

GAO

Testimony

Before the Subcommittee on Health,
Committee on Ways and Means, House of
Representatives

For Release on Delivery
Expected at 10:00 a.m. EST
Thursday, February 28, 2008

MEDICARE ADVANTAGE

Higher Spending Relative to Medicare Fee-for-Service May Not Ensure Lower Out-of-Pocket Costs for Beneficiaries

Statement of James Cosgrove, Acting Director
Health Care





Highlights of [GAO-08-522T](#), a testimony before the Subcommittee on Health, Committee on Ways and Means, House of Representatives

Why GAO Did This Study

Although private health plans were originally envisioned in the 1980s as a potential source of Medicare savings, such plans have generally increased program spending. In 2006, Medicare paid \$59 billion to Medicare Advantage (MA) plans—an estimated \$7.1 billion more than Medicare would have spent if MA beneficiaries had received care in Medicare fee-for-service (FFS).

MA plans receive a per member per month (PMPM) payment to provide services covered under Medicare FFS. Almost all MA plans receive an additional Medicare payment, known as a rebate. Plans use rebates and sometimes additional beneficiary premiums to fund benefits not covered under Medicare fee-for-service; reduce premiums; or reduce beneficiary cost sharing. In 2007, MA plans received about \$8.3 billion in rebate payments.

This testimony is based on GAO's report, *Medicare Advantage: Increased Spending Relative to Medicare Fee-for-Service May Not Always Reduce Beneficiary Out-of-Pocket Costs* ([GAO-08-359](#), February 2008). For this testimony, GAO examined MA plans' (1) projected allocation of rebates, (2) projected cost sharing, and (3) projected revenues and expenses. GAO used 2007 data on MA plans' projected revenues and covered benefits, accounting for 71 percent of beneficiaries in MA plans.

To view the full product, including the scope and methodology, click on [GAO-08-522T](#). For more information, contact James Cosgrove at (202) 512-7114 or cosgrove@gao.gov.

MEDICARE ADVANTAGE

Higher Spending Relative to Medicare Fee-for-Service May Not Ensure Lower Out-of-Pocket Costs for Beneficiaries

What GAO Found

GAO found that MA plans projected they would use their rebates primarily to reduce cost sharing, with relatively little of their rebates projected to be spent on additional benefits. Nearly all plans—91 percent of the 2,055 plans in the study—received a rebate. Of the average rebate payment of \$87 PMPM, plans projected they would allocate about \$78 PMPM (89 percent) to reduced cost sharing and reduced premiums and \$10 PMPM (11 percent) to additional benefits. The average projected PMPM costs of specific additional benefits across all MA plans ranged from \$0.11 PMPM for international outpatient emergency services to \$4 PMPM for dental care.

While MA plans projected that, on average, beneficiaries in their plans would have cost sharing that was 42 percent of Medicare FFS cost-sharing estimates, some beneficiaries could have higher cost sharing for certain service categories. For example, some plans projected that their beneficiaries would have higher cost sharing, on average, for home health services and inpatient stays, than in Medicare FFS. If beneficiaries frequently used these services that required higher cost sharing than Medicare FFS, it was possible that their overall cost sharing was higher than what they would have paid under Medicare FFS.

Out of total revenues of \$783 PMPM, on average, MA plans projected that they would allocate about 87 percent (\$683 PMPM) to medical expenses. MA plans projected they would allocate, on average, about 9 percent of total revenue (\$71 PMPM) to nonmedical expenses, including administration and marketing expenses; and about 4 percent (\$30 PMPM) to the plans' profits. About 30 percent of beneficiaries were enrolled in plans that projected they would allocate less than 85 percent of their revenues to medical expenses.

As GAO concluded in its report, whether the value that MA beneficiaries receive in the form of reduced cost sharing, lower premiums, and additional benefits is worth the additional cost to Medicare is a decision for policymakers. However, if the policy objective is to subsidize health care costs of low-income Medicare beneficiaries, it may be more efficient to directly target subsidies to a defined low-income population than to subsidize premiums and cost sharing for all MA beneficiaries, including those who are well off. As Congress considers the design and cost of MA, it will be important for policymakers to balance the needs of beneficiaries and the necessity of addressing Medicare's long-term financial health.

