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Report to Congressional Requesters

April 2010

MEDICARE ADVANTAGE

Relationship between Benefit Package Designs and Plans' Average Beneficiary Health Status

GAO-10-403

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Highlights

Highlights of GAO-10-403, a report to congressional requesters

Why GAO Did This Study

Nearly 11 million Medicare beneficiaries are enrolled in Medicare Advantage (MA), Medicare's private health insurance option. Benefits vary by MA plan and may include coverage for services not available in traditional Medicare. To ensure MA plan benefit package designs do not discriminate against beneficiaries in poor health with high expected health care costs, the Centers for Medicare & Medicaid Services (CMS) reviews and approves all benefit packages yearly.

GAO examined (1) MA plan benefit packages by average health status of plans' enrolled beneficiaries, (2) distribution and characteristics of MA plans by average beneficiary health status, and (3) CMS's process for ensuring that benefit packages do not discriminate with respect to health status. Using 2008 data on beneficiaries' expected health care costs, the most recent data available, GAO sorted 2,899 plans enrolling 7.5 million beneficiaries into three groups: good health (below-average expected costs), average health, and poor health (above-average expected costs). GAO then analyzed MA plan benefit packages by health group and reviewed CMS documentation and interviewed agency officials on CMS's benefit package review process. GAO did not determine whether plans structured benefit packages in response to enrolled beneficiaries' health status or beneficiaries in particular health groups chose plans because of the benefits.

View GAO-10-403 or key components.
For more information, contact James C. Cosgrove at (202) 512-7114 or cosgrovej@gao.gov.

What GAO Found

In 2008, plans in the good health group generally had lower premiums, higher cost sharing for certain services, and fewer additional benefits than plans in the poor health group. Almost half of the plans in the good health group did not have an MA premium for medical or drug coverage, while about one-fifth of plans in the poor health group had no MA premium. Plans in the good health group had higher cost sharing, weighted by enrollment, for inpatient hospital care, skilled nursing facility stays, and renal dialysis than plans in the poor health group. Plans in the good health group were more likely to have an out-of-pocket (OOP) maximum, but the average OOP maximum for plans in that group, weighted by enrollment, was 55 percent higher than that for plans in the poor health group. Comprehensive dental and hearing aid benefits were more likely to be included in the benefit packages for beneficiaries in the poor health group of plans whereas fitness benefits were more likely to be included in the benefit packages for beneficiaries in the good health group of plans.

Forty-three percent of plans were in the good health group, 37 percent in the average health group, and 20 percent in the poor health group. Twenty-nine percent of MA beneficiaries were in plans in the good health group, 55 percent in plans in the average health group, and 16 percent in plans in the poor health group. Among the five largest companies sponsoring MA plans, beneficiary health varied: one sponsor had 17 percent of its beneficiaries in plans in the good health group and 17 percent in plans in the poor health group; another sponsor had 49 percent of beneficiaries in plans in the good health group and less than 1 percent in plans in the poor health group. Average beneficiary health status also varied by other factors, such as plan type and plan size.

CMS has revised its process for reviewing MA plans for the likelihood of discrimination. It developed a new methodology for setting cost-sharing thresholds—criteria used to identify benefit packages likely to discriminate against certain beneficiaries. For contract year 2010, CMS contacted all MA plans with benefit packages identified as likely to discriminate, and all plans subsequently met cost-sharing thresholds. The new methodology for setting cost-sharing thresholds allowed higher cost sharing for some services relative to 2009. For example, among plans without an OOP maximum or one above $3,400 for 2010, allowed cost sharing for a typical inpatient mental health stay doubled, from $61 per day to $130 per day, and allowed cost sharing for a typical skilled nursing facility stay increased from $53 to $70 per day, compared to 2009.

In comments on a draft of this report, CMS noted that GAO's findings are consistent with the agency's experience. CMS also stated that, prior to contract year 2010, it targeted for cost-sharing reductions plans with the most egregious cost sharing and often reduced cost-sharing amounts, but to amounts that were still above the thresholds.

Contents

Abbreviations

AHIP	America's Health Insurance Plans
CMS	Centers for Medicare & Medicaid Services
DME	durable medical equipment
FFS	fee-for-service
HMO	health maintenance organization
MA	Medicare Advantage
MAO	Medicare Advantage organization
MedPAC	Medicare Payment Advisory Commission
PBP	plan benefit package
PFFS	private fee-for-service
PPO	preferred provider organization
OOP	out-of-pocket
SNF	skilled nursing facility
SNP	special needs plan

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April 30, 2010

Congressional Requesters

Nearly one out of every four Medicare beneficiaries is enrolled in a Medicare Advantage (MA) plan—an alternative to original Medicare fee-for-service (FFS)—in which private insurance plans offer health care coverage to Medicare beneficiaries. As of December 2009, nearly 11 million Medicare beneficiaries were enrolled in approximately 4,700 plans offered by 188 MA organizations (MAO).[1] Medicare payments to MA plans were approximately $109.7 billion in fiscal year 2009.[2] In addition to covering services paid for under Medicare FFS, many MA plans offer additional benefits, such as vision, hearing, or dental care and MA plans typically have premiums lower than those of Medicare supplemental policies purchased by FFS beneficiaries (known as Medigap).[3] MA beneficiaries generally have an array of plans to choose from, each with different coverage, premiums, and cost sharing—the portion of medical expenses that the beneficiary is responsible for paying out-of-pocket (OOP).

The Centers for Medicare & Medicaid Services (CMS)—the agency that administers the Medicare program—pays MA plans a fixed amount to cover each beneficiary and oversees plan benefit designs. CMS adjusts payments to plans using risk scores, which estimate the expected health care costs of the beneficiaries enrolled in a plan.[4] Risk scores are developed from data on individuals' demographics and diagnoses. As a result, MA plans receive relatively lower payments for beneficiaries who

[1]MAOs may offer multiple MA plans with different combinations of authorization requirements, non-Medicare benefits, cost sharing, and premiums. MA plans must cover Medicare-covered benefits except hospice care.

[2]Centers for Medicare & Medicaid Services (CMS), *CMS Financial Report Fiscal Year 2009* (Baltimore, Md.: November 2009)

[3]Medicare FFS beneficiaries can purchase Medigap insurance policies, offered by private insurers, that help cover cost-sharing amounts for Medicare-covered services.

[4]Medicare spending is concentrated among a small proportion of beneficiaries. The most expensive 5 percent of Medicare beneficiaries account for roughly half of all spending in the Medicare FFS program. See MedPAC, *Report to the Congress: New Approaches in Medicare* (Washington, D.C.: June 2004).

are healthier than average, and relatively higher payments for beneficiaries who are sicker than average.

The Medicare Payment Advisory Commission (MedPAC) reported that Medicare's risk-adjustment methodology may tend to set payments too low for beneficiaries in poor health, who tend to have high expected health care costs, and set payments too high for the healthiest beneficiaries who tend to have low expected health care costs.[5] As a result, MAOs may have a financial incentive to discourage new or continued enrollment of beneficiaries in poor health. It is possible that some MAOs could do this through the design of their plan benefit packages. For example, a plan that charges relatively high cost-sharing amounts for certain services commonly used by beneficiaries in poor health may prove particularly undesirable to them. MA plans have flexibility in designing their benefit packages, but (1) they must provide all Medicare-covered services except hospice care, (2) their overall cost-sharing requirements must be actuarially equivalent or lower than those under Medicare FFS,[6] and (3) they cannot discriminate on the basis of health status. By law, CMS may not approve MA plan benefit packages if their designs are likely to substantially discourage enrollment of certain beneficiaries.[7] To determine whether an MA plan benefit package is likely to substantially discourage enrollment of certain beneficiaries, CMS reviews cost sharing for certain services for which excessively high cost sharing could be considered discriminatory.

We reported in 2008 that 2007 cost sharing for certain services, such as home health and inpatient hospital stays, was higher in some MA plans than in Medicare FFS.[8] However, we have not previously examined how plan benefit design varied among MA plans by average beneficiary health status. Therefore, you asked that we review MA plan benefit designs, enrollment patterns, and related CMS oversight. This report examines (1) benefit packages of MA plans by average health status of plans'

[5]Medicare Payment Advisory Commission (MedPAC), *Report to the Congress: Issues in a Modernized Medicare Program* (Washington, D.C.: June 2005).

[6]Actuarial equivalence is demonstrated by a qualified actuary's certification that overall cost sharing in an MA plan is no more than the overall cost sharing in Medicare FFS.

[7]42 U.S.C. § 1395w-22(b)(1)(A).

[8]See GAO, *Medicare Advantage: Increased Spending Relative to Medicare Fee-for-Service May Not Always Reduce Beneficiary Out-of-Pocket Costs*, GAO-08-359 (Washington, D.C.: Feb. 22, 2008).

enrolled beneficiaries, (2) the distribution and characteristics of MA plans by average beneficiary health status, and (3) CMS's process for ensuring that MA plan benefit packages are not discriminatory with respect to health status.

To address these issues, we focused on four types of MA plans that together accounted for nearly all of MA enrollment in 2009—health maintenance organizations (HMO), private fee-for-service (PFFS) plans, local preferred provider organizations (PPO), and regional PPOs.[9] We included special needs plans (SNP), which are allowed to limit enrollment to a targeted beneficiary population; SNPs can be HMOs, local PPOs, or regional PPOs.[10] After certain exclusions, we analyzed data for 2,899 plans (including 621 SNPs), offered by 192 MAOs that enrolled 74 percent of all MA beneficiaries—7.5 million—as of July 2008.[11] Of the 973,923 beneficiaries enrolled in SNPs, over two-thirds were in plans that targeted enrollment to dual-eligible beneficiaries—those entitled to both Medicare and Medicaid. In some of our analyses, we reported our results for SNPs separately in order to highlight the distinct characteristics of such plans.

Using CMS's 2008 plan-level risk score data by county, the most recent data available, we categorized the average health status of MA plans as good, average, or poor in the areas that they served. Risk scores are based on beneficiaries' projected health care costs, which CMS develops using

[9]Beneficiaries in HMOs are generally restricted to seeing providers within a network, while PFFS beneficiaries can see any provider authorized to provide Medicare services that accepts the plan's payment terms. Beneficiaries in PPOs can see both in-network and out-of-network providers but may pay higher cost-sharing amounts if they use out-of-network services. A regional PPO serves an entire state or multiple states, whereas local PPOs may serve a county, partial county, or multiple counties.

[10]SNPs are permitted to target enrollment to (1) beneficiaries entitled to Medicare and Medicaid (dual-eligible beneficiaries), (2) beneficiaries with severe or disabling chronic conditions, and (3) institutionalized beneficiaries. They may either exclusively or disproportionately enroll beneficiaries from one of these three categories.

[11]We excluded from our analysis employer plans, religious fraternal benefit plans, Part B only plans, CMS demonstrations, programs of all-inclusive care for the elderly, cost plans, provider sponsored organizations (as they constituted less than 1 percent of MA enrollment), medical savings accounts, beneficiaries with end-stage renal disease, beneficiaries located in areas outside the 50 states and the District of Columbia, and MA plans with fewer than 10 beneficiaries.

demographic information and diagnosis codes.[12] At the plan level, risk scores indicate the average health status of the plans' beneficiaries. Because the overall Medicare population may be healthier in some geographic areas than in others, we calculated an indexed (relative) health risk score for each plan as the ratio of an MA plan's risk score to the overall Medicare average risk score in each county. We then averaged each plan's indexed risk score across the counties that comprised the plan's service area, weighted by July 2008 enrollment. With 1.00 as the average risk score for all Medicare beneficiaries—in FFS and MA—we placed the MA plans in one of three groups.

