

Paying Medicare Advantage Plans by a Blend-Based System: Where Are the Gains and Losses?

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ABSTRACT: Medicare Advantage (MA) plans are now paid \$11 billion a year and \$150 billion over 10 years more than costs in fee-for-service (FFS) Medicare. In the past two years there have been discussions about reducing MA payments to the level of FFS costs and using the savings to offset the costs of new Federal initiatives such as health care reform. These discussions have included a number of options on the specific new approach to pay plans including: average FFS costs in each county; a blend of local county FFS costs and national FFS average costs; and a regional system based on FFS costs in multi-county regions.

Setting MA payment equal to local county FFS costs would result in a national average of payments that is equal to FFS costs and eliminate extra payments to MA plans. The local/national blend option would pay plans nationwide an average of 99 percent of FFS costs. It would, however, leave plans in counties with FFS costs below the national average with extra payments of approximately 5 percent, while plans in counties with FFS costs above the national average would be paid as much as 10 percent less than FFS costs in the county.

A regional payment system would provide MA plans in suburban counties with FFS costs lower than the regional average extra payments of 10 percent or more and pay plans in many core urban counties with FFS costs higher than the regional average up to 10 percent less than FFS costs in the county. Because MA plan enrollment rates are higher in the core counties than the suburban counties, the overall effect of a regional blend payment system would be to reduce the national average of MA payments to less than 100 percent of FFS costs.

OVERVIEW

Medicare Advantage (MA) plans are paid over \$11 billion more than it would cost Medicare if all 10 million MA enrollees instead participated in traditional fee-for-service (FFS) Medicare. These sums – payments to MA plans greater than 100 percent of average costs in FFS Medicare – are here

are termed “extra payments” and are often referred to elsewhere as “over payments”.¹

The \$11 billion in extra payments to MA plans are the product of explicit Medicare policies adopted by the Congress from 1997 to 2003. These policies replaced a system enacted in 1982 that paid Medicare private

plans 95 percent of the average adjusted per capita cost (AAPCC) of fee-for-service Medicare in each county.²

Over the past two years, Barack Obama, first as a Presidential candidate and now as President, has consistently stated that extra payments to Medicare private plans constitute wasteful Federal spending and should be eliminated.

In the fall of 2008, the Obama campaign platform stated: “We need to eliminate the excessive subsidies to Medicare Advantage plans and pay them the same amount it would cost to treat the same patients under regular Medicare.”³ More recently, the President said, “We are spending a lot of money subsidizing the insurance companies around something called Medicare Advantage, a program that gives them subsidies to accept Medicare recipients but doesn’t necessarily make people on Medicare healthier.”⁴

A new policy of setting payments to MA plans at the same level as costs in FFS service Medicare has also been supported by health leaders in the Congress. This policy was included in *Call to Action: Health Reform in 2009*, a white paper on health care reform by Sen. Max Baucus, the Chair of the Senate Finance Committee, released in November 2008: “Congress must act to level the playing field between traditional Medicare and Medicare Advantage payments and the Baucus plan would do so.”⁵ Earlier, the House of Representatives included a four year phase-out of extra payments to MA plans in the Children’s Health and Medicare Protection Act (CHAMP Act) that it passed in August of 2007.

The Congressional Budget Office has projected that eliminating extra payments to Medicare private plans would reduce Federal spending by over \$150 billion from 2010 to 2019.⁶ Savings from reduced payments to MA plans have been included in summaries of sources of funding for expanded health insurance coverage and other initiatives in a health care reform program.

The new interest in reducing payments to MA plans has raised questions of what the new payment policy should be: What does paying MA private plans “the same amount it would cost to treat the same patients under regular Medicare” mean?

This question was addressed in the Medicare Improvements for Patients and Providers Act (MIPPA), enacted in July of 2008, which directed the Medicare Payment Advisory Commission (MedPAC) to review and comment on alternative approaches to paying Medicare Advantage plans.^{7,8}

This paper analyzes three major options that have been discussed as ways of paying MA plans the same as costs in FFS Medicare. These options would pay MA plans: (1) average FFS costs in each county; (2) a blend of 75 percent local FFS costs and 25 percent national FFS average costs; or a regional payment system based on FFS costs of the counties in multiple contiguous counties. This analysis will present the effects of each of the three options on payments to MA plans in the geographic units most affected.

An additional option--paying MA plans using a bid-based system--was proposed by the Office of Management and Budget in February of this year. This approach to payments would be based on private health insurance firms’ internal costs rather than the external costs in FFS Medicare. It would thus be fundamentally different from any previous Medicare plan payment system. This bid-based payment option has been analyzed in two earlier papers by the authors: *Paying Medicare Private Plans by Competitive Bidding: Where is the Competition?*⁹ and *Paying Medicare Private Plans by Competitive Bidding: Not the Same as Costs in Regular Medicare.*¹⁰

HISTORY OF MEDICARE PAYING PRIVATE PLANS THE SAME AS FEE-FOR-SERVICE COSTS

Since 1971, with the first proposal for an increased reliance on private plans in Medicare by the Nixon

Administration, the rationale for private plans has been that they can provide care more efficiently and at lower costs than the unorganized fee-for-service health care system.¹¹

Given this premise, the overall approach to Medicare prospective payment to private plans was value-neutral regarding the existence of plans in any area. If one or more private plans could provide care more efficiently than Medicare FFS in an area, then the plan(s) would participate in Medicare and attract beneficiaries as members. But if, for whatever reason, plans could not be more efficient than fee-for-service Medicare, the policy did not artificially subsidize their presence in an area. This policy, included in Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), paid plans 95 percent of each county's average FFS costs.

The TEFRA policy was in effect until the Balanced Budget Act of 1997 changed Medicare payments to private plans in rural areas by instituting a floor on payments to plans in these counties. The Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) and the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) expanded the policy of extra payments so that plans in virtually all counties are now paid more than FFS costs in the county.

Despite the introduction of policies providing extra payments to MA plans, MedPAC has maintained that paying plans 100 percent of local FFS is consistent with the premise that if private plans provide services more efficiently, they should be able to attract Medicare beneficiaries. As MedPAC noted in its June 2009 report, "The Commission has maintained that 100 percent of FFS is the correct target for benchmarks because it would encourage the entrance of plans that are more efficient than Medicare FFS. An MA plan that is more efficient than Medicare FFS could provide the traditional benefits at a lower cost and would be able to pro-

vide additional benefits to beneficiaries, who would then be encouraged to enroll in the plan. An MA plan that is not more efficient than FFS Medicare would likely not enter the program."

OPTIONS FOR PAYING MA PLANS THE SAME AS COSTS IN FEE-FOR-SERVICE MEDICARE

Three major options that have been discussed over the past year as possibilities for paying MA plans the same as costs in FFS Medicare include setting payments at:

- 100 percent of average local FFS costs;
- A blend payment system of 75 percent local FFS costs and 25 percent average national FFS costs;
- A regional payment system based on the FFS costs in geographic areas larger than counties – assumed here to be the U.S. Bureau of Labor Statistics Metropolitan Statistical Areas (MSAs) and residual rural areas within states.

This paper will analyze the effect of payments to MA plans under these three options. This analysis uses data from MA payments and county FFS costs in 2009 and will present the impact of the policies as if the policies were fully in effect in 2009. To consider the first two approaches broadly, counties were assigned to ten cohorts of counties with approximately equal numbers of Medicare plan enrollees. Further, this analysis projects payments based on full implementation of MA policies enacted in past years that have not been fully implemented to date. The policies include: the elimination of the BNRA payments; double payments for Indirect Medicare Education; and the enrollment in 2009 of 2.5 million beneficiaries in Private Fee-for-Service (PFFS) MA plans in 2,347 counties with two or more network plans.

