Insight on the Issues

Supplemental Benefits under Medicare Advantage: An In-Depth Look at What They Are Today

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INTRODUCTION

Medicare beneficiaries have a choice of traditional Medicare[1] or private Medicare Advantage[2] (MA) plans.[3] In 2017, the number of Medicare beneficiaries enrolled in MA plans reached 19 million,[4] or about one in three people with Medicare nationwide. With a steadily increasing share of Medicare's population opting for MA and growth projected to continue,[5] MA's already important role within the Medicare program will only increase in coming years.

Medicare Advantage, otherwise known as Medicare Part C, must cover all the benefits that traditional Medicare covers under its hospital insurance (Part A) and medical insurance (Part B).[6] However, MA plans can also offer additional benefits outside those covered in traditional Medicare. Collectively known as supplemental benefits, these extra services have commonly included benefits such as dental, vision, and hearing. Supplemental benefits are a key difference between MA and traditional Medicare,[7] and their availability may be one important reason why some beneficiaries opt for MA.

Starting in 2019, there will be significant changes to MA supplemental benefits, with important consequences for consumers. These changes will implement new policies established by the Centers for Medicare and Medicaid Services (CMS)[8] and enacted by the Bipartisan Budget Act of 2018[9] earlier this year.

This paper is the first of *Insight on the Issues* in a series of analyses reports that examine MA's supplemental benefits. In this *Insight on the Issues*, we set the stage to discuss the impact of impending changes to MA supplemental benefits by explaining how supplemental benefits have worked in recent years. In doing so, we present new data on the supplemental benefits that MA plans offer. In a forthcoming *Insight on the Issues*, we will detail upcoming changes to the rules that govern supplemental benefits, discuss possible implications for MA enrollees, and propose policy options to ensure strong consumer protections as MA plans implement these changes. We will also monitor changes to MA's supplemental benefits and publish analyses of how plans will implement them in the coming years.

SUPPLEMENTAL BENEFITS DEFINED

Each year MA insurers decide which, if any, supplemental benefits they will include in their health plans. For CMS to approve supplemental benefits in plan years 2018 and earlier, benefits had to meet certain requirements:[10]

Not already covered by traditional Medicare—Supplemental benefits commonly include services that traditional Medicare does not cover at all. For example, traditional Medicare does not cover preventive vision benefits, but MA plans may offer them as supplemental benefits. In other cases, supplemental benefits extend traditional Medicare's benefits. For example, traditional Medicare covers a limited number of visits for smoking cessation counseling, but MA plans may cover more counseling sessions than traditional Medicare as supplemental benefits. Supplemental benefits can also extend coverage of certain services included in traditional Medicare to people who do not qualify under traditional Medicare's rules.[11]

Primarily health-related—Prior to 2019, CMS had interpreted the requirement that supplemental benefits be "primarily health-related" relatively narrowly, to mean that the benefit's primary purpose must be to "prevent, cure or diminish an illness or injury."[12] (This definition will change beginning in plan year 2019. We will examine this change and its implications in a companion *Insight on the Issues*.)

Uniformity and Nondiscrimination—In offering supplemental benefits, insurers must also meet uniformity and nondiscrimination requirements.[13] Prior to 2019, the uniformity rule required that MA plans cover the same supplemental benefits for all enrollees in a service area[14] and charge the same premium and cost sharing to all enrollees.[15] In addition, MA plans have not been allowed to vary benefits based on factors such as a person's health, preexisting condition, age, race/ethnicity, or disability. However, these requirements are changing starting in 2019.

Benefits not allowed—Under CMS's pre-2019 interpretation of "primarily health-related," benefits intended for daily maintenance or comfort do not qualify as supplemental benefits. As such, benefits like maid services, smoke detectors, or massages have not been allowed as supplemental benefits.[16] CMS has also ruled out supplemental benefits that cover long-term services and supports such as in-home assistance and services to a person other than the enrollee, including caregivers.[17] New rules for plan years 2019 and beyond will change the scope of benefits that insurers are allowed to offer as supplemental benefits.

HOW MEDICARE ADVANTAGE PLANS FINANCE SUPPLEMENTAL BENEFITS

MA insurers can offer each supplemental benefit in one of two ways: they can include it in the plan's basic benefit package and cover every person enrolled in the plan,[18] or they can offer it to all enrollees as a separate optional policy[19] (i.e., an insurance policy rider).

Those two means of offering supplemental benefits are significant because they each have a different funding mechanism. Insurers can pay for supplemental benefits that are part of the MA plan's basic benefit package by charging all enrollees a plan premium and/or cost sharing. Insurers can also pay for these types of benefits (fully or in part) through the plan's rebate dollars[20]—a payment[21] that MA plans receive when their bid to provide Part A and Part B benefits[22] is lower than what CMS estimates it would be under traditional Medicare (known as the benchmark[23]). In contrast, insurers can finance optional supplemental benefits only through a "rider premium" and/or cost sharing paid only by enrollees who elect the optional benefit. Rider premiums and cost sharing could be in addition to any plan premium and/or cost sharing.

SUPPLEMENTAL BENEFITS: ANALYSIS OF SCOPE, AVAILABILITY, AND PREMIUMS

Having a clear understanding of how MA's supplemental benefits have worked so far is crucial as insurers start to implement new policies for next year. To further that understanding, we conducted an in-depth examination of MA plans' supplemental benefits and the premiums enrollees pay for them. Our analysis is based on 2017 MA plan data (see appendix for Methods) that have information on each MA plan's supplemental benefits, enrollment numbers, service area, and plan premiums.[24] This gives us insights into how MA plans offered supplemental benefits and the extent to which consumers enrolled in plans with supplemental benefits prior to 2019.

