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Report to the Ranking Member, Committee on Ways and Means, House of Representatives

December 2013

MEDICARE ADVANTAGE

2011 Profits Similar to Projections for Most Plans, but Higher for Plans with Specific Eligibility Requirements

GAO-14-148

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GAO Highlights

Highlights of GAO-14-148, a report to the Ranking Member, Committee on Ways and Means, House of Representatives

Why GAO Did This Study

MA organizations are entities that contract with the Centers for Medicare & Medicaid Services (CMS) to offer one or more private plans as an alternative to the Medicare fee-for-service (FFS) program. These MA plans are generally available to all Medicare beneficiaries, although certain types of plans, such as employer group plans, have specific eligibility requirements. Payments to MA organizations are based, in part, on the projected expenses and profits that MA organizations submit to CMS. These projections also affect (1) the extent to which MA beneficiaries receive additional benefits not provided under FFS and (2) beneficiary cost-sharing and premium amounts. The Patient Protection and Affordable Care Act (PPACA) required that, starting in 2014, MA organizations have a minimum medical loss ratio of 85 percent—that is, they must spend 85 percent of revenue on medical expenses, quality-improving activities, and reduced premiums.

This report examines how MA organizations' actual expenses and profits for 2011 as a percentage of revenue and in dollars compared to projections for the same year, both for plans available to all Medicare beneficiaries and for plans with specific eligibility requirements. GAO analyzed data on MA organizations' projected and actual allocation of revenue to expenses and profits. The percentage of revenue spent on medical expenses reported in GAO's study is not directly comparable to the PPACA medical loss ratio calculation, as the final rule defining the calculation was issued after actual 2011 data were submitted.

View GAO-14-148. For more information, contact James Cosgrove at (202) 512-7114 or cosgrovej@gao.gov.

What GAO Found

Medicare Advantage (MA) organizations' actual medical expenses, nonmedical expenses (such as marketing, sales, and administration) and profits as a percentage of total revenue were, on average, similar to projected values for plans available to all beneficiaries in 2011, the most recent year for which data were available at the time of the request for this work. MA organizations' actual medical expenses, nonmedical expenses, and profits were 86.3 percent, 9.1 percent, and 4.5 percent of total revenue, respectively. As a percentage of revenue, all three categories were within 0.3 percentage points of what MA organizations had projected. In addition, MA organizations received, on average, $9,893 in total revenue per beneficiary, slightly higher than the projected amount of $9,635.

The percentage of revenue spent on medical expenses and profits varied between MA contracts. For example, while MA organizations spent an average of 86.3 percent of revenue on medical expenses, 39 percent of beneficiaries were covered under contracts where less than 85 percent of revenue was spent on medical expenses. In addition, the accuracy of MA organizations' projections varied on the basis of the type of plans offered under the contract. For example, contracts for private fee-for-service plans—a plan type with new provider network requirements in 2011—had average profit margins that were 4 percentage points lower than projected.

In 2011, plans offered by MA organizations with specific eligibility requirements had higher-than-projected profits. Special needs plans (SNP), which serve specific populations, such as those with specific chronic conditions, had an 8.6 percent profit margin, but had projected 6.2 percent. This higher percentage, combined with higher-than-projected revenue, resulted in SNPs reporting an average profit per beneficiary of $1,115, or 44 percent higher than projected ($777). Employer group plans, which are offered by employers or unions to their employees or retirees, as well as to Medicare-eligible spouses and dependants of participants in such plans, had a 7.6 percent profit margin, but had projected 4.2 percent. The higher profit margin, combined with higher-than-projected revenue, resulted in employer plans receiving an average profit per beneficiary of $861, or 108 percent higher than projected ($413).

GAO requested comments from CMS, but none were provided.

Contents

Abbreviations

CMS	Centers for Medicare & Medicaid Services
ESRD	end-stage renal disease
FFS	fee-for-service
HMO	health maintenance organization
MA	Medicare Advantage
PFFS	private fee-for-service
PMPM	per member per month
PPACA	Patient Protection and Affordable Care Act
PPO	preferred provider organization
SNP	special needs plan

U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
Washington, DC 20548

December 19, 2013

The Honorable Sander M. Levin
Ranking Member
Committee on Ways and Means
House of Representatives

Dear Mr. Levin:

In 2011, the federal government paid Medicare Advantage (MA) organizations—entities that offer a private health plan alternative to Medicare fee-for-service (FFS)—approximately $124 billion, or about 23 percent of all Medicare spending, to provide health care services to 12.1 million Medicare beneficiaries. The private health plans offered by MA organizations are generally available to all Medicare beneficiaries in the plans' service areas.[1] However, certain types of plans, such as employer group plans—which are offered by employers or unions—and special needs plans (SNP)—which serve specific populations—have more specific eligibility requirements.[2] Payments to MA organizations are based in part on the projected medical expenses, nonmedical expenses (such as marketing, sales, and administration), and profits, which organizations submit in their bids for providing Medicare-covered services, and on actual enrollment and beneficiary health status.[3] In addition to projections, MA organizations are required to report actual

[1]Medicare beneficiaries with end-stage renal disease (ESRD) can only enroll in an MA plan if they meet certain criteria. For example, beneficiaries with ESRD may enroll in an MA plan if (1) they were already enrolled in the MA plan when they developed ESRD; (2) they are eligible for a plan offered by their current or former employer or union that has opted to enroll beneficiaries with ESRD; or (3) they had a successful kidney transplant.