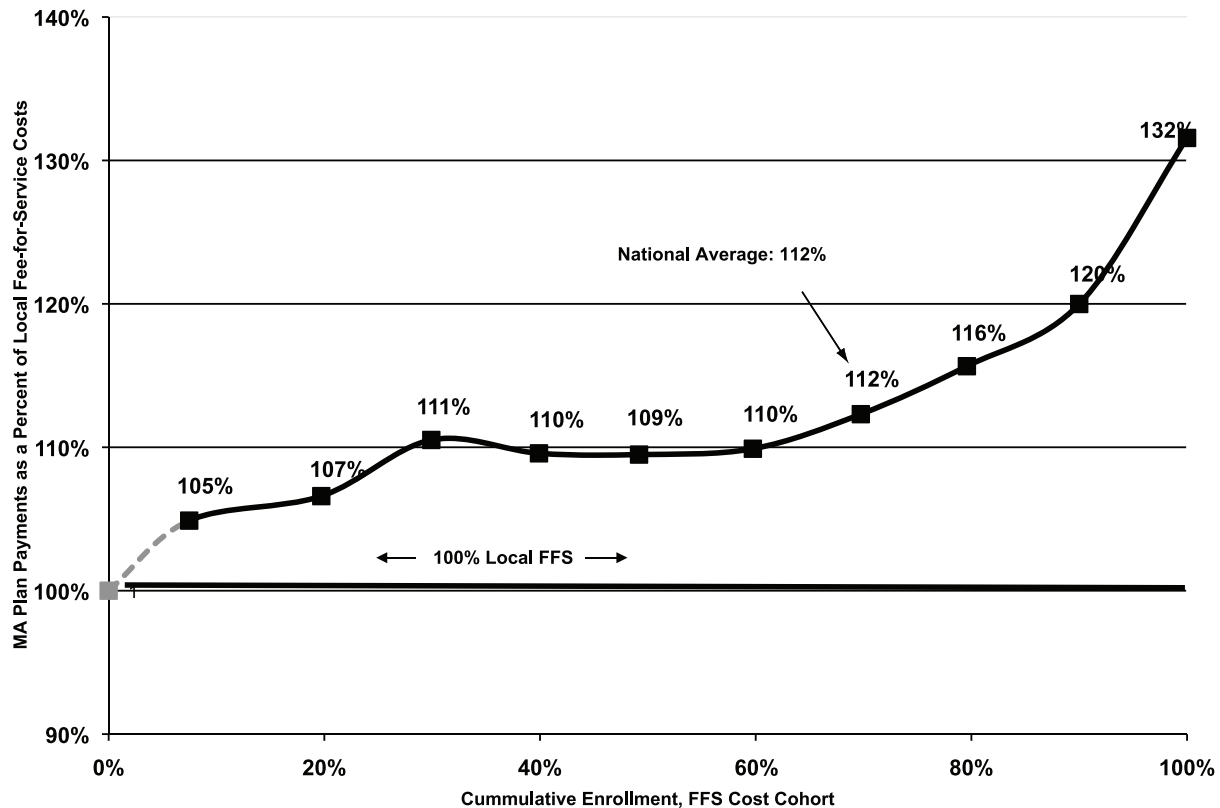
Paying MA Plans 100 Percent of FFS at the County Level

The most straightforward approach to paying plans “...the same amount it would cost to treat the same patients under regular Medicare” would be to set payments at 100 percent of FFS costs in each county in the nation (Figure 1). This policy would restore Medicare payments to private plans to the TEFRA approach of basing MA payments on FFS costs that was used to pay plans from 1982 to 1997, except that payments would equal local FFS costs instead of 95 percent of FFS costs.

Under this approach, payments could be phased from their current levels to equal local FFS costs over four years. If enacted in 2009, this approach would not change payments in 2010. In 2011, two-thirds of the payment in each county would reflect current policy and one-third would be projected county FFS costs. In 2012, one-third of the total payment would reflect current policy and two-thirds would be local FFS costs; in 2013 payments would equal projected FFS costs.¹²

Under this approach, Medicare private plans would, reflecting patterns in medical practice and

Figure 1. Current MA Plan Payments Compared to Local Fee-for-Service Costs, 2009



Sources: The George Washington University analysis of Centers for Medicare and Medicaid Services Medicare Advantage enrollment and payment data for February 2009.

costs in FFS Medicare, be paid different amounts in the different counties. These differences would simply follow the differences in costs in FFS Medicare in the counties and not any arbitrary reduction or subsidy to plans in some areas.

Local FFS costs per beneficiary now vary from a high of \$14,559 in South Florida’s Miami-Dade County, \$11,317 in Ft. Lauderdale’s Broward County and \$10,932 per year in New York City’s Bronx County to \$7,086 in Portland, Oregon’s Multnomah

Figure 2. MA Plan Payment Compared to FFS Costs in Selected Large Urban Counties with the High and Low FFS Costs

County	State	Medicare Beneficiaries	MA Plan Enrollees ¹	MA Plan Penetration	Annual FFS Costs per Enrollee ²	Local to National FFS Costs
National		44,575,208	7,861,722	18%	\$8,928	100%
10 High Fee-for-Service Cost Counties						
Miami-Dade	Florida	353,100	170,871	48%	\$14,559	163%
Broward	Florida	243,640	108,510	45%	\$11,317	127%
Baltimore City	Maryland	88,950	10,300	12%	\$10,955	123%
Bronx	New York	159,382	65,542	41%	\$10,932	122%
Kings	New York	299,252	96,767	32%	\$10,832	121%
Harris	Texas	354,017	87,481	25%	\$10,675	120%
Los Angeles	California	1,114,034	400,564	36%	\$10,599	119%
New York	New York	225,906	60,387	27%	\$10,270	115%
Nassau	New York	219,565	40,133	18%	\$10,200	114%
Queens	New York	287,588	98,350	34%	\$10,170	114%
10 Low Fee-for-Service Cost Counties						
King	Washington	221,368	48,188	22%	\$7,770	87%
Pierce	Washington	101,266	17,841	18%	\$7,755	87%
Salt Lake	Utah	97,689	24,389	25%	\$7,731	87%
Fresno	California	103,529	18,786	18%	\$7,615	85%
Sacramento	California	178,058	68,968	39%	\$7,269	81%
Lancaster	Pennsylvania	83,394	11,873	14%	\$7,224	81%
Multnomah	Oregon	88,626	43,064	49%	\$7,086	79%
Erie	New York	170,920	82,638	48%	\$7,026	79%
Bernalillo	New Mexico	88,672	36,243	41%	\$6,974	78%
Honolulu	Hawaii	139,922	25,860	19%	\$6,663	75%

Source: The George Washington University analysis of Centers for Medicare and Medicaid Services Medicare Managed Care State/County/Contract Data File, released February 2009; Medicare Managed Care State/County Penetration Data File, released February 2009; and the Medicare Advantage 2009 Rate Calculation Data Spreadsheet.

- 1 Excludes enrollees in private FFS plans in counties with 2 or more plans where private FFS plans will not be allowed after 2010 as provided by MIPPA, 2008. Enrollees in plans from the U.S. Territories including Puerto Rico and cost plans are also excluded.
- 2 Subtracts Indirect Medical Education payments which will be phased out in 2010 as provided in MIPPA, 2008.

County, and \$6,974 in Albuquerque’s Bernalillo County (Figure 2).

As Dartmouth Atlas project analysts and CBO commentators have noted, these FFS cost differences are primarily related to the utilization of health services, especially high tech medical procedures and tests, and not to area price differences, which are reflected in Medicare’s hospital DRG wage index and physician RBRVS geographic practice cost index (GPCI).^{13, 14, 15}

Paying MA Plans a Blend of 100 Percent of FFS Costs in the Local County and the National Average of FFS Costs

A second approach to paying MA plans the same as costs in regular FFS Medicare would set plan payments using a blend of local FFS costs and the national average. Over the past year, in response to the assignment in MIPPA, MedPAC analyzed a local/national blend approach. After some early review of a broad range of options, most of the

attention of this work focused on a blend set at 75 percent of local FFS costs and 25 percent of the national average of FFS costs.

This approach would result in payment rates that average 99 percent of FFS costs on a nationwide basis but payments at the local level would, in many areas, be higher or lower than local FFS costs.¹⁶ Payments in counties with FFS costs lower than the national average would be paid more than 100 percent of FFS costs in the county, while plans in counties with FFS costs higher than the national average would be paid less than 100 percent of FFS costs.

