Private Fee for Service (PFFS) Plans: How They Differ from Other Medicare Advantage Plans

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Summary

The Balanced Budget Act of 1997 (BBA, P.L. 105-33) established the Medicare+Choice program (now called Medicare Advantage), creating new options for the delivery of required benefits under Medicare. One of these options is a Private Fee-For-Service plan (PFFS), statutorily defined as a plan that (1) reimburses hospitals, physicians, and other providers on a fee-for-service basis without placing the provider at financial risk; (2) does not vary rates for a provider based on utilization relating to that provider; and (3) does not restrict the selection of providers from among those who are lawfully authorized to provide services and agree to accept the terms and conditions of payment established by the plan.

Recently enrollment in PFFS plans has increased dramatically. In April 2003, there were 22,344 Medicare beneficiaries enrolled in one of the three available PFFS plans and one PFFS demonstration program. In April 2004, CMS had contracts with six PFFS organizations, with total enrollment of 31,550. By April 2007, CMS had 47 PFFS contracts and enrollment had jumped to 1.5 million, an increase of over 4,000% in three years. Approximately 18% of all Medicare Advantage beneficiaries are enrolled in a PFFS plan, and CBO projects this number to grow to approximately one-third of all MA enrollment by 2017. Plans operate in nearly all United States counties, giving every Medicare beneficiary access to at least one PFFS plan.

The majority of PFFS enrollees reside in urban areas. However, close to half of all rural beneficiaries participating in Medicare Advantage plans are enrolled in a PFFS plan. Unlike coordinated care plans, which tend to serve more densely populated areas, PFFS plans also choose to serve rural areas. PFFS plans may choose their service areas because (1) Medicare private plan payments are higher than the average cost of traditional Medicare in many of the counties a PFFS plan chooses to serve, and (2) PFFS plans are not required to form networks. Establishing and maintaining networks of providers can be costly, particularly in rural areas.

Congressional attention to these plans has increased this past year for a number of reasons. First, enrollment in these plans has risen significantly. Second, payments to PFFS plans are typically higher than payments to other managed care plans and higher than expenditures in FFS Medicare. Third, the marketing and sales tactics of PFFS plans has raised concerns related to beneficiary protection. Lastly, PFFS plans are subject to different statutory requirements than other Medicare private plans.

This report examines the differences between PFFS plans and other Medicare private plans, specifically local health maintenance organizations (HMOs) and regional preferred provider plans (PPOs). Some of the reasons for growth in PFFS plans are also discussed, as well as advantages and disadvantages of these plans. The report concludes with a brief discussion surrounding current issues.

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Introduction

Medicare is the nation's health insurance program for the aged, disabled, and persons with End Stage Renal Disease. Medicare part A, the Hospital Insurance program, covers hospital services, post-hospital services, and hospice services. Part B, the Supplementary Medical Insurance program, covers a broad range of complementary medical services, including physician, laboratory, outpatient hospital services, and durable medical equipment. Beneficiaries choosing traditional fee-for-service Medicare may receive covered benefits from any qualified provider who participates in the Medicare program. Alternatively, beneficiaries eligible for Medicare part A and enrolled in part B may choose to enroll in a Medicare private plan, under part C of Medicare (the Medicare Advantage program), and receive all required parts A and B benefits (except hospice services) through a private plan. Medicare part D provides prescription drug coverage available through either a stand-alone drug plan (PDP), or for most Medicare Advantage enrollees through their plan.[1]

Medicare has offered its beneficiaries enrollment in a private plan as an alternative to the traditional fee-for-service (FFS) program since the 1970s, not long after the establishment of Medicare. Over the years, Congress has continued to legislate an increasing number of private plan options for Medicare. In 1982, Congress created Medicare's risk contract program, allowing private entities, mostly health maintenance organizations (HMOs), to contract with Medicare. In 1997, Congress passed the Balanced Budget Act of 1997 (BBA, P.L. 105-33), creating the Medicare+Choice (M+C) program, offering new types of private plans, including private fee-for-service (PFFS) plans. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173) changed the name of the program to Medicare Advantage (MA) and further expanded Medicare's private plan options with the addition of new regional preferred provider organizations (PPOs), among others. Further modifications to the MA program were made in the Deficit Reduction Act of 2005 (P.L. 109-171, DRA) and the Tax Relief and Health Care Act of 2006 (P.L. 109-432).

Recently, congressional attention has turned to the MA program, focusing in large part on PFFS plans. There are a number of reasons for this attention. First, enrollment in these plans has risen significantly—increasing from 22,344 beneficiaries in April of 2003 to almost 1.5 million four years later. Second, payments to PFFS plans are typically higher than payments to other MA plans and higher than expenditures in FFS Medicare. Recent analysis conducted by the Medicare Payment Advisory Commission (MEDPAC) demonstrated that in 2006, payments to PFFS plans averaged 119% of FFS expenditures. This is in contrast to payments to all MA plans, which averaged 112% of expected FFS expenditures, and payments to HMOs, which averaged 110%.[2]

Complaints have also been made related to allegedly aggressive and potentially misleading marketing practices of PFFS plans, leading some to question Medicare's oversight of these plans.[3]

[1] MA organizations must offer at least one plan in each area they serve that provides qualified part D prescription drug benefits, except for PFFS plans which may offer, but are not required to offer, part D coverage. Enrollees in a PFFS plan that does not offer qualified prescription drug coverage may buy a stand-alone PDP, while enrollees in other MA plans that do not offer qualified drug coverage may not buy a stand-alone PDP.

[2] Report to the Congress: Promoting Greater Efficiency in Medicare. Medicare Payment Advisory Commission (MEDPAC). Chapter 3 - Update on the Medicare Advantage Program and Implementing Past Recommendations. June 2007.

[3] The Senate Special Committee on Aging held a hearing on May 15, 2007, to examine marketing and sales of MA (continued...)

Most recently, in an agreement with the Centers for Medicare and Medicaid Services (CMS), seven health care organizations representing 90% of the non-group PFFS market voluntarily agreed to suspend marketing of their PFFS products because of complaints and accusations of deceptive marketing practices.[4] According to CMS, the suspension for a given plan will be lifted when the plan meets specified conditions.

Finally, PFFS plans are subject to different statutory and administrative requirements than other Medicare private plans, specifically those related to access, quality, review of plan premiums, Medicare prescription drug benefits, and balance billing. Policy makers and beneficiary advocates are questioning whether beneficiaries fully understand these differences when they enroll in a PFFS plan and what their implications are for beneficiary spending, access to providers, and adequacy of benefits.

This report focuses on PFFS plans and how they differ from two other widely available MA options, local HMOs and regional PPOs.[5] Background information related to enrollment and the characteristics of these plans is presented, as well as a discussion surrounding current issues. **Appendix** provides a side-by-side comparison of the major statutory differences between these three types of plans. It does not include all provisions of the law, rather only those for which there are significant differences. Some regulatory differences are also included, when applicable.

Background

About 8.5 million of Medicare's 44.6 million beneficiaries (19%) are enrolled in a MA plan. Most MA enrollees choose a local HMO. **Figure 1** shows enrollment as of April 2007 by plan type, with 5.7 million beneficiaries in local HMOs, 1.5 million beneficiaries in PFFS plans, 136,000 beneficiaries in regional PPOs, and the remaining 1.2 million beneficiaries divided among other types of plans.[6] However, the proportion of beneficiaries enrolled in each plan type varies by state.[7]

(...continued)

plans to Medicare beneficiaries. http://aging.senate.gov/hearing_detail.cfm?id=274320&; the House Committee on Ways and Means, Subcommittee on Health held a hearing on May 22, 2007 on MA PFFS plans, which addressed marketing practices; the House Energy and Commerce, Subcommittee on Oversight and Investigations held a hearing on June 26, 2007 on the marketing of MA plans.

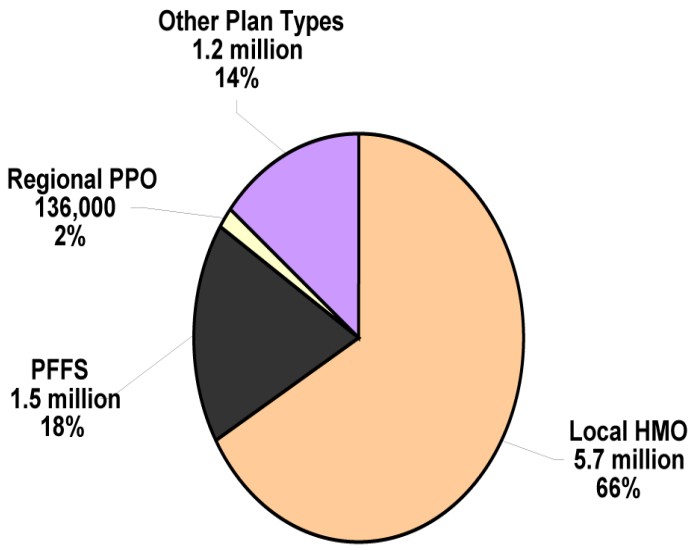
[4] CMS news release, "Plans Suspend PFFS Marketing: Plans adopt strict guidelines in response to deceptive marketing practices," June 15, 2007. The seven companies included in the voluntary suspension are: United Healthcare, Humana, Wellcare, Universal American Financial Corporation, Coventry, Sterling, and Blue Cross Blue Shield of Tennessee.