[2]Employer group plans can be offered to employers' or unions' Medicare-eligible retirees and Medicare-eligible active employees, as well as to Medicare-eligible spouses and dependants of participants in such plans. For active employees, the employer group plan would serve as a secondary payer, while the employer's non-MA plan for active employees would serve as the primary payer. SNPs offer benefit packages tailored to beneficiaries who are dually eligible for Medicare and Medicaid, are institutionalized, or have certain chronic conditions.

[3]Profits refer to plans' remaining revenue after medical expenses and nonmedical expenses are paid. In certain circumstances, such as for new market entrants, the Centers for Medicare & Medicaid Services (CMS) allows a plan to have a negative profit, meaning that the plan's revenue is less than its combined medical and nonmedical expenses.

medical expenses, nonmedical expenses, and profits for the year 2 years prior to the upcoming year. For example, MA organizations reported their actual 2011 expenses in their bid submission for 2013.

In June and December 2008, we reported on MA organizations' projected and actual medical expenses, nonmedical expenses, and profits for 2005 and 2006, respectively.[4] We reported that, on average, MA organizations' self-reported actual medical expenses as a percentage of revenue were lower in 2005 and 2006 than they had projected. Specifically, MA organizations projected that they would spend, on average, 90.2 percent of revenue on medical expenses in 2005 and 86.9 percent in 2006. However, MA organizations' self-reported actual medical expenses were 85.7 percent of revenue, on average, in 2005, and 83.3 percent in 2006. The lower-than-projected expenses resulted in MA organizations receiving more profits, on average, than projected. Specifically, MA organizations earned profits of $1.1 billion more than projected in 2005 and $1.3 billion more than projected in 2006.

The accuracy of MA organizations' projections is important because, in addition to determining Medicare payments to these organizations, these projections affect the extent to which MA beneficiaries receive additional benefits not provided under FFS and the amounts beneficiaries pay in cost-sharing and premiums. Specifically, once Medicare payments are determined, they are not modified if there are differences between actual and projected expenses. Thus, if MA organizations had more accurately projected their revenue and expenses in 2005 and 2006, they would have, on average, been able to provide beneficiaries with additional benefits or cost-sharing reductions and still maintain the level of profits projected.

The Patient Protection and Affordable Care Act (PPACA) included a new requirement that, starting in 2014, MA organizations' must have a minimum medical loss ratio of 85 percent—that is, they must spend at least 85 percent of their revenue on medical expenses, quality improving

[4]See: GAO, *Medicare Advantage Organizations: Actual Expenses and Profits Compared to Projections for 2005*, GAO-08-827R (Washington, D.C.: June 24, 2008) and GAO, *Medicare Advantage Organizations: Actual Expenses and Profits Compared to Projections for 2006*, GAO-09-132R (Washington, D.C.: Dec. 8, 2008).

activities, and reduced premiums.[5] If an MA organization spends less than 85 percent of its revenue on such expenses in a given year, it must refund payments to the Centers for Medicare & Medicaid Services (CMS) equal to 85 percent of its revenue less its actual expenses related to medical services, quality-improving activities, and reduced premiums.[6] If an MA organization fails to spend at least 85 percent of its revenue on medical expenses, quality-improving activities, and reduced premiums for more than 3 consecutive years, it will be subject to enrollment sanctions and, after 5 consecutive years, to contract termination.

You asked us to provide baseline information on how MA organizations' self-reported actual expenses and profits compared to their projections prior to the effective date of the PPACA requirement for an 85 percent medical loss ratio. In this report, we examine how MA organizations' actual medical expenses, nonmedical expenses, and profits as a percentage of revenues and in dollars for 2011—the most recent year for which data were available at the time of your request—compared to projections for the same year, both for plans available to all Medicare beneficiaries and for plans with specific eligibility requirements.

