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January 2023

MEDICARE ADVANTAGE

Plans Generally Offered Some Supplemental Benefits, but CMS Has Limited Data on Utilization

GAO-23-105527

GAO Highlights

Highlights of GAO-23-105527, a report to congressional committees

January 2023

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Why GAO Did This Study

MA plans decide which, if any, supplemental benefits to offer. These benefits may be attractive to Medicare beneficiaries, but little is known about their use.

The Bipartisan Budget Act of 2018 includes a provision for GAO to review supplemental benefits. Among other things, this report describes the supplemental benefits offered by MA plans in 2022 and examines the information that CMS has on enrollees' use of supplemental benefits and their effects on enrollees' health and function.

GAO analyzed plan benefit data for 3,893 MA plans in the 50 states and District of Columbia. GAO excluded certain plans, such as plans participating in the Value-Based Insurance Design Model and employer plans, to ensure comparability between plans. GAO also reviewed CMS regulations and guidance and interviewed officials from CMS and six MA organizations selected based on enrollment, geographic coverage, and other factors.

What GAO Recommends

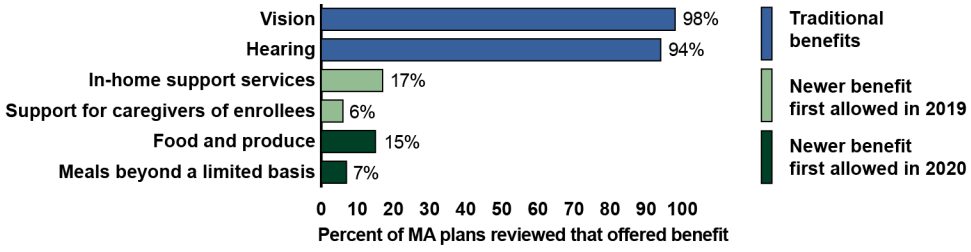
GAO is making two recommendations to CMS: (1) clarify guidance on the extent to which encounter data submissions must include data on the utilization of supplemental benefits and (2) address circumstances where submitting encounter data for supplemental benefits is challenging for MA plans, such as when a given benefit lacks an applicable procedure code. The Department of Health and Human Services concurred with the recommendations.

View GAO-23-105527. For more information, contact Michelle B. Rosenberg at (202) 512-7114 or RosenbergM@gao.gov.

What GAO Found

Under Medicare Advantage (MA), a private plan option in Medicare, plans can offer supplemental benefits not covered under Original Medicare. Supplemental benefits have long included traditional health-related benefits. In 2022, all but one plan reviewed by GAO offered at least one such benefit; the most common were vision and hearing. (See figure.) MA plans can also offer two newer types of benefits. First, starting in 2019, plans could offer benefits intended to reduce avoidable health care use, among other things. Second, starting in 2020, plans could offer benefits with a reasonable expectation of improving or maintaining the health or function of chronically ill enrollees. In 2022, about one-third of plans reviewed offered at least one of the newer types of benefits; the most common were in-home support services and food and produce.

Most Common Supplemental Benefits, by Type, Offered by Medicare Advantage (MA) Plans Reviewed, 2022



Source: GAO review of Centers for Medicare & Medicaid Services data. | GAO-23-105527

MA plans are required to submit detailed, service-level utilization data to the Centers for Medicare & Medicaid Services (CMS), the agency that oversees MA. These data—known as encounter data—must include supplemental benefits to the extent required by CMS. However, GAO found that information submitted by plans on enrollees' use of supplemental benefits is limited for two reasons:

- CMS guidance on encounter data does not specifically mention the submission of such data for supplemental benefits, although it says plans must submit encounter data for each benefit provided to an enrollee. CMS officials told GAO that the inclusion of supplemental benefits in this requirement is clear, noting the guidance does not differentiate between supplemental and Original Medicare benefits. However, officials from three MA organizations told GAO they are not required to submit encounter data for some or all supplemental benefits and therefore do not do so.
- Officials from CMS and two MA organizations told GAO there are challenges collecting and submitting encounter data for certain supplemental benefits. For example, officials said there is no procedure code for some of the newer supplemental benefits, such as food and produce.

As of October 2022, CMS was in the early stages of assessing the completeness of the encounter data for supplemental benefits and identifying options for collecting enrollee utilization data for the newer benefits but did not have a workplan or timeline for next steps. More complete information on enrollees' use of supplemental benefits would put CMS in a stronger position to ensure the benefits effectively support the health and social needs of enrollees.

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Abbreviations

CMS	Centers for Medicare & Medicaid Services
MA	Medicare Advantage
SNP	special needs plan
SSBCI	Special Supplemental Benefits for the Chronically Ill
VBID	Value-Based Insurance Design

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January 31, 2023

Chair
Ranking Member
Committee on Finance
United States Senate

The Honorable Cathy McMorris Rodgers
Chair
The Honorable Frank Pallone, Jr.
Ranking Member
Committee on Energy and Commerce
House of Representatives

The Honorable Jason Smith
Chair
The Honorable Richard Neal
Ranking Member
Committee on Ways and Means
House of Representatives

In April 2022, about 49 percent of eligible Medicare beneficiaries (28.81 million beneficiaries) were enrolled in Medicare Advantage (MA), a private plan alternative to Original Medicare, and that percentage is projected to exceed 50 percent by 2023.[1] MA plans have long been able to offer additional or supplemental benefits not covered under Original Medicare, including coverage for dental, vision, and hearing.[2] More recently, MA plans were allowed to offer two newer types of supplemental benefits. First, starting in 2019, plans could offer benefits intended to ameliorate the effect of injuries or health conditions or reduce avoidable health care

[1]Under Original Medicare, the Centers for Medicare & Medicaid Services (CMS) pays claims for health care services directly to health care providers. In contrast, CMS pays MA plans a fixed monthly payment per enrollee to provide health coverage no matter how many services are provided or how much those services cost.

[2]In general, MA plans must offer all benefits covered under Original Medicare and can choose whether, and to what extent, to offer supplemental benefits. In addition, MA plans may also offer other enhancements not covered by Original Medicare. These include the extension of Original Medicare benefits (such as covering additional skilled nursing facility days), reductions in cost-sharing (such as copayments) for Original Medicare benefits, or reductions in premiums. These other enhancements are outside the scope of this report.

use, among other things.[3] For example, plans could offer support for caregivers of enrollees as a supplemental benefit. Second, starting in 2020, plans could offer benefits that had a reasonable expectation of improving or maintaining the health or function of chronically ill enrollees. For example, transportation for non-medical needs (e.g., to a grocery store or a bank) was among the newer supplemental benefits that plans could offer. The intended purpose of this type of benefit was, in part, to enable MA plans to address gaps in care and improve health outcomes for chronically ill enrollees.[4]

MA plans may offer supplemental benefits, in part, to differentiate themselves from Original Medicare or other MA plans. Plans have flexibility in determining what supplemental benefits they offer. Plans must submit information on plan benefits each year to the Centers for Medicare & Medicaid Services (CMS), which is the agency within the Department of Health and Human Services that oversees the MA program, for review and approval. This information includes the supplemental benefits that plans are offering, whether they are offering a given benefit to all enrollees or targeting the benefit at certain subgroups of enrollees (such as chronically ill enrollees), and how they are financing those benefits.

Supplemental benefits may be attractive to beneficiaries and may contribute to the growing enrollment in MA. However, little is known about the extent to which MA enrollees are using supplemental benefits and the extent to which the benefits are serving their intended purpose. The Bipartisan Budget Act of 2018 includes a provision for us to review MA supplemental benefits.[5] This report

1. describes the supplemental benefits offered by MA plans in 2022,
2. describes MA plans' projected costs for supplemental benefits in 2022 and how plans expected to finance them, and

[3]See Centers for Medicare & Medicaid Services, Medicare Drug & Health Plan Contract Administration Group, *Reinterpretation of "Primarily Health Related" for Supplemental Benefits* (Baltimore, Md.: Apr. 27, 2018).

[4]See Centers for Medicare & Medicaid Services, Medicare Drug & Health Plan Contract Administration Group, *Implementing Supplemental Benefits for Chronically Ill Enrollees* (Baltimore, Md.: Apr. 24, 2019).

[5]Pub. L. 115–123, § 50322(b), 132 Stat. 64, 201–02.

3. examines the information that CMS has on enrollees' use of supplemental benefits and their effects on enrollees' health and function.

To describe the supplemental benefits offered by MA plans in 2022, we analyzed the plan benefit data submitted to CMS for 2022 and enrollment data as of April 2022, which were the most recent data at the time of our analysis.[6] We focused on mandatory supplemental benefits for which enrollees receive coverage by default of being enrolled in the plan.[7] We analyzed data for 3,893 MA plans in the 50 states and District of Columbia for each of 63 supplemental benefits reviewed.[8] Our analysis included special needs plans (SNP), which provide care for beneficiaries in one of three classes of special needs such as having a severe or chronic condition.[9] To ensure comparability between plans, we excluded Medicare-Medicaid Plans, Program of All-Inclusive Care for the Elderly plans, Cost plans, plans that did not offer prescription drug benefits, plans participating in the Value-Based Insurance Design (VBID) Model, and employer plans.[10] The plans included in our analysis had total enrollment

[6]We analyzed the second quarter Plan Benefit Package data for 2022, which is the first version that contains information on the full range of supplemental benefits offered by each plan, as approved by CMS.

We use "plan" to refer to each unique set of benefits submitted by an MA organization (the legal entity that has a contract with the Medicare program to provide coverage) for a specific geographic region. A plan can offer a specific benefit to all enrollees or to targeted subgroups of enrollees, but each plan was only counted once when determining the number of plans that offered a specific benefit.

[7]We excluded optional supplemental benefits for which individual enrollees must specifically elect to receive coverage and pay a separate premium.

[8]The Plan Benefit Package data have predefined fields for almost all supplemental benefits. For certain types of supplemental benefits, plans can offer and specify other supplemental benefits that are not already defined. We analyzed whether plans offered at least one benefit not in the predefined list for each applicable type. However, we did not further analyze these fields because of the unique nature of the benefits entered by plans.

[9]Medicare beneficiaries can enroll in a SNP if they are dually eligible for Medicare and Medicaid, require an institutional level of care, or have a severe or chronic condition. We excluded SNPs focused on end-stage renal disease because of differences in the reporting format of some of their data.

[10]The VBID Model, which began in 2017 and is scheduled to run through 2024, is designed to test a broad array of alternative ways to deliver and pay for services in MA. For example, in 2022, VBID plans could target benefits to enrollees based exclusively on socioeconomic status.

of about 15.98 million in April 2022.[11] This represented approximately two-thirds of enrollees in non-employer MA plans in the 50 states and District of Columbia. We assessed the reliability of the plan benefit and enrollment data by reviewing related documentation, interviewing knowledgeable officials, and checking for internal and external consistency for a subset of variables. We determined the data were sufficiently reliable for the purposes of this report.

To describe MA plans' projected costs for supplemental benefits in 2022 and how plans expected to finance them, we analyzed bid pricing data submitted by MA plans to CMS for 2022, which were the most recent data available at the time of our analysis. Specifically, we analyzed data on each plan's net projected costs and expected financing sources.[12] We assessed the reliability of these data by reviewing related documentation, interviewing knowledgeable officials, and checking for internal consistency. We determined the data were sufficiently reliable for the purposes of this report. We also interviewed officials from six MA organizations that operated plans with supplemental benefits. We selected the organizations based on criteria such as enrollment and geographic coverage. We requested and reviewed summary data on projected costs for supplemental benefits from these organizations. Although the perspectives and data from these six organizations are not generalizable across all MA organizations, they enrolled about 16.89 million Medicare beneficiaries as of April 2022 and provided insights on supplemental benefits.[13] We also interviewed officials from two beneficiary advocacy groups.

To examine the information that CMS has about enrollees' use of supplemental benefits and their effects on enrollees' health and function, we reviewed relevant CMS regulations and guidance and interviewed officials from CMS about the information it receives on enrollees' use of supplemental benefits from the encounter data and bid pricing data

[11]Not all enrollees in a plan may be eligible for a given benefit because plans may offer supplemental benefits to targeted subgroups of enrollees.

[12]The Bid Pricing Tool data on plans' net projected costs are the amounts that plans expected to pay for supplemental benefits and do not include cost-sharing (such as copayments) that plans may require of enrollees. In addition, the plans' projected costs do not reflect actual or final spending for 2022.

[13]Some of the 16.89 million MA enrollees were in plans not included in our review.

submitted by plans.[14] We also interviewed the officials about CMS's efforts to assess the completeness and reliability of these data and plans for improving the data on supplemental benefits. We assessed this information against the initiative in CMS's 2022 strategic framework, which calls for the agency to increase the use of data in decision-making.[15] To supplement this information, we also interviewed representatives from the six selected MA organizations, the two beneficiary advocacy groups, and researchers from two organizations about plans' experiences and challenges with reporting utilization data on supplemental benefits to CMS or what is known about the effects of those benefits on enrollees' health and function.

We conducted this performance audit from October 2021 to January 2023 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

MA Plans and Types of Supplemental Benefits

MA plans are generally available to all Medicare beneficiaries in the plans' service areas, although there are some MA plans with more specific eligibility requirements. For example, SNPs exclusively serve Medicare beneficiaries who are dually eligible for Medicare and Medicaid, require an institutional level of care, or have a severe or chronic condition. SNPs are required to provide certain specialized services, such as performing health risk assessments, creating individualized care plans, and providing an interdisciplinary care team for each enrollee.

[14]MA plans submit encounter data on benefits provided to enrollees. As instructed by CMS, encounter data must include the procedure code for each benefit provided, which enrollee used it, who provided it, and the date or dates of service, among other information.

