

September 2004

MEDICARE DEMONSTRATION PPOs

Financial and Other Advantages for Plans, Few Advantages for Beneficiaries

Correction made on 9/29/04 to p. 4, line 36 through p. 5, line 1, revised to read "About 9.9 million, or 98 percent, of the 10.1 million eligible beneficiaries living in counties where demonstration PPOs operated, had M+C plans available in their counties". Also, correction made on p. 47, footnote 5, line 4, revised to read "GAO, Medigap Insurance: Plans are Widely Available but Have Limited Benefits and May Have High Costs, GAO-01-941 (Washington D.C.: July 2001)".



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Highlights of [GAO-04-960](#), a report to the Ranking Minority Member, Committee on Finance, U.S. Senate

Why GAO Did This Study

Preferred provider organizations (PPO) are more prevalent than other types of health plans in the private market, but, in 2003, only six PPOs contracted to serve Medicare beneficiaries in Medicare+Choice (M+C), Medicare's private health plan option. In recent years, the Centers for Medicare & Medicaid Services (CMS), the agency that administers Medicare, initiated two demonstrations that include a total of 34 PPOs. GAO (1) described how CMS used its statutory authority to conduct the two demonstrations, (2) assessed the extent to which demonstration PPOs expanded access to Medicare health plans and attracted enrollees in 2003, (3) compared CMS's estimates of out-of-pocket costs beneficiaries incurred in demonstration PPOs with those of other types of coverage, including fee-for-service (FFS) Medicare, M+C plans, and Medigap policies in 2003, and (4) determined the effects of demonstration PPOs on Medicare spending.

What GAO Recommends

GAO recommends that the Administrator of CMS promptly instruct plans in the Medicare PPO Demonstration to provide coverage for all plan services furnished by any provider authorized to provide Medicare services who accepts the plans' terms and conditions of payment. CMS agreed to implement the recommendation, and stated that it believes the demonstrations are worthwhile.

www.gao.gov/cgi-bin/getrpt?GAO-04-960.

To view the full product, including the scope and methodology, click on the link above. For more information, contact A. Bruce Steinwald at (202) 512-7119.

MEDICARE DEMONSTRATION PPOs

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What GAO Found

CMS used its statutory authority to offer health-care organizations financial incentives to participate in the two demonstrations. CMS, however, exceeded its authority when it allowed 29 of the 33 plans in the second demonstration, the Medicare PPO Demonstration, to cover certain services, such as skilled nursing, home health, and routine physical examinations, only if beneficiaries obtained them from the plans' network providers. In general, beneficiaries in Medicare PPO Demonstration plans who received care from non-network providers for these services were liable for the full cost of their care.

The demonstration PPOs attracted relatively few enrollees and did little to expand Medicare beneficiaries' access to private health plans. About 98,000, or less than 1 percent, of the 10.1 million eligible Medicare beneficiaries living in counties where demonstration PPOs operated had enrolled in the demonstration PPOs by October 2003. Further, although one of the goals of the Medicare PPO Demonstration was to attract beneficiaries from traditional FFS Medicare and Medigap plans, only 26 percent of enrollees in its plans came from FFS Medicare, with all others coming from M+C plans. About 9.9 million, or 98 percent, of the 10.1 million eligible Medicare beneficiaries also had M+C plans available in their counties. Virtually no enrollment occurred in counties where only demonstration PPOs operated.

According to CMS's 2003 estimates, on average demonstration PPO enrollees could have expected to incur total out-of-pocket costs—expenses for premiums, cost sharing and noncovered items and services—that were the same or higher than those they would have incurred with nearly all other types of Medicare coverage. However, relative costs by type of coverage varied somewhat depending on beneficiary health status. For certain services and items, such as prescription drugs and inpatient hospitalization, demonstration plans provided better benefits relative to some other types of Medicare coverage.

Although it is too early to determine the actual program costs of the two demonstrations, CMS originally projected that the first demonstration would increase Medicare spending by \$750 per enrollee per year and the second demonstration would increase Medicare spending by \$652 per enrollee per year. Based on the agency's original enrollment projections, which exceed 2003 actual enrollment, CMS estimated the demonstration PPOs would increase program spending by \$100 million for 2002 and 2003 combined.

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Abbreviations

ACRP	Adjusted Community Rate Proposal
BBA	Balanced Budget Act of 1997
CMS	Centers for Medicare & Medicaid Services
FFS	fee-for-service
Fu	Fu Associates, Ltd.
GSA	Geographic Service Area
HMO	health maintenance organization
M+C	Medicare+Choice
MHPC	Medicare Health Plan Compare
MLR	medical loss ratio
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003
MMCC	Medicare Managed Care Contract
MPPF	Medicare Personal Plan Finder
OACT	Office of the Actuary
ORDI	Office of Research, Development, and Information
PFFS	private fee-for-service
PPO	preferred provider organization

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United States Government Accountability Office
Washington, DC 20548

September 27, 2004

The Honorable Max Baucus
Ranking Minority Member
Committee on Finance
United States Senate

Dear Senator Baucus:

In recent years, concerns have been raised that Medicare beneficiaries lack access to the type of health plan that is most prevalent in the private health insurance market, the preferred provider organization (PPO). In 2003, only six PPOs—plans that allow enrollees to obtain care from any provider, but charge enrollees less if they obtain care from the plans’ networks of preferred providers—participated in Medicare’s program for private health plans, known as Medicare+Choice (M+C).¹ About 3,000 of Medicare’s 41 million beneficiaries were enrolled in the six M+C PPOs. In contrast, 4.6 million Medicare beneficiaries were enrolled in 142 M+C health maintenance organization (HMO) plans, which generally require enrollees to obtain all covered services from the plans’ networks of providers.² The vast majority of Medicare beneficiaries, about 35.6 million, were not enrolled in private health plans participating in Medicare, but rather were enrolled in the traditional fee-for-service (FFS) program, in which they could obtain care from any Medicare provider. The percentage of Medicare beneficiaries enrolled in traditional FFS Medicare has increased in recent years, rising from 83 percent in 1998 to 87 percent in 2003—as the total number of private plans participating in M+C declined, and their benefit packages grew less generous.

The Centers for Medicare & Medicaid Services (CMS), the agency that administers Medicare, has authority under section 402(a) of the Social Security Amendments of 1967 to conduct demonstration programs to test methods of payment that have the potential to increase the efficiency and

¹The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) changed the name “Medicare+Choice” to “Medicare Advantage.” See Pub. L. No. 108-173, § 201, 117 Stat. 2066, 2176.

²Approximately 46,000 beneficiaries were enrolled in M+C plans that were not HMOs or PPOs.

economy of Medicare.³ CMS is authorized to waive Medicare payment rules under the demonstrations, which may result in increased Medicare spending.⁴ CMS used this statutory authority to initiate two demonstration programs that included health plans designed to operate under the PPO model.⁵ In January 2002, CMS began the M+C Alternative Payment Demonstration, which was intended to encourage certain M+C plans to remain in the Medicare program. One PPO, Independence Blue Cross, participated in 2003.⁶ In January 2003, CMS began a second demonstration, known as the Medicare PPO Demonstration, that included 33 plans. The goals of this demonstration were to encourage plans to participate in the Medicare program under the PPO model, extend beneficiary access to private health plans, and provide a health plan option that would attract beneficiaries from FFS Medicare and Medigap plans.⁷ Subsequent to the start of these two demonstrations, Congress passed the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), which revised Medicare's program for private plans and provided for a new PPO component to begin in 2006.

Because the experience gained through the two demonstrations may help guide future efforts to incorporate private plans into Medicare, you asked us to study the demonstrations' implementation and outcomes as they pertain to PPOs. Specifically, we (1) described how CMS used its statutory authority to conduct the two demonstrations; (2) assessed the extent to

³See Social Security Amendments of 1967, Pub. L. No. 90-248, § 402(a), 81 Stat. 821, 930-31 (1968) (codified at 42 U.S.C. § 1395b-1(a)(1)(A) (2000)).

⁴Pub. L. No. 90-248, § 402(b), 81 Stat. 821, 930-31 (1968) (codified at 42 U.S.C. § 1395b-1(b) (2000)).

⁵The term "PPO" appears in a variety of contexts in this report. For the remainder of the report, we use the term "PPO" alone to refer to the preferred provider model, in which enrollees can obtain services from providers outside the network if they agree to bear a greater share of the costs for those services. We use the term "M+C PPO" to refer to non-demonstration PPO plans participating in Medicare's M+C program. We use the term "demonstration PPO" to refer to demonstration plans that are intended to operate as PPOs. The distinction between M+C PPO and demonstration PPO is important because CMS established different sets of requirements for the two types of plans. In this report, we do not refer to the health plans participating in the two demonstration programs as "M+C plans."

⁶In addition to Independence Blue Cross, seven non-PPO plans participated in the M+C Alternative Payment Demonstration in 2003.

⁷A Medigap plan is a private insurance plan designed to supplement FFS Medicare by covering some Medicare cost-sharing amounts and possibly additional benefits, depending on the type of plan selected.

which demonstration PPOs expanded access to Medicare health plans and attracted enrollees in 2003; (3) compared CMS's estimates of the out-of-pocket costs beneficiaries incurred in demonstration PPOs with those of other types of coverage, including FFS Medicare, M+C plans, and Medigap policies in 2003; and (4) determined the effects of demonstration PPOs on Medicare spending prior to the passage of MMA.

To describe CMS's statutory authority to conduct demonstrations, we reviewed applicable federal law and regulations. We also solicited the agency's views on its interpretation of relevant statutes and regulations. Appendix I contains our legal analysis on the Medicare PPO Demonstration plans' restriction of enrollees' choice of providers. To assess health plan participation and enrollment, we used CMS's monthly reports on Medicare's private health plans, as well as historical enrollment data for demonstration PPO enrollees provided by CMS's Office of Research, Development, and Information (ORDI), which oversees the demonstrations. To compare beneficiary out-of-pocket costs between demonstration PPOs, M+C plans, Medigap policies, and FFS Medicare in 2003, we used estimates generated for CMS by Fu Associates, Ltd. (Fu), a private firm. CMS includes these estimates on the Medicare Web site, www.Medicare.gov, as a tool to help beneficiaries evaluate their coverage options. We conducted these comparisons for beneficiaries aged 65 through 69, the age group most likely to join M+C plans, in the 41 counties with approximately 90 percent of the enrollment in demonstration PPOs. We analyzed the reliability of CMS's enrollment data and estimates by conducting interviews with CMS's Office of the Actuary (OACT), ORDI, and Fu and determined that the data were sufficiently reliable for our purposes. To determine the effects of demonstration PPOs on Medicare spending, we used projections developed by OACT and conducted interviews with OACT staff. For all four objectives, we interviewed ORDI and OACT staff and reviewed relevant CMS materials. Appendix II contains a complete description of our methodology. We conducted our work from June 2003 through August 2004 in accordance with generally accepted government auditing standards.

Results in Brief

Under section 402(b) of the Social Security Amendments of 1967, CMS was authorized to waive Medicare payment requirements for health plans participating in the two demonstrations, but improperly waived requirements unrelated to payment.⁸ Under this authority, CMS offered financial incentives to Independence Blue Cross and the plans in the Medicare PPO Demonstration that were not available to M+C plans, such as payment rates that could exceed M+C payment rates and the opportunity to bear less financial risk by signing risk-sharing agreements with CMS. Under these agreements, a portion of the burden resulting from unexpectedly high costs, as well as any financial gains if costs were unexpectedly low, would be shared by both the plan and CMS. In addition, CMS allowed the plans to charge enrollees more in cost sharing than would have been permitted in the M+C program. However, CMS exceeded its authority with respect to the Medicare PPO Demonstration when it tacitly waived plan requirements that were unrelated to payment. By law, these plans should have been required to cover all services in their benefit packages even if those services were obtained from providers outside the plans' provider networks, as long as those providers accepted the plans' payment terms and were legally authorized to provide the services. However, the agency allowed 29 of the 33 plans in the Medicare PPO Demonstration to cover some services only when they were obtained from providers within their networks. In general, beneficiaries who received care from non-network providers for these services in these plans were liable for the full cost of their care. Examples of such services include skilled nursing and home health, which are covered under FFS Medicare, and dental care and routine physical examinations, which are not covered under FFS Medicare.

Demonstration PPOs attracted relatively few enrollees and did little to expand Medicare beneficiaries' access to private health plans in 2003. About 98,000, or less than 1 percent, of the 10.1 million eligible beneficiaries living in counties where demonstration PPOs operated had enrolled in demonstration PPOs by October 2003. Further, although one of the goals of the Medicare PPO Demonstration was to attract beneficiaries from FFS Medicare and Medigap plans, only 26 percent of enrollees in Medicare PPO Demonstration plans came from FFS Medicare, with all others coming from M+C plans. About 9.9 million, or 98 percent, of the 10.1 million eligible beneficiaries living in counties where demonstration

⁸Pub. L. No. 90-248, § 402(b), 81 Stat. 821, 930-31(1968)(codified at 42 U.S.C. 1395b-1(b) (2000)).

PPOs operated, had M+C plans available in their counties. Virtually no enrollment occurred in counties where only demonstration PPOs operated. Demonstration PPO enrollment was concentrated in two plans: one that existed prior to the launch of the demonstrations and another that replaced an HMO previously offered by the same organization.⁹

According to estimates prepared by CMS, and available on the Medicare Web site in 2003, beneficiaries who enrolled in demonstration PPOs could have expected to incur total out-of-pocket costs—expenses for premiums, cost sharing and noncovered services and items—that were the same or higher than those they would have incurred with nearly all other types of coverage if they used network providers. On average, the expected beneficiary out-of-pocket costs for demonstration PPOs were similar to those for Medigap plans F and I—private insurance plans that supplement FFS Medicare. Demonstration PPOs were estimated to have out-of-pocket costs that were higher than FFS Medicare, M+C HMO, and M+C PPO plans, but lower than M+C private fee-for-service (PFFS) plans, which in function resemble FFS Medicare but are operated by private companies.¹⁰ To the extent that beneficiaries in demonstration PPOs obtained services from non-network providers, their out-of-pocket costs would have been higher than those estimated on the Medicare Web site. For example, a six-night stay in a network hospital in 2003 was projected to cost a demonstration PPO enrollee an average of \$421, while the same length of stay in a non-network hospital cost an average of \$1,223. In addition, demonstration PPOs compared more favorably to other types of coverage for beneficiaries in poor health; for these beneficiaries, only Medigap plans F and I offered lower costs. Further, while demonstration PPOs showed out-of-pocket costs at least as high as most other options, CMS estimates suggest that demonstration PPOs generally provided better coverage for certain benefits, such as prescription drugs and inpatient hospitalization, than some other beneficiary options.

While it is too early for CMS to determine the effect of demonstration PPOs on Medicare spending, CMS's OACT originally projected that demonstration PPOs would increase Medicare spending by \$750 per enrollee per year for the M+C Alternative Payment Demonstration for 2002

⁹The term “organization” refers to a corporation or other business entity that may offer one or more health plans within a geographic region.

¹⁰PFFS plans allow enrollees to obtain services from any provider who is legally authorized to provide those services and accepts the plan's terms and conditions of payment.

and 2003 combined, and \$652 per enrollee per year in 2003 for the Medicare PPO Demonstration. Overall, the demonstration PPOs were estimated to increase Medicare spending by about \$100 million for 2002 and 2003 combined. OACT's estimates were based on monthly payments to plans for their enrolled beneficiaries and losses CMS might share with plans under the risk-sharing agreements. Specifically, OACT projected that the PPO plan in the M+C Alternative Payment Demonstration would increase spending by about \$25.2 million in 2002 and 2003 combined—\$10.1 million due to monthly payments to plans and \$15.1 million due to CMS's participation in risk-sharing agreements. OACT projected that the Medicare PPO Demonstration would increase spending by \$75 million in 2003, due to monthly payments to plans, but that there would be no additional spending due to the risk-sharing agreements. Total enrollment in demonstration PPOs has been lower than CMS anticipated, so actual spending may be less than OACT projected. CMS does not yet have data on the actual cost of the demonstrations in 2003.

