

## **MEDICARE ADVANTAGE PRIVATE FEE-FOR-SERVICE (PFFS) PLANS: A PRIMER FOR ADVOCATES<sup>1</sup>**

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### **INTRODUCTION**

Medicare Part C, the Medicare Advantage (MA) program, describes a number of private plan options for the delivery of Medicare-covered services to beneficiaries who choose to enroll in one of these plans.<sup>2</sup> The fastest growing of these options are private fee-for-service (PFFS) plans.<sup>3</sup> According to a recent Kaiser Family Foundation Report, 100 percent of Medicare beneficiaries in both rural and urban counties have access to at least one PFFS plan, while 95 percent of all Medicare beneficiaries have access to other Medicare Advantage options.<sup>4</sup>

PFFS plans have been touted by health insurance organizations as providing Medicare beneficiaries with all the services of traditional Medicare – and sometimes more – with fewer limitations than other MA plans impose on the doctors and hospitals beneficiaries can use.<sup>5</sup> These claims are incomplete and misleading. It is true that PFFS plans, like all MA plans, are required by law to provide all medically necessary health care services covered by Parts A and B. And PFFS plans do not restrict beneficiaries to a network of providers but allow enrollees to go to any Medicare-eligible doctor or hospital in the United States that is willing to provide care and accepts the plan's terms of payment.

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<sup>2</sup> 42 U.S.C. §§1395w-21 et seq. The options include coordinated care plans such as Health Maintenance Organizations (HMOs) and preferred provided organizations (PPOs), private fee-for service (PFFS) plans, and Medicare Savings Accounts (MSAs).

<sup>3</sup> See “Tracking Medicare Health and Prescription Drug Plans Report,” Kaiser Family Foundation, [http://www.kff.org/medicare/advantage/trackingreport\\_current.cfm](http://www.kff.org/medicare/advantage/trackingreport_current.cfm).

<sup>4</sup> “An Examination of Medicare Private Fee-For-Service Plans,” Kaiser Family Foundation, pp. 7-8 (March 2007) (hereinafter “Kaiser Examination 2007”).

<sup>5</sup> See comments of Gary Jacobs, senior vice president of Universal American Financial Corporation, which operates PFFS plans, in “Medicare Policy Workshop on the Rise of Private Fee-For-Service Plans,” Kaiser Family Foundation, pp. 25-26 (March 16, 2007), [http://www.kaisernetwork.org/health\\_cast/hcast\\_index.cfm?display=detail&hc=2076](http://www.kaisernetwork.org/health_cast/hcast_index.cfm?display=detail&hc=2076).

However, Medicare-participating providers are permitted to refuse to treat PFFS enrollees, so beneficiaries' access to services may not be as broad as the plans assert. In fact, a recent study found that PFFS enrollees have experienced difficulty finding doctors who will treat them.<sup>6</sup> Moreover, whether a PFFS plan offers services identical to those provided under traditional Medicare or covers additional services as well, there is no limit on the premium the plan can charge beneficiaries in addition to the Part B premium. Although PFFS plans typically adopt Medicare billing practices, a PFFS plan enrollee could potentially pay much more than a traditional Medicare or MA coordinated care enrollee for identical services (and without the benefits of coordination of care present in the latter case). In addition, the PFFS plan is permitted to charge deductible, co-payment and co-insurance amounts different from those under Medicare and charge a premium for "extra" benefits, including prescription drugs.

PFFS plans are also exempt from patient-protective statutory and regulatory standards that apply to other MA plans. PFFS plans do not have to pay Medicare standard rates to providers; secure agreements with a minimum number of providers in an area to ensure beneficiary access to care; establish a program to improve the quality of care provided to enrollees; undergo Centers for Medicare & Medicaid Services' (CMS)  review or negotiation of rates and premiums; offer prescription drug coverage; submit negotiated drug prices to CMS; require pharmacies dispensing covered drugs to inform enrollees of the lowest-priced generic bioequivalent; or establish a drug utilization management program or medication therapy management program (MTMP) to reduce the risk of adverse events.

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<sup>6</sup> D. Lipschutz, P. Precht, B. Burns, "After the Goldrush: The Marketing of Medicare Advantage and Part D Plans," California Health Advocates and the Medicare Rights Center, (January 2007), p. 7, <http://www.cahealthadvocates.org/pdf/advocacy/2007/CHA-MRC-Brief-AfterTheGoldrush-2007-01.pdf> (hereinafter "Goldrush"). Doctors, in turn, have reported frustration with PFFS plans because the plans can reimburse doctors at a lower rate than Medicare standard rates, which may help explain providers' reluctance to accept PFFS enrollees as patients.

This report provides an in-depth examination of the statutory requirements and regulations related to PFFS plans. The report also contrasts the various beneficiary cost-sharing requirements of major PFFS plans in three states with the cost-sharing requirements of traditional Medicare (with and without a supplemental Medigap policy).

## **WHAT IS AN MA PFFS PLAN?**

A PFFS plan is an MA plan that:

- (A) reimburses hospitals, physicians, and other providers at a rate determined by the plan on a fee-for-service basis without placing the provider at financial risk;
- (B) does not vary provider reimbursement rates based on utilization relating to the providers; 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.<sup>7</sup>

In 2004, CMS, the federal agency responsible for administering Medicare, published a booklet, *Your Guide to Private Fee-for-Service Plans*, to describe PFFS plans to beneficiaries who may be interested in enrolling in one.<sup>8</sup> The booklet explains that Medicare pays a set amount of money every month to the private insurance company sponsoring the PFFS plan to provide health care coverage to people with Medicare on a pay-per-service arrangement. PFFS plans must cover all services covered under Medicare Parts A and B, but they may charge a monthly premium greater than, and in addition to, the Part B premium. PFFS plans can also charge deductible and co-insurance amounts that are different from those under the traditional

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<sup>7</sup> 42 U.S.C.A. §1395w-28(b)(2); 42 C.F.R. §422.4(a)(3).

<sup>8</sup> Centers for Medicare & Medicaid Services (CMS), *Your Guide to Private Fee-for-Service Plans*, pp. 1-4, [www.medicare.gov/Publications/Pubs/pdf/10144.pdf](http://www.medicare.gov/Publications/Pubs/pdf/10144.pdf) (hereinafter “CMS Guide to PFFS”).

Medicare program and can charge a premium for supplemental benefits such as prescription drugs. PFFS plans may offer the following supplemental (or “extra”) benefits: vision benefits, hearing benefits, a physical exam, podiatry, and chiropractic benefits.<sup>9</sup> There is no limit on the premium amount PFFS plans can charge, nor on the supplemental premium charged for extra benefits.

PFFS plans are sometimes referred to as “Medicare replacement plans” or “Medicare replacement insurance.”<sup>10</sup> This simply means that people eligible for Medicare who enroll in a PFFS plan are no longer part of traditional Medicare. Although the PFFS plan is required by law to provide at least all of the services Medicare provides under Parts A and B, and most enrollees must continue to pay the Part B premium each month to Medicare, providers are reimbursed for their services by the private insurance company sponsoring the PFFS plan rather than directly by Medicare.

## **PFFS PLAN REQUIREMENTS**

### Information

All MA plans must provide certain information to the public to promote informed choice among plans. This information includes the benefits covered under the plan, and for a PFFS

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<sup>9</sup> “2006 Medicare Advantage Benefits and Premiums,” AARP Policy Institute, p. 28 (November 2006).

<sup>10</sup> For example, SecureHorizons Direct (a PFFS sponsor) and Regional Health Services of Howard County (a Critical Access Hospital in Iowa) both use the terms “Medicare PFFS plan” and “Medicare replacement insurance” interchangeably. However, this use of the term “Medicare replacement insurance” is not universal. The state of Wisconsin’s statutory definition of the term “Medicare replacement policy” is “a medicare+choice plan” (now called Medicare Advantage) or similar plan, contract or policy. Lovelace Health Plan calls its Premier Choice MA-PPO a “Medicare replacement product.” Dixon Hughes Certified Public Accountants and Advisors defines Medicare replacement coverage as Medicare coverage provided through private insurance programs, which would include all MA plans (PFFS, PPO, and HMO).

plan, any differences in cost sharing, premiums, and balance billing<sup>11</sup> under the plan compared with other MA plans.<sup>12</sup>

### Beneficiary Liability

Every MA organization that offers a PFFS plan is required to provide enrollees with an explanation of benefits and a clear statement of the enrollee's liability with respect to payments for services, including any balance billing liability.<sup>13</sup> Balance billing refers to a provider's charge above the Medicare-approved rate, for which the beneficiary must pay the difference. Federal law sets a limit on the amount that may be balance billed. The MA organization must also require inpatient hospitals providing services to give notice to enrollees, before services are furnished, of the fact that balance billing is permitted, as well as a good faith estimate of the likely balance billing amount based on the enrollee's condition.<sup>14</sup>

Once services have been provided, for each claim filed by an enrollee or provider, an MA organization providing a PFFS plan is required to provide appropriate explanation of benefits, including a clear statement of the enrollee's liability for deductibles, co-insurance, copayment, and balance billing.<sup>15</sup>

Appendix A contains a comparison of PFFS plan cost-sharing structures and those of other MA plans.

