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Report to Congressional Requesters

October 2011

MEDICARE ADVANTAGE

Enrollment Increased from 2010 to 2011 while Premiums Decreased and Benefit Packages Were Stable

GAO-12-93

October 2011

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Accountability * Integrity * Reliability

Highlights

Highlights of GAO-12-93, a report to congressional requesters

MEDICARE ADVANTAGE

Enrollment Increased from 2010 to 2011 while Premiums Decreased and Benefit Packages Were Stable

Why GAO Did This Study

Enrollment and spending in Medicare Advantage (MA) plans—the private plan alternative to the Medicare fee-for-service (FFS) program—have more than doubled since 2004. MA plans generally receive larger payments from Medicare than what these plans would require to provide the original Medicare FFS benefit package. Plans must use this additional money to reduce cost sharing, reduce premiums, and offer additional benefits. The Patient Protection and Affordable Care Act, enacted in 2010, required that the Centers for Medicare & Medicaid Services (CMS)—the agency within the Department of Health and Human Services (HHS) that administers Medicare—make changes in how Medicare pays MA plans. These changes, once fully implemented, are expected to reduce MA enrollment and payments, and lead to less generous benefit packages. GAO was asked to examine trends in MA from 2010 to 2011. This study assesses the extent to which the following changed from 2010 to 2011: (1) MA enrollment, (2) MA premiums and cost-sharing requirements, and (3) the additional benefits offered by MA plans. GAO analyzed data for the most common types of MA plans, accounting for about 71 percent of both the 11.1 million MA beneficiaries in April 2010 and the 11.8 million MA beneficiaries in April 2011. GAO used MA enrollment data to identify enrollment trends. GAO also analyzed data on MA plans' projected revenue requirements and benefit packages. GAO assessed the reliability of the data by interviewing CMS officials, conducting logic tests, and comparing results to published sources.

View GAO-12-93 or key components.
For more information, contact James Cosgrove at (202) 512-7114 or cosgrovej@gao.gov.

What GAO Found

Enrollment in the MA plans GAO analyzed increased by about 6 percent—from 7.9 million to 8.4 million beneficiaries—from April 2010 through April 2011. There was substantial variation by plan type in enrollment levels and how they changed from 2010 to 2011. Enrollment in health maintenance organizations (HMO), which account for about two-thirds of total MA enrollment in 2011, increased by about 9 percent, from about 5.2 million beneficiaries to about 5.6 million beneficiaries. Local and regional preferred provider organizations (PPO), which comprise a much smaller portion of total MA enrollment, experienced the highest percentage growth in enrollment—local PPOs increased by 38 percent and regional PPOs increased by 58 percent. In contrast, private fee-for-service (PFFS) plans experienced a 54 percent decline in enrollment, which was likely due to requirements that most PFFS plans establish provider networks beginning in 2011. Even with the increase in enrollment from April 2010 through April 2011, the number of MA plans decreased from 2,307 to 1,964, and this was due primarily to a decrease in PFFS plan offerings, from 435 plans to 239.

The average monthly premium for beneficiaries in MA plans decreased from $28 in 2010 to $24 in 2011, about a 14 percent reduction. The extent of the reduction and the premium amount varied substantially among plan types. For example, the average monthly premium for beneficiaries in PFFS plans fell from $33 in 2010 to $26 in 2011, about 21 percent, while the average monthly premium for beneficiaries in HMOs fell from $25 in 2010 to $23 in 2011, about 8 percent. In information MA plans submitted to CMS prior to the contract year, MA plans projected that their cost-sharing requirements would be about half of the level in Medicare FFS in both 2010 and 2011. In both years HMOs had the lowest cost-sharing requirements—40 to 42 percent of the Medicare FFS average, while regional PPOs had the highest cost-sharing requirements—about 76 to 77 percent of the Medicare FFS average. In addition, from 2010 to 2011, the percent of MA beneficiaries in plans with limits on beneficiaries' out-of-pocket health care costs increased from 74 percent to 100 percent. This increase is not surprising given that, effective in 2011, CMS requires all MA plans to have such limits, called out-of-pocket maximums. In contrast, Medicare FFS does not have an out-of-pocket maximum.

MA beneficiaries generally received coverage for additional benefits at similar levels in 2010 and 2011. For example, at least 64 percent of beneficiaries were in plans providing benefits such as hearing and vision in both 2010 and 2011. There were some changes, however, in the percentage of beneficiaries with certain benefits. For example, the percentage of MA beneficiaries with coverage for vision services decreased from 84 percent to 79 percent, while the percentage of MA beneficiaries with outpatient blood benefits beyond what Medicare FFS covers increased from 87 to 91 percent.

GAO obtained comments on a draft of this report from HHS.

Contents

Abbreviations

CMS	Centers for Medicare & Medicaid Services
FFS	fee-for-service
HHS	Department of Health and Human Services
HMO	health maintenance organization
MA	Medicare Advantage
MedPAC	Medicare Payment Advisory Commission
PPACA	Patient Protection and Affordable Care Act
PFFS	private fee-for-service
PPO	preferred provider organization
PSO	provider-sponsored organization
SNP	special needs plan

GAO
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United States Government Accountability Office
Washington, DC 20548

October 31, 2011

The Honorable Max Baucus
Chairman
Committee on Finance
United States Senate

The Honorable Tom Harkin
Chairman
Committee on Health, Education, Labor and Pensions
United States Senate

Enrollment and spending in Medicare Advantage (MA) plans have more than doubled since 2004 and accounted for about 11.1 million beneficiaries and $115 billion in 2010.[1] The MA program is Medicare's private plan alternative to the original Medicare fee-for-service (FFS) program in which MA plans provide health care coverage to Medicare beneficiaries. MA plans generally receive larger payments from Medicare than what these plans would require to provide the original Medicare FFS benefit package. Plans must use this additional money to reduce premiums, reduce cost sharing, and offer additional benefits.