Our top-level findings are the following:

- MA plans can offer a broad scope of supplemental benefits.
- There is wide variation in MA plans' offering of each supplemental benefit.
- MA plans' supplemental benefits offerings vary widely by geographic location.
- In most cases, MA plans with supplemental benefits are less likely to charge a plan premium than plans without such benefits.

Following is a look at those findings in greater depth.

MA plans can offer a broad scope of supplemental benefits

Insurers can include a variety of supplemental benefits in their MA plans. People are commonly aware that MA plans can cover supplemental benefits such as dental, vision, and hearing benefits. However, under pre-2019 rules, MA plans could offer many more types of supplemental benefits (see table 1 for a full list).

Dental, vision, and hearing

MA plans can include a variety of benefits in their dental, vision, and hearing coverage. For example, dental benefits can range from limited coverage for preventive care (e.g., dental x-ray, oral exam, cleaning) to comprehensive coverage for treatments that maintain or restore dental health (e.g., diagnosis, treatment for missing teeth or *prosthodontics*, treatment for gum diseases, *periodontics*). Supplemental vision benefits can include a basic eye exam or they can also cover eyewear (e.g., contact lenses, eyeglass frames, eyeglass lenses). Similarly, hearing benefits range from a hearing exam (routine exam or evaluation for a hearing aid) to coverage for hearing aids.

Preventive care, clinical services, and auxiliary services

In addition to dental, vision, and hearing benefits, MA plans can offer supplemental benefits under three other broad categories: preventive health care benefits, clinical services, and auxiliary services. The preventive health category has the largest number of benefits, and includes fitness benefits.[25] Under certain circumstances, MA plans can offer other preventive health benefits such as nutrition counseling,[26] bathroom safety devices,[27] or personal emergency response systems.[28] Clinical services are supplemental benefits that cover chiropractic care,[29] foot care, acupuncture,[30] and other alternative therapies.[31] Finally, MA plans can cover auxiliary services such as emergency coverage abroad, meals,[32] and nonemergency transportation.[33]

Wide variation exists in MA plans' offering of each supplemental benefit

MA plans vary in which supplemental benefits they offer. Consequently, MA enrollees may or may not have access to a given supplemental benefit, depending on the plan they select.

A relatively large share of MA enrollees were in plans with supplemental benefits (table 2). For example, about 80 percent of MA enrollees were in a plan that included some vision or preventive health coverage; more than 60 percent of MA enrollees were in a plan with some dental or hearing benefits.

Across the nation, the vast majority of MA plans include supplemental benefits (table 2). More than 8 out of 10 plans offer some type of vision benefits and about 7 out of 10 plans have some dental or hearing coverage. Other categories of supplemental benefits are also common: 86 percent of plans have some form of preventive care benefit and 86 percent have auxiliary benefits. The least common category of supplemental benefit in MA plans is clinical services: 42 percent of plans offer that type of benefit.

The five specific supplemental benefits that insurers were most likely to include in their MA plans are eye exams (83 percent), emergency coverage abroad (77 percent), gym membership (75 percent), remote access technology[34] (70 percent), and oral (dental) exams (67 percent). At the other extreme, MA plans were very unlikely to offer supplemental benefits such as personal emergency response systems (1 percent), alternative therapies[35] (2 percent), bathroom safety devices (2 percent), or in-home medication reconciliation following a hospital stay (3 percent).

TABLE 1
Supplemental Benefits in Medicare Advantage Plans, 2017

Dental	Vision	Hearing	Clinical	Preventive Health	Auxiliary
Preventive • Dental x-ray • Oral exam • Dental cleaning (prophylaxis) • Fluoride **Comprehensive** • Prosthodontics, maxillofacial surgery • Non-routine services • Diagnostic services • Restorative services • Endodontics, periodontics, extractions	**Eye exam** **Eyewear** • Upgrades • Contact lenses • Glasses: lenses and frames • Glasses: lenses only • Glasses: frames only	**Hearing aids** **Hearing exam** • Fitting and evaluation for hearing aid • Routine hearing exam	• Chiropractic maintenance care Routine foot care • Acupuncture • Other alternative therapies • Residential substance abuse treatment	• Health education • Nutrition counseling • Enhanced smoking cessation counseling • Gym membership • Enhanced disease management • Telemonitoring • Remote access technology[1] • Bathroom safety devices • Counseling services • In-home safety assessments • Personal emergency response systems • Medical nutrition therapy • Post-discharge in-home medication reconciliation • Weight management program • Annual physical exam • Enhanced screening EKG[2]	• Emergency coverage abroad • Nonemergency transportation • Meals • Wigs for hair loss related to chemotherapy • Over-the-counter drugs/ items

Source: AARP Public Policy Institute analysis of the 2017 "Plan Benefit Package" file.