[5] This report does not discuss other types of MA plans, such as Specialized MA Plans for Special Needs Individuals (SNPs), or Medical Savings Accounts.

[6] Other plans include (1) local PPOs, which operate similarly to regional PPOs but are not required to cover an entire region (380,000 enrollees); (2) provider sponsored plans which are another type of coordinated care plan established or organized by providers (77,000 enrollees); (3) medical savings accounts which are a type of high deductible plan (2,300 enrollees); (4) cost plans which are the original private plan option under which plans are reimbursed on a cost basis rather than a monthly capitated amount (307,000 enrollees); and (5) demonstrations, Health Care Prepayment plans (HCPP) which only provide part B services, and Program of All Inclusive Care for the Elderly (PACE) contracts (305,000 enrollees). Another 138,00 individuals are included in CMS's total count of MA enrollees, but they are excluded here because they represent Medicare fee-for-service beneficiaries who receive care management for chronic conditions.

[7] State-level data is calculated as of February 2007 when PFFS enrollment was 16% of MA enrollment; it grew to 18% by April.

Figure 1. Number and Proportion of Medicare Beneficiaries Enrolled in Medicare Advantage Plans, by Plan Type, April 2007



Source: Figure created by the Congressional Research Service based on data from the Centers for Medicare and Medicaid Services.

Table 1 shows that in some states, the proportion of MA enrollees enrolled in PFFS plans may be as low as 0% or 1% or over 90%.

Table 1. Medicare Advantage Enrollment in Local HMOs, Regional PPOs, and PFFS Plans, by State, February 2007

State	Medicare beneficiaries	Total MA enrollees[a]	Local HMO	Regional PPO	PFFS	Percentage of MA enrollees in PFFS
Alabama	775,560	105,440	83,176	0	14,425	14%
Alaska	55,059	39	11	0	28	72%
Arizona	819,728	283,235	245,945	2,593	28,462	10%
Arkansas	487,263	32,864	5,319	270	26,559	81%
California	4,301,714	1,439,888	1,280,166	21,728	22,549	2%
Colorado	544,023	160,776	118,576	0	13,030	8%
Connecticut	530,419	45,382	42,608	0	813	2%
Delaware	73,734	2,256	244	518	1,142	51%
District of Columbia	132,497	6,883	768	0	189	3%
Florida	3,088,474	778,896	609,079	44,377	42,957	6%
Georgia	1,084,004	102,282	18,685	917	64,885	63%
Hawaii	186,532	66,723	21,989	1,522	988	1%

State	Medicare beneficiaries	Total MA enrollees[a]	Local HMO	Regional PPO	PFFS	Percentage of MA enrollees in PFFS
Idaho	200,695	35,148	14,764	0	15,516	44%
Illinois	1,719,005	145,600	67,238	2,270	35,527	24%
Indiana	925,517	76,493	70	1,844	51,435	67%
Iowa	495,304	50,684	4,612	2,414	28,856	57%
Kansas	407,111	27,249	10,063	36	10,037	37%
Kentucky	697,972	69,957	18,298	899	40,657	58%
Louisiana	626,696	98,633	80,677	557	16,354	17%
Maine	241,795	3,411	261	0	1,979	58%
Maryland	712,684	52,196	12,010	202	1,226	2%
Massachusetts	984,764	166,837	134,395	0	14,774	9%
Michigan	1,517,697	200,624	38,516	958	159,933	80%
Minnesota	717,234	199,931	37,666	6,668	52,016	26%
Mississippi	462,962	41,929	1,786	95	24,137	58%
Missouri	933,358	142,108	106,663	330	23,962	17%
Montana	152,711	15,035	0	247	13,751	91%
Nebraska	265,165	21,889	9,017	834	10,108	46%
Nevada	309,722	91,257	33,166	1,591	2,816	3%
New Hampshire	193,988	2,252	27	0	2,188	97%
New Jersey	1,246,793	110,401	100,313	125	909	1%
New Mexico	278,046	57,674	42,656	0	6,380	11%
New York	2,817,400	649,827	548,736	5,383	17,690	3%
North Carolina	1,324,008	160,089	76,601	112	80,043	50%
North Dakota	104,181	5,430	0	11	4,560	84%
Ohio	1,782,109	297,829	203,099	4,636	51,632	17%
Oklahoma	555,853	60,805	46,285	0	13,353	22%
Oregon	555,180	210,827	126,193	0	12,844	6%
Pennsylvania	2,161,162	708,906	572,650	200	36,808	5%
Puerto Rico	604,176	333,490	309,621	0	256	0%
Rhode Island	173,831	60,379	58,483	0	434	1%
South Carolina	677,260	50,753	547	1,735	47,341	93%
South Dakota	127,082	5,469	1,720	572	3,144	57%
Tennessee	952,096	162,658	118,082	39	32,876	20%
Texas	2,647,533	355,366	214,775	8,758	51,524	14%
Utah	247,193	46,907	5,587	0	29,106	58%
Vermont	99,632	487	0	0	487	100%

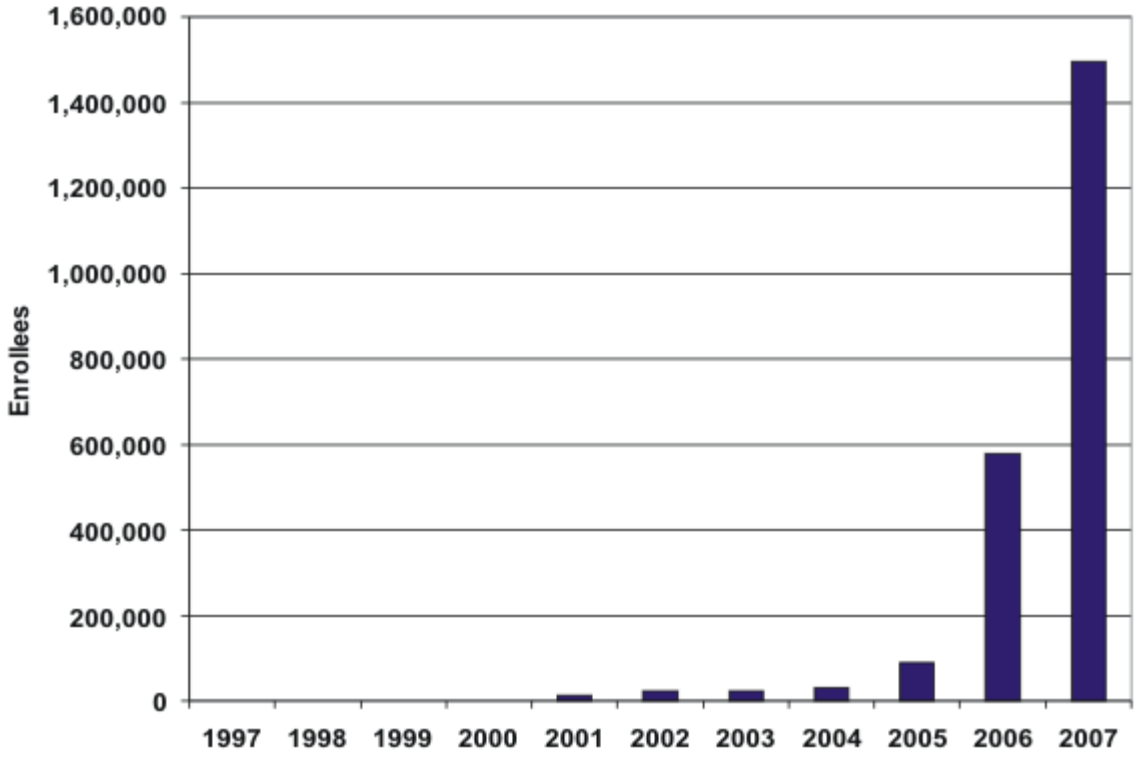
State	Medicare beneficiaries	Total MA enrollees[a]	Local HMO	Regional PPO	PFFS	Percentage of MA enrollees in PFFS
Virginia	1,025,906	82,356	6,114	86	60,769	74%
Washington	852,602	155,644	115,024	0	28,937	19%
West Virginia	362,606	34,389	4,098	0	9,250	27%
Wisconsin	843,204	151,403	41,594	430	86,600	57%
Wyoming	72,809	2,788	0	26	1,893	68%
UNITED STATES	43,154,049	8,172,774	5,587,973	112,983	1,298,136	16%

Source: Table created by the Congressional Research Service based on data from the Centers for Medicare and Medicaid Services.

a. Total enrollment also includes local PPOs, PSOs, Cost plans, Demonstrations, MSAs, and HCPPS.

