

December 2009

**MEDICARE  
MANAGED CARE**

**Observations about  
Medicare Cost Plans**



**GAO**

Accountability \* Integrity \* Reliability



Highlights of [GAO-10-185](#), a report to congressional committees

## Why GAO Did This Study

Medicare cost plans—managed care plans paid based on the reasonable costs of delivering Medicare-covered services—enroll a small number of beneficiaries compared to Medicare Advantage (MA), Medicare’s managed care program in which the plans accept financial risk if their costs exceed fixed payments received for each enrolled beneficiary. Despite the small enrollment, industry representatives stated that cost plans provide a managed care option in areas that traditionally had few or no MA plans. Current law allows existing cost plans to continue operating unless specific MA plans of sufficient enrollment serve the same area. In such cases, the cost plan must discontinue serving that area beginning in 2011. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) required GAO to examine issues related to the conversion of Medicare cost plans to MA plans. In response, GAO (1) determined the MA options available to beneficiaries in cost plans, (2) described key differences for beneficiaries between cost plans, MA plans, and Medicare fee-for-service (FFS); (3) determined the extent to which organizations offering cost plans also offer MA plans; and (4) described concerns cost plans have about converting to MA plans. GAO analyzed data from the Centers for Medicare & Medicaid Services (CMS), the agency that administers Medicare. GAO also reviewed requirements for Medicare managed care plans and interviewed officials from all Medicare cost plans and CMS.

[View GAO-10-185 or key components.](#)  
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# MEDICARE MANAGED CARE

## Observations about Medicare Cost Plans

### What GAO Found

All Medicare beneficiaries enrolled in the 22 cost plans had multiple MA options available to them. Nearly all beneficiaries enrolled in cost plans had at least 5 MA plans serving their county in June 2009, and more than 57 percent had a choice of 15 or more MA plans.

Some of the differences between cost plans and MA plans that affect beneficiaries are out-of-network coverage, enrollment periods, and prescription drug coverage. Cost plans’ quality scores, on average, were higher than the average of competing MA plans’ scores in the county with the cost plan’s highest enrollment. Estimated out-of-pocket costs varied between cost plans and other options depending on the self-reported health status of the beneficiary. In general, beneficiaries reporting poor health had lower estimated average out-of-pocket costs in most cost plans compared to competitor MA plans and FFS, while beneficiaries reporting good or excellent health had relatively higher estimated costs in most cost plans compared to MA plans and FFS.

Half of the 18 organizations offering cost plans also offered at least one MA plan in some or all of their cost plans’ service area. These 9 organizations operated a total of 12 cost plans. In general, organizations that offer cost plans and MA plans in the same service area must close their cost plan to enrollment.

Officials from organizations that offered cost plans cited potential future changes to MA payments and difficulty assuming financial risk as concerns about converting cost plans to MA plans. Unlike cost plans, MA plans assume financial risk if payments from CMS do not cover their costs. Officials from 13 of the 18 organizations offering cost plans identified past and the potential for future payment changes in the MA program as reasons the decision to convert was difficult, though 6 of these organizations offered an MA plan in some or all of their cost plan’s service area in 2009. Additionally, officials from 5 organizations said that their enrollment was insufficient to manage the financial risk plans would need to accept in the MA program. Officials from more than half of the organizations that offered cost plans also expressed concerns about the potential disruption to beneficiaries caused by transferring beneficiaries from cost plans to MA plans.

GAO provided a draft of this report to CMS. CMS provided GAO with technical comments, which were incorporated as appropriate.

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## Abbreviations

AEP	annual election period
BBA	Balanced Budget Act of 1997
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CCP	coordinated care plan
CMS	Centers for Medicare & Medicaid Services
FFS	fee-for-service
HEDIS	Health Effectiveness Data and Information Set
HMO	health maintenance organization
MA	Medicare Advantage
M+C	Medicare+Choice
MIPPA	Medicare Improvements for Patients and Providers Act of 2008
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003
MSA	metropolitan statistical area
NAIC	National Association of Insurance Commissioners
OEP	open enrollment period
PDP	prescription drug plan
PFFS	private fee-for-service
PPO	preferred provider organization
PSO	provider sponsored organization
RBC	risk-based capital
SEP	special enrollment period
TEFRA	Tax Equity and Fiscal Responsibility Act of 1982

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United States Government Accountability Office  
Washington, DC 20548

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December 28, 2009

The Honorable Max Baucus  
Chairman  
The Honorable Chuck Grassley  
Ranking Member  
Committee on Finance  
United States Senate

The Honorable Henry A. Waxman  
Chairman  
The Honorable Joe Barton  
Ranking Member  
Committee on Energy and Commerce  
House of Representatives

The Honorable Charles B. Rangel  
Chairman  
The Honorable Dave Camp  
Ranking Member  
Committee on Ways and Means  
House of Representatives

Medicare cost plans—managed care plans paid based on their reasonable costs incurred delivering Medicare-covered services—enroll a small number of Medicare beneficiaries compared with the number enrolled in Medicare Advantage (MA), Medicare’s managed care program that pays health plans on a risk basis.<sup>1</sup> Risk-based plans are paid a fixed monthly payment per beneficiary enrolled in the plan to furnish Medicare-covered services, and the health plans bear financial risk if their costs exceed Medicare payments.<sup>2</sup>

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<sup>1</sup>We use the term Medicare cost plans to refer to Section 1876 Medicare cost contracts. Section 1876 refers to the section of the Social Security Act that authorizes the operation of cost plans.

<sup>2</sup>Medicare Parts A and B are known as original Medicare or Medicare fee-for-service (FFS). Medicare Part A covers hospital and other inpatient stays. Medicare Part B is optional insurance, and covers hospital outpatient, physician, and other services. MA plans must cover services covered under Parts A and B, except for hospice care.

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As of June 2009, 22 Medicare cost plans enrolled approximately 288,000 Medicare beneficiaries, compared to 633 MA plans that served approximately 10.7 million Medicare beneficiaries. Despite their relatively small enrollment, industry representatives stated that cost plans fill a unique niche by providing a Medicare managed care option in rural and other areas that traditionally had few or no MA plans. Congress acted to curtail the expansion of cost plans multiple times. In 1997 Congress passed legislation prohibiting new cost plans from entering the Medicare market and prohibiting existing cost plans from being renewed or extended beyond 2002. Subsequent legislation extended the authorization of existing cost plans and, most recently, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) allowed existing Medicare cost plans to continue to operate except where MA plans of sufficient enrollment served a cost plan's service area for the previous year.<sup>3</sup> In such cases, the cost plan must discontinue serving that area beginning January 1, 2011.

MIPPA also required GAO to report, by December 31, 2009, on issues related to the conversion of Medicare cost plans to MA plans. To respond to the mandate, we (1) determined the MA options available to beneficiaries enrolled in Medicare cost plans; (2) described the key differences for beneficiaries between cost plans, MA plans, and Medicare fee-for-service (FFS); (3) determined the extent to which organizations offering cost plans also offer MA plans; and (4) described concerns cost plans have about converting to MA plans.

To determine the MA options available to beneficiaries enrolled in Medicare cost plans, we analyzed June 2009 MA and cost plan service area and enrollment data at the contract level from the Centers for Medicare & Medicaid Services (CMS), the agency that administers the Medicare program.<sup>4</sup>

To describe the key differences for beneficiaries between cost plans, MA plans, and Medicare FFS, we reviewed CMS requirements for Medicare cost plans, MA plans, and Medicare FFS. We examined quality data for

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<sup>3</sup>A cost plan's service area generally comprises one or more counties.

<sup>4</sup>Agreements between CMS and an organization to provide one or more benefit packages of the same type in a specified geographic region are referred to as contracts. Benefit packages can have different monthly premiums or beneficiary cost-sharing requirements. For this report, we use the term plan to refer to the agreement at the contract level. Organizations may have more than one contract with CMS.

