

**PRIVATE FEE-FOR-SERVICE PLANS IN MEDICARE  
ADVANTAGE: A CLOSER LOOK**

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**HEARING**  
BEFORE THE  
**COMMITTEE ON FINANCE**  
**UNITED STATES SENATE**  
ONE HUNDRED TENTH CONGRESS

SECOND SESSION

—————  
JANUARY 30, 2008  
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## **PRIVATE FEE-FOR-SERVICE PLANS IN MEDICARE ADVANTAGE: A CLOSER LOOK**

**WEDNESDAY, JANUARY 30, 2008**

U.S. SENATE,  
COMMITTEE ON FINANCE,  
*Washington, DC.*

The hearing was convened, pursuant to notice, at 10:10 a.m., in room SD-215, Dirksen Senate Office Building, Hon. Max Baucus (chairman of the committee) presiding.

Present: Senators Rockefeller, Lincoln, Wyden, Stabenow, Cantwell, Salazar, Grassley, and Smith.

### **OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA, CHAIRMAN, COMMITTEE ON FINANCE**

The CHAIRMAN. The hearing will come to order.

On July 30, 1965, when he signed the law creating Medicare, President Johnson said, "No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings that they have so carefully put away over a lifetime. No longer will this Nation refuse the hand of justice to those who have given a lifetime of service, and wisdom, and labor to the progress of this progressive country."

Today we are here again to make sure that Medicare is keeping these promises. We are here to examine the effects of what are called private fee-for-service plans in Medicare, and we are here to make sure that these plans are doing their part to keep the promise of Medicare.

People with Medicare have a choice of how to receive their health care benefits. They receive Medicare through the traditional fee-for-service program or they can sign up for what is called Medicare Advantage. Private health insurers contract with the government on an annual basis to provide Medicare Advantage plans. Insurers receive a monthly payment from Medicare for each beneficiary enrolled.

In 2003, Congress changed the way that private insurers contract with Medicare, and in 2003 Congress also significantly increased Medicare payment rates for private plans. As a result of these changes and the way that the administration implemented them, the number of Medicare Advantage plans and beneficiaries enrolled in them has grown rapidly. Four years ago, only 1 in 10 Medicare beneficiaries got care through a private plan; today, more than 1 in every 5 do.

This new enrollment in Medicare Advantage is due mostly to growth in private fee-for-service plans. In 2005, 200,000 bene-

ficiaries enrolled in these types of plans. Last year, nearly 1.7 million did. That is a growth rate of nearly 1,000 percent over just 2 years.

In my home State of Montana, more than 90 percent of all Medicare Advantage enrollees are in private fee-for-service plans rather than in health maintenance organizations or preferred provider organizations. Most rural areas have similar statistics. Even urban and suburban areas with historically high enrollment in private plans has seen the most explosive growth from new private fee-for-service plans.

These trends far exceed any predictions that Congress received when we passed legislation to create them. We will gather more data on these plans from MedPAC today. Growth rates like these raise concerns. They require us to take a closer look at what drives them. Last year, Senator Grassley and I decided to do just that.

Here is what we learned. The law gives private fee-for-service plans several allowances that make them easier to get up and running than any other type of Medicare Advantage plan. First, the law does not require private fee-for-service plans to have relationships with providers to ensure that the providers will serve the people enrolled in private fee-for-service plans. Doctors and hospitals who do not have a contract with the plan can decide not to treat a patient in one of these plans at any time, and providers can deny treatment even if those providers participate in traditional Medicare.

Second, the law does not require private fee-for-service plans to submit any data about the quality of care that the enrollees receive. That is different from health maintenance organizations or preferred provider organizations.

The Centers for Medicare and Medicaid Services cannot oversee and regulate the benefits of private fee-for-service plans as they do other Medicare Advantage plans. That means that private fee-for-service plans can require the beneficiary to pay more than traditional Medicare.

In my home State of Montana, providers like the Billings Clinic tell me that they are more than frustrated with private fee-for-service. They feel that these plans are burdensome, less transparent, and pay less than traditional Medicare.

Critical access hospitals like Fallon Medical Complex in Baker, MT are especially concerned. The lack of a contractual relationship means that providers have little protection and recourse when these plans under-pay or deny care. We will hear more about provider problems from our witnesses today.

Providers in my State also tell me that these private fee-for-service plans are confusing beneficiaries. We will hear more about problems beneficiaries face from our witnesses today.

Scores of advocates, family members, and reporters from across the country have told us about deceptive and abusive marketing tactics used by these private fee-for-service plans. Plans have employed these tactics to enroll seniors and people with disabilities. The administration's lax oversight of sales and marketing tactics is another factor that has led to extensive growth in private fee-for-service plans. We will delve into issues of marketing in Medicare Advantage at a separate hearing in coming weeks.

Today, we will take a close look at private fee-for-service plans. We will look at the real problems with the most rapidly expanding type of Medicare Advantage plan. We will consider what we need to do to reform private fee-for-service plans. We will consider whether we need to check their growth, and we will consider whether we can better design the law to ensure that these plans serve the needs of beneficiaries.

We must ensure that Medicare continues to allow older Americans “the healing miracle of modern medicine,” we must ensure that Medicare continues to “protect the savings that they have so carefully put away over a lifetime,” and we must ensure that Medicare continues to “extend the hand of justice to those who have given a lifetime of service, wisdom, and labor to the progress of our country.”

I would now like to turn to my colleague, Senator Grassley.

**OPENING STATEMENT OF HON. CHUCK GRASSLEY,  
A U.S. SENATOR FROM IOWA**

Senator GRASSLEY. Mr. Chairman, I think you have covered most of the points that I was going to cover in my statement, so I am going to put the entire statement in the record.

But I just wanted to refer to a situation in my State that gives me concern, and why we need to look at this and get some of these things under control. When I say this, I want to emphasize, before I refer to the specific Iowa example, that I and you, 3 or 4 years ago, and for years before that, worked very hard to make sure that our constituents had the same access to Medicare Advantage that people in California, big cities, and in Florida, Texas, et cetera, had to it, because we did not have access to it except for one Iowa county out of 99. That is because they were across the river from Omaha, where there is Medicare Advantage.

So we want equal access, but we want to make sure that it is not abused. So we are looking at these things and what maybe can be corrected without reducing this access. I want to make that very clear.

But one example of why we have to do something. In December, a large physician group in Des Moines announced that it was refusing to treat beneficiaries with private fee-for-service plan coverage. It even took out an ad in the State’s biggest newspaper, the *Des Moines Register*. It took this extraordinary step because the physicians did not think that the payment situation was fair. They thought if a plan was paid the benchmark, at the very least it should have a contract with them. I have heard from some Iowans who are worried that their doctors now will not treat them.

One Iowan who contacted me has bladder cancer, but fortunately his wife saw this ad in the newspaper in time and was able to get him to a different plan. If physicians had decided mid-year not to accept the plan, it could have spelled disaster.

I am disturbed that my constituents may have a hard time getting access to doctors; because these plans do not really have participating providers, it is hard to figure out. But those are things that we are going to have to work on. I want to make sure that my constituents have access to Medicare Advantage just like they do in other States.

Thank you. I will put my entire statement in the record.  
[The prepared statement of Senator Grassley appears in the appendix.]

The CHAIRMAN. Thank you, Senator, very much.

I would like to now welcome our witnesses. First we will hear from Mark Miller, the Executive Director at MedPAC, a non-partisan Federal agency that advises the U.S. Congress very often—and I might say very well—on Medicare payment, quality, and access issues. We depend very much on MedPAC, as you know, Dr. Miller. We thank you very much for your service.

Second is Ms. Elyse Politi, State Health Insurer Program counselor at New River Valley Area Agency on Aging in Pulaski, VA. She has been helping beneficiaries navigate Medicare for over 13 years.

Third, Dr. Albert Fisk, medical director at the Everett Clinic in Washington State. Thank you, Dr. Fisk, for coming here.

Fourth is Mr. David Fillman, who is executive director of the American Federation of State, County, and Municipal Employees, Council 13, in Harrisburg, PA.

Fifth, Mr. Daryl Weaver, administrator and CEO of King's Daughters Hospital in Yazoo City, MS.

To all witnesses, I ask that you limit your oral remarks to 5 minutes. Your prepared statements will automatically be included in the record. Just let 'er rip.

Dr. Miller?

**STATEMENT OF MARK E. MILLER, Ph.D., EXECUTIVE DIRECTOR, MEDICARE PAYMENT ADVISORY COMMISSION (MedPAC), WASHINGTON, DC**

Dr. MILLER. Chairman Baucus, Ranking Member Grassley, distinguished committee members, I appreciate you asking MedPAC to testify today.

The original intent of the managed care program in Medicare was for plans to use networks and care coordination to deliver care more efficiently than the fragmented fee-for-service system. From these efficiencies, plans would be able to provide additional benefits to beneficiaries and, in turn, attract beneficiaries into managed care plans.

For this reason, the Commission has long supported managed care plans as a choice in Medicare. Plans have the flexibility to use managed care techniques that fee-for-service does not, and, if paid appropriately, they have incentives to be efficient.

With respect to payment, the Commission supports the principle that Medicare payments should be neutral. It should be the same for whether a beneficiary chooses fee-for-service or managed care. Like our other payment recommendations, we try to recommend to Congress payment amounts that will produce efficiency among all providers, whether it is fee-for-service or managed care.

The current managed care payment system is not neutral to beneficiary choice and it does not encourage efficiency. It is based on an inflated set of administrative benchmarks that plans bid against. Those benchmarks are 18 percent above fee-for-service, and, through the bidding process, that results in payments that are



13 percent above fee-for-service, in other words, \$10 billion a year more for these beneficiaries than had they been in fee-for-service.

Now, this 13 percent does pay for additional benefits for beneficiaries, but the issue that we raise is that these benefits come out of the trust fund, general revenues, and beneficiary premiums and they are paid by beneficiaries regardless of whether the beneficiary is in a managed care plan or not.

Furthermore, these benefits are fully loaded in that they include administrative marketing and profit in addition to the benefits that go to beneficiaries. This committee knows that we have recommended reducing the benchmarks to traditional fee-for-service payments. The Congress faces difficult choices regarding Medicare's future, and it is in that spirit that we offer the recommendation. We believe there are managed care plans that can be efficient, and reducing the benchmarks will encourage efficient managed care plans.

With respect to private fee-for-service plans, they do not have the characteristics originally conceived, though, for managed care plans. They do not have coordinated care networks. They do not negotiate contracts with providers. They generally pay traditional fee-for-service rates. There are also exceptions in law that give them competitive advantages over other plan types. They do not have the same quality reporting requirements. Their bids and benefits are not reviewed in the same way that other plans are, and they have no restrictions on offering employer-only plans, which I can explain on questioning.

Because there are no contracts with providers—and this is the point that you made, Senator—the provider makes the decision at the point of contact whether to accept the patient or not, and this has led to confusion among beneficiaries and providers, and I suspect other people on the panel will address that.

It is useful to recall the original intent of private fee-for-service plans. The law explicitly contemplated them as not managing care. The higher costs that they were expected to incur were expected to be borne by the beneficiary, but because of changes in law and the MMA, those costs are now borne by the program. Medicare pays 17 percent more than fee-for-service for these plans. This is in part based on where they draw their enrollment and in part based on their bids, which are inefficient. Private fee-for-service plans bid 8 percent more than traditional fee-for-service to provide the same standard benefit package.

Of particular concern to the Commission is that private fee-for-service plan enrollment is growing very rapidly. It increased 120 percent last year. It accounted for nearly 60 percent of all new enrollment in managed care, and there are now 1.7 million private fee-for-service enrollees. Private fee-for-service plans are the dominant managed care model in rural areas, but more recently they are now available in all parts of the country, and the most rapid growth rates are in urban and suburban counties.

In closing, both MedPAC and CBO have testified in front of this committee expressing concern over this rapid enrollment. It results in higher Medicare expenditures and puts beneficiaries in plans that are poorly organized to either contain costs or to improve quality. The current payment mechanism is flawed. It invites inefficient

plans to join Medicare, and private fee-for-service plans are a serious example of the program.

I look forward to your questions.

[The prepared statement of Dr. Miller appears in the appendix.]

The CHAIRMAN. Thank you, Dr. Miller.

Ms. Politi?

**STATEMENT OF ELYSE POLITI, STATE HEALTH INSURER PROGRAM COUNSELOR, NEW RIVER VALLEY AREA AGENCY ON AGING, PULASKI, VA**

Ms. POLITI. Thank you, Chairman Baucus. Chairman Baucus, Senator Grassley, and members of the committee, thank you very much for this opportunity to testify regarding private fee-for-service plans in the Medicare Advantage program.

My name is Elyse Politi. I am the current State Health Insurer Program counselor for the New River Valley Agency on Aging. I provide services to seniors in the counties of Montgomery, Pulaski, Giles, Floyd, and the city of Radford, VA. I am sure everybody knows about Radford.

The SHIP program was established in 1993 in Virginia, and I am one of the original coordinators, having spent 13 years in Northern Virginia until last fall, when I transferred to the southwest part of Virginia. In Virginia, the SHIP program is called VICAP, Virginia Insurance Counseling and Assistance Program.

The SHIP program was established to help Medicare beneficiaries and their families, whether over or under 65, understand and navigate through the Medicare, Medicaid, Medigap maze, as well as provide counseling on the impact of other forms of health insurance on their Medicare status.

During the last 3 years, as a result of the MMA of 2003, the burden on the SHIPs to constantly reeducate ourselves on the Medicare Advantage plan offerings and the stand-alone prescription drug plans has increased exponentially, and our efforts at outreach and education with the Medicare population, regardless of where they live, have grown at the same rapid rate. Added to this burden is the imperative to find low-income beneficiaries who qualify for the extra help.

My testimony will focus on five points: the private fee-for-service promises of reduced costs to rural residents; marketing problems which continue to plague beneficiaries; Medicare beneficiaries' need for qualified, knowledgeable counselors; frustration of providers in dealing with private fee-for-service plans; and concerns about additional funding levels appropriated for the SHIP program.

Private fee-for-service promised reduced costs. Many people were very encouraged and excited in 2006 to find that there were some plans that were planning no premiums through either health insurance other than the Part B premium, and no premium for their medications. Since there was little oversight at the time, rampant poor sales techniques were used to enroll the rural folk in several private fee-for-service plans in my area.

People were told that there were extra benefits, such as hearing, dental, and vision coverage, in addition to exercise programs that they could join. They were not told, however, that there could be an out-of-pocket maximum of up to \$5,000 per year beyond their

prescription costs, much greater than with a Medigap policy, or that their hospital co-pays for one plan in particular could be \$525, another plan is \$185 for the first 5 days. In addition, there would be daily co-pays for skilled nursing facilities after 5 days instead of after 20 days, as the original Medicare plan.

The durable medical equipment and Medicare Part B drugs would have the same 20 percent that would have been payable under original Medicare. Most of the private fee services are also charging high ambulance co-pays and are requiring substantial co-pays for people receiving dialysis and diabetic supplies.

People who gave up their Medigap policies suddenly had to pay these large, unexpected costs out of their own pocket. One woman I spoke with found that she had to pay the \$525 hospital bill, and then received a bill for her 100-day skilled nursing facility stay in the amount of \$8,000. She thought the end of the world had come and realized what a bad decision she had made. I helped her, first, by contacting the plan to advise them that they needed to work out the billing issue because she had gone over her \$4,000 out-of-pocket maximum.

I then disenrolled her from the plan, got her back into original Medicare, a Part B plan, and also helped fill out a Medicaid application, since she had earned enough to spend down to meet the requirements for Medicaid. Had she stayed with her Medicare and Medigap policy, her out-of-pocket costs would have been equal to her original Medigap premium, or \$1,800 a year.

Other people find that a health care provider will not accept their private fee-for-service plans just as they are scheduled to receive a needed health care service. On Friday afternoon this past December 28th, I was contacted by a frantic son whose mother was scheduled to enter a skilled nursing facility the following week.

The nursing home had advised him that they would not accept the private fee-for-service that she was enrolled in, and, even if they did, she would be responsible for the co-pays for the first 5 days she was there. This nursing home was the closest facility to her home in Stanley, and the son was worried that other facilities further away might not take the private fee-for-service plan also. After talking with his mother, they decided that she needed to be disenrolled.

Marketing problems. I had a beneficiary that was approached by a salesman in a local Wal-Mart. When she told him that she had Tricare and the Federal Blue Cross/Blue Shield Standard Option, he advised her that she needed to also sign up for the private fee-for-service plan because neither of those plans offered her full protection. He did not indicate that she could suspend her Federal plan.

I counseled her on the benefits of both the Tricare and the Blue Cross/Blue Shield plan, advised her that she definitely did not need the private fee-for-service plan, and possibly could actually suspend her Blue Cross/Blue Shield since the Tricare plan is pretty inclusive. She is going to investigate and make her own decision.

Another person was told by a marketing contact that the plan wanted to meet with the enrollee—and I am going to run out of time—about, that he needed to change his plan. He had talked

with the SHIP last year. He knew that he needed to further investigate these problems.

Beneficiaries need knowledgeable counselors. Counseling sessions can be difficult and time-consuming because they need to be individualized. They require more knowledge about private fee-for-service plans and other Medicare Advantage options. They require knowledge of original Medicare, Medigap, Medicare savings plans, and Medicaid.

I have been contacted by two doctors in rural areas who asked us to please set up individual counseling programs for his 40 patients so that they could understand the private fee-for-service that they were in and try to convince them that they needed to get out because he no longer wanted to deal with it because of the burdens that the private fee-for-service plans had put on him, paper-wise, not getting paid at the same time, at the right time, at the right fees. He just wanted out. The other doctor felt the same way.

The CHAIRMAN. Thank you, Ms. Politi, very much.

Ms. POLITI. I am sorry that I did not finish.

The CHAIRMAN. No, that is fine.

Ms. POLITI. It is all here.

The CHAIRMAN. Thank you very, very much. I appreciate that.

[The prepared statement of Ms. Politi appears in the appendix.]

The CHAIRMAN. Dr. Fisk?

**STATEMENT OF DR. ALBERT W. FISK, MEDICAL DIRECTOR,  
THE EVERETT CLINIC, EVERETT, WA**

Dr. FISK. Mr. Chairman and distinguished members of the committee, thank you for inviting me to discuss Medicare Advantage private fee-for-service plans.

I am Dr. Al Fisk, Medical Director of the Everett Clinic. The Everett Clinic serves more than 250,000 patients throughout Snohomish County, WA, which is 30 miles north of Seattle.

The Everett Clinic is a physician-owned group practice that has been operating for more than 80 years. We have more than 270 physicians and offer 40 diverse specialty services. We have received national recognition for innovative approaches to patient care and medicine. For example, we just received the 2007 Acclaim Award for Quality, which is the most prestigious award presented by the American Medical Group Association.

Medicare is a subject that concerns us deeply. We serve more than 20,000 Medicare patients, and the number is growing rapidly. Last year we lost more than \$7.5 million on Medicare. We need to find a sustainable model that will allow us to meet our ethical obligation to care for all those Medicare patients who choose to seek care with us.

A portion of our losses can be traced directly to private fee-for-service plans. Since the private fee-for-service plans were the most rapidly growing part of our Medicare business, it became clear to us that we could not afford to continue to offer care under this program. So last fall, we informed 1,400 patients that, beginning in January of 2009, we would no longer accept private fee-for-service plans. We encouraged these patients to enroll instead in managed Medicare Advantage plans.

The decision to curtail the program led to increased communication with our patients. We openly shared our dilemma with the patients and our reasoning for curtailing the program. In addition to written material, we also held workshops, attended by more than 400 patients. We laid the rationale for our decision on the table and shared the economics in a very transparent manner. We explained that we were losing money on private fee-for-service plans.

The feedback we received was reassuring. Patients understood why we needed to make the change. They had no idea that their program, if allowed to grow unchecked, would ultimately threaten the economic health of the clinic and make it impossible to continue to provide the best possible care to our patients. They were very surprised to learn that the program did not cover its costs.

Economics are important, but the problem here extends far beyond the financial burden that we have experienced. Among our core values is to do what is right for every patient. This means delivering coordinated care and promoting health and wellness. Candidly, this approach is difficult with private fee-for-service plans.

Efficient, effective health care is provided when the primary care physicians and specialists consult with each other on an ongoing basis, view the same medical histories, and coordinate treatment plans. Coordinated care ensures that effective disease management and preventative care can be delivered to each and every patient.

This approach benefits the patient and ultimately saves money for the payor. Give us the tools and the resources to provide coordinated care and you will have a program that provides better outcomes at lower cost. The system must be structured so patients can receive both preventative care and optimal management of chronic disease.

In the current reality where private fee-for-service plans can deem providers to be part of their network, none of the increased funding over traditional Medicare is shared with providers, which makes it difficult for us to sustain these needed cost-saving services.

In addition, unlike the Medicare Advantage HMO and PPO plans that we participate with, the private fee-for-service plans do not share cost of care and quality information with providers. It makes no sense to structure a Medicare plan that provides additional funding only to health plans, not to providers, and does not support improving quality while managing the cost of care.

Thank you very much for your time. I am happy to answer questions.

The CHAIRMAN. Thank you, Dr. Fisk.

[The prepared statement of Dr. Fisk appears in the appendix.]

The CHAIRMAN. Next, Mr. Fillman?

**STATEMENT OF DAVID FILLMAN, EXECUTIVE DIRECTOR,  
AFSCME COUNCIL 13, HARRISBURG, PA**

Mr. FILLMAN. Thank you. Chairman Baucus and Senator Grassley, members of the Senate Finance Committee, I want to thank you for the opportunity to testify today.

My name is David Fillman. I am an international vice president of the American Federation of State, County, and Municipal Employees, AFSCME, which includes 1.4 million working members, a

majority of current and former employees of State and local governments, and 230,000 retirees. I am also the executive director of AFSCME Council 13 in Pennsylvania, representing more than 65,000 employees. My testimony today focuses on our union's perspective on Medicare Advantage private fee-for-service plans.

The root of many of the problems with private fee-for-service Medicare Advantage plans stems from the 2003 change in Medicare law, which gave insurance companies significant profit incentives to offer Medicare Advantage plans as a replacement for traditional Medicare. In the past, Medicare Advantage-like plans were products that competed on a level payment playing field with traditional Medicare. We are concerned that the current enhanced incentives for private products as a replacement to Medicare come at too great a cost to beneficiaries, taxpayers, and the integrity of the Medicare program.

Current estimates are that, for every dollar spent for benefits under traditional Medicare, it costs \$1.17 when a private fee-for-service plan provides the benefits. Not surprisingly, with that enhanced profit, MA private fee-for-service has grown at an alarmingly rapid rate over the past year, to more than 1.9 million beneficiaries.

These significant incentives have led to predatory marketing practices by insurance companies on the individual market, but they have also distorted the group retiree health care market. Offers to pass through some of the Federal subsidies to State and local governments are being made.

The new accounting laws issued by the Governmental Accounting Standards Board, or GASB, place a tremendous strain on public retiree health benefits and add to the lure of these private Medicare plans. To reduce this paper liability, more public employers are proposing a switch from their own Medicare retiree health plans to these private Medicare plans.

