

Medicare Advantage Supplemental Benefits and Improved Healthcare Use

May 2024
Revised October 2024



Contents

Overview	3
Background	4
Methods	5
Results	6
Discussion	9
Conclusion	10
Endnotes	11

Key Takeaways

- Use of Medicare Advantage (MA) supplemental benefits is associated with a decreased likelihood of having an inpatient admission or non-emergent emergency department visit.
- Supplemental benefit use is also associated with an increased likelihood of having an annual wellness visit, office visit, or preventative screening.
- Many results were especially favorable among dual eligible members, which underscores the importance of supplemental benefits for members who may have greater health-related social needs.

Overview

The Medicare Advantage (MA) program has grown significantly in the last two decades. In 2023, over 32 million beneficiaries – more than half of eligible Medicare beneficiaries – chose to enroll in an MA plan to access their benefits.¹

Under the MA program, private plans can offer benefits that are not covered under Traditional Medicare (or Medicare fee-for-service [FFS]), known as supplemental benefits. The number of plans offering at least one supplemental benefit has grown substantially; from 2020 to 2023, this number grew by 250 percent, from 626 to 2,207 plans.² In addition, the array of supplemental benefits offered by plans has also broadened.

Originally, supplemental benefits were defined as “primarily health related” benefits that are not covered under Medicare FFS. However, recent regulatory and legislative changes have allowed for more flexibility in supplemental benefit design, permitting plans to test innovative benefits and modify those benefits over time based on beneficiary experience and health outcomes. Some examples of newer types of supplemental benefits include transportation, over-the-counter, and home modification benefits.

With this rapid growth in supplemental benefit offerings, policy makers and stakeholders understandably want to know more about how beneficiaries are using supplemental benefits and the resulting impact on health outcomes. To address the former, the Elevance Health Public Policy Institute published a previous analysis in 2023,³ which found tremendous uptake of supplemental benefits with many members using multiple supplemental benefits. Further, the study found that supplemental benefits were often used by members with greater health-related social needs (HRSN), such as those living in areas with lower socioeconomic status and food deserts.

However, to date, there is still a gap in the literature regarding the relationship between supplemental benefit use and healthcare outcomes. The purpose of this analysis is to bridge the existing knowledge gap by identifying the association between supplemental benefits and healthcare utilization.



The objective of this analysis is to identify the association between supplemental benefits and healthcare use.

Background

In the last five years, MA supplemental benefits have evolved considerably, with newer regulation and legislation allowing plans more flexibility than previously in designing and offering innovative new benefits.



MA plans have flexibility in tailoring supplemental benefits to fit their members' needs.

Prior to 2019, supplemental benefits were narrowly defined as benefits not covered by Medicare FFS that were “primarily health related,” such as dental, vision, and hearing benefits. In addition, MA plans were required to offer identical benefits to all enrollees. In 2019, the Centers for Medicare & Medicaid Services (CMS) expanded the definition of primarily health related supplemental benefits to encompass certain nonmedical supplemental benefits, which allowed plans to offer broader use of transportation and food benefits. CMS also removed the uniformity requirement, so that plans can offer different cost-sharing or specially tailored benefits to members who meet specific medical criteria. The following year in 2020, under the CHRONIC Care Act, additional flexibility was granted to plans, as they could now offer Special Supplemental Benefits for the Chronically Ill (SSBCI) to members with certain chronic conditions. SSBCI, unlike other conventional supplemental benefits, can include non-primarily health related benefits.

Plans have used these new flexibilities to tailor supplemental benefits to address their members’ HRSN. For instance, while medically tailored meals have been offered as a conventional supplemental benefit for some time, under the expanded benefits definition and SSBCI, some plans now offer additional nutrition benefits such as grocery cards, which provide a monthly allowance in the form of a prepaid card so that members can purchase food, including produce, at participating grocery stores.

Methods

This analysis included members from Elevance Health-affiliated MA plans who were continuously enrolled for 12 months in 2021 and/or 2022. Thirty-six of the 42 supplemental benefits that the MA plans offered were analyzed,⁴ including both conventional supplemental benefits and SSBCI.

Members with access to any of the 36 supplemental benefits were divided into two groups: users and non-users. Users included members who used one or more of the supplemental benefits offered to them through their plan at least once in 2021 and/or 2022. There were 799,258 non-dual eligible and 461,863 dual eligible MA supplemental benefit users in the analysis sample.⁵ Non-users included members who were offered any of the 36 supplemental benefits through their plan but did not use any in 2021 and/or 2022. There were 292,296 non-dual eligible and 105,723 dual eligible non-users in the sample.

