FOR THE RECORD

Statement
on
The Future of the Medicare Advantage Program

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Submitted to the
House Ways and Means Committee
Subcommittee on Health

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I. Introduction

America’s Health Insurance Plans (AHIP) is the national association representing health insurance plans. Our members provide health and supplemental benefits to more than 200 million Americans through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid. AHIP advocates for public policies that expand access to affordable health care coverage to all Americans through a competitive marketplace that fosters choice, quality, and innovation.

We appreciate the subcommittee’s interest in examining the future of the Medicare Advantage (MA) program. We also appreciate that many subcommittee members – both Republicans and Democrats – have demonstrated strong support for adequately funding the MA program, including letters that several of you addressed to the Centers for Medicare & Medicaid Services (CMS) earlier this year during the MA rate development process for 2015.

To contribute to the discussion at today’s hearing, our statement focuses on the following:

- Background information about the MA program, including its role as a safety net for more than 15 million seniors and individuals with disabilities and the value MA plans deliver to beneficiaries.

- Key factors that impact the final MA rates and payments for 2015.

- Recommendations for preserving the MA program for beneficiaries.

II. Background Information on the Medicare Advantage Program

More than 15 million seniors and people with disabilities currently are enrolled in MA plans because they value the care coordination and disease management activities, improved quality of care, and innovative services and benefits that are available through these plans. These MA enrollees account for approximately 29 percent of the Medicare population.
MA Plans Provide Value to Beneficiaries

MA plans offer a different approach to health care delivery than beneficiaries experience under the Medicare fee-for-service (FFS) program. MA plans have developed systems of coordinated care for ensuring that beneficiaries receive health care services on a timely basis, while also emphasizing prevention and providing access to disease management services for their chronic conditions. These coordinated care systems provide for the seamless delivery of health care services across the continuum of care. Physician services, hospital care, prescription drugs, and other health care services are integrated and delivered through an organized system whose overriding purpose is to prevent illness, manage chronic conditions, improve health status, and employ best practices to swiftly treat medical conditions as they occur, rather than waiting until they have advanced to a more serious stage. MA plans also help to reduce emergency room visits for routine care, ensure prompt access to primary care physicians and specialists when care is needed, and promote communication among treating physicians about the various treatments and medications a patient needs.

The success of these strategies is evidenced by survey findings which show that MA enrollees are highly satisfied with the care they receive through their health plans. A February 2013 North Star Opinion Research survey found that 90 percent of beneficiaries are satisfied with their MA plans, 94 percent are satisfied with the quality of care they receive, and 90 percent are satisfied with the benefits they receive.¹

Furthermore, a broad range of research findings consistently demonstrate that the innovative strategies adopted by MA plans translate into better health outcomes for enrollees:

- A 2013 study published in Health Affairs found that MA plans’ performance measures for breast cancer screening, diabetes care, and cholesterol testing were consistently better when compared to FFS Medicare. For example, in 2009 mammography screening rates were over 13 percent higher, eye tests for individuals with diabetes were 17 percent higher, and cholesterol screening rates for individuals with diabetes and cardiovascular disease were 7-9 percent higher in MA plans compared to FFS.²

• Data published in February 2012 in the *American Journal of Managed Care* indicated that the hospital readmission rate for MA enrollees was about 13 percent to 20 percent lower than for Medicare FFS enrollees.\(^3\)

• A study published in the January 2012 edition of *Health Affairs* found that beneficiaries with diabetes in a MA special needs plan (SNP) had “seven percent more primary care physician office visits; nine percent lower hospital admission rates; 19 percent fewer hospital days; and 28 percent fewer hospital readmissions compared to patients in FFS Medicare.”\(^4\)

• Research published in November 2010 in the *American Journal of Managed Care*, co-authored by researchers affiliated with The Brookings Institution and Harvard University Department of Economics, concluded that MA plans outperformed the Medicare FFS program in 9 out of 11 clinical quality measures.\(^5\)

The value that MA enrollees receive through their plans also can be seen in the additional services and benefits that are offered by MA plans – but are not available in the Medicare FFS program. While these extra features vary from plan to plan, the following are specific examples of the additional services and benefits that many MA plans offer to improve enrollees’ coverage and manage their overall health and well-being on an ongoing basis:

