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

Medicare Advantage: Special Needs Plans Were More Profitable, on Average, than Plans Available to All Beneficiaries in 2011

Dear Mr. Levin:

In 2011, the federal government paid approximately $124 billion to Medicare Advantage (MA) organizations—entities that offer a private health plan alternative to Medicare fee-for-service (FFS). The private plans offered by MA organizations are generally available to all Medicare beneficiaries in the plans' service areas, although there are some MA plans with more specific eligibility requirements. For example, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 authorized the establishment of special needs plans (SNP) that exclusively serve Medicare beneficiaries in one of three classes of special needs: (1) beneficiaries dually eligible for Medicaid, (2) beneficiaries with severe or disabling chronic conditions, or (3) institutionalized beneficiaries.[1] As of November 2011, approximately 1.4 million beneficiaries, or about 12 percent of all beneficiaries enrolled in MA, were in SNPs.

Medicare payments to SNPs tend to be higher than payments to other MA plans, in part, because the beneficiaries enrolled in SNPs are generally in poorer health and are expected to use more health services relative to enrollees in other MA plans. However, even after accounting for differences in relative health status, payments to SNPs were higher in 2011, on average, than payments to the average MA plan. The Medicare Payment Advisory Commission (MedPAC) reported in March 2011 that payments to SNPs for 2011 were projected to be, on average, 113 percent of FFS costs for a like set of beneficiaries enrolled in Medicare FFS. In contrast, the payments for all MA plans—including SNPs—were projected to be, on average, 110 percent of costs for a like set of beneficiaries enrolled in Medicare FFS.

Earlier this year, you asked us to provide information on how MA organizations' self-reported actual expenses and profits compared to their projections for all MA plans, including SNPs. To address this, we examined how MA organizations' actual expenses for 2011—the most recent year for which data were available at the time of your request—compared to the organizations' projections for the same year. This information will be contained in a forthcoming report.

You asked us to provide additional information about how SNPs allocated the payments they received to medical expenses, nonmedical expenses (such as marketing, sales, and administration), and profits, and how these allocations compared to those made by MA

[1]Pub. L. No. 108-173, § 231, 117 Stat. 2066, 2207(2003) (codified at 42 U.S.C. § 1395w-21(a)(2)(A)(ii)).

plans available to all beneficiaries.[2] In this report, we examined the extent to which actual expenses and profits in 2011 differed, if at all, between SNPs and MA plans available to all beneficiaries. On November 27, 2013, we presented our findings to committee staff (see enc. 1).

To report actual 2011 medical expenses, nonmedical expenses, and profits for SNPs and MA plans available to all beneficiaries, we analyzed 2013 bid data,[3] which MA organizations submitted to the Centers for Medicare & Medicaid Services (CMS) in 2012 and which include MA organizations' actual experience for 2011.[4] For our analyses of SNPs and plans available to all beneficiaries, we excluded (1) plans that were not included in both an MA organization's 2011 and 2013 bids;[5] (2) regional preferred provider organizations (PPO);[6] (3) plans that had values equal to zero for per member per month (PMPM) total revenue, PMPM medical expenses, PMPM nonmedical expenses, or total member months; and (4) Part D benefits.[7]

For our analyses of MA plans available to all beneficiaries, we also excluded (1) SNPs, (2) employer group plans,[8] and (3) plans with fewer than 24,000 member months (equivalent to 2,000 beneficiaries enrolled for a full year).[9] After all exclusions, our analysis of plans available to all beneficiaries included 691 plans, which enrolled the equivalent of approximately 7.0 million beneficiaries—82 percent of the total MA enrollment in plans available to all Medicare beneficiaries in 2011.

For our analyses of SNPs, we also excluded (1) MA plans available to all Medicare beneficiaries, (2) employer group plans, and (3) SNPs with fewer than 24,000 member months. After all exclusions, our SNP analysis included 121 plans, which enrolled the equivalent of approximately 1.0 million beneficiaries—71 percent of the total SNP enrollment in 2011.

[2]Profits refer to plans' remaining revenue after medical expenses and nonmedical expenses are paid. In certain circumstances, a plan may have a negative profit, meaning that the plan's revenue is less than its combined medical and nonmedical expenses.

[3]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.

