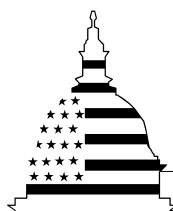


December 2008

MEDICARE ADVANTAGE

Characteristics, Financial Risks, and Disenrollment Rates of Beneficiaries in Private Fee-for- Service Plans

**This Report Is Temporarily Restricted Pending
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Highlights of [GAO-09-25](#), a report to congressional requesters

Why GAO Did This Study

Medicare Advantage (MA) plans are an alternative to the original Medicare fee-for-service (FFS) program. Private fee-for-service (PFFS) plans—one type of MA plan—give beneficiaries an option that is more like Medicare FFS than other MA plans, with a wider choice of providers and less plan management of services and providers. PFFS enrollment increased from about 35,000 beneficiaries in June 2004 to about 2.3 million in June 2008. This report compares PFFS plans to other MA plans and Medicare FFS in three areas: (1) characteristics of beneficiaries, (2) financial risks for beneficiaries who do not contact their plans before receiving services, and (3) disenrollment rates. To do this work, GAO reviewed materials from a selected sample of nine PFFS plan sponsors, analyzed Medicare data, and interviewed officials from CMS, which administers the Medicare program, and other organizations.

What GAO Recommends

GAO recommends that CMS (1) investigate the extent to which PFFS beneficiaries face unexpected costs for not contacting their plan before receiving care, (2) ensure that CMS guidance on prior authorization reflects CMS policy, and (3) mail MA plan disenrollment rates to beneficiaries, as required by statute, and update rates on Medicare's Web site. CMS outlined the steps it was taking to respond to all three recommendations, but did not address how it would distribute disenrollment rates.

To view the full product, including the scope and methodology, click on [GAO-09-25](#). For more information, contact James Cosgrove at (202) 512-7114 or cosgrovej@gao.gov.

MEDICARE ADVANTAGE

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What GAO Found

In April 2007, beneficiaries in PFFS plans tended to be healthier and generally younger than beneficiaries in other MA plans and Medicare FFS. Specifically, projected health care expenditures for PFFS beneficiaries were 7 percent less than the projected average for beneficiaries in other MA plans and 10 percent less than the projected average for beneficiaries in Medicare FFS. Beneficiaries in PFFS plans also generally were more likely than beneficiaries in other MA plans and Medicare FFS to reside in rural areas where fewer other MA plans were available. In addition, about 81 percent of beneficiaries who were new enrollees in PFFS plans were in Medicare FFS before enrolling in their plan, compared to 65 percent in other MA plans.

PFFS beneficiaries may have faced certain financial risks if they did not contact their plan before receiving services. These risks were generally not assumed by beneficiaries in other MA plans and Medicare FFS. Specifically, if beneficiaries or their providers did not contact their PFFS plans before obtaining a service to make sure it would be covered, beneficiaries unexpectedly may have had to pay for the entire cost of the service if coverage was later denied by their plan. CMS officials told GAO they did not have data on the extent to which PFFS beneficiaries were faced with such costs. Furthermore, some beneficiaries likely experienced higher out-of-pocket costs for covered services if they did not contact their plan before obtaining the services. For example, one sponsor of PFFS plans increased the share of the cost for which beneficiaries were responsible from 30 percent to 70 percent if the beneficiaries did not contact the plan before obtaining certain durable equipment. GAO found that some PFFS plans were inappropriately using the term prior authorization, which can involve denying service coverage if prior plan approval is not obtained, in their informational materials. CMS officials stated that PFFS plans should not have used this term because these plans were not permitted to deny service coverage due to lack of prior plan approval. However, CMS guidance on this issue has been inconsistent and sometimes incorrect.

From January through April 2007, beneficiaries in PFFS plans disenrolled at an average rate of 21 percent compared to 9 percent for other MA plans, and GAO concludes that CMS has not complied with statutory requirements to mail disenrollment rates to Medicare beneficiaries. Disenrollment rates can reflect factors such as beneficiary satisfaction and CMS is required by law to mail this information to Medicare beneficiaries to help them compare available MA plans in their area. Although CMS has not mailed disenrollment rates to beneficiaries since 2000, the agency did provide disenrollment rates through Medicare's Web site. However, this information was based on disenrollment in 2004 and 2005 and, given the enrollment growth since then, may not accurately reflect plans available to beneficiaries in 2008.

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Abbreviations

AHIP	America's Health Insurance Plans
CBO	Congressional Budget Office
CMS	Centers for Medicare & Medicaid Services
CRS	Congressional Research Service
FFS	fee-for-service
HHS	Department of Health and Human Services
HMO	Health Maintenance Organization
MA	Medicare Advantage
MedPAC	Medicare Payment Advisory Commission
MIIR	Management Information Integrated Repository
MIPPA	Medicare Improvements for Patients and Providers Act of 2008
MOC	Medicare Options Compare
PBP	Plan Benefit Package
PFFS	private fee-for-service
PPO	Preferred Provider Organization
PSO	Provider-Sponsored Organization
SNP	Special Needs Plan

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United States Government Accountability Office
Washington, DC 20548

December 15, 2008

Congressional Requesters

Medicare Advantage (MA) plans are an alternative to original Medicare fee-for-service (FFS) in which private plans provide Medicare benefits to enrolled beneficiaries.¹ Enrollment in MA plans has grown substantially in recent years from about 4.7 million beneficiaries in June 2004 to 9.6 million—about 1 out of every 5 Medicare beneficiaries—as of June 2008. This increase in enrollment followed the enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003,² which among other things, resulted in increased payments to MA plans. MA plans are able to use the increased payments to offer more benefits and reduce beneficiary cost sharing relative to Medicare FFS. In addition, the increased payments allowed MA plans to expand into geographic areas where previously plan options had been very limited, resulting in more plan choices for beneficiaries.

Nearly half of the recent growth in MA enrollment, about 45 percent, occurred in one type of plan—private fee-for-service (PFFS) plans.³ Enrollment in these plans increased from about 35,000 beneficiaries in June 2004 to about 2.3 million beneficiaries in June 2008. About one-quarter of beneficiaries enrolled in MA plans in June 2008 were enrolled in a PFFS plan, and 99 percent of Medicare beneficiaries in 2008 had access to a PFFS plan—up from 41 percent in 2005. The Congressional Budget

¹Medicare is the federally financed health insurance program for persons age 65 and older, 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 Medicare FFS.

²Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, §§ 211, et seq., 117 Stat. 2066, 2176-2207 (2003) (codified, as amended, at 42 U.S.C. §§ 1395w-21, et seq.).

³PFFS plans were first authorized for Medicare beneficiaries under the Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4001, 111 Stat. 251, 275-327 (1997) (codified, as amended, at 42 U.S.C. §§ 1395w-21, et seq.).

Office (CBO) projects continued growth in PFFS and other MA plans through 2013, though at a slower pace.⁴

The growth in enrollment and availability of MA plans has financial implications for the Medicare program because the program pays more for beneficiaries in these plans than it would if they were in Medicare FFS. The federal government is projected to spend about \$91 billion on the MA program in 2008.⁵ According to the Medicare Payment Advisory Commission (MedPAC), in 2008, Medicare is projected to pay about 13 percent more for beneficiaries in MA plans overall and 17 percent more for beneficiaries in PFFS plans than what the program would have paid for these beneficiaries under Medicare FFS.⁶

PFFS plans are designed to offer beneficiaries an MA option that is more like Medicare FFS. Compared to other MA plans, PFFS plans generally offer a wider choice of providers and impose less plan management of health care services and providers. Unlike other types of MA plans, such as Health Maintenance Organizations (HMO) and Preferred Provider Organizations (PPO),⁷ PFFS plans are not required to have networks of contracted providers if they pay providers Medicare FFS rates or higher.⁸

⁴CBO, *Cost Estimate, Medicare Improvements for Patients and Providers Act of 2008* (July 23, 2008).

⁵CBO, *The Medicare Advantage Program: Trends and Options*, Testimony of Peter R. Orszag before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives (Mar. 21, 2007).

⁶Medicare Payment Advisory Commission (MedPAC), *Report to the Congress: Medicare Payment Policy* (Washington, D.C.: March 2008).

⁷We use the term other MA plans to refer to network-based HMOs, PPOs, and Provider-Sponsored Organizations (PSO). Beneficiaries in HMOs are generally restricted to seeing providers within a network. Beneficiaries in regional and local PPOs can see both in-network and out-of-network providers but usually must pay higher cost-sharing amounts if they use out-of-network services. A regional PPO serves an entire state or multiple states, whereas local PPOs may serve a county, partial county, or multiple counties. PSOs are operated by a provider or a group of affiliated providers where a substantial proportion of health care services are provided directly through the provider or providers.

⁸A PFFS plan sponsor must demonstrate to the Secretary of Health and Human Services that it has a sufficient number and range of providers willing to furnish services under the plan by either (1) the plan establishing provider payment rates that are not less than the rates that apply under Medicare FFS, (2) the plan establishing contracts or agreements with a sufficient number and range of providers to furnish the services covered under the PFFS plan, or (3) a combination of the two options. 42 U.S.C. § 1395w-22(d)(4). Hereafter in this report, we refer to organizations offering MA plans, including PFFS plans, as plan sponsors.