The Patient Protection and Affordable Care Act (PPACA), enacted in 2010, required changes in how MA plan payments are set.[2] The Congressional Budget Office projected that these changes would reduce

[1]Medicare FFS, also known as original Medicare, includes Medicare Parts A and B. Medicare Part A covers hospital and other inpatient stays. Medicare Part B is optional insurance, which covers hospital outpatient, physician, and other services and requires a monthly premium. Medicare beneficiaries who enroll in Part B have the option of enrolling in an MA plan—which operates under Medicare Part C—to receive their Parts A and B benefits. In addition, all Medicare beneficiaries may opt to receive prescription drug coverage under Medicare Part D either through a separate Part D plan or through an MA plan that offers prescription drug benefits.

[2]See Pub. L. No. 111-148, title III, subtitle C, 124 Stat. 119, 442 et seq. (2010) (as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1102, 124 Stat. 1029, 1040 et seq.). For purposes of this report, references to PPACA include the amendments made by the Health Care and Education Reconciliation Act of 2010.

Medicare payments to MA plans by $136 billion[3] and decrease enrollment by about 35 percent through 2019. [4] In addition, the Office of the Actuary of the Centers for Medicare & Medicaid Services (CMS) within the Department of Health and Human Services (HHS) determined that the reduction in payments to MA plans required by PPACA would eventually lead to MA plans offering benefit packages that are less generous than what is currently provided to beneficiaries.[5] However, it is uncertain what impact, if any, these payment changes have had thus far on MA plan enrollment, the premiums and cost sharing they require from beneficiaries, and the additional benefits they offer. You asked us to examine these issues. This study assesses the extent to which the following changed from 2010 to 2011: (1) MA enrollment, (2) MA premiums and cost-sharing requirements, and (3) the additional benefits offered by MA plans.

To assess the extent to which MA enrollment changed from 2010 to 2011, we used MA enrollment data for April of each year that we obtained from CMS. We focused our analysis on the following types of MA plans: health maintenance organizations (HMO), local preferred provider organizations (PPO), regional PPOs, and private fee-for-service (PFFS) plans.[6] We excluded one type of MA plan—medical savings accounts, which accounted for about 600 beneficiaries in 2010 and about 1,500 beneficiaries in 2011, because they operate differently than other MA plans.[7] In addition, we excluded plans that only provided Medicare Part B

[3]See Congressional Budget Office, *H.R. 4872, Reconciliation Act of 2010 (Final Health Care Legislation)*, March 20, 2010 (based on MA provisions in a combination of prior versions of PPACA and the Health Care and Education Reconciliation Act of 2010).

[4]The Congressional Budget Office projected that, under PPACA, about 9.1 million beneficiaries would be enrolled in MA plans in 2019—about 4.8 million fewer than it projected would enroll in the absence of PPACA. See Congressional Budget Office, *Comparison of Projected Enrollment in Medicare Advantage Plans and Subsidies for Extra Benefits Not Covered by Medicare Under Current Law and Under Reconciliation Legislation Combined with H.R. 3590 as Passed by the Senate*, March 19, 2010 (based on a preliminary estimate of MA provisions in a prior version of PPACA combined with draft language for the Health Care and Education Reconciliation Act of 2010).

[5]CMS is the agency that administers the Medicare program.

[6]We also included provider-sponsored organizations (PSO) in our analysis.

[7]Beneficiaries in a medical savings account plan receive annual deposits from CMS into an interest-bearing account to help them cover their health care costs until they have reached their plan's deductible, after which the plan is responsible for all Medicare-covered costs.

benefits and plans that restricted enrollment to members of an employer group or to beneficiaries with certain health conditions or needs—called special needs plans (SNP).[8] After implementing these exclusions, our analysis included about 71 percent of both the 11.1 million MA beneficiaries in April 2010 and the 11.8 million MA beneficiaries in April 2011.

To assess the extent to which MA premiums and cost-sharing requirements changed from 2010 to 2011, we used two data sources: (1) Bid Pricing Tool data, which contain information MA plans submitted to CMS on their projected revenue requirements for providing Medicare-covered services to enrolled beneficiaries; and (2) data on plan benefit packages. We used the bid data to calculate MA plans' average premium. For purposes of this report, the term MA plan premium applies to health benefits and excludes Part D coverage, unless otherwise noted. We also used the bid data to calculate plans' projected total cost sharing for beneficiaries as a percentage of projected cost sharing for these beneficiaries had they remained in Medicare FFS. Because our cost-sharing analysis is based on plans' projections for 2010 and 2011, our results may differ from plans' actual experience during these years. We obtained information on plans' out-of-pocket maximums from the benefit package data.[9] For plans with an out-of-pocket maximum for in-network services and also one for combined in- and out-of-network services, we used the lower value for this analysis.

To assess the extent to which the additional benefits MA plans offered changed from 2010 to 2011, we analyzed the benefit package data. We focused on the categories of additional benefits that were most commonly

[8]We also excluded Program of All Inclusive Care for the Elderly plans, which provide social and medical services primarily in adult day health centers, CMS demonstration plans, and cost plans.

[9]Thirteen of the 2,307 plans in our analysis for 2010, accounting for about 0.2 percent of total enrollment, did not have data on out-of-pocket maximums in the benefit package data, so we used the out-of-pocket maximum information in the bid data. All of the 1,964 plans in our analysis for 2011 had out-of-pocket maximum information in the benefit package data.

offered by MA plans and that were available to all plan beneficiaries.[10] We weighted results for all of our analyses by each plan's enrollment in April of 2010 or 2011. We assessed the reliability of the MA plan enrollment, bid, and benefit package data by interviewing CMS officials, conducting logic tests, and comparing our results to published sources.

We conducted this performance audit from February 2011 through October 2011 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 based on our audit objectives.