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cost plans and MA plans.<sup>5</sup> We limited our quality analysis to the county in each cost plan’s service area with the highest cost plan enrollment because the MA competitor plans for a cost plan may differ depending on the county within the service area. If a cost plan was missing a quality score, we did not report a comparison.<sup>6</sup> We also analyzed CMS data that estimate total monthly out-of-pocket costs for beneficiaries in different managed care benefit packages and Medicare FFS. CMS reports the estimated out-of-pocket costs according to self-reported health status within a range of age groups, for example, among 80 to 84 year olds reporting good health.<sup>7</sup> For our analysis, we compared enrollment-weighted averages of estimated out-of-pocket costs for each cost plan benefit package to enrollment-weighted estimates for MA benefit packages in the same service area. We separated the analysis according to whether the benefit package included Part D, Medicare’s prescription drug benefit.<sup>8</sup> Similarly, because the FFS-only estimate does not include Part D coverage, we compared the estimated out-of-pocket costs for beneficiaries enrolled in non-Part D cost plan benefit packages to the out-of-pocket costs for beneficiaries in Medicare FFS. We presented the results for beneficiaries

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<sup>5</sup>CMS quality scores are based on information from the Health Effectiveness Data and Information Set (HEDIS), a tool developed and maintained by the National Committee for Quality Assurance that is used by health plans to measure performance on dimensions of care; the Consumer Assessment of Healthcare Providers and Systems (CAHPS), a group of surveys that asks consumers and patients to report on and evaluate their experiences with healthcare; and appeals data. CMS reports the data using a rating system, where 1 is the lowest possible score and 5 is the highest possible score. We present information on the five quality dimensions that CMS reports and the plan summary score. CMS calculates the dimension scores by averaging individual quality measures in a given topic area. For example, the quality dimension for “Managing Chronic Conditions” uses individual measures of osteoporosis management, diabetes care, and rheumatoid arthritis management. CMS then calculates the plan summary score by averaging the individual quality measures and the dimension scores, as well as applying an integration factor that rewards plans for consistent high scores.

<sup>6</sup>CMS reports quality scores for managed care plans that have been operational for a full year and meet minimum enrollment criteria.

<sup>7</sup>The estimates of out-of-pocket costs are based on the reported utilization patterns of Medicare FFS beneficiaries who participated in the Medicare Current Beneficiary Survey, which is a CMS-sponsored, continuing survey of a nationally representative sample of aged, disabled, and institutionalized Medicare beneficiaries. These utilization patterns are combined with price data and benefit package information to estimate beneficiary out-of-pocket costs for beneficiaries in six age ranges (under 65, 65-69, 70-74, 75-79, 80-84, and 85 and above) and five self-reported health statuses (excellent, very good, good, fair, and poor).

<sup>8</sup>We excluded from the cost-sharing analysis 8 of 22 cost plans because they did not have estimated out-of-pocket cost data.



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that reported themselves as 80 to 84 years old and in poor, good, and excellent health; we used results for this age group because officials from the industry and CMS told us that beneficiaries in cost plans are generally older than the average MA beneficiary.

To determine the extent to which organizations that offer cost plans also offer MA plans, we analyzed CMS service area and enrollment data to identify organizations offering both. We interviewed officials from each organization that offers a cost plan to verify the CMS data. We then compared the service areas of the MA plans with those of the cost plans offered by the same organizations.

To describe the concerns that cost plans have about converting to MA plans, we interviewed officials from each organization that offers a cost plan, the CMS office responsible for oversight of Medicare's managed care programs, the Medicare Cost Contractors Alliance, which is an alliance of cost plans that advocates for cost plans in Congress and with CMS, and the National Association of Insurance Commissioners (NAIC), which is the organization of state insurance regulators.

To determine the reliability of the data, we reviewed documentation for all the data sets we used. We conducted tests to look for obvious errors in the data and compared results to other published sources for CMS data on cost plan and MA plan service areas and enrollment. We interviewed CMS officials regarding the reliability of the out-of-pocket cost data and the quality ratings data. We determined that all data were sufficiently reliable for our purposes.

We conducted our work from February 2009 to November 2009 in accordance with all sections of GAO's Quality Assurance Framework that are relevant to our objectives. The framework requires that we plan and perform the engagement to obtain sufficient and appropriate evidence to meet our stated objectives and to discuss any limitations in our work. We believe that the information and data obtained, and the analysis conducted, provide a reasonable basis for any findings and conclusions in this product.

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## Background

Medicare began contracting with managed care plans on a cost-reimbursement basis in the 1970s. In 1982, Congress passed the Tax Equity and Fiscal Responsibility Act (TEFRA), which created the first Medicare risk contracting program for managed care plans beginning in 1985. The Medicare risk program evolved into today's MA program. TEFRA also

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retained and authorized Medicare cost plans as an option if an organization did not have the capacity to bear the risk of potential losses, had an insufficient number of members to be eligible for a risk-sharing contract, or the organization elected to offer a cost plan rather than a risk plan.

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## Evolution of Medicare Advantage

Enrollment in the Medicare risk program grew from nearly 498,000 in 1985 to about 5.2 million beneficiaries by 1997, primarily concentrated in urban counties. The Balanced Budget Act of 1997 (BBA) phased out the existing risk program and created a new risk program called Medicare+Choice (M+C). Under the M+C program, the method used to pay participating plans was revised significantly, and, due in part to these payment changes, by 2000 many health plans began to withdraw from the program. Enrollment fell from 6.3 million in 1999 to 4.6 million by 2003. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) renamed the M+C program Medicare Advantage and provided increases to MA plan payment rates and other program changes. MA enrollment increased steadily from 2003 to 2009.

The MA program includes several types of plans:

- Local coordinated care plans (CCP) consist of:
  - Health maintenance organizations (HMO), which have defined provider networks and primary care gatekeepers. Beneficiaries enrolled in HMOs generally are required to obtain services from hospitals and doctors in the plan's network, but some HMOs offer a point-of-service option under which a beneficiary may elect to obtain services from a non-network provider, though at a higher out-of-pocket cost.
  - Preferred provider organizations (PPO), which have defined provider networks and no requirement that beneficiaries obtain referrals for care. Beneficiaries enrolled in PPOs can use non-network providers, but at a higher out-of-pocket cost than in-network providers.
  - Provider sponsored organizations (PSO), which doctors, hospitals, or other Medicare providers operate rather than a health insurance company. The providers that operate the PSO furnish the majority of the health care and share in the financial risk of providing the health care to the beneficiaries enrolled in the plan.

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- Regional PPOs, which have a service area comprising 1 or more of 26 state-level or multistate-level CMS-defined regions. Regional PPOs are also CCPs.
  - Special needs plans exclusively or disproportionately enroll special needs individuals. Special needs individuals are beneficiaries who are institutionalized, eligible for both Medicare and Medicaid, or have a disability or chronic condition.<sup>9</sup> Special needs plans can be any type of CCP.
  - Private fee-for-service (PFFS) plans, which are local plans that are not required to have a contracted provider network as long as they pay willing providers at least the Medicare FFS rate.<sup>10</sup>

MA benefit packages may include Medicare Part D coverage; however, all CCPs must offer at least one benefit package with Part D coverage.

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<sup>9</sup>Medicaid is a joint federal-state program that finances health care for certain categories of low-income individuals, including children, families, persons with disabilities, and persons who are elderly.

<sup>10</sup>Beginning in 2011, PFFS plans will be required to form contracted networks of providers in areas that have at least two available network-based plans (such as an HMO or PPO). In areas with fewer than two network-based plans, PFFS plans not sponsored by employers or union groups will continue to have the option of operating without networks if they pay providers at Medicare FFS rates or higher. A network-based plan is defined as (1) an MA plan that is a CCP, (2) a cost plan, or (3) a network-based Medical Savings Account plan. Beneficiaries in a Medical Savings Account plan receive annual deposits from CMS into an interest-bearing account to help them cover their health care costs until they have reached their plan's deductible, after which the plan is responsible for all Medicare-covered costs. A network-based plan does not include regional PPOs that do not meet provider access standards through written contracts.

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## Medicare Cost Plans

CMS pays cost plans the reasonable cost of the Medicare-covered services they furnish directly to, or arrange for, Medicare beneficiaries enrolled in their plan, less the value of the deductible and coinsurance.<sup>11</sup> In addition to the costs directly related to the provision of health services, CMS also pays reasonable costs associated with operating a health plan, such as marketing, enrollment, and membership expenses. Cost plans receive an advance interim payment per member per month based on the cost plan's estimated reimbursable costs. CMS and the cost plans make adjustments after the contract period to align the payments with the actual costs incurred following the plan's submission of an independently certified cost report that details cost, utilization, and enrollment data for the entire contract period.

