December 8, 2008

The Honorable Pete Stark  
Chairman  
Subcommittee on Health  
Committee on Ways and Means  
House of Representatives

Subject: Medicare Advantage Organizations: Actual Expenses and Profits Compared to Projections for 2006

Dear Mr. Chairman:

The federal government’s spending on the Medicare Advantage (MA) program has grown substantially in recent years, from approximately $60 billion in 2006 and $77 billion in 2007 to an estimated $91 billion in 2008.\(^1\) MA organizations provide health care coverage to Medicare beneficiaries through private health plans, thus offering an alternative to the original Medicare fee-for-service (FFS) program.\(^2\) Payments to MA organizations are, in part, based on the projected expenditures organizations submit in their bids for providing Medicare-covered services, as well as actual enrollment and beneficiary health status. Once Medicare payments are determined, they are not modified based on differences between actual and projected expenses.\(^3\) MA organizations are not required to submit claims data to the Centers for Medicare & Medicaid Services (CMS)—the agency that administers Medicare—but they must report actual expenditures for the year 2 years prior to the upcoming contract year. For example, MA organizations reported their actual 2006 expenditures in their bid submission for contract year 2008. When MA organizations submit their bids, the actual expenditures reported in their bid submissions reflect the MA organizations’ most recent full calendar year of actual expenditure data.


\(^{2}\)Medicare is the federally financed health insurance program for persons aged 65 and over, certain individuals with disabilities, and individuals with end-stage renal disease. Medicare Part A covers hospital and other inpatient stays. Medicare Part B is optional insurance, and covers hospital outpatient, physician, and other services. Medicare Parts A and B are known as original Medicare or Medicare FFS. Medicare beneficiaries have the option of obtaining coverage for Medicare Parts A and B services from private health plans that participate in Medicare’s MA program—also known as Medicare Part C. All Medicare beneficiaries are eligible for coverage for outpatient prescription drugs under Medicare Part D.

\(^{3}\)However, payments to MA organizations may be modified based on differences in actual and projected beneficiary health status, beneficiary residence, and enrollment. Actual expenses may be used to inform projections for future contract years.
In June 2008, we reported that for 2005, MA organizations generally spent less on medical expenses and earned more profits than projected. MA organizations’ self-reported actual profit margin was approximately 5 percent of total revenue, on average, which was approximately $1.1 billion more in 2005 than MA organizations had projected.

The accuracy of MA organizations’ projections is important because, in addition to determining Medicare payments, these projections also affect the extent to which MA beneficiaries receive additional benefits not provided under FFS and the amounts beneficiaries pay in cost sharing and premiums. For example, if MA organizations had more accurately projected their revenues and expenses in 2005, they would have been able to provide beneficiaries with additional benefits or cost-sharing reductions, and still maintain the level of profits projected.

This report responds to your request for updated information on the accuracy of MA organizations’ projections. Specifically, this report compares MA organizations’ 2006 actual medical expenses, non-medical expenses, and profits to projections for the same year, and compares 2006 results to 2005 results. When we requested data from CMS, 2006 was the most recent year for which data were available.

To report MA organizations’ actual expenditures, actual profits and projections for 2006, we analyzed the two-year look-back form that MA organizations submitted in 2007 to CMS with the 2008 Bid Pricing Tool. The 2008 two-year look-back form contains MA organizations’ self-reported actual medical expenses, non-medical expenses, and profits for 2006, in addition to the projections for 2006 the organizations submitted in 2005. MA organizations submit a single two-year look-back form for each of their contracts, which may include more than one health benefit plan. We excluded employer group health plans because these plans are not open to the general Medicare population, and actual and projected expenses are calculated differently than for other plans. We also excluded small contracts, defined as those 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. Additionally, we excluded two contracts for which actual or projected expenditures were missing. After all exclusions, our analysis included 224 contracts, representing about 57 percent of the contracts for which a two-year look-back form was submitted and about

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5MA organizations are required to submit bids annually for review and approval for each plan they intend to offer. The bid submission includes a Bid Pricing Tool, which contains MA organizations’ projections of their revenue requirements and revenue sources.

