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The Emerging Role of Group Medicare Private Fee-for-Service Plans

Prepared by

Ruth Brown, Miryam Frieder, Jonathan Blum, and Penny Mills
Avalere Health

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EXECUTIVE SUMMARY

Medicare Advantage (MA) plans, mainly Health Maintenance Organizations (HMOs), have been an option for employers offering retiree health benefits since the 1970s, but only in recent years has enrollment taken off, primarily in private fee-for-service (PFFS) plans. As of June 2008, nearly 1.7 million Medicare beneficiaries were enrolled in employer plans that contract with MA (known as "group MA" plans), up from just over 900,000 in 2006. Most of the growth in group MA plans has been in PFFS plans, which have grown in enrollment from 32,890 in 2006 to 600,543 in 2008. The rapid growth of group PFFS plans has important implications for retirees, employers and policymakers.

PFFS plans are private MA plans that are offered alongside HMOs and other MA plan options, however they are similar to Original Medicare in that they are currently not required to create networks of providers and they are restricted from employing utilization management controls. Enrollees may see any provider willing to accept Medicare and the individual plan's terms and conditions. Enrollees receive all of their Medicare benefits through the PFFS plan, and may also receive supplemental benefits or Part D prescription drug benefits through the plan. Group PFFS plans are offered exclusively to employer groups, instead of in the individual market, to provide retiree health coverage for that employer's retirees.

This paper reviews legislative and regulatory changes that have contributed to the growth in group PFFS enrollment. It describes the current payment system for group MA plans and presents trends in enrollment and plan participation, based on CMS administrative files. The paper also summarizes interviews with key stakeholders involved in the emergence of group PFFS, including large employers, unions, health plans, employee benefit consultants and beneficiary advocates, to describe factors that contribute to employers' interest in PFFS, and their views about the potential for enrollment growth in the future.

Key Findings

Over the past several years, changes in law and regulations have encouraged greater plan participation and enrollment growth in the MA employer group market. Group PFFS plans are of interest to employers for the following reasons:

- Group PFFS plans have the potential to reduce employers' retiree health costs. The payments that MA plans, including PFFS, receive from the federal government may be generous enough, in some instances, to allow the MA plan to offer employers a retiree healthcare package that is less expensive than the employer's prior retiree coverage, typically a Medicare supplemental plan. Whether or not this is the case for individual employers depends on various factors explained throughout this paper.

- PFFS plans allow employers to offer uniform benefits nationwide to Medicare-eligible retirees, with minimal administrative burdens. Unlike network-based HMOs or PPOs, PFFS can easily be offered as a national plan, available to retirees wherever they live or move across the country. A national plan with a uniform benefits package increases equity across an employer's retirees.

- PFFS allows employers to maintain benefit design and minimize change for retirees as they transition from other coverage to group MA plan coverage as Medicare-eligible retirees. Without a network of providers in a group PFFS plan, retirees may not have to worry about switching to a new provider in their Medicare plan's network, as they would under a Medicare HMO or PPO. Group PFFS plans may be willing to tailor benefits and cost sharing to match the employer's needs.

- Group PFFS plans are now being offered by some of the larger, national insurance companies with which employers and benefit consultants are more familiar. Employers are more comfortable contracting with these firms as they may trust their stability in the marketplace, or have experience contracting with them for coverage for their other employees.

Despite rapid enrollment growth, prospects for continued growth in the group PFFS market are uncertain:

- The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) requires group PFFS plans to create provider networks in all areas in which they operate. This new requirement does not take effect until 2011; however, the non-network nature of PFFS plans is a primary reason why employers and unions choose group PFFS products.

- Future growth will depend in part on the outlook for MA payment rates. Employers are mindful of payment changes that occurred in the 1990s, and they do not want to experience a repeat of the Medicare+Choice (former name of Medicare Advantage) plan pullouts which caused anxiety for retirees and employers.

- Not all employers will realize savings by shifting retirees to PFFS plans – even if MA payment rates remain stable. Whether employers can save money with group PFFS depends on various factors and employers are unlikely to contract with PFFS unless they would realize cost savings.

In light of the current appeal of the group PFFS plan option for many employers, the trends in this market have important implications for retirees and policymakers.

INTRODUCTION

The role of Medicare Advantage (MA) plans in providing employer and union-sponsored retiree health benefits, referred to as group MA plans, has emerged as an issue of increasing interest to policymakers. As of June 2008, nearly 1.7 million Medicare beneficiaries were enrolled in group MA plans, up from just over 900,000 in 2006.[1] One particular type of MA plan, the private fee-for-service (PFFS) plan, has captured the majority of new enrollment in group MA plans over the past several years, with enrollment increasing from about 33,000 in 2006 to more than 600,000 in 2008. Policymakers are increasingly interested in PFFS plans, and group PFFS plans in particular, primarily because the federal government pays PFFS plans (as well as other types of MA plans) at a higher rate than the per capita costs of Original Medicare, and these increased subsidies drive up overall Medicare costs, especially as enrollment in PFFS climbs rapidly.

