Medicare Advantage Enrollees Weigh In:

4 Recommendations to Improve Supplemental Benefits

By Ciannah Correa, Matthew Fox, and Carrie Graham

Medicare Policy Initiative
Center on Health Insurance Reforms
Georgetown University

July 2026

Table of Contents

Medicare Advantage Enrollees Weigh In:
Four Recommendations to Improve Supplemental Benefits

Executive Summary

Medicare Advantage (MA) plans can offer supplemental benefits that are not included in traditional Medicare, such as dental, vision, and hearing coverage, as well as over-the-counter (OTC) allowances, among others. Supplemental benefits are one of the most heavily marketed features of MA plans and a strong driver of MA enrollment. While these supplemental benefits are highly valued by MA enrollees, they are also a growing financial investment for both the federal government and Medicare beneficiaries. They are partially funded through the Part B premiums paid by all Medicare beneficiaries, including those in traditional Medicare who cannot receive them. However, there is little public information on how many enrollees receive these benefits, or whether they actually improve health outcomes.

To better understand enrollees' perspectives, the Medicare Policy Initiative (MPI) at Georgetown University convened the second session of its Medicare Advantage Enrollee Advisory Group (AG) in April 2026. The AG includes 17 MA enrollees from eight states with diverse backgrounds and health needs. In this session, participants shared their experiences evaluating supplemental benefit offerings, accessing benefits once enrolled, and navigating benefit limitations.

Overall, AG members expressed strong appreciation for supplemental benefits and viewed them as an important source of financial support and access to care. Dental coverage and OTC allowances were particularly valued by participants for helping to meet everyday health needs and reduce out-of-pocket costs. Most reported that supplemental benefits influenced their plan selection decisions and helped them manage expenses on fixed incomes.

However, many participants described the process of comparing supplemental benefits across plans as confusing and burdensome, because benefits vary in scope, eligibility requirements, geographic availability, cost sharing, and in-network provider capacity. AG members reported difficulty determining what was actually covered prior to enrollment as well as frustration with reductions in the scope and generosity of benefits from one year to the next. Others described challenges finding in-network providers for dental, vision, and hearing services, as well as concerns that certain OTC benefits were difficult to use or delivered less value than advertised because of restrictions on where covered goods could be purchased.

Based on these experiences, AG members identified four priorities for policymakers seeking to improve supplemental benefits in Medicare Advantage:

1. **Simplify and standardize supplemental benefit offerings.** Create standardized packages (and definitions) of supplemental benefits (e.g., "low," "standard," and "high" tiers) to increase comparability and beneficiary confidence in plan offerings.
2. **Protect enrollees from large fluctuations in benefit value.** Establish a cap on year-over-year benefit changes to provide greater financial stability and help beneficiaries avoid unexpected costs.
3. **Improve access to providers that deliver supplemental benefits.** Create network adequacy standards, accurate provider directories, and improved continuity of care to help ensure that advertised benefits are actually usable.
4. **Strengthen oversight of OTC benefit delivery models.** Require OTC allowances to be useable at physical as well as online retailers so that enrollees can shop for the best prices for covered goods.

Introduction

On April 16, 2026, the Medicare Policy Initiative (MPI) at Georgetown University convened the second session of the Medicare Advantage (MA) Enrollee Advisory Group (AG), with the discussion focused on supplemental benefits in MA. The purpose of the AG is to elevate the perspectives and lived experiences of MA enrollees—who are the foremost experts on the program—to inform MA policy. This group was convened with the support of The SCAN Foundation.

The AG is composed of 17 MA enrollees representing eight states. The group includes a range of ages, health statuses, education levels, and socioeconomic backgrounds. All AG members are currently enrolled in conventional MA plans,* with 13 in plans from large national insurance carriers, and four in smaller or regional plans. Most (11) AG members reported incomes below 138% of the Federal Poverty Level (FPL), and the remaining six reported incomes between 138–400% of the FPL. The first AG convening was on the topic of MA enrollment and plan choice.

