



TO: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS)

FROM: The Commonwealth Fund

DATE: August 30, 2022

SUBJECT: CMS-4203-NC; Request for Information on Medicare Advantage

Thank you for the opportunity to respond to your [request for information](#) on various aspects of the Medicare Advantage (MA) program on behalf of the Commonwealth Fund. The Fund supports independent research on health care issues and makes grants to promote better access, improved quality, and greater efficiency in health care, particularly for underserved communities, including people of color, people with low income, and those who are uninsured.

FOUNDATIONAL RESOURCES ON MEDICARE ADVANTAGE

“Taking Stock of Medicare Advantage”

The Commonwealth Fund and Arnold Ventures supported [a series of blog posts](#) that examine the challenges and opportunities for MA plans on issues regarding payment, risk adjustment, choice, quality, special needs plans, and benefit design. We asked diverse groups of experts how well different features of the program are working and how they might be strengthened for the future.

The Medicare Data Hub

The Commonwealth Fund’s [Medicare Data Hub](#) provides up-to-date facts, research, and analyses on the following topics: Medicare solvency and spending, MA, traditional Medicare (TM), prescription and outpatient drugs, enrollment and beneficiary characteristics, COVID-19, international comparisons, and the Medicare marketplace.

“Medicare Advantage: A Policy Primer”

[This primer](#) explores key differences between MA plans and TM in terms of access to providers, managed care, covered benefits, costs (to both the government and beneficiaries), and quality of care. It also explains how MA plans are paid and describes the choice and competition landscape among plans.

“Medicare Advantage vs. Traditional Medicare: How Do Beneficiaries’ Characteristics and Experiences Differ?”

[This issue brief](#) illustrates that MA enrollees do not differ significantly from beneficiaries in TM in terms of their age, race, income, chronic conditions, satisfaction with care, or access to care, after excluding SNP enrollees. Both groups reported waiting more than a month for physician office visits. Similar shares of MA and TM enrollees report out-of-pocket costs that make it difficult to obtain care. The care management services provided by MA plans appear to neither impede access to care nor reduce concerns about costs. Overall, the analysis highlights substantial barriers to care that all beneficiaries seem to be experiencing.

ADVANCE HEALTH EQUITY

Advancing Social Drivers of Health (DOH)

The past ten years of experimentation within the Center for Medicare and Medicaid Innovation (CMMI) have shed light on five areas where CMS can focus efforts to advance health equity through payment and delivery system reform:

- Improve data collection on race, ethnicity, and DOH;
- Monitor the impact of payment programs on health equity (e.g., reported quality or outcomes by race/ethnicity, geography, or social needs) by building these analyses into evaluations;
- Shift from pay-for-performance to invest-for-equity by strengthening investment in under-resourced communities using proxy measures for socioeconomic disadvantage;
- Ensure innovative models reach under-resourced communities by increasing safety net provider participation via financial support and technical assistance; and
- Align incentives across programs.

Source: <https://www.commonwealthfund.org/blog/2022/advancing-health-equity-through-federal-payment-and-delivery-system-reforms>

Special Needs Plans (SNPs)

Enrollment in SNPs has nearly tripled in the past decade, with the most growth seen among dually eligible beneficiaries enrolling in D-SNPs. Compared with other MA plans, SNPs serve disproportionate shares of Black and Hispanic people and individuals with low incomes. People enrolled in SNPs are a diverse group: some are relatively healthy, but others have severe chronic conditions, mental illnesses, cognitive impairments, or permanent disabilities.

SNPs are a good platform for tailoring care to people’s needs, but not enough is known about whether and how SNPs are customizing care and affecting beneficiaries’ health. Policymakers could consider:

- Fine-tuning quality measures to detect differences in treatment and outcomes among different subpopulations (e.g., younger beneficiaries with disabilities vs. frail, older adults);
- Rating the performances of each type of SNP separately, rather than combining quality scores of plans of different types (as well as SNPs and non-SNPs);
- Incentivizing studies to explore which services help which SNP enrollees, as seen in CMS’ proposed rule requiring D-SNPs to ask beneficiaries about certain drivers of health; and
- Support and incentivize states to promote integrated care.

Source: <https://www.commonwealthfund.org/blog/2022/taking-stock-medicare-advantage-special-needs-plans>

EXPAND ACCESS: COVERAGE AND CARE

Supplemental Benefits

Since 2019, MA plans have had the flexibility to address enrollees’ unmet needs by targeting benefits to beneficiaries with chronic illnesses and offering a wider array of “primarily health-related” benefits. As of 2020, plans can also offer Special Supplemental Benefits for the Chronically Ill (SSBCI) — nonmedical services such as pest control.

