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United States Government Accountability Office
Washington, DC 20548

June 24, 2008

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

Subject: *Medicare Advantage Organizations: Actual Expenses and Profits Compared to Projections for 2005*

This Report Is Temporarily
Restricted Pending Official Public
Release.

Medicare Advantage (MA) organizations offer an alternative to the original Medicare fee-for-service (FFS) program.¹ Payments to MA organizations are, in part, based on the revenue and expenditure projections MA organizations submit to the Centers for Medicare & Medicaid Services (CMS)—the agency that administers Medicare—prior to the start of each contract year. Once Medicare payments are determined, they are not modified based on differences between actual and projected expenses.² In February 2008, we reported that, on average, MA organizations projected they would spend approximately 87 percent of their 2007 revenue on medical expenses, 9 percent on non-medical expenses, and that the remaining 4 percent would go to profits.³ The accuracy of MA organizations' projections is important because, in addition to determining Medicare payments, these projections also affect the extent to which MA beneficiaries receive additional benefits not provided under FFS and the amounts beneficiaries pay in cost sharing and premiums.

¹Medicare is the federally financed health insurance program for persons aged 65 and over, certain individuals with disabilities, and individuals with end-stage renal disease. Medicare Part A covers hospital and other inpatient stays. Medicare Part B is optional insurance, and covers hospital outpatient, physician, and other services. Medicare Parts A and B are known as original Medicare or Medicare FFS. Medicare beneficiaries have the option of obtaining coverage for Medicare Parts A and B services from private health plans that participate in Medicare's MA program—also known as Medicare Part C. All Medicare beneficiaries may purchase coverage for outpatient prescription drugs under Medicare Part D.

²However, payments to MA organizations may be modified based on differences in actual and projected beneficiary health status, beneficiary residence, and enrollment. Actual expenses may be used to inform projections for future contract years. In 2007, payments to MA organizations totaled an estimated \$77 billion.

³See GAO, *Medicare Advantage: Increased Spending Relative to Medicare Fee-for-Service May Not Always Reduce Beneficiary Out-of-Pocket Costs*, [GAO-08-359](#) (Washington, D.C.: Feb. 22, 2008). Profits refer to MA organizations' remaining revenue after medical and non-medical expenses are paid. In certain circumstances, such as for new market entrants, CMS allows an MA organization to have a negative profit, meaning that the organization's revenue is less than its combined medical and non-medical expenses.

This report responds to your request for additional information on the accuracy of MA organizations' projections. Specifically, this report focuses on how organizations' 2005 actual medical expenses, non-medical expenses, and profits compare to projections for the same year.⁴ A forthcoming report will provide a similar analysis of 2006 data.⁵

To report MA organizations' 2005 actual expenditures, actual profits, and projections for 2005, we analyzed the two-year look-back form that MA organizations submitted to CMS with the 2007 Bid Pricing Tool.⁶ The 2007 two-year look-back form contains MA organizations' self-reported actual medical expenses, non-medical expenses, and profits for 2005. The form also contains the 2005 projections for those categories that the organizations submitted in 2004.⁷ MA organizations submit a single two-year look-back form for each of their contracts, which may include more than one health benefit plan. We excluded employer group health plans because these plans are not open to the general Medicare population, and actual and projected expenses are calculated differently than for other plans. We also excluded small contracts, defined as those with fewer than 24,000 "member months" (equivalent to 2,000 beneficiaries enrolled for a full year), because CMS officials stated that they do not consider data from these contracts to be fully credible.⁸ Additionally, we excluded 15 contracts for which actual or projected expenditures were missing. After all exclusions, our analysis included 120 contracts, representing about 81 percent of the contracts for which two-year look-back forms were submitted and about 78 percent of MA enrollment, equivalent to approximately 3.9 million beneficiaries enrolled in contracted plans for a full year. To compare actual and projected profits for 2005, we multiplied both actual and projected per member per month profits by actual 2005 enrollment in member months and took the difference. Reported results are for the 2005 contract year and may not be representative of or generalizable to other contract years.

