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Prevalence of supplemental benefits in the D-SNP Medicare Advantage marketplace: 2017 to 2021

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Overview

In an increasingly competitive Medicare Advantage (MA) marketplace,[1] supplemental benefits are one of the primary ways Medicare Advantage organizations (MAOs) can differentiate their plans from competitors' plans. A supplemental benefit is an additional benefit MAOs cover for their members, but which is not covered under traditional fee-for-service (FFS) Medicare. MAOs offer these benefits to attract Medicare-eligible individuals to their plans. Supplemental benefit coverage can either be mandatory, meaning all enrollees in a particular plan receive coverage, or optional, meaning all enrollees in a particular plan can elect to receive coverage for an additional premium.[2] Due to recent Centers for Medicare And Medicaid Services (CMS) demonstration programs and expansions in supplemental benefit flexibilities,[3,4,5] MAOs may also limit mandatory supplemental benefits to plan enrollees who meet certain conditions, such as having a diabetes diagnosis. These types of benefits are only offered to a specific subset of a plan's population, and therefore are not part of this analysis. This analysis focuses on mandatory supplemental benefits offered by Dual Eligible Special Needs Plans (D-SNPs) from 2017 to 2021.

Supplemental benefits are particularly important for D-SNPs for a few key reasons:

- Cost sharing for dual-eligible individuals is generally covered by Medicaid, so lowering traditional Medicare-covered cost sharing does not have an impact on a dual-eligible individual's out-of-pocket cost. Therefore, D-SNPs typically do not enhance Medicare-covered benefits.
- D-SNPs typically target a $0 premium after government premium subsidies, and there is minimal competition on premium for dual-eligible members.

Because D-SNPs cannot attract members by enhancing Medicare-covered benefits or reducing member premium, supplemental benefits are the key distinguishing plan design factor in the D-SNP market.

Analysis

We utilized publicly available data from CMS for this analysis. The 2017 through2020 membership is based on February plan enrollment, and the 2021 membership is based on September 2020 plan enrollment crosswalked to 2021.[6] Benefit data for all years was summarized from the plan benefit packages (PBPs) published by CMS for each year.[7]

Vision, hearing, and dental benefits are among the most common supplemental benefits historically offered by MA plans. Figure 1 shows the percentage of members in D-SNPs from 2017 to 2021 with coverage for these benefits.

[1] Friedman, J.M., Swanson, B.L., Yeh, M.G., & Cates, J. (February 2020). State of the 2020 Medicare Advantage Industry: As Strong as Ever. Milliman Research Report. Retrieved December 2, 2020, from https://us.milliman.com/en/insight/state-of-the-2020--medicare-advantage-industry-as-strong-as-ever.

[2] CMS (April 22, 2016). Medicare Managed Care Manual: Chapter 4: Benefits and Beneficiary Protections. Retrieved December 2, 2020, from https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf.

[3] CMS. Medicare Advantage Value-Based Insurance Design Model. Retrieved December 2, 2020, from https://innovation.cms.gov/innovation-models/vbid.

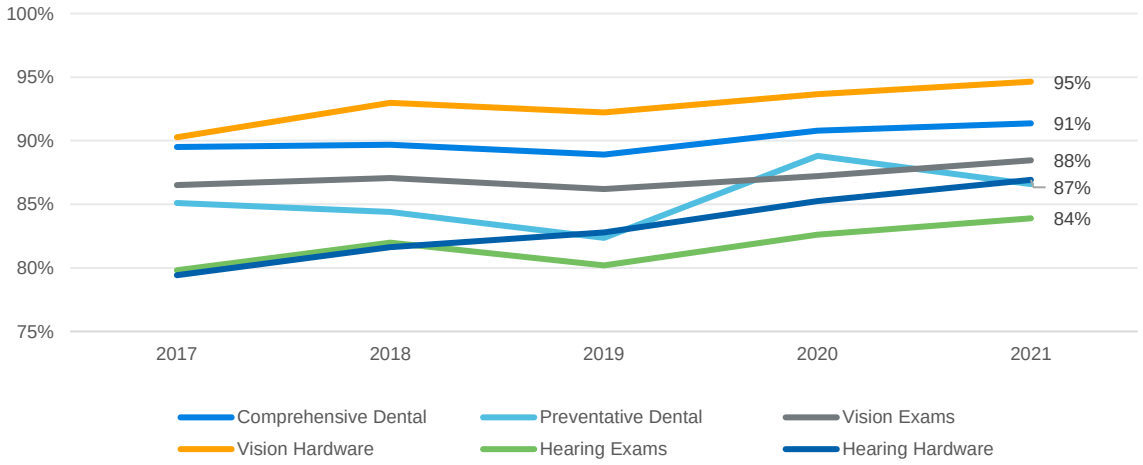
[4] CMS (April 27, 2018). Reinterpretation of the Uniformity Requirement. Retrieved December 2, 2020, from https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/HPMS/HPMS-Memos-Archive-Weekly-Items/SysHPMS-Memo-2018-Week4-Apr-23-27.

