

Private Fee-for-Service Plans in Medicare Advantage

January 30, 2008

Statement of
Mark E. Miller, Ph.D.

Executive Director
Medicare Payment Advisory Commission

Before the
Committee on Finance
U.S. Senate

Chairman Baucus, Ranking Member Grassley, distinguished Committee 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) program and private fee-for-service (PFFS) plans.

MedPAC is charged by the Congress to make recommendations on payment policy both for providers in Medicare's traditional fee-for-service (FFS) program and for MA plans. 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 and taxpayers get maximum value for each dollar spent in the program. Providers who are put under fiscal pressure, whether FFS or MA plans, are more likely to contain costs and innovate new care delivery mechanisms.

Private plan participation in Medicare was originally intended as a way to achieve efficiency through care coordination and other innovations in the delivery of care. Managed care plans have greater flexibility to innovate and the presence of an appropriately paid managed care choice is consistent with MedPAC's goals of improving the value of the program. As initially designed, plans were to be paid 95 percent of projected FFS spending for each enrollee. The thought was that 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.

Over time, however, this original vision of the potential of private plans has been compromised and ultimately undermined by successive payment increases to plans. Payment increases have been so large that plans no longer need to be efficient to attract enrollees. The result is that, on average, Medicare pays far more for each beneficiary who opts for an MA plan than it would if they stayed in FFS. In addition to promoting inefficiency in MA, this misalignment increases the burden on taxpayers and beneficiaries, who must pay higher Part B premiums, whether they are in managed care plans or not. Furthermore, MA

overpayments contribute to undermining the long-term sustainability of the Medicare program.

MedPAC believes that adhering to the principle of financial neutrality is key to ensuring that private plans add value to the program. Financial neutrality means that the Medicare program should pay the same amount, adjusting for risk, regardless of which Medicare option a beneficiary chooses. 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. When private plans are paid in this way, they have greater incentives to undertake innovations in care delivery and management and to negotiate with providers over levels and methods of payment. Indeed, they have the flexibility to use care management techniques that FFS Medicare does not encourage.

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 a reasonable standard of efficiency—either in terms of program costs or in terms of the value beneficiaries receive for each dollar of program expenditures. In fact, much of our work is devoted to identifying inefficiencies in FFS Medicare and suggesting improvements in the program. 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. These plans will also have the incentive to discover innovations in care management and provider payment, which in turn could provide useful ideas for the FFS program.

PFFS plans

MedPAC has particular concern about the impact of PFFS plans, one of the types of plans participating in MA, on the financial integrity of the program and their inconsistency with MedPAC’s basic payment principles. One dynamic spurring the Commission’s concern is the dramatic increase in PFFS enrollment. Enrollment in these plans has increased 8-fold in just two years, and now totals 1.7 million enrollees (Table 1). PFFS plans generally operate

like managed care plans. They do not have contracted provider networks and are prohibited by law from linking provider payments to efficiency. Given that Medicare spends 17 percent more than it would if these beneficiaries had stayed in FFS and they do not manage care, enrollment growth in PFFS plans comes at an unacceptably high cost to Medicare.

MedPAC is also concerned that PFFS plans are not held to the same quality standards and regulations that other MA plans are, offering them a competitive advantage over other types of MA plans (such as health maintenance organizations (HMOs)). In particular, we believe PFFS plans should report on the quality of care for their enrollees so that beneficiaries can use quality as a factor in judging whether to enroll in these plans and Medicare can better judge the value PFFS plans provide relative to other MA plan types and to the FFS program.

Table 1: Private fee-for-service plan enrollment has grown more than other types of Medicare Advantage plans in the last two years

Plan type	Enrollment (in millions)			Net enrollment growth	
	December 2005	August 2006	November 2007	Dec. 2005 to Aug. 2006	Aug. 2006 to Nov. 2007
Local HMOs and PPOs	5.2	5.9	6.3	0.8	0.4
PFFS	0.2	0.8	1.7	0.6	0.9
Regional PPOs	None available	0.1	0.2	N/A	0.1

Note: PPO (preferred provider organization), PFFS (private fee-for-service), N/A (not applicable). Numbers may not add due to rounding.

Source: CMS enrollment data.

Why does Medicare pay more for MA plan enrollees?

The three main types of plans participating in MA are local managed care plans (HMOs and preferred provider organizations (PPOs)), PFFS and regional PPOs. Payment for all of them is determined through the MA bidding system that began in 2006. The design of the bidding system and the residual effect of geographically- specific “payment floors” explains why MA payment rates are higher than FFS and how they vary by plan type. Among plan types, PFFS plans have one of the highest ratios of plan payments to Medicare FFS expenditures—not because they were intended to be paid differently but because of where they have enrollment

and because of the costs they incur in providing the Medicare benefit package, as described below.

The bidding system

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, for each region. The benchmarks are bidding targets for the plans and the maximum amounts Medicare will pay an MA plan.

To determine the amount Medicare will pay a plan and beneficiary premiums, each plan gives 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 raised the 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 120 percent of FFS for the BBA-floor (mainly rural) counties (weighted by the number of Medicare beneficiaries in each county). Benchmarks average 112 percent of FFS in non-floor 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 November 2007, about 79 percent of PFFS enrollment was in floor counties.

Consequently, our projection of the 2008 enrollment-weighted level of benchmarks for PFFS plans is 120 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 package. The Medicare program pays, on average, 108 percent of FFS for a PFFS plan to provide the Medicare Part A and Part B benefit package—making PFFS one of the least efficient plan types 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 subsidized in part by

Medicare. The extra benefits are also subsidized by beneficiary Part B premiums whether the beneficiary is enrolled in an MA plan or not.