Further, providers can agree to accept a PFFS beneficiary on a service-by-service basis. Almost all PFFS plans operate without networks.⁹ Paying providers at Medicare FFS rates or higher suggests that beneficiaries in PFFS plans will have access to those providers who accept beneficiaries from Medicare's FFS program. However, there have been reports that, in some areas, it may be more difficult for beneficiaries to obtain care while in PFFS plans than it would be if they were in Medicare FFS.¹⁰

Under federal law, PFFS plans may not place providers at financial risk or restrict beneficiary access to providers.¹¹ The Centers for Medicare & Medicaid Services (CMS), the agency that administers the Medicare program,¹² prohibits PFFS plans—but not other types of MA plans—from requiring that providers or beneficiaries obtain plan approval before a service is furnished as a condition of coverage, a process known as prior authorization. However, sponsors of PFFS plans, like sponsors of other MA plans, must provide an advance coverage determination, should beneficiaries or their providers request one.¹³ An advance coverage determination informs beneficiaries before they receive services whether the services will be covered and the amount that the beneficiary must pay with respect to such services. In finalizing regulations in 1998 for the MA program (then called the Medicare+Choice program), CMS considered requiring PFFS plan sponsors to mandate that providers who serve PFFS plan beneficiaries assume the responsibility for acquiring advance coverage determinations or risk being unable to charge beneficiaries if the

⁹PFFS plans may treat providers as if they have a written contract with the plan if before rendering covered services, the provider has been informed of the beneficiary's enrollment in the plan and knows of, or had a reasonable opportunity to obtain, the terms and conditions of the plan. 42 U.S.C. § 1395w-22(j)(6).

¹⁰Congressional Research Service (CRS), *CRS Report for Congress: Private Fee for Service (PFFS) Plans - How They Differ From Other Medicare Advantage Plans* (Washington, D.C.: 2007).

¹¹PFFS plans must pay providers at a rate determined by the plan on a fee-for-service basis without placing the provider at financial risk. The plans also may not vary the rates for a provider based on the utilization of that provider's services nor restrict enrollees' choices among providers who are lawfully authorized to provide services and agree to accept the plan's terms and conditions of payment. 42 U.S.C. § 1395w-28(b)(2).

¹²CMS is an agency within the Department of Health and Human Services (HHS), to which HHS has delegated the responsibility for administering the Medicare program.

¹³MA plan sponsors must have procedures for making timely determinations on whether a beneficiary is entitled to receive a service and the amount, if any, the beneficiary must pay for the service. 42 U.S.C. § 1395w-22(g)(1).

plan later denied payments for the services.¹⁴ CMS, however, determined that this beneficiary protection would be inconsistent with federal statutory provisions that prohibit PFFS plans from placing their providers at financial risk.

The rapid growth in PFFS plan enrollment highlights the need for more information about who is enrolling in, and disenrolling from, these plans. Specifically, if healthier beneficiaries are enrolling and staying in PFFS plans, this could leave other MA plans or the Medicare FFS program with sicker and potentially more costly beneficiaries. Also, if PFFS plans have high disenrollment rates compared to other MA plans, this could be an indicator of beneficiary dissatisfaction with access or quality of care or could indicate that other plans with more attractive benefit packages are available. In order to help Medicare beneficiaries compare and select MA plans, CMS is required by law to mail certain information to beneficiaries annually, including MA plan disenrollment rates for the previous 2 years to the extent that these disenrollment rates are available.¹⁵

Certain features of PFFS plans will change as a result of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA).¹⁶ Beginning in 2011, PFFS plans will be required to form contracted networks of providers in areas that have at least two available network-based plans

¹⁴Medicare Program: Establishment of the Medicare+Choice Program, 63 *Fed. Reg.* 34968, 35042-43 (June 26, 1998).

¹⁵At least 15 days prior to each year's annual coordinated election period, the Secretary of Health and Human Services is required to mail to each Medicare beneficiary information comparing MA plans that are or will become available in the beneficiary's area including, to the extent available, disenrollment rates for the previous 2 years (excluding disenrollment due to death or moving outside the plan's service area). The Secretary must also mail this same information, to the extent practicable, to newly eligible Medicare beneficiaries at least 30 days prior to the beginning of the individuals' initial enrollment period under the MA program. 42 U.S.C. §§ 1395w-21(d)(2)(A), (B).

¹⁶Pub. L. No. 110-275, §§ 162-163, 122 Stat. 2494 (codified, as amended, at 42 U.S.C. § 1395w-22(d), (e)). CMS has also published an interim final rule to implement these statutory requirements. 73 *Fed. Reg.* 54226 (Sept. 18, 2008).

(such as HMOs or PPOs).¹⁷ In areas with fewer than two network-based plans, most PFFS plans will continue to have the option of operating without networks if they pay providers at Medicare FFS rates or higher.¹⁸ In addition, beginning in 2010, PFFS plan sponsors will be required to have quality improvement programs for each plan and report related quality information to CMS.¹⁹

Given the uniqueness of PFFS plans and their rapid enrollment growth, you asked us to examine the characteristics of beneficiaries in these plans, PFFS plan features, and beneficiary disenrollment patterns. Our report addresses the following objectives: (1) compare the characteristics of beneficiaries in PFFS plans to the characteristics of beneficiaries in other MA plans and Medicare FFS; (2) describe the financial risks that beneficiaries in PFFS plans face, compared to beneficiaries in other MA plans and Medicare FFS, if they do not contact their plan prior to receiving services; and (3) compare the rates at which beneficiaries in PFFS plans disenroll to the rates for other MA plans and evaluate whether CMS met statutory requirements to mail disenrollment rates to beneficiaries.

To compare the characteristics of beneficiaries in PFFS plans, specifically age, gender, and residential location, to the characteristics of beneficiaries in other MA plans and Medicare FFS, we analyzed Medicare enrollment data for April 2007. We restricted our analysis to five types of MA plans that accounted for more than 99 percent of the approximately 7.8 million beneficiaries in MA plans at that time—PFFS plans, HMOs, local PPOs, regional PPOs, and Provider-Sponsored Organizations (PSO). After excluding plans that restrict enrollment and certain beneficiaries from our analysis, we analyzed data as of April 2007 for about 5.8 million

¹⁷PFFS plans will need to demonstrate that their networks meet criteria now applicable to other MA plans, including (1) ensuring, when medically necessary, benefits are available 24 hours a day and 7 days a week, and (2) providing access to appropriate providers, including specialists for medically necessary services. A network-based plan is defined as (1) an MA plan that is a coordinated care plan, (2) a reasonable cost reimbursement plan under section 1876 of the Social Security Act, or (3) a network-based Medical Savings Account plan. A network-based plan does not include regional PPOs that do not meet provider access standards through written contracts.

¹⁸Beginning in 2011, PFFS plans that are sponsored by employers or unions, however, must contract with providers as part of a network regardless of their location.

¹⁹Unlike other MA plan sponsors, PFFS plan sponsors are currently exempt from the requirement to have quality improvement programs and are, therefore, not required to report certain quality-related information to CMS.

beneficiaries in 1,998 MA plans and about 31.7 million beneficiaries in Medicare FFS.²⁰ To compare the health status of PFFS and other Medicare beneficiaries, we obtained plan-level risk scores from CMS, which are based on projected health care expenditures of plan beneficiaries and provide an indicator of the health status of the plans' beneficiaries. We also examined the type of Medicare coverage that MA beneficiaries held previously. For this analysis, we identified beneficiaries who were new to an MA plan type in April 2007 and examined their Medicare coverage in December 2006. MA plans that beneficiaries selected for 2007 generally took effect from January through April 2007.

To describe the financial risks that beneficiaries in PFFS plans face, compared to beneficiaries in other MA plans and Medicare FFS, if they do not contact their plan prior to receiving services, we reviewed relevant laws, regulations, documentation from CMS, and materials from nine PFFS plan sponsors interviewed that accounted for about 81 percent of PFFS enrollment in July 2007.²¹ We reviewed 2008 plan benefit information provided to beneficiaries as well as provider terms and conditions of payment for 30 PFFS plans, accounting for more than half of each sponsor's total enrollment in PFFS plans. We reviewed 2008 plan benefit information provided to beneficiaries for 33 HMO or PPO plans operated by the same nine plan sponsors, accounting for more than half of each sponsor's total enrollment in other MA plans. We also interviewed officials from CMS and the plan sponsors. Information gathered from our review of the benefit information provided to beneficiaries for PFFS and other MA plans may not be representative of, or generalizable to, other MA plans offered by these and other plan sponsors that were not in our sample.

²⁰We analyzed beneficiaries in Medicare FFS who had both Medicare Part A and Part B. We excluded plans with certain enrollment restrictions, such as plans that restrict enrollment to members of an employer group, plans that cover only Medicare Part B services, and beneficiaries in plans who live outside the 50 states, the District of Columbia, and Puerto Rico.

²¹The nine PFFS plan sponsors in our review were Blue Cross Blue Shield of Michigan; Coventry Health Care, Inc.; Geisinger Health System; Humana, Inc.; Metropolitan Health Plan; Sterling Life Insurance Company; Universal American Corporation; University of Pittsburgh Medical Center Health Plan, Inc.; and Wellpoint, Inc. We selected the largest five PFFS plan sponsors based on enrollment in July 2007 and randomly selected three PFFS plan sponsors with enrollment that ranked between the 10th and 50th percentile among all PFFS plan sponsors. We also selected one plan sponsor that was the first to offer a PFFS plan.

To compare the rates at which beneficiaries in PFFS plans disenroll to the rates for other MA plans, we used Medicare enrollment data for beneficiaries in PFFS and other MA plans in December 2006 and April 2007 to identify beneficiaries whose disenrollment took effect from January through April 2007.²² We calculated disenrollment rates for each MA contract, which covered one or more MA plans of the same plan type.²³ To compare the health status of disenrollees to beneficiaries overall in PFFS and other MA plans, we used risk scores for 2006 as a proxy for health status. To evaluate whether CMS met statutory requirements to mail disenrollment rates to beneficiaries, we interviewed CMS officials, analyzed relevant federal laws and regulations, and reviewed disenrollment information CMS provided to Medicare beneficiaries through, for example, Medicare Options Compare (MOC) on Medicare's Web site.²⁴ MOC is a source of information through which beneficiaries can compare the quality, benefits, and premiums of MA plans.

