BNA, INC.

HEALTH PLAN & PROVIDER

BNA Employee-Owned Since 1947

REPORT

Medicare Private Fee-for-Service Plans: A Market-Driven Blueprint For Enhancing Value

By John Gorman and Jean LeMasurier

Summary

Almost 1.5 million Medicare beneficiaries are enrolled in Private Fee-for-Service (PFFS) plans, which are among the fastest growing types of Medicare Advantage (MA) plans operating today. Although the rapid proliferation of PFFS plans has provided greater beneficiary choices and enhanced access to MA plans, especially in rural areas, it has also created problems. These include provider refusal to serve beneficiaries who enroll in PFFS plans, higher out of pocket costs for beneficiaries who get sick, and, in some cases, marketing and sales abuses among brokers and agents who recruit beneficiaries into these types of plans.

As enrollment in PFFS plans has soared, and as more of these problems have come to light, providers, beneficiaries, traditional MA plan sponsors, and policymakers including members of Congress, have started to ask hard questions. Do PFFS products provide real value to beneficiaries and the Medicare program as a whole, or should new laws and regulations be enacted to curtail their growth or eliminate them altogether?

Gorman is chief executive officer and LeMasurier is director of the Employer Group Practice for Gorman Health Group LLC. Gorman Health Group is a leading consulting services and business solutions firm specializing in Medicare managed care. The company is based in Washington, D.C. For more information, call (202) 364-8283 or e-mail info@gormanhealthgroup.com.

This article looks at the history and evolution of PFFS plans and examines the regulatory and market forces that have been driving their rapid growth. We also discuss the strengths and limitations of PFFS plans as they operate in the market today. Finally, we suggest specific steps commercial insurers can take to enhance the value of their PFFS products for both Medicare beneficiaries and the Medicare program as a whole—steps we believe are necessary to ensure the viability of these products in the long term.

Introduction

Less than four years after enactment of the Medicare Modernization Act (MMA) of 2003, 99 percent of beneficiaries now have access to a Medicare Advantage (MA) plan. A major contributor has been the growth of MA Private Fee-for-Service (PFFS) plans. Between 2005 and April 2007, the number of insurers offering a PFFS product doubled, and PFFS enrollment grew from 200,000 to almost 1.5 million. Today, commercial insurers such as Humana, WellPoint, Coventry, and Aetna offer PFFS products nationwide.

Almost overnight, many of the long-established Medicare HMOs and Medigap supplemental insurers woke up to as find many as 22 new, competing, low-cost PFFS benefit plans in their service areas. Meanwhile, Medicare beneficiaries suddenly had access to MA products that appeared to offer them the freedom to see any doctor and not have to switch providers.

History and Background of PFFS

It wasn't always this way. In fact, PFFS plans had very slow beginnings and limited market uptake. They were first created under the Balanced Budget Act of 1997 to allay concerns among indemnity proponents that managed care plans likely to thrive under that bill's

 ISSN 1528-2953

boost to the Medicare+Choice program would eventually take away provider choice and limit access to services. Few managed care observers believed PFFS plans would ever get off the ground, largely because these plans would not have the tools to effectively manage the risks of their capitated payments. (The legislation specifically required PFFS plans to accept any willing provider, allowed members to self-refer, prohibited use of prior authorization and required fee-for-service payments to providers at Medicare rates.)

CMS developed a regulatory structure for PFFS plans that included the concept of a ''deemed'' network, under which any provider who knew the terms and conditions of the plan's payment and who agreed to serve a Medicare beneficiary enrolled in the plan would be considered a ''deemed'' provider for that service. The regulations also allowed plans to create provider networks and pay fees higher or lower than original Medicare. A few insurers did, in fact, subsequently offer PFFS products, but with limited success.

Why PFFS Plans Have Mushroomed Under MMA

Under the MMA, Medicare payment rates were increased for all types of MA plans, including HMOs and PPOs, to encourage more plans to participate and to give beneficiaries greater choices than previously existed. CMS also imposed a two-year ban on local PPOs in order to promote the development of larger regional PPOs that could, in theory, serve larger numbers of beneficiaries, and thereby increase beneficiary access to MA options.

But regional PPOs are much less attractive to insurers than local PPOs because MA payment rates vary widely by county. For a company to offer a regional PPO, it would have to blend high and low payment rates across their service areas to offer the required uniform benefits package. By contrast, local MA plans can designate their service area on a county-by-county basis. Also, to offer a regional PPO, insurers have to build large provider networks that meet minimum access standards in both urban and rural areas. It is much easier to build smaller networks at the local level (and in urban-only markets).