We recommend that the Administrator of CMS promptly instruct plans in the Medicare PPO Demonstration to provide coverage for all plan services furnished by any provider authorized to provide Medicare services who accepts the plans' terms and conditions of payment.

CMS agreed to implement our recommendation and said it is working with the PPO demonstration plans to ensure that they come into compliance with the provisions that govern their Medicare participation. CMS expressed concern about the tone of the report and believes that the demonstrations are worthwhile.

Background

To reduce out-of-pocket costs that result from cost sharing and the utilization of non-Medicare covered services and items, FFS Medicare beneficiaries may either purchase a private supplemental insurance policy, known as a Medigap plan, or enroll in a private health plan that has contracted to serve Medicare beneficiaries. From 1998 through 2003, M+C, Medicare's private health plan program, allowed participation by a variety of plan types, including HMOs, PPOs, and PFFS plans, as long as these plans met certain organizational and operational requirements. Unlike in the private insurance market, where PPO plans were the most prevalent type of health plan, the vast majority of M+C plans were HMOs. CMS launched two demonstrations that included plans intended to operate under the PPO model.

Beneficiaries Purchase Medigap Plans or Enroll in Private Health Plans

Beneficiaries in FFS Medicare, which consists of Medicare part A and part B, may incur substantial out-of-pocket costs. Part A helps pay for inpatient hospital, skilled nursing facility, hospice, and certain home health services, although beneficiaries remain liable for a share of the cost of most covered services. For example, Medicare requires beneficiaries to pay a deductible for each hospital benefit period,¹¹ which was \$840 in 2003, and covers a maximum of 90 days per benefit period.¹² Medicare part B helps pay for selected physician, outpatient hospital, laboratory, and other services. Enrollment in part B is voluntary and requires a beneficiary to pay a monthly premium and an annual deductible for most types of part B services — \$58.70 and \$100, respectively, in 2003 — and may require coinsurance of up to 50 percent for some services. Beneficiaries are also liable for items and services not covered by FFS Medicare, such as routine physical examinations and most outpatient prescription drugs.

Many beneficiaries in FFS obtain more comprehensive coverage through supplemental health insurance provided by a former employer or purchased from a private insurer (Medigap). Although many employers do not offer supplemental health insurance to their retirees, Medigap policies are available nationwide. In most states, Medigap policies are organized into 10 standardized plans offering varying levels of supplemental coverage. Medigap plan F is the plan most widely selected by beneficiaries, although it does not offer prescription drug coverage; Medigap plan I offers similar coverage but includes some coverage for prescription drugs.¹³ Beneficiaries with Medigap policies receive coverage for services from any provider who is legally authorized to provide Medicare services.

Most beneficiaries may also obtain more comprehensive coverage by choosing to receive Medicare benefits through private health plans that participate in Medicare instead of through FFS Medicare. While private Medicare health plans are not available nationwide, about 80 percent of

¹¹A benefit period begins the first day a beneficiary receives care from the hospital and ends when the beneficiary has not been hospitalized or received skilled nursing care for 60 consecutive days.

¹²After the first 90 days of inpatient care, Medicare may help pay for an additional 60 days of inpatient care (days 91-150). Each beneficiary is entitled to a lifetime reserve of 60 days of inpatient coverage. Each reserve day may be used only once in a beneficiary's lifetime.

¹³Medigap plans F and I include coverage for additional lifetime hospital days, part A and part B coinsurance and deductibles, and foreign travel emergencies. Medigap plan I also covers 50 percent of prescription drug costs subject to a \$250 deductible and a \$1,250 cap.

beneficiaries in 2003 had access to at least one plan within the counties where they lived. Beneficiaries who enroll in a private plan may pay a monthly premium, in addition to the Medicare part B premium, and agree to receive their Medicare-covered benefits, except hospice, through the plan. In return, beneficiaries may receive additional non-Medicare benefits and may be subject to reduced cost sharing for Medicare-covered benefits.¹⁴ Beneficiaries who enroll in a private plan that contracts with Medicare are entitled to coverage for all services and items included in the plan's benefit package, regardless of whether the service or item is covered under FFS Medicare.

M+C Established Definitions and Operational Requirements for Participating Plans

Congress created the M+C program, in part, to expand health plan options for beneficiaries. Previously, private plan participation in Medicare had been largely limited to HMOs. The M+C program provided the opportunity for PPOs and PFFS plans to serve beneficiaries as well. Generally, M+C plan types differed by the extent to which they used provider networks.¹⁵ M+C HMOs were required to maintain networks of providers, and they generally covered services furnished only by providers in their networks, except in limited circumstances such as urgent or emergency situations. (See table 1.) M+C PPOs were also required to maintain provider networks. Unlike M+C HMOs, M+C PPOs were required to pay for covered services obtained from non-network providers, although they could charge beneficiaries additional cost sharing for these services. A third type of M+C plan, the PFFS plan, was not required to maintain provider networks. Rather, M+C PFFS plans were required to pay for all covered services obtained from any provider authorized to furnish Medicare-covered services who accepted the plan's terms and conditions of payment.

¹⁴In some instances, a plan may elect to pay all or part of the beneficiary's part B premium.

¹⁵Though the M+C program has been changed to Medicare Advantage, statutory provisions under the M+C program concerning plan designs and operational requirements are the same in 2004 as they were in 2003.

Table 1: Characteristics of HMO, PPO, and PFFS plans under M+C

Type of M+C Plan	Does plan use provider networks?	May plan require beneficiaries to use only network providers?
HMO	Yes	Yes ^a
PPO	Yes	No
PFFS	No	N/A

Source: 42 Code of Federal Regulations Part 422 (2003).

^aHMOs must cover certain services received from non-network providers, such as emergency care or urgent care.

While many M+C requirements were uniform across the different types of plans, two categories of requirements varied by the type of plan: those that were intended to ensure that enrollees had sufficient and timely access to covered services, known as access-to-services requirements, and those that were intended to ensure that services furnished were of sufficient quality, known as quality assurance requirements. (See table 2.) In general, plans that restricted enrollees to provider networks were subject to more extensive access-to-services and quality assurance requirements than those that did not. Accordingly, M+C HMO plans were subject to more extensive quality assurance and access-to-services requirements than M+C PFFS plans. M+C PPOs were subject to the more extensive access-to-services requirements of M+C HMOs, but the less extensive quality assurance requirements of PFFS plans.¹⁶ For example, in order to demonstrate that they provided sufficient access to services, M+C HMOs and M+C PPOs were required to monitor and document the timeliness of the care their enrollees received from providers, while M+C PFFS plans were not required to monitor care in this way. With regard to quality assurance, M+C HMOs each year had to initiate a multi-year quality improvement project, such as a provider or enrollee education program,

¹⁶Under the Balanced Budget Act of 1997, M+C PPOs had been subject to the more extensive quality assurance requirements of HMOs. Section 520 of the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999 made M+C PPOs subject to the less extensive standards effective in January 2000. Pub. L. No. 106-113, App. F, § 520 (b), 113 Stat. 1501 A-321, 1501A-385-86.

while M+C PPOs and M+C PFFS plans were not subject to this requirement.¹⁷

Table 2: Quality Assurance and Access-to-Services Requirements for M+C PPOs and M+C PFFS Plans Compared to M+C HMOs, 2003

	Quality assurance requirements (compared to M+C HMOs)	Access-to-services requirements (compared to M+C HMOs)
M+C PPOs	Less extensive	Same
M+C PFFS plans	Less extensive	Less extensive

Source: 42 Code of Federal Regulations Part 422 (2003).

M+C HMOs, M+C PPOs, and M+C PFFS plans all were paid a monthly payment per enrollee according to a statutory formula. The M+C payment rate varied by county and could be higher or lower than FFS Medicare’s per capita spending in a county. An M+C plan was at full risk for the costs of covered services for its enrollees. If these costs made up a higher than anticipated portion of the plan’s total revenues—consisting of enrollee premiums and monthly payments from CMS—then the plan would have less than it anticipated for administration, profit, and other contingencies.

Plan Participation in M+C Did Not Reflect the Private Marketplace

In recent years, PPO plans have become increasingly prevalent in the private insurance market and tended to displace other types of plans, such as HMOs, that offered less provider choice. From 1996 through 2002, the percentage of individuals with employer-sponsored coverage who were enrolled in HMO plans decreased from 31 percent to 26 percent, while the percentage of individuals with employer-sponsored coverage enrolled in PPOs increased from 28 percent to 52 percent. In contrast, there were approximately 3,000 Medicare beneficiaries enrolled in a total of six M+C PPO plans by 2003. From 1998 through 2003, the total number of M+C plans, the vast majority of which were HMOs, decreased from 346 to 155. The number of beneficiaries covered by M+C plans also fell, from 6.1 million in 1998, or about 16 percent of all beneficiaries, to 4.6 million in 2003, or about 11 percent of all beneficiaries.

¹⁷If an M+C PPO were offered by an organization licensed as an HMO, it would have to abide by the quality assurance requirements for M+C HMOs, not M+C PPOs. A similar requirement does not exist for organizations licensed as HMOs that offer PFFS plans. Pub. L. No. 106-113, App. F, § 520, 113 Stat. 1501A-321, 1501A-385-86.

CMS Launched Two Demonstrations That Include Plans Designed to Operate as PPOs

Section 402(a) of the Social Security Amendments of 1967 authorizes CMS to conduct demonstrations to identify whether changes in methods of payment or reimbursement in Medicare and other specified health care programs would increase the efficiency and economy of those programs without adversely affecting the quality of services. In addition, under section 402(b), CMS may waive requirements relating to payment or reimbursement for health care services in connection with these demonstrations.¹⁸ For example, CMS may be able to offer demonstration plans alternative methods of payment or other financial incentives that are not offered to other providers in the Medicare program. However, CMS does not have the authority to waive rules not related to payment or reimbursement.

Prior to the passage of MMA, CMS launched both the M+C Alternative Payment Demonstration and the Medicare PPO Demonstration. The M+C Alternative Payment Demonstration began in 2002 and included one organization offering a PPO in 2003. It is set to expire in December 2004. The Medicare PPO Demonstration, which began in 2003, included 17 organizations representing 33 plans. This demonstration is set to expire in December 2005.

CMS Offered All Demonstration PPOs Financial Incentives, but Improperly Allowed Plans in the Medicare PPO Demonstration to Limit Coverage

Using its authority to waive requirements related to payment and reimbursement, CMS offered financial incentives to Independence Blue Cross and the plans in the Medicare PPO Demonstration that they did not offer to typical M+C plans. These incentives included potentially higher payments and the opportunity to reduce their exposure to financial risk by entering into risk-sharing agreements. CMS also allowed the plans to exceed the limits on the cost sharing that M+C plans could charge beneficiaries. Under federal law, plans in the Medicare PPO Demonstration should have been required to allow beneficiaries to obtain plan services from providers of their choice, as long as those providers were legally authorized to furnish them and accepted the plans' terms and conditions of payment. CMS did not have authority to waive this requirement, as it was unrelated to payment or reimbursement. However, CMS improperly allowed 29 of the 33 plans in the Medicare PPO Demonstration to require, as a condition of coverage for certain services, that beneficiaries obtain those services only from network providers.

¹⁸Demonstrations may increase Medicare spending as long as the additional spending is related to the waiver of the payment or reimbursement rule.

CMS Used its Statutory Authority to Offer Plans Financial Incentives to Participate in Demonstrations

Under its authority to waive requirements related to payment for demonstration participants, CMS offered demonstration PPOs a number of financial incentives to participate in the demonstrations. By waiving the M+C requirements applicable to plan payment, CMS offered Independence Blue Cross and the plans in the Medicare PPO Demonstration an opportunity to receive payment rates that could be higher than those received by M+C plans. Per enrollee per month,¹⁹ demonstration PPOs received the higher of the county-based M+C rate or a rate based on the average amount Medicare spent in that county for each FFS beneficiary.²⁰ A plan's ability to receive the higher of the M+C rate or FFS-based rate could substantially increase its payment rates, depending on the counties it served. In 44 of the 214 counties where the plans in the Medicare PPO Demonstration were available in 2003, the FFS-based rate ranged from approximately 0.3 percent to 15.1 percent higher than the M+C payment rate.²¹ For example, in Clark County, Nevada, the FFS-based rate was \$635.79, or 5.6 percent higher than the M+C payment rate of \$599.95.

CMS also used its waiver authority to allow Independence Blue Cross and the plans in the Medicare PPO Demonstration to reduce their financial risk through risk-sharing agreements. Risk-sharing agreements were not available to non-demonstration M+C plans, which were required to accept full financial risk for the cost of providing covered services to their enrollees. For contract year 2003, CMS signed risk-sharing agreements with 13 organizations offering a total of 29 plans. The terms of the agreements varied. Each agreement specified an expected "medical loss ratio" (MLR), the percentage of a plan's annual revenue (comprised of monthly payments from CMS and any enrollee premiums) that would be spent on medical expenses. Generally, plans could designate the remaining percentage of revenue for administrative expenses, profit, and other contingencies. For the 12 organizations in the Medicare PPO Demonstration that had risk-sharing agreements with CMS, medical

¹⁹As with M+C plans, CMS adjusts a portion of the monthly payments to demonstration PPOs to account for the health and demographic characteristics of enrollees.

²⁰The FFS-based rate for the PPO in the M+C Alternative Payment Demonstration was 98.5 percent of average county-level FFS spending per beneficiary, as estimated by CMS. The FFS-based rate for the plans in the Medicare PPO Demonstration was 99 percent of average county-level FFS spending per beneficiary, as estimated by CMS.

²¹Of the 44 counties where 99 percent of average county-level FFS spending per beneficiary is higher than the M+C payment rate, 17 are included in the sample of counties we used to compare expected out-of-pocket costs between types of coverage. This sample consists of 41 counties with approximately 90 percent of all demonstration PPO enrollment.

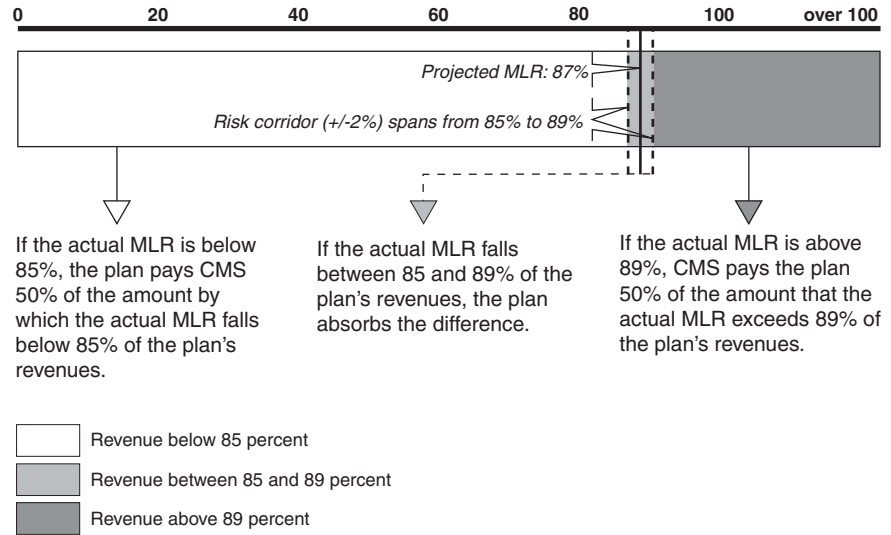
expenses represented a median 87 percent of plan revenue. CMS agreed to share a designated percentage, negotiated separately with each plan, of any difference between the plan's actual MLR and the expected MLR that fell outside a range around the expected MLR, known as a risk corridor.²² For each plan, the designated percentage with which it would share risk with CMS was identical whether the actual MLR was greater or lower than the expected MLR.²³

For example, a plan's contract might have specified an MLR of 87 percent, a percentage of shared risk of 50 percent, and a risk corridor of 2 percent above and below the expected MLR (See fig. 1.) If that plan's actual medical expenses exceeded 89 percent of its revenue, CMS would pay the plan 50 percent of the amount by which the actual MLR exceeded 89 percent. If the plan's actual MLR was lower than 85 percent of its revenue, the plan would pay CMS 50 percent of the amount that the actual MLR fell below 85 percent.

