Testimony on

The Medicare Advantage Program

By

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I. Introduction

Mr. Chairman, Senator Grassley, and members of the committee, my name is Dr. Steven Udvarhelyi. I am Senior Vice President and Chief Medical Officer of Independence Blue Cross, and I appreciate this opportunity to testify about the Medicare Advantage program and its role in providing Medicare beneficiaries with options for high quality, affordable, comprehensive health coverage. Independence Blue Cross is a non-profit health insurer that serves 3.4 million members, approximately 225,000 of which are Medicare beneficiaries; and is part of the national network of 39 Blue Cross and Blue Shield plans that insure approximately one out of every three Americans. Most of our members are in the greater Philadelphia region, and we are both the region's most preferred health insurer as well as the insurer of last resort. We offer a range of coverage options to Medicare beneficiaries, including HMO plans, point-of-service (POS) plans, PPO plans, Medicare Part D coverage, and supplemental coverage.

Independence Blue Cross is strongly committed to the long-term success of the Medicare Advantage program. We are proud to sponsor plans that offer many services and innovations that are not included in the Medicare fee-for-service program. Our Medicare Advantage plans serve a critical role in providing comprehensive, coordinated benefits for many seniors and disabled Americans – including low-income and minority beneficiaries who cannot afford the high out-of-pocket costs they would incur under the Medicare fee-for-service program.

My testimony today will focus on three broad areas:

- the conceptual rationale for why Medicare Advantage plans add value over the Medicare fee-for-service program;

- advances in care coordination and disease management that are significantly improving patient care for beneficiaries enrolled in Medicare Advantage plans; and

- the value the Medicare Advantage program offers beneficiaries, particularly those who need assistance managing their multiple chronic conditions.

II. Why Medicare Advantage Adds Value Not Found in Medicare FFS

The fundamental difference between Medicare Advantage plans and the Medicare fee-for-service program is that the former have established an infrastructure for improving health care quality on an ongoing basis. This is critical, because it is well documented that we have significant shortcomings in the quality of health care under our current system in general and the Medicare program in particular. Over the past decade, the Institute of Medicine (IOM) has focused the nation's attention on the critical need to improve health care quality and patient safety, coordinate chronic care, and support evidence-based medicine. A 1999 IOM report[1] found that medical errors could result in as many as 98,000 deaths annually, and a more recent IOM report acknowledged the fragmented nature of care delivery in the FFS Medicare program, which does "little to encourage coordinated, preventive, and primary care that could save money and produce better health outcomes."[2]

Other studies have documented specific shortfalls in quality. For example a study conducted by RAND[3], found that patients received only 55 percent of recommended care for their medical conditions, and a recent study by MedPAC[4] showed that only two-thirds of Medicare beneficiaries received necessary care for 20 of 32 indicators. The MedPAC report concluded that "care coordination is more difficult to do in the FFS program because it requires managing patients across settings and over time, neither of which is supported by current payment methods or organizational structure." Additional studies indicate that Americans frequently receive inappropriate care in a variety of settings and for many different medical procedures, tests, and

[1] "To Err is Human," Institute of Medicine, 1999
[2] IOM Report: "Rewarding Provider Performance: Aligning Incentives In Medicare," IOM, 9/21/06
[3] "The Quality of Health Care Delivered to Adults in the United States.," Elizabeth A. McGlynn, RAND, June 25, 2003
[4] MedPAC, Report to Congress: Increasing the Value of Medicare, June 2006

treatments. Such inappropriate care includes the overuse, underuse, or misuse of medical services.

Medicare Advantage plans focus on identifying members with important clinical needs, including those not receiving preventive care, those that are frail, and those with chronic illness. Because Medicare Advantage plans have an infrastructure to coordinate and improve the care for these members, there is a proven track record of making a positive difference in the lives of Medicare beneficiaries. The 2006 NCQA State of Quality Report documents significant improvements over time in the quality of care for Medicare beneficiaries enrolled in Medicare Advantage plans, and a good example of this is the improvement in care for cardiac patients. In 2005, approximately 94 percent of Medicare beneficiaries in Medicare Advantage plans received a beta-blocker upon discharge from a hospital after having a heart attack. Nine years earlier that number was close to 60 percent. Beta blockers have been proven to save lives if given after a heart attack, so this significant increase in the use of beta blockers is saving lives and the favorable trend for Medicare Advantage members is not matched in the FFS program.

