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Growth in Medicare Advantage Raises Concerns

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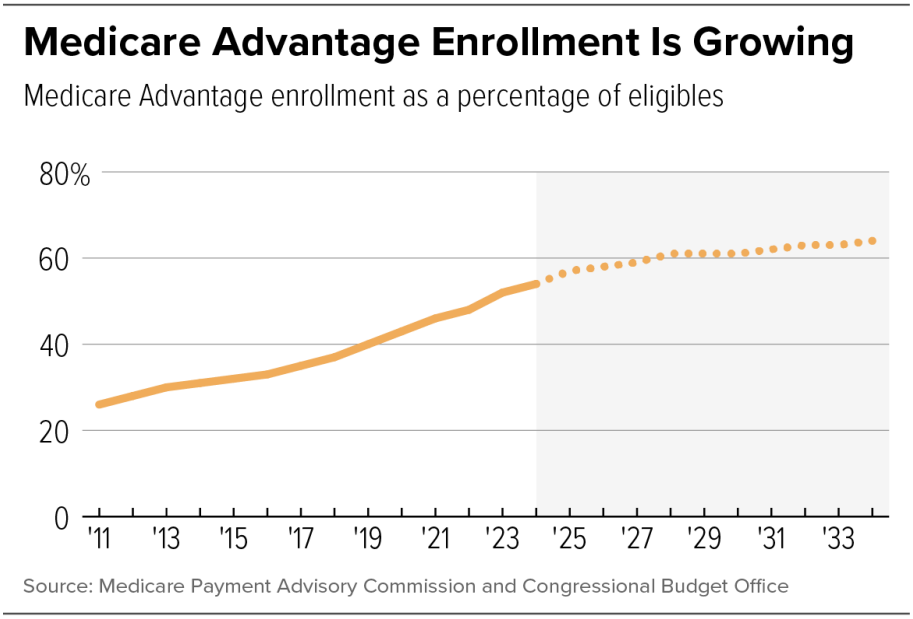
Increasingly, Medicare enrollees receive their benefits through a Medicare Advantage (MA) health plan offered by a private insurer rather than from traditional Medicare, which is a government-run, single-payer program. The Congressional Budget Office (CBO) projects that the Medicare Advantage share will grow from 54 percent of eligible Medicare beneficiaries in 2024 to about 64 percent in ten years if it continues on its current course. (See Figure 1.) The growth of Medicare Advantage heightens several long-standing concerns.

FIGURE 1



MA plans are substantially overpaid compared to traditional Medicare. Congress's Medicare Payment Advisory Commission (MedPAC) estimates that MA payments in 2024 were 22 percent above traditional Medicare — a difference that amounts to $83 billion in annual spending.[1]

[1] MedPAC, *Report to the Congress: Medicare Payment Policy,* March 2024, Chapter 12, "The Medicare Advantage Program," p. 372, https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_Ch12_MedPAC_Report_To_Congress_SEC-1.pdf.

Much of these overpayments benefit the MA plans rather than their enrollees. MA plans receive a fixed payment for each member, regardless of services delivered. That gives plans a financial incentive to restrict care once people are enrolled, sometimes resulting in service delays or denials. MA enrollees may also face inadequate provider networks, which limits access to timely, needed care and imposes burdensome travel. Meanwhile, misleading marketing exaggerates MA plans' benefits and obscures their limitations, enticing some Medicare beneficiaries to enroll in disadvantageous MA plans.

Adding more consumer protections would help ensure that MA enrollees get the care to which they are entitled in a timely and affordable way. For instance, the Centers for Medicare & Medicaid Services (CMS) and Congress can take steps to counter MA plans' inappropriate use of prior authorizations that can discourage care, to ensure that plans' provider networks are adequate, and to curb their use of improper marketing.

Traditional Medicare, meanwhile, lacks certain important benefits that MA plans offer — notably an annual limit on out-of-pocket spending. Reducing MA overpayments would free up resources that could be used to improve benefits for all Medicare beneficiaries.

As enrollment in Medicare Advantage plans grows, it is important to maintain traditional Medicare as a strong, viable public option. Traditional Medicare, with its low administrative overhead, broad network of providers, and strong beneficiary protections, delivers important competition to for-profit MA plans. Many MA plans use traditional Medicare's payment rates, and traditional Medicare plays an important role in shaping the overall health care system.

To ensure that traditional Medicare can continue to play this crucial role, Medicare's benefit and payment policies should not be tilted in favor of Medicare Advantage plans. At the same time, MA enrollees should be provided the information they need to make informed choices and be assured that they receive the health care to which they are entitled in a timely fashion.