- Case management services;
- Disease management programs;
- Wellness and prevention programs;

\(^3\) Lemieux, Jeff, MA; Cary Sennett, MD; Ray Wang, MS; Teresa Mulligan, MHSA; and Jon Bumbaugh, MA. “Hospital Readmission Rates in Medicare Advantage Plans.” *American Journal of Managed Care.* February 2012. Vol. 18, no. 2, p. 96-104. This study was preceded by a series of working papers and reports published by AHIP’s Center for Policy and Research. One earlier study based on an analysis of hospital discharge datasets in five states estimated that risk-adjusted 30-day readmissions per patient with an admission ranged from 12-27 percent lower in Medicare Advantage than in Medicare FFS among patients with at least one admission.


• Coordinated care programs;

• Prescription drug management tools integrated with medical benefits;

• Tools and data collection to address disparities in care for minorities;

• Nurse help hotlines;

• Enhanced coverage of home infusion, personal care and durable medical equipment;

• Personal health records to offer beneficiaries greater control over their health information and to coordinate information better; and

• Vision, hearing, and dental benefits coordinated with medical services.

MA plans also protect beneficiaries from high out-of-pocket costs. In 2014, all MA plans offer an out-of-pocket maximum for beneficiary costs, and almost 60 percent of enrollees are in plans that have annual out-of-pocket maximums of $5,000 or less. These out-of-pocket maximums – which are not offered by the Medicare FFS program – help protect Medicare beneficiaries from catastrophic health care expenses that otherwise might pose a serious threat to their financial security. MA plans also help reduce out-of-pocket costs for enrollees by reducing premiums for Part B and Part D, and by limiting cost-sharing for Medicare-covered services, including primary care physician visits and inpatient hospital stays.

**MA Has Strong Consumer Protections**

Another important feature of the MA program is that enrollees have strong consumer protections. Coverage is “guaranteed issue” and MA plans offer coverage to all beneficiaries regardless of their age or health status, although Special Needs Plans (SNPs) enroll only vulnerable beneficiaries who meet certain criteria. All beneficiaries who choose an MA plan pay the same premium as all other plan enrollees. CMS performs annual reviews of MA plan benefit packages to ensure that they are appropriate to beneficiaries with all health conditions. In addition, nearly 90 percent of all MA enrollees are enrolled in MA plans that offer Part D prescription drug benefits, which allows beneficiaries to receive medical and prescription drug coverage from the same health plan – similar to how people receive coverage in the commercial market. MA plans typically re-design and reduce the cost sharing that applies under the Medicare FFS program.
They may offer lower cost sharing as an additional benefit and typically eliminate deductibles and establish copayments rather than coinsurance.

CMS has also established network adequacy standards to ensure that enrollees in MA plans have access to all provider types, including primary care physicians and specialists, within a reasonable time and distance. The agency works with MA plans when network changes are made to ensure that beneficiaries continue to have access to the benefits and services they need.

Additional consumer protections provide that an MA enrollee who is not satisfied with a plan’s decision about providing or paying for covered services may exercise appeal rights through an internal plan appeals process, as well as automatic external review if the plan’s decision is not wholly in the beneficiary’s favor. MA plans also comply with detailed requirements associated with CMS oversight activities that include operational and financial audits, evaluation of quality improvement projects, validation and evaluation of data on a broad spectrum of operational activities (e.g., customer service, resolution of appeals, and provider network adequacy), review and approval of plan marketing materials, and strong standards for the conduct of marketing activities.

III. Key Factors Impacting 2015 Final Medicare Advantage Rates and Payments

Since 2010, funding for the MA program has been cut in a number of ways. The Affordable Care Act (ACA) includes MA funding cuts that are projected to total more than $200 billion over a ten-year period. The ACA also establishes a new health insurance tax that, beginning in 2014, further reduces the resources that are available to support the health benefits of MA enrollees. An additional $10 billion in cuts are imposed by the American Taxpayer Relief Act of 2012.

