CHAPTER 2

Supplemental benefits in Medicare Advantage

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Chapter summary

In addition to covering basic Part A and Part B services, Medicare Advantage (MA) plans may provide "supplemental" benefits to their enrollees, such as reduced cost sharing for Part A and Part B services, reduced Part B and Part D premiums, enhanced Part D benefits, and other benefits not covered under fee-for-service (FFS) Medicare such as dental, vision, or hearing services (non-Medicare services). These supplemental benefits, which are intended to provide more generous coverage and better financial protection for MA enrollees, are a defining feature of MA, but relatively little is known about the use of the benefits and the costs associated with them.

The majority of the supplemental benefits provided by MA plans are financed by the rebates that plans receive from Medicare. Medicare spending on plan rebates has increased sharply in recent years. Our analysis shows that, in 2025, Medicare will pay MA plans approximately $86 billion in rebates—or about $2,530 per enrollee (roughly 17 percent of Medicare's payments to MA plans)—to provide supplemental benefits, up from $21 billion (or about $1,160 per enrollee) in 2018.

According to their 2025 bid projections, plans expect to use about $39 billion (of the total $86 billion, equivalent to about $100 per member per month (PMPM)) to provide non-Medicare services to their enrollees and

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about $27 billion ($64 PMPM) to reduce enrollees' cost sharing for Medicare-covered services (such as doctors' visits). Though plans' bids indicate how they intend to use rebate dollars, projections may vary from actual experience, and little is known about how MA rebate dollars are actually spent. Because Part D benefit enhancements and Part D and Part B premium reductions are adjudicated directly between CMS and MA plans, there is less uncertainty about plans' spending for these supplemental benefits. For 2025, we estimate that MA plans will use about $15 billion of the rebates they receive from Medicare to enhance Part D benefits and reduce Part D premiums (equivalent to about $37 PMPM), and they will use about $5 billion ($10 PMPM) to reduce their enrollees' Part B premiums.

Different types of MA plans tend to offer different types of supplemental benefits. Conventional MA plans (i.e., nonemployer, non-special-needs plans) typically allocate the largest share of their rebate dollars to reducing enrollee cost sharing for Part A and B services. In contrast, special-needs plans (SNPs) report allocating a small share of their rebates to reducing cost sharing because most of their enrollees are dually eligible for Medicare and Medicaid and so will have their out-of-pocket (OOP) costs covered by Medicaid and other programs. Instead, SNPs allocate most of their rebate dollars to the provision of non-Medicare services.

In recent years, CMS and the Congress have gradually increased plans' flexibility in the types of supplemental benefits that can be offered, and plans can now target supplemental benefits to enrollees with a particular health status or disease state. Plans also can provide supplemental benefits that are not primarily health related to chronically ill enrollees; these benefits—which include services like meals, nonmedical transportation, and pest-control services—are known as special supplemental benefits for the chronically ill (SSBCI).

These new flexibilities, combined with the growth in rebate dollars, have allowed MA plans to significantly expand the number of supplemental benefits they offer. Across almost every type of supplemental benefit, our analysis of benefits offered by plans finds that the share of MA enrollees in plans offering these benefits has increased since 2018. Many plans offer supplemental benefits as "combination benefits," in which enrollees are provided with a "flex card" that can be used to pay for a number of different services. Growth in the share of SNP enrollees in plans offering the newer forms of benefits has been particularly dramatic. According to plans' bid data, SNPs now intend to devote

more rebate dollars to other non-Medicare services than to dental, vision, hearing, and transportation benefits combined.

As Medicare spending for MA supplemental benefits grows, it becomes increasingly valuable for policymakers to fully understand their use. CMS requires MA organizations to submit encounter records for all health care items and services, including supplemental benefits, provided to their enrollees. Accordingly, MA encounter data should be the most detailed source of information for assessing MA enrollees' use of services. However, the Commission has found that encounter data for some MA plans and for some services (including inpatient, home health, and skilled nursing facility services) are incomplete. And to the best of our knowledge, no studies have used encounter data to assess MA enrollees' use of supplemental benefits—likely because the reliability of the data has been unclear.

Indeed, until 2024, the system that CMS used to collect encounter records was not configured to accept records for dental services. For this report, we used data from the Medicare Current Beneficiary Survey (MCBS) to assess how enrollees use and pay for dental care. We found that between 2017 and 2022, just over half of non–dually eligible MA enrollees who had dental coverage through their MA plan visited the dentist during the year. These enrollees paid for a considerable portion of their dental expenses OOP, but the percentage decreased over time, falling from 61 percent in 2017 to 35 percent in 2022. In both 2017 and 2022, a small share of non–dually eligible MA enrollees reported difficulty accessing dental care due to cost. For most of the outcomes we assessed, trends for FFS beneficiaries without a form of dental coverage followed a directional trend similar to that of MA enrollees with dental coverage. However, FFS beneficiaries without a form of dental coverage paid for a significantly larger share of their dental care OOP. The similar trends in dental utilization for MA and FFS beneficiaries suggest that the recent decline in OOP costs for non-dually eligible MA enrollees cannot be attributed entirely to growth in MA supplemental benefits. Other underlying factors may also have played a role. Without further analysis, it is difficult to assess the extent to which the changes observed for MA enrollees are due to changes in MA supplemental benefits, to broader changes affecting the Medicare population as a whole, or to other changes such as the composition of the MA population. Survey data, however, offer limited insight into how MA enrollees use and pay for dental care, underscoring the need for better encounter data pertaining to the services.

We analyzed encounter data for 2021 to assess whether plans are submitting records for other supplemental benefits and whether the submission rates are suggestive of problems with the reliability of the data. Our analysis is a preliminary and exploratory first step toward using encounter data to assess the use of supplemental benefits. As such, we did not attempt—at this stage—to measure utilization rates or draw conclusions about access or value based on our findings. Instead, we focused on assessing whether plans are submitting records and characterizing the potential uses or limitations of the data.

We identified significant limitations to using the encounter data to assess supplemental benefits. First, as noted above, few encounter records have been collected for dental services, which is one of the largest categories of supplemental benefits. Second, MA plans have reported that the supplemental-benefit encounter records that they do submit are incomplete because of confusion about reporting requirements and how to populate the records for services that do not have well-established procedure codes. Third, the encounter data system does not contain a way to distinguish which records are for basic or supplemental services or for optional or mandatory supplemental benefits.

Nevertheless, for some services—particularly vision and hearing services—plans experience fewer technical limitations to submitting the data. We found that for these services, MA plans are submitting records and that the submission rates follow patterns in line with what can reasonably be expected based on survey data about MA enrollees' use of vision and hearing services. This is an encouraging sign that indicates that it may be feasible to use encounter data to explore MA enrollees' use of supplemental vision and hearing benefits. For other types of supplemental benefits, however, we found few encounter records, and the submission rates were well below the utilization rates suggested by survey data. Considering the well-documented data limitations and the discrepancies between encounter data and other sources, we can conclude that—for most supplemental benefits other than vision and hearing services—the encounter data are insufficient for characterizing enrollees' use of the benefits.

In 2024, CMS began implementing a series of actions to improve and increase the amount of data that plans report regarding utilization of and spending for supplemental benefits. The new data-reporting requirements will address some, but not all, of the data limitations that hinder our ability to assess how MA enrollees use supplemental benefits and how much plans spend on the

benefits, and it will be several more years before the full range of data are available for analysis.

In addition to assessing the data pertaining to MA enrollees' use of supplemental benefits, we provide information about how MA plans administer supplemental benefits. Because many supplemental benefits are nonmedical, MA organizations (MAOs) often contract with third parties such as businesses or community-based organizations to provide or administer the benefits. Medicare does not collect information about the entities with which MAOs contract. To better understand how supplemental benefits are administered, we reviewed the websites of MAOs and entities that administer MA supplemental benefits. Several themes emerged from our review. First, we found that many MAOs contract with dental and/or vision insurers that manage the supplemental dental and vision benefits on behalf of the MA plan, although some insurers manage the benefits themselves or have acquired organizations that manage the benefits on their behalf. Second, we found that MAOs often contract with for-profit vendors to provide nonmedical supplemental benefits. Plans may also contract with community-based organizations, though information about these arrangements was harder to find. Third, we found that MAOs frequently administer supplemental benefits through entities with which the insurer is vertically integrated and that several of the large MAOs have acquired or developed subsidiary businesses that specialize in providing services that can be offered as supplemental benefits. We also found several instances in which MAOs structure their supplemental benefits to be provided exclusively by providers owned by the plan's parent organization.

Altogether, our review of numerous data sources pertaining to MA supplemental benefits reveals a fundamental lack of transparency about how often enrollees use the benefits and plans' spending for the benefits. The data that Medicare collects are currently insufficient for examining the use of most of these benefits. The lack of reliable data makes it difficult to answer many important questions about how the rebates Medicare pays to MA plans are used. For example, we do not know how much plans spend on each type of benefit, which enrollees use each benefit (and how frequently), or whether service use differs by such factors as age, sex, race, disability status, and geographic area. The Medicare program currently relies on competition between insurers to incentivize plans to offer benefits that enrollees will value and use. But, because of different challenges in the program, including the complexity of the choice environment and the absence of reliable data,

it is unclear to what extent supplemental benefits address enrollees' needs or affect outcomes. Without reliable information about how the benefits are used or administered, it is difficult for policymakers to assess the adequacy of the access provided or to know whether the spending provides good value to enrollees and the taxpayers who fund the program. Better information could be used to help beneficiaries navigate the options available to them and could help policymakers identify ways of making the program work more efficiently. ■

The Medicare Advantage (MA) program gives Medicare beneficiaries the option of receiving benefits from private plans rather than from the traditional fee-for-service (FFS) Medicare program. MA plans are required, with few exceptions, to cover all Part A and Part B services to which Medicare beneficiaries are entitled.[1] MA plans may also provide their enrollees with "supplemental" benefits such as reduced cost sharing for Part A and Part B services, reduced Part B and Part D premiums, enhanced Part D benefits, and coverage of non-Medicare services (services not covered under FFS Medicare, such as dental, vision, and hearing services). For beneficiaries, a primary trade-off in choosing between MA and FFS is access to the supplemental benefits that plans provide versus a broader choice of providers and minimal utilization management in FFS.

The Commission has noted that supplemental benefits are intended to provide more generous coverage and better financial protection for MA enrollees. Supplemental benefits may provide MA enrollees with access to important services not covered by Medicare or address health-related challenges beneficiaries face, but little is known about enrollees' use of the benefits. The Medicare program currently relies on competition between insurers to incentivize plans to offer benefits that enrollees will value and use, but evidence regarding the extent to which supplemental benefits address enrollees' needs or affect outcomes is lacking and the reliability of the data Medicare collects about the benefits has not been well explored. Without reliable information about how the benefits are used or administered, it is difficult for policymakers to assess the adequacy of the access provided or to know whether the spending provides good value to enrollees and the taxpayers who fund the program. Better information could be used to help beneficiaries navigate the options available to them and could help policymakers identify ways of making the program work more efficiently.

CMS requires MA organizations (MAOs) to submit encounter records for all health care items and services, including supplemental benefits, provided to their enrollees. Accordingly, MA encounter data should be the most detailed source of information for assessing MA enrollees' use of services. However, the Commission has found that encounter data for some MA plans and for some services (including inpatient, home health, and skilled nursing facility services) are incomplete. The Commission has not previously assessed encounter data for MA supplemental benefits.

In this chapter, we explore trends in the rebates paid to MA plans to finance the provision of supplemental benefits, measure the premium and cost-sharing reductions provided as supplemental benefits, chart changes in the types of benefits plans offer enrollees, and analyze MA encounter data to better understand the data and their potential utility for measuring enrollees' use of supplemental benefits. Because encounter data for dental services are unavailable, we also use data from the Medicare Current Beneficiary Survey (MCBS) to assess how enrollees use and pay for dental care. For assessing vision and hearing benefits, we use encounter data because there are well-defined procedure codes that should make it possible for plans to submit encounter records related to the services. For other non-Medicare services that are commonly offered as supplemental benefits, we analyze the encounter data and outline the data limitations that hinder our ability to reliably assess enrollees' use of the services. Last, we provide information about how MA plans are administering supplemental benefits and the entities with which plans are partnering to provide the services.

Background

MA supplemental benefits can be organized into four broad categories: reduced cost sharing for Part A and Part B services, reduced Part B premiums, enhanced Part D benefits (including reduced Part D premiums), and coverage of non-Medicare services (services not covered under FFS Medicare, such as dental, vision, and hearing services). Plans have flexibility regarding which supplemental benefits they offer and the generosity of the coverage. The Congress and CMS have gradually expanded the types of supplemental benefits that MA plans can offer and how the benefits can be offered.

Supplemental benefits in MA are financed primarily by rebates

MA plans primarily finance the provision of supplemental benefits using "rebates" that are added to the capitated payments they receive to cover basic

Medicare benefits. The rebate amount a plan receives is determined by Medicare's payment formula for MA plans and depends on how the plan's bid compares with a county-specific payment benchmark, as well as on a plan's star rating.

Organizations seeking to offer MA plans submit bids representing the dollar amount that the plan estimates will cover the Part A and Part B benefit package for a beneficiary of average spending risk.[2] Plans' bids are compared with a benchmark amount that is based on the projected costs of providing Part A and Part B services to FFS beneficiaries in the county; the benchmark is the maximum amount Medicare will pay for an MA plan to provide Part A and Part B benefits.[3] If a plan's bid is below the benchmark, its payment rate is its bid plus a share of the difference between the plan's bid and the benchmark (as low as 50 percent but typically either 65 percent or 70 percent, depending on a plan's quality ratings). The added payment to the plan, based on the difference between the bid and the benchmark, is referred to as the "rebate." Plans are required to use the rebate to provide supplemental benefits. For 2025, almost 100 percent of plans bid below their benchmarks and received rebates to offer supplemental benefits.[4]

Plans have the option of offering more supplemental benefits than what can be covered by the rebate they receive from Medicare. In such cases, plans typically charge enrollees additional premiums to cover the costs of providing the benefits. This arrangement rarely takes place: In an analysis of plans' bid data for 2022, the Government Accountability Office (GAO) found that 83 percent of MA plans, enrolling 86 percent of MA enrollees, expected to finance supplemental benefits solely with rebates; for special-needs plans (SNPs), the share was even higher, at 96 percent (Government Accountability Office 2023).[5] In other words, the supplemental benefits offered by MA plans are primarily financed by the rebates the plans receive from Medicare.

Medicare has gradually expanded the types of supplemental benefits that MA plans can offer

MA plans' supplemental benefits are intended to provide more generous coverage and better financial protection for MA enrollees (Medicare Payment Advisory Commission 2024b). The supplemental benefits that MA plans may offer fall into four broad categories: reduced cost sharing for Part A and Part B services, reduced Part B premiums, enhanced Part D benefits (including lower premiums), and coverage of non-Medicare services (services not covered under FFS Medicare, such as dental, vision, and hearing services). Plans have flexibility regarding which supplemental benefits they offer and the generosity of the additional coverage. Each category is subject to some limitations, but—over time—CMS and the Congress have gradually increased plan flexibility and expanded the types of supplemental benefits that MA plans can offer and how the benefits can be offered.

Cost-sharing reductions

MA plans have the flexibility to develop their own cost-sharing rules instead of using those applied under FFS Medicare. However, plans are subject to limitations intended to guard against the use of benefit designs that might discriminate against beneficiaries who are sicker by charging high cost sharing for the services those enrollees are likely to use. Plans must abide by these rules but may charge cost sharing below the minimum required levels. Some of the limitations apply to overall cost sharing, while others apply to cost sharing for particular services.[6]

The level of overall cost sharing that plans can impose is constrained in two ways. First, plans must ensure that their cost sharing for all Part A and Part B services is, in aggregate, at least actuarially equivalent to FFS cost sharing. To maintain actuarial equivalence, any increase in cost sharing for some services must be offset by lower cost sharing for other services. Second, MA plans must provide an annual cap on enrollees' out-of-pocket (OOP) spending for in-network services, known as a maximum out-of-pocket (MOOP) limit.[7]

In addition to the limits on aggregate cost sharing, plans must also comply with a complex set of limits on the cost sharing they can charge for certain service categories (Medicare Payment Advisory Commission 2023). Conceptually, there are three major types of service-specific limits:

- Services for which plans cannot charge more in cost sharing than FFS Medicare does. This limit applies to such major categories as inpatient care, skilled nursing facility (SNF) care, dialysis, and Part B drugs.

- Services for which plans can charge more than FFS does but are subject to some specified limit. This limit applies to categories such as physician services.
- Services for which plans cannot charge more than 50 percent in coinsurance or an actuarially equivalent copayment. This general limit applies to any categories, such as outpatient hospital services, for which CMS does not have any specific limits on cost sharing.

Some of these limits—such as the prohibition on charging higher cost sharing than FFS for dialysis, SNF care, or Part B drugs—are specified in law. CMS also has the authority to put cost-sharing limits on other services to prevent plans from using benefit designs that the agency considers discriminatory. For example, CMS added cost-sharing limits for rehabilitation services, starting with the 2020 plan year, and has indicated that it may add a limit for ambulance services in the future (Centers for Medicare & Medicaid Services 2022b). MA enrollees may also pay cost sharing for non-Medicare services that their plan offers as supplemental benefits; CMS does not set limits on the cost sharing that can be charged for these services, and the cost sharing enrollees pay for them does not count toward the MOOP limit.[8]

Altogether, plans can charge less in overall cost sharing than would be charged under FFS as long as their benefit design complies with the limitations described above. For plans providing more generous coverage than would be provided under FFS, the difference between the two amounts is treated as a supplemental benefit.

Enhanced Part D benefits and Part B premium reductions

All beneficiaries enrolling in Medicare Part B, regardless of their decision to receive benefits through FFS Medicare or MA, are required to pay the Medicare Part B premium.[9] However, MA plans may pay a portion of their members' Part B premium as a supplemental MA benefit. Beneficiaries may face an additional premium to enroll in Part D; MA prescription drug plans (MA–PDs), which provide integrated Part C and Part D coverage under the same plan, can also reduce or eliminate the Part D premium as a supplemental MA benefit. Further, MA–PDs may provide additional Part D benefit enhancements as a supplemental benefit, such as reduced cost sharing or coverage of additional drugs.

For plans reducing their enrollees' Part B premium, CMS limits the amount by which the premium can be reduced; the maximum reduction is generally equal to the Part B premium for the year preceding the contract year (although this rule is typically not binding since very few plans offer full Part B–premium reductions).[10] For plans reducing or eliminating the Part D premium for their enrollees, the maximum reduction is based on the Part D premium for that plan, and the plan cannot reduce the total Part D premium below zero.

Coverage of non-Medicare services

MA plans may offer coverage of non-Medicare services (those not covered under FFS Medicare) as a supplemental benefit. Plans' ability to offer these benefits has always been subject to limitations that specify the types of benefits that can be offered and the types of enrollees who can receive them. For many years, two key requirements were that the benefits had to be (1) "primarily health related," meaning that their main purpose was "to prevent, cure, or diminish an illness or injury," and (2) "offered uniformly to all enrollees" (Centers for Medicare & Medicaid Services 2016). These requirements had prevented plans from providing benefits that were not directly health related but that could address other enrollee needs (such as in-home supports for people with functional limitations) and from targeting benefits to specific types of enrollees (such as those with a particular health condition).

Policymakers have taken several steps in recent years to loosen those requirements:

- In 2018, CMS broadened its definition of "primarily health related" to include services that address physical impairments, lessen the functional or psychological impact of injuries, or reduce avoidable health care utilization (Centers for Medicare & Medicaid Services 2018c). Under this new definition, plans can provide services such as in-home support services and home modifications. This change took effect in 2019.
- At the same time, CMS modified the uniformity requirement to let plans target supplemental benefits to enrollees with a particular "health

status or disease state" (Centers for Medicare & Medicaid Services 2018d). Plans that choose to target benefits in this manner must ensure that all enrollees with the targeted health status or disease state are treated in the same manner. This change also took effect in 2019.

- The Bipartisan Budget Act of 2018 gave plans the flexibility to provide to chronically ill enrollees supplemental benefits that "have a reasonable expectation of improving or maintaining the health or overall function" and do not have to be primarily health related. These benefits are known as special supplemental benefits for the chronically ill (SSBCI). Plans can use this authority to cover services such as meals, food and produce, nonmedical transportation, and pest-control services (Centers for Medicare & Medicaid Services 2019b). This change took effect in 2020.
- In 2017, the Center for Medicare & Medicaid Innovation (the CMS Innovation Center) started a demonstration called the Medicare Advantage Value-Based Insurance Design (VBID) Model that let participating plans offer a wider range of supplemental benefits and target them to certain types of enrollees. The demonstration evolved over time and the types of benefits that were initially permitted only under the VBID model were later permitted more broadly under the policy changes listed above, which gave plans some of the same flexibilities. For example, beginning in 2017, plans participating in the VBID model were permitted to target supplemental benefits to enrollees with certain clinical conditions; this flexibility was extended to non-VBID plans (under the SSBCI policy described above) beginning in 2020. However, the demonstration was distinctive because it provided the only way for plans to target supplemental benefits to beneficiaries based on socioeconomic status instead of chronic illness or disease state and to reduce or eliminate cost sharing for Part D drugs.[11] The VBID demonstration began with nine MA organizations in seven states; it was incrementally expanded to additional states in subsequent years and was expanded by law to all states beginning in 2020. In 2024, CMS announced that it would terminate the demonstration at the end of 2025, citing "substantial and unmitigable costs to the Medicare Trust Funds," driven by faster risk-score growth and higher Part D expenditures (Centers for Medicare & Medicaid Services 2024e, Centers for Medicare & Medicaid Services 2023c).

As a result of these changes, the types of supplemental benefits that MA plans can offer to their enrollees has widened. Table 2-A1 of the appendix (p. 119) lists examples of the supplemental benefits MA plans may offer.

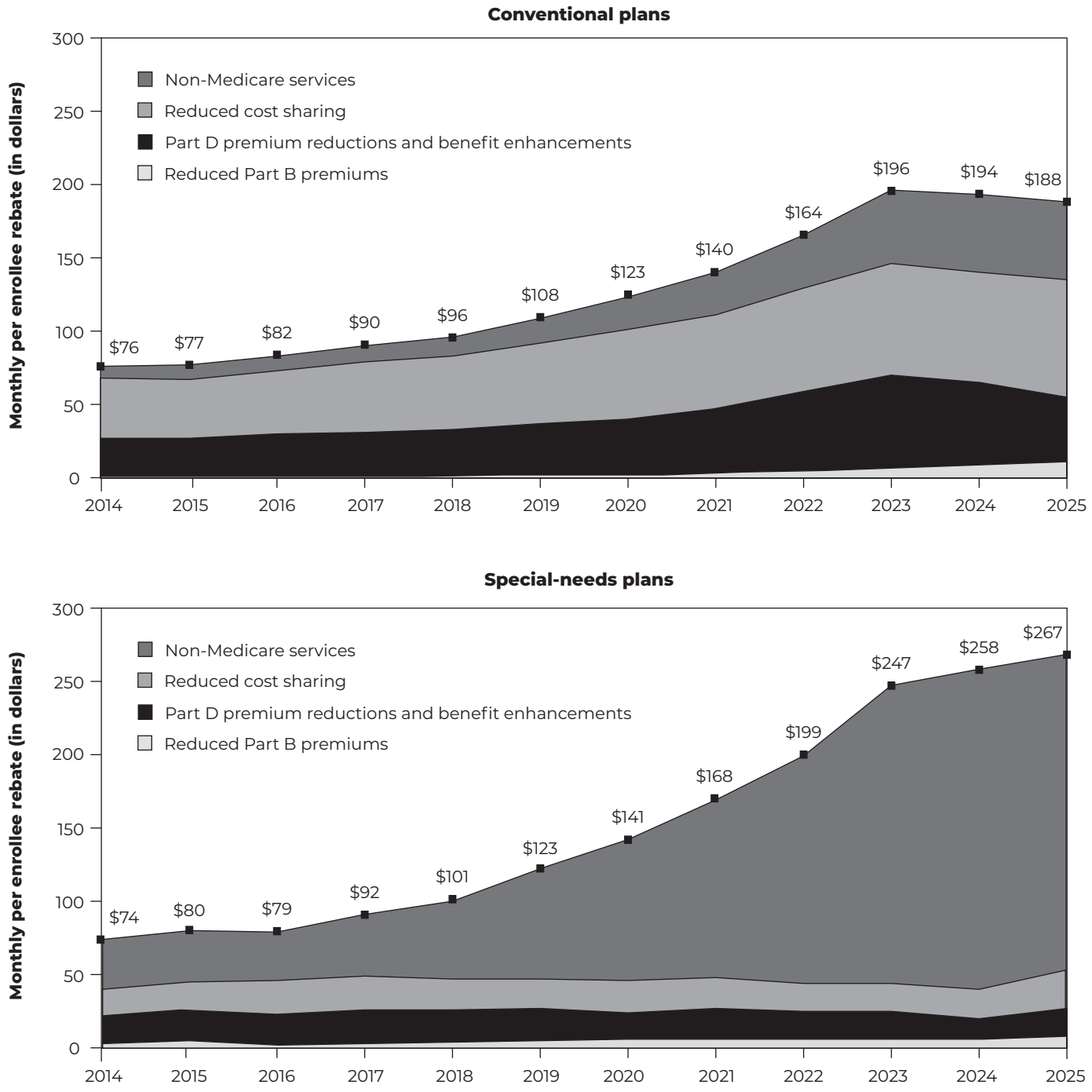
Marked growth since 2018 in the rebates that finance MA supplemental benefits

The rebates that Medicare pays to MA plans have grown significantly in recent years. The average rebate paid to conventional MA plans (i.e., nonemployer, non-special-needs plans) nearly doubled on a nominal basis between 2018 and 2025: Rebates rose from $96 per member per month (PMPM) in 2018 to an all-time high of $196 in 2023; they then declined slightly to $188 PMPM in 2025 (Figure 2-1). For special-needs plans (SNPs), the average rebate is significantly higher—$267 PMPM in 2025—and has increased in every year since 2016. In 2025, Medicare will pay MA plans (including both conventional plans and SNPs) approximately $2,530 per enrollee per year to provide supplemental benefits. The increase in the average rebate per member, combined with rapid MA enrollment growth, has resulted in a significant increase in the amount Medicare spends on rebates. In 2018, Medicare paid MA plans (including conventional plans, SNPs, and employer plans) an estimated $21 billion in rebates (roughly 10 percent of payments to MA plans in that year); in 2025 the program will spend approximately $86 billion (or 17 percent of MA payments) on rebates (Figure 2-2, p. 68).[12]

Conceptually, the rebates paid to MA plans were originally intended to be a form of shared savings in which plans would be rewarded for providing Medicare benefits at a lower cost than would have been the case under FFS.[13] However, the Commission's previous work has shown that elements of MA payment policy have resulted in benchmarks that are higher than the expected costs of the MA population (Medicare Payment Advisory Commission 2025). Because plan bids are meant to reflect plan costs and because

FIGURE 2–1

Monthly MA rebates have nearly doubled since 2018; plans allocate a significant share of rebates to non-Medicare services

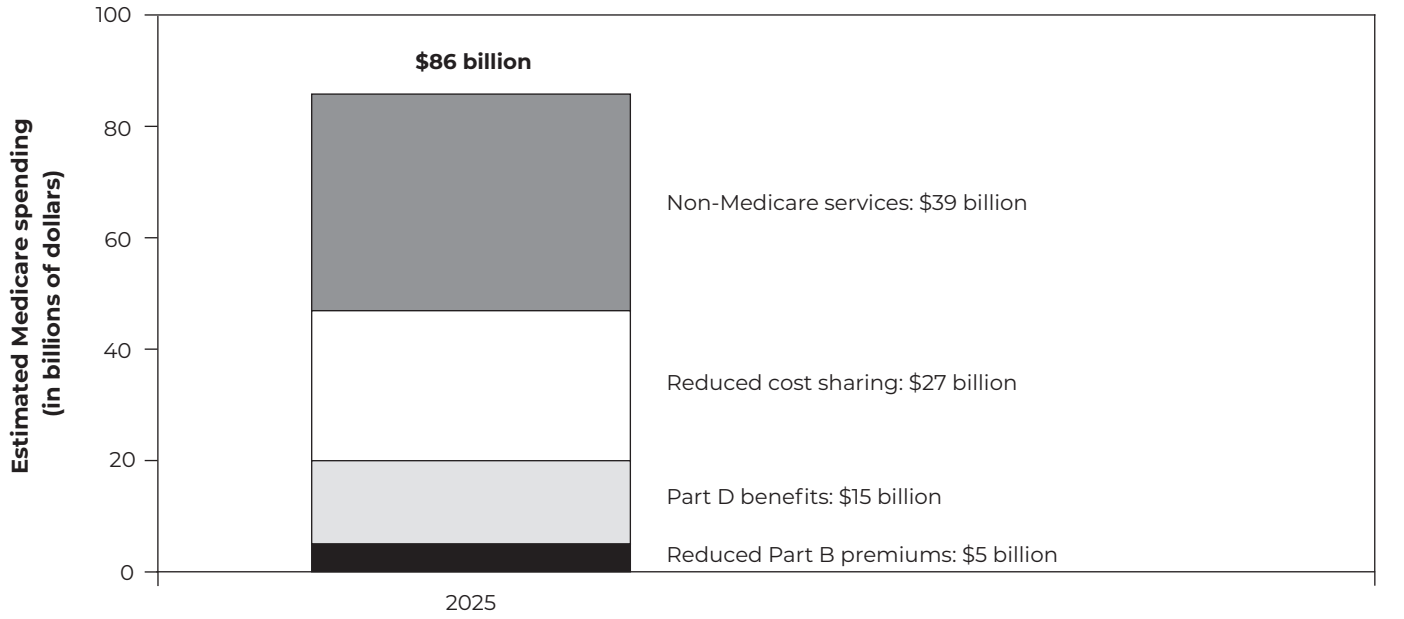


Note: MA (Medicare Advantage). MA plans must report in their bids how much of their rebate they plan to allocate to reduced Part B premiums, reduced cost sharing, Part D benefits, and non-Medicare services, but these projections may not reflect actual use. "Conventional plans" excludes employer group plans, special-needs plans, and plans that do not offer Part D coverage. "Special-needs plans" excludes employer group plans, non-special-needs plans, and plans that do not offer Part D coverage. The plan rebate is the per beneficiary per month amount that the plan offers as premium-free extra benefits. Rebate dollar amounts are based on the national average and reflect plan risk scores in plan bids but do not reflect payment adjustments for sequestration. Dollar amounts are nominal figures, not adjusted for inflation.

Source: MedPAC analysis of MA bid data.

