

**Special Report: Recent Changes in Law, Regulations and Guidance
Relating to Medicare Advantage and the Prescription Drug Benefit Program**

Discussion & Conclusion

September 2018

Introduction

Numerous changes were made to Medicare law, regulations and guidance during the first half of 2018. The changes are particularly noteworthy regarding Part C, governing private Medicare plans, known as Medicare Advantage (MA), and Part D, the prescription drug benefit. This report focuses on the impact to Medicare beneficiaries from changes to Parts C and D, pursuant to the Bipartisan Budget Act of 2018 (BBA), a final rule issued on Parts C and D (CMS-4182-F), and the Final Call Letter for 2019.¹

While the BBA made a number of significant changes to Medicare beyond Parts C and D, those changes are not generally discussed here.² Instead, this report highlights many of the changes to MA and Part D most relevant to Medicare beneficiaries and those supporting or assisting them. Part I of the report provides a summary of these changes, along with relevant citations, and is organized by changes to MA, Part D and changes that impact both programs. Part II of the report considers the potential impact of some of these changes, particularly with respect to MA benefits, consumer decision-making and informed choice, and the impact of the changes on the traditional Medicare program.

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I. Discussion

A. Introduction

As discussed above, Congress and CMS have created significant changes to private Medicare health and prescription drug plans, particularly concerning Medicare Advantage (MA). Much of stakeholders' attention has been focused on the new flexibilities granted to MA plans, namely the new targeted and supplemental benefits.

The changes certainly have the potential to enhance some people's coverage for items and services they would otherwise be unable to obtain. However, the rationale for expanding coverage in MA – enhancing quality of life, health outcomes – applies equally to those in traditional Medicare. Yet these coverage changes and flexibilities are not being incorporated into the traditional Medicare program.

Another concern is how these changes will affect informed choice and consumer decision-making. Elimination of the meaningful difference standard, loosening of uniformity requirements, redefining of supplemental benefits and other changes could dramatically increase the range of benefits and could make informed decision-making much more difficult.

There are many unanswered questions and very little clarity regarding how these changes will impact Medicare beneficiaries. CMS indicates that the Medicare Plan Finder and plan-issued materials such as the Evidence of Coverage (EOC) will contain new information, but how much? Will it be searchable electronically? How will people be able to compare plans? By health condition? How much will counseling (by objective parties such as State Health Insurance Assistance Programs (SHIPs), and by those motivated by profit interests, such as agents and brokers) now turn on a person's health conditions and needs? How will this be taken advantage of, or lead to unintended effects?

CMS states supplemental benefits cannot be offered solely as an inducement to enroll, and plans must be “mindful” of non-discrimination provisions. But in an era of deregulation, can we expect regulators to engage in necessary monitoring and oversight? If “intent” must be shown, how will beneficiaries and advocates be able to do so?

The following discussion considers how recent legislative, regulatory and other CMS action, including consumer materials, have worked to tip the scales in favor of Medicare Advantage over traditional Medicare. Oversight of and education surrounding the new MA flexibilities are then discussed, as is the need for more robust oversight.

B. MA v. Traditional Medicare

Medicare Advantage, Medicare's private plan option, currently enrolls approximately one-third of all enrollees, a figure that is projected to rise.³ Despite the Affordable Care Act's efforts to rein in significant overpayments to plans, at one point averaging 114% of what traditional Medicare would spend on a comparable individual, Medicare Advantage still costs the Medicare program more than the program spends on enrollees in traditional Medicare.⁴ This extra funding, however, has not clearly led to better health outcomes for MA enrollees.⁵

Despite the increased costs and mixed outcomes, both policymakers and program administrators continue to take measures to favor the MA program in relation to traditional Medicare. This “tipping of the scales” towards MA includes giving MA plans more flexibility in their benefit offerings than available in traditional Medicare as well as governmental efforts to steer people towards MA. In short, time, money, energy, focus and flexibility is being poured into the MA program in a manner that is not being done for traditional Medicare.

