

September 17, 2026

Abe Sutton, JD
Deputy Administrator and Director
Center for Medicare & Medicaid Innovation
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201

Re: A CMMI Model to Strengthen Informed Decision-Making Among Medicare-Eligible Beneficiaries

Dear Deputy Administrator Sutton:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing to ask the Center for Medicare & Medicaid Innovation (CMMI) to test a demonstration that helps individuals approaching Medicare eligibility make better-informed coverage decisions and evaluates how those decisions affect quality of care and Medicare spending.

The need for such a demonstration stems from persistent shortcomings throughout the Medicare enrollment process. Many individuals nearing Medicare eligibility receive no proactive outreach from the federal government alerting them to their upcoming eligibility or preparing them for the decisions ahead, while others piece together information from fragmented sources and agencies to navigate overlapping deadlines and complex rules governing coverage transitions. Inadequately prepared, enrollees must then compare an increasingly large and complex set of coverage options and select among them, often without visibility into the plan features that determine access to and cost of care. Overwhelmed by these choices and without access to neutral, trusted decision support, many turn to agents and brokers for guidance, giving those with a financial stake in the decision outsized influence over the outcome. This enrollment environment leads to beneficiaries selecting coverage that does not align with their health needs or financial circumstances, driving rapid disenrollment and plan switching, disruptions in care, administrative churn, and greater spending for both beneficiaries and the Medicare program.

These outcomes are not inevitable. A substantial body of evidence demonstrates that targeted interventions can improve decision-making and the associated downstream outcomes, but important questions remain about which interventions are most effective, how to combine them, and whether better-informed choices ultimately improve quality of care and reduce Medicare spending. A CMMI demonstration could answer those questions while advancing three of the Innovation Center's own priorities: empowering beneficiaries to make informed coverage decisions, strengthening competition among plans, and reducing the avoidable spending that poorly aligned coverage decisions generate.

I. Proposed Model Overview

Model objective. Test whether early enrollment outreach, standardized and curated coverage options, greater visibility into key plan features, and high-quality enrollment support strengthen coverage alignment and stability and, in turn, improve quality of care and reduce Medicare spending.

Model participants. Medicare Advantage (MA) organizations (MAOs) offering coverage in select markets.

Core interventions. The proposed Medicare Informed Choice Model would test four complementary interventions:

1. **Early enrollment outreach and point-of-decision guidance.** Beneficiaries would receive comprehensive enrollment materials 12, six, and three months before the Initial Enrollment Period, with key information reinforced through Social Security communications. Medicare.gov would also provide context-specific guidance at key points in the enrollment process as individuals nearing age 65 compare coverage options and make enrollment decisions.
2. **Standardized plan designs and curated coverage options.** The Centers for Medicare & Medicaid Services (CMS) would standardize selected benefit-design and cost-sharing features across Medicare Advantage (MA) plans offered by participating MAOs, and Medicare Plan Finder (MPF), would present those comparing MA plans with a personalized, curated set of options before displaying the full market.
3. **Clear, comparable information on costs, benefits, and restrictions to care.** MPF would present prospective enrollees with a side-by-side comparison of total premiums and cost sharing for a bundled Traditional Medicare (TM) pathway versus selected MA plans. The platform would also increase visibility into each MA plan's prior authorization (PA) requirements and performance metrics, how its physician and hospital network compares with the pool of physicians and hospitals available under TM in the same geographic area, and the scope and limitations of its supplemental benefits.
4. **Trusted, high-quality enrollment support.** CMS would expand access to State Health Insurance Assistance Program (SHIP) counseling by offering prescheduled appointments to individuals approaching Medicare eligibility and improve the quality and consistency of counseling through additional training, standardized scripts, and decision-support protocols designed to support accurate, individualized guidance.

Model design. CMMI would implement the model in select geographic markets, randomizing market assignment where feasible and designating comparable non-model markets as the comparison group.

