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Report to Congressional Committees

September 2024

BEHAVIORAL HEALTH

Information on Cost-Sharing in Medicare and Medicare Advantage

GAO-24-106794

GAO Highlights

Highlights of GAO-24-106794, a report to congressional committees

September 2024

BEHAVIORAL HEALTH

Information on Cost-Sharing in Medicare and Medicare Advantage

Why GAO Did This Study

Behavioral health conditions were estimated to affect at least one-quarter of the 66.7 million Medicare beneficiaries in the U.S. in 2023. Treatment for behavioral health disorders can help individuals manage their symptoms, reduce or stop substance use, and improve their quality of life.

The Consolidated Appropriations Act, 2023, includes a provision for GAO to review behavioral health benefits in traditional Medicare and MA. This report describes (1) cost-sharing for behavioral health basic benefits in traditional Medicare and MA plans in 2024, (2) the scope of behavioral health supplemental benefits offered by MA plans in 2024, and (3) CMS's oversight of cost-sharing in MA plans for behavioral health services.

GAO analyzed CMS data and manuals on basic benefits and cost-sharing for behavioral health services in traditional Medicare and MA plans in 2024 and supplemental benefits offered by MA plans in 2024. GAO's analysis included 5,702 MA plans that were health maintenance organization, preferred provider organization, and special needs plans. It excluded other plan types such as private fee-for-service and employer plans. The plans in GAO's analysis covered about 82.3 percent of MA beneficiaries in CMS's February 2024 enrollment data.

GAO also reviewed CMS guidance, regulations, and other documents and interviewed CMS officials to obtain information about CMS's oversight efforts.

View GAO-24-106794. For more information, contact Leslie V. Gordon at (202) 512-7114 or GordonLV@gao.gov.

What GAO Found

Medicare covers inpatient and outpatient services for the diagnosis and treatment of behavioral health conditions, which include mental health and substance use disorders. Both traditional Medicare and Medicare Advantage (MA) plans—the private plan alternative to traditional Medicare—are required to offer these as basic benefits.

Examples of Behavioral Health Services Covered by Medicare, 2024

Service category	Type of benefit
Inpatient services	• Acute inpatient hospitalization • Psychiatric inpatient hospitalization
Outpatient services	• Psychotherapy • Visits with a physician (including psychiatrist) or other behavioral health providers • Partial hospitalization program services • Opioid use disorder treatment services • Screenings for depression, alcohol misuse, or other behavioral health conditions

Source: Centers for Medicare & Medicaid Services documents. | GAO-24-106794

Note: Medicare beneficiaries who experience an acute behavioral health crisis can receive inpatient services either in an acute care hospital or in an inpatient psychiatric hospital.

Beneficiaries in traditional Medicare and MA plans had cost-sharing for many of these behavioral health benefits in 2024. Cost-sharing is the portion of costs that beneficiaries are expected to pay, such as deductibles, coinsurance, and co-payments.

- Traditional Medicare beneficiaries generally had deductibles and coinsurance for inpatient behavioral health services, and coinsurance for many outpatient behavioral health services in 2024. For example, beneficiaries were required to pay 20 percent of the Medicare-approved amount in coinsurance for an individual session with a mental health provider in 2024.
- Beneficiaries in most of the MA plans in GAO's analysis had co-payments for both inpatient and outpatient behavioral health services although exact co-payment amounts varied. For example, at least 70 percent of MA plans GAO analyzed required beneficiary co-payments for an individual session with a mental health provider, and the median amount was $30.

MA plans can also offer behavioral health supplemental benefits not covered by traditional Medicare. For example, about 8 percent of plans in GAO's analysis covered additional days of an inpatient psychiatric hospitalization. In addition, almost 30 percent of plans covered additional sessions of smoking and tobacco cessation counseling as an outpatient service in 2024.

The Centers for Medicare & Medicaid Services (CMS) oversees MA plans' overall cost-sharing through several efforts. These efforts generally do not focus specifically on behavioral health services. For example, to help protect beneficiaries from significant out-of-pocket costs, CMS sets limits on cost-sharing that MA plans can charge beneficiaries. In addition, CMS audits plans' coverage of a sample of services to determine whether plans are charging the plans' agreed-upon out-of-pocket costs. These audits may include behavioral health services if they are in the sample.

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Abbreviations

CMS	Centers for Medicare & Medicaid Services
HMO	health maintenance organization
MA	Medicare Advantage
PPO	preferred provider organization
SNP	special needs plan

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U.S. GOVERNMENT ACCOUNTABILITY OFFICE
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September 11, 2024

The Honorable Ron Wyden
Chair
The Honorable Mike Crapo
Ranking Member
Committee on Finance
United States Senate

The Honorable Cathy McMorris Rodgers
Chair
The Honorable Frank Pallone, Jr.
Ranking Member
Committee on Energy and Commerce
House of Representatives

The Honorable Jason Smith
Chair
The Honorable Richard Neal
Ranking Member
Committee on Ways and Means
House of Representatives

Behavioral health conditions, which include mental health conditions and substance use disorders, affect many Medicare beneficiaries. Mental health conditions were estimated to affect one-quarter of the 66.7 million Medicare beneficiaries in the U.S. in 2023, according to the Centers for Medicare & Medicaid Services (CMS).[1] Treatment for behavioral health conditions can help individuals manage their symptoms, reduce or stop substance use, and improve their quality of life. When these disorders go untreated, individuals may suffer potential consequences, such as worsening health, frequent emergency department visits, hospitalizations,

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[1]We define behavioral health conditions as all mental health conditions and substance use disorders that are included in the Diagnostic and Statistical Manual of Mental Disorders. Examples of mental health conditions include anxiety disorders; mood disorders, such as depression; post-traumatic stress disorder; and schizophrenia. Examples of substance use disorders include alcohol use disorder and opioid use disorder.

Centers for Medicare & Medicaid Services, "Innovation in Behavioral Health (IBH) Model," accessed May 17, 2024, https://www.cms.gov/priorities/innovation/innovation-models/innovation-behavioral-health-ibh-model.

or premature death.[2] For these reasons, access to services is important for Medicare beneficiaries to manage their behavioral health conditions. There have been longstanding concerns in the U.S. about the accessibility of mental health services, even for those with health coverage. We have previously reported on shortages of qualified behavioral health providers, including shortages of mental health professionals.[3]

Traditional Medicare and Medicare Advantage (MA), Medicare's private plan alternative, are required to cover a range of services for diagnosing and treating behavioral health conditions.[4] Beneficiaries in both traditional Medicare and MA pay a portion of the costs for behavioral health services (referred to as cost-sharing). In addition to the basic benefits in traditional Medicare and MA plans, MA plans also can offer supplemental benefits related to behavioral health conditions. Supplemental benefits can be enhancements of basic benefits or additional benefits that are not included in traditional Medicare.[5]

CMS administers the Medicare program and sets the cost-sharing amounts for traditional Medicare each year. CMS also oversees MA plans, including reviewing benefits that plans offer. In addition, MA plans are able to determine cost-sharing amounts, although they cannot exceed limits set by CMS.[6]

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[2]Centers for Medicare & Medicaid Services, "Innovation in Behavioral Health (IBH) Model."

[3]See GAO, *Behavioral Health: Options for Low-Income Adults to Receive Treatment in Selected States*, GAO-15-449 (Washington, D.C.: June 19, 2015) and *Mental Health Care: Access Challenges for Covered Consumers and Relevant Federal Efforts*, GAO-22-104597 (Washington, D.C.: Mar. 29, 2022).

[4]Under traditional Medicare, CMS pays claims for health care services directly to health care providers. In contrast, CMS pays MA plans a fixed monthly payment per enrollee to provide health coverage no matter how many services are provided or how much those services cost.

In 2024, 50.3 percent of beneficiaries in Medicare are expected to be enrolled in an MA plan, according to the 2023 Medicare Trustees Report. The Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *The 2023 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* (Washington, D.C.: Mar. 31, 2023).

[5]In general, MA plans must offer all benefits covered under traditional Medicare and can choose whether, and to what extent, to offer supplemental benefits.

[6]See 42 C.F.R. § 422.100(f).

The Consolidated Appropriations Act, 2023, includes a provision for us to review the mental health and substance use disorder benefits offered in traditional Medicare and MA.[7] This report describes

1. cost-sharing for behavioral health basic benefits in traditional Medicare and MA plans in 2024,
2. the scope of behavioral health supplemental benefits offered by MA plans in 2024, and
3. CMS's oversight of cost-sharing in MA plans for behavioral health services.

To describe cost-sharing for behavioral health basic benefits in traditional Medicare, we reviewed CMS manuals and other documents for information on benefits and cost-sharing for 2024. To describe MA plans' (a) cost-sharing for behavioral health basic benefits and (b) behavioral health supplemental benefits, we analyzed the plan benefit data submitted by MA plans to CMS for the first quarter of 2024 and enrollment data as of February 2024, which were the most recent data available at the time of our analysis.[8]

We analyzed plan benefit data for 5,702 MA plans in the 50 states, District of Columbia, and Puerto Rico.[9] Our analysis included MA plans that were health maintenance organization (HMO) and preferred provider

[7]Pub. L. No. 117-328, § 4130, 136 Stat. 4459, 5917 (2022).

[8]Our analysis of basic benefits focused on in-network services. Enrollment in MA plans may vary from month to month, including between January and March as MA beneficiaries can switch MA plans or switch to traditional Medicare during this period.

In addition, our analysis focused on benefits and cost-sharing, which are two of several components of MA plans' benefit package. We also analyzed two other components of a plan's benefit package—authorizations and referrals. We did not analyze other components of a plan's benefit package, such as provider networks and other utilization management tools (e.g., treatment limits).

[9]We use the term "plan" to refer to each unique set of benefits submitted by an MA organization (the entity that has a contract with the Medicare program to provide coverage). A plan may have multiple segments in which the benefits are the same, but the supplemental benefits, premiums, and cost-sharing can be different in different service areas. In addition, plans may have different enrollment. To provide an aggregate view of benefits and cost-sharing, we analyzed each segment of a plan as a separate, individual plan.

organization (PPO) plans.[10] We also included MA plans that were special needs plans (SNP), which provide care for beneficiaries in one of three classes of special needs, such as having a severe or chronic condition.[11] The 5,702 plans included in our analysis had total enrollment of about 82.3 percent of MA beneficiaries in the February 2024 CMS enrollment data.

