HEALTH MANAGEMENT ASSOCIATES

ISSUE BRIEF #1

Medicare Advantage Supplemental Benefit Flexibilities: Adoption of and Access to Newly Expanded Supplemental Benefits in 2020

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Supplemental Benefits Background and Overview

The Medicare Program permits all beneficiaries enrolled in both Medicare Part A and Part B to elect to receive their Medicare benefits through a private health plan if offered in their geographic regions. Today, more than one-third of all Medicare beneficiaries (36 percent) have enrolled in a MA plan. The majority of these beneficiaries have enrolled in standard Medicare Advantage plans, which are available to all Medicare beneficiaries, irrespective of their income, home setting, or health condition. Plan sponsors are able to offer Special Needs Plans (SNPs) and provide tailored benefits to meet the needs of beneficiaries that meet certain criteria: 1) receiving Medicaid benefits (i.e., dual eligible); 2) residing in an institutional care setting; or 3) having a chronic condition[1]. Of the 24.1 million total Medicare Advantage enrollees, 3.4 million (14 percent) are enrolled in a SNP.

Supplemental Benefits Defined

The Medicare program encourages MA plans to provide supplemental benefits to their enrollees. These benefits fall into one of two categories: 1) reductions in plan premiums and/or cost-sharing for Medicare-covered services (e.g., reduced copayments for certain physician office visits or hospital stays), or 2) additive benefits that are not covered under traditional Medicare.

In order to meet the definition of a "supplemental benefit," items or services must meet three criteria:

1. The item or service must not be covered by Medicare Part A or Part B;
2. The benefit must be "primarily health-related", which, up until 2019 meant the purpose of the benefit is to prevent, cure or diminish an illness or injury; and
3. The MA plan must incur a non-zero direct medical cost in providing the benefit.

These requirements apply to all MA plans that seek to offer supplemental benefits, with the exception of certain Dual-eligible Special Needs Plans (D-SNPs) that offer "highly integrated" Medicare and Medicaid benefits (subject to determination by CMS). Such D-SNPs are able to offer certain non-primarily health-related benefits that are intended to bridge a gap between Medicare and Medicaid covered services, such as home meal deliveries, adult day care, and caregiver support services.

Financing of Supplemental Benefits

Although MA plans must incur a direct cost in order to provide these benefits, the Medicare program does not provide additional funding for them. MA plans must finance these supplemental benefits through rebate dollars[2] or through additional premiums charged to enrollees. MA plans may place cost-sharing requirements and other utilization controls on the coverage of supplemental benefits, thereby limiting their use. Historically, CMS required supplemental benefits, like other MA-covered services, to be provided to all enrollees uniformly. That is, MA plans were not permitted to restrict benefits to certain categories of enrollees or tailor them to serve the needs of beneficiaries with a particular chronic condition or disease (e.g., home monitoring only for enrollees with congestive heart failure).

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[1] CMS defines 15 chronic conditions for which Chronic Condition SNPs (C-SNPs) can restrict enrollment. A complete list of these qualifying conditions can be found at https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/C-SNPs.

[2] MA plans that bid below the benchmark (the CMS target against which plans bid to provide coverage of Medicare A/B services) receive a percentage of the difference between the bid and benchmark in the form of a rebate. Rebate amounts range between 50% and 70% of the difference between the bid and the benchmark; this percentage is determined by a plan's star rating. Plans with higher star ratings receive a higher percentage of the difference as a rebate.

Plans that receive rebates must use those funds to either reduce enrollee out-of-pocket costs or to provide additional supplemental benefits. Plans may choose whether and how to allocate rebate dollars toward premium reductions, cost sharing reductions, or additive supplemental benefits. In addition, the amount of rebate dollars varies significantly among plans and across the country. Rebates are determined by the difference between MA plans' bids and the benchmark rate in the county in which a plan is being offered, which vary across the country. They are also determined by a plan's star rating -- a measure of quality and performance assigned by CMS. Plans with a high star rating (4 stars or higher) receive additional rebate dollars to apply towards supplemental benefits. That is, the geographic location of a plan and its quality rating often contribute to a plan's ability to provide generous supplemental benefits.

