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MEDICARE ADVANTAGE

Increased Spending Relative to Medicare Fee-for-Service May Not Always Reduce Beneficiary Out-of-Pocket Costs

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Highlights

Highlights of GAO-08-359, a report to congressional requesters

Why GAO Did This Study

In 2006, the federal government spent about $59 billion on Medicare Advantage (MA) plans, an alternative to the original Medicare fee-for-service (FFS) program. Although health plans were originally envisioned in the 1980s as a potential source of Medicare savings, such plans have generally increased program spending. Payments to MA plans have been estimated to be 12 percent greater than what Medicare would have spent in 2006 had MA beneficiaries been enrolled in Medicare FFS. Some policymakers are concerned about the cost of the MA program and its contribution to overall spending on the Medicare program, which already faces serious long-term financial challenges.

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 FFS, reduce premiums, or reduce beneficiary cost sharing.

This report examines for 2007 (1) MA plans' projected rebate allocations; (2) additional benefits MA plans commonly covered and their costs; (3) MA plans' projected cost sharing; and (4) MA plans' allocation of projected revenues and expenses. GAO analyzed data on MA plans' projected revenues and covered benefits for the most common types of MA plans, accounting for 71 percent of all beneficiaries in MA plans.

To view the full product, including the scope and methodology, click on GAO-08-359. For more information, contact James Cosgrove at (202) 512-7114 or cosgrovej@gao.gov.

What GAO Found

In 2007, plans projected that relatively little of their rebates would be spent on additional benefits compared to cost-sharing and premium reductions. Of the average projected rebate amount of $87 PMPM, plans projected they would allocate about $10 PMPM (11 percent) to additional benefits, about $61 PMPM (69 percent) to reduced cost sharing, and about $17 PMPM (20 percent) to reduced premiums.

Using funding from both rebates and additional premiums, plans covered a variety of additional benefits not covered by Medicare FFS in 2007, including dental and vision benefits. On the basis of plans' projections, GAO estimated that rebates would pay for approximately 77 percent of additional benefits and additional beneficiary premiums would pay for the remaining 23 percent.

MA plans projected that, on average, beneficiaries in their plans would have lower cost sharing than Medicare FFS cost-sharing estimates, although some MA plans projected that their beneficiaries would have higher cost sharing for certain service categories, such as home health care and inpatient services. Because cost sharing was projected to be higher for some categories of services, beneficiaries who frequently used these services could have had overall cost sharing that would be higher than under Medicare FFS.

On average, MA plans projected that they would allocate about 87 percent of total revenue ($683 of $783 PMPM) to medical expenses; approximately 9 percent ($71 PMPM) to non-medical expenses, including administration, marketing, and sales; and approximately 4 percent ($30 PMPM) to the plans' margin, sometimes called the plans' profit. About 30 percent of beneficiaries were enrolled in plans that projected they would allocate less than 85 percent of their revenues to medical expenses.

Whether the value that MA beneficiaries receive in the form of reduced cost sharing, lower premiums, and additional benefits is worth the additional cost 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.

In commenting on a draft of this report, the Centers for Medicare & Medicaid Services expressed concern that the report was not balanced because it did not sufficiently focus on the advantages of MA plans. GAO disagrees. This report provides information on how plans projected they would use rebates and identified instances in which MA beneficiaries could have out-of-pocket costs higher than they would have experienced under Medicare FFS.