American Academy of Actuaries
ISSUE BRIEF
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Medicare Advantage Payment Reform

OVERVIEW

Medicare is the federal program providing health insurance to virtually all Americans over the age of 65 and many long-term disabled individuals. Medicare beneficiaries can access Medicare benefits through either the original Medicare fee-for-service (FFS) program or Medicare Advantage (MA) plans offered by private health plans. The FFS program is run by the Center for Medicare & Medicaid Services (CMS), a federal government agency. It provides coverage for hospital services (Part A), for physicians and outpatient care services (Part B), and for prescription drugs (Part D). Beneficiaries may purchase Medigap policies to help fill in the gaps in Part A and B coverage. Medicare Advantage plans are offered by private health plans that contract with CMS. CMS pays health plans a fixed amount each month for providing coverage. The plans must cover at least all of the services that the FFS program covers; however, they may offer extra benefits either at no additional cost or for an additional premium. Medigap policies are not sold to beneficiaries covered under MA plans.

Introduction

Current health care reform legislation includes various proposals that address the financing structure of Medicare Advantage (MA) plans. One initial goal of the Medicare Advantage program was to offer a more cost-effective alternative to the FFS program by providing beneficiaries access to coordinated delivery systems and care management with enhanced benefits. Proponents believed that a well-managed MA plan would cost less than the FFS benefits and would offer a comprehensive benefit package for a modest additional premium. MA plans are reimbursed by CMS based on "benchmark rates." The MA benchmark rate is the maximum amount paid to health plans, and it is set by law. When the benchmark is higher than what it costs an MA plan to provide the FFS benefits, the MA plan is required to "return" the additional payments to the beneficiaries by either enhancing the benefits beyond FFS level or reducing the beneficiaries' Part B/Part D premiums (i.e., also known as the "rebate").

In many geographic areas, MA plans have provided comprehensive benefits that replace the combination of FFS and Medigap policies. Over time, due to the changing goals set by policymakers (e.g., to enable beneficiaries access to MA plans in all geographic areas), and the subsequently enacted payment policy changes (that set the mechanism by which the benchmark is determined), the MA benchmarks have become higher than the FFS costs in many geographic areas. As part of the current health care reform discussion, various approaches have been proposed to bring the MA payments in line with, or lower than, the FFS costs.

The Medicare Payment Advisory Commission (MedPAC) estimates

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that in 2009, Medicare is paying approximately $12 billion per year more for those individuals enrolled in MA plans than it would have had they been enrolled in FFS program.[1] As noted in the annual Medicare trustees' report, the intermediate-term solvency of the Medicare program cannot be sustained, with the current revenue/funding structure, given current costs and demographic trends. With approximately 20 percent of Medicare beneficiaries enrolled in a MA plan, the higher cost of MA plans, compared to the FFS program, adds pressure on overall program solvency and increases Part B premium costs for all beneficiaries.

This issue brief, developed by the American Academy of Actuaries' Medicare Steering Committee, describes the current payment system, provides an overview of the goals of the MA program and addresses two of the alternative mechanisms (and some variations) for reducing payments to Medicare Advantage plans.

- Payment based on a percentage of the FFS costs
- Payment based on a competitive-bidding program

When considering reform of the current Medicare Advantage payment system, policymakers should clearly identify the program goals and their relative importance and be conscious of changes that would retain the benefits of the current program while addressing some of the perceived disadvantages. The program goals could include the following:

- Reduce payment rates for private plans so that they are not paid more than the FFS program; either by payment area or in aggregate nationally;
- Reward efficient provision of services and care management;
- Promote improvements in quality of care;
- Maintain or improve beneficiary access to providers;
- Limit beneficiary disruptions of access or premium changes;
- Maintain alternatives to the FFS program.

Benefits of the current MA program include providing an affordable alternative to the FFS program; access to private plans in many rural areas that often have limited choice or are underserved; and reduced cost-sharing and additional benefits such as longer acute-care stays, reduced cost of drug benefits, vision, dental, and hearing.

