

Prevalence of supplemental benefits in the general enrollment Medicare Advantage marketplace: 2017 to 2021

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Overview

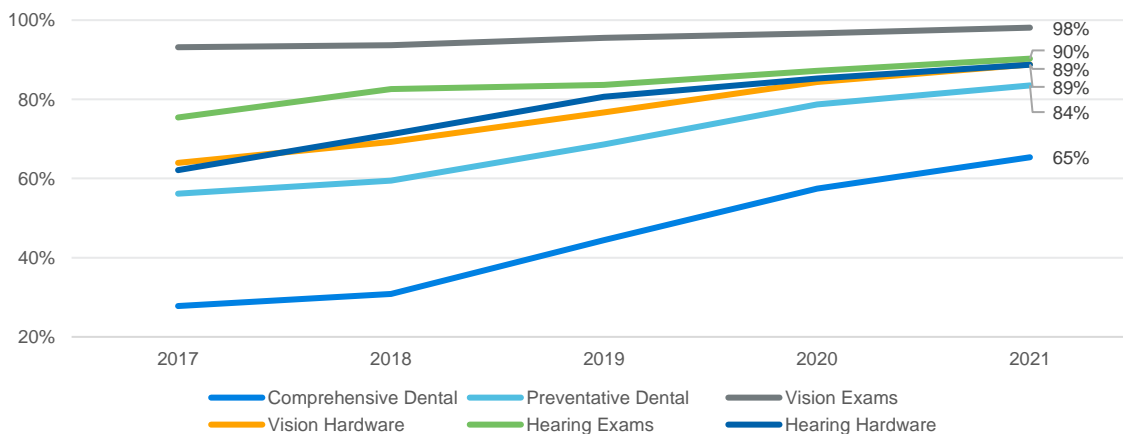
In an increasingly competitive Medicare Advantage (MA) marketplace,¹ supplemental benefits are one of the primary ways Medicare Advantage organizations (MAOs) can differentiate their plans from competitors' plans. A supplemental benefit is an additional benefit MAOs cover for their members, but which is not covered under traditional fee-for-service (FFS) Medicare. MAOs offer these benefits to attract Medicare-eligible individuals to their plans. Supplemental benefit coverage can either be mandatory, meaning all enrollees in a particular plan receive coverage, or optional, meaning all enrollees in a particular plan can elect to receive coverage for an additional premium.² Due to recent Centers for Medicare and Medicaid Services (CMS) demonstration programs and expansions in supplemental benefit flexibilities,^{3,4,5} MAOs may also limit mandatory supplemental benefits to plan enrollees who meet certain conditions, such as having a diabetes diagnosis. These types of benefits are only offered to a specific subset of a plan's population, and therefore are not part of this analysis. This analysis focuses on mandatory supplemental benefits offered by general enrollment plans from 2017 to 2021.

Analysis

We utilized publicly available data from CMS for this analysis. The 2017 through 2020 membership is based on February plan enrollment, and the 2021 membership is based on September 2020 plan enrollment crosswalked to 2021.⁶ Benefit data for all years was summarized from the plan benefit packages (PBPs) published by CMS for each year.⁷

Vision, hearing, and dental benefits are among the most common supplemental benefits historically offered by MA plans. Figure 1 shows the percentage of members in general enrollment plans from 2017 to 2021 with coverage for these benefits.

FIGURE 1: PERCENTAGE OF MEMBERS WITH BENEFIT COVERAGE OF THE MOST COMMON SUPPLEMENTAL BENEFITS



¹ Friedman, J.M., Swanson, B.L., Yeh, M.G., & Cates, J. (February 2020). State of the 2020 Medicare Advantage Industry: As Strong as Ever. Milliman Research Report. Retrieved December 2, 2020, from <https://us.milliman.com/en/insight/state-of-the-2020--medicare-advantage-industry-as-strong-as-ever>.

² CMS (April 22, 2016). Medicare Managed Care Manual: Chapter 4: Benefits and Beneficiary Protections. Retrieved December 2, 2020, from <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf>.

³ CMS. Medicare Advantage Value-Based Insurance Design Model. Retrieved December 2, 2020, from <https://innovation.cms.gov/innovation-models/vbid>.