We analyzed the plan benefit data for both basic and supplemental benefits using service categories that were either specific to behavioral health services (such as individual sessions with a mental health specialty provider) or could have included behavioral health services (such as acute inpatient hospitalization).[12] For our analysis of supplemental benefits, we focused primarily on mandatory supplemental benefits for which MA beneficiaries receive coverage by being enrolled in the plan.[13]

We assessed the reliability of the plan benefit and enrollment data by reviewing related documentation, interviewing knowledgeable officials, and checking for internal and external consistency for a subset of variables. We determined the data were sufficiently reliable for the purposes of this report.

In addition, to obtain perspectives on benefits and cost-sharing for basic and supplemental benefits in traditional Medicare and MA plans, we interviewed representatives from a nongeneralizable selection of six MA organizations. We selected these organizations to provide variation in enrollment size and geographic location. We also interviewed representatives from a nongeneralizable sample of 11 beneficiary

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[10]We included both HMO and HMO point-of-service plans, local PPOs, and regional PPOs. To ensure comparability between plans in our analysis, we excluded Medicare-Medicaid plans, Program of All-Inclusive Care for the Elderly Plans, Cost plans, private fee-for-service plans, and employer plans.

[11]Medicare beneficiaries can enroll in a SNP if they are dually eligible for Medicare and Medicaid, require an institutional level of care, or have a severe or chronic condition.

[12]In general, plans must offer benefits uniformly to all beneficiaries in their plans. We did not conduct a separate analysis of certain flexibilities—such as the Value-Based Insurance Design model—that allow MA plans to offer specific benefits to a subset of beneficiaries enrolled in the plan. However, we included plans that used those flexibilities in our analysis.

[13]Nearly all of the supplemental benefits data we analyzed were for mandatory benefits. A small number of MA plans also offered optional supplemental benefits for certain benefits we analyzed, which individual MA beneficiaries must specifically elect to receive coverage and pay a separate premium.

advocacy and research organizations, and associations representing behavioral health providers.

To describe CMS's efforts to oversee cost-sharing in MA plans for behavioral health services, we reviewed CMS guidance, regulations, and other reports. We also interviewed CMS officials about their oversight efforts.

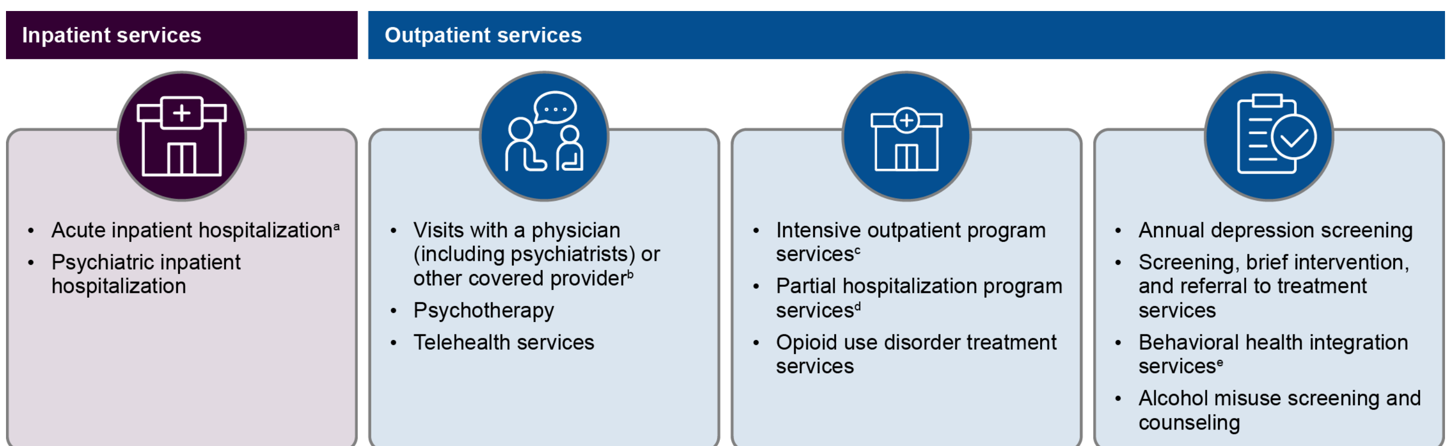
We conducted this performance audit from April 2023 to September 2024 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Medicare Coverage for Behavioral Health Services

Medicare covers certain inpatient and outpatient services for the diagnosis and treatment of behavioral health conditions. (See figure 1.)

Figure 1: Key Behavioral Health Services Covered under Medicare



Source: GAO analysis of CMS information (text); artnazu/stock.adobe.com. | GAO-24-106794

[a]Medicare beneficiaries who experience an acute behavioral health crisis can receive inpatient services either in an acute care hospital or in an inpatient psychiatric hospital.

[b]Other covered providers include clinical psychologists, licensed clinical social workers, nurse practitioners, clinical nurse specialists, certified nurse-midwives, physician assistants, marriage and family therapists, and mental health counselors.

[c]An intensive outpatient program is a distinct and organized outpatient program of psychiatric services for patients who have an acute mental illness. This program provides treatment at a level more intense than outpatient day treatment or psychosocial rehabilitation, but less intense than a partial hospitalization program.

[d]Partial hospitalization program services are structured programs of outpatient psychiatric services as an alternative to inpatient psychiatric care.

[e]Behavioral health integration services, such as care planning, ongoing assessments, medication support, and counseling, are services to help manage behavioral health conditions.

Medicare covers behavioral health services delivered by a range of providers, including physicians, clinical psychologists, licensed clinical social workers, nurse practitioners, clinical nurse specialists, certified nurse-midwives, physician assistants, marriage and family therapists, and mental health counselors. In order to bill for services provided to Medicare beneficiaries, providers must enroll with CMS. Medicare will not pay for any services furnished by providers who are not enrolled, so in these cases, beneficiaries must pay the provider's entire charge out of pocket.

Cost-Sharing

Both traditional Medicare and MA plans require beneficiaries to pay cost-sharing for certain covered services.[14] Medicare has three common forms of cost-sharing.

- **Deductibles.** The amount beneficiaries pay for covered services before traditional Medicare or the MA plan starts to pay.[15]
- **Co-payments.** A fixed amount beneficiaries pay for covered services after paying any required deductible.
- **Coinsurance.** The amount (usually a percentage of the traditional Medicare- or MA plan-approved amount for the service) beneficiaries pay for covered services after paying any required deductible.

Each year, MA plans determine how much beneficiaries will pay in cost-sharing for covered services, and the overall cost-sharing must be actuarially equivalent to the cost-sharing charged to traditional Medicare

[14]In addition to cost-sharing for specific services, beneficiaries may also pay a premium—a standard amount typically paid monthly for coverage through traditional Medicare or MA.

[15]MA plans can have deductibles that are specific to certain services. They can also have a plan-level deductible—a deductible that applies collectively to several services and often needs to be paid before services are covered by the MA plan.

beneficiaries.[16] MA plans also have a yearly limit on beneficiaries' out-of-pocket costs for covered services (e.g., co-payments, coinsurance, and deductibles) that beneficiaries may pay for covered services, while traditional Medicare does not.[17]

In general, when beneficiaries first become eligible for Medicare, they can purchase a Medigap plan (a private insurance plan) to help cover some of the cost-sharing in traditional Medicare.[18] Beneficiaries pay a premium for a Medigap plan. They may also be eligible for other programs, such as Medicaid, that may help with their cost-sharing.

MA Plans and Bid Process

MA plans operate under annual contracts with CMS and can differ from traditional Medicare in several ways. While MA plans are required to offer the same basic benefits in traditional Medicare, they differentiate their services through the other benefits they offer and out-of-pocket fees to beneficiaries. Specifically, plans can offer supplemental benefits, charge different cost-sharing within certain limits, and determine whether a service requires prior authorization or a referral.[19]

There are several types of MA plans, and beneficiaries may have different provider networks and varying referral requirements depending on the plan type. For example, HMOs generally cover providers within the plan's network and require referrals for specialist care.[20] Meanwhile, PPOs may allow beneficiaries to receive services from providers outside of the plan's

[16]42 C.F.R. § 422.100(f)(6). Actuarial equivalence is demonstrated, at the time of bid submission, by a qualified actuary's certification that overall cost-sharing in an MA plan is no more than the overall cost-sharing in traditional Medicare. CMS reviews the MA bid submissions to ensure compliance.

[17]42 C.F.R. § 422.100(f)(4).

[18]Under federal law, beneficiaries have a one-time Medigap open enrollment period during the first six months they are both age 65 or older and are enrolled in the medical insurance portion of Medicare (Part B). During this open enrollment period, they cannot be denied enrollment or charged more due to their health history. 42 U.S.C. § 1395ss(s)(2). After the open enrollment period, beneficiaries may not be able to enroll in a Medigap plan or they may have to pay more to enroll. Medigap plans do not cover cost-sharing for MA beneficiaries.

[19]Prior authorization is a pre-approval from an insurance plan to cover a service, drug, or supplies. There is limited use of prior authorization in traditional Medicare. A referral is a written order from a primary care provider to receive specialist care or certain other medical services.

[20]For HMOs, certain services such as emergency care are covered even if they are out of the plans' network. Additionally, HMO point-of-service plans may allow beneficiaries to receive some services from out-of-network providers for higher cost-sharing.

network and may charge higher cost-sharing for those services.[21] Additionally, PPOs do not generally require a referral for specialist care. There are also SNPs that provide benefits to beneficiaries with particular needs, such as those with chronic conditions or those who require an institutional level of care.[22] SNPs can either be an HMO or PPO.

MA plans submit bids annually with information on plan benefits and cost-sharing. These bids outline the estimated total monthly amount required for the coverage of basic benefits for beneficiaries, as well as the cost to the plans for providing any offered supplemental benefits. CMS reviews the bids annually and can conduct negotiations with plans regarding the estimated bid amounts.[23]

CMS's Role in MA Plan Oversight

CMS sets MA program requirements and rules and conducts oversight of MA plans through a number of efforts. For example, CMS sets limits on how much MA plans can require beneficiaries to pay in annual maximum out-of-pocket costs—the maximum amount that an MA beneficiary would have to pay in cost-sharing for all covered services.[24] CMS also limits

[21]There are both regional and local PPOs. Regional PPOs operate in one or multiple of the 26 MA regions determined by CMS. Local PPOs operate in a smaller service area, typically one or multiple counties.

