

# Advancing Non-Medical Supplemental Benefits in Medicare Advantage Frequently Asked Questions *April 2021*

Learn more about SSBCI and other non-medical supplemental benefits at <https://atiadvisory.com/advancing-non-medical-supplemental-benefits-in-medicare-advantage/>.

These questions originated from an event with the Long-Term Care Discussion Group in December 2020. ATI and LTQA will update this document as more questions surface.

## Overview and Methods of Plans Offering Non-Medical Supplemental Benefits

### **1. How many MA plans are there? What percent have Special Supplemental Benefits for the Chronically Ill (SSBCI) benefits?**

#### *Methods*

There are 6,219 plans in 2021, excluding Prescription Drug Plans (PDP), Medicare-Medicaid Plans (MMP), Part B-only plans, and PACE. For 2020, using this method, there were 5,604 plans. 2020 and 2021 analyses detailed below include employer plans, however, excluding these plans, there are 4,350 plans in 2020 and 4,911 plans in 2021.

#### *Prevalence of SSBCI*

For 2020, using the exclusions noted above, 4.8% percent of plans, including employer plans, offered any SSBCI. For 2021, we saw a four-fold increase in the number of plans choosing to offer SSBCI up to 15.1%. Excluding employer plans, these numbers change to 6.1% of plans offering SSBCI in 2020 and 18.9% of plans in 2021.

#### *Prevalence in Special Needs Plans (SNPs)*

Data reveal that SNPs are offering these benefits at higher rates than non-SNP plans. In 2021, 29.1% of SNPs were offering at least one SSBCI compared to 12.4% of non-SNPs. Dual-Eligible Special Needs Plans (D-SNPs) are the most likely to offer SSBCI with 207 plans, or 33.0% of all D-SNPs, offering an SSBCI in 2021.

### **2. Do we know if the plans that are offering this are fully integrated?**

Of the 207 D-SNPs offering an SSBCI, 84 (40.6%) are HIDE-SNPs and 25 (12.1%) are FIDE-SNPs. Alternatively, 98 D-SNPs (47.3%) are coordination-only plans and do not have a contract with the state that includes any sort of behavioral health services or long-term services and supports. Out of 627 total D-SNPs in 2021, 210 (33.5%) are HIDE-SNPs, 69 (11.0%) are FIDE-SNPs, and 348 (55.5%) are coordination-only plans.

**Details on Specific Supplemental Benefits**

**1. What types of personal care services are being offered and what is the extent of these benefits (e.g., short-term post-hospital vs. longer-term benefits)?**

While in-home supports and personal care services are now available in Medicare Advantage through supplemental benefits, these services are not as extensive as the services provided in Medicaid and are shorter-term in nature. These supplemental benefits allow for services to help with ADLs (e.g., light housekeeping, transferring, etc.).

In 2020, 52.5 percent of MA plans offering this benefit limited services to 24 total hours, or fewer, per year or hospital discharge. A little less than a third of these plans offered 60 hours or more of benefits, with the highest offering at 248 hours a year, although this was only available in 2 plans.

**2. What do family caregiver supports include? Any insight into why the number of plans offering caregiver supports dropped in 2021 compared to 2020?**

Based on Internet and desktop research, caregiver supports can include a wide variety of services. It can range, for example, from a call-in support line, to respite care, to caregiver training and educational resources.

There were 125 plans offering caregiver supports in 2020 and, in 2021, 95 plans are offering this benefit. While this number decreased by 30 plans, this likely does not reflect an ongoing trend. The decrease in 2021 appears to be, in part, due to two major insurers choosing to reduce the number of plans in which they will be offering a caregiver support call-in line. Additionally, while the number of individual plans choosing to offer this benefit has decreased, the number of Medicare Advantage Organizations offering this benefit increased.

**3. Do you think increases in in-home health care benefits will continue to significantly increase post-pandemic?**

In-home care benefits are likely to increase post-pandemic, although people are still learning what this benefit means in Medicare. This benefit can be confusing to enrollees since it is not home health or the in-home medical benefit people are more familiar with. These benefits include a mix of services offered post-hospitalization as well as services offered to those who need it throughout the course of the year. We expect to see the number of plans offering this benefit continue to grow so long as plans and providers can work through contracting and logistic hurdles.

While Plan Year 2020, even going into Plan Year 2021, has been challenging for the healthcare ecosystem because of the COVID-19 public health emergency, this event has underlined the importance of care and services delivered in the home. As such, we believe that plans will not simply dissolve services they have provided in the home during the pandemic, but rather, continue to build on these offerings as care shifts into the home.