We conducted interviews with CMS officials on the reliability of the CMS data used in our analysis. We also reviewed data documentation and performed certain data checks to ensure the data were reasonable and consistent. We determined that the data were sufficiently reliable for our purposes. We conducted our work from July 2007 through October 2008 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. See appendix I for more details on our scope and methodology.

²²We excluded plans with certain enrollment restrictions and beneficiaries in plans who live outside the 50 states, the District of Columbia, and Puerto Rico.

²³An MA contract is an agreement between CMS and an MA plan sponsor that covers one or more MA plans of the same type. For example, a contract between CMS and a plan sponsor may cover at least one PFFS plan or possibly several PFFS plans.

²⁴Medicare Options Compare is available at www.medicare.gov. Beneficiaries also can call 1-800-MEDICARE and have printed information sent to them if they do not have Internet access, or contact their State Health Insurance Assistance Program for help in choosing a plan.

Results in Brief

Beneficiaries in PFFS plans in April 2007 tended to be healthier and generally younger than beneficiaries in other MA plans and Medicare FFS, and were more likely to reside in rural areas where fewer other MA plan options were available. Specifically, beneficiaries in PFFS plans had projected health care expenditures—an indicator of health status—that were 7 percent less than the average for beneficiaries in other MA plans and 10 percent less than the average for beneficiaries in Medicare FFS. Beneficiaries in PFFS plans were less likely to be age 85 or older, and were more likely to reside in rural areas where, on average, beneficiaries had access to about 12 different PFFS plans but only about 4 other MA plans. In addition, about 81 percent of new enrollees in PFFS plans had been enrolled in Medicare FFS before enrolling in their plan, compared to about 65 percent of new enrollees in other MA plans.

If beneficiaries in PFFS plans did not contact their plans before obtaining services, they may have faced certain financial risks. These risks were generally not assumed by beneficiaries in other MA plans and Medicare FFS. Specifically, if beneficiaries in PFFS plans or their providers did not request an advance coverage determination from their plan before obtaining a service to ensure the service would be covered, beneficiaries unexpectedly may have had to pay for the entire cost of the service if coverage was later denied. However, beneficiaries in other MA plans and Medicare FFS generally had certain protections from this financial risk. CMS officials told us that they thought it was rare for PFFS beneficiaries to face unexpected costs of denied claims, but the agency did not have data on the extent to which this occurred. In addition, even when plans covered certain services, some PFFS beneficiaries likely experienced higher cost sharing if they or their providers did not notify their plans before receiving these services—a process called prenotification. For example, the coinsurance rate for certain durable medical equipment for one PFFS plan changed from 30 percent to 70 percent if beneficiaries or their providers did not prenotify their plan. In contrast, the other MA plans we reviewed did not have prenotification requirements, and Medicare FFS also had no such requirements. Furthermore, some PFFS plans' inappropriate use of the term prior authorization in their informational materials to describe beneficiary responsibilities for contacting their plan before receiving services may have confused beneficiaries and providers. According to CMS officials, PFFS plans should not have used the term prior authorization because PFFS plans cannot deny service coverage for lack of prior approval. However, CMS has provided inconsistent and sometimes incorrect guidance related to prior authorization for PFFS plans.

From January through April 2007, beneficiaries in PFFS plans disenrolled at an average rate of 21 percent compared to 9 percent for other MA plans, and we conclude that CMS did not comply with statutory requirements to mail information on MA plan disenrollment rates to beneficiaries. Beneficiaries who disenrolled from PFFS plans, on average, were sicker compared to all beneficiaries in PFFS plans, with projected health care expenditures that were about 6 percent higher than the average for all beneficiaries in these plans. The same pattern existed for other MA plans, though the difference was less pronounced. MA disenrollment rates varied depending on beneficiaries' age and location. For example, older beneficiaries in PFFS plans, such as those who were age 85 and older, disenrolled at higher rates, but this was not the case for other MA plans. PFFS beneficiaries in urban areas disenrolled at higher rates than beneficiaries in rural areas, while in other MA plans, beneficiaries in urban areas disenrolled at slightly lower rates. MA plan disenrollment rates can reflect differences across plans because of factors such as beneficiary satisfaction with care and out-of-pocket costs. CMS is required by law to mail disenrollment rates for the previous 2 years, to the extent available, to Medicare beneficiaries at least 15 days prior to each year's annual coordinated election period. CMS officials informed us that they had not mailed disenrollment rates to all Medicare beneficiaries since the fall of 2000. As these disenrollment rates were available to CMS, we conclude that CMS has not complied with statutory requirements to mail Medicare beneficiaries disenrollment rates for MA plans in their areas. CMS provided information on disenrollment rates and reasons for disenrollment to beneficiaries through MOC as of August 2008, but this information was based on data for 2004 and 2005.

We recommend that the Acting Administrator of CMS (1) investigate the extent to which beneficiaries in PFFS plans are faced with unexpected out-of-pocket costs due to the denial of coverage when they did not obtain an advance coverage determination from their plan; (2) ensure that CMS guidance on prior authorization accurately reflects CMS policy and that PFFS plan materials conform to CMS requirements; and (3) mail to Medicare beneficiaries MA plan disenrollment rates for the previous 2 years for MA plans that are or will be available in their areas, as required by statute, and update disenrollment rates provided to Medicare beneficiaries through MOC.

In commenting on a draft of this report, CMS described the steps it would take to address each of our three recommendations. In response to our recommendation that CMS investigate the extent to which beneficiaries in PFFS plans are faced with out-of-pocket costs due to the denial of

coverage from their plan, CMS noted that it is examining coverage denials and complaints. In response to our recommendation that CMS correct its guidance related to prior authorization, CMS described several steps it has taken and plans to take, including issuing new guidance. In response to our recommendation that the agency mail disenrollment rates to beneficiaries and update the rates on its Web site, the agency commented that it had recently awarded a contract to obtain disenrollment rates and other performance metrics by late 2009. However, the agency did not indicate how it would provide disenrollment rate information to beneficiaries. We also obtained comments from representatives of America's Health Insurance Plans (AHIP), a national association that represents private health plans, who raised certain points they thought the report should have emphasized and made several other observations.

Background

Medicare is the federal government's health insurance program that covers more than 44 million people age 65 and older and certain individuals who are disabled or have end-stage renal disease. Most Medicare beneficiaries can choose to receive covered services through Medicare FFS or through an MA plan if one is offered where they live.²⁵ Beneficiaries in Medicare FFS and in MA plans, including PFFS plans, pay monthly premiums and are responsible for cost sharing, which can be in the form of coinsurance (a percentage payment for a given service that a beneficiary must pay), a copayment (a standard amount a beneficiary must pay for a medical service), or a deductible (the amount a beneficiary must pay before Medicare FFS or an MA plan begins to pay). MA plans operate under annual contracts between MA plan sponsors and CMS and provide Medicare benefits in exchange for a monthly payment from CMS for each beneficiary enrolled in the plan.²⁶

Beneficiaries can disenroll from MA plans during the annual coordinated election period, from November 15 through December 31 of a given year by enrolling in another plan or in Medicare FFS. Changes made during the annual coordinated election period take effect on January 1 of the following year. Beneficiaries can also disenroll from MA plans once during

²⁵Individuals with end-stage renal disease are not eligible to enroll in most MA plans. However, if these individuals develop the disease while enrolled in an MA plan, they may remain enrolled in their plan or change plans if their plan is terminated. 42 U.S.C. §1395w-21(a)(3)(B).

²⁶MA plans do not cover hospice care, a benefit that is provided under Medicare FFS.

the open enrollment period, from January 1 through March 31 of a given year.²⁷ Changes made during this time period take effect on the first day of the month following the plan's receipt of the beneficiary's request.

Beneficiaries in PFFS Plans Were Healthier and Younger Than Beneficiaries in Other MA Plans and Medicare FFS and Differed in Other Ways

Relative to beneficiaries in other MA plans and Medicare FFS in April 2007, beneficiaries in PFFS plans were healthier, generally younger, and more likely to live in rural areas with fewer MA options. Specifically, beneficiaries in PFFS plans had projected health care expenditures—an indicator of health status—that were lower, on average, than those of beneficiaries in other MA plans and Medicare FFS. Beneficiaries in PFFS plans had projected health care expenditures that were 7 percent less than those of beneficiaries in other MA plans and 10 percent less than beneficiaries in Medicare FFS.

Beneficiaries in PFFS plans were generally more likely to be younger and reside in rural areas than beneficiaries in other MA plans and Medicare FFS (see table 1). PFFS plans had a smaller percentage of beneficiaries age 85 or older compared to other MA plans and Medicare FFS. Approximately 14 percent of PFFS beneficiaries lived in rural areas compared to 1 percent of beneficiaries in other MA plans and 10 percent of beneficiaries in Medicare FFS. Medicare beneficiaries in rural areas, on average, had access to about 12 different PFFS plan options, but only about 4 other MA plan options. In contrast, Medicare beneficiaries in urban areas had access to an average of about 13 PFFS plan options and about 12 other MA plan options. As a result, beneficiaries in rural areas might have been more likely to enroll in a PFFS plan because there were fewer other MA options available in those areas.

²⁷Medicare beneficiaries enrolled in an MA Medical Savings Account plan generally may not disenroll during the open enrollment period. There are other circumstances when Medicare beneficiaries can disenroll from MA plans. For example, institutionalized Medicare beneficiaries may disenroll from MA plans and elect other plans or Medicare FFS at any time during the year. Medicare beneficiaries may also disenroll from MA plans during special election periods as approved by CMS.

Table 1: Beneficiary Age, Gender, and Residence by Type of Medicare Coverage, 2007

	PFFS (percentage)	Other MA plans ^a (percentage)	Medicare FFS (percentage)
Age			
Under 65	16	9	17
65-74	52	45	41
75-84	26	34	30
85+	6	11	12
Gender			
Male	45	42	44
Female	55	58	56
Residence			
Urban ^b	86	99	89
Rural ^c	14	1	10

Sources: GAO analysis of CMS data and the Health Resources and Services Administration's Area Resource File.