[22]There are three types of SNPs: (1) Chronic condition SNPs, which are for beneficiaries with severe or chronic conditions; (2) Dual-eligible SNPs, which are for individuals eligible for both Medicare and Medicaid; and (3) Institutional SNPs, which are for individuals who require an institutional level of care.

[23]For each MA beneficiary, CMS pays MA plans a monthly amount determined by the plan's estimated costs to provide basic benefits in relation to a benchmark, which is the maximum amount the Medicare program will pay MA plans in a given locality or region. If a plan's bid is less than the benchmark, a portion of the difference is paid to the MA plan as a rebate, which must be used to reduce premiums or cost-sharing or to provide supplemental benefits for plan beneficiaries. If a plan's bid exceeds the benchmark, the plan will charge each of its beneficiaries an additional premium to make up the difference. See 42 C.F.R. part 422, subpart F.

[24]MA plans choose the maximum out-of-pocket amount for their benefit design. The maximum amount must fall within one of three maximum levels that CMS sets annually to limit the beneficiary's out-of-pocket costs: a mandatory limit (the highest possible amount), an intermediate limit, and a lower limit. Plans with a maximum amount that falls within the highest allowed maximum level (i.e., mandatory) have lower limits on what they can require beneficiaries to pay in cost-sharing for individual service categories. Conversely, plans that have chosen the lower maximum level have higher limits on what beneficiaries pay in cost-sharing for individual service categories. See 42 C.F.R. § 422.100(f)(4)-(6).

how much MA plans can require beneficiaries to pay in cost-sharing for specific services.[25]

In addition, CMS reviews and conducts audits of MA plans. For example, CMS validates the benefit and cost-sharing information in MA plan bid and benefit packages before bids are accepted to ensure MA plans are complying with CMS rules. CMS conducts different types of audits of MA plans. These include audits—called Medicare Part C and D Program audits—to ensure plans provide beneficiaries with the appropriate health services and medications as required under their contracts with CMS, and financial audits. If compliance issues are identified, CMS has a number of tools it can use to correct noncompliance.[26]

Beneficiaries Had Cost-Sharing for Many Basic Behavioral Health Services in Traditional Medicare and Most MA Plans

In 2024, beneficiaries in traditional Medicare were required to pay cost-sharing for many behavioral health services. Their cost-sharing was typically in the form of deductibles and coinsurance for both inpatient and outpatient services. Beneficiaries enrolled in most of the 5,702 MA plans in our analysis had co-payments for the inpatient and outpatient behavioral health services we reviewed.

Beneficiaries Generally Had Deductibles and Coinsurance for Inpatient and Outpatient Behavioral Health Services in Traditional Medicare

Cost-sharing for beneficiaries in traditional Medicare was generally in the form of deductibles and coinsurance in 2024 for the inpatient behavioral health services we examined. For outpatient behavioral health services, beneficiary cost-sharing was typically in the form of coinsurance. Beneficiaries in traditional Medicare can receive assistance with cost-sharing in a few ways, including purchasing a Medigap plan.

[25]See 42 C.F.R. § 422.100(f)(6)(iii).

[26]CMS compliance actions include notices of noncompliance, warning letters, and requests for corrective action plans. Enforcement actions include civil money penalties, enrollment and marketing sanctions, and contract terminations.

Inpatient Services

Hypothetical Example of Cost-Sharing for Inpatient Behavioral Health Service for a Traditional Medicare Beneficiary

A traditional Medicare beneficiary was diagnosed with alcohol use disorder. He has been struggling with alcohol dependence for several years and experienced withdrawal symptoms when he tried to quit or cut back on alcohol. He was admitted to an inpatient treatment center to undergo medically supervised detoxification for 10 days.

Under traditional Medicare in 2024, this beneficiary would need to pay the $1,632 deductible for his 10-day hospitalization and would have additional cost-sharing for any services provided by doctors or certain other providers during his hospital stay.

Source: GAO analysis based on Centers for Medicare & Medicaid Services documents and other documents. | GAO-24-106794

In traditional Medicare, beneficiaries were required to pay a deductible of $1,632 for days 1 to 60 of an acute or psychiatric inpatient hospital stay in 2024.[27] For hospitalizations longer than 60 days, beneficiaries were required to pay a coinsurance amount for each additional day, and there were limits on how many days of a hospitalization were covered per benefit period, which refers to consecutive days of receiving covered services. In addition, for inpatient hospitalizations in freestanding inpatient psychiatric facilities, beneficiaries are limited to coverage for 190 days in total over the course of their lifetime. Traditional Medicare beneficiaries were not required to pay a co-payment for these inpatient hospitalizations beyond the deductible and coinsurance. See table 1.

Table 1: Cost-Sharing in Traditional Medicare for Selected Behavioral Health Inpatient Services, 2024

Selected inpatient services	Deductible	Coinsurance	Co-payment
Acute inpatient hospitalization Psychiatric inpatient hospitalization	$1,632 for days 1-60	$408 per day for days 61-90, $816 per day for days 91-150[a,b]	None

Source: Centers for Medicare & Medicaid Services documents. | GAO-24-106794

Note: Medicare beneficiaries who experience an acute behavioral health crisis can receive inpatient services either in an acute care hospital or in an inpatient psychiatric hospital.

[a]Days 91-150 are referred to as lifetime reserve days. Beneficiaries in traditional Medicare have 60 days of inpatient hospital services over the course of their lifetime to cover any inpatient hospital services that last more than 90 days in a benefit period. A benefit period refers to consecutive days of receiving covered services. A new benefit period starts after the beneficiary has not received inpatient services for 60 consecutive days. For inpatient hospitalizations in freestanding inpatient psychiatric facilities, beneficiaries are limited to coverage for 190 days in total over the course of their lifetime.

[b]Beneficiaries in traditional Medicare may need to pay 20 percent coinsurance of the Medicare-approved amount for clinician services that they receive during an acute or psychiatric inpatient hospitalization.

[27]Medicare beneficiaries who experience an acute behavioral health crisis can receive inpatient services either in an acute care hospital or in an inpatient psychiatric hospital. The deductible must be paid for each benefit period, which is a period of consecutive days of receiving covered services.

Outpatient Services

Hypothetical Example of Cost-Sharing for Outpatient Behavioral Health Services for a Traditional Medicare Beneficiary

A traditional Medicare beneficiary has been experiencing feelings of prolonged sadness, fatigue, loss of interest in leisure activities, and insomnia for the past 6 months. She complains that she has a difficult time concentrating and is unable to complete tasks in her home. She recently saw a psychiatrist who diagnosed her with depression and prescribed antidepressant medications. She also started weekly 45-minute cognitive behavioral therapy sessions with a mental health counselor to develop healthy coping mechanisms to manage her symptoms of depression.

The beneficiary had already met her annual $240 deductible for other health care services she received under traditional Medicare in 2024. For the depression treatment, she paid 20 percent coinsurance for the visit with the psychiatrist (which was about $39 for the $194 Medicare-approved amount) and 20 percent coinsurance for each visit with the mental health counselor (which was about $15 for the $77 Medicare-approved amount).

Source: GAO analysis based on Centers for Medicare & Medicaid Services documents and other documents. | GAO-24-106794

In traditional Medicare, beneficiaries were required to pay an annual deductible of $240 in 2024 for certain outpatient services, including for behavioral health services. The deductible was applied collectively across several outpatient services, including services without a behavioral health component and services related to or specific to behavioral health (such as visits with mental health providers, psychiatry services, and opioid treatment programs). For example, the amounts paid by a Medicare beneficiary who received services from three different specialist physicians would all count toward the $240 deductible.

In addition to the deductible, traditional Medicare beneficiaries had a 20 percent coinsurance of the Medicare-approved amount for most outpatient behavioral health services in 2024. For example, in a 60-minute individual session with a psychiatrist, the Medicare-approved payment was about $150, which means the beneficiary would be required to pay about $30 in coinsurance for that visit.[28]

Traditional Medicare beneficiaries were generally not required to pay co-payments in 2024 for the outpatient behavioral health services we examined (with the exception of emergency department services). In addition, traditional Medicare beneficiaries were not required to pay cost-sharing for certain services, including preventive services, wellness exams, and behavioral health screenings (such as for depression and alcohol misuse). See table 2.

Table 2: Cost-Sharing in Traditional Medicare for Selected Behavioral Health Outpatient Services, 2024

	Deductible[a]	Coinsurance[b]	Co-payment
Behavioral health-specific services			
Partial hospitalization[c]	●	●[d]	—
Individual or group sessions for mental health specialty services	●	●	—
Individual or group sessions for psychiatric services	●	●	—
Individual or group sessions for outpatient substance use services	●	●	—
Opioid treatment program services	●	—	—
Depression screening, alcohol misuse screening, and counseling and early intervention for nondependent substance use	—	—	—
Smoking and tobacco use cessation counseling sessions[e]	—	—	—

[28]The Medicare-approved payment varies geographically so the amount that beneficiaries are required to pay also varies.

	Deductible[a]	Coinsurance[b]	Co-payment
Other services that may include behavioral health services			
Emergency department services	●	●	●
Primary care physician services	—	●	—
Other health care professional	—	●	—
Telehealth services	●	●	—
Preventive services	—	—	—
Wellness exams	—	—	—

Legend: ● = service has that type of cost-sharing; — = service does not have that type of cost-sharing

Source: Centers for Medicare & Medicaid Services documents. | GAO-24-106794

Note: This table includes selected outpatient services that are specific to behavioral health or may include behavioral health services. Other outpatient services that required cost-sharing in traditional Medicare are not included in this table.

[a]The deductible, which was $240 in 2024, applies collectively across several outpatient services.

[b]The coinsurance amount is generally 20 percent of the Medicare-approved amount.

[c]Partial hospitalization is a structured program of outpatient psychiatric services provided as an alternative to inpatient psychiatric care. It is more intensive than the care provided in a mental health provider's office and is provided during the day but does not require an overnight stay.

[d]For partial hospitalization services, Medicare beneficiaries pay a percentage of the Medicare-approved amount for each outpatient service provided. In addition, Medicare beneficiaries pay coinsurance for each day of the partial hospitalization after the outpatient deductible has been met.

[e]Traditional Medicare covers up to eight sessions in a 12-month period.