As of December 2009, 18 organizations operated 22 cost plans, with enrollments ranging from 50 to 74,190. Of the 22 cost plans, 15 were open to enrollment. Nonprofit organizations operated 17 of the 22 cost plans. (See app. I for a list of the organizations that offer cost plans.) Eight cost plans offered Part D coverage in 2009.<sup>12</sup> Cost plans served at least one county in 16 states and the District of Columbia in 2009.<sup>13</sup> Cost plans were most prevalent in Minnesota, where 3 cost plans operated across most of the state.<sup>14</sup> (See fig. 1.)

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<sup>11</sup>The cost plan may charge Medicare enrollees for these costs in the form of premiums, copayments, or similar charges.

<sup>12</sup>Cost plans may, but are not required to, offer Part D coverage.

<sup>13</sup>Throughout the rest of this report, we will use the term states as inclusive of the District of Columbia.

<sup>14</sup>Minnesota cost plan enrollment in June 2009 accounted for about 36 percent of cost plan enrollment nationwide.

**Figure 1: Counties Served by Medicare Cost Plans, 2009**



Source: GAO analysis of CMS data.

Congress acted to curtail the expansion of cost plans multiple times. The BBA provided that upon enactment, with few exceptions, the Secretary of Health and Human Services could not enter into any new cost plan contracts and could not extend or renew a cost plan contract beyond

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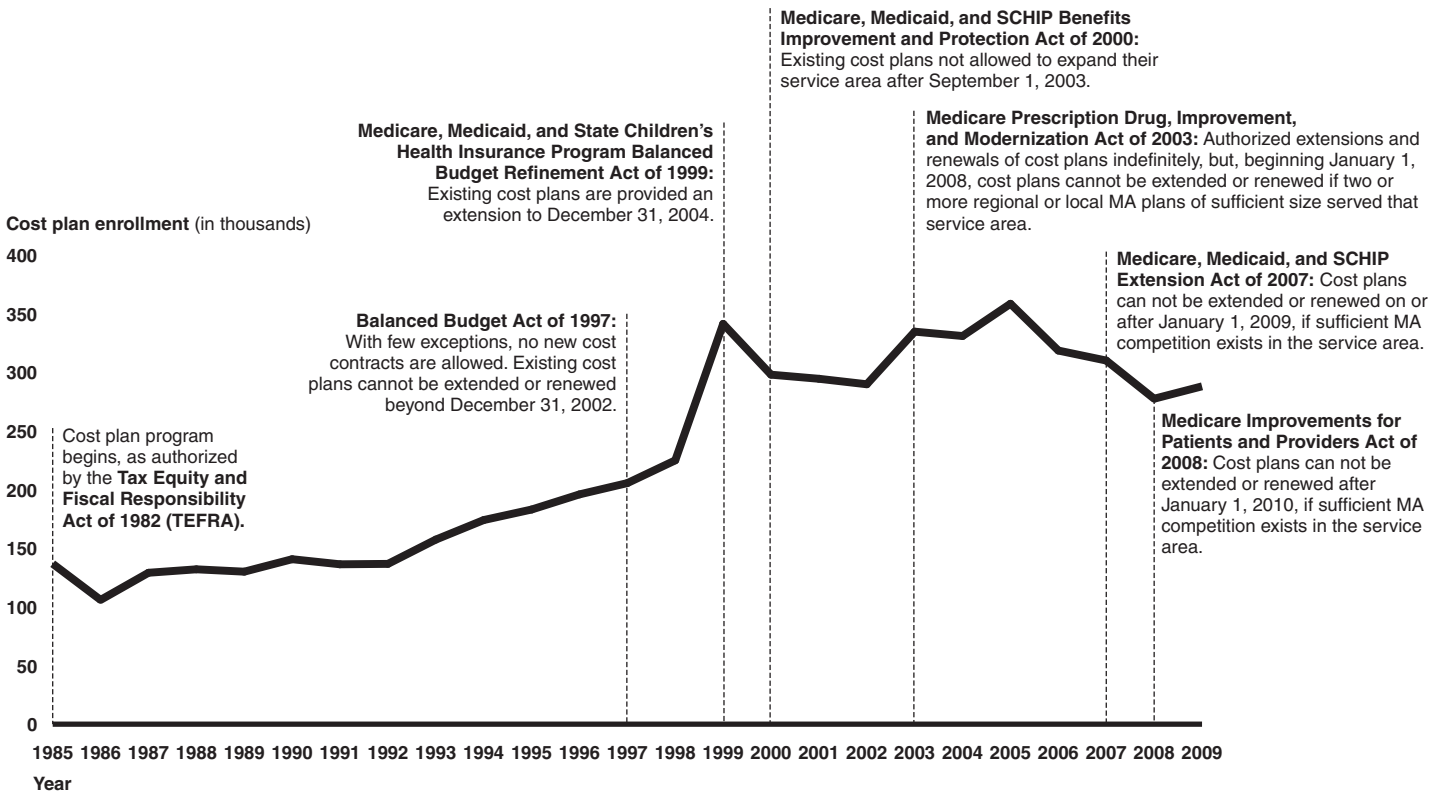
December 31, 2002.<sup>15</sup> Subsequent laws modified the circumstances under which existing cost plans could continue to operate. The MMA, for example, allowed existing cost plans to be extended indefinitely, with the exception that, beginning January 1, 2008, the Secretary could no longer renew or extend contracts for cost plans serving an area that for the previous year was also served by two or more regional CCPs or two or more local CCPs and that also met specified enrollment thresholds.<sup>16</sup> A cost plan would only be required to leave the counties within its service area that were also served by the CCPs. Most recently, MIPPA extended the exception provision to January 1, 2010, meaning cost plans affected by this provision would close at the beginning of calendar year 2011. MIPPA also requires that the qualifying CCPs used to determine whether the cost plan must close must be offered by more than one organization (see fig. 2). Separately, CMS requires organizations operating cost plans to close their cost plans to new enrollment if they open an MA plan in the same service area.

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<sup>15</sup>Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4002(b), 111 Stat. 251, 328-329. Section 1833 health care prepayment plans, which are employer- or union-sponsored Medicare managed care plans that provide or arrange for some or all Medicare Part B benefits on a prepayment basis, were allowed to convert to a Medicare cost plan.

<sup>16</sup>To be considered a CCP with sufficient enrollment, the CCP must, with respect to any portion of the area involved that is within a MSA with a population of more than 250,000 and counties contiguous to such MSA, enroll at least 5,000 individuals. MIPPA further provides that if the service area includes a portion in more than one MSA with a population of more than 250,000, the minimum enrollment determination shall be made with respect to each MSA. With respect to any other portion of such service area, the CCP must enroll at least 1,500 individuals. PFFS plans are not CCPs.

**Figure 2: Time Line of Legislation Related to Medicare Cost Plans**



Source: GAO analysis.

Note: TEFRA authorized Section 1876 cost plans, which we refer to as cost plans. Medicare began contracting with health plans on a cost-reimbursement basis in the 1970s.

Based on 2009 enrollment information through December, CMS’s preliminary estimates were that 7 of the 22 cost plans would need to withdraw from some or all of their 2009 service area in 2011.<sup>17</sup> Three of the 7 cost plans would need to withdraw from their entire service area. All 3 of these plans already were closed to new enrollment in 2009. In total, CMS estimated that approximately 8,000 beneficiaries enrolled in cost plans, or about 3 percent of total cost plan enrollment, are in counties where their

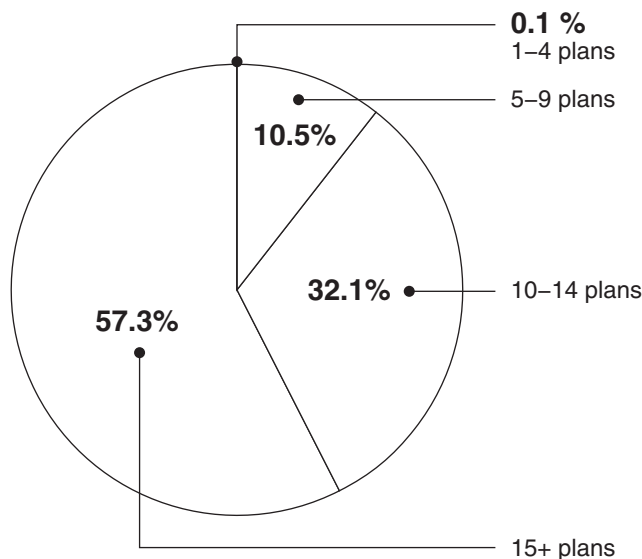
<sup>17</sup>CMS excluded special needs plans and employer group health plans that are not open to enrollment by non-employer group members from the CCPs considered to be available MA plans for the purposes of its analysis. CMS analyzed MA competitor enrollment at the benefit package level to determine which cost plans would need to discontinue serving portions of their service area in 2011.

cost plan must discontinue service in 2011. (See app. II for a list of the cost plans that would likely be affected by the MIPPA provision.)