[15]Specifically, the agency has a cross-cutting initiative to accelerate the appropriate use of data to deliver on its mission and allow it to make more informed policy decisions. See Centers for Medicare & Medicaid Services, "2022 CMS Strategic Framework" (Baltimore, Md.: June 8, 2022), accessed Aug. 12, 2022, https://www.cms.gov/files/document/2022-cms-strategic-framework.pdf.

In addition to generally covering all the benefits offered under Original Medicare, MA plans can offer supplemental benefits. These supplemental benefits may include traditional health-related supplemental benefits (referred to in this report as traditional supplemental benefits), such as dental and vision.[16] In addition, beginning in 2019 and 2020 respectively, MA plans could begin offering two newer types of supplemental benefits—(1) expanded primarily health-related supplemental benefits and (2) Special Supplemental Benefits for the Chronically Ill (SSBCI), which do not have to be primarily health related.[17] As shown in table 1, each type of benefit addresses different aspects of enrollees' health and function.

Table 1: Types of Supplemental Benefits Offered by Medicare Advantage Plans

Type (number of benefits GAO reviewed)	Examples of benefits	First year available	Purpose
Traditional supplemental benefits			
Traditional supplemental benefits (47[a])	• Vision[b] • Fitness • Hearing[b] • Dental[b] • Transportation for medical needs (e.g., to a doctor's office) • Over-the-counter items (e.g., nonprescription pain relievers)	Prior to 2019	Primary purpose is to prevent, cure, or diminish an illness or injury.
Newer types of supplemental benefits			
Expanded primarily health-related supplemental benefits (5)	• In-home support services (e.g., to assist individuals in performing activities such as dressing, eating, and housework) • Support for caregivers of enrollees • Therapeutic massage • Home-based palliative care • Adult day health services	2019	Act to ameliorate the functional/psychological effect of injuries or health conditions or reduce avoidable emergency and health care utilization, among other things.

[16]Traditional supplemental benefits are not the same as benefits covered under Original Medicare. Rather, they are extra benefits that can only be offered as part of MA. Traditional supplemental benefits are primarily health related under CMS's pre-2019 definition of the term; that is, the benefits' primary purpose is to prevent, cure, or diminish an illness or injury.

[17]See Centers for Medicare & Medicaid Services, *Reinterpretation of "Primarily Health Related" for Supplemental Benefits* and *Implementing Supplemental Benefits for Chronically Ill Enrollees*.

Type (number of benefits GAO reviewed)	Examples of benefits	First year available	Purpose
Special Supplemental Benefits for the Chronically Ill (SSBCI) (11[c])	• Food and produce (e.g., frozen foods, canned goods, and produce to assist enrollees in meeting nutritional needs) • Meals beyond a limited basis • Transportation for non-medical needs (e.g., to a grocery store or a bank) • General supports for living (e.g., subsidies for rent or utilities)	2020	Do not have to be primarily health related, but must have a reasonable expectation of improving or maintaining the health or overall function of chronically ill enrollees.

Source: GAO review of Centers for Medicare & Medicaid Services (CMS) guidance. | GAO-23-105527

[a]Plans report to CMS whether they offer each of 46 traditional supplemental benefits defined by CMS. Plans can also report up to three other traditional supplemental benefits not in the defined list—which GAO collapsed into and counted as a single benefit.

[b]There are multiple vision, hearing, and dental benefits. For example, specific dental benefits include oral exams, cleaning, fluoride, and X-rays.

[c]Plans report to CMS whether they offer each of 10 SSBCIs defined by CMS. Plans can also report up to five other SSBCIs not in the defined list—which GAO collapsed into and counted as a single benefit.

Plans can target these three types of supplemental benefits to subgroups of enrollees in different ways.

- **Traditional and expanded primarily health-related supplemental benefits.** Plans can offer these benefits uniformly to all enrollees in their plans. Plans may also target the benefits to enrollees based on health status or disease state, or to chronically ill enrollees as defined by CMS.[18] For example, a plan could offer transportation to primary care visits only to enrollees with congestive heart failure.
- **SSBCI.** Plans must target SSBCIs only at chronically ill enrollees as defined by CMS.

[18]If a plan offers a benefit only to targeted subgroups of enrollees, it must offer the benefit to all plan enrollees with the specified health status or disease state(s). See Centers for Medicare & Medicaid Services, Medicare Drug & Health Plan Contract Administration Group, *Reinterpretation of the Uniformity Requirement* (Baltimore, Md.: Apr. 27, 2018).

CMS defines chronically ill enrollees as individuals who (1) have one or more comorbid and medically complex chronic conditions that is life-threatening or significantly limits the overall health or function of the enrollee, (2) have a high risk of hospitalization or other adverse health outcomes, and (3) require intensive care coordination. When determining and designing benefits to be offered, plans may consider social determinants of health, such as socioeconomic status, as secondary criteria. See Centers for Medicare & Medicaid Services, *Implementing Supplemental Benefits for Chronically Ill Enrollees*.

In addition, MA plans vary in their level of coverage for given supplemental benefits and may require enrollees to pay cost-sharing, such as copayments. For example, the Medicare Payment Advisory Commission reviewed the 2,400 MA plans that had a hearing aid benefit in 2016. The commission found 123 unique variations of hearing aid coverage. Variations included dollar limits on the amount of coverage, in-network or out-of-network providers, type of hearing aids covered, and type of cost-sharing.[19]

Financing for Supplemental Benefits

MA plans' options for financing supplemental benefits depend, in part, on the bids they submit each year to CMS with their projected costs to provide the benefits covered under Original Medicare. In particular, the amount of the plan's bid relative to CMS's benchmark, the bidding target for that locality (i.e., county) or MA region, determines if the plan will receive a rebate from CMS, which is one potential financing source for supplemental benefits.[20] If a plan's bid is below the benchmark, CMS pays the plan a rebate, which is a percentage of the difference between the bid and the benchmark.[21] A plan can only use its rebate to finance supplemental benefits, other MA enhancements (such as reductions in cost-sharing for benefits covered under Original Medicare), and plans' related administrative expenses and profit margins as applicable. In addition, another financing source, supplemental premiums paid by enrollees, is available to all plans regardless of their bid relative to the benchmark. Namely, plans can charge a supplemental premium in order to finance supplemental benefits and other MA enhancements that are not otherwise financed through the rebate.[22] (See fig. 1.)

[19]Medicare Payment Advisory Commission, *Report to the Congress: Medicare and the Health Care Delivery System* (Washington, D.C: June 2017).

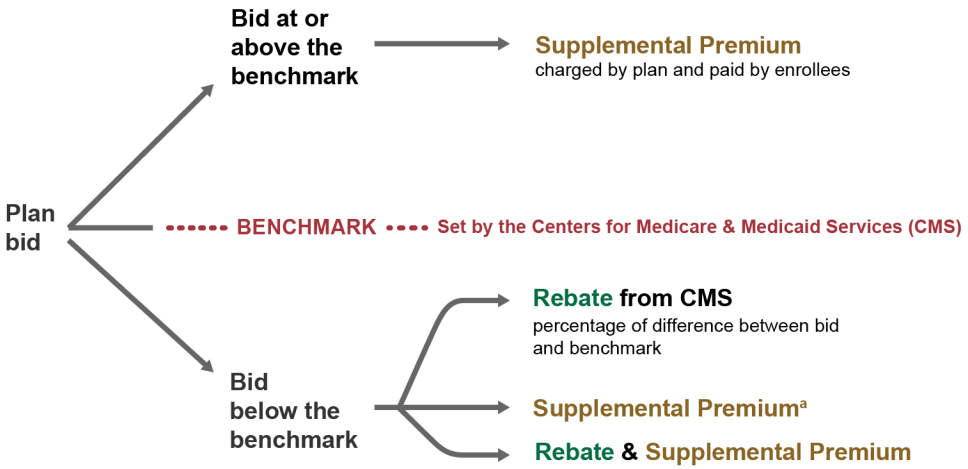
[20]CMS determines the benchmark for each county based on statutory formulas and average Original Medicare spending per beneficiary. CMS determines the regional benchmark for each MA region, which covers one or more entire states, using a different statutory formula that incorporates regional plans' bids. In addition, the benchmark also varies based on the plan's quality rating. In general, a bonus amount is added to the benchmark for plans within contracts with the highest quality ratings.

[21]The rebate is 50, 65, or 70 percent of the difference between the plan's bid and the benchmark after it is adjusted for beneficiary characteristics such as age and prior health conditions. A higher percentage is generally used for plans with higher quality ratings.

[22]A plan with a bid that is above the benchmark also charges an enrollee basic premium, which is equal to the difference between the bid and benchmark.

Figure 1: Medicare Advantage (MA) Plans' Financing Options for Supplemental Benefits

An MA plan's financing options for supplemental benefits depend, in part, on the amount of its bid (its projected costs to provide benefits covered under Original Medicare) relative to the benchmark (bidding target).



Source: GAO review of CMS guidance. | GAO-23-105527

Notes: The figure shows MA plans' financing options for mandatory supplemental benefits for which enrollees receive coverage by default of being enrolled in the plan.

Benchmarks differ by locality (i.e., county) or MA region. The supplemental premium shown is separate from the enrollee basic premium charged by plans with a bid that is above the benchmark. The enrollee basic premium is equal to the difference between the bid and benchmark.

[a]These plans use their rebate for MA enhancements other than supplemental benefits.

Almost All MA Plans Reviewed Offered Traditional Supplemental Benefits; Fewer Offered Newer Benefits

Over 99 Percent of Plans Offered At Least One Traditional Supplemental Benefit, and One-Third Offered At Least One Newer Benefit in 2022

CMS data show the 3,893 MA plans that we reviewed differed in the types and number of supplemental benefits they offered in 2022. Over 99 percent of the plans offered at least one traditional supplemental benefit, while about 34 percent of the plans offered at least one of the newer types of benefits that were first allowed in 2019 and 2020.

Traditional Supplemental Benefits

All but one of the plans we reviewed offered at least one traditional supplemental benefit in 2022. Plans offered a median of 23 out of the 47 traditional supplemental benefits reviewed. The most commonly offered benefits were vision, hearing, fitness, and dental. For example, nearly 98 percent of plans offered at least one vision benefit, and just over 94 percent of plans offered at least one hearing benefit. (See table 2.) In addition, a majority of plans offered annual/routine physical exams, over-the-counter items, remote access technology (e.g., nurse hotlines), and meals for a limited period (e.g., after an inpatient hospital stay). Less than half of the plans reviewed offered other traditional supplemental benefits in 2022. For example, about 48 percent of plans offered transportation for medical needs (e.g., to a doctor's office). Even fewer plans offered other benefits. For example, about 3 percent of plans reviewed offered readmission prevention and post-discharge in-home medication reconciliation.

Table 2: Most Common Traditional Supplemental Benefits Offered by Medicare Advantage Plans, 2022

Supplemental benefit	Number of plans that offered benefit (N=3,893)	Percent
Vision[a]	3,801	97.6
Hearing[a]	3,668	94.2
Fitness	3,632	93.3
Dental[a]	3,539	90.9
Annual/routine physical exam[b]	3,327	85.5
Over-the-counter items (e.g., nonprescription pain relievers)	3,190	81.9
Remote access technology (e.g., nurse hotlines)	3,118	80.1
Meals for a limited period (e.g., after an inpatient hospital stay)	2,485	63.8
Any of the 47 traditional supplemental benefits GAO reviewed[c]	**3,892[d]**	**>99.9[d]**

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data. | GAO-23-105527

Notes: Traditional supplemental benefits have a primary purpose of preventing, curing, or diminishing an illness or injury.

GAO uses "plan" to refer to each unique set of benefits submitted by a Medicare Advantage organization for a specific geographic region. GAO excluded certain plans, including plans outside the 50 states and District of Columbia, Medicare-Medicaid plans, Cost plans, plans that did not offer prescription drug benefits, plans participating in the Value-Based Insurance Design Model, and employer plans.

[a]There are multiple vision, hearing, and dental benefits. For example, specific dental benefits include oral exams, cleaning, fluoride, and X-rays. A plan is counted as offering the benefit if it offers at least one such specific benefit.

[b]In general, Original Medicare covers an initial preventive physical exam within the enrollee's first 12 months of Medicare enrollment. It also covers an annual wellness visit that includes a health risk assessment. However, it does not cover a routine physical exam that is not related to treating or diagnosing a specific illness, symptom, complaint, or injury.

[c]Plans report to CMS whether they offer each of 46 traditional supplemental benefits defined by CMS. Plans can also report up to three other traditional supplemental benefits not in the defined list—which GAO collapsed into and counted as a single benefit.

[d]The number and percentage do not equal the sum of the previous rows because not all benefits are listed. In addition, plans could offer more than one benefit.

Given the overall prevalence of traditional supplemental benefits, nearly all of the MA enrollees in the plans we reviewed were in plans that offered at least one traditional supplemental benefit. Traditional supplemental benefits were generally offered by plans uniformly to all enrollees. However, some plans may require enrollees to seek advance approval for certain benefits.

Newer Types of Supplemental Benefits

Expanded primarily health-related. Almost one-quarter of the plans we reviewed offered at least one expanded primarily health-related supplemental benefit in 2022. Of the plans that offered these benefits, about 69 percent offered only one such benefit, and about 31 percent offered two or more of the five benefits reviewed. The most commonly offered expanded benefit was in-home support services (e.g., to assist individuals in performing activities such as dressing, eating, and housework), which was offered by slightly over 17 percent of plans reviewed. Support for caregivers of enrollees and therapeutic massage were the next most commonly offered expanded benefits. (See table 3.)

