Statement for Hearing on
"Protecting America's Seniors: Oversight of Private Sector Medicare Advantage Plans"

House Committee on Energy and Commerce
Subcommittee on Oversight and Investigations

June 28, 2022

Every American deserves access to affordable, high-quality coverage and care, including America's seniors and people with disabilities. As the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day, AHIP appreciates the Subcommittee's attention to ensuring the Medicare Advantage (MA) program is providing America's seniors high-quality, affordable health care.

AHIP is committed to market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone. As a strong demonstration of public-private partnerships that work, MA continues to deliver better service, access to care, and value for nearly 30 million seniors and people with disabilities and for American taxpayers. In 2022, approximately half of eligible persons are enrolled in MA plans. For several years, seniors have awarded the MA programs with satisfaction rates of 90% or higher.[1]

MA plans also consistently outperform original Medicare on clinical quality measures and efficiency of care delivery. MA plans offer greater value to enrollees by reducing cost sharing and placing caps on out-of-pocket costs. MA plans are critical to supporting racially and ethnically diverse communities by providing affordable, comprehensive, integrated care delivery. For these numerous reasons outlined above, the MA program continues to have strong bipartisan support from Congress and offer essential health care services to millions of Americans.

Several tools and processes are essential to MA plans' ability to efficiently provide better quality and access to care than original Medicare. Medical management, care coordination, case management, and other clinical programs are among the tools employed by MA plans to achieve these key improvements over original Medicare. With their comprehensive view of the health care system and each patient's medical claims history, health insurance providers can leverage these data to ensure that medications or treatments prescribed by clinicians are safe, effective, and affordable for patients. Together, this results in better outcomes and lower costs for patients.

[1] https://medicarechoices.org/americans-like-ma-2022/

As one of these medical management tools, prior authorization ("PA") is used on a limited basis by applying and leveraging medical evidence to ensure that the right care is delivered at the right time in the right setting to give patients the most effective, safe, and affordable care.

The structure of the MA program combines monthly "capitated" payments with a quality ratings program. This incentivizes MA plans to develop robust provider networks, contract with high-quality providers, and implement benefit designs that encourage high-value care while limiting costly, low-value care. This structure also supports MA plans' efforts to integrate care, better manage chronic conditions, and improve wellness and quality based on information about patient health. This information is incorporated into the MA risk adjustment program, which ensures that MA plans serving sicker enrollees have the resources needed to provide the benefits and services these enrollees need and deserve for better health.

AHIP and our member organizations are committed to our continued work with the Subcommittee to improve existing medical management tools and fair risk adjustment processes to strengthen the MA program for millions of seniors and hardworking taxpayers.

Medicare Advantage Is Essential to Delivering Care to Millions of Americans

There are several key ways that MA plans have demonstrated excellent delivery of health care services and care:

- **Peer-reviewed research has consistently found that MA plans outperform the original Medicare program on clinical quality measures.** MA plans employ value-based payment arrangements to improve survival rates while lowering costs; reduce hospital readmissions, as well as patient days spent in rehabilitation facilities and nursing homes; and lower hospital use in the last days of life.[2]
- **The MA program is more efficient than original Medicare.** For 2022, plan bids average 85% of the cost of delivering that same care through original Medicare, almost $2,000 less per enrollee per year.[3] Moreover, if one accounts for key differences between MA and original Medicare, including the fact that MA delivers protections against high annual out-of-pocket costs – protections that do not exist in original Medicare -- and the fact that certain individuals with lower annual healthcare costs who enroll in original

[2] See, for example, Timbie, Justin W., Bogart, Andy, Damberg, Cheryl et al. Medicare Advantage and fee-for-service performance on clinical quality and patient experience measures: Comparisons from three large states. Health Services Research 52(6), Part I: 2038-2060. December 2017; Teno, Joan M., Gozalo, Pedro, Trivedi, Amal N. et al. Site of death, place of care, and health care transitions among US Medicare beneficiaries, 2000-2015. JAMA Published online June 25, 2018; Kumar, Amit, Rahman, Momotazur, Trivedi, Amal N. et al. Comparing post-acute rehabilitation use, length of stay, and outcomes experienced by Medicare fee-for-service and Medicare Advantage beneficiaries with hip fracture in the United States: A secondary analysis of administrative data. PLoSMed 15(6): e1002592; Mandal, Aloke K., Tagomori, Gene K., Felix, Randell V. et al. Value-based contracting innovated Medicare Advantage healthcare delivery and improved survival. American Journal of Managed Care 23(2): e41-e49. February 2017.