⁴ CMS (April 27, 2018). Reinterpretation of the Uniformity Requirement. Retrieved December 2, 2020, from <https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/HPMS/HPMS-Memos-Archive-Weekly-Items/SysHPMS-Memo-2018-Week4-Apr-23-27>.

⁵ CMS (April 24, 2019). Implementing Supplemental Benefits for Chronically Ill Enrollees. Retrieved December 2, 2020, from https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Downloads/Supplemental_Benefits_Chronically_Ill_HPMS_042419.pdf.

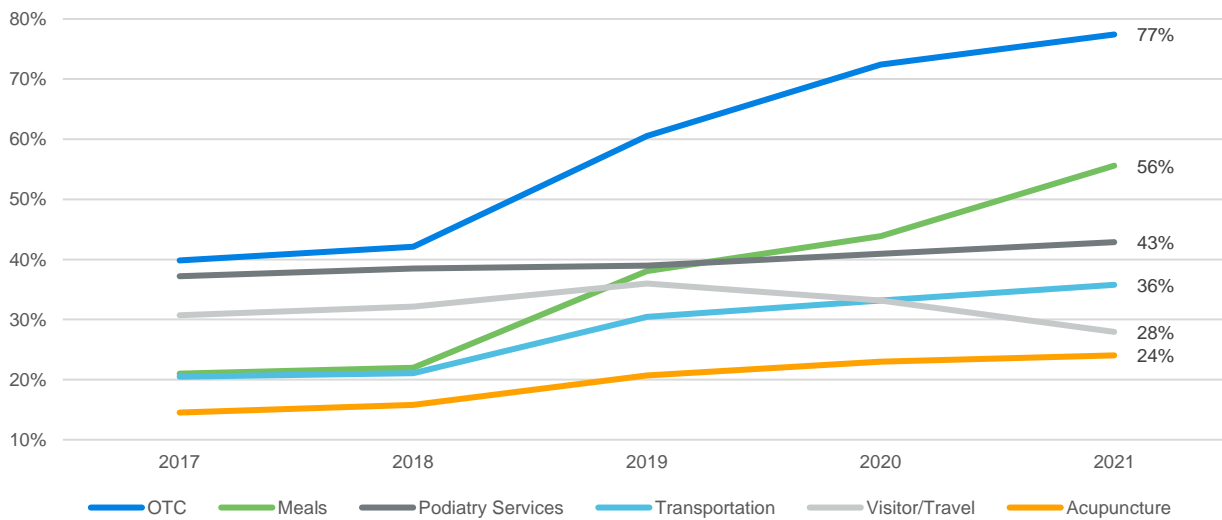
⁶ CMS. Monthly Enrollment by Contract/Plan/State/County. Retrieved December 2, 2020, from <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDenrolData/Monthly-Enrollment-by-Contract-Plan-State-County>.

⁷ CMS. Benefits Data. Retrieved December 2, 2020, from <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDenrolData/Benefits-Data>.

Plans with these benefits include an increasing percentage of members from 2017 to 2021. Vision exams are available to almost all members, while preventive and comprehensive dental coverage continue to increase in prevalence. MAOs tend to offer dental and hearing aid benefits with some level of member cost sharing, while the hearing exam, vision exam, and vision hardware benefits tend to have little to no cost sharing. Across all of these benefits from 2017 to 2021, the average member copays have been decreasing, and plan coverage limits have been increasing, meaning that these benefit offerings have become richer while also covering a larger portion of general enrollment members.

MAOs can offer numerous additional supplemental benefits beyond vision, hearing, and dental. Figure 2 shows the percentage of members in general enrollment plans from 2017 to 2021 with coverage for other common supplemental benefits, including over-the-counter (OTC) drug cards, meals, podiatry services, transportation, visitor/travel benefits, and acupuncture.