Assistance with Cost-Sharing

Beneficiaries in traditional Medicare may be able to receive assistance with deductibles, coinsurance, and co-payments for behavioral health services. One primary way is through the purchase of a Medigap plan, which helps cover some of a beneficiary's cost-sharing. For example, the two Medigap plans with the highest enrollment covered 100 percent of the inpatient services deductible, meaning that a beneficiary would not have to pay any of the $1,632 deductible for a psychiatric inpatient hospitalization. In addition, beneficiaries who were eligible for other programs, such as through Medicaid, Veterans Affairs, or employer coverage, could receive assistance with cost-sharing in traditional Medicare.

Beneficiaries Had Co-payments for Behavioral Health Services in Most Medicare Advantage Plans We Analyzed

Beneficiaries in most of the 5,702 MA plans had co-payments for both inpatient and outpatient behavioral health services based on our analysis of 2024 data. In addition to cost-sharing, MA plans have requirements related to prior authorizations, referrals, and out-of-network services.

Inpatient Services

Co-payments. Co-payments were the most common form of cost-sharing for beneficiaries enrolled in MA plans in 2024 for the two inpatient hospitalization service categories we examined. Specifically, about 87 percent and 88 percent of plans in our analysis had co-payments for acute inpatient hospitalization and psychiatric inpatient hospitalization, respectively.[29] Of those plans, most had co-payment amounts that varied based on the beneficiary's length of stay. In contrast, some of these plans required a single co-payment for an acute or psychiatric inpatient hospitalization regardless of the length of the hospital stay.

The median co-payment amounts were generally similar for coverage of acute inpatient hospitalizations and psychiatric inpatient hospitalizations.[30] For example, the median co-payment for a 60-day acute inpatient hospitalization was $1,710, and the median co-payment for a 60-day psychiatric inpatient hospitalization was $1,620. In addition, the co-payment amounts generally leveled off as the length of the hospital stay increased. See table 3.

Table 3: Medicare Advantage (MA) Plans' Median Co-payment for Inpatient Hospitalization by Length of Stay, 2024

Selected inpatient services[a]	Length of stay	Median co-payment for entire stay
Acute inpatient hospitalization	3 days	$900
	6 days	$1,650
	10 days	$1,700
	60 days	$1,710
Psychiatric inpatient hospitalization	8 days	$1,620
	15 days	$1,620
	60 days	$1,620

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data on MA plan benefit packages. | GAO-24-106794

Notes: GAO analyzed in-network services of 5,702 MA plans that were health maintenance organization plans and preferred provider organization plans; this included special needs plans.

GAO's analysis for this table included MA plans that had co-payments for acute inpatient hospitalization (about 87 percent of plans in GAO's analysis) or psychiatric inpatient hospitalization (about 88 percent of plans).

[29]Medicare beneficiaries who experience an acute behavioral health crisis can receive inpatient services either in an acute care hospital or in an inpatient psychiatric hospital.

[30]We calculated the co-payment amount for 3-, 6-, 10-, and 60-day acute inpatient hospitalizations and 8-, 15-, and 60-day psychiatric inpatient hospitalizations in 2024. These lengths of stay are based on the CMS service category cost-sharing limits, which restrict how much MA plans can require beneficiaries to pay in cost-sharing. CMS sets those limits using utilization data for traditional Medicare beneficiaries.

GAO calculated the co-payment for different lengths of stay using the 2024 service category cost-sharing limits that CMS set on acute and psychiatric inpatient hospitalizations, which restricted how much MA plans could require beneficiaries to pay in cost-sharing. CMS's limits for acute inpatient hospitalization were for different lengths of stay than those for psychiatric inpatient hospitalization. In addition, there were plans that required a single co-payment for an acute or psychiatric inpatient hospitalization regardless of the length of the hospital stay, which GAO included in each of the day-stay calculations of the median.

[a]Medicare beneficiaries who experience an acute behavioral health crisis can receive inpatient services either in an acute care hospital or in an inpatient psychiatric hospital.

Hypothetical Example of Co-payment for Inpatient Behavioral Health Service under One Medicare Advantage (MA) plan

An MA beneficiary recently lost a spouse to cancer. His emotional distress has escalated to the point where he isolates himself from his family and is severely depressed. The beneficiary was admitted to a psychiatric hospital and seen by a psychiatrist who evaluated him for depression. His hospitalization lasted for 8 days, and he was placed on a medication regimen to address his emotional distress, stabilize his mood, and alleviate the symptoms of depression.

Under one MA plan in 2024, the beneficiary needed to pay $1,620 as a co-payment for his 8-day hospitalization and would not have a deductible or co-insurance for the hospitalization.

Source: GAO analysis based on Centers for Medicare & Medicaid Services documents and data, and other documents. | GAO-24-106794

Co-payment amounts for acute and psychiatric inpatient hospitalizations varied by plan and SNP type. HMOs generally had slightly lower median co-payment amounts compared with PPOs. In addition, dual-eligible SNPs tended to have higher co-payments for both acute and psychiatric inpatient hospitalizations. Beneficiaries in dual-eligible SNPs may have received assistance with their cost-sharing obligations through the state's Medicaid program. See appendix I for additional details on the percentiles of co-payments for inpatient hospitalizations by plan type and SNP type.

Coinsurance. Very few plans (about 4 percent of the 5,702 plans in our analysis) required beneficiaries to pay coinsurance for acute and psychiatric inpatient hospitalizations. Nearly all of these plans used the Medicare-defined amounts, meaning that beneficiaries would be required to pay the same coinsurance and deductible that are required in traditional Medicare.[31]

Deductibles. None of the 5,702 MA plans in our analysis required their beneficiaries to pay deductibles specific to acute and psychiatric inpatient hospitalizations in 2024. However, these plans could have a plan-level deductible—a deductible that applies collectively to several services and often needs to be paid before services are covered by the MA plan—that may include acute or psychiatric inpatient hospitalizations.

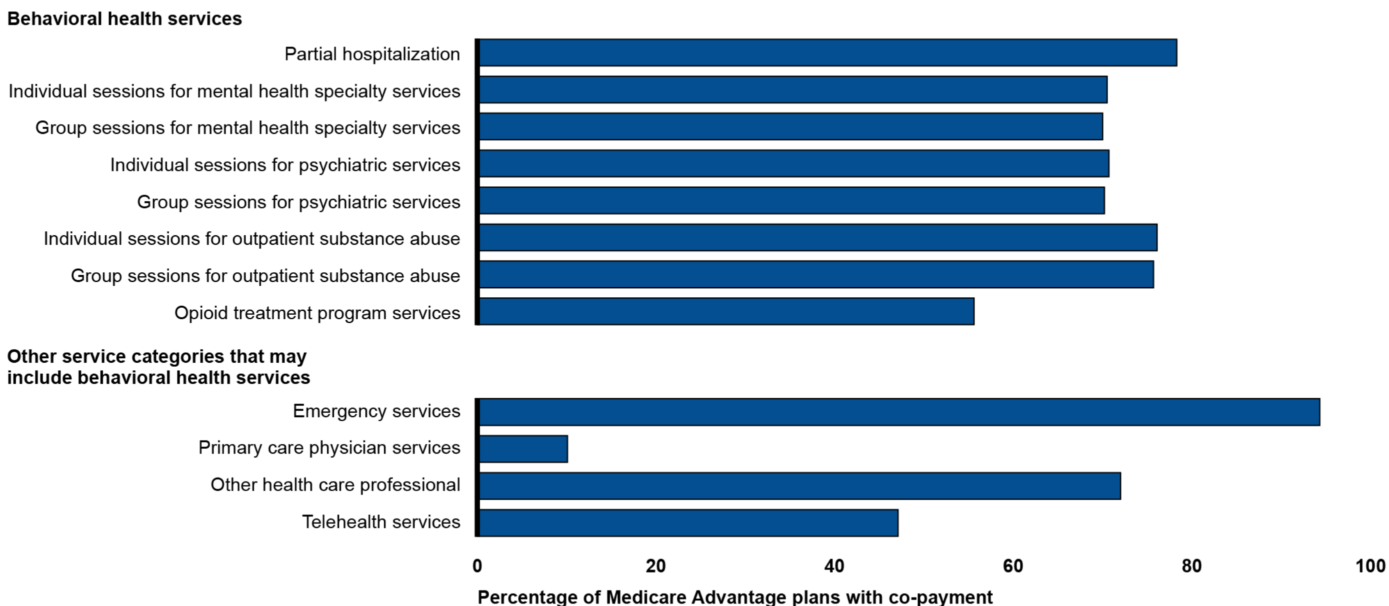
Outpatient Services

Co-payments. Most MA plans (70 percent or more) in our analysis required beneficiary co-payments for the majority of the outpatient behavioral health service categories we examined. For all but one of the behavioral health service categories, about 70 percent or more of MA plans required co-payments for these outpatient services. The one

[31]Traditional Medicare beneficiaries were responsible for a deductible for the first 60 days of an acute or psychiatric inpatient hospitalizations and a coinsurance for stays that lasted more than 60 days in 2024. Specifically, beneficiaries were required to pay a $1,632 deductible for days 1-60, $408 per day in coinsurance for days 61-90 of a hospitalization, and $816 per day for days 91-150.

exception was opioid treatment program services with about 56 percent of plans requiring co-payments. In contrast, for the service categories that may have included behavioral health services (along with non-behavioral health services), the percentage of plans that required co-payments was more varied. For example, about 10 percent of plans required co-payments for primary care physician services whereas 73 percent required co-payments for other health care professional services. See figure 2.

Figure 2: Percentage of Medicare Advantage (MA) Plans with Co-payments for Selected Outpatient Behavioral Health Service Categories, 2024



Source: GAO analysis of plan benefit package data from the Centers for Medicare & Medicaid Services. | GAO-24-106794

Notes: GAO analyzed in-network services of 5,702 MA plans that were health maintenance organization plans and preferred provider organization plans; this included special needs plans.

This figure outlines MA plans with co-payments for selected behavioral health services. When calculating the percentage of plans with a co-payment for each service category, GAO did not consider a plan to have a co-payment if it reported a co-payment of $0. This was to ensure consistency with plans that reported not having a co-payment. In addition, MA plans may require beneficiaries to pay coinsurance for these services, which is not reflected in this figure.

MA plans are also required to cover certain preventive services beyond the selected service categories included in this figure. MA plans need to cover these services without a co-payment or other cost-sharing consistent with traditional Medicare.