The Current Medicare Advantage Payment System

Per capita payments to MA plans currently exceed per capita costs in the FFS program. The mechanisms that generate the excess in payments compared to the FFS program are described in more detail below. While MA plan payments in the aggregate exceed payments that would have been made for the FFS program, in some high-cost areas MA plans have the proven capability to provide the equivalent FFS benefits more efficiently than the FFS program. As currently designed, efficient plans have an incentive because they can use the efficiency gains to provide additional benefits (such as reduced cost sharing, reduced premiums and subsidized prescription drug cover-

[1]MedPac. *Improving Incentives in the Medicare Program,* June 2009, p.169.

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age) to lower out-of-pocket cost and enhance beneficiary well-being. These additional benefits result in better market position and ultimately increased market penetration for the MA plans.

Under current law, MA payment benchmarks are set at the greater of 1) prior year benchmarks increased by the percentage change in overall Medicare per capita costs (the "minimum update") or 2) 100 percent of the county-level FFS costs in "rebasing" years. Current law requires that the county-level FFS costs be reset ("rebased") at least every three years to update the estimate of per capita FFS spending. During rebasing years, in counties where the FFS cost has declined, the benchmark is the prior year's benchmark increased by the minimum update. As a result, the spread between the benchmarks and FFS costs can only increase, not decrease—an effect which is sometimes referred to as "ratcheting."

Over the years, the difference between the benchmarks and FFS costs has continued to increase due to this ratcheting effect, the minimum payment floors established by Congress, and the increased number of beneficiaries in MA plans in counties with large spreads. This has resulted in Medicare paying an average of 14 percent more for those individuals enrolled in MA plans than for those in the FFS program in 2009.[2]

There are dramatic differences in the medical-service costs by county in the FFS program. For example, see Table 1 for CMS's estimated 2009 monthly FFS cost for the low-cost area of Carter County, Mont., versus the high-cost area of Dade County, Fla. Similarly, the benchmarks display a wide variance but are a little more compressed. A common measurement of the benchmarks is the ratio of the benchmarks to the FFS spending level. The ratio of the benchmarks to the FFS cost varies greatly from county to county. The ratio of the benchmark to the FFS cost is 1.53 (or 153 percent) for Carter County versus 1.01 (or 101 percent) for Dade County. The high-ratio counties are driven by how the benchmarks have historically been set—at one point, Congress set floors (minimum benchmark levels) to encourage the availability of plans in areas where FFS spending was unusually low.

TABLE 1: Select CMS Estimated 2009 FFS Costs (monthly)

Description	County	2009 FFS Cost	2009 Benchmark	Ratio of Benchmark to FFS Cost
Low-cost county example	Carter County, MT	$480	$741	153%
High-cost county example	Dade County, FL	$1,227	$1,238	101%

Source: Centers for Medicare and Medicaid Services (CMS), *Medicare Advantage-Rates & Statistics,* 2009 Rate Calculation Data

MA payments are either less than or equal to the benchmarks (i.e., they are determined based on the relativity of the plan's "bid" for the FFS level of benefits and the benchmark). For plan bids that are less than the benchmark, plans receive a payment equal to the bid amount plus a rebate equal to 75 percent of the benchmark less the plan-bid amount. Current law requires that MA organizations use the rebates to provide additional benefits, such as reduced cost sharing for the FFS benefits, a reduction in the member premium for the Medicare prescription drug benefit, or additional benefits such as vision, dental, or hearing services that are not covered by the FFS program. See Table 2 for a simplified example.

For plan bids that are greater than the

TABLE 2: Illustration of Plan Bids Less Than the Benchmark

Description	PMPM
Plan bid on FFS benefits	$900
Benchmark	$1000
Difference	$100
Rebate (75% of difference)	$75
Payment to MA plan (plan bid plus rebate)	$975

[2]MedPac. *Improving Incentives in the Medicare Program,* June 2009, p.172

benchmark, the total payment to the plan equals the benchmark. Even though payments for MA plans generally always are less than or equal to the benchmark, the benchmarks on average are much higher than the FFS costs.

