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COMMITTEE ON ENERGY AND COMMERCE
MAJORITY STAFF
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**PROFITS, MARKETING, AND CORPORATE
EXPENSES IN THE MEDICARE ADVANTAGE
MARKET**

PREPARED BY COMMITTEE STAFF FOR

**CHAIRMAN HENRY A. WAXMAN
SUBCOMMITTEE CHAIRMAN BART STUPAK**

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EXECUTIVE SUMMARY

Medicare Advantage is an alternative to the traditional Medicare program in which private plans run by health insurance companies provide health care benefits that eligible beneficiaries would otherwise receive directly from the Medicare program. In 2009, federal payments to private health insurance companies through the Medicare Advantage program will total \$110.2 billion. The federal government is projected to pay, on average, 14% more per Medicare Advantage beneficiary in 2009 than it does for beneficiaries under the traditional Medicare program. This 14% average difference means that Medicare will pay \$12 billion more for Medicare Advantage beneficiaries this year than it would if those same people had obtained their health care coverage through traditional Medicare.

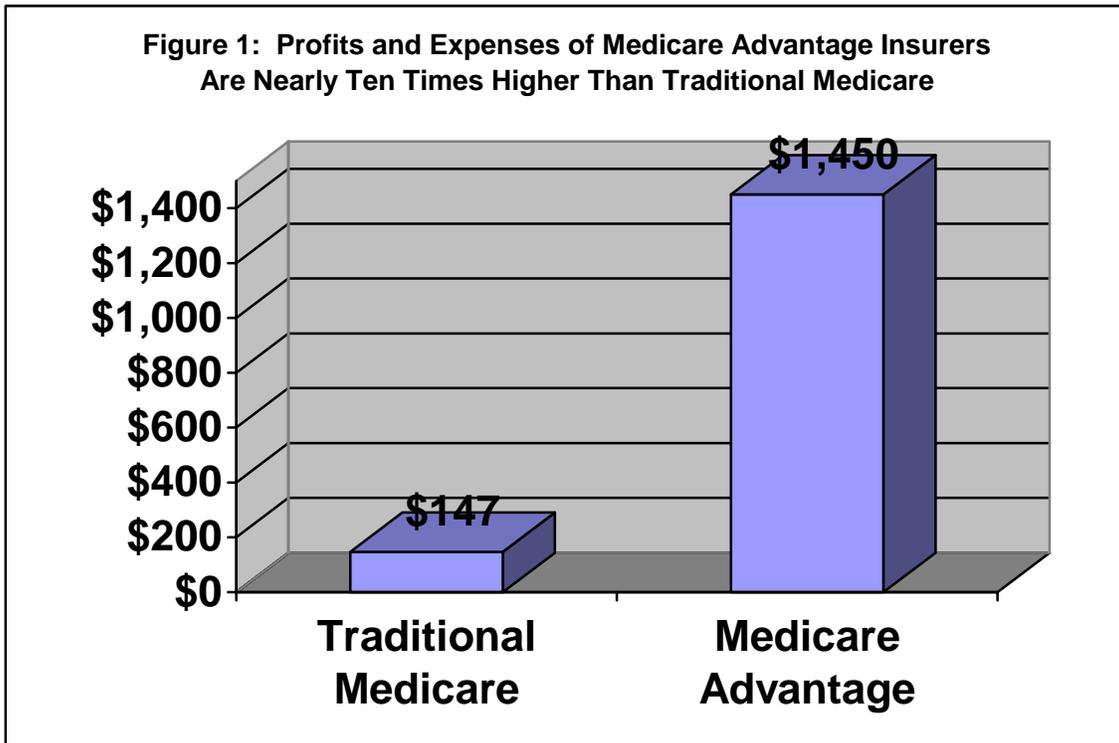
At the request of Committee Chairman Henry A. Waxman and Subcommittee Chairman Bart Stupak, this report offers new insights into the Medicare Advantage market by analyzing data from 34 major Medicare Advantage insurers. The Committee obtained information on premium revenues, medical claims payments, marketing costs, administrative expenses, executive compensation practices, corporate events, and profits.