In the face of these funding cuts, MA plans are working hard to maintain access to high-value benefits and services for their enrollees. However, the year-over-year cuts are creating an uncertain environment for 2015 MA plans and the choices available to beneficiaries. In April 2014, CMS announced final 2015 MA county rates and an assortment of changes to the MA payment methodology. While several components of the 2015 Final Rate Notice reduce county rates, CMS also announced key payment policies that are expected to partially mitigate the impact of these cuts. Analysts have estimated that the total impact of the CMS 2015 rate and payment policies will be an average payment reduction of -3.0% to -3.5% next year.
The MA payment methodology is complex and includes a number of factors that interact to impact payments to MA organizations. Below we discuss the key factors that impact final MA rates and payments for 2015.

**MA and FFS Growth Percentages and the MA Growth Rate**
The MA Growth Rate is one of the factors used to update MA rates from year to year. Currently, CMS calculates two growth percentages to determine MA county rates due to the phase-in of the new ACA rates occurring from 2012 – 2017:

- The 2015 National Per Capita MA Growth Percentage, which is used in the pre-ACA rate methodology that is phasing out, is a reduction of -4.07%.

- The 2015 FFS Growth Percentage, which is used to calculate rates under the ACA payment system, is a reduction of -3.3%.

CMS has calculated that the combination of these growth percentages, which the agency refers to as the “MA Growth Rate,” is a reduction of -3.4% in 2015. As shown below in Exhibit 1, this is much lower than in previous years and significantly below the preliminary 2015 MA Growth Rate of -1.9% announced by CMS in February 2014.

![Exhibit 1: Estimated Annual MA Growth Rate, 2012 – 2015](image)

CMS has indicated that the decline in the 2015 MA Growth Rate is the result of adjustments to growth rates in prior years, primarily due to lower utilization of services such as inpatient hospitalizations than previously projected.
Continued Phase-In of the ACA Funding Cuts
The 2015 MA county rates reflect the continued phase-in of ACA provisions that will reduce MA funding by more than $200 billion in 2010 – 2019, according to estimates by the Congressional Budget Office (CBO).

Effective 2012, the ACA established a new blended benchmark as the MA county rate. The blended benchmark is the combination of two components: (1) the “applicable amount” calculated using the pre-ACA methodology; and (2) the “specified” amount calculated as required under the ACA. The specified amount is determined by ranking all counties from high to low FFS costs, dividing the counties into quartiles, and assigning a percentage ranging from 95% for areas with the highest FFS costs to 115% for areas with the lowest FFS costs.

The ACA payment system is being phased in over either 2, 4, or 6 years based upon the estimated impact of the ACA changes in the county. Two-year counties were fully phased in starting in 2013, meaning that county rates in these areas are calculated solely based on the specified ACA amount. Rates in 4 and 6-year counties in which 78% of MA enrollees live (see Exhibit 2 below) are continuing the phase-in process. 2015 will be the first year in which rates in 4-year counties will be calculated solely based on the ACA rate. All counties, including 6-year counties, will be fully phased in starting in 2017.

Exhibit 2:

<table>
<thead>
<tr>
<th></th>
<th>End of Phase-In Period</th>
<th>Percentage of US Counties</th>
<th>Percentage of MA Enrollment (March 2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-Year Counties</td>
<td>2013</td>
<td>54%</td>
<td>22%</td>
</tr>
<tr>
<td>4-Year Counties</td>
<td>2015</td>
<td>24%</td>
<td>46%</td>
</tr>
<tr>
<td>6-Year Counties</td>
<td>2017</td>
<td>21%</td>
<td>32%</td>
</tr>
</tbody>
</table>

Pursuant to the ACA, the 2015 final county rates reflect the continued phase-in of these funding cuts, and approximately $24.5 billion of these cuts, or 12%, are scheduled to go into effect in 2015 alone, according to the 2010 CBO score. At the end of 2014, 20% of the ACA cuts will have gone into effect.
End of the Quality Bonus Demonstration Project

The ACA enacted quality bonuses for MA plans receiving 4 Stars and above (on a 5-Star scale) and established a cap to prevent rates from exceeding pre-ACA levels. CMS subsequently announced a nationwide demonstration to test, in 2012 – 2014, an alternative method for determining quality bonus payment percentages. The expiration of the three-year Demonstration Project in 2015 will negatively impact county rates in several different ways:

- **Bonuses for 3 and 3.5 Star Plans:** Under the ACA, MA contracts achieving an overall rating of at least 4 Stars on the CMS Star Rating System receive an increase in county rates. The Demonstration Project extended bonuses in lower amounts to contracts receiving 3 and 3.5 Stars during 2012 – 2014. The end of the Demonstration Project means that these plans, which enroll approximately 48% of all MA enrollees, will no longer receive bonuses starting in 2015.

