Elevance Health | Public Policy Institute

Medicare Advantage Supplemental Benefits Address Health-Related Social Needs

July 2023

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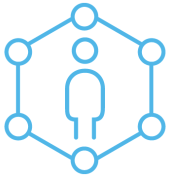
Key Takeaways

- The vast majority of Elevance Health affiliated MA plan enrollees used supplemental benefits in 2022, with most using multiple benefits.
- Enrollees who used at least one supplemental benefit were more likely to live in areas with fewer resources, such as food deserts and areas with lower socioeconomic status.
- Supplemental benefits are being used by members who could greatly benefit from them, suggesting that these benefits are helping CMS and plans address beneficiaries' health-related social needs.

Overview

Medicare Advantage (MA) plans are private health plans that partner with the Centers for Medicare & Medicaid Services (CMS) to offer benefits to Medicare beneficiaries. MA plans provide all Traditional Medicare (TM) benefits at a cost that is often less than that of TM. As a result, MA plans use the savings to offer other benefits that are not covered under TM, known as supplemental benefits.



Medicare-eligible individuals can choose an MA plan that offers supplemental benefits specific to their health needs.

Supplemental benefits fall into four categories:

1. Providing coverage that goes above and beyond TM covered services, including lowering the standard deductible or other cost sharing,
2. Enhancing the Part D benefit,
3. Offering benefits not covered by TM, such as dental and vision, and
4. Buying down the standard Part B premium.

This analysis focused specifically on the benefits in category 3.

MA continues to rapidly grow, covering half of all eligible Medicare individuals,[1] all with unique health needs and diverse backgrounds. Over one-third of MA beneficiaries identify as a racial or ethnic minority and over half of MA beneficiaries have annual incomes less than $25,000.[2] Further, beneficiaries with one or more chronic conditions are more likely to enroll in MA compared to those with no chronic conditions, and the likelihood increases with the number of chronic conditions.[3] That said, the MA program serves a population of people who are more diverse and have more clinically complex conditions when compared to TM.[4]

Supplemental benefits are an important component of the benefit package for the Medicare population and a valuable differentiator for MA. The range of supplemental benefit offerings allows beneficiaries to choose a plan that best supports their current health status and future health goals. For instance, a Medicare-eligible individual who wears glasses may opt for an MA plan that offers coverage assistance for exams and eyewear. In recent years, Congress expanded supplemental benefits to allow MA plans to address health-related social needs (HRSN). As an example, an MA-eligible beneficiary who experiences food insecurity might select an MA plan that includes meal benefits.

Though there have been calls to increase data sharing on supplemental benefit uptake among MA members, little has been shared publicly, especially regarding the new, recently expanded in scope supplemental benefits, such as non-medical transportation and nutrition benefits. The purpose of this analysis is to describe supplemental benefit uptake across groups of members within Elevance Health's affiliated MA plans.

Background

Since the inception of MA, plans have invested savings from efficiencies unique to the care model into supplemental benefits. As required by law, these benefits must either reduce beneficiary costs or enhance Medicare coverage by providing additional services.

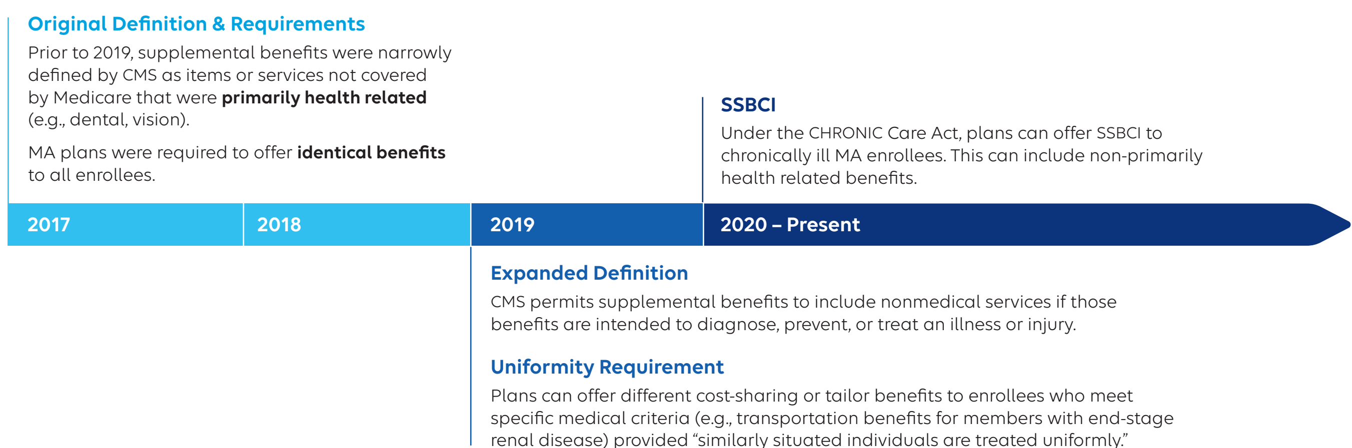
Regulatory and legislative changes for plan years 2019 and 2020, respectively, gave plans new flexibility to expand the types of supplemental benefits offered to MA enrollees and to better address HRSN. Figure 1 displays those changes.