This report finds:

- **From 2005 through 2008, the average Medicare Advantage insurer spent over 15% of premium revenue on profits, marketing, and other corporate expenses.** Two-thirds of the Medicare Advantage insurers surveyed by the Committee had a “medical loss ratio” – the percentage of premium revenue used to pay medical claims – below 85% during at least one of the four years examined. In 2007, one insurer had a medical loss ratio of just 37%, meaning it spent over 60% of its premium revenue on profits, marketing, and other expenses. Six of the insurers had medical loss ratios below 75% in one or more years. In comparison, traditional Medicare spends less than 1.5% on administrative expenses and over 98% on health care. In the aggregate, the Medicare Advantage insurers spent \$1,450 per beneficiary in 2008 on profits, marketing, and other corporate expenses, nearly ten times as much as traditional Medicare spent on administrative expenses.
- **Requiring all Medicare Advantage insurers to have a medical loss ratio of 85% would provide billions of dollars in additional medical services to seniors.** The total amount spent on profits, marketing, and other corporate expenses by Medicare Advantage insurers over the last four years was \$27 billion. The House health care reform bill requires Medicare Advantage plans to spend at least 85% of their total premium revenues on medical claims. If this threshold had been in effect from 2005 through 2008, the Medicare Advantage insurers would have spent an additional \$3 billion on their beneficiaries’ medical care, enough to eliminate all copays for preventive care for all Medicare beneficiaries for ten years.
- **In 2007 and 2008, Medicare Advantage insurers with medical loss ratios lower than 85% paid their executives over \$1.2 billion.** In 2007, a company that had a medical loss ratio of 79% paid an executive over \$35 million. The same company paid 16 more

executives salaries and bonuses worth \$1 million or more. Another company with a medical loss ratio of 79% paid more than \$210 million in compensation to 260 executives. These insurers engage in other lines of business besides Medicare Advantage, and the data did not indicate what portion of the compensation paid to their executives related to Medicare Advantage.

- **Medicare Advantage insurers have spent millions on expensive retreats.** In 2007, one company with a medical loss ratio of 83% spent \$3.1 million for two events in Hawaii. In 2007, a company with a medical loss ratio of 84% spent \$2.5 million on employees and agents at a retreat in San Jose del Cabo, Mexico, and \$1.4 million on an event in Rome, Italy. In 2008, a company with a medical loss ratio of 82% spent \$1.5 million on a meeting in Edinburgh, Scotland, and \$1.8 million on a trip to Cancun, Mexico. As in the case of the executive compensation data, the data on corporate retreats did not indicate what portion of the retreat expenses related to Medicare Advantage.



I. INTRODUCTION

Medicare is a federal health insurance program that insures the elderly, the disabled, and people with End Stage Renal Disease. Medicare provides for the health care of 45 million individuals and accounts for 22% of national health spending and 13% of the federal budget.¹ Traditional Medicare benefits are administered through a fee for service arrangement in which covered individuals receive care from any qualified provider who participates in Medicare. Medicare Advantage, or Medicare Part C, is an alternative to the traditional fee for service Medicare program in which beneficiaries enroll in private health plans, such as health maintenance organizations, preferred provider organizations, or private fee for service organizations, and, with some exceptions, receive benefits similar to what traditional Medicare offers.

Federal payments to Medicare Advantage will total \$110.2 billion in 2009.² Approximately 22% of Medicare beneficiaries are enrolled in Medicare Advantage plans.³ The number of Medicare beneficiaries enrolled in Medicare Advantage has nearly doubled from 5.3 million in 2003 to 10.2 million in 2009.⁴ The number of Medicare Advantage plans has increased dramatically since 2005. In 2005, 190 Medicare Advantage plans were offered; in 2009, 623 Medicare Advantage plans were offered.⁵ This year, all Medicare beneficiaries have access to at least one Medicare Advantage plan.⁶

A. Payment Structure of the Medicare Advantage Program

Under the current payment structure for Medicare Advantage, health insurance companies submit bids to the Secretary of Health and Human Services representing the revenues necessary to provide Medicare services to beneficiaries. The bids include anticipated costs due to medical claims, marketing costs, administrative expenses, and profits. The Secretary compares the companies' bids to local benchmarks. Medicare pays private plans the bid amount if the bids are less than the benchmarks. Those plans bidding below the benchmarks also receive rebates from the federal government of 75% of the difference between the companies' original bids and the determined benchmarks. If a bid is higher than the benchmark, beneficiaries in that Medicare Advantage plan must pay the difference between the bid and the benchmark through additional premiums.⁷

¹ The Henry J. Kaiser Family Foundation, *Medicare Spending and Financing Fact Sheet* (May 2009).