Overview of Medicare Advantage

Medicare has four parts. Most seniors and disabled beneficiaries are covered by premium-free Hospital Insurance (Part A) because they or their spouse have paid Medicare payroll taxes for at least ten years. Enrollment in Supplementary Medical Insurance (Part B), which pays for physician and other health services, and outpatient prescription drug coverage (Part D) each requires payment of a monthly premium that covers about 25 percent of the cost of Part B and a smaller share for Part D. General revenues cover most of the remaining cost.

The basic Part B premium is a uniform national amount (in 2025, $185 a month) that does not vary with a beneficiary's age or place of residence. Low-income beneficiaries are eligible for extra assistance to help pay their Part B and D premiums and cost sharing, and high-income beneficiaries pay additional income-related premiums. Under Part D, Medicare delivers prescription drug coverage exclusively through private insurance plans that contract with the program: either stand-alone drug plans or Medicare Advantage plans that package drug coverage with the rest of Medicare. All Medicare Advantage (Part C) plans must provide benefits under parts A and B, and most MA plans cover Part D benefits as well.

Medicare pays MA plans a fixed amount per enrollee that does not depend on the amount of health care services the enrollee uses. Those payments are generally tied to local "benchmarks" (which are a function of per capita expenditures in traditional Medicare) and to the plans' "bids" (their estimated cost of providing Part A and B benefits to an average enrollee). Plans with higher star ratings on a quality-rating scale receive higher benchmarks and payments. Medicare also risk-adjusts payments to MA plans to reflect the health status of each plan's enrollees.[2]

Beneficiaries enrolled in an MA plan must pay the Part B premium (less any rebate that the plan may provide), and they may pay an additional premium specific to the MA plan for prescription drug coverage and supplemental benefits. To the extent that MA plans are overpaid or can deliver care more efficiently, they can offer supplemental benefits beyond those that traditional Medicare provides, in most cases without charging more than the basic Part B premium. About three-quarters of Medicare Advantage enrollees choose zero-premium plans.[3] The most common enhancements are dental, vision, hearing, and fitness benefits. MA plans must also limit total annual out-of-pocket costs for Part A and Part B services; traditional Medicare has no such limit. Many enrollees in traditional Medicare purchase a separate Medicare supplement ("Medigap") plan, offered by private insurers, to provide catastrophic protection and cover other cost sharing.

Offering supplemental benefits with little or no additional premium makes MA plans very attractive to beneficiaries. In return, MA enrollees must accept the plans' procedures for accessing care (such as prior authorization) and more limited networks of health care providers. MA plans can negotiate lower provider payment rates than traditional Medicare in some instances. And they receive capitation payments — fixed, upfront amounts to cover future costs — from Medicare for their enrollees that, on average, exceed what those enrollees would cost to cover in traditional Medicare. Together, these overpayments and cost savings cover plans' profits and administrative expenses and allow room for extra benefits. In addition, MA plans offer the convenience of one-stop shopping by combining the equivalent of traditional Medicare, a prescription drug plan, and a Medigap policy all in a single package.

Medicare Advantage Overpayments Should Be Reined In

When private plans were first introduced into Medicare in the 1970s, they were sold as saving Medicare money. That promise, however, has not been fulfilled. MedPAC finds that in 2024 Medicare paid 22 percent more for enrollees in MA than it would pay if those enrollees participated in traditional Medicare.[4] (See Figure 2.) These overpayments arise for three main reasons explained below: higher coding intensity, favorable selection, and quality bonuses. Taking additional factors

[2] For further explanation of how MA plans are paid, see Medicare Payment Advisory Commission (MedPAC), *Medicare Advantage Program Payment System Payment Basics*, October 2024, https://www.medpac.gov/wp-content/uploads/2024/10/MedPAC_Payment_Basics_24_MA_FINAL_SEC.pdf.

[3] Meredith Freed *et al.*, *Medicare Advantage in 2024: Premiums, Out-of-Pocket Limits, Cost Sharing, Supplemental Benefits, and Prior Authorization,* KFF, August 8, 2024, https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2024-premiums-out-of-pocket-limits-supplemental-benefits-and-prior-authorization/.