The prevalence of supplemental benefits has grown in recent years with nearly all MA plans offering at least one supplemental benefit in 2022 across all benefit categories.[5] In particular, the number of plans that offer Special Supplemental Benefits for the Chronically Ill (SSBCI) has increased three-fold, from 626 to 1,851 plans, which is 34 percent of plans.[6] As part of the SSBCI offerings, these non-medical benefits include supports to address HRSN, such as non-medical transportation, meal and nutrition benefits, and supports to reduce loneliness and social isolation. The growth in supplemental benefits, especially within SSBCI, illustrates MA plans' commitments to addressing factors that impact beneficiaries' health that occur outside of the traditional healthcare system. The flexibility permitted under the MA program allows plans to test innovative benefits and modify the benefits over time based on beneficiary experience and health outcomes.

Prior literature has described MA plans' supplemental benefits offerings across the country, but no research has described the uptake of supplemental benefits among enrollees.[7-11] This paper describes enrollees' utilization of supplemental benefits within their selected plans overall, as well as by demographic characteristics.

Figure 1

Timeline of CMS' Supplemental Benefits Policy



Source. Murphy-Barron, C., Buzby, E., & Pittinger, S. (2022, February). Overview of Medicare Advantage Supplemental Healthcare Benefits and Review of Contract Year 2022 Offerings. Retrieved March 14, 2023, from https://bettermedicarealliance.org/wp-content/uploads/2022/03/MA-Supplemental-Benefits-Milliman-Brief_20220225.pdf.

Note. CMS = Centers for Medicare & Medicaid Services; MA = Medicare Advantage; SSBCI = Special Supplemental Benefits for the Chronically Ill.

Methodology

This cross-sectional study used data on supplemental benefit utilization and member characteristics from Elevance Health's affiliated MA plans in 24 states across the United States along with HRSN data.

This analysis focused on use of 36 of the 42 offered supplemental benefits due to data availability. The sample included 861,657 MA beneficiaries, 568,463 non-dual eligible and 293,194 dual eligible beneficiaries,[12] continuously enrolled for 12 months in one plan with access to at least one supplemental benefit in 2022. Enrollees in Employer Group Waiver Plans (EGWPs) and Medicare-Medicaid Plans (MMPs) were not included in the study.

Use of supplemental benefits was examined separately among non-dual eligible members and dual eligible members. MA members were assigned to one of the following three groups for each supplemental benefit:

1. **Utilizer of the supplemental benefit** if the member's MA plan offered the supplemental benefit and the member utilized it at least one time in 2022.
2. **Non-utilizer of the supplemental benefit** if the member's MA plan offered the supplemental benefit and the member did not utilize it in 2022.[13]
3. **No access to the supplemental benefit** if the member's MA plan did not offer the supplemental benefit. This group was out of scope for the analysis, but it is worth noting that not all enrollees had access to all offered supplemental benefits; benefits vary by plan, enrollees may be offered a choice from among several benefits, and SSBCIs are limited to eligible enrollees.

The analysis examined the total number of supplemental benefits a member utilized in 2022. In addition, the analysis examined differences in member characteristics for any use of supplemental benefits and among three commonly utilized supplemental benefits: transportation, over-the-counter (OTC) allotment, and grocery card. MA member characteristics include a combination of plan-level, residential area-level, and individual-level characteristics.

This analysis included residential area-level variables for:

Primary Care Provider (PCP) shortage area. Member resides in a county with PCP shortage defined as more than 3,000 people to 1 PCP per the U.S. Department of Health and Human Services' Area Health Resources Files.