Mr. Chairman and Members of the Subcommittee,

I am pleased to be here today to discuss the findings from our February 2008 report, *Medicare Advantage: Increased Spending Relative to Medicare Fee-for-Service May Not Always Reduce Beneficiary Out-of-Pocket Costs*.¹ Under the Medicare Advantage (MA) program, which represents an alternative to Medicare's traditional fee-for-service (FFS) program, beneficiaries may receive their covered benefits through private health plans that contract with Medicare. As of August 2007, approximately 20 percent of beneficiaries—or about 8.1 million beneficiaries—were enrolled in private plans, up from about 11 percent in 2003. The growth in enrollment was largely due to provisions of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).² The MMA, among other things, increased payment rates for private plans to encourage their participation and enable plans to enhance their benefit packages to attract beneficiaries. The subsequent rapid growth of Medicare spending on the MA program, resulting from increases in both payment rates and enrollment, underscores the importance of today's hearing and the need to better understand how MA plans use the funding they receive.

In 2006, Medicare paid \$59 billion to MA plans—an estimated \$7.1 billion more than Medicare would have spent if MA plan beneficiaries had instead received care through the FFS program. Although adding a private health plan component to Medicare was envisioned in the 1980s as a potential source of program savings, private health plans have generally increased overall Medicare spending. Spending pressures increased as policy objectives evolved to foster private health plan participation and provide Medicare beneficiaries with more health plan choices. According to Medicare's Office of the Actuary, the additional spending for the MA program has hastened the exhaustion of the Federal Hospital Insurance Trust Fund that helps finance Medicare. It has also resulted in higher Medicare premiums for all beneficiaries—including those in the FFS program—because premiums paid by Medicare FFS beneficiaries are tied to the costs of both Medicare FFS and MA programs. The Congressional Budget Office estimated that \$54 billion in projected Medicare spending

¹*Medicare Advantage: Increased Spending Relative to Medicare Fee-for-Service May Not Always Reduce Beneficiary Out-of-Pocket Costs*, [GAO-08-359](#) (Washington, D.C.: February 2008).

²Pub. L. No. 108-173, § 201, et. seq., 117 Stat. 2066, 2176.

from 2009 through 2012 is the result of setting MA plan payments above Medicare FFS spending.³ The continued cost escalation associated with MA plans relative to Medicare FFS raise further concerns about the long-term financial implications of the MA program on the financial health of the Medicare program. Even without the added costs of the MA program, Medicare faces serious long-term financial challenges due to factors such as the rising cost of care and the retirement of the baby boom generation.

The federal government spends relatively more for beneficiaries in MA plans, in part, because most MA plans receive payments known as rebates, in addition to the payments they receive for providing Medicare-covered services. Beginning in 2006, MA plans were required to submit bids for providing Medicare-covered services. An MA plan qualifies for a rebate if its bid is less than a predetermined amount known as a benchmark.⁴ A portion, 75 percent, of the difference between the benchmark and the plan's bid, is returned to the plan in the form of a rebate.⁵ In 2007, the total amount of rebates paid to MA plans was about \$8.3 billion.⁶ Plans must use rebates to provide benefits or reduce beneficiary out-of-pocket costs in any combination of the following ways: (1) provide additional benefits not covered under Medicare FFS, such as dental and hearing benefits; (2) reduce beneficiary cost sharing; or (3) reduce premiums.

Proponents of the MA program note that rebates enable plans to provide valuable extra benefits to beneficiaries and reduce beneficiary out-of-pocket costs, thereby making health care more affordable. They point out that individuals with low incomes who do not qualify for other government health care coverage may receive some financial relief by enrolling in an MA plan. Critics question the cost of the current MA program and suggest that if the policy objective is to subsidize the health care costs of individuals with low incomes, it would be more efficient to directly target subsidies to a well-defined low-income population instead of subsidizing the cost of all MA beneficiaries. Further, they are concerned that the

³Congressional Budget Office, *The Medicare Advantage Program: Enrollment Trends and Budgetary Effects* (Washington, D.C.: April 2007).