To report actual 2011 medical expenses, nonmedical expenses, and profits, we analyzed 2013 bid data, which MA organizations submitted in

[5]Throughout this report, references to PPACA include any amendments made by the Health Care and Education Reconciliation Act of 2010. Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1103, 124 Stat. 1029, 1047 (2010) (adding section 1857(e)(4) of the Social Security Act). CMS regulations set forth specific requirements for calculating the PPACA medical loss ratio. Medicare Program; Medical Loss Ratio Requirements for the Medicare Advantage and the Medicare Prescription Drug Benefit Programs, 78 Fed. Reg. 31284 (May 23, 2013) (to be codified at 42 CFR Part 422). PPACA similarly requires non-Medicare private health plans to spend a minimum percentage of the plans' revenue on medical expenses and quality-improving activities. Effective January 1, 2011, plans that do not meet these requirements must provide a partial refund to those individuals enrolled in the plan. Pub. L. No. 111-148, §§ 1001(5), 10101(f), 124 Stat. 119, 130, 885 (2010) (inserting and amending a new section 2718 in the Public Health Service Act). For information on the early experiences associated with implementing these requirements, see GAO, *Private Health Insurance: Early Experiences Implementing New Medical Loss Ratio Requirements*, GAO-11-711 (Washington, D.C.: July 29, 2011).

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

2012 and which include MA organizations' actual experience for 2011.[7] To report projected 2011 expenses and profits, we analyzed 2011 bid data, which MA organizations submitted to CMS in 2010. Both the 2011 and 2013 bid data contain self-reported information on plan-level expenses and profits. We excluded Part D benefits from our analysis.[8] We also excluded (1) plans that were not included in both an MA organization's 2011 and 2013 bids, (2) regional preferred provider organizations (PPO),[9] and (3) plans that had values equal to zero for per member per month (PMPM) total revenue, PMPM medical expenses, PMPM nonmedical expenses, or member months. To determine actual and projected expenses and profits for 2011, we multiplied both actual and projected PMPM expenses and profits by actual enrollment in member months for that year.

We analyzed plans available to all Medicare beneficiaries at the contract level.[10] Because employer group plans and SNPs have specific eligibility requirements and are not available to all Medicare beneficiaries, we analyzed such plans separately and excluded them from this part of our analysis. We also excluded contracts with fewer than 24,000 member months (equivalent to 2,000 beneficiaries enrolled for a full year), because CMS officials stated they do not consider data from these contracts to be fully credible. After all exclusions, our analysis included

[7]To secure the award of an MA contract, MA organizations must submit bids to CMS for each plan they intend to offer under the contract. In some cases, plans available in 2011 were consolidated with other plans by 2013 or the plans were closed and the enrollees were expected to primarily be enrolled in other plans offered by the MA organizations in 2013. In either of these situations, MA organizations may have reported data in their 2013 bids that reflected the combined actual expenses and profits for more than one plan. The bid data were not structured in a way that allowed us to disaggregate the expenses and profits by plan in these cases. As a result, we assigned the expenses and profits reported on the bid to the plan that submitted the bid.

[8]Medicare Part D provides coverage for outpatient prescription drugs to beneficiaries purchasing such coverage. MA plans may provide coverage for Medicare Part D benefits and bid separately to offer this coverage.

[9]Beneficiaries in PPOs can see both in-network and out-of-network providers but pay higher cost-sharing amounts if they use out-of-network services. Regional PPOs serve state or multistate regions established by CMS. We excluded regional PPOs from our analysis because of differences in the way such plans are paid by Medicare.

[10]MA organizations contract with CMS to provide health benefits to Medicare beneficiaries. Under each contract, MA organizations can offer multiple health plans from which beneficiaries choose.

322 contracts and 1,242 plans, which enrolled the equivalent of approximately 7.5 million beneficiaries—88 percent of the total MA enrollment in plans available to all Medicare beneficiaries in 2011. We also determined whether differences in projected and actual expenses and profits for plans available to all Medicare beneficiaries varied on the basis of the type of plans under each contract or whether contracts had a high or low benchmark—the maximum amount Medicare will pay plans to serve an average beneficiary and which vary based on plans' service areas. We analyzed projected and actual expenses and profits for contracts that had the following plan types: health maintenance organizations (HMO), PPOs, and private fee-for-service (PFFS) plans.[11] We calculated benchmarks at the contract level. Using county-level enrollment and benchmark data from CMS, we defined MA organizations' contracts as having a high benchmark if their enrollment-weighted average benchmark was above the enrollment-weighted average benchmark for all MA contracts in our analysis.[12] We defined MA organizations' contracts as having a low benchmark if their enrollment-weighted average benchmark was equal to or below the enrollment-weighted average benchmark for all MA contracts in our analysis.

