

Private Fee-for-Service Plans in Medicare Advantage

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Chairman Stark, Ranking Member Camp, distinguished Subcommittee members, I am Mark Miller, Executive Director of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to be here with you this afternoon to discuss Medicare Advantage (MA) private fee-for-service (PFFS) plans.

MedPAC is charged by the Congress with making recommendations on payment policy both for providers in Medicare's traditional fee-for-service (FFS) program and for MA organizations. The Commission's goal is for Medicare payments to cover the costs that efficient providers and organizations incur in furnishing care to beneficiaries, while ensuring that providers are paid fairly and that beneficiaries have access to the care they need. MedPAC focuses on ensuring that Medicare program dollars are spent wisely—ensuring that beneficiaries receive efficient, high-quality care and that beneficiaries and taxpayers get maximum value for each dollar spent in the program. We are striving to make Medicare a more efficient program while improving the quality of care beneficiaries receive. This is our framework for making recommendations on payment policy for providers in FFS Medicare; it is the same framework we use in making recommendations on MA payment policy.

The Commission supports the participation of private health plans in Medicare. Beneficiaries should be able to choose health plans that seek greater efficiency in the delivery of health care and improved outcomes for enrollees. Private plans have the flexibility to use care management techniques that FFS Medicare does not encourage. When private plans are paid appropriately, they have greater incentives to undertake innovations in care delivery and management and to negotiate with providers over levels and methods of payment. The Commission believes that the MA program as currently structured is not promoting greater efficiency because plans are not being paid appropriately.

The current MA payment policy is inconsistent with MedPAC's principles of payment equity between MA and the traditional FFS program. The Commission believes that payment policy in the MA program should be built on a foundation of financial neutrality between payments in the traditional FFS program and payments to private plans. Financial neutrality means that the Medicare program should pay the same amount, adjusting for the risk status of each beneficiary, regardless of which Medicare option a beneficiary chooses. Moreover, the

program applies the standards and rules inequitably among different types of MA plans. Equity and efficiency issues are of particular concern with Medicare facing long-run issues of financial sustainability, discussed in our March 2007 report to the Congress.

MedPAC recommendation on MA payment

Medicare's private plan option was originally designed to produce efficiency in the delivery of health care, to the benefit of both the program and plan enrollees. Efficient plans would be able to provide extra benefits to enrollees, and greater efficiency would lead to higher plan enrollment. Competition among plans for enrollees would promote further efficiency.

Although MA uses a type of bidding system to determine plan payments and beneficiary premiums, the MA payment system does not promote efficiency because MA plans are bidding against benchmarks that have been set at very high levels through various legislative changes. As a result, plans that are more costly than traditional Medicare can attract enrollment by offering extra benefits financed by the higher payments. Inefficient plans—as well as efficient plans—are able to provide enhanced coverage. The enhanced coverage is possible because of generous MA program payments in excess of Medicare FFS payment levels.

Beginning with our March 2001 report to the Congress, the Commission has recommended that Medicare payment policy should be neutral to whether a beneficiary chooses a private plan or remains in the traditional FFS program. What this means for MA payment policy is that benchmarks—the basis of payment in MA—should be set at 100 percent of FFS Medicare rates.

To say that MA benchmarks should be at 100 percent of Medicare FFS expenditures does not mean the Commission considers the traditional FFS program to be the “gold standard” of efficiency—either in terms of program costs or in terms of the value beneficiaries receive for each dollar of program expenditures. In FFS, we know that, among providers and across geographic areas, there are varying levels of efficiency and varying levels of quality. The same is true of MA health plans. Efficiency and quality vary across plans and across plan types. The Commission's recommendation that MA benchmarks be set at 100 percent of FFS

would allow plans that are efficient, relative to FFS Medicare, to participate successfully in Medicare and offer enrollees extra benefits financed by plan efficiencies.

Having recommended that benchmarks be set at 100 percent of FFS, the Commission also recognizes that changing MA plan payment rates to achieve financial neutrality too quickly will cause disruptions for beneficiaries in some markets, and thus the Congress may want a transition period as payment changes are made.