⁴Benchmarks represent the maximum amount that Medicare will pay plans, on a per beneficiary per month basis, for providing Medicare-covered services. Benchmarks always equal or exceed average per capita FFS spending.

⁵If a plan's bid for providing Medicare-covered services is higher than the benchmark, the plan must charge beneficiaries the difference in the form of a premium.

⁶Office of the Actuary, Centers for Medicare & Medicaid Services.

additional payments to MA plans are funded in part by the approximately 80 percent of beneficiaries in the FFS program who do not receive enhanced benefits.

My remarks today are based on the findings of our recent report.⁷ Specifically, my testimony will focus on (1) how plans projected they would allocate their rebates to additional benefits, reduced cost sharing, and reduced premiums; (2) how projected cost sharing in MA plans compared to projected cost sharing in Medicare FFS; and (3) how MA plans projected they would allocate their revenue to medical and other expenses.

To conduct our work for the report, we analyzed MA plans' 2007 projected revenues, projected costs, and covered benefits from data that plans submitted to the Centers for Medicare & Medicaid Services (CMS), the agency that administers Medicare. We were limited to analyzing projections because MA plans are not required to submit detailed information on actual revenues or costs. We excluded plans that restricted enrollment and plans with service areas that are exclusively outside the 50 states and the District of Columbia.⁸ After all exclusions, we had 2,055 plans in our study that accounted for 71 percent of all MA beneficiaries. Our results are weighted by August 2007 plan enrollment and are standardized to represent a Medicare beneficiary of average health status. Our work for the report was conducted from April 2007 through February 2008 in accordance with generally accepted government auditing standards.

In summary, we found that most of the MA plans we reviewed received rebates and allocated them primarily to beneficiary cost sharing and premium reductions. In 2007, 91 percent of these MA plans (1,874 of 2,055) received an average rebate of about \$87 per member per month (PMPM). Based on the projections submitted to CMS, MA plans allocated about 89 percent of their rebates to beneficiary cost sharing and premium reductions. Plans allocated about 11 percent of the rebates to provide additional benefits, such as dental services, that are not covered under Medicare FFS. The average dollar amounts plans projected they would pay for additional benefits ranged from \$0.11 PMPM for international

⁷GAO-08-359.

⁸We excluded plans that have restrictions on enrollment, such as employer plans and plans that only cover certain Medicare FFS services.

outpatient emergency services to \$4 PMPM for dental care. Some plans charged an additional premium that supplements the rebate to pay for additional benefits, cost-sharing reductions, or a combination of the two. We also found that, despite the rebates paid to MA plans, some beneficiaries in MA plans could pay more for services than they would in FFS. For example, depending on the MA plan in which they were enrolled and their health care needs, some beneficiaries who frequently used home health or inpatient services could have had overall cost sharing that was higher than what they would have paid under Medicare FFS. Finally, we found that MA plans projected spending, on average, 87 percent of total revenues (\$683 of \$783 PMPM) on medical expenses. They projected that the remainder would be allocated to a combination of nonmedical expenses (9 percent), such as administration and marketing expenses, and plans' profits (4 percent).⁹ However, the percentage allocated to medical expenses varied widely by plan. About 30 percent of MA beneficiaries were enrolled in plans that projected spending less than 85 percent on medical expenses.

Background

Medicare FFS consists of Part A, hospital insurance, which covers inpatient stays, care in skilled nursing facilities, hospice care, and some home health care; and Part B, which covers certain physician visits, outpatient hospital treatments, and laboratory services, among other services. Most persons aged 65 and older, certain individuals with disabilities, and most individuals with end-stage renal disease are eligible to receive coverage for Part A services at no premium. Individuals eligible for Part A can also enroll in Part B, although they are charged a Part B premium.¹⁰ MA plans are required to provide benefits that are covered under the Medicare FFS program.¹¹ Most Medicare beneficiaries who are eligible for Medicare FFS can choose to enroll in the MA program, operated through Medicare Part C, instead of Medicare FFS.¹² All Medicare

⁹In this testimony, we use the term profits to refer to for-profit and nonprofit plans' remaining revenue after medical and nonmedical expenses are paid.

