CHAPTER 3

Standardized benefits in Medicare Advantage plans

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Chapter summary

This year, Medicare beneficiaries have an average of 41 Medicare Advantage (MA) plans (offered by an average of 8 insurers) available in their area. The average number of available plans has more than doubled in the last five years. Plan benefit packages vary, and research has found that beneficiaries have difficulty comparing plans and deciding which one best meets their needs when they have many choices.

One source of variation is cost sharing for Part A and Part B services, which MA plans are required to cover (with the exception of hospice). MA plans can develop their own cost-sharing rules for these services, but their cost sharing must be actuarially equivalent to cost sharing in Medicare's traditional fee-for-service (FFS) program, and there are limits on how much plans can charge for certain services. Plans must also have an annual cap on out-of-pocket costs. Most plans use some of the rebates they receive under the MA payment system to reduce enrollee cost sharing. Conventional plans (plans that are available to all beneficiaries) tend to use the same broad type of cost sharing for a given service, such as daily copayments for inpatient acute care, coinsurance for dialysis, and flat per service copayments for physician visits. However, the actual amounts that plans charge for some services vary widely. Special needs plans have different incentives than conventional plans when developing

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cost-sharing rules and are more likely to either use the same cost sharing as FFS Medicare or have no cost sharing.

Another source of variation is the coverage of non-Medicare supplemental benefits. All plans cover at least some supplemental benefits, and they play an important role in attracting enrollment. However, the coverage of these benefits is entirely optional, unlike coverage for Part A and Part B services, and varies widely across plans. Some of the most common supplemental benefits are vision, fitness, hearing, and dental benefits, but plans can cover a variety of other benefits as well. In recent years, plans have been given more flexibility to cover a wider range of benefits, such as nonmedical benefits like meals or transportation, and to target benefits to disease-specific groups of enrollees. Our understanding of utilization and spending trends for supplemental benefits is limited because plans do not submit encounter data for them.

One way for beneficiaries to compare plans more easily would be to require plans to have standardized benefits. This approach is used in both the Medigap market and the health insurance exchanges created by the Affordable Care Act of 2010. We use the term *standardization* to refer to both (1) the set of services covered by the plan and (2) the cost sharing that the plan's enrollees pay for those services. For Part A and Part B services, standardization would be limited to changes in enrollee cost sharing since all plans cover the same required set of services. For supplemental benefits, standardization would be more complicated because it would raise questions about what services plans should cover and how those services should be defined, in addition to changes in enrollee cost sharing.

The use of standardized benefits in MA would require policymakers to consider a number of complex issues, such as the number and design of any standardized benefit packages and whether insurers could still offer plans that are not standardized. One option would be to develop a limited number of benefit packages for Part A and Part B cost sharing and require insurers to use them in their plans. These packages would specify the plan's annual limit on enrollee out-of-pocket costs and the cost-sharing amounts for all major services.

Standardizing supplemental benefits could make these benefits more transparent and help ensure that plans provide sufficient value to MA enrollees and taxpayers, but policymakers would need to balance the goals of making it easier for beneficiaries to compare plans and letting plans design

their own benefits. One way to realize some of the gains from standardized benefits while giving plans flexibility would be to standardize a limited number of common supplemental benefits, such as dental, hearing, and vision benefits. For example, policymakers could specify the coverage limits, cost-sharing rules, and per enrollee spending limits for those benefits. These requirements would apply only to plans that chose to provide dental, hearing, and vision benefits. The rules that govern all other supplemental benefits would remain the same.

Using the approach outlined in this chapter, beneficiaries who compare MA plans would be able to understand with relative ease what each plan charges for Part A and Part B services and the major supplemental benefits it provides. Selecting a plan would still involve other important factors—such as the plan's premium, the drugs on its formulary, and its provider network—but these changes would make the process simpler and easier to navigate. In addition, by requiring MA plans to submit encounter data for supplemental benefits, policymakers and researchers can better understand the impact of supplemental benefits on MA enrollees. ■

Introduction

Enrollment in the Medicare Advantage (MA) program has grown steadily for years, and this year a majority of beneficiaries with Part A and Part B coverage are enrolled in MA plans. Between 2018 and 2023, the average number of plans available to beneficiaries more than doubled, from 20 to 41.[1] MA plans can design their own benefit packages, which usually include extra benefits not offered in Medicare's traditional fee-for-service (FFS) program, such as reduced cost sharing for Part A and Part B services and non-Medicare supplemental benefits, such as dental, hearing, and vision services. The large number of plans, combined with the variation in benefits, can make it difficult for beneficiaries to compare plans and select the one that best meets their needs.

One way to address this challenge would be to require plans to have standardized benefits. We use this term to refer to both (1) the set of services covered by the plan and (2) the cost sharing that the plan's enrollees pay for those services. There are several ways to standardize benefits, but they often involve specifying some or all of the services that plans must cover and some or all of the cost-sharing amounts that plans charge for those services. This arrangement would make it easier for beneficiaries to compare plans by giving them a more clearly defined set of choices.

This chapter reviews the difficulties beneficiaries face when comparing a large number of health plans and efforts to standardize benefits in other programs. We examine the cost-sharing rules that MA plans use for Part A and Part B services, which all plans are required to cover (with the exception of hospice), and plans' coverage of supplemental benefits, where coverage is entirely optional and varies widely across plans. We then consider some ways that policymakers could standardize MA benefits. For Part A and Part B services, standardization would be limited to changes in enrollee cost sharing since all plans cover the same required set of services. For supplemental benefits, standardization would be more complicated because, in addition to changes in cost sharing, it would raise questions about what services plans should cover and how those services should be defined.

Selecting an MA plan can be a challenging process for beneficiaries

The MA program gives beneficiaries the option of receiving their Medicare benefits through a managed care plan. Beneficiaries who wish to enroll select a plan in a regulated market in which competing insurers offer a variety of plans. A fundamental assumption of this model is that beneficiaries are in the best position to decide which plan meets their needs.

However, selecting a plan is difficult because plans differ in many respects: premiums, cost-sharing rules, provider networks, supplemental benefits, the drugs they cover (for plans that include Part D drug coverage), quality, and other factors, such as brand reputation. CMS has taken actions to make it easier for beneficiaries to get information on the plans available in their area, such as requiring plans to use standard marketing materials and creating the Medicare Plan Finder website, but the process remains challenging.

The increasing number of MA plans adds to the difficulty. Between 2018 and 2023, the average number of plans available to beneficiaries more than doubled, from 20 to 41. The entry of new insurers into the MA market and regulatory changes that have made it easier for insurers to offer multiple plans are among the reasons for this growth.[2]

Researchers have found that individuals have more difficulty selecting a health plan when they have many choices. Studies included in a review of the literature on consumer decision-making for health plans have found that, as the number of choices increases, individuals are less likely to correctly identify the lowest-cost plan, less likely to review all of their coverage options, and more likely to select a plan that is clearly inferior to another available plan (Taylor et al. 2016). Many of those studies found that individuals had difficulties even when the increase in the number of choices was relatively small—for example, from around 5 choices to around 10. The same literature review found that many people have difficulty understanding concepts such as coinsurance and deductibles, tend to put too much emphasis on premiums over cost sharing when picking plans, and are susceptible to how plan choices are presented.

One study that compared growth in MA enrollment with growth in the number of MA plans found that enrollment grew faster in areas where the increase in the number of plans was relatively small (fewer than 15 plans), suggesting that beneficiaries were more likely to enroll when they had a more manageable number of choices (McWilliams et al. 2011). The same study also found that beneficiaries with some degree of cognitive impairment did a poorer job of selecting plans that minimized their out-of-pocket costs.

One way that policymakers could address these challenges is by requiring MA plans to have standardized benefits. Standardization could be implemented in several ways, but one approach, used in other health insurance programs, would be for Medicare to develop a limited number of benefit packages that insurers would be required to offer in their plans. This approach would make it easier for beneficiaries to compare plans by giving them a more clearly defined set of choices.

Standardization has been used in other health insurance markets

The MA program's basic structure, where beneficiaries select a health insurance plan from a range of available options, is used in other health care programs, such as Medigap and the health insurance exchanges created by the Affordable Care Act of 2010 (ACA). These programs have also faced the challenge of ensuring that individuals can adequately understand their plan options and select one that meets their needs. In our view, standardization in these programs can be instructive for standardization efforts in MA.

The Medigap market

One of the best-known examples of standardization is the market for Medicare supplemental or Medigap policies, which are private insurance policies that cover some or all of the cost sharing for Part A and Part B services. Medigap policies can be sold only to beneficiaries enrolled in Medicare FFS. Prior to standardization, there had been persistent concerns that the market was too confusing for beneficiaries—insurers sold hundreds of different policies, which made it difficult to compare plans—and was prone to marketing abuses, such as agents selling multiple policies with duplicative coverage to the same person. In 1990, the Congress addressed those concerns by requiring all Medigap policies to have standard benefit packages. This requirement applies to all policies sold after July 31, 1992 (McCormack et al. 1996).[3]

The Congress assigned the task of developing the standardized plans to the National Association of Insurance Commissioners, which created 10 plans known simply as Plan A through Plan J. The plans were roughly ordered from least comprehensive to most comprehensive, with Plan A covering a minimum set of "core benefits" and the other plans covering both the core benefits and a variety of additional benefits.[4]

Since then, there have been relatively few changes to the lineup of standardized plans:

- Four original plans—E, H, I, and J—were closed to new entrants in 2010 following legislative changes to the Medicare benefit package. Plan E was the only plan that covered certain preventive and at-home recovery services; it became redundant when Medicare added coverage for those services. Similarly, Plans H, I, and J were the only plans with prescription drug coverage; they became redundant following the creation of the Part D drug benefit.
- Four new plans—K, L, M, and N—have been added. Plans K and L were added in 2005; they cover less cost sharing than other Medigap plans but also have an annual limit on out-of-pocket costs. Plans M and N were added in 2010; Plan M differs from most other plans because it covers only half of the hospital deductible, while Plan N is distinctive because beneficiaries have copayments of $20 for physician office visits and $50 for emergency room visits.
- Plans C and F were closed to new entrants in 2020. They were the only plans that covered the Part B deductible; the Congress closed them due to concerns that their "first dollar" coverage led to higher Medicare spending. Beneficiaries who already had C or F policies were allowed to keep them.

Table 3-1 shows which types of cost sharing are covered by each Medigap plan. Most plans cover either all or none of a particular type of cost sharing (indicated by "Yes" and "No," respectively). Three

TABLE 3–1

Benefits covered by the 10 standard Medigap plans

	Plan type									
	A	B	C	D	F	G	K	L	M	N
Part A cost sharing										
Hospital deductible	No	Yes	Yes	Yes	Yes	Yes	50%	75%	50%	Yes
Hospital coinsurance and 365 additional lifetime days	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Skilled nursing facility coinsurance	No	No	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes
Hospice coinsurance or copayment	Yes	Yes	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes
Part B cost sharing										
Deductible	No	No	Yes	No	Yes	No	No	No	No	No
Coinsurance or copayment	Yes	Yes	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes
Excess charges	No	No	No	No	Yes	Yes	No	No	No	No
Other benefits										
Blood deductible	Yes	Yes	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes
Foreign travel exchange	No	No	80%	80%	80%	80%	No	No	80%	80%
Out-of-pocket limit	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	N/A	N/A

Note: N/A (not applicable). Plans C and F have been closed to new entrants since the start of 2020. Plan N requires beneficiaries to make copayments for physician office visits and emergency room visits. Plans F and G have a high-deductible option in some states.

Source: "How to compare Medigap policies" on the Medicare.gov website.

plans—K, L, and M—cover either 50 percent or 75 percent of some types of cost sharing. In addition, six plans cover emergency care received during foreign travel, which Medicare does not cover. Despite the array of options, most Medigap enrollment is concentrated in a handful of plans. In 2020, almost 90 percent of beneficiaries with standardized plans were enrolled in Plan F (49 percent), Plan G (29 percent), or Plan N (11 percent) (America's Health Insurance Plans 2022).

The adoption of standardized Medigap plans is generally viewed as a success, with consumer representatives and state insurance regulators reporting that beneficiaries found it easier to compare plans, consumer complaints declined, and the overall market remained stable. However, it is unclear whether the reforms made the market more competitive (Fox et al. 2003, McCormack et al. 1996). One study found that the scope for price competition is limited because the market is dominated by two large insurers and beneficiaries have strong brand preferences (Starc 2014). Another study found that standardization reduced the share of beneficiaries with Medigap coverage because it raised the minimum level of coverage relative to some pre-reform policies and thus made it more expensive (Finkelstein 2004).

The ACA's health insurance exchanges

The ACA created state-based health insurance exchanges to replace the individual and small-group markets, and it provides subsidies to help people who meet certain income limits buy coverage through

those exchanges. States can either develop their own exchange or let CMS provide coverage through a federally run exchange. As of 2023, 20 states and the District of Columbia have their own exchanges; the other 30 states use the federally run exchange (Kaiser Family Foundation 2023).[5]

The ACA exchanges have several structural features that have helped standardize their plans. Most notably, all plans are grouped into four "metal tiers" that use actuarial value—the average share of spending covered by the plan—to measure the generosity of the plans' coverage. Plans in the lowest tier, bronze, cover 60 percent of spending, followed by silver (70 percent), gold (80 percent), and platinum (90 percent). All plans must also cover a set of essential health benefits and have a cap on annual out-of-pocket spending. These provisions still give insurers significant flexibility to develop their own benefit packages and have raised concerns that the resulting variation in plan benefits makes it difficult to compare plans, even within the same metal tier.