Hypothetical Example of Co-payment for Behavioral Health Service under One Medicare Advantage (MA) plan

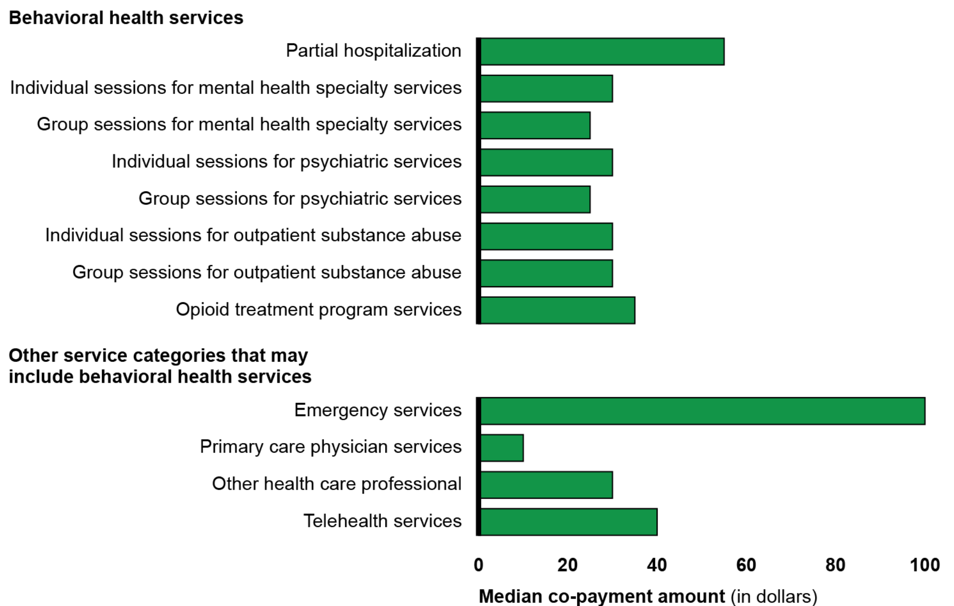
An MA beneficiary has been experiencing excessive worry, restlessness, and physical symptoms, such as trembling and sweating. She reported to a psychiatrist that she had difficulty controlling her anxiety and often found herself avoiding situations that she knew were potential triggers. The psychiatrist prescribed antianxiety medication. She has a follow-up appointment with the psychiatrist every month to review her response to the medication.

Under one MA plan in 2024, the beneficiary would have a $30 co-payment for each visit with the psychiatrist and may pay $360 in total for 12 visits over the course of a year of this treatment.

Source: GAO analysis based on Centers for Medicare & Medicaid Services documents and data, and other documents. | GAO-24-106794

The median co-payment amounts varied in the outpatient service categories we examined.[32] Specifically, the median co-payments for sessions for mental health specialty services, psychiatric services, and outpatient substance abuse services were $30 for individual sessions and $25 or $30 for group sessions. The median co-payment for partial hospitalization services was $55. Officials from one of the MA organizations we spoke with said that they try to minimize the amount of cost-sharing for services that are used frequently, like sessions with a mental health provider. See figure 3.

Figure 3: Median Co-payment Amount for Medicare Advantage (MA) Plans for Selected Outpatient Behavioral Health Service Categories, 2024



Source: GAO analysis of plan benefit package data from the Centers for Medicare & Medicaid Services. | GAO-24-106794

[32]When calculating the percentage of plans with a co-payment for each service category, we did not consider a plan to have a co-payment if it reported a co-payment of $0. This was to ensure consistency with plans that reported not having a co-payment.

Notes: GAO analyzed in-network services for 5,702 MA plans that were health maintenance organization plans and preferred provider organization plans; this included special needs plans.

This figure is based on MA plans in GAO's analysis that had a co-payment for the particular service category. GAO did not consider a plan to have a co-payment if it reported a co-payment of $0. This was to ensure consistency with plans that reported not having a co-payment. The number of MA plans that had co-payments varied for each service category. In addition, MA plans reported a minimum and a maximum co-payment amount in the Centers for Medicare & Medicaid Services (CMS) plan benefit package 2024 data. For this analysis, GAO used the maximum co-payment amount. In addition, MA plans may require beneficiaries to pay coinsurance for these services, which is not reflected in this figure.

MA plans are also required to cover certain preventive services beyond the selected service categories included in this figure. MA plans need to cover these services without a co-payment or other cost-sharing consistent with traditional Medicare.

CMS set limits on how much MA plans can require beneficiaries to pay in cost-sharing for the following outpatient service categories in 2024: partial hospitalization, individual and group sessions for mental health specialty services, and individual and group sessions for psychiatry services.

See appendix I for additional details on the percentiles of co-payments for outpatient services.

Coinsurance. In our analysis, the percentage of MA plans that required beneficiaries to pay coinsurance ranged from about 4 percent for emergency services to about 19 percent for telehealth services.[33] In addition, between 14 and 16 percent of plans had coinsurance for individual or group sessions for mental health specialty services, psychiatric services, or outpatient substance abuse services. The median coinsurance amount was 20 percent for the service categories we analyzed.

Deductibles. No plans required deductibles for the outpatient service categories we analyzed, although these plans may have a plan-level deductible that could include outpatient services.

Requirements for Prior Authorizations, Referrals, and Out-of-Network Services

In addition to cost-sharing, MA plans set requirements for prior authorizations, referrals, and coverage of out-of-network services.

Prior authorizations. Most plans in our analysis required prior authorization—a process through which a health care provider is required to obtain advance approval from the MA plan for services provided to a beneficiary—for most of the behavioral health service categories we examined. However, the percentage of plans requiring prior authorization varied by service category. For example, 93 percent of MA plans in our

[33]This analysis was specific to coinsurance. Some MA plans may charge co-payments in addition to coinsurance for specific services in certain situations.

analysis required prior authorizations for partial hospitalizations while 28 percent of plans required prior authorization for telehealth services. Between 79 and 80 percent of plans required prior authorizations for individual sessions with mental health specialty services, psychiatric services, or outpatient substance abuse services. See appendix I for additional details on prior authorizations.

Referrals. About 9 to 20 percent of MA plans required referrals from a beneficiary's primary care provider for most of the behavioral health services we examined. For example, about 14 to 15 percent of MA plans required referrals for individual sessions with mental health specialty services, psychiatric services, or outpatient substance abuse services. See appendix I for additional details on referrals.

Out-of-network services. Coverage of out-of-network behavioral health services varied depending on the type of MA plan. For example, HMOs do not cover most out-of-network services, so beneficiaries in these plans who received services out of network would be responsible for paying for those services out of pocket. Other MA plans such as PPOs cover out-of-network services and typically require beneficiaries to pay higher cost-sharing than for in-network services.

Beneficiaries seeking behavioral health services out of network potentially have higher costs and more limited access to these services. First, providers of behavioral health services tend to opt out (meaning they choose not to participate) of traditional Medicare and MA plans at higher rates than other providers.[34] As a result, beneficiaries seeking behavioral health services might not be able to easily find a provider that is in their plan's network and instead need to see a provider that is out of network, resulting in higher cost-sharing.[35] Second, many behavioral health services are used frequently, such as weekly sessions with a mental

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[34]For example, according to 2023 analysis from KFF, psychiatrists opted out of traditional Medicare at a rate of 7.7 percent compared with the combined total for all physician specialties at 1.1 percent. KFF, "How Many Physicians Have Opted Out of the Medicare Program?" (Sept. 11, 2023), accessed June 5, 2024, https://www.kff.org/medicare/issue-brief/how-many-physicians-have-opted-out-of-the-medicare-program/. In addition, according to a 2023 study, most MA networks for psychiatrists contained fewer than 25 percent of providers in the plan's service area, and there was not a similar pattern for primary care physicians or other physician specialists. Jane Zhu, et.al., "Psychiatrist Networks in Medicare Advantage Plans Are Substantially Narrower Than in Medicaid and ACA Markets." *Health Affairs*, vol. 42, no. 7 (2023), 909-918.

[35]There may be some limits on the amounts that can be charged by a provider who is out of the MA plan's network but who is a participating Medicare provider.

health provider. The frequency of these services could result in higher total cost-sharing for beneficiaries, especially if the services are provided out of network.

Some MA Plans Offered Supplemental Benefits Specific to Behavioral Health

Some MA plans offered supplemental benefits for behavioral health-specific services not covered by traditional Medicare.[36] For example, of the 5,702 plans included in our analysis for 2024, about 8 percent offered additional days of an inpatient psychiatric hospitalization. In addition, almost 30 percent of plans offered additional sessions of smoking and tobacco cessation counseling as an outpatient supplemental benefit in 2024.

Inpatient services. About 8 percent of MA plans in our analysis offered additional days during a psychiatric inpatient hospitalization as a supplemental benefit.[37] Fewer plans (about 1 percent or less) offered other inpatient stay options, which would not be approved according to Medicare coverage guidelines, or room upgrades (e.g., a private room or access to a telephone and television if there is a separate charge for these items). In addition, almost 80 percent of plans offered additional days for an acute inpatient hospitalization as a supplemental benefit in 2024. While this supplemental benefit was not specific to behavioral health services, it could apply to acute inpatient hospitalizations for a behavioral health condition. With regard to enrollment, the percentage of beneficiaries enrolled in plans that offered a specific supplemental benefit was generally similar to the percentage of plans offering the benefit. For example, the plans that offered the additional days for an acute inpatient hospitalization as a supplemental benefit accounted for about 88 percent of beneficiaries enrolled in the 5,702 plans included in our analysis. See table 4.

Table 4: Behavioral Health Supplemental Benefits for Inpatient Services Offered by Medicare Advantage (MA) Plans, 2024

Inpatient service categories	Percentage of plans offering the benefit	Percentage of beneficiaries enrolled in plans offering the benefit as of February 2024
Acute inpatient hospitalization		
Additional days	79.50%	88.38%

[36]MA plans offer coverage for the supplemental benefits, meaning the plans will pay for those services that are provided by health care providers.

[37]For both an acute and psychiatric inpatient hospitalization, MA plans may cover up to an unlimited number of additional days.

Inpatient service categories	Percentage of plans offering the benefit	Percentage of beneficiaries enrolled in plans offering the benefit as of February 2024
Other inpatient stay options[a]	1.02%	0.66%
Room upgrades	0.79%	3.57%
Psychiatric inpatient hospitalization		
Additional days	7.58%	9.42%
Other inpatient stay options[a]	0.32%	0.08%

Source: GAO analysis of MA plan benefit package data from the Centers for Medicare & Medicaid Services (CMS). | GAO-24-106794

Notes: GAO analyzed in-network services of 5,702 MA plans that were health maintenance organization plans and preferred provider organization plans; this included special needs plans.

