Insight on the Issues

Supplemental Benefits in Medicare Advantage: Recent Public Policy Changes and What They Mean for Consumers

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Last year ushered in significant changes to public policies governing "supplemental benefits" that Medicare's private plans (known as Medicare Advantage, or MA plans¹) can offer, but that are not covered under traditional Medicare². MA plans have long been allowed to offer such extra benefits (e.g. dental care, vision services, and gym memberships)³ and their availability is one of several key differences between MA and traditional Medicare.⁴ However, with the enactment of the Bipartisan Budget Act of 2018⁵ (Budget Act) and new regulations⁶ issued by the Centers for Medicare & Medicaid Services (CMS), MA plans can now cover a wider array of extra benefits than was previously allowed. In addition, insurers now have greater flexibility to design and target those benefits.

Many of these changes could have important implications for consumers. An increasing share of Medicare beneficiaries choose to get their coverage through Medicare's private plans⁷—rather than traditional Medicare. In 2018, over 20 million beneficiaries⁸ (about a third of all people with Medicare) were enrolled in MA, and projections

show that this number will continue to grow in the coming years.⁹

This *Insight on the Issues* is part of a series examining MA's supplemental benefits. The first report in the series explained how supplemental benefits worked in years prior to 2019. In this second publication, we detail recent changes to MA supplemental benefit policies and present new data about the supplemental benefits available in 2019. We also discuss implications for Medicare beneficiaries and propose policy improvements to ensure strong consumer protections going forward. We will continue to monitor changes to MA's supplemental benefits and how plans are implementing them in 2020 and beyond.

A NEW PUBLIC POLICY LANDSCAPE FOR SUPPLEMENTAL BENEFITS

A first set of regulatory changes to policies governing MA supplemental benefits took effect for plans sold in 2019. However, the full range of changes will be implemented only in 2020,



when provisions of the Budget Act take effect (see Appendix for a summary table of the changes).

Fully implemented, the new rules and law make the following changes to MA supplemental benefits:

- Allow more benefits to qualify as "primarily health-related";
- Allow special benefits for people with chronic diseases; and
- Allow insurers to tailor supplemental benefits to enrollees.

Here is a detailed look at these changes:

Allow more benefits to qualify as "primarily health-related." Generally, supplemental benefits must be "primarily health related." In the past, CMS interpreted this requirement narrowly, allowing only supplemental benefits whose primary purpose was to "prevent, cure or diminish an illness or injury." Under new regulations effective this year, CMS broadened the definition of a "primarily health-related" benefit^{13,14} to include those that "diagnose, prevent, or treat an illness or injury; compensate for physical impairments; act to ameliorate the functional/psychological impact of injuries or health conditions; or reduce avoidable emergency and healthcare utilization." ¹⁷⁵

CMS also lifted a ban on services for daily maintenance (e.g., maid services, smoke detectors, or massages) and on supplemental benefits covering long-term services and supports (e.g., inhome assistance, services to family caregivers).¹⁶

Thus, while supplemental benefits must still focus directly on an enrollee's health care needs, as of 2019, MA plans can cover a wider range of benefits such as: adult day care¹⁷, in-home personal care attendants¹⁸, support for beneficiaries' family caregivers¹⁹, home safety and assistive devices²⁰ (e.g., portable wheelchair ramps), non-opioid pain treatment alternatives (e.g., massages), and memory fitness services.²¹ CMS has provided MA insurers with limited guidance on what some of the newly allowable benefits can cover. However, in general, CMS' process for supplemental benefits is not

prescriptive and insurers must typically propose specific benefit offerings for CMS' approval.²²

Allow special benefits for people with chronic diseases. The Budget Act partially lifts the requirement that supplemental benefits be primarily health related in other ways. Starting in 2020, MA plans will be allowed to offer enrollees with a chronic illness²³ supplemental benefits that are not healthrelated—as long as the benefit has "a reasonable expectation of improving or maintaining" the enrollees' "health or overall function." With this new policy, MA plans can offer chronically ill enrollees supplemental benefits that provide "social supports"²⁴ or address social determinants of health²⁵. In theory, these could include benefits such as ride-hailing nonmedical transportation, home-delivered hot meals, airconditioners, in-home help with bathing and dressing, minor home repairs²⁶, or supervised housing.²⁷

