

August 30, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD. 21244

Re: CMS-4203-NC, Request for Information on Medicare

Dear Administrator Brooks-LaSure:

We are responding to your request for ideas that CMS can implement to ensure Medicare beneficiaries will receive more equitable, high quality, and whole-person care that is both affordable and sustainable. Our recommendations take into account the financial vulnerability of the Medicare population, where half of beneficiaries have incomes below \$29,650¹ and minority populations represent nearly one-fifth of Medicare Advantage beneficiaries and over half of beneficiaries enrolled in special needs plans (SNPs).² At the same time, we recognize the challenges that CMS and health plans face in confronting monopoly power in care delivery markets³ and the lack of innovation in care delivery, best exemplified by twenty seven years of flat labor productivity growth in hospital markets.⁴

In this setting we envision a modernized, competition-driven Medicare program promoting increased transparency, flexibility, and personalization. To achieve that goal, we recommend reforms centered on the following concepts:

- Transparency of plan options to better inform beneficiaries and policymakers
- Coordinated and integrated care with enhanced financial protections for beneficiaries.
- Customized care to better meet the needs of beneficiaries suffering from severe chronic or disabling diseases.

The following summarizes practical first steps needed to transform Medicare into a more personalized and effective program that meets the needs of beneficiaries while ensuring its financial stability for future generations. Additional reforms—including restructuring the Medicare benefit, simplifying cost-sharing requirements in traditional Medicare, and promoting direct price competition between traditional Medicare and Medicare Advantage—are needed if we are to live up to the promises Medicare has made to beneficiaries and taxpayers.

Improving Transparency

Individuals enrolling in Medicare are faced with a baffling array of options and limited information to guide their decisions. Individuals may choose traditional fee-for-service Medicare (which covers hospital and inpatient services under Part A, and physician and outpatient services under Part B) or enroll in a private Medicare Advantage plan. In addition, individuals may pay an additional premium for prescription drug coverage through the voluntary Part D program.

¹ Neuman T, Smith K, Jacobson G, and Koma W. Medicare beneficiaries' financial security before the coronavirus pandemic. *Kaiser Family Foundation*. April 24, 2020. <https://www.kff.org/medicare/issue-brief/medicare-beneficiaries-financial-security-before-the-coronavirus-pandemic>.

² Jacobson G, Cicchiello, Sutton JP, Shah A. "Medicare Advantage vs. Traditional Medicare: How Do Beneficiaries' Characteristics and Experiences Differ?" *The Commonwealth Fund*. October 14, 2021. <https://www.commonwealthfund.org/publications/issue-briefs/2021/oct/medicare-advantage-vs-traditional-medicare-beneficiaries-differ>

³ Fulton BD. Health Care Market Concentration Trends In The United States: Evidence and Policy Responses. *Health Affairs* 2017;36(9):1530-1538.

⁴ Private Community Hospitals Labor Productivity. Bureau of Labor Statistics. Modified June 30, 2022. Accessed August 4, 2022. <https://www.bls.gov/productivity/highlights/hospitals-labor-productivity.htm>

Enrollees in traditional Medicare are subject to complex cost-sharing requirements that vary depending on the type of service, without a catastrophic annual limit on out-of-pocket spending. Consequently, most enrollees in the traditional program purchase supplemental coverage through a private Medigap plan or an employer retiree plans, or acquire similar coverage through Medicaid if eligible. In contrast, Medicare Advantage plans cap annual out-of-pocket spending for their enrollees and frequently offer additional benefits not covered by traditional Medicare such as dental, vision, and hearing coverage.

There is no program-level framework to make meaningful comparisons to guide both beneficiaries and policymakers. Because of the numerous coverage options available to beneficiaries, health benefits packages should be broken down component by component. The following steps would provide a consistent basis for comparing the advantages and disadvantages of traditional Medicare (including options for supplemental coverage) and Medicare Advantage:

- Base cost comparisons on beneficiaries enrolled in both Part A and Part B. All Medicare Advantage plans include Part B coverage, but some enrollees in traditional Medicare opt to not enroll in Part B. Excluding from the cost calculation the minority of enrollees who have only Part A coverage would correct a bias in currently available cost comparisons.
- Provide cost information for standard Part A and Part B benefits.
- Provide separate cost estimates for other benefits, including valuations for reduced cost sharing in Medicare Advantage, extra benefits (such as dental, vision, or hearing services) offered by Medicare Advantage plans, typical cost and savings from Medigap and other supplemental coverage, and prescription drug benefits.

This approach would allow beneficiaries to better compare the costs and value of their total health benefits package options under traditional Medicare and Medicare Advantage and choose the combination of health benefits that work best for them.

Promoting Effective Integrated Care

Coordinated and integrated care is largely unavailable in traditional Medicare. This is primarily due to the reliance on administratively set prices, which rewards clinicians based on the volume or intensity of services that they provide. In contrast, Medicare Advantage plans receive a fixed monthly amount per beneficiary (adjusted to account for each beneficiary's health and eligibility status) to account for the total predicted future cost of their care. The fixed payment creates an incentive for plans to provide more efficient care rather than more services and greater intensity of services.

Research on Medicare Advantage has found significant health benefits for enrollees, including less intense post-acute care use, lower readmission and preventable hospital rates, more appropriate health care utilization, and decreased intensive care unit use. While researchers debate whether these results are generalizable, Medicare Advantage offers the potential for integrated care that is less likely in a fee-for-service setting.