FIGURE 2: PERCENTAGE OF MEMBERS WITH BENEFIT COVERAGE OF VARIOUS OTHER SUPPLEMENTAL BENEFITS

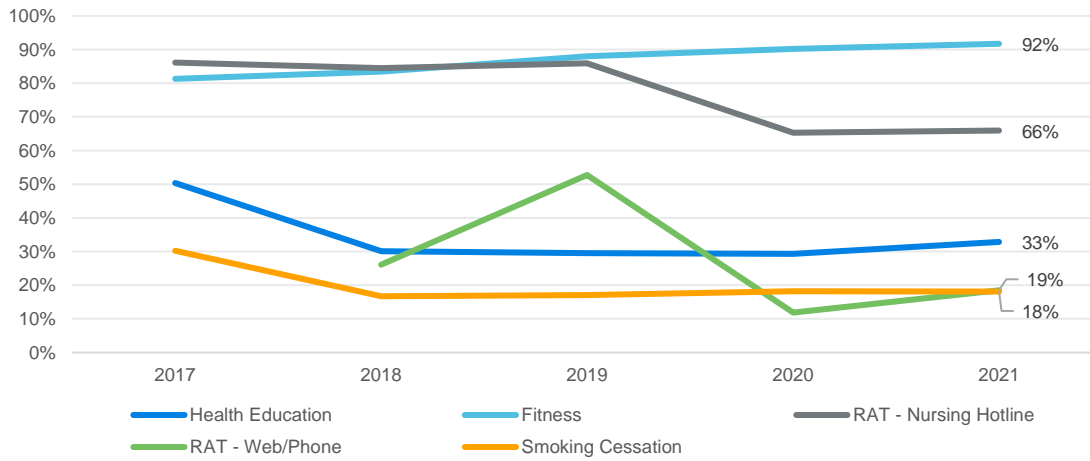


OTC drug card and meal benefit coverage both grew about 35% from 2018 to 2021. Other benefits steadily increased with the exception of visitor/travel, which was relatively flat across the entire time period. The coverage of the visitor/travel benefit in 2021 at approximately 28% is due to a decrease in visitor/travel benefit coverage in 2021 by health maintenance organization (HMO) plans. Just under 70% of membership is covered by the visitor/travel benefit in preferred provider organization (PPO) plans.

Average copays for podiatry and acupuncture decreased from 2017 to 2021 by about \$6 and \$4 in total, respectively. Meals, transportation, and visitor/travel benefits are typically offered without member cost sharing. The average OTC monthly drug card limit has increased from about \$16 in 2017 to about \$22 in 2021.

Multiple supplemental benefits fall under the 14c “preventative” benefit category in the PBP. Figure 3 shows the percentage of members in general enrollment plans from 2017 to 2021 with coverage for some of the most prevalent 14c benefits: health education, fitness, remote access technologies (RAT),⁸ and smoking cessation.

FIGURE 3: PERCENTAGE OF MEMBERS WITH BENEFIT COVERAGE OF VARIOUS PBP 14C “PREVENTATIVE” BENEFITS



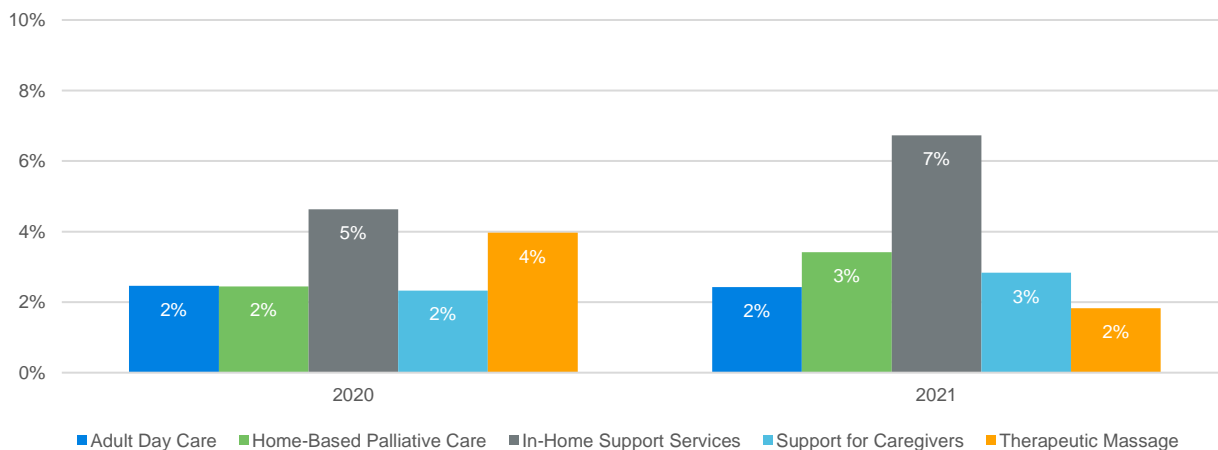
Fitness coverage has steadily increased from 2017 to 2021 and is offered to 92% of members in 2021. All other benefits in Figure 3 have decreased in membership covered over this period. These benefits are most commonly offered without cost sharing.