Evaluation. CMMI would evaluate whether the model improves coverage alignment and stability, and whether those changes translate into higher quality of care and lower Medicare spending.

II. Barriers to informed decision-making among Medicare-eligible individuals

1. Fragmented, mistimed, and incomplete enrollment information

A growing number of Americans delay claiming Social Security benefits and thus are not automatically enrolled in Medicare at age 65. These individuals must navigate the enrollment process independently, a task that involves determining eligibility, understanding how existing coverage affects enrollment timing, and navigating time-sensitive rules for transitioning to Medicare and supplemental coverage. The process is especially complicated for individuals who continue working past 65 and must coordinate Medicare

with employer coverage, reconciling information from the Social Security Administration (SSA), Medicare, and their employers while tracking multiple, often overlapping deadlines, including the eight-month Part B Special Enrollment Period after active employer coverage ends, the 63-day Part D window after loss of creditable drug coverage, and the 60-day COBRA election period following a qualifying event.

Despite the complexity and consequences of these decisions, the federal government provides no single, comprehensive communication before the Initial Enrollment Period that alerts individuals to approaching Medicare eligibility, notifies them of enrollment deadlines, and outlines the steps required to transition from their existing coverage to Medicare. The Medicare Payment Advisory Commission [estimates](#) that approximately 30 percent of individuals turning 65 may receive no notice of their Medicare enrollment responsibilities at all.

Inadequate enrollment information can carry significant long-term financial consequences. Nearly 800,000 beneficiaries [paid](#) a Part B late-enrollment penalty in 2021, with premiums averaging 27 percent higher, and roughly 2.5 million paid a Part D late-enrollment penalty in 2022. Individuals who miss the six-month Medigap Open Enrollment Period or the enrollment window associated with a guaranteed-issue (GI) right can also face higher premiums or denial of Medigap altogether, limiting future coverage choices by putting supplemental insurance out of reach.

2. Excessive number, complexity, and variation of plan options

Since the rollback of the meaningful-difference rule in 2019, beneficiaries have faced a rapidly expanding array of MA plan options. In 2026, the average beneficiary can choose [among](#) 39 MA plans, including 32 MA-PD plans, and nearly one-third live in counties offering more than 50 MA plans. Compounding the sheer number of choices, plans differ across multiple consequential dimensions, including cost-sharing structures, network breadth, utilization management requirements, and supplemental benefits.

The number and complexity of these options make plan comparison and informed decision-making exceedingly difficult. A [large body](#) of [literature](#) confirms that larger choice sets make it harder for beneficiaries to distinguish among plan features and identify coverage that best meets their needs. Faced with this complexity, many disengage from comparison altogether: a KFF analysis [found](#) that 69 percent of beneficiaries did not compare plans during a recent open enrollment period, with comparison least common among populations already more likely to struggle with complex coverage decisions.

3. Limited visibility into coverage features that shape costs and access to care

Among enrollees who do actively compare coverage options, many encounter another obstacle: a federal plan comparison tool that omits information on the plan features that most directly affect costs and access to care.

TM vs. MA total cost comparison. Beneficiaries' expectations about their overall costs under MA and TM strongly [influence](#) their coverage decisions. Yet research indicates that many enrollees have difficulty [estimating](#) what they are likely to [spend](#) under either option, and that those who switch to MA [often](#) experience similar or higher spending, depending on their health care needs. Beneficiaries' difficulty comparing costs stems in large part from how MPF displays the two options. While the platform presents MA as a single bundled coverage package that often combines medical and prescription drug coverage, it provides no comparable bundled presentation of TM or its associated premiums. Instead, beneficiaries must identify and add together the premiums for Part B, a stand-alone Part D plan, and supplemental coverage, then account for the cost sharing associated with each option to determine how their overall

financial exposure compares. This requires a level of knowledge and effort that is unrealistic to expect of most beneficiaries.