PFFS plans are paid by the federal government under the same capitated payment system as other MA plans.[2] However, PFFS plans more closely resemble a privately-administered version of Original Medicare and share few characteristics with Medicare managed care plans such as HMOs and PPOs. Most notably, PFFS plans are not currently required to create networks of providers, though plans may create networks and many PFFS plans will be required to do so in 2011 and thereafter. Enrollees may see any provider willing to accept Medicare and the individual plan's terms and conditions. PFFS plans that currently do not have networks must pay providers rates equal to, or greater than, what Original Medicare pays. PFFS plans may also not employ utilization management techniques commonly used by HMOs and they may not put providers at any financial risk.[3] In addition, PFFS plans are exempt from many requirements for other types of MA plans, such as offering the Part D drug benefit.

The share of employers offering retiree health benefits has declined over time, but nearly one-third of all large employers with 200 or more workers (31 percent) offer heath benefits to retirees,[4] and more than one-third of Medicare beneficiaries accessed health benefits through some type of employer-sponsored plan in 2006.[5] Employers and unions that offer health benefits for Medicare-eligible retirees have several choices for delivering these benefits.[6] Typically, large employers provide wrap-around coverage to retirees under self-insured plans. Others offer premium assistance to help retirees purchase supplemental plans in the individual market, either through a Medigap insurer or through a MA plan. More than one-third of large private-sector employers reported that they offered a group MA plan to retirees over age 65 in 2006.[7]

This paper focuses on the role of employer- and union-sponsored group PFFS plans in providing health benefits to Medicare-eligible retirees and the implications for beneficiaries and the Medicare program. It describes key changes in legislation and regulations that have helped to make PFFS plans a more attractive option for employer and union groups, as well as the current payment system for group MA plans. The paper summarizes interviews from key stakeholders to help explain why employers and unions may (or may not) find group PFFS plans attractive, underscores key considerations for retirees, and discusses prospects for future growth in group PFFS enrollment. Finally, this paper highlights the implications of enrollment trends in group PFFS plans for Medicare beneficiaries and the Medicare program overall.

METHODOLOGY

For this study, we conducted 18 interviews with representatives from employers, unions, health plans, employee benefit consultants, and beneficiary advocacy groups, including:

- Three large, national, private-sector employers offering retirees a group PFFS plan in 2008;
- One retiree healthcare purchasing coalition for large, private-sector employers that offered group PFFS plans in 2008;
- Three states or unions of state employees contracted with group PFFS plans,
- Five benefits consultants who work primarily with mid- to large-sized private and public sector employers that at least considered group PFFS plans as a retiree healthcare option;
- Three health plans that offer group PFFS plans to employers and/or unions, as well as participate in the individual MA market, and
- Three beneficiary advocates, including a State Health Insurance Program regional director, who have counseled Medicare beneficiaries enrolled in a group PFFS plan.

We conducted our interviews in April and May of 2008 using a standard interview protocol. To promote candor, all interviewees were offered full confidentiality. Those who wished to be identified are listed at the end of this paper. We supplemented our interviews with a literature review and thorough analyses of administrative data files supplied by the Centers for Medicare & Medicaid Services (CMS).

LEGISLATIVE AND REGULATORY HISTORY

Employers and unions have had the option to provide healthcare benefits to their Medicare-eligible retirees through private plans in Medicare since the Medicare program began.[8] Beginning in the 1970s, health maintenance organizations (HMOs) became the primary Medicare managed care plan type available to contract with employers (referred to as “group” plans).

The Medicare+Choice (M+C) program created by the 1997 Balanced Budget Act (BBA) further expanded private plan options for employers and individuals to include preferred provider organizations (PPOs), PFFS plans, medical savings accounts (MSAs), and provider-sponsored organizations (PSOs). Group MA plans cover all Medicare statutory benefits and can negotiate with employers to provide a range of supplemental services and/or reduced cost sharing for retirees. Retirees who enroll in a group MA plan receive all Medicare-covered and supplemental benefits covered under the contract through the MA plan. In creating the PFFS plan option, Congress hoped to provide Medicare beneficiaries a diverse range of plan choices and also foster more private plan availability in rural areas where HMOs historically had difficulty operating due to provider network requirements. Congress was also responding to pressure to create a private plan option in Medicare that offered unmanaged, unrestricted access to care.[9]

In 2003, the Medicare Modernization Act (MMA) authorized the Medicare Advantage (MA) program, which replaced the M+C program. The MMA increased payment rates to encourage plan participation and to stabilize the private Medicare plan market after

general declines in managed care and payment changes in the 1997 BBA led many M+C plans to reduce service areas or shut down altogether. The MMA also authorized the Medicare Part D prescription drug benefit, requiring most MA plans to offer drug coverage. Additional funding provided by the MMA also created greater opportunities for some employers to maintain healthcare benefits or reduce costs, as discussed in a later section of this paper.

Subsequent to the MMA, CMS issued several regulatory waivers to make group PFFS plans more attractive to employers, unions and plan sponsors by reducing the administrative and operational barriers to extending coverage to all retirees nationwide. Beginning in 2006, CMS allowed group PFFS plans to submit one national plan application that covers retirees throughout the entire country, instead of submitting multiple applications that target specific counties where retirees live.[10] This decision reduced employers' administrative burdens in establishing group PFFS plans, enabling them to offer national coverage to their retirees regardless of where they live or move.