²²The risk-sharing agreement between CMS and Independence Blue Cross differed somewhat from the risk-sharing agreements between CMS and the plans in the Medicare PPO Demonstration. Rather than negotiate directly with the plan, CMS derived the expected MLR for Independence Blue Cross from the plan's Adjusted Community Rate Proposal (ACRP) for 2003. The ACRP is submitted by M+C plans and provides detailed estimates of a plan's expected costs and revenues associated with providing covered benefits, and a description of the plan benefit package. CMS subtracted the plan's expected administrative costs in the ACRP, which CMS subjects to certain limits, from the plan's total expected revenue to arrive at the expected MLR. In addition, unlike the risk-sharing agreements between CMS and the plans in the Medicare PPO Demonstration, there was no corridor in which Independence Blue Cross was at full risk.

²³All 28 plans with risk-sharing agreements in the Medicare PPO Demonstration had risk corridors of at least 2 percent above and below the expected MLR.

Figure 1: Illustration of a Hypothetical Risk-Sharing Agreement (MLR of 87 Percent, Shared Risk of 50 Percent, Risk Corridor of 2 Percent)



Source: GAO.

In order to allow organizations with HMO licenses to offer PPO-model health plans without having to meet the more stringent quality assurance requirements of M+C HMOs, CMS had organizations sign PFFS contracts and also waived certain M+C payment requirements. Of the 33 plans in the Medicare PPO Demonstration, 13 were offered by organizations with HMO licenses. Under M+C requirements, a PPO offered by an organization licensed as an HMO would have to adhere to the more stringent quality assurance standards applicable to HMOs.²⁴ CMS indicated that it could permit licensed HMOs to establish PPO-type networks without being subject to the more stringent quality assurance requirements applicable to HMOs by structuring their plans as PFFS plans. CMS contracted with all plans participating in the Medicare PPO Demonstration as M+C PFFS

²⁴In commenting on a draft of this report, CMS stated that it had interpreted its regulations as precluding licensed HMOs from offering PPO plans. We note that more recent guidance issued by CMS to prospective Medicare Advantage contractors now states that licensed HMOs may offer PPO plans as long as they follow the more stringent quality assurance requirements. CMS has not modified the regulations on which it based its earlier interpretation.

plans because M+C did not prohibit organizations licensed as HMOs from offering PFFS plans.²⁵ Although M+C requires PFFS plans to pay each class of provider uniformly, CMS waived this payment-related requirement, thereby enabling these plans to establish provider networks by paying providers differently depending on whether they belonged to their networks.

CMS also waived the M+C limits on beneficiary cost sharing. An M+C plan may set beneficiary cost-sharing requirements that differ from those in FFS Medicare, but these requirements are subject to statutory limits that vary by plan type. For example, under M+C rules for PFFS plans, the actuarial value, or estimated dollar value, of the cost-sharing requirements for benefits that CMS requires the plans to cover could not exceed the actuarial value of cost-sharing requirements in FFS Medicare, which was about \$1,200 annually per beneficiary in 2003. Because CMS waived this provision for demonstration PPOs, these plans were subject to no statutory or regulatory cost-sharing limits.

CMS Exceeded Its Authority by Allowing Medicare PPO Demonstration Plans to Restrict Coverage for Certain Services to Network Providers

Because CMS signed PFFS plan contracts with all of the plans in the Medicare PPO Demonstration, these plans should have been subject to all PFFS plan requirements. In particular, by federal law, M+C PFFS plans were required to allow enrollees to receive all covered services from any provider who is legally authorized to provide Medicare services and accepts the plans' terms and conditions of payment. CMS does not have the authority to waive this requirement because it pertains to beneficiary access to providers, not payment. However, CMS allowed 29 of the 33 plans in the Medicare PPO Demonstration to establish provider networks and to exclude coverage for some services, both those covered and not covered by FFS Medicare, obtained outside the provider network.²⁶ Examples of such services include skilled nursing and home health, which are covered under FFS Medicare, and dental care and routine physical examinations, which are not covered under FFS Medicare.

²⁵According to CMS officials, CMS signed PFFS contracts with all organizations in the Medicare PPO Demonstration, even those without HMO licenses, so that all plans participating in the demonstration would be subject to the same set of requirements.

²⁶Nearly all beneficiaries in Medicare PPO Demonstration plans were enrolled in plans that excluded coverage for some services obtained outside the provider network.

In response to our inquiries, CMS, in a letter dated June 15, 2004, agreed with our view that the restriction of Medicare-covered services to network providers by plans in the Medicare PPO Demonstration violated Medicare requirements. The agency noted, however, that the plans did not place such coverage restrictions on most services in their benefit packages. In its letter, CMS said that it would instruct plans in the Medicare PPO Demonstration to provide out-of-network coverage for Medicare-covered services in 2005, if they want to continue to operate as PFFS plans and avail themselves of the quality assurance requirements available to M+C PFFS plans. However, CMS indicated that it would not require plans that cover non-Medicare services only in network to provide out-of-network coverage for these services.

We maintain that the Medicare PPO Demonstration plans' restriction on coverage of services obtained outside their provider networks is unlawful. The Social Security Act²⁷ does not distinguish between Medicare and non-Medicare-covered services with respect to an M+C PFFS plan's obligation to cover plan benefits. According to the law, M+C PFFS plans must allow enrollees to obtain all covered plan services—both Medicare-covered and non-Medicare-covered—from any provider authorized to provide the services who accepts the plans' terms of payment.

Furthermore, allowing plans in the Medicare PPO Demonstration to limit coverage of certain benefits to network providers is inconsistent with statutory and regulatory requirements intended to promote quality of care for beneficiaries in M+C plans. Under M+C, PFFS and PPO plans were held to less extensive quality assurance requirements than HMOs due, in part, to the greater choice these plans' enrollees have in obtaining services from providers.²⁸ However, plans in the Medicare PPO Demonstration were allowed to restrict beneficiary choice of provider for certain services but were not held to the quality assurance standards that apply to M+C plans that restrict choice.

²⁷See Social Security Act §1859(b)(2)(C).

²⁸See 65 Fed. Reg. 40170, 40294. In response to a comment submitted during M+C rule-making that expressed concern that M+C PFFS plan quality assurance requirements were inadequate to protect enrollees, CMS acknowledged that PFFS plan quality assurance standards were less stringent than HMO standards. CMS nevertheless explained that quality assurance standards for PFFS plans may not be as important in the case of PFFS plans, "in which the enrollee has complete freedom of choice to use any provider in the country, and is not limited to a defined network of providers." *Id.* at 40220.

Demonstration PPOs Did Little to Expand Health Plan Options, and Have Enrolled Relatively Few Beneficiaries

Demonstration PPOs did little to expand access to private Medicare health plans for beneficiaries who lacked such access. In addition, they enrolled relatively few beneficiaries, less than 1 percent of those living in counties where they operated. Furthermore, beneficiaries who enrolled in Medicare PPO Demonstration plans were far more likely to have switched from an M+C plan instead of FFS Medicare. About 98 percent of the beneficiaries who lived in counties with demonstration PPOs had other Medicare private health plans available.

Demonstration PPOs Did Little to Expand Access to Private Health Plans

Although demonstration PPOs provided beneficiaries with an additional plan option in the counties where they operated, they did little to attract private health plans to counties where no M+C plans existed. In October 2003, demonstration PPOs were available in 214 counties nationwide, where approximately 10.1 million beneficiaries resided.²⁹ Some form of M+C plan was available in 205 of the 214 counties. (See table 3.) About 200,000 of the 10.1 million beneficiaries, or about 2 percent, lived in the nine counties where only demonstration PPOs were available.³⁰ (See fig. 2.)

Table 3: M+C Plan Availability in the 214 Counties Where Demonstration PPO Plans Were Available, 2003

Type of M+C plan	Number of counties	Number of eligible Medicare beneficiaries (millions)
HMO	193	9.6
PPO	23	2.4
PFFS	95	3.4
Any M+C plan	205	9.9

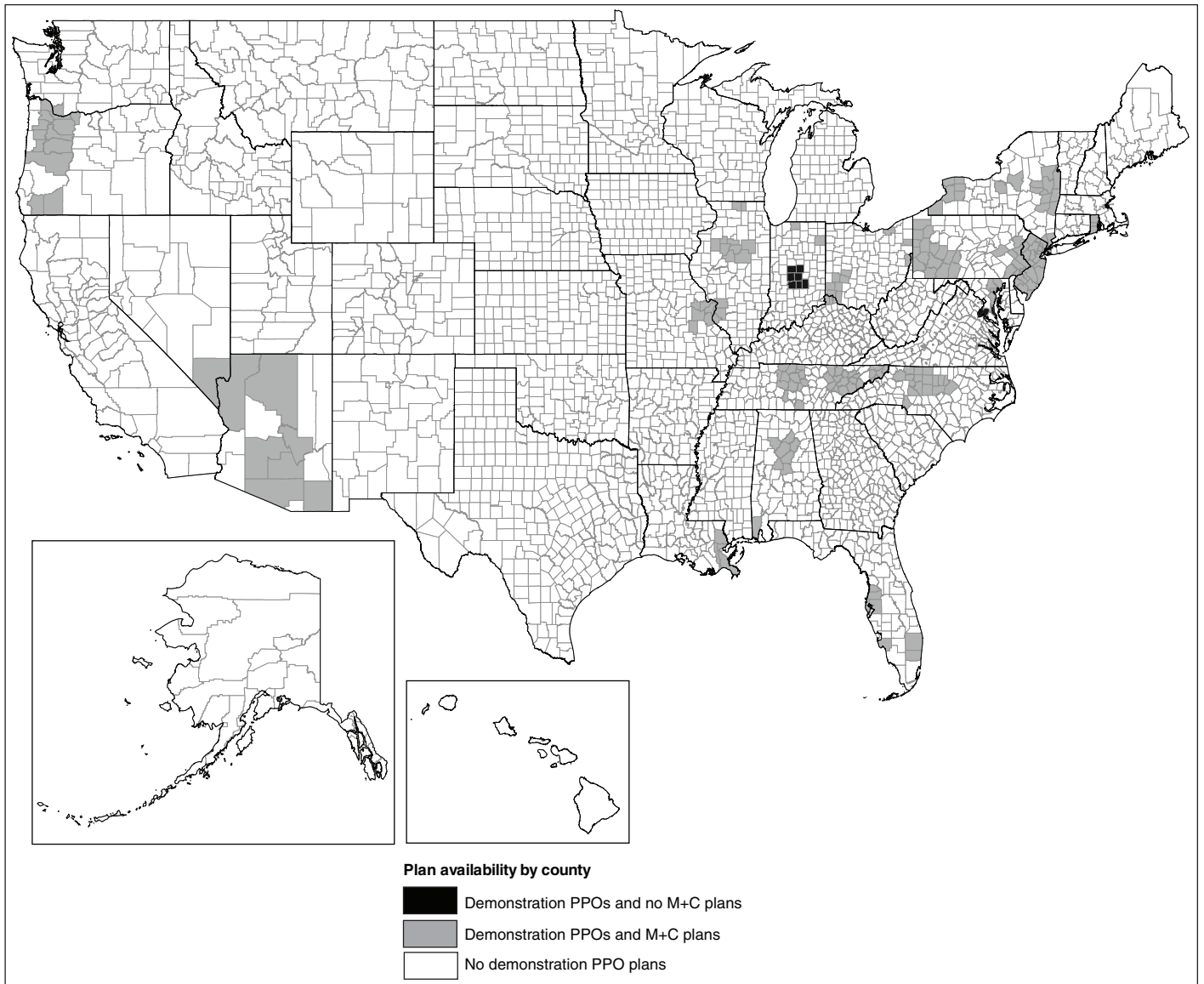
Source: CMS.

Note: The nine counties where only demonstration PPOs were available are not represented in this table.

²⁹We excluded employer-only M+C and demonstration PPO plans from our analysis because these plans, by design, are only available to retirees through their former employers, and therefore are not available to all beneficiaries.

³⁰The nine counties include Calvert and Charles counties, Maryland, and Boone, Hamilton, Hendricks, Johnson, Marion, Morgan, and Shelby counties of Indiana in 2003.

Figure 2: Location of Demonstration PPOs and M+C Plans by County, 2003



Source: GAO.

Note: Data are from CMS's Geographic Service Area file (October 2003). Although demonstration PPOs and M+C plans were available in the shaded counties, these plans may not have been available to all Medicare beneficiaries in these counties because plans may serve only part of a county. M+C plans include M+C HMOs, M+C PPOs, and M+C PFFS plans.

Demonstration PPOs Enrolled Relatively Few Beneficiaries

Enrollment in demonstration PPOs was relatively low. Of the 10.1 million eligible Medicare beneficiaries living in demonstration PPO counties, about 98,000, or less than 1 percent, had enrolled by October 2003.³¹ (See table 4.) These 98,000 enrollees represented about 5 percent of the total enrollment in Medicare private health plans in demonstration PPO counties. Enrollment in demonstration PPOs was particularly low in the nine counties with no M+C plans. In these counties, only about 100 of the approximately 203,000 beneficiaries living there enrolled.

Table 4: Demonstration PPO Market Penetration in Counties With and without M+C Plans, October 2003

Type of county	Number of eligible Medicare beneficiaries	Number enrolled in private health plans		Percentage of eligible beneficiaries enrolled in private health plans		Percentage of all enrollees in Medicare private health plans in demonstration PPOs
		M+C plans	Demonstration PPOs	M+C plans	Demonstration PPOs	
205 counties with a demonstration PPO plan and M+C plan	9,900,803	1,870,384	98,047	18.9	1.0	5.0
9 counties with only a demonstration PPO plan	203,535	N/A	117	N/A	0.1	100.0
214 (total number of counties with demonstration PPOs)	10,104,338	1,870,384	98,164	18.5	1.0	5.0

Source: CMS.

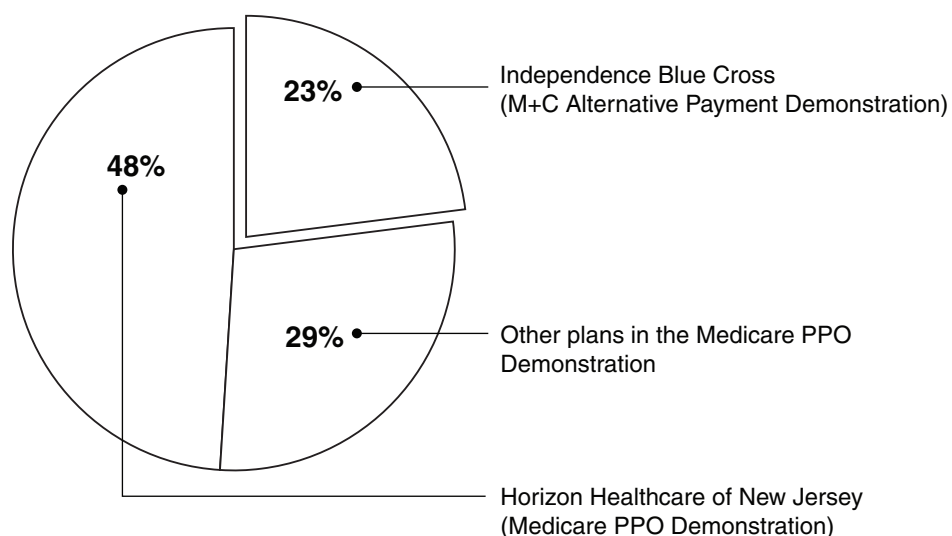
Note: Data are from CMS's Geographic Services Area file (GSA) for 2003. GSA excludes counties with 10 or fewer enrollees in demonstration PPOs, resulting in slightly lower enrollment figures. The number of eligible Medicare beneficiaries was drawn from the September 2003 GSA, gathered quarterly, because it is the nearest estimate of eligible Medicare beneficiaries to October 2003.

