Statement on

Implementing the Medicare Prescription Drug Benefit and Medicare Advantage Program: Perspectives on the Proposed Rules

by

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Good morning, Mr. Chairman and members of the committee. I am Karen Ignagni, President and CEO of America's Health Insurance Plans (AHIP). I appreciate having this opportunity to testify on implementation of the Medicare Advantage program and the Medicare Part D prescription drug program.

Introduction

AHIP is the national trade association representing nearly 1,300 private sector companies providing health insurance coverage to more than 200 million Americans. Our members offer a broad range of health insurance products in the commercial marketplace and also have demonstrated a strong commitment to participation in public programs.

For more than 20 years, our member companies have been working to meet the health care needs of Medicare beneficiaries. Our broad-based membership includes Medicare Advantage organizations and Medicare cost contractors that cover almost 5 million beneficiaries and Medigap carriers that cover 10 million beneficiaries.

All segments of our membership, regardless of which products they offer, are committed to providing beneficiaries with affordable protection against high out-of-pocket health care costs. By covering more than the traditional Medicare program, our members serve as a crucial health care safety net for many minority beneficiaries with chronic diseases and for many low-income beneficiaries who cannot afford the high out-of-pocket costs they would incur under the traditional Medicare program.

Our member companies enthusiastically support the Medicare Modernization Act of 2003 (MMA), and we applaud Congress for enacting this historic legislation to improve choices and benefits for Medicare beneficiaries. As a direct result of this legislation, millions of beneficiaries already are receiving improved health coverage that AHIP's member companies are offering through the Medicare Advantage program and prescription drug assistance that our members are sponsoring through the Medicare-Endorsed Prescription Drug Discount Card Program. In

addition, beginning in 2006, our members will be offering local health plan options, new regional health plan options, a prescription drug benefit, and two new Medigap options.

Importance of Short-Term MMA Reforms

The MMA reforms scheduled for implementation in 2006 are closely linked to the stability of the current private sector Medicare program. Recognizing this reality, the MMA provided an immediate funding increase for Medicare Advantage, in both 2004 and 2005, to ensure that the existing locally-based program would remain in place as a solid platform for launching new components of the Medicare program in 2006. This was a critical step that Congress needed to take, first, to address the instability in the private sector Medicare program caused by the unintended consequences of the Balanced Budget Act of 1997 (BBA) and, second, to expand beneficiary choices through both local and regional plans in 2006 and beyond.

For the past five years, AHIP and our members have urged Congress to address the funding crisis in the private sector Medicare program. During most of these years, funding for the benefits of a significant majority of private health plan enrollees increased by only 2 percent annually, at a time when health care costs were increasing by 8 to 10 percent annually. Congress addressed this problem by providing funds to stabilize private health plan benefits and choices. This funding increase was included in the MMA largely because a core group of 130 Members of Congress – 81 Democrats and 49 Republicans – worked hard to build support for this priority. The Finance Committee deserves special credit for working to ensure that these funds were passed into law.

Just as Congress did its part to strengthen Medicare for seniors and individuals with disabilities, I am proud to report that our members have followed through by using the 2004 funding increase to expand benefits and reduce costs for the beneficiaries they serve. The Centers for Medicare and Medicaid Services (CMS) has reported that 95 percent of the additional funding is being used to help beneficiaries this year through reduced premiums and cost-sharing, increased benefits, and enhanced access to providers. The remaining five percent has been put in a reserve fund to stabilize benefits in 2005.

As a direct result of the MMA, 3.7 million beneficiaries – accounting for 80 percent of all Medicare Advantage enrollees – have received increased benefits through their Medicare Advantage plans since March 2004. In addition, premiums have been reduced for 1.9 million enrollees and co-payments have been reduced for 2 million enrollees in Medicare Advantage plans. Overall, premiums for all Medicare Advantage enrollees nationwide have declined by an average of 26 percent. These coverage improvements are clear evidence that the MMA is providing significant value for Medicare Advantage enrollees and, at the same time, has helped to stabilize the existing program as a foundation for implementing future reforms.