Figure 2 shows PFFS enrollment over time. Interestingly, PFFS enrollment was only 22,344 in April, 2003, and 31,550 as of April 2004. By April 2007, enrollment jumped to 1.5 million, an increase of over 4,000% in three years. Comparatively, enrollment in all other MA plans was 5.3 million in December 2004 and 6.9 million in April 2007, an increase of about 30%.

Figure 2. Enrollment in Medicare Private Fee-for-Service Plans, 1997 to 2007



Source: Figure created by the Congressional Research Service based on data from the Centers for Medicare and Medicaid Services.

Local HMOs, regional PPOs, and PFFS plans, while sharing many characteristics, also have many differences that may be important in determining who enrolls, the average generosity of benefits, and payment and geographic differences. First, it is important to understand the basic structure of each of these types of plans:

- **Local HMO**—A local HMO is a public or private entity that meets all of the required solvency and other standards and has a contract with CMS to provide required and other health benefits. Members receive services mainly through the plan's network, although plans may allow out-of-network coverage. HMO's typically serve one county, but are allowed to expand their service area to more than one county if they wish. Each MA participating organization offering a local HMO is required to provide at least one MA plan with qualified Part D prescription drug coverage in its service area.[8]
- **Regional PPO**—In addition to requirements for local plans, a regional PPO must provide for reimbursement for all covered benefits, regardless of whether the benefits are provided in or out of the network. At a minimum, a regional PPO must cover an entire region. It must also have a unified part A and B deductible and a catastrophic cap on out-of-pocket expenses.[9] Like MA participating organizations that offer local HMOs, each regional PPO must offer a plan with qualified prescription drug coverage.
- **PFFS plan**—In addition to the solvency and other standard requirements for local plans, a PFFS plan (1) must reimburse hospitals, doctors, and other providers at a rate determined by the plan on a fee-for-service basis without placing the providers at financial risk; (2) can not vary rates based on utilization relating to the provider; and (3) can 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. Enrollees in PFFS plans are generally not restricted to a network of providers, although PFFS plans have the option to form networks. In contrast to other MA participating organizations, PFFS plans are not required to offer qualified prescription drug coverage.

Differences Between PFFS and Other Plans

In some aspects, PFFS plans are more closely related to traditional fee-for-service Medicare, than to other MA private plans. While almost all MA plans provide a full range of services to enrollees in exchange for a monthly capitated payment,[10] local HMOs act as both the insurer and provider of health care services. To receive benefits, the enrollee must get medical care through a network of providers managed by the plan, with very few exceptions, such as emergency care.

[8] CMS defines an MA organization as a public or private entity organized and licensed by a state as a risk bearing entity that is certified by CMS as meeting the MA contract requirements. Each MA organization may offer multiple health plans in its service area.

[9] For a discussion of Medicare Part A and B and deductibles under those parts of Medicare, please see CRS Report RL33712, *Medicare: A Primer*, by Jennifer O'Sullivan.

[10] The exception is for cost plans, which are reimbursed on a cost basis rather than a monthly capitated amount.

In contrast, PFFS plans cover enrollees through a private indemnity health insurance policy. The insurer reimburses hospitals, doctors, and other providers on a fee-for-service basis at a rate determined by the plan. The structure of PFFS plans allows enrollees greater flexibility in choosing a provider than in other MA plans. In HMOs, for example, beneficiaries typically have to visit their primary care physician and get a referral before seeing a specialist. In PFFS plans, beneficiaries can visit a specialist or any provider, who agrees to the terms and conditions of the plan, without prior authorization. Enrollees can also receive services from providers outside of their service area.

Regional PPOs operate somewhere in between, in that members can choose in or out-of-network coverage. Members, however, save in out-of-pocket costs when selecting in-network providers. While regional plans have a low enrollment compared to other types of MA plans, they are included in this analysis because they are a new option with unique requirements under the statutes, and because they may also have exceptions to network requirements. Also, similar to PFFS plans, regional PPOs are providing access to Medicare managed care plans in areas that traditionally have not been served by managed care in the past.

Appendix provides a detailed comparison of local HMOs, regional PPOs, and PFFS plans, following the sequence of the Social Security statues for Medicare Advantage, including information on residency requirements, information requirements, required benefits, beneficiary financial liability, access to services and networks, quality, payments to plans, premiums, and prescription drugs. These differences are important in determining the key issues surrounding these plans and their implications for beneficiaries. The most significant statutory differences are highlighted below.

Access to Providers

Enrollees in a PFFS plan may obtain covered services from any Medicare eligible provider who is willing to furnish services and accept the PFFS plan's terms and conditions of payment.[11] Although a PFFS plan does not have to establish a provider network, it must meet certain access requirements and demonstrate to the Secretary that professionals and providers are willing to provide services under the terms of the plan. The plan may satisfy this requirement by (1) establishing payment rates that are not less than those under traditional fee-for-service Medicare, or (2) having signed (direct) contracts with a sufficient number and range of providers in a particular category that agree to the plan's fee schedule. Most PFFS plans are meeting access requirements by paying providers at the Medicare rates.

Most PFFS plans deliver services through "deemed contracting" providers. A deemed provider is a provider who, before delivering a service, knows that a beneficiary is enrolled in the PFFS plan and has been given, or has reasonable access to, the PFFS plan's terms and conditions for participation.[12] In general, if a PFFS enrollee notifies the provider that he or she is in a PFFS plan

[11] A Medicare eligible provider must be state licensed and have a Medicare billing number. Institutional providers, such as hospitals and skilled nursing facilities, must be certified to treat Medicare beneficiaries.

[12] A PFFS plan is required to make its terms and conditions of participation reasonably available to providers. According to the CMS, posting the terms and conditions on a website and making them available upon request is sufficient. The terms and conditions specify (1) the amount the PFFS organization will pay for covered services, (2) provider billing procedures, (3) the amount the provider is permitted to collect from the enrollee, and (4) whether the provider must obtain advance authorization from the PFFS organization before furnishing a particular service. Once the provider knows an enrollee is a PFFS plan member, the provider has the responsibility to access the plan's website or (continued...)

and the provider chooses to furnish services, the provider *automatically* becomes a deemed provider for that service. If the provider furnishes services to a PFFS enrollee but the deeming requirements are not met, generally because the provider does not know that the patient is a PFFS enrollee (i.e., an emergency situation), the provider becomes a "non-contracting" provider. A "non-contracting" provider is entitled to receive the same amount the provider would have received under traditional Medicare as payment in full for a given service.

Local HMOs, in contrast, are required to form provider networks to meet access requirements. Each provider has a written contract or agreement to furnish services to enrollees in the plan's network. Care is generally not covered if received from a provider who is not in the HMO's network.[13] Regional PPOs have less restrictive networks; enrollees can see a provider outside the plan's network but must pay a greater portion of the cost of their care for doing so. Further if the plans demonstrates that it can not set up a network in part of the region, it has the option, with CMS pre-approval, to use methods other than written agreements to establish that access requirements are met.

Quality Assurance

All Medicare Advantage health plans, except PFFS plans and Medical Savings Accounts (MSAs), are required to have a quality improvement program. As part of the quality improvement program, plans must collect, analyze, and report data to measure health outcomes and other indices. Specific requirements include designing a chronic care improvement program, conducting quality improvement projects, and encouraging providers to participate in quality initiatives. Plans are required to annually assess the impact and effectiveness of their quality improvement programs and take timely action to correct any systemic problems that come to their attention.

CMS requires that MA plans collect and report on a subset of performance measures from the National Committee for Quality Assurance's (NCQA) Health Plan Employer Data and Information Set (HEDIS), the Consumer Assessment of Health Plans Study (CAHPS), and the Medicare Health Outcomes Survey (HOS).[14] Beginning in 2006, CMS began using this data to develop report cards to assist beneficiaries in choosing a health plan. Data is also used to support the plan's internal quality improvement programs and evaluate plan performance by CMS. CMS encourages, but does not require, PFFS plans to report the same HEDIS performance measures as other Medicare Advantage plans. Those that do not report performance measures will not be included on the report cards, which will be available to the public in November 2007.

(...continued)

make a phone call to determine the plan's terms and conditions of participation.

