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Medicare Advantage Medicare Advantage: Relationship Between Benefit Package Designs and Plans' Average Beneficiary Health Status Assuring Force Readiness and Beneficiary Health Through Health Promotion and Preventive Medicine in the Military Health System Civilian Health and Medical Program, Department of Veterans Affairs Medicare Medicare Advantage CHAMPVA Civilian Health and Medical Program Research and Statistics Note Preventive Health Services for Medicare Beneficiaries Supplemental Health Insurance Coverage Among Aged Medicare Beneficiaries OASDI Beneficiaries by State and County DEFENSE HEALTH CARE: Access to Care for Beneficiaries Who Have Not Enrolled in TRICARE's Managed Care Option Social Security Disability Designation of Beneficiary Outreach Efforts in the Supplemental Security Income and Qualified Medicare Beneficiary Programs Medicare The Medicare Handbook Medicare Coverage Decisions and Beneficiary Appeals The Military Health Service System Health Information Technology Medicare Managed Care Directory of Beneficiary

Organizations Medicare Advantage Environmental Assessment of Beneficiary Demographics Needs and Demands, and Incidence of Disease for Wilford Hall USAF Medical Center Service Area Patient-centered Medical Home Features and Health Care Expenditures of Medicare Beneficiaries with Chronic Disease Dyads Medicare Medicare A Beneficiary Assessment of the Second Population, Health, and Nutrition Project Medicare Beneficiary Satisfaction with and Understanding of Home Health Services Medicare Advantage Medigap Medicare 2000 Medicaid Assisted Living Services Social security reform : potential effects on SSA's disability programs and beneficiaries : report to the ranking member, Subcommittee on Labor, Health and Human Services, Education, and Related Agencies, Committee on Appropriations, U.S. Senate Home Health Services Civilian Health and Medical Program, Department of Veterans Affairs Oral Health and Medicare Beneficiaries Beneficiary Perspectives of Medicare Risk HMO's Medicare Advantage, CMS Should Use Data on Disenrollment and Beneficiary Health Status to Strengthen Oversight Medicaid Eligibility Quality Control

Medicare is a federal program that pays for health care services for individuals 65 years and older and certain individuals with disabilities. In 2011, Medicare covered about 48.4 million of these individuals, and total expenditures for this coverage were approximately $565 billion.

CMS, the agency within the Department of Health and Human Services that administers Medicare, is responsible for ensuring that proper payments are made on behalf of the program's beneficiaries. In response to HIPAA requirements, CMS developed and implemented an information technology system to help providers determine beneficiaries' eligibility for Medicare coverage. In May 2005 CMS began offering automated services through HETS, a query and response system that provides data to users about Medicare beneficiaries and their eligibility to receive payment for health care services and supplies. Because of the important role that HETS plays in providers having access to timely and accurate data to determine eligibility, GAO was asked to (1) identify the operational status of HETS, (2) identify any steps CMS has taken to ensure users' satisfaction and plans to take to ensure the system supports future requirements, and (3) describe CMS's policies, processes, and procedures for protecting the privacy of data provided by HETS. To do so, GAO collected and analyzed documentation from program officials, such as reports on transaction volume and response times, agreements with users, and CMS's privacy impact and risk assessments of HETS. GAO also interviewed program officials and system users. Nearly 11 million Medicare beneficiaries are enrolled in Medicare Advantage (MA), Medicare's private health insur. option. Benefits vary by MA plan and may include coverage for

services not avail. in traditional Medicare. To ensure MA plan benefit package designs do not discriminate against beneficiaries in poor health with high expected health care costs, the Centers for Medicare & Medicaid Serv. (CMS) reviews and approves all benefit packages yearly. This report examined: (1) MA plan benefit packages by average health status of plans' enrolled beneficiaries; (2) dist. and characteristics of MA plans by average beneficiary health status; and (3) CMS's process for ensuring that benefit packages do not discriminate with respect to health status. Charts and tables. "The Centers for Medicare & Medicaid Services (CMS) pays plans in Medicare Advantage (MA)-the private plan alternative to Medicare fee-for-service (FFS)-an amount per beneficiary that is adjusted to reflect beneficiary health status. This adjustment, called risk adjustment, helps ensure that health plans have the same financial incentive to enroll and care for beneficiaries regardless of their health status. In 2010, CMS announced plans to revise the major medical conditions included in its principal risk-adjustment model-the community model-and add a model for new enrollees in chronic condition special needs plans (C-SNP), which target beneficiaries with certain severe or disabling chronic conditions. CMS began using the C-SNP new enrollee model in 2011, in place of the general new enrollee model, to adjust MA payments for new Medicare beneficiaries who enroll in a C-SNP. GAO was asked to examine the accuracy of

