

Private Medicare Plans' Cost Questioned

By ROBERT PEAR

WASHINGTON – Private Medicare plans often cost beneficiaries more than the traditional government-run Medicare program, Congressional investigators say.

Many private plans advertise extra benefits and low costs. But in a report to be issued Thursday, the Government Accountability Office, an investigative arm of Congress, says that many people in private plans face higher costs for home health care, nursing homes and some hospital stays.

About one-fifth of the 44 million Medicare beneficiaries – 9 million people – are in private plans, known as Medicare Advantage plans.

The report says, “Medicare spends more per beneficiary in Medicare Advantage than it does for beneficiaries in the original Medicare fee-for-service program, at an estimated additional cost to Medicare of \$54 billion from 2009 through 2012.”

Bush administration officials and insurance executives say the private plans provide a bargain. “Medicare Advantage plans are offering an average of approximately \$1,100 in additional annual value to beneficiaries in terms of cost savings and added benefits,” said Kerry N. Weems, the acting administrator of the Centers for Medicare and Medicaid Services.

Moreover, insurers say, co-payments and deductibles are generally lower in private plans than in traditional Medicare. In data submitted to the government, insurers estimated that their beneficiaries paid, on average, \$49 a month in such costs, or 42 percent of what they would have paid in traditional Medicare.

But the Government Accountability Office said the experience of particular beneficiaries might not match the average, so their out-of-pocket costs could substantially exceed those in traditional Medicare.

Last year, it said, “19 percent of Medicare Advantage beneficiaries were in plans that projected higher cost-sharing for home health services, and 16 percent of beneficiaries were in plans that projected higher cost-sharing for inpatient services.”

Insurers often boast that they protect Medicare beneficiaries against high out-of-pocket costs by setting annual limits.

The Government Accountability Office found that “48 percent of Medicare Advantage beneficiaries were in plans that had an out-of-pocket maximum.” The limits typically ranged from \$2,750 to \$4,600 a year and averaged about \$3,500.

But, the report said, certain costs are not counted toward the out-of-pocket limits established by some insurers. Thus, it said, among Medicare plans with out-of-pocket limits, 29 percent exclude the cost of some cancer drugs, 23 percent exclude the cost of some mental health services and 21 percent exclude home health care expenses.

“Beneficiaries who use these excluded services may pay more in total cost-sharing than is indicated by the plan’s out-of-pocket maximum,” the report said.

Medicare makes substantial contributions to the earnings of insurers like Humana and UnitedHealth.

Representative Pete Stark, the California Democrat who is chairman of the Ways and Means Subcommittee on Health, said, “Medicare overpayments fatten company profits, even as many seniors face higher costs in private plans than they would in traditional Medicare.”

Democrats tried unsuccessfully last year to cut Medicare payments to private plans. CIBC World Markets, an investment bank, predicted last month that “Humana and the Medicare industry will have at least two years, and probably three years, of continued strong enrollment and earnings growth.”

Medicare actuaries estimate that more than 27 percent of beneficiaries will be in private plans by 2017.

Critics of private plans often assert that they have higher marketing and administrative costs than traditional Medicare, but figures have been elusive.

The accountability office found that private Medicare plans “allocate about 87 percent of total revenue (\$683 of \$783 per member per month) to medical expenses; approximately 9 percent (\$71) to nonmedical expenses, including administration,

marketing and sales; and approximately 4 percent (\$30) to the plans' margin, sometimes called the plans' profit."

Insurers say that low-income people rely heavily on Medicare Advantage because it provides more comprehensive benefits than traditional Medicare, and they cannot easily afford supplemental policies.

But the accountability office said the subsidies were not well focused.

"If the policy objective is to subsidize health care costs of low-income Medicare beneficiaries," the report said, "it may be more efficient to directly target subsidies to a defined low-income population than to subsidize premiums and cost-sharing for all Medicare Advantage beneficiaries, including those who are well off."