Further, as of 2008, group PFFS plans are no longer required to extend coverage to individual Medicare beneficiaries (those not covered by groups) who live in the service area where group plans are offered, whereas HMOs and PPOs are required to do so.[11] Therefore, PFFS plans that prefer to contract solely with employer groups can restrict enrollment exclusively to the employer's retirees, rather than also allow individual Medicare beneficiaries to enroll in the plan. To the extent that plans value the ability to select particular counties in which to operate – since payment levels are county-specific – PFFS plans can more easily offer nationwide group coverage without facing the possibility that individuals in low-payment counties who are not part of the employer or union group will enroll.

Along with these favorable regulatory provisions, a more recent change by CMS and Congress may increase the appeal of group HMOs and PPOs relative to PFFS plans. Beginning in 2009, CMS will allow group HMOs and PPOs to extend coverage to retirees living in areas where the plans are not able to establish provider networks. Plans must establish networks for at least a majority of the employer's retirees but will be allowed to function like a non-network PFFS plan in certain counties where retirees live.[12]

Of greater significance, Congress recently enacted the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) which requires group PFFS plans to create provider networks in all areas in which they operate. This new requirement does not take effect until 2011; however, the non-network nature of PFFS plans is a primary reason why employers and unions choose group PFFS products. Observers expect slower enrollment in group PFFS plans due to this policy change.

HOW GROUP MEDICARE ADVANTAGE PLANS ARE PAID

All MA plans, whether group or individual, are paid by the federal government using the same payment formula. Plans submit bids to CMS that represent the estimated cost of providing Medicare Parts A and B benefits in specific counties. These bids are compared to county-level benchmark rates that are set by CMS. The benchmark rates are never below projected Original Medicare costs in each county, and on average, exceed Original Medicare costs by 18 percent.[13] If the bid is below the benchmark rate,

the plan is paid the bid amount plus a "rebate" of 75 percent of the difference between the bid and the benchmark. The remaining 25 percent is returned to the federal government. The plan must use this rebate to reduce beneficiary premiums and/or cost sharing or to offer supplemental benefits to enrollees, such as vision or hearing services. If the bid is above the benchmark, the plan is paid the benchmark amount and the plan's enrollees pay the difference between the bid and the benchmark in the form of a monthly premium. Payments to MA plans are adjusted by certain demographic factors and by the expected health risk of the enrollees.

The Medicare Payment Advisory Commission (MedPAC) has found that, on average, MA plans are paid 13 percent more than it would cost the government to provide services for those enrollees through Original Medicare.[14] This is due, in part, to the benchmark rates being set higher than projected Original Medicare costs in order to encourage plan participation. Depending on various factors, plans may get paid more or less than this average. According to MedPAC, group MA plans, on average, are paid 16 percent above Original Medicare costs – three percentage points higher, on average, than individual MA plans.[15] The difference is due to group plans submitting higher bids, on average, which result in higher payments.[16] While individual MA plans may aim to submit low bids in order to maximize their federal rebates to offer zero premiums and supplemental benefits to attract enrollees, group MA plans have flexibility to negotiate premiums and benefits with employers and therefore may aim to maximize revenue from the federal government by submitting relatively higher bids. This flexibility results from the "placeholder" bid that group MA plans submit to CMS which may or may not reflect the actual benefit package that plans separately negotiate with employers. In this negotiation with the employer, the group plan may be able to share its higher revenue from the federal government with the employer in the form of reduced premiums or cost sharing, or more supplemental benefits for retirees.

Exhibit 1 illustrates why a group MA plan may be attractive to an employer, from a financial perspective. In this example, an employer has a choice between Option 1 – offering retirees Original Medicare and subsidizing premiums for a Medigap plan – and Option 2 – contracting with a group MA plan and subsidizing the MA plan premium. If the employer chooses to subsidize a Medigap premium, the federal government spends $1,000 per month for the retiree in Original Medicare, and the employer spends $100 per month for the retiree's Medigap premium. In Option 2, however, the retiree is enrolled in a group MA plan which costs the federal government $1,160 per month (group MA plans on average are paid 116 percent of Original Medicare costs), and the MA plan uses the $160 in extra funding to reduce the premium to zero and offer

Exhibit 1

Retiree Health Care Benefits Options

	Option 1: Original Medicare + Medigap	Option 2: Medicare Advantage
Government Spending*	$1,000 (Cost of Original Medicare)	$1,160 (MA Payment, 16% above cost of Original Medicare)
Employer Spending*	$100 (Medigap Premium)	$0 ($160 buys down MA premium and/or reduces cost sharing for retirees)

NOTES: *Spending is per member, per month.
SOURCE: Avalere Health analysis for the Kaiser Family Foundation, 2008.

supplemental benefits to retirees. As a result of the extra payment from the government, the employer in Option 2 can reduce costs and offer similar or better benefits to its retirees.

