GAO REPORT CONFIRMS MEDICARE ADVANTAGE OVERPAYMENTS ARE A RAW DEAL FOR TAXPAYERS AND SENIORS

Wednesday, 27 February 2008

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FOR IMMEDIATE RELEASE, Thursday, February 28, 2008

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WASHINGTON – Energy and Commerce Committee Chair John Dingell (D-MI), Ways and Means Chair Charles B. Rangel (D-NY), Oversight and Government Reform Committee Chair Henry Waxman (D-CA), Ways and Means Health Subcommittee Chair Pete Stark (D-CA), and Energy and Commerce Health Subcommittee Chair Frank Pallone (D-NJ) today released a report by the Government Accountability Office (GAO) titled “Medicare Advantage (MA): Increased Spending Relative to Medicare Fee-for-Service (FFS) May Not Always Reduce Beneficiary Out-of-Pocket Costs.” The report will soon be available on GAO’s website.

“This report confirms what many of us have known about -- and raised concerns about -- for some time. Medicare Advantage does not contain costs and there’s no evidence that the value provided to beneficiaries is commensurate with the program’s high price tag,” said Dingell. “The real beneficiaries of Medicare Advantage are the insurance companies, which have profited handsomely. It’s time to stop overpayments to the insurance industry and use these funds to support the health of elderly and disabled Americans.”

“The GAO report adds to the concerns already raised by numerous credible, independent sources that we pay too much to Medicare Advantage plans. Now we know that frequently beneficiaries don’t get much benefit from these overpayments, and that targeted reductions in premiums and cost-sharing for those who need it could be done much more effectively with direct program changes than through overpayments to plans that spend too much on marketing and take too much in profits. Particularly disturbing are the findings that people who are sick actually may face higher cost sharing in these plans when they use inpatient hospital or home health benefits,” said Waxman.

“Massive overpayments to MA plans are a raw deal for seniors and taxpayers,” said Stark. “Overpayments fatten company profits, even as many seniors face higher costs in MA plans than they would in traditional Medicare. Enriching private plans and privatizing Medicare, as President Bush and Republicans prefer, destroys the program and unnecessarily increases Medicare spending. Investing in Medicare would be a more efficient and effective way to improve benefits and lower beneficiary costs.”

"Once again, Medicare Advantage is shown to offer no bang for the buck," said Pallone. "This report shows that overpayments to Medicare Advantage have resulted in few additional benefits, higher administrative costs, and, in some instances, higher cost-sharing. It is time to end this wasteful subsidization of the insurance industry and refocus our attention on strengthening Medicare to better serve our seniors and disabled.”

The Medicare Payment Advisory Commission (MedPAC) estimates that MA plans were paid, on average, 13 percent more that the cost of care in traditional fee-for-service (FFS) Medicare in 2007. The Congressional Budget Office estimated that eliminating the overpayments, as included in the House-passed CHAMP Act (HR 3162) last year, would save more than $157 billion from 2009 to 2017. The Centers for Medicare and Medicaid Services’ (CMS)Actuary estimated that eliminating these overpayments would extend the solvency of Medicare’s trust fund by three years, and address the requirements of the new so-called 45 percent trigger.

In a report released today based on data provided by MA plans, the GAO determined (direct excerpts in quotes):

* Despite MA overpayments, many beneficiaries face higher costs in MA plans than they would in traditional Medicare: “19 percent of MA beneficiaries were in plans that projected higher cost sharing for home health services and 16 percent of beneficiaries were in plans that projected higher cost sharing for inpatient services. Because cost sharing was projected to be higher for some categories of services, beneficiaries who frequently used these services could have had overall cost sharing that would be higher than under Medicare FFS.” Nine percent of MA beneficiaries were in plans with projected higher costs for skilled nursing facilities. Many seniors and people with disabilities enrolled in MA plans also face higher costs for durable medical equipment, Part B drugs, outpatient facility services and physician visits, therapy, and radiology. (See chart on page 20 of the report).

In certain plan types, the percentage of beneficiaries facing higher costs is even larger. In Preferred Provider Organizations (PPO) plans, 84 percent of enrollees face higher costs for home health services and 22 percent face higher costs for inpatient services. In Private Fee-for-Service (PFFS) plans, 28 percent of beneficiaries face higher costs for home health services. In Health Maintenance Organizations (HMO) plans, 10 percent of enrollees face higher costs for skilled nursing facilities.

* MA overpayments are inefficiently targeted: MA overpayments go to private plans and are partially passed through to MA enrollees, rather than provided directly to low-income Medicare beneficiaries. As GAO states, “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.”

* MA overpayments are inefficiently administered: Traditional fee-for-service Medicare runs on administrative costs of less than 2 percent – and allocates 98 percent of its funds for medical care. In contrast, “MA plans projected they would allocate about 87 percent of total revenue to medical expenses, approximately 9 percent to non-medical expenses, including administration, marketing, and sales; and approximately 4 percent to the plans’ margin, sometimes called the plans’ profit. About 30 percent of beneficiaries were enrolled in plans that projected they would allocate less than 85 percent of their revenues to medical expenses.” The House-passed CHAMP Act (HR 3162) required plans to uniformly report these data and dedicate at least 85 percent of their revenue to medical care.

* Despite overpayments, most MA plans do NOT cap beneficiaries’ spending – and those that do often exclude certain services: MA supporters frequently tout plans’ limits on beneficiaries’ spending. But fewer than half, “48 percent, of MA beneficiaries were enrolled in plans that had an out-of-pocket maximum.” Even this is an illusory benefit. GAO elaborates that MA plans’ “out-of-pocket maximum does not always cover all categories of services. Some MA plans excluded some services from the out of pocket maximum. Beneficiaries who use these excluded services may pay more in total cost sharing than is indicated by the plan’s out-of-pocket maximum.”

Items and services most often excluded from the out-of-pocket limit are those that sick beneficiaries tend to need, and include those services for which MA plans often charge more than traditional Medicare. For example, 40 percent of beneficiaries were enrolled in plans that excluded Part B drugs (another area in which plans are likely to charge more than Medicare and which targets beneficiaries with cancer and other serious health problems), 24 percent were in plans that excluded outpatient substance abuse, 23 percent were in plans that excluded physician specialist and mental health services, 22 percent were in plans that excluded psychiatric services and prosthetics, and 21 percent were in plans that excluded home health services and durable medical equipment. (See chart on Page 26 of the report).ý