Notes: Percentages may not sum to 100 due to rounding. Results are based on Medicare enrollment data as of April 2007 for 431 PFFS plans in which 1,304,288 beneficiaries were enrolled and 1,567 other MA plans in which 4,535,881 beneficiaries were enrolled.

^aOther MA plans include HMOs, local PPOs, regional PPOs, and PSOs.

^bUrban areas are defined as those areas that are classified either as Metropolitan Statistical Areas or Micropolitan Statistical Areas. Metropolitan Statistical Areas have at least one urbanized area with a population of 50,000 or more, plus adjacent territory that has a high degree of social and economic integration with the core as measured by commuting ties. Micropolitan Statistical Areas have at least one urban cluster with a population of at least 10,000 but less than 50,000, plus adjacent territory that has a high degree of social and economic integration with the core as measured by commuting ties.

^cRural areas are defined as those areas that are neither Metropolitan Statistical nor Micropolitan Statistical Areas and are not unknown.

New enrollees in PFFS plans as of April 2007 were more likely than new enrollees in other MA plans to have been in Medicare FFS prior to enrollment but less likely to have been new to Medicare altogether or previously in a different type of plan. About 81 percent of new enrollees in PFFS plans were in Medicare FFS prior to joining their plan, compared to 65 percent of new enrollees in other MA plans (see table 2). About 6 percent of new PFFS enrollees were new Medicare beneficiaries prior to joining their plan, compared to about 13 percent of new enrollees in other MA plans. About 13 percent of new enrollees in PFFS plans were in a different type of plan before enrolling in their current plan, compared to 23 percent of new enrollees in other MA plans.

Table 2: Type of Medicare Coverage before Enrollment for New Enrollees in PFFS or Other MA Plans, April 2007

Medicare coverage before enrollment	New enrollees in PFFS plans		New enrollees in other MA plans ^b	
	Number	Percentage	Number	Percentage
Medicare FFS	467,458	81	309,572	65
New to Medicare	34,645	6	61,909	13
Other ^a	78,103	13	108,135	23
Total	580,206		479,616	

Sources: GAO analysis of CMS data.

Notes: Percentages may not sum to 100 due to rounding. New enrollees in PFFS and other MA plans were defined as beneficiaries who were in a given MA plan type (i.e., PFFS, HMO, local PPO, regional PPO, PSO) in April 2007 but who were not in that same plan type in December 2006.

^aIncludes enrollment in any type of Medicare private plan in which a beneficiary was enrolled in December 2006 that was different than their type of plan in April 2007.

^bOther MA plans include HMOs, local PPOs, regional PPOs, and PSOs.

PFFS Beneficiaries May Have Faced Certain Financial Risks Generally Not Assumed by Beneficiaries in Other MA Plans and Medicare FFS

In contrast to most beneficiaries in other MA plans and Medicare FFS, beneficiaries in PFFS plans may have faced certain financial risks if they or their providers did not contact their plan before receiving services. Specifically, if PFFS beneficiaries or their providers did not obtain advance coverage determinations, which specified whether services would be covered and how much beneficiaries would have to pay, beneficiaries unexpectedly may have been responsible for the entire cost of the service if coverage was later denied by their PFFS plans as not medically necessary.²⁸ In addition, even if PFFS plans covered the services as medically necessary, some PFFS beneficiaries may have experienced substantially higher cost sharing if they or their providers did not contact their plans before receiving certain services. PFFS plans sometimes used the term prior authorization inappropriately to describe beneficiary or provider responsibilities for contacting their plans. CMS officials stated that PFFS plans should not have used this term because PFFS plans are not permitted to deny coverage for services when prior plan approval was not obtained. However, CMS guidance for PFFS plans related to prior authorization has been inconsistent and sometimes incorrect.

²⁸We use the term medically necessary to refer to Medicare-covered services that are needed for the diagnosis and treatment of a beneficiary's medical condition and meet accepted standards of medical practice.

PFFS Beneficiaries Who Did Not Contact Their Plans to Determine Service Coverage before Receiving Services May Have Faced Unexpected Costs

If PFFS beneficiaries or their providers did not contact their plan before receiving a service to obtain an advance coverage determination, beneficiaries may have been responsible for the entire cost of the service if coverage for it was later denied by the plan because it was not medically necessary. Beneficiaries may have learned, from the information they received from their PFFS plan, whether a particular type of service would be covered, subject to a determination of medical necessity.²⁹ However, from that information, the beneficiary would not know whether the plan would determine a service to be medically necessary in a specific instance. To ascertain before a specific service was received whether it would be covered, beneficiaries or their providers may request an advance coverage determination from the PFFS plan.³⁰ CMS officials told us that they thought it was rare for beneficiaries in PFFS plans to face unexpected costs of denied claims, but they did not have data on the extent to which this occurs.³¹

Beneficiaries in other MA plans, such as HMOs and PPOs, generally had certain protections from unexpected costs when receiving services from network providers.³² Pursuant to CMS policy, when beneficiaries in other MA plans seek care from network providers and these providers are required to fulfill plan procedures to ensure coverage of services, such as obtaining a referral or prior authorization, beneficiaries are held harmless

²⁹When beneficiaries enroll in any type of MA plan, including PFFS plans, and annually thereafter, the plan sponsor is required to furnish them with certain information, including the services that are covered (when medically necessary) and the associated cost-sharing obligations.

³⁰MA plan sponsors and providers are also required to furnish beneficiaries with certain written notices indicating when their coverage in inpatient facilities will end and when the plan denies coverage for a service. These notices include the *Important Message from Medicare About Your Rights*, *Notice of Medicare Non-Coverage*, *Notice of Denial of Medical Coverage*, and *Detailed Explanation of Non-Coverage*. In addition, PFFS plans may allow certain providers who render services to PFFS beneficiaries to receive up to 115 percent of the contracted payment rate and bill beneficiaries the amount that exceeds the contracted rate. In this circumstance, before rendering services, hospitals must provide PFFS beneficiaries with an estimate of the cost for which the beneficiaries will be responsible.

³¹All beneficiaries enrolled in MA plans, including PFFS plans, can file an appeal if their plan will not pay for a service that a beneficiary thinks should be covered or provided.

³²CMS officials stated that, similar to beneficiaries in PFFS plans, beneficiaries in PPO plans receiving services from out-of-network providers that do not contact their plan in advance to determine service coverage may face unexpected costs if coverage is later denied.

financially when providers fail to take these steps.³³ In this circumstance, if beneficiaries in other MA plans reasonably believe that services would be covered, they would only be liable for their plan's cost sharing for the services, even if their plan later denies coverage. In addition, when these beneficiaries are responsible for taking steps to ensure coverage of services they receive from network providers, providers are required to inform beneficiaries of their responsibilities before providing these services. If the providers fail to do so, beneficiaries are responsible only for their plans' cost sharing for the services even if their plans later deny coverage. Because virtually all PFFS plans did not have provider networks, they did not provide these beneficiary protections.

Beneficiaries in Medicare FFS also had protection from the unexpected costs of claims that were denied when services provided were subsequently determined to be not medically necessary. Specifically, beneficiaries in Medicare FFS generally are protected from incurring financial liability if they do not receive an advance beneficiary notice notifying them when Medicare is expected to deny coverage for a given service because it was not medically necessary.

Some PFFS plans—plans administered by four of the nine PFFS plan sponsors we reviewed—required their providers, under the terms and conditions of the plans, to inform beneficiaries if a specific service was likely to be denied by the plan. However, these terms and conditions did not specify the penalty, if any, for not complying with this requirement. The terms and conditions of the remaining five plan sponsors did not require that providers notify beneficiaries if a service was likely to be denied by the plan.

Even When Certain Services Were Covered, Some PFFS Beneficiaries Likely Experienced Higher Cost Sharing If They Did Not Contact Their Plans before Receiving Such Services

Beneficiaries in some PFFS plans were responsible for higher cost-sharing amounts if they (or their health care providers) did not contact their plans in advance (a process called prenotification) before obtaining certain covered services. Under CMS policy, PFFS plans can vary cost sharing depending on whether beneficiaries (or their providers) have notified the plan before receiving certain services. Four of the nine PFFS plan sponsors in our review offered plans that charged higher cost sharing if prenotification did not occur for certain services, such as inpatient hospital stays, durable medical equipment, inpatient mental health

³³70 *Fed. Reg.* 4588, 4618 (Jan. 28, 2005); 42 C.F.R. § 422.504(g).

services, and skilled nursing services. The specific services subject to prenotification requirements and the amount of additional cost sharing varied by PFFS plan and could have been substantial (see table 3), as the following examples illustrate.

- Three PFFS plan sponsors offered plans that required prenotification for inpatient hospital stays. Plans offered by two of the three PFFS plan sponsors increased required cost sharing by \$100 to \$150 per inpatient hospital admission without prenotification, while plans offered by the third sponsor required an additional \$50 per day up to a maximum of \$500 per admission.
- Four PFFS plan sponsors offered plans that required prenotification for durable medical equipment, and doubled, or more than doubled, beneficiary coinsurance rates if prenotification did not occur. One plan increased the coinsurance rate for durable medical equipment and prosthetic devices from 30 percent to 70 percent for items that cost more than \$750 if beneficiaries or their providers did not prenotify. In these plans, for example, cost sharing for beneficiaries who purchased a power wheelchair for approximately \$4,000 could increase from about \$1,200 if they notified their plan to about \$2,800 if they did not.
- Three PFFS plan sponsors offered plans that required prenotification for inpatient mental health stays and increased cost sharing in amounts ranging from \$100 per admission to \$50 per day up to a maximum of \$500 if prenotification did not occur.
- One PFFS plan sponsor offered plans that required prenotification for skilled nursing facility stays and increased cost sharing by \$50 per day up to a maximum of \$500 if prenotification did not occur.

