



Testimony

Before the Subcommittee on Health,
Committee on Ways and Means, House
of Representatives

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MEDICARE PRIVATE HEALTH PLANS

Selected Current Issues

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Highlights of [GAO-12-1045T](#), a testimony before the Subcommittee on Health, Committee on Ways and Means, House of Representatives

Why GAO Did This Study

As of August 2012, approximately 13.6 million Medicare beneficiaries were enrolled in MA plans or Medicare cost plans—two private health plan alternatives to the original Medicare fee-for-service program. This testimony discusses work GAO has done that may help inform the Congress as it examines the status of the MA program and the private health plans that serve Medicare beneficiaries. It is based on key background and findings from three previously issued GAO reports on (1) the MA quality bonus payment demonstration, (2) D-SNPs, and (3) Medicare cost plans. This information on cost plans was updated, based on information supplied by CMS, to reflect the status of cost plans in March 2012.

What GAO Recommends

In a March 2012 report on the MA quality bonus payment demonstration, GAO recommended that HHS cancel the MA quality bonus demonstration. HHS did not concur with this recommendation. In a September 2012 report on D-SNPs, GAO recommended that D-SNPs improve their reporting of services provided to beneficiaries and that this information be made public. HHS agreed with these recommendations.

View [GAO-12-1045T](#). For more information, contact James Cosgrove at (202) 512-7114 or cosgrovej@gao.gov.

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What GAO Found

In March 2012, GAO issued a report on the Centers for Medicare & Medicaid Services' (CMS) Medicare Advantage (MA) quality bonus payment demonstration—a demonstration CMS initiated rather than implementing the quality bonus program established under the Patient Protection and Affordable Care Act (PPACA). Compared to the PPACA quality bonus program, CMS's demonstration increases the number of plans eligible for a bonus, enlarges the size of payments for some plans, and accelerates payment phase-in. CMS stated that the demonstration's research goal is to test whether scaling bonus payments to quality scores MA plans receive increases the speed and degree of annual quality improvements for plans compared with what would have occurred under PPACA. GAO reported that CMS's Office of the Actuary estimated that the demonstration would cost \$8.35 billion over 10 years—an amount greater than the combined budgetary impact of all Medicare demonstrations conducted since 1995. In addition, GAO also found several shortcomings of the demonstration design that preclude a credible evaluation of its effectiveness in achieving CMS's stated research goal. In July 2012, GAO sent a letter to the Secretary of Health and Human Services (HHS), the head of the agency of which CMS is a part, stating that CMS had not established that its demonstration met the criteria in the Social Security Act of 1967, as amended, under which the demonstration is being performed.

In September 2012, GAO issued a report on Medicare dual-eligible special needs plans (D-SNP), a type of MA plan exclusively for beneficiaries that are eligible for Medicare and Medicaid. Dual-eligible beneficiaries are costly to Medicare and Medicaid in part because they are more likely than other beneficiaries to be disabled, report poor health status, and have limitations in activities of daily living. GAO found that two-thirds of 2012 D-SNP contracts with state Medicaid agencies that it reviewed did not expressly provide for the integration of Medicare and Medicaid benefits. Additionally, GAO found that compared to other MA plans, D-SNPs provided fewer, but more comprehensive supplemental benefits, such as vision, and were less likely to use rebates—additional Medicare payments received by many MA plans—for reducing beneficiary cost-sharing. GAO could not report on the extent to which benefits specific to D-SNPs were actually provided to beneficiaries because CMS did not collect the information. GAO also found that plans did not use standardized performance measures, limiting the amount of comparable information available to CMS.

In December 2009, GAO issued a report on Medicare cost plans, which, unlike MA plans, are paid based on their reasonable costs incurred delivering Medicare-covered services and allow beneficiaries to disenroll at any time. GAO found that the approximately 288,000 Medicare beneficiaries enrolled in cost plans as of June 2009 had multiple MA options available to them. GAO updated this work using March 2012 data and found that enrollment in cost plans had increased to approximately 392,000 and that 99 percent of Medicare beneficiaries enrolled in cost plans had at least one MA option available to them, although generally fewer options than in 2009.

Chairman Herger, Ranking Member Stark, and Members of the Subcommittee:

I appreciate the opportunity to participate in today's hearing on the status of the Medicare Advantage (MA) program and Medicare cost plans—two private health plan alternatives to the original Medicare fee-for-service (FFS) program.¹ As of August 2012, approximately 13.6 million Medicare beneficiaries—or about 1 of every 4—were enrolled in these Medicare private health plan options. Expenditures for Medicare private health plans reached approximately \$123.7 billion in 2011.