We analyzed plans with specific eligibility requirements at the plan level, because SNPs and employer group plans can be included in contracts with plans available to all Medicare beneficiaries. We excluded SNPs and employer group plans with fewer than 24,000 member months. After all exclusions, our SNP analysis included 99 contracts and 121 plans, which enrolled the equivalent of approximately 1.0 million beneficiaries—71 percent of the total SNP enrollment in 2011. After all exclusions, our employer group plan analysis included 77 contracts and 111 plans, which

[11]While each contract may include more than one plan, each contract is designated as having only one plan type. Beneficiaries in HMOs are generally restricted to seeing providers within a network. Beneficiaries enrolled in PFFS plans may generally see any provider that accepts the plan's payment terms; however, since 2011, these plans have been generally required to maintain a network of contracted providers, and beneficiaries that see out-of-network providers may pay higher cost-sharing amounts.

[12]We used CMS's publicly available county-level MA enrollment data to calculate benchmark weights. These data do not include enrollment counts for counties in which a plan has 10 or fewer enrollees. Because of this exclusion, the population we used to calculate benchmark weights represented approximately 97 percent of the total MA population.

enrolled the equivalent of approximately 1.7 million beneficiaries—77 percent of the total MA employer group enrollment in 2011.[13]

The results are reported for 2011 and may not be representative of or generalizable to other years.[14] In addition, the percentage of total revenue spent on medical expenses reported in our study is not directly comparable to the PPACA medical loss ratio calculation. CMS issued its final rule defining the PPACA medical loss ratio calculation in 2013, which was after MA organizations submitted their bids for 2013 that contained MA organizations' actual 2011 expenses and profits.[15]

We took several steps to ensure that the data used to produce this report were sufficiently reliable. Specifically, we assessed the reliability of the CMS data we used by interviewing relevant officials, reviewing data documentation, and examining the data for obvious errors. We determined that the data were sufficiently reliable for the purposes of our study.

We conducted this performance audit from August 2013 through December 2013 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.

[13]Our total study population included approximately 10.1 million beneficiaries—83 percent of the total MA enrollment in 2011, when combining the three populations studied (MA beneficiaries enrolled in plans available to all Medicare beneficiaries, SNPs, and employer group plans).

[14]Because of differences in our methodologies, the results presented in this report are not directly comparable to our past reports on this topic. For instance, we analyzed SNPs separately in this report, whereas SNPs were not separated out in our previous reports because such data were not available.

[15]For example, CMS's 2013 final rule defined quality-improving activities that could be included in the PPACA medical loss ratio calculation. While MA organizations' 2013 bids included information on quality-improving activity expenditures, CMS officials had told MA organizations that the information was being collected for informational purposes only and told us that MA organizations' methodologies used to calculate quality-improving activities and the accuracy of the information provided was unclear. See *Medicare Program; Medical Loss Ratio Requirements for the Medicare Advantage and the Medicare Prescription Drug Benefit Programs; Final Rule,* 78 Fed. Reg. 31,284 (May 23, 2013).

Background

Payments to MA organizations are based on the MA organization's bid and benchmark and are adjusted for differences in projected and actual enrollment, beneficiary residence, and health status. PPACA changed how the benchmark and rebate are calculated.

Payments to MA Organizations

Payments to MA organizations and the additional benefits that MA organizations offer are based in part on the relationship between the MA organizations' bids—their projection of the revenue required to provide beneficiaries with services that are covered under Medicare FFS—and a benchmark.[16] If an MA organization's bid is higher than the benchmark, the organization must charge beneficiaries a premium to collect the amount by which the bid exceeds the benchmark. If an MA organization's bid is lower than the benchmark, the organization receives the amount of the bid plus additional payments, known as rebates, equal to a percentage of the difference between the benchmark and the bid. MA organizations are required to use rebates to provide additional benefits, such as dental or vision services; reduce cost-sharing; reduce premiums; or some combination of the three.

CMS adjusts payments to MA organizations to account for differences in projected and actual enrollment, beneficiary residence, and health status. CMS adjusts for differences in projected and actual enrollment through its method for paying MA organizations. Specifically, MA organizations get paid a PMPM amount and thus only get paid for actual enrollees. CMS also adjusts PMPM payments to MA organizations on the basis of the ratio of the benchmark rate in the beneficiary's county to the plan benchmark. Thus, if a beneficiary comes from a county that has a benchmark rate that is lower than the plan's benchmark, the plan will receive a lower PMPM payment for that beneficiary. Finally, to help ensure that health plans have the same financial incentive to enroll and care for beneficiaries regardless of their health status, payments to MA organizations are adjusted for beneficiary health status—a process known as risk adjustment. Final payments are adjusted to account for

[16]Benchmarks are based on county-level payment rates used to pay MA plans before 2006. From 2007 through 2010, benchmarks were generally updated annually by the overall growth in Medicare expenditures. PPACA changed how benchmarks were calculated beginning in 2011, principally by more closely aligning the benchmark with Medicare FFS spending. Benchmarks are calculated differently for regional PPOs. Specifically, benchmarks for regional PPOs are updated by combining the county benchmarks in each region with a weighted average of regional plan bids.

differences between the projected average risk score—a relative measure of expected health care use for each beneficiary—submitted in plans' bids and the actual risk scores for enrolled beneficiaries.