- **Good health group**: MA plans with an average indexed risk score less than 0.90, meaning the projected health care costs for the average beneficiary in the plan were at least 10 percent lower than those for an average Medicare beneficiary living in the plan's service area.

- **Average health group**: MA plans with an average indexed risk score between 0.90 and 1.10, meaning the projected health care costs for the average beneficiary in the plan were within 10 percent of those for an average Medicare beneficiary living in the plan's service area.

- **Poor health group**: MA plans with an average indexed risk score greater than 1.10, meaning the projected health care costs for the average beneficiary in the plan were at least 10 percent higher than those for an average Medicare beneficiary living in the plan's service area.

To compare the benefit packages of MA plans by the average health status of plans' enrolled beneficiaries, we analyzed CMS plan benefit package (PBP) data for contract year 2008 (as the risk score data used in our analysis is based on MA plan enrollment as of July 2008). CMS's PBP data contain each MA plan's premiums, cost-sharing requirements, and additional benefits. We analyzed cost sharing for eight services for which CMS considers high cost sharing to be potentially discriminatory because these services typically are used by Medicare beneficiaries in poor health and are usually associated with acute and chronic conditions, high

[12]Diagnosis codes are assigned by providers and reported for FFS beneficiaries in Medicare claims data. MA plans are responsible for providing CMS with the appropriate diagnosis codes for their enrolled beneficiaries as the Medicare program does not have claims data for these beneficiaries.

utilization, and high cost.[13] For several services, we simulated beneficiary OOP costs using average beneficiary utilization profiles developed by CMS and accounted for plans that charged service-specific deductibles or had service-specific OOP maximums—dollar limits on the amount a beneficiary must pay in cost sharing in a period of coverage (typically 1 year).[14] We also determined whether MA plans provided additional coverage for dental, vision, or hearing services; and fitness benefits.[15] We did not determine whether MAOs structured their plan benefit packages in response to enrolled beneficiaries' health status or whether beneficiaries of a given health status chose certain MA plans specifically because of their benefit package designs.

To examine the distribution and characteristics of MA plans by beneficiary health status, we analyzed 2008 MA plan-level risk score data, the most recent data available, and calculated the number of MA plans and the percentage of plan beneficiaries in each health group. We further examined the differences across the health groups (1) among the five largest MAOs, (2) by plan type, (3) by plan size, (4) and by the percentage difference between the MA payment benchmarks and estimated FFS spending across a plan's service area.

To describe CMS's process for ensuring that MA plan benefit packages are not discriminatory with respect to health status, we interviewed CMS officials, including staff responsible for reviewing and approving plan benefit packages; and reviewed relevant laws and regulations, CMS standard operating procedures, and other agency documentation on the review process. We determined the outcome of CMS's review process by analyzing data for contract years 2008 and 2009 on MA plans that CMS initially identified as having potentially discriminatory cost sharing and

[13]Services typically used by sicker beneficiaries, for whom CMS considers high cost sharing to be potentially discriminatory, include: inpatient hospital acute care, inpatient mental health care, renal dialysis, chemotherapy drugs and other part B drugs, skilled nursing facility stays, home health visits, and durable medical equipment (DME).

[14]A deductible is an amount (typically annual) that a beneficiary is responsible for before an insurer will make payments.

[15]Dental, vision, hearing, and fitness benefits (which may include gym memberships and fitness classes) are not provided under Medicare FFS but may be offered by MA plans as mandatory or optional supplemental benefits. Mandatory benefits must be provided for every person enrolled in the plan, whereas optional supplemental benefits are available to those enrollees who elect and pay for them.

data on MA plans' final cost-sharing requirements for contract years 2008 through 2010.

We interviewed CMS officials about reliability of the CMS data used in our analysis. We also reviewed data documentation and performed certain data checks to ensure the data were reasonable and consistent. For example, we compared the results of our cost sharing analysis using PBP data with information from the Medicare Options Compare Web site.[16] We determined that the data were sufficiently reliable for our purposes. We conducted our work from April 2009 through April 2010 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings.

Background

Most Medicare beneficiaries can choose to receive covered services through Medicare FFS or through an MA plan—which operates under Medicare Part C—if one is offered where they live.[17] MAOs are allowed flexibility in designing their plan benefit packages and cost sharing for certain services can vary widely by MA plan.

Medicare Advantage Coverage and Payment

MA plans operate under annual contracts between MAOs and CMS and must offer benefits that are covered under Medicare FFS.[18] These benefits consist of Part A hospital insurance, which covers inpatient stays, care in skilled nursing facilities, and some home health care; and Part B medical insurance, which covers certain physician, outpatient hospital, and laboratory services, among other services. All beneficiaries enrolled in Part B are charged a Part B premium. In general, in order to enroll in a MA

[16]Medicare Options Compare (available at www.medicare.gov) provides information, using CMS PBP data, to beneficiaries so they can find and compare MA plans available in the area where they live.

[17]Individuals with end-stage renal disease are not eligible to enroll in most MA plans. However, if these individuals develop the disease while enrolled in an MA plan, they may remain enrolled in their plan or move to a different MA plan if their plan is terminated. 42 U.S.C. § 1395w-21(a)(3)(B).

[18]The exception is hospice care, which FFS covers and MA plans do not.

plan, beneficiaries must be entitled to benefits under Part A and enrolled in Part B.

Regardless of their source of coverage, all Medicare beneficiaries have the option of receiving prescription drug coverage through Medicare Part D. Medicare FFS beneficiaries can enroll in stand-alone prescription drug plans, which are operated by private plan sponsors, and they generally must pay an additional premium to receive Part D coverage. MA beneficiaries who also want prescription drug coverage generally receive that coverage through their MA plans, which may or may not charge an additional premium for Part D coverage.

In addition to monthly premiums, beneficiaries in Medicare FFS or in MA plans typically are responsible for cost sharing, which can be in the form of a deductible, coinsurance, or a copayment.[19] To help provide financial protection to beneficiaries who might otherwise have high cost-sharing expenses for Part A and Part B services, MAOs may voluntarily establish OOP maximums, or dollar limits on the amount a beneficiary must pay in cost sharing in a period of coverage (typically 1 year).[20] For contract year 2010, CMS sought to allow MA plans with an OOP maximum at or below $3,400 greater flexibility in establishing cost-sharing amounts.[21]

For each MA beneficiary, CMS pays MA plans a monthly amount determined by the plan bid—the plan's estimated cost of providing Medicare Part A and Part B benefits—in relation to a benchmark, which is the maximum amount the Medicare program will pay MA plans in a given locality. If a plan's bid is less than the benchmark, the difference is partially rebated to the MA plan and must be used to reduce premiums,

[19]Coinsurance is a percentage payment for a given service that a beneficiary must pay, such as 20 percent of the total payment for Part B drugs. A copayment is a standard amount that a beneficiary must pay for a given service, such as $200 per day for days 1 through 6 of an inpatient acute hospital stay.

[20]Regional PPOs are required to have OOP maximums, and Medicare FFS has no OOP maximum. Beginning January 1, 2011, CMS will require local MA plans to have an OOP maximum, the amount of which would be set annually by CMS. See 75 *Fed. Reg.* 19678, 19709-19711 (2010).

[21]Each year CMS publishes the OOP maximum threshold in its annual Call Letter to MA plans. This value represents the maximum amount that 85 percent of Medicare FFS beneficiaries are expected to incur in Parts A and B deductibles and coinsurance in a given year. For calendar years 2008 and 2009 the OOP maximum thresholds were $3,250 and $3,350, respectively.

reduce cost sharing, or provide additional benefits for plan beneficiaries. If a plan's bid exceeds the benchmark, the plan will charge each of its beneficiaries an additional premium to make up the difference. MA plans offering prescription drug coverage have a separate payment benchmark for Part D prescription drug benefits. CMS risk-adjusts the monthly payments to MA plans to take into account the health status of the plan's beneficiaries.

MA Plan Benefit Package Designs

As previously reported, cost sharing can vary widely among MA plans for particular categories of services as a result of the flexibility given MAOs in designing their plan benefit packages.[22] For example, in 2007, 9 percent of beneficiaries were enrolled in MA plans that had no cost sharing for inpatient services, whereas 16 percent of beneficiaries were enrolled in MA plans with cost sharing for inpatient services that was higher than that of Medicare FFS. Similarly, an AARP study reported that in 2008 the average MA beneficiary with a 10-day inpatient hospital stay would incur $823 in cost sharing, less than the $1,068 incurred for beneficiaries in Medicare FFS, but 12 percent of beneficiaries would incur cost sharing of $2,000 or more.[23]

The Secretary of Health and Human Services is obliged by statute to not contract with a MAO if its plan benefit design is likely to substantially discourage enrollment in the MA plan by certain individuals.[24] To implement this provision of the statute, CMS identified in the Medicare Managed Care Manual certain services for which high cost sharing could be considered potentially discriminatory and provides further guidance in its annual MA Call Letter to MA plans on how it will review benefit packages for the likelihood of discrimination. CMS has never barred a plan

[22]See GAO, *Medicare Advantage: Increased Spending Relative to Medicare Fee-for-Service May Not Always Reduce Beneficiary Out-of-Pocket Costs*, GAO-08-359 (Washington, D.C.: Feb. 22, 2008).

[23]Gold, M. and Hudson, M.C., *Medicare Advantage Benefit Design: What Does It Provide, What Doesn't It Provide, and Should Standards Apply?*, A report for AARP Public Policy Institute (Washington, D.C.: March 2009).

[24]See 42 U.S.C. § 1395w-22(b)(1)(A). Regulations provide that CMS shall review and approve MA plan benefit packages to ensure MAOs are not designing benefits to discriminate against beneficiaries, promote discrimination, discourage enrollment or encourage enrollment, steer subsets of particular beneficiaries, or inhibit access to services. See 42 CFR § 422.100(f).

from participation in the MA program because of cost sharing that was likely to substantially discourage enrollment.

Certain aspects of MA cost-sharing requirements and payment will change as a result of the Patient Protection and Affordable Care Act. Beginning with bids submitted for contract year 2011, the Secretary of Health and Human Services has the authority to not contract with an MAO if it proposes significant increases in cost sharing or decreases benefits offered by a plan.[25] In addition, for plan years beginning January 1, 2011, the cost sharing required for chemotherapy services, renal dialysis, skilled nursing care, and any other service that the Secretary determines appropriate can be no more than the cost sharing required in Medicare FFS.[26]

The Good Health Group of Plans Generally Charged Lower Premiums and Higher Cost Sharing for Certain Benefits, and Offered Fewer Additional Benefits

The good health group of plans—MA plans in which the average beneficiary had projected health care costs at least 10 percent below those for an average Medicare beneficiary within the plan's service area—generally charged lower premiums and had higher cost sharing for certain services compared with the poor health group of plans. Plans in the good health group also were less likely to include additional benefits, such as vision and dental care coverage.

