

MEDICARE

ISSUE BRIEF

An Examination of Medicare Private Fee-for-Service Plans

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Prepared by

**Jonathan Blum, Ruth Brown, and Miryam Frieder
Avalere Health LLC.**

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I. INTRODUCTION

Medicare beneficiaries have the option of receiving Medicare benefits either through the traditional fee-for-service program (Original Medicare) or through a range of different private plan options, referred to as Medicare Advantage (MA) plans.¹ Among the range of several private plan options, beneficiaries may enroll in Private Fee-for-Service (PFFS) plans. These plans were created by the Balanced Budget Act of 1997 (BBA) when various interest groups came together to promote their creation, and were subsequently modified by the Medicare Modernization Act of 2003 (MMA). Very recently, the number of companies offering PFFS plans, and the number of Medicare beneficiaries enrolled in these plans, has increased rapidly. This paper reviews the brief history of PFFS plans, examines how they differ from other MA plans, and considers the implications of these trends both for beneficiaries and the Medicare program.

PFFS plans most closely resemble a privately-administered version of traditional fee-for-service (FFS) Medicare and share few characteristics with Medicare managed care plans, such as Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs). Unlike most other MA plans, PFFS plans are exempt from many of Medicare's requirements for HMOs or PPOs, such as employing provider networks or conducting utilization management. They are paid under the same capitated payment system as traditional managed care plans, though they pay providers strictly on a fee-for-service basis.

PFFS plan participants account for 18 percent of total MA enrollment as of February 2007. PFFS enrollment and plan availability have grown rapidly since enactment of the MMA and implementation of the Part D Medicare drug benefit, and industry analysts expect continued growth in 2007 and beyond. From December 2005 to February 2007, enrollment in HMOs and PPOs increased from 5,157,627 enrollees to 6,064,666, a growth of 18 percent. Enrollment in PFFS plans over the same time period increased from 208,990 enrollees to 1,338,026, a growth of 535 percent.² Plan availability has seen parallel growth, with PFFS plans now the most widely accessible type of MA plan; in 2007, 99 percent of beneficiaries have access to at least one type of PFFS plan.

This issue brief describes what PFFS plans are and their legislative history. In addition, this brief highlights recent trends and examines key characteristics of PFFS plans such as covered services, cost-sharing and provider accessibility. This analysis is based on publicly available administrative data files from the Centers for Medicare and Medicaid Services (CMS), interviews with former congressional and CMS staff involved in the legislative processes and implementation of PFFS (all of whom requested to provide comments without attribution), and a

¹ MA plan options include: Health Maintenance Organizations, Preferred Provider Organizations, Provider Sponsored Organizations, Private Fee-for-Service Plans, Special Needs Plans, Medical Savings Accounts, and Employer Direct PFFS. Total MA enrollment counts referred to in this paper include enrollment reported by CMS in these MA plan options, and exclude enrollment in Demonstration plans, 1876 Cost plans, 1833 Cost (HCPP), PACE and Medicare Health Support Pilot programs.

² Centers for Medicare and Medicaid Services, *Medicare Advantage, Cost, PACE, Demo, and Prescription Drug Plan Organizations – Monthly Summary Reports*, http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/02_EnrollmentData.asp

review of literature including plan marketing materials and industry analyses. Finally, this issue brief discusses the potential implications of the recent rapid growth in PFFS plans, such as impacts on beneficiary out-of-pocket costs, access to physicians and hospitals, and overall program spending.

II. WHY PRIVATE FEE-FOR-SERVICE MEDICARE PLANS?

THE LEGISLATIVE HISTORY

PFFS plans were originally authorized by the Balanced Budget Act of 1997 (BBA). The BBA created the Medicare+Choice program, which was intended to expand the availability of private plans to Medicare beneficiaries. In addition to HMOs, which have been available to Medicare beneficiaries since the 1970s, the Medicare+Choice program authorized several new plan options, including Medical Savings Accounts (MSAs), Preferred Provider Organizations (PPOs), Provider Sponsored Organizations (PSOs), and PFFS plans (Figure 1).

Congress included PFFS plans under the Medicare+Choice program for three primary reasons. First, Congress sought to grant Medicare beneficiaries a wide variety of private plan choices, ranging from more restrictive forms of managed care (HMOs) to more open plans (PPOs, MSAs, and PFFS). Second, Congress sought to extend private plan options to rural areas, which were historically not well-served by Medicare private plans. It believed that PFFS plans could be formed more easily in rural areas since they would not have the same provider network adequacy requirements as traditional HMOs.

And third, Congress heard concerns voiced by right-to-life interests about the expansion of restrictive managed care plans in Medicare. Right-to-life interests believed that Medicare beneficiaries should always have the option of an open-access plan to preserve their right to receive care to extend life as long as possible.

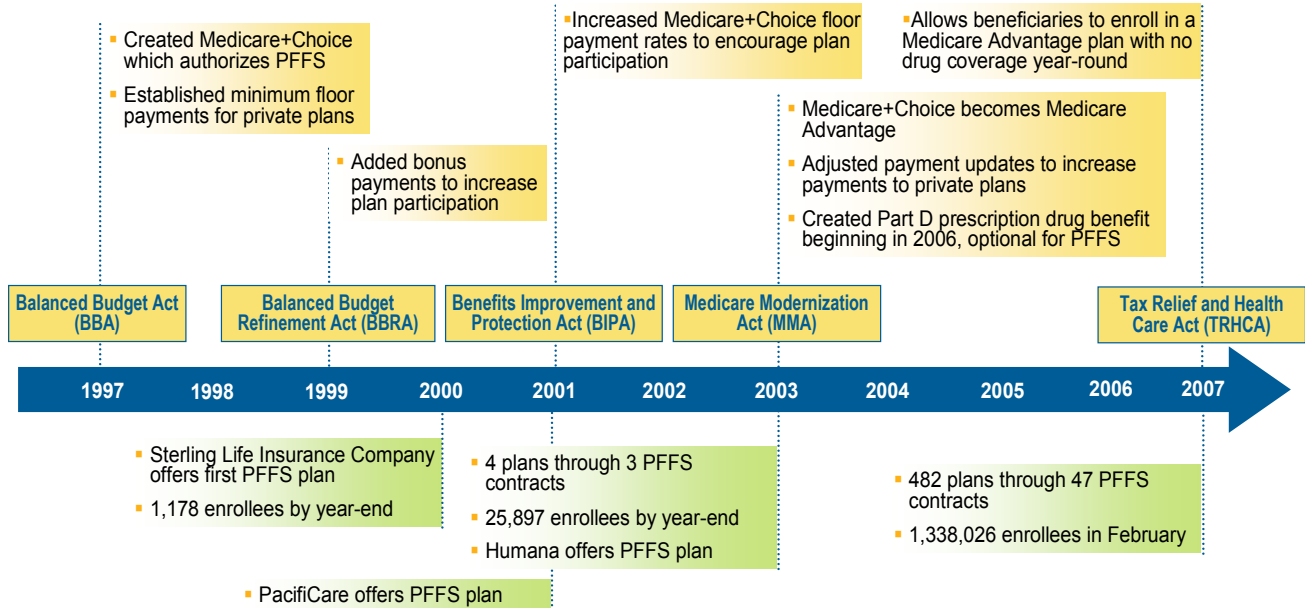
In 2003, when enacting the MMA, Congress raised payments to private plans—and renamed the program Medicare Advantage—to increase their availability to all Medicare beneficiaries. It also required most plans to offer the new Medicare prescription drug benefit (Part D). But PFFS plans were explicitly exempted from the requirement to offer the prescription drug benefit.