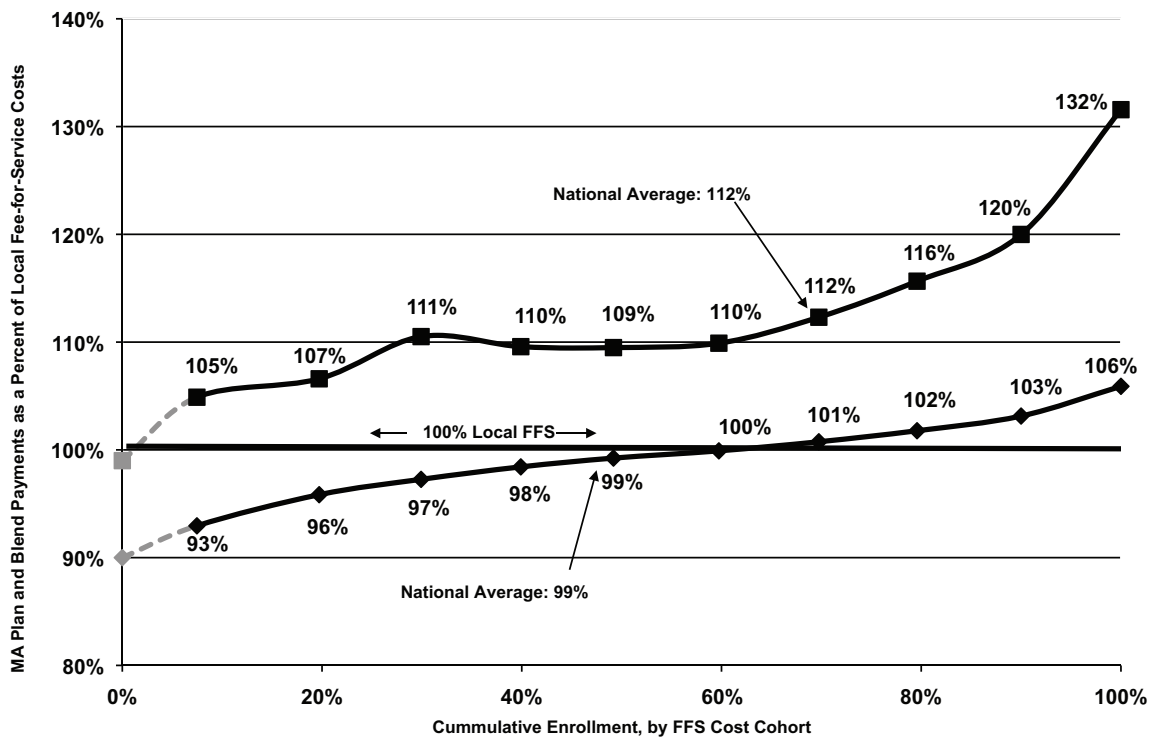
The blend policy would thus explicitly continue the current policy of extra payments to MA plans in selected counties across the nation (Figure 3). Extra payments to MA plans would continue in

2,247 counties with 55 percent of total Medicare beneficiaries.

The blend policy would balance the continued extra payments in some counties with a new policy of under payments to plans in other counties, resulting in a national average of the blend policy equal to close to 100 percent of FFS costs. The distribution of payments relative to FFS costs is presented in Figure 3.

To consider this approach broadly, counties were assigned to ten cohorts of counties with approximately equal numbers of Medicare plan enrollees (Figure 4). This analysis shows that the cohort of counties with the highest FFS costs would receive under payments averaging 7.0 percent or \$848 per enrollee a year. Ninety-four percent of beneficiaries in this cohort reside in urban counties.

Figure 3. Current MA Payment Policy and Blend MA Payment Policy Compared to Local Fee-for-Service Costs, 2009



Sources: The George Washington University analysis of Centers for Medicare and Medicaid Services Medicare Advantage enrollment and payment data for February 2009

**Figure 4. Blend MA Payment Policy Compared to Local Fee-for-Service Costs
10 Local FFS Cost Cohorts, 2009**

Blend to FFS, Annual Plan Gain/Loss						
Cohort ¹	MA Plan Enrollees ²	Annual FFS Costs per Enrollee ³	Annual Blend Payment per Enrollee ⁴	Percentage	Per Enrollee	Total (In Millions)
National	7,861,722	\$8,928	\$8,855	-0.8%	-\$73	-\$573
1	587,335	\$12,027	\$11,180	-7.0%	-\$848	-\$498
2	884,776	\$10,360	\$9,929	-4.2%	-\$431	-\$381
3	794,803	\$9,697	\$9,432	-2.7%	-\$265	-\$211
4	791,837	\$9,218	\$9,073	-1.6%	-\$146	-\$115
5	799,692	\$8,908	\$8,840	-0.8%	-\$68	-\$54
6	799,904	\$8,668	\$8,660	-0.1%	-\$8	-\$6
7	786,532	\$8,384	\$8,447	0.8%	\$63	\$50
8	804,737	\$8,063	\$8,207	1.8%	\$143	\$115
9	799,146	\$7,673	\$7,914	3.1%	\$241	\$192
10	812,960	\$6,988	\$7,400	5.9%	\$412	\$335

Source: The George Washington University analysis of Centers for Medicare and Medicaid Services Medicare Managed Care State/County/Contract Data File, released February 2009; Medicare Managed Care State/County Penetration Data File, released February 2009; and the Medicare Advantage 2009 Rate Calculation Data Spreadsheet.

- 1 Determined by sorting counties by FFS costs and creating cohorts with approximately 1/10 of the total number of MA plan enrollees. The discrepancy between the number of enrollees in cohorts 1, 2 and the remaining 8 is due to Los Angeles County, California
- 2 Excludes enrollees in private FFS plans in counties with 2 or more plans where private FFS plans will not be allowed after 2010 as provided by MIPPA, 2008. Enrollees in plans from the U.S. Territories including Puerto Rico and cost plans are also excluded.
- 3 Subtracts Indirect Medical Education payments which will be phased out in 2010 as provided in MIPPA, 2008.
- 4 National fee-for-service value used to determine blend is beneficiary-weighted and equal to \$8,636 per beneficiary per year.

In contrast, the cohort of counties with the lowest FFS costs would receive extra payments averaging 5.9 percent or \$412 per enrollee per year due. Fifty-four percent of beneficiaries in this cohort reside in rural counties. Nationally, urban counties would be under paid by \$724 million and rural counties would be over paid by \$151 million under a blend policy.¹⁷

At the state level, the blend approach would result in the largest under payments in Florida, which would be under paid by 4.3 percent or \$386 million per year, and Louisiana, which would be under paid by 3.5 percent or \$42 million (Appen-

dix 1). The total value of under payments would also be substantial in California with \$246 million per year, Texas with \$107 million and New York with \$90 million.

The states where the blend policy would give extra payments to plans include Hawaii by 7.3 percent or \$17 million per year and New Mexico by 6.0 percent or \$26 million a year. The total value of the extra payments would be the greatest in Oregon, with an additional \$64 million a year and Washington State with \$41 million per year.

Analysis at the state level, however, obscures the major impact of the blend policy, as counties

with both substantial increases and reductions are often located in the same state. California, New York and Florida each have some counties that would receive substantial extra payments and others that would be considerably under paid.

Among the 100 counties with the largest number of Medicare beneficiaries, a blend policy would under pay Miami-Dade County 10.2 percent or

\$253 million per year, Los Angeles County 4.6 percent or \$197 million per year and Houston's Harris County 4.8 percent or \$45 million per year (Figure 5, Appendix 2).

In the South Florida region Miami-Dade, Broward and Palm Beach counties would be under paid \$353 million a year. In the Los Angeles region, under payments to plans in Los Angeles,

**Figure 5. Blend Payment Policy Compared to Local Fee-for-Service Costs
Selected Large Urban Counties, 2009**

County	State	Medicare Beneficiaries	MA Plan Enrollees ¹	Annual FFS Costs per Enrollee ²	Annual Blend Payment per Enrollee ³	Blend to FFS, Annual Plan Gain/Loss		
						Percentage	Per Enrollee	Total (In Millions)
National		44,575,208	7,861,722	\$8,928	\$8,855	-0.8%	-\$73	-\$573.3
10 High Fee-For-Service Cost Counties								
Miami-Dade	Florida	353,100	170,871	\$14,559	\$13,078	-10.2%	-\$1,481	-\$253.0
Los Angeles	California	1,114,034	400,564	\$10,599	\$10,109	-4.6%	-\$491	-\$196.6
Broward	Florida	243,640	108,510	\$11,317	\$10,647	-5.9%	-\$670	-\$72.8
Kings	New York	299,252	96,767	\$10,832	\$10,283	-5.1%	-\$549	-\$53.1
Harris	Texas	354,017	87,481	\$10,675	\$10,165	-4.8%	-\$510	-\$44.6
Queens	New York	287,588	98,350	\$10,170	\$9,786	-3.8%	-\$383	-\$37.7
Bronx	New York	159,382	65,542	\$10,932	\$10,358	-5.2%	-\$574	-\$37.6
New York	New York	225,906	60,387	\$10,270	\$9,862	-4.0%	-\$408	-\$24.7
Nassau	New York	219,565	40,133	\$10,200	\$9,809	-3.8%	-\$391	-\$15.7
Baltimore City	Maryland	88,950	10,300	\$10,955	\$10,376	-5.3%	-\$580	-\$6.0
10 Low Fee-For-Service Cost Counties								
Pierce	Washington	101,266	17,841	\$7,755	\$7,976	2.8%	\$220	\$3.9
Lancaster	Pennsylvania	83,394	11,873	\$7,224	\$7,577	4.9%	\$353	\$4.2
Fresno	California	103,529	18,786	\$7,615	\$7,870	3.4%	\$255	\$4.8
Salt Lake	Utah	97,689	24,389	\$7,731	\$7,957	2.9%	\$226	\$5.5
King	Washington	221,368	48,188	\$7,770	\$7,986	2.8%	\$217	\$10.4
Honolulu	Hawaii	139,922	25,860	\$6,663	\$7,157	7.4%	\$493	\$12.8
Bernalillo	New Mexico	88,672	36,243	\$6,974	\$7,390	6.0%	\$415	\$15.1
Multnomah	Oregon	88,626	43,064	\$7,086	\$7,474	5.5%	\$388	\$16.7
Sacramento	California	178,058	68,968	\$7,269	\$7,611	4.7%	\$342	\$23.6
Erie	New York	170,920	82,638	\$7,026	\$7,429	5.7%	\$403	\$33.3

1 Excludes enrollees in private FFS plans in counties with 2 or more plans where private FFS plans will not be allowed after 2010 as provided by MIPPA, 2008. Enrollees in plans from the U.S. Territories including Puerto Rico and cost plans are also excluded.