The Good Health Group of Plans Generally Charged Lower Premiums or None at All

The good health group of plans generally charged lower premiums relative to the poor health group of plans. (See fig. 1.) For example, in 2008,

- almost half of the good health group of plans—46 percent—did not have a premium for Part C (medical) or Part D (prescription drug) coverage, while about one-fifth of the poor health group of plans had no premium.
- for MA plans that included prescription drug coverage as part of their benefit package, the combined (Part C and Part D) monthly premium for

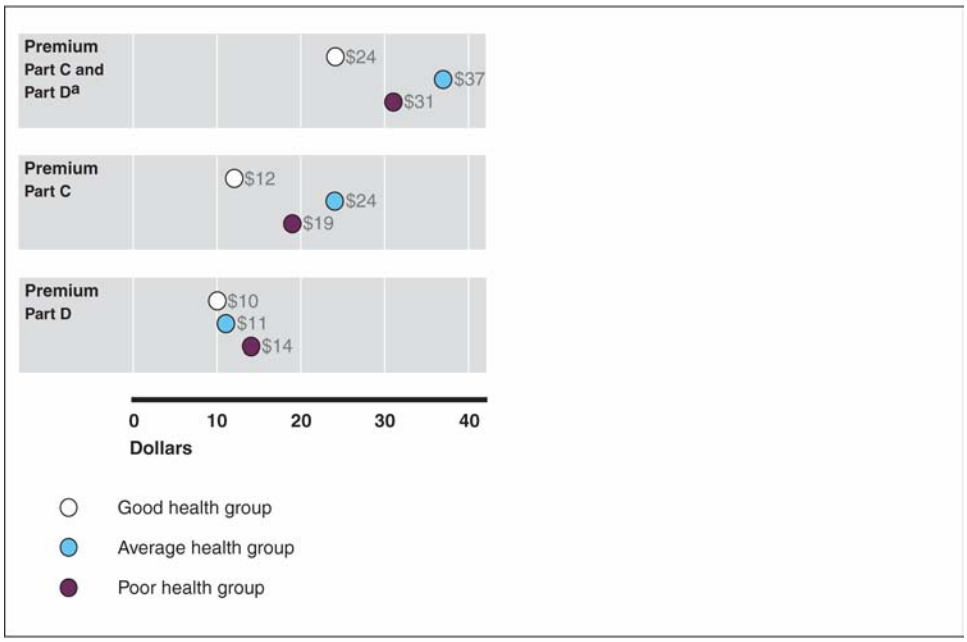
[25]See Pub. L. No. 111-148, § 3209, _Stat._ (2010).

[26]See Pub. L. No. 111-148, § 3202, _Stat._ (2010).

the good health group of plans—$24—was lower than that for the poor health group, which was $31.

- taken separately, Part C and Part D premiums for the good health group of plans also were lower than the corresponding premiums for the poor health group.

Figure 1: Average Combined, Part C, and Part D MA Plan Premiums by Health Group, 2008



Source: GAO analysis of 2008 CMS Plan Benefit Package data.

Notes: Dollar amounts are weighted by July 2008 enrollment and include zero-premium MA plans. Using CMS's 2008 plan-level risk score data by county, we categorized the health status of MA plans as good, average, or poor based on the average health status of their enrolled beneficiaries in the areas that they served. This analysis included 2,899 MA plans that enrolled a total of 7,553,600 beneficiaries.

[a]The combined Part C and D premium reflects the premium for plans that included the Part D prescription drug coverage as part of their MA plan benefit package.

In 2008, 12 percent of plans in the good health group reduced beneficiaries' Part B premium, while 4 percent of plans in the poor health group did so. Among plans that reduced the Part B premium, plans in the

good health group reduced it by a larger amount than plans in the poor health group—averaging $48 and $36, respectively.[27]

The Good Health Group of Plans Generally Had Higher Cost Sharing for Certain Services

The good health group of plans tended to have higher cost sharing for the services we reviewed—which included inpatient hospital acute stays, inpatient mental health stays, skilled nursing facility (SNF) stays, and renal dialysis—than the poor health group of plans.[28] (See fig. 2.) For example, in 2008,

- the average plan in the good health group charged about $100 more in cost sharing for a typical inpatient hospital stay (6 days)[29] and about $150 more for a typical inpatient mental health stay (21 days)[30] than the average plan in the poor health group.
- the average plan in the good health group charged about $500 more in cost sharing for a typical SNF stay (35 days) than the average plan in the poor health group.[31]
- the average plan in the good health group charged over $300 more in cost sharing for a year of renal dialysis (156 sessions)[32] than the average plan in the poor health group.

[27]Results weighted by July 2008 enrollment.

[28]Of the 2,899 plans in our analysis, 5 percent required enrollees to pay a deductible before plan coverage began. We considered an MA plan to have a deductible if the plan had either an in-network deductible or a deductible for both in-network and out-of-network services.

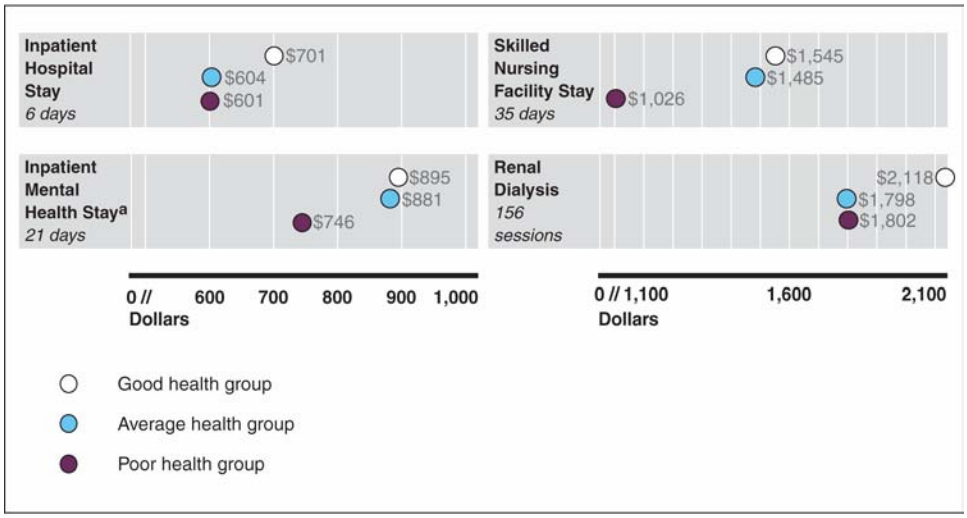
[29]For a 6-day inpatient hospital stay, 15 percent of MA plans in our analysis did not charge cost sharing.

[30]For inpatient mental health stays, CMS does not calculate an average cost per day. As a result, we were only able to estimate the average OOP cost for a 21-day inpatient mental health stay for plans that charged a copayment. Approximately 14 percent of MA plans in our analysis did not charge cost sharing for a 21-day stay.

[31]For a 35-day SNF stay, 16 percent of MA plans in our analysis did not charge cost sharing.

[32]For 156 renal dialysis sessions, 37 percent of MA plans in our analysis did not charge cost sharing.

Figure 2: Average MA Plan Cost Sharing for Selected Services by Health Group, 2008



Source: GAO analysis of 2008 CMS Plan Benefit Package data.

Notes: Dollar amounts are weighted by July 2008 enrollment and include MA plans that did not charge cost sharing for the indicated services. Using CMS's 2008 plan-level risk score data by county, we categorized the health status of MA plans as good, average, or poor based on the average health status of their enrolled beneficiaries in the areas that they served. This analysis included 2,899 MA plans that enrolled 7,553,600 beneficiaries.

[a]CMS does not calculate an average cost per day for an inpatient mental health stay. As a result, we were only able to estimate the average OOP cost for a 21-day inpatient mental health stay for plans that charged a copayment. Of the 2,899 plans in our analysis, approximately 90 percent indicated that they charged a copayment for an inpatient mental health stay.

The good health group of plans had similar cost sharing for Part B chemotherapy drugs, other Part B drugs, DME, and home health compared with the poor health group of plans.[33] For example, in 2008,

- an average plan in both the good health group and the poor health group charged 20 percent coinsurance for Part B chemotherapy drugs and charged 20 and 19 percent coinsurance, respectively, for other Part B drugs.

[33]Among the plans in our analysis that charged cost sharing for Part B chemotherapy drugs, other Part B drugs, and DME, 85 percent charged coinsurance for Part B chemotherapy drugs, 84 percent charged coinsurance for other Part B drugs, and 99 percent charged coinsurance for DME. For 27 home health visits, 75 percent of plans in our analysis did not charge cost sharing. Among the plans that charged cost sharing for home health, 62 percent charged a copayment.

- an average plan in the good health group charged 23 percent coinsurance for DME, compared with 21 percent for the average plan in the poor health group.

- for the relatively small share of plans that charged cost sharing for home health care, an average plan in the good health group charged $568 for 27 home health visits compared to $597 for the average plan in the poor health group.

In 2008, a greater share of plans in the good health group had an OOP maximum that limited their beneficiaries' overall financial risk compared to plans in the poor health group—63 percent compared with 40 percent, respectively.[34] However, the OOP maximum for the good health group of plans averaged 55 percent higher than the OOP maximum for the poor health group ($3,515 compared with $2,262).[35] In designing their benefit packages, some plans excluded cost sharing incurred for certain services from expenses that counted toward the OOP maximum.[36] Approximately 14 percent of plans in the good health group had an OOP maximum and excluded one or more services for which they required cost sharing, compared with 13 percent of plans in the average health and poor health groups.[37] Plans were most likely to exclude Part B drugs (15 percent of plans), renal dialysis (6 percent of plans), and DME (6 percent of plans) from their OOP maximum.[38]

[34]We considered a plan to have an OOP maximum if the plan had either an in-network OOP maximum or an OOP maximum for both in-network and out-of-network services. If a plan had two OOP maximums—one for in-network services and one for combined in- and out-of-network services, then we used the in-network value for this analysis.

[35]Results were weighted by July 2008 enrollment.

[36]A plan was considered to have excluded a service category from the OOP maximum if the OOP maximum did not cover that service category and if the plan had no service-specific maximum for that category. Plans that excluded a certain service category from the OOP maximum did not necessarily exclude all services from that category.

[37]We examined whether a plan charged cost sharing and excluded the following services from their OOP maximum: inpatient hospital acute care, inpatient mental health care, skilled nursing facility stays, home health visits, renal dialysis, Part B drugs, and DME.

[38]In determining whether plans charged cost sharing for services excluded from the OOP maximum, we examined plan cost sharing for a 6-day inpatient hospital acute stay, a 21-day inpatient mental health stay, a 35-day skilled nursing facility stay, 27 home health visits, 1 year of dialysis (156 sessions), Part B drugs, and DME.

