The State of Medicare Advantage 2022

Center for Medicare
Centers for Medicare & Medicaid Services

November 18, 2021

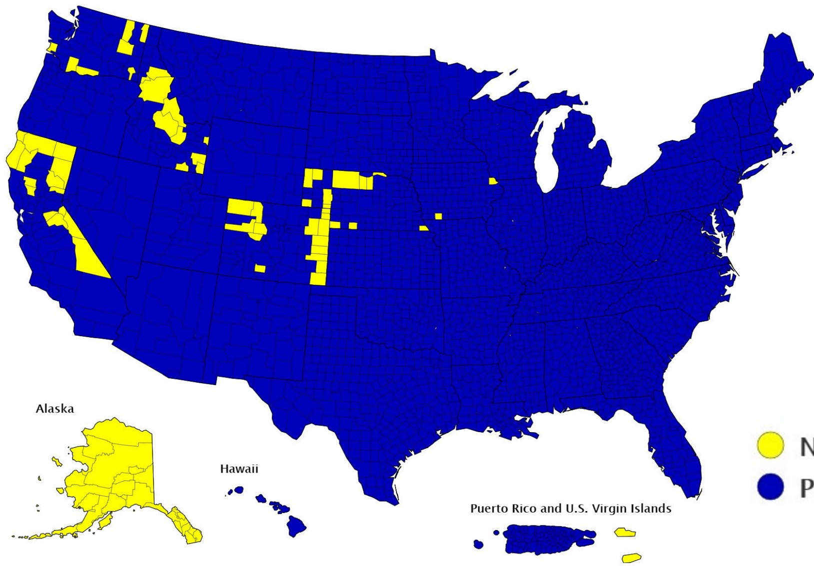
2022 – A Year of Continued Growth

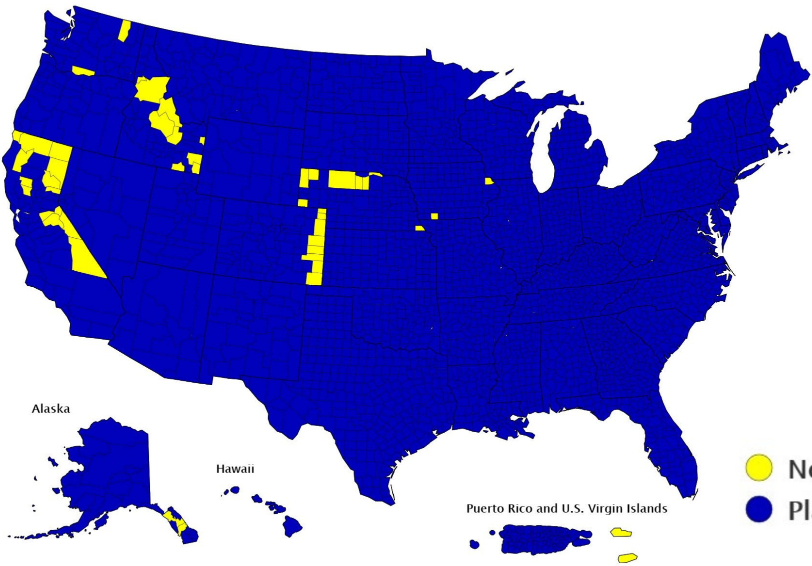
- **Access remains strong and stable**
- **Enrollment is expected to continue growing**
- **Supplemental benefit offerings are increasing**