As a result, in 2022, 11 of the 21 states that operated their own exchanges required insurers to offer some type of standardized plan.[6] The level of standardization varied. For example, Maryland had a low level of standardization; it required all standardized plans within a given metal tier to have the same deductible, but insurers developed the other cost-sharing rules and could still offer nonstandardized plans. In contrast, nine states with higher levels of standardization had detailed plan designs that specified the exact deductible, annual out-of-pocket limit, and cost-sharing amounts to be used in each metal tier. Six of these states also limited the sale of nonstandardized plans. For example, California prohibits the sale of nonstandardized plans entirely and, starting in 2023, Washington limits insurers to one or two nonstandardized plans in each metal tier (Assistant Secretary for Planning and Evaluation 2022).

One prominent state that uses standardized plans is Massachusetts, which created its exchange in 2006 and served as a model for the ACA. The state required insurers to sell standardized plans starting in 2010. One study found that this change led consumers to select more generous plans—the share of people enrolled in bronze plans declined—and resulted in "substantial shifts" in the market shares for participating insurers. The study attributed these effects to changes in the consumer decision-making process (standardization made the differences between metal tiers more apparent) and the mix of plans being offered (standardization led insurers to offer plans that had not been available previously). There was relatively little impact on premiums (Marzilli Ericson and Starc 2016).

More recently, CMS required insurers to sell standardized ACA plans on the federally run exchange starting in 2023.[7] A key motivation for this requirement was the rapid growth in the number of plans due to changes such as an increase in the number of insurers selling ACA plans and the repeal of rules requiring insurers to offer plans with "meaningful differences." Between 2019 and 2022, the average number of plans available on the exchange (across all metal tiers) grew from 26 to 108, and in 2022 almost three-quarters of enrollees (73 percent) had more than 60 plans available (Assistant Secretary for Planning and Evaluation 2022). Under the new policy, in areas where insurers offer a nonstandardized plan, they must also offer a standardized plan with the same metal tier and product type (such as an HMO or preferred provider organization (PPO)) (Centers for Medicare & Medicaid Services 2022c). CMS did not initially put any limits on the sale of nonstandardized plans but announced earlier this year that, within a given metal tier and product type, insurers will be limited to four nonstandardized plans in 2024 and two nonstandardized plans in 2025 and later years (Centers for Medicare and Medicaid Services 2023).

The designs for the federally standardized plans are shown in Table 3-2. Each design specifies the plan's deductible, out-of-pocket limit, and cost-sharing amount for most major service categories, including prescription drugs. CMS aimed to make the standardized plans similar to the most popular existing plans and developed these designs by using 2021 enrollment and benefit data to calculate the enrollment-weighted median cost-sharing amount for each metal tier and service category.

Since plans become more generous across the metal tiers ranging from bronze to platinum, the cost-sharing requirements become steadily smaller. The bronze plan is effectively a form of catastrophic coverage since it does not provide any coverage until enrollees have met a $9,100 deductible and then covers all costs

TABLE 3–2

Standardized plan designs that are offered in the federal health insurance exchange in 2023

Service category	Metal tier			
	Bronze	Silver	Gold	Platinum
Annual limit on cost sharing	$9,100	$8,900	$8,700	$3,000
Deductible	$9,100	$5,800	$2,000	$0
Inpatient hospital services	NCAD	40%	25%	$250*
Skilled nursing facility	NCAD	40%	25%	$150*
Outpatient facility fee	NCAD	40%	25%	$150*
Outpatient surgery physician and services	NCAD	40%	25%	$150*
Emergency room services	NCAD	40%	25%	$100*
Primary care visit	NCAD	$40*	$30*	$10*
Urgent care	NCAD	$60*	$45*	$15*
Specialist visit	NCAD	$80*	$60*	$20*
Mental health and substance abuse disorder outpatient office visit	NCAD	$40*	$30*	$10*
Speech therapy	NCAD	$30*	$30*	$10*
Occupational and physical therapy	NCAD	$30*	$30*	$10*
Imaging (CT/PET scans, MRIs)	NCAD	40%	25%	$100*
X-rays and diagnostic imaging	NCAD	40%	25%	$30*
Laboratory services	NCAD	40%	25%	$30*
Generic drugs	NCAD	$20*	$15*	$5*
Preferred brand drugs	NCAD	$40*	$30*	$10*
Nonpreferred brand drugs	NCAD	$80	$60*	$50*
Specialty drugs	NCAD	$350	$250*	$150*

Note: NCAD (no charge after deductible is met), CT (computed tomography), PET (positron emission tomography), MRI (magnetic resonance imaging). This table does not include designs for an "expanded bronze" plan or for three types of silver plans for individuals who receive cost-sharing reduction subsidies. The requirement to offer these standardized plans does not apply to states with their own health insurance exchanges. There are slightly different plan designs for Delaware and Louisiana.
*Plan deductibles do not apply to these services.

Source: HHS Notice of Benefit and Payment Parameters for 2023, table 12.

beyond that point. The other three plans have a mix of copayments and coinsurance. Copayments are used for professional services (such as primary care visits and physical therapy) and prescription drugs, while coinsurance is largely used for the other service categories. The high deductibles in many ACA plans have been a concern for policymakers, so designs for the silver, gold, and platinum plans specify that some services (marked with an asterisk) are not subject to the deductible.[8]

MA cost sharing for Part A and Part B services

The MA program differs from traditional Medicare because it relies on private plans that receive capitated payments instead of FFS reimbursement to deliver the Part A and Part B benefit package. As an alternate delivery system, MA plans can manage costs using a

TABLE 3–3

The in-network MOOP limits for MA plans have increased since 2020

Limit type	2011–2020	2021	2022	2023	2024
Lower	$3,400	$3,450	$3,450	$3,650	$3,750
Intermediate	N/A	N/A	N/A	6,000	6,450
Mandatory	6,700	7,550	7,550	8,300	9,100

Note: MOOP (maximum out-of-pocket), MA (Medicare Advantage), N/A (not applicable). Between 2011 and 2022, the lower limit was known as the voluntary limit. The figures for 2024 are projections that CMS will update as more recent fee-for-service spending data become available.

Source: MedPAC analysis of MA rate announcements (2011–2020), Health Plan Management System memoranda (2021–2022), and 2022 final rule on MOOP limits and service category cost-sharing standards (2023–2024).

variety of tools that are unavailable to the FFS program, such as provider networks and prior authorization, and that can affect how enrollees receive services.

MA plans also have the flexibility to develop their own cost-sharing rules instead of using FFS cost-sharing rules. However, this flexibility is subject to numerous limitations that are aimed at ensuring that plans do not have benefit designs that discriminate against beneficiaries who are sicker and use more services. Some of those limitations apply to aggregate cost sharing, while others apply to cost sharing for particular services.

Aggregate limits on cost sharing

MA plans' overall cost sharing is constrained in two ways. First, plans must ensure that their cost sharing for all Part A and Part B services is, in aggregate, actuarially equivalent to FFS cost sharing. As a result, any efforts by plans to charge higher cost sharing for some services must be offset by lower cost sharing on other services. Plans can also charge less in overall cost sharing than FFS; if they do, the difference between the two amounts is treated as an extra benefit and financed by plan rebates or supplemental enrollee premiums.

Second, MA plans must have an annual cap on out-of-pocket spending for in-network services, known as a maximum out-of-pocket (MOOP) limit.[9] CMS calculates three types of limits based on FFS spending data:

- The mandatory limit is based on the 95th percentile of out-of-pocket FFS spending.
- The lower limit (known in earlier years as the voluntary limit) is based on the 85th percentile of out-of-pocket FFS spending, a lower amount.
- Starting this year, CMS has added an intermediate limit, which is the midpoint between the lower and mandatory limits.[10]

Plans have the flexibility to set their MOOP limit anywhere between $0 and the mandatory limit. CMS encourages plans to have more generous limits by allowing plans that are at or below the intermediate limit to charge higher cost sharing for certain services. If an MA plan has the same distribution of per beneficiary spending as in FFS, roughly 5 percent of its enrollees will reach the mandatory limit and 15 percent will reach the lower limit.

The MOOP limits have increased since 2020 after remaining unchanged for a decade (Table 3-3). The higher limits are largely due to the enactment of the 21st Century Cures Act, which in 2021 lifted restrictions on the ability of beneficiaries with end-stage renal disease (ESRD) to enroll in MA plans.[11] Before then, beneficiaries with ESRD were largely prohibited from enrolling in MA, so CMS excluded them from the FFS spending data used to calculate the MOOP limits. After the prohibition was lifted, CMS began including them in its calculations. Since beneficiaries with ESRD typically have very high spending, this change has resulted in higher MOOP limits, especially the mandatory limit. CMS is gradually phasing in the effects of including the ESRD population and expects

to complete this transition in 2024. At that point, the voluntary and mandatory limits will be about 10 percent and 36 percent higher, respectively, than they were in 2020.

The increase in the MOOP limits has raised concerns that some MA plans will increase their limits accordingly and thus provide less protection against high out-of-pocket costs. In response, CMS added the intermediate limit and broadened the range of services for which plans with more generous MOOP limits can charge higher cost sharing. CMS intends for the added flexibility to provide a sufficient incentive to keep plans from raising their MOOP limits.

In 2023, among conventional MA plans, 29 percent have MOOP limits in the lower range ($0 to $3,650), 47 percent have limits in the intermediate range ($3,651 to $6,000), and 24 percent have limits in the mandatory range ($6,001 to $8,300). Those shares have changed relatively little since 2015 (we combined the figures for the intermediate and mandatory ranges to make the 2023 data comparable with earlier years) (Centers for Medicare & Medicaid Services 2022b). The median in-network limit for conventional MA plans (plans that are available to all beneficiaries) is $4,700, and 50 percent of enrollees are in plans that have limits between $3,450 and $6,000. Only 2 percent of enrollees are in plans that use the mandatory limit of $8,300. This pattern suggests that competitive pressures lead most plans to provide greater protection against out-of-pocket costs than the minimum CMS requirement. However, the lack of plans with very low MOOP limits (only 8 percent of conventional plans have limits of $2,000 or less) also suggests that plans believe there is a point at which enrollees are more interested in other plan features.

Service-specific limits on cost sharing

In addition to the aggregate limits, plans must also comply with a complex set of limits on the cost sharing they can charge for certain service categories (Table 3-4, p. 120). Conceptually, there are three major types of service-specific limits:

- Services for which plans cannot charge more in cost sharing than FFS does. This limit applies to such major categories as inpatient care, skilled nursing facility (SNF) care, dialysis, and Part B drugs.
- Services for which plans can charge more than FFS does but that are subject to some specified limit. This limit applies to categories such as physician services.
- Services for which plans cannot charge more than 50 percent in coinsurance or an actuarially equivalent copayment. This general limit applies to any categories, such as outpatient hospital services, for which CMS does not have any specific limits on cost sharing.

Some of these limits—such as the prohibition on charging higher cost sharing than FFS for dialysis, SNF care, or Part B drugs—are specified in law. CMS also has the authority to put cost-sharing limits on other services to prevent plans from using benefit designs that the agency considers discriminatory. For example, CMS added cost-sharing limits for rehabilitation services, starting with the 2020 plan year, and has indicated it may add a limit for ambulance services in the future (Centers for Medicare & Medicaid Services 2022b).

The service-specific limits take several forms. Some put a cap on allowable coinsurance; for example, plans with mandatory MOOP limits cannot charge more than 20 percent in coinsurance for some types of durable medical equipment (DME). Some put a cap on allowable copayments, such as the 2023 limits of $95 for an emergency room visit (for plans with mandatory MOOP limits) or $196 per day for SNF care. And some services have both types of limits; for example, in 2023 plans cannot charge more than 20 percent in coinsurance or a $65 copayment for therapeutic radiological services. CMS uses FFS spending data to determine the copayment limits. For example, if CMS wanted to limit copayments for a particular service category to the equivalent of 40 percent in coinsurance, it would calculate the average FFS-allowed amount for the service category, multiply that figure by 40 percent, and use the resulting dollar amount as the copayment limit. However, the agency has not updated its copayment limits regularly.

Some limits have a much greater effect on plan behavior than others. For example, the limits for physician services have relatively little effect: In 2023, less than 1 percent of conventional MA plans charge the maximum copayment for primary care and

TABLE 3–4

MA plans are subject to several service-specific limits on cost sharing

Type of service-specific limit	Services affected	Can plans with more generous MOOP limits charge more?
Plans cannot charge higher cost sharing than FFS	Inpatient (acute and psychiatric)	Yes, up to 125% of FFS
	Skilled nursing facility care	Yes, can charge copayments during first 20 days of stay
	Home health	Yes, can impose cost sharing
	Dialysis	No
	Part B drugs	No
	DME	Yes, for some types of DME, but limit still applies to overall cost sharing for all DME services
Plans can charge higher cost sharing than FFS but are still subject to limits 2022: Copayment limits that were originally equal to 50% coinsurance but were not updated regularly 2023–2026: Transition to new limit of 30% coinsurance or equivalent copayments	Physician services Rehabilitation services Urgent care Partial hospitalization	2022: No 2023–2026: Yes, transition to new limits of 40% coinsurance (intermediate MOOP plans) or 50% coinsurance (lower MOOP plans) or equivalent copayments
Plans must charge lower cost sharing than FFS (15% of projected 2021 median FFS cost)	Emergency services	Yes, can charge up to 20% of projected 2021 median FFS cost
Plans cannot charge cost sharing	Preventive services	No
Plans cannot charge more than 50% coinsurance or an equivalent copayment	Any services not listed above	No

Note: MA (Medicare Advantage), MOOP (maximum out-of-pocket), FFS (fee-for-service), DME (durable medical equipment). These limits apply only to in-network care.