The Good Health Group of Plans Generally Had Fewer Additional Benefits

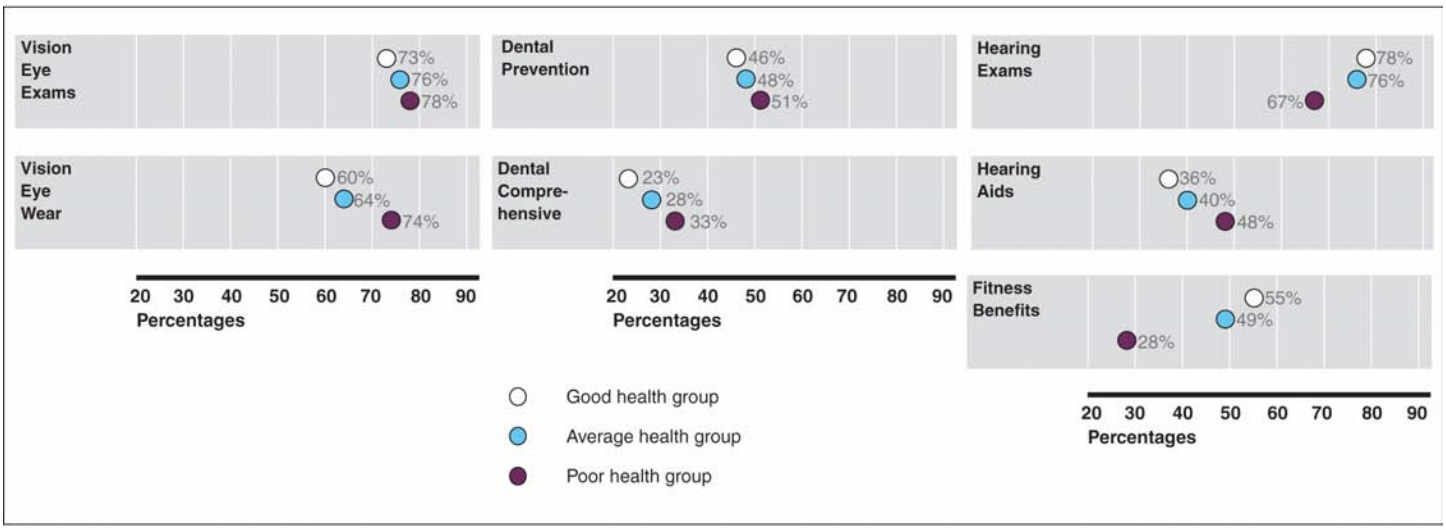
Plans in the good health group were less likely to include certain additional benefits in their benefit packages, such as vision and dental care coverage, but were more likely to include a fitness benefit than plans in the poor health group.[39] (See fig. 3.) For example, in 2008,

- seventy-three percent of plans in the good health group included coverage for eye exams and 60 percent included coverage for eyewear compared with 78 percent and 74 percent, respectively, of plans that covered these benefits in the poor health group.
- twenty-three percent of plans in the good health group included coverage for comprehensive dental benefits compared with 33 percent of plans in the poor health group.[40]
- while plans in the good health group were more likely to cover hearing tests, they were less likely than plans in the poor health group to cover hearing aids—36 percent versus 48 percent.
- the percentage of plans in the good health group that included fitness benefits was approximately twice that of plans in the poor health group—55 percent compared with 28 percent.

[39]Results include MA plans that provided dental, vision, hearing, and fitness benefits as mandatory supplemental benefits.

[40]Comprehensive dental benefits may include restorative services (e.g., fillings), root canals, oral surgery, extractions, and dentures.

Figure 3: Percentage of Beneficiaries in MA Plans with Selected Additional Benefits by Health Group, 2008



Source: GAO analysis of 2008 CMS Plan Benefit Package data.

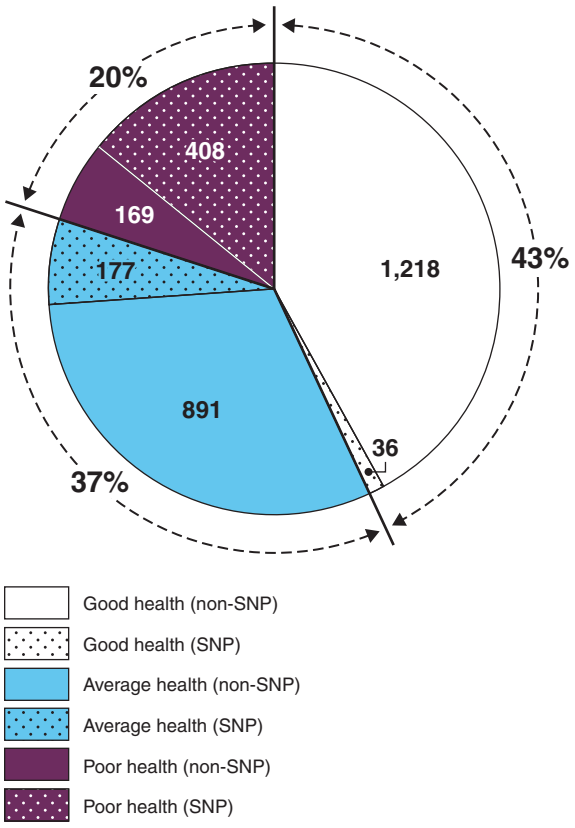
Notes: Percentages are weighed by July 2008 enrollment. Results include MA plans that provided dental, vision, hearing, and fitness benefits as mandatory supplemental benefits. Using CMS's 2008 plan-level risk score data by county, we categorized the health status of MA plans as good, average, or poor based on the average health status of their enrolled beneficiaries in the areas that they served. This analysis included 2,899 MA plans that enrolled 7,553,600 beneficiaries.

More MA Plans and Beneficiaries Were in the Good Health Group than in the Poor Health Group of Plans

In 2008, the plans in the good health group differed with those in the poor health group by plan type, plan size, and, for HMOs, by the difference between MA payment benchmarks and estimated FFS spending. Our analysis of MA plans' average indexed risk scores, including SNPs, by health group showed that 1,254 plans (43 percent) were in the good health group, 1,068 plans (37 percent) were in the average health group, and 577 plans (20 percent) were in the poor health group.[41] (See fig. 4.) Across all 2,899 MA plans in our review, the average indexed risk scores—adjusted for geographic variations in the average health of all Medicare beneficiaries—ranged from 0.38 to 2.65.

[41]See app. I for the number of MA plans and percentage of beneficiaries by average indexed risk score and health group.

Figure 4: MA Plans According to Health Group, 2008

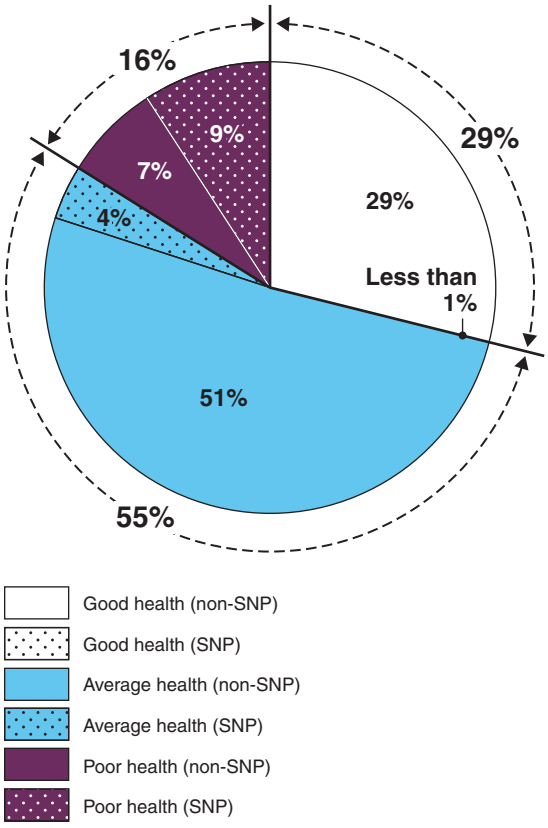


Source: GAO analysis of 2008 CMS risk score data.

Notes: Using CMS's 2008 plan-level risk score data by county, we categorized the health status of MA plans as good, average, or poor based on the average health status of their enrolled beneficiaries in the areas that they served. This analysis included 2,899 MA plans, of which 621 were SNPs that are allowed to limit enrollment to a targeted beneficiary population.

Our analysis of the percentage of beneficiaries, including those enrolled in SNPs, by health group showed that 29 percent were in the good health group of plans, 55 percent in the average health group of plans, and 16 percent in the poor health group of plans. (See fig. 5.)

Figure 5: MA Beneficiaries According to Plan Health Group, 2008

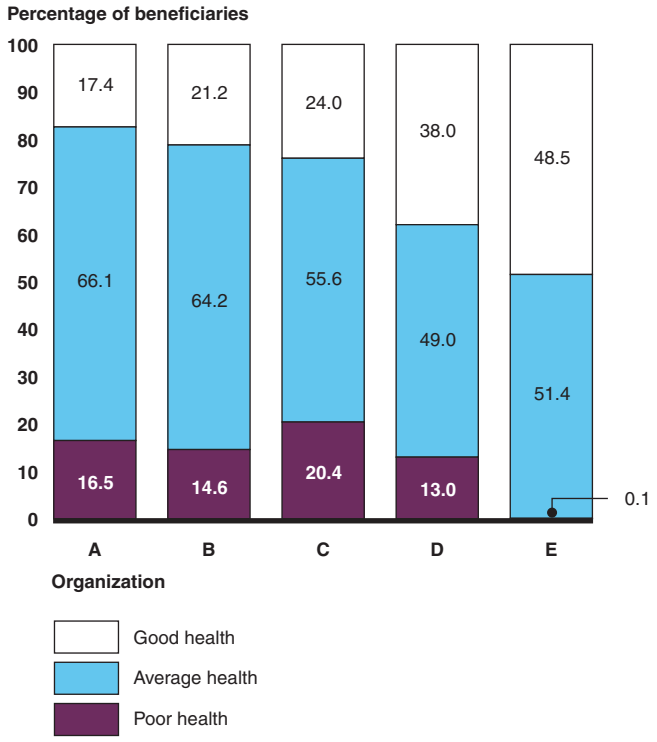


Source: GAO analysis of 2008 CMS risk score data.

Notes: Using CMS's 2008 plan-level risk score data by county, we categorized the health status of MA plans as good, average, or poor based on the average health status of their enrolled beneficiaries in the areas that they served. This analysis included 7,553,600 MA beneficiaries, of which 973,923 were enrolled in SNPs as of July 2008. SNPs are allowed to limit enrollment to a targeted beneficiary population.

Average indexed risk scores ranged from 0.90 to 1.03 for the five largest organizations in the MA program, which together accounted for nearly 50 percent of MA enrollment in 2008. The five MAOs varied in the extent to which their plans fell into the good, average, and poor beneficiary health status groups. (See fig. 6.) For example, one MAO had 17 percent of its beneficiaries in plans in the good health group and 17 percent in plans in the poor health group, while another had 49 percent of its beneficiaries in plans in the good health group and less than 1 percent in plans in the poor health group.

Figure 6: Percentage of Beneficiaries in MA Plans, by Plan Health Group, for the Five Largest MA Organizations, 2008



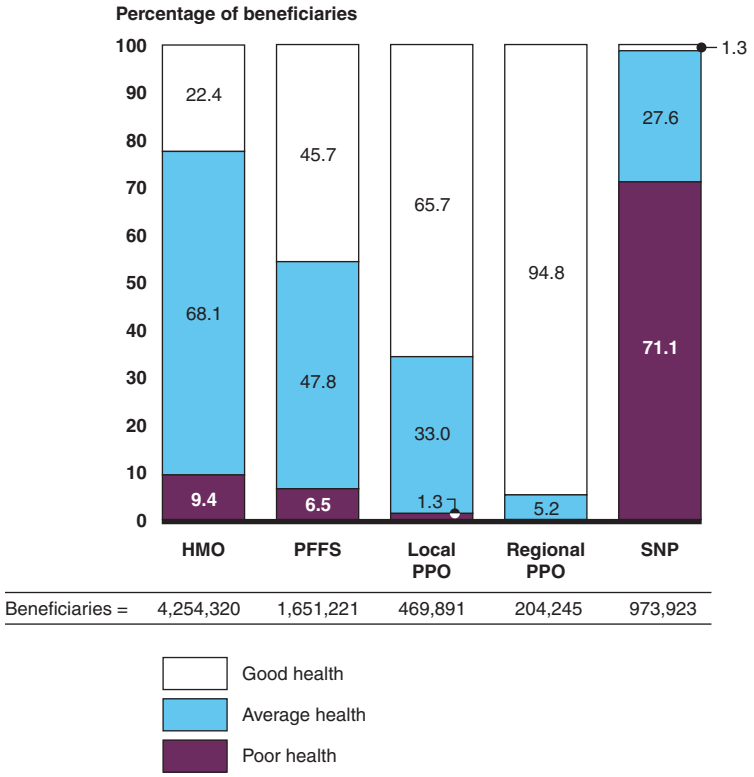
Source: GAO analysis of 2008 CMS risk score data.

