

**Testimony of
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On
Medicare Advantage Private Fee-For-Service Plans
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Chairman Stark, Ranking Member Camp and members of the Subcommittee, thank you for inviting me here today to discuss Medicare Advantage Private Fee-for-Service (PFFS) plans. Medicare Advantage offers an affordable, high value-choice in comprehensive health care coverage for all Medicare beneficiaries. Enrollment in Medicare Advantage is now at an all-time high and plans are available in every state across the country, including rural areas. Growth in PFFS plan offerings has been a key factor in expanded access to MA plans for rural beneficiaries. At the same time, a majority of beneficiary complaints regarding Medicare Advantage are tied to PFFS plans and the way they have been marketed. For these reasons, the Centers for Medicare & Medicaid Services (CMS) appreciates your efforts to look at this segment of the Medicare Advantage market, and I am pleased to be here today.

My testimony will focus primarily on the facts related to PFFS plans: the background and current benefit structure of PFFS plans, enrollment trends, and examples of the extra benefits that PFFS plans provide, as well as some of the issues associated with PFFS plans. I will then highlight a number of steps CMS has taken to address concerns we are hearing about PFFS plans, particularly in the areas of marketing oversight and beneficiary and provider education.

Background

Medicare has a long history of offering alternatives to the traditional Medicare fee-for-service (Original Medicare) program. In the 1970's, Congress authorized Medicare risk contracting with managed care plans, and in the 1980's further modified the program to make it more attractive to managed care companies and the Medicare beneficiaries they serve. Under that program, health maintenance organizations (HMOs) contracted with Medicare to provide the full range of Medicare benefits in return for monthly "per person" or "capitated" payment rates. In the Balanced Budget Act of 1997 (BBA), Congress created the Medicare+Choice program to provide more health care choices for Medicare beneficiaries beyond HMO plans. In addition, the BBA corrected perceived flaws in the risk contracting program, including significant payment differences across geographic areas. In 1997, there was well over a three-fold difference between the highest and lowest county payment rates, which were \$767 and \$221. Since then, Congress has continued to refine the program, which is now called "Medicare Advantage" as specified under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).¹

The BBA authorized PFFS plans and other new options. PFFS plans generally represented a less restrictive type of private plan option than the HMO plans that had been available under risk contracting. While traditional HMO-model plans rely on a closed network of providers and a primary care "gatekeeper" model, the PFFS plan model allows enrollees greater flexibility in choosing and accessing providers. In addition, the PFFS plan, along with preferred provider organizations (PPOs) and medical savings accounts (MSAs), were an expanded continuum of

¹ For consistency, we will use the term "Medicare Advantage" or MA throughout the testimony rather than Medicare+Choice or other superseded names.

potential Medicare plan designs. With more options, it was hoped that a higher level of plan penetration could be achieved in historically underserved areas. Finally, due to a statutory provision exempting these plans from any limit on premiums that they can charge enrollees, PFFS responded to beneficiary interest in the availability of a potentially higher-cost option that would allow enrollees to receive care to extend life as long as possible.

Although the Medicare law permits PFFS plans to meet access requirements by entering into written contracts with a network of providers, and to impose lower cost sharing for such network providers, existing PFFS plans generally have not opted for this approach. Regardless of whether written contracts are signed with a network of providers, the law provides that PFFS plans are “deemed” to have a contract in place with any provider eligible to provide Medicare-covered services if that provider is provided with an opportunity to get information on the PFFS plan’s payment terms and conditions (*e.g.*, if they are set forth on a website), and agrees to provide services to the PFFS plan enrollee. In general, this design allows beneficiaries the option of the value of the MA program (including reduced cost-sharing and additional benefits), with fewer restrictions on their choice of provider than other types of MA plans can offer, and with no prior authorization required to access providers.

The vast majority of PFFS plans have chosen to operate exclusively under the deemed network approach, without entering into written contracts with providers. Enrollees in such plans can go to any provider in the U.S. eligible to bill Medicare who will accept their plan’s payment terms, and will pay the same cost-sharing regardless of which provider they choose to see.² However,

² As noted above, if a PFFS plan has met access requirements through written contracts, it may charge higher cost-sharing for seeing a “deemed” provider.

providers who have not signed written contracts are not required to accept PFFS plan enrollees for treatment as a “deemed” provider, even if the PFFS plan payment amount is equal to or greater than the Original Medicare amount. Providers may at any point up until services are rendered decide not to provide services to a PFFS plan enrollee, even if they previously have agreed to accept that PFFS plan’s terms when treating other enrollees of the same PFFS plan, or even if they have agreed to treat that enrollee on earlier occasions. This contrasts with coordinated care plans, where enrollees have the ability to verify with the plan prior to a visit, whether a particular provider is in the network, and where the enrollee thus would be ensured in advance that they would be treated by that network provider.