FIGURE 2–2

Medicare will spend an estimated $86 billion on MA rebates in 2025



Note: MA (Medicare Advantage). In the bids they submit to CMS, MA plans must report how much of their rebate they plan to allocate to reduced Part B premiums, reduced cost sharing, Part D benefits, and non-Medicare services. These projections may not reflect actual use. Rebates paid to nonemployer plans were estimated using rebate amounts from MA bids and monthly enrollment data for nonemployer plans. Rebates for employer plans were estimated using the same method CMS uses to determine employer-plan payment rates, in which the difference between the county-specific benchmark and base payment rate for employer plans (based on the average bid-to-benchmark ratio for nonemployer plans in the payment quartile of the county) is multiplied by the plan-specific rebate percentage (based on the plan's star rating) and the risk score.

Source: MedPAC analysis of MA bid data, 2025.

rebates are a share of the difference between plan bids and benchmarks, inaccurate benchmarks can increase the rebates plans receive. Our previous work has shown that the difference between benchmarks and plan bids has widened over time, thereby increasing rebates. The extent of this effect varies across MA organizations but has become particularly pronounced for some plans. One potential implication of this effect is that a large portion of the rebates Medicare pays to MA plans may be financed by additional program spending and not by savings derived from plan efficiencies. Additionally, because MA rebates are paid from the Medicare trust funds, they are partially financed by Part B premiums collected from all beneficiaries (including those in FFS Medicare). The Commission estimates that Part B premiums will finance about $13 billion of MA rebates in 2025, with nearly $6 billion coming from FFS beneficiaries who do not have access to the supplemental benefits financed by the rebates.[14]

Conventional MA plans and SNPs report using rebates very differently

In the bids they submit to CMS, MA plans must report how much of their rebate they plan to allocate to each type of supplemental benefit: reducing enrollees' cost sharing, reducing enrollees' Part B or Part D premiums, enhancing Part D benefits, or covering non-Medicare services. Plans are required to allocate the full value of the total rebate to at least one of the supplemental-benefit categories. Plans' rebate allocations are a projection of how the plan anticipates rebate dollars will be used but might not reflect actual use. For example, consider a hypothetical plan that prospectively allocates half of its rebate to reducing cost sharing and half to covering non-Medicare services: If the plan's members use more Medicare-

TABLE 2–1

Conventional MA plans report allocating the largest share of rebate dollars to reducing cost sharing; SNPs report allocating the largest share to covering non-Medicare services, 2025

			Distribution of allocated rebate					
	Total		Benefit expenses		Administrative costs		Profit margin	
Category	Dollar	Percent	Dollar	Percent	Dollar	Percent	Dollar	Percent
Conventional MA plans	**$188**	**100%**	**$173**	**92%**	**$14**	**7%**	**$2**	**1%**
Reduced Part A and Part B cost sharing	80	43	71	89	8	10	1	1
Non-Medicare services	53	28	47	88	6	11	1	1
Reduced Part B premium	11	6	11	100	—		—	
Part D benefits	44	23	44	100	—*		—*	
Reduced basic premium	*15*	*8*	*15*	*100*	—*		—*	
Enhanced coverage	*29*	*15*	*29*	*100*	—*		—*	
Special-needs plans	**$267**	**100%**	**$233**	**87%**	**$22**	**8%**	**$12**	**5%**
Reduced Part A and Part B cost sharing	26	10	22	86	2	9	1	5
Non-Medicare services	215	80	184	86	20	9	11	5
Reduced Part B premium	8	3	8	100	—		—	
Part D benefits	19	7	19	100	—*		—*	
Reduced basic premium	*11*	*4*	*11*	*100*	—*		—*	
Enhanced coverage	*8*	*3*	*8*	*100*	—*		—*	

Note: MA (Medicare Advantage), SNP (special-needs plan), N/A (not applicable). MA plans must report in their bids how much of their rebate they plan to allocate to reduced Part B premiums, reduced cost sharing, Part D benefits, and non-Medicare services, but these projections may not reflect actual use. "Conventional plans" excludes employer group plans, special-needs plans, and plans that do not offer Part D coverage. "Special-needs plans" excludes employer group plans, non-special-needs plans, and plans that do not offer Part D coverage. The plan rebate is the per beneficiary per month amount that the plan offers as premium-free supplemental benefits. Rebate dollar amounts are based on the national average and reflect plan risk scores in plan bids but do not reflect payment adjustments for sequestration. No rebate dollars used to reduce Part B premiums can be apportioned for administrative costs or profit. Components may not sum to totals due to rounding.
* Because Part D premiums typically reflect some amount of administrative costs and profit for the Part D plan, some of the rebate dollars allocated to the reduction of Part D premiums are also devoted to administrative costs or profits, though less directly.

Source: MedPAC analysis of MA bid data, 2025.

covered services than the plan anticipated and use fewer non-Medicare services than anticipated, the distribution of actual spending by the plan would skew toward greater spending on cost-sharing reductions relative to the distribution suggested by the allocations reported in the bid. As a result, we are able to summarize how plans allocate (i.e., expect to use) their rebates but know considerably less about how the funds are ultimately used.

Plans that use rebate dollars to lower cost sharing for basic Medicare services or to provide non-Medicare benefits apportion some of the rebate to their administrative costs and margin (positive or negative).[15] As shown in Table 2-1, in 2025, conventional plans intend to allocate about 8 percent and SNPs intend to allocate about 13 percent of their rebate to such purposes. In 2025, as in most previous years, conventional MA plans allocated the largest share of their rebate dollars to reducing cost sharing for Part A and Part B services. Because this cost sharing is often already covered for SNP enrollees, SNPs have always allocated the largest share of their rebates to

covering non-Medicare services. However, between 2018 and 2023, both conventional plans and SNPs sharply increased the share of rebate dollars allocated to coverage of non-Medicare services; both types of plans have continued to allocate a significant portion of rebates to those services in recent years.

Reduced cost sharing

In 2025, as in most previous years, conventional MA plans allocated the largest share of their rebate dollars (43 percent) to reducing cost sharing for Part A and Part B services (Table 2-1, p. 69). In contrast, SNPs allocated a small share of their rebate (10 percent) to reducing cost sharing.[16] Because most of their enrollees (about 90 percent) are dually eligible for Medicare and Medicaid, many OOP costs for these beneficiaries are already covered by other programs: Medicaid covers Part A and Part B cost sharing and pays the Part B premium in most cases, and Medicare's Part D low-income subsidy typically covers the premium and all or most cost sharing for prescription drug coverage. As a result, SNPs have less reason than conventional plans to use their rebates to cover these costs.

Enhanced Part D benefits and Part B premium reductions

MA plans also provide financial protections by allocating rebate dollars to reducing basic Part D premiums and enhancing Part D benefits, and reducing Part B premiums. Specifically, plans can use rebate dollars to lower the basic Part D premium or can reduce the premium enrollees pay for enhanced Part D benefits (such as lower cost sharing or coverage of additional drugs).[17] Part D premium reductions are strategically important for plans because low premiums are an effective way to attract enrollees. In interviews with MedPAC staff, MA actuaries and plan representatives have shared that Part D premium reductions are a first-order consideration with regard to how rebate dollars are allocated. In 2025, conventional MA plans allocated 23 percent of their rebate dollars to Part D benefits. MA plans may also use rebates to reduce the standard Medicare Part B premium for their enrollees. However, this arrangement is less common and plans typically devote a small share of rebate dollars (6 percent among conventional plans in 2025) to such reductions.[18] Conventional plans allocate more rebate dollars to reducing Part D premiums (consistent with the lower share of LIS enrollees receiving premium assistance through Part D in those plans). Part B premium reductions are primarily concentrated in the plans receiving the largest rebates, suggesting that plans appear to prioritize Part D premiums, cost-sharing reductions, and coverage of non-Medicare services over Part B premium reductions.

Coverage of non-Medicare services

In recent years, plans have allocated a large share of their rebates to the provision of non-Medicare services (Figure 2-1, p. 67). The share of rebates allocated to these types of benefits grew dramatically between 2018 and 2023, but it has leveled off somewhat in recent years. Nevertheless, plans continue to anticipate using a large share of rebate dollars for non-Medicare services. Across all MA plans, the share of rebates allocated for coverage of non-Medicare services doubled between 2018 and 2025—rising from roughly 20 percent to 40 percent—largely driven by the increase in the share of non-Medicare services for SNPs. In 2025, on an annual basis, conventional MA plans and SNPs allocated about $636 and $2,580 in rebates per enrollee, respectively, to coverage of non-Medicare services (figures based on total rebate, including administrative costs and profit margin).

For conventional MA plans, the share of rebates allocated to non-Medicare services rose from 15 percent in 2019 to 28 percent in 2025. In total since 2014, according to plans' bid projections, more than 40 percent of the growth in conventional plans' rebates has been allocated to non-Medicare services. SNPs have always allocated a larger share of their rebates to covering non-Medicare services—56 percent, on average, between 2014 and 2018—but the share for these plans has also risen since 2019: In 2025, SNPs allocated 80 percent of their rebates to non-Medicare services. Since 2014, nearly all of the growth in SNP rebates has been allocated to these benefits.

The increase in the share of rebate dollars allocated for coverage of non-Medicare services coincides with a period of rapid rebate growth. The fact that plans allocated a larger share of each marginal rebate dollar to these benefits (instead of to cost-sharing reductions) could reflect that cost sharing is an important utilization-management tool for plans and could indicate that there are limits to the extent to which plans are willing to reduce enrollee cost sharing.

Other factors, such as the expansion in 2019 and 2020 of the types of benefits MA plans could offer and how they could be targeted to enrollees, could also have contributed to the increase.

Little is known about use of supplemental benefits

Little is known about the extent to which MA enrollees use the many supplemental benefits available to them. For many of the benefits, the data that Medicare collects are insufficient for examining the use of the services. The lack of reliable data makes it impossible to answer many important questions about how the rebates that Medicare pays to MA plans are used. For example, we do not know how much plans spend on each type of benefit, which enrollees used each benefit (and how frequently), or whether service use differs by such factors as age, sex, race, disability status, and geographic area. Without this information, GAO has noted, it is difficult to determine whether the benefits improve MA enrollees' health (Government Accountability Office 2023). As such, policymakers do not have good information about whether the spending provides good value to MA enrollees and the taxpayers who fund the program. Part B and Part D premium reductions are the two categories for which we can be most sure of enrollees' use of the benefits because the reductions are adjudicated automatically between CMS and plans offering the benefits. For cost-sharing reductions and coverage of non-Medicare services such as dental care, however, current data sources do not provide reliable information.

Before 2024, Medicare primarily collected information about supplemental benefits from MA plans in three datasets: plan benefits data, bid data, and encounter data. Each of these has significant limitations for analyzing the use of such benefits.

- **Plan benefit data.** MA plans are required to submit information to CMS about the benefits they cover and the structure of that coverage (e.g., deductible amount, use of copayments or coinsurance, requirements for referral or prior authorization), but the data do not include any information about enrollees' use of the benefits or plans' spending for them. The data are published concurrent with the year in which the coverage applies. The data include information about what benefits each plan offers, including information about supplemental benefits, and CMS lists nearly 100 supplemental benefits that plans may offer, grouped into approximately 14 service categories (e.g., inpatient hospital benefits, dental services). CMS also provides an option for plans to enter additional benefits beyond those listed in the submission form.

- **Bid data.** As part of the annual bidding process, MA plans submit utilization and spending information, aggregated to the plan and service-category level. The primary function of the bid data is facilitation of the MA bidding process, not oversight of supplemental-benefit use and delivery. As such, the data (appropriately) include information that is necessary for monitoring plan bids and exclude other information that would be useful for overseeing the delivery and use of supplemental benefits. However, we can use the bid data to glean some insights about plans' spending on supplemental benefits.[19] The data are reported using broad service categories (e.g., dental, vision, hearing, transportation, and "other supplemental benefits"). For each service category, MA plans report how much they spent (on a per member per month (PMPM) basis) during the preceding year (referred to as the "base period"). Plans also submit projections of their expected costs for each broad service category in the upcoming year. Those projections, along with a set of other factors, determine the plan's bid for the year.[20,21]

  Of the roughly 14 service categories in which plans can offer supplemental benefits, only four are separately and distinctly reported in bid data: dental, vision, hearing, and transportation services. Information for other supplemental benefits is either reported under a broad category (e.g., "other non-Medicare services") or combined with information about Medicare-covered services (e.g., additional days of inpatient hospital care provided as a supplemental benefit is reported under the "inpatient hospital" category, along with information about Medicare-covered hospital stays) (Centers for Medicare & Medicaid Services 2023b). This aggregation severely limits the extent to which bid data can be used to comprehensively assess supplemental-benefit use or spending.

- **MA encounter data.** CMS requires MA organizations to submit encounter records for all health care items and services, including supplemental benefits, provided to their enrollees.[22] Accordingly, MA encounter data should be the most detailed source of information for assessing MA enrollees' use of services. However, the Commission has found that the encounter data that plans have submitted to date are incomplete and cannot be used for many analyses (the Commission is actively exploring whether there are targeted analyses for which the data can be used) (Medicare Payment Advisory Commission 2024a).[23]

  Several factors limit the possibility of using encounter data to assess supplemental-benefit utilization. One limitation is that, up until 2024, the Encounter Data Processing System (EDPS) that CMS uses to collect encounter records from MA plans was not configured to accept dental claims (Centers for Medicare & Medicaid Services 2024h).[24] As a result, the encounter data cannot be used to assess dental services, yet plan bids show that dental is a major category of supplemental benefits. A second limitation is that, although MA plans have long been required to submit encounter records for supplemental benefits, CMS did not provide instructions for submitting records for supplemental benefits for years prior to 2024 (Centers for Medicare & Medicaid Services 2024h). GAO has previously reported that this lack of guidance, along with technical limitations of the EDPS, has resulted in confusion among MA plan officials about whether and how to submit encounter records for supplemental benefits (Government Accountability Office 2023). See the text box on using encounter data to assess use of MA supplemental benefits for more information (pp. 96–99).

  As a result of these limitations, it is unclear to what extent encounter data could be used to assess MA enrollees' use of supplemental benefits. In this chapter, we explore whether there are certain categories of supplemental benefits for which it may be feasible to use encounter data to assess utilization of the services. Our preliminary analysis of encounter data for 2021 (the latest data available at the time of our analysis) suggests that the encounter data for vision and hearing services may be usable, but the data for other supplemental benefits appear to be incomplete.

New data submission requirements for 2024 will provide more information about supplemental benefits

In 2024, CMS began implementing a series of actions to improve and increase the amount of data that plans report regarding use of and spending for supplemental benefits. The changes include:

- **Dental encounter records.** Beginning in 2024, the EDPS—which plans use to submit encounter records to Medicare—was updated to accept submission of encounter records for supplemental dental benefits.

- **Encounter records for other non-Medicare services.** In 2024, CMS issued new guidance for how encounter records for supplemental benefits should be submitted to the EDPS, including a supplemental-benefit indicator that can be used to identify encounter records for supplemental benefits and a set of "default" codes that are to be used to report items or services for which a typical diagnosis, procedure, and/or revenue code does not apply (Centers for Medicare & Medicaid Services 2024c). CMS also provided instructions for submitting information about supplemental benefits that do not produce the same types of utilization data as medical services (e.g., fitness benefits or over-the-counter (OTC) debit cards).

  Encounter data could, in theory, also be a vehicle for collecting information about how much plans and enrollees spend on services. Such information could be used to assess the reductions in cost sharing that MA plans provide; however, the payment-related fields of the encounter data are incompletely populated and of unknown reliability. This shortcoming is not addressed in CMS's recent changes.

- **Plan-level use and spending data.** Starting with the 2024 plan year, as part of the Part C Reporting Requirements (generally used to monitor plans), CMS began requiring MA plans to report aggregated information about their enrollees' use of supplemental benefits and their spending on those benefits (Centers for Medicare & Medicaid Services 2024g). Plans will be required to report:

- the number of enrollees eligible for the benefit,
- the number of enrollees who used the benefit at least once,
- the total instances of utilization among eligible enrollees,
- the median number of utilizations among enrollees who used the benefit at least once,
- the total net amount incurred by the plan to offer the benefit,
- the type of payment arrangement(s) the plan used to implement the benefit (e.g., capitation, flat fee),
- how the plan accounts for the cost of the benefit (how the plan determines and measures administrative costs, costs to deliver, and any other costs the plan captures), and
- the total out-of-pocket cost per utilization for enrollees who used the benefit.

The data will be reported for approximately 100 supplemental benefits spread across 14 categories, including dental, vision, hearing, transportation, and SSBCI (Centers for Medicare & Medicaid Services 2024g). These new data should provide an overarching view of use of and spending for supplemental benefits. However, the utility of the new data will be somewhat limited because the data will be reported at the MA plan level, so it will not be possible to assess which enrollees within a plan are using the benefits. That level of aggregation will limit the types of analysis that can be conducted; for example, without knowledge of who used a benefit, it is difficult to assess how the use of the benefit relates to the individual's medical or social needs. This limitation leaves a general lack of transparency about who is using supplemental benefits, whether the benefits are being accessed by beneficiaries who could most benefit from them, and the value of the benefits for beneficiaries and taxpayers. We anticipate that the data for 2024 will be available for analysis sometime in the second half of 2025 or in 2026.

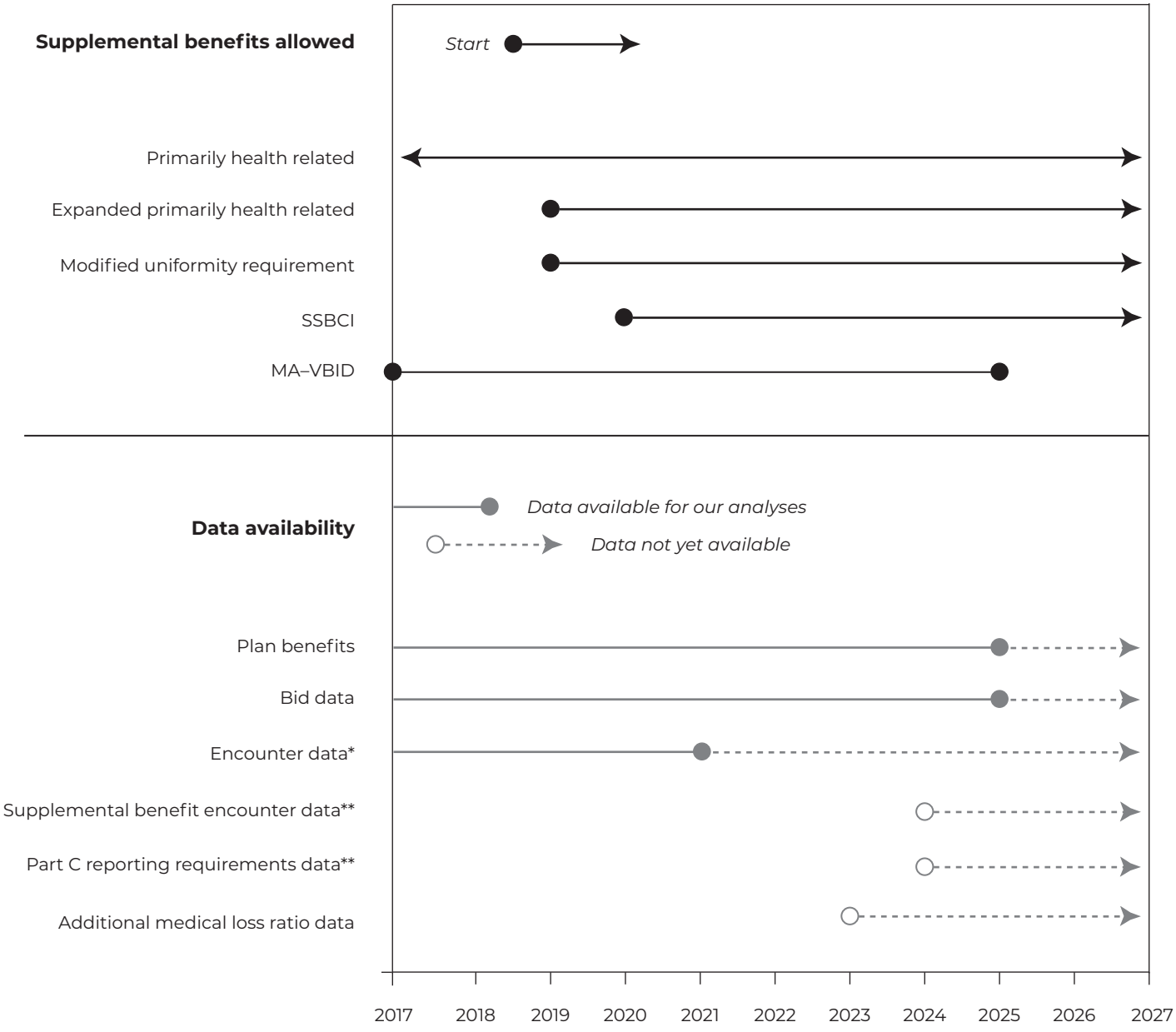
- **Detailed medical loss ratio data.** MA plans are required to maintain a medical loss ratio (MLR) of 85 percent (42 CFR Sec. 422.2410(b)).[25] To monitor and enforce this requirement, CMS collects data from MAOs about their revenues and expenditures in each plan year. The amount of detail that CMS collects for such purposes has fluctuated over time. Starting with plan-year 2023, CMS began requiring MA plans to report additional detail about their expenditures on supplemental benefits as part of the required data. MAOs are required to report, for each contract, their expenditures for 16 different MA supplemental benefits (each separately reported), as well as their expenditures for SSBCI and "all other primarily health related supplemental benefits" (18 total reporting categories). The data are collected toward the end of the calendar year following the contract year (i.e., data pertaining to 2023 are collected at the end of 2024), and the time it takes to make the data publicly available varies. The additional details collected for 2023 were not available at the time of our analysis. This information will provide a better understanding of MAOs' spending on supplemental benefits but will be limited by the fact that the information will be reported at the contract level.

Altogether, the new data-reporting requirements will address some, but not all, of the data limitations that hinder our ability to assess how MA enrollees use supplemental benefits and how much plans spend on the benefits. Due to lags between when the data are collected, reported, and made available to researchers, it may be several more years before the full range of data are available for analysis. Figure 2-3 (p. 74) illustrates the time frames in which information about MA benefits is available and how the schedule limits our analysis of supplemental benefit use. Note that, at the time of our analysis, the most recently available encounter data were for 2021. Our analysis of plan bids and benefit data suggests that spending for supplemental benefits has grown significantly since 2021 and that the types of benefits being offered to MA enrollees have expanded in the intervening years.

Until better data are available, we must rely on existing data sources to try to understand MA enrollees' use of supplemental benefits. In the rest of this chapter, we analyze plan benefit data to assess trends in the types of benefits MA plans offer to their enrollees. Where possible, we also assess sources of

FIGURE 2–3

Lags in data availability hinder analysis of supplemental benefit utilization



Note: SSBCI (special supplemental benefits for the chronically ill), MA (Medicare Advantage), VBID (Value-Based Insurance Design). CMS broadened its definition of "primarily health related" and relaxed the requirement that benefits be offered uniformly to all enrollees beginning in 2019, expanding the types of supplemental benefits that plans could offer and enabling plans to target supplemental benefits to particular groups of enrollees. The Bipartisan Budget Act (BBA) of 2018 gave plans the flexibility to provide supplemental benefits that are not primarily health related to chronically ill enrollees (known as "special supplemental benefits for the chronically ill"). This change took effect in 2020. In 2017, the Center for Medicare & Medicaid Innovation (the CMS Innovation Center) started a demonstration called the Medicare Advantage Value-Based Insurance Design (MA–VBID) Model that lets participating plans offer a wider range of supplemental benefits and target them to certain types of enrollees. The model was initially limited to a small number of insurers offering plans in seven states. The BBA of 2018 expanded the model to all states starting in 2020. In 2024, CMS announced that the model will cease at the end of 2025.
* Before 2024, the Encounter Data Processing System used to collect encounter data from plans was not configured to accept data on the use of supplemental dental benefits.
** Points indicate the measurement years for which the plans are required to begin reporting and do not reflect delays between the measurement year and the year in which the data are available for analysis.

Source: MedPAC analysis of MA policies and data resources.

information about MA enrollees' use of the benefits. For dental benefits, because encounter data are not available, we analyze data from the MCBS. For other benefits, we conducted an analysis of the data to explore the extent to which the data can be used to assess the use of supplemental benefits.

Supplemental benefits: Cost-sharing and premium reductions

MA plans can use the rebates they receive from Medicare to reduce cost sharing and Part B and Part D premiums for their enrollees. In this section, we use plans' bid data to summarize the services for which MA plans report reducing cost sharing and the availability of premium reductions. Complete and accurate MA encounter data would be the best vehicle for collecting information about the cost sharing paid by MA enrollees; unfortunately, the cost-sharing fields in the encounter data are incompletely populated and of unknown reliability. In lieu of reliable claims-level information, we must use the information from plans' bid data, which include plans' estimates of cost sharing for broadly defined service categories reported on a per member per month (PMPM) basis. As such, bid data cannot be used to assess what enrollees actually pay or which enrollees benefited from plan-provided cost-sharing reductions, but bid data can provide an aggregated view of how plans anticipate using rebate dollars allocated for cost-sharing reductions. The premium reductions that plans provide as supplemental benefits are used equally by all enrollees in a plan and so do not produce (or require) utilization data like those required for understanding the use of other supplemental benefits.

Reduced cost sharing for Part A and Part B services

Reduced cost sharing for Part A and B services is one of the most common MA supplemental benefits: Nearly all conventional MA plans allocate a portion of rebate dollars to reducing the amount enrollees pay OOP for care. In 2025, conventional MA plans allocated more of their rebate to reducing cost sharing (43 percent) than to any other category of supplemental benefits (Table 2-1, p. 69). Those dollars can be used both to reduce the amount enrollees pay for particular services and to finance the MOOP limit plans are required to offer.[26] Understanding how much MA enrollees pay for care is important for several reasons. First, it is important to assess whether plans are adhering to Medicare's cost-sharing rules for MA plans. Second, beneficiaries who are choosing between FFS Medicare (with the potential purchase of a Medigap plan) and MA could use the information to inform their decision.[27] Third, lessons from MA could provide insights into how to improve the cost-sharing structure of FFS Medicare.

In contrast with other types of supplemental benefits, there is little question as to whether MA enrollees use the cost-sharing reductions that MA plans offer as supplemental benefits. Because the reductions are often applied to commonly used services and are adjudicated at the point of service, most MA enrollees who use at least one Medicare-covered service during the year are likely to use at least one service for which cost sharing under their plan is lower than what they would have paid if they had been enrolled in FFS Medicare without another form of coverage (such as Medigap). In addition, all enrollees who reach the MOOP limit that plans are required to provide can be considered to have "used" the benefit. However, the number of enrollees affected by the cost-sharing reductions in any given plan depends on the types of services for which the plan chooses to reduce cost sharing and the types of services that enrollees use. Unfortunately, inadequate data limit our ability to assess the cost sharing paid by MA enrollees: No publicly available resources contain reliable claim- or beneficiary-level cost-sharing information. MA encounter data would be the best vehicle for collecting information about cost sharing, but the cost-sharing fields in the data are incompletely populated and of unknown reliability.[28] In lieu of reliable claims-level information, we must use information from plans' bids, which include financial projections for the plan.

In their bids, plans estimate the amount that they anticipate their enrollees will pay in cost sharing for Medicare-covered services in the upcoming year (reflecting the combined effects of the required MOOP limit in MA, plans' benefit design decisions, plans' use of rebates, and plans' expectations about the services enrollees will use). The bid pricing tool that CMS uses to collect bids automatically calculates an estimate of

the actuarially equivalent amount of cost sharing that would be charged for Medicare-covered services if the same population were enrolled in FFS Medicare (without an additional form of coverage, such as Medigap). The actuarial-equivalence calculations hold utilization constant and do not reflect the possibility that beneficiaries would likely use services differently if charged different cost sharing. The net difference between a plan's cost sharing for Medicare-covered services and the estimated amount in FFS (for enrollees without an additional form of coverage) is considered a supplemental benefit that can be financed using the plan's rebate (if the cost sharing under the plan is lower, which is generally the case). Because the calculations in the bid pricing tool are made separately for each service category, we can gain a rough sense of the service categories for which plans expect to use relatively more rebate dollars to reduce enrollees' cost sharing.

Table 2-2 shows conventional plans' estimates of the cost-sharing reductions their members will experience in 2025, expressed on a PMPM basis. The table also shows MedPAC's estimates of the per unit cost-sharing reductions that enrollees might experience when using a particular service (estimated using the PMPM cost-sharing reduction and the utilization rates that plans report in their bids). We focus on the cost-sharing reductions provided by conventional plans because enrollees in those plans are less likely to be dually eligible, and are therefore less likely to have help from Medicaid paying their cost sharing. Further, because SNPs devote a smaller portion of their rebates to reducing cost sharing (due to the high percentage of enrollees who are dually eligible), cost-sharing reductions in MA are concentrated in conventional plans. To provide a sense of the relative cost of each type of service, we also show an estimate of the "allowed amount," which is the plan's negotiated payment rate for the service—typically shared between the plan and the enrollee through cost sharing.[29] The reductions shown in the table reflect the combined effects of the required MOOP limit in MA, plans' benefit design decisions, and plans' use of rebates. Because the bid pricing tool does not account for the fact that roughly 85 percent of FFS enrollees have another form of coverage that reduces their out-of-pocket costs, the data indicate how plans estimate that rebate dollars will be distributed across service categories but do not reflect how enrollees' true OOP costs in MA differ from the amount they might have paid if they enrolled in FFS Medicare and purchased an additional form of coverage (Medicare Payment Advisory Commission 2024b). In 2025, conventional plans project that cost sharing for Medicare-covered services for their members will be lower than the amount those members would be expected to face if they were in FFS Medicare without another form of coverage for almost all service categories.[30] The two exceptions are ambulance and home health services. CMS does not impose a service-specific limit on cost sharing for ambulance services in MA, so plans are subject to the general rule that they cannot charge more than 50 percent in coinsurance or an actuarially equivalent copayment for the services (CMS has previously contemplated adding a service-specific cost-sharing limit for ambulance services (Centers for Medicare & Medicaid Services 2022b)). For home health, FFS Medicare does not charge cost sharing, while some MA plans do.