Notes: Using CMS's 2008 plan-level risk score data by county, we categorized the health status of MA plans as good, average, or poor based on the average health status of their enrolled beneficiaries in the areas that they served. These five MA organizations accounted for 48 percent (3,656,396 beneficiaries) of MA enrollment, including enrollment in SNPs, as of July 2008. SNPs are allowed to limit enrollment to a targeted beneficiary population.

The four types of plans we reviewed differed as to the average health status of their beneficiaries. Excluding SNPs, regional PPOs and local PPOs had the largest percentage of beneficiaries in plans in the good health group—95 percent and 66 percent, respectively. Regional PPOs did not have any beneficiaries in the poor health group of plans and local PPOs had 1 percent of their beneficiaries in the poor health group of plans. HMOs and PFFS plans had the largest share of beneficiaries in the average health group of plans—68 percent and 48 percent of beneficiaries, respectively—and each had less than 10 percent of their beneficiaries in

the poor health group of plans.[42] (See fig. 7.) SNPs, by definition, had the largest percentage of beneficiaries (71 percent) in the poor health group of plans and had nearly all of their remaining beneficiaries in the average health group of plans.

Figure 7: Percentage of Beneficiaries in MA Plans, by Plan Health Group and Plan Type, 2008



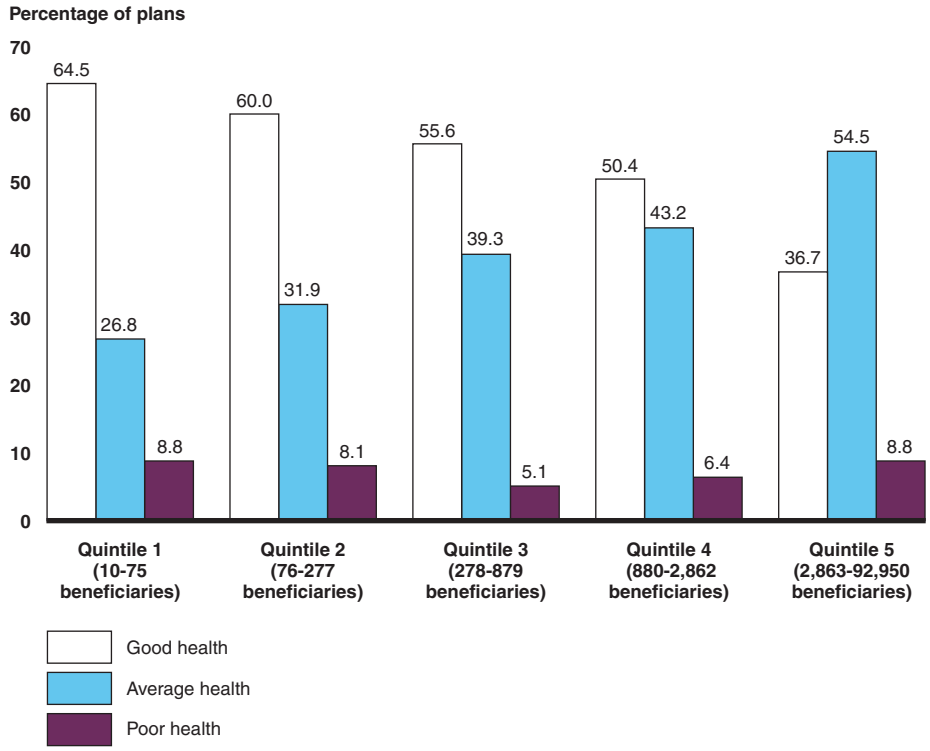
Source: GAO analysis of 2008 CMS risk score data.

Notes: Results are based on MA enrollment as of July 2008. Using CMS's 2008 plan-level risk score data by county, we categorized the health status of MA plans as good, average, or poor based on the average health status of their enrolled beneficiaries in the areas that they served. SNPs are allowed to limit enrollment to a targeted beneficiary population.

[42]In 2008, we reported that beneficiaries in PFFS plans tended to be healthier than beneficiaries in other MA plans and Medicare FFS. Specifically, projected health care expenditures for PFFS beneficiaries were 7 percent less than the projected average for beneficiaries in other MA plans and 10 percent less than the projected average for beneficiaries in Medicare FFS. See GAO, *Medicare Advantage: Characteristics, Financial Risks, and Disenrollment Rates of Beneficiaries in Private Fee-for-Service Plans*, GAO-09-25 (Washington, D.C.: Dec. 15, 2008).

Excluding SNPs, MA plans with lower enrollment were more likely to be in the good health group than plans with higher enrollment. (See fig. 8.) About two-thirds of MA plans with 10 to 75 beneficiaries were in the good health group of plans, while roughly one-third of MA plans with the largest enrollment (2,863 to 92,950 beneficiaries) were in the good health group.

Figure 8: Percentage of MA Plans, by Plan Health Group and Plan Size (excluding SNPs), 2008

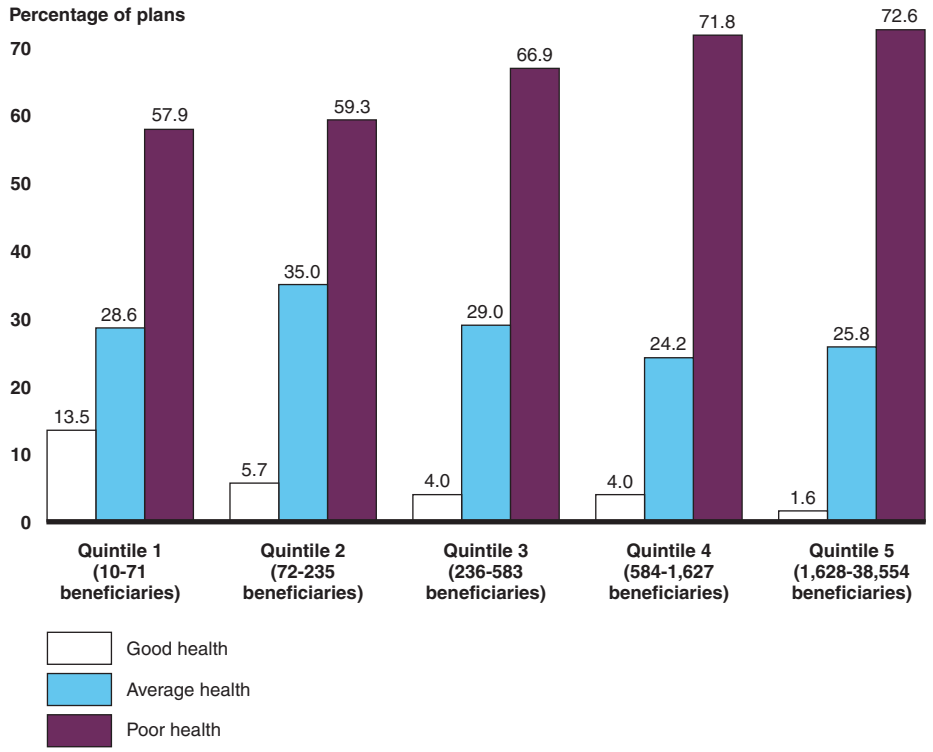


Source: GAO analysis of 2008 CMS risk score data.

Notes: Results are based on MA enrollment as of July 2008. Using CMS's 2008 plan-level risk score data by county, we categorized the health status of MA plans as good, average, or poor based on the average health status of their enrolled beneficiaries in the areas that they served. SNPs are allowed to limit enrollment to a targeted beneficiary population.

While SNPs of any plan size were most likely to have beneficiaries in the poor health group, 58 percent of the smallest SNPs were in the poor health group and 73 percent of the largest SNPs were in the poor health group. (See fig. 9.)

Figure 9: Percentage of SNPs, by Plan Health Group and Plan Size, 2008



Source: GAO analysis of 2008 CMS risk score data.

Notes: Results are based on MA enrollment as of July 2008. Using CMS's 2008 plan-level risk score data by county, we categorized the health status of MA plans as good, average, or poor based on the average health status of their enrolled beneficiaries in the areas that they served. SNPs are allowed to limit enrollment to a targeted beneficiary population.

HMOs, including SNPs, in the good health group of plans tended to be located in areas where the percentage difference between the 2008 MA payment benchmarks and estimated 2008 FFS spending was smaller.[43] MA payment benchmarks averaged 13 percent higher than estimated FFS spending in areas where HMOs in the good health group of plans were

[43]To calculate the extent to which MA payment benchmarks exceeded estimated FFS spending, we first projected 2008 FFS spending by county using 2007 estimates in the 2008 MA ratebook updated by the CMS estimate of growth in national spending for 2008. We discounted spending related to the double payment for indirect medical education payments made to teaching hospitals. We used the statutory benchmarks in our analysis of regional PPOs and did not examine the competitively set benchmark amounts.

located, but benchmarks were 16 percent higher where HMOs in the poor health group were located.[44]

CMS Recently Revised Its Process for Ensuring That MA Plan Benefit Packages Do Not Discriminate against Beneficiaries in Poor Health

For contract year 2010, CMS modified the process it used to ensure MA plan benefit packages do not discriminate against beneficiaries in poor health. The agency revised the way it determines cost-sharing thresholds used to identify benefit packages that are likely discriminatory, and as a result, some of the thresholds used in contract year 2010 reviews allowed higher cost-sharing amounts than in previous years. CMS also revised its process for contacting plans for benefit package modifications by contacting all, instead of a selection of, MA plans found to have cost sharing that exceeded CMS thresholds. For contract year 2010, all plans met cost-sharing thresholds after discussions with CMS, but if contract year 2009 thresholds were applied to the approved contract year 2010 plans, approximately 38 percent of the plans we examined would have exceeded cost-sharing thresholds.

CMS Revised the Way It Identifies Benefit Packages Likely to be Discriminatory, and Some New Review Thresholds Allowed Higher Cost Sharing

For contract year 2010, CMS modified the benefit package review process used in previous years. CMS developed a new methodology to determine cost-sharing thresholds and included actuarial equivalence tests as part of the review process. Under the new process for reviewing MA plans for the likelihood of discrimination, CMS examined plans' 2010 OOP maximums and identified MA plans with comparatively high cost-sharing amounts. Plans' OOP maximums determined the level of scrutiny the benefit packages received, with greater scrutiny given to plans with no OOP maximum or with an OOP maximum above CMS's OOP maximum threshold.[45] For selected services—those typically used by sicker beneficiaries—CMS compared plans' cost-sharing amounts with threshold amounts set relative to cost sharing for all MA plans. Benefit packages were considered likely to be discriminatory if the cost sharing for one or

[44]We did not find a relationship between an MA plan's average indexed risk score and the percent difference between MA payment benchmarks and estimated FFS spending in 2008 for the other types of MA plans included in our analysis (local PPOs, regional PPOs, or PFFS plans).