Source: MedPAC analysis of MA rate announcements, Health Plan Management System memoranda, and 2022 final rule on MA cost-sharing limits.

only 3 percent charge the maximum copayment for specialist care. Conversely, 98 percent of plans charge the maximum amounts for chemotherapy drugs and dialysis.

Changes to the MOOP limits that took effect in 2023 were accompanied by several changes to the service-specific limits. Two changes are particularly noteworthy. First, the limits for categories such as physician services, which previously had copayment limits that applied equally to all plans, have been replaced with a three-tiered system that allows plans with more generous MOOP limits to charge higher cost sharing. Under the new system, plans with mandatory

MOOPs can charge up to 30 percent in coinsurance, plans with intermediate MOOPs can charge up to 40 percent, and plans with lower MOOPs can charge up to 50 percent. (Each tier also has an actuarially equivalent limit on copayments.) Second, many copayment limits are being increased to reflect more current FFS spending data. Some increases will be substantial because many limits had not been updated for years. The changes for Part B drugs are especially large; the copayment limit for chemotherapy drugs will rise from $75 to $280, and the limit for other drugs will rise from $50 to $320. Most changes to the service-specific limits are being implemented over a four-year period and will take full effect in 2026.

Plans with more generous MOOP limits already had the ability to charge higher cost sharing for some services—such as inpatient acute and psychiatric care, the first 20 days of SNF care, home health care, and emergency services—so the new flexibility described above is an incremental expansion. Overall, relatively few conventional MA plans with more generous MOOP limits take advantage of the ability to charge higher cost sharing than they could with a mandatory MOOP. For example, in 2023, the share of plans with lower or intermediate MOOPs that charge higher cost sharing than they could with a mandatory MOOP is less than 1 percent for inpatient acute care, 4 percent for inpatient psychiatric care, 7 percent for SNF care, and 1 percent for home health care. The main exception is emergency services, where 43 percent of plans with lower and intermediate MOOPs charge higher cost sharing.

How much do MA plans charge in cost sharing for Part A and Part B services?

Any discussion of using standardized benefits in MA should be informed by an understanding of what plans now charge in cost sharing for Part A and Part B services, how that cost sharing varies across plans, and how MA cost sharing differs from FFS cost sharing. We therefore examined the current cost-sharing arrangements in MA plans using plan-level benefit data for 2022 and 2023 that MA insurers submitted as part of the bid process. We used the cost-sharing amounts that plans charge for in-network care. We excluded employer-sponsored plans from our analysis because they are available only to beneficiaries who previously worked for certain employers; we also excluded private fee-for-service plans and Medicare medical savings account plans because they have relatively low enrollment (as of February 2023, about 37,000 beneficiaries and 8,000 beneficiaries, respectively). We divided the remaining plans into two groups: conventional plans, which are available to all beneficiaries who have both Part A and Part B and live in a plan's service area, and special needs plans (SNPs), which serve only beneficiaries who have both Medicare and Medicaid, need the level of care provided in a long-term care facility, or have certain chronic conditions. Unless indicated otherwise, the figures we present are weighted by plan enrollment.

Three general differences between MA and FFS cost sharing make it more difficult to compare the two sectors. First, the type of cost sharing used can differ. The FFS program has uniform cost-sharing rules that largely use copayments for Part A services and coinsurance of 20 percent for Part B services.[12] In contrast, MA plans can use either coinsurance or copayments for most services.[13] CMS encourages plans to use copayments because they are easier for beneficiaries to understand, but plans nonetheless use a variety of arrangements.

Second, when FFS beneficiaries receive services in a facility such as a hospital, they typically have to make multiple cost-sharing payments. For example, a beneficiary who has outpatient surgery could have to pay cost sharing to three different providers—the hospital, the surgeon, and the anesthesiologist. In contrast, MA plans are required to charge a single, bundled cost-sharing amount (paid to the facility) for the entire service.

Third, nearly all MA plans receive rebates that they use to provide extra benefits to their enrollees. In 2023, conventional plans receive an average of $196 per member per month in rebates and use $76 of that amount (39 percent) to reduce cost sharing for Part A and Part B services (Medicare Payment Advisory Commission 2023). Plans can deduct administrative costs and profits from the rebates they use to reduce cost sharing; when those amounts are excluded, conventional plans spend about $66 per member per month to reduce cost sharing. The benefit data we used for our analysis include the effect of rebates but do not specify which services have lower cost sharing as a result.

TABLE 3–5

Conventional MA plans' daily copayments for inpatient acute care vary widely, but two-thirds fall within a narrower range

	Number of copay days							
Daily copayment	**1–3**	**4**	**5**	**6**	**7**	**8+**	**Total plans**	**Share**
$0–$50	5	3	38	7	6	4	63	2%
$50–$100	2	9	56	13	9	15	104	3
$100–$150	9	7	65	24	22	13	140	4
$150–$200	4	10	107	59	62	25	267	7
$200–$250	2	11	174	134	122	41	484	13
$250–$300	2	30	374	409	208	12	1,035	28
$300–$350	3	54	424	269	62	2	814	22
$350–$400	4	99	456	58	0	0	617	16
$400–$450	5	81	42	0	0	0	128	3
$450–$500	8	62	3	0	0	0	73	2
Above $500	13	7	0	0	0	0	20	1
Total plans	57	373	1,739	973	491	112	3,745	100%
Share	2%	10%	46%	26%	13%	3%	100%	

Note: MA (Medicare Advantage). Copayment amounts are for in-network care. The figures in this table exclude special needs plans, employer-sponsored plans, private fee-for-service plans, and Medicare medical savings account plans. We also excluded a small number of plans that use more than one daily copayment amount. We counted "plans" using unique combinations of contract number, plan number, and segment number. About two-thirds of all plans fall in the gray shaded area. Components may not sum to totals due to rounding.

Source: MedPAC analysis of 2023 plan benefit package data.

Part A services

For Part A services, we focused on cost sharing for inpatient acute care and SNF care. We did not include other major services such as inpatient psychiatric care, where our findings were broadly similar to those for inpatient acute care; home health care, for which plans rarely charge cost sharing; or hospice, which MA plans do not cover.

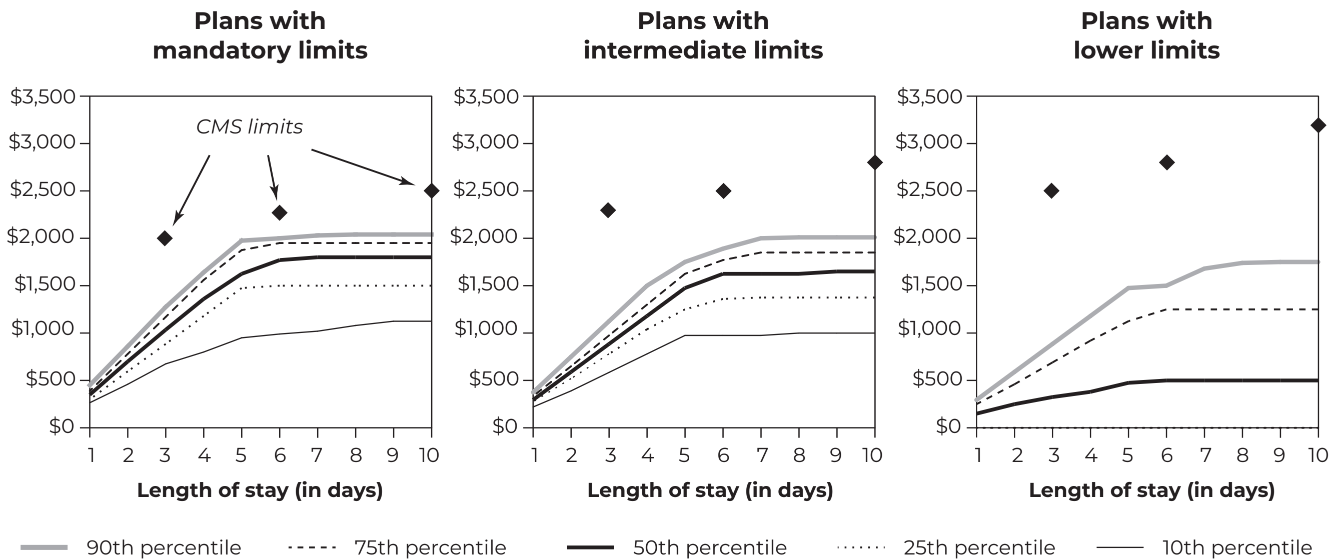
Inpatient acute care Under FFS, beneficiaries who receive inpatient care must pay the Part A deductible ($1,600 in 2023) but have no other Part A cost sharing until they have been in the hospital for 60 days. They must also pay cost sharing (typically 20 percent coinsurance) for any Part B services they receive during the stay, such as physician services.

In contrast, conventional MA plans typically use daily copayments for inpatient acute care. In 2023, 83 percent of plans use daily copayments, 7 percent use a flat, per admission copayment (akin to the Part A deductible), and 9 percent have no cost sharing. Less than 1 percent of plans use FFS cost-sharing rules. Since MA plans use bundled cost sharing, their copayments cover all services received during the inpatient stay. Plans likely prefer daily copayments because they are more attractive to beneficiaries than the Part A deductible and may be particularly appealing to healthier beneficiaries.

Among the plans that use daily copayments, both the amount of the copayment and the number of days for which a copayment is charged vary (Table 3-5). This year, 79 percent of plans charge between $200

FIGURE 3–1

Total cost sharing for an inpatient acute stay, by type of MOOP limit and percentile, 2023



Note: MOOP (maximum out-of-pocket). Cost-sharing amounts are for in-network care. These figures exclude special needs plans, employer-sponsored plans, private fee-for-service plans, and Medicare medical savings account plans. We also excluded a small number of plans that use more than one daily copayment amount. All percentiles are enrollment weighted.

Source: MedPAC analysis of 2023 plan benefit package data.

and $400 per day, and 85 percent of plans charge copayments for between five days and seven days. About two-thirds of all plans fall within the relatively small area on the table shaded in gray.

Plans with mandatory MOOP limits cannot charge higher cost sharing than FFS for inpatient care. (Plans with more generous limits are allowed to charge higher cost sharing than FFS.) CMS enforces this requirement by calculating the average amount that FFS beneficiaries pay in cost sharing (under both Part A and Part B) for inpatient stays that last 3, 6, 10, and 60 days. Plans must ensure that their cost sharing for stays of those lengths does not exceed the FFS average. For plans that use daily copayments, this approach creates a trade–off between the size of the copayment and the number of copayment days—plans with higher copayments charge for fewer days, and vice versa.

Figure 3-1 shows how the total cost sharing that conventional MA plans charge for inpatient acute care varies by length of stay and the plan's MOOP limit. The CMS limits for 3-day, 6-day, and 10-day stays are also shown; the limits for plans with intermediate and lower MOOPs are 12.5 percent and 25 percent higher, respectively, than the limits for plans with mandatory MOOPs. The preference for daily copayments means that cost sharing typically rises for the first 5–7 days of the stay and then flattens out.

Nearly all plans charge less than the CMS cost-sharing limits, with many plans charging much less. (The only CMS limit that appears to have any noticeable impact is the six-day limit for plans with mandatory MOOPs.) The clear implication is that most MA enrollees pay less for inpatient acute care than they would if they were enrolled in FFS and did not have supplemental coverage. Nonetheless, cost sharing varies substantially

TABLE 3–6

Conventional MA plans vary in cost sharing charged for SNF care, 2023

Daily copayment	Number of days for which copayment is charged	Share of plans	Share of enrollees
$196 (maximum)	80 (maximum)	34%	31%
<$196	80	27	25
$196	<80	28	33
<$196	<80	10	11

Note: MA (Medicare Advantage), SNF (skilled nursing facility). Copayment amounts are for in-network care. The figures in this table exclude special needs plans, employer-sponsored plans, private fee-for-service plans, and Medicare medical savings account plans. All figures are for days 21–100 of a SNF stay. We also excluded plans that either impose no cost sharing or use fee-for-service cost-sharing rules (these two groups collectively account for about 3 percent of all conventional MA plans). We counted "plans" using unique combinations of contract number, plan number, and segment number.

Source: MedPAC analysis of 2023 plan benefit package data.

across plans. For example, the median cost sharing for a five-day stay is $1,450, but the plan at the 10th percentile charges $120 and the plan at the 90th percentile charges $1,860.

Although plans with more generous MOOPs are allowed to charge higher cost sharing, plans with intermediate MOOPs tend to charge somewhat less cost sharing than plans with mandatory MOOPs, while plans with lower MOOPs tend to charge much less. For example, the median cost sharing for a five-day stay is $1,625 for plans with mandatory MOOPs and $1,475 for plans with intermediate MOOPs, but only $475 for plans with lower MOOPs. (More than 25 percent of plans with lower MOOPs have no cost sharing for inpatient acute care.) This discrepancy suggests that plans with more generous MOOP limits actually tend to have lower cost sharing, instead of offering a trade-off between a more generous MOOP limit and higher cost sharing.