Adoption of SSBCI was relatively limited initially: only 6 percent of MA plans offered these benefits in 2020. The relatively small percentage of plans offering SSBCI in 2020 may be due in part to operational

and logistic challenges. But based on 2021 plan benefit offerings, the trend toward more benefits that address social determinants of health will continue.

Plans offering additional, primarily health-related supplemental benefits increased substantially between 2018 and 2020, including meal provision (20% of plans to 46% of plans), transportation (19% to 35%), in-home support services (8% to 16%), and acupuncture (11% to 20%). None are as widely offered as some dental and hearing benefits.

We offer considerations for stakeholders working to increase the adoption and efficacy of supplemental benefits, better serve high-need members, and address social drivers of health:

- Develop strategies for supporting partnerships between plans and third-party organizations providing supplemental benefits;
- Help beneficiaries compare plans based on supplemental benefits; and
- Increase data collection to build an evidence base for providing supplemental benefits, including reporting on the number of individuals who receive these benefits, in which locations, and at what frequency.

Sources:

<https://www.commonwealthfund.org/publications/issue-briefs/2021/feb/medicare-advantage-plans-supplemental-benefits>;
<https://www.commonwealthfund.org/blog/2021/increasing-availability-new-supplemental-benefits-medicare-advantage>

Benefit Design: Cost Sharing and Prior Authorization

MA plans can vary what they charge for specific medical services, unlike TM, which has a set cost-sharing structure. One expert suggested giving plans greater flexibility to increase cost sharing for low-value services and argued against standardization, saying it did not make sense to create private plans and then constrain what they do.

Some experts raised concerns about the ubiquity of prior authorization requests, noting they are increasing as more people enroll in MA. The burden of responding to prior authorization requests falls on providers, who argue the requests divert their attention from treating patients and delay necessary care. A related concern is that plans are using proprietary, algorithm-driven systems to make decisions (including those requiring prior authorization) about approving coverage for services.

Source: <https://www.commonwealthfund.org/blog/2022/taking-stock-medicare-advantage-benefit-design>

Consumer Choice Landscape

Choosing among MA plans can be difficult, even for the savviest consumers. Beneficiaries must pay close attention to the types of benefits and services provided, but most aren't making informed or active decisions. Instead, many choose plans based on advertising, word-of-mouth, or brand loyalty, then stay with those plans year after year, even if another plan would better serve their interests.

The consequences of not making informed choices are significant. One study found some MA beneficiaries paid up to \$1,000 more annually for plans that didn't offer any more generous benefits or a wider network of providers than cheaper plans. When faced with high out-of-pocket costs, some people skip care and jeopardize their health. One study found that when people were defaulted into Part D plans that didn't cover the drugs they need, many simply stopped taking their medications.

Experts' suggestions for helping beneficiaries make more informed choices include:

- More robust oversight of plan and marketing communications;

- Standardizing and curating plans;
- Strengthening public reporting on plan quality and variation;
- Experimenting with defaults;
- Keeping beneficiaries' options open; and
- Giving MA plans incentives or mandates to be proactive in helping enrollees understand their benefits.

Source: <https://www.commonwealthfund.org/blog/2022/taking-stock-medicare-advantage-choice>

Agents and Plan Choice

Licensed agents and brokers contract with plans through a commission-based model that compensates them on a per-enrollment basis.

Nearly all (96%) MA and Part D plans contract with agents, who are not required to represent all available plans. An analysis across five markets of three large, online broker plan selection tools found that, on average, each tool includes less than half (43.3%) of MA plans and less than two-thirds (64.7%) of Part D plans. In the analysis of online searches, more than one-third (36%) of results from the first page led to agents' or health insurers' websites.

While agents play an important role for beneficiaries, the existing approach affects information about coverage options and may not optimally serve beneficiaries' needs by limiting their choice. The products they sell are typically dictated by the plans with which they have contracts. This narrowing of choice is not immediately apparent to consumers, who need transparency to understand when financial incentives may be guiding the recommendations they receive.

