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MEDICARE ADVANTAGE

Higher Spending Relative to Medicare Fee-for-Service May Not Ensure Lower Out-of-Pocket Costs for Beneficiaries

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Highlights

Highlights of GAO-08-522T, a testimony before the Subcommittee on Health, Committee on Ways and Means, House of Representatives

Why GAO Did This Study

Although private health plans were originally envisioned in the 1980s as a potential source of Medicare savings, such plans have generally increased program spending. In 2006, Medicare paid $59 billion to Medicare Advantage (MA) plans—an estimated $7.1 billion more than Medicare would have spent if MA beneficiaries had received care in Medicare fee-for-service (FFS).

MA plans receive a per member per month (PMPM) payment to provide services covered under Medicare FFS. Almost all MA plans receive an additional Medicare payment, known as a rebate. Plans use rebates and sometimes additional beneficiary premiums to fund benefits not covered under Medicare fee-for-service; reduce premiums; or reduce beneficiary cost sharing. In 2007, MA plans received about $8.3 billion in rebate payments.

This testimony is based on GAO's report, *Medicare Advantage: Increased Spending Relative to Medicare Fee-for-Service May Not Always Reduce Beneficiary Out-of-Pocket Costs* (GAO-08-359, February 2008). For this testimony, GAO examined MA plans' (1) projected allocation of rebates, (2) projected cost sharing, and (3) projected revenues and expenses. GAO used 2007 data on MA plans' projected revenues and covered benefits, accounting for 71 percent of beneficiaries in MA plans.

To view the full product, including the scope and methodology, click on GAO-08-522T. For more information, contact James Cosgrove at (202) 512-7114 or cosgrove@gao.gov.

What GAO Found

GAO found that MA plans projected they would use their rebates primarily to reduce cost sharing, with relatively little of their rebates projected to be spent on additional benefits. Nearly all plans—91 percent of the 2,055 plans in the study—received a rebate. Of the average rebate payment of $87 PMPM, plans projected they would allocate about $78 PMPM (89 percent) to reduced cost sharing and reduced premiums and $10 PMPM (11 percent) to additional benefits. The average projected PMPM costs of specific additional benefits across all MA plans ranged from $0.11 PMPM for international outpatient emergency services to $4 PMPM for dental care.

While MA plans projected that, on average, beneficiaries in their plans would have cost sharing that was 42 percent of Medicare FFS cost-sharing estimates, some beneficiaries could have higher cost sharing for certain service categories. For example, some plans projected that their beneficiaries would have higher cost sharing, on average, for home health services and inpatient stays, than in Medicare FFS. If beneficiaries frequently used these services that required higher cost sharing than Medicare FFS, it was possible that their overall cost sharing was higher than what they would have paid under Medicare FFS.

Out of total revenues of $783 PMPM, on average, MA plans projected that they would allocate about 87 percent ($683 PMPM) to medical expenses. MA plans projected they would allocate, on average, about 9 percent of total revenue ($71 PMPM) to nonmedical expenses, including administration and marketing expenses; and about 4 percent ($30 PMPM) to the plans' profits. About 30 percent of beneficiaries were enrolled in plans that projected they would allocate less than 85 percent of their revenues to medical expenses.

As GAO concluded in its report, whether the value that MA beneficiaries receive in the form of reduced cost sharing, lower premiums, and additional benefits is worth the additional cost to Medicare is a decision for policymakers. However, if the policy objective is to subsidize health care costs of low-income Medicare beneficiaries, it may be more efficient to directly target subsidies to a defined low-income population than to subsidize premiums and cost sharing for all MA beneficiaries, including those who are well off. As Congress considers the design and cost of MA, it will be important for policymakers to balance the needs of beneficiaries and the necessity of addressing Medicare's long-term financial health.