[13] Some HMOs offer a point-of-service product which allows enrollees to obtain services from providers outside of the network, but the enrollee must pay a higher proportion of the cost of the services received.

[14] HEDIS measures health plan performance in the areas of effectiveness, access, beneficiary satisfaction, plan stability, utilization, and costs. The CAHPS survey is a survey of beneficiaries on their experiences with MA plans, and the HOS measures certain patient-reported health outcomes. For more information on the types of quality measures collected by MA health plans, see the CMS Medicare Managed Care Manual Chapter 5 at http://www.cms.hhs.gov/Manuals/Downloads/mc86c05.pdf.

Review of Plan Premiums

While PFFS plans must submit bids detailing the estimated costs of providing Medicare-covered benefits to enrollees, and describe the applicable premiums, coinsurances, copayments, and benefits, CMS does not have the authority to review these bids.[15] A PFFS plan must demonstrate that the actuarial value of any deductibles, copayments, or coinsurances for Medicare-covered benefits does not exceed the actuarial value of cost-sharing under traditional Medicare. A PFFS plan is subject to the same requirements as other MA plans to provide additional benefits to enrollees if their bid for providing required parts A and B benefits is lower than the benchmark amount determined by CMS. However, unlike other MA plans, the Secretary does not review, approve, or disapprove the PFFS plan's basic or supplemental premiums.[16] Thus PFFS plans could charge their enrollees any premium they choose. The limiting factor, in this case, would be that as the premium increases, enrollees may not see the plan as a good value and would not join a PFFS plan with a premium that seemed too high relative to the benefits.

Medicare Part D Prescription Drug Coverage

While MA participating organizations that offer local HMOs and regional PPOs must offer at least one plan in an area with qualified part D prescription drug coverage, PFFS plans are not subject to this requirement. According to CMS, approximately 60% of PFFS enrollees are in a plan that includes part D coverage.[17] If a Medicare beneficiary enrolls in a PFFS plan that does not provide drug coverage, he or she may enroll in any available stand-alone Prescription Drug Plan (PDP). However, enrollees in other types of MA plans who want part D prescription drug coverage must choose a Medicare Advantage Prescription Drug (MA-PD) plan, which is an MA plan that provides all Medicare required parts A, B, and D benefits. If a Medicare beneficiary enrolls in a local HMO or regional PPO that does not offer drug coverage, he or she does not have the option to enroll in a stand-alone PDP plan.

Balance Billing

Under the Medicare statutes, providers participating in PFFS plans may bill enrollees up to 15% above the fee schedule the plan uses, subject to the terms and conditions of a particular plan. This is in addition to any cost sharing established by the plan and applies to all types of Medicare providers. PFFS plans are obligated to inform beneficiaries of these balance billing amounts. Additionally, hospitals are required to provide PFFS enrollees advance notice of any balance

[15] Beginning in 2006, payments to local MA health plans are determined by comparing a plan's bid to a statutorily determined benchmark for each local service area. By the first Monday in June, each local plan must submit to the Secretary an aggregate monthly bid amount for each MA plan it intends to offer in the upcoming year. Plans that bid below the benchmark for their local service area, receive a payment equal to their bid amount plus 75% of the difference between the benchmark and their bid amount. This rebate must be returned to the enrollee in the form of supplemental benefits, reduced cost sharing, or reduced premiums.

[16] A basic premium is the amount a plan charges for coverage of required Medicare benefits, when its bid amount to provide those services is higher than the benchmark amount paid by CMS. A supplemental premium is the amount a plan charges for coverage of optional supplemental benefits that are not covered by Medicare and not required under the bid and benchmark process.

[17] As reported by Abby Block, Director, Centers for Medicare and Medicaid Services (CMS) in Testimony before The House Committee on Ways and Means, Subcommittee on Health on May 22, 2007, on Medicare Advantage Private Fee-For-Service Plans. http://waysandmeans.house.gov/media/pdf/110/block%20testimony.pdf.

billing charges when these amounts may be substantial. In traditional Medicare, participating physicians are not allowed to balance bill beneficiaries.

Reasons for Growth in PFFS Plans

Payment

Payments to PFFS plans are typically higher than payments to other MA plans. According to the Medicare Payment Advisory Commission, payments to PFFS plans in 2006 averaged 119% of expected FFS expenditures. Payments to all MA plans averaged 112% of expected FFS spending. Payments to MA HMOs averaged 110% of expected FFS expenditures.[18] One of the reasons for this differential is that PFFS plans have chosen to operate in areas with historically higher Medicare payments. These areas are often referred to as *floor counties*.[19] Payments in floor counties, which are mainly rural and sparsely populated areas, are among the highest in the country. Local HMOs have typically chosen not to offer managed care plans in these areas because the costs of forming provider networks can be significant. Because PFFS plans are exempt from network requirements and they face little competition from other plan types, they have been able to offer and maintain coverage in these areas. As of July 2006, approximately 87% of PFFS plan enrollees resided in floor counties.[20]

Network Exceptions

Unlike local HMOs and regional PPOs, PFFS plans are not required to establish networks of providers to serve beneficiaries. This gives PFFS plans an advantage, particularly in rural areas, where forming networks is difficult because of the limited number of providers and small population of Medicare beneficiaries.[21] This exception also makes PFFS plans attractive to beneficiaries because an enrollee can visit any provider willing to accept the plan's terms of payment and conditions. However, the lack of a written agreement between the plan and provider

[18] Report to the Congress: Promoting Greater Efficiency in Medicare. Medicare Payment Advisory Commission (MEDPAC). Chapter 3—Update on the Medicare Advantage Program and Implementing Past Recommendations. June 2007.

[19] Congress created floor payment rates with the BBA to help reduce geographic variation in payment rates across the country and attract private plans to areas with historically low FFS costs, predominantly rural areas. By establishing minimum amounts that could be paid to a plan, the BBA raised payment rates in certain areas, sometimes by as much as 100%. Further legislation established multiple floor rates based on population and location, which raised payment rates in rural areas as well as small urban markets. Although plans are no longer paid these floor payments, counties whose current MA payment rates are based on yearly increases to the original floor amounts, are still referred to as floor counties.

[20] As reported by Mark Miller, Executive Director, Medicare Payment Advisory Commission in testimony before the House Committee on Ways and Means, Subcommittee on Health on May 22, 2007 on MA PFFS plans http://waysandmeans.house.gov/media/pdf/110/block%20testimony.pdf.

[21] In its June 2001 report titled "Medicare in Rural America," MEDPAC documents a number of obstacles to forming networks in rural areas. With fewer providers in rural areas, health plans have less leverage to negotiate discounted prices in exchange for delivering a large number of patients to the provider—the primary tool health plans have to persuade providers to accept lower rates. Additionally, health plans prefer to enroll a high volume of beneficiaries because it enables them to spread their costs and protect themselves from risk. Finally, health plans must meet certain state and federal regulatory requirements when forming provider networks, such as distance and timeliness standards, which pose significant challenges to health plans operating in rural areas.

means that providers are not required to treat the enrollee. Recent anecdotal evidence suggests that this may be posing access barriers for beneficiaries in certain areas as providers are unwilling to accept the PFFS plans' terms of payment.[22]

PFFS plans are not required to establish networks through contracts with providers and typically pay providers the same rate they would receive from traditional Medicare. However, if the PFFS plan establishes an adequate network with a particular type of provider, the PFFS plan must pay all providers of that type the same amount (even those who do not have a contract), which may be less than or greater than traditional Medicare amounts. The only exception would be for providers who did not know that the patient was enrolled in a PFFS plan, such as an emergency room physician treating a patient who could not communicate; those providers receive the Medicare rate.

Beneficiary Choice

PFFS plans offer beneficiaries, particularly those residing in areas with few Medicare private plans, the choice to opt out of traditional fee-for-service Medicare. In certain parts of the country, PFFS plans may be the only managed care option available to beneficiaries. Therefore, some of the recent growth in PFFS enrollment could be attributed to the extra value they may offer to beneficiaries who for the first time have the option to enroll in a private plan. Additionally, many MA plans offer extra benefits above and beyond what is offered in traditional Medicare or reduced cost sharing, making these plans attractive alternatives to fee-for-service. According to the CMS, in 2007, PFFS plan enrollees are receiving an average of $756 per year in additional benefits above what is being offered in traditional Medicare, compared with an average of $1,032 per year in additional benefits for all MA plans.[23]

Marketing

The rapid increase in the number of PFFS plans available to beneficiaries, particularly in rural areas, may have contributed to a surge in marketing and sales of these plans across the country, thereby contributing to rising enrollment in these plans. The Tax Relief and Health Care Act of 2006 (P.L. 109-432) added a provision for 2007 and 2008 granting beneficiaries currently enrolled in traditional Medicare the option to enroll in a PFFS plan or non-drug MA plan anytime during the year. Because local HMO and regional MA plans are statutorily required to offer a least one prescription drug plan in their service area (PFFS plans are exempt from this requirement), this may have provided PFFS plans with an incentive to market to beneficiaries all year round. This provision has since been repealed as of July 31, 2007.[24]

Additionally, some growth in PFFS may be due to questionable marketing practices. In response to marketing concerns, CMS announced in June that seven health insurance plans offering PFFS

[22] The House Committee on Ways and Means, Subcommittee on Health held a hearing on May 22, 2007 on Private Fee-for-Service Plans in Medicare Advantage. See testimonies from the California Health Advocates, the American Medical Association, and the Henry J. Kaiser Family Foundation for reports related to access to providers in PFFS plans. http://waysandmeans.house.gov/hearings.asp?formmode=detail&hearing=561.