Table 3: Examples of Cost Sharing with and without Prenotification In PFFS Plans Offered by Four Different Sponsors, 2008

	Cost sharing with prenotification	Cost sharing without prenotification
Plan A		
Inpatient hospital care ^a	Days 1–5: \$150 copayment per day Days 6+: \$0 copayment per day	Additional \$50 per day up to \$500 in additional payments
Durable medical equipment and prosthetic devices	30 percent coinsurance	70 percent coinsurance for equipment or a device that costs more than \$750
Inpatient mental health	\$500 copayment per hospital admission	Additional \$50 per day up to \$500 in additional payments
Skilled nursing facility	Days 1–20: \$0 copayment per day Days 21–100: \$50 copayment per day	Additional \$50 per day up to \$500 in additional payments
Plan B		
Inpatient hospital care ^a	\$195 copayment per hospital admission	Additional \$150 per hospital admission
Durable medical equipment and prosthetic devices	20 percent coinsurance	50 percent coinsurance for purchases of equipment or a device over \$750
Inpatient mental health	Days 1–5 : \$95 copayment per day Days 6–90: \$0 copayment per day	Additional \$50 each day up to \$250 in additional payments
Skilled nursing facility	Days 1–20: \$0 copayment per day Days 21–100: \$100 copayment per day	NA—Prenotification not required
Plan C		
Inpatient hospital care ^a	\$200 copayment per hospital admission	Additional \$100 per hospital admission
Durable medical equipment	20 percent coinsurance	40 percent coinsurance for equipment that costs over \$500
Inpatient mental health	\$200 copayment per hospital admission	Additional \$100 per admission
Skilled nursing facility	Days 1–15: \$0 copayment per day Days 16–100: \$80 copayment per day	NA—Prenotification not required
Plan D		
Inpatient hospital care ^a	Days 1–5: \$100 copayment per day Days 6+: \$0 copayment per day	NA—Prenotification not required
Durable medical equipment and prosthetic devices	20 percent coinsurance	50 percent coinsurance for equipment or a device over \$750
Inpatient mental health	Days 1–5: \$100 copayment per day Days 6+: \$0 copayment per day	NA—Prenotification not required
Skilled nursing facility	Days 1–10: \$0 copayment per day Days 11–100: \$30 copayment per day	NA—Prenotification not required

Sources: PFFS plan sponsors.

^aIncludes substance abuse and rehabilitation services.

In contrast to PFFS plans, the other MA plans we reviewed did not appear to have prenotification requirements for services received from network providers. CMS officials noted that prenotification was generally unnecessary in HMOs, which accounted for about 89 percent of beneficiaries in other MA plans in April 2007, because HMOs typically had a primary care physician who authorized care for the beneficiary.³⁴ CMS officials also confirmed that Medicare FFS does not have prenotification requirements.

Administrators from one of the four plan sponsors that required prenotification told us that they did so for inpatient hospital stays and other services in order to help them identify beneficiaries for case and disease management and for discharge planning.³⁵ Administrators from another plan sponsor stated that they decided to require prenotification for durable medical equipment because the benefit typically had a high likelihood of abuse. A representative from another plan sponsor said that when the plan was prenotified it determined whether the equipment was medically necessary and informed the beneficiary of the potential financial liability that would be associated with the use or purchase of the durable medical equipment. The same representative noted that durable medical equipment was often determined to be not medically necessary.

Some PFFS plans we reviewed inappropriately used the term prior authorization rather than prenotification in the informational materials they distributed to beneficiaries, which may have caused confusion about beneficiaries' financial risks. CMS officials stated that PFFS plans should not have used the term prior authorization because PFFS plans are not permitted to deny service coverage due to lack of prior plan approval.

Inconsistent information that CMS provided to PFFS plans may have contributed to some PFFS plans' inappropriate use of the term prior authorization. One source of CMS guidance—a CMS manual—incorrectly

³⁴We calculated the percentage of MA beneficiaries in HMOs after excluding beneficiaries who (1) were in plans with certain enrollment restrictions (i.e., employer plans, Special Needs Plans, plans that only cover Medicare Part B services) or (2) lived outside the 50 states, the District of Columbia, and Puerto Rico.

³⁵Case and disease management are designed to help coordinate and manage beneficiaries' care. Discharge planning facilitates beneficiaries' discharge from a hospital. Representatives from all nine PFFS plan sponsors we interviewed stated that they offered either case or disease management to their beneficiaries, and eight sponsors stated that they also conducted discharge planning.

stated that PFFS plans' terms and conditions were required to indicate "whether the provider must obtain advance authorization from the PFFS organization before furnishing a particular service."³⁶ CMS officials acknowledged when we interviewed them in April 2008 that this statement was incorrect and should be deleted from its manual; however, as of August 2008 it had not been deleted.

Another source of inconsistent guidance from CMS was the data system that the agency used to obtain benefits information from PFFS and other MA plans. CMS officials explained that, prior to our inquiries, they did not realize that the Plan Benefit Package (PBP) software, which PFFS plans used to specify their benefits, did not allow plans to enter their prenotification information, but did allow plans to specify whether they had prior authorization requirements. As a result, some PFFS plans' summaries of benefits incorrectly indicated that these plans had prior authorization requirements. CMS officials said that they would update the PBP software for contract year 2010 to ensure that PFFS plans would be unable to specify prior authorization requirements and would make available a screen where PFFS plans could enter their prenotification information for specific services.

Following our inquiries on prior authorization and prenotification, CMS issued guidance to all PFFS plan sponsors in May 2008 through an operational policy memorandum to clarify its policy in these areas.³⁷ This policy memorandum reiterated that PFFS plans could not require prior authorization from providers or beneficiaries as a condition of coverage. Regarding prenotification, the policy memorandum clarified that PFFS plans could not impose penalties, but that they were permitted to offer cost-sharing reductions for complying with voluntary prenotification protocols.

³⁶CMS, *Medicare Managed Care Manual*, Chapter 4, Section 150.2 (Revised June 8, 2007).

³⁷CMS, *2008 operational policy for PFFS plans with prior authorization and referral requirements and 2009 PBP guidance; Additional guidance on prior notification rules*, May 29, 2008. CMS had previously issued guidance for PFFS plans on prior authorization and prenotification in its 2009 Call Letter, dated March 17, 2008.

PFFS Plans Had Relatively High Beneficiary Disenrollment Rates and CMS Did Not Comply with Statutory Requirements to Mail Current Rates

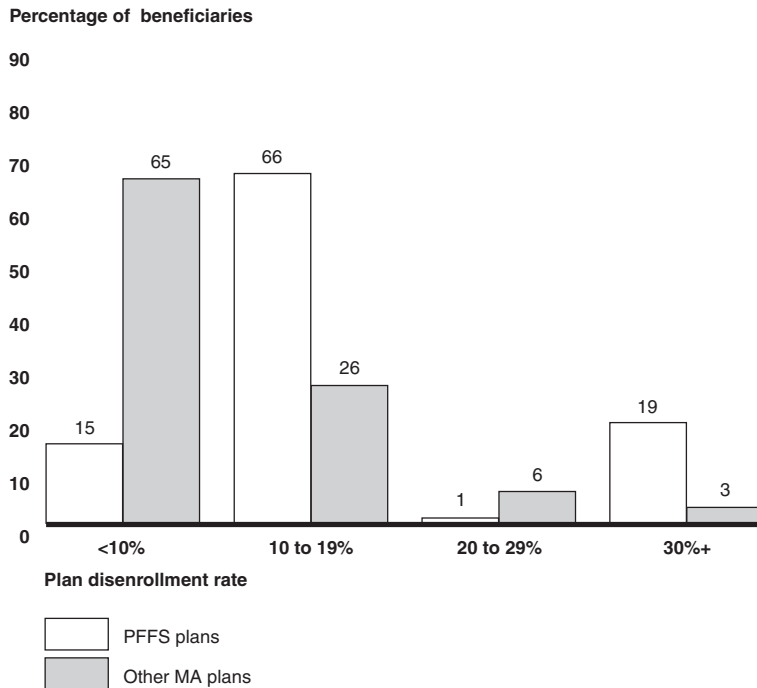
From January through April 2007, beneficiaries in PFFS plans disenrolled at an average rate that was more than twice that of other MA plans, and we conclude that CMS did not comply with statutory requirements to mail disenrollment rates to Medicare beneficiaries for the previous 2 years for MA plans in their area. Furthermore, information CMS has provided to beneficiaries on MA plan disenrollment rates and reasons for disenrollment is outdated.

Beneficiaries Disenrolled from PFFS Plans at a Higher Rate Than from Other MA Plans

Beneficiaries in PFFS plans were more than twice as likely to disenroll as beneficiaries in other MA plans from January through April 2007. PFFS beneficiaries disenrolled at an average rate of about 21 percent, compared to about 9 percent for beneficiaries in other MA plans. Disenrollment rates varied by plan, which could reflect plan-level differences in factors such as beneficiary satisfaction with care, service, and out-of-pocket costs. The range of disenrollment rates for PFFS plans—about 4 percent to 59 percent—was similar to the range of rates for other MA plans—about 2 percent to 54 percent.³⁸ However, PFFS beneficiaries were more likely than other MA beneficiaries to be in a plan with high disenrollment rates. For example, about 19 percent of PFFS beneficiaries were in plans that experienced disenrollment rates of 30 percent or more. In contrast, only 3 percent of other MA beneficiaries were in plans that experienced such high disenrollment rates. Approximately 15 percent of PFFS beneficiaries, but about 65 percent of other MA beneficiaries, were in plans that had disenrollment rates below 10 percent. (See fig. 1.)

³⁸To calculate this range, we excluded 10 of 158 PFFS plans and 95 of 1,410 other MA plans that were under MA contracts with fewer than 250 beneficiaries.