² Congressional Budget Office, *CBO's March 2009 Baseline: Medicare* (Mar. 24, 2009).

³ Medicare Payment Advisory Commission, *Report to Congress: Medicare Payment Policy* (Mar. 2009).

⁴ The Henry J. Kaiser Family Foundation, *Medicare Advantage Fact Sheet* (Nov. 2009).

⁵ Congressional Research Service, *Medicare Advantage*, R40374 (Mar. 3, 2009).

⁶ Medicare Payment Advisory Commission, *Report to Congress: Medicare Payment Policy* (Mar. 2009).

⁷ Medicare Payment Advisory Commission, *Medicare Advantage Program Payment System* (Oct. 2008).

Congress has increased the benchmark payments to Medicare Advantage plans above the amount that is required to pay for medical services in order to increase participation in the program by private insurance companies and to attract plans to rural areas and certain urban centers.⁸ The independent Medicare Payment Advisory Commission (MedPAC) reports that federal payments to Medicare Advantage plans will average 14% more per beneficiary than payments to the traditional Medicare fee for service benefit plan.⁹ MedPAC estimates that Medicare will pay \$12 billion more for Medicare Advantage beneficiaries than it would if the beneficiaries had been enrolled in traditional Medicare in 2009.¹⁰ The Centers for Medicare and Medicaid Services Office of the Actuary found that these overpayments cost all beneficiaries, regardless of whether they are enrolled in the Medicare Advantage program, approximately \$48 annually in extra premiums.¹¹

The Government Accountability Office has found that Medicare Advantage plans on average retained more profits and spent less on medical claims than they estimated in the original bids submitted to the Department of Health and Human Services.¹² MedPAC has determined that the overpayments to Medicare Advantage have led some insurance companies to offer plans that imitate the traditional Medicare fee for service structure, but at significantly higher costs than the federal government would pay under traditional Medicare.¹³ MedPAC found that only half of Medicare beneficiaries nationwide can obtain a plan rated “above average” by the Centers for Medicare and Medicaid Services.¹⁴

⁸ The Henry J. Kaiser Family Foundation, *Medicare Advantage Fact Sheet* (Nov. 2009).

⁹ Medicare Payment Advisory Commission, *Report to Congress: Improving Incentives in the Medicare Program* (June 2009).

¹⁰ *Id.*

¹¹ Letter from Richard S. Foster, Chief Actuary, Office of the Actuary, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, to Rep. Pete Stark, Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives (June 25, 2009).

¹² Letter from James C. Cosgrove, Director, Health Care, U.S. Government Accountability Office, to Rep. Pete Stark, Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives (June 24, 2008); Letter from James C. Cosgrove, Director, Health Care, U.S. Government Accountability Office, to Rep. Pete Stark, Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives (Dec. 8, 2008).

¹³ Medicare Payment Advisory Commission, *Report to Congress: Improving Incentives in the Medicare Program* (June 2009).

¹⁴ *Id.*

B. Legislative Reforms to Medicare Advantage

The House of Representatives passed H.R. 3962, the Affordable Health Care for America Act, on November 7, 2009. H.R. 3962 would gradually reset Medicare Advantage benchmarks to mirror traditional Medicare fee for service rates in each county.¹⁵ As a result, Medicare would no longer pay private health insurance companies more money to provide health care than it costs for Medicare to provide coverage under the traditional fee for service program. The Congressional Budget Office estimates that the readjustment of the Medicare Advantage benchmarks will save \$154 billion from 2010 through 2019.¹⁶ In addition, section 1162 of H.R. 3962 would require the Secretary of Health and Human Services to adjust plan payments for “upcoding,” a practice that makes a plan’s beneficiaries appear sicker than they are and triggers additional payments from Medicare.¹⁷ That provision would save \$15.5 billion, for a total of \$170 billion in savings.¹⁸ Among other reforms, H.R. 3962 would require all private health insurance companies offering Medicare Advantage plans to spend at least 85% of premium revenues on their beneficiaries’ medical claims.¹⁹ It would also require Medicare Advantage plans to have cost sharing no greater than the traditional Medicare fee for service program, meaning that the Medicare Advantage plans would not be able to impose on beneficiaries more of the cost of their care than they would bear under the traditional program.²⁰

The Senate is currently considering The Patient Protection and Affordable Care Act, an amendment in the nature of a substitute to H.R. 3590. This legislation would require the Secretary of Health and Human Services to determine payment rates by averaging the bids submitted by the Medicare Advantage plans in each county.²¹ The Congressional Budget Office estimates that this benchmark realignment will save \$118 billion from 2010 through 2019.²² Section 3203 of the Senate bill would also save \$1.9 billion by adjusting Medicare Advantage payments for upcoding, for a total savings of \$120 billion.²³

¹⁵ Congressional Research Service, *Medicare Program Changes in H.R. 3962, Affordable Health Care for America Act*, R40898 (Nov. 9, 2009).