TRENDS IN GROUP PFFS ENROLLMENT AND PLAN AVAILABILITY

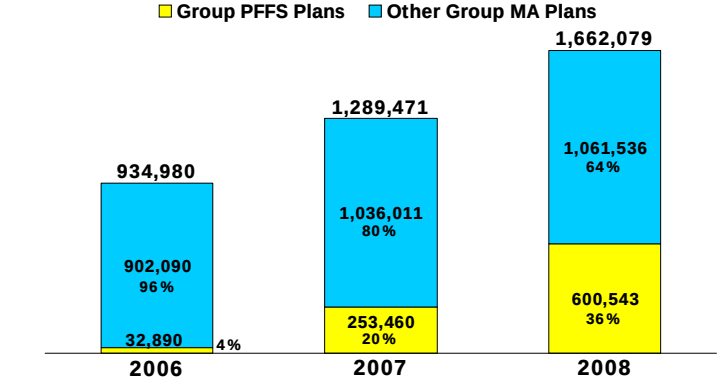
Group PFFS enrollment has grown rapidly.

Enrollment in group PFFS has expanded rapidly from almost 33,000 in 2006 to over 600,000 enrollees in 2008 (Exhibit 2). Today, group PFFS enrollment represents 36 percent of total group MA enrollment, up from 4 percent in 2006, and accounts for more than three-quarters of the overall growth in group MA enrollment. CMS does not currently collect information on which employers contract with MA plans; therefore, the number of employers who offer group PFFS plans for retirees is unknown.[17]

Steep enrollment growth in group PFFS plans is part of the explanation for the large gains in overall PFFS enrollment. While individual enrollment still accounts for about 75 percent of total PFFS enrollment, group plans are growing at a faster rate than enrollment in individual PFFS plans. In 2006, group PFFS enrollment represented 4 percent of total PFFS enrollment, growing to 27 percent by 2008.[18]

Exhibit 2

Enrollment in Group Medicare Advantage Plans, 2006-2008



NOTES: Enrollment excludes 1876 Cost Plans and Demonstration plans.
SOURCE: Avalere Health analysis of 2006-2008 plan enrollment data from the Centers for Medicare & Medicaid Services for the Kaiser Family Foundation, 2008.

PFFS plans are not required to provide the Medicare Part D prescription drug benefit. Fewer than half of retirees enrolled in group PFFS plans receive Part D through their plan.[19] These retirees may access Part D by enrolling in a stand-alone prescription drug plan (PDP) or through their employer's self-funded drug benefit, potentially subsidized in part by the Retiree Drug Subsidy (RDS).[20] In comparison, 88 percent of enrollees in group HMOs or PPOs receive Part D through their same MA plan.[21] Since the RDS is exempt from federal taxes, employers with higher marginal tax rates may face an economic incentive to carve drug benefits out of the PFFS plan. Non-profit or government employers, who do not have any federal tax liability, have less incentive to continue direct sponsorship of the drug benefit with the RDS.

Major health plan sponsors are entering the group PFFS market.

Health plan sponsors are actively pursuing the group PFFS market. In 2006, nine health plan organizations offered group PFFS plans. In 2008, there are 41 sponsoring organizations.[22] Observers note that enrollment could grow even faster as more health plan sponsors offer group PFFS products.

Though many more plans are entering this market, the top ten group PFFS plans have captured over 95 percent of enrollment in this product to date. Aetna and BCBS of Michigan have the most enrollees in group PFFS plans, together capturing over half of the market. Coventry (15 percent) and Humana (10 percent) are also major players, while WellPoint, Highmark, Preferred Care, Deseret Mutual Benefit Administrators, University of Pittsburgh Medical Center, and Medical Mutual of Ohio each have just a few percent of total group PFFS enrollment.[23]

Other major players in the individual PFFS market, such as Universal American, WellCare, and United Healthcare, have a relatively modest share of group PFFS enrollment, if any. For some plans, a single contract comprises the bulk of its PFFS plan enrollment. For example, BCBS of Michigan contracts with the Michigan Public School Employees Retirement System to cover more than 115,000 of its retirees,[24] more than half of BCBS of Michigan's total group PFFS enrollees. Similarly, Coventry recently contracted with the Commonwealth of Pennsylvania to provide retiree healthcare coverage.[25] After enrollment began in April 2008, Coventry's group PFFS enrollment grew from 37,012 to 87,673 by May 2008.[26]

STAKEHOLDER PERSPECTIVES

Stakeholder interviews with employers, unions, health plans, benefit consultants, and beneficiary representatives offered insights on why some employers are (and are not) attracted to group PFFS plans for their Medicare-eligible retirees. Interviews also revealed key considerations of the rapid growth in the group PFFS market for retirees.

Some employers are attracted to Medicare Advantage plans (and PFFS plans in particular) because of the potential to reduce retiree health costs.

Because federal payments to MA plans are greater than the cost of providing services through Original Medicare, MA plans may be willing to pass on some of this "extra" payment to employers in the form of reduced cost sharing or richer benefits. It is possible for some employers to provide a package of benefits through an MA plan at a lower cost than through other types of Medicare supplemental coverage (as illustrated in Exhibit 1).