Figure 1: Disenrollment Rates of PFFS and Other MA Plans for January through April 2007



Source: GAO analysis of Medicare enrollment data for December 2006 and April 2007.
 Notes: Percentages may not sum to 100 due to rounding. Results are based on disenrollment that occurred from January through April 2007 for 158 PFFS plans in which 805,734 beneficiaries were enrolled and 1,410 other MA plans in which 4,488,653 beneficiaries were enrolled in December 2006. The disenrollment rate for a given MA contract applies to all plans under that contract. Other MA plans include HMOs, local PPOs, regional PPOs, and PSOs.

On average, disenrollees from PFFS plans were generally sicker compared to the average for all beneficiaries in PFFS plans. This pattern was also evident in other MA plans, although the average health status difference between disenrollees and all beneficiaries in these plans was less pronounced. Beneficiaries' risk scores indicated that the projected health care expenditures, on average, of disenrollees from PFFS plans were estimated to be about 6 percent higher than the average for all PFFS beneficiaries.³⁹ Similarly, beneficiaries who disenrolled from other MA plans had projected health care expenditures that were, on average,

³⁹All PFFS beneficiaries include those individuals who remained enrolled in their plans and those who subsequently disenrolled.

estimated to be about 3 percent higher compared to average projected health care expenditures for all beneficiaries in other MA plans.⁴⁰

PFFS disenrollment rates differed depending on beneficiaries' age group and location (see table 4). Older beneficiaries in PFFS plans tended to disenroll at higher rates. For example, PFFS beneficiaries age 85 and older had the highest disenrollment rate (about 25 percent) while beneficiaries younger than age 65 had the lowest disenrollment rate (about 18 percent). In contrast, there was no such relationship between age and disenrollment rates for other MA plans. Also, beneficiaries in PFFS plans who resided in urban areas were more likely than rural beneficiaries to disenroll, but this was not the case for other MA plans.

Table 4: Disenrollment Rates for PFFS and Other MA Plans by Beneficiary Characteristic, for January through April 2007

	PFFS plans	Other MA plans ^a
Beneficiaries overall	21.3	8.9
Age		
Under 65	18.2	9.8
65 to 74	20.3	9.1
75 to 84	24.1	8.3
85+	24.9	9.3
Residence		
Urban	22.0	8.9
Rural	17.2	10.6

Sources: GAO analysis of Medicare enrollment data for December 2006 and April 2007 and the Health Resources and Services Administration's Area Resource File.

Note: Results are based on disenrollment that occurred from January through April 2007 for 158 PFFS plans in which 805,734 beneficiaries were enrolled and 1,410 other MA plans in which 4,488,653 beneficiaries were enrolled in December 2006.

^aOther MA plans include HMOs, local PPOs, regional PPOs, and PSOs.

⁴⁰These results may underestimate the percentage difference in projected health care expenditures between disenrollees and beneficiaries overall in PFFS and other MA plans. See appendix I for more detail.

CMS Did Not Comply with Statutory Requirements to Mail Current Disenrollment Rates to Medicare Beneficiaries

We conclude that CMS did not comply with statutory requirements to mail disenrollment rates to Medicare beneficiaries prior to the annual coordinated election period.⁴¹ In creating the MA program (previously called the Medicare+Choice program), Congress required CMS to annually mail information to beneficiaries comparing MA plans, including PFFS plans.⁴² The mailings were required to contain information about each MA plan available in a beneficiary's area, including beneficiary disenrollment rates for the previous 2 years, to the extent that these data were available.⁴³

CMS officials informed us that they had not mailed disenrollment rate information to all Medicare beneficiaries since the Medicare & You 2001 handbook was sent in fall 2000, but more recent data were available. MA plan sponsors are required to provide CMS with disenrollment rates for beneficiaries who had been enrolled in their plans.⁴⁴ Although CMS did not respond to our questions about whether MA plan sponsors complied with requirements to provide CMS with disenrollment rates, CMS does have the information needed to calculate current disenrollment rates by using Medicare enrollment data. We used Medicare enrollment data from CMS to

⁴¹See 42 U.S.C. § 1395w-21(d)(2)(A).

⁴²Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4001, 111 Stat. 251, 276-286 (1997) (adding new section 1851 to the Social Security Act) (codified, as amended, at 42 U.S.C. § 1395w-21).

⁴³At least 15 days prior to each year's annual coordinated election period, the Secretary is required to mail to each Medicare beneficiary information comparing MA plans that are or will become available in the beneficiary's area including, to the extent available, disenrollment rates for the previous 2 years (excluding disenrollment due to death or moving outside the plan's service area). 42 U.S.C. § 1395w-21(d)(2)(A); *see also Gray Panthers Project Fund, et al. v. Thompson*, 273 F.Supp.2d 32 (D.D.C. 2002) (holding that the Secretary was required to comply with statutory mandates requiring mailing of comparative information to MA beneficiaries "even if compliance is cumbersome, burdensome, or costly"). In addition, the Secretary must mail these disenrollment rates, to the extent practicable, to newly eligible Medicare beneficiaries at least 30 days prior to the beginning of the individuals' initial enrollment period under the MA program. 42 U.S.C. § 1395w-21(d)(2)(B).

⁴⁴MA plan sponsors must provide, on an annual basis, the information necessary to enable CMS to provide current and potential Medicare beneficiaries the information they need to make informed decisions with respect to available choices for Medicare coverage. See 42 U.S.C. § 1395w-21(d)(7), *see also* 42 C.F.R. § 422.64. In addition, as required under the contract between CMS and MA plan sponsors, plan sponsors specifically must provide to CMS disenrollment rates for Medicare beneficiaries for the previous 2 years. 42 C.F.R. § 422.504(f)(2).

calculate disenrollment rates presented in this report for January through April 2007 and also in previous reports in 1996 and 1998.⁴⁵

In response to our inquiries, CMS officials stated that there is no requirement to mail disenrollment rates to Medicare beneficiaries, but did not provide any explanation for the agency's position. We, however, disagree as under federal law, prior to each annual coordinated election period, CMS is required to provide to Medicare beneficiaries disenrollment rates for plans in their area to the extent these rates are available. Because we concluded that disenrollment rates for MA plans were available, CMS was required to include relevant disenrollment rates in annual mailings to Medicare beneficiaries to enable them to make informed choices about their Medicare coverage.

CMS published disenrollment rates and reasons for disenrollment through MOC on Medicare's Web site. As of August 2008, this information was available through MOC based on data for 2004 and 2005. However, given the recent growth in PFFS plans, from about 109,000 beneficiaries in June 2005 to about 2.3 million beneficiaries in June 2008, disenrollment rates and reasons for disenrollment based on disenrollment in 2004 and 2005 may not accurately represent the experience of PFFS plans available to beneficiaries in 2008. CMS officials stated that information on beneficiaries' reasons for disenrollment is necessary to understand the underlying differences in disenrollment rates across plans. Nonetheless, CMS officials said that the disenrollment reasons survey was discontinued after 2005 due to budget constraints. A CMS official also noted that providing disenrollment rates without reasons for disenrollment would be misleading because one would not know the extent to which beneficiaries left a plan, for example, because another plan was less expensive or due to poor quality care. We disagree with CMS's position. Although it would be useful to know the reasons behind beneficiaries' disenrollment decisions, disenrollment rates alone can provide useful relative information about MA plans and prompt beneficiaries to investigate plans further.

⁴⁵See GAO, *Medicare: Many HMOs Experience High Rates of Beneficiary Disenrollment*, [GAO/HEHS-98-142](#) (Washington, D.C.: Apr. 30, 1998); and *Medicare: HCFA Should Release Data to Aid Consumers, Prompt Better HMO Performance*, [GAO/HEHS-97-23](#) (Washington, D.C.: Oct. 22, 1996).

Conclusions

The substantial enrollment growth in PFFS plans shows that these plans are an attractive option for Medicare beneficiaries. Yet, beneficiaries in these plans may have faced unexpected out-of-pocket costs if plans denied coverage for services for which beneficiaries or their providers had not obtained an advance coverage determination. While officials from CMS did not believe that PFFS plans often denied services unexpectedly for not being medically necessary, it is important to determine the extent to which such denials occur. Having this knowledge would inform CMS and policy makers about whether additional protective measures or beneficiary educational efforts are warranted. It is also important that beneficiaries have accurate and current information about MA plans' policies and procedures. As such, ensuring that prior authorization guidance is accurate will help beneficiaries and providers better understand the obligations and financial risks associated with PFFS plans. Similarly, providing beneficiaries with current information about MA plan disenrollment rates would help them make more informed choices when considering enrolling in an MA plan.

Recommendations for Executive Action

We recommend that the Acting Administrator of CMS take the following three actions:

- investigate the extent to which beneficiaries in PFFS plans are faced with unexpected out-of-pocket costs due to the denial of coverage when they did not obtain an advance coverage determination from their plan;
- ensure that CMS guidance on prior authorization accurately reflects CMS policy and that PFFS plan materials conform to CMS requirements; and
- mail to Medicare beneficiaries MA plan disenrollment rates for the previous 2 years for MA plans that are or will be available in their areas, as required by statute, and update disenrollment rates provided to Medicare beneficiaries through MOC.

Agency and Other External Comments

We provided a draft of this report to CMS and AHIP for comment. CMS provided us with written comments that are reprinted in appendix II, and representatives from AHIP provided us with oral comments.

CMS Comments

CMS stated that beneficiaries may have more certainty that a particular service will be covered if that service is obtained from a provider in a plan's network. As a consequence, CMS stated that it is important for beneficiaries in non-network plans (such as virtually all PFFS plans) to understand their rights and obligations. CMS advised that beneficiaries in non-network plans may want to consider obtaining advance determinations from their plans in appropriate circumstances. CMS said that it would continue to work closely with Congress, GAO, beneficiary advocacy groups, and other interested parties to ensure that beneficiaries receive appropriate health care and do not incur unexpected financial risks.