¹⁰For 2007, the monthly Part B premium was set at \$93.50, although high-income beneficiaries pay more.

¹¹MA plans do not cover hospice care, a benefit which is provided under Medicare FFS.

¹²Individuals with end-stage renal disease are not eligible for most MA plans, unless they develop the disease while enrolled in an MA plan. 42 U.S.C. § 1395w-21(a)(3)(B)(2000).

beneficiaries, regardless of their source of coverage, can choose to receive outpatient prescription drug coverage through Medicare Part D.

Beneficiaries in both Medicare FFS and MA face cost-sharing requirements for medical services. In Medicare FFS, cost sharing includes a Part A and a Part B deductible, the amount beneficiaries must pay for services before Medicare FFS begins to pay.¹³ Medicare FFS cost sharing also includes coinsurance—a percentage payment for a given service that a beneficiary must pay,¹⁴ and copayments—a standard amount a beneficiary must pay for a medical service.¹⁵ Medicare allows MA plans to have cost-sharing requirements that are different from Medicare FFS's cost-sharing requirements, although an MA plan cannot require overall projected average cost sharing that exceeds what beneficiaries would be expected to pay under Medicare FFS. MA plans are permitted to establish dollar limits on the amount a beneficiary spends on cost sharing in a year of coverage, although Medicare FFS has no total cost-sharing limit.¹⁶ MA plans can use both out-of-pocket maximums, limits that can apply to all services but can exclude certain service categories, and service-specific maximums, which are limits that apply to a single service category. These limits help provide financial protection to beneficiaries who might otherwise have high cost-sharing expenses.

MA Plans Projected They Would Allocate Most of the Rebates to Beneficiaries in the Form of Reduced Cost Sharing and Reduced Premiums

MA plans projected that, on average, they would allocate most of the rebates to beneficiaries as reduced cost sharing and reduced premiums for Part B services, Part D services, or both. In 2007, almost all MA plans in our study (1,874 of the 2,055 plans, or 91 percent) received a rebate payment from Medicare that averaged \$87 PMPM. MA plans projected they would allocate 69 percent of the rebate (\$61 PMPM) to reduced cost sharing and 20 percent (\$17 PMPM) to reduced premiums. MA plans projected they would allocate relatively little of the rebates (11 percent or

¹³For example, in 2007, Medicare FFS required a deductible payment of \$992 before it began paying for an inpatient stay, and \$131 before it began paying for any Part B services.

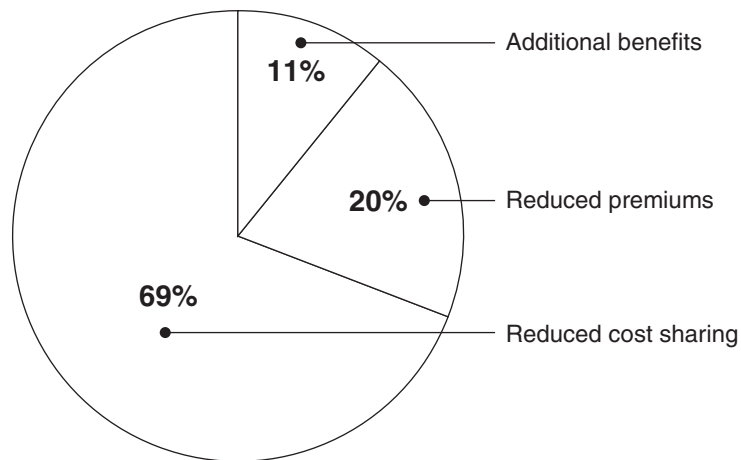
¹⁴For example, coinsurance might require a beneficiary to pay 20 percent of the total payment for physician visits.

¹⁵For example, in 2007, the Medicare copayment for days 61 through 90 of an inpatient stay was \$248 per day.

¹⁶Many Medicare FFS beneficiaries pay premiums for a type of supplemental insurance known as Medigap, which limits beneficiary cost sharing for Medicare-covered services. Medigap policies are not available to lower the cost sharing of MA beneficiaries.