In my State, Governor Rendell plans to replace our retired employees' health program for State government retirees with the Medicare Advantage private fee-for-service plan. He is removing retirees who are aged 65 and older from the secure State plan and forcing them out of the traditional Medicare program. Although these private Medicare replacement plans must be the actuarial equivalent of Medicare, they have a broad hand in shaping the details and setting co-payments, premiums, and the real value of benefits from year to year.

We oppose this forced switch, both from our understanding of its impact on Medicare generally, as well as our fellow AFSCME members' experiences in West Virginia and Ohio. West Virginia retirees were forced out of Medicare and into an MA private fee-for-service plan last July.

In West Virginia, 37,000 retired State employees and teachers were forced out of traditional Medicare and stripped of their supplemental plan. They were enrolled in Advance for Freedom, an MA plan administered by the for-profit giant, Coventry Health Care, the same as being offered in Pennsylvania.

Specifically, AFSCME is concerned about the following complaints we received from West Virginia and other States regarding PFFS plans. Even though these plans are marketed as nationwide,

this is false. They limit access to care and choice because significant numbers of doctors and hospitals have refused to accept the card. For example, many West Virginia retirees who moved out of State could get no doctor to accept the private MA plan.

MA private fee-for-service plans may offer additional benefits such as gym memberships or hearing aids, but they modify other benefits to cut corners in more important areas, such as limiting hospital stays or charging higher co-pays for nursing homes than Medicare. PFFS plans more frequently deny claims in order to hold down costs, and the appeals process is more difficult under the private plans. Retirees are no longer enrolled in traditional Medicare and must go through the company rather than Medicare's transparent appeals process.

The plans are not stable. They can, and do, pull out of markets, disrupting health care services. There is a lack of quality and accountability. These private replacements for Medicare are exempt from basic quality reporting requirements. When Congress opened up Medicare to private plans, it was based on a claim that the health insurance industry would be more efficient, provide more care coordination, and do so at less cost to taxpayers. These plans do none of the above. State and local governments see money on the table and are going after it.

We concur with the recommendations made by MedPAC that MA private plans should compete on a level payment playing field. AFSCME urges you to act quickly this year and pass legislation to stop corporate greed from ruining our retirees' health care.

Thank you again for the opportunity to appear here today.

The CHAIRMAN. Thank you very much, Mr. Fillman.

[The prepared statement of Mr. Fillman appears in the appendix.]

The CHAIRMAN. Mr. Weaver, you are next. Thank you.

**STATEMENT OF DARYL WEAVER, ADMINISTRATOR AND CEO,  
KING'S DAUGHTERS HOSPITAL, YAZOO CITY, MS**

Mr. WEAVER. Mr. Chairman, distinguished members of the committee, thank you for the opportunity to testify regarding the impact of Medicare Advantage private fee-for-service plans in rural America.

My name is Daryl Weaver, and I am honored today to represent the National Rural Health Association and King's Daughters Hospital in Yazoo City, MS, and to express our concerns over the growth and implementation of private fee-for-service plans in rural America.

Last week in my home State of Mississippi, the sole provider of ambulance service to 23 of our rural counties went out of business, literally overnight. EmergyStat's closure also impacted counties in Kansas and five other States in the southeast. One of the factors contributing to this crisis was the lack of cash flow from Medicare Advantage plans, over \$200,000 in unpaid claims.

For rural providers of all stripes, cash flow is a critical issue, and it is not uncommon for it to take as long as a year to receive payment from Medicare Advantage plans, and this only after multiple phone calls, letters, and e-mails by myself and my billing staff, which has increased by 20 percent over the last year, to deal spe-

cifically with this issue. Contrast this with traditional Medicare which pays claims within 15 days and you can begin to understand our predicament. Congress must act to ensure that EmergencyStat is the anomaly and not the proverbial canary in a coal mine. Mr. Chairman, I do not have to tell you that canaries in coal mines are useless during a cave-in.

When speaking about MA plans, the rural experience is almost exclusively with private fee-for-service, especially in the most rural parts of our Nation. In my State, almost 99 percent of rural MA beneficiaries are in these types of plans, the private fee-for-service ones.

The NRHA has long embraced, and continues to support, efforts to offer rural seniors choice, especially managed care offerings. But we are concerned that the only plans available in most of our rural communities really offer no choice at all.

The challenges of beneficiary confusion and unscrupulous marketing tactics by these plans have been well documented; therefore, I will simply add these two points. First of all, many of the MA patients my hospital sees are not even aware that they have been enrolled in anything other than traditional Medicare with a prescription drug plan.

Second, last year, both then-Senator Lott and a Mississippi State Insurance Commissioner issued strong statements warning seniors to avoid private fee-for-service plans. Not only did this advice protect seniors, it also helped prevent these plans from literally unraveling the entire fragile rural health care safety net.

For instance, these plans have not always paid critical access hospitals like mine the very minimum amounts to which we are entitled. Hospitals are not alone in dealing with these issues. Not one of my admitting physicians electively admits Medicare Advantage patients. This is also the case with most of our local home health care agencies and skilled nursing facilities.

I cannot tell you how often my hospital provides care to critically ill patients in the emergency department only to learn after the fact that he or she is an MA enrollee. Simply by doing the right thing for a sick individual, we become a deemed provider and thereby agree to accept whatever payment is offered.

Mr. Chairman, the NRHA and the 62 million people we serve ask that this committee implement the following recommendations:

(1) Ensure that rural providers receive equitable and prompt reimbursement from MA plans. At a minimum, this reimbursement must be no less than what would be paid under traditional Medicare.

(2) Eliminate deemed status, especially in the case of emergency care.

(3) Policymakers must hear the rural voice. We encourage you to expand the authority of the Office of Rural Health Policy to provide technical assistance to rural providers and mandate proportionate representation on MedPAC.

(4) Require greater scrutiny and oversight of MA plans by both CMS and State insurance regulators.

(5) Finally, require more transparency on the part of MA plans so choices and changes are better understood by all interested parties.



Mr. Chairman, Medicare must continue to improve, but the fragility of both our seniors and the rural health care infrastructure demands something more than the Medicare Advantage plans of today. We can, and must, do better for our seniors.

Thank you again for the opportunity to speak with you today.

[The prepared statement of Mr. Weaver appears in the appendix.]

The CHAIRMAN. Dr. Miller, I just want to clear up a point that I think MedPAC is making. It gets to efficiency, a point that you made. Is it true that in your judgment, MedPAC's judgment, that Medicare pays private fee-for-service plans, on average, about 108 percent of the cost of traditional Medicare provided to beneficiaries with the same level of benefits offered in traditional Medicare? That is, stripping away profits and everything else, the payments that Medicare pays for beneficiaries under private fee-for-service versus Medicare.

Dr. MILLER. Yes, that is correct. Just to be clear, this is our calculation using the data as opposed to a judgment. What happens is, plans come in and bid on the basic hospital and physician benefits in Medicare. On average, across the country, private fee-for-service plans bid 8 percent more than traditional fee-for-service to provide the same benefits. Then we pay more on top of that through the rebate price, 9 points on top of that, for a total payment to these plans of 117 percent, or 17 percent more than fee-for-service.

The CHAIRMAN. And compare that with what Medicare pays HMOs for the same level of benefits offered under traditional Medicare.

Dr. MILLER. For HMOs, the bid on HMOs is 99 percent of fee-for-service, so they actually do bid below fee-for-service. We actually pay 12 percent more than fee-for-service to HMOs. They actually bid, when they submit their bid, below fee-for-service. So the comparative numbers are: HMOs, on average across the country, are 99 percent on their bid for the standard benefit compared to private fee-for-service, which are 8 percent above fee-for-service; and then our payment system gives 12 percent more to HMOs and 17 percent more to private fee-for-service. Then there are whole sets of differences about the requirements, which we can talk about.

The CHAIRMAN. I was quite surprised to learn that sometimes providers are paid at less than the reimbursement rate under traditional fee-for-service. How prevalent is that, and by how much are those payments lower than those received under traditional Medicare? Mr. Weaver?

Mr. WEAVER. My experience has been that most of these plans do not understand critical access hospitals, which is my experience. So the typical approach is to come in the door. If they present a plan to us and our Medicare payment rate is the starting point and they want to negotiate downward from there, usually they will offer you 90 percent of your Medicare rate. We have to explain to them, we are paid cost plus 1 percent. You are asking me to literally take a loss on every patient that I care for. I would say every plan that I have talked to regarding a contract in the last 2 years has offered something less than Medicare, and we just have to tell

them we cannot provide service at that rate. It literally is a loss for every patient.

The CHAIRMAN. From a beneficiary's perspective, is the problem this? Say I am a senior. I come in for some kind of procedure provided at a clinic, by a doctor, or something, and I belong to a private fee-for-service plan. I guess the problem is that there is no guarantee that that doctor, that provider, is going to take me because I belong to private fee-for-service. So from a beneficiary's perspective, it is very unsettling that a provider does not necessarily have to take me. Is that correct?

Mr. WEAVER. Rural enrollees have never, for the most part, dealt with managed care. They are always surprised inevitably to find that their doctor, who has cared for them for 30 years, has to look them in the face and say, I cannot be your doctor anymore because I do not participate in this plan. The patient says, but I have Medicare.

The CHAIRMAN. All right. But let us say now that the provider does take me. The next problem is, as I understand it, that the plan may not reimburse the provider, either adequately or promptly, and it would be very frustrating for the provider. Is that correct or not correct?

Mr. WEAVER. That is correct.

The CHAIRMAN. Is that basically correct?

Mr. WEAVER. Yes.

The CHAIRMAN. And it is because there is no networking, that is, among providers. That is not a requirement? Private fee-for-service plans do not have to set up networks, is that correct?

Mr. WEAVER. Correct. The other issue that affects hospitals is, 80 percent of my patients come through the emergency department. We have to provide care first in emergency situations and worry about payor source later. So this whole idea of deemed status for hospitals is, frankly, sort of ludicrous because we do not have the opportunity in many cases to discuss what sort of payment, if there is payment, for the care we are providing until we have dealt with the crisis at hand.

The CHAIRMAN. And the quality requirements are much lower compared with other Medicare Advantage plans. Is that correct, too?

Mr. WEAVER. It can be, yes.

The CHAIRMAN. All right.

Senator Grassley?

Senator GRASSLEY. Dr. Miller, employers seem to be more interested in moving retirees to private fee-for-service plans and other types of plans than retaining their current plans, which usually wrap around Medicare. Can you explain the benefit to an employer of transitioning to a private fee-for-service plan?

Dr. MILLER. I will do my best. I would organize the information into kind of two categories. One is that these plans have a competitive advantage to other products. So, since they do not establish networks, since they do not generally have provider contracts, they do not have the same kinds of quality requirements, some of which has been stated here, it is much easier to set up a plan across State lines, across the country, if your retirees have moved around. So, relative to other plans trying to get into the employer market,

they have some advantage there to say, I can do this more quickly and easily.

The second concern that we have has to do with the competitiveness of what the bid is and, ultimately, what Medicare pays. The concern here is that, unlike the individual market, the beneficiary is not choosing between plans, which is what is supposed to put a downward pressure on the premium because you want to offer a low premium to get people in, but in this market you are taking whole groups of people from an employer at a given time.

So our concern is, and we are trying to look into this now, there is not as much pressure on the bid so that the bid ends up being higher and what we pay tends to be higher. Then the plan can come to the employer—sorry this is so complicated, but I am assuming this is what you want—and basically say, I can offer you either the same or perhaps a better benefit and at a cost that is lower to you than the wrap-around that you are currently paying.

So, if I have this wrap-around and I am an employer, I pay a premium for that wrap-around. But if the cost sharing, for example, is much lower in private fee-for-service because we pay so much, I can say to the employer, I can remove that cost for you. So that is why I think it is two reasons. It is easier in terms of their competitive advantage and they can buy out some of the employer's cost.

Senator GRASSLEY. We are substituting taxpayers' dollars for what would have been private dollars.

Dr. MILLER. And I want to be clear what I am talking about here. This is the incentive structure that is concerning us. We are trying to look at this now. That is the concern, that these payment rates are subsidized by taxpayer dollars, and that that is why it is attractive.

Senator GRASSLEY. Yes.

Also, Dr. Miller, private fee-for-service plans are not required to have networks. That has been emphasized here. In suburbs and cities, there are usually plenty of providers to provide a network, and yet private fee-for-service plans appear to be gaining ground even in urban areas.

Dr. Miller, do these plans undermine Medicare Advantage plans that have to form networks and pay provider-competitive rates and coordinate care?

Dr. MILLER. Yes. I mean, what we would say is, for the vast majority of people who are enrolled in these plans, in private fee-for-service plans, there are other alternative managed care plans in the area for them. Not in all areas. Particularly in remote rural areas, that may not be the case. But overwhelmingly for the number of people who are enrolled in these plans, there is another managed care alternative.

The point I am trying to drive at is, there may be some competitive advantage. We have made the point here that plans should be on a level playing field and we do not see these plans on a level playing field with other plans, so we think the competitive advantage is unfair relative to other managed care plans.

Senator GRASSLEY. Dr. Fisk, you testified that your experience with private fee-for-service plans on care coordination has been abysmal. Care coordination is obviously very important for patients

with chronic conditions like diabetes and heart disease and, quite frankly, an advantage of having people in Medicare Advantage.

Would you elaborate on how private fee-for-service plans differ from other Medicare Advantage plans in terms of patient care?

Dr. FISK. Yes, Senator. I think that the private fee-for-service plans differ in two ways that fail to support coordinated care. First of all, the Medicare Advantage HMO and PPO plans, since they have to contract with us, they share some of their increased funding that they receive over fee-for-service Medicare with us so we can begin to afford to provide these extra services.

Second, the HMO and PPO plans share quality information with us and share cost of care information with us so that we can learn to perform better, whereas, the private fee-for-service plans pay us exactly the fee-for-service rate, none of that extra funding, and they do not share any quality or cost of care information with us.

Senator GRASSLEY. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Next, Senator Wyden.

Senator WYDEN. Thank you, Mr. Chairman. And thank all of you.

For those of us who believe that fixing health care requires a wide array of private choices, this product gives the private sector a bad name. What is striking to me is how removed this product is from the Medigap model, and I want to discuss that with you.

Before I came to Congress, I was co-director of the Gray Panthers at home for 7 years. Back then, it was common for a senior to have a shoe box full of private insurance policies that were not worth the paper they were written on. Then, as you will recall, in the early 1990s we wrote this law that standardized the market. You can walk in now to any senior citizen's center in the United States and people can walk a senior and their family through their choices, and the market has worked for older people, it has worked for private insurers, it has worked for taxpayers. It has made a lot of sense.

Now we have this private fee-for-service market. I think that you all are describing it as something kind of like Dodge City before the marshals showed up. I really appreciate you going into the detail. We asked the Centers for Medicare and Medicaid Services for a spreadsheet on this, and they reported to us that there were 1,189 individual plans in my small State.

Now, of course they vary county by county because that is how at least we get some assistance in place. But to me, the bottom line is, unlike Medigap or even the traditional Medicare Advantage, here we have no oversight on the way they do their business, no scrutiny on quality or what kind of provider networks they have, or even if there is a network in the first place.

So what I would like to ask you—this product is different than Medigap. Maybe we will start with you, Ms. Politi.

Would it not make sense to take some of the principles from Medigap: more standardization, easy disclosure, comparability? It is a different product than traditional Medigap. But I think most of the same common-sense principles of consumer protection can apply here in private fee-for-service. Does that make sense to you as somebody who is on the front lines?

Ms. POLITI. Actually, it absolutely does. There are 46 plans in my five counties. Not all 46 plans are in all counties. The biggest problem that I have is, I have 10 pages of spreadsheets with the same kind of information for all of the benefits, for all of the plans. I would love to see, if these things are going to stay around, that the benefits be standardized so that when I talk about one plan I can talk about the other one and say this one has this, this one has that.

My biggest concern, really, is the fact that every one of these plans, with the exception of a few, has basically the same co-insurances and deductibles that exist under original Medicare, which means that if a person has original Medicare they can pick up a Medigap policy and they pay a premium which is standardized every month, and all of their co-insurances and deductibles are taken away.

With these plans, they can pay up to the \$1,000 hospital fee. They can pay the \$120, \$135 for skilled nursing facilities. Just about every one of them requires the durable medical equipment 20 percent co-pay; with original Medicare it would be paid by the beneficiary. There is no option, other than with the private fee-for-service to pick up another supplemental insurance, that will cover those co-insurances. So even though the private fee-for-services have no premiums for the most part, they still have to pay exactly what they would have to pay with original Medicare, and that just seems terribly wrong.

Senator WYDEN. Mr. Weaver, I am pretty sure that providers are with the seniors on this. What is your assessment of that?

Mr. WEAVER. With the seniors from the perspective of their frustration. We deal with it every day. As I stated in my comments, we have increased our business office staff significantly just to sit and counsel—and there are other resources in the community as well—patients about what they have gotten themselves into, the best way to get out of it. One of the other interesting things in my State of Mississippi—

Senator WYDEN. So moving towards more standardization.

Mr. WEAVER. Oh, absolutely.

Senator WYDEN. All right. Thank you.

Mr. WEAVER. If I could make one other comment.

Senator WYDEN. Please. Please.

Mr. WEAVER. For the first 2 years of these plans in Mississippi, Mississippi Medicaid refused to coordinate benefits for patients who were dually eligible. So for a patient who was dually qualified for Medicare and Medicaid, who under traditional Medicare would have had their co-pay and deductible for their hospital stay picked up, when they switched over to these MA plans the patients found out, much to their chagrin, that they are now responsible, a Medicaid-eligible patient, for co-pays and deductibles. That has now been resolved in the State of Mississippi after a lot of complaining, but it was a huge issue.

Senator WYDEN. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator, very much.

Senator LINCOLN, you are next.

Senator LINCOLN. Thanks, Mr. Chairman.

To touch a little bit on what the Chairman had asked, and any of you all can answer, Mr. Weaver, you talked about, from the provider's standpoint—I have to say, my granddaddy was from Yazoo City, MS.

But I have heard from some of the providers like yourself who have been really frustrated with the length of time that it takes to get the reimbursement from the private fee-for-service plans. Maybe you might comment on the length of time that it is taking for plans to pay. Do you see a trend in that? I mean, is there a trend in terms of how much time it is taking them to pay? Where do you think the issue falls in the priority for providers who choose not to accept it? Maybe they are not reimbursing enough. But is the timeliness an issue that is causing them not to contract with them?

Mr. WEAVER. This is probably the biggest issue. Rural hospitals and rural providers are different than our urban counterparts for the most part, especially in poorer areas of the country like the Mississippi delta. The money that we collect from Medicare and other payors this week, in many cases, is literally what we use to make payroll and pay our accounts payable to our vendors the next week. It is embarrassing that you function on that narrow a margin, but that is just life in rural Mississippi for health care providers.

So when you take a plan, switching payments from Medicare for 15-day turnaround—we call it the bait-and-switch—where you start dealing with these MA plans, and we never got your claim, you did not submit a clean claim, we are not set up to take electronic claim submissions, and that is one of the big problems we do face. The thing gets drug out forever. At the point that my billing folks are so frustrated that I have to take my time to start making phone calls and being unpleasant with people, and suddenly we will seem to get paid. Many times it is 9 months or more later.

Senator LINCOLN. Oh, that is phenomenal. That is definitely an issue.

Mr. WEAVER. It does improve as the plans get set up. It seems like early on there is a huge issue. Then they sort of get their act together. They will get a little better about paying us, but nowhere near what we are used to getting from traditional Medicare.

Senator LINCOLN. All right.

Ms. Politi, in your testimony you mentioned concerns that CMS may be considering keeping funds that we have allocated to the SHIP in the appropriations bills and the Medicare extender bills that we have done. Maybe you could elaborate on this. I know when we had our dual eligibles on the Medicare Part D, our SHIPs were enormously helpful, our Area Agencies on Aging. We pulled everybody into the fold to make sure that we did as much as we possibly could to expedite what was happening there.

I think both a number of our colleagues here and outside the Finance Committee—I know I have—worked hard to increase the funding for our SHIPs and for our AAAs for that reason, because they are facilitators and they are helpful. As you mentioned, there are others in the community besides what you all provide in coun-

seling, Mr. Weaver. But could you elaborate on some of your comments there?

Ms. POLITI. Well, the latest news bulletin I got is that that is no longer an issue, that money will be distributed out to all the SHIPs across the country. I do appreciate your support tremendously, because it has been an overwhelming job. Most of the SHIP counselors work part-time. We do not have consistent and stable funding, so therefore none of us can sit and say, well, in 5 years we can grow our program and include more than one staff person most of the time. I work in a nonprofit Area Agency on Aging at the moment and I basically get paid what I get through the SHIP program, and it is not a whole lot.

Senator LINCOLN. Right.

Ms. POLITI. My understanding is that CMS will go there. But I would ask and would plead with you once again to make sure that that funding stays in place and is consistently given out year to year, and that maybe you might consider us for a cost of living increase also.

Senator LINCOLN. Well, we will keep a watch on it as well as you, because I know our staff, particularly in our State offices—I mean, I have one or two staffers who are devoted to working with these individuals who have in many ways been duped, almost, into these policies, and then all of a sudden find that their doctor of 30 or 40 years is not going to see them. Where do they go? How do they change? And then spending the time with CMS to get them back into traditional Medicare has been a nightmare. So we need your help. We cannot do it all in our offices as well.

Ms. POLITI. Thank you.

Senator LINCOLN. You bet.

Ms. POLITI. We pretty much enjoy what we are doing.

Senator LINCOLN. Good.

Dr. Miller, just a quick question. Senator Grassley brought up the issue of the plans without networks and why that is important, or why it is not important, or whether it is working or not. There has been some argument as well in terms of the right to life, that the plans have to be without networks so that life-sustaining or lifesaving treatment will not be withheld. I have some concern about that and would love to hear what you all have found, if anything. Is there evidence of care rationing to any degree in any of the Medicare Advantage plan types, like the HMOs or others? Do the beneficiaries who enroll in them seem to be satisfied with those plans?

Dr. MILLER. Yes. I think satisfaction on the part of the beneficiaries is relatively high in managed care plans across the board. Some of that might be expected, given the fact that, if they get additional benefits and they can kind of go into a plan with a zero-based premium, they often are satisfied.

Senator LINCOLN. Of course, their costs when they actually seek services—

Dr. MILLER. That is a different thing. That is where I was going. When you look at a plan, and a plan, say, has a zero-based premium or an out-of-pocket cap, you think this is a good deal. I have to say, for many beneficiaries, let us be clear. We are talking about additional benefits, so they are getting extra benefits and they are

happy about it. But what has happened, and I think there are people at the table who are much more versed in this than I, is you can change the benefit structure.

So we have found things like Part D cancer drugs, very high co-insurance amounts, higher than traditional fee-for-service, or co-payments for inpatient days. So depending on the patient and their particular health status, they might find themselves in a plan that has a cost sharing structure that they had not anticipated.

Senator LINCOLN. Well, I just know from our experience in Arkansas, we are seeing anywhere from 16 to 19 percent in terms of additional costs over the traditional Medicare fee-for-service. So my hope is that we will get some more efficiency in the plans if they are going to continue to be marketed. Our next hearing will be on the marketing aspect of that, so I will not go into that today.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Lincoln.

Senator Cantwell?

Senator CANTWELL. Thank you, Mr. Chairman.

Dr. Fisk, thank you for traveling here from the Pacific Northwest. Are you seeing other providers in the region making the same decision that you have made in not accepting private fee-for-service?

