

H.R. 6331

THE MEDICARE IMPROVEMENTS FOR PATIENTS AND PROVIDERS ACT:

NEEDED REFORMS TO MEDICARE ADVANTAGE

Federal spending for private Medicare Advantage (MA) plans - including health maintenance organizations, preferred provider organizations, and private fee-for-service plans - has grown rapidly since Congress increased payments for MA in the Medicare Modernization Act of 2003. The Congressional Budget Office estimates that overpayments to Medicare Advantage plans cost taxpayers \$150 billion/10 years. They are paid at a rate 13 percent higher than traditional Medicare fee-for-service providers. Private fee-for-service plans, in particular, get a special deal that costs taxpayers and beneficiaries alike. They are not required to have contracts with hospitals or doctors, which causes confusion for Medicare beneficiaries and providers. They are also exempt from reporting quality measures that contribute to efficiency in care.

The Medicare Payment Advisory Commission (MedPAC) has identified an additional source of overpayment to Medicare Advantage plans, compared to rates for traditional fee-for-service. Indirect medical education (IME) payments, which are meant to defray the higher patient care costs at facilities with graduate medical education programs, are being made twice: once to the facility itself, and again to Medicare Advantage plans, with no requirement that plans pass the IME payment along to the teaching facilities. H.R. 6331 provides a modest and balanced approach to addressing these inequities in the Medicare Advantage program, which will save taxpayers \$12 billion over five years with the following reforms:

- **Require Private-Fee-for-Service Plans to Form Provider Networks:** Private fee-for-service plans will be required to have contracts with hospitals and providers. The Congressional Budget Office (CBO) projects that this safeguard for seniors will stop the skewing of growth in Medicare toward uncontrolled, overpaid private plans that currently do not always guarantee beneficiaries access to doctors and hospitals. The Medicare bill will get rid of the special network exemption for private fee-for-service plans by 2011. This change will only apply to plans in areas with two or more non-PFFS plan choices.
- **Require Private Fee-For-Service Plans to Report Quality Measures:** Evidence shows that when providers or benefit plans are required to measure the quality of care they deliver and report, quality increases and resulting public information helps patients become better health care consumers. Currently, private-fee-for-service plans in Medicare Advantage are exempt from reporting quality measures, even though other MA plans must do so. The Medicare Improvements for Patients and Providers Act will eliminate the quality reporting exemption by 2010. CBO does not project cash savings from this measure, but seniors' health and the quality of their care will be improved.
- **Eliminate Double Payment to MA Plans:** Each time a Medicare beneficiary is admitted to a teaching hospital, the facility receives an Indirect Medical Education (IME) payment to defray the cost of educating doctors and providing more sophisticated care. But the current reimbursement rate for Medicare Advantage plans is also adjusted upward to reflect IME payments made by Medicare at the local level. Medicare Advantage plans get a higher payment for every enrollee, whether enrollees ever receive care at such facilities or not. MA plans are not required to pass the payment along to teaching hospitals at any time. The Medicare Improvements for Patients and Providers Act eliminates the needless double payment, still reimbursing the teaching facility directly for the higher cost of care, but eliminating the second payment, the IME adjustment in Medicare Advantage rates.