¹⁶ *Id.*

¹⁷ H.R. 3962 § 1162.

¹⁸ Letter from Douglas W. Elmendorf, Director, Congressional Budget Office, to John D. Dingell, Chairman Emeritus, Committee on Energy and Commerce, U.S. House of Representatives (Nov. 20, 2009).

¹⁹ H.R. 3962 § 1173.

²⁰ H.R. 3962 § 1171.

²¹ Letter from Douglas W. Elmendorf, Director, Congressional Budget Office, to Senator Harry Reid, Majority Leader, U.S. Senate (Nov. 18, 2009).

²² *Id.*

²³ *Id.*

II. METHODOLOGY

This report is based on information provided to the Committee on Energy and Commerce by the top health insurance providers as determined by premium volume. On August 17, 2009, Chairman Henry A. Waxman and Chairman Bart Stupak requested detailed financial information from major health insurers concerning their private and governmental business segments. Additionally, the Committee requested information on executive compensation, profits, and conferences paid for by the companies and held outside company facilities.²⁴

The information requests were sent to the largest health insurance companies by premium volume across private and governmental business segments, representing more than 75% of the total health insurance market. On August 24, 2009, Chairman Waxman and Chairman Stupak narrowed the inquiry to the companies that sell comprehensive health insurance or derive a material amount of revenue from sales of comprehensive health insurance, which resulted in 41 insurers being subject to the Committee's request.²⁵

Among other requests, the Committee sought information from health insurance companies on "premium revenue, claims payments, sales expenses, other general or administrative expenses, and profits . . . for Medicare Advantage."²⁶ The Committee received information from 34 insurers that participate in the Medicare Advantage market.²⁷ All companies provided

²⁴ Letter from Henry A. Waxman, Chairman, Committee on Energy and Commerce, and Bart Stupak, Chairman, Subcommittee on Oversight and Investigations, Committee on Energy and Commerce, to major insurance companies (Aug. 17, 2009).

²⁵ Letter from Henry A. Waxman, Chairman, Committee on Energy and Commerce, and Bart Stupak, Chairman, Subcommittee on Oversight and Investigations, Committee on Energy and Commerce, to major insurance companies (Aug. 24, 2009).

²⁶ Letter from Henry A. Waxman, Chairman, Committee on Energy and Commerce, and Bart Stupak, Chairman, Subcommittee on Oversight and Investigations, Committee on Energy and Commerce, to major insurance companies (Aug. 17, 2009).

²⁷ The 34 insurers are Aetna Inc., Amerigroup Corporation, Blue Cross Blue Shield of Alabama, Blue Cross Blue Shield of Florida, Blue Cross Blue Shield of Massachusetts, Blue Cross Blue Shield of Michigan, Blue Cross Blue Shield of Minnesota, Blue Cross Blue Shield of North Carolina, Blue Cross of South Carolina, Blue Cross Blue Shield of Tennessee, Blue Shield of California, CIGNA Corporation, Coventry Health Care, Group Health Cooperative, Harvard Pilgrim Health Care, Health Care Service Corporation, Health Net, Inc., HealthNow New York, Highmark Inc., Horizon Blue Cross Blue Shield of New Jersey, Humana Inc., Independence Blue Cross, Lifetime Healthcare Companies, Medica, Medical Mutual of Ohio, Molina Healthcare, The Regence Group, Tufts Health Plan, UnitedHealth Group, Universal American Corporation, UPMC Health Plan, WellCare Health Plans, Inc., Wellmark, Inc., and WellPoint. According to the Centers for Medicare and Medicaid Services, these 34 insurers collectively provide coverage to 6.3 million Medicare Advantage beneficiaries. The Committee excluded Kaiser Foundation Health Plan, Inc. from its calculation because of the company's unique role as an insurer that directly provides health care to its subscribers. The Committee excluded

information voluntarily. Because the insurers asserted that the information they provided is proprietary, this report was prepared to present the data without identification of individual health insurance companies.