Employers, union representatives, and benefit consultants report that employers are struggling to find ways to minimize their financial liability for retiree health benefits. Many of them are exploring the potential for PFFS plans to help reduce costs, citing rapidly rising healthcare costs as a significant challenge in maintaining coverage for both active and retired workers.[27] In addition, the 1990 Financial Accounting Standards (FAS) requires employers to report healthcare costs on an accrual basis rather than on a cost basis.[28] In practice, this means that company balance sheets must reflect the present value of future retiree health cost liabilities, not just current period obligations. More recently, the Government Accounting Standards Board

> *"All private sector employers have to address the FAS 106 liabilities. MA is attractive if it can lower future liabilities and is not too administratively complex. If MA leads to higher future liabilities that is a deal-killer."* – Benefit Consultant

(GASB) issued a similar accounting statement, known as GASB 45, requiring public employers to comply on statements in 2008.[29] Interviewees noted that credit rating agencies pay close attention to these requirements, and public employers feel pressure to reduce future costs for retiree healthcare in order to maintain favorable credit ratings.

Beneficiary advocates expressed some concern that employers could use the transition to PFFS as an opportunity to lower their own costs *and* reduce benefit levels, either through offering fewer benefits or increasing cost sharing.

However, not all employers can achieve savings by shifting retirees to group PFFS plans. Whether an employer can save money is in part a function of the MA payment formula, which takes into account the geographic distribution and risk profile of the group's retirees.

Whether an employer can find cost savings by switching to a group PFFS plan for retiree healthcare benefits depends on the characteristics of the employer's retiree population. Since MA payments from the federal government are in part based on the geographic location and specific health characteristics of a plan's enrollees, the payment rates for group MA plans vary, reflecting differences in the geographic distribution, demographics and risk profile of employers' retirees. According to benefit consultants interviewed for this paper, employers with a substantial concentration of retirees residing in relatively high payment areas and with favorable risk profiles have the greatest opportunity to benefit from PFFS. Those with a high concentration of retirees residing in relatively low payment areas and with unfavorable risk profiles may not stand to benefit. Interviews indicate that a substantial number of employers have opted against offering retirees a PFFS plan because the MA payment formula did not work in their favor.

> *"There is no conventional wisdom about whether MA will make a dent in accounting sheets."* – Benefit Consultant

Benefits consultants advise employers to analyze the geographic and risk profile of their retiree group before deciding to contract with a group PFFS plan, and only employers who could realize cost savings from PFFS consider this a viable retiree healthcare option.

PFFS may offer employers an administratively simpler option for providing coverage to retirees nationwide rather than patching together a network of HMOs and PPOs in every county where their retirees live.

Interviewees attribute the rapid enrollment growth in group PFFS plans to the current non-network nature of PFFS, enabling employers to contract with a single health plan to provide identical healthcare coverage to all of its retirees. Because PFFS plans are not required to have provider networks, health plans can offer employers a single group PFFS plan that operates nationally and can cover retirees wherever they live. In contrast, network-based HMOs and PPOs are localized in nature and cannot meet CMS' provider access requirements without the high-cost administrative burden of setting up networks in each county where retirees live, especially for those retirees who spend time

> "*We chose PFFS because there was very little interest among retirees in HMOs (surveys showed that only 2% of retirees were interested in HMOs). There was also logistical complexity to having lots of HMOs*" – Public Sector Employer

in multiple locations during the year. However, this will change in 2009 when group HMOs and PPOs will be permitted to operate as non-network plans in some counties. Interviewees suggested that currently, assembling a patchwork of HMOs and PPOs to effectively cover the entire country is prohibitively expensive for an employer.

Employers and unions favor an option that allows them to offer uniform benefits to retirees nationwide.

Interviewees noted that a uniform, national benefit enhances the equity of benefits across retirees. With PFFS, employers can offer all retirees an identical benefit package with the same retiree contribution and cost sharing nationwide, thereby eliminating historical disparities in benefit packages available to retirees in different locations under group HMOs. Beneficiary advocates noted that though benefit designs and premiums may remain the same, some retirees have encountered difficulties accessing benefits because providers are unwilling to participate in the group PFFS plan.

> *"PFFS is the only option for employers who want to offer a national product with a benefit design that mirrors previous benefits." – Benefit Consultant*

Employers also value the ability of PFFS plans to minimize disruption for retirees by exactly mirroring their current Medicare supplemental plan benefit designs.

According to interviews, a substantial portion of employers have a strong commitment to maintaining consistent benefit designs for retiree healthcare. Employers with contractual requirements to maintain certain levels of coverage (e.g. for unionized workers) and public employers with legislative or regulatory constraints on changing benefit designs place a particularly high premium on mirroring benefit designs. Private employers also noted that they prefer to minimize change for retirees who may find benefit design transitions highly disruptive, and will loudly voice their complaints.

Typically, employers are looking for alternatives to their Medicare supplemental benefits, and they report that PFFS plans are better suited than other MA plan types to mirror benefit designs of an employer's Medicare supplemental product due to the absence of provider network requirements. Switching retirees from a Medicare supplemental plan without a network into a network-based MA plan could be considered a material change in benefit design and may not be permitted due to contractual or statutory/regulatory constraints in the case of public employers.