[23] Ibid.

[24] P.L. 110-48, signed on July 18, 2007.

options have agreed to voluntarily suspend marketing of their plans until the plans meet criteria specified by CMS.[25] In August, CMS lifted the suspension for three of the seven plans.

Advantages and Disadvantages of Participating in a PFFS Plan

Advantages to Providers

A PFFS plan pays medical providers on a fee-for-service basis (i.e., separate payment for each service provided). PFFS plans pay providers either a negotiated amount established in a contract between the plan and provider or the equivalent of the current Medicare allowable charge. Because PFFS plans pay providers on a fee-for-service basis, the providers face no incentives to limit services to enrollees. In contrast, providers contracting with a local HMO or regional PPO plan can be placed at financial risk for providing all covered services for a capitated amount. Under capitation, providers receive one monthly payment for every enrollee, despite an enrollee's actual service use. These plans may offer bonuses or withhold certain payments in an attempt to promote efficient use of services.

Providers have more flexibility under a PFFS plan than a coordinated care plan because they do not sign contracts requiring them to provide services to a select group of enrollees. Providers can choose to accept PFFS patients, on an enrollee-by-enrollee basis, and even on a service-by-service basis.[26]

Disadvantages to Providers

PFFS plans operate under a different set of rules and requirements than other MA plans, which could be unfamiliar and confusing to providers. When an enrollee visits a provider, it is up to the provider to educate himself/herself on the plan's terms and conditions of payment, which in some cases may be different than those under traditional Medicare. This must be done prior to treating the patient. Once services have been provided, the physician is required to comply with the plan's terms and conditions as a "deemed contracting" provider. These terms and conditions may include different balance billing or cost sharing requirements than traditional Medicare and different administrative or documentation requirements. In the months to come, these disadvantages may emerge, disappear, or become less problematic as the operations and structure of these plans become more understood.

Advantages to Beneficiaries

PFFS plans have advantages for beneficiaries over traditional fee-for-service Medicare and other private plans. Beneficiaries enrolled in a PFFS plan may choose any lawfully authorized provider

[25] The marketing of PFFS plans is discussed in more detail in the "Current Issues" section of this report.

[26] In traditional fee-for-service Medicare, "non-participating" providers also have this option; they may agree to accept assignment for payment for some services and not accept assignment for other services provided to that same beneficiary. However, physicians who do not accept assignment can balance bill their patients up to 115% of Medicare rate, but are paid a lower rate by the Medicare program than physicians who accept assignment.

who accepts the plan's terms and conditions of participation. Provider choice is very important to some beneficiaries[27] and may be a benefit over local HMOs and regional PPOs that require enrollees to receive services from network providers. To demonstrate that providers are willing to serve PFFS plan enrollees, as required by statute, the plans pay providers an amount that is not less than what they would receive under traditional Medicare or an amount negotiated in a contract between the plan and provider. If the disadvantages to providers of serving PFFS plan enrollees, as discussed above, do not deter providers from participating, then the monetary compensation and flexibility of participation, both comparable to traditional Medicare, suggest that PFFS plan enrollees would have a choice of providers comparable to their choice under traditional Medicare.

Enrollees in PFFS may receive greater benefits than individuals in traditional fee-for-service Medicare, such as a "catastrophic cap" on out-of-pocket spending, emergency care overseas, and lower cost-sharing for at least some services. Depending on an individual's needs and preferences, a particular set of benefits included in a PFFS plan may be more attractive than traditional fee-for-service. Also, enrollees in PFFS plans do not have to receive prior authorization from a primary care physician to see a specialist. For some beneficiaries, having this freedom to choose is attractive.

Disadvantages to Beneficiaries

PFFS plans also have disadvantages over other MA options and traditional fee-for-service Medicare. From an enrollee's perspective, if providers choose not to serve PFFS enrollees, then their choice of providers is limited, much as it would be limited by network membership under a coordinated care plan, or by providers choosing not to serve Medicare beneficiaries. PFFS providers can choose to participate on a service-by-service basis. This means that enrollees are not guaranteed that a provider who saw them previously for a particular service will agree to see them for the same service in the future. The onus is on the enrollee to determine which providers are willing to serve them. With local HMOs and Regional PPOs, providers are required to participate for the duration of their contract with the plan, guaranteeing access to the same providers at least for the duration of the provider's contract with the plan.

Enrollees in coordinated care plans can check to see whether a provider is in the plan's network before seeking services. Enrollees in PFFS may find themselves in a situation where a provider may decline to provide services, even if they previously served another plan enrollee or that enrollee.

[27] Forty-nine percent of beneficiaries said that "choice of personal doctor" would be "extremely important" if choosing a health plan today. *Medicare Beneficiaries and Health Plan Choice*, Mathematica Policy Research, January 2001. The Mathematica Policy Research report is based on a national survey of 6,620 Medicare beneficiaries conducted in the spring of 2000.

Current Issues

Increasing Costs

Enrollment in Medicare Advantage PFFS plans is still relatively low—approximately 18% of all MA beneficiaries and only 3% of the total Medicare population. Because payments to PFFS plans are higher than payments to other MA plans, increases in enrollment could raise Medicare costs over the next 5 to 10 years. A recent CBO analysis showed that if Medicare were to reduce payments to PFFS plans to 100% of local FFS costs, Medicare would save $54B between 2009 and 2012 and as much as $149B between 2009 and 2017.[28] On the other hand, reducing payments would likely have an impact on the availability of these plans to serve beneficiaries. Since PFFS plans serve some beneficiaries who do not have access to alternative private plan options, reductions in payment could result in certain PFFS plans leaving the MA program. As a result, some Medicare beneficiaries could loose access to any MA plan. According to CMS, in some states, such as Alaska, Utah, Maine, Idaho, and New Hampshire, PPFS plans are the only MA option in some, if not all counties.[29]

Access to Providers

One of the reasons Congress established PFFS plans in the BBA was to provide Medicare beneficiaries with the option to enroll in a health insurance plan that would not restrict or limit choice of providers. Specifically, the law states that PFFS enrollees can see any Medicare-eligible provider that is willing to treat the enrollee and accept the plan's payment terms and conditions. However, providers are not required to accept PFFS beneficiaries. Recent press reports and advocates report that at least in some areas beneficiaries are having trouble finding a provider who is willing to accept the plan's payment terms and conditions and provide care to the enrollee.[30] Some of the reasons cited for providers unwillingness to participate in these plans are confusion surrounding payment rates, receiving lower payment rates than traditional Medicare, having difficulty accessing plans terms and conditions, and other administrative hassles related to reimbursement.[31] Although PFFS plans have been around for a decade, enrollment was low enough that most providers were not exposed to these products. With enrollment on the rise, providers are just now becoming familiar with the rules governing these plans.

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[28] The House Committee on the Budget held a hearing on June 28, 2007 to examine the Medicare Advantage Program and the Federal Budget. This excerpt was taken from the testimony of Peter Orszag from the Congressional Budget Office. http://budget.house.gov/Orszag%20Testimony.pdf.

[29] As reported by Abby Block, Director, Centers for Medicare and Medicaid Services (CMS) in testimony before The House Committee on Ways and Means, Subcommittee on Health on May 22, 2007 on Medicare Advantage Private Fee-For-Service Plans. http://waysandmeans.house.gov/media/pdf/110/block%20testimony.pdf.

[30] The House Committee on Ways and Means, Subcommittee on Health held a hearing on May 22, 2007 on Private Fee-for-Service Plans in Medicare Advantage. See testimonies from the California Health Advocates, the American Medical Association, and the Henry J. Kaiser Family Foundation for reports related to access to providers in PFFS plans. http://waysandmeans.house.gov/hearings.asp?formmode=detail&hearing=561. Examples of press reports include "Politics & Economics: Medicare's Growing Pains; Alternative Plan's Sales Tactics, Subsidies Draw Ire," by Jane Zhang, Wall Street Journal, May 8, 2007; "Universal In Limbo Over PFFS Plan," by Carol Gentry, Tampa Tribune, April 29, 2007; and "Any Members?" by Harry Wessel, Orlando Sentinel, March 15, 2007.