Allow insurers to tailor supplemental benefits to enrollees. In the past, MA insurers were required to cover the same supplemental benefits for all enrollees in a service area²⁸ and to charge the same premium and cost sharing to all enrollees²⁹—a requirement known as the "uniformity rule."30 CMS' regulations for plan year 2019 and beyond relax this requirement to allow insurers to offer targeted benefits: MA plans may now offer different supplemental benefits and charge reduced cost-sharing to enrollees with a diagnosed medical condition³¹, as long as all enrollees with that condition are offered the same benefits and cost-sharing.³² For example, an MA plan could decide to cover more frequent foot exams, reduce cost-sharing for endocrinologist visits or offer a lower deductible only for enrollees with diabetes. However, CMS continues to require that MA insurers charge the same premium to all enrollees in the plan.³³

In addition, the Budget Act gives the Secretary of Health and Human Services (HHS) the authority to waive the uniformity requirement altogether in the case of non-health related supplemental benefits for enrollees with a chronic condition, starting in 2020. Under this new flexibility, MA plans can offer each chronically ill enrollee different supplemental benefits tailored to their specific medical condition and needs.³⁴

New Categories of Supplemental Benefits

As a result of these various policy changes, beginning in 2020, there will be three different categories of supplemental benefits:³⁵

- *Standard*—offered to all enrollees, must be health-related.
- Targeted—offered only to qualifying enrollees with a diagnosed medical condition, must be health-related, and
- Chronic—offered only to qualifying enrollees with a chronic illness, does not have to be health-related.

AN IN-DEPTH LOOK AT MEDICARE ADVANTAGE PLANS' SUPPLEMENTAL BENEFITS OFFERINGS IN 2019

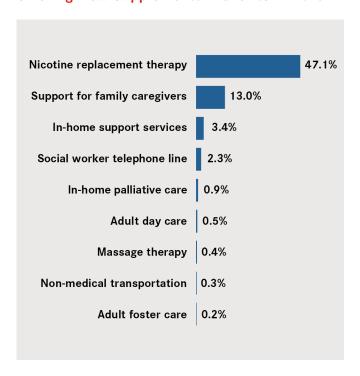
To understand how insurers are responding to these new policies, we examined supplemental benefits included in MA plans for 2019. Our analysis is based on data from the first year that CMS' new regulations are in effect, and gives us an important initial look at where MA plans may be headed.

In 2019, Medicare Advantage Plans Include Few New Benefits

This year, only a small fraction of all MA plans offer newly allowed supplemental benefits (Figure 1). The only exception to this finding is a new nicotine replacement therapy benefit that almost half of all MA plans are covering in 2019. The share of MA plans covering other new supplemental benefits is significantly smaller. The second most commonly covered type of new benefit is support for family caregivers³⁶ (e.g. respite care, which could include counseling and training courses), which is covered by 13 percent of MA plans; followed by in-home support services (e.g. housekeeping, personal care services³⁷), which are covered by 3 percent of plans; and by social worker telephone lines, which are covered by 2 percent of plans.

A much smaller share of plans offered other new benefits this year. In fact, out of six new supplemental benefits that CMS explicitly called out in guidance to insurers last year³⁸, four are covered by less than 1 percent of MA plans (in-

FIGURE 1
Percentage of Medicare Advantage Plans
Offering New Supplemental Benefits in 2019



home palliative care, adult day care, massage therapy and memory fitness).

A likely reason why few plans include new supplemental benefits this year is that CMS announced its changes to MA regulations only a short time before insurers were required to submit their 2019 plan bids. Any more significant changes in supplemental benefits are likely to appear in 2020, when policy changes included in the Budget Act take effect. We will monitor how MA plans implement these changes and plan to publish an analysis of the supplemental benefits that plans offer in 2020.

New Supplemental Benefits Are Only Available in Some Areas for 2019

Our analysis also shows that some of the new supplemental benefits offered by a very small percentage of MA plans (e.g., in-home support services, social worker telephone lines) were only available in a few counties (Figure 2). However, despite being covered by only a little more than

METHODS

Our findings are based on Medicare Advantage (MA) plan data that include information on each plan's supplemental benefits and service area. We identified MA plans with coverage for new supplemental benefits this year based on the 2019 MA Landscape Source File.³⁹ Our analysis excludes PACE, Part B Only Plans, and employer-sponsored plans since they are not represented in the MA Landscape files. To calculate the share of plans offering a given supplemental benefit, we merged information from the 2019-Quarter 1 Plan Benefit Package file⁴⁰ (PBP) into the MA Landscape file. The PBP file contains all benefits approved by CMS for plans sold in 2019. For 2017, we identified MA plans using the 2017 MA/Part D Contract and Enrollment "Monthly Enrollment by Plan" file⁴¹ for the month of December. The information on supplemental benefits included in MA plans sold in 2017 came from the 2017 Plan Benefit Package file.⁴²

1 in every 10 plans, new supplemental benefits that cover support services for family caregivers were available in many places across the country. This is because service areas for many of the plans with this supplemental benefits span several counties.