Right-to-life interests played a key role in lobbying for the change that exempted PFFS plans from the requirement to provide the Part D drug benefit. Part D, as it was being contemplated, would permit private drug plans to implement formularies and other benefit management tools seen as potentially restricting access to prescription drugs. The right-to-life interests argued that PFFS plans should not be permitted to implement restrictive cost-management tools and that PFFS enrollees should have open access to all drugs. Congress disagreed; it felt that formularies and other benefit management tools were necessary to limit the costs of the drug benefit and that no plan should be exempt from implementing these tools. As a compromise, the MMA granted PFFS plans the option not to offer the prescription drug benefit. If they do offer the benefit, PFFS plans are permitted to implement drug formularies and other cost-management tools for prescription drugs.

The Tax Relief and Health Care Act of 2006 made an additional modification to the MA program for 2007 and 2008 that is expected to promote enrollment into certain PFFS plans. The legislation included a provision that permits Medicare beneficiaries enrolled in traditional fee-for-

service (Original) Medicare a one-time opportunity to enroll in an MA plan that does not offer the drug benefit at any time during the year rather than only during the open and annual enrollment periods from November 15 to March 31.³ The provision permits beneficiaries who are enrolled in Original Medicare and a stand-alone prescription drug plan (PDP) to enroll into PFFS plans.

**Figure 1
Timeline of PFFS Legislation and Market Changes**



Source: Avalere Health LLC.

III. OVERVIEW OF PRIVATE-FEE-FOR-SERVICE PLANS

KEY FEATURES OF PFFS PLANS

Benefits and Cost-sharing. PFFS plans are operated by private health plan sponsors that contract with CMS on an at-risk, capitation payment basis while paying providers on a fee-for-service basis. From a beneficiary’s perspective, PFFS plans generally offer the same, unrestricted and open-network benefits as Original Medicare for traditional Part A and Part B services, though they may choose to offer enhanced benefits or reduced cost-sharing to their enrollees. Consistent with Medicare HMOs and PPOs, PFFS plans may provide stop-loss coverage for traditional Medicare Part A and B services. PFFS enrollees are not permitted to purchase a Medigap plan to supplement their cost-sharing requirements, as is true for all other all MA enrollees.

³ *Tax Relief and Health Care Act of 2006*, Public Law 432, 109th Cong., 2nd sess., (December 20, 2006), §206. Centers for Medicare and Medicaid Services, *New Medicare Advantage Enrollment Period for MA-Only Plans* (February 2007).

PFFS plans may provide Part D prescription drug coverage but, unlike Medicare HMOs and PPOs, they are not required to do so.⁴ In 2006, almost half of all PFFS plans offer the Part D benefit.

Premiums. Enrollees are required to pay monthly premiums, either directly to the plan or through deductions from their Social Security check, which generally exceed the standard Part B premium requirement. For PFFS plans that offer the prescription drug benefit, the average monthly premium (not weighted for enrollment) in 2007, is \$143.97 (including the standard Part B premium of \$93.50). For PFFS plans that do *not* offer the prescription drug benefit, the average monthly premium is \$136.85. More than one-third of PFFS plans do not charge a premium over the monthly Part B premium. In comparison, the average monthly premium for HMOs that offer the prescription drug benefit is \$130.71, and \$112.94 for HMOs that do *not* offer a prescription drug benefit.⁵

PFFS PLAN REQUIREMENTS

PFFS plans are exempt from many legislative and regulatory requirements that apply to traditional MA plans (Figure 2). Some of these exemptions are summarized below:

Provider Access. Unlike HMOs or PPOs, PFFS plans are not required to establish networks of physicians, hospitals and other providers, and the vast majority of PFFS plans have chosen to operate without a network.⁶ A beneficiary enrolled in a non-network PFFS plan can access any provider that is willing to accept both Medicare beneficiaries and the plan's terms of payment. Providers are not required to accept enrollees of PFFS plans even if they accept patients enrolled in Original Medicare.⁷ Because there is no direct contract between the PFFS plan and provider prior to an enrollee's seeking treatment, it falls to the enrollee to inform the provider of his or her PFFS plan enrollment. Providers can choose whether or not to accept the PFFS plan and provide services to an enrollee at each provider visit.

Provider Payment. PFFS plans that create provider networks may set such payment levels as they agree upon with participating providers. Absent a network, a plan must pay at least the same payment rate as Original Medicare pays. Such PFFS plans would pay inpatient hospitals under the current DRG-based prospective payment system administered by CMS and they would pay physicians at Original Medicare rates.

Unlike other forms of MA plans, PFFS plans cannot put providers at financial risk, such as by paying capitated payments or by offering bonuses tied to utilization or other underwriting factors. PFFS plans must create a uniform payment system for an item or service across all providers. Similar to those that participate in Original Medicare, physicians may balance bill up to 115 percent of the physician fee schedule.

⁴ HMO and PPO plan sponsors may offer a benefit plan without drug coverage provided they also offer a plan with drug coverage.

⁵ Average monthly premium amounts weighted by number of counties in which the plan is offered. Avalere Health analysis of Centers for Medicare and Medicaid Services, *2007 MA Landscape Source File* (2006).

⁶ Gold, Marsha, *The Growth of Private Plans in Medicare, 2006* (Washington, DC: The Henry J. Kaiser Family Foundation, 2006).