We interviewed officials at CMS about data reliability, reviewed all data for reasonableness and consistency, and determined that the data were sufficiently reliable for our purposes. However, we did not independently audit MA organizations' self-reported data. We conducted this performance audit from April 2008 to June 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

⁴Prior to 2006, private health plans provided health coverage to Medicare beneficiaries through the Medicare + Choice program. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 renamed that program Medicare Advantage among other changes. Pub. L. No. 108-173, § 201, 117 Stat. 2066, 2176. Organizations were required to begin using the new program name in 2006, but CMS encouraged MA organizations to transition to "Medicare Advantage" in all plan materials for the 2005 contract year.

⁵At the time of this report, 2005 and 2006 were the most recent years for which two-year look-back data were available.

⁶MA organizations are required to annually submit bids for review and approval for each plan they intend to offer. The bid submission includes a Bid Pricing Tool, which contains MA organizations' projections of their revenue requirements and revenue sources.

⁷The two-year look-back form is so named because it provides data for the calendar year 2 years prior to the upcoming contract year. The two-year look-back form was not subject to CMS audit in 2007 and is not certified by the MA plan's actuary.

⁸Member months is the sum of a given contract's total monthly enrollments in a year. For example, if 1,500 members were enrolled in an organization's plans for January and February and 2,000 members were enrolled in its plans for March through December, the contract would have 23,000 member months.

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.

Results in Brief

On average, MA organizations' self-reported actual medical expenditures as a percentage of revenue were lower in 2005 than they had projected. MA organizations, on average, reported spending 85.7 percent of total revenue on medical expenses in 2005, but had projected medical expenditures of 90.2 percent of total revenue. Because organizations spent less revenue on medical expenses than projected, they earned higher average profits than projected. On average, MA organizations' self-reported actual profit margin was 5.1 percent of total revenue, which is approximately \$1.14 billion more in profits in 2005 than MA organizations projected. There were several outlier contracts whose relatively large differences between actual and projected profits made up more than half of the \$1.14 billion difference. Nearly two-thirds of beneficiaries were enrolled in health benefit plans offered by MA organizations for which the percentage of revenue dedicated to profits was greater than projected and the percentage of revenue dedicated to expenditures (medical and non-medical combined) was lower than projected. CMS officials stated that projections submitted by MA organizations in 2005 may be less reliable than those submitted in 2006 and subsequent years because, among other factors, actuaries were not required to attest to the accuracy of projections until 2006.

In commenting on a draft of this report, CMS stated that the report was factually accurate but that the findings were not relevant to assessing the operation of the Medicare Advantage program in 2006 and subsequent years. Among other comments, CMS stated that the report should more clearly recognize the changes to the program that have occurred since 2005, and should mention that differences between projected and actual expenses and profits did not affect Medicare payments to MA organizations or the benefits they would have provided. We generally disagree with CMS. While we state in our report that the 2005 findings may not be representative of or generalizable to subsequent contract years, it would be incorrect to suggest that there is no relationship between the payment system in 2005 and the bidding process that began in 2006. Also, although differences between projected and actual expenses and profits may not have affected Medicare payments to MA organizations, the inaccuracy of projections could have impacted the types and costs of services that MA beneficiaries received. CMS also supplied specific technical comments that we incorporated as appropriate.

Background

Since the 1980s, organizations that participate in Medicare's program for private health plans have been required to submit projections of their expenses and profits to CMS.⁹ There have been changes over time, however, in how these projections were used. In 2005, MA organizations submitted to CMS projected revenue requirements for the medical expenses, non-medical expenses, and profit margin associated with supplying an FFS benefit package. MA organizations were paid the administratively set rate regardless of their projections. However, if an MA organization's projection was less than the administratively set rate, the organization was required to spend the surplus Medicare payment on beneficiaries by adding extra benefits or reducing beneficiary cost sharing.

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

Under the payment system effective in 2006 and subsequent years, MA organizations submit bids to CMS that reflect their projected revenue requirements for the medical expenses, non-medical expenses, and profit margin associated with supplying an FFS benefit package. If the organization's bid is higher than the administratively set rates, known as benchmarks, Medicare pays the organization the amount of the benchmark, and the organization must charge beneficiaries a premium to collect the amount by which the bid exceeds the benchmark. If the organization's bid is lower than the benchmark, the organization receives the amount of the bid plus additional payments, known as rebates, equal to 75 percent of the difference between the benchmark and the bid. MA organizations are required to spend their rebates on additional benefits, reduced cost sharing, reduced premiums, or a combination of the three.