6The two-year look-back form is so named because it provides data for the calendar year 2 years prior to the upcoming contract year. The two-year look-back form was not certified by the MA plan’s actuary in 2008.

7“Member months” is the sum of a given contract’s total monthly enrollments in a year. For example, if 1,500 members were enrolled in an organization’s plan for January and February and 2,000 members were enrolled in its plans for March through December, the contract would have 23,000 member months. Contracts with relatively low enrollments are not credible because their expenses can be unduly affected by outlier cases.
84 percent of MA enrollment, equivalent to approximately 5.6 million beneficiaries enrolled in
c合约计划的全部一年。在我们的样本中，我们分析了三种不同类型的计划数据：健康维护组织（HMO）、私人自负盈亏（PFFS）计划，以及首选供应商组织（PPO）。

这些计划类型占2005年和2006年实际和预期费用和利润的82%和55%。这些计划类型占2005年和2006年实际和预期费用和利润的82%和55%。合同的年份。为了确定实际和预期费用和利润，我们乘以实际和预期的月度成员费用和利润。为了计算实际和预期费用和利润占收入的平均值，我们根据每个MA组织的收入对每个MA组织的百分比进行了加权。这种方法与我们在2008年6月报告中使用的加权方法略有不同，但两个方法的结果几乎相同。我们在2008年6月报告中报告的百分比包括在背景部分。结果报告为具体合同年份，可能不代表其他合同年份的可比性。

我们采访了CMS的官员，对数据进行了可靠性审查，并检查了所有数据的合理性。虽然我们没有独立审计MA组织自我报告的数据，但我们能够确定这些数据对我们的目的来说是足够可靠的。我们于2008年10月至2008年11月进行了这项绩效审计，符合政府审计标准。这些标准要求我们根据审计目标制定和执行审计，以获得足够的适当证据，为我们的发现和结论提供合理的基础。我们相信，我们获得的证据为我们的发现和结论提供了合理的基础，基于我们的审计目标。

**Results in Brief**

在2006年，MA组织平均报告的利润为6.6%的总收入，这比他们预期的利润4.1%高。MA组织报告平均将83.3%的总收入用于医疗费用，但预计平均将86.9%的总收入用于这些费用。超过一半的受益者被纳入由MA组织提供的医疗福利计划，其中利润收入占收入的百分比大于预期，且综合医疗和非医疗费用收入百分比低于预期。在MA健康计划的3种最大化入会计划——HMOs、PPOs和PFFS计划——实际利润高于预期，医疗费用低于预期。利润预测与实际利润的差额在2006年（2.5个百分点）低于在2005年（3.2个百分点）。然而，由于入会人数增加约40%，实际利润增加从2005年的11亿美元到2006年的13亿美元。

8While each contract may include more than one health benefit plan, each contract is designated as

having only one plan type. Beneficiaries in HMOs are generally restricted to seeing providers within a

network, while PFFS beneficiaries can see any provider that accepts the plan’s payment terms. Beneficiaries in PPOs can see both in-network and out-of-network providers but must pay higher cost-sharing amounts if they use out-of-network services. We did not include regional PPOs in the PPO category.
In commenting on a draft of our report, CMS stated that it agreed with our findings. In addition, CMS stated that the small difference between MA organizations’ actual and projected aggregate medical expenses was within the prevailing range of such differences for a 1-year-ahead estimate. CMS further noted that MA organizations’ higher-than-projected profits were due primarily to higher-than-projected revenues from Medicare. As we stated in our report, however, if MA organizations had more accurately projected both their revenues and expenses, they would have been able to provide beneficiaries with additional benefits or cost-sharing reductions, and still maintain the level of profits projected.

