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TO: Centers for Medicare and Medicaid Services, Department of Health and Human Services

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DATE: May 16, 2024

RE: CMS–4207–NC; Request for Information: Medicare Advantage Data

Thank you for the opportunity to respond to your request for information on Medicare Advantage (MA) data. Informed by Commonwealth Fund-supported research and conversations with experts and stakeholders in the field, we offer considerations for the Centers for Medicare and Medicaid Services (CMS) in three categories: MA supplemental benefits, MA denials and appeals, and brokers and marketing.[1]

Supplemental Benefits

MA plans provide supplemental benefits that traditional Medicare (TM) does not cover, such as dental and vision care or allowances for over-the-counter medications, fitness benefits, or groceries. CMS and the CHRONIC Care Act of 2018 have enabled MA plans to flexibly offer nonmedical health-related services that may help their enrollees maintain or improve health, as well as meet the needs of beneficiaries who are chronically ill.[2] These benefits have the potential to help meet beneficiaries' social needs that drive their overall health and well-being, such as transportation, nutrition, and home modifications.[3]

However, little is known about how beneficiaries utilize these benefits, which ones they value, and the restrictions they may face in using benefits, which can also vary across plans. A recent Commonwealth Survey of a nationally representative sample of Medicare beneficiaries ages 18 and older found that just 69% of those enrolled in MA plans had used one or more of their plan's supplemental benefits in the

[1] The views presented here are those of the authors and not necessarily those of the Commonwealth Fund or its directors, officers, or staff.
[2] Martha Hostetter and Sarah Klein, "Taking Stock of Medicare Advantage: Benefit Design," *To the Point* (blog), Commonwealth Fund, Mar. 31, 2022. https://doi.org/10.26099/r575-gg76.
[3] Thomas Kornfield et al., *Medicare Advantage Plans Offering Expanded Supplemental Benefits: A Look at Availability and Enrollment* (Commonwealth Fund, Feb. 2021). https://doi.org/10.26099/345k-kc32.

past year.[4] Dental care, vision care, and an allowance for over-the-counter medications were the benefits most often used. Of the 31% who said they did not use any supplemental benefits in the past year, the majority (63%) said they hadn't needed the benefits, 24% said they did not know what benefits their plan offers, 9% said the benefits are hard to use, and 4% said it costs too much to use the benefits; 6% cited additional reasons.

Supplemental benefits in MA are financed by rebates CMS pays to plans, which have increased dramatically over the past decade, rising from $12.0 billion in 2014 to $60.5 billion in 2023.[5] Collecting and releasing additional data related to supplemental benefits would enable researchers and policymakers to better understand their cost impacts for plans and beneficiaries, as well as MA beneficiaries' uptake of benefits offered and potential barriers limiting their use. CMS should consider collecting data on:

- Networks used for supplemental benefits (e.g., dental, vision) if networks are used.
- Percentage of providers in county included in networks, by supplemental benefit, if networks are used.
- Projected and actual utilization of supplemental benefits, by type of supplemental benefit.
- Encounter data for dental claims.
- Amount of supplemental benefits used by benefit type and Medicare ID number.
- Beneficiary liability for supplemental benefits, among beneficiaries who used the benefit, by type of supplemental benefit, including average per capita liability among users per contract-plan ID, and liability for users by Medicare ID number.
- Plan payment for supplemental benefits, by type of supplemental benefit. Includes reporting of plan payment per beneficiary eligible for the benefit and plan payment per user.
- Qualitative explanation of how supplemental benefit utilization influences either care management recommendations or care plans.
- Evidence that supplemental benefit improves health outcomes or reduces the need for other health services.
- Identifying subcontractors used to provide supplemental benefits.

Denials and Appeals

Prior authorization allows MA plans to ensure services and payments are appropriately used. However, the process for prior authorization, including denials and appeals, can create delays in accessing services, and its application can vary widely by MA plan. The Commonwealth Fund 2024 Value of Medicare Survey found that 22% of beneficiaries with an MA plan said their care was delayed because it required approval, such as prior authorization, compared to 13% of beneficiaries in TM.[6] With so many

[4] Gretchen Jacobson et al., *What Do Medicare Beneficiaries Value About Their Coverage?: Findings from the Commonwealth Fund 2024 Value of Medicare Survey* (Commonwealth Fund, Feb. 2024). https://doi.org/10.26099/gq43-qs40.

[5] The 2024 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, https://www.cms.gov/oact/tr/2024.

