June 22, 2015

The Honorable Orrin Hatch
Chairman
Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Johnny Isakson
Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Mark Warner
Committee on Finance
United States Senate
Washington, DC 20510

Re: Improving Outcomes for Medicare Patients with Chronic Conditions

Submitted Electronically

Dear Chairman Hatch, Ranking Member Wyden, Senator Isakson, and Senator Warner:

On behalf of the Council for Affordable Health Coverage (CAHC), I am writing to thank you for seeking input from our organization as you work to develop solutions to improve health outcomes for Medicare beneficiaries with chronic conditions.

Background

CAHC is a broad-based alliance with a singular focus: bringing down the cost of health care for all Americans. Our membership represents a broad range of interests – organizations representing small and large employers, manufacturers, retailers, insurers, brokers and agents, physicians, and consumer organizations. We believe that care for those with chronic conditions would improve if delivery systems, built on the strengths of the private sector, were used as a model to empower Medicare beneficiaries to engage in medical decisions about their health and health care spending.

Health Spending and Chronic Care

Health spending is highly concentrated among patients with chronic illnesses, conditions which are long in duration and have no definite cure. According to the Medicare Payment Advisory Commission's (MedPAC) March 2015 report, Medicare beneficiaries with six or more chronic conditions accounted for 46 percent of all program spending in 2010 - at an average $32,658 per beneficiary, compared with an average of $9,738 across all other fee-for-service beneficiaries. In 2010, the costliest 5 percent of beneficiaries accounted for 39 percent of annual Medicare FFS spending, and the costliest 25 percent accounted for 82 percent. The vast majority of these costs are for medical services.

Many preventable spending And conditions are the result of insufficient screening for diseases, such as colon or prostate cancer. A 2003 study calculated that a concerted effort by employers, insurers, governments and communities to address these risk factors could save $220 billion annually by 2023.[i] A 2009 report by the Trust for America's Health points to a potential 6:1 return on investments in prevention.[ii] Another key avenue for cost saving involves the implementation of protocols and interventions designed to reduce the intensity of care. For example, in 1987 spending per morbidly obese person was about 18 percent higher than spending per person of normal weight. By 2001, it was 70 percent higher.[iii] Yet, many analysts argue that achieving productivity gains on a system-wide basis will require a realignment of financial incentives at the provider level to reward wellness and value.

Even without system-wide payment reform, the dispersion of best practices in chronic care may be having system-wide impacts. Spending accounted for by the most expensive 5 percent of patients has come down by 16 points since 1996, when it stood at 55 percent. This decline indicates that some of the "low hanging fruit" has been harvested, which in turn might limit the scope of future productivity gains. As a result, chronic illness will continue to be a powerful underlying driver of health spending so long as its prevalence continues to rise.

For these reasons, CAHC believes that improving the management of chronic conditions for the sickest portion of the population provides the single most promising avenue for improving health system productivity and to lower health costs. Our recommendations on better managing care for chronic illness are outlined below.

Recommendations

1. First, Do No Harm

CAHC believes that Medicare Part D is critical to Medicare beneficiaries and their ability to effectively manage chronic illness. Costly medical conditions like diabetes, heart disease, and asthma threaten Medicare beneficiaries and our economy. Access to prescription medication has made management of these diseases financially manageable as well.

Part D has set the standard for delivering better value at a lower cost. The average Part D premium, thanks largely to competition, has held steady the past five years. In fact, the average monthly Part D premium is $32, nearly half the Medicare Trustees' original 2006 projection. Total Part D costs are 45 percent or $349 billion lower than the Congressional Budget Office's (CBO) projections for the 2004-2013 budget window. Looking forward, CBO reduced its 10-year baseline forecast for total Part D spending by $56 billion in 2014 alone. Put simply, Part D is working. This strong track record provides a compelling argument to maintain the competitive structure of Part D and build upon its demonstrated success.

As the Committee seeks to improve care management for Medicare beneficiaries, we strongly encourage you to first do no harm by protecting and preserving Part D as it currently exists today.

