Committee on Ways and Means

Representative Charles B. Rangel, Chairman

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Controlling Private Fee-For-Service Spending and Growth: *Ending Wasteful Overpayments, Preserving Medicare*

Private Fee-For-Service (PFFS) plans are one subset of Medicare Advantage plans. They differ from other MA plans in several important ways. First, they do not have to develop provider networks. They can "deem" providers into the plan, which means any doctor can choose to accept – or reject -- PFFS plan payment at the point of service. This creates tremendous uncertainty and confusion for both beneficiaries and providers. Second, PFFS plans do not have to meet even the few quality measures that are required of other Medicare Advantage plans. Third, they are the most overpaid and least efficient of all MA plans, costing taxpayers an additional $13 billion/5 years.

Even strong supporters of Medicare Advantage privately acknowledge that PFFS plans "give MA a bad name". PFFS plans exist in both rural and urban areas. Enrollment in PFFS plans is growing rapidly in part because of the aggressive marketing tactics that these plans employ to enroll beneficiaries, and the lack of plan requirements or oversight, which makes it easier for plans to enter the market. It is imperative that Congress act now to stop the growth in these plans in their current form.

PFFS plans have an unfair advantage over other MA plans. PFFS plans are given preferential treatment on several issues relative to other types of MA plans, including that they do not coordinate care, are not subject to quality reporting requirements, and have bids that are not subject to review by the Secretary. This sets up a tension within the industry, where the plans that have historically

had the largest presence in Medicare are disadvantaged relative to these plans that cost the most and tend to offer the least.

PFFS plans are bad for providers—they often pay incorrectly or late, and don't give providers an opportunity to evaluate their terms and conditions. Because PFFS plans are allowed to "deem" doctors, hospitals and others into the plan, providers are often asked when the patient is in the doctors' office whether the doctor will accept payment from a PFFS plan. Doctors and others often have not reviewed the plans' terms and conditions and may refuse to accept payment, in which case the beneficiary is fully liable. Indeed, it is virtually impossible for a beneficiary to determine during open enrollment whether their providers will participate in PFFS at all, much less throughout the year. Several major hospital systems in Philadelphia refuse to participate in PFFS plans because of the problems they have encountered. A recent witness who runs a critical access hospital in rural Oregon testified before the Ways and Means Health Subcommittee that PFFS plans have a payment error rate of 40 percent.

PFFS plans are the most overpaid of all the MA plans -- yet offer fewer benefits than other plans. A February 2008 GAO report found that, on average, PFFS plans use just 8 percent of their rebates to offer benefits beyond those offered in traditional Medicare compared to 16 percent for PPOs.[1]

On average, cost-sharing for PFFS beneficiaries is higher than in other MA plans. Despite the overpayments, GAO found that 28 percent of PFFS enrollees are in plans where they would pay more for home health they would in traditional Medicare and 12 percent would pay more for hospital stays. [2] In fact, PFFS plans often use excessive cost sharing requirements for certain services in place of prior authorization or other access limitations found in more coordinated plans. For example, a PFFS plan in California has no out-of-pocket limit and charges its enrollees 30 percent of the cost of durable medical equipment (DME); however, if a beneficiary buys

[1] GAO-08-359, Medicare Advantage: Increased Spending Relative to Fee-For-Service May Not Always Reduce Beneficiary Out-Of-Pocket Costs, February 2008.
[2] Ibid

equipment or a device that costs more than $750, and does not notify the plan before the purchase, they pay 70 percent of the cost. In contrast, a Medicare beneficiary enrolled in traditional Medicare pay 20 percent of the cost of DME.

PFFS plans have the worst examples of marketing abuses. MedPAC's March 2008 report indicates that PFFS plans and their brokers are responsible for a large portion of the MA marketing abuses. State enforcement agencies and beneficiary advocates have documented instances where agents for PFFS plans intentionally mislead beneficiaries by describing PFFS as Medigap and failing to explain to potential enrollees that their doctors may not accept PFFS or that they may have to pay more than they would under traditional Medicare.

PFFS plans act like traditional Medicare fee-for-service, the federal government should pay them accordingly. According to MedPAC, PFFS plans do not have provider networks nor do they coordinate care or report on quality improvement activities, as other MA plans are theoretically required to do. Furthermore, PFFS plans pay providers at Medicare rates. There is no reason that they should be paid a penny over traditional Medicare fee-for-service rates.