Table 3: Expanded Primarily Health-Related Supplemental Benefits Offered by Medicare Advantage Plans, 2022

Supplemental benefit	Number of plans that offered benefit (N=3,893)	Percent
In-home support services (e.g., to assist individuals in performing activities such as dressing, eating, and housework)	672	17.3
Support for caregivers of enrollees	233	6.0
Therapeutic massage	181	4.6
Home-based palliative care	128	3.3
Adult day health services	73	1.9
Any of the five expanded primarily health-related supplemental benefits GAO reviewed	**931[a]**	**23.9[a]**

Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-23-105527

Notes: Expanded primarily health-related benefits act to ameliorate the functional/psychological effect of injuries or health conditions or reduce avoidable emergency and health care utilization, among other things.

GAO uses "plan" to refer to each unique set of benefits submitted by a Medicare Advantage organization for a specific geographic region. GAO excluded certain plans, including plans outside the 50 states and District of Columbia, Medicare-Medicaid plans, Cost plans, plans that did not offer prescription drug benefits, plans participating in the Value-Based Insurance Design Model, and employer plans.

[a]The number and percentage do not equal the sum of the previous rows because plans could offer more than one of these benefits.

Almost one-quarter of the MA enrollees in the plans we reviewed were in plans that offered an expanded primarily health-related benefit. Expanded benefits were generally offered uniformly to all enrollees in the plan, although plans may require enrollees to seek advance approval for certain benefits. However, some of the plans that offered an expanded benefit did so only for a targeted subgroup of enrollees. For example, approximately 40 percent of the plans that offered adult day health services targeted the benefit to chronically ill enrollees.

SSBCI. Slightly over one-fifth of the plans we reviewed offered at least one SSBCI in 2022. The most commonly offered benefit of the 11 SSBCIs reviewed was food and produce (e.g., frozen foods, canned goods, and produce to assist enrollees in meeting nutritional needs), which was offered by almost 15 percent of plans. Meals beyond a limited basis and transportation for non-medical needs (e.g., to a grocery store or a bank) were the next most commonly offered benefits. (See table 4.) Other SSBCIs were offered by less than 2 percent of the plans reviewed. These included structural home modifications (e.g., permanent mobility ramps or

widening of hallways), services supporting self-direction (e.g., interpreter services for encounters with health care providers, financial literacy classes, or other services that help enrollees to be responsible for managing their care), and complementary therapies (therapies offered alongside traditional medical treatment).

Table 4: Most Common Special Supplemental Benefits for the Chronically Ill (SSBCI) Offered by Medicare Advantage Plans, 2022

Supplemental benefit	Number of plans that offered benefit (N=3,893)	Percent
Food and produce (e.g., frozen foods, canned goods, and produce to assist enrollees in meeting nutritional needs)	571	14.7
Meals beyond a limited basis	257	6.6
Transportation for non-medical needs (e.g., to a grocery store or a bank)	236	6.1
Social needs benefit (e.g., access to community or plan-sponsored programs and events to address enrollee isolation)	204	5.2
General supports for living (e.g., subsidies for rent or utilities)	193	5.0
Pest control	191	4.9
Any of the 11 SSBCIs GAO reviewed[a]	**851[b]**	**21.9[b]**

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data. | GAO-23-105527

Notes: SSBCIs do not have to be primarily health related, but must have a reasonable expectation of improving or maintaining the health or overall function of chronically ill enrollees. When determining and designing benefits to be offered, plans may consider social determinants of health, such as socioeconomic status, as secondary criteria.

GAO uses “plan” to refer to each unique set of benefits submitted by a Medicare Advantage organization for a specific geographic region. GAO excluded certain plans, including plans outside the 50 states and District of Columbia, Medicare-Medicaid plans, Cost plans, plans that did not offer prescription drug benefits, plans participating in the Value-Based Insurance Design Model, and employer plans.

[a]Plans report to CMS whether they offer each of 10 SSBCIs defined by CMS. Plans can also report up to five other additional SSBCIs not in the defined list—which GAO collapsed into and counted as a single benefit.

[b]The number and percentage do not equal the sum of the previous rows because not all benefits are listed. In addition, plans could offer more than one benefit.

Almost one-fifth of the MA enrollees in the plans we reviewed were in plans that offered at least one SSBCI. However, not all of these enrollees would be eligible to receive the benefits because the benefits are only available to chronically ill enrollees.

Appendix I provides more information on the number of plans offering each supplemental benefit and the number of enrollees in those plans.

Compared to Non-SNPs, a Greater Percentage of SNPs Reviewed Offered the Newer Types of Supplemental Benefits

Among the MA plans we reviewed, a higher percentage of SNPs compared to non-SNPs offered at least one of the newer types of benefits in 2022.[23] For example, as shown in table 5, about 45 percent of the 745 SNPs we reviewed offered at least one SSBCI compared to about 16 percent of the 3,148 non-SNPs. In addition, a higher percentage of SNP enrollees were in plans that offered at least one of the newer types of benefits compared to non-SNP enrollees. (See app. II for additional information on the number of enrollees in the plans that offered each benefit.[24])

Table 5: Types of Supplemental Benefits Offered by Medicare Advantage Special Needs Plans (SNP) Compared to Non-SNPs, 2022

Type of supplemental benefit	SNPs that offered at least one benefit		Non-SNPs that offered at least one benefit		Percentage point difference in plans that offered at least one benefit
	Number of SNPs (N=745)	Percent of SNPs	Number of non-SNPs (N=3,148)	Percent of non-SNPs	
Any of the 47 traditional supplemental benefits GAO reviewed[a]	744	99.9	3,148	100.0	<1.0 ■
Any of the five expanded primarily health-related supplemental benefits GAO reviewed[b]	257	34.5	674	21.4	13.1 ▲
Any of the 11 Special Supplemental Benefits for the Chronically Ill (SSBCI) GAO reviewed[c]	337	45.2	514	16.3	28.9 ▲

Legend:

▲: A higher percentage of SNPs than non-SNPs offered at least one benefit of that type

■: A similar percentage of SNPs and non-SNPs offered at least one benefit of that type

Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-23-105527

Note: GAO uses “plan” to refer to each unique set of benefits submitted by a Medicare Advantage organization for a specific geographic region. GAO excluded certain plans, including plans outside the 50 states and District of Columbia, Medicare-Medicaid plans, Cost plans, plans that did not offer

[23]SNPs exclusively serve Medicare beneficiaries who are dually eligible for Medicare and Medicaid, require an institutional level of care, or have a severe or chronic condition. Almost every SNP and all non-SNPs we reviewed offered at least one traditional supplemental benefit; therefore, there was no overall difference in the percentage of plans that offered at least one of these benefits.

[24]We separately analyzed plans participating in the VBID Model, which includes a majority of SNP enrollees. See appendix III for more information about VBID plans.

prescription drug benefits, plans participating in the Value-Based Insurance Design Model (which includes most SNP enrollees), and employer plans.

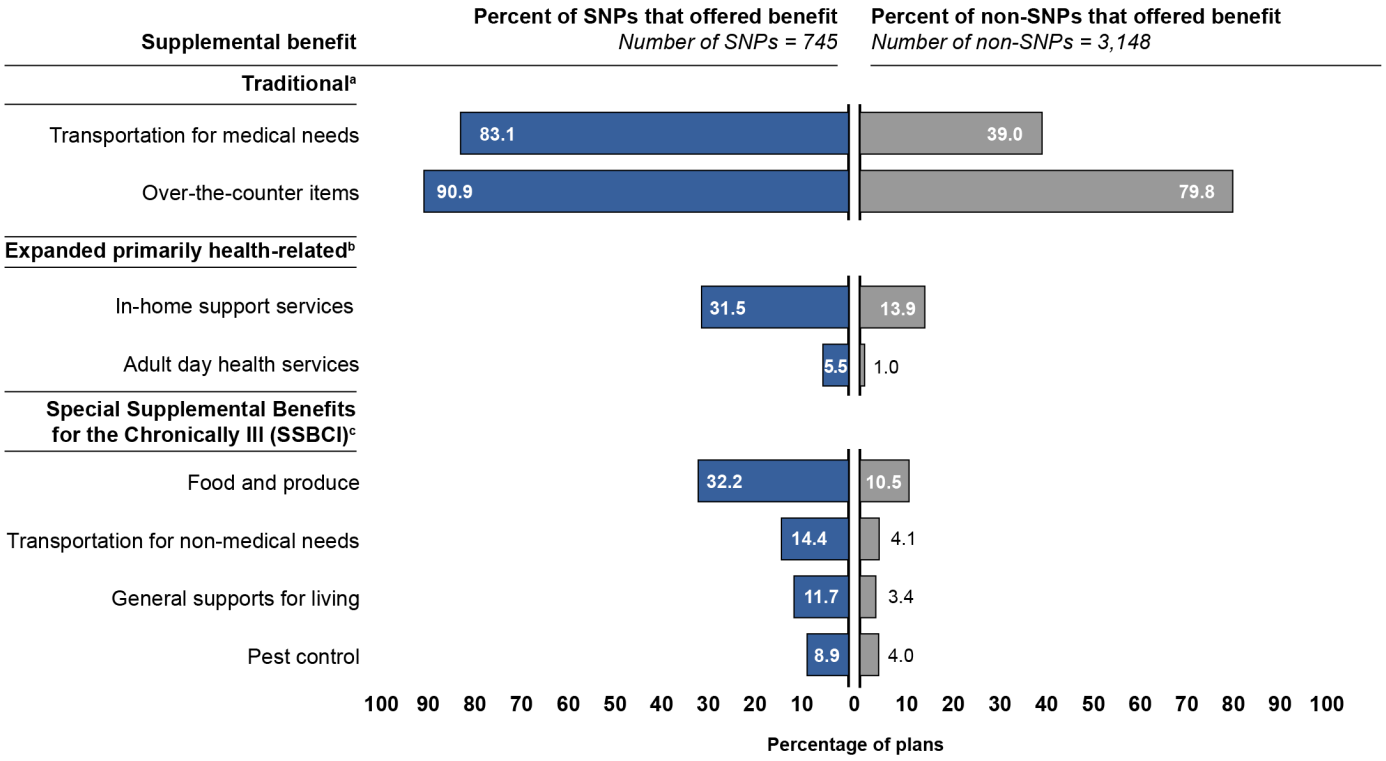
[a]Traditional supplemental benefits have a primary purpose of preventing, curing, or diminishing an illness or injury.

[b]Expanded primarily health-related benefits act to ameliorate the functional/psychological effect of injuries or health conditions or reduce avoidable emergency and health care utilization, among other things.

[c]SSBCIs do not have to be primarily health related, but must have a reasonable expectation of improving or maintaining the health or overall function of chronically ill enrollees. When determining and designing benefits to be offered, plans may consider social determinants of health, such as socioeconomic status, as secondary criteria.

Within each type of supplemental benefit, there were also specific benefits that SNPs offered more often than non-SNPs. For example, for traditional supplemental benefits, a higher percentage of SNPs than non-SNPs offered transportation for medical needs and over-the-counter items. In addition, a higher percentage of SNPs than non-SNPs offered the expanded primarily health-related benefit of in-home support services and all SSBCIs, including food and produce. (See fig. 2.)

Figure 2: Examples of Supplemental Benefits Offered by a Higher Percentage of Medicare Advantage Special Needs Plans (SNP) Compared to Non-SNPs, 2022



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-23-105527

Notes: GAO uses "plan" to refer to each unique set of benefits submitted by a Medicare Advantage organization for a specific geographic region. GAO excluded certain plans, including plans outside the 50 states and District of Columbia, Medicare-Medicaid plans, Cost plans, plans that did not offer prescription drug benefits, plans participating in the Value-Based Insurance Design Model (which includes most SNP enrollees), and employer plans.

Transportation for medical needs can include destinations such as doctor's offices. Over-the-counter items can include nonprescription pain relievers. In-home support services assist individuals in performing activities such as dressing, eating, and housework. Food and produce can include frozen foods, canned goods, and produce to assist enrollees in meeting nutritional needs. Transportation for non-medical needs can include trips to grocery stores or a bank. General supports for living can include subsidies for rent or utilities.

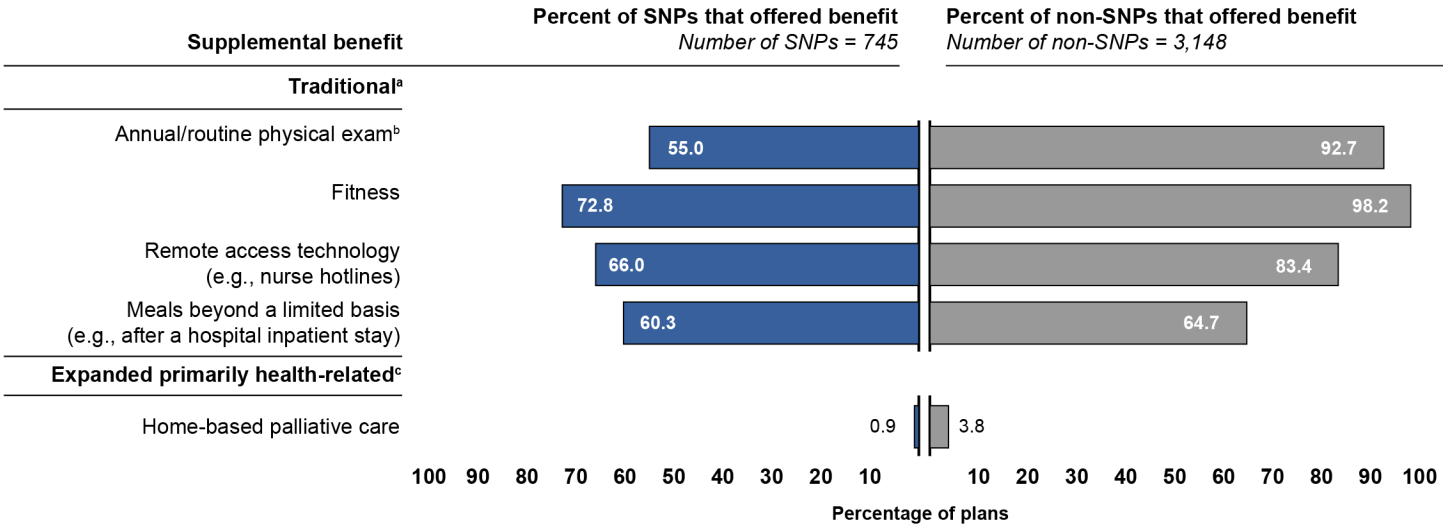
[a]Traditional supplemental benefits have a primary purpose of preventing, curing, or diminishing an illness or injury.