GAO selected service categories from the plan benefit package data that GAO determined included behavioral health services. MA plans can offer more than one type of supplemental benefit for inpatient services. In addition, MA plans offer coverage for the supplemental benefits, meaning the plans will pay for those services that are provided by health care providers.

All plans that offered these supplemental benefits did so as mandatory supplemental benefits for which MA beneficiaries receive coverage by default of being enrolled in the plan. In addition, 10 of these plans also offered coverage for additional days for acute (9 plans) or psychiatric (1 plan) inpatient hospitalizations as optional supplemental benefits for which individual MA beneficiaries must specifically elect to receive coverage and pay a separate premium.

Unlike additional days and other inpatient stay options, room upgrades are only offered within the acute inpatient hospitalization service category.

[a]Other inpatient stay options include MA plans that offered coverage for inpatient stays that would not be approved according to Medicare coverage guidelines or stays in a facility that is not certified by Medicare. CMS refers to these other inpatient stay options as non-Medicare covered stays.

Outpatient services. Some plans offered supplemental benefits in the service categories that were solely for behavioral health services. For example, almost 30 percent of plans offered coverage for additional sessions of smoking and tobacco cessation counseling. In addition, around 2 percent of plans offered counseling services as a supplemental benefit, and less than 1 percent of plans offered residential treatment services for behavioral health conditions as a supplemental benefit.[38] Most plans (about 91 percent) offered an annual physical exam as a supplemental benefit.[39] Although this benefit was not solely for behavioral

[38]Counseling and therapy (group and individual) sessions are distinct services in relation to behavioral health treatment. Counseling typically focuses on specific issues and is generally shorter in duration. While group and individual therapy can be short-term, they are typically longer in duration and are aimed at treating a broader range of issues.

[39]In general, traditional Medicare covers an initial preventive visit within the beneficiary's first 12 months of Medicare enrollment. It also covers an annual wellness visit that includes a health risk assessment. However, it does not cover a routine physical exam that is not related to treating or diagnosing a specific illness, symptom, complaint, or injury.

health, an annual physical exam could include a review of medications taken for a behavioral health condition or a discussion of any new symptoms, such as depression symptoms. Similar to inpatient services, we found that the percentage of beneficiaries enrolled in plans that offered a specific outpatient supplemental benefit was generally similar to the percentage of plans offering the benefit. For example, the plans that offered an annual physical exam as a supplemental benefit accounted for about 93 percent of beneficiaries enrolled in the 5,702 plans included in our analysis for 2024. See table 5.

Table 5: Behavioral Health Supplemental Benefits for Outpatient Services Offered by Medicare Advantage (MA) Plans, 2024

Outpatient service categories	Percentage of plans offering the benefit	Percentage of beneficiaries enrolled in plans offering the benefit as of February 2024
Behavioral health-specific service categories		
Residential treatment services for behavioral health conditions	0.91%	3.99%
Additional sessions of smoking and tobacco cessation counseling	29.94%	24.24%
Counseling services	2.16%	2.58%
Other service categories that may address behavioral health		
Annual physical exam	90.92%	93.32%
Weight management programs	5.82%	2.93%
Alternative therapies	6.93%	5.18%

Source: GAO analysis of MA plan benefit package data from the Centers for Medicare & Medicaid Services (CMS). | GAO-24-106794

Notes: GAO analyzed in-network services of 5,702 MA plans that were health maintenance organization plans and preferred provider organization plans; this included special needs plans.

GAO selected service categories from the plan benefit package data that GAO determined included behavioral health services. For the residential treatment services for behavioral health conditions (which included mental health, chemical dependency, or substance use disorder) category, MA plans wrote in one of these services as an "other" supplemental benefit.

All plans that offered these supplemental benefits did so as mandatory supplemental benefits for which MA beneficiaries receive coverage by default of being enrolled in the plan.

We found that a small percentage of plans required cost-sharing for the supplemental benefits they offered. For example, less than 1 percent of the plans that offered additional days for acute inpatient hospitalization had co-payments for the additional days of coverage. One exception was coverage for residential treatment services for behavioral health conditions offered as a supplemental benefit. This benefit was offered by less than 1 percent of plans, but around 85 percent of those plans required co-payments.

Different plan types (HMOs and PPOs) and SNP types followed a similar pattern as our general analysis. Within plan and SNP type, supplemental benefits in service categories that may address behavioral health were generally offered at a higher rate than supplemental benefits that were specific to behavioral health.

Representatives from all six of the MA organizations we interviewed said that they consider a number of factors when deciding which benefits to offer, such as feedback they receive through brokers and member advocates, utilization data, and consumer research. Representatives from all six MA organizations also said that they review market trends. For example, representatives from one MA organization said that they look at what benefits are offered by other MA plans in order to design competitive benefits. However, representatives from one MA organization told us that beneficiaries typically do not request behavioral health supplemental benefits.

CMS Oversight of MA Plans' Cost-Sharing for Behavioral Health Services

CMS oversees MA plans' cost-sharing through several efforts that generally do not focus specifically on behavioral health services. In general, this oversight comprises statutory limits on cost-sharing and reviews of MA plan cost-sharing.

Limits on cost-sharing to prevent discriminatory practices. CMS sets limits on cost-sharing that MA plans can charge beneficiaries to avoid discriminatory practices and protect beneficiaries from significant out-of-pocket costs, according to an April 2022 final rule.[40] CMS sets limits on both the maximum amount MA plans can require beneficiaries to pay in out-of-pocket costs, as well as cost-sharing for specific services. The service-level cost-sharing limits include several categories that are specific to behavioral health services: acute inpatient hospitalization, psychiatric inpatient hospitalization, partial hospitalization, mental health specialty services, and psychiatric services.[41]

[40]Medicare Program; Maximum Out-of-Pocket (MOOP) Limits and Service Category Cost Sharing Standards, 87 Fed. Reg. 22,290 (Apr. 14, 2022).

[41]MA plans are able to choose from one of three levels for beneficiaries' maximum out-of-pocket limits. For example, MA plans that chose the high level for the maximum out-of-pocket limit (meaning beneficiaries pay more in cost-sharing before hitting the plan's limit) cannot require beneficiaries to pay more than $1,937 in cost-sharing for an 8-day psychiatric inpatient hospital stay in 2024. In contrast, plans that chose the lower level for the maximum out-of-pocket limit (meaning beneficiaries pay less in cost-sharing before hitting the plan's limit) cannot require beneficiaries to pay more than $2,421.

These limits help ensure that beneficiaries with significant health care needs are not required to pay significant amounts of cost-sharing for these services. CMS officials also said the agency is lowering the cost-sharing levels for certain service categories for contract year 2026 and future years.[42]

Review of MA plan bid and benefit package. CMS's annual review of all MA plan bid and benefit packages is not focused specifically on behavioral health services, although they may be a part of the review. CMS officials annually review plan bids to ensure MA plans are in compliance with CMS's MA plan benefit package rules and regulations. In these reviews, CMS officials also review plan bids for outliers or other concerns, such as the highest possible cost-sharing based on service category cost-sharing limits or a significant increase in cost-sharing from the previous year. If they identify any concerns, they may ask the plan to substantiate the cost-sharing amount or make changes to its bid, according to CMS officials. CMS also has the authority to decline to approve an MA plan bid if the plan proposes significant increases in cost-sharing or decreases in benefits offered compared with the previous year.[43]

Audits of MA plans. CMS's audits of MA plans may include reviews of, but are not specific to, behavioral health services. For example, officials said that one type of audit CMS conducts—the Medicare Part C audits to determine plans' compliance with the terms of their contracts with CMS—is not behavioral health specific and instead mainly focuses on ensuring plans are meeting requirements associated with access to medical services, drugs, and other enrollee protections. CMS selects the MA plans being audited based on its internal risk analysis and factors such as the length of time since their last audit, or complaints received from whistleblowers, attorneys, and advocacy groups, according to CMS officials.

[42]In the April 2022 final rule, CMS finalized a four-year transition to lower professional behavioral health service category cost-sharing limits. Since contract year 2023, cost-sharing has shifted from 50 percent coinsurance to a range of lower cost-sharing limits (30 percent to 50 percent coinsurance) based on maximum out-of-pocket type. This range of cost sharing limits applies to mental health specialty services, psychiatric services, partial hospitalization, and intensive outpatient program services. See 87 Fed. Reg. 22,290 (Apr. 14, 2022).

[43]42 C.F.R. § 422.256(a).

As another example, CMS's financial audits look at whether plans are charging the cost-sharing amounts in their bid for a sample of services, among other things.[44] These audits only include behavioral health services if they are in the random sample selected from all services, according to CMS officials. CMS officials said that the audits do not focus on cost-sharing related to specific services or benefits, although behavioral health services might be included depending on the sample selected. CMS officials said they have not seen or identified any findings or issues related to behavioral health in these audits.

Additional oversight efforts. Other efforts may alert CMS to issues with service-level cost-sharing for behavioral health services, according to CMS officials. Beneficiary appeals and complaints, and occasional inquiries from other plans that trigger internal investigations may alert CMS to issues.[45] These activities are not specifically focused on, but may include, identification of issues related to cost-sharing limits for behavioral health services.

CMS officials said they may also become aware of issues with cost-sharing for behavioral health services through retrospective reviews of plans' Evidence of Coverage documents, which must reflect the cost-sharing limits in the plan benefit package data. CMS conducts these reviews as part of routine compliance activities, according to CMS officials.

CMS does not specifically track compliance related to behavioral health services, but does track compliance actions through an internal system, according to CMS officials. This system would indicate if the noncompliance was related to behavioral health services. In addition, CMS collects data related to health plan network providers as part of formal network adequacy reviews, according to CMS officials. As part of these reviews, CMS collects plan network adequacy information on several behavioral health service types including psychiatry, clinical

[44]See 42 C.F.R. § 422.503(d)(1).

[45]According to CMS officials, CMS may become aware of beneficiary complaints through a tracking system it uses as a central repository for complaints received from various sources, including 1-800-Medicare call centers and CMS regional offices. Beneficiaries may also submit a grievance directly to an MA plan, and plans are required to report these grievances to CMS.