III. Advances in Care Coordination and Disease Management

The participation of private health insurance plans in Medicare has enabled millions of seniors and disabled persons to benefit from chronic care initiatives and other innovations that are improving their health care and enhancing their overall quality of life. Many Medicare beneficiaries suffer from multiple chronic conditions – such as diabetes, heart disease, cancer, asthma, and depression – and one recent study suggests that over 80 percent of Medicare beneficiaries have at least one chronic condition.[5] Medicare Advantage plans meet a critical need by offering care coordination and management for diseases that commonly afflict the elderly.

[5] Wolff, Starfield and Anderson, "Prevlalence, Exprenditures and Complications of Multiple Chronic Conditions in the Elderly," Archives of Internal Medicine, November 11, 2002.

Health insurance plans are playing a leadership role in developing strategies and programs to improve patient care for persons with chronic conditions. We are focused not only on ensuring that patients with chronic conditions live longer – but we also are helping them live healthier lives, with fewer symptoms, so they can fully participate in the activities they enjoy. This requires a strong emphasis on preventive care, personal responsibility for healthy lifestyles, and early intervention to promote care strategies that are effective in improving the patient's quality of life.

Health plans have a strong track record of encouraging prevention and evidence-based care for individuals with chronic conditions. We also are working on an ongoing basis to continue to develop new tools and greater expertise to help physicians customize care strategies to meet the unique needs and circumstances of individual patients. Building upon the success of early innovations in disease management, we are taking personalized service to a new level through a new generation of chronic care initiatives. Recent publications by America's Health Insurance Plans (AHIP) [6] and the Blue Cross Blue Shield Association[7] document numerous examples of health plan programs that provide the frail elderly and others with chronic conditions the care they need. These efforts reflect the following interconnected trends:

- First, plans are using increasingly sophisticated data mining techniques, such as informatics and predictive modeling, to identify high risk members and members with document gaps in care. The most recent advances in the use of information technology including moving toward personal health records (PHRs) for health plan enrollees – to improve the delivery of care, enhance health care quality, and increase productivity. In November 2006, the Board of Directors of our industry association, AHIP, endorsed a set of recommendations calling for the industry to implement steps to standardize health plan-based PHRs. These recommendations, developed in partnership with the BlueCross BlueShield Association, will facilitate both information sharing between consumers and caregivers, and portability when a consumer changes health plans.

[6] AHIP, *Innovations in Chronic Care*, March 2007
[7] Blue Cross Blue Shield Association, *Medicare Advantage: Improving Care Through Prevention, Coordination, and Management,* February, 2007.

- Second, plans are proactively reaching out to members who are at high risk, and to their physicians, to offer information, guidance and support on closing these gaps in care, increasing the use of preventive care, and improving self-management and provider management of chronic illnesses.

- Third, plans are offering health coaching to change patient behavior. Through the use of nurses and other health professionals who are trained to serve as health coaches, we are helping health plan enrollees to better understand their treatment options to make more informed health care decisions; to make lifestyle changes to improve their health; to understand and follow their doctors' treatment plans; and to address other health and social service needs.

- Fourth, plans are recognizing that patients are well served by a comprehensive strategy that addresses the needs of each person as a whole, rather than a narrow approach that targets individual diseases. Accordingly, we are using nurse case managers to identify barriers to effective care (including financial, transportation, or social support issues, and a lack of integration between health care providers) and are helping individuals overcome these barriers and get their care better coordinated.

- Finally, plans are placing a greater focus on prevention, wellness and the continuum of health care services that people need throughout their lives. By providing a full spectrum of services – ranging from wellness and prevention to acute, chronic, and end-of-life care – we are improving health outcomes and addressing the unique needs and circumstances of each individual patient.