Prior authorization. Medicare beneficiaries face significantly different exposure to PA depending on their coverage. In 2024, MA enrollees were [subject to](#) 1.7 PA requests per person, compared with 0.02 among TM beneficiaries. These differences directly affect beneficiaries' ability to access timely care: 22 percent of MA enrollees that year [reported](#) care delays attributable to PA, compared with 13 percent of TM beneficiaries. Even within MA, beneficiaries face markedly different PA burden depending on their plan, with a recent KFF [analysis](#) of the six largest MA insurers finding that a beneficiary's likelihood of having a PA request denied varied more than threefold depending on the insurer. These barriers ultimately drive many beneficiaries out of their plans. A 2023 Commonwealth Fund analysis [found](#) that difficulty accessing care was the leading reason beneficiaries reported for leaving MA plans, and a 2026 Health Affairs [study](#) identifies PA specifically as a driver of that churn: beneficiaries enrolled in MA contracts with the highest rates of PA were 44 percent more likely to disenroll than those in contracts with the lowest rates.

Despite these stakes, plans' PA practices remain largely invisible to prospective enrollees comparing coverage options. CMS took an important step toward transparency in the Interoperability and Prior Authorization final rule (CMS-0057-F), which requires payers to publicly disclose their PA requirements and performance metrics, but aspects of the policy's design have limited the usefulness of those disclosures for plan selection. Most notably, reporting occurs at the contract level rather than the plan level. Because a single contract can encompass multiple plans with markedly different PA practices, contract-level reporting tells a prospective enrollee little about the PA burden that any particular option would impose. The rule also does not establish a uniform location for these disclosures or require a standardized format for reporting them, enabling payers to bury the information deep within their websites or in nested PDFs, publish service lists of thousands of procedure codes with no plain-language descriptions, and carve out entire categories of care from their reporting. Unable to find, understand, or compare plans' PA practices, many prospective enrollees are thus left to discover barriers to care only after enrollment, when they experience those barriers firsthand.

Network directory accuracy and breadth. Access to preferred physicians and hospitals is a major consideration in plan selection, yet many individuals make enrollment decisions without an accurate understanding of the providers available through each coverage option. This stems, in large part, from two shortcomings of MPF. First, the platform's provider directories contain persistent, widespread inaccuracies. A 2026 [study](#) found that, in the average MA network, 17.5 percent of listed primary care physicians were unavailable to any Medicare beneficiary, while another 11.5 percent were unavailable to beneficiaries enrolled in the network that listed them. A 2025 OIG investigation [documented](#) similarly pervasive errors in MA behavioral health directories, finding that at least one-third of listed providers were inactive in more than half of plans reviewed. These discrepancies directly undermine informed choice: in a 2022 Commonwealth Fund survey, 12 percent of enrollees [reported](#) choosing a plan because they believed a particular provider was in network, only to discover after enrollment that the provider was not.

MPF also omits another key piece of information: how the breadth of a given MA plan's physician and hospital network compares with the providers available through TM in the same area. The difference can be stark. A 2025 KFF [analysis](#) found that MA enrollees were, on average, in plans whose networks included only 48 percent of the physicians available to TM beneficiaries in their area; among enrollees in the narrowest-network plans, that share fell to roughly one-third. A separate KFF [analysis](#) found a similarly large gap in hospital access, with MA plans including only half of area hospitals.

Supplemental benefits. Supplemental benefits weigh heavily on enrollment decisions. In a 2024 Commonwealth Fund survey, 89 percent of MA beneficiaries [said](#) they were important to their coverage, and in a 2022 survey, participants [cited](#) these benefits more often than any other factor when explaining why they chose MA over TM. Yet today, individuals select plans without a clear understanding of the scope and value of these benefits. Neither MPF nor most plan materials disclose the specific services covered within each broad benefit category (e.g., dental and vision); applicable eligibility requirements; benefit limits; network restrictions; or, for dually eligible beneficiaries, how coverage coordinates with Medicaid. Individuals thus often choose plans based on the expectation that supplemental benefits will be far more generous and accessible than they prove to be in practice.