In an effort to contain costs and encourage Medicare private health plans to utilize resources effectively, the Patient Protection and Affordable Care Act (PPACA) made changes to how MA plans are paid and introduced bonus payments linked to the quality of care that they provide. In November 2010, the Centers for Medicare & Medicaid Services (CMS), the agency that administers Medicare, announced that instead of implementing the PPACA quality bonus payment provisions, it would conduct a demonstration of an alternative bonus payment system from 2012 through 2014 in which all plans would participate unless they affirmatively opt out.

PPACA also included provisions that extended the availability of certain types of Medicare private health plan options for beneficiaries. Specifically, PPACA extended the authorization of special needs plans (SNP)—a type of MA plan intended for beneficiaries with special needs, such as those dually eligible for Medicare and Medicaid—through December 31, 2013. PPACA also extended until January 1, 2013, the deadline after which Medicare cost plans in service areas with sufficient MA competition may no longer be renewed. Medicare cost plans differ from MA plans in that they are paid on the basis of their reasonable costs incurred delivering Medicare-covered services. In comparison, MA plans are paid a fixed monthly payment per beneficiary and bear financial risk if their costs exceed Medicare payments.

¹Both MA plans and Medicare cost plans—the term we use to refer to Social Security Act §1876 Medicare cost contracts—are generally required to provide the same benefits as Medicare FFS. In addition, MA plans may offer benefits not provided under Medicare FFS, such as reduced cost sharing or vision and dental coverage. Medicare cost plans may also offer optional additional benefits to beneficiaries, but beneficiaries who opt for these additional benefits would be responsible for their entire cost.

We have conducted several analyses that may help inform the Congress as it examines the status of the MA program and the private health plans that serve Medicare beneficiaries. My remarks today will focus on three of these analyses. Specifically, I will discuss key background information and findings from our recent work on (1) the MA quality bonus payment demonstration, (2) SNPs for dual-eligible beneficiaries, and (3) Medicare cost plans. My remarks are based largely on our previously issued work.² We updated our prior work on Medicare cost plans by including more recent data supplied by CMS on the number of Medicare cost contracts, enrollment in cost plans, and the number of MA options available to beneficiaries enrolled in cost plans. We conducted this performance audit 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. In addition to these three reports, my statement includes information from a legal analysis we recently issued on the MA Quality Bonus Payment Demonstration.³

MA Quality Bonus Payment Demonstration

CMS's quality bonus payment demonstration includes several key changes from the quality bonus system established by PPACA. Specifically, PPACA required CMS to provide quality bonus payments to MA plans that achieve 4, 4.5, or 5 stars on a 5-star quality rating system developed by CMS.⁴ In contrast, the demonstration significantly increases the number of plans eligible for a bonus, enlarges the size of payments for some plans, and accelerates payment phase-in. In announcing the

²See GAO, *Medicare Managed Care: Observations about Medicare Cost Plans*, [GAO-10-185](#) (Washington, D.C.: Dec. 28, 2009); *Medicare Advantage: Quality Bonus Payment Demonstration Undermined by High Estimated Costs and Design Shortcomings*, [GAO-12-409R](#) (Washington, D.C.: Mar. 21, 2012); and *Medicare Special Needs Plans: CMS Should Improve Information Available about Dual-Eligible Plans' Performance*, [GAO-12-864](#) (Washington, D.C.: Sept. 14, 2012). See individual reports for details on the objectives, scopes, and methodologies.

³See GAO, *Medicare-Advantage Quality Bonus Payment Demonstration*, B-323170, July 11, 2012.

⁴Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §§ 3201-02, 124 Stat. 119, 442, 454 (Mar. 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1102, 124 Stat. 1029, 1040 (Mar. 30, 2010) (hereafter, "PPACA").

demonstration, CMS stated that the demonstration's research goal is to test whether scaling bonus payments to the number of stars MA plans receive under the quality rating system leads to larger and faster annual quality improvement for plans at various star rating levels compared with what would have occurred under PPACA.