As a result, many insurers steered clear of offering regional PPO products during the same period that they were barred from entering the local PPO market. Suddenly, PFFS looked like an attractive option for plans wanting to expand their MA product offerings and service areas. Insurers offering a PFFS product could enter the market very quickly because they did not have to build provider networks. Under the MMA, Medicare would pay the PFFS plan the higher of the MA rate or 100 percent of the amount original Medicare paid in that county. Companies offering PFFS products, therefore, could target more profitable counties, including rural floor counties and high payment urban counties.

Upsides, Downsides of PFFS Today for Beneficiaries and Employers

Thanks to the growth of PFFS, congressional intent that more private plans serve rural America has been largely accomplished. But the plans serving rural America are not the large regional PPOs originally anticipated by the legislation's proponents, but the PFFS plans that, until recently, had not been on many lawmakers' radar screens.

There are many aspects of PFFS plans that make them attractive for beneficiaries and employers that provide health coverage for their Medicare-eligible retirees. But there are also downsides. Let's look at these in detail.

Beneficiary Upsides:

PFFS plans often have low premiums and provide additional supplemental coverage that many beneficiaries otherwise could not afford. Many PFFS plans appear to be a bargain on the surface because they provide the same services covered under original Medicare, plus a supplemental policy, for substantially less than beneficiaries would pay otherwise. For example, a fully insured beneficiary in original Medicare would need to pay the Part B premium ($93.50 for 2007), and a Medigap premium, (e.g., $150 a month for ''Plan F'' which does not have copays or deductibles). By contrast, a PFFS plan offers the same coverage as original Medicare plus a Medigap policy for as little as a $0 premium, plus copays. In addition, some PFFS plans offer rebates up to the full $93.50 monthly Part B premium. In fact, more than a quarter-million beneficiaries are now enrolled in PFFS plans that offer partial or full Part B premium rebates.

PFFS plans often include additional benefits for little or no additional costs. These may include eyeglasses, hearing aids, or Silver Sneaker fitness programs.

PFFS plans are perceived as offering greater access to physicians compared with other MA products. Most PFFS plans market themselves as giving enrollees the ''freedom'' to choose any provider that accepts Medicare. Beneficiaries often sign up because they expect to be able to retain the same providers and physicians they have always had.

Beneficiary Downsides:

Beneficiaries who get sick often incur higher, unexpected, out-of-pocket costs if they are hospitalized or placed into a nursing home. Unfortunately, this unpleasant surprise often occurs only after the beneficiary is already locked into their plan for a year.

Why these higher costs? In exchange for $0 or low premiums, most PFFS plans today charge higher coinsurance. For example, one large PFFS plan charges $180 a day for a five-day hospital stay, while another charges $300 a day for the first seven days. A beneficiary in the latter plan who is hospitalized for a week would be liable for $2,100 in out-of-pocket costs. By contrast, a beneficiary in original Medicare with a ''F'' Medigap supplemental policy would incur no out of pocket costs other than premiums. Even a beneficiary in original Medicare who lacks supplemental insurance would incur only a $992 deductible for the first 60 days of hospitalization.

Also, many services covered under PFFS require the same coinsurance as original Medicare. For example, a beneficiary will pay 20 percent coinsurance for DME and could face out of pocket maximums as high as $5,000. Many beneficiaries who enroll in PFFS, however, mistakenly think they are buying insurance protection that would shield them from such costs.

Although beneficiaries can choose any provider, that provider does not have to accept the patient if the provider doesn't like the plan's payment terms. In fact, for a number of reasons we will explore below, many providers have few if any financial incentives to participate

  HPPR ISSN 1528-2953

in PFFS. As a result, physicians and other providers in some parts of the country are refusing to serve PFFS enrollees, reducing beneficiary access to medical services. A beneficiary who enrolls in a PFFS plan and subsequently finds that his or her physician will no longer accept him or her will be locked into that plan, and, therefore, forced to find an alternate provider for the remainder of the lock-in period.

Employer Upsides:

PFFS products offer employers more convenient and affordable options for covering Medicare-eligible retirees. First, the non-network model is a highly feasible option for employers with retirees scattered throughout the country. In fact, many of the large commercial insurance companies, recognizing this opportunity, entered the PFFS market by offering a nationwide product that would appeal to the large employer segment. Because many PFFS plans have $0 or low premiums, employers can save significant costs, effectively allowing them to offer their retirees a defined contribution plan. Most importantly, both private and public sector employers can shift their retiree health care liability to PFFS plans and gain substantial FASB/GASB advantages in the process (these employers would not have to pre-fund their retiree health care liabilities on their financial statements).

