



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.