Skilled nursing facility care Compared with inpatient acute care, there are fewer differences between FFS and MA cost sharing for SNF care. In FFS, there is no cost sharing for the first 20 days of a SNF stay, followed by a daily copayment for days 21 through 100. After that, Medicare coverage ends. The MA cost-sharing limits are similar. Plans cannot charge cost sharing during the first 20 days of a stay and cannot charge more than the projected FFS copayment during days 21 through 100. (The two copayment amounts typically differ slightly—in 2023, the FFS copayment is $200 per day while the MA limit is $196 per day—because CMS calculates them at different points in time using somewhat different data.) Plans with lower or intermediate MOOP limits can charge modest copayments during the first 20 days, but as noted earlier, relatively few do so. Plans have the option of charging lower copayments, charging copayments for fewer than 80 days, or both. As a practical matter, many MA enrollees with very long SNF stays will not pay cost sharing for the entire stay due to their plan's MOOP limit.

This year, almost a third of conventional MA plans (31 percent) essentially use FFS cost-sharing rules because their copayments are set at the $196 maximum and they charge copayments for the entire 80-day period (Table 3-6). The other 69 percent of plans have cost sharing that is lower than the FFS amounts. Most of these plans either use the maximum copayment but have fewer than 80 copayment days (33 percent) or charge less than the $196 maximum copayment but have 80 copayment days (25 percent). Only 11 percent of plans have both lower copayments and fewer copayment days.

However, among plans that have lower cost sharing than FFS, the differences are often relatively modest. For example, about 50 percent of the plans that charge less than the $196 maximum and have 80 copayment

days still charge more than $175 per day, and about 90 percent of the plans that use the maximum copayment but have fewer copayment days still require enrollees to pay copayments for at least days 21 through 40 of their stay, which is well above the average length of stay (figures not shown in table).

Part B services

Table 3-7 (p. 126) shows the amounts that conventional MA plans charged in 2022 for some selected Part B services. We used 2022 data for this table so we could include the average cost-sharing amounts (in dollar terms) in FFS for comparison. We took these FFS figures from the 2022 final rule that updated the MOOP and service-specific limits for MA plans; that rule did not include equivalent amounts for services that do not have a cost-sharing limit, such as outpatient hospital services. The table also shows the share of plans that used each type of cost sharing (copayments, FFS rules, other, or none) and, for plans that used copayments, the distribution of the copayment amounts. The "copayment" category is limited to plans that used the same copayment for all services in a given category, while the "other" category is used for plans with cost-sharing rules that did not fit within the other three categories, such as coinsurance that was lower than FFS, a mix of copayments and coinsurance, or variable copayments.

Copayments were the predominant type of cost sharing used for the services shown in the table, with some exceptions. Most plans in the "other" category for outpatient hospital services and urgent care also used copayments but had no cost sharing for certain services. For example, roughly a third of the "other" plans in the outpatient hospital category had no cost sharing for a single service (diagnostic colonoscopies) and more than half of the "other" plans in the urgent care category had no cost sharing for care provided by the enrollee's primary care physician. The two exceptions to the use of copayments were primary care, where almost three-quarters of plans had no cost sharing, and dialysis, where almost all plans followed FFS rules and charged 20 percent coinsurance.[14]

Copayment amounts for a given service often varied substantially across plans. For four of the five services for which we show the distribution of copayments, plans at the 90th percentile charged two to three times more than plans at the 10th percentile. Emergency services were the exception since nearly all plans used the maximum copayment allowed at the time by CMS.

The relationship between MA and FFS cost sharing varied by service:

- Almost all MA plans charged lower cost sharing than FFS for primary care visits—nearly three-quarters of plans had no cost sharing, and those that did tended to have relatively low copayments (a median copayment of $10 vs. an average FFS amount of $23). Compared with FFS, plans have an incentive to promote the use of primary care over other, more expensive alternatives. Plans charged about the same as FFS for specialist visits ($35 vs. $36).
- MA plans charged lower cost sharing for emergency services than the FFS average ($90 vs. $150), due to the relatively low CMS limits on cost sharing for those services, and more for urgent care ($40 vs. $27).
- Even though FFS and MA both use 20 percent coinsurance for dialysis, MA cost sharing was probably higher in dollar terms in most instances because many plans pay providers more than FFS rates for dialysis services (Lin et al. 2022, Medicare Payment Advisory Commission 2021). However, MA enrollees who receive dialysis likely benefit from their plan's MOOP limit.

Another notable difference between FFS and MA cost sharing, which is not shown in the table, is the use of a deductible. The FFS program includes a deductible for Part B services—$233 in 2022—but only 3 percent of conventional MA plans have a deductible for medical services. (However, many plans have a separate deductible for Part D drug benefits.) When plans do use a deductible, they have flexibility to specify which Part A and Part B services are subject to it.

The MA cost-sharing amounts for the services shown in Table 3-7 (p. 126) changed relatively little between 2022 and 2023. The median copayments for the five services with copayment data remained the same except for outpatient hospital services, where the median copayment fell from $275 to $250. The only notable changes in the type of cost sharing used were for primary care services, where the share of plans that do not charge cost sharing rose from 73 percent to

TABLE 3–7

Type of cost sharing used by conventional MA plans and copayment amounts for selected Part B services, 2022

FFS cost sharing	MA cost sharing						
			Percentile amounts				
	Type of cost sharing used	Share of enrollees	10th	25th	50th	75th	90th
Primary care visit							
20% coinsurance (~$23 on average)	Copayments	23%	$5	$5	$10	$10	$15
	FFS rules	1					
	Other	3					
	None	73					
Specialist visit							
20% coinsurance (~$36 on average)	Copayments	85	20	25	35	40	45
	FFS rules	1					
	Other	4					
	None	10					
Outpatient hospital							
20% coinsurance	Copayments	19	125	200	275	325	350
	FFS rules	2					
	Other	73					
	None	6					
Emergency services							
20% coinsurance (~$150 on average)	Copayments	99	90	90	90	90	120
	FFS rules	<1					
	Other	<1					
	None	<1					
Urgent care							
20% coinsurance (~$27 on average)	Copayments	64	20	30	40	45	55
	FFS rules	1					
	Other	27					
	None	8					
Outpatient dialysis							
20% coinsurance (~$64 on average)	Copayments	1					
	FFS rules	97					
	Other	1					
	None	1					

Note: MA (Medicare Advantage), FFS (fee-for-service). MA cost-sharing amounts are for in-network care. The figures in this table exclude special needs plans, employer-sponsored plans, private fee-for-service plans, and Medicare medical savings account plans. “Copayments” indicates that the plan has a single copayment for all services in the benefit category. “Other” refers to any approach not captured by the other cost-sharing categories used in the table, such as a combination of coinsurance and copayments, coinsurance that is lower than FFS rules, or variable copayments. Components may not sum to totals due to rounding.

Source: MedPAC analysis of 2022 plan benefit package data and 2022 final rule on MA cost–sharing limits.

86 percent, and urgent care, where the share of plans using copayments rose from 64 percent to 82 percent.

SNPs often have different cost-sharing rules than conventional MA plans

We looked separately at SNPs in our analysis because they have very different incentives when it comes to cost sharing. SNPs are based on the rationale that certain beneficiaries will receive better care from a specialized MA plan that is tailored to meet their distinct care needs than from conventional MA plans. There are three types of SNPs: those serving beneficiaries with certain chronic conditions (known as C–SNPs), those serving dual-eligible beneficiaries (D–SNPs), and those serving beneficiaries in long-term care institutions (I–SNPs).[15] Beneficiaries must belong to one of those groups to enroll in a SNP, but they also have the option of enrolling in conventional MA plans.

The vast majority of SNP enrollees (90 percent) are dual-eligible beneficiaries, who qualify for both Medicare and Medicaid, compared with only 12 percent of enrollees in conventional MA plans. Medicaid covers Part A and Part B cost sharing for most dual-eligible beneficiaries, while other MA enrollees—aside from those in employer-sponsored plans—typically do not have any supplemental coverage. The ability to offer lower cost sharing for Part A and Part B services (through the use of MA rebates) thus helps conventional MA plans attract enrollment but does relatively little to help SNPs attract enrollment. Instead, SNPs largely use their rebates to cover non-Medicare supplemental benefits (Medicare Payment Advisory Commission 2019).

As a result, cost sharing for Part A and Part B services can differ significantly between conventional plans and SNPs. Figure 3-2 (p. 128) compares the MOOP limits in 2023 for conventional plans and SNPs. The vertical axis shows the share of total enrollment for each plan type. The limits for most conventional plans are distributed relatively evenly between $3,400 and about $7,500. In contrast, 70 percent of SNPs use the mandatory limit of $8,300, the highest possible amount. Since most SNP enrollees do not pay cost sharing, those plans have an incentive to use the mandatory limit to minimize the cost of the MOOP limit.

There are also noticeable differences between conventional MA plans and SNPs in the type of cost sharing used for individual services. The figures shown in Table 3-8 (p. 129) for Part B services (“primary care visit” through “dialysis”) provided by conventional plans are identical to those shown in Table 3-7, so they also reflect 2022 data. Compared with conventional plans, the rationale for SNPs to use copayments is weaker: Since most enrollees pay no cost sharing, they do not benefit from the predictability of copayments, and plans can do relatively little to use cost sharing to encourage or discourage the use of specific services. As a result, the share of SNPs that either used FFS cost-sharing rules or had no cost sharing was much higher for many services. For example, for outpatient hospital services, only 2 percent of conventional plans used FFS rules and only 6 percent had no cost sharing. The corresponding figures for SNPs were 39 percent and 20 percent, respectively. When SNPs did use copayments, their median copayments did not appear to be consistently higher or lower than the median copayments for conventional plans.

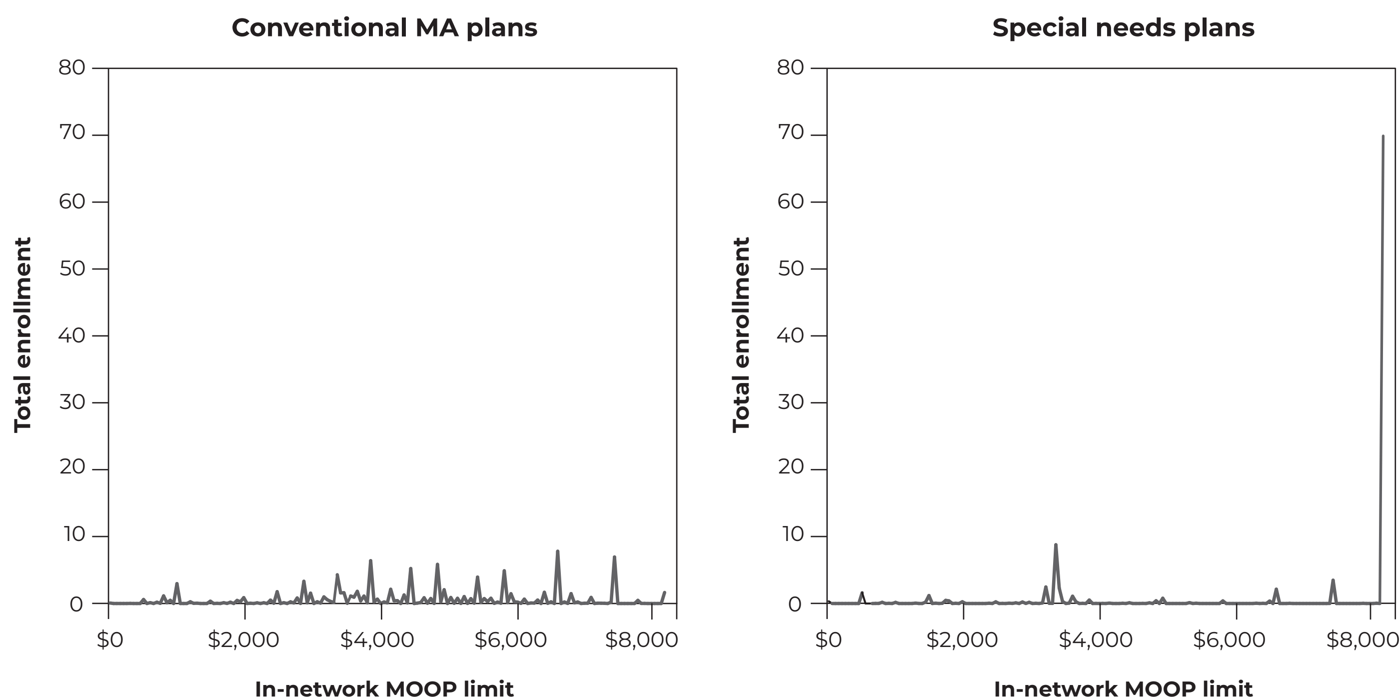
Coverage of supplemental benefits

Under the MA program, plans are required to provide the Part A and Part B benefit package, but they can also provide extra benefits not covered under traditional FFS. Many of those extra benefits are tied to Medicare-covered services in some way, such as lower cost sharing for Part A and Part B services, enhanced Part D drug coverage, lower Part D premiums, and lower Part B premiums. However, plans can also provide a variety of supplemental medical and nonmedical benefits that FFS Medicare does not cover.[16]

Plans can offer a supplemental benefit as either a *mandatory* or *optional* benefit. Mandatory benefits are part of the plan’s standard benefit package and are available to all enrollees; they are financed by the rebates that most plans receive under the MA payment system, premiums paid by enrollees, or both. Optional benefits are not part of the plan’s standard benefit package; enrollees must pay an additional premium to receive them and plans cannot use rebates to finance their costs. Our work focuses on mandatory benefits because they account for the vast majority of MA supplemental benefits.[17]

FIGURE 3–2

Conventional MA plans and SNPs often have different MOOP limits



Note: MA (Medicare Advantage), SNP (special needs plan), MOOP (maximum out-of-pocket). The vertical axis shows the share of enrollees in plans with a given MOOP limit. For 2023, the highest amount that plans can use as their in-network MOOP limit is $8,300. Figure does not include employer-sponsored plans, private fee-for-service plans, or Medicare medical savings account plans.

