

# ISSUE BRIEF

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## Expanded Health Benefits for Seniors: The Trump Administration's Changes to Medicare Advantage's Supplemental Benefits

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Next year, because of new rules issued by the Trump Administration, millions of seniors enrolled in Medicare Advantage (MA) will enjoy new and more flexible supplemental health benefit offerings.<sup>1</sup> The Centers for Medicare and Medicaid Services (CMS), the agency that runs the Medicare program, is giving MA health plans greater flexibility to respond to seniors' needs and changing demands for benefits. Specifically, health plans will be able to deliver targeted, innovative, and patient-centered supplemental benefits, particularly to seniors suffering from chronic medical conditions who need a broader and more targeted set of care options. In a rare instance of consensus on health policy, the Administration's new final rule thus far enjoys strong bipartisan support.<sup>2</sup>

### Consequential Change

For care delivery, the new MA rules could prove profoundly consequential. Medicare Advantage is a large and rapidly growing system of competing private health plans that today enrolls more than 21 million seniors, approximately 36 percent of the total Medicare population.<sup>3</sup> Chronic illness is the biggest driver of America's health care costs; 68 percent of the Medicare population suffers from multiple chronic conditions.<sup>4</sup> With the new rules, MA

plans will have a greater opportunity to focus more effectively on the particular needs of individual patients, to develop more innovative care delivery options, and help drive more intense competition based on the value of care provided to patients.

### Overcoming Rigidity

Traditional Medicare covers hospital and physician services (Parts A and B), and provides an optional, additional prescription-drug (Part D) benefit. MA plans must offer Parts A and B benefits, and may also include Part D benefits. The difference between MA and traditional Medicare is in the payment and benefit structure. In traditional Medicare, doctors are paid on a "fee-for-service" basis, with the traditional program operating as a single payer: The Medicare bureaucracy fixes provider payment and, subject to statutory authority, regulates and caps payment for medical services.

In MA, however, private plans are paid on a per capita basis, determined by a combination of competitive bidding and Medicare's benchmark pricing. MA pays providers on a private contractual basis, and the payment models among competing plans vary. MA plans very much resemble typical private insurance arrangements, with comprehensive care and catastrophic protection.

Subsequent to the annual MA competitive-bidding process, when the cost of an MA plan is less than traditional Medicare, that plan must return the value of the difference to the beneficiaries in the form of a rebate. For the beneficiaries, the rebate can be lower premiums or richer "supplemental benefits" that go beyond Parts A and B provisions.<sup>5</sup> These benefits can range from the unconventional, such as gym memberships,<sup>6</sup> to more basic, such as dental, vision, and hearing coverage.<sup>7</sup>

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This paper, in its entirety, can be found at <http://report.heritage.org/ib4900>

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The Administration's new rules address two key problems in Medicare Advantage's supplemental benefits regulations:

1. An overly stringent "uniformity" requirement, which limits plans' ability to target benefits and cost-sharing to beneficiaries with specific conditions.
2. An overly stringent definition and application of the "primarily health-related" standard, which limits the scope of benefits that plans could offer.

Under the old rules MA supplemental benefits are governed by a "uniformity" requirement. Until recently, this has meant that all enrollees in a particular plan must be treated the same, including by providing them the same supplemental benefits at the same level of cost-sharing.<sup>8</sup> Though intended to prevent discrimination against sicker enrollees, this restricts plans' ability to tailor benefits to enrollees' personal needs. To offer a special benefit, a plan must offer it to *all* enrollees, at the same level of cost-sharing, under the "uniformity" requirement. Under old rules, in other words, plans must choose between raising costs (at the cost-sharing or premium level) or dropping the benefit entirely for all beneficiaries. This regime discourages patient-centered care, undercuts innovation in care delivery, and denies

patients the opportunity to get the same quality of coverage and care as they could in an otherwise more flexible regulatory environment.