[b]Expanded primarily health-related benefits act to ameliorate the functional/psychological effect of injuries or health conditions or reduce avoidable emergency and health care utilization, among other things.

[c]SSBCIs do not have to be primarily health related, but must have a reasonable expectation of improving or maintaining the health or overall function of chronically ill enrollees. When determining and designing benefits to be offered, plans may consider social determinants of health, such as socioeconomic status, as secondary criteria.

There were also specific traditional and expanded primarily health-related benefits that SNPs offered less often than non-SNPs.[25] For example, a lower percentage of SNPs offered annual/routine physical exams, fitness, remote access technology, and meals for a limited period. (See fig. 3.)

Figure 3: Examples of Supplemental Benefits Offered by a Lower Percentage of Medicare Advantage Special Needs Plans (SNP) Compared to Non-SNPs, 2022



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-23-105527

Note: GAO uses "plan" to refer to each unique set of benefits submitted by a Medicare Advantage organization for a specific geographic region. GAO excluded certain plans, including plans outside the 50 states and District of Columbia, Medicare-Medicaid plans, Cost plans, plans that did not offer prescription drug benefits, plans participating in the Value-Based Insurance Design Model (which includes most SNP enrollees), and employer plans.

[a]Traditional supplemental benefits have a primary purpose of preventing, curing, or diminishing an illness or injury.

[b]In general, Original Medicare covers an initial preventive physical exam within the enrollee's first 12 months of Medicare enrollment. It also covers an annual wellness visit that includes a health risk assessment. However, it does not cover a routine physical exam that is not related to treating or diagnosing a specific illness, symptom, complaint, or injury.

[c]Expanded primarily health-related benefits act to ameliorate the functional/psychological effect of injuries or health conditions or reduce avoidable emergency and health care utilization, among other things.

[25]There were no SSBCIs that SNPs offered less often than non-SNPs.

MA Plans' Projected Costs for Supplemental Benefits Varied Widely in 2022; Most Expected to Finance the Benefits with Rebates

MA Plans Reviewed Had a Median Net Projected Cost for Supplemental Benefits of $27 per Enrollee per Month in 2022, but Amounts Varied Widely

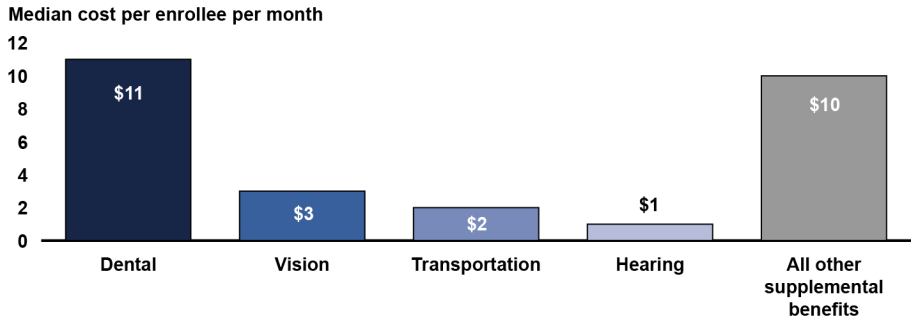
The 3,893 MA plans reviewed had a median net projected cost for supplemental benefits of about $27 per enrollee per month in 2022—approximately $6.4 billion in total—according to our analysis of the CMS bid pricing data.[26] The net projected costs reflect the amounts that plans expected to pay for supplemental benefits and do not include cost-sharing (such as copayments) that plans may require of enrollees.[27]

Dental supplemental benefits accounted for the largest portion of plans' net projected costs for supplemental benefits. As shown in figure 4, the median net projected cost for dental benefits was approximately $11 per enrollee per month for plans that offered these benefits. In comparison, the median net projected cost for vision benefits was approximately $3 per enrollee per month for plans that offered these benefits.

[26]The total amount of net projected costs for all MA plans, including those that were not in our analysis, would be higher than $6.4 billion.

[27]This amount also does not include plans' administrative expenses or profit margins for supplemental benefits.

Figure 4: Medicare Advantage Plans' Net Projected Costs for Supplemental Benefits, 2022



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-23-105527

Notes: Plans' net projected costs are rounded to the nearest dollar and do not include cost-sharing (such as copayments) that plans may require of enrollees. They also do not include plans' administrative expenses or profit margins for supplemental benefits.

GAO uses "plan" to refer to each unique set of benefits submitted by a Medicare Advantage organization for a specific geographic region. The median costs shown are for the plans that offered the benefit. Plans report separate data only for dental (offered by 3,539 plans out of 3,893 plans analyzed), vision (offered by 3,801 plans), transportation (offered by 1,848 plans), and hearing (offered by 3,668 plans). Plans report combined data for all other supplemental benefits (offered by 3,871 plans). GAO excluded certain plans, including plans outside the 50 states and District of Columbia, Medicare-Medicaid plans, Cost plans, plans that did not offer prescription drug benefits, plans participating in the Value-Based Insurance Design Model, and employer plans.

Although the MA plans we reviewed had a median net projected cost of about $27 per enrollee per month, this amount varied widely. For example, the middle 50 percent of the plans' net projected costs ranged from about $17 to $43 per enrollee per month. In addition, the median net projected cost was slightly over $57 per enrollee per month for SNPs reviewed compared to slightly over $24 for non-SNPs reviewed.

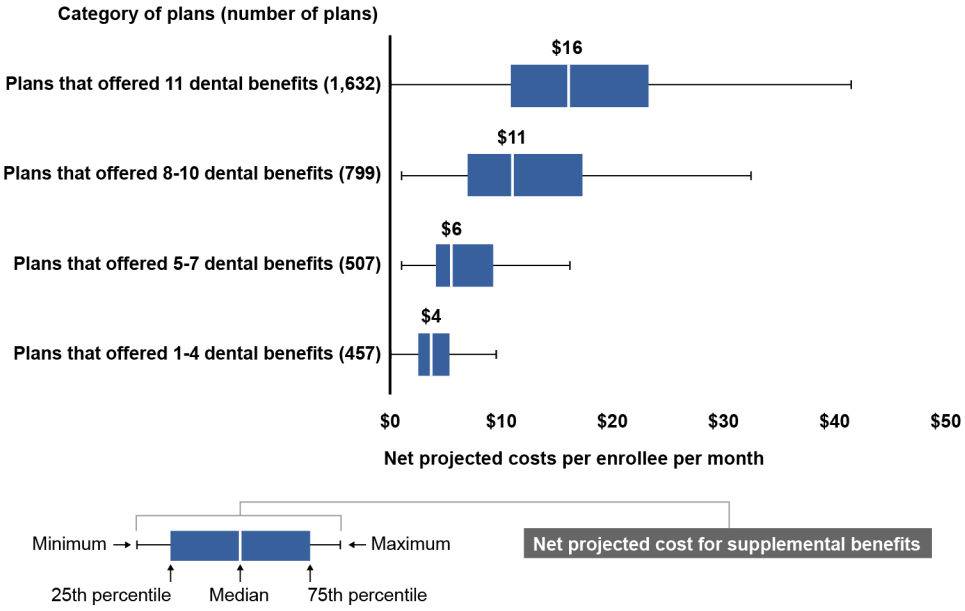
One reason for the variation in plans' net projected costs could be differences in the number, type, and levels of coverage for benefits. For example, as shown in figure 5, plans that offered more dental benefits had a higher median net projected cost than plans that offered fewer dental benefits. However, there was still wide variation in costs within each category, which may be due in part to differences in the mix of individual dental benefits and the levels of coverage for those benefits. For example, of the plans that offered all 11 dental benefits, the middle 50 percent of plans' net projected costs ranged from about $11 to $23 per enrollee per month.

Beneficiary Understanding of Supplemental Benefits

Enrollees may not understand the different levels of coverage for benefits, according to beneficiary advocacy groups GAO interviewed. For example, officials from one beneficiary advocacy group said dental is the supplemental benefit on which they receive the most complaints, often about plans' limits on what or how much is covered. The group said enrollees might complain because, although they were able to get a cleaning and X-rays, they also need dentures or implants.

Source: GAO interviews of beneficiary advocacy groups. | GAO-23-105527

Figure 5: Variation in Medicare Advantage Plans' Net Projected Costs for Dental Supplemental Benefits, 2022



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-23-105527

Notes: Plans' net projected costs are rounded to the nearest dollar and do not include cost-sharing (such as copayments) that plans may require of enrollees. They also do not include plans' administrative expenses or profit margins for these benefits.

GAO uses "plan" to refer to each unique set of benefits submitted by a Medicare Advantage organization for a specific geographic region. GAO excluded certain plans, including plans outside the 50 states and District of Columbia, Medicare-Medicaid plans, Cost plans, plans that did not offer prescription drug benefits, plans participating in the Value-Based Insurance Design Model, and employer plans.

Out of the plans reviewed, 3,539 plans offered at least one dental benefit, such as oral exams, cleaning, fluoride, X-rays, periodontics, and extractions. Plans may differ in the mix of individual dental benefits offered and levels of coverage for those benefits. The figure shows 3,395 plans after the exclusion of 144 plans whose net projected costs for dental benefits were identified as outliers within each category of plans. GAO identified outliers as those with net projected costs greater than 1.5 times the interquartile range below the 25th percentile or above the 75th percentile.

Another reason for variation in plans' net projected costs can be differences in plans' projections of enrollees' use of specific benefits and the expected cost per use, according to officials from MA organizations interviewed. Officials said they projected enrollees' use of a benefit based on several factors including: past rates of use where available, estimates of the number of enrollees who would be eligible for the benefit (e.g., SSBCI estimates would be based in part on the number of enrollees with the targeted chronic illness), the type or extent of outreach being

conducted for the benefit, and the effect of cost-sharing.[28] As a result, different plans have different projected costs for specific supplemental benefits. For example, information provided by three of the MA organizations in our review indicated that their plans that offered fitness benefits had net projected costs of around $1, $2, and $4 per enrollee per month respectively in 2022. For in-home support services, information from two MA organizations showed net projected costs of less than $1 per enrollee per month in their plans that offered the benefit. In contrast, information from another MA organization showed two different types of in-home support services—one with net projected costs of around $2 per enrollee per month and the other with net projected costs of around $1 per enrollee per month in their plans that offered these benefits.

Over 80 Percent of MA Plans Reviewed Expected to Finance Supplemental Benefits in 2022 Solely with Rebates

In 2022, according to our analysis of the CMS bid pricing data, slightly over 83 percent of the 3,893 MA plans reviewed expected to finance supplemental benefits solely with rebates, and the remaining plans expected to use supplemental premiums alone or in combination with rebates.[29] (See table 6.) Further, almost 86 percent of MA enrollees in the plans reviewed were in plans that expected to finance their supplemental benefits with rebates alone. In addition, about 96 percent of the SNPs we reviewed expected to finance supplemental benefits solely with rebates.

[28]The percentage of enrollees who use supplemental benefits can vary, according to data for 2020 provided by two MA organizations interviewed, although utilization in that year was affected by the start of the COVID-19 pandemic. For example, about 21 and 6 percent of enrollees in applicable plans used the dental benefit in the two MA organizations respectively. About 26 percent of enrollees in applicable plans used the vision benefit (eye exams or eyewear) in one of the MA organizations, and about 24 percent used the eye exam benefit and about 15 percent used the eyewear benefit in the other MA organization.

[29]Some plans that expected to both receive a rebate and also charge a supplemental premium reported they expected to use only one or the other to finance their supplemental benefits. Specifically, there were 3,240 plans that expected to finance supplemental benefits with rebates alone—160 of which charged a supplemental premium that was used for MA enhancements other than supplemental benefits. In addition, there were 208 plans that expected to finance supplemental benefits with the supplemental premiums alone—183 of which received a rebate that was used for MA enhancements other than supplemental benefits.

Table 6: Medicare Advantage Plans' Expected Financing Sources for Supplemental Benefits, 2022

Financing source reported by plan	Number of plans	Percent of plans
Rebate[a]	3,240	83
Supplemental premium	208	5
Both rebate and supplemental premium	444	11
Not applicable; plan did not offer supplemental benefits	1	<1
Total number of plans GAO reviewed	**3,893**	**100**

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data. | GAO-23-105527

Note: Totals may not sum due to rounding. GAO uses "plan" to refer to each unique set of benefits submitted by a Medicare Advantage organization for a specific geographic region. GAO excluded certain plans, including plans outside the 50 states and District of Columbia, Medicare-Medicaid plans, Cost plans, plans that did not offer prescription drug benefits, plans participating in the Value-Based Insurance Design Model, and employer plans.