Source: MedPAC analysis of 2023 plan benefit package data.

Plans have been using a growing share of their rebates to provide supplemental benefits (Table 3-9, p. 130). The figures in this table are based on MA bid data, in which plans indicate how they will spend their rebates on five broad categories of extra benefits. Between 2020 and 2023, the share of rebates used for supplemental benefits rose from 18 percent to 26 percent for conventional plans, and from 68 percent to 82 percent for SNPs. In 2023, on an annual basis, conventional MA plans and SNPs spend about $600 and $2,430 in rebates per enrollee, respectively, on supplemental benefits (figures not shown in table).

Compared with conventional MA plans, SNPs use a much higher share of their rebates to provide supplemental benefits because most of their enrollees (about 90 percent) are dually eligible for Medicare and Medicaid. Many out-of-pocket costs for these beneficiaries are already covered by other programs: Medicaid covers Part A and Part B cost sharing and pays the Part B premium in most cases, and Part D's low-income subsidy typically covers the premium and all or most cost sharing for prescription drug coverage. As a result, SNPs have less reason than conventional plans to use their rebates to cover these costs.

Plans have been given greater flexibility in how they provide supplemental benefits

Plans' ability to offer supplemental benefits has always been subject to requirements that specify the types of benefits that can be offered and the types of enrollees who can receive them. For many years, two key requirements were that supplemental benefits had to

TABLE 3–8

Conventional MA plans and SNPs often use different types of cost sharing

Service category	Type of cost sharing used	Conventional MA plans: Share of enrollees	Conventional MA plans: Median copayment	Special needs plans: Share of enrollees	Special needs plans: Median copayment
Inpatient acute	Daily copayment	82%	$295	14%	$325
	Flat copayment	8	325	46	1,480
	FFS rules	<1		22	
	None	9		19	
Skilled nursing facility (days 21–100)	Copayments	96	188	30	188
	FFS rules	1		51	
	None	3		19	
Primary care visit	Copayments	23	10	1	5
	FFS rules	1		53	
	Other	3		2	
	None	73		44	
Specialist visit	Copayments	85	35	6	20
	FFS rules	1		64	
	Other	4		2	
	None	10		27	
Outpatient hospital	Copayments	19	275	2	195
	FFS rules	2		39	
	Other	73		39	
	None	6		20	
Emergency services	Copayments	99	90	71	90
	FFS rules	<1		15	
	Other	<1		1	
	None	<1		13	
Urgent care	Copayments	64	40	48	65
	FFS rules	1		28	
	Other	27		2	
	None	8		22	
Dialysis	Copayments	1		<1	
	FFS rules	97		82	
	Other	1		1	
	None	1		16	

Note: MA (Medicare Advantage), SNP (special needs plan), MOOP (maximum out-of-pocket), FFS (fee-for-service). Copayment amounts are for in-network care. The figures in this table exclude employer-sponsored plans, private fee-for-service plans, and Medicare medical savings account plans. Components may not sum to totals due to rounding.

Source: MedPAC analysis of 2022 plan benefit package data.

TABLE 3–9

Conventional MA plans' supplemental benefits have grown sharply since 2020, and special needs plans use a growing share of their rebates to provide supplemental benefits

	Conventional MA plans		Special needs plans	
Service category	**2020**	**2023**	**2020**	**2023**
Average rebate (per member per month)	$122	$196	$141	$247
Average allocation of rebates:				
Reduced cost sharing for Part A/Part B services	49%	39%	15%	8%
Supplemental benefits	18	26	68	82
Enhanced drug coverage	18	19	6	3
Reduction in Part D premium	13	14	7	4
Reduction in Part B premium	2	3	4	2

Note: MA (Medicare Advantage). Figures do not include plans that do not provide Part D drug coverage, employer-sponsored plans, private fee-for-service plans, or Medicare medical savings account plans. Components may not sum to totals due to rounding.

Source: MedPAC analysis of MA bid data for 2020 and 2023.

be (1) "primarily health related," meaning that their main purpose was "to prevent, cure, or diminish an illness or injury," and (2) "offered uniformly to all enrollees" (Centers for Medicare & Medicaid Services 2016). These requirements prevented plans from providing benefits that were not directly health related but could address other enrollee needs (such as in-home supports for people with functional limitations) and from targeting benefits to specific types of enrollees (such as those with a particular health condition).

However, policymakers have taken several steps in recent years to loosen those requirements:

- In 2018, CMS broadened its definition of "primarily health related" to include services that address physical impairments, lessen the functional or psychological impact of injuries, or reduce avoidable health care utilization (Centers for Medicare & Medicaid Services 2018a). Under this new definition, plans can provide services such as in-home support services and home modifications. This change took effect in 2019.
- At the same time, CMS modified the uniformity requirement to let plans target supplemental benefits to enrollees with a particular "health status or disease state" (Centers for Medicare & Medicaid Services 2018b). Plans that choose to target benefits in this manner must ensure that all enrollees with the targeted health status or disease state are treated in the same manner. This change also took effect in 2019.
- The Bipartisan Budget Act of 2018 gave plans the flexibility to provide supplemental benefits to chronically ill enrollees that "have a reasonable expectation of improving or maintaining the health or overall function" and do not have to be primarily health related. These benefits are known as special supplemental benefits for the chronically ill (SSBCI). Plans can use this authority to cover services such as meals, food and produce, nonmedical transportation, and pest control services (Centers for Medicare & Medicaid Services 2019).[18] This change took effect in 2020.
- In 2017, the Center for Medicare & Medicaid Innovation started a demonstration called the Medicare Advantage Value-Based Insurance Design (VBID) Model that lets participating plans offer a wider range of supplemental benefits

and target them to certain types of enrollees. The demonstration has been partly overtaken by the subsequent policy changes listed above, which gave plans some of the same flexibilities. However, the demonstration remains distinctive because it provides the only way for plans to target supplemental benefits to beneficiaries based on socioeconomic status instead of chronic illness or disease state (more specifically, plans can target beneficiaries who receive Part D's low-income subsidy) and reduce or eliminate cost sharing for Part D drugs. The VBID demonstration is scheduled to continue through 2030.

As a result of these changes, MA plans can now provide a wider range of supplemental benefits to their enrollees and target them under certain circumstances. In recent years, there has been widespread interest in using health plans to provide nonmedical services that address social determinants of health (SDOH), such as housing and nutrition. Although MA plans now have the authority to provide some of those services, they are not allowed to target benefits on the basis of SDOH alone.

Supplemental benefits play an important role in the competition among MA plans

Beneficiaries enroll in MA plans voluntarily, and insurers rely on extra benefits to make their plans attractive. This dynamic gives insurers an incentive to offer multiple plans, each with a different package of extra benefits, that can appeal to beneficiaries with different preferences. MA insurers also compete with each other to attract enrollment and need to ensure that the extra benefits in their plans are comparable, if not superior, to those offered by other plans. As shown in Table 3-9, supplemental benefits are just part of the extra benefits that MA plans provide, but they nonetheless play an important role.

For example, one recent study examined differences between plans that gained or lost enrollment during the 2022 open enrollment period (Cates et al. 2022). Among conventional MA plans, those gaining enrollment tended to have lower premiums and lower copayments for primary care visits. They were also more likely to offer certain supplemental benefits—dental coverage, eyeglasses or contacts, hearing aids, and an allowance for over-the-counter (OTC) items—and their coverage of those benefits tended to be more generous than the coverage for plans that lost enrollment. Other features were relatively similar between gaining and losing plans, such as overall cost sharing for Part A and Part B services, copayments for specialists, and maximum out-of-pocket limits. Among dual-eligible SNPs, plans that gained enrollment were much more likely to participate in the VBID demonstration and waive all cost sharing for Part D drugs.

Few data exist on utilization of and spending for supplemental benefits

CMS requires all MA plans to submit encounter data (analogous to FFS claims data) for the Part A and Part B services they provide to their enrollees. These data should be a valuable source of information about a host of MA-related issues, such as patterns of service use and quality of care, but the Commission has found that the encounter data that plans have submitted to date are incomplete and cannot be used for many analyses (Medicare Payment Advisory Commission 2019).

One particular limitation is that plans are not required to submit encounter data for supplemental benefits. As a result, while the government has reasonably good information about the specific types of supplemental benefits that each plan offers (information that is collected through the MA bid process), there is almost no data on actual service use and plan spending for those benefits. For example, though Medicare and its beneficiaries subsidize the provision of supplemental benefits, policymakers do not know how much plans spend on each supplemental benefit, what share of enrollees use those benefits, or whether service use differs by such factors as age, sex, race, disability status, and geographic area. In 2019, the Commission made a recommendation to improve the accuracy and completeness of MA encounter data that included the use of a payment withhold to give plans a financial incentive to submit more accurate and complete data (Medicare Payment Advisory Commission 2019). That work focused on encounter data for Part A and Part B services but would apply equally well to encounter data for supplemental benefits.

Despite the lack of encounter data, information from other sources indicates that service use of one prominent supplemental benefit—dental services—is relatively low. A small study by the actuarial firm Milliman analyzed 2018 MA claims for 1.9 million beneficiaries who were 65 or older and enrolled in

plans that provided dental coverage as a mandatory benefit (Wix and Fontana 2020). The study found that only 11 percent of enrollees had MA-covered claims for preventive dental care (which the study defined as cleanings, oral exams, and periodontal cleanings) and another 1 percent had claims for some other type of dental care. The study did not indicate which dental services were covered by the unnamed MA insurer(s) that provided the claims data; the low utilization rates, especially for other types of dental care, could be because those plans had limited coverage of those services. According to the study, low utilization could also have been due to enrollees being unaware of their plan's dental benefits or enrollees finding that their dentist did not participate in the plan's provider network.[19] More broadly, MA plans arguably have an incentive to emphasize their coverage of supplemental benefits at a high level while downplaying features that limit the actual scope of those benefits.

Another study that used the annual Medicare Current Beneficiary Survey also found that MA dental coverage has a somewhat limited impact on enrollees (Willink et al. 2020). The study found that, in 2016, 55 percent of MA enrollees with dental coverage had a dental visit in the past year, about the same as the figure for MA enrollees without dental coverage (52 percent). Those figures count dental visits regardless of whether they were covered by insurance or paid for on an out-of-pocket basis. The discrepancy between over half of MA enrollees using dental care in a given year and the Milliman finding that only 12 percent of enrollees had MA-covered dental claims suggests that many enrollees are either unaware of their plan's dental coverage or do not use it. The Willink study also found that, among those using dental services, MA enrollees with dental coverage had higher spending on dental care than MA enrollees without such coverage ($1,331 vs. $925). However, MA enrollees with dental coverage had substantial out-of-pocket costs that equaled 76 percent of their overall spending on dental care, underscoring the limited scope of their dental coverage. One potential limitation of the study is that the share of MA enrollees with dental coverage has increased significantly since 2016 and patterns of service use may have changed.

Starting with the 2023 plan year, MA plans will provide some information about their spending on supplemental benefits when they report their medical loss ratios (MLRs). The MLR is the percentage of total revenues that plans spend on medical and other benefits; the ACA requires plans to have an MLR of 85 percent or higher to limit their spending on administrative costs and profits. Plans with MLRs below 85 percent must remit the difference to CMS.

The information that MA plans are required to submit when they report their MLRs has changed over time. From 2014 to 2017, plans had to provide supporting data for their MLR calculation that included their overall combined spending on all Medicare-covered and supplemental benefits. From 2018 to 2022, plans did not have to provide any supporting data, just their MLR and any remittance amount. Starting in 2023, CMS will again require plans to provide supporting data, but this time plans will have to break out their spending for 18 types of supplemental benefits, including dental, vision, hearing, transportation, fitness benefits, OTC items, and SSBCI (Centers for Medicare & Medicaid Services 2022a).

These more detailed MLR data should provide a high-level picture of spending on supplemental benefits—for example, it should help show how much plans spend on SSBCI relative to more traditional benefits such as vision or hearing—but its usefulness will be somewhat limited. The main reason is that insurers report MLRs at the MA contract level, so the data cannot be used to assess spending on supplemental benefits for individual plans. In addition, many insurers offer both conventional MA plans and SNPs under the same contract, so the data cannot be used to compare spending on supplemental benefits across those two plan types. The MLR data for 2023 should be available sometime in the second half of 2025.

The current landscape of MA supplemental benefits

Although MA plans have the flexibility to cover a wide range of supplemental benefits, they have typically favored some benefits over others. Table 3-10 uses information that plans submit as part of the MA bid process to show the share of conventional plans and D–SNPs that covered 15 types of supplemental benefits in 2018 and 2022. (The table is not an exhaustive list but includes most of the major "primarily health-related" benefits.) In 2022, the most common benefits were vision, fitness, hearing, and dental benefits,

TABLE 3–10

MA coverage of many supplemental benefits increased between 2018 and 2022

Service category	Share of conventional plans with coverage 2018	Share of conventional plans with coverage 2022	Share of D–SNPs with coverage 2018	Share of D–SNPs with coverage 2022
Vision benefits				
Eye exams	93%	99%	87%	92%
Eyewear	68	92	93	97
Fitness benefits	84	98	68	93
Hearing benefits				
Hearing exams	82	92	82	89
Hearing aids	72	94	82	92
Dental benefits				
Preventive services	60	93	85	90
Comprehensive services	30	82	90	96
Over–the–counter benefits	41	84	89	97
Meals	22	71	32	81
Acupuncture	16	45	44	53
Podiatry	39	45	63	76
Transportation	21	39	78	90
Health education	30	31	32	27
Nutritional/dietary benefits	13	24	13	26
Smoking cessation	18	22	22	35

Note: MA (Medicare Advantage), D–SNP (dual–eligible special needs plan). Figures are based on plans that cover the given service as a mandatory supplemental benefit. Figures exclude employer-sponsored plans. All figures are weighted by enrollment. This table does not include every type of supplemental benefit that plans can provide.

