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United States Government Accountability Office
Washington, DC 20548

December 8, 2008

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

Subject: *Medicare Advantage Organizations: Actual Expenses and Profits Compared to Projections for 2006*

Dear Mr. Chairman:

The federal government's spending on the Medicare Advantage (MA) program has grown substantially in recent years, from approximately $60 billion in 2006 and $77 billion in 2007 to an estimated $91 billion in 2008.[1] MA organizations provide health care coverage to Medicare beneficiaries through private health plans, thus offering an alternative to the original Medicare fee-for-service (FFS) program.[2] Payments to MA organizations are, in part, based on the projected expenditures organizations submit in their bids for providing Medicare-covered services, as well as actual enrollment and beneficiary health status. Once Medicare payments are determined, they are not modified based on differences between actual and projected expenses.[3] MA organizations are not required to submit claims data to the Centers for Medicare & Medicaid Services (CMS)—the agency that administers Medicare—but they must report actual expenditures for the year 2 years prior to the upcoming contract year. For example, MA organizations reported their actual 2006 expenditures in their bid submission for contract year 2008. When MA organizations submit their bids, the actual expenditures reported in their bid submissions reflect the MA organizations' most recent full calendar year of actual expenditure data.

[1]Statement of Peter R. Orszag, Congressional Budget Office, *The Medicare Advantage Program: Enrollment Trends and Budgetary Effects*, testimony before the Senate Committee on Finance, April 11, 2007.

[2]Medicare is the federally financed health insurance program for persons aged 65 and over, certain individuals with disabilities, and individuals with end-stage renal disease. Medicare Part A covers hospital and other inpatient stays. Medicare Part B is optional insurance, and covers hospital outpatient, physician, and other services. Medicare Parts A and B are known as original Medicare or Medicare FFS. Medicare beneficiaries have the option of obtaining coverage for Medicare Parts A and B services from private health plans that participate in Medicare's MA program—also known as Medicare Part C. All Medicare beneficiaries are eligible for coverage for outpatient prescription drugs under Medicare Part D.

[3]However, payments to MA organizations may be modified based on differences in actual and projected beneficiary health status, beneficiary residence, and enrollment. Actual expenses may be used to inform projections for future contract years.

In June 2008, we reported that for 2005, MA organizations generally spent less on medical expenses and earned more profits than projected.[4] MA organizations' self-reported actual profit margin was approximately 5 percent of total revenue, on average, which was approximately $1.1 billion more in 2005 than MA organizations had projected.

The accuracy of MA organizations' projections is important because, in addition to determining Medicare payments, these projections also affect the extent to which MA beneficiaries receive additional benefits not provided under FFS and the amounts beneficiaries pay in cost sharing and premiums. For example, if MA organizations had more accurately projected their revenues and expenses in 2005, they would have been able to provide beneficiaries with additional benefits or cost-sharing reductions, and still maintain the level of profits projected.

This report responds to your request for updated information on the accuracy of MA organizations' projections. Specifically, this report compares MA organizations' 2006 actual medical expenses, non-medical expenses, and profits to projections for the same year, and compares 2006 results to 2005 results. When we requested data from CMS, 2006 was the most recent year for which data were available.

To report MA organizations' actual expenditures, actual profits and projections for 2006, we analyzed the two-year look-back form that MA organizations submitted in 2007 to CMS with the 2008 Bid Pricing Tool.[5] The 2008 two-year look-back form contains MA organizations' self-reported actual medical expenses, non-medical expenses, and profits for 2006, in addition to the projections for 2006 the organizations submitted in 2005.[6] MA organizations submit a single two-year look-back form for each of their contracts, which may include more than one health benefit plan. We excluded employer group health plans because these plans are not open to the general Medicare population, and actual and projected expenses are calculated differently than for other plans. We also excluded small contracts, defined as those with fewer than 24,000 "member months" (equivalent to 2,000 beneficiaries enrolled for a full year), because CMS officials stated they do not consider data from these contracts to be fully credible.[7] Additionally, we excluded two contracts for which actual or projected expenditures were missing. After all exclusions, our analysis included 224 contracts, representing about 57 percent of the contracts for which a two-year look-back form was submitted and about

[4]See GAO, *Medicare Advantage Organizations: Actual Expenses and Profits Compared to Projections for 2005*, GAO-08-827R (Washington, D.C.: June 24, 2008). Prior to 2006, private health plans provided health coverage to Medicare beneficiaries through the Medicare + Choice program. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 renamed that program "Medicare Advantage" among other changes. Pub. L. No. 108-173, § 201, 117 Stat. 2066, 2176. Organizations were required to begin using the new program name in 2006, but CMS encouraged MA organizations to transition to "Medicare Advantage" in all plan materials for the 2005 contract year.

