August 31, 2022

Submitted via www.regulations.gov

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4203-NC
P.O. Box 8013
Baltimore, MD 21244-8013

Re: Medicare Program; Request for Information on Medicare

Dear Sir or Madam,

I write on behalf of the American Benefits Council ("the Council") in connection with the request for information (RFI) issued by the Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid Services (CMS) on various aspects of the Medicare Advantage (MA) program, published in the Federal Register on August 1, 2022.

The Council is a Washington D.C.-based employee benefits public policy organization. The Council advocates for employers dedicated to the achievement of best-in-class solutions that protect and encourage the health and financial well-being of their workers, retirees and families. Council members include over 220 of the world's largest corporations and collectively either directly sponsor or administer health and retirement benefits for virtually all Americans covered by employer-sponsored plans.

The RFI asks a wide range of questions and seeks feedback to strengthen MA, including feedback on how to enhance health equity for all enrollees in MA. The RFI also provides that one of HHS's and CMS's goals in issuing the RFI is to create more opportunities for HHS and CMS to engage with stakeholders on MA. And in the RFI, the agencies encourage input from a wide variety of stakeholders, specifically including employers.

The Council very much appreciates these efforts by HHS and CMS to engage with stakeholders and, in particular, fully supports efforts by HHS and CMS to advance health

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equity, including through MA – health equity is also a priority for the Council and its members.

In addition, we appreciate that HHS and CMS specifically included employers in the list of stakeholders impacted by any MA changes. In that vein, we are responding to the RFI to confirm and emphasize that employer plan sponsors are a key stakeholder group that should be considered and engaged with as part of future policy making regarding MA.

For context, many employers sponsor health plans for retired employees and their dependents. Fully 49% percent of very large firms (those with 5,000 or more workers) and 27% of large firms (200 or more workers) offer retiree health benefits.[1] Employers offer retiree health benefits in several ways, with a substantial portion of employers offering retiree benefits through MA (referred to as "employer group waiver plans" or "EGWPs").[2] Of large employers that offer retiree health benefits, 45% do so by offering an EGWP.[3] Employers can provide an EGWP by directly contracting with HHS/CMS or by offering an insured plan where the carrier contracts with HHS/CMS.

Enrollment in EGWPs is substantial and has grown significantly over time. In 2022, there are over 5.1 million individuals enrolled in MA through an EGWP, which accounts for almost 20% of total MA enrollment.[4] And the number of individuals enrolled in MA through EGWPs increased from 1.8 million in 2010 to 5.1 million in 2022, consistent with growth in MA enrollment overall.[5]

EGWPs can be customized for the unions and employers that offer them. This is because CMS has the statutory authority to waive or modify MA requirements that hinder EGWPs. CMS has issued several waivers accordingly – for example, employers can set their own open enrollment window (rather than use the MA window), employers can create and send information about the plan to employees (rather than having to use CMS

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[1] *See* Kaiser Family Foundation, Employer Health Benefits 2021 Annual Survey at https://files.kff.org/attachment/Report-Employer-Health-Benefits-2021-Annual-Survey.pdf.

[2] We note that EGWPs can also be used to provide only prescription drug coverage but this letter is focused on EGWPs that offer MA (some of which also include prescription drug coverage).

[3] *See* Kaiser Family Foundation, Employer Health Benefits 2021 Annual Survey at https://files.kff.org/attachment/Report-Employer-Health-Benefits-2021-Annual-Survey.pdf.

[4] *See* https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-Contract-and-Enrollment-Summary-Report and Kaiser Family Foundation: Medicare Advantage in 2022: Enrollment Update and Key Trends at https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-enrollment-update-and-key-trends/.

[5] *Id*.

communications), employers have additional flexibility with regard to which supplemental benefits to offer, and employers can subsidize retiree premiums.[6]

EGWPs often provide additional benefits beyond a typical MA plan (*e.g.*, reduced co-pays) and are designed to be similar to employer-sponsored coverage provided to active employees, in that the coverage is coordinated and comprehensive. This can improve the transition for employees from active employee coverage to retiree coverage. And EGWPs also allow employers to leverage the value associated more generally with MA, including a range of supplemental benefits (*e.g.*, vision benefits, dental benefits, hearing exams, fitness benefits), low or no supplemental premiums, a high satisfaction rate among seniors[7] and lower rates of avoidable hospitalizations, as compared to traditional Medicare.[8]

Because of the value of EGWPs to retirees and employers and the prevalence of these plans, we were glad to see that HHS and CMS acknowledged EGWPs in the RFI, and we ask that HHS and CMS continue to consider EGWPs in future policy making, including the impact of such policymaking on EGWPs whether as a result of general or EGWP-specific changes. We also ask that HHS and CMS take actions that support, and avoid actions that undermine, employers' ability to continue to provide these important benefits. We also ask that any future policy changes or updates provide sufficient comment opportunities for all affected stakeholders and sufficient lead time for implementation.

We also note that the Council is happy to act as a resource to HHS and CMS and to answer any questions about the way in which EGWPs are currently offered and the possible impact of any future policy changes.

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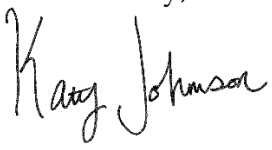
Thank you for the opportunity to submit these comments. If you have any questions or would like to discuss further, please contact us at (202) 289-6700.

Sincerely,



Katy Johnson
Senior Counsel, Health Policy

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[6] *See* Medicare Managed Care Manual Chapter 9 – Employer/Union Sponsored Group Health Plans at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c09.pdf.

[7] *See* https://bettermedicarealliance.org/wp-content/uploads/2022/01/BMA_Seniors-on-Medicare-Memo_final3.pdf.

[8] *See* https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-premiums-out-of-pocket-limits-cost-sharing-supplemental-benefits-prior-authorization-and-star-ratings/ and https://bettermedicarealliance.org/wp-content/uploads/2020/12/BMA-High-Need-Report.pdf.