These groups were separately matched to FFS beneficiaries using propensity score matching on observed individual, ZIP code, and county-level demographic characteristics and an exact match on state of residence. This method selects the optimal match between an MA user or non-user and a corresponding FFS beneficiary who resided in the same state and had similar baseline characteristics.⁶ The quality of the match was assessed by analyzing the standardized mean differences (SMD) between the observed characteristics of the MA users and non-users and their matched FFS beneficiaries. The matches were considered appropriately balanced with SMD <0.2 among the observed individual, ZIP code, and county-level demographic characteristics.

Results were analyzed separately among non-dual eligible members and dual eligible members. Healthcare utilization was measured using MA medical claims and FFS claims (from the 100% FFS files). The Elevance Health Public Policy Institute analyzed the MA data; the Berkeley Research Group (BRG) analyzed the Medicare FFS data under a Data Use Agreement with CMS.

After the sample was identified, a difference-in-differences (DID) design was used, which measured the difference in outcomes between MA users and non-users relative to the differences with their respective FFS matched groups. An example of this calculation is shown in Table 1 using illustrative numbers.

Table 1
Example of
Difference-in-Differences (DID)
Estimate Calculation

	Fee-For-Service*	Medicare Advantage	Difference
Users	40.3%	41.3%	1.0%
Non-Users	37.6%	26.6%	-11.0%
DID Estimate			12.0%

Note. * = Fee-for-service refers to the sample of fee-for-service individuals who were matched to Medicare Advantage users or Medicare Advantage non-users.

First, the differences between MA users and their matched FFS beneficiaries and between MA non-users and their matched FFS beneficiaries were calculated. Then, the difference in those differences was calculated, thereby giving the DID estimate. This method was used because it adjusts for both selection into utilizing a supplemental benefit and the impact of enrolling in a managed care plan, leaving just the added value of supplemental benefit use.

Limitations

While the matches were well-balanced with SMD <0.2, a more conservative cut-off for SMD is <0.1. Allowing for a larger SMD means that there could be larger differences in observable individual, ZIP code, and county-level characteristics between an individual and their match. While most characteristics had an SMD <0.1, the difference in health risk status (CMS-HCC score) between the MA cohort and their matched FFS groups was between 0.1 and 0.2. Particularly in the dual eligible sample, we found that on average, MA users had a lower health risk score (i.e., had lower predicted health spending) compared to their matched FFS group than did MA non-users compared to their matched FFS group. Therefore, the results for this group may be affected by both the impact of supplemental benefit use and a difference in health status.

Additionally, enrollment into MA plans and use of supplemental benefits was not randomized. Though this analysis accounts for observed characteristics that may influence enrollment into MA and use of supplemental benefits, unobserved characteristics and unmeasured confounding were not accounted for.

Results

Among both dual eligible and non-dual eligible members, the use of at least one supplemental benefit was associated with a decreased likelihood of having an inpatient admission, and an increased likelihood of having an outpatient visit or preventative screening. Additionally, the use of at least one supplemental benefit among non-dual eligible members was associated with a decreased likelihood of having a non-emergent⁷ emergency department (ED) visit.

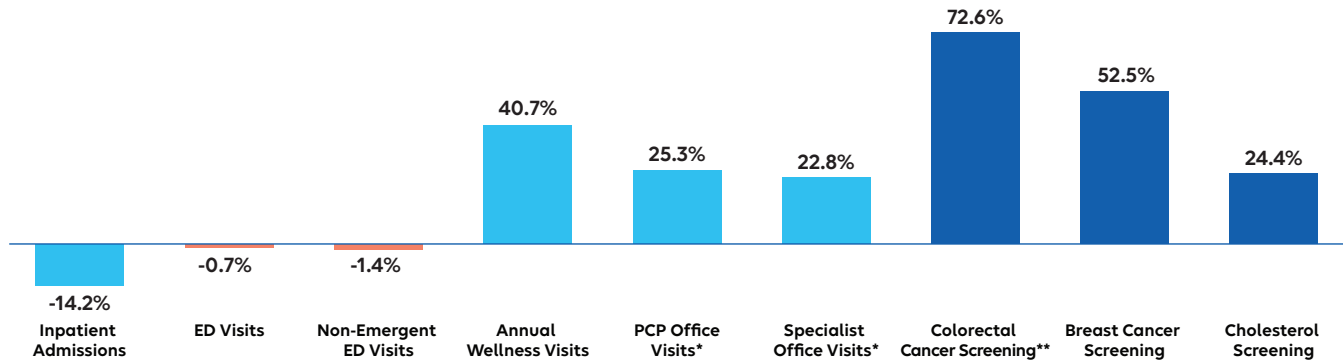
Notably, supplemental benefit use was associated with an increased likelihood of having at least one annual wellness visit, primary care physician (PCP) or specialist office visit, colorectal or breast cancer screening, or cholesterol screening for both dual eligible and non-dual eligible members. The results for dual eligible and non-dual eligible members who had any type of ED visit (emergent and non-emergent) were not statistically significant. (Figure 1)