Background

MA plans must offer benefits covered under Medicare FFS, which consist of Part A and Part B-covered services, except hospice care. MA plans also have the option of offering health benefits, such as dental and vision coverage, beyond what is included in the Medicare FFS benefit package. MA plans may charge a monthly premium to cover the health benefits they offer, although many do not. In addition to health benefits, MA plans generally offer Part D prescription drug coverage, for which they may charge an additional premium.

MA plans, like Medicare FFS, can require that beneficiaries pay cost sharing when they receive medical services.[11] CMS permits MA plans to have cost-sharing requirements that differ from Medicare FFS.[12]

[10]We excluded the 13 plans from our analysis of additional benefits in 2010 that did not have this information in the benefit package data. The Social Security Act uses the term supplemental benefits; throughout this report, we use the term additional benefits to refer to supplemental benefits. Our analysis addresses mandatory supplemental benefits, which are benefits in addition to the Medicare FFS benefit package that must be available to every beneficiary enrolled in the plan. We did not analyze optional supplemental benefits, which are available to those enrollees who elect and pay for them.

[11]Beneficiary cost sharing can be in the form of (1) a deductible—the amount a beneficiary pays for services before the plan or Medicare FFS begins to pay; (2) coinsurance—a percentage of the cost for a given service that a beneficiary must pay; and (3) copayments—a standard amount a beneficiary must pay for a service.

[12]In 2011, Medicare FFS cost-sharing requirements include a deductible of $1,132 for inpatient care—covered under Medicare Part A—and a $162 deductible and 20 percent coinsurance for Part B physician services.

However, CMS requires that an MA plan's projected total cost sharing, on average, be no greater than the projected amount for beneficiaries in Medicare FFS.[13] CMS also requires that, beginning in 2011, plans establish limits on the amount a beneficiary spends on cost sharing in a given year, called out-of-pocket maximums. These limits provide financial protection to beneficiaries who otherwise would have higher cost-sharing expenses. In contrast to MA plans, Medicare FFS does not have an out-of-pocket maximum.

Medicare pays MA plans a monthly amount to provide health coverage for enrolled beneficiaries. CMS determines this amount based on a plan's bid—the plan's projected cost of providing Medicare Part A and Part B benefits—in relation to a benchmark, which is the maximum amount the Medicare program will pay MA plans in a given locality.[14] If an MA plan's bid exceeds the benchmark, the plan must charge each of its beneficiaries an additional premium to make up the difference. If a plan's bid is less than the benchmark, 75 percent of the difference is returned to the plan as a rebate, which must be used to reduce premiums, reduce cost sharing, or provide additional benefits.[15] Because the benchmarks are generally greater than spending in FFS, even plans that bid below FFS spending levels in their service areas are paid above FFS spending amounts.

PPACA required CMS to change the way Medicare pays MA plans by revising plan benchmarks and rebates and by linking these payments to the quality of care that MA plans provide. In 2011, rather than increasing benchmarks annually as in previous years, they were frozen at 2010

[13]Under this total, CMS limits cost sharing to an amount that is actuarially equivalent to the Medicare FFS amount for certain services, such as inpatient facility and skilled nursing facility.

[14]MA plans offering Part D prescription drug coverage undergo a separate process to determine monthly Medicare payments for Part D benefits, including enrollee premiums. This process involves comparing a plan's bid for providing Part D benefits to the average bid among plans nationally.

[15]The remaining 25 percent of the difference between an MA plan's bid and the benchmark is retained by the government.

levels.[16] Revised benchmarks will be phased in over a 2- to 6-year period beginning in 2012. These benchmarks will be lower, on average, and are designed to align more closely with Medicare FFS spending.[17] PPACA also phases in reduced MA plan rebates from 2012 through 2014 and varies rebate amounts based on CMS's assessments of plan quality.[18] Finally, PPACA required that, beginning in 2012, CMS increase payments to MA plans with quality ratings above a certain threshold, with higher quality plans receiving greater increases and the lowest quality plans receiving no increase.[19]

MA Plan Enrollment Increased by about 6 Percent from 2010 to 2011

Enrollment in the MA plans we analyzed increased by about 6 percent—from 7.9 million beneficiaries in April 2010 to 8.4 million beneficiaries in April 2011—and enrollment growth varied substantially by MA plan type. HMOs, which account for about two-thirds of total MA enrollment in 2011, increased by about 9 percent, from about 5.2 million beneficiaries to about 5.6 million beneficiaries (see fig. 1). Local and regional PPOs, which comprise a much smaller portion of total MA enrollment compared to HMOs, experienced the highest percentage growth in enrollment—local PPOs increased by 38 percent and regional PPOs increased by 58 percent. In contrast, PFFS plans experienced a 54 percent decline in

[16]Pub. L. No. 111-148, § 3201, 124 Stat. 119, 442 (as amended by Pub. L. No. 111-152, § 1102, 124 Stat. 1029, 1040). The benchmark for an MA plan is calculated based on the county-level benchmarks in the plan's service area. From 2007 through 2010, CMS generally updated county benchmarks annually for local MA plans by the growth of Medicare expenditures. Benchmarks for regional MA plans are updated by combining the county benchmarks in each region with a weighted average of regional plan bids.