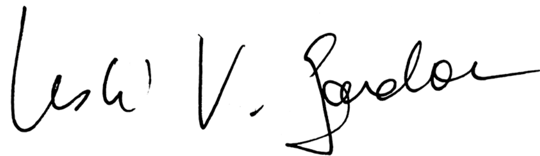
psychology, clinical social work, and inpatient psychiatric facility services.[46]

Agency Comments

We provided a draft of this report to the Department of Health and Human Services for review and comment. The Department of Health and Human Services provided technical comments, which we incorporated as appropriate.

We are sending copies of this report to the appropriate congressional committees, the Secretary of Health and Human Services, and other interested parties. In addition, the report is available at no charge on the GAO website at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or GordonLV@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Major contributors to this report are listed in appendix II.



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Director, Health Care

[46]Beginning in 2025, CMS will also collect network adequacy information for a new specialty category, called outpatient behavioral health. This category can include behavioral health providers such as marriage and family therapists, mental health counselors, opioid treatment programs, community mental health programs, addiction medicine physicians, and other providers.

Appendix I: Data on Basic Benefits and Cost-Sharing for Behavioral Health Services in Reviewed Medicare Advantage Plans

This appendix provides additional details on basic benefits and cost-sharing for behavioral health services for the Medicare Advantage (MA) plans in our analysis.

- Table 6 outlines the number and percentage of MA plans in our analysis by plan type along with the number and percentage of beneficiaries enrolled in these MA plans.
- Table 7 outlines the number and percentage of special needs plans (SNP) in our analysis by SNP type along with the number and percentage of beneficiaries enrolled in these plans.
- Table 8 details the number and percentage of MA plans in our analysis that had deductibles, coinsurance, or co-payments for inpatient hospitalization services.
- Table 9 details the percentiles for MA plans in our analysis that had co-payments for acute inpatient hospitalization by length of stay and MA plan type.
- Table 10 details the percentiles for MA plans in our analysis that had co-payments for psychiatric inpatient hospitalization by length of stay and MA plan type.
- Table 11 details the percentiles for SNPs in our analysis that had co-payments for acute inpatient hospitalization by length of stay and SNP type.
- Table 12 details the percentiles for SNPs in our analysis that had co-payments for psychiatric inpatient hospitalization by length of stay and SNP type.
- Table 13 outlines the percentage of MA plans in our analysis that had coinsurance or co-payments for selected outpatient service categories.
- Table 14 outlines the percentiles for MA plans in our analysis that had co-payments for selected outpatient services categories.
- Table 15 outlines the percentage of MA plans in our analysis that required prior authorization or referrals for selected outpatient service categories.

Table 6: Number and Percentage of Medicare Advantage (MA) Plans Included in Analysis and Number and Percentage of Beneficiaries Enrolled in These Plans, 2024

MA plan type	MA plans		MA beneficiaries enrolled as of February 2024	
	Number	Percent	Number	Percent
Health maintenance organization (HMO)	2,595	45.5	10,902,459	39.9
HMO Point-of-Service	1,002	17.6	6,629,164	24.3
Local preferred provider organization (PPO)	2,045	35.9	9,388,971	34.4
Regional PPO	60	1.1	374,796	1.4
Total MA plans	**5,702**	**100.0%**	**27,295,390**	**100.0%**

Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-24-106794

Notes: GAO's analysis included 5,702 MA plans that were health maintenance organization plans and preferred provider organization plans; this included special needs plans.

The percent of plans and percent of MA beneficiaries are based on the total number of MA plans in the analysis and beneficiaries enrolled in these plans. Percentages may not add to 100 percent due to rounding.

Table 7: Number and Percentage of Medicare Advantage Special Needs Plans (SNP) Included in Analysis and Number and Percentage of Beneficiaries Enrolled in These Plans, 2024

SNP type	SNPs		SNP beneficiaries enrolled as of February 2024	
	Number	Percent	Number	Percent
Chronic condition SNP	322	23.3	680,894	10.2
Dual-eligible SNP	884	63.9	5,880,035	88.1
Institutional SNP	177	12.8	117,045	1.8
Total SNPs	**1,383**	**100.0%**	**6,677,974**	**100.0%**

Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-24-106794

Note: GAO's analysis included SNPs that were health maintenance organization plans, health maintenance organization point-of-service plans, and local and regional preferred provider organization plans. The percent of plans and percent of MA beneficiaries are based on the total number of SNPs in the analysis and beneficiaries enrolled in those SNPs. Percentages may not add to 100 percent due to rounding.

Table 8: Number and Percentage of Medicare Advantage (MA) Plans with Deductibles, Coinsurance, and Co-payments for Inpatient Services Categories, 2024

Inpatient service category	Deductibles		Coinsurance		Co-payments	
	Number of MA plans	Percent of MA plans	Number of MA plans	Percent of MA plans	Number of MA plans	Percent of MA plans
Acute inpatient hospitalization	0	0	216[a]	3.8	4,970	87.2
Psychiatric inpatient hospitalization	0	0	219[a]	3.8	5,013	87.9

Source: GAO analysis of data from MA plans submitted to the Centers for Medicare & Medicaid Services. | GAO-24-106794

Notes: GAO analyzed in-network services of 5,702 MA plans that were health maintenance organization plans and preferred provider organization plans; this included special needs plans. The percent of plans are based on the total number of plans in the analysis for the particular cost-sharing. GAO did not consider a plan to have the particular cost-sharing if the amount was 0. This was to ensure consistency with plans that reported not having that cost-sharing.

Medicare beneficiaries who experience an acute behavioral health crisis can receive inpatient services either in an acute care hospital or in an inpatient psychiatric hospital.

[a]For acute inpatient hospitalization, all 216 plans indicated that they had coinsurance and that they charge the Medicare-defined cost-sharing amount. For psychiatric inpatient hospitalization, three plans indicated they had a coinsurance; the other 216 plans indicated they had coinsurance and that they charge the Medicare-defined cost-sharing amount.

Table 9: Number of Medicare Advantage (MA) Plans with Co-payments for Acute Inpatient Hospitalizations and Percentiles for Co-payment Amounts by Length of Hospital Stay and Plan Type, 2024

Length of stay	Plan type	Number of MA plans with co-payments	Percentiles for co-payment amounts				
			Minimum	25th percentile	Median (50th percentile)	75th percentile	Maximum
3-day stay	Health maintenance organizations	1,954	$12	$585	$885	$1,080	$2,340
	Health maintenance organizations point of service	921	$50	$675	$885	$1,050	$2,080
	Local preferred provider organizations	2,008	$35	$840	$975	$1,125	$2,080
	Regional preferred provider organizations	59	$585	$885	$1,080	$1,275	$2,000
	All plans	**4,942**	**$12**	**$700**	**$900**	**$1,110**	**$2,340**
6-day stay	Health maintenance organizations	1,975	$12	$975	$1,500	$1,800	$2,550
	Health maintenance organizations point of service	925	$40	$1,230	$1,625	$1,850	$2,550

Length of stay	Plan type	Number of MA plans with co-payments	Percentiles for co-payment amounts				
			Minimum	25th percentile	Median (50th percentile)	75th percentile	Maximum
	Local preferred provider organizations	2,008	$35	$1,475	$1,750	$1,950	$2,750
	Regional preferred provider organizations	59	$1,000	$1,625	$1,770	$1,950	$2,400
	All plans	**4,967**	**$12**	**$1,250**	**$1,650**	**$1,875**	**$2,750**

Source: GAO analysis of plan benefit package data from the Centers for Medicare & Medicaid Services (CMS). | GAO-24-106794

Notes: GAO analyzed in-network services of 5,702 MA plans that were health maintenance organization plans and preferred provider organization plans; this included special needs plans.

GAO's analysis for this table included MA plans that had co-payments for acute inpatient hospitalization. GAO did not consider a plan to have a co-payment if the amount was $0. This was to ensure consistency with plans that reported not having a co-payment.

GAO calculated the co-payment for different lengths of stay using the 2024 service category cost-sharing limits that CMS set on acute inpatient hospitalizations, which restricted how much MA plans could require beneficiaries to pay in cost-sharing. In addition, there were 743 plans that required a single co-payment for an acute inpatient hospitalization regardless of the length of the hospital stay, which GAO included in each of the day-stay calculations of the median.

Medicare beneficiaries who experience an acute behavioral health crisis can receive inpatient services either in an acute care hospital or in an inpatient psychiatric hospital.

The percentiles for co-payments for 10-day and 60-day stays of an acute inpatient hospitalization were generally similar to the percentiles for 6-day stays for all MA plan types and thus were not included in this table.

Table 10: Number of Medicare Advantage (MA) Plans with Co-payments for Psychiatric Inpatient Hospitalizations and Percentiles for Co-payment Amounts by Length of Hospital Stay and Plan Type, 2024

Length of stay	Plan type	Number of MA plans with co-payments	Percentiles for co-payment amounts				
			Minimum	25th percentile	Median (50th percentile)	75th percentile	Maximum
8-day stay	Health maintenance organizations	1,999	$12	$1,025	$1,500	$1,785	$2,350
	Health maintenance organizations point of service	933	$50	$1,340	$1,590	$1,830	$2,400
	Local preferred provider organizations	2,018	$25	$1,475	$1,680	$1,850	$2,400
	Regional preferred provider organizations	60	$250	$1,458	$1,584	$1,766	$2,065
	All plans	**5,010**	**$12**	**$1,340**	**$1,610**	**$1,820**	**$2,400**
15-day stay	Health maintenance organizations	2,002	$12	$1,050	$1,530	$1,785	$2,610

Length of stay	Plan type	Number of MA plans with co-payments	Percentiles for co-payment amounts				
			Minimum	25th percentile	Median (50th percentile)	75th percentile	Maximum
	Health maintenance organizations point of service	933	$50	$1,350	$1,600	$1,840	$2,400
	Local preferred provider organizations	2,018	$25	$1,475	$1,680	$1,850	$2,400
	Regional preferred provider organizations	60	$250	$1,458	$1,589	$1,766	$2,065
	All plans	**5,013**	**$12**	**$1,350**	**$1,620**	**$1,830**	**$2,610**

Source: GAO analysis of plan benefit package data from the Centers for Medicare & Medicaid Services (CMS). | GAO-24-106794

Notes: GAO analyzed in-network services of 5,702 MA plans that were health maintenance organization plans and preferred provider organization plans; this included special needs plans.

GAO's analysis for this table included MA plans that had co-payments for psychiatric inpatient hospitalization. GAO did not consider a plan to have a co-payment if the amount was $0. This was to ensure consistency with plans that reported not having a co-payment.

