United States Senate
Committee on Finance

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Opening Statement of Sen. Chuck Grassley
Senate Finance Committee Hearing
"Private Fee-For-Service Plans in Medicare Advantage: A Closer Look"
Wednesday, January 30, 2008

I want to thank Senator Baucus for holding this hearing today. This is a very important issue and I am glad we are looking at it closely. Private fee-for-service plans have grown significantly in the last few years. In fact, most of the Medicare Advantage plans in Iowa are private fee-for-service plans. In some areas, there is only one other option for enrolling in a Medicare Advantage plan. I appreciate that my constituents have a choice of Medicare plans. But several issues have been raised about private fee-for-service plans.

First, the plans have little accountability, either by contract or in statute. Providers are frustrated and oversight is difficult. Second, in some areas, beneficiaries report that their hospitals and doctors will not treat them because they do not accept patients in private fee for service plans. And third, it appears that some employers are using these plans to lower their own costs for retiree coverage, but at taxpayer expense. This hearing will examine these problems.

Congress created the private fee-for-service plans in the 1998 Balanced Budget Act. The goal was to address potential concerns that HMO gatekeepers might ration care. Beneficiaries enrolled in a private fee-for-service plan could go to any doctor or hospital that would take the plan. The private fee-for-service plan did not need a contract with the providers. And it could pay the same rates that Medicare pays.

The first private fee-for-service plans came online in 2000. They took a while to catch on. In 2004, there were only 50,000 people in private fee-for-service plans. Last January, enrollment had surged to a little over a million. This year, about 1.9 million people enrolled. That is 1.9 million out of a total of 9.2 million Medicare Advantage enrollees. These plans are growing very rapidly. And they are growing faster than other kinds of Medicare Advantage plans. Enrollment in coordinated care

plans – HMOs and PPOs – grew only about 13 percent this year. That's compared to 85 percent growth in private fee-for-service plans.

Unlike other Medicare Advantage or M-A plans, private fee-for-service plans are not held to the same level of accountability. They provide no quality data, as other plans do. So beneficiaries cannot compare plans on quality. Their bids are not subject to review or oversight. The private fee-for-service plans do not have to coordinate care. They do not have to help patients manage chronic illness. And these plans can force providers to accept the lower government-set Medicare payment rates instead of having to pay the market rate. Yet, despite lack of chronic care management and paying lower provider rates, these plans still get paid the full Medicare Advantage benchmark payments.

Most insurance plans have a network of participating providers. These are doctors and clinics that have signed contracts to provide care to the plan's enrollees. So when you enrollee in the plan, you can know whether your doctor participates. And for many people, that is a very important thing to know. You want to be able to keep seeing the doctor you know and trust.

But that's not the way private fee-for service plans work. These plans are not required to have a network of participating providers. So, the doctor can decide at each visit whether to accept the plan. A beneficiary could find that her long-time doctor decides not to treat her. These plans advertise that enrollees can go to ANY doctor or hospital. But they sometimes fail to explain that the hospital or doctor may refuse them.

In December, a large physician group in Des Moines announced it was refusing to treat beneficiaries with private fee for service plan coverage. It took ads out in the newspaper. It took this extraordinary step because the physicians did not think the payment situation was fair. They thought that if the plan was paid the benchmark at the very least it should have to contract with them. I have heard from some Iowans who are worried that their doctors now will not treat them. One Iowan who contacted me has bladder cancer, but fortunately, his wife saw the ad in time and was able to get into a different plan. If the physicians had decided mid-year not to accept the plan it could have spelled disaster. I am disturbed that my constituents may have a hard time getting access to their doctors. And because these plans don't really have participating providers, it's hard to figure out.

Now, here is another issue with private fee-for-service plans. Many employers are rushing to replace their retiree coverage with Medicare private fee for service plans. This allows them to take advantage of government-set Medicare rates to pay providers. Like other private fee-for-service plans, they don't have to coordinate care or manage chronic illnesses. Yet, the retiree plan still gets the full Medicare Advantage benchmark when they do it. To me that sounds like a government windfall. And retirees may be getting the shaft in the process.

As I said earlier, in many parts of Iowa, private fee-for-service plans provide a choice for beneficiaries. Some plans have told us that they view these products as a first step toward getting rural health care providers accustomed to private plans. They say they intend to form networks and create preferred provider networks. I hope that is the case.

But these private fee-for-service plans are growing in urban and suburban areas where insurers already have provider networks. This suggests that plans are more interested in pressing a market advantage based on using the government rate than in building provider networks. And that is not good for beneficiaries.

In Iowa, at least two major systems are refusing to accept these plans. And this is a problem too. I am frankly mystified why providers would not accept the same Medicare payment from a plan that they will from Medicare itself. So this morning we will hear from some providers on their experience with these plans. I look forward to hearing from our witnesses about how these plans operate in the market and their experiences with them.

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