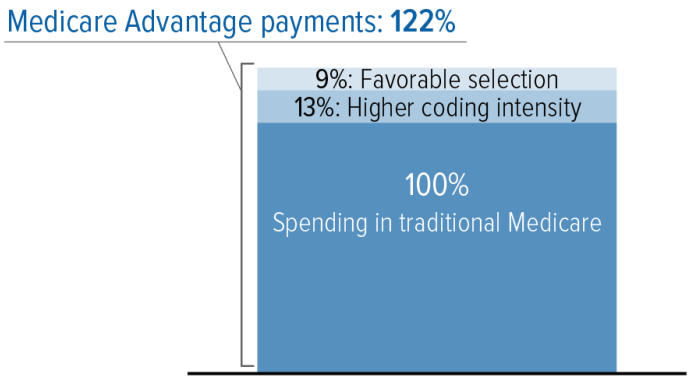
[4] MedPAC, March 2024, p. 372.

into account, other researchers have estimated that MA overpayments could be as high as 39 percent.[5]

The benefits of these MA overpayments accrue partly to the insurers sponsoring MA plans (in the form of higher profits) and partly to the plans' enrollees (as higher benefits). At the same time, overpayments increase Part B premiums for all Medicare beneficiaries, including those in traditional Medicare, and the taxpayer share of Part B. They also speed the depletion of Medicare's Hospital Insurance trust fund. CMS and Congress should take steps to rein in these overpayments.

FIGURE 2

Medicare Advantage Plans Are Substantially Overpaid



Note: "Favorable selection" is the extent to which Medicare Advantage enrollees have lower health spending than those in traditional Medicare with the same risk scores. "Coding intensity" is a difference in diagnostic coding practices that makes Medicare Advantage enrollees look sicker than similar enrollees in traditional Medicare.

Source: Medicare Payment Advisory Commission, 2024

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Coding intensity. MedPAC has long found evidence that Medicare Advantage plans have a higher diagnostic "coding intensity" than traditional Medicare. Because Medicare's payments to MA plans are higher for less-healthy enrollees, MA plans have an incentive to identify as many health conditions (diagnoses) as possible for each enrollee. Health care providers in traditional Medicare have no such incentive because their payments depend on the services they provide, not the number of diagnoses. It is therefore not surprising that MA plans record more health condition diagnoses than traditional Medicare for comparable beneficiaries (termed higher "coding intensity"). Because of higher coding intensity, MedPAC estimates, Medicare spends 13 percent more for MA enrollees than it would if they were enrolled in traditional Medicare. That difference accounts for $50 billion in MA overpayments in 2024.[6]

[5] Micah Johnson, Donald Berwick, and Richard J. Gilfillan, *Ending Overpayments in Medicare Advantage,* Center for American Progress, March 2024, https://www.americanprogress.org/article/ending-overpayment-in-medicare-advantage/.

[6] MedPAC, March 2024, p. 380.

Favorable selection. Estimates of the cost of higher coding intensity in MA plans assume that, on average, enrollees in MA and traditional Medicare with similar risk scores have similar health spending, but that assumption increasingly appears to be incorrect. Recent research demonstrates that MA enrollees are distinctly healthier — a situation termed "favorable selection." That is likely because people who need more health care are less willing to accept the restrictions (such as prior authorization and limited networks) that MA plans impose.

Failing to account for favorable selection, like higher coding intensity, makes MA enrollees appear less healthy than they really are and thus results in overpayments. MedPAC estimates that favorable selection adds 9 percent to MA spending compared to traditional Medicare. That amount is in addition to the effect of higher coding intensity. It represents $35 billion in additional MA spending in 2024 relative to what it would be in traditional Medicare.[7]

Quality bonuses.[8] Quality in health care is hard to measure. MedPAC has stated for several years that current data are inadequate for assessing the quality of care in Medicare Advantage and comparing it to traditional Medicare. "Findings are sufficiently mixed on patient experience and outcomes that the Commission cannot conclude that MA plans systematically provide better quality over FFS [traditional Medicare]."[9]

By law, Medicare rates MA plans on a 5-star scale and generally increases benchmark payment rates by 5 percent for plans with 4 or 5 stars. About 62 percent of enrollees in MA prescription drug plans are in plans that will have 4 or 5 stars in 2025 and will receive payment bonuses in 2026.[10] Unlike many other features of Medicare payment policy, the quality bonus program is not designed to be budget neutral and increases MA payments relative to traditional Medicare. MedPAC finds that the star rating system "does not provide a reliable basis for evaluating quality across MA plans in meaningful ways" and has led to "unwarranted bonus payments."[11] Quality bonuses total an estimated $15 billion in 2024.[12]

Options for Reducing Overpayments

Reducing or eliminating the three sources of overpayments is technically feasible but politically challenging. Existing law authorizes CMS to reduce MA payment rates to correct for coding intensity and requires CMS to make a minimum adjustment of 5.9 percent. Up to now CMS has made only the minimum required adjustment. MedPAC recommends that the agency make a larger adjustment that fully accounts for coding differences, after making improvements in the risk adjustment model.

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[7] MedPAC, March 2024, pp. 375, 377.

[8] MedPAC, March 2024, p. 362.