## Beneficiaries in Cost Plans Had Multiple MA Options

All beneficiaries enrolled in cost plans had multiple MA options available to them. Nearly 100 percent of beneficiaries enrolled in cost plans had at least 5 MA plans serving their county in June 2009, and more than 57 percent had a choice of 15 or more MA plans (see fig. 3). About 10 percent of beneficiaries enrolled in cost plans had no local CCPs in their county, which is the MA plan type with the highest enrollment. Two cost plans, located in Colorado and Texas, enrolled about 90 percent of the beneficiaries without a local CCP plan option.

**Figure 3: Number of MA Plans Available to Beneficiaries Enrolled in Cost Plans, as of June 2009**



Source: GAO analysis of CMS data.

Note: We conducted this analysis at the contract level. Within each contract, an organization may offer one or more benefit packages. The number of options would be greater if we conducted the analysis at the benefit package level.

About 10 percent of beneficiaries in cost plans were in counties without an HMO, about 62 percent were in counties without a local PPO, and about 8 percent were in counties without a regional PPO. Approximately 42 percent of beneficiaries enrolled in a cost plan were in counties with five or more MA HMOs. All beneficiaries enrolled in a cost plan could enroll in a PFFS plan in June 2009. (See table 1.)



**Table 1: Percentage of Beneficiaries Enrolled in Cost Plans Who Have Access to Medicare Advantage (MA) Plans, by MA Plan Type, June 2009**

Number of MA options within plan type	Percentage of beneficiaries enrolled in cost plans				
	HMOs available	PPOs available	PSOs available	Regional PPOs available	PFFS plans available
0	10.2	62.3	100.0	7.9	0.0
1-4	47.5	31.3	0.0	92.2	4.4
5-9	17.5	6.4	0.0	0.0	87.9
10-14	24.1	0.0	0.0	0.0	7.7
15+	0.7	0.0	0.0	0.0	0.0
<b>Total</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>

Source: GAO analysis of CMS data.

Note: Some percentages may not add to 100 because of rounding. We conducted this analysis at the contract level. Within each contract, an organization may offer one or more benefit packages. The number of options would be greater if we conducted the analysis at the benefit package level.

## Cost Plan Quality Scores Higher Than MA Plans While Estimated Out-of-Pocket Costs Vary by Health Status

Some of the differences between cost plans and MA plans that affect beneficiaries involve out-of-network coverage, enrollment periods, and prescription drug coverage. Cost plans generally scored higher than competing MA plans on the quality scores CMS reports, and their estimated out-of-pocket costs compared to competing MA plans and FFS varied by health status.

## Cost Plan Structure Differs from MA Plans and Medicare FFS

Cost plans differ structurally from MA plans and Medicare FFS in several ways, including enrollment periods, out-of-network coverage, and prescription drug coverage. For example, cost plans that are open to enrollment must have an open enrollment period of at least 30 consecutive days annually, and some cost plans choose to allow new enrollment all year. Beneficiaries enrolled in cost plans may disenroll at any time. In contrast, beneficiaries enrolled in an MA plan can join, switch, or drop plans, or join FFS, only during certain specified enrollment periods.

Beneficiaries enrolled in cost plans who receive Medicare-covered services out of network are covered by Medicare FFS. These services are therefore subject to Medicare FFS coinsurance and deductibles. Out-of-network coverage varies among MA plans according to plan type, but if offered, it is covered by the MA plan, not Medicare FFS. Medicare FFS

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beneficiaries can receive services from any provider that accepts Medicare.

Beneficiaries enrolled in cost plans may obtain Medicare prescription drug coverage by enrolling in any stand-alone Part D plan or a Part D plan offered by the cost plan sponsor. Beneficiaries enrolled in MA plans must choose a Part D plan offered by the MA plan sponsor. Beneficiaries enrolled in PFFS plans also must choose a Part D plan offered by the PFFS sponsor, unless the sponsor does not offer one, in which case beneficiaries can choose any Part D Plan. Beneficiaries enrolled in FFS may choose any Part D plan. For additional information about structural differences between cost plans, MA plans, and Medicare FFS, see appendix III.

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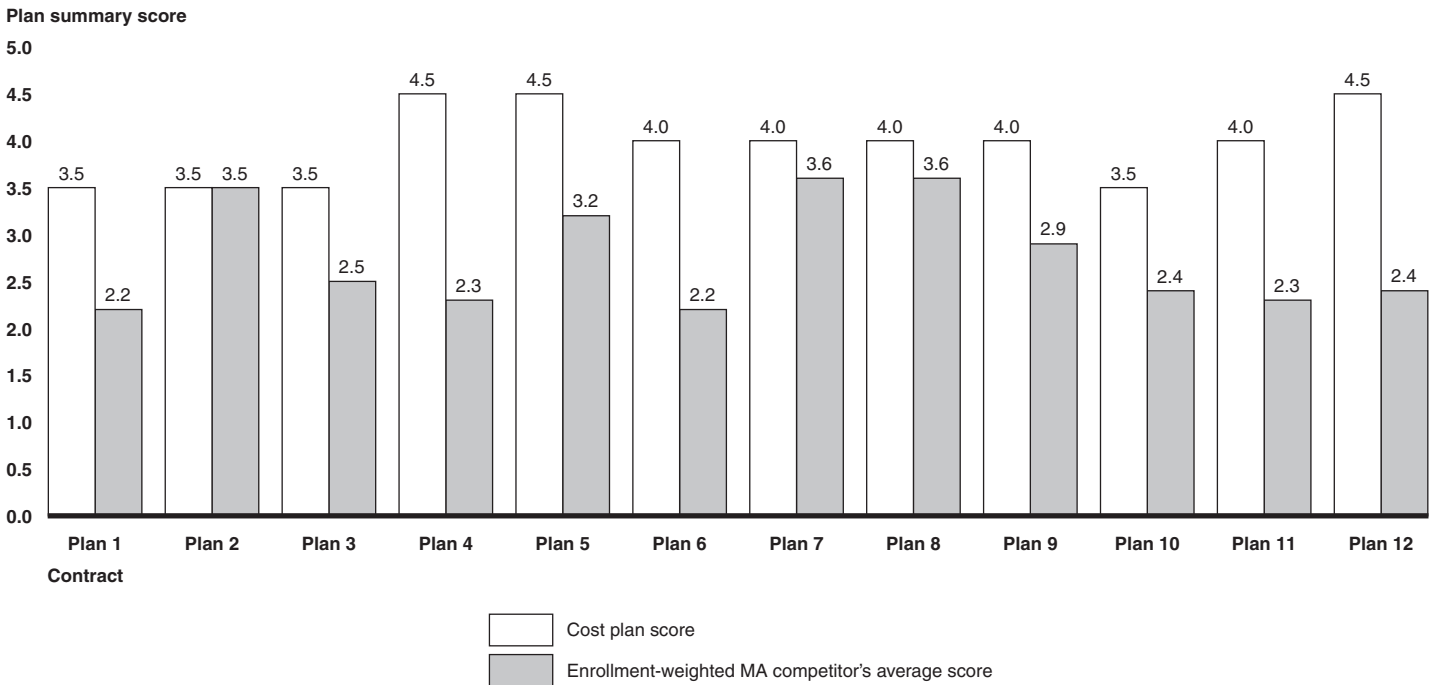
### Cost Plan Quality Scores Generally Higher Than Competitor MA Plans

Our analysis of CMS quality scores found that cost plans' quality scores, on average, were higher than the average of competing MA plans. All 12 of the cost plans with plan summary scores, based on a scale of 1 (poor quality) to 5 (excellent quality), were rated higher than or the same as their MA competitors in the county with the cost plan's highest enrollment.<sup>18</sup> These 12 cost plans enrolled about 202,500 beneficiaries, or about 70 percent of the total cost plan enrollment nationwide. (See fig. 4.)

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<sup>18</sup>CMS only reports data for managed care plans that have operated for a full year and meet minimum enrollment criteria. Therefore, not all cost plans and competitor plans have a plan summary score. We did not report comparisons for cost plans without a plan summary score, and we excluded competitor plans without plan summary scores from our analysis.

