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Chairman Roskam, Ranking Member Levin, and members of the subcommittee, good morning and thank you for the invitation to testify at today's hearing on "The Current Status of and Quality in the Medicare Program." My name is Daphne Klausner and I am the Senior Vice President for Senior Markets at Independence Blue Cross based in Philadelphia, Pennsylvania. Through our parent company Independence Health Group, we serve 8.4 million people in 24 states and the District of Columbia.

In the Medicare Advantage market, we are proud to be the most popular plan in Southeast Pennsylvania, where we have served the community for nearly 80 years. Our 100,000+ members live in a diverse region that includes the poorest large city in America as well as several world class academic medical centers that we partner with as part of our collaborative Facilitated Health Network. These include the University of Pennsylvania, Temple University, and Jefferson Health System. As we transition to greater reforms that incentivize value over volume, we believe we offer a unique perspective in this important debate.

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Growth and Value of Medicare Advantage is Well Documented

I have been working in the Medicare market at Independence for 23 years and have been amazed by the progress made since the demonstration programs of the 1990s to what Medicare Advantage is today. Nationally, about one-third of all Medicare beneficiaries – over 21 million Americans – choose Medicare Advantage over traditional Medicare, an increase of 70 percent since 2010. If these trends continue, estimates suggest that the program will account for 42 percent of all beneficiaries in less than ten years[1]. Other factors, such as the policy changes prohibiting first dollar coverage in Medicare supplemental plans under MACRA, will likely accelerate this growth.

This demand has prompted unprecedented competition in certain markets, including Philadelphia, where 14 health insurers offered products during the 2018 open enrollment cycle. We welcome competition because it is good for consumers and we responded by offering a new, zero-premium product across our entire coverage area with additional benefits not found in the traditional Medicare program. This product includes hearing aid coverage, a fitness benefit, and a 24/7 nursing hotline – all while our members continue to be protected by limits on their out-of-pocket costs, which traditional Medicare does not provide.

Affordability, added benefits, and greater care coordination are driving the program's popularity nationwide. Studies continue to show that Medicare Advantage plans are providing better quality and leading to better health outcomes. A recent peer-reviewed study published in Health Services Research found that Medicare Advantage plans outperformed traditional

[1] Congressional Budget Office (CBO) Medicare Baseline. April 2018.

Medicare on 16 different clinical quality measures, including preventative screenings and nine other measures of care and service[2]. Further, MedPAC's December 2017 status report concluded that payments to plans are now roughly in line with traditional Medicare, making the program a cost-effective use of taxpayer dollars[3].

Recent Congressional and CMS Policy Reforms Show Commitment to Program's Success

We are optimistic that these successes will only continue based on the recent legislative reforms that emanated from this committee as well as many of the regulatory changes promulgated by CMS for the 2019 plan year. Collectively, these policies demonstrate the federal government's programmatic commitment to affordability, innovation, and flexibility.

On affordability, we were pleased that Congress acted to suspend the Health Insurance Tax (HIT) for 2019. The HIT is in effect this year and has put added pressure on premiums, cost-sharing and benefits. According to an October 2017 study by Oliver Wyman, the tax equates to $245 per enrollee[4]. That burden has been lifted for 2019.

On innovation, CMS is now developing telemedicine guidelines at the direction of Congress in order to expand the availability of these services in the Medicare Advantage program nationwide. Telemedicine platforms, which are commonly used today in commercial employer plans, will give beneficiaries access to on-demand clinical care in their own home or

[2] Health Services Research: "Medicare Advantage and Fee-for-Service Performance on Clinical Quality and Patient Experience Measures." Volume 52, Issue 6 (December 2017).
[3] Medicare Payment Advisory Commission (MedPAC). "Medicare Advantage Program: Status Report" [presentation]. December 2017.
[4] Oliver Wyman. "How the ACA's HIT Will Impact 2018 Premiums." October 10, 2017.

while on the go. On April 19th, we announced a new partnership with Comcast to develop a patient-centered portal that will include telemedicine capabilities alongside other digital health features. Our goal is to have these technologies improve access to primary and preventive care, ultimately reducing preventable ER visits and hospital readmissions.

On flexibility, policy changes from Congress and CMS will allow plans to offer an array of supplemental benefits and reduced cost-sharing to our most vulnerable members with chronic conditions. Recent policy changes will enable plans to work more closely with the provider community and local community organizations to ensure our members select the most appropriate plan and obtain clinical care while reducing their cost-sharing obligation. Such changes, like lowering out-of-pocket costs for diabetic supplies or waiving a copay to see a certain specialist, will hopefully improve beneficiary outcomes and generate cost savings in the long term.

We're hopeful that these reforms, in addition to others not listed here, will spur new models of care management that increase value for Medicare Advantage beneficiaries and taxpayers. At Independence, our goal is to use innovative plan designs to begin focusing more heavily on the social determinants of health that can impact our members as much as medications or wellness visits do now. We were encouraged to see CMS recently issue guidance on the types of new supplemental benefits that plans could offer in the future, including home

improvement services to prevent falls, adult day care services, and caregiver support, to name just a few[5].

