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Medicare Advantage Payments

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Medicare Advantage Payments

Summary

Medicare has a long-standing history of offering its beneficiaries managed care coverage through private plans as an alternative to the traditional fee-for-service (FFS) program, in which a payment is made for each Medicare-covered service provided to a beneficiary. Beginning in the 1970s, private health plans were allowed to contract with Medicare on a cost-reimbursement basis. In 1982, Medicare's risk contract program was created, allowing private entities, mostly health maintenance organizations (HMOs), to contract with Medicare. Then, in 1997, Congress passed the Balanced Budget Act of 1997 (BBA, P.L. 105-33), replacing the risk contract program with the Medicare+Choice (M+C) program. Most recently, Congress passed the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA, P.L.108-173) which included provisions to create the Medicare Advantage (MA) program offering a variety of managed care options for Medicare beneficiaries. The MA program replaces the M+C program.

The newly created MA program offers a new payment structure and provides more options than its predecessor, the M+C program. In addition to the immediate payment increases to plans, beginning in 2006, the MA program will change the payment structure and introduce regional plans that operate like Preferred Provider Organizations — a popular option in the private health insurance market. The MA program provides financial incentives for plans to participate in this new regional option. Additionally, in 2006, beneficiaries will have access to a Medicare Part D prescription drug plan whether they are in fee-for-service Medicare or enrolled in Medicare managed care. Finally, beginning in 2010, for a six-year period, a limited number of geographic areas will be selected to examine enhanced competition among local MA plans and competition between private plans and FFS Medicare.

This report focuses on MA payments. For a discussion on the effect of the MMA on Medicare managed care, see CRS Report RS21761, *Medicare Advantage: What Does It Mean for Private Plans Currently Serving Medicare Beneficiaries?* This report will be updated as necessary to reflect significant changes to the program.

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Medicare Advantage Payments

Introduction

Medicare has a long-standing history of offering its beneficiaries managed care coverage through private plans as an alternative to the traditional fee-for-service (FFS) program, in which a payment is made for each Medicare-covered service provided to a beneficiary. Beginning in the 1970s, private health plans were allowed to contract with Medicare on a cost-reimbursement basis. In 1982, Medicare's risk contract program was created, allowing private entities, mostly health maintenance organizations (HMOs), to contract with Medicare.

Then, in 1997, Congress passed the Balanced Budget Act of 1997 (BBA, P.L. 105-33), replacing the risk contract program with the Medicare+Choice (M+C) program. The M+C program established a new payment structure, designed to achieve two major goals: (1) reduce spending, and (2) reduce the variation in payments across the country. In general, the program made monthly payments in advance to participating private health plans for each enrolled beneficiary in a payment area (typically a county). In exchange, the plans agreed to furnish all required Medicare-covered items and services, except hospice services, to each enrollee. Several legislative changes have been enacted since 1999, to address some of the issues arising from the passage of the BBA.[1]

Most recently, Congress made substantial changes to the M+C program with the passage of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA, P.L.108-173). The act creates the Medicare Advantage (MA) program to replace the M+C program and introduces several enhancements intended to increase the availability of private plans to Medicare beneficiaries. In addition to the immediate payment increases to plans, beginning in 2006, the MA program will change the payment structure for local plans and introduce regional plans that operate like Preferred Provider Organizations — a popular option in the private health insurance market. The MA program provides financial incentives for plans to participate in this new regional option. Additionally, in 2006 beneficiaries will have access to a Medicare Part D prescription drug plan whether they are in FFS Medicare or enrolled in Medicare managed care.[2] Finally, beginning in 2010 a limited number

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[1] The Balanced Budget Refinement Act of 1999 (BBRA, P.L. 106-113) as well as the Medicare, Medicaid, and SCHIP Benefits Improvements and Protection Act of 2000 (BIPA, P.L. 106-554) amended M+C to increase reimbursement and to make it easier for Medicare beneficiaries and plans to participate in the program.

[2] For more information on the Medicare Part D program, see CRS Report RL31966, *Overview of the Medicare Prescription Drug, Improvement and Modernization Act of 2003*,
(continued...)

of geographic areas will be selected to examine enhanced competition among local MA plans and competition between those private plans and FFS Medicare.

Overview of Payment Changes in MMA

The MMA made many changes to the payments for Medicare managed care plans, including immediate changes, effective March 2004, and then other changes that do not take effect until 2006 and 2010. This set of changes creates a multi-tiered payment system, one for local plans, another for regional plans and then beginning in 2010 another one for local plans in areas designated as cost containment areas.

The immediate changes became effective on March 1, 2004. First, a fourth payment mechanism was added to the calculation of MA payments, so that in 2004, plans are paid the highest of the floor, minimum percent increase, the blend, or a new amount. (See below for a description of the three previous payment amounts.) The new payment amount is 100% of fee-for-service (FFS) payments made for persons enrolled in traditional Medicare. The FFS payment is calculated based on the adjusted average per capita costs for the year for an MA payment area (a county), for services covered under Medicare Parts A and B for beneficiaries entitled to benefits under Part A, enrolled in Part B and not enrolled in an MA plan. Other immediate changes were also made to modify the statutory formulas used to calculate MA payments. All of these immediate changes, discussed in more detail below, had the effect of increasing payments to MA plans.

Additional changes to payments for local MA plans will be made, beginning in 2006. The Secretary will determine MA payment rates by comparing plan *bids* (the plan's estimated average revenue requirement, (i.e., their estimate of the cost of providing required Medicare Parts A and B services) to a *benchmark* (the maximum amount the federal government is willing to pay a plan for providing these required benefits). After plans submit their bids, the Secretary will have the authority to negotiate the bid amount, similar to the authority of the Director of the Office of Personnel Management (OPM) with respect to the Federal Employees Health Benefits program. The Secretary will calculate the benchmark by updating the previous year's payment in a local area by the statutorily required increase. If a plan's bid is less than the benchmark, its payment will equal its bid plus a rebate of 75% of the difference (between the benchmark and the bid). The rebate may be used to provide additional benefits, reduce cost sharing, or may be applied towards the monthly Part B premium, prescription drug premium, or supplemental premium (for services beyond required Medicare benefits). The remaining 25% of the difference will be retained by the federal government. If a plan's bid is equal to or above the benchmark, its payment will be the benchmark amount and each enrollee in that plan will pay an additional premium equal to the amount by which the bid exceeds the benchmark.

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[2] (...continued)
by Jennifer O'Sullivan, (name redacted), (name redacted), Jennifer Boulanger, and Paulette Morgan.

Although the program is identified as competitive beginning in 2006, in fact the local benchmark will not be determined in a competitive manner; that is, a payment to one plan in an area will not be based on any other plan's bid to provide the standard package of Medicare services. Local plans will still continue to compete with one another in order to attract beneficiaries, but payments to plans in local areas will continue to be based solely on statutorily defined increases. Beginning in 2006, MA plans that choose to offer prescription drug coverage, will also receive a benchmark payment for Part D prescription drug benefits. The benchmark will be competitively determined, based on an adjusted average of all plan bids for the area. By basing the benchmark for Part D benefits on the bids submitted by other plans, the payment methodology applied to MA plans for providing prescription drug coverage introduces a new form of competition into the program.

Also beginning in 2006, the MA program will begin to offer MA regional plans in 26 regions across the country. MA regional plans cover both in- and out-of-network required services and have both a limit on out-of-pocket expenses and a unified Parts A and B deductible. Each year an organization will submit a separate monthly *bid* amount for *each* plan it intends to offer in a region. The regional *benchmark*, will include two components; (1) a statutorily determined increase, and (2) a weighted average of plan bids. As with the Part D benchmark for MA plans that offer a prescription drug benefit, the addition of the second component introduces a new form of competition among plans, by basing part of the benchmark on the bids submitted by the plans. Similar to local plans, plans with bids below the benchmark will be given a rebate while plans with bids above the benchmark will require an additional enrollee premium.

Additional financial incentives will be provided to encourage regional plan participation. First, starting in 2007, the MMA establishes a stabilization fund to provide incentives for regional plans to enter into and to remain in the MA program. There will be $10 billion initially provided to the stabilization fund in 2007 and additional amounts will be added to the fund. Second, during 2006 and 2007, Medicare will share risk with an MA regional plan if its costs fall above or below a statutorily-specified risk corridor. Third, there will be $25 million available beginning in 2006 (with an increased amount each year) for additional payments to certain hospitals in regional areas that demonstrate they have high costs, that would otherwise prevent them from joining an MA network.

The MMA requires the Secretary to establish a program for the application of comparative cost adjustment (CCA) in CCA areas. The six-year CCA program is required to begin January 1, 2010, and to end December 31, 2015, in a fixed number of geographic locations. The program is designed to examine the efficiency both among local private plans and between the MA program and traditional Medicare. For that purpose (1) payments to local MA plans will, in part, be based on competitive bids (similar to payments for regional MA plans), and (2) Part B premiums for individuals enrolled in traditional Medicare may be adjusted, either up of down, depending on the relative costs of Medicare FFS and managed care. This program will be phased-in so that payments and Part B premium adjustments will be fully phased in by the beginning of the fourth year. There is also a 5% annual limit on the Part B premium adjustment, so that the amount of the adjustment for a year can not exceed 5% of the amount of the monthly Part B premium, in non-CCA areas.

In addition to these payment changes, all MA plans will be able to offer Part D Medicare prescription drug coverage beginning in 2006. As part of the annual bidding process, managed care organizations offering MA plans with prescription drug coverage must include their estimate for the cost of the Part D prescription drug coverage for each MA plan they intend to offer. Plans may also choose to offer supplemental benefits, such as vision or dental coverage, which are not included in the basic Medicare package. Plans will be required to submit a bid for any supplemental benefits they intend to offer.