2 Subtracts Indirect Medical Education payments which will be phased out in 2010 as provided in MIPPA, 2008.

3 National fee-for-service value used to determine blend is beneficiary-weighted and equal to \$8,636 per beneficiary per year.

Orange and Riverside counties would be \$261 million. Plans in New York City's five boroughs would be under paid by \$167 million.

The counties with substantial levels of continued extra payments would include Honolulu County with 7.4 percent or \$13 million per year, Albuquerque's Bernalillo County with 6.0 percent or \$15 million, Buffalo's Erie County with 5.7 percent or \$33 million, and Portland's Multnomah County with 5.5 percent or \$17 million. Other counties with significant total extra payments would include Sacramento County with \$24 million, Rochester's Monroe County with \$13 million and Seattle's King County and Tucson's Pima County with \$10 million each.

Paying MA Plans a Regional Blend of 100 Percent of FFS Costs

A third approach to paying Medicare plans would be to use a regional average of FFS costs rather than individual county costs. For analytical purposes, these multi-county regions are here assumed to be the U. S. Bureau of Labor Statistics Metropolitan Statistical Areas (MSAs) and all residual rural counties within each state. These regions are similar to the regions that Medicare uses for the payment of the hospital DRG wage index adjustment.

Under this regional average approach, payments to plans would be set at the beneficiary-weighted average of FFS costs of all of the counties in the region.¹⁸ This would mean that MA plans with enrollees who live in counties with higher FFS costs than the regional average would be paid less than FFS costs in their home county. In contrast, MA plans with enrollees who live in counties with lower FFS costs than the regional average costs would be paid more than 100 percent of FFS costs in their home county.

Appendices 3-7 present the pattern of costs in 4 major metropolitan areas – Washington, Baltimore, Philadelphia, and St. Louis.

In the Washington, D.C. metro area, FFS costs per beneficiary range from \$9,144 and \$10,064 in the central counties of Washington, D.C. and Prince George's County, Maryland to \$8,365 and \$8,144 in the suburban counties of Loudoun and Fauquier in Virginia (Appendix 3). FFS costs in the individual counties in the D.C. metro area vary from 128 percent to 88 percent of the regional FFS average of \$8,895. Under a regional payment system, MA plans in Prince George's County would be under paid by 13 percent or \$1,170 per enrollee per year, while plans in Fauquier County would be over paid by 8 percent, or \$751 per enrollee per year.

In the Baltimore metro area, FFS costs in the central county of Baltimore City are 110 percent of the regional average while in suburban Howard County they are only 91 percent of the regional average of \$9,926 (Appendix 4). A regional payment system would under pay plans in Baltimore City by 10 percent or \$1,029 per year, while plans in Howard County would be over paid by 8 percent or \$873 annually per enrollee.

In the Philadelphia metro area, FFS costs in the central county of Philadelphia are 107 percent of the regional average while in suburban Bucks and Montgomery Counties they are 95 percent of the regional FFS average of \$8,905. Payments under a new regional system would range from under payments in Philadelphia City of 6 percent or \$588 per enrollee per year to overpayments of 4 percent or \$413 in New Castle County, Delaware (Appendix 5).

In the St. Louis metro area, the FFS costs vary from \$9,084 in St. Louis City to \$8,141 in nearby St. Charles County, a range of 109 percent to 94 percent of the region wide average of \$8,336 (Appendix 6). MA payments would be 9 percent or \$748 less than FFS costs in St. Louis City. In Warren County, Missouri, payments would be 6 percent or \$499 higher than FFS costs.

A regional payment system would also require setting the rate for rural areas on a multi-county basis. The wide variation in FFS costs among counties in metropolitan areas is also present in rural areas.

The calculation of a regional rate for all of the non-urban counties in Pennsylvania illustrates this variation. These counties have a total of 389,000 Medicare beneficiaries and 78,000 MA plan enrollees (Appendix 7). Among these counties, FFS costs vary from \$6,594 per year in Bradford County, to \$7,569 in Wayne County, and \$9,371 in Indiana County. Medicare would under pay plans in Greene County 29 percent, or \$2,240 per enrollee, and over pay plans 19 percent, or \$1,453 per enrollee, in Sullivan County.

CONCLUSION

Since 1997, Medicare polices have been adopted that pay Medicare Advantage private plans more than the average of costs in traditional FFS Medicare. These extra payments to MA plans now total over \$11 billion a year and \$150 billion over 10 years.

Over the past year, President Obama has indicated that “We need to eliminate the excessive subsidies to Medicare Advantage plans and pay them the same amount it would cost to treat the same patients under regular Medicare.” Congressional leaders have made similar comments regarding payments to Medicare private plans. The savings from a reduction in payments to MA plans is viewed as a major source of funds to help make the new Federal costs of a health care reform program budget neutral.

With a new Medicare plan payment policy under consideration, the question of what “the same amount it would cost ... under regular Medicare” means has been raised. Options for a new MA payment policy include paying MA plans at FFS costs in each county, a blend of 75 percent

local FFS costs and 25 percent national FFS average costs, and a regional average of FFS costs in metropolitan statistical areas and residual rural counties. The impact of each of these options on MA plans and their Medicare beneficiary enrollees would be quite different.

The first option would return the payment of Medicare private plans to the model used from 1982 to 1997. Plan payment would be based on FFS costs in the enrollee’s home county. Plans that are more efficient than the local FFS system could attract enrollees by providing additional benefits. Plans that are less efficient than FFS Medicare would be need to charge a monthly premium for additional benefits. They would thus compete with Medigap plans for Medicare supplemental benefits on a level playing field and might or might not be attractive to beneficiaries depending on their efficiency.

A second option would pay plans a blend of local county and average national FFS costs. This policy would balance under payments of over a billion dollars a year from some counties (mostly core counties in large urban areas like Los Angeles, New York City and Chicago with high FFS costs) with over payments to other counties (mostly counties in smaller urban areas and rural areas with low FFS costs). The counties analyzed for this paper with the largest under payments would receive an average of \$848 per enrollee per year or 7.0 percent less than FFS costs while the counties with the largest extra payments would receive an average of \$412 per enrollee per year or 5.9 percent more than FFS costs.

Under this approach, plans in high FFS counties that are more efficient than the local FFS system would be paid less than FFS costs and so would have fewer funds to provide additional benefits. Conversely, plans in low FFS counties that are less efficient than the local FFS system would be paid more than FFS costs and so would have more funds to provide additional benefits. In this

case, plans in neither high nor low FFS counties would compete with Medigap plans on a level playing field. The MA plans could be less attractive to beneficiaries in high FFS cost counties and more attractive in low FFS cost counties.

A third option would pay plans a rate based on regional, rather than county-based, FFS costs. These larger regions could be the U.S. Bureau of Labor Statistics MSAs. In rural areas, they might be the residual rural counties not affiliated with an MSA in each state.

This policy would again shift billions of dollars in Medicare payments from plans in some counties to those in others. In this case, the transfer would be mostly from core urban counties to suburban counties. MA plans would thus be less attractive to beneficiaries in the core county with high costs of services and more attractive to beneficiaries in outer-tier low cost counties. This regional average approach to payments would give plans in metro areas a substantial incentive to focus their marketing and provider networks on beneficiaries in the outer tier county portions of the region, where the

costs of providing care are substantially lower than the region-wide average costs. Within a region, plans could compete with Medigap plans on a level playing field depending on service costs in the specific area within the region.