The goal of the second convening was to learn specifically about MA enrollees' experiences with certain supplemental benefits they receive through their MA plans—i.e., benefits not covered in traditional fee-for-service (FFS) Medicare such as dental, vision, hearing, over-the-counter benefits, etc.—and to glean their recommendations for policymakers on ways to improve the transparency and accessibility of those services.

This policy brief summarizes the themes from both the group convening and individual telephone interviews, including AG members' experiences researching MA supplemental benefits during open enrollment and accessing those services, as well as their suggestions for policymakers to improve the transparency, accessibility, and simplicity of supplemental benefits.

Background

What Are Supplemental Benefits?

MA plans may offer supplemental benefits that are not covered under traditional Medicare, such as dental, vision, and hearing coverage, as well as over-the-counter (OTC) allowances and other health-related services. While supplemental benefits have historically focused on dental, vision, and hearing coverage, beginning in 2017, various laws, the Centers for Medicare and Medicaid Services' (CMS) regulatory guidance, and a CMS demonstration project expanded the definition of "health-related benefits" to include those that address "health-related social needs" for enrollees with certain chronic conditions. As a result, MA plans may now offer a wide range of services as supplemental benefits, including transportation assistance, meal benefits, utility assistance, and caregiver support, among others.

Supplemental Benefits Vary Widely Across Plans

MA plans have significant flexibility in designing supplemental benefit packages: they determine which benefits to offer, who is eligible to receive them, the scope of coverage, cost-sharing requirements, provider networks, and how benefits are accessed. For example, plans may differ in the amount of dental coverage provided, the value and allowable uses of OTC benefits, or eligibility requirements for transportation and other special supplemental benefits. As a result, benefits that appear similar on paper can differ substantially in generosity, accessibility, and usability.

* To be eligible for the AG, individuals needed to be currently enrolled in a "conventional" Medicare Advantage plan. We excluded people who were dually eligible for Medicare and Medicaid, as well as those in MA Special Needs Plans (SNPs) and PACE programs.

Comparing Supplemental Benefits Can Be Challenging

The majority of MA advertisements tout supplemental benefit offerings. During open enrollment, beneficiaries must compare not only premiums and provider networks, but also differences in supplemental benefits, coverage limits, costs, and eligibility requirements. Beneficiaries may rely on resources such as the online Medicare Plan Finder, the "Medicare and You" handbook, third-party brokers and agents, and volunteer counselors through the State Health Insurance Assistance Program (SHIP). For the roughly one-third of Medicare beneficiaries who actively shop for coverage during open enrollment, comparing supplemental benefits can be particularly challenging because information is often presented inconsistently across plans and may not fully convey the scope of coverage or ease of access.

The Cost and Impact of Supplemental Benefits

Supplemental benefits have become an increasingly prominent feature of MA plans, but also an increasingly expensive one for the federal government, for Medicare beneficiaries, and for MA plans themselves. In 2025, the federal government spent roughly $86 billion on rebates—which fund supplemental benefits—to MA plans compared to just $21 billion in 2018.

All Medicare beneficiaries, including those enrolled in traditional Medicare, pay for the supplemental benefits provided to MA enrollees. This is because the aforementioned rebates are financed in part through the monthly Medicare Part B premiums paid by all Medicare beneficiaries. In 2025, Medicare beneficiaries were estimated to pay approximately $13 billion in additional Part B premiums associated with MA rebate payments, including nearly $6 billion paid by beneficiaries enrolled in traditional Medicare.

MA plans' projected spending on supplemental benefits has increased from approximately $75 per member per month in 2014 to $194 in 2024. At the same time, recent data suggest this growth may be slowing, with fewer plans offering certain benefits such as OTC allowances, meals, transportation services, and remote access technologies in 2026 compared to 2025.