In contrast to coordinated care plans in Medicare Advantage (*e.g.*, HMOs or PPOs), PFFS plan sponsors are not required to offer at least one option with Medicare prescription drug coverage (Part D). A sponsor may offer a “MA-only” PFFS plan, which does not include Part D coverage, as its only option. Beneficiaries enrolled in MA-only PFFS plans may enroll in a stand-alone prescription drug plan. That said, over 60 percent of PFFS plan enrollees are in a plan that includes Part D coverage. The others may be receiving prescription drug coverage from other sources, such as a former employer.

Enrollment in PFFS Plans

While the overwhelming majority of Medicare Advantage enrollment is in coordinated care plans such as HMOs and PPOs, PFFS plan enrollment currently comprises about 18 percent of total Medicare Advantage enrollment. Initially, few PFFS plans entered the Medicare Advantage program. The first PFFS plan began enrolling beneficiaries in 2000. The year 2004 saw a

noticeable increase in PFFS enrollment, with over 50,000 beneficiaries electing a PFFS plan. Since 2004, growth has been very strong, with enrollment of over 1.3 million, excluding employer-only plans, or 1.55 million in total, for 2007.

Recent rapid growth in PFFS enrollment may be a reflection of improved benefits and value offered to beneficiaries, particularly in rural areas. PFFS plans often locate in areas where Medicare Advantage plans have not traditionally been available. In some states, such as Alaska, Utah, Maine, Idaho and New Hampshire, PFFS plans are the only Medicare Advantage options available in some, if not all, counties. Of the total enrollment in PFFS plans for 2007, 31 percent are beneficiaries from rural areas. Fifty-nine percent of all Medicare Advantage enrollees from rural areas are in PFFS plans.

PFFS plans also are attractive to employers and unions throughout the country, because they can readily provide coverage nationwide, including coverage that is adaptable to seasonal changes in residence. Roughly 15 percent of PFFS enrollment in 2007 derives from employer group and union plans, compared to just 5 percent in 2006. One of the largest additions to PFFS employer group enrollment for 2007 was the Michigan Public School Employees Retirement System, which has close to 100,000 retirees.

Additional Benefits for PFFS Enrollees

Like other Medicare Advantage enrollees, PFFS plan enrollees can receive benefits beyond traditional Medicare. On average, PFFS plan enrollees receive about \$63 per month in additional benefits. As is the case for all Medicare Advantage plans, PFFS plans use most of this value to

reduce enrollee cost sharing for Medicare benefits, by reducing the Part D and Part B premiums. Lesser amounts are devoted to providing non-Medicare benefits such as dental and vision care. Nearly half of all Medicare beneficiaries have access to a PFFS plan with no cost sharing for physician visits. Over 90 percent of all beneficiaries have access to a PFFS plan with a copayment of \$10 or less for primary care visits, and \$20 or less for a specialist visit. With respect to hospital stays, over 50 percent have access to plans with no cost sharing for both long (90-day) and short (6-day) stays.

Beneficiaries enrolled in Original Medicare pay co-insurance of 20 percent of the Medicare-approved amount for most doctor services, and must pay 100 percent of the first \$131 yearly for Medicare Part B-covered services or items (including physician visits). In the case of hospital stays, beneficiaries enrolled in Original Medicare pay \$992 for days 1-60 in each benefit period; \$248 per day for days 61-90 in each benefit period; and \$496 per day for days 91-150 in each benefit period. Beneficiaries enrolled in Original Medicare are entitled to “lifetime reserve days” as well – these are 60 extra days of coverage that can be used through a beneficiary’s lifetime. Beneficiary cost-sharing for such days currently is \$496 per day.

The chart on the next page illustrates some of the benefits beyond Original Medicare that current PFFS plan enrollees enjoy.

Percent of PFFS Beneficiaries Enrolled in PFFS Plans with Specific Attributes	
<i>Benefit Structure</i>	<i>Percent of PFFS Beneficiaries Enrolled in a PFFS Plan of this Type</i>
Catastrophic cap between \$1,001 and \$5,000	60%
\$1,000 or less for a 90-day hospital stay	68%
No premium beyond the Part B premium	75%
Unlimited coverage for inpatient hospital days	77%
No prior hospitalization requirement before a SNF admission	83%
Primary care physician copayments of \$20 or less	85%
Prostate and cervical and cancer screening with no coinsurance	88%