1. *Tipping the Scales to Favor Medicare Advantage*

As the Center for Medicare Advocacy noted in a March 2018 *CMA Alert*, recent changes in law, regulation and sub-regulatory guidance combine to tip the scales in favor of Medicare Advantage v. traditional Medicare.⁶ For example, MACRA (2015) will prohibit people eligible for Medicare on or after January 1, 2020 from purchasing a Medigap policy that covers the Part B deductible (sometimes referred to as policies that offer “first dollar coverage”); CURES Act (2016) implemented a new MA-Open Enrollment Period (discussed above) that can only be utilized by those enrolled in an MA plan and expanded MA access to people with End Stage Renal Disease (ESRD) while failing to extend Medigap rights to the same population; and, as described above, the Bipartisan Budget Act (BBA) of 2018 expands supplemental benefits in MA to individuals with chronic conditions, but not in traditional Medicare.

Administrative actions have also tipped the scales, including the new flexibilities allowed for MA benefits described in this report. In the current climate of “deregulation” a number of policies are being implemented that enhance Medicare Advantage “flexibility” in a way that that will disadvantage traditional Medicare beneficiaries.

2. *Steering in CMS Materials*

There are advantages and disadvantages to consider when choosing an MA plan or traditional Medicare. There are many factors that individuals should weigh in making such choices.⁷ To help people decide what best meets their needs, a good, unbiased counselor will point out the pluses and minuses of the different options. Similarly, CMS should objectively present the pros and cons. However, CMS appears to be working to tip the scales in favor of Medicare Advantage, failing to paint an accurate picture of the advantages and disadvantages of choosing MA or traditional Medicare.

Documents issued by CMS in Fall 2017 and thus far in 2018,⁸ emphasize the benefits of enrolling in an MA plan, minimize the drawbacks, and neglect the advantage of traditional Medicare - leaving readers with a misleading overview of MA and the Medicare program.

As noted in an October 2017 *CMA Alert*,⁹ official CMS Medicare Open Enrollment materials for 2018 – issued in Fall 2017 – encouraged beneficiaries to choose a private Medicare Advantage plan over original Medicare. On November 9, 2017, the Leadership Council of Aging Organizations (LCAO), a member coalition of national non-profit organizations serving older Americans, sent a letter expressing concern about this to CMS and committees of jurisdiction in Congress.¹⁰ The organizations listed in the LCAO letter wrote to express concerns that during the last Medicare open election period, CMS encouraged entities that assist Medicare beneficiaries with enrollment choices to disseminate information that was incomplete, biased towards Medicare Advantage,

and often failed to even mention traditional Medicare. The organizations urged CMS to take immediate corrective action to include and accurately portray the benefits and drawbacks of all coverage options in CMS materials.

Instead of heeding such concerns, CMS made such bias towards MA even more pronounced in the draft *2019 Medicare & You Handbook*. For example, the draft *Handbook* indicates that MA is the less expensive alternative for beneficiaries and fails to highlight the key distinction between traditional Medicare and MA: Traditional Medicare provides access to all Medicare participating providers nationwide, while MA limits access to a set network of providers in a specific geographic area. The draft *Handbook* also characterizes prior authorization requirements in MA plans, which are restrictions on access to services, as a benefit, rather than what they are: Mandatory hurdles for MA members not required for individuals in traditional Medicare. The Center for Medicare Advocacy joined Justice in Aging and the Medicare Rights Center and wrote to CMS conveying our concern that, rather than presenting information in an objective and unbiased way, the draft *2019 Medicare & You Handbook's* information about traditional Medicare and Medicare Advantage (MA) distorts and mischaracterizes facts in serious ways.¹¹

CMS continues this trend on its medicare.gov website, where there is a “new consumer friendly tool” for the next open enrollment period that “assists beneficiaries in choosing a plan that meets their unique health and financial needs based on a set of 10 quick questions.”¹² This tool, too, promotes MA enrollment over traditional Medicare; for example, it only provides information about the MA program in response to certain questions.¹³

As the Center has noted,¹⁴ the Medicare statute obligates the Secretary of Health and Human Services, and, by extension, CMS, to provide and promote accurate information about the Medicare program. For example, 42 U.S. Code §1395w-21(d)(1) states: “The Secretary shall provide for activities under this subsection to broadly disseminate information to Medicare beneficiaries (and prospective Medicare beneficiaries) on the coverage options provided under this section **in order to promote an active, informed selection among such options.**” [Emphasis added.] Recent materials issued by CMS do not meet this criteria.