Source: Friedman and Yeh 2022a, Friedman and Yeh 2022b.

which in many cases were covered by more than 90 percent of conventional plans and D–SNPs. Nearly all D–SNPs also covered OTC benefits (97 percent) and transportation (90 percent). At the same time, less than half of conventional plans covered benefits such as acupuncture, health education, or additional sessions of smoking cessation counseling.

With the exception of health education, the share of plans covering each supplemental benefit shown in Table 3-10 increased between 2018 and 2022. These increases are consistent with our findings that MA rebates have risen rapidly in recent years and that plans are now using a larger share of their rebates to provide supplemental benefits (see Table 3-9, p. 130).

The increases in coverage were much larger for certain benefits. For conventional plans, the largest increases were for meals, OTC benefits, and comprehensive dental services; for D–SNPs, the largest increases were for meals and fitness benefits.

The uneven growth between 2018 and 2022 gives us a sense of plans' priorities for providing supplemental benefits. Since plans were less likely to cover certain benefits when they had more limited rebate dollars, many plans appear to think the benefits that experienced large increases in coverage during this period fall somewhere in the middle in terms of their attractiveness to enrollees, had been too expensive to provide previously, or both. In 2018, when rebates were lower, plans preferred to cover other benefits such as eye exams, hearing benefits, and fitness benefits. By 2022, when rebates were higher, plans prioritized enhancing their coverage of dental services, OTC benefits, and meals over services such as podiatry and acupuncture. The policy changes that broadened what plans could cover as supplemental benefits likely also played a role in the increases for some categories, such as meals.

Plans have gradually expanded their coverage of supplemental benefits that take advantage of the SSBCI authority and changes to the "primarily health related" and uniformity requirements, but those benefits are not as widely available as many of the traditional supplemental benefits shown in Table 3-10 (p. 133):

- Between 2020 (the first year of implementation) and 2022, the share of nonemployer MA plans providing some type of SSBCI increased from 7 percent to 24 percent (ATI Advisory 2022). SNPs are much more likely to provide SSBCI than conventional plans are (42 percent vs. 19 percent in 2022). Plans have largely used the SSBCI authority to provide nonmedical benefits; in 2022, the most common nonmedical benefits were food and produce, expanded coverage of meals, and nonmedical transportation.
- Between 2020 and 2022, the share of nonemployer plans that provide supplemental benefits under the expanded "primarily health related" definition grew from 11 percent to 19 percent (ATI Advisory 2022). In 2022, the most popular benefit was in-home support services, which were covered by 12 percent of conventional MA plans and 20 percent of D–SNPs (Friedman and Yeh 2022a, Friedman and Yeh 2022b).
- In 2022, about 10 percent of nonemployer plans targeted some supplemental benefits to disease-specific groups of enrollees based on the change to the uniformity requirement (Murphy-Barron et al. 2022). The most common diseases for which plans targeted their benefits were diabetes, congestive heart failure, and chronic obstructive pulmonary disease. Plans have been more likely to use the new flexibility to target additional supplemental benefits rather than reduce cost sharing.

Several factors might explain the somewhat limited availability of the "newer" supplemental benefits. First, plans must use their existing rebate dollars to finance any new benefits, and they may be reluctant to pare back longer-standing supplemental benefits. This reluctance could lead plans to gradually add newer supplemental benefits over time as rebates increase. Second, plans have an incentive to offer supplemental benefits with broad appeal, and they may determine that the newer benefits are less attractive, on balance, than the more traditional benefits. (Since eligibility is tied to specific health conditions, the share of enrollees who qualify for SSBCI will typically be smaller than the share who qualify for more traditional benefits, and beneficiaries may have difficulty determining whether they would qualify.) Finally, plans may need time to develop the infrastructure to offer some of the newer benefits, such as finding a suitable vendor for delivering food and produce and prepared meals (Kornfield et al. 2021).

Dental, hearing, and vision benefits illustrate how MA coverage can vary across plans

Efforts to compare MA supplemental benefits are further complicated by the fact that, even when plans cover the same benefit, their coverage can vary in several ways. Three high-profile benefits that nearly all MA plans cover—dental, hearing, and vision services—illustrate these coverage differences.

Plans can limit the type and number of services that are covered

MA plans are required to cover the same Part A and Part B services as FFS Medicare, with the exception of hospice, so the coverage of these services is the same across plans. In contrast, supplemental benefits are not tethered to a common reference point like the FFS

TABLE 3–11

Supplemental dental, hearing, and vision benefits encompass a range of distinct services

Dental benefits (11 services)	Preventive services (4 services)	Oral exams Prophylaxis (cleaning) Dental X-rays Fluoride treatment
	Comprehensive services (7 services)	Restorative services Extractions Periodontics Endodontics Prosthodontics Diagnostic services Nonroutine services
Hearing benefits (6 services)	Hearing exams (2 services)	Routine hearing exam Fitting/evaluation for hearing aid
	Hearing aids (4 services)	Hearing aids (all types) Hearing aids (over the ear) Hearing aids (inner ear) Hearing aids (outer ear)
Vision benefits (7 services)	Eye exams (2 services)	Routine eye exams Other eye exams
	Eyewear (5 services)	Contact lenses Eyeglasses (lenses and frames) Eyeglass lenses Eyeglass frames Upgrades

Source: MedPAC analysis of 2023 plan benefit package data.

program, and plans have the flexibility to determine the extent of their coverage for each benefit.

As part of their bid, plans indicate which types of dental, hearing, and vision services they plan to cover as supplemental benefits. For 2023, plans had to provide information for 11 distinct types of dental services, 6 types of hearing services, and 7 types of vision services (Table 3-11). Plans decide whether they will cover none, some, or all of these services. (When plans cover a service, they can also limit the amount they spend per enrollee and charge cost sharing.) Plans get credit in the Medicare Plan Finder tool for providing benefits in the broader categories listed on the left of Table 3-11 if they cover at least one of the services listed. For example, a plan that covers only routine hearing exams gets credit for providing hearing benefits, as does a plan that covers hearing exams, fittings and evaluations for hearing aids, and the hearing aids themselves.

TABLE 3–12

Differences in coverage of preventive and comprehensive dental services between conventional MA plans and special needs plans

	Share of plans covering service	
	Conventional MA plans	**Special needs plans**
Preventive services:		
Oral examinations	97%	87%
Prophylaxis (cleaning)	97	86
Dental X-rays	97	87
Fluoride treatment	77	81
Comprehensive services:		
Extractions	86	88
Periodontics	85	88
Restorative services	84	93
Diagnostic services	82	84
Prosthodontics	79	91
Endodontics	77	86
Nonroutine services	71	80

Note: MA (Medicare Advantage). Figures are based on plans that cover service as a mandatory supplemental benefit. Figures for conventional plans exclude employer-sponsored plans, private fee-for-service plans, and Medicare medical savings account plans. All figures are enrollment weighted. Plan coverage may include limits on the number and type of services that enrollees can receive, limits on per enrollee benefit spending, and enrollee cost sharing.

Source: MedPAC analysis of 2023 plan benefit package data.

Among these three types of benefits, coverage of services is more varied for dental benefits than for hearing or vision benefits. The share of conventional MA plans and SNPs that cover each type of dental service is shown in Table 3-12. Among preventive services, nearly all plans with dental coverage cover oral exams, cleanings, and dental X-rays. A smaller share of plans cover fluoride treatments. The coverage of comprehensive services is more variable, ranging for conventional plans from 86 percent for extractions to 71 percent for nonroutine services. The share of SNPs that cover a given comprehensive service is consistently somewhat higher than the corresponding figure for conventional plans. The differences between conventional plans and SNPs used to be much larger, but the coverage rates for the former have increased significantly in recent years. We found that 61 percent of conventional plans and 70 percent of SNPs have some coverage of services in all 11 dental categories (figures not shown in table).

In contrast to the variation in dental coverage, we found that 93 percent of plans with hearing benefits cover routine exams and hearing aids; 68 percent of those plans also cover fittings and evaluations for hearing aids.[20] Similarly, 97 percent of plans with vision benefits cover routine exams, contact lenses, and eyeglasses.

Even when MA plans cover a particular supplemental benefit, they may limit the number and type of services that enrollees can receive. Service limits are particularly common for routine, relatively low-cost services where plans typically do not use cost sharing. For example, between 76 percent and 82 percent of plans have limits for the various types of preventive dental services, while 98 percent and 95 percent of

plans have limits for routine hearing and eye exams, respectively. Those limits are relatively uniform across plans for some services (nearly all plans with hearing benefits cover one routine hearing exam per year) and more variable for other services (34 percent of plans with dental benefits cover two cleanings per year, while 27 percent cover three cleanings per year, 18 percent have no limit, 11 percent cover six cleanings per year, and 6 percent cover one cleaning every six months).

The use of service limits is less common for more complicated dental, hearing, and vision services, although in most cases a majority of plans still have them. Limits on these services could be less important because plans typically use other mechanisms to manage spending, such as maximum per enrollee spending limits or cost sharing.

Determining exactly what services an MA plan covers can be challenging, and beneficiaries will likely need to examine a plan's marketing or member materials, or contact a plan representative, to get an accurate picture. For example, when the Kaiser Family Foundation tried to determine in 2021 whether a sample of 10 plans covered dentures (which are part of the "prosthodontics" category under comprehensive dental services), they had to examine each plan's Evidence of Coverage document, which describes all of the services covered by the plan and is often more than 200 pages long (Freed et al. 2021).

Plans can limit benefit spending and charge cost sharing

In addition to limiting the number of services, MA plans can also limit the amount they will spend per enrollee on a supplemental benefit. These limits are common for dental, hearing, and vision benefits (Table 3-13, p. 138). In 2023, among conventional plans, spending limits are used by 87 percent of plans with dental benefits, 38 percent of plans with hearing benefits, and over 99 percent of plans with vision benefits. The corresponding figures for SNPs are similar, except that SNPs are much more likely to limit spending on hearing benefits (78 percent vs. 38 percent).

The type of spending limit used varies, both across and within benefits. For dental benefits, the most common approach is a combined limit that applies to all dental benefits, with a smaller share of plans using limits that apply only to comprehensive services. Plans with hearing and vision benefits typically use limits that apply only to so-called hardware (hearing aids, eyeglasses, contacts). Even then, there are also differences: Some plans have a limit on spending for hearing aids that applies to both ears, while other plans have separate limits for each ear.

For conventional plans, the median spending limits are higher for dental benefits ($1,500 across all dental services) and hearing benefits ($1,500 for limits that apply to spending on hearing aids for both ears) than for vision benefits ($200 across all types of eyewear). SNPs have higher median limits than conventional plans for all three types of benefits. The richer coverage reflects the fact that SNPs typically use a larger share of their rebates to provide supplemental benefits.

Plans can also charge cost sharing for supplemental benefits, and in 2023, notable differences exist among conventional MA plans across the three services:

- For dental benefits, plans are more likely to use cost sharing for comprehensive services (22 percent charge cost sharing for at least one service) than for preventive services (only 2 percent charge cost sharing for at least one service). When plans charge cost sharing for comprehensive services, they mainly use coinsurance; the median coinsurance rate for each service is 50 percent.
- For hearing benefits, plans are more likely to use cost sharing for hearing aids (62 percent of plans) than for routine hearing exams (6 percent). Nearly all plans that charge cost sharing for hearing aids rely on copayments and charge different amounts, depending on the product model. One distinctive feature of MA hearing benefits is the interplay between cost sharing and per enrollee spending limits. Nearly all plans use one or the other, but not both: 61 percent charge cost sharing but have no spending limit, and 37 percent have a spending limit but do not charge cost sharing. The contrast between these approaches makes it more difficult for beneficiaries to compare the hearing benefits for different plans.
- For vision benefits, cost sharing is rare: About 6 percent of plans charge cost sharing for eye exams and less than 1 percent charge cost sharing for eyeglasses or contacts.

TABLE 3–13

Dental, hearing, and vision benefits often have per enrollee spending limits, 2023

	Conventional MA plans	Special needs plans
Dental benefits		
Type of limit used		
Limit applies to all dental services	68%	64%
Limit applies to comprehensive services only	18	19
Other type of limit	<1	<1
No limit	13	17
Median limits		
Limit applies to all dental services	$1,500	$3,500
Limit applies to comprehensive services only	1,500	3,500
Hearing benefits		
Type of limit used		
Limit applies to hearing aids only, both ears	13%	57%
Limit applies to hearing aids only, per ear	24	20
Other type of limit	1	1
No limit	62	22
Median limits		
Limit applies to hearing aids only, both ears	$1,500	$3,000
Limit applies to hearing aids only, per ear	1,000	1,000
Vision services		
Type of limit used		
Limit applies to all eyewear	86%	90%
Separate limits for exams and eyewear	11	5
Other type of limit	3	4
No limit	<1	1
Median limit		
Limit applies to all eyewear	$200	$400

Note: MA (Medicare Advantage). Figures are based on plans that cover, as mandatory supplemental benefits, both preventive and comprehensive dental care, both hearing exams and hearing aids, or both eye exams and eyewear. Figures for conventional plans exclude employer-sponsored plans, private fee-for-service plans, and Medicare medical savings account plans. All figures are enrollment weighted. Components may not sum to totals due to rounding.