**Figure 4: 2007 Plan Summary Scores for Cost Plans Compared with Those for MA Competitors**

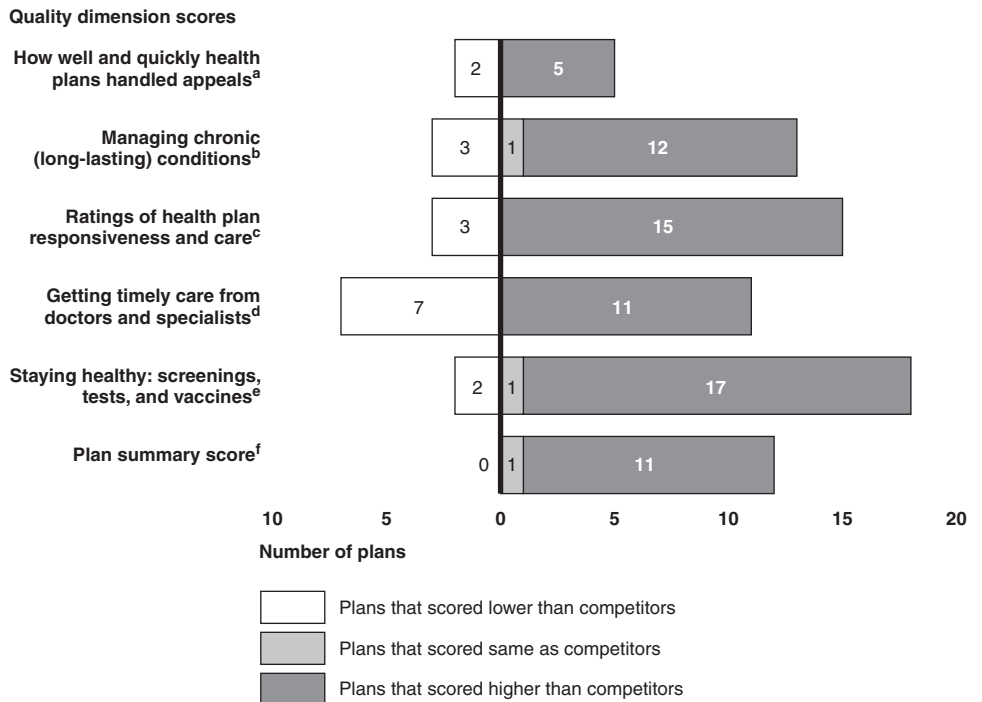


Source: GAO analysis of CMS data.

Note: Cost plan and competitor scores are based on the counties with the cost plan's highest enrollment. CMS computes these scores at the contract level based on reported information from the Health Effectiveness Data and Information Set (HEDIS), a tool that is used by health plans to measure performance on dimensions of care; the Consumer Assessment of Healthcare Providers and Systems (CAHPS), which is a group of surveys that asks consumers and patients to report on and evaluate their experiences with healthcare; and appeals data. Ratings for competitors are an enrollment-weighted average. CMS only reports data for managed care plans that have been operational for a full year and meet minimum enrollment criteria. Therefore, not all cost plans and competitor plans have a plan summary score. Plans without plan summary scores were excluded from the analysis. Data for 2007 were the most recent available.

The majority of cost plans had higher scores than their MA competitors in each of the five quality dimensions that make up the plan summary score. For example, 15 of the 18 cost plans with a score for the dimension "Ratings of Health Plans Responsiveness and Care," which includes ratings of beneficiary satisfaction with the plan, were rated higher than their MA competitors. Similarly, 17 of the 20 cost plans with a score for the dimension "Staying Healthy," which includes how often beneficiaries got various screening tests, vaccines, and other check-ups, were rated higher than their competitors. The majority of cost plans also rated higher than their competitors in the other three quality dimensions reported by CMS. (See fig. 5.)

**Figure 5: Number of Cost Plans with Quality Scores Higher, the Same, or Lower than Competitors**



Source: GAO analysis of CMS data.

Note: Cost plan and competitor scores are based on the counties with the cost plan’s highest enrollment. CMS computes these scores at the contract level based on reported information from the Health Effectiveness Data and Information Set (HEDIS), a tool that is used by health plans to measure performance on dimensions of care; the Consumer Assessment of Healthcare Providers and Systems (CAHPS), which is a group of surveys that asks consumers and patients to report on and evaluate their experiences with healthcare; and appeals data. Scores for competitors are an enrollment-weighted average. CMS only reports data for managed care plans that have been operational for a full year and meet minimum enrollment criteria or, in cases where an individual quality score reports on a subpopulation, a minimum number of beneficiaries within that subpopulation. Consequently, not all plans had scores for each quality dimension or plan summary scores. If the score for the cost plan was missing, we did not report a comparison.

<sup>a</sup>CMS calculates the score for this dimension by using individual measures regarding the plan’s ability to make timely decisions about appeals and their review of appeals decisions.

<sup>b</sup>CMS calculates the score for this dimension by using individual measures that include rates of osteoporosis management, diabetes care, and rheumatoid arthritis management.

<sup>c</sup>CMS calculates the score for this dimension by using individual measures that include beneficiary reports of their ability to get appointments and care quickly, overall health care quality, and doctors’ communication.

<sup>d</sup>CMS calculates the score for this dimension by using individual measures that include follow-up visit rates following hospital stays for mental illness, doctor follow up for depression, and beneficiary reports of their ability to get needed care without delays.

<sup>e</sup>CMS calculates the score for this dimension by using individual measures that include breast and colorectal cancer screening rates, diabetes care, osteoporosis testing, and administration of the annual flu vaccine.

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CMS calculates the plan summary score by averaging the individual measures and the five quality dimensions, as well as applying an integration factor that rewards plans for consistently high scores.

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### Cost Plans' Estimated Average Out-of-Pocket Costs Generally Lower for Beneficiaries Reporting Poor Health, Higher for Beneficiaries Reporting Good and Excellent Health

In 2009, estimated average out-of-pocket costs in cost plans, MA plans, and Medicare FFS varied by the health status of beneficiaries. In general, beneficiaries 80 to 84 years old reporting poor health had lower estimated average out-of-pocket costs in cost plans compared to competitor MA plans and Medicare FFS, while beneficiaries in the same age group in cost plans reporting good or excellent health had higher estimated average out-of-pocket costs.<sup>19</sup> Specifically, we found estimated out-of-pocket costs for beneficiaries reporting poor health in 11 of the 12 cost plans without drug coverage to be lower than other MA options, on average, ranging from 69 to 99 percent of the competitor MA plans.<sup>20</sup> Similarly, beneficiaries reporting poor health in all of the cost plans without drug coverage had out-of-pocket costs that ranged from 67 to 92 percent of Medicare FFS. We also found out-of-pocket costs to be lower by similar amounts for beneficiaries in poor health in 4 of the 8 cost plans with drug coverage compared to other MA plans with drug coverage.<sup>21</sup> (See fig. 6.)

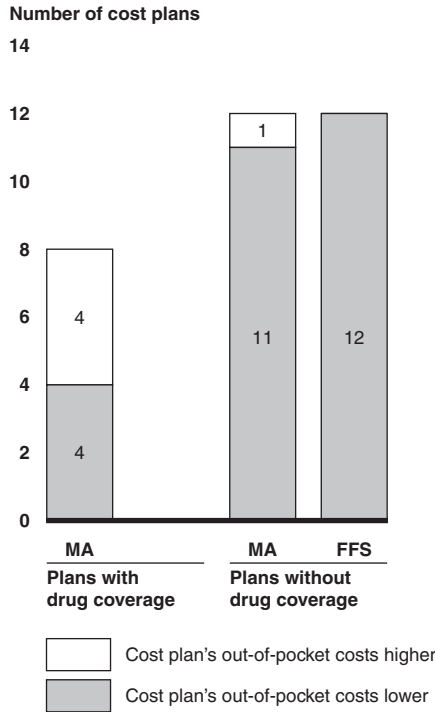
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<sup>19</sup>The estimates of out-of-pocket costs are based on the reported utilization patterns of Medicare FFS beneficiaries who participated in the Medicare Current Beneficiary Survey. These utilization patterns are combined with price data and benefit package information to estimate beneficiary out-of-pocket costs in different age groups and self-reported health categories. We compared data for the 80-84 age group because industry representatives and CMS officials told us that beneficiaries enrolled in cost plans tend to be older than the average MA beneficiary. We excluded special needs plans from this analysis because their benefit packages may be tailored to the specific special needs population that each plan serves and may not be an appropriate alternative to beneficiaries in cost plans.