An Increase in Expanded Benefits That Were Already Allowed before 2019

Some of the supplemental benefits offered this year under the new rules were already allowed before 2019, but under more limited circumstances. For example, MA plans could cover meals, but only for a limited time and only if a clinician ordered the meals for an enrollee with a recent hospital stay or surgery. Similarly, MA plans could cover home safety devices, but only if they were located in a bathroom. We regulations for 2019 and beyond lifted those types of restrictions. In addition, the new regulations expanded some pre-existing supplemental benefits to cover more services.

Our analysis shows a significant growth in these types of benefits that MA plans could already cover before 2019 (Figure 3). For example, before 2019, only 36 percent of plans covered over-the-counter (OTC) benefits, which at the time included non-prescription medicines and items like bandages. Now under the new rules, 63 percent of all plans include coverage for this type of benefit, which was expanded to include items such as pill cutters, pill crushers, pill bottle openers, and personal electronic activity trackers.

WHAT ARE THE IMPLICATIONS FOR MEDICARE BENEFICIARIES?

The changes in public policies that govern MA supplemental benefits could have significant implications for Medicare beneficiaries—both positive and negative.

Policy Changes May Provide Access to Important Benefits and More Comprehensive Care

Should insurers choose to use the new flexibility to offer supplemental benefits, MA enrollees could have access to insurance coverage for important services and items that was previously unavailable. The new policies could also mean that MA plans are able to more fully respond to individual Medicare beneficiaries' needs—for example by addressing enrollees' social and functional needs. Experts have long recognized that people's medical conditions and health outcomes can drastically improve with certain types of non-medical support, such as long-term services and supports, family caregiver support services or interventions that address social determinants of health. 45,46,47 The new MA rules could steer MA plans toward adopting a more inclusive view of what matters to MA enrollees' health. For example, MA plans could cover fall prevention benefits such as ramps or grab bars to reduce the risk of serious injuries often associated with falls. Or, recognizing the importance of nutrition on people's health, MA plans could chose to cover meals as a supplemental benefit.

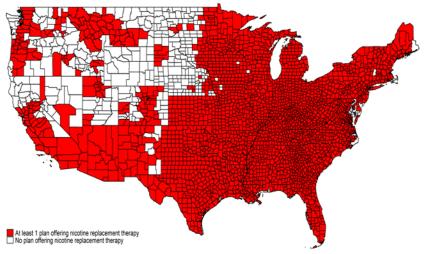
The new policies also recognize that family caregivers play a critical role in maintaining or

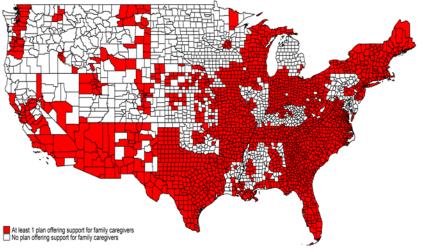
JULY 2019

FIGURE 2

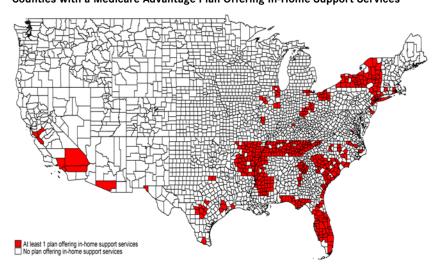
Counties Where the Four Most Common New Supplemental Benefits Are Sold, 2019*



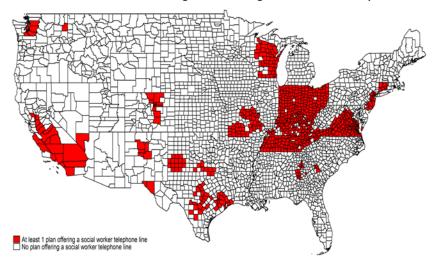




Counties with a Medicare Advantage Plan Offering In-Home Support Services



Counties with a Medicare Advantage Plan Offering a Social Worker Telephone Line

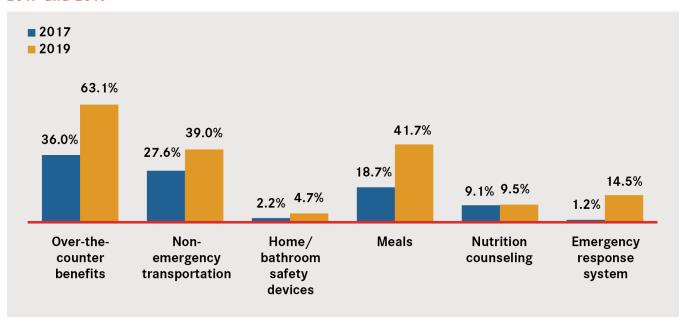


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^{*}Alaska and Hawaii are not shown.