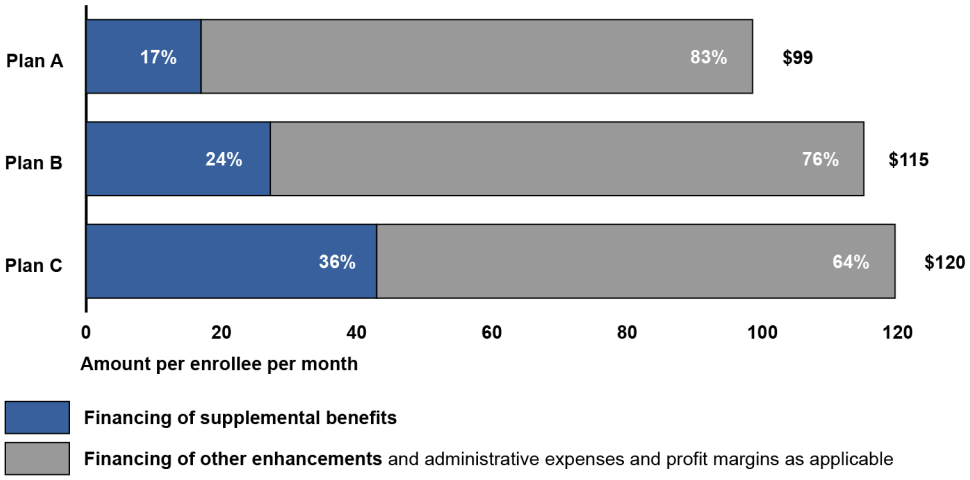
[a]CMS pays a rebate to a plan if its projected costs to provide benefits covered under Original Medicare are below CMS's bidding target for the plan's locality (i.e., county) or Medicare Advantage region.

Officials from some of the MA organizations in our review cited two factors that may influence plans' decisions on the use of different financing sources for supplemental benefits. First, officials from two MA organizations cited overall market pressures not to charge any premiums—meaning supplemental benefits are financed solely by rebates. For example, officials from one of those two MA organizations said they need to offer plans without premiums to be competitive in their market. These officials said that, instead of charging a premium, they will adjust their projected profit margins to generate the rebate needed to finance the supplemental benefits that they want to offer. Second, officials from two other MA organizations said that they may have plans that charge premiums alongside plans in that same market that do not charge premiums. According to those officials, a plan with a premium may offer more supplemental benefits, as well as other MA enhancements, such as lower copayments or a greater extension of Original Medicare services.

In addition to financing supplemental benefits, MA plans could also use these financing sources (rebates, supplemental premiums, or both) for other MA enhancements, such as reductions in the cost-sharing for benefits covered under Original Medicare. According to our analysis of the CMS bid pricing data, the share of available resources from those financing sources allocated by plans to supplemental benefits varied—as did their net projected costs for supplemental benefits and their projected

amounts of available resources. See figure 6, which provides examples of how three different plans expected to use their available resources. These examples are from the plans with net projected costs for supplemental benefits at the 25th percentile, median, and 75th percentile respectively.[30]

Figure 6: Examples of Medicare Advantage Plans' Expected Use of Projected Available Resources, 2022



Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data. | GAO-23-105527

Notes: Plans have resources from CMS or enrollees that they can use to finance supplemental benefits and other Medicare Advantage enhancements such as reductions in cost-sharing for benefits covered under Original Medicare. This figure shows how three Medicare Advantage plans expected to use their projected available resources. These three plans' net projected costs for supplemental benefits were at the 25th percentile, median, and 75th percentile respectively.

The amount that plans expected to use to finance supplemental benefits equal their net projected costs for the benefits. The net projected costs are rounded to the nearest dollar and do not include cost-sharing (such as copayments) that plans may require of enrollees. They also do not include plans' administrative expenses or profit margins for these benefits.

[30]In figure 6, the second plan shown (plan B) had net projected costs for supplemental benefits equal to the median of about $27 per enrollee per month for all plans reviewed.

CMS Has Limited Information on Enrollees' Use of Supplemental Benefits and Their Effects

The information CMS collects on supplemental benefits offered by MA plans is limited; it does not include complete information on the extent to which enrollees are using the supplemental benefits that plans offer. According to federal regulation, plans must submit encounter data for supplemental benefits to the extent required by CMS.[31] However, we found that encounter data submitted by plans do not provide complete information on enrollees' use of supplemental benefits for two primary reasons:

- **Confusion about reporting requirements.** CMS's current guidance on the submission of encounter data does not specifically mention or discuss the submission of encounter data for supplemental benefits. The guidance says that plans must submit encounter data for each service or item covered by the plan and provided to an enrollee. CMS officials told us that the inclusion of supplemental benefits in this requirement is clear and noted that the guidance does not differentiate between Original Medicare benefits and supplemental benefits. However, officials we interviewed from selected MA organizations in our review had mixed understandings of the requirement and do not consistently report data for supplemental benefits. For example, officials from two of the MA organizations interviewed said they are not required to submit encounter data for some supplemental benefits and submit encounter data for a limited set of supplemental benefits. One of the two MA organizations submitted encounter data for transportation, meals, and vision, according to organization officials. Officials from a third MA organization said they are not required to submit encounter data for any supplemental benefits and therefore do not submit such data. In contrast, officials from one MA organization said they are required to submit encounter data for all supplemental benefits and submit encounter data for as many supplemental benefits as possible.
- **Challenges with procedure codes.** Officials from two MA organizations and CMS said that procedure-code challenges can

[31]Each MA organization must submit to CMS (in accordance with CMS instructions) the data necessary to characterize the context and purposes of each item and service provided to a Medicare enrollee by a provider, supplier, physician, or other practitioner. To the extent required by CMS, those data must account for benefits covered under Original Medicare, Medicare-covered benefits for which Medicare is not the primary payer, and supplemental benefits. 42 C.F.R. § 422.310(b)(c).

In general, CMS uses encounter data, which are similar to provider claims data in Original Medicare, to adjust payments to MA plans to reflect beneficiaries' projected health care costs. CMS also uses the data for other purposes such as quality measurement and program evaluation.

make it difficult to collect and submit encounter data for certain supplemental benefits. The officials said that, in some cases, there are no procedure codes for the benefit, such as SSBCIs, and CMS officials said its system does not currently take in encounter data for benefits that do not have procedure codes. As a result, officials from one MA organization said they used a general procedure code for submitting encounter data on their supplemental benefit that provides deliveries of fruit and vegetables to enrollees because there was not an applicable procedure code. In addition, officials from another organization said the procedure codes for some supplemental benefits do not align with how they offer the benefits, which may cause them not to report utilization of those benefits at all. For example, they said there is a procedure code for an annual gym membership, but they did not know how to use that procedure code to report utilization for an enrollee who, for example, attends two different gyms at the same time, as allowed under that organization's fitness benefit.[32]

CMS officials reported starting some efforts to analyze the extent to which the encounter data submitted by plans include supplemental benefits and otherwise understand enrollees' use of supplemental benefits. Specifically, as of October 2022, CMS was in the early stages of assessing the completeness of the encounter data it receives for supplemental benefits. According to CMS officials, the agency's current focus on encounter data for supplemental benefits is because of the increased offering of such benefits. CMS's prior focus was on the data for required benefits, namely those covered under Original Medicare. CMS officials told us that, as part of the current efforts, the agency had started to determine which procedure codes match the supplemental benefits being offered by plans, which they said could allow them to assess how

[32]Officials from CMS and four MA organizations interviewed said that MA plans may also find it challenging to submit encounter data for services provided or managed through vendors. For example, plans may not receive utilization data from their vendors in a standard claims format and with all data elements needed for submitting encounter data. However, CMS does not have a direct role in what data plans receive from their vendors, according to agency officials. The format and extent of data received instead depend on the contracts plans have with their vendors, entities plans pay to provide or manage given benefits.

those benefits are being reported.[33] CMS was also in the early stages of identifying options for collecting enrollee utilization data on SSBCIs, which are less likely to have associated procedure codes. Officials said these options could include the creation of new procedure codes or a new data submission format, but also said they needed to do more work to know about the feasibility of these options. Finally, in August 2022, CMS asked the public for information on, among other things, the rate at which enrollees use food-, nutrition-, and physical activity-related supplemental benefits.[34]

However, as of October 2022, CMS officials told us the agency did not have a workplan or timeline for future analyses or actions that the agency could take based on those efforts. As a result, it is not clear whether these efforts will result in more complete information on enrollees' use of supplemental benefits.

Having more complete information on the extent to which enrollees are using supplemental benefits, such as from the encounter data, would put CMS in a stronger position to make more informed policy decisions, consistent with its 2022 strategic framework, and meet goals it has stated related to supplemental benefits.[35] For example, CMS has a goal of gaining a greater understanding of how supplemental benefits are meeting their intended purposes, such as improving or maintaining

[33]CMS officials said the agency was exploring how to assess the encounter data and address certain complexities in the data. For example, one complexity is assessing when certain benefits (such as dental, vison, and hearing) were covered by plans as a supplemental benefit or as an Original Medicare benefit. This is because Original Medicare covers dental, vision, and hearing services in limited circumstances, such as covering one pair of eyeglasses or contact lenses after cataract surgery with the insertion of an intraocular lens. According to CMS officials, the same procedure codes can be used for supplemental and Original Medicare benefits.

[34]87 Fed. Reg. 46,918 (Aug. 1, 2022). In this request for information, CMS also asked for information on standardized data elements that it could collect to better understand the effects of supplemental benefits on enrollees' health outcomes, social determinants of health, and health equity. As of October 2022, CMS was still reviewing the responses received from this request for information.

[35]In CMS's 2022 strategic framework, the agency established a cross-cutting initiative to accelerate the appropriate use of data to deliver on the agency's mission and allow it to make more informed policy decisions. As part of this initiative, the agency said it is working to fully leverage the value of data by improving its data collection and management, among other things. See Centers for Medicare & Medicaid Services, *2022 CMS Strategic Framework.*

enrollees' overall health and social needs.[36] A second goal is ensuring that supplemental benefits are addressing the most critical care gaps and barriers to care.[37] A third goal is improving the transparency of how Medicare dollars are being spent on certain benefits, including supplemental benefits.[38]

Although limited, encounter data are currently the agency's primary source of information on enrollees' use of supplemental benefits. The bid pricing data submitted by plans to CMS also contain some information on the use of certain supplemental benefits. The purpose of these data, however, is to show how each plan developed its projected costs for providing those benefits. As such, there are certain factors that limit the use of these data in assessing utilization of supplemental benefits. For example, plans report utilization data separately for certain traditional supplemental benefits only: dental, hearing, transportation, and vision. The data for all other supplemental benefits—which includes other traditional supplemental benefits (such as fitness or over-the-counter items) and all newer types of benefits—are rolled up into two other categories.[39] Furthermore, even for types of supplemental benefits reported separately, there was some variation in the units of services used by plans. For example, according to the bid pricing instructions, plans have the option of reporting dental benefits in terms of the number of visits or in the number of procedures.

Conclusions

In recent years, MA plans have been allowed to offer a wider range of supplemental benefits. These include newer types of benefits that are intended to ameliorate the effect of injuries or health conditions, reduce avoidable emergency and health care utilization, or have a reasonable expectation of improving or maintaining the health or overall function of chronically ill enrollees. Supplemental benefits, which are financed mostly

[36]Meena Seshamani, Elizabeth Fowler, and Chiquita Brooks-LaSure, "Building on the CMS Strategic Vision: Working Together for a Stronger Medicare," *Health Affairs Forefront*, Jan. 11, 2022.

[37]Centers for Medicare & Medicaid Services, *Advance Notice of Methodological Changes for Calendar Year (CY) 2023 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies* (Feb. 2, 2022).

[38]In May 2022, CMS finalized regulations that will require plans to report the amounts spent on certain supplemental benefits starting in 2023. See 87 Fed. Reg. 27,831 (May 9, 2022).

[39]One is for benefits listed in the Medicare managed care manual, and the other is for all other supplemental benefits. However, CMS officials told us there are differences in how various plans assign benefits into each of those two categories.

from CMS rebates, have net projected costs of about $6.4 billion in 2022 for the plans we reviewed.

The offering of supplemental benefits is one way that MA plans differentiate themselves from their competitors, and they may be attractive to Medicare beneficiaries when deciding whether to enroll in MA and which MA plan to select. However, CMS has limited information on enrollees' use of supplemental benefits, especially the newer types. Our review found that selected MA organizations were not always reporting encounter data for supplemental benefits. This is because the agency's guidance does not clearly indicate that information on enrollees' use of supplemental benefits must be included in MA plans' encounter data submissions, and some supplemental benefits lack procedure codes, which are required in the submission of encounter data. While CMS has begun to look at the procedure code issue, it is not yet clear whether CMS will make changes allowing it to collect more complete information on enrollees' use of supplemental benefits. Having such information would put CMS in a stronger position to make informed policy decisions about supplemental benefits. For example, more complete information on the utilization of supplemental benefits could help CMS determine whether or to what extent they support the health and social needs of Medicare enrollees.

Recommendations for Executive Action

We are making the following two recommendations to CMS:

The Administrator of CMS should clarify guidance to MA plans on the extent to which encounter data submissions must include data on the utilization of supplemental benefits. (Recommendation 1)

The Administrator of CMS should take actions to address circumstances where submitting encounter data for supplemental benefits is challenging for MA plans, such as when a given benefit lacks an applicable procedure code. Such actions may include the creation of new procedure codes or a new data submission format. (Recommendation 2)

Agency Comments

The Department of Health and Human Services provided written comments on a draft of this report, which are reproduced in appendix IV. In its written comments, the department concurred with our recommendations and said it plans to issue guidance to clarify the extent to which MA plans' encounter data submissions must include data on supplemental benefit utilization. It also noted a commitment to addressing challenges that MA plans experience when submitting encounter data for

supplemental benefits. The department provided technical comments, which we incorporated as appropriate.