Looking across service categories, on a PMPM basis, conventional plans anticipate that (in 2025) the largest reduction in cost sharing will be for professional services such as primary care and specialty visits—a reduction of $32 PMPM, or roughly 13 percent of the allowed amount (the negotiated payment rate between the plan and the provider). Because the actuarially equivalent cost sharing in FFS Medicare would be roughly 20 percent, this reduction equates to the MA plan reducing the cost sharing by slightly more than half (relative to FFS Medicare without additional coverage).[31]

PMPM estimates, however, do not account for the fact that not all enrollees will use certain services during the year. To better convey how cost-sharing reductions may affect certain MA enrollees, we recalculated the cost-sharing reductions on a "per unit" basis using the plans' projections of utilization for each service category (Table 2-2).[32] On a per unit basis, we estimate that conventional plans expect the largest cost-sharing reductions per service to be for outpatient surgical visits, with a reduction of roughly $342 per visit (or about 12 percent of the allowed amount per visit). Ultimately, though, the total value of cost-sharing reductions for any given enrollee depends on the mix of services they use, the amount of a service they use, whether they receive the services within their plan's network, and other aspects of their plan's benefit design. For example, some plans apply service-specific

TABLE 2–2

Conventional plans' estimates of MA cost-sharing reductions vary by service category, but effects on enrollees depend on the services used, 2025

		Average cost-sharing reduction relative to FFS Medicare without additional coverage		Average allowed amount[b]		Reduction as percentage of allowed amount	
Service category[a]	**Unit**	**PMPM**	**Per unit of service**	**PMPM**	**Per unit of service**	**PMPM**	**Per unit of service**
Inpatient facility	Days	$5	$66	$280	$3,137	2%	2%
Skilled nursing facility	Days	3	57	34	633	9	9
Home health[c]	—	0	—	24	—	–1	—
Ambulance	Trips	–1	–50	14	679	–7	–7
DME[d]	—	1	6	20	105	5	6
Outpatient, emergency	Visits	5	104	46	996	10	10
Outpatient, surgery	Visits	11	342	90	2,839	12	12
Outpatient, other	Visits	9	17	124	233	8	7
Professional	Visits	32	20	254	157	13	13
Part B drugs	Scripts	9	53	97	588	9	9

Note: MA (Medicare Advantage), FFS (fee-for-service), PMPM (per member per month), DME (durable medical equipment). "Conventional plans" excludes employer group plans and special-needs plans. Positive numbers indicate that estimated cost sharing in MA is lower than the estimated cost sharing in FFS without additional forms of coverage; negative numbers indicate that MA cost sharing is higher than in FFS without additional forms of coverage. All dollar figures are rounded to the nearest dollar. Plan bids include estimates of the amount that the plan will spend PMPM on cost-sharing reductions for their enrollees, by service category, but these projections may not reflect actual plan spending. The reductions shown in the table reflect the combined effects of the required maximum out-of-pocket limit in MA, plans' benefit design decisions, and plans' use of rebates. The figures shown here include the cost-sharing reductions offered by plans that charge a Part C (MA) premium; for those plans, the cost-sharing reductions may be financed partially by Part C premiums paid by enrollees. To estimate per unit cost-sharing reductions, we calculated total plan spending on cost-sharing reductions as the product of the PMPM rate and the plan's projected membership for the year, divided by the number of plan-estimated units (units are typically visits, trips, or days, calculated as the plan-estimated utilization rate times the number of members). Estimates for each service category are based on data only for plans that reported data using the most common reporting unit for the category.
[a] The bid pricing tool that plans use to submit bids includes 11 Medicare-covered service categories. We excluded the "other Part B services" category because there is variation in whether plans report data in the category.
[b] The allowed amount is the plan's negotiated payment rate for the service, typically shared between the plan and the enrollee through cost sharing.
[c] We do not calculate per unit amounts for home health because we have previously found that plans appear to use different units when reporting home health utilization in their bids (Medicare Payment Advisory Commission 2024a).
[d] The DME service category includes DME, prosthetics, and certain diabetes-related products. The unit used to report DME products in the bid pricing tool is most commonly listed as "other."

Source: MedPAC analysis of MA bid data.

deductibles or use tiered cost sharing that varies based on the provider delivering the services. As such, these figures can give only a rough impression of cost sharing in MA, and data limitations prevent us from being able to reliably assess how variation in cost sharing within and across MA plans affects MA enrollees.

MA plans generally operationalize cost-sharing reductions through changes to their benefit design—dialing up or down the amount of cost sharing charged to enrollees for specific services. However, since 2021, CMS has permitted plans to use an additional method—referred to as a "reduction in cost sharing" benefit, or RICS—to deliver further cost-sharing reductions for their enrollees. Under a RICS benefit, the plan designates a list of services and a monetary limit; plan enrollees can use the RICS benefit to cover cost-sharing expenses for any of the plan-designated services, up to the limit set by the plan. Typically, the benefit is delivered using a prefunded debit card

provided to the enrollee. For enrollees, the RICS may provide an attractive mix of flexibility and extra financial protection. For plans, the RICS benefit may be appealing because it can be simpler to administer for certain types of services because the plan's financial liability can be capped at a plan-designated limit and because the plan can design the benefit to encourage use of services that it views to be of higher value.

The share of MA enrollees in conventional plans that offered the RICS benefit rose from 1 percent in 2021 to a peak of 12 percent in 2023. Since then, the percentage has declined; in 2025 only 6 percent of conventional plan enrollees were in a plan offering a RICS benefit. In the initial years of the benefit, plans mostly allowed enrollees to use the benefit to pay only for dental services or only for dental, vision, and hearing services. More recently, plans have granted enrollees more flexibility, allowing them to use the benefit on Medicare-covered services (such as doctors' visits) in addition to supplemental benefits. In 2025, about 20 percent of plans offering a RICS benefit allow their enrollees to use the benefit to reduce or cover cost sharing for essentially any of the major Medicare-covered service categories; roughly half allow the benefit to be used only for cost sharing for Medicare-covered services, one-third allow use for both Medicare and non-Medicare services, and the remainder allow use for only non-Medicare services.[33] The average estimated monthly limit for 2025 was $36, a significant decrease from $81 in 2021 when the benefit was first offered.[34] Plans offering RICS in 2025 typically projected similar cost-sharing levels (excluding the effects of the RICS) to plans not offering RICS and allocated a similar percentage of their rebate to the traditional forms of cost-sharing reduction (i.e., using the benefit design), suggesting that the RICS benefit is being offered as an additional form of cost-sharing assistance for enrollees rather than as a substitute for lowering cost sharing through the benefit design.

Part B and Part D premium reductions

MA plans commonly use rebate dollars to reduce or eliminate Part D premiums for their members; some plans also offer reduced Part B premiums (though this choice is less common). In 2025, nearly 100 percent of eligible Medicare beneficiaries (those with Part A and Part B coverage) have access to at least one conventional MA plan (i.e., excluding SNPs and employer group plans) that includes Part D drug coverage and charges no Part C or Part D premium (enrollees still pay the Medicare Part B premium) (Medicare Payment Advisory Commission 2025).

In contrast to cost-sharing reductions and coverage of non-Medicare services, estimating enrollees' use of premium reductions is relatively straightforward because the premium reductions are adjudicated automatically between CMS and the plans, requiring no action by the enrollees. About 76 percent of MA enrollment in 2025 is projected to be in the "zero-premium" plans that include Part D coverage and charge no Part C or Part D premium. Ninety-nine percent of beneficiaries have access to plans that offer some reduction in the Part B premium; about 32 percent of 2025 conventional plan enrollees were projected (in plan bids) to be in these premium-reduction plans, and the average monthly premium reduction was $44 (the monthly Part B premium for 2025 was $185) (Centers for Medicare & Medicaid Services 2024b).

Using data from plans' bids, in which plans report the amount of MA rebate used to reduce Part D or Part B premiums, it is possible to estimate total Medicare spending on premium reductions and MA enrollees' financial savings on premiums. Using rebate data for 2025, we estimate that Medicare will pay MA plans (via rebates) about $20 billion to reduce Part D and Part B premiums and enhance Part D benefits for their enrollees (about $15 billion of which was for Part D premium reductions and benefit enhancements).

Supplemental benefits: Non-Medicare services

In recent years, plans have allocated (in their bid projections) a growing share of MA rebates to the provision of non-Medicare services, such as dental, vision, and hearing services. For many years, when CMS required that supplemental benefits be primarily health related, dental, vision, and hearing services were among the most common supplemental benefits. As described earlier, significant policy changes have gradually expanded the types of benefits that plans may offer. As a result, plans are gradually covering a larger number of non-Medicare services. According to CMS,

over 99 percent of MA plans offered at least one such benefit in 2022, and the median number of benefits offered was 23; dental, vision, hearing, and fitness benefits were the most common (Centers for Medicare & Medicaid Services 2024g).

Figure 2-4 (p. 80) uses the projections from plans' bid data to assess which non-Medicare services plans expect to spend the most delivering (on a PMPM basis). Plan projections are reported using highly aggregated categories: Projected spending for dental, vision, hearing, and transportation benefits are reported separately; spending for all other non-Medicare services is reported in a pair of catch-all categories. As such, we are unable to break out the spending for services like gym memberships or OTC cards. The data show that, in 2025, conventional plans prioritize using rebate dollars to provide dental benefits while SNPs prioritize other types of benefits (such as OTC items, food and produce, or flexible-benefit cards).[35] Although dental benefits accounted for a smaller percentage of SNPs' estimated spending, because total SNP rebates are so much larger than those of conventional plans, SNPs projected spending more than conventional plans on dental benefits (about $26 PMPM, versus $19 for conventional plans). SNPs expected to spend considerably more (roughly $130 PMPM, versus $14 PMPM in conventional plans) on other types of supplemental benefits. SNPs' projected spending for these services has grown substantially over the last five years, and SNPs now report spending more than twice as much on these benefits as they do on all other non-Medicare services combined (including dental, vision, hearing, and transportation benefits).

Enrollment in plans offering supplemental dental, vision, and hearing coverage has increased since 2014

Dental, vision, and hearing benefits are among the most commonly offered supplemental benefits and have been allowed under CMS rules for many years. These benefits address health challenges that many seniors face as they age and for which there is limited coverage under traditional FFS Medicare (see text box for more information on supplemental benefits, pp. 81–83). As shown in Figure 2-4 (p. 80), these benefits continue to constitute a majority of conventional plans' reported projected spending on non-Medicare services each year: In 2025, conventional MA plans estimated that dental, vision, and hearing benefits would account for about 53 percent of plan spending on non-Medicare benefits, up from 35 percent in 2014 (2014 data not shown). For SNPs, growth in the projected spending on newer types of benefits has outpaced spending on dental, vision, and hearing services. Projected SNP spending on dental, vision, and hearing services—as a share of total non-Medicare benefit spending—fell from 43 percent to roughly 20 percent between 2014 and 2025, despite rising in nominal dollar terms from $12 to nearly $40 PMPM (2014 data not shown).

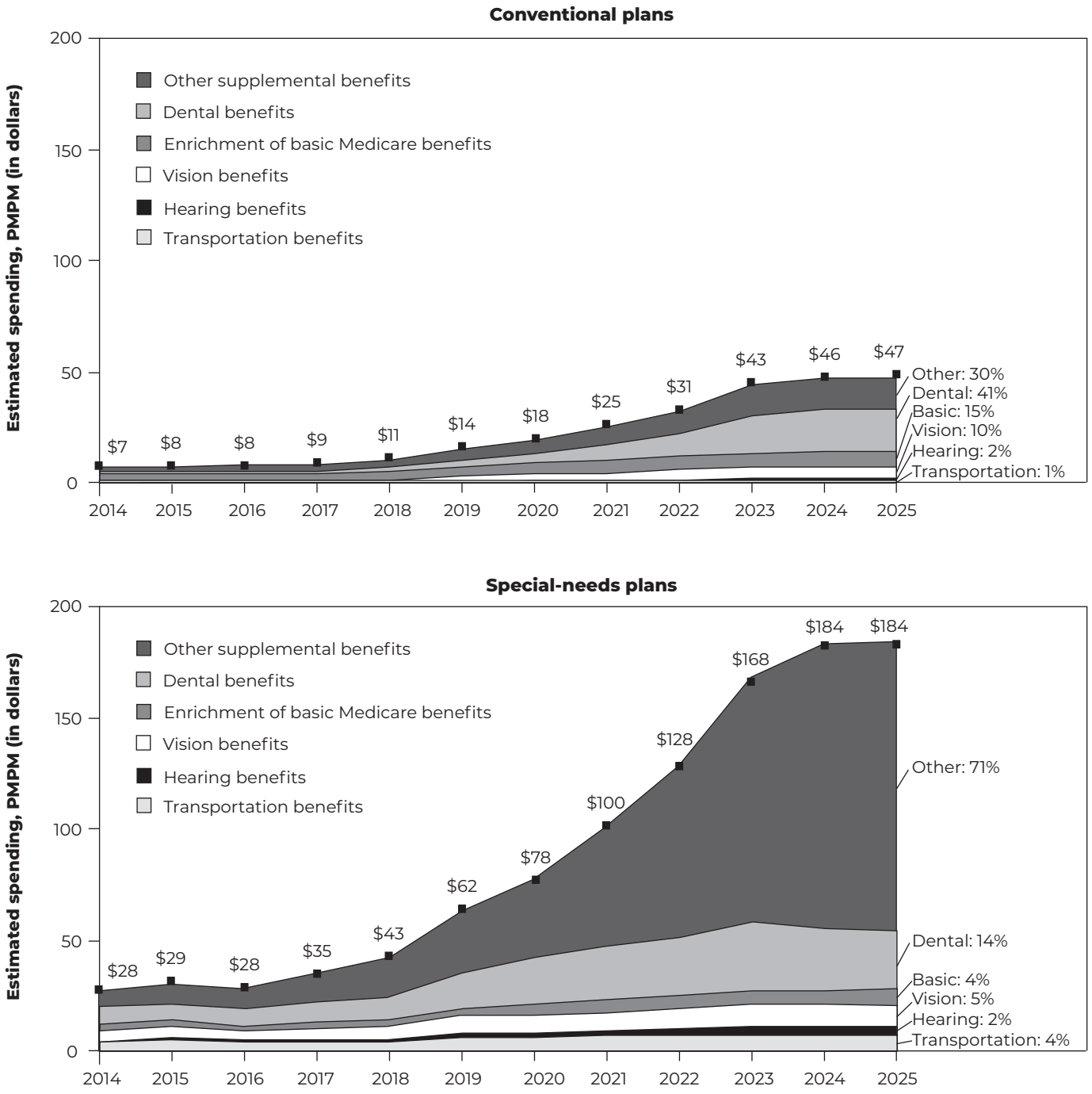
We analyzed plan benefit-package data for 2014 through 2025 to assess how the percentage of MA enrollees in plans offering supplemental dental, vision, and hearing services has changed over time. Enrollment in such plans could change because the number of plans offering the benefit changed, because enrollees selected plans that offered the coverage, or both. The share of MA enrollees in conventional plans that offer these benefits has increased significantly since 2014. In SNPs, the share of enrollees in such plans has long been higher than in conventional plans and has been more stable over time, but the services offered within each benefit have shifted gradually in the direction of covering more types of services.

Efforts to summarize and compare MA supplemental benefits are complicated by the fact that plans' coverage of the services can vary in many ways. For example, plans can choose which types of dental, vision, or hearing services they cover. In 2024, for instance, CMS required plans to provide information about whether and how they cover 11 distinct subcategories of dental services, 6 subcategories of hearing services, and 7 subcategories of vision services.[36] Plans decide whether they will cover none, some, or all of these services. The Medicare Plan Finder tool uses a checkmark to indicate which benefit category (e.g., dental, vision, and/or hearing) each plan covers, but plans receive a checkmark if they cover any (at least one) service in one of the relevant subcategories for the benefit. For example, a plan that covers only routine hearing exams would receive a checkmark for providing hearing benefits, as would a plan that covers hearing exams, fittings and evaluations for hearing aids, and the hearing aids themselves.

Even when MA plans cover a particular benefit, they may limit the number and type of services that

FIGURE 2–4

Plans project that a majority of rebate-financed spending on non-Medicare services is for dental and other types of benefits, 2014–2025



Note: PMPM (per member per month). "Conventional plans" excludes employer group plans and special-needs plans. "Special-needs plans" excludes employer group plans and non-special-needs plans. "Other supplemental benefits" includes benefits such as fitness benefits, over-the-counter items, and special supplemental benefits for the chronically ill. Figures represent plans' projected spending PMPM for each service category (these projections may not reflect actual plan spending), excluding amounts financed by Part C premiums paid by Medicare Advantage enrollees. Figures are based on the enrollment-weighted national average. Dollar amounts are nominal figures, not adjusted for inflation.

Source: MedPAC analysis of MA bid data.

Supplemental benefits may address health and social needs faced by many Medicare beneficiaries, but evidence on outcomes is lacking

Medicare Advantage (MA) supplemental benefits have the potential to address challenges that many Medicare beneficiaries face. For example, a significant percentage of Medicare beneficiaries report having dental, vision, or hearing difficulties. These challenges generally increase with age but are also common for beneficiaries under age 65, who are typically eligible for Medicare due to a disability. Supplemental benefits may also address health-related social needs that affect many Medicare beneficiaries, such as food insecurity or transportation difficulties. However, evidence regarding the extent to which supplemental benefits address enrollees' needs or affect their health outcomes is lacking. Focus groups and surveys of beneficiaries suggest that beneficiaries appreciate having access to supplemental benefits, but the findings from such studies do not shed light on whether the benefits meet beneficiaries' needs or provide good value relative to their cost.

Dental, vision, and hearing challenges faced by Medicare beneficiaries

A significant percentage of Medicare beneficiaries report having vision-, hearing-, or dental-related difficulties. Nearly all Medicare beneficiaries (over 94 percent) report having vision problems, and roughly 46 percent report using a hearing aid or having trouble hearing (Centers for Medicare & Medicaid Services 2022a). One analysis of the 2016 MCBS found that, among beneficiaries 65 and older, more than half of beneficiaries with vision problems also reported having some degree of hearing impairment (Assi et al. 2022). At the same time, according to the Medicare Current Beneficiary Survey (MCBS), about 15 percent of Medicare beneficiaries living in the community have trouble eating solid food because of dental problems (Centers for Medicare & Medicaid Services 2025a). Approximately 7 percent have chronic tooth pain, while nearly 17 percent have lost (or had removed) all of their natural teeth. For all three measures of oral health, beneficiaries under 65 are substantially more likely to report having difficulties than other beneficiaries: Nearly 30 percent of these enrollees report having difficulty eating solid foods due to trouble with their mouth or teeth, and roughly a quarter report having chronic tooth or jaw pain (Centers for Medicare & Medicaid Services 2021a, Centers for Medicare & Medicaid Services 2020a). Supplemental benefits are one way that MA plans and enrollees may seek to address enrollees' vision, hearing, and dental needs. However, to date, there is relatively limited evidence about the effects of supplemental benefits on the vision, hearing, and dental outcomes of MA enrollees.

Medicare beneficiaries also face health-related social needs

Health outcomes can be affected by nonmedical aspects of life such as access to adequate housing, transportation, or nutrition. People's health-related social needs (HRSN) are shaped by social determinants of health (SDOH), which are the conditions and environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes.

Evidence from the MCBS and other sources suggests that a significant percentage of Medicare beneficiaries face HRSN. Roughly 14 percent of Medicare beneficiaries living in the community

(continued next page)

enrollees can receive and the maximum amount the plan will spend on the benefit. Service-specific quantity limits are particularly common for routine, relatively low-cost services where plans typically do not require cost sharing. For more complicated dental, hearing, and vision services, plans typically use other mechanisms such as cost sharing, deductibles, or maximum coverage limits to control spending. In 2024, among conventional plans, spending limits were used by nearly 90 percent of plans with dental benefits, roughly 40

Supplemental benefits may address health and social needs faced by many Medicare beneficiaries, but evidence on outcomes is lacking (cont.)

report having trouble getting to places such as doctors' appointments. About 18 percent do not drive or have given up driving, and about 23 percent report asking others for rides (Centers for Medicare & Medicaid Services 2024a). Seventeen percent of beneficiaries are food insecure, meaning that in the last year there was a time in which their food did not last and they had no money to buy more (12.5 percent), they skipped or reduced the size of their meals to stretch their food supplies (6.3 percent), they ate less because they did not have enough money for food (6.1 percent), they did not eat because they did not have enough money for food (3.1 percent), or they could not afford a balanced meal (12.3 percent) (Centers for Medicare & Medicaid Services 2024a). For both transportation difficulties and food insecurity, beneficiaries under 65 reported significantly more challenges than the overall Medicare population.

Compared with fee-for-service (FFS) Medicare, MA plans and entities operating under alternative payment models such as accountable care organizations (ACOs) have more flexibility and incentives to address the HRSN of their patients or enrollees. Capitated payments under MA provide incentives for plans to consider patient health more holistically as a way of managing spending or improving quality scores, which can mean attending to enrollees' social needs. MA supplemental benefits—particularly the special supplemental benefits for the chronically ill, which plans have had the option to offer since 2020—are one route through which plans can attempt to address those needs. In interviews with researchers, officials from MA plans have reported an increasing interest in addressing members' HRSN, but perspectives have varied as to whether and how to do so (Thomas et al. 2019).

In a previous analytic cycle, MedPAC contracted with L & M Policy Research to conduct a literature review and interview stakeholders about steps that health care providers, payers, and other organizations have taken to address SDOH (L & M Policy Research 2023).[37] The literature review found that, although many organizations are working to address SDOH, there is a great deal of heterogeneity among interventions, and objective evaluations of the interventions are limited. The most common types of interventions addressed by the studies included in our literature review involved coordination of care (i.e., connecting at-risk patients with various social and medical services), food insecurity and nutrition, and housing needs. Most interventions in the literature were associated with improvements in some measures, but others showed mixed or inconclusive results. Altogether, there is strong evidence that SDOH and the HRSN that stem from them can create health challenges, but whether MA plans can design and implement interventions that meet those needs and whether such interventions are an efficient way to improve health outcomes or reduce overall spending remains a question.

Beneficiary perspectives on supplemental benefits

Because MA supplemental benefits are intended to address important challenges facing beneficiaries, we reviewed sources of information on enrollees' perspectives on the benefits. Evidence from the Commission's annual beneficiary focus groups and surveys conducted by other researchers generally suggests that beneficiaries appreciate having access to supplemental benefits, but their perspectives vary regarding the importance of the benefits (relative to other aspects of their coverage). In MedPAC's annual beneficiary focus groups, MA enrollees have tended to say that supplemental benefits are nice to have access to but were not the primary factor affecting their coverage decisions (NORC at the University of Chicago 2024, NORC at the University of Chicago 2023). For example, one beneficiary stated, "I just started getting [the supplemental benefit] last year. It was an added benefit, and it is a nice feature, but it wouldn't be the decision-maker for me." Another noted, "It

(continued next page)

Supplemental benefits may address health and social needs faced by many Medicare beneficiaries, but evidence on outcomes is lacking (cont.)

didn't factor into choosing the plan. . . . I don't take many over-the-counter [drugs] because of all the prescriptions I take. So we struggle to use even half of [the supplemental over-the-counter card value] every quarter." Among dually eligible MA enrollees, very few reported considering supplemental benefits when selecting a plan, instead prioritizing coverage of their prescription drugs and primary care providers. Some enrollees, however, weighed supplemental benefits more highly: One (non–dually eligible) MA enrollee said that "every year when the book or the email comes as to how the benefits are going to change, I just go right to there and say which one's better [for me]? . . . Whatever gives me the most [supplemental benefits]." Dually eligible enrollees who considered supplemental benefits when making enrollment decisions reported that they valued the card-based benefits that can be used to pay for over-the-counter (OTC) items, copays, and other items. For example, one enrollee reported that "now [the MA plan is] offering $157 in terms of food, the OTC benefit. That's [a] huge attraction." Some MA enrollees mentioned liking the dental, vision, and hearing benefits and that the inclusion of those benefits had led them to choose MA over FFS Medicare (NORC at the University of Chicago 2023).

The extent to which MA enrollees in our focus groups used their supplemental benefits varied. One beneficiary reported that they signed up for MA to specifically to "get all the benefits they could get" but had not used any dental, vision, hearing, or gym benefits since enrolling (NORC at the University of Chicago 2024). Of beneficiaries with access to a gym benefit, a subset of enrollees reported using the benefits; some rural participants noted that the gyms covered by the benefit were too far away (NORC at the University of Chicago 2023). Some participants also described using their transportation benefits: "[When I switched to] Medicare Advantage . . . they asked me, 'Do you want transportation?' I'm like, 'Sure, is it free?' and he said yes, so I'm like, OK, I can get a ride to the doctor and back" (NORC at the University of Chicago 2023). Participants living in urban areas reported using the transportation benefit to see their preferred provider, and some reported using the benefit to travel farther to be seen at larger academic medical centers. Rural beneficiaries had fewer experiences with supplemental transportation benefits, but a few had used the services, one with mixed satisfaction. These perspectives are generally in line with other studies that have asked beneficiaries about their views of supplemental benefits.

One study by the Commonwealth Fund asked Medicare beneficiaries how important, if at all, was access to extra benefits beyond doctor and hospital coverage (Commonwealth Fund 2025b). Across all Medicare beneficiaries, 83 percent considered supplemental benefits to be important; the share was higher among MA enrollees, with 89 percent of enrollees considering the benefits important (compared with 74 percent among FFS beneficiaries).[38] However, other surveys by the Commonwealth Fund have found that MA enrollees ranked supplemental benefits as less important than getting high-quality care, having access to providers, and having low out-of-pocket costs (Commonwealth Fund 2024). The survey also asked enrollees about their use of supplemental benefits. Across multiple types of benefits, use was higher among beneficiaries who considered the benefits to be important: Roughly 73 percent of MA enrollees who considered supplemental benefits important reported using any of the benefits, while 47 percent of those who did not think the benefits were important reported any use.

Altogether, findings from beneficiary focus groups and surveys suggest that MA enrollees appreciate having access to supplemental benefits, but that use of the benefits is varied. The variability highlights the need for better data regarding enrollees' use of supplemental benefits. Otherwise, it is impossible to know whether supplemental benefits are being used to meaningfully address enrollees' needs and whether the value they provide is commensurate with the high levels of program spending going toward them. ■

percent of plans with hearing benefits, and essentially all plans with vision benefits.[39] In addition to spending and quantity limits, plans can use networks to restrict coverage to providers (such as dentists or audiologists) with which the plan contracts; there are no network-adequacy requirements for supplemental benefits, and limited participation by providers could limit enrollees' ability to access the benefits.

Altogether, although we are able to broadly characterize the percentage of MA enrollees who are in plans that offer some level of coverage for dental, vision, hearing, and other benefits, the data mask considerable variation in the nature of the coverage being provided.

Most MA enrollees have some dental coverage, but plans' offerings may vary widely, and relatively little is known about enrollees' use of dental benefits

Our analysis of plan benefit data found that 90 percent or more of MA enrollees are in plans that offer some coverage of dental services, but plans have significant discretion regarding what dental services they cover, and available data do not enable us to know what specific services or procedures may be covered (plan benefits data indicate the subcategories of dental care for which plans offer any coverage but do not indicate which specific procedures or services within the subcategory are—or are not—covered). Plans also have discretion over the level of cost sharing required for dental services, the dentists included in the plan's network, whether prior authorization or referral is required for coverage, and the amount of financial protection provided. The coverage limitations that plans apply can have important implications for enrollees, but beneficiaries might not have sufficient information with which to evaluate the dental coverage offered by different plans.

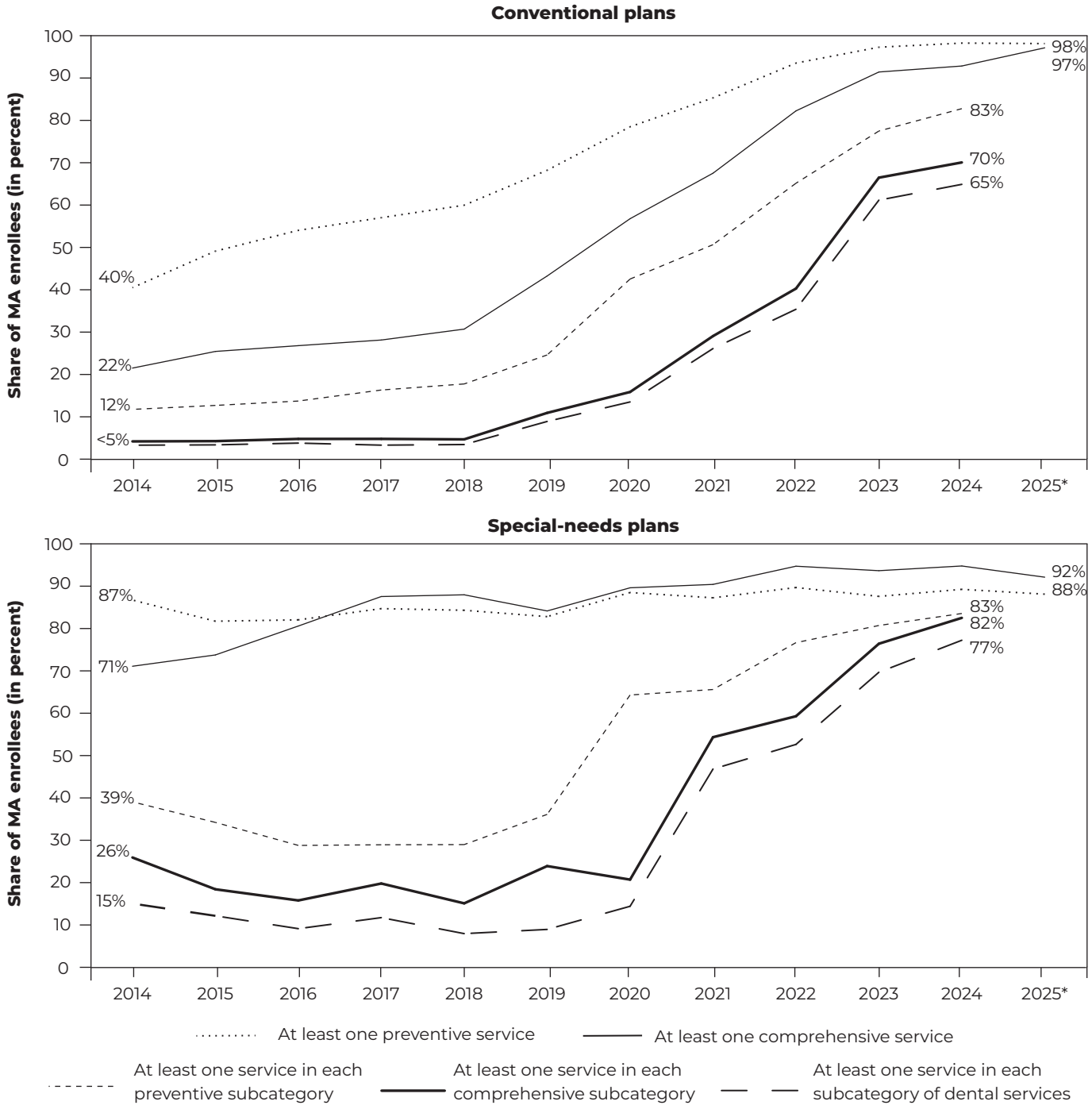
The system that CMS uses to collect encounter data was not configured to accept dental claims until 2024, so relatively little is known about how much enrollees use dental benefits. MA plans project significant spending on dental benefits, constituting a significant gap in our knowledge of how rebates and supplemental benefits are used. MedPAC's analysis of data from the MCBS found that between 2017 and 2022, more than half of non–dually eligible MA enrollees with dental coverage through their MA plan visited a dentist during the year. MA enrollees paid much of their dental expenses OOP, but—for non–dually eligible MA enrollees—the percentage decreased over time, from 61 percent in 2017 to 35 percent in 2022. In both 2017 and 2022, a small share of MA enrollees reported difficulty accessing dental care due to cost. Still, the large decline in OOP costs for non–dually eligible MA enrollees suggests that supplemental dental benefits may have provided increased financial assistance for MA enrollees over the period, but other factors may also have played a role. Further analysis is needed to assess how much the changes observed for MA enrollees are due to changes in supplemental benefits, to broader changes affecting the Medicare population as a whole, or to changes such as the composition of the MA population.

