



June 2021

MEDICARE ADVANTAGE

Beneficiary Disenrollments to Fee-for-Service in Last Year of Life Increase Medicare Spending

Accessible Version



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GAO@100 Highlights

Highlights of [GAO-21-482](#), a report to congressional requesters

Why GAO Did This Study

In contrast to Medicare FFS, which pays providers for claims for services, CMS pays MA plans a fixed monthly amount per beneficiary to provide health care coverage. For beneficiaries with higher expected health care costs, MA payments are increased. In 2019, CMS paid MA plans about \$274 billion to cover about 22 million beneficiaries.

Prior GAO and other studies have shown that beneficiaries in poorer health are more likely to disenroll from MA to join FFS, which may indicate that they encountered issues with their care under MA. Beneficiaries in the last year of life are generally in poorer health and often require high-cost care.

GAO was asked to review disenrollment by MA beneficiaries in the last year of life. In this report, GAO examined (1) disenrollments from MA to join FFS by beneficiaries in the last year of life, and CMS's associated monitoring; and (2) the costs of such disenrollments to Medicare.

GAO analyzed CMS disenrollment and mortality data for 2015 through 2018—the most current data at the time of the analysis—to examine the extent of MA beneficiary disenrollment in the last year of life. To estimate the costs of disenrollment, GAO used CMS data to estimate payments for disenrolled beneficiaries had they remained in MA, and compared those estimates against those beneficiaries' actual FFS costs.

What GAO Recommends

GAO recommends that CMS review disenrollments by MA beneficiaries in the last year of life as part of its monitoring. The Department of Health and Human Services concurred with GAO's recommendation.

View [GAO-21-482](#). For more information, contact Jessica Farb at (202) 512-7114 or FarbJ@gao.gov.

June 2021

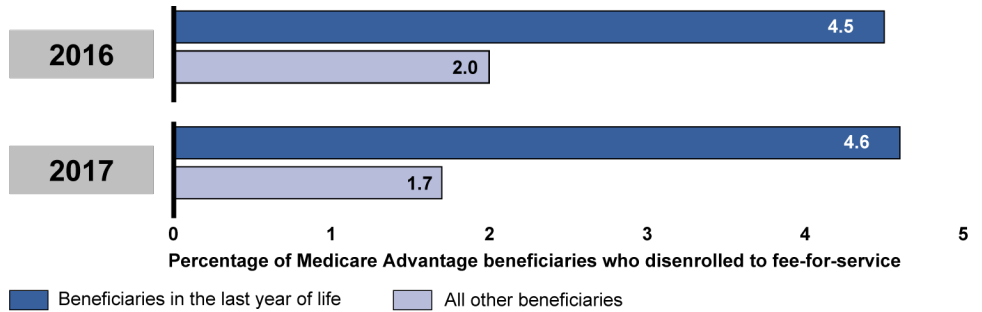
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Beneficiary Disenrollments to Fee-for-Service in Last Year of Life Increase Medicare Spending

What GAO Found

Under Medicare Advantage (MA), the Centers for Medicare & Medicaid Services (CMS) contracts with private MA plans to provide health care coverage to Medicare beneficiaries. MA beneficiaries in the last year of life disenrolled to join Medicare fee-for-service (FFS) at more than twice the rate of all other MA beneficiaries, GAO's analysis found. MA plans are prohibited from limiting coverage based on beneficiary health status, and disproportionate disenrollment by MA beneficiaries in the last of year life may indicate potential issues with their care. Stakeholders told GAO that, among other reasons, beneficiaries in the last of year life may disenroll because of potential limitations accessing specialized care under MA. While CMS monitors MA disenrollments, the agency does not specifically review disenrollments by beneficiaries in the last year of life. Doing so could help CMS better ensure the care provided to these beneficiaries.

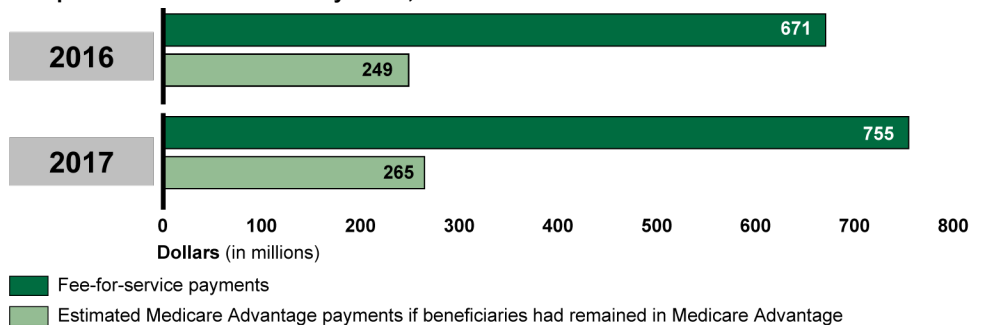
Medicare Advantage Beneficiary Disenrollments to Join Fee-for-Service, 2016-2017



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-21-482

Beneficiaries in the last year of life who disenrolled from MA to join FFS increased Medicare costs as they moved from MA's fixed payment arrangement to FFS, where payments are based on the amount and cost of services provided. GAO's analysis shows that FFS payments for such beneficiaries who disenrolled in 2016 were \$422 million higher than their estimated MA payments had they remained in MA, and were \$490 million higher for those that disenrolled in 2017.

Estimated Medicare Advantage Payments for Beneficiaries in Last Year of Life that Disenrolled Compared to Fee-for-Service Payments, 2016-2017



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-21-482

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Abbreviations

CMS	Centers for Medicare & Medicaid Services
HMO	health maintenance organization
FFS	fee-for-service
MA	Medicare Advantage
MAO	Medicare Advantage organization
PPO	preferred provider organization

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June 28, 2021

The Honorable Debbie Stabenow
Chair
Subcommittee on Health Care
Committee on Finance
United States Senate

The Honorable Bill Cassidy, M.D.
United States Senate

Under the Medicare Advantage (MA) program, the Centers for Medicare & Medicaid Services (CMS) contracts with private MA organizations (MAO) that offer plans that provide health care coverage to Medicare beneficiaries.¹ In contrast to the Medicare fee-for-service (FFS) program, which directly pays claims to any health care provider who accepts Medicare, CMS pays MA plans a fixed monthly payment per beneficiary to provide health benefits. In 2019, CMS paid MA plans about \$274 billion to provide coverage to about 22 million beneficiaries, accounting for about 35 percent of all Medicare beneficiaries.²

MA plans are prohibited from limiting their coverage or benefits based on beneficiary health status.³ CMS has certain policies and protections in place to help ensure that MA plans have the same incentives to enroll beneficiaries regardless of health status, and that MA plans adequately meet the needs of beneficiaries who are more costly and in poorer health. For example, CMS increases payments to MA plans for beneficiaries who are projected to have higher health care costs.⁴ MAOs can specify networks of health care providers from whom their beneficiaries can receive care, and CMS requires that MAOs ensure their networks are

¹CMS is the agency within the Department of Health and Human Services that administers the Medicare program.

²Medicare Payment Advisory Commission, "Section 9: Medicare Advantage," *A Data Book: Health care spending and the Medicare program* (Washington, D.C., July 2020).

³42 U.S.C. § 1395w-22(b)(1).

⁴MA payments account for differences in beneficiaries' health status and demographic factors. For example, MA payments increase for older beneficiaries, and increase based on beneficiaries' diagnosed chronic conditions, such as cancer or diabetes.

sufficient to provide adequate access to covered services for all beneficiaries.⁵

CMS encourages MA beneficiaries to annually review their enrollment decisions, because the benefit packages offered by MA plans—which vary in their cost sharing requirements, covered benefits, and provider networks—can change from one year to the next. When reviewing plan offerings, beneficiaries may choose to remain in their current plan, or may disenroll from their plan by enrolling in another MA plan, or leaving MA to join Medicare FFS.⁶

While disenrollment among some beneficiaries is expected, high levels of disenrollment, or disparities in disenrollment among beneficiaries in poorer health, may indicate potential issues with beneficiary access to care or with the quality of care provided. CMS accordingly monitors disenrollment rates as part of its Five-Star Rating System of MA plan quality, and high levels of disenrollment may negatively affect a plan's quality rating. CMS also surveys disenrolled beneficiaries to learn about the reasons they disenrolled from their MA plan, which the agency then uses to provide feedback to MA plans to help them facilitate quality improvement efforts.

However, prior to 2017, CMS did not review disenrollment by beneficiary health status to identify potential disparities in disenrollments as part of the agency's monitoring. In a 2017 report, we identified certain plans with disproportionate disenrollment by beneficiaries in poorer health and recommended that CMS review data on disenrollments by health status.⁷

⁵Part C-Medicare Advantage Application, §§ 2.8; 3.11.A.; see also 42 C.F.R. § 422.112(a)(1)(i) (2019). For additional information on CMS oversight of MA network adequacy, see GAO, *Medicare Advantage: Actions Needed to Enhance CMS Oversight of Provider Network Adequacy*, [GAO-15-710](#) (Washington, D.C.: Aug. 31, 2015).

CMS also does not allow MA plans to market benefit packages that discourage the enrollment of certain beneficiaries, such as those with chronic conditions. 42 C.F.R. § 422.100(f) (2019).

⁶Beneficiaries who choose to enroll in a different plan under the same MA contract have elected to stay in the same type of plan offered by the same MAO, and are not considered by CMS to have disenrolled.

⁷See GAO, *Medicare Advantage: CMS Should Use Data on Disenrollment and Beneficiary Health Status to Strengthen Oversight*, [GAO-17-393](#) (Washington, D.C.: Apr. 28, 2017).

CMS agreed with our recommendation and began analyzing disenrollments by health status starting in 2017.