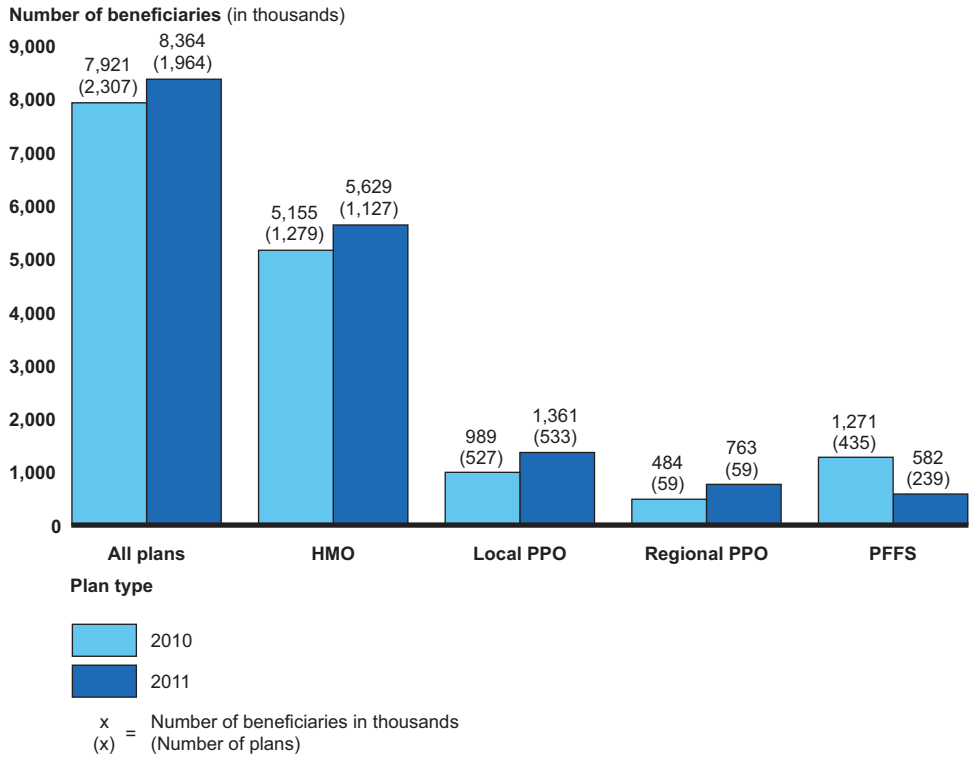
[17]Under the revised methodology, county benchmarks will range from 95 percent of Medicare FFS spending per beneficiary for MA plans in areas with the highest FFS spending levels to 115 percent of FFS spending per beneficiary for plans in areas with the lowest FFS spending levels. The Medicare Payment Advisory Commission (MedPAC) estimated that the revised methodology would reduce the average benchmark from an average of 113 percent of Medicare FFS spending per beneficiary in 2011 to 101 percent in 2017. MedPAC, *Report to the Congress: Medicare Payment Policy* (March 2011).

[18]CMS assesses plan quality using a five-star rating scale based on measures of clinical quality, patients' reported care experience, and contract performance. Once fully phased in, the revised rebates will range from 50 percent of the difference between a plan's bid and benchmark for plans with the lowest quality ratings to 70 percent of the difference for plans with the highest quality ratings.

[19]On November 10, 2010, CMS announced that it would provide bonus payments to MA plans beginning in 2012 through a new demonstration project called the Quality Bonus Payment Demonstration.

enrollment, which was likely due to requirements that most PFFS plans establish provider networks beginning in 2011.[20]

Figure 1: MA Enrollment in 2010 and 2011, by Plan Type



Source: GAO analysis of CMS data on MA enrollment in April 2010 and April 2011.

Notes: The "All plans" category includes PSOs in addition to the other types of MA plans shown above. Results are not reported separately for PSOs because these plans constituted less than 1 percent of total enrollment in 2010 and 2011. We excluded the following types of plans from our analysis: employer plans, Part B-only plans, SNPs, Program of All Inclusive Care for the Elderly plans, demonstration plans, and cost plans.

Despite the increase in enrollment from April 2010 through April 2011, the number of MA plans decreased from 2,307 to 1,964. Most of this

[20]The Medicare Improvements for Patients and Providers Act of 2008 required PFFS plans to establish provider networks beginning in 2011 if these plans were in areas with at least two available network-based plans (such as HMOs or PPOs). In areas with fewer than two network-based plans, most PFFS plans will continue to have the option of operating without networks if they pay providers at Medicare FFS rates or higher. Pub. L. No. 110-275, §162, 122 Stat. 2494, 2569.

reduction was a decrease in PFFS plan offerings, from 435 plans to 239. CMS officials told us that about 75 percent of the beneficiaries in MA plans that were not renewed in 2011 were in PFFS plans. The number of HMO plans also decreased—from 1,279 in 2010 to 1,127 in 2011, which in part may be due to CMS's efforts to simplify MA plan offerings by eliminating potentially duplicative plans and those with low enrollment.[21] According to CMS officials, 84 plans with low enrollment were either consolidated with other plans or eliminated.[22] CMS officials identified and encouraged MA plan sponsors to consolidate potentially duplicative plans so that beneficiaries would more easily be able to differentiate among MA plans offered and select the plan that best meets their needs.

Average MA Premiums Decreased from 2010 to 2011, and Projected Cost Sharing Was Stable

The average monthly premium for beneficiaries in MA plans decreased from $28 in 2010 to $24 in 2011.[23] This was about a 14 percent reduction in the average monthly premium (see fig. 2).[24] The extent of the reduction and the premium amount varied substantially among plan types. For example, the average monthly premium for beneficiaries in PFFS plans fell by about 21 percent from 2010 to 2011, while the average monthly premium for beneficiaries in HMOs fell by about 8 percent. In 2011, beneficiaries in local PPOs continued to pay over twice as much for their monthly premium as beneficiaries in regional PPOs.