### Access to Services

An organization that offers a PFFS plan must demonstrate to the Secretary of the Department of Health and Human Services (HHS) that the organization has a sufficient number and range of health care professionals and providers willing to provide services under the plan's

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<sup>11</sup> See Beneficiary Liability, below, for a discussion of balance billing.

<sup>12</sup> 42 U.S.C.A. §1395w-21(d)(4)(A)(v).

<sup>13</sup> 42 U.S.C.A. §1395w-22(k)(2)(C)(i).

<sup>14</sup> 42 U.S.C.A. §1395w-22(k)(2)(C)(ii).

<sup>15</sup> 42 C.F.R. §422.216(d)(1).

terms.<sup>16</sup> The Secretary is directed by statute to find that an organization has met that requirement for a category of provider if: (A) the plan has established provider payment rates for covered services that are not less than the provider rates under Parts A and B of Medicare, or (B) the plan has contracts or agreements (other than “deemed” contracts<sup>17</sup>) with a sufficient number or range of providers in a category to provide covered services. If a plan meets this requirement with respect to a category of provider based on subparagraph (B), the plan may provide for a higher beneficiary co-payment for using providers in that category who do not have contracts or agreements (other than “deemed”) to provide covered services under the terms of the plan.<sup>18</sup>

Notably, the statute does not prohibit the Secretary from finding that a plan has sufficient providers even if the plan meets neither standard described above. Still, the Medicare Managed Care Manual (MMCM) provides that for a PFFS plan to meet its requirement of offering sufficient access to health care, either payment rates to providers must equal or exceed the rates under traditional Medicare, or, if the plan pays less than traditional Medicare for a given service, the plan must demonstrate that it can meet access requirements through a network of direct-contracting providers. The plan can satisfy the requirement in different ways, depending on the category of provider. For one category, the plan may demonstrate that it pays the category of provider at or above the payment rate. For another category of provider for which the plan pays less than the Medicare rate, the plan may demonstrate that it has a “sufficient range and number of direct contracts” with providers in that category.<sup>19</sup> The term “sufficient range and number” is not defined in the regulations nor in the MMCM. Implementation of the above requirement

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<sup>16</sup> 42 U.S.C.A. §1395w-22(d)(4). The review is conducted by CMS.

<sup>17</sup> See, Contracting and Deemed Providers, *infra*, for an explanation of contracting and deemed providers.

<sup>18</sup> 42 U.S.C.A. §§1395w-22(d)(4)(A) & (B); 42 C.F.R. §422.114.

<sup>19</sup> CMS Pub. 100-16, Medicare Managed Care Manual, Chapter 4, §§150.4, 150.5, <http://www.cms.hhs.gov/manuals/downloads/mc86c04.pdf> (hereinafter “MMCM”).

can be problematic. For example, a Connecticut couple reported enrolling in a PFFS plan only to learn that the nearest hospital that accepted the plan was 160 miles away.

PFFS plans must allow enrollees to obtain services from any entity that is authorized to provide services under Medicare Parts A and B and that agrees to provide services under the terms of the PFFS plan.<sup>20</sup> Although in general, MA organizations may refuse to grant participation to health care professionals in excess of the number necessary to meet the needs of the plan's enrollees, PFFS plans may not refuse to contract for this reason.<sup>21</sup>

### Appeals

An MA organization offering a PFFS plan must meet general requirements for MA organizations, including providing for all traditional Medicare-covered services, providing for emergency and urgent care, and allowing beneficiary appeals for services that are limited, not provided, not paid for, or not allowed.<sup>22</sup>

However, PFFS plan beneficiaries are not protected from having to pay for services received that the PFFS plan does not consider medically necessary. CMS advises beneficiaries that they are entitled to appeal a coverage decision, but they must pay for and receive the service first.<sup>23</sup> The appeal rights for PFFS plans are the same as the appeal rights for all other MA plans, and include the right to pre-termination review of certain services.<sup>24</sup>

### Quality

PFFS plans are statutorily exempt from the requirement that MA organizations “shall have” an ongoing program to improve the quality of care provided to enrollees.<sup>25</sup> However,

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<sup>20</sup> 42 C.F.R. §422.114(b).

<sup>21</sup> 42 C.F.R. §422.205(b)(1).

<sup>22</sup> MMCM, Chapter 4, §150.1.

<sup>23</sup> CMS Guide to PFFS, supra at pp. 7 & 11.

<sup>24</sup> 42 C.F.R. §§422.560 – 422.626.

<sup>25</sup> 42 U.S.C.A. §1395w-22(e)(1); 42 C.F.R. § 422.152(a).

CMS has determined that PFFS plans are subject to the following quality requirements: they must maintain health insurance systems, ensure information from providers is reliable and complete, make all collected information available to CMS to conduct quality reviews, and take corrective action for all problems that come to their attention.<sup>26</sup>

Reporting requirements for PFFS (and PPO) plans are listed in Appendix B.

### Payment Rates to Providers

An MA organization must make available to providers information on reimbursement rates for services covered under the PFFS plan, and payment rates to signed and deemed contract providers must be uniform.<sup>27</sup> The MA organization must specify in provider contracts the amount of cost-sharing and balance billing permitted, and must use the same amounts for both contracting and “deemed” contract providers.<sup>28</sup> The MA organization is required to enforce this limit, develop and document violations, and forward them to CMS.<sup>29</sup>

While other MA plans may operate physician incentive plans, subject to requirements and limitations, PFFS plans may not operate physician incentive plans.<sup>30</sup>

### Marketing

MA organizations are prohibited from offering cash or rebates to induce enrollment, soliciting Medicare beneficiaries door-to-door, or misleading or confusing beneficiaries.<sup>31</sup> However, because PFFS plans are paid at a very high rate, are exempt from the bid review process, and are allowed to enroll individuals year-round, there are both incentives and opportunities for MA organizations to aggressively market their PFFS products.

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<sup>26</sup> MMCM, Chapter 5, §26.

<sup>27</sup> 42 C.F.R. §422.216(a)(1).

<sup>28</sup> 42 C.F.R. §422.216(b)(1).

<sup>29</sup> 42 C.F.R. §422.216(c).

<sup>30</sup> 42 C.F.R. §422.208(e).

<sup>31</sup> 42 C.F.R. §422.80(e)(1).

Some prospective enrollees have been subjected to high-pressure house calls and have been told they can see any doctor they want, or any doctor that accepts Medicare, without the important caveat that some providers will not accept the plan's payments.<sup>32</sup> For example, an advocate reported that an illiterate beneficiary was told by a sales representative who was sitting in a doctor's waiting room that he could sign up for additional drug coverage for free. He did not know that his doctor does not accept the PFFS plan in which he enrolled and he now owes the doctor for tests he received, yet for which he cannot pay.

Because of reports of these and other marketing abuses, CMS included additional restrictions and oversight of marketing by PFFS plans in its 2008 Call Letter for Medicare Advantage contracts.<sup>33</sup>

## **PROVIDER REQUIREMENTS**

### Contracting and Deemed Providers

Providers, including Medicare-eligible providers who accept traditional Medicare or other (non-PFFS) MA plans, are not required to accept PFFS enrollees as patients. However, both contract and "deemed" contract providers are required to comply with the terms and conditions of the PFFS plan.<sup>34</sup>

A Medicare-eligible provider (a physician, hospital, nursing facility, or other entity) who does not have a contract with a PFFS organization but who furnishes services covered under the PFFS plan to a PFFS enrollee may be "deemed" a contracting provider. A provider is "deemed" a contracting provider if, before furnishing services the provider:

- Has been informed of the individual's enrollment under the plan, and

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<sup>32</sup> Goldrush, p. 6.

<sup>33</sup> <http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/CallLetter.pdf>.

<sup>34</sup> 42 C.F.R. §422.216(f).

- Has either been informed of the terms and conditions of payment for the services under the plan, or
- Is given reasonable opportunity to obtain that information.<sup>35</sup>

A provider is considered aware in advance of enrollment in a PFFS plan if notice was obtained from the enrollee, CMS, a Medicare intermediary, a carrier, or the MA organization.<sup>36</sup> If the plan makes terms and conditions accessible through the postal service, electronic mail, fax, telephone, or a plan website, a provider has reasonable access to the plan's terms and conditions of participation.<sup>37</sup> The provider is responsible to call or fax the PFFS plan or visit the PFFS website to obtain this information.<sup>38</sup> Because the "reasonable opportunity" bar is set very low, in practice, providers are generally considered "deemed" if they have been informed of the patient's enrollment under the plan before providing treatment.

