Private Fee-For-Service Plans in Medicare:

Rapid Growth and Future Implications

Patricia Neuman, Sc.D.
Vice President and Director, Medicare Policy Project
The Henry J. Kaiser Family Foundation

A Hearing of the

Subcommittee on Health
Committee on Ways and Means
United States House of Representatives

May 22, 2007

Statement of Patricia Neuman, Sc.D

Chairman Stark, Mr. Camp, distinguished members of the Committee, thank you for inviting me here today to discuss Medicare Advantage Private Fee-for-Service plans. I am Patricia Neuman, a Vice President of the Kaiser Family Foundation and Director of the Foundation's Medicare Policy Project.

Medicare Private Fee-for-Service plans are one among many private plan options offered to beneficiaries under the Medicare Advantage program. As with other types of Medicare Advantage plans, Medicare Private Fee-for-Service plans are offered by health insurance companies that receive capitated payments from Medicare to provide health benefits for each Medicare enrollee. My testimony draws on a number of studies commissioned and conducted by the Kaiser Family Foundation, as well as other reports. This testimony reviews the role of Private Fee-for-Service plans under Medicare; examines how Private Fee-for-Service plans differ from other Medicare Advantage plans; and discusses key issues for beneficiaries and long-term implications for Medicare.

Why Focus on Medicare Private Fee-for-Service Plans

Over the past two years, Medicare Private Fee-for-Service plans have grown much faster than many expected, and recently we have seen signs of growing pains. We have heard and read reports about aggressive marketing practices, confused beneficiaries, and doctors and hospitals refusing to see patients who are enrolled in Private Fee-for Service plans. MedPAC, the Congressional Budget Office and the HHS Office of the Actuary are in agreement that the shift of beneficiaries from traditional Medicare to Medicare Advantage plans increases Medicare spending, leading others to raise concerns about whether the Private Fee-for-Service plan option provides adequate value to beneficiaries and taxpayers.

Private Fee-for-Service plans collectively enroll a very small share (3 percent) of the total Medicare population and less than 20 percent of all Medicare Advantage enrollees, yet their role in the Medicare program has emerged as a front-burner issue (Exhibits 1 and 2).

First, there has been a rapid increase in the number of beneficiaries enrolling in Private Fee-for-Service plans since 2005 (Exhibit 3). Private Fee-for Service plans were first authorized in 1997, but received minimal attention with enrollment hovering at about 25,000 enrollees. Today, 1.5 million Medicare beneficiaries are enrolled in Private Fee-for-Service plans, up from 209,000 in 2005. CBO projects that enrollment levels will double within two years, and nearly triple within ten years, and projects that this jump in enrollment will lead to an increase in Medicare spending as beneficiaries shift from traditional Medicare to Medicare Advantage plans (Exhibit 4).

Second, Medicare pays more for Medicare Advantage enrollees, on average, than it would pay for the same beneficiaries in traditional Medicare. Medicare pays, on average, 12 percent more for beneficiaries who enroll in Medicare Advantage plans than it would pay for the same individuals to be covered under the traditional Medicare program, and pays 19 percent more, on average, for beneficiaries who enroll in Private Fee-for-Service plans, according to MedPAC (Exhibit 5). Medicare's payments do not vary by type of Medicare Advantage plan, but are higher for Private Fee-for-Service plans because the counties in which they operate tend to have high payments relative to costs (MedPAC, 2007; Gold, 2007a).

Third, Private Fee-for-Service plans operate under a different set of rules and requirements than other Medicare Advantage plans (Blum, 2007). Firms that offer Private Fee-for-Service plans are not required to provide a plan with a Medicare Part D drug benefit, nor are they required to have quality and utilization review and reporting procedures. They are also exempt from a provision that allows the Secretary to negotiate monthly bid amounts and supplemental benefits with plans, unlike other Medicare Advantage plans (Exhibit 6).