FIGURE 3

Percentage of Medicare Advantage Plans Offering Previously Allowed Supplemental Benefits, 2017 and 2019



improving their loved one's health. Family caregivers are instrumental in allowing enrollees to remain at home and in preventing or reducing premature nursing home placements and hospital readmissions. Under prior rules, MA plans were not allowed to cover benefits that directly support family caregivers and were only limited to providing family caregivers with educational information.⁴⁸ Under the expanded reinterpretation of what qualifies as "primarily health-related," MA plans can include coverage for people caring for MA enrollees, such as short-term respite care, which could include counseling and training courses for family caregivers.

Finally, much of the new flexibility with supplemental benefits is intended to help MA plans improve care for people with chronic illnesses. A key incentive for insurers is the ability to target benefits to people in this group, without having to provide the same potentially expensive coverage to all enrollees in the plan. Two thirds of people with Medicare have two or more chronic conditions. ⁴⁹ Beneficiaries with multiple chronic conditions could have better health outcomes and improved quality of life if increased supplemental benefit flexibilities

means that MA plans can more effectively manage their care. In turn, this could also reduce Medicare spending for a group that is significantly more costly than people without chronic conditions.⁵⁰

The New Policies Also Raise Potential Challenges for Medicare Beneficiaries

Second, insurers' ability to target benefits to certain enrollees could mean that consumers have a harder time figuring out exactly what their MA plan covers—especially if there is a lack of transparency about benefit eligibility. What's more, consumers also run the risk of choosing a plan based on a supplemental benefit they may not be eligible for if insurers market and advertise new supplemental benefits to all prospective enrollees—while, in reality, they are only available to some.

Third, while MA plans are required to comply with non-discrimination requirements, there is a potential that greater flexibility to tailor supplemental benefits could allow insurers to design benefit packages to attract relatively lower-cost beneficiaries—leaving less healthy and more costly beneficiaries with fewer coverage options.

All these potential concerns are compounded by the fact that, so far, CMS has provided only very limited guidelines on how insurers can market or communicate to enrollees about the new supplemental benefits. At this point, there are no clear prohibitions on marketing or communications and no detailed guidance to prohibit improper steering of consumers into certain MA plans.

An Opportunity to Include Comparable Innovations for People with Traditional Medicare

More broadly, in the long term, changes in MA supplemental benefits could affect the entire Medicare program. Under current law, traditional Medicare cannot offer popular supplemental benefits such as dental and vision that have long been available under MA—although beneficiaries enrolled in traditional Medicare can purchase coverage for these benefits on their own. The changes in supplemental benefits policies do not affect traditional Medicare, and new and targeted benefits are only available to people with Medicare Advantage. Policymakers should explore innovative ways to encourage similar types of improvements in coverage for the two thirds of beneficiaries who have opted for traditional Medicare.

Keeping an Eye on the Magnitude of the Changes for Consumers

It is up to insurers to decide the extent to which they will respond to the rule changes and which newly permitted supplemental benefits they will offer. While MA plans can now include a much wider range of supplemental benefits and have significantly more flexibility to offer targeted benefits, the new public policies do not require insurers to implement either of those changes. In the past, relatively few insurers chose to offer supplemental benefits related to the newly allowable ones⁵¹, even though they were permitted under certain circumstances (e.g., in-home safety assessments, transportation, meals, bathroom safety devices).52 In addition, insurers will also have to decide which health conditions to focus on, for the new targeted supplemental benefits and for benefits offered to enrollees with a chronic condition.