Any provider furnishing health services, other than emergency services in a Medicare hospital, to a PFFS enrollee, and who has not entered into a contract to provide services under the plan, is treated as having a contract in effect and is subject to limitations applicable to contract providers.<sup>39</sup>

Note that a doctor or facility that is "deemed" a contracting provider for an enrollee for one visit does not have to accept the PFFS plan and provide services to that enrollee at subsequent visits. Nor does the doctor or facility have to accept the PFFS plan and provide services to another enrollee in the same plan. In other words, a provider may accept the terms of the PFFS plan on an enrollee by enrollee and service by service basis.<sup>40</sup>

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<sup>35</sup> 42 U.S.C.A. §1395w-22(j)(6).

<sup>36</sup> MMCM, Chapter 4, §150.3.

<sup>37</sup> *Id.*

<sup>38</sup> *Id.*

<sup>39</sup> 42 C.F.R. §422.216(f).

<sup>40</sup> Kaiser Examination 2007, p. 4.

For example, a Florida beneficiary, newly enrolled in a PFFS plan, received a phone call from his doctor three hours before a scheduled biopsy of a mass in his pectoral muscle cancelling the appointment. The doctor no longer accepted the terms and conditions of the plan in which he was enrolled. Similarly, another beneficiary who was referred to a hospital that specializes in the cancer surgery she needs was informed that the hospital did not accept her PFFS plan.

### Balance Billing

PFFS plans are allowed, but not required, to permit direct- or deemed-contracting providers to balance bill their PFFS patients.<sup>41</sup> A provider of services that does not have a contract establishing payment amounts for services with a PFFS plan has to accept as payment in full for covered services to a PFFS enrollee, the amounts that the provider could collect if the individual were not enrolled in a PFFS plan, i.e., the amount the provider would have received if the enrollee had remained in traditional Medicare.<sup>42</sup>

A provider of services that has either a direct or a deemed contract is subject to a balance billing limit of no more than 115% of the contracted payment rate.<sup>43</sup> In other words, a contract provider may bill the PFFS enrollee 15% more than the PFFS rate. A doctor with a PFFS contract may balance bill even if the doctor would normally accept assignment under traditional Medicare and not bill the beneficiary more than the Medicare approved charge.

The MMCM provides the following example of how balance billing works in PFFS plans:

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<sup>41</sup> The balance billing rules apply to providers of supplies and durable medical equipment, hospitals and other institutional providers, and non- institutional providers. MMCM, Chapter 4, §150.5.

<sup>42</sup> 42 U.S.C.A. §1395cc(a)(1)(O); 42 C.F.R. §422.216(a)(4).

<sup>43</sup> 42 U.S.C.A. §1395w-22(k)(2)(A); 42 C.F.R. §422.216(b)(1).

**EXAMPLE:** A plan determines a total reimbursement rate for a service to be \$80. The in-network cost sharing is 20% and the out-of-network cost sharing is 25%. The plan allows the maximum balance-billing amount, 15%.

For Direct-Contracting, In-Network Providers:

- The provider collects 20% of \$80 = \$16 cost sharing from the enrollee;
- The provider collects the total reimbursement amount less cost sharing, \$80-\$16=\$64, from the plan;
- The provider collects 15% of \$80=\$12 from the enrollee.

For Deemed-Contracting, Out-of-Network Providers:

- The provider collects 25% of \$80=\$20 cost sharing from the enrollee;
- The provider collects the total reimbursement amount less cost sharing, \$80-\$20=\$60 from the plan;
- The provider collects 15% of \$80=\$12 from the enrollee.”<sup>44</sup>

Note that, under traditional Medicare, a “participating physician” is a physician who “accepts assignment,” i.e., who accepts the Medicare approved amount as payment in full, may not balance bill. Physicians and suppliers who participate in the assignment program receive a higher Medicare fee schedule, and their names are listed in directories prepared by CMS.<sup>45</sup> According to the Medicare Payment Advisory Commission (MedPAC), in 2006 93.3% of physicians and non-physician providers who billed Medicare “participated” in Medicare. MedPAC also reported that claims data show that 99.3 percent of allowed charges for physician services were assigned in 2005. In other words, physicians accepted the Medicare payment rate

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<sup>44</sup> MMCM, Chapter 4, §150.5.

<sup>45</sup> 42 U.S.C. §§1395u(b)(3), (4), 1395w-4(g).

as payment in full for virtually every claim filed.<sup>46</sup> Thus, using the PFFS examples above, a beneficiary who remains in traditional Medicare would only be responsible for the 20% cost-sharing, or \$16, and would not be liable for any balance billing.

## **CMS REVIEW PROCESS**

In general, CMS is required to review and approve or disapprove adjusted community rates and the amounts of basic and supplemental premiums submitted by MA organizations.<sup>47</sup> However, CMS is not permitted to review, approve, or disapprove these amounts for PFFS plans.<sup>48</sup> PFFS plans, like all other MA plans, must submit to CMS an aggregate monthly bid amount each year; however, CMS will not review, negotiate, or approve the bid amount, the basic premium, or the supplemental premium for PFFS plans.<sup>49</sup>

Likewise, although CMS has the authority to negotiate regarding monthly bid amounts and supplemental benefits of MA plans in general (and is permitted to accept only bid amounts supported by certain actuarial bases that reasonably and equitably reflect the revenue requirements of benefits provided under the plan), CMS is prohibited from negotiating these items with respect to PFFS plans.<sup>50</sup>

Although CMS may not review or negotiate such items with respect to PFFS plans, in any MA plan (including PFFS plans), the actuarial value of the deductibles, co-insurance, and copayments applicable on average to individuals in a given year may not exceed the average actuarial value that would apply to individuals who were not MA members.<sup>51</sup>

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<sup>46</sup> Medicare Payment Advisory Commission, “Report to the Congress: Medicare Payment Policy” (March 2007), Section 2b, p. 109. [http://www.medpac.gov/publications%5Ccongressional\\_reports%5CMar07\\_Ch02b.pdf](http://www.medpac.gov/publications%5Ccongressional_reports%5CMar07_Ch02b.pdf)

<sup>47</sup> 42 U.S.C.A. §1395w-24(a)(5)(A).

<sup>48</sup> 42 U.S.C.A. §1395w-24(a)(5)(B).

<sup>49</sup> 42 C.F.R. §422.256(d).

<sup>50</sup> 42 U.S.C.A. §1395w-24(a)(6)(B)(iv).

<sup>51</sup> 42 U.S.C.A. §1395w-24(e)(4).

PFFS plans that offer prescription drug coverage are similarly exempt from the review and negotiation process and revenue requirements that apply to other Part D sponsors. PFFS plans are not required to provide CMS with access to negotiated prices, but if they do, they are subject to the actuarial requirements that apply to other Part D sponsors.<sup>52</sup>

## **PFFS & PART D PRESCRIPTION DRUG COVERAGE**

Although MA coordinated care plans must offer qualified Part D coverage in every area in which they offer a plan,<sup>53</sup> MA organizations that offer private PFFS plans can choose whether to offer qualified Part D coverage.<sup>54</sup> Prescription drug coverage (other than that required under Parts A and B) offered by an MA organization under a PFFS plan must meet the requirements of Part D.<sup>55</sup>

A Part D-eligible individual enrolled in a PFFS plan that does not offer prescription drug coverage may obtain coverage through a qualified prescription drug plan (PDP).<sup>56</sup> Individuals who are dually eligible for Medicare and Medicaid (dual eligibles) who enrolled in a PFFS plan that does not offer qualified prescription coverage, and who do not enroll in a PDP, must be automatically enrolled in a PDP on a random basis.<sup>57</sup>

PDPs and MA plans that offer drug coverage are subject to pharmacy access requirements for a contracted network of pharmacies. The network must include a sufficient number of pharmacies in locations convenient enough to serve the majority of Medicare

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<sup>52</sup> 42 C.F.R. §423.272(d).

<sup>53</sup> 42 C.F.R. §422.4(c)(1).

<sup>54</sup> 42 C.F.R. §422.4(c)(3). Note that MSA plans are not permitted to offer prescription drug coverage other than that required under Parts A and B. 42 C.F.R. §422.4(c)(2).

<sup>55</sup> 42 C.F.R. §423.104(f)(3)(ii)(b).

<sup>56</sup> 42 U.S.C.A. §1395w-101; 42 C.F.R. §423.30(b)(1).

<sup>57</sup> 42 C.F.R. §423.34(d)(2).

beneficiaries in the region.<sup>58</sup> These requirements are waived for PFFS plans that offer qualified prescription drug coverage and provide plan enrollees with access to covered Part D drugs dispensed at all pharmacies, without regard to whether they are contracted network pharmacies and without charging cost sharing in excess of 25% coinsurance.<sup>59</sup>

Most Part D sponsors must require a pharmacy dispensing a covered Part D drug to inform an enrollee of any differential in price between that drug and the lowest-priced generic version of the covered Part D drug that is therapeutically equivalent, bioequivalent, and available at that pharmacy.<sup>60</sup> However, that disclosure requirement is waived for PFFS plans that offer qualified prescription drug coverage and provide enrollees with access to covered Part D drugs dispensed at all pharmacies and that do not charge additional cost-sharing for access to Part D drugs dispensed by out-of-network pharmacies.<sup>61</sup>

Most Part D sponsors must establish a reasonable and appropriate drug utilization management program, including incentives to reduce costs and policies preventing over- and under-utilization of prescribed medications. Sponsors must also establish a medication therapy management program (MTMP) that, for targeted beneficiaries, ensures that covered Part D drugs are appropriately used to optimize therapeutic outcomes and reduces risk of adverse events.<sup>62</sup> These requirements do not apply to PFFS plans providing qualified prescription drug coverage.<sup>63</sup>

## **PFFS PLANS AS AN ALTERNATIVE TO MEDIGAP POLICIES**

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<sup>58</sup> 42 C.F.R. §423.120(a)(1).