Each of the 34 Medicare Advantage insurers provided financial information that included premium revenues, claims payments, sales expenses, general and administrative expenses, and profits for the Medicare Advantage market from 2005 through 2008. This information was used to calculate the percentage of premium revenues that each company paid for medical claims during the years surveyed.

In addition to financial information, the Committee requested tables identifying all compensation of employees and officers who received more than \$500,000 in one year. The Committee did not require companies to identify the employees or officers by name. The Committee also reviewed thousands of pages of materials relating to the development of compensation plans, as well as tables listing conferences, retreats, and other events held outside company facilities.

Committee staff spoke with representatives of the Medicare Advantage insurers; received briefings by regulators on medical loss ratio calculations, including by the National Association of Insurance Commissioners and the New Jersey Department of Banking and Insurance; contacted independent experts on the Medicare Advantage program, including experts within the Congressional Research Service and the Government Accountability Office; and spoke to outside experts on executive compensation.

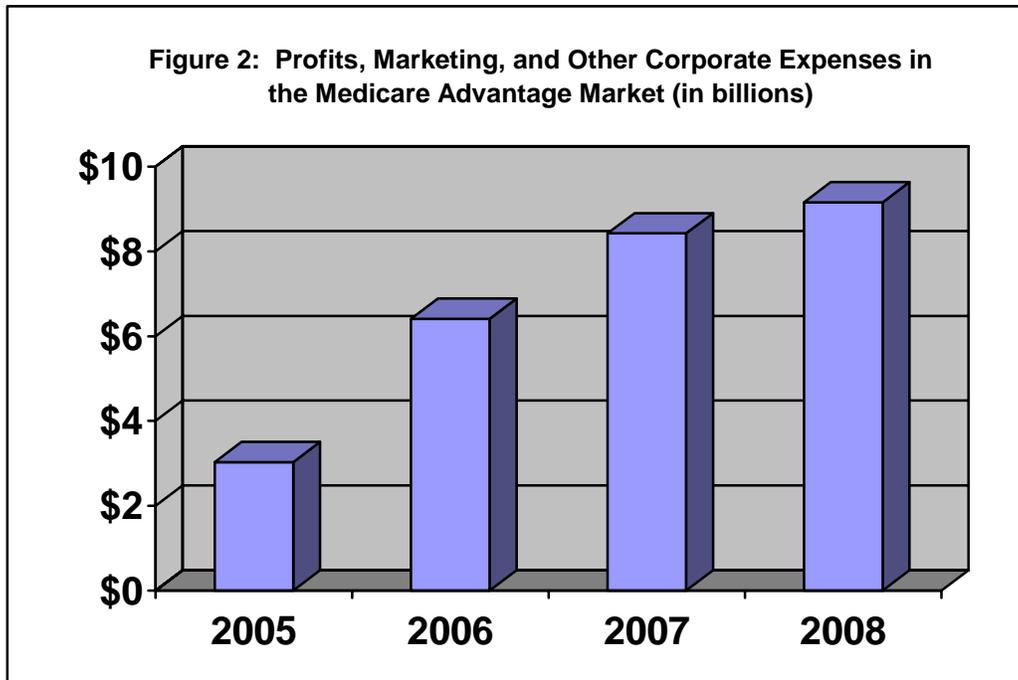
III. FINDINGS

A. Profits, Marketing, and Other Corporate Expenses

From 2005 through 2008, the 34 companies offering Medicare Advantage plans reported over \$27 billion in profits, marketing, and other corporate expenses.

The profits, marketing, and other corporate expenses of the Medicare Advantage insurers increased each year from 2005 through 2008. In 2005, profits, marketing, and other corporate expenses were \$3 billion. Profits, marketing, and other corporate expenses increased to \$6.4 billion in 2006 and \$8.4 billion in 2007. In 2008, profits, marketing, and other corporate expenses reached \$9.1 billion.

CareFirst Blue Cross Blue Shield from its calculation because the company did not report a statistically significant amount of Medicare Advantage business.