[3] https://www.cms.gov/files/document/2022-announcement.pdf

Medicare are ineligible to enroll in MA, average spending in MA -- even when including supplemental benefits offered by MA plans – is lower than original Medicare.[4]

- **MA plans deliver savings to the entire Medicare Program.** Research shows that in areas where MA penetration is highest, MA has delivered significant decreases in original Medicare spending growth.[5] In addition, annual HHS agency financial reports show that net improper payments in MA are much lower than net improper payments in original Medicare.[6]
- **MA plans deliver significantly greater value for enrollees and taxpayers.** MA plans provide reduced cost sharing and a cap on out-of-pocket costs.[7] In addition, MA plans often provide, at no additional premium, integrated drug coverage; supplemental benefits like dental, vision, and hearing; and benefits that address social barriers to better health like nutrition, transportation, and in-home support services. Data clearly show that MA enrollees have lower out-of-pocket health care spending than those in original Medicare. In fact, one analysis found that MA enrollees save an average of nearly $2,000 a year in total health care expenditures compared to those in original Medicare, resulting in a 35% lower cost burden for beneficiaries.[8]
- **MA plans are critical to coverage for millions of vulnerable Americans**. MA enrollees represent a more racially-diverse population (32%) than original Medicare (21%) and more than 9 million MA enrollees have incomes below 200% of the federal poverty level.[9] Nearly half of all individuals eligible for Medicare who are Hispanic or African American choose MA, and 57% of MA enrollees are women.
- **The MA program enjoys incredibly strong and broad support.** For several years, seniors have awarded their MA plans with satisfaction rates of 90% or higher. The MA program also has strong bipartisan support from Congress. In 2022, 346 Members of the House of Representatives signed a letter urging the Centers for Medicare & Medicaid Services (CMS) to protect seniors from further cuts to their MA coverage.[10] MA has strong bipartisan support because it is a prime example of the government and free market working together to deliver lower costs, more choices, and better outcomes for the American people.

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[4] An analysis of actual spending from Medicare Trustees' data shows lower average per-enrollee spending in MA compared to original Medicare when the appropriate original Medicare comparison population is identified. See: https://www.ahip.org/documents/20201118-Anthem-PPI-MedPAC-Spending-Estimates-Memo.pdf

[5] One Health Affairs study found this "spillover effect" was $154 in annual per capita cost-savings for each 10-percentage point increase in MA penetration. Comparative analyses never take those effects into account. See: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2015.1468

[6] In 2021, HHS found the 'net' improper payment rate – excluding underpayments – in MA was only about half that of original Medicare (3.18% vs. 6.04%). Further, over the past decade (2011-2020), the net improper payment rate for MA declined by 89%, while that of FFS improved by only 27% over the same period. See: https://www.hhs.gov/sites/default/files/fy-2021-hhs-agency-financial-report.pdf

[7] https://bettermedicarealliance.org/wp-content/uploads/2022/04/BMA-Medicare-Advantage-Cost-Protections-Data-Brief_FIN.pdf

[8] https://bettermedicarealliance.org/news/study-medicare-advantage-saves-seniors-nearly-2000-a-year-compared-to-ffs-medicare/

[9] https://medicarechoices.org/diverse-at-risk-americans-rely-on-medicare-advantage-to-overcome-barriers-to-health/

[10] https://ahiporg-production.s3.amazonaws.com/documents/final_2022_house_ma_letter.pdf

- **MA plans are required to abide by comprehensive network adequacy standards.** CMS requires MA plans to meet comprehensive network adequacy requirements and monitors compliance through network adequacy reviews. CMS also requires MA plans to continuously monitor their provider networks throughout the plan year to ensure compliance with the agency's network adequacy criteria. The MA network adequacy criteria cover many provider and facility types that must be available in accordance with specified number, time, and distance standards.[11]

Protecting Patients through Cost-Savings, Safety Promotion, and Waste-Prevention
Prior authorization is an essential medical management tool that allows MA plans to facilitate clinically appropriate, evidence-based care for enrollees and helps those plans to eliminate unnecessary, inappropriate, or more costly care.