4. Limited access to neutral, personalized counseling

Despite the complexity and consequences of the decisions involved in Medicare enrollment, individuals have little access to impartial, personalized guidance as they navigate the process. Federally funded SHIPs are the principal source of free, unbiased Medicare counseling, but several barriers limit their reach and effectiveness. First, because SHIPs are not integrated into the Medicare enrollment process, beneficiaries must learn about them independently, [most often](#) through word of mouth or referrals. Not surprisingly, relatively few beneficiaries receive this assistance: a 2024 [survey](#) found that only 31 percent of adults aged 65 and older were familiar with SHIPs and only 5 percent had ever used their services. Even those who know about the program face substantial barriers to obtaining high-quality counseling. Flat federal [funding](#) has constrained SHIPs' ability to recruit, train, and support enough counselors to serve a growing Medicare population and meet rising demand for assistance. A 2025 national mystery-shopping [study](#) illustrates the consequences: nearly 40 percent of attempted contacts with SHIP sites were unsuccessful, most often because callers never received a return call. Counseling quality also varied substantially. Across completed encounters, counselors provided accurate and complete responses only 40 percent of the time, on average, and just 5.7 percent adequately explained the differences between TM and MA when callers asked.

In the absence of accessible neutral counseling, individuals turn to agents and brokers, who actively and aggressively solicit them in the lead-up to Medicare enrollment periods. A 2022 Commonwealth Fund survey [found](#) that one in three respondents received seven or more Medicare marketing calls per week and that many beneficiaries did not understand that agents and brokers have financial incentives to steer enrollment toward particular plans. CMS has since weakened several safeguards governing these marketing interactions, eliminating the 48-hour waiting period before personal marketing appointments, rescinding third-party marketing organizations' mandate to inform enrollees about SHIP counseling, and repealing brokers' obligation to disclose how many insurers and Medicare plans they represent within the first minute of a sales call. These changes further tilt Medicare enrollment away from informed decision-making and toward choices shaped by those with a financial stake in the outcome.

III. Consequences of poorly informed coverage decisions

When individuals select coverage that does not align with their health needs or financial circumstances, the poor fit leads to disenrollment and plan switching—both of which have increased sharply in recent years. Beneficiaries who recognize the mismatch soon after enrollment rapidly disenroll, a trend that more than [tripled](#) among MA beneficiaries between 2017 and 2022, from 3.5 percent to 12.2 percent. Others discover the limitations of their coverage and switch plans only after developing serious health conditions. An August 2026 Journal of the American Medical Association study [found](#) that disenrollment from MA rose steeply as beneficiaries developed new complex medical conditions: 37.3 percent of those who developed four or more new complex conditions had left their plans by the following year, compared with 17.6 percent of those who developed none. The relationship strengthened with each additional

diagnosis: developing one new complex condition increased disenrollment by 1.4 percentage points, while developing four or more increased it by 12.8 percentage points. Of note, disenrollment to TM was substantially higher in states with GI and community-rating protections, leading the authors to conclude that their findings likely understate how many beneficiaries would have left MA if affordable Medigap coverage were more broadly available.

This coverage instability has widespread consequences. For beneficiaries, coverage disruptions are [associated](#) with substantially lower receipt of preventive care, more than threefold higher odds of cost-related medication nonadherence, more than fourfold higher odds of forgoing needed care because of cost, and [substantially higher](#) out-of-pocket costs even with gaps of only one to five months. Even when beneficiaries remain continuously insured, changes in coverage are [associated](#) with the loss of established physician relationships, greater emergency department use, and declines in self-reported quality of care and health status.