Each part of the MA local, regional, and CCA payment structure is discussed in more detail below, along with an analysis of the effect of the change in the MMA on Medicare managed care.

Payments for Local MA Plans

The Medicare statute for the M+C program set the annual managed care per capita rate for a payment area (for a contract in a calendar year) at the highest of one of three amounts calculated *for each county*:

- a rate calculated as a blend of an area-specific (local) rate and a national rate,
- a minimum payment (or floor) rate, or
- a rate reflecting a minimum increase from the prior year's rate.

The revised law for the MA program added a fourth payment type so that beginning March 2004, MA plans are paid the highest of the floor, minimum percent increase, the blend, or a new amount. The new payment amount is 100% of fee-for-service (FFS) payments made for persons enrolled in traditional Medicare in the county. Beginning in 2005, the law no longer allows MA payments to be annually updated by the floor or blend, although the increase that was applied to both the floor and blend, the national growth percentage, is incorporated into the minimum increase amount.

Beginning in 2006, the MMA changes the payment structure for MA local plans by establishing benchmarks. In general, the benchmark amount is the maximum amount that the federal government would be willing to pay to private plans in an area for the provision of required Medicare Parts A and B benefits. The benchmark amount for a local plan will be calculated by increasing the previous year's payment rate by the minimum increase, or in certain years,[3] by the greater of the minimum increase or 100% of the per capita FFS amount.

[3] The Secretary must rebase, or update, 100% of FFS at least once every three years, but may also choose to update as often as annually. For 2005, the Secretary chose to rebase FFS, and as a result, the 2005 payment rate will be the higher of the minimum increase or the FFS amount. In years in which the Secretary does not rebase FFS payments, MA payments will be based on the minimum increase update only.

Although many of the components of the MA payment structure are not in effect after 2004, each is described in more detail below, in part to provide an historical perspective and in part to provide a better understanding of the effect of the MMA on Medicare managed care. The major factors for determining Medicare's annual local MA per capita rates are summarized in **Table 1**.

Blended Rates

The goal of the blended rate was to reduce variation in payments across the country by gradually shifting county rates away from solely local rates (reflecting wide variations in fee-for-service costs) toward a national average rate. Blending is designed to reduce payments in counties where the adjusted average per capita costs (AAPCCs)[4] historically were higher than the national average rate, and to increase payments in counties where AAPCCs were lower. The blended rate in effect for 2004 was based on 50% of the annual area-specific M+C per capita rate for the year for the payment area and 50% of the input-price adjusted annual national M+C per capita rate for the year.

The component of the blend determined by the area-specific (local) rate is based on the 1997 AAPCC for the payment area with two adjustments. First, the area-specific rate is reduced to remove an amount corresponding to graduate medical education (GME)[5] payments. Second, rates are updated each year by a national growth percentage (described below). The component of the blend determined by the national rate is a weighted average of all local area-specific rates. This component of the blend is adjusted to reflect differences in certain input prices, such as hospital labor costs, by a formula stated in the law. Each year, the blended rates are raised or lowered to achieve budget neutrality; however, there was no budget neutrality adjustment for payments effective March 2004 (described below).

Effect of MMA. Although the blend will not be used to update payments after 2004, eliminating it will have almost no material effect on payments to plans. Because of the budget neutrality requirement, the blend was used only once to update payments between 1998 and 2003. The MMA waives budget neutrality for 2004, only, so that plans in about 3% of counties (covering about 8% of enrollees) were paid the blend in 2004. (See budget neutrality, below.) Additionally, for 2004, the MMA required an adjustment to the local component of the blend to include

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[4] Prior to enactment of the BBA, payments for care of Medicare beneficiaries in risk health maintenance organizations (HMOs) were based on the AAPCC. The AAPCC represented a monthly payment to cover the cost of treatment in a Medicare risk HMO. It was calculated according to a complex formula based on the cost of providing Medicare benefits to beneficiaries in the fee-for-service portion of the Medicare program. The per capita payment was set at 95% of the AAPCC, and was adjusted for certain demographic characteristics of HMO enrollees. The FFS payment, which was added in the MMA, is also based on the AAPCC (for an MA payment area — a county).

[5] Medicare pays for the both the direct and indirect costs of GME. Direct payments include payment for expenses such as salaries of residents, interns and faculty. The indirect adjustment accounts for factors not directly related to education which may increase the costs in teaching hospitals, such as treating more severely ill patients and increased testing.

additional payments that would have been made to plans if Medicare beneficiaries entitled to benefits from facilities of the Department of Veteran Affairs (VA) and the Department of Defense (DOD) had not used those services (VA/DOD adjustment). Including the adjustment may have increased payments to plans; however, CMS did not implement this adjustment as it did not have the necessary data.

Minimum Payment (Floor) Rate

Each county is also subject to a floor rate, designed to raise payments in certain counties more quickly than would occur through the blend alone. Initially, the BBA provided for a floor rate that would apply to all counties *within* the United States and for 2000 this minimum rate was $402 per month. A separate minimum was also established for areas *outside* (i.e., territories) the United States. Beginning March 2001, BIPA established multiple floor rates, based on population and location. For 2001, the floor was $525 for aged enrollees *within* the 50 states and the District of Columbia residing in a Metropolitan Statistical Area (MSA) with a population of more than 250,000. For any other areas *within* the 50 states and the District of Columbia, the floor was $475. For any area *outside* the 50 states and the District of Columbia, the $525 and $475 floor amounts were also applied, except that the 2001 floor could not exceed 120% of the 2000 floor amount. As required by law, these payment amounts are increased annually by a measure of growth in program spending (see discussion of national growth percentage, below). In 2002, the floor was $553 for the larger MSAs and $500 for any other areas within the 50 states. The 2003 floors were lower than the 2002 floors; $548 for the larger MSAs and $495 for any other areas within the 50 states.[6] The March 2004 floors were $614 for the larger MSAs and $555 for any other areas within the states.

Effect of MMA. The floor will not be used to update payments after 2004. The floor amount was included in the original M+C payment structure as a means to achieve one of its goals — reducing variation in payments across the country. The BBA established a minimum amount that could be paid to a plan; increasing the lowest plan payments in the country. For example, prior to M+C the lowest payment to a plan in 1997 was $221 and with the introduction of the floor, that payment was increased to $367 in 1998, a jump of 67%. In 1997, the gap from lowest to highest payment was $546, declining to $416 with the introduction of the floor. Payments for the floor were reset in 2001, which further decreased variation. In 2004, plans in about 67% of counties (covering about 29% of enrollees) were paid based on the floor. The gap from lowest to highest payment increased in 2004 to $592 and is expected to continue to increase under the new payment rules for MA plans created in the MMA.

Minimum Percentage Increase

Historically, the minimum increase rule was included to protect counties that would otherwise receive only a small (if any) increase. In 1998, the minimum rate for any payment area was 102% of its 1997 AAPCC. For 1999 and 2000, the

[6] See discussion of national growth percentage for an explanation of how the adjustment for prior year's errors actually lowered the floor payments in 2003.

increase was 102% of the annual M+C per capita rate for the previous year. BIPA applied a 3% minimum update for 2001, beginning in March. For subsequent years, the minimum increase returned to an annual January update of an additional 2% over the previous year's amount. The minimum percentage increase was the only positive update for 2003 M+C payments. The MMA changed the calculation of the minimum percentage increase. For 2004 and beyond the minimum percentage increase will be the greater of a 2% increase over the previous year's payment rate (as under current law), or the previous year's payment increased by the national growth percentage (discussed below).

Effect of MMA. Previously, the national growth percentage was only applied to the floor rate or the local portion of the blend rate.[7] Plans received the minimum update rate only if they fared better with a (2% or 3%) minimum update to their previous year's rate, than if they received a payment calculated by increasing the floor by the national growth percentage. This was the case for minimum update counties because their payment rate from the prior year was so much higher than the floor rate. Under the new MA payment rules, a plan has its *prior year amount* increased by the higher of the minimum update or the increase in the national growth percentage. This could result in higher payments to plans than under the previous system. Adding the second component to the minimum increase (the national growth percentage) incorporates the increase that had been used to update the floor and blend, both of which will no longer be used after 2004.

Another difference is that the calculation of the national growth percentage includes an adjustment for prior year's errors. MMA eliminated the effect of prior years errors for years before 2004. In 2004, plans in about 4% of counties (covering about 23% of enrollees) were paid based on the new minimum increase. In 2005, about 21% of counties (covering about 53% of enrollees) are paid based on the new minimum increase. In 2006, all counties will receive the minimum update payment.

Fee-for-Service Rate

For payments, effective March 2004, a fourth payment type was added. The new payment amount is 100% of fee-for-service (FFS) payments made for persons enrolled in traditional Medicare. The FFS payment is calculated based on the adjusted average per capita cost for the year for an MA payment area (a county), for services covered under Medicare Parts A and B for beneficiaries entitled to benefits under Part A, enrolled in Part B and not enrolled in an MA plan. This payment is adjusted to remove payments for direct medical education costs and to include the VA/DOD adjustment.[8]

Effect of MMA. In 2004, payments in about 26% of counties (covering about 40% of enrollees) were based on the FFS payments. In future years, the Secretary must rebase FFS at least once every three years, but could choose to rebase more often, such as each year or every two years. For 2005, the Secretary decided to

[7] The blend is more difficult to assess, because of the budget neutrality which prevented the blend payments from being paid in all years except 2000 and 2004, when it was eliminated.