Since the enactment of the MMA, 22 Medicare Advantage organizations have expanded their service areas, thus providing new Medicare health plan choices for 9 million beneficiaries. CMS will announce additional expansions in the very near future. Yesterday, September 13, was the deadline by which Medicare Advantage organizations were required to notify CMS of their intention to participate in the program during the 2005 contract year and, additionally, submit proposed premiums and benefits for next year. In our ongoing discussions with our member companies, they have consistently expressed their interest in expanding their participation in the Medicare Advantage program. We are working to compile information on the expanded choices that will be available to Medicare Advantage enrollees in 2005. We hope to be able to share this information with the committee in our oral testimony.

MMA Reforms Scheduled for Implementation in 2006

Looking ahead to 2006, our member companies are strongly committed to the success of the improvements the MMA establishes for the Medicare program. Many of our members are now considering the opportunities for participation in the new Medicare program in 2006 – offering Medicare Advantage local and regional plans that include prescription drug benefits, offering prescription drug plans (PDPs), and offering the new Medigap benefit packages. Therefore, we are working diligently to provide feedback to CMS on a broad range of implementation issues.

We appreciate the agency's efforts to solicit input from health plans and other entities that are planning to continue their Medicare Advantage local plan participation and considering entering the new programs. CMS has dedicated significant resources to working with the private sector to ensure that expanded choices and benefits will be available to beneficiaries. Our member companies are also pleased that the agency is demonstrating a commitment to establishing a strong public-private partnership that will provide a foundation for implementation of the MMA reforms. CMS' efforts have included:

- a willingness to hear from stakeholders during development of the proposed regulations concerning practical issues and questions related to implementation of the MMA;

- public meetings to solicit comments on the implementation of Medicare Advantage and the Part D prescription drug benefit and on the USP draft model guidelines; and

- solicitation in the proposed regulations of comments from stakeholders on a broad spectrum of issues in an effort to make the final regulations workable and to support successful initial implementation of the program.

While we recognize that the implementation timeframes are challenging for both the government and the private sector, our members are focused on meeting these challenges and offering beneficiaries a wide range of choices. We are working with our member companies to develop detailed comments on all key aspects of the proposed rules and each of the specific programs they cover by October 4, which is the deadline CMS has established for submission of public comments. We would be delighted to provide the committee with our comments, and we would be pleased to provide any additional information or respond to any questions you may have.

As our members evaluate the proposed rules, we will be making comments that reflect our emphasis on three broad principles that may also be useful for the committee:

- Program Administration: We hope that our comments on the proposed rule will assist CMS in its goal to further establish a regulatory framework that adds value for beneficiaries and makes judicious use of CMS and private sector resources.

- Time Frames: We have asked CMS to provide guidance on key implementation issues as quickly as possible to allow the private sector to develop the operational capacity to participate in the new programs that will be implemented in 2006.

- Beneficiary Information: The wide dissemination of clear, user friendly, and balanced information about the new programs will be critical to the ability of beneficiaries to select the options that best meet their needs. We will be encouraging CMS to begin an effort to work with a broad spectrum of stakeholders in the planning and implementation of an outreach effort.

With these guiding principles, we have been working with our members to evaluate all of the specific issues imbedded in the regulations, to understand their administrative implications and to provide the best possible advice about how to implement their many parts. The following pages highlight a small but important sample of the dozens of administrative and regulatory issues associated with these MMA reforms. Our final comment letter to CMS will include more specifics on these issues and myriad technical recommendations.

USP Model Categories and Classes

We generally support the approach the U.S. Pharmacopeia (USP) has proposed for establishing model categories, classes, and subdivisions of prescription drugs that Prescription Drug Plan sponsors and Medicare Advantage organizations may use in developing their formularies and providing clinically appropriate, affordable drug benefits for Medicare beneficiaries. AHIP and our member companies were active participants in an advisory group that provided input to the USP's Model Guidelines Expert Committee regarding the development of these draft guidelines.

While we anticipate providing recommendations to improve the USP draft guidelines, we believe that the approach proposed by the USP provides a workable foundation for balancing the

important goals of providing coverage for the drugs needed to treat the conditions Medicare beneficiaries experience while making the drugs accessible by keeping coverage affordable. One way in which the USP draft guidelines promote access to these drugs is by proposing a framework that provides sufficient flexibility for private sector organizations to use proven strategies to encourage clinical best practices and keep Part D coverage affordable.