Issues Raised About PFFS Plans

Rapid growth in PFFS enrollment in recent years has raised some issues, generating increased scrutiny of the PFFS option and the ways in which it differs from other Medicare Advantage plan types. Some have raised concerns that the Medicare program pays more for beneficiaries enrolled in Medicare Advantage plans, including PFFS, than it would if the beneficiaries stayed in Original Medicare. Medicare Advantage plans submit bids for the expected costs of delivering Part A and Part B services to plan enrollees.³ These bids are then compared to plan-specific benchmarks to determine the total payment to plans.⁴ By statute, 75 percent of the

³ The plan bid is each plan's estimate of the cost of delivering Part A and Part B services to the average Medicare beneficiary. It is risk-adjusted based on the characteristics of individual plan enrollees. Pursuant to the Deficit Reduction Act and a CMS announcement in 2005, budget neutral risk adjustment, which had historically increased plan payments, is being phased out. The phase-out began in 2007, with 55 percent of the budget neutrality factor included in plan payments. The phase out will be completed in 2011. In addition, to the extent the plan provides care coordination services, these costs or savings are included as part of their bid.

⁴ Benchmarks are the maximum amount Medicare will pay a plan for delivering Part A and B benefits in a specific geographic area; they are determined by the Secretary each year under a methodology provided in the Medicare law. For most plans, benchmarks are based on the county capitation rates used for payment purposes before the bidding system began in 2006. Plan benchmarks are averages of county rates in the plan service area weighted based on projected plan enrollment in each county. (Regional PPO plan benchmarks are based primarily on county capitation rates, but plan bids are also factored in). The vast majority of plan bids are below their respective benchmarks. If a

difference between a plan's bid and the benchmark must be returned to plan enrollees in the form of additional benefits, including lower cost sharing. However, on average, PFFS plan bids are higher than local coordinated care plan bids, or than Medicare Advantage plan bids in general. This difference means that fewer dollars are available for additional benefits, as described below.

The average monthly dollar value of additional benefits provided to PFFS plan enrollees is \$63 which is lower than the \$86 average for all Medicare Advantage enrollees. Nonetheless, PFFS plans provide valued additional benefits to many enrollees. Some of these beneficiaries have few, if any, other options for additional benefits under the Medicare Advantage program. Others may seek to benefit from the value offered by Medicare Advantage (*e.g.*, reduced cost-sharing and/or additional covered services) while having enhanced flexibility to choose providers as allowed through a PFFS plan.

While on average beneficiaries in PFFS receive \$63 per month in additional benefits, in some specific cases, beneficiary cost sharing for certain services may be higher or lower under a PFFS plan than cost sharing under FFS Medicare. All Medicare Advantage plans have flexibility in how they structure their cost sharing for plan benefits, subject to the longstanding requirement that the average actuarial value of the plan's cost sharing for Medicare benefits may not exceed the average actuarial value of cost sharing in Original Medicare. Such flexibility can have the effect of generating cost sharing amounts for certain services that are higher than Original Medicare's in any Medicare Advantage plan, depending on the plan's cost sharing structure and the medical services needed by an individual enrollee.

plan bid is above the benchmark, the enrollee must pay the difference in the form of a premium, referred to as the "basic beneficiary premium."

In addition, the Medicare law explicitly exempts PFFS plans from most of the quality assessment and reporting requirements that Medicare Advantage coordinated care plans must meet. Some plans assert that many of the requirements were designed with network-based plans in mind, making certain types of reporting (*e.g.*, those requiring medical record review) difficult for PFFS plans that do not have networks. However, other requirements such as beneficiary surveys and claims-based quality metrics may be possible for a non-network plan, when the statute permits.

Finally, there have been numerous complaints about the marketing practices of PFFS plans and enrollee issues with access to services. Some enrollees report that the plan's representatives did not adequately explain that providers may refuse to treat plan enrollees. Other enrollees report problems finding providers that will accept their plan's payment terms. As described in further detail below, CMS takes these concerns very seriously, and we are taking steps to ensure that beneficiaries are protected, and that there is better understanding of the PFFS product on the part of beneficiaries as well as providers.

CMS Oversight of PFFS Plans

CMS is aware that there are concerns about the marketing practices of some plans, as well as frequent misunderstandings on the part of both beneficiaries and providers about the nature of PFFS plans. We are particularly concerned about reports of marketing schemes designed to confuse, mislead or defraud beneficiaries, and are taking vigorous action to address violations. Possible CMS enforcement responses to marketing violations range from issuing a warning letter or corrective action plan, to suspension of enrollment, civil monetary penalties, or even

termination of the plan from the program. This year alone CMS has fined PFFS plans more than \$400,000 in civil monetary penalties for failing to provide information to beneficiaries in a timely manner. Also to date, 98 plans have been put on a corrective action plan to fix identified problems and allow CMS to monitor progress.