In addition to our 2017 report, a number of other studies have found that beneficiaries in poorer health may be more likely to disenroll from MA to join FFS.⁸ To the extent that MA beneficiaries in poorer health disenroll to join FFS, particularly those with high-cost care needs, it could increase Medicare program costs. This may occur since these beneficiaries are leaving fixed payment arrangements under MA to join FFS, under which Medicare payments for services are generally based on the amount and cost of services provided.⁹ At the same time, MA plans could benefit financially from such disenrollments if the costs of providing services to these beneficiaries exceed the fixed payments the plans would have otherwise received had the beneficiaries remained in MA.

With studies indicating that beneficiaries in poorer health disproportionately disenroll from MA to join FFS, questions have been raised specifically regarding disenrollment by MA beneficiaries in the last year of life. Beneficiaries in the last year of life are generally high-cost and disproportionately require specialized care, with a few studies estimating that they may account for as much as a fifth to a quarter of all FFS

⁸See David J. Meyers et al., “Limited Medigap Consumer Protections Are Associated With Higher Reenrollment In Medicare Advantage Plans,” *Health Affairs*, vol. 38, no. 5 (2019); David J. Meyers et al., “Analysis of Drivers of Disenrollment and Plan Switching Among Medicare Advantage Beneficiaries,” *JAMA Intern Med*, (2019) Vol. 179, No. 4 (2019); Elizabeth M. Goldberg et al., “Favorable Risk Selection in Medicare Advantage: Trends in Mortality and Plan Exits Among Nursing Home Beneficiaries,” *Medical Care Research and Review*, vol. 74, no. 6, (2017); Momotazur Rahman et al., “High-Cost Patients Had Substantial Rates of Leaving Medicare Advantage and Joining Traditional Medicare,” *Health Affairs*, vol. 34, no. 10 (2015); Gretchen Jacobson et al., “At Least Half of New Medicare Advantage Enrollees Had Switched From Traditional Medicare During 2006-11,” *Health Affairs*, vol. 34, no. 1 (2015); and Gerald F. Riley, “Impact of Continued Biased Disenrollment from the Medicare Advantage Program to Fee-for-Service,” *Medicare & Medicaid Research Review*, vol. 2, no. 4 (2012).

⁹Disenrollment from MA by these beneficiaries may also increase their out-of-pocket costs, because they may face substantial cost sharing under FFS and difficulties obtaining supplemental Medicare coverage. Beneficiaries in FFS can purchase supplemental Medicare coverage—known as Medigap plans—offered by private organizations that help pay for cost sharing and some out-of-pocket costs not covered under FFS. In most states, Medigap plans may deny coverage or charge higher premiums on the basis of preexisting health conditions for beneficiaries that are not new Medicare enrollees, according to a *Health Affairs* study. See Meyers et al., “Limited Medigap Consumer Protections.”

spending.¹⁰ A recent study also identified potential concerns about the quality of end-of-life care under MA.¹¹

In light of these issues, you asked us to review disenrollment by MA beneficiaries in the last year of life. In this report, we examine

1. the extent of disenrollment from MA to join FFS by beneficiaries in the last year of life, and CMS's monitoring of such disenrollments; and
2. the costs to Medicare from beneficiaries in the last year of life who disenroll from MA to join FFS.

To examine the extent of disenrollment from MA to join FFS by beneficiaries in the last year of life, we examined enrollment, voluntary disenrollment, and mortality data from CMS for 2015 through 2018.¹² Data for 2018 represented the most recent year of data available at the time of our analysis.¹³ We examined disenrollment from MA to join FFS and mortality data for two separate cohorts of MA beneficiaries: beneficiaries enrolled in MA as of December 2015, and beneficiaries enrolled as of December 2016.¹⁴ For each December cohort, we identified beneficiaries who disenrolled from MA to join FFS in the subsequent calendar year,

¹⁰See Ian Duncan et al., "Medicare Cost at End of Life," *American Journal of Hospice & Palliative Medicine*, vol. 36, no. 8 (2019); and Gerald F Riley and James D. Lubitz, "Long-term Trends in Medicare Payments in the Last Year of Life," *Health Services Research*, vol. 45 no. 2 (2010).

¹¹See Claire K. Ankuda et al., "Family and Friend Perceptions of Quality of End-of-Life Care in Medicare Advantage vs Traditional Medicare," *JAMA Network Open*, vol.3 no. 10 (2020).

¹²Our analysis only includes beneficiary disenrollments that CMS considers voluntary. Certain disenrollments, such as beneficiaries who enroll in a new plan after moving outside of their existing plan's service area, are not considered voluntary disenrollments.

¹³CMS tracks MA disenrollments as part of its MA Five-Star Rating System, and the data used for the ratings reflect past performance. For example, the 2020 MA Five-Star Ratings tracked disenrollments by beneficiaries in 2018.

¹⁴We examined two cohorts to ensure any findings were consistent across years. Certain MA beneficiaries were excluded from our cohorts. See appendix I for additional information on these exclusions.

2016 and 2017, respectively.¹⁵ For beneficiaries who remained in their MA plan in 2016 and 2017, we identified whether they were in the last year of life by tracking whether they died as of the end of the subsequent calendar year. For beneficiaries who disenrolled in 2016 and 2017, we identified whether they were in the last year of life by tracking whether they died within a year of their disenrollment.¹⁶ We compared disenrollment rates between those in the last year of life against all other MA beneficiaries who were not in the last year of life, and examined rates by beneficiaries' MA plan type and dual eligible status.¹⁷ Additionally, to understand and contextualize the causes of MA disenrollment, we interviewed various stakeholders, including several authors of relevant studies on disenrollment, three organizations representing providers and MA plans, and two Medicare beneficiary advocacy organizations. We selected our stakeholders to obtain a wide variety of perspectives on the issue.

To examine CMS's monitoring of disenrollments from MA to join FFS by beneficiaries in the last year of life, we interviewed CMS officials regarding their monitoring related to MA disenrollments, and reviewed CMS analyses conducted in response to our 2017 report on MA disenrollment. We determined that the information and communication component of internal control was significant to this objective, along with the underlying principle that management should use quality

¹⁵The majority of beneficiary disenrollments are associated with the Medicare annual open enrollment period, with changes in enrollment taking effect the first day of the following calendar year. For example, 67 percent of disenrollments by beneficiaries in the December 2015 cohort were associated with the open enrollment period and took effect on January 1, 2016. For the purposes of reporting, we refer to and present results according to the calendar year in which beneficiary enrollment changes take effect. For example, we report data for the December 2015 cohort as year 2016 data.

¹⁶For example, if a beneficiary in the December 2016 cohort disenrolled to join FFS on January 1, 2017, we tracked whether the beneficiary died in calendar year 2017; if a beneficiary in the same cohort disenrolled on April 1, 2017, we tracked whether the beneficiary died on or after April 1, 2017, through March 31, 2018.

¹⁷Dual eligible beneficiaries are those who are eligible for both Medicare and Medicaid, a joint federal-state program that finances health insurance coverage for certain low-income and medically needy individuals. We examined dual eligible beneficiaries since they are generally in poorer health relative to non-dual beneficiaries, and prior studies have found that they have higher rates of MA disenrollment. See Meyers et al., "Limited Medigap Consumer Protections"; Meyers et al., "Analysis of Drivers of Disenrollment"; Rahman et al., "High-Cost Patients"; and Jacobson et al. "New Medicare Advantage Enrollees."

information.¹⁸ We examined CMS's monitoring of disenrollment by beneficiaries in the last year of life to determine whether the agency is using available information to implement effective MA program monitoring.

To examine the costs to Medicare from beneficiaries in the last year of life who disenroll from MA to join FFS, we estimated MA payments for these beneficiaries had they remained in MA, and compared our estimated payments against their actual FFS payments.¹⁹ We used CMS's MA benchmark and Medicare beneficiary risk score data for 2016 through 2018 to estimate MA payments for disenrolled beneficiaries from the month of their disenrollment through the month of their death. MA benchmark amounts represent the maximum, non-risk adjusted amount that Medicare will pay per enrolled beneficiary in a given county or region. Beneficiary risk scores are based on demographic and diagnosis information and are used to adjust how much Medicare pays MA plans to provide care, with higher payments for beneficiaries with higher risk scores.²⁰ Accordingly, we used beneficiaries' risk scores to adjust the benchmark amounts to estimate beneficiary-level MA payments.

We used Medicare payment data to determine beneficiaries' actual post-disenrollment FFS payments. We excluded FFS hospice payments from our comparison, because hospice services for MA beneficiaries are provided under FFS, and Medicare payments for hospice services are accordingly not shifted from MA to FFS when MA beneficiaries disenroll to join FFS.

We likely underestimate the costs to Medicare from beneficiaries in the last year of life who disenroll from MA to join FFS. Our MA payment estimates are likely overestimates, because we used benchmark payment

¹⁸See GAO, *Standards for Internal Control in the Federal Government*, [GAO-14-704G](#) (Washington, D.C.: Sept. 10 2014). Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved.

¹⁹Our analysis compared Medicare program payments, and did not include beneficiary cost sharing payments, such as deductibles and copayments.

²⁰The average beneficiary risk score is 1.0, and higher or lower scores correspond to higher or lower projected health care costs. For example, a score of 2.0 indicates a beneficiary has projected spending twice the national average. Beneficiary-level MA payments are risk adjusted by multiplying MA plan payment amounts by beneficiaries' risk scores.

maximum amounts to estimate payments, among other factors. To the extent that beneficiaries' actual FFS payments were greater than our estimated MA payments, our overestimated MA payments lower the differential.²¹ (See app. II for additional information about our MA payment estimation methodology and comparison to FFS payments.)

To assess the reliability of all electronic data used, we reviewed relevant documentation, interviewed CMS officials, and examined the data for obvious errors. We determined that the data were sufficiently reliable for the purposes of our reporting objectives.