In March 2012, we reported that CMS's Office of the Actuary (OACT) estimated that the demonstration would cost \$8.35 billion over 10 years—an amount that is at least seven times larger than that of any other Medicare demonstration conducted since 1995 and greater than the combined budgetary effect of all those demonstrations.⁵ The cost is largely for quality bonus payments more generous than those prescribed in PPACA. Plans are required to use these payments to provide their enrollees enhanced benefits, lower premiums, or reduced cost-sharing.⁶ We also found that the additional Medicare spending will mainly benefit average-performing plans—those receiving 3 and 3.5-star ratings—and that about 90 percent of MA enrollees in 2012 and 2013 would be in plans eligible for a bonus payment. As we noted in our report, while a reduction in MA payments was projected to occur as a result of PPACA's payment reforms, OACT estimated that the demonstration would offset more than 70 percent of these payment reductions projected for 2012 alone and more than one-third of the reductions for 2012 through 2014.

Our March 2012 report also identified several shortcomings of the demonstration's design that preclude a credible evaluation of its effectiveness in achieving CMS's stated research goal. Notably, the bonus payments are based largely on plan performance that predates the demonstration. In particular, all of the performance data used to determine the 2012 bonus payments and nearly all of the data used to determine the 2013 bonus payments were collected before the demonstration's final specifications were published. In addition, under the demonstration's design, the bonus percentages are not continuously scaled. For example, in 2014, plans with 4, 4.5, and 5 stars will all receive the same bonus percentage. Finally, since all plans may participate in the demonstration, there is no adequate comparison group for determining whether the demonstration's bonus structure provided better incentives

⁵[GAO-12-409R](#).

⁶Bonuses under the demonstration increase the size of plan rebates, which are additional payments received by many plans.

for improving quality than PPACA's bonus structure. We therefore concluded that it is unlikely that the demonstration will produce meaningful results.

Given the findings from our program review of the demonstration's features, we recommended in our March 2012 report that the Secretary of Health and Human Services (HHS), who heads the agency of which CMS is a part, cancel the demonstration and allow the MA quality bonus payment system authorized by PPACA to take effect. We further recommended that if that bonus payment system does not adequately promote quality improvement, HHS should determine ways to modify it, which could include conducting an appropriately designed demonstration. HHS did not agree. It stated that, in contrast to PPACA, the demonstration establishes immediate incentives for quality improvement throughout the range of quality ratings. Regarding their proposed evaluation of the demonstration, HHS did not consider the timing of data collection to be a problem and said that the comparison group it would use would enable them to determine the demonstration's impact. We continue to believe that, given the problems we cited, the demonstration should be canceled.

In addition to our March 2012 report, we sent a letter on July 11, 2012, to HHS regarding CMS's authority to conduct the demonstration.⁷ In our letter, we stated that CMS had not established that the demonstration met the criteria set forth in the Social Security Amendments of 1967, as amended—the statute under which CMS is conducting the demonstration. Specifically, the statute authorizes the Secretary to conduct demonstration projects to determine whether changes in payment methods would increase the efficiency and economy of Medicare services through the creation of additional incentives, without adversely affecting quality.⁸ However, features of the demonstration, particularly those

⁷GAO, *Medicare Advantage Quality Bonus Payment Demonstration*.

⁸Section 402(a)(1)(A) authorizes the Secretary to develop and engage in experiments and demonstration projects "to determine whether, and if so which, changes in methods of payment or reimbursement for health care and services under health programs established by the Social Security Act ... would have the effect of increasing the efficiency and economy of health services under such programs through the creation of additional incentives to these ends without adversely affecting the quality of such services." Relatedly, section 402(b) authorizes the Secretary to waive Medicare payment requirements to carry out such demonstrations.

regarding the timing of data collection for plan star ratings, call into question whether the demonstration includes additional incentives to increase the efficiency and economy of Medicare services and raise concerns about the agency's ability to determine whether the payment changes under the demonstration result in increased efficiency and economy compared to the payment methods in place under PPACA.

SNPs for Dual-Eligible Beneficiaries

In 2003, Congress authorized the establishment of three types of MA coordinated care plans for individuals with special needs: dual-eligible special needs plans (D-SNP), which are exclusively for beneficiaries eligible for both Medicare and Medicaid; institutional special needs plans for individuals in nursing homes, and chronic condition special needs plans for individuals with severe or disabling chronic conditions. Of the three types of SNPs, D-SNPs are by far the most common, accounting for about 80 percent of SNP enrollment as of September 2012.