PFFS plans: Enrollment growth, payment levels, and their efficiency

PFFS plans were authorized in the Balanced Budget Act of 1997 (BBA), but it has only been recently that enrollment has grown in these plans. In December 2005, there were about 200,000 PFFS enrollees, and Medicare had contracts with 17 PFFS plans. As of February 2007 there were 47 contracts and the PFFS plans had about 1.3 million enrollees—a growth rate of nearly 300 percent over a year and a half, or 1.1 million new enrollees (Table 1).

Table 1 Private fee-for-service plan enrollment has grown at a faster rate than other types of Medicare Advantage plans in the last two years

Plan type	Enrollment			Net enrollment growth	
	December 2005	August 2006	February 2007	Dec. 2005 to Aug. 2006	Aug. 2006 to Feb. 2007
Local HMOs and PPOs	5,157,627	5,921,837	6,064,666	15%	2%
PFFS	208,990	802,068	1,327,826	284%	66%
Regional PPOs	None available	89,492	120,770	N/A	35%

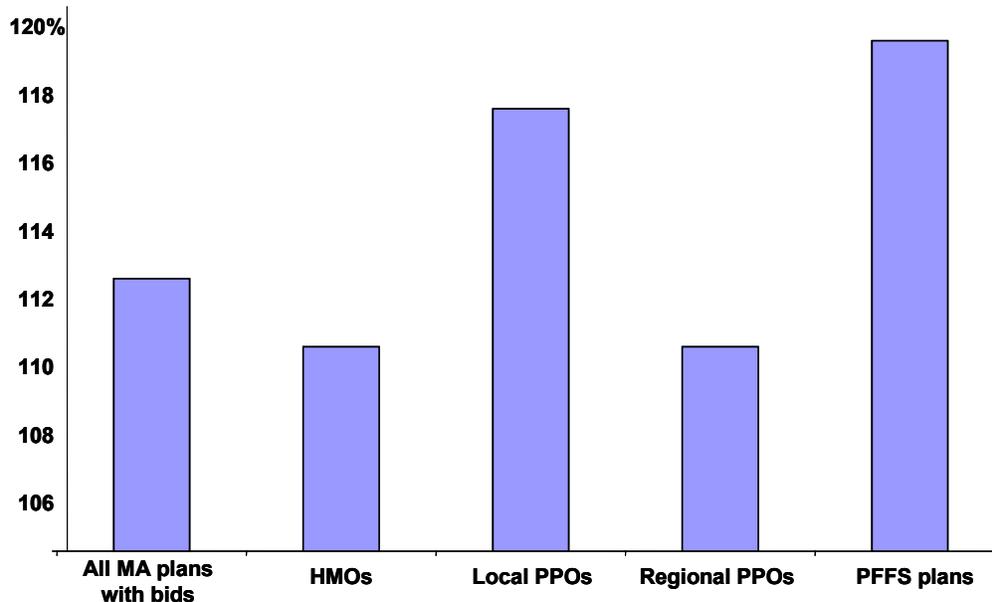
Note: PPO (preferred provider organization), PFFS (private fee-for-service), N/A (not applicable).

Source: CMS enrollment data.

The remarkable growth in PFFS enrollment is due to a number of factors, with the primary factor being MA payment policy. Currently, all plan types receive MA program payments for their enrollees that, on average, are greater than program expenditures would have been if the beneficiaries had remained in FFS Medicare. Among plan types, PFFS plans have the highest ratio of plan payments to Medicare FFS expenditures—not because they are paid differently but because of where they operate and the counties where they have enrollment and because of the costs they incur in providing the Medicare benefit package, as I explain below. On

average, for PFFS enrollees, the program spends 119 percent of what the program would have spent in FFS Medicare (Figure 1).

Figure 1 PFFS plans, on average, have the highest relative percentage of MA plan payments compared to Medicare FFS spending



Note: PFFS (private fee-for-service), MA (Medicare Advantage), FFS (fee-for-service), PPO (preferred provider organization). Data are enrollment-weighted numbers as of July 2006.

Source: MedPAC analysis of CMS bid data.

MA benchmarks and plan payments

Figure 1 represent the payments to each plan type for both the Medicare Part A and Part B benefit package and the extra benefits that MA plans will provide, as determined through the MA bidding system that began in 2006.

Under the MA bidding system, payments to MA plans are based on benchmarks for each county or, in the case of regional preferred provider organization (PPO) plans, benchmarks for each region. The benchmarks are bidding targets for the plans. The benchmark is the maximum amount Medicare will pay an MA plan. Any other revenue that the plan needs to cover the cost of providing the Medicare benefit package to its enrollees has to come from beneficiaries—in the form of a plan premium or cost sharing for plan services.