We conducted this performance audit from November 2019 to June 2021 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.

Background

The MA program is the private plan alternative to the Medicare FFS program. MA plans must provide coverage for Medicare FFS services with a few exceptions, including hospice services, which are covered under FFS for all Medicare beneficiaries.²² MA plans may offer more generous benefits, such as less cost sharing, and additional covered services, such as vision or dental care. To control utilization, MA plans may implement practices such as referral and prior authorization requirements.²³ MA plans may also limit beneficiaries' access to care to a network of physicians, hospitals, and other providers that contract with

²¹For a point of comparison to beneficiaries in the last year of life, we also estimated the costs to Medicare for disenrolled beneficiaries who were not in the last year of life. We estimated their MA payments for the 12 months after their disenrollment, and compared our estimated MA payments against their actual post-disenrollment FFS payments.

²²MA beneficiaries who elect hospice can remain enrolled in their MA plan, though care related to their terminal illness and related conditions is generally provided under FFS. Medicare payments to MA plans are accordingly reduced to reflect the plans' limited financial responsibility for care. CMS currently has a demonstration underway in which certain MA plans are covering hospice services as an MA benefit.

²³Prior authorization requires providers to obtain MA plan approval before certain services are provided to beneficiaries.

their MAO. If a given physician or hospital is not in the MA plan's network, beneficiaries' out-of-pocket costs to use that physician or hospital may be considerably higher than the costs associated with the plan's network.

MA benefits are provided under various types of plans, principally health maintenance organizations (HMO) and preferred provider organizations (PPO). HMOs generally restrict beneficiary access to providers in their network, and are offered as local plans that serve a county, partial county, or multiple counties. According to CMS data, HMOs accounted for about 60 percent of MA enrollment in 2019. PPOs also have networks, but allow beneficiaries access to non-network providers by paying higher cost sharing amounts. PPOs are offered as both local plans and as regional plans that serve an entire state or multiple states. They accounted for over 35 percent of MA enrollment in 2019, according to CMS data.

Beneficiaries enrolled in MA are generally locked into their plan for a year from January through December, though they may disenroll during the year under certain conditions. During the annual Medicare open enrollment period, from October 15 to December 7, all Medicare beneficiaries may change their MA plan selection or enroll in FFS, with enrollment changes taking effect on January 1 of the following calendar year. This is followed by the MA open enrollment period, from January 1 to March 31, when MA beneficiaries may change their MA plan selection or enroll in FFS.²⁴ CMS also allows certain MA beneficiaries to change their enrollment at other times under certain circumstances. For example, dual eligible MA beneficiaries may change their enrollment once per quarter during the first 9 months of the year.²⁵

²⁴Prior to 2019—and during the period of our analysis—the MA open enrollment period was known as the MA disenrollment period. The MA disenrollment period went from January 1 to February 14, and beneficiaries could only disenroll from their MA plan to join FFS.

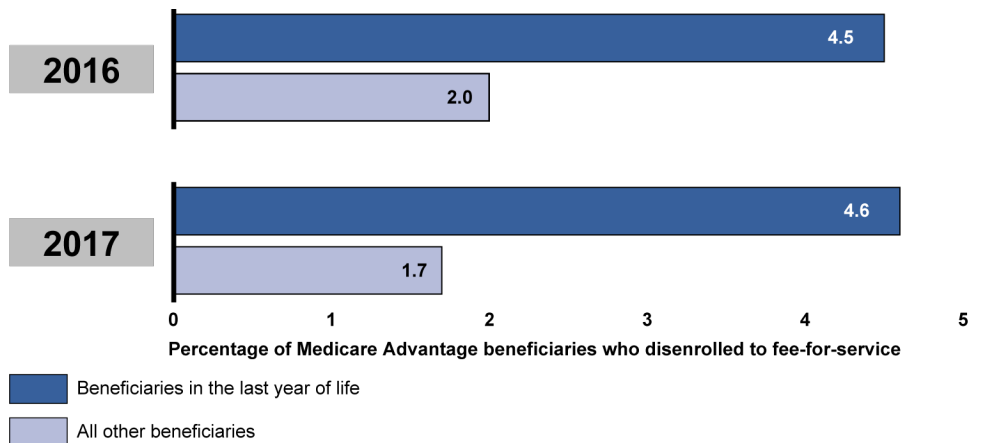
²⁵Prior to 2019—and during the period of our analysis—dual eligible beneficiaries could change their enrollment on the first day of any month.

MA Beneficiaries in the Last Year of Life Disenrolled to Join FFS at Substantially Higher Rates than Other MA Beneficiaries

MA Beneficiaries in the Last Year of Life Disenrolled to Join FFS at More than Twice the Rate of All Other MA Beneficiaries

Our analysis of CMS data show that while a small percentage of MA beneficiaries in the last year of life disenrolled to join FFS in 2016 and 2017, these beneficiaries disenrolled at more than twice the rate of all other MA beneficiaries. Specifically, in 2016, 4.5 percent of beneficiaries in the last year of life disenrolled to join FFS, compared to 2.0 percent of all other beneficiaries. In 2017, 4.6 percent of beneficiaries in the last year of life did so, compared to 1.7 percent of all other beneficiaries. (See fig. 1.)

Figure 1: Medicare Advantage Disenrollments to Join Medicare Fee-for-Service by Beneficiaries in the Last Year of Life Compared to All Other Beneficiaries, 2016-2017



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-21-482

	2016	2017
Beneficiaries in the last year of life	4.5%	4.6%
All other beneficiaries	2.0%	1.7%

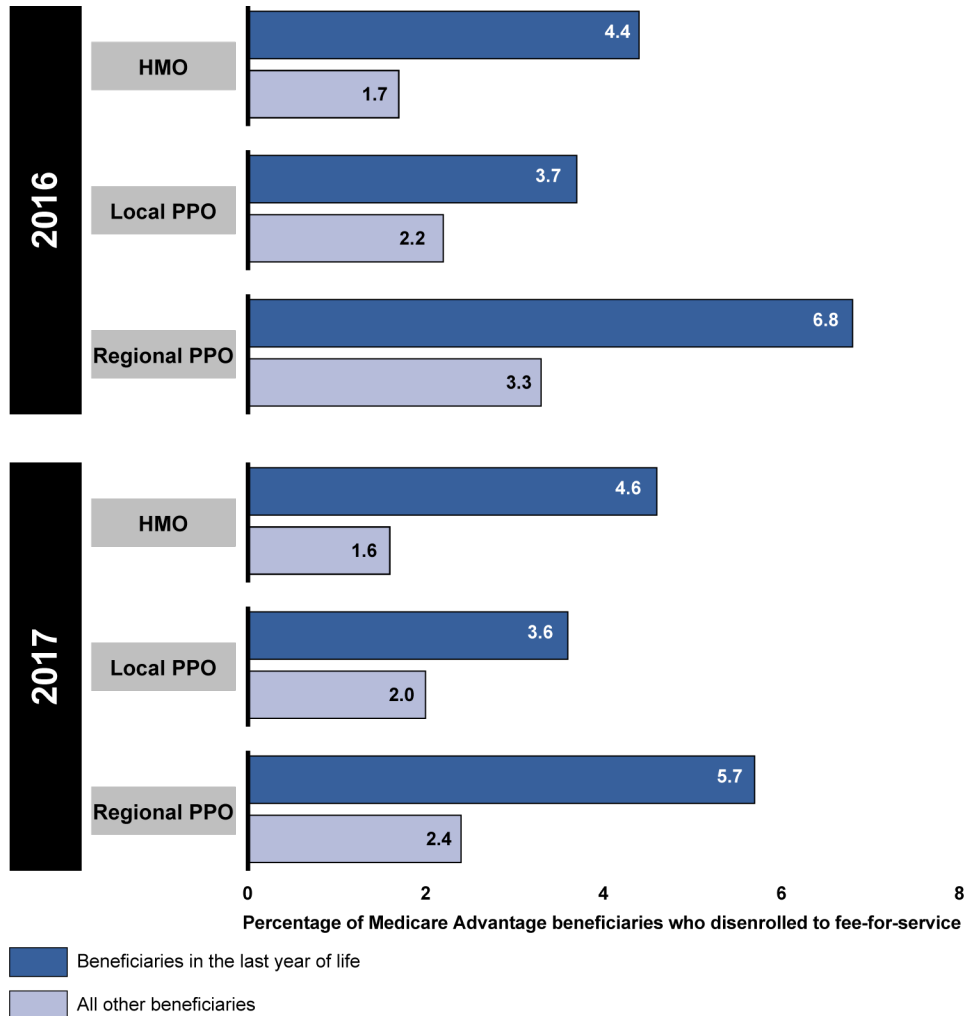
Several stakeholders we spoke with told us that beneficiaries in poorer health, particularly those in the last year of life, may be relatively more inclined to disenroll to join FFS, because of potential issues affecting their access to care or the quality of their care. These stakeholders noted that certain MA plans' provider networks may provide limited access to specialized care. Several stakeholders also cited potential issues with the quality of post-acute care, such as skilled nursing facility and home health care, under certain MA plans as a possible factor driving such disenrollment.²⁶ Further, a number of stakeholders also noted that beneficiaries in the last year of life generally have high levels of service utilization, and certain MA plan practices, such as prior authorization, may present administrative burdens to accessing care.²⁷

Regional PPO plans had the highest rate of disenrollment from MA to join FFS by beneficiaries in the last year of life compared to HMO and local PPO plans in 2016 and 2017. However, beneficiaries in the last year of life who were enrolled in HMO plans had the greatest relative increase in their rate of disenrollment from MA to join FFS in both 2016 and 2017, as they disenrolled to join FFS at nearly three times the rate of all other beneficiaries in HMOs. For example, in 2017, 4.6 percent of beneficiaries in the last year of life enrolled in HMOs disenrolled to join FFS, compared to 1.6 percent of all other beneficiaries enrolled in HMOs. (See fig. 2.)