A 2019 study in JAMA found that "the estimated cost of waste in the U.S. health care system ranged from $760 billion to $935 billion, approximately 25% of total health care spending," and much of this could be attributed to low-value medication, screening, testing, or procedures.[12] A 2018 report to Congress by the Medicare Payment Advisory Commission (MedPAC) found that PA provided a successful policy approach to reduce the amount of low-value care delivered to Medicare beneficiaries and, in doing so, helps prevent health care waste.[13] Medical management tools like PA are increasingly relied upon by government-sponsored health care programs like Medicare and Medicaid. In fact, CMS has expanded the use of PA under original Medicare.

Even doctors can agree that waste exists in health care. In fact, 65% of physicians have said that at least 15-30% of medical care is unnecessary,[14] underscoring the importance of medical management tools like PA. Furthermore, a Johns Hopkins study found that medical errors, including "unwarranted variation in physician practice patterns that lack accountability," are now the third leading cause of death in the United States.[15] PA is a critical tool in helping to prevent unnecessary and unsafe care.

PA encourages high quality care decisions at the point of care for MA beneficiaries. The vast majority of health insurance providers report that their PA programs have an overall positive impact on quality of care (91%), affordability (91%), and patient safety (84%).[16] Health insurance providers are using peer-reviewed studies (98%) and federal studies or guidelines (89%) when making PA decisions.[17]

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[11] https://www.cms.gov/files/document/medicare-advantage-and-section-1876-cost-plan-network-adequacy-guidance06132022.pdf
[12] https://jamanetwork.com/journals/jama/article-abstract/2752664
[13] https://www.medpac.gov/document/http-www-medpac-gov-docs-default-source-reports-jun18_medpacreporttocongress_rev_nov2019_note_sec-pdf/
[14] https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0181970
[15]https://www.hopkinsmedicine.org/news/media/releases/study_suggests_medical_errors_now_third_leading_cause_of_death_in_the_us
[16] https://www.ahip.org/news/press-releases/ahip-survey-prior-authorization-grounded-in-clinical-evidence-and-selectively-used
[17] Id.

While noting the importance and positive impact of the use of PA in MA, we recognize that the PA process can be improved. AHIP and its members are committed to reducing unnecessary burden, increasing patient satisfaction, and improving quality and outcomes. That is why we support implementing innovative solutions to streamline processes, improve the quality of care, reduce costs, and enhance a patient's overall care experience.

For example, in 2018 AHIP and other key stakeholders agreed on a Consensus Statement recommending opportunities to improve the PA process.[18] One solution was to increase the adoption of electronic prior authorization (ePA). Building on the Consensus Statement, AHIP launched the Fast Prior Authorization Technology Highway (Fast PATH) initiative in 2020 to better understand the impact of ePA on improving the PA process. The findings of this study showed that ePA delivered improvements with a strong majority of experienced providers reporting faster time to patient care, fewer phone calls and faxes, better understanding of PA requirements, and faster time to decisions.

The initiative clearly showed that to maximize the efficiencies of ePA, strong provider adoption of the technology solution is critical. AHIP has recommended pathways be explored to increase provider adoption of ePA technology. These pathways could include a combination of: (i) increasing the availability of the technology enabling ePA; and (ii) increasing the use of the technology where it is already available by identifying and addressing challenges, such as provider readiness and training, workflow integration, and incentives for providers to use the technology.[19]

AHIP welcomes the opportunity to work with the Subcommittee to develop innovative solutions, such as increasing provider adoption rates of ePA, to improve PA processes, and to make health care more efficient and effective for all.

Inaccuracies in Reporting on Several Recent Government Studies of MA Prior Authorization. A recent report released by the Department of Health and Human Services' (HHS) Office of Inspector General (OIG) raised certain concerns regarding claims denied by MA plans through PA.[20] However, the data from the report show that the overwhelming majority of PA requests made to MA plans are approved (95% approval rate in 2018). Further, 87% of the coverage denials the OIG reviewed in its sample of claims were found to be appropriate. While the OIG raised questions about a small number of the remaining denials, a key concern they identified was the need for additional CMS guidance on the criteria plans are permitted to use in determining coverage. AHIP supports such clarification.

