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# Medicare Advantage Plan Growth in Rural America: Availability of Supplemental Benefits

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## Background and Purpose

Since 2009, the RUPRI Center has published annual Medicare Advantage (MA) enrollment updates examining beneficiary characteristics and differences in MA configuration among noncore, micropolitan, and metropolitan geographies. This project extends the Center's work on MA enrollment by exploring differences in benefits offered by MA plans. The enactment of the CHRONIC Care Act in 2018 influenced the growth rate in MA plan enrollment by offering more plan options that have extended benefits for MA beneficiaries.[1] The Act gave MA plans the flexibility to offer new supplemental benefits to address enrollees' broader health and social needs. In this brief, we have used data from the Centers for Medicare & Medicaid Services (CMS) about benefits offered by MA plans, such as transportation services, meals, social needs, and home modifications. We group supplemental benefits into three categories: (1) traditional primarily health-related (established prior to 2019), (2) expanded primarily health-related (started in 2019, including services such as in-home support, therapeutic massage, caregiver support, home-based palliative care, and adult day health services), and (3) special supplemental benefits for the chronically ill (SSBCI, available starting in 2020, including services such as food and produce, meals, transportation, and pest control).

## Key Findings

- MA plans providing any supplemental benefit were less commonly offered in noncore counties (87.2 percent of plans), followed by micropolitan counties (94.6 percent) and metropolitan counties (97.6 percent) in 2022. Expanded benefits and SSBCI are less likely to be offered than traditional health benefits across all geographies.
- Between 10 to 20 percent of plans offered expanded supplemental benefits or SSBCI across all three geographies.
- Plans with traditional primarily health-related supplemental benefits most frequently included vision (97.6 percent), hearing (95.2 percent), fitness (94.6 percent), and dental services (93.6 percent). Significantly fewer plans offered expanded supplemental benefits and SSBCI that address beneficiaries' broader health and social needs. Declining availability of all supplemental benefit types was seen as geography shifted from metropolitan to noncore counties.

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- Noncore counties in the West region are most likely to be "supplemental benefit deserts" (i.e., counties with no plans offering supplemental benefits) while counties in the Northeast region are the least likely.

## Methods

Data on supplemental benefits provided by MA plans[*] were obtained from the CMS Plan Benefit Package (PBP) file, which provides the universe of PBP data for all active contracts and contains all the approved benefit and financial data submitted as part of the CY 2022 Bid Submission by Medicare Advantage and Part D organizations.[2] Benefit data from the third quarter of 2022 were used in this analysis. Matching data on states and counties where plans were available and data on Medicare beneficiaries and MA enrollment were also downloaded from CMS websites.[3,4]

The following plan types were excluded from the analysis: Employer Group Health Plans, standalone Prescription Drug Plans, Medicare-Medicaid Plans, Part B-only plans, PACE plans, and Medical Savings Account plans. Note that data from Special Needs Plans (SNPs) have been retained. Data includes only plans offered in any of the 50 United States and the District of Columbia. Medicare enrollment and MA penetration data were not available for 8 counties (7 in Alaska and 1 in South Dakota), and those counties were not included in the analysis. The final dataset contained information on 5,259 MA plans and 3,134 counties.

## Results and Findings

Table 1a shows the availability of MA plans offering any supplemental benefits across metropolitan, micropolitan, and noncore counties. Metropolitan counties had double the average number of available MA plans as noncore counties. Metropolitan counties had the greatest proportion of plans offering any supplemental benefits (97.6 percent), followed by micropolitan counties (94.6 percent) and noncore counties (87.2 percent). Plans offering traditional primarily health-related benefits were relatively common across all three geographies, whereas only 10.1 to 19.5 percent of plans offered expanded or special supplementary benefits.