In 2008, the profits, marketing, and other corporate expenses of the 34 Medicare Advantage insurers were higher than the administrative expenses for all of traditional Medicare, even though Medicare Advantage only insures 22% of all Medicare beneficiaries. In 2008, when the Medicare Advantage insurers had profits, marketing, and other corporate expenses of \$9.1 billion, the administrative expenses of the traditional Medicare program, which covers 78% of all beneficiaries, were just \$6.5 billion.²⁸

On a per-beneficiary basis, profits, marketing, and other corporate expenses averaged \$1,450 per Medicare Advantage beneficiary in 2008.²⁹ In contrast, traditional Medicare spent only \$147 in administrative costs per beneficiary.

Four companies were unable to provide the Committee with separate accounting for marketing costs distinct from general expenses. For the 30 companies that provided the Committee with information on marketing costs, these expenses totaled \$2.7 billion over the four years. Marketing costs in the Medicare Advantage market include marketing and advertising, brokerage fees, and salaries for marketing executives.

²⁸ The Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2009 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* (May 12, 2009).

²⁹ Excel Spreadsheet of Parent Organization Enrollment 2008 provided by Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, to Committee on Energy and Commerce Staff (Dec. 8, 2009)

B. Medical Claims Payments

A “medical loss ratio,” also referred to as a medical benefit ratio, is the proportion of premium revenues that a health insurance plan uses to pay medical claims. The remaining percentage of premium revenues goes to other expenses such as marketing costs, administrative expenses, executive compensation, and profits. The health insurance reform legislation passed by the U.S. House of Representatives would require Medicare Advantage plans to have medical loss ratios of 85%, which would require all plans to spend at least 85% of their premium revenues on health care services.³⁰

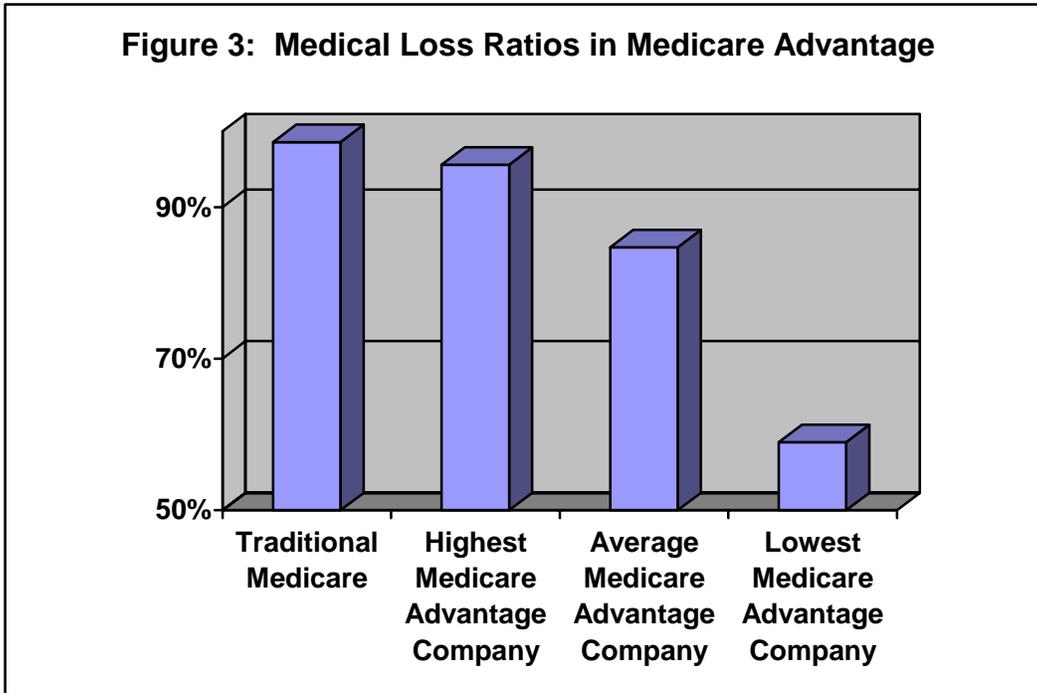
From 2005 through 2008, the medical loss ratio for the 34 Medicare Advantage insurers averaged 84.8%. The average medical loss ratios varied slightly each year. The lowest average medical loss ratio was 83.6% in 2007, and the highest average medical loss ratio was 85.8% in 2008. Over the four year period, the insurance companies surveyed collected \$177 billion in premium revenues for their Medicare Advantage plans and they paid \$150.4 billion in medical claims. Their average medical loss ratio of 84.8% is significantly lower than the medical loss ratio for traditional Medicare, which is 98.6%.