[6] Gretchen Jacobson et al., *What Do Medicare Beneficiaries Value About Their Coverage?.*

beneficiaries in MA experiencing such delays, it is important to ensure that plans are using prior authorization appropriately and that it is not negatively impacting beneficiaries' access to care.[7]

A 2018 federal audit found that between 2014 and 2016, MA plans overturned 75 percent of payment denials that had been appealed, yet beneficiaries and providers appealed only 1 percent of such denials.[8] A subsequent 2022 federal audit found that 13% of denials were for services that met TM's coverage rules, like medical necessity.[9] Evidence of improper application of, or errors in, denials suggests that requiring plans to share more information about their coverage determinations and processes could help ensure beneficiaries are not being denied access to care that should be covered. To help put the data on MA denials into context, it would be beneficial to have similar data on denials in TM from the Medicare Administrative Contractors.

Experts agreed that not enough is known about prior authorization in MA; how much time there is between request and approval, how many requests were denied and with which services those requests were associated. Are there some services that have more denials than others? Are their certain demographic groups that experience more delays in care due to prior authorization?

Information that would be most effective at answering questions around denials and appeals in MA and TM include:

- Percent of claims for the service that were approved with prior authorization, by service and plan (applicable for MA plans only).
- Percent of claims for the service that were denied because of lack of prior authorization and percent denied for other reasons, by service and plan (applicable for MA plans only).
- Number of beneficiaries who died while waiting for prior authorization by plan (applicable for MA plans only).
- Average, minimum, and maximum time between prior authorization request and approval by plan (applicable for MA plans only).
- Reporting denied services by standard codes, such as ICD-10, CPT and HCPCS codes for both MA and TM. Current reporting does not require these codes to be used.
- Percent of denials that were appealed by plan for both MA and TM.
- Percent of appeals that were overturned by plan for both MA and TM.
- Rate of denials by clinical condition and point of care by plan for both MA and TM.
- Reporting whether review of denied service involved a medical necessity review, by denied claim for both MA and TM.

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[7] Kelly E. Anderson, Michael Darden, and Amit Jain, "Improving Prior Authorization in Medicare Advantage," *JAMA* 328, no. 15 (October 2022): 1497-1498, https://doi.org/10.1001/jama.2022.17732; Kelly E. Anderson et al., "Medicare Advantage coverage restrictions for the costliest physician-administered drugs," *American Journal of Managed Care* 28, no. 7 (July 2022), https://doi.org/10.37765/ajmc.2022.89184.

[8] U.S. Department of Health and Human Services, Office of Inspector General, *Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials* (HHS OIG, September 2018), https://oig.hhs.gov/oei/reports/oei-09-16-00410.asp.

[9] U.S. Department of Health and Human Services, Office of Inspector General, *Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care* (HHS OIG, April 2022), https://oig.hhs.gov/reports-and-publications/all-reports-and-publications/some-medicare-advantage-organization-denials-of-prior-authorization-requests-raise-concerns-about-beneficiary-access-to-medically-necessary-care/.

- Reporting whether any artificial intelligence (AI) applications were used in the review of the denied claim for both MA and TM.
- Reporting a plan's process to remediate denials by plan for MA only.
- Reporting whether subcontractors were used to assess claims payment by plan for MA only.
- Percent of claim denials that were denied because of inaccurate or incomplete data on the claim by plan for both MA and TM.
- Percent of claims partially paid as a percentage of all claims by plan for both MA and TM.

Disenrollment

Issues with delays in care, denials of services, or misleading marketing may drive beneficiaries to disenroll from their MA plan. In 2021, MA plans averaged a disenrollment rate of 17%, up from 10% in 2017.[10] Among the dominant reasons given for disenrollment was problems with physician or hospital coverage under the plan, reported by nearly one-quarter of beneficiaries. More information to characterize beneficiary dissatisfaction with MA plans and why they leave plans is needed to better understand disenrollment.

Experts said the following information would help answer questions around disenrollment in MA:

- Number of grievances filed, by reason for grievance and by plan.
- Number of providers departing the plan network, per plan year and by plan.
- Number of beneficiaries who disenrolled from the contract-plan, including rapid disenrollments, special enrollment period disenrollments, open enrollment period disenrollments, and Medicare Advantage open enrollment period disenrollments.
- Share of beneficiaries who disenrolled from the contract-plan who had a claim denied.