[1] *Web-/phone-based or nursing hotline.*

[2] *EKG = electrocardiogram*

TABLE 2
Prevalence of Medicare Advantage Supplemental Benefits, 2017

Benefit Type	Plans *% offering*	Beneficiaries *% in plans offering*
Dental	68	62
Preventive dental	67	61
Comprehensive dental	47	45
Vision	84	79
Eyewear	67	61
Eye exam	83	78
Hearing	68	66
Hearing exam	67	65
Hearing aids	55	57
Clinical services	42	45
Preventive health	86	78
Auxiliary	86	80
10 Most Common Benefits[1]		
Eye exam	83	78
Emergency coverage abroad	77	76
Gym membership	75	69
Remote access technology2	70	68
Oral exam	67	61
Dental cleaning (prophylaxis)	67	61
Routine hearing exam	67	64
Annual physical exam	65	64
Dental x-ray	63	58
Contact lenses	63	58
10 Least Common Benefits[1]		
Residential substance abuse treatment	1	4
Personal emergency response systems	1	1
Alternative therapies3	2	2
Bathroom safety devices	2	2
Post-discharge in-home medication reconciliation	3	2
In-home safety assessments	3	2
Weight management program	4	3
Wigs for hair loss related to chemotherapy	4	3
Medical nutrition therapy	5	4
Telemonitoring	6	4

Source: AARP Public Policy Institute analysis of the December 2017 MA/Part D Contract and Enrollment "Monthly Enrollment by Plan" file and of the 2017 "Plan Benefit Package" file.

See table 1 for a list of individual benefits included in each benefit type.

[1] Based on percentage of plans offering.

[2] Web-/phone-based or nursing hotline.

[3] Other than chiropractic care, foot care, and acupuncture.

See appendix table A1 for prevalence figures on all MA supplemental benefits.

MA plans' supplemental benefits offerings vary widely by geographic location

Taken together, plan-to-plan differences in supplemental benefit offerings result in important geographic disparities in the share of MA plans with supplemental benefits. For example, there are significant differences by state in MA plans' offering of dental benefits—with the percentage of MA plans offering any benefits in this category ranging from 79 percent in Florida to 33 percent in New Hampshire (figure 1). We found similarly large variations in the share of MA plans offering other types of benefits.

It is not clear why such large geographic differences exist. One hypothesis is that they might partly reflect disparities in the rebate dollars that plans receive across the nation[36]—as rebates are a key source of financing for MA supplemental benefits. We did not have access to information on the amount of each plan's rebate for the 2017 plan year. However, we were able to test this idea by using high health care costs in a plan's service area as a proxy for relatively large rebate payments (see box for details).

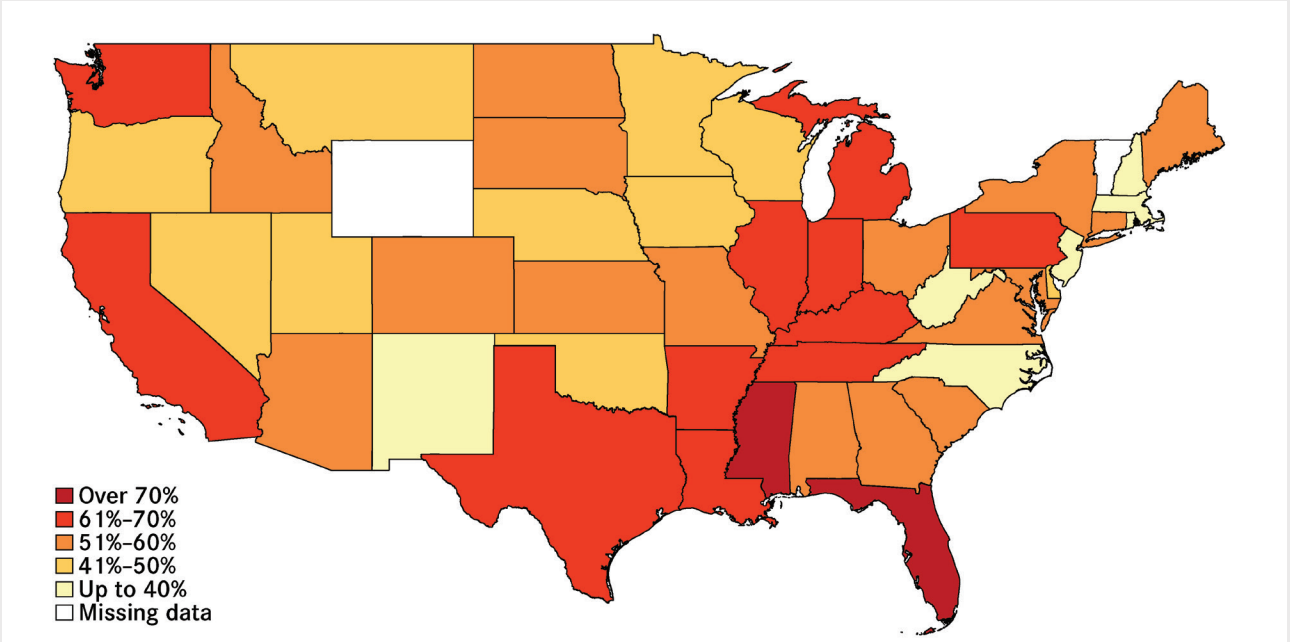
DETAILS ON TESTING WHETHER REBATE DOLLARS EXPLAIN GEOGRAPHIC VARIATIONS IN SUPPLEMENTAL BENEFITS OFFERINGS

Health care costs have been linked to MA plans' cost-efficiency relative to traditional Medicare[37,38]—and, consequently, also to the rebate dollars each plan is generally able to receive. Specifically, in high-cost areas, MA plans are often able to bid lower relative to CMS' benchmark than plans in low-cost areas. This gives plans sold in high-cost areas an advantage in obtaining rebate dollars to pay for supplemental benefits. Therefore, our hypothesis would predict that plans sold in high-cost areas offer more generous supplemental benefit packages than those sold in low-cost areas.