<sup>59</sup> 42 C.F.R. §423.120(a)(7)(i); 42 C.F.R. §423.104(d)(2).

<sup>60</sup> 42 C.F.R. §423.132(a).

<sup>61</sup> 42 C.F.R. §423.132(c).

<sup>62</sup> Targeted beneficiaries are Part D enrollees who have multiple chronic diseases, are taking multiple Part D drugs, and are likely to incur annual costs for covered Part D drugs that exceed a predetermined level specified by the Secretary. 42 C.F.R. §423.153(d)(2).

<sup>63</sup> 42 C.F.R. §423.153(e).

PFFS plan advocates claim the plans provide cost savings for beneficiaries. They highlight lower PFFS premiums compared with those of some other Medicare Advantage plans (such as HMOs and PPOs) and extra benefits not included in traditional Medicare. But PFFS does not necessarily lower beneficiary costs overall. As the following comparisons of PFFS plans and traditional Medicare demonstrate, some PFFS plans can provide savings over Medicare alone, depending on the services a beneficiary requires. Other plans may result in higher out-of-pocket costs for their enrollees, particularly those who require more costly services.

However, many people with traditional Medicare also have Medicare Supplemental, or Medigap, insurance.<sup>64</sup> Private insurers, many of which also offer MA plans, offer Medigap insurance that supplements Medicare coverage by covering Medicare deductibles, co-payments, coinsurance and other cost-sharing. Medigap policies must conform to standardized model policies, referred to as policies “A” through “L,” developed by the National Association of Insurance Commissioners (NAIC).<sup>65</sup> For services commonly used by Medicare beneficiaries, traditional Medicare supplemented by a Medigap policy is almost always less costly than PFFS plan coverage.

### **COMPARING TRADITIONAL MEDICARE AND MEDIGAP WITH PFFS IN THREE STATES**

This report compares traditional Medicare and PFFS options in three states: Connecticut, a state with urban populations where PFFS is just beginning to be offered; Montana, a large rural state with few other Medicare Advantage options, where PFFS has been available for a while; and Oregon, which has numerous well-established HMO and PPO options. The charts in the

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<sup>64</sup> Nine million Medicare beneficiaries have purchased Medigap policies. “Fact Sheet: Medicare at a Glance,” Kaiser Family Foundation (February 2007), <http://www.kff.org/medicare/upload/1066-10.pdf>.

<sup>65</sup> 42 U.S.C. §1395ss.

Appendices compare traditional Medicare and the PFFS plans in each state with respect to premiums, maximum out-of-pocket limits, and cost-sharing for various covered services, including inpatient hospital care, skilled nursing facility (SNF) care, home health care, doctor visits, durable medical equipment (DME), and Part B covered drugs. The discussion also considers the effect on cost-sharing if a beneficiary in traditional Medicare also has a Medigap policy.

For purposes of comparison, it is important to note the 2007 Medicare deductible, co-insurance and premium amounts:

PART A

Hospital Deductible: \$992.00

Hospital Coinsurance:

1st through 60th day: \$0

61st through 90th day: \$248.00/day

91st through 150th day: \$496.00/day

Skilled Nursing Facility Co-insurance:

1st through 20th day: \$0

21st through 100th day: \$124.00/day

Home health cost-sharing: \$0

PART B

Deductible: \$131/year

Standard Premium: \$93.50/month

Co-insurance (including Part B drugs) 20%

Home health cost-sharing: \$0

Notes on Connecticut Cost-Sharing and the Role of Medigap Plans<sup>66</sup>:

Three major companies—HealthNet, Humana, and Heritage (a subsidiary of Universal American)—currently offer at least one PFFS option in Connecticut. All PFFS plan enrollees in Connecticut must pay the standard Part B premium. The additional PFFS plan premiums range from \$0/month to \$159/month for HealthNet’s highest premium plan. All PFFS plan options include a maximum out-of-pocket limit.

The highest-premium PFFS plan does not collect co-payments for hospital stays regardless of their length. Among the other plans and traditional Medicare, cost-sharing for enrollees is as low as \$150 and up to \$1,050 (Option 2 under the Heritage Today’s Options plan) for inpatient hospital care lasting six days.<sup>67</sup> Traditional Medicare imposes a \$992 deductible for the first 60 days of a hospital stay. Note that, unlike traditional Medicare, the two PFFS plans that impose inpatient hospital cost-sharing charge per hospital stay, not per spell of illness or benefit period. A beneficiary in traditional Medicare who returned to the hospital within 60 days of the original hospital stay would not have to pay an additional \$992 deductible. Someone in the Humana PFFS plan would be charged \$550 for each stay, or \$1,100.

Two of the three Connecticut PFFS plans, like traditional Medicare, impose no cost sharing for the first twenty days in a SNF. Humana charges \$90/day starting at day 4 of a SNF stay, so that an enrollee would incur a \$1,530 bill for care during that time period. After day 20, the other two PFFS plans charge less per day than traditional Medicare.<sup>68</sup>

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<sup>66</sup> See Appendix C chart, “Connecticut Cost-Sharing Structures: Traditional Medicare vs. PFFS Plans.”

<sup>67</sup> Six days is the average inpatient hospital stay among Medicare beneficiaries in Connecticut. CMS, “100% MEDPAR Inpatient Hospital Fiscal Year 2005, Short Stay Inpatient by State,” <http://www.cms.hhs.gov/MedicareFeeForSvcPartsAB/Downloads/DRGstate05.pdf> (hereinafter “MEDPAR 2005”).

<sup>68</sup> The average stay in a Skilled Nursing Facility (SNF) is 26 days for Medicare beneficiaries nationwide. CMS, “Medicare & Medicaid Statistical Supplement: Details for Medicare Skilled Nursing Facilities,” Table 6.2 (2006), <http://www.cms.hhs.gov/MedicareMedicaidStatSupp/LT/itemdetail.asp?filterType=none&filterByDID=0&sortByDI D=2&sortOrder=descending&itemID=CMS1190559&intNumPerPage=10> (hereinafter “CMS SNF Statistics 2006”).

Cost-sharing may also differ from traditional Medicare for other items and services. The plans charge between \$5 and \$15 copayments for each primary care visit and from \$15 to \$30 copayments for each visit to a specialist, as opposed to the 20% co-insurance under Medicare Part B. The lowest-premium plan requires cost-sharing for home health care – 15% of the cost for Medicare-covered home health visits; there is no cost-sharing for home health services in traditional Medicare. While Medicare collects payments of 20% of Medicare-approved amounts for DME, all of the PFFS plans charge enrollees 20% of the *cost* for each Medicare-covered item. The difference may be substantial if the DME supplier normally charges a higher price for equipment than Medicare pays. The lowest-premium plan also requires advance notice of equipment or device purchases over \$750; without such notice, the enrollee must pay 50% of the billed charges. All of the plans charge 20% of the cost for Part B-covered drugs.

A beneficiary in traditional Medicare who also has a Medigap (Medicare Supplement Insurance) policy may pay less for the services described above. Medigap policies cover, as part of their core benefit package, the hospital co-insurance that starts at day 61 of a hospital stay as well as the 20% co-insurance for Part B-covered services, including physician visits, DME, and Part B-covered drugs. Thus, unlike enrollees in a PFFS plan, beneficiaries in traditional Medicare who had any Medigap policy “A” through “J”<sup>69</sup> would have no additional out-of-pocket expenses for these services.

Standard Medigap policies “C” through “J” also cover the inpatient hospital deductible and the copayment for SNF stays. Even when the premium for the most popular policies, plans “C” and “F”,<sup>70</sup> is taken into account,<sup>71</sup> a Connecticut resident who has one of these policies and

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<sup>69</sup> The Medicare Modernization Act created two new standard policies, “K” and “L” that cover the same core benefits as the other standard policies but with different cost-sharing. 42 U.S.C. §1395ss(w).