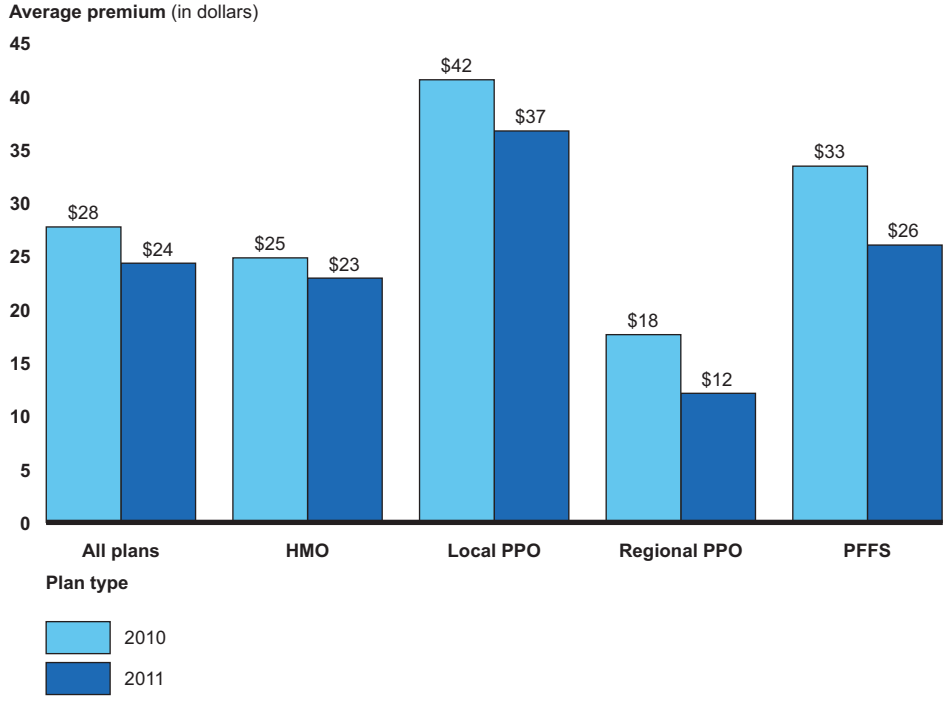
[21]CMS identified potentially duplicative plans by determining if plans of similar plan types offered by a given MA organization had meaningful differences in the projected level of beneficiaries' out-of-pocket costs. CMS considered two plans of the same sponsor and plan type as potentially duplicative if the difference in beneficiaries' projected out-of-pocket costs was less than $20.

[22]CMS officials said that most of these plans, which include SNPs and in total accounted for about 16,000 MA beneficiaries, were consolidated rather than eliminated. CMS considered plans to have low enrollment if they had fewer than 500 beneficiaries for non-SNP plans and fewer than 100 for SNPs. According to CMS, the agency maintains a flexible approach in enforcing these thresholds to ensure that geographic areas have a suitable number of plan options. CMS noted that it also considers the specific populations served by the plan and locality needs, among other factors that may cause the plan to have low enrollment.

[23]Beneficiaries in MA plans also continue to pay the Part B premium; however, MA plans may use their rebates to reduce beneficiaries' Part B premiums. In 2011, for most Medicare beneficiaries, the Medicare Part B monthly premium was between $96.40 and $115.40.

[24]The total MA plan premium—including the premium for Part D prescription drug coverage—for the over 90 percent of beneficiaries in our analysis who were in MA plans with Part D coverage, decreased from $41 in 2010 to $36 in 2011.

Figure 2: Average Premium Charged by MA Plans in 2010 and 2011, by Plan Type



Source: GAO analysis of 2010 and 2011 CMS Bid Pricing Tool and enrollment data.

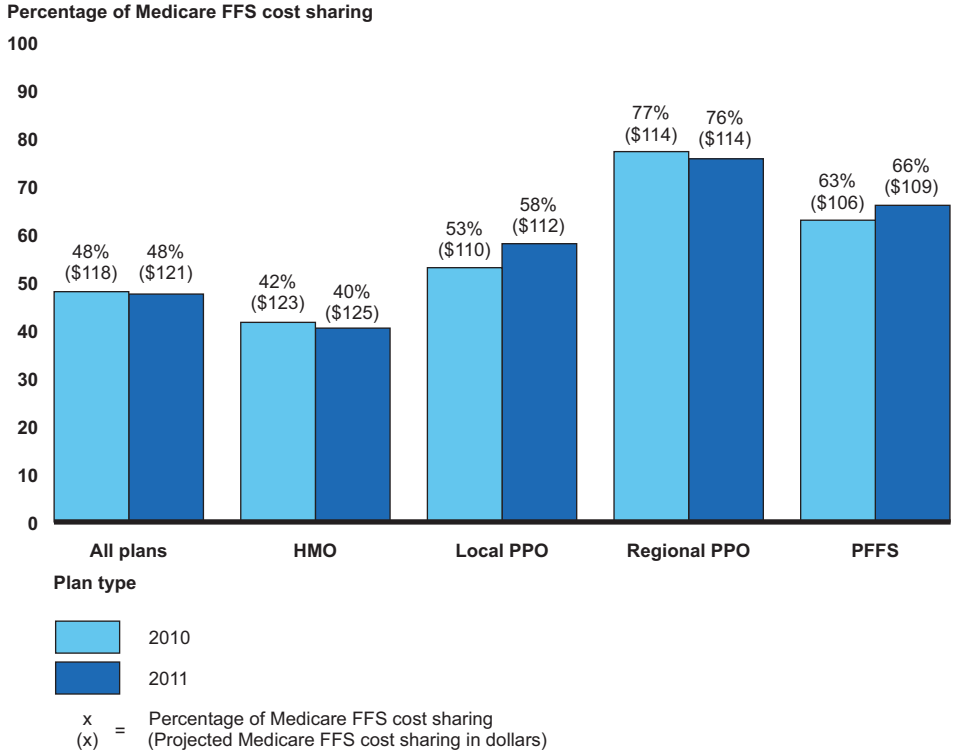
Notes: Results are weighted by plan enrollment in April of each year. Average premium amounts are for health benefits and do not include premiums for Part D prescription drug coverage. Results are based on all plans in the analysis, including plans that do not charge a premium. The “All plans” category includes PSOs in addition to the other types of MA plans shown above. Results are not reported separately for PSOs because these plans constituted less than 1 percent of total enrollment in 2010 and 2011. We excluded the following types of plans from our analysis: employer plans, Part B-only plans, SNPs, Program of All Inclusive Care for the Elderly plans, demonstration plans, and cost plans.