[45]For contract years 2011 and later, CMS will require local MA plans to have an OOP maximum, the amount of which would be set annually by CMS. If plans establish OOP maximums lower than the mandatory amount, they will be allowed more flexibility in establishing cost-sharing amounts for individual services. See *Fed. Reg.* 19678, 19709-19711 (2010).

more of the selected services exceeded the threshold and was higher than cost sharing for Medicare FFS.[46] For contract year 2010, the process was as follows.

- If a plan had an OOP maximum at or below the amount specified in the annual Call Letter ($3,400 for 2010),[47] CMS limited its benefit package review to cost sharing for five selected services: renal dialysis (156 sessions), Part B drugs, home health (37 visits), inpatient mental health stays (15 days), and SNF stays (42 days). MA plans were considered likely to discriminate if their cost sharing for any of these services was at or above the 95th percentile relative to the other MA plans and was greater than the cost sharing under Medicare FFS.[48]

- If a plan did not have an OOP maximum or if the OOP maximum exceeded the amount specified in the Call Letter, CMS reviewed cost sharing for 14 selected services: the 5 listed above plus inpatient hospital stays (10 days), inpatient hospital catastrophic stays (90 days), physician mental health visits, Part B chemotherapy drugs, Part B radiology, and 4 DME services—equipment, prosthetics, supplies, and diabetes tests. MA plans were considered likely to discriminate if cost sharing for any of the 14 services was at or above the 75th percentile relative to other MA plans and was greater than the cost sharing under Medicare FFS.[49]

  As part of the revised review process, in addition to determining whether MA plans' benefit packages were actuarially equivalent to Medicare FFS, CMS began reviewing MA plans' pricing data for the likelihood of discriminatory cost sharing. CMS reviewed MA plans' cost sharing for five selected services. For inpatient hospital care (including mental health), SNF stays, home health visits, DME, and Part B drugs, CMS calculated the

[46]CMS annually determines the length of stay or number of visits or sessions and the cost of certain services in order to determine whether the cost-sharing amount charged by an MA plan is potentially discriminatory.

[47]According to CMS, if a plan with a qualifying OOP maximum excluded any Medicare service from its OOP maximum, it was evaluated based on more stringent standards.

[48]For 2010, beneficiaries in Medicare FFS are charged 20 percent coinsurance for renal dialysis and Part B drugs; nothing per home health visit; $1,100 for a 15-day inpatient mental health stay; and $3,025 for a 42-day SNF stay.

[49]For 2010, beneficiaries in Medicare FFS are charged $1,100 for a 10-day inpatient hospital stay; $9,350 for a 90-day inpatient hospital catastrophic stay; 45 percent coinsurance for a physician mental health visit; and 20 percent coinsurance for Part B chemotherapy drugs, Part B radiology, and DME (including equipment, prosthetics, supplies, and diabetes tests).

difference between the plans' cost sharing and an amount that was actuarially equivalent to cost sharing under Medicare FFS. If the difference was higher than a tolerance amount—the greater of 50 cents or 5 percent of FFS cost sharing—the benefit package was identified as likely to be discriminatory and plans were instructed to modify the cost sharing in the bid pricing tool submitted to CMS.

The 2010 contract year process differs from the process for previous years in key ways. For contract years 2008 and 2009, a plan with cost sharing that exceeded CMS thresholds for one or more selected services but with an OOP maximum at or below the amount specified in CMS's Call Letter was not considered likely to be discriminatory because the OOP maximum would limit beneficiaries' OOP costs. If a plan had cost sharing for one or more selected services that exceeded the CMS thresholds and did not have an OOP maximum or if the OOP maximum was above the amount specified in the Call Letter, CMS considered the plan likely to be discriminatory.[50] In contract years 2008 and 2009, CMS generally set thresholds based on cost sharing under Medicare FFS, not at amounts that were relative to all MA plans' cost-sharing amounts. For example, for contract year 2008 CMS set the MA cost-sharing threshold for Part B drugs at 20 percent coinsurance, equivalent to that under Medicare FFS.

The methodology CMS used in contract year 2010 resulted in thresholds that allowed higher cost-sharing amounts for some services than those applicable in contract year 2009. For example, among plans without an OOP maximum or one above the amount specified in the 2010 Call Letter, the copayment allowed for a typical inpatient mental health stay doubled from $61 to $130 per day and the copayment allowed for a typical SNF stay increased from $53 to $70 per day. For other services that CMS reviewed for discriminatory cost sharing, new thresholds allowed cost-sharing amounts in contract year 2010 that were comparable or lower than those

[50]In prior years, CMS also considered MA plan stability grades that assessed whether plan cost sharing amounts differed substantially from one year to the next. According to CMS officials, these grades were implemented because beneficiaries were often unaware of plan benefit changes from one year to the next and CMS wanted to identify plans that were making significant changes to their benefit packages. However, CMS did not use the stability grades to determine if a plan was likely to be discriminatory and is not using plan stability grades in the new review process.

in contract year 2009.[51] For example, the copayment allowed for a typical inpatient hospital stay was reduced from $213 to $175 per day and the cost sharing allowed for home health visits was reduced to zero.

CMS Revised How It Selects Plans to Contact for Benefit Package Modifications; All Plans Met New Cost-Sharing Thresholds

Under the revised process, for contract year 2010 CMS contacted all MA plans identified as having benefit packages likely to be discriminatory—those that exceeded agency thresholds. In addition, all plans contacted subsequently reduced cost-sharing amounts to at or below agency thresholds. In contrast, in previous years, CMS did not contact all plans exceeding the thresholds and not all plans contacted reduced their cost-sharing amounts to equal to or below agency thresholds. In previous years, CMS's policy did not require disapproval of a plan benefit package if cost sharing was above CMS's cost-sharing thresholds.

CMS's new selection process is intended to ensure that all MA plans identified as likely to be discriminatory are contacted regarding lowering their cost sharing to meet the new thresholds. According to agency officials, of the 2,930 MA plan benefit packages submitted for contract year 2010, about 40 percent were identified as likely to be discriminatory. CMS staff contacted all of those plans about complying with cost-sharing thresholds, and all plans subsequently reduced cost-sharing amounts to at or below the new thresholds.[52] However, if CMS had applied the contract year 2009 review methodology—with its lower thresholds for certain services—to the plans submitted for contract year 2010, approximately

[51]For plan years beginning January 1, 2011, cost sharing for chemotherapy services, renal dialysis, and skilled nursing care may be no more than cost sharing in Medicare FFS. See Pub. L. No. 111-148, § 3202, _Stat._ (2010). The Part B chemotherapy drugs and renal dialysis cost-sharing thresholds for contract year 2010 were equal to the cost sharing charged in Medicare FFS. For MA plans without an OOP maximum, or with an OOP maximum above the amount specified in the 2010 Call Letter, the cost-sharing threshold for a 42-day SNF stay was less than the cost sharing charged in Medicare FFS for a Part A SNF stay. For MA plans with an OOP maximum at or below the amount specified in the 2010 Call Letter, the cost-sharing threshold for a 42-day SNF stay was $359 more than the cost sharing charged in Medicare FFS for a Part A SNF stay.

[52]Of the 1,719 MA plans included in our analysis for contract year 2010, 35 had cost sharing that appeared to exceed CMS's thresholds. Agency officials commented that these plans had extenuating circumstances or other financial protections for beneficiaries enrolled in those plans.

38 percent of the plans in our analysis would have exceeded cost-sharing thresholds.[53]

In previous years, CMS approved some MA plans that did not meet its cost-sharing thresholds. For contract years 2008 and 2009, over one in four and nearly one in three plans, respectively, had cost sharing that exceeded one or more CMS thresholds. (See table 1.) Our analysis indicated that the percentage of plans initially exceeding and remaining above one or more cost-sharing thresholds in those 2 years varied by plans' average beneficiary health status, as follows:

- Among the good health group of plans reviewed for contract year 2008, 39 percent were initially identified as having cost sharing that exceeded CMS's cost-sharing thresholds and 33 percent were approved with cost sharing that exceeded CMS's cost-sharing thresholds, a decrease of 6 percentage points. The percentage of plans in the poor health group that exceeded CMS's thresholds prior to and after plans were approved also decreased by 6 percentage points, from 20 percent to 14 percent.

- Among the good health group of plans reviewed for contract year 2009, 35 percent were initially identified as having cost sharing that exceeded CMS's cost-sharing thresholds and 29 percent were approved with cost sharing that exceeded CMS's cost-sharing thresholds, a decrease of 6 percentage points. The percentage of plans in the poor health group that exceeded CMS's thresholds prior to and after plans were approved decreased by 1 percentage point, from 38 percent to 37 percent.

[53]We analyzed data for 2,899 MA plans that were offered in contract year 2008, 2,482 MA plans that were offered again in 2009, and 1,719 MA plans that were offered again in 2010 and we maintained them in their 2008 health groups. Some plans withdrew from the MA program, were terminated, consolidated, or split into multiple plans between contract years 2008, 2009, and 2010.

Table 1: Percentage of MA Plans that Exceeded CMS Cost-Sharing Thresholds, Contract Years 2008 and 2009

Contract year 2008	Percentage of plans that initially exceeded one or more CMS thresholds	Percentage of approved plans that exceeded one or more CMS thresholds
All plans (n=2,899)	34	28
Good health plans (n=1,254)	39	33
Average health plans (n=1,068)	35	30
Poor health plans (n=577)	20	14
Contract year 2009		
All plans (n=2,482)	37	30
Good health plans (n=1,050)	35	29
Average health plans (n=912)	38	29
Poor health plans (n=520)	38	37

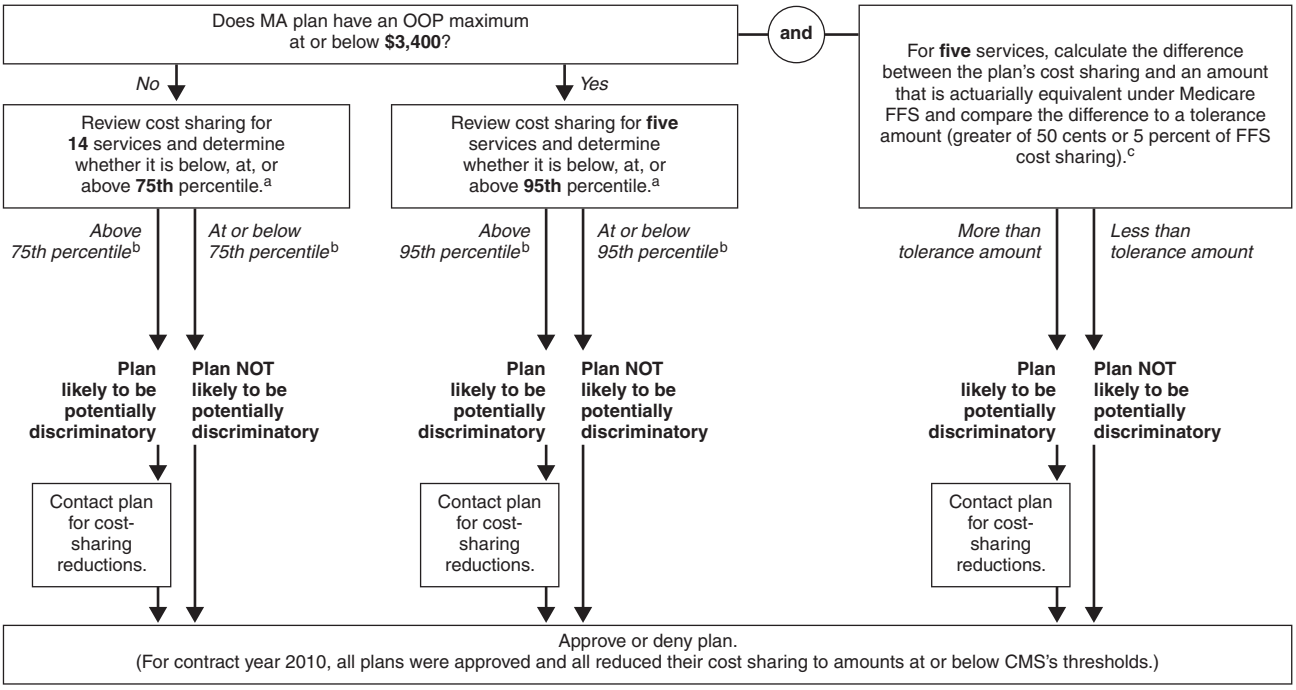
Source: GAO analysis of CMS data.