Despite the growing investment in supplemental benefits, little public information is available about their utilization, quality, spending, or impact on health outcomes. While CMS has begun collecting additional data, they are not yet publicly available. As a result, policymakers, researchers, and beneficiaries have limited information about how these benefits are used and whether supplemental benefits result in better health and financial security for enrollees.

Medicare Advantage Enrollee Recommendations to Improve Supplemental Benefits

Most AG members said they generally appreciated the supplemental benefits offered by their MA plan, and the majority believed that these benefits have saved them money and helped them take care of their health. Several AG members with lower incomes viewed these benefits as critical to their economic security. Most also said that supplemental benefit offerings influenced their choice of MA plan and that they were featured prominently in MA marketing materials. OTC allowances and dental coverage were the most highly valued of all the supplemental benefits on offer.

That said, AG members also reported problems with benefit transparency and hurdles to using the full value of marketed benefits, among other challenges. Below, we identify several recommendations to make changes to MA consistent with the concerns and suggestions shared by AG members.

ADVISORY GROUP RECOMMENDATION 1:

Simplify supplemental benefit offerings by standardizing benefit packages and benefit definitions.

"If there's one thing I'd like to tell the policymakers to do it's just to standardize the [supplemental benefit offerings]... I personally would prefer to know what I'm getting." – "Charles"

MA enrollee experiences that informed Recommendation #1

The complexity and variability of supplemental benefit offerings across plans options was a primary frustration for AG members. For example, differences in scope of coverage for supplemental benefits (e.g., dental benefits that cover only routine cleanings vs. those that cover dentures) were not always clear in marketing materials and were difficult to decipher using the tools available. In a previous AG convening, members reported that assessing differences across a multitude of different plan offerings required significant time and effort—including reviewing materials from a variety of sources and consulting with multiple insurance agents.

For some, the lack of transparency in supplemental benefits offerings led to surprise out-of-pocket costs. One AG member described how she chose an MA plan with dental coverage, only to learn at the dentist's office that the coverage was not as generous as she thought it was, resulting in a large, unexpected bill.

> *"When I called to re-enroll, I changed plans to one that would have dental. I was able to get some [dental] work done, but it was only the cleaning they paid for. The other work that I had to get done, [the MA plan only paid] 50%, and that doesn't go very far for the work that I needed to have done."* – "Renee"

Many AG members also questioned the fairness of geographic differences in supplemental benefit offerings and costs. Because supplemental benefits' funding is tied to geographic spending in traditional Medicare and yearly quality ratings, people in different counties can be offered plans with different benefits and cost-sharing requirements. Several members expressed that those offerings should be standardized across geographies.

"Why [do we] have a $500 deductible in one state, and a zero deductible in another state is my question." – "Charles"

"I think it's very confusing, that when I've looked in Medicare [and] You, and... you can be in one county, and your benefits are… different [within] the state, not just state to state, but location to location. And I find that very confusing, and I would like to know why." – "Mabel"

"I have to agree with everybody that it should be more even across the board, okay? I have a stent in my heart, so they call that a chronic condition, and I get $130 a month. Now, why isn't it the same for every state? Because of the insurance company?" – "Larena"

Example Policy Options*

- Standardize supplemental benefit offerings by creating either 1) standardized tiers within each type of supplemental benefit (e.g., "low," "standard," or "high" dental or OTC benefit options); or 2) defined packages of various supplemental benefits similar to standardized Medigap policies or Affordable Care Act plans.
- Introduce "meaningful difference" standards for supplemental benefits to prevent plan sponsors from offering multiple plans in the same county with only slight differences in supplemental benefits offerings.
- Improve the Medicare Plan Finder comparison feature and require MA marketing materials to clearly present the scope and cost for each supplemental benefit offered.

Considerations and Tradeoffs

Standardizing supplemental benefits could limit insurers' flexibility, potentially prompting MA plans to offer fewer supplemental benefits or cluster their offerings in lower, less generous tiers. Furthermore, "meaningful difference" guidelines and standardized benefit tiers are complicated to define and would require a substantial upgrade to CMS comparison tools.

