

MEDICARE ADVANTAGE BENCHMARKS AND PAYMENTS COMPARED WITH AVERAGE MEDICARE FEE-FOR-SERVICE SPENDING

Medicare**briefs**

The purpose of this report is to present data on the level of Medicare Advantage (MA) payments for Parts A and B services relative to the spending on similar beneficiaries in Medicare's traditional fee-for-service (FFS) program. This responds to requests from Congressional committees to update our past analyses. The last time MedPAC staff estimated this relationship, in April 2004, we found that the average payment to MA plans was 107 percent of the cost of demographically and geographically similar beneficiaries in the FFS program. The 107 percent figure did not account for any health risk differences between the plan and FFS populations because we could not independently estimate those differences.

Several changes in MA payment have occurred that require us to update our modeling of the relative payment analysis. First, Medicare payments to plans are determined differently than in 2004. CMS no longer determines MA plan payments based solely on administratively set payment rates. Plans now submit formal bids, and then CMS compares the bids with benchmarks to determine payment. Benchmarks are bidding targets that CMS sets for every county administratively, as directed by law. The exception is the case of MA regional preferred provider organizations (PPOs), for which the benchmarks are based in part on bids that are submitted by the plans. For both local plans and regional PPOs, Medicare's payment declines if bids are lower than the benchmarks.

Also, there are more plans and greater beneficiary enrollment in plans than in 2004. In 2006, virtually all Medicare beneficiaries have an MA plan available. (More detail on plan availability can be found in Chapter 9 of MedPAC's forthcoming June 2006 report.) Plan

service areas have expanded to more rural and other areas with benchmarks that are high relative to Medicare FFS spending. The benchmarks were relatively high because these areas were given increases in payment rates under earlier law.

Finally, the risk adjustment system has changed payment rates. In 2004, the Centers for Medicare & Medicaid Services (CMS) adjusted plan payments with a blend of 70 percent demographic factors and 30 percent health risk factors. For 2006, 25 percent of each payment is based on the demographic factors and 75 percent is based on the health risk factors. By 2007, payments will be based 100 percent on risk-adjusted rates.

2004 findings

Our findings in April 2004 were based on 2004 county payment rates and enrollment as of December 2002 as published by CMS for aged beneficiaries.¹ We found that the MA payment rates resulted in payments to MA plans averaging 107 percent of expected Medicare FFS costs for demographically and geographically similar beneficiaries. We noted in our presentation of this finding that any effects of health risk differences between the plan and FFS populations were not accounted for with this analysis.

Updating and refining the analysis

We update the analysis through the use of 2006 data for enrollment and payment changes. CMS no longer sets purely administrative payment rates. Instead, the agency publishes county (and regional) benchmarks. The 2006 benchmarks are the 2005 MA county payment rates, updated by the projected national growth rate in per capita Medicare spending.²

MedPAC

601 New Jersey Ave., NW
Suite 9000
Washington, DC 20001
ph: 202-220-3700
fax: 202-220-3759
www.medpac.gov

Table 1 Medicare Advantage benchmarks and payments compared with average Medicare FFS spending

	2004 demographic payments based on 2002 enrollment without risk adjustment	2006 demographic payments based on 2005 enrollment without risk adjustment	2006 demographic and risk payments based on 2005 enrollment with hold-harmless adjustment
Benchmarks (or 2004 payment rates) relative to FFS	107%	108%	115%
Medicare plan payments relative to FFS	107	104	111

Note: FFS (fee-for-service). All enrollment data are for December. 2004 demographic data are for aged beneficiaries.

Source: MedPAC analysis of plan bids, enrollment, and benchmarks published in the 2006 Medicare Advantage rate final notice.

CMS bases the payment for private plans on the relationship between their bids and the benchmarks. If a plan's bid falls above the benchmark, then the plan receives the benchmark as its payment and the enrollees will have to pay an additional premium that equals the difference between the bid and the benchmark. If the plan's bid falls below the benchmark, the Medicare program retains 25 percent of the difference, and the plan receives the other 75 percent as a rebate, in addition to the amount of its bid. The plan must return the rebate to its enrollees in the form of lower Medicare cost sharing, lower Part B or Part D premiums, or non-Medicare supplemental benefits. Thus Medicare will never pay the plan more than the benchmark and will usually pay less than the benchmark. For 2006, 95 percent of plans bid below their benchmarks. (More detail on plan bidding is available in Chapter 9 of MedPAC's forthcoming June 2006 report.)

The first two columns of Table 1 show the effects of updating the enrollment data and comparing 2004 and 2006 MA payments relative to FFS on a common basis—that is adjusting for demography and geography only. The comparison also includes the change from administratively set payment rates to the new bidding process. The weighted benchmarks rose slightly relative to FFS Medicare spending (from 107 percent to 108 percent) because

enrollment grew in areas with higher benchmarks relative to FFS. At the same time, the bidding lowered plan payments below the benchmarks. In 2004, MA plans were paid an average of 107 percent of the FFS Medicare spending for the demographic share of payments, compared with 104 percent projected in 2006.

However, this percentage does not tell the whole story. Our April 2004 calculation did not account for the relative disease burden of the MA enrollees. CMS's estimate of that disease burden indicated that managed care enrollees were healthier than those in fee-for-service Medicare. (CMS's estimate of the disease burden is published each year in the final MA payment notice.) Our earlier figure of 107 percent would have been higher if we had included those estimates of risk differences.

With the introduction of risk adjustment, the payment system now explicitly takes into account the relative disease burden of the MA population. Risk adjustment (applied to 75 percent of payments in 2006) generally would lower payments to plans if they enrolled beneficiaries who were healthier. But CMS has taken steps to prevent overall payments to plans from going down. A hold-harmless adjustment increases the benchmark rates in 2006 by the amount that CMS expects payments would fall because of risk adjustment.

Even though the hold-harmless adjustment is scheduled to fall over time as a result of the Deficit Reduction Act of 2005, in 2006 it still has the effect of raising the benchmarks significantly. In 2007 (and subsequent years), the hold-harmless effect on the benchmarks will decline. The impact of the decline in the hold-harmless effect on payments, of course, can not be estimated because payments depend strongly of future plan bids.

The last column on the table shows the result of all these changes together for 2006. We find that the combined benchmarks are set at an average of 115 percent of FFS Medicare in 2006. After taking into account the amount that plans return to the trust fund through the bidding process, the 115 percent

figure falls to 111 percent. In sum, this 111 percent includes all three factors we have discussed: the relationship of the MA benchmarks to FFS rates, the effect of bidding and returning funds to the trust funds, and the hold-harmless provisions.

Bear in mind that these calculations are national averages, and there are areas of the country where MA payments are less than FFS. Moreover, calculations carried out on more recent and detailed data could produce estimates that vary somewhat. ■

- 1 December 2002 was the most recent count of aged enrollees.
- 2 If a local MA plan serves a multicounty area, the benchmark against which it bids is an average of the different benchmarks for the counties it serves, weighted by its projected enrollment from each county.