[18] https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc-public/prior-authorization-consensus-statement.pdf
[19] https://www.ahip.org/prior-authorization-helping-patients-receive-safe-effective-and-appropriate-care
[20] https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf

It is also important to recognize that in its response to the OIG report, CMS noted that plan performance is improving, with the average number of issues cited per audit declining "approximately 70% from 2012 to 2019."[21]

Risk Adjustment in MA. Risk adjustment is used to ensure that MA plans are appropriately compensated based on expected health care costs of their enrollees. Some concerns were raised in another OIG report as to the overall number of diagnoses identified through health risk assessments (HRAs) in MA relative to original Medicare.[22] However, the report did not determine that any of the codes generated through HRAs were wrong or inappropriate. MA plans and their provider partners consider HRAs a vital tool for care management, improved health, and efficient use of heath care resources. HRAs are a tool that MA plans use to obtain a holistic view of a patient's health status. Considered a best practice by CMS, HRAs are critical for identifying enrollee needs, and along with chart reviews, help reduce provider burden by identifying needs and diagnoses that providers found but did not report.

A recent report from MedPAC suggests that risk scores in the MA program are inappropriately higher than original Medicare, translating to excess payments to MA plans. [23] However, risk coding in original Medicare is widely known to be prone to inaccuracies and should not be seen as a reliable benchmark for MA coding.[24] Furthermore, data from beneficiary surveys shows higher rates of many chronic illnesses among MA enrollees, including those enrolled in special needs plans, than those in original Medicare, suggesting that higher risk scores in MA reflect the actual health status of members.[25] And, an analysis of actual spending from Medicare Trustees' data, which shows lower average per-enrollee spending in MA compared to original Medicare when the appropriate original Medicare comparison population is identified, accounts for the impact of any coding differences in MA and original Medicare.[26]

Risk adjusting payments is essential to ensuring continued fair options for all MA beneficiaries. It removes structural features that could otherwise create perverse incentives by penalizing plans that provide care for the most seriously ill beneficiaries.

MA Disenrollment Rate. A June 2021 study by the Government Accountability Office (GAO) of data from 2016 and 2017 concludes that a "relatively small percentage of Medicare beneficiaries" in the last year of life disenrolled from MA to join original Medicare, but this rate was higher than the disenrollment rate for other MA beneficiaries.[27] The study asserts that this difference in MA disenrollment rates during the last year of life may suggest potential problems

[21] Id.
[22] https://oig.hhs.gov/oei/reports/OEI-03-17-00474.asp
[23] https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_SEC.pdf
[24] https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.0714
[25] NORC Spotlight on Health: Analysis of COVID-19 Impact on Medicare Advantage and Fee-for-Service Beneficiaries, May 18, 2021, available at: https://www.norc.org/PDFs/ASonHealth/20210518_NORC%20-%20Duals%20in%20COVID_FINAL.pdf
[26] https://www.ahip.org/documents/20201118-Anthem-PPI-MedPAC-Spending-Estimates-Memo.pdf
[27] https://www.gao.gov/assets/gao-21-482.pdf

MA enrollees have with their plan. However, the GAO did not determine that there were in fact care access issues. In reality, the existence of a slightly higher disenrollment rate is not necessarily a negative. Instead, it represents the inherent flexibility and choice built into the MA program at work. A plan that meets the needs of a patient at one point in life may not be the best fit at a different time.

A beneficiary may decide to move from one MA plan to another or from MA to original Medicare during their last year of life for many reasons: for example, the person might move out of the existing plan's service area to be near family a particular health facility; there might be a desire to see a specific provider or receive treatment at a particular facility outside the plan's network; or the person might reevaluate health care needs, priorities, and preferences at the end of life. Some beneficiaries may also choose to go into hospice at the appropriate time. While a small number of MA plans offer hospice benefits as a part of the MA value-based insurance design model developed by the Center for Medicare & Medicaid Innovation, this program was not available during the studied period and hospice coverage is otherwise provided through the original Medicare program.

Beneficiaries (along with their family and caregivers) should always be encouraged to assess what coverage best meets their needs. While oversight of disenrollment rates may be one metric for CMS to evaluate when overseeing MA plans, the data need to be assessed in context and combined with additional analyses before drawing inappropriate conclusions about care access.