**Table 1a. Average Number of MA Plans Available and Percent of Plans with Supplemental Benefits by Metropolitan, Micropolitan, and Noncore Counties, 2022******

| | Metropolitan (n = 1,166) | Micropolitan (n = 641) | Noncore (n = 1,327) |
|---|---|---|---|
| Average number of available MA plans | 41.5 | 28.0 | 21.5 |
| % plans offering any supplemental benefits | 97.6% | 94.6% | 87.2% |
| % plans offering any traditional supplemental benefits | 97.5% | 94.6% | 87.1% |
| % plans offering any expanded supplemental benefits | 14.9% | 12.6% | 10.1% |
| % plans offering any SSBCIs*** | 19.5% | 15.5% | 12.5% |

** Average counts and percents of plans in metropolitan counties, micropolitan counties, and noncore counties.
*** Special Supplemental Benefits for the Chronically Ill

Table 1b displays the availability of MA plans offering supplemental benefits by type offered overall and in metropolitan, micropolitan, and noncore counties. The most common supplemental benefits include vision (97.6 percent), hearing (95.2 percent), fitness (94.6

[*] We identified plans based on a combination of contract-plan-segment ID. Reports from other organizations may show plan counts lower than those reported by CMS and others because they use overall plan counts and not plan segments. Segments generally permit MA organizations to offer the "same" local plan, but supplemental benefits, premiums, and cost sharing may vary in service areas. We only assess the presence or absence of benefits – we did not attempt to assign values or value-equivalents to types of benefits.

percent), and dental services (93.6 percent). In-home support services for MA beneficiaries is the most common expanded primarily health-related benefit (13.8 percent). Eighty-two percent of plans in metropolitan counties offered in-home support services while 53.8 percent of plans in noncore counties offered this benefit. The proportion of plans offering SSBCI was markedly low compared to traditional benefits. Food and produce, meals, and transportation were the most frequently offered SSBCI benefit. Nearly eighty (79.9) percent of MA plans in metropolitan counties offered transportation for non-medical needs while plans in noncore counties were much less likely to offer this benefit. Overall, the same pattern of declining availability of all benefits was seen as geography shifted from metropolitan to noncore.

**Table 1b. MA Plans Offering Supplemental Benefits, and Counties with Plans Offering Supplemental Benefits, 2022**

| **Traditional Primarily Health-Related Benefits** | | | | |
|---|---|---|---|---|
| | **Plans with benefits** | **Counties with plan** | | |
| **Benefit** | | **Metro** | **Micro** | **Noncore** |
| Vision | 97.6% | 99.5% | 96.7% | 92.1% |
| Hearing | 95.2% | 99.4% | 96.7% | 92.1% |
| Fitness | 94.6% | 99.4% | 96.4% | 90.5% |
| Dental | 93.6% | 99.4% | 95.9% | 90.8% |
| Over-the-counter benefits | 84.6% | 99.4% | 95.9% | 90.1% |
| Remote access technologies | 71.4% | 99.4% | 94.9% | 87.7% |
| Limited meals following inpatient stay | 69.0% | 98.8% | 94.4% | 87.0% |
| Rides to medical appointments | 49.5% | 98.6% | 92.5% | 81.0% |
| **Expanded Primarily Health-Related Benefits** | | | | |
| **Benefit** | **Plans with benefits** | **Metro** | **Micro** | **Noncore** |
| In-home support services | 13.8% | 82.3% | 68.6% | 53.8% |
| Therapeutic massage | 3.2% | 23.7% | 17.3% | 7.6% |
| Support for caregivers of enrollees | 3.0% | 26.1% | 16.4% | 15.8% |
| Home-based palliative care | 2.8% | 14.5% | 13.4% | 5.5% |
| Adult day health services | 1.0% | 13.1% | 4.8% | 5.9% |
| **Special Supplemental Benefits for the Chronically Ill** | | | | |
| **Benefit** | **Plans with benefits** | **Metro** | **Micro** | **Noncore** |
| Food and produce | 16.1% | 91.0% | 79.1% | 63.6% |
| Meals (beyond limited basis) | 7.9% | 77.5% | 61.0% | 50.9% |
| Transportation for non-medical needs | 7.4% | 79.9% | 64.7% | 55.3% |
| Pest control | 6.4% | 74.9% | 63.0% | 50.6% |
| General supports for living | 5.5% | 69.5% | 57.7% | 42.8% |
| Social needs benefit | 4.6% | 48.5% | 31.7% | 21.5% |
| Indoor air quality equipment & services | 3.1% | 43.7% | 33.9% | 28.3% |
| Services supporting self-direction | 2.8% | 41.7% | 33.9% | 28.7% |
| Complementary therapies | 2.3% | 39.5% | 32.6% | 27.8% |

Table design adapted from Thomas Kornfield et al., *Medicare Advantage Plans Offering Expanded Supplemental Benefits: A Look at Availability and Enrollment* (Commonwealth Fund, Feb. 2021). https://doi.org/10.26099/345k-kc32

The greatest proportion of counties with no MA supplemental benefits plans were noncore. Expanded benefits and SSBCI were less likely to be offered than traditional, primarily health-related, benefits among the three geographies. The largest proportion of these “supplemental benefit deserts” were seen in noncore counties in the West region while the lowest proportion was found in counties in the Northeast region (Table 2).