Employers may become more comfortable with PFFS plans as more national insurers offer them.

Although PFFS was created in 1997, initially only a small number of relatively local plans offered PFFS products. However, in response to the financial incentives created by the MMA, health plan interest in MA, and PFFS in particular, has burgeoned. Several employers and benefits consultants noted in interviews that many more health plans – including well-known, national carriers – are actively marketing group PFFS plans, lending credibility to this market. As well-known health plans increasingly offer

> *"PFFS has very aggressive competition among carriers because the government subsidy makes it an attractive plan offering. Carriers are entering the PFFS market that have not historically been in the Medicare market." –* Industry Expert

group PFFS products, employers may be more willing to explore a group PFFS plan for their retirees and may have greater comfort in contracting with them.

Despite interest among employers and unions, several stakeholders expressed concerns about the group PFFS market, and reservations about prospects for growth in the future.

> *"In rural areas last spring, brokers pushed PFFS and people signed up as a result of unethical practices. Providers were unfamiliar with PFFS."* – SHIP Representative

Retirees in group PFFS plans typically were previously enrolled in an employer-sponsored Medicare supplemental plan. Beneficiaries' experience switching into a group PFFS plan largely depends on how the benefit design and access to providers under the prior coverage compares with the group PFFS plan, as well as on how smoothly the transition is implemented.

According to interviews, providers may refuse to accept PFFS enrollees for a variety of reasons. First, because PFFS plans are a relatively new type of Medicare plan, providers may not be familiar with their unique features and therefore are hesitant to see patients with PFFS. Second, in certain areas of the country, providers may have had negative experiences with a particular PFFS plan, for instance if the plan paid providers more slowly than other MA plan types or Original Medicare. Third, providers may receive higher rates than Original Medicare from HMOs or PPOs and therefore are unwilling to accept PFFS payment rates which may be equal to Original Medicare rates. Interviewees report that many of these initial concerns have abated, and that more providers are accepting PFFS enrollees.

> *"Once PFFS is implemented, it's not as good as promised. Retirees have provider access issues and problems with continuity of care."*– Employee Union

Depending on where retirees live, access to providers may still present problems. Stakeholders interviewed stated that in most cases plans and/or employers were able to identify why retirees experienced access issues and were subsequently able to resolve any issues. However, depending on the circumstance, the resolution may involve the retiree switching to a different provider. Plans and employers reported that they run educational sessions for providers in areas with a high concentration of retirees before starting up their PFFS plans. Employers and plans may assist retirees on an individual basis outside of these concentrated areas when access issues arise.

Finally, beneficiary advocates expressed concern that the group MA market – and especially group PFFS plans – may provide less stable benefits than those offered by Original Medicare and employer supplemental plans. Though employers always have the option to drop or reduce retiree healthcare coverage regardless of how benefits are offered, the MA program is subject to changes made by both the federal government and the private plan market. Interviewees cited the exiting of plans from the M+C market in the late 1990s and concerns that Congress may again reduce payment rates to MA plans, driving a large exit of group PFFS plans.

Interviews reveal no clear consensus on the potential for continued enrollment in group PFFS plans, although recent Medicare legislation may constrain future growth.

While recent trends show rapid growth in group PFFS enrollment, interviews with employers, employee benefit consultants, and health plans revealed widely divergent opinions on anticipated enrollment growth in group PFFS plans in the near term. Comments from interviews ranged from "*Growth will continue or accelerate – the potential is staggering*," to "*We don't expect much growth because of concerns about the future of PFFS*." Growth in group PFFS enrollment will be significantly influenced by four key factors:

- Future MA payment rates,
- Number of employers who can achieve savings through PFFS plans,
- Familiarity and comfort with group PFFS products, and
- How plans respond to MIPPA network requirements for group PFFS.

> *"Knowledgeable employers are skeptical about the viability of the PFFS market because these plans have historically high margins and Congress may be more likely to cut payments. There is more skepticism than one year ago."* – Benefit Consultant

Employers are concerned about uncertain MA payment rates. Many employers and benefits consultants are concerned that MA payment rates could fall in the future, tempering their interest in contracting with PFFS plans. Interviewees cited *"bad memories of Medicare+Choice"* as a deterrent to offering a PFFS plan, referring to the mass exodus of plans from the M+C program after the BBA reduced plan payment rates. This has made some employers concerned as to whether the federal government will continue to support private plans in Medicare at current funding levels.

> *"Savvy employers are aware of the Medicare+Choice-type thundercloud on the horizon but a lot of employers are not thinking about that – they are just trying to figure out what makes sense right now."* – Benefit Consultant

Interviewees consistently noted that the growth trajectory of group PFFS enrollment will depend on both *expectations* regarding MA payment rates as well as *actual* payment rates. For employers, the chief attraction of PFFS (and MA plans generally) is the potential for cost savings in providing retiree healthcare. As discussed earlier, cost savings to employers is directly related to MA payment levels; for some plans, payment levels may be high enough that employers can provide similar benefit levels at a lower cost by switching from Medicare supplemental products to MA.