Food desert. Member lived in a census tract with low access to food defined as at least 500 people and/or 33 percent of the community living more than one mile from a supermarket or grocery store in urban tracts or more than 10 miles in rural tracts as defined by the U.S. Department of Agriculture's 2019 Food Access Research Atlas.

Socioeconomic Status (SES) index by quartile. A composite measure based on seven Social Determinants of Health variables as defined by the Agency for Healthcare Research and Quality. A score of four indicates the member lived in a census block group in the top 25 percent of SES and a score of one indicates the member lived in a census block group in the bottom 25 percent of SES using census block group from the 2017 American Community Survey (ACS) as the reference basis for calculation.

Median family income. The median family income in 2017 inflation-adjusted dollars based on member's census block group from the 2017 ACS.

Plan-level and individual-level characteristics in this analysis were captured as of January 1, 2022. These characteristics include: age, sex, region based on the member's residence, CMS Hierarchical Condition Category (HCC) Risk Score, CMS race and ethnicity (i.e., White (non-Hispanic); Black (non-Hispanic); Hispanic; Asian, Asian American, or Pacific Islander; American Indian or Alaska Native; Other; and Unknown), and plan type, which indicates if the member was enrolled in a dual eligible special needs plan (D-SNP) in coverage year 2022.

This analysis compared members in the non-utilizer and utilizer groups. Chi-square tests and t-tests were used to assess the statistical significance of differences between the non-utilizer and utilizer groups. In the findings presented in this paper, results of all chi-square tests and t-tests are statistically significant ($p<0.0001$).

Findings

Supplemental Benefits: Overall Findings

In 2022, the uptake of supplemental benefits among Elevance Health's affiliated MA plan enrollees was strong. 83 percent of dual eligible individuals and 75 percent of non-dual eligible individuals used one or more of the available supplemental benefits during the calendar year.

Sixty-four percent of dual eligible individuals and 48 percent of non-dual eligible individuals used at least two different supplemental benefits. (Figure 2)

Members who used at least one supplemental benefit had meaningfully different characteristics from those who did not. For instance, among dual eligible enrollees, utilizers were 20.0 percentage points (PP) more likely to be enrolled in MA D-SNPs than non-utilizers, potentially indicating that enrollees who have higher healthcare needs could be self-selecting into plans with more robust benefit offerings, including supplemental benefits.

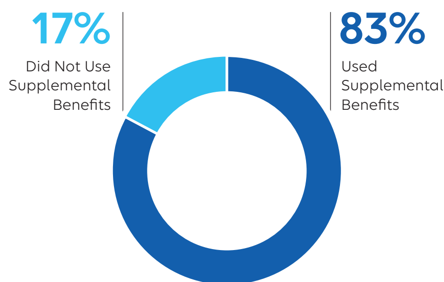
Dual eligible utilizers also were 2.4 PP more likely to live in a food desert, and 4.6 PP more likely to be in the lower two SES quartiles, both of which could indicate that enrollees using supplemental benefits are more likely to live in underserved areas than those not using these benefits. Further, dual eligible utilizers have a higher average CMS-HCC risk score[14] than non-utilizers (average 1.39 versus 1.24), suggesting they could be using their supplemental benefits to help address more intensive healthcare needs.

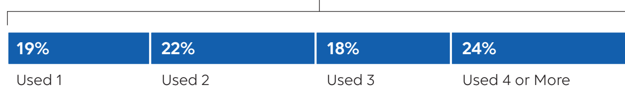
Among non-dual eligible members, utilizers were 5.6 PP more likely to reside in a food desert, and 3.1 PP more likely to live in a rural area. The neighborhood characteristics of those who use supplemental benefits show they are more likely to be from underserved communities, meaning that the supplemental benefit offerings are important in connecting these individuals to needed resources. (Figure 3)

Figure 2

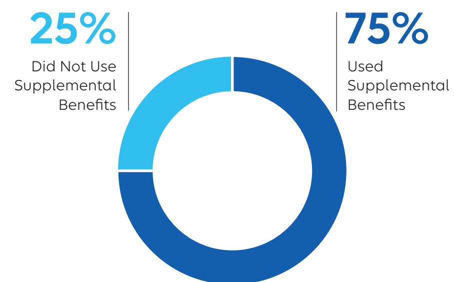
Supplemental Benefit Utilization by Dual Eligibility Status, 2022