Medicare Advantage Access Remains Strong

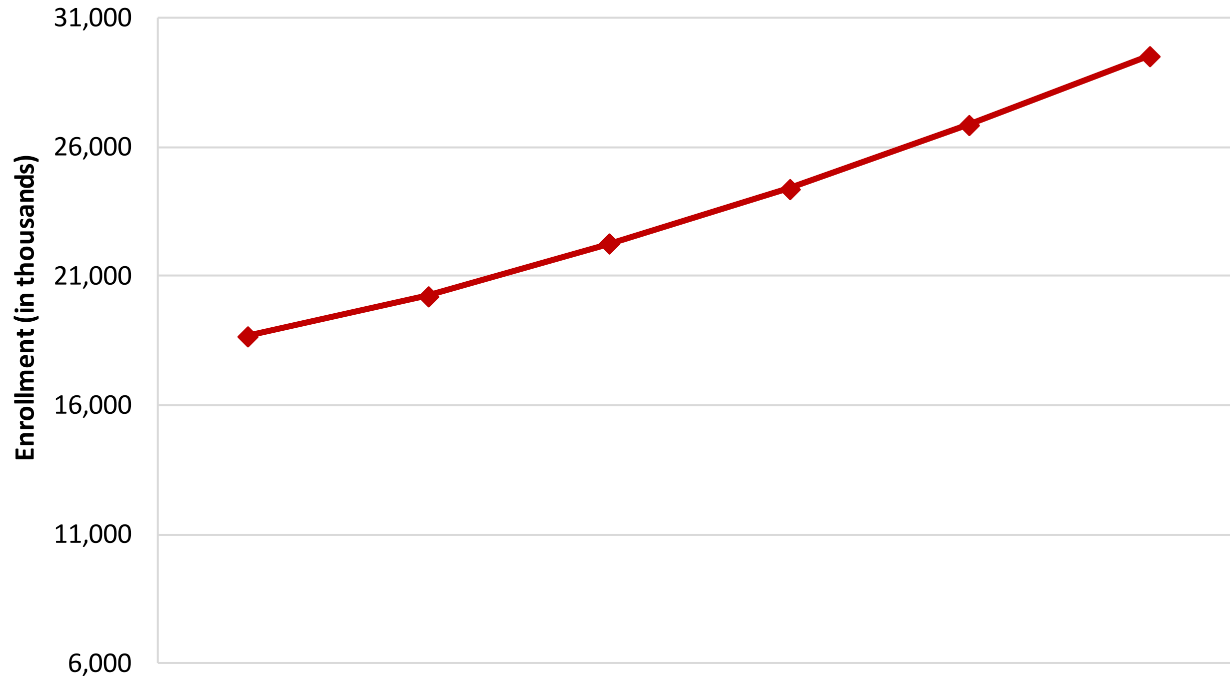
2021

2022





Enrollment Projected to Increase in 2022



	2017	2018	2019	2020	2021	2022
Actual Enrollment	18,689	20,241	22,243	24,369	26,864	29,543
Growth Percentage*	7.79%	8.30%	9.89%	9.56%	10.24%	9.97%

* Growth percentage is based on actual enrollment with the exception of 2022, which is based on projected enrollment. July enrollment of the plan year is used for actual enrollment for 2017-2021.

Premiums Projected to Decrease

Weighted Average Monthly Premium Over Time

Note: 2017-2021 averages are weighted by July enrollment. 2022 value is weighted by projected enrollment.

2022 Benefit Offerings & Flexibilities

Additional Telehealth Benefits

- 42 CFR 422.135 allows MA plans to offer "additional telehealth benefits" beyond what is currently allowable under the original Medicare telehealth benefit, and treat them as basic benefits for purposes of bid submission and payment by CMS.

Expansion of Supplemental Benefits

- In 2019, expanded "health related" benefits and reinterpreted "uniformity" of benefits.
- In 2020, permitted Special Supplemental Benefits for the Chronically Ill.

Expanded Supplemental Benefits

Expanded Definition of "Health-Related"

- About 1,000 plans nationwide are providing access to expanded health related supplemental benefits
  - Adult Day Health Services
  - Home Based Services
  - Caregiver Support

Targeting Benefits to Specific Health Conditions *(Uniformity)*

- About 500 plans are offering benefits at reduced cost sharing and/or additional benefits for enrollees with certain health conditions
  - Diabetes
  - Congestive Heart Failure

Expanded Supplemental Benefits

Special Supplemental Benefits for the Chronically Ill

- 42 CFR 422.102(f) allows MA plans to offer special supplemental benefits to chronically ill individuals who:
  - Have one or more comorbid, medically complex chronic conditions that is life-threatening or significantly limits the overall health or function of the enrollee;
  - Have a high risk of hospitalization or other adverse health outcomes; and
  - Require intensive care coordination.