The approximately 9 million dual-eligible beneficiaries are particularly costly to both Medicare and Medicaid in part because they are more likely than other Medicare beneficiaries to be disabled, report poor health status, and have limitations in activities of daily living. Furthermore, their care must be coordinated across Medicare and Medicaid, and each program has its own set of covered services and requirements.

In September 2012, we reported that the 2012 D-SNP contracts with state Medicaid agencies that we reviewed varied considerably in their provisions for integration of benefits.⁹ Two-thirds of the 124 contracts between D-SNPs and state Medicaid agencies that were submitted to CMS for 2012 did not expressly provide for the integration of any benefits. To carry out the requirement in the Medicare Improvements for Patients and Providers Act of 2008 that each D-SNP contract provide or arrange for Medicaid benefits to be provided,¹⁰ CMS guidance required that, at a minimum, contracts list the Medicaid benefits that dual-eligible

⁹[GAO-12-864](#)

¹⁰Pub. L. No. 110-275, §164, 122 Stat. 2494, 2571.

beneficiaries could receive directly from the state Medicaid agency or the state's Medicaid managed care contractor(s).¹¹

Like other MA plans, D-SNPs must cover all the benefits of fee-for-service, with the exception of hospice, and may offer supplemental benefits, such as vision and dental care. In addition, they must develop a model of care that describes their approach to caring for their enrollees. The model of care describes how the plan will address 11 elements, including tracking measureable goals, performing health risk assessments, providing care management for the most vulnerable beneficiaries, and measuring plan performance and outcomes; and D-SNPs must offer the benefits that allow them to actualize these elements.

In our September 2012 report, we examined the supplemental benefits offered by D-SNPs and found that D-SNPs provided fewer supplemental benefits than other MA plans. However, the individual services covered under vision and dental benefits were generally more comprehensive than in other MA plans. Despite offering these supplemental benefits somewhat less often than other MA plans, D-SNPs allocated a larger percentage of their rebates—additional Medicare payments received by many plans—to these benefits than other MA plans. They were able to do so largely because they allocated a smaller percentage of rebates to reducing cost-sharing.

We could not report on the extent to which benefits specific to D-SNPs and described in the model of care were actually provided to beneficiaries because CMS did not collect the information. For the 15 models of care we reviewed, most did not report—and were not required by CMS to report—the number of beneficiaries who received a risk assessment, for example, or the number or proportion of beneficiaries who would be targeted as “most vulnerable.” However, of the models of care we reviewed, past completion rates for risk assessment varied widely among the 4 plans that provided this information. None of the models of care we reviewed reported the number of beneficiaries that were expected to receive add-on services, such as social support services, that were intended for the most-vulnerable beneficiaries.

¹¹Only new and expanding D-SNPs are required to contract with state Medicaid agencies in 2012. Beginning in 2013, all D-SNPs must contract with state Medicaid agencies. CMS stated in its 2013 training materials that contracts must specify how Medicare and Medicaid benefits are integrated and coordinated.

We found that plans do not use standardized performance measures in their models of care, limiting the amount of comparable information available to CMS. Although the D-SNPs are required to report how they intend to evaluate their performance and measure outcomes, CMS does not stipulate the use of standard outcome or performance measures, making it difficult to use any data it might collect to compare D-SNPs' effectiveness or evaluate how well they have done in meeting their goals. Furthermore, without standard measures, it would not be possible for CMS to fully evaluate the relative performance of D-SNPs.

We concluded that there was little evidence available on how well D-SNPs are meeting their goals of helping dual-eligible beneficiaries to navigate two different health care systems and receive services that meet their individual needs. Consequently, we recommended in our September 2012 report that CMS require D-SNPs to state explicitly in their models of care the extent of services they expect to provide, require D-SNPs to collect and report to CMS standard performance and outcome measures, systematically analyze these data and make the results routinely available to the public, and conduct an evaluation of the extent to which D-SNPs have provided sufficient and appropriate care to their enrollees. HHS agreed with our recommendations and in its comments on a draft of our report, said that it plans to obtain more information from D-SNPs.

CMS is embarking on a new demonstration in up to 26 states with as many as 2 million beneficiaries to financially realign Medicare and Medicaid services so as to serve dual-eligible beneficiaries more effectively. CMS has approved one state demonstration—Massachusetts—and continues to work with other states. If CMS systematically evaluates D-SNP performance, it can use information from the evaluation to inform the implementation and reporting requirements of this major new initiative.