**Table 2. Number and Percent of Counties Lacking MA Plans with Supplemental Benefits, 2022**

| Nationwide | Metro | | Micro | | Noncore | |
|---|---|---|---|---|---|---|
| Traditional Primarily Health-Related Benefits | 6 | 0.5% | 21 | 3.3% | 105 | 7.9% |
| Expanded Primarily Health-Related Benefits | 142 | 12.2% | 161 | 25.1% | 543 | 40.9 |
| Special Supplemental Benefits for the Chronically Ill | 84 | 7.2% | 112 | 17.5% | 456 | 34.4 |
| | | | | | | |
| **Midwest Region** | **Metro** | | **Micro** | | **Noncore** | |
| Traditional Primarily Health-Related Benefits | 1 | 0.3% | 9 | 3.9% | 35 | 6.7% |
| Expanded Primarily Health-Related Benefits | 35 | 11.6% | 42 | 18.1% | 205 | 39.4 |
| Special Supplemental Benefits for the Chronically Ill | 29 | 9.6% | 38 | 16.4% | 205 | 39.4 |
| | | | | | | |
| **Northeast Region** | **Metro** | | **Micro** | | **Noncore** | |
| Traditional Primarily Health-Related Benefits | 0 | | 0 | | 0 | |
| Expanded Primarily Health-Related Benefits | 5 | 3.9% | 1 | 2.2% | 1 | 2.4% |
| Special Supplemental Benefits for the Chronically Ill | 3 | 2.3% | 1 | 2.2% | 1 | 2.4% |
| | | | | | | |
| **South Region** | **Metro** | | **Micro** | | **Noncore** | |
| Traditional Primarily Health-Related Benefits | 1 | 0.2% | 1 | 0.4% | 0 | |
| Expanded Primarily Health-Related Benefits | 73 | 12.3% | 63 | 24.1% | 156 | 27.4 |
| Special Supplemental Benefits for the Chronically Ill | 26 | 4.4% | 33 | 12.6% | 89 | 15.6 |
| | | | | | | |
| **West Region** | **Metro** | | **Micro** | | **Noncore** | |
| Traditional Primarily Health-Related Benefits | 4 | 2.8% | 11 | 10.8% | 70 | 34.3 |
| Expanded Primarily Health-Related Benefits | 29 | 20.4% | 55 | 53.9% | 181 | 88.7 |
| Special Supplemental Benefits for the Chronically Ill | 26 | 18.3% | 40 | 39.2% | 161 | 78.9 |

Figures 1,2, and 3 show noncore, micropolitan, and metropolitan counties by region with and without supplemental benefit availability. The distribution of plan deserts changes by supplemental benefit category. The most common "benefit deserts" were counties with no plans offering expanded benefits or SSBCI.

**Figure 1. Counties with and without MA Plans Offering Traditional Primarily Health-Related Supplemental Benefits, 2022**

