Center on Health Policy at BROOKINGS

January 27, 2025

Re: Medicare and Medicaid Programs; Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly [CMS-4208-P]

To Whom It May Concern:

Thank you for the opportunity to comment on the above-referenced proposed rule. In what follows, I comment on two issues contained in the proposed rule. They are: 1) the maximum cost sharing standard established for behavioral health services; and 2) the request for information regarding policy towards the Medical Loss Ratio (MLR) requirements.

1. Centers for Medicare and Medicaid Services (CMS) proposes to require Medicare Advantage plans cost sharing for in-network behavioral health services to "be no greater than that in Traditional Medicare beginning January 1, 2026."

I applaud CMS' attention to the need to improve access to and quality of behavioral health services (services to treat mental illnesses and substance use disorders) in Medicare Advantage (MA). Articulation of a maximum cost sharing standard is clearly a step in the right direction.

However, it is not clear that the appropriate standard should be the Traditional Medicare (TM) cost sharing level. In TM, cost sharing is the main tool for addressing the potential overuse of services. Starting in 2008, TM has phased in lower cost sharing for Part B outpatient mental health services such as psychotherapy from 50% to 20%. This was an effort to achieve greater parity in financial access between mental health and medical-surgical services. A recent report from the HHS Office of the Inspector General noted that access to behavioral health care remains problematic in both TM and MA.[1] The evolution of cost sharing has been slow. So, while the shift to a 20% cost sharing standard in TM was an improvement and has resulted in some expansion of access to care, there remains more to be done if TM is to improve access to behavioral health care. Reducing cost sharing further would likely serve to support further increases in access to behavioral health services.

In MA, there are a variety of mechanisms that can be used to address the potential overutilization of services. They include provider network design, prior authorization, concurrent review, and referral requirements, among others. Therefore, MA plans do not rely solely on cost sharing to promote appropriate utilization of behavioral health services. So, cost sharing has a markedly

[1] Office of the Inspector General (OIG). *A lack of behavioral health providers in Medicare and Medicaid impedes enrollees' access to care.* 2024. https://oig.hhs.gov/reports/all/2024/a-lack-of-behavioral-health-providers-in-medicare-and-medicaid-impedes-enrollees-access-to-care/

different role in MA relative to TM. Specifically, there is evidence that MA plans apply utilization management tools more stringently to behavioral health services than they do to medical-surgical services, which, in turn, has led to too little access to services. As noted earlier, the Office of the Inspector General found that access to in-network care for behavioral health services was limited due to narrow provider networks.[2] Likewise, KFF reported that access to psychiatrists was more restricted than was the case for any other type of physician.[3] In addition, a 2023 KFF survey of consumers found that over 25% of those seeking care for behavioral health problems were subject to prior authorization compared to about 13% of consumers not seeking behavioral health services.[4] These consumer responses were consistent with results from a 2022 Government Accountability Office (GAO) report reporting more stringent application of prior authorization to behavioral health services.[5]

Together, the evidence suggests that even in TM, which has decreased the level of cost sharing, access to behavioral health services remains constrained. At the same time, evidence shows that utilization management tools are applied more stringently to behavioral health services relative to other types of patients, leading to still more limited access to care. This may be the result of selection incentives to avoid people with behavioral health problems, as they are more costly. It may also stem from an absence of incentives to maintain access to quality behavioral health services, as no behavioral health quality indicators are attached to financial consequences for plans. The implication is that the evidence does not support 20% as the right level of cost sharing in TM, where it is the main utilization control mechanism. Since MA has both other methods of controlling use and evidence indicating that plans use the wide discretion given plans to apply those tools more stringently to behavioral health care, it suggests that the 20% cost sharing level is likely too high. I would propose that an alternative approach would be to set a lower cost sharing standard than that found in TM, such as 15%, as a prudent step that would be unlikely to create financial threats to MA plans.

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[2] Ibid., 2024.