For many employers, the savings potential remains unclear. The prospect for growth in group PFFS will be a function of employers' expectations about future savings. Since the geographic distribution and risk profile of an employer's retirees factor into the payment rate for a group MA plan, not all employers benefit financially from switching to PFFS. Interviews indicate that a substantial number of employers have opted against offering retirees a group PFFS plan because the MA payment formula did not work in their favor, even though group PFFS plans on average are paid 16 percent more than the cost under Original Medicare. Whether an employer can save money on retiree healthcare by contracting with a PFFS plan is determined on a case-by-case basis; therefore it is difficult to estimate the portion of the employer market that could see cost

savings. According to an employee benefits consultant, if switching to PFFS would not deliver sufficient savings, then the *"conversation is over."*

Growing familiarity with group PFFS may promote future enrollment. Interviews suggest that increased awareness and familiarity with PFFS may lead to enrollment growth in group PFFS. As is typical with the introduction of new products into a market, there is a leading edge of adoption followed by mass entry into the market of both suppliers and purchasers of the product. Some people interviewed believe that PFFS is now further along the adoption curve and that, absent a disruption such as a major payment reduction, enrollment could increase substantially over the next several years.

> *"Growth in PFFS is constrained by lack of awareness among employers and benefit consultants. Need education and awareness and this takes time."* – Health Plan

Recently enacted legislation may hinder growth. Recently enacted legislation has the potential to dampen group PFFS enrollment, though it is unclear at this point how large the impact will be. MIPPA requires all group PFFS plans to create provider networks by 2011.[30] As discussed earlier in the paper, the non-network nature of PFFS plans is the primary feature that makes PFFS attractive to employers relative to other MA plan types. It is possible that the network requirements placed on PFFS plans by MIPPA will make it harder for PFFS plans to provide sufficiently broad national coverage, and over time employers may find PFFS plans less attractive.

The Congressional Budget Office (CBO) estimates that as a result of MIPPA's new restrictions on non-network PFFS plans, enrollment in PFFS will be about one-third lower than previously expected, though CBO still expects continued growth in the overall PFFS market.[31]

While PFFS plans may become less attractive to employers beginning in 2011 when the new provider network requirements take effect, HMOs and PPOs may become more attractive to employers in the coming years. As discussed previously, CMS has extended to HMOs and PPOs waivers that may place HMOs, PPOs, and PFFS plans on a more level playing field in competing for enrollment in the group market. Specifically, the waiver allowing group HMOs and PPOs to offer retiree coverage in certain areas where the plan is unable to set up a provider network may actually make these plan types more attractive to employers beginning in 2011, when group PFFS plans must have networks in every county in which they operate.

DISCUSSION

The considerable growth in group PFFS plans appears to be largely driven by employers and unions seeking to constrain both the current costs of retiree healthcare – for themselves as sponsors of retiree healthcare as well as for their retirees – and liabilities for future costs. Employers, benefit consultants, and health plans consistently pointed out that the MA payment rates established by Congress and CMS, combined with the non-network nature of PFFS, create an opportunity for some employers to reduce costs while maintaining the level of benefits provided to retirees.

For some employers, the option to contract with a group PFFS plan may forestall decisions to reduce or drop retiree health benefits altogether. However, because relatively high MA payment rates are one primary factor contributing to the growth in group PFFS plans, the Medicare Trust Funds and Medicare premiums paid by all Medicare beneficiaries may be subsidizing retiree health coverage for retirees with access to employer-sponsored healthcare. Some have raised the question of whether the MA program is the most cost-efficient method for supporting retiree healthcare benefits.

Employers and benefit consultants interviewed for this paper have mixed views on whether growth in group PFFS plans will continue. While some experts believe that many more employers will choose this option, others think that the growth trend will attenuate or even reverse, especially after the implementation of the MIPPA requirement that all group PFFS plans establish provider networks. This new requirement may limit PFFS plans' ability to efficiently and affordably offer services throughout the entire country. Additionally, virtually all those interviewed stated that significant MA payment reductions in the future would severely reverse recent growth trends and could cause some employers to suspend their contracts. As a result, retirees may experience disruptions in their care as their employers seek new coverage arrangements.

When PFFS began to expand rapidly, many enrollees reported difficulty in accessing providers. Beneficiary advocates report that particularly in the early phase of implementing a group PFFS plan, some retirees describe difficulty accessing providers. Interviews indicate that access issues are often quickly addressed by employers or plans who reach out to providers on behalf of retirees, however retirees may have to switch to a new provider to access their healthcare benefits. Based on anecdotal reports, provider access problems appear to have abated due to expanded provider and consumer education efforts. Benefits also appear to be generally comparable to what retirees were offered prior to enrolling in a group PFFS plan. Nevertheless, virtually no statistically reliable information exists to assess the extent to which provider access issues have continued and how benefit levels compare across plans and between group MA plans and individual MA plans. In short, policymakers may not fully know what the Medicare program is paying for and whether or not access to providers remains a concern.