The medical loss ratio varied significantly among companies within the Medicare Advantage market. Twenty-three of the 34 companies in the Medicare Advantage market failed to maintain a medical loss ratio of 85% in one of the four years. Six of the 34 companies spent less than 75% of their premium revenues on their beneficiaries’ medical care in one of the years. Four companies maintained a medical loss ratio below 85% in all of the years they offered a Medicare Advantage plan.

Some companies spent a surprisingly low portion of premium revenues on health care services. For example, in 2007, one company had a medical loss ratio in the Medicare Advantage market of 36%. In the other two years the company offered plans in the Medicare Advantage market, the company had medical loss ratios of 66% and 68%. From 2006 through 2008, this company spent nearly one-third of all its premium revenues on profits, marketing, and other corporate expenses.

Other companies consistently exceeded the 85% level that would be required by the House legislation, indicating that some insurers are able to meet and surpass this standard. Eleven companies maintained a medical loss ratio above 85% for all years they offered Medicare Advantage plans. Six companies spent, on average, more than 90% of premium revenues on the payment of medical claims. One company paid 96% of its revenues from the Medicare Advantage market directly to medical expenses.

³⁰ H.R. 3962 § 1173.



Half of the largest ten Medicare Advantage companies by premium revenue maintained an average medical loss ratio lower than 85%. These five insurers had average medical loss ratios of 84%, 83%, 83%, 82%, and 82%. Together, they account for over \$104 billion in Medicare Advantage revenues from 2005 through 2008 and represent 59% of the total premium revenue of all surveyed companies.

C. Savings from Increasing Medical Loss Ratios

If the insurers whose medical loss ratios were lower than 85% in the Medicare Advantage market had been required to maintain a ratio of 85% over the past four years, the insurers would have spent an additional \$3 billion of their premium revenues on their beneficiaries' medical care, instead of spending the funds on profits, marketing, and other corporate expenses.

The \$3 billion resulting from low medical loss ratios, if returned to the taxpayers, would cover the full price of the House bill's provision to eliminate cost sharing for Medicare preventative services for the next ten years, meaning that beneficiaries would not pay a share of these charges (\$2.7 billion).³¹ Alternatively, this \$3 billion could pay for improved access to flu and other

³¹ Letter from Douglas W. Elmendorf, Director, Congressional Budget Office, to John D. Dingell, Chairman Emeritus, Committee on Energy and Commerce, U.S. House of Representatives (Nov. 20, 2009).

vaccines for the next decade (\$1.5 billion)³² and cover increases in subsidies for low-income beneficiaries for one year (\$1 billion).³³

D. Executive Compensation

Company documents received by the Committee show that some health insurance companies used the medical loss ratio as a performance measure in determining compensation for their top executives. One company used the medical loss ratio as a factor to award restricted stock under the company's long term incentive plan.³⁴ Another company used a "ratio of claims to revenues" as part of its performance criteria for bonus awards.³⁵ Documents from a third company show that the "underwriting margin" is a factor in their long term incentive program.³⁶

In 2007, 13 companies had a medical loss ratio in the Medicare Advantage market lower than 85%. These 13 companies paid 544 executives over \$500,000 in 2007, compensating them, in total, over \$841 million. In 2008, nine companies maintained a medical loss ratio in the Medicare Advantage market lower than 85%. These nine companies compensated 357 senior executives more than \$500,000 each that year, awarding them total compensation of more than \$370 million.

One company that had a medical loss ratio of 79% in 2007 paid over \$35 million to a single executive that same year. In addition, the same company awarded compensation packages worth more than \$1 million each to 16 other executives. In 2007, a company with a medical loss ratio of 83% compensated 77 executives more than \$79 million. That same year, a company with a medical loss ratio of 79% paid more than \$210 million to 260 executives.

In 2008, the company with the lowest medical loss ratio of 66% awarded \$34 million in compensation to 16 executives. Four companies with a medical loss ratio below 80% compensated 57 executives over \$105 million. One company with a medical loss ratio of 82% paid over \$128 million to 180 of its executives.

The insurers that provided data on Medicare Advantage to the Committee generally engage in other lines of business. In the examples described in this section, the percentage of company revenue attributable to Medicare Advantage ranged from less than 5% to over 45%. The companies that provided data to the Committee did not include a basis for attributing executive compensation specifically to their Medicare Advantage line of business.

