NATIONAL HEALTH POLICY FORUM

Forum Session
Meeting Announcement

Friday, April 11, 2008
8:45–9:15am — Breakfast
9:15–10:45am — Session

Employer Use of Medicare Private Fee-for-Service Plans as a Retiree Health Benefit

A Discussion Featuring:

Mark E. Miller, PhD
Executive Director
Medicare Payment Advisory Commission

Abby L. Block
Director, Center for Beneficiary Choices
Centers for Medicare & Medicaid Services

Lawrence Becker
Director, Benefits
Xerox Corporation

Location

Reserve Officers Association of the United States
One Constitution Avenue, NE
Congressional Hall of Honor
Fifth Floor
(Across from the Dirksen Senate Office Building)

Registration Required

Space is limited. Please respond as soon as possible.

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THE GEORGE WASHINGTON UNIVERSITY
WASHINGTON DC

Employer Use of Medicare Private Fee-for-Service Plans as a Retiree Health Benefit

OVERVIEW

Medicare private fee-for-service (PFFS) plans are Medicare Advantage (MA) plans that are similar in design to traditional Medicare and commercially available fee-for-service plans. Enrollment in PFFS plans has increased substantially in recent years. Employer interest in offering PFFS plans to retirees has also increased, in part because the plans can be less expensive and easy to manage, and because PFFS plans are available nationwide. This Forum session will explore why PFFS plans are an attractive option to many employers and retirees; whether Medicare is paying too much for them (and giving employers a great deal at Medicare's expense); and the potential impact on employers and retirees if Congress lowers payments to MA plans, including PFFS.

SESSION

PFFS plans were created in the Balanced Budget Act of 1997 (BBA) in order to expand MA options, particularly in some rural areas that had not experienced any significant MA plan penetration. Although PFFS plans are MA plans, they more closely resemble fee-for-service Medicare than other types of MA plans. The most important similarity is that PFFS plans do not contract with networks of physicians and other providers; enrollees are permitted to select any provider willing to accept payment (usually Medicare payment rates) and other terms of the PFFS plan. Ideally, enrollees would be able to choose among a full range of providers and would not be limited in choice by customary managed care networks. In addition, PFFS plans can offer nationwide benefit packages and premiums. Several large insurers, including Advantra Freedom, Aetna, Humana, and UnitedHealthcare, offer PFFS plans.

PFFS plans have become an increasingly popular option for beneficiaries. While the majority of Medicare beneficiaries have a more traditional managed care product such as an HMO (health maintenance organization) or PPO (preferred provider organization) available to them in 2008 (85 to 87 percent, depending on the type of plan), virtually all beneficiaries have a PFFS plan available to them.[1] About 20 percent (nearly 9 million) of Medicare beneficiaries were enrolled in a Medicare Advantage plan as of November 2007.[2] Although PFFS plans accounted for only 1.7 million of those beneficiaries, enrollment in these plans has grown surprisingly fast. Between November 2006 and November 2007, enrollment in PFFS plans

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doubled.[3] Part of this growth in enrollment is attributable to the interest employers have shown in offering PFFS plans to their retirees.[4]

PFFS plans are an attractive option among employers for their retirees for a number of reasons. First, employers can offer one seamless benefit plan. That is, employers can offer a single national PFFS plan option that has the same benefit package and premium for all their retirees. In contrast, other MA plans are offered at a state or local level, and benefit packages and premiums vary across geographic areas. With PFFS, employers can contract with one plan that is accessible to all its retirees regardless of where they live, making the plans easy for the employer to administer. In addition, PFFS plans may offer extra benefits, such as care coordination in a FFS environment. Employers can offer to pay some or all of a Medicare PFFS plan premium and cost sharing instead of paying for coverage that wraps around traditional fee-for-service Medicare coverage; this is often a less expensive alternative than paying for wrap-around coverage. Further, PFFS plans, which are not required to contract with a network of providers, can in theory offer access to any provider willing to accept their payment terms. Finally, PFFS gives employers an MA option in some rural areas where HMO or PPO plans may not be available, a goal of the original legislation.

Despite some potentially very positive attributes, PFFS plans have been controversial for several reasons. On average, PFFS plans cost Medicare more than most other MA options, and significantly more than traditional Medicare FFS. According to the Medicare Payment Advisory Commission (MedPAC), Medicare payments to PFFS plans were 17 percent higher for a typical beneficiary than if the beneficiary remained in traditional Medicare and higher than if the beneficiary were enrolled in most other MA options.[5] At a time when long-term financing of Medicare is not stable, many question the policy rationale for maintaining the current payment differential. In addition, some question the value of the extra benefits being offered by PFFS plans. MedPAC indicates that one outcome of the way Medicare pays PFFS plans is that they can offer extra benefits without being any more efficient than fee-for-service Medicare.[6] Moreover, a recent study indicates that a typical beneficiary enrolled in a PFFS plan was offered less in extra benefits than other types of MA plans (HMOs and PPOs) in 2006.[7]

Concerns have also been raised about protecting beneficiaries in PFFS. Some contend that access to providers is uncertain under PFFS because not all providers are willing to accept the terms and conditions—including payment—of PFFS plans. In addition, PFFS plans are not subject to the same rules and oversight provisions as other MA plans. There are no requirements that PFFS plans conduct activities common among MA plans, including coordinating care, conducting utilization review, or reporting measures of quality to CMS or the public. While that may make plans easier to administer for both plans and employers, some argue that policymakers have fewer options in their toolbox when it comes to beneficiary protection and oversight.