Figure 1

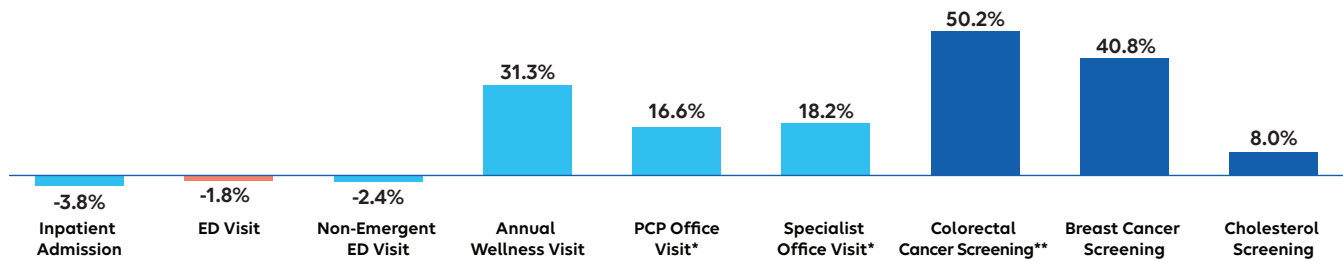
Relative Change in Likelihood of Healthcare Utilization With Any Supplemental Benefit Use

- Inpatient and Outpatient Visits, statistically significant (p<0.05)
- Inpatient and Outpatient Visits, not statistically significant
- Preventative Screenings, statistically significant (p<0.05)

Dual Eligible Population



Non-Dual Eligible Population



Note. Relative changes in likelihood of healthcare utilization were derived from the sample by dividing the difference-in-differences estimates of all outcomes by the sample mean of the outcomes.

* = Office visits include in-person and telehealth office visits and are based on the presence of an outpatient evaluation and management billing code.

** = Colorectal cancer screening was limited to colonoscopies.

ED = Emergency Department; PCP = Primary Care Physician.

To further put these percentages into context, Table 2 shows the sample means (the average percentage of members who annually had at least one visit or screening across MA users and non-users and their matched FFS groups, calculated separately for dual eligible individuals and non-dual eligible individuals) and the percentage point DID estimates. The DID estimate was divided by the sample mean to get the relative change in likelihood percentages shown in Figure 1.

When interpreting the results from this analysis, it is helpful to look at both the relative change in likelihood percentages from Figure 1 and the sample means and DID estimates from Table 2. While the relative change in likelihood percentage may appear high for an outcome, if the sample mean for that outcome is small, the small denominator (i.e. small sample mean) will make the change in likelihood percentage appear larger. For instance, this is the case with colorectal cancer screenings. In the dual eligible population, the likelihood of having a colorectal cancer screening increases by 72.6% with any use of supplemental benefits, but that is relative to a relatively low sample mean of 7.3%. Conversely, a larger sample mean may lead to a relative change in likelihood percentage that appears smaller for an outcome.

Table 2
Sample Means and Percentage
Point Difference-in-Differences
(DID) Estimates For Any
Supplemental Benefit Use

	Dual Eligible Population		Non-Dual Eligible Population	
	Sample Mean	Percentage Point DID Estimate	Sample Mean	Percentage Point DID Estimate
Inpatient Admission	17.1%	-2.4%	12.4%	-0.5%
ED Visit	33.0%	-0.2%	21.3%	-0.4%
Non-Emergent ED Visit	19.1%	-0.3%	10.5%	-0.2%
Annual Wellness Visit	27.6%	11.2%	38.4%	12.0%
PCP Office Visit	63.6%	16.1%	69.6%	11.6%
Specialist Office Visit	75.9%	17.3%	79.9%	14.6%
Colorectal Cancer Screening	7.3%	5.3%	8.9%	4.5%
Breast Cancer Screening	35.0%	18.4%	46.8%	19.1%
Cholesterol Screening	55.9%	13.6%	56.6%	4.5%

Note. ED = Emergency Department; PCP = Primary Care Physician.

Discussion

This analysis, in conjunction with the paper published previously,⁸ demonstrates the value of MA supplemental benefits and addresses calls for increased data sharing on supplemental benefit use and its impact on health outcomes.



Supplemental benefit use is associated with improved healthcare utilization.

The 2023 paper reported on the uptake of supplemental benefits and the demographics of those using supplemental benefits. Overall, it found that a large majority of members enrolled in an Elevance Health-affiliated MA plan used at least one supplemental benefit (83% of dual eligible members; 75% of non-dual eligible members). Of those who used supplemental benefits, most used more than one. Further, supplemental benefits were used by members who could greatly benefit from them, such as those living in areas with lower socioeconomic status and food deserts. This suggests that supplemental benefits can help address enrollees' HRSN.

