

Financial Planning

Medicare Choices

Medicare private fee-for-service plans have stirred up Congress while growing 30-fold-plus in the past three years. How do you evaluate them?

By Donald Jay Korn

November 1, 2007- As recently as year-end 2004, "What is a Medicare private fee-for-service plan?" would have been a great trivia question. Of nearly 42 million Medicare beneficiaries, barely 50,000 were members of these plans.

Now the numbers are far from trivial. By the summer of 2007, enrollment in so-called PFFS plans reached 1.7 million, according to Michelle Kitchman Strollo, a principal policy analyst with the Kaiser Family Foundation in Washington, D.C. During that two-and-a-half-year period, more than half of all enrollment in nontraditional Medicare occurred in PFFS plans.

Since then, the plot has thickened. In June, the seven insurance companies that account for most PFFS plans "voluntarily agreed" with the federal Centers for Medicare and Medicaid Services (CMS) to suspend marketing these plans after it received numerous complaints of misleading sales tactics. Consequently, as of early fall, Congress was working on a bill that, if passed, might drastically cut back government support of PFFS plans.

NETWORK-FREE

What are PFFS plans and why did their fortunes rise and fall so dramatically? Most important, if these plans survive in their current form, should advisors suggest them for clients enrolled in or approaching Medicare eligibility?

The primary draw of PFFS plans is that unlike HMOs or PPOs, PFFS plans don't have any network of healthcare providers. With HMOs and PPOs, patients receive relatively comprehensive healthcare with only modest copayments if they see doctors and go to hospitals within the network, but they face higher fees if they venture outside the network. Enrollees in HMO, PPO and PFFS plans don't need a Medicare supplementary, or Medigap, insurance policy so they are spared what could be a considerable expense.

Like Medicare HMOs and PPOs, PFFS plans fall into the Medicare Advantage category, which essentially means that they are run by health insurance companies under contract to the federal government. Strollo says that nearly 20% of all Medicare enrollees are in a private Medicare Advantage program while the other 80% or so are enrolled in traditional Medicare, which is administered by CMS.

In all Medicare Advantage plans, enrollees pay the same Part B premiums for coverage of doctor bills as seniors in traditional Medicare. Part A, which covers hospital costs, is free for most Medicare beneficiaries. Enrollees pay additional fees for a Medicare Advantage plan but in return receive more extensive benefits than those offered in traditional Medicare and reduced out-of-pocket exposure. Original Medicare charges 20% coinsurance versus a modest copay for most Medicare Advantage plans. This modest copay usually obviates the need for a \$1,000 per year Medigap policy.

As part of Medicare Advantage, PFFS plans also promise comprehensive care with lower out-of-pocket costs, but they have none of the network restrictions of HMOs and PPOs. Sponsors claim that this makes the plans more portable than HMOs or PPOs because they may provide benefits anywhere in the U.S. "PFFS plans require no network of physicians, specialists or hospitals," says Dick Brown, director of public relations at Humana, the largest PFFS sponsor. "The healthcare provider need only accept Medicare reimbursement and accept the terms and conditions of the health plan providing benefits through a PFFS." In essence, seniors are told they can go to any doctor who accepts the terms of the plan, show their PFFS card and receive treatment.

AGGRESSIVE MARKETING

Despite this apparent advantage, the plans, authorized by the Balanced Budget Act of 1997,

didn't attract much attention until the Medicare Modernization Act of 2003 raised payments to private Medicare plans. Consequently, more healthcare companies decided to sponsor PFFS plans and promote them to Medicare beneficiaries.

As a result of more aggressive marketing, many more beneficiaries started signing up for the plans. According to a recent paper prepared for the Kaiser Family Foundation by healthcare consultant Avalere Health in Washington, D.C., "Ninety percent of PFFS enrollment is now found in high-payment counties." That is, the plans are patronized most in locales where private plans receive high Medicare payments (relative to local medical costs) and market PFFS plans most aggressively. "There was a scam PFFS in our community," says Steve Podnos, a medical doctor and CFP who is principal of Wealth Care on Merritt Island, Fla. "It collected premiums and told enrollees they could see any provider. However, almost no physicians had agreed to see the patients."

It seems that even legitimate PFFS plans may not offer enrollees a vast choice of waiting rooms. "PFFS plans are terrible for providers," says Podnos. "They demand that the provider decide whether to offer care under the plan's terms at each visit. The plans are free to change those terms at any time. No physician can really decide whether or not to accept a patient on a visit-by-visit basis."

As a result, some seniors who had been told they could enroll in a PFFS plan and go to any doctor found that few physicians would treat them. Several stories were reported in the local media and, last June, CMS got seven companies (United Healthcare, Humana, Wellcare, Universal American Financial Corp., Coventry, Sterling and Blue Cross/Blue Shield of Tennessee) to stop actively marketing PFFS plans until CMS could certify that adequate systems and management controls were in place. They apparently passed the test because they are all now selling the plans again.