For instance, Independence is exploring the possibility of offering a nutrition benefit for recently discharged hospital patients. Shopping for groceries or attempting to cook can be extremely difficult for a senior recovering from an acute inpatient stay. Lack of access to quality meals and the struggle to secure them can impede a patient's recovery. Research studies, including one by the Metropolitan Area Neighborhood Nutritional Alliance (MANNA), a local non-profit in Philadelphia, have shown that increased access to nutrition services can decrease hospital readmissions and improve patient outcomes[6]. Access to transportation is often identified as another barrier to care, with an estimated 3.6 million Americans foregoing medical care due to this obstacle[7]. We hope to more adequately address transportation needs for our members thanks to the new flexibility in benefits.

Ongoing Areas for Collaboration

Encounter Data

Independence remains excited about the future and we know there are areas where additional collaboration between CMS and plans will enhance quality and value for our members. We are pleased that CMS, members of Congress, and other key stakeholders are aware of the debate surrounding the Encounter Data System (EDS) and are committed to exploring

[5] CMS: "HPMS Memo Uniformity Requirements" (Guidance on MA Benefit Design Flexibility). April 2018.
[6] Journal of Primary Care & Community Health: "Examining Health Care Costs Among MANNA Clients and a Comparison Group." June 2013.
[7] American Hospital Association: "Social Determinants of Health Series: Transportation." November 2017.

ways to improve it. We support the goal of the EDS system, which is to increase transparency and more accurately compensate plans for the relative health risks of their members.

Recent reports published by the Government Accountability Office (GAO) and the HHS Office of Inspector General (OIG) have documented implementation concerns with the use of the EDS as a source of diagnosis for risk adjustment purposes[8-9]. As the Blue Cross and Blue Shield Association indicated in its comments to CMS in March, plans remain in the dark about how certain claims are translated into the system, and they are generally frustrated with the long lag time between when plans submit data and when the agency can render a decision about how it will be used for risk adjustment purposes.

CMS has reissued these return files – called 'MAO-004 reports' – multiple times in the past two years. We continue to believe that, since CMS issues the MAO-004 report on a monthly basis – in contrast to other risk adjustment return files, which are provided on a daily basis – we cannot identify errors in EDS and resubmit data in a timely fashion. Furthermore, CMS could improve the process through which encounter data payment and operational issues are approached by having regular, transparent, and structured collaboration with the industry.

While we recognize that the EDS system is improving, it may be prudent for CMS and Congress to curtail the use of this data for program payment purposes until processing times improve and plans have more clarity on how submissions are adjudicated. Otherwise, the EDS

[8] GAO. "Medicare Advantage: Limited Progress Made to Validate Encounter Data Used to Ensure Proper Payments." January 2017.
[9] OIG: "Medicare Advantage Encounter Data Show Promise for Program Oversight, But Improvements Are Needed." January 2018.

system could act as an arbitrary reduction in funding to the program, which was not its intended goal.

The Star Rating System

Independence applauds the value-based intent of the Star Rating System, which ties reimbursement to measurable performance on over 40 different clinical and patient experience metrics. This has driven a profound reorganization in how plans operate. For example, it has solidified our role as partners in care working with our provider community to ensure that necessary screenings take place, chronic conditions are properly managed, and readmission rates are being curbed, all of which promote better health for beneficiaries.

Nevertheless, the program is in need of reforms that will enable the scoring process to be more reflective of true quality in a way that helps beneficiaries interpret meaningful differences between plans. We encourage CMS to develop new Star measures that push plans to continue improving their members' health outcomes. At the same time, the agency should also consider reorienting how it calibrates the existing measures.

For this we recommend three actionable policies. First, we urge CMS to retire "topped out" measures on which almost all plans are doing exceedingly well, and where differences among plans are not statistically significant. Our second recommendation is to consider regional adjustments for Star Ratings, which may better account for differences in beneficiary populations. Regional adjustments could also provide additional information to beneficiaries on local performance of national contracts. Lastly, while member experience is an important factor

for indicating quality, the customer (CAHPS) surveys conducted by CMS are not always the most useful proxy. Our experience has been that the questions are subjective, the surveys are conducted on paper, and they are sometimes sent to members in different plans by mistake. In short, they do not give plans meaningful feedback on how to improve quality or the beneficiary experience, despite accounting for 17 percent of a plan's Star score – a disproportionate weight for these measures.

That said, we look forward to learning more about CMS's proposal to create a technical expert panel of representatives from various stakeholder groups to offer input on the program's framework, measures, and methodology. Additionally, the agency's plan to implement material changes through the formal rulemaking process as opposed to the annual call letter will enable greater dialogue and afford plans more time to operationalize changes.

In closing, we want to reiterate how pleased we are with many of the policy changes Congress and CMS have made recently to allow plans more flexibility in addressing social determinants of health and providing coordinated care for our members in a holistic way. We also applaud the efforts to accelerate the transition to value-based payment as we move away from a volume-based system. We are eager to see how future program reforms can enable plans to continue improving our members' experience, health, and wellbeing.

On behalf of Independence Blue Cross and our CEO Dan Hilferty, I want to thank the members of this Committee for the opportunity to share my thoughts with you today. We are excited to be part of this important discussion and we look forward to working with

all of you to ensure the continued success of the Medicare Advantage program. Our seniors are counting on us.