[5] CMS (April 24, 2019). Implementing Supplemental Benefits for Chronically Ill Enrollees. Retrieved December 2, 2020, from https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Downloads/Supplemental_Benefits_Chronically_Ill_HPMS_042419.pdf.

[6] CMS. Monthly Enrollment by Contract/Plan/State/County. Retrieved December 2, 2020, from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-Enrollment-by-Contract-Plan-State-County.

[7] CMS. Benefits Data. Retrieved December 2, 2020, from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Benefits-Data.

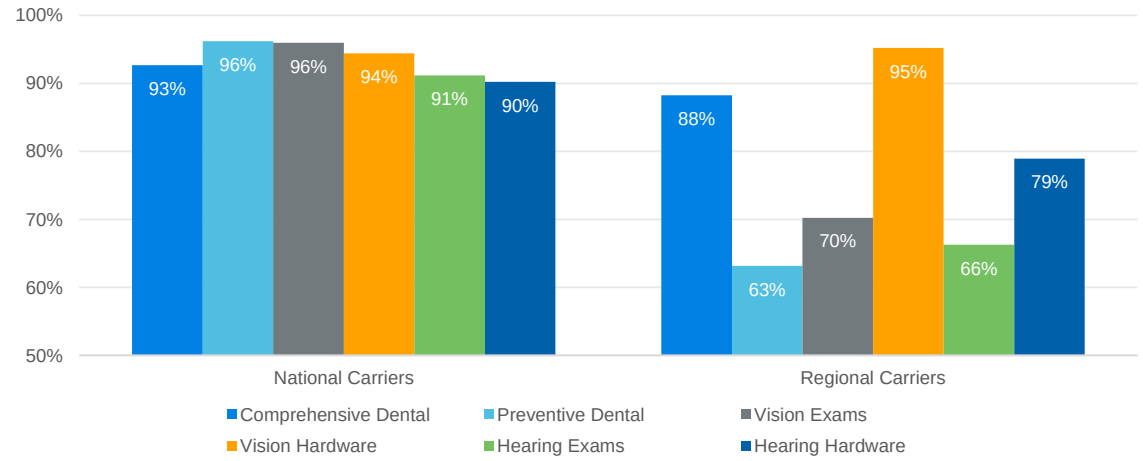
FIGURE 1: PERCENTAGE OF MEMBERS WITH BENEFIT COVERAGE OF THE MOST COMMON SUPPLEMENTAL BENEFITS



MAOs offered these benefits to a very high percentage of D-SNP enrollees from 2017 to 2021 with modest increases in coverage over the five years. With the exception of vision hardware, which is available to 95% of members, the remainder of these benefits have approximately 85% to 90% prevalence in the 2021 marketplace for D-SNP plans.