Employer Downsides:

Provider push back is reducing beneficiary access to the point that PFFS is becoming an unreliable option. In fact, one private employer with one of the largest Medicare retiree health liabilities discarded a full PFFS replacement strategy for 2006 because of provider refusal to serve PFFS enrollees. Until the provider access issue can be addressed, employers will be slow to adopt PFFS on a wide scale.

Why Many Providers Refuse to Accept Beneficiaries Enrolled in PFFS

Because PFFS plans are required to pay providers the same as they would under original Medicare, many observers initially assumed, erroneously, that this would create a level reimbursement playing field. But it's not level, thanks largely to the complexity of the original Medicare and Medicare Advantage payment systems. Only now that more beneficiaries have enrolled in PFFS are these inequities and their consequences (i.e., lack of provider participation and the resulting reductions in beneficiary access) coming to light.

PFFS plans often pay providers less than what original Medicare and some MA plans pay. Non-participating physicians and those who don't accept assignment under original Medicare may be worse off under PFFS. Under original Medicare, non-participating physicians are paid 95 percent of the original Medicare fee schedule, but are allowed to balance bill the beneficiary an additional 15 percent, allowing them to earn 108 percent of the Medicare fee schedule. PFFS plans, by contrast, are allowed to limit payments to non-participating physicians to 100 percent of the original Medicare fee schedule, but prohibit physicians from balance billing. These physicians, therefore, could be paid 8 percent less under many PFFS plans than they would be paid under original Medicare.

Likewise, providers who have already negotiated higher payment rates with a MA plan than what original Medicare pays (in some cases, 135 percent of Medicare's original fee schedule) would be worse off accepting PFFS patients. Similarly, because some MA plans pay hospitals more than current Diagnostic Related Group (DRG) rates under original Medicare, these providers also have no incentives to accept PFFS enrollees.

Providers often fail to fully understand the PFFS plans' terms and conditions beforehand, putting them at financial risk. Many providers, for example, may not be aware upon initially accepting PFFS patients that they could be paid less than original Medicare or less than they would under another MA contract with the same insurer that's offering the PFFS option . Anecdotal evidence suggests that some PFFS plans may not have made their Terms and Conditions easily accessible on their websites, or have been unresponsive to provider inquiries regarding payment terms, adding to this lack of physician understanding.

Many PFFS plans do not reimburse providers in a timely or accurate fashion. As with original Medicare, PFFS plans must pay clean claims within 30 days of receipt. However, many providers who accept original Medicare are often paid within 14 days. Also, anecdotal reports suggest there is widespread difficulty among PFFS plans in paying claims accurately under the dozens of complex Medicare fee schedules, causing some to delay payment beyond 30 days to review claims' appropriateness. Thus, provider cash flow is an issue.

PFFS plans may deny more claims than original Medicare carriers. Even though non-network PFFS plans cannot impose prior utilization review, they can review claims retrospectively for medical necessity. In areas where the PFFS plans' standards are more stringent than those of the original Medicare carriers or fiscal intermediaries, providers may see more of their PFFS claims denied than they would under original Medicare.

Do PFFS Plans Offer Medicare a Reasonable Return on Investment?

As we have discussed, PFFS plans offer additional benefits that many beneficiaries find attractive and often provide a lower cost option that allows beneficiaries to purchase supplemental insurance that they might not otherwise be able to afford. And the growth of PFFS has made these additional benefits and lower-cost options available to more seniors living in more areas, especially rural communities, than at any time previously.

But are these benefits worth the added costs to the Medicare program, especially when we consider the provider access and beneficiary out-of-pocket cost issues that have recently emerged with PFFS plans?

According to recent studies by the Medicare Payment Advisory Commission (MedPAC) and the Commonwealth Fund, PFFS plans are paid 119 percent of original Medicare (based on the counties in which they are currently offered and driven by higher rates in rural areas and small urban ''floor'' rates). By contrast, other MA plans are paid 112 percent of original Medicare.

Managed care proponents contend that MA plans provide added value to the Medicare program that justifies the higher reimbursement rates, including lower out-of-pocket costs and greater levels of benefits for enrollees, greater levels of patient care coordination, quality improvement initiatives, and, most importantly, capitation—*which shifts financial risk away from the Medicare program.*

However, as Congress and policymakers scrutinize MA payment rates, many are skeptical of what value, if any, PFFS plans provide, for that extra 19 percent in federal spending. According to CBO and MedPAC, only 10 percent of the additional 19 percent is returned to the beneficiary, with the balance retained by the plan for administrative costs and profits. In fact, under MMA, Congress specifically excluded PFFS plans, which are essentially indemnity products, from the quality and chronic care improvement requirements that apply to other MA plans. Because virtually all PFFS plans operating today are non-network PFFS plans, they have little ability to conduct care coordination or other quality initiatives, except for the occasional voluntary nurse call line.