Source: MedPAC analysis of 2023 plan benefit package data.

Plans can also have benefit-specific deductibles, but very few plans use them for dental benefits, and no plans use them for hearing or vision benefits. Compared with conventional plans, the share of SNPs that use cost sharing is much lower (about 4 percent for comprehensive dental services and 9 percent for hearing aids).

The extent to which plans' coverage of a particular supplemental benefit can vary is illustrated by Humana,

TABLE 3–14

Conventional MA plans that receive higher rebates have more generous dental, vision, and hearing benefits in 2023

Plan rebate (per member per month)	$0–$50	$50–$100	$100–$150	$150–$200	$200–$250	Over $250
Number of plans	67	391	1,160	1,475	714	498
Dental benefits						
Share of plans covering comprehensive dental	41%	62%	79%	93%	98%	98%
Average number of service categories covered (maximum = 7)	6.0	5.4	5.9	6.2	6.3	6.2
Average spending limit	$1,079	$1,411	$1,592	$2,049	$1,902	$2,241
Hearing benefits						
Share of plans covering hearing aids	71%	87%	94%	97%	98%	99%
Average spending limit	$1,200	$1,129	$1,453	$1,639	$1,270	$1,570
Vision services						
Share of plans covering eyeglasses	71%	84%	94%	97%	99%	99%
Average spending limit	$180	$200	$196	$207	$247	$332

Note: MA (Medicare Advantage). Figures are based on conventional MA plans and do not include special needs plans, employer-sponsored plans, private fee-for-service plans, or Medicare medical savings account plans. Figures are based on plans that provide the benefit as a mandatory supplemental benefit; figures for the share of plans covering each benefit are enrollment weighted. Average spending limits are based on plans that use a limit that applies to all dental services (dental benefits), plans that use a limit that applies to spending on hearing aids for both ears (hearing benefits), and plans that use a limit that applies to all eyewear (vision benefits).

Source: MedPAC analysis of 2023 plan benefit package and bid data.

which is the second-largest MA insurer and has 234 distinct dental packages in the MA plans it offers in 2023 (Humana 2023).

Prevalence and generosity of benefits vary based on plan rebates

As noted earlier, MA rebates play a key role in financing supplemental benefits. Rebates also vary geographically and are typically larger in areas with high FFS spending. Table 3-14 shows the relationship in 2023 between plan rebates (shown on a per member per month basis) and conventional MA plans' coverage of dental, hearing, and vision benefits. As rebates increase, plans are more likely to cover more expensive items and services—comprehensive dental services, hearing aids, and eyeglasses—as mandatory benefits. For example, among plans that receive less than $50 in rebates, 41 percent cover comprehensive dental services, 71 percent cover hearing aids, and 71 percent cover eyeglasses. The corresponding figures for plans that receive more than $250 in rebates are 98 percent, 99 percent, and 99 percent, respectively.

Plans also tend to provide more generous benefits as rebates increase. The plans that provide comprehensive

dental services cover a wider range of services, based on how many of the seven types of comprehensive dental services they cover. When plans have limits on per enrollee spending, the average spending limit for all three types of benefits also tends to be higher for plans that receive more rebates.

Policy options for standardizing MA benefits

Experience in the Medigap and ACA markets illustrates that "standardized benefits" is a broad term that can be used to describe a wide range of policies. For the MA program, standardization would involve both advantages and tradeoffs. Since MA plans are required to cover Part A and Part B services but have flexibility to decide which supplemental benefits to cover, policymakers would likely want to use different approaches to standardize the two types of benefits.

Cost sharing for Part A and Part B services

Since all MA plans cover the same required set of Part A and Part B services, standardization for these services would be limited to changes in enrollee cost sharing. Similar to the Medigap and ACA markets, the standardization of enrollee cost sharing would most likely involve the development of a limited number of distinct benefit packages.

How many standardized benefit packages would there be, and how would they differ?

One key question is the number of benefit packages that would be developed. Using a larger number of benefit packages would provide more choice but might not make it easier for beneficiaries to compare plans; using a smaller number would limit beneficiary choice but might make it easier to compare plans.

One factor to consider is whether MA insurers would be able to offer plans that use the same benefit package but have different provider networks. For example, California's health insurance exchange has standardized plans but allows insurers to offer one HMO version and one PPO version of each plan. The MA program also has HMOs and PPOs, and both have significant enrollment, suggesting that beneficiary preferences vary when it comes to provider networks. If insurers could offer plans with different networks, fewer benefit packages would arguably keep the overall number of plans more manageable. For example, if the MA program had three benefit packages and insurers could offer HMO and PPO versions of each benefit package, insurers would be able to offer up to six plans in a market. Under this scenario, an area with 8 insurers (the current MA average) would still have as many as 48 plans.

There are several ways that benefits could be standardized. One less prescriptive option would be to require all MA plans to have certain actuarial values, similar to the ACA's metal tiers, but otherwise allow them to develop their own benefit designs. For example, all MA plans could be required to have an actuarial value of 105 percent, 110 percent, or 115 percent of FFS. (Those percentages are purely illustrative.)

A more prescriptive option would be to specify the cost-sharing amounts for major service categories, similar to many standardized ACA plans. Table 3-15 provides an illustrative example of this approach. In this example, there would be three benefit packages for MA cost sharing for Part A and Part B services: lower generosity, medium generosity, and higher generosity. The more generous packages would have lower MOOP limits and lower cost sharing for many services. All conventional MA plans could be required to use one of these benefit packages. Policymakers would also need to decide whether this requirement would apply to SNPs; since most SNP enrollees do not pay cost sharing, those plans could potentially be exempt from the requirement or be required to use a separate set of benefit packages.

The parameters for these benefit packages are illustrative, but they are informed by current cost-sharing practices among conventional MA plans. We measured each plan's generosity using 2023 data for plan bids and any rebates used to reduce Part A and Part B cost sharing; plans that used more rebates to reduce cost sharing were considered more generous. We stratified plans based on their generosity and divided them by enrollment into three equal groups. The cost-sharing amounts shown in the table are similar to the enrollment-weighted median amounts for each group. Since nearly all conventional MA plans use at least some rebates to reduce Part A and Part B

TABLE 3–15

Illustrative MA benefit packages with standardized cost sharing for Part A and Part B services

Service category	Package 1 (lower generosity)	Package 2 (medium generosity)	Package 3 (higher generosity)
Maximum out-of-pocket limit	$6,200	$4,900	$3,400
Deductible	$0	$0	$0
Inpatient acute care (days 1–5 of stay)	$335 per day	$300 per day	$225 per day
Skilled nursing care (days 21–100 of stay)	$196 per day	$196 per day	$178 per day
Primary care visit	$0	$0	$0
Specialist visit	$40	$35	$20
Outpatient hospital service	$300	$295	$200
Emergency care	$90	$90	$90
Urgent care	$40	$40	$30
Dialysis	20%	20%	20%

Note: MA (Medicare Advantage). All amounts are for in-network care.

cost sharing, enrollees would pay less in cost sharing (at least in aggregate) under each benefit package than they would in FFS.

For the sake of simplicity, the illustrative packages show only the Part A and Part B services discussed earlier in the chapter. In practice, the benefit packages would likely specify the cost-sharing amounts for other services as well, similar to the standardized ACA plans shown in Table 3-2 (p. 117). MA plans would still be required to cover any Part A and Part B services that are not covered by the benefit packages, other than hospice, but plans would have the flexibility to develop their own cost-sharing rules for those services. (That flexibility could nonetheless be subject to certain limits, much like current MA cost-sharing rules.)

Policymakers would need to consider whether the benefit packages continued to follow the existing service-specific limits on cost sharing. If the service-specific limits remained in place, benefit packages could vary little in cost sharing for services such as SNF care, emergency services, and dialysis. However, under a policy allowing some benefit packages to charge higher cost sharing for these services, some enrollees would face higher out-of-pocket spending than others, which could deter enrollees from seeking necessary care, depending on the plan they chose.

Would insurers be required to offer every type of standardized plan? Would they be able to offer nonstandardized plans?

Policymakers would also need to decide whether MA insurers would be required to offer one or more of the standardized benefit packages. Several other programs have this feature: All Medigap insurers must offer Plan A, all ACA insurers must offer silver and gold plans, and all insurers that sell stand-alone Part D prescription drug plans (PDPs) must offer a plan with basic coverage. The goal of these requirements is to ensure that all beneficiaries have a minimum level of access to standardized plans, but their impact can be fairly limited if the plans that insurers are required to offer are unpopular (with either beneficiaries or insurers). For example, Plan A accounts for less than 1 percent of all Medigap policies (America's Health Insurance Plans 2022). Some PDP insurers charge high premiums for their basic plans and do little to promote them because they are more interested in offering plans with enhanced coverage.

A more important issue is whether insurers would still be allowed to offer nonstandardized plans. There

are several potential options. When Medigap plans were standardized, beneficiaries could keep their existing policies but insurers could not sell any more nonstandardized policies.[21] Some states with standardized ACA plans do not allow insurers to sell any other plans, while other states allow insurers to sell a limited number of nonstandardized plans. CMS added standardized plans to the federal ACA exchange without putting any limits on nonstandardized plans but will impose limits starting in 2024.

Allowing insurers to offer both standardized and nonstandardized plans would minimize disruption for existing enrollees but limit the potential gains from using standardized plans. In some ways, such an arrangement could make it even harder to compare plans because more plans would be on the market, and insurers would likely not promote the standardized plans if they viewed them as less profitable or attractive products. On the other hand, requiring all MA plans to have standardized benefit packages could cause disruption for many enrollees, although the amount of disruption would depend on the standardized plans' designs. There would be less disruption if the standardized plans were similar to the large plans now on the market. It is also worth noting that enrollees can already experience disruption under the current MA program when plans may make year-to-year changes in their premiums, cost-sharing rules, supplemental benefits, provider networks, and drug formularies.

Supplemental benefits

The starting point for efforts to standardize supplemental benefits would be quite different from standardizing cost sharing for Part A and Part B services because plans currently decide which supplemental benefits to provide and the extent of their coverage. Policymakers would need to balance the competing goals of allowing plans to design their own benefits with making it easier for beneficiaries to distinguish among plans so they can select the one that best meets their needs. Standardization could make supplemental benefits more transparent to beneficiaries by clarifying what plans cover and could help ensure that plans provide sufficient value to MA enrollees and taxpayers, which is a particular concern given the lack of utilization and spending data.

One way to realize some of the gains from standardized benefits while giving plans a significant amount of flexibility would be to focus on standardizing a limited number of common supplemental benefits. Dental, hearing, and vision benefits could be candidates for standardization for several reasons. Almost all MA plans cover these benefits (at least to some extent), and they are often highlighted in plan marketing efforts, suggesting that they play a more important role in beneficiary decision-making than many other supplemental benefits. Currently, the specific services that plans cover as part of these benefits, the cost-sharing rules, and the plan spending limits all vary. Finally, all three benefits have been offered for many years and are well developed, unlike services such as SSBCI, where plans have relatively limited experience.

There are several ways that Medicare could standardize these benefits. Some options would focus on the specific services that plans cover as part of these benefits, while others would focus on the types of enrollee cost sharing and per enrollee spending limits that plans use.

Standardizing the services that plans cover

One option for standardizing dental, hearing, and vision benefits would be to require plans to cover certain services as part of the benefit. For example, plans with dental benefits could be required to cover all preventive services, which would largely expand coverage of fluoride treatments, or they could be required to cover all 11 categories of preventive and comprehensive dental services (see Table 3-11, p. 135). Similarly, almost all plans with hearing benefits now cover routine exams and hearing aids; they could also be required to cover fittings and evaluations for hearing aids. The standards could require plans to cover at least some services in each category; plans would continue to determine the exact coverage limits for each service.

Policymakers could also develop standards that are more prescriptive. Instead of a more general requirement for plans to cover at least some services in particular benefit categories, Medicare could specify at a more granular level the number and type of services that plans would need to cover, while letting plans use more generous coverage limits if they wanted. This approach would make it easier for

enrollees to understand what services are covered and at least partly replace the coverage limits now set by plans. The coverage requirements could be based on the typical limits now used by MA plans and, for dental and vision benefits, could also be informed by the limits used in commercial plans. As an example, this year almost all conventional MA plans with hearing benefits cover hearing aids, but 77 percent cover two hearing aids per year, 13 percent have less generous limits (such as covering two hearing aids every two years or every three years), and 10 percent have no limit. Requiring plans to cover two hearing aids per year would thus affect 13 percent of plans, and a less stringent requirement, such as covering two hearing aids every two years, would affect an even smaller share of plans.

