so it was likely a better match to the markets served by MA plans. We have no reason to believe plan market areas have substantially changed since the June 2005 report, so we use the MSA–HSA definition as an illustration of how payment areas larger than the county can address the problems presented by counties.
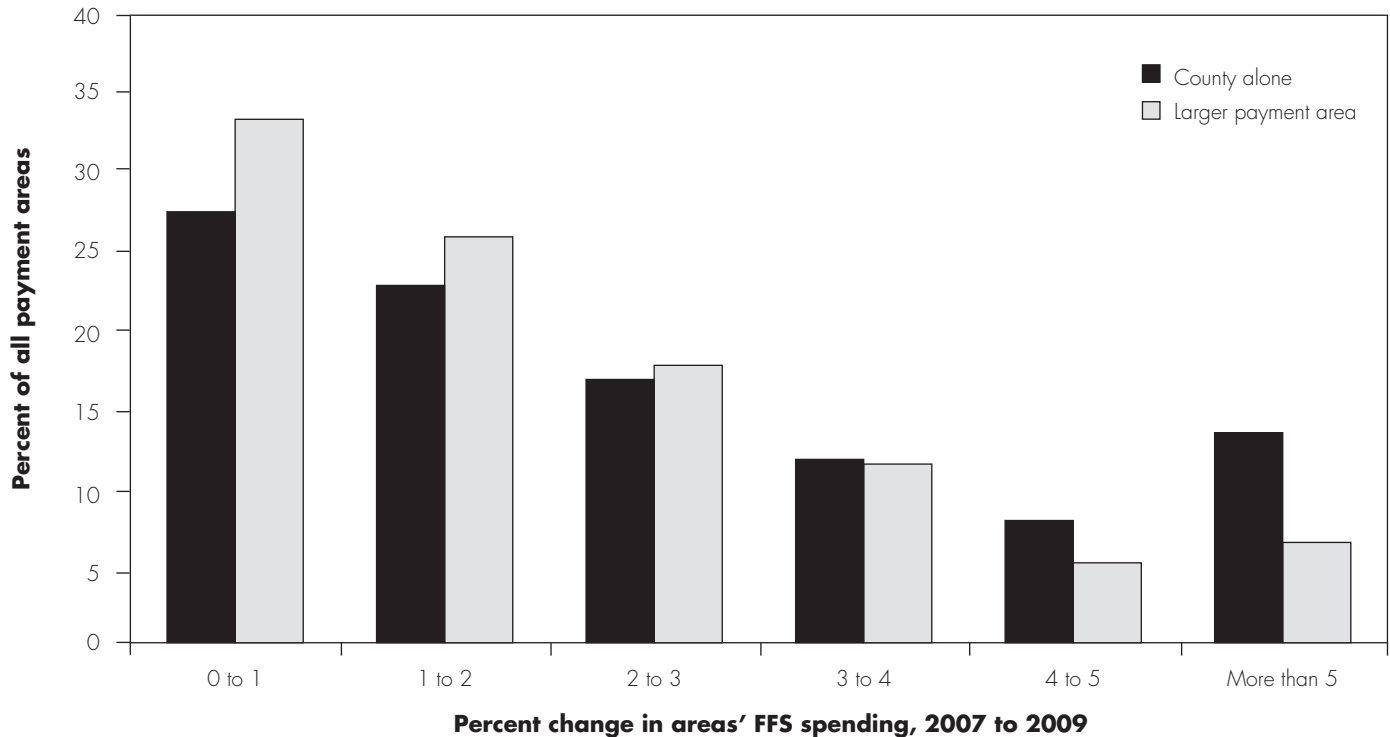
Benefits of larger payment areas

We used CMS's estimates of counties' per capita FFS spending to evaluate how larger payment areas affect stability of FFS spending and the differences in FFS spending between adjacent counties.