Medical Expenses, on Average, Were Lower Than Projected, Leading to Higher Profits

MA organizations' self-reported actual medical expenditures as a percentage of revenue were, on average, lower in 2005 than they had projected. MA organizations reported spending an average of 85.7 percent of total revenue on medical expenses in 2005, but had projected medical expenses of 90.2 percent of total revenue, on average. Because organizations spent less revenue on medical expenses than projected, they earned higher average profits than projected. On average, MA organizations' self-reported actual profit margin was 5.1 percent of total revenue—nearly three times their projected profit margin of 1.8 percent of total revenue. (See table 1.) MA organizations included in our analysis received a total of \$35 billion in revenues, \$1.3 billion more than projected, after weighting for actual enrollment. Revenues were higher than projected because MA organizations received additional revenues to compensate for enrollees who were either potentially more costly because of increased severity of illness, were disproportionately from counties with higher administratively set rates, or some combination of the two. However, even after accounting for increased severity of illness and disproportionately higher enrollment from certain counties, MA organizations still over-projected their medical expenses compared to actual medical expenses and under-projected non-medical expenses and profits.

Table 1: Actual and Projected Medical Expenses, Non-Medical Expenses, and Profits as Amounts and Percentages of Revenue, 2005

	Actual		Projected	
	Percentage of Revenue	Amount in dollars (billions)	Percentage of Revenue	Amount in dollars (billions)
Medical Expenses^a	85.7	30.06	90.2	30.46
Non-Medical Expenses	9.2	3.21	7.9	2.65
Profits	5.1	1.74	1.8	0.60
Total Revenue ^b		35.01		33.71

Source: GAO analysis of CMS's two-year look-back data for 2005.

Notes: Data on actual expenses and profits were self-reported by MA organizations. Percentages are weighted by 2005 actual enrollment. Percentage totals may add to less than 100 due to rounding. We excluded from our analysis employer group health plans, contracts for which revenue projections or actual expenditures were not reported, and contracts that had fewer than 24,000 member months. Twenty-four thousand member months is equivalent to 2,000 beneficiaries enrolled for a full year. This analysis includes 120 contracts, representing about 81 percent of the contracts for which two-year look-back forms were submitted in 2007 and about 78 percent of MA enrollment.

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

^bRevenues were higher than projected because MA organizations received additional revenues to compensate for enrollees who were either potentially more costly because of increased severity of illness, were disproportionately from counties with higher administratively set rates, or some combination of the two.

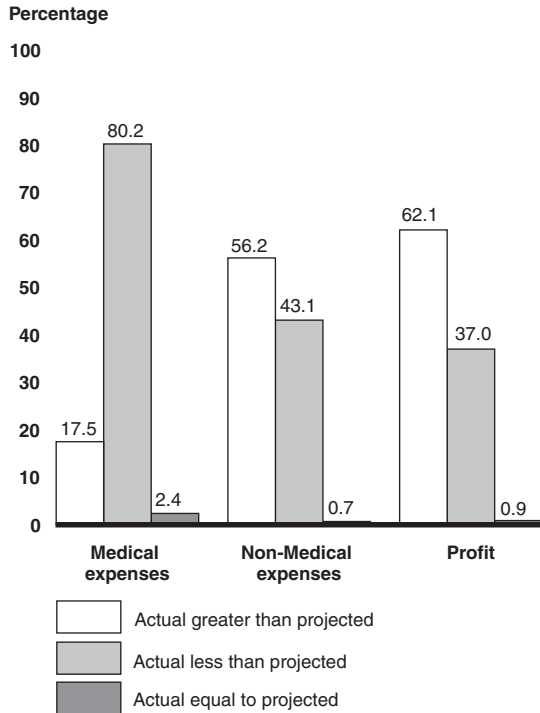
The difference between MA organizations' self-reported actual and projected profit margins translates to approximately \$1.14 billion more in profits in 2005 than MA organizations projected. The median amount of actual profits earned above projections per contract was approximately \$2.8 million.¹⁰ There were several outlier contracts whose relatively large differences in actual and projected profits made up more than half of the \$1.14 billion difference. However, even after removing outliers, the remaining contracts exhibited lower medical expenses and higher profits than projected, on average.¹¹

Nearly two-thirds of beneficiaries were enrolled in health benefits plans offered by MA organizations for which the percentage of revenue dedicated to profits was greater than projected and the percentage of revenue dedicated to actual expenses (medical and non-medical combined) was less than projected. This was largely driven by MA organizations' over-projection of medical expenses—about 80 percent of beneficiaries were enrolled in plans for which projected medical expenses were greater than actual medical expenses as a percentage of revenue. In contrast, about 56 percent of beneficiaries were enrolled in health benefit plans offered by MA organizations for which actual non-medical expenses were greater than projected non-medical expenses as a percentage of revenue. (See fig. 1.)