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

[5]We used similar exclusions for this report and our forthcoming report on how MA organizations' actual and projected expenses and profits compared in 2011. We required plans to be included in both 2011 and 2013 bids to ensure that we had reliable data on MA organization's projected and actual expenses and profits for 2011.

[6]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.

[7]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.

[8]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 plans.

[9]We excluded plans with fewer than 24,000 member months because CMS officials stated that they do not consider data from these plans to be fully credible.

To determine how SNPs and plans available to all beneficiaries allocated their revenues, we calculated enrollment-weighted profits, medical expenses, and nonmedical expenses. We examined the distribution of profit margins among SNPs and MA plans available to all beneficiaries. We also examined SNPs' profits and expenses by the type of SNP—dual-eligible SNP (D-SNP), chronic condition SNP (C-SNP), and institutional SNP (I-SNP). Using publicly available county-level MA enrollment and benchmark data from CMS, we stratified our analysis by whether a plan had a high or low enrollment-weighted average benchmark.[10] We defined an enrollment-weighted average benchmark as low if it was equal to or below the enrollment-weighted average benchmark for MA plans in our analysis that were available to all beneficiaries. Similarly, we defined an enrollment-weighted average benchmark as high if it was above that threshold. To determine whether differences between SNPs and plans available to all beneficiaries varied on the basis of plan characteristics, we stratified our analysis by plan type. Specifically, we compared SNPs and plans available to all beneficiaries that were health maintenance organizations (HMO) or PPOs.[11] We excluded private fee-for-service (PFFS) plans from this analysis because there are no SNPs with a PFFS plan type.[12] We also performed several analyses after excluding SNPs located in Puerto Rico. The MA market in Puerto Rico has some unusual characteristics, such as having benchmarks that are substantially higher relative to Medicare FFS than other areas of the United States.

The results we report are for 2011 and may not be representative of or generalizable to other years. 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 reviewing our previous work on MA bids, examining data documentation, and analyzing 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 November 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.

In summary, we found that SNPs reported having higher profit margins and spending a lower percentage of total revenues on medical expenses, on average, than plans available to all beneficiaries in 2011. SNPs also had higher profit margins, on average, and reported spending a lower percentage of total revenues on medical expenses relative to plans available to all beneficiaries regardless of the type of SNP (D-SNP, C-SNP, or I-SNP); whether the plan had a high or low enrollment-weighted benchmark; or the type of plan (HMO or PPO).

[10]A benchmark is the maximum amount Medicare will pay plans to serve an average beneficiary. Benchmarks vary on the basis of plans' service areas. CMS's publicly available county-level MA enrollment data do not include enrollment counts for counties in which a plan has 10 or fewer enrollees. Because of this exclusion, we used approximately 98 percent and 93 percent of our SNP population and population in plans available to all beneficiaries, respectively, to calculate benchmark weights.

[11]Beneficiaries in HMOs generally are restricted to seeing providers within a network.

[12]Beneficiaries enrolled in PFFS plans generally may see any provider that accepts the plan's payment terms; however, since 2011, these plans generally have been required to maintain a network of contracted providers, and beneficiaries that see out-of-network providers may pay higher cost-sharing amounts.

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 have any questions about this report, please contact me at (202) 512-7114 or cosgrovej@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. In addition to the contact named below, individuals making key contributions to this report include Christine Brudevold, Assistant Director; Sandra George; Gregory Giusto; Brian O'Donnell; and Elizabeth T. Morrison.

Sincerely yours,

James Cosgrove
Director, Health Care

Enclosure

GAO

MEDICARE ADVANTAGE: Special Needs Plans Were More Profitable, on Average, than Plans Available to All Beneficiaries in 2011

Briefing to staff of the
House Committee on Ways and Means

November 27, 2013
(updated)

Page 1 For more information, contact James Cosgrove at (202) 512-7114 or cosgrovej@gao.gov

GAO

Introduction

- In 2011, the federal government paid approximately $124 billion to Medicare Advantage (MA) organizations—entities that offer a private health plan alternative to Medicare fee-for-service (FFS).
- The health plans offered by MA organizations are generally available to all Medicare beneficiaries in the plans' service areas, although there are some MA plans with more specific eligibility requirements. For example, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 authorized the establishment of special needs plans (SNP) that exclusively serve Medicare beneficiaries in one of three classes of special needs: (1) beneficiaries dually eligible for Medicaid, (2) beneficiaries with severe or disabling chronic conditions, or (3) institutionalized beneficiaries.[1]
- As of November 2011, approximately 1.4 million beneficiaries, or about 12 percent of all beneficiaries enrolled in MA, were enrolled in SNPs.