[5]MA organizations are required to submit bids annually for review and approval for each plan they intend to offer. The bid submission includes a Bid Pricing Tool, which contains MA organizations' projections of their revenue requirements and revenue sources.

[6]The two-year look-back form is so named because it provides data for the calendar year 2 years prior to the upcoming contract year. The two-year look-back form was not certified by the MA plan's actuary in 2008.

[7]"Member months" is the sum of a given contract's total monthly enrollments in a year. For example, if 1,500 members were enrolled in an organization's plan for January and February and 2,000 members were enrolled in its plans for March through December, the contract would have 23,000 member months. Contracts with relatively low enrollments are not credible because their expenses can be unduly affected by outlier cases.

84 percent of MA enrollment, equivalent to approximately 5.6 million beneficiaries enrolled in contracted plans for a full year. Within our sample of contracts, we analyzed data for three different plan types: Health Maintenance Organizations (HMO), Private Fee-for-Service (PFFS) plans, and Preferred Provider Organizations (PPO).[8] These plan types account for 82 percent of enrollment and 55 percent of contracts for which a two-year look-back form was submitted. To determine actual and projected expenses and profits for 2005 and 2006, we multiplied both actual and projected per member per month expenses and profits by actual enrollment in member months for that year. To compute average actual and projected expenses and profits as a percentage of revenue, we weighted each MA organization's percentage by its total revenue. This approach differs slightly from the enrollment weighting approach we used in our June 2008 report, although the two approaches yield nearly identical results. The percentages reported in our June 2008 report are included in the background section. Results are reported for the specific contract year and may not be representative of or generalizable to other contract years.

We interviewed officials at CMS about data reliability and reviewed all data for reasonableness and consistency; while we did not independently audit MA organizations' self-reported data, we were able to determine that the data were sufficiently reliable for our purposes. We conducted this performance audit from October 2008 to November 2008, 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 and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Results in Brief

On average, MA organizations reported earning profits of 6.6 percent of total revenue in 2006—which was higher than their projected profits of 4.1 percent. MA organizations reported spending an average of 83.3 percent of total revenue on medical expenses, but had projected spending an average of 86.9 percent of total revenue on those expenses. More than half of beneficiaries were enrolled in health benefits plans offered by MA organizations for which profits as a percentage of revenue were greater than projected and the combined medical and non-medical expenses as a percentage of revenue were lower than projected. Among the three types of MA health plans with the largest enrollments—HMOs, PPOs, and PFFS plans—there was a consistent pattern of actual profits being higher than projected and medical expenses being lower than projected. Projections of profits were closer to actual profits as a percentage of revenue in 2006 (2.5 percentage points difference) than they were in 2005 (3.2 percentage points difference). However, largely due to an approximate 40 percent increase in enrollment between the 2 years, the actual dollar amount of the difference between actual and projected profits increased from $1.1 billion in 2005 to $1.3 billion in 2006.

[8]While each contract may include more than one health benefit plan, each contract is designated as having only one plan type. Beneficiaries in HMOs are generally restricted to seeing providers within a network, while PFFS beneficiaries can see any provider that accepts the plan's payment terms. Beneficiaries in PPOs can see both in-network and out-of-network providers but must pay higher cost-sharing amounts if they use out-of-network services. We did not include regional PPOs in the PPO category.

In commenting on a draft of our report, CMS stated that it agreed with our findings. In addition, CMS stated that the small difference between MA organizations' actual and projected aggregate medical expenses was within the prevailing range of such differences for a 1-year-ahead estimate. CMS further noted that MA organizations' higher-than-projected profits were due primarily to higher-than-projected revenues from Medicare. As we stated in our report, however, if MA organizations had more accurately projected both their revenues and expenses, they would have been able to provide beneficiaries with additional benefits or cost-sharing reductions, and still maintain the level of profits projected.

