STATEMENT FOR THE RECORD

Submitted to the
House Ways and Means Committee
Subcommittee on Health

“The Current Status of and Quality in the Medicare Advantage Program”

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America’s Health Insurance Plans (AHIP) appreciates this opportunity to offer our comments on opportunities to improve and grow the Medicare Advantage (MA) program.

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. Our members have a long track record in serving Medicare beneficiaries and providing coverage for cost-effective, high quality health care through the MA program.

We thank the subcommittee for strongly supporting the MA program and for Chairman Peter Roskam’s statement acknowledging that the MA program has provided quality care to seniors and individuals with disabilities for many years. Given the long-standing value of the MA program, many committee members—both Republicans and Democrats—signed letters earlier this year, urging the Centers for Medicare & Medicaid Services (CMS) to maintain stable coverage options for beneficiaries in the 2019 rate setting process. Overall, more than 360 members of Congress addressed letters to CMS, expressing support for the MA program, in the weeks leading up to the April 2 announcement of 2019 MA payment rates.

Our statement focuses on the following:

- The continued value provided to beneficiaries under the MA program;
- Opportunities for improving the MA program resulting from the recent passage of the Bipartisan Budget Act of 2018 and policy changes finalized by CMS in early April; and
- Additional improvements that are needed to further strengthen the MA program.

The Continued Value Provided to Beneficiaries Under the MA Program

Approximately 20 million Americans, or about one-third of all Medicare beneficiaries, have chosen to enroll in the MA program. Enrollment has increased by 8 percent in the last year alone and by more than 70 percent since 2010. MA plans are popular among Medicare beneficiaries
because of their success in advancing innovative, patient-centered programs that improve care, reduce beneficiary costs, and address the needs of low-income and other vulnerable individuals.

- **Medicare Advantage plans offer a different approach to care delivery.** Unlike the traditional Medicare fee-for-service (FFS) program, MA plans implement programs that integrate and coordinate care, and effectively help patients prevent, detect, and manage chronic conditions. In addition, while the benefit package in the Medicare FFS program is largely stuck in time, reflecting its 1960s origins, MA plans often provide a more comprehensive benefit package. Additional valuable benefits may include vision, dental, and hearing coverage. Many plans also offer drug coverage at no additional cost to enrollees. Unlike Medicare FFS, the financial stability of MA enrollees is protected by annual out-of-pocket caps on their costs.

- **Medicare Advantage plays a crucial role in enhancing the delivery of high quality care.** A recent peer-reviewed study found that, on average, MA provides “substantially higher quality of care” by outperforming Medicare FFS on 16 out of 16 clinical quality measures, and achieving equivalent or higher scores on five out of six patient experience measures.\(^1\) Another recent study found that value-based care in MA has resulted in lower costs while improving survival rates.\(^2\) In other studies, MA has proven to reduce hospital readmissions and institutional post-acute care admissions while also increasing rates of annual preventive care visits and screenings.\(^3,4,5,6\) Further, the MA program has a beneficiary satisfaction rate of 90 percent for plans, preventive care coverage, benefits, and choice of provider.\(^7\)

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• **Medicare Advantage has proven to be cost-effective.** For many years, average plan bids for delivering the basic Medicare benefit have been well below Medicare FFS costs. Further, in 2018, average payments to MA plans will be roughly equivalent to Medicare FFS costs, according to the Medicare Payment Advisory Commission (MedPAC). Moreover, in many geographies with high MA enrollment, spending in the FFS program actually goes down as providers adopt practice patterns and care guidelines that “spill over” into their care of patients who remain in FFS Medicare. In fact, MA plans pioneered many of the FFS payment and delivery reform efforts that CMS has undertaken.

**Opportunities Resulting from the Recent Passage of the Bipartisan Budget Act of 2018 and CMS Policy Changes**

The Bipartisan Budget Act of 2018, enacted on February 9, included many significant health care provisions that will improve the MA program for beneficiaries. Key provisions included:

- Permanently reauthorizing MA Special Needs Plans (SNPs);
- Closing the donut hole for beneficiaries in the Part D program in 2019 instead of in 2020;
- Permitting MA plans to offer additional telehealth benefits as part of the basic benefit in 2020;
- Allowing MA plans to offer targeted supplemental benefits to chronically ill enrollees in 2020; and
- Expanding CMS’ Center for Medicare and Medicaid Innovation (CMMI) MA-Value-Based Insurance Design (VBID) model testing nationwide by 2020.