[9] MedPAC, *Report to the Congress: Medicare Payment Policy,* March 2023, p. 325, https://www.medpac.gov/wp-content/uploads/2023/03/Ch11_Mar23_MedPAC_Report_To_Congress_SEC.pdf.

[10] CMS, *Fact Sheet: 2025 Medicare Advantage and Part D Star Ratings*, October 10, 2024, https://www.cms.gov/newsroom/fact-sheets/2025-medicare-advantage-and-part-d-star-ratings.

[11] MedPAC, March 2023, pp. 363-65.

[12] MedPAC, March 2024, p. 362.

MedPAC also recommends replacing the current star rating system with a new value incentive program for MA using a small number of outcome measures at the local market level and accounting for enrollees' social risk factors. The program should be budget neutral, according to MedPAC, with rewards and penalties applied at the local level.[13]

Favorable selection is the most difficult problem to solve, and MedPAC and analysts at USC's Schaeffer Center offer a wide range of options for addressing it. These include revising the risk adjustment process in incremental or fundamental ways; paying MA plans for high-spending beneficiaries using retrospective reinsurance rather than prospective risk-adjusted payments; setting MA benchmarks using competitive bidding; basing benchmarks on spending in both MA and traditional Medicare; and updating benchmarks with administratively set growth rates.[14] CMS is phasing in a new risk adjustment model that will go at least some way toward reducing this source of overpayments.

A budget-neutral change that would improve Medicare overall would reduce overpayments to MA plans and use those savings to fill some of the gaps in traditional Medicare, such as adding an out-of-pocket limit and improving low-income protections. Improving traditional Medicare *would* make it more affordable for low- and moderate-income beneficiaries, giving them access to its broad choice of providers and sparing them from MA's utilization management procedures. Making such improvements would also protect MA beneficiaries when overpayments are reduced, since MA plans must offer at least the same benefits as traditional Medicare.

MA Overpayments Don't Improve Health Care Equity

Low-income Medicare beneficiaries are disproportionately Black and Hispanic due to long-standing structural racism that depresses their earnings, Social Security benefits, and retirement savings. MA enrollment is higher among Black and Hispanic Medicare beneficiaries, but overpayments to MA plans have not improved health care quality or health equity.[15] In 2021, 59 percent of Black beneficiaries and 67 percent of Hispanic beneficiaries were enrolled in MA, compared to 43 percent of white beneficiaries.[16] Those differences likely arise in large part because MA plans' supplemental coverage and low or zero premiums are particularly attractive to low-income beneficiaries and to those also eligible for Medicaid, among whom Black and Hispanic people are over-represented.[17]

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[13] MedPAC, March 2023, p. 330.

[14] Steven M. Lieberman, Paul B. Ginsburg, and Eugene Lin, "Lowering Medicare Advantage Overpayments from Favorable Selection by Reforming Risk Adjustment," *Health Affairs*, July 13, 2023, https://www.healthaffairs.org/content/forefront/lowering-medicare-advantage-overpayments-favorable-selection-reforming-risk-adjustment; MedPAC, *Medicare and the Health Care Delivery System,* June 2023, pp. 155-58, https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_MedPAC_Report_To_Congress_SEC.pdf.

[15] Johnson, Berwick, and Gilfillan.

[16] Nancy Ochieng *et al.*, *Disparities in Health Measures by Race and Ethnicity Among Beneficiaries in Medicare Advantage: A Review of the Literature,* KFF, December 13, 2023, https://www.kff.org/medicare/report/disparities-in-health-measures-by-race-and-ethnicity-among-beneficiaries-in-medicare-advantage-a-review-of-the-literature/

[17] Nancy Ochieng, Juliette Cubanski, and Tricia Neuman, *A Snapshot of Sources of Coverage Among Medicare Beneficiaries*, KFF, September 2024, https://www.kff.org/medicare/issue-brief/a-snapshot-of-sources-of-coverage-among-medicare-beneficiaries/.

One award-winning study finds that enrollees who are people of color have fewer highly rated MA plans available to them than white enrollees.[18] A review of the literature finds that Black MA enrollees fare worse than white enrollees on more than half (52 percent) of the quality measures studied and better on only 17 percent.[19] Other studies find no consistent differences in quality between traditional Medicare and Medicare Advantage.

More Consumer Protections Needed in Medicare Advantage

Since MA plans receive a fixed payment for each member, irrespective of services delivered, plans have a financial incentive to restrict care once people are enrolled. This may result in delays and denials of services, inadequate provider networks, and aggressive and misleading marketing techniques that cause beneficiaries to choose plans poorly suited to their needs. These issues are of particular concern for Black and Hispanic Medicare beneficiaries because of their higher rates of enrollment in MA.