Decisions regarding whether to prioritize additive supplemental benefits over reductions in premiums or cost-sharing vary by plan and geography, and may be influenced by a number of factors. These include competitor offerings, current and prospective enrollee needs or expected demand, and the anticipated impact of various supplemental benefit offerings on total cost of care and enrollee satisfaction.

Four Recent Changes to Supplemental Benefit Policies and Early Findings

Congress and CMS have recently expanded the definition of supplemental benefit policies to grant MA plans more flexibility than ever before to design and target these benefits. These include: 1) expansion of the definition of "primarily health-related;" 2) the ability to target benefits to certain sub-populations only (i.e., offer them non-uniformly); 3) implementation of the value-based insurance design (VBID) demonstration; and 4) establishment of special supplemental benefits for the chronically ill (SSBCI). Each has been adopted by MA plans to varying extents. The following provides detail on each of these opportunities and examines plan adoption for 2020. (Note: some plans may have made changes to their benefits in response to the novel coronavirus pandemic (COVID-19), which are not reflected in this data).

Flexibility 1: Expansion of "Primarily Health-Related" Definition

In 2019, using existing regulatory authorities, CMS reinterpreted its determination of "primarily health-related" for defining and approving MA plans' supplemental benefit offerings. Under CMS's new definition, plans may offer supplemental benefits if they seek to seek to:

1. Diagnose or compensate for physical impairments;
2. Ameliorate the functional/psychological impact of injuries or health conditions; or
3. Reduce avoidable emergency and health care utilization.

In its regulatory expansion, CMS explicitly stated that items or services that are "solely or primarily used for cosmetic, comfort, general use, or social determinant purposes" do not meet its new definition. As with other supplemental benefits, CMS stipulated that these benefits must be offered to all enrollees, though other CMS policies described below provide exceptions to this requirement.

Analysis of MA Adoption of and Enrollment in Plans with Expanded Primarily Health-Related Supplemental Benefits

In 2020, 2.5 million individuals (or 10.2% of all MA enrollees) are enrolled in MA plans offering at least one expanded primarily health-related benefit (Table A1). The most commonly offered benefits are therapeutic massage, in-home services and supports, and support for caregivers. A significant

proportion of plans offering these benefits are Special Needs Plans (SNPs), with significant offerings of support for caregivers (Table A2).

Five MA organizations (Anthem, UnitedHealth, WellCare, UPMC Health System and Humana) account for 1.6 million, or nearly two-thirds, of enrollees in plans offering expanded primarily health-related benefits (Table A3). Availability of plans offering at least one expanded primarily health-related benefit varies significantly by geography, with large concentrations of offerings in Pennsylvania, Ohio, Tennessee, Southern California, and Florida (Figure 1), which are among the highest enrollment and competitive MA markets in the US.

Table A1. Plans Offering Select Primarily Health-Related Benefits and Enrollment

All Medicare Advantage Plans (Including SNP)	Number	Percent of Total
MA Parent Organizations Offering Select Primarily Health-Related Benefits	37	19.7%
MA Plans Offering Select Primarily Health-Related Benefits	511	9.2%
Enrollment in Plans Offering Select Primarily Health-Related Benefits	2,457,743	10.2%
SNPs	**Number**	**Percent of Total**
SNPs Offering Select Primarily Health-Related Benefits	184	21.1%
Enrollment in SNPs Offering Select Primarily Health-Related Benefits	940,935	27.6%