Policymakers could consider:

- Reimagining compensation to ensure that incentives are more closely aligned with the aims of providing guidance and counsel to beneficiaries and without the risk of competing financial interests;
- Redesigning Medicare.gov in a way that would allow beneficiaries to easily evaluate and comprehensively compare their private plan options;
- Cultivating information on agent quality, such as providing a rating of customer satisfaction; and
- Expanding support of nonprofit and government programs to ensure that more beneficiaries can find, access, and utilize these services.

Sources:

<https://www.commonwealthfund.org/blog/2021/agent-commissions-medicare-and-impact-beneficiary-choice>

<https://www.commonwealthfund.org/publications/fund-reports/2021/apr/how-agents-influence-medicare-beneficiaries-plan-choices>

<https://www.commonwealthfund.org/blog/2020/making-medicare-more-navigable>

DRIVE INNOVATION TO PROMOTE PERSON-CENTERED CARE

CMMI DOH Opportunities

Social, economic, and location-based drivers of health (DOH) impact health—especially for Medicare and Medicaid beneficiaries, many of whom are frail, have low incomes, or have complex medical needs. CMMI addresses DOH in many of their health care payment and care delivery models, but lessons from them have not been synthesized.

In 23 of 40 models, participants addressed DOH-related needs to some degree. For some models, CMMI required these activities; in others, participants voluntarily pursued them. Common strategies included screening beneficiaries for nonmedical, social needs and/or referring beneficiaries to social services and community-based organizations. Participants were rarely required to assess or address DOH needs, however, and evaluations, when conducted, were not standardized. Participants noted that greater financial support, financial incentives, and technical assistance would enable them to better address patients' DOH needs. CMMI might also consider requiring standardized DOH screening and incorporating performance measures in evaluations.

Source: <https://www.commonwealthfund.org/publications/issue-briefs/2022/aug/how-cmmi-payment-delivery-reforms-address-drivers-health>

Quality Reporting and Bonuses

Many experts agreed that while the star ratings help beneficiaries screen out the lowest-performing plans, they do not help discern how well plans serve people like themselves. It is also hard for beneficiaries to assess access to care and quality of care in local markets because quality scores are combined across plans operating in different states and those serving different types of enrollees (e.g., plans that focus on people with serious chronic illnesses or disabilities and those that do not). This practice also makes it difficult for federal regulators to assess trends in plan performance over time.

Several of the experts we spoke with consider the quality bonuses unjustifiably expensive and ineffective. Studies have found that neither the single nor double bonuses are associated with improvements in quality. Most experts thought the public reporting of star ratings was enough to incentivize plans to invest in quality improvement, obviating the need for additional payments based on performance.

How does MA compare to TM when it comes to quality of care? The experts pointed to robust evidence that hospitalizations are lower for enrollees in MA, but the reasons are unclear. They also acknowledged the difficulty of making head-to-head comparisons: researchers have much more information on health care service use for people in TM than those in MA. The experts suggested that CMS could compare the two programs by looking at outcomes for patients with complex medical needs who would ostensibly benefit from the case management services MA plans provide. Other important research topics suggested by the experts include the factors driving disenrollment from MA plans as patients become sicker, and how plans' prior authorization requirements affect quality of care.

The experts said that CMS could consider:

- Placing greater weight on clinical measures and less on customer service metrics to keep the focus on areas consumers cannot judge for themselves.
- Setting absolute performance targets and reward plans that make progress, rather than limiting rewards to those with four or more stars.

We asked experts whether quality measurement in MA plans should be adjusted to account for the fact that some enrollees face more social and economic barriers in accessing medical care and adhering to treatment recommendations. One saw merit in doing so, saying it would reduce any incentive plans have to focus on populations whose needs may be easy to address; another worried that adjusting plan ratings for enrollees' social risks might lower the bar for performance. One alternative suggested by experts would be to track quality for different populations and use the data to target additional payment to plans and providers serving enrollees with complex needs.

Source: <https://www.commonwealthfund.org/blog/2022/taking-stock-medicare-advantage-quality-reporting-and-quality-bonuses>

Primary Care Investment

Medicare, like other health care payers, continues to test alternative primary care-focused payment and delivery models. Evaluations of Medicare's primary care models to date have found they do not meet statutory criteria for reducing overall spending or improving quality, both key goals for CMMI demonstrations. The two newest primary care payment models offer more flexibility than prior approaches. Providers favor this flexibility but also suggest replacing fee-for-service with alternative payment arrangements and shifting more care to primary care providers.

To increase the likelihood that models achieve overall cost savings and/or quality improvement, one option for CMMI is to test approaches that add flexibility and significantly increase the share of total health care spending devoted to primary care.