These disruptions also carry costs for the Medicare program, where churn generates avoidable spending through several mechanisms. Each coverage transition requires processing disenrollment and enrollment, verifying and updating eligibility, updating beneficiary and payment records, and reauthorizing ongoing treatments and referrals. When beneficiaries must establish care with new physicians, Medicare incurs additional spending on new-patient visits, repeat testing, duplicative referrals, and other services needed to reestablish care. Gaps in coverage also delay needed care, allowing conditions to worsen and increasing downstream utilization and spending.

Beyond these direct costs, the selective disenrollment of sicker, higher-cost beneficiaries from MA to TM described above creates a structural distortion in MA payment. As these beneficiaries move to TM, their subsequent expenditures enter the FFS spending base used to calculate future MA benchmarks, pushing benchmarks upward, while their departure removes their costliest periods from MA plans' expenditure experience, lowering the expected claims costs reflected in subsequent bids. This divergence widens the bid-benchmark gap and, because Medicare returns a substantial share of that difference to plans through rebates, increases federal MA payments even after the beneficiaries generating those expenditures have moved to TM. A 2026 analysis [estimated](#) that this dynamic widened the bid-benchmark gap by 0.9 percentage points and increased MA rebates by approximately \$6 per enrollee per month, or roughly 4 percent of the average rebate in 2021.

IV. Proposed model components

The Medicare Informed Choice Model would test whether early enrollment outreach and point-of-decision guidance, standardized and curated plan options, clear and comparable information on key plan features, and trusted, high-quality decision support enable individuals to make better-informed coverage decisions, and whether those decisions in turn improve quality of care and reduce Medicare spending.

1. Early enrollment outreach and point-of-decision guidance

- a. Send official pre-enrollment materials to all individuals approaching Medicare eligibility.** CMS should send a pre-enrollment packet to all individuals approximately 12, six, and three months before the start of their Initial Enrollment Period. The packet should explain the basic structure of Medicare Parts A, B, and D; the differences between TM and MA; the role of Medigap and other supplemental coverage; and core insurance concepts, including premiums, cost sharing, and provider networks. It should also include enrollment calendars specifying the deadlines and coverage periods that apply under common circumstances, including transitions from employer-sponsored insurance, Consolidated Omnibus Budget Reconciliation Act, and

retiree coverage; Medigap enrollment protections; and a list of additional sources of enrollment assistance. The three-month packet should also include the date and time of a prescheduled SHIP counseling appointment and instructions for keeping, rescheduling, or declining the appointment.

- b. Expand Medicare content in Social Security communications.** CMS should partner with SSA to enhance the Medicare information included in annual Social Security Statements beginning at age 60. Communications should remind individuals that Medicare enrollment is approaching, explain that missing applicable enrollment deadlines can result in lifetime penalties, and direct them to CMS pre-enrollment materials and SHIP counseling for more detailed information and assistance.
- c. Provide guidance at key decision points during the enrollment process.** CMS should embed brief, personalized prompts in online enrollment workflows immediately before prospective enrollees make consequential or irreversible decisions. These prompts should identify the implications of the specific choice before enrollment is finalized and direct attention to protections, deadlines, or coverage rules that could materially affect the beneficiary's options. For example, when an individual elects MA, the system could display whether the individual remains within the six-month Medigap Open Enrollment Period and, if so, how much time remains; explain the potential for medical underwriting after that period ends; describe applicable federal trial rights; and identify additional guaranteed-issue or switching protections available under state law. Similarly, if an individual declines or delays Part B, a prompt could explain that if they plan to rely on employer coverage, only coverage based on *current* employment preserves the Part B Special Enrollment Period and that relying on COBRA or retiree coverage can result in a coverage gap and lifetime late-enrollment penalties.