Likewise, under old rules, supplemental benefits must be "primarily health-related." Benefits that are primarily health-related exist primarily to "prevent, cure or diminish an illness or injury."<sup>9</sup> Narrow interpretations of the "health related" language inhibit optimal coverage for chronically ill beneficiaries, as the best value for health care dollars may sometimes be secured in ways that do not fit squarely within Medicare's often-rigid regulatory standards. For instance, a patient who needed a grab-bar in the shower could not previously obtain that coverage under her MA plan. The new rules permit "Home & Bathroom Safety Devices & Modifications" as supplemental benefits, explicitly naming grab-bars among other devices.<sup>10</sup>

Plans must continue to meet the uniformity and—in many cases—the "health-related" standards. However, the CMS has redefined these terms to expand plans' ability to target benefits and cost sharing in a way that meets the needs of beneficiaries.

## New Flexibility

Under the new rules, MA plans are allowed to provide three kinds of supplemental benefits: (1) basic supplemental benefits, (2) targeted supplemental benefits for specific health needs, and (3) chronic care supplemental benefits.<sup>11</sup>

1. Centers for Medicare and Medicaid Services, "Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program," *Federal Register*, Vol. 83, No. 73 (April 16, 2018), <https://www.gpo.gov/fdsys/pkg/FR-2018-04-16/pdf/2018-07179.pdf> (accessed August 30, 2018). Hereafter cited as Contract Year 2019 CMS rule.
2. Robert Pear, "Medicare Allows More Benefits for Chronically Ill, Aiming to Improve Care for Millions," *The New York Times*, June 24, 2018, <https://www.nytimes.com/2018/06/24/us/politics/medicare-chronic-illness-benefits.html> (accessed June 29, 2018).
3. Centers for Medicare and Medicaid Services, *2018 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, June 5, 2018, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2018.pdf> (accessed August 30, 2018).
4. Robert E. Moffit and Jean Morrow, "Chronic Illness Is an Epidemic in America. This Senate Bill Will Help Address It," *The Daily Signal*, May 18, 2017, <https://www.dailysignal.com/2017/05/18/chronic-illness-epidemic-america-senate-bill-will-help-address/>.
5. Christopher Pope, "Supplemental Benefits Under Medicare Advantage," *Health Affairs*, January 21, 2016, <https://www.healthaffairs.org/doi/10.1377/hblog20160121.052787/full/> (accessed August 30, 2018).
6. For example, see Aetna, "Enjoy Fitness Benefits with SilverSneakers," <https://www.aetnamedicare.com/en/live-well/gym-memberships-fitness-classes.html> (accessed August 3, 2018).
7. Pope, "Supplemental Benefits Under Medicare Advantage."
8. Legal Information Institute, 42 CFR § 422.100(d), <https://www.law.cornell.edu/cfr/text/42/422.100> (accessed August 30, 2018).
9. Centers for Medicare and Medicaid Services, "CMS Manual System," June 22, 2012, <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R107MCM.pdf> (accessed August 30, 2018).
10. Centers for Medicare and Medicaid Services, "Reinterpretation of 'Primarily Health Related' for Supplemental Benefits," April 27, 2018, <https://www.nahc.org/wp-content/uploads/2018/05/HPMS-Memo-Primarily-Health-Related-4-27-18.pdf> (accessed August 30, 2018).
11. Contract Year 2019 CMS Rule, p. 16482.

**Basic Supplemental Benefits.** MA plans may continue to provide the same supplemental benefits they have always provided. Plans must continue to comply with the traditional “uniformity” requirement, and benefits must remain primarily health related, as defined by previous MA rules. However, the CMS expanded the definition of “primarily health-related” to now include “an item or service whose primary purpose to diagnose, prevent, or treat an illness or injury, compensate for physical impairments, act to ameliorate the functional/psychological impact of injuries or health conditions, or reduce avoidable emergency and healthcare utilization.”<sup>12</sup> The new language permits health plans to cover more preventive and wellness services—a crucial improvement for a chronically ill population.<sup>13</sup>

**Targeted Supplemental Benefits.** MA plans may now offer targeted supplemental benefits under a new reinterpretation of the uniformity requirement.<sup>14</sup> Previously, plans had to offer the same benefits to beneficiaries at the same level of cost-sharing; the new rule allows them to offer the same benefits to beneficiaries *with the same condition* at the same level of cost-sharing.<sup>15</sup> In other words, a class of persons who all experience a certain disease may be offered a benefit specific to that disease, so long as all other persons in that same class receive it at the same level of cost-sharing. The benefit or service need not be offered to all persons in the plan, and certainly not at the same level of cost-sharing. The CMS gives the example of a plan offering “more frequent foot exams as a tailored, supplemental benefit” for diabetic patients.<sup>16</sup>