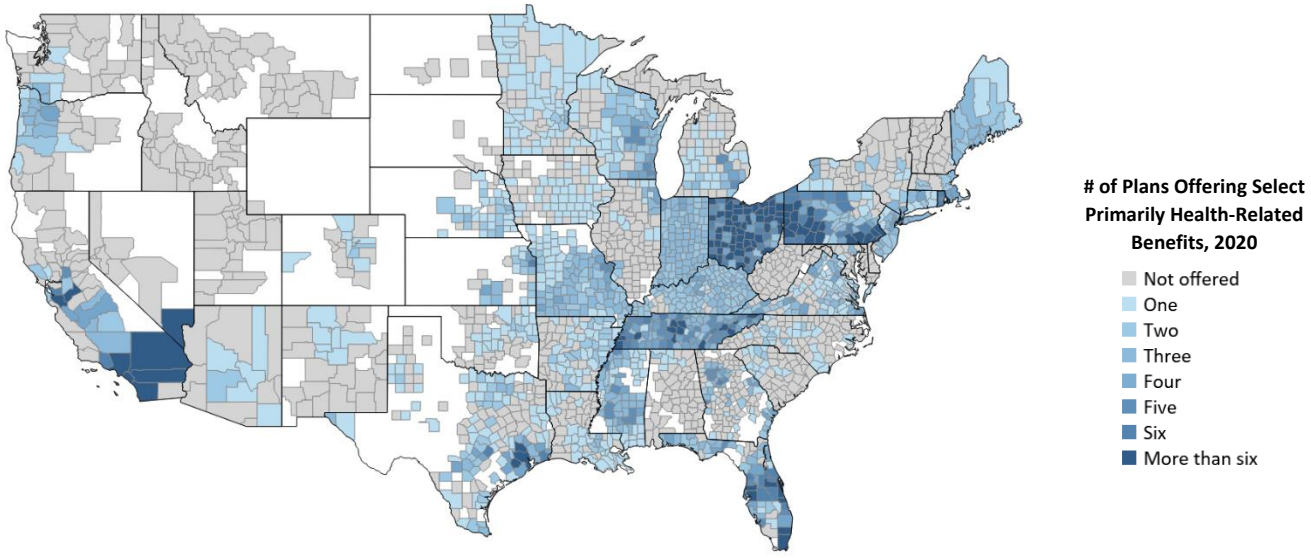
Table A2. 2020 Adoption of Expanded Primarily Health-Related Benefits (2020)

Benefit	2020 # Traditional MA Plans	2020 Traditional MA Enrollment	2020 # SNPs	2020 SNP Enrollment	Total 2020 # Plans	Total 2020 Enrollment
Home-Based Palliative Care	58	386,409	3	33,360	**61**	**419,769**
Support for Caregivers	53	368,256	72	517,098	**125**	**885,354**
Adult Day Care	42	388,645	42	130,466	**84**	**519,111**
In-Home Support Services	115	730,989	108	334,911	**223**	**1,065,900**
Therapeutic Massage	180	626,029	62	238,043	**242**	**864,072**

Table A3. Top MA Organizations Offering Expanded Primarily Health-Related Benefits (2020)

Parent Organization	2020 # Plans Offering Expanded Benefits	2020 Enrollment in Plans Offering Expanded Benefits
Anthem	99	556,228
UnitedHealth	45	454,939
WellCare	93	225,658
UPMC Health System	19	187,442
Humana	19	169,688

Figure 1. Areas with MA Plans Offering at Least One Expanded Primarily Health Related Benefit, 2020



Flexibility 2: Benefits Offered Non-uniformly

Until recently, CMS required MA plans to offer all benefits uniformly to their enrollees, including supplemental benefits. For 2019, CMS removed this requirement to permit MA plans to offer tailored supplemental benefits or cost sharing for "similarly situated individuals" based on disease state or condition ("Uniform Flexibility" or "UF Benefits"). MA plans are now able to identify and select target population(s) based on clinical criteria for expanded benefits.

Analysis of Uniform Flexibility Enrollment and Adoption

In 2020, 308 MA plans offered UF Benefits for select populations, and approximately 1.2 million individuals (or 5% of MA enrollees) are enrolled in these plans. Of the plans that offer UF Benefits, 228 provided additive supplemental benefits while 137 provided targeted cost-sharing reductions (Table B1). Additive benefits may include nutrition counseling for enrollees with diabetes, while cost-sharing reductions may include reduced or $0 cost-sharing endocrinologist visits or $0 cost-sharing for diabetes medications. The number of enrollees in plans with additive supplemental benefits is double those in plans with cost-sharing reductions, suggesting that plans may find more value in adding benefits than cost-sharing reductions. Further, the majority of these plans offer UF Benefits to individuals with diabetes (Table B2).

Five MA organizations comprise more than half of the enrollment in plans offering UF Benefits– InnovaCare, UPMC Health System, Cambia Health Solutions, Tufts Health Plan, and Independence Health Group (Table B3). The majority of MA plans offering UF Benefits are located in the Northeast or Pacific Northwest (Figure 2). Many of these are provider-sponsored plans, which may suggest that plans with strong relationships to their health care providers may be more willing to offer these benefits.