USP has proposed categories and classes of drugs to which CMS' proposed requirement for the coverage of two drugs in each category or class would apply and additional subdivisions that highlight drugs that should also be included in drug plan formularies, but for which the two drugs per category/class requirement would be inappropriate. This approach should allow drug plan Pharmacy and Therapeutics (P&T) Committees to make evidence-based decisions about the selection of drugs that will be included in formularies to meet beneficiary needs and establish clinical programs that promote the appropriate use of covered drugs. This approach also will preserve the opportunity for drug plans to obtain favorable pricing agreements through their negotiations with manufacturers. If the model were to include a significantly larger number of categories and classes, the effectiveness of all of these activities would be seriously undermined with the result that drugs could be less accessible for beneficiaries.

In addition, we believe it is important to evaluate the proposed USP model within the broader framework of CMS' standards for formulary review and approval.

Formulary and Benefit Design

We will be encouraging CMS to establish criteria for the review and approval of formularies and benefits that will allow Medicare Advantage plan and Prescription Drug Plan Pharmacy and Therapeutics (P&T) Committees to maximize the value of evidence-based research and other relevant data in designing formularies and to establish related clinical guidelines and other programs to promote appropriate use of formulary drugs and quality care. These private sector tools and techniques help to integrate prescription drug benefits into comprehensive health coverage and, in the process, improve the quality and affordability of health care for Medicare beneficiaries.

From a beneficiary perspective, it also will be important to make full use of the flexibility available under the statute for the design of qualified prescription drug benefits to maximize this coverage. To this end, we support immediate implementation, on January 1, 2006, of the reinsurance demonstration that was authorized by the MMA to increase opportunities to offer coverage to fill the "donut hole" in the Part D benefit. We are in discussions with CMS about options for the design of the demonstration.

Designation of Regions

We have worked intensively with our members to develop a recommendation concerning the number of regions that should be established to fulfill the goal of maximizing the availability of Medicare Advantage regional plans to beneficiaries.

Our members strongly support Congress' objective of providing private sector options to beneficiaries in rural as well as urban areas. In response to CMS' request for comments on this topic in July, we reflected the view of many of our members that it would be prudent to begin with 50 regions, because under the challenging time frames of the MMA, building on current state-based licensure and provider networks will make broader plan participation possible in the near term. At the same time, we have indicated to the agency that we also have some members who prefer fewer regions and are looking carefully at the operational issues that would be involved in serving beneficiaries in multiple states.

In addition, as our members have been considering the question of how many regions should be established for the Part D prescription drug program, our July comments reflected the support of many of our members for 50 PDP regions in order to reduce the uncertainties inherent in the new program and provide opportunities for more sponsors to offer choices for beneficiaries. However, for this program, as well, we have members who are interested in serving multi-state regions.

All of our members are continuing to work through the many administrative issues involved in both of these areas.

Network Access Standards

Throughout the 2003 Medicare debate, our members offered a range of solutions for removing obstacles to health plan participation in areas where plans face serious challenges in reaching economically viable agreements with health care providers. We identified this issue as one of the most significant barriers to bringing Medicare Advantage options to rural areas. The MMA partially addressed this concern by providing modest additional funding for essential hospitals, which AHIP supported, in the event that negotiations conducted by Medicare Advantage regional plans are unsuccessful. This also remains a serious issue for Medicare Advantage local plans.

We will be supporting provisions of the proposed rules that would allow flexibility in the application of network adequacy standards. This flexibility is important, because in a number of rural and urban areas in the country, providers have been unwilling to contract with Medicare managed care plans, even at Medicare fee-for-service rates. This is particularly true in areas where provider competition is limited or nonexistent. Where these contracting problems occur, the regulations provide alternatives that continue to ensure enrollee access to covered services. We hope that these alternatives for meeting network adequacy standards under the Medicare Advantage program can be available to both local and regional plans to ensure that beneficiaries have broad access to the choices that are envisioned under the statute.

Coverage for Dual Eligibles

Meeting the special needs of beneficiaries who are dually eligible under the Medicare and Medicaid programs will be an important priority under the Medicare Advantage and Part D prescription drug programs in 2006 and beyond. We will be making two broad recommendations in this critical area.