Expanded Supplemental Benefits

Special Supplemental Benefits for the Chronically Ill (cont.)

- Benefits do not have to be "primarily health-related,"
- Do not have to be offered uniformly to eligible chronically ill enrollees, so long as
- The item or service has a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee.
- In 2022, more than 1,300 plans will offer SSBCI
  - Food and produce
  - Meal delivery (beyond a limited basis)
  - Transportation for non-medical needs
  - Home environment services

COVID-19 Related Services and Flexibilities

- In response to the COVID-19 outbreak, CMS exercised enforcement discretion in connection with:
  - Mid-year benefit enhancements
  - Waiving or reducing enrollee cost-sharing
  - Expanding coverage of telehealth services beyond those approved by CMS
  - Model of Care changes
  - Involuntary disenrollment flexibilities
  - Encouraged plans to waive or relax prior authorization requirements

COVID-19 Related Services and Flexibilities

- Testing to diagnose or aid in the diagnosis of COVID-19 without any cost-sharing to enrollees (including antibody or “serology” tests)
- COVID-19 Vaccine:
  - For Calendar Years (CYs) 2020 and 2021, Medicare payment for the COVID-19 vaccine and its administration for MA enrollees was made through the original fee-for-service Medicare program.
  - In CY 2022, MA plans will be responsible for payment of the COVID-19 vaccine and its administration. This includes payment of monoclonal antibody products to treat COVID-19.

Plan Marketing and Communication Updates

- Update to the regulation (4190-F2)
  - Published on 1/19/2021, effective on 3/22/2021
  - Codified the majority of our marketing guidance
- Currently reviewing the Annual Notice of Change (ANOC) and Evidence of Coverage (EOC)
  - Making them more beneficiary friendly
  - Reducing duplicative language and streamlining sections
- Third party marketing memo
  - Released October 8, 2021
  - Advertisements that mention benefits but don’t mention a plan by name are STILL considered marketing and must be submitted.

HPMS Marketing Module Redesign

- Released May 28, 2021
- To move the marketing module more in line with current regulations
- To make marketing submissions more intuitive
- To give plans the ability to better manage their materials
- To help CMS reviewers manage workload
- To allow CMS to better identify marketing materials based on more detailed information

Medicare Advantage and Part D Star Ratings

- Medicare Advantage and Part D Star Ratings helps Medicare consumers compare the quality of Medicare health and drug plans being offered.
- People with Medicare can compare quality through the Star Ratings, along with other information such as cost and coverage, on the online Medicare Plan Finder tool available on Medicare.gov.
- According to the latest data, approximately 68 percent of Medicare Advantage plans that offer prescription drug coverage will have an overall rating of four stars or higher in 2022, up from 49 percent in 2021.
- For contract year 2022, there are no contracts identified on the Medicare Plan Finder with a low performance icon for consistently low quality ratings.

Surveillance & Compliance Activities

- Annual ANOC/EOC Timeliness and Accuracy Review
- Retrospective Review of Marketing and Communications Materials
- Continue to Encourage Improvements in the Accuracy of Provider Directories
- Ensuring Compliance with Network Adequacy Standards

Ensuring Access to Services

- Network Reviews for Existing Organizations
  - CMS reviews an organization's contract-level network at least once every three years (OMB Control Number: CMS-10636, OMB 0938-1346)
  - Networks also are reviewed based on triggering events
  - Organizations that fail to meet network adequacy standards are subject to compliance actions.

Ensuring Access to Services

- Network Reviews for New MA Applicants
  - Networks no longer part of the initial application approval process, which occurs in the beginning of each calendar year.
  - Applicants' networks are reviewed in June.
  - Applicants with network failures may be suppressed from Medicare Plan Finder during the Annual Open Enrollment Period.
  - Must be in compliance with our standards by January 1 of the contract year.

Ensuring Access to Services

- Network Consultation
  - All organizations have the ability to consult with CMS each year prior to formal network reviews.
    - CMS gives priority to organizations selected for a formal review in June.
    - Organizations may submit exceptions to CMS for an informal review as part of consultation.

Questions

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