Allow me to provide some examples of these types of programs that are in place at Independence Blue Cross. Our Medicare Advantage members benefit from a variety of programs aimed to improve their care, that include the promotion of prevention and wellness. Here are some specifics of these programs:

- Our Connections[SM] Health Management program is designed to help our Medicare Advantage members by making them more informed about their health conditions, assisting them in making difficult treatment decisions, helping them and their physicians improve the management of chronic conditions, and assisting members and their physicians with the coordination of care.
    - This program is available to all 175,000 of our Medicare Advantage members, and only about 2% of these beneficiaries opt out of the program.
    - Approximately 75,000 of these members have one or more of five common chronic illnesses: coronary heart disease, congestive heart failure, diabetes, chronic obstructive pulmonary disease, or asthma. An additional 2600 members have one of 16 less common chronic illnesses such as Parkinson's Disease, rheumatoid arthritis, or seizure disorders; and 500 have end stage renal disease.
    - Using sophisticated predictive modeling tools, we identify those members who are at highest risk for future health care events, and identify specific gaps in care. Examples of these gaps in care would include such events as members with congestive heart failure not on appropriate medication therapy, elevated cholesterol levels in members with heart disease, lack of appropriate monitoring of blood sugars in diabetics or blood sugar levels that are too high, or the last of a prescription for a medication included in evidence based recommendations for a particular disease or condition.
    - Specially trained health coaches, who are typically RNs and are available 24/7, 365 days a year, do telephonic outreach to these members to address their care gaps, and to help them understand their physician's treatment plan and improve self-management of their chronic conditions.
    - These health coaches can also provide shared decision-making support for any member facing a number of specific treatment decisions, such as the treatment of low back pain, or the treatment of prostate or breast cancer.
    - The physicians caring for these patients receive a comprehensive registry, the SMART[TM] Registry that lists each of their patients with a chronic illness, what specific gaps in care exist for each patient, and how that practice's overall performance in the management of chronic disease compares to their peers. In

addition, patient specific "action" sheets are provided to the physician to place in each patient's chart.

- The results of this program are impressive:
  - 87% of the participants were satisfied and 90% would recommend the program to others.
  - 69% of participants with chronic conditions stated that the program helped them better manage their condition, and 90% stated that the program improved the quality of their care
  - Through prevention of complications and relapses of chronic illness, there was a 10% – 15% reduction in the use of inpatient hospital days and of professional services such as office visits.
  - Overall medical cost trends came down 1.5 to 2% in year one of the program and 3% to 5% for year two of the program.
  - There have also been increases in specific quality indicators related to each of the chronic conditions.

Medicare Advantage members have enthusiastically embraced wellness programs in addition to the support for chronic illness. At Independence Blue Cross, during 2006 over 9,000 seniors enrolled in our fitness programs, designed to encourage and promote healthy, active lifestyles. Almost 60% of these seniors completed the program target of 120 visits per year, double the rate of or non-Medicare members who enrolled in the program!

Another program we have implemented for Medicare Advantage members is our Physician Home Visit program. This is program targeted at keeping home bound members healthy. These members are some of the most medically frail members we have, but their underlying condition is often a barrier to them keeping appointments for physician visits, and in the absence of timely care their condition deteriorates. Home visits by a physician are an ideal solution, but no longer available to most of our members. Therefore, we identified a group of physicians willing to make "house calls." Our program provides for a physician to conduct a proactive home visit to assess members, and then the physician provides follow up care as needed. This physician also

coordinates care with the member's primary care physician and other specialty physicians as needed. While our program only began this year, other health plans have implemented similar programs and seen high levels of member satisfaction, improved control of chronic illnesses and reduced use of emergency services.

Finally, on an ongoing basis we provide Medicare Advantage members with access to care coordination throughout their health care experience. Examples of this are proactive coordination of post-hospitalization care needs. When a member is scheduled for an elective admission, such as a total knee replacement, we reach out to the member to identify their anticipated post-hospital needs, coordinate with their surgeon, and begin to make arrangements for post-hospital care, such as rehabilitation, before the member actually goes to the hospital. In selected cases, we have identified important pre-operative risks that needed to be resolved before surgery. Upon discharge, we follow up with 48 hours of discharge to make sure the member understands their post-hospital treatment plan and that all necessary care has, in fact, been put in place.

Our programs are carefully selected to meet the local needs of our members, but are similar to those of other health plans. In fact, most Medicare Advantage plans offer these types of valuable services to their members. The latest generation of innovations builds upon the lessons health insurance plans have learned over the past decade about outreach strategies that work, about incentives that encourage healthy lifestyle changes and the use of effective treatments, and about how to track patients' progress in obtaining recommended care. While traditional population-based approaches have offered educational materials and other services to individuals identified as having certain conditions, a growing number of plans are now implementing multi-dimensional programs that offer customized care to reflect the severity of each individual's illness.