Background

Organizations that participate in Medicare's program for private health plans have been required to submit projections of their expenses and profits to CMS since the 1980s.[9] Beginning in 2006, MA organizations have been required to submit bids to CMS that reflect their projected revenue requirements for the medical expenses, non-medical expenses, and profit margin associated with offering the same benefits available in the FFS program.[10] Medicare pays an MA organization an amount per member per month based on the relationship between the organization's bid and an administratively set rate known as a benchmark. Benchmarks are the maximum amount Medicare will pay an organization to serve an average beneficiary, and while they vary by county, every county in the United States had a benchmark that was at least as high as the average spending per member per month for all FFS Medicare enrollees in that county. If an MA organization's bid is higher than the benchmark, Medicare pays the organization the amount of the benchmark, and the organization must charge beneficiaries a premium to collect the amount by which the bid exceeds the benchmark. If an MA organization's bid is lower than the benchmark, the organization receives the amount of the bid plus additional payments, known as rebates, equal to 75 percent of the difference between the benchmark and the bid.[11] MA organizations are required to spend their rebates on additional benefits, reduced cost sharing, reduced premiums, or a combination of the three.

In June 2008, we reported that for 2005, on average, MA organizations reported that they spent less on medical expenses and earned more profits than projected.[12] MA organizations, on average, reported spending 85.7 percent of total revenue on medical expenses in 2005, but had projected medical expenditures of 90.2 percent of total revenue. On average, MA organizations' self-reported actual profit margin was 5.1 percent of total revenue compared to a projected profit margin of 1.8 percent of total revenue, which is approximately $1.1 billion more in 2005 than MA organizations had projected.[13] In commenting on a draft of that report, CMS stated that the finding was not relevant to assessment of the MA program because the

[9]Before July 1, 2001, CMS was known as the Health Care Financing Administration.

[10]Profits or profit margins refer to MA organizations' remaining revenue after medical and non-medical expenses are paid. Profits may include other revenue offsets that are not captured in the non-medical expenses category, such as income taxes. In certain circumstances, such as for new market entrants, CMS allows MA organizations to have a negative profit, meaning that the organization's revenue is less than its combined medical and non-medical expenses.

[11]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).

[12]GAO-08-827R.

[13]There were several large outlier contracts whose relatively large difference between actual and projected profits made up more than half of the $1.1 billion difference.

payment system in 2005 was different from the current competitive bidding process, which took effect in 2006. CMS stated that the competitive bidding model brought market discipline to the Medicare program, and consisted of a rigorous system of actuarial bid submissions that were subject to careful review by the Office of the Actuary at CMS.

Profits and Non-Medical Expenses Were Higher While Medical Expenses Were Lower Than Projected, on Average

MA organizations' self-reported profits and non-medical expenses were, on average, higher in 2006 than they had projected, while medical expenses were lower than projected. Specifically, MA organizations reported, on average, earning profits of 6.6 percent of total revenue in 2006—which was higher than their projected profits of 4.1 percent. Actual non-medical expenses (10.1 percent of total revenue) were higher than projected (9.0 percent of total revenue) as well. MA organizations reported spending an average of 83.3 percent of total revenue on medical expenses, but had projected spending an average of 86.9 percent of total revenue on those expenses.

MA organizations included in our analysis received $1.7 billion more in revenues than projected, based on the actual number of enrolled beneficiaries.[14] CMS officials stated that changes in the mix and health status of projected versus actually enrolled beneficiaries may have produced differences between actual expenditures and projections. That is, MA organizations received higher-than-projected revenues because Medicare paid additional amounts to compensate for enrollees who were deemed potentially more costly because of their health status,[15] who were disproportionately from counties with higher benchmarks, who were disproportionately enrolled in more expensive plans, or a combination of the three. The MA organizations' aggregate data show, however, that the increased payments were not accompanied by commensurately higher-than-projected expenses. MA organizations self-reported spending slightly less on medical expenses ($42.2 billion) than the amount projected ($42.5 billion), and slightly more on non-medical expenses ($5.1 billion) than the amount projected ($4.4 billion). Overall, actual expenses ($47.3 billion) were about the same as projected ($46.9 billion). Consequently, MA organizations earned $1.3 billion more in profits than projected in 2006. (See table 1.)

[14]To adjust for any misestimates of the number of enrolled beneficiaries, we multiplied both actual and projected per member per month revenues and profits by actual 2006 enrollment.

[15]CMS assigns Medicare enrollees a health status score based on their diagnoses and demographic characteristics. MA organizations are paid more for beneficiaries who are expected to need more care or more expensive care.