these models for high-risk beneficiaries. Using data for a nationally representative sample of 2007 FFS beneficiaries, GAO computed the amount that expenditure estimates were above or below actual expenditures for 2007, the most recent data available at the time. GAO compared the accuracy of the current and revised community models for three high-risk groups: beneficiaries with multiple chronic conditions, with low income, and with dementia. GAO compared the accuracy of the general and C-SNP new enrollee models for new enrollees eligible to enroll in a C-SNP. What GAO Found The effect of CMS's revised community model on payment accuracy varied for the high-risk groups studied. Specifically, compared with the current community model, the revised community model slightly reduced the accuracy of MA payment adjustments for beneficiaries with multiple chronic conditions by $164, or about 1 percent of average actual expenditures. For beneficiaries with low income, the accuracy of the revised and the current community models was similar: estimates differed by $5, o..." Medicare Advantage: Relationship between Benefit Package Designs and Plans' Average Beneficiary Health Status TMA and its MCSCs use various methods to evaluate access to care, and according to TMA and MCSC officials, the resulting measures indicate that nonenrolled TRICARE beneficiaries access to care is generally sufficient and that access problems appear to be minimal. Among methods used by TMA to evaluate

access to care are its recently implemented civilian provider survey and an annual beneficiary health care survey. The survey of civilian providers, which includes network and nonnetwork providers, is designed to measure access to care by identifying how many civilian providers are willing to accept nonenrolled TRICARE beneficiaries as new patients. The first round of this survey, implemented in 2005, focused on 20 states and found that 14 percent of civilian providers were not accepting new patients from any government or commercial health plan. Of those accepting new patients, about 80 percent would accept nonenrolled TRICARE beneficiaries as new patients. In addition, the results of each of TMA s annual beneficiary health care surveys for 2003 through 2005 show that nonenrolled TRICARE beneficiaries satisfaction with access to care was similar to satisfaction reported by participants in commercial health plans. TMA and the TROs also receive anecdotal information through beneficiary feedback, and, according to these officials, complaints about access to care are infrequent. Each of the MCSCs also has its own methods of monitoring access to care, including analyzing provider and beneficiary locations as part of their responsibility for ensuring sufficient network capacity for all TRICARE beneficiaries residing in locations with civilian provider networks. While the MCSCs methods were not designed specifically to evaluate access for

nonenrolled TRICARE beneficiaries, they do provide helpful information that allows the MCSCs to monitor the availability of both network and nonnetwork civilian providers for this population. According to MCSC officials, their measures indic. Three out of 4 Medicare beneficiaries have multiple chronic conditions, and managing the care of this growing population can be complex and costly because of care coordination challenges. This study assesses how different elements of the patient-centered medical home (PCMH) model may impact the health care expenditures of Medicare beneficiaries with the most prevalent chronic disease dyads (ie, co-occurring high cholesterol and high blood pressure, high cholesterol and heart disease, high cholesterol and diabetes, high cholesterol and arthritis, heart disease and high blood pressure). Data from the 2007-2011 Medical Expenditure Panel Survey suggest that increased access to PCMH features may differentially impact the distribution of health care expenditures across health care service categories depending on the combination of chronic conditions experienced by each beneficiary. For example, having no difficulty contacting a provider after regular hours was associated with significantly lower outpatient expenditures for beneficiaries with high cholesterol and diabetes, but it was associated with significantly higher inpatient expenditures for beneficiaries with high blood pressure and high cholesterol, and no significant

differences in expenditures in any category for beneficiaries with high blood pressure and heart disease. However, average total health care expenditures are largely unaffected by implementing the PCMH features considered. Understanding how the needs of Medicare beneficiaries with multiple chronic conditions can be met through the adoption of the PCMH model is important not only to be able to provide high-quality care but also to control costs. This thesis investigates several factors associated with the current military health benefit. These included: (1) beneficiary satisfaction with military as well as civilian medical treatment facilities, (2) the number of active duty military personnel who choose to use military facilities and the personal cost incurred in making that decision, (3) the number of active duty military personnel who would purchase civilian health insurance, (4) and the benefits of retaining the current military health benefit as opposed to instituting a civilian group health insurance plan in its place. Five hundred forty-nine officers completed a questionnaire that was developed to address these issues. Trends noted were: (1) a slight rise in the level of dissatisfaction with the care provided by the current military health care benefit as time in service increases and (2) an increase in the use of civilian services in the military health service system, such as medical care for military beneficiaries at civilian treatment facilities