Brokers and Marketing

Given the complexity of the Medicare coverage landscape and plan selection process, beneficiaries often rely on licensed agents or brokers to help them choose their benefit structure (e.g., TM combined with a stand-alone Part D plan and/or Medigap vs. Medicare Advantage), select their plans, and use their coverage.[11] However, beneficiaries lack information into how brokers filter their plan options and how brokers' financial incentives might affect the advice they give.[12] Since 2022, brokers have had to disclose to clients whether they offer all plans in an area, though they are not required to disclose what proportion of plans in the area they sell, or how their compensation differs across plans.[13]

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[10] Janet P. Sutton, "Medicare Advantage Disenrollment Rates Can Help Beneficiaries Make Informed Decisions," *To the Point* (blog), Commonwealth Fund, Feb. 22, 2023. https://doi.org/10.26099/d0fa-j742.
[11] Riaz Ali et al., *How Agents Influence Medicare Beneficiaries' Plan Choices* (Commonwealth Fund, Apr. 2021). https://doi.org/10.26099/32d2-pz96; Gretchen Jacobson et al., *The Private Plan Pitch: Seniors' Experiences with Medicare Marketing and Advertising* (Commonwealth Fund, Aug. 2023). https://doi.org/10.26099/a9bz-by48.
[12] Faith Leonard et al., "The Challenges of Choosing Medicare Coverage: Views from Insurance Brokers and Agents," feature article, Commonwealth Fund, Feb. 28, 2023. https://doi.org/10.26099/wb6n-yf79.
[13] Ibid.

Brokers and agents are paid by insurers for enrollments and renewals. Over the past several years, brokers' payment structures have raised questions over whether or how brokers balance their volume-driven financial incentives with beneficiaries' needs, preferences, and constraints.[14] Recent Medicare Advantage and Part D rulemaking by CMS adds guardrails to stop anti-competitive steering, reduce variability in payments, and prohibit certain contract terms like volume-based bonuses for enrollment.[15] These changes build on past rulemaking to address beneficiaries' marketing complaints and better ensure that their needs are centered in the plan marketing and enrollment process.[16]

To shed more light on brokers' financial incentives and how they might affect beneficiary enrollment patterns, CMS should consider collecting more data on brokers' relationships with insurers and providers.[17] Moreover, quantifying beneficiaries' complaints against brokers and the extent of plan disenrollment would also help with the oversight of aggressive, misleading marketing tactics and identification of potential bad actors. CMS should consider requiring insurers to report the following data:

- Number of captive brokers, i.e., the number of brokers who contractually only sell plans by one insurer.
- Number of sales representatives employed by the insurer.
- Number of brokers who receive a W-2 or 1099.
- Brokers certified to sell the insurers' plans, by National Producer Number (NPN). This information would provide insight into the proportion of plans in an area that a broker is certified to sell.
- Total amount paid in commissions to brokers, agents, and brokerages for Medicare enrollments, separated by Medicare Advantage, Part D, and Medigap commissions.
- Percent of new enrollees who were rapidly disenrolled per plan. A 2022 report from Senate Finance Committee majority staff recommended closer monitoring of disenrollment rates from plans, as high rates may suggest that enrollees were misled by aggressive marketing tactics.[18]
- Place of a beneficiary's plan enrollment (e.g., doctor's waiting room, other in-person enrollment, telephonic, online). Given the range of settings for allowable marketing and sales activities, such data would improve oversight of where and how beneficiaries are being contacted.
- Number of beneficiary complaints about brokers, and reason for complaint, by broker (NPN). CMS should also consider ways to place this data in a standardized, usable database in which beneficiaries can search and evaluate brokers as they navigate the enrollment process.[19]
- For new enrollments, Medicare ID number of new enrollee by NPN.

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[14] Riaz Ali and Lesley Hellow, "Agent Commissions in Medicare and the Impact on Beneficiary Choice," *To the Point* (blog), Commonwealth Fund, Oct. 12, 2021. https://doi.org/10.26099/kwgc-8k34.

[15] Centers for Medicare and Medicaid Services, Contract Year 2025 Medicare Advantage and Part D Final Rule (CMS-4205-F), https://www.cms.gov/newsroom/fact-sheets/contract-year-2025-medicare-advantage-and-part-d-final-rule-cms-4205-f.

[16] Steven Findlay, Gretchen Jacobson, and Faith Leonard, "The Role of Marketing in Medicare Beneficiaries' Coverage Choices" (explainer), Commonwealth Fund, Jan. 5, 2023. https://doi.org/10.26099/6qnb-fa27.

[17] Ibid.