¹⁰In an ordered set of values, the median is a value below and above which there is an equal number of values; if there is no one middle number, it is the arithmetic mean (average) of the two middle values.

¹¹After removing outliers, as a percentage of revenue MA organizations reported spending 85.5 percent on medical expenses compared to projections of 88.3 percent, 9.1 percent on non-medical expenses compared to projections of 8.7 percent, and had a profit margin of 5.4 percent compared to projections of 3.1 percent on average.

Figure 1: Percentage of Beneficiaries Covered by MA Organizations with Reported Expenses and Profits as a Percentage of Revenue that Were Greater Than, Less Than, or Equal to Projections, 2005



Source: GAO analysis of CMS's two-year look-back data for 2005.

Notes: Data on actual expenses and profits were self-reported by MA organizations. Percentage totals may be greater than 100 due to rounding. We used member months as our measure of beneficiary enrollment. Twelve member months is equivalent to one beneficiary enrolled in a contracted plan for a full year. We excluded from our analysis employer group health plans, contracts for which revenue projections or actual expenditures were not reported, and contracts that had fewer than 24,000 member months. Twenty-four thousand member months is equivalent to 2,000 beneficiaries enrolled for a full year. This analysis includes 120 contracts, representing about 81 percent of the contracts for which two-year look-back forms were submitted in 2007 and about 78 percent of MA enrollment.

CMS officials suggested factors that could explain the difference between actual and projected revenue allocations for 2005. CMS officials stated that changes in the mix and health status of projected versus actually enrolled beneficiaries may also have produced differences between actual expenditures and projections. Additionally, CMS officials cautioned against drawing conclusions based on a single year of data. The reported actual allocations of revenue to medical expenses, non-medical expenses, and profits in 2005 were similar to MA organizations' projected allocations for 2007.¹²

CMS officials also stated that the projections submitted by MA organizations in 2005 may be less reliable than those submitted in 2006 and subsequent years. CMS officials stated that in 2005 MA organizations' actuaries were not required to attest to the accuracy of projections and that MA organizations were not required to base their projections on actuarial projections. Specifically, CMS officials stated that MA organizations used trends from their commercial experience to project MA costs. Although an actuarial attestation was not

¹²[GAO-08-359](#).

required in 2005, 53 percent of 2004 projections were accompanied by actuarial attestations. Additionally, in 2005, the chief executive officer or the chief financial officer of the MA organization was required to certify that projections were accurate. Regarding how MA organizations determined projections in 2005, CMS instructed MA organizations to adjust their cost trend estimates if they did not believe the projections based on their commercial experience were appropriate for their Medicare population. CMS also noted in instructions to MA organizations that there were acceptable actuarial techniques that supplement actual plan experience with other data sources in projecting costs. CMS officials also stated that the projections submitted in 2005 by MA organizations did not explicitly list their profit projections. CMS calculated projected profits for the 2005 two-year look-back form by subtracting expenses from revenue. However, CMS officials stated that they were not sure that this accurately reflected what the MA organization would have expected its profit to be in 2005.

Agency Comments and Our Evaluation

In commenting on a draft of this report, CMS stated that the report was factually accurate but that the findings were not relevant to assessing the operation of the MA program in 2006 and subsequent years. CMS said that the accuracy of estimates has increased since the inception of the MA program and that the agency is continuing to improve the methodology used to produce estimates. CMS also stated that the report should more clearly recognize the changes that have occurred since 2005 and provide greater context for the findings. In general, CMS's comments can be grouped into four categories: (1) results from 2005 are of historical significance only, (2) differences between projected and actual expenses and profits did not affect Medicare payments to MA organizations or the benefits they would have provided, (3) one outlier MA organization was responsible for nearly half the aggregate difference between projected and actual profits, and (4) MA organizations may have made mistakes in their Adjusted Community Rate Proposals (ACRPs),¹³ thus contributing to the observed differences between projected and actual values. We elaborate on CMS's key comments and respond below. CMS also supplied specific technical comments that we incorporated as appropriate. CMS comments are reprinted in enclosure I.