Background

Organizations that participate in Medicare’s program for private health plans have been required to submit projections of their expenses and profits to CMS since the 1980s.9 Beginning in 2006, MA organizations have been required to submit bids to CMS that reflect their projected revenue requirements for the medical expenses, non-medical expenses, and profit margin associated with offering the same benefits available in the FFS program.10 Medicare pays an MA organization an amount per member per month based on the relationship between the organization’s bid and an administratively set rate known as a benchmark. Benchmarks are the maximum amount Medicare will pay an organization to serve an average beneficiary, and while they vary by county, every county in the United States had a benchmark that was at least as high as the average spending per member per month for all FFS Medicare enrollees in that county. If an MA organization’s bid is higher than the benchmark, Medicare pays the organization the amount of the benchmark, and 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 75 percent of the difference between the benchmark and the bid.11 MA organizations are required to spend their rebates on additional benefits, reduced cost sharing, reduced premiums, or a combination of the three.

In June 2008, we reported that for 2005, on average, MA organizations reported that they spent less on medical expenses and earned more profits than projected.12 MA organizations, on average, reported spending 85.7 percent of total revenue on medical expenses in 2005, but had projected medical expenditures of 90.2 percent of total revenue. On average, MA organizations’ self-reported actual profit margin was 5.1 percent of total revenue compared to a projected profit margin of 1.8 percent of total revenue, which is approximately $1.1 billion more in 2005 than MA organizations had projected.13 In commenting on a draft of that report, CMS stated that the finding was not relevant to assessment of the MA program because the

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9Before July 1, 2001, CMS was known as the Health Care Financing Administration.

10Profits or profit margins refer to MA organizations’ remaining revenue after medical and non-medical expenses are paid. Profits may include other revenue offsets that are not captured in the non-medical expenses category, such as income taxes. In certain circumstances, such as for new market entrants, CMS allows MA organizations to have a negative profit, meaning that the organization’s revenue is less than its combined medical and non-medical expenses.


12GAO-08-827R.

13There were several large outlier contracts whose relatively large difference between actual and projected profits made up more than half of the $1.1 billion difference.
payment system in 2005 was different from the current competitive bidding process, which took effect in 2006. CMS stated that the competitive bidding model brought market discipline to the Medicare program, and consisted of a rigorous system of actuarial bid submissions that were subject to careful review by the Office of the Actuary at CMS.

**Profits and Non-Medical Expenses Were Higher While Medical Expenses Were Lower Than Projected, on Average**

MA organizations’ self-reported profits and non-medical expenses were, on average, higher in 2006 than they had projected, while medical expenses were lower than projected. Specifically, MA organizations reported, on average, earning profits of 6.6 percent of total revenue in 2006—which was higher than their projected profits of 4.1 percent. Actual non-medical expenses (10.1 percent of total revenue) were higher than projected (9.0 percent of total revenue) as well. MA organizations reported spending an average of 83.3 percent of total revenue on medical expenses, but had projected spending an average of 86.9 percent of total revenue on those expenses.

MA organizations included in our analysis received $1.7 billion more in revenues than projected, based on the actual number of enrolled beneficiaries. CMS officials stated that changes in the mix and health status of projected versus actually enrolled beneficiaries may have produced differences between actual expenditures and projections. That is, MA organizations received higher-than-projected revenues because Medicare paid additional amounts to compensate for enrollees who were deemed potentially more costly because of their health status, who were disproportionately from counties with higher benchmarks, who were disproportionately enrolled in more expensive plans, or a combination of the three. The MA organizations’ aggregate data show, however, that the increased payments were not accompanied by commensurately higher-than-projected expenses. MA organizations self-reported spending slightly less on medical expenses ($42.2 billion) than the amount projected ($42.5 billion), and slightly more on non-medical expenses ($5.1 billion) than the amount projected ($4.4 billion). Overall, actual expenses ($47.3 billion) were about the same as projected ($46.9 billion). Consequently, MA organizations earned $1.3 billion more in profits than projected in 2006. (See table 1.)