Supplemental benefit prevalence varies significantly between national and regional MAOs. National players are defined as those that have more than 250,000 members in total (including all enrollment types),[8] and regional players are the remainder. There was a decrease in 2019 and large increases in 2020 and 2021 of preventive dental offerings driven by the national players, which now have 96% prevalence for preventive dental benefits in the D-SNP market. Regional players, on the other hand, saw a marked decrease in members covered by this benefit in 2021 with only 63% of membership covered by this benefit. The reduced prevalence of preventive dental coverage is a divergence from all other common supplemental benefits for regional players, which continued to see increased penetration in 2021 relative to 2020, though still less penetration than the national players, with the exception of vision hardware. The notable difference in benefit coverage between national and regional players in 2021 is evident in Figure 2.

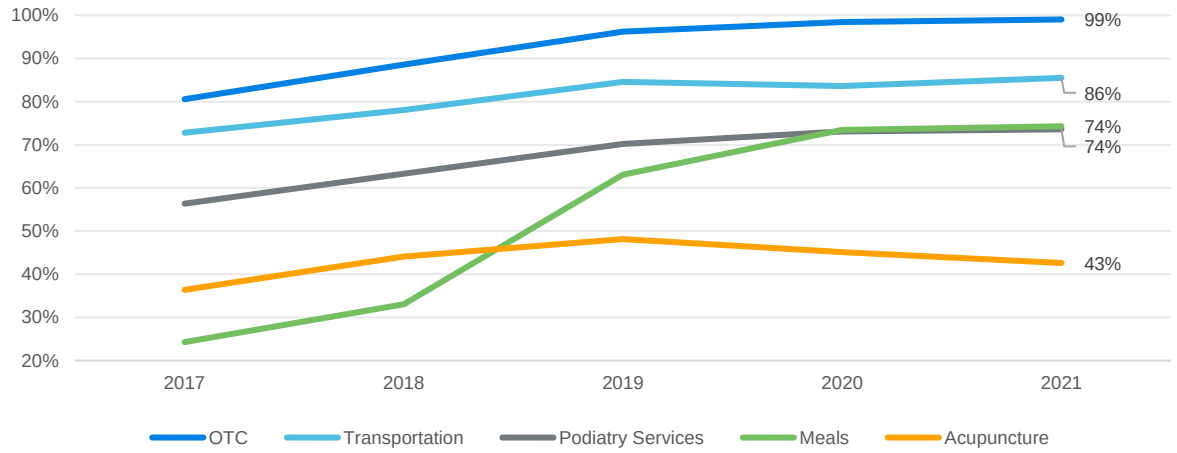
FIGURE 2: PERCENTAGE OF MEMBERS WITH BENEFIT COVERAGE IN 2021, BY REGIONAL AND NATIONAL CARRIERS



[8] Anthem, CIGNA, Centene Corporation, CVS Health Corporation, Humana, Kaiser Foundation Health Plan, and UnitedHealth Group are national players for this analysis due to their total enrollment counts.

MAOs can offer numerous additional supplemental benefits beyond vision, hearing, and dental. Figure 3 shows the percentage of members in D-SNPs from 2017 to 2021 with coverage for other common supplemental benefits, including over-the-counter (OTC) drug cards, transportation, podiatry services, meals, and acupuncture.

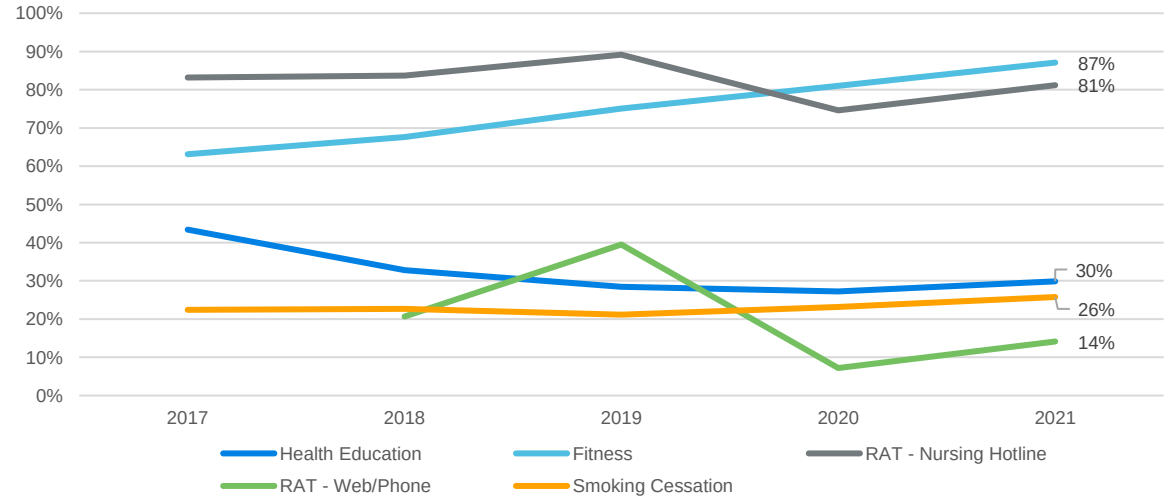
FIGURE 3: PERCENTAGE OF MEMBERS WITH BENEFIT COVERAGE OF VARIOUS OTHER SUPPLEMENTAL BENEFITS