[1]Pub. L. No. 108-173, § 231, 117 Stat. 2066, 2207 (2003) (codified at 42 U.S.C. § 1395w-21(a)(2)(A)(ii)).

Page 2

GAO

Introduction (cont.)

- Medicare payments to SNPs tend to be higher than payments to other MA plans, in part, because beneficiaries enrolled in SNPs generally are in poorer health and are expected to use more health services relative to enrollees in other MA plans.
- However, even after accounting for differences in relative health status of beneficiaries enrolled in SNPs and in the average MA plan, payments to SNPs were higher in 2011, on average.
  - The Medicare Payment Advisory Commission (MedPAC) reported in March 2011 that payments to SNPs for 2011 were projected to be, on average, 113 percent of FFS costs for a like set of beneficiaries enrolled in Medicare FFS.
  - In contrast, the payment for all MA plans—including SNPs—was projected to be, on average, 110 percent of costs for a like set of beneficiaries enrolled in Medicare FFS.

Page 3

GAO

Introduction (cont.)

- At the time of your request for this work, little was known about how SNPs allocated the payments they received to medical expenses, nonmedical expenses, and profits,[2] or how these allocations compared to those made by MA plans available to all beneficiaries.

[2]Profits refer to plans' remaining revenue after medical expenses and nonmedical expenses are paid. In certain circumstances, a plan may have a negative profit, meaning that the plan's revenue is less than its combined medical and nonmedical expenses.

Page 4


GAO
Objective
This report examines the extent to which actual expenses and profits in 2011 differed, if at all, between SNPs and MA plans available to all beneficiaries.
Page 5

GAO

Scope and Methodology

- To report actual 2011 medical expenses, nonmedical expenses, and profits for SNPs and MA plans available to all beneficiaries, we analyzed 2013 bid data, which MA organizations submitted to the Centers for Medicare & Medicaid Services (CMS) in 2012 and which included MA organizations' actual experience for 2011.
- For both our analysis of SNPs and plans available to all beneficiaries, we excluded
  - plans that were not included in both an MA organization's 2011 and 2013 bids;
  - regional preferred provider organizations (PPO);[3]
  - plans that had values equal to zero for per member per month (PMPM) total revenue, PMPM medical expenses, PMPM nonmedical expenses, or total member months; and
  - Part D benefits.[4]

[3]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.

[4]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.

Page 6

GAO

Scope and Methodology (cont.)

- For our analysis of plans available to all Medicare beneficiaries, we excluded
  - SNPs;
  - employer group plans;[5] and
  - plans with fewer than 24,000 member months (equivalent to 2,000 beneficiaries enrolled for a full year).
- After all exclusions, our analysis of MA plans available to all beneficiaries included 691 plans, which enrolled the equivalent of approximately 7.0 million beneficiaries—82 percent of the total MA enrollment in plans available to all Medicare beneficiaries in 2011.

[5]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 plans.

Page 7

GAO

Scope and Methodology (cont.)

- For our analysis of SNPs, we excluded
  - MA plans available to all beneficiaries;
  - employer group plans; and
  - SNPs with fewer than 24,000 member months.
- After all exclusions, our SNP analysis included 121 plans, which enrolled the equivalent of approximately 1.0 million beneficiaries—71 percent of the total SNP enrollment in 2011.
- We examined the distribution of profit margins for SNPs and MA plans available to all beneficiaries.[6]
- We also examined SNPs' profits and expenses by the type of SNP—dual-eligible SNP (D-SNP), chronic condition SNP (C-SNP), and institutional SNP (I-SNP).

[6]Throughout the report, we calculate profit margins by dividing profits by total revenue.

Page 8

GAO

Scope and Methodology (cont.)