Two plans, Independence Blue Cross and Horizon Healthcare of New Jersey, accounted for more than 70 percent of all demonstration PPO enrollment. (See fig. 3.) Of the approximately 98,000 beneficiaries enrolled in demonstration PPOs, about 23,000, or 23 percent, were enrolled in Independence Blue Cross, the one PPO plan in the M+C Alternative Payment Demonstration. Approximately 47,000, or about 48 percent of all demonstration PPO enrollees, were enrolled in Horizon Healthcare of New Jersey, a participant in the Medicare PPO Demonstration. The

³¹By July 2004, enrollment in demonstration PPOs had increased to 127,336.

approximately 28,000 remaining beneficiaries were enrolled in the 32 other plans in the Medicare PPO Demonstration. These plans had an average enrollment of 878 beneficiaries.

Figure 3: Percentage of Enrollment in Demonstration PPOs by Plan, 2003



Source: CMS.

Note: Data were prepared by GAO from CMS's Geographic Services Area file (2003) and the Medicare Health Plan Compare data set (2003).

The Medicare PPO Demonstration largely did not fulfill CMS's goal of attracting beneficiaries from FFS Medicare; most beneficiaries who enrolled in demonstration PPOs came from M+C plans. Specifically, in the 211 counties where plans participating in the Medicare PPO Demonstration were available, 26 percent of beneficiaries who were enrolled in Medicare PPO Demonstration plans were formerly enrolled in FFS Medicare, while 74 percent of these beneficiaries were formerly enrolled in M+C plans.³² In these same counties, 1 percent were enrolled in demonstration PPO plans, 81 percent were enrolled in FFS Medicare, and approximately 18 percent of Medicare beneficiaries were enrolled in M+C plans.

³²Between January and July 2004 the proportion of demonstration PPO enrollees coming from traditional FFS Medicare increased each month. While 30 percent of new demonstration PPO enrollees were previously enrolled in FFS Medicare in January 2004, 73 percent were from FFS Medicare by July 2004.

The disproportionately high enrollment in demonstration PPOs by previous enrollees in M+C plans is partially attributable to Horizon Healthcare of New Jersey, which terminated its M+C HMO plan at the end of 2002 and offered a demonstration PPO plan in 2003 in the same 21 counties where its HMO had operated in 2002. Nearly all 45,000 beneficiaries who enrolled in the Horizon demonstration plan in the beginning of 2003 were previously enrolled in the HMO plan that the demonstration plan replaced. However, even when Horizon enrollees are excluded from the analysis, 47 percent of enrollees in the other Medicare PPO Demonstration plans were previously enrolled in M+C plans.

Demonstration PPOs Left Beneficiaries Exposed to Relatively High Total Out-of-pocket Costs, but Offered Slightly Better Coverage for Some Benefits

According to CMS estimates available on the Medicare Web site, an average beneficiary aged 65 to 69 enrolled in a demonstration PPO could expect to incur \$391 per month in health care expenses for premiums, cost sharing, and utilization of noncovered items and services. This amount was generally similar or higher than the expected out-of-pocket costs associated with other types of health care coverage. Excluding premiums, or focusing on beneficiaries in poor health, however, somewhat changed the pattern of relative cost by type of coverage. To the degree that enrollees in demonstration PPO plans obtained services from non-network providers, their average out-of-pocket costs would have been higher than CMS estimates. Despite the same or higher estimated out-of-pocket costs, demonstration PPOs may have offered slightly better coverage for certain items and services, such as prescription drugs and inpatient hospitalization.

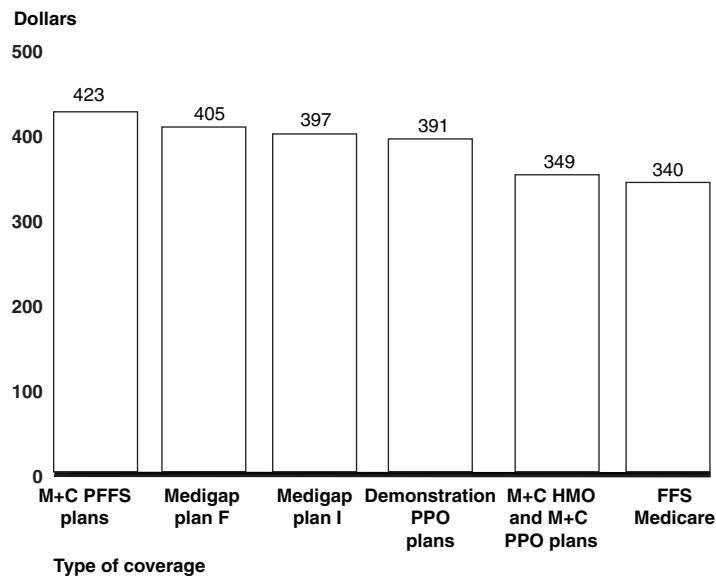
Estimated Out-of-pocket Costs in Demonstration PPOs Were at Least as High as Most Other Types of Coverage

In 41 counties with approximately 90 percent of enrollment in demonstration PPOs, beneficiaries in demonstration PPOs who used only network providers were estimated to have incurred average monthly out-of-pocket costs of \$391. That amount is similar to what beneficiaries with Medigap plans F and I would have incurred, which averaged \$405 and \$397, respectively.³³ (See fig. 4.) Enrollees in M+C HMO and M+C PPO plans and FFS Medicare were estimated by CMS to have incurred lower monthly out-of-pocket costs, averaging \$349 and \$340, respectively. The highest monthly out-of-pocket costs were estimated to have been incurred

³³Out-of-pocket spending estimates are based on national averages. The 41 counties used in this analysis are high Medicare spending counties, so MPPF estimates may be lower than actual out-of-pocket costs for beneficiaries living in the 41 counties.

by beneficiaries in M+C PFFS plans, which averaged \$423 per month.³⁴ Because the reported out-of-pocket costs were averages across beneficiaries, the difference among types of plans represent the variation in plans' premiums, covered benefits, and cost sharing—not the characteristics of enrollees.

Figure 4: Estimated Average Beneficiary Out-of-pocket Health Care Costs for Premiums, Cost Sharing, and Noncovered Items and Services per Month, by Type of Coverage, 2003



Source: CMS.

Note: Data are from CMS's Medicare Personal Plan Finder (2003). Analysis is based on data from 41 counties. The FFS Medicare part B premium is included in total out-of-pocket costs.

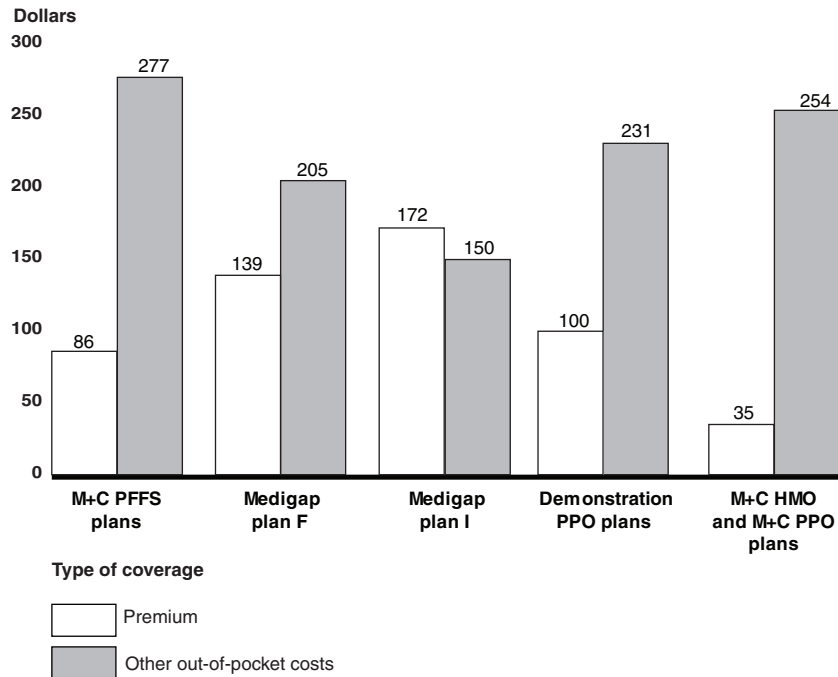
³⁴ Across our sample of 41 counties, 49 M+C HMO plans and M+C PPO plans (46 M+C HMO plans and 3 M+C PPO plans) and 2 M+C PFFS plans participated in M+C, although each of these plans were not available in all the counties. Because the average out-of-pocket costs of M+C HMOs and M+C PPOs were significantly different from those of M+C PFFS plans, we reported one figure for both M+C HMOs and M+C PPOs and a separate figure for M+C PFFS plans.

Excluding Premiums or Focusing on Beneficiaries in Poor Health Changed Relative Patterns of Out-of-pocket Costs

Monthly premiums, which represent a predictable expense, accounted for a relatively high percentage (26 percent) of expected out-of-pocket costs in demonstration PPOs compared to FFS Medicare and M+C plans. Demonstration PPOs had an average monthly premium of \$100, which was higher than the average premium of M+C plans (\$35 for M+C HMOs and PPOs and \$86 for M+C PFFS plans) and lower than the average premium for the two Medigap plans (\$139 for plan F and \$172 for plan I).³⁵ (See fig. 5.) Excluding premiums, out-of-pocket costs in demonstration PPOs were somewhat lower than M+C plans, but higher than Medigap plans. Specifically, beneficiaries could expect an average of \$231 per month in demonstration PPOs, \$254 in M+C HMOs and M+C PPOs, and \$277 in M+C PFFS plans. Beneficiaries with Medigap plans F and I could expect monthly expenses for cost sharing and noncovered items and services to total \$205 and \$150, respectively.

³⁵The FFS Medicare part B premium of \$58.70 was excluded from our analysis of premiums and other out-of-pocket costs, in order to reflect the additional monthly costs beneficiaries can expect to incur that are unique to each type of coverage. The FFS Medicare part B premium is a required cost for enrollees in each of the six types of coverage. In some instances, however, a plan may pay all or part of a beneficiary's part B premium.

Figure 5: Estimated Average Beneficiary Premiums and Other Out-of-pocket Costs by Type of Coverage per Month, Excluding FFS Medicare Part B Premium, 2003



Source: CMS.

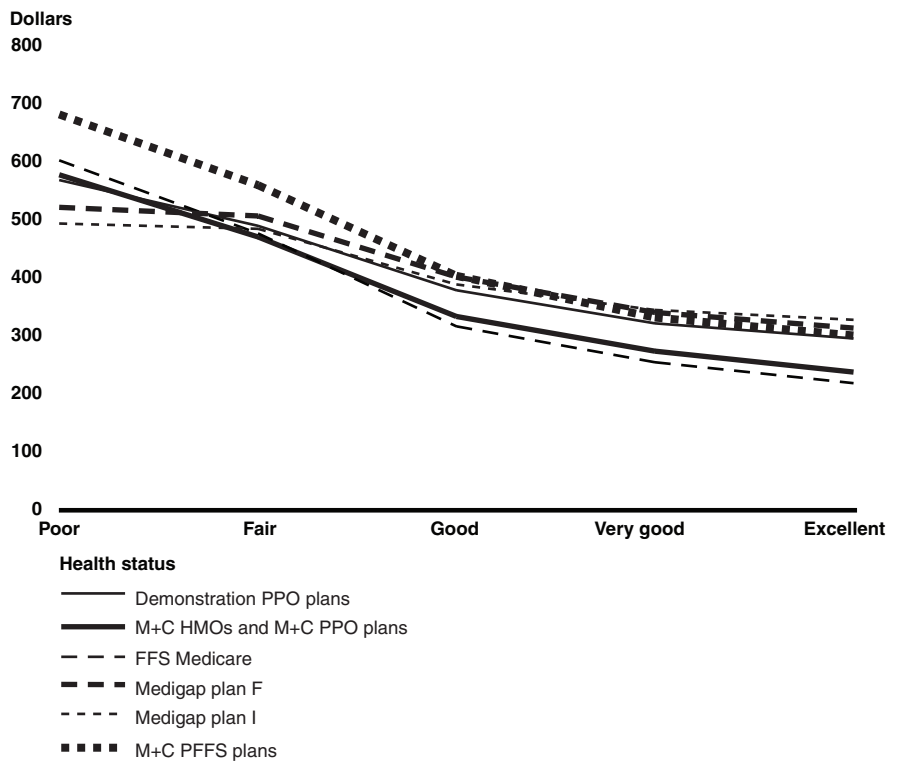
Note: Data are from CMS's Medicare Personal Plan Finder (2003). Analysis is based on data from 41 counties. We excluded the FFS Medicare part B premium of \$58.70 from the measure of other out-of-pocket costs, and rounding prevents the combination of premiums, other out-of-pocket costs, and the part B premium from adding up to the total out-of-pocket costs for each plan as displayed in fig. 4.

Relative out-of-pocket costs for beneficiaries in demonstration PPOs also depended on their expected health status.³⁶ For beneficiaries expected to be in poor health, demonstration PPOs were estimated to be less costly than FFS Medicare, M+C HMOs and M+C PPOs, and M+C PFFS plans but more costly than Medigap plans F and I. (See fig. 6.) For beneficiaries expected to be in excellent health, demonstration PPOs were estimated to

³⁶The Medicare Web site provides separate out-of-pocket cost estimates for each of five self-reported health statuses: poor, fair, good, very good, and excellent.

be less costly than M+C PFFS plans and Medigap plans F and I, but more costly than FFS Medicare and M+C HMOs and M+C PPOs.³⁷

Figure 6: Estimated Beneficiary Out-of-pocket Health Care Costs per Month by Type of Coverage and Beneficiary Health Status, 2003



Source: CMS.

Note: Data are from CMS's Medicare Personal Plan Finder (2003). Analysis is based on data from 41 counties

³⁷We also conducted a comparison of estimated beneficiary out-of-pocket costs by expected health status for beneficiaries aged 80 to 84, and found results similar to our analysis of beneficiaries aged 65 to 69.

Obtaining Services Outside the Demonstration PPO Network Would Increase Beneficiaries' Costs

To the degree that enrollees in demonstration PPOs obtained services from non-network providers, their average out-of-pocket costs would have been higher than those reflected on the Medicare Web site. Most demonstration PPOs excluded at least one service from coverage if it was furnished by non-network providers. When beneficiaries obtained services that were covered outside their plans' provider networks, they were required to pay more in cost sharing relative to what they would have paid for the same services from network providers. Demonstration PPOs anticipated that at least some enrollees would obtain covered services from non-network providers. According to 2004 estimates submitted to CMS by organizations participating in the Medicare PPO Demonstration, a median of 11 percent of enrollee medical costs would be associated with covered services from non-network providers and thus higher cost sharing. For example, a six-night stay in a network hospital in 2003 was projected to cost a demonstration PPO enrollee an average of \$421, while the same length of stay in a non-network hospital cost an average of \$1,223. Across all services in the Medicare benefit package that were covered both within and outside the plans' provider networks, the plans projected to CMS that, in 2004, enrollees would bear a median of 7 percent of the costs of those services if they obtained them from network providers, while they would bear a median of 15 percent of the costs of those services if they obtained them outside the provider networks.