Furthermore, unlike other Medicare Advantage plans, Private-Fee-for-Service plans are not required to establish networks of physicians, hospitals and other providers – and most have elected to operate without a network. This makes it easier for Private Fee-for-Service Plans to enter the market, but the downside for enrollees is that, without contractual relationships, Private Fee-for-Service plans are unable to guarantee access to physicians and other providers for their enrollees, and have limited ability to coordinate or manage care.

A recent legislative change gives certain Private Fee-for-Service plans a leg up in growing market share by allowing plans that do not provide the Part D drug benefit to enroll beneficiaries who are in traditional Medicare throughout the entire calendar year in 2007 and 2008, rather than in the more limited existing open enrollment period that applies to other plans.

The Current Medicare Private Fee-for-Service Landscape

Despite initial skepticism about the need for or viability of Medicare Private Fee-for-Service plans, dozens of companies are currently offering these plans throughout the country (Gold, 2007b). All beneficiaries now have the option to enroll in one or more Private Fee-for-Service plans, and half of all beneficiaries (52 percent) can choose among six or more firms offering a Medicare Private Fee-for-Service option (Gold, 2007b). In some areas, such as Madison County, Wisconsin, beneficiaries can choose from among 27 Medicare Advantage plans, 19 of which are Private Fee-for-Service plans offered by five different firms.

From an insurer's perspective, there are a number of features of Private Fee-for-Service plans that make them appealing, relative to other Medicare

Advantage plans. Unlike Regional Preferred Provider Organizations (PPOs) which were authorized under the Medicare Modernization Act of 2003, Private Fee-for-Service plans are permitted to operate at the county level, rather than serve an entire region, giving firms the flexibility to strategically pursue new enrollees in relatively high payment areas. However, unlike other Medicare Advantage plans that operate at the county level, such as HMOs, Private Fee-for-Service plans are not required to establish a network of providers, which eases the administrative burden of market entry and reduces start-up costs. In addition, firms that currently offer Medigap policies may see Medicare Private Fee-for-Service plans as an attractive alternative for their Medigap policyholders, because they can now offer a government-subsidized source of supplemental coverage that could help reduce the monthly premiums they charge.

Looking to the future, some believe that Private Fee-for-Service plans will become more popular among employers who offer health benefits to Medicare-eligible retirees. Private Fee-for-Service plans that have no provider network are uniquely positioned to provide coverage to retirees throughout the country. Currently, enrollment among retirees in employer plans represents a very small share of total Private Fee-for-Service enrollment because employers have been slow to take up this option. In fact, more than six of ten large private sector employers (62%) that offer benefits to age 65+ retirees said they did not offer a Medicare Advantage plan option in 2006 (Kaiser/Hewitt, 2006).

Characteristics of Beneficiaries in Private Fee-for-Service Plans

Little is known about the characteristics of beneficiaries who are choosing to enroll in Medicare Private Fee-for-Service plans, why they are enrolling, the services they receive or the extent to which they are able to see their doctors, specialists and other health care providers.

Private Fee-for-Service enrollees are spread throughout the country, with roughly three quarters of all enrollees coming from urban floor counties (such as Arlington, Virginia or Greensboro, North Carolina) and rural floor counties (MedPAC, 2007b). MedPAC also reports that the majority of Private Fee-for-Service enrollees live in urban areas and that about five percent of all beneficiaries living in rural areas are enrolled in a Medicare Private Fee-for-Service plan. In 2006, six states (GA, MI, MN, NC, VA, WI) had between 40,000 and 70,000 enrollees, while 12 states had fewer than 1,000 enrollees and another 14 states had between 1,000 and 10,000 Private Fee-for-Service enrollees (Gold, 2007b).

