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MEDICARE ADVANTAGE

Characteristics, Financial Risks, and Disenrollment Rates of Beneficiaries in Private Fee-for-Service Plans

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Highlights

Highlights of GAO-09-25, a report to congressional requesters

Why GAO Did This Study

Medicare Advantage (MA) plans are an alternative to the original Medicare fee-for-service (FFS) program. Private fee-for-service (PFFS) plans—one type of MA plan—give beneficiaries an option that is more like Medicare FFS than other MA plans, with a wider choice of providers and less plan management of services and providers. PFFS enrollment increased from about 35,000 beneficiaries in June 2004 to about 2.3 million in June 2008. This report compares PFFS plans to other MA plans and Medicare FFS in three areas: (1) characteristics of beneficiaries, (2) financial risks for beneficiaries who do not contact their plans before receiving services, and (3) disenrollment rates. To do this work, GAO reviewed materials from a selected sample of nine PFFS plan sponsors, analyzed Medicare data, and interviewed officials from CMS, which administers the Medicare program, and other organizations.

What GAO Recommends

GAO recommends that CMS (1) investigate the extent to which PFFS beneficiaries face unexpected costs for not contacting their plan before receiving care, (2) ensure that CMS guidance on prior authorization reflects CMS policy, and (3) mail MA plan disenrollment rates to beneficiaries, as required by statute, and update rates on Medicare's Web site. CMS outlined the steps it was taking to respond to all three recommendations, but did not address how it would distribute disenrollment rates.

To view the full product, including the scope and methodology, click on GAO-09-25. For more information, contact James Cosgrove at (202) 512-7114 or cosgrovej@gao.gov.

What GAO Found

In April 2007, beneficiaries in PFFS plans tended to be healthier and generally younger 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. Beneficiaries in PFFS plans also generally were more likely than beneficiaries in other MA plans and Medicare FFS to reside in rural areas where fewer other MA plans were available. In addition, about 81 percent of beneficiaries who were new enrollees in PFFS plans were in Medicare FFS before enrolling in their plan, compared to 65 percent in other MA plans.

PFFS beneficiaries may have faced certain financial risks if they did not contact their plan before receiving services. These risks were generally not assumed by beneficiaries in other MA plans and Medicare FFS. Specifically, if beneficiaries or their providers did not contact their PFFS plans before obtaining a service to make sure it would be covered, beneficiaries unexpectedly may have had to pay for the entire cost of the service if coverage was later denied by their plan. CMS officials told GAO they did not have data on the extent to which PFFS beneficiaries were faced with such costs. Furthermore, some beneficiaries likely experienced higher out-of-pocket costs for covered services if they did not contact their plan before obtaining the services. For example, one sponsor of PFFS plans increased the share of the cost for which beneficiaries were responsible from 30 percent to 70 percent if the beneficiaries did not contact the plan before obtaining certain durable equipment. GAO found that some PFFS plans were inappropriately using the term prior authorization, which can involve denying service coverage if prior plan approval is not obtained, in their informational materials. CMS officials stated that PFFS plans should not have used this term because these plans were not permitted to deny service coverage due to lack of prior plan approval. However, CMS guidance on this issue has been inconsistent and sometimes incorrect.

From January through April 2007, beneficiaries in PFFS plans disenrolled at an average rate of 21 percent compared to 9 percent for other MA plans, and GAO concludes that CMS has not complied with statutory requirements to mail disenrollment rates to Medicare beneficiaries. Disenrollment rates can reflect factors such as beneficiary satisfaction and CMS is required by law to mail this information to Medicare beneficiaries to help them compare available MA plans in their area. Although CMS has not mailed disenrollment rates to beneficiaries since 2000, the agency did provide disenrollment rates through Medicare's Web site. However, this information was based on disenrollment in 2004 and 2005 and, given the enrollment growth since then, may not accurately reflect plans available to beneficiaries in 2008.