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CONTROVERSIAL PROVISION OF "DOCTOR FIX" BILL WOULD IMPROVE MEDICARE AND HELP KEEP BILL DEFICIT-NEUTRAL

When the Senate returns from its July 4th recess, it is expected to reconsider H.R. 6331, the Medicare "doctor fix" bill that failed to advance by one vote last month. Despite overwhelming bipartisan support in the House (which passed it by a 355-59 vote), the bill stalled in the Senate, largely due to objections from the Administration and many Senate Republicans to a provision concerning Medicare Advantage. (This is the program through which Medicare beneficiaries can elect to receive coverage through private insurance companies instead of regular Medicare.)

The provision in dispute was suggested last year by Mark McClellan, a noted Republican health care economist and strong Medicare Advantage supporter who was the Administrator of the Centers for Medicare and Medicaid Services for the Bush Administration from 2004 to 2006. It would narrow the unjustified competitive advantage that "private fee for service" (PFFS) plans have over other Medicare Advantage plans (i.e., HMOs or preferred-provider organizations) by requiring PFFS plans to establish provider networks and collect health care quality data, as other Medicare Advantage plans already must do.

The provision would *not* cut payment rates to PFFS plans, contrary to some misleading claims, and is quite modest compared to the recommendations by Congress's expert Medicare Payment Advisory Commission (MedPAC) that the massive overpayments to Medicare Advantage plans be eliminated (see below). The provision would, however, generate some savings to help cover the cost of the "doctor fix" bill, which averts the scheduled reduction in Medicare physician fees and makes long-overdue improvements to help low-income Medicare beneficiaries afford health care.

The Administration has threatened to veto the bill because of this and other Medicare Advantage provisions, and Senate opponents have mounted and sustained a filibuster against the bill largely because of this provision alone.

The high costs of Medicare Advantage — and of PFFS plans in particular — are creating a major fiscal dilemma for Medicare.

- Private insurance companies were brought into Medicare to *lower* costs. MedPAC has found that the private plans in general receive 13 percent more, on average, than it would cost traditional Medicare to cover the same people. Last year the Congressional Budget Office estimated that these additional payments will cost Medicare $149 billion over the next ten years. MedPAC has warned that these costs are weakening Medicare's financial stability.

- PFFS plans play a large role here. They are the fastest growing type of Medicare Advantage plans and receive the largest overpayments. (MedPAC reports that it costs 17 percent more, on average, to cover a beneficiary under PFFS than under regular Medicare.) MedPAC also reports that PFFS plans are the least efficient of Medicare Advantage plans, with nearly half of these excess payments going to administrative costs, marketing, and profits rather than to additional health benefits provide to enrollees.

Unlike other Medicare Advantage plans, PFFS plans do not have to establish provider networks to ensure that beneficiaries have access to needed care.

- Instead, Medicare considers any health care provider who treats a Medicare beneficiary who has enrolled in a PFFS plan to be a participating provider in that plan, even if there is no formal agreement between the provider and the plan. The provider is automatically "deemed" to have agreed to the plan's fee schedule, billing procedures, utilization rules, and the like.

- This can place both physicians and beneficiaries in a quandary. Physicians who do not want to terminate longstanding patients who have switched from regular Medicare to PFFS have no choice but to participate in the PFFS plan and accept its conditions. This situation has drawn complaints from the American Medical Association and rural health care providers, including the National Rural Health Association. Rural hospitals and physicians, in particular, have documented numerous instances where PFFS payments have been late or less than expected (or not provided at all).

- This also can pose a problem for beneficiaries. If physicians decline to continue treating Medicare patients who have switched to PFFS plans, the beneficiaries can lose access to their longstanding doctors and hospitals.

- Finally, this "deeming authority" gives PFFS plans a competitive advantage over other Medicare Advantage plans. Freed from the usual start-up costs of establishing a provider network, PFFS plans that enter new geographic areas can instead focus on aggressive marketing initiatives to encourage beneficiaries to switch to their plans. Media reports, recent congressional testimony, and state insurance commissioners have reported extensive abuses in PFFS marketing practices.

Starting in 2011, H.R. 6331 would require most PFFS plans to establish provider networks.

- The bill, however, would *exempt* from this requirement all non-employer PFFS plans operating in geographic areas that do not already have two other Medicare Advantage plans with provider networks. The exemption, which will apply to a number of rural PFFS plans, responds to concerns made by some critics that the network requirement would cause rural beneficiaries to lose access to Medicare Advantage because they live in areas where networks are traditionally difficult to establish.

- The provision would address the concerns about the PFFS "deeming rules" while also generating modest savings to help offset the bill's overall cost. These savings would not come by cutting payments to PFFS plans, but rather by making PFFS plans compete on a more equal basis with other plans and thereby slowing their explosive enrollment growth. Since PFFS plans receive larger overpayments and constitute the bulk of the recent overall growth in Medicare Advantage enrollment, slowing their rapid growth would achieve savings for Medicare while improving beneficiary access to health care providers.

H.R. 6331 would also require PFFS plans to report on health care quality, as other Medicare Advantage plans must.

- Unlike all other Medicare Advantage plans, PFFS plans are not required to collect data on the quality of health care they provide, even though evidence shows that when providers or plans are required to measure the quality of care they deliver, quality improves. The bill would end this unjustified exemption starting in 2010, requiring PFFS plans to meet the same quality reporting standards that apply to other Medicare Advantage plans.