<sup>70</sup> Plans “C” and “F” are the most popular Medigap policies. “Talking About Medicare: Insurance to Supplement Medicare,” Kaiser Family Foundation (November 2006), [http://www.kff.org/medicare/7067/med\\_supplement.cfm](http://www.kff.org/medicare/7067/med_supplement.cfm).

who spends six days in a hospital followed by twenty-six days in a SNF will pay considerably less than under every available PFFS plan.<sup>72</sup>

Notes on Montana Cost-Sharing and the Role of Medigap Plans<sup>73</sup>:

Five major companies—Advantra, Humana, Sterling, Unicare, and Wellcare—currently offer at least one PFFS option in Montana. All PFFS plan enrollees in Montana must pay the standard Part B premium. The additional PFFS plan premiums range from \$0/month to \$139/month for Wellcare’s highest premium plan. Four of the five major PFFS plan sponsors, including Wellcare, offer at least one PFFS plan with no additional premium above the \$93.50/month Part B premium. Three of the five plans have a maximum out-of-pocket limit; however, Wellcare’s limit of \$3,650/year does not include the cost of DME or Part B-covered drugs.

Copayments for inpatient hospital care are as low as \$50 (for Unicare’s higher premium plans) and as high as \$1,125 for a five-day hospital stay.<sup>74</sup> (Wellcare charges \$225 per day for the first five days of a hospital stay). Unicare imposes a \$50 per day surcharge, up to a maximum of \$500 per admission, for failure to notify the plan in advance of a planned hospital stay. As with the Connecticut PFFS plans, the Montana PFFS plans assess inpatient hospital cost sharing for each hospital stay, regardless of whether the hospitalization occurs within the same spell of illness or benefit period as the earlier hospital stay. Thus, a Montana PFFS enrollee who

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<sup>71</sup> The premiums for these policies range from \$248-\$255/month. The least expensive premium for the most basic Medigap policy, Plan “A,” is \$98 per month. Plan “A” covers Part B cost-sharing, hospital cost-sharing after day 61, 365 additional days of hospital care, and the Part A and B blood deductible <http://medicareoptions.info/Mgediap%20Plans%20in%20Connecticut.htm>.

<sup>72</sup> Costs under the HealthNet PFFS plan come closest to the costs with a Medigap policy “C” or “F.” A HealthNet PFFS enrollee would pay a premium of \$139 or \$159 per month, depending on the plan, no cost-sharing for the hospital stay, and \$250 (\$50 per day times 5 days) for the SNF stay, for a total cost of between \$389 and \$409. A beneficiary with the most costly Medigap policy “C” or “F” would only pay the \$255 premium for the policy.

<sup>73</sup> See Appendix D chart, “Montana Cost-Sharing Structures: Traditional Medicare vs. PFFS Plans.”

<sup>74</sup> The average inpatient stay among Medicare beneficiaries in Montana is 4.7 days. MEDPAR 2005.

returns to the hospital within the same spell of illness may pay substantially more than if the enrollee were in traditional Medicare.

Only the Unicare plans and traditional Medicare impose no cost-sharing for the first 20 days in a SNF. Advantra and Humana plans impose a \$90 per day cost-sharing requirement starting at day 4; Sterling imposes a \$35 per day cost-sharing starting at day 11; and Wellcare imposes a \$90 per day cost-sharing requirement starting at day 16. After day 20, all of the plans charge less per day than traditional Medicare. Nevertheless, twenty-six days in a SNF<sup>75</sup> could cost an enrollee in the Advantra and Humana plans more than twice as much (\$1,890) than the cost to someone in traditional Medicare (\$744). The cost to someone in a Wellcare PFFS plan (\$990) would also be higher than the cost under traditional Medicare.

Cost-sharing may also differ from traditional Medicare for other items and services. The Montana PFFS plans, like the Connecticut PFFS plans, charge flat rates (\$10-\$15) for each primary care visit and for each specialist visit (\$10-\$35), as opposed to the 20% co-insurance under traditional Medicare. The Sterling plan requires a 15% cost-sharing of the cost for Medicare-covered home health visits; Wellcare imposes a charge of up to \$35 for each visit. All of the PFFS plans calculate enrollee cost-sharing for DME on the cost of the item. Three of the plans charge more than the Medicare 20% co-insurance: Sterling charges up to 50%; Unicare charges up to 30%; and Wellcare charges 25%. Both Sterling and Unicare assess a penalty for failure to notify the plan in advance of a purchase of equipment or a device valued over \$750. The Unicare enrollee may be liable for 70% of billed charges. Finally, Wellcare requires its enrollees to pay 25%, instead of 20%, of the cost of Part B-covered drugs.

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<sup>75</sup> Twenty-six days is the average length of stay in a SNF for Medicare beneficiaries nationwide. CMS SNF Statistics 2006.

As explained earlier in this report, a beneficiary in traditional Medicare who also has a Medigap policy may pay less for the services described above. Because Medigap policies cover, as part of their core benefit package, the hospital co-insurance that starts at day 61 of a hospital stay as well as the 20% co-insurance for Part B-covered services, including physician visits, DME, and Part B-covered drugs, a beneficiary with a Medigap policy would have no additional out-of-pocket expenses for these services. Montana beneficiaries with standard Medigap policies “C” through “J,”<sup>76</sup> which also cover the inpatient hospital deductible and the copayment for SNF stays, would pay less for these services than if in all but the least costly Unicare PFFS plan.

Notes on Oregon Cost-Sharing and the Role of Medigap Plans<sup>77</sup>:

Seven major companies—Advantra, Humana, Sterling, UnitedHealthcare, Heritage, Unicare, and Wellcare—currently offer at least one PFFS option in Oregon. All PFFS enrollees in Oregon must pay the standard Part B premium. The additional PFFS plan premiums range from \$0 per month to \$139 per month for Wellcare’s highest premium plan.<sup>78</sup> Four of the plans have a maximum out-of-pocket limit (ranging from \$2,500 to \$5,000 per year); however, Wellcare’s limit of \$3,650/year does not include the cost of DME or Part B-covered drugs.

Copayments for inpatient hospital care are as low as \$50 (for Unicare’s higher premium plans) and as high as \$1,125 (Wellcare’s plan charging \$225 per day) for five days, as compared with the \$992 deductible in traditional Medicare.<sup>79</sup> The Today’s Options offered by Heritage and the Unicare plans impose a surcharge that could increase the cost of the hospitalization if the

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<sup>76</sup> Montana has 30 Medigap sponsors who offer Plan “F” policies; 27 of these offer Plan “C” policies. Each sponsor offers policies at a wide range of rates, which depend on the age of the enrollee. The comparative calculation is based on a \$165 premium; the average of the median rates for “C” and “F” policies for every sponsor. (The averages within Plan “C” and Plan “F” are virtually identical, so they have been aggregated here). <http://sao.mt.gov/consumers/Guide%20-%20Medicare%20Supplement%20Insurance2.pdf>.

<sup>77</sup> See Appendix E chart, “Oregon Cost-Sharing Structures: Traditional Medicare vs. PFFS Plans.”

<sup>78</sup> Four of the seven primary PFFS plan sponsors, including Wellcare, offer at least one PFFS plan with no additional premium above the \$93.50/month Part B premium.

<sup>79</sup> The average inpatient hospital stay among Medicare beneficiaries in Oregon is 5 days. MEDPAR 2005.

enrollee fails to notify the plan in advance of a planned inpatient admission. As in Connecticut and Montana, the Oregon PFFS plans impose inpatient hospital cost-sharing on a per hospital stay basis, not per spell of illness or benefit period. A beneficiary in traditional Medicare who returned to the hospital within 6 days of the original 5-day hospital stay would not have to pay an additional \$992 deductible. Someone in the Wellcare plan would pay \$1,125 for the first five days of hospitalization plus an additional \$225 for each day during the second hospital stay.

One of the PFFS plans does not impose cost-sharing for SNF care. Only two of the other plans follow traditional Medicare and impose no cost-sharing for the first twenty days of SNF care. The other plans begin assessing cost-sharing as early as day four. Twenty-six days in a SNF<sup>80</sup> would cost someone in traditional Medicare \$744 (6 days at \$124 per day) but would cost a PFFS plan enrollee as much as \$2,070 in an Advantra- or Humana-sponsored plan (23 days at \$90 per day).

Cost-sharing may also differ from traditional Medicare for other items and services. The plans charge \$5-\$15 for primary care visits and \$15-\$35 for each specialist visit, as opposed to the 20% co-insurance under Medicare Part B. Three of the plans require varying cost-sharing for home health services, either 15% of the cost for the Medicare-covered visits or up to \$35 for each visit. One plan which, like traditional Medicare imposes no cost-sharing for home health services, indicates that prior authorization rules may apply. While Medicare collects payments of 20% of Medicare-approved amounts for DME, all of the PFFS plans charge at least 20% of the *cost* for each Medicare-covered item, and three plans collect up to 25% (Wellcare), 30% (Unicare), or 50% (Sterling) of the cost for each item. Sterling, Today's Options, and Unicare also require prior notification of equipment or device purchases over \$750. Failure to notify the

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<sup>80</sup> Twenty-six days is the average length of stay in an SNF for Medicare beneficiaries nationwide. CMS SNF Statistics 2006.

plan in advance of such a purchase results in enrollee liability for 50% (Sterling and Today's Options) or 70% (Unicare) of the billed charges for those items. The Wellcare plan also charges more for Part B-covered drugs (25% instead of 20%).