Dr. FISK. Yes. There are several that are doing this. I mean, for example, the Polyclinic in Seattle has done the same thing, and there are a number even outside the State that have contacted us to understand the process that we have gone through of giving patients 15 months' notice. So, I know there are a lot of organized groups that are thinking that and will be doing this in the future.

Senator CANTWELL. Could you elaborate? I know Senator Grassley asked you about this issue of private fee-for-service and its incompatibility with coordinated care, but could you give us a specific example of how that impacts the Everett Clinic or an example of a certain type of care that ends up costing more to the system because you do not have that continuity with private fee-for-service?

Dr. FISK. Sure. First of all, we treat all our patients the same, so even if they are in a private fee-for-service plan we are not going to treat them differently. It is just a question of figuring out a way for us to afford to do what is right.

Examples would be, we have a hospital coach, a nurse who visits every patient as they are about to leave the hospital to make sure they understand their diagnosis and understand the medicines they are on, and then makes sure they have a follow-up appointment with their primary care physician.

Another example is, we have nurse case managers for the most complex sick patients to try to coordinate their care optimally. Another example is that we have multi-disciplinary teams of physicians and nurses and other individuals that work on specific diseases, like diabetes or coronary disease or asthma, to figure out how to improve our quality. That all costs us money. Then last of all, we have a dedicated team of physicians and nurse practitioners that cares for our patients who are in skilled nursing facilities, because those people these days are pretty ill. On that alone, we lose \$200,000 annually.



Senator CANTWELL. Not to interrupt, but is that where you see the biggest costs, if you had to say where they were across the board? Is it for the elderly in nursing care?

Dr. FISK. Well, that is just one. I mean, I think the problem is, as you well know, that Medicare in the State of Washington pays maybe 60 percent of commercial payment for taking care of the most complex sick patients. It is hard to make it pencil out. That is why we appreciate the Medicare Advantage HMO and PPO plans, because they share some of that increased funding with us.

Senator CANTWELL. Dr. Miller, we obviously are seeing a great proliferation of these plans in the market, the private fee-for-service. I think, for example, in Spokane County—Spokane is the second largest city in our State—there were 22 private fee-for-service plans a year ago, and that number has jumped to 45 this year. The same for King County—where Seattle is located—which saw a jump from 22 to 39.

So what is going to happen if more patients are lured into these private fee-for-service plans who do not pencil out economically to providers and more providers like the Everett Clinic make these decisions not to do business with them? What is going to happen?

Dr. MILLER. Well, I mean, I think there are at least two reactions to that. I mean, our concern also is that, in general, we now have across the country an average choice of 35 plans per county, just about in every county in the United States. To the extent that it increases—and private fee-for-service is rapidly growing just like you said—you are going to get more people enrolled in these plans.

The first thing I would say, and I tried to say this in my opening comments—and it is not quite to your question—is we are going to be paying more and more for these plans out of Medicare generally and we are going to start to encounter the fiscal stresses that come from that: trust funds being exhausted, 45-percent trigger being hit, beneficiaries paying higher premiums. More and more, we are going to be in these kinds of meetings, discussing what to do about Medicare spending.

To the extent in these plans we sort of hope money moves down to the provider, to the penciling it out point, we pay the managed care plans. The managed care plans have an administrative structure, marketing, profit, then they pay additional benefits to the beneficiary, and then if they choose, they pay more to the provider. So, if our concern here is to pay more to providers—and I will not go into this in detail—we have whole sets of recommendations that we have not discussed here in MedPAC to try to move money out into the fee-for-service sector, and it is very much what Dr. Fisk was talking about.

If we could reward providers on the basis of higher quality, the efficiency, the coordination of care—and I am blowing through things very quickly here because I know you have a time limit—that is how we think the type of practice of medicine that Dr. Fisk is talking about should be rewarded. We have tried to make recommendations for the last 3 years in fee-for-service to move that money out to reward providers who do that type of work.

Senator CANTWELL. And HMOs are doing that. Is that correct, Dr. Fisk?

Dr. FISK. Yes. They do share some of the increased funding with us.

Senator CANTWELL. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Next, is—

Senator ROCKEFELLER. Senator Rockefeller.

The CHAIRMAN. You are right. Senator Rockefeller. [Laughter.] Welcome back to the committee.

Senator ROCKEFELLER. Thank you.

The CHAIRMAN. Welcome back to the committee after all of your intelligence and FISA work.

Senator ROCKEFELLER. Yes. Yes. Yes.

A couple of questions, one taking off of what Senator Lincoln was talking about. Just, when you read this, these private fee-for-service plans are proliferating in rural counties, and I think in West Virginia, this cannot be. They are more expensive, whatever, whatever, whatever, whatever. It does not make sense to me. The idea—and Senator Lincoln began to advance it—was that we started this in 1997 and then we took off some of the regulations, I guess, in 2003 or something of that sort. The Right to Life movement was very active in promoting all of this because they did not want to see anything done with euthanasia.

Now, I have no way of understanding any of this, but I am mystified by why a poor county in rural West Virginia would be attacked by these plans. Dr. Miller?

Dr. MILLER. Yes. May I take a shot at that, unless somebody else wants to.

Ms. POLITI. I would like to take a shot, too.

Senator ROCKEFELLER. Quick shots.

Ms. POLITI. A very big quick shot. Buckshot.

Dr. MILLER. All right. I think what the history here is that, when managed care was growing very rapidly in the mid-1990s, it was the concern that many, many people would be enrolled in managed care and there was a concern that there should be an option that you could go into in which people would not make decisions about the type of care that you get, that it would not be managed. The private fee-for-service option was created at that time to say there will be such an option, and the beneficiary, if they choose to go away from managed care, would go into this plan and pay the difference so that no management of my care would occur.

When the MMA came along, the law changed. What happened is, instead of the beneficiary payment difference, the program stepped in and paid that difference. So what we created was a mechanism where the managed care—and this is true of managed care plans generally and private fee-for-service plans too—program subsidized additional benefits, but the private fee-for-service mechanism is this “no managed care” mechanism. So the history was, it was not supposed to be a managed care plan. It was explicitly in law not managed care and the beneficiary was to pay the difference, but now the program is paying for the difference.

I am getting that look like I did not answer the question.

Senator ROCKEFELLER. No, you did not, but it was still interesting. [Laughter.]

Dr. MILLER. I get a lot of that. [Laughter.]

Senator ROCKEFELLER. Your shot.

Ms. POLITI. All right. I will see if I can answer this one. I think there are a couple of key words in how quickly these plans would proliferate, and one of them is “free.” When a salesperson comes to you and says I have the greatest thing that could ever happen to you and it is not going to cost you anything, most people in rural communities have a problem paying what they have now, and “free” sounds even better than fruit, especially if they are having problems paying for their medications and their fuel bills and getting from their little house on the top of the hill down to wherever they are going to get services.

A lot of people in my area go from Radford, VA all the way into Richmond, which is a 4-hour one-way trip, to get their health care. That is an entire day to see one doctor. So when somebody says “free,” this is the best thing since ice cream. Once they get in it—

Senator ROCKEFELLER. It is. The second question really perplexes me, and either of you can answer it. Two, I remember a fight, and the President did not want to do this and was very abrasive about it, on dual eligibles. West Virginia has a whole lot of dual eligibles. These are the poorest of the poor that qualify for both Medicare because of their age, and Medicaid because of their lack of income. Private fee-for-service is making specific inroads into dual eligibles. That, to me, is unconscionable. But I want to make sure that you feel that that is the case.

Ms. POLITI. It is unconscionable. When a person gets all of their services through Medicaid and Medicare, I have a hard time justifying why they need to go into another form of administration and pay situations where Medicaid may not pay that provider and the beneficiary ends up with a co-payment when they would not have had one in the past. That is probably the hardest thing that I have to educate dual eligibles on because a lot of them are not highly educated.

Senator ROCKEFELLER. No.

Ms. POLITI. They may not even have a good grasp of the English language. So trying to tell them that they just joined a plan that is not going to pay what they got with Medicaid and Medicare is ludicrous. It is absolutely ludicrous. It does happen. It happens more often than not.

Senator ROCKEFELLER. That alone is a reason to eliminate that whole program.

Ms. POLITI. I have a university in Virginia that is sponsoring a dual eligible Medicare Advantage plan. They are targeting the fully dual eligibles. When the salesperson came to talk to me because she thought this was a great plan, my question to her—and I do this all the time—is, why should the university get the additional funds to provide services that would normally happen under Medicare and Medicaid? Why do we need another set of administrative levels to provide the same services that are being done efficiently? And even more so, if we had more money to support Medicare and Medicaid, why bring a third party in?

Senator ROCKEFELLER. When you talk to them, do you go to the press afterwards or do you just hold your counsel?

Ms. POLITI. No, I do not do that. I send them away and I tell them that if they can answer my question, I will be more than happy to introduce them to people who might benefit from their services. But they never come back, so I do not think they can come up with a good excuse.

Senator ROCKEFELLER. Thank you.

Senator STABENOW?

Senator STABENOW. Thank you very much. Thank you to each of you for being here.

In my State, most of the private fee-for-service plans are in a group market. I am wondering, Dr. Miller, have you found any differences between the group market and the individual market in looking at this and how they are operating, or costs, concerns?

Dr. MILLER. Well, the data that I have suggests that—I think this might answer your question. I am not doing too well here. [Laughter.]

Senator STABENOW. But make it interesting. [Laughter.]

Dr. MILLER. Good one. All right.

What we do find is that employer plans across the Nation—so I am not speaking of Michigan specifically—tend to have higher bids for any of the plan types. So we are seeing—and this is a point that I was trying to make in my opening statement, or somewhere along the line—and we are concerned that the same incentives to hold premiums down, because you are trying to attract beneficiaries, are not present in the employer market, that in fact the pressure may be much less. You come in with a high bid so that then, as a plan, you can go to an employer and say, I can offer you a lot of benefits and I might be able to buy out some of what you are currently paying.

So one of the concerns we have—and I do not have hard evidence on this except that employer plans' bids tend to be pretty uniformly higher—is that the same economic pressures to restrain costs do not exist in those markets when they bid.

Senator STABENOW. When we talk about the higher payments and over-payments, and of course, you have very eloquently talked about how that impacts the Part A trust fund and what that means for other beneficiaries as well, but when we look at this, these types of plans are not required to provide quality data.

Dr. MILLER. Private fee-for-service.

Senator STABENOW. Right. Private fee-for-service. Or offer chronic care improvement plans which other MA plans are required to do. Again, in our own Michigan experience, Blue Cross/Blue Shield does in fact provide chronic care management, but it is not required to do that. I am wondering, when we look at the fact that the Urban Institute says 20 percent of Medicare beneficiaries have five or more chronic conditions—we all know this—and account for over two-thirds of Medicare spending, as we look at all of this, what are your thoughts about adding benefits that they are required to provide to beneficiaries at this point if they are receiving more dollars? We can certainly address the whole issue of their receiving more dollars, but they are not even required to provide additional services with those dollars.

Dr. MILLER. Well, they are required to take a portion of the money that comes back to them and provide additional benefits,

but you are correct that there is no specific set of benefits that they have to require.

Senator STABENOW. So they are, in general, required.

Dr. MILLER. Yes.

Senator STABENOW. But it is not focused on chronic care management.

Dr. MILLER. It does not say you have to do this or you have to do that. In fact, the tension there is, do you want to be specific and say, "here are our sets of benefits you have to provide." What some of the thought of private plans is in innovation, so that the plan can kind of innovate different types of coordination strategies for controlling costs and improving quality. The way I would answer your question is, what the Commission's view of this is, look, set the payment at a rate that drives efficiency. And not just managed care plans, but fee-for-service, too. We are only talking about managed care here, but that is our principle in fee-for-service as well.

Then this is what managed care was supposed to be about: I take the risk, I get this payment, and then what I do are some of the things, for example, that Dr. Fisk was referring to, where I coordinate care, I avoid hospital readmissions, I manage beneficiaries with multiple conditions by making sure when they are discharged from the hospital they know what their follow-up care is, because as a matter of course it is good clinical and business sense. That is what the managed care plans were supposed to be about. But we are paying more than that and then not saying that you have to do a particular set of benefits.

Senator STABENOW. And finally, when folks from Michigan found out we were doing this hearing today, I received an e-mail from one of our hospitals about private fee-for-service and the concerns they have because of the deeming process. The e-mail basically indicated that this particular plan was not allowing patients treated in the hospital to see the hospital's orthotic or prosthetic services division. They said they can be down the hall receiving services from the physician, therapy, or clinic services, but then have to leave and go to another provider to get these other services.

I am wondering, when there is a conflict at this point, is there any mechanism for resolving disputes? Should CMS have some kind of a system that would resolve disputes, with accountability as it relates to these kinds of decisions?

Dr. MILLER. I am not sure I can speak to whether there is a mechanism at CMS to resolve these disputes. I do not know if anyone else on the panel can.

Senator STABENOW. And right now, what happens in this circumstance, the patient just has to abide by the decision. Correct?

Ms. POLITI. If I can comment on that.

Senator STABENOW. Yes.

Ms. POLITI. Ten years ago, I found it a lot easier to deal with HMOs and PPOs to try to get appeals filed and get health care decisions worked out so that best practices could be followed. I find it very difficult to find the appropriate person in these private fee-for-services. One plan, they have six different plans. One insurance company may have six different plans. My experience has been, there are different people for each one of these plans who do one of these things, and trying for me, as a coordinator, a SHIP coordi-

nator, to negotiate to try to find that right person that I need to talk to, is virtually impossible. I end up going to CMS.

Senator STABENOW. Thank you.

Senator ROCKEFELLER. It is a sad way to end up a question.

Senator STABENOW. I know. Does anyone else want to respond or have a suggestion?

Ms. POLITI. Can I add one comment, please?

Senator STABENOW. Yes.

Senator ROCKEFELLER. Yes.

Ms. POLITI. Yesterday afternoon before I came down here, I received a letter from one of the people that I work with from Humana. If you want copies, I brought the letter. Humana wrote to this person, who lives in the Meadows of Dan. Meadows of Dan is kind of exactly what it sounds like. Their closest pharmacy is 14 miles away. Humana wrote to them and told them that this individual pharmacy out in the middle of nowhere was being dropped from the preferred network, that they would have to go out and find another: "You can choose from a wide variety of pharmacy chains, as well as many independent pharmacies."

The next pharmacy closest to this person was 18 miles away. It does not sound like much, but it is an additional eight-mile round trip to go to this other pharmacy. My question to you all is, does this person pay the additional fuel costs to get the discounted price, the deep discounted price, or do they continue going to their local pharmacy and pay the increased pharmacy price? That is it.

Senator ROCKEFELLER. That is a better way to end up the question.

Ms. POLITI. Well, that is one for you to resolve for me, please.

Senator ROCKEFELLER. All right.

This has been very helpful and very useful, as hearings tend to be, because you are talking to people who are on the ground and who understand exactly what the consequences are. So, I thank you all very much.

The hearing is adjourned.

[Whereupon, at 11:32 a.m., the hearing was concluded.]

**A P P E N D I X**

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

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**Testimony of David R. Fillman, Executive Director  
Council 13**

**of the**

**American Federation of State, County and Municipal  
Employees (AFSCME)**

**before the**

**Committee on Finance**

**United States Senate**

**on**

**“Private Fee For Service Plans in Medicare Advantage:  
A Closer Look”**

**January 30, 2008**

Chairman Baucus and members of the Senate Finance Committee, I want to thank you for the opportunity to testify today. My name is David Fillman, and I am an International Vice President of the American Federation of State, County and Municipal Employees (AFSCME), which includes 1.4 million working members, the majority current and former employees of state and local governments, and 230,000 retirees. I am also the Executive Director of AFSCME Council 13 in Pennsylvania, representing more than 65,000 public employees. Our Retiree Chapter 13 counts over 12,000 members statewide.

As requested, my testimony today focuses on our union's perspective on Medicare Advantage private fee-for-service, including our experience in Pennsylvania and in other states experimenting with Medicare Advantage private fee-for-service (PFFS) plans.

The root of many of the problems with private fee-for-service Medicare Advantage plans stem from a 2003 change in Medicare law which gave insurance companies significant profit incentives to offer Medicare Advantage plans as a replacement for traditional Medicare. In the past, Medicare Advantage (MA) plans, which went by other names, were products that competed on a level payment playing field with traditional Medicare. We are concerned that the current enhanced incentives for private products as a replacement – not a supplement – to Medicare come at a great cost to beneficiaries, taxpayers and the integrity of the Medicare program.

Current estimates are that for every dollar spent for benefits under traditional Medicare it costs \$1.17 when a private fee-for-service plan provides the benefits. Not surprisingly, with that enhanced profit, incentives enrollment in MA private fee-for-service has grown at an alarmingly rapid rate over the past year. There are now more than 1.9 million beneficiaries enrolled in MA private-fee-for service plans.

These significant incentives have led to predatory and often unscrupulous marketing practices by insurance companies on the individual market but they have also distorted the group retiree health care market. This overpayment windfall is luring more public employers to consider ill-advised changes to their coverage plans. Insurance companies have targeted our employers for the hard sell, including offers to pass through some of the federal subsidies to state and local governments. Using the overpayment windfall and with a blessing from the Centers for Medicare and Medicaid Services (CMS), insurance companies can develop a replacement for Medicare with an MA private-fee-for-service plan designed exclusively for an employer's retirees.

The new accounting rules issued by the Governmental Accounting Standards Board (GASB) place a tremendous strain on public retiree health benefits and add to the lure of these private Medicare plans. The GASB rules require public employers to estimate future costs of their retiree health benefits – 35 years into the future – and publish them on their annual financial statements. To reduce this paper liability, more public employers are proposing a switch from



their own solid retiree health plans, which include traditional Medicare, to these private Medicare plans. This is a major factor in public employers' decisions to switch to Medicare Advantage private fee-for-service plans.

In my state, Governor Rendell plans to replace our Retired Employees Health Program (REHP) for state government retirees with a Medicare Advantage private-fee-for-service plan and proposes to cut our prescription drug benefits. *He is removing retirees who are aged 65 and older from the secure state plan and forcing them out of the traditional Medicare program* By removing retirees from the secure state public plan (REHP), the Governor is denying them their right to access the secure Medicare program they have paid into all their lives.

Our retirees are moving from the Medicare defined benefit plan with a solid wrap-around supplemental, to an unknown plan. Although these private Medicare replacement plans must be the actuarial equivalent of Medicare they have a broad hand in shaping the details and setting co-payments, premiums and the real value of benefits from year to year. Experts have joked that if you have seen one Medicare Advantage fee-for-service plan then you've seen one MA plan – for that year. Aside from the confusion and added complexity, the forced shift to a Medicare replacement product can obscure a reduction in benefits and a shift of costs onto beneficiaries who have limited incomes and may be in fragile health.

We oppose this forced switch both from our understanding of its impact on Medicare generally as well as our fellow AFSCME members' experiences in West Virginia. Those retirees were forced out of Medicare and into an MA private fee-for-service plan last July. We also are beginning to hear from AFSCME retirees in Ohio who were just switched over this month to a Medicare Advantage private fee-for-service plan.

In West Virginia, 37,000 retired state employees and teachers covered by the Public Employees Insurance Agency (PEIA) were forced out of traditional Medicare and stripped of their supplemental plan. They were enrolled in Advantra Freedom, an MA plan administered by the for-profit giant, Coventry Health Care. In November, in PEIA hearings, hundreds of angry West Virginian retirees testified against Advantra Freedom.

One senior at the Charleston hearing, Peggy Beavers, complained that Coventry is "known throughout the country to cut costs any way they can", and said she did not understand why she would be forced out of Medicare into a replacement product offered by "a company that's all about making a profit for itself."

Specifically, AFSCME is concerned about the following complaints we have received from West Virginia and other states regarding PFFS plans. These concerns are typical of the problems inherent to MA private-fee-for service plans.

- Even though these plans are marketed as nationwide and have no networks – this is false. They limit access to care and choice because significant numbers of doctors and hospitals have refused to accept the card, especially out-of-state. For example, many West Virginia retirees who moved out of state could get no doctor to accept the private MA plan.

- MA private fee-for-service plans may offer additional benefits, such as gym memberships (the only major additional benefit in West Virginia), or hearing aids and eyeglass coverage, but they modify their benefits to cut corners in more important areas, such as limiting hospital days or charging higher co-pays for nursing homes than Medicare. Indeed, officials in West Virginia actually told a state legislative committee in November that “we know that ... retirees who use more medical care will be worse off under this plan”.
- PFFS plans more frequently deny claims in order to hold down costs.
- The appeals processes are more difficult under the private plans. Retirees are no longer enrolled in traditional Medicare and must go through the company rather than Medicare’s transparent appeals process. Further, beneficiaries are often bounced between CMS and the insurance company seeking redress.
- The subsidy to the private plans causes government employers, many of whom have secure, self-insured medical plans, to switch control of their medical decisions to these private companies, break up their efficient risk pools, and allow private companies to profit off our retirees.
- The plans are not stable. They can and do pull out of markets, disrupting health care services and causing much anxiety among beneficiaries.
- There is a lack of quality and accountability. These private replacements for Medicare are exempt from basic quality reporting requirements. It is unclear how CMS overseers will be able to determine if these private fee-for-service plans deliver health care services more efficiently or increase consumer health outcomes.

In addition, we are concerned that Medicare Advantage plans are a drain on our state and its retirees. The more than one million Pennsylvania seniors who are enrolled in traditional Medicare are paying about \$25 million in extra premiums to subsidize the 32 percent of beneficiaries who are enrolled in Medicare Advantage plans. The State is also paying for these subsidies. The Medicaid program in Pennsylvania pays Part B premiums for low-income beneficiaries and this cost was an extra \$6.3 million in FY 2007.

When Congress opened up Medicare to private plans, it was based on the claim that the health insurance industry would be more efficient, provide more care coordination, and do so at less cost to taxpayers. PFFS plans do none of the above, and enrollees who are forced into them are no longer enrolled in Medicare.

State and local governments see money on the table, and they are, in economist-speak, “acting rationally” and grabbing the cash, at the expense, particularly, of the federal government. It has nothing to do with the superiority of these plans.

Again, the root of these problems is the enhanced profit incentives paid to these plans, by taxpayers and beneficiaries. Congress should know that cost shifting to the federal government was the top reason for West Virginia’s switch, and frankly, for every other public employer that

considers a PFFS plan. West Virginia's PEIA said its decision was influenced by the higher reimbursements given to MA plans and that "these are federal dollars that will help pay the medical costs of Medicare retirees." Moreover, PEIA additionally offloaded major costs to the federal government by switching to a Medicare Advantage prescription drug plan.

With all this cost-shifting, the irony is that in West Virginia, Pennsylvania, and elsewhere, we as a nation are paying more to these private plans, for less. States easily use the switch as an opportunity to cut benefits, which is a serious additional risk of shifting retirees into these private replacements for Medicare.

Again, the root of these problems is the excessive financial incentives to develop and market these products which are designed to replace the tried and true Medicare program. These problems, the trend towards private plans, and the devastating privatization of our traditional Medicare program must be addressed. We concur with the recommendations made by MedPAC that MA private plans should compete on a level payment playing field. AFSCME urges you to act quickly, this year, and pass legislation to stop corporate greed from ruining our retirees' health.

Thank you again for the opportunity to appear here today.