As a final point, it should be emphasized that the real effect of any MA plan payment policy is not so much on the MA plans themselves, but on the Medicare beneficiaries who enroll in the plans. A plan's costs of providing Medicare services are included in the annual bid, which reflects the plan's projected costs of providing Medicare Part A and B services. The difference between the plan costs - reported as its bid - and the Medicare payment amount must be provided as extra benefits to the plan's Medicare enrollees if the difference is positive or paid by the plan's enrollees as premiums or cost-sharing for services if the difference is negative. The real impact of setting MA payments higher or lower than local FFS costs in specified areas is mostly to decrease or increase out-of-pocket costs for supplemental benefits paid by the elderly and disabled in these areas.

Notes

- 1 B. Biles, J. Pozen, and S. Guterman. *The Continuing Cost of Privatization: Extra Payments to Medicare Advantage Plans Jump to \$11.4 Billion in 2009*, The Commonwealth Fund, May 2009.
- 2 Excludes counties in Puerto Rico, Guam, American Samoa and the Virgin Islands, and those with “pending” names.
- 3 Barack Obama and Joe Biden’s Health Care Plan, available at www.barackobama.com, September 2008.
- 4 Barack Obama on “This Week with George Stephanopoulos” ABC News, January 11, 2009.
- 5 Max Baucus, “Call to Action: Health Reform 2009”, November 12, 2008.
- 6 Congressional Budget Office, *Budget Options Volume 1: Health Care*, p. 119 (Washington, D.C.: CBO Dec. 2008) available at <http://www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf>.
- 7 Medicare Improvements for Patients and Providers Act of 2008, Section 169. Medicare Payment Advisory Commission (MedPAC) meeting transcript, p. 84, September 4, 2008.
- 8 Medicare Payment Advisory Commission, *Report to Congress: Improving Incentives in the Medicare Program* (Washington, D.C. MedPAC June 2009) available at http://www.medpac.gov/documents/Jun09_EntireReport.pdf.
- 9 B. Biles, J. Pozen, and S. Guterman. *Paying Medicare Private Plans by Competitive Bidding: There is Little Competition among MA Plans Today*, The Commonwealth Fund, 2009.
- 10 B. Biles, and J. Pozen, *Paying Medicare Private Plans by Competitive Bidding: Not the Same as Costs in Regular Medicare*, The George Washington University, 2009.
- 11 Towards a Comprehensive Health Policy for the 1970s: A WHITE PAPER, p 31 – 37, US Department of Health, Education and Welfare, May 1971.
- 12 This approach might also eliminate the current plan “bid” policy that reduces payments by 25 percent of the difference between the plans bid and the benchmarks and return to the earlier “adjusted community rate” policy of paying plans a specified amount and requiring them to use all of any extra funds to provide extra benefits to plan enrollees.
- 13 “Supply-Sensitive Care”. Dartmouth Atlas Project Topic Brief. Dartmouth Center for Evaluative Clinical Services. 2007. Available online at: www.dartmouthatlas.org.
- 14 “Preference-Sensitive Care”. Dartmouth Atlas Project Topic Brief. Dartmouth Center for Evaluative Clinical Services. 2007. www.dartmouthatlas.org.
- 15 “Effective Care”. Dartmouth Atlas Project Topic Brief. Dartmouth Center for Evaluative Clinical Services. 2007. www.dartmouthatlas.org.
- 16 The national average of the blend payment system is 99 percent rather than 100 percent of FFS costs because there is slightly more enrollment in MA plans in areas with high FFS costs.
- 17 Over all, the blend payment system would pay plans a total of roughly \$500 m a year less than 100 percent of FFS in all counties nationwide due to the higher MA enrollment rate in urban, high FFS cost counties.
- 18 Medicare Payment Advisory Commission, *Report to Congress: Improving Incentives in the Medicare Program, Appendix: Medicare Advantage payment areas on regional payments* p 209 (Washington, D.C. MedPAC June 2009) Available at http://www.medpac.gov/documents/Jun09_EntireReport.pdf.

Appendix 1.
Medicare Advantage Plan Bids vs. 100% Local Fee-for-Service Costs by State, 2009¹

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

South Dakota	132,581	9,424	\$7,238	\$8,211	13.4%	\$972	\$9
Tennessee	1,007,924	221,207	\$8,254	\$8,392	1.7%	\$138	\$31
Texas	2,826,361	488,491	\$9,612	\$9,515	-1.0%	-\$97	-\$47
Utah	266,648	79,422	\$7,908	\$8,445	6.8%	\$537	\$43
Vermont	105,682	3,800	\$7,290	\$8,314	14.0%	\$1,024	\$4
Virginia	1,085,920	132,793	\$7,350	\$8,549	16.3%	\$1,200	\$159
Washington	910,436	215,825	\$7,622	\$8,982	17.8%	\$1,360	\$293
West Virginia	373,403	73,546	\$7,798	\$8,672	11.2%	\$875	\$64
Wisconsin	877,674	216,329	\$7,440	\$8,486	14.1%	\$1,046	\$226
Wyoming	76,546	3,638	\$7,995	\$8,728	9.2%	\$734	\$3

Sources:

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

Notes:

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

Appendix 2. Blend Payment Policy Compared to Local Fee-for-Service Costs 100 Counties with Largest Number of Medicare Beneficiaries, 2009

County	State	Medicare Beneficiaries	MA Plan Enrollees ¹	Annual FFS Costs per Enrollee ²	Annual Blend Payment per Enrollee ³	Blend to FFS, Annual Plan Gain/Loss		
						Percentage	Per Enrollee	Total (In Millions)
National		44,575,208	7,861,722	\$8,928	\$8,855	-0.8%	-\$73	-\$573.3
Miami-Dade	Florida	353,100	170,871	\$14,559	\$13,078	-10.2%	-\$1,481	-\$253.0
Los Angeles	California	1,114,034	400,564	\$10,599	\$10,109	-4.6%	-\$491	-\$196.6
Broward	Florida	243,640	108,510	\$11,317	\$10,647	-5.9%	-\$670	-\$72.8
Kings	New York	299,252	96,767	\$10,832	\$10,283	-5.1%	-\$549	-\$53.1
Orange	California	355,904	142,362	\$10,059	\$9,703	-3.5%	-\$356	-\$50.6
Harris	Texas	354,017	87,481	\$10,675	\$10,165	-4.8%	-\$510	-\$44.6
Queens	New York	287,588	98,350	\$10,170	\$9,786	-3.8%	-\$383	-\$37.7
Bronx	New York	159,382	65,542	\$10,932	\$10,358	-5.2%	-\$574	-\$37.6
Palm Beach	Florida	246,880	72,492	\$10,122	\$9,751	-3.7%	-\$371	-\$26.9
Clark	Nevada	221,389	76,283	\$10,018	\$9,673	-3.4%	-\$345	-\$26.4
New York	New York	225,906	60,387	\$10,270	\$9,862	-4.0%	-\$408	-\$24.7
Philadelphia	Pennsylvania	223,525	101,584	\$9,493	\$9,279	-2.3%	-\$214	-\$21.8
Cook	Illinois	681,359	54,646	\$9,845	\$9,543	-3.1%	-\$302	-\$16.5
Contra Costa	California	136,049	58,218	\$9,739	\$9,463	-2.8%	-\$276	-\$16.0
Nassau	New York	219,565	40,133	\$10,200	\$9,809	-3.8%	-\$391	-\$15.7