Enrollment in plans offering dental benefits

FFS Medicare generally does not cover dental services like routine cleanings, tooth extractions, or dentures. Some dental services, however, can be covered if they are directly related to a covered medical service or if they require an inpatient admission (Centers for Medicare & Medicaid Services 2021c). Beginning in 2023, FFS Medicare's coverage expanded to include additional clinical scenarios in which Medicare will pay for dental services (Freed et al. 2024). However, these expansions are modest and will impact a relatively small number of Medicare beneficiaries (Freed et al. 2024). MA plans offering supplemental dental benefits can provide a range of services not covered by FFS Medicare. Up until 2025, the dental services that MA plans cover as supplemental benefits were generally subdivided into two categories of services: preventive and comprehensive. Preventive services were subcategorized into oral exams, prophylaxis (cleaning), fluoride treatment, and dental X-rays. Comprehensive services were subcategorized into nonroutine services, diagnostic services, restorative services, endodontics, periodontics, extractions, prosthodontics, other oral/maxillofacial surgery, and other services. Beginning in 2025, CMS reorganized the subcategories of dental services and stopped distinguishing between preventive and comprehensive services. To show trends in dental benefit offerings for 2014 through 2025, we categorized as preventive dental services (for 2025) all of the dental service subcategories that have historically been categorized as preventive services (oral exams, cleanings, fluoride treatments, and X-rays) (Figure 2-5). We categorized all other subcategories of dental services for 2025 as comprehensive services.

FIGURE 2–5

MA enrollment in plans offering some degree of preventive and comprehensive dental coverage has increased, 2014–2025



Note: MA (Medicare Advantage). "Conventional plans" excludes employer group plans and special-needs plans. "Special-needs plans" excludes employer group plans and non-special-needs plans. Figure shows the share of MA enrollees in plans that cover at least one service in the given category; plan-specified coverage limits may apply. Beginning in 2025, CMS reorganized how plans report the dental services they cover and stopped distinguishing between preventive and comprehensive services. To show how dental benefits in 2025 compare to those offered in prior years, we categorized oral exams, cleanings, fluoride treatments, and X-rays (which CMS has historically categorized as preventive services) as preventive dental services for 2025; we categorized all other subcategories of dental services for 2025 as comprehensive services.
* We exclude subcategory detail for 2025 because CMS reorganized how dental services are reported beginning in 2025.

Source: MedPAC analysis of MA bid data.

Our analysis of plan benefit data found that the share of MA enrollees in plans offering some coverage of dental services has risen significantly since 2017. Other analyses of plan benefit data have found similar results (McCormack and Trish 2023). In 2025, more than 95 percent of MA enrollees in conventional plans are in plans that cover at least one preventive dental service or at least one comprehensive service (Figure 2-5, p. 85). Roughly 68 percent of conventional plan enrollees in 2025 are in plans that offer coverage of at least one service in all four subcategories of preventive services—down from over 80 percent in 2024. In 2024, roughly 70 percent of conventional plan enrollees were in plans that covered at least one service in each subcategory of comprehensive services. In 2025, at least 70 percent of conventional plan enrollees are in plans that cover at least one diagnostic, restorative, endodontic, or periodontic service—services that were categorized as comprehensive services prior to CMS's reorganization of how dental services are reported. However, CMS's new taxonomy includes several new dental service subcategories, with new detail about services like removable prosthodontics (dentures), dental implants, and orthodontics. Fewer conventional plan enrollees are in plans offering these subcategories of benefits (69 percent, 16 percent, and 8 percent, respectively). Given the change in reporting detail, subcategory detail for 2025 is excluded in Figure 2-5.

For enrollees in SNPs, the share of enrollees in plans covering at least one preventive service or one comprehensive service has long been higher than in conventional plans, and in 2025, nearly 90 percent of SNP enrollees are in plans that cover at least one preventive service, and more than 90 percent are in plans that cover at least one comprehensive service. Some SNP enrollees may have access to Medicaid-covered dental services, which could result in differences between the dental benefits offered in conventional MA plans and SNPs. The share of SNP enrollees in plans covering services in all subcategories of preventive or comprehensive dental services has risen sharply since 2018, such that in 2024, roughly three-quarters of SNP enrollees were in these plans. Similar to conventional plans, the change in reporting requirements makes it difficult to characterize how coverage of comprehensive dental services in SNPs changed between 2024 and 2025. However, in 2025, at least three-quarters of SNP enrollees are in plans that cover at least one diagnostic, restorative, endodontic, or periodontic service (which were categorized as comprehensive services prior to the reporting change). For the new, more detailed dental service subcategories, 83 percent of SNP enrollees are in plans that offer some coverage of dentures, 26 percent are in plans offering some coverage of dental implants, and 14 percent are in plans offering some coverage of orthodontics.

Supplemental dental benefits vary across plans

MA plans have significant discretion regarding what dental services they cover as part of their supplemental benefits and the nature of the coverage. This discretion allows plans to tailor their benefit packages to include services that are attractive to members but may also make it difficult for beneficiaries to understand how coverage varies across plans.

As described above, the services that MA plans cover as supplemental benefits were generally subdivided into two categories of services prior to 2025: preventive services (made up of four subcategories) and comprehensive services (made up of seven subcategories). (CMS stopped distinguishing between preventive and comprehensive services beginning in 2025; however, it remains useful to understand the distinction because studies from earlier years use it to characterize MA plans' dental benefits.) In the benefit data they report to CMS, plans indicate—for each subcategory of services—whether they cover at least one service in the subcategory. The data do not enable us to know whether the plans cover all services in the subcategory or just some. Plans also have discretion over other important features of the supplemental dental benefits they offer, including the level of cost sharing, which dentists to include in the plan's network, and whether prior authorization or referral is required for coverage. Further, plans can implement benefit limits that cap the amount of financial protection provided under the plan.

Because plans have discretion over the design of the supplemental dental benefit they offer, there is wide variation across plans in the form and generosity of the coverage. In a review of the dental benefits offered by MA plans in 2023, researchers found that, of MA plans that offered dental coverage as a mandatory supplemental benefit (i.e., those that included the

coverage in the base benefit package for all enrollees), only 8.4 percent offered coverage that met the researchers' definition of "comprehensive" dental coverage (not to be confused with comprehensive services discussed above) (Simon et al. 2025).[40] The study also showed that, although most seniors (66 percent) live in a county in which at least one MA plan offers a comprehensive dental benefit, only 4 percent of MA enrollees are enrolled in such plans.

The coverage limitations that MA plans apply can have important implications for beneficiaries. An analysis of 2019 MCBS data and plan benefit data found that (when controlling for individual- and county-level covariates) enrollees in HMOs were 7 percentage points more likely to report unmet dental needs and 4.4 percentage points more likely to report unmet dental need due to cost than enrollees in PPOs (Nasseh et al. 2025). Enrollees in plans requiring prior authorization for preventive services and those in plans covering only preventive dental services were more likely to report unmet dental needs (differences of 4.5 percentage points and 12 percentage points, respectively) than those in other plans offering dental benefits. Benefit limits were also found to be correlated with rates of unmet need: Enrollees in plans with no benefit limit reported rates of unmet dental need that were 12.4 percentage points lower than those in plans with an annual benefit limit of $500 or less. Higher benefit limits were associated with lower rates of unmet need due to cost and higher probabilities of having a dental visit. Enrollees in plans that required cost sharing for comprehensive services were less likely to visit a dentist within the year. Although this study was cross-sectional and cannot establish the causal effects of plan characteristics on dental utilization, it illustrates the variability of dental benefits across MA plans and is suggestive of the potential implications for enrollees. The coverage decisions also affect plans' financial liability for dental care: Previous work by GAO has shown that MA plans covering a larger number of dental services projected spending more on dental services (Government Accountability Office 2023).

The Medicare Plan Finder indicates which MA plans offer supplemental dental benefits with a checkmark. However, dental coverage configurations are far more complex than the Plan Finder would suggest. Plans receive a checkmark if they cover at least one dental service; a plan that covers only one annual cleaning would receive a checkmark for providing dental benefits, as would a plan that covers all dental services. This lack of specificity raises concerns about whether enrollees are given sufficient information with which to evaluate the dental coverage offered by different plans. Multiple sources suggest that MA enrollees have difficulty understanding the limits of the dental coverage provided by MA plans. In interviews with GAO, stakeholders have reported that "dental is the supplemental benefit on which [advocacy groups] receive the most complaints, often about plans' limits on what or how much is covered. The [stakeholder] said enrollees might complain because, although they were able to get a cleaning and X-rays, they also need dentures or implants" (Government Accountability Office 2023). The Commission has previously contemplated the merits of standardizing the supplemental dental, vision, and hearing benefits that plans can offer, but has not—as of 2025—made recommendations on the topic (Medicare Payment Advisory Commission 2023).

Survey data provide a limited view of how MA enrollees use and pay for dental services

Despite the growing enrollment in plans offering dental benefits in MA, relatively little is known about the extent to which enrollees use the benefits. MA encounter data should be the most detailed source of information about MA enrollees' use of services, but the EDPS that CMS uses to collect encounter data was not configured to accept dental claims until 2024. Thus, we do not have reliable encounter data with which to analyze how MA enrollees use and pay for dental services.[41]

In the absence of reliable encounter data, we used data from the MCBS to assess dental utilization and spending among MA enrollees. The survey data provide a limited, overarching view of dental use and spending. One limitation, for example, is that the survey data count dental visits regardless of whether they were covered by insurance (such as through an MA supplemental dental benefit) or paid for OOP. Some MA enrollees may have dental coverage through Medicaid or private insurance. To better understand the role of MA supplemental dental benefits, we analyzed the data for MA enrollees for whom MA was their only form of dental coverage. Specifically, we limited our analysis to

TABLE 2–3

Non–dually eligible Medicare beneficiaries' use of and spending for dental services: Findings from an analysis of MCBS data from 2017 and 2022

Outcome	MCBS year 2017	2022	Percentage change
Percentage of non–dually eligible beneficiaries with a dental visit during the year			
FFS beneficiaries with no dental coverage	51%	61%	20%
MA enrollees with dental coverage through their MA plan	56	57	2
Medicare beneficiaries with a private source of dental coverage	78	82	5
Total dental spending by non–dually eligible beneficiaries			
FFS beneficiaries with no dental coverage	$580	$861	48%
MA enrollees with dental coverage through their MA plan	521	892	71
Medicare beneficiaries with a private source of dental coverage	1,028	940	–8
Percentage of dental spending paid out of pocket by non–dually eligible beneficiaries			
FFS beneficiaries with no dental coverage	90%	96%	6%
MA enrollees with dental coverage through their MA plan	61	35	–43
Medicare beneficiaries with a private source of dental coverage	52	49	–6
Percentage of non–dually eligible beneficiaries who had trouble accessing dental care due to cost			
FFS beneficiaries with no dental coverage	6.8%	3.6%	–47%
MA enrollees with dental coverage through their MA plan	7.3	4.0	–45
Medicare beneficiaries with a private source of dental coverage	2	2	0

Note: MCBS (Medicare Current Beneficiary Survey), FFS (fee-for-service), MA (Medicare Advantage). Figures for beneficiaries with private dental coverage include data for FFS beneficiaries and MA enrollees with a private source of coverage, the majority of whom are in FFS Medicare. Calculations were made on unrounded data.

Source: MedPAC analysis of Medicare Current Beneficiary Survey data, 2017–2022.

community-dwelling Medicare beneficiaries who were enrolled in MA for 12 months of the year and reported having dental insurance through their MA plan. We limited our analysis to nonemployer coordinated-care plans (HMOs and PPOs) that provided dental benefits consistently across the plan's service area.[42] To provide additional context, we include results for Medicare beneficiaries (in MA or FFS) who reported having a privately purchased source of dental coverage and for FFS Medicare beneficiaries who reported having no source of dental coverage. We excluded results for beneficiaries who were dually eligible for Medicare and Medicaid because changes in states' Medicaid coverage of dental services during the period make it difficult to disentangle the potential effects of supplemental benefits from other factors.

We found that between 2017 and 2022, more than half (56 percent) of non–dually eligible MA enrollees who had dental coverage through their MA plan visited the dentist in any given year (Table 2-3). The share using dental services was relatively similar in the two years we analyzed. Average dental spending by the enrollees in our sample increased over the study period, rising from $521 in 2017 to $892 in 2022. The share of dental expenses paid OOP by non-dually eligible MA enrollees decreased over time, falling from 61 percent in 2017 to 35 percent in 2022. In both 2017 and 2022, a small share (less than 10 percent) of MA enrollees reported difficulty accessing dental care. For respondents who report that there was a time in the last year in which they did not receive needed dental care, the MCBS asks what the reasons

Studies assessing how Medicare beneficiaries use and pay for dental care

Numerous studies have used survey data to assess how Medicare Advantage (MA) enrollees use and pay for dental care. Our review of more than a dozen studies found that roughly 40 percent to 60 percent of MA enrollees use dental services in a year.[43] Surveys have generally found that MA enrollees pay for a significant share of their dental spending out of pocket. Despite methodological differences, the results were relatively consistent across the studies we examined. However, it is important to note that the share of MA enrollees in plans offering supplemental dental coverage increased rapidly between 2018 and 2023, the period encompassing many of the studies (McCormack and Trish 2023). As such, results from a prior period might not be reflective of recent trends.

Roughly half of MA enrollees visit a dentist in a year, with non–dually eligible enrollees more likely to receive care

Research drawing from four nationally representative surveys suggests that between 40 percent and 60 percent of MA enrollees visit the dentist in any given year, and that dually eligible enrollees are generally less likely (than non–dually eligible enrollees) to have had a visit in the last year. The most recent data on MA dental-service utilization comes from a 2023 survey conducted by the Commonwealth Fund, which found that 42 percent of MA enrollees reported using dental benefits in the past year (Commonwealth Fund 2025b). Other studies, using Medicare Current Beneficiary Survey (MCBS) data from earlier years, have found similar rates of use. For example, in an analysis of the 2021 MCBS, CMS found that 55 percent of non–dually eligible enrollees in MA plans offering dental coverage had at least one dental visit during the year, and one-third of dually eligible enrollees with dental coverage through MA had a visit (Centers for Medicare & Medicaid Services 2021d). An analysis of 2019 MCBS data found that between 40 percent and 50 percent of MA enrollees in plans offering supplemental dental coverage had a visit in the year. An analysis of 2016 MCBS data found that 55 percent of non–dually eligible MA enrollees who were in plans offering supplemental dental coverage (and 27 percent of dually eligible Medicare beneficiaries with dental coverage) saw a dentist in the year (Nasseh et al. 2025, Willink et al. 2020). Evidence from a study that used (pooled) Medical Expenditure Panel Survey (MEPS) data for 2010 through 2021 found similar use rates: In that study, 47 percent of MA enrollees received any dental care in the year (Simon and Cai 2024). Over the study period, the estimated percentage of MA enrollees with a dental visit rose from less than 45 percent in 2010 to slightly more than 50 percent in 2021.

Across most studies, utilization among low-income or dually eligible enrollees was generally lower than use among higher-income groups. In the Commonwealth Fund survey, the share of enrollees reporting use of dental benefits in the past year ranged from 40 percent to 50 percent for all income and racial or ethnic groups; among beneficiaries with incomes below $100,000, the share of beneficiaries using dental care was positively associated with higher incomes (Commonwealth Fund 2025b). In CMS's analysis of 2021 MCBS data, one-third of dually eligible MA enrollees in plans offering dental coverage saw a dentist in the year; another analysis of the 2019 MCBS (also conducted by CMS) found similarly low percentages among dual-eligible enrollees (Centers for Medicare & Medicaid Services 2021b, Centers for Medicare & Medicaid Services 2021d). One study, which used pooled data from the Health and Retirement Study for 2014 to 2020, estimated that among MA enrollees ages 65 to 70 who were likely to be eligible for Medicaid and who lived in Medicaid-expansion states, roughly 69 percent had a dental visit in the last two years (Elani et al. 2024). The higher percentage of enrollees using dental care in this study may be related to the longer (two-year) time frame.

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Studies assessing how Medicare beneficiaries use and pay for dental care (cont.)

All of the studies we reviewed found that most dental utilization is for preventive services. Analysis of the MCBS and MEPS suggests that roughly 20 percent to 30 percent of MA enrollees had a nonpreventive visit in the year (Centers for Medicare & Medicaid Services 2021d, Simon and Cai 2024). A study by the actuarial firm Milliman analyzed claims from 2021 through 2023 for 1.1 million MA enrollees enrolled in plans that provided supplemental dental coverage and found that approximately 70 percent of dental claims were for preventive services (Wix and Fontana 2024).

MA enrollees' out-of-pocket spending for dental services

Several studies using data from the MCBS and MEPS have found that MA enrollees pay for a sizable fraction of their dental care out of pocket (OOP). For example, a study that used both MEPS and MCBS data for 2017 through 2021 found that OOP costs for non–dually eligible MA enrollees accounted for about 60 percent of their total dental spending (Cai et al. 2025). A different study of (pooled) MEPS data for 2010 through 2021 found that OOP costs accounted for roughly 62 percent of MA enrollees' total dental costs (Simon and Cai 2024). An earlier study of the 2016 MCBS found that OOP costs accounted for approximately 76 percent of overall dental spending for MA enrollees with dental coverage (Willink et al. 2020).

These results are difficult to square with the cost-sharing structures that MA plans report using for their supplemental dental benefits. For example, a recent analysis of 2023 MA plan benefit files found that roughly 35 percent of plans required no cost sharing for preventive services (Nasseh et al. 2025). For more than 60 percent of plans, the maximum cost sharing for nonpreventive services averaged (across all nonpreventive services) less than 30 percent. Several factors may contribute to the disconnect between what appears to be low cost sharing among MA plans and the high OOP costs reported in survey data.

First, the survey data capture all dental visits regardless of whether the visit was covered by insurance. Many MA plans cover only certain dental services delivered through in-network providers; beneficiaries using noncovered services or who choose to visit an out-of-network dentist (or who have trouble finding an in-network dentist) might face higher cost sharing.[44] The Government Accountability Office has reported that MA enrollees frequently report difficulty understanding the limits of the dental coverage provided by MA plans (Government Accountability Office 2023). Second, many plans apply benefit limits that cap the plan's liability for dental benefits. Beneficiaries who reach the benefit limit could face high OOP costs, despite being enrolled in a plan that charges low cost sharing below the benefit limit. In 2023, more than three-quarters of MA plans used a limit of at least $1,500 (Nasseh et al. 2025). MedPAC's analysis of the MCBS found that the share of dental expenses paid OOP by non–dually eligible MA enrollees fell from 61 percent in 2017 to 35 percent in 2022 (see Table 2-3, p. 88). Given that MA plans have rapidly expanded their dental coverage in recent years (see Figure 2-5, p. 85), some of the higher OOP costs reported in the literature may be due to the use of data from earlier years.

A small share of MA enrollees report cost-related barriers to accessing dental care

Both the MCBS and the MEPS ask beneficiaries about their ability to access needed dental services and—for those experiencing access issues—the extent to which cost was a barrier to getting care. Results from multiple studies using various data sources show that most MA enrollees do not face cost-related difficulties accessing needed dental care.[45] Multiple analyses of MCBS have found that roughly 10 percent to 15 percent of MA enrollees had a time in which they could not get needed dental care (Centers for Medicare & Medicaid Services 2020a, Nasseh et al. 2025). Additional studies have found that, among enrollees experiencing difficulties accessing care, cost was a common barrier: Overall,

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Studies assessing how Medicare beneficiaries use and pay for dental care (cont.)

roughly 10 percent of MA enrollees reported that cost-related issues were a reason for not being able to get needed dental care (Gupta et al. 2024a, Hames et al. 2024, Nasseh et al. 2025). However, none of the studies we reviewed provided information about the dental needs of the enrollees who reported cost-related issues and the types of services they had difficulty accessing. Additionally, many of the studies use data from earlier years, in which dental benefits may not have been as expansive as they are today.

Dually eligible enrollees and individuals with low incomes are more likely to report cost-related access difficulties (Centers for Medicare & Medicaid Services 2020a, Gupta et al. 2024a). One study found that, among non–dually eligible MA enrollees who had no stand-alone dental coverage, roughly 11 percent reported unmet dental need due to cost. Enrollees with incomes below 200 percent of the poverty line, however, were 6 percentage points more likely to report cost-related barriers than other enrollees (Gupta et al. 2024a).

In addition to reporting access issues, some MA enrollees also report delaying dental care due to cost concerns. A study of MEPS data for 2018 through 2021 (pooled) found that 16 percent of MA enrollees delayed any dental care due to cost; results from earlier years analyzed in the same study suggest that beneficiaries are less likely to delay care they deem "necessary": From 2010 to 2017, roughly 5 percent of respondents reported delaying necessary dental care (Simon and Cai 2024). A different study that focused on non–dually eligible MA enrollees found that roughly 10 percent of those enrollees delayed dental care in the year, and 6 percent delayed care due to cost (Cai et al. 2025). Evidence suggests that dually eligible enrollees may be more likely to delay care due to cost: A study that used data from the 2019 the National Health Interview Survey found that nearly 28 percent of low-income MA enrollees (those with incomes below 200 percent of the federal poverty line) reported delaying dental care due to cost (Agarwal et al. 2022).

The limitations of studies comparing use of dental care in MA and fee-for-service Medicare make it difficult to assess the effects of MA supplemental dental benefits

Many of the studies analyzing how MA enrollees use and pay for dental care have compared the utilization and spending of MA enrollees with that of beneficiaries in fee-for-service (FFS) Medicare. Many of the comparisons do not account for important differences between the MA and FFS populations, such as demographic and socioeconomic differences. However, access to dental coverage and use of dental services vary widely by income level and dual-eligibility status and across racial and ethnic groups (Centers for Medicare & Medicaid Services 2021d, Centers for Medicare & Medicaid Services 2019a). Thus, it is important to keep these variations in mind when comparing patterns of dental use for MA and FFS beneficiaries. Compared with beneficiaries in FFS Medicare, a higher proportion of MA enrollees are Black or Hispanic or have relatively low incomes (Ochieng et al. 2024). Further, among MA enrollees, Black enrollees, enrollees with low incomes, and enrollees without a college degree have been shown to be more likely to enroll in plans offering supplemental dental benefits (Gupta et al. 2024b).[46] This nonrandom sorting of beneficiaries into different programs and different types of dental coverage makes it difficult to disentangle whether lower or higher utilization in MA or FFS is due to enrollees' dental coverage or to other factors.

Among the studies that do account for such differences, few account for the fact that, though many FFS Medicare beneficiaries do not have any form of dental insurance, some beneficiaries obtain coverage through employer-sponsored/retiree benefits or through privately purchased stand-alone dental plans. Beneficiaries who are dually eligible for Medicare and Medicaid may, in some states, have coverage through their state's Medicaid program. The comprehensiveness of coverage provided through each of these

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Studies assessing how Medicare beneficiaries use and pay for dental care (cont.)

sources varies, as does the extent to which MA and FFS enrollees have coverage through any of the sources. Medicare beneficiaries who obtain private dental coverage (most of whom are in FFS Medicare) likely pay premiums for that coverage. The cost of those premiums is generally not reflected in the measures of OOP costs assessed in the studies comparing dental care in MA and FFS. In contrast, many MA enrollees have access to some level of supplemental dental benefits with no additional associated premium. Plans can charge premiums for dental coverage, use the rebates they receive from Medicare in lieu of premiums, or use a mix of premiums and rebates to finance dental benefits. Plans use rebates to finance essentially all mandatory supplemental benefits (i.e., those that are automatically included in the plan's benefit package); MA enrollees purchasing optional supplemental dental benefits must pay a premium for that coverage. This dynamic complicates interpretation of studies that compare OOP dental costs for MA and FFS beneficiaries. Further, because most studies of dental-care utilization among Medicare beneficiaries use a cross-sectional study design, the studies can generally be used to characterize how beneficiaries in the two programs use dental care but cannot shed light on important questions such as whether supplemental dental coverage in MA improves access to dental care relative to the care that similarly situated individuals would have received had they enrolled in FFS (or vice versa).

Altogether, though numerous studies using data from four nationally representative surveys have assessed how MA enrollees use and pay for dental care, the studies provide limited insight into the effects of the dental benefits that MA plans provide as supplemental benefits. These limitations highlight the importance of having reliable encounter data for MA dental benefits. The encounter-data updates that CMS implemented for 2024 (discussed on p. 72) are an important step in this direction, but we do not expect those data to be available for analysis until 2026 or 2027. ■

were for not getting the care. In 2022, roughly 4 percent of non–dually eligible MA enrollees reported not receiving dental care because of cost, down from 7 percent in 2017.[47]

Our analysis of the data for 2017 and 2022 provides a snapshot of how MA enrollees used and paid for dental services in two years that bookend a period of rapid growth in MA supplemental benefits. The analysis is descriptive, and we did not attempt to quantify what fraction of the difference between 2017 and 2022 is attributable to changes in MA supplemental benefits. Other dynamics, such as changes in the composition of the MA population or broader trends in the overall Medicare population, could also play a role in how things changed over time.

To contextualize how the experience of MA enrollees compared with that of other Medicare beneficiaries, we looked at the data for Medicare beneficiaries (in MA or FFS Medicare) who had a private source of dental coverage, as well as for FFS beneficiaries who were not dually eligible and lacked dental coverage. The trends for these groups may provide some information about underlying changes in how Medicare beneficiaries were using dental coverage over this period. For most of the outcomes we assessed, the trend for FFS beneficiaries without a form of dental coverage followed a directional trend similar to that of MA enrollees: The share visiting a dentist increased, dental spending increased, and rates of cost-related access issues fell (Table 2-3, p. 88). FFS beneficiaries paid for a significantly larger share of their dental care OOP. Between 2017 and 2022, the OOP trend for FFS beneficiaries and MA enrollees trended in opposite directions. For FFS beneficiaries without coverage, the OOP share rose from 90 percent to 96 percent between 2017 and 2022. For MA enrollees, the OOP share declined (from 61 percent to 35 percent for non–dually eligible enrollees). The similar trends in dental

utilization for MA and FFS beneficiaries suggest that the differences between the 2017 and 2022 OOP point-in-time estimates cannot be attributed entirely to growth in MA supplemental benefits; the large decline in OOP costs for non–dually eligible MA enrollees suggests that supplemental dental benefits may have provided increased financial assistance over the period, but other underlying factors may also have played a role. Without further analysis, it is difficult to assess the extent to which the changes observed for MA enrollees are due to changes in MA supplemental benefits, due to broader changes affecting the Medicare population as a whole, or due to other changes such as the composition of the MA population.

Our results are consistent with a number of other studies that have used the MCBS and other surveys to assess how MA enrollees use and pay for dental care. See the text box about studies assessing how Medicare beneficiaries use and pay for dental care for more information about other studies.

Most MA enrollees are in plans offering some coverage of vision and hearing services; preliminary analysis suggests it may be feasible to use encounter data to assess use of the benefits, though limitations remain

Our analysis of plan benefit data shows that more than 90 percent of MA enrollees are in plans that offer some coverage of vision and hearing services. Research on MA enrollees' use of these services has been relatively limited, however, and prior studies have relied primarily on survey data. To the best of our knowledge, no studies have used encounter data to assess MA enrollees' use of vision and hearing services—likely because the reliability of the data has been unclear. To explore what the data contain and identify potential uses of the data, we analyzed encounter data for 2021 to assess whether plans are submitting records for the services. Although there are many limitations to how the data can be used and interpreted, we found that the vast majority of plans offering vision and hearing benefits reported encounter records pertaining to the services. For vision and hearing exams, eyewear, and hearing aids, the percentage of MA enrollees with corresponding encounter records appears to be in the range suggested by survey data. This is an encouraging sign that it may be feasible to use encounter data to explore MA enrollees' use of supplemental vision and hearing benefits.

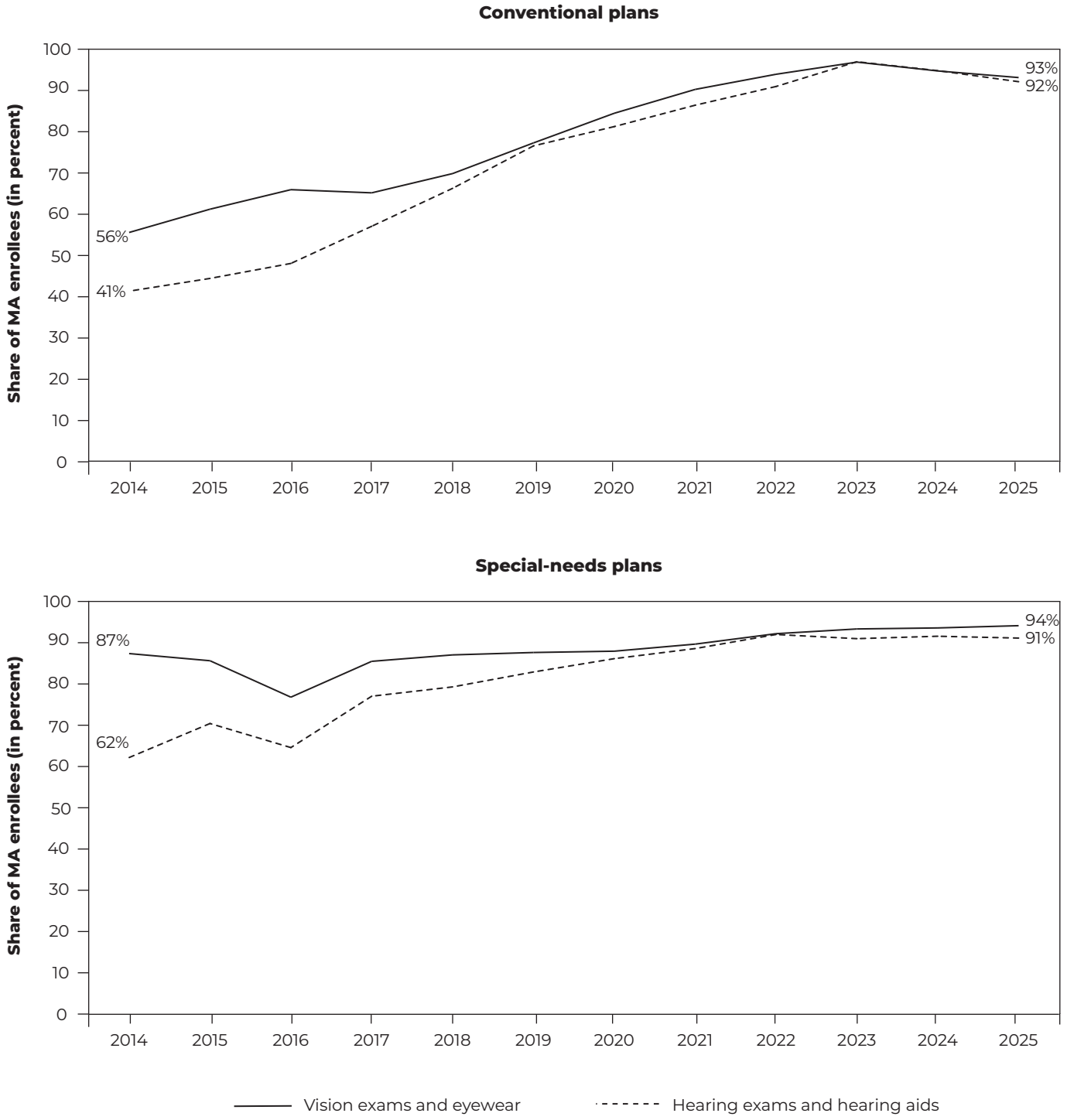
Enrollment in plans offering vision and hearing benefits

Traditional FFS Medicare generally does not cover routine eye exams, eyeglasses for day-to-day use, or contact lenses (Centers for Medicare & Medicaid Services 2021c). There are a few services, though, that Medicare will cover for certain populations, such as annual eye exams for diabetic retinopathy in people with diabetes and annual glaucoma screenings for people deemed at high risk for developing the disease (Centers for Medicare & Medicaid Services 2021c). MA plans offering supplemental vision benefits can cover eye exams and eyewear (including glasses and/or contacts) for their enrollees. Among enrollees in conventional MA plans, most enrollees—nearly 95 percent—are in plans offering coverage for eye exams and eyewear (Figure 2-6, p. 94). The share of enrollees in such plans rose significantly, from 56 percent to 93 percent, between 2014 and 2025. For SNPs, the share of enrollees in plans offering both eye exams and eyewear has historically been higher than in conventional plans, but rates for the two plan types were relatively comparable in 2025.