**The Everett Clinic's Experience with  
Private Fee for Service Medicare Advantage Plans**

**Statement by Albert Fisk, MD, MMM  
Medical Director  
The Everett Clinic**

**Before the United States Senate  
Committee on Finance**

**Private Fee for Service Plans in Medicare Advantage: A Closer Look**

**January 30, 2008**

Chairman Baucus, Senator Grassley, and members of the Committee, thank you for the opportunity to testify regarding Private Fee for Service Medicare Advantage. My name is Dr. Al Fisk, and I am Medical Director for The Everett Clinic, a 270 physician multi-specialty physician group practice serving nearly 250,000 residents of Snohomish County, Washington, just 30 miles north of Seattle.

The Everett Clinic was founded over 80 years ago and modeled after the Mayo Clinic principles of physician directed, patient centric care. We hold dear three core values:

- We do what is right for each patient
- We provide an enriching and supportive workplace, and
- Our team focuses on value: service, quality, and cost

The Everett Clinic is one of ten participants in the **Physician Group Practice Demonstration Project** sponsored by the Centers for Medicare and Medicaid Services (CMS). We embrace coordination of care and evidence based medicine. We are proud of the fact that we score very high on the quality measures defined in the CMS demonstration project. We are also leaders in the Puget Sound for cost effectiveness with pharmaceuticals, saving nearly \$30 Million annually for commercial payers and the Medicare program by high use of generic alternatives. We have put into place an electronic medical record and many other systems for care of patients with expensive chronic conditions. All of these efforts require infrastructure and significant resources but our experience shows they are worth the effort.

My testimony today will focus on four key points:

- Our experience with caring for Medicare patients and particularly patients enrolled in Medicare Advantage Private Fee for Service (PFFS) plans,
- Our decision to stop seeing patients with Private Fee for Service Medicare Advantage coverage effective January 2009,
- Our experience with communicating this decision to patients, and
- Our advice to Congress as providers who want to care for Medicare patients but need to stay viable in doing so.

#### **Our Experience in Caring for Medicare Patients**

The Everett Clinic cares for nearly 21,000 Medicare patients. Nearly 7,000 of those patients are enrolled in Medicare Advantage programs. Approximately

5,600 are enrolled in HMO / PPO Medicare Advantage plans and the remaining 1,400 are enrolled in Medicare Advantage Private Fee for Service plans.

The enrollees in the Medicare Advantage HMO / PPO plans are primarily members of four plans in our state, including a Special Needs Plan. We have contracted with those plans to coordinate their many care needs across the care continuum (inpatient, skilled nursing facility, outpatient and ambulatory and home health). Most of these arrangements currently are fee-for-service where we receive funding above Medicare fees to reduce our losses. The coordination of care efforts by our physicians is quite effective. We have programs to target patient populations with chronic illnesses that historically have consumed tremendous resource for the Medicare program. Examples of chronic care programs include: diabetes, coronary heart disease, congestive heart failure, asthma, and high blood pressure. We also partner with our local hospital on a palliative care program that provides a high quality of care at end of life.

The Everett Clinic estimates that we lose nearly \$7.5 million per year on providing care to Medicare patients. The Medicare Advantage HMO / PPO plan structure allows us to negotiate with plans and obtain additional funding that pays for very useful care coordination and begins to offset the losses of traditional Medicare funding. Such arrangements are not currently possible with Medicare Advantage Private Fee for Service plans.

Private Fee for Service (PFFS) Medicare Advantage plans are extremely hard to deal with both in terms of negotiating fair rates and collaborating on care coordination. We have been very frustrated with both identifying the PFFS plans and negotiating fair funding. It seems like the intention of Congress with Medicare Advantage plans was to provide an alternative funding mechanism that allowed for care coordination that benefited both patients and providers. Our experience has been positive with Medicare Advantage HMO / PPO plans but abysmal with Medicare Advantage PFFS.

#### **Our Decision to Stop Seeing Medicare Advantage Private Fee for Service Plans**

The Everett Clinic has spent years examining how to participate in Medicare in a way that allows us to stay viable. We tried to initiate negotiations with Private Fee for Service (PFFS) plans for 2 years without success. In April of 2005, we began participating in a four-year national Medicare Physician Group Practice Demonstration project for patients on Original Medicare. The program is designed to help providers groups establish clinical care processes that lead to measurably better management of total costs (Parts A and B) and improved clinical quality, while rewarding the provider group for performance. Our decision

to participate in this project was driven largely by our goal to develop a robust clinical care model for all our seniors, based on having the primary care physician and his/her team being the anchor for meeting the patient's total healthcare needs. This enables us to better manage the rise in total healthcare costs by coordinating ambulatory services and facility-based services (hospital and skilled nursing) while improving quality in measurable ways related to preventive care and chronic conditions like diabetes and coronary artery disease.

Recognizing that the Medicare population in our county would grow 20% in 5 years, and that further cuts to the Medicare program were looming, we reached the difficult conclusion that PFFS Medicare Advantage was not the mechanism which would allow us to do what is right for our patients. Therefore, in October of 2007, our Board of Directors announced the decision to no longer see PFFS Medicare Advantage plans after a 15 month period of notice to our seniors. Interestingly enough, during the same time we studied this decision, the product offerings of PFFS Medicare Advantage in our county ballooned from 5 to 45 plans for 2008.

#### **Our Experience Communicating This Decision to Patients**

We have approximately 1,400 Medicare Advantage PFFS patients. Knowing that this was potentially an emotional and politically charged issue, we immediately began a process of communicating this decision to three key groups, 1) our patients, 2) our doctors, and 3) our elected leaders. All patients affected received a letter and attachments explaining our decision and offering help in finding a Medicare Advantage Plan that allowed them to keep their physician. They also received a phone call and an invitation to meetings where the CEO of our group or myself could explain and answer questions about the decision.

Over 400 seniors attended these sessions. We explained the financing mechanisms we faced and the rationale behind our decision. Representatives from four major HMO / PPO Medicare Advantage plans that we contract with were also in attendance to meet with beneficiaries and answer questions. Our own analysis of these plans shows that they represent a good value in the marketplace and also allow us the funding to afford proven efforts at coordinating care and adding value.

The feedback we received was reassuring. Patients understood why we needed to make the change. They had no idea that their program, if allowed to grow unchecked, would ultimately threaten the economic health of the clinic, and make it impossible to continue to provide the best possible care to our patients. They were very surprised to learn that the program did not cover its cost.

We now are in the process of working with these patients on other Medicare Advantage alternatives. We have a customer service line established and staffed and remain willing to help patients maintain their relationship with The Everett Clinic. We also plan to continue monthly meetings with our Medicare patients hosted by our senior leadership.

#### **A Provider Perspective on what to do with Medicare PFFS**

- We would urge that Congress recognize the value added by Medicare Advantage HMO / PPO plans and maintain their funding levels. The advantages to patients that we have seen through coordinated care and involving engaged providers is significant. Expensive hospital admissions are appropriately lowered by delivering care at the right time and place, patients are satisfied with the attention they receive, and overall quality is improved. This type of delivery system offered by medical groups such as ours offers hope for the future of the Medicare program.
- Our experience suggests that PFFS Medicare Advantage plans do not add value to the patient and represent an area that Congress should scrutinize. In our locale, the high funding levels and "deeming" process allowed Medicare Advantage PFFS has attracted a plethora of plans that do not work with providers to fund efforts at coordinating disease management or compliance with needed preventive care. We support the idea of removing their "deeming " authority and requiring these plans to work with providers in a fashion that promotes care coordination and information sharing.
- Finally, it is important to recognize that the Medicare program is in need of a greater fix than just changes to Medicare Advantage PFFS. Providers in our state are penalized because their care has historically cost less because overall our utilization of services is much lower than other parts of the country. The program needs to evolve to recognize efficiency and reward it.

Thank you for the opportunity to testify on this important subject. I hope that our sharing of experience is helpful to you as you formulate important policy. The Everett Clinic stands willing to serve as a resource to the Senate Finance Committee in the future. Please do not hesitate to contact us if we can be of assistance.





**Reponses to Questions Submitted for the Record**  
**Al Fisk, MD - The Everett Clinic**  
United States Committee on Finance  
"Private Fee for Service Plans in Medicare Advantage: A Closer Look"  
Public Hearing - January 30, 2008

**Senator Baucus:**

*Question 1. Both of you testified that PFFS plans are difficult to deal with — they often don't pay correctly or on time or will deny services normally covered by traditional Medicare. Despite these problems, do PFFS plans add value for your patients? If not, is there anything that can be done so PFFS plans add value for the beneficiaries and communities you serve?*

**Dr. Fisk Response:**

I apologize for any confusion, however, my testimony did not include information stating that PFFS plans were not paying on time and were denying services usually covered. My focus was on the fact that, as they are currently structured, the PFFS plans do not add value for our patients.

Plans provide value when they support coordinated care to ensure that effective disease management and preventive care can be delivered to each and every patient. The result is care that is delivered at the right time and place, expensive hospital admissions are lowered, overall care quality is improved and patients are satisfied — and healthier.

In contrast, our experience is that PFFS plans do not share any of the increased funding they receive from Medicare with providers to help fund coordinated care and disease management. Further, PFFS plans are not required to provide quality or cost data. These are grave oversights that must be remedied. That is why we will no longer be accepting PFFS plans beginning in January 2009.

If Congress were to mandate that PFFS plans report quality and cost data and contract with providers, then these plans would be in a position to add value to beneficiaries and our communities.

We also urge Congress to recognize the value currently added by Medicare Advantage HMO/PPO plans and maintain funding for these plans.

*Question 2. The Everett Clinic will no longer accept PFFS patients in 2009. What will be the effect of this decision on access to care for PFFS enrollees in your community? What will happen to your patients who do not switch to other plans or traditional Medicare?*

Dr. Fisk Response:

The Everett Clinic is working very closely with our patients to ensure that they can find an HMO or PPO plan that fits their needs and supports coordinated care. We believe that patients appreciate choices, and we have contracted with four Medicare Advantage HMO and PPO plans that are available to our patients. Based on our experience, these plans provide a much better value for our patients. Fortunately, most of our patients are very loyal and we believe that the vast majority will switch to a plan we contract with. For patients who choose to continue with PFFS plans, there are other providers in our area who still accept these plans.

**Senator Kerry:**

*Question 1. Do you consider physician networks to be a fundamental component of a modern insurance plan? What is the value of a physician network to the beneficiaries of health plans and to the health care system writ large? Do they ensure access to certain providers and/or help constraint cost growth?*

Dr. Fisk Response:

The delivery system plays a very important role in managing cost and quality for Medicare beneficiaries. To be most effective, a delivery system should embrace certain attributes that provide value to patients and payors. These include a very deliberate focus on quality, the infrastructure to coordinate patient care and decrease expensive, fragmented care, an investment in electronic health records, and tools to increase compliance with preventive health and chronic disease management. Examples of these attributes in our organization include the use of disease management registries which inform physicians about how well their diabetic patients are complying with important health measures and the employment of nurses who monitor the care of patients with congestive heart failure, frequently checking their blood pressure and diet.

Congress ultimately directs the payment system for Medicare and hence controls the incentives. If there is agreement that these attributes of care are more likely to provide value to beneficiaries and our communities, then we believe Congress should start aligning incentives to achieve these outcomes.

*Question 2. Are there any instances —certain geographies or patient populations — where Private Fee-For-Service plans are more efficient for the Medicare program than traditional managed care products, such as HMOs and PPOs?*

Dr. Fisk Response:

Based on our experience with a three-year Medicare demonstration project, it seems

clear that HMOs and PPOs are the most efficient plans for the Medicare Advantage program. HMOs and PPOs provide incentives to deliver preventive, coordinated care, which benefits the patients and also the payors. As part of the demonstration project, we have been able to provide higher quality care and significantly lower health care costs. Providing preventive care and chronic disease management reduces hospitalizations and readmissions, resulting in significant savings to Medicare.

*Question 3. What type of beneficiary — in terms of health and wealth status — is best served by a Private-Fee-for-Service plan?*

**Dr. Fisk Response:**

We believe that all Medicare patients deserve the highest quality care available. Patients benefit when their care is coordinated and when prevention and chronic disease management are priorities. These critical components of high-quality, efficient care are not priorities with Private Fee-for-Service plans in their current form.

**Senator Cantwell:**

*Question 1. In your testimony you refer to The Everett Clinic's participation in the Physician Group Practice Demonstration Project. Can you describe in detail how The Everett Clinic has utilized the program to enhance patient care? How might the program be improved to ensure that providers are sufficiently rewarded for efficient, quality care?*

**Dr. Fisk Response:**

The goal of the Physician Group Practice Demonstration Project, sponsored by the national Centers for Medicare and Medicaid Services (CMS), was to develop care delivery approaches that would result in measurable benefits for seniors. We implemented several specific approaches that improved care for seniors:

1. Management of chronic conditions with appropriate preventive services;
2. Care transition upon hospital discharge; and
3. Specialized palliative care for frail elderly, which helps reduce the severity of disease symptoms and can slow a disease's progress.

Our experience demonstrates that each of these three approaches improved care for seniors and reduced overall costs. For example, according to a CMS analysis, in the first year we were able to treat patients for \$407,850 less than the cost of treating comparable types of patients at other area medical clinics. Based on the results of the Demonstration Project, it is clear that if providers are given the tools and resources to provide coordinated care, we can provide better outcomes at lower costs.

The current CMS demonstration program has the correct incentives (sharing in demonstrated savings if key quality metrics are met), but the magnitude of the savings shared is inadequate. For example, CMS calculated that we saved \$407,850 in the first year, yet we did not receive any of those savings because the first two percent of savings were not shared with providers.

Congress could, for example, mandate a new demonstration program with The Everett Clinic and other multi-specialty groups. CMS could contract directly with group practices and provide a budget. The program could be funded similar to Medicare Advantage plans, with required quality reporting. Demonstrated cost savings could be shared with CMS. Such a program could potentially be a variant of the Medicare demonstration programs authorized under section 646 of the Medicare Modernization Act. There are a large number of multi-specialty group practices and integrated delivery practices in this country that could participate in this type of program.

The Medicare system should be structured so that providers receive incentives to keep patients healthy through coordinated, preventive care. Medicare Advantage HMOs and PPOs are a step in the right direction. We support these types of plans because they focus on preventing health problems, not just treating them after they occur.

*Question 2. I understand that The Everett Clinic attempted to negotiate with private fee-for-service plans for better rates before deciding to end participation with them. Can you describe your efforts as well as the plans' response?*

**Dr. Fisk Response:**

We tried for two years to negotiate fair contracts with Private Fee-for-Service plans. We were not successful, in part because it was difficult to even identify with whom we should negotiate. In a two-year period, the number of PFFS plans in our area increased from 5 to 45.

Further, in our discussion with these plans, it was clear they had no interest in developing contracts that would cover cost-saving coordinated and preventive care. Their approach is not in the best interest of the patient, the taxpayer, or the health care system.

These PFFS plans have no incentive to negotiate contracts with providers, because they are not required to do so and instead are allowed to "deem" providers. Because contracts are not required, none of the increased funding over traditional Medicare is shared with providers. The Everett Clinic is losing \$7.5 million annually on Medicare. We are very committed to serving seniors in our community; however, these huge losses are just not sustainable. As front-line providers, we strongly urge Congress to fund Medicare at a level that covers the costs of care and to structure Medicare to reward providers based on both the quality of care and cost effectiveness.

**Senator Salazar:**

*Question. It seems to me that many of the challenges with accepting private-fee-for-service plans you mentioned in your testimony can be tied to the lack of a contract with these plans. Do you think your practice would be more willing to take these plans if they were required to have network contracts? How do you think this contacting process would be impacted by the current market phenomenon of plans entering and exiting the market on an annual basis?*

Dr. Fisk Response:

The requirement that the PFFS plan assemble a network of providers is critical. If PFFS plans had to contract with The Everett Clinic, we would insist upon funding for critical elements of quality care, including coordinated care and disease management.

The PFFS plans should also be required to provide the same data on quality and cost of care that is provided by other HMOs and PPOs. This information is essential to improve quality of care. We are willing to contract with plans that agree to support care coordination and collaborate on ways to improve care and reduce costs.

There are currently 45 PFFS plans in the area we serve. I suspect that if they were required to contract with providers and report quality metrics to CMS, the number of such plans would shrink dramatically. Hopefully, our community would end up with a core group of plans willing to collaborate on long-term solutions, resulting in optimal care for all Medicare beneficiaries.

*United States Senate*  
*Committee on Finance*



*Sen. Chuck Grassley · Iowa*  
*Ranking Member*

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

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

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

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

The first private fee-for-service plans came online in 2000. They took a while to catch on. In 2004, there were only 50,000 people in private fee-for-service plans. Last January, enrollment had surged to a little over a million. This year, about 1.9 million people enrolled. That is 1.9 million out of a total of 9.2 million Medicare Advantage enrollees. These plans are growing very rapidly. And they are growing faster than other kinds of Medicare Advantage plans. Enrollment in coordinated care plans – HMOs and PPOs – grew only about 13 percent this year. That’s compared to 85 percent growth in private fee-for-service plans.

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

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

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

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

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

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

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

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

Private Fee-for-Service Plans  
in Medicare Advantage

January 30, 2008

Statement of  
Mark E. Miller, Ph.D.

Executive Director  
Medicare Payment Advisory Commission

Before the  
Committee on Finance  
U.S. Senate



Chairman Baucus, Ranking Member Grassley, distinguished Committee members, I am Mark Miller, Executive Director of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to be here with you this afternoon to discuss Medicare Advantage (MA) program and private fee-for-service (PFFS) plans.

MedPAC is charged by the Congress to make recommendations on payment policy both for providers in Medicare's traditional fee-for-service (FFS) program and for MA plans. The Commission's goal is for Medicare payments to cover the costs that efficient providers and organizations incur in furnishing care to beneficiaries, while ensuring that providers are paid fairly and that beneficiaries have access to the care they need. MedPAC focuses on ensuring that Medicare program dollars are spent wisely—ensuring that beneficiaries and taxpayers get maximum value for each dollar spent in the program. Providers who are put under fiscal pressure, whether FFS or MA plans, are more likely to contain costs and innovate new care delivery mechanisms.

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

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

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

MedPAC believes that adhering to the principle of financial neutrality is key to ensuring that private plans add value to the program. Financial neutrality means that the Medicare program should pay the same amount, adjusting for risk, regardless of which Medicare option a beneficiary chooses. What this means for MA payment policy is that benchmarks—the basis of payment in MA—should be set at 100 percent of FFS Medicare rates. When private plans are paid in this way, they have greater incentives to undertake innovations in care delivery and management and to negotiate with providers over levels and methods of payment. Indeed, they have the flexibility to use care management techniques that FFS Medicare does not encourage.

To say that MA benchmarks should be at 100 percent of Medicare FFS expenditures does not mean the Commission considers the traditional FFS program to be a reasonable standard of efficiency—either in terms of program costs or in terms of the value beneficiaries receive for each dollar of program expenditures. In fact, much of our work is devoted to identifying inefficiencies in FFS Medicare and suggesting improvements in the program. The Commission's recommendation that MA benchmarks be set at 100 percent of FFS would allow plans that are efficient, relative to FFS Medicare, to participate successfully in Medicare and offer enrollees extra benefits financed by plan efficiencies. These plans will also have the incentive to discover innovations in care management and provider payment, which in turn could provide useful ideas for the FFS program.

### **PFFS plans**

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

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

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

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

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

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

Source: CMS enrollment data.

### **Why does Medicare pay more for MA plan enrollees?**

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

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

### **The bidding system**

Under the MA bidding system, payments to MA plans are based on benchmarks for each county or, in the case of regional preferred provider organization (PPO) plans, for each region. The benchmarks are bidding targets for the plans and the maximum amounts Medicare will pay an MA plan.

To determine the amount Medicare will pay a plan and beneficiary premiums, each plan gives CMS a bid stating what it will cost the plan to provide the Medicare Part A and Part B benefit package. If the plan bid exceeds the benchmark, the plan charges a premium to make up the revenue it needs to cover the cost of providing the Medicare benefit package. If a plan bid for the Medicare benefit package is below the benchmark, 25 percent of the difference is retained in the Medicare trust funds, and the plan is required to use the remaining 75 percent, referred to as the “rebate,” to finance extra benefits, such as reduced Part B or Part D premiums, reduced cost sharing, or added benefits not covered by Medicare (e.g., routine vision and dental coverage). Plan bids for all benefits—both the Medicare Part A and Part B benefit package and extra benefits—include costs for administration, marketing, and profit or retained earnings.

Virtually all plans participating in MA are bidding below their area benchmarks. In part, this is because benchmarks are very high in relation to FFS as a result of a number of statutory provisions introduced over the years that raised the benchmark levels. For example, statutory provisions introduced minimum county payment rates, or floors, intended to attract or retain private plans in Medicare.

### **The effect of floor payment rates on MA benchmarks**

Payment floors were introduced in the BBA in 1997. The BBA established a payment floor for counties with relatively low FFS expenditures. The BBA floor is often called the rural floor because it applies mainly to rural counties and was primarily intended to attract plans to rural areas. What is referred to as the large urban floor, or the metropolitan statistical area

(MSA) floor, applies to counties within large MSAs. The MSA floor was introduced in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) and was effective as of March 2001. BIPA also provided an increase in the BBA floor rate. In many cases, the floor rates resulted in plan payment rates that were well above Medicare FFS expenditure levels in a given county.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, which introduced the MA program, made changes to the methodology for determining plan payment rates (i.e., the benchmarks, in the bidding system). One aspect of the payment changes is that there is no longer a payment floor provision in the law. However, the effect of the earlier floors is still seen in MA benchmarks for counties that historically had been floor counties. These counties still have very high relative benchmarks compared with other geographic areas: On average, the benchmarks are 121 percent of FFS for the MSA-floor counties and 120 percent of FFS for the BBA-floor (mainly rural) counties (weighted by the number of Medicare beneficiaries in each county). Benchmarks average 112 percent of FFS in non-floor counties.

### **MA benchmarks and plan payments: PFFS versus other plans**

Enrollment in PFFS tends to be concentrated in counties with benchmarks based on floor rates—i.e., rates that were often significantly higher than FFS expenditure levels for the county. This explains the difference in benchmarks for PFFS plans compared to other plan types in MA, which do not have their enrollment so highly concentrated in floor counties.

In November 2007, about 79 percent of PFFS enrollment was in floor counties.

Consequently, our projection of the 2008 enrollment-weighted level of benchmarks for PFFS plans is 120 percent of FFS. The high benchmarks allow PFFS plans to have high bids that enable these plans to finance their cost of providing the Medicare Part A and Part B benefit package. The Medicare program pays, on average, 108 percent of FFS for a PFFS plan to provide the Medicare Part A and Part B benefit package—making PFFS one of the least efficient plan types when measured against expenditures in Medicare's traditional FFS program (Table 2). The benchmarks are also high enough that, on average, all plan types—including the least efficient ones—are able to offer extra benefits subsidized in part by

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

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

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

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

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

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

The Commission has recommended that benchmarks be set at 100 percent of FFS to create incentives for private plans to be efficient and to improve the long run sustainability of the Medicare program. The Commission recommended in its June 2005 report to the Congress that the 25 percent difference between the benchmark amount and bids below 100 percent of the benchmark that is currently retained in the Medicare trust funds should be used to fund a pay-for-performance program in MA. (Note that, for regional PPO plans, one-half of the 25

percent difference is reserved in a stabilization fund that can be used to promote regional PPO participation, but the funds are not available until 2013.)