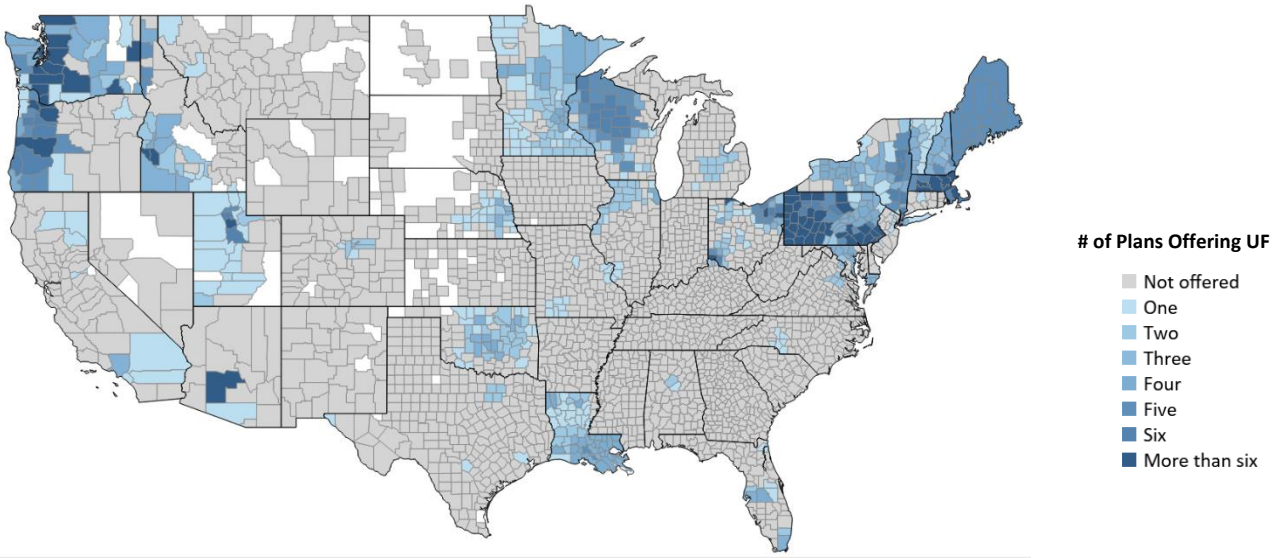
Table B1. Plans Offering UF Benefits and Enrollment		
All Medicare Advantage Plans (including SNPs)	**Number**	**Percent of Total**
MA Parent Organizations Offering UF Benefits	34	18.1%
MA Plans with UF Offerings	308	5.5%
Number of Plans with Reduced Cost-Sharing as UF Benefit	137	2.5%
Number of Plans with Additive Supplemental Benefits as UF Benefits	228	4.1%
2020 Enrollment in MA Plans Offering UF Benefits	1,209,943	5.0%
2020 Enrollment in MA Plans Offering UF Reduced Cost-Sharing	542,641	2.2%
2020 Enrollment in MA Plans Offering UF Additional Benefits	1,100,247	4.6%
SNPs	**Number**	**Percent of Total**
Number of SNPs Offering UF Benefits	31	3.6%
Enrollment in SNPs Offering UF Benefits	187,598	5.5%

Table B2. Top Conditions Targeted for UF Benefits, of Plans Offering UF Benefits (by Enrollment 2020)[3]		
Condition	**# Plans offering UF**	**Enrollment in Plans Offering UF**
Diabetes	222	822,118
Congestive Heart Failure (CHF)	98	684,052
Chronic Obstructive Pulmonary Disease (COPD)	69	522,026
Pre-diabetes	60	98,711
Hypertension	28	115,506
Pneumonia	24	84,256
Cellulitis	24	84,256
Hip Replacement	18	22,556
Knee Replacement	18	22,556
Femur Fracture	18	22,556

Table B3. Top MA Organizations Offering UF Benefits (2020)		
Parent Organization	**# 2020 Plans Offering UF Benefits**	**2020 Enrollment in Plans Offering UF Benefits**
InnovaCare	13	226,613
UPMC Health System	17	156,950
Cambia Health Solutions	60	98,711
Tufts Health Plan	24	84,256
Independence Health Group	12	83,595