MA plans projected that their cost-sharing requirements would be about half of the level in Medicare FFS in both 2010 and 2011.[25] Cost sharing was generally stable across plan types, with at most a 5 percentage point change from 2010 to 2011, but the level of cost sharing varied substantially (see fig. 3). For example, in both years HMOs had the lowest cost-sharing requirement—40 to 42 percent of the Medicare FFS average—and regional PPOs had the highest cost-sharing requirement—76 to 77 percent of the average in Medicare FFS. In both 2010 and 2011, most of the funding that MA plans used to pay for lower cost sharing than Medicare FFS was from Medicare rebates, with the remainder coming from additional beneficiary premiums.[26]

[25]Medicare FFS cost sharing takes different forms. In 2011, Medicare FFS required a deductible payment of $1,132 before it began paying for an inpatient stay, and $162 before it began paying for any Part B services. For certain benefits Medicare FFS requires coinsurance, such as 20 percent of the total payment for physician visits, while for other benefits Medicare FFS requires copayments, such as $283 per day for days 61 through 90 of an inpatient stay in 2011.

[26]Based on MA plans' projections, we estimated that about 69 percent of the funding MA plans used to reduce cost sharing or provide additional benefits in 2010 was from their rebates, and in 2011 it was about 73 percent.

Figure 3: Average Projected Cost Sharing for MA Beneficiaries Compared to Their Cost Sharing in Medicare FFS, 2010 and 2011



Source: GAO analysis of 2010 and 2011 CMS Bid Pricing Tool and enrollment data.

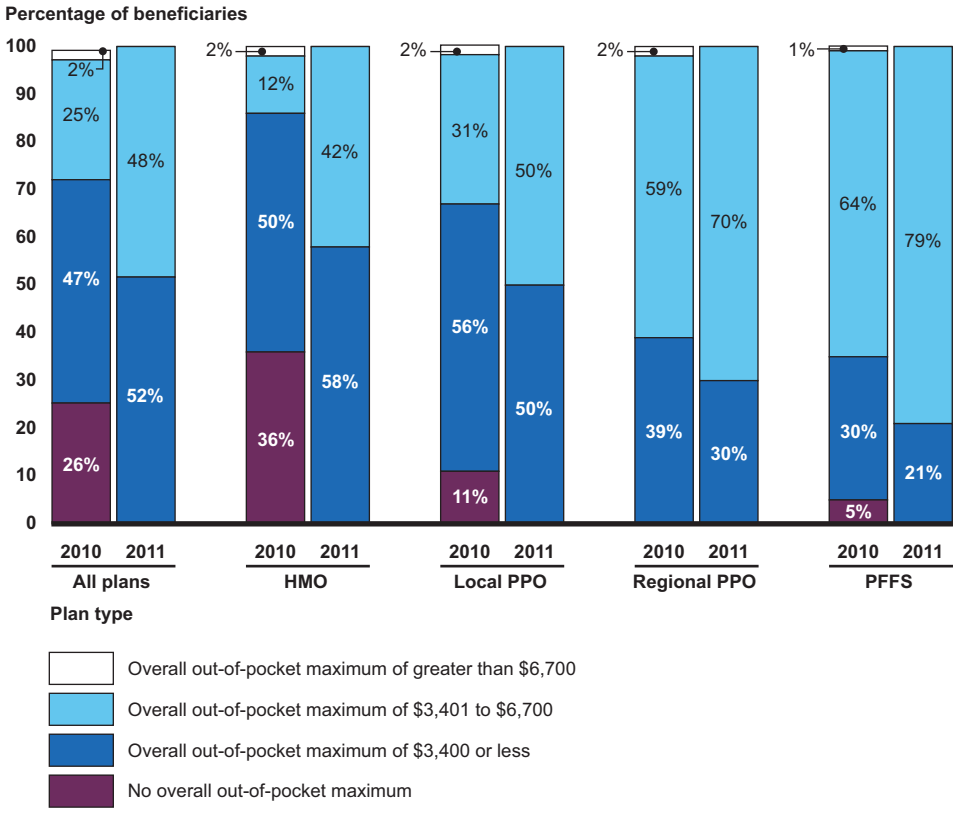
Notes: Results are weighted by plan enrollment in April of each year. The “All plans” category includes PSOs in addition to the other types of MA plans shown above. Results are not reported separately for PSOs because these plans constituted less than 1 percent of total enrollment in 2010 and 2011. We excluded the following types of plans from our analysis: employer plans, Part B-only plans, SNPs, Program of All Inclusive Care for the Elderly plans, demonstration plans, and cost plans.

From 2010 to 2011, the percent of MA beneficiaries in plans with an out-of-pocket maximum increased from 74 percent to 100 percent. This increase is not surprising given that, effective in 2011, CMS requires all MA plans to have an out-of-pocket maximum.[27] The proportion of MA beneficiaries in plans with out-of-pocket maximums at or below $3,400 also increased—from 47 percent in 2010 to 52 percent in 2011 (see fig. 4).[28] In 2011, MA beneficiaries in Regional PPOs and PFFS plans were more likely than MA beneficiaries in HMOs or local PPOs to be enrolled in plans with out-of-pocket maximums between $3,401 to $6,700. Unlike MA plans, Medicare FFS does not limit beneficiaries' out-of-pocket costs.

[27]In 2011, HMOs and PFFS plans were required to establish mandatory out-of-pocket maximums of no more than $6,700. Local PPOs were required to establish in-network out-of-pocket maximums of no more than $6,700 and catastrophic out-of-pocket maximums of no more than $10,000. Regional PPOs could determine their own in-network and catastrophic limits. Beginning in 2012, regional PPOs will have the same out-of-pocket maximum requirement as local PPOs.

[28]In 2010 and 2011, CMS gave plans with out-of-pocket maximums of $3,400 or below greater flexibility in the design of their cost-sharing requirements than plans with higher out-of-pocket maximums. For example, in 2011, plans with out-of-pocket maximums higher than $3,400 could not charge beneficiaries more than $1,613 for a 6-day inpatient facility stay, while plans with out-of-pocket maximums at or below $3,400 could charge beneficiaries up to $2,016 for a 6-day inpatient facility stay.