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14To adjust for any misestimates of the number of enrolled beneficiaries, we multiplied both actual and projected per member per month revenues and profits by actual 2006 enrollment.

15CMS assigns Medicare enrollees a health status score based on their diagnoses and demographic characteristics. MA organizations are paid more for beneficiaries who are expected to need more care or more expensive care.
Table 1: Actual and Projected Medical Expenses, Non-Medical Expenses, and Profits as Amounts and Percentages of Revenue, 2006

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th></th>
<th></th>
<th>Projected</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Percentage of revenue</td>
<td>Amount in dollars per beneficiary</td>
<td>Amount in dollars (billions)</td>
<td>Percentage of revenue</td>
<td>Amount in dollars per beneficiary</td>
<td>Amount in dollars (billions)</td>
</tr>
<tr>
<td>Medical expenses</td>
<td>83.3%</td>
<td>7,551.38</td>
<td>42.15</td>
<td>86.9%</td>
<td>7,614.39</td>
<td>42.51</td>
</tr>
<tr>
<td>Non-medical expenses</td>
<td>10.1%</td>
<td>913.59</td>
<td>5.10</td>
<td>9.0%</td>
<td>785.72</td>
<td>4.39</td>
</tr>
<tr>
<td>Profits</td>
<td>6.6%</td>
<td>601.79</td>
<td>3.36</td>
<td>4.1%</td>
<td>363.13</td>
<td>2.03</td>
</tr>
<tr>
<td><strong>Total Revenue</strong></td>
<td>9,066.76</td>
<td>50.61</td>
<td></td>
<td><strong>8,763.24</strong></td>
<td></td>
<td><strong>48.92</strong></td>
</tr>
</tbody>
</table>

Source: CMS.

Notes: Data on actual expenses and profits were self-reported by MA organizations. Percentages are weighted total revenue. Percentage totals may add to less than 100 due to rounding. We excluded from our analysis employer group health plans and contracts for which revenue projections or actual expenditures were not reported. We also excluded from our analysis contracts that had fewer than 24,000 member months, which is equivalent to 2,000 beneficiaries enrolled for a full year. The analysis includes 224 contracts, representing about 57 percent of the contracts for which a two-year look-back form was submitted and about 84 percent of MA enrollment, equivalent to approximately 5.6 million beneficiaries enrolled in contracted plans for a full year.

A CMS official we spoke with stated that medical expenses as a percentage of revenue may vary for reasons other than utilization and cost of providing care. Some MA organizations, for example, may categorize the costs of delivering care management services as medical expenses, while other MA organizations may classify these as non-medical expenses.

A CMS official we spoke with stated that revenues were higher than projected because MA organizations received additional payments to compensate for enrollees who were potentially more costly because of severity of illness, were disproportionately from counties with higher benchmarks, were disproportionately enrolled in more expensive plans, or a combination of the three.

More than half of beneficiaries were enrolled in health benefits plans offered by MA organizations for which actual profits were greater than projections as a percentage of revenue. More than two-thirds of beneficiaries were enrolled in health benefit plans for which actual medical expenses were less than projections as a percentage of revenue. In contrast, more than two-thirds of beneficiaries were enrolled in plans for which actual non-medical expenses were greater than projections as a percentage of revenue. (See fig. 1.)
Figure 1: Percentage of Beneficiaries Covered by MA Organizations with Reported Expenses and Profits as a Percentage of Revenue That Were Greater Than or Less Than Projections, 2006

<table>
<thead>
<tr>
<th>Profits</th>
<th>Medical expenses</th>
<th>Non-medical expenses</th>
</tr>
</thead>
<tbody>
<tr>
<td>42.7%</td>
<td>71.8%</td>
<td>30.4%</td>
</tr>
<tr>
<td>57.4%</td>
<td>28.2%</td>
<td>69.6%</td>
</tr>
</tbody>
</table>

Source: CMS.