To test this hypothesis, we ranked all US counties according to their traditional Medicare spending per beneficiary, from high to low. We defined the top-ranked 10 percent of counties as high health care cost counties and the bottom-ranked 10 percent of counties as low-cost counties. We then compared the supplemental benefit packages of plans in the top 10 percent ranking to those in the bottom 10 percent ranking.

FIGURE 1

Percentage of Medicare Advantage Plans Offering Some Dental Benefits, 2017



Source: AARP Public Policy Institute analysis of the December 2017 MA/Part D Contract and Enrollment "Monthly Enrollment by Plan" and "Monthly Enrollment by Contract/Plan/State/County" files and of the 2017 "Plan Benefit Package" file.

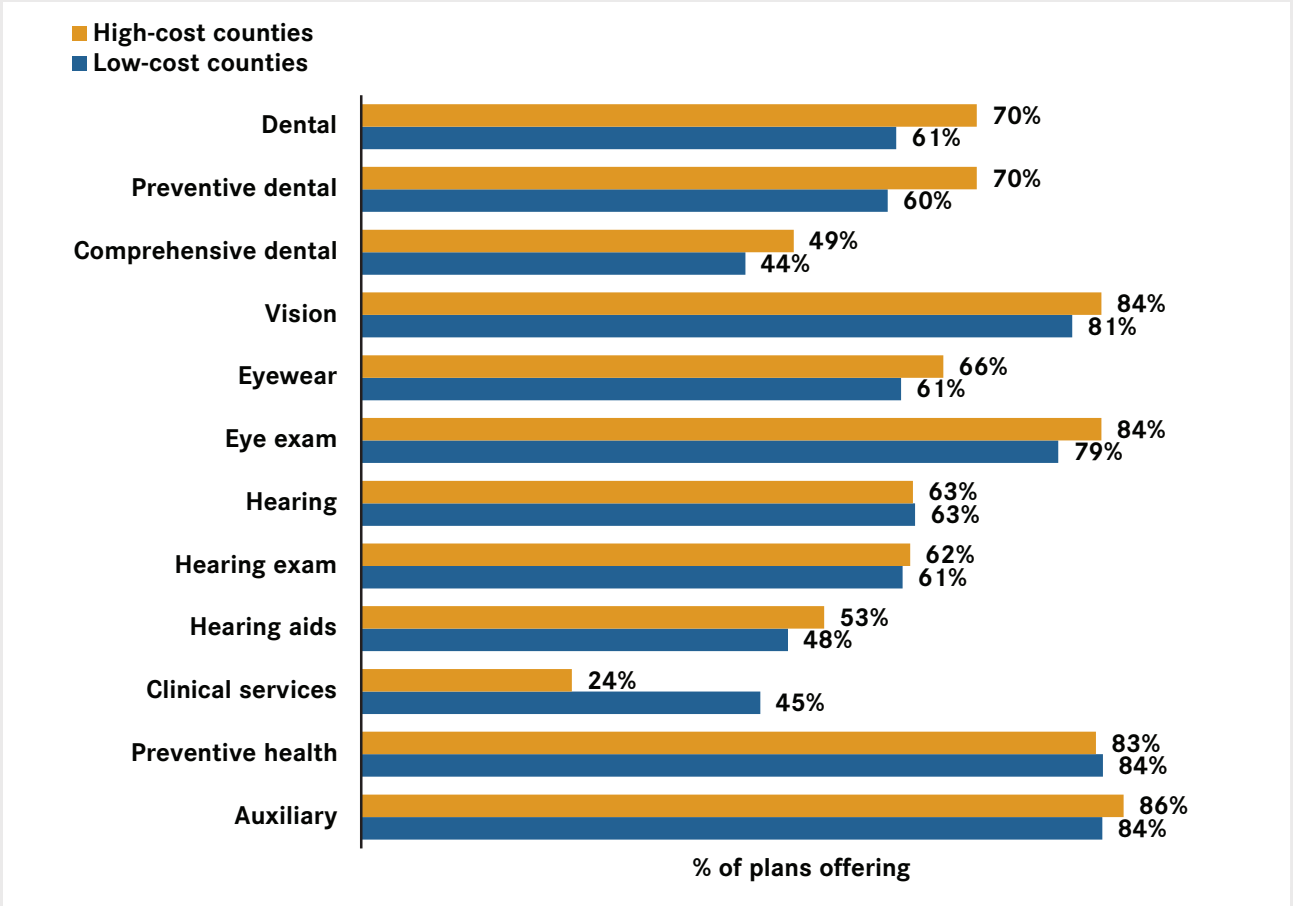
We excluded the following states due to missing data: Alaska, Vermont, and Wyoming. Hawaii not shown; 36 percent of MA plans offered some dental benefits in Hawaii.

We found only partial support for the idea that differences in MA plans' rebate dollars drive geographic variations in plans' benefits offerings (figure 2). On the one hand, MA plans sold in high-cost counties were more likely to offer certain supplemental benefits than plans sold in low-cost counties, including preventive dental care (+10 percentage points), comprehensive dental care (+6 percentage points), eyewear (+5 percentage points), and eye exams (+5 percentage points).

However, MA plans were also less likely to cover clinical services (–21 percentage points) and preventive health (–1 percentage point) in high-cost counties. More research is needed to fully understand the drivers behind geographic variations in plans' choice of supplemental benefits offerings.