The definition of “primarily health related benefits”⁹ was expanded starting in the 2019 bid cycle to cover services used to:

- Diagnose
- Compensate for physical impairments
- Ameliorate the functional/psychological impact of injuries or health conditions
- Reduce avoidable emergency and healthcare utilization

This includes adult day care, home-based palliative care, in-home support services, support for caregivers, and therapeutic massage (for pain management). The percentage of members in general enrollment plans with coverage for these expanded primarily health related benefits in 2020 and 2021 are displayed in Figure 4.

FIGURE 4: PERCENTAGE OF MEMBERS WITH EXPANDED PRIMARILY HEALTH RELATED BENEFIT COVERAGE, COMPARISON OF 2020 TO 2021



⁸ The 2017 PBP only contained one entry for RAT, which is displayed in Figure 3 as “RAT – Nursing Hotline.” In the 2018 PBP and beyond, separate entries were made for “RAT – Nursing Hotline” and “RAT – Web/Phone.” Therefore, we excluded 2017 from the RAT Web/Phone analysis.

⁹ CMS (April 2, 2018). Announcement of Calendar Year (CY) 2019 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter. Retrieved December 2, 2020, from <https://www.cms.gov/MEDICARE/HEALTH-PLANS/MEDICAREADVTGSPCRATESTATS/DOWNLOADS/ANNOUNCEMENT2019.PDF>.

Compared to other supplemental benefits discussed above, MAOs provide these services to a relatively low percentage of members, with modest changes from 2020 to 2021. These benefits are generally offered without member cost sharing.

Many MAOs provided supplemental benefits coverage in 2021 to address the impact of COVID-19, assuming the public health emergency would continue into 2021. These benefits could cover services related to COVID-19, such as personal protective equipment (PPE) or reduced cost sharing on related benefits. Thirty-four percent of members in general enrollment plans are covered by a COVID-19 supplemental benefit in 2021.

Methodology

In performing this analysis, we relied on the 2021 Milliman MACVAT®. The Milliman MACVAT contains MA plan details and benefit offerings for 2017 through 2021. The Milliman MACVAT uses publicly available data released by CMS, which is then compiled, sorted, and summarized into a user-friendly format. We used the February membership from each applicable year (2017 through 2020), with the exception of 2021, for which we used the September 2020 membership that has been crosswalked to the 2021 plans. This analysis includes general enrollment MA plans only.

Caveats and Limitations

Julia M. Friedman and Mary G. Yeh are actuaries for Milliman, members of the American Academy of Actuaries, and meet the qualification standards of the Academy to render the actuarial opinion contained herein. To the best of our knowledge and belief, this information is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices.

The material in this report represents the opinion of the authors and is not representative of the view of Milliman. As such, Milliman is not advocating for, or endorsing, any specific views contained in this report related to the Medicare Advantage program.

This report is intended to summarize supplemental benefits offered by MA plans from 2017 through 2021. This information may not be appropriate, and should not be used, for other purposes. We do not intend this information to benefit, and assume no duty of liability to, any third party that receives this work product. Any third-party recipient of this report that desires professional guidance should not rely upon Milliman's work product, but should engage qualified professionals for advice appropriate to its specific needs.

The credibility of certain comparisons provided in this report may be limited, particularly where the number of plans in certain groupings is low. Some metrics may also be distorted by benefit changes in a few plans with particularly high enrollment.

In preparing our analysis, we relied upon public information from CMS, which we accepted without audit. However, we did review it for general reasonableness. If this information is inaccurate or incomplete, conclusions drawn from it may change.



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