Notes: Data on actual expenses and profits were self-reported by MA organizations. Percentage totals may add to more than 100 due to rounding. We used member months as our measure of beneficiary enrollment. Twelve member months is equivalent to one beneficiary enrolled in a contracted plan for a full year. We excluded from our analysis employer group health plans and contracts for which revenue projections or actual expenditures were not reported. We also excluded from our analysis contracts that had fewer than 24,000 member months, which is equivalent to 2,000 beneficiaries enrolled for a full year. The analysis includes 224 contracts, representing about 57 percent of the contracts for which a two-year look-back form was submitted and about 84 percent of MA enrollment, equivalent to approximately 5.6 million beneficiaries enrolled in contracted plans for a full year.

Among the three types of MA health plans with the largest enrollments—HMOs, PPOs, and PFFS plans—there was a consistent pattern of actual profits being higher than projected and medical expenses being lower than projected. On average, HMO plans reported the largest profit margin as a percentage of total revenue (7.2 percent) whereas PFFS plans reported the smallest (3.1 percent). (See table 2.) PPO plans reported spending the highest percentage of total revenue on medical expenses (85.5 percent) while PFFS plans reported the smallest (81.3 percent). PFFS plans reported spending 15.6 percent of total revenue on non-medical expenses, more than HMO plans (9.4 percent) or PPO plans (10.5 percent) and more than 50 percent greater than what they projected.
### Table 2: Actual and Projected Medical Expenses, Non-Medical Expenses, and Profits as Amounts and Percentages of Revenue among HMOs, PPOs, and PFFS, 2006

<table>
<thead>
<tr>
<th></th>
<th>Actual Percentage of Revenue</th>
<th>Actual Amount in Dollars (billions)</th>
<th>Projected Percentage of Revenue</th>
<th>Projected Amount in Dollars (billions)</th>
<th>Difference between actual and projected Percentage of Revenue</th>
<th>Difference between actual and projected Amount in Dollars (billions)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HMOs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contracts = 165</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beneficiaries = 4,606,255</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical expenses*</td>
<td>83.4</td>
<td>35.74</td>
<td>86.8</td>
<td>35.57</td>
<td>-3.4</td>
<td>0.18</td>
</tr>
<tr>
<td>Non-medical expenses</td>
<td>9.4</td>
<td>4.01</td>
<td>8.7</td>
<td>3.58</td>
<td>0.6</td>
<td>0.42</td>
</tr>
<tr>
<td>Profits</td>
<td>7.2</td>
<td>3.10</td>
<td>4.4</td>
<td>1.82</td>
<td>2.8</td>
<td>1.28</td>
</tr>
<tr>
<td><strong>PPOs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contracts = 42</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beneficiaries = 238,258</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical expenses*</td>
<td>85.5</td>
<td>1.83</td>
<td>88.0</td>
<td>1.94</td>
<td>-2.5</td>
<td>-0.11</td>
</tr>
<tr>
<td>Non-medical expenses</td>
<td>10.5</td>
<td>0.23</td>
<td>9.4</td>
<td>0.21</td>
<td>1.2</td>
<td>0.02</td>
</tr>
<tr>
<td>Profits</td>
<td>4.0</td>
<td>0.08</td>
<td>2.7</td>
<td>0.06</td>
<td>1.3</td>
<td>0.03</td>
</tr>
<tr>
<td><strong>PFFS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contracts = 10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beneficiaries = 635,126</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical expenses*</td>
<td>81.3</td>
<td>3.86</td>
<td>87.7</td>
<td>4.23</td>
<td>-6.4</td>
<td>-0.37</td>
</tr>
<tr>
<td>Non-medical expenses</td>
<td>15.6</td>
<td>0.74</td>
<td>10.0</td>
<td>0.48</td>
<td>5.6</td>
<td>0.26</td>
</tr>
<tr>
<td>Profits</td>
<td>3.1</td>
<td>0.15</td>
<td>2.3</td>
<td>0.11</td>
<td>0.8</td>
<td>0.04</td>
</tr>
</tbody>
</table>

Source: CMS.