Medicare Cost Plans

In contrast to MA plans, which have a financial incentive to control their costs, a small number of Medicare private health plans—called cost plans—are paid on the basis of their reasonable costs incurred delivering Medicare-covered services. Medicare cost plans also differ structurally from MA plans in several ways. For example, cost plans, unlike MA plans, allow beneficiaries to disenroll at any time. Despite their enrollment only totaling under 3 percent of Medicare private health plan enrollment, industry representatives stated that cost plans fill a unique niche by providing a Medicare private health plan option in rural and other areas that traditionally have had few or no MA plans. Under current law, new

cost contracts are not being entered into and contracts with existing cost plans cannot be extended or renewed after January 1, 2013 if sufficient MA competition exists in the service area.¹² Additionally, in general, organizations that offer cost plans and MA plans in the same area must close their cost plan to new enrollment.

In our December 2009 report on cost plans, we examined the MA options available to beneficiaries in these plans and found that all of the approximately 288,000 Medicare beneficiaries enrolled in cost plans as of June 2009 had multiple MA options available to them.¹³ We also found that, of the 22 cost plan contracts, 7 were closed to new enrollment in 2009. We recently updated this work with March 2012 data and found that the number of cost plan contracts decreased from 22 in 2009 to 20 in 2012, with 6 of the 20 contracts being closed to enrollment.¹⁴ Despite this slight reduction in the number of contracts, enrollment in cost plans increased by 36 percent during this time.¹⁵ Of the approximately 392,000 Medicare beneficiaries enrolled in cost plans in March 2012, we found that over 99 percent of cost plan enrollees continue to have at least one MA option in March 2012; however, they generally have fewer MA options than in June 2009 (see table 1).¹⁶ This decrease in MA options for beneficiaries enrolled in cost plans is consistent with the overall decrease in MA plans over this period, as well as with CMS's efforts to simplify MA

¹²Social Security Act, §1876(h)(5).

¹³[GAO-10-185](#)

¹⁴Between 2009 and March 2012, 1 new cost contract was closed to new enrollment. Of the 7 cost plan contracts that were closed to enrollment in 2009, 5 remain closed to enrollment, 1 contract is no longer in operation, and 1 has since become open to new enrollment. All 7 of the cost plan contracts that were closed to enrollment in 2009—including 1 contract that has since become open to enrollment—had lower enrollment in March 2012 than they did at the end of 2009.

¹⁵This increase in enrollment was primarily due to increases in two plans in the Midwest—one operated by Blue Cross Blue Shield of Minnesota, which exclusively serves enrollees in Minnesota and gained over 65,000 enrollees, and another operated by Medica Insurance Company, which primarily serves enrollees in Minnesota, North Dakota, South Dakota, and Wisconsin and gained 54,000 enrollees.

¹⁶We conducted our analysis of MA options at the contract level. Within each contract, an organization may offer one or more plans with different benefit packages. The percentage of beneficiaries enrolled in cost plans with access to a given number of MA options would be greater if we conducted the analysis at the plan level.

plan offerings by eliminating potentially duplicative plans and those with low enrollment.

Table 1: Medicare Cost Plan Summary Statistics, June 2009 and March 2012

	June 2009	March 2012
Number of contracts	22	20
Enrollment	287,796	392,048
Number of contracts closed to new enrollment	7	6
Percentage of beneficiaries enrolled in cost plans with access to at least		
1 Medicare Advantage (MA) option	100%	99%
5 MA options	99%	80%
10 MA options	89%	25%
15 MA options	57%	1%

Source: GAO analysis of CMS data.

Note: We conducted our analysis of MA options at the contract level. Within each contract, an organization may offer one or more plans with different benefit packages. The percentage of beneficiaries enrolled in cost plans with access to a given number of MA options would be greater if we conducted the analysis at the plan level.

As part of our 2009 report on cost plans we also described the concerns of officials from Medicare cost plans about converting to MA plans. We found that the most-common concerns cited by these officials from organizations that offered Medicare cost plans were potential future changes to MA payments that may then necessitate closing the plan, difficulty assuming financial risk given their small enrollment, and potential disruption to beneficiaries during the transition.

Contact and Acknowledgments

For future contacts regarding this testimony, please call James Cosgrove 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 statement. Other individuals who made key contributions include Phyllis Thorburn, Assistant Director; Alison Binkowski; Krister Friday; Gregory Giusto; and Eric Wedum.

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