Table 1: Actual and Projected Medical Expenses, Non-Medical Expenses, and Profits as Amounts and Percentages of Revenue, 2006

	Actual			Projected		
	Percentage of revenue	Amount in dollars per beneficiary	Amount in dollars (billions)	Percentage of revenue	Amount in dollars per beneficiary	Amount in dollars (billions)
Medical expenses[a]	83.3	7,551.38	42.15	86.9	7,614.39	42.51
Non-medical expenses	10.1	913.59	5.10	9.0	785.72	4.39
Profits	6.6	601.79	3.36	4.1	363.13	2.03
Total Revenue[b]		**9,066.76**	**50.61**		**8,763.24**	**48.92**

Source: CMS.

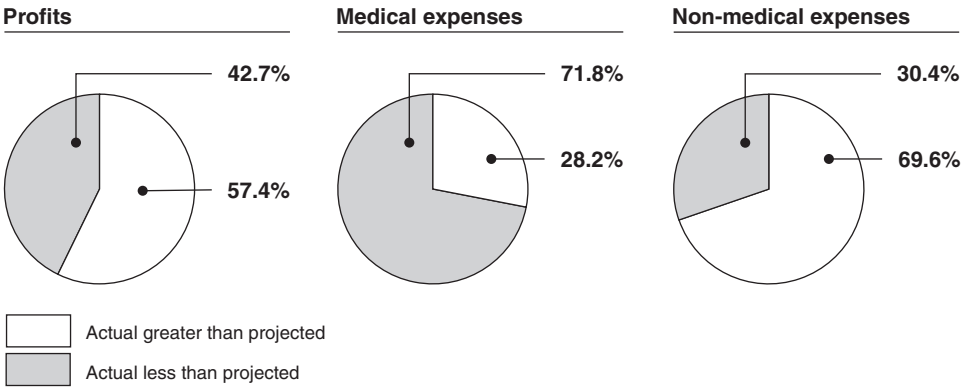
Notes: Data on actual expenses and profits were self-reported by MA organizations. Percentages are weighted total revenue. Percentage totals may add to less than 100 due to rounding. We excluded from our analysis employer group health plans and contracts for which revenue projections or actual expenditures were not reported. We also excluded from our analysis contracts that had fewer than 24,000 member months, which is equivalent to 2,000 beneficiaries enrolled for a full year. The analysis includes 224 contracts, representing about 57 percent of the contracts for which a two-year look-back form was submitted and about 84 percent of MA enrollment, equivalent to approximately 5.6 million beneficiaries enrolled in contracted plans for a full year.

[a]A CMS official we spoke with stated that medical expenses as a percentage of revenue may vary for reasons other than utilization and cost of providing care. Some MA organizations, for example, may categorize the costs of delivering care management services as medical expenses, while other MA organizations may classify these as non-medical expenses.

[b]A CMS official we spoke with stated that revenues were higher than projected because MA organizations received additional payments to compensate for enrollees who were potentially more costly because of severity of illness, were disproportionately from counties with higher benchmarks, were disproportionately enrolled in more expensive plans, or a combination of the three.

More than half of beneficiaries were enrolled in health benefits plans offered by MA organizations for which actual profits were greater than projections as a percentage of revenue. More than two-thirds of beneficiaries were enrolled in health benefit plans for which actual medical expenses were less than projections as a percentage of revenue. In contrast, more than two-thirds of beneficiaries were enrolled in plans for which actual non-medical expenses were greater than projections as a percentage of revenue. (See fig. 1.)

Figure 1: Percentage of Beneficiaries Covered by MA Organizations with Reported Expenses and Profits as a Percentage of Revenue That Were Greater Than or Less Than Projections, 2006



Source: CMS.

Notes: Data on actual expenses and profits were self-reported by MA organizations. Percentage totals may add to more than 100 due to rounding. We used member months as our measure of beneficiary enrollment. Twelve member months is equivalent to one beneficiary enrolled in a contracted plan for a full year. We excluded from our analysis employer group health plans and contracts for which revenue projections or actual expenditures were not reported. We also excluded from our analysis contracts that had fewer than 24,000 member months, which is equivalent to 2,000 beneficiaries enrolled for a full year. The analysis includes 224 contracts, representing about 57 percent of the contracts for which a two-year look-back form was submitted and about 84 percent of MA enrollment, equivalent to approximately 5.6 million beneficiaries enrolled in contracted plans for a full year.