Notes: Data on actual expenses and profits were self-reported by MA organizations. Percentages are weighted by total revenue. Percentage totals may add to more or less than 100 due to rounding. We did not include regional PPOs in the PPO category. We excluded from our analysis employer group health plans and contracts for which revenue projections or actual expenditures were not reported. We also excluded from our analysis contracts that had fewer than 24,000 member months, which is equivalent to 2,000 beneficiaries enrolled for a full year. We reported enrollment by plan type in terms of the number of beneficiaries; each beneficiary is equivalent to 12 member months. The analysis includes 217 contracts, representing about 55 percent of the contracts for which a two-year look-back form was submitted and about 82 percent of MA enrollment, equivalent to approximately 5.5 million beneficiaries enrolled in contracted plans for a full year.

*A CMS official we spoke with stated that medical expenses as a percentage of revenue may vary for reasons other than utilization and cost of providing care. Some MA organizations, for example, may categorize the costs of care management services as medical expenses, while other MA organizations may classify these as non-medical expenses.
In 2006, MA organizations had greater profits as a percentage of revenue (6.6 percent) than in 2005 (5.0 percent).\(^{16}\) (See table 3.) Although the increase in profits as a percentage of revenue from 2005 to 2006 was only 1.6 percentage points, MA organizations' aggregate profits nearly doubled from 2005 to 2006. The increase was largely driven by the approximate 40 percent increase in enrollment between the 2 years.

### Table 3: Actual Medical Expenses, Non-Medical Expenses, and Profits as Amounts and Percentages of Revenue, 2005 and 2006

<table>
<thead>
<tr>
<th></th>
<th>2005</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Percentage of revenue</td>
<td>Amount in dollars per beneficiary</td>
</tr>
<tr>
<td>Medical expenses(^a)</td>
<td>85.9</td>
<td>7,749.66</td>
</tr>
<tr>
<td>Non-medical expenses</td>
<td>9.2</td>
<td>827.72</td>
</tr>
<tr>
<td>Profits</td>
<td>5.0</td>
<td>448.12</td>
</tr>
<tr>
<td>Total Revenue</td>
<td>9,025.50</td>
<td>35.01</td>
</tr>
</tbody>
</table>

Source: CMS.

Notes: Data on actual expenses and profits were self-reported by MA organizations. Percentages for 2005 and 2006 are weighted by 2005 and 2006 total revenue, respectively. Percentage totals may add to more than 100 due to rounding. We excluded from our analysis employer group health plans and contracts for which revenue projections or actual expenditures were not reported. We also excluded from our analysis contracts that had fewer than 24,000 member months, which is equivalent to 2,000 beneficiaries enrolled for a full year. The 2005 analysis includes 120 contracts, representing about 81 percent of the contracts for which a two-year look-back form was submitted and about 78 percent of MA enrollment, equivalent to approximately 3.9 million beneficiaries enrolled in contracted plans for a full year. The 2006 analysis includes 224 contracts, representing about 57 percent of the contracts for which a two-year look-back form was submitted and about 84 percent of MA enrollment, equivalent to approximately 5.6 million beneficiaries enrolled in contracted plans for a full year.

\(^{a}\)A CMS official we spoke with stated that medical expenses as a percentage of revenue may vary for reasons other than utilization and cost of providing care. Some MA organizations, for example, may categorize the costs of delivering care management services as medical expenses, while other MA organizations may classify these as non-medical expenses.