### **PFFS plans: Their history and how they differ from other MA plans**

In addition to differing from other plan types in their level of efficiency, PFFS plans differ in many other ways, including in their plan structure; the statutory, regulatory, and administrative requirements applicable to these plans; and the historical basis for including PFFS plans as a Medicare option.

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

Within the MA program, there are several types of plan options, with different features that might attract beneficiaries looking at their options in terms of cost (or cost savings), quality, and plan features. The current MA options range from HMOs that use staff or group practices or have other network arrangements; to HMOs with point-of-service options that cover some out-of-network care; to PPOs that have in-network as well as out-of-network coverage; to the least restrictive option, PFFS plans; and other options such as cost-reimbursed plans and medical savings account plans.

The law defines a PFFS plan as one in which the plan, “(A) reimburses hospitals, physicians, and other providers at a rate determined by the plan on a FFS basis without placing the provider at financial risk; (B) does not vary such rates for such a provider based on utilization relating to such provider; and (C) does not restrict the selection of providers among those who are lawfully authorized to provide the covered services and agree to accept the terms and conditions of payment established by the plan” (section 1859(b)(2) of the Social Security Act).

Although the statute permits PFFS plans to negotiate payments with providers if they form networks of providers, to date virtually all PFFS plans are paying providers at Medicare FFS rates and have not formed networks. Instead, PFFS plans rely mainly on “deemed”

participation of providers to provide care to their enrollees. Under this policy, the plan deems a provider to be in the PFFS plan if the beneficiary states that he or she is a PFFS plan enrollee and the provider treats the patient after learning about the plan's terms and conditions of payment.

The BBA introduced the PFFS option to allow for a private plan that guaranteed access to all Medicare providers without imposing utilization controls on the providers. Policymakers developed this option because, in the 1990s, during the period of greatest growth in managed care enrollment, they feared that there could be rationing of health care as a result of the general movement toward managed care, utilization management, and restrictive provider networks in the health care system. They wanted an option without limitations on enrollees' ability to obtain care through the providers of their choice.

However, while including the PFFS option in the BBA, the Congress also intended that enrollees bear the added cost of a private health plan offering free access to providers. As noted in the BBA conference report, "the private fee-for-service Medicare+Choice option authorized by this agreement represents the first defined contribution plan in which beneficiaries may enroll in the history of the program." PFFS was a defined contribution plan under Medicare+Choice (the predecessor to MA) because, unlike other plans, a PFFS plan could charge a premium for its cost of providing the Medicare Part A and Part B benefit package in excess of the actuarial value of Part A and Part B cost sharing in FFS Medicare. That is, the Congress expected PFFS plans to be more expensive than FFS Medicare. Beneficiary premiums were intended to make up the shortfall in revenue, and beneficiaries would be willing to pay an extra premium to guarantee what the beneficiary would consider adequate access to providers and adequate access to Medicare-covered services. Currently, PFFS plans are more expensive than the traditional FFS program, but taxpayers and all beneficiaries pay the difference in cost, not the just beneficiaries enrolling in these plans, as intended. Taxpayers and all beneficiaries subsidize these plans for both the cost of the Medicare benefit package as well as the cost of extra benefits.

The payment floors created an opportunity for PFFS plans to play a different role from what was envisioned for these plans when they were created. The current MA benchmarks are high



enough to permit PFFS plans to cover their cost of providing the Medicare Part A and Part B benefit and to offer extra benefits to enrollees. Because floor payments in rural areas and certain MSA counties are so far above Medicare FFS expenditure levels, PFFS plans have been able to operate as non-network plans, pay FFS Medicare rates to providers, *and* offer reduced cost sharing and extra benefits to enrollees. If benchmarks were not so high, it is unlikely that PFFS plans could do all this and thus would be less attractive for beneficiaries. PFFS plans do not use the mechanisms that managed care plans use to increase efficiency (e.g., formation of networks, careful utilization controls) and therefore would not be able to offer attractive benefit packages if MA benchmarks were closer to Medicare FFS expenditure levels.

PFFS plans have an advantage over other MA plan types in that they do not have to set up networks of providers. In certain geographic areas, such as rural areas, there are many barriers to setting up networks, which the Commission documented in a June 2001 report to the Congress. In the same report, we anticipated the possibility that PFFS plans would be providing extra benefits solely because of the higher payment rates and noted that this “would not appear to be paying the cost of an efficient provider—the basic axiom of Medicare payment policy. Paying PFFS plans at ... [higher] rate[s] is an expensive way to get extra benefits for Medicare beneficiaries in some counties.” Moreover, increasing MA payments in low-cost regions does little to reward the providers in those regions. A better approach would be to reward providers in low-cost regions through the FFS payment structure—or better yet, through innovative new payment systems.

### **Advantages enjoyed by PFFS plans compared to other plans**

In addition to being exempted from network adequacy requirements, PFFS plans have other advantages over other MA plans. They are subject to fewer requirements and benefit from certain statutory and administrative rules. The differences are outlined in Table 3.

The Commission supports equity in the treatment of different plan types within the private plan sector. The Commission favors a level playing field for all plan types, with no type having an advantage over another type unless special circumstances dictate otherwise. The

Commission believes, for example, that PFFS plans should report on the quality of care for their enrollees so that beneficiaries and the Medicare program can use quality as a factor in judging these plans.

**Table 3: Different requirements and provisions apply to different types of MA plans**

	PFFS	Medical savings account	HMO/local PPO	Regional PPO	SNP
Must build networks of providers <sup>a</sup>			✓	✓	✓
Must report quality measures			✓	✓	✓
Must have bids reviewed and negotiated by CMS			✓	✓	✓
Must return to the trust funds 25 percent of the difference between bid and benchmark <sup>b</sup>	✓		✓	✓	✓
Must offer Part D coverage <sup>c</sup>			✓	✓	✓
Must have an out-of-pocket limit on enrollee expenditures		✓		✓	
Can limit enrollment to targeted beneficiaries <sup>d</sup>					✓
Must offer individual MA plan if offering employer group plan <sup>e</sup>			✓	✓	✓

Note: MA (Medicare Advantage), PFFS (private fee-for-service), PPO (preferred provider organization), SNP (special needs plan).

<sup>a</sup>PFFS plans are exempted from other MA plans' network adequacy requirements if they pay providers Medicare fee-for-service rates.

<sup>b</sup>This provision applies when bids are under the benchmark. For regional PPO plans, one-half of the 25 percent amount is retained, and the remainder is included in the stabilization fund that, as of 2013, may be used to retain or attract such plans.

<sup>c</sup>Medical savings account plans are prohibited from offering Part D coverage. PFFS plans may offer Part D coverage, but special rules apply to such plans (e.g., it is not required that they receive drugs at a discounted rate when the deductible applies or the person is in the Part D coverage gap).

<sup>d</sup>MA plans must allow all Medicare beneficiaries in their service area to enroll with few exceptions (e.g., beneficiaries with end-stage renal disease). Other exceptions apply to medical savings account plans (e.g., Medicaid beneficiaries may not enroll in such plans). SNPs are permitted to limit their enrollment to their targeted beneficiary population (i.e., dual eligibles, beneficiaries who reside in an institution, or those with a chronic or disabling condition). SNPs can be local or regional coordinated care plans. They cannot be medical savings account or PFFS plans.

<sup>e</sup>Only non-network PFFS plans can operate exclusively as plans limited to employer group enrollees.

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

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

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

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

We are especially concerned about the interaction of employer-sponsored and PFFS plans. PFFS plans (and medical savings account plans) will have an advantage over other MA plan types in their ability to offer retiree coverage to an employer or union for the entity's Medicare population. Other types of organizations with network plans that wish to offer plans tailored for employer-group-sponsored retirees must have plans that are available to individual, non-group-sponsored beneficiaries (i.e., to have a group contract they must also be operating in the individual Medicare market). As of 2008, non-network PFFS plans and medical savings account plans will not have this requirement, so they will be able to offer plans exclusively to employers or unions.

### **Conclusion: FFS Medicare, MA, and PFFS plans**

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

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

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

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

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

In conclusion, the Commission believes that the Medicare program achieves greater efficiency when organizations face financial pressure. The Medicare program needs to exert consistent financial pressure on both the traditional FFS program and the MA program. This financial pressure, coupled with meaningful measurement of quality and resource use to reward efficient care, will maximize the value of Medicare for the taxpayers and beneficiaries who finance the program. Current MA payment policy is not exerting the kind of financial pressure that can maximize efficiency. MA payment policy is actively shaping the market for Medicare health plans, but the current policy conveys the message that Medicare values private plans that cost more than FFS and that Medicare is willing to subsidize beneficiary enrollment in MA.



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Glenn M. Hackbarth, J.D., Chairman  
 Robert D. Reischauer, Ph.D., Vice Chairman  
 Mark E. Miller, Ph.D., Executive Director

February 29, 2008

The Honorable Max Baucus  
 Chairman, Committee on Finance  
 219 Dirksen Senate Office Building  
 Washington, DC 20510

Re: Questions for the record from the Finance Committee hearing entitled, "Private Fee for Service Plans in Medicare Advantage: A Closer Look"

Dear Senator Baucus:

This letter is in response to the questions you sent us on January 30, 2008. Answers to the questions are as follows:

*Replies to questions from Senator Kerry*

**a) Do you consider physician networks to be a fundamental component of a modern insurance plan? What is the value of a physician network to the beneficiaries of health plans and to the health care system writ large? Do they ensure access to certain providers and/or help constrain cost growth?**

The Commission has not taken up this question directly; however, one of the concerns expressed by the Commission regarding the direction of the MA program is that we are encouraging plans that are poorly designed to manage care and improve quality. PFFS plans are one of the worst examples of this trend and as you may know, PFFS plans do not use contracted physician networks.

**b) Are there any instances – certain geographies or patient populations – where Private Fee-for-Service plans are more efficient for the Medicare program than traditional managed care products, such as HMOs and PPOs?**

There are no instances where PFFS plans with any significant enrollment are paid less than Medicare FFS spending. Similarly, there are no PPOs with significant enrollment that are paid less than FFS spending. HMOs are the only type of plan that sometimes produces savings for the Medicare program. That being said, most HMOs do not produce Medicare savings and all Medicare beneficiaries do not have access to an HMO.

**c) What type of beneficiary – in terms of health and wealth status – is best served by a Private Fee-for-Service plan?**

Beneficiaries that would be attracted to these plans are the ones who want no restrictions on the use of providers.

**4. a) *Upcoding*** Last year, CMS issued rules related to payments to hospitals and home health agencies that attempted to address the problem of "upcoding" or "coding creep" which history shows can often occur. We stepped in last fall to modify the rules for hospital payments to make sure that CMS wasn't going too far but let the rule for home health go into full effect. We required the Administration, as part of the Deficit Reduction Act of 2005, to address the problem of upcoding in Medicare Advantage but while CMS has found some evidence of upcoding (as has CBO), it has done nothing about it. Do you believe that upcoding poses a significant threat to accurate risk adjustment of Medicare Advantage payments? Have you examined the issue of upcoding and whether it is occurring among Medicare Advantage plans? If upcoding is occurring, and Medicare Advantage plans are enrolling beneficiaries who are healthier, on average, than those in fee-for-service, doesn't this mean that the average overpayment per beneficiary is even higher than 112% of fee-for-service?

To the extent that upcoding occurs in any system – in traditional Medicare or Medicare Advantage – it is an issue. We have not studied the issue of upcoding in Medicare Advantage directly; however, to the extent that it is going on, it would increase the 113%.

**b) *Quality of Care*** When examining quality measures, is there compelling evidence that Medicare Advantage plans, on average, do significantly better than commercial and Medicaid plans? Are they providing higher quality of care than traditional fee-for-service?

We can use HEDIS data to compare MA plan quality measures to commercial and Medicaid plans. Medicare performs better than commercial plans for about half of the HEDIS measures common to both sectors, with commercial plans better for the other half. A concern, however, is that Medicare plans are not improving their performance to the same extent as commercial and Medicaid plans. While commercial and Medicaid plans improved significantly between 2005 and 2006, in releasing the SOHCQ report for 2006, NCQA pointed to the lower level of improvement among Medicare plans and commented that the Medicare results "highlight ... a need to refocus on quality improvement efforts in this key public program" (NCQA 2007). NCQA reported that, between 2005 and 2006, Medicare plans improved on only 6 of 38 HEDIS effectiveness-of-care measures, compared with 30 of 44 measures for commercial plans and 34 of 43 measures for Medicaid plans that showed improvement. For 4 of the 13 measures for

which Medicare plans showed no improvement, Medicare scores are better than commercial scores; in 9 of the 13 measures, they are worse.

We can use CAHPS survey results to compare MA quality to traditional fee for service. The FFS CAHPS results can be used to compare beneficiaries' reported experiences in FFS with the experiences of MA enrollees for the domains CAHPS covers: access to medical care, impressions of the health plan (or the FFS program) and providers, and overall rating of the care beneficiaries receive. The FFS CAHPS survey was first fielded in 2000, and the latest results released were for 2004. The FFS CAHPS was fielded again in 2007 but results are not yet available. The 2004 Medicare FFS CAHPS results showed that FFS beneficiaries gave the traditional Medicare program ratings similar to those MA enrollees gave their plans, with Medicare FFS receiving slightly higher ratings in terms of getting needed care. Medicare FFS beneficiaries were more likely than MA plan enrollees to give higher ratings for the quality of their health care and satisfaction with their health plan (RTI International and RAND 2005). (It should be noted that these findings pertain to 2004).

Another source of information comparing the experiences of MA enrollees and beneficiaries in FFS Medicare is the Medicare Current Beneficiary Survey (MCBS). MCBS data from 2005 show that beneficiaries in FFS and MA report similar trouble in getting access to care, getting needed care, and delaying care because of the cost (differences of 1 or 2 percentage points in each case). Higher proportions of FFS enrollees reported not having a usual source of care (2 percent in MA vs. 5 percent in FFS) or not having a usual doctor (8 percent in MA vs. 19 percent in FFS) (CMS 2007).

You can find a more in-depth discussion of Medicare Advantage quality findings in our *March 2008 Report to the Congress* which was released today on our website ([www.medpac.gov](http://www.medpac.gov)).

**c) *Overpayments*** Last year, I understand both MedPAC and CBO estimated that payments to Medicare Advantage plans constituted 112% of fee-for-service costs for comparable beneficiaries. Is it correct that you are now estimating payments to be even higher relative to fee-for service at 113% in 2008? What is driving these payments higher? Is it correct that PFFS plans bid, on average, 107% of fee-for-service and are paid on average 117% of PFFS, slightly lower than last year? What is driving these PFFS numbers? Are the numbers slightly lower than last year simply because having previously targeted areas with the highest overpayments, PFFS plans are now spreading nationwide, including to counties with lower overpayments?

MA plan bids for traditional Medicare services relative to Medicare FFS spending increased over the ratio we found for 2006, and costs for MA plans continue to exceed Medicare FFS expenditures. We are projecting that MA payments will be 113 percent of

FFS expenditures for 2008. Among plan types, PFFS plans have one of the highest ratios of plan payments to Medicare FFS expenditures (117%)—not because they were intended to be paid differently but because of where they have enrollment and because of the costs they incur in providing the Medicare benefit package.

Enrollment in PFFS tends to be concentrated in counties with benchmarks based on floor rates—i.e., rates that were often significantly higher than FFS expenditure levels for the county. This explains the difference in benchmarks for PFFS plans compared to other plan types in MA, which do not have their enrollment so highly concentrated in floor counties.

In November 2007, about 79 percent of PFFS enrollment was in floor counties. Consequently, our projection of the 2008 enrollment-weighted level of benchmarks for PFFS plans is 120 percent of FFS. The high benchmarks allow PFFS plans to have high bids that enable these plans to finance their cost of providing the Medicare Part A and Part B benefit package. The Medicare program pays, on average, 108 percent of FFS for a PFFS plan to provide the Medicare Part A and Part B benefit package—making PFFS one of the least efficient plan types when measured against expenditures in Medicare's traditional FFS program (Table 2). The benchmarks are also high enough that, on average, all plan types—including the least efficient ones—are able to offer extra benefits subsidized in part by Medicare. The extra benefits are also subsidized by beneficiary Part B premiums whether the beneficiary is enrolled in an MA plan or not.

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

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

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

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

It is true that PFFS reduced their bids relative to FFS compared with 2006. This is likely due to the fact that PFFS plans have expanded and are now available in all areas; as they expand, they draw enrollment from counties with benchmarks that are closer to FFS, so their bids are closer to FFS.



**The Commission and I share a strong interest in moving Medicare toward payment systems that promote and recognize quality. MedPAC has recommended that Congress should consider using funds retained by the Treasury when Medicare Advantage bids come in below the benchmark to create a pay for performance system for Medicare Advantage. Senator Baucus and I spelled out how we thought that could work in our bill – the Medicare Value-Based Purchasing Act, but I’d be interested in hearing your thoughts on this matter too. How do you think that quality payments could work?**

In our March 2004 *Report to the Congress*, the Commission recommended that the Congress establish a quality incentive payment policy for all MA plans. (We reiterated this recommendation in our March 2007 and 2008 reports as well.) There were a number of reasons for making this recommendation, including the relatively advanced state of quality measurement for plans, and the position of these organizations, who take risk for the full array of benefits, to use incentives to promote quality among plan providers. We know that there is wide variation among plans in their performance on the existing measures—indicating that there is room for plans to improve their performance. We also have recommended pay-for-performance systems for the traditional fee-for-service (FFS) program. Measuring quality at the plan level may help identify effective mechanisms for better coordination, imparting lessons that may be useful in the FFS program.

Most MA plans [other than private fee-for-service (PFFS) and medical savings account (MSA) plans] are reporting information on a number of quality measures through the Health Plan Employer Data and Information Set (HEDIS®), with preferred provider organizations reporting on a more limited set of measures. (It should be noted that MedPAC has recommended that *all* MA plans report on quality measures.) The Medicare program also obtains information on the health status of MA enrollees through the Health Outcomes Survey, and information on satisfaction measures through the Consumer Assessment of Healthcare Providers and Systems (CAHPS®). In other words, there are well-accepted quality measures in use. The measure sets should evolve over time, and there could be new measures, such as those dealing with efficiency and appropriate use of resources.

The Commission supports pay-for-performance incentives for both improvement and attainment. The Commission has recommended that a portion of plan payments be used to fund a P4P program in MA. A P4P program would encourage plans to improve their performance and could help address our concerns about the relatively poorer performance of some MA plans on quality measures.

*Replies to questions from Senator Smith*

**a) *Ensuring market stability*** You have noted that plan benchmarks in certain areas – such as in rural communities – tend to be higher than what traditional Medicare would pay. This is based upon a number of factors, such as direct congressional intervention to help markets develop. To improve the MA program overall, you have recommended that all plan benchmarks be set at a rate not to exceed 100 percent of Medicare fee-for-service rates. However, I am concerned that setting this type of cap will continue to penalize states, such as Oregon, that have developed efficient and high-quality care delivery but that receive very low Medicare reimbursement rates, while rewarding high-cost, lower quality states. How can Congress make improvements to the MA program without further penalizing efficient states like Oregon?

The lower fee-for-service spending in Oregon results from lower than average service use. This is not a bad result as it means that beneficiaries in Oregon have the same or better quality as the rest of the nation but pay lower cost sharing. However, the Medicare payment system does not reward providers for lower resource use and higher quality; the best way to do that would be to make changes to the Medicare FFS payment systems to reward quality and efficiency so that geographic differences are reduced. It makes little sense to use the MA payment system to address geographic differences in the use of services in traditional FFS. If we pay plans more than FFS in areas where the FFS system supplies high quality care and is relatively efficient, and less than FFS in areas where FFS is less efficient, we would be encouraging beneficiaries to leave FFS and join plans where FFS is most efficient and encouraging beneficiaries to remain in the FFS system where that system is inefficient.

Two MedPAC policy recommendations may reward providers in areas of the country where there is higher quality of care and lower resource use. First, pay-for-performance programs would redistribute funds from lower quality providers to higher quality ones. Second, the Commission has called for CMS to report to physicians on the resource use associated with their practice patterns. These data could become the foundation for a pay-for-performance or other incentive program that rewards providers who are most efficient.

To answer the second part of your question, the Commission recognizes that moving Medicare Advantage payment levels to 100% of fee-for-service rates would be disruptive to beneficiaries enrolled in plans with extra benefits. As such, the Congress may wish to employ a transition in implementing the Commission's recommendation on payment rates. Possible approaches might be to (a) freeze all county rates at their current levels until each county's rate is at the FFS level; (b) differentially reduce MA rates, with counties in which payments are highest in relation to Medicare FFS facing a larger

reduction to more rapidly arrive at FFS rates in each county; or (c) reduce rates in all counties at the same percentage each year until arriving at FFS rates in each county. Other transition strategies are also possible.

**b) *Data Access from CMS* I am a supporter of Medicare Advantage and believe that MA provides many services that otherwise would not be covered under traditional Medicare. However, I realize that there is a strong need to critically evaluate and look for opportunities to increase efficiencies and make improvements to the program wherever we can. Unfortunately, in a recent article, I read that the Congressional Budget Office was having trouble accessing data that they feel is necessary to make the assumptions and evaluations they need to determine the effectiveness of MA plans. Do you feel that MedPAC has received the data from CMS necessary to make accurate assumptions and evaluations of the MA program, particularly for the private fee-for-service (PFFS) plans, and how can Congress help, if you are not receiving the information you need?**

We believe the CBO article to which you are referring pertains to Part D drug data. Because of gaps in available data, there are fundamental questions that the Commission and other organizations cannot answer about how Medicare prescription drug benefit (Part D) is operating. These include questions such as:

- which prescription drugs enrollees are using most widely;
- how much, on average, enrollees are paying out of pocket for their medicine; and
- how many beneficiaries are entering Part D's coverage gap.

In our March 2008 report, the Commission recommended that the Congress direct the Secretary to make Part D claims data available regularly and in a timely manner to congressional support agencies and selected executive branch agencies for purposes of program evaluation, public health, and safety. Congressional support agencies must report to the Congress about the effects of Medicare payment policies on cost, quality, and access. Data on Part D are necessary for analyzing program performance and making policy recommendations. Detailed data on quality measures would help evaluate the performance of individual plans and providers, which could help Part D beneficiaries make more informed choices. Other federal agencies need Part D data to carry out post-marketing surveillance of drug safety and efficacy, to help monitor the prevalence and treatment of specific conditions, and to support research on clinical outcomes and the effectiveness of covered drugs. Federal and private researchers could make significant contributions to public health and health services research by analyzing linked files of Part A, Part B, and Part D claims. Without this data the Commission will be severely inhibited from carrying out its duty to provide policy recommendations to the Congress.

**c) *Efficient models of care delivery*** In your testimony you noted that the efficiency by which managed care plans deliver services varies by the type of plan. Health Maintenance Organizations, or HMOs, tend to deliver care most efficiently, while private fee-for-service plans appear – at least from MedPAC’s analysis – to be the least efficient. Apart from the care delivery model used to provide care, what other factors contribute to a plan’s efficiency in delivering care and enhance the level of care provided? How could all plans better utilize these factors under the current MA program to enhance care and is there a role for the government to play to encourage it?