Among the three types of MA health plans with the largest enrollments—HMOs, PPOs, and PFFS plans—there was a consistent pattern of actual profits being higher than projected and medical expenses being lower than projected. On average, HMO plans reported the largest profit margin as a percentage of total revenue (7.2 percent) whereas PFFS plans reported the smallest (3.1 percent). (See table 2.) PPO plans reported spending the highest percentage of total revenue on medical expenses (85.5 percent) while PFFS plans reported the smallest (81.3 percent). PFFS plans reported spending 15.6 percent of total revenue on non-medical expenses, more than HMO plans (9.4 percent) or PPO plans (10.5 percent) and more than 50 percent greater than what they projected.

Table 2: Actual and Projected Medical Expenses, Non-Medical Expenses, and Profits as Amounts and Percentages of Revenue among HMOs, PPOs, and PFFS, 2006

	Actual		Projected		Difference between actual and projected	
	Percentage of revenue	Amount in dollars (billions)	Percentage of revenue	Amount in dollars (billions)	Percentage of revenue	Amount in dollars (billions)
HMOs						
Contracts = 165						
Beneficiaries = 4,606,255						
Medical expenses[a]	83.4	35.74	86.8	35.57	-3.4	0.18
Non-medical expenses	9.4	4.01	8.7	3.58	0.6	0.42
Profits	7.2	3.10	4.4	1.82	2.8	1.28
PPOs						
Contracts = 42						
Beneficiaries = 238,258						
Medical expenses[a]	85.5	1.83	88.0	1.94	-2.5	-0.11
Non-medical expenses	10.5	0.23	9.4	0.21	1.2	0.02
Profits	4.0	0.08	2.7	0.06	1.3	0.03
PFFS						
Contracts = 10						
Beneficiaries = 635,126						
Medical expenses[a]	81.3	3.86	87.7	4.23	-6.4	-0.37
Non-medical expenses	15.6	0.74	10.0	0.48	5.6	0.26
Profits	3.1	0.15	2.3	0.11	0.8	0.04

Source: CMS.

Notes: Data on actual expenses and profits were self-reported by MA organizations. Percentages are weighted by total revenue. Percentage totals may add to more or less than 100 due to rounding. We did not include regional PPOs in the PPO category. We excluded from our analysis employer group health plans and contracts for which revenue projections or actual expenditures were not reported. We also excluded from our analysis contracts that had fewer than 24,000 member months, which is equivalent to 2,000 beneficiaries enrolled for a full year. We reported enrollment by plan type in terms of the number of beneficiaries; each beneficiary is equivalent to 12 member months. The analysis includes 217 contracts, representing about 55 percent of the contracts for which a two-year look-back form was submitted and about 82 percent of MA enrollment, equivalent to approximately 5.5 million beneficiaries enrolled in contracted plans for a full year.

[a]A CMS official we spoke with stated that medical expenses as a percentage of revenue may vary for reasons other than utilization and cost of providing care. Some MA organizations, for example, may categorize the costs of care management services as medical expenses, while other MA organizations may classify these as non-medical expenses.

In 2006, MA organizations had greater profits as a percentage of revenue (6.6 percent) than in 2005 (5.0 percent).[16] (See table 3.) Although the increase in profits as a percentage of revenue from 2005 to 2006 was only 1.6 percentage points, MA organizations' aggregate profits nearly doubled from 2005 to 2006. The increase was largely driven by the approximate 40 percent increase in enrollment between the 2 years.

Table 3: Actual Medical Expenses, Non-Medical Expenses, and Profits as Amounts and Percentages of Revenue, 2005 and 2006

	2005			2006		
	Percentage of revenue	Amount in dollars per beneficiary	Amount in dollars (billions)	Percentage of revenue	Amount in dollars per beneficiary	Amount in dollars (billions)
Medical expenses[a]	85.9	7,749.66	30.06	83.3	7,551.38	42.15
Non-medical expenses	9.2	827.72	3.21	10.1	913.59	5.10
Profits	5.0	448.12	1.74	6.6	601.79	3.36
Total Revenue		**9,025.50**	**35.01**		**9,066.76**	**50.61**

Source: CMS.

Notes: Data on actual expenses and profits were self-reported by MA organizations. Percentages for 2005 and 2006 are weighted by 2005 and 2006 total revenue, respectively. Percentage totals may add to more than 100 due to rounding. We excluded from our analysis employer group health plans and contracts for which revenue projections or actual expenditures were not reported. We also excluded from our analysis contracts that had fewer than 24,000 member months, which is equivalent to 2,000 beneficiaries enrolled for a full year. The 2005 analysis includes 120 contracts, representing about 81 percent of the contracts for which a two-year look-back form was submitted and about 78 percent of MA enrollment, equivalent to approximately 3.9 million beneficiaries enrolled in contracted plans for a full year. The 2006 analysis includes 224 contracts, representing about 57 percent of the contracts for which a two-year look-back form was submitted and about 84 percent of MA enrollment, equivalent to approximately 5.6 million beneficiaries enrolled in contracted plans for a full year.