For Certain Benefits, Demonstration PPO Coverage Was Better Than That of M+C Plans or FFS Medicare

Although demonstration PPOs had higher enrollee out-of-pocket costs than M+C plans, except M+C PFFS plans, demonstration PPOs tended to offer slightly better coverage for some benefits, such as prescription drugs and inpatient hospitalization. While all beneficiaries living in counties with demonstration PPOs had at least one demonstration PPO with a prescription drug benefit operating in their county, only 61 percent had an M+C HMO or M+C PPO plan with a drug benefit operating in their county, and none had an M+C PFFS plan with a drug benefit operating in their county.³⁸ In 16 of the 41 counties in our sample, at least one demonstration PPO and one M+C HMO or M+C PPO offered prescription drug coverage. In these counties, demonstration PPOs offered drug coverage that resulted in the same out-of-pocket costs for beneficiaries as the drug coverage offered by M+C HMO and M+C PPO plans (\$167 per month), but higher

³⁸While 2.4 million eligible Medicare beneficiaries live in counties where an M+C plan offers drug coverage, 4.0 million eligible Medicare beneficiaries live in counties where a demonstration PPO offers drug coverage.

out-of-pocket costs than the drug coverage offered by Medigap plan I (\$124 per month).³⁹

Demonstration PPOs were more likely than M+C HMO and M+C PPO plans to cover brand-name drugs in counties where both types of plans offered drug coverage. About 47 percent of the demonstration PPOs in our sample offered coverage for brand-name drugs, while 37 percent of M+C HMO and M+C PPO plans covered brand-name drugs. All demonstration PPOs, M+C HMOs, and M+C PPOs offered some coverage for generic drugs in these counties. M+C PFFS plans did not offer any drug coverage. Medigap plan I did not differentiate between generic and brand-name drug coverage.⁴⁰

For example, in Hillsborough County, Florida,⁴¹ beneficiaries could choose between five different plans offering prescription drug coverage in 2003; one demonstration PPO, three M+C HMO plans, and Medigap plan I. (See table 5.) The demonstration PPO provided both generic and brand-name drug coverage and required a \$12 copayment per prescription for generic drugs, a \$55 copayment per prescription for brand-name drugs, and capped coverage for all drugs at \$750 annually. None of the M+C HMOs covered brand-name drugs. However, two of the M+C HMOs offered unlimited coverage for generic drugs, while the third capped coverage at \$500 per year. The three M+C HMOs charged between \$7 and \$15 per prescription. Insurers in Hillsborough County offered the standard Medigap plan I drug coverage: a \$250 annual deductible, 50 percent of all costs, and a \$1,250 annual limit. Medigap plan I does not differentiate between generic and brand-name drugs.

³⁹PFFS plans are available in 8 of these 16 counties, but they did not include prescription drug coverage in their benefit packages.

⁴⁰Medigap plan F does not offer prescription drug coverage.

⁴¹We used Hillsborough County, Florida, for this example because the demonstration PPO and M+C HMO plans available to Medicare beneficiaries in this county in 2003 each included prescription drug coverage.

Table 5: Prescription Drug Benefits Offered in Hillsborough County, Fla., in 2003, by Type of Coverage

Type of coverage	Annual deductible	Beneficiary cost sharing for prescription drugs		Cap on prescription drug coverage
		Generic	Brand name	
Demonstration PPO	None	\$12/prescription	\$55/prescription	All drugs: \$750
M+C HMO 1	None	\$7-15/prescription	Not covered	Generic drugs: no limit Brand-name drugs: not covered.
M+C HMO 2	None	\$15/prescription	Not covered	Generic drugs: no limit Brand-name drugs: not covered.
M+C HMO 3	None	\$15/prescription	Not covered	Generic drugs: \$500 Brand-name drugs: not covered.
Medigap plan I	\$250	50 percent of all costs	50 percent of all costs	All drugs: \$1,250

Source: CMS.

Note: Data are from CMS's Medicare Health Plan Compare (2003) and 2003 guide to "Choosing a Medigap Policy."

Compared to M+C HMOs and M+C PPOs, FFS Medicare, and M+C PFFS plans, demonstration PPOs tended to offer lower out-of-pocket costs related to inpatient hospitalization. In 2003, a six-night stay in a network hospital would have cost enrollees in demonstration PPOs an average of \$421, while the same six-night stay would have cost enrollees in M+C plans and FFS Medicare an average of \$636 and \$840, respectively.⁴² A six-night hospitalization for an enrollee in an M+C PFFS plan would have cost an average of \$750. In contrast, beneficiaries with either of the two Medigap policies would have paid nothing for a six-night hospital stay.

Demonstration PPOs Were Projected to Increase Medicare Spending

At the time the demonstrations were launched, CMS's OACT projected that demonstration PPOs would increase Medicare spending by about \$100 million over 2002 and 2003 combined. Specifically, OACT projected that the PPO plan in the M+C Alternative Payment Demonstration would increase Medicare spending by a total of \$25.2 million over 2002 and 2003 combined, or \$750 per enrollee per year, due to higher plan payments and CMS's sharing in the plan's financial risk. The Medicare PPO Demonstration was projected to increase Medicare spending by a total of

⁴²We generated the six-night hospital stay estimates based on plan benefit descriptions and CMS's estimate for the average inpatient hospital length of stay for Medicare beneficiaries.

\$75 million in 2003, or \$652 per enrollee per year, due to plan payments. The risk-sharing agreements with Medicare Demonstration PPO plans were not projected to result in additional Medicare spending. CMS does not yet have data on the actual cost of the demonstrations in 2003.

Medicare Payments to Demonstration PPOs Were Projected by CMS to Result in Increased Medicare Spending

CMS's OACT projected that for 2002 and 2003 additional payments to demonstration PPOs would increase Medicare spending.⁴³ According to its estimates, an average of 16,800 beneficiaries per month would be enrolled in Independence Blue Cross, the PPO in the M+C Alternative Payment Demonstration, in 2002 and 2003, and monthly payments for these beneficiaries would increase Medicare spending by \$4.5 million in 2002 and \$5.6 million in 2003, or about \$300 per enrollee per year. OACT projected that plans in the Medicare PPO Demonstration would have an average monthly enrollment of 115,000 in 2003, and that monthly payments to plans for these enrollees would increase Medicare spending by \$75 million, or about \$652 per enrollee during the year.

OACT projected that Medicare spending would increase as a result of its risk-sharing agreement with Independence Blue Cross. OACT projected that the plan's actual MLR would be greater than the MLR the plan projected in 2002 and 2003. OACT estimated that Medicare's share of the difference between the actual and projected MLR would be \$4.8 million in 2002 and \$10.3 million in 2003, or an average of \$450 per enrollee per year. In contrast, CMS expected that it would neither save nor incur additional expenses from risk-sharing under any of the agreements in the Medicare PPO Demonstration, because OACT projected that the actual MLR would equal the projected MLR.

⁴³To arrive at this projection, OACT compared how much Medicare would pay demonstration PPO plans per enrollee with the amount Medicare would spend on those beneficiaries if the demonstration did not exist and beneficiaries were instead enrolled in M+C plans or FFS Medicare. For Independence Blue Cross, which previously participated in M+C, OACT assumed that the plan's enrollment as a demonstration participant would resemble its previous enrollment. For plans in the Medicare PPO Demonstration, OACT calculated the market penetration of M+C plans in each county and then assumed that, because demonstration PPOs were specifically targeting FFS beneficiaries for enrollment, FFS beneficiaries would be three times more likely than beneficiaries enrolled in M+C plans to enroll in demonstration PPO plans. Increased spending would result if demonstration PPO enrollees were drawn from FFS Medicare in counties where the M+C rate was higher than the FFS-based payment rate, or they were beneficiaries drawn from M+C plans in counties where the FFS-based payment rate was higher than the M+C rate.

Actual Spending Due to Demonstration PPOs Cannot Yet be Determined

At present, it is too early to determine the actual costs of the demonstrations in 2002 and 2003. As of July 2004, risk-sharing agreements had not yet been reconciled for any demonstration PPOs. During the reconciliation process, plans will report their actual MLRs to CMS, and depending on the difference between the expected and actual MLR, payment may be made either by the plan to CMS, or by CMS to the plan under the terms of the risk-sharing agreement. CMS also has not completed a more recent estimate of the cost of the demonstrations, which would compare spending for actual enrollment in demonstration PPOs with projected spending on enrollment in other M+C plans and FFS Medicare if the demonstrations did not exist. Enrollment in demonstration PPOs has been different than OACT anticipated, which would affect such a comparison. Actual monthly enrollment in Independence Blue Cross averaged 21,840 in 2002 and 22,835 in 2003, somewhat higher than the estimated average monthly enrollment of 16,800 in both years. Conversely, enrollment in the Medicare PPO Demonstration in 2003 was roughly half of projected enrollment. While OACT estimated an average monthly enrollment of 115,000 across all participating plans in that demonstration, the actual average monthly enrollment was 61,738. In addition to differing levels of enrollment, the demonstrations also experienced much higher than anticipated enrollment by former enrollees of other M+C plans.⁴⁴

Conclusions

CMS initiated two demonstrations to expand the number of Medicare health plans operating like PPOs. To encourage participation in the demonstrations, CMS used its statutory authority to provide financial incentives to plans, such as payment rates that exceeded M+C rates and the opportunity to share financial risk with Medicare. CMS also allowed plans in the Medicare PPO Demonstration to require, as a condition of coverage for certain services, that enrollees obtain care for those services only from network providers. However, such a requirement is inconsistent with federal law for plans in the demonstration, and CMS did not have the authority to allow plans to restrict enrollees' choice of providers so long as they were authorized Medicare providers who accepted the plans' terms and conditions of payment.

⁴⁴OACT assumed that between 54 percent and 99 percent of demonstration PPO enrollees in each county would have switched over from FFS Medicare, depending on the counties where the plans operate.

Despite CMS's efforts, demonstration PPOs have not yet proven to be an attractive option for beneficiaries or the Medicare program. The plans were primarily offered in areas where M+C plans were already available, and enrollment has been relatively low, even in the few areas where no M+C plans existed. According to the estimates available to beneficiaries on the Medicare Web site, enrollees in demonstration PPOs could expect out-of-pocket costs that were higher than those they would have incurred in FFS Medicare or M+C plans, other than M+C PFFS plans, and no less than those they would have incurred with Medigap plans F and I. In addition to potentially higher costs for beneficiaries, demonstration PPOs may also have resulted in \$100 million in higher Medicare spending in 2002 and 2003, according to initial CMS estimates.

Recommendation for Executive Action

We recommend that the Administrator of CMS promptly instruct plans in the Medicare PPO Demonstration to provide coverage for all plan services furnished by any provider authorized to provide Medicare services who accepts the plans' terms and conditions of payment.

Agency Comments and Our Evaluation

In written comments, CMS agreed to implement our recommendation and said it is working to ensure that Medicare PPO Demonstration plans come into compliance with the provisions that govern their Medicare participation. CMS also expressed general concern about the tone of the report and said that beneficiaries benefit from increased access to PPOs. The agency stated that lessons learned from the Medicare PPO Demonstration will help the agency implement the new Medicare Advantage regional PPO plan option in 2006. CMS's specific comments largely fell into four areas: the report's focus on initial demonstration outcomes, the inclusion of the PPO plan in the M+C Alternative Payment Demonstration in the analysis, the methodology and data we used to illustrate potential out-of-pocket costs for the options available to beneficiaries, and the discussion of our conclusion that CMS exceeded its statutory authority with respect to the Medicare PPO Demonstration. A summary of CMS's specific comments and our evaluation is provided below. The full text of CMS's written comments is reprinted in appendix III. The agency also provided technical comments, which we incorporated as appropriate.

First, CMS stated that the report, by focusing on the Medicare PPO Demonstration's initial outcomes, did not adequately present the context and value of the demonstration. CMS said that the demonstration is an experiment designed to increase availability of the PPO model in the

Medicare setting, and that it will provide valuable lessons for nationwide implementation of the new Medicare Advantage regional PPO component in 2006. Because the demonstration was not intended to be a fully developed program, CMS felt that our characterization of enrollment as “low” was unwarranted. CMS also stated that the financial arrangements developed for this demonstration, such as the risk-sharing agreements, were intended to encourage plans to participate, and they provide an example of how Medicare can encourage PPOs to enter and remain in the new Medicare Advantage program.

We were asked to evaluate the initial experience of demonstration plans operating under the PPO model because this experience could help inform future efforts to incorporate private plans into Medicare. We state in the report that our findings apply only to 2003, the first year of the Medicare PPO Demonstration and the second year of the M+C Alternative Payment Demonstration. We based our evaluation on enrollment in demonstration PPOs, the out-of-pocket costs Medicare beneficiaries could expect in demonstration PPOs relative to other types of coverage, and the effect of demonstration PPOs on Medicare spending. Overall, we found that less than 1 percent of the beneficiaries living in counties where demonstration PPOs operated had enrolled in demonstration PPOs, that most of the enrollees came from M+C plans, and that demonstration PPOs did not offer lower estimated out-of-pocket costs than most other types of Medicare coverage, even if beneficiaries obtained services only from network providers. PPO plans in the demonstrations could receive higher payment rates and be subject to less financial risk, relative to M+C plans. We acknowledge that the demonstrations are continuing and that CMS has contracted for independent evaluations of the demonstrations.

Second, CMS stated that the inclusion of the Independence Blue Cross PPO from the M+C Alternative Payment Demonstration, along with the plans from the Medicare PPO Demonstration, was potentially confusing and did not adequately distinguish the different objectives of the two separate demonstrations. According to CMS, the purpose of the M+C Alternative Payment Demonstration was simply to prevent health plans from leaving the M+C program by offering alternative payment arrangements. Furthermore, CMS stated that the demonstration was not designed to encourage alternative delivery systems in general or the PPO model specifically, and that Independence Blue Cross’s status as a PPO was irrelevant.

We thought it appropriate to evaluate the Independence Blue Cross plan and the Medicare PPO Demonstration plans together because the plan

types were similar and because the demonstrations were conducted under the same statutory authority. Independence Blue Cross and the Medicare PPO Demonstration plans all operate under the PPO model, and in that sense the plans in the two demonstrations are indistinguishable to beneficiaries. While the purposes of the M+C Alternative Payment Demonstration and the Medicare PPO Demonstration differed, as our report states, CMS used the same statutory authority to conduct both demonstrations. This authority permits demonstrations that are designed to identify whether changes in methods of payment or reimbursement in Medicare would increase the efficiency and economy of the program without adversely affecting the quality of services. CMS's characterization in its comments of the purpose of the M+C Alternative Payment Demonstration appears to be inconsistent with the statutory authority.

Third, CMS expressed concerns with the methodology and data we used to compare the out-of-pocket costs beneficiaries could expect to incur in demonstration PPOs with those they could expect to incur with other types of Medicare coverage. In CMS's opinion, our comparison was hypothetical because it was based on estimates of enrollees' utilization of services, not actual utilization of services, and potentially unreliable because it may not account for regional variation in health care costs. CMS also stated that our findings for Medicare beneficiaries aged 65 to 69 may not be applicable for older beneficiaries. Finally, CMS stated that including Horizon Healthcare of New Jersey in our analysis may have skewed our calculations because it had the largest in-network deductible for inpatient hospital services of all demonstration PPOs.