* The policy options described in this brief are generally derived from existing policy proposals and are listed primarily because of the direct relation to addressing AG members' vocalized recommendations and sentiments. Policies are not necessarily endorsed by MPI or the SCAN Foundation.

ADVISORY GROUP RECOMMENDATION 2:

Protect enrollees from unpredictable, year-over-year reductions in supplemental benefit value and scope.

"It's not fair for these insurance companies to... give you a higher amount in the beginning, and then keep knocking it down so much every year." – "Larena"

MA enrollee experiences that informed Recommendation #2

Over half of AG members described how their supplemental benefits had decreased in scope or value over the last few years.

"I've been in that plan for three years, and it started off at $150 per quarter, and then the next year was $90. And this year […] I think it's $50 a quarter, so every year it's dwindled." – "Mabel"

"I've been retired for five years, and I know that [OTC benefit has] been gradually declining in almost every plan. And this one's pretty low for me. I think it's $50 a quarter. I mean, that's pretty low." – "Brian"

Several AG members reported that supplemental benefits were not keeping up with the realities of inflation, affordability, and the higher cost of living—leaving them financially vulnerable.

"So, if they say the cost of living is going up 30%, but we're only gonna increase the benefits by 15%, then hey, we're in the backseat to start with… We're worse off this year than ever before. And I'd like to see Congress, or the insurance companies, or whoever makes the decisions to try to help our benefits keep up with the cost of living better." – "Esme"

Some AG members described having to make hard choices between plans that have critical supplemental benefits versus networks that include their preferred medical providers. One AG member described how she switched plans for dental coverage knowing she would lose access to her hospital, only to find her primary care doctor was also no longer in network.

"One other [AG member] mentioned that her primary care was no longer in network, and the same thing happened to me [after changing plans to keep dental coverage this year]. Right now, the only hospital in my area is not in network, and I would have to go out of my local area if I needed to have inpatient care, or lab work, or any auxiliary services… So, I have to hope not to get sick, basically."
– "Rose"

Some members worried that reductions in dental, vision and hearing services undermined preventive care and could lead to long-term, costlier health problems. As two AG members put it:

> *"Dental health is closely linked to cardiovascular health, high blood pressure, and heart disease. Poor vision is linked to greater instances, higher percentages of dementia. Which we know how expensive that care is. So, these types of things, they don't want to pay now, but the population is aging and living longer. It's much more expensive to care for people with these more advanced diseases than put in the money for the preventive care up front and just bite the bullet and do it. It has to happen, or else we're all just saying, 'okay, we're just willing to die younger, that's fine, and the span of life that we do have, the quality is not going to be there that we could have.'"* – "Marge"

> *"This removal of preventive, medical, dental, visual [care], on the people who are of modest income, or below, is extremely unwise, and will lead to higher costs."* – "Nicholas"

One AG member with a specific chronic condition reported that her MA plan stopped offering dental benefits, putting her at high risk for cardiovascular disease.

> *"This year, [my plan] completely went and did away with [dental benefits]…[My dentists] recommend that I go four times a year for cleanings to help keep up with [my chronic cardiovascular condition]. I can't afford it. I pay out of pocket the entire fee, and I try and go at least twice a year. But I just got a crown done, in January, and that was about $3,000 out of pocket."* – "Marge"

Some AG members felt that MA plans' supplemental benefits offerings were influenced more by profitability than by the health and quality of life of enrollees.

> *"Every year the over-the-counter benefits have been decreasing and decreasing, and now it is down to $50 a quarter, which is basically less than a dollar a day. You know, those kinds of decisions which basically benefit the insurance companies and their profitability."* – "Charles"

Example Policy Options

- Establish a limit to how much supplemental benefits can fluctuate in value from one year to the next, similar to the Part D demonstration.
- Offer options for multi-year enrollment in MA plans to improve enrollment predictability for MA plans and allow for more stable benefit offerings for enrollees.