2. Standardized plan designs and curated plan options

- a. Establish standardized MA benefit designs.** CMS should reduce the cognitive burden associated with selecting among numerous complex plan options by establishing a limited set of standardized benefit designs and requiring participating MAOs to offer plans based on those designs. Standardizing core features such as deductibles, cost-sharing structures, and out-of-pocket limits would make plans easier to compare by allowing prospective enrollees to focus on meaningful differences rather than deciphering numerous benefit configurations.
- b. Display a personalized set of coverage options.** MPF should prompt individuals comparing MA and MA-PD plans to specify their coverage needs and preferences—including medications, preferred physicians and hospitals, expected health care use, and financial priorities—and use those inputs to display a small, personalized set of plans. To simplify initial comparison without restricting choice, MPF should allow beneficiaries to expand the results and view all plans available in their area.

3. Visibility into the plan features that determine access and cost of care

- a. Enable side-by-side comparison of total costs across TM and MA.** MPF should present individuals with a direct comparison of their total costs under TM and selected MA plans. For TM, MPF should display the premiums associated with Part B, a selected Part D plan, and the enrollee's chosen source of supplemental coverage, along with the combined monthly premium and maximum additional annual out-of-pocket costs. MPF should display the same measures for each MA plan, enabling easy comparison of costs across coverage options, as illustrated in Figure 1.

Your personalized cost comparison	
Based on the 4 medications you entered.	
ORIGINAL MEDICARE + MEDIGAP + PART D	
Part B premium	\$185.00
Medigap Plan G* premium	\$165.00
Part D premium	\$28.40
Total monthly premiums	\$378.40
Maximum additional annual cost if you use care	\$2,257
\$257 Part B deductible + \$2,000 Part D cap. Medigap Plan G covers all other cost-sharing.	
*Shown with Medigap Plan G, the most common choice for new enrollees. Switch to a different Medigap plan.	
MEDICARE ADVANTAGE PLANS IN MIAMI-DADE COUNTY	
Leon MediExtra (HMO)	
Part B premium	\$185.00
Plan premium	\$0.00
Total monthly premiums	\$185.00
Maximum additional annual cost if you use care	\$3,000
\$1,000 plan OOP cap (in-network) + \$2,000 Part D cap.	
UnitedHealthcare Dual Complete (HMO)	
Part B premium	\$185.00
Plan premium	\$35.00
Total monthly premiums	\$220.00
Maximum additional annual cost if you use care	\$10,850
\$8,850 plan OOP cap (in-network) + \$2,000 Part D cap.	

Figure 1. Illustrative MPF display comparing premiums and out-of-pocket costs under TM and MA.

- b. **Integrate plan-level PA information into MPF.** CMS should provide beneficiaries with PA information that is sufficiently granular to inform plan selection and readily accessible within the enrollment process. To achieve this, the agency should require MAOs to submit plan-level PA requirements and performance metrics and integrate those data directly into MPF, making them accessible from each plan card and available through MPF’s existing plan comparison tool.
- c. **Surface directory accuracy and network breadth.** MPF should display a provider-directory accuracy score on each MA plan card to inform beneficiaries of the reliability of the directory on which they base enrollment decisions. MPF should also report the percentage of Medicare-participating physicians in the plan’s geographic area who are included in its network, enabling beneficiaries to compare the breadth of provider access under a given MA plan with that under TM. Where reliable data permit, MPF should provide the same comparison for specialists and hospitals.
- d. **Provide detailed information about supplemental benefits.** MPF should specify, for each broad benefit category, the specific services covered, applicable eligibility criteria, dollar or visit limits, network restrictions, and utilization management requirements. MPF should also explain how each benefit coordinates with Medicaid-covered services and identify the responsible payer when Medicare and Medicaid coverage overlap.

Figure 2 provides an example of a redesigned MA plan card displaying the provider-directory accuracy, network-breadth, prior authorization, and supplemental-benefit information described above.