Our out-of-pocket cost comparisons used the same estimates that CMS makes available on the Medicare Web site through the Medicare Personal Plan Finder (MPPF), which is intended to help beneficiaries compare their health coverage options. These estimates, developed by Fu for CMS, enabled us to compare out-of-pocket costs among various types of coverage for beneficiaries of various ages and health statuses, which actual utilization data would not have enabled us to do. Fu developed these estimates by applying utilization and spending data from the Medicare Current Beneficiary Survey (MCBS), a national sample of beneficiaries, to the 2003 benefit packages and premiums offered locally by various types of Medicare coverage. Therefore, the estimates for all types of coverage were derived consistently. If utilization and spending in our sample were higher than the national average, then actual out-of-pocket costs would have been higher than those we estimated; however, the relative differences between the types of coverage—which form the basis for our finding—would be expected to be similar. In conducting our

comparisons, we sought to capture the typical plan options available to all eligible Medicare beneficiaries—not only PPO enrollees—residing in areas with demonstration PPOs. To capture the typical plan option in these areas, we chose a sample of 41 counties containing 90 percent of enrollment in demonstration PPOs and weighted our calculations by the number of eligible beneficiaries residing in each county. Horizon Healthcare of New Jersey remained in our analysis because Horizon's demonstration PPO plan was available to 32 percent of all eligible beneficiaries in these 41 counties in December of 2003. We presented results for beneficiaries aged 65 to 69, the largest of the six Medicare age groups for which Fu calculated out-of-pocket cost estimates. We also conducted our comparison on a substantially older age group—beneficiaries aged 80 to 84—and found similar results.

Fourth, CMS stated that our legal finding—that the agency exceeded its authority by allowing plans in the Medicare PPO Demonstration to cover certain services only if beneficiaries obtained them from the plans' network providers—should be discussed in the context of the demonstration's objectives. The agency agreed with our recommendation that Medicare PPO Demonstration plan participants be instructed to remove impermissible restrictions on enrollees' access to providers for all covered plan benefits, and not just those covered under parts A and B, but did not provide a date by which the recommendation would be fully effectuated. CMS stated, however, that the legal finding needed to be viewed in the context of the policies the agency intended to advance through the Medicare PPO Demonstration. CMS reiterated many of the factors that it believes discouraged the offering of PPO plans in the M+C program, and said that the agency wanted to provide flexibility in the demonstration in order to facilitate participation by plans. CMS indicated that it had taken sufficient measures during the Medicare PPO Demonstration qualification process to ensure that all demonstration plans provided enrollees with adequate access to network providers for all covered services, and all plans were required to offer some out-of-network coverage. In addition, the agency indicated that all PPO plans were required to provide full disclosure to enrollees concerning the costs for in-network and out-of-network services.

CMS had already identified for us many of the reasons that led it to implement the Medicare PPO Demonstration in the manner in which it did, and we included them in this report. The context within which CMS believes the legal finding must be placed is not relevant to the issue of whether CMS exceeded its authority. The waiver authority at issue is limited, and its use must conform to those limits. CMS's reiteration of the

policy objectives the demonstration was intended to achieve, its explanations for why some plans did not cover all plan services out of network, and its discussion of the measures that it took to ensure adequate access to services and enrollee education are not relevant considerations and do not make CMS's actions any less unlawful.

We are sending copies of this report to the Administrator of CMS and appropriate congressional committees. The report is available at no charge on GAO's Web site at <http://www.gao.gov>. We will also make copies available to others upon request.

If you or your staffs have any questions, please call me at (202) 512-7119. Another contact and staff acknowledgments are listed in Appendix III.



A. Bruce Steinwald
Director, Health Care Economic
and Payment Issues

Appendix I: Analysis of PPO Demonstration Participants' Restriction on Enrollee Choice of Provider

In 2003, the Centers for Medicare & Medicaid Services (CMS) initiated the Medicare Preferred Provider Organization (PPO) Demonstration. To facilitate participation in the demonstration, CMS permitted organizations participating in the demonstration (demonstration participants) to require their enrollees to obtain specified services, including services covered by parts A and B of the Medicare program, only from “network” providers in order to be covered. As discussed below, we believe that CMS’s decision to permit demonstration participants to restrict enrollees’ choice of providers exceeded its authority and was, therefore, unlawful.

Background

The Balanced Budget Act of 1997 (BBA) established a new part C of the Medicare program, known as the Medicare+Choice (M+C) program,¹ adding sections 1851 through 1859 to the Social Security Act (act).² Under section 1851(a)(1) of the act, every individual entitled to Medicare part A and enrolled under part B may elect to receive benefits through either the Medicare fee-for-service program or a part C M+C plan, if one is offered where he or she lives.³ In general, M+C organizations⁴ must provide coverage for all services that are covered under parts A and B of Medicare.⁵ M+C organizations also may include coverage for other health care services that are not covered under parts A and B of Medicare.⁶ They may satisfy their coverage obligations by furnishing services themselves,

¹The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 established the “Medicare Advantage” program and replaced the term “Medicare +Choice” with “Medicare Advantage.” See Pub. L. No. 108-173, § 201, 117 Stat. 2066, 2176. To avoid confusion, we refer to the program by the name it had at the time CMS initiated the Medicare PPO Demonstration.

²See Pub. L. No. 105-33, § 4001, 111 Stat. 251, 275-327 (adding new sections 1851 through 1859 to the Social Security Act)(codified at 42 U.S.C. §§ 1395w-21 – 1395w-28) (2000 and 2001 Supp.)).

³Certain exceptions exist for enrollment in M+C plans by persons diagnosed with end-stage renal disease. See Social Security Act § 1851(a)(3)(B)(codified at 42 U.S.C. § 1395w-21(a)(3)(B) (2000)).

⁴An M+C organization is a public or private entity that meets the requirements of part C for offering an M+C plan. See Social Security Act § 1859(a)(1)(codified at 42 U.S.C. § 1395w-28(a)(1) (2000)).

⁵Social Security Act § 1852(a)(1) (codified at 42 U.S.C. § 1395w-22(a)(1) (2000)).

⁶See Social Security Act §§ 1852(a)(1)(B), (a)(3) (codified at 42 U.S.C. §§ 1395w-22(a)(1)(B), (a)(3) (2000), respectively).

arranging for enrollees to receive services through contracts with providers, or by reimbursing providers who furnish services to enrollees.⁷

Section 1851(a)(2) of the act authorizes several types of M+C plans, two of which are relevant to the Medicare PPO Demonstration: “coordinated care plans” and “private fee-for-service plans.” M+C coordinated care plans include health maintenance organization (HMO) plans, with or without point of service options, and PPO plans. As defined by CMS, coordinated care plans have a CMS-approved network of providers under contract or arrangement with the M+C organization to deliver health care to enrollees.⁸ M+C organizations offering coordinated care plans may specify the network of providers from whom enrollees may receive services if they demonstrate that all covered services are available and accessible under the plan.⁹ Unlike most other coordinated care plans, PPO plans must provide coverage for all covered benefits out of network.¹⁰ Generally, PPO plans require enrollees to pay additional costs for services furnished by providers outside the network.

Section 1859(b)(2) of the Social Security Act defines the term “private fee-for-service plan” for purposes of the M+C program. As defined, private fee-for-service plans are required to reimburse hospitals and other providers on a fee-for-service basis without placing the providers at financial risk.¹¹ These plans may not vary the amounts paid based on the number or volume of services they provide.¹² Moreover, in contrast to coordinated care plans, private fee-for-service plans are not required to have networks of providers; instead they must allow enrollees to obtain covered services from any provider who is lawfully authorized to provide them and who agrees to the terms and conditions of payment, regardless of whether the provider has a written contract with the plan to furnish services to enrollees.¹³

⁷42 C.F.R. § 422.101(a) (2003).

⁸See 42 C.F.R. § 422.4(a)(1) (2003).

⁹See 42 C.F.R. § 422.112(a) (2003).

¹⁰See 42 C.F.R. § 422.4(a)(1)(iii), (iv)(2003).

¹¹See Social Security Act § 1859(b)(2)(A)(codified at 42 U.S.C. § 1395w-28(b)(2)(A) (2000)).

¹²See Social Security Act § 1859(b)(2)(B)(codified at 42 U.S.C. § 1395w-28(b)(2)(B) (2000)).

¹³See Social Security Act § 1859(b)(2)(C)(codified at 42 U.S.C. § 1395w-28(b)(2)(C) (2000)).

While many of the statutory and regulatory requirements governing M+C plans are similar, others vary by plan type. M+C organizations generally must be licensed as “risk-bearing entities” by the states where they offer M+C plans.¹⁴ HMO plans and most other coordinated care plans, however, are subject to more stringent quality assurance requirements than PPO and private fee-for-service plans.¹⁵ For example, HMO plans are required by statute to implement programs to improve quality and assess the effectiveness of such programs through systemic follow-up and to make information on quality and outcomes measures available to beneficiaries to facilitate comparisons among health care options. These requirements do not apply to private fee-for-service and PPO plans. HMO plans, as well as other coordinated care plans, are also held to more extensive access requirements than private fee-for-service plans to ensure timely access to care.¹⁶ Finally, although M+C PPO plans generally are held to less stringent quality assurance standards than other coordinated care plans, M+C organizations licensed as HMOs that offer M+C PPO plans may not avail themselves of the less stringent quality assurance standards applicable to M+C PPOs. Instead, a licensed HMO that offers an M+C PPO plan must comply with the quality assurance standards applicable to HMOs.¹⁷

CMS is authorized by section 402(a)(1)(A) of the Social Security Amendments of 1967 to conduct demonstrations designed to test whether

¹⁴See Social Security Act § 1855(a)(1)(codified at 42 U.S.C. § 1395w-25(a)(1) (2000)); see also 42 C.F.R. § 422.501(b)(1)(2003). An organization is considered to be licensed by the state as a “risk-bearing entity” if it is licensed or otherwise authorized by the state to assume risk for offering health insurance or health benefits coverage, so that the entity is authorized to accept prepaid capitated payments for providing, arranging, or paying for comprehensive health services. See 42 C.F.R. § 422.2 (2003).

¹⁵Compare Social Security Act § 1852(e)(2)(A)(codified at 42 U.S.C. § 1395w-22(e)(2)(A) (2000))(applicable to plans that are not private fee-for-service or PPO plans) with Social Security Act § 1852(e)(2)(B)(codified at 42 U.S.C. § 1395w-22(e)(2)(B) (2000))(applicable to plans that are private fee-for-service plans and PPO plans); see also CMS Pub. 100-16, Medicare Managed Care Manual, Chapter 5, Quality Assessment (Rev. 39, 11-07-03).

¹⁶See 42 C.F.R. § 422.112 (2003).

¹⁷The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA) revised the quality assurance standards for PPO plans under the M+C program and defined a PPO plan in that context as one that is “offered by an organization that is not licensed or organized under State law as a health maintenance organization.” Pub. L. No. 106-113, App. F, § 520, 113 Stat. 1501A-321, 1501A-385-86 (amending section 1852(e)(2) of the Social Security Act)(codified at 42 U.S.C. § 1395w-22(e)(2) (2000)). Based on this provision of the BBRA, CMS amended its regulations to define a PPO plan, in part, as one that is offered by an organization not licensed or organized under state law as an HMO. See 42 C.F.R. §§ 422.4(a)(1)(iii), (iv), (b)(2003); 65 Fed. Reg. 40170, 40175 (2000).

changes in methods of payment or reimbursement in Medicare and other specified health care programs would increase the efficiency and economy of those programs without adversely affecting the quality of services.¹⁸ Section 402(b) authorizes CMS to waive requirements related to payment or reimbursement for providers, services, and other items for purposes of demonstration projects, but does not authorize the agency to waive requirements unrelated to payment or reimbursement.¹⁹ Section 402(b) also authorizes CMS to pay costs in excess of those that would ordinarily be payable or reimbursable, to the extent that the waiver applies to these excess costs.²⁰

According to CMS, the agency initiated the 3-year Medicare PPO Demonstration in January 2003 to make the PPO health care option, which had been found to be successful in non-Medicare markets, more widely available to Medicare beneficiaries.²¹ Its objective was to introduce more variety into the M+C program so that Medicare beneficiaries would have more options available to them.²² In addition, CMS believed that the PPO demonstration plans would introduce incentives that would result in more efficient and cost-effective use of medical services.²³

CMS entered into contracts with all demonstration participants. To facilitate HMO participation in the Medicare PPO Demonstration, CMS permitted licensed HMOs, as well as all other demonstration participants,

¹⁸See Pub. L. No. 90-248, § 402(a)(1)(A), 81 Stat. 821, 930-31 (1968), as amended by Pub. L. No. 92-603, § 222(b), 86 Stat. 1329, 1391-93 (1972) (codified at 42 U.S.C. § 1395b-1(a)(1)(A) (2000)).

¹⁹Pub. L. No. 90-248, § 402(b), 81 Stat. at 931, as amended by Pub. L. No. 92-603, § 222(b)(2), 86 Stat. at 1393 (codified at 42 U.S.C. § 1395b-1(b) (2000)). Specifically, section 402(b) provides the following: "In the case of any experiment or demonstration project under section 402(a)(1), the Secretary may waive compliance with the requirements of title XVIII and title XIX of the Social Security Act insofar as such requirements relate to reimbursement or payment on the basis of reasonable cost, or (in the case of physicians) on the basis of reasonable charge, or to reimbursement or payment only for such services or items as may be specified in the experiment."

²⁰*Id.*

²¹See 67 Fed. Reg. 18209 (2002)(soliciting applications for demonstration participants).

²²*Id.*

²³*Id.* at 18211.

to offer private fee-for-service plans.²⁴ Exercising its authority under section 402(b), CMS waived statutory and regulatory payment requirements applicable to private fee-for-service plans, allowing the participating organizations to vary the amount of payments among providers, among other things, so that the plans offered would more closely resemble PPO plans. As a result, M+C organizations with HMO licenses were able to establish PPO-type plans and were not subject to the more stringent quality assurance standards applicable to HMOs and most other coordinated care plans. The private fee-for-service plan model contract provided that requirements that were not expressly waived by CMS would remain in effect during the term of the contract. Nevertheless, CMS approved plan provisions that required enrollees to obtain various items and services, including those covered under parts A and B of Medicare, from “network” providers. CMS officials told us that prospective demonstration participants had expressed concerns about their ability to determine appropriate payment rates for providers who were not under contract with the demonstration participant, and that the agency had decided to afford demonstration participants flexibility in this area in order to get the demonstration project underway. CMS officials also indicated that they had encouraged the demonstration participants to cover all benefits “out of network” before the end of the demonstration period. Notably, guidance issued by CMS to assist M+C organizations, including demonstration participants, in developing plan brochures for 2004 contained specific instructions for demonstration participants to indicate in their brochures if they do not cover all Medicare benefits “out of network.”

Discussion

The Social Security Act places restrictions on private fee-for-service plans' authority to limit enrollees' selection of providers. Specifically, section 1852(d)(4) requires an organization offering an M+C private fee-for-service plan to demonstrate that the plan affords sufficient access to health care providers by showing that it has established payment rates that are no lower than the corresponding rates under the Medicare fee-for-service program or that it has contracts with a sufficient number of providers to

²⁴Thirteen of the 33 plans participating in the PPO Demonstration are offered by organizations with HMO licenses. All plans were presented to potential enrollees as being either HMO plans with a point of service option or PPO plans, both of which are coordinated care plans.

provide covered services, or both.²⁵ That section also provides that the access standards may not be used to restrict the persons from whom enrollees may obtain covered services, thus suggesting that private fee-for-service plans are not authorized to limit their enrollees' selection of providers, for example, to those within an established "network." The definition of the term "private fee-for-service plan" at section 1859(b)(2) echoes this provision, stating that such plans do not restrict the selection of providers from among those who may lawfully provide covered services and agree to accept the terms and conditions of payment.