Given the absence of publicly-available data on the characteristics of Medicare Advantage enrollees, by plan type, it is not possible to paint a demographic picture of the Medicare Private Fee-for-Service population, nor determine if beneficiaries enrolled in these plans are disproportionately vulnerable relative to enrollees in other Medicare Advantage plans or traditional

Medicare. In general, Medicare Advantage plan enrollees tend to be in better health and have fewer chronic diseases than their counterparts in traditional Medicare, based on our analysis of the 2003 Medicare Current Beneficiary Survey. Medicare Advantage plans also enroll a smaller share of beneficiaries who are under age-65 who have permanent disabilities. As new data become available, it will be important to examine the characteristics of beneficiaries who are enrolling in various types of Medicare plans. However, there are currently no data available to determine whether Private Fee-for-Service enrollees differ from other Medicare Advantage enrollees in terms of medical needs or other characteristics, such as income or gender.

Key Considerations for Beneficiaries

Because Medicare Private Fee-for-Service plans are relatively new, and because they differ from other types of Medicare Advantage plans, beneficiaries have had little time to understand how they differ from the traditional fee-for-service Medicare program. A number of issues have emerged that have implications for beneficiaries.

Out-of-Pocket Spending and Benefits.

Many Private Fee-for-Service plans waive deductibles, offer a stop-loss limit on catastrophic spending for services covered under Parts A and B, unlike traditional Medicare, and also provide some additional benefits; however, even with these additional benefits, sicker beneficiaries could be disadvantaged by high cost-sharing requirements under Private Fee-for-Service plans relative to traditional Medicare (Gold, 2007a).

Unlike traditional Medicare, some Private Fee-for-Service plans impose daily hospital copayments, daily copayments for home health visits, and daily copayments for the first several days in a skilled nursing facility. Only about half of all Medicare Private Fee-for-Service plans offered a drug benefit in 2006, and none of these plans covered brand-name drugs in the so-called “doughnut hole” (Gold, 2007a).

To illustrate the potential for higher out-of-pocket costs under Private Fee-for-Service plans than traditional Medicare, consider three different Private Fee-for-Service plans offered in Madison County, Wisconsin for a hypothetical but not atypical elderly woman on Medicare (Exhibit 7).

> Mrs. Rollins broke her hip, was admitted to the hospital for 8 days, then transferred to a skilled nursing facility (27 days) before going home and receiving home health visits to support her rehabilitation (47 visits). Mrs. Rollins would pay the monthly Part B premium under all three Private Fee-for-Service plans and traditional Medicare, and a supplementary premium under two of the Private Fee-For-Service plans. Under one of the plans,

she would pay a supplemental premium of $99/month (~$1,200/year) but would not get the Part D drug benefit.

Mrs. Rollins would pay $1,860 out-of-pocket in traditional Medicare, but $2,688, $2,710 or $3,519.50 under the three Private Fee-for-Service plans, taking into account the supplemental premiums and the stop-loss protection. Under the first plan, she would be helped by a $1,500 stop loss, but have higher costs due to the supplemental premium.

In other words, beneficiaries requiring a hospital stay and post-acute care, such as the hypothetical Mrs. Rollins, would pay more under each of the three Medicare Private Fee-for-Service plans than under traditional Medicare. This example also illustrates the wide range in out-of-pocket spending that beneficiaries may incur, depending on the plan they select. Beneficiaries could be hard-pressed to sort out these differences and others prior to enrollment in order to choose the least-costly plan for themselves.

Access to Physicians and Other Health Care Providers.

A central notion behind Private Fee-for-Service plans was that beneficiaries would have unfettered access to their medical providers, in contrast to more "managed" types of Medicare Advantage plans. However, providers are not required to accept Private Fee-for-Service enrollees – even if they accept other Medicare patients. There is mounting evidence from press reports that at least some beneficiaries enrolled in Private Fee-for-Service plans have been denied care by their medical providers (e.g. *Wall Street Journal*, May 8, 2007; *Tampa Tribune*, April 29, 2007)

It is not clear why some providers are refusing to treat patients who are enrolled in Private Fee-for-Service plans. Some have suggested that physicians are not familiar with the terms and conditions of Private Fee-for-Service plans, are wary of agreeing to see a patient without fully understanding how the plan works, and are concerned about administrative hassles. Other issues include concerns about payment levels and the amount of time it may take to get paid by such plans.