Bidding rules for employer health plans differ from those for MA plans available to all beneficiaries and SNPs. Specifically, MA organizations are able to negotiate specific benefit packages and cost-sharing amounts with employers after the MA organizations submit their bid for an employer group plan. In contrast, MA organizations' bids for all other MA plans must reflect their actual benefit package—including additional benefits, reduced cost-sharing, and reduced premiums—and MA organizations cannot change the benefits after the bid is approved by CMS.

Changes under PPACA

PPACA changed how the benchmark is calculated beginning in 2011. These changes have resulted in a decrease, on average, in county benchmarks relative to average Medicare FFS expenditures. In 2011, benchmark rates were held constant at 2010 benchmark rates. From 2012 through 2016, the benchmark will be a blend of the traditional benchmark formula and a new quartile-based formula. Counties will be stratified into quartiles based on their Medicare FFS expenditures, with the first quartile of counties (the 25 percent of counties that have the highest Medicare FFS expenditures) having a benchmark equal to 95 percent of FFS expenditures. Counties in the second, third, and fourth quartiles will have benchmarks of 100 percent, 107.5 percent, and 115 percent, respectively, of FFS expenditures. In addition, any MA organization that receives 3 or more stars on CMS's 5-star quality rating system will receive a bonus to the PPACA portion of their blended benchmark.[17] In 2017 and future years, the quartile-based formula will determine 100 percent of the benchmark value.

PPACA also changed how the rebate is calculated. This change resulted in decreased rebate amounts starting in 2012. By 2014, the rebate amounts will be equal to 50, 65, or 70 percent of the difference between

[17]In 2008, CMS implemented a 5-star quality rating system—with 5 stars indicating the highest quality—for MA plans as a tool to help beneficiaries make enrollment decisions. Stars are assigned at the contract level, with every plan covered under the same contract receiving the same star rating. Plans' overall star ratings indicate their performance relative to that of all other plans on about 50 measures of clinical quality, patient experience, and contract performance.

the benchmark and the bid, depending on the number of stars a plan receives on CMS's 5-star quality scale. Prior to 2012, MA organizations received a rebate equal to 75 percent of the difference between the benchmark and the bid.

MA Plans with Specific Eligibility Requirements

SNPs and employer group plans have specific eligibility requirements. SNPs serve specific populations, including beneficiaries who are dually eligible for Medicare and Medicaid, are institutionalized, or have certain chronic conditions. Employer group plans are MA plans offered by employers or unions to their Medicare-eligible retirees and Medicare-eligible active employees, as well as to Medicare-eligible spouses and dependants of participants in such a plan. In those cases where an active employee is enrolled in an employer's non-Medicare health plan, the Medicare employer group plan would serve as a secondary payer, while the employer's non-MA plan for active employees would serve as the primary payer.

2011 Expenses and Profits Were Similar to Projections for Plans Available to All Beneficiaries, but Plans with Specific Eligibility Requirements Had Higher-than-Projected Profits

Among plans available to all beneficiaries, 2011 expenses and profits represented similar percentages of total revenue compared to projections. Among plans with specific eligibility requirements—that is, SNPs and employer group plans—2011 expenses were lower and profits were higher as a percentage of revenue compared to projections.

For Plans Available to All Beneficiaries in 2011, Expenses and Profits Represented Similar Percentages of Total Revenue Compared to Projections

As a percentage of 2011 total revenue, MA organizations' actual medical expenses, nonmedical expenses, and profits were, on average, similar to projected values for plans available to all beneficiaries.[18] As a percentage of revenue, medical expenses and profits were slightly lower than projected, while nonmedical expenses were slightly higher. Also, as a percentage of revenue, all three categories were within 0.3 percentage points of what MA organizations had projected (see table 1).

Table1: Actual and Projected Expenses and Profits as Amounts and Percentages of Revenue, for Plans Available to all Beneficiaries, 2011

	Actual			Projected		
	Percentage of revenue	Amount per beneficiary	Amount (dollars in billions)	Percentage of revenue	Amount per beneficiary	Amount (dollars in billions)
Medical expenses	86.3%	$8,541	$63.6	86.5%	$8,337	$62.1
Nonmedical expenses	9.1	905	6.7	8.8	844	6.3
Profits	4.5	447	3.3	4.7	453	3.4
Total revenue		**$9,893**	**$73.7**		**$9,635**	**$71.8**

Source: GAO analysis of CMS data.

Notes: Table includes data from 322 contracts and 1,242 plans, which enrolled the equivalent of approximately 7.5 million beneficiaries—88 percent of the total MA enrollment in plans available to all Medicare beneficiaries in 2011. To determine actual and projected expenses and profits for 2011, we multiplied both actual and projected per member per month expenses and profits by actual enrollment in member months for that year. Data on actual and projected expenses and profits were self-reported by MA organizations. Percentages may not add to 100 and medical expenses, nonmedical expenses, and profits may not equal total revenue because of rounding.

