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MEDICARE ADVANTAGE

Relationship between Benefit Package Designs and Plans' Average Beneficiary Health Status

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Highlights

Highlights of GAO-10-403, a report to congressional requesters

Why GAO Did This Study

Nearly 11 million Medicare beneficiaries are enrolled in Medicare Advantage (MA), Medicare's private health insurance option. Benefits vary by MA plan and may include coverage for services not available in traditional Medicare. To ensure MA plan benefit package designs do not discriminate against beneficiaries in poor health with high expected health care costs, the Centers for Medicare & Medicaid Services (CMS) reviews and approves all benefit packages yearly.

GAO examined (1) MA plan benefit packages by average health status of plans' enrolled beneficiaries, (2) distribution and characteristics of MA plans by average beneficiary health status, and (3) CMS's process for ensuring that benefit packages do not discriminate with respect to health status. Using 2008 data on beneficiaries' expected health care costs, the most recent data available, GAO sorted 2,899 plans enrolling 7.5 million beneficiaries into three groups: good health (below-average expected costs), average health, and poor health (above-average expected costs). GAO then analyzed MA plan benefit packages by health group and reviewed CMS documentation and interviewed agency officials on CMS's benefit package review process. GAO did not determine whether plans structured benefit packages in response to enrolled beneficiaries' health status or beneficiaries in particular health groups chose plans because of the benefits.

View GAO-10-403 or key components.
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What GAO Found

In 2008, plans in the good health group generally had lower premiums, higher cost sharing for certain services, and fewer additional benefits than plans in the poor health group. Almost half of the plans in the good health group did not have an MA premium for medical or drug coverage, while about one-fifth of plans in the poor health group had no MA premium. Plans in the good health group had higher cost sharing, weighted by enrollment, for inpatient hospital care, skilled nursing facility stays, and renal dialysis than plans in the poor health group. Plans in the good health group were more likely to have an out-of-pocket (OOP) maximum, but the average OOP maximum for plans in that group, weighted by enrollment, was 55 percent higher than that for plans in the poor health group. Comprehensive dental and hearing aid benefits were more likely to be included in the benefit packages for beneficiaries in the poor health group of plans whereas fitness benefits were more likely to be included in the benefit packages for beneficiaries in the good health group of plans.

Forty-three percent of plans were in the good health group, 37 percent in the average health group, and 20 percent in the poor health group. Twenty-nine percent of MA beneficiaries were in plans in the good health group, 55 percent in plans in the average health group, and 16 percent in plans in the poor health group. Among the five largest companies sponsoring MA plans, beneficiary health varied: one sponsor had 17 percent of its beneficiaries in plans in the good health group and 17 percent in plans in the poor health group; another sponsor had 49 percent of beneficiaries in plans in the good health group and less than 1 percent in plans in the poor health group. Average beneficiary health status also varied by other factors, such as plan type and plan size.

CMS has revised its process for reviewing MA plans for the likelihood of discrimination. It developed a new methodology for setting cost-sharing thresholds—criteria used to identify benefit packages likely to discriminate against certain beneficiaries. For contract year 2010, CMS contacted all MA plans with benefit packages identified as likely to discriminate, and all plans subsequently met cost-sharing thresholds. The new methodology for setting cost-sharing thresholds allowed higher cost sharing for some services relative to 2009. For example, among plans without an OOP maximum or one above $3,400 for 2010, allowed cost sharing for a typical inpatient mental health stay doubled, from $61 per day to $130 per day, and allowed cost sharing for a typical skilled nursing facility stay increased from $53 to $70 per day, compared to 2009.

In comments on a draft of this report, CMS noted that GAO's findings are consistent with the agency's experience. CMS also stated that, prior to contract year 2010, it targeted for cost-sharing reductions plans with the most egregious cost sharing and often reduced cost-sharing amounts, but to amounts that were still above the thresholds.