POLICY RECOMMENDATIONS

Given uncertainties around how insurers will respond to the new supplemental benefit

flexibilities, it is critical that CMS provide active oversight as MA plans implement the new policies and closely monitor any changes in supplemental benefits offerings. Specifically, CMS should:

- Increase oversight of non-discrimination requirements to ensure that insurers do not use new supplemental benefit flexibility to design plans in a discriminatory manner, attempt to attract more financially advantageous enrollees, or steer enrollees into certain plans.
- Ensure that MA plans use new supplemental benefit flexibility to provide meaningful coverage and such benefits are not simply used as a marketing advantage to attract additional enrollees.
- Encourage insurers to offer supplemental benefits that are informed by best practices (e.g., from Medicaid managed care) or that have been shown to improve care and health outcomes in other settings.
- Provide marketing and advertising guidelines to ensure that plan marketing materials minimize consumer confusion and clearly specify which enrollees are eligible for new supplemental benefits and provide clear information about limitations on such benefits.
- Ensure that State Health Insurance Assistance Programs (SHIPs) and other trusted sources for Medicare beneficiaries have the necessary information to answer consumers' questions about changes to supplemental benefits.
- Consider similar innovations within traditional Medicare to encourage access to comparable benefits for all Medicare beneficiaries.

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APPENDIX. RECENT CHANGES IN PUBLIC POLICIES GOVERNING MEDICARE ADVANTAGE SUPPLEMENTAL BENEFITS

| | CMS Policy Prior to Changes | New CMS Policy/Law | | | |
|--|---|--|---|--|--|
| | Medicare Managed Care Manual, Chapter 4 (Revision 121) ¹ | 2019 Medicare Advantage and Part D Final Rate Notice and Call Letter ² | Contract Year 2019 Policy and Technical Changes to the Medicare Advantage Program ³ | Bipartisan Budget Act of 2018 ⁴ | |
| Date Issued/Enacted | Last revision 04/22/2016 | 04/02/2018 | 04/16/2018 | 02/09/2018 | |
| Effective Year | For 2018 plans and prior | For 2019 plans and beyond | For 2019 plans and beyond | For 2020 plans and beyond | |
| Meaning of Primarily Health Related Supplemental Benefits | All enrollees: Item or service must prevent, cure or diminish an illness or injury. Explicitly excludes items or services whose purpose is comfort, cosmetic, or daily maintenance. | All enrollees: Item or service must do either of the following: Diagnose, prevent, or treat an illness or injury Compensate for physical impairments Ameliorate the functional/psychological impact of injuries or health conditions Reduce avoidable emergency and healthcare utilization Suggests that item or service may: Enhance beneficiaries' quality of life Improve health outcomes Explicitly includes items or services with a significant purpose of daily maintenance (e.g. fall prevention devices). Excludes items or services used for cosmetic, comfort, general use, or social determinant purposes.⁵ | • Not specified | No explicit definition Enrollees with chronic illnesses: Item or service must have a reasonable expectation of improving or maintaining health or overall function No explicit definition The provided service must have a reasonable expectation of improving or maintaining health or overall function | |
| Supplemental Benefits That Are Not <i>Primarily</i> Health Related | Not permitted | Not addressed | Not addressed | Permitted for enrollees with chronic illnesses | |

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| | CMS Policy Prior to Changes | New CMS Policy/Law | | |
|--|--|---|---|--|
| | Medicare Managed Care Manual, Chapter 4 (Revision 121) ¹ | 2019 Medicare Advantage and Part D Final Rate Notice and Call Letter ² | Contract Year 2019 Policy and Technical Changes to the Medicare Advantage Program ³ | Bipartisan Budget Act of 2018 ⁴ |
| Uniformity Requirement for Supplemental Benefits | Requires uniformity: Insurers must offer the same supplemental benefits to all enrollees and are prohibited from varying premiums or cost-sharing between MA plan enrollees. | Relaxes uniformity requirement: Insurers may offer different supplemental benefits and impose different cost-sharing to enrollees with different diagnosed medical conditions so long as all enrollees with a given condition are offered the same benefits and cost- sharing. ⁶ | Relaxes uniformity requirement: Insurers may offer different supplemental benefits and impose different cost-sharing to enrollees with different diagnosed medical conditions so long as all enrollees with a given condition are offered the same benefits and cost-sharing. ⁶ | Allows waiver of uniformity requirement: Insurers may waive uniformity requirement for enrollees with chronic illnesses. MA plans may tailor supplemental benefits to individual chronically ill enrollee's specific medical condition.⁷ |
| Geographic <i>Uniformity</i> | Requires benefit uniformity across segments: MA plans with multiple segments in their service area can vary premiums and cost-sharing but not supplemental benefits across segments. | Relaxes uniformity across segments: MA plans with multiple segments in their service area can vary premiums, cost-sharing and supplemental benefits across segments. Insurers are prohibited from varying premiums across a non-segmented plan's service area. | Relaxes uniformity across segments: MA plans with multiple segments in their service area can vary premiums, cost-sharing and supplemental benefits across segments. Insurers are prohibited from varying premiums across a non-segmented plan's service area. | Not addressed |