MA plans can influence their enrollees' care choice through their provider network, cost-sharing requirements, and other utilization management tools. Adding similar tools to allow models to influence enrollees' care choices could increase the likelihood of meeting CMMI's savings and quality goals.

Source: <https://www.commonwealthfund.org/publications/issue-briefs/2022/mar/increasing-medicares-investment-primary-care>

SUPPORT AFFORDABILITY AND SUSTAINABILITY

Enrollment

Declining enrollment in TM poses challenges to the Medicare program as well as the rest of the US health care system. One of the most apparent challenges is the need to find new ways to set MA payment rates. Currently, MA plans in local markets are paid to cover Medicare benefits based on the average costs of providing those same benefits to patients in TM within the same market. Yet, basing payments on the costs of covering remaining enrollees in TM will be less appropriate as these individuals become less representative of the Medicare population—and thus less meaningful as a benchmark for MA performance.

Other challenges include: the impact of TM on shaping quality standards and measures for the whole health care system; the availability of TM claims data to compare patterns of care across the country; TM support for rural health care centers and graduate medical education; and TM innovations in payment models.

An MA-dominated system also raises questions about how Medicare would work through private plans to achieve the many other public purposes that Medicare has served. The Medicare program must also consider how to sustain Medicare's record of innovation in payment and delivery system reform in a program in which the nature and results of innovation are increasingly the proprietary property of private entities.

Source: <https://jamanetwork.com/journals/jama/article-abstract/2792809>

Beneficiary Affordability

Unlike most older adults in other high-income countries, those in the U.S. face significant financial barriers to getting health care, despite Medicare's universal coverage. While Medicare offers significant

protections for older adults against high health care costs, it does not cover the full cost of care. Out-of-pocket costs, including deductibles and coinsurance for some services, result in postponed care for some Medicare beneficiaries, including many Black and Latinx older adults who have low incomes, complex health needs, and difficulties paying medical bills.

One-fifth of older Americans spent more than \$2,000 out of pocket on health care in the past year. Only a small share of older adults in most of the other surveyed countries had such high out-of-pocket health costs. Similarly, a higher share of older Americans reported forgoing health care because of costs. Rates of skipping dental care because of costs were similar for older adults in nations that do not offer coverage of such services, including the U.S.

In a series of [Fund-supported focus groups held by PerryUndem](#), many Black and Latinx older adults told stories of being uninsured and struggling to afford care and how they thought enrolling in Medicare would put an end to these worries. They expressed frustration that they must still consider costs before seeking care. Participants also discussed how unexpected or high costs caused them to second-guess or delay care. This is consistent with previous research, which has found that roughly 10 percent of beneficiaries postpone or avoid care because of costs.

Not only do participants feel costs are too high, but they also feel it is their responsibility to stay on top of their costs. Many share experiences of questioning bills, checking with their insurance plans, and challenging their providers.

They want more price transparency to ensure they know upfront how much their care will cost. Some also want health coverage—namely supplemental health plans—to be more affordable and support expansions in affordable health coverage.

Sources:

<https://www.commonwealthfund.org/publications/surveys/2021/oct/when-costs-are-barrier-getting-health-care-older-adults-survey>

<https://www.commonwealthfund.org/blog/2022/older-black-and-latinx-adults-talk-about-affordability-challenges>

Medicare Trust Fund Solvency

The Medicare Hospital Insurance Trust Fund is projected to become insolvent in 2028. Ensuring that the trust fund can sufficiently cover the entire cost of beneficiaries' care requires reforms that increase revenues and reduce unnecessary spending. To that end, policymakers could consider the following reforms to MA, as suggested by Medicare thought leaders:

- Enhance the coding intensity adjustment;
- Adjust MA payments to account for reduced utilization stemming from COVID-19;
- Change the framing of MA premium prices to beneficiaries;
- Base MA benchmarks on competitive bidding;
- Define benchmarks based on local MA plan bids rather than local costs in TM to push bids toward the costs of a standardized benefit package;
- Reform the quality bonus program to be budget-neutral, redistributing quality bonuses and penalties among plans.