[a]A CMS official we spoke with stated that medical expenses as a percentage of revenue may vary for reasons other than utilization and cost of providing care. Some MA organizations, for example, may categorize the costs of delivering care management services as medical expenses, while other MA organizations may classify these as non-medical expenses.

MA organizations in aggregate earned $1.3 billion more in profits than projected in 2006, compared to $1.1 billion more in profits than projected in 2005. While the difference between actual and projected profits as a percentage of revenue in 2006 (2.5 percentage points) was less than the difference in 2005 (3.2 percentage points), the total difference between actual and projected profits was greater because of enrollment growth. The median amount of actual profits earned above projections per contract was approximately $1.7 million in 2006, compared to the 2005 median of $2.8 million actual profits above projected.[17]

[16]Under the payment system in 2005, MA organizations were paid an administrative set rate regardless of their projections. If an MA organization's projection was less than the administratively set rate, the organization was required to spend the surplus Medicare payment on beneficiaries by adding extra benefits, reducing beneficiary cost sharing, or contributing to a benefit stabilization fund.

[17]In an ordered set of values, the median is a value below and above which there is an equal number of values; if there is no one middle number, it is the arithmetic mean (average) of the two middle values.

Agency Comments

In commenting on a draft of our report, CMS stated that it agreed with our findings. In addition, CMS stated that the small difference between MA organizations' actual and projected aggregate medical expenses was within the prevailing range of such differences for a one-year-ahead estimate. CMS further noted that MA organizations' higher-than-projected profits were due primarily to higher-than-projected revenues from Medicare, and that the increase in revenues was at least partially due to higher-than-projected risk scores, reflecting enrollees who were deemed potentially more costly because of their health status.

We stated in our report that MA organizations self-reported spending only slightly less on medical expenses than projected; however, they received $1.7 billion more in revenues than projected. If MA organizations had more accurately projected both their revenues and expenses, they would have been able to provide beneficiaries with additional benefits or cost-sharing reductions, and still maintain the level of profits projected.

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

If you or your staff have any questions regarding 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. Christine Brudevold, Assistant Director; Gregory Giusto; Dan Lee; and Jessica T. Lee were major contributors to this report.

Sincerely yours,

James C. Cosgrove
Director, Health Care

Enclosure

Enclosure I

Comments from the Centers for Medicare & Medicaid Services

DEPARTMENT OF HEALTH & HUMAN SERVICES OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

DEC 02 2008

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

Dear Mr. Cosgrove:

Enclosed are the Department's comments on the U.S. Government Accountability Office's (GAO) draft report entitled: "Medicare Advantage Organizations: Actual Expenses and Profits Compared to Projections" (GAO 09-132R).

The Department appreciates the opportunity to comment on this draft report before its publication.

Sincerely,

Jennifer R. Luong for
Vincent J. Ventimiglia, Jr.
Assistant Secretary for Legislation

Attachment

Enclosure I

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

DATE: DEC 0 2 2008

TO: Vincent J. Ventimiglia, Jr.
Assistant Secretary for Legislation
Department of Health and Human Services

FROM: Kerry Weems
Acting Administrator

SUBJECT: Government Accountability Office (GAO) Draft Correspondence: "Medicare Advantage Organizations: Actual Expenses and Profits Compared to Projections" (GAO-09-132R)

Thank you for the opportunity to review and comment on the GAO correspondence entitled, "Draft Correspondence: Medicare Advantage Organizations: Actual Expenses and Profits Compared to Projections." While CMS agrees with the findings set forth in this draft report, we have one comment.

As illustrated in Table 1, the aggregate actual medical expenses were within one percent of projected. The very small difference shown in this comparison is significant because of the inherent variability in medical trends and difficulty in forecasting medical spending—the result is well within the prevailing range of such differences for a one-year-ahead estimate. Further, it appears that the primary reason actual profit margins were higher than projected is that plans received greater revenue than projected. Projections of plan revenue, which are included in plan bids, were based in part on projected risk scores, which were lower than the subsequent actual risk scores. Since actual risk scores were greater than projected, plans received greater revenue than projected based on these risk scores.

Again, CMS appreciates the opportunity to review and comment on this draft report.

(290729)

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