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Highlights

Highlights of GAO-12-93, a report to congressional requesters

MEDICARE ADVANTAGE

Enrollment Increased from 2010 to 2011 while Premiums Decreased and Benefit Packages Were Stable

Why GAO Did This Study

Enrollment and spending in Medicare Advantage (MA) plans—the private plan alternative to the Medicare fee-for-service (FFS) program—have more than doubled since 2004. MA plans generally receive larger payments from Medicare than what these plans would require to provide the original Medicare FFS benefit package. Plans must use this additional money to reduce cost sharing, reduce premiums, and offer additional benefits. The Patient Protection and Affordable Care Act, enacted in 2010, required that the Centers for Medicare & Medicaid Services (CMS)—the agency within the Department of Health and Human Services (HHS) that administers Medicare—make changes in how Medicare pays MA plans. These changes, once fully implemented, are expected to reduce MA enrollment and payments, and lead to less generous benefit packages. GAO was asked to examine trends in MA from 2010 to 2011. This study assesses the extent to which the following changed from 2010 to 2011: (1) MA enrollment, (2) MA premiums and cost-sharing requirements, and (3) the additional benefits offered by MA plans. GAO analyzed data for the most common types of MA plans, accounting for about 71 percent of both the 11.1 million MA beneficiaries in April 2010 and the 11.8 million MA beneficiaries in April 2011. GAO used MA enrollment data to identify enrollment trends. GAO also analyzed data on MA plans' projected revenue requirements and benefit packages. GAO assessed the reliability of the data by interviewing CMS officials, conducting logic tests, and comparing results to published sources.

View GAO-12-93 or key components.
For more information, contact James Cosgrove at (202) 512-7114 or cosgrovej@gao.gov.

What GAO Found

Enrollment in the MA plans GAO analyzed increased by about 6 percent—from 7.9 million to 8.4 million beneficiaries—from April 2010 through April 2011. There was substantial variation by plan type in enrollment levels and how they changed from 2010 to 2011. Enrollment in health maintenance organizations (HMO), which account for about two-thirds of total MA enrollment in 2011, increased by about 9 percent, from about 5.2 million beneficiaries to about 5.6 million beneficiaries. Local and regional preferred provider organizations (PPO), which comprise a much smaller portion of total MA enrollment, experienced the highest percentage growth in enrollment—local PPOs increased by 38 percent and regional PPOs increased by 58 percent. In contrast, private fee-for-service (PFFS) plans experienced a 54 percent decline in enrollment, which was likely due to requirements that most PFFS plans establish provider networks beginning in 2011. Even with the increase in enrollment from April 2010 through April 2011, the number of MA plans decreased from 2,307 to 1,964, and this was due primarily to a decrease in PFFS plan offerings, from 435 plans to 239.

The average monthly premium for beneficiaries in MA plans decreased from $28 in 2010 to $24 in 2011, about a 14 percent reduction. The extent of the reduction and the premium amount varied substantially among plan types. For example, the average monthly premium for beneficiaries in PFFS plans fell from $33 in 2010 to $26 in 2011, about 21 percent, while the average monthly premium for beneficiaries in HMOs fell from $25 in 2010 to $23 in 2011, about 8 percent. In information MA plans submitted to CMS prior to the contract year, MA plans projected that their cost-sharing requirements would be about half of the level in Medicare FFS in both 2010 and 2011. In both years HMOs had the lowest cost-sharing requirements—40 to 42 percent of the Medicare FFS average, while regional PPOs had the highest cost-sharing requirements—about 76 to 77 percent of the Medicare FFS average. In addition, from 2010 to 2011, the percent of MA beneficiaries in plans with limits on beneficiaries' out-of-pocket health care costs increased from 74 percent to 100 percent. This increase is not surprising given that, effective in 2011, CMS requires all MA plans to have such limits, called out-of-pocket maximums. In contrast, Medicare FFS does not have an out-of-pocket maximum.

MA beneficiaries generally received coverage for additional benefits at similar levels in 2010 and 2011. For example, at least 64 percent of beneficiaries were in plans providing benefits such as hearing and vision in both 2010 and 2011. There were some changes, however, in the percentage of beneficiaries with certain benefits. For example, the percentage of MA beneficiaries with coverage for vision services decreased from 84 percent to 79 percent, while the percentage of MA beneficiaries with outpatient blood benefits beyond what Medicare FFS covers increased from 87 to 91 percent.

GAO obtained comments on a draft of this report from HHS.