Prior authorization. Medicare Advantage plans must provide coverage for all the same health care items and services as traditional Medicare, but MA plans are more restrictive in determining whether a particular item or service is considered medically necessary. Virtually all MA enrollees are in plans that require prior authorization for some services. Plans typically require prior authorization for high-cost services, such as Part B drugs, skilled nursing facility stays, inpatient hospital stays, and certain diagnostic procedures. Prior authorization is also frequently required for supplemental benefits, such as dental, hearing, and eye exams.[20] Providers submitted over 46 million requests for prior authorization to MA plans in 2022[21]

In contrast, traditional Medicare requires prior authorization only in limited cases — certain hospital outpatient department services, non-emergency ambulance transportation, and some durable medical equipment. In 2021 and 2022 traditional Medicare received fewer than 200,000 requests a year for prior authorization.[22]

The prior authorization process in MA can all too often delay, deny, or terminate the provision of needed medical care that traditional Medicare would cover. A KFF survey found that 11 percent of all Medicare beneficiaries had a problem with prior authorization in the previous year.[23] That finding

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[18] Sungchul Park, Rachel M. Werner, and Norma B. Coe, "Racial and ethnic disparities in access to and enrollment in high-quality Medicare Advantage Plans," Health Services Research, Vol. 58, Issue 2, April 2023, https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13977.

[19] Ochieng *et al.*

[20] Freed *et al.*

[21] Jeannie Fuglesten Biniek, Nolan Sroczynski, and Tricia Neuman, *Use of Prior Authorization in Medicare Advantage Exceeded 46 Million Requests in 2022*, KFF, August 8, 2024, https://www.kff.org/medicare/issue-brief/use-of-prior-authorization-in-medicare-advantage-exceeded-46-million-requests-in-2022/.

[22] CMS, *Prior Authorization and Pre-Claim Review Program Stats*, September 15, 2023, https://www.cms.gov/files/document/prior-authorization-and-pre-claim-review-program-statistics.pdf.

[23] Karen Pollitz *et al.*, *Consumer Problems with Prior Authorization: Evidence from KFF Survey*, KFF, September 29, 2023, https://www.kff.org/health-reform/issue-brief/consumer-problems-with-prior-authorization-evidence-from-kff-survey/.

suggests that about one-fifth of MA enrollees had a prior authorization problem, since prior authorization is rare in traditional Medicare. In an audit, the Office of Inspector General (OIG) at the Department of Health and Human Services (HHS) found that 13 percent of prior authorization denials in MA "were for service requests that met Medicare coverage rules, likely preventing or denying medically necessary care for Medicare Advantage beneficiaries." The OIG also found that among payment requests that were denied, 18 percent met coverage and billing rules, thereby delaying or preventing payments to providers for services already rendered.[24]

CMS has recently taken several regulatory steps to improve the prior authorization process and assure that MA enrollees receive the care to which they are entitled. Although these changes could potentially reduce problems with prior authorization, the effectiveness with which they will be administered, and their actual impact remain to be seen.

For instance, a January 2024 final rule standardizes the electronic exchange of health care data between providers, payers, and patients; encourages doctors and hospitals to use electronic prior authorization; and thereby streamlines the prior authorization process. The rule requires MA plans and most other affected payers to respond to prior authorization requests within seven days for standard requests (down from as many as 14 days for MA plans today) and 72 hours for urgent ones (unchanged from the current standard).[25]

The MA final rule for contract year 2025 requires MA plans to conduct an annual analysis of their prior authorization policies and procedures from a health equity perspective. This review will identify practices that could have a disproportionate impact on certain populations, including Medicare-Medicaid dual eligibles, recipients of the low-income drug subsidy, and people with disabilities.[26]

Congress is considering legislation that would make further improvements in the prior authorization process. For example, the House Ways and Means Committee in September 2023 reported a bill that would require MA plans to establish an electronic prior authorization process and respond to prior authorization requests in "real time." The bill would require plans to respond to urgent requests within 24 hours. It would also require plans to provide detailed data on prior authorization criteria and decisions.[27] The House approved a similar provision in 2022.

Network adequacy. Another way that MA plans can hold down costs is through limiting the network of doctors and hospitals that participate in the plan. In contrast, traditional Medicare offers access to any provider that accepts Medicare, which almost all do. Questions often arise about whether MA plans' provider networks are large and comprehensive enough to meet their enrollees'

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[24] 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*, April 2022, https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf.

[25] CMS, *CMS Interoperability and Prior Authorization Final Rule CMS-0057-F: Fact Sheet*, January 17, 2024, https://www.cms.gov/newsroom/fact-sheets/cms-interoperability-and-prior-authorization-final-rule-cms-0057-f.