CMS stated that results from 2005, under the ACRP process, are of only historical significance. We state in our report that the 2005 findings may not be representative of or generalizable to subsequent years. However, it would be incorrect to suggest that there is no relationship between the ACRP process in 2005 and the bidding process that began in 2006. The current MA bidding system evolved from the earlier ACRP process. Both require MA organizations' projections that help to determine the extent to which benefit packages are enhanced and both include incentives for plan competition. Similar to the current bidding system, if MA organizations projected revenue requirements in their ACRPs that were lower than the administratively set rate (known as a benchmark under the current competitive bidding process), they were required to provide additional benefits or reduce beneficiaries'

¹³Before 2006, MA organizations were required to annually submit an ACRP for each health benefit plan that they intended to offer to CMS for its review and approval. The ACRP identified the health services the MA organization would provide to its Medicare enrollees and the estimated cost of providing those services. It also showed the estimated payments that the MA organization expected to receive for providing these services.

cost sharing.¹⁴ As such, MA organizations under both systems enhanced benefit packages to attract higher enrollment. The ACRP projections were of sufficient importance that Congress required CMS to audit at least one-third of the financial records of MA organizations, including data related to the ACRP projections, in order to determine whether payments were proper.¹⁵ CMS stated that the rigorous competitive bidding system, which began in 2006, improved the methodology used to make and use projections. Evaluation of that process was outside the scope of our work, but we will provide a similar analysis of 2006 data in a forthcoming report.

CMS commented that even if MA organizations' 2005 profit projections had accurately reflected actual 2005 profits, there would have been no additional federal payments and there would have been no requirements for these organizations to provide any additional benefits. We agree that regardless of whether 2005 projections more closely reflected actual 2005 profits and expenses, federal payments to MA organizations would not have changed. However, the inaccuracy of projections could have impacted the extent to which benefit packages were enhanced. If MA organizations' projections for medical expenses more accurately reflected the cost and utilization of services in 2005, organizations would have been able to provide additional benefits or cost-sharing reductions to beneficiaries and still have maintained the level of profits they projected.

CMS also stated that our analysis did not consider that 45 percent of the \$1.14 billion difference between the projected and actual profits was due to one contract. We did not highlight that single contract because, while it had the largest enrollment among all the outliers we identified, other outliers with lower enrollment had greater differences between projected and actual profits. In our draft, we reported values with and without outliers to show their impact. As suggested by CMS in its comments, we added additional context by providing information on total revenues, profits, and MA spending in 2005 for the contracts in our analysis.

CMS commented that MA organizations may have miscalculated or provided inaccurate information in their ACRP projections, contributing to the differences between projected and actual values. CMS noted the example of the one large MA organization that accounted for 45 percent of the difference between actual and projected profits as being a likely mistake. Determining whether the outlier organization's projections were incorrect was outside the scope of our work. However, CMS was required by law to review and approve those projections and they were the basis for additional benefits.¹⁶ Additionally, CMS officials stated that the newness of many MA health benefit plans in 2006 may partially explain the differences between actual expenses and projections for that year. While CMS did not offer the newness of MA health benefit contracts in 2005 as an explanation for the variances from projections, there was significant growth in the number of MA contracts in 2005 as well as 2006. We did not analyze the impact of new plans on the accuracy of projections, but the outlier contract CMS described was an established private health contract with high enrollment.

¹⁴Under the MA program's competitive bidding process, MA organizations can also use the difference between their projections and the benchmark to reduce beneficiaries' Part B and Part D premiums.

¹⁵See 42 U.S.C. §1395w-27(d)(1).

¹⁶See 42 U.S.C. §1395w-24(a)(5).

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

If you or your staff have any questions regarding this report, please contact me at (202) 512-7114 or cosgrovej@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Christine Brudevold, Assistant Director; Gregory Giusto; Dan Lee; and Jessica T. Lee were major contributors to this report.