Standardizing cost sharing and plan spending limits

As with covered services, efforts to standardize enrollee cost sharing and per enrollee spending limits for supplemental benefits can be less prescriptive or more prescriptive. One example of a less prescriptive approach would be to specify the types of cost sharing or spending limits that plans could use, without specifying the exact amounts. For example, based on current MA plan designs:

- For dental services, plans that wanted to charge cost sharing for comprehensive services could be required to use coinsurance, and those that wanted to use a spending limit could be required to use a single limit that applied to all dental benefits.
- For hearing benefits, plans that wanted to charge cost sharing could be required to use copayments, and those that wanted to use a spending limit could be required to use a limit that applied to spending on hearing aids for both ears.
- For vision benefits, where cost sharing is rarely used, plans could be required to use a limit that applied to total spending on eyewear only.

These steps would make it easier to compare plans on an apples-to-apples basis while still giving plans flexibility to determine the exact features of their supplemental benefits.

Policymakers could also go further and put some limits on actual cost-sharing amounts for a given supplemental benefit. For example, the general prohibition on MA plans charging more than 50 percent in coinsurance (or an actuarially equivalent copayment) for Part A or Part B services could also be applied to some supplemental benefits. However, any limits on cost sharing would not apply after beneficiaries reached their plan's per enrollee spending limit.

Giving plans a limited number of ways to provide a particular supplemental benefit would achieve a high level of standardization

The options outlined above could be combined into a single approach that standardizes both the set of services covered and enrollee cost sharing. One alternative that could achieve a high level of standardization would be to give plans a limited number of options for covering a particular supplemental benefit. These options would essentially be benefit-specific versions of the standard packages for Part A and Part B cost sharing. Each option would specify the benefit's coverage limits, cost-sharing rules, and per enrollee spending limit. This approach could make it easier for beneficiaries to compare MA plans and understand how their coverage differs.

Table 3-16 (p. 144) provides an illustrative example of standardized options for dental benefits. This example is based partly on current MA dental benefits and partly on the stand-alone dental plans sold in the Federal Employees Dental and Vision Insurance Program (FEDVIP). FEDVIP plans are not fully standardized, but they nonetheless have several common elements. Each insurer offers only two types of coverage—standard and high—and the high coverage is clearly more generous, with lower cost sharing and a higher annual limit (and a higher premium). The dental services covered by the plans are also divided into three standard categories:

- Class A (preventive services, such as oral exams);
- Class B (intermediate services, such as fillings); and
- Class C (major services, such as root canals or crowns).

In this example, conventional MA plans that wanted to cover dental benefits would have only two options,

TABLE 3–16

Illustrative example of standardized options for MA dental benefits

	Annual benefit limit	Deductible	Beneficiary coinsurance: Class A: Preventive services	Beneficiary coinsurance: Class B: Intermediate services	Beneficiary coinsurance: Class C: Major services
Options for conventional MA plans:					
Standard	$1,500	$0	0%	30%	50%
High	No limit	0	0	20	35
Options for SNPs:					
Standard	$2,500	0	0	0	0
High	No limit	0	0	0	0

Note: MA (Medicare Advantage), SNP (special needs plan).

standard and high coverage. Both options would have the same limits on the number and type of services covered. Consistent with the typical features in existing MA dental benefits, these options would have no deductible, no cost sharing for preventive services, and a maximum coinsurance rate of 50 percent for major services. The standard option would have a specific annual benefit limit, while the high option would not. SNPs could have a separate set of options with higher annual limits and no cost sharing, features that would be consistent with the dental benefits those plans typically offer.

Standardizing supplemental benefits in this fashion would resemble the approach that Medigap plans used to provide prescription drug coverage prior to the start of the Part D benefit. In that case, when standard Medigap plans were created, 3 of the 10 plan designs included drug coverage. The only difference in their drug coverage was the annual limit: Each plan required beneficiaries to pay a $250 deductible and 50 percent coinsurance, two plans had the same annual drug coverage limit of $1,250, and the third plan had a limit of $3,000.

For hearing benefits, one challenge with standardization would be to address the differences among plans in the use of cost sharing and annual limits for hearing aids. More than half of conventional MA plans use cost sharing without any annual limit, but a substantial minority of plans do the opposite and use an annual limit without any cost sharing. In addition, when plans charge copayments for hearing aids, the amount that enrollees pay often varies depending on the specific model chosen. If the standard options used the same approach, policymakers would likely need to provide guidance on the cost-sharing amount that would apply to each hearing aid model.

Compared with dental and hearing benefits, the development of standard options for vision benefits could be more straightforward since almost all plans with vision benefits already cover the same services (eye exams, contacts, and eyeglasses) and very few plans use cost sharing. In this case, the only difference between the standard packages might be the annual limit.

Some potential implications of standardization

Efforts to standardize supplemental benefits would require MA insurers to modify their plan designs and would thus lead to some disruption in the market. The level of disruption would depend on the extent

to which the standardized benefits were similar to current MA plan designs.

Standardization could also lead plans to change their bidding behavior. If plans did not have enough rebates to provide a particular benefit package, they could finance the added cost by lowering their bids to generate more rebates, raising their premiums, or adjusting their coverage of benefits not covered by the standardization requirements. (In cases where a nonstandardized benefit is a Part A or Part B service, plans could charge higher cost sharing. For supplemental benefits, plans could charge higher cost sharing, reduce the scope of their coverage, or eliminate their coverage entirely.) Similarly, plans that have more rebates than needed to provide a particular benefit package could respond by increasing their bids (since they would need fewer rebates), lowering their premiums, or enriching their coverage of nonstandardized benefits.

The use of standardized benefits would also give plans fewer ways to respond to changes in payment rates. For example, plans could not respond to lower payment rates by making targeted changes to specific benefits—such as raising their MOOP limit, charging higher cost sharing for an inpatient stay, or lowering the annual limit for dental benefits. Plans would instead be limited to switching to a less generous standardized benefit package, if one were available. Changes in MA payment rates could thus have a particularly large impact on any services not covered by the standardization requirements. Plans might also be more likely to respond by reducing the size of their provider networks and adjusting the rates they use to pay providers.

Even with standardization, there would still be geographic variation in MA plan benefits due to the underlying variation in plan rebates and the high correlation between rebates and benefit generosity. This variation would likely affect the mix of standardized plans offered in each area. For example, if MA plans had to offer dental benefits that use the standard and high options in Table 3-16, low-rebate areas could generally have plans with standard coverage (or no dental coverage), medium-rebate areas could have a mix of plans with standard coverage and plans with high coverage, and high-rebate areas could generally have plans with high coverage. Standardizing supplemental benefits in a way that leaves some flexibility for plans should thus also be viewed as a way to accommodate geographic variation in MA rebates.

How the process of selecting an MA plan might look with standardized benefits

For beneficiaries, the process of comparing MA plans and selecting the one that best meets their needs is challenging because plans can differ in multiple ways. The continued growth in the number of MA plans adds to the difficulty. The use of standardized benefits would make it easier for beneficiaries to compare plans by giving them a more clearly defined set of choices.

This chapter has outlined an approach for standardizing benefits that has three key elements:

- For Part A and Part B services, plans would be required to use a limited number of benefit packages that specify the plan's MOOP limit and cost-sharing amounts for most major services. The generosity of those benefit packages would vary, but in ways that beneficiaries could easily identify.
- For certain high-profile supplemental benefits like dental, hearing, and vision benefits, plans would have a limited number of options for providing the benefit, such as "standard" and "high" options. Each option would specify the benefit's coverage limits, cost-sharing rules, and per enrollee spending limit. These requirements would apply only to plans that chose to provide dental, hearing, and vision benefits.
- For all other supplemental benefits, the current rules would remain the same. Plans could provide the same benefits they do now, including benefits that are not primarily health related, and could still target those benefits to certain types of enrollees.

The use of standardized benefits could be accompanied by supporting changes aimed at helping beneficiaries understand the coverage that each MA plan offers. For example, plan marketing materials and Medicare Plan Finder could use standard terms to describe each plan's benefits (such as "Lower Out-of-Pocket Costs" vs. "Medium Out-of-Pocket Costs" vs. "Higher Out-of-Pocket Costs" for Part A and Part B services and "Standard Dental" vs. "High Dental" for dental benefits). MA insurers could also be required to include some

or all of this information in plan names, similar to the practice of including the metal tier in the names of ACA plans.

Plans could also be required to submit encounter data for supplemental benefits so that policymakers and researchers could better understand the impact of these benefits on MA enrollees.

With these changes, beneficiaries who compare MA plans would be able to understand with relative ease what each plan charges for Part A and Part B services and the major supplemental benefits it provides. Selecting a plan would still involve other important factors—such as the plan's premium, the drugs on its formulary, and its provider network—but these changes would make the process simpler and easier to navigate. ■

Endnotes

1 These figures are based on conventional MA plans that are open to all beneficiaries who have Part A and Part B and live in the plan's service area. They do not include specialized plans that serve only certain types of beneficiaries, such as special needs plans (SNPs) or employer-sponsored plans. The numbers of SNPs and employer-sponsored plans have also grown in recent years.

2 Between 2011 and 2018, CMS limited the number of MA plans an insurer could offer by requiring the insurer to demonstrate that its plans had "meaningful differences" from each other. CMS eliminated this requirement starting in 2019.

3 Beneficiaries who purchased Medigap policies before this date were allowed to keep them. In addition, the requirement does not apply to policies sold in Massachusetts, Minnesota, or Wisconsin because those states had already standardized their Medigap markets.

4 Although Medigap policies have been standardized in terms of their coverage of Part A and Part B cost sharing, Medigap insurers have some flexibility to offer benefits that are not part of traditional Medicare, such as dental, vision, or hearing coverage. However, in 2020, only about 7 percent of Medigap plans covered any additional benefits (Ali and Hellow 2021).

5 The states with their own exchanges include three states that rely on the federal Healthcare.gov website to perform eligibility and enrollment functions.

6 Another state (Colorado) began offering standardized plans in 2023.

7 CMS also gave insurers the option of offering standardized plans in 2017 and 2018.

8 The high deductibles for many ACA plans are due to the interaction of (1) the highly skewed distribution of health care spending, (2) the program's annual out-of-pocket limit, and (3) the generosity levels of the metal tiers. Among people ages 18 to 64 (roughly the population served by the exchanges), 10 percent of people account for 67 percent of total health care spending (Kaiser Family Foundation 2021). Plan coverage of spending above the out-of-pocket limit thus represents a relatively large share of overall spending, which forces plans to cover a relatively low share of the spending for their other enrollees, especially in the lower metal tiers, and leads to high deductibles.

9 Plans that use a PPO model, which provides some coverage for services provided by out-of-network providers, must also have a cap on total out-of-pocket spending for both in-network and out-of-network services.

10 CMS rounds each MOOP limit to the nearest $50, but the intermediate limit is calculated using the unrounded values for the lower and mandatory limits. As a result, once the rounding rules have been applied, the intermediate limit may differ slightly from the midpoint of the lower and mandatory limits.

11 Before the enactment of the Cures Act, beneficiaries with ESRD could enroll in MA plans only if (1) they had ESRD while enrolled in a commercial plan and enrolled in an MA plan offered by the same company when they became eligible for Medicare, (2) they enrolled in an MA plan before they were diagnosed with ESRD, or (3) they enrolled in one of a small number of MA special needs plans that serve beneficiaries with ESRD.

12 Somewhat confusingly, many Part A cost-sharing requirements are referred to as "coinsurance" even though they are really copayments (specific dollar amounts that beneficiaries pay regardless of the overall cost of the service).

13 If a particular service has a cost-sharing limit that is based solely on coinsurance and a plan would prefer to use copayments, it generally can use a copayment that is actuarially equivalent. The same principle applies to services with cost-sharing limits that are based solely on copayments.

14 Plans are prohibited by law from charging more than FFS for dialysis. As a result, when CMS first put limits on dialysis cost sharing in 2011, it specified that plans could not charge more than 20 percent coinsurance (the same as in FFS) or a $30 copayment. At the time, the two amounts were actuarially equivalent. However, CMS did not update the copayment limit to reflect newer data until 2022, when it calculated that the actuarially equivalent copayment had increased to $64. The updated figure implies that the $30 limit had become roughly equal to 10 percent coinsurance and that any effort to use copayments meant, in effect, charging much lower cost sharing than FFS. This discrepancy between the coinsurance and copayment limits may be one reason why almost all plans now use 20 percent coinsurance for dialysis. The updated copayment limit (rounded to $65) will be phased in between 2023 and 2026; at that point, some plans might begin using copayments.

15 I-SNPs can also enroll beneficiaries who live in the community but need the level of care provided in a long-term care institution.

16 Although the term “supplemental benefits” is used to refer to items and services that traditional Medicare does not cover, some supplemental benefits may still be closely related to Part A and Part B services. For example, most MA plans cover an unlimited number of additional inpatient hospital days (beyond Medicare’s limit of 60 lifetime reserve days) as a supplemental benefit.

17 In 2021, between 35 percent and 40 percent of conventional MA plans offered optional supplemental benefits. Dental coverage accounted for the vast majority of the optional benefits (Friedman and Yeh 2021).

18 Plans had already been able to provide meals as a primarily health-related benefit on a limited basis following surgery or an inpatient stay.

19 MA plans do not have to meet any network adequacy requirements for their provision of supplemental benefits.

20 In 2022, the Food and Drug Administration issued a regulation that allows consumers to buy hearing aids for mild to moderate hearing loss without a prescription. The first OTC hearing aids have begun to enter the market, and observers expect them to be significantly less expensive than traditional hearing aids. The introduction of OTC hearing aids could prompt MA plans to revisit both their hearing benefits (which could cover hearing aids for severe hearing loss where beneficiaries still need a prescription) and their OTC benefits (which could cover the new hearing aids).

21 A small number of these nonstandardized policies are still in effect more than 30 years later.

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