[26] CMS, *Contract Year 2025 Medicare Advantage and Part D Final Rule (CMS-4205-F): Fact Sheet*, April 4, 2024, https://www.cms.gov/newsroom/fact-sheets/contract-year-2025-medicare-advantage-and-part-d-final-rule-cms-4205-f.

[27] Ways and Means Committee, *Health Care Price Transparency Act of 2023*, House Report 118-231 to accompany H.R. 4822, section 301, September 29, 2023, https://www.congress.gov/118/crpt/hrpt231/CRPT-118hrpt231.pdf.

needs for health care. The Center for Medicare Advocacy (which provides legal assistance to Medicare beneficiaries) reports that it "regularly hears from MA enrollees that they are unable to obtain medically necessary care from an in-network provider" in a timely way.[28]

CMS requires MA plans to include in their networks a minimum number of physician specialists and hospitals within a certain driving time and distance of beneficiaries, but little is known about how far MA plans exceed the bare minimum.[29] Time-and-distance standards measure the geographic accessibility of health care providers, but they do not account for other aspects of provider availability. They do not measure the breadth of a network, nor do they indicate whether a provider is accepting new patients.[30] Moreover, the Government Accountability Office (GAO) has found that CMS does not adequately verify the accuracy of the provider information provided by MA plans and therefore cannot be sure that the plans are meeting even the minimum standards.[31]

Limited networks can have serious health consequences. For example, MA enrollees are less likely to receive complex cancer surgery in designated cancer centers or high-volume hospitals that have better outcomes. This limited access likely contributes to significantly higher post-surgery mortality rates for MA beneficiaries.[32]

Various steps could help ensure that MA networks are adequate and accurately reported. For example, GAO has recommended that CMS verify the accuracy of provider information provided by MA plans and update its criteria for network adequacy to account for provider availability. In December 2023 the Senate Finance Committee approved a bill that would require MA plans to verify the accuracy of provider directories at least every 90 days and protect beneficiaries from higher cost sharing when relying on an inaccurate directory.[33] Other possible improvements include limiting plans' ability to terminate providers in the middle of a year, strengthening the time-and-distance standards, and establishing standards for the timely receipt of care.

Marketing practices. Medicare Advantage is a profitable line of business, and MA insurers make every effort to attract more enrollees. Insurance agents and brokers, who receive commissions on sales, also have a financial incentive to steer Medicare beneficiaries toward MA plans. As a result, some plans, agents, and brokers have employed misleading or dishonest marketing tactics, such as

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[28] David Lipschutz, "Advocacy Tip for Medicare Advantage Enrollees Facing Difficulty Obtaining In-Network Care," Center for Medicare Advocacy, January 18, 2024, https://medicareadvocacy.org/advocacy-tip-for-medicare-advantage-enrollees-facing-difficulty-obtaining-in-network-care/.

[29] Gretchen Jacobson *et al.*, *Medicare Advantage: How Robust Are Plans' Physician Networks?* KFF, October 5, 2017, https://www.kff.org/report-section/medicare-advantage-how-robust-are-plans-physician-networks-report/.

[30] Karen Pollitz, *Network Adequacy Standards and Enforcement*, KFF, February 4, 2022, https://www.kff.org/health-reform/issue-brief/network-adequacy-standards-and-enforcement/.

[31] Government Accountability Office (GAO), *Medicare Advantage: Continued Monitoring and Implementing GAO Recommendations Could Improve Oversight; Statement of Leslie V Gordon*, June 28, 2022, https://www.gao.gov/assets/gao-22-106026.pdf.

[32] Mustafa Raoof *et al.*, "Medicare Advantage: A Disadvantage for Complex Cancer Surgery Patients," Journal of Clinical Oncology, Vol. 41, No. 6, November 10, 2022, https://ascopubs.org/doi/full/10.1200/JCO.21.01359.

[33] S. 3430, *Better Mental Health Care, Lower-Cost Drugs, and Extenders Act of 2023*, December 7, 2023, section 109, https://www.congress.gov/bill/118th-congress/senate-bill/3430.

exaggerating the benefits of MA plans and not explaining their limitations, and have enticed some Medicare beneficiaries to enroll in MA plans that proved very disadvantageous.[34]

CMS has recently taken a number of steps to protect consumers from improper marketing. The 2024 Medicare Advantage final rule adds a long list of requirements designed to curb aggressive and deceptive marketing practices, including standards for televised and other advertisements. CMS has begun reviewing television commercials for consistency with the new rules and has rejected a substantial number. CMS is also asking beneficiaries to report other instances of misleading marketing.[35] The 2025 MA final rule eliminates the incentive of insurance agents and brokers to direct beneficiaries to particular MA plans by standardizing and tightening the regulatory limits on their compensation, but legal challenges are delaying its implementation.