CMS outlined the steps that it was taking, or planned to take, in response to each of our three recommendations. In response to our recommendation that CMS investigate the extent to which beneficiaries in PFFS plans are faced with out-of-pocket costs due to the denial of coverage when they did not obtain an advance coverage determination from their plan, CMS is examining coverage denials and complaints, and will be collecting new information from plans and refining its complaint tracking module to support this effort. In response to our recommendation that CMS ensure prior authorization guidance accurately reflects CMS policy, the agency described several steps it has already taken and planned to take to address the inaccuracies, including providing new guidance, modifying the PBP, and providing model terms and conditions that PFFS plans will be required to use in 2009. In response to our recommendation that CMS mail disenrollment rates to Medicare beneficiaries and update disenrollment rates through MOC, the agency commented that it had recently awarded a contract to obtain disenrollment rates and other performance metrics by late 2009. However, the agency was silent as to how it would distribute information on MA plan disenrollment rates to beneficiaries.

AHIP Comments

In general, AHIP representatives thought the report could better highlight certain points related to prenotification, MIPPA, and case management, and AHIP representatives made several observations about other aspects of the report.

AHIP representatives stated that, while our presentation of prenotification requirements was accurate, the report should have more clearly stated that we did not know the extent to which beneficiaries actually faced higher cost sharing as a result of not fulfilling prenotification requirements. They also stated that our discussion of MIPPA should have occurred earlier in the report given the potential impact of this legislation on PFFS plans, and suggested that our finding that all nine PFFS organizations in our study provided either case management or disease management services should have been given greater prominence in the report. We believe our methodology and findings regarding prenotification are clearly presented in the report and do not agree that clarifications are warranted. We also believe the placement and emphasis on MIPPA and case and disease management are appropriate given the focus and timing of our work.

AHIP representatives made several other observations they thought might help clarify aspects of the report. They explained that prenotification was originally intended to protect beneficiaries by providing them with an incentive to contact their plan to determine whether a service was covered before the service was rendered. AHIP representatives informed us that CMS had posted standard terms and conditions on its Web site that would help to address use of incorrect terms by the industry. They also stated that one explanation for our finding that beneficiaries in PFFS plans were younger on average could be that younger beneficiaries were more likely to try new types of plans. In addition, AHIP representatives emphasized the importance of collecting information about beneficiary reasons for disenrollment and endorsed making this information available to beneficiaries.

As agreed with your offices, 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 Acting CMS Administrator, appropriate congressional committees and others. The report also will be available at no charge on the GAO Web site 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. GAO staff who made major contributions to this report are listed in appendix III.

A handwritten signature in black ink, appearing to read 'James C. Cosgrove', written in a cursive style.

James C. Cosgrove
Director, Health Care

List of Requesters

The Honorable John D. Dingell
Chairman
Committee on Energy and Commerce
House of Representatives

The Honorable Henry A. Waxman
Chairman
Committee on Oversight and Government Reform
House of Representatives

The Honorable Charles B. Rangel
Chairman
Committee on Ways and Means
House of Representatives

The Honorable Frank J. Pallone, Jr.
Chairman
Subcommittee on Health
Committee on Energy and Commerce
House of Representatives

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

Appendix I: Scope and Methodology

This appendix explains the scope and methodology that we used to address our reporting objectives that (1) compare the characteristics of beneficiaries in private fee-for-service (PFFS) plans to the characteristics of beneficiaries in other MA plans and Medicare FFS; (2) describe the financial risks that beneficiaries in PFFS plans face, compared to beneficiaries in other Medicare Advantage (MA) plans and Medicare fee-for-service (FFS), if they do not contact their plan prior to receiving services; and (3) compare the rates at which beneficiaries in PFFS plans disenroll to the rates for other MA plans and evaluate whether the Centers for Medicare & Medicaid Services (CMS) met statutory requirements to mail disenrollment rates to beneficiaries.

To compare the characteristics of beneficiaries in PFFS plans, specifically age, gender, and residential location, to the characteristics of beneficiaries in other MA plans and Medicare FFS, we used Medicare enrollment data from CMS for April 2007 from the Management Information Integrated Repository (MIIR) database and data from CMS on the average risk score for each MA plan in 2007, which provide an indicator of the health status of the plan's beneficiaries.¹ We focused our analysis on beneficiaries enrolled in five types of MA plans as of April 2007 that accounted for more than 99 percent of the approximately 7.8 million beneficiaries in MA plans at that time—PFFS plans and four other types of MA plans—Health Maintenance Organizations (HMO), Local Preferred Provider Organizations (PPO), regional PPOs, and Provider-Sponsored Organizations (PSO).² Among beneficiaries in the five MA plan types in our analysis, we excluded those (1) who were in plans that have enrollment restrictions (i.e., employer plans, Special Needs Plans (SNP), and plans that only cover Medicare Part B services) and (2) who live outside the 50 states, the District of Columbia, and Puerto Rico. After implementing these exclusions, we analyzed data as of April 2007 for 1,304,288 beneficiaries in 431 PFFS plans, 4,535,881 beneficiaries in 1,567 other MA plans, and 31,680,824 beneficiaries in Medicare FFS.³ We used the Health Resources

¹These risk scores were calculated for beneficiaries enrolled in July of that year and were normalized so that the average risk score for Medicare FFS beneficiaries was approximately 1.00.

²We did not include the 2,223 beneficiaries in Medical Savings Account plans as of April 2007 in our analysis because these plans operate differently from other MA plan types. Beneficiaries in a Medical Savings Account plan receive annual deposits from CMS into an interest-bearing account to help them cover their health care costs until they have reached their plan's deductible, after which the plan is responsible for all Medicare-covered costs.

³We analyzed beneficiaries in Medicare FFS who had both Part A and Part B.

and Services Administration's Area Resource File for 2006 to obtain data on counties' level of urbanization.⁴ We defined new enrollees in PFFS and other MA plans as beneficiaries who were in a given MA plan type in April 2007, based on data from the MIIR database, but who were not in that same plan type in December 2006. To compare the health status of beneficiaries in PFFS plans, other MA plans, and Medicare FFS, we used plan-level risk scores from CMS as a proxy for health status. After excluding beneficiaries in employer plans, SNPs, and plans that only cover certain Medicare FFS services as described above, we analyzed risk scores for 430 PFFS plans in which 1,371,169 beneficiaries were enrolled and 1,576 other MA plans in which 4,610,368 beneficiaries were enrolled as of July 2007.

To describe the financial risks that beneficiaries in PFFS plans face, compared to beneficiaries in other MA plans and Medicare FFS, if they do not contact their plan prior to receiving services, we reviewed relevant laws, regulations, documentation from CMS, and materials from nine PFFS plan sponsors interviewed that accounted for about 81 percent of PFFS enrollment in July 2007.⁵ We reviewed plan benefit information for 2008 provided to beneficiaries as well as provider terms and conditions of payment for 30 PFFS plans, accounting for more than half of each sponsor's total PFFS plan enrollment. We reviewed plan benefit information for 2008 provided to beneficiaries for 33 HMO or PPO plans operated by the same nine plan sponsors, accounting for more than half of each sponsor's total enrollment in other MA plans. If the plan's benefit information provided to beneficiaries explicitly stated that beneficiaries

⁴We defined urban areas as those areas that are either classified as Metropolitan Statistical Areas or Micropolitan Statistical Areas. Metropolitan Statistical Areas have at least one urbanized area with a population of 50,000 or more, plus adjacent territory that has a high degree of social and economic integration with the core as measured by commuting ties. Micropolitan Statistical Areas have at least one urban cluster with a population of at least 10,000 but less than 50,000, plus adjacent territory that has a high degree of social and economic integration with the core as measured by commuting ties. We defined rural areas as those that are neither Metropolitan Statistical nor Micropolitan Statistical Areas and are not unknown.

⁵The nine PFFS plan sponsors in our review were Blue Cross Blue Shield of Michigan; Coventry Health Care, Inc.; Geisinger Health System; Humana, Inc.; Metropolitan Health Plan; Sterling Life Insurance Company; Universal American Corporation; University of Pittsburgh Medical Center Health Plan, Inc.; and Wellpoint, Inc. We selected the largest five PFFS plan sponsors based on enrollment in July 2007 and randomly selected three PFFS plan sponsors with enrollment that ranked between the 10th and 50th percentile among all PFFS plan sponsors. We also selected one plan sponsor that was the first to offer a PFFS plan.

would face higher cost sharing for certain services if they or their provider did not notify the plan before receiving such services, we considered that plan to have a prenotification requirement. We also interviewed officials from CMS and the plan sponsors. Information gathered from our review of the benefit information provided to beneficiaries for PFFS and other MA plans may not be representative of, or generalizable to, other types of plans offered by these plan sponsors or to other PFFS and other MA plans that were not in our sample.

To compare the rates at which beneficiaries in PFFS plans disenroll to the rates for other MA plans, we used Medicare enrollment data from the MIIR database for 6,913,780 beneficiaries in MA plans in December 2006. Because MA plan selections for 2007 generally take effect from January through April 2007, we identified disenrollees as beneficiaries who were covered under a given MA contract in December 2006 but were no longer covered under that contract in April 2007 based on Medicare enrollment data.⁶ Because we calculated disenrollment at the MA contract level, we did not address the extent to which beneficiaries transferred from one plan to another within an MA contract. We chose to calculate disenrollment rates at the MA contract level, rather than at the MA plan level, for two reasons: (1) transferring from one plan to another within a contract can occur for administrative reasons and therefore may not reflect beneficiary decisions, and (2) a beneficiary's decision to transfer, for example, from a zero premium plan to a plan within the same MA contract that charges a premium and has a richer benefit package does not suggest dissatisfaction with the type of MA plan or the sponsor that administers it. We calculated disenrollment rates for each MA contract as the total number of beneficiaries who disenrolled from their MA contract divided by total enrollment in that contract.⁷ The disenrollment rate for an MA contract applies to all plans under that contract.