To determine beneficiary premiums and to determine the amount Medicare will pay a plan, plans give CMS a bid stating what it will cost the plan to provide the Medicare Part A and Part B benefit package. If the plan bid exceeds the benchmark, the plan charges a premium to make up the revenue it needs to cover the cost of providing the Medicare benefit package. If a plan bid for the Medicare benefit package is below the benchmark, 25 percent of the difference is retained in the Medicare trust funds, and the plan is required to use the remaining 75 percent, referred to as the “rebate,” to finance extra benefits, such as reduced Part B or Part D premiums, reduced cost sharing, or added benefits not covered by Medicare (e.g., routine vision and dental coverage). Plan bids for all benefits—both the Medicare Part A and Part B benefit package and extra benefits—include costs for administration, marketing, and profit or retained earnings.

Virtually all plans participating in MA are bidding below their area benchmarks. In part, this is because benchmarks are very high in relation to FFS as a result of a number of statutory provisions introduced over the years that affected benchmark levels. For example, statutory provisions introduced minimum county payment rates, or floors, intended to attract or retain private plans in Medicare.

The effect of floor payment rates on MA benchmarks

Payment floors were introduced in the BBA in 1997. The BBA established a payment floor for counties with relatively low FFS expenditures. The BBA floor is often called the rural floor because it applies mainly to rural counties and was primarily intended to attract plans to rural areas. What is referred to as the large urban floor, or the metropolitan statistical area (MSA) floor, applies to counties within large MSAs. The MSA floor was introduced in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) and was effective as of March 2001. BIPA also provided an increase in the BBA floor rate. In many cases, the floor rates resulted in plan payment rates that were well above Medicare FFS expenditure levels in a given county.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, which introduced the MA program, made changes to the methodology for determining plan payment rates (i.e., the benchmarks, in the bidding system). One aspect of the payment

changes is that there is no longer a payment floor provision in the law. However, the effect of the earlier floors is still seen in MA benchmarks for counties that historically had been floor counties. These counties still have very high relative benchmarks compared with other geographic areas: On average, the benchmarks are 121 percent of FFS for the MSA floor counties and 134 percent of FFS for the floor established in the BBA (mainly rural counties).

MA benchmarks and plan payments: PFFS versus other plans

Enrollment in PFFS tends to be concentrated in counties with benchmarks based on floor rates—i.e., rates that were often significantly higher than FFS expenditure levels for the county. This explains the difference in benchmarks for PFFS plans compared to other plan types in MA, which do not have their enrollment so highly concentrated in floor counties.

In July 2006, about 87 percent of PFFS enrollment was in floor counties. Consequently, the July 2006 enrollment-weighted level of benchmarks for PFFS plans was at 122 percent of FFS. The high benchmarks allow PFFS plans to have high bids that enable these plans to finance their cost of providing the Medicare Part A and Part B benefit. The Medicare program pays, on average, 109 percent of FFS for each enrollee for a PFFS plan to provide the Medicare Part A and Part B benefit package—making PFFS the least efficient plan type when measured against expenditures in Medicare’s traditional FFS program (Table 2). The benchmarks are also high enough that, on average, all plan types—including the least efficient ones—are able to offer extra benefits financed by rebate dollars.

Table 2 PFFS plans are the least efficient plan type in MA

	All MA plans with bids	HMO	Local PPO	Regional PPO	PFFS
Benchmark/FFS expenditures	116%	115%	120%	112%	122%
Bid (for Medicare Part A and Part B benefit) in relation to FFS	99	97	108	103	109
Rebate as percent of FFS	13	13	9	7	10
Payment (bid + rebates)/FFS	112	110	117	110	119

Note: PFFS (private fee-for-service), MA (Medicare Advantage), PPO (preferred provider organization), FFS (fee-for-service). Data are for July 2006, weighted by plan enrollment.

Source: MedPAC analysis of CMS bid data.

While PFFS plans are the least efficient plans, HMOs are the most efficient MA plans. That is, for a comparable beneficiary and a comparable benefit package, HMOs deliver the traditional FFS benefits much more efficiently than PFFS plans. HMO plans can provide the Medicare Part A and Part B benefit for 97 percent of Medicare’s FFS costs, on average.

