Private Fee-for-Service (PFFS)

A Medicare (PFFS) operates much differently than other MA plan types. PFFS plans may cover just Part A and Part B, can be set up for Part A, Part B and Part D, or be combined with a separate stand-alone prescription drug plan. Someone with a PFFS plan can see any physician that accepts Medicare. The physician they see must accept the reimbursement rates set by the plan. This is often referred to as a fee schedule, or usual customary and reasonable rates, depending on the state.

Services are usually subject to co-pays, deductibles and co-insurance like other MA plans, and there could also be an additional 15% charged for balanced billing if the plan allows. These plans cannot have a maximum out-of-pocket cost higher than $6,700 annually.

Out-of-network providers can deny services to a PFFS policyholder, even if they accept Medicare assignment, and can chose to see them and accept payment on a case-by-case basis. In other words, a physician can treat a PFFS policyholder today and then decide tomorrow to no longer do so. Whenever someone with a PFFS plan seeks care outside of their network, they must inform the provider that they have a PFFS. The only exception is for emergency care, where no notification needs to be made.

Out-of-network services also have higher cost sharing with a PFFS. A PFFS usually only reimburses out-of-network providers at the same rate as Original Medicare, but can specify a different amount in its terms. Providers cannot charge the policyholder anything additional if they accept the plan’s payment.