<sup>20</sup>Eight cost plans did not submit plan benefit package information through CMS's plan benefit package submission module and are therefore not included in this analysis. Of the remaining 14 plans, as of May 2009, 6 had enrollment only in benefit packages without Part D, 2 had enrollment only in benefit packages with Part D, and 6 had enrollment in benefit packages both with and without Part D.

<sup>21</sup>As of June 2009, 65 percent of beneficiaries in cost plans had Part D coverage through their cost plan.

**Figure 6: Number of Cost Plans with Higher or Lower Estimated Out-of-Pocket Costs for 80- to 84-Year-Old Beneficiaries Reporting Poor Health, Compared with Competing MA Plans and Medicare FFS, 2009**



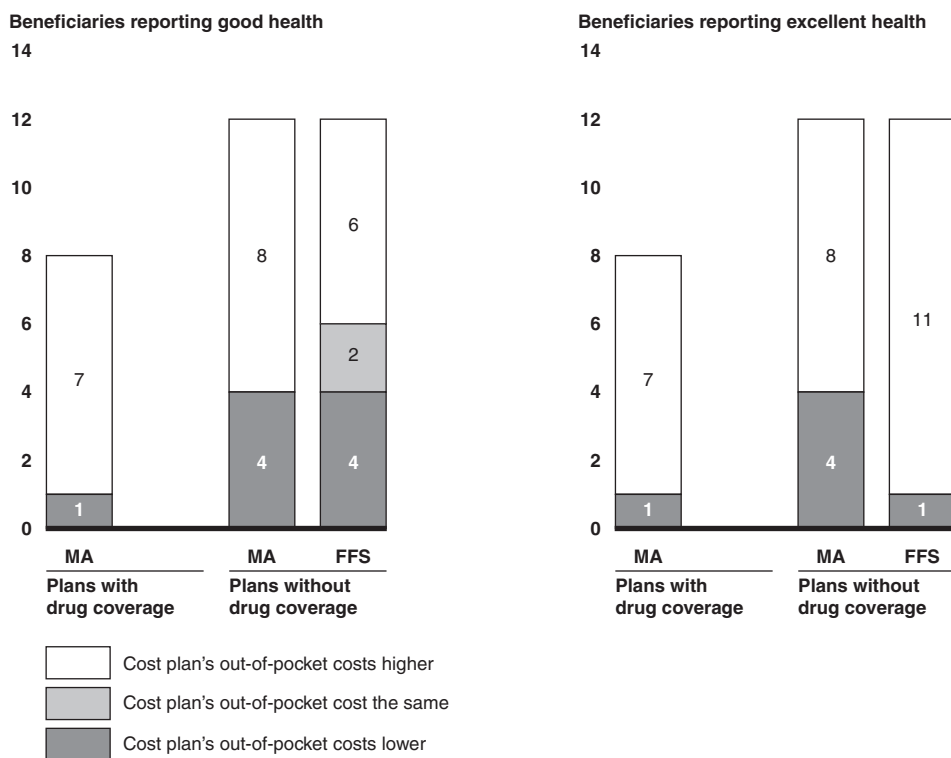
Source: GAO analysis of CMS data.

Note: We compared the estimates for cost plan benefit packages without Part D coverage to competitor MA benefit packages without Part D coverage and to Medicare FFS for beneficiaries 80 to 84 years old reporting poor health. Out-of-pocket cost data are available for six different age groups. We chose the 80 to 84 age group because industry representatives and CMS officials told us that beneficiaries enrolled in cost plans tend to be older than the average MA beneficiary. We did not compare the estimates for cost plan benefit packages with Part D to FFS because the FFS estimate assumes no drug coverage. We weighted estimates for both cost plans and MA plans according to their enrollment throughout the cost plan's service area. Eight cost plans did not submit plan benefit package information through CMS's plan benefit package submission module and are therefore not included in this analysis. Of the remaining 14 plans, as of May 2009, 6 had enrollment only in benefit packages without Part D, 2 had enrollment only in benefit packages with Part D, and 6 had enrollment in benefit packages both with and without Part D.

For 80- to 84-year-old beneficiaries reporting good and excellent health in 8 of the 12 cost plans without drug coverage, we found estimated out-of-pocket costs, on average, that were 5 to 37 percent higher than in competing MA plans without drug coverage. Beneficiaries in the same age category reporting good health in 6 of the 12 cost plans without drug coverage had, on average, higher out-of-pocket costs than FFS, and beneficiaries reporting excellent health in 11 of the 12 cost plans had higher estimated out-of-pocket costs than FFS. Similarly, for beneficiaries

reporting good and excellent health in 7 of the 8 cost plans with drug coverage, the estimated out-of-pocket costs were 6 to 36 percent higher than competitor MA plans with drug coverage.

**Figure 7: Number of Cost Plans with Higher or Lower Estimated Out-of-Pocket Costs for 80- to 84-Year-Old Beneficiaries Reporting Good and Excellent Health, Compared with Competing MA Plans and Medicare FFS, 2009**



Source: GAO analysis of CMS data.

Note: We compared the estimates for cost plan benefit packages without Part D Coverage to competitor MA benefit packages without Part D coverage and to Medicare FFS for beneficiaries 80 to 84 years old reporting good and excellent health. Out-of-pocket cost data are available for six different age groups. We chose the 80 to 84 age group because industry representatives and CMS officials told us that beneficiaries enrolled in cost plans tend to be older than the average MA beneficiary. We did not compare the estimates for cost plan benefit packages with Part D to FFS because the FFS estimate assumes no drug coverage. We weighted estimates for both cost plans and MA plans according to their enrollment throughout the cost plan's service area. Eight cost plans did not submit plan benefit package information through CMS's plan benefit package submission module and are therefore not included in this analysis. Of the remaining 14 plans, as of May 2009, 6 had enrollment only in benefit packages without Part D, 2 had enrollment only in benefit packages with Part D, and 6 had enrollment in benefit packages both with and without Part D.

## Half of Organizations Offering Cost Plans Also Offered MA Plans

In June 2009, 9 of the 18 organizations offering cost plans also offered MA plans in some or all of their cost plans' service area, which demonstrates that these organizations were capable of bearing financial risk. (See table 2.) These 9 organizations operated a total of 12 cost plans. The combined enrollment in these 12 cost plans in June 2009 was 124,467, or 43 percent of all beneficiaries in cost plans. Seven of the 12 cost plans enrolled fewer than 2,000 beneficiaries, and 2 of the plans enrolled more than 30,000 beneficiaries. Of the 9 organizations that offered both cost plans and MA plans, 1 organization's only MA plan was a special needs plan. Special needs plans exclusively or disproportionately enroll special needs individuals, so these plans may not be an appropriate option for the beneficiaries enrolled in this organization's cost plan.

**Table 2: Organizations That Offered Cost Plans and MA Plans, June 2009**

Organization offered a cost plan and also offered	Number of organizations	Percentage of organizations with cost plan	Percentage of total beneficiaries enrolled in cost plans
No MA plan	9	50	57
1 or more MA plan(s)	9	50	43
<b>Total</b>	<b>18</b>	<b>100</b>	<b>100</b>

Source: GAO analysis of CMS data.

Note: For this analysis, we counted all the MA plans (local HMOs, local PPOs, local PSOs, regional PPOs, PFFS plans, and MA special needs plans) under each organization. In some situations we also counted the MA plans under each parent organization. This determination of whether to count MA plans offered by the parent organization was based on the information provided by cost plan representatives we interviewed and verified by CMS reports and the organizations' Web sites.

All eight organizations offering both cost plans and MA plans that were not special needs plans operated at least one MA plan in some or all of their cost plan's service area. Seven operated at least one MA plan in their cost plan's entire service area and one operated at least one MA plan in part of their cost plan's service area. CMS requires that organizations that offer an MA plan in the same service area as their cost plan close the cost plan to new enrollment. However, officials from CMS stated that there are some exceptions to this requirement. For instance, some organizations were able to keep their cost plan open to enrollment because the units of the organization that contracted with CMS were two distinct entities. The officials stated that they may inspect these organizations to ensure that they do not share beneficiary information across companies and do not route certain beneficiaries into different plans to maximize their profits.