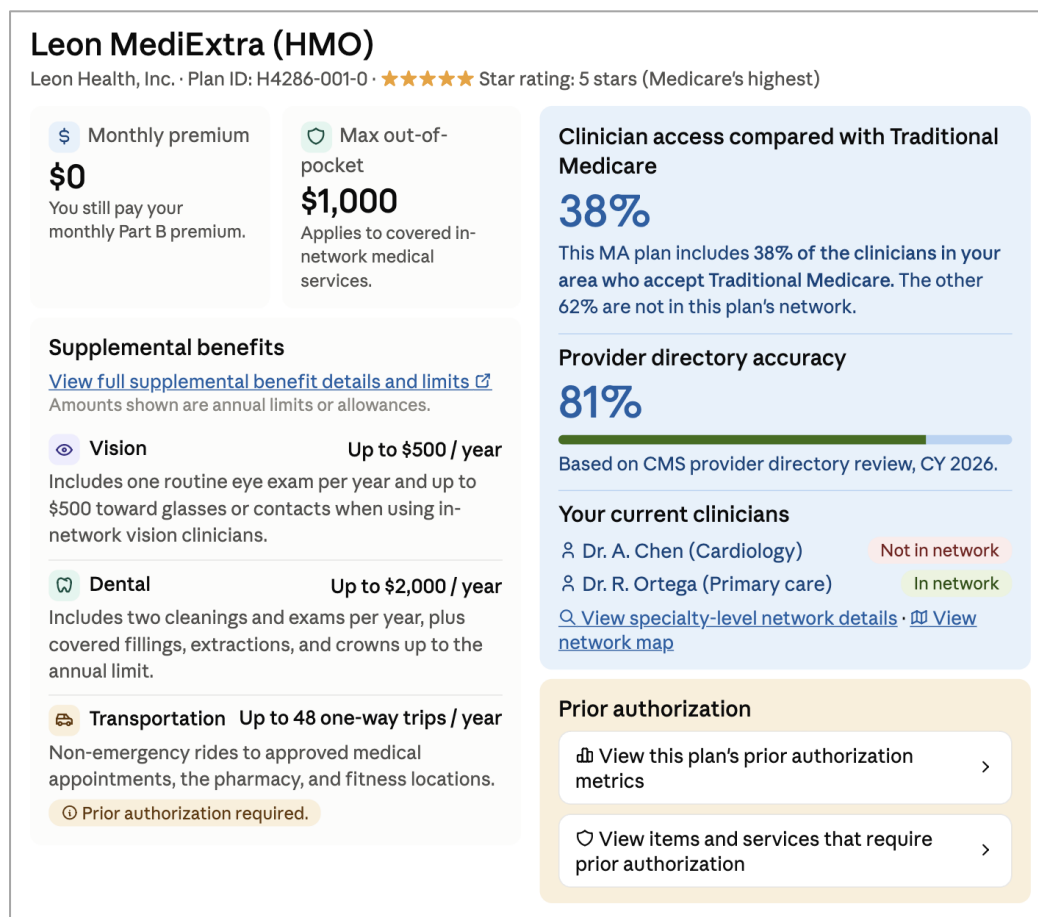


Figure 2. Illustrative redesigned MA plan card on MPF.

Beyond improving beneficiaries' coverage decisions, making consequential differences in costs, network breadth, supplemental benefit design, and PA burden visible at the point of enrollment could incentivize MAOs to compete more directly on those dimensions, leading to lower premiums and out-of-pocket maximums, broader networks, fewer barriers to care, and more generous supplemental benefits.

4. Trusted, high-quality decision support

CMS should expand access to objective, unbiased enrollment support by increasing SHIP's reach and improving the quality and consistency of its counseling. In addition to offering prescheduled appointments to increase awareness and use of the program, CMS should establish rigorous, uniform counselor training and provide standardized scripts and decision-support protocols for use during counseling. These resources should help counselors explain Medicare coverage options, guide beneficiaries through the tradeoffs among them, and provide accurate, individualized guidance when beneficiaries have more complex coverage circumstances, including dual eligibility or other overlapping sources of coverage.