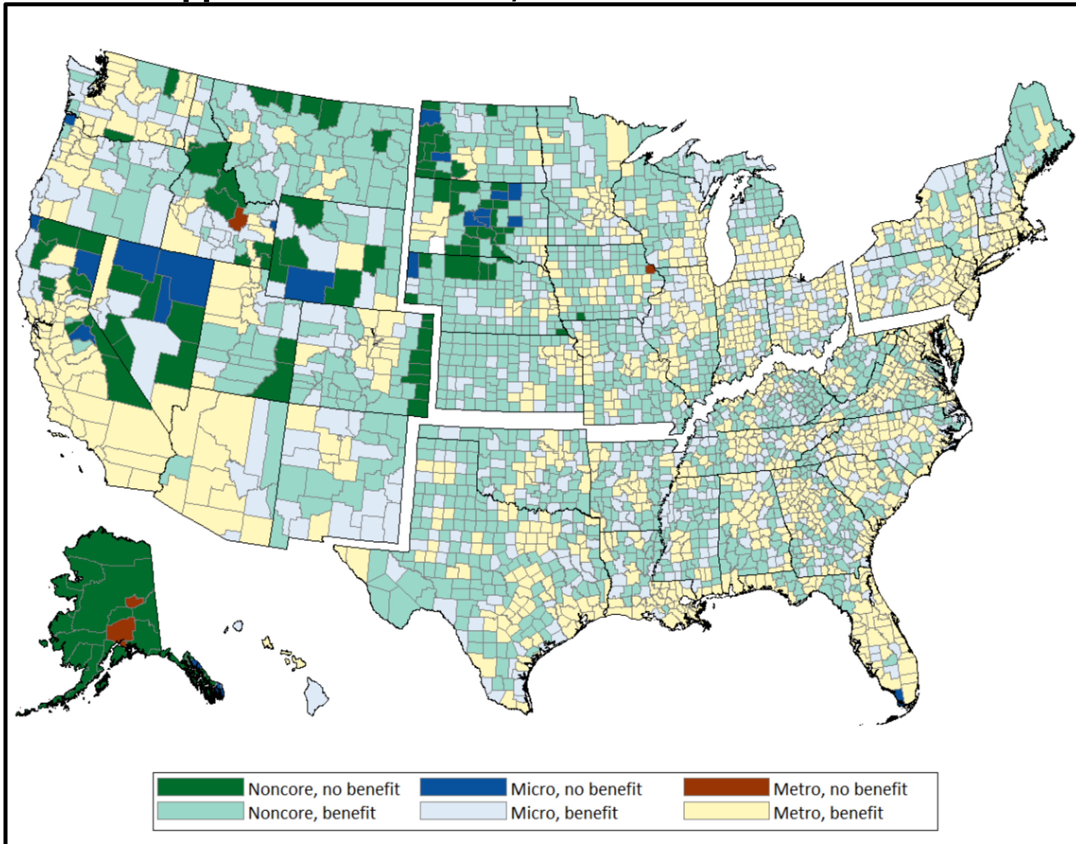



**Figure 2. Counties with and without MA Plans Offering Expanded Primarily Health-Related Supplemental Benefits, 2022**

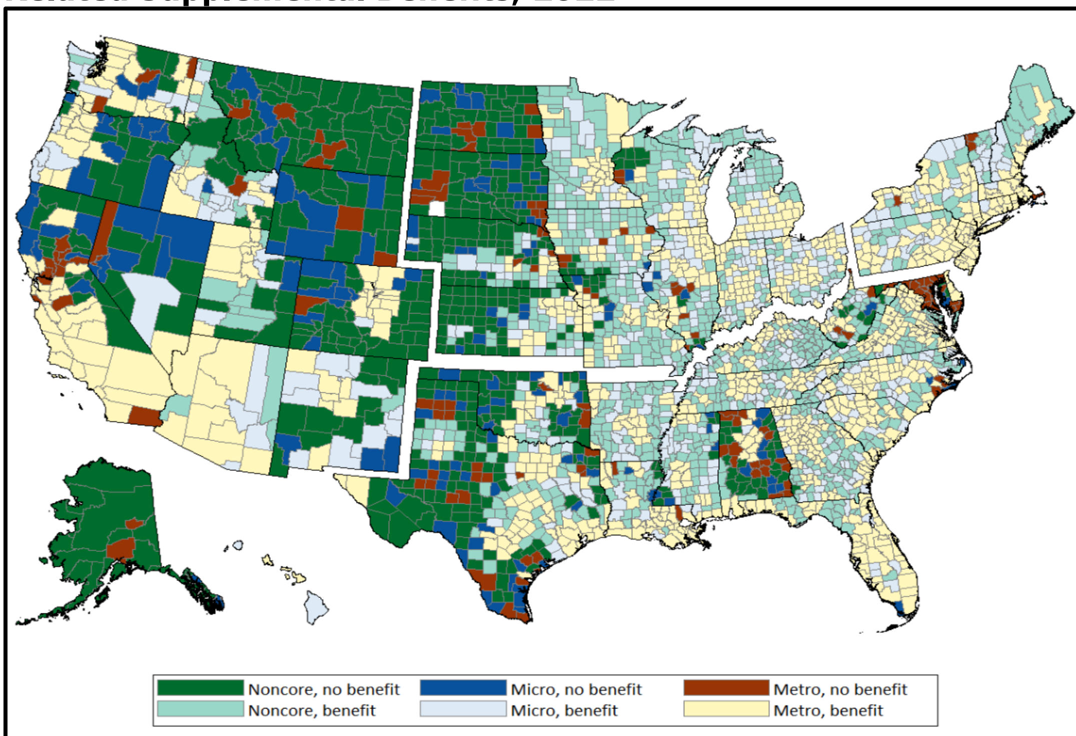
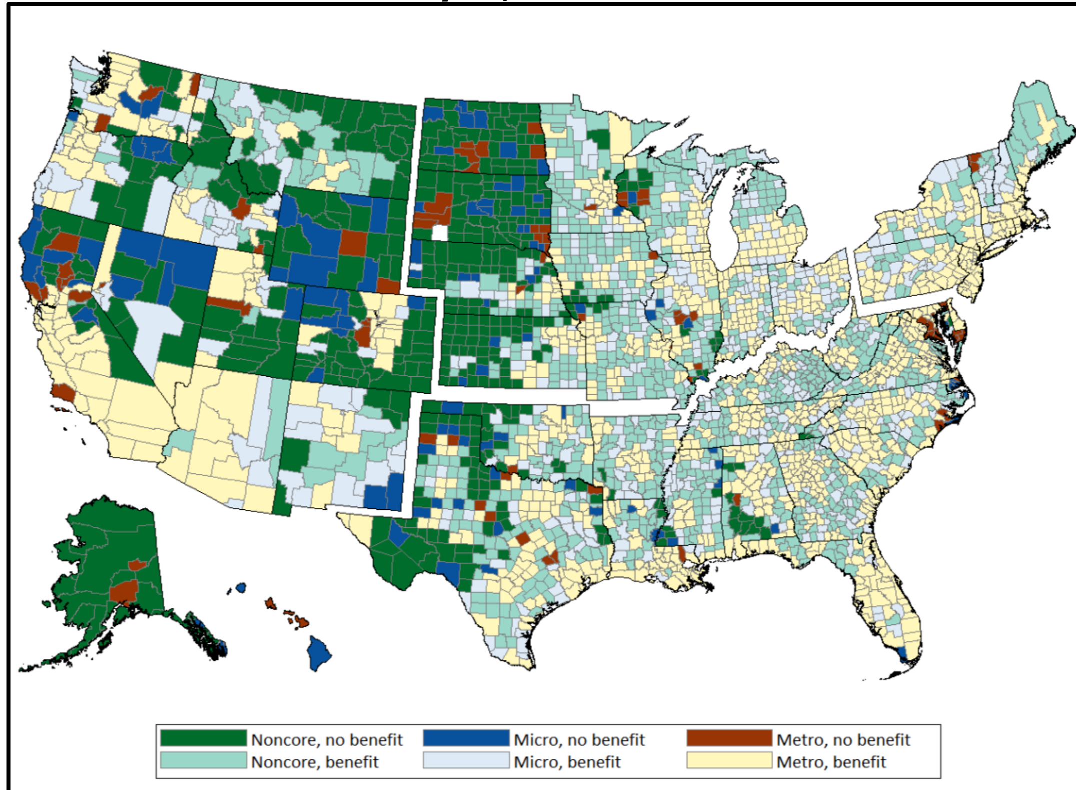


**Figure 3. Counties with and without MA Plans Offering Special Supplemental Benefits for the Chronically Ill, 2022**




## Discussion

In 2023, more than half (52.3 percent) of all Medicare beneficiaries enrolled in an MA plan. MA plans have now been selected by 53.9 percent of enrollees living in metropolitan areas, and the current rate of growth is similar in nonmetropolitan enrollees.[5] The passage of the CHRONIC Care Act in 2018 accelerated the rate of MA plan penetration.[6] In 2020, the Act allowed MA plans to further expand the number of supplemental benefits to their members, including the offer of special supplemental benefits for those who are chronically ill and meet eligibility criteria.[7] This shift in Medicare policy gave MA plans the opportunity to address health-related social needs apart from medical care. However, insurers vary in their response to this policy change because the legislation does not require them to offer these benefits, and it waived the "uniformity standard" that had previously required plans to offer identical benefits to all enrollees.[8] Instead, insurers are given the latitude to target specific markets.