In most cases, MA plans with supplemental benefits are less likely to charge a plan premium
In addition to financing supplemental benefits through rebate dollars, MA plans can also charge

FIGURE 2
Supplemental Benefits Offerings for Medicare Advantage Plans Sold in High and Low Health Care Cost Counties, 2017



Source: AARP Public Policy Institute analysis of the December 2017 MA/Part D Contract and Enrollment "Monthly Enrollment by Plan" and "Monthly Enrollment by Contract/Plan/State/County" files, of the 2017 "Plan Benefit Package" file, and of the "Medicare Geographic Variation Public Use File—State/County Table" (2016).
See table 1 for a list of individual benefits included in each benefit type.

beneficiaries a premium. We examined premium data to evaluate the extent to which plans are charging premiums for supplemental benefits rather than relying on their rebate payments.

In 2017, about half of all MA enrollees were in a plan that charged a plan premium ($36 per month, on average) in addition to Medicare's Part B premium.[39] Because insurers can finance supplemental benefits through enrollee premiums, we would expect more plans with supplemental benefits to charge a premium than plans without supplemental benefits—especially for costly benefits like comprehensive dental care. There are two different ways for insurers to charge consumers a premium in exchange for supplemental benefits. First, they can offer supplemental benefits as insurance riders that enrollees can only access in exchange for a rider premium. Or, insurers can include supplemental benefits as part of the MA plan's basic policy and charge a plan premium to everyone enrolled in the plan.

Our analysis of MA plan data reveals that almost all MA plans offered coverage for supplemental benefits as part of their basic policy (table 3). For example, only 3 percent of plans with some vision coverage and 2 percent of plans with some hearing coverage included these types of supplemental benefits as optional insurance riders. However, there is one important exception: about one in every five MA plans covered dental benefits as optional benefits. Dental insurance riders were especially common for relatively expensive comprehensive dental care benefits (28 percent, overall). For example, 29 percent of plans covering teeth restoration; 30 percent of plans covering endodontics, periodontics, or extractions; and 38 percent of plans covering non-routine complex dental care did so by offering the services to enrollees as additional elective benefits over those included in the basic policy, in exchange

TABLE 3
Percentage of Medicare Advantage Plans That Include Supplemental Benefits in Their Basic Policy versus as an Optional Insurance Rider, 2017

Benefit Type	% of Plans Including:	
	In basic policy[1]	As optional insurance rider[2]
Dental	83	17
Preventive dental	83	17
Comprehensive dental	72	28
Vision	97	3
Eyewear	93	7
Eye exam	97	3
Hearing	98	2
Hearing exam	98	2
Hearing aids	74	6
Clinical Services	99	1
Preventive Health	100	0
Auxiliary Benefits	100	0

Source: AARP Public Policy Institute analysis of the December 2017 MA/Part D Contract and Enrollment "Monthly Enrollment by Plan" file and of the 2017 "Plan Benefit Package" file.

Data are based on plans that offer at least one benefit of each type.

See Methods in the appendix for a list of individual benefits included in each benefit type.

[1] Includes plans that offer at least one individual benefit in the benefit type in their basic policy.

[2] Includes plans that offer all individual benefits in the benefit type through an insurance rider.

for a premium (appendix table A2). Therefore, many MA enrollees pay a separate insurance rider premium, potentially in addition to any plan premium, for insurance that covers major dental care.

We also identified plans that cover supplemental benefits in their basic policy and compared them to plans that do not[40] in terms of their likelihood to charge enrollees a plan premium (table 4). The data show that, in fact, MA plans with supplemental benefits in their basic policy are generally *less* likely—not *more* likely—to charge plan premiums.[41] For example, 75 percent of plans without vision coverage in their basic policy charged a plan

TABLE 4

Percentage of Plans Charging a Plan Premium among Medicare Advantage Plans That Cover Supplemental Benefits in Their Basic Policy and Plans That Do Not, 2017

Benefit Type	% of Plans Charging a Premium	
	Plan includes benefit in basic policy[1]	Plan does not include benefit in basic policy[2]
Dental	65	65
Preventive dental	65	65
Comprehensive dental	65	65
Vision	64	75
Eyewear	64	69
Eye exam	64	75
Hearing	61	76
Hearing exam	61	75
Hearing aids	61	72
Clinical services	63	67
Preventive health	60	70
Auxiliary benefits	65	80
10 Most Common Benefits[3]		
Eye exam	64	71
Emergency coverage abroad	64	71
Gym membership	64	71
Remote access technology[4]	65	65
Oral exam	65	65
Dental cleaning (prophylaxis)	62	75
Routine hearing exam	64	50
Annual physical exam	66	64
Dental x-ray	64	68
Contact lenses	64	75

Source: AARP Public Policy Institute analysis of the December 2017 MA/Part D Contract and Enrollment "Monthly Enrollment by Plan" file, the 2017 "Plan Benefit Package" file, and the 2017 "Medicare Advantage Landscape Source" files.

See Methods in the appendix for a list of individual benefits included in each benefit type.

[1] For benefit types, includes plans that offer at least 1 individual benefit in the benefit type in their basic policy. For individual benefits in the list of 10 most common benefits, includes plans that offer the individual benefit in their basic policy.

[2] For benefit types, includes plans that offer all individual benefits in the category through an insurance rider and plans that do not offer any of the individual benefits in the category. For individual benefits in the list of 10 most common benefits, includes plans that offer the individual benefit through an insurance rider and plans that do not offer the benefit.