Efforts by Private Fee-for-Service plans to educate providers may address these issues over time, but in the short-term, providers' decisions to refuse to treat Private Fee-for-Service patients may come as an unpleasant surprise to seniors who elected this plan option under the impression that they could be treated by virtually any provider, just as they could under traditional Medicare. The fact that most Private Fee-for-Service plans do not have networks makes it difficult for beneficiaries to determine if their various doctors, specialists or even hospitals will accept a plan.

Questionable Marketing Practices.

In recent months, there have also been a number of reports and press accounts about aggressive, high-pressure marketing activities designed to lure beneficiaries into Medicare Advantage plans, including but not limited to Private Fee-for-Service plans. For example, a recent survey conducted by the National Association of Insurance Commissioners reports that 39 of 43 states received complaints about misrepresentations and inappropriate marketing practices, and 37 of 43 states reported that these practices led some beneficiaries to enroll in a Medicare Advantage plan without fully understanding the implications of their choice (Dilweg, 2007). These marketing activities are a particular concern, given the vulnerabilities of so many Medicare beneficiaries, including the roughly 25 percent of beneficiaries with cognitive impairments, such as Alzheimer's disease.

The concern, according to senior advocates and insurance commissioners, is that beneficiaries are finding themselves enrolled in Medicare Advantage plans in which they did not intend to enroll, and without a good understanding of how their plan operates. It is easy to see how a senior could be confused about the differences between traditional fee-for-service Medicare and Medicare Advantage Private Fee-for-Service plans, or confused about the different types of Medicare Advantage plans. These differences could have significant implications for beneficiaries' out-of-pocket spending and provider access.

Efforts to curb overly aggressive and misleading sales practices are critical, particularly given beneficiaries lack of understanding about the various types of Medicare plans (Hibbard, 2006).

Equity Concerns: Who Pays?

An often overlooked aspect of the Medicare Advantage program, and its current payment system, is the effects on beneficiaries who are covered under traditional Medicare. Because Medicare Advantage plans cover benefits under Medicare Parts A and B, the financing for Medicare Advantage benefits directly affects the Part A Trust Fund and Part B premiums.

According to the Office of the Actuary at HHS, the current payment system has the effect of cutting by two years the solvency of the Part A trust fund, potentially affecting coverage for current beneficiaries as well as pre-65 adults who are approaching the age of Medicare eligibility.

In addition, the HHS Actuary recently announced that the current payment system for Medicare Advantage plans has increased Part B premiums by an additional $2/month. These costs are borne by an estimated 29 million beneficiaries and by all states that contribute to Part B premiums on behalf of beneficiaries who are dually eligible for Medicare and Medicaid (Exhibit 8).

Summary

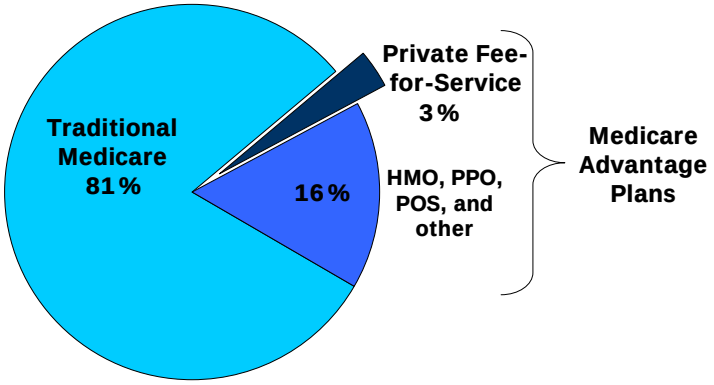
A review of Private Fee-for-Service plans reveals a number of issues for beneficiaries, taxpayers and the Medicare program itself. With about three percent of all beneficiaries enrolled today, and before a growing number of beneficiaries migrate to Medicare Private Fee-for-Service plans, now may be the time to focus greater attention on a number of issues that have surfaced.