\$10 PMPM) to additional benefits that are not covered under Medicare FFS. (See fig. 1.) On average, for plans that provided detailed cost estimates, the projected dollar amounts of the common additional benefits ranged from a low of \$0.11 PMPM for international outpatient emergency services to \$4 PMPM for dental services. Additional benefits commonly offered included dental services, health education services, and hearing services.

Figure 1: Projected Rebate Allocation to Additional Benefits, Premium Reductions, and Cost-Sharing Reductions, 2007



Source: GAO analysis of 2007 CMS Bid Pricing Tool data.

Note: Percentages are weighted by August 2007 plan enrollment. This analysis is based on 1,874 plans. We excluded from our analysis plans that restricted enrollment, plans with service areas that are exclusively outside the 50 states and the District of Columbia, and plans that did not receive a rebate.

About 41 percent of beneficiaries, or 2.3 million people, were enrolled in an MA plan that also charged additional premiums to pay for additional benefits, reduced cost sharing, or a combination of the two. The average additional premium charged was \$58 PMPM. Based on plans' projections, we estimated that about 77 percent of the additional benefits and reduction in beneficiary cost sharing was funded by rebates, with the remainder being funded by additional beneficiary premiums.

MA Plans Projected that MA Beneficiaries, on Average, Would Have Lower Cost Sharing than if They Were in Medicare FFS, but Some MA Beneficiaries Could Pay More

For 2007, MA plans projected that MA beneficiary cost sharing, funded by both rebates and additional premiums, would be 42 percent of estimated cost sharing in Medicare FFS. Plans projected that their beneficiaries, on average, would pay \$49 PMPM in cost sharing, and they estimated that the Medicare FFS equivalent cost sharing for their beneficiaries was \$116 PMPM.

Although plans projected that beneficiaries' overall cost sharing was lower, on average, than Medicare FFS cost-sharing estimates, some MA plans projected that cost sharing for certain categories of services was higher than Medicare FFS cost-sharing estimates. This is because overall cost sharing in MA plans is required to be actuarially equivalent or lower compared to overall cost sharing in Medicare FFS, but may be higher or lower for specific categories of services. For example, 19 percent of MA beneficiaries were enrolled in plans that projected higher cost sharing for home health services, on average, than in Medicare FFS, which does not require any cost sharing for home health services. Similarly, 16 percent of MA beneficiaries were in plans with higher projected cost sharing for inpatient services relative to Medicare FFS.¹⁷ (See table 1.) Some MA beneficiaries who frequently used these services with higher cost sharing than Medicare FFS could have had overall cost sharing that was higher than what they would pay under Medicare FFS.

¹⁷Average cost sharing reflects expenditures for the entire population and includes both beneficiaries who are projected to use a certain category of service and beneficiaries who are not projected to use that service.

Table 1: Beneficiaries in MA Plans with Higher Projected Cost Sharing than Medicare FFS for a Given Service Category, 2007

	All plans Plans = 2,055 Beneficiaries = 5,764,368	
	Number	Percent
Home health services ^a	1,069,023	19
Inpatient services ^b	937,246	16
Skilled nursing facility services	499,071	9
Durable medical equipment, prosthetics, and supplies	215,541	4
Part B drugs ^c	101,416	2
Professional services ^b	47,033	1
Outpatient facility services ^d	31,497	1

Source: GAO analysis of 2007 CMS Bid Pricing Tool data.

Note: We excluded plans that restricted enrollment and plans with service areas that are exclusively outside the 50 states and the District of Columbia.

^aHome health services include skilled nursing services, home health aides, and certain therapy services, all provided in the home setting.

^bMany MA plans include cost sharing for professional services, such as physician visits received during an inpatient stay, in their inpatient cost-sharing amount. As a result, the cost sharing for professional services may be understated, while the inpatient cost sharing may be overstated. Professional services include physician visits, therapy, and radiology, among other services.

^cPart B drugs are drugs that are covered under Medicare Part B, and they include drugs that are typically administered by a physician. Many plans excluded Part B drugs from the out-of-pocket maximum if they were obtained from a pharmacy, but according to CMS, did not exclude Part B drugs administered by a physician.