[3] Freed, Meredith, Juliette Cubanski, and Tricia Neuman. FAQs on Mental Health and Substance Use Disorder Coverage in Medicare. 2024. https://www.kff.org/mental-health/issue-brief/faqs-on-mental-health-and-substance-use-disorder-coverage-in-medicare/#:~:text=Medicare%20Advantage%20plans%20can%20and%20do%20apply,can%20restrict%20beneficiary%20choice%20of%20in%2Dnetwork%20physicians.&text=Prior%20to%202010%2C%20Medicare%20beneficiaries%20paid%20a,outpatient%20services%20covered%20under%20Part%20B%20(20%).

[4] Pollitz, Karen, Kendal Pestaina, Liz Lopes, Robin Wallace, and Jennifer Lo. *Consumer problems with prior authorization: Evidence from KFF survey.* 2023. https://www.kff.org/affordable-care-act/issuebrief/consumer-problems-with-prior-authorization-evidence-from-kff-survey/ (accessed June 11, 2024).

[5] Government Accountability Office (GAO). *Mental Health Care: Access Challenges for Covered Consumers and Relevant Federal Efforts.* GAO-22-104597. Washington, D.C.: U.S Government Accountability Office, March 29, 2022. https://www.gao.gov/products/gao-22-104597

2. Request for information on potential policies that CMS could adopt regarding how the MA and Part D MLRs are calculated to enable policymakers to address concerns surrounding vertical integration in MA and Part D.

It is a positive development that CMS is proposing to extend its scrutiny and oversight of the MLR requirements in both MA and Part D plans. The proposed rule constructively seeks to expand reporting requirements and identifies the allocation of spending across related entities. These are vital and necessary steps. A key element necessary for making judgments regarding how reasonable allocation schemes are involves establishing benchmarks for evaluating transfer prices used to move funds between related entities (e.g., health plans and Pharmacy Benefit Managers (PBMs) owned by the same parent company).[6]

For many services, the Medicare fees schedule in TM offers a natural benchmark against which transfer prices can be evaluated. For example, payment rates by an owned physician practice to its owner health plan could be compared to the service prices set out in the Medicare physician fee schedule. This approach can be applied when a fee schedule exists. There are important cases where no such schedule will exist, like fees paid to PBMs for prescription drug claims.

Tax authorities have prior experience regulating transfer prices to combat tax avoidance by multi-national firms that operate in countries with very different tax structures. These include national tax authorities such as the Internal Revenue Service (IRS) and international economic organizations such as the Organization for Economic Cooperation and Development (OECD). This experience can help inform the regulation of transfer prices in the context of the MA MLR rules. The dominant line of thinking in the tax policy context is that transfer prices should be judged against an "arm's length" benchmark. That is, the benchmark should be the price that would be charged between two similarly situated entities that are not vertically integrated.

Developing a PBM benchmark would be considerably more difficult, given the very complicated pricing dynamics of prescription drug markets. One approach consistent with the use of non-vertically integrated exchanges to create a benchmark would be to use contracts between MA plans and independent PBMs. This would rely on information from a small segment of the market, given the high levels of insurer concentration among plans that own PBMs.

Another strategy would be to employ so-called Advanced Pricing Agreements (APAs). APAs would be prospectively developed agreements between CMS and MA plans that would establish approved methods and pricing mechanisms for transfer prices. This would potentially work by having an application process to propose a transfer pricing approach. The application would include financial records from the firm and information on internal company transactions. The application would propose a method for arriving at transfer prices. CMS would review the application and negotiate the terms of the transfer pricing agreement with the MA parent company.

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[6] Frank Richard G., and Conrad Milhaupt. *Medicare Advantage Spending, Medical Loss Ratios, and Related Businesses: An Initial Investigation*. The Brookings Institution, March 24, 2023. https://www.brookings.edu/articles/medicare-advantage-spending-medical-loss-ratios-and-related-businesses-an-initial-investigation/

This would be expected to involve assessing which transactions were the most relevant to establishing a benchmark. APAs could reduce uncertainty for MA plans and transparently set out an agreed-upon approach to establishing transfer prices.

I appreciate the opportunity to comment on this rule. I hope these comments will be helpful to this important effort.

Sincerely,

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