MA plans that were available to all beneficiaries received slightly higher total revenue per beneficiary than projected, which could be a result of differences between actual and projected health status and geographic location of beneficiaries who enrolled. For instance, MA plans could have received additional Medicare payments if they enrolled beneficiaries who were expected to need more health care, who were disproportionately from counties with higher benchmarks, or a combination of these two reasons. Because of the higher total revenue, medical expenses as a percentage of revenue were 0.2 percentage points lower than projected,

[18]Throughout this report, we examined aggregate expenses and profits by weighting the average per member per month profits and expenses for individual plans and contracts by actual enrollment.

despite MA organizations' spending more dollars on medical expenses than projected.

The percentage of revenue spent on medical expenses and profits varied substantially between MA contracts. For example, while MA organizations spent an average of 86.3 percent of revenue on medical expenses, approximately 39 percent of beneficiaries were covered by contracts where less than 85 percent of revenue was spent on medical expenses, and 13 percent of beneficiaries were covered by contracts where less than 80 percent of revenue was spent on medical expenses (see table 2). Further, while the average profit margin was 4.5 percent among plans available to all beneficiaries, 26 percent of beneficiaries in our analysis were covered by contracts where profit margins were negative. In contrast, 15 percent of beneficiaries in our analysis were covered by contracts where profit margins were 10 percent or higher.[19]

[19]All contracts with profit margins of 10 percent or higher spent less than 85 percent of their total revenues on medical expenses. Among these contracts, the median percentage spent on medical expenses was approximately 77 percent. Throughout the report, we calculate profit margins by dividing profits by total revenue.

Table 2: Distribution of the Percentage of Total Revenue Spent on Medical Expenses and Profits, 2011

	Number of contracts	Number of beneficiaries	Percentage of beneficiaries	Cumulative percentage of beneficiaries
Percentage of total revenue spent on medical expenses				
≥ 95	30	797,156	11%	100%
90 to <95	53	1,267,042	17	89
85 to <90	93	2,457,568	33	72
80 to <85	89	1,957,797	26	39
75 to <80	49	841,323	11	13
< 75	8	131,208	2	2
Percentage of total revenues dedicated to profit				
≥ 15	8	299,085	4	100
10 to <15	37	834,500	11	96
5 to <10	86	2,261,036	30	85
0 to <5	103	2,122,766	28	54
-5 to <0	53	1,471,869	20	26
< -5	35	462,837	6	6

Source: GAO analysis of CMS data.

Notes: Table includes data from 322 contracts and 1,242 plans, which enrolled the equivalent of approximately 7.5 million beneficiaries—88 percent of the total MA enrollment in plans available to all Medicare beneficiaries in 2011. For each contract, we weighted the percentage of total revenue spent on medical expenses and profits by actual 2011 enrollment.

For MA organizations with either high or low benchmarks, profit margins and the percentage of total revenue devoted to expenses were, on average, similar to projections. As a percentage of revenue, MA organizations with high benchmarks had slightly lower-than-projected medical expenses but slightly higher-than-projected nonmedical expenses and profits (see table 3). As a percentage of revenue, MA organizations with low benchmarks had slightly higher-than-projected medical expenses and nonmedical expenses but slightly lower profits. In addition, MA organizations with high benchmarks had higher profit margins compared to those with low benchmarks. Specifically, organizations with high benchmarks had an average profit margin of 5.9 percent and made $668 per beneficiary compared to 3.5 percent and $313 per beneficiary for organizations with low benchmarks.

Table 3: Actual and Projected Expenses and Profits as Amounts and Percentages of Revenue by Contracts with High and Low Benchmarks, 2011

	Actual			Projected		
	Percentage of revenue	Amount per beneficiary	Amount (dollars in billions)	Percentage of revenue	Amount per beneficiary	Amount (dollars in billions)
Contracts with high benchmarks Contracts = 90 Beneficiaries = 2,821,676						
Medical expenses	85.8%	$9,737	$27.4	86.8%	$9,641	$27.2
Nonmedical expenses	8.3	937	2.6	7.7	853	2.4
Profits	5.9	668	1.9	5.6	617	1.7
Total revenue		**$11,342**	**$32.0**		**$11,111**	**$31.4**
Contracts with low benchmarks Contracts = 232 Beneficiaries = 4,630,418						
Medical expenses	86.7	7,812	36.2	86.4	7,543	34.9
Nonmedical expenses	9.8	886	4.1	9.6	839	3.9
Profits	3.5	313	1.4	4.0	353	1.6
Total revenue		**$9,010**	**$41.7**		**$8,735**	**$40.4**

Source: GAO analysis of CMS data.