Although these regulatory and legislative changes are welcome, CMS and Congress could take further steps to deter deceptive marketing and avoid steering beneficiaries to inappropriate MA plans. To simplify choice, Congress could require MA organizations to offer plans with standardized cost sharing and supplemental benefits.[36] Policymakers could restructure the commissions of insurance agents to reduce their financial incentive to promote MA over traditional Medicare. CMS regulates the maximum commissions that insurers pay to agents who sell MA or Part D plans; commissions for Medigap plans are not set by CMS or the states. Currently, commissions are higher for MA plans than for stand-alone drug plans and Medigap; this disparity could be reduced.[37] Congress should ensure that CMS has sufficient program management funding to monitor and oversee the marketing and other practices of MA plans. It should also provide additional funding for State Health Insurance Assistance Programs, which offer free, independent counseling to Medicare beneficiaries on enrollment and other issues.

In November 2024, under the outgoing Biden Administration, CMS issued a proposed rule for 2026 that would add more consumer protections to help assure that MA enrollees get needed care in a timely manner.[38] Its provisions include curbing inappropriate use of prior authorization and denials of coverage, assuring that provider directories are accurate and easily accessible, requiring agents and brokers to more fully inform beneficiaries about their options, expanding oversight of marketing materials, and regulating the use of debit cards to administer supplemental benefits. The rule would

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[34] Susan Jaffe, "Uncle Sam Wants You . . . to Help Stop Bogus Medicare Advantage Sales Tactics," KFF Health News, November 30, 2023, https://kffhealthnews.org/news/article/medicare-advantage-deceptive-sales-tactics-federal-crackdown/.

[35] Jaffe.

[36] For options to standardize benefits, see Eric Rollins, "Standardized benefits in Medicare Advantage plans: Policy options," MedPAC, January 12, 2024, https://www.medpac.gov/wp-content/uploads/2023/10/MedPAC-MA-standardized-benefits-Jan-2024.pdf.

[37] Riaz Ali and Lesley Hellow, *Agent Commissions in Medicare and the Impact on Beneficiary Choice*, Commonwealth Fund, October 2021, https://www.commonwealthfund.org/blog/2021/agent-commissions-medicare-and-impact-beneficiary-choice.

[38] CMS, *Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly (CMS-4208-P): Fact Sheet,* November 26, 2024, https://www.cms.gov/newsroom/fact-sheets/contract-year-2026-policy-and-technical-changes-medicare-advantage-program-medicare-prescription.

also expand Medicare coverage of anti-obesity medication. The Trump Administration will determine the shape of the final regulation.

Improving Traditional Medicare Would Reduce Disparities With Medicare Advantage

Certain features of Medicare tilt the playing field in favor of MA compared to traditional Medicare. First, and most important, MA plans include an annual catastrophic limit on total out-of-pocket spending, but traditional Medicare does not. Second, beneficiaries who enroll in MA but later wish to return to traditional Medicare may find that supplementary Medigap coverage is unavailable or unaffordable. Third, most MA plans offer some routine dental, hearing, and vision coverage, which traditional Medicare does not provide. Filling these gaps would not only benefit enrollees in traditional Medicare but would also protect MA beneficiaries when overpayments to plans are reduced.

Catastrophic limit. Protection against very high levels of spending is a primary purpose of insurance, yet an area where traditional Medicare falls short. The Inflation Reduction Act of 2022 established an annual limit on out-of-pocket spending for Medicare Part D drugs, of $2,000 starting in 2025, but traditional Medicare has no limit on out-of-pocket spending for Part A and B services.

Since 2011, MA plans must include a limit on total annual spending for covered services. That limit may not exceed $9,350 for in-network services in 2025 although most MA plans set a lower limit. The average out-of-pocket limit in 2024 in MA plans was $4,882 for in-network services and $8,707 for both in-network and out-of-network services.[39] The lack of a comparable out-of-pocket limit for parts A and B of traditional Medicare is a glaring gap in protection that disadvantages traditional Medicare and should be closed.

Supplemental coverage. In order to obtain catastrophic protection and other reductions in cost sharing, enrollees in traditional Medicare who are not covered by Medicaid or an employer-sponsored plan must purchase a separate Medicare supplement policy at extra expense. As of 2022, 21 percent of all Medicare enrollees, amounting to about 42 percent of enrollees in traditional Medicare, purchased supplemental coverage through Medigap. Only 11 percent of enrollees in traditional Medicare have no form of supplemental coverage.[40]

A survey finds that beneficiaries in traditional Medicare are less likely to experience cost-related problems in getting health care than those in Medicare Advantage, largely because of supplemental coverage. Among Black beneficiaries, 20 percent of those with traditional Medicare and some supplemental coverage experienced cost-related problems, compared to 32 percent of those with Medicare Advantage.[41]

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[39] Freed *et al.*

[40] Ochieng, Cubanski, and Neuman.