[8] As previously mentioned, CMS is currently unable to make this adjustment.

rebase FFS. Rebasing FFS rates means that the Centers for Medicare and Medicaid Services (CMS) actuaries recalculate the per capita FFS expenditures for each county (for End Stage Renal Disease (ESRD) beneficiaries FFS expenditures are calculated by state) so that FFS rates reflect more recent growth in FFS expenditures. In 2005, payments in about 21% of counties are based on the updated FFS rates. In these counties, the rebased FFS local growth rates were larger than the national growth percentage (used in the minimum percentage increase) for that year, and the MA payment increase was be based on 100% FFS service. However, about 80% of counties had slower (or negative) growth in FFS compared to national rates, and in those counties the minimum update was applied. In 2006, the Secretary will not rebase FFS rates. In years in which the Secretary chooses to rebase more frequently than required by statute, the announcement will be provided in the annual "Advance Notice" (released 45 days prior to the first Monday in April).

Exclusion of Payments for Graduate Medical Education (GME)

The BBA required that payments for GME, including both indirect and direct medical expenses, must be excluded or "carved out'" of the payments to M+C plans, phased in over five years (by 2002). According to the BBA, GME payments can only be carved out of the blend payment amount, not the floor or minimum increase payment. As a result, the GME carve out could not occur in a year in which no payment was based on the blended rate. The MMA allows a GME carve-out for payments to MA plans when based on 100% of FFS, but only for Direct Medical education costs.

Effect of MMA. Beginning in 2005, when the blend payment is no longer used to update payments for plans, there will no longer be any carve-out for Indirect Medical education costs. Further, any adjustment for Direct Medical education costs will be limited to those MA plans whose payments are based on 100% of FFS. Payments can only be based on 100% FFS in years in which the Secretary rebases FFS. However, as previously discussed, Medicare payments to plans have rarely been based on the blend, the only payment mechanism that allowed a GME adjustment prior to the passage of MMA. Therefore, this change should have very little material impact on MA payments to local plans.

Budget Neutrality

The BBA required that once the preliminary rate was determined for each county, a budget neutrality adjustment would be applied to determine final payment rates. This adjustment was made so that estimated total M+C payments in a given year would equal total payments that would be made if payments were based solely on area-specific rates. A budget neutrality adjustment was only applied to the blended rates because rates could not be reduced below the floor or minimum increase amounts. As a result of this limitation, it was not always possible to achieve budget neutrality. The law made no provision for achieving budget neutrality after all county rates were assigned either the floor or minimum increase. When this situation occurred for the 1998, 1999, 2001, 2002, and 2003 rates, the Centers for Medicare and Medicaid Services (CMS) chose to waive the budget-neutrality rule

rather than the floor or minimum rate rules. While the cost of waiving budget neutrality was not significant in 1998 and 1999 (less than $100,000 each year), the cost was about $1 billion in 2002, and $900 million in 2003. In 2004, the MMA did not allow the budget neutrality adjustment to be applied to blend payments and beginning in 2005, the blend will no longer be used to update payments.

Effect of MMA. Budget neutrality is only eliminated for 2004. However, it only affects the blend, which will not be used after 2004. Eliminating budget neutrality in 2004 ensured that the blend payment did not have to be reduced and plans in 3% of counties were able to get a payment based on the blend.

National Growth Percentage

The national per capita M+C growth percentage is defined as the projected per capita increase in total Medicare expenditures minus a specific reduction set in law for certain years.[9] Because this increase is tied to total Medicare expenditures, it maintains a link between national Medicare fee-for-service spending and managed care spending. Starting with the 1999 M+C payments, adjustments were also made for errors in the previous years' spending projection.

The national growth percentage for 2001, after the reduction and adjustments, was -1.3%. However because BIPA set the floor rates in 2001, the national growth percentage was not used to calculate the floor rate in 2001. It was only used to calculate the blend rate for 2001.

For 2002, the estimated national growth percentage increase over the pre-BIPA payment amount (used for January and February of 2001) was 8.3%. This figure was based on a 5.6% projected per capita increase in total Medicare expenditures, a 0.3 percentage point reduction set by the BBRA, a minus 0.3% adjustment for errors in the previous years' projection of spending (1998 - 2001), and an increase of 3.2% to account for the impact of BIPA.[10] The increase used to calculate the floor payment for 2002 was 5.3%, reflecting only the projected per capita increase in total Medicare expenditures of 5.6% and the 0.3 percentage point reduction set by the BBA. There was no adjustment for prior year errors, as the floor amounts were reset by the amounts established in BIPA.

For 2003, the projected national growth percentage increase was actually a decrease of 2.9%. This decrease reflected a 0.9% increase in per capita costs and a negative 3.8% adjustment for prior years' errors. The -2.9% factor was used to

[9] In 1998, the reduction was 0.8 percentage points, from 1999 through 2001 it was 0.5 percentage points, and in 2002 the BBRA set the reduction at 0.3 percentage points. There is no reduction after 2002.

[10] Because BIPA increased M+C payments beginning in March 2001, CMS calculated a revised national growth percentage of 4.9% for 2002 to be applied to these new BIPA payment levels. The difference between the revised national growth percentage increase and the original increase is the 3.2% increase for BIPA adjustments. It was not necessary to include this 3.2% adjustment in the revised increase, as it was already reflected in the Mar. 1, 2001, payment levels.

update the 2002 blend rate. The 2003 update for the floor was -1%, reflecting the same 0.9% increase in per capita costs, but only a 1.9% decrease for the prior year error in 2002 estimates.[11] Because both of these updates were negative, the minimum percentage increase was the only positive update for 2003, yielding the highest M+C payment for most counties.

For 2004, the projected national growth percentage increase for January and February was 9.5% for the blend and 8.2% for the floor. The revised projection, due to the passage of the MMA was 12.9% for the blend and 12.1% for the floor, beginning in March. As required by the MMA, the revised increases did not include an adjustment for prior year's errors.

For 2005, the projected national growth percentage increase is 6.6%. This increase reflects a .5% correction for prior year's (2004) estimates.

For 2006, the projected national growth percentage is 4.8%. This increase reflects a -.3% correction for prior years (2004 and 2005) estimates.

Effect of MMA. Although both the blend and floor payments will not be used to update payments after 2004, the same increase that was applied to these payments every year, the national growth percentage, will continue to be a part of the "MA payment calculation," as it will become one of the two possible increases to the minimum increase amount. Historically, the adjustment for prior year's errors was negative each year. The MMA wipes the slate clean of prior year adjustments, so that there will be no adjustments for prior year's errors before 2004. However, for 2004 payments, the adjustments would have been positive, so that in fact if these adjustments had been included in the calculation of the national percentage growth increase, the increase for MA payments in 2004 would have been higher; 29.4% for the blend instead of a 12.9% and 16.9% for the floor instead of 12.1%. Had this occurred, the increase is large enough that payments in many more counties would have been based on either the blend or the floor.

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[11] Because BIPA reset the floor payments in 2001, adjustments to the floor were only made for prior year errors occurring in 2002 and beyond.

Table 1. Major Factors for Determining Medicare Payments to Local Medicare Advantage Plans

Factor	Rule established in BBA 97, BBRA 99, BIPA, or MMA	
Blend of local and national rates	General	Transition over six years to 50-50 blend of local and national rates. National rates are adjusted for differences in input prices.
	1998	90% local, 10% national
	1999	82% local, 18% national
	2000	74% local, 26% national
	2001	66% local, 34% national
	2002	58% local, 42% national
	2003-2004	50% local, 50% national
Minimum payment (floor) rate	1998	$367 (or 150% of 1997 payment outside United States)
	1999-2004	Previous year's payment times annual percentage increase, except for 2001 when the amount was set in law ($380 for 1999, $402 for 2000, and $525/$475 for 2001-or 120% of 2000 payment outside United States, $553/$500 for 2002, $548/$495 for 2003, and $614/$555 for 2004)[a]
Minimum percent increase	1998	102% of 1997 AAPCC payment rate
	1999-2000	102% of prior year's rate
	2001	103% of prior year's rate
	2002-2003	102% of prior year's rate
	From 2004	Higher of 102% of prior year's rate or increase in national growth percentage
Fee-for-service	2004	100% FFS payments for persons enrolled in FFS
	From 2005	Must be rebased at least once every three years
Graduate Medical Education (direct and indirect)	General	GME payments excluded (from blended rate only) phased in beginning in 1998, over five years.
	2004	Remove GME from blend and DME from FFS.
	From 2005	Only DME removed from FFS.
Budget neutrality	General	Total M+C payments must equal what would have been spent if payments were entirely based on local rates (except no rate can be reduced below the floor or minimum)
	2004	Cannot be applied to blend payments
National growth percentage	1998	Increase in Medicare per capita expenditures (MPCE) minus 0.8 percentage points
	1999-2001	Increase in MPCE minus 0.5 percentage points
	2002	Increase in MPCE minus 0.3 percentage points
	From 2003	Increase in MPCE
Risk adjustment	2000-2003	10% health status, 90% demographic
	2004	30% inpatient and ambulatory, 70% demographic
	2005	50% inpatient and ambulatory, 50% demographic
	2006	75% inpatient and ambulatory, 25% demographic
	From 2007	100 % inpatient and ambulatory

Source: Congressional Research Service (CRS) analysis of provisions in BBA, BBRA, BIPA, and MMA.

Note: Information for payment rules is not provided beyond 2004 if rule no longer applies.

a. Beginning in 2001, there is a higher floor payment for counties within MSAs with a population of more than 250,000 and a lower floor payment for any other county in the United States.

Risk Adjustment

MA (formerly M+C) payments are risk adjusted to control for variations in the cost of providing health care among Medicare beneficiaries. For example, if sicker and older patients all sign up for one plan, risk adjustment is designed to compensate the plan for their above average health expenses. The former Medicare risk contract program adjusted the AAPCCs for demographic risk factors, and when the M+C program was implemented, it also used these demographic risk adjusters. Demographic risk adjusters include those for age, gender, working status, Medicaid coverage, whether the beneficiary originally qualified for Medicare on the basis of disability, and institutional (nursing home) status.