Notes: Table includes data from 322 contracts and 1,242 plans, which enrolled the equivalent of approximately 7.5 million beneficiaries—88 percent of the total MA enrollment in plans available to all Medicare beneficiaries in 2011. To determine actual and projected expenses and profits for 2011, we multiplied both actual and projected per member per month expenses and profits by actual enrollment in member months for that year. Data on actual and projected expenses and profits were self-reported by MA organizations. Percentages may not add to 100 and medical expenses, nonmedical expenses, and profits may not equal total revenue because of rounding.

The accuracy of MA organizations' projections varied on the basis of the type of plan they offered under each contract. Among the three plan types studied (HMO, PPO, and PFFS), PFFS contracts had the largest differences, in percentage point terms, between their actual and projected expenses and profits. For example, as a result of spending, on average, a higher-than-projected percentage of total revenue on medical and nonmedical expenses, PFFS contracts reported an actual profit margin of only 0.3 percent after projecting a 4.3 percent profit margin (see table 4). HMO contracts had the highest profit margins and were the only type of contract, among the three studied, that averaged higher profits than projected. Specifically, HMO contracts had a 5.3 percent profit margin, which was slightly higher than projected—5.0 percent—and substantially higher than the profit margins of PPO and PPFS contracts—2.5 percent and 0.3 percent, respectively.

Table 4: Actual and Projected Expenses and Profits as Amounts and Percentages of Revenue among HMO, PPO, and PFFS Contracts, 2011

	Actual		Projected		Difference between actual and projected	
	Percentage of revenue	Amount (dollars in billions)	Percentage of revenue	Amount (dollars in billions)	Percentage of revenue (percentage points)	Amount (dollars in billions)
HMO Contracts = 214 Beneficiaries = 5,558,740						
Medical expenses	86.0%	$49.2	86.7%	$48.1	-0.7	$1.1
Nonmedical expenses	8.7	5.0	8.4	4.6	0.3	0.3
Profits	5.3	3.0	5.0	2.7	0.3	0.3
PPO Contracts = 95 Beneficiaries = 1,348,788						
Medical expenses	87.3	10.2	86.4	9.9	0.9	0.3
Nonmedical expenses	10.2	1.2	9.9	1.1	0.3	0.1
Profits	2.5	0.3	3.7	0.4	-1.2	-0.1
PFFS Contracts = 13 Beneficiaries = 544,565						
Medical expenses	87.8	4.3	85.0	4.1	2.8	0.1
Nonmedical expenses	12.0	0.6	10.7	0.5	1.3	0.1
Profits	0.3	0.0	4.3	0.2	-4.0	-0.2

Source: GAO analysis of CMS data.

Notes: Table includes data from 322 contracts and 1,242 plans, which enrolled the equivalent of approximately 7.5 million beneficiaries—88 percent of the total MA enrollment in plans available to all Medicare beneficiaries in 2011. To determine actual and projected expenses and profits for 2011, we multiplied both actual and projected per member per month expenses and profits by actual enrollment in member months for that year. Data on actual and projected expenses and profits were self-reported by MA organizations. Percentages may not add to 100 and medical expenses, nonmedical expenses, and profits may not equal total revenue because of rounding. Regional PPOs were excluded from the PPO category in this analysis because of differences in the way such plans are paid by Medicare.

For Plans with Specific Eligibility Requirements in 2011, Expenses Were Lower and Profits Were Higher as a Percentage of Total Revenue Compared to Projections

SNPs' profits were higher than projected both in terms of a percentage of total revenue and in dollars. SNPs received somewhat higher revenue than projected and spent a lower percentage of total revenue on medical and nonmedical expenses than projected (see table 5). As a result of the higher-than-projected revenue and spending a lower percentage of revenue on expenses, SNPs reported an average profit per beneficiary of $1,115, which was 44 percent higher than projected ($777) and 149 percent higher than the profit per beneficiary for plans available to all Medicare beneficiaries ($447).[20] Compared to plans available to all Medicare beneficiaries, SNPs spent more in terms of amount per beneficiary, but less in percentage terms, on medical and nonmedical expenses. CMS officials said SNPs might have higher profit margins because of the potential additional risk of providing a plan that targets a specific population. For instance, the officials noted that it may be more difficult to predict revenue and spending for a SNP's targeted population. SNPs may face higher medical expenses because beneficiaries enrolled in such plans may have increased health care needs. According to CMS officials, SNPs may also face higher administrative expenses for several reasons, such as potentially higher marketing expenses associated with targeting SNPs' designated population.