Medicare’s private plan option was originally designed as a program that would produce efficiency in the delivery of health care. Through the use of coordinated care techniques, selected provider networks and negotiated fees, plans would be more efficient than the traditional FFS program. Efficient plans would be able to provide extra benefits to beneficiaries choosing to enroll in such plans, and this in turn would lead to higher plan enrollment. Unfortunately, MA has instead become a program in which there are few incentives for efficiency. Although MA uses "bidding" as the means of determining plan payments and beneficiary premiums, the bids are against administratively-set benchmarks. Setting benchmarks well above the cost of traditional Medicare signals that the program welcomes plans that are more costly than traditional Medicare. Put differently, inefficient plans—as well as efficient plans—are able to provide the kind of enhanced coverage that attracts beneficiaries to private plans because of generous MA program payments. These additional payments are funded by all taxpayers. Furthermore, all Medicare beneficiaries—not just the 20 percent of beneficiaries enrolled in private plans—pay higher Part B premiums to fund these payments in excess of Medicare FFS levels.

Our recommendation to lower the MA benchmarks to FFS levels is intended to encourage efficient models of care delivery and attract efficient plans to the program.

**d) *PFFS and Employer-Sponsored Plans*** I expect we will hear a great deal more about this from our second panel, but in your testimony you mention concern about the interaction of private fee-for-service plans and employer-sponsored plans. Specifically, you mention that, unlike other MA plans, PFFS does not have an obligation to operate in the individual MA market, and therefore will be able to offer plans exclusively to employers or unions. Unfortunately, you didn’t expand upon the reason for your concern. I am interested in hearing what issues or inefficiencies you think this competitive advantage will have other non-private fee-for-service plans, and whether beneficiaries will be helped or harmed in the long run?

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

We are especially concerned about the interaction of employer-sponsored and PFFS plans. PFFS plans (and medical savings account plans) will have an advantage over other MA plan types in their ability to offer retiree coverage to an employer or union for the entity's Medicare population. Other types of organizations with network plans that wish to offer plans tailored for employer-group-sponsored retirees must have plans that are available to individual, non-group-sponsored beneficiaries (i.e., to have a group contract they must also be operating in the individual Medicare market). As of 2008, non-network PFFS plans and medical savings account plans will not have this requirement, so they will be able to offer plans exclusively to employers or unions. Currently, CMS can compare the employer-only bids with the plan's non-group bids. If there are no non-group bids, CMS might have more trouble determining the accuracy of the employer-only bids.

*Replies to questions from Senator Cantwell*

**7. Dr. Miller, you write in your testimony that the payment disparities experienced by providers in efficient, low-cost regions could be addressed through the traditional fee-for-service payment structure. What changes to the existing structure could Congress make in the near future to ensure that providers in low-cost regions are reimbursed fairly?**

Two MedPAC policy recommendations may reward providers in areas of the country where there is higher quality of care and lower resource use. First, pay-for-performance programs would redistribute funds from lower quality providers to higher quality ones. Second, the Commission has called for CMS to report to physicians on the resource use associated with their practice patterns. These data could become the foundation for a pay-for-performance or other incentive program that rewards providers who are most efficient.

*Replies to questions from Senator Salazar*

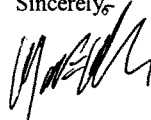
**Based upon the reports I have heard from my home state of Colorado and other areas of the country, I'm not so sure that we are seeing the extra money in private fee for service plans produce measurable benefits. Based upon MedPAC's work on this issue, how would you rate the "value" of these plans compared to other Medicare options? Are there specific changes we could make to increase the "value" we are getting from private fee for service products?**

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

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

Please feel free to follow up with me on any of these issues. Again, we appreciate the opportunity to testify on this topic and commend the Committee's leadership in this area.

Sincerely,



Mark E. Miller  
Executive Director

**The New River Valley Agency on Aging in  
Virginia's Experience with Private Fee for  
Service Medicare Advantage Plans**

**Statement by Elyse Politi  
SHIP Coordinator  
New River Valley Agency on Aging in Virginia**

**Before the United States Senate  
Committee on Finance**

**Private Fee for Service Plans in Medicare Advantage:  
A Closer Look**

**January 30, 2008**

Chairman Baucus, Senator Grassley, and members of the Committee, thank you for the opportunity to testify regarding Private Fee for Service plans in the Medicare Advantage program. My name is Elyse Politi, the current State Health Insurance Program Coordinator (SHIP) for the New River Valley Agency on Aging, which provides services to seniors in the counties of Montgomery, Pulaski, Giles, and Floyd, and the City of Radford, Virginia.

The SHIP program was established in 1993 in Virginia and I am one of the original coordinators, having spent 13 years in the Northern Virginia area until last fall, when I transferred to the Southwest part of Virginia. In Virginia, the SHIP program is called VICAP – Virginia Insurance Counseling and Assistance Program.

The SHIP program was established to help Medicare beneficiaries and their families, whether over or under 65, understand and navigate through the Medicare, Medicaid, Medigap maze, as well as provide counseling on the impact of other forms of health insurance on their Medicare status. During the past three years, as a result of the MMA of 2003, the burden on the SHIPs to constantly re-educate themselves on the Medicare Advantage (MA) plan offerings and the stand alone prescription drug plans has increased exponentially, and our efforts at outreach and education with the Medicare population, regardless of where they live has grown at the same rapid rate. Added to this burden is the imperative to find low-income beneficiaries who qualify for the extra help to pay for prescriptions. The increased number of beneficiaries reached, the amount of effort to keep ourselves and the beneficiaries educated has been shown in the numbers from across the country for the total SHIP program.

My testimony today will focus on 5 points:

- Private Fee for Service promises of reduced costs to rural residents.
- Marketing problems which continue to plague beneficiaries.
- Medicare beneficiaries need for qualified, knowledgeable counselors.
- Frustration of providers in dealing with PFFS plans.
- Concerns about the use of the additional funds appropriated for SHIP programs.

**PFFS promised reduced costs to residents in rural areas.**

Many people were very encouraged and excited in 2006 to find out that there were some plans that were claiming no premiums for either health insurance other than the Part B premium, and no premium for their medications. Since there was little oversight at the time, rampant poor sales techniques were used to enroll the rural folk into several PFFS plans this area. People were told that there were extra benefits such as hearing, dental and vision coverage in addition to exercise programs that they could join. They were not told, however, that there was an out-of-pocket maximum of \$4000 - \$5000 per year beyond their prescription costs, (much greater than with a Medigap policy), or that their hospital co-pay for one plan would be \$525 and the other \$185/day for the 1<sup>st</sup> five days. In addition, there would be daily co-pays for Skilled Nursing stays after 5 days instead of after 20 days as in Original Medicare, and the durable medical equipment and Medicare part B drugs would have the same 20% co-pay that would have been payable under Original Medicare. Most of the PFFS plans are also charging high ambulance co-pays and are requiring substantial co-pays for people receiving dialysis and diabetic supplies regardless of whether the plans charge a premium for the health costs

People who gave up their Medigap policies suddenly had to pay these large, unexpected costs out of their own pocket. When one woman I spoke with found out that she had to pay the \$525



hospital bill, and then received a bill for her 100 day Skilled Nursing Facility stay in the amount of \$8000, she thought the end of the world had come and realized what a bad decision she made. I helped her first by contacting the plan to advise them that they needed to work out the billing issue since she obviously had gone over her \$4000 out-of-pocket maximum. I then dis-enrolled her from the plan, got her back into Original Medicare and a Part D plan, and also helped her fill out a Medicaid application since she had spent enough to meet the requirements for a spend down. Had she stayed with her Medicare and Medigap, her out-of-pocket costs would have been equal to her original Medigap premium, or \$1,800 and she would not have had to apply for Medicaid.

Other people find out that a health care provider will not accept their PFFS plan just as they are scheduled to receive a needed health care service. On Friday afternoon, December 28, I was contacted by a frantic son whose mother was scheduled to enter Skilled Nursing Facility the following week. The Nursing home advised him that they would not accept the PFFS she was enrolled in, and even if they did, she would be responsible for co-pays after the first 5 days she was there. This Nursing Home was the closest facility to her home and family, and the son was worried that other facilities further away might not take the PFFS plan either. After talking with his mother they decided that she needed to be dis-enrolled from the PFFS before December 31 so that when she entered the Nursing Home, she would at least be covered under Original Medicare 100% for the first 20 days.

**Marketing problems continue to be rampant with PFFS plans in rural Virginia.**

A beneficiary was approached by a salesperson in a local Wal-Mart. When she told him that she had TRICARE, and the Federal Blue Cross/Blue Shield Standard option, he advised her that she needed to also sign up for the PFFS plan since neither of those plans offered her full protection. He did not indicate that she could suspend her FEHBP plan. I counseled her on the benefits of both TRICARE and BC/BS, advised her that she did not need the PFFS, and possibly could suspend her BC/BS since the TRICARE was fairly inclusive. She said she would investigate further and make her decision. I reported this salesperson, who has been "working this area for the past 3 years" to both CMS and our Virginia Bureau of Insurance. The Bureau of Insurance has received several complaints about this particular salesperson on other occasions.

Another person was told by a marketing contact that the plan wanted to meet with the enrollee since the benefits of the person's PDP were changing and that the Enhanced PFFS would not only reduce his drug costs but give him added benefits. Since he had talked with a SHIP counselor last year, he knew that further investigation was needed. When I compared plans for him, and advised him of all the co-pays and liabilities he would incur by cancelling his Medigap and enrolling in this PFFS, he chose to change his PDP to a lower cost plan, and keep his Medigap. He told the salesperson that since this new plan would actually cost him more potentially he did not feel he could gamble his savings against his health.

The mother in law of the Director of the New River Valley Agency on Aging called to say that a very polite gentleman called her in response to her inquiry into joining a PFFS he represented. Since she had not talked to anyone about changing plans, she asked her daughter-in-law, the Director, to talk with the salesperson. When asked about how in fact he had gotten her mother-in-law's telephone number, he replied that the plan had given him several names of people who said they were interested... This salesperson became concerned after talking with my Director, that indeed the people on this "list" given him by the PFFS contained people who in fact had not been interested, but rather a list of "cold contacts" to call.

**Medicare beneficiaries need knowledgeable counselors.**

These situations require many hours of counseling, and I was grateful that I knew what the PFFS plans covered so that my help was valuable. Before the detailed benefits for each plan were uploaded to the Medicare website, I made a spreadsheet of all MA and MAPDs available to each one of the five counties I cover. Not all plans are offered in all 5 counties. I called each plan, went down the list of benefits and had this spreadsheet to show to people so that they could understand the costs. Most found it difficult to understand, especially when they realized that the co-pays, other than the \$10-15 for their primary care doctor could be as much as the costs of original Medicare without a Medigap plan.

Counseling sessions can be difficult and time consuming because they need to be individualized. They require more than knowledge about the PFFS plan and other Medicare Advantage options. They require knowledge of Original Medicare, Medigap, Medicare Saving programs, and Medicaid.

Two doctors in small towns called me and asked to have counseling sessions for their patients to advise them of all the Medicare options available to their patients. In one town, the doctor's staff asked the local library to open before hours so that I could counsel 40 patients. Most had had Medigap before joining the PFFS and were swayed by the no premium, small co-pays that seemed to sound great. Some of the patients were younger people with disabilities who were not eligible to get a Medigap policy because it would have cost \$500-\$700 per month. Some of the people could get help paying for their drugs through "extra help". Since some people were just above the level for QMB, (Qualified Medicare Beneficiary) and received help to pay for the Medicare Part B and reduced drug costs, there was still no way to pay for the large co-payments and deductibles incurred with PFFS plans. The seemingly low-cost PFFS plan was of no help to the patients who needed the most costly services. For example, one person who was on oxygen full time still had to pay 20% of the cost of that service in the PFFS plan.

The counseling session for the person who used oxygen, which included various financial scenarios, was 5 hours over the course of several days, with an additional 2 hours spent analyzing all the possibilities. I am not sure I found them all, but I guarantee that the salesperson that sold him the PFFS plan did not do anything of the type of counseling I did.

Another emerging situation is that doctors are feeling extremely pressured to accept payment from PFFS plans because their long-time patients have signed up unknowing what they got themselves into. The two doctors that asked me to do counseling sessions for their patients felt close to being family friends – at the very least, very close to the community. They both expressed increasing difficulties in getting timely payments from PFFS plans, and were irritated by constantly having to provide more and more paper to prove that what they were doing was correct and to justify their standard procedures. These same doctors also expressed frustration with stand alone drug plans as well, when asked to furnish detailed patient notes on why certain drugs were prescribed. Additionally, this year several PFFS plans have announced that they will charge additional money if they are not notified prior to a patient is admitted to a hospital, or a Skilled Nursing Facility. This puts an additional burden on physicians, facilities, Medicare beneficiaries and their families to understand the complexities of PFFS plans. Providers need to understand all the subtle difference between 46 possible choices.

PFFS plans promise to save people money, promise to provide extra benefits, and promise to provide the same Medicare coverage as original Medicare. The plans don't tell beneficiaries that the beneficiaries may end up paying more and getting less. They don't discuss the burdens of having to find out whether providers accept the plan or of giving the plan notice before getting some services. PFFS plans increase the workload of already busy SHIP counselors who have to re-counsel beneficiaries who get less than they were promised by the sales agents and the plans on how to make future changes.

The saddest part about Medicare Advantage is that there is less control over how the Private Fee for Service plans operate, put operating budgets together, and how they choose to charge for services and how they sell their products. With the additional money they receive, they are held to lower standards than Original Medicare. Since there are no provider networks, like with an HMO, there is no way to count on any provider being there if you needed them twice in a row. Unless there is a specific dollar amount to dispute, filing an appeal is nebulous.

In addition, the manpower cost to keep educated on all a person needs to know inadvertently undermines the SHIP program. Since it takes a long time to train new paid coordinators and additional time to train volunteers on how to diagnose and analyze all issues faced by beneficiaries and their care givers, what should be easy turns out to be complex counseling, many times looking at different financial scenarios to determine what is best. If a counselor does not work with Medicare consistently, it is impossible to know all differences between Original Medicare and all the different flavors of Medicare Advantage. It is easy to see this when all the training, teleconference and counseling hours are added up during the year and how many more are added as Annual Enrollment Plan gets closer and then all the additional training of volunteers, it does become apparent that enough time and money is not being spent on the people who do the most objective and intensive counseling.

I have heard from my SHIP colleagues across the country and they report the same concerns about questionable marketing and sales tactics from insurance agents selling PFFS plans and the coverage these plans provide. Like me, they are seeing most clients after the damage is done, rather than having the time to spend on outreach and education. We can only spread ourselves just so thin and it is disappointing to see so many fall into large debt as a consequence of enrolling in PFFS plans.

I would ask that this Committee review the entire Medicare Advantage structure, because the primary thing that is happening is our seniors and people with disabilities are being taken advantage of rather than given positive advantages for their health care.

Some immediate fixes could include:

1. Much tighter control over marketing and sales materials and approaches by insurance agents.
2. Requiring PFFS plans to have a minimum network of providers that people could see and rely on during the course of a year. This should not be the enrollee's responsibility on an ongoing basis.
3. A set of benefits and requirements so that it would be easier to compare products. To see 46 different plans, with even primary physician co-pay as varied as \$10 to as much as 40% of the charge is too hard to compare.

I want to express to this Committee how deeply we (SHIP Coordinators) appreciate the allocation of additional funds for 2008 through the Omnibus Appropriations Act and the

Medicare, Medicaid, and SCHIP Extension Act of 2007. I have heard though, that CMS is possibly considering keeping these funds and not distributing them to the SHIP program. I currently can spend 24 hours a week focused on SHIP activities, which is little more than a half time position. If I spend 2 – 7 hours per client, it does not allow me to see many people. With additional funds, I could either work full time, or pay for additional staff that I could train so that they could learn and take forward the valuable information from year to year.

Thank you for opportunity to testify on this important subject. I hope that my sharing of experience is helpful to you as you formulate important policy. The New River Valley Agency on Aging in Virginia stands willing to serve as a resource to the Senate Finance Committee in the future. Please do not hesitate to contact us if we can be of assistance.

**NEW RIVER VALLEY  
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February 20, 2008

Committee on Finance  
219 Dirksen Senate Office Building  
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VIA FAX and e-mail

Thank you very much for the opportunity once again to testify on behalf of the Medicare beneficiaries with whom I have worked over this past year.

In response to the questions posed by the Committee in Senator Baucus' letter of February 11, 2008, I submit the following:

**Senator Kerry:**

**3(a)** I do believe that an established network of physicians is fundamental to a modern insurance plan. Having a primary care doctor where all records are compiled from all specialists allow physicians to monitor the continuum of care. For a beneficiary, (especially when there are multiple issues affecting a person), the person ideally will be able to get follow up information easily. Medications can be monitored, diagnostic tests can be followed and duplicate services possibly eliminated by having more than one provider ordering the same tests.. In theory this should also help specialists "turn over" a client to the primary care and assure appropriate follow-up and further coordination of care that may be required.

When a system that does have a network is followed, one must be careful on how primary care providers are incentivised so that the primary physician is not discouraged from using specialists for the benefit of cost reduction. Under strict managed care rules, the primary care physician, who is usually a generalist, still needs to be able to refer out clients for specialist services easily. If not, then you will have generalist providing specialist care which could cause even more costly health issues.

**3(b)** PFFS plans as a basic philosophy have no efficiencies in ANY area that I can see. Since this is a replacement administrative effort for Medicare, and one in which the government must offer a high monetary incentive over traditional Medicare to duplicate the same overhead costs over many plans, and one where the liabilities to beneficiaries is greater than the standard alternative, does not seem to be a fiscally sound policy. It has always been held that to contain costs, one must centralize to eliminate duplicate efforts,

but PFFS plans have expanded duplicity, manpower, technical computer issues, at an exponential rate, all in the hope of saving money. They have fractured services, continuity of care and caused confusion among providers and beneficiaries alike. For those PFFS plans that also have prescription coverage, it also means that as drug coverage changes from year to year, a person must pick a new health plan that will also be acceptable to the providers and offer the right drug coverage. Once again the choices become voluminous and too confusing to explain and understand.

**3(c)** To be best served by a PFFS plan, one must have savings enough to cover the out-of-pocket maxs a plan has. Plus any charges that might be incurred for services that fall outside the out-of-pocket max. With these maxs varying from as little as \$1000 per year to, in some cases NO max at all, it is hard to compare the balance of the benefits. Also, one must be able to determine if their health status will remain good enough where there is little risk of using many services. Since these plans are a direct replacement to Medicare, Medigap type plans should be allowed to help offset the PFFS co-pays and deductibles. But once again, if these plans end up with the same or close to the same look and feel that traditional Medicare has, then how can they be justified as cost savers?

**Senator Salazar:**

**9(a) Payment Rates should be equal to Medicare payments.**

Only then will a real comparison of savings between these plans and original Medicare be able to take place. If a plan offers more than original Medicare, they should be rewarded for their creativeness. Now CMS is offering incentives so that they will offer other benefits. However, the other benefits are so meager, that they are not worth the liability and risk of not having regular health bills being paid for.

**(b) Mandate Specific structure and comparability.**

Medicare Advantage plans must have much more structure in how much they can deviate from the traditional Medicare plan. They must be made compare-able – they are not now and they need to be restricted in the number of plans available in any one area. Having one company for example xyz offering 5 plans in an area each with different options, is confusing. Additionally, if a plan is offered in one county, all the towns and subdivisions of that county must also be covered. To have a city in the heart of a county excluded by a plan covering that county is absurd. It seems that plans choose their service area based on reimbursement rates, not actual geographically congruous territory.

**(c) Change the name of what these plans are.**

I believe that the main confusion for beneficiaries and providers alike both come from the way these options have been named.

In the BBA of 1997 we were given **Medicare + Choice**. Although we argued at that time that this was a misnomer, **Medicare Advantage** is ultimately worse. MA implies that there is an advantage NOT to have Medicare: the ones who seem to have the advantage are the insurance companies administering these plans. Certainly the provider or beneficiary who has been left holding a bag of

unpaid bills has not received an advantage. Instead of calling Medicare fee-for-service, please say **traditional** or **original** Medicare.

I would be more than happy to continue to share my experiences. What I know, having worked in both a large metropolitan area (Washington, DC) and now in a very rural area, is that the complaints and concerns are valid in both locations. I have read the testimony from Humana, and I contend that the beneficiary that is hurt the worst is those they say benefits the most - the ones whose income is between \$10,000 and \$20,000- We have created a new level of poverty or even worse, removed another segment of society from the middle class American.

Thank you for this opportunity,  
Sincerely,

Elyse Politi  
VICAP Coordinator

**STATEMENT OF SENATOR GORDON H. SMITH**

U.S. Senate Finance Committee

"Private Fee for Service Plans in Medicare Advantage: A Closer Look"

January 30, 2008

Thank you, Chairman Baucus and Senator Grassley, for providing the Finance Committee with an opportunity to examine the performance of Private Fee-for-Service plans.

For years, traditional Medicare was the only option available to seniors. But recent Medicare reform laws have provided expanded choices in healthcare coverage, and increasing numbers of beneficiaries now are opting for Medicare Advantage (MA) plans, particularly private-fee-for-service (PFFS). Recent data indicates that enrollment in these plans has grown 75 percent over the past year.

However, due to explosion of interest in these plans, insurers and their sales agents are aggressively competing to enroll beneficiaries. Last year was tumultuous, to say the least, for Medicare Advantage in general, and Private Fee-for-Service in particular. Predatory marketing practices prompted a series of Congressional hearings, a CMS-imposed marketing moratorium for PFFS plans, and tensions escalated between state and federal regulators. In the midst of this chaos, beneficiaries continued to bear the brunt of administrative and regulatory inefficiencies.

As Ranking Member on the Aging Committee, I continue to receive complaints of hard sell tactics, confusion over whether services will be covered by a particular provider and billing and payment difficulties faced by doctors – some of whom are now refusing to accept PFFS patients. Further, I am deeply troubled by emerging areas of fraud relating to forged outbound verification calls and sales of MA supplemental insurance plans.

These problems have cast a shadow over a program that I fundamentally support. MA plans provide valuable benefits to beneficiaries, including reduction or elimination of premiums and cost-sharing, care management services and, in many cases, additional coverage such as vision and dental that traditional Medicare does not cover. Therefore, it is incumbent upon Congress, the administration and industry stakeholders to act quickly to address ongoing problems to ensure seamless service delivery and preserve seniors' confidence in this program.

As we look forward to the many critical health priorities facing the Committee this year, including the reauthorization of State Children's Health Insurance Program (SCHIP), expansion of health insurance coverage and Medicare physician payment reform, it is critical that we explore options that do not weaken one program in order to benefit another. I hope today's hearing sheds light on what steps can be taken to generate greater efficiencies in delivery of services in the MA program. However, I hope we reject the position that MA plans are inherently bad simply because private companies deliver the benefit.

I look forward to today's discussion, and hope that it facilitates a thoughtful examination of the Medicare Advantage program. I believe it is a valuable component of Medicare and should be preserved, if not expanded, so that more beneficiaries have access to better coordinated and enhanced benefits offered by MA plans. I sincerely hope my colleagues on both sides of the aisle will act thoughtfully to enact MA payment reforms that not only improve efficiency, but help place the program on solid footing for years to come.