James C. Cosgrove
Director, Health Care

Enclosure – 1

Comments from the Centers for Medicare & Medicaid Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Assistant Secretary
for Legislation

Washington, D.C. 20201

JUN 20 2008

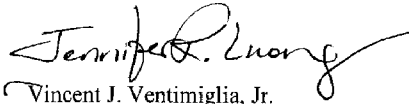
James Cosgrove
Director, Health
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Mr. Cosgrove:

Enclosed are the Department's comments on the U.S. Government Accountability Office's (GAO) draft report entitled: Medicare Advantage Organizations: Actual Expenses and Profits Compared to Projections for 2005" (GAO 08-827R).

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

Sincerely,


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

Attachment



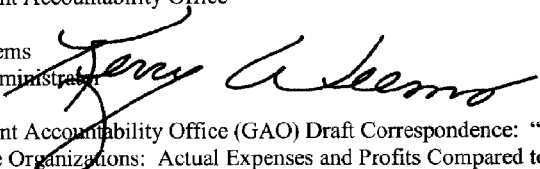
DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: JUN 19 2008

TO: James Cosgrove
Director, Health Care
Government Accountability Office

FROM: Kerry Weems
Acting Administrator 

SUBJECT: Government Accountability Office (GAO) Draft Correspondence: "Medicare Advantage Organizations: Actual Expenses and Profits Compared to Projections for 2005" (GAO-08-827R)

Thank you for the opportunity to review and comment on the above GAO Draft Correspondence Report. The draft report focuses on how the actual medical expenses, non-medical expenses, and profits of Medicare Advantage plans in 2005 compared to the plans' projections for that year. While the report is generally factually accurate (see specific corrections below), it fails to adequately note the important differences between the prior Adjusted Community Rate Proposal (ACRP) process and the current competitive bidding system that began in 2006. Please also note that while the program name was changed in 2004 from Medicare + Choice to Medicare Advantage, pursuant to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), the methodology for 2005 still employed the old ACRP process.

The report does not fully recognize that the 2005 base year was vastly different from the current competitive bidding process mandated by the MMA. As indicated below, 2005 was priced under the now no longer existing ACRP system that did not have the discipline of the current system. In essence, the report indicates that the Medicare Advantage (MA) plans earned \$1.14 billion more profit than projected. Much of this conclusion is misleading because the requirements of the ACRP process and the 2007 two-year look-back process are significantly different. In addition, the conclusion fails to take into consideration that 45 percent of the \$1.14 billion difference between the calculated profit expectation and the actual profit is due to a loss by one major plan. More importantly, it must be understood that the total amount of dollars the MA organizations received in 2005 would not have changed if the expectations were closer to the actual.

The 2005 base year was the final year ACRPs were submitted to the Centers for Medicare & Medicaid Services (CMS) by MA organizations. The ACRP pricing methodology was replaced in 2006 with the current competitive bidding process in accordance with the MMA. The competitive bidding model brought the discipline of the market to the Medicare program and was implemented through a rigorous system of actuarial bid submissions, subject to careful review by

Page 2 – James Cosgrove

the Office of the Actuary at CMS. Organizations are required to make competitive bids based on actuarial principals to provide competitive premiums and benefit packages to Medicare beneficiaries. The bids must be submitted and certified by accredited actuaries and must be prepared following the Actuarial Standards of Practice developed by the Actuarial Standards Board. In contrast, the ACRP model established set payments to private Medicare health organizations that did not require the rigor of the current bid process regarding projections or allocating the payment to categories of expenses.

The draft GAO report acknowledges the distinction between the ACRP and actuarial bid processes, but does not adequately reflect or describe its importance. As a result, the use of 2005 for such a comparison may have some significance to historical Medicare policy, but it is not relevant to an assessment of the operation of the MA program in 2006 and later.

CMS believes the value of the Medicare Advantage program is self evident, and more than 20 percent of Medicare beneficiaries – some 9.5 million seniors and disabled Americans – have chosen the benefits of MA plans. These individuals enjoy additional value when compared to traditional Medicare, such as reduced premiums, lower co-payments and extra benefits. Perhaps most importantly, they have injected into Medicare greater choice and competition – two virtues that are critical to addressing the long-term sustainability of the Medicare program.

Although CMS agrees with the findings in this report, they apply to a system that has changed significantly since the period GAO examined. CMS is improving the methodology used in order to produce more accurate estimates and we will make further improvements in the future. Today estimates are more accurate than they were at the inception of the Medicare Advantage program, and they will be still more accurate in the months and years ahead.