- Using CMS's publicly available county-level MA enrollment and benchmark data, we also stratified our analysis by whether a plan had a high or low enrollment-weighted average benchmark.
  - We defined an enrollment-weighted average benchmark as low if it was equal to or below the enrollment-weighted average benchmark for MA plans in our analysis that were available to all beneficiaries and as high if it was above that threshold.
- To determine whether differences between SNPs and plans available to all beneficiaries varied on the basis of plan characteristics, we stratified our analysis by plan type. Specifically, we compared SNPs and plans available to all beneficiaries that were health maintenance organizations (HMO) or PPOs. We excluded private fee-for-service (PFFS) plans from this analysis because there were no SNPs with a PFFS plan type.[7]
- We also performed several analyses after excluding SNPs located in Puerto Rico. The MA market in Puerto Rico has some unusual characteristics, such as having benchmarks that are substantially higher relative to Medicare FFS than other areas of the United States.

[7]Beneficiaries in HMOs generally are restricted to seeing providers within a network. Beneficiaries enrolled in PFFS plans generally may see any provider that accepts the plan's payment terms; however, since 2011, these plans generally have been required to maintain a network of contracted providers, and beneficiaries that see out-of-network providers may pay higher cost-sharing amounts.

Page 9

GAO

Scope and Methodology (cont.)

- The results we report are for 2011 and may not be representative of or generalizable to other years.
- We took several steps to ensure that the data we used were sufficiently reliable. Specifically, we assessed the reliability of the CMS data we used by reviewing our previous work on MA bids, examining 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 November 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.

Page 10

GAO

Background

- Payments for SNPs and MA plans available to all beneficiaries are based in part on the relationship between MA organizations' plan bids—their projection of the revenue required to provide beneficiaries with services that are covered under Medicare FFS—and a benchmark—the maximum amount Medicare will pay plans to serve an average beneficiary and which may vary based on plans' service areas.
  - 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.

Page 11

GAO

Results

- SNPs had higher profit margins and reported spending a lower percentage of total revenues on medical expenses, on average, than MA plans available to all beneficiaries in 2011.
- SNPs also had higher profit margins and reported spending a lower percentage of total revenues on medical expenses relative to plans available to all beneficiaries regardless of
  - the type of SNP plan (dual-eligible, chronic condition, or institutional);
  - whether the plan had a high or low enrollment-weighted benchmark; or
  - the type of plan (HMO or PPO).

Page 12

GAO

SNPs were more profitable than MA plans available to all beneficiaries

Compared to plans available to all beneficiaries, SNPs had substantially higher profit margins and reported spending a lower percentage of total revenue on medical expenses.

SNPs received higher total revenue per beneficiary than plans available to all beneficiaries, which could be, in part, because beneficiaries enrolled in such plans may have greater health care needs (see table 1).

After excluding SNPs in Puerto Rico, the average profit margin for SNPs fell from 8.6 percent to 7.3 percent but remained substantially higher than the 4.6 percent average profit margin for plans available to all beneficiaries.

Table 1: Actual Expenses and Profits for Special Needs Plans and Plans Available to All Beneficiaries, 2011

	Special needs plans			Plans available to all beneficiaries		
	Percentage of revenue	Amount per beneficiary	Total (dollars in billions)	Percentage of revenue	Amount per beneficiary	Total (dollars in billions)
Medical expenses	82.7%	$10,711	$10.5	86.4%	$8,579	$60.0
Nonmedical expenses	8.7	1,133	1.1	9.0	895	6.3
Profits	8.6	1,115	1.1	4.6	461	3.2
Total revenue		$12,959	$12.8		$9,934	$69.4

Source: GAO analysis of CMS data.

Note: Data for plans available to all beneficiaries include 691 plans, which enrolled the equivalent of approximately 7.0 million beneficiaries—82 percent of the total MA enrollment in plans available to all Medicare beneficiaries in 2011. Data for special needs plans include 121 plans, which enrolled the equivalent of approximately 1.0 million beneficiaries—71 percent of the total SNP enrollment in 2011. Medical expenses, nonmedical expenses, and profits may not equal total revenue due to rounding.

Page 13

SNPs were more profitable than MA plans available to all beneficiaries (cont.)

Twenty-three percent of beneficiaries enrolled in SNPs were in plans with profit margins of 15 percent or higher, while only 6 percent of beneficiaries enrolled in plans available to all beneficiaries were enrolled in plans with profits of 15 percent or higher (see table 2).