Figure 4: MA Beneficiaries' Out-of-Pocket Maximum by Plan Type, 2010 and 2011



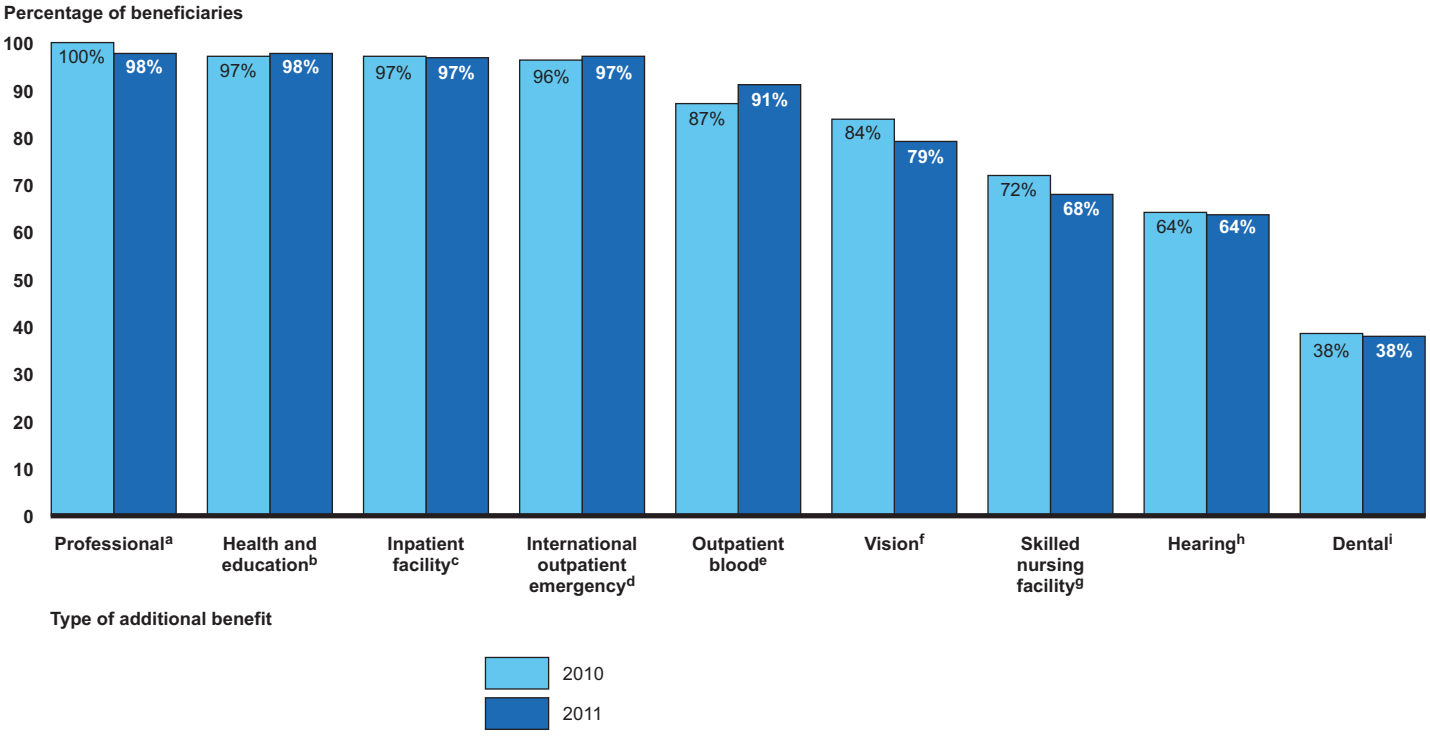
Source: GAO analysis of 2010 and 2011 CMS plan benefit package data and enrollment data.

Notes: Results are weighted by plan enrollment in April of each year. The "All plans" category includes PSOs in addition to the other types of MA plans shown above. Results are not reported separately for PSOs because these plans constituted less than 1 percent of total enrollment in 2010 and 2011. We excluded the following types of plans from our analysis: employer plans, Part B-only plans, SNPs, Program of All Inclusive Care for the Elderly plans, demonstration plans, and cost plans. If a plan had two out-of-pocket maximums—one for in-network services and one for combined in- and out-of-network services, then we used the lower value for this analysis.

MA Plans' Coverage of Additional Benefits Was Generally Similar in 2010 and 2011

The percentage of MA beneficiaries in plans that offered additional benefits was generally similar in 2010 and 2011. In both years, at least 64 percent of beneficiaries were in plans providing benefits such as hearing and vision. There were some changes, however, between 2010 and 2011 in the percentage of beneficiaries with certain benefits. For example, the proportion of MA beneficiaries with vision coverage decreased from 84 percent to 79 percent (see fig. 5). Such changes could be due to changes in plan offerings, changes in beneficiaries' plan selections, or some combination of the two. See appendix I for details on changes in the proportion of MA beneficiaries who received coverage for additional benefits by plan type.

Figure 5: MA Beneficiaries in Plans that Offered Additional Benefits, 2010 and 2011



Source: GAO analysis of 2010 and 2011 CMS plan benefit package and enrollment data.

Notes: Results are weighted by plan enrollment in April of each year. The "All plans" category includes PSOs in addition to the other types of MA plans shown above. Results are not reported separately for PSOs because these plans constituted less than 1 percent of total enrollment in 2010 and 2011. We excluded the following types of plans from our analysis: employer plans, Part B-only plans, SNPs, Program of All Inclusive Care for the Elderly plans, demonstration plans, and cost plans.

[a]Professional services benefits may include screenings and immunizations beyond what Medicare FFS covers.

[b]Health and education benefits may include nutritional training, smoking cessation, health club memberships, or nursing hotlines.

[c]Inpatient facility benefits may include additional days beyond what Medicare FFS covers.

[d]International outpatient emergency benefits may include additional services beyond what Medicare FFS covers.