We are sending copies of this report to the appropriate congressional committees, the Secretary of Health and Human Services, and other interested parties. In addition, the report is available at no charge on the GAO website at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or RosenbergM@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix V.

Michelle B. Rosenberg
Director, Health Care

Appendix I: Supplemental Benefits Offered by Medicare Advantage Plans GAO Reviewed

Table 7 provides the number and percentage of Medicare Advantage (MA) plans we reviewed that offered each supplemental benefit in 2022 along with the number and percentage of enrollees in those plans. The number and percentage of enrollees in a plan that offers a given benefit show the potential reach of that benefit but do not necessarily reflect the number of enrollees who are eligible for or receive the benefit. This is because plans can target their benefits to certain enrollees. For example, plans can offer two of the three types of supplemental benefits—traditional and expanded primarily health-related supplemental benefits—only to targeted subgroups of enrollees based on health status or disease state.[1] In addition, the third type of supplemental benefits—Special Supplemental Benefits for the Chronically Ill—are only for chronically ill enrollees, and plans may consider social determinants of health, such as socioeconomic status, as secondary criteria when determining and designing benefits to be offered.

Table 7: Supplemental Benefits Offered by Medicare Advantage Plans, 2022

	Plans		Enrollment in April 2022	
Supplemental benefit	**Number (N=3,893)**	**Percent**	**Number in thousands[a] (N=15,980)**	**Percent**
Traditional supplemental benefits[b]				
Any transportation for medical needs (e.g., to a doctor's office)	1,848	47.5	6,570	41.1
Acupuncture	1,046	26.9	5,150	32.3
Over-the-counter items (e.g., nonprescription pain relievers)	3,190	81.9	13,310	83.3
Meals for a limited period	2,485	63.8	10,970	68.7
Other supplemental services not defined by the Centers for Medicare & Medicaid Services (CMS)[c]	775	19.9	3,760	23.5
Annual/routine physical exam[d]	3,327	85.5	14,680	91.9
Health education	1,437	36.9	5,900	36.9
Nutritional/dietary benefit	1,158	29.7	4,650	29.1
Smoking and tobacco cessation counseling	1,301	33.4	4,270	26.7
Fitness	3,632	93.3	15,550	97.3
Enhanced disease management	256	6.6	1,170	7.3
Telemonitoring services	255	6.6	1,100	6.9
Remote access technology (e.g., nurse hotlines)	3,118	80.1	13,920	87.1

[1]For example, a plan may offer a certain number of transports to primary care visits only to enrollees with congestive heart failure. If a plan offers a benefit only to targeted subgroups of enrollees, it must offer the benefit to all plan enrollees with the specified health status or disease state(s).

	Plans		Enrollment in April 2022	
Supplemental benefit	Number (N=3,893)	Percent	Number in thousands[a] (N=15,980)	Percent
Home and bathroom safety devices and modifications	486	12.5	2,080	13.0
Counseling services	567	14.6	1,750	11.0
In-home safety assessment	226	5.8	920	5.8
Personal emergency response system	886	22.8	4,250	26.6
Medical nutrition therapy	419	10.8	1,510	9.5
Post discharge in-home medication reconciliation	106	2.7	360	2.3
Re-admission prevention	115	3.0	300	1.9
Wigs for hair loss related to chemotherapy	144	3.7	420	2.6
Weight management programs	198	5.1	500	3.1
Alternative therapies	212	5.4	810	5.1
Any dental	3,539[e]	90.9[e]	14,910[e]	93.3[e]
Oral exam	3,520	90.4	14,860	93.0
Prophylaxis (cleaning)	3,513	90.2	14,800	92.7
Fluoride treatment	2,528	64.9	10,730	67.1
Dental X-rays	3,481	89.4	14,740	92.2
Non-routine services	2,266	58.2	9,000	56.3
Diagnostic services	2,541	65.3	11,060	69.2
Restorative services	2,870	73.7	11,730	73.4
Endodontics	2,466	63.3	9,790	61.3
Periodontics	2,663	68.4	11,300	70.7
Extractions	2,719	69.8	11,320	70.9
Prosthodontics	2,638	67.8	10,850	67.9
Any vision	3,801[e]	97.6[e]	15,840[e]	99.1[e]
Routine eye exams	3,771	96.9	15,750	98.6
Other eye exam	606	15.6	2,180	13.6
Contact lenses	3,551	91.2	14,790	92.6
Eyeglasses (frames and lenses)	3,289	84.5	14,060	88.0
Eyeglass lenses	2,563	65.8	8,660	54.2
Eyeglass frames	2,567	65.9	8,670	54.3
Eyewear upgrades	1,885	48.4	5,980	37.4
Any hearing	3,668[e]	94.2[e]	14,670[e]	91.8[e]
Routine hearing exams	3,631	93.3	14,530	90.9
Fitting/evaluation for hearing aids	2,823	72.5	9,550	59.8
Hearing aids (all types)	3,502	90.0	14,160	88.6
Hearing aids - inner ear	28	0.7	10	0.1

Supplemental benefit	Plans		Enrollment in April 2022	
	Number (N=3,893)	Percent	Number in thousands[a] (N=15,980)	Percent
Hearing aids - outer ear	28	0.7	10	0.1
Hearing aids - over the ear	28	0.7	10	0.1
Any of the 47 traditional supplemental benefits GAO reviewed	3,892[e]	>99.9[e]	15,980[e]	>99.9[e]
Expanded primarily health-related supplemental benefits[f]				
Therapeutic massage	181	4.6	480	3.0
Adult day health services	73	1.9	110	0.7
Home-based palliative care	128	3.3	610	3.8
In-home support services (e.g., to assist individuals in performing activities such as dressing, eating, and housework)	672	17.3	2,600	16.3
Support for caregivers of enrollees	233	6.0	940	5.9
Any of the five expanded primarily health-related supplemental benefits GAO reviewed	931[e]	23.9[e]	3,570[e]	22.3[e]
Special Supplemental Benefits for the Chronically Ill (SSBCI)[g]				
Food and produce (e.g., frozen foods, canned goods, and produce to assist enrollees in meeting nutritional needs)	571	14.7	1,990	12.5
Meals beyond a limited basis	257	6.6	1,040	6.5
Pest control	191	4.9	800	5.0
Any transportation for non-medical needs (e.g., to a grocery store or a bank)	236	6.1	1,050	6.6
Indoor air quality equipment and services	69	1.8	230	1.4
Social needs benefit (e.g., access to community or plan-sponsored programs and events to address enrollee isolation)	204	5.2	460	2.9
Complementary therapies (therapies offered alongside traditional medical treatment)	30	0.8	60	0.4
Services supporting self-direction (e.g., interpreter services for encounters with health care providers, financial literacy classes, or other services that help enrollees to be responsible for managing their care)	52	1.3	130	0.8
Structural home modifications (e.g., permanent mobility ramps or widening of hallways)	53	1.4	150	0.9
General supports for living (e.g., subsidies for rent or utilities)	193	5.0	490	3.1
Other SSBCIs not defined by CMS[h]	197	5.1	780	4.9
Any of the 11 SSBCIs GAO reviewed	**851[e]**	**21.9[e]**	**2,760[e]**	**17.3[e]**

Source: GAO analysis of CMS data. | GAO-23-105527

Note: GAO uses “plan” to refer to each unique set of benefits submitted by a Medicare Advantage organization for a specific geographic region. GAO excluded certain plans, including plans outside the 50 states and District of Columbia, Medicare-Medicaid plans, Cost plans, plans that did not offer prescription drug benefits, plans participating in the Value-Based Insurance Design Model, and employer plans. The benefits are listed in the same order as the benefit information plans submit to CMS.

[a]Enrollment numbers are rounded to the nearest ten thousand.

[b]Traditional supplemental benefits have a primary purpose of preventing, curing, or diminishing an illness or injury.

[c]Plans can submit up to three other traditional supplemental benefits not defined by CMS. For example, in 2022, some plans listed compression socks or face masks as a traditional supplemental benefit. The count of plans reflect any plans that offered at least one other benefit.

[d]In general, Original Medicare covers an initial preventive physical exam within the enrollee's first 12 months of Medicare enrollment. It also covers an annual wellness visit that includes a health risk assessment. However, it does not cover a routine physical exam that is not related to treating or diagnosing a specific illness, symptom, complaint, or injury.

[e]The number and percentage of plans for a group of benefits or a given type of benefit do not equal the sum of the related rows because plans could offer more than one of these benefits.

[f]Expanded primarily health-related benefits act to ameliorate the functional/psychological effect of injuries or health conditions or reduce avoidable emergency and health care utilization, among other things.

[g]SSBCIs do not have to be primarily health related, but must have a reasonable expectation of improving or maintaining the health or overall function of chronically ill enrollees. When determining and designing benefits to be offered, plans may consider social determinants of health, such as socioeconomic status, as secondary criteria.

[h]Plans can submit up to five other SSBCIs not defined by CMS. For example, in 2022, some plans listed support for service animals as an SSBCI. The count of plans reflect any plans that offered at least one other benefit.

Appendix II: Supplemental Benefits Offered by Medicare Advantage Special Needs Plans (SNP) and Non-SNPs GAO Reviewed

There are some Medicare Advantage plans with specific eligibility requirements. For example, certain plans, referred to as special needs plans (SNP), exclusively serve Medicare beneficiaries who are dually eligible for Medicare and Medicaid, require an institutional level of care, or have a severe or chronic condition.

Table 8 shows the number and percentage of SNPs and non-SNPs we reviewed that offered each supplemental benefit in 2022 along with the number and percentage of enrollees in those plans. The number and percentage of enrollees in a plan that offers a given benefit show the potential reach of that benefit but do not necessarily reflect the number of enrollees who are eligible for or receive the benefit. This is because plans can target their benefits to certain enrollees, such as enrollees who are chronically ill or who have a specified health status or disease state.[1]

Table 8: Supplemental Benefits Offered by Medicare Advantage Special Needs Plans (SNP) Compared to Non-SNPs, 2022

	SNPs that offered benefit		Non-SNPs that offered benefit		
Supplemental benefit	**Number of SNPs (percent) (N=745)**	**Enrollment in April 2022 in thousands[a] (percent) (N=1,510)**	**Number of non-SNPs (percent) (N=3,148)**	**Enrollment in April 2022 in thousands[a] (percent) (N=14,470)**	**Percentage point difference in plans that offered benefit[b]**
Traditional supplemental benefits[c]					
Transportation for medical needs (e.g., to a doctor's office)	619 (83)	1,260 (83)	1,229 (39)	5,320 (37)	44.0 ▲
Acupuncture	175 (23)	460 (31)	871 (28)	4,690 (32)	4.2 ▼
Over-the-counter items (e.g., nonprescription pain relievers)	677 (91)	1,440 (95)	2,513 (80)	11,870 (82)	11.0 ▲
Meals for a limited period	449 (60)	1,110 (74)	2,036 (65)	9,860 (68)	4.4 ▼
Other supplemental services not defined by the Centers for Medicare & Medicaid Services (CMS)[d]	166 (22)	360 (24)	609 (19)	3,400 (24)	2.9 ▲
Annual/routine physical exam[e]	410 (55)	770 (51)	2,917 (93)	13,910 (96)	37.6 ▼
Health education	213 (29)	580 (38)	1,224 (39)	5,320 (37)	10.3 ▼
Nutritional/dietary benefit	215 (29)	650 (43)	943 (30)	4,010 (28)	1.1 ▼
Smoking and tobacco cessation counseling	182 (24)	580 (38)	1,119 (36)	3,690 (26)	11.1 ▼

[1]For example, a plan may offer a certain number of transports to primary care visits only to enrollees with congestive heart failure. If a plan offers a benefit only to targeted subgroups of enrollees, it must offer the benefit to all plan enrollees with the specified health status or disease state(s).