CMS has recently undertaken new efforts to collect information on group PFFS plans, which to date are only focused on employer participation and beneficiary enrollment. As more retirees enroll in group PFFS, it will become increasingly important for policymakers to fully ensure that retirees do not experience access and quality issues in group PFFS plans. Policymakers may wish to expand data collection and plan reporting requirements to include information on benefits and provider networks. Congress and other policymakers should continue to monitor the group MA market – particularly the rapidly growing group PFFS market – to guarantee that all MA enrollees have adequate access to providers and healthcare services and to assess the impact of recent legislative changes.

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ENDNOTES

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[3] Beginning in 2011, PFFS plans may vary payment rates to providers based on provider specialty, location, or other factors unrelated to utilization, and may increase payment based on increased use of preventive services.
[4] Kaiser Family Foundation/HRET Employer Health Benefits 2008 Annual Survey, September 2008.
[5] Kaiser Family Foundation, *Examining Sources of Coverage Among Medicare Beneficiaries: Supplemental Insurance, Medicare Advantage, and Prescription Drug Coverage,* July 2008.
[6] CMS, "Medicare Advantage/Prescription Drug Benefit 2008 Application Instructions for MA Organizations to Offer New Employer/Union-Only Group Waiver Plans (EGWPs)," January 16, 2007.
[7] Kaiser Family Foundation/Hewitt 2006 Survey on Retiree Health Benefits, December 2006.
[8] Zarabozo, Carlos. "Milestones in Medicare Managed Care." *Health Care Financing Review.* Fall 2000, vol.22, issue 1, page 61.
[9] Blum, March 2007.
[10] This applies to non-network PFFS plans only. States may still require plans to be licensed even though CMS does not. "2006 Employer/Union-Only Non-Network Private Fee-For-Service (PFFS) Plan Service Area Waiver Guidance." Accessed at: http://www.cms.hhs.gov/EmpGrpWaivers/Downloads/ServiceAreaWaiverPFFS.pdf.
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[14] "Employer Group Plans in the Medicare Advantage Program," Scott Harrison, MedPAC, April 9, 2008 Accessed at: http://medpac.gov/transcripts/04090410medpac.final.pdf.
[15] Ibid.
[16] MedPAC found that while individual MA plan bids are 15 percentage points below the benchmark amount, group MA plan bids are only 5 percentage points below the benchmark. "Employer Group Plans in the Medicare Advantage Program," Scott Harrison, MedPAC, April 9, 2008 Accessed at: http://medpac.gov/transcripts/04090410medpac.final.pdf.
[17] In a June 26, 2008 notice in the *Federal Register*, CMS proposed to collect new data from MA plans beginning in 2009 including names of employers contracted with group MA plans.
[18] Avalere Health analysis of CMS *Annual Enrollment by Plan,* July 2006 and 2007 and CMS *Monthly Enrollment by Plan*, June 2008.
[19] Avalere Health analysis of CMS *Monthly Enrollment by Plan*, June 2008.
[20] For employers offering prescription drug benefits at least as generous as Part D, the RDS offers a tax-free subsidy payment of 28 percent of allowable retiree prescription drug costs to encourage employers to continue covering this benefit.
[21] Avalere Health analysis of CMS *Monthly Enrollment by Plan*, June 2008.
[22] Avalere Health analysis of CMS *Annual Enrollment by Plan*, July 2006 and CMS *Monthly Enrollment by Plan*, June 2008.
[23] Avalere Health analysis of CMS *Monthly Enrollment by Plan*, June 2008.

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[26] Avalere Health analysis of CMS *Monthly Enrollment by Plan* files, May and June 2008. Note: Coventry may have contracts with other employers that contribute to this total enrollment.

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[28] "Statement of Financial Accounting Standards No. 106." *Financial Accounting Standards Board.* December 1990. Accessed at: http://www.fasb.org/pdf/fas106.pdf.

[29] "Accounting and Financial Reporting by Employers for Postemployment Benefits Other Than Pensions." *Government Accounting Standards Board.* June 2004. Summary accessed at: http://www.gasb.org/st/summary/gstsm45.html. This rule requires government employers with more than $100 million in annual revenues to account for their retiree medical benefits on an accrual basis rather than "pay-as-you-go" beginning in the first fiscal year after December 15, 2006. For those with revenues of $10-$100 million, the rules become effective beginning with the first fiscal year after December 15, 2007; for those with revenues under $10 million, the effective date is the first fiscal year after December 15, 2008.

[30] Individual PFFS plans in counties with network-based MA plans offered by two or more parent organizations are required to fulfill CMS' network adequacy requirements by 2011 by contracting with a network of providers. All employer group MA plans are required to create provider networks by 2011.

[31] CBO letter to the Honorable Judd Gregg (R-NH), July 8, 2008. Accessed at: http://www.cbo.gov/ftpdocs/95xx/doc9550/hr6331GreggLtr.pdf.

The Henry J. Kaiser Family Foundation

Headquarters
2400 Sand Hill Road
Menlo Park, CA 94025
(650) 854-9400 Fax: (650) 854-4800

Washington Offices and
Barbara Jordan Conference Center
1330 G Street, NW
Washington, DC 20005
(202) 347-5270 Fax: (202) 347-5274

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