Care for Diverse and Vulnerable Populations

MA serves a diverse population of Americans. In fact, 32% of MA enrollees are minorities, compared with 21% of those in original Medicare, and that share has grown in recent years.[28] In 2019, almost half of all racial and ethnic minorities eligible for Medicare were enrolled in MA, up from 31% in 2013.[29] Minority populations are especially reliant on MA plans that combine both medical and prescription drug coverage with no monthly premium beyond the standard Part B premium.[30] MA plans also care for a growing share of Medicare beneficiaries dually eligible for Medicare and Medicaid benefits. In 2019, 44% of dual-eligible beneficiaries were enrolled in MA, up from 25% in 2013[31], and research shows dual-eligible enrolled in MA have greater health needs than those in original Medicare.[32]

[28] Murphy-Barron, C, Pyenson, B, Ferro, C, et. al. "Comparing the Demographics of Enrollees in Medicare Advantage and Fee-For-Service Medicare." Milliman. October 2020.
[29] Id.
[30] NORC analysis of June 2021 CMS Medicare enrollment and demographic data, conducted for AHIP. December 2021.
[31] Murphy-Barron, C, Pyenson, B, Ferro, C, et. al. "Comparing the Demographics of Enrollees in Medicare Advantage and Fee-For-Service Medicare." Milliman. October 2020.
[32] NORC at the University of Chicago. "Analysis of COVID-19 Impact on Medicare Advantage and Fee-for-Service Beneficiaries." May 2021.

MA has been shown to provide better quality of care on various clinical quality measures compared to original Medicare.[33,34] Peer-reviewed research has also found that MA plans outperform original Medicare across a range of metrics, including better access to preventive care and better clinical outcomes.[35] For example, MA enrollees are more likely to receive important preventive services like annual wellness exams and cognitive screenings than their counterparts in original Medicare.[36]

MA plans are also committed to addressing social barriers to health. MA plans provide services directly and work with community partners to address a variety of needs, ranging from food insecurity, lack of transportation, social isolation, housing instability and homelessness, among others.[37] Research has demonstrated that many services and interventions that address the health-related social needs of MA enrollees result in improved quality of life, improved health outcomes, and significant savings by reducing unnecessary health care utilization.

MA plans are also actively implementing innovative programs to improve the quality of care of their patient populations and reduce disparities and are coordinating with CMS, providers, enrollees, and other stakeholders on disparity reduction efforts. AHIP also partners with CMS and other health care stakeholders to identify best available quality measures through the Core Quality Measures Collaborative (CQMC). The purpose of this multi-payer collaborative is to create consistent, parsimonious measure sets for use in value-based payment. The CQMC has been working for some time to identify quality measures that can be used to evaluate health equity and to leverage its existing core measure sets to address disparities in care both in MA and other insurance products.

Conclusion

MA plans provide high quality, integrated health care to millions of Americans including seniors, racially-diverse communities, and those with incomes below 200% of the federal poverty level. To continue providing quality, affordable health care, MA plans utilize tools like PA to ensure patients are getting the right care in the right setting at the right time. AHIP and our member plans are committed to continued collaboration with providers and other stakeholders to improve the PA process.

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[33] Timbie, Justin W., Bogart, Andy, Damberg, Cheryl et al. Medicare Advantage and fee-for-service performance on clinical quality and patient experience measures: Comparisons from three large states. Health Services Research 52(6), Part I: 2038-2060. December 2017.

[34] Agarwal, Rajender, Connolly, John, Gupta, Shweta, et al. Comparing Medicare Advantage And Traditional Medicare: A Systematic Review. Health Affairs 40(6): 937-944. June 2021.

[35] DuGoff, Eva, Rabak, Ruth, Diduch, Tyler, et al. Quality, Health, and Spending in Medicare Advantage and Traditional Medicare. The American Journal of Managed Care 27(9). September 2021.

[36] Jacobson, Mireille, Thunell, Johanna, and Zissimopoulos, J. Cognitive Assessment at Medicare's Annual Wellness Visit in Fee-For-Service and Medicare Advantage Plans. Health Affairs 39 (11): 1935–1942. November 2020.

[37] https://www.ahip.org/documents/SDOH-MA-IssueBrief-2021.pdf

MA plan options are available at affordable costs to the diverse population of MA enrollees with a wide range of benefits made available to beneficiaries. It is essential that the MA program is evaluated fairly and that appropriate funding mechanisms continue to be available to ensure that millions of seniors and people with disabilities who rely on MA plans continue to receive the high-quality, coordinated care they deserve.

Health insurance providers are committed to providing quality and affordable coverage. Whether it's offering more choices for the health plan that fits an individual's needs, more widespread availability of high-quality, integrated health coverage, or greater access to health plans with lower premiums and drug coverage. The MA program is helping drive greater quality and value for the millions of Americans the program serves. We look forward to working with the Subcommittee further to improve patient health, patient safety, and affordability for everyone.