Sources:

<https://www.commonwealthfund.org/blog/2021/improving-financial-condition-medicare-health-insurance-trust-fund>

<https://www.commonwealthfund.org/blog/2021/addressing-medicare-solvency-will-require-both-revenue-and-spending-changes>

MA Plan Profits and Medical Loss Ratios

Most MA enrollees are served by MA plans that are large insurers that sell insurance to multiple markets and that have multiple related and unrelated businesses. The related businesses can account from about 20% to as much as 71% of spending. For health plans serving most MA beneficiaries, related businesses offer an opportunity for pricing practices within the parent firm umbrella that can shield profits from the terms of MLR regulations. The extent to which parent companies engage in such practices is yet unknown, but the potential for these practices places smaller plans without related businesses at a competitive disadvantage. CMS guidance on transfer prices and monitoring of MLR reporting is quite limited. This may change in the future as the 2022 payment regulations governing MA plans call for renewed efforts to monitor reporting connected to MLR regulations.

Source: <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2022/07/13/profits-medical-loss-ratios-and-the-ownership-structure-of-medicare-advantage-plans/>

Plan Payments

If the primary purpose of Medicare payments to private plans is to use the private sector to achieve greater efficiency and savings for Medicare, this could be achieved by lowering reimbursements. But if MA is viewed as a tool to provide extra benefits to enrollees, lowering payment may mean taking benefits away. To guard against this, one expert interviewed suggested starting modestly with a 2 percent across-the-board payment cut (a recommendation the Medicare Payment Advisory Commission (MedPAC) also has made). CMS could also set benchmarks by averaging fee-for-service spending at the local and national levels, reforming the system that currently boosts payments to attract plans to counties with the lowest FFS spending. Another expert thought it was possible to implement larger cuts — on the order of 4 percent or more — without harming beneficiaries. Other experts interviewed were interested in using competitive bidding among plans to bring down payment rates, saying CMS has sufficient information to set benchmarks using plan-submitted information rather than basing them on projected FFS spending. Even if the existing benchmarking system is retained, many thought counties were too small a unit of measure to set benchmarks. One thought that bundling counties together and requiring plans to serve an entire region might increase competition.

The current rebate system favors counties where TM spending is high, such as Miami's Dade County. MA beneficiaries there receive more supplemental benefits than those in areas of the country where health care spending is lower, like Iowa or Minnesota. One option suggested by interviewed experts is to convert rebates to a cash equivalent and give beneficiaries the option of how to use them — from paying down premiums to purchasing personalized supplemental benefits. Another option suggested by experts is to place a financial cap on the actuarial value of supplemental benefits and/or standardize the menu of supplemental benefits available. At minimum, many experts wanted to see greater transparency around rebate dollars to understand how they are applied and the value of the benefits they are used to purchase. One concern expressed by the experts is whether plans are purchasing benefits from entities owned by their plan's parent company at inflated prices to increase profits.

Another fundamental question is whether MA benchmarks should be tied to FFS spending. This question becomes more pressing as MA enrollment increases. Some of the experts we interviewed suggest if we continue to use FFS spending as the benchmark, we should make sure the benchmarks are not inflated by inefficiencies in the FFS program, including greater use of skilled nursing facilities or institutional care in some regions of the country. Benchmarks also could be adjusted downward to account for the effects of Medigap policies, the supplemental insurance that many people buy to defray the cost of coinsurance in the FFS program.

Source: <https://www.commonwealthfund.org/blog/2022/taking-stock-medicare-advantage-payment>

Risk Adjustment

When asked for policies in need of change, all experts pointed to the “coding intensity adjustment” — an across-the-board cut that CMS makes to plans’ payments meant to adjust for the fact that some plans may be coding too intensely. CMS has the authority to raise or lower the amount of this adjustment; it now reduces all plans’ payment by 5.91 percent. Experts view the coding intensity adjustment as a blunt instrument, affecting all plans regardless of their behavior. They noted that even with the adjustment, payments to MA plans continue to be above what CMS spends on comparable beneficiaries in TM.

Instead of an across-the-board payment cut, some said there should be targeted efforts. For example, CMS could set a threshold level of coding and audit plans that exceed that threshold to make sure their risk assessments are accurate.

Because the current RA model relies heavily on past medical spending to determine future payments, it could worsen inequities in the system. For example, the model may underestimate the costs of caring for populations that use fewer services. These populations may include racial and ethnic minorities and rural residents living in communities with fewer providers.

Experts suggested that one way RA can be improved is by modifying the data on which the model is built, such as by using two years’ worth of medical claims rather than one. Some experts recommended that every diagnosis in a health assessment be associated with some actual treatment delivered to be counted for RA.

Source: <https://www.commonwealthfund.org/blog/2022/taking-stock-medicare-advantage-risk-adjustment>