⁷ *Balanced Budget Act of 1997*, Public Law 33, 105th Cong., 1st sess., (August 5, 1997), §1852.

In order for providers to be deemed to have a contract with the PFFS plan, enrollees must present providers with verification of enrollment at each point of service – generally by the plan enrollment card – and the opportunity to obtain more information about the terms and conditions of payment for services. If these conditions are met, once the patient is treated, the provider is deemed to have a contract with the PFFS plan and can bill the plan for the Original Medicare payment rate, or a higher amount if established by the plan. The provider may bill the enrollee only for the established cost-sharing amount plus any balance billing allowed under the plan, and must bill the plan for the remainder. Providers may not bill the full cost of services to enrollees once they are deemed to have a contract with a PFFS plan.⁸

Quality and Utilization Review. Unlike most other MA plans, PFFS plans are not required to have quality and utilization review policies, though they are not prohibited from doing so. Plans are not required to establish written protocols for utilization review or to employ mechanisms to detect either under- or over-utilization of health care services among enrollees.

Prescription Drug Coverage. PFFS plans are not required to offer the Part D prescription drug benefit to enrollees, unlike most other MA plans. Beneficiaries enrolled in PFFS plans that do not offer the drug benefit may enroll in a stand-alone prescription drug plan (PDP), just as enrollees in Original Medicare may do. PFFS plans that offer the Part D drug benefit are exempt from some of the benefit's requirements. Specifically, PFFS plans are not required to provide negotiated drug prices to enrollees (i.e., the amount they would pay in the deductible period or coverage gap) or to require that pharmacists disclose to patients the availability of lower-priced generic drugs. PFFS plans that include the drug benefit are also not required to offer medication therapy management programs (MTMPs).⁹

Annual Enrollment Period. Beneficiaries may enroll in any MA plan or switch from an MA plan to Original Medicare during the annual election period (AEP) from November 15 to December 31, and they are allowed one additional switch that doesn't affect prescription drug coverage during the open enrollment period (OEP) from January 1 to March 31. Outside of these periods, beneficiaries are locked into their MA plan for the rest of the year.¹⁰ In 2007 and 2008, however, beneficiaries have a one-time enrollment opportunity, outside of these enrollment periods, into a PFFS plan that does not offer a prescription drug benefit.

⁸ Medicare Program; establishment of the Medicare+Choice Program, final rule, 63 *Federal Register*, 35089 (1998).

⁹ *Medicare Prescription Drug, Improvement, and Modernization Act of 2003*, Public Law 173, 108th Cong., 1st sess., (December 8, 2003), §101.

¹⁰ Special enrollment periods are available for beneficiaries who move or are in non-compliant plans, for example.

Figure 2
Comparison of Requirements for Private FFS (Non-Network) Plans and
other Medicare Advantage Plans*

Medicare Advantage Beneficiary Protection Plan Requirements	Network MA Plans (HMOs, PPOs)	PFFS Plans (non-network)
Beneficiary Protections		
Conduct a baseline health assessment of new enrollees	Required	Not Required
Ensure that services are accessible to members with diverse cultural and ethnic backgrounds	Required	Not Required
Identify and coordinate care of members with complex or serious medical conditions and arrange for necessary specialty care	Required	Not Required
Work with community and social service programs to ensure continuity of care and integration of services	Required	Not Required
Provider Requirements		
Establish written standards for provider consideration of member input into proposed treatment plan and advanced directives	Required	Not Required
Ensure that the hours of provider operation are convenient and do not discriminate against members	Required	Not Required
Guarantee that providers maintain member health records in accordance with established standards	Required	Not Required
Plan Review and Provider Monitoring		
Conduct utilization review and develop mechanisms to detect under- and over-utilization	Required	Not Required
Work with an independent quality review and improvement organization to perform external plan reviews	Required	Required if plan has written utilization review protocols
Collect and report data through the Health Plan Employer Data and Information Set (HEDIS) to assess and compare plan performance	Required	Not Required
Have written standards for timeliness of access to care and member services that meet or exceed CMS's standards and continuously monitor providers for compliance	Required	Not Required
Part D		
Offer an MA plan that includes the Part D drug benefit	Required	Not Required
Plans offering Part D must negotiate drug prices with manufacturers in order to provide discounted prices to members	Required	Not Required
Plans offering Part D must have a drug utilization management program and a medication therapy management program (MTMP)	Required	Not Required
Plans offering Part D must require pharmacists to disclose lower-priced generic drug options to enrollees	Required	Not Required

Source: "Medicare+Choice Private Fee for Service Monitoring Review Guide, Version 1," Centers for Medicare and Medicaid Services, April 1, 2004. Medicare Program; establishment of the Medicare+Choice Program, final rule, 63 *Federal Register*, 35042 (1998).

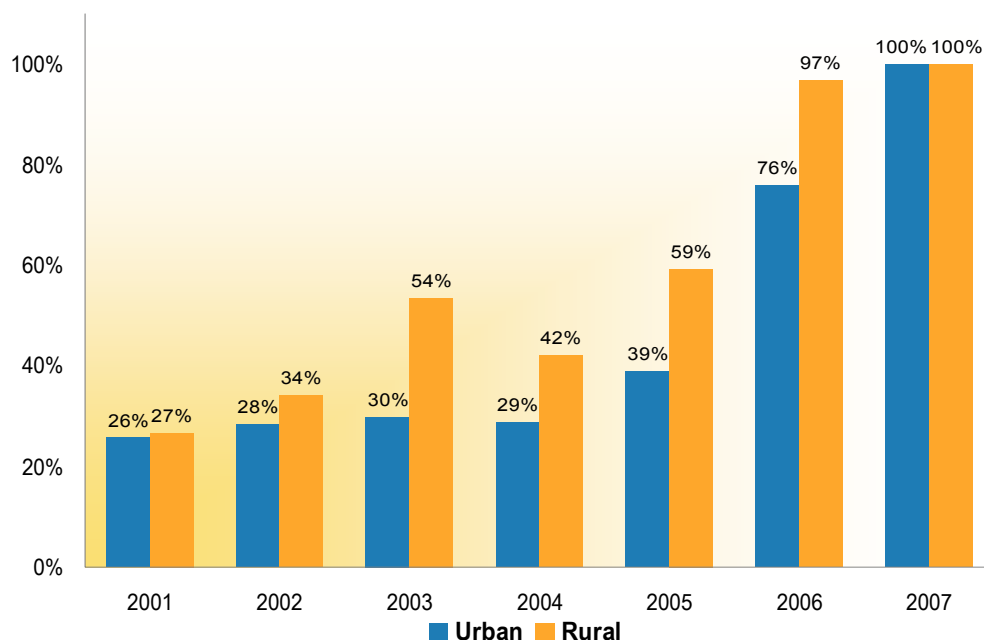
*The vast majority of PFFS plans are non-network plans.