²⁶A few studies have raised concerns that MA beneficiaries are more likely to receive care from lower quality rated home health agencies and skilled nursing facilities compared to FFS beneficiaries. See Margot L. Schwartz et al., "Quality of Home Health Agencies Serving Traditional Medicare vs Medicare Advantage Beneficiaries," *JAMA Network Open*, vol. 2, no. 9 (2019); and David J. Meyers et al., "Medicare Advantage Enrollees More Likely To Enter Lower-Quality Nursing Homes Compared To Fee-For-Service Enrollees," *Health Affairs*, vol. 37, no. 1 (2018).

²⁷In a 2018 report, the Department of Health and Human Services Office of Inspector General raised concerns regarding the possibility that MAOs have inappropriately denied prior authorization requests based on the high proportion of request denials that are overturned upon appeal. See Department of Health and Human Services Office of Inspector General, *Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials*, OEI-09-16-00410 (Washington, D.C.: September 2018). The Department of Health and Human Services Office of Inspector General has additional ongoing work examining the potential extent of inappropriate denials.

Figure 2: Medicare Advantage Disenrollments to Join Medicare Fee-for-Service by Beneficiaries in the Last Year of Life Compared to All Other Beneficiaries, by Plan Type, 2016-2017



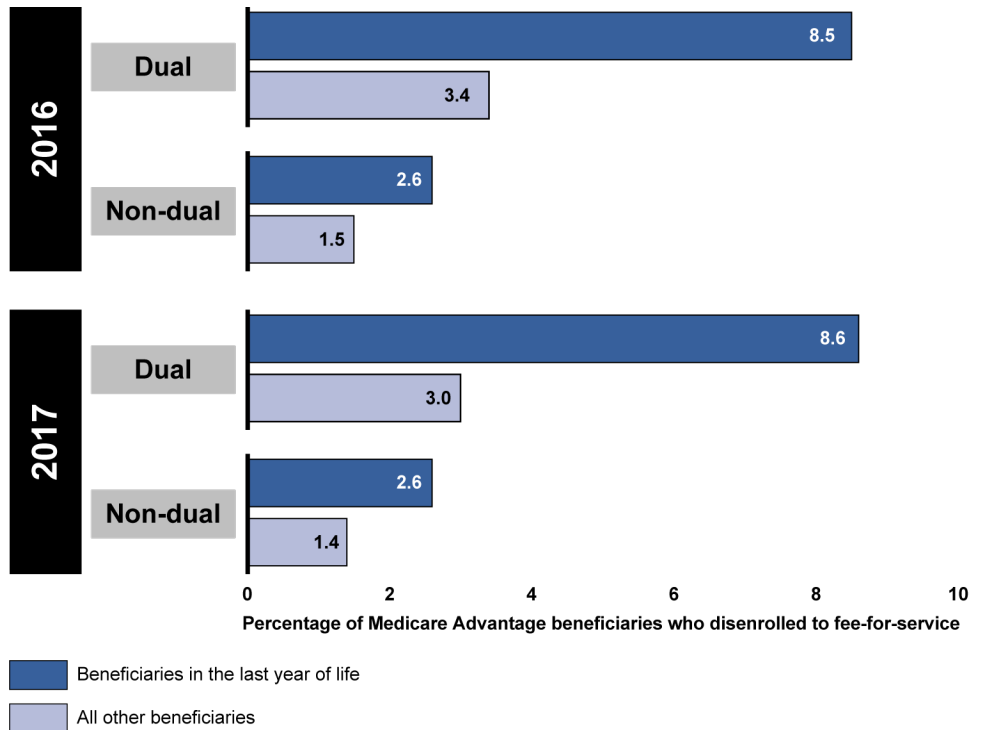
Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-21-482

Note: In both 2016 and 2017, beneficiaries enrolled in health maintenance organizations (HMO) made up 74 percent of our cohort analysis population, beneficiaries in local preferred provider organizations (PPO) made up 16 percent, and beneficiaries in regional PPOs made up 10 percent.

	2016			2017		
	HMO	Local PPO	Regional PPO	HMO	Local PPO	Regional PPO
Beneficiaries in the last year of life	4.4%	3.7%	6.8%	4.6%	3.6%	5.7%
All other beneficiaries	1.7%	2.2%	3.3%	1.6%	2.0%	2.4%

In 2016 and 2017, dual eligible beneficiaries had a greater relative increase in their rate of disenrollment from MA to join FFS in the last year of life compared to non-dual beneficiaries. In particular, dual eligible beneficiaries in the last year of life disenrolled to join FFS at nearly three times the rate of all other dual eligible beneficiaries, while non-dual beneficiaries in the last year of life disenrolled to join FFS at about twice the rate of all other non-dual beneficiaries. (See fig. 3.)

Figure 3: Medicare Advantage Disenrollments to Join Medicare Fee-for-Service by Beneficiaries in the Last Year of Life Compared to All Other Beneficiaries, by Dual Eligible Status, 2016-2017



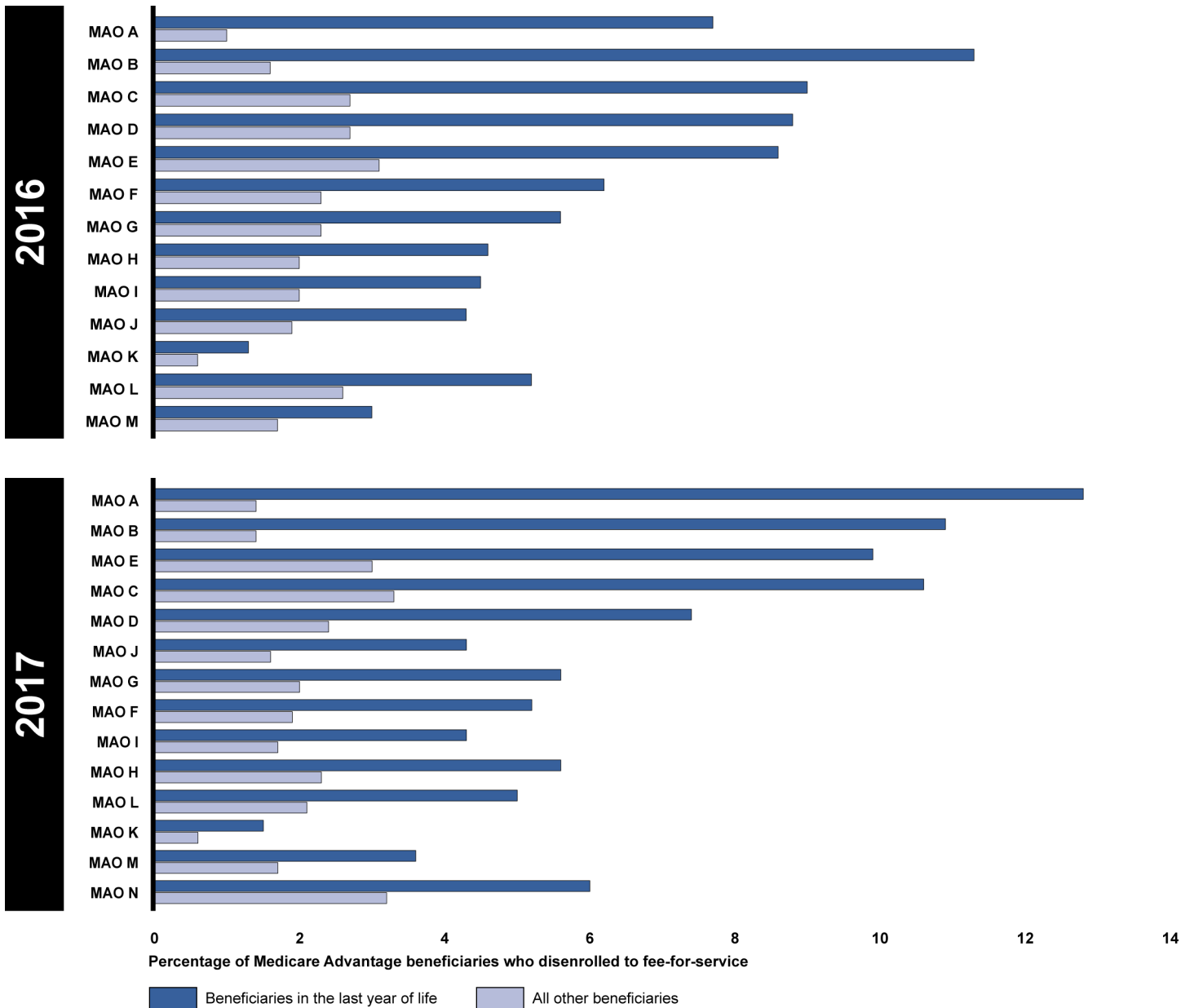
Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-21-482

Note: Dual eligible beneficiaries are those who are eligible for both Medicare and Medicaid, a joint federal-state program that finances health insurance coverage for certain low-income and medically needy individuals. In both 2016 and 2017, non-dual eligible beneficiaries made up 77 percent of our cohort analysis population, and 68 percent of those in the last year of life. Dual eligible beneficiaries made up 23 percent of our cohort population, and 32 percent of those in the last year of life.

	2016		2017	
	Dual	Non-dual	Dual	Non-dual
Beneficiaries in the last year of life	8.5%	2.6%	8.6%	2.6%
All other beneficiaries	3.4%	1.5%	3.0%	1.4%

Certain MAOs—which may offer multiple MA plans—had substantially higher relative increases in disenrollments to join FFS by beneficiaries in the last year of life compared to other MAOs. For example, in 2017, the MAO with the highest relative increase in disenrollments to join FFS saw beneficiaries in the last year of life disenroll at nearly 10 times the rate of all other beneficiaries. (See fig. 4.) In both 2016 and 2017, the same two MAOs had the highest relative increase in disenrollments by beneficiaries in the last year of life. (For additional data on MA beneficiary disenrollment, see app. III.)