[18] U.S. Senate Committee on Finance, Majority Staff, *Deceptive Marketing Practices Flourish in Medicare Advantage* (November 2022), https://www.finance.senate.gov/chairmans-news/wyden-reports-deceptive-marketing-practices-in-medicare-advantage-that-harm-seniors; Findlay, Jacobson, and Leonard, "The Role of Marketing."

[19] Ali et al., *How Agents Influence.*

- Amount paid in commissions, by NPN, and whether the commission was for new enrollment or renewal, by Medicare ID number, for Medicare Advantage, Medigap, and Part D enrollments.
- Number and percent of enrollments by internal sales, captive agents, or independent agents.

CMS should also consider requiring brokers to report on all physician, hospital, health system, and supplemental benefit provider groups with whom they have a financial relationship. These financial relationships could include educational grants, marketing sponsorships, or other service-based arrangements.

Thank you for the opportunity to respond to your request for information. We are happy to further discuss these ideas at your convenience.

Appendix Table: Data Element Recommendations

	Data Element	MA	MA & TM
Supplemental Benefits	Networks used for supplemental benefits (e.g., dental, vision) if networks are used	X	
	Percentage of providers in county included in networks, by supplemental benefit, if networks are used	X	
	Projected and actual utilization of supplemental benefits, by type of supplemental benefit	X	
	Encounter data for dental claims	X	
	Amount of supplemental benefits used by benefit type and Medicare ID number.	X	
	Beneficiary liability for supplemental benefits, among beneficiaries who used the benefit, by type of supplemental benefit, including average per capita liability among users per contract-plan ID, and liability for users by Medicare ID number	X	
	Plan payment for supplemental benefits, by type of supplemental benefit. Includes reporting of plan payment per beneficiary eligible for the benefit and plan payment per user	X	
	Qualitative explanation of how supplemental benefit utilization influences either care management recommendations or care plans	X	
	Evidence that supplemental benefit improves health outcomes or reduces the need for other health services	X	
	Identifying subcontractors used to provide supplemental benefits	X	
Claims Denials	Percent of claims for the service that were approved with prior authorization, by service and plan	X	
	Percent of claims for the service that were denied because of lack of prior authorization and percent denied for other reasons, by service and plan	X	
	Number of beneficiaries who died while waiting for prior authorization by plan	X	
	Average, minimum, and maximum time between prior authorization request and approval	X	
	Reporting denied services by standard codes, such as ICD-10, CPT and HCPCS codes		X
	Percent of denials that were appealed		X
	Percent of appeals that were overturned		X
	Rate of denials by clinical condition and point of care		X
	Reporting whether review of denied service involved a medical necessity review, by denied claim		X
	Reporting whether any artificial intelligence (AI) applications were used in the review of the denied claim		X
	Reporting a plan's process to remediate denials by plan	X	
	Reporting whether subcontractors were used to assess claims payment by plan	X	
	Percent of claim denials that were denied because of inaccurate or incomplete data on the claim		X
	Percent of claims partially paid as a percentage of all claims		X

	Number of grievances filed, by reason for grievance and by plan	X	
	Number of providers departing the plan network, per plan year and by plan	X	
	Number of beneficiaries who disenrolled from the contract-plan, including rapid disenrollments, special enrollment period disenrollments, open enrollment period disenrollments, and Medicare Advantage open enrollment period disenrollments	X	
	Share of beneficiaries who disenrolled from the contract-plan who had a claim denied	X	
Brokers & Marketing	Number of captive brokers, i.e., the number of brokers who contractually only sell plans by one insurer		X
	Number of sales representatives employed by the insurer		X
	Number of brokers who receive a W-2 or 1099		X
	Brokers certified to sell the insurers' plans, by National Producer Number (NPN)		X
	Total amount paid in commissions to brokers, agents, and brokerages for Medicare enrollments, separated by Medicare Advantage, Part D, and Medigap commissions		X
	Percent of new enrollees who were rapidly disenrolled per plan	X	
	Place of a beneficiary's plan enrollment (e.g., doctor's waiting room, other in-person enrollment, telephonic, online)		X
	Number of beneficiary complaints about brokers, and reason for complaint, by broker (NPN)		X
	For new enrollments, Medicare ID number of new enrollee by NPN		X
	Amount paid in commissions, by NPN, and whether the commission was for new enrollment or renewal, by Medicare ID number, for Medicare Advantage, Medigap, and Part D enrollments		X
	Number and percent of enrollments by internal sales, captive agents, or independent agents		X
	All physician, hospital, health system, and supplemental benefit provider groups with whom brokers have a financial relationship		X