[3] Some plans offer UF for multiple conditions

Figure 2. Areas with MA Plans Offering Uniform Flexibility, 2020



Flexibility 3: Medicare Advantage Value-based Insurance Design (VBID)

Using authorities under the Center for Medicare and Medicaid Innovation (CMMI), CMS established the Medicare Advantage Value-Based Insurance Design (VBID) to test alternative supplemental benefit offerings. The VBID model permits MA plans to structure enrollee cost-sharing and other health plan design elements to encourage enrollees to use high-value clinical services. Under this demonstration program, plans may provide reduced cost-sharing or additional supplemental benefits for enrollees based on condition and/or certain *socioeconomic* (i.e. low-income subsidy eligibility or dual-eligible) status (SES). These flexibilities include supplemental benefits that are "non-primarily health-related." Since this program is being offered on a demonstration basis, MA plans must apply and receive approval to participate. Until 2020, only plans in a limited number of states were eligible to apply, but Congress expanded the scope of the demonstration to include all 50 states through the Bipartisan Budget Act of 2018 (BBA 2018).

Analysis of VBID Enrollment and Adoption

In 2020, 14 MA organizations, representing 157 plans, offer VBID programs for specific conditions or SES (Figure C1). Enrollment in MA plans participating in VBID programs exceeded 1.2 million beneficiaries (or about six percent of all MA enrollees). Chronic obstructive pulmonary disease (COPD) is the top condition targeted (Table C2). Over half of VBID enrollees are in plans offered by Humana or UnitedHealth (Table C3). VBID offerings are largely concentrated in the tri-state area of New York, New Jersey, Pennsylvania and Puerto Rico (Figure 3).

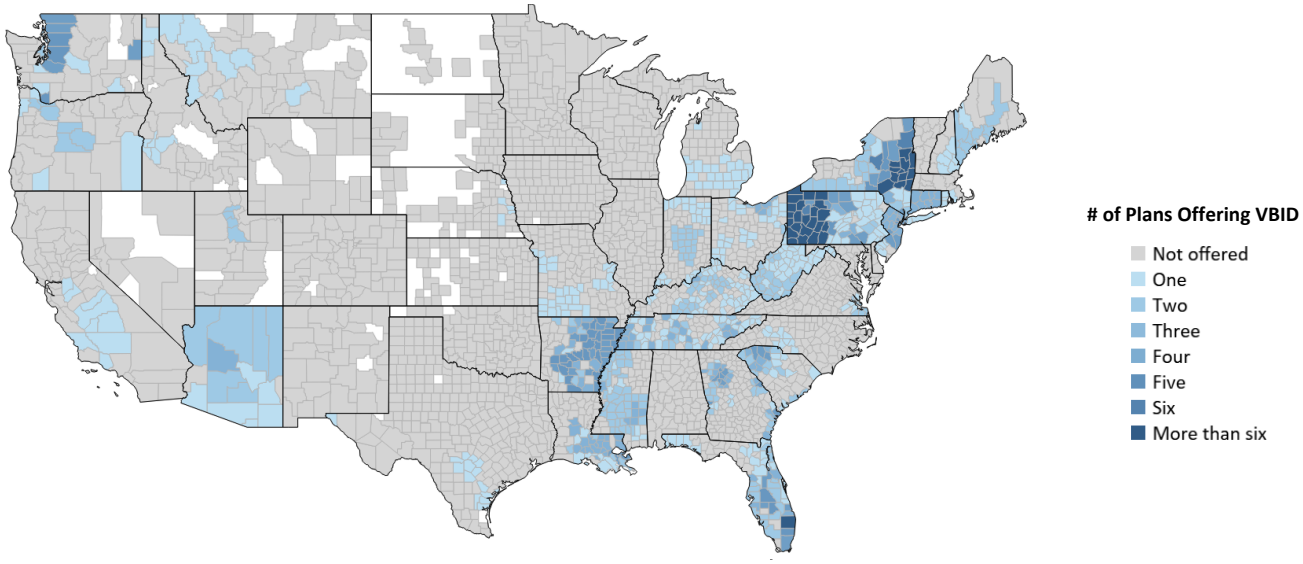
Table C1. Plans Offering VBID for Targeted Conditions or SES and Enrollment		
All Medicare Advantage Plans (Including SNPs)	**Number**	**Percent of Total**
MA Parent Organizations Offering VBID for Specific Conditions or SES	14	7.4%
MA Plans Offering VBID for Specific Conditions or SES	157	2.8%
2020 Enrollment in MA Plans Offering VBID for Specific Conditions or SES	1,232,925	5.1%
SNPs	**Number**	**Percent of Total**
SNPs Offering VBID for Specific Conditions or SES	42	4.8%
2020 Enrollment in SNPs Targeting Specific Conditions or SES	238,722	7.0%
Number of SNPs Offering VBID for SES	31	3.6%
2020 Enrollment in SNPs Targeting SES	81,394	2.4%