- **Reduced Bonuses:** The ACA provides that quality bonuses are applied only to the portion of the county rate that is calculated under the ACA methodology, as counties are phased in to these rates. The Demonstration Project applied quality bonuses to both the pre-ACA and ACA portions of the rate during 2012 – 2014 and increased the amount of the bonus that was...
applied during the three years of the Demonstration. Application of the bonus to both portions of the rate continues to be important for 6-year phase-in counties that will continue to be paid on a combined pre-ACA/ACA basis through 2016. However, due to the end of the Demonstration, bonuses for plans earning at least 4 Stars in these counties will be lower in 2015 than they would have been if the Demonstration Project had been extended.

- **Suspension of ACA Cap**: Pursuant to the ACA, MA rates calculated under the new methodology can be no higher than the pre-ACA amount. CMS did not apply this “ACA Cap” from 2012 – 2014 under the Demonstration Project. The 2015 final rates implement the ACA Cap for the first time, impacting plans enrolling approximately 2 million beneficiaries in almost 1,500 counties and reducing rates in these areas by an average of $27 per member per month.

**Coding Intensity**
The Medicare statute provides for a coding intensity adjustment that is intended to account for differences in coding between the MA and Medicare FFS programs. Under current law, the minimum coding intensity adjustment for 2015 is 5.16%, an increase of 0.25% from 2014. CMS has taken the position that the coding intensity adjustment and separate changes to the MA risk adjustment model are not inappropriately duplicative. We are concerned that the combination of these two adjustments has a negative impact on MA payments and, as a result, reduces the resources available for focused programs designed to slow the progression of chronic conditions and improve quality of life for beneficiaries.

**Health Insurance Tax**
The new ACA health insurance tax, which begins this year, is another factor that impacts the overall MA funding picture. An actuarial study\(^6\) by Oliver Wyman found that this tax will require MA plans to allocate an estimated $16 to $20 per enrollee per month in 2014 and $32 to $42 per enrollee per month by 2023 for the ACA health insurance tax, which is imposed on top of the ACA’s significant funding cuts. The average expected increase in the cost of MA coverage as a result of the health insurance tax is estimated to be $3,590 per enrollee over ten years. This number represents a direct reduction in the resources that will be available to support the health care benefits of more than 15 million Medicare beneficiaries who value the improved quality of care, additional benefits, and innovative services their MA plans provide.

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**CMS Administrative Actions**

Decisions made by CMS on various administrative issues have a significant impact on MA rates and payments. This is particularly true with respect to the agency’s approach to calculating the FFS normalization factor and implementation of the MA risk adjustment model.

**FFS Normalization:** Each year, CMS applies a FFS normalization factor to MA plan risk scores to account for underlying trends in FFS coding practices since the data year on which the risk adjustment model is based. In calculating the normalization factor for 2015, CMS adopted a change in how it estimates the annual trend for risk score growth in the FFS program to account for the increasing proportion of baby boomers entering Medicare, who overall tend to be younger and healthier than the general Medicare population. This new methodology resulted in an increase that applies to plan payments.

**MA Risk Adjustment Model:** For the 2014 payment year, CMS began to phase in a clinically revised risk adjustment model that was designed to reduce payments for diagnosis codes for early stages of certain chronic conditions identified to a greater extent by MA plans than under the Medicare FFS program. MA plans raised concerns that this policy is inconsistent with efforts, supported by the ACA and broader delivery system reform, to ensure the early identification of chronic conditions to support systematic approaches to slow their progression. CMS estimated that the changes in the 2014 model would reduce payments to plans by an average of 2.5% and decided to mitigate this impact in 2014 by blending risk scores calculated under the new model (75%) with the risk scores calculated under the previous model (25%). For 2015, CMS changed the blending approach by setting the percentages at 33% for the 2014 model and 67% for the previous model. The agency has estimated that the change in this blending approach will increase MA payments in 2015.