FFS Medicare also does not cover hearing aids or exams for hearing aid fittings. In limited circumstances, hearing and balance exams can be covered if they are related to or being used for diagnosis of a medical condition, and annual audiologist visits can be covered if related to diagnostic or nonacute hearing conditions (Centers for Medicare & Medicaid Services 2021c). MA plans can offer enhanced coverage of Medicare-covered hearing benefits, as well as routine hearing exams, fittings and evaluations for hearing aids, and/or hearing aids. Plans have discretion over which types of hearing aids they cover (e.g., inner ear, outer ear, or over the ear) and which providers are covered by the benefit. As with dental and vision benefits, the share of enrollees in plans offering these benefits has risen since 2014 (Figure 2-6, p. 94). The share of enrollees in conventional MA plans offering coverage for both hearing exams and hearing aids rose from roughly 41 percent to 92 percent between 2014 and 2025. For SNPs, the share of enrollees in plans offering exams and hearing aids has also risen—from 62 percent to 91 percent between 2014 and 2025. For SNPs, the share of enrollees in plans offering exams and hearing aids has also risen—from 62 percent to over 90 percent between 2014 and 2024.

FIGURE 2–6

MA enrollment in plans offering vision and hearing benefits has increased



Note: MA (Medicare Advantage). "Conventional plans" excludes employer group plans and special-needs plans. "Special-needs plans" excludes employer group plans and non-special-needs plans. Figure shows the share of MA enrollees in plans covering at least one service in the service category; plan-specified coverage limits may apply.

Source: MedPAC analysis of MA bid data.

MA enrollees' use of vision and hearing benefits

As with dental benefits, relatively little is known about the extent to which MA enrollees use the supplemental vision and hearing benefits offered by MA plans. Survey data provide some insights regarding the percentage of MA enrollees who use vision or hearing services in any given year—although the extent to which enrollees use their plan benefits to pay for their vision and hearing care is unclear. Surveys also find that use of hearing services is generally lower than use of vision services, as is to be expected based on the relative prevalence of vision and hearing needs among the Medicare population. In contrast to dental services, CMS's encounter data systems have always been configured to accept encounter records for vision and hearing services. Further, there are well-established procedure codes that MA plans should be able to use to report on their enrollees' use of these services. However, little is known about the extent to which MA plans are submitting encounter records for supplemental vision and hearing benefits and the reliability of the data. We analyzed encounter data for 2021 and found that MA plans are submitting records for vision and hearing services. Our findings suggest that, although the data have many limitations, it may be possible to use the encounter data to answer some questions about the use of vision and hearing services in MA.

Survey data provide a limited view of MA enrollees' use of vision and hearing services Evidence from multiple studies suggests that between 40 percent and 60 percent of MA enrollees use vision services in any given year. A survey by the Commonwealth Fund found that 41 percent of MA enrollees reported using vision benefits in the past 12 months (Commonwealth Fund 2025b). Use rates were considerably higher among the under-65 population: 80 percent of MA enrollees under age 65 reported using vision benefits (Commonwealth Fund 2025a). For the overall Medicare population, other studies have found higher utilization rates than those reported in the Commonwealth Fund survey—generally indicating that between 50 percent and 60 percent of MA enrollees used vision services in the year (Cai et al. 2025, Hames et al. 2024, Willink et al. 2020).

As with dental care, survey data suggest that MA enrollees pay for a significant portion of their vision care—between 60 and 70 percent—OOP (though one study found that the share paid OOP was lower (29 percent) for optometry visits than for glasses (72 percent)) (Cai et al. 2025, Willink et al. 2020). Estimates vary of how frequently MA enrollees experience cost-related difficulties accessing vision care. One study that used 2018 and 2019 MCBS data found that, overall, only 4 percent of MA enrollees experienced cost-related access issues (Gupta et al. 2024a). However, that study and others have found that enrollees with lower incomes and enrollees under age 65 have more issues accessing vision care. One study found that, among enrollees age 65 and older with incomes below 200 percent of the federal poverty line, two-thirds reported delaying an eye examination due to cost (Agarwal et al. 2022). The Commonwealth Fund survey found that a quarter (26 percent) of MA enrollees under age 65 reported experiencing cost-related barriers to vision care (Commonwealth Fund 2025a).

For hearing services, research suggests that, compared with dental and vision services, the share of MA enrollees using services is relatively low. This finding is likely due—at least in part—to differences in beneficiaries' need for the services and their propensity to seek hearing care. Overall, roughly 8 percent of MA enrollees report using hearing services in a year (Commonwealth Fund 2025b, Willink et al. 2020). MA enrollees under age 65 were more likely to use hearing care; the Commonwealth Fund survey found that roughly one-third of MA enrollees under 65 used hearing care in the last year (Commonwealth Fund 2025a). Among MA enrollees under 65 who did not receive hearing services in the year, 8 percent cited cost as the primary reason for not getting care (Commonwealth Fund 2025a). An analysis of the 2018 MCBS by KFF found that MA enrollees who used hearing care paid (on average) $763 OOP for the services—roughly $220 less than beneficiaries in FFS Medicare (not controlling for differences between the two populations) (Freed et al. 2021).

Using encounter data to assess MA enrollees' use of supplemental vision and hearing benefits To the best of our knowledge, no studies have used encounter data to assess MA enrollees' use of vision and hearing services—likely because the reliability of the data has been unclear. To explore what the data contain and to identify potential uses of the data, we analyzed encounter data for 2021 to assess whether plans are submitting records for the services and whether the

Using encounter data to assess use of Medicare Advantage supplemental benefits

Federal regulations require Medicare Advantage (MA) plans to submit encounter records for all items and services provided to their enrollees, including items and services provided as supplemental benefits (42 CFR Sec. 422.310(b)). However, in assessing the encounter data for basic Medicare services (including inpatient, home health, and skilled nursing facility services), the Commission has previously found that the encounter data that plans have submitted to date are incomplete and cannot be used for many analyses (Medicare Payment Advisory Commission 2024a). (The Commission is actively exploring whether there are targeted analyses for which the data can be used.) The Commission has not previously assessed encounter data for MA supplemental benefits.

Limitations of relying on encounter data to assess use of supplemental benefits

There are several reasons to expect that the encounter data that plans submit for supplemental benefits do not provide complete information about enrollees' use of the benefits.

- **Limitations of the MA encounter data system.** Until 2024, the Encounter Data Processing System (EDPS) that CMS uses to collect encounter records from MA plans was not configured to accept dental claims (Centers for Medicare & Medicaid Services 2024h). As a result, the encounter data cannot be used to assess utilization of supplemental dental benefits and we exclude dental benefits from our analysis.

- **Confusion about reporting requirements.** The Government Accountability Office (GAO) has reported confusion among MA organizations (MAOs) about the reporting requirements for MA supplemental-benefit encounter data (Government Accountability Office 2023). Although federal regulations have long required MA plans to submit encounter records for all items and services provided to their enrollees (including items and services provided as supplemental benefits), CMS's Encounter Data Submission and Processing Guide has previously limited the requirement to submit encounter records for supplemental services to those for which the plan had sufficient data to populate an encounter record (Centers for Medicare & Medicaid Services 2025b). In interviews with officials from MAOs, GAO found that MAOs' understanding of the reporting requirements varied: Officials for several organizations stated that encounter record submission was required for only some supplemental benefits, officials from one other organization stated that they were not required to submit records for any supplemental benefits, and officials from another organization stated that encounter records were required for all services. The plan representatives reported submitting encounter records in accordance with their understanding of the requirements.

- **Challenges with procedure codes.** The system that CMS uses to collect encounter data from MA plans requires that each record have a procedure code—either a Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT) code (Government Accountability Office 2023). Because some MA supplemental benefits are nonmedical (e.g., rent and utility subsidies), there are not procedure codes corresponding to all the benefits that plans might offer. In such cases, prior to 2024, it was not possible for plans to submit an encounter record for such services. In interviews with GAO, officials from MAOs described examples of such situations: Officials from one organization described "us[ing] 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" (Government Accountability Office 2023). In other instances, procedure codes might exist for the service, but

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Using encounter data to assess use of Medicare Advantage supplemental benefits (cont.)

plans might refrain from using the codes due to confusion about whether the code appropriately aligned with the benefit the plan provided (Government Accountability Office 2023). Plan officials described this challenge to GAO, stating that "there is a procedure code for an annual gym membership, but [the plan] did not know how to use that procedure code to report utilization" (Government Accountability Office 2023).

- **Insufficient data collected from supplemental-benefit vendors.** MAOs often contract with third-party vendors or community-based organizations to provide supplemental benefits to their enrollees (for details, see the section "Supplemental benefits: Vendors, community-based organizations, and vertically integrated entities," p. 110). In such arrangements, MAOs report that the data they receive from vendors are limited and sometimes do not have sufficient detail with which to submit an encounter record for the services provided (Government Accountability Office 2023).

CMS made changes to address several of these challenges starting in 2024 (see p. 72 for an overview of those changes).

MedPAC's assessment of MA encounter data for supplemental benefits

We analyzed MA encounter data for 2021 to assess whether MAOs are submitting encounter records for supplemental benefits. Because there are not standardized code sets that pertain to MA supplemental benefits, we worked with our staff physician to develop lists of HCPCS and CPT codes that may pertain to MA supplemental benefits. We relied on descriptions of the benefits provided by CMS to develop our code lists, which are available in the appendix to this chapter (p. 118) (Centers for Medicare & Medicaid Services 2019b, Centers for Medicare & Medicaid Services 2018c, Centers for Medicare & Medicaid Services 2016). We then assessed the number of beneficiaries for whom an encounter record was submitted using one of the codes in our code list. We excluded chart reviews from our analysis to avoid double counting services that were reported in both an encounter record and a chart-review record. In addition, for our analysis of vision and hearing benefits, we limited our analysis to nonemployer HMO and PPO plans with at least 1,000 enrollees to ensure that the plans we assessed were large enough to have a reasonable likelihood of including enrollees that used the benefits of interest.

Limitations of our analysis

There are significant limitations to what can be assessed using encounter data for 2021 (some of which will be addressed by CMS's recent encounter data changes).

- **Identifying procedure codes and the corresponding benefit:** Because there are no instructions or standards regarding which HCPCS or CPT codes refer to which supplemental benefit, it is difficult to know (in some instances) to which supplemental benefit an encounter record might relate. For example, a record with a code of S5170 (home-delivered prepared meal) could relate to either a supplemental benefit that provides meals on a temporary basis (e.g., following an inpatient admission) or the special supplemental benefit for the chronically ill that provides meals beyond a limited basis.

- **Distinguishing between mandatory and optional supplemental benefits:** MA plans can offer supplemental benefits on a mandatory or optional basis. Mandatory supplemental benefits are automatically included as part of the benefit package for all enrollees in a plan, and plans can use rebates to finance the benefits. Optional benefits are not automatically included in a plan's benefit package; instead, enrollees have the option of paying an additional premium to access the benefits. Plans cannot use rebates to finance optional supplemental benefits. A study

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Using encounter data to assess use of Medicare Advantage supplemental benefits (cont.)

by Milliman found dental benefits to be the most commonly offered optional supplemental benefit, followed by vision and hearing benefits (Friedman and Yeh 2021).[48] No Medicare enrollment data provide information about which MA enrollees purchase optional supplemental benefits; thus, for plans that offer optional supplemental benefits, we were unable to differentiate between encounter records related to mandatory or optional benefits. Some MA plans offer dental, vision, and/or hearing services on both a mandatory and optional basis. In such instances, it is typical for a plan to include a basic version of the benefit as a mandatory supplemental benefit and offer an optional benefit (sometimes referred to as a "rider") that enrollees seeking additional coverage can purchase for an additional premium.

- **Inability to assess data completeness:** Another limitation is the absence of another, independent data source with which to compare the encounter records we identified. Given the barriers to encounter data submission (described previously), it is reasonable to conclude that the encounter data we assessed cannot provide a complete picture of MA enrollees' use of supplemental benefits. As such, we did not attempt to measure utilization rates or draw conclusions about access or value based on our findings. Instead, our focus was on assessing whether plans are submitting records and characterizing the potential uses or limitations of the data.

- **Inability to assess which records are for covered services:** In some cases, it is difficult to distinguish between encounter records for basic and supplemental Medicare benefits. For example, dental services are generally not covered by Medicare but may be covered in some circumstances. Similarly, Medicare does not generally cover eyeglasses but does cover them after cataract surgery. The encounter data we used in our analysis do not include a mechanism for distinguishing between basic and supplemental services in such instances. However, this issue likely affects a relatively small number of records

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submission rates suggest problems with the reliability of the data. The text box "Using encounter data to assess use of Medicare Advantage supplemental benefits" discusses our analytic approach as well as the barriers and limitations to using the data. This analysis is a preliminary and exploratory first step toward using encounter data to assess the use of supplemental benefits. As such, we did not attempt—at this stage—to measure utilization rates or draw conclusions about access or value based on our findings. Instead, our focus here is on assessing whether plans are submitting records and characterizing the potential uses or limitations of the data.

MA encounter data for supplemental vision and hearing benefits

We first looked to see if MA plans that offered vision or hearing coverage as mandatory supplemental benefits submitted any records for those services, to check that plans were generally able to submit records for these services. We found that the vast majority of plans offering the benefits reported at least one record that contained a vision- or hearing-related Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code. Nearly all plans (more than 95 percent) that covered vision

Using encounter data to assess use of Medicare Advantage supplemental benefits (cont.)

given the relatively narrow scope of vision and hearing coverage in FFS Medicare in 2021.

In other cases, the encounter records we identify might include some noncovered services for which the plan did not make payment. MA plans are required to submit encounter records for all items and services delivered to MA enrollees, regardless of whether the plan made payment to the provider for the services. Accordingly, the encounter data may include records for claims that were not covered (i.e., were denied). For example, enrollees who received a noncovered hearing or vision service or who visited a provider outside of the plan's network might have an encounter record for the visit but might have paid for the services OOP. However, plans can generate encounter records only if they receive any claim information from the provider or enrollee. If an enrollee purchases glasses or hearing aids (both of which are available over the counter) and does not attempt to use their insurance, the purchase will not be reflected in the encounter data. Thus, encounter data are not a reliable way to identify all of the enrollees who wear glasses or use hearing aids. Further, some items (such as hearing aids) might not be purchased every year. Because we looked at only one year of data, our analysis captures only records for enrollees who received the item or service in the year of analysis and will not reflect the fact that some enrollees may have used the benefits in a previous year.

Given the significant barriers to reliably measuring utilization rates using encounter data, we focused first on assessing whether plans are submitting encounter records for supplemental benefits, the percentage of enrollees who had records for supplemental benefits submitted, and whether the submission of encounter records aligns with the benefits offered by the plan. ■

exams, eyewear, or hearing exams as a mandatory supplemental benefit submitted at least one encounter record corresponding to the relevant benefit; 85 percent of plans that offered coverage of hearing aids submitted at least one corresponding record. These high rates suggest that plans are generally able to submit encounter records for vision and hearing services and that they use the procedure codes we identified for each type of service.

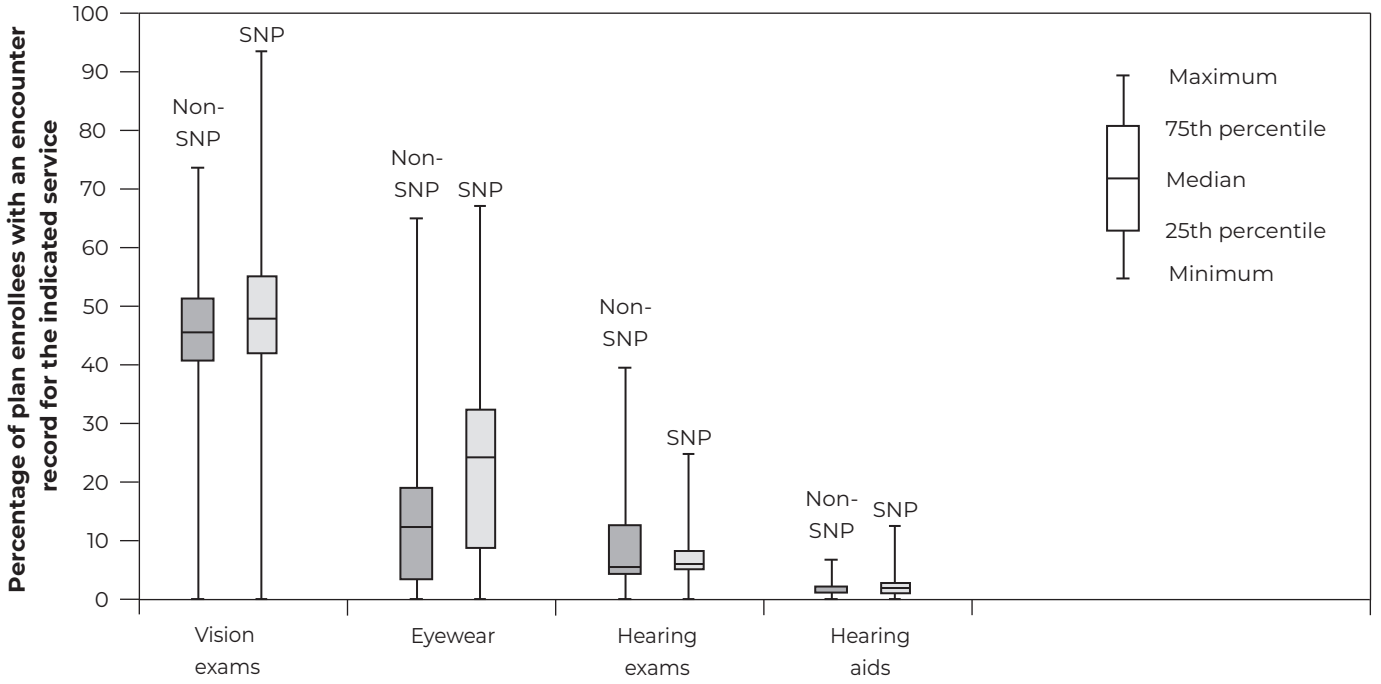
We next assessed—for each type of vision and hearing benefit—the percentage of enrollees for which plans submitted an encounter record corresponding to the covered benefit. We refer to this percentage as the "submission rate."

The submission rates for vision and hearing services varied widely across plans, with some plans submitting no records and some submitting records for a large number of the plan's enrollees (Figure 2-7, p. 100). Figure 2-7 illustrates the range of submission rates; the figure is enrollment weighted so as to better reflect the submission rates of the plans that MA enrollees are in. (Enrollment weighting means that the boxes of the box-and-whisker plot represent the submission rates of plans enrolling 50 percent of MA enrollees. The horizontal line within each box—representing the median of the distribution—divides the distribution in half: Half of MA enrollees are in plans with submission rates below the level indicated by the line, and half are in plans with submission rates above that level.)

The submission rate for plans offering vision exams as a mandatory supplemental benefit ranged from 0 percent to 75 percent among conventional plans and

FIGURE 2–7

The share of MA enrollees with a vision or hearing encounter record varied widely across plans, 2021



Note: MA (Medicare Advantage), SNP (special-needs plan). Figure includes only nonemployer coordinated-care plans with at least 1,000 enrollees. Distributions are enrollment weighted such that the median value represents the central enrollee rather than the central plan.

Source: MedPAC analysis of MA plan benefits data and MA encounter data for 2021.

from 0 percent to 96 percent among SNPs. Roughly half of MA enrollees in both conventional plans and SNPs were in plans with submission rates between 40 percent and 60 percent; this range aligns with the findings from surveys (described above) which have generally found that somewhere between 40 percent and 60 percent of MA enrollees use vision services within the year.

The submission rates for eyewear-related encounter records were generally lower than the rates for vision exams, as is to be expected (not all enrollees who get an exam will need glasses, and not all enrollees who get glasses will replace them in every year). In conventional plans, the median submission rate was 14 percent of enrollees, and for SNPs the median submission rate was 23 percent. These rates mean that half of MA enrollees in plans offering eyewear benefits were in plans that submitted records for less than a quarter (and for conventional plans, less than a fifth) of their enrollees. Because analyses of survey data have tended not to report on the percentage of people purchasing new glasses in a year, it is difficult to determine whether these submission rates are suggestive of incomplete data or in line with expected rates.

As we would expect based on survey data, rates of submitting encounter data for hearing services were generally lower than for vision services. For hearing exams, the median submission rates were 5 percent and 6 percent for conventional plans and SNPs, respectively; for hearing aids, the median submission rates were 1 percent and 2 percent, respectively. These rates appear to be in the range of the rates found in survey data (though slightly lower; survey data suggest that about 8 percent of MA enrollees use hearing services in a year). As with eyewear, enrollees might not replace their hearing aids each year, and survey data

do not shed light on the question, so it is difficult to conclude whether the submission rates we observed are suggestive of incomplete data. At this stage, we can conclude only that a large number of MA plans have submitted encounter records that likely pertain to supplemental vision and hearing benefits. This finding is an encouraging sign that it may be feasible to use encounter data to explore MA enrollees' use of supplemental vision and hearing benefits.

MA plans increasingly offer other types of supplemental benefits, but encounter data are currently inadequate for assessing utilization

In addition to dental, vision, and hearing services, MA plans are increasingly offering an array of other non-Medicare services such as transportation assistance, fitness benefits, meal-delivery services, OTC items, social support services, and subsidies for rent and utilities. The proliferation of these types of benefits has, to some extent, been facilitated by legislative and regulatory changes implemented over the last decade. The growth in MA rebates has likely been an accelerant, providing plans with additional funds to use on supplemental benefits. Despite their increasing prevalence, little is known about MA enrollees' use of these newer types of benefits. Our analysis of encounter data for 2021, presented below, suggests that the data are inadequate for assessing utilization, making it difficult to determine whether the benefits provide good value to Medicare and the taxpayers who fund the program.

MA plans have long been allowed to offer, as supplemental benefits, non-Medicare services other than dental, vision, and hearing benefits. For many years, the additional benefits were required to be "primarily health related," meaning that their main purpose had to be "to prevent, cure, or diminish an illness or injury" (Centers for Medicare & Medicaid Services 2016). This definition included dental, vision, and hearing services, but also included enhanced or expanded coverage of Medicare-covered services (e.g., additional days of inpatient care), health-related transportation services, fitness benefits, acupuncture, enhanced disease-management services, bathroom safety devices, posthospitalization meals, OTC items, and other benefits (see Appendix 2-A for additional examples). Beginning in plan-year 2019, CMS broadened its definition of "primarily health related" to permit additional services that address physical impairments, lessen the functional or psychological impact of injuries, or reduce avoidable health care utilization (Centers for Medicare & Medicaid Services 2018c). Under this new definition, plans can provide services such as adult day-care services, home-based palliative care, in-home support services, or support for caregivers of enrollees (see Appendix 2-A for additional examples). Further, starting in 2020, the Bipartisan Budget Act of 2018 gave plans the flexibility to provide chronically ill enrollees with supplemental benefits that "have a reasonable expectation of improving or maintaining the health or overall function" and do not have to be primarily health related. These benefits are known as special supplemental benefits for the chronically ill (SSBCI). Plans can use this authority to cover services such as meals, food and produce, nonmedical transportation, and pest-control services (Centers for Medicare & Medicaid Services 2019b) (see Appendix 2-A for descriptions of the services plans can offer as SSBCI).

MA plans have an incentive to experiment with offering the new categories of supplemental benefits, and the benefits play an important role in the MA marketplace. Studies have found that enrollees consider supplemental benefits when picking an MA plan and gravitate toward plans offering the benefits (Freed et al. 2023, Gupta et al. 2024b, Zhao et al. 2021). For example, one recent study examined differences between plans that gained or lost enrollment during the 2022 open enrollment period (Cates et al. 2022). Among conventional MA plans, those gaining enrollment offered certain supplemental benefits—dental coverage, eyeglasses or contacts, hearing aids, and an allowance for OTC items—more often than other plans, and their coverage of those benefits tended to be more generous than the coverage for plans that lost enrollment (plans gaining enrollment also tended to have lower premiums and lower copayments for primary care visits). Other studies have demonstrated that supplemental benefits may play a role in attracting different groups of enrollees, shifting the enrollment mix of MA plans, though the direction and strength of such effects likely depends on the supplemental benefit being assessed (Cooper and Trivedi 2012, Tucher et al. 2024a). One study found that adoption of newer forms of supplemental benefits was associated with improved ratings on the MA Consumer Assessment of Healthcare Providers and Systems (MA–CAHPS); plans

have a strong incentive to keep their members satisfied and to increase their MA–CAHPS rating because it is one of the measures used to calculate the star ratings that factor into the formula used to determine plan payments (Tucher et al. 2024b). Additionally, some have speculated that supplemental benefits may be a mechanism through which MA plans can address social determinants of health, thereby improving beneficiaries' access to care and lowering health care costs. Given the data limitations discussed throughout this chapter, such claims are hard to evaluate at this time (Government Accountability Office 2023).

Enrollment in plans offering primarily health-related supplemental benefits has increased unevenly since 2018

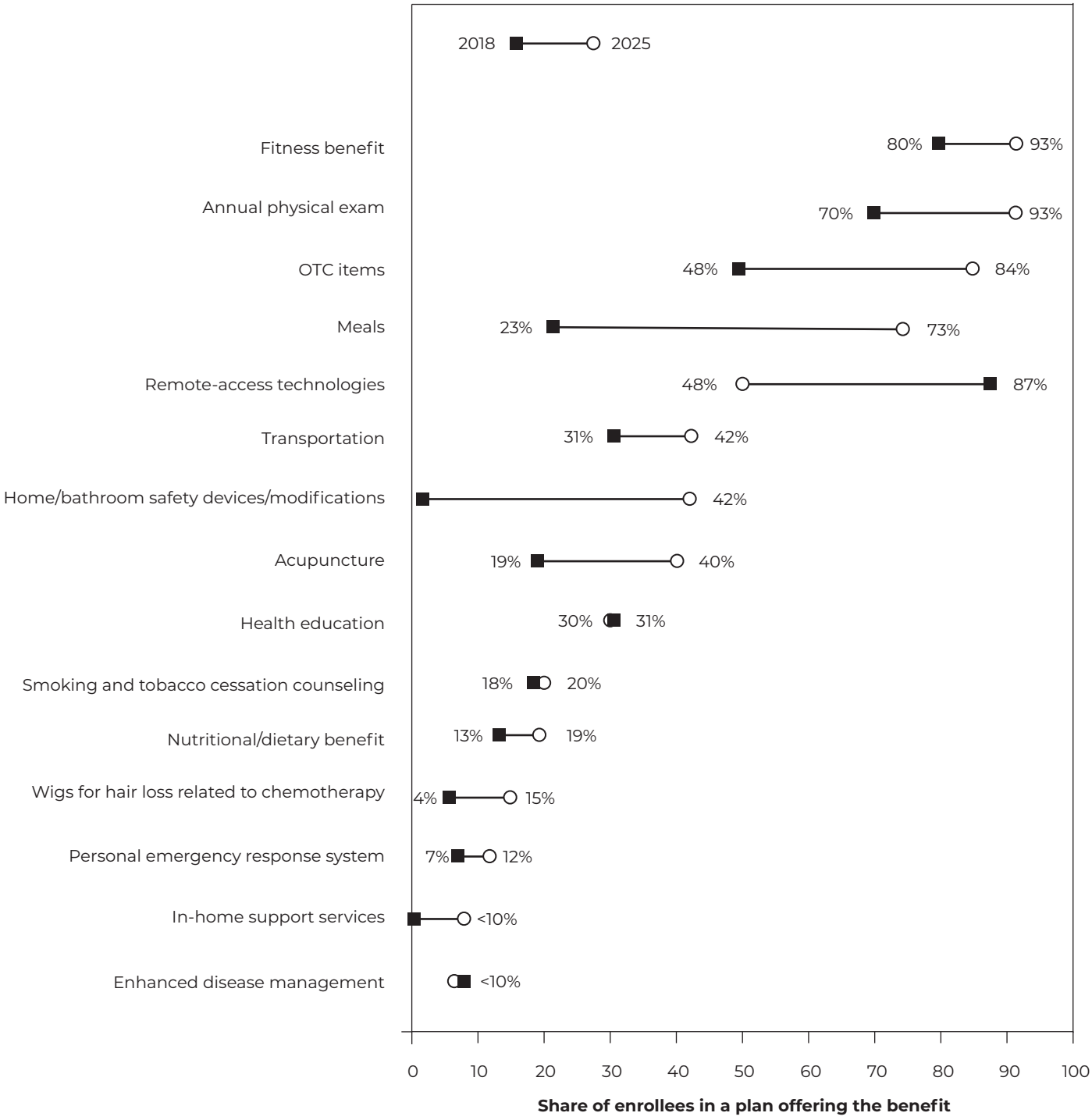
Although MA plans have the flexibility to cover a wide range of non-Medicare services as supplemental benefits, they have typically favored some benefits over others. Figure 2-8 shows how the share of enrollees in plans offering various primarily health-related (i.e., non-SSBCI) benefits has changed since 2018. The figure shows the 15 most commonly available benefits in 2025 (ranked by the percentage of enrollees in plans offering the benefit and excluding dental, vision, hearing, and SSBCI benefits). (Many MA plans offer other primarily health-related benefits, but a relatively small share of total MA enrollment was in such plans in 2025.) In 2025, the four most common benefits (other than dental, vision, and hearing benefits) were fitness benefits (e.g., gym memberships), annual physical exams, OTC drugs and items, and meals. More than half of MA enrollees are in plans that offered each of these benefits in 2025. SNPs are particularly likely to offer the benefits, and more than 90 percent of SNP enrollees were in plans offering a fitness, OTC, and/or transportation benefit in 2025 (data not shown). The percentage of MA enrollees in plans offering OTC items and/or meals has expanded significantly since 2018: The share of MA enrollees in plans that offer OTC benefits rose from 48 percent to 84 percent over the 2018 to 2025 period, and the share enrolled in a plan offering meals rose from 23 percent to 73 percent. Some benefits are offered less frequently, however. For example, less than half of MA enrollees are in plans offering acupuncture, health education, additional sessions of smoking cessation counseling (beyond those covered under Medicare), or nutritional or dietary counseling benefits. For a small number of benefits, the share of enrollees in a plan offering the benefit has decreased since 2018. The most notable change has been for remote-access technology benefits, a decrease that may be associated with the expanded coverage of telehealth in FFS Medicare.