Considerations and Tradeoffs

Restricting plans' year-over-year flexibility in benefit offerings introduces the risk that MA plans may offer benefit packages that are less generous in exchange for increased stability. Moreover, policymakers would have to carefully decide what constitutes a "significant" change to supplemental benefit packages, and how much annual fluctuation in benefits is acceptable. On the other hand, multi-year enrollment plans may limit consumer choice and restrict freedom to change plans annually if enrollees are unsatisfied, unless such a policy is paired with more flexibility in Special Enrollment Periods.

ADVISORY GROUP RECOMMENDATION 3:

Establish network adequacy and provider directory accuracy requirements for supplemental benefit providers.

"I think, if they're gonna change [network coverage] after we sign up for a program, they should change it in the enrollment period, so we can look at another plan… Say, this hospital and that insurance company say, 'okay, this is our [network] agreement.' They should not be able to break that agreement until the next enrollment period." – "Esme"

MA enrollee experiences that informed Recommendation #3

Many enrollees reported that the availability of in-network, high-quality, and geographically accessible dentists has been declining in the past few years.

"I just experienced the need to find a dentist… it was hard for me to find a dentist that accepted the MA plan network, and then the out-of-network fee was very, very restrictive, so it was not very easy to find a dentist that accepted the plan that I have currently." – "Charles"

"Finding dental care, when it was offered, it was still expensive, the co-pays were high, and it was difficult to find someone in network… The previous two years, it was getting harder and harder to find a [dental] provider that was in network [to provide the dental care I needed]." – "Marge"

For one AG member, the sudden change in network designation worked in his favor, but still illustrates the volatility of provider networks that are necessary to provide supplemental benefits.

"The dentist I had been with on my previous plan initially was not part of the [new MA plan's] network, so I had to seek other options… then it turned out, when I went for my final visit under the old plan in December, I showed him my card, I'm like, 'just one more try, can you see if… are you in network with this [new MA plan]?' And they said, yes. So, here I was, I was [suddenly] able to stay with my dentist." – "Brian"

It was frustrating to some enrollees that supplemental benefit providers can leave or join the MA network mid-year, but enrollees must remain in the plan until the next Medicare open enrollment period.

"And [the dentist was] originally in the network, and I had to get a cap done, and they only covered like 60% of it, or something like that. And then I had to get another cap [that year], so I went back to them. And they said, 'oh, we stopped accepting [your MA plan] altogether.' And so, I had to go find another dentist." – "Arthur"

One enrollee reported that he even had trouble locating the directory for supplemental benefit providers.

"I've been looking for the [MA plan's provider directory] to find the dentist who's in network. I'm kind of stuck in that process of finding [that resource]. Where is the list of dentists that's in the network? And, you know, I'm new to this plan. I had a prior insurer that it was relatively easy to find that information, but with this new insurer, it's difficult to find that list of network dentists." – "Charles"

Example Policy Options

- Establish provider network adequacy requirements for supplemental benefit providers similar to those currently in effect for provider networks that cover Part A and Part B services.
- Require plans to include supplemental benefit providers as part of the new requirements to maintain accurate and accessible provider directories.
- Require CMS to establish a National Provider Directory that includes supplemental benefit providers and clearly indicates their in-network status for each plan.
- Establish a Special Enrollment Period that is triggered when an enrollee loses any provider in the middle of the year, including those providing supplemental benefits, similar to a CMS unfinalized proposal.
- Require network contracts to remain stable annually to mitigate mid-year fluctuations in enrollee access to supplemental benefit providers.

Considerations and Tradeoffs

Establishing network adequacy requirements could result in plans offering fewer supplemental benefits. This could be particularly impactful in rural areas where providers are scarce, and plans may be unable to as easily meet network adequacy requirements.

Requiring year-long contracts between MA plans and their contracted providers or vendors is unprecedented, as CMS does not currently have the authority to intervene in MA contracts due to "non-interference" statutes. Such a policy would require legislation to implement.