Payment Based on a Percentage of FFS Costs

Phasing down the benchmarks to 100 percent of FFS

This option is one of the simplest, straightforward methods to ensure that the payments to MA plans are consistent with the amount Medicare would spend on Parts A and B benefits if those enrollees were in the FFS program. This method is similar to one of the earlier payment methods (1982-1997) under which the rates were set at 95 percent of the FFS costs by county.[3] Below is a description of this approach, followed by some comments on how a phase-down to 100 percent of FFS might affect the MA program.

In a phase-down to 100 percent of FFS, the county-level benchmarks for the MA program gradually would be reduced to equal 100 percent of the FFS costs (FFS rates) in each county. This phase-down could be accomplished in multiple ways over a set number of years, such as capping the benchmarks at various percentages of the FFS costs, taking a blend of the current benchmark and 100 percent of FFS costs, etc. It is generally assumed that the current mechanism of bidding and providing the value of the rebate in the form of supplemental benefits to the beneficiaries would be maintained. Actual payments would be less than 100 percent of FFS, as plans bidding below the benchmark would receive payments less than 100 percent of FFS.

Compared to competitive bidding, phasing down to 100 percent of FFS provides a relatively predictable outcome. As previously noted, the current rate-setting process creates a 100 percent FFS rate book at least every third year, which would presumably be the process for setting benchmarks under this scenario. It would create substantial savings in areas where benchmarks currently exceed FFS costs.

However, given the large variance in FFS costs by geographic area, moving to 100 percent of FFS would result in more payment variance by county than currently exists today. Those areas with benchmarks close to the FFS costs (e.g., Dade County, Fla.; Clark County, Nev.; and Suffolk County, N.Y.) will experience little or no impact on payment rates, while those areas with benchmarks that exceed the FFS costs (e.g., Carter County, Mont.; Honolulu County, Hi.; and Albany County, N.Y.) will experience significant reductions in payment rates. The payment reductions will result in benefit reductions and potentially the exit of MA plans.

Other issues stemming from setting rates by county with small populations will arise. Counties with small populations may have FFS payment levels that are not credible because the enrollment base is too small. This could result in estimated FFS payment levels that are not an accurate estimate of the true cost of providing care in an area—payment levels that are too low, too high, or that vary abruptly between adjacent counties. Contiguous counties that have different rates may experience service disruptions as plans focus on counties with the higher payment rates. Rates and benefits may fluctuate from year to year as the FFS costs in a county vary from year to year.

Several adjustments to the straight 100 percent FFS methodology have been proposed to alleviate some of the issues above:

- Expanding the rate setting area to be a broader geographical area than county;
- Paying incentive payments to those plans that meet certain quality and outcomes standards;

[3]Prior to 1997, the plans were paid 95 percent of FFS. Congress changed the payment rules to the plans starting with the *Balanced Budget Act of 1997* (BBA), increasing payments in the low-cost areas. This was to address the inequity of beneficiaries in certain areas (mostly high-cost areas) having access to plans with additional benefits and others (mostly low-cost areas) with no or limited access.

- Examining the drivers of the FFS program cost differences in order to identify fraud, overutilization and mismanagement in the FFS program;
- Providing a hybrid model that sets minimum and maximum rates, resulting in some rates being less than the FFS costs and some being more (the variance in the rates between counties would be reduced);
- Adjusting national benchmarks for local input prices;
- Blending local and national benchmarks.

Blend of Local and National Cost Levels

A variation to setting MA benchmark rates on local FFS costs would be to base them on a blend of local FFS spending and national average spending levels. Including national average spending in the calculation moderates the geographic differences in payment levels that would be seen if benchmarks were based on local FFS spending. In evaluating this option, MedPac has noted that the blend that came closest to matching the actual pattern of plan costs gave 75 percent weight to local FFS spending and 25 percent weight to the national spending level.[4] As summarized in Table 3, there are advantages and disadvantages to this approach.

Competitive Bidding

Competitive bidding is an approach in which the payment rates would be set using an average of submitted bids. Under this approach, the payment rates most would not be directly linked to the FFS costs, although various versions of competitive bidding include capping the average bids at the FFS levels of costs or including the projected FFS costs as one of the "competitive bids."