Private Fee-for-Service plans have given more people on Medicare the option of choosing a private plan for their Medicare benefits, and have the potential to reduce enrollees' out-of-pocket costs. However, Private Fee-for-Service plans also have the potential to increase out-of-pocket costs for enrollees with serious health needs, and there is evidence that at least some patients enrolled in these plans have been denied care by physicians, specialists and other providers, despite expectations of unfettered access, similar to traditional Medicare.

With cost pressures facing Medicare and competing priorities for limited resources, serious issues for lawmakers to consider include whether Private Fee-for-Service plans offer value to Medicare constituents, and at what cost; whether Private Fee-for-Service plans should be exempt from requirements that apply to other plans; and whether sustaining current payment levels for Medicare Advantage plans is affordable, given the fiscal challenges that lie ahead.

Exhibit 1

Medicare Private Fee-for-Service Enrollment as a Share of the Total Medicare Population, 2007

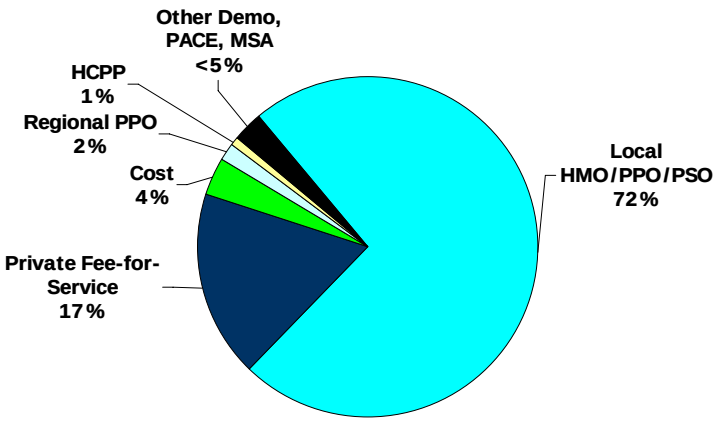


Total Medicare Beneficiaries = 44 million

SOURCE: Centers for Medicare and Medicaid Services, Medicare Advantage, Cost, PACE, Demo and Prescription Drug Plan Contract Report – Monthly Summary Report (Data as of May 2007).

Exhibit 2

Medicare Advantage Enrollment By Plan Type, 2007

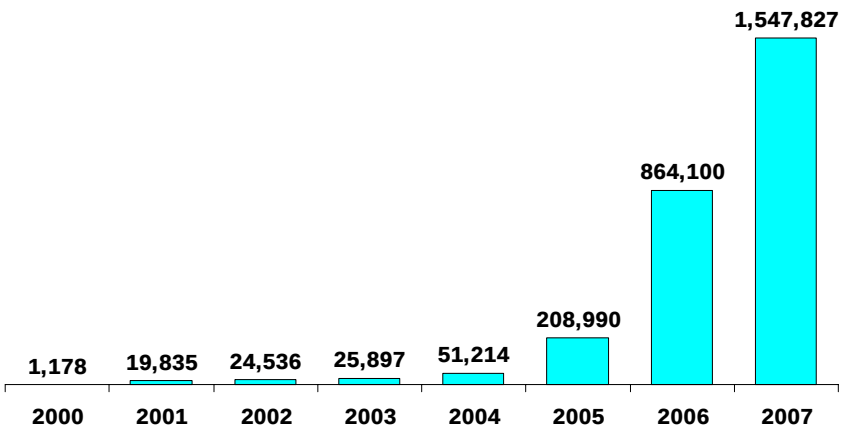


Total Medicare Advantage Enrollment = 8.6 million

SOURCE: Centers for Medicare and Medicaid Services, Medicare Advantage, Cost, PACE, Demo and Prescription Drug Plan Contract Report – Monthly Summary Report (Data as of May 2007).