ADVISORY GROUP RECOMMENDATION 4:

Enforce flexibility in how enrollees can shop for OTC benefits so they can look for the lowest prices and maximize the dollar value that was advertised.

"I mean, [the OTC benefit] is free, right? But you don't get as much as they used to give you and they double or triple the price of [OTC items in the catalog], so you might get two things for $100. I'm serious, two or three things, okay?" – "Lenny"

MA enrollee experiences that informed Recommendation #4

OTC benefits were highly valued by MA enrollees, especially for those with low incomes. Several AG members living on fixed incomes reported that OTC allowances helped them purchase needed items.

"[With the OTC card], I was able to buy things I needed but didn't have to spend my own money on." – "Renee"

Many AG members reported concern over various ways they could miss out on using the full value of the benefit. All but one AG member believed it would be helpful if MA plans were required to send a mid-year notice of unused supplemental benefits, saying:

"If you know that you have benefits that you're not aware of, then you can follow up and use those benefits. A lot of times as seniors, we're not really aware of the benefits we have." – "Renee"

"That would very helpful. Having a periodic update or reminder would be extremely motivating and helpful [to use my unused supplemental benefits]." – "Nicholas"

"Yes, they should be required to [send mid-year notices], I would love that. I would love to use it if I have something left that I wasn't using yet. Especially knowing how much transportation I have left would be a big help." – "Grace"

The one dissenting AG member reported they already received frequent, tailored communication about their unused benefits from their MA plan via text reminders and the patient online portal. On the whole, active communication from MA plans was perceived as important and useful for utilizing supplemental benefits, with several members explicitly mentioning the value of proactive texts or emails about unused benefits, available balances, or rewards.

Most AG members reported using tools for tracking their OTC spending and remaining value through their plan's app or online catalogs. Members were also generally very knowledgeable about where and how to use their OTC benefits.

"We use the plan's app, which easily gives you updates on how much [OTC benefit] spending you have left." – "Julie" and "Lenny"

"I know my OTC benefit can be used at CVS and Walgreens, and there is an online catalog as well. CVS and Walgreens do a good job of labeling what's eligible for OTC card in the store, whereas at Walmart you have to check some complicated system on their website." – "Mabel"

"I don't like surprises in healthcare. I feel fairly adept at navigating the system so as to not be caught off guard […] and the online shopping site has everything broken down in categories. It's been very easy to know what I can buy […] I make sure to use all of my benefits every quarter." – "Rose"

One enrollee mentioned how the fact that their unused benefits would "roll over" to the next year gave them peace of mind.

"The one thing that I think is good about [my plan] is [that the OTC benefits] roll over, so if you're left with some dollars at the end, you can roll it into the next quarter. I know, I was with my aunt recently, and looking at her plan, and it cuts off every quarter. So, you have to use it up. But I was able to access and use it mostly for vitamins, supplements, things like that." – "Brian"

Some enrollees reported that their MA plan had imposed restrictions on where they could shop for OTC benefits. Some were limited to online catalogs or one specific chain pharmacy. This concerned enrollees as it prevented them from shopping for the best prices to maximize the value of the benefit. AG members strongly preferred flexible, debit-card-like benefits that could be used at brick-and-mortar pharmacies and online to get the best deal.

"One of the things that I do like about it is I can go to several different stores—Walmart, Walgreens, CVS—and get the supplies and things."– "Mabel"

"I just wish my local grocery store would accept OTC." – "Donna"

When enrollees were restricted to OTC catalogs, there were various ways they were prevented from accessing the full value of the benefit. For example, two AG members who were restricted to a catalog reported that the products were priced much higher than identical items sold on retail shelves. This means that an advertised "$100 benefit" yielded only a fraction of its advertised value.