The median plan-level profit margin for SNPs was 7.1 percent, compared to 3.2 percent for plans available to all beneficiaries.

Table 2: Distribution of Profit Margins for Special Needs Plans (SNP) and Plans Available to All Beneficiaries, 2011

	Special needs plans			Plans available to all beneficiaries		
Profit margin	Number of beneficiaries in SNPs	Percentage of beneficiaries in SNPs	Cumulative percentage of beneficiaries in SNPs	Number of beneficiaries in plans available to all beneficiaries	Percentage of beneficiaries in plans available to all beneficiaries	Cumulative percentage of beneficiaries in plans available to all beneficiaries
≥ 15	229,607	23%	100%	444,284	6%	100
10 to <15	197,632	20	77	765,050	11	94
5 to <10	258,414	26	57	1,990,476	28	83
0 to <5	189,603	19	30	1,772,470	25	54
-5 to <0	54,362	6	11	1,431,968	20	29
< -5	55,135	6	6	585,442	8	8

Source: GAO analysis of CMS data.

Note: Data for plans available to all beneficiaries include 691 plans, which enrolled the equivalent of approximately 7.0 million beneficiaries—82 percent of the total MA enrollment in plans available to all Medicare beneficiaries in 2011. Data for special needs plans include 121 plans, which enrolled the equivalent of approximately 1.0 million beneficiaries—71 percent of the total SNP enrollment in 2011.

Page 14

GAO

Dual-eligible, chronic condition, and institutional SNPs were more profitable, on average, than MA plans available to all beneficiaries

With average profit margins of at least 8.4 percent, all three types of SNPs had higher average profit margins than the 4.6 percent profit margin for plans available to all beneficiaries.

None of the three types of SNPs reported spending more than 82.9 percent of their total revenue on medical expenses, which is less than the 86.4 percent of total revenue that plans available to all beneficiaries spent, on average, for medical expenses (see table 3).

Table 3: Actual Expenses and Profits for Dual-Eligible, Chronic Condition, and Institutional Special Needs Plans, 2011

	Percentage of revenue	Amount per beneficiary	Total (dollars in billions)
Dual-eligible special needs plans Beneficiaries = 904,483			
Medical expenses	82.9%	$10,585	$9.6
Nonmedical expenses	8.8	1,117	1.0
Profits	8.4	1,067	1.0
Total revenue		$12,770	$11.5
Chronic condition special needs plans Beneficiaries = 56,522			
Medical expenses	80.6%	$9,702	$0.5
Nonmedical expenses	9.8	1,182	0.1
Profits	9.6	1,149	0.1
Total revenue		$12,033	$0.7
Institutional special needs plans Beneficiaries = 23,748			
Medical expenses	80.1%	$17,928	$0.4
Nonmedical expenses	7.1	1,590	0.0
Profits	12.8	2,855	0.1
Total revenue		$22,372	$0.5

Source: GAO analysis of CMS data.

Note: The table includes 79 percent of the total 2011 Medicare Advantage dual-eligible SNP population; it includes approximately 30 percent of the total populations of chronic condition and institutional SNPs. In total, the table includes data from 121 SNPs, which enrolled the equivalent of approximately 1.0 million beneficiaries—71 percent of the total SNP enrollment in 2011. Medical expenses, nonmedical expenses, and profits may not equal total revenue due to rounding.

Page 15

GAO

SNPs were more profitable than MA plans available to all beneficiaries, regardless of high or low benchmarks

On average, SNPs had higher profit margins and reported spending a lower percentage of their total revenue on medical expenses in both high and low benchmark areas compared to plans available to all beneficiaries (see table 4).

After excluding SNPs in Puerto Rico, the average profit margin for low benchmark SNPs fell from 9.5 percent to 6.9 percent but remained substantially higher than the 3.5 percent average profit margin for plans available to all beneficiaries. The average profit margin remained the same for high benchmark SNPs after excluding SNPs in Puerto Rico.