^dOutpatient facility services include surgery, emergency, and other services provided in an outpatient facility.

Cost sharing for particular categories of services varied substantially among MA plans. For example, with regards to inpatient cost sharing, more than half a million beneficiaries were in MA plans that had no cost sharing at all. In contrast, a similar number of beneficiaries were in MA plans that required cost sharing that could result in \$2,000 or more for a 10-day hospital stay and \$3,000 or more for three average-length hospital stays.¹⁸ In Medicare FFS in 2007, beneficiaries paid a \$992 deductible for the first hospital stay in a benefit period, no deductible for subsequent

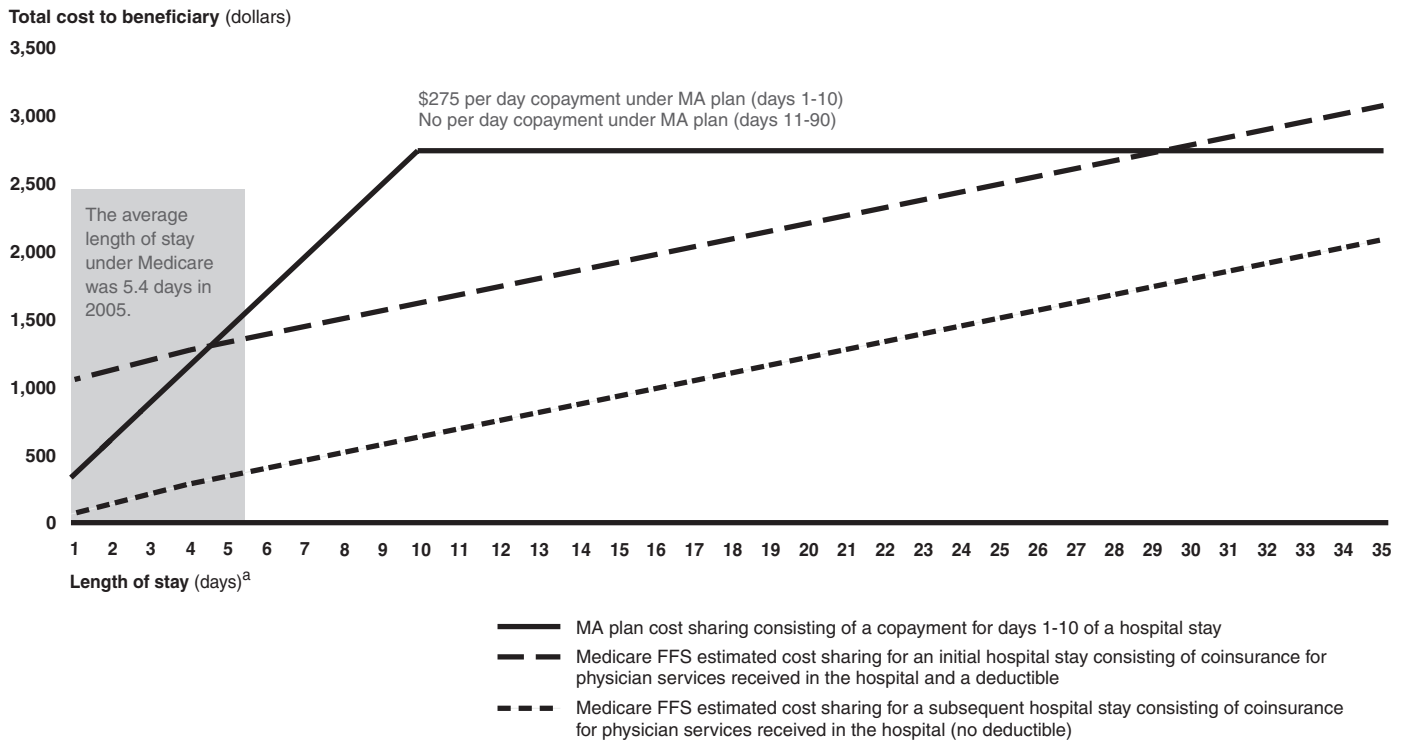
¹⁸The average length of stay for Medicare FFS was 5.4 days in 2005 according to a MedPAC analysis of Medicare cost report data.