OTC drug card has grown from 80% D-SNP member coverage in 2017 to nearly 100% in 2021. Meal benefit coverage grew about 50% from 2017 to 2021, with most of those gains happening between 2018 and 2019, and near 75% penetration of this benefit in 2021. Podiatry has seen slower gains in member penetration, but increased nearly 20% to nearly reach 75% penetration in 2021. Transportation and acupuncture experienced lesser increases in coverage over the last five years, but transportation is approaching 90% member coverage.

Multiple supplemental benefits fall under the 14c "preventative" benefit category in the PBP. Figure 4 shows the percentage of members in D-SNPs from 2017 to 2021 with coverage for some of the most prevalent 14c benefits: health education, fitness, remote access technologies (RAT),[9] and smoking cessation.

FIGURE 4: PERCENTAGE OF MEMBERS WITH BENEFIT COVERAGE OF VARIOUS PBP 14C "PREVENTATIVE" BENEFITS



[9] The 2017 PBP only contained one entry for RAT, which is displayed in Figure 4 as "RAT – Nursing Hotline." In the 2018 PBP and beyond, separate entries were made for "RAT – Nursing Hotline" and "RAT – Web/Phone." Therefore, we excluded 2017 from the RAT Web/Phone analysis.

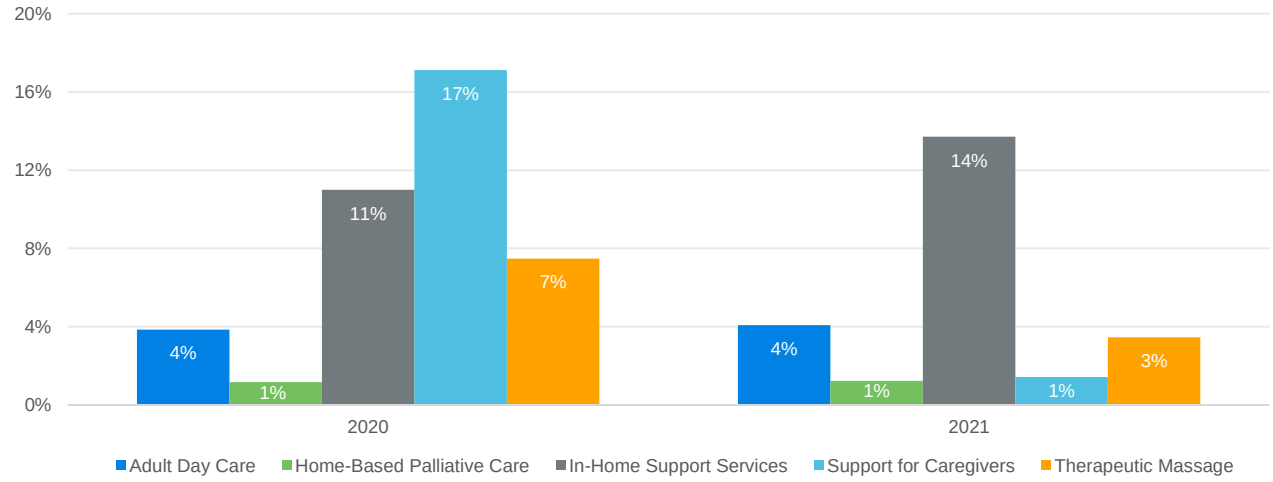
Fitness and smoking cessation coverage have increased from 2017 to 2021, while all other benefits in Figure 4 have decreased in membership covered over this period.