Supplemental benefit	SNPs that offered benefit: Number of SNPs (percent) (N=745)	SNPs that offered benefit: Enrollment in April 2022 in thousands[a] (percent) (N=1,510)	Non-SNPs that offered benefit: Number of non-SNPs (percent) (N=3,148)	Non-SNPs that offered benefit: Enrollment in April 2022 in thousands[a] (percent) (N=14,470)	Percentage point difference in plans that offered benefit[b]
Fitness	542 (73)	1,310 (87)	3,090 (98)	14,240 (98)	25.4 ▼
Enhanced disease management	13 (2)	20 (1)	243 (8)	1,150 (8)	6.0 ▼
Telemonitoring services	50 (7)	70 (5)	205 (7)	1,020 (7)	0.2 ▲
Remote access technology (e.g., nurse hotlines)	492 (66)	1,290 (86)	2,626 (83)	12,630 (87)	17.4 ▼
Home and bathroom safety devices and modifications	105 (14)	240 (16)	381 (12)	1,850 (13)	2.0 ▲
Counseling services	129 (17)	410 (27)	438 (14)	1,340 (9)	3.4 ▲
In-home safety assessment	38 (5)	110 (8)	188 (6)	810 (6)	0.9 ▼
Personal emergency response system	317 (43)	870 (58)	569 (18)	3,380 (23)	24.5 ▲
Medical nutrition therapy	13 (2)	70 (5)	406 (13)	1,440 (10)	11.2 ▼
Post discharge in-home medication reconciliation	10 (1)	30 (2)	96 (3)	330 (2)	1.7 ▼
Re-admission prevention	27 (4)	70 (5)	88 (3)	230 (2)	0.8 ▲
Wigs for hair loss related to chemotherapy	25 (3)	20 (1)	119 (4)	390 (3)	0.4 ▼
Weight management programs	36 (5)	60 (4)	162 (5)	440 (3)	0.3 ▼
Alternative therapies	55 (7)	70 (5)	157 (5)	740 (5)	2.4 ▲
Any dental	655 (88)[f]	1,370 (91)[f]	2,884 (92)[f]	13,540 (94)[f]	3.7 ▼
Oral exam	637 (86)	1,320 (88)	2,883 (92)	13,530 (94)	6.1 ▼
Prophylaxis (cleaning)	630 (85)	1,270 (84)	2,883 (92)	13,530 (94)	7.0 ▼
Fluoride treatment	432 (58)	990 (66)	2,096 (67)	9,740 (67)	8.6 ▼
Dental X-rays	629 (84)	1,310 (87)	2,852 (91)	13,430 (93)	6.2 ▼
Non-routine services	443 (59)	1,080 (72)	1,823 (58)	7,920 (55)	1.6 ▲
Diagnostic services	464 (62)	1,060 (70)	2,077 (66)	10,000 (69)	3.7 ▼
Restorative services	590 (79)	1,340 (89)	2,280 (72)	10,390 (72)	6.8 ▲
Endodontics	542 (73)	1,230 (82)	1,924 (61)	8,560 (59)	11.6 ▲
Periodontics	565 (76)	1,280 (85)	2,098 (67)	10,020 (69)	9.2 ▲
Extractions	557 (75)	1,220 (81)	2,162 (69)	10,100 (70)	6.1 ▲
Prosthodontics	567 (76)	1,240 (82)	2,071 (66)	9,620 (66)	10.3 ▲
Any vision	712 (96)[f]	1,440 (96)[f]	3,089 (98)[f]	14,400 (99)[f]	2.6 ▼
Routine eye exams	688 (92)	1,360 (90)	3,083 (98)	14,390 (99)	5.6 ▼
Other eye exam	26 (3)	30 (2)	580 (18)	2,150 (15)	14.9 ▼
Contact lenses	676 (91)	1,380 (91)	2,875 (91)	13,420 (93)	0.6 ▼

Supplemental benefit	SNPs that offered benefit: Number of SNPs (percent) (N=745)	SNPs that offered benefit: Enrollment in April 2022 in thousands[a] (percent) (N=1,510)	Non-SNPs that offered benefit: Number of non-SNPs (percent) (N=3,148)	Non-SNPs that offered benefit: Enrollment in April 2022 in thousands[a] (percent) (N=14,470)	Percentage point difference in plans that offered benefit[b]
Eyeglasses (frames and lenses)	636 (85)	1,320 (88)	2,653 (84)	12,730 (88)	1.1 ▲
Eyeglass lenses	504 (68)	870 (58)	2,059 (65)	7,780 (54)	2.2 ▲
Eyeglass frames	508 (68)	890 (59)	2,059 (65)	7,780 (54)	2.8 ▲
Eyewear upgrades	374 (50)	820 (55)	1,511 (48)	5,150 (36)	2.2 ▲
Any hearing	674 (90)[f]	1,250 (83)[f]	2,994 (95)[f]	13,420 (93)[f]	4.6 ▼
Routine hearing exams	661 (89)	1,240 (83)	2,970 (94)	13,280 (92)	5.6 ▼
Fitting/evaluation for hearing aids	548 (74)	990 (66)	2,275 (72)	8,560 (59)	1.3 ▲
Hearing aids (all types)	644 (86)	1,230 (82)	2,858 (91)	12,930 (89)	4.3 ▼
Hearing aids - inner ear	18 (2)	10 (1)	10 (<1)	<10 (<1)	2.1 ▲
Hearing aids - outer ear	18 (2)	10 (1)	10 (<1)	<10 (<1)	2.1 ▲
Hearing aids - over the ear	18 (2)	10 (1)	10 (<1)	<10 (<1)	2.1 ▲
Any of the 47 traditional supplemental benefits GAO reviewed	**744 (>99)[f]**	**1,500 (>99)[f]**	**3,148 (100)[f]**	**14,470 (100)[f]**	**<1.0 ■**
Expanded primarily health-related supplemental benefits[g]					
Therapeutic massage	34 (5)	50 (3)	147 (5)	430 (3)	<1.0 ■
Adult day health services	41 (6)	20 (1)	32 (1)	90 (1)	4.5 ▲
Home-based palliative care	7 (1)	50 (3)	121 (4)	560 (4)	2.9 ▼
In-home support services (e.g., to assist individuals in performing activities such as dressing, eating, and housework)	235 (32)	440 (29)	437 (14)	2,160 (15)	17.7 ▲
Support for caregivers of enrollees	70 (9)	130 (9)	163 (5)	810 (6)	4.2 ▲
Any of the five expanded primarily health-related supplemental benefits GAO reviewed	**257 (34)[f]**	**510 (34)[f]**	**674 (21)[f]**	**3,050 (21)[f]**	**13.1 ▲**
Special Supplemental Benefits for the Chronically Ill (SSBCI)[h]					
Food and produce (e.g., frozen foods, canned goods, and produce to assist enrollees in meeting nutritional needs)	240 (32)	680 (45)	331 (11)	1,310 (9)	21.7 ▲
Meals beyond a limited basis	78 (10)	110 (7)	179 (6)	930 (6)	4.8 ▲
Pest control	66 (9)	110 (7)	125 (4)	690 (5)	4.9 ▲
Any transportation for non-medical needs (e.g., to a grocery store or a bank)	107 (14)	280 (19)	129 (4)	770 (5)	10.3 ▲

Supplemental benefit	SNPs that offered benefit: Number of SNPs (percent) (N=745)	SNPs that offered benefit: Enrollment in April 2022 in thousands[a] (percent) (N=1,510)	Non-SNPs that offered benefit: Number of non-SNPs (percent) (N=3,148)	Non-SNPs that offered benefit: Enrollment in April 2022 in thousands[a] (percent) (N=14,470)	Percentage point difference in plans that offered benefit[b]
Indoor air quality equipment and services	32 (4)	70 (5)	37 (1)	150 (1)	3.1 ▲
Social needs benefit (e.g., access to community or plan-sponsored programs and events to address enrollee isolation)	61 (8)	130 (8)	143 (5)	330 (2)	3.6 ▲
Complementary therapies (therapies offered alongside traditional medical treatment)	16 (2)	<10 (<1)	14 (<1)	60 (<1)	1.7 ▲
Services supporting self-direction (e.g., interpreter services for encounters with health care providers, financial literacy classes, or other services that help enrollees to be responsible for managing their care)	22 (3)	10 (1)	30 (1)	120 (1)	2.0 ▲
Structural home modifications (e.g., permanent mobility ramps or widening of hallways)	17 (2)	40 (2)	36 (1)	110 (1)	1.1 ▲
General supports for living (e.g., subsidies for rent or utilities)	87 (12)	230 (15)	106 (3)	260 (2)	8.3 ▲
Other SSBCIs not defined by CMSi	52 (7)	100 (6)	145 (5)	680 (5)	2.4 ▲
Any of the 11 SSBCIs GAO reviewed	**337 (45)[f]**	**830 (55)[f]**	**514 (16)[f]**	**1,930 (13)[f]**	**28.9 ▲**

Legend

▲: A higher percentage of SNPs than non-SNPs offered the benefit

■: A similar percentage of SNPs and non-SNPs offered the benefit

▼: A lower percentage of SNPs than non-SNPs offered the benefit

Source: GAO analysis of CMS data. | GAO-23-105527

Note: GAO uses “plan” to refer to each unique set of benefits submitted by a Medicare Advantage organization for a specific geographic region. GAO excluded certain plans, including plans outside the 50 states and District of Columbia, Medicare-Medicaid plans, Cost plans, plans that did not offer prescription drug benefits, plans participating in the Value-Based Insurance Design Model (which includes most SNP enrollees), and employer plans. The benefits are listed in the same order as the benefit information plans submit to CMS.

[a]Enrollment numbers are rounded to the nearest ten thousand.

[b]This is the absolute difference between the percentage of SNPs and non-SNPs that offered at least one benefit. The difference shown may not equal the difference in percentages for SNPs versus non-SNPs due to rounding.

[c]Traditional supplemental benefits have a primary purpose of preventing, curing, or diminishing an illness or injury.

[d]Plans can submit up to three other traditional supplemental benefits not defined by CMS. For example, in 2022, some plans listed compression socks or face masks as a traditional supplemental benefit. The count of plans reflect any plans that offered at least one other benefit.

[e]In general, Original Medicare covers an initial preventive physical exam within the enrollee's first 12 months of Medicare enrollment. It also covers an annual wellness visit that includes a health risk assessment. However, it does not cover a routine physical exam that is not related to treating or diagnosing a specific illness, symptom, complaint, or injury.

[f]The number and percentage of plans for a group of benefits or a given type of benefit do not equal the sum of the related rows because plans could offer more than one of these benefits.

[g]Expanded primarily health-related benefits act to ameliorate the functional/psychological effect of injuries or health conditions or reduce avoidable emergency and health care utilization, among other things.

[h]SSBCIs do not have to be primarily health related, but must have a reasonable expectation of improving or maintaining the health or overall function of chronically ill enrollees. When determining and designing benefits to be offered, plans may consider social determinants of health, such as socioeconomic status, as secondary criteria.

[i]Plans can submit up to five other SSBCIs not defined by CMS. For example, in 2022, some plans listed support for service animals as an SSBCI. The count of plans reflect any plans that offered at least one other benefit.

Appendix III: Supplemental Benefits Offered by Medicare Advantage Plans GAO Reviewed in the Value-Based Insurance Design Model

The Centers for Medicare & Medicaid Services (CMS) began the Value-Based Insurance Design (VBID) Model in January 2017, and it is scheduled to run until December 2024. The VBID Model tests different ways to deliver and pay for services in Medicare Advantage (MA). For example, in 2022, the VBID Model allowed plans unique flexibilities for targeting supplemental benefits to subgroups of enrollees. Unlike non-VBID plans, they could target supplemental benefits at subgroups of enrollees based on the enrollees' (1) chronic condition or conditions or (2) socioeconomic status, as identified by eligibility for Medicare's Low Income Subsidy that assists with costs associated with the prescription drug benefit program.[1] For example, a plan could offer certain supplemental benefits only to enrollees who were eligible for the Low Income Subsidy and who have chronic obstructive pulmonary disease.

To describe the supplemental benefits offered by VBID plans, we analyzed the plan benefit data submitted to CMS for 2022.[2] We analyzed data for 957 VBID plans—410 special needs plans (SNP) and 547 non-SNPs—that were in the 50 states and District of Columbia and offered prescription drug benefits.[3] In April 2022, the VBID plans reviewed had total enrollment of approximately 6.58 million, including approximately 2.95 million SNP enrollees and 3.63 million non-SNP enrollees.

We found that VBID plans we reviewed offered an array of supplemental benefits in 2022 with some benefits offered only to targeted subgroups of enrollees.

- **Traditional supplemental benefits.** All VBID plans reviewed offered at least one of these benefits, which have a primary purpose of

[1]If a plan offers a benefit only to targeted subgroups of enrollees, it must offer the benefit in a non-discriminatory manner—that is, to all enrollees who meet the criteria established by the MA plan.

[2]We analyzed the second quarter Plan Benefit Package data for 2022, which is the first version that contains information on the full range of supplemental benefits offered by each plan, as approved by CMS.

We use "plan" to refer to each unique set of benefits submitted by an MA organization (the legal entity that has a contract with the Medicare program to provide coverage) for a specific geographic region. A plan can offer a specific benefit to all enrollees or targeted subgroups of enrollees, but each plan was only counted once when determining the number of plans that offered a specific benefit.

[3]Medicare beneficiaries can enroll in a SNP if they are dually eligible for Medicare and Medicaid, require an institutional level of care, or have a severe or chronic condition.

preventing, curing, or diminishing an illness or injury. The most common benefits offered were fitness, vision, over-the-counter items (such as non-prescription pain relievers), hearing, annual/routine physical exams, meals for a limited period (e.g., after an inpatient hospital stay), and dental. In general, most VBID plans offered the traditional supplemental benefits uniformly. However, for a subset of these benefits, plans more commonly targeted them to enrollees based on their socioeconomic status or chronic condition, or to chronically ill enrollees. These benefits included the alternative therapies, weight management, and home and bathroom safety devices and modifications.

- **Expanded primarily health-related supplemental benefits.** About one-fourth of VBID plans reviewed offered at least one of these benefits, which act to ameliorate the functional/psychological effect of injuries or health conditions or reduce avoidable emergency and health care utilization, among other things. The most common such benefit offered by VBID plans was in-home support services (e.g., to assist individuals in performing activities such as dressing, eating, and housework).

  The VBID plans generally targeted some of the expanded primarily health-related benefits—support for caregivers, therapeutic massage, and adult day health services—at chronically ill enrollees. Plans more commonly offered the other two expanded benefits—in-home support services and home-based palliative care—uniformly to all enrollees. In addition, plans rarely targeted the expanded benefits to enrollees based on socioeconomic status. For example, 2 percent of VBID plans reviewed that offered in-home support services did so based solely on socioeconomic status, and the plans did not target any other expanded benefits based solely on socioeconomic status.

- **Non-primarily health-related supplemental benefits.** About one-third of VBID plans reviewed offered at least one of these benefits, which must have a reasonable expectation of improving or maintaining the health or overall function of the enrollee.[4] The most commonly offered non-primarily health-related benefits were food and produce (e.g., frozen foods, canned goods, and produce to assist enrollees in meeting nutritional needs), meals beyond a limited basis,

[4]These non-primarily health-related supplemental benefits are of the same type and scope as Special Supplemental Benefits for the Chronically Ill, which can be offered to only chronically ill enrollees. In the VBID Model, these benefits can also be offered to subgroups of enrollees based on the enrollees' (1) chronic condition or conditions or (2) socioeconomic status, as identified by eligibility for Medicare's Low Income Subsidy.

and transportation for non-medical needs (e.g., to a grocery store or a bank). Among VBID plans that offered these types of benefits, varying percentages targeted the benefits based solely on socioeconomic status. For example, around 40 percent of plans that offered food and produce and around 30 percent of plans that offered meals beyond a limited basis did so based solely on socioeconomic status.