As explained earlier in this report, a beneficiary in traditional Medicare who also has a Medigap policy may pay less for the services described above. Because Medigap policies cover, as part of their core benefit package, the hospital co-insurance that starts at day 61 of a hospital stay as well as the 20% co-insurance for Part B-covered services, including physician visits, DME, and Part B-covered drugs, a beneficiary with a Medigap policy would have no additional out-of-pocket expenses for these services. Even when the premium for a Medigap policy "C" or "F" is taken into account, an Oregon resident who has one of these policies and who spends five days in a hospital followed by twenty-six days in an SNF will pay, on average, around \$513.<sup>81</sup> That figure is less than the beneficiary would pay under every PFFS plan except Unicare's lowest cost plan, and \$2,748 less than the most expensive PFFS plan (Humana) in Oregon.

## CONCLUSION

Insurance marketers and other proponents of PFFS plans want Medicare beneficiaries to believe that PFFS is the same as the familiar traditional Medicare program, only better. This is not the case. Enrollees in PFFS plans do not have the same access to providers that they would have under traditional Medicare. PFFS plans are exempt from many of the consumer-protective requirements of Medicare Advantage (MA) coordinated care plans. And, perhaps most

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<sup>81</sup> Forty of Oregon's 48 Medigap plan sponsors offer Plan "F" policies; 29 sponsors offer Plan "C" policies. Each sponsor offers policies at a wide range of rates, which depend on the age of the enrollee. The \$163/month Medigap rate is the average of the median rates for Plan "C" and Plan "F" policies for every sponsor (the average within Plan "C" and Plan "F" are virtually identical, so for simplicity they have been aggregated here). [http://egov.oregon.gov/DCBS/SHIBA/guide\\_2007.shtml](http://egov.oregon.gov/DCBS/SHIBA/guide_2007.shtml).

important, the true cost of services provided under PFFS plans can be much greater than under traditional Medicare, especially when supplemented by a Medigap policy.

Nevertheless, the Medicare Payment Advisory Commission, an independent oversight body that advises Congress, has estimated that payments to PFFS plans nationwide are 19% above the cost of servicing the same beneficiaries in traditional Medicare.<sup>82</sup> One expert recently summarized these incongruities:

The additional PFFS plan choices essentially allow firms to “piggyback” on Medicare’s existing investment and policies and do relatively little to improve care management because they are precluded from doing so by both Medicare and their own reservations. To the extent that PFFS enrollment grows, Medicare’s risk pool is fragmented, and the program’s purchasing power with providers is diluted.<sup>83</sup>

In other words, PFFS plans masquerade as a lower cost alternative to traditional Medicare. However, they result in extra costs for taxpayers and for many of the beneficiaries who enroll in these plans. Most important, their payment and regulatory structures have the effect of weakening traditional Medicare for the majority of beneficiaries who remain in that program. Advocates and policymakers are advised to look closely at PFFS plans to ensure that older people and people with disabilities do not lose the protections they enjoy in traditional Medicare as a result of the proliferation of the PFFS option.

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<sup>82</sup> Medicare Payment Advisory Commission, “Report to the Congress: Medicare Payment Policy” (Mar. 2007), Section 4, p.244. [http://www.medpac.gov/publications/congressional\\_reports/Mar07\\_Ch04.pdf](http://www.medpac.gov/publications/congressional_reports/Mar07_Ch04.pdf).

<sup>83</sup> Marsha Gold, “Medicare Advantage in 2006-2007: What Congress Intended?” *Health Affairs* 26, no. 4 (2007): w445-w455.

**APPENDIX A<sup>84</sup>**

**MEAN CO-PAYMENTS FOR THE LOWEST-PREMIUM MA PLANS  
WITH PRESCRIPTION DRUG BENEFITS NATIONWIDE IN 2006**

<b>Benefit</b>	<b>All Plan Types</b>	<b>HMO</b>	<b>Local PPO</b>	<b>PFFS</b>	<b>Regional PPO</b>	<b>SNP</b>
<b>Primary Care Physician Visit</b>	\$9.68	\$8.32	\$11.26	\$14.75	\$11.12	\$0.00
<b>Specialist Visit</b>	\$21.67	\$20.06	\$22.81	\$27.05	\$30.77	\$0.00
<b>Rx Premium</b>	\$12.14	\$8.37	\$21.88	\$16.43	\$14.74	\$19.04
<b>Hospital Stay (3 days)</b>	--	\$371	\$369	\$524	\$543	\$277
<b>Outpatient Mental Health Visit</b>	--	\$25.17	\$26.33	\$23.33	\$33.60	\$16.07
<b>Annual Out-of-Pocket<sup>85</sup></b>	\$299 \$88 \$1,823	\$275 \$80 \$1,676	\$324 \$107 \$1,901	\$367 \$79 \$2,462	\$463 \$187 \$2,498	-- \$49 \$1,174

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<sup>84</sup> Data are from the AARP Public Policy Institute Report, “2006 Medicare Advantage Benefits and Premiums” (November 2006) (hereinafter “AARP 2006 Report”). Mathematica Policy Research, Inc., which prepared the report, collected data from the “lowest premium [MA] plans” with prescription drug benefits -of which 66% were HMOs, 20% were local PPOs, 11% were PFFS plans, and 3 percent were regional PPO plans- and from the lowest premium SNPs.

<sup>85</sup> Physician & hospital cost-sharing for all enrollees, healthy enrollees, and those with chronic needs. AARP 2006 Report.

## APPENDIX B

### REPORTING REQUIREMENTS APPLICABLE TO PFFS/PPO PLANS:

- Breast cancer screening
- Osteoporosis management in women who have had a fracture
  - o Must be reported only by plans with pharmacy benefit
- Cholesterol management after acute cardiovascular events
  - o Screening rate is required, but LDL-C level is not
- Comprehensive diabetes care
  - o Rates required for HbA1c testing, eye exams, and LDL-C screening
  - o Rates not required for HbA1c control, LDL-C control, or monitoring for diabetic nephropathy
- Follow-up after hospitalization for mental illness
- Antidepressant medication management
  - o Must be reported only by plans with pharmacy and mental health benefit
- Medicare health outcomes survey (HOS)
- Management of urinary incontinence in older adults
  - o Collected through HOS
- Adults' access to preventive/ambulatory health services
- Initiation and engagement of alcohol and other drug dependence treatment
- Claims timeliness
- Call answer timeliness
- Call abandonment
- Practitioner turnover
  - o Must be reported only by PPOs with a contracted physician network
- Years in business/total membership
- Frequency of selected procedures
- Inpatient utilization – general hospital/acute care
- Ambulatory care
- Inpatient utilization – non-acute care
- Mental health utilization – inpatient discharges and average length of stay
- Mental health utilization – percentage of members receiving services
- Chemical dependency utilization – inpatient discharges and average length of stay
- Identification of alcohol and other drug services
- Outpatient drug utilization
  - o Limited to plans with pharmacy benefit
- Board certification
  - o Must be reported only by PPOs with a contracted physician network
- Total enrollment by percentage
- Enrollment by product line (member years/member months)

### REPORTING REQUIREMENTS NOT APPLICABLE TO PFFS/PPO

- Colorectal cancer screening
- Controlling high blood pressure
- Beta blocker treatment after a heart attack

## APPENDIX C

### CONNECTICUT COST-SHARING STRUCTURES: TRADITIONAL MEDICARE AND PFFS PLANS

<b>Benefit</b>	<b>Traditional Medicare</b>	<b>Health Net<sup>86</sup></b>	<b>Humana<sup>87</sup></b>	<b>Heritage (Today's Options)</b>
<b><i>Part B Premium</i></b>	\$93.50/month	\$93.50/month	\$93.50/month	\$93.50/month
<b><i>PFFS Premium</i></b>	--	\$139 or \$159/month depending on plan	\$99/month including Part D benefits	\$0-\$85/month depending on plan and county
<b><i>Maximum Out-of-Pocket Limit</i></b>	--	\$500/year	\$5,000/year	\$2,500-\$3,000/year
<b><i>Doctor Visits</i></b>	20% of Medicare-approved amounts	\$5 per primary care doctor office visit or specialist visit for Medicare-covered services	\$15 per primary care doctor office visit and \$30 per specialist visit for Medicare-covered services	<i>Option 1</i> \$5 per primary care doctor office visit, \$15 per specialist visit for Medicare-covered svcs. <i>Option 2</i> \$15 per primary care doctor office visit, \$30 per specialist visit for Medicare-covered services
<b><i>Part B Covered Drugs</i></b>	20% of cost for Part B-covered drugs	20% of cost for Part B-covered drugs	\$4-\$60 (or 20% of cost) for Part B-covered drugs	20% of cost for Part B-covered drugs

<sup>86</sup> The Health Net “Pearl” PFFS plan is available in the following Connecticut counties: Hartford, Middlesex, New Haven, New London, Tolland and Windham.

<sup>87</sup> Humana’s “Gold Choice” PFFS plan is available in the following Connecticut counties: Hartford, Litchfield, Middlesex and Tolland.