hospital stays in the same benefit period, and a 20 percent coinsurance for physician services that averaged \$73 per day for the first 4 days of a hospital stay and \$58 per day for subsequent days in the stay.¹⁹

Figure 2 provides an illustrative example of an MA plan that could have exposed a beneficiary to higher inpatient costs than under Medicare FFS. While the plan in this illustrative example had lower cost sharing than Medicare FFS for initial hospital stays of 4 days or less as well as initial hospital stays of 30 days or more, for stays of other lengths the MA plan could have cost beneficiaries more than \$1,000 above out-of-pocket costs under Medicare FFS. The disparity between out-of-pocket costs under the MA plan and costs under Medicare FFS was largest when comparing additional hospital visits in the same benefit period, since Medicare FFS does not charge a deductible if an admission occurs within 60 days of a previous admission.

¹⁹Medicare FFS cost-sharing requirements also include a \$248 daily charge for hospital stays lasting between 61 and 90 days.

Figure 2: Example of an MA Plan with Inpatient Cost Sharing Different from the Medicare FFS Program



Source: GAO analysis of 2007 CMS Plan Benefit Package data and CMS actuarial data.

Notes: In this example, the MA plan charged a \$275 daily copayment for the first 10 days of the hospital stay, and charged no additional copayment for days 11 through 90. The plan had a \$4,000 out-of-pocket maximum. In contrast, in 2007 Medicare FFS charged a \$992 deductible for an initial hospital stay of a benefit period and \$248 per day for days 61 through 90 of a hospital stay. Medicare FFS beneficiaries paid no deductible for an additional hospital stay if it occurred within 60 days of the previous stay. In addition, Medicare FFS beneficiaries must pay coinsurance for physician services received while in the hospital. The charges associated with these physician services averaged \$73 per day for the first 4 days of the hospital stay, and \$58 per day for the remaining days of a hospital stay through 90 days. This example assumes that the beneficiary was charged the average coinsurance. The actual amount of coinsurance a beneficiary pays varies based on the amount of services a beneficiary receives, and charges can be above or below the average.

^aNearly 88 percent of hospital stays under Medicare were 10 days or less in 2004 according to CMS data. About 1 percent of hospital stays were longer than 30 days.

Some MA plans had out-of-pocket maximums, which help protect beneficiaries against high spending on cost sharing. As of August 2007, about 48 percent of beneficiaries were enrolled in plans that had an out-of-pocket maximum. However, some plans excluded certain services from the out-of-pocket maximum. Services that were typically excluded were

Part B drugs obtained from a pharmacy,²⁰ outpatient substance abuse and mental health services, home health services, and durable medical equipment.

MA Plans Projected Approximately 87 Percent of Total Revenue Would be Spent on Medical Expenses

For 2007, MA plans projected that of their total revenues (\$783 PMPM), they would spend approximately 87 percent (\$683 PMPM) on medical expenses. Plans further projected they would spend approximately 9 percent of total revenue (\$71 PMPM) on nonmedical expenses, such as administration expenses and marketing expenses, and approximately 4 percent (\$30 PMPM) on the plans' profits, on average. There was variation among individual plans in the percent of revenues projected to be spent on medical expenses. For example, about 30 percent of beneficiaries—1.7 million—were enrolled in plans that projected spending less than 85 percent on medical expenses. While there is no definitive standard for the percentage of revenues that should be spent on medical expenses, Congress adopted the 85 percent threshold to require minimum thresholds for MA plans in the Children's Health and Medicare Protection Act of 2007.²¹

MA plans projected expenses separately for certain categories of nonmedical expenses, including marketing and sales. One type of MA plan—Private Fee-for-Service (PFFS)—allocated a larger percentage of revenue to marketing and sales than other plan types.²² On average, as a percentage of total revenue, marketing and sales expenses were 3.6 percent for PFFS plans compared to 2.4 percent for all MA plans.