However, these demographic risk adjusters accounted for only a very limited portion of the variation in health care costs, and as a result, the BBA required the Secretary of HHS to develop a new risk adjustment mechanism that would also account for variations in health status. Beginning in January 2000, CMS implemented this new risk adjustment mechanism built on 15 principal inpatient diagnostic cost groups (PIP-DCGs). Payments were adjusted based on inpatient data using the PIP-DCG adjuster and demographic factors, so that this new system accounted for both demographic and health-status variations. In addition to a demographic adjustment, under this mechanism, the per capita payment made to a plan for an enrollee was also adjusted if that enrollee had an inpatient stay during the previous year. Separate demographically-based payments were used for newly eligible aged persons, newly eligible disabled Medicare enrollees, and others without a medical history.

The BBRA and BIPA made changes to the Secretary's proposed phase-in schedule of this new system, through 2002. Plans were concerned because this new risk adjustment methodology reduced aggregate M+C payments; slowing down its implementation lessened the reduction. Through 2003, 10% of payments included risk adjustment adding the PIP-DCG method and 90% were based solely on the older demographic method.

BIPA made additional changes to risk adjustment, in order to account for more of the variation in health status. A new risk adjustment methodology began in 2004, which adds data from ambulatory settings. This new risk adjustment will be phased in at the rate of 30% in 2004, 50% in 2005, 75% in 2006 and 100% beginning in 2007. In March 2002, CMS announced that the new risk adjustment methodology would be based on a "selected significant condition" model comprised of approximately 61 disease groups chosen because of their statistical and clinical significance for the Medicare population. Beginning July 1, 2002, M+C organizations have been required to collect information on the selected diagnoses and they have been required to submit that data to CMS since October 2002.

Effect of MMA. Starting in 2006, MMA expands risk adjustment in two ways. First, it introduces a new measure of risk when adjusting beneficiary rebates. MMA directs the Secretary to adjust the benchmark and the bid for the average of demographic and health history risk characteristics of MA enrollees, as described in the law, when calculating a beneficiary rebate. For local plans, the Secretary has the discretion to calculate average risk based on the demographic and health

characteristics of enrollees in each state, or on a basis other than states, such as the enrollment of an individual plan. The beneficiary rebate for a local MA plan is calculated as 75% of the amount by which the MA area-specific non-drug monthly benchmark, adjusted with the average risk adjustment factor, exceeds the MA statutory non-drug monthly bid, adjusted with the average risk adjustment factor. By applying the average risk adjustment factor to the benchmark and the bid, all private plans that are equally efficient will offer the same rebate to beneficiaries in a particular market.

Second, MMA expands the Secretary's discretion when risk adjusting payments to private plans. Previously, payments to plans were adjusted based solely on the demographic and health status risk factors associated with each enrollee. MMA expands the Secretary's ability to adjust payments by directing the Secretary to consider variation in local payment rates within an area. Ultimately, the Secretary is directed to ensure that the sum of the payment from CMS, and the basic beneficiary premium do not exceed a plan's risk adjusted bid. This provision ensures that plans are not paid more than their estimated cost of serving beneficiaries.

Summary of Local MA Plan Payments

A summary of payments made to local MA plans is provided in **Table 2**. The table includes the payment made to a plan for covered Medicare services, depending on whether the plan's bid or benchmark is higher. It also includes any required enrollee basic beneficiary premium or rebate. The table provides an explanation of how risk adjustment is applied to the different payments. Not included, are any payments made to plans that choose to offer a Medicare prescription drug program. Plans that provide Medicare prescription drug coverage will receive a separate additional payment.[12]

[12] See CRS Report RL31966, *Overview of the Medicare Prescription Drug, Improvement and Modernization Act of 2003*, by Jennifer O'Sullivan, (name redacted), (name redacted), Jennifer Boulanger, and Paulette Morgan.

Table 2. Total Non-Drug Payments to MA Local Plans for Required Parts A and B Services, Starting in 2006

Payments, including any plan premium or rebate	Payment amount if MA statutory non-drug monthly bid is greater than or equal to the MA area-specific non-drug monthly benchmark (bid ≥ benchmark)	Payment amount if MA area-specific non-drug monthly benchmark is greater than the MA statutory non-drug monthly bid (benchmark > bid)
CMS payment to a plan for original FFS Medicare benefits (other than hospice care)	MA area-specific non-drug monthly benchmark (**benchmark**) adjusted for the demographic and health history risk characteristics of the enrollee, and at the Secretary's discretion, intra-area variation, subject to an additional constraint.[a]	MA area-specific non-drug monthly bid (**bid**) adjusted for the demographic and health history characteristics of the enrollee, and at the Secretary's discretion, intra-area variation, subject to an additional constraint.[a]
Enrollee payment to a plan (Basic Beneficiary Premium)	The amount by which the unadjusted **bid** *exceeds* the unadjusted **benchmark**.	$0
Enrollee rebate from a plan	$0	The plan receives 75% of the amount by which the adjusted **benchmark** *exceeds* the adjusted **bid**.[b] The adjustment is based on the state-wide average of demographic and health status risk factors (or some other basis, at the Secretary's discretion). This amount is reduced by any Part B premium rebate offered by the plan.
Government savings (government's share of rebate)	$0	The government receives 25% of the amount by which the adjusted **benchmark** *exceeds* the adjusted **bid**. The adjustment is based on the statewide average of demographic and health status risk factors (or some other basis, at the Secretary's discretion).

Source: The Congressional Research Service (CRS) analysis of MMA provisions.

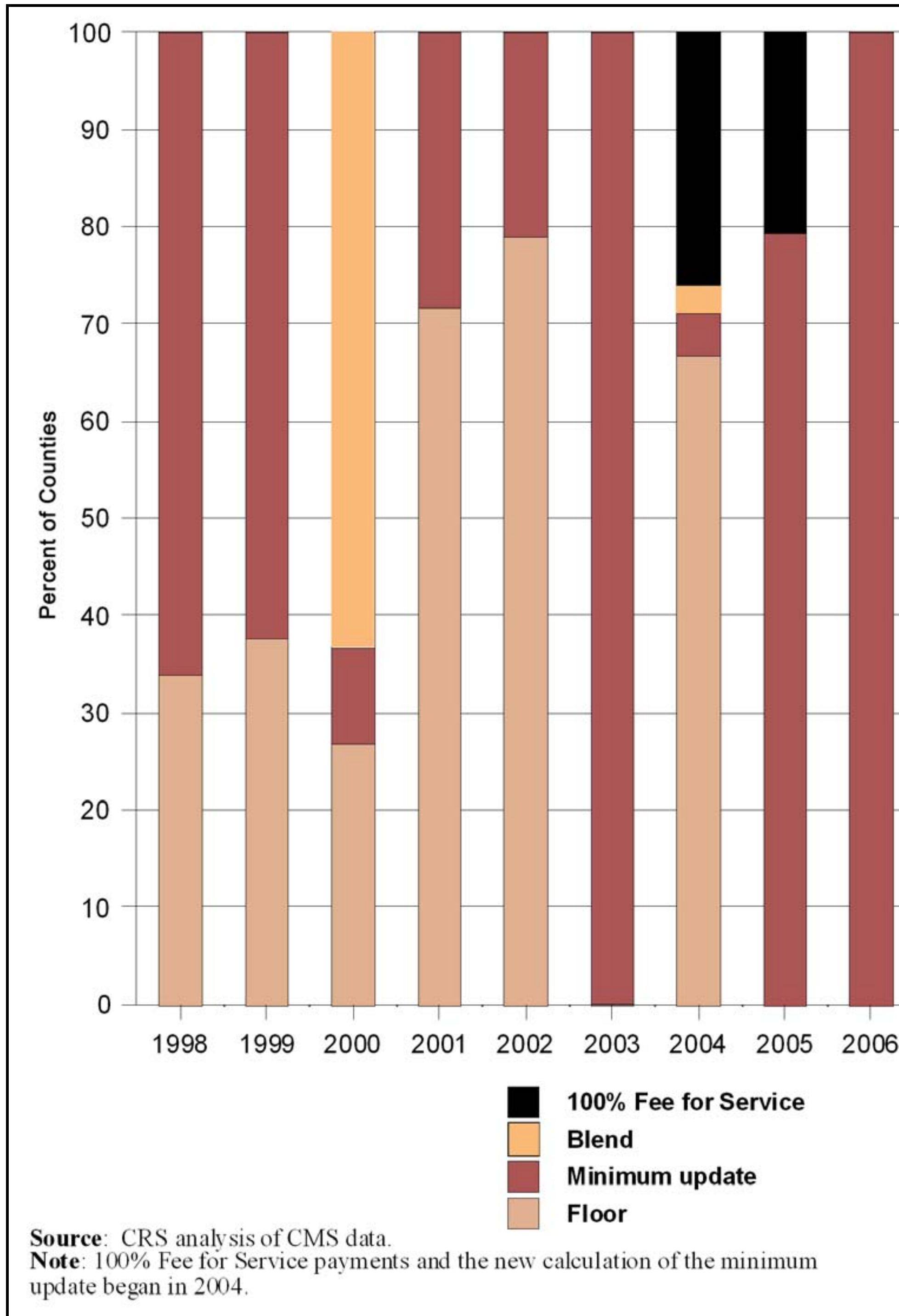
a. The Secretary must adjust payments to local MA plans to ensure that the sum of the payment from CMS and the Basic Beneficiary Premium does not exceed the plan bid, adjusted for the demographic and health history risk factors of plan enrollees.

b. The rebate to be paid to the plan, the beneficiary rebate, may only be used to provide additional benefits, reduce cost sharing, or applied towards the monthly Part B premium, prescription drug premium, or supplemental premium (for services beyond required Medicare benefits).