**4. Are any MA plans targeting/considering/addressing chronic pain or opioid use disorder using these new benefits?**

There is a specific filed benefit related to non-opioid pain relief: therapeutic massage. We have seen a decrease in therapeutic massage benefits probably, in large part, due to COVID-19. Additional detail is included in the question below. Moreover, there are other supplemental benefit categories not included in our data that may also address these issues.

**5. Any ideas why massage therapy dropped?**

A significant contribution to the decrease in message therapy appears to be through one major insurer choosing to reduce the number of plans where they are offering this benefit. It seems likely that there was less interest in this benefit due to the in-person nature of the service during the COVID-19 pandemic. It will be important to track what happens for this benefit category in Plan Years 2022 and 2023.

**Using Data to Drive Plan Decisions on Benefits**

**1. When engaging health plans, you have suggested being prepared to show data. Do you have examples of data used? What convinced decision makers who were initially skeptical?**

If a provider can demonstrate data showing direct effects on medical expenditures (e.g., reduced hospitalizations, reduced ER utilization, etc.), that is optimal. However, this can be very difficult to prove. Data on consumer satisfaction are also valuable, for example, data that demonstrate to plans that individuals who use your services are highly satisfied, likely to recommend your services to others, and that they tend to be loyal customers. Importantly, plans really want reliable, high-quality partners so any data on service delivery (e.g., time of first contact following referral, ability to track and identify patient change in condition, etc.) can also be of value.

**2. What insight do we have about how plans are deciding which specific SSBCI to offer to which members? Are they using any "science" to determine how a service will translate into health or cost improvements? Can there be any incentives for plans to do so?**

There is no one-size-fits all approach to deciding which SSBCI to offer. SSBCI are viewed as a market differentiator in a competitive market. There is absolutely an incentive to include benefits that translate into health and cost improvements as savings in healthcare costs accrue to the plan, though it often takes some time for these savings to accumulate.

Plans consider a wide range of questions when deciding whether to offer SSBCI including what benefits are attractive to enrollees, who should be eligible for specific benefits, what can help to reduce healthcare utilization and improve health outcomes, what can the plan afford, what was in the benefit package last year, and what competitors are offering, to name a few.

**Policy and Financial Considerations**

**1. In a D-SNP, how would supplemental benefits be coordinated with Medicaid LTC benefits?**

All D-SNPs are legally required to coordinate the delivery of Medicaid benefits, regardless of whether the D-SNP is at risk for Medicaid benefits. Additionally, because Medicare Advantage supplemental benefit dollars are limited, D-SNP supplemental benefits can complement, but should not be used to replace, the Medicaid benefits enrollees receive. As an example, one integrated D-SNP identified transportation as a challenge through their Medicaid transportation provider and sought to offer more flexible transportation options through SSBCI, in complement to the state’s benefit. Additionally, some states work with their D-SNPs as part of the annual benefit design to maximize the likelihood that D-SNP benefits complement the state’s vision.

**2. Is it in the plans' interest to advertise and work towards higher uptake of these benefits given the PMPM pay structure?**

Plans want members to use these benefits; they invest significant resources designing benefits, pricing the services, and building a network for benefit provision with the goal of providing benefits that members find valuable and use. In fact, plans design their bids based on a certain amount of uptake of these benefits and are at risk of falling below their Medical Loss Ratio (MLR) requirement if that level of uptake is not met. If plans fall below the MLR requirement, they can owe funds back to the government.

**3. Can plans that want to provide in excess of their rebate dollars either charge subscribers extra for these benefits or if they find that certain ones would save money, give them away for free or is that considered a kickback?**

Plans can finance supplemental benefits via premiums in addition to financing them via rebate dollars. The cost of providing the benefit, including if savings can be included, is determined by the actuaries who price the bid.

**4. As you know, being limited to MA plans' discretion means different benefits are available depending on the MA plan you are in, and anyone with original Medicare cannot access these benefits at all. Has the Biden Administration taken a position on expanding these benefits or making other changes?**

The administration has not taken a position on expanding these benefits in Medicare. The current administration has include a significant investment in expanding HCBS in Medicaid and supporting caregivers as part of the [American Jobs Plan](#). The Biden campaign also proposed creating a LTSS Innovation Fund to be housed in CMMI.

*Supported by a grant from The SCAN Foundation - advancing a coordinated and easily navigated system of high-quality services for older adults that preserve dignity and independence. For more information, visit [www.TheSCANFoundation.org](http://www.TheSCANFoundation.org).*