**IV. Recommendations for Preserving the Medicare Advantage Program for Beneficiaries**

Looking forward, we believe it is important for Congress and the Administration to take strong steps to preserve the Medicare Advantage program to ensure that beneficiaries continue to have access to high quality health plan choices. Below we outline several key recommendations for addressing this priority.
Adequately Funding the MA Program

We have serious concerns about the underfunding of the MA program and how this will harm beneficiaries – particularly vulnerable enrollees with complex needs and low incomes – as the ACA’s funding cuts are phased in at an increasingly faster rate over the next several years. Past history indicates that the continued erosion of funding may lead to increased costs for beneficiaries and reduced access to MA plans for beneficiaries. The last time cuts of this magnitude were implemented, enrollment in MA (then known as Medicare+Choice) experienced multi-year declines following enactment of the Balanced Budget Act of 1997:

- Between December 2001 and December 2002, Medicare+Choice enrollment declined by more than 900,000.
- From 1999 to 2003, nearly 2.4 million Medicare beneficiaries were impacted by plan withdrawals and benefit reductions.

These concerns underscore the importance of maintaining the future viability of the MA program and avoiding any additional funding cuts through either the legislative or regulatory process. We urge the subcommittee and the entire Congress to focus instead on providing relief to avoid further disruptions in the choices and benefits of MA enrollees. Options to preserve sustainable funding could include:

- Promoting more transparency in the growth rate calculation, including greater opportunities for MA plan actuaries and CMS to exchange information prior to the agency’s issuance of preliminary growth rates in February of each year.
- Considering additional ways to reward performance and outcomes, including targeted solutions to address the concerns of MA plans focusing on low-income populations discussed below.
- Supporting proposals to increase the percentage of rebates for MA plans bidding below benchmark amounts that are used to enhance benefits and/or reduce beneficiary cost-sharing.

We also are working with the agency to ensure that any changes to the MA risk adjustment model appropriately reimburse plans for the health status of their enrollees. As noted above, CMS recently implemented changes to the model that are inconsistent with national policy goals.
to promote the early detection of chronic diseases. This work is a key component of strategies to preserve the sustainability of the MA program.

**Maintaining MA Options for Low-Income Populations**

Millions of low-income Medicare beneficiaries rely on the MA program as their only option for high quality, affordable health coverage. We offer the following recommendations for protecting the benefits and choices of these low-income beneficiaries.

**Reauthorization of MA Special Needs Plans:**
SNPs have played an important role in meeting the health care needs of Medicare beneficiaries. SNPs serve as a crucial safety net for almost 2 million of our nation’s most vulnerable seniors, many of whom have disabilities and chronic conditions. Enrollees in SNPs benefit from the coordinated care, disease management, and other initiatives our members have pioneered to ensure that they receive high quality health care across the entire continuum of services they need.

SNPs were authorized by the Medicare Modernization Act of 2003 to provide new coverage options to beneficiaries with specific health care challenges. Three categories of SNPs are authorized under current law: (1) Dual Eligible SNPs serve beneficiaries who are dually eligible for both Medicare and Medicaid; (2) Chronic Care SNPs serve beneficiaries with severe or disabling chronic conditions; and (3) Institutional SNPs serve beneficiaries who live in skilled nursing facilities or other long-term care institutions or who qualify for an institutional level of care and live in the community. All three types of SNPs tailor their benefits and services to address the unique needs of the specific populations they serve.

Under current law, the authorization for SNPs ends on December 31, 2016. It is important for Congress to provide for a long-term reauthorization of this program to ensure that SNP enrollees will have peace of mind in knowing that they will continue to have access to plans tailored to address their unique needs.