Variations in Local MA Payment Rates

As noted above, between 1997 and 2003, under the M+C program, each county rate was set at the highest amount calculated under three rules (blend, minimum increase, and floor), and then adjusted for budget neutrality. In 2004, plans were paid the highest amount calculated under four rules, with 100% of FFS payments for persons enrolled in traditional Medicare added to the calculation. **Figure 1** shows the distribution of payment types by year, since the beginning of the M+C program. Because of the low national growth percentage in 1998 and 1999, no county rate was set by the blended-rate rule after applying the budget neutrality adjustments. In 2000, the national growth percentage was sufficiently large (5%), so that payments in 63% of counties were based on the blended-rate rule. However, the national growth percentage for 2001 was -1.3%, as previously discussed. Therefore, in 2001, no county was paid using the blended-rate rule and about 72% of all county payments were set at the floor, with the remainder of counties receiving the minimum 3% increase. Similarly in 2002, no county was paid using the blended-rate rule, and about 79% of all counties had their payment set at the floor with the remainder of payments set at the minimum update of 2%. For 2003, all but six counties had their payments set at the minimum update of 2%, with the remaining six set at the higher floor payment ($548). In 2004 about 26% of counties were paid 100% of FFS, while most counties, about 67%, were paid the floor; 4% were paid the minimum update and 3% received the blend. In 2005, the Secretary chose to rebase payment rates, or in other words, allow the county rate to equal 100% of FFS if that rate was higher than the previous year's rate increased by the minimum percentage increase (6.6% in 2005). As a result, in 2005, about 20% of county payment rates are based on the 100 percent of FFS payment rate, with the remaining 80% based on the minimum percentage increase. In 2006, the Secretary will not rebase payment rates and all county rates will be based on the minimum percent increase (4.8%) above the county's 2005 rate.

Figure 1. Rule Used to Determine County Payment Rates, by Year, 1998-2006



Source: CRS analysis of CMS data.
Note: 100% Fee for Service payments and the new calculation of the minimum update began in 2004.

Calculations for selected 2004 county payment rates are shown in **Table 3**. The table shows the calculation under the four rules. For the eight counties selected, two have their rate set using the minimum update (Los Angeles, California; Dade, Florida;), two set at the floor amount (Hennepin, Minnesota; and Fairfax, Virginia), two set at the blended rate (Bristol Bay, Alaska and San Benito, California) and two set at 100% FFS (Lackawanna, Pennsylvania and Queens, New York). Starting in 2005, county payment rates will be based on the minimum update rate, or, if larger, 100% of FFS in years when the Secretary rebases payment rates. The floor and blend payments will be eliminated in 2005.

Table 3. Calculation of Monthly Payment Rates for Selected Counties, 2004

Selected counties	Calculation using each of the four separate rules			
	Minimum update	Floor	Blend 50% local and 50% national	100% fee-for-service
Los Angeles, CA	**$753**	$614	$715	$742
Dade, FL	**905**	614	770	891
Hennepin, MN	600	**614**	547	597
Fairfax, VA	600	**614**	557	557
Bristol Bay, AK	543	555	**579**	472
San Benito, CA	566	614	**618**	616
Lackawanna PA	606	614	585	**641**
Queens, NY	796	614	742	**804**

Source: Congressional Research Service (CRS) analysis of CMS data.

Geographic Payment Rates

Large variation in county payment rates was one of the motivating forces behind changes enacted in the Balanced Budget Act. The M+C payment method was designed to reduce this variation. Raising the floor in 2001 supported the goal of reducing both the overall variation and increasing the average payment. However, the effect of "negative" updates for both the blend and floor payments in 2003 slightly increased variation in payments across counties. The effect of the payment rule changes in the MMA will no longer decrease variation, and in fact over time, variation will begin to increase.

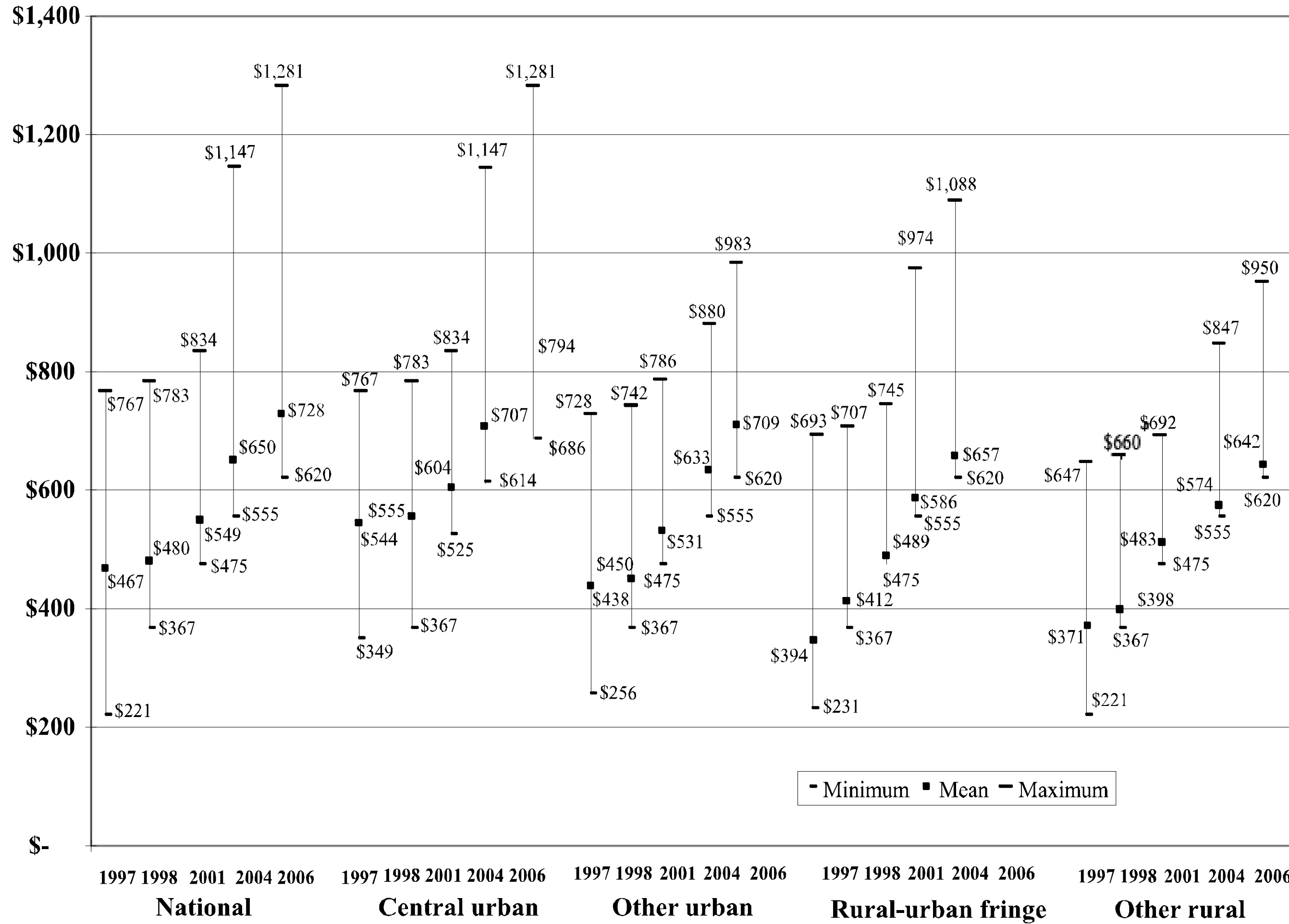
Examining variations across all counties, **Figure 2** shows that the substantial range above and below the average payment rate will continue to exist in 2006. Although the differences between highest and lowest payment had diminished each year since the start of the M+C program through 2002, in 2004, the gap increased a to $592. For example, in 1997, the average monthly payment rate weighted by the

number of Medicare beneficiaries in each county was $467. The lowest rates in the country were $221 in two rural Nebraska counties (Arthur and Banner). The highest rates in 1997 were $767 and $748, respectively, in Richmond County, New York (Staten Island), and Dade County, Florida (Miami). Examining the variation, from highest to lowest payments, the range was $546 in 1997. By 2002, the range had diminished to $356, as the lower floor rate was $500 and the highest rate (Richmond County) was $856. The average payment in 2002 was $571. Although not shown in the table, in 2003, the range from lowest to highest payment increased to $363 (an increase of $7 per month per beneficiary, i.e., 2% higher than $356). The average payment increased to $582, an increase of $11 per month per beneficiary over the 2002 amount. While the low floor payment decreased from $500 to $495, no M+C plan was paid that amount. The lowest rate in the country was $510, representing a 2% increase over the low floor rate of $500 for 2002. The highest rate in 2003 was again in Richmond County at $873, with Dade County (Miami) at $851 and Bronx, New York at $828. In 2004, the highest rate was in St. Bernard (New Orleans) at $1,147, with Dade County (Miami) at $905. The lowest rate, the floor in non-MSA areas, was $555 in areas such as Champaign (Illinois), San Luis Obispo (California), Santa Cruz (Arizona), and Chautauqua (New York). In 2005, the difference between the highest and lowest payments is $630, with the highest rate, again, in St. Bernard (New Orleans) at $1,222. The lowest rate in 2005 is $592, in areas that had previously received the low floor payment, such as Champaign (Illinois), San Luis Obispo (California), and Santa Cruz (Arizona). In 2006, all payment rates will be increased by a 4.8% increase over the 2005 payment. Even though all county rates will increase by the same percentage, the difference between the highest and lowest rates will increase to $661. The highest rate in 2006 will be $1,281 in St. Bernard (New Orleans). The lowest rate in 2006 will be $620 in counties that had in prior years received a low floor payment.