2. *Build on What Works*

Research shows that increased access to prescription drugs through Medicare Part D is achieving positive health for Medicare beneficiaries. In fact, a recent study published in the *Journal of American Medical Association* found that implementation of Medicare Part D resulted in a savings of more than $1,200 per year in non-drug medical spending among those who previously had limited drug coverage.[iv] Another study showed that the introduction of Medicare Part D significantly reduced hospitalizations for eight medical conditions. The study, which included a sample of 20 million elderly Medicare beneficiaries each year, suggests that Medicare Part D led to 42,000 fewer hospitalizations. If this result were applied to the entire Medicare population, it would represent approximately 77,000 fewer hospitalizations annually.[v]

We support the following actions to build on what works:

- We strongly believe that Medicare Part D should be protected and used as an example of how competition would work in a restructured Medicare program for all beneficiaries. Encouraging strong competition among health plans who are working diligently to keep costs down and negotiate for savings can be leveraged program wide. CAHC believes those beneficiaries who currently incur the highest costs will have the most to gain through system-wide Medicare reform. More specifically, we encourage the Committee to explore anew premium support for Medicare as a way to create powerful competitive incentives to hold down costs while better managing care.

- Expand the use of medication adherence in Medicare. Ninety percent of chronic diseases require medications as first-line therapy. Because of this, it is imperative to pair chronic care with proper medication management. The current Part D medication therapy management (MTM) benefit is not working as intended, and we support reforms that change program eligibility and service definition that more effectively target benefits to those in need. We have submitted detailed comments on this approach through CAHC's campaign, Prescriptions for a Healthy America[vi].

3. Coordinate Care for Medicare's Sickest and Most Vulnerable Patients

As we noted above, Medicare beneficiaries with six or more chronic conditions accounted for 46 percent of all program spending in 2010—at an average $32,658 per beneficiary, compared with an average of $9,738 across all other fee-for-service beneficiaries. In 2010, the costliest 5 percent of beneficiaries accounted for 39 percent of annual Medicare FFS spending, and the costliest 25 percent accounted for 82 percent. The vast majority of these costs are for medical services.

Aggressively managing these costs within should be a priority, but determining what works best is not readily known nor is it, we believe, desirable to uniformly apply each solution to each population. We urge Congress to use the Center for Medicare and Medicaid Innovation (CMMI) to test models of care focused on the costliest ten percent of beneficiaries. We encourage the Committee to direct CMMI to test approaches in Medicare Advantage (MA) and Accountable Care Organization (ACO) models that: allow

coverage of enhanced benefits not currently covered under the Medicare program, such as in-home personal care and telehealth services; the reduction or elimination of cost-sharing; the establishment of provider networks sufficient to ensure integrated and coordinated care, and; the ability to explore new enrollment approaches, such as requiring identification of high-cost enrollees and proactive outreach on behalf of health plans and CMS, along with passive and continuous enrollment.

4. Support New Interventions

New insurance models – called value based insurance design (VBID) – have made promising progress in creating incentives for patients to access care based on proven benefits. Value-based benefit packages adjust patients' out-of-pocket costs for health services on an assessment of the clinical benefit to the individual patient, based on population studies. Thus, the more clinically beneficial the therapy for the patient, the lower that patient's cost share will be.

Pitney Bowes and other companies have adopted this model to great effect. The Pitney Bowes program eliminated copayments for cholesterol-lowering statins and reduced them for a blood clot inhibitor. The change immediately increased adherence to statins relative to controls, which was maintained over time. The improvements in adherence reduced non-drug spending by 17 percent, and offset the cost of eliminating cost sharing on the medications. Others have found that while the programs may increase costs for medication for the plan sponsors, it reduced costs for patients and may generate savings by reducing other medical costs such as hospitalizations.[vii]

The House recently passed legislation to test this concept in Medicare, and we encourage the Committee to include this approach, with certain parameters, particularly enhanced patient protections, in any legislation you produce to address chronic illness in Medicare.