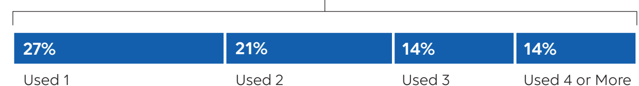
Dual Eligible Individuals





Non-Dual Eligible Individuals



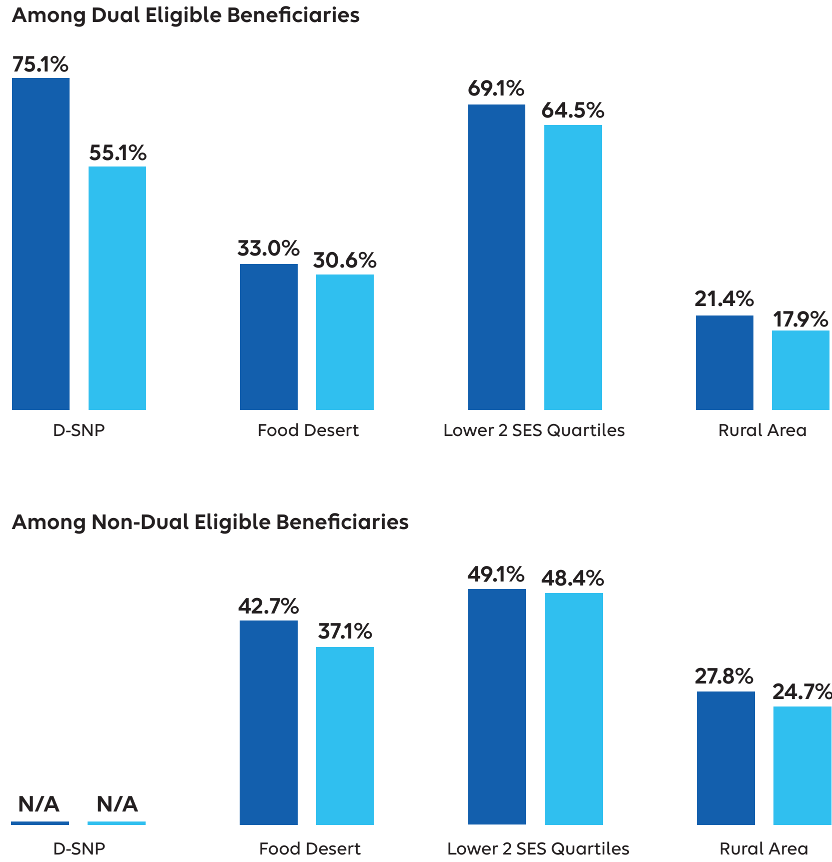


Source. Claims data from 861,657 MA enrollees, including 568,463 non-dual eligible and 293,194 dual eligible individuals.

Note. Figures may not sum to 100 due to rounding.

Figure 3

Percentage of Supplemental Benefit Utilizers and Non-Utilizers by Demographic Characteristics, 2022



Source. Claims data from 861,657 MA enrollees, including 568,463 non-dual eligible and 293,194 dual eligible individuals.

Note. D-SNP = Dual Eligible Special Needs Plan; SES = Socioeconomic Status.

Supplemental Benefits: By Type

This study focused on three commonly offered and used benefits that are uniquely designed to address HRSN: transportation, OTC allowances, and grocery benefits.

Transportation

Within SSBCI, MA plans can provide transportation for non-medical needs, such as grocery shopping and banking, along with other health-care-related eligible needs.[15] Depending on the selected Elevance Health affiliated MA plan, members may have access to a specified number of, or even unlimited, rides for non-medical needs. These rides can be arranged, reimbursed, or provided directly by the MA plan, depending on the specific plan benefits.

Member acuity differed among those who used the transportation benefit at least once (utilizers), as measured by the CMS-HCC risk scores. Non-dual eligible transportation utilizers have notably higher risk scores, indicating higher healthcare needs, than non-utilizers (1.55 v. 1.06).