The share of MA enrollees in plans offering non-primarily health-related supplemental benefits has grown since 2020

Beginning in 2020, as required by the Bipartisan Budget Act of 2018, MA plans were given the ability to offer non–primarily health-related items or services to chronically ill enrollees, so long as there is a "reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee" (Centers for Medicare & Medicaid Services 2019b). These benefits are required to be targeted to MA enrollees who (1) have one or more comorbid and medically complex chronic conditions that are life threatening or significantly limit the overall health or function of the enrollee; (2) have a high risk of hospitalization or other adverse health outcome; and (3) require intensive care coordination. MA plans determine which of their enrollees meet this definition, and CMS requires that the plans document how they make such determinations. CMS provides examples of benefits that meet the SSBCI "reasonable expectation" requirement, but plans can also propose other benefits (see Appendix 2-A for examples). Due to concerns about whether the benefits offered as SSBCI are meeting the requirement, starting in 2025, CMS began requiring MA organizations to develop and maintain "bibliographies of relevant research studies or other data" to demonstrate that benefits offered as SSBCI meet the "reasonable expectation" criteria (Centers for Medicare & Medicaid Services 2024g). MA plans participating in the MA-VBID model demonstration are also permitted to offer non–primarily health related benefits but have additional flexibility to target the benefits to enrollees on the basis of socioeconomic status (Centers for Medicare & Medicaid Services 2020b). Beginning in 2025, plans participating in the demonstration are required to offer at least two supplemental benefits intended to address enrollees' health-related social needs (the benefits can be primarily health related or non–primarily health related but must relate to food and nutrition, transportation, or housing and living environment) (Centers for

FIGURE 2–8

The share of MA enrollees in plans offering primarily health-related supplemental benefits has expanded significantly since 2018, 2018–2025



Note: MA (Medicare Advantage), OTC (over the counter). Includes conventional plans and special-needs plans; excludes employer group plans. Figure shows the share of MA enrollees in plans offering any mandatory coverage of the service; plan-specified coverage limits may apply. Figure shows the 15 most commonly offered benefits (ranked by percentage of MA enrollees in plans offering the benefit); dental, vision, hearing, and special supplemental benefits for the chronically ill are excluded.

Source: MedPAC analysis of MA plan benefits data.

Medicare & Medicaid Services and Center for Medicare & Medicaid Innovation 2023).

Plans have gradually expanded their coverage of non–primarily health-related supplemental benefits. The benefits are particularly common among SNPs: As shown in Figure 2-9, the most common of these benefits in 2025 are food and produce, and "general supports for living," which may include plan-provided housing support, plan-provided housing consultations, subsidies for rent or assisted living communities, and subsidies for utilities (Centers for Medicare & Medicaid Services 2019b). In contrast, a relatively low share of enrollees in conventional MA plans are in plans that offer these benefits.

A significant share of MA plans offering non-primarily health-related benefits do so through the MA-VBID model demonstration (ATI Advisory 2023). This is especially true for D-SNPs: In 2025, the MA-VBID model is the predonominant pathway by which D-SNPs will offer non–primarily health-related supplemental benefits (Friedman et al. 2024). However, because CMS has announced that the MA-VBID model demonstration will end at the end of 2025, this pattern is likely to change in future years.

Several factors might explain the somewhat limited enrollment among conventional plan enrollees in plans offering SSBCI and other "newer" supplemental benefits (e.g., those available under the CMS's expanded definition of primarily health related). First, plans must use rebate dollars to finance any new benefits, and they may be reluctant to pare back longer-standing benefits. This reluctance could lead plans to gradually add newer benefits over time as rebates increase. Second, plans have an incentive to offer supplemental benefits with broad appeal, and they may determine that the newer benefits are less attractive, on balance, than the more traditional benefits. (Since eligibility is tied to specific health conditions, the share of enrollees who qualify for SSBCI will typically be smaller than the share who qualify for more traditional benefits, and beneficiaries may have difficulty determining whether they would qualify.) This may partially explain the higher prevalence of non–primarily health-related benefits among D-SNPs; because all D-SNP enrollees meet the low-income requirement, D-SNPs participating in the MA-VBID demonstration can make the benefits available to essentially all enrollees in the plan. Finally, plans may need time to develop the infrastructure to offer some of the newer benefits, such as finding a suitable vendor for delivering food and produce and prepared meals (Kornfield et al. 2021).

MA plans often administer supplemental benefits through combination benefits and flex cards

Since 2021, it has become increasingly common for MA plans to offer supplemental benefits as "combined" supplemental benefits, in which enrollees can select services from a plan-provided list. To manage their spending on the services, plans can set guardrails on how such benefits are used by:

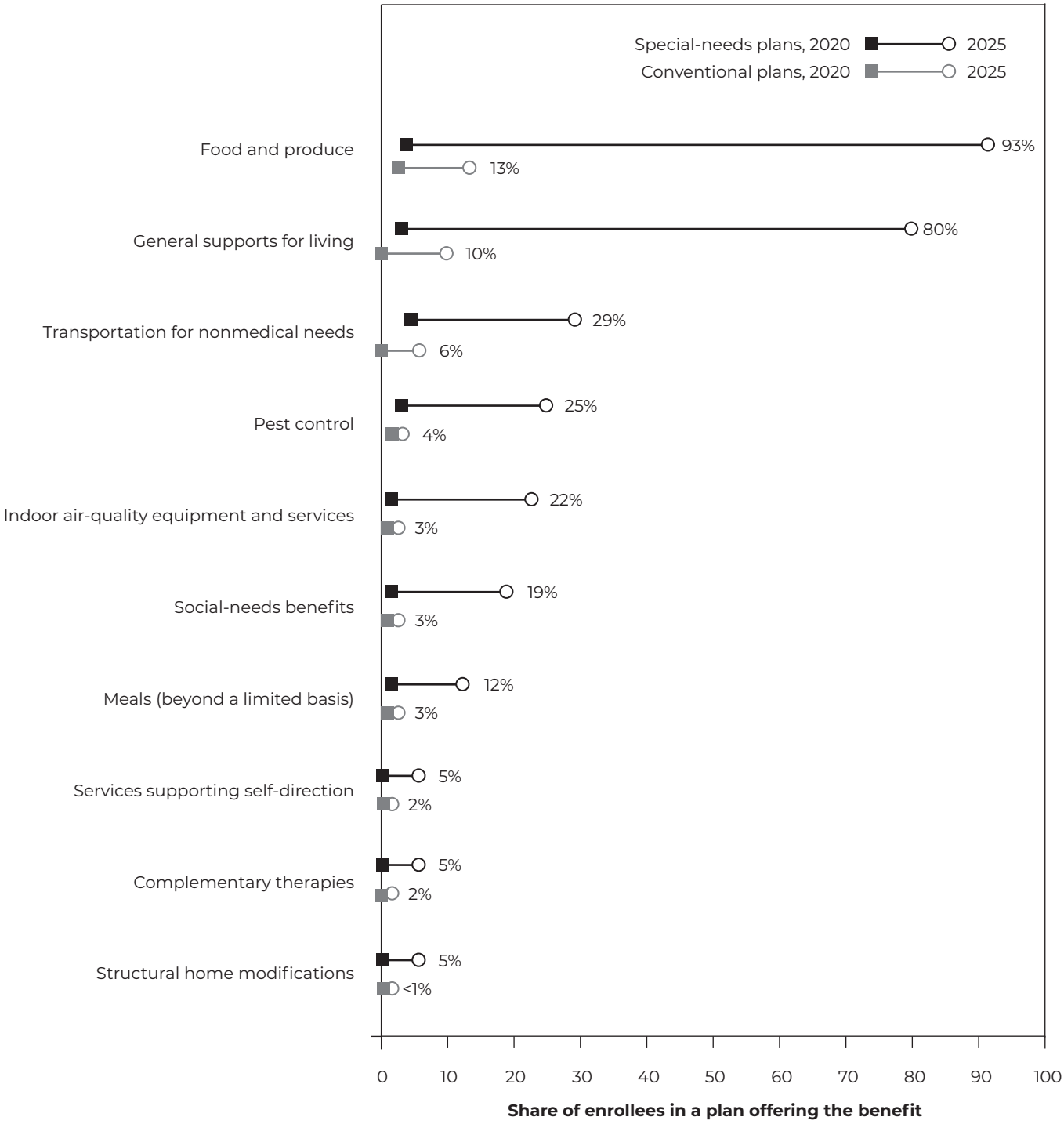
- limiting the type and number of benefits an enrollee can select and requiring the enrollee to select the benefits from a plan-provided list in advance of coverage;
- setting a monetary limit on the value of the coverage;
- limiting the number of visits, uses, or trips (in the case of transportation benefits) that can be covered by the benefit; and
- defining a time period in which the benefits can be used (e.g., annually, semiannually, quarterly).

The benefits are often delivered in the form of a prefunded debit card, sometimes referred to as a "flex card," but they can also be delivered by having enrollees select items from a plan-provided list or through a catalog, managed through a reimbursement system or traditional claims processing. Table 2-4 (p. 106) shows the share of enrollees in plans offering at least one combination benefit (plans can offer up to five distinct combinations of benefits per plan).[49] The table also shows the average estimated annualized benefit limit (i.e., the maximum amount the plan will make available to the enrollee under the combined benefit on an annual basis) for several commonly offered benefit combinations.[50]

We found that the spending limits for combination benefits, which plans report in the plan benefit-package data they submit with their bids, have increased significantly for certain combinations over the five years that plans have been permitted to offer such benefits. For some (but not all) combinations, spending limits in 2025 are below the levels for

FIGURE 2–9

The share of MA enrollees in plans offering non–primarily health-related supplemental benefits has expanded since 2020, 2020–2025



Note: MA (Medicare Advantage). "Conventional plans" excludes employer group plans and special-needs plans. "Special-needs plans" excludes employer group plans and non-special-needs plans. Figure shows the share of MA enrollees in plans offering any mandatory coverage of the service, including benefits provided as special supplemental benefits for the chronically ill or through the MA-VBID model; plan-specified coverage limits may apply.

Source: MedPAC analysis of MA plan benefits data.

TABLE 2–4

MA plans have increasingly been delivering supplemental benefits using flex cards and other flexible benefit arrangements, 2021–2025

	2021	2022	2023	2024	2025
Share of enrollees in plan offering a combined benefit					
Conventional plans	4%	12%	25%	45%	54%
SNPs	6	48	62	86	92
Share of enrollees in an uncapped combined benefit					
Conventional plans	3%	7%	<1%	<1%	4%
SNPs	5	9	<1	<1	<1
Average annualized spending limit in capped combined benefit plans					
Combination includes only dental and vision or hearing services	$387	$757	$709	$810	$745
Conventional plans	387	838	641	646	733
SNPs	N/A	523	869	1,165	787
Combination includes only an OTC benefit and SSBCI items or services	447	980	1,314	1,508	989
Conventional plans	55	248	376	452	365
SNPs	513	1,417	1,595	1,798	1,289
All other combinations that include an OTC benefit	719	518	557	687	879
Conventional plans	915	426	472	320	288
SNPs	325	768	831	1,341	1,522

Note: MA (Medicare Advantage), SNP (special-needs plan), N/A (not applicable), OTC (over the counter), SSBCI (special supplemental benefits for the chronically ill). "Conventional plans" excludes employer group plans and special-needs plans. "Special-needs plans" excludes employer group plans and non-special-needs plans. "Combined benefit plans" excludes "dental-only" plans in which the plan offers only dental services under the combination benefit. Dollar amounts are not adjusted for inflation. We estimate the annualized limit for each plan by scaling the value of the benefit according to the time and dollar limits applied by each plan. For example, for a plan using a limit of $100 per quarter, we would calculate an annualized limit of $400. Flex cards are prefunded debit cards through which plans can administer benefits that are offered under a combined benefit configuration.

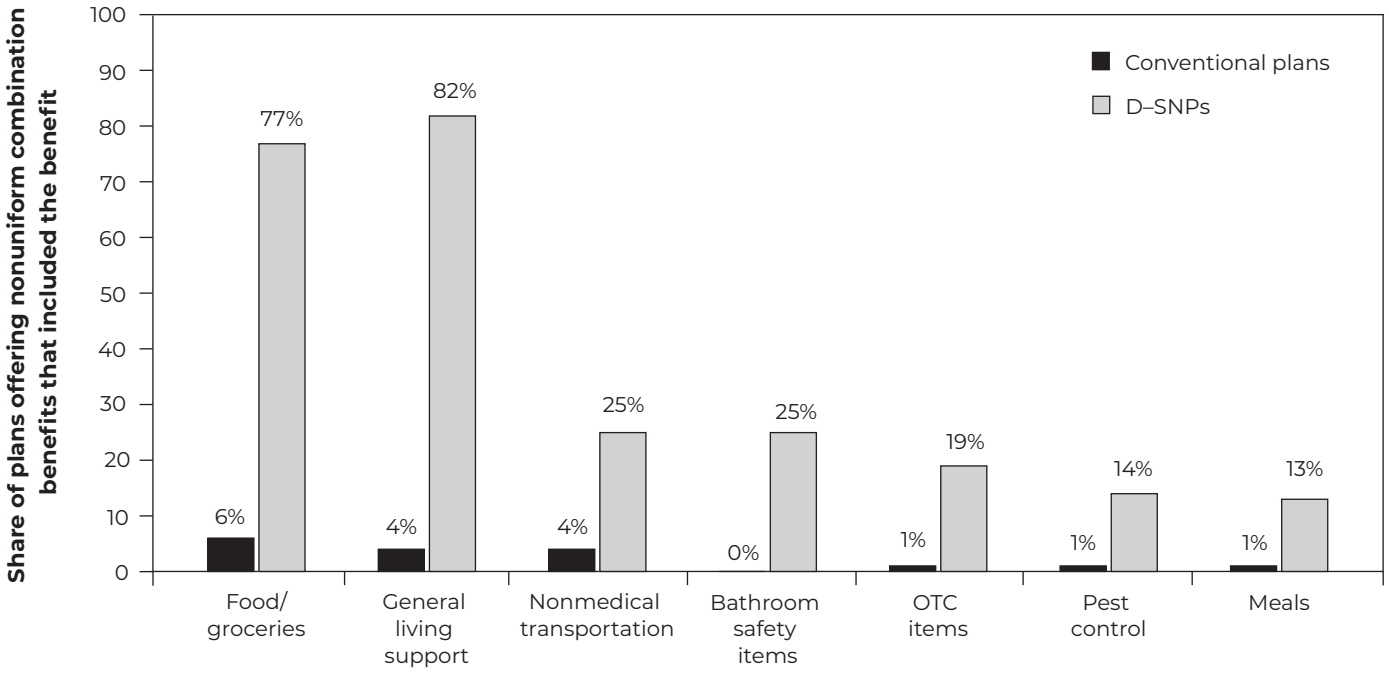
Source: MedPAC analysis of MA plan benefits data.

2024; nevertheless, spending limits for almost all combinations remain well above their 2021 level. For example, the estimated annualized limit for combinations that include only dental and vision and/or hearing benefits roughly doubled from $387 in 2021 to $745 in 2025.

Some combinations of benefits are more frequently offered than others. In 2024, 41 percent of MA plans offered combination benefits that included OTC items as a possible use; 31 percent included an option to use the benefit for home and bathroom safety devices and modifications; and roughly a quarter included "nonuniform" benefits (i.e., those targeting a subset of MA enrollees as SSBCI, benefits offered under the MA–VBID demonstration, or benefits offered under the uniform flexibility rules) (Yeh and Yen 2024). These benefits are particularly common among dual-eligible special-needs plans (D-SNPs), with more than half of D–SNP enrollees in plans that include either OTC items or nonuniform benefits in a combination benefit (Friedman et al. 2023). In 2024, roughly 10 percent of

FIGURE 2–10

Plans offering combination benefits frequently allow enrollees to use the benefits for food and other basic cost-of-living expenses, 2024



Note: D–SNP (dual-eligible special-needs plan), OTC (over the counter). "Conventional plans" excludes employer group plans and special-needs plans. "Special-needs plans" excludes employer group plans and non-special-needs plans. "Nonuniform" benefits include special supplemental benefits for the chronically ill, benefits targeted to groups of enrollees under the MA Value-Based Insurance Design demonstration, and benefits offered under CMS reinterpretation of the uniformity requirement (Centers for Medicare & Medicaid Services 2018d). Food/grocery benefits may include items such as (but not limited to) produce, frozen foods, and canned goods. Tobacco and alcohol are not permitted (Centers for Medicare & Medicaid Services 2019b). "General living support" benefits "may be provided to chronically ill enrollees if the benefit has a reasonable expectation of improving or maintaining the health or overall function of the enrollee" and may include plan-sponsored housing consultations and/or subsidies for rent or assisted living, and/or subsidies for utilities such as gas, electricity, and water (Centers for Medicare & Medicaid Services 2019b).

Source: MedPAC recreation of Figure 6 from Yeh and Yen (2024).

all MA plans offered a combination plan that included only OTC and nonuniform benefits. Figure 2-10 shows the most common benefits offered within the nonuniform benefits category for such plans in 2024. Common benefits included support for purchasing food/groceries and "general living support," which can include subsidies for rent and/or subsidies for utilities such as gas, electricity, and water.[51] As shown in Table 2-4, we estimate that, in 2025, the average amount available to eligible enrollees in SNPs offering an OTC/SSBCI-only combination benefit is approximately $1,300 (for the year), down from about $1,800 in 2024 (our estimates are similar to other published estimates) (Yeh and Yen 2024).

Limited evidence about MA enrollees' use of SSBCI and other non-Medicare services

Relatively little comprehensive or generalizable research exists about the extent to which MA enrollees use supplemental benefits other than dental, vision, or hearing services. Most available evidence comes from broad surveys or from analyses conducted by MA plans. A survey by the Commonwealth Fund asked MA enrollees about their use of common supplemental benefits (but did not ask whether respondents were in a plan that offered the benefit) (Commonwealth Fund 2024). The survey found that 69 percent of enrollees used at least one supplemental benefit (including dental, vision, or hearing benefits); 13 percent used

a transportation benefit; 19 percent used a gym membership; 46 percent used an OTC allowance; 12 percent used a grocery allowance; and 2 percent used a meal-delivery benefit.

One plan sponsor, Elevance Health, has released several internally conducted analyses of its enrollees' use of supplemental benefits. The first analysis compared characteristics of enrollees who used supplemental benefits and those who did not for a sample of about 860,000 MA enrollees in 2022 (Elevance Health 2023). For 6 of the plan's 42 supplemental benefits (nurse hotline, nutrition consultations, nutrition therapy services, orthotics, telemonitoring, and transitional-care services), the plan did not have the available data to report utilization. For the remaining 36 benefits that were assessed, most enrollees used 2 or fewer of the benefits (not all 36 benefits were available in each plan, and the way benefits were offered could vary across plans). Although some benefits have restricted availability, the plan did not identify the share of enrollees eligible for each benefit or which benefits were used most frequently. Among the plan's non–dually eligible enrollees, 25 percent did not use any of the 36 supplemental benefits, the majority (52 percent) used 1 or fewer benefits during the year, and 86 percent used 3 or fewer benefits. Among the plan's dual-eligible enrollees, 17 percent did not use any of the 36 supplemental benefits, 36 percent used 1 or fewer benefits, and 76 percent used 3 or fewer benefits. The plan did not report what share of enrollees used any specific benefit, including benefits that are intended to address social determinants of health.

A second analysis conducted by Elevance Health assessed health care utilization rates of MA enrollees who used at least 1 of 36 supplemental benefits in either 2021 or 2022 using a sample that included 1.3 million supplemental-benefit utilizers, roughly 398,000 nonutilizers, and matched cohorts drawn from the FFS population (Elevance Health 2024). The study used propensity-score matching and a difference-in-difference design to attempt to measure the incremental effect of using supplemental benefits.[52] This method aims to control for differences between the MA and FFS populations so that differences in utilization can be attributed to the use of supplemental benefits. However, the study does not present evidence to show that the baseline utilization rates of the matched groups were similar, which makes it difficult to determine whether results are due to the use of supplemental benefits or underlying differences between the two groups; the study's authors acknowledge that unmeasured confounding factors could affect their results. In addition, the study matches individuals in MA to individuals in FFS with similar hierarchical condition category (HCC) risk scores (though did not require an exact match). The Commission has previously found that individuals in MA have higher risk scores, on average, due to more exhaustive reporting of diagnostic codes in MA (Medicare Payment Advisory Commission 2024b). As a result, the study may have matched MA enrollees with FFS individuals who have comparatively more intense health care needs despite having similar risk scores, which could lead the study to overstate the effects of supplemental benefits.[53] The study found that individuals who used supplemental benefits had different patterns of health care use than nonusers, but due to the study's limitations, it is difficult to draw conclusions about the findings.

One trade association examined data in 2020 for 30,000 MA enrollees in a regional plan who had access to the OTC benefit. That analysis found that 33 percent of eligible beneficiaries in 2020 used the OTC benefit, which provides an allowance for beneficiaries to receive specified nonprescription items from pharmacies (Consumer Healthcare Products Association 2021). Additionally, one analysis of a posthospitalization meal-delivery benefit found that roughly 57 percent of eligible patients accepted or received the benefit; some eligible patients did not receive the benefit because the plan's case managers had difficulty contacting the patient, the patient said they already had help with meals or were able to prepare meals themselves, or the patient declined the meals with no reasons provided (Nguyen et al. 2023). Altogether, the limited evidence that is available from surveys and other studies provides little insight into MA enrollees' use of supplemental benefits and leaves basic questions unanswered.

Current MA encounter data are insufficient for assessing use of many supplemental benefits

MA encounter data should be the most detailed source of information about the services that MA enrollees use, but no research has yet explored whether the data can provide information about enrollees' use of

non-Medicare services. As discussed in the text box on using encounter data to assess use of MA supplemental benefits (pp. 96–99), confusion among MA plan officials about if and how to submit encounter records for some services suggests that the data are likely incomplete for some services and some plans. However, the potential strengths or weaknesses of the data have not previously been well documented. To fill this gap and to explore whether there are services for which the data might be used, we analyzed encounter data for 2021. The 2021 data were the most recent data available at the time of our analysis. However, for some types of supplemental benefits (e.g., SSBCI), 2021 was one of the first years in which plans could offer the benefits. As such, utilization may have been low, and plans and supplemental benefit vendors may still have been developing their processes for collecting and reporting data for such benefits.

One major barrier to using the encounter data to analyze non-Medicare services is the absence of standardized procedure codes corresponding to the benefits that plans offer. (This barrier should be addressed by CMS's updated guidance for 2024 encounter data, but those data are not yet available for analysis.) We used descriptions of supplemental benefits published in CMS guidance and worked with our staff physician to identify CPT and HCPCS codes that could plausibly relate to these types of supplemental benefits (see Table 2-A3 for a list of the codes we used in our analysis, pp. 122–123). Table 2-5 (p. 111) shows, for each non-Medicare service that we assessed, the percentage of MA enrollees in plans that offered the benefit on a mandatory basis in 2021, the number of codes we used to analyze the benefit, and the percentage of MA enrollees in plans offering the benefit who had an encounter record that contained at least one of the codes we linked to the benefit.

We found encounter records for each of the types of supplemental benefits we assessed. However, because some of the codes we used can refer to Medicare-covered services, we are unable to confirm that all of the records we found represented utilization of a supplemental benefit (Table 2-A3 in the appendix indicates relative frequencies of the codes we identified in our searches, pp. 122–123). The percentage of unique enrollees who had at least one encounter record that included one of the codes we looked for ranged from less than 1 percent (for many benefits) to just over 50 percent (for annual physical exams). For most benefits, however, the share of enrollees in plans that offered the benefit who also had a corresponding encounter record was relatively low. For 16 of the 18 benefits we analyzed, fewer than 10 percent of enrollees in plans offering the benefits had corresponding encounter records.

Because we do not have a way to assess the completeness of the data, it is difficult to know whether this measure provides a reliable signal about the extent to which MA enrollees use the supplemental benefits available to them. If the data are incomplete, the utilization we identified may be a lower bound on the true level of utilization; on the other hand, if the procedure codes we used include some services that were not actually supplemental benefits, the utilization we identified could overstate the use of some benefits. Of the benefits we assessed, transportation benefits were the only category for which the percentage of enrollees with an encounter record was roughly in line with the rate suggested by survey data: We found that about 20 percent of enrollees in plans offering transportation benefits had a corresponding encounter record, which is slightly higher than the percentage of survey respondents who reported getting transportation help from their plan in a 2023 survey by the Commonwealth Fund (Commonwealth Fund 2024). For many of the other benefits, the percentage of enrollees with encounter records differs considerably from survey results. The surveys discussed previously found that between one-third and two-thirds of enrollees with access to OTC benefits used the benefit (Commonwealth Fund 2024, Consumer Healthcare Products Association 2021, Elevance Health 2023). However, only 7 percent of enrollees in plans with access to an OTC benefit in our analysis had a corresponding encounter record. For meal- and food-related benefits, the surveys suggest that somewhere between 2 percent and 33 percent of enrollees in plans offering a grocery benefit used it (Commonwealth Fund 2024, Elevance Health 2023). We found that less than 1 percent of enrollees in plans offering such benefits had a corresponding encounter record. For gym memberships and fitness benefits, the Commonwealth Fund survey found that 19 percent of enrollees used the benefit, but less than 1 percent of enrollees in plans with fitness benefits had corresponding encounter records in our analysis (Commonwealth Fund 2024).

Altogether, considering the well-documented data limitations and the discrepancies between encounter data and other sources, we can conclude that—for most supplemental benefits other than vision and hearing benefits—the encounter data are insufficient for characterizing enrollees' use of the benefits. Given the considerable amount of Medicare spending going toward these benefits in the form of MA rebates, the lack of transparency around use of the benefits is concerning.

The role of vendors, community-based organizations, and vertically integrated entities

Just as little is known about MA enrollees' use of supplemental benefits, relatively little is known about how MAOs administer the benefits. Because many supplemental benefits are nonmedical, MAOs often contract with third parties such as businesses or community-based organizations to provide or administer the benefits. Medicare does not collect information about the entities with which MAOs contract. To better understand how supplemental benefits are administered, we reviewed the websites of MAOs and entities that administer MA supplemental benefits (see methods text box, p. 112).

Several themes emerged from our review. First, we found that many MAOs contract with dental and/or vision insurers that manage the supplemental dental and vision benefits on behalf of the MA plan, although some insurers manage the benefits themselves or have acquired organizations that manage the benefits on their behalf. Second, we found that MAOs often contract with for-profit vendors to provide nonmedical supplemental benefits. Plans may also contract with community-based organizations, though information about these arrangements was harder to find. Third, we found that MAOs frequently administer supplemental benefits through entities with which the insurer is vertically integrated and that several of the large MAOs have acquired or developed subsidiary businesses that specialize in providing services that can be offered as supplemental benefits. We also found several instances in which MAOs structured their supplemental benefits to be provided exclusively by providers owned by the plan's parent organization.

Supplemental dental and vision benefits are often administered through external dental and vision insurers

Many of the MAOs we reviewed arranged for their supplemental dental and vision benefits to be administered by dental or vision insurance companies that specialize in administering insurance benefits for a specific category of services. In addition to managing dental or vision supplemental benefits for MA plans, these organizations sometimes offer stand-alone dental or vision insurance plans in the commercial market or contract with employers to provide ancillary dental or vision benefits. Most of the MAOs we reviewed contracted with at least one of these types of entities. The companies can provide a range of services for MA plans, such as organizing networks of clinicians (e.g., dentists, audiologists, or opticians), processing claims, negotiating payment rates or discounts, confirming enrollees' eligibility for coverage, and ensuring compliance with regulations. Some companies may also take on risk for the benefit(s) they manage, but the prevalence of risk-sharing arrangements is unclear.

For dental benefits, many of the MAOs we reviewed contracted with one of several large dental insurers that offer dental plans in multiple markets across the country. For both vision and hearing benefits, the entities listed as managing the supplemental benefits on behalf of MAOs were often parts of large, vertically integrated organizations that manufacture eyewear or hearing aids, own optometry or audiology practices, and operate retail businesses oriented toward selling eyewear or hearing aids (EssilorLuxottica 2025, EyeMed 2025, Mark Farrah Associates 2023, Vision Service Plan 2025a). Some of the hearing-oriented entities that we identified most frequently in our review are owned by a hearing-aid manufacturer that also owns several hearing-related retail chains and online stores (WS Audiology 2025). Another hearing-oriented company used by several of the MAOs we reviewed is owned by an organization that operates a suite of companies that specialize in administering supplemental benefits on behalf of managed care plans, including hearing benefits, vision services, OTC items, meals and groceries, nutrition counseling, transportation, personal emergency response services, and wellness kits (Hearing Review 2020, NationsBenefits 2025a).