Figure 4: Medicare Advantage Disenrollments to Join Medicare Fee-for-Service by Beneficiaries in the Last Year of Life Compared to All Other Beneficiaries, by MAO, 2016-2017



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-21-482

Note: Medicare Advantage organizations (MAO) cover beneficiaries under their Medicare Advantage plans. MAOs have been deidentified and are ordered according to the highest to lowest relative increase in the disenrollment rate to join fee-for-service by beneficiaries in the last year of life compared to the disenrollment rate for all other beneficiaries. The figure only includes organizations

that had at least 200 Medicare Advantage beneficiaries in the last year of life who disenrolled to join Medicare fee-for-service, of which there were 13 in 2016 and 14 in 2017. These organizations accounted for 71 percent and 72 percent of Medicare Advantage beneficiary enrollment in our 2016 and 2017 cohorts, respectively.

2016	Beneficiaries in last year of life	All other beneficiaries
MAO A	7.7	1.0
MAO B	11.3	1.6
MAO C	9.0	2.7
MAO D	8.8	2.7
MAO E	8.6	3.1
MAO F	6.2	2.3
MAO G	5.6	2.3
MAO H	4.6	2.0
MAO I	4.5	2.0
MAO J	4.3	1.9
MAO K	1.3	0.6
MAO L	5.2	2.6
MAO M	3.0	1.7

CMS Does Not Monitor Disenrollments by MA Beneficiaries in the Last Year of Life

CMS examines a variety of MA plan performance data, including data tracked as part of the agency’s Five-Star Rating System of MA plan quality, to determine whether plans adhere to MA program requirements. Accordingly, CMS tracks and reviews MA plans’ disenrollment rates to monitor plan performance and help ensure that all beneficiaries have adequate access to covered services. In response to our 2017 report that identified certain plans with disproportionate disenrollment among beneficiaries in poorer health, CMS began to review disenrollments by such beneficiaries.²⁸ CMS officials told us that their monitoring of beneficiary disenrollments, including disenrollments by those in poorer health, has focused on identifying MA plans with high rates of

²⁸See [GAO-17-393](#).

disenrollment.²⁹ High rates of disenrollment may lead to CMS scrutiny of plan performance and adherence to MA program requirements.³⁰

However, CMS officials told us that the agency does not examine MA disenrollment rates for beneficiaries in the last year of life. Federal internal control standards call for agencies to use quality information to implement effective monitoring, and CMS has available data that it could use to monitor disenrollment by beneficiaries in the last year of life. The agency already tracks disenrollment rates as part of its MA Five-Star Rating System, and could use data on beneficiary mortality to identify beneficiaries who disenrolled in the last year of life. A specific focus on reviewing disenrollments by beneficiaries in the last year of life could help CMS better monitor MA for potential concerns regarding the care provided to these beneficiaries—especially given their disproportionate rates of disenrollment to FFS, particularly among certain MAOs, and their need for high-cost, specialized care.

MA Beneficiaries in the Last Year of Life Who Disenrolled to Join FFS in 2016 and 2017 Increased Medicare Program Costs by Nearly Half a Billion Dollars Each Year

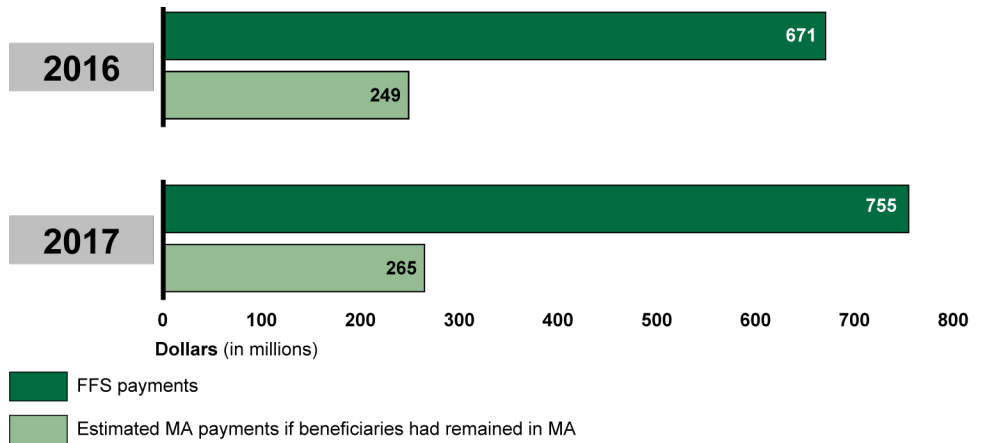
Our analysis of CMS data shows that the beneficiaries in the last year of life who disenrolled from MA to join FFS in 2016 and 2017 increased Medicare costs by nearly half of a billion dollars in each year. FFS payments in 2016 for these beneficiaries were \$671 million—\$422 million higher than our estimated MA payments of \$249 million had they remained in MA. In 2017, FFS payments for these beneficiaries were \$755 million—\$490 million higher than our estimated MA payments of \$265 million. (See fig. 5.) The increased costs stem from these beneficiaries switching from the fixed monthly payment arrangement of MA to join FFS, where payments are based on the amount and cost of services provided. The majority of the actual FFS costs for these

²⁹To better understand disenrollment patterns and drivers of disenrollment, CMS also surveys disenrolled beneficiaries on the reasons for their disenrollments, and has also examined overall MA to FFS disenrollments by beneficiary age and risk score.

³⁰CMS may impose sanctions and penalties on MA plans that are found to be noncompliant with MA program requirements.

beneficiaries—about 75 percent in both 2016 and 2017—were for inpatient and skilled nursing facility services.

Figure 5: Estimated Medicare Advantage (MA) Payments for Beneficiaries in the Last Year of Life Who Disenrolled to Fee-for-Service (FFS) Compared to Actual FFS Payments, 2016-2017



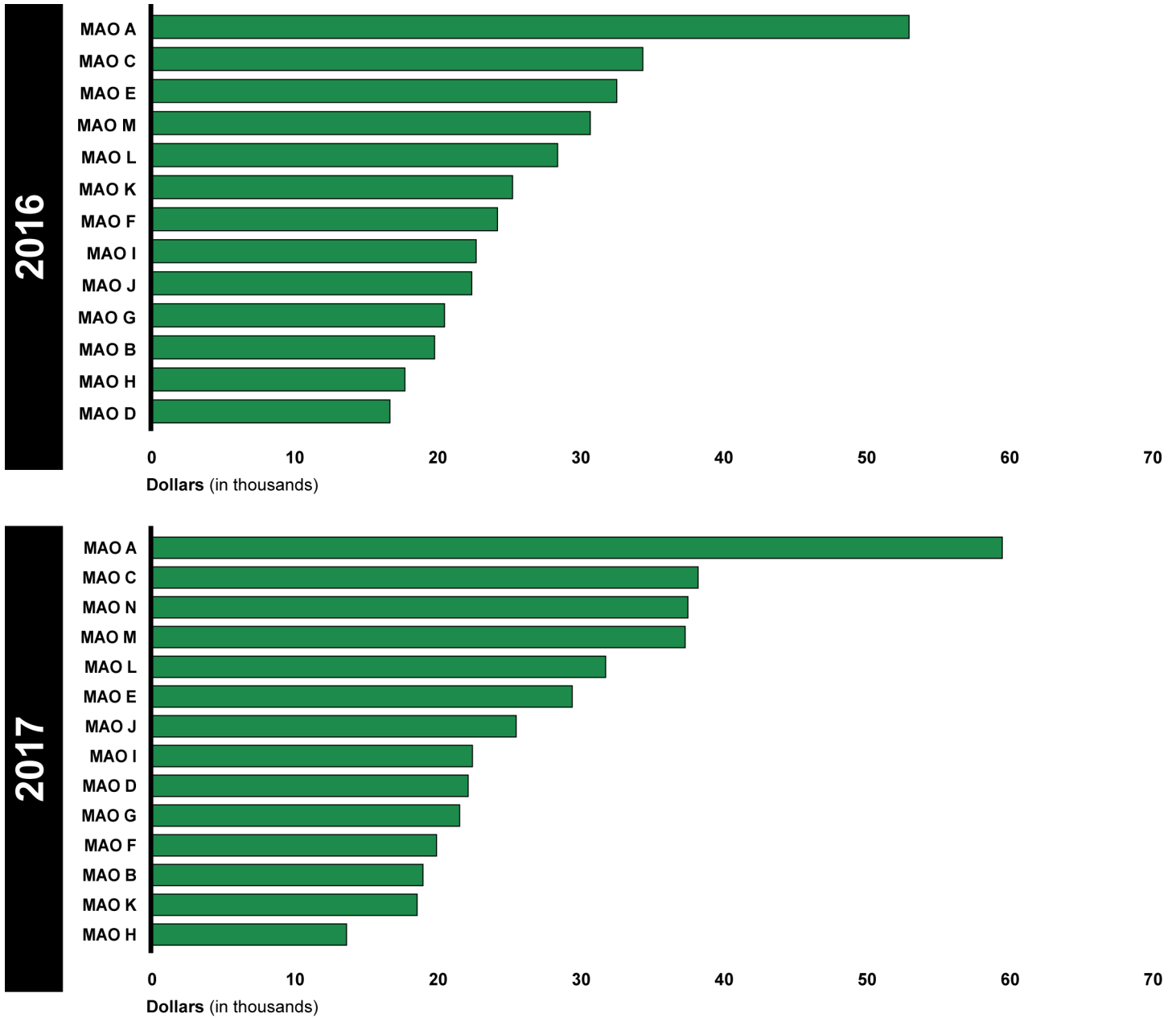
Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-21-482

Note: MA payments are fixed, risk adjusted monthly payments to MA plans, while FFS payments to providers are based on the amount and cost of services provided. We used MA benchmark and Medicare beneficiary risk score data to estimate MA payments for disenrolled beneficiaries from the month of their disenrollment through the month of their death, and compared our estimated MA payments against beneficiaries' actual post-disenrollment FFS payments. The data include payments for the following year for some beneficiaries who disenrolled mid-year.