¹ Available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86co4.pdf

² Available at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents-Items/2019Announcement.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending

³ Available at: https://www.federalregister.gov/documents/2018/04/16/2018-07179/medicare-program-contract-year-2019-policy-and-technical-changes-to-the-medicare-advantage-medicare

 $^{^4 \} Available \ at: \ \underline{https://www.congress.gov/bill/115th-congress/house-bill/1892?q=\%7B\%22search\%22\%3A\%5B\%22bipartisan+budget+act+of+2018\%22\%5D\%7D\&r=12018\%22\%3A\%5B\%22bipartisan+budget+act+of+2018\%22\%5D\%7D\&r=12018\%22\%3A\%5B\%22bipartisan+budget+act+of+2018\%22\%5D\%7D\&r=12018\%22\%3A\%5B\%22bipartisan+budget+act+of+2018\%22\%5D\%7D\&r=12018\%22\%3A\%5B\%22bipartisan+budget+act+of+2018\%22\%5D\%7D\&r=12018\%22\%5D\%7D\%22\%5D\%7D\&r=12018\%22\%5D\%7D\&r=12018\%22\%5D\%7D\%22\%5D\%7D\%22\%5D\%22\%5D\%7D\%22\%5D\%7D\%22\%5D\%7D\%22\%5D\%7D\%22\%5D\%7D\%22\%5D\%22\%5D\%7D\%22\%5D\%7D\%22\%5D\%7D\%22\%5D\%7D\%22\%5D\%7D\%22\%5D\%7D\%22\%5D\%7D\%22\%5D\%7D\%22\%5D\%7D\%22\%5D\%7D\%22\%5D\%7D\%22\%5D\%7D\%22\%5D\%7D\%22\%5D\%22\%5D\%7D\%22\%5D\%7D\%22\%5D\%7D\%22\%5D\%20\%20$

⁵ Clarified in CMS memo to Medicare Advantage Organizations and Section 1876 Cost Contract Plans, Reinterpretation of "Primarily Health Related" for Supplemental Benefits, April 27, 2018.

⁶ Under this interpretation of the uniformity requirement, supplemental benefits must be related to the beneficiary's medical condition.

⁷ As specified in Contract Year 2019 Policy and Technical Changes to the Medicare Advantage Program Final Rule, p16481.

- 1 Medicare Advantage (MA) is also called Medicare Part C. 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. Many MA plans also include Medicare prescription drug coverage (Part D).
- 2 Traditional Medicare is also called Original or fee-for-service Medicare.
- 3 Claire Noel-Miller and Jane Sung, "Supplemental Benefits Under Medicare Advantage An In Depth Look at What They Are Today", AARP Public Policy Institute, December 2018. https://www.aarp.org/ppi/info-2019/supplemental-benefits-under-medicare-advantage.html
- 4 MA and traditional Medicare coverage differ in other significant ways: (1) People with traditional Medicare can receive covered services from any health care provider that accepts Medicare, whereas most MA enrollees are subject to their plan's provider network requirements, (2) MA plans must limit enrollees' total out-of-pocket spending on deductibles, co-payments and co-insurance (cost-sharing), (3) premiums and cost-sharing obligations are fixed for all beneficiaries in traditional Medicare whereas each MA plan has its own cost-sharing structure and service costs (subject to certain limitations).
- 5 Enacted Feb. 9, 2018. (Accessible at: https://bit.ly/2P41nMv). The Budget Act includes provisions of the Creating High Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act.
- 6 Outlined in the 2019 Medicare Advantage and Part D Rate Announcement and Call Letter (Issued on April 4th 2018. Accessible at: 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 16th 2018. Accessible at: https://bit.lv/2qF6d7U).
- 7 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.
- 8 Jacobson G., Damico A., and Neuman T., "A Dozen Facts About Medicare Advantage", Data Note, Kaiser Family Foundation, November 13, 2018. Accessible at: https://bit.ly/2ROJbYO
- 9 The 2018 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, Table IV.C1. Accessible at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2018.pdf