Several of the large MAOs included in our review have established or acquired dental-, vision-, or

TABLE 2–5

A small share of MA enrollees have encounter records that might correspond to supplemental benefits, 2021

Supplemental benefit	Number of CPT or HCPCS codes assessed	Percentage of MA enrollees in plans that offered the benefit*	Percentage of enrollees in plans that offered the benefit who had a corresponding encounter record
Fitness benefit	10	91%	<1%
Annual physical exam	26	88	51
OTC items	66	82	7
Food			
Meals (limited duration)	7	56	<1
Food and produce (SSBCI)	7	9	<1
Meals (SSBCI)	7	7	<1
Transportation	97	46	20
Acupuncture	6	26	1
Home modifications			
Home and bathroom safety devices and modifications	74	8	5
Structural home modifications (SSBCI)	5	<1	7
Personal emergency response system	3	24	3
Health education	31	32	<1
Smoking and tobacco cessation	14	20	3
Nutrition/dietary counseling	7	15	1
Wigs for chemotherapy hair loss	1	4	<1
In-home support service	127	8	2
Medical nutritional therapy	2	6	<1
Enhanced disease management	16	6	<1

Note: MA (Medicare Advantage), CPT (Current Procedural Terminology), HCPCS (Healthcare Common Procedure Coding System), OTC (over the counter), SSBCI (special supplemental benefits for the chronically ill). Excludes chart-review encounter records. See appendix for a list of the codes we used to identify each type of supplemental benefit.
* Includes plans offering the supplemental benefits on a mandatory basis.

Source: MedPAC analysis of MA plan benefit data and MA encounter data, 2021.

hearing-oriented companies and now manage the benefits "in house." For example, UnitedHealthcare has acquired several companies that now operate as UnitedHealthcare subsidiaries and administer supplemental dental, vision, and hearing benefits for UnitedHealthcare's MA plans (Baltimore Sun 2021, EPIC Hearing Healthcare 2025, United Healthcare 2025a, United Healthcare 2025b, UnitedHealth Group 2019). All three subsidiaries also manage the supplemental benefits of other MAOs (Blue Shield California 2025, MercyOne 2024, Trinity Health Plan of Michigan 2025). Other MAOs, including Humana and Capital Blue Cross, have made similar acquisitions (Capital Blue Cross 2025, CompBenefits 2010).[54] However, not all of the MAOs we reviewed listed a third-party entity as managing their dental, vision, or hearing benefit—perhaps because the benefit manager was not listed (or we were not able to identify it) or because some organizations manage the

Methods used to identify and learn about how MA supplemental benefits are administered

To better understand how supplemental benefits are being administered, we reviewed the websites of a nonrandom sample of Medicare Advantage organizations (MAOs) and collected information about the entities with which plans are contracting. Our sample included a mix of large for-profit organizations that offer plans nationally, nonprofit organizations, regional organizations, and provider-owned organizations.[55] We reviewed the websites in January 2025. Information about supplemental-benefit vendors—when it was available at all—was sometimes found in the "Evidence of Coverage" documents that plans are required to provide to members, but information was sometimes listed elsewhere on the plan's website (for example, some organizations posted "vendor information sheets" while others had a page of their website dedicated to supplemental benefits). After reviewing MAO websites to identify the entities with which plans partner, we visited the websites of the entities listed by MAOs to collect information about their business models, how they market their services to MAOs, their ownership structure and financial relationships, and other information. We also conducted an internet search to identify additional organizations that market themselves as providing MA supplemental benefits and conducted a similar review of those organizations. Information about the entities that administer supplemental benefits was limited. As such, our findings can provide illustrative examples of how some MAOs administer supplemental benefits but might not be representative of the industry as a whole. ■

benefits internally.[56] Altogether, we found that MAOs used a variety of approaches to administer dental, vision, and hearing benefits. Although our review suggested that partnerships with dental or vision insurers are common, existing data sources do not enable us to quantify which types of relationships are most prevalent.

MAOs often contract with vendors or community-based organizations to administer nonmedical supplemental benefits

We found that MAOs frequently contract with vendors (typically for-profit entities) to administer nonmedical supplemental benefits such as meals, transportation, and in-home supports and services. Nearly all of the MAOs included in our review contracted with at least one such vendor. Most of the vendors we identified specialized in providing one type of MA supplemental benefit. However, many of the plans we reviewed administered at least one supplemental benefit through a prepaid debit card, such as an "OTC card" or flex card. Because flex cards can be used by enrollees to pay for an array of supplemental benefits (defined by the plan), the vendors that administer the cards were often listed in plan documents as the vendor for multiple supplemental benefits. Some vendors operate businesses related to multiple supplemental benefits and offer a flex card as the mechanism through which the benefits are financed and/or accessed. For example, one company offers a flex card that enrollees can use to purchase OTC products, groceries, nonemergency transportation, meals, and exercise kits—all provided through subsidiaries of the company administering the card (MA plans using the vendor can decide which of the benefits their members can access) (NationsBenefits 2025a).

The parent organizations of some MAOs own or operate businesses that administer OTC cards and flex cards. For example, CVS Health owns OTC Health Solutions, which offers a platform through which

MAOs can administer a flex card or OTC benefit (OTC Health Solutions 2025a, OTC Health Solutions 2025b). The platform includes a mobile application and online portal through which MA enrollees can browse a catalog of OTC items (including CVS Health products) and order them for home delivery or pickup at a CVS retail location; the flex card can be used at CVS retail locations as well as other plan-specified locations. Similarly, UnitedHealth Group, through its subsidiary Optum, owns HealthyBenefits+ and Solutran, which offer MAOs a platform for administering OTC and flex-card benefits (Healthy Benefits 2025, Solutran 2025). The MA plans owned by these parent organizations typically administer supplemental benefits through the related subsidiary. Many of the other MAOs in our review also used these companies to administer their OTC or flex-card benefits.

We found several additional instances of MA plans administering supplemental benefits through entities owned by the plan's parent organization. The Commission has previously reported that vertical integration of MAOs has increased since 2022, as measured by the share of MA expenses paid to related parties during a year (Medicare Payment Advisory Commission 2025). Payments from MA plans to related subsidiaries providing supplemental benefits are one potential source of vertical integration. However, due to data limitations, we are unable to quantify the extent to which payments to supplemental-benefit vendors have contributed to the increase in vertical integration and cannot determine what share of rebate dollars are paid to vertically integrated entities.

Information about the role of community-based organizations was harder to find on plan websites

MAOs may also partner with nonprofit community-based organizations (CBOs) to provide supplemental benefits.[57] However, information about partnerships with CBOs was difficult to locate on plan websites. Perhaps MAOs did not list (or we could not find) the names of CBOs with which they partner, or perhaps they did not partner with CBOs for the benefits we reviewed. To better understand the role of CBOs in providing supplemental benefits, we reviewed case studies and academic studies that described MAOs partnering with CBOs. We found a relatively limited set of case studies, which described partnerships between MAOs and Meals on Wheels, the YMCA, a nonprofit organization that provides home-based nursing care, Area Agencies on Aging, and other nonprofits (Aging and Disability Business Institute 2022, Aging and Disability Business Institute 2021, Aging and Disability Business Institute 2019, Better Medicare Alliance 2016).

One annually conducted survey of CBOs found that a growing share of them are partnering with MAOs. The survey—which included Area Agencies on Aging, Centers for Independent Living, and other CBOs—found that the share of organizations contracting with MAOs rose from 16 percent in 2021 to 21 percent in 2023 (Kunkel and Lackmeyer 2024).[58] Older adults and people with disabilities were the populations most often served through the partnerships, and case-management/care-coordination services were the most frequently provided services.[59] Several of the less frequently provided services (reported by about one-third of survey respondents) are services that MAOs can offer as supplemental benefits, including nutrition programs, home-care services, caregiver support and training, medical and nonmedical transportation, and environmental modifications. See the text box on factors affecting MAOs' decisions about how to administer supplemental benefits (pp. 114–117).

Vertical integration and the lack of transparency around supplemental benefits

Our review found that some MAOs administer supplemental benefits through entities with which the insurer is vertically integrated or with which the plan has a financial interest. On the one hand, this type of integration may enhance coordination of services; on the other, the integration makes it difficult to understand whether the rebates that fund supplemental benefits are being used efficiently. As described earlier in this section, UnitedHealthcare and several other large insurers own subsidiary businesses that administer supplemental dental, vision, or hearing services for the company's MA plans. Additionally, several of the large insurers own subsidiary organizations that administer card-based supplemental benefits. Further, some MAOs require beneficiaries to access supplemental benefits from entities owned by the same parent organization as the plan. For example, several of the large health systems that offer MA plans require that their enrollees access

Factors affecting Medicare Advantage organizations' decisions about how to administer supplemental benefits

Because many supplemental benefits are nonmedical, Medicare Advantage organizations (MAOs) often contract with third parties such as businesses or community-based organizations to provide or administer the benefits. In interviews with MA plan leaders and other stakeholders, researchers have explored how MAOs are choosing to administer supplemental benefits (Baehr et al. 2024, Crook et al. 2019, Durfey et al. 2022, NORC at the University of Chicago 2021, Thomas et al. 2019, Urban Institute 2019). The interviews have found that MAOs typically partner with third-party entities—often vendors or community-based organizations (CBOs)—to provide access to the new benefits. In addition, stakeholders have described the characteristics they value and look for in potential partners (Durfey et al. 2022, Thomas et al. 2019). These attributes include:

- alignment of organizational goals;
- the ability to provide data showing a positive impact on health outcomes, quality of care, or return on investment;
- operational capacity to work with MA plans and scale service delivery; and
- other factors such as expertise, experience providing the services, familiarity with local communities, and strong positive relationships in those communities.

Across multiple studies, stakeholders have described how challenges relating to these factors have hindered MAO–CBO partnerships and favored partnerships with vendors or larger (regional or national) organizations. In our review of plan websites, we found many instances of MAOs contracting with vendors and little information about MAO–CBO partnerships. We found that the vendors we reviewed advertised themselves as being highly focused on plan-aligned goals, provided quantitative information about the effects of their services, and emphasized their ability to work with MA plans and scale delivery.

MA supplemental-benefit vendors heavily advertise their ability to achieve plan goals

The vendors we identified through our review seemed purpose-built to partner with MAOs: Vendors' websites emphasized their capacity to address nearly all of the themes that researchers have found to be important to health plans.

Alignment of organizational goals

In their interviews with researchers, officials from MA plans stated that they prioritize partnerships in which the partner and the MAO have shared goals (Durfey et al. 2022, Thomas et al. 2019). Multiple interviewees identified improved star ratings and enrollment as important goals for the plans.[60] Similarly, a survey by the actuarial firm Wakely found that MAO leaders ranked improving clinical outcomes, improving star-rating measures, and attracting or retaining new members as "very important" considerations in their decision-making about supplemental benefits (Baehr et al. 2024). Researchers have noted that, unlike vendors, CBOs often have their own goals, which might not align with that of an MA plan, and may be "concerned that partnering with health care organizations can lead to a loss of autonomy and to an overmedicalization of their goals and services" (Durfey et al. 2022, Taylor and Byhoff 2021). In contrast, we found that supplemental-benefit vendors often advertised their alignment with plans' goals—particularly their ability to help plans lower costs and increase revenue.

Most of the vendor websites we explored advertised their ability to keep a plan's members healthy and reduce their health care costs. In addition, many vendors were specific about how their services could improve financial performance for MAO partners—particularly through membership growth and retention, improved star ratings, and improved

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Factors affecting Medicare Advantage organizations' decisions about how to administer supplemental benefits (cont.)

risk scores. For example, one of the most widely used vendors of fitness benefits advertises its ability to help MA plans achieve "high member acquisition," "high member retention," and "lower health care cost claims" (SilverSneakers 2025). A company that administers a flex card and other supplemental benefits advertises its ability to provide "targeted interventions driving CAHPS [Consumer Assessment of Healthcare Providers and Systems] and STARS improvement" as well as its ability to "help support HEI [Health Equity Index] capture and connect members to SDOH [social determinants of health] programs" (NationsBenefits 2025b).[61] A company managing vision benefits for MA plans claimed that "not offering the right vision plan can lead to missed opportunities to improve member health, satisfaction, HEDIS [Healthcare Effectiveness Data and Information Set] scores and star ratings, growth, retention and profitability" (Vision Service Plan 2025b). Two vendors providing food-related supplemental benefits advertised their ability to improve health outcomes, lower medical costs, improve quality or star ratings, and increase enrollment (FarmboxRx 2025, GA Foods 2025). One of the meal-delivery vendors also advertised that it could help plans with "accurate and timely risk score coding."

Vendors providing in-home supplemental benefits emphasized their ability to identify members' diagnoses and boost star ratings. For example, one company that provides in-home health risk assessments advertises that its employees "know how to look for and document member issues beyond the screening(s) they perform" (HealPros 2025).[62] Another offers an in-home visit "designed to optimize chronic condition recapture rate and quality gap closure" as well as telehealth "assessments that address HEDIS and Star Gap measures to optimize reimbursement and value-based payment potential" (Medigence Health 2025).[63] One company, owned by a large national insurer, advertises that its services "provide timely and valuable diagnostic screenings . . . [that] are crucial for meeting quality measures and improving health plan member satisfaction scores. They also positively impact star ratings. Accurate coding and documentation are key for appropriate reimbursement" (Signify Health 2025). And one care-coordination vendor described itself as "the sole care coordination program focused on Quality Stars and Risk Adjustment" (Porter 2024). The company provides MA enrollees with a "comprehensive in-home assessment [that] addresses quality and risk adjustment first." The company touts its ability to "identify and address risk-adjustable conditions and novel HCCs [hierarchical condition categories]" alongside its ability to coordinate care.

Operational capacity to work with MA plans and scale service delivery

In interviews with researchers, officials from MA plans described seeking partners that have "infrastructure aligning with that of MA plans," meaning the operational capacity to comply with CMS rules and regulations, work within the MA bidding cycle, and understand the competitive pressures facing MAOs. For example, researchers have reported that CBOs "may have limited experience and capacity to contract with health insurance plans" because they "may not meet the liability insurance requirements to contract with plans or may not have the technical capacity to receive, store, and share any health-related information on beneficiaries in a manner required by Health Insurance Portability and Accountability Act (HIPAA) regulations" (Crook et al. 2019). Some interviewees stated that a lack of "plan literacy" on the part of CBOs can be a barrier to partnership, while another pointed out that MA plans and CBOs often have "business models and missions [that] are inherently different" (Durfey et al. 2022).

In contrast, the vendors identified through our review of plan websites foregrounded their understanding of MA regulatory, operational, and

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Factors affecting Medicare Advantage organizations' decisions about how to administer supplemental benefits (cont.)

business considerations. Vendors touted their ability to handle members' data appropriately and comply with CMS regulations. They also advertised their services as being highly customizable in order to meet the varying needs and interests of different MAOs. Considering the value that plans place on finding partners that have "aligned infrastructure," it is perhaps less surprising that entities owned and operated by MA parent organizations have been able to develop businesses that are widely used by MA plans to administer supplemental benefits.

Officials from MAOs also cited the ability to scale services to wider geographic areas as an important capacity for potential partners. MAOs are required to offer supplemental benefits uniformly within a given plan's service area. CBOs often serve a more limited service area and may struggle to meet the needs of an MAO partner. Some CBOs have overcome this obstacle by forming "networks" of CBOs that together cover a larger service area (ATI Advisory 2020). Some vendors take a similar approach, serving as "aggregators" that develop, through subcontracts with locally operating businesses or nonprofits, networks of providers that can deliver supplemental benefits across a wider service area (ATI Advisory 2020, NORC at the University of Chicago 2021).

The work of assembling such networks can be significant and might deter plans from partnering with local, independent CBOs. By contrast, the vendors we reviewed emphasized their ability to scale and provide consistent service across large geographic areas. Researchers have reported that "some health plans report that it is easier to contract with national umbrella organizations because they can scale benefits more effectively, take advantage of more advanced contracting capabilities, or ensure high levels of liability coverage required under corporate risk management policies" (NORC at the University of Chicago 2021).

Ability to provide data showing a positive impact on health outcomes, quality of care, or return on investment

MAO officials have also stated that they value having data about how a potential partner can help them achieve their goals (Durfey et al. 2022). This capacity may be increasingly important because, beginning in 2025, CMS is requiring MAOs to maintain "bibliographies" that demonstrate that benefits offered as special supplemental benefits for the chronically ill (SSBCI) have a reasonable likelihood of maintaining or improving the health of their enrollees (Centers for Medicare & Medicaid Services 2024g). Researchers have interviewed MA

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hearing or vision benefits through providers that are affiliated with the health system. For example, some plans offered by an MAO that is owned by a large health system cover hearing aids only if they are furnished by audiology clinics owned by the health system (Select Health 2024).

Vertical integration can create opportunities to coordinate services and deliver benefits more efficiently. However, when an MA plan contracts with an owned subsidiary to deliver supplemental benefits, or when the benefits are required to be delivered through owned providers, there is also an opportunity for the parent organization to retain a larger fraction of each dollar flowing through the supply chain as profit. Plans receiving a rebate from Medicare to finance supplemental benefits typically allocate some fraction of the rebate to administrative costs and profits. The remainder is paid to entities that provide the supplemental benefits to MA enrollees; some of the payment is used to cover that entity's

Factors affecting Medicare Advantage organizations' decisions about how to administer supplemental benefits (cont.)

plan officials about the evidence they use to make decisions about supplemental benefits and found that MA decision-makers typically rely on multiple data sources to determine how to target benefits to MA enrollees, that gaps in evidence hinder decision-making about newer "non–primarily health-related" supplemental benefits, and that some MAOs conduct their own research to fill gaps in knowledge (Shields-Zeeman et al. 2022).

On the websites of the vendors we reviewed, we noted that many provided quantitative information about the services they provide and how their services may relate to MAO goals. The statistics frequently relate to member-satisfaction surveys, membership growth or retention, improvements in health outcomes, or reductions in medical costs. However, much of the evidence we found on plan or vendor websites was cross-sectional and did not provide strong evidence of the causal effects of the interventions on health, enrollment patterns, quality of care, or other outcomes. Recent academic research has assessed the effects of MA supplemental-benefit adoption on patterns of plan disenrollment and plan-satisfaction ratings. One study showed that plan adoption of supplemental benefits (either primarily health-related benefits or special supplemental benefits for the chronically ill (SSBCI)) was not associated with the rate of plan disenrollment (for both dually and non–dually eligible beneficiaries) (Tucher et al. 2025). Another study found that adopting both a primarily health-related benefit and an SSBCI benefit was associated with slightly higher plan-satisfaction ratings (as measured using the MA–CAHPS); adopting just one of the two benefit types had no significant effect (Tucher et al. 2024b). Nevertheless, vendors may be providing their own data to plans in an effort to demonstrate their potential value, and those data may pertain to outcomes that are of significant interest to the plans. CBOs, on the other hand, might prioritize alternative measures of success and "may not necessarily have previously needed to provide evidence of the population health or financial impact of their services to medically oriented health care entities," making them a potentially less attractive partner to MAOs (Durfey et al. 2022).

Altogether, our findings—considered in the context of previous research—provide some insight as to how MAOs might be making decisions about the entities with which they partner to administer supplemental benefits. Multiple factors suggest that operational considerations and business incentives may lead plans to favor partnerships with vendors or other large organizations over partnerships with local, independent CBOs, which might have competing goals and operational differences that hinder partnerships with MAOs. ■

administrative costs and profit margin. A vertically integrated entity could therefore capture a larger fraction of each rebate dollar by paying an owned entity to administer supplemental benefits on behalf of the plan. The data that MA plans are currently required to report to Medicare provide no information about the administrative costs or profits of third-party entities delivering MA supplemental benefits. Patterns of high spending and low use could be a sign that the benefits are not being administered efficiently or that program spending is being captured by entities in the supply chain. The lack of transparency, combined with the high levels of vertical integration we observed in a sample of MAOs, underscores how little is known about enrollees' use of supplemental benefits. ■

APPENDIX 2–A

Additional information about supplemental benefits

TABLE 2–A1

Examples of supplemental benefits

Service category	Examples
Supplemental benefits meeting CMS's original definition of "primarily health related"	
Extensions of covered Medicare benefits	Additional days of inpatient acute care, inpatient stay upgrades, additional days of inpatient psychiatric care, additional days of SNF care, SNF stay with waived hospital-stay requirement
Dental	Oral exams, prophylaxis (cleanings), fluoride treatment, dental X-rays, diagnostic dental services, restorative dental services, endodontics, periodontics, extractions, prosthodontics
Vision	Routine eye exams, contact lenses, eyeglasses (lenses and/or frames)
Hearing	Routine hearing exams, fitting/evaluation for hearing aids, hearing aids
Other	Acupuncture, bathroom safety devices, fitness benefits, enhanced disease management, health education, in-home safety assessments, meals (needed due to an illness and offered for a limited duration), OTC items, personal emergency response system, medication reconciliations, remote-access technologies, telemonitoring services, transportation related to health care needs, wigs for hair loss related to chemotherapy, worldwide coverage
Supplemental benefits meeting CMS's expanded definition of "primarily health related"	
Other	Adult day care services, home-based palliative care, in-home support services, support for caregivers of enrollees, medically approved non-opioid pain management, stand-alone memory fitness benefit, home and bathroom safety devices and modifications, transportation to additional health-related locations, OTC benefits
Special supplemental benefits for the chronically ill (SSBCI)	
Other	Complementary therapies, food and produce, meals (beyond limited basis), pest control, transportation for nonmedical needs, indoor air quality equipment and services, social-needs benefit, services supporting self-direction, structural home modifications, general supports for living

Note: SNF (skilled nursing facility), OTC (over the counter). This list is not exhaustive of the supplemental benefits MA plans can offer. Prior to 2020, MA supplemental benefits were required to be "primarily health related," which CMS originally defined as benefits for which the primary purpose is "to prevent, cure, or diminish an illness or injury" (Centers for Medicare & Medicaid Services 2016). Beginning in 2019, CMS broadened its definition to permit services that address physical impairments, lessen the functional or psychological impact of injuries, or reduce avoidable health care utilization (Centers for Medicare & Medicaid Services 2018c). Services that met the original definition continue to be permitted under the expanded definition. Beginning in 2017, MA plans participating in the MA Value-Based Insurance Design Model demonstration were permitted to target supplemental benefits to certain categories of enrollees (Centers for Medicare & Medicaid Services 2018b). Beginning in 2019, the ability to target supplemental benefits to clinically specific groups of enrollees was extended to all plans (Centers for Medicare & Medicaid Services 2018d). Beginning in 2020, all plans were granted the option to provide "non–primarily health-related" supplemental benefits that "have a reasonable expectation of improving or maintaining the health or overall function" for chronically ill enrollees, known as special supplemental benefits for the chronically ill (SSBCI) (Centers for Medicare & Medicaid Services 2019b).

Source: MedPAC summary of CMS guidance documents.

TABLE 2–A2 **CMS descriptions of special supplemental benefits for the chronically ill (cont. next page)**

Benefit	Description
Complementary therapies	Complementary therapies offered alongside traditional medical treatment may be offered as non–primarily health-related SSBCI. Complementary therapies must be provided by practitioners who are licensed or certified, as applicable, in the state in which they practice and are furnishing services within the scope of practice defined by their licensing or certifying state. Alternative therapies that are considered primarily health related may be offered by an MA plan as a non-SSBCI benefit.
Food and produce	Food and produce to assist chronically ill enrollees in meeting nutritional needs may be covered as SSBCI. Plans may include items such as produce, frozen foods, and canned goods. Tobacco and alcohol are not permitted.
General supports for living	General supports for living such as housing may be provided to chronically ill enrollees if the benefit has a reasonable expectation of improving or maintaining the health or overall function of the enrollee. General supports for living may be provided for a limited or extended duration as determined by the plan. The benefit may include plan-sponsored housing consultations and/or subsidies for rent or assisted living communities. Plans may also include subsidies for utilities such as gas, electric, and water as part of the benefit.
Indoor air quality equipment and services	Equipment and services to improve indoor air quality, such as temporary or portable air-conditioning units, humidifiers, dehumidifiers, High Efficiency Particulate Air filters, and carpet cleaning, may be covered as SSBCI. Plans may also include installation and servicing of equipment as part of the benefit.
Meals (beyond limited basis)	Meals are considered a primarily health-related benefit (i.e., non-SSBCI) when provided to enrollees for a limited period immediately following surgery or an inpatient hospitalization or due to a chronic illness (so long as the meals are needed due to an illness, are consistent with established medical treatment of the illness, and are offered for a short duration). Meals may be offered beyond a limited basis as a non–primarily health-related benefit; meals may be home delivered and/or offered in a congregate setting.
Pest control	Pest-eradication services that are necessary to ensure the health, welfare, and safety of a chronically ill enrollee. Services may include pest-control treatment(s) or products that may assist the enrollee in the pest eradication (e.g., traps, pest-control sprays, cleaning supplies).
Services supporting self-direction	Services supporting self-direction allow enrollees to have the responsibility for managing all aspects of health care delivery in a person-centered planning process; while such services are a non–primarily health-related benefit, they may have a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee. Plans may provide services to assist in the establishment of decision-making authority for health care needs (e.g., power of attorney for health services) and/or may provide education such as financial literacy classes, technology education, and language classes. Interpreter services may also be provided to enrollees to facilitate encounters with health care providers. Primarily health-related education and/or medical nutrition therapy services that are primarily health related may be offered by an MA plan as non-SSBCI supplemental benefits.
Social-needs benefits	Access to community or plan-sponsored programs and events to address enrollee social needs, such as non–fitness club memberships, community or social clubs, park passes, and access to companion care, marital counseling, family counseling, classes for enrollees with primary caregiving responsibilities for a child, or programs or events to address enrollee isolation and improve emotional and/or cognitive function, are non–primarily health-related benefits that may be covered as SSBCI.

TABLE 2–A2

CMS descriptions of special supplemental benefits for the chronically ill (cont.)

Benefit	Description
Structural home modifications	Structural modifications to the home that may assist with the chronically ill enrollee's overall function, health, or mobility are permitted if those items and services have a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee (e.g., widening of hallways or doorways, permanent mobility ramps, easy-to-use doorknobs and faucets).
Transportation for nonmedical needs	Transportation to obtain nonmedical items and services, such as for grocery shopping, banking, and transportation related to any other SSBCI, is a non–primarily health-related benefit. Such transportation may be reimbursed, arranged, or directly provided by an MA plan as a SSBCI.

Note: MA (Medicare Advantage), SSBCI (special supplemental benefit for the chronically ill). CMS provides MA plans with these examples of non–primarily health-related supplemental benefits (known as special supplemental benefits for the chronically ill, or SSBCI). This list is not exhaustive of the SSBCI that plans can offer. Plans participating in the MA Value-Based Insurance Design (MA-VBID) Model are granted additional flexibility to target non–primarily health-related supplemental benefits to enrollees on the basis of socioeconomic status (Centers for Medicare & Medicaid Services 2020b).

Source: MedPAC reproduction of CMS guidance documentation (Centers for Medicare & Medicaid Services 2019b). Descriptions of some benefits have been edited to remove detail not relevant to a general audience.

TABLE 2–A3

CPT and HCPCS codes for analysis of other supplemental benefits in 2021 MA encounter data (cont. next page)

Supplemental-benefit category	HCPCS and CPT codes (percentage of enrollees with an encounter record for the category who had an encounter record for that code)
Fitness benefit	S9970 (83%), S9451 (10%), A9300 (7%), 97170 (<1%), 97169 (<1%), 97005 (<1%), 97172 (<1%), 97171 (<1%)
Annual physical exam	G0439 (72%), 99397 (28%), G0438 (12%), 99396 (4%), 99387 (2%), 99401 (1%), 99386 (1%), 99395 (<1%), 99402 (<1%), 99385 (<1%), S0612 (<1%), 99429 (<1%), 99403 (<1%), 99404 (<1%), S0610 (<1%), S0613 (<1%), 99411 (<1%), 99412 (<1%), 99391 (<1%), 99394 (<1%), 99381 (<1%), 99393 (<1%), 99384 (<1%), 99392 (<1%), 99383 (<1%), 99382 (<1%)
OTC items	A9270 (77%), A6402 (7%), A6446 (5%), A4927 (4%), T4535 (3%), A6449 (2%), A9150 (2%), A4554 (2%), A6219 (2%), T4541 (2%), A4670 (1%), T4527 (1%), A6454 (1%), T4526 (1%), A6457 (1%), A6443 (1%), T4528 (1%), T4537 (1%), A4930 (1%), T4523 (1%), T4522 (1%), A6441 (1%), T4524 (<1%), A6220 (<1%), A6452 (<1%), A6450 (<1%), A6448 (<1%), A6445 (<1%), A6413 (<1%), A6403 (<1%), A6453 (<1%), T4544 (<1%), A6442 (<1%), T4543 (<1%), T4525 (<1%), A4553 (<1%), A6447 (<1%), T4540 (<1%), A9286 (<1%), A6455 (<1%), T4539 (<1%), T4521 (<1%), A6451 (<1%), A4928 (<1%), S5199 (<1%), A4663 (<1%), A6218 (<1%), A6221 (<1%), A6444 (<1%), T4542 (<1%), A9153 (<1%), A4660 (<1%), A4931 (<1%), A6404 (<1%), T4534 (<1%), T4536 (<1%), A9152 (<1%), T4533 (<1%), T4530 (<1%), T4529 (<1%), S0197 (<1%), T4532 (<1%), T4531 (<1%), T4538 (<1%), A9180 (<1%), T4545 (<1%)
Meals (limited basis)	S5170 (83%), S9977 (17%), S9433 (<1%), A0190 (<1%), A0210 (<1%), S9435 (<1%), S9434 (<1%)
Meals (beyond a limited basis) (SSBCI)	S5170 (73%), S9977 (29%), A0190 (<1%), S9433 (<1%)
Food and produce (SSBCI)	S5170 (96%), S9977 (5%), S9433 (<1%), A0190 (<1%), S9435 (<1%)
Transportation	A0425 (78%), A0427 (51%), A0429 (32%), A0428 (20%), A0100 (16%), P9604 (8%), P9603 (6%), A0426 (4%), A0130 (4%), T2003 (4%), A0110 (3%), A0398 (2%), A0422 (2%), A0999 (2%), A0382 (2%), S0215 (2%), A0998 (2%), A0120 (2%), A0433 (1%), A0170 (1%), S0209 (1%), A0434 (1%), A0431 (1%), A0436 (1%), T2005 (1%), A0380 (1%), A0394 (<1%), A0200 (<1%), A0420 (<1%), A0888 (<1%), A0090 (<1%), T2049 (<1%), A0080 (<1%), A0432 (<1%), A0392 (<1%), A0396 (<1%), T2007 (<1%), A0430 (<1%), A0160 (<1%), A0435 (<1%), A0424 (<1%), A0390 (<1%), T2001 (<1%), S0207 (<1%), A0384 (<1%), T2002 (<1%), T2004 (<1%), A0140 (<1%), A0180 (<1%), S9992 (<1%), A0190 (<1%), S0208 (<1%), A0210 (<1%), A0021 (<1%), A0225 (<1%)
Transportation for nonmedical needs (SSBCI)	A0425 (78%), A0427 (44%), A0429 (28%), A0100 (20%), A0428 (17%), P9604 (13%), A0110 (11%), A0130 (4%), P9603 (4%), A0426 (3%), A0380 (2%), T2003 (2%), A0999 (1%), T2005 (1%), A0422 (1%), A0998 (1%), S0209 (1%), A0433 (1%), S0215 (1%), A0382 (1%), A0120 (1%), A0434 (1%), A0398 (1%), A0431 (1%), A0436 (1%), T2049 (<1%), A0080 (<1%), A0394 (<1%), A0420 (<1%), A0888 (<1%), A0090 (<1%), A0424 (<1%), A0160 (<1%), A0396 (<1%), A0432 (<1%), A0170 (<1%), A0200 (<1%), A0392 (<1%), A0435 (<1%), A0430 (<1%), A0390 (<1%), T2007 (<1%), S0207 (<1%), A0190 (<1%), T2001 (<1%), A0140 (<1%), S9992 (<1%), T2002 (<1%), T2004 (<1%), A0021 (<1%), A0384 (<1%)
Acupuncture	97810 (72%), 97811 (48%), 97813 (37%), 97814 (29%), 20560 (1%), 20561 (1%),
Home and bathroom safety devices and modifications	E0143 (52%), E0156 (21%), E0163 (15%), E0240 (10%), E0244 (7%), E0246 (7%), E0100 (5%), E0248 (3%), E0135 (3%), E0105 (3%), E0149 (3%), E0185 (2%), E0700 (2%), E0730 (2%), E0627 (1%), E0247 (1%), E0165 (1%), E0245 (1%), E0168 (1%), E0277 (1%), E0159 (1%), E0184 (1%), E0271 (1%), E0154 (1%), E0155 (1%), E0241 (<1%), E0147 (<1%), E0305 (<1%), S5165 (<1%), E0148 (<1%), E0272 (<1%), E0189 (<1%), E0310 (<1%), E0720 (<1%), E0191 (<1%), E0188 (<1%), E0731 (<1%), E0325 (<1%), E0210 (<1%), E0190 (<1%), E0243 (<1%), E0141 (<1%), E0186 (<1%), E0158 (<1%), E0144 (<1%), E0167 (<1%), E0130 (<1%), E0275 (<1%), E0274 (<1%), E0199 (<1%), E0215 (<1%), E0153 (<1%), E0196 (<1%), E0197 (<1%), E0140 (<1%), E0203 (<1%), E0315 (<1%), E0157 (<1%), E0605 (<1%), E0276 (<1%), E0326 (<1%), E0205 (<1%), E0280 (<1%), E0629 (<1%), E0170 (<1%), E0273 (<1%)

TABLE 2–A3

CPT and HCPCS codes for analysis of other supplemental benefits in 2021 MA encounter data (cont.)