C. MA Changes – Laissez Faire Oversight and Education

As described above, CMS has reinterpreted its authority under the Medicare statute and regulations to “permit MA organizations the ability to reduce cost-sharing for certain covered benefits, offer specific tailored supplemental benefits, and offer lower deductibles for enrollees that meet specific medical criteria, provided that similarly situated enrollees (that is, all enrollees who meet the identified criteria) are treated the same and enjoy the same access to these targeted benefits.”¹⁵ CMS reminds MA plans that as they implement this new flexibility, “they must be mindful of ensuring compliance with non-discrimination responsibilities and obligations.”¹⁶

CMS first articulated their reinterpretation of the MA plan uniformity standards in the proposed Parts C and D Rule (CMS-4182-P) published in the Federal Register on November 28, 2017 (82 FR 56336). The Center submitted extensive comments about this policy change, some of which are reproduced here.¹⁷

As CMS noted in the preamble to the proposed rule, CMS began to test Value-Based Insurance Design (VBID) through the Centers for Medicare and Medicaid Innovation (CMMI) beginning in January 2017. The demo is

limited by condition, geography and plan and incorporates significant consumer protections. By loosening uniformity standards for all plans prior to completing and analyzing VBID results, CMS is putting the proverbial cart before the horse scaling up an experiment before obtaining meaningful results, including whether such flexibility improves health outcomes – even for a much smaller cohort with specific conditions. CMS’ policy change is premature; there is not yet actionable, long-term feedback or lessons from the VBID demo about whether altering benefits and cost-sharing in this manner is effective among the MA population. This should be a crucial first step before significantly altering plan requirements.

As noted above, the Bipartisan Budget Act of 2018, signed into law on February 9, 2018 following issuance of the draft Call Letter, expands testing of the VBID demonstration nationally by 2020. Through this provision of the Budget Act, Congress has expressed its intent to introduce flexibility in MA benefits through the parameters of the pre-existing VBID demonstration model, including the built-in consumer protections. Congress did not express an intent to loosen MA restrictions in the manner contemplated by CMS in either the proposed C and D rule or the draft Call Letter.

Loosening uniformity requirements in the manner CMS proposes could, by itself, create a chaotic environment for Medicare beneficiaries trying to make informed decisions about what options might be best for them. To do so without issuing strong consumer protections and more firm restrictions on plans is a stark departure from the more thoughtful and cautious approach recently taken by CMS in rolling out the VBID demo.

When CMMI first proposed a VBID demo, the Center and other consumer advocates provided extensive feedback.¹⁸ The resulting demonstration model reflects CMS’ careful consideration of many important beneficiary protections. Such protections included strong and clear parameters for program design, including a multi-stakeholder and transparent process for identifying high-value services and developing conditions of participation; permitting only cost-sharing reductions; limiting or prohibiting advertising and other pre-enrollment marketing of cost-sharing adjustments; and opt-in beneficiary selection. Here, CMS allows alteration of benefits and cost-sharing without regard to the extensive consumer protections included in the limited VBID demo.

In response to comments “suggesting that this reinterpretation is premature” and that CMS wait until the VBID demo has concluded, CMS replied in the final rule that “While we have adopted features of the VBID demonstration, the VBID demonstration and the new uniformity flexibilities are distinct.” CMS has “no plans” to adopt additional demonstration requirements from VBID (oversight requirements, including marketing restrictions, monitoring to ensure compliance with demo rules, data reporting to help CMS evaluate outcomes, restricting low performing plans). CMS continued:

First, CMS has a robust compliance and auditing program to oversee MA plans and all benefit packages are reviewed by CMS. Therefore, we do not believe any additional monitoring or compliance is needed. Second, MA rules require that this benefit be available in marketing materials and transparent to enrollees. Therefore, we cannot restrict marketing this benefit.¹⁹

D. Consumer Decision-Making

A beneficiary's ability to make an informed decision about one's health care has been complicated by the recent changes mentioned above. On the one hand, CMS' elimination of the meaningful difference requirement for MA plans could make it harder to distinguish between plans offered by the same plan sponsor in a given service area. On the other hand, the reinterpretation of the uniformity requirements could significantly increase the variation between plans, including which enrollees within a given plan are entitled to what benefit.

As we noted in our comments to the proposed C and D Rule, there exists a large body of research and analysis that explores the challenges consumers face in making choices about their health insurance coverage, including when there are myriad plan options, with little to no standardization.²⁰ Much of the findings in this work weigh against CMS' proposal to loosen both meaningful difference standards and uniformity requirements.