The Medicare managed care enrollment composition for the eight organizations that operated both a cost plan and an MA plan that were not special needs plans varied.<sup>22</sup> All eight of these organizations had a total enrollment, including both their cost plan enrollment and MA enrollment, of at least 3,000 beneficiaries. Four of the eight organizations enrolled more than 95 percent of their total Medicare managed care enrollment in their MA plans. Another organization's Medicare managed care enrollment was fairly evenly split between its MA plan and cost plan. The remaining three organizations had more than 75 percent of their Medicare managed care enrollment in their cost plan. Six of the 11 MA plans offered by organizations that offered both cost plans and MA plans were local HMOs (see table 3).

**Table 3: Types of MA Plans Offered by Organizations That Offer Cost Plans and MA Plans, June 2009**

Type of MA plan	Number of organizations offering each plan type
Local HMOs	6
Local PSO	1
Local PPOs	1
PFFS plans	2
Regional PPOs	1

Source: GAO analysis of CMS data.

Note: Special needs plans are not included in this analysis. Three of the organizations offered two different types of MA plans and were counted in this table under each plan type.

## Financial and Beneficiary Transition Issues Cited as Concerns Regarding Conversion to MA Plans

Officials from organizations that offered cost plans cited potential future changes to MA payments and difficulty assuming financial risk as concerns about converting cost plans to MA plans. Officials also expressed concerns about the potential disruption to beneficiaries that could be caused by transferring beneficiaries in cost plans to an MA plan.

<sup>22</sup> Medicare managed care enrollment includes local HMOs, local PSOs, local PPOs, PFFS plans, regional PPOs, and cost plans open to individuals.

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## Organizations Cited MA Payment Rates and Financial Risk as Concerns to Becoming MA Plans

Officials from organizations that offered cost plans reported that potential changes to MA payments were a significant concern in their decision about whether to convert their cost plans to MA plans. Officials from 13 of the 18 organizations that offered cost plans identified past payment changes in the Medicare risk programs and the potential for future payment changes in the MA program as making the decision to convert difficult, though 6 of these organizations offered an MA plan in some or all of their cost plan's service area in 2009. For instance, officials from one organization who told us that they would prefer to convert their cost plan to an MA plan, said they have not done so because of concerns future MA payment changes may then necessitate closing the plan. Recent congressional and administration proposals have called for slowing the increase in or reducing MA payments.

Officials from some organizations said that the size of their enrollment was insufficient to manage the financial risk associated with the MA program. Officials from 5 of the 18 organizations that offered cost plans stated that their enrollment was too low to spread financial risk. For example, an official from 1 of these 5 organizations stated that, because of the plan's location in a rural area, its enrollment would never be large, and its cost plan could not take on the financial risk. This official told us that a few high-cost beneficiaries would consume the payments the plan would receive from CMS. In June 2009, the cost plan enrollment levels for these 5 organizations ranged from fewer than 500 beneficiaries to about 37,000 beneficiaries.<sup>23</sup> Despite the concerns of these 5 organizations, we found that plans of equivalent size were able to operate in the MA program. Nationwide, 130 MA plans, or about 21 percent of all MA plans, enrolled fewer than 500 beneficiaries, and 69 percent of MA plans enrolled from 501 to 37,000 beneficiaries. Eleven percent of MA plans enrolled more than 37,000 beneficiaries.<sup>24</sup> According to CMS officials, after 3 years of operation, MA organizations should be able to meet the agency's enrollment threshold of 1,500 in rural areas and 5,000 in urban areas. However, these officials noted that the total enrollment can include enrollment from other lines of business if the enrollment is with the same legal entity that holds the contract with CMS.

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<sup>23</sup>One of these five organizations also operates an MA special needs plan. The other four do not operate any MA plans.

<sup>24</sup>Percentages do not equal 100 because of rounding.

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Officials from 3 of the 18 organizations that offered cost plans expressed concern about meeting risk-based capital (RBC) requirements, should they be required to convert to an MA plan.<sup>25</sup> An official from the Medicare Cost Contractors Alliance also expressed concern about the ability of some organizations that offered cost plans to raise RBC in the event of a required conversion to an MA plan. The official noted that nonprofit organizations operate most cost plans, and some of these organizations have reservations about their ability to raise additional capital. NAIC officials confirmed that if an organization converted a cost plan to an MA plan, thus assuming more financial risk, the organization would probably need to raise more capital, though the extent of capital needed would depend on the size of the organization and how much of the organization's business was dependent on Medicare enrollment. Two of the three organizations that reported concerns about RBC did not have an MA plan in June 2009. The third organization operated at least one MA plan, but nearly 85 percent of the organization's Medicare managed care enrollment was in its cost plan.

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### Cost Plans Cited Concerns about Transitioning Beneficiaries

Officials from more than half of the 18 organizations with cost plans stated they were concerned about the potential disruption to beneficiaries if they were required to convert to a MA plan. Some of these officials noted that the beneficiaries enrolled in their cost plan(s) would not understand the process and would default to Medicare FFS. Officials from two organizations with closed cost plans stated that they have tried in the past to transfer the beneficiaries enrolled in their cost plan into the organization's MA plan, but had trouble convincing beneficiaries to change plans.

In general, if an organization decided to convert a cost plan to an MA plan, the organization would need to close the cost plan and open a new MA plan, if the organization did not already have one. Beneficiaries who wish to enroll in an MA plan offered by the organization that offered their cost plan must affirmatively enroll in the organization's MA plan. Those who do

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<sup>25</sup>RBC refers to the minimum amount of capital an insurer should hold in order to ensure that it can pay its obligations. The NAIC established a formula to calculate RBC that takes into account the risk profile and size of a plan. Generally, the more risk a health insurer takes on, the more RBC the health insurer needs in reserve. Based on NAIC's model law, if a health insurer has less than 150 percent of the RBC required by the formula, a state insurance regulator may begin taking action to require the insurer to raise its capital reserves.

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not choose a plan—whether unintentionally or by design—will be enrolled by default in Medicare FFS.

CMS does have a standard process in place to alert beneficiaries when their MA or cost plan discontinues serving the beneficiaries' area. CMS requires cost plans that discontinue serving an area to notify each Medicare beneficiary enrolled in the plan by mail at least 60 days prior to the end of the contract period and notify the general public at least 30 days prior to the end of the contract period. CMS stated that they would strongly suggest that the cost plans adhere to the more stringent MA requirements regarding plan closures, which require the organization offering the plan to notify each Medicare beneficiary enrolled in the plan at least 90 days before it stops operating by sending a CMS-approved notice to beneficiaries describing available alternatives for obtaining Medicare services within the service area, including MA plans and Medicare FFS. The organization also must publish a notice in one or more local newspapers at least 90 days before the end of the calendar year to alert the public.

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## Agency and Other External Comments

We provided a draft of this report to CMS and the Medicare Cost Contractors Alliance. CMS provided us with technical comments, which we have incorporated as appropriate, and representatives from the Medicare Cost Contractors Alliance provided us with oral comments.

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## Medicare Cost Contractors Alliance Comments

Officials from the Medicare Cost Contractors Alliance stated that it was important to know whether cost plans were open or closed to enrollment in our discussion of competitors and the discussion of organizations offering both cost plans and MA plans. Information on the enrollment status of cost plans is provided in appendices I and II. The Medicare Cost Contractors Alliance officials also stated that cost plans have been in the Medicare managed care market significantly longer than most MA plans and it is this experience that has led the organizations to be weary of potential payment changes to the MA program. In addition, the Medicare Cost Contractors Alliance officials provided technical comments, which we incorporated as appropriate.

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We are sending copies of this report to the Administrator of CMS and other interested parties. In addition, this report will be available at no charge on the GAO Web site at <http://www.gao.gov>.

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If you or your staff have any questions about this report, please contact me at (202) 512-7114 or [cosgrovej@gao.gov](mailto:cosgrovej@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix IV.

A handwritten signature in black ink, appearing to read 'James C. Cosgrove', written in a cursive style.

James C. Cosgrove  
Director, Health Care

# Appendix I: Organizations That Offer Medicare Cost Plans

As of December 2009, 18 organizations operated 22 cost plans, with enrollments ranging from 50 to 74,190. Of the 22 cost plans, 15 were open to enrollment. Nonprofit organizations operated 17 of the 22 cost plans.