[31] The House Committee on Ways and Means, Subcommittee on Health held a hearing on May 22, 2007 on Private Fee-for-Service Plans in Medicare Advantage. See statement of the American Medical Association. http://waysandmeans.house.gov/hearings.asp?formmode=view&id=6209.

Benefit Structure/Cost Sharing

The benefit structure and cost sharing features of some PFFS plans and the proportion of enrollees subject to those features are shown in **Table 2**. Many PFFS enrollees are enrolled in plans that have benefit structures or cost sharing that appear more generous than traditional Medicare. For example, 60% of PFFS enrollees are enrolled in a plan with a catastrophic cap on out-of-pocket spending that is between $1,001 and $5,000, whereas traditional Medicare does not have a catastrophic cap. In another example, 68% of PFFS enrollees are enrolled in a plan that covers a 90-day hospital stay for $1,000 or less out-of-pocket. This is considerably less than the $8,432 out-of-pocket cost for a 90-day hospital stay under traditional Medicare. However, PFFS plans are not always more generous than traditional Medicare. Statutorily, the actuarial value of cost sharing for Medicare benefits in MA plans cannot exceed the actuarial value of cost sharing in traditional Medicare. Cost sharing for some services in PFFS plans may be higher than the amounts in traditional Medicare or lower than the amounts in traditional Medicare depending on the service and plan. While HMOs may also have different cost sharing than traditional Medicare, more individuals are familiar with HMOs than with PFFS plans. PFFS plans may be more confusing because beneficiaries expect them to be more similar to traditional Medicare. For example, unlike traditional Medicare, some plans charge an additional co-payment if the beneficiary fails to inform the plan of a scheduled hospital admission. For another example, under some plans, a beneficiary could pay $2,000 more for a hospital admission than they would have paid under traditional Medicare, depending on the length of the admission. Such unexpected variations in cost sharing can be confusing and surprising to beneficiaries. Furthermore, these differences make it unclear whether or not participating in PFFS plans actually save beneficiaries money. It is likely that for some enrollees, total costs would be lower than those they would have incurred had they been participating in traditional Medicare. However, for others, costs may be higher.

Additionally, Medicare statutes allow providers participating in PFFS plans, including hospitals, to balance bill enrollees up to 15% above the reimbursement rate set by the plan, subject to the plan's terms and conditions. This is in addition to the plan's co-payments and coinsurance amounts. Despite having the option, PFFS plans do not currently allow physicians to balance bill beneficiaries. In traditional Medicare, most physicians agree not to balance bill.

Table 2. Percentage of Private Fee-for-Service Enrollees with Specified Benefit Structure/Cost Sharing, 2007

Benefit Structure/Cost Sharing	Percentage of PFFS Enrollees
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 skilled nursing facility admission.	83%
Primary care physician copayment of $20 or less	85%
Prostate and cervical cancer screening with no co-insurance	88%

Source: As reported by Abby Block, Director, Center for Beneficiary Choices in Testimony before The House Committee on Ways and Means, Subcommittee on Health on May 22, 2007.

Marketing

Questionable marketing conduct on the part of PFFS plans has raised concerns among policy makers. Advocates and state health commissioners report receiving complaints related to allegedly deceptive and aggressive sales practices by PFFS plans that have resulted in beneficiaries either being unintentionally enrolled in a PFFS plan or enrolling in a PFFS plan without fully understanding the plan's coverage policies.[32] Between December 2006 and April 2007, CMS reported received approximately 2,700 complaints related to Medicare Advantage plan marketing.[33]

On June 15, CMS announced that in response to marketing concerns, seven health insurance plans offering PFFS options agreed to voluntarily suspend their marketing of these plans.[34] These seven plans represent 90% of PFFS enrollment.[35] Before they can resume marketing to beneficiaries, plans must demonstrate their compliance with a series of provisions. CMS has since lifted the suspension for three of these plans allowing them to resume their marketing practices to beneficiaries. Among these provisions are applying CMS-developed disclaimer language on all enrollment and marketing materials, requiring that all sales agents pass a written test to demonstrate product knowledge, conducting verification calls to beneficiaries to ensure they understand the plan and implementing a provider outreach and education program to ensure that providers have reasonable access to the plan's terms and conditions. Violations of these provisions can result in sanctions such as enrollment suspensions and civil monetary penalties. Although state health insurance departments may receive complaints from beneficiaries related to marketing misconduct, CMS maintains sole authority for sanctioning and disciplining plans.

Quality

By forming networks of providers, local HMOs and Regional PPOs may be better able to manage the utilization and delivery of care furnished by their providers. Plans do this by developing care coordination, disease management, preventive care, and other quality-related programs. Without networks and contracts, PFFS plans have less control over the numbers and types of services provided by their providers, as well as the quality of those services. The same holds for traditional Medicare, which also pays providers on a fee-for-service basis and does not form provider networks. Furthermore, PFFS plans are exempt from having to establish and monitor a quality improvement program, which provides for the collection and ongoing analysis of quality

[32] Advocates and state insurance commissioners report receiving the following types of complaints from beneficiaries enrolled in PFFS plans: being told they can see any Medicare provider without explaining that the provider must accept the plan's terms and conditions for payment; being enrolled in a plan without their knowledge (i.e., falsifying signatures on applications or telling beneficiaries they are signing an attendance sheet or other form when they were actually signing an enrollment application); receiving door-to-door solicitations from plan agents despite being prohibited under CMS marketing guidelines; and being told that they must change their policy because it's required by Medicare. See written testimonies from the House Committee on Energy and Commerce Hearing on Predatory Sales Practices in Medicare Advantage on June 26, 2007. http://energycommerce.house.gov/cmte_mtgs/110-oi-hrg.062607.MedicareAdvantage.shtml.

[33] CMS Press Release. "Plan Suspend PFFS Marketing; Plans adopt strict guidelines in response to deceptive marketing practices." June 15, 2007.

[34] The seven companies included in the voluntary suspension are: United Healthcare, Humana, Wellcare, Universal American Financial Corporation, Coventry, Sterling, and Blue Cross Blue Shield of Tennessee. In August, CMS announced that Coventry, Universal American Financial Corporation, and WellCare have been found to be compliant with CMS marketing guidelines and are allowed to resume advertising practices.

[35] See CMS website at http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/CallLetter.pdf.

measures related to health outcomes. Although the evidence that managed care plans produce better health outcomes or deliver more cost-effective care is mixed, without consistent quality reporting across all types of health plans, discerning whether higher payments to PFFS plans result in improved quality will be difficult to assess.

Conclusion

Significant growth in enrollment in PFFS plans raises concerns among policy makers because payments to PFFS plans are higher than payments to other MA plans and costs in the traditional Medicare program. With enrollment in these plans projected to double over the next 10 years, payments to these plans will increase Medicare spending. Furthermore, differences between PFFS plans and other MA plans have important implications for beneficiaries, the impact of which are not yet fully understood. In the coming months, policy makers will want to assess whether the intended benefits associated with participation in these plans outweigh their added costs.

Appendix. Comparison of Major Differences Between Local HMOs, Regional PPOs, and PFFS Plans

Eligibility and Enrollment (§1851)

Residency and service area requirements (§1851(b))

Local HMO	Regional PPO	PFFS
An MA eligible individual may only enroll in an MA plan that serves the geographic area in which the individual resides, with two exceptions (1) a plan may allow an individual to remain in a local plan, even if he or she no longer resides in the service area, so long as the plan provides reasonable access within that geographic area to the full range of basic benefits, with reasonable cost sharing; and (2) a local MA organization that eliminates a payment area which was previously within its service area, may choose to offer enrollees in all or part of the affected area continued enrollment in the plan, under certain conditions. Local HMOs may determine their own service area, consisting of counties or equivalent areas. Nothing prevents a local plan from being offered in more than one MA area.	The general rules for beneficiary residency apply, without the exceptions that may be offered to beneficiaries enrolled in MA local plans. Currently there are 26 regions. The term "MA region" refers to a region within the 50 States and the District of Columbia as established by the Secretary. The Secretary may periodically review & revise such regions if the Secretary determines such revision to be appropriate. There shall be no fewer than 10 regions, and no more than 50 regions. The regions shall maximize the availability of MA regional plans to all MA eligible individuals without regard to health status, especially those residing in rural areas. Before establishing MA regions, the Secretary shall conduct a market survey and analysis, including an examination of current insurance markets, to determine how the regions should be established. Nothing prevents an MA regional plan from being offered in more than one MA region (including all regions).	Generally the beneficiary residency rules apply. While there is no specific language for PFFS plans, nothing precludes a local PFFS plan from offering the same exceptions available to local plans. The service area requirements are generally the same as those for local HMOs.