Rather than loosening plan requirements, which will result in making informed choices far more difficult for beneficiaries, CMS should focus on addressing current methods of beneficiary decision-making, including enhancing consumer-directed tools (as we also discussed in our comments to the proposed rule). To the contrary, unfortunately, CMS notes in materials summarizing these changes that it "expects that eliminating the meaningful difference requirement will improve the plan options available for beneficiaries. New flexibilities in benefit design and more sophisticated approaches to consumer engagement and decision-making should help beneficiaries, caregivers, and family members make more informed plan choices."²¹

In response to concerns that the new MA flexibilities could increase beneficiary confusion, particularly as it relates to marketing materials provided during the annual election process, CMS responded in the final rule that "[t]o mitigate beneficiary confusion, CMS will require MA plans that take advantage of this flexibility to include benefit flexibility information in the CY 2019 EOC [Evidence of Coverage]. Also, indication of additional benefits and/or reduced cost-sharing for enrollees with certain health conditions will be displayed in Medicare Plan Finder."²²

Information about these new benefits has – as of the date of publication of this report – been lacking. The CMS Model documents, from which health plans create their individual Annual Notices of Change (ANOCs), Evidence of Coverage (EOC) documents, among others, make minimal reference to the new MA flexibilities.²³

In the final 2019 Call Letter describing these MA changes, CMS states that "supplemental benefits do not include items or services solely to induce enrollment."²⁴ Most surprisingly, CMS' 2019 marketing guidelines, renamed Communications & Marketing Guidelines, make no mention of new MA flexibilities.²⁵ There is no guidance to plans about how such benefits can be described, nor are there any rules for agents and brokers concerning how such benefits will be marketed.

In April 2018, contrary to usual procedure, instead of providing draft language for revisions to the existing marketing guidelines about which comments can be more thoughtfully tailored (particularly after the significant changes in MA rules following the final C and D Rule), CMS instead flagged a few issues that it proposed to change and solicited a broad call for comments, without an actual draft of the new guidelines. In comments to the then-unknown proposed changes in marketing guidelines, the Center and other advocacy organizations urged specific education/templates for describing these benefits.²⁶

In our comments, the Center highlighted that it is critical to ensure that information about these changes, and resulting plan-specific benefits, are presented in a manner that is not unduly confusing and does not deter enrollment by individuals based upon their health conditions or other factors. These consumer protections require firm oversight from CMS, not a relaxation of standards and restrictions.

The Center also called on CMS to issue new restrictions on agents and brokers, specifically to include a prohibition on those marketing plans from engaging or soliciting information about an individual's health condition. In the Center's comments²⁷, which were not incorporated in the final Communications and Marketing Guidelines, we distinguished marketing of Special Needs Plans for Chronically Ill individuals (C-SNPs), which can be targeted to individuals with certain health conditions, and the new more broad flexibilities for MA plans. As we stated:

These new flexibilities, including additional benefits and/or reduced cost-sharing for individuals with certain conditions, as chosen by individual plans, is extremely ripe for confusion, misunderstanding, and susceptibility to be misled, intentional or otherwise. CMS must act to minimize confusion and potential misconduct relating to the sale and marketing of such benefits.

We assert that anyone marketing MA plans – including first-tier, downstream and related entities – should be prohibited from asking prospective enrollees about their health condition(s). For various reasons, an individual's health condition should not drive marketing conversations or materials; among other things, such disclosures can lead to risk selection, or inappropriate steering either to or away from a given plan. Further, an individual's health condition(s)/status is a sensitive topic for many consumers, and they should not be made to believe that they need to or should disclose their health status. Under such conditions, people may easily be either led to believe that a particular plan is the best for them based upon what extra benefits might be available for them, or particularly ill-suited for them because it does not offer anything extra for people with their particular condition(s).

Since these extra benefits are contingent upon a plan's diagnosis (or confirmation) of conditions for which the extra benefits are tailored, an agent/broker or other representative marketing the plan is in no position to make clinical judgements, proclamations about health conditions, or promises or inducements based on such information.

Without more guidance from CMS, there is much uncertainty about how the new benefits will be marketed. Many questions remain, including:

- How will one compare all the plan variations on the Medicare Plan Finder (e.g., Will the new targeted benefits be searchable by health condition? Will estimated costs reflect cost-sharing reductions?)
- Will an individual's health condition drive communications and marketing, leading to risk selection, steering, etc.?
- In an era of deregulation and an emphasis on reducing the burden on plans, can we rely on regulators to engage in the extra analysis and oversight that will be required?

