STATEMENT FOR THE RECORD

Submitted to the
House Ways and Means Committee
Subcommittee on Health

The Medicare Advantage and Part D Prescription Drug Programs
May 18, 2017

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America’s Health Insurance Plans (AHIP) is the national association whose members provide coverage for health care and related services to millions of Americans every day. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access and well-being for consumers.

We appreciate the committee’s interest in strengthening the Medicare program and we welcome this opportunity to offer our comments on issues surrounding the Medicare Advantage (MA) and Medicare Part D prescription drug programs. Through their participation in the MA program, our members have a long track record in emphasizing prevention, providing access to disease management services for chronic conditions, implementing value-based care, and offering systems of coordinated care for ensuring that beneficiaries receive the health care services they need. Similarly, as sponsors of Part D plans, our members have demonstrated strong leadership in reducing medication errors, promoting clinically sound drug usage, and holding down costs for beneficiaries.

We appreciate the committee’s support for the MA and Part D programs, including the leadership demonstrated by many members – both Republicans and Democrats – who signed letters earlier this year, urging the Centers for Medicare & Medicaid Services (CMS) to avoid further MA payment cuts and maintain stable coverage options for beneficiaries in the 2018 rate setting process. Overall, more than 320 members of Congress addressed letters to CMS, expressing support for the MA program, in the weeks leading up to the April 3 announcement of 2018 MA payment rates.

Our statement focuses on two topics: (1) the value offered to beneficiaries by the MA and Part D programs; and (2) legislative recommendations for strengthening the MA and Part D programs.

**Value of Medicare Advantage (MA) and Medicare Part D Programs**

AHIP’s members are strongly committed to serving Medicare beneficiaries under the MA and Part D programs and continuing to provide cost-effective, high quality, and accessible health care. Plans are implementing patient-centered innovations that include:
• Integrating and coordinating care for beneficiaries;

• Mitigating the harm of chronic diseases by focusing on prevention, early detection, and care management;

• Reducing beneficiary costs;

• Addressing the needs of vulnerable individuals, including low-income beneficiaries; and

• Applying clinical best practices to increase patient safety and to limit unnecessary utilization of services.

Today more than 18.5 million Americans – about 32 percent of all Medicare beneficiaries – have chosen to enroll in the MA program, and 16.6 million of them receive drug benefits through their plan. An additional 25 million Americans receive drug coverage through a stand-alone Prescription Drug Plan (PDP). Since 2010, MA enrollment has increased by 60 percent, and Part D enrollment has increased from 24 million in 2007 to over 42 million today. While the average payment to MA plans is equivalent to fee-for-service (FFS) costs, MA bids are 10 percent below FFS costs and MA plans often offer additional benefits to enrollees for no additional premium. Ninety percent of beneficiaries can choose from at least five MA plans.

Moreover, MA plans have proven to be more efficient than FFS in delivering access to care in an impactful manner. For example, in one study, post-acute care utilization in MA after hospital discharge was lower than FFS. Readmission rates for MA enrollees also were found to be about 13 percent to 20 percent lower than FFS. Another study found that MA plans had higher rates of annual preventive care visits (53 percent vs. 33 percent in FFS). Part D coverage also has been shown to reduce spending: one study found that enrollees with Part D coverage had 8

percent fewer hospital admissions, incurred 7 percent lower Medicare expenditures, and used 12 percent fewer total resources than beneficiaries without Part D coverage.\textsuperscript{5}

**Legislative Recommendations for Strengthening MA and Part D Programs**

Even with the demonstrated success of the MA and Part D programs, there are several areas where Congress can take action to further strengthen these programs and enhance the value they provide to our nation’s Medicare beneficiaries.

**Allow MA Plans to Include Telehealth Services in Basic Benefits Package**

Health plans have embraced telehealth through the widespread use of nurse hotlines, remote monitoring services, electronic office visits, and other innovative ways of providing value to enrollees. However, current law limits MA plans from incorporating telehealth benefits into their basic benefit package that go beyond the scope of services included in the FFS benefit. As a result, MA plans must use supplemental benefits funded by rebates or premiums to offer expanded coverage of remote access technologies, which has reduced flexibility in plan financing and limited the availability of other additional benefits or buy-downs of Medicare cost sharing. Permitting MA plans to broaden the use of telehealth in delivering basic benefits would be more consistent with modern medical practices and should enhance value and reduce premiums for enrollees.