and the use of commercial insurance plans for psychiatric treatment. The arguments presented in this thesis on this very sensitive issue will continue to be debated by both the Department of Defense and the legislative branch of the government. This brief describes the oral health of Medicare beneficiaries, examines sources of dental coverage for the Medicare population, and examines the utilization of dental services, out-of-pocket spending on dental care and access problems. This analysis uses data from the National Health and Nutrition Examination Survey (NHANES), the Medicare Current Beneficiary Survey Cost and Use file (MCBS), the National Health Interview Survey (NHIS) and the Kaiser Family Foundation Survey of Health Care Among Nonelderly People with Disabilities and Seniors on Medicare, 2008. The evolution of the Military Health System (MHS) from a traditional model to a system of managed care precipitated a fundamental shift in the design and delivery of health care. These MHS changes mirror trends in the civilian sector: orientation to prevention and health promotion; a more quantitative approach to quality of care; and a customer-focused approach. The MHS has always provided health promotion and preventive medicine (HP/PM) services. In the current prevention-oriented system, however, HP/PM becomes a focal point in the continuum of care by contributing to cost savings or cost avoidance in addition to providing high quality, customer-focused care tailored to the MHS population. This

paper will propose the elements of a health system that delivers HP/PM as a focal point, describe the transition of the MHS to a prevention approach, and discuss the work that needs to be done to achieve an accountable, comprehensive prevention- oriented system. The MHS has the opportunity to emerge as a model health care delivery system. " Nearly 7 million individuals aged 55 to 64—more than 18 percent of the pre-Medicare population—lacked health insurance coverage in the first half of 2012. Health insurance protects individuals from the risk of financial hardship when they need medical care, and uninsured individuals may refrain from seeking necessary care because of the cost. If they forgo medical care beforehand, these individuals may be in worse health and need costlier medical services after enrolling in Medicare compared to those with prior insurance. GAO was asked to review the effects of having prior health insurance coverage on Medicare beneficiaries. This report examines the health status, program spending, and use of services of Medicare beneficiaries with and without continuous health insurance coverage before Medicare enrollment. To examine the effects of beneficiaries' prior insurance coverage, GAO used data from the Health and Retirement Study and Medicare claims to conduct two types of multivariate analysis. GAO predicted probabilities of beneficiaries' reporting being in good health or better and values for program

spending and beneficiaries' use of services. In comments on a draft of this report, the Department of Health and Human Services highlighted a key finding in GAO's report that beneficiaries with prior insurance used fewer or less costly medical services in Medicare compared with those without prior" "Nearly 11 million Medicare beneficiaries are enrolled in Medicare Advantage (MA), Medicare's private health insurance option. Benefits vary by MA plan and may include coverage for services not available in traditional Medicare. To ensure MA plan benefit package designs do not discriminate against beneficiaries in poor health with high expected health care costs, the Centers for Medicare & Medicaid Services (CMS) reviews and approves all benefit packages yearly.GAO examined (1) MA plan benefit packages by average health status of plans' enrolled beneficiaries, (2) distribution and characteristics of MA plans by average beneficiary health status, and (3) CMS's process for ensuring that benefit packages do not discriminate with respect to health status. Using 2008 data on beneficiaries' expected health care costs, the most recent data available, GAO sorted 2,899 plans enrolling 7.5 million beneficiaries into three groups: good health (below-average expected costs), average health, and poor health (above-average expected costs). GAO then analyzed MA plan benefit packages by health group and reviewed CMS documentation and interviewed agency officials on CMS's benefit package review

process. GAO did not determine whether plans structured benefit packages..." " In 2016, over 30 percent of Medicare beneficiaries were enrolled in the MA program. Each year beneficiaries have an opportunity to join or leave their MA plan. GAO was asked to review MA disenrollment by health status and CMS oversight. This report examines, among other issues, (1) the extent of any health-biased disenrollment, (2) beneficiaries' reasons for leaving contracts with and without health biased disenrollment, and (3) how, if at all, CMS identifies contracts with health-biased disenrollment, for routine oversight purposes. GAO analyzed 2014 disenrollment rates for the 252 MA contracts that had a sufficient number of disenrollees and met other criteria. For the 126 contracts with disenrollment rates above the median rate, GAO used beneficiaries' projected health care costs to identify those in poor health and better health. GAO examined data from CMS's Disenrollment Reasons Survey to learn why beneficiaries reported leaving the 126 contracts with relatively high disenrollment rates. GAO also interviewed CMS officials and compared their oversight to federal standards for internal control. " "Medicaid is the largest payer of mental health services in the United States and Medicaid spending on such services is likely to grow. Some states provide mental health services to Medicaid beneficiaries separately from physical health care services through contracts