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**Testimony of Daryl Weaver**  
**CEO, Yazoo Community Hospital**  
**National Rural Health Association**  
**Senate Finance Committee**  
**Hearing on Medicare Advantage Private Fee-For-Service Plans**  
**January 30, 2008**

On behalf of the National Rural Health Association (NRHA) and as administrator of a critical access hospital in Yazoo City, Mississippi, thank you for this opportunity to testify before the committee on the impact of Medicare Advantage (MA) plans, especially Private Fee-for-Service (PFFS) Plans, in rural America. The NRHA is a national, non-profit membership organization whose mission is to improve the health of rural Americans. The NRHA provides leadership on rural health issues through advocacy, communications, education and research.

Although my comments will specifically address the impact of MA plans on rural Mississippi, interaction with colleagues across the county support the existence of similar trends in many other markets. In discussing rural MA, we are almost exclusively talking about the rise of PFFS plans as this is where most of the enrollment growth has been over the last two years. Since December 2005, rural America has seen a 362 percent growth in MA enrollment. In December 2005, 18 percent of rural MA enrollees were in PFFS plans, today it is 62 percent (compared to 16 percent for urban beneficiaries). Rural beneficiaries enrolled in PFFS disproportionately outnumber their urban counterparts and often require greater chronic care. Rural Medicare beneficiaries deserve a Medicare plan that is sensitive to their needs and preserves the fragile rural health care safety net. This testimony focuses on the NRHA's concerns for MA expansion in rural areas across the nation and the NRHA's recommendations to Congress on how to best provide for the needs of our elderly populations in rural America. Our primary concern is payment equity and access to care in the Medicare system, especially in traditional Fee-for-Service and PFFS, where rural beneficiaries are most likely to enroll.

**INTRODUCTION**

The enactment of the Medicare Prescription Drug Improvement and Modernization Act of 2003 fundamentally changes Medicare in ways not yet fully understood by either the public or providers. Medicare Advantage (MA) is intended to fulfill the goals of (1) substantially increasing the number of Medicare beneficiaries enrolled in private health insurance, based on the premise believed by many policy makers that competition among these private health plans and between these plans and the traditional fee-for-service Medicare program will reduce federal spending; and (2) creating opportunities for beneficiaries to enroll in richer benefit packages than those available through traditional Medicare (sometimes with tradeoffs regarding choice of providers and drug formularies, and oftentimes at a higher cost than the cost of care under traditional Medicare fee-for-service). Policy makers may also believe, at least implicitly, that private health plans can be held accountable for healthy outcomes for enrollees, as measured against benchmarks established by the National Committee for Quality Assurance.

The focus of my testimony is to address MA implementation in regard to PFFS issues relevant to rural communities. It assumes that the federal policy of “privatizing” Medicare to create a competitive structure to cut costs will continue. It is left to others to argue the probability of MA taking permanent root in rural America, in a way its predecessor, Medicare+Choice, did not. This is a serious question. As of this month, only 10.1 percent of rural Medicare beneficiaries have joined an MA plan at a significantly higher cost to the federal budget. However, those that join MA plans in rural America are nearly four times more likely to join PFFS plans than their urban counterparts (62 percent of rural MA enrollees compared with 16 percent urban). We know from this is that if and as MA plans gain rural market share, the potential consequences to rural health from PFFS are significant and potentially quite negative.

Rural America cannot wait to fully understand what MA does or does not do. Problems have already been identified and they need to be resolved before the MA program becomes entrenched and less malleable. Congress must assure that MA is implemented and administered in a manner that is sensitive to the needs of rural communities. If not, the devastation to the rural health care infrastructure could take a generation or more to rebuild. Medicare beneficiaries should not be required to lose access to local services to obtain the promise of increased benefits.

#### **WHAT IS THE POTENTIAL DOWNSIDE OF MEDICARE ADVANTAGE IN RURAL COMMUNITIES?**

With MA, beneficiaries’ access to benefits and to local providers is determined by private sector health plan contracts with beneficiaries and with providers and only indirectly by Medicare. The spread of MA fundamentally changes how beneficiaries, providers, private health insurance plans and the Centers for Medicare and Medicaid Services (CMS) relate to and work with each other. As these relationships change, there is a real and significant risk to beneficiaries’ access to local care and to the ability of rural hospitals and doctors to provide local services. Medicare must continue to improve, but the fragility of our seniors and the rural health infrastructure demand something more than the haphazard approach observed to date.

Private Fee-for-Service (PFFS), unlike other MA plans, resembles traditional Medicare in that they do not include a care management component. Presently, PFFS plans are available in 96 percent of rural counties, and they are the most prevalent type of private Medicare plan in rural areas. There are two kinds of PFFS plans that are quite different. The first, the “non-network” model, allows PFFS plans to operate without a contracted network of providers, but these plans must pay all providers at rates that are “comparable to traditional Medicare rates.” For providers whose payments are “cost-based” under traditional Medicare, this provision appears to be being interpreted as the provider’s interim payment rate (without the usual year-end cost settlement). The second model, still rare, is a PFFS plan with a contracted network. Contracted or deemed providers in these plans may be paid at rates lower than traditional Medicare, if community access standards are met.

Under both PFFS models, providers can be “deemed” (for a particular plan enrollee for a particular visit or admission) to be PFFS plan providers. This means, without knowing it, the provider may have agreed to accept the plan’s terms and conditions, including the rate of payment. Three conditions must be met for a provider to be deemed a PFFS plan provider: (1) the provider must know that the patient is a member of a PFFS plan, (2) the provider must be aware of a PFFS plan’s terms and conditions, and (3) the provider must perform a covered service for the patient. As a deemed PFFS plan provider, a provider must accept, as payment in full, whatever rate that particular PFFS plan pays their

other contracted providers. Consider the practicality of this in terms of billing. It is not as though we can submit charges to traditional Medicare with a note that says “we didn’t know the patient was an MA beneficiary.” In addition, emergency room patients are of particular concern since they account for 80 percent of my facility’s admissions. This is serious flaw in the system and a grave concern for many rural providers since they are ethically, practically and legally required to provide services prior to determination of ability to pay. This will have the effect of reversing programs established by Congress, such as Critical Access Hospitals and Rural Health Clinics, which have helped to provide adequate payments and ensure access to care in rural communities. In addition, as “non-network” PFFS plans gain market share, it is reasonable to assume these plans will convert to the “network” PFFS model and become aggressive in negotiating rates below traditional Medicare payment rates and below the cost of care in rural communities.

Many rural facilities, especially Critical Access Hospitals in poorer areas of the county, function on a cash basis (i.e. the cash received this week is needed to make payroll or pay accounts payable next week). PFFS MA plans often require literally months of manual follow-up via multiple letters and phone calls to receive accurate payment for services rendered to beneficiaries. Sometimes these delays are due to poorly developed electronic or even manual billing systems in place at PFFS claims processing. Other times these delays appear to be intentional. On several occasions, I have had to personally intervene in these payment delays due to the absolute frustration of my billing staff. And, only after threatening to complain to the state insurance commissioner did we receive payment for services rendered as much as 12 months in arrears. Compare this to traditional Medicare under which my facility may routinely expect payment within 15 days of submission of a clean claim. Whatever the reason for the delays, at my facility, this has contributed to a 30 percent increase in accounts receivable representing almost \$1 million in unrealized cash. This has also required a 20 percent increase in business office staffing in addition to pulling additional resources from other staff including administration, nursing and case management or social work. It is also not at all uncommon to encounter retrospective denials for Swing bed admissions based on MA plan criteria as many of these plans require multiple certifications and recertifications throughout the patient stay as opposed to traditional Medicare which employs no such process.

The experience in my state of Mississippi mirrors the national trends. While, Mississippi lags behind the nation in enrollment in MA plans, 5.7 percent of all rural Medicare beneficiaries (6.8 percent statewide). The vast majority of this population is enrolled in PFFS plans. In fact, as of September, less than 300 people in rural Mississippi were enrolled in any other type of plan. While this population still represents a fraction of the overall Medicare population, the effects of MA plans are already being felt. In my own hospital, we counsel and assist confused and frustrated beneficiaries daily. Often these individuals have no comprehension that they opted out of traditional Medicare and are horrified to learn that the physician who has provided their primary care for most of their lives is not a participant in the PFFS plan they selected. It is not at all uncommon to encounter patients who have no idea that they have joined an MA plan. They simply thought they were signing up for Medicare drug benefits. Other times, beneficiaries are shocked to learn that the “low cost” plan they opted for will actually cost them sometimes twice as much in copays and deductibles as they would have paid for an acute stay under traditional Medicare. Add to this the fact that none of the physicians who admit to my facility accept Medicare Advantage plans nor do most of the home healthcare agencies to which we often discharge. This contributes to increased lengths of stay and cost to MA beneficiaries, yet often the plans refuse to reimburse for the added days of care.

In addition, last week the sole emergency medical services provider (EMS) to 23 Mississippi counties, in addition to counties in Kansas, Alabama, Georgia, Tennessee, Virginia and Florida, Emergystat, went out of business literally overnight. While there were many contributing factors, one of the points of uncertainty in our state was the lack of cash flow from MA plans. Again, these plans often pay much slower than traditional Medicare and as stated, provide a payment that is uncertain and often inaccurate for rural providers. Rural EMS is difficult to provide nationwide due to the high costs of transportation and training for relatively low volume. To have one company, which provided much of the rural EMS service to our state, go out of business is disastrous to our entire rural health care safety net. We must make sure that they are the anomaly and not the proverbial "canary in the coal mine." And, a canary in a coal mine is useless during a cave in.

MA has produced significant beneficiary confusion. Consumer choice is generally understood to be desirable, but too much choice, too much variation and a large number of contingencies make comparison shopping difficult, particularly for the elderly. The potential for confusion extends to the type of private plans and their relative merits in comparison to one other and to traditional Medicare. This leads to a concern regarding potential abuse of the system. Testimony at field hearings by the National Advisory Committee on Rural Health and Human Services cited significant confusion by the elderly, an issue that is not unique to rural beneficiaries. Recently, the HHS Office of the Inspector General announced that the Office is evaluating whether certain health insurers are coercing beneficiaries to enroll in an MA plan that would include prescription drug benefit (MA-PD) versus a stand-alone drug benefit program. Congress and CMS over the last year have spent a great deal of time working to rectify some of these problems so I will not detail them again at great length. In May 2007, then Mississippi Senator Trent Lott advised Mississippi beneficiaries to "stay on traditional Medicare plans." And, MS Deputy Insurance Commissioner, Lee Harrell testified before Congress on June 26, 2007 regarding "Abusive Medicare Advantage Sales Practices."

Enforcement of Community Access Standards is absolutely critical to prevent steering of Medicare beneficiaries and inordinate leverage by MA plans against rural providers. The MA program statutes and regulations require CMS to ensure that plan enrollees have reasonable local access to covered services. How CMS and MA plans interpret what is "reasonable" is critically important to rural beneficiaries and providers as well as to the acceptance of MA plans in rural communities. As stated in the CMS Medicare Managed Care Manual: "Plans must...ensure that services are geographically accessible and consistent with local community patterns of care." It is not yet known how or whether CMS is enforcing this provision with PFFS and RPO plans. Anecdotal evidence to date indicates enforcement is lax at best.

If beneficiaries enrolled in an MA plan are not well informed about their rights to access care locally, they are less likely to exercise that right. If CMS does not diligently monitor and enforce plan compliance, plans will have significantly less incentive to contract with a region's rural providers, undermining the rural health infrastructure in the affected communities. Plans could ultimately steer rural beneficiaries away from their local health care providers, forcing beneficiaries to leave their communities for care that is available locally. This loss of critical volume could lead to the closure of local facilities and loss of access to care for all beneficiaries in the community as well as all other local residents.

MA has the potential to destabilize the existing rural safety net. Whether or not MA plans will honor existing rural add-on payments for safety net providers is not known. All MA plans, except "non-network" model PFFS plans, are permitted to negotiate payment rates with providers at levels below

amounts the providers would receive under traditional fee-for-service Medicare. This is a process that seems to favor the MA plans, particularly in rural areas where providers may have little managed care contracting experience and little or no negotiating power such as in less remote areas where MA plans can threaten to steer patients to other contracted providers. In some rural areas, individual providers may be able to force fair negotiations because of isolation from other providers and therefore a position of strength vis-à-vis health plans needing to include them to meet access standards.

Most MA plans base payments on a percentage of the interim Medicare rate for Critical Access Hospitals. Unfortunately, as more beneficiaries move to MA plans, the shift in traditional Medicare percentage ratchets the interim payment rate down which in turn drives the MA payment rate down as well. So, logic dictates that as MA plans grow, and to the extent that MA payment rates are based on the interim rate for traditional Medicare, the downward spiral of payment will ultimately ratchet down to a level significantly below cost and place facilities in jeopardy.

Under traditional Medicare, many rural providers receive special payment rates to reflect the various financial challenges of providing health care in rural areas. These payments were factored into CMS' benchmarking process described below. Whether the MA plans will recognize these targeted rural special payments that have been part of traditional Medicare payments to rural providers is of concern. If not, the previously referenced Emergystat crisis from my state will not be the last.

The promise of additional benefits to beneficiaries from MA plans is unevenly distributed. The technical specifics of the MA bidding process create inequities in the availability of plans with reduced cost sharing or additional benefits in rural areas. The benchmarks used in the bidding process are based on historical Medicare fee-for-service payments at the county level, incorporating historical geographical variation in Medicare expenditures. In general, urban areas have higher physician-to-patient ratios, higher rates of utilization and consequently higher benchmark rates. The degree to which rural county level payment "floors" mitigate this issue is not known. Opportunities for additional savings and benefits should not be based on a system that primarily rewards areas that historically have excess utilization and provides minimal incentives to maintain reasonable utilization in those places where the amount of care provided is already close to appropriate levels, or in fact too low.

Traditional Medicare is not a safe harbor. If the past is a guide, economic incentives will provoke MA plans to expand by attracting healthier, lower-cost beneficiaries from traditional Medicare (based on the experiences of Medicare HMOs in the 1980s and 1990s). This would have a negative effect on the traditional Medicare program, leaving it with a disproportionate number of sicker and older patients. Traditional Medicare would be left burdened with higher costs, increasing the political pressure to reduce traditional Medicare's benefits and provider payments. The actual impact of enrollment in MA plans will be more complex than earlier managed care efforts because of provisions of the 2003 legislations that provided for full implementation of risk adjustment, use of corridors to protect plans from unpredicted risk associated with adverse selection, and enrollment in special needs plans that are marketed specifically for chronically ill beneficiaries (the number of such plans grew in 2006 and again in 2007). Nevertheless, the possibility remains that the earlier experience of favorable risk enrollment in MA plans could be repeated.

CMS needs to walk the transparency talk. CMS's Hospital Compare web site is based on the concept that it is good to make provider performance available to the public. Similarly, detailed data describing CMS and plan performance must be publicly available. Just one example: enrollment figures

for MA plans in rural communities were not made public until almost a year after MA plans began enrolling beneficiaries. How plans are managing the communication with beneficiaries around the key issue of access standards and how CMS is monitoring compliance to these standards is also unknown.

#### **RECOMMENDATIONS of the NRHA**

1. Ensure that rural providers receive equitable reimbursements in amounts no less than they would be paid by traditional Medicare. Legislation has been introduced to assure this. The Congress should pass this legislation so that Critical Access Hospitals and Rural Health Clinics among other providers are able to continue to serve rural America.
2. Payments to MA plans should not rely on a payment mechanism that rewards regions with high utilization at the expense of regions with lower utilization.
3. Make sure that the rural voice is represented with policy makers and that policy makers work more closely with rural communities.
  - Require CMS to engage with rural health experts regarding how best to determine and enforce rural community access standards consistent with individual communities' historic/present patterns of care. CMS must also engage with rural citizens about these standards by developing more user- friendly web sites, train more call center workers who understand the "older learner" and/or their (mature) children or friends who have questions.
  - Provide the Federal Office of Rural Health Policy, Health Resources and Services Administration with expanded authority to provide technical assistance and outreach on ways rural providers can collaborate in the review of MA contracts.
  - Ensure that the Medicare Payment Advisory Commission that statute says must have rural-urban "balance" achieves it by mandating proportional representation.
4. Require a much higher level of scrutiny and oversight of MA plans, especially PFFS.
  - CMS must take action to ensure that beneficiaries are given the information and support to allow them to make well-informed decisions, particularly for rural beneficiaries who typically have less experience with managed care.
  - CMS Regional Offices must regain their role as an access point for providers in their regions for definitive information and an ombudsman for dispute resolution with plans.
  - State insurance commissioners' offices should be encouraged to act as state level ombudsmen for rural beneficiaries enrolled with MA plans.
5. Require more transparency on the part of MA plans so that providers, policymakers and beneficiaries understand the choices and changes that have been made.
  - CMS needs to continue providing county or equivalent specific plan enrollment data and in a timely manner (quarterly over time).
  - A web site is needed for providers to verify beneficiaries' current plan enrollments.
  - The approval process of MA plans and amendments needs to be transparent, including web-based access to the details of the approved applications.

**CONCLUSION**

Medicare Advantage is still unfolding, with its full impact yet to be realized. The continued privatization of Medicare in rural America, even if only partially accomplished, will certainly transform the rural health landscape. It is imperative that (1) rural beneficiaries are ensured appropriate and ongoing access to local care, (2) rural beneficiaries have access to and receive the benefits equivalent to those offered by MA in urban communities, (3) payment rates are high enough to sustain a viable rural health system, and that (4) the relationship among beneficiaries, providers, plans and CMS be well integrated.

**SOURCES**

Numbers of enrollees in MA plans both urban and rural come from the RUPRI Center for Rural Health Policy Analysis, based on CMS data. Nationwide data is current as of January 2008 with state-level data current as of September 2007.

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*Clarion Ledger*, "Tax Commission Seizing Ala. AMS Firm's Property."

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March 5, 2008

The Honorable Max Baucus  
511 Hart Senate Office Building  
Washington, D.C. 20510

Dear Chairman Baucus,

Once again, I appreciated the opportunity to testify before the Committee during an oversight hearing on the topic of "Private Fee for Service Plans in Medicare Advantage: A Closer Look" on January 30, 2008. On behalf of the National Rural Health Association (NRHA), a national nonprofit membership organization with more than 18,000 members that provides leadership on rural health issues, I thank you both for your leadership in addressing the needs of our rural providers and seniors.

My letter today responds to the follow-up questions submitted to me on February 11, 2008. The questions and answers follow.

1. Senator Baucus – Both of you testified that PFFS plans are difficult to deal with – they often don't pay correctly or on time or will deny services normally covered by traditional Medicare. Despite these problems, do PFFS plans add value for your patients? If not, is there anything that can be done so PFFS plans add value for the beneficiaries and communities you serve?

**Obviously, some beneficiaries have found benefit from PFFS plans. As part of the overpayment, Congress mandated additional benefits. For the ten percent of rural beneficiaries nationwide that have chosen PFFS plans, this has done such things as help pay for their Prescription Drug coverage or glasses and eye care coverage. In this way, MA PFFS has provided additional benefits for rural some seniors. However, Congress must ask at what cost these benefits have come. With overpayments averaging nearly a fifth of the normal total expenditure per beneficiary in traditional Medicare, PFFS are an expensive way to add benefits to a small portion of the rural population.**

**The NRHA's primary concern with these overpayments is their effect on the access to care in the overall Medicare system, especially in Private Fee-for-Service where the majority of rural seniors are likely to enroll. As I stated throughout my testimony, if PFFS plans do not pay their fair share for rural coverage in a timely fashion, rural**



providers will have a difficult time keeping their doors open. This will be a disaster for the entire rural health landscape and no matter how many free pairs of glasses a PFFS plan provides, they will not be able to make up the loss of local care as one-by-one cash-starved rural providers cease to exist.

Overall, local care is the value that PFFS plans must respect for both beneficiaries and their communities. In my testimony I talked of PFFS beneficiaries that did not understand that they were enrolled in anything other than traditional Medicare plus a Prescription Drug plan. In addition, many of the PFFS beneficiaries we deal with in my hospital on a daily basis do not understand how their choice of a PFFS plan affects their ability to access local care. PFFS false claims that they will be accepted “wherever Medicare is accepted” have been well documented. What has been largely ignored is that PFFS plans do not necessarily allow even deemed providers to provide the equivalent access and quality locally when compared to traditional Medicare. For example, many seniors in my community are surprised to learn their “low cost” PFFS plan can end up costing them significantly more “out of pocket” for certain procedures and routine rural services such as swing beds because these are either not covered or a severely rationed under their plan. Sometimes, these beneficiaries find that they pay twice as much as traditional Medicare would have cost and may require trips out of the community just to receive their normal services.

If beneficiaries enrolled in an MA plan are not well informed about their rights to access care locally, which we do not believe they are, they are less likely to exercise these rights. Since it can be in the PFFS plans best interest not to inform enrollees of these rights, CMS must diligently monitor and enforce plan compliance and let beneficiaries know their rights. If this does not occur, plans will have significantly less incentive to acknowledge rural care like swing beds or to contract with a region’s rural providers, undermining the rural health infrastructure in the affected communities. Plans could ultimately steer rural beneficiaries away from their local health care providers, forcing beneficiaries to leave their communities for care that is available locally.

Congress should not find this acceptable. So even with extra benefits through PFFS plans, major changes are needed to make this a program that works for rural communities such as the ones outlined in my testimony.

3. Senator Kerry –

- a. Do you consider physician networks to be a fundamental component of a modern insurance plan?

I apologize, but I cannot answer this question fully. From the rural perspective, many communities consider themselves fortunate to have one primary care

physician, much less a network. Also, the term “network” can have many connotations and take many forms.

- b. Are there any instances – certain geographies or patient populations – where PFFS plans are more efficient for the Medicare program than traditional managed care products, such as HMOs and PPOs?

Considering the huge premium paid by CMS as incentives for PFFS plan writers, it would be almost impossible to imagine a situation in which PFFS is more efficient than the HMO/PPO models for CMS. Understandably, the insurance companies who stand to profit by writing PFFS plans contend they are more efficient and provide more value than other managed care products in the rural environment. Statistically, we know that only 16 percent of urban MA beneficiaries are enrolled in PFFS compared to 62 percent of rural MA beneficiaries. (These numbers grow even higher in the most rural of communities.) For an association that represents rural interests this is disconcerting. The past tells us that when urban and rural America have widely differing benefit packages and plan mechanisms, rural communities and beneficiaries will be at a severe disadvantage.

- c. What type of beneficiary – in terms of health and wealth status – is best served by a PFFS plan?

As I stated in my testimony, if the MA experience models the Medicare HMOs of the 1980s and 1990s, MA plans will expand by attracting healthier, lower-cost beneficiaries from traditional Medicare. This will have a negative effect on the traditional Medicare program, leaving it with a disproportionate number of sicker and older patients. This will burden it with higher costs, increased political pressure to reduce traditional Medicare’s benefits and provider payments, and misleading “evidence” that MA plans are cheaper. The evidence does not indicate this has yet happened. And, Congress in the MMA put provisions in place that provided for risk adjustment and other mechanisms to prevent this from occurring. Nevertheless, the possibility remains that the earlier experience of favorable risk enrollment in MA plans could be repeated to the detriment of the traditional Medicare system and the most needy beneficiaries.