CMS has recognized that private fee-for-service plans may not restrict enrollees to specified providers for covered services. In promulgating regulations to implement section 1852(d)(4), CMS interpreted that provision as requiring private fee-for-service plans to permit enrollees to receive covered services from any provider who is authorized to provide services under the Medicare fee-for-service program.²⁶ Explaining the new regulatory provision—headed by the caption "freedom of choice"—CMS stated:

In 42 C.F.R. § 422.114(b), we specify that the plan must permit the enrollees to receive services from any provider that is authorized to provide the service under original Medicare. This implements that part of section 1852(d)(4) that says that the access requirements cannot be construed as restricting the persons from whom enrollees of the M+C private fee-for-service plan may obtain covered services.²⁷

²⁵The statute provides as follows: "In the case of an M+C private fee-for-service plan, the organization offering the plan must demonstrate to the Secretary that the organization has a sufficient number and range of health care professionals and providers willing to provide services under the terms of the plan. The Secretary shall find that an organization has met such requirement with respect to any category of health care professional or provider if, with respect to that category of provider – the plan has established payment rates for covered services furnished by that category of provider that are not less than the payment rates provided for under part A, part B, or both for such services, or the plan has contracts or agreements with a sufficient number and range of providers within such category to provide covered services under the terms of the plan, or a combination of both. *The previous sentence shall not be construed as restricting the persons from whom enrollees under such a plan may obtain covered benefits.*" Social Security Act § 1852(d)(4)(codified at 42 U.S.C. § 1395w-22(d)(4) (2000))(emphasis added).

²⁶See 63 Fed. Reg. 34968, 35039 (1998). See also 65 Fed. Reg. 40170, 40296 (2000)(under § 1852(d)(4), M+C organizations offering private fee-for-service plans cannot restrict providers from whom beneficiary can receive care).

²⁷63 Fed. Reg. at 35039.

In light of the statutory language and CMS's interpretation, we conclude that Medicare PPO Demonstration plan provisions limiting enrollees to "network" providers are inconsistent with sections 1852(d)(4) and 1859(b)(2) of the act. Because these sections are unrelated to payment, CMS was not authorized to waive them in connection with the Medicare PPO Demonstration.

Further, the plans' exclusions of coverage for services furnished by "non-network" providers are incompatible with statutory requirements designed to ensure quality of care to enrollees in M+C plans. As discussed earlier, private fee-for-service and PPO plans participating in the M+C program are held to less stringent quality assurance standards than HMOs and certain other coordinated care plans. The applicability of less stringent quality assurance standards is due, in part, to the increased choices enrollees in private fee-for-service and PPO plans have in comparison to enrollees in most other types of plans. CMS has expressly recognized this rationale for the distinction among various types of plans. In connection with an M+C rulemaking on the matter, CMS responded to a concern that private fee-for-service plan quality assurance requirements were inadequate to protect enrollees by explaining that quality assurance standards may not be as important in the case of private fee-for-service plans "in which the enrollee has complete freedom of choice to use any provider in the country, and is not limited to a defined network of providers."²⁸ CMS's approval of restrictions on enrollee choice and simultaneous failure to apply the more stringent quality standards applicable to HMO and most other coordinated care plans were inconsistent with the statutory framework under which M+C plans are required to operate.

Moreover, while CMS stated that the demonstration was intended to offer beneficiaries greater choice by encouraging the availability of PPO-type plans, regulatory provisions applicable to M+C PPO plans would have precluded demonstration participants from requiring enrollees to obtain services only from "network" providers as a condition of coverage. CMS has defined a PPO plan, in part, as a plan that "provides for reimbursement for all covered benefits regardless of whether the benefits are provided

²⁸See 65 Fed. Reg. 40170, 40294 (2000). CMS also explained that, in enacting the quality assurance standards of the BBA, "Congress recognized that not all of the quality assessment and performance improvement activities that are appropriate for a plan with a defined provider network would be appropriate for . . . an M+C private fee-for-service plan." *Id.* at 40220.

within the network of providers.”²⁹ (Emphasis added). Since this regulatory provision is not related to payment or reimbursement, section 402(b) of the Social Security Amendments of 1967 would not have authorized CMS to waive it in connection with the Medicare PPO Demonstration.

In its written response to our inquiry about the demonstration, CMS indicated that the demonstration plans' conditioning coverage of “Medicare-covered services” (those services covered under parts A & B of Medicare) on their being furnished by “network” providers violates statutory access requirements applicable to private fee-for-service plans. CMS explained, however, that while it had reviewed all plans to ensure that services covered by parts A and B of the Medicare program were covered “in network,” some organizations had indicated that they were unable to cover certain services “out of network” because of the complexities associated with determining payment for “out-of-network” providers. CMS, nevertheless, believed that “the basic principle of out-of-network access was satisfied” because “the demonstration products offer access to most Medicare-covered services.” CMS also denied that it had waived applicable access requirements, stating that it did not have the authority to do so.

CMS indicated that it will instruct demonstration participants that they must provide out-of-network coverage for all “Medicare-covered services” in 2005, the third year of the Medicare PPO Demonstration, if they wish to continue to avail themselves of the quality assurance standards applicable to private fee-for-service plans. CMS also indicated, however, that it will not require plans to provide out-of-network coverage for other covered benefits for which the demonstration plans provide only in-network coverage. CMS did not provide a legal basis for distinguishing between Medicare-covered services and other plan services with respect to a demonstration plan's obligation to provide “out-of-network” coverage.

We disagree with CMS's assertion that it did not waive the statutory requirements at issue. CMS knowingly permitted organizations participating in the demonstration to operate in a manner that was inconsistent with sections 1852(d)(4) and 1859(b)(2) of the Social Security Act. The agency's decision to do so achieved a result for demonstration

²⁹See 42 C.F.R. § 422.4(a)(1)(iv)(2003).

participants that CMS acknowledges it did not have the authority to provide. Therefore, we view CMS's action as tantamount to a waiver.

We also conclude that all benefits covered under a PPO demonstration plan, not just services covered under parts A and B, must be covered “out of network” by demonstration plans. The Social Security Act defines a private-fee-for service plan, in part, as a “Medicare+Choice plan” that “does not restrict the selection of providers among those who are lawfully authorized to provide the covered services.”³⁰ A “Medicare+Choice plan,” for purposes of the definition of a private fee-for-service plan, is defined, in part, as “health benefits coverage offered under a policy, contract, or plan by a Medicare+Choice organization.”³¹ Furthermore, CMS guidance also provides that enrollees in M+C private fee-for-service plans can obtain “plan covered health care services from any entity that is authorized to provide services under parts A and B and who is willing to accept the plan’s terms and conditions of payment.”³² The act, therefore, does not distinguish between Medicare covered services and other covered services in specifying the private fee-for-service plan’s obligations to cover plan benefits.

Section 402(b) of the Social Security Amendments of 1967 provides CMS with waiver authority, but also limits that authority by providing that the agency may only waive requirements related to payment or reimbursement. In connection with the Medicare PPO Demonstration, CMS overrode the limitation contained in section 402(b), tacitly waiving statutory provisions unrelated to payment. As a general matter, agencies may not override statutory limitations on their activities by administrative action.³³ Therefore, we conclude that CMS’s decision to allow

³⁰See Social Security Act § 1859(b)(2)(C)(codified at 42 U.S.C. § 1395w-28(b)(2)(C) (2000)).

³¹See Social Security Act § 1859(b)(1)(codified at 42 U.S.C. § 1395w-28(b)(1) (2000)).

³²See CMS Pub. 100-16, Medicare Managed Care Manual, Chapter 4, Benefits and Beneficiary Protections,150 (Rev. 23, 06-06-03). The Medicare Managed Care Manual provides the following: “To be eligible to furnish care to a private fee-for-service enrollee: (1) Physicians must be state licensed, and either have a Medicare billing number or be eligible to obtain one; and (2) Institutional providers, such as hospitals and skilled nursing facilities, must be certified to treat Medicare beneficiaries.” *Id.* See also 42 C.F.R. § 422.114(b)(2003)(private fee-for-service plan must allow enrollees “to obtain services from any entity that is authorized to provide services under Medicare parts A and B”).

³³See *Morton v. Ruiz*, 415 U.S. 199, 231-32 (1974); *Natural Resources Defense Council v. EPA*, 907 F.2d 1146, 1165 (D.C. Cir. 1990); and *United States v. Detroit*, 720 F.2d 443, 451 (6th Cir. 1983)(administrative agencies may not override an express statutory requirement).

**Appendix I: Analysis of PPO Demonstration
Participants' Restriction on Enrollee Choice
of Provider**

demonstration participants to restrict enrollees' access to providers for any services covered by the plans exceeds its authority and is, therefore, unlawful.

Appendix II: Scope and Methodology

This appendix provides additional information on the key aspects of our analysis. First, it describes the Centers for Medicare & Medicaid Services' (CMS) administrative data sources we used to assess demonstration preferred provider organization (PPO) enrollment and plan participation. Second, it describes the CMS data sources we used to compare estimated beneficiary out-of-pocket costs between six types of coverage. Third, it describes CMS data sources used to compare 2003 benefits between the six types of coverage. Fourth, it describes CMS data we used to estimate the proportion of expected 2004 annual out-of-pocket costs and cost sharing when demonstration PPO enrollees utilize services outside of plan provider networks. Fifth, it describes how CMS estimated the effect of demonstration PPOs on Medicare spending. Finally, it addresses data reliability issues and limitations.

Enrollment

We used the following CMS administrative data sets to identify the number of eligible Medicare beneficiaries and enrollment by health plan in each county where demonstration PPOs operated: the Geographic Service Area (GSA) file for October 2003, the Medicare Managed Care Plan Monthly Report for October 2003, and the Medicare Managed Care Contract (MMCC) report of 2003.¹ Because the focus of our analysis was on plans available to Medicare beneficiaries at large, we used plan enrollment data from GSA to exclude demonstration PPO and Medicare+Choice (M+C) plans that were employer-only plans; cost plans; and demonstration plans only available to specific beneficiaries such as Medicare dual-eligibles.² Demonstration PPO and M+C plan county data from GSA were also used to construct our county-level U.S. map.

¹GSA, which provides a monthly list of service areas for all risk and cost Medicare managed care contracts, allowed us to tie plan option contract identification numbers to specific service areas. However, CMS's Medicare Managed Care Monthly Report, which provides regular monthly updates of active and terminated Medicare contracts, and MMCC, which provides statistics regarding all Medicare contract managed care plans, we also used because they can be more accurate than the GSA at calculating overall demonstration PPO enrollment. This is because GSA excludes enrollment in service areas that have ten or fewer enrollees.

²Employer-only plans, by design are only available to retirees through their former employers. Employer-only plans exist in demonstration PPO form and in M+C plan form; therefore we specifically eliminated employer-only plans from both types of plans. Dual-eligibles are Medicare beneficiaries who are also eligible for Medicaid services.

Estimated Out-of-pocket Cost Comparisons

To compare out-of-pocket costs for beneficiaries, we used administrative data from GSA and CMS's 2003 Medicare Health Plan Compare (MHPC) data set³ to identify private health plans. For each plan in each county, we then used CMS's 2003 Medicare Personal Plan Finder (MPPF)⁴ to obtain estimated monthly out-of-pocket costs. We then averaged these costs across counties for enrollees in demonstration PPOs, M+C health maintenance organizations (HMO) and M+C PPOs, M+C private fee-for-service (PFFS) plans, Medigap plans F and I, and fee-for-service (FFS) Medicare.⁵

First, we used data from MHPC to identify one plan offered by each organization in each county where demonstration PPOs were available. Because organizations may offer numerous options for each plan, each with its own benefit package and premium, we selected the one option that was most favorable for beneficiaries in each service area.⁶ Selecting one option for each plan may have resulted in underestimated actual beneficiary out-of-pocket costs for beneficiaries in some health plans. In addition, we established a sample group of 41 counties containing approximately 90 percent of all demonstration PPO enrollment. This sample group includes the 21 counties where Horizon Healthcare of New

³CMS's Medicare Health Plan Compare is used as an administrative data set to track all participating private health plan benefit information.

⁴CMS's MPPF is a Web tool intended to assist Medicare beneficiaries with selecting a Medicare health plan. MPPF contains information on M+C plan availability by geographic location, estimated beneficiary out-of-pocket costs, and certain benefits provided by each available type of Medicare coverage. MPPF can be found at the following Web address www.medicare.gov/MPPF/home.asp.

⁵Throughout our analysis we compare demonstration PPO plans to Medigap plans F and I. As of 1999, Plan F enrolled the most Medicare beneficiaries of the 10 available Medigap policies, and Plan I was the most widely offered Medigap policy that included a prescription drug benefit. GAO, *Medigap Insurance: Plans are Widely Available but Have Limited Benefits and May Have High Costs*, [GAO-01-941](#) (Washington D.C.: July 2001).

⁶In cases where a demonstration PPO or M+C plan offered a plan with multiple options, or different sets of benefit packages and premiums, in a county, we used four criteria to identify the plan option that was most favorable for beneficiaries. We first selected plan options for each organization that included prescription drug coverage. If there was more than one, we selected the option with the lowest premium. If there were two drug plans with identical premiums, we selected the option that offered brand-name drug coverage and lowest deductible. If there was more than one plan that met the first three criteria, we selected the option with the lowest out-of-pocket cost spending cap.

Jersey's demonstration PPO plan was available,⁷ and the 23 counties that made up 80 percent of enrollment in demonstration PPOs other than Horizon.⁸

Next, we used estimated beneficiary out-of-pocket cost data from CMS's MPPF to calculate the 2003 average monthly out-of-pocket costs for enrollees in demonstration PPOs and the other types of coverage. CMS, and its contractor Fu Associates, Ltd. (Fu), estimated all costs related to covered and noncovered benefits when an enrollee utilizes services within the plan's network of providers.⁹ We calculated average monthly out-of-pocket costs for beneficiaries aged 65 to 69 for each type of coverage, in each county, and across all health statuses.¹⁰ We weighted the estimates of demonstration PPOs, M+C HMO and M+C PPO plans, M+C PFFS plans, and Medigap plans F and I by the distribution of health statuses of the beneficiary cohorts used to create Fu's estimates, and the number of eligible Medicare beneficiaries in each county. We separated M+C PFFS plans from M+C HMOs and PPOs, because the out-of-pocket costs of enrollees in M+C PFFS plans tended to be substantially higher than the other two types of M+C plans.

Benefits Comparison

We used CMS's 2003 MHPC administrative data set in conjunction with CMS's 2003 guide to "Choosing a Medigap Policy" to compare the benefit packages for enrollees in demonstration PPOs, M+C HMOs and M+C

⁷Because Horizon's 2003 demonstration PPO is the only demonstration PPO that was an M+C HMO in 2002 and Horizon has the largest proportion of demonstration PPO enrollees, we included all service areas where Horizon's demonstration PPO was available.

⁸Overlap exists between these two groups of counties. Bergen, Monmouth and Ocean counties of New Jersey contain Horizon demonstration PPOs and have a significant amount of enrollment in Aetna's demonstration PPO.

⁹Fu defined a cohort of FFS individuals based on the 1998 and 1999 Medicare Current Beneficiary Surveys (MCBS). This cohort provides the basis from which to identify the utilization measures and out-of-pocket costs for the Medicare Personal Plan Finder (MPPF) database. Actual 2003 premiums, deductibles, and selected fee-for-service copayments from this cohort formed the basis for the fee-for-service component of the MPPF database. The contract year 2003 plan benefit packages were used to define the out-of-pocket costs associated with contract year 2003 M+C plans and demonstration PPOs. Finally, Medigap premium data were used to define the out-of-pocket costs for contract year 2003 Medigap plans.

¹⁰Beneficiaries aged 65 to 69 are generally the newest to the Medicare program and, in 1999, were the largest age group in the Medicare program. We conducted a similar analysis for beneficiaries aged 80 to 84.

PPOs, M+C PFFS plans, Medigap plans F and I, and traditional FFS Medicare.¹¹ We compared prescription drug coverage and inpatient hospital services for each type of coverage using our sample of plans in 41 counties. We selected the one plan option for each plan that appeared most favorable to beneficiaries. We also compared prescription drug coverage between these types of plans in a sample of 16 counties where at least one demonstration PPO and one M+C plan offered prescription drug coverage as a part of their benefit package. In addition, data from CMS's Health Plan Management System (HPMS)¹² were used to compare the non-network benefits offered by each demonstration PPO to the 2003 network benefits offered by demonstration PPOs.