For example, an asthma patient who has experienced multiple trips to the emergency room would receive specialized attention, including regular phone consultations with a nurse case manager. Another asthma patient who also suffers from depression would be paired with nurses and social workers who could provide a more intensive level of case management. Yet another

asthma patient who takes his medications regularly and has not had any recent emergencies would receive quarterly newsletters and access to a toll-free hotline so he can contact a nurse with questions or concerns.

Another major area of activity for health insurance plans is the movement to promote greater transparency and value-based competition throughout the U.S. health care system. This effort is focused on empowering consumers to be more actively engaged in making decisions – based on reliable, user-friendly data – about their medical treatments and how their health care dollars are spent. To meet this challenge, we are working through a broad-based coalition – known as the AQA – to develop uniform processes for performance measurement and reporting. Those processes are ongoing, and would *first*, allow patients and purchasers to evaluate the cost, quality and efficiency of care delivered, and *second*, enable practitioners to determine how their performance compares with their peers in similar specialties. This effort now involves more than 125 organizations, including AHIP, BCBSA, consumer groups, physician groups, hospitals, accrediting organizations, private sector employers and business coalitions, and government representatives.

The AQA has approved 121 clinical performance measures for the ambulatory care setting, many of which are being incorporated into provider contracts. These measures represent an important first step in establishing a broad range of quality measurement and helping to give consumers the information they need to make informed health care decisions. In addition, a standard tool designed by the Agency for Healthcare Research and Quality (AHRQ) to measure patient satisfaction in the ambulatory care setting has been approved for use by consumers.

Additionally, the AQA has implemented a pilot program in six sites across the country, with support from the Centers for Medicare & Medicaid Services (CMS) and AHRQ, to combine public and private sector quality data on physician performance. This pilot program is testing various approaches to aggregating and reporting data on physician performance, while also testing the most effective methods for providing consumers with meaningful information they can use to make choices about which physicians best meet their needs. Ultimately, we anticipate that the results of this pilot program will lead to a national framework for measurement and

public reporting of physician performance, which is an important step toward advancing transparency and providing reliable information for consumer decision-making.

Through all of these activities, health insurance plans are working on a daily basis to add value to the U.S. health care system and improve patient care for Americans – including Medicare beneficiaries – who have chronic conditions. By promoting healthy behaviors and preventing unnecessary complications and health emergencies, our innovative tools and programs are promoting the best possible use of our nation's health care dollars and enhancing the health, well-being, and productivity of the American people.

IV. The Value of the Medicare Advantage Program

The creation of the Medicare Advantage program, as renamed and revitalized under the Medicare Modernization Act of 2003 (MMA), has provided valuable opportunities for seniors and disabled Americans to benefit from the innovations developed and implemented by private health insurance plans. Approximately 8 million beneficiaries currently receive high quality coverage through the Medicare Advantage program.

Medicare Advantage plans offer a different approach to health care than beneficiaries experience under the Medicare fee-for-service program. Instead of focusing almost exclusively on treating beneficiaries when they are sick or injured, we also place a strong emphasis on preventive health care services that help to keep beneficiaries healthy, detect diseases at an early stage, and work to avoid preventable illnesses.

The chronic care initiatives outlined in the previous section have special significance for our nation's Medicare beneficiaries. Independence Blue Cross and other Medicare Advantage plans have been at the forefront in offering care coordination and management services that are not available in the Medicare fee-for-service program. The entire scope of private sector strategies – from health coaching to predictive modeling to customized care plans – are an integral part of the value beneficiaries receive through Medicare Advantage. These benefits are particularly

important to the frail elderly and others with multiple chronic conditions.

In addition to improving patient care for chronic illnesses, the Medicare Advantage program also provides many additional benefits that are not included in the Medicare fee-for-service benefits package. According to CMS, Medicare Advantage plans are providing enrollees with, on average, savings of more than $1,000 annually – through improved benefits and lower out-of-pocket costs – compared to what they would pay in the Medicare fee-for-service program. Examples of the additional benefits Medicare Advantage plans provide to beneficiaries include:

- **Protection against out-of-pocket costs:** 93% of all beneficiaries nationwide have access to Medicare Advantage plans that provide protection against out-of-pocket costs for Medicare-covered (non-drug) benefits of $2,500 or less. This protection is not available in the fee-for-service program.