Equalizing PFFS with Medicare FFS will not eliminate choices for Medicare beneficiaries, including those in rural states. It is a red herring to claim that eliminating PFFS eliminates MA in rural areas or elsewhere. A full 99% of Medicare beneficiaries have access to a non-PFFS MA plan. Only AK, NH, VT have only PFFS plans, with total enrollment in NH and VT at less than 5,000 beneficiaries and no beneficiaries enrolled in Alaska.[3] A reduction in payment would not eliminate the PFFS plan option.

In fact, most of the PFFS enrollment is in urban, not rural, areas. The Administration and few defenders of PFFS argue that it is necessary for choice in rural areas, but the majority of PFFS enrollees are in urban areas. About 70% of PFFS enrollment is in urban counties where multiple HMOs and local PPOs are available.

[3] MedPAC July 2007 Data book, Healthcare Spending and the Medicare Program, p.155.

And, with few exceptions, beneficiaries in urban areas have chosen other MA options. Fewer than 4% of urban area beneficiaries are enrolled in PFFS. [4]

By acting quickly, Congress can achieve PFFS savings largely by avoiding future enrollment. The percent enrollment in PFFS remains in the single digits for all but a few states (see attached chart). Congress needs to act to stop the wasteful spending in PFFS before more beneficiaries enroll in these inefficient plans.

PFFS plans are the most inefficient of all the MA plans. According to MedPAC, PFFS plans bid 8 percentage points higher than it would cost Medicare to deliver the SAME benefit package, meaning their costs are actually substantially higher. This is higher than all other types of MA plans.

Overpayments for employer PFFS plans are a cost shift from the private sector to the federal government. Approximately 15 percent of PFFS enrollment is in employer plans[5]; this is an area of projected growth that taxpayers cannot afford as more employers consider this option. Overpaying employer PFFS allows employers to reduce their contributions because the higher reimbursements from the government fill in for reduced employer dollars. This "crowd out" means that public dollars are substituting for private sector dollars that would otherwise be spent on retiree health programs. Given that the Administration and many Congressional Republicans opposed expanding the children's health insurance program (CHIP) because they were concerned it would lead to similar crowd out, supporting PFFS is the height of hypocrisy.

[4] http://www.kff.org/medicare/upload/7775.pdf
[5] Ibid

State-by-State Enrollment in PFFS Plans

NOTE: States where PFFS is only option are italicized and bold

State	Medicare Eligibles	% of state's Medicare beneficiaries Enrolled in PFFS	Number of beneficiaries
Alaska	***55,000***	***0%***	***0***
Alabama	782,000	2%	15,640
Arkansas	489,000	7%	34,230
Arizona	819,000	4%	32,760
California	4,386,000	1%	43,860
Colorado	541,000	3%	16,230
Connecticut	54,000	1%	540
DC	78,000	1%	780
Delaware	132,000	1%	1,320
Florida	3,130,000	2%	62,600
Georgia	1,077,000	7%	75,390
Hawaii	189,000	1%	1,890
Iowa	503,000	6%	30,180
Idaho	199,000	9%	17,910
Illinois	1,749,000	2%	34,980
Indiana	935,000	6%	56,100
Kansas	410,000	3%	12,300
Kentucky	705,000	7%	49,350
Louisiana	643,000	3%	19,290
Massachusetts	1,007,000	2%	20,140
Maryland	718,000	0%	0
Maine	243,000	1%	2,430
Michigan	1,538,000	11%	169,180
Minnesota	722,000	8%	57,760
Missouri	943,000	3%	28,290
Mississippi	472,000	6%	28,320
Montana	153,000	11%	16,830
North Carolina	1,319,000	7%	92,330
North Dakota	106,000	5%	5,300
Nebraska	268,000	5%	13,400
New Hampshire	***194,000***	***2%***	3,880
New Jersey	1,270,000	0%	0
New Mexico	278,000	3%	8,340
Nevada	309,000	1%	3,090
New York	2,879,000	1%	28,790
Ohio	1,812,000	3%	54,360

Oklahoma	560,000	3%	16,800
Oregon	558,000	3%	16,740
Pennsylvania	2,189,000	2%	43,780
Puerto Rico	620,000	0%	0
Rhode Island	178,000	1%	1,780
South Carolina	674,000	8%	53,920
South Dakota	955,000	4%	38,200
Texas	2,641,000	3%	79,230
Utah	245,000	13%	31,850
Virginia	1,022,000	7%	71,540
Vermont	***100,000***	***1%***	1,000
Washington	852,000	4%	34,080
Wisconsin	855,000	11%	94,050
West Virginia	367,000	3%	11,010
Wyoming	74,000	3%	2,220
U.S. Total	**43,597,000**	**4%**	**1,743,880**

Source: MedPAC, July 2007 Data Book