[e]Outpatient blood benefits may include payment associated with pints of blood received as an outpatient or as part of a Part B-covered service beyond what Medicare FFS covers.

[f]Vision benefits may include coverage for routine eye exams, contact lenses, or eyeglasses (lenses and frames).

[g]Skilled nursing facility benefits may include waiving the 3-day inpatient hospital stay requirement in Medicare FFS.

[h]Hearing benefits may include coverage for hearing tests, hearing aid fittings, and hearing aid evaluations.

[i]Dental benefits may include oral exams, teeth cleanings, fluoride treatments, dental X-rays, or emergency dental services.

Agency Comments

We received written comments from HHS on a draft version of this report. HHS did not comment directly on our results for 2010 and 2011. However, HHS stated that MA premiums would be 4 percent lower, on average, in 2012 compared to 2011 but that 2012 benefits would remain consistent with those offered in 2011. HHS also stated that MA plans projected that enrollment would be 10 percent higher in 2012 than in 2011. HHS provided technical comments, which we incorporated as appropriate. We reprinted the letter from HHS in appendix II.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Secretary of HHS and to interested congressional committees. In addition, the report will be available at no charge on the GAO Web site at http://www.gao.gov. If you or your staff have any questions about 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. GAO staff who made major contributions to this report are listed in appendix III.

James C. Cosgrove
Director, Health Care

Appendix I: MA Beneficiaries Receiving Coverage for Additional Benefits by Plan Type, 2010 and 2011

Table 1: Percent of MA Beneficiaries in Plans that Offered Additional Benefits in 2010 and 2011, by Plan Type

	All plans		HMO		Local PPO		Regional PPO		PFFS	
Service category	**2010**	**2011**	**2010**	**2011**	**2010**	**2011**	**2010**	**2011**	**2010**	**2011**
Professional[a]	100%	98%	100%	98%	99%	95%	100%	98%	100%	100%
Health and education[b]	97%	98%	98%	98%	97%	96%	95%	97%	94%	99%
Inpatient facility[c]	97%	97%	97%	96%	99%	99%	99%	99%	96%	97%
International outpatient emergency[d]	96%	97%	97%	97%	93%	95%	100%	100%	96%	100%
Outpatient blood[e]	87%	91%	85%	90%	90%	94%	100%	98%	87%	92%
Vision[f]	84%	79%	94%	90%	73%	65%	63%	46%	60%	50%
Skilled nursing facility[g]	72%	68%	69%	64%	83%	80%	68%	65%	77%	76%
Hearing[h]	64%	64%	70%	72%	46%	44%	49%	48%	58%	50%
Dental[i]	38%	38%	37%	36%	55%	47%	60%	51%	22%	15%
Number of plans	2,294	1,964	1,266	1,127	527	533	59	59	435	239
Number of beneficiaries	7,903,152	8,364,464	5,137,525	5,629,092	988,821	1,360,888	484,041	762,754	1,270,904	581,644

Source: GAO analysis of 2010 and 2011 CMS plan benefit package and enrollment data.

Notes: Results are weighted by plan enrollment in April of each year. The "All plans" category includes PSOs in addition to the other types of MA plans shown above. Results are not reported separately for PSOs because these plans constituted less than 1 percent of total enrollment in 2010 and 2011. We excluded the following types of plans from our analysis: employer plans, Part B-only plans, SNPs, Program of All Inclusive Care for the Elderly plans, demonstration plans, and cost plans.

[a]Professional services benefits may include screenings and immunizations beyond what Medicare FFS covers.

[b]Health and education benefits may include nutritional training, smoking cessation, health club memberships, or nursing hotlines.

[c]Inpatient facility benefits may include additional days beyond what Medicare FFS covers.

[d]International outpatient emergency benefits may include additional services beyond what Medicare FFS covers.

[e]Outpatient blood benefits may include payment associated with pints of blood received as an outpatient or as part of a Part B covered service beyond what Medicare FFS covers.

[f]Vision benefits may include coverage for routine eye exams, contact lenses, or eyeglasses (lenses and frames).

[g]Skilled nursing facility benefits may include waiving the 3-day inpatient hospital stay requirement in Medicare FFS.

[h]Hearing benefits may include coverage for hearing tests, hearing aid fittings, and hearing aid evaluations.

[i]Dental benefits may include oral exams, teeth cleanings, fluoride treatments, dental X-rays, or emergency dental services.

Appendix II: Comments from the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES — OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

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

OCT 07 2011

Dear Mr. Cosgrove:

Attached are comments on the U.S. Government Accountability Office's (GAO) draft report entitled, "MEDICARE ADVANTAGE: Enrollment Increased from 2010 to 2011 while Premiums Decreased and Benefit Packages Were Stable" (GAO-12-93).

The Department appreciates the opportunity to review this report before its publication.

Sincerely,

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "MEDICARE ADVANTAGE: ENROLLMENT INCREASED FROM 2010 TO 2011 WHILE PREMIUMS DECREASED AND BENEFIT PACKAGES WERE STABLE" (GAO-12-93)

The Department recently announced that 2012 Medicare Advantage premiums are falling and projected enrollment is rising. On average, Medicare Advantage premiums will be 4 percent lower in 2012 than in 2011, and plans project enrollment to increase by 10 percent. Of people with Medicare, 99.7 percent continue to enjoy access to a Medicare Advantage plan, and benefits remain consistent with those offered in 2011. The Centers for Medicare and Medicaid Services (CMS) was able to use authority provided by the Affordable Care Act to protect beneficiaries from significant increases in costs or cuts in benefits in 2012. In addition, average premiums are declining for the second year in a row: 2012 premiums are projected to be 11.5 percent below 2010 premiums.

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

James C. Cosgrove, (202) 512-7114 or CosgroveJ@gao.gov

Acknowledgments

In addition to the contact named above, Christine Brudevold, Assistant Director; William Black; George Bogart; Elizabeth Morrison; and Kristal Vardaman made key contributions to this report.

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