IV. MARKET AND ENROLLMENT TRENDS

GROWING PLAN AVAILABILITY

CMS approved the first PFFS contract in July of 2000 for Sterling Life Insurance. Sterling initially offered plans in all or part of 25 states.¹¹ PacifiCare entered the market in 2001, followed by Humana in 2003. Initial growth in number of plans and beneficiary access was relatively modest in urban areas, plan availability initially grew more rapidly in rural parts of the country. In 2001, nearly 30 percent of all Medicare beneficiaries had access to at least one PFFS plan. By 2003, 34 percent of Medicare beneficiaries had access to a PFFS plan; 54 percent of rural beneficiaries had access compared to about 30 percent for urban beneficiaries (see Figures 3 and 4).

Figure 3
Medicare Beneficiaries with Access to PFFS, Urban and Rural Counties
2001-2007



Sources: The Henry J. Kaiser Family Foundation, "Medicare Health and Prescription Drug Plan Tracker" <http://www.kff.org/medicare/healthplantracker/index.jsp>; Mathematica Policy Research analysis of CMS Geographic Service Area Files from March of the given year(s) prior to 2006. Starting in 2006, data are from MPR analysis of a file created using the CMS Medicare Personal Plan Finder. Data on the total number of Medicare eligibles from December 2005 used to calculate plan penetration for 2006 and 2007.

¹¹ Gold, Marsha., "Medicare's Private Fee-for-Service Plan: Sterling's Structure, Opportunities, and Risks," *Monitoring Medicare+Choice, Operational Insights 4* (July 2001).

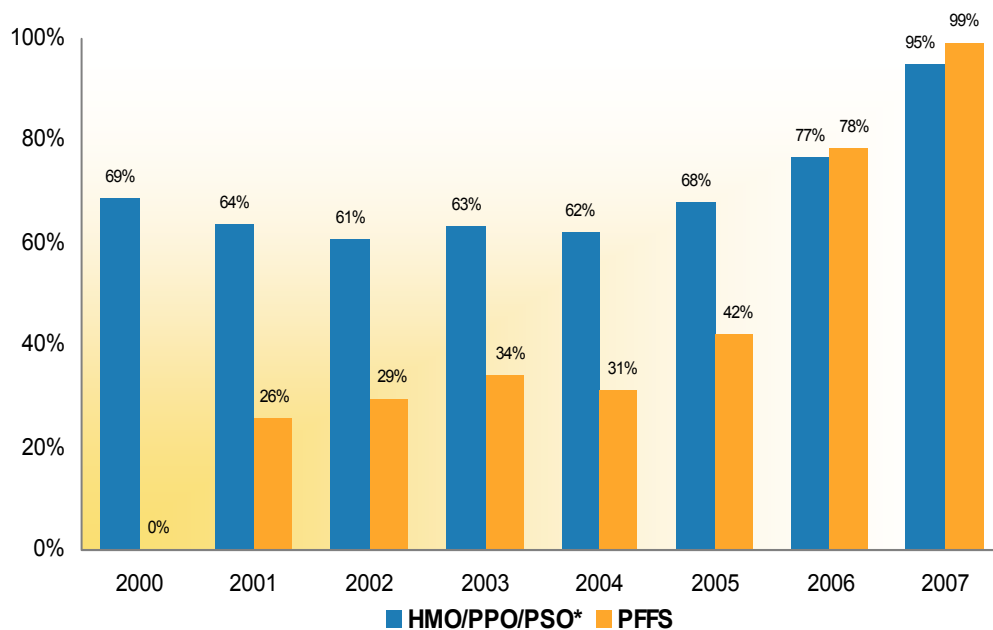
PFFS plan availability grew much more rapidly after enactment of the MMA in 2003. As the number of plan sponsors grew, so too did beneficiaries' access to a PFFS plan in their area. By 2007, 37 plan sponsors had entered the PFFS market.¹² Today the leading PFFS plan sponsors are Humana, BlueCross BlueShield of Michigan, United Healthcare (which acquired PacifiCare in early 2006), and WellPoint (see Figure 6).

Almost one-half of the plans operating in 2006—140 out of 287—offered the Part D prescription drug benefit, despite being exempt from the requirement. Enrollment in PFFS plans that offer Part D comprises more than 60 percent of total PFFS enrollment (Figure 5), a much lower percentage than the more than 90 percent of enrollees in an HMO or PPO with Part D.

For 2007, there are 482 unique plan designs and premium combinations in operation and all Medicare beneficiaries, urban and rural, have access to at least one PFFS plan.

Most beneficiaries have more than one PFFS option to consider, in addition to other types of MA plans. On average, Medicare beneficiaries may choose from among 11 different PFFS plans.¹³

Figure 4
Medicare Beneficiaries with Access to MA Plans by Type
2000-2007



Source: The Henry J. Kaiser Family Foundation, "Medicare Health and Prescription Drug Plan Tracker" <http://www.kff.org/medicare/healthplantracker/index.jsp>; Mathematica Policy Research analysis of CMS Geographic Service Area Files from March of the given year(s) prior to 2006. Starting in 2006, data are from MPR analysis of a file created using the CMS Medicare Personal Plan Finder. Data on the total number of Medicare eligibles from December 2005 used to calculate plan penetration for 2006 and 2007.

*Includes HMO, local PPO, and PSO contracts, and PPO demonstrations (relevant through 2005).

¹² Centers for Medicare and Medicaid Services, *2007 MA Landscape Source File* (November 2006), <http://www.medicare.gov/medicarereform/local-plans-2007.asp>.

¹³ Centers for Medicare and Medicaid Services, *2007 MA Landscape Source File* (November 2006).

Industry analysts cite several reasons for the rapid growth in PFFS plan availability over the past several years. First, as explained in a later section of this paper, the MMA boosted payment rates for all MA plans, including PFFS plans. These payment enhancements, combined with the relative ease of establishing a plan given that no provider network need be established, encouraged plan participation.