Congress has considered changes to the MA program, including reducing payments to PFFS plans. If lower Medicare payments result in some PFFS plans exiting the Medicare market, there could be financial impacts on employers that have adopted PFFS plans. These employers include several state governments, such as Kentucky, Michigan, Pennsylvania (effective May 1, 2008), and West Virginia, that offer PFFS plans to their Medicare-eligible retirees. While the potential effects on employers likely will not be the sole determinant of policy direction, these effects may need to be considered as payment and other policy changes are weighed by Congress.

KEY QUESTIONS

- What are the factors making Medicare PFFS plans a more attractive option than traditional Medicare Advantage plans for employers to offer their retirees? What are the drawbacks to employers offering PFFS plans?
- What makes Medicare PFFS plans attractive to beneficiaries, particularly those enrolled through a former employer? What are the drawbacks for beneficiaries of the PFFS option?
- Are employers getting an overly generous subsidy from Medicare by offering PFFS plans? Are employers shifting more of the cost of retiree health care onto Medicare?
- Is Medicare paying more for PFFS plans, and are beneficiaries getting less in benefits?
- If Congress reduces payments to Medicare Advantage plans, including PFFS plans, would PFFS plans continue to be offered? What would the effect be on employers' desire to offer PFFS options?
- Should federal policymakers consider the financial effects on employers and states of reducing Medicare payments to PFFS plans?

SPEAKERS

Mark Miller is executive director of the Medicare Payment Advisory Commission (MedPAC). Prior to MedPAC, Dr. Miller served at the Congressional Budget Office (CBO), where he was assistant director of the Health and Human Resources Division. Before joining CBO, Dr. Miller was deputy director of Health Plans at the Centers for Medicare & Medicaid Services (CMS, formerly the Health Care Financing Administration), responsible for Medicare private plan policy and operations, quality standards, demonstrations, and beneficiary education. He was previously chief of the Health Financing Branch at the Office of Management and Budget, where his responsibilities included budget and policy analysis related to Medicare, Medicaid, the State Children's Health Insurance Program, private health insurance, and CMS's discretionary budget. Earlier, Dr. Miller

was a senior research associate at the Urban Institute, where he wrote and published on such issues as Medicare hospital and physician payment systems, geographic variation in the use of health services, beneficiary access to Medicare, and Medicaid managed care. Dr. Miller holds a PhD degree in public policy analysis from the State University of New York at Binghamton.

Abby L. Block is director of the Center for Beneficiary Choices at the Centers for Medicare & Medicaid Services (CMS), where she directs Medicare Advantage and prescription drug benefit activities. Before assuming this role in 2005, she served as senior advisor to the CMS Administrator, playing a lead role in implementing the Medicare drug benefit and Medicare Advantage provisions of the Medicare Modernization Act (2003). Prior to joining CMS, Ms. Block was deputy associate director at the U.S. Office of Personnel Management (OPM), responsible for both policy development and contract administration for the Federal Employees Health Benefits (FEHB) Program and the Federal Employees' Group Life Insurance (FEGLI) program. She also played a key role in the development and implementation of the Federal Long-Term Care Insurance Program and the Flexible Spending Account Program for federal employees. Ms. Block came to OPM as a presidential management intern in 1979. She has MA, MSW, and MBA degrees from Columbia University.

Lawrence Becker is director, benefits for Xerox Corporation. He was named to this position February 2000. In this capacity, Mr. Becker is responsible for all health and welfare plans at Xerox, as well as defined benefit plans. Mr. Becker joined Xerox Corporation in 1990 and has served in several capacities in benefits, compensation, technology, and operations. Prior to joining Xerox, he held positions at Baltimore Bancorp, Formica Corporation, Exxon Corporation, and American Can Company in a variety of benefits, compensation, operations, and industrial relations roles. Mr. Becker is currently a member of the Executive Board of ERIC (ERISA Industry Committee) and a member of the Board of Directors and the Finance Committee of the National Quality Forum, and he serves on the NQF Steering Committee on priorities, goals, and metrics. In addition, Mr. Becker is a member of the HHS Quality Alliance Steering Committee Expansion Workgroup as well as a member of the Vision Workgroup. He also serves on the National Business Group on Health Public Policy Committee. In his local community, he is on the Board of Directors of the Greater Rochester Health Information Operation (RHIO). Mr. Becker received a bachelor of science degree from Cornell University's Industrial and Labor Relations School.

ENDNOTES

1. Medicare Payment Advisory Commission (MedPAC), *Report to Congress: Medicare Payment Policy*, table 3-2, March 2008, p. 245; available at www.medpac.gov/documents/Mar08_EntireReport.pdf.

2. MedPAC, *Report to Congress*, table 3-1, p. 244.

3. MedPAC, *Report to Congress*, table 3-1, p. 244.

4. While all beneficiaries have access to a PFFS plan through Medicare, only some employers offer it as a sponsored option under a retiree health benefits plan.

5. MedPAC, *Report to Congress*, table 3-3, p. 247.

6. Mark E. Miller, MedPAC, "Private Fee-for-Service Plans in Medicare Advantage," testimony before the Committee on Finance, U.S. Senate, January 30, 2008, p. 9; available at www.medpac.gov/documents/MedPAC_Jan08_testimony_PFFS.pdf.

7. Mark Merlis, "The Value of Extra Benefits Offered by Medicare Advantage Plans in 2006," Kaiser Family Foundation, January 2008, p. 1; available at www.kff.org/medicare/7744.cfm.