CMS also takes steps to ensure that beneficiaries are protected. For example, it is long-standing policy that any beneficiary who believes he or she was enrolled in a plan without consent may contact the plan, 1-800-MEDICARE, or a CMS Regional Office for assistance in disenrolling from the plan and returning to Original Medicare if desired. CMS has caseworkers in all Regional Offices and in our Central Office available to assist beneficiaries in resolving such issues.

The CMS Medicare Marketing Guidelines include policies for MA plans designed to protect beneficiaries from inappropriate sales tactics. Medicare Advantage organizations must monitor the activities of employees and contractors engaged in marketing of plans to potential enrollees to ensure that their activities comply with applicable Medicare and other Federal healthcare laws. The guidelines explicitly address compensation of individuals involved in marketing, for example, stating that compensation must be in line with the industry standard for services provided and that compensation is to be withheld or withdrawn if an enrollee chooses to disenroll in an unreasonably short timeframe.

CMS requires that MA plans use only State-licensed marketing representatives, ensure that the identity and other information of a marketing representative is reported to a State when required,

cooperate with reasonable requests from a State that is investigating a marketing agent and ensure that terminations for cause are reported to the appropriate State agent, if the State has such a requirement. CMS also is working with State insurance department officials and the National Association of Insurance Commissioners (NAIC) to address problems with marketing. Part of this effort includes a Memorandum of Understanding (MOU) that allows States and CMS to share information more easily. For example, CMS can immediately share name specific agent/broker complaints with State Department's of Insurance. States are able to share with CMS their findings from Market Conduct reports. To date, 20 States and Puerto Rico have signed the MOU. The MOU has already facilitated action in some States to address complaints about marketing. CMS, NAIC and the States are working together to complete a full implementation of the MOU, which will provide a national structure for sharing information consistently.

In order to ensure that the marketing and outreach by PFFS plans is accurate and complies with all program requirements, CMS is in the process of clarifying current policy and developing additional PFFS marketing documents and other outreach materials. The list of actions is lengthy, but includes initiatives focused on:

- **Marketing.** Beginning no later than the November / December 2007 open enrollment period for the 2008 benefit year, CMS is requiring PFFS plans to include specific CMS-developed disclaimer language in all pre-enrollment materials as well as sales presentations explaining how PFFS plans work with respect to obtaining care from doctors and hospitals. Plans are encouraged to put this practice into place even sooner than the 2008 coordinated election period if possible. Certain plans also are currently

required under corrective action plans to call-back beneficiaries after an initial enrollment to confirm the intent to enroll.

- ***Training.*** For plan year 2008, CMS is requiring PFFS plans to provide documented training of marketing agents and brokers on Medicare Advantage policy as well as unique aspects of the PFFS product.
- ***Enrollment verification.*** Effective for the November / December 2007 open enrollment period for the 2008 benefit year, CMS is requiring PFFS plans to call all new applicants to confirm that applicants do, in fact, wish to enroll and that they understand the features of the plan.
- ***Provider payment policies.*** For the 2008 plan benefit year, CMS is strengthening requirements on transparency of provider payment rates, timeliness of payments to providers, and provider payment dispute processes.
- ***Provider education.*** For the 2008 plan benefit year, CMS is requiring plans to provide all enrollees with a uniform tear sheet explaining the PFFS option, which enrollees can use to discuss coverage with their treating providers.
- ***Medicare Handbook.*** For the November / December 2007 open enrollment period for the 2008 benefit year, CMS is adding clarifying language to the Medicare & You Handbook to ensure beneficiaries understand how the PFFS option works. As with all Medicare & You revisions, draft language is being vetted with beneficiary focus groups, policymakers and advocacy groups to help ensure effective messaging for people with Medicare.

Building upon lessons learned and information gathered during 2006, CMS is strengthening its oversight of Medicare Advantage plans across-the-board. CMS has improved its method for

identifying companies for compliance audits, making more efficient use of the resources available for ensuring compliance, and developing a closer relationship with State regulators. For example, CMS is working with a contractor to augment the internal agency resources available for compliance audits. Among other things, the contractor is conducting “secret shopping” of sales events across the country; such information enables CMS to learn firsthand what is happening in the sales marketplace and to identify organizations for compliance intervention that are not meeting CMS marketing and enrollment requirements. CMS is committed to taking whatever steps are necessary to ensure people with Medicare are not misled or harmed by Medicare Advantage plans or their agents.

Conclusion

Mr. Chairman, thank you again for this opportunity to testify regarding PFFS plans under Medicare Advantage. I would be happy to answer any of your questions.