<b>Benefit</b>	<b>Traditional Medicare</b>	<b>Health Net</b>	<b>Humana</b>	<b>Heritage (Today's Options)</b>
<b><i>Inpatient Hospital Care</i></b>	Day(s) 1-60: \$992 deductible per benefit period <sup>88</sup> Days 61-90: \$248/day Days 91-150: \$496/lifetime reserve day <sup>89</sup>	No co-payment for unlimited number of days	\$550 per Medicare-covered stay for unlimited number of days	<i>Option 1</i> \$150 per Medicare-covered stay for unlimited number of days <i>Option 2</i> Day(s) 1-4: \$175/day Days 5-90+: \$0 *\$150 penalty for failure to notify plan prior to admission
<b><i>Skilled Nursing Facility</i></b>	Day(s) 1-20: \$0 Days 21-100: \$124/day *3-day prior hospital stay required *Coverage for 100 days each benefit period	Day(s) 1-20: \$0 Days 21-100: \$50/day *No prior hospital stay required *Coverage for 100 days each benefit period	Day(s) 1-3: \$0 Days 4-100: \$90/day *No prior hospital stay required *Coverage for 100 days each benefit period	Day(s) 1-20: \$0 Days 21-100: \$100/day *No prior hospital stay required *Coverage for 100 days each benefit period
<b><i>Home Health Care</i></b>	No copayment	No copayment	No copayment	15% of cost for Medicare-covered home health visits
<b><i>Durable Medical Equipment</i></b>	20% of Medicare-approved amounts	20% of cost for each Medicare-covered item	20% of the cost for each Medicare-covered item	20% of the cost for each Medicare-covered item *Penalty for failure to notify <sup>90</sup>

<sup>88</sup> A benefit period begins the first day a Medicare beneficiary enters a hospital or SNF and ends when s/he has been at less than a skilled level of care, or outside a hospital or SNF, for 60 consecutive days. If the beneficiary re-enters a hospital or SNF during those 60 days s/he does not pay a new deductible. Alfred J. Chiplin, Jr. & Judith A. Stein (Eds.), *2007 Medicare Handbook* §3.03[E] (2007) (hereinafter “2007 Medicare Handbook”).

<sup>89</sup> Part A benefits allow for 60 lifetime reserve days for use after a 90-day benefit period has been exhausted. The 60 days are not renewable and may be used only once during a beneficiary’s lifetime. CMS, “Medicare Benefit Policy Manual,” Chapter 3, <http://www.cms.hhs.gov/manuals/Downloads/bp102c03.pdf> (hereinafter “MBPM”).

<sup>90</sup> Failure to notify the plan of an equipment or device purchase over \$750 results in enrollee liability for 50% of the billed charges.

## APPENDIX D

### MONTANA COST-SHARING STRUCTURES: TRADITIONAL MEDICARE AND PFFS PLANS

<b>Benefit</b>	<b>Traditional Medicare</b>	<b>Advantra<sup>91</sup></b>	<b>Humana</b>	<b>Sterling</b>	<b>Unicare<sup>92</sup></b>	<b>Wellcare<sup>93</sup></b>
<b><i>Part B Premium</i></b>	\$93.50/mo.	\$93.50/mo.	\$93.50/mo.	\$93.50/mo.	\$93.50/mo.	\$93.50/mo.
<b><i>PFFS Premium</i></b>	--	--	--	\$28.70/mo. including Part D benefits	\$0-\$56/mo. depending on the plan	\$0-\$139/mo. depending on the plan
<b><i>Maximum Out-of-Pocket Limit</i></b>	--	\$3,000/year	\$5,000/year	--	--	\$3,650/year, excluding DME & Part B-covered drugs
<b><i>Doctor Visits</i></b>	20% of Medicare-approved amounts	\$15 per primary care office visit and \$30 per specialist visit for Medicare-covered services	\$15 per primary care office visit and \$30 per specialist visit for Medicare-covered services	\$10 per primary care office visit and \$35 per specialist visit for Medicare-covered services	\$10 per primary care office visit and \$10-\$25 per specialist visit for Medicare-covered services	\$10 per primary care office visit and \$35 per specialist visit for Medicare-covered services
<b><i>Part B Covered Drugs</i></b>	20% of cost for Part B-covered drugs	20% of cost for Part B-covered drugs	\$4-\$60 (or 20% of cost) for Part B-covered drugs	20% of cost for Part B-covered drugs	0%-20% of cost for Part B-covered drugs, depending on the plan	25% of cost for Part B-covered drugs

<sup>91</sup> Advantra’s “Freedom” PFFS plan is available in the following Montana counties: Beaverhead, Broadwater, Carter, Custer, Dawson, Fallon, Fergus, Flathead, Gallatin, Garfield, Golden Valley, Jefferson, Judith Basin, Lake, Lewis and Clark, Lincoln, McCone, Petroleum, Powder River, Powell, Prairie, Ravalli, Richland, Rosebud, Sanders, Sheridan, Stillwater, Sweet Grass, Treasure, Wheatland, Wibaux and Yellowstone.

<sup>92</sup> Unicare’s “Security Choice” PFFS plan is available in the following Montana counties: Broadwater, Carter, Custer, Dawson, Fergus, Flathead, Gallatin, Garfield, Jefferson, Judith Basin, Lewis and Clark, Lincoln, McCone, Meagher, Petroleum, Powder River, Powell, Prairie, Richland, Sheridan, Stillwater, Sweet Grass, Treasure, Wheatland and Wibaux.

<sup>93</sup> Wellcare’s “Concert” PFFS plan is available in the following Montana counties: Broadwater, Fergus, Flathead, Lewis and Clark, Lincoln, Sanders and Teton.

<b>Benefit</b>	<b>Traditional Medicare</b>	<b>Advantra</b>	<b>Humana</b>	<b>Sterling</b>	<b>Unicare</b>	<b>Wellcare</b>
<b><i>Inpatient Hospital Care</i></b>	Day(s) 1-60: \$992 deductible per benefit period <sup>94</sup> Days 61-90: \$248/day Days 91-150: \$496/lifetime reserve day <sup>95</sup>	Day(s) 1-5: \$180/day Days 6-90+: \$0	\$550 per Medicare-covered stay for unlimited number of days	Day(s) 1-5: \$150/day Days 6-90+: \$0	<i>Option 1</i> Day(s) 1-5: \$150-\$200/day Days 6-90: \$0 <i>Option 2</i> \$50 per Medicare-covered stay *Penalty for failure to notify <sup>96</sup>	Day(s) 1-5: \$225/day Days 6-90: \$0
<b><i>Skilled Nursing Facility</i></b>	Day(s) 1-20: \$0 Days 21-100: \$124/day *3-day prior hosp. stay required *Coverage for 100 days each benefit period	Day(s) 1-3: \$0 Days 4-100: \$90  *No prior hospital stay required *Coverage for 100 days each benefit period	Day(s) 1-3: \$0 Days 4-100: \$90  *No prior hospital stay required *Coverage for 100 days each benefit period	Day(s) 1-10: \$0 Days 11-100: \$35/day *3-day prior hospital stay required *Coverage for 100 days each benefit period	<i>Option 1</i> Day(s) 1-20: \$0 Days 21-100: \$25-100/day <i>Option 2</i> No co-payment *Penalty for failure to notify <sup>97</sup>	Day(s) 1-15: \$0 Days 16-60: \$90/day Days 61-100: \$0 *No prior hospital stay required *Coverage for 100 days each benefit period
<b><i>Home Health Care</i></b>	No copayment	No copayment	No copayment	15% of the cost for Medicare-covered home visits	No copayment	\$0-\$35 for Medicare-covered home health visits
<b><i>Durable Medical Equipment</i></b>	20% of Medicare-approved amounts	20% of the cost for each Medicare-covered item	20% of the cost for each Medicare-covered item	20%-50% of the cost for each Medicare-covered item *Penalty for failure to notify <sup>98</sup>	20%-30% of the cost for each Medicare-covered item *Penalty for failure to notify <sup>99</sup>	25% of the cost for each Medicare-covered item

<sup>94</sup> A benefit period begins the first day a Medicare beneficiary enters a hospital or SNF and ends when s/he has been at less than a skilled level of care, or outside a hospital or SNF, for 60 consecutive days. If the beneficiary re-enters a hospital or SNF during those 60 days he/she does not pay a new deductible. 2007 Medicare Handbook, §3.03[E].

<sup>95</sup> Part A benefits allow for 60 lifetime reserve days for use after a 90-day benefit period has been exhausted. The 60 days are not renewable and may be used only once during a beneficiary's lifetime. MBPM, Chapter 3.

<sup>96</sup> Failure to notify the plan of planned inpatient admission results in \$50 per day surcharge, up to a maximum of \$500 per admission.

<sup>97</sup> Failure to notify the plan of a planned inpatient admission results in a \$50/day surcharge, up to a maximum of \$500 per admission.

<sup>98</sup> Failure to notify the plan of an equipment purchase over \$750 makes enrollee liable for 50% of billed charges.