Alameda	California	175,737	68,225	\$9,485	\$9,273	-2.2%	-\$212	-\$14.5
Riverside	California	257,183	117,306	\$9,112	\$8,993	-1.3%	-\$119	-\$14.0
Dallas	Texas	231,817	40,312	\$10,006	\$9,664	-3.4%	-\$342	-\$13.8
San Bernardino	California	202,740	92,286	\$9,152	\$9,023	-1.4%	-\$129	-\$11.9
Tarrant	Texas	173,587	46,639	\$9,628	\$9,380	-2.6%	-\$248	-\$11.6
Pinellas	Florida	194,633	65,845	\$9,237	\$9,087	-1.6%	-\$150	-\$9.9
Suffolk	New York	226,775	34,527	\$9,781	\$9,495	-2.9%	-\$286	-\$9.9
Westchester	New York	144,471	23,656	\$9,935	\$9,610	-3.3%	-\$325	-\$7.7
Bexar	Texas	201,148	62,053	\$9,040	\$8,939	-1.1%	-\$101	-\$6.3
Wayne	Michigan	283,538	26,708	\$9,546	\$9,318	-2.4%	-\$227	-\$6.0
Baltimore City	Maryland	88,950	10,300	\$10,955	\$10,376	-5.3%	-\$580	-\$6.0
Brevard	Florida	114,436	31,067	\$9,344	\$9,167	-1.9%	-\$177	-\$5.5
Hillsborough	Florida	154,603	56,854	\$9,014	\$8,920	-1.0%	-\$94	-\$5.4
Maricopa	Arizona	454,221	187,144	\$8,746	\$8,719	-0.3%	-\$28	-\$5.1
Orange	Florida	120,292	33,105	\$9,258	\$9,102	-1.7%	-\$155	-\$5.1
New Haven	Connecticut	136,721	24,608	\$9,363	\$9,181	-1.9%	-\$182	-\$4.5
Middlesex	Massachusetts	214,482	38,068	\$9,106	\$8,988	-1.3%	-\$117	-\$4.5
Hennepin	Minnesota	143,831	27,146	\$9,284	\$9,122	-1.7%	-\$162	-\$4.4
Allegheny	Pennsylvania	232,857	131,740	\$8,763	\$8,731	-0.4%	-\$32	-\$4.2
Fairfield	Connecticut	128,681	21,971	\$9,382	\$9,196	-2.0%	-\$186	-\$4.1
Oklahoma	Oklahoma	99,284	17,200	\$9,545	\$9,318	-2.4%	-\$227	-\$3.9
Duval	Florida	110,245	19,773	\$9,423	\$9,226	-2.1%	-\$197	-\$3.9
Essex	New Jersey	99,215	11,751	\$9,939	\$9,613	-3.3%	-\$326	-\$3.9
Delaware	Pennsylvania	89,749	31,436	\$9,053	\$8,949	-1.2%	-\$104	-\$3.3
Bergen	New Jersey	141,913	13,161	\$9,527	\$9,304	-2.3%	-\$223	-\$2.9
Norfolk	Massachusetts	103,789	16,583	\$9,340	\$9,164	-1.9%	-\$176	-\$2.9
Ocean	New Jersey	131,139	16,143	\$9,350	\$9,171	-1.9%	-\$178	-\$2.9
Ventura	California	103,198	25,654	\$9,021	\$8,925	-1.1%	-\$96	-\$2.5
Baltimore	Maryland	126,884	7,395	\$9,808	\$9,515	-3.0%	-\$293	-\$2.2
Tulsa	Oklahoma	84,853	23,867	\$8,982	\$8,896	-1.0%	-\$86	-\$2.0
Essex	Massachusetts	118,590	13,263	\$9,193	\$9,054	-1.5%	-\$139	-\$1.8
Middlesex	New Jersey	105,566	9,851	\$9,345	\$9,168	-1.9%	-\$177	-\$1.7
Oakland	Michigan	174,936	11,531	\$9,038	\$8,938	-1.1%	-\$100	-\$1.2
Monmouth	New Jersey	93,888	8,712	\$9,167	\$9,034	-1.4%	-\$133	-\$1.2
San Mateo	California	97,560	40,117	\$8,750	\$8,722	-0.3%	-\$28	-\$1.1
Lee	Florida	120,467	19,414	\$8,866	\$8,809	-0.6%	-\$57	-\$1.1
Suffolk	Massachusetts	87,531	9,389	\$9,089	\$8,976	-1.2%	-\$113	-\$1.1
Prince George's	Maryland	84,653	2,674	\$10,064	\$9,707	-3.5%	-\$357	-\$1.0
Macomb	Michigan	133,524	9,300	\$9,036	\$8,936	-1.1%	-\$100	-\$0.9
Pasco	Florida	98,193	40,316	\$8,723	\$8,701	-0.2%	-\$22	-\$0.9
Jefferson	Alabama	109,290	41,930	\$8,713	\$8,694	-0.2%	-\$19	-\$0.8
Shelby	Tennessee	112,740	14,837	\$8,849	\$8,796	-0.6%	-\$53	-\$0.8
DuPage	Illinois	112,085	2,285	\$9,284	\$9,122	-1.7%	-\$162	-\$0.4
Kern	California	89,137	29,629	\$8,686	\$8,674	-0.1%	-\$12	-\$0.4
San Diego	California	376,543	146,577	\$8,644	\$8,642	0.0%	-\$2	-\$0.3

Montgomery	Maryland	113,418	2,245	\$9,089	\$8,976	-1.2%	-\$113	-\$0.3
Polk	Florida	110,194	31,287	\$8,634	\$8,635	0.0%	\$1	\$0.0
Fairfax	Virginia	100,564	834	\$8,109	\$8,241	1.6%	\$132	\$0.1
Sarasota	Florida	101,155	10,503	\$8,586	\$8,599	0.1%	\$13	\$0.1
Bristol	Massachusetts	93,345	10,133	\$8,515	\$8,545	0.4%	\$30	\$0.3
Marion	Indiana	115,374	8,351	\$8,470	\$8,511	0.5%	\$42	\$0.3
Jefferson	Kentucky	117,159	18,132	\$8,541	\$8,565	0.3%	\$24	\$0.4
Worcester	Massachusetts	119,074	43,247	\$8,579	\$8,593	0.2%	\$14	\$0.6
Hartford	Connecticut	144,753	21,442	\$8,451	\$8,497	0.5%	\$46	\$1.0
Cuyahoga	Ohio	223,020	37,769	\$8,498	\$8,532	0.4%	\$35	\$1.3
Wake	North Carolina	83,256	8,604	\$8,021	\$8,175	1.9%	\$154	\$1.3
Fulton	Georgia	91,173	11,816	\$8,167	\$8,285	1.4%	\$117	\$1.4
Mecklenburg	North Carolina	88,755	9,697	\$8,032	\$8,183	1.9%	\$151	\$1.5
Milwaukee	Wisconsin	131,495	22,153	\$8,336	\$8,411	0.9%	\$75	\$1.7
Bucks	Pennsylvania	100,657	35,760	\$8,445	\$8,493	0.6%	\$48	\$1.7
Marion	Florida	86,817	17,459	\$8,241	\$8,340	1.2%	\$99	\$1.7
Jackson	Missouri	99,225	26,823	\$8,302	\$8,386	1.0%	\$84	\$2.2
Montgomery	Pennsylvania	126,906	44,568	\$8,430	\$8,481	0.6%	\$52	\$2.3
Franklin	Ohio	133,310	24,512	\$8,211	\$8,317	1.3%	\$106	\$2.6
El Paso	Texas	92,679	22,449	\$8,114	\$8,244	1.6%	\$131	\$3.0
Hamilton	Ohio	125,114	26,900	\$8,173	\$8,289	1.4%	\$116	\$3.1
Montgomery	Ohio	92,820	20,539	\$8,010	\$8,167	2.0%	\$157	\$3.2
Summit	Ohio	88,911	22,479	\$8,024	\$8,177	1.9%	\$153	\$3.4
St. Louis	Missouri	163,883	42,148	\$8,267	\$8,359	1.1%	\$92	\$3.9
Pierce	Washington	101,266	17,841	\$7,755	\$7,976	2.8%	\$220	\$3.9
Volusia	Florida	109,289	38,298	\$8,212	\$8,318	1.3%	\$106	\$4.1
Lancaster	Pennsylvania	83,394	11,873	\$7,224	\$7,577	4.9%	\$353	\$4.2
Santa Clara	California	201,429	72,860	\$8,405	\$8,463	0.7%	\$58	\$4.2
Fresno	California	103,529	18,786	\$7,615	\$7,870	3.4%	\$255	\$4.8
Salt Lake	Utah	97,689	24,389	\$7,731	\$7,957	2.9%	\$226	\$5.5
San Francisco	California	120,842	40,556	\$7,957	\$8,127	2.1%	\$170	\$6.9
Providence	Rhode Island	101,501	37,874	\$7,792	\$8,003	2.7%	\$211	\$8.0
Pima	Arizona	154,475	63,391	\$8,027	\$8,179	1.9%	\$152	\$9.7
King	Washington	221,368	48,188	\$7,770	\$7,986	2.8%	\$217	\$10.4
Honolulu	Hawaii	139,922	25,860	\$6,663	\$7,157	7.4%	\$493	\$12.8
Monroe	New York	121,215	68,071	\$7,870	\$8,062	2.4%	\$192	\$13.0
Bernalillo	New Mexico	88,672	36,243	\$6,974	\$7,390	6.0%	\$415	\$15.1
Multnomah	Oregon	88,626	43,064	\$7,086	\$7,474	5.5%	\$388	\$16.7
Sacramento	California	178,058	68,968	\$7,269	\$7,611	4.7%	\$342	\$23.6
Erie	New York	170,920	82,638	\$7,026	\$7,429	5.7%	\$403	\$33.3

Notes

- 1 Excludes enrollees in private FFS plans in counties with 2 or more plans where private FFS plans will not be allowed after 2010 as provided by MIPPA, 2008. Enrollees in plans from the U.S. Territories including Puerto Rico and cost plans are also excluded.
- 2 Subtracts Indirect Medical Education payments which will be phased out in 2010 as provided in MIPPA, 2008.
- 3 National fee-for-service value used to determine blend is beneficiary-weighted and equal to \$8,636 per beneficiary per year.