²⁰According to CMS, plans that excluded Part B drugs from the out-of-pocket maximum excluded drugs obtained from a pharmacy and did not exclude drugs that were administered by a physician.

²¹The Children's Health and Medicare Protection Act of 2007 (CHAMP Act), H.R. 3162, 110th Cong., § 414 (2007), was passed in the House of Representatives on August 1, 2007.

²²PFFS plans allow beneficiaries to see any provider that accepts the plan's payment terms. Other plan types in addition to PFFS plans that we included in our analyses were Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO) and Provider-Sponsored Organizations (PSO). Beneficiaries in HMOs are generally restricted to seeing providers within a network, while 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. PSOs are MA plans that are operated by a provider or providers.

Concluding Observations

Medicare spends more per beneficiary in MA than it does for beneficiaries in Medicare FFS, at an estimated additional cost to Medicare of \$54 billion from 2009 through 2012. In 2007, the average MA plan receives a Medicare rebate equal to approximately \$87 PMPM, on average. MA plans projected they would allocate the vast majority of their rebates—approximately 89 percent—to beneficiaries to reduce premiums and to lower their cost-sharing for Medicare-covered services. Plans projected they would use a relatively small portion of their rebates—approximately 11 percent—to provide additional benefits that are not covered under Medicare FFS. Although the rebates generally have helped to make health care more affordable for many beneficiaries enrolled in MA plans, some beneficiaries may face higher expenses than they would in Medicare FFS. Further, because premiums paid by beneficiaries in Medicare FFS are tied to both Medicare FFS and MA costs, beneficiaries covered under Medicare FFS are subsidizing the additional benefits and lower costs that MA beneficiaries receive. Whether the value that MA beneficiaries receive in the form of reduced cost sharing, lower premiums, and extra benefits is worth the increased cost borne by beneficiaries in Medicare FFS is a decision for policymakers. However, if the policy objective is to subsidize health-care costs of low-income Medicare beneficiaries, it may be more efficient to directly target subsidies to a defined low-income population than to subsidize premiums and cost sharing for all MA beneficiaries, including those who are well off. As Congress considers the design and cost of the MA program, it will be important for policymakers to balance the needs of beneficiaries—including those in MA plans and those in Medicare FFS—with the necessity of addressing Medicare’s long-term financial health.

Mr. Chairman, this completes my prepared remarks. I would be happy to respond to any questions you or other Members of the Subcommittee may have at this time.

For further information about this testimony, please contact James Cosgrove 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 statement. Christine Brudevold, Assistant Director; Jennie Apter, Alexander Dworkowitz, Gregory Giusto, Drew Long, and Christina C. Serna made key contributions to this statement.

This is a work of the U.S. government and is not subject to copyright protection in the United States. It may be reproduced and distributed in its entirety without further permission from GAO. However, because this work may contain copyrighted images or other material, permission from the copyright holder may be necessary if you wish to reproduce this material separately.

GAO's Mission

The Government Accountability Office, the audit, evaluation, and investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.

Obtaining Copies of GAO Reports and Testimony

The fastest and easiest way to obtain copies of GAO documents at no cost is through GAO's Web site (www.gao.gov). Each weekday, GAO posts newly released reports, testimony, and correspondence on its Web site. To have GAO e-mail you a list of newly posted products every afternoon, go to www.gao.gov and select "E-mail Updates."

Order by Mail or Phone

The first copy of each printed report is free. Additional copies are \$2 each. A check or money order should be made out to the Superintendent of Documents. GAO also accepts VISA and Mastercard. Orders for 100 or more copies mailed to a single address are discounted 25 percent. Orders should be sent to:

U.S. Government Accountability Office
441 G Street NW, Room LM
Washington, DC 20548

To order by Phone: Voice: (202) 512-6000
TDD: (202) 512-2537
Fax: (202) 512-6061

To Report Fraud, Waste, and Abuse in Federal Programs

Contact:

Web site: www.gao.gov/fraudnet/fraudnet.htm

E-mail: fraudnet@gao.gov

Automated answering system: (800) 424-5454 or (202) 512-7470

Congressional Relations

Ralph Dawn, Managing Director, dawnr@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