Table 2: PFFS plans are among the least efficient plan types in MA

	All MA plans with bids	HMO	Local PPO	Regional PPO	PFFS
Benchmark/FFS expenditures	118%	117%	122%	115%	120%
Bid (for Medicare Part A and Part B benefit) in relation to FFS	101	99	108	103	108
Rebate as percent of FFS	13	14	11	9	9
Payment (bid + rebates)/FFS	113	112	119	112	117

Note: PFFS (private fee-for-service), MA (Medicare Advantage), PPO (preferred provider organization), FFS (fee-for-service). Data are for 2008, weighted by plan enrollment in November 2007. Enrollment includes only plans that submitted a bid for 2008 and had the same plan ID in 2007.

Source: MedPAC analysis of data from CMS on plan bids, enrollment, benchmarks, and fee-for-service expenditures.

While PFFS plans are among 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 provide the Medicare Part A and Part B benefit package for 99 percent of Medicare’s FFS costs, on average. The amount that an MA plan gets paid is based on a combination of its bid and the benchmarks in areas that it serves. On average, HMO plans are paid 12 percent above FFS costs. In contrast, PFFS are paid 17 percent above FFS, as a result of both serving areas with higher benchmarks relative to FFS and submitting less efficient bids for providing the Medicare Part A and Part B benefit package.

The Commission has recommended that benchmarks be set at 100 percent of FFS to create incentives for private plans to be efficient and to improve the long run sustainability of the Medicare program. The Commission recommended in its 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 2013.)

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.

A review some of the history of private plan contracting in Medicare and the history of the PFFS option in particular is necessary to understand the role of PFFS plans in Medicare and how that role has changed in the MA program.

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 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 FFS 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 negotiate payments with providers if they form networks of providers, 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.

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.

However, 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 were intended to 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 taxpayers and all beneficiaries pay the difference in cost, not the just beneficiaries enrolling in these plans, as intended. Taxpayers and all beneficiaries subsidize 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 when they were created. 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 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 could do all this and thus would be less 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.

PFFS plans have an advantage over other MA plan types in that they do not have to set up networks of providers. In certain geographic areas, such as rural areas, 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.” Moreover, increasing MA payments in low-cost regions does little to reward the providers in those regions. A better approach would be to reward providers in low-cost regions through the FFS payment structure—or better yet, through innovative new payment systems.

Advantages enjoyed by PFFS plans compared to other plans

In addition to being exempted from network adequacy requirements, PFFS plans have other advantages over other MA plans. They are subject to fewer requirements and benefit from certain statutory and administrative rules. 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 and the Medicare program 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			✓	✓	✓
Must return to the trust funds 25 percent of the difference between bid and benchmark ^b	✓		✓	✓	✓
Must offer Part D coverage ^c			✓	✓	✓
Must have an out-of-pocket limit on enrollee expenditures		✓		✓	
Can limit enrollment to targeted beneficiaries ^d					✓
Must offer individual MA plan if offering employer group plan ^e			✓	✓	✓

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.

^bThis 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 2013, may be used to retain or attract such plans.

^cMedical 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).

^dMA 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.

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

We are concerned that PFFS plans might undermine more efficient managed care plans.

PFFS are now available in every area of the country, which means that all other types of MA plans must compete with them to attract enrollment. PFFS plans now account for more than

three-quarters of all plan options open to all Medicare beneficiaries (not counting special needs plans and employer-only plans that are open to only a subset of beneficiaries). While PFFS plans account for only 19 percent of MA plan enrollment, they accounted for about 60 percent of total enrollment growth from 2006 to 2007. During this time, enrollment in managed care plans open to all enrollees remained flat.

We are also concerned that employer-sponsored plans might create new inefficiencies in MA that would result in the program spending even more. Employer-only plans tended to bid higher for 2008 than other plans (108 percent) and their payments averaged 116 percent of FFS spending. Because these plans do not have to market to individuals, the Medicare bids may not be as competitive. Employer-only plans can negotiate with employers after the Medicare bidding process is complete, which may result in some employer costs being shifted into the Medicare bid and payment.

We are especially concerned about the interaction of employer-sponsored and PFFS plans. PFFS plans (and medical savings account plans) will have an advantage over other MA plan types 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.

Conclusion: FFS Medicare, MA, and PFFS plans

While we focus today on our concerns about PFFS, the problem lies more broadly in overall MA payment policy.

Offering private plans was originally considered a way to increase efficiency in Medicare through care coordination and other delivery system innovations. Under the current MA program and the increasing payment rates, we are encouraging inefficient plans and

expanding tax-subsidized benefits. Some have also suggested that high MA payments reward regions with low costs in traditional Medicare.

The current system undermines incentives for efficiency and innovation by failing to exert the kind of financial pressure that can maximize efficiency. Although MA plans provide extra benefits, their costs for providing the Part A and B benefit package are demonstrably higher than FFS. For example, PFFS plan bids indicate they can deliver Part A and B services at 108 percent of the cost of FFS. These higher costs likely apply to the additional benefits as well.

By emphasizing neutrality, we are urging that efficiency and innovation be restored as the primary goal of the MA program. Policymakers interested in expanding benefits and rewarding low-cost regions should pursue those goals through other more direct and effective means. A better approach for the latter would be to reward providers in low-cost regions through the FFS payment structure—or better yet, through innovative new payment systems, such as pay-for-performance.

In conclusion, 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. 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 that Medicare is willing to subsidize beneficiary enrollment in MA.