	2016	2017
Fee-for-service payments	\$671 million	\$755 million
Estimated Medicare Advantage payments if beneficiaries had remained in Medicare Advantage	\$249 million	\$265 million

On average, each MA beneficiary in the last year of life who disenrolled from MA to join FFS in 2016 increased Medicare costs by about \$24,000, and each MA beneficiary in the last year of life who disenrolled in 2017 increased Medicare costs by about \$25,000. The average per beneficiary increase in costs varied by MAO. (See fig. 6.) In both 2016 and 2017, the same MAO had the highest average disenrollee costs to Medicare. This MAO also had the highest relative increase in beneficiaries in the last year of life disenrolling from MA to join FFS in both 2016 and 2017.

Figure 6: Average Increased Costs to Medicare per Beneficiary Disenrollment to Join Fee-for-Service by Beneficiaries in Last Year of Life by Medicare Advantage Organization, 2016-2017



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-21-482

Notes: Medicare Advantage organizations (MAO) cover beneficiaries under their Medicare Advantage (MA) plans. Each bar represents an MAO and MAOs have been deidentified. The figure only includes organizations that had at least 200 beneficiaries in the last year of life who disenrolled to join fee-for-

service (FFS), of which there were in 13 in 2016 and 14 in 2017. These organizations accounted for 71 percent and 72 percent of MA beneficiary enrollment in our 2016 and 2017 cohorts, respectively.

MA payments are fixed, risk adjusted monthly payments to MA plans, while FFS payments to providers are based on the amount and cost of services provided. We used MA benchmark and Medicare beneficiary risk score data to estimate MA payments for disenrolled beneficiaries from the month of their disenrollment through the month of their death, and compared our estimated MA payments against beneficiaries' actual post-disenrollment FFS payments. The data include payments for the following year for some beneficiaries who disenrolled mid-year.

2016	Amount	2017	Amount
MAO A	52.95	MAO A	59.444
MAO C	34.335	MAO C	38.17
MAO E	32.507	MAO N	37.459
MAO M	30.662	MAO M	37.266
MAO L	28.376	MAO L	31.711
MAO K	25.225	MAO E	29.366
MAO F	24.168	MAO J	25.455
MAO I	22.678	MAO I	22.388
MAO J	22.37	MAO D	22.09
MAO G	20.462	MAO G	21.499
MAO B	19.774	MAO F	19.88
MAO H	17.691	MAO B	18.932
MAO D	16.645	MAO K	18.524
		MAO H	13.591

While MA beneficiaries in the last year of life who disenrolled to join FFS increased costs to Medicare, there was a relatively minimal difference in our estimated MA payments and FFS payments for all other disenrollees. (See table 1.) Accordingly, the additional costs to Medicare stemming from MA to FFS disenrollments may be almost exclusively attributable to the high cost of care for beneficiaries in the last year of life.

Table 1: Estimated Medicare Advantage (MA) Payments for Beneficiaries Who Disenrolled to Fee-for-Service (FFS) Compared to Actual FFS Payments, 2016-2017

	MA beneficiaries in the last year of life who disenrolled to join FFS			All other MA beneficiaries who disenrolled to join FFS		
	Average monthly FFS payments (dollars)	Estimated average monthly MA payment (dollars)	Difference in Medicare payments (dollars)	Average monthly FFS payment (dollars)	Estimated average monthly MA payment (dollars)	Difference in Medicare payments (dollars)
2016	6,500	2,400	4,100	1,100	1,200	(100)
2017	7,000	2,400	4,500	1,200	1,200	(100)

Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-21-482

Notes: MA payments are fixed, risk adjusted monthly payments to MA plans, while FFS payments to providers are based on the amount and cost of services provided. We used MA benchmark and Medicare beneficiary risk score data to estimate MA payments for disenrolled beneficiaries in the last year of life from the month of their disenrollment through the month of their death, and compared our estimated MA payments against beneficiaries' actual post-disenrollment FFS payments. We also calculated estimated MA payments for all other disenrolled beneficiaries who were not in the last year of life for the 12 month period after their disenrollment, and similarly compared our estimated MA payments against their FFS payments. The data include payments for the following year for some beneficiaries who disenrolled mid-year.

Data may not sum due to rounding. Parentheses denote negative numbers.

Beneficiaries who disenroll from MA to join FFS in the last year of life impose substantial additional costs to Medicare, and uniquely do so relative to other disenrollees. Federal agencies have a responsibility to be efficient purchasers of services. By not using available information to monitor MA for disproportionate disenrollments by beneficiaries in the last year of life—and potentially limit their inclination to disenroll to FFS by better ensuring the quality of their care—CMS may be missing an opportunity to ensure more efficient Medicare program spending. In addition, our analysis shows that disenrollments to join FFS by MA beneficiaries in the last year of life are likely financially advantageous for MA plans since the costs to provide care for these beneficiaries exceeded the fixed payment MA plans would have received. Accordingly, this may further warrant a specific focus on monitoring disenrollments by beneficiaries in the last year of life.

Conclusions

A relatively small percentage of Medicare beneficiaries in the last year of life—4.5 percent in 2016 and 4.6 percent in 2017—disenrolled from MA to join FFS, but their higher levels of disenrollment compared to all other beneficiaries may indicate potential issues with their access to care or the quality of care provided under MA. Further, the higher rate of disenrollment by these disproportionately high-cost beneficiaries imposes hundreds of millions of dollars of additional costs on the Medicare program annually. CMS already examines disenrollments by MA beneficiaries in poorer health as part of its monitoring, and higher rates of disenrollment may lead to CMS scrutiny of plan performance. Given their high costs and specialized care needs, a specific focus on disenrollments by beneficiaries in the last year of life could help CMS better identify and address potential concerns regarding their care under MA, and ensure more efficient Medicare program spending.

Recommendation

The Administrator of CMS should review disenrollments by MA beneficiaries in the last year of life as part of the agency's broader efforts to review disenrollments by MA beneficiaries in poorer health. (Recommendation 1)

Agency Comments

We provided a draft of this report to the Department of Health and Human Services for comment. In its written comments, which are reprinted in appendix IV, the department concurred with our recommendation. The department noted that it conducts a range of oversight activities to ensure that MA plans adequately meet the care needs of MA beneficiaries regardless of their health status, and that it will review disenrollments by MA beneficiaries in the last year of life and determine any appropriate next steps.

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 appropriate congressional committees and the Secretary of Health and Human Services. In addition, the report will be available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staffs have any questions about this report, please contact me at (202) 512-7114 or FarbJ@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report.



Jessica Farb
Director, Health Care

Appendix I: Beneficiary Cohorts for Disenrollment Analysis

Using enrollment, disenrollment, and mortality data from the Centers for Medicare & Medicaid Services (CMS), we examined Medicare Advantage (MA) disenrollment and mortality for two separate cohorts of MA beneficiaries—beneficiaries enrolled in MA as of December 2015, and beneficiaries enrolled as of December 2016. Our cohorts included 70 percent of beneficiaries enrolled in MA in December 2015, and 71 percent of beneficiaries enrolled in MA in December 2016. We excluded the following MA beneficiaries from our analysis:

- beneficiaries enrolled in certain types of MA plans, including Cost, Programs of All-Inclusive Care for the Elderly, employer group waiver, private fee-for-service, and Religious-Fraternal Benefit MA plans;
- beneficiaries enrolled in MA contracts with fewer than 1,000 beneficiaries;
- beneficiaries with end-stage renal disease;
- beneficiaries residing outside of the 50 states and Washington, D.C.;
- beneficiaries who died during the respective cohort month, such as beneficiaries enrolled in MA in December 2015, but who died during the month;
- beneficiaries who used hospice services in the cohort year, such as beneficiaries in the December 2015 cohort that elected hospice services at any point in 2015, since their care was already generally being provided under fee-for-service (FFS);¹ and
- beneficiaries who had more than one enrollment change during the subsequent calendar year: calendar year 2016 for the December 2015 cohort, or calendar year 2017 for the December 2016 cohort. This exclusion includes beneficiaries who had multiple disenrollments from MA contracts, and beneficiaries who disenrolled to join FFS and then reenrolled in MA. For both cohorts, beneficiaries with multiple enrollment changes represented less than 1 percent of all beneficiaries in the cohorts, and 7 percent of beneficiaries who

¹Beneficiaries that used hospice in the subsequent calendar year, such as beneficiaries in the December 2015 cohort that used hospice services in 2016, are included in the cohorts.

**Appendix I: Beneficiary Cohorts for
Disenrollment Analysis**

disenrolled to either another MA contract or to join FFS in the December 2015 cohort, and 8 percent in the December 2016 cohort.

Additionally, due to limitations matching certain beneficiary-level data, our analysis of the costs to Medicare from MA beneficiaries in the last year of life who disenroll to join FFS excluded 5 percent of such beneficiaries in the December 2015 cohort, and 7 percent of such beneficiaries in the December 2016 cohort.

Appendix II: Methodology for Comparing Estimated Medicare Advantage Payments for Disenrolled Beneficiaries to Actual Fee-for-Service Payments

To examine the costs to Medicare from beneficiaries who disenrolled from Medicare Advantage (MA) to join fee-for-service (FFS) in 2016 and 2017, we estimated MA payments for these beneficiaries had they remained in MA, and compared our estimate to their actual post-disenrollment FFS payments.