[3] Based on percentage of plans offering.

[4] Web-/phone-based or nursing hotline.

premium; however, only 64 percent of plans with such coverage had a plan premium.

Overall, our results suggest that MA plans rely primarily on their rebate dollars to finance supplemental benefits[42], and that they often combine supplemental benefits and zero-premium plans to design attractive benefit packages. Due to data limitations, we did not examine cost-sharing requirements (e.g., deductible, co-insurance) for supplemental benefits—which MA plans can impose regardless of whether they charge a premium.

CONCLUSION

MA's supplemental benefits are a key difference between traditional Medicare and Medicare Advantage. While vision, dental, and hearing benefits are among the most commonly recognized supplemental benefits, MA plans have been allowed to offer a much more diverse set of supplemental benefits—including gym memberships, bathroom safety devices, transportation, and emergency coverage abroad. The extent to which MA plans cover each supplemental benefit varies; for example, a large majority of MA enrollees have some type of vision or fitness coverage, but only a very small share of enrollees have coverage for benefits such as bathroom safety devices, personal emergency response systems, and alternative therapies. There are also important geographic differences in MA plans' supplemental benefit offerings, although it is not fully clear why. Despite MA plans' ability to charge premiums in exchange for supplemental benefits, our analysis shows that, in most cases, MA enrollees in plans with supplemental benefits are less likely to face a premium than people in plans without such benefits.

As a result of policy changes that will take effect beginning in 2019, insurers could decide to increase their offering of many of the supplemental benefits that have historically been uncommon. Under the new rules, MA plans will also be allowed to offer a much broader scope of supplemental benefits than those permitted today and will be able to target those benefits to certain enrollees. These changes could be consequential for Medicare beneficiaries. Having examined how supplemental benefits have worked to date, in a forthcoming *Insight on the Issues* we will take an in-depth look at the new policy landscape for MA supplemental benefits and its implications for consumers.

Appendix

METHODS

We identified MA plans based on the 2017 MA/Part D Contract and Enrollment "Monthly Enrollment by Plan" file for the month of December.[43] The data have enrollment information for 3,118 MA plans.[44] We excluded 9 health care prepayment plan (HCPP)-1833 Cost plans because they did not have information on supplemental benefits. Our national-level analytical sample was comprised of 3,109 MA plans covering a total of 20,029,604 enrollees.

To calculate the share of plans offering a given supplemental benefit and the share of beneficiaries in a plan offering the benefit, we merged information from the 2017 "Plan Benefit Package" (PBP) file[45] into the plan-level enrollment file. The PBP file provides the universe of CMS-approved benefits for all MA plans[46] sold in 2017. The data are for individual supplemental benefits as well as for some subcategories (e.g., preventive dental, comprehensive dental, eyewear). The file also details whether the supplemental benefit is offered as part of the plan's basic benefit package or as an optional benefit. All analyses of MA supplemental benefits are based on plans with complete data across a benefit type (e.g., data on coverage of dental x-rays is based on plans with complete data on all individual dental supplemental benefits).[47]

Information on each plan's service area comes from the 2017 MA/Part D Contract and Enrollment "Monthly Enrollment by Contract/Plan/State/County" file for the month of December.[48] For the analysis of geographic variation in MA plans' offering of supplemental benefits, we appended information on each MA plan's state and county to the plan-level enrollment file. We excluded Alaska, Vermont, and Wyoming from the state-level analysis due to missing data. For the analysis of supplemental benefits included in plans sold in high- and low-cost areas, we defined the top and bottom 10 percent of counties for Medicare fee-for-service spending by calculating the 10th and 90th percentiles of 2016 per capita[49] FFS Medicare spending[50] in the "Medicare Geographic Variation Public Use File–State/County Table."[51]

The premium data come from the 2017 "Medicare Advantage Landscape Source" files,[52] which include information on MA plans approved for the 2017 contract year. Because the MA Landscape files exclude Program of All-Inclusive Care for the Elderly (PACE) plans, Part B Only plans, and employer-sponsored plans, the analysis of plan premiums relies on a smaller sample of 2,628 MA plans (or 85 percent of plans in the MA plan-level enrollment file) and 16,112,920 enrollees (or 80 percent of all enrollees in the plan-level enrollment file). For segmented plans that were permitted to vary premiums between segments,[53] we assigned the unweighted average of all segment premiums to the plan-level premium.

TABLE A1

Prevalence of Medicare Advantage Supplemental Benefits, 2017

Benefit Type	Benefit	Plans *% offering*	Beneficiaries *% in plans offering*
Dental	Dental x-ray	63	58
	Oral exam	67	61
	Dental cleaning (prophylaxis)	67	61
	Fluoride	22	18
	Prosthodontics/maxillofacial surgery	35	34
	Non-routine services	23	23
	Diagnostic services	23	20
	Restorative services	45	41
	Endodontics/periodontics/extractions	42	38
Vision	Eye exam	83	78
	Eyewear upgrades	9	6
	Contact lenses	63	58
	Glasses: lenses and frames	54	48
	Glasses: lenses only	38	34
	Glasses: frames only	37	30
Hearing	Fitting/evaluation for hearing aid	40	36
	Routine hearing exam	67	64
	Hearing aids	55	57
Clinical Services	Chiropractic maintenance care	12	11
	Routine foot care	32	32
	Acupuncture	11	15
	Other alternative therapies	2	2
	Residential substance abuse treatment	1	4
Preventive Health	Health education	43	39
	Nutrition counseling	9	11
	Enhanced smoking cessation counseling	26	23
	Gym membership	75	69
	Enhanced disease management	11	8
	Telemonitoring	6	4
	Remote access technology[1]	70	68
	Bathroom safety devices	2	2
	Counseling services	17	17
	In-home safety assessments	3	2
	Personal emergency response systems	1	1
	Medical nutrition therapy	5	4
	Post-discharge in-home medication reconciliation	3	2
	Weight management program	4	3
	Annual physical exam	65	64
	Enhanced screening EKG[2]	14	15
Auxiliary	Emergency coverage abroad	77	76
	Nonemergency transportation	28	25
	Meals	19	17
	Wigs for hair loss related to chemotherapy	4	3
	Over-the-counter drugs/items	36	36