Enrollment in Medicare Advantage plans has grown steadily over the past 15 years, rising from 19 percent of the Medicare population in 2007 to 48 percent in 2022.⁵ Nonetheless, traditional Medicare will continue to account for a large portion of total enrollment for the foreseeable future. By 2040, more than 38 million people—45 percent of the Medicare population—are projected to enroll in traditional Medicare.⁶

One reason for this is that individuals who are initially eligible for Medicare when they turn 65 years old and who are receiving Social Security benefits are automatically enrolled in traditional Medicare. For many beneficiaries, a Medicare Advantage plan with integrated, coordinated benefits and increased out of pocket financial protections would be a better choice.

⁵ Freed M, et al. "Medicare Advantage in 2022: Enrollment and Key Trends." *Kaiser Family Foundation* August 25, 2022. Available at: <https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-enrollment-update-and-key-trends/>

⁶ Table V.B3 <https://www.cms.gov/files/document/2022-medicare-trustees-report.pdf>

Instead of the current autoenrollment process, newly eligible individuals should be automatically assigned to a Medicare Advantage plan if they have not already selected a Medicare Advantage plan or traditional Medicare. Only plans with star ratings of 3.5 or higher would be included to protect beneficiaries from lower-quality plans. In addition, health plans participating in auto-assignment would be required to offer at least one basic coverage plan providing minimum Part A, B, and D benefits for zero additional premium beyond the standard Part B premium. These requirements would level the playing field among the health plans competing for the same beneficiaries, with the January to March open-enrollment period for Medicare Advantage providing beneficiaries an opportunity to change plans.

Improving Care for Beneficiaries with Complex Conditions

One of the frequent critiques of the Medicare Advantage program is that beneficiaries with severe or disabling chronic conditions face an abundance of plan choices – 39 on average – and suffer from “choice paralysis,” frequently selecting a sub-optimal benefits package. Furthermore, while we note the benefits of integrated and coordinated care in the Medicare Advantage program as compared to traditional Medicare, some populations of beneficiaries both need and desire further care customization.

In the aim of supporting beneficiaries with severe or disabling chronic conditions, Congress created Medicare Advantage Chronic Condition Special Needs Plans or C-SNPs. A relatively small market with 404,000 beneficiaries enrolled in 283 plans primarily in the Southeastern U.S., this marketplace proffers great potential for vulnerable beneficiaries who frequently have significant impairments in functional status.

Noting that Congress directed CMS to redefine the disease targets as part of the program’s 2018 permanent authorization, we suggest narrowing the program to diseases in which known interventions driven by insurance design can reduce meaningful morbidity, comorbidity, or costs. Disease targets must have significant prevalence or incidence in the Medicare program. Further, disease-related morbidity must threaten the health and function of beneficiaries (e.g. difficulty with daily activities such as bathing or climbing stairs for heart failure patients)⁷ and have significant programmatic impact (e.g. expensive frequent hospitalization for heart failure exacerbations). Parsing these requirements, we suggest narrowing the C-SNPs program to five already-specified conditions: congestive heart failure, diabetes, chronic obstructive pulmonary disease, advanced chronic kidney disease and end stage renal disease, and opioid disorder.

This is not enough to ensure the program’s long-term success. Noting the challenges of hospital consolidation and lack of health care service labor productivity growth, an indirect marker of ossification of clinical operations, CMS must undertake specific regulatory policy changes to improve the effectiveness of insurance design at closing care gaps for these diseases. Specifically, CMS can increase the credit for utilization of telehealth for network access requirements, permit multi-county bidding, allow MA Part D plans additional flexibility for clinical outcomes-based contracting, and permit targeted marketing to beneficiaries with the specified qualifying disease(s).

Together, these changes would enable beneficiaries and their proxies to clearly identify plans with disease-specific benefits, improve care customization, and improve outcomes for both the beneficiaries and the Medicare program overall. While a small share of the Medicare program overall, the C-SNPs program holds great promise for mass-produced, mass-customized care.

Conclusion

With the Medicare Hospital Trust fund facing insolvency as soon as 2028, creating a sustainable path forward for the Medicare program is a bipartisan national imperative. With a plethora of options and two primary pathways for

⁷ E.g. functional impairment in congestive heart failure is significant, with 45.9% having difficulty climbing stairs and 15.2% experiencing difficulty with bathing. See: Dunlay, Shannon M., Sheila M. Manemann, Alanna M. Chamberlain, Andrea L. Cheville, Ruoxiang Jiang, Susan A. Weston, and Véronique L. Roger. 2015. “Activities of Daily Living and Outcomes in Heart Failure.” *Circulation: Heart Failure* 8, no. 2 (February 25). <https://doi.org/10.1161/CIRCHEARTFAILURE.114.001542>.

which Medicare-eligible Americans can access their Medicare benefits, transparency of the components of Medicare benefits is critical to informed choice. As the burden of chronic disease grows and Americans live almost a decade longer than prior generations, personalization of care is critical to preserving independence and health.

Our recommendations address each of these critical challenges, and will help to place the Medicare program on a sustainable path so that future generations may continue to enjoy the security of old age.

We have enclosed several papers describing these policy proposals in greater detail for staff review. We welcome the opportunity to discuss our ideas with you further, I can be reached at brian@brianjmillermd.com

Sincerely,



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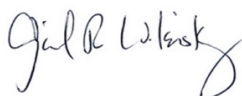
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Enclosures:

1. Miller BJ, Parente S, Wilensky GR. "[Comparing Spending Across Medicare Programs](#)" *AJMC* 2022. Online first.
2. Miller BJ, Zima SC, Wilensky GR. "[Customized Care for Complex Conditions in Medicare Advantage.](#)" *AEI Economic Perspectives* August 25, 2022.
3. Miller BJ, Wilensky GR. "[The Next Step in Medicare Reform.](#)" *The Heritage Foundation* Backgrounder No. 3531, September 16, 2020.