A main argument for implementing competitive bidding is that it would level the playing field among geographic regions within the MA program by paying plans based on a defined level of benefits (founded on actuarial equivalence relative to FFS benefits) and by utilizing market forces to fund enhanced benefits. Competitive bidding may encourage plans to be more efficient and could result in

Table 3: Blend of Local FFS Spending and National Average Spending Levels

ADVANTAGES	DISADVANTAGES
This approach could directly adjust the general level of payments to MA plans (i.e., both the local and national portions of the benchmark could be set at 100 percent of the estimated FFS spending levels, or any other percentage of those levels chosen by Congress).	It would not fully reflect actual differences in cost attributable to geographic differences in utilization patterns and provider prices.
It would not fundamentally change the current MA bidding process.	There would be disruptions in the cost and availability of plans as payment levels changed, and these disruptions could vary significantly by geographic areas.
It would moderate the variations caused by counties with small enrollment.	There are more direct approaches to resolve the issue of rate fluctuations in counties with small enrollment. One approach as recommended by MedPAC is expanding the rate setting area to be a broader geographical area than an individual county.
By including the national average, it would moderate the effect on areas with very low FFS spending.	It does not address the underlying issue of large variations in medical services by geographical areas.

[4]MedPac. *Improving Incentives in the Medicare Program,* June 2009, p.190.

lower benchmarks as higher-cost plans withdraw from the market. Most of the federal cost savings in competitive bidding would result from payment reductions in counties where MA plans are more efficient than the FFS program. In counties where plan bids currently exceed FFS cost, a pure competitive-bidding approach could result in maintaining payment levels above FFS. This may increase the likelihood of preserving access to MA plans in rural areas compared to the phase-down to 100 percent FFS approach to reducing MA payments.

One variation could be to cap competitive benchmarks at the FFS level of cost. This would produce savings to the government but would likely reduce the number of MA plans in rural areas. Policymakers would need to weigh cost reduction versus preservation of plan access when reforming the current payment system.

A main argument against competitive bidding is that an immediate transition to such a system would be highly disruptive to beneficiaries due to the potential elimination of access to enhanced benefits or a significant increase in premiums for enhanced benefits. The resulting net migration out of MA plans into FFS program and Medicare Supplement plans, especially in high-cost areas, could offset the savings to the government that would be gained by preserving membership in the MA program.

The following illustration (Table 4), representative of a high-cost county, compares payments to plans under competitive bidding and the current system. It also illustrates changes in enhanced benefits and member premiums that could result from a competitive-bidding system.

Example Assumptions

- Three plans in the marketplace, each with an equal number of enrollees
- Plan bids for FFS benefits:
  - Plan A: $900
  - Plan B: $850
  - Plan C: $800
- Benchmark under current law = $1,000
- Benchmark under competitive bidding = $850 (weighted average of plan bids)
- FFS average per capita cost = $1,000

As shown in the table below, only plans bidding below the competitive bid average (such as Plan C above) would be able to offer enhanced benefits without charging a member premium. The enhanced benefits would be at a level well below those in the current system ($50 versus $150). Other plans, such as Plan A, would have to charge a premium just to offer the FFS benefits. While some beneficiaries would likely migrate from Plan A and B to Plan C, others would instead return to the FFS program, resulting in a higher costs to Medicare. For those who return to the FFS program, the average per capita cost is $1,000. Under the current system, the cost ranges from $950 to $975.

Another consequence highlighted by the example above is that competitive bidding could lead to fewer plans in the market. Because Plan A must charge a premium for the FFS level of benefits while Plan C may offer enhanced benefits for no member premium, the loss of membership in Plan A to either Plan C or to FFS program could likely force Plan A to exit the MA program. As less-efficient

TABLE 4: Illustrative Comparison of Plans Under the Current System to a Competitive Bidding System

	CMS Payment to Plan		Rebate (CMS Funding for Enhanced Benefits)		Member Premium for FFS Benefits	
	Current	Competitive Bidding	Current	Competitive Bidding	Current	Competitive Bidding
Plan A	$975	$850	$75	$0	$0	$50
Plan B	$962.50	$850	$112.50	$0	$0	$0
Plan C	$950	$850	$150	$50	$0	$0

plans are driven out of the market, there will be both fewer plans and less variation in plan bids. As a result of the shrinking variance in plan bid amounts, there could be fewer rebates available for enhanced benefits, little differentiation in benefits between the MA and FFS programs, and fewer options available to the beneficiaries.