Source: AARP Public Policy Institute analysis of the December 2017 MA/Part D Contract and Enrollment "Monthly Enrollment by Plan" file and of the 2017 "Plan Benefit Package" file.

[1] *Web-/phone-based or nursing hotline.*

[2] *EKG = electrocardiogram*

TABLE A2

Percentage of Medicare Advantage Plans That Include Dental Benefits in Their Basic Policy and as an Optional Insurance Rider, 2017

Dental Benefit	% of Plans Including:	
	In basic policy	As optional insurance rider
Dental X-Ray	82	18
Oral Exam	83	17
Prophylaxis/Cleaning	83	17
Fluoride	83	17
Prosthodontics/Maxillofacial Surgery	70	30
Non-Routine Services	62	38
Diagnostic Services	67	33
Restorative Services	71	29
Endodontics/Periodontics/Extractions	70	30

Source: AARP Public Policy Institute analysis of the December 2017 MA/Part D Contract and Enrollment "Monthly Enrollment by Plan" file and of the 2017 "Plan Benefit Package" file.

Data are based on plans that offer the benefit.

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1 Traditional Medicare is also known as Original Medicare or fee-for-service (FFS) Medicare.

2 Under current law, all Medicare beneficiaries except those with end-stage renal disease (ESRD) qualify to enroll in an MA plan. Beginning in 2021, Medicare beneficiaries with ESRD will also be eligible to enroll in an MA plan.

3 There are different types of Medicare Advantage plans, including health maintenance organizations (HMOs), preferred provider organizations (PPOs), private fee-for-service (PFFS) plans, HMO point-of-service (HMO-POS) plans, and special needs plans (SNPs). Plan availability varies by geographic area.

4 G. Jacobson, A. Damico, T. Neuman, and M. Gold, "Medicare Advantage 2017 Spotlight: Enrollment Market Update," Issue Brief, Kaiser Family Foundation, Menlo Park, CA, June 2017, https://www.kff.org/medicare/issue-brief/medicare-advantage-2017-spotlight-enrollment-market-update/.

5 CMS projects that in 2019, 22.6 million people will be in Medicare Advantage—an 11.5 percent increase compared with 2018. MA enrollees will make up an estimated 36.7 percent of all Medicare beneficiaries in 2019. See https://go.cms.gov/2QgzBMN.

6 MA does not cover hospice care. Traditional Medicare covers hospice, even for people enrolled in MA. Many MA plans also include Medicare prescription drug coverage (Part D).

7 There are several other important differences between MA and traditional Medicare. MA plans generally have a provider network, whereas people with traditional Medicare can get services from any health care provider that accepts Medicare. MA plans are required to cap the total amount enrollees pay out-of-pocket each year for deductibles, co-payments, and co-insurance (cost sharing), while there is no such limit under traditional Medicare. Each MA plan has its own premium and cost-sharing requirements (subject to certain limitations), whereas beneficiaries in traditional Medicare generally face the same costs.

8 The new CMS administrative policies are outlined in the *2019 Medicare Advantage and Part D Rate Announcement and Call Letter* (issued on April 4, 2018, https://go.cms.gov/2NVAy0x) and the *Contract Year 2019 Policy and Technical Changes for Medicare Advantage and the Prescription Drug Benefit Program Rule* (published on April 16, 2018, https://bit.ly/2qF6d7U).

9 The law includes provisions of the *Creating High Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act*. It was enacted February 9, 2018, https://bit.ly/2P41nMv.

10 *Medicare Managed Care Manual*, Chapter 4, Section 30.1, "Definition of Supplemental Benefits," https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf. In addition to the requirements outlined here, (1) MA plans must incur a medical cost for the supplemental benefits they cover and (2) supplemental benefits must be medically necessary health care benefits.

11 For example, traditional Medicare may cover routine nonemergency ambulance transportation, but only if other forms of transportation are dangerous to a beneficiary's health and after a clinician certifies that it is medically necessary. MA plans can cover nonemergency routine transportation without imposing all those qualifying criteria.

12 *Medicare Managed Care Manual*, "Definition of Supplemental Benefits."

13 *Medicare Managed Care Manual*, Chapter 4, Section 10.5.1, "Uniformity," https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf.

14 In some cases, MA plans can or must target supplemental benefits to plan enrollees with a certain health profile. For example, MA plans that offer enhanced disease management services (e.g., assigned case manager, disease monitoring, or educational activities) as a supplemental benefit, must target those services to enrollees with or at risk for a specific condition, such as diabetes, heart failure, or dementia.

15 MA plans with multiple segments in their service area can vary premiums and cost sharing (but not supplemental benefits) across segments.