Table C2. 2020 Top Targeted VBID Conditions, of Plans Offering VBID Supplemental Benefits (by Enrollment)[4]		
Condition	**# Plans offering VBID**	**Enrollment in Plans Offering VBID**
Chronic Obstructive Pulmonary Disease (COPD)	58	553,902
"Other CMS-Approved Disease State"	56	518,697
Low Socioeconomic Status	34	184,668
Diabetes	34	260,894
Coronary Artery Disease	31	107,157
Hypertension	26	105,533
Congestive Heart Failure (CHF)	24	201,990
Dementia	9	38,035
Patient with Past Stroke	8	32,225
Mood Disorders	8	32,225

Figure C3. Top MA Organizations Offering VBID (2020)		
Parent Organization	**# 2020 Plans Offering VBID**	**2020 Enrollment in Plans Offering VBID**
Humana	79	540,952
UnitedHealth Group	18	260,151
UPMC Health System	6	123,621
WellCare	22	84,880
Medical Card System	6	82,276

[4] Some plans offer VBID for multiple conditions

Figure 3. Areas with MA Plans Offering VBID, 2020



Flexibility 4: Special Supplemental Benefits for the Chronically Ill (SSBCI)

The BBA 2018 included a provision permitting MA plans to vary supplemental benefit offerings based on the medical conditions and needs of chronically ill enrollees. Specifically, plans may offer supplemental benefits that are "non-primarily health-related" non-uniformly to eligible chronically ill enrollees. This eligibility is based on enrollees having one or more specified chronic condition or illness.[5] The legislation provided that SSBCI benefits must have a reasonable expectation to improve or maintain health or overall function related to chronic condition or illness. Unlike other supplemental benefit flexibilities created by CMS, SSBCI may include capital or structural improvements to homes. To be eligible to provide benefits, plans must develop objective criteria and maintain documentation for determining beneficiary need. CMS, through implementing regulations, provided that financial need or social risk factors is *not* a criterion for enrollee eligibility for SSBCI.

Analysis of Enrollment and Adoption of SSBCI

In 2020, approximately 1.4 million individuals are enrolled in plans offering SSBCI—or about six percent of all MA enrollees (Table D1). One-third of plans offering SSBCI are SNPs, most of which are dual eligible SNPs (D-SNP). The dual eligible population has higher rates of chronic conditions than the overall Medicare population, reporting poor health status.[6] D-SNPs were permitted to offer some of these benefits, such as meals, prior to implementation of SSBCI. In total, enrollment in SNPs represents slightly more than one-quarter of total enrollment in plans offering SSBCI benefits. The most commonly offered SSBCI is food and produce, which often includes monthly delivery of non-perishable pantry items to the home; 101 plans offer the benefit and approximately 710,000 individuals are enrolled in those plans (Table D2). Adoption of SSBCI is generally higher among smaller MA organizations. Anthem is the only national MA organizations to provide widescale adoption, with 554,000 enrollees (Table D3). Medicare

[5] CMS defined 15 eligible chronic conditions in its implementing guidance documents.
[6] https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO_Factsheet.pdf