V. Model Participants, Target Population, and Test Design

Model participants would be MAOs offering coverage in select markets. The demonstration should include a sufficiently diverse set of markets to assess how the intervention performs across Medicare environments that vary in MA penetration, plan availability and complexity, provider supply, and

beneficiary characteristics. Participating MAOs would be required to offer the standardized benefit designs established under the model and submit the plan-level information necessary to support the proposed MPF measures.

The target population would include Medicare-eligible individuals approaching their Initial Enrollment Period. CMS could also test adapted interventions for current beneficiaries during annual Open Enrollment and evaluate that population separately given their prior experience with Medicare and different information needs.

CMS should evaluate the intervention package as a whole and, where feasible, assess individual components to identify which drive the observed outcomes and quantify the magnitude of their effects.

VI. Model Evaluation

CMMI should evaluate the model across three outcome categories: primary outcomes measuring effects on quality of care and Medicare spending; intermediate outcomes assessing changes in coverage alignment and stability; and secondary outcomes capturing changes in beneficiary financial exposure and MA market response. Illustrative measures for each outcome domain are shown in Table 1.

Table 1. Proposed evaluation framework for the Medicare Informed Choice Model

Evaluation category	Outcome domain	Illustrative measures
Primary outcomes	Quality of care	Patient experience, share with usual source of care, preventive care completion, avoidable utilization
	Medicare spending	Total Medicare program expenditures per beneficiary; standardized service-level spending using TM claims and MA encounter data
	Coverage alignment	Values-choice concordance, objective choice quality
Intermediate outcomes	Coverage stability	Continuous enrollment, rapid disenrollment, plan switching, coverage gaps within defined lookback period
Secondary outcomes	Beneficiary financial exposure	Out-of-pocket spending; share of beneficiaries subject to Part B or Part D late-enrollment penalties
	MA market response	Bids and premiums, network breadth, per-enrollee PA burden, and supplemental benefit generosity

For the Medicare spending outcome, CMMI should measure both actual Medicare program expenditures and service-level spending. Because Medicare pays MA plans on a capitated basis, changes in the amount or cost of care beneficiaries receive are not necessarily reflected in Medicare’s payments to plans. Relying on program expenditures alone could therefore obscure important spending effects. CMMI should pair actual Medicare expenditures with a service-level spending measure based on TM claims and MA encounter data, using available service-level payment information or standardized Medicare prices. This approach would allow the evaluation to capture changes in the amount and cost of care beneficiaries receive even when those changes are not reflected in Medicare’s capitated payments to MA plans.

CMMI should also evaluate the interventions’ impact on competition among MA organizations, as reflected in changes in bids and premiums, network breadth, per-enrollee PA burden, and supplemental benefit generosity. CMMI should compare changes in these measures between model and non-model markets over time to estimate the model’s effect on each dimension of MA market response.

Conclusion

Medicare enrollment asks individuals to make lasting coverage decisions with little notice, incomplete information, and few sources of impartial help, and both beneficiaries and the program suffer the consequences. The Medicare Informed Choice Model would test whether earlier outreach, simpler and more comparable options, visibility into the features that govern cost and access, and neutral counseling produce better-informed decisions, and whether those decisions yield higher quality of care and lower spending. The model would thereby advance the Administration's priorities of giving beneficiaries greater control over their coverage decisions, strengthening accountability and competition in MA, and protecting taxpayer dollars and the Medicare program for decades to come.

The AMA appreciates the Administration's consideration of this proposal and welcomes the opportunity to work with CMMI on the model's design and implementation should the Innovation Center choose to pursue it. Please reach out to me directly at 312-464-5288 or John.Whyte@amaassn.org if you have questions or need further information.

Sincerely,

A handwritten signature in black ink, appearing to read 'John Whyte', with a stylized, cursive script.

John Whyte, MD, MPH