Exhibit 3

Private Fee-For-Service Enrollment, 2000-2007

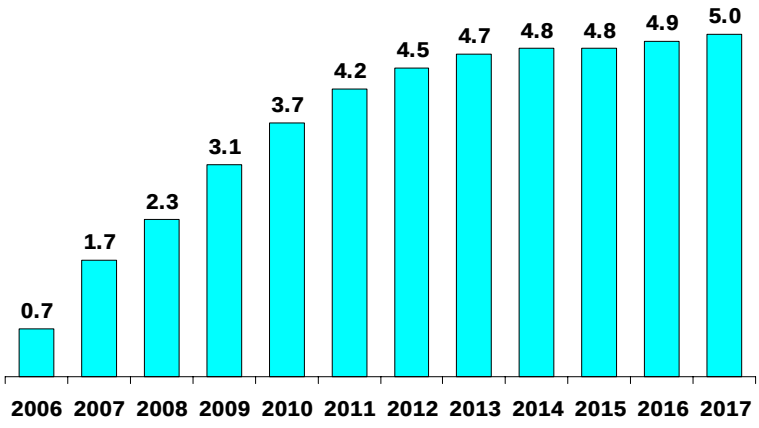


SOURCE: Avalere Health analysis of Centers for Medicare and Medicaid Services, Medicare Managed Care Contract Report (2000-2005); Centers for Medicare and Medicaid Services, Monthly Summary Report (2006-2007). Figures are year-end for 2000-2006 and as of May for 2007.

Exhibit 4

Current and Projected Enrollment in Medicare Private Fee-for-Service Plans, 2006-2017

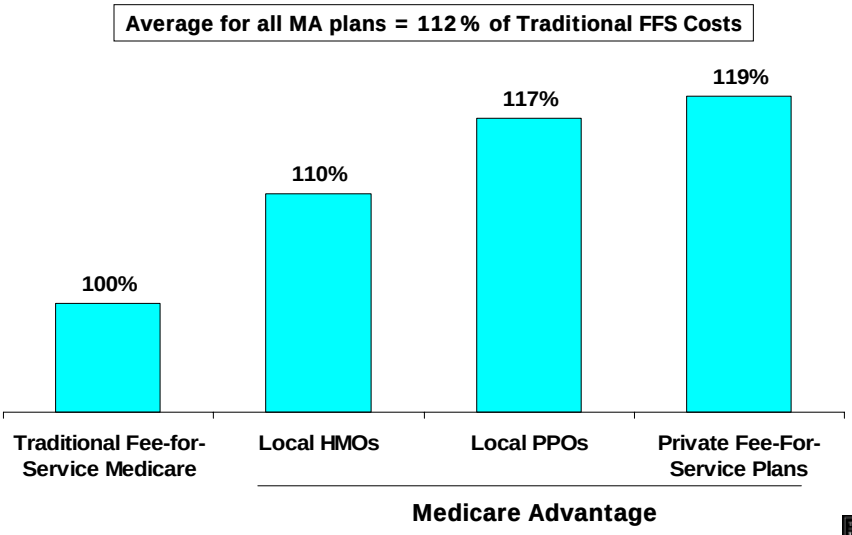
Enrollment Growth (in millions):



SOURCE: Congressional Budget Office, The Medicare Advantage Program: Enrollment Trends and Budgetary Effects, CBO Testimony, April 11, 2007.

Exhibit 5

Payments to Medicare Advantage Plans as a Share of Medicare Fee-for-Service Costs, 2006



Source: Medicare Payment Advisory Committee, March 2007.