<sup>99</sup> Failure to notify the plan of an equipment purchase over \$750 makes enrollee liable for 70% of billed charges.

## APPENDIX E

### OREGON COST-SHARING STRUCTURES: TRADITIONAL MEDICARE AND PFFS PLANS

<b>Benefit</b>	<b>Traditional Medicare</b>	<b>Advantra<sup>100</sup></b>	<b>Humana<sup>101</sup></b>	<b>Sterling</b>	<b>Secure Horizons<sup>102</sup></b>	<b>Heritage (Today's Options)</b>	<b>Unicare<sup>103</sup></b>	<b>Wellcare<sup>104</sup></b>
<b>Part B Premium</b>	\$93.50/mo.	\$93.50/mo.	\$93.50/mo.	\$93.50/mo.	\$93.50/mo.	\$93.50/mo.	\$93.50/mo.	\$93.50/mo.
<b>MA Premium</b>	--	--	\$22, \$32, or \$52/mo.	\$28.70/mo. including Part D benefits	\$60/mo. including Part D benefits	\$10-\$117/mo.	\$0-\$56/mo.	\$0-\$139/mo.
<b>Maximum Out-of-Pocket Limit</b>	--	\$3,000/yr.	\$5,000/yr.	--	--	\$2500-\$3000/yr.	--	\$3,650/yr. <sup>105</sup>
<b>Doctor Visits</b>	20% of Medicare-approved amounts	\$15 per primary care visit and \$30 per specialist visit for Medicare-covered services	\$15 per primary care visit and \$30 per specialist visit for Medicare-covered services	\$10 per primary care visit and \$35 per specialist visit for Medicare-covered services	\$15 per primary care visit and \$30 per specialist visit for Medicare-covered services	\$5-\$15 per primary care visit, \$15-\$30 per specialist visit for Medicare-covered services	\$10 per primary care visit and \$10-\$25 per specialist visit for Medicare-covered services	\$10 per primary care visit and \$35 per specialist visit for Medicare-covered services

<sup>100</sup> Advantra's "Freedom" PFFS plan is available in the following Oregon counties: Baker, Benton, Clackamas, Columbia, Crook, Deschutes, Hood River, Klamath, Lake, Lincoln, Malheur, Marion, Multnomah, Polk, Sherman, Umatilla, Union, Wasco and Washington.

<sup>101</sup> Humana's "Gold Choice" PFFS plan is available in the following Oregon counties: Baker, Benton, Clackamas, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Grant, Harney, Hood River, Jefferson, Klamath, Lake, Lincoln, Malheur, Marion, Multnomah, Polk, Sherman, Umatilla, Union, Wallowa, Wasco, Washington, Wheeler and Yamhill.

<sup>102</sup> This UnitedHealthcare (SecureHorizons) "Medicare Complete" PFFS plan is available in the following Oregon counties: Clackamas, Marion, Multnomah, Polk and Washington.

<sup>103</sup> Unicare's "SecurityChoice" PFFS plan is available in the following Oregon counties: Baker, Benton, Clackamas, Columbia, Crook, Deschutes, Hood River, Klamath, Lake, Lincoln, Malheur, Marion, Multnomah, Polk, Sherman, Umatilla, Union, Wasco and Washington.

<sup>104</sup> Wellcare's "Concert" PFFS plan is available in the following Oregon counties: Baker, Benton, Clackamas, Columbia, Douglas, Hood River, Jackson, Klamath, Lane, Lincoln, Malheur, Marion, Multnomah, Polk, Sherman, Umatilla, Union and Washington.

<sup>105</sup> Excludes DME and Part B-covered drugs.

<b>Benefit</b>	<b>Traditional Medicare</b>	<b>Advantra</b>	<b>Humana</b>	<b>Sterling</b>	<b>Secure Horizons</b>	<b>Heritage (Today's Options)</b>	<b>Unicare</b>	<b>Wellcare</b>
<b><i>Part B Covered Drugs</i></b>	20% of cost for Part B-covered drugs	20% of cost for Part B-covered drugs	20% of cost for Part B-covered drugs	20% of cost for Part B-covered drugs	20% of cost for Part B-covered drugs	20% of cost for Part B-covered drugs	0%-20% of cost for Part B-covered drugs, depending on the plan	25% of cost for Part B-covered drugs
<b><i>Inpatient Hospital Care</i></b>	Day(s) 1-60: \$992 deductible per benefit period <sup>106</sup> Days 61-90: \$248/day  Days 91-150: \$496/lifetime reserve day <sup>107</sup>	Day(s) 1-5: \$180/day Days 6-90+: \$0	\$550 per Medicare-covered hospital stay (for lower premium plans) ..... Day(s) 1-5: \$180/day Days 6-90: \$0 (for higher premium plan)	Day(s) 1-5: \$150/day Days 6-90+: \$0	Day(s) 1-5: \$200/day Days 6-90+: \$0 *Except in an emergency, provider must obtain authorization from the plan	Day(s) 1-4: \$175/day Days 5-90+: \$0 *\$1700 max out-of-pocket limit each year *Penalty for failure to notify <sup>108</sup>	<i>Option 1</i> Day(s) 1-5: \$150-\$200/day Days 6-90: \$0 <i>Option 2</i> \$50 per Medicare-covered stay *Penalty for failure to notify <sup>109</sup>	Day(s) 1-5: \$225/day Days 6-90: \$0

<sup>106</sup> A benefit period begins the first day a Medicare beneficiary enters a hospital or SNF and ends when he/she has been at less than a skilled level of care, or outside a hospital or SNF, for 60 consecutive days. If the beneficiary re-enters a hospital or SNF during those 60 days he/she does not pay a new deductible. 2007 Medicare Handbook, §3.03[E].

<sup>107</sup> Part A benefits allow for 60 lifetime reserve days for use after a 90-day benefit period has been exhausted. The 60 days are not renewable and may be used only once during a beneficiary's lifetime. MBPM, Chapter 3.

<sup>108</sup> Failure to notify the plan of a planned inpatient admission results in \$150 per day surcharge, up to a maximum of \$150.

<sup>109</sup> Failure to notify the plan of a planned inpatient admission results in \$50 per day surcharge, up to a max of \$500 per admission.

<b>Benefit</b>	<b>Traditional Medicare</b>	<b>Advantra</b>	<b>Humana</b>	<b>Sterling</b>	<b>Secure Horizons</b>	<b>Heritage (Today's Options)</b>	<b>Unicare</b>	<b>Wellcare</b>
<b><i>Skilled Nursing Facility</i></b>	Day(s) 1-20: \$0 Days 21-100: \$124/day *3-day prior hospital stay required *Coverage for 100 days each benefit period	Day(s) 1-3: \$0 Days 4-100: \$90/day <sup>2</sup> *No prior hospital stay required *Coverage for 100 days each benefit period	Day(s) 1-3: \$0 Days 4-100: \$90/day *No prior hospital stay required *Coverage for 100 days each benefit period	Day(s) 1-10: \$0 Days 11-100: \$35/day *3-day prior hospital stay required *Coverage for 100 days each benefit period	Day(s) 1-10: \$0 Days 11-100: \$100/day *No prior hospital stay required *Coverage for 100 days each benefit period	Day(s) 1-20: \$0 Days 21-100: \$100/day *No prior hospital stay required *Coverage for 100 days each benefit period	<i>Option 1</i> Day(s) 1-20: \$0 Days 21-100: \$25-100/day <i>Option 2</i> No co-payment *Penalty for failure to notify <sup>110</sup>	Day(s) 1-15: \$0 Days 16-60: \$90/day Days 61-100: \$0 *No prior hospital stay required *Coverage for 100 days each benefit period
<b><i>Home Health Care</i></b>	No copayment	No copayment	No copayment	15% of the cost for Medicare-covered home visits	No copayment *Authorization rules may apply	15% of the cost for Medicare-covered home visits	No copayment	\$0-\$35 for Medicare-covered home health visits
<b><i>Durable Medical Equipment</i></b>	20% of Medicare-approved amounts	20% of the cost for each Medicare-covered item	20% of the cost for each Medicare-covered item	20%-50% of the cost for each Medicare-covered item *Penalty for failure to notify <sup>111</sup>	20% of the cost for each Medicare-covered item *Authorization rules may apply	20% of the cost for each Medicare-covered item *Penalty for failure to notify <sup>112</sup>	20%-30% of the cost for each Medicare-covered item *Penalty for failure to notify <sup>113</sup>	25% of the cost for each Medicare-covered item

<sup>110</sup> Failure to notify the plan of a planned inpatient admission results in \$50 per day surcharge, up to a max of \$500 per admission.

<sup>111</sup> Failure to notify the plan of an equipment purchase over \$750 makes enrollee liable for 50% of billed charges.

<sup>112</sup> Failure to notify the plan of an equipment purchase over \$750 makes enrollee liable for 50% of billed charges.

<sup>113</sup> Failure to notify the plan of an equipment purchase over \$750 makes enrollee liable for 70% of billed charges.