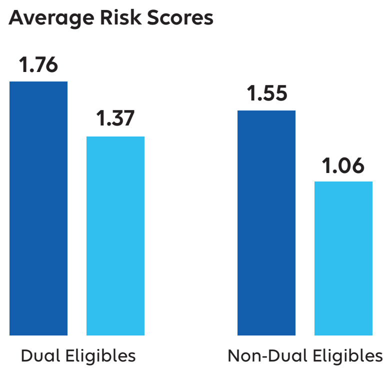
Dual eligible utilizers also have higher risk scores than non-utilizers (1.76 v. 1.37), though the difference is slightly less pronounced than it is among the non-dual eligible individuals. Members who used the transportation benefit were more likely to be Black non-Hispanic (dual: 13.4 PP; non-dual: 8.9 PP) and in the lower two SES quartiles (dual: 3.3 PP; non-dual: 3.8 PP). (Figure 4)

Figure 4

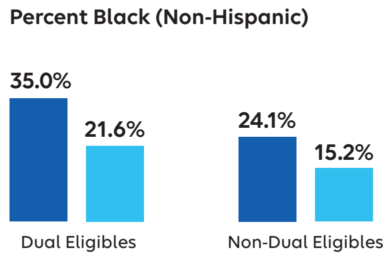
Demographic Characteristics of Enrollees Who Used the Transportation Benefit vs. Non-Utilizers, 2022

Utilizers
Non-Utilizers

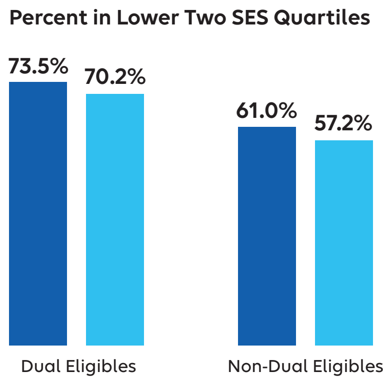
Average Risk Scores



Percent Black (Non-Hispanic)



Percent in Lower Two SES Quartiles



Source. Claims data from 861,657 MA enrollees, including 568,463 non-dual eligible and 293,194 dual eligible individuals.

Note. SES = Socioeconomic Status.

Over-the-Counter Cards

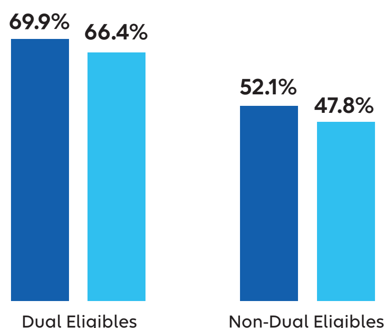
Certain Elevance Health affiliated MA plans offer prepaid cards that can be used at many retail pharmacies to purchase OTC medications and health supplies. The specific products covered by MA OTC cards vary by plan, but generally include items like cold, cough, and flu medications; antibiotic ointment; pain relievers; and sleep aids.[16]

Those who used OTC benefits, as compared to those who did not, were more likely to be in the lower two SES quartiles (dual: 3.5 PP; non-dual: 4.3 PP). (Figure 5) This suggests that members who have lower incomes, and therefore are more sensitive to costs related to OTC medications, are using this benefit.

Figure 5

Percent of OTC Benefit Card Utilizers vs. Non-Utilizers in the Lower Two SES Quartiles, 2022

Utilizers
Non-Utilizers



Source. Claims data from 861,657 MA enrollees, including 568,463 non-dual eligible and 293,194 dual eligible individuals.

Note. OTC = Over-the-Counter; SES = Socioeconomic Status.

Grocery Benefits

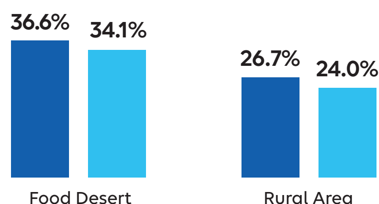
MA plans can offer grocery allowances through prepaid cards that allow members to purchase food and produce at participating grocery stores. This benefit became newly available under SSBCI.

In general, only Elevance Health's affiliated D-SNPs and chronic condition SNPs (C-SNPs) include grocery card benefits, as these plan types are designed specifically for Medicare beneficiaries who are most likely to also qualify for SSBCI. Among D-SNP enrollees, utilizers of the grocery card are 2.5 PP more likely to live in a food desert and 2.7 PP more likely to live in a rural area as compared to non-utilizers of the benefit. (Figure 6)

Figure 6

Percentage of D-SNP Enrollees Who Used the Grocery Benefit Card vs. Non-Utilizers by Demographic, 2022

Utilizers
Non-Utilizers



Source. Claims data from 210,340 D-SNP MA enrollees.