II. Conclusion

In the final rule implementing these significant changes to MA benefits, CMS states: “[a]s MA plans consider this new flexibility in meeting the uniformity requirement, they must be mindful of ensuring compliance with non-discrimination responsibilities and obligations. MA plans that exercise this flexibility must ensure that the cost-sharing reductions and targeted supplemental benefits are for health care services that are medically related to each disease condition.”²⁸

As noted in a recent blog by the Commonwealth Fund,²⁹ these new flexibilities for MA plans come at a time when the MA industry will see a significant increase in revenue, which together beg for greater oversight:

The confluence of higher rates and less restrictions on extra benefits should lead to greater scrutiny on plans by CMS. As these benefits are implemented, the agency will need to ensure that new benefits actually improve outcomes and are allocated in an equitable way. For example, CMS’ review of benefit design will need to ensure that high-cost enrollees are not being excluded in favor of healthier patients and that eligibility is based on objective, measurable medical criteria. Another important question is what happens when a patient has begun to rely on these new services if plans encounter a less favorable rate environment and cease to offer them.

Similarly, a recent article in the *New England Journal of Medicine* noted that there are potential pitfalls surrounding such expansion within MA, including favorable risk selection of healthier patients created by MA plans through the choice of benefits or coverage levels of costly services.³⁰ The Center for Medicare Advocacy couldn’t agree more with the authors’ statement: CMS oversight of both the design and marketing of supplemental benefits will be critical. Given the current climate of deregulation, and based on what our organization has seen emerge from CMS so far with respect to these new benefits, such oversight appears to be lacking and unlikely to appropriately increase.

Finally, as noted in the *NEJM* article, expansion of these benefits just in Medicare Advantage “leaves open the question of how to address the needs of similarly impaired beneficiaries in traditional Medicare.” In order to provide equitable access to benefits and services for all Medicare beneficiaries, policymakers should immediately develop equivalent benefits in traditional Medicare.

ENDNOTES

¹ The Bipartisan Budget Act of 2018 (BBA) was signed into law on February 9, 2018 (Public Law No. 115-123) see Division E – Health & Human Services Extenders; the bill is available [here](#). The final rule for Parts C & D (CMS-4182-F) was published on April 16, 2018 – entitled “Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program”, 83 Fed Reg 16440 (April 16, 2018), is available [here](#) (also see this Centers for Medicare & Medicaid Services (CMS) press release summarizing the rule [here](#)). The Final Call Letter, which is sub-regulatory guidance, was released on April 2, 2018, formally known as the Announcement of Calendar Year (CY) 2019 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter, is available [here](#); also see CMS press releases discussing the Call Letter [here](#) and [here](#). Note that some of the descriptions of changes in law and rules are taken directly from summaries provided by CMS.

² For an overview of the Center’s analysis of the BBA of 2018, see “Center for Medicare Advocacy Statement on the Health Extenders in the Budget Agreement”, February 9, 2018, at: <http://www.medicareadvocacy.org/statement-on-the-health-extenders-in-the-budget-agreement/>.

³ See, e.g., Kaiser Family Foundation, “Medicare Advantage 2017 Spotlight: Enrollment Market Update” (June 2017), which notes that MA enrollment is projected to rise to 41 percent of all Medicare beneficiaries by 2027 (citing January 2017 analysis by the Congressional Budget Office), available at: <https://www.kff.org/medicare/issue-brief/medicare-advantage-2017-spotlight-enrollment-market-update/>.

⁴ The Medicare Payment Advisory Commission (MedPAC), projected that 2018 MA payments would be 98 percent of fee-for-service spending, however, including other factors such as quality bonuses and “higher coding intensity” MA payments average 103 percent of fee-for-service spending. See “Report to the Congress: Medicare Payment Policy,” MedPAC (2018), available at: http://medpac.gov/docs/default-source/reports/mar18_medpac_ch13_sec.pdf?sfvrsn=0.

⁵ See, e.g., *Journal of the American Medical Association* (JAMA) Viewpoint article entitled “Time to Release Medicare Advantage Claims Data” by Niall Brennan, Charles Ornstein, and Austin B. Frakt (February 19, 2018), abstract available at: <https://jamanetwork.com/journals/jama/article-abstract/2673277>. The authors note “some studies show that Medicare Advantage has higher quality in certain dimensions, such as higher rates of preventive care and screenings among recipients” but other studies “suggest that Medicare Advantage does not serve certain beneficiaries well, such as those with greater illness severity.”