For beneficiaries who disenrolled mid-year, our comparison of estimated MA payments against FFS payments may include payments for the year following the beneficiaries' disenrollment to join FFS. For example, if a beneficiary in the December 2016 cohort disenrolls to join FFS in July 2017 and dies in June 2018, our comparison would include payments for January through June 2018. For the sake of simplicity, we present our payment comparison data based on the year of the beneficiaries' disenrollments. In the example above, all estimated MA payments and FFS payments for the beneficiary are presented as 2017 data.

We estimated MA payments for disenrolled beneficiaries using MA benchmark and Medicare beneficiary risk score data for 2016 through 2018. MA benchmark amounts represent the maximum, non-risk adjusted amount that Medicare will pay per enrolled beneficiary in a given county for local plans, or a given region for regional plans. We used beneficiaries' state and county residence information to identify applicable county-level benchmark amounts for beneficiaries who disenrolled from local plans, and region-level benchmark amounts for beneficiaries who disenrolled from regional plans. Additionally, MA contracts that meet certain quality metrics receive quality bonuses that increase their benchmark amount by 5 percent, and by 10 percent for local plans in certain counties. Our MA payment estimates were based on the increased quality bonus benchmark amounts.

**Appendix II: Methodology for Comparing
Estimated Medicare Advantage Payments for
Disenrolled Beneficiaries to Actual Fee-for-
Service Payments**

Actual MA payments are generally lower than benchmark amounts, as MA payments are based on plan bids to cover an average, non-risk adjusted beneficiary in a given county or region. Benchmarks serve as a bidding target for MA plans, and Medicare and MA plans share savings derived from bids below the benchmark.¹ In 2017, for example, the Medicare Payment Advisory Commission estimated that MA payments were on average 6 percent lower than benchmark amounts.

We multiplied beneficiaries' applicable benchmark amounts by beneficiaries' risk scores to estimate their MA payments. MA payments are risk-adjusted using risk scores that are based on beneficiaries' demographic and diagnosis information. The average beneficiary score is 1.0, and higher or lower scores correspond to higher or lower predicted health care costs. For example, a score of 2.0 indicates a beneficiary has projected spending twice the national average.²

Risk adjustments are generally higher for beneficiaries who are dual eligible for both Medicare and Medicaid, and for institutionalized beneficiaries. Mid-year changes to beneficiary dual eligibility or institutional status can accordingly increase beneficiaries' risk adjustment and MA payment amounts. For beneficiaries who had such mid-year changes, we applied beneficiaries' highest risk adjustment status to the entire calendar year to calculate our estimated payments. For example, if a beneficiary in the December 2016 cohort was a full dual eligible beneficiary for one month in 2017, we applied the beneficiary's full dual eligible risk score for all months we calculated payments for in 2017. For beneficiaries who disenrolled mid-year, we used the applicable calendar year risk score if the period after their disenrollment crossed years.³

¹Plans that bid below the benchmark receive payment from Medicare in the form of a rebate that must be returned to its enrollees in the form of supplemental benefits or lower premiums.

²For additional information on MA payments, see Medicare Payment Advisory Commission, *Medicare Advantage Program Payment System*, revised Oct. 2020, accessed Nov. 19, 2020, http://medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_20_ma_final_sec.pdf.

³For example, if a beneficiary in the December 2015 cohort disenrolls to join FFS in July 2016 and dies in June 2017, we applied the beneficiary's 2016 risk score to estimate payments for July through December 2016, and the beneficiary's 2017 risk score to estimate payments for January through June 2017.

**Appendix II: Methodology for Comparing
Estimated Medicare Advantage Payments for
Disenrolled Beneficiaries to Actual Fee-for-
Service Payments**

Our estimates of MA payments assume that Medicare Advantage organizations would have continued to receive full payments for beneficiaries through the month of their death, and do not account for payment reductions for beneficiaries who elected hospice services. Hospice services are covered under FFS, and MA payments are accordingly reduced for beneficiaries who elect hospice services to reflect plans' limited financial responsibility for care.

On aggregate, we likely overestimate MA payments for disenrolled beneficiaries because

- we used benchmark amounts, which are greater than actual payments on aggregate;
- we used quality bonus benchmark amounts, even for beneficiaries who disenrolled from MA contracts that did not receive quality bonuses;
- we applied beneficiaries' highest risk adjustment status to all calendar year months to risk adjust our estimated payments for beneficiaries that were dual eligible or institutionalized for only part of a year; and
- we did not account for MA payment reductions for beneficiaries who elected hospice services.

Because we likely overestimate MA payments, to the extent that disenrollees' FFS payments were greater than our estimated MA payments, we likely underestimate the amount by which FFS payments were higher.

Appendix III: Additional Data on Medicare Advantage Disenrollments by Beneficiaries in the Last Year of Life and Their Costs to Medicare

This appendix provides additional data on disenrollment by Medicare Advantage (MA) beneficiaries in the last year of life, and their associated costs to the Medicare program. Beneficiaries who disenroll from their MA plan may join a plan offered under a different MA contract or join Medicare fee-for-service (FFS). Table 2 provides data on all disenrollments by MA beneficiaries in the last year of life in 2016 and 2017.

Table 2: Medicare Advantage (MA) Beneficiary Disenrollments to another MA Contract or Medicare Fee-for-Service (FFS), 2016-2017

		Number of beneficiaries in the last year of life	Percent of beneficiaries in the last year of life who disenrolled	Percent of all other beneficiaries who disenrolled	Disenrollment ratio of beneficiaries in the last year of life compared to all other beneficiaries
2016	Disenrolled to another MA contract	27,854	6.6	7.7	.9
	Disenrolled to join FFS	18,970	4.5	2.0	2.3
	Total disenrollments	46,824	11.1	9.7	1.2
2017	Disenrolled to another MA contract	31,707	7.0	7.9	.9
	Disenrolled to join FFS	20,749	4.6	1.7	2.6
	Total disenrollments	52,456	11.6	9.7	1.2

Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-21-482

Note: Data may not sum due to rounding.

Table 3 provides data on disenrollments to join FFS by MA beneficiaries in the last year of life, by age group in 2016 and 2017.

Appendix III: Additional Data on Medicare Advantage Disenrollments by Beneficiaries in the Last Year of Life and Their Costs to Medicare

Table 3: Medicare Advantage Beneficiary Disenrollments to Join Medicare Fee-for-Service, by Age, 2016-2017

	Age	Percent of cohort beneficiaries	Percent of cohort beneficiaries in the last year of life	Percent of beneficiaries in the last year of life who disenrolled	Percent of all other beneficiaries who disenrolled	Disenrollment ratio of beneficiaries in the last year of life compared to all other beneficiaries
2016	Under 65	20	11	5.2	2.8	1.9
	65-74	45	24	4.5	1.8	2.5
	75-84	26	33	4.5	1.6	2.8
	85 and above	9	32	4.2	1.7	2.5
2017	Under 65	20	11	5.0	2.5	2.0
	65-74	45	24	4.5	1.6	2.8
	75-84	26	32	4.6	1.4	3.2
	85 and above	9	33	4.4	1.6	2.7

Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-21-482

Our analysis excluded beneficiaries who used hospice services in the cohort year, such as beneficiaries in the December 2015 cohort that elected hospice services at any point in 2015. Table 4 provides data on the number of beneficiaries excluded because of cohort year, or prior year hospice use, and their rates of disenrollment from MA to join FFS.

Table 4: Medicare Advantage Beneficiary Disenrollments to Join Medicare Fee-for-Service for Beneficiaries with Cohort Year Hospice Use, December 2015-2016 Cohorts

Cohort	Number of beneficiaries	Number of beneficiary disenrollments	Percent of beneficiaries who disenrolled
December 2015	75,977	2,344	3.1
December 2016	83,388	2,533	3.0

Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-21-482

Note: Data includes hospice beneficiaries who were not in the last year of life.

Table 5 provides data on the use of hospice among MA beneficiaries in the last year of life, along with data on their rates of disenrollment. The table presents hospice use for the December 2015 and 2016 cohorts in the subsequent years, 2016 and 2017 (those that used hospice services in the cohort year, such as beneficiaries in the December 2015 cohort that elected hospice services at any point in 2015, were excluded from our analysis).

Appendix III: Additional Data on Medicare Advantage Disenrollments by Beneficiaries in the Last Year of Life and Their Costs to Medicare

Table 5: Hospice Use and Disenrollments to Join Medicare Fee-for-Service by Medicare Advantage Beneficiaries in the Last Year of Life, 2016-2017

		Number of beneficiaries in last year of life	Percent of beneficiaries in the last year of life	Number of beneficiary disenrollments	Percent of beneficiaries who disenrolled
2016	Hospice user	199,484	47	9,419	4.7
	Non-hospice user	221,413	53	9,551	4.3
	Total	420,897	-	18,970	4.5
2017	Hospice user	216,890	48	10,380	4.8
	Non-hospice user	237,207	52	10,369	4.3
	Total	454,097	-	20,749	4.6

Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-21-482

Tables 6 and 7 compare our estimated MA payments for disenrolled beneficiaries against their post-disenrollment FFS payments in 2016 and 2017 by Medicaid dual eligible status and plan type, respectively.