Note. D-SNP = Dual Eligible Special Needs Plan.

Discussion

Overall, the vast majority of Elevance Health's affiliated MA plan enrollees used at least one supplemental benefit in 2022, with a majority using multiple supplemental benefits. These findings suggest that beneficiaries see value in these offerings to augment the TM benefit package and/or to address their HRSN.

In addition to more "typical" supplemental benefits like dental and vision care, MA plans have expanded the range of benefits available to address HRSN, reflecting the increasing diversity of needs among enrollees. Given that MA members come from more diverse backgrounds than TM beneficiaries,[17] MA plans can use supplemental benefits to reduce health inequities.

The benefits analyzed in this paper are being utilized by members who could greatly benefit from them.

This analysis shows that the identified benefits are being utilized by members who could greatly benefit from them. For instance, dual eligible individuals used supplemental benefits at higher rates than non-dual eligible individuals. Prior research has found that robust supplemental benefits help keep dual eligible individuals enrolled in D-SNPs, which contributes to continuity of care.[18]

The utilization rates also suggest that CMS' and plans' goals for addressing HRSN can be achieved, in part, by offering these additional benefits to MA members. Enrollees who used at least one supplemental benefit were more likely to live in areas with fewer resources, such as food deserts. Likewise, uptake of the grocery benefits was higher among enrollees living in a food desert or in rural areas. Enrollees living in these areas likely have fewer choices for economical shopping or might need to travel further for nutritious, fresh food. The grocery card, which acts like a debit card in major grocery chains, allows enrollees to stretch their grocery budget.

In addition, utilizers of the transportation benefit were more likely to have higher CMS-HCC scores, identify as Black non-Hispanic, and live in a neighborhood with lower SES. Previous research has shown that transportation benefits are associated with higher member satisfaction, sense of safety, and ability to take control of healthcare decision-making via the ability to have access to healthcare providers when needed.[19]

Finally, members who used the OTC benefit were more likely to live in areas with lower SES. Beneficiaries with lower incomes especially benefit from OTC benefits, as additional funding through this resource can help them purchase the supplies they need (e.g., aspirin, bandages).

Conclusion

Supplemental benefits are highly utilized by beneficiaries and are critically important supports for the health and HRSN of vulnerable, low-income MA enrollees. This analysis demonstrates the positive effect regulatory and legislative changes had, via the bipartisan CHRONIC Care Act, in supporting plans toward expanding needed MA supplemental benefits.

It also highlights efforts by MA plans to tailor supplemental benefits for individuals with greater, more complex health and health-related social needs. Congress and CMS should continue to support MA plans' ability to provide innovative supplemental benefits that promote health and health equity. For instance, expanding the population eligible for SSBCI beyond just those with chronic conditions could give other high-risk populations (e.g., low-income, beneficiaries with social needs) a vehicle to address their HRSN. While this analysis looked at utilization, further research could assess the impact of supplemental benefit use on health outcomes and well-being among MA enrollees.

Endnotes

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[6] Ibid.

[7] Ibid.

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[11] Meyers, D.J., Tucher, E., & Thomas, K.S. (2022, October 6). Addressing Social Needs Through Medicare Advantage Plans' Supplemental Benefits—A Potential Not Yet Realized. *JAMA Network Open 5*(10). Retrieved May 9, 2023, from https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2797049.

[12] Dual eligible beneficiaries are individuals who qualify for, and are enrolled in, both Medicare and Medicaid.

[13] Non-utilizer group includes members who may have utilized one of six additional benefits with missing utilization data: nurse hotline, nutrition consult, nutrition therapy, orthotics, telemonitoring, and transitional care.

[14] CMS uses CMS-HCC risk scores to pay Medicare Advantage Organizations differentially based on the disease burden and demographic factors of plans' enrollees. The average enrollee has a risk score of 1.0; higher values indicate higher than average risk and expected cost while values below 1.0 indicate lower than average risk and expected cost. In financial terms, if the per member per month (PMPM) payment for 1.0 risk beneficiaries is $1,000, the PMPM payment for 1.5 risk beneficiaries is $1,500, or 1.5 times that for 1.0 risk beneficiaries.

[15] Centers for Medicare & Medicaid Services. (2021, December 1). Non-Emergency Medical Transportation (NEMT). Retrieved May 9, 2023, from https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Program/Education/Non-Emergency-Medical-Transport.

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