Supplemental-benefit category	HCPCS and CPT codes (percentage of enrollees with an encounter record for the category who had an encounter record for that code)
Structural home modifications (SSBCI)	E0246 (43%), E0241 (29%), E0243 (29%)
Personal emergency response system	S5161 (100%), S5160 (1%), S5162 (<1%)
Health education	98960 (52%), G0495 (25%), G0496 (8%), G0445 (5%), G0420 (4%), S9110 (3%), 99473 (1%), G0177 (1%), 99078 (1%), 98961 (1%), S9449 (1%), H0025 (1%), 98962 (<1%), S9446 (<1%), H2027 (<1%), S9441 (<1%), G0421 (<1%), S9445 (<1%), S9454 (<1%), H1010 (<1%), T1018 (<1%), S9443 (<1%), H1003 (<1%), T2013 (<1%), G9357 (<1%), S9436 (<1%), S9442 (<1%), S9444 (<1%), T1027 (<1%), T2012 (<1%)
Smoking and tobacco cessation	99406 (53%), 4004F (44%), 99407 (7%), 4000F (6%), 4001F (<1%), G9016 (<1%), D1320 (<1%), S4991 (<1%), S9453 (<1%), G0436 (<1%), S4990 (<1%), G0437 (<1%)
Nutrition/dietary counseling	97802 (71%), 97803 (36%), G0270 (10%), S9470 (6%), 97804 (2%), S9452 (1%), G0271 (<1%), D1310 (<1%), S9465 (<1%)
Wigs for chemotherapy hair loss	A9282 (100%)
In-home support service	S9131 (28%), S9123 (24%), S9129 (14%), T1019 (14%), T1030 (13%), S9500 (11%), S5125 (8%), S9122 (6%), S9501 (5%), S9127 (4%), S9502 (4%), S5131 (3%), S9128 (3%), S9343 (2%), S9124 (2%), T1031 (2%), S9328 (2%), S9342 (2%), S9374 (2%), T1001 (1%), S5498 (1%), S9494 (1%), S9379 (1%), S5116 (1%), S5102 (1%), T1028 (1%), S9338 (1%), S5135 (1%), S9503 (1%), S5501 (1%), S9542 (1%), S9366 (1%), S9348 (<1%), S5150 (<1%), S5130 (<1%), S9330 (<1%), T1005 (<1%), T1021 (<1%), S5502 (<1%), T1002 (<1%), S5517 (<1%), S9341 (<1%), T1004 (<1%), S5126 (<1%), S9490 (<1%), S9375 (<1%), S9373 (<1%), S9367 (<1%), S9504 (<1%), T2031 (<1%), T2030 (<1%), T1003 (<1%), S9097 (<1%), S9359 (<1%), S5105 (<1%), S9125 (<1%), T1020 (<1%), S9361 (<1%), S9363 (<1%), S9372 (<1%), S5109 (<1%), S9351 (<1%), S9365 (<1%), S5100 (<1%), S9340 (<1%), S5101 (<1%), S9347 (<1%), S5522 (<1%), S9346 (<1%), S5523 (<1%), S9364 (<1%), S5520 (<1%), S9529 (<1%), S9376 (<1%), S5521 (<1%), S9368 (<1%), T2033 (<1%), S5185 (<1%), S9370 (<1%), S9325 (<1%), S9326 (<1%), S9537 (<1%), S9590 (<1%), S5121 (<1%), S9329 (<1%), S5497 (<1%), S9331 (<1%), S9357 (<1%), T1000 (<1%), H0043 (<1%), S5110 (<1%), S5120 (<1%), S5136 (<1%), S9355 (<1%), S0271 (<1%), S5151 (<1%), S9212 (<1%), S9327 (<1%), S5111 (<1%), S5518 (<1%), S9214 (<1%), S9336 (<1%), S9339 (<1%), S9345 (<1%), S9353 (<1%), S9497 (<1%), S9560 (<1%), S9810 (<1%), T1022 (<1%)
Medical nutritional therapy	G0270 (98%), G0271 (4%)
Enhanced disease management	S9140 (75%), S0316 (7%), G2065 (7%), S0315 (4%), G2064 (4%), S0317 (2%), S0353 (2%), S0354 (1%), S0341 (1%), S0340 (<1%), S0311 (<1%), S9141 (<1%), S0280 (<1%), S0281 (<1%)

Note: CPT (Current Procedural Terminology), HCPCS (Healthcare Common Procedure Coding System), MA (Medicare Advantage), SSBCI (special supplemental benefits for the chronically ill), OTC (over the counter). Percentages may sum to more than 100 percent because an enrollee could have encounter records that use more than one of the relevant codes for the category. Codes for which we found no encounter records are not shown.

Source: MedPAC analysis of MA encounter data and interpretation of CMS descriptions of supplemental benefits (Centers for Medicare & Medicaid Services 2019b, Centers for Medicare & Medicaid Services 2018c, Centers for Medicare & Medicaid Services 2016).

Endnotes

1 These required services are referred to as "basic" services or "Medicare-covered" services, to distinguish them from the supplemental services that plans may provide that are not covered by traditional Medicare. We use the term "supplemental benefits" to refer to the full collection of additional benefits that MA plans may provide, following the term used in program guidance (42 CFR 422.102). These benefits are sometimes also referred to as "extra benefits" but should not be confused with the "supplemental" coverage that FFS beneficiaries can purchase through a Medigap plan.

2 Risk scores adjust a plan's base rate to account for differences in expected beneficiary medical costs by increasing a plan's payment rate for beneficiaries who are projected to have higher medical expenses and decreasing the payment rate for beneficiaries who are projected to have lower medical expenses.

3 Benchmarks are increased for plans with higher quality ratings.

4 In the rare circumstance where a plan's bid is above the benchmark (after both have been adjusted to reflect a person of average risk), the plan's base payment rate is set at the benchmark and enrollees must pay a premium (in addition to the usual Part B premium) equal to the difference.

5 Premiums for "optional" supplemental benefits that are not automatically included in the plan's benefit package were excluded from the study's calculations.

6 See the Commission's June 2023 report to the Congress for additional detail on the limits placed on MA plans' flexibility to use cost-sharing structures that differ from the cost-sharing rules used in FFS Medicare.

7 CMS calculates three types of limits using FFS spending data: A mandatory limit based on the 95th percentile of out-of-pocket FFS spending, a lower limit (known in earlier years as the voluntary limit) based on the 85th percentile of out-of-pocket FFS spending, and—starting in 2023—an intermediate limit. Plans have the flexibility to set their MOOP limit anywhere between $0 and the mandatory limit. CMS encourages plans to have more-generous limits by allowing plans that are at or below the intermediate limit to charge higher cost sharing for certain services.

8 Cost sharing for supplemental benefits must be below 100 percent of the cost of the item or service; that is, the plan must incur a nonzero direct cost associated with the benefit (Centers for Medicare & Medicaid Services 2016). Plans have the option of setting a service-specific maximum OOP limit for the non-Medicare services they cover as supplemental benefits.

9 Medicaid pays the Part B premium for most dually eligible beneficiaries.

10 The Part B premium for the preceding year is used as the limit because plan bids are due in June of the year preceding the benefit year, before the actual Part B premium for the upcoming benefit year is announced. In 2025, for example, the maximum Part B premium reduction was $174.70, equal to the Part B premium for 2024. In November, CMS announced that the Part B premium for 2025 would be $185.00, meaning that enrollees in plans offering the maximum premium reduction would owe a Part B premium of about $10 per month (Centers for Medicare & Medicaid Services 2024b, Centers for Medicare & Medicaid Services 2023a). Because the Part B premium generally increases from one year to the next, MA enrollees will typically owe some portion of the Part B premium, even in plans offering the maximum reduction. An additional implication of the limit is that MA enrollees will continue to be liable for the income-related portion of the premium and the Part B late-enrollment penalty (if applicable), regardless of any plan-provided premium reduction.

11 Plans participating in the VBID demonstration could target beneficiaries who receive Part D's low-income subsidy or who live in disadvantaged areas—as defined using the area deprivation index.

12 We estimate that Medicare will pay approximately $72 billion and $14 billion in rebates to nonemployer plans and employer plans, respectively, in 2025. Rebates paid to nonemployer plans were estimated using rebate amounts from MA bids and monthly enrollment data for nonemployer plans. Employer plans do not submit bids. Instead, starting in 2019, CMS began paying employer plans based on the bidding behavior of nonemployer plans in the prior year. Because employer plans are mostly preferred provider organizations (PPOs), their payment in 2025 largely reflects the average bidding behavior of nonemployer PPOs in 2024. We use employer-plan enrollment data for 2025 and apply 2025 employer-plan payment rates (adjusted to reflect recent employer-plan risk-score trends) to estimate Medicare's payments to employer plans. Rebates for employer plans are estimated using the same method CMS uses to determine employer-plan payment rates, in which the difference between the county-specific benchmark and base payment rate for employer plans (based on the average bid-to-benchmark ratio for

nonemployer plans in the payment quartile of the county) is multiplied by the plan-specific rebate percentage (based on the plan's star rating) and the risk score.

13 Title 42 USC 1395w-23 describes the rebate for plans "for which there are average per capita monthly savings described in Section 1395w–24(b)(3)(C) or 1395w–24(b)(4)(C)." Sections 1395w–24(b)(3)(C) and 42 USC 1395w–24(b)(4)(C) define "average per capita monthly savings" as the difference between the plan's risk-adjusted benchmark and bid.

14 We estimate that total rebate spending for 2025 will be $86 billion. Roughly 60 percent of Medicare payments to MA plans are made from the Part B Trust Fund, and beneficiary premiums finance roughly a quarter of Part B spending. Thus, roughly 15 percent (60 percent × 25 percent) of rebate spending is financed by beneficiary premiums. Roughly 15 percent of FFS enrollees are dually eligible and thus receive Part B premium assistance through Medicaid.

15 Because Part D premiums typically reflect some degree of administrative costs and profit for the Part D plan, some of the rebate dollars allocated to the reduction of Part D premiums is also devoted to administrative costs or profits, though more indirectly. No rebate dollars used to reduce Part B premiums can be apportioned for administrative costs or profit.

16 Across all nonemployer plans (i.e., conventional plans and SNPs) in 2025, plans allocated about $100 per member per month (PMPM) to provide non-Medicare services, $64 PMPM to reduce enrollees' cost sharing, $37 PMPM to make Part D enhancements and premium reductions, and $10 PMPM to reduce enrollees' Part B premiums.

17 Part D benefit enhancements include things like lowering Part D cost sharing or providing coverage of additional drugs. Using rebate dollars for such enhancements is sometimes described as a reduction in Part D supplemental premiums because the rebate enables the plan to offer the enhancements without a commensurate increase in beneficiary premiums.

18 In 2025, plans allocated more rebate dollars to Part B premium reductions than in previous years. This change is likely due primarily to changes to the structure of the Part D direct-subsidy amount, which may have resulted in plans overestimating the amount of Part C rebates needed for their target Part D premium. Part D–premium targets are initially calculated before plans know how much rebate funding they need to cover their target Part D premium (which is only known after Part D plans submit bids and CMS calculates the national average bid amount). After plans know how much they will need in rebates to cover their target Part D premium, plans reallocate their rebate to ensure that plan enrollees receive the full value of the rebate. However, CMS restricts changes in projected Part C margins that result from rebate allocations to an average of $1 per member per month. If an MA plan overestimated the amount of Part C rebates needed for their Part D premium, they would likely need to reallocate rebate funding from the Part D–premium buydown to the Part B–premium buydown, the only rebate-funded benefit for which plans do not receive a margin.

19 Plans' bid data must be certified by an actuary, they are subject to review and audit by CMS, and CMS requires that the base-period data match the MA organization's audited financial statements (Centers for Medicare & Medicaid Services 2023b). As such, they may be a reliable source of data for learning about utilization and spending in MA. However, because financial statements generally do not contain information about service use, the utilization rates reported in the data might not receive the same scrutiny and may not be as reliable as the report fields that describe the payments. We interviewed actuaries who prepare MA bids to learn more about the preparation of the data and gather their perspectives about the reliability of the data. They generally supported the view that the utilization rates reported in the bid data are a reasonable source of information about a plan's base-period experience because they are typically derived from the same claims data that are used to populate the payment fields; however, actuaries noted that different plans may use different methods to summarize and report utilization data.

20 Other factors can include sales and marketing expenses, administrative costs, reinsurance costs, and profit margin (Centers for Medicare & Medicaid Services 2023b).

21 In years prior to 2020, the bid pricing tool required plans to report the number of beneficiaries utilizing each category of service. However, CMS stopped collecting this information in 2020; as a result, the 2020 bids—reporting about use of services in 2018—are the last year of bid data that included this information.

22 Federal regulations require MA plans to submit encounter records for all items and services provided to enrollees (42 CFR Sec. 422.310(b)), including items and services provided through supplemental benefits; however, prior to 2024, CMS's Encounter Data Submission and Processing guidance limited that requirement to supplemental services for which the plan has sufficient data to populate an encounter record (Centers for Medicare & Medicaid Services 2025b).

23 In 2019, the Commission made a recommendation to improve the accuracy and completeness of MA encounter data that included the use of a payment withhold to give plans a

financial incentive to submit more accurate and complete data (Medicare Payment Advisory Commission 2019). That work focused on encounter data for Part A and Part B services but would apply equally well to encounter data for supplemental benefits.

24 Prior to 2024, the EDPS was configured to accept encounter records that used the 837–I and 837–P claims formats. A few MA plans have submitted dental encounter records using these formats. However, most dental claims are adjudicated using the 837–D format, which the EDPS was not configured to accept until 2024, and plans have reported not submitting dental records before that time (Centers for Medicare & Medicaid Services 2025b, Centers for Medicare & Medicaid Services 2024d, Government Accountability Office 2023).

25 The MLR is the minimum percentage of revenue that an insurer is required to spend on benefits for its members. An MLR requirement of 85 percent means that the insurer is required to spend at least 85 percent of its revenue on care for its enrollees and can use no more than 15 percent of its revenue for administrative costs and profit. MLR requirements for MA organizations are monitored at the contract level. The numerator of the MLR includes incurred expenses for members' medical claims, including both Medicare and non-Medicare services (i.e., basic and supplemental benefits).

26 CMS generally expects MA plans to use their rebate dollars to cover expenses associated with the cap on enrollees' OOP costs. In 2025, plans project that their liability for the OOP cap will be $14 per enrollee per month—equivalent to 7 percent of rebates and 1 percent of projected plan payments (Medicare Payment Advisory Commission 2025).

27 Medicare also does not have comprehensive data about the effect of Medigap coverage, or other forms of secondary insurance, on the cost sharing paid by beneficiaries in FFS Medicare. FFS claims data contain information about the total cost-sharing liability for FFS beneficiaries but not whether the beneficiary or another party made the payment.

28 The form CMS uses to collect encounter records includes fields that plans can use to report the amount they paid to providers as well as the enrollees' cost-sharing liability. The data collected in those fields are not included in the public versions of the encounter data available to researchers.

29 The allowed amounts shown in the table are derived from plan bids and may reflect other spending for the service category, such as spending related to risk-sharing arrangements between plans and providers, in addition to the negotiated payment rate.

30 For HMOs, the estimates are based on the cost-sharing amount charged for in-network services. For enrollees in preferred provider organizations (PPOs), the data reflect use of both in-network and out-of-network services; the difference between MA and FFS cost sharing for PPO enrollees may vary for in-network and out-of-network services.

31 The actuarially equivalent amount for cost sharing for professional services in FFS Medicare is not exactly 20 percent because of the Part B deductible and special cost-sharing rules for certain services (e.g., certain preventive services).

32 Plans can choose the unit of measure they use to report the data from a list of CMS-provided options. For example, roughly 90 percent of bids report the number of days of inpatient care for their members, while roughly 10 percent report the number of inpatient admissions. We included bids that used the most common unit for each category: days for inpatient and skilled nursing facility services; visits for home health care, outpatient, and professional services; trips for ambulance services; scripts for Part B drugs; and "other" for durable medical equipment.

33 Many plans that offer a RICS benefit that can be used on most Medicare-covered services do not allow the benefit to be used to pay cost sharing for home health services.

34 Plans can limit the RICS allowance that enrollees can access in a given period such as one year, six months, one month, or other. In 2025, most plans administer the RICS benefit using an annual or quarterly limit. We calculated the monthly limit for each plan by scaling the value of the benefit according to the time limit applied by each plan to calculate an annualized limit, then divided that figure by 12. For example, for a plan offering $100 of RICS per quarter, we would calculate an annualized RICS of $400 and a monthly limit of $33.

35 Some plans include more supplemental benefits in their benefit package than can be covered by the plan's rebate. Beneficiaries enrolling in those plans pay a premium to finance the portion of the supplemental benefits not covered by the rebate. Because our primary interest is in Medicare's spending for supplemental benefits, we estimate how much of the rebate is used to cover non-Medicare services and exclude amounts that are financed by enrollee premiums. The distribution of spending across non-Medicare service categories is based on plans' projections of all spending for non-Medicare services, inclusive of spending financed by enrollee premiums.

36 Determining exactly what services an MA plan covers can be challenging, and beneficiaries will likely need to examine a plan's marketing or member materials, or contact a plan

representative, to get an accurate picture. For example, when KFF tried to determine in 2021 whether a sample of 10 plans covered dentures (which are part of the "prosthodontics" category under comprehensive dental services), they had to examine each plan's Evidence of Coverage document, which describes all of the services covered by the plan and is often more than 200 pages long (Freed et al. 2021).

37 The literature review included peer-reviewed studies, gray literature, and government reports that examine interventions intended to address social risks and the impact those programs had on health outcomes, utilization, and/or health expenditures. The review focused on interventions that include older Americans or Medicare beneficiaries in the U.S. The final review included 33 articles that cover a mix of social needs and types of interventions. Ten organizations conducting programs to address HRSN in the older adult population were also selected to participate in structured interviews. The interviewees represented three health care plans offering MA products, a Medicare ACO, three integrated health care systems (one of which has several ACOs), two organizations taking part in the Center for Medicare and Medicaid Innovation's Accountable Health Communities model, and a state Medicaid agency.

38 The survey asked FFS beneficiaries and MA enrollees, "How important to you, if at all, is having access to extra benefits beyond doctor and hospital coverage?" (Commonwealth Fund 2025b).

39 See the Commission's June 2023 report to the Congress (Chapter 3) for an in-depth description of the variation in benefit design for MA supplemental benefits (Medicare Payment Advisory Commission 2023).

40 The study defined a "comprehensive dental benefit" as coverage that includes no coinsurance for preventive services, no prior authorization for preventive services, coverage of at least two dental cleanings per year, no referral required for preventive services, coverage of nonpreventive services, coverage of the full range of nonpreventive services (diagnostic, restorative, endodontic, periodontic, prosthodontic services, and extractions), a maximum annual benefit limit of no less than $1,500, a maximum average coinsurance of 30 percent for nonpreventive services, and no additional premium for preventive and nonpreventive services. The criteria were intended to define a dental benefit that "represents parity with employer-sponsored [dental] plans" and were developed based on literature reviews, the authors' expertise in the field of dental insurance, and consultation with government officials, academics, clinicians, and experts from the insurance industry.

41 Comprehensive data regarding FFS beneficiaries' use of dental services are also unavailable.

42 MA plans are allowed to vary premiums, cost sharing, and supplemental benefits across parts of a plan's service area, called "segments." Each segment consists of at least one county, and benefits, premiums, and cost sharing must be the same within each segment (Centers for Medicare & Medicaid Services 2018a). Accordingly, MA enrollees in one segment of a plan's service area may have access to different supplemental benefits than enrollees in another segment of the same plan. This variation is relatively rare, and most plans cover the same set of dental service categories across all plan segments.

43 Several studies have used proprietary claims data to report on MA enrollees' use of supplemental dental benefits, but it is unclear whether findings from those studies are representative patterns of use in MA overall. For example, a study by the actuarial firm Milliman analyzed 2018 claims for 1.9 million MA enrollees who were 65 or older and enrolled in plans that provided dental coverage as a mandatory benefit (meaning that the benefit was automatically included in the benefit package for all enrollees) (Wix and Fontana 2020). Roughly 8 million enrollees in 2018 were in conventional MA plans that offered some coverage of preventive dental services (Friedman and Yeh 2022). The study found that only 11 percent of enrollees had claims for preventive dental care (which the study defined as cleanings, oral exams, and periodontal cleanings) and another 1 percent had claims for some other type of dental care. The study did not indicate which dental services were covered by the unnamed MA insurer(s) that provided the claims data; the low utilization rates, especially for other types of dental care, could be because the plan(s) had limited coverage of those services. According to the study, low utilization could also have been due to enrollees being unaware of their plan's dental benefits or enrollees finding that their dentist did not participate in the plan's provider network. A later study, also by Milliman, reported that year-over-year rates of dental utilization in MA rose in 2022 and 2023, but the study did not report percentages for how many enrollees used dental services in those years (Wix and Fontana 2024). The study found that more than two-thirds of dental claims were for preventive services (e.g., oral exams and X-rays). The authors hypothesized that rising utilization rates could be related to plans covering a wider set of services over time, easing of benefit limits (e.g., limitations on how many visits are covered per year or how much the plan will spend for any given enrollee), an increase in the number dentists participating in MA dental networks, improved awareness by MA enrollees about dental benefits, and pent-up demand following the coronavirus pandemic.

44 MA network-adequacy requirements do not apply to supplemental benefits.

45 The MCBS, the MEPS, and the National Health Interview Survey (NHIS) ask respondents about their access to dental care. The MCBS asks respondents if there was ever a time in the last year in which they could not receive needed dental care and, if so, what the reasons were for not getting the care. For survey years 2010 through 2017, the MEPS respondents were asked if they delayed any necessary dental care in the past year; for 2018 through 2021, respondents were asked if they delayed any dental care in the past year due to cost. The NHIS also asks about delaying care due to cost. The studies use different methods to define cost-related access problems. Some studies define "cost" as the respondent endorsing that "could not afford the cost" was a reason they could not get dental care. Other studies also include "didn't want to spend the money" and "insurance did not cover [the] recommended procedures" in the definition.

46 These groups of enrollees were also more likely to enroll in plans offering supplemental vision benefits (Gupta et al. 2024b). Although White Medicare beneficiaries were more likely to have some form of private dental coverage, White beneficiaries were more likely overall to have no dental coverage due to a large share of Black and Hispanic beneficiaries having some amount of dental coverage through Medicaid or MA (Centers for Medicare & Medicaid Services 2021b).

47 We categorized the following responses as being cost related: "could not afford the cost," "insurance did not cover the recommended procedures," and "did not want to spend the money." We did not count responses as being cost related if the respondent endorsed that they did not receive the care because they "did not think anything serious was wrong/expected dental problems to go away."

48 Milliman's analysis showed that in 2021, 37 percent of conventional MA plans offered comprehensive dental coverage as an optional supplemental benefit, and 28 percent offered optional preventive dental benefits. More than 95 percent of plans that offered any optional supplemental benefits offered optional comprehensive dental benefits. The share of plans offering optional preventive dental benefits has decreased over time as more plans include those as mandatory supplemental benefits.

49 Many plans provide a "dental-only" combination benefit that includes only dental services up to a plan-specified spending limit. Consistent with other analyses of MA plan benefit offerings, we exclude dental-only combination benefits in our summary of combination benefits (Yeh and Yen 2024).

50 We estimate the annualized limit for each plan by scaling the value of the benefit according to the time and dollar limits applied by each plan. For example, for a plan using a limit of $100 per quarter, we would calculate an annualized limit of $400.

51 CMS guidance documents state that food and produce—including but not limited to produce, frozen foods, and canned goods—may be provided as SSBCI to assist chronically ill enrollees in meeting nutritional needs; tobacco and alcohol are not permitted under the benefit (Centers for Medicare & Medicaid Services 2019b).

52 The propensity score used in the analysis included age; sex; race/ethnicity; CMS-HCC risk score; dual-eligibility status; residence in a rural area or primary care provider shortage area (from the Department of Health and Human Services' Area Health Resources Files) and/or a food desert (defined using the U.S. Department of Agriculture's Food Access Research Atlas); and a neighborhood-level measure of socioeconomic disadvantage.

53 A second shortcoming of using HCC risk scores to control for acuity in studies measuring health care utilization is that CMS's HCC risk scores are designed to capture differences in health care spending, not utilization. The study did not assess whether the HCC risk scores are correlated with use of the services analyzed in the study.

54 We found that both UnitedHealthcare and Humana also partner with other independent companies to administer the benefits for some of their plans (Humana 2025, United Healthcare 2025c).

55 The organizations included in our review were Alignment Healthcare USA, Banner Health, Blue Cross Blue Shield of Michigan, Blue Cross and Blue Shield of North Carolina, California Physicians' Service, Cambia Health Solutions, Capital Blue Cross, CareFirst, Centene, Cigna Group, Clover Health, CVS Health, Devoted Health, Elevance Health, Henry Ford Health System, Highmark Health, Horizon Mutual Holdings, Humana, Intermountain Health Care, Kaiser Foundation Health Plan, Marshfield Clinic Health System, Risant Health, SCAN Group, United Healthcare, UPMC Health System, and Trinity Health Plan.

56 One analysis of the dental insurance market showed that some of the parent organizations that offer MA plans may also offer dental plans, which suggests that the companies have the capacity to administer the benefits internally (Vujicic et al. 2018).

57 CMS defines CBOs as "public or private not-for-profit entities that provide specific services to the community, or targeted populations in the community, to address the health and social needs of those populations. They may include community-action agencies, housing agencies, area agencies on aging, centers for independent living, aging and disability

resource centers, or other nonprofits that apply for grants to perform social services" (Centers for Medicare & Medicaid Services 2024f).

58 The survey found that 47 percent of CBOs in 2023 contracted with at least one health care entity (up from 38 percent in 2017) (Kunkel and Lackmeyer 2024). Medicaid managed care plans were the most common type of partnership among the surveyed organizations, followed by state Medicaid agencies, hospital or health systems, the Veterans Administration, commercial insurers, and then MAOs. On average, the surveyed CBOs reported having three to four active contracts with health care entities.

59 MA coordinated-care plans are required to "ensure continuity of care and integration of services through arrangements with contracted providers that include . . . [p]rograms for coordination of plan services with community and social services generally available through contracting or noncontracting providers in the area served by the MA plan, including nursing home and community-based services, and behavioral health services" (42 CFR Sec. 422.112(b)).

60 CMS uses a 5-star rating system to characterize MA plan performance (Medicare Payment Advisory Commission 2025). Star ratings are based on measures tied to clinical quality, administrative capability, and patient experience. Medicare currently collects close to 100 MA quality measures, over 40 of which are used to determine a star rating from 1 to 5 for each MA contract. These ratings are made available through the Medicare Plan Finder website to enable beneficiaries to compare across plans. Since 2012, the MA star-rating system has been the basis of the MA quality-bonus program, which increases benchmarks for MA contracts rated 4 stars or higher. The star rating also contributes to the level of rebate payments. Plans with higher star ratings retain a higher share of the difference between a plan bid and the benchmark when bids are below the benchmark.

61 "HEI" refers to the Health Equity Index, which CMS developed to encourage plans to address health disparities. The HEI is scheduled to be incorporated into 2027 MA star ratings (Centers for Medicare & Medicaid Services 2023d). In 2025, CMS announced that it plans to update the HEI reward to call it the Excellent Health Outcomes for All (EHO4all) reward (Centers for Medicare & Medicaid Services 2025c).

62 Health risk assessments are provided to Medicare beneficiaries as part of an annual wellness visit, and, for MA enrollees, health risk assessments are often provided during a plan-initiated home visit. The Commission has previously identified health risk assessments and in-home visits as mechanisms by which MA plans record more diagnoses for their members, thereby increasing risk scores and payments from Medicare (Medicare Payment Advisory Commission 2025). The Commission has previously shown that health risk assessments are often used to identify diagnosis codes that are not documented on subsequent encounters with providers. For example, for 2023, we found that diagnoses identified only through health risk assessments accounted for $15 billion in payments to MA plans, or a little more than 3 percent of all payments to MA plans. About 80 percent of these payments were from health risk assessments conducted as part of an annual wellness visit or initial preventive physical examination, while the rest of these payments were from in-home health risk assessments. The Commission has previously reported that chart reviews and health risk assessments are opportunities to record diagnoses for MA enrollees that are not available in FFS Medicare; additional interactions with members through supplemental benefits may be another such factor.

63 "Star Gap measures" is a reference to the MA star-rating system and plans' efforts to increase MA enrollees' use of services that affect the plans' star ratings by closing "gaps" between the observed and plan-targeted level of utilization for those services.

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