First, the MMA contains authority for the establishment of special needs plans that exclusively or predominantly serve dually eligible beneficiaries and those with other special health care needs. To take full advantage of the opportunity to establish plans that focus on the unique needs of these beneficiaries, we believe that CMS should provide flexibility for private organizations to make proposals to CMS regarding the special populations that may be served (e.g., the frail

elderly) and the ways in which program administration should be tailored to facilitate the offering of special needs Medicare Advantage plans.

Second, in transitioning fully dual eligibles from Medicaid coverage of their prescription drugs to coverage under Part D, these beneficiaries will have an opportunity to select a drug plan. If they do not do so, they will be assigned to plans through a default enrollment process, subject to their ability to subsequently change plans if they choose to do so. We support an intensive outreach and information initiative to provide beneficiaries with user-friendly information to help them maintain continuity of care by staying in their current health plans with their existing physicians and other health care providers.

Systems Infrastructure for Coordination of Benefits

We will be supporting CMS' initiative to create a systems capability that will allow for the submission and accessibility of data that Medicare Advantage organizations and Prescription Drug Plan sponsors will need to administer the drug benefit for beneficiaries and that CMS will need to implement reinsurance and risk sharing provisions of the MMA. This capability is critically important to the goal of ensuring that beneficiaries are protected against catastrophic prescription drug costs. It is essential for this infrastructure to be in place on January 1, 2006.

Medigap

I also want to highlight our recommendations on two MMA issues that have significant implications for Medigap carriers and their policyholders. First, our members are concerned about changes that CMS has proposed to the standardized notice that the National Association of Insurance Commissioners (NAIC) has developed for informing Medigap policyholders about their options for prescription drug coverage. We have supported the notice that has been developed by the NAIC and will be providing detailed comments regarding the issues raised by the CMS draft. We are pleased that the NAIC's process for developing the notice has provided an opportunity for input from a broad range of interested parties, including our member companies. We are committed to working with the NAIC and CMS to develop a standardized notice that will enable beneficiaries to make thoughtful, informed decisions when choosing

between new and existing Medigap options, as well as the new Medicare Part D prescription drug plans.

Disclosure Requirements for Creditable Coverage

We also will be urging CMS to minimize administrative burdens as it works to implement the MMA's disclosure requirements for creditable prescription drug coverage. The MMA requires certain entities to disclose whether prescription drug coverage they offer or provide to Medicare beneficiaries is "creditable coverage" under the new Medicare Part D prescription drug benefit. This requirement, which applies broadly to insurers in the group and individual markets, should be implemented with two key goals in mind: (1) providing clear, accurate information to beneficiaries; and (2) limiting administrative burdens for the private sector.

Employer/Group Union Issues

We also have several recommendations to facilitate the offering of retiree drug coverage through Medicare Advantage and Prescription Drug Plans. A key issue for employers and unions and their retirees is the MMA subsidy for retiree drug benefits, which will be available to employers that offer drug coverage that meets a test, established by CMS, of actuarial equivalency to the standard Part D benefit. We believe this actuarial equivalency test should strike an appropriate balance between two important priorities: (1) allowing employers to qualify without being subjected to overly burdensome or complex requirements; and (2) avoiding potential windfalls to employers so that retirees will be helped by the subsidy and will not be disadvantaged. Also, we urge CMS to ensure that the subsidy program's data collection and reporting requirements for employers and unions are reasonable and that a payment process is established that will permit employers and unions to receive their payments in a timely fashion.

Additionally, to accommodate employers and union trust funds with retirees in multiple states, we support the implementation of a waiver for a national offering for the employer market. We commend CMS for indicating its willingness to follow the waiver structure established under the Medicare+Choice program. We support CMS' view that waivers, once approved, should generally apply to any plan offering that meets the waiver criteria. We also support CMS' view that waivers should allow maximum flexibility so that plans may determine which program

requirements need to be waived in order to structure benefits according to the needs of a particular employer plan.

Beneficiaries Are Well-Served by Private Sector Participation in Medicare

We are proud of the success our member companies have demonstrated in meeting the health care needs of Medicare beneficiaries. The private sector has a strong track record of providing high value under the Medicare program.