11. Senator Salazar – Mr. Weaver, you bring an important perspective to this discussion, and I appreciate the opportunity to hear about the impact of PFFS plans in rural communities. As many on the Committee have heard me say before, I have mixed feelings on PFFS plans. On the one hand, the flexibility we have given these plans have allowed them to serve rural areas where beneficiaries have historically had little or no choice of Medicare plans. But as you have highlighted

here today, this flexibility can also cause problems for beneficiaries and providers who are dealing with these plans. In your view, is their potential to reform these plans so that they can continue to serve rural areas, or should we be looking elsewhere for options for beneficiaries in more remote communities?

**Yes, Senator Salazar, there is ample opportunity to reform these plans. The NRHA understands your concern about choice. I want to state clearly emphatically that we are not opposed to the idea of choice nor the concept of Medicare Advantage. We supported the creation of these plans and continue to support beneficiary choice for seniors. Yet, the idea of "choice" cannot be allowed to destroy the very safety net that rural seniors need in order to access care. It should not have to be an either-or decision for Congress. In my testimony, I highlighted a number of recommendations that would begin to address the concerns of our association. To respond to your question, I would just reiterate the following points:**

- 1. Rural providers must receive an appropriate reimbursement rate in amounts no less than they would be paid by traditional Medicare. This includes the cost-based reimbursement received by Critical Access Hospitals and Rural Health Clinics, the payment bonuses received by physicians in Physician Scarcity Areas and other rural payment provisions. Although not addressed per se in my testimony, it is imperative that utilization by MA beneficiaries be included and allowable in the Medicare cost reports for CAHs and other cost-based providers. Seemingly subtle and insignificant, the current policy of disallowing these costs artificially deflates the true cost of providing care to Medicare beneficiaries and can have a huge negative impact on reimbursement for CAH facilities in communities with high MA market penetration.**
- 2. An understanding of the rural delivery system is needed with PFFS plans. Delivery mechanisms such as swing beds need to be covered in full and plans should not force patients to be transferred to equivalent levels of care in a different setting as a cost saver.**
- 3. The rural voice is needed to be heard by policy makers so that they make sure that rural communities are not negatively impacted by programs such as Medicare Advantage. This includes requiring CMS to work with rural health experts, providing the Federal Office of Rural Health Policy (ORHP) expanded authority to work on Medicare Advantage, and ensuring that the Medicare Payment Advisory Commission has rural balance.**
- 4. Require a much higher level of scrutiny and oversight of MA plans, especially PFFS. This oversight is needed to help beneficiaries make informed choices, help rural communities assure that PFFS plans are not**

ignoring local access standards, and allow state insurance commissioners' offices, who understand their state, to serve as state-level ombudsmen.

5. Finally, rural providers may need assistance in reviewing MA plan contracts, especially for providers that do not have a large managed care presence in their community. Rural providers should be allowed to work together to review contracts and receive technical assistance from the ORHP to do so.

Addressing these concerns would go a long way to making PFFS plans work for rural providers and beneficiaries. These steps, in conjunction with addressing the issues of beneficiary confusion and predatory marketing practices, could make PFFS plans a powerful instrument to assure rural access to choice and also a tool to strengthen the rural health landscape. However, to do this, insurance companies may rightly point out that the current payment levels, already much higher than traditional Medicare, are inadequate. Congress will need to decide whether these changes and higher costs are more appropriate than other alternatives such as working to expand managed care MA plans to rural communities or expanding traditional Medicare benefits to what is hoped from MA plans.

Mr. Chairman and other distinguished members of the Committee, thank you for this opportunity to respond to your questions on PFFS plans in the rural context. If you are in need of further follow-up or clarification, please feel free to contact myself or Tim Fry, NRHA Government Affairs Manager (202-639-0550 or [fry@NRHArural.org](mailto:fry@NRHArural.org)).

Sincerely,



Daryl Weaver  
Administrator and CEO  
King's Daughters Hospital  
Yazoo City, MS

## COMMUNICATIONS

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### AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS



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**Statement by William Samuel, Director of Government Affairs, AFL-CIO  
on the Senate Finance Committee Hearing  
Private Fee for Service Plans in Medicare Advantage: A Closer Look  
January 30, 2008**

We applaud the Senate Finance Committee for examining the role of Private-Fee-For-Service plans in the Medicare program. These plans are the fastest growing and most costly plans under the Medicare Advantage (MA) program.

Although private plans were brought into Medicare with the promise of saving the program money, private-fee-for-service (PFFS) plans are paid, on average, 17 percent more than traditional Medicare – yet they have provided no evidence that they deliver better care through coordination. In fact, just this week, Congressional Budget Office Director Peter Orszag said MA plans and PFFS plans in particular have provided little data to demonstrate their success. But the substantial subsidies continue to flow.

Furthermore, the subsidies for these unproven plans threaten the fiscal health of the program, advancing Medicare's date of insolvency by two years. If these overpayments continue, Congress will be forced to make deep cuts or raise taxes just to keep up with the ballooning cost of paying the very plans that were meant to save money. And the vast majority of beneficiaries who remain in traditional Medicare – 80 percent of beneficiaries – are helping to subsidize these private plans through higher premiums.

While there are many improvements this committee can make in the oversight and marketing of PFFS plans, it is the substantial overpayments – and the financial gain to be made with rapidly growing enrollment – that are driving the problems that have been documented in the program.

We urge the committee to consider MedPAC's recommendation to establish financial neutrality between all private plans and the traditional program, beginning with the most costly and problematic of those plans, private-fee-for-service plans.

**Statement**  
**of the**  
**American Medical Association**  
**For the Record**  
**to the**  
**Committee on Finance**  
**United States Senate**

**RE: Private Fee for Service Plans in Medicare Advantage: A Closer Look**

**January 30, 2008**

The American Medical Association (AMA) appreciates the opportunity to provide our views regarding Medicare Advantage (MA) Private Fee-For-Service (PFFS) plans. We commend Chairman Baucus and Members of the Finance Committee for your leadership in recognizing the need to examine the impact of the PFFS plans on Medicare patients and physicians. In sum, the current PFFS program structure, marketing, implementation, and oversight have created confusion, undermined beneficiary access to care, and created additional administrative and financial burdens for beneficiaries and physician alike. Furthermore, the dramatic growth of PFFS has only served to deepen the attendant problems that this widespread confusion has generated while adversely impacting the long-term fiscal viability of the Medicare program.

PFFS plans are not delivering on the promise to provide access and significantly enhanced care to patients in exchange for enormous government subsidies. In an AMA survey, 2,202 physicians reported on their experience with PFFS plans. The results illuminate serious and ongoing problems with PFFS plans that are neither isolated nor limited, but are faced by a significant number of physicians and their patients. Even though PFFS plans receive 17 percent of regular Medicare, nearly half of the physicians who had patients in PFFS responded that the payment that they received from PFFS plans were below the regular Medicare rate. Equally troubling, 45 percent reported that they have experienced denial of services that are typically covered in the regular Medicare program. Contrary to the widely reported claim that MA plans provide more benefits to patients, physicians state that patients in PFFS plans may be getting even fewer benefits than they receive in regular Medicare.

Physicians are facing additional financial and administrative burdens in order to secure payment when accepting PFFS beneficiaries. According to the AMA survey, three out of five

physicians reported that they were not reimbursed in a timely or accurate fashion by MA plans. An important underpinning of robust competition is that it should promote streamlining of the administrative process, remove bureaucratic red tape, and enhance the efficient operation of health care delivery. The responses of the AMA surveyed physicians highlight the burdens that PFFS plans have placed on physician practices:

- Nearly six out of ten physicians indicated that they had experienced excessive hold times when attempting to contact the PFFS plans.
- Over half stated that PFFS plans have requested excessive or additional documentation for payment of claims.

These responses demonstrate that PFFS plans have not enhanced, but instead hampered operational efficiency on the front lines of health care delivery—physician offices—to the detriment of physicians and their patients.

The AMA survey also corroborated reports from patient advocacy groups and state insurance commissioners that PFFS plan representatives have either mislead, confused, or pressured beneficiaries in order to switch them to PFFS plans. An overwhelming number of physicians—eight out of ten—who treated PFFS plan patients stated that their patients have difficulty understanding how their PFFS plan works. Providing patients with options is important, but patients must be provided accurate and salient information in order to make choices that promote their best interest. PFFS plans have failed in their obligation to provide patients with basic information in an accessible and comprehensible fashion. This failure has real consequences for seniors who may have their health care services interrupted or incur significant unanticipated costs when they are least able to afford them.

PFFS plan representatives have signed-up patients for plans that will end up costing the beneficiary more out-of-pocket expenses (relative to regular Medicare) and misleading patients regarding which physicians accept the PFFS plans. Reportedly, many PFFS plans were marketing themselves as providing patients the “freedom” to choose any provider that accepts Medicare. As a result, regular Medicare patients signed-up for PFFS with the expectation that they would be able to continue receiving their health care from their physician. Although CMS allows patients who have been misled to drop the PFFS plan and re-enroll in regular Medicare and supplemental Medigap plan, this is a difficult, time-consuming process and can impact the delivery of health care services.

The AMA urges Congress to mandate that before finalizing an enrollment decision, PFFS plans counsel patients to contact their physicians to determine if the physician accepts the PFFS plan. Furthermore, in all instances PFFS marketing agents should be required to provide detailed information in a comprehensible format concerning the plan’s coverage policies as well as the beneficiary’s potential responsibility for co-pays and deductibles as compared to the beneficiary’s existing coverage. The AMA also strongly urges Congress to mandate a minimum seven-day period during which beneficiaries may cancel their PFFS enrollment and revert back to their prior coverage, including supplemental plans, without penalty. In addition, the current and proposed CMS mandated Disclaimer Language for MA

policies remains inadequate and the AMA urges Congress to direct CMS to require that all MA plans utilize the following Disclaimer Language:

THIS COVERAGE IS NOT TRADITIONAL MEDICARE. YOU HAVE CHOSEN TO CANCEL YOUR TRADITIONAL MEDICARE COVERAGE; NOT ALL PHYSICIANS, HOSPITALS AND LABORATORIES ACCEPT THIS NEW MEDICARE ADVANTAGE POLICY AND YOU MAY PERMANENTLY LOSE THE ABILITY TO PURCHASE MEDIGAP SECONDARY INSURANCE. YOU ARE STRONGLY URGED TO CONTACT YOUR PHYSICIAN(S) TO DETERMINE WHETHER THEY WILL ACCEPT THIS PLAN BEFORE CHANGING YOUR EXISTING COVERAGE.

The foregoing are actions that would ameliorate some of the adverse consequences to seniors of abusive PFFS plan practices—many who are ill-equipped to deal with the overwhelming flood of information and high pressure sales tactics.

Detailed information about PFFS plans is also inaccessible to physicians. In the AMA survey, over half of the physicians treating PFFS patients stated that they did not have access to or knowledge of the PFFS plans' Terms and Conditions. This alone is cause for a serious examination of PFFS plans as ready access to Terms and Conditions of payment and coverage is a cornerstone of the PFFS plan concept. (If physicians—who are more likely than their patients to have access to resources to secure such information—are experiencing significant difficulty in obtaining this basic information, the hurdles faced by patients—the most vulnerable in particular—should be obvious.) Lack of access to essential PFFS plan Terms and Conditions is compounded by ineffective outreach and provider education by PFFS plans.

The failure of PFFS plans to provide essential information is exacerbated by the practice of physician deeming. PFFS plans “deem” a physician (for a particular plan enrollee for a particular visit or admission) without having ever entered into contract negotiations. In practice, it is not uncommon that physicians do not actually know that their patient is a member of a PFFS plan nor does the patient until the patient has arrived for their appointment. The ability of PFFS plans to deem physicians undermines any incentive for PFFS plans to cease employing the very practices that result in confusion, interruption to care, and the rapid multiplication in administrative burdens as these plans proliferate. We urge Congress to bring an immediate end to physician deeming.

Although the insurance industry has issued reports touting the benefits of the MA program to rural beneficiaries, reports from rural providers and patient advocates do not support these assertions. As the National Rural Health Association (NHRA) testified before this Committee as well as to the House Ways and Means Health Subcommittee, if PFFS plans are left on their current course, these plans have the “potential to destabilize the existing rural safety net.” For example, NHRA testified previously that there was an open question as to whether PFFS plans will honor existing rural add-on payments that safety net providers receive under regular Medicare. A Texas nurse wrote to the AMA about her experience as the practice manager of a rural health clinic (RHC). She stated that the RHC received a per visit rate from regular



Medicare of \$68.13—this amount covers everything provided by the RHC and all codes. However, an administrative and financial nightmare has ensued because while PFFS plans have informed patients that they can see any physician in the clinic, some of the plans have been unwilling to pay the RHC at the higher rates that it is entitled to receive because it serves a rural community. In fact, the nurse manager wrote that one PFFS plan is paying a rate that is less than half the clinic's RHC rate under regular Medicare. Far from increasing access to rural beneficiaries, MA plans could well result in fewer rural physicians being able to accept Medicare patients. As these plans grow, the need to address the shortcomings in the PFFS program become ever more urgent particularly for patients and physicians in rural America.

PFFS plans end up costing all Medicare patients including those in PFFS plans more. The Medicare Payment Advisory Commission (MedPAC) has estimated that on average every Medicare beneficiary pays approximately \$2.00 per month extra to finance the higher payments that only benefit a subset of beneficiaries. Equally troubling, PFFS patients who experience a significant health event are subjected to a heightened risk that they will incur higher, unexpected, out-of-pocket costs if they are hospitalized or placed into a nursing home. It has been reported that a number of PFFS plans offer low premiums to attract beneficiaries, but require substantial co-payments. A beneficiary who is hospitalized for a week would be liable for thousands of dollars in out-of-pocket costs. When patients have regular Medicare and a supplemental Medigap plan, their out-of-pocket expenses would be substantially less in many cases. MedPAC and the Medicare Rights Center have reported that MA plans have higher cost-sharing for "nondiscretionary" services such as chemotherapy. PFFS patients who develop cancer could find the 20 percent cost-sharing for their chemotherapy drugs to be a significant financial burden, whereas the supplemental coverage that even American Health Insurance Plans (AHIP) says is most common among low- and moderate-income rural patients, would have covered the cost-sharing for chemotherapy drugs. These are the consequences beneficiaries face as a result of high pressure and deceptive sales tactics.

While the AMA continues to be a strong proponent of greater competition in the Medicare program to help strengthen patient choice and the program's long-term financial sustainability, the experience of physicians and patients clearly indicate that PFFS plans do neither. Rather than induce competition, the 17 percent subsidy paid to PFFS plans has hastened the insolvency of the Medicare program by rewarding inefficient behavior by the private plans. The budgetary burden of PFFS will be exacerbated as a direct result of the rapid proliferation of PFFS plan offerings and the sharp rise in enrollment. In 2006, payments to PFFS totaled approximately \$5 billion, subsequently increased to \$13 billion in 2007, and are projected to reach \$59 billion in 2017. The explosive rates of enrollment and the large disparity in payment between PFFS plans and regular Medicare are not fiscally sustainable.

There are real tradeoffs involved in the public policy choices that Congress currently faces. An average 17 percent add-on payment is being provided to PFFS plans, while the physicians who care for the 81 percent of Medicare beneficiaries face a cut of 10.6 percent on July 1, 2008. The CBO and the Medicare Actuary have noted that Medicare cost growth is now projected to rise even more rapidly as a result of the rapid growth in PFFS plans which receive a 17 percent average subsidy. We urge Congress to establish fiscal parity in the

Medicare program instead of making extra payments to PFFS plans that drive Medicare faster toward insolvency.

The AMA joins the chorus of health care stakeholders, including the AARP and the Medicare Rights Center, advocating for financial neutrality between the regular Medicare program and PFFS plans as well as for systematic reform to the PFFS program. The AMA concurs with MedPAC that “the Medicare program should pay the same amount, adjusting for the risk status of each beneficiary, regardless of which Medicare option a beneficiary chooses.” However, fiscal neutrality is not enough. The AMA is committed to the goal articulated by the MedPAC of “ensuring that providers are paid fairly and beneficiaries have access to the care they need.” In addition to leveling the playing field between regular Medicare and PFFS plans, the AMA urges Congress to implement changes to protect beneficiary choice and access to care and reduce the administrative and financial burdens that both physicians and patients have shouldered as PFFS plans have grown unchecked.

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The AMA appreciates the opportunity to provide our views to the Finance Committee concerning PFFS plans. We look forward to working with the Committee and Congress to preserve patient access to health care and to find solutions to address the long-term financial sustainability of the Medicare program.

**NCPSSM National Committee to Preserve  
Social Security and Medicare**

*Barbara B. Kennelly  
President & CEO*

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**Testimony for the Record  
Barbara B. Kennelly, President and CEO  
National Committee to Preserve Social Security and Medicare**

**United States Senate  
Committee on Finance  
Hearing on "Private Fee for Service Plans in  
Medicare Advantage: A Closer Look"**

**January 30, 2008**

Mr. Chairman and Members of the Committee:

I am Barbara Kennelly, President and Chief Executive Officer of the National Committee to Preserve Social Security and Medicare, and I appreciate the opportunity to submit this statement for the record. With millions of members and supporters across America, the National Committee is a grassroots advocacy and education organization devoted to preserving and promoting the financial security and health of maturing Americans.

Over the coming weeks, Congress and the American public will hear many experts talk about the strains that growing health care costs place on our nation's budget. Part of this discussion will occur due to a provision in the *Medicare Modernization Act of 2003* that placed an arbitrary cap on the use of general revenue financing for Medicare. This cap, which was triggered with the release of the last Trustees report, requires the President to submit and Congress to consider proposals to reduce Medicare spending this year. The primary purpose of this cap was to make it easier for Congress to enact cuts in Medicare. This singling out of the program comes despite the fact that Medicare spending is rising for the same reasons health care costs are skyrocketing for workers and their employers.

It is impossible to effectively slow Medicare spending without addressing the problems plaguing our nation's health care system. However, I do believe there are some steps that we can take to more efficiently spend Medicare's precious dollars. One particularly egregious example of Medicare overspending occurs in the Medicare Advantage program. Private health plans, now called Medicare Advantage plans, were first allowed to participate in Medicare because policymakers believed they could provide better services at a lower cost than traditional Medicare. In fact, because it was anticipated private plans would be so efficient, the government initially paid them five percent less for each beneficiary they enrolled than it would have cost to cover that same beneficiary in traditional Medicare.

Medicare now pays private plans significantly *more* than it would cost to cover the same beneficiaries through traditional fee-for-service Medicare. Today the government pays an average of 13 percent more to cover a beneficiary in a private Medicare Advantage plan than it would cost to cover *that same beneficiary* in traditional Medicare. In simple dollar terms, Medicare pays about \$1,000 more a year to cover a beneficiary in a private plan than it would cost to provide care to that same beneficiary under traditional Medicare.

All beneficiaries, whether they enroll in a private plan or not, subsidize payments to private companies by paying higher Part B premiums. Today, these premiums are almost \$50 per year higher per couple than they would be absent the subsidies to private plans. This number will continue to grow exponentially in future years. These increases are in addition to the record-setting increases in Part B premiums beneficiaries have already experienced – and which are expected to continue – as a result of increases in the cost of health care.

In addition to adding costs for individual beneficiaries, subsidies to Medicare Advantage plans result in higher costs to the federal government. Medicare's actuaries estimate that eliminating these subsidies would add two years of solvency to Medicare's hospital insurance trust fund. According to the Congressional Budget Office (CBO), paying private plans at the same rate as traditional Medicare would save \$54 billion over the next five years and \$149 billion over the next ten years.

For all of these reasons, I support the Medicare Payment Advisory Commission's (MedPAC) recommendation that payment policy should be built on a foundation of financial neutrality between payments in the traditional fee-for-service program and payments to private plans. We should be using taxpayer dollars to promote efficiency and quality in Medicare, instead of bestowing unwarranted subsidies on inefficient private plans that serve a fraction of Medicare beneficiaries.

Mr. Chairman, today's hearing focuses on Private Fee-For-Service (PFFS) plans, which are the most highly subsidized type of Medicare Advantage plan. On average, the government pays PFFS plans 17 percent more than would be paid per beneficiary under traditional Medicare coverage. And according to MedPAC, half of the subsidy to PFFS plans goes to administrative costs, marketing and profits, rather than to additional benefits for beneficiaries.

The excessive subsidies to PFFS plans are driving enrollment in Medicare Advantage to historically high levels despite the absence of any hard evidence they are providing better care than traditional Medicare. Currently about 20 percent of all Medicare beneficiaries (or nine million people) are enrolled in Medicare Advantage plans. The CBO projects that enrollment in Medicare Advantage will grow at an annual average rate of about seven percent over the next 10 years—reaching 26 percent of total enrollment by 2017. PFFS plans have experienced substantial growth under the Medicare Advantage program. At the end of 2005, only 200,000 beneficiaries were enrolled in PFFS plans. Currently, there are over 1.9 million beneficiaries enrolled in PFFS plans. And the CBO projects

that by 2017, there will be over five million beneficiaries (one-third of all Medicare Advantage enrollees) enrolled in PFFS plans.

Despite receiving these excessive subsidies, PFFS are inefficient and largely unregulated by the government. For example, PFFS plans are purposefully enrolling beneficiaries in areas where they can receive the highest payment benchmarks from the Centers for Medicare and Medicaid Services (CMS). And although they are the highest paid type of Medicare Advantage plan, PFFS plans do not have to coordinate care, provide prescription drug coverage, or collect data on quality of care. PFFS plans are also exempt from CMS review and monitoring requirements that apply to other MA plans.

The insurance industry makes the dubious claim that PFFS plans can serve Medicare beneficiaries all over the country. A beneficiary is able to see any provider that is willing to accept the plans terms of payment. However, since PFFS plans are not required to build networks of physicians, hospitals and other providers, many beneficiaries are experiencing difficulties finding doctors and hospitals that will treat them. I have heard countless stories from our members and supporters across the country who have been denied access to doctors because they were enrolled in a PFFS plan.

Many of our members who are Michigan public school retirees have experienced problems with their PFFS plan when they retired to another state. Two of our members, a married couple aged 90 and 87, live in Florida and are unable to find a general practitioner in the area who will accept their PFFS plan. They are unable to use their health care plan because they cannot drive far distances to find a physician who will accept it. Another one of our members retired to North Carolina and is unable to find any physicians who will accept her PFFS plan. As a result, she has forgone some medical tests because she cannot afford the out-of-pocket costs.

Unfortunately, the experiences of National Committee members are not unique, and the plans in which beneficiaries are experiencing the most difficulty are also the most excessively subsidized and least regulated. Mr. Chairman, on behalf of the members and supporters of the National Committee to Preserve Social Security and Medicare, I encourage the Senate to level the playing field and remove the unfair advantage of PFFS plans. Instead of being paid more than traditional Medicare, PFFS plans should be paid at a rate equal to the costs of traditional Medicare in every part of country. In addition, the Senate should also establish additional monitoring requirements for PFFS plans and require them to build a network of providers, similar to the requirements expected of other Medicare Advantage plans.

Mr. Chairman, thank you for holding this hearing today. As you know, the vast majority of Medicare beneficiaries remain in the traditional program. In a time of budgetary challenges, we cannot continue to reward inefficient and inferior plans with taxpayer and beneficiary-funded subsidies. I look forward to working with you and other members of this committee to restrain excessive spending in the Medicare Advantage program and to ensure that traditional Medicare is preserved for generations to come.