Notes: Using CMS's 2008 plan-level risk score data by county, we categorized the health status of MA plans as good, average, or poor based on the average health status of their enrolled beneficiaries in the areas that they served. The services we analyzed for contract years 2008 and 2009 included inpatient hospital stays, inpatient mental health stays, SNF stays, home health visits, renal dialysis, Part B drugs, Part B chemotherapy drugs, Part C premium, and Part C deductible. This analysis included 2,899 MA plans that were offered in 2008 and 2,482 MA plans that were offered again in 2009 and we maintained plans in their 2008 health groups.

In contract years 2008 and 2009, CMS did not contact all plans initially found to have cost sharing that exceeded one or more thresholds. CMS primarily selected plans to contact for cost-sharing reductions from among those identified as likely to be discriminatory by considering (1) the number of services for which cost sharing exceeded the CMS threshold (2) how much the plan exceeded the cost-sharing threshold, and (3) how the plan's cost sharing compared with that of other MA plans within the same service area. In addition, CMS officials told us the process used to select plans for cost-sharing discussions in these years had the potential to be subjective; decisions were based on individual reviewers' evaluations of cost sharing and judgments about how much the cost sharing exceeded CMS's thresholds. Among the plans contacted for cost-sharing reductions in these years, CMS reported that some reduced their cost-sharing amounts, but they remained above the thresholds. For example, for contract year 2008, CMS reported that nearly half of the MA plans initially identified as likely to be discriminatory reduced cost sharing as a result of being contacted by CMS.

Figures 10 and 11 show the review process for contract year 2010 and for contract years 2008 and 2009, respectively.

Figure 10: CMS's Process for Identifying Plans with Cost Sharing Likely to Be Discriminatory and Contacting Plans for Cost-Sharing Reductions, Contract Year 2010



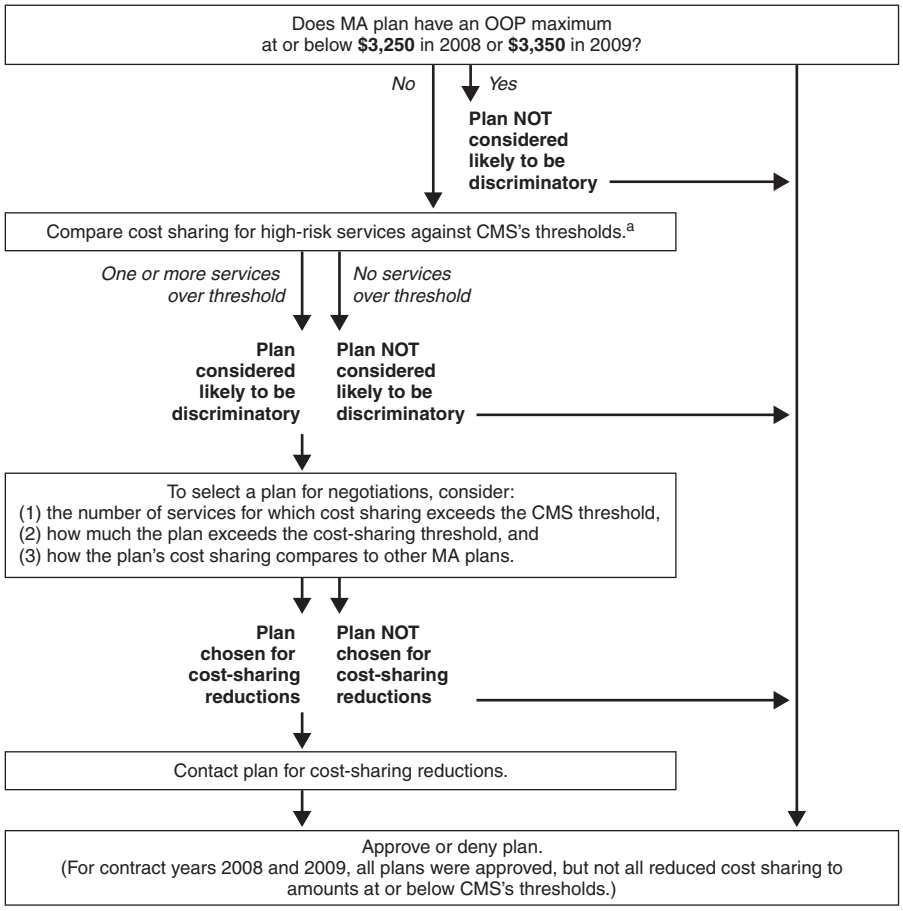
Source: GAO analysis of CMS documents and interviews.

[a]CMS reviews cost sharing for renal dialysis, Part B drugs, home health visits, inpatient mental health stays, and SNF stays if the plan has an OOP maximum at or below the amount specified in the annual Call Letter ($3,400 for contract year 2010). If the plan does not have an OOP maximum or it is above the amount specified in the annual Call Letter, CMS reviews cost sharing for the five services listed above and for inpatient hospital stays, inpatient hospital catastrophic stays, physician mental health visits, Part B chemotherapy drugs, Part B radiology, DME equipment, DME prosthetics, DME supplies, and DME diabetes tests.

[b]CMS does not consider an MA plan with cost sharing above the 75th or 95th percentile, but below Medicare FFS cost sharing, as likely to be discriminatory.

[c]CMS analyzes MA plan bid pricing data on cost sharing for inpatient hospital care (including mental health), skilled nursing facility, home health, DME, and Part B drugs.

Figure 11: CMS's Process for Identifying Plans with Cost Sharing Likely to be Discriminatory and Selecting Plans for Cost-Sharing Reductions, Contract Years 2008 and 2009



Source: GAO analysis of CMS documents and interviews.

[a]High-risk services where high cost sharing could be considered likely to be discriminatory include inpatient hospital stays, inpatient hospital catastrophic stays, inpatient mental health stays, SNF stays, home health visits, physician mental health visits, Part B drugs, Part B chemotherapy, renal dialysis, and DME cost sharing as reported in the bid pricing tool.

Agency and Other External Comments and Our Evaluation

We obtained comments on a draft of this report from CMS and America's Health Insurance Plans (AHIP), a national organization that represents private health insurance companies, including those that participate in the MA program. CMS provided written comments (see app. II) and technical comments that we incorporated where appropriate. Representatives from AHIP provided us with oral comments.

CMS Comments

CMS stated that the agency's general experience with beneficiaries—that beneficiaries select MA plans based on their individual health status—is consistent with the report's findings. CMS also noted that the report showed that plans with, on average, beneficiaries in poor health did not charge comparatively higher cost sharing. The agency believes that this is a result, in part, of CMS's efforts in ensuring that plan benefit packages are not likely to discriminate on the basis of health status.

CMS commented that the report does not mention that the agency's benefit package review process prior to contract year 2010, by design, encouraged plans to establish OOP maximums by affording them flexibility in establishing cost-sharing amounts for individual services. We believe that the third finding of the report adequately conveys that information. Figure 11 shows that plans with an OOP maximum at or below the amount specified in the Call Letter were not considered likely to be discriminatory regardless of their cost-sharing amounts for particular services. Further, CMS pointed out that its policy until 2009 did not require disapproval of a plan benefit package if cost sharing was above CMS's cost-sharing thresholds. We added this information to the report. In addition to these points, CMS described other aspects of its previous and current benefit review process for context.

CMS suggested a number of presentation modifications to the report. For example, because the agency's reviews focus on protecting vulnerable beneficiaries, CMS suggested that we present more information on the benefit packages of plans in the average or poor health group. The section of our report on benefit package designs contrasted the good health group of plans with the poor health group and the figures present information on plans in the average health group as well.

AHIP Comments

AHIP representatives stated that the report's analysis demonstrates that MAOs are offering beneficiaries the types of plans that best meet their health care needs. The findings also show that special needs plans, which target enrollment to certain vulnerable groups of Medicare beneficiaries that typically have higher health care costs, are serving the types of beneficiaries that the program intended.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the CMS Administrator and interested congressional committees. The report will also be available at no charge on the GAO Web site at http://www.gao.gov.

Should you or your staff have any questions on matters discussed in this report, please contact me at (202) 512-7114 or 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 members who made contributions to this report are listed in appendix III.

James C. Cosgrove
Director, Health Care

List of Requesters

The Honorable Henry A. Waxman
Chairman
The Honorable John D. Dingell
Chairman Emeritus
Committee on Energy and Commerce
House of Representatives

The Honorable Sander M. Levin
Chairman
Committee on Ways and Means
House of Representatives

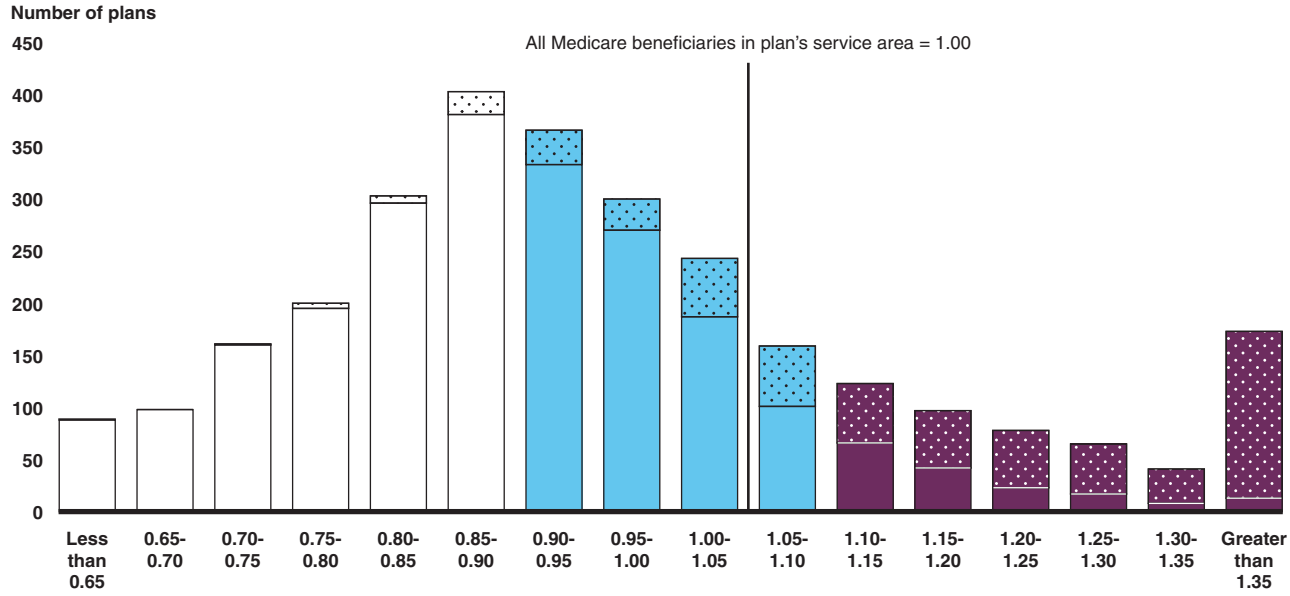
The Honorable Frank Pallone, Jr.
Chairman
Subcommittee on Health
Committee on Energy and Commerce
House of Representatives