⁶ Center for Medicare Advocacy Weekly Alert “Tipping the Scales Toward Medicare Advantage” (March 21, 2018) <http://www.medicareadvocacy.org/tipping-the-scales-toward-medicare-advantage/>.

⁷ See, e.g., resources available on the Center for Medicare Advocacy’s website, including <http://www.medicareadvocacy.org/choosing-between-traditional-medicare-and-a-medicare-advantage-plan/> and <http://www.medicareadvocacy.org/what-would-work-better-for-you-deciding-between-traditional-medicare-and-a-medicare-advantage-plan/>.

⁸ Note that at the time of publication of this report, CMS had not yet released the final 2019 Medicare & You booklet and other Fall 2018 enrollment and outreach materials.

⁹ Center for Medicare Advocacy Weekly Alert “Remember You CAN Choose Original Medicare; Equitable Relief; This Week’s Sabotage News” (October 27, 2017), available at: <http://www.medicareadvocacy.org/cma-alert-remember-you-can-choose-original-medicare-equitable-relief-this-weeks-sabotage-news/>.

¹⁰ Leadership Council of Aging Organizations, http://www.lcao.org/files/2017/11/LCAO-Open-Enrollment-Letter-to-CMS_11_2017.pdf.

¹¹ See CMA Weekly Alert “Advocates Raise Concerns About Inaccuracies and Bias in Draft MEDICARE & YOU Handbook” (May 31, 2018), available at: <http://www.medicareadvocacy.org/advocates-raise-concerns-about-comparisons-between-traditional-medicare-and-medicare-advantage-in-draft-2019-medicare-you-handbook/>, and links to joint letter and press release therein.

¹² Note that when providing a defense for eliminating the MA meaningful difference rule, CMS notes, in mitigation, that “more sophisticated approaches to consumer engagement and decision-making should help beneficiaries, caregivers and family members make informed plan choices. [In the proposed rule] CMS cited supporting 1-800-MEDICARE and enhancements to [Medicare Plan Finder] that have improved the customer experience, such as including MA and Part D benefits and a new consumer friendly tool for the CY 2018 Medicare open enrollment period. This new tool assists beneficiaries in choosing a plan that meets their unique health and financial needs based on a set of 10 quick questions.” 83 Fed Reg 16491. It appears that CMS may be referring to the following tool on the www.medicare.gov website. At the launch page for the Medicare Plan Finder (<https://www.medicare.gov/find-a-plan/questions/home.aspx>) there is a box entitled “Additional Tools” that includes a link entitled “Help with Your Medicare Choices” (<https://www.medicare.gov/medicarecoverageoptions/>) which pulls up “10 questions to coverage.”

¹³ Some questions and answers in this online tool provide straightforward and helpful information, such as **question 4**, which addresses access to providers in traditional Medicare vs. MA. Other questions, however, only provide information about MA as an option, and/or are misleading. For example, **question 8** asks “Do you have a chronic condition or illness?” and if you “Yes”, the following appears: “You may want to consider a special type of Medicare Advantage (MA) Plan designed for people with specific diseases or conditions. Special Needs Plans tailor their benefits, provider choices, and drug formularies to best meet the specific needs of the groups they serve. All Medicare Advantage (MA) Plans have a yearly limit on your out-of-pocket costs for medical services. Once you reach this limit, you’ll pay nothing for covered services for the rest of the year.” Other than flagging the availability of SNPs, this answer does nothing to assist an individual with choosing between MA plans. In addition, putting aside the issue of whether or not MA plans do, indeed, serve people with chronic conditions better than traditional Medicare, this question clearly steers people towards MA plans. Further, it fails to mention that people with Medigaps, Medicaid and other forms of additional coverage are also often protected against out-of-pocket costs. **Question 9** asks “Is a low monthly premium for extra coverage important to you?” and if you answer “YES” the following appears: “The monthly premium you pay for a MA Plan is likely to be less than the combined premiums of Original Medicare, a Part D plan, and a Medigap policy, but premiums can vary widely depending on the type of plan you choose and where you live. Each type of plan covers different services and has different levels of deductibles, copayments, and coinsurance. This means that a plan with a higher monthly premium could possibly result in lower out-of-pocket expenses.” Even if one answers “NO” to question 9 the exact same response turns up. Not only is the question loaded by implying that one can get “extra coverage” for a low premium, it fails to account for someone who would rather have a known, stable expense that might be higher (e.g. monthly Medigap premium) in exchange for knowing that their cost-sharing will be covered, vs. a lower MA premium with high cost-sharing if and when services are needed and incurred.