Information requirements (§1851(d))

Local HMO	Regional PPO	Private FFS
The Secretary must provide for activities to disseminate information to current and prospective Medicare beneficiaries about MA plans, including, but not limited to benefits, cost sharing, service area, access, out-of-area coverage, emergency coverage, and supplemental benefits.	In addition to required information for local plans, information for regional PPOs must also include a description of the catastrophic coverage and the single deductible for the plan.	In addition to required information for local plans, information for PFFS plans must also include differences in cost sharing, premiums, and balance billing under the PFFS plan compared to other MA plans.

Benefits and Beneficiary Protections (§1852)

Required benefits (§1852(a))

Local HMO	Regional PPO	Private FFS
Each MA plan must provide all items and services (other than hospice) for required benefits under Part A and B to individuals entitled to Part A and enrolled in Part B, with cost sharing for those services as required under Part A and B, or an actuarially equivalent level of cost sharing. For any services furnished through non-contract providers, a plan satisfies benefit requirements by providing payment so that the sum of the payment amount (including cost sharing) is equal to at least the total that would otherwise be authorized under Part A and B (including any balance billing permitted under such parts).	Regional PPO plans must provide the same basic required benefits as local HMOs with the addition of (1) a single deductible for Part A and Part B services, which may be applied differentially for in-network and out-of-network services and may be waived for preventive or other items or services, and (2) a catastrophic limit on out-of-pocket expenditures for in-network benefits covered under original Medicare, and a catastrophic limit on out-of-pocket expenses for all benefits covered under the original Medicare program.	The same basic required benefits apply for PFFS plans as for local HMOs except for allowances for balanced billing, as discussed below.

Beneficiary financial liability (including balance billing) (§1852(a) and (k))

Local HMO	Regional PPO	Private FFS
The amount of cost sharing per MA enrollee for covered services can be no more than the actuarial value of the deductible, coinsurance, and copayment under traditional Medicare. A physician or other entity (other than a provider of services) that does not have a contract establishing payment amounts for services furnished to an MA enrollee shall accept as payment in full for covered services the amounts that the physician or other entity could collect if the individual were not so enrolled, including any permitted balance billing.	Similar to local plans, except in determining the actuarial equivalent level of cost sharing requirements the plan will also take into account those services furnished in network with respect to the application of the catastrophic limit.	Generally contract providers may bill enrollees in PFFS plans up to 15% above the fee schedule the plan uses. In contrast to traditional Medicare, this extends to all categories of providers, including hospitals. PFFS plans must provide enrollees with a clear statement of the amount of the beneficiary's liability, including any balance billing amounts. Similarly, hospitals must provide advance notice before receipt of inpatient services and certain other services, for which the amount of balance billing could be substantial. Under traditional Medicare, only non-participating physicians are allowed to balance bill.

Supplemental benefits (§1852(a))

Local HMO	Regional PPO	Private FFS
Subject to the Secretary's approval, MA organizations may provide enrollees with supplemental health benefits not covered under the original Medicare program. The Secretary approves such benefits unless the Secretary determines that the benefits would substantially discourage enrollment in the plan. Supplemental benefits can either be paid by the plan with any *average per capita monthly savings* resulting from the bid process (explained in detail below), or supplemental benefits can be paid by the beneficiary through increased plan premiums. Any supplemental benefits that an enrollee is required to accept or pay for are called *mandatory supplemental benefits*. In contrast, *optional supplemental benefits*, are supplemental benefits that are purchased at the discretion of the enrollee and must be offered to all beneficiaries enrolled in the plan. In addition to extra benefits such as vision or dental care, supplemental benefits may include reductions in deductibles, coinsurance and co-payments below the actuarial value for items and services provided, on average, to individuals in original Medicare.	Same as for local HMOs.	The statute specifies that PFFS plans are not prevented from offering supplemental benefits including payment for some or all of the allowed balance billing amounts and coverage of additional benefits that the plan finds medically necessary.

Access to services and networks (§1852(d))

Local HMO	Regional PPO	Private FFS
The MA organization may select providers from whom benefits are provided as long as five conditions apply (1) benefits are available and accessible with reasonable promptness and in a manner that assures continuity in the provision of benefits; (2) medically necessary care is available 24 hours a day and 7 days a week; (3) out-of-network services are covered if a) the services were not emergency services but were medically necessary and immediately required and it was not reasonable under the circumstances to obtain them from a network provider, (b) the service was renal dialysis while a beneficiary is traveling outside the service area, or (c) the service is maintenance care or post stabilization care; (4) the organization provides access to appropriate providers; and (5) emergency services are provided without regard to prior authorization or the providers contractual relationship with the organization. To accomplish these access requirements, Medicare regulations include a requirement that coordinated care plans maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to covered services to meet the needs of the plan enrollees.	Regional PPO plans are required to follow the same access to services and network requirements as local HMOs, except that MA regional plans, upon CMS pre-approval, can use methods other than written agreements to establish that access requirements are met.	PFFS organizations must demonstrate that a sufficient number and range of providers are willing to provide services under the terms and conditions of the plan. Organizations meet these requirements by: (1) establishing payment rates for covered items and services that are not less than the payment provided under traditional Medicare for Part A or B services, or (2) the plan has signed contracts or agreements with a sufficient number or range of providers in a category or service that agree to the plan's fee schedule.

Quality improvement program/quality measurement reporting (§1852(e))

Local HMO	Regional PPO	Private FFS
Each organization must have an ongoing quality improvement program. It must provide for the collection, analysis, and reporting of data that permits the measurement of health outcomes and other indices of quality. As part of this program, each MA organization is required to have a chronic care improvement program designed to monitor and identify enrollees with severe chronic conditions.	Similar to local HMOs, each regional plan must have an ongoing quality improvement program. However, the Secretary determines for the Regional PPOs the requirements for collection, analysis and reporting of data. Data collection for the program is limited to in-network services.	PFFS organizations are not required to have a quality improvement program.

Payments to Medicare Advantage Organizations (§1853, §1854 and §1858)

Process for determining monthly payments for part A and B services (§1853 and §1858)

Local HMO	Regional PPO	Private FFS
In general, beginning in year 2006, payments to local MA health plans for Part A and B services are determined by comparing a plan's bid to a statutorily determined benchmark. Plans bidding below the benchmark receive a rebate and plans bidding above the benchmark may charge a premium. Before calculating the monthly payment to a plan, the premium and the rebate, both the bid and benchmark must be adjusted for several factors. Payments are then calculated by comparing the adjusted bids to adjusted benchmarks. Detailed descriptions of the bids, benchmarks, rebates, premiums, and adjustments follow.	The process for determining payments to regional plans is the same as local plans. However the bids, benchmarks, rebates and premiums are calculated differently for regional plans than for local plans (description follows).	Same as local HMOs.

Bids (§1853(a-c) and (§1854(a))

Local HMO	Regional PPO	Private FFS
By the first Monday in June, each local MA health plan must submit to the Secretary an aggregate monthly bid amount (which includes separate bids for required services, any offered supplemental benefits, and any offered drug benefits) for each MA plan it intends to offer in the upcoming calendar year. The bid is based on the average revenue requirements in the payment area for an enrollee with a national average risk profile. The Secretary has the authority to evaluate and negotiate the plan's bid amounts and its proposed benefit packages.	Same as local HMOs, except calculated on a regional basis.	The Secretary does not have the authority to review and negotiate the bid amounts for PFFS plans.

Calculation of the benchmark (§1853(a-c) and (§1858(f)))

Local HMO	Regional PPO	Private FFS
The benchmark amount is a county-specific per capita payment rate. In most years, the benchmark amount for each local service area will be based on the minimum percentage increase rate (the greater of 102% of the per capita payment rate for the preceding year, or the per capita payment rate for the preceding year increased by the national per capita MA growth percentage). In a "rebasing" year, the benchmark amount for a local service area is the greater of the minimum percentage increase rate, or 100% of the per capita FFS amount for that area. Beginning in 2004 and at a minimum every third year, CMS is required to rebase FFS payment rates. Rebasing means CMS updates the FFS rates to reflect more recent county growth trends. CMS rebased the FFS rates in 2007 and will not be rebasing the rates in 2008, so the benchmark amount will be based on the minimum percentage increase rate in 2008. The Secretary is required to announce the benchmark amounts as well as the factors that will be used to adjust these amounts by the first Monday in April.	The regional benchmarks are announced at the same time as the local benchmarks, however, they are calculated differently than the local benchmarks. Unlike the benchmark for local plans, the regional benchmark depends, in part, on plans bids. The regional benchmark is the sum of two components (1) a statutorily determined increase, and (2) a weighted average of plan bids. The regional statutory component is the weighted average of all the statutorily determined local payment rates in the region. The weight for the statutory component is based on the percentage of eligible beneficiaries in the area, as opposed to enrollees. The plan-bid component is the weighted average of all the MA regional bids submitted in a region. This weight is based on projected enrollment by plan. By incorporating the plan bid into the calculation of the benchmark, the payment amount to any one plan that participates in a region will depend on the bids submitted by other plans in the region. This introduces a new type of competition, not previously used in determining Medicare payments.	Same as local HMO.