Exhibit 6

Comparison of Selected Requirements for Non-Network Private Fee-for-Service Plans and Other Medicare Advantage Plans

Requirements	Network MA Plans (HMOs, PPOs)	Non-Network PFFS Plans
Plan must offer an MA plan that includes the Part D drug benefit	Yes	No
Plan must conduct baseline health assessment of new enrollees	Yes	No
Plan must identify and coordinate care of members with complex or serious medical conditions and arrange for necessary specialty care	Yes	No
Plan must conduct utilization review and develop mechanisms to detect under- and over-utilization	Yes	No
Plan must work with an independent quality review and improvement organization to perform external plan reviews	Yes	No
Plan must collect and report HEDIS data to assess and compare plan performance	Yes	No
CMS has authority to negotiate monthly bid amounts with plan, including supplemental benefits	Yes	No

SOURCE: Blum, Jonathan, Ruth Brown, and Miryam Frieder, "An Examination of Medicare Private Fee-for-Service Plans," for the Henry J. Kaiser Family Foundation, March 2007.

Exhibit 7

Comparison of Medicare Cost-Sharing Requirements in Traditional Medicare vs. Three Private Fee-for-Service Plans

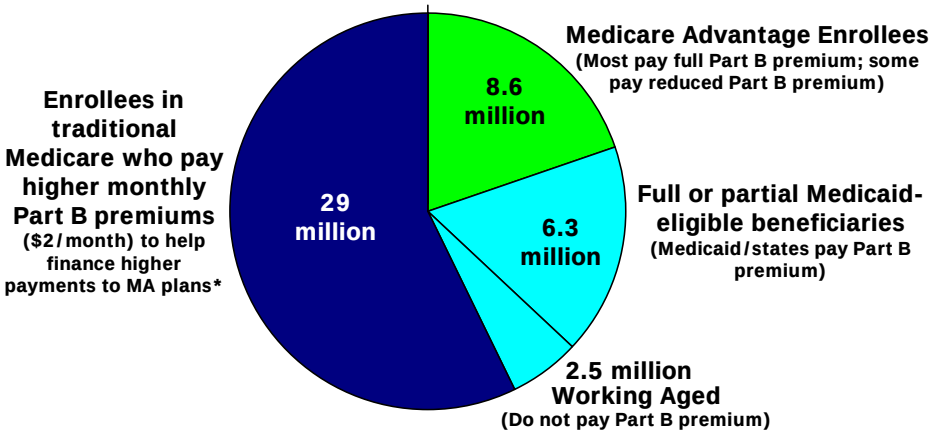
(Case Example: Madison, Wisconsin – zip code 53717)

COST-SHARING (Traditional Medicare)	Private Fee-for-Service Plans		
	SecureHorizons MedicareDirect Premier 300 (UnitedHealth)	Humana Gold Choice PFFS	Concert (Wellcare)
Monthly Premium (in addition to Part B $93.50/month)	$99	$0	$41
Inpatient Hospital Care ($992/deductible, coins. after 60 days)	$100/day for days 1-90	$550 copay for each hospital stay	$225/day days 1-5; $0/day days 6-90
Home Health (No Copayment)	$0	$0	$0 to $35 per day*
Skilled Nursing Facility ($0 days 1-20; $124 days 21-100)	$0 days 1-10; $115 days 11-100	$0 days 1-3; $90 days 4-100	$0 days 1-15; $90 days 16-60
OOP Limit (None)	$1,500/year	$5,000/year	$3,650/year
Rx Drugs (Access to Stand-Alone drug plans (PDPs))	No drug benefit	Drug benefit; No coverage in the doughnut hole	Drug benefit; No coverage in the doughnut hole

SOURCE: Medicare Plan Finder, www.Medicare.gov. * Case study assumed mid-point of $17.50/day

Exhibit 8

Distributional Impact of Higher Payments to Medicare Advantage Plans Relative to Traditional Medicare



Total Number of Beneficiaries = 44 Million

NOTE: *Effect on Part B premium provided by HHS Office of the Actuary, 2007.

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