**Appendix 3. Regional Average of Fee-for-Service Costs Compared to Local Average
Fee-For-Service Costs, Washington, D.C. Metropolitan Region, 2009¹**

County	State	Degree of Proximity ²	Medicare Beneficiaries	MA Plan Enrollees ³	Annual FFS Costs per Beneficiary ⁴	Regional Payment to Local FFS Costs, Annual Plan Gain/Loss		
						Percent	Per Enrollee	Total
Region	Region		555,279	10,729	\$8,895	-3.4%	-\$303	-\$3,251,015
District of Columbia	District of Columbia	1	75,319	2,550	\$9,144	-2.8%	-\$250	-\$637,080
Prince George's	Maryland	2	84,653	2,674	\$10,064	-13.2%	-\$1,170	-\$3,127,814
Montgomery	Maryland	2	113,418	2,245	\$9,089	-2.2%	-\$195	-\$436,982
Falls Church City	Virginia	2	1,395	23	\$8,600	3.3%	\$295	\$6,787
Alexandria City	Virginia	2	12,335	122	\$8,520	4.2%	\$374	\$45,655
Arlington	Virginia	2	17,823	136	\$8,260	7.1%	\$634	\$86,290
Fairfax	Virginia	2	100,564	834	\$8,109	8.8%	\$785	\$655,058
Fairfax City	Virginia	2	2,775	42	\$8,097	9.0%	\$797	\$33,495
Manassas Park City	Virginia	3	756	21	\$11,373	-27.9%	-\$2,479	-\$52,054
Charles	Maryland	3	14,603	346	\$9,796	-10.1%	-\$901	-\$311,775
Frederick	Maryland	3	27,314	567	\$9,309	-4.7%	-\$414	-\$234,978
Calvert	Maryland	3	10,190	230	\$8,948	-0.6%	-\$53	-\$12,220
Fredericksburg City	Virginia	3	2,937	39	\$8,581	3.5%	\$313	\$12,215
Loudoun	Virginia	3	18,446	148	\$8,365	6.0%	\$529	\$78,363
Stafford	Virginia	3	9,752	77	\$8,252	7.2%	\$643	\$49,488
Spotsylvania	Virginia	3	11,038	74	\$8,176	8.1%	\$719	\$53,195
Fauquier	Virginia	3	8,275	64	\$8,144	8.4%	\$751	\$48,070
Manassas City	Virginia	3	2,853	70	\$8,091	9.0%	\$804	\$56,277
Prince William	Virginia	3	26,164	199	\$8,088	9.1%	\$806	\$160,451
Warren	Virginia	3	5,237	56	\$7,994	10.1%	\$900	\$50,427
Jefferson	West Virginia	3	7,111	162	\$7,831	12.0%	\$1,063	\$172,282
Clarke	Virginia	3	2,321	50	\$7,818	12.1%	\$1,077	\$53,835

Notes:

- 1 Determined by metropolitan statistical areas.
- 2 Degree of proximity is determined as (1) core urban county; (2) counties contiguous to core county; and (3) outlying suburban counties.
- 3 Excludes enrollees in private FFS plans in counties with 2 or more plans where private FFS plans will not be allowed after 2010 as provided by MIPPA, 2008. Enrollees in plans from the U.S. Territories including Puerto Rico and cost plans are also excluded.
- 4 Subtracts Indirect Medical Education payments which will be phased out in 2010 as provided in MIPPA, 2008.

**Appendix 4. Regional Average of Fee-for-Service Costs Compared to Local Average
Fee-For-Service Costs, Baltimore, Maryland Metropolitan Region, 2009¹**

County	State	Degree of Proximity ²	Medicare Beneficiaries	MA Plan Enrollees ³	Annual FFS Costs per Beneficiary ⁴	Regional Payment to Local FFS, Annual Plan Gain/Loss		
						Percent	Per Enrollee	Total (In Millions)
Region	Region		373,543	22,865	\$9,926	-3.2%	-\$320	-\$7.3
Baltimore City	Maryland	1	88,950	10,300	\$10,955	-10.4%	-\$1,029	-\$10.6
Baltimore	Maryland	2	126,884	7,395	\$9,808	1.2%	\$118	\$0.9
Anne Arundel	Maryland	2	66,576	2,323	\$9,434	5.0%	\$492	\$1.1
Harford	Maryland	3	32,921	1,500	\$9,689	2.4%	\$238	\$0.4
Carroll	Maryland	3	23,575	422	\$9,646	2.8%	\$280	\$0.1
Queen Anne's	Maryland	3	6,677	133	\$9,178	7.5%	\$748	\$0.1
Howard	Maryland	3	27,960	792	\$9,053	8.8%	\$873	\$0.7

Notes:

- 1 Determined by metropolitan statistical areas.
- 2 Degree of proximity is determined as (1) core urban county; (2) counties contiguous to core county; and (3) outlying suburban counties.
- 3 Excludes enrollees in private FFS plans in counties with 2 or more plans where private FFS plans will not be allowed after 2010 as provided by MIPPA, 2008. Enrollees in plans from the U.S. Territories including Puerto Rico and cost plans are also excluded.
- 4 Subtracts Indirect Medical Education payments which will be phased out in 2010 as provided in MIPPA, 2008.

**Appendix 5. Regional Average of Fee-for-Service Costs Compared to Local Average
Fee-For-Service Costs, Philadelphia, Pennsylvania Metropolitan Region, 2009¹**

County	State	Degree of Proximity ²	Medicare Beneficiaries	MA Plan Enrollees ³	Annual FFS Costs per Beneficiary ⁴	Regional Payment to Local FFS Costs, Annual Plan Gain/Loss		
						Percent	Per Enrollee	Total
Region	Region		891,599	262,020	\$8,905	-1.0%	-\$85	-\$22,306,944
Philadelphia	Pennsylvania	1	223,525	101,584	\$9,493	-6.6%	-\$588	-\$59,771,628
Camden	New Jersey	2	75,435	11,265	\$9,152	-2.8%	-\$247	-\$2,784,239
Delaware	Pennsylvania	2	89,749	31,436	\$9,053	-1.7%	-\$148	-\$4,652,711
Gloucester	New Jersey	2	40,569	4,990	\$9,022	-1.3%	-\$117	-\$585,836
Burlington	New Jersey	2	68,285	9,525	\$8,660	2.7%	\$245	\$2,330,161
Bucks	Pennsylvania	2	100,657	35,760	\$8,445	5.2%	\$460	\$16,450,839
Montgomery	Pennsylvania	2	126,906	44,568	\$8,430	5.3%	\$475	\$21,170,793
Cecil	Maryland	3	13,418	238	\$9,238	-3.7%	-\$333	-\$79,368
Chester	Pennsylvania	3	66,970	19,877	\$8,676	2.6%	\$229	\$4,546,902
Salem	New Jersey	3	11,481	606	\$8,623	3.2%	\$282	\$170,734
New Castle	Delaware	3	74,604	2,171	\$8,492	4.6%	\$413	\$897,409

Notes:

- 1 Determined by metropolitan statistical areas.
- 2 Degree of proximity is determined as (1) core urban county; (2) counties contiguous to core county; and (3) outlying suburban counties.
- 3 Excludes enrollees in private FFS plans in counties with 2 or more plans where private FFS plans will not be allowed after 2010 as provided by MIPPA, 2008. Enrollees in plans from the U.S. Territories including Puerto Rico and cost plans are also excluded.
- 4 Subtracts Indirect Medical Education payments which will be phased out in 2010 as provided in MIPPA, 2008.