16 For more examples, see *Medicare Managed Care Manual*, Chapter 4, Section 30.4, "Items and Services Not Eligible as Supplemental Benefits," https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf.

17 However, plans may provide information about caregiver services.

18 CMS refers to these benefits as *mandatory supplemental benefits*.

19 CMS refers to these benefits as *optional supplemental benefits*. MA plans can offer enrollees a set of services as one optional supplemental benefit, offer services individually, or offer a combination of both.

20 MA plans can also return the rebate dollars to enrollees by lowering their premiums. Medicare beneficiaries enrolled in MA plans typically pay a premium for Part B. Some beneficiaries may also owe a premium for Part A. If the MA plan includes prescription drug coverage, beneficiaries would also pay a premium for their Part D coverage.

21 The rebate is either 50, 65, or 70 percent of the difference between the benchmark and the plan bid, depending on the plan's rating on CMS's star system.

22 Plan bids are based on an average Medicare beneficiary and include administrative costs and profit.

23 For local MA plans, the benchmark is set at 95, 100, 107.5, or 115 percent of the county-level per capita FFS cost for the year (subject to caps). To help attract plans, low-FFS-spending counties are assigned to benchmarks that are higher than FFS costs. Conversely, high-FFS-spending counties have benchmarks lower than FFS to generate Medicare savings. In addition, benchmarks vary with plans' quality of care rating on CMS's star system. For more information, see Medicare Payment Advisory Commission (MEDPAC), "Payment Basics: Medicare Advantage Program Payment System," MEDPAC, Washington, DC, October 2017, https://bit.ly/2Q3Ai0z.

24 We did not have information on premiums for supplemental benefits included in an insurance rider.

25 Examples of fitness benefits include gym membership, exercise and yoga classes, a personalized exercise plan, or sessions with a certified trainer.

26 MA plans could cover nutrition classes and/or individual nutritional counseling provided by state-licensed clinicians.

27 MA plans could also include an in-home bathroom safety inspection if it was conducted by a qualified health professional.

28 MA plans were prohibited from including cell phones in their personal emergency response supplemental benefits.

29 Provided by state-licensed chiropractors.

30 Provided by state-licensed or state-certified practitioners.

31 Provided by state-licensed or state-certified practitioners.

32 Insurers could cover meals only when ordered by a clinician immediately following a hospital stay or surgery and for a limited time. In certain cases, MA plans could also cover meals that beneficiaries need because of a chronic condition.

33 MA plans could offer transportation only for health-related reasons (e.g., transportation to doctor visits).

34 Web-/phone-based or nursing hotline.

35 Other than chiropractic care, foot care, and acupuncture.

36 S. Zuckerman, L. Skopec, and S. Guterman, "Do Medicare Advantage Plans Minimize Costs? Investigating the Relationship between Benchmarks, Costs, and Rebates," Issue Brief, The Commonwealth Fund, New York, NY, December 21, 2017, https://bit.ly/2xYp4yw.

37 B. Biles, G. Casillas, and S. Guterman, "Does Medicare Advantage Cost Less Than Traditional Medicare?" Issue Brief, The Commonwealth Fund, New York, NY, January 28, 2016, https://bit.ly/2R7LxSg.

38 B. Biles, G. Casillas, and S. Guterman, "Variations in County-Level Costs between Traditional Medicare and Medicare Advantage Have Implications for Premium Support," *Health Affairs* 34, no. 1 (2015, January), https://bit.ly/2xQRxXK.

39 Jacobson, Damico, Neuman, and Gold, "Medicare Advantage 2017 Spotlight."

40 Either because they offer the benefit as an insurance rider or because they do not offer the benefit at all.

41 For a similar finding, see C. Pope, "Supplemental Benefits under Medicare Advantage," *Health Affairs* (blog), January 21, 2016, https://www.healthaffairs.org/do/10.1377/hblog20160121.052787/full/.

42 MA plans' ability to leverage efficiencies in the delivery of care to enrollees is reflected in their rebate dollars.

43 Publicly available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-Enrollment-by-Plan-Items/Monthly-Enrollment-by-Plan-2017-12.

44 The MA/Part D Contract and Enrollment files include information on the following types of plans: 1876 Cost, HCPP-1833 Cost, HMO, HMO-POS, local PPO, Medicare Medical Savings Account, Medicare-Medicaid Plan HMO, Medicare-Medicaid Plan HMO-POS, national Program of All-Inclusive Care for the Elderly (PACE), PFFS, and Regional PPO.

45 Publicly available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Benefits-Data-Items/2017-PBP-Benefits-.

46 Including plans involved in the Value Based Insurance Design Demonstration.

47 For most supplemental benefits categories, fewer than 5 percent of plans had incomplete data on whether they covered either of the individual supplemental benefits.

48 Publicly available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-Enrollment-by-Contract-Plan-State-County-Items/Monthly-Enrollment-by-CPSC-2017-12.

49 Standardized risk-adjusted per capita costs.

50 Bottom 10 percent = standardized risk-adjusted per capita costs ≤ $9,024; top 10 percent = standardized risk-adjusted per capita costs ≥ $11,892.

51 Publicly available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Geographic-Variation/GV_PUF.html.

52 Publicly available at https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/index.html?redirect=/PrescriptionDrugCovGenIn/02_EnrollmentData.asp.

53 About 4 percent of plans in the MA Landscape file.

Insight on the Issues 140, December 2019

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https://doi.org/10.26419/ppi.00075.001

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