America's Health
Insurance Plans

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March 1, 2013

Jonathan Blum, Director, Center for Medicare
Paul Spitalnic, A.S.A., M.A.A.A., Director, Parts C & D Actuarial Group
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244

RE: Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies

Dear Mr. Blum and Mr. Spitalnic:

America's Health Insurance Plans (AHIP) appreciates the opportunity to comment on the Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies.

Our members are strongly committed to serving Medicare beneficiaries under the MA and Part D programs, and our comments are designed to promote stability for the beneficiaries they serve. Currently, more than 14 million Americans, or roughly 28 percent of all Medicare beneficiaries, have chosen to enroll in a Medicare Advantage plan because of the better services, higher-quality care, and additional benefits these plans provide. A recent survey found that nine out of ten beneficiaries are satisfied with the coverage their Medicare Advantage plan provides.

Unfortunately, proposals in the Advance Notice and draft Call Letter will reduce Medicare Advantage payments next year at a time when the program is already facing billions of dollars in cuts and taxes included in the Affordable Care Act (ACA). Unless significant changes are made by April 1, seniors and people with disabilities enrolled in Medicare Advantage will experience higher costs, reduced benefits, and fewer health care choices.

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CMS has proposed an MA growth rate for 2014 of negative 2.3 percent – the most severe growth rate reduction in the history of the MA program and a dramatic decline relative to the 2013 MA growth rate of plus 2.8 percent. In no part of the delivery system is health care projected to be cheaper next year than this year. In fact, economists are projecting medical costs to increase by an additional 3 percent next year.

A recently released report by actuaries at Oliver Wyman estimates that the cumulative impact of the new proposed payment cuts combined with the steep cuts and new health insurance tax included in the ACA, will result in Medicare Advantage plans facing a 6.9 to 7.8 percent reduction in payments next year. The report projects that these cuts will result in Medicare Advantage beneficiaries facing an average of $50 to $90 per month in higher costs and benefit reductions.

EXHIBIT 2: ESTIMATED REVENUE REDUCTION IN 2014 FOR MAOS[1]

	HIGH	LOW
Projected insurer fees for 2014	-1.9%	-2.3%
ACA quartile impact for 2014	-2.5%	-2.5%
Stars bonus increase for 2014	1.0%	0.5%
Coding intensity change for 2014	-1.5%	-1.5%
Ratebook change for 2014	-2.2%	-2.2%
Total Reduction for 2014	-6.9%	-7.8%

The discrepancy between these payment cuts and cost growth will be a crushing blow to the millions of beneficiaries who rely on Medicare Advantage for their health security. We appreciate that CMS has acknowledged that plans are facing ACA-mandated changes[2], in addition to the impact of this proposal, and has invited comments on how to address these challenges. However, the magnitude of the change produced by these factors will have an abrupt and severely detrimental impact on beneficiaries by forcing plans to make difficult decisions about reducing benefits, increasing premiums, and discontinuing participation.

This would weaken the MA program at a time when the role of health plans in the Medicare program has never been more important to Medicare beneficiaries. MA organizations are leading the way in program-wide delivery system reforms that focus on promoting quality and coordination of services across the continuum of care. In addition, studies in peer-reviewed

[1] *Proposed changes to 2014 Medicare Advantage payment methodology and the effect on Medicare Advantage organizations and beneficiaries*, Glenn Giese, FSA, MAA, and Chris Carlson, FSA, MAA, Actuarial Practice of Oliver Wyman, February 26, 2013.
[2] Note that the America's Taxpayer Relief Act (ATRA) also included provisions that would reduce MA payments by an additional $5 billion over the next ten years.

journals have documented MA organizations' success in reducing unnecessary hospital admissions and readmissions along with improving access to primary care.

Moreover, a recent report found that low-income and minority Medicare beneficiaries continue to rely on the high-quality health care coverage provided by MA plans. The report found that 41 percent of MA beneficiaries have incomes below $20,000 and nearly 1 in 5 are minorities. The Oliver Wyman analysis projects that, as a result of the MA cuts, "those who utilize services the most will be required to pay even higher cost sharing or be forced by higher MA premiums or loss of access to MA plans to move back into FFS Medicare with its large cost sharing requirements and lack of coordinated care."

In our comments, we offer recommendations for changes to the proposals in the Advance Notice to stabilize this program and prevent the collision course laid out on February 15th. Our key issues and recommendations, which are discussed in greater depth in our attached detailed comments, begin with a discussion of the Sustainable Growth Rate (SGR). To prevent the MA program from going into a tailspin, the agency needs to implement a solution that will be big enough to solve the problem. Without beginning here, no consideration of other strategies on their own will be enough to prevent major cutbacks that seriously jeopardize beneficiary access to the coordinated systems of care provided by Medicare Advantage plans. At the same time, we detail other specific recommendations which need to be combined with the SGR. For example, proposed changes in risk adjustment will disadvantage the sickest and most vulnerable beneficiaries. Given the need to coordinate care for chronically ill individuals, this will have deleterious consequences for beneficiaries, and will add to the cost of the program.

We are urging the agency to consider the following six principal recommendations and are available at your convenience to discuss them.