Payment rates vary geographically, as well, with higher payments generally occurring in more urban areas (**Figure 2**). Because the blend rate was only paid in 2000 and 2004, the large variations in payment rates that existed prior to the M+C program, have been only partially reduced. The 2001 floor rate (increased by BIPA) mostly affected rural counties, but it raised rates for some urban counties as well. Payments continue to be higher in urban areas and lower in most rural areas. The 2005 average payment is $758 in central urban counties, $82 above that for other urban counties, $131 above that for rural-urban fringe counties, and $145 above that for other rural counties.[13] In 2006, the average payment rate will be approximately $794 in central urban counties, $85 above that for other urban counties, $167 above that for rural-urban fringe counties, and $152 above that for other rural counties. The range within each of the urban — rural categories remains substantial as well.

[13] Central urban counties are the central counties in metropolitan areas of 1 million population or more. Other urban refers to other counties in those metropolitan areas and any county in smaller metropolitan areas. Rural-urban fringe counties are defined as those non-metropolitan counties that are adjacent to a metropolitan area, and other rural refers to non-metropolitan counties not adjacent to a metropolitan area.

Figure 2. Range of County Medicare Managed Care Payment Rates for the Aged, by Location, 1997-2006



Payment rates range widely across geographic areas, as well as within geographic areas, as shown in **Table 4**. For example, plans serving Miami are paid an average of $986 per month in 2005, compared with $654 in Fairfax County, Virginia. But even within neighboring geographic areas, there can be wide variation in payment rates. The payment rate for Dade County in southern Florida is $123 more than the rate for neighboring Palm Beach County in 2005 and $128 more in 2006. Furthermore, plans competing in the same market may receive substantially different payments for beneficiaries who live on opposite sides of a county boundary. As illustrated in the Washington, DC metro area and the New Orleans metro area, these differing payment levels may affect plan participation and enrollment.

Table 4. Monthly Payment Rates for Aged Enrollees in Selected Areas, in 2005 and 2006

County	Payment 2005	Payment 2006
Washington, DC-Maryland-Virginia		
Prince George's County, MD	$814	$853
Washington, DC	779	816
Montgomery County, MD	700	733
Falls Church City, VA	689	722
Arlington County, VA	661	693
Alexandria City, VA	654	686
Fairfax City, VA	654	686
Loudoun, VA	654	686
Fairfax County, VA	654	686
Southern Florida		
Dade (Miami)	$986	$1,033
Broward (Ft. Lauderdale)	917	961
Palm Beach	863	905
Southern California		
Los Angeles	$813	$852
Orange	769	806
Riverside	750	786
San Bernardino	748	784
New Orleans-Metarie-Kenner, Louisiana, Metropolitan statistical area		
St. Bernard	$1,222	$1,281
Plaquemines	938	983
St. John Baptist	901	945
St. Tammany	892	934
Orleans	866	907
Jefferson	839	879
St. Charles	821	860

Source: Centers for Medicare and Medicaid Services.

Payments for Regional MA Plans

Starting in 2006, the MA program will allow plans to operate regionally. MA plans may serve a single region or multiple regions (including all 26 regions) as part of a new regional program. The regional program is designed to encourage plans to serve areas they had not previously served, particularly rural areas. Regional plans will operate like Preferred Provider Organizations — a popular option in the private health insurance market so that a plan participating in the new regional program will (1) have a network of providers who agree to a contractually specified reimbursement for covered benefits, and (2) provide for reimbursement for all covered benefits, regardless of whether the benefits are provided within the network. In addition, both Medical Savings Account (MSA) plans and Private Fee-for-Service (PFFS) plans may serve one or more regions.[14]

The Secretary established 26 regions taking into account such factors as (1) an adequate number of eligible beneficiaries, (2) presence of existing commercial and Federal Employees Health Benefits plans that may consider serving an MA region, (3) limiting the variation of payment rates within regions, and (4) preservation of existing patient flow in areas where beneficiaries have a tendency to seek care outside of their state of residence. **Table 5** shows the 26 MA regions, the number of beneficiaries in each region, the range of risk adjusted county-level MA rates in the region, the difference between the highest and lowest risk adjusted county-level MA rate in each region, and an average risk adjusted region-level MA rate. The number of eligible beneficiaries in each MA region range from a high of about 4 million in Region 24 (California), to a low of approximately 50 thousand in Region 26 (Alaska). The difference between the highest and lowest risk adjusted MA rate in each region range from a high of $493 in Region 17 (Texas) to a low of $64 in Region 1 (Maine and New Hampshire), Region 21 (Arizona) and Region 25 (Hawaii). Because the Secretary has the discretion to make adjustments to account for intra-regional variation, the spread of MA rates within a region might not pose as much of a risk to plans as it might otherwise have. An MA regional plan may choose to serve more than one region, or may serve the entire nation, but it can not segment its service area to offer either different benefits or different cost-sharing requirements to beneficiaries within the same region.

Only the regional plans (not local plans) will be required to have both a single deductible for Parts A and B services and a catastrophic limit on expenditures. The deductible may be applied differently for in-network services and may be waived for preventive or other items and services. The law specifies that there be one catastrophic limit for in-network required Parts A and B services and another for all required Parts A and B services, although the amount of the catastrophic limit is not specified in the law.

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[14] A Medical Savings Account (MSA) is a combination of a high deductible insurance policy and tax-advantaged personal savings account for medical expenses. A Private Fee-for-Service (PFFS) plan is a private indemnity health insurance policy. In a PFFS plan, the insurer reimburses hospitals, doctors and other providers at a rate determined by the plan on a fee-for-service basis without placing the providers at any financial risk.

Table 5. Medicare Advantage Regions, Beneficiaries and Per Capita Monthly Payments for Aged Beneficiaries, 2005

Region	States	Total beneficiaries	Range of county level rates within each region	Difference between the highest and lowest county rate	Average risk adjusted region level rate
1	Maine, New Hampshire	422,515	$614-$678	$64	$613
2	Connecticut, Massachusetts, Rhode Island and Vermont	1,805,085	$614-$831	$217	$746
3	New York	2,845,450	$614-$903	$289	$814
4	New Jersey	1,255,829	$678-$786	$108	$790
5	Delaware, District of Columbia and Maryland	901,259	$614-$811	$197	$741
6	Pennsylvania and West Virginia	2,527,088	$614-$787	$173	$746
7	North Carolina and Virginia	2,239,963	$614-$789	$175	$634
8	Georgia and South Carolina	1,655,581	$614-$741	$127	$647
9	Florida	3,041,852	$614-$893	$279	$777
10	Alabama and Tennessee	1,663,097	$614-$842	$228	$655
11	Michigan	1,501,197	$614-$826	$212	$690
12	Ohio	1,784,284	$614-$868	$254	$687
13	Indiana and Kentucky	1,588,640	$614-$749	$135	$641
14	Illinois and Wisconsin	2,555,008	$614-$722	$108	$641
15	Arkansas and Missouri	1,389,193	$614-$778	$164	$644
16	Louisiana and Mississippi	1,107,824	$614-$1,101	$487	$785
17	Texas	2,504,912	$614-$1,107	$493	$777
18	Kansas and Oklahoma	947,170	$614-$845	$231	$648
19	Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota, Wyoming	1,913,827	$614-$836	$222	$581
20	Colorado, New Mexico	778,442	$614-$861	$247	$628
21	Arizona	769,443	$614-$678	$64	$633
22	Nevada	291,959	$614-$792	$178	$688
23	Idaho, Oregon, Utah, Washington	1,764,310	$614-$793	$179	$615
24	California	4,257,579	$614-$1,046	$432	$778
25	Hawaii	182,651	$614-$678	$64	$623
26	Alaska	51,198	$614-$921	$307	$624

Source: Table created by the Congressional Research Service (CRS) based on CMS analysis.

Note: Payment rates in this table are risk adjusted. Region level rates are adjusted using average state aggregate risk scores multiplied by the weighted 2005 county rates in each state.

Payments to regional plans, like local plans, will also be based on a benchmark amount. However, the calculation of regional benchmarks will be different than the

calculation of the local benchmarks. For a region, the benchmark for part A ad B benefits is comprised of two components, one determined according to statute and one based on plan bids. The regional statutory component is the weighted average of all the statutorily determined local payment rates in the region. The weight for the statutory component is based on the percent of eligible individuals in the area, as opposed to enrollees.[15] The plan-bid component is the weighted average of all the MA regional bids submitted in a region. This weight is based on enrollment by plan. Similar to local plans, each regional plan will submit a *bid* to provide coverage of all required benefits, but unlike the benchmark for local plans, the regional benchmark depends on all plan bids. By incorporating the plan bid into the calculation of the benchmark, the payments amount to any one plan that participates in a region will depend on the bids submitted by other plans in the region. This introduces a new type of competition, not previously used in determining Medicare payments.

Calculation of the Regional Monthly Benchmark

The MA monthly region-specific non-drug benchmark amount will be calculated according to the following formula, for a region for a month in a year.

$$\begin{pmatrix} Regional \\ Benchmark \end{pmatrix} = \begin{pmatrix} Statutory \\ Component \end{pmatrix} + \begin{pmatrix} Plan-Bid \\ Component \end{pmatrix}$$

1. The statutory component of the benchmark is calculated as follows, for a region and year:

$$\begin{matrix} Statutory \\ component \end{matrix} = \begin{pmatrix} Statutory \quad Regional \quad Specific \\ non-drug \quad amount \end{pmatrix} \times \begin{pmatrix} Statutory \quad National \\ market \quad share \quad percentage \end{pmatrix}$$

a. The statutory region-specific non-drug amount is equal to the sum **(for each of the MA local areas within the region)** of the calculations for the following formula:

> (MA area-specific non-drug monthly benchmark amount for the area and the year) x (number of MA eligible individuals residing in the local area/total number of MA eligible individuals residing in the region)

b. The statutory national market share percentage is the proportion of MA eligible individuals nationally who were **not** enrolled in an MA plan during the reference month. The reference month is defined as the most recent month during the previous year for which data are available.