To evaluate the stability of FFS spending, we used CMS's estimate of county-level FFS spending that the agency used to set benchmarks in 2007 and 2009. We found that FFS spending is more stable under the MSA–HSA payment areas than under the county payment areas. At the county level, the average change in FFS spending from 2007 to 2009 is 2.0 percent under the MSA–HSA definition but 2.6 percent under the county definition. More important is that the MSA–HSA definition has fewer large annual changes in FFS spending than the county definition. Under the county definition, 13 percent of counties had a change in FFS spending of more than 5 percent from 2007 to 2009 compared with only 6 percent under the MSA–HSA definition. Conversely, 34 percent had a change of less than 1 percent under the MSA–HSA definition compared with 28 percent under the county definition (Figure 7-1A).

Greater stability under the MSA–HSA definition reflects the fact that it would generally increase (and never decrease) the number of beneficiaries in each payment area. Larger payment areas are especially helpful in improving measured stability of FFS spending in the counties with the lowest Medicare enrollment. For the counties with the lowest 10 percent of Medicare enrollment, the average change in per capita FFS spending from 2007 to 2009 is

FIGURE
7–1A

Larger payment areas result in more stable FFS spending

Note: FFS (fee-for-service). Larger payment areas are a combination of counties in a metropolitan statistical area (MSA) for urban counties and health service areas (HSAs) for rural counties. If an MSA or HSA is divided by state borders, the part in each state is a distinct payment area. The results reflect absolute values of the percent change in county per capita FFS spending from 2007 to 2009.

Source: MedPAC analysis of county-level per capita FFS spending from CMS.

4.7 percent under the county definition but only 2.8 percent under the MSA–HSA definition.

We also found that large differences in FFS spending between adjacent counties occur half as frequently under the larger payment areas. Under the MSA–HSA definition, 12 percent of counties have an adjacent county with per capita FFS spending at least 15 percent higher. Under the county definition, 24 percent of counties have an adjacent county with per capita FFS spending at least 15 percent higher (Figure 7-2A, p. 212).

CMS should use larger payment areas in the MA program

We do not consider the MSA–HSA definition to be an optimal payment area definition, which is to be expected; no single method of grouping counties can perfectly match

all plan market areas because markets differ. However, the Commission finds the MSA–HSA definition preferable to the county definition. Moreover, the Commission finds it preferable to other alternatives because it is the best match to plan market areas (see our June 2005 report for analysis).

More recent data indicate the MSA–HSA definition is still a reasonably good match to plan market areas. We have identified two measures that provide a sense of how well a payment area definition matches plan market areas:

- If a plan currently serves at least one county of an MSA–HSA, what percent of the beneficiaries in the MSA–HSA does it serve? For example, if an MSA–HSA has three counties with a total of 500,000 beneficiaries and a plan serves two of these counties that have 400,000 beneficiaries, we would say the plan serves 80 percent of the beneficiaries in the MSA–HSA.

- If a plan serves at least one county in an MSA–HSA, does it serve the entire MSA–HSA?

FIGURE
7–2A

Larger payment areas smooth differences in FFS spending among counties
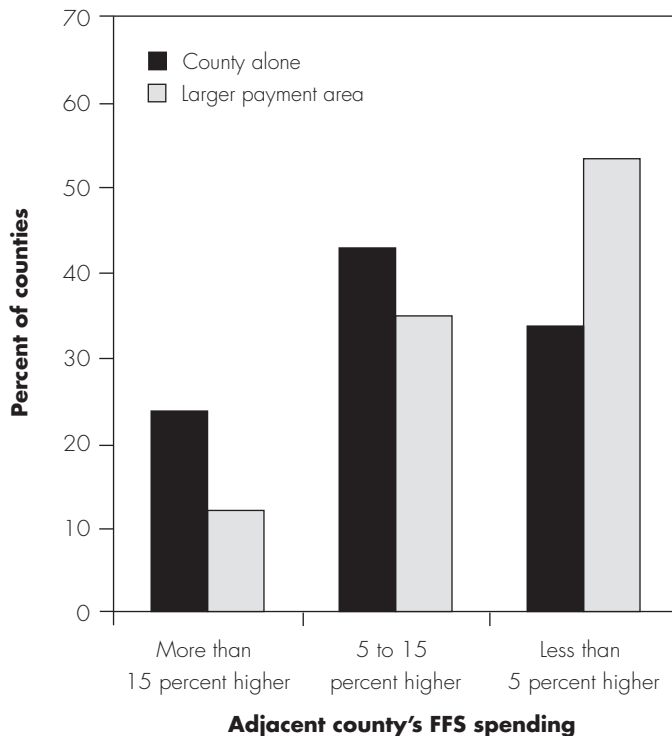
Note: FFS (fee-for-service). Larger payment areas are a combination of metropolitan statistical areas (MSAs) for urban counties and health service areas (HSAs) for rural counties. If an MSA or HSA is divided by state borders, the part in each state is a distinct payment area.