with limited benefit plans, which are paid on a per person basis to provide a defined set of services. While using these plans to provide mental health services may control costs, it can also increase the risk that these services will not be coordinated with physical health care services. Coordinated care is important for Medicaid beneficiaries with mental illnesses because they are more likely than others to have ongoing health conditions. GAO was asked for information on states' use of Medicaid managed care. In this report, GAO examined the (1) extent that states provide mental health services through limited benefit plans, and (2) steps states and CMS have taken to facilitate the coordination of mental and physical health care services for adult beneficiaries enrolled in these plans.GAO collected information on enrollment, payments, and services from the 13 states that contracted with limited benefit plans to provide mental health services to adult beneficiaries. GAO also selected 4 states based on, among other criteria, the number of beneficiaries enrolled in limited benefit plans. GAO reviewed documents from the 4 states and CMS, and interviewed officials to identify steps taken to coordinate care.The Department of Health and Human" "Profile of national organizations that represent or relate to beneficiaries of Medicare and Medicaid." Source of information was the organizations. Alphabetical arrangement under 4 sections, i.e., the handicapped, mental health,

and general. Each entry gives address, contact person, description, publications, and meeting. No index. Medicare is a nationwide health insurance program for individuals aged 65 and over and certain disabled individuals. The basic Medicare benefit package (termed “Original Medicare” in this report) provides broad protection against the costs of many, primarily acute, health care services. However, Medicare beneficiaries may still have significant additional costs, including copayments, coinsurance, deductibles, and the full cost of services that are not covered by Medicare. All Medigap plans cover some percentage of Medicare's cost-sharing. Some plans offer additions to these basics, including various combinations of greater coverage of Medicare cost-sharing, and care associated with foreign travel emergencies. The most popular plans are the most comprehensive, and cover all deductibles, copayments, and coinsurance not covered by Medicare. Medigap generally does not cover medical treatments not covered by Medicare, although it does extend coverage for certain covered services, such as coverage for additional hospital days beyond the Medicare benefit limit. Medigap is financed through beneficiary payments to the private insurance firms. Federal law requires that Medigap insurers observe many consumer protections. Consumer protections are especially strong during open enrollment, which is a six-month period that begins for most individuals

during the month they turn 65. During this period, individuals are protected against insurers refusing to sell them any Medigap policy that the insurer offers, insurers setting premiums based on the individual's health, and insurers imposing waiting times on the start of the policy, other than a maximum of a six-month waiting period for preexisting conditions. Following the open-enrollment period, beneficiaries have other rights in limited situations, such as when they move to a different state. Guaranteed issue (or the right to buy a plan, to have the plan's premium not depend on health status, and in some cases to have the plan start coverage of preexisting conditions immediately) is one such right. The right of guaranteed renewability is available in a wide variety of situations, and genetic discrimination is forbidden. Moreover, Medigap insurers must pay out at least 65% (and sometimes 75%) of total premiums as claims to the beneficiaries. Recent data show that Medigap premiums vary by states and other factors. A relatively small number of insurance firms sell Medigap plans. In addition, Medigap beneficiaries are concentrated in certain areas of the country and are more likely to have lower incomes than those holding employer-sponsored retiree health insurance. The Patient Protection and Affordable Care Act (P.L. 111-148 as amended by P.L. 111-152, ACA) requests that the Secretary of Health and Human Services ask the National Association of Insurance

Commissioners to review and revise existing standards to examine greater cost-sharing for Medigap beneficiaries. In addition, the President's 2013 budget proposal would provide incentives to increase cost-sharing. One rationale for these proposals is that beneficiaries on average reduce their use of medical care following an increase in cost-sharing. This decrease in medical care by Medicare beneficiaries could reduce Medicare expenditures and the federal deficit. On the other hand, if these reductions in medical care ultimately lower health status, the individuals might require more treatments or more expensive care. This report provides a broad overview of Medigap insurance. The report covers the history of Medigap legislation, the various types of Medigap plans, consumer protections awarded to Medigap beneficiaries, and the requirements facing the insurance providers and the NAIC. Following an empirical description of Medigap markets, the report discusses proposals related to the percentages of a Medigap insurer's revenue that is returned as benefits to the policy holders and Medigap cost-sharing requirements.

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