2. The plan-bid component of the benchmark is calculated as follows, for a region and a year:

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[15] This weight may be based on eligible individuals, rather than enrollees because the ratio of eligible individuals may be a more stable percentage than those who chose to enroll.

$$\begin{matrix} Plan\,bid \\ component \end{matrix} = \begin{pmatrix} Weighted\ average \\ of\ \ plan\,bids \end{pmatrix} \times \begin{pmatrix} Non\,statutory \\ market\ \ share \\ percentage \end{pmatrix}$$

a. The weighted average of plan bids for an MA region and a year is equal to the sum **(for all MA regional plans in that region and year)** of the calculations of the following formula:

> (unadjusted MA statutory non-drug monthly bid[16] amount for the plan for the year) x (number of individuals who reside in the region who were enrolled under that regional plan during the reference month/total number of individuals for all MA regional plans for that region and year, for plans offered in the region in the reference month)

b. The non-statutory market share percentage is the complement of the statutory market share percentage (1-statutory market share percentage) and is the proportion of MA eligible individuals who were enrolled in an MA plan.

Plans not offered in the previous year are excluded. The Secretary will compute the benchmark for each region before the beginning of each annual election period.

Risk Adjustment

Beginning in 2006, the Secretary will annually determine the average of the risk adjustment factors to be applied to regional plan payments. If no plan was offered in the region in the previous year, the Secretary will generate an estimate using factors such as the average for comparable regions or the national average. The Secretary could apply risk adjustment factors other than on a regional basis, including a state basis, or a plan-specific basis.

Both the plans bids and benchmarks will be risk-adjusted for demographic factors (including age, disability, gender, institutional status), health status, intra-regional variation, and if applicable, a monthly rebate. To adjust for intra-regional variation, the Secretary will adjust the amounts to take into account variation in MA local payment rates among the different MA local areas included in the region. The Secretary shall adjust payments to MA regional plans to ensure that the sum of the monthly payment and any required basic beneficiary premium equals the unadjusted MA statutory non-drug bid amount, adjusted for the demographic factors and intra-regional variation.

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[16] The statutory non-drug monthly bid amount is the portion of the bid amount attributable to the provision of benefits under original Medicare Parts A and B fee-for-service.

Stabilization Fund

The MMA establishes a regional plan stabilization fund to encourage regional plans to serve at least one or even all regions, and to encourage plans to stay in regions they might otherwise leave. Initially, in 2007, $10 billion is to be available to the fund, but additional amounts may be added.[17] The funds are to be available through December 2013. The Secretary will be responsible for determining the amounts that may be given to MA regional plans from this fund, based on statutory requirements.

These funds can be offered either on a national or regional basis. The nationally based bonus payment will be available for one year to an MA organization that offers a MA regional plan in **all** regions, but only if there was no national plan in the previous year. The national bonus amount is 3% of the benchmark amount otherwise applicable for each MA regional plan offered by the organization (the national plan is comprised of regional plans offered in all regions). More than one national plan could qualify for this bonus, if the plans were first offered in the same year. However, there would be no regional bonus in a year that a national bonus was awarded.

If no national plan was offered in a year, regional bonuses could be awarded. To encourage participation in regions, the Secretary may increase the benchmark in a region that offered no regional MA plans in the previous year. The Secretary will determine the bonus amount which will be based on the bids submitted for each qualifying plan and could vary across regions. Funding could be available for more than one year.

Further, if a plan indicates that it will leave a region, the Secretary may increase the benchmark, within limits for up to two years, in that region in order to retain and attract new plans. In this situation, the plan exits must result in fewer than two remaining regional organizations, and the percentage of MA enrollment in the region must be less than the national percentage enrollment. Plans receiving an increased payment for entering an area would not be able to receive an increased payment for retention, in the following year. The increased payment amount would be the greater of: (1) 3% of the benchmark amount in the region, or (2) an amount that makes the following two ratios equal to each other — (a) the benchmark plus bonus amount divided by the adjusted average per capita cost for the region, as risk adjusted and (b) the weighted average of the benchmarks for all regions, divided by the average per capita cost for the United States, as risk adjusted.

For payments from the stabilization fund, the Secretary must certify that the there are adequate funds to cover payments and may limit enrollment in regional plans receiving the bonus to ensure adequate funding.

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[17] If a plan's bid is below the benchmark, then 75% of the savings is returned to the plan for the beneficiary according to statutory limitations and 25% is returned to the government. One-half of the government's share of rebates, attributable to regional plans, will be used to increase funding for the stabilization fund.

Risk Corridors

To further encourage plan participation in the regional program, Medicare will initially share risk with MA regional plans in 2006 and 2007. If a plan's costs fall outside of a specified range or "risk corridor," plans will assume only a portion of the risk for unexpected high costs and plans will be required to return a portion of the savings to Medicare for unexpected low costs. A plan's allowable costs will be measured against a target amount.[18]

If allowable costs are between 97% and 103% of the target amount for the plan for the year, there will be no payment adjustment for the plan. If the Secretary determines that a plan's allowable costs are over 103% but no greater than 108% of a specified target amount, the plan will receive an additional payment equal to 50% of the difference between the allowable costs and 103% of the target amount. For costs above 108% of the target amount, the Secretary will increase the payment by the sum of 2.5% of the target and 80% of the difference between allowable costs and 108% of the target.

Conversely, if a regional plan's allowable costs are less than 97% but greater than or equal to 92% of the target amount, the Secretary will reduce the payments by 50% of the difference between 97% of the target amount and allowable costs. If allowable costs are less than 92% of the target amount for the plan and year, the Secretary will reduce the monthly payment by the sum of 2.5% of the target amount and 80% of the difference between 92% of the target amount and such allowable costs.

Essential Hospitals

The MMA also allows the Secretary to provide for an increased payment amount for certain hospitals that provide inpatient hospital services to MA regional plan enrollees. This provision was designed to aid MA organizations who offer regional plans to meet the provider access requirement. To qualify for these payments, an MA organization offering a plan must certify to the Secretary that the organization was unable to reach an agreement with an essential hospital[19] to provide inpatient hospital services to plan enrollees. Further, the hospital must prove that the costs of serving the plan's enrollees exceeds the Medicare Part A payment. In such

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[18] Allowable costs include the total amount of costs that an organization incurred in providing required Parts A and B benefits for all enrollees under the plan in the region in the year, reduced by the portion of such costs attributable to administrative expenses, plus the total amount of costs the organization incurred in providing any supplemental benefits as part of any required rebate. The target amount is the sum of total monthly payments made to the organization for enrollees in the plan for the year for required Parts A and B benefit, total MA monthly basic beneficiary premium, and the total amount of the rebates, reduced by the amount of administrative expenses assumed in the bid.

[19] An essential hospital is defined in this section as a general acute care hospital, as defined in Section 1886(d) of the Social Security Act, that the Secretary determines must be part of a regional plan's network in order for the plan to meet the access requirements. 69 *Federal Register* 46883, Aug. 3, 2004.

cases, the plan must also pay the hospital at least the Medicare Part A payment for inpatient hospital services provided to enrollees. Beginning in 2006, there is to be $25 million available (with an increased amount each year) for these payments.

Summary of Regional MA Plan Payments

A summary of payments made to regional MA plans is provided in **Table 6**. The table includes the payment made to a plan for covered Medicare services, depending on whether the plan's bid or benchmark is higher. It also includes any required enrollee basic beneficiary premium or rebate. The table provides an explanation of how risk adjustment is applied to the different payments. Not included, are any payments made to plans that choose to offer a Medicare prescription drug program. Plans that provide Medicare prescription drug coverage will receive an separate additional payment.

Table 6. Total Non-Drug Payments to MA Regional Plans for Required Part A and B Services, Starting in 2006

Payments, including any plan premium or rebate, and other adjustments	Payment if MA statutory non-drug monthly bid is greater than or equal to MA region-specific non-drug monthly benchmark (bid ≥ benchmark)	Payment if MA region-specific non-drug monthly benchmark is greater than MA statutory non-drug monthly bid (benchmark > bid)
CMS payment to a plan for original FFS Medicare benefits (other than hospice care), including an in-network plan and total catastrophic limit	MA region-specific non-drug monthly benchmark (**benchmark**) adjusted for the demographic and health history risk characteristics of the enrollee, and at the Secretary's discretion, intra-regional variation, subject to an additional constraint.[a]	MA region-specific non-drug monthly bid (**bid**) adjusted for the demographic and health history characteristics of the enrollee, and at the Secretary's discretion, intra-regional variation, subject to an additional constraint.[a]
Basic beneficiary premium — enrollee payment to a plan	The amount by which the unadjusted **bid** *exceeds* the unadjusted **benchmark**.	$0
Enrollee rebate from a plan	$0	The plan receives 75% of the amount by which the adjusted **benchmark** *exceeds* the adjusted **bid**.[b] The adjustment is based on the region-wide average of demographic and health status risk factors (or some other basis, at the Secretary's discretion). This amount is reduced by any Part B premium rebate offered by the plan.

Payments, including any plan premium or rebate, and other adjustments	Payment if MA statutory non-drug monthly bid is greater than or equal to MA region-specific non-drug monthly benchmark (bid ≥ benchmark)	Payment if MA region-specific non-drug monthly benchmark is greater than MA statutory non-drug monthly bid (benchmark > bid)
Government savings (government's share of rebate)	$0	The government receives 25% of amount by which adjusted **benchmark** *exceeds* the adjusted **bid**. Adjustment based on region-wide average of demographic and health status risk factors (or some other basis, at the Secretary's discretion).
Stabilization fund payments	Secretary may increase benchmark in region to promote plan entry and plan retention.	Same as previous column, although unlikely to occur if bid was less than benchmark.
Risk Corridors — CMS payment to plan based on shared risk	Additional payment will be made to plan in 2006 and 2007 if its cost exceed a specified risk corridor.	Same as previous column.
Risk corridors — government savings based on shared risk	Reduced payment will be made to plan in 2006 and 2007 if its costs are below a specified risk corridor.	Same as previous column.
Essential hospital payments	Secretary could allow for increased payment to certain hospitals that prove costs for serving plan exceed the Medicare Part A payment.	Same as previous column, although unlikely to occur if bid was less than benchmark.