The annual plan election period for seniors already participating in Medicare begins on Nov. 15 (through Dec. 31), and the question remains whether advisors should counsel clients to consider the plans. Congress is currently working on a bill that could affect Medicare Advantage, and PFFS plans in particular. Strollo says that it's hard to speculate on what will be included in the bill-or if it will be enacted-but as a result of the PFFS problems, the rules for these plans may be tightened.

"PFFS plans are subject to different rules than other Medicare Advantage plans," says Strollo. "For example, PFFS plans are not required to report the same quality performance data as other plans." A new law might level the playing field and remove some advantages PFFS plans now enjoy.

Moreover, the legislation might trim all Medicare Advantage outlays, to bring them in line with what is reportedly spent on traditional Medicare. If so, PFFS plans may receive lower payments from the federal government, especially if they are now receiving relatively high ones.

If the rules on PFFS plans are tightened and federal payments are cut, the plans are likely to raise costs or trim benefits to enrollees. Some PFFS plans might drop out of the Medicare Advantage altogether.

Given all this uncertainty at the start of the open enrollment period, how can planners advise clients who want to know about Medicare choices for themselves or their parents? "Check to see if their current healthcare provider will accept the PFFS terms and conditions from the sponsoring health plan and Medicare," suggests Brown. "That has been the critical issue surrounding this type of plan." If a client has been seeing several doctors, none of whom will accept terms from the PFFS plan, such a choice may be ill-advised.

A GOOD DEAL?

Costs count, too. All Medicare beneficiaries must pay a premium for Part B coverage of doctors' bills that is typically \$93.50 per month this year (but higher for certain upper-income seniors). Avalere Health found that more than one-third of all PFFS plans do not charge an additional fee above that for Part B.

Some PFFS plans charge up to \$144 per month (including the part B premium) especially if they offer a prescription drug benefit. Because of lower cost-sharing for some services and stop-loss coverage (meaning beneficiaries don't have to pay above a certain maximum), Avalere Health concludes that a PFFS plan "has the prospect of reducing out-of-pocket costs for many Medicare beneficiaries." This is also the case because enrollees don't have to pay for Medigap.

But not all PFFS enrollees enjoy cost reduction. The plans often charge copayments (as opposed to 20% coinsurance for regular Medicare) on doctors' visits and hospital stays, on top of the monthly premium, and those copayments can vary widely from plan to plan. For some services, such as extended post-acute care stays, PFFS members may end up paying higher out-of-pocket costs than original Medicare with a Medigap policy, the Avalere Health report notes.

"PFFS plans offer 'any hospital, any doctor' solutions," says Dave Holman, an employee benefits representative with Ashley Insurance Group in Maumee, Ohio. "But they are usually very close in price to Medicare Supplement [or Medigap] insurance policies." When you factor in the copays required at a doctor's office or a hospital, PFFS costs can be even more than those for traditional Medicare, he says.

With original Medicare, clients will pay a Part B premium and probably will add a Medigap policy as well as a prescription drug plan (PDP). "In our area, the total cost might be around \$250 per month [\$3,000 per year], says Holman. "That may be the same or even less than a client would wind up paying with a PFFS plan, but traditional Medicare offers complete freedom of choice."

Podnos tells his medical patients as well as his financial planning clients to choose PFFS if they can afford it. "Most can, and they enjoy the liberal access to doctors," he says. But, some clients and patients are attracted to Medicare Advantage plans, including PFFS plans, because of the potentially lower costs. The PFFS plans that charge no premium on top of Part B can be a really good deal, says Holman. Especially the 50% of plans that have a drug benefit too.

SUITABILITY

So who is most suitable for Medicare Advantage plans? Those with "serious health issues who are outside the guaranteed acceptance window for a Medicare Supplement policy," says Holman. That is, Medigap insurers must allow seniors to buy any policy at the standard rate-with no waiting period before preexisting conditions will be covered-within six months of first enrolling in Medicare Part B. After those six months, that guarantee no longer applies so such clients may be better off in a Medicare Advantage plan, where virtually all applicants must be accepted, regardless of their health or preexisting conditions.

Most clients, however can choose among a PFFS plan, some other Medicare Advantage plan and traditional Medicare with supplemental insurance by comparing costs. "Find out how restricted access to healthcare providers will be if you go outside of traditional Medicare," says Podnos. "Then estimate the cost saving and see if the restricted access is worth the money that will be saved."

After the annual election period each year, with few exceptions, seniors will be locked in to a plan for the next calendar year. Planners who want to save their clients some grief as well as money should take care when prescribing the right choice.

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