GAO calculated the co-payment for different lengths of stay using the 2024 service category cost-sharing limits that CMS set on psychiatric inpatient hospitalizations, which restricted how much MA plans could require beneficiaries to pay in cost-sharing. In addition, there were 729 plans that required a single co-payment for a psychiatric inpatient hospitalization, which GAO included in each of the day-stay calculations of the median.

Medicare beneficiaries who experience an acute behavioral health crisis can receive inpatient services either in an acute care hospital or in an inpatient psychiatric hospital.

The percentiles for co-payments for 60-day stays of a psychiatric inpatient hospitalization were generally similar to the percentiles for 15-day stays for all MA plan types and thus were not included in this table.

Table 11: Number of Medicare Advantage (MA) Special Needs Plans with Co-payments for Acute Inpatient Hospitalizations and Percentiles for Co-payment Amounts by Length of Hospital Stay and Special Needs Plan Type, 2024

Length of stay	Special needs plan type	Number of MA plans with co-payments	Percentiles for co-payment amounts				
			Minimum	25th percentile	Median (50th percentile)	75th percentile	Maximum
3-day stay	Chronic condition special needs plan	234	$60	$450	$675	$900	$1,925
	Dual eligible special needs plan	532	$12	$1,119	$1,715	$2,000	$2,080
	Institutional special needs plan	98	$150	$600	$835	$1,628	$1,707

Length of stay	Special needs plan type	Number of MA plans with co-payments	Percentiles for co-payment amounts				
			Minimum	25th percentile	Median (50th percentile)	75th percentile	Maximum
6-day stay	Chronic condition special needs plan	239	$100	$600	$1,170	$1,590	$2,276
	Dual eligible special needs plan	532	$12	$1,550	$1,820	$2,058	$2,276
	Institutional special needs plan	100	$250	$1,000	$1,275	$1,628	$2,276

Source: GAO analysis of plan benefit package data from the Centers for Medicare & Medicaid Services (CMS). | GAO-24-106794

Notes: GAO analyzed in-network services of 5,702 MA plans that were health maintenance organization plans and preferred provider organization plans; this included 1,383 special needs plans.

GAO's analysis for this table included special needs plans that had co-payments for acute inpatient hospitalization. GAO did not consider a plan to have a co-payment if the amount was $0. This was to ensure consistency with plans that reported not having a co-payment.

GAO calculated the co-payment for different lengths of stay using the 2024 service category cost-sharing limits that CMS set on acute inpatient hospitalizations, which restricted how much MA plans could require beneficiaries to pay in cost-sharing.

Medicare beneficiaries who experience an acute behavioral health crisis can receive inpatient services either in an acute care hospital or in an inpatient psychiatric hospital.

The percentiles for co-payments for 10-day and 60-day stays of an acute inpatient hospitalization were generally similar to the percentiles for 6-day stays for all MA plan types and thus were not included in this table.

Table 12: Number of Medicare Advantage (MA) Special Needs Plans with Co-payments for Psychiatric Inpatient Hospitalizations and Percentiles for Co-payment Amounts by Length of Hospital Stay and Special Needs Plan Type, 2024

Length of stay	Special needs plan type	Number of MA plans with co-payments	Percentiles for Co-payment amounts				
			Minimum	25th percentile	Median (50th percentile)	75th percentile	Maximum
8-day stay	Chronic condition special needs plan	248	$50	$725	$1,250	$1,610	$2,100
	Dual eligible special needs plan	529	$12	$1,562	$1,840	$1,937	$2,350
	Institutional special needs plan	100	$250	$1,225	$1,500	$1,628	$2,177
15-day stay	Chronic condition special needs plan	250	$50	$700	$1,250	$1,610	$2,210
	Dual eligible special needs plan	529	$12	$1,562	$1,845	$1,937	$2,350

Length of stay	Special needs plan type	Number of MA plans with co-payments	Percentiles for Co-payment amounts				
			Minimum	25th percentile	Median (50th percentile)	75th percentile	Maximum
	Institutional special needs plan	100	$250	$1,275	$1,500	$1,628	$2,177

Source: GAO analysis of plan benefit package data from the Centers for Medicare & Medicaid Services (CMS). | GAO-24-106794

Notes: GAO analyzed in-network services of 5,702 MA plans that were health maintenance organization plans and preferred provider organization plans; this included 1,383 special needs plans.

GAO's analysis for this table included special needs plans that had co-payments for a psychiatric inpatient hospitalization. GAO did not consider a plan to have a co-payment if the amount was $0. This was to ensure consistency with plans that reported not having a co-payment.

GAO calculated the co-payment for different lengths of stay using the 2024 service category cost-sharing limits that CMS set on psychiatric inpatient hospitalizations, which restricted how much MA plans could require beneficiaries to pay in cost-sharing.

Medicare beneficiaries who experience an acute behavioral health crisis can receive inpatient services either in an acute care hospital or in an inpatient psychiatric hospital.

The percentiles for co-payments for 60-day stays of a psychiatric inpatient hospitalization were generally similar to the percentiles for 8-day stays for all MA plan types and thus were not included in this table.

Table 13: Number and Percentage of Medicare Advantage (MA) Plans with Coinsurance and Co-payments for Outpatient Service Categories, 2024

Outpatient service category	Coinsurance		Co-payments	
	Number of MA plans	Percent of MA plans	Number of MA plans	Percent of MA plans
Behavioral health-specific service categories				
Partial hospitalization	544	9.5	4,465	78.3
Individual sessions for mental health specialty services	805	14.1	4,018	70.5
Group sessions for mental health specialty services	805	14.1	3,990	70.0
Individual sessions for psychiatric services	826	14.5	4,030	70.7
Group sessions for psychiatric services	826	14.5	4,002	70.2
Individual sessions for outpatient substance abuse	946	16.6	4,340	76.1
Group sessions for outpatient substance abuse	946	16.6	4,314	75.7
Opioid treatment program services	862	15.1	3,170	55.6
Other service categories that may include behavioral health services				
Emergency services	219	3.8	5,379	94.3

Outpatient service category	Coinsurance		Co-payments	
	Number of MA plans	Percent of MA plans	Number of MA plans	Percent of MA plans
Primary care physician services	613	10.8	575	10.1
Other health care professional services	817	14.3	4,158	72.9
Telehealth services	1,068	18.7	2,686	47.1

Source: GAO analysis of data from MA plans submitted to the Centers for Medicare & Medicaid Services. | GAO-24-106794

Notes: GAO analyzed in-network services of 5,702 MA plans that were health maintenance organization plans and preferred provider organization plans; this included special needs plans.

The percent of plans is based on the total number of plans in the analysis for the particular cost-sharing. GAO did not consider a plan to have the particular cost-sharing if the amount was 0. This was to ensure consistency with plans that reported not having that cost-sharing. There were no MA plans that had deductibles for these particular services.

Table 14: Number of Medicare Advantage (MA) Plans with Co-payments for Selected Outpatient Behavioral Health Services and Percentiles of Co-payment Amounts, 2024

Outpatient service category	Number of plans with co-payments	Percentiles for co-payment amounts				
		Minimum	25th percentile	Median (50th percentile)	75th percentile	Maximum
Behavioral health-specific service categories						
Partial hospitalization	4,465	$5	$55	$55	$70	$100
Individual sessions for mental health specialty services	4,018	$3	$25	$30	$40	$60
Group sessions for mental health specialty services	3,990	$2	$15	$25	$40	$60
Individual sessions for psychiatric services	4,030	$3	$25	$30	$40	$60
Group sessions for psychiatric services	4,002	$2	$15	$25	$40	$60
Individual sessions for outpatient substance abuse	4,340	$5	$25	$30	$40	$250
Group sessions for outpatient substance abuse	4,314	$2	$20	$30	$40	$250
Opioid treatment program services	3,170	$5	$25	$35	$40	$250
Other service categories that may include behavioral health services						
Emergency services	5,379	$20	$100	$100	$120	$135
Primary care physician services	575	$4	$5	$10	$10	$35
Other health care professional services	4,158	$3	$25	$30	$40	$75

Outpatient service category	Number of plans with co-payments	Percentiles for co-payment amounts				
		Minimum	25th percentile	Median (50th percentile)	75th percentile	Maximum
Telehealth services	2,686	$3	$30	$40	$50	$395

Source: GAO analysis of data from MA plans submitted to the Centers for Medicare & Medicaid Services. | GAO-24-106794

Note: GAO analyzed in-network services of 5,702 MA plans that were health maintenance organization plans and preferred provider organization plans; this included special needs plans.

The percent of plans is based on the total number of plans in the analysis that had co-payments for a particular service category. GAO did not consider a plan to have a co-payment if the amount was 0. This was to ensure consistency with plans that reported not having co-payments.

Table 15: Number and Percentage of Medicare Advantage (MA) Plans with Prior Authorization or Referrals for Outpatient Services Categories, 2024

Outpatient service categories	Number of plans with prior authorization	Percent of plans with prior authorization	Number of plans with referral	Percent of plans with referral
Behavioral health-specific service categories				
Partial hospitalization	5,322	93.3	748	13.1
Individual or group sessions for mental health specialty services	4,586	80.4	801	14.0
Individual or group sessions for psychiatric services	4,559	80.0	871	15.3
Individual or group sessions for outpatient substance abuse	4,510	79.1	800	14.0
Opioid treatment program services	4,590	80.5	914	16.0
Other service categories that may include behavioral health services				
Emergency services	n/a	n/a	n/a	n/a
Primary care physician services	n/a	n/a	n/a	n/a
Other health care professional services	3,715	65.2	1,150	20.2
Telehealth services	1,608	28.2	532	9.3

Source: GAO analysis of data from MA plans submitted to the Centers for Medicare & Medicaid Services. | GAO-24-106794

Note: GAO analyzed in-network services of 5,702 MA plans that were health maintenance organization plans and preferred provider organization plans; this included special needs plans. MA plans are not allowed to require prior authorization for emergency services. Certain plan types may use referrals more often than other plan types.

Appendix II: GAO Contact and Staff Acknowledgments

GAO Contact

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Staff Acknowledgments

In addition to the contact named above, Corissa Kiyan-Fukumoto (Assistant Director), Christie Enders (Analyst-in-Charge), Madison Herin, Dan Lee, Foster Ritchie, Lily Schultze, and Briscoe Turner made key contributions to this report. Also contributing were Sonia Chakrabarty, Joycelyn Cudjoe, Ying Hu, David Jones, and Ravi Sharma.

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