Table 6: Estimated Medicare Advantage (MA) Payments for Beneficiaries in the Last Year of Life Who Disenrolled to Fee-for-Service (FFS) Compared to FFS Payments, by Dual Status, 2016-2017

	Dual eligible			Non-dual eligible		
	Average per beneficiary FFS payments (dollars in thousands)	Average per beneficiary estimated MA payments (dollars in thousands)	Average increased Medicare payments (dollars in thousands)	Average per beneficiary FFS payments (dollars in thousands)	Average per beneficiary estimated MA payments (dollars in thousands)	Average increased Medicare payments (dollars in thousands)
2016	39.1	15.0	24.1	34.9	12.2	22.8
2017	40.7	14.9	25.7	36.3	11.7	24.6

Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-21-482

Notes: MA payments are fixed, risk adjusted monthly payments to MA plans, while FFS payments to providers are based on the amount and cost of services provided. We used MA benchmark and Medicare beneficiary risk score data to estimate MA payments for disenrolled beneficiaries from the month of their disenrollment through the month of their death, and compared our estimated MA payments against beneficiaries' actual post-disenrollment FFS payments. The data include payments for the following year for some beneficiaries who disenrolled mid-year.

Dual eligible beneficiaries are those who are eligible for both Medicare and Medicaid, a joint federal-state program that finances health insurance coverage for certain low-income and medically needy individuals. In both 2016 and 2017, non-dual eligible beneficiaries made up 77 percent of our cohort analysis population, and 68 percent of those in the last year of life. Dual eligible beneficiaries made up 23 percent of our cohort population, and 32 percent of those in the last year of life.

Data may not sum due to rounding.

Appendix III: Additional Data on Medicare Advantage Disenrollments by Beneficiaries in the Last Year of Life and Their Costs to Medicare

Table 7: Estimated Per Beneficiary MA Payments for Beneficiaries in the Last Year of Life Who Disenrolled to FFS Compared to Their FFS Payments, by Plan Type, 2016-2017

	HMO			PPO		
	Average per beneficiary FFS payments (dollars in thousands)	Average per beneficiary estimated MA payments (dollars in thousands)	Increased Medicare payments (dollars in thousands)	Average per beneficiary FFS payments (dollars in thousands)	Average per beneficiary estimated MA payments (dollars in thousands)	Increased Medicare payments (dollars in thousands)
2016	39.0	13.8	25.1	33.5	14.0	19.5
2017	40.8	13.8	27.0	33.5	13.4	20.1

Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-21-482

Notes: Medicare Advantage (MA) payments are fixed, risk adjusted monthly payments to MA plans, while fee-for-service (FFS) payments to providers are based on the amount and cost of services provided. We used MA benchmark and Medicare beneficiary risk score data to estimate MA payments for disenrolled beneficiaries from the month of their disenrollment through the month of their death, and compared our estimated MA payments against beneficiaries' actual post-disenrollment FFS payments. The data include payments for the following year for some beneficiaries who disenrolled mid-year.

In both 2016 and 2017, beneficiaries enrolled in health maintenance organizations (HMO) made up 74 percent of our cohort analysis population, beneficiaries in local preferred provider organizations (PPO) made up 16 percent, and beneficiaries in regional PPOs made up 10 percent.

Data may not sum due to rounding.

Table 8 provides data on Medicare FFS spending for certain services for beneficiaries in the last year of life that disenrolled from MA to join FFS, all other beneficiaries that disenrolled from MA to join FFS, and FFS beneficiaries more generally.

Appendix III: Additional Data on Medicare Advantage Disenrollments by Beneficiaries in the Last Year of Life and Their Costs to Medicare

Table 8: Medicare Fee-for-Service (FFS) Utilization and Payments for Beneficiaries Who Disenrolled from Medicare Advantage and All Medicare FFS Beneficiaries, 2016-2017

		Percent of beneficiaries using services (percentage)			Average monthly FFS payments per beneficiary (dollars)		
		Disenrolled beneficiaries in the last year of life	All other disenrolled beneficiaries	All Medicare FFS beneficiaries	Disenrolled beneficiaries in the last year of life	All other disenrolled beneficiaries	All Medicare FFS beneficiaries
2016	Inpatient	64	24	17	3,589	367	290
	Outpatient	69	74	67	467	178	169
	Skilled nursing facility	41	10	5	1,234	150	62
	Home health	25	16	9	193	68	43
	Physician and other services	95	92	87	1,055	310	257
2017	Inpatient	63	24	17	3,798	393	294
	Outpatient	68	74	67	496	197	180
	Skilled nursing facility	44	11	5	1,407	180	61
	Home health	24	16	9	189	71	42
	Physician and other services	94	92	87	1,083	320	262

Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-21-482

Notes: For beneficiaries in the last year of life, the table presents FFS payments from the month of their disenrollment through the month of their death. For all other disenrolled beneficiaries, the table presents payments for the 12 month period after disenrollment. The data for disenrolled beneficiaries include payments made in the following year for some beneficiaries who disenrolled mid-year.

The data for all Medicare FFS beneficiaries represents calendar year service use and payments, and is inclusive of all beneficiaries, including those that disenrolled from Medicare Advantage to join FFS.

Appendix IV: 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

June 4, 2021

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

Dear Ms. Farb:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "*MEDICARE ADVANTAGE: Beneficiary Disenrollments to Fee-For-Service in Last Year of Life Increase Medicare Spending*" (Job code 103926/GAO-21-482).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

**Rose M.
Sullivan -S**

Rose Sullivan
Acting Assistant Secretary for Legislation
Principal Deputy Assistant Secretary for Legislation

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Sullivan -S
Date: 2021.06.09 12:18:31
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Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICARE ADVANTAGE: BENEFICIARY DISENROLLMENTS TO FEE-FOR-SERVICE IN LAST YEAR OF LIFE INCREASE MEDICARE SPENDING (GAO-21-482)

The Department of Health & Human Services (HHS) appreciates the opportunity to review and comment on the Government Accountability Office's (GAO) draft report.

HHS is committed to ensuring that beneficiaries enrolled in Medicare Advantage (MA) in their last year of life are able to access quality care through the plan of their choice, regardless of their health care needs or health status.

In the MA program, HHS enters into contracts with Medicare Advantage Organizations (MAOs), which offer private health insurance plans to Medicare beneficiaries. MAOs must provide coverage for all traditional Medicare services and are paid fixed monthly payments by CMS that are dependent upon the relative health status of the MAOs' beneficiaries.

HHS conducts oversight of MA plans offered by MAOs to ensure that they comply with federal requirements. For example, as part of our oversight, HHS evaluates each plan benefit package to ensure that it does not offer cost-sharing structures or plan benefits that encourage disenrollment, steer specific subsets of Medicare beneficiaries to particular MA plans, inhibit access to services, or include supplemental benefits that only appeal to healthier beneficiaries. HHS also analyzes MA plan data to ensure that all required benefits are covered, that cost sharing complies with Medicare restrictions on out-of-pocket costs, and that Medicare network adequacy requirements are met. HHS continues to conduct oversight of the plan through annual audits and through its HHS Account Managers and other mechanisms to ensure that MA plans are meeting all regulatory requirements, including ensuring that MA enrollees are provided equal access to health care services regardless of health status.

Every year, HHS measures the quality of health and drug services received by beneficiaries enrolled in MA and Prescription Drug Plans (PDPs) and publishes plan performance as the Medicare Star Ratings. This measurement of plan quality and performance allows for oversight and quality monitoring, and is used to determine the MA Quality Bonus Payments. Included in the Star Ratings measures for both MA and Part D is a measure called "Members Choosing to Leave the Plan" that measures beneficiary rates of voluntary disenrollment from a plan. Each plan's Star Rating on this measure, as well as Star Ratings for the other measures, are publically displayed on the Medicare Plan Finder tool. The Plan Finder tool helps beneficiaries make informed choices about their health care coverage by providing information so that they may consider a plan's quality, cost, and coverage, thus incentivizing quality improvement by plans seeking to attract enrollees. HHS also publishes the underlying data indicating the percent of plan members who voluntarily disenrolled from the plan.

Further, every year, HHS surveys a sample of beneficiaries who voluntarily disenrolled from MA plans and PDPs to learn about their reasons for choosing to disenroll. HHS provides the survey results to plans to help them facilitate quality improvement efforts. The survey results are also grouped together into five composite measures—"Financial Reasons for Disenrollment,"

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICARE ADVANTAGE: BENEFICIARY DISENROLLMENTS TO FEE-FOR-SERVICE IN LAST YEAR OF LIFE INCREASE MEDICARE SPENDING (GAO-21-482)

“Problems with Prescription Drug Benefits and Coverage,” “Problems Getting Information and Help from the Plan,” “Problems Getting the Plan to Provide and Pay for Needed Care” and “Problems with Coverage of Doctors and Hospitals”—that are included as MA and Part D display measures. HHS publicizes these display measures on cms.gov in order to further strengthen oversight of MA plans.

GAO Recommendation

The Administrator of CMS should review disenrollments by MA beneficiaries in the last year of life as part of the agency's broader efforts to review disenrollment by MA beneficiaries in poorer health.

HHS Response

HHS concurs with GAO's recommendation.

CMS will review disenrollments by MA beneficiaries in the last year of life and determine any appropriate next steps.

Agency Comment Letter

Text of Appendix IV: Comments from the Department of Health and Human Services

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GAO Recommendation

The Administrator of CMS should review disenrollments by MA beneficiaries in the last year of life as part of the agency’s broader efforts to review disenrollment by MA beneficiaries in poorer health.

HHS Response

HHS concurs with GAO’s recommendation.

CMS will review disenrollments by MA beneficiaries in the last year of life and determine any appropriate next steps.

Appendix V: GAO Contact and Staff Acknowledgments

GAO Contact

Jessica Farb, (202) 512-7114 or FarbJ@gao.gov.

Staff Acknowledgment

In addition to the individual named above, Martin T. Gahart (Assistant Director), Michael Erhardt (Analyst-in-Charge), Todd Anderson, Karen (Maggie) Bryson, Sonia Chakrabarty, James Cosgrove, Rich Lipinski, Drew Long, Leslie McNamara, Vikki Porter, and Ravi Sharma made key contributions to this report.

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