- 10 Claire Noel-Miller and Jane Sung, "Supplemental Benefits Under Medicare Advantage An In Depth Look at What They Are Today", AARP Public Policy Institute, December 2018. https://www.aarp.org/ppi/info-2019/supplemental-benefits-under-medicare-advantage.html
- 11 CMS also requires that (1) MA plans incur a medical cost for the supplemental benefits they cover and (2) supplemental benefits be medically necessary healthcare benefits.
- 12 Medicare Managed Care Manual, Chapter 4, Section 30.1 "Definition of Supplemental Benefits", accessed at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf on 8/12/2018.
- 13 2019 Medicare Advantage and Part D Final Rate Notice and Call Letter. Accessible at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents-Items/2019Announcement.html?DLPage=1
 &DLEntries=10&DLSort=2&DLSortDir=descending
- 14 CMS memo to Medicare Advantage Organizations and Section 1876 Cost Contract Plans, Reinterpretation of "Primarily Health Related" for Supplemental Benefits, April 27, 2018. Available at: https://bit.ly/2ExcSZR
- 15 The supplemental benefit must be medically appropriate. In addition, a licensed clinician must recommend the supplemental benefit as part of a care plan or alternatively, they must directly provide the service. CMS also suggests that the supplemental benefit may be time-limited, enhance beneficiaries' quality of life and improve health outcomes.
- 16 Under the new rules, CMS excludes items or services used for cosmetic, comfort, general use, or social determinant purposes. Clarified in CMS memo to Medicare Advantage Organizations and Section 1876 Cost Contract Plans, Reinterpretation of "Primarily Health Related" for Supplemental Benefits, April 27, 2018.
- 17 In a memo to insurers CMS cited the following as examples of services that a beneficiary can receive at adult day care: help with activities of daily living (e.g. eating, dressing, bathing), physical rehabilitation activities, social work services geared toward improving the beneficiary's physical or mental health, recreational and social activities that support health related services. MA plans can also include transportation to and from the adult day care facility. CMS requires that adult day care staff meet their state's licensing requirements. CMS memo to Medicare Advantage Organizations and Section 1876 Cost Contract Plans, Reinterpretation of "Primarily Health Related" for Supplemental Benefits, April 27, 2018. Available at: https://bit.ly/2ExcSZR
- 18 In a memo to insurers, CMS specified that in-home workers can assist beneficiaries who have difficulties performing activities of daily life such as eating, dressing or walking. Or they can provide personal services that improve the physical and psychological impact of an illness or injury. In-home

- workers must hold a license to provide personal care in their state. CMS memo to Medicare Advantage Organizations and Section 1876 Cost Contract Plans, Reinterpretation of "Primarily Health Related" for Supplemental Benefits, April 27, 2018. Available at: https://bit.ly/2ExcSZR
- 19 In a memo to insurers CMS cited the following as examples of family caregiver support services: short-term respite care (through a personal care attendant or short-term institutional-based care, as appropriate), family caregiver counseling, and training courses. CMS memo to Medicare Advantage Organizations and Section 1876 Cost Contract Plans, Reinterpretation of "Primarily Health Related" for Supplemental Benefits, April 27, 2018. Available at: https://bit.ly/2ExcSZR
- 20 CMS guidelines expand allowable safety devices to items located throughout the house and not only in the bathroom, as was the case before 2019. Other examples of such items are: stair rails, grab bars, raised toilet seats, temporary mobility ramps, night lights, and stair treads. Smoke detectors and fire alarms are excluded.
- 21 CMS memo to Medicare Advantage Organizations and Section 1876 Cost Contract Plans, Reinterpretation of "Primarily Health Related" for Supplemental Benefits, April 27, 2018. Available at: https://bit.ly/2ExcSZR
- 22 In future work, we may interview plans to find out the exact benefits they cover.
- 23 Defined as enrollees (1) with at least one complex chronic condition that is life threatening or significantly limits overall health or function, (2) at high risk of hospitalization or other adverse health outcomes, and (3) who require intensive care coordination.
- 24 As specified in *Contract Year 2019 Policy and Technical Changes to the Medicare Advantage Program Final Rule*, p. 16483. Accessible at: https://bit.ly/2qF6d7U).
- 25 Social determinants of health are conditions in the places where people live, learn, work, and play that can affect a wide range of health risks and outcomes (e.g. income, housing stability, neighborhood safety, education level).
- 26 Non-health related supplemental benefits can include structural improvements to the enrollee's home that would increase the property's value (e.g., permanent ramps, wider doorways or hallways).
- 27 Contract Year 2019 Policy and Technical Changes for Medicare Advantage and the Prescription Drug Benefit Program Rule. Accessible at: https://bit.ly/2qF6d7U).
- 28 In a small number of cases, MA plans could or had to target supplemental benefits to plan enrollees with a certain health profile. For example, MA plans that offered enhanced disease management services (e.g., assigned case manager, disease monitoring, or educational activities) as a supplemental benefit, were required to target those services