Additional concern with competitive bidding is over the "blind" bidding process that creates unpredictable competitive-bid averages. This makes it difficult for MA plans to maintain consistent benefits from one year to the next and could create beneficiary disruptions.

In order to mitigate the concerns noted above, some alternative structures for a competitive bidding program should be considered. They include:

- Setting the benchmark in advance based on bid amounts from the previous year. This would retain the feature of the current system in which benchmarks are known prior to bid submission and plan benefits are designed based on the known "rebate," thus mitigating the potential for highly variable benefits from year to year.
- Allowing plans to bid on a standard benefit design that is slightly richer than the FFS level of benefits. In many high-cost areas, a slightly enhanced benefit package would still cost less than the FFS program and would provide incentives for members to stay in a MA plan that is less costly to the government.
- Allowing plans that bid below the local FFS cost to retain a portion of the difference between the FFS amount and the bid amount to fund enhanced benefits. This would provide the same incentives as the second option above, but would also create incentives for plans in low-cost areas to reduce their cost to below the FFS level.
- Phasing in competitive bidding over a period of time.
- Implementing a quality bonus program, enabling only higher-quality plans to receive add-on payments to fund enhanced benefits. For example, the CMS star-rating system could be used to determine those plans that qualify for add-on payments. Other options may include rewards for certain care management or disease management activities or for demonstrated improvement in plan quality from year to year.
- Creating a combination of the above approaches.

Other Considerations Under Payment Reform

With payment reform, either under competitive bidding or percent of FFS, there will be an adverse impact on low-income beneficiaries who are not eligible for the Medicaid program. They are more likely to enroll in MA plans.[5] Increases in member premiums and reductions in benefits in MA program would result in these low-income beneficiaries transferring out of the MA program and into the FFS program, which, with no cap on out-of-pocket expenses, may cause many low-income beneficiaries to forgo needed care. For beneficiaries who choose not to forgo the care but who may not be able to afford the out-of-pocket expense, physicians and hospitals would face an increase in "bad debt."

There are many variations of MA plans, including HMOs, local PPOs, regional PPOs, special needs plans (SNPs) and private fee-for-service (PFFS) plans. Since they have different cost structures, the changes as a result of reforms would have varying degree of impact on these plans. For example, the bids of HMO plans are, on average, below the FFS spending level, while PFFS plans bids are above the FFS spending level. Payment reforms that set the maximum reimbursements at a 100 percent FFS level would have the most impact on the

[5] *Value of Medicare Advantage to Low Income and Minority Medicare Beneficiaries,* September 2005, Adam Atherly, Ph.D. and Kenneth E. Thorpe, Ph.D. and Kaiser Family Foundation, *Examining Sources of Supplemental Insurance & Prescription Drug Coverage Among Medicare Beneficiaries,* August 2009

PFFS plans and the areas they serve.

Should MA plan payments be reduced, most MA plans would have to charge additional premium to offer enhanced benefits. MA plans would become more directly comparable to the combination of FFS and Medigap plans. However, there are inherent differences between MA plans and Medigap plans. Since MA plans are driven by CMS regulations and Medigap plans are driven by state requirements, the plan options and features are not directly comparable. This could be confusing to the beneficiaries and more beneficiary education may be needed. An example of the difference is that Medigap premiums vary by age groups in most states, whereas MA member premiums are the same for all members in the service area, regardless of age. Another example is that MA plans have an annual open-enrollment period, and beneficiaries can enroll without medical underwriting during that period, whereas Medigap plans are not required to have annual open-enrollment period and can medically underwrite non-newly eligible Medicare beneficiaries.

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