5. Encourage Medicare Beneficiaries to Engage in Healthy Behaviors

Many of our members have long been proponents of wellness programs. We believe that a key to achieving savings in the health care system is to provide rewards to people for engaging in healthy behaviors. For example, one analysis found that medical costs fell by $3.27 for every $1.00 spent on wellness programs.[viii]

We encourage the Committee to apply the incentives in the Affordable Care Act (ACA, Section 1201) to the Medicare program. For example, Medicare beneficiaries could be provided with financial incentives, such as Medicare Part B and/or Medicare Advantage premium discounts or rebates, for engaging in healthy behaviors and addressing health goals related to tobacco cessation, weight management, diabetes management, blood pressure, and cholesterol.

The "Welcome to Medicare" visit could be used to help inform Medicare beneficiaries of their health status and develop goals and plans to make health improvements. Beneficiaries who voluntarily agree to participate in such wellness efforts could be provided with an appropriate amount of time to address health goals. Premiums could then be adjusted.

If Medicare beneficiaries are more responsible for their health care decisions and are rewarded for engaging in healthy behaviors, we believe beneficiaries will choose to maximize both their health and financial benefits. This will drive down costs for taxpayers and beneficiaries alike, while helping to improve outcomes.

6. Empower Medicare Beneficiaries in Accountable Care Organizations

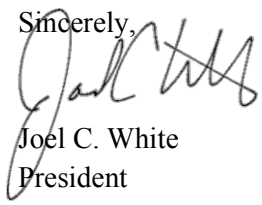
We appreciate the work the Committee is doing to move toward more accountable care. As the Committee examines the Medicare Shared Savings Program (MSSP), we believe it has an opportunity to build a stronger relationship between healthcare providers and Medicare beneficiaries. Specifically, we believe that patient engagement would increase if the beneficiary were allowed to share in a portion of the savings that are realized, along with taxpayers (Medicare) and providers.

Consistent with MA plans, ACOs should share some of the savings with beneficiaries who select high value providers. Providing a financial incentive to do so will create patient demand for transparency, efficiency, quality and accountability. Leaving the beneficiary out of financial gains sends a powerful message and financial signal that the ACO program is more important to providers and their payer, in this case CMS, than to patients. While we believe the broad authority established under Section 1899(a), which allows the Secretary to waive any portion of Title 18 to facilitate the goals of the program, provides sufficient legal basis to waive cost sharing, HHS has not chosen to do so. We urge the Finance Committee to statutorily require shared savings with consumers to better align incentives between payers, providers and patients. It will also make the program attractive to beneficiaries and engage them in the decision making process, thereby creating consumer demand for better quality care that will help drive costs even lower.

Closing

CAHC appreciates your careful consideration of our comments and stands ready to serve as a resource to the Committee as it develops initiatives to improve health outcomes for Medicare beneficiaries with chronic conditions. Should you have any questions, please do not hesitate to contact me or Michelle Stevens of my staff at michelle.stevens@cahc.net.

Sincerely,



Joel C. White
President

---

[i] DeVol, Ross, and Armen Bedroussian, *An Unhealthy America: The Economic Burden of Chronic Disease*, Milken Institute, January 2014. http://assets1c.milkeninstitute.org/assets/Publication/ResearchReport/PDF/Checkup-Time-Chronic-Disease-and-Wellness-in-America.pdf

[ii] http://www.healthyamericans.org/reports/prevention08/Prevention08.pdf

[iii] http://www.cbo.gov/ftpdocs/89xx/doc8947/01-31-TechHealth.pdf

[iv] http://jama.jamanetwork.com/article.aspx?articleid=1104150

[v] Christopher Afendulis et. al. "The Impact of Medicare Part D on Hospitalization Rates. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3165176/ August 2011.

[vi] www.adhereforhealth.org

[vii] Gibson, TB, "A Value-Based Insurance Design Program At A Large Company Boosted Medication Adherence For Employees With Chronic Illnesses", HEALTH AFFAIRS Volume: 30 Issue: 1 Pages: 109-117 Published: JAN 2011

[viii] http://content.healthaffairs.org/content/29/2/304.full