- **Sustainable Growth Rate (SGR):** We strongly urge CMS to revise its assumptions for the MA growth percentage and Fee-for-Service (FFS) growth percentage by taking into account the anticipated Congressional action to negate the negative 30 percent physician fee reduction that would otherwise apply for 2014 under the SGR formula. The Advance Notice reflects CMS' current position that the Social Security Act requires the agency to assume implementation of the physician fee update required under the SGR formula, as required under the law in

effect at the time the MA rates are developed. However, as outlined below, we believe that the statute clearly permits CMS to assume that an "SGR fix" will be enacted:

-- **The agency clearly has the authority and discretion to assume that there will be an SGR fix.** CMS' current position relies on an interpretation of the Social Security Act (See § 1853(c)(6), National Per Capita MA Growth Percentage) to require the agency to calculate MA rates based on physician payment rates required "under this title (Title XVIII)" at the time the MA rates are finalized. However, an analysis of this section and a closely related statutory provision (§ 1876(a)(4), Adjusted Average Per Capita Cost) demonstrates that in its development of the MA and FFS growth rates, the agency has the authority to rely on the best available information in developing estimated Medicare program costs.

-- **CMS has recognized that assuming the SGR fix bolsters the validity of program cost estimates, because CMS requires that the MA plans include this assumption in their bids and the agency has made this assumption when setting Part B premiums.** CMS requires that MA plan bids must be based upon their best estimates, including foreseeable events such as the legislative override of the physician fee schedule reduction. Also, the agency has recently included an assumption that reflects the "strong" possibility of increased Part B costs due to the anticipated SGR fix in determining the amount of the contingency reserve that is a required step in developing the Part B premium.

-- **The law does not present an obstacle to CMS' assumption of an SGR fix and the agency should reconsider its past practice and do so in light of the impending cuts to the program and their impact on beneficiaries.** Incorporating the SGR fix into the assumptions for the MA and FFS growth is the principal step CMS can take to have large enough impact to mitigate the significant disruption for the 14 million beneficiaries enrolled in MA plans that will result from the changes included in the Advance Notice.

- **Recalibration and Update of the MA Risk Adjustment Model:** We strongly recommend that CMS not implement the agency's proposed changes to the MA risk adjustment model for the CY 2014 payment year. We are concerned that CMS' proposed changes have the potential to produce a greater negative impact than the agency's proposed phase-in

strategy will address, particularly for MA organizations serving higher proportions of individuals with complex health care needs and their enrollees. For example, by focusing risk adjustment changes on diagnoses that are reported at higher rates by MA organizations than by fee-for-service providers, these changes penalize beneficiaries who benefit from disease and care management programs targeted to address their needs and plan efforts to identify the diagnoses important to their care. This would be a u-turn on the path to providing better, safer and more cost effective care for individuals with chronic health conditions. These cuts also have the practical effect of adding another negative adjustment to plan payments in a year when the impact of the proposals in the Advance Notice already is expected to have severe implications. CMS should provide additional time for CMS and MA organizations to analyze the implications of changes in the risk adjustment model and should reconsider whether to implement the changes based upon further analysis and comment.

- **Transparency:** We recommend that CMS release underlying data and assumptions used by CMS in the development of the preliminary estimates of the MA growth percentage and Fee-for-Service (FFS) growth percentage. This transparency is critical to MA organizations' planning and bid development activities that allow them to maintain offerings that meet the needs and expectations of MA enrollees. The agency should provide sufficient information for MA organizations to replicate these projections. The data request is highly time-sensitive, and we urge CMS to provide as much data as possible by March 8 and additional data as quickly thereafter as possible.

- **Total Beneficiary Cost (TBC):** At a minimum, we recommend that CMS retain the CY 2013 TBC amount of $36 for CY 2014 rather than reducing it to $30 as proposed. CMS should not place greater constraints on permissible adjustments to MA plan benefits and premiums for CY 2014 than in CY 2013 when MA organizations could experience estimated reductions in payments of nearly 8 percent in CY 2014. The more stringent standard has the potential to make it more difficult for plans to remain in some geographic areas where beneficiaries rely on them and threaten beneficiary access to the disease management, care coordination, and other plan programs and services that they value.

- **Star Ratings:** We recommend that CMS should not implement the proposed change to the calculation of CY 2014 overall star ratings for MA and Part D contracts that would affect quality bonuses in CY 2015.

CMS' proposal would base overall ratings on individual measure scores rather than on the average of the star ratings themselves, and initial MA organization evaluations indicate that this change could result in material shifts in the ratings. For example, some contracts that would otherwise meet established 4-star thresholds would become 3-star plans. The resulting loss of quality bonuses in 2015 would inappropriately impact benefits for beneficiaries in these highly rated plans. While CMS has provided examples and a technical description of the methodology, MA organizations need more detailed information to assess fully its implications. We strongly recommend that CMS issue a more detailed technical description of the proposed methodology along with the agency's evaluation of its anticipated impact and provide a further comment opportunity of no less than 30 days to allow time for MA organizations to assess the proposal.

- **MA Enrollee Health Risk Assessments:** We recommend that CMS reconsider the proposal to eliminate for payment year 2015 the use of diagnoses collected through required health risk assessments from the MA risk adjustment methodology. This action would ensure that CMS does not inappropriately limit inclusion of diagnoses from the 2014 data year that are valid predictors of health status in the subsequent payment year. MA organizations work hard to reduce unnecessary visits and support beneficiary health by enrolling patients in disease management and medication therapy programs, which should be considered before any precipitous charges are made.

We believe that the Advance Notice puts the program on precarious footing and threatens the health security of low-income Medicare Advantage beneficiaries. We urge you to adopt these recommendations to avert this crisis. Please contact us if additional information would be helpful or if you have questions about the issues we have raised.

Sincerely,

Karen Ignagni
President and CEO

Attachment