Plans could also offer a general benefit to a target population at a lower level of cost-sharing. For example, the CMS notes that a diabetic could secure lower cost-sharing for endocrinologist visits than a non-diabetic, or a plan could eliminate cost-sharing for a benefit in a target population altogether.<sup>17</sup>

Targeted benefits must be tied to the patient’s health status or disease state, and applied to services that are medically related to each disease condition.<sup>18</sup> Moreover, existing anti-discrimination and health-status discrimination rules apply, and all criteria used to determine target populations must be “objective and measurable.” Plans may also help consumers obtain best-value care by limiting lowered cost-sharing to certain high-quality network providers.

**Chronic Care Supplemental Benefits.** The “chronic care” category provides the highest level of flexibility for plans focused on targeting benefits and lower cost-sharing for chronically ill beneficiaries. Chronically ill patients are defined as “individuals with (1) one or more morbidities that is life threatening and limits overall function, (2) has a high risk of hospitalization and adverse outcomes, and (3) requires intensive care coordination.”<sup>19</sup>

“Chronic care” benefits need not be health related, but only related to the beneficiary’s “health or overall function.” A chronic care beneficiary might receive an in-home care benefit designed to reduce the potentially high cost of repeated emergency visits, and enjoy a less-costly, more convenient, and more comfortable, patient-centered approach to his care. Likewise, a chronically ill patient with a condition limiting her ability to drive could secure contracted ride-sharing services at special rates.

### **Toward Patient-Centered, Consumer-Driven Care**

While the Trump Administration’s new rules for Medicare Advantage plans are a step in the right direction, Congress and the Administration still must make additional reforms to ensure that the program serves current and future enrollees.

The Trump Administration’s rule changes move the Medicare system further toward a patient-centered, con-

12. Centers for Medicare and Medicaid Services, “2019 Medicare Advantage and Part D Rate Announcement and Call Letter,” April 2, 2018, <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-04-02-2.html> (accessed August 30, 2018).

13. If the patient’s provider does not offer a particular service, that provider must also certify that the service is medically appropriate before the patient may seek coverage to receive the service elsewhere.

14. The requirement remains intact, the CMS has only redefined it. Contract Year 2019 CMS Rule, p. 16480.

15. Contract Year 2019 CMS Rule, p. 16480.

16. *Ibid.*

17. *Ibid.*

18. *Ibid.*, p. 16482.

19. *Ibid.*, p. 16481, footnote 19.

sumer-driven program. Under the new rules, plans can evaluate the unique needs of their enrollees, and target benefits to fit those needs. Safeguards are still in place to ensure that plans use this new flexibility primarily to benefit patients, and not merely to boost their own enrollment.

The new rules will build on the success of Medicare Advantage, the system of competing private plans that has proven far more flexible than traditional Medicare. MA has pioneered case management and care coordination, and has become a strong vehicle for innovative private plans' efforts to deliver value for their health care dollars.<sup>20</sup> These new rules will allow plans to further expand patient choice of different care options, enable plans to introduce innovative and targeted care delivery options, and intensify the competition that will secure better care at lower cost.

Even though MA is far more flexible than traditional Medicare, the program as a whole needs improvement. Millions of Americans remain poorly served by traditional Medicare's regulatory regime, which often inhibits change and innovation, as its traditional standardized care delivery leaves patients, regardless of their often radically different needs, locked into complex bureaucratic benefit categories and cost-sharing. As Heritage experts, among others, have long argued, the program needs major reforms to preserve it for future retirees.<sup>21</sup>

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20. For a discussion of MA's progress in improving patient care and satisfaction, see Robert E. Moffit, Rita E. Numerof, and Christen M. Buseman, "Let the Market Compete: Learning from Medicare Advantage to Move Toward Value-Based Care," Health Affairs Blog, January 25, 2018, <https://www.healthaffairs.org/doi/10.1377/hblog20180122.210298/full/> (accessed August 30, 2018).

21. Robert E. Moffit, "Medicare's Next 50 Years: Preserving the Program for Future Retirees," Heritage Foundation *Special Report* No 185, July 29, 2016, <https://www.heritage.org/health-care-reform/report/medicares-next-50-years-preserving-the-program-future-retirees>.