[20]Compared to plans available to all beneficiaries, SNPs had a higher median profit margin. In addition, SNPs' average profit margin was higher than that of plans available to all beneficiaries after accounting for plan type (i.e., HMO or PPO), whether the plans had high or low benchmarks, and after excluding plans located in Puerto Rico, where the MA market has some unusual characteristics, such as having benchmarks that are substantially higher relative to Medicare FFS than other areas of the United States. Further, all three types of SNPs—dual-eligible, chronic condition, and institutional SNPs—had profit margins of at least 8.4 percent. Because our exclusion criteria resulted in our excluding a higher percentage of chronic care and institutional SNPs than dual-eligible SNPs, our SNP population was disproportionately composed of dual-eligible SNPs, and the population of chronic care and institutional SNPs studied was relatively small. For instance, 92 percent of the beneficiaries enrolled in the SNPs we studied were enrolled in dual-eligible SNPs, whereas approximately 81 percent of the total SNP population was enrolled in dual-eligible SNPs in 2011.

Table 5: Actual and Projected Expenses and Profits as Amounts and Percentages of Revenue for Special Needs Plans, 2011

	Actual			Projected		
	Percentage of revenue	Amount per beneficiary	Amount (dollars in billions)	Percentage of revenue	Amount per beneficiary	Amount (dollars in billions)
Medical expenses	82.7%	$10,711	$10.5	84.5%	$10,588	$10.4
Nonmedical expenses	8.7	1,133	1.1	9.3	1,172	1.2
Profits	8.6	1,115	1.1	6.2	777	0.8
Total revenue		**$12,959**	**$12.8**		**$12,537**	**$12.3**

Source: GAO analysis of CMS data.

Notes: Table includes data from 99 contracts and 121 plans, which enrolled the equivalent of approximately 1.0 million beneficiaries—71 percent of the total SNP enrollment in 2011. To eliminate the effects caused by any differences between actual and projected enrollment, we used actual enrollment to calculate both projected and actual expenses and profits. Data on actual and projected expenses and profits were self-reported by MA organizations. Medical expenses, nonmedical expenses, and profits may not equal total revenue because of rounding.

Employer group plans had higher revenue, had higher profit margins, and spent a lower percentage of total revenue on expenses than projected. Specifically, total revenue per beneficiary was about 14 percent higher than projected—$11,364 compared to $9,957 (see table 6). In addition, employer group plans spent 86.3 and 6.1 percent of total revenue on medical expenses and nonmedical expenses, respectively, compared to a projected 89.5 and 6.3 percent, and these plans also had an actual profit margin of 7.6 percent compared to a 4.2 percent projected profit margin. The combined effects of higher revenue and a higher profit margin translated into average profits per beneficiary of $861, which was 108 percent higher than projected ($413) and 93 percent higher than the profit per beneficiary for plans available to all Medicare beneficiaries ($447).[21] Unlike other MA plans, projections for employer group plans may vary from their actual profits and expenses because MA organizations that offer such plans are able to negotiate specific benefit packages and cost-sharing amounts with employers after they submit their bids to CMS.

[21]Compared to plans available to all beneficiaries, employer group plans had a higher median profit margin. In addition, employer plans received higher total revenues per beneficiary and had a higher average profit margin than plans available to all beneficiaries after accounting for plan type (i.e., HMO or PPO) and whether the plans had high or low benchmarks.

Table 6: Actual and Projected Expenses and Profits as Amounts and Percentages of Revenue for Employer Group Plans, 2011

	Actual			Projected		
	Percentage of revenue	Amount per beneficiary	Amount (dollars in billions)	Percentage of revenue	Amount per beneficiary	Amount (dollars in billions)
Medical expenses	86.3%	$9,806	$16.5	89.5%	$8,912	$15.0
Nonmedical expenses	6.1	697	1.2	6.3	632	1.1
Profits	7.6	861	1.5	4.2	413	0.7
Total revenue		**$11,364**	**$19.2**		**$9,957**	**$16.8**

Source: GAO analysis of CMS data.

Notes: Table includes data from 77 contracts and 111 plans, which enrolled the equivalent of approximately 1.7 million beneficiaries—77 percent of the total MA employer group enrollment in 2011. To eliminate the effects caused by any differences between actual and projected enrollment, we used actual enrollment to calculate both projected and actual expenses and profits. Data on actual and projected expenses and profits were self-reported by MA organizations.

Agency Comments

We requested comments from CMS, but none were provided.

As agreed with your office, 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 Health and Human Services, interested congressional committees, and others. In addition, the report will be available at no charge on the GAO website at http://www.gao.gov.

If you or your staff has 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 I.

Sincerely yours,

James Cosgrove
Director, Health Care

Appendix I: GAO Contact and Staff Acknowledgments

GAO Contact

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Staff Acknowledgments

In addition to the contact named above, Christine Brudevold, Assistant Director; Sandra George; Gregory Giusto; Brian O'Donnell; and Elizabeth T. Morrison made key contributions to this report.