Second, the broad geographic availability and absence of managed care restrictions makes the PFFS model particularly attractive to employers that offer retiree health benefits.¹⁴ For employers who want to drop or reduce their self-insured retiree coverage in favor of enrolling retirees into MA plans, PFFS plans may be more appealing than an HMO or PPO. The ease of market entry for plans, with no network requirements, makes it much more feasible for PFFS plans to offer national or near-national coverage, therefore facilitating enrollment for multi-state employers and for those with retirees that move to different parts of the country upon retirement. PFFS plan sponsors may also target the employer market through offering employer- or union-only sponsored group plans. Unlike most other types of MA plans, beginning in 2008 non-network PFFS plans that offer an employer- or union-only sponsored group plan do not have to make a plan available for individuals under the same contract as this group plan, and can instead offer the plan exclusively to the employer or union group.¹⁵ For 2006, 124 of the 287 PFFS plans were available only to employer or union groups.¹⁶ Beginning in 2007, one employer has contracted directly with CMS to offer a group plan, rather than contract through an established health insurance plan. This is the first direct contract plan of any MA plan type to be established, and has already attracted over 10,000 enrollees.¹⁷

ENROLLMENT JUMPS IN 2006 AND 2007

Despite a slow start, beneficiary enrollment in PFFS plans has grown more rapidly than enrollment in traditional MA plans in 2006 and into 2007. In 2001, fewer than 20,000 Medicare beneficiaries were enrolled in PFFS plans; six years later, enrollment is over one million beneficiaries. Industry analysts expect this enrollment trend to continue through 2007.¹⁸

From December 2005 to February 2007, enrollment in HMOs and PPOs increased from 5,157,627 enrollees to 6,064,666, a growth of 18 percent. Enrollment in PFFS plans over the same time period increased from 208,990 enrollees to 1,338,026, a growth of 535 percent.¹⁹ In fact, 57 percent of all new enrollment in MA plans between 2005 and 2007 is in PFFS plans.²⁰

¹⁴ "MA Plans Urged to Start '08 Planning Even While Facing Operational Challenges for '07," *AIS Managed Care* (June 29, 2006),

http://www.aishhealth.com/ManagedCare/Medicare/MAN_MA_Plans_Urged_08_Planning.html.

¹⁵ "2008 Employer Group Waiver Policy." Centers for Medicare and Medicaid Services memorandum. November 13, 2006. <http://www.cms.hhs.gov/EmpGrpWaivers/Downloads/2008NexusPolicy.pdf>.

¹⁶ Centers for Medicare and Medicaid Services, *Medicare Advantage, Cost, PACE, Demo, and Prescription Drug Plan Organizations – Annual Report by Plan*.

¹⁷ Centers for Medicare and Medicaid Services, *Medicare Advantage, Cost, PACE, Demo, and Prescription Drug Plan Organizations – Monthly Summary Report* (February 2007).

¹⁸ "MA Plans Urged to Start '08 Planning Even While Facing Operational Challenges for '07." *Medicare Advantage News*. June 29, 2006.

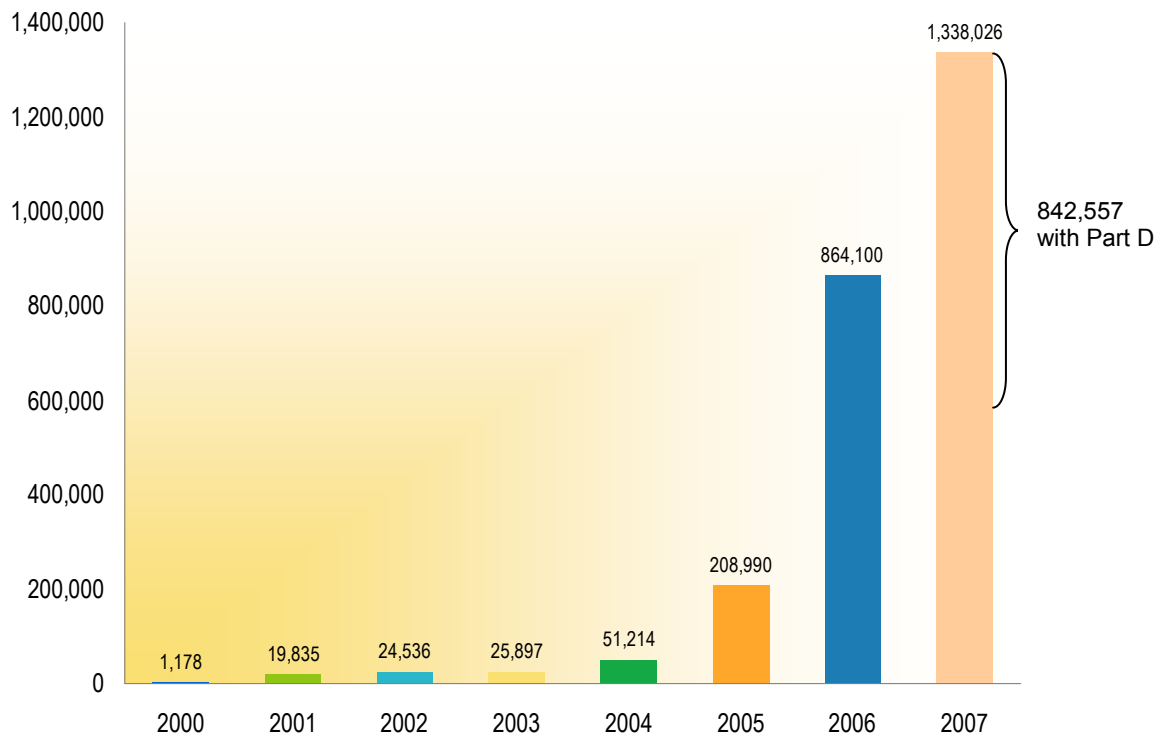
¹⁹ Centers for Medicare and Medicaid Services, *Medicare Advantage, Cost, PACE, Demo, and Prescription Drug Plan Organizations – Monthly Summary Reports*, http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/02_EnrollmentData.asp

²⁰ Centers for Medicare and Medicaid Services, *Medicare Managed Care Contract Report* (December 2004) http://www.cms.hhs.gov/HealthPlanRepFileData/04_Monthly.asp#TopOfPage; Centers for Medicare and Medicaid Services, *Monthly Summary Report* (February 2007).

That is, much of the new enrollment into MA plans since implementation of Part D is not into plans that coordinate care but rather into plans that offer open-network, unmanaged care.