Table 4: Actual Expenses and Profits for Special Needs Plans and Plans Available to All Beneficiaries by High or Low Benchmarks, 2011

	Special needs plans			Plans available to all beneficiaries		
	Percentage of revenue	Amount per beneficiary	Total (dollars in billions)	Percentage of revenue	Amount per beneficiary	Total (dollars in billions)
High benchmarks		Beneficiaries = 400,224			Beneficiaries = 2,222,954	
Medical expenses	84.0%	$12,766	$5.1	85.1%	$9,807	21.8
Nonmedical expenses	8.4	1,274	0.5	8.3	961	2.1
Profits	7.6	1,162	0.5	6.5	749	1.7
Total revenue		$15,202	$6.1		$11,518	$25.6
Low benchmarks		Beneficiaries = 584,529			Beneficiaries = 4,766,736	
Medical expenses	81.5%	$9,305	5.4	87.1	8,006	38.2
Nonmedical expenses	9.1	1,036	0.6	9.4	864	4.1
Profits	9.5	1,082	0.6	3.5	326	1.6
Total revenue		$11,423	$6.7		$9,196	$43.8

Source: GAO analysis of CMS data.

Note: Data for plans available to all beneficiaries include 691plans, which enrolled the equivalent of approximately 7.0 million beneficiaries—82 percent of the total MA enrollment in plans available to all Medicare beneficiaries in 2011. Data for special needs plans include 121 plans, which enrolled the equivalent of approximately 1.0 million beneficiaries—71 percent of the total SNP enrollment in 2011. We defined an enrollment-weighted average benchmark as low if it was equal to or below the weighted average benchmark for MA plans in our analysis that were available to all beneficiaries and as high if it was above that threshold. Percentages may not add to 100, and medical expenses, nonmedical expenses, and profits may not equal total revenue due to rounding.

Page 16

GAO

SNPs were more profitable than MA plans available to all beneficiaries, regardless of plan type

SNPs were predominantly HMOs.

For both HMOs and PPOs, SNPs, on average, had higher profit margins and reported spending a lower percentage of total revenue on medical expenses compared to plans available to all beneficiaries (see table 5).

After excluding SNPs in Puerto Rico, the average profit margin for HMO SNPs fell from 8.4 percent to 7.1 percent but remained substantially higher than the 5.4 percent average profit margin for HMOs available to all beneficiaries. The average profit margin remained the same for PPO SNPs after excluding SNPs in Puerto Rico.

Table 5: Actual Expenses and Profits for Special Needs Plans and Plans Available to All Beneficiaries by Type of Plan, 2011

	Special needs plans		Plans available to all beneficiaries	
	Percentage of revenue	Total (dollars in billions)	Percentage of revenue	Total (dollars in billions)
HMO	Beneficiaries = 958,488		Beneficiaries = 5,273,550	
Medical expenses	82.8%	$10.2	86.0%	$46.9
Nonmedical expenses	8.7	1.1	8.6	4.7
Profits	8.4	1.0	5.4	2.9
PPO	Beneficiaries = 26,266		Beneficiaries = 1,228,214	
Medical expenses	77.0	0.3	87.4	9.3
Nonmedical expenses	8.7	0.0	10.0	1.1
Profits	14.3	0.1	2.5	0.3

Source: GAO analysis of CMS data.

Note: Data for plans available to all beneficiaries include 625 plans, which enrolled the equivalent of approximately 6.5 million beneficiaries—76 percent of the total MA enrollment in plans available to all Medicare beneficiaries in 2011. Data for special needs plans include 121 plans, which enrolled the equivalent of approximately 1.0 million beneficiaries—71 percent of the total SNP enrollment in 2011. Percentages may not add to 100 due to rounding. Regional PPOs were excluded from the PPO category in this analysis because of differences in the way such plans are paid by Medicare. Private fee-for-service plans were excluded from our analysis because there are no special needs plans with a PFFS plan type.

Page 17

GAO

GAO on the Web
Web site: http://www.gao.gov/

Congressional Relations
Katherine Siggerud, Managing Director, siggerudk@gao.gov
(202) 512-4400, U.S. Government Accountability Office
441 G Street, NW, Room 7125, Washington, DC 20548

Public Affairs
Chuck Young, Managing Director, youngc1@gao.gov
(202) 512-4800, U.S. Government Accountability Office
441 G Street, NW, Room 7149, Washington, DC 20548

(291183)