The analysis described in this report adds to this previous research by showing that the use of supplemental benefits is associated with better member outcomes. The findings indicate that members' access to and use of one or more supplemental benefits is associated with improved healthcare utilization, with a decrease in use of costly inpatient visits and an increase in use of outpatient visits and preventative screenings. Among non-dual members, this also includes a decrease in use of non-emergent ED visits.

Further, the results for many outcomes were even more favorable among dual eligible members than for non-dual eligible members. For example, while the likelihood of having an inpatient admission decreased for both dual eligible and non-dual eligible populations, this decrease was greater in the dual eligible group than the non-dual eligible group (-14.2% in dual eligible group; -3.8% in non-dual eligible group). This perhaps suggests that dual eligible members, who generally have higher needs than non-dual eligible members, may stand to benefit more from supplemental benefit use. Given that previous research shows that robust supplemental benefits help keep dual eligible individuals enrolled in Dual Eligible Special Needs Plans (D-SNPs),⁹ the findings from this study underscore the importance of supplemental benefits for these members in improving their healthcare outcomes and promoting more appropriate use of care.

Overall, the findings from this study suggest a strong association between supplemental benefit use and healthcare utilization. This research, as the first known work to analyze the relationship between supplemental benefits and healthcare outcomes, may spur future studies. Since there is continued interest in understanding the impact of supplemental benefits—particularly the non-medical supplemental benefits, such as grocery card benefits—future work could focus on analyzing the association between those specific supplemental benefits and healthcare outcomes.

Conclusion

Supplemental benefits are valuable supports for millions of older adults and people with disabilities and are a crucial component of the MA benefit package. Findings from this study suggest that the use of supplemental benefits can improve health and wellbeing for members, which further underscores the value to MA beneficiaries in having access to and using these benefits.

In addition, this research shows a more pronounced impact of supplemental benefits on dual eligible members, as it is associated with even more favorable healthcare utilization among dual eligible members than among non-dual eligible members. Having robust supplemental benefit offerings for dual eligible members is critically important in supporting these individuals who may have greater health needs and/or HRSN.

Continued support of the MA program generally, and MA plans' ability to offer meaningful supplemental benefits specifically, can be an effective approach to encourage high quality care and favorable outcomes for Medicare beneficiaries.

The Elevance Health Public Policy Institute gratefully acknowledges the analytic contributions of the Berkeley Research Group in the conduct of this study.

Revision in October 2024 addressed an update to the non-emergent ED visit results.

Endnotes

- ¹ Ochieng, N., et al. (2023, August 9). Medicare Advantage in 2023: Enrollment Update and Key Trends. Kaiser Family Foundation. Retrieved March 21, 2024, from <https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-enrollment-update-and-key-trends/>.
- ² ATI Advisory. (2023, February 21). New, Non-Medical Supplemental Benefits in Medicare Advantage in 2023. Retrieved March 21, 2024, from <https://atiadvisory.com/resources/wp-content/uploads/2023/02/2023-New-Non-Medical-Supplemental-Benefits.pdf>.
- ³ Elevance Health Public Policy Institute. (2023, July). Medicare Advantage Supplemental Benefits Address Health-Related Social Needs. Retrieved March 21, 2024, from <https://www.elevancehealth.com/public-policy-institute/medicare-advantage-supplemental-benefits-can-address-hrsn>.
- ⁴ Six supplemental benefits were excluded due to unavailable utilization data: Nurse Hotline, Nutrition Consult, Nutrition Therapy, Orthotics, Telemonitoring, and Transitional Care.
- ⁵ Dual eligible beneficiaries are individuals who qualify for, and are enrolled in, both Medicare and Medicaid.
- ⁶ Characteristics used for propensity score matching included: age as of January 1 of coverage year (2021 and 2022); gender; race/ethnicity (White, Black, Hispanic, other); CMS-HCC risk score; dual eligibility; Social Deprivation Index (SDI); and residence in a rural area, primary care provider (PCP) shortage area, and/or food desert.
- ⁷ Non-emergent emergency department (ED) visits are as defined by the New York University (NYU) ED algorithm, meaning that the patient's initial complaint, presenting symptoms, vital signs, medical history, and age indicated that immediate medical care was not required within 12 hours.
- ⁸ Elevance Health Public Policy Institute. (2023, July).
- ⁹ Lipson, D., et al. (2021, January 15). Why Dually Eligible Beneficiaries Stay or Leave Integrated Care Plans. Mathematica. Retrieved March 21, 2024, from <https://www.mathematica.org/publications/why-dually-eligible-beneficiaries-stay-or-leave-integrated-care-plans>.

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