Source: MedPAC analysis of county-level per capita spending from CMS.

The logic underlying both measures is to identify how likely a plan is to cover an entire MSA–HSA given that the plan has chosen to serve at least one county in the MSA–HSA.

Our analysis indicates that if a plan covers at least one county in an MSA–HSA, it covers 86 percent of the beneficiaries in the MSA–HSA, on average. Also, if a plan covers at least one county in an MSA–HSA, it covers the entire MSA–HSA about 72 percent of the time. We also find that private FFS plans are a little more likely to cover entire MSA–HSAs than are HMOs or local preferred provider organizations (Table 7-1A). (We also examined this issue in relation to the availability of higher quality plans (those with CMS star ratings of 3.5 or higher) and found that 75 percent of those plans cover an entire MSA–HSA (not shown).)

One consequence of larger payment areas is that, relative to current benchmarks, some counties will have higher benchmarks and other counties will have lower benchmarks. Revenue will increase for plans in counties where benchmarks increase and will decrease for plans in counties where benchmarks decrease. It is difficult to say what method the Congress would mandate for setting benchmarks under larger payment areas, but we evaluated what would happen under one possibility: Set the benchmark for each payment area under the MSA–HSA definition equal to a weighted average of the current benchmarks for the counties that make up the payment area. The weights are equal to each county's total Medicare population. We estimate that 20 percent of counties would have lower benchmarks, 31 percent would have higher benchmarks, and 49 percent would have the same benchmark.

The MSA–HSA definition would redistribute MA program spending among counties located in MSAs as well as among counties located outside MSAs. However, spending would not be redistributed from counties outside MSAs to counties located in MSAs, or the other way around, which means that total revenue going to metropolitan counties would not change, nor would total revenue change for nonmetropolitan counties. The way that revenue would be redistributed is an artifact of the way the MSA–HSA definition is constructed. Counties in MSAs are combined with other counties in MSAs. Likewise, counties outside MSAs are combined with other counties outside MSAs.

The MSA–HSA definition also would not redistribute MA program spending among states. Each state would have the same MA revenue as it has under the county definition of payment areas, assuming MA enrollment does not change. This situation again is an artifact of the way the MSA–HSA payment areas are constructed. Counties must be in the same state to be in the same payment area. Therefore, even though revenue is redistributed among counties, it is done among counties in the same state. Therefore, each state has the same amount of MA revenue under the MSA–HSA definition as it has under the county definition.

Because the MSA–HSA definition would redistribute spending among counties, plan participation and beneficiary enrollment would likely change. However, we do not know the extent or magnitude of these changes. Relative to the county definition, the MSA–HSA definition would tend to increase plan participation and beneficiary enrollment in counties whose benchmarks would increase

The health service areas (HSAs) we used in our analysis consist of collections of counties in which most of the short-term hospital care received by beneficiaries living in those counties occurs in hospitals in the same collection of counties. Very little short-term care occurs in hospitals outside those counties.