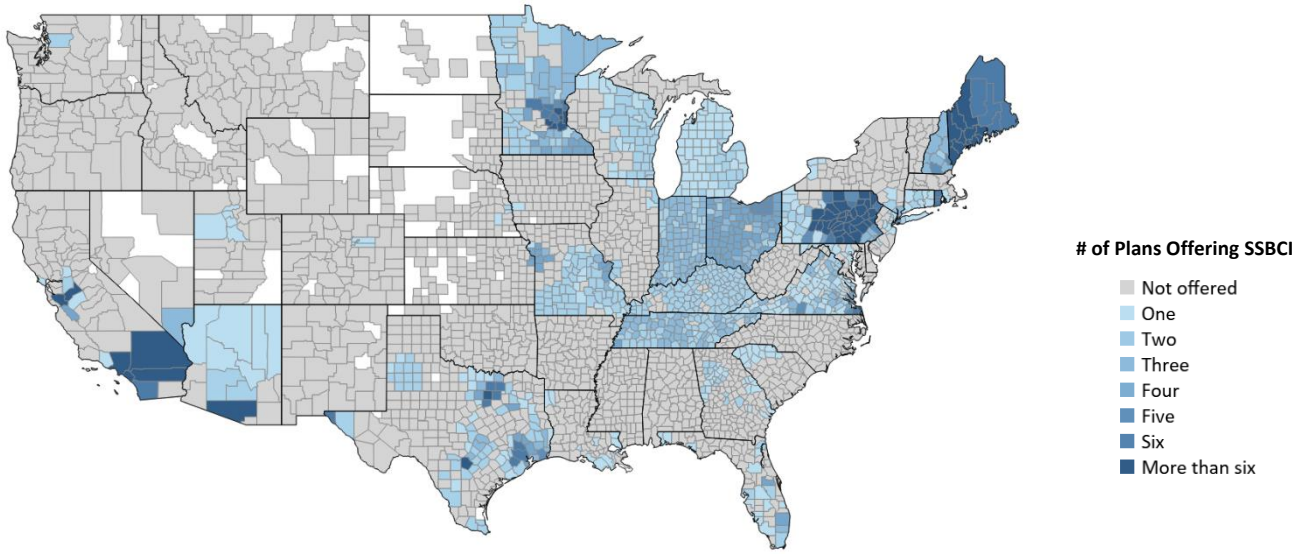
beneficiaries in many parts of the Midwest have access to at least one plan offering SSBCI. Those residing in select areas of the Northeast have a choice of six or more offerings with SSBCI (Figure 4).

Table D1. Plans Offering SSBCI and Enrollment		
All Medicare Advantage Plans (Including SNPs)	**Number**	**Percent of Total**
MA Parent Organizations Offering SSBCI	30	16.0%
MA Plans with SSBCI Offerings	267	4.8%
Number Plans with Reduced Cost Sharing as SSBCI	3	0.05%
Number of Plans with Additive Benefits as SSBCI	267	4.8%
2020 Enrollment in MA Plans Offering SSBCI	1,371,606	5.7%
SNPs	**Number**	**Percent of Total**
SNPs Offering SSBCI	89	10.2%
2020 Enrollment in SNPs Offering SSBCI	369,411	10.8%

Table D2. Adoption of Items or Services Benefits Offered Under SSBCI (2020)						
Benefit	**2020 # Traditional MA Plans**	**2020 Traditional MA Enrollment**	**2020 # SNPs**	**2020 SNP Enrollment**	**Total 2020 # Plans**	**Total 2020 Enrollment**
Transitional/Temporary Supports	52	184,740	15	106,103	**67**	**290,843**
Food and Produce	63	517,766	38	191,757	**101**	**709,523**
Meals (beyond limited basis)	40	183,326	31	94,466	**71**	**277,792**
Pest Control	86	516,276	32	128,848	**118**	**645,124**
Transportation for Non-Medical Needs	60	196,926	28	177,793	**88**	**374,719**
Indoor Air Quality Equipment and Services	50	201,665	2	49,537	**52**	**251,202**
Social Needs Benefit	21	134,949	13	16,835	**34**	**151,784**
Complementary Therapies	1	37,150	0	0	**1**	**37,150**
Services Supporting Self-Direction	16	103,135	4	12,363	**20**	**115,498**
Structural Home Modifications	43	80,889	1	9,038	**44**	**89,927**
Service Dog Support	30	350,793	21	105,071	**51**	**455,864**