The Honorable Pete Stark
Chairman
Subcommittee on Health
Committee on Ways and Means
House of Representatives

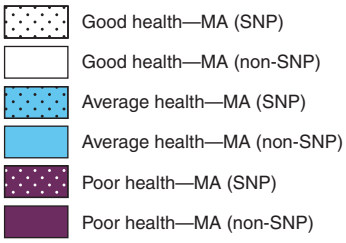
The Honorable Charles B. Rangel
House of Representatives

Appendix I: Medicare Advantage Plans and Beneficiaries by Average Indexed Risk Score and Health Group, 2008

Figure 12: Number of Medicare Advantage Plans by Average Indexed Risk Score and Health Group, 2008



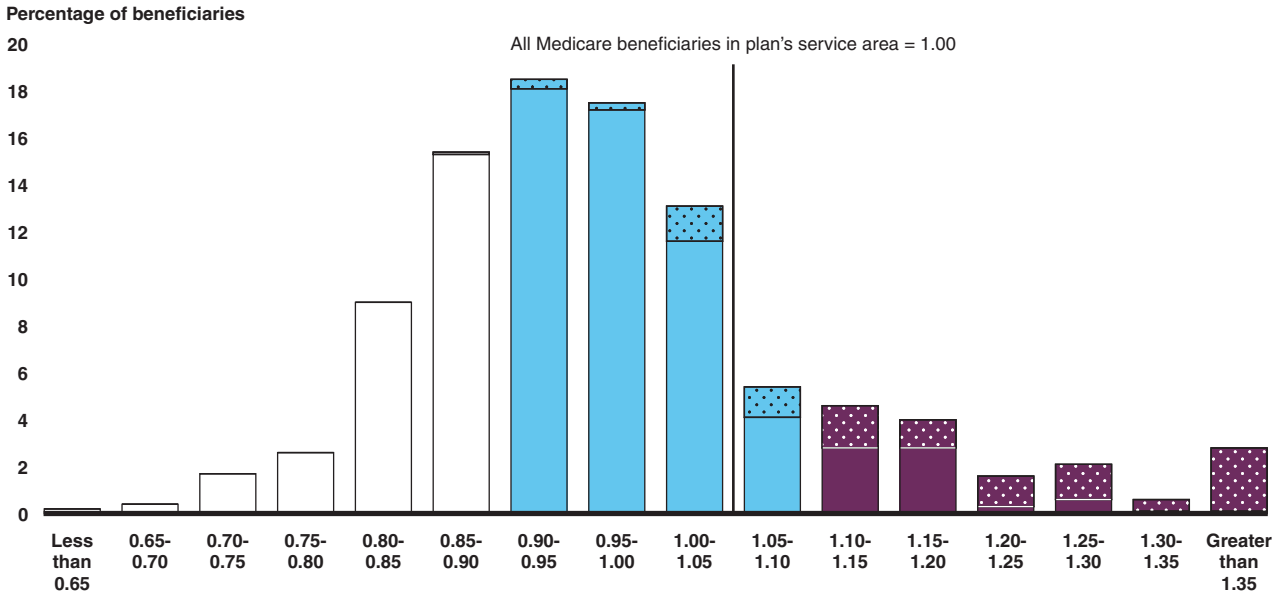
Number of plans																
MA (SNP)	1	0	1	5	7	22	33	30	56	58	57	55	55	48	33	160
MA (non-SNP)	88	98	160	195	296	381	333	270	187	101	66	42	23	17	8	13



Source: GAO analysis of 2008 CMS risk score data.

Notes: Using the Centers for Medicare & Medicaid Services (CMS) 2008 plan-level risk score data by county, we categorized the health status of Medicare Advantage plans as good, average, or poor based on the average health status of their enrolled beneficiaries in the areas that they served. This analysis included 2,899 MA plans, of which 621 were SNPs that are allowed to limit enrollment to a targeted beneficiary population.

Figure 13: Percentage of Medicare Advantage Beneficiaries by MA Plans' Average Indexed Risk Score and Health Group, 2008



Percentage of beneficiaries																
MA (SNP)	0	0	0	0	0	0.1	0.4	0.3	1.5	1.3	1.8	1.2	1.3	1.5	0.5	2.7
MA (non-SNP)	0.2	0.4	1.7	2.6	9	15.3	18.1	17.2	11.6	4.1	2.8	2.8	0.3	0.6	0.1	0.1

Good health—MA (SNP)
Good health—MA (non-SNP)
Average health—MA (SNP)
Average health—MA (non-SNP)
Poor health—MA (SNP)
Poor health—MA (non-SNP)

Source: GAO analysis of 2008 CMS risk score data.

Notes: Results are based on Medicare enrollment as of July 2008. Using CMS's 2008 plan-level risk score data by county, we categorized the health status of MA plans as good, average, or poor based on the average health status of their enrolled beneficiaries in the areas that they served. This analysis included 7,553,600 MA beneficiaries, of which 973,923 were enrolled in SNPs that are allowed to limit enrollment to a targeted beneficiary population.

Appendix II: Comments from the Centers for Medicare & Medicaid Services

DEPARTMENT OF HEALTH & HUMAN SERVICES OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

APR 07 2010

James C. Cosgrove
Director, Health Care
U.S. Government Accountability Office
441 G Street N.W.
Washington, DC 20548

Dear Mr. Cosgrove:

Enclosed are comments on the U.S. Government Accountability Office's (GAO) report entitled: "MEDICARE ADVANTAGE: Relationship Between Benefit Package Designs and Plans' Average Beneficiary Health Status" (GAO-10-403).

The Department appreciates the opportunity to review this report before its publication.

Sincerely,

Andrea Palm
Acting Assistant Secretary for Legislation

Enclosure

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: APR - 5 2010

TO: Andrea Palm
Acting Assistant Secretary for Legislation
Office of the Secretary

FROM: Charlene Frizzera
Acting Administrator

SUBJECT: Government Accountability Office (GAO) Report: "MEDICARE ADVANTAGE: Relationship Between Benefit Package Designs and Plans' Average Beneficiary Health Status" (GAO-10-403)

Thank you for the opportunity to comment on the GAO report, "MEDICARE ADVANTAGE: Relationship between Benefit Package Designs and Plans' Average Beneficiary Health Status" (GAO-10-403). The report compares the benefit packages of Medicare Advantage (MA) organizations based on enrollees' average risk scores: "good," "average," and "poor" and found that, generally, those plans with enrollees in "good" health based on their average risk scores charged lower premiums and higher cost-sharing for certain benefits and offered fewer additional benefits. In contrast, those plans with enrollees in "poor" health charged higher premiums and lower cost-sharing for certain benefits. Notably, however, the report did not determine whether MA organizations structured their plan benefit packages in response to enrolled beneficiaries' health status or whether beneficiaries of a given health status chose certain MA plans specifically because of their design. We believe that the report's findings are consistent with our general experience with beneficiaries – that beneficiaries select health plans based on their individual health status, and therefore, beneficiaries with poorer health status tend to choose plans with higher premiums and lower cost sharing, and, conversely, healthier beneficiaries choose to make lower premium payments in favor of higher cost sharing.

We find promising the conclusion that plans with beneficiaries in poor health status are not charging higher cost-sharing; we believe that this is a result, in part, of CMS' efforts to prevent MA organizations from designing benefit packages that discriminate against sicker beneficiaries and discourage them from joining their plans. We have made it a priority to protect our most vulnerable beneficiaries from being faced with choices of MA plans that discriminate against them. We examine benefits and cost sharing designs for situations in which the plan offered is designed to discourage enrollment or to charge excessively high cost-sharing after enrollment for those beneficiaries who are in poor health and more likely to use health care services. To that end, we would like to see more information presented in the report about the benefit packages of plans with enrollees in "average" and "poor" health.

Since the report describes our previous efforts to review benefits and protect beneficiaries against discriminatory plan offerings, we would like to provide additional context for CMS' benefit review efforts prior to contract year (CY) 2010. While CMS' selection of plans with possible discriminatory cost sharing was less comprehensive prior to CY 2010, and we did not contact all plans with high cost sharing issues, we did identify and negotiate with plans that had the most egregious cost sharing issues in an effort to reduce cost sharing to our target amount or as close to it as we were able to negotiate. We used a variety of factors, in addition to cost sharing values, to assess whether to contact plans to request changes in cost-sharing. The report fails to mention that, by design, we encouraged plans to establish a maximum out-of-pocket (MOOP) limit for all Medicare-covered benefits by affording them flexibility in their cost-sharing amounts for individual services.

Additionally, we determined that excessive charges for certain benefits (e.g., renal dialysis and Part B prescription drugs) were the most problematic for beneficiaries, and considered not just a plan's cost-sharing requirements, but the amount by which the plan's cost sharing exceeded the CMS target amount. Also, part of our decision to negotiate cost sharing amounts was based on how a plan's cost sharing charges compared with those of other MA plans under review in the same service area because CMS wanted to evaluate whether higher cost sharing was a market phenomenon or possible discrimination by a single plan. In many cases, although CMS negotiated cost sharing improvements, the decreases were not great enough to put plans' levels below the CMS threshold and thus CMS' impact on reducing high cost sharing is not obvious and is subject to understatement. It is also important to point out that CMS' policy until 2009 did not require disapproval of a plan benefit package if cost sharing was above the threshold.

Finally, the report correctly points out that CMS revised its methodology for identifying, reviewing and approving benefits packages for Contract Year 2010. The change in methodology included the development of standards based on outlier cost sharing analysis – higher allowable cost sharing standards for plans that offered a qualified MOOP of $3,400 and more restrictive cost sharing for plans without a qualified MOOP. The new methodology also required MA plans to adhere to CMS' cost sharing standards in order to receive approval of their bid. Therefore, given the significant differences between our processes in 2009 and 2010, we suggest that the report describe the process for these two years separately.

In addition to these thematic concerns, CMS has several general and technical comments which are attached. Again, we thank you for the opportunity to review and comment on this draft report.

Appendix III: GAO Contact and Staff Acknowledgments

Contact

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

Acknowledgments

Other contributors to this report include Rosamond Katz, Assistant Director; Elizabeth Conklin; Ba Lin; Hillary Loeffler; Kevin Milne; Elizabeth Morrison; and Kristal Vardaman.

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