When a plan bid is lower than the benchmark, the total program payment to an MA plan consists of the payment of the plan bid for the Part A and Part B benefit plus the rebate dollars (75 percent of the bid-to-benchmark difference). When plan bids are low, more money is available for extra benefits financed by rebate dollars, and more is retained in the trust funds. When looking at Medicare payments to plans—the bid plus the rebate amount—PFFS plans are again the least efficient plan type. The combined program payment, the bid plus rebate dollars, is at 119 percent of FFS for these plans. In contrast, even though HMOs operate in areas with lower average benchmark ratios than PFFS plans, HMOs provide a higher level of extra benefits than PFFS plans—13 percent of FFS expenditures for HMOs versus 10 percent of FFS for PFFS plans—and they do so with better overall efficiency. That is, HMOs provide the Medicare Part A and Part B benefit package, and extra benefits, at a far lower total program cost (110 percent of FFS) than PFFS plans (119 percent of FFS).

While the Commission has recommended that benchmarks be set at 100 percent of FFS, the Commission also recommended in the June 2005 report to the Congress that the 25 percent difference between the benchmark amount and bids below 100 percent of the benchmark that is currently retained in the Medicare trust funds should be used to fund a pay-for-

performance program in MA. (Note that, for regional PPO plans, one-half of the 25 percent difference is reserved in a stabilization fund that can be used to promote regional PPO participation, but the funds are not available until 2012.)

PFFS plans: Their history and how they differ from other MA plans

In addition to differing from other plan types in their level of efficiency, PFFS plans differ in many other ways, including in their plan structure; the statutory, regulatory, and administrative requirements applicable to these plans; and the historical basis for including PFFS plans as a Medicare option.

To understand the role of PFFS plans in Medicare, and how that role has changed in the MA program, I will review some of the history of private plan contracting in Medicare and the history of the PFFS option in particular.

Within the MA program, there are several types of plan options, with different features that might attract beneficiaries looking at their options in terms of cost (or cost savings), quality, and plan features. The current MA options range from HMOs that use staff or group practices or have other network arrangements; to HMOs with point-of-service options that cover some level of out-of-network care; to PPOs that have in-network as well as out-of-network coverage; to the least restrictive option, PFFS plans; and other options such as cost-reimbursed plans and medical savings account plans.

The law defines a PFFS plan as one in which the plan, “(A) reimburses hospitals, physicians, and other providers at a rate determined by the plan on a fee-for-service basis without placing the provider at financial risk; (B) does not vary such rates for such a provider based on utilization relating to such provider; and (C) does not restrict the selection of providers among those who are lawfully authorized to provide the covered services and agree to accept the terms and conditions of payment established by the plan” (section 1859(b)(2) of the Social Security Act).

Although the statute permits PFFS plans to form networks of providers paid on a FFS basis, to date virtually all PFFS plans are paying providers at Medicare FFS rates and have not

formed networks. Instead, PFFS plans rely mainly on “deemed” participation of providers to provide care to their enrollees. Under this policy, the plan deems a provider to be in the PFFS plan if the beneficiary states that he or she is a PFFS plan enrollee and the provider treats the patient after learning about the plan’s terms and conditions of payment. A provider also is deemed if he or she has had reasonable opportunity to obtain information about terms and conditions (such as being provided with an Internet source for the terms and conditions). PFFS plans essentially mimic FFS Medicare in their structure and their payment and contracting arrangements with providers.

The BBA introduced the PFFS option to allow for a private plan that guaranteed access to all Medicare providers without imposing utilization controls on the providers. Policymakers developed this option because, in the 1990s, during the period of greatest growth in managed care enrollment, they feared that there could be rationing of health care as a result of the general movement toward managed care, utilization management, and restrictive provider networks in the health care system. They wanted an option without limitations on enrollees’ ability to obtain care through the providers of their choice.