When the new Medicare options are launched in 2006, our members will continue to use private sector pharmacy benefit management tools and techniques to reduce out-of-pocket costs for beneficiaries and to improve quality by reducing medication errors. These tools and techniques include:

- programs that encourage the use of generic drugs;
- step therapy programs that promote proven drug therapies before moving to newer, different treatments that are not necessarily better;
- negotiated discounts with pharmacies that participate in a plan's network;
- disease management techniques that include practice guidelines to encourage the use of the most appropriate medications; and
- appropriate use of mail-service pharmacies.

Although government programs do not always use all of these techniques, a number of studies have demonstrated that the use of these techniques by private sector health plans is beneficial to enrollees in public programs. For example, a 2003 study, conducted by Associates and Wilson on behalf of AHIP, found that the PACE program in Pennsylvania – the largest state pharmacy

assistance program in the nation – could save up to 40 percent by adopting the full range of private sector pharmacy benefit management techniques.

Another 2003 study – conducted by the Lewin Group for the Center for Health Care Strategies – found that Medicaid managed care plans reduced prescription drug costs by 15 percent below the level states would otherwise have experienced under Medicaid fee-for-service programs. Health plans achieved these savings by performing drug utilization review, establishing pharmacy networks, and encouraging patients to take the most appropriate medications.

In addition, the Government Accountability Office (GAO) has reported that pharmacy benefit management techniques used by health plans in the Federal Employees Health Benefits Program (FEHBP) resulted in savings of 18 percent for brand-name drugs and 47 percent for generic drugs, compared to the average cash price customers would pay at retail pharmacies.

These findings demonstrate that the private sector is well-positioned to use its experience and capabilities to make prescription drugs more affordable for a broader range of Medicare beneficiaries.

In addition to improving access to safe, affordable prescription drugs, our members have longstanding experience providing comprehensive health coverage to Medicare beneficiaries. Let me briefly review several examples of how beneficiaries are well-served by our members' innovative practices in the Medicare Advantage program.

Private sector plans have applied the concept of disease management programs to their Medicare Advantage plans to improve quality of care for beneficiaries with chronic conditions by focusing on the comprehensive care of patients over time, rather than individual episodes of care. These programs provide specialized care to beneficiaries who have diabetes, congestive heart failure, end-stage renal disease, depression, cancer, and other medical conditions that commonly afflict the elderly. Currently, disease management programs are available to only a small number of Medicare fee-for-service enrollees under demonstration initiatives.

Private sector health plans and insurers also play an important role in providing health coverage to beneficiaries who are financially vulnerable. For many beneficiaries who are not eligible for retiree health benefits or Medicaid, the Medicare Advantage program serves as a health care safety net by providing comprehensive, affordable coverage that is not available under the Medicare fee-for-service program. Studies show that low-income and minority beneficiaries are more likely to enroll in Medicare Advantage plans than other beneficiaries.

The private sector also helps to keep out-of-pocket costs low for beneficiaries. A Rand study published in May 2003 found that Medicare health plans, when compared to the Medicare fee-for-service program, reduced out-of-pocket health care costs by $809 annually for the average beneficiary and by $2,160 annually for beneficiaries with the highest health care costs.

Enhanced benefits are another advantage of private sector participation in Medicare. CMS recently reported that 80 percent of all Medicare Advantage enrollees receive some form of prescription drug coverage in 2004. This is true even though government payments to plans do not yet include funding for prescription drugs.

These facts clearly demonstrate that beneficiaries are well-served by private sector participation in Medicare. With respect to both the quality and affordability of health care, the private sector has a strong track record that bodes well for its long-term role in the Medicare program.

Conclusion

Once again, we would like to commend CMS for its strong commitment to advancing a stable public-private partnership to ensure that beneficiaries receive prescription drug benefits that are affordable, effective, and accessible.

I also would like to reemphasize that our testimony today highlights only a sample of the many important issues that will impact the future success of the MMA reforms. When we submit our comments to CMS in early October, we will address the full range of implementation issues and

we will provide comprehensive and detailed comments that reflect our members' best recommendations on how to administer the programs in a way that meets beneficiaries' needs.

We appreciate the opportunity to testify today and will be delighted to share our detailed comments with the committee as soon as we submit them to the agency.