The definition of "primarily health related benefits"[10] was expanded starting in the 2019 bid cycle to cover services used to:

- Diagnose
- Compensate for physical impairments
- Ameliorate the functional/psychological impact of injuries or health conditions
- Reduce avoidable emergency and healthcare utilization

This includes adult day care, home-based palliative care, in-home support services, support for caregivers, and therapeutic massage (for pain management). The percentages of members in D-SNPs with coverage for these expanded primarily health related benefits in 2020 and 2021 are displayed in Figure 5.

FIGURE 5: PERCENTAGE OF MEMBERS WITH EXPANDED PRIMARILY HEALTH RELATED BENEFIT COVERAGE, COMPARISON OF 2020 TO 2021



While D-SNPs could provide a subset of these types of benefits prior to the expansion of primarily health related supplemental benefits, D-SNP MAOs provide these services to a relatively low percentage of members compared to other supplemental benefits discussed above, though higher than general enrollment plans for adult day care, in-home support services, and therapeutic massage. Support for caregivers of enrollees was the most common expanded primarily health related benefit in 2020, but dropped off considerably in 2021 to be replaced by in-home support services as the leading expanded primarily health related benefit for dual-eligible members.

Many MAOs provided supplemental benefits coverage in 2021 to address the impact of COVID-19 assuming the public health emergency would continue into 2021. These benefits could cover services related to COVID-19, such as personal protective equipment (PPE), testing, or reduced cost sharing on related benefits. Seventeen and a half percent of members in D-SNPs are covered by a COVID-19 supplemental benefit in 2021. Coverage is driven by nationwide carriers, with 20% of their members covered by a COVID-19 supplemental benefit, while only 15% of members in regional D-SNPs are covered by a COVID-19 supplemental benefit.

[10] CMS (April 2, 2018). Announcement of Calendar Year (CY) 2019 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter. Retrieved December 2, 2020, from https://www.cms.gov/MEDICARE/HEALTH-PLANS/MEDICAREADVTGSPECRATESTATS/DOWNLOADS/ANNOUNCEMENT2019.PDF

Methodology

In performing this analysis, we relied on the 2021 Milliman MACVAT®. The Milliman MACVAT contains MA plan details and benefit offerings for 2017 through 2021. The Milliman MACVAT uses publicly available data released by CMS, which is then compiled, sorted, and summarized into a user-friendly format. We used the February membership from each applicable year (2017 through 2020), with the exception of 2021, for which we used the September 2020 membership that has been crosswalked to the 2021 plans. This analysis includes dual-eligible MA plans only.

Caveats and Limitations

Julia M. Friedman and Mary G. Yeh are actuaries for Milliman, members of the American Academy of Actuaries, and meet the qualification standards of the Academy to render the actuarial opinion contained herein. To the best of our knowledge and belief, this information is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices.

The material in this report represents the opinion of the authors and is not representative of the view of Milliman. As such, Milliman is not advocating for, or endorsing, any specific views contained in this report related to the Medicare Advantage program.

This report is intended to summarize supplemental benefits offered by MA plans from 2017 through 2021. This information may not be appropriate, and should not be used, for other purposes. We do not intend this information to benefit, and assume no duty of liability to, any third party that receives this work product. Any third-party recipient of this report that desires professional guidance should not rely upon Milliman's work product, but should engage qualified professionals for advice appropriate to its specific needs.

The credibility of certain comparisons provided in this report may be limited, particularly where the number of plans in certain groupings is low. Some metrics may also be distorted by benefit changes in a few plans with particularly high enrollment.

In preparing our analysis, we relied upon public information from CMS, which we accepted without audit. However, we did review it for general reasonableness. If this information is inaccurate or incomplete, conclusions drawn from it may change.

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