Appendix 6. Regional Average of Fee-for-Service Costs Compared to Local Average Fee-For-Service Costs, St. Louis, Missouri Metropolitan Region, 2009¹

County	State	Degree of Proximity ²	Medicare Beneficiaries	MA Plan Enrollees ³	Annual FFS Costs per Beneficiary ⁴	Regional Payment to Local FFS Cost, Annual Plan Gain/Loss		
						Percent	Per Enrollee	Total
Region	Region		434,922	100,628	\$8,336	0.0%	-\$2	-\$171,773
St. Louis City	Missouri	1	47,053	12,252	\$9,084	-9.0%	-\$748	-\$9,166,600
St. Clair	Illinois	2	39,499	7,555	\$8,312	0.3%	\$24	\$178,554
St. Louis	Missouri	2	163,883	42,148	\$8,267	0.8%	\$69	\$2,900,614
Madison	Illinois	2	45,219	8,462	\$8,130	2.5%	\$206	\$1,741,249
Monroe	Illinois	2	4,923	832	\$8,066	3.2%	\$270	\$224,618
Bond	Illinois	3	3,048	104	\$8,604	-3.2%	-\$268	-\$27,902
Jefferson	Missouri	3	29,853	8,300	\$8,482	-1.8%	-\$146	-\$1,214,440
Clinton	Illinois	3	5,852	188	\$8,262	0.9%	\$74	\$13,930
St. Charles	Missouri	3	43,505	12,178	\$8,141	2.3%	\$195	\$2,370,403
Franklin	Missouri	3	16,499	4,838	\$7,930	4.9%	\$406	\$1,964,429
Jersey	Illinois	4	4,114	147	\$8,627	-3.5%	-\$291	-\$42,770
Calhoun	Illinois	4	1,121	16	\$8,621	-3.4%	-\$285	-\$4,560
Crawford	Missouri	4	4,885	597	\$8,525	-2.3%	-\$190	-\$113,216
Washington	Missouri	4	4,102	158	\$8,429	-1.1%	-\$93	-\$14,716
Macoupin	Illinois	4	9,375	117	\$8,255	1.0%	\$81	\$9,475
Lincoln	Missouri	4	6,875	1,239	\$8,124	2.5%	\$212	\$262,579
Warren	Missouri	4	5,116	1,497	\$7,837	6.0%	\$499	\$746,581

Notes:

- 1 Determined by metropolitan statistical areas.
- 2 Degree of proximity is determined as (1) core urban county; (2) counties contiguous to core county; and (3) outlying suburban counties.
- 3 Excludes enrollees in private FFS plans in counties with 2 or more plans where private FFS plans will not be allowed after 2010 as provided by MIPPA, 2008. Enrollees in plans from the U.S. Territories including Puerto Rico and cost plans are also excluded.
- 4 Subtracts Indirect Medical Education payments which will be phased out in 2010 as provided in MIPPA, 2008.

Appendix 7. Regional Average of Fee-for-Service Costs Compared to Local Fee-For-Service Costs, Pennsylvania Counties Not Associated with a Metropolitan Area, 2009¹

County	Medicare Beneficiaries	MA Plan Enrollees ²	Annual FFS Costs per Beneficiary ³	Regional Payment to Local FFS Costs, Annual Plan Gain/Loss		
				Percent	Per Enrollee	Total
Region	388,894	78,099	\$7,825	-3.9%	-\$304	-\$23,777,917
Greene	7,125	2,403	\$10,066	-28.6%	-\$2,240	-\$5,383,666
Indiana	15,903	7,530	\$9,371	-19.7%	-\$1,545	-\$11,636,879
Somerset	16,434	8,197	\$8,702	-11.2%	-\$877	-\$7,186,140
Venango	12,142	2,136	\$8,621	-10.2%	-\$796	-\$1,700,050
Forest	1,431	206	\$8,606	-10.0%	-\$781	-\$160,819
Monroe	24,590	2,493	\$8,573	-9.6%	-\$748	-\$1,864,315
Lawrence	20,378	10,948	\$8,429	-7.7%	-\$604	-\$6,608,512
Clearfield	16,665	4,007	\$8,286	-5.9%	-\$460	-\$1,843,913
Clarion	8,042	1,125	\$8,265	-5.6%	-\$440	-\$494,441
Crawford	17,666	2,785	\$8,000	-2.2%	-\$174	-\$485,933
Jefferson	9,678	1,686	\$7,979	-2.0%	-\$153	-\$258,680
Elk	7,214	674	\$7,918	-1.2%	-\$93	-\$62,555
Fulton	2,947	164	\$7,911	-1.1%	-\$85	-\$14,000
Cameron	1,304	123	\$7,821	0.1%	\$4	\$491
Bedford	10,711	4,519	\$7,743	1.1%	\$83	\$372,943
Mifflin	9,792	3,094	\$7,710	1.5%	\$116	\$358,003
Schuylkill	31,763	4,862	\$7,695	1.7%	\$130	\$633,220
Wayne	10,651	301	\$7,569	3.3%	\$256	\$77,117
Columbia	12,390	4,177	\$7,552	3.5%	\$274	\$1,143,754
Warren	8,874	207	\$7,505	4.1%	\$320	\$66,258
Huntingdon	8,544	856	\$7,417	5.2%	\$408	\$349,475
McKean	9,009	675	\$7,401	5.4%	\$424	\$286,476
Adams	17,328	2,338	\$7,389	5.6%	\$437	\$1,020,561
Juniata	4,361	1,285	\$7,388	5.6%	\$437	\$562,116
Susquehanna	8,591	424	\$7,312	6.6%	\$513	\$217,704
Northumberland	20,222	3,094	\$7,295	6.8%	\$530	\$1,639,884
Potter	3,854	132	\$7,261	7.2%	\$564	\$74,454
Franklin	23,229	741	\$7,255	7.3%	\$570	\$422,322
Montour	3,733	1,660	\$7,097	9.3%	\$729	\$1,209,792
Snyder	6,841	1,782	\$7,017	10.3%	\$809	\$1,440,909
Tioga	8,834	114	\$6,938	11.3%	\$888	\$101,179
Union	6,885	1,428	\$6,688	14.5%	\$1,138	\$1,624,425
Clinton	7,390	1,387	\$6,651	15.0%	\$1,174	\$1,628,718
Bradford	12,728	456	\$6,594	15.7%	\$1,231	\$561,379
Sullivan	1,645	90	\$6,372	18.6%	\$1,453	\$130,805

Notes:

- 1 Determined by Metropolitan Statistical Areas.
- 2 Excludes enrollees in private FFS plans in counties with 2 or more plans where private FFS plans will not be allowed after 2010 as provided by MIPPA, 2008. Enrollees in plans from the U.S. Territories including Puerto Rico and cost plans are also excluded.
- 3 Subtracts Indirect Medical Education payments which will be phased out in 2010 as provided in MIPPA, 2008.

Study Methods

This report's 2009 analysis is based on data on county fee-for-service (FFS) expenditure averages in the 2009 CMS Medicare Advantage Rate Calculation Data spreadsheet.¹ The number of Medicare beneficiaries and Medicare Advantage enrollees by county is taken from the CMS State/County Penetration data file and the CMS State/County/Contract data file for February 2009. These data are posted on the website of the Centers for Medicare and Medicaid Services, <http://www.cms.hhs.gov>.²

As noted in the Brief, this analysis is based on projection of current MA policy enacted in past years that have not been fully implemented to date. The policies include: the elimination of the BNRA payments that are .9 percent in 2009; double payments for Indirect Medicare Education payment that average 2.4 percent in 2009 and vary by county; and the enrollment in 2009 of 2.5 million beneficiaries in Private Fee-for-Service (PFFS) MA plans in 2,347 counties with two network plans.

Over 300,000 MA enrollees are in Medicare "cost" plans, paid on the basis of costs. Although these beneficiaries (identified through the CMS Medicare Advantage State/County/Contract data file for February 2009) receive Medicare benefits through managed care plans, they do not generate extra payments based on MA plan payment rates.³ Cost beneficiaries were removed from the Medicare Advantage enrollee totals by county but are included in the number of overall Medicare beneficiaries. Puerto Rico, Guam, American Samoa and the Virgin Islands are not included in the analysis.

The national average FFS value used to determine each county's 75% local, 25% national blend costs is beneficiary-weighted and equal to \$8,636 per beneficiary per year. Likewise, the each regional average FFS value is beneficiary-weighted. However, the overall plan gain/loss calculations – including 100% local FFS costs – are MA plan enrollee-weighted to reflect variations in projected enrollment and payment rates.

Notes:

- 1 Centers for Medicare and Medicaid Services, Rate Calculation Data Risk 2009 spreadsheet (Baltimore, Md.: CMS, Apr. 2008), available at <http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/>
- 2 Centers for Medicare and Medicaid Services, Monthly Medicare Advantage State/County/Contract Data and Monthly Medicare Advantage State/County Penetration Data (Baltimore, Md.: CMS, Feb. 2009), available at <http://www.cms.hhs.gov/MCRAAdvPartDENrolData/>
- 3 Centers for Medicare and Medicaid Services, Monthly Medicare Advantage State/County/Contract Data (Baltimore, Md.: CMS, Feb. 2009), available at <http://www.cms.hhs.gov/MCRAAdvPartDENrolData/>

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