**Addressing Disparities in the Star Rating System**
MA plans that focus on serving dual eligibles and other low-income beneficiaries – who are more likely to have multiple chronic diseases, cognitive impairments, or need help with Activities of Daily Living – face unique challenges to achieving high scores on the Star Rating System. AHIP’s multi-year analysis has found that MA contracts focusing on low-income populations scored 0.5 Stars lower in 2014 than contracts without this focus and this disparity in
performance has increased since 2011. We believe changes are needed to avoid beneficiary disruptions that could occur due to the difficulties that low-income focused MA plans face under the Star Rating System. We offer the following recommendations to improve the Star System and prevent these disruptions:

- The Star System should include an emphasis on improvement to appropriately reward efforts by low-income focused plans to achieve better results for beneficiaries and to recognize plan achievements in reducing health disparities.

- CMS should consider reversing its decision to eliminate pre-determined 4-Star thresholds. Keeping these thresholds will allow MA plans to work effectively and efficiently toward well-defined goals that reflect CMS priorities and ensure that beneficiaries receive high quality care.

- A longer phase-in period should be provided for triple weighting measures to allow sufficient time for plans to develop tools and techniques to address the unique needs of low-income populations and address the observed disparity in plan performance.

**Protecting Beneficiaries From Plan Terminations**

Under a CMS policy, MA plans receiving a low performance indicator (LPI) for three consecutive years under the Star Rating System are at risk of being terminated. We are concerned that vulnerable beneficiaries, including many who receive low-income subsidies and who are enrolled in SNP plans, stand to be disproportionately impacted by potential plan terminations. As we discuss above, MA plans that serve these vulnerable populations face systemic difficulties and barriers to achieving high ratings under the current methodology for the Star Rating System, largely because of the challenges presented by the low-income status, complex health care conditions, and other unique health care needs of these beneficiaries.

Terminating MA plans that face these barriers – when it is not clear that low Star ratings are a definitive indicator of low quality for these plans – ultimately will penalize beneficiaries who may lose access to the coordinated care and enhanced benefits they currently receive through the MA program. Because of these serious concerns, we are recommending that CMS not terminate MA plans due to the LPI.
Allowing Innovation to Flourish
Health plans participating in the MA program have a long history of pioneering new innovations to improve health care quality, enhance patient care, and increase value for their enrollees. The future success of the program depends heavily on the continued ability of plan sponsors to pursue new innovations, without facing excessive regulatory barriers. Below we highlight two areas where innovative practices have received increased attention.

Preserving In-Home Health Risk Assessments
In-home clinical encounters are an important component of disease management programs that help promote early identification of chronic conditions and focus on prevention, wellness, and care coordination. In its Advance Notice issued in February 2014, CMS proposed eliminating any risk adjustment payments based on diagnoses that come from doctors or other clinicians visiting a patient’s home. CMS later decided not to implement the proposal for 2015, but left open the possibility of revisiting this issue for 2016 and future years based on a forthcoming evaluation of data on diagnoses from home visits for MA enrollees.

We strongly believe this proposal is misguided and should not be reconsidered in the future. CMS has not provided any evidence that diagnoses resulting from home-based clinical encounters are inappropriate or differ in any relevant way for risk adjustment purposes from clinical encounters in other settings. Recognizing the value of in-home clinical encounters in evaluating the health status of beneficiaries, MA plans should not face financial disincentives for using this tool to improve patient care for their enrollees.

Preserving High-Value Provider Networks
It is important for MA plans to continue to have the flexibility to advance high-value provider networks – along with other innovations that promote quality and efficiency for Medicare beneficiaries – to mitigate the cost impact on beneficiaries whose choices and benefits are being threatened by repeated cuts in MA funding.

A central goal of MA plans’ high-value provider networks is to improve both health care quality and efficiency through ongoing evaluation of provider performance, assessment of resource use, referrals to other high-performing providers, and the exchange of health information with the plan and other providers caring for the same patient. High-value networks also discourage enrollees from using poor quality providers and services that have been shown by evidence to be ineffective. Another key advantage of high-value networks is that they create strong incentives for providers to offer competitive prices, in response to the increased number of patients they
gain as a member of the network. This, in turn, enables health plans to deliver substantial savings to their enrollees, in addition to connecting them to high-quality providers.

V. Conclusion

Thank you considering our views and recommendations on these important issues. Our members are strongly committed to meeting the health care needs of Medicare beneficiaries and, additionally, working with Congress to strengthen and preserve high quality, affordable health plan choices through the Medicare Advantage program.