Of the beneficiaries enrolled in PFFS plans as of February 2007, 63 percent were enrolled in PFFS plans that offer the prescription drug benefit (see Figure 5). Enrollment in employer-sponsored plans was relatively low in 2006, with fewer than 33,000 enrollees. Only 30 percent of those enrollees were in PFFS plans that offer the prescription drug benefit.²¹

**Figure 5
PFFS Enrollment
2000-2007**



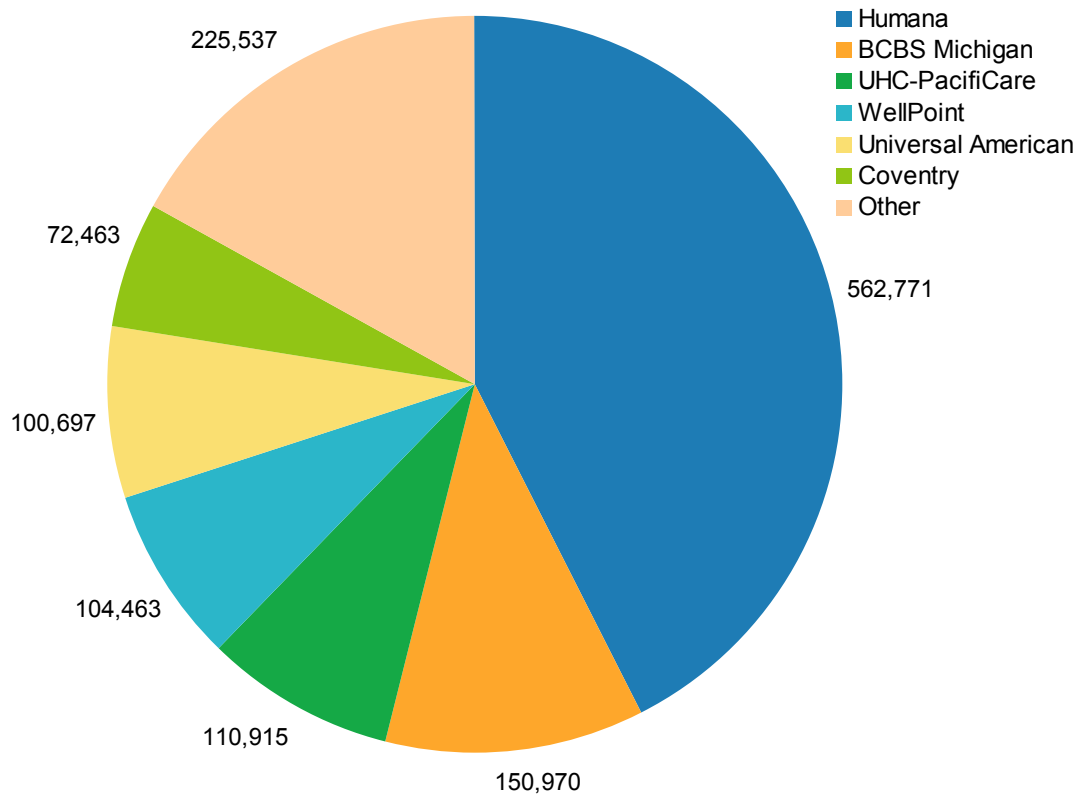
Source: Avalere Health analysis of Centers for Medicare and Medicaid Services, *Medicare Managed Care Contract Report* (2000-2005); Centers for Medicare and Medicaid Services, *Monthly Summary Report* (2006-2007). Figures are year-end for 2000-2006 and as of February for 2007.

ENROLLMENT IS CONCENTRATED IN SIX PLAN SPONSORS

Humana has the most PFFS enrollment with 42 percent of the total market as of February 2007, followed by BlueCross BlueShield of Michigan (11 percent) and United Healthcare-PacifiCare (see Figure 6). Of these major players, some have clearly emphasized the Part D drug benefit more than others, either through targeted marketing or plan offerings. Humana and BCBS of Michigan have over 95 percent of enrollees in plans that include the Part D benefit, while United Healthcare-PacifiCare has only 17 percent and WellPoint has only 21 percent enrolled in plans with the drug benefit.

²¹ Centers for Medicare and Medicaid Services, *Medicare Advantage, Cost, PACE, Demo, and Prescription Drug Plan Organizations – Annual Report by Plan*.

Figure 6
PFFS Enrollment by Plan Sponsor
2007

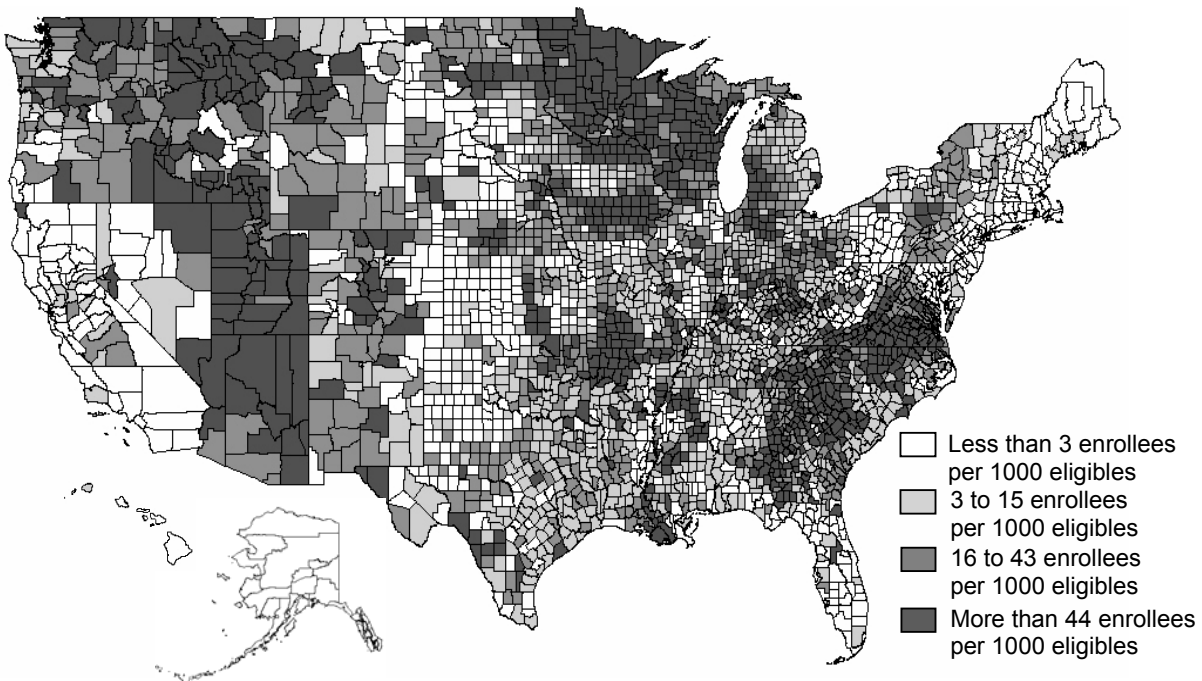


Source: Avalere Health analysis of Centers for Medicare and Medicaid Services, *Medicare Advantage, Cost, PACE, Demo, and Prescription Drug Plan Organizations – Monthly Report by Contract* (February 2007).