**Allow MA Plans to Offer Non-Medical Benefits as Supplemental Benefits**

MA plans should be permitted to offer non-medical benefits as part of the supplemental benefits they provide to their enrollees. This includes housing and nutrition-related services as well as other social services that can help improve the overall well-being and health status of beneficiaries with chronic conditions. Allowing MA plans to offer non-medical benefits would be consistent with the goals of CMS’ Accountable Health Communities Model, which is funding bridge organizations to screen Medicare beneficiaries for health-related social needs and refer them to, or provide them with, services that meet these needs. Moreover, this additional

flexibility would allow health plans to apply lessons learned from participating in state Medicaid programs or in the Social HMO demonstration to coordinate medical and non-medical benefits, including long-term services and supports for Medicare beneficiaries.

**Establish Unified Grievances and Appeals Process for Individuals Enrolled in D-SNPs**

Currently, grievance and appeals procedures for beneficiaries in dual eligible Special Needs Plans (D-SNPs) are governed by separate state and federal requirements. These redundancies create confusion for beneficiaries and caregivers, and result in decreased efficiency and increased administrative burdens for plans. Enrollees in D-SNP plans would be better served by a unified grievance and appeals process.

**Eliminate the MA Benchmark Cap**

To the extent that CMS is unable to identify statutory authority to do so, we urge Congress to repeal the benchmark cap that currently prohibits some MA plans from receiving the full bonus payments they have earned under the program’s Star Ratings System. This existing policy continues to be problematic for beneficiaries enrolling in these plans, who are likely to experience additional costs or reduced supplemental benefits as a result, and is inconsistent with the broader health system goals of incentivizing high quality performance. Removing this cap is an important step toward preserving and rewarding the innovative programs and strategies through which MA plans are working to provide value to seniors and individuals with disabilities.

**Allow for Non-Uniform Benefits by Expanding Value-Based Insurance Design**

Our members have pioneered innovative benefit designs that use research and clinical guidelines to promote better health, manage chronic conditions, and target populations with specific health needs. These types of value-based insurance design (VBID) features can improve quality of care by encouraging individuals to access critically needed, high-value services and health improvement activities including preventive care. These strategies align with the national goals of providing patient-centered care, improving patients’ overall health status, and changing financial incentives in a way that drives quality in health care delivery. We urge Congress to expand the use of VBID in the MA program nationally to permit more beneficiaries with chronic conditions to receive customized benefits through these models and to support participation by all MA organizations.
Permanently Reauthorize Special Needs Plans

We encourage Congress to permanently reauthorize all Special Needs Plans (SNPs) including D-SNPs, plans for beneficiaries with specified chronic conditions (C-SNPs), and those for beneficiaries who require an institutional level of care (I-SNPs). Plans have made substantial investments to develop and operate these products, which are demonstrating success in improving beneficiary outcomes in comparison to the FFS program.6 Short-term reauthorizations create uncertainty and are inconsistent with the continued development of these innovative programs. Permanent reauthorization would alleviate this uncertainty and further our members’ commitment to creating programs tailored to enrollees with special needs.

Allow MA Plans to be Considered Alternative Payment Models

The Medicare Access and CHIP Reauthorization Act (MACRA) defines an Alternative Payment Model (APM) as a CMS Innovation Center model, the Shared Savings Program, the Health Care Quality Demonstration, or a federally-required demonstration. MA plans have partnered with providers in developing APMs that contribute to the delivery of care that is of higher quality and lower cost than care delivered through FFS coverage.7 Accordingly, we believe that the statute should be modified to allow MA plans to be defined as APMs. This step would level the playing field by providing risk arrangements in MA the same treatment as risk arrangements in traditional Medicare, resulting in more equitable opportunities for physicians.

Improve Part D Flexibility to Use Effective Management Tools

The expansion of robust utilization management tools in the Part D program would create more value for beneficiaries and the Medicare program. Namely, we support steps that would increase plan sponsor flexibility around the tools used to manage effective and efficient medication use, including: removal of Part D protected classes; requiring coverage of one drug per class; applying the coverage gap discount program to biosimilars; relaxing the meaningful difference

standards; and allowing more flexibility for formulary design (e.g., preferred and non-preferred specialty drug tiers).

Thank you for considering our recommendations for strengthening the MA and Part D programs. We look forward to working with the committee as you consider legislation addressing these important issues.