³² *Id.*

³³ *Id.*

³⁴ *Long-Term Incentive Plan (Amended and Restated Effective as of January 1, 2008)* (Jan. 1, 2008) [redacted]-HEC-00361-00362.

³⁵ Letter from Senior Vice President to Members of the Committee on Compensation and Organization (Feb. 17, 2005) [redacted]-EC1-00397.

³⁶ Human Resources Committee, *2006 Incentive Programs – Status* (Feb. 1, 2007) [redacted]-EC-00096.

E. Executive Retreats

Documents obtained by the Committee show that companies that spent less than 85% of their Medicare Advantage premium revenues on medical care funded expensive retreats for company executives, brokers, and board members. In all, the 23 companies that did not maintain medical loss ratios of 85% in all four years reported to the Committee that they paid \$121 million for 355 events that cost more than \$100,000 each between 2007 and 2009. Many companies reported expending large sums on one single event.

One insurance company with a medical loss ratio of 82% in 2008 spent nearly \$2 million that year to send 445 employees to Cancun, Mexico for a week-long sales meeting.³⁷ That same year, the company also paid over \$1.5 million to send 198 employees to a broker meeting in Edinburgh, Scotland.³⁸

An insurer with a medical loss ratio of 83% in 2008 spent \$1.4 million on a “President’s Award Trip” in Colorado Springs, Colorado.³⁹ The year before, when its medical loss ratio was 84%, it spent \$2.5 million to send employees and agents on a retreat in San Jose del Cabo, Mexico, and over \$1.4 million on an event in Rome, Italy.⁴⁰

In 2007, an insurer with a medical loss ratio of 83% spent \$3.1 million for two events in Kauai and Kohala Coast, Hawaii.⁴¹

³⁷ Letter from Counsel to Henry A. Waxman, Chairman, Committee on Energy and Commerce, and Bart Stupak, Chairman, Subcommittee on Oversight and Investigations, Committee on Energy and Commerce (Sept. 25, 2009) [redacted]-EC1-048233.

³⁸ *Id.*

³⁹ Letter from Counsel to Henry A. Waxman, Chairman, Committee on Energy and Commerce, and Bart Stupak, Chairman, Subcommittee on Oversight and Investigations, Committee on Energy and Commerce (Sept. 4, 2009).

⁴⁰ *Id.*

⁴¹ Letter from Counsel to Henry A. Waxman, Chairman, Committee on Energy and Commerce, and Bart Stupak, Chairman, Subcommittee on Oversight and Investigations, Committee on Energy and Commerce (Sept. 10, 2009) [redacted]-ECC-00138 – 00143,

**Table 1: Selected Executive Retreats
2007 – 2008**

Location	Year	Total Cost	Medical Loss Ratio
San Jose del Cabo, Mexico	2007	\$2.56 million	83.9%
Cancun, Mexico	2008	\$1.83 million	82.1%
Kauai, Hawaii	2007	\$1.64 million	83.3%
Edinburgh, Scotland	2008	\$1.53 million	82.1%
Kohala Coast, Hawaii	2007	\$1.52 million	83.3%
Rome, Italy	2007	\$1.49 million	83.9%
Colorado Spring, Colorado	2008	\$1.45 million	83.2%

The insurers that provided data on Medicare Advantage to the Committee generally engage in other lines of business. In the examples described in this section, the percentage of company revenue attributable to Medicare Advantage ranged from 20% to over 60%. The companies that provided data to the Committee did not include a basis for attributing the expenses of the retreats specifically to their Medicare Advantage line of business.

CONCLUSION

The data provided to the Committee indicate that Medicare Advantage insurers expended significant sums on profits, marketing, and other corporate expenses. Last year, the insurers spent an average of \$1,450 per beneficiary on profits, marketing, and other corporate expenses, nearly ten times as much as traditional Medicare spent on administrative expenses. On average, the insurers had a medical loss ratio of 84.8% from 2005 through 2008. Many of the insurers had medical loss ratios below 85%, including one insurer that had a medical loss ratio below 40% in 2007. In contrast, traditional Medicare has a medical loss ratio of over 98%. If all Medicare Advantage plans had spent at least 85% of their premium dollars on medical care from 2005 through 2008, they would have spent an additional \$3 billion on their beneficiaries' medical care.