The supplemental benefits provided by MA plans have an unknown effect on health outcomes and affordability[9]. In part, this is due to the limited transparency in MA data reporting and publishing. For example, data have not been previously reported on the proportion of MA beneficiaries using supplemental benefits offered by MA plans. In addition, procedural codes accounting for many supplemental benefits do not exist.[10] CMS responded by proposing a requirement for collecting more detailed utilization data on supplemental benefits beginning in 2024.[11] As of 2023, CMS requires MA insurers to report data on supplemental benefits spending and reinstated medical loss ratio requirements to improve program performance.[9]

The intent in expanding supplemental benefits and including SSBCI is to influence better health outcomes. However, the availability of supplemental benefits varies by geography. Metropolitan counties have the greatest proportion of MA plans offering supplemental benefits, with fewer options in micropolitan counties and even fewer options in noncore

counties. An overwhelming proportion (98 percent) of plans that offer supplemental benefits are offered in the traditional primarily health-related benefits category. Between 10.1 and 19.5 percent of plans offer extended primarily health-related benefits or SSBCI, with noncore counties being offered the least number of such plans (Table 1a). Few MA plans leverage the opportunity to offer these supplemental benefits to rural residents who experience higher rates of poverty, less access to health care, and generally have poorer health status than their urban counterparts[13]. These conditions place rural beneficiaries, especially dual-eligible beneficiaries, at greater risk for poor health outcomes and increased rates of mortality.[12,13]

Payments to MA plans are four to ten percent higher compared to traditional Medicare.[10,14,15] Additionally, MedPAC reported estimates of $27 billion in overpayment to MA plans in 2023.[15] Not surprisingly, eighty-three percent of MA plans expect to finance supplemental benefits for MA beneficiaries through shares of plan rebates.[9] This suggests that MA plans are in a financial position to address their members' social needs, though it seems that plans offering supplemental benefits are less frequently found in nonmetropolitan counties where beneficiaries are more likely to present with greater social and medical needs.[16,17]

MA plans encounter several challenges when considering offering supplemental benefits. Thomas et al. (2019) conducted interviews with several MA plan chief executives and health policy directors representing different MA plans regionally and nationally to understand MA insurers' perspectives on addressing members' social needs. These representatives recognized that addressing social needs is crucial to improve the health of their members and health care delivery but varied in their views about their role to directly address such needs and questioned whether it was within their purview to do so.[8] Forming a partnership with community-based organizations was a commonly suggested alternative, though they also recognized the challenge of developing new relationships with such organizations. Nonetheless, representatives indicated that the lack of standardized data collection and evaluative measures limits how plans can optimize service delivery.[8] Furthermore, the uncertainty of a return on investment and whether the offer of supplemental benefits would result in actual cost reduction seemed to impede program planning.[8]

MA plans appeal to Medicare enrollees in part because they offer benefits that traditional Medicare does not offer, with little to no out-of-pocket costs.[1] However, the offer of supplemental benefits across the U.S. is skewed and continues to widen health disparity gaps across geographies, as offering supplemental benefits is more prevalent in metropolitan areas than in noncore areas. Expanded benefits and SSBCI primarily addressing social needs are the least likely to be offered to beneficiaries living in noncore counties who are at increased risk for worsening health compared to those living in metropolitan counties. Recent studies indicate that rural MA beneficiaries switch back to traditional Medicare at twice the rate of metropolitan beneficiaries. Switching rates are associated with dissatisfaction with care access, ease of getting to physicians, and poorer health status (i.e., beneficiaries who had higher costs and higher needs).[9,12] With MA as the program of choice for the majority of beneficiaries in metropolitan counties and with beneficiaries in noncore counties soon to follow, it is critical to support and conduct robust studies investigating how well MA serves its beneficiaries across geographies, especially in noncore areas where the needs are greater.

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