Table D3. Top MA Organizations Offering SSBCI (2020)		
Parent Organization	**2020 # Plans Offering SSBCI**	**2020 Enrollment in Plans Offering SSBCI**
Anthem	98	544,251
Medical Card System	13	146,334
CIGNA	8	92,585
Geisinger Health	44	89,927
Martin's Point Health Care	12	53,402

Figure 4. Areas with MA Plans Offering SSBCI, 2020



Conclusions and Next Steps

Approximately 4.5 million individuals (19% of total 2020 MA enrollment) in a small number of geographies are enrolled in plans offering at least one new supplemental benefit flexibility. Table E summarizes the adoption and enrollment by each type of flexibility. Select primarily health-related benefits is the most widely adopted benefit flexibility followed by Uniform Flexibility, SSBCI and VBID. Further research is needed to understand why plans elected to adopt one flexibility over another or for plans that adopted multiple flexibilities, what factors contributed to that decision.

Table E. Summary of Supplemental Benefit Flexibilities Adoption and Enrollment (as % of all MA plans)					
All Medicare Advantage Plans (Including SNP)	**Flexibility 1: Select Primarily Health- Related Benefits**	**Flexibility 2: Uniform Flexibility**	**Flexibility 3: VBID**	**Flexibility 4: SSBCI**	**At Least One Flexibility**
MA Parent Organizations	19.7%	18.1%	7.4%	16.0%	41.4%
MA Plans	9.2%	5.5%	2.8%	4.8%	18.0%
Enrollment as a % of Total MA Enrollment	10.2%	5.0%	5.1%	5.7%	19.1%

The vast majority of individuals enrolled in plans offering at least one new supplemental benefit are enrolled in plans with star ratings of four stars or above, raising the question whether the availability of additional rebate dollars factored into a plan's determination to offer these benefits. It is also important to note that the proportion of enrollee population that qualifies for these new benefits are unknown, since plans may tailor benefits to certain enrollees with plan-specific policies and processes to extend them to eligible enrollees.

SNPs, and particularly D-SNPs, account for a significant proportion of individuals with access to new supplemental benefits, specifically for select primarily health-related benefits and SSBCI. For some benefits, such as caregiver supports, individuals enrolled in SNPs account for more than half of those enrolled in a plan that offers the benefit.

The items and services offered across and within the new supplemental benefit flexibility categories are diverse in nature suggesting that plans may be experimenting with these new flexibilities to determine which ones have the best outcomes. Further research is needed to understand the extent to which the specific benefits offered across plans actually meet the needs of the individuals served. Adoption of new supplemental benefit opportunities also varies significantly across MA organizations, geographies, and flexibility type, prompting questions regarding whether further adoption may remain offered in certain parts of the country.

In the coming months, HMA will conduct additional analyses including interviews with health plan executives, beneficiary advocates, and leaders from community-based organizations to inform the policy community on the opportunities and challenges with the adoption and implementation of new supplemental benefits. Subsequent analyses and interviews will seek to address the following questions:

1. What are reasons for or against offering supplemental benefit under newly afforded flexibilities? Are there factors that serve as barriers to adoption (e.g., uncertainty regarding costs and outcomes, availability of service providers, operational complexities)?
2. What are the trade-offs that plans consider when offering a new flexible benefit and to what extent did plans have to make modifications to other benefits (e.g., reductions in enrollee out-of-pocket costs, additional premiums for supplemental benefits)? Does this vary by factors that typically result in a higher rebate (i.e., plan star rating and/or county benchmark)?
3. For those plans that did elect to offer supplemental benefits under new flexibilities, what factors contributed to the flexibility chosen? Did plans elect to offer certain supplemental benefits based on identified need or on the ability to attract new members? How was this need identified/determined?
4. To what extent do offerings of the same benefit vary across plans? For example, how might the "food and produce" SSBCI benefit offered by one plan differ from the "food and produce" SSBCI benefit offered by another plan?
5. Are enrollees able to access the new benefits? How are current and prospective enrollees made aware of these benefits? What policy changes might contribute to better enrollee education, awareness, and use?
6. Is this level of adoption expected to change over time? What policy changes or additional federal support could contribute to increased adoption? Should policymakers be encouraging further adoption?
7. What are the