Costs of Out-of-network Services

CMS's Office of the Actuary (OACT), which projects trends in Medicare spending, provided the data we used to compare the proportion of expected 2004 gross annual out-of-pocket costs and cost sharing when demonstration PPO enrollees utilize services inside and outside of plan provider networks. The data we obtained were submitted by plans to OACT as part of their annual revenue and medical expense projections and contained estimates of per member per month gross medical costs and target medical loss ratio (MLR) for 2004.¹³ We contacted OACT to verify that we possessed a submission for each of the 20 demonstration PPOs in our sample of 41 counties.

Effect on Medicare Spending

To determine the effects of demonstration PPOs on Medicare spending, we used projections developed by OACT and conducted interviews with OACT staff. To arrive at these projections, OACT compared how much Medicare would pay demonstration PPOs per enrollee with the amount Medicare would spend on those beneficiaries if the demonstration did not exist and those beneficiaries were instead enrolled in M+C plans or FFS

¹¹Data were drawn from Fiscal Year 2003 Medicare Health Plans Compare data set on September 11, 2003, the final version for that year.

¹²CMS's HPMS captures Medicare private health plans non-network benefits.

¹³Prior to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) CMS required that organizations participating in the PPO demonstration submit estimates of enrollee costs for 2004, because they were not required to submit the standard M+C adjusted community rate proposal. Plans' estimates of enrollee costs, broken down between services obtained within and outside their provider networks, do not reflect revenues included in MMA, which was enacted in December 2003.

Medicare. OACT also estimated the effect that risk-sharing agreements signed between CMS and demonstration PPOs had on Medicare spending.

Data Reliability

We used a variety of CMS data sources in our analysis; October 2003 GSA file, October 2003 Monthly Report, October 2003 MMCC, 2003 MPPF, 2003 HPMS, 2003 MHPC, and the estimated 2004 Medicare PPO Demonstration plan medical cost files. In each case, we determined that the data were sufficiently reliable for our purposes in addressing the report's objectives.

We verified the reliability of the administrative data we used to determine enrollment figures—CMS's GSA, M+C Monthly Report, and MMCC—by comparing the list of unique demonstration PPO contract identification numbers and organization names to CMS's list of participating demonstration PPO plans and organizations. We did not find any discrepancies between the two lists. We worked closely with CMS staff and Fu to verify the validity of out-of-pocket cost estimates from the 2003 MPPF. We verified that the results of our out-of-pocket cost analysis were consistent with CMS's initial tests of its own data, and that our methodology, in conjunction with its methodology, did not introduce bias. In addition, we worked with CMS to verify the validity of the 2004 Medicare PPO Demonstration plan medical cost files submitted by the health care organizations by assuring that the information they provided to us corresponded with our data for the sample of 41 counties.

We identified three potential limitations of our analysis; however we have addressed these limitations through conversations with CMS and Fu, and by using the best available data. Our report focuses on the results of our analysis of estimated enrollee out-of-pocket costs for beneficiaries aged 65 to 69. We also obtained similar results when we analyzed estimated enrollee out-of-pocket costs for beneficiaries aged 80 to 84. In addition, we verified with CMS and Fu that the trends associated with the 2003 out-of-pocket costs of the 65 to 69 age group were similar to the out-of-pocket costs of Medicare beneficiaries aged 70 to 74. Second, for our out-of-pocket cost analysis, we used national FFS Medicare estimates, rather than county-level estimates, because county-level estimates were not available. Based on our conversations with CMS and Fu, we believe that CMS's national figures were more accurate than adjusting the national estimates to the county level using national FFS spending in each county. Third, while county-level Medigap out-of-pocket costs and benefit package information were not available to us, we used CMS estimates of national Medigap out-of-pocket costs and standardized national Medigap benefits descriptions for our benefits comparison.

Appendix III: CMS Comments




DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: SEP - 8 2004

TO: A. Bruce Steinwald
Director, Health Care – Economic
and Payment Issues
Government Accountability Office

FROM: Mark B. McClellan, M.D., Ph.D. 
Administrator

SUBJECT: Government Accountability Office (GAO) Draft Report: *MEDICARE DEMONSTRATION PPOs: Financial and Other Advantages for Plans, Few Advantages for Beneficiaries* (GAO-04-960)

Thank you for the opportunity to review and comment on the above-referenced draft report.

We are extremely concerned about the tone of this report, however, beginning with the title, which is misleading, unfair, and not supported by the information presented in the report itself. We believe beneficiaries benefit substantially from increased access to the Preferred Provider Organization (PPO) model, and will, in the long run, be better off for the availability of these types of plans in the new Medicare Advantage program.

It is important to note that the PPO Demonstration is just that, a demonstration. The financial arrangements developed for the project were intended to encourage plans to participate in this experiment, and they should be viewed as a first step in the development of better ways to establish partnerships between the Medicare program and private plans for the benefit of Medicare beneficiaries.

We have learned a great deal from conducting this demonstration, and we look forward to applying these valuable lessons in implementing the new Medicare Advantage regional PPO plan option in 2006 as a choice for Medicare beneficiaries throughout the country. In addition to a risk-sharing model similar to the one used for some plans in the PPO Demonstration, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) created a stabilization fund that will encourage plans to enter and remain in the Medicare Advantage regions. The MMA also allocated funding to help plans contract with hospitals necessary to provide beneficiaries with a full range of care in their area. In addition, there are certain beneficiary protections available to regional PPOs enrollees that are not available to local plan enrollees.

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The Centers for Medicare & Medicaid Services (CMS) is working with the PPO Demonstration plans to ensure that they come into compliance with the provisions that govern their participation in the Medicare program. Because these plans are under a private fee-for-service contract for purposes of this demonstration, they are required to provide coverage for all plan services furnished by any Medicare authorized provider who accepts the plan's terms and conditions of payment. It should be noted that we have received no indication that the current benefits offered by these plans has disadvantaged their enrollees. We will comply with the recommendation made in the report while working to ensure a smooth transition for enrollees and plans.

The report, overall, fails to adequately reflect the context in which the PPO Demonstration was developed and the reasons for its implementation. The CMS began to consider a PPO demonstration initiative in 2001, three years before passage of the MMA, and before many of the current policies and procedures pertaining to PPOs had been formulated.

At the time the demonstration was developed, beneficiaries had a very limited choice of managed care delivery models. The PPO model, popular in the private sector, was available only on a limited basis to Medicare beneficiaries under the Medicare + Choice program.

Three years later, the demonstrations have clearly provided valuable information to both CMS and health care providers as we work to make the PPO model a central feature of the new Medicare Advantage program.

We wanted the PPO Demonstration model to include three fundamental components that we thought would appeal to beneficiaries. The first was a robust network of preferred providers that would be available to provide traditional Medicare benefits as well as some additional benefits, such as prescription drugs, with modest cost-sharing. The second was the ability of enrollees to use services from non-preferred providers, with the understanding that there may be significant cost sharing. The third was limits on out-of-pocket cost-sharing when possible. All of these features are common in private sector PPOs.

In order to provide these features within the structural constraints of the existing Medicare + Choice program, we implemented the model using a Medicare + Choice private fee-for-service contract vehicle, which would allow both the program and the participating plans as much flexibility as possible. We also considered the constraints and limitations faced by the organizations that volunteered to test the new Medicare PPO model. The entire developmental process occurred over a four-month period in order for new PPO options to be available for Medicare's 2003 open enrollment period.

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In this expedited process, we considered what organizational requirements would be the most appropriate for the program, health plans, and beneficiaries. One factor that had to be confronted was that many of the organizations interested in testing the PPO model had existing HMO licenses in their States, which would have prohibited them from offering formal PPOs. We also wanted the demonstration organizations to be able to accurately pay claim costs incurred by enrollees who accessed services through non-preferred providers and protect them from incurring any costs other than the stated out-of-pocket cost associated with the particular service. We created a PPO demonstration that was not exactly like any of the existing Medicare + Choice coordinated care products, yet provided positive incentives to beneficiaries, assured quality of care, and served their interests well.

There are multiple references throughout the report to the low enrollment levels in the PPO Demonstration products. We believe that this misses the point of demonstration projects. The primary objective of this initiative was to test ways to develop and implement additional coverage options for Medicare beneficiaries. It was not—nor was it intended to be—a fully developed program.

That said, about 105,000 Medicare beneficiaries are enrolled in the demonstration sites as of August 2004, and the number of enrollees is growing steadily. We expect that as more PPOs enter the Medicare program because of the new Medicare Advantage provisions of the MMA, more beneficiaries will enroll in these plans.

A primary reason for conducting demonstrations is to learn about how best to design, develop, and implement potential improvements in the Medicare program. As this demonstration has progressed, we have learned a great deal that can be applied in the future. In particular, as the new Medicare Advantage program has been fleshed out, CMS has been able to use information from the demonstration experience to address issues related to payment mechanisms, the dissemination of information to beneficiaries, and quality assurance. We anticipate that all of the PPO Demonstration sites will continue to participate in the Medicare Advantage program in 2006, and we believe the experience gained from their participation in this demonstration will ensure that they will continue to offer beneficiaries attractive options under the Medicare Advantage program.

We also must point out that your report creates potential confusion by combining analysis of the Independence Blue Cross PPO product with the Medicare PPO Demonstration. The Independence plan was one of nine products and the only PPO product offered as part of the M+C Alternative Payment Demonstration. In discussions with GAO, CMS staff repeatedly suggested that the Independence PPO plan be considered separately from the PPO products offered under the Medicare PPO Demonstration. The report combines the Independence discussion with that of the PPO Demonstration products in discussions of cost estimates and enrollment, but we do not believe the report adequately distinguishes the unique objectives of each demonstration initiative.

Page 4 - A. Bruce Steinwald

The intent of the Medicare + Choice Alternative Payment Demonstration was to prevent health plans from leaving the Medicare + Choice program. Unlike the Medicare PPO Demonstration, there was never any intent to explore or encourage alternative delivery systems in general or the PPO model specifically as part of the M+C Alternative Payment Demonstration. Rather, this initiative was simply an attempt to try alternative payment options to prevent plan withdrawal. The fact that Independence was a PPO plan is completely irrelevant. Therefore, we would again suggest that the Independence PPO plan be discussed separately in the report. (We would note that, unless otherwise stated, comments in this response are specific to the Medicare PPO Demonstration only, not the Independence Medicare + Choice Alternative Payment Demonstration.)

The key objective in all Medicare demonstration initiatives is to learn from different approaches employed in the demonstration model. The report does not acknowledge that an independent evaluation of the demonstration is being conducted by Research Triangle Institute, Inc. This evaluation includes a survey component to assess why beneficiaries are or are not attracted to the products offered under the demonstration. The survey will provide valuable information with regard to: beneficiary awareness and understanding of the PPO option; specific reasons for enrollment; experience and overall satisfaction with the plan; and reasons for disenrollment.

Thank you again for the opportunity to review and comment on the draft report. Attached are more specific comments on the report and its contents.

Attachment

**Centers for Medicare & Medicaid Services' Comments to the Draft GAO Report:
MEDICARE DEMONSTRATION PPOs: Financial and Other Advantages for Plans,
Few Advantages for Beneficiaries (GAO-04-960)**

GAO Recommendation

That the Administrator of CMS promptly instruct plans in the Medicare PPO demonstration to provide coverage for all plan services furnished by any provider authorized to provide Medicare services who accepts the plan's terms and conditions of payment.

CMS Response

The CMS is working with the PPO Demonstration plans to ensure that they come into compliance with the provisions that govern their participation in the Medicare program. It should be noted that we have received no indication that the current availability of covered services offered by these plans has disadvantaged their enrollees. We will comply with the recommendation made in the report while working with the plans to ensure a smooth transition.

In responding to GAO's recommendation, we believe it is important to provide the policy context for structuring the PPO Demonstration as we did. As we had indicated in communications with GAO during the review of the PPO Demonstration, the solicitation for the demonstration specified that all plans under the initiative must offer access to out-of-network benefits. Some of the PPO Demonstration plans were concerned that they would not be able to pay the correct Medicare allowable amounts for certain services provided out-of-network and believed that there was more than adequate ability to provide these services in-network. In developing the demonstration, we chose to waive certain payment provisions of the private-fee-for-service (PFFS) contract under which the demonstration plans operate in order to maintain maximum flexibility to create products that resemble commercial PPO models.

We wanted to provide some flexibility in these demonstrations in order to mimic private sector PPO models and to facilitate rapid implementation for the 2003 open enrollment season. However, we made every effort to ensure that all Medicare-covered Part A and Part B services were covered in-network and, in fact, a significant focus of the qualification reviews conducted by CMS was to confirm that there was adequate access to network providers.

In addition, in order to protect beneficiaries, CMS ensured the following:

- PPO plans had to provide access to all plan-covered services through network providers.

Page 2 – Attachment

- PPO plans provided full disclosure to members with regard to coverage and costs for all services, both those provided in-network and out-of-network. CMS has put a significant amount of effort into the development of specific guidance for the PPO Demonstration plans to ensure that in-network and out-of-network benefits are clearly described in plan marketing material and the plans' Evidence of Coverage, a document that details the benefits offered by the demonstration plans.
- PPO Demonstration enrollees had the ability to disenroll on a month-to-month basis.

These protections will continue to apply in contract year 2005, the last year of the demonstration. Moreover, we have received no indication that enrollees in these plans have been disadvantaged in any way.

General Comments

- 1) There is concern about the methodology used to estimate out-of-pocket costs incurred by demonstration enrollees, as compared to out-of-pocket costs of beneficiaries with other types of coverage. There is insufficient detail regarding methodology for us to fully comprehend how the average out-of-pocket costs were derived. GAO's analysis is based on national utilization assumptions, not PPO Demonstration enrollees' actual utilization of services. Without knowledge of actual utilization patterns of PPO Demonstration enrollees, any conclusions with regard to out-of-pocket costs are purely hypothetical.

It is also worth noting that GAO used national average spending estimates for Medicare FFS and Medigap to compare with the county-estimated out-of-pocket costs for Medicare + Choice plans and demonstration PPO plans. We would note that most of the demonstration PPO plans are in high-cost areas; therefore, it is reasonable to believe that GAO's out-of-pocket cost comparison is potentially unreliable.

We are also concerned with GAO's focus on the 65 to 69 age group to estimate and compare out-of-pocket costs for the different types of coverage available to Medicare beneficiaries. The analysis completely disregards the important fact that most Medigap policies are age rated, and premiums increase dramatically as beneficiaries' age. Additionally, unlike Medicare + Choice enrollees, Medigap applicants are often subject to medical underwriting or screening. In contrast, PPO premiums are the same for all beneficiaries, regardless of age or health status. As a result, Medicare + Choice PPO plans may experience adverse selection. Clearly, PPO out-of-pocket costs are being compared to the most favorable Medigap out-of-pocket cost scenario. We believe that limiting the analysis to the 65 to 69 age group is a serious limitation that should be addressed.

Page 3 – Attachment

GAO was informed of this concern at the exit conference, but the report fails to address the issue.

In addition, GAO used a sample group of 41 counties containing about 90 percent of all demonstration PPO enrollment. The sample group includes Horizon's 21-county service area. Horizon had the largest in-network deductible for inpatient hospital services of all the demonstration PPO plans. This, too, could have an impact on the analysis, for the sample may be skewed towards the high out-of-pocket costs for the demonstration PPO plans.

- 2) The correct reference for "Fu Associates" is "Fu Associates, Ltd."

Appendix IV: GAO Contact and Staff Acknowledgments

GAO Contact

James C. Cosgrove at (202) 512-7029.

Acknowledgments

In addition to the person named above, key contributors to this report were: Yorick F. Uzes, Zachary R. Gaumer, Jennifer R. Podulka, Jennie F. Apter, Helen T. Desaulniers, and Kevin C. Milne.

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