**Table 4: Organizations That Offer Medicare Cost Plans**

Organization	States served	Number of cost contracts	Open/closed enrollment <sup>a</sup>	Corporate status	Total enrollment as of December 2009
Blue Cross Blue Shield of Minnesota	MN	1	Open	Nonprofit	791
Clarian Health Plans, Inc.	IN	1	Open	For-Profit	4,807
Colorado Choice Health Plans	CO	1	Open	Nonprofit	547
Contra Costa Health Plan	CA	1	Closed	Nonprofit	578
Dean Health Plan, Inc.	WI	1	Open	For-Profit	13,417
Excellus Health Plans, Inc.	NY	2	Closed	Nonprofit	2,736
Group Health, Inc. (HealthPartners, Inc.)	MN, WI	1	Open	Nonprofit	36,676
Hawaii Medical Service Association	HI	1	Open	Nonprofit	36,107
Heart of America HMO	ND	1	Open	Nonprofit	454
HIP of Greater New York	NY	1	Closed	Nonprofit	1,248
Kaiser Foundation Health Plan of the Mid Atlantic States	DC, MD, VA	1	Open	Nonprofit	37,680
Kaiser Foundation Health Plan, Inc.	CA, HI	3	Closed	Nonprofit	4,445
Kaiser Foundation Health Plan, Inc. of Ohio	OH	1	Open	Nonprofit	19,680
Medica Insurance Company	MN, ND, SD, WI	1	Open	For-Profit	74,190
Medical Associates Clinic	IA, IL, WI	2	Open	For-Profit/Nonprofit <sup>b</sup>	10,562
Rocky Mountain Health Maintenance Organization	CO, WY	1	Open	Nonprofit	21,813
Scott and White Health Plan	TX	1	Open	Nonprofit	23,526
Welborn Health Plan	IN	1	Open	For-Profit	1,502

Source: GAO analysis of CMS data.

<sup>a</sup>CMS requires organizations operating cost plans to close their cost plans to new enrollment if they open an MA plan in the same service area.

<sup>b</sup>Medical Associates Clinic operated two cost plans. The plan that served Iowa and Illinois operated as a for-profit organization and the plan that served Wisconsin operated as a nonprofit organization.

# Appendix II: Organizations That Would Likely Be Affected by Medicare Improvements for Patients and Providers Act of 2008 Provision

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) provides that, the Secretary of Health and Human Services would not extend or renew cost plan contracts for service areas where, during the entire previous year, two or more regional coordinated care plans (CCP) or two or more local CCPs were offered by different organizations, if the MA plans met specified enrollment thresholds. Private fee-for-service plans are not CCPs.

**Table 5: Preliminary Centers for Medicare & Medicaid Services (CMS) Estimates of the Cost Plans and Percentage of Cost Plan Enrollment Likely Affected by MIPPA Provision**

Organization	States Served	Total enrollment in organization's cost plan as of December 2009	Percentage of total cost plan enrollment affected	Open/closed enrollment <sup>b</sup>
Contra Costa Health Plan	CA	578	100	Closed
Excellus Health Plans, Inc <sup>a</sup>	NY	2,686	100	Closed
Excellus Health Plans, Inc <sup>a</sup>	NY	50	100	Closed
HIP Of Greater New York	NY	1,248	93	Closed
Kaiser Foundation Health Plan, Inc <sup>a</sup>	CA	958	98	Closed
Kaiser Foundation Health Plan, Inc <sup>a</sup>	CA	3,224	68	Closed
Rocky Mountain Health Maintenance Organization	CO, WY	21,813	17	Open

Source: CMS.

Note: CMS excluded special needs plans and employer group health plans that are not open to enrollment by non-employer group members from the CCPs considered to be available MA plans for the purposes of its analysis. CMS analyzed MA competitor enrollment at the benefit package level to determine which cost plans would need to discontinue serving portions of their service area in 2011. By analyzing at this level rather than at the contract level, it is likely that fewer competitors would have sufficient enrollment to meet the thresholds because enrollment in a contract would be divided among the benefit packages offered under a contract.

<sup>a</sup>Excellus Health Plans, Inc, and Kaiser Foundation Health Plan, Inc. operated more than one cost plan that will likely be affected by the MIPPA provision regarding the extension of cost plan contracts.

<sup>b</sup>CMS requires organizations operating cost plans to close them to new enrollment if the organization opens an MA plan in the same service area.

# Appendix III: Structural Differences among Cost Plans, MA Plans, and Medicare FFS for Beneficiaries

Coordinated Care Plans					
	Cost plan	Medicare Advantage (MA) Preferred Provider Organization (PPO) (Local & Regional)	MA Health Maintenance Organization (HMO)	MA Private Fee-For-Service (PFFS) plan	Medicare Fee-For-Service (FFS)
<b>Enrollment period</b>	Cost plans that are open to enrollment must have an open enrollment period of at least 30 consecutive days annually.	When beneficiary becomes eligible for Medicare, during the Annual Election Period (AEP), the MA Open Enrollment Period (MA OEP), or a Special Enrollment Period (SEP). <sup>a</sup>	When beneficiary becomes eligible for Medicare, during the AEP, the MA OEP, or a SEP. <sup>a</sup>	When beneficiary becomes eligible for Medicare, during the AEP, the MA OEP, or a SEP. <sup>a</sup>	When beneficiary becomes eligible for Medicare, during the general enrollment period of January 1st to March 31st of each year, or during a SEP. <sup>a</sup>
<b>Disenrollment</b>	Beneficiary may disenroll at any time and return to FFS.	In most cases, beneficiary must stay enrolled for the calendar year in which coverage begins. <sup>b</sup>	In most cases, beneficiary must stay enrolled for the calendar year in which coverage begins. <sup>b</sup>	In most cases, beneficiary must stay enrolled for the calendar year in which coverage begins. <sup>b</sup>	In most cases, beneficiary must stay enrolled until next AEP or MA-OEP.
<b>Online enrollment</b>	Not available	Available	Available	Available	Not applicable
<b>Out-of-network coverage</b>	Through Medicare FFS; beneficiary is responsible for FFS coinsurance and deductibles. <sup>c</sup>	Services received out of network will generally cost more, but they are covered by the plan. <sup>c</sup>	Beneficiary generally responsible for full cost of out-of-network services, however some plans may cover certain services out of network at a higher cost. <sup>c</sup>	Any Medicare-approved provider that accepts the plan's terms. <sup>d</sup>	Any provider that accepts Medicare.
<b>Part D coverage</b>	Any stand-alone Medicare Prescription Drug Plan (PDP) or PDP offered by the cost plan organization.	A Part D plan offered by the MA organization.	A Part D plan offered by the MA organization.	A PDP offered by the PFFS organization. If the organization does not offer a PDP plan, beneficiaries can choose any PDP.	Any PDP.
<b>Initial appeals<sup>e</sup></b>	Subject to cost plan's internal appeal process.	Subject to MA plan's internal appeal process.	Subject to MA plan's internal appeal process.	Subject to MA plan's internal appeal process.	Subject to Medicare appeals process.

Source: GAO.

<sup>a</sup>The Annual Election Period (AEP) is from November 15th to December 31st, the MA Open Enrollment Period (MA OEP) is from January 1st to March 31st, and Special Enrollment Periods (SEP) apply whenever a beneficiary meets certain criteria, such as moving out of their current plan's service area.

<sup>b</sup>If the beneficiary moves out of the plan's service area, has both Medicare and Medicaid, qualifies for the Part D low-income subsidy, or lives in an institution, they may be able to drop their plans at other times.



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**Appendix III: Structural Differences among  
Cost Plans, MA Plans, and Medicare FFS for  
Beneficiaries**

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<sup>c</sup>The plan is responsible for certain services provided out of network, including emergency services.

<sup>d</sup>Beginning in 2011, all employer- or union-sponsored PFFS plans, and all nonemployer- or union-sponsored PFFS plans in areas that have at least two available network-based plans, (such as an HMO or PPO) must form contracted networks of providers. In areas with fewer than two network-based plans, PFFS plans not sponsored by employer or union groups will continue to have the option of operating without networks if they pay providers at Medicare FFS rates or higher.

<sup>e</sup>Beneficiaries have the right to appeal coverage decisions. This chart relates to the first of the five levels of appeals.

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# Appendix IV: GAO Contact and Staff Acknowledgments

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## GAO Contact

James C. Cosgrove, (202) 512-7114 or [cosgrovej@gao.gov](mailto:cosgrovej@gao.gov)

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## Staff Acknowledgments

In addition to the contact above, Christine Brudevold, Assistant Director; Lori Achman; Julianne Flowers; Hannah Marston; Sarah Marshall; Elizabeth T. Morrison; and Amanda Pusey made key contributions to this report.

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