Adjustments to monthly payments (§1853(a-c))

Local HMO	Regional PPO	Private FFS
The law requires that the Secretary make a number of adjustments to the monthly bids and benchmark amounts for local MA health plans. These include, but are not limited to, the following: • adjustment for demographics and health status (i.e. risk adjustment—which increases payments to plans for "sicker" enrollees and reduces payment for "healthier" enrollees); • adjustments to phase-out budget neutrality as applied to risk adjustment, by the end of 2010	Same as local HMO, but calculated on a regional basis.	Same as local HMOs.

Local HMO	Regional PPO	Private FFS
(budget neutrality was used to keep payments from being reduced or increased overall, when they were risk adjusted— - this adjustment would allow payments to be reduced if, overall, MA plans enrolled a "healthier than average" group of beneficiaries relative to traditional Medicare); • adjustments for differences in coding between MA plans and FFS, effective in 2008 through 2010 (to adjust the risk scores for differences between MA coding patterns that differ from patterns in FFS); • and adjustments for variations within local payment areas.		

Other payment provisions (§1853(d))

Local HMO	Regional PPO	Private FFS
A state can request that the Secretary make a geographic adjustment to payments to local MA plans in a state. The state can request that the entire state be considered a single payment area, that each metropolitan statistical area (MSA) within a state be considered separate payment areas, or that certain non-contiguous counties be consolidated into a single payment area. (No state is paid on this basis.)	Does not apply to regional PPOs.	Same as local HMOs.

Risk corridors (§1858(c))

Local HMO	Regional PPO	Private FFS
Not Applicable	For 2006 and 2007, Medicare will share risk with MA regional plans if plan costs fall above or below a statutorily specified risk corridor. A plan's allowable costs are measured against a target amount. If allowable costs are over 103% but no greater than 108% of a specified target amount, the plan receives an additional payment equal to 50% of the difference between the allowable costs and 103% of the target amount. For costs above 108% of the target amount, the Secretary will increase the payment by the sum of 2.5% of the target and 80% of the difference between allowable costs and 108% of the target. Conversely, if a regional plan's allowable costs are less than 97% but greater than or equal to 92% of the target amount, the Secretary will reduce the payments by 50% of the difference between 97% of the target amount and allowable costs. If allowable costs are less than 92% of the target amount for the plan and year, the Secretary will reduce the monthly payment by the sum of 2.5% of the target amount and 80% of the difference between 92% of the target amount and such allowable costs.	Not Applicable

Stabilization fund (§1858(e))

Local HMO	Regional PPO	Private FFS
Not Applicable	The Secretary must establish a MA Regional Plan Stabilization Fund to provide incentives for plan entry in each region and plan retention in certain MA regions with below average MA penetration. Funding will be $1.6 billion in 2012 and $1.79 billion in 2013. Additional funds are to be available in an amount equal to 12.5% of *average per capita monthly savings* from regional plans.	Not Applicable

Essential hospitals (§1858(h))

Local HMO	Regional PPO	Private FFS
Not Applicable	There is $25 million available beginning in 2006 (increased each year) for additional payments to *essential* hospitals in regional areas demonstrating they have high costs, among other requirements.	Not Applicable

Premiums (§1854)

Monthly premium for required part A and B services (§1854(b))

Local HMO	Regional PPO	Private FFS
The MA monthly beneficiary premium depends on how much the MA health plan bids. If the unadjusted MA plan bid is at or below the unadjusted MA benchmark amount for its local area, the amount of the beneficiary premium is equal to zero. For plans bidding above the benchmark, the MA monthly beneficiary premium is equal to the difference between the health plan's unadjusted bid amount and the unadjusted benchmark for that area.	Same as local HMO, except applied on a regional basis.	The Secretary does not have the authority to review and negotiate the premium amounts for PFFS plans.

Rebates (§1854(b))

Local HMO	Regional PPO	Private FFS
When an MA plan bids below its benchmark amount, the MA plan is required to return 75% of the *adjusted average per capita savings* to the enrollee as a rebate. The *adjusted average per capita monthly savings* is the amount (if any) by which the risk adjusted benchmark exceeds the risk adjusted bid. The risk adjusted benchmark and risk adjusted bids reflect the average of the risk adjustment factors for enrollees in that area for MA local plans. The rebate must be returned to the enrollee through reduced Part B or D premiums, reduced cost sharing, or supplemental benefits. The remaining 25% of the *adjusted average per capita savings* is kept by the federal government.	Same as local HMO, except applied on a regional basis.	Same as local HMO, but may also use the rebate to reduce any balance billing amounts.

Organization and Financial Requirements (§1855)

State laws (§1855(a)

Local HMO	Regional PPO	Private FFS
Each organization must be organized and licenced under state law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each state in which it offers a plan.	If the organization meets the organizing and licensing requirements in one state within the region and has filed the necessary application to meet the requirements in the remaining states in the region, the Secretary may wave the organizing and licensing requirement for a period of time determined by the Secretary.	Same as for local HMO.

Part D Prescription Drug Benefits for Medicare Advantage Plans (1860D)

Access to MA prescription drug plans (1860D-1)

Local HMO	Regional PPO	Private FFS
At least one plan offered by an MA organization in an area is required to be an Medicare Advantage-Prescription Drug (MA-PD) plan, one that offers qualified Part D prescription drug coverage. Therefore, if only one organization offers an MA plan in an area and it offers only one plan, that plan would have to be an MA-PD and the beneficiary would have to enroll in Part D in order to enroll in an MA plan. In this situation, a beneficiary who did not want to enroll in Part D would have to receive Medicare services through traditional FFS Medicare. If an MA organization offers more than one plan in an area, only one is required to provide Part D prescription drug coverage. Each organization in an area is subject to this standard, so that even if there are multiple plans in an area, each organization must offer at least one plan that includes prescription drug coverage.	Similar to local plans, but applies on a regional basis.	PFFS plans are not required to offer qualified prescription drug benefits. If a beneficiary enrolls in a PFFS plan that doesn't provide prescription drug coverage, he/she can enroll in a stand-alone PDP in addition to the PFFS plan. However, if a PFFS plan does offer drug coverage, the plan is not subject to the same rules that apply to other MA-PD plans. These excluded rules include providing negotiated drug prices to enrollees, requiring pharmacists to disclose to patients the availability of generic drugs, or offer drug utilization and medication therapy management programs to enrollees, among others.

Payment for the prescription drug component of the MA plan (1860D-15)

Local HMO	Regional PPO	Private FFS
MA organizations offering prescription drug coverage receive a direct subsidy for each enrollee in an MA-PD plan equal to the plan's adjusted standardized bid amount for its prescription drug benefit (reduced by the base beneficiary Part D premium). The plan also receives the reinsurance payment amount of 80% of the costs for drugs exceeding the annual out-of-pocket threshold for an enrollee ($3,850 in 2007). Finally, MA-PD plans receive reimbursement for premium and cost-sharing reduction for their qualifying low-income enrollees.	Same as local plans.	Same as local plans, if PFFS plan includes qualified drugs.

Premiums for the prescription drug component of the MA plan (1860D-13)

Local HMO	Regional PPO	Private FFS
Beneficiaries who enroll in an MA plan offering Part D, must pay the plan the standard Part D premium. However, MA-PD plans offering a rebate, may use all or part of that rebate as a credit toward the MA monthly prescription drug beneficiary premium.	Same as local plans.	Same as local plans, if PFFS plan includes qualified drugs.

Part D enrollment for MA plan enrollees (§1860D-1)

Local HMO	Regional PPO	Private FFS
In general, MA-PD rules are similar to rules for MA enrollment, dis-enrollment, termination and change of enrollment. Individuals who enroll in local MA plans, must receive their Part D prescription drug benefits through an MA-PD plan (i.e., a Medicare Advantage plan that provides qualified Medicare prescription drug coverage). If an individual enrolls in an MA plan that does not offer a qualified prescription drug program, they may not enroll in a Medicare Prescription Drug Plan (PDP) for their Part D benefits.	Same as local plans.	Individuals enrolled in a PFFS plan that does not provide qualified prescription drug coverage may enroll in Medicare Prescription Drug Plan (PDP) for their Part D benefits.

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