While including the PFFS option in the BBA, the Congress also intended that enrollees bear the added cost of a private health plan offering free access to providers. As noted in the BBA conference report, “the private fee-for-service Medicare+Choice option authorized by this agreement represents the first defined contribution plan in which beneficiaries may enroll in the history of the program.” PFFS was a defined contribution plan under Medicare+Choice (the predecessor to MA) because, unlike other plans, a PFFS plan could charge a premium for its cost of providing the Medicare Part A and Part B benefit package in excess of the actuarial value of Part A and Part B cost sharing in FFS Medicare. That is, the Congress expected PFFS plans to be more expensive than FFS Medicare. Beneficiary premiums would make up the shortfall in revenue, and beneficiaries would be willing to pay an extra premium to guarantee what the beneficiary would consider adequate access to providers and adequate access to Medicare-covered services. Currently, PFFS plans are more expensive than the traditional FFS program, but the Medicare program, not the beneficiaries enrolling in these plans, pays the difference in cost. Medicare is subsidizing these plans for both the cost of the Medicare benefit package as well as the cost of extra benefits.

The payment floors created an opportunity for PFFS plans to play a different role from what was envisioned for these plans in 1997. The current MA benchmarks are high enough to permit PFFS plans to cover their cost of providing the Medicare Part A and Part B benefit and high enough to allow the plans to offer extra benefits to enrollees. Because floor payments in rural areas and certain MSA counties are so far above Medicare FFS expenditure levels, PFFS plans have been able to operate as non-network plans, pay FFS Medicare rates to providers, *and* offer reduced cost sharing and extra benefits to enrollees. If benchmarks were not so high, it is unlikely that PFFS plans would be attractive for beneficiaries. PFFS plans do not use the mechanisms that managed care plans use to increase efficiency (e.g., formation of networks, careful utilization controls) and therefore would not be able to offer attractive benefit packages if MA benchmarks were closer to Medicare FFS expenditure levels.

The high MA benchmarks have allowed PFFS plans to attract enrollment in areas with limited competition from other plan types. In certain types of geographic areas, PFFS plans have an advantage over other MA plan types that must set up networks of providers. In rural areas, for example, there are many barriers to setting up networks, which the Commission documented in a June 2001 report to the Congress. In the same report, we anticipated the possibility that PFFS plans would be providing extra benefits solely because of the higher payment rates and noted that this “would not appear to be paying the cost of an efficient provider—the basic axiom of Medicare payment policy. Paying PFFS plans at ... [higher] rate[s] is an expensive way to get extra benefits for Medicare beneficiaries in some counties.”

Advantages enjoyed by PFFS plans compared to other plans

In addition to their non-network structure and the ability to piggyback on Medicare rates to pay providers, PFFS plans have an advantage over other MA plans because they are subject to fewer requirements, and certain statutory and administrative rules provide additional advantages to these plans. The differences are outlined in Table 3.

The Commission supports equity in the treatment of different plan types within the private plan sector. The Commission favors a level playing field for all plan types, with no type having an advantage over another type unless special circumstances dictate otherwise. The

Commission believes, for example, that PFFS plans should report on the quality of care for their enrollees so that beneficiaries can use quality as a factor in judging these plans.

Table 3 Different requirements and provisions apply to different types of MA plans

	PFFS	Medical Savings Account	HMO/ Local PPO	Regional PPO	SNP
Must build networks of providers ^a			✓	✓	✓
Must report quality measures			✓	✓	✓
Must have bids reviewed and negotiated by CMS			✓	✓	✓
Protected from some risk through risk corridors ^b				✓	
Must return to the trust funds 25 percent of the difference between bid and benchmark ^c	✓		✓	✓	✓
Must offer Part D coverage ^d			✓	✓	✓
Must have an out-of-pocket limit on enrollee expenditures		✓		✓	
Can limit enrollment to targeted beneficiaries ^e					✓
Must offer individual MA plan if offering employer group plan ^f			✓	✓	✓

Note: MA (Medicare Advantage), PFFS (private fee-for-service), PPO (preferred provider organization), SNP (special needs plan).

^aPFFS plans are exempted from other MA plans' network adequacy requirements if they pay providers Medicare fee-for-service rates.

^bRisk corridors are available only in 2006 and 2007.

^cThis provision applies when bids are under the benchmark. For regional PPO plans, one-half of the 25 percent amount is retained, and the remainder is included in the stabilization fund that, as of 2012, may be used to retain or attract such plans.

^dMedical savings account plans are prohibited from offering Part D coverage. PFFS plans may offer Part D coverage, but special rules apply to such plans (e.g., it is not required that they receive drugs at a discounted rate when the deductible applies or the person is in the Part D coverage gap).