[41] Jeannie Fugelsten Biniek *et al.*, *Cost-Related Problems Are Less Common among Beneficiaries in Traditional Medicare Than in Medicare Advantage, Mainly Due to Supplemental Coverage*, KFF, June 25, 2021, https://www.kff.org/medicare/issue-brief/cost-related-problems-are-less-common-among-beneficiaries-in-traditional-medicare-than-in-medicare-advantage-mainly-due-to-supplemental-coverage/.

Medicare beneficiaries who have enrolled in an MA plan and wish to return to traditional Medicare may find that Medigap coverage is out of reach. Federal Medicare law provides for open enrollment only when beneficiaries age 65 and over initially sign up for Part B or if they switch to traditional Medicare during their first 12 months in an MA plan. Disabled beneficiaries under age 65 have no opportunity to purchase Medigap with "guaranteed issue" (that is, enrollment regardless of factors such as health status).

States may create additional consumer protections, including for disabled beneficiaries, but only four states offer an opportunity for guaranteed issue of Medigap policies after initial enrollment without regard to pre-existing conditions. As a result, once beneficiaries have chosen an MA plan, they can be effectively locked into MA.[42] Requiring Medigap plans to hold an annual open enrollment period for beneficiaries leaving MA for traditional Medicare would solve this problem, although it would increase Medigap premiums.[43] A more comprehensive solution would be to add an out-of-pocket limit to traditional Medicare and improve low-income premium and cost-sharing assistance, thereby making Medigap unnecessary for many beneficiaries.

Dental, hearing, and vision benefits. Traditional Medicare explicitly excludes coverage for most dental services, hearing aids, and eyeglasses, whereas almost all MA plans provide some coverage of these items. "Though these benefits are widely available" in MA plans, KFF reports, "the scope of specific services varies." For example, a dental benefit may cover only preventive care, be subject to an annual dollar limit, or be available only through a limited network of providers.[44] Moreover, data on the extent to which MA enrollees actually use these benefits are limited.[45]

Various legislative options are available for expanding dental, hearing, and vision coverage under traditional Medicare. The most straightforward and comprehensive approach would be to add those benefits to Part B of Medicare, as in H.R. 3, which the House passed in December 2019. Another would create a new voluntary benefit under a separate part of Medicare similar to the prescription drug benefit under Part D. A limited option would offer a discount card or cash assistance to help cover the cost of services.[46]

Although traditional Medicare does not cover most dental services, the law does provide for coverage of "medically necessary" dental care. CMS has interpreted this category of services very narrowly, however, and advocates have long argued that CMS policy is needlessly restrictive. CMS

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[42] Sarah Jane Tribble, "Older Americans Say They Feel Trapped in Medicare Advantage Plans," KFF Health News, January 5, 2024, https://kffhealthnews.org/news/article/medicare-advantage-medigap-enrollment-trap-switch-preexisting-conditions/.

[43] Kata Kertesz, "Expansions of Medigap Consumer Protections Are Necessary to Promote Health Equity in the Medicare Program," Journal of Aging Law and Policy, Vol. 13, Spring 2022, https://medicareadvocacy.org/wp-content/uploads/2022/07/kertesz-medigap-spring-2022.pdf.

[44] Freed *et al.*

[45] Brian Keyser and Andrea Ducas, *6 Medicare Advantage Data Gaps That the Centers for Medicare and Medicaid Services Must Fill,* Center for American Progress, July 29, 2024, https://www.americanprogress.org/article/6-medicare-advantage-data-gaps-that-the-centers-for-medicare-and-medicaid-services-must-fill/.

[46] Hannah Katch and Paul N. Van de Water, *Medicaid and Medicare Enrollees Need Dental, Vision, and Hearing Benefits*, Center on Budget and Policy Priorities, December 2020, https://www.cbpp.org/research/health/medicaid-and-medicare-enrollees-need-dental-vision-and-hearing-benefits.

has responded to this criticism and modestly expanded the types of dental services considered medically necessary.[47] Some further broadening of this category of services would be desirable but would benefit relatively few people.

[47] Meredith Freed, Tricia Neuman, and Juliette Cubanski, *Coverage of Dental Services in Traditional Medicare*, KFF, November 25, 2024, https://www.kff.org/medicare/issue-brief/coverage-of-dental-services-in-traditional-medicare/.