It is no wonder that providers, beneficiaries, traditional MA plan sponsors, and members of Congress have raised concerns about the way PFFS plans have been implemented, how they are paid, and what's happening in the marketplace. In fact, we would argue that if PFFS plans are to survive and thrive in the long-term, they must make some fundamental structural and operational changes.

A Recommended Blueprint for Improving the Medicare PFFS Program

We believe there are several areas where PFFS plans can make immediate improvements that would help them retain beneficiaries, achieve greater levels of provider participation, and quell some of the concerns raised by lawmakers.

Adopt a hybrid-network approach. Medicare regulations give PFFS plans the flexibility to include a network of key, select, contracted providers for providing some or all services to Medicare beneficiaries. We believe market forces will push PFFS plans to morph into hybrid, ''PPO-lite'' products in which the plan would contract with certain key providers in order to ensure provider access for beneficiaries. Employer groups that have purchased PFFS replacement products for their Medicare-eligible retirees simply will not stand by idly and allow these beneficiaries to be stranded within the system. (In fact, in the short term, plans will increasingly come under pressure from these purchasers to help retirees book medical appointments.)

Reduce the payment hassle factor. If PFFS plans could assure providers of reimbursement within 14 days, more providers would accept PFFS patients. Plans could reduce reimbursement lag times by adopting employer HSA-style debit cards or electronic funds transfer systems with banking institutions.

Get proactive with care coordination and quality improvement. Even within the limitations of the PFFS product structure, plans already have some tools for doing this. These can include setting specific terms and conditions with providers, conducting retrospective claims review, and implementing voluntary care coordination or disease management programs, making advance coverage determinations, and conducting risk assessment. By moving toward a hybrid network as we described earlier, PFFS plans will have a new vehicle to provide support to beneficiaries regarding their provider choices and implement care coordination and quality improvement initiatives.

Improve benefit design. PFFS plans should be real insurance policies that don't financially penalize beneficiaries who get sick. To that end, PFFS should offer higher-premium ''Cadillac'' model plans that would still be able to compete with Medigap alternatives. Meanwhile, lower premium plans should be redesigned to include out-of-pocket caps and a steady deductible amount (perhaps $500), rather than unpredictably high coinsurance.

Train, manage, and monitor sales agents and brokers to make sure they accurately and honestly represent PFFS and other MA products to beneficiaries. Increasingly, MA plans have relied largely on outside, contracted sales agents, rather than in-house sales personnel to sell their products. (The limited beneficiary open enrollment period makes it more cost effective for MA plans to contract with outside agents. This is especially true for PFFS plans, given their rapid expansion). Meanwhile, CMS has reported numerous instances of sales agents engaging in egregious marketing practices with beneficiaries. The agency vows to crack down, and stated in its recent 2008 call letter to plans that it will closely scrutinize PFFS sales agent activities in this regard.

Given the complexity of the PFFS product, including the notion of a ''deemed network,'' it can easily fall prey to confusing marketing and sales practices by brokers — intentional or not. Many agents simply don't understand the product well enough to explain it accurately to beneficiaries. In other cases, agents may have deliberately told beneficiaries they were ''guaranteed'' access to any provider – even though that is not true – in order to entice more people to enroll.

These practices need to end. All MA plans should recognize the threat that independent agents who misrepresent PFFS plans pose to beneficiaries and to the industry as a whole. PFFS plans need to undertake more aggressive, proactive efforts to better educate, monitor and manage their sales forces.

Conclusion

We believe that PFFS plans offer value in the marketplace. With almost 1.5 million beneficiaries now enrolled in PFFS plans, they clearly represent a popular option. But a skeptical Congress—including key lawmakers from rural states that have benefited from the growth of PFFS—is asking hard questions about the value provided by PFFS plans and MA plans generally. In fact, proposed legislation detrimental to the Medicare Advantage program overall is being driven largely by the reimbursement considerations, structural defects, and market conduct of PFFS plans.

With the stakes this high, PFFS plans must change how they operate and do business to drive genuine program improvements. Failure to do so will only result in internecine warfare among plan types as well as targeted regulation of and enforcement against PFFS plans, and possibly, against MA plans generally.

  HPPR ISSN 1528-2953