Below are the technical changes that CMS suggests be made to the GAO correspondence report.

Pages 3 & 5

- It should be noted that if the actual higher level of profit of MA organizations had been anticipated and reflected in the 2005 ACRPs, there would have been no additional federal payments and there would have been no requirement for these organizations to provide any additional benefits.

Pages 3-4, Results in Brief

- The report indicates on average that MA organizations' actual profit margins were 5.1 percent of total revenue, which is approximately \$1.14 billion more in profit for 2005 than MA organizations had projected. The report also indicates that more than half of the \$1.14 billion is attributable to several outlier contracts. We recommend more context be provided around these figures (e.g., total revenue, profit, and MA spending for 2005). Otherwise, it is difficult for an average reader to interpret the relative magnitude of the amount in question.

Page 3 – James Cosgrove

- This section states “CMS officials stated that projections submitted by MA organizations in 2005 may be less reliable than those submitted in 2006 and subsequent years because, among other factors, actuaries were not required to attest to the accuracy of projections until 2006.” While this factor may be one reason why 2005 projections are less reliable than 2006, we recommend GAO also mention other potentially more critical factors such as the significant changes made to the program between 2005 and 2006—especially the change away from the ACRP process and to the system of competitive actuarial bid submissions. The same incomplete point is also made in the body of the report on page 8 and should be elaborated upon in that section.

Page 4

- This section should note that CMS officials indicated that the projections submitted by MA organizations before 2006 may be less reliable than those submitted in 2006 and subsequent years because the ACRP was not required to be based on an actuarial projection. For example, the development of cost growth trend assumptions were generally based on the MA organization’s commercial experience as compared to the projection for the Medicare covered population.

Pages 5-6, Medical Expenses, on Average, Were Lower than Projected Leading to Higher Profits

- This section outlines the key finding of the report and includes, in Table 1, the actual and projected medical expenses, non-medical expenses, and profit as a percentage of revenue for 2005. In this section, the report indicates several outlier contracts whose large differences in actual and projected profit made up more than half of the \$1.14 billion difference. Footnote 11 provides all of the same data presented in Table 1 based on excluding the outlier plans. We recommend GAO present the data directly in Table 1 with and without the outliers included. This will indicate the sensitivity of the comparison to the small number of outlier plans and also show that the differences between actual expenses and profit and projected expenses and profit are much smaller when the outliers are removed.

Page 7

- The draft report states that “They [CMS officials] stated that differences may partially be explained by the newness of many MA plans in 2005; ...” This is not an accurate summary of comments from CMS officials. CMS officials stated that the differences for 2006 (which subsequently were not studied by the GAO) may be partially explained by the newness of many MA plans in 2006. The presence of many new MA plans in 2006 has no meaningful effect on the 2005 experience.

Page 8

Page 4 – James Cosgrove

- The draft report indicates that the head marketing official of the MA organization was required to certify that the projections were accurate. In fact, the certification of the head marketing official was not required for the 2005 ACRPs.
- The report notes that the ACRP projections submitted for 2005 by MA organizations did not explicitly list their profit projections and that the implicit profit projections for 2005 had to be estimated from other aspects of the ACRP information. This point would benefit from further elaboration. In particular, the ACRP summary sheet, Worksheet E, is not organized in a way that allows for ready determination of the profit expectations for the company. That is, the purpose of Worksheet E is to calculate the level of extra benefits to be provided to plan enrollees, and it is not a summary of expected company results. Further, some of the terms used in Worksheet E are not commonly used within the managed care industry: for example, "additional revenue," "adjusted excess amount," and "remaining excess." This position is underscored by the large implicit projected loss (in the hundreds of millions of dollars) represented by the largest contract in 2005, which was operated by a well-established health plan. As mentioned previously, that particular plan accounts for 45 percent of the \$1.14 billion difference between projected and actual profits. Given the company realized a reasonable profit for 2005, we suspect their actual expectation was almost certainly for a profit, and the implicit loss in the ACRP was likely a consequence of the process itself and a miscalculation on the part of the plan.

Lastly, we suggest adding some descriptive information regarding the ACRPs, including that they are a health care cost spending projection and that it is expected that actual expenditures will vary from the original projections. Moreover, the variations seen here between actual and projected expenditures are not uncommon in the health insurance market.

We appreciate the opportunity to review and comment on this draft correspondence.

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