- **No cost sharing for preventive screening:** All Medicare beneficiaries have access to a Medicare Advantage plan that does not require cost sharing for screenings for breast cancer, cervical cancer, and prostate cancer.

- **Extra benefits not available in FFS:** Medicare Advantage plans are widely available that provide hearing, vision, and other benefits that the Medicare program does not offer. For example, all Medicare beneficiaries can choose from a Medicare Advantage plan that covers hearing benefits. Over 98% of beneficiaries can enroll in a Medicare Advantage plan offering preventive dental benefits.

- **Comprehensive prescription drug benefits:** Almost every Medicare beneficiary can choose from a Medicare Advantage plan that provides protection in the Part D coverage gap. Almost 90% of beneficiaries can choose a Medicare Advantage plan that provides Part D benefits for no additional premium. Only Medicare Advantage members can access their A, B, and D benefits through a single card.

Research studies indicate that these additional benefits are particularly important to low-income and minority Medicare beneficiaries, especially those who fall just short of qualifying for Medicaid.[8,9] Beneficiaries in the lower income categories are less likely to have employer-based coverage and those with incomes in the range of $10,000 to $20,000 generally are not eligible for Medicaid – meaning that Medicare Advantage is their only option for comprehensive, affordable coverage.

The study published by AHIP in February 2007 indicated that 49 percent of Medicare Advantage enrollees in 2004 had incomes below $20,000 and among minority (non-white) beneficiaries in Medicare Advantage, 68 percent had incomes below $20,000; while 70 percent of African-American and Hispanic Medicare Advantage enrollees had incomes below $20,000. These findings demonstrate that Medicare Advantage plans play an important role in providing health care coverage to many minority beneficiaries and many low-income beneficiaries who cannot afford the high out-of-pocket costs they would incur under the Medicare fee-for-service program.

Finally, I want to highlight the findings of two new surveys, released by AHIP on March 20, regarding the important role Medicare Advantage plans play in providing health security to Medicare beneficiaries.

The first survey[10] found that beneficiaries are highly satisfied with the Medicare Advantage program and, additionally, that more than one-third of seniors would skip needed medical services if their Medicare Advantage plan was taken away. The second survey[11] found that a large majority of physicians believe Medicare Advantage funding cuts would harm seniors. Moreover, when physicians were asked about options for preventing cuts in Medicare physician reimbursement, more than 80 percent suggested that Congress should either cut other programs

[8] AHIP, *Low-Income and Minority Medicare Beneficiaries in Medicare Advantage Plans*, February 2007
[9] Atherly, A. and Thorpe, K.E. *Value of Medicare Advantage to Low-Income and Minority Medicare Beneficiaries*, Emory University, September 20, 2005.
[10] Ayres, McHenry & Associates, Inc. and The Glover Park Group, *National Survey Of Seniors Regarding Medicare Advantage*, February 26 - March 2, 2007
[11] Ayres, McHenry & Associates, Inc., *National Survey of Physicians Regarding Medical Issues*, October 6 - November 2, 2006

or raise taxes, rather than cut Medicare Advantage, to offset the costs of a Medicare physician payment "fix."

Key findings of the two surveys include:

- Thirty-five percent of seniors – including 62 percent of low-income seniors – enrolled in Medicare Advantage say they would skip some of the health care treatments they currently receive if the option of choosing a Medicare Advantage plan was taken away. Another 42 percent say they would pay higher out-of-pocket costs if the option of choosing a Medicare Advantage plan was taken away.

- Ninety percent of beneficiaries enrolled in Medicare Advantage are satisfied with their coverage overall.

- Seventy-four percent of physicians believe that cutting funds from the Medicare Advantage program would have a negative effect on seniors enrolled in the program.

V. Conclusion

Thank you for considering our perspectives on the Medicare Advantage program. We appreciate this opportunity to testify about the role health insurance plans are playing in providing Medicare beneficiaries with high quality, affordable, comprehensive health coverage. We urge the committee to continue to support adequate funding for the system of competition, choice, and innovation that is delivering savings and value to more than 8 million Medicare Advantage enrollees.