¹⁴ CMA Weekly Alert “Advocates Raise Concerns About Inaccuracies and Bias in Draft MEDICARE & YOU Handbook” (May 31, 2018), available at: <http://www.medicareadvocacy.org/advocates-raise-concerns-about-comparisons-between-traditional-medicare-and-medicare-advantage-in-draft-2019-medicare-you-handbook/>.

¹⁵ Final 2019 Call Letter, p. 209.

¹⁶ 83 Fed Reg 16481.

¹⁷ Center for Medicare Advocacy Comments on Proposed Rule for Medicare Parts C & D (January 17, 2018): <http://www.medicareadvocacy.org/center-comments-on-proposed-rule-for-medicare-parts-c-d/>; also see Center for Medicare

Advocacy Comments on CMS' Draft 2019 Call Letter for Medicare Advantage And Part D (March 5, 2018) available at: <http://www.medicareadvocacy.org/cma-comments-on-cms-draft-2019-call-letter/>.

¹⁸ See CMA Comments re: Medicare Advantage (MA) Value-Based Insurance Design (VBID) Model September 17, 2015 available at: <http://www.medicareadvocacy.org/cma-comments-re-medicare-advantage-ma-value-based-insurance-design-vbid-model/>.

¹⁹ See discussion at 83 Fed Reg 16484.

²⁰ See, e.g., footnote 1 in the Center's Comments on Proposed Rule for Medicare Parts C & D (January 17, 2018): <http://www.medicareadvocacy.org/center-comments-on-proposed-rule-for-medicare-parts-c-d/>.

²¹ CMS Press Release entitled "CMS Finalizes Policy Changes and Updates for Medicare Advantage and the Prescription Drug Benefit Program for Contract Year 2019 (CMS-4182-F)" (April 2, 2018), available at: <https://www.cms.gov/newsroom/fact-sheets/cms-finalizes-policy-changes-and-updates-medicare-advantage-and-prescription-drug-benefit-program>.

²² 83 Fed Reg. 16484.

²³ See the CMS website at: <https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/MarketngModelsStandardDocumentsandEducationalMaterial.html>; specifically, see: https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/2019-Model-Materials_Updated_072418.zip for The Model Evidence of Coverage (EOC) for Medicare Advantage HMOs (entitled "CY2019_7_HMO_MA_EOC_07192018.doc"); see Chapter 4, pp. 50-51 and p. 60.

²⁴ 2019 Final Call Letter, p. 208.

²⁵ See CMS' 2019 Medicare Communications and Marketing Guidelines, available at: https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/CY2019_Medicare_Communications_and_Marketing_Guidelines.pdf.

²⁶ Center Comments to Medicare Marketing Guidelines (MMG) (April 2018), available at: <http://www.medicareadvocacy.org/center-comments-to-medicare-marketing-guidelines-mmg/>.

²⁷ Center Comments to Medicare Marketing Guidelines (MMG) (April 2018), available at: <http://www.medicareadvocacy.org/center-comments-to-medicare-marketing-guidelines-mmg/>.

²⁸ 83 Fed Reg 16481 (citations omitted).

²⁹ Commonwealth Fund, "With Great Power Comes Great Responsibility: Medicare Advantage's Newfound Supplemental Benefit Flexibility" by Billy Wynne and Max Horowitz (June 7, 2018), available at: <https://www.commonwealthfund.org/blog/2018/great-power-comes-great-responsibility-medicare-advantages-newfound-supplemental-benefit>.

³⁰ "Integrating Medical and Nonmedical Services — The Promise and Pitfalls of the CHRONIC Care Act" Amber Willink, Ph.D., and Eva H. DuGoff, Ph.D. (June 7, 2018), *New England Journal of Medicine*; cite: N Engl J Med 2018; 378:2153-2155; available at: <https://www.nejm.org/doi/full/10.1056/NEJMp1803292>.