Enrollment in PFFS plans is not uniform across the country, and some parts of the country have much higher PFFS enrollment as a percent of Medicare-eligible individuals than others, particularly rural areas (see Figure 7). Initially, PFFS plans were more prevalent in rural areas than urban areas and, as a result, enrollment in rural areas was relatively high compared to enrollment in other MA plans. PFFS plans are now currently available to virtually all beneficiaries, and though enrollment remains higher in rural parts of the country, counties that have a historically high payment rate relative to local costs of Original Medicare, both urban and rural, are attracting an increasing number of PFFS enrollees. As explained in the next section of the paper, payments to MA plans are higher in rural and in some urban parts of the country, as percent of local costs of Original Medicare. Ninety (90) percent of PFFS enrollment is now found in these high-payment counties.²²

²² Harrison, Scott, Rachel Schmidt, and Carlos Zarabozo, “Update on Medicare Private Plans and Review of Past Recommendations” (presentation, Medicare Payment Advisory Committee, Washington, DC, November 2006).

Figure 7
PFFS Enrollees per 1000 Medicare-eligible Individuals by County
2006



Source: Avalere Health analysis of Centers for Medicare and Medicaid Services, *MA Monthly Enrollment by State/County/Contract*, (October 2006).

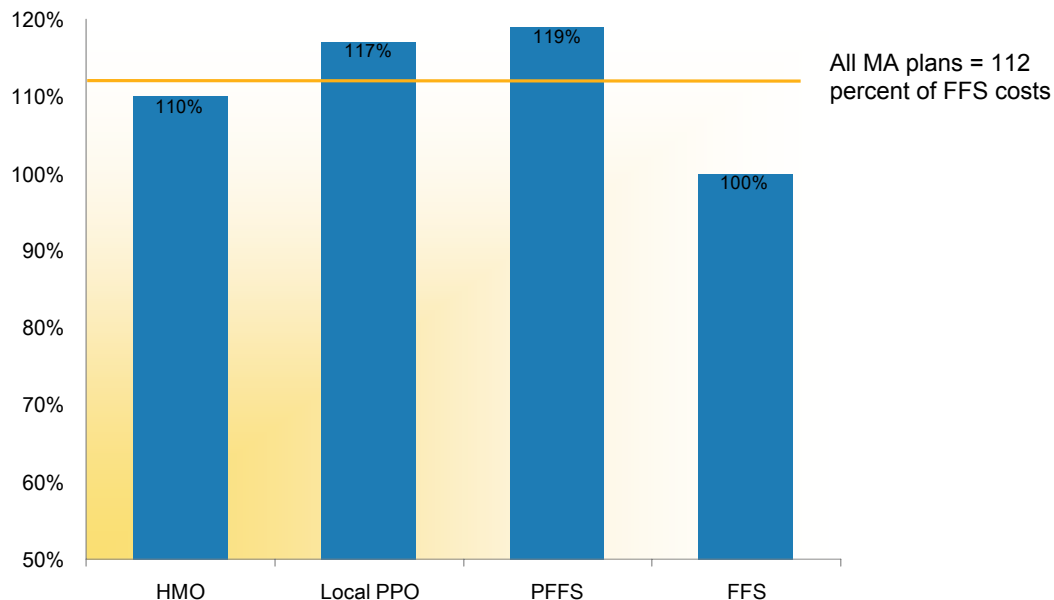
V. PAYMENT

For traditional Medicare services, PFFS plans are paid under the same capitated payment mechanism as county-based, or local, HMOs and PPOs (the payment methodology for regional PPOs is somewhat different). Each year, CMS publishes a list of estimated per-capita fee-for-service costs of Original Medicare services for each county. CMS also publishes an MA benchmark rate for each county. The benchmark rate is the greater of the fee-for-service costs and a figure derived from a formula set by the BBA and subsequent legislation that was meant to raise payment levels for private plans operating in rural areas and small urban markets. Consequently, for many counties, often referred to as “floor counties,” the benchmark payment rate reflects a significant increment above Original Medicare fee-for-service costs.

MA plans, including PFFS plans, that bid above this benchmark must charge the difference to enrollees in the form of a monthly premium. However, plans that bid below the benchmark rate may keep 75 percent of the difference, though they are required to enhance benefits for enrollees, such as by lowering enrollee cost-sharing, adding services not covered by Original Medicare, or buying down the enrollee’s Part B premium. CMS retains the remaining 25 percent as “savings.”

Many PFFS sponsors have targeted their offerings toward the “floor counties,” and 90 percent of PFFS plan enrollees reside in these areas.²³ As a result, PFFS plan payments are estimated to be much higher than what CMS pays providers through Original Medicare in the same county. According to the Medicare Payment Advisory Commission (MedPAC), in 2006 PFFS plans on average were paid 119 percent of the local costs of Original Medicare, before adjusting for the relative risk of enrollees. In contrast, Medicare HMOs are paid 110 percent of the local costs of Original Medicare before adjusting for risk (see Figure 8).

Figure 8
Payment to MA Plans vs. Traditional FFS Medicare Costs
2006



Source: Harrison, Scott, Rachel Schmidt, and Carlos Zarabozo, “Update on Medicare Private Plans and Review of Past Recommendations” (presentation, Medicare Payment Advisory Committee, Washington, DC, November 2006).

For the prescription drug benefit, the payment benchmark is set as the weighted average of all Part D plan bids (PDPs and Medicare Advantage prescription drug plans combined). PFFS plans that bid above the benchmark must charge a higher-than-average Part D premium. PFFS plans that bid below the benchmark must offer a reduced Part D premium.

The MMA included several provisions to permit CMS to negotiate with most MA plans over their bid submissions. For example, CMS is permitted to review plan bids to ensure that they “reasonably and equitably” reflect the costs of health care services and supplies provided. However, the statute prohibits CMS from reviewing PFFS plans’ bids.²⁴ Congress included this prohibition to ensure that PFFS plans were able to freely provide health care services without restriction or oversight from the federal government.

²³ Harrison, Scott, Rachel Schmidt, and Carlos Zarabozo, “Update on Medicare Private Plans and Review of Past Recommendations” (presentation, Medicare Payment Advisory Committee, Washington, DC, November 2006).

²⁴ Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 173, 108th Cong., 1st sess., (December 8, 2003), §222.

VI. CONSIDERATIONS FOR MEDICARE BENEFICIARIES

PFFS plans are becoming increasingly popular. They offer enrollees the prospect of reduced out-of-pocket costs with few restrictions on access to care. Yet, Medicare analysts and beneficiary advocates have raised several concerns for Medicare beneficiaries who have enrolled, or are contemplating enrolling, in these plans.

Out-of-Pocket Spending. PFFS plans offer potential to reduce out-of-pocket costs for enrollees because they may offer lower cost-sharing for some services compared to Original Medicare, and they provide stop-loss coverage for traditional Part A and Part B services. Compared to enrollment in Original Medicare and a Medigap supplemental plan, PFFS plans afford beneficiaries the potential for receiving benefits that are greater in value and possibly lower in cost. However, PFFS plans' ability to lower enrollees' overall out-of-pocket costs is uncertain and determined by the particular services a beneficiary may require during the year. For some services, such as extended post-acute care stays, Medicare beneficiaries may end up paying higher out-of-pocket costs.

Access to Physicians. PFFS plans are relatively new, so neither beneficiaries nor health care providers have much experience with these products. As a result, PFFS plan enrollees may have difficulty accessing every Medicare-participating physician or hospital if the provider is unfamiliar with the plan type and refuses to accept payment and to provide services. Indeed, beneficiary advocates have voiced concerns that some PFFS enrollees have had trouble accessing health care services for this reason. The extent to which this is occurring is unknown and should be a factor for beneficiaries considering these plans.

Providers are not required to seek advance coverage determinations before providing services. Hence, there is a risk that beneficiaries in non-network PFFS plans would be liable for full payment if the plan denies coverage retroactively. Though CMS considered imposing requirements that would protect beneficiaries from liability in this situation, these protections were not put in place because CMS felt that such requirements would be "contrary to the spirit and intent" of the unrestricted PFFS plan model.²⁵

Marketing Abuses. As enrollment in PFFS plans continues to surge, there are early reports that reveal some particular difficulties. Though anecdotal and relatively sporadic, there are reports of beneficiaries being enrolled in PFFS plans unknowingly or not realizing that it was an MA plan rather than Original Medicare.²⁶ Further, some plan sponsors have publicly stated that expanding enrollment into PFFS plans is a strategy to eventually switch enrollees to coordinated care plans like HMOs and PPOs that may offer higher profit potential.

Plan Stability. For now, average PFFS plan payments are higher than Original Medicare and even other MA plans. There is a risk that Congress may act to reduce payments to these plans. Lower payment rates may lead some PFFS plans to reduce services, raise cost-sharing

²⁵ Medicare Program; establishment of the Medicare+Choice Program, final rule, 63 *Federal Register*, 35042 (1998).

²⁶ Freudenheim, Milt. 2006. Luring Customers from Medicare. *New York Times*, September 22, Business section. Appleby, Julie. 2006. Fiscal Experts Question Cost Effectiveness of Medicare Plans. *USA Today*, August 8. Colliver, Victoria. 2007. Medicare Plans Under Scrutiny. *San Francisco Chronicle*, January 26. Zhang, Jane and Vanessa Fuhrmans. 2006. Seniors Flock to Private Medicare Plans. *Wall Street Journal*, August 29.

requirements, or pull out of the market altogether. Such changes could disrupt health care services for Medicare beneficiaries and cause much anxiety.

Quality Reporting. PFFS plans are exempt from some quality reporting requirements, such as Health Plan Employer Data and Information Set (HEDIS) measures. It is unclear how accurately Medicare program overseers will be able to determine if PFFS plans deliver health care services more efficiently or increase consumer satisfaction relative to Original Medicare or other MA plans.

VII. CONCLUSION

Enrollment in PFFS plans has grown at a much more rapid rate than in other forms of MA plans, accounting for more than half of all new enrollment in MA plans since 2005. It is the only plan type that is available to virtually all Medicare beneficiaries, and has the prospect of reducing out-of-pocket costs for many Medicare beneficiaries. Partly due to the favorable payment climate, plan sponsors continue to expand plan offerings across the country and enrollment continues to climb.

PFFS plans have a unique legislative history. Congress authorized these plans as a way to expand private plan options to more parts of the country, especially rural areas. It also authorized these plans in response to concerns raised by right-to-life interests, which lobbied for preserving unrestricted access to health care services as the Medicare program encouraged more private plan delivery.

Recent reports of patients having difficulty accessing physicians and other health care providers have increased scrutiny of these plans. Further, some stakeholders have raised concerns that these plans are being marketed aggressively to Medicare beneficiaries, leading some to enroll without being fully aware that they may have more restricted access to care.

PFFS plans, on average, are paid at a relatively high rate. Questions loom whether the higher payments are justified given that PFFS plans may not be applying measures to assure and improve quality and to reduce unnecessary health care services. This situation could spur heightened scrutiny of the payment formula, perhaps leading to payment reductions. Beneficiaries considering these plans should be aware that their benefits and premiums may change over time or their particular plan could exit the program if Congress were to reduce payments. On the other hand, the burgeoning PFFS enrollment has created a constituency for these plans, possibly dampening Congress's desire to squeeze payment if overall beneficiary satisfaction is high.

As PFFS offerings and enrollment continues to build, further monitoring and evaluation will be necessary to assess whether PFFS plans are able to decrease out-of-pocket costs for enrollees; provide adequate access to physicians, hospitals, and other health care providers; improve quality and health outcomes; and lower overall Medicare spending. Further monitoring and evaluation is also necessary to ensure that these plans are being marketed to beneficiaries fairly and accurately, including disclosure that enrollees may not get full, open access to all Medicare-participating physicians and other health care providers.



The Henry J. Kaiser Family Foundation

Headquarters

2400 Sand Hill Road
Menlo Park, CA 94025
(650) 854-9400 Fax: (650) 854-4800

**Washington Offices and
Barbara Jordan Conference Center**

1330 G Street, NW
Washington, DC 20005
(202) 347-5270 Fax: (202) 347-5274

www.kff.org

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