These provisions will help support MA plan innovations to improve care management and coordination activities and ensure that Medicare beneficiaries continue to have access to high quality, affordable health care through the MA program. In addition, Congress suspended the Health Insurance Tax (HIT) for 2019, thereby reducing premiums for MA members.

On April 2, 2018, CMS published several important documents—a Final Notice, Final Call Letter, and Final Rule—implementing numerous program improvements that will provide greater flexibility to MA plan sponsors, beginning in 2019, to advance new innovations on behalf of their beneficiaries.

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enrollees. Many of these improvements were recommended by AHIP in letters we submitted to CMS during the public comment process.\textsuperscript{10,11} For example:

- CMS has expanded the definition of “healthcare benefits” that MA plans can offer as supplemental benefits in 2019.
- CMS will allow MA plans to reduce cost-sharing and tailor supplemental benefits for certain covered benefits.
- CMS will eliminate “meaningful difference” requirements that had limited the ability of MA plans to offer innovative options to best meet beneficiary needs.
- CMS will allow more materials, including Evidence of Coverage (EOC) documents, to be provided electronically and take other steps to reduce paperwork requirements.
- CMS will provide additional flexibility on formulary changes, including the ability for plan sponsors to more easily modify formularies to include newly available generic products soon after they enter the market.
- CMS will convene a technical expert panel (TEP) to address key structural, policy, and operational issues in the Star Ratings program.

These policies will further strengthen and improve the MA program by enabling plans to offer seniors better services, better care, and better value.

**Additional Improvements That Would Further Strengthen the MA Program**

While we appreciate the recent changes that both Congress and CMS have made, we believe that there are additional changes that would further strengthen the MA program for beneficiaries. In our comments to CMS, we have provided the agency with specific recommendations on the improvements that are needed to promote stability, innovation, and high-quality care for beneficiaries served by the MA and Part D programs.\textsuperscript{12} We would recommend the following key policy improvements:

\textsuperscript{10} AHIP comment letter on CMS proposed rule for Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program. January 16, 2018.
\textsuperscript{12} AHIP comment letter responding to CMS Request for Information (RFI) from Final Announcement of Calendar Year (CY) 2018 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter. April 24, 2017
**Permanently repeal the Health Insurance Tax.** This tax is a sales tax on health insurance, which directly increases the premiums that MA enrollees must pay. While Congress did suspend the tax for 2019, premiums could increase or benefits decrease in 2020 if Congress does not take action. In order to avoid this possibility, Congress should permanently repeal the Health Insurance Tax.

**Remove the cap on county benchmark rates for high quality plans.** The Affordable Care Act, which established higher payments for MA plans based on quality ratings, capped all county benchmark rates at the level that would have been set had the ACA not passed. As a result of these caps, millions of beneficiaries are in high quality plans that do not receive quality bonus payments from CMS. CMS has acknowledged that this “benchmark cap” is inconsistent with the goal of incentivizing continuous improvement in the care delivered to Medicare beneficiaries. To the extent that CMS has not identified regulatory authority to exclude quality bonus payments from the application of the pre-ACA benchmark cap, we would encourage Congress to pass legislation that would lift this cap.

**Calculate county benchmarks using only beneficiaries with Medicare Parts A and B coverage.** MedPAC has recommended that CMS calculate all county benchmarks—which are based on FFS costs—using claims data for individuals with both Parts A and B coverage (this is currently done only in Puerto Rico). AHIP concurs with MedPAC that this adjustment is appropriate in all geographies, given that Medicare Advantage enrollees must have both Medicare Parts A and B and the fact that Part A only enrollees have different health and utilization patterns.\(^\text{13}\) That is, current calculation methodologies underestimate the true cost to cover individuals eligible to enroll in Medicare Advantage; therefore, expenditures for beneficiaries enrolled only in Part A should not be included in the calculation of the FFS benchmarks to ensure an accurate determination of FFS costs.\(^\text{14}\) As MA penetration rates continue to increase throughout the country, the higher the percentage of enrollees left in the FFS benchmark without Parts A and B coverage and the greater the negative impact on MA. In fact, the percentage of Medicare enrollees with only Part A has increased to 12.4 percent of all beneficiaries in 2015 from 10.2 percent in 2014.\(^\text{13}\)