A study by Makuc and colleagues defines the HSAs (Makuc et al. 1991). Their method for grouping counties has the following features:

- They predetermined that the number of HSAs should be about 800. They based this number on previous work that defined health care market areas.

- In the initial step, the number of groups equaled the number of counties (about 3,100).

- In the second step, they combined the two groups (counties) with the greatest "flow" of short-term hospital care among Medicare beneficiaries. They defined flow as the proportion of all hospital stays among beneficiaries in one group that occurs in hospitals in another group.

- In each subsequent step, they combined the two groups with the greatest flow of short-term hospital care.

They continued until they obtained the predetermined number of HSAs. ∎

and would decrease plan participation and beneficiary enrollment where benchmarks decrease.

An issue that occurs no matter how we define payment areas is that costs of serving beneficiaries vary within a single payment area. Consequently, some parts of a payment area are more profitable to a plan than other parts. Plans benefit financially if they are able to serve the parts of a payment area where they are profitable and avoid the parts where they are not profitable. To prevent this selection from occurring, plans should, in general, be required to bid on and serve entire payment areas. Provider networks should be required to have reasonably convenient access for enrollees to obtain care in any part

of a payment area. Current law largely addresses these issues of enrollees' access by stating that an MA plan must "make their benefits available and accessible to each individual electing the plan within the plan service area with reasonable promptness and in a manner which assures continuity in the provision of benefits."

However, as payment areas increase in size, it becomes increasingly likely that plans would have difficulty maintaining provider networks throughout a payment area. Therefore, the Secretary should be allowed to make exceptions if plans can prove that it is difficult to maintain provider networks throughout a payment area.[2]

TABLE
7–1A

The MSA–HSA definition of payment areas provides a good match to market areas served by MA plans

	All types of local MA plans	HMOs	Local PPOs	PFFS
If plan serves MSA–HSA, percent of beneficiaries served	86.0%	83.8%	85.7%	87.4%
If plan serves one county of MSA–HSA, likelihood all counties served	71.7	62.2	63.7	74.3

Note: MSA (metropolitan statistical area), HSA (health service area), MA (Medicare Advantage), PPO (preferred provider organization), PFFS (private fee-for-service). The MSA–HSA definition collects metropolitan counties into MSAs and nonmetropolitan counties into HSAs. The HSAs were developed by Makuc et al. (1991).

Source: MedPAC analysis of Medicare Advantage and total Medicare enrollment data for 2008, by county.

One way that plans could try to circumvent rules that require them to serve entire payment areas is to market their products so they target beneficiaries in the parts of a payment area where the benchmark is favorable relative to costs of care. CMS would need to ensure that plans market their products so information about them is widely known throughout each payment area a plan serves.

Finally, no payment area definition is perfect. One problem with the MSA–HSA definition is that payment areas in HSAs may be in noncontiguous counties. Nevertheless, the MSA–HSA definition is better than the current county definition. If the MSA–HSA definition does create noncontiguous payment areas, the Secretary could examine those situations to determine whether to break up an HSA into smaller groups of counties.

On the basis of our assessment of payment areas in the MA program, we reiterate our recommendations from the June 2005 report.

We caution that the HSA definition we used in our analysis is purely for illustrative purposes. Makuc and colleagues defined HSAs by using data from hospital inpatient stays that occurred in 1988 (Makuc et al. 1991). If the Congress chooses HSAs as a payment area, the Secretary should update those HSAs and keep them up to date. The Secretary should use the most recent source data and make sure the updates reflect changes in service areas. The update will be a complicated process, and the Secretary should allow ample time for it to be done properly. ■

Endnotes

1   For example, CMS has estimated per capita FFS spending for each county in 2009. To obtain these estimates, CMS calculated per capita FFS spending in each county over five years, 2002 through 2006. Estimated FFS spending is based on the average for these five years.

2   The Secretary has this authority under the county definition and has used it in these counties: Los Angeles (CA), Kern (CA), Orange (CA), Riverside (CA), and Pinal (AZ).

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