"With the flex card, you have so much money every quarter, and it's the over-the-counter benefit. And when you open up the catalog, you'll look and see, let's say, denture tabs, right? They're like $20 for 96 tablets. You go to any store, they're like $10. So, they're doubling the cost of that. They're gonna make money on that, okay? And basically, I mean, it's free, right, but you don't get as much as they used to give you and they double or triple the price of it, so you might get two things for $100. I'm serious, two or three things, okay?" – "Lenny"

Restrictions of OTC cards to only one online site or one storefront can be a challenge for people who do not have geographic access or limited transportation options—especially when items are priced higher.

"Just because you can't make it to the store doesn't mean that you should be charged that much extra." – "Larena"

One AG member reported that the plan's catalog system did not allow users to pay the difference out-of-pocket if an item exceeded their remaining balance. When she had only a few dollars left over, the lack of low-cost items in the catalog forced her to surrender the money back to the plan rather than use the remaining sum to pay for part of another item.

"One of the problems with going online [is], if my [OTC benefit] is $50 a quarter, and... I [use] $47—well, there's nothing on that catalog that's $3. So, you end up losing money when you use the catalog. Now, if I go to the store, and then I can always pay the extra money, and not lose that $3." – "Mabel"

Notably, most AG members enrolled in plans with flexible OTC benefits that allowed for both in-person and catalog shopping were satisfied with their ability to access the items they needed at fair prices.

Example Policy Options

- Require that plans with catalog-only OTC benefits must abide by a price-matching policy to allow enrollees to price-shop and ensure that MA enrollees can utilize the full marketed value of the OTC benefit.
- Establish a "street-pricing" policy for plans with catalog-only OTC benefits to ensure enrollees are not price-gouged after becoming a "captive audience," similar to rules enacted in some airports or proposed policies for concession prices at sports venues.
- Require plans to offer a variety of sites where enrollees can shop for OTC items rather than limiting them to one store or to a catalog.
- Increase reporting and oversight of OTC benefits administration and prices to monitor how frequently catalog prices are significantly more expensive than market value.

Considerations and Tradeoffs

Requiring plans to offer more flexibility and choices for where to purchase OTC benefits could be a barrier to plans that may have a financial reason for needing to offer OTC benefits through a catalog and could potentially result in some plans removing the OTC benefit altogether. However, OTC benefits help attract enrollees to MA plans in competitive markets. Price-limiting policies could potentially require legislation if the catalog is provided through a contract with a vendor, as CMS currently statutorily prohibited from intervening in MA contracts due to "non-interference" statutes.

Conclusion

Supplemental benefits are highly valued by enrollees and are a driving force behind MA enrollment, particularly for enrollees living on fixed or lower incomes. Yet they can often be marred by complexity, volatility, and barriers to access. AG members reported that benefits that appear robust in marketing materials can lose their value when enrollees confront sparse provider networks, unpredictable year-over-year reductions, and access challenges. AG members also reported that the lack of clear information on supplemental benefit scope, eligibility, cost and provider networks often resulted in a discrepancy between their expectations and the reality of what services they could access—sometimes resulting in surprise out-of-pocket costs that were difficult to absorb.

Supplemental benefits were created to improve the health and financial security of MA enrollees, a goal which justifies the significant public investment. Oversight of this public investment should be informed by feedback from the public—i.e., enrollees themselves. Feedback from enrollees who have lower incomes—especially those who do not qualify for Medicaid and the extra benefits that program provides—is increasingly important to ensure new policies do not threaten the economic security of Medicare beneficiaries.

This advisory group elucidates where the status quo hits the mark and where supplemental benefits currently fall short for a small group of MA enrollees. Moving forward, we hope the perspectives compiled here can provide a new unique and essential reference point for policymakers beyond typical academia and policy echo chambers as they weigh policy changes to the MA program.

This policy brief is part of a series highlighting insights and guidance from the Medicare Advantage Advisory Group, convened by the Medicare Policy Initiative within Georgetown University's Center on Health Insurance Reforms.

The Medicare Advantage Advisory Group is sponsored by The SCAN Foundation. Visit The SCAN Foundation.