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\(^\text{13}\) MedPAC found that “Part A spending for beneficiaries enrolled in Part A and Part B all year averaged 8 percent more than average Part A spending for beneficiaries enrolled in Part A (with or without Part B).” MedPAC also found that average risk scores are higher for beneficiaries enrolled in both Parts A and B compared to all FFS beneficiaries.

\(^\text{14}\) Additional independent analysis has shown that excluding Medicare beneficiaries with Part A only from the calculation of FFS costs would increase per capita FFS cost by 5 percent nationally, ranging from 3 percent to 10 percent among states. See Ashby, Jack, Young, Paul Y. Problems with CMS’s per capita cost measure push down Medicare Advantage rates and create geographic inequities. *Health Affairs Blog*. 25 January 2018. Available at: https://www.healthaffairs.org/do/10.1377/hblog20180119.528795/full/
percent in 2009. We expect this trend to continue and worsen in the future. Furthermore, CMS’ current method for calculating benchmarks does not meet the statutory requirements under a plain reading of the Social Security Act.15

**Adopt a collaborative process for addressing critical payment issues.** CMS uses a closed process for developing and updating the risk adjustment model, with a limited comment opportunity that often occurs after substantial resources have been devoted toward changes in the model. In addition, documented operational and system issues continue to affect the acceptance and processing of encounter data for risk adjustment purposes. However, no intensive work group or other process to collaborate with stakeholders on encounter data system problems has been implemented at this time. As such, CMS should create a workgroup—similar to the group being created for the Star Ratings program—that would collaborate to identify and find solutions on both the risk adjustment model and on encounter data. This workgroup could also provide an opportunity for CMS to determine the accuracy and reliability of the encounter data and identify any potential problems with the data such that the encounter data are not misused to develop erroneous conclusions about the MA program.

**Develop a long-term solution for addressing the impact of socioeconomic status and other factors on Star Ratings performance.** CMS continues to use the categorical adjustment index (CAI), an interim analytic adjustment, to account for disparities due to the impact of socioeconomic status (SES) and other factors on MA plan performance in Star Ratings. A long-term solution that appropriately addresses this issue is needed. CMS should work with MA plans, the Office of the Assistant Secretary for Planning and Evaluation (ASPE), and other relevant stakeholders to determine the approach and methods for permanently adjusting Star Ratings measures for SES and other factors. Moreover, until a permanent solution is developed and adopted, CMS should not terminate contracts based solely on Star Ratings performance. CMS should also develop a comparable Star Ratings quality metrics system for Medicare FFS that will enable beneficiaries to compare MA plans with the FFS option.

**Improve the Medicare Plan Finder Tool.** The Medicare Plan Finder (MPF) is an important tool that allows Medicare beneficiaries to compare MA and Part D plan options where they reside, but the site still remains difficult for beneficiaries and family members to navigate and understand.

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CMS should work to make the site more consumer friendly and help beneficiaries to better understand their options, including by showing comparable quality ratings for FFS in a region compared to MA. The Clear Choices Campaign and the National Council on Aging (NCOA) recently released a report that evaluates MPF and provides a series of recommendations for how it can be improved. CMS should create a task force comprised of CMS staff, plans, beneficiary advocates, providers, and other stakeholders to review key findings and recommendations outlined in the Clear Choices Campaign and NCOA report and consider ways to improve and modernize the MPF. Improving the MPF tool will help beneficiaries consider and compare all Medicare plan options available to them and identify the plans that best meet their specific needs.

Conclusion

AHIP and our members are strongly committed to continuing our engagement with Congress and CMS on opportunities for improving and strengthening the MA program. We stand ready to provide support and assistance as Congress and the Administration build upon the success of the MA program, and we look forward to working with you to improve this important program to provide better care, better outcomes, and lower costs for Medicare beneficiaries.

16 Modernizing Medicare Plan Finder: Evaluating and Improving Medicare’s Online Comparison Shopping Experience