MA organizations in aggregate earned $1.3 billion more in profits than projected in 2006, compared to $1.1 billion more in profits than projected in 2005. While the difference between actual and projected profits as a percentage of revenue in 2006 (2.5 percentage points) was less than the difference in 2005 (3.2 percentage points), the total difference between actual and projected profits was greater because of enrollment growth. The median amount of actual profits earned above projections per contract was approximately $1.7 million in 2006, compared to the 2005 median of $2.8 million actual profits above projected.\(^{17}\)

\(^{16}\)Under the payment system in 2005, MA organizations were paid an administrative set rate regardless of their projections. If an MA organization's projection was less than the administratively set rate, the organization was required to spend the surplus Medicare payment on beneficiaries by adding extra benefits, reducing beneficiary cost sharing, or contributing to a benefit stabilization fund.

\(^{17}\)In an ordered set of values, the median is a value below and above which there is an equal number of values; if there is no one middle number, it is the arithmetic mean (average) of the two middle values.
Agency Comments

In commenting on a draft of our report, CMS stated that it agreed with our findings. In addition, CMS stated that the small difference between MA organizations’ actual and projected aggregate medical expenses was within the prevailing range of such differences for a one-year-ahead estimate. CMS further noted that MA organizations’ higher-than-projected profits were due primarily to higher-than-projected revenues from Medicare, and that the increase in revenues was at least partially due to higher-than-projected risk scores, reflecting enrollees who were deemed potentially more costly because of their health status.

We stated in our report that MA organizations self-reported spending only slightly less on medical expenses than projected; however, they received $1.7 billion more in revenues than projected. If MA organizations had more accurately projected both their revenues and expenses, they would have been able to provide beneficiaries with additional benefits or cost-sharing reductions, and still maintain the level of profits projected.

As agreed with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from its date. At that time, we will send copies of this report to the Acting Administrator of CMS and relevant congressional committees and other interested members. The report will also be available at no charge on the GAO Web site at http://www.gao.gov.

If you or your staff have any questions regarding 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. Christine Brudevold, Assistant Director; Gregory Giusto; Dan Lee; and Jessica T. Lee were major contributors to this report.

Sincerely yours,

James C. Cosgrove
Director, Health Care

Enclosure
Enclosure I

Comments from the Centers for Medicare & Medicaid Services

DEC 02 2008

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

Dear Mr. Cosgrove:

Enclosed are the Department’s comments on the U.S. Government Accountability Office’s (GAO) draft report entitled: “Medicare Advantage Organizations: Actual Expenses and Profits Compared to Projections” (GAO 09-132R).

The Department appreciates the opportunity to comment on this draft report before its publication.

Sincerely,

[Signature]

Vincent J. Ventimiglia, Jr.
Assistant Secretary for Legislation

Attachment
DATE: DEC 0 8 2008

TO: Vincent J. Ventimiglia, Jr.
Assistant Secretary for Legislation
Department of Health and Human Services

FROM: Kerry Weems
Acting Administrator

SUBJECT: Government Accountability Office (GAO) Draft Correspondence: “Medicare Advantage Organizations: Actual Expenses and Profits Compared to Projections” (GAO-09-132R)

Thank you for the opportunity to review and comment on the GAO correspondence entitled, “Draft Correspondence: Medicare Advantage Organizations: Actual Expenses and Profits Compared to Projections.” While CMS agrees with the findings set forth in this draft report, we have one comment.

As illustrated in Table 1, the aggregate actual medical expenses were within one percent of projected. The very small difference shown in this comparison is significant because of the inherent variability in medical trends and difficulty in forecasting medical spending—the result is well within the prevailing range of such differences for a one-year-ahead estimate. Further, it appears that the primary reason actual profit margins were higher than projected is that plans received greater revenue than projected. Projections of plan revenue, which are included in plan bids, were based on projected risk scores, which were lower than the subsequent actual risk scores. Since actual risk scores were greater than projected, plans received greater revenue than projected based on these risk scores.

Again, CMS appreciates the opportunity to review and comment on this draft report.

(200729)
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