Finally, we found that, among VBID plans reviewed, a higher percentage of SNPs offered certain benefits compared to non-SNPs. These included traditional supplemental benefits such as transportation for medical needs (e.g., to a doctor's office), personal emergency response systems, and remote access technology (e.g., nurse hotlines). They also included in-home support services (e.g., to assist individuals in performing activities such as dressing, eating, and housework), which is an expanded primarily health-related supplemental benefit. Finally, all but one of the non-primarily health-related benefits was offered by a higher percentage of SNPs we reviewed compared to non-SNPs.

See table 9 for additional information on the supplemental benefits offered by VBID plans.

Table 9: Examples of Supplemental Benefits Offered by Medicare Advantage Plans in the Value-Based Insurance Design Model, Including Special Needs Plans (SNP) and Non-SNPs, 2022

		SNPs that offered benefit		Non-SNPs that offered benefit		
Supplemental benefit	Total number of plans that offered benefit (percent) (N=957)	Number of SNPs (N=410)	Percent of SNPs	Number of non-SNPs (N=547)	Percent of non-SNPs	Percentage point difference in plans that offered benefit[a]
Traditional supplemental benefits[b]						
Fitness	932 (97)	390	95	542	99	4 ▼
Vision[c]	922 (96)	399	97	523	96	2 ▲
Over-the-counter items (e.g., nonprescription pain relievers)	916 (96)	406	99	510	93	6 ▲
Hearing[c]	910 (95)	398	97	512	94	4 ▲
Annual/routine physical examd	904 (94)	370	90	534	98	7 ▼
Meals for a limited period (e.g., after an inpatient hospital stay)	892 (93)	368	90	524	96	6 ▼
Dental[c]	885 (92)	401	98	484	88	9 ▲
Other supplemental services not defined by the Centers for Medicare & Medicaid Services (CMS)[e]	737 (77)	281	69	456	83	15 ▼

Supplemental benefit	Total number of plans that offered benefit (percent) (N=957)	SNPs that offered benefit: Number of SNPs (N=410)	SNPs that offered benefit: Percent of SNPs	Non-SNPs that offered benefit: Number of non-SNPs (N=547)	Non-SNPs that offered benefit: Percent of non-SNPs	Percentage point difference in plans that offered benefit[a]
Acupuncture	662 (69)	214	52	448	82	30 ▼
Transportation for medical needs (e.g., to a doctor's office)	648 (68)	379	92	269	49	43 ▲
Personal emergency response system	469 (49)	310	76	159	29	47 ▲
Remote access technology (e.g., nurse hotlines)	343 (36)	267	65	76	14	51 ▲
Home and bathroom safety devices and modifications	272 (28)	179	44	93	17	27 ▲
Smoking and tobacco cessation counseling	238 (25)	173	42	65	12	30 ▲
Health education	203 (21)	119	29	84	15	14 ▲
Wigs for hair loss related to chemotherapy	197 (21)	131	32	66	12	20 ▲
Any of the 47 traditional supplemental benefits GAO reviewed[f]	**957 (100)[g]**	**410[g]**	**100[g]**	**547[g]**	**100[g]**	**0 ■**
Expanded primarily health-related supplemental benefits[h]						
In-home support services (e.g., to assist individuals in performing activities such as dressing, eating, and housework)	219 (23)	143	35	76	14	21 ▲
Therapeutic massage	100 (10)	56	14	44	8	6 ▲
Adult day health services	96 (10)	58	14	38	7	7 ▲
Support for caregivers of enrollees	96 (10)	57	14	39	7	7 ▲
Home-based palliative care	22 (2)	1	0	21	4	4 ▼
Any of the five expanded primarily health-related supplemental benefits GAO reviewed	**240 (25)[g]**	**149[g]**	**36[g]**	**91[g]**	**17[g]**	**20 ▲**
Non-primarily health-related supplemental benefits[i]						
Food and produce (e.g., frozen foods, canned goods, and produce to assist enrollees in meeting nutritional needs)	262 (27)	208	51	54	10	41 ▲
Other non-primarily health-related supplemental benefits not defined by CMS[j]	158 (17)	92	22	66	12	10 ▲
Meals beyond a limited basis	149 (16)	97	24	52	10	14 ▲

Supplemental benefit	Total number of plans that offered benefit (percent) (N=957)	SNPs that offered benefit: Number of SNPs (N=410)	SNPs that offered benefit: Percent of SNPs	Non-SNPs that offered benefit: Number of non-SNPs (N=547)	Non-SNPs that offered benefit: Percent of non-SNPs	Percentage point difference in plans that offered benefit[a]
Transportation for non-medical needs (e.g., to a grocery store or a bank)	144 (15)	98	24	46	8	16 ▲
Pest control	132 (14)	94	23	38	7	16 ▲
General supports for living (e.g., subsidies for rent or utilities)	97 (10)	59	14	38	7	7 ▲
Services supporting self-direction (e.g., interpreter services for encounters with health care providers, financial literacy classes, or other services that help enrollees to be responsible for managing their care)	96 (10)	53	13	43	8	5 ▲
Indoor air quality equipment and services	92 (10)	54	13	38	7	6 ▲
Complementary therapies (therapies offered alongside traditional medical treatment)	91 (10)	53	13	38	7	6 ▲
Social needs benefit (e.g., access to community or plan-sponsored programs and events to address enrollee isolation)	36 (4)	24	6	12	2	4 ▲
Structural home modifications (e.g., permanent mobility ramps or widening of hallways)	13 (1)	5	1	8	1	<1 ■
Any of the 11 non-primarily health-related supplemental benefits GAO reviewed	**308 (32)[g]**	**211[g]**	**51[g]**	**97[g]**	**18[g]**	**34 ▲**

Legend:

▲: A higher percentage of SNPs than non-SNPs offered the benefit

■: A similar percentage of SNPs and non-SNPs offered the benefit

▼: A lower percentage of SNPs than non-SNPs offered the benefit

Source: GAO analysis of CMS data. | GAO-23-105527

Note: The Value-Based Insurance Design (VBID) Model is designed to test a broad array of alternative ways to deliver and pay for services in Medicare Advantage. GAO uses “plan” to refer to each unique set of benefits submitted by a Medicare Advantage organization in a specific geographic region. GAO excluded plans outside the 50 states and District of Columbia and plans that did not offer prescription drug benefits.

[a]This is the absolute difference between the percentage of SNPs and non-SNPs that offered at least one benefit.

[b]Traditional supplemental benefits have a primary purpose of preventing, curing, or diminishing an illness or injury. Only the most commonly offered traditional supplemental benefits are listed.

[c]There are multiple vision, hearing, and dental benefits. For example, specific dental benefits include oral exams, cleaning, fluoride, and X-rays. A plan is counted as offering the benefit if it offers at least one such specific benefit.

[d]In general, Original Medicare covers an initial preventive physical exam within the enrollee's first 12 months of Medicare enrollment. It also covers an annual wellness visit that includes a health risk assessment. However, it does not cover a routine physical exam that is not related to treating or diagnosing a specific illness, symptom, complaint, or injury.

[e]Plans can submit up to three other traditional supplemental benefits not defined by CMS. For example, in 2022, some VBID plans offered a monthly allowance that members could spend on certain healthy foods as a traditional supplemental benefit. The count of plans reflect any plans that offered at least one other benefit.

[f]Plans report to CMS whether they offer each of 46 traditional supplemental benefits defined by CMS. Plans can also report up to three other traditional supplemental benefits not in the defined list—which GAO collapsed into and counted as a single benefit.

[g]The number and percentage do not equal the sum of the previous rows because plans could offer more than one of these benefits. In addition, for traditional supplemental benefits, not all benefits are listed.

[h]Expanded primarily health-related supplemental benefits act to ameliorate the functional/psychological effect of injuries or health conditions or reduce avoidable emergency and health care utilization, among other things.

[i]Non-primarily health-related supplemental benefits must have a reasonable expectation of improving or maintaining the health or overall function of the enrollee. These benefits are of the same type and scope as Special Supplemental Benefits for the Chronically Ill, which can be offered to only chronically ill enrollees. In the VBID Model, these benefits can also be offered to subgroups of enrollees based on the enrollees' (1) chronic condition or conditions or (2) socioeconomic status, as identified by eligibility for Medicare's Low Income Subsidy.

[j]Plans can submit up to five other non-primarily health-related supplemental benefits not listed elsewhere. For example, in 2022, some VBID plans listed pet care assistance as a non-primarily health-related supplemental benefit. The count of plans reflect any plans that offered at least one other benefit.

Appendix IV: Comments from the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

January 10, 2023

Michelle Rosenberg
Director, Health Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Ms. Rosenberg:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, **"MEDICARE ADVANTAGE: Plans Generally Offered Some Supplemental Benefits, but CMS Has Limited Data on Utilization" (GAO-23-105527).**

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

Melanie Anne Egorin

Melanie Anne Egorin, PhD
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT - MEDICARE ADVANTAGE: PLANS GENERALLY OFFERED SOME SUPPLEMENTAL BENEFITS, BUT CMS HAS LIMITED DATA ON UTILIZATION (GAO-23-105527)

The Department of Health and Human Services (HHS) appreciates the opportunity to review and comment on this draft report. HHS is committed to ensuring that Medicare Advantage (MA) supplemental benefits effectively support the health and social needs of people with Medicare.

As noted by the GAO, MA plans can offer additional benefits not covered under Original Medicare (called "supplemental benefits"), including coverage for dental, vision and hearing. There are specific legal standards in statute and regulation for supplemental benefits. Historically, a supplemental benefit must be primarily health related. Starting in 2019, the definition of "primarily health related" was expanded such that MA plans could offer an expanded scope of supplemental benefits. In addition, starting in 2020, MA plans could offer special non-primarily health related supplemental benefits that had a reasonable expectation of improving or maintaining the health or function of a chronically ill enrollee known as Special Supplemental Benefits for the Chronically Ill (SSBCI).[1] For example, MA plans can offer transportation for non-medical needs or structural home modifications. MA plans have flexibility in determining which supplemental benefits they offer; however, plans must submit information to HHS on all plan benefits on an annual basis. For supplemental benefits, this includes information on whether the plan is offering the benefit to all enrollees or certain subgroups, as well as how the benefits will be financed.

MA plans are also required to submit an encounter data record for each item and service provided to their enrollees. This includes submission of encounter data for supplemental benefits. As HHS continues to collect encounter data on enrollees, it is committed to confirming that all supplemental benefits offered by MA plans are reported and that MA organizations (MAOs) have clear guidance on how to report these benefits. Since supplemental benefits such as in- home support services, support for caregivers of enrollees, and food and produce assistance were recently introduced, it is important to note that HHS is still developing guidance on the encounter data collection process pertaining to these more recently implemented benefits.

In addition, HHS recently released a Medicare Advantage Request for Information, seeking input from the public regarding various aspects of the MA program, including supplemental benefits.[2] The comment period closed on August 31, 2022. At this time, HHS is in the process of reviewing and analyzing the comments received. HHS may use this input to inform future rulemaking or other policy development.

Lastly, in the Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs final rule which appeared in the Federal Register on May 9, 2022, HHS required MAOs to report expenditures through the Medical Loss Ratio reports for various categories of supplemental benefits not available under Original Medicare.[3] This requirement takes effect for Medical Loss Ratio reporting for contract year 2023; MAOs and Part D

[1] https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Downloads/Supplemental_Benefits_Chronically_Ill_HPMS_042419.pdf HPMS Memo "Reinterpretation of "Primarily Health Related" for Supplemental Benefits"
[2] https://www.govinfo.gov/content/pkg/FR-2022-08-01/pdf/2022-16463.pdf
[3] https://www.govinfo.gov/content/pkg/FR-2022-05-09/pdf/2022-09375.pdf

1

sponsors submit these reports approximately one year after the end of the reporting year.[4]

GAO Recommendation 1
The Administrator of CMS should clarify guidance to MA plans on the extent to which encounter data submissions must include data on the utilization of supplemental benefits.

HHS Response
HHS concurs with GAO's recommendation and plans to issue guidance to MA plans to clarify the extent to which MA plans' encounter data submissions must include data on supplemental benefit utilization.

GAO Recommendation 2
The Administrator of CMS should take actions to address circumstances where submitting encounter data for supplemental benefits is challenging for MA plans, such as when a given benefit lacks an applicable procedure code. Such actions may include the creation of new procedure codes or of a new data-submission format.

HHS Response
HHS concurs with GAO's recommendation and is committed to addressing challenges that MA plans experience when submitting supplemental benefits encounter data. HHS will assess challenges faced by MA organizations in submitting encounter data on supplemental benefits. HHS will use information from this assessment to develop guidance to address these challenges.

HHS thanks GAO for their efforts on this issue and looks forward to working with GAO on this and other issues in the future.

[4] https://www.cms.gov/newsroom/fact-sheets/cy-2023-medicare-advantage-and-part-d-final-rule-cms-4192-f

Appendix V: GAO Contact and Staff Acknowledgments

GAO Contact

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Staff Acknowledgments

In addition to the contact named above, Iola D'Souza (Assistant Director), Corissa Kiyan-Fukumoto (Analyst-in-Charge), and Elizabeth Flow-Delwiche made key contributions to this report. Sam Amrhein, Todd Anderson, Zhi Boon, Sonia Chakrabarty, and Ying Hu also made important contributions.

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