- to enrollees with or at risk for a specific condition, such as diabetes, heart failure, or dementia.
- 29 MA plans with multiple segments in their service area could vary premiums and cost sharing (but not supplemental benefits) across segments.
- 30 Medicare Managed Care Manual, Chapter 4, Section 10.5.1, "Uniformity," https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf.
- 31 MA insurers choose the health conditions for which they will vary supplemental benefits and/or cost sharing and must develop criteria to determine whether an enrollee is eligible for such benefits.
- 32 The new tailored supplemental benefits and lower costsharing must be for benefits that are directly related to the enrollees' medical condition. MA plans can reduce enrollees' cost-sharing only for a subset of "high quality providers". Insurers can also choose to limit such targeted benefits to enrollees who participate in a plan sponsored wellness or care management program.
- 33 Starting in 2019, MA plans with multiple segments in their service area can vary their supplemental benefits across segments in addition to already being able to vary premiums and cost-sharing.
- 34 Specified in *Contract Year 2019 Policy and Technical Changes* to the Medicare Advantage Program Final Rule, p. 16481.
- 35 Contract Year 2019 Policy and Technical Changes for Medicare Advantage and the Prescription Drug Benefit Program Rule. Accessible at: https://bit.ly/2qF6d7U).
- 36 For example, according to United Health group, the "Solutions for Caregivers" benefit available in 2019 to nearly all United Healthcare's Medicare Advantage plans, included the following: telephonic coaching/support, access to personalized research and identification of caregiver resources, and geriatric care case manager services for one in-person assessment or up to 6 hours of telephonic caregiver consultation per year. Accessed at https://www.united healthgroup.com/newsroom/2018/2018-10-1-united healthcare-medicare-plan-value.html
- 37 For example, for 2019 Anthem offered a variety of benefit packages in several states that included benefits such as: a limited number of home-delivered meals, transportation to health-related appointments, a limited number of hours of in-home support, an allowance for home safety devices, a limited number of hours for adult day services, and/ or limited acupuncture or therapeutic massage visits. See "What a Medicare Advantage Personal Care Benefit Looks Like", by Howard Gleckman, Forbes, October 5, 2018, accessible at https://www.forbes.com/sites/howardgleckman/2018/10/05/what-a-medicare-advantage-personal-services-benefit-looks-like/#77863c016066

SUPPLEMENTAL BENEFITS IN MEDICARE ADVANTAGE

- 38 Adult day care, in-home palliative care, in-home support services, support for family caregivers, non-opioid pain management such as massage therapy, memory fitness.
- 39 Available at: https://go.cms.gov/2Bcazts
- 40 Available at: https://go.cms.gov/2DN1LvA
- 41 Available at: https://go.cms.gov/2Wu5wO1
- 42 Available at: https://go.cms.gov/2DLm6RP
- 43 In certain cases, MA plans could also cover meals that enrollees needed because of a chronic condition.
- 44 MA plans could also include an in-home bathroom safety inspection as long as it was conducted by a qualified health professional.
- 45 Artiga S. and Hinton E., "Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity", Issue Brief, Kaiser Family Foundation, May 10, 2018. Accessible at: https://bit.ly/2xUpd3U
- 46 Super N., Kaschak M., and Blair E., "Health Care And Community-Based Organizations Have Finally Begun Partnering To Integrate Health And Long-Term Care", Health Affairs Blog, Health Affairs, February 2, 2018. Accessible at: https://bit.ly/2E4ERxD

- 47 National Academies of Sciences, Engineering, and Medicine. Families Caring for an Aging America (Washington, DC: 2016).
- 48 Medicare Managed Care Manual, Chapter 4, Section 30.1 "Definition of Supplemental Benefits", accessed at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf on 8/12/2018.
- 49 Centers for Medicare & Medicaid Services (CMS) "Chronic Conditions Charts", Figure 5: Prevalence of Multiple Chronic Conditions among Fee-for-Service Beneficiaries: 2015. Accessible at: https://go.cms.gov/2zlb6qr
- 50 Erdem E., Prada S. I., Haffer, S. C., "Medicare Payments: How Much Do Chronic Conditions Matter?", Medicare & Medicaid Research Review, 2013, Volume 3(2): E1-E15. Accessible at: https://www.cms.gov/mmrr/Downloads/MMRR2013_003_02_b02.pdf
- 51 Claire Noel-Miller and Jane Sung, "Supplemental Benefits Under Medicare Advantage An In Depth Look at What They Are Today", AARP Public Policy Institute, December 2018. https://www.aarp.org/ppi/info-2019/supplemental-benefits-under-medicare-advantage.html
- 52 Some MA plans have stated that the requirement to offer the same supplemental benefits to all enrollees created financial challenges.

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