We did not include beneficiaries in disenrollment rate calculations if they disenrolled involuntarily due to factors such as death, loss of Medicare eligibility, moving out of their MA contract's service area, or to administrative factors such as a change in their MA contract's service area

⁶An MA contract is an agreement between CMS and an MA plan sponsor that covers one or more MA plans of the same type. For example, a contract between CMS and a plan sponsor may cover at least one PFFS plan or possibly several PFFS plans.

⁷When calculating disenrollment rates for PFFS and other MA plans overall, we divided the total number of disenrollees by total enrollment in these plans.

or a termination of their MA contract or plan.⁸ After excluding beneficiaries (1) in certain plans and locations as described above and (2) in contracts or plans that were terminated in 2006 or 2007, we analyzed data for 158 PFFS plans accounting for 805,734 beneficiaries and 169,465 disenrollees and for 1,410 other MA plans accounting for 4,488,653 beneficiaries and 392,704 disenrollees.

We used risk scores for 2006—an indicator of projected health care expenditures—to compare the health status of disenrollees to beneficiaries overall in PFFS and other MA plans. To estimate average risk scores of disenrollees from PFFS and other MA plans, we used 2006 beneficiary-level risk scores for 169,271 beneficiaries who disenrolled from PFFS plans and for 391,126 beneficiaries who disenrolled from other MA plans from January through April 2007. To estimate the average risk scores of beneficiaries overall in these plans, we used 2006 plan-level risk scores, which are based on 725,110 beneficiaries in 154 PFFS plans and 4,421,308 beneficiaries in 1,400 other MA plans in July 2006, and weighted each plan's risk score by its July 2006 enrollment. According to a CMS official, MA plans' risk scores generally decline over the course of a year, so a plan's risk score based on beneficiaries in the plan in July 2006 could be higher than it would have been based on beneficiaries in the plan in December 2006.⁹ As a result, the actual percentage difference between the average projected health care expenditures for disenrollees in PFFS and other MA plans and beneficiaries overall in these plans may be larger than our estimates indicate. To evaluate whether CMS met statutory requirements to mail disenrollment rates to beneficiaries, we interviewed CMS officials, analyzed relevant federal laws and regulations, and

⁸The number of beneficiaries in these plans includes 8,918 beneficiaries in PFFS plans and 79,827 beneficiaries in other MA plans who disenrolled involuntarily and were not included in the calculation of disenrollment rates.

⁹This official noted that the decline in a plan's risk score over the course of a year occurs because plans generally have a higher proportion of new Medicare beneficiaries (i.e., beneficiaries age 65 to 67 who have relatively low risk scores) at the end of the year and some older beneficiaries die who have relatively high risk scores. A plan's risk score, according to a CMS official, can decrease from, for example, 1.00 for beneficiaries in the plan in January to 0.95 for beneficiaries in the plan in December.

reviewed information CMS provided to Medicare beneficiaries through, for example, Medicare Options Compare (MOC) on Medicare's Web site.¹⁰

¹⁰Medicare Options Compare is available at www.medicare.gov. Beneficiaries can also call 1-800-MEDICARE and have printed information sent to them if they do not have Internet access, or contact their State Health Insurance Assistance Program for help in choosing a plan.

Appendix II: Comments from the Centers for Medicare & Medicaid Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for
Washington, DC 20201

DEC 01 2008

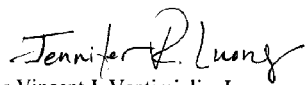
James Cosgrove
Director, Health Care
U.S. Government Accountability Office
441 G Street N.W.
Washington, DC 20548

Dear Mr. Cosgrove:

Enclosed are comments on the U.S. Government Accountability Office's (GAO) report entitled: "Medicare Advantage: Characteristics, Financial Risks, and Disenrollment Rates of Beneficiaries in private Fee-for-Service Plans" (GAO 09-25).

The Department appreciates the opportunity to review this report before its publication.

Sincerely,


for Vincent J. Ventimiglia, Jr.
Assistant Secretary for Legislation

Attachment

Appendix II: Comments from the Centers for Medicare & Medicaid Services




DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

DATE: NOV 25 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 Report: "Medicare Advantage: Characteristics, Financial Risks, and Disenrollment Rates of Beneficiaries in Private Fee-for-Service Plans" (GAO-09-25)

Thank you for the opportunity to review and comment on the GAO Draft Report titled "MEDICARE ADVANTAGE: Characteristics, Financial Risks, and Disenrollment Rates of Beneficiaries in Private Fee-for-Service Plans" (GAO-09-25). The Centers for Medicare & Medicaid Services (CMS) is committed to ensuring that Medicare beneficiaries receive appropriate health care services.

There are certain important elements that beneficiaries in a health plan offering coverage through non-network providers must consider. The report highlights one of those elements - that using network providers may provide a greater degree of certainty that all procedural claims rules will be followed and a particular service will in fact be covered by the plan. Thus, it is important for beneficiaries in non-network plans to understand their rights and obligations, and they may want to consider obtaining advance determinations from their plans in appropriate circumstances.

Consistent with GAO's recommendations, CMS is reviewing the adequacy of information that Medicare Advantage (MA) private fee-for-service (PFFS) plans have provided with respect to advance coverage determinations and notices. CMS has also clarified and is monitoring compliance with our rules that prohibit prior authorization for covered services.

The CMS will continue to work closely with Congress, GAO, beneficiary advocacy groups, and other interested parties to ensure that beneficiaries receive appropriate health care and do not incur unexpected financial risks.

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GAO Recommendation

The GAO recommends CMS investigate the extent to which beneficiaries in PFFS plans are faced with unexpected out-of-pocket costs due to the denial of coverage where they did not obtain an advance coverage determination from their plan.

CMS Response

We are looking at coverage denials and complaints to determine whether there may be a problem with the adequacy of communication between plans and members, and whether it suggests that beneficiaries are not sufficiently taking advantage of their rights to receive an advance coverage determination.

On October 3, 2008, CMS published a summary of proposed data collection requirements for Medicare Advantage organizations (MAOs) in the *Federal Register*. CMS proposed to collect organization determinations and reconsiderations data from PFFS plans as well as other MA plans to ensure that PFFS plans are not inappropriately denying plan-covered services. CMS will monitor the number of denial of coverage cases generated by PFFS plans on a quarterly basis, and will release the final data collection requirements in December 2008.

The CMS is also refining its process for prioritizing beneficiary complaints to ensure that access to care complaints entered into the complaint tracking module (CTM) receive first priority. We believe a systematic monitoring of complaints will enable CMS to identify those PFFS plans as well as other MA plans that are inappropriately denying their enrollees health care services.

In cases of denied coverage of plan-covered services, the beneficiary has recourse to a comprehensive and well established appeals process that furnishes enrollees access to an independent review entity and additionally an administrative law judge (see 42 CFR Subpart M). Also, the plan is obligated to provide the beneficiary with a Notice of Denial of Medical Coverage, which explains the beneficiary's appeal rights and why the service was denied coverage.

PFFS plans must cover all medically necessary services covered by Original Medicare, in addition to any supplemental services covered by the plan. PFFS plans must use Medicare's coverage rules to decide what services are medically necessary. If a service is medically necessary under Original Medicare, then the PFFS plan must cover the service. PFFS plans must ensure there is no difference in access to covered services between beneficiaries enrolled in a PFFS plan and beneficiaries enrolled in Original Medicare.

GAO Recommendation

The GAO recommends CMS ensure guidance regarding prior authorization accurately reflects CMS policy and that PFFS plan materials conform to CMS requirements.

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CMS Response

We concur with the GAO's recommendation and have already taken several steps to ensure that guidance to plans accurately reflects CMS' policy that PFFS Plans cannot require prior authorization as a condition of coverage and PFFS plan materials conform to CMS requirements.

- In the 2009 Call Letter released on March 17, 2008, CMS described its policy that PFFS plans may not require enrollees or providers to obtain prior authorization from the plan as a condition of coverage. CMS reiterated this policy in a memorandum to PFFS plans that was released on May 29, 2008.
- CMS modified the Plan Benefit Package (PBP) for contract year 2010 so that PFFS plans are no longer able to indicate that they have prior authorization requirements.
- On September 12, 2008, CMS released a memorandum to PFFS plans titled "Instructions For Model Private Fee-For-Service Terms And Conditions of Payment". This memorandum provided PFFS plans with a model terms and conditions of payment, which reiterated CMS' policy that prior authorization cannot be required as a condition of coverage when medically necessary, plan-covered services are furnished to enrollees. CMS also indicated in this memorandum that, effective January 1, 2009, it expects all PFFS plans to have implemented the model terms and conditions of payment.
- We are currently in the process of revising the Medicare Managed Care Manual to accurately reflect our policy on prior authorization for PFFS plans.
- CMS will also review plan materials to ensure plan materials accurately describe CMS' prior authorization requirements.

GAO Recommendation

The GAO recommends CMS comply with statutory requirements to mail to Medicare beneficiaries MA plan disenrollment rates for the previous two years for MA plans that are or will be available in their areas, and update disenrollment rates provided to Medicare beneficiaries through MOC.

CMS Response

The CMS has recently awarded a contract to develop performance metrics for Medicare Advantage plans, including PFFS plans. CMS will have information on PFFS disenrollment rates from this contract by late 2009.

Again, we thank you for the opportunity to review and comment on this draft report.

Appendix III: GAO Contact and Staff Acknowledgments

Contact

James C. Cosgrove, (202) 512-7114 or cosgrovej@gao.gov

Acknowledgments

Other contributors to this report include Christine Brudevold, Assistant Director; Jennie Apter; William Black; Daniel Lee; Ba Lin; Hillary Loeffler; and Hemi Tewarson.

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