Source: The Congressional Research Service (CRS) analysis of MMA provisions.

a. The Secretary must adjust payments to regional MA plans to ensure that the sum of the payment from CMS and the Basic Beneficiary Premium do not exceed the plan bid, adjusted for the demographic and health history risk factors of plan enrollees and subject to intra-regional variation.

b. The rebate to be paid to the plan, the beneficiary rebate, may only be used to provide additional benefits, reduce cost sharing, or applied towards the monthly Part B premium, prescription drug premium, or supplemental premium (for services beyond required Medicare benefits).

Payments for MA Plans and FFS Premiums in Cost Containment Areas

Beginning in 2010, the Secretary will establish a program for the application of comparative cost adjustment (CCA) in CCA areas. The six-year program will begin January 1, 2010 and end December 31, 2015. The program is designed to test direct

competition among local MA plans, as well as competition between local MA plans and fee-for-service Medicare.

This program will only occur in a limited number of statutorily qualifying areas in the country. The Secretary will select CCA areas from among those Metropolitan Statistical Areas (MSAs), or such similar areas as the Secretary recognizes, which meet the following requirements for the relevant reference month: (1) at least 25% of MA eligible individuals who reside in the MSA were enrolled in an MA local plan; and (2) before the beginning of 2010, at least two MA local plans will be offered by different organizations in the MSA during the annual coordinated election period, each meeting the current law minimum enrollment requirements for a plan. The total number of CCA areas will be the lesser of six MSAs or 25% of the number of MSAs meeting the requirements. Additionally, an MA local area (a county) in an MSA will be excluded from the CCA area, if, in 2010 it does not offer at least two MA local plans, each offered by a different MA organization. If an MA local area meets the requirement for 2010 it will continue to be included in the CCA area for subsequent years, even if it no longer meets the requirements as long as there is at least one MA local plan offered in the local area.

The benchmark for MA local plans in a CCA area will be calculated using a formula that weights the FFS portion and a local plan portion, described below. The FFS portion is based on the projected FFS amount for the area, with certain adjustments for demographics and health status. The local plan portion is based on a weighted average of bids for plans in the area.

For Medicare beneficiaries in FFS, Part B premiums in CCA areas will be adjusted either up or down, depending on whether the FFS amount is more or less than the CCA area benchmark. If the FFS amount is greater than the benchmark, beneficiaries in traditional Medicare FFS will pay a higher Part B premium than other FFS beneficiaries in non-CCA areas. If the FFS amount is less than the benchmark, the Part B premium for FFS beneficiaries will be reduced by 75% of the difference. These increases and decreases are subject to a 5% limit, that is, adjustments to Part B premiums in CCA areas cannot exceed 5% of the national part B premium. Beneficiaries in traditional Medicare FFS with incomes below 150% of poverty, who qualify for low-income subsides under the Medicare prescription drug program, will not have their Part B premium increased.

Calculation of the "Comparative Cost Adjustment (CCA) Benchmark Amount

Beginning in 2010, the CCA non-drug monthly benchmark amount will be calculated according to the following formula, for a CCA area for a month in a year.

$$\begin{pmatrix} \textbf{CCA Non-Drug} \\ \textbf{Monthly Benchmark Amount} \end{pmatrix} = \begin{pmatrix} \textbf{MA local} \\ \textbf{component} \end{pmatrix} + \begin{pmatrix} \textbf{FFS} \\ \textbf{component} \end{pmatrix}$$

1. The MA local component is calculated as follows, for an area in a year:

$$\begin{matrix} MA\ local \\ component \end{matrix} = \begin{pmatrix} Weighted\ average\ of \\ the\ MA\ plan\ bids \end{pmatrix} \times \begin{pmatrix} MA\ (NonFFS) \\ market\ share \\ percentage \end{pmatrix}$$

a. The weighted average[20] of the MA plan bids is equal to the sum **(across each of the MA local plans for the area)** of the calculations for the following formula:

> (the accepted unadjusted MA statutory non-drug monthly bid) x (number of individuals who reside in the area and who were enrolled under the plan during the reference month for that year/total enrollees for all MA plans for that area and year, for plans offered in the CCA in the reference month).

b. The MA (non FFS) market share percentage is the proportion of MA eligible individuals who, during the reference month, were enrolled in an MA plan, or if greater, the same proportion determined on a national basis.

2. The FFS component is calculated as follows, for an area in a year:

$$\begin{matrix} FFS \\ component \end{matrix} = \begin{pmatrix} FFS\ area\ specific \\ non\ drug\ amount \end{pmatrix} \times \begin{pmatrix} FFS \\ market\ share \end{pmatrix}$$

a. The FFS area-specific non-drug amount is the adjusted average per capita cost, which is risk adjusted and also excludes direct graduate medical education and includes the additional payments that would have been made if Medicare beneficiaries entitled to benefits from facilities of the Department of Veteran Affairs (VA) and the Department of Defense (DOD) hadn't used those services.

b. The FFS market share percentage is complement of the MA market share percentage (1- MA market share percentage). It is the proportion of MA eligible individuals who, during the reference month, were **not** enrolled in an MA plan, or if greater, the same proportion determined on a national basis.

Plans not offered in the previous year are excluded. The Secretary will compute the benchmark for each CCA area before the beginning of each annual election period, beginning in 2010 and continuing until the end of the program. The CCA program will be phased-in over four years, so that in 2010 only one-fourth of the benchmark will be based on the CCA benchmark and three-fourths of the benchmark

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[20] In the case of an MA local plan that has only part of its service area located in the CCA area, the MA organization offering the plan will submit a separate bid for the portion within the CCA area.

will be calculated in the same manner as the benchmark for local MA plans. By 2013, the benchmark will be 100% CCA.

Payments to MA Plans for Part D Medicare Prescription Drug Benefits

Beginning in June 2004, MA plans could begin offering Medicare-endorsed drug discount cards, that were effective in July 2004, to their own enrollees through the newly established drug discount card program under MMA. The cards can provide discounts on drug prices even if the plan does not have a drug benefit, or if the plan benefit cap is reached.

Beginning in 2006, MA plans may, but are not required to, offer Part D prescription drug coverage. Furthermore, enrollment in Part D is voluntary and as a result, beneficiaries who chose to enroll in MA plans will not be required to enroll in an MA-Prescription drug (MA-PD) plan. However, the requirements placed on MA plans could lead to a situation in which the only MA plans available in an area are those offering prescription drug coverage. At least one plan offered by an MA organization in an area is required to be an MA-PD plan, one that offers Part D prescription drug coverage. Therefore, if only one organization offers an MA plan in an area and it offers only one plan, that plan would have to be an MA-PD and the beneficiary would have to enroll in Part D in order to enroll in an MA plan. In this situation, a beneficiary who did not want to enroll in Part D would have to receive Medicare services through traditional FFS Medicare. If an MA organization offers more than one plan in an area, only one is required to provide Part D prescription drug coverage. Each organization in an area is subject to this standard, so that even if there are multiple plans in an area, each organization must offer at least one plan that includes prescription drug coverage.

MA-PD plans will receive drug subsidies, for their enrollees. MA organizations offering prescription drug coverage will receive a direct subsidy for each enrollee in an MA-PD plan equal to the plan's risk adjusted standardized bid amount (reduced by the base beneficiary premium). The plan will also receive the reinsurance payment amount[21] for the federal share. Finally, an MA-PD plan will also receive reimbursement for premium and cost-sharing reduction for its qualifying low-income enrollees.

Beneficiaries who enroll in a plan offering Part D, must pay the standard Part D premium. However, MA-PD plans offering a rebate, may use all or part of that rebate as a credit toward the MA monthly prescription drug beneficiary premium.

The prescription drug programs offered through MA plans have the potential to be very different than coverage offered to FFS beneficiaries, and as a result, costs

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[21] Assuming the standard drug package in 2006, plans will receive 80% of qualifying drug expenditures between $250 and $2250 and 90% for qualifying expenditures over $5,100.

and/or enrollment in MA plans could be affected. Plans might be able to decrease costs or increase services, thus becoming a more attractive benefit, for the following reasons: (1) MA plans that currently offer prescription drug coverage will have more experience working with Medicare beneficiaries and may be more efficient; (2) MA plans could augment funds they already use for prescription drugs and offer more generous coverage than the standard benefit; (3) MA plans could also transfer their "old" prescription drug money to offer other services; and (4) MA plans cover Parts A and B benefits and may therefore be able to realize some savings (which could be passed onto the beneficiary), such as reduced hospitalization, from Medicare's prescription drug coverage. On the other hand, enrollment in MA plans could decrease if beneficiaries move from MA plans to FFS, once they can receive prescription drug coverage without the restrictions of a more limited provider network.

Conclusion

The MMA made many substantial changes to the Medicare managed care program, ranging from increasing funds to creating a new regional program. By 2010, a limited number of geographic areas will be selected to examine enhanced competition among local MA plans and competition between private plans and FFS Medicare. These changes are designed to increase private plan participation in Medicare and thus provide more Medicare beneficiaries with an alternative to FFS coverage. The M+C program had difficulty meeting similar goals and the MMA changes were designed to address some of these problems. As the major program changes in MA will not take effect until 2006, it will take a few years, at a minimum, to determine the success of these changes. Part of the success will depend on whether private plans are receptive to providing services in accordance with these new statutes.

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