^eMA plans must allow all Medicare beneficiaries in their service area to enroll with few exceptions (e.g., beneficiaries with end-stage renal disease). Other exceptions apply to medical savings account plans (e.g., Medicaid beneficiaries may not enroll in such plans). SNPs are permitted to limit their enrollment to their targeted beneficiary population (i.e., dual eligibles, beneficiaries who reside in an institution, or those with a chronic or disabling condition). SNPs can be local or regional coordinated care plans. They cannot be medical savings account or PFFS plans.

^fOnly non-network PFFS plans can operate exclusively as plans limited to employer group enrollees.

To highlight another major difference from other plan types, PFFS plans (and medical savings account plans) will have an advantage in their ability to offer retiree coverage to an

employer or union for the entity's Medicare population. Other types of organizations with network plans that wish to offer plans tailored for employer-group-sponsored retirees must have plans that are available to individual, non-group-sponsored beneficiaries (i.e., to have a group contract they must also be operating in the individual Medicare market). As of 2008, non-network PFFS plans and medical savings account plans will not have this requirement, so they will be able to offer plans exclusively to employers or unions.

The Commission is also concerned about a recent statutory provision that gives an unfair advantage to PFFS plans. The Tax Relief and Health Care Act of 2006 added a provision, effective only for 2007 and 2008, which allows a beneficiary who is not an MA enrollee (i.e., is in FFS Medicare) to enroll in an MA-only (nondrug) plan outside of the open enrollment period. These MA-only plans can thus have year-round enrollment, while other plans may accept new enrollees only during the open enrollment period (or if a person is newly entitled to Medicare, or is a dual eligible). In particular, the provision gives an advantage to PFFS plans. The CMS guidance on this provision states that beneficiaries will lose their Part D coverage in a stand-alone drug plan if they take this option and enroll in an MA organization that has drug coverage (an organization with an MA–Prescription Drug option). In effect, if such a person wishes to continue Part D drug coverage and wants to enroll in MA, the only available option is a PFFS plan not offering drug coverage. Beneficiaries without drug coverage may enroll in any MA-only plan, but people with Part D coverage would have the drug coverage continue only if they enroll in a PFFS MA-only plan.

Conclusion: FFS Medicare, MA, and PFFS plans

In MA, plans compete against the traditional program to attract enrollees, and plans in a given market area compete against each other to attract enrollees. MA plans distinguish themselves from traditional FFS Medicare, and from other competing plans, on the basis of reduced cost and added benefits, quality, and other features that beneficiaries find attractive.

PFFS plans were designed to meet a perceived need. As originally conceived, the Congress did not expect that PFFS plans would be able to offer reduced costs or extra benefits to enrollees choosing the option. In fact, PFFS plans were expected to have additional

premiums that enrollees would have to pay. What would attract beneficiaries to PFFS plans would be the assurance that they could receive care through an FFS system where providers were not subject to utilization controls.

The current MA payment system has set up the wrong market dynamic. Setting benchmarks well above the cost of traditional Medicare signals that the program welcomes plans that are more costly than traditional Medicare. Both PFFS plans, which are inefficient when measured against FFS program costs, as well as other types of MA plans that are efficient, provide the kind of enhanced coverage that attracts beneficiaries to private plans. In many cases, generous MA program payments that are in excess of Medicare FFS payment levels are financing these benefits. All taxpayers, and all Medicare beneficiaries—not just the 18 percent of beneficiaries enrolled in private plans—are funding the MA payments in excess of Medicare FFS levels.

The current MA payment policy is inconsistent with MedPAC's principles of payment equity between MA and the traditional FFS program. Moreover, the program applies the standards and rules inequitably among different types of MA plans. Equity and efficiency issues are of particular concern with Medicare facing long-run issues of financial sustainability.

The Commission believes that the Medicare program achieves greater efficiency when organizations face financial pressure. The Medicare program needs to exert consistent financial pressure on both the traditional FFS program and the MA program. This financial pressure, coupled with meaningful measurement of quality and resource use to reward efficient care, will maximize the value of Medicare for the taxpayers and beneficiaries who finance the program. The current MA payment policy is not exerting the kind of financial pressure that can maximize efficiency. MA payment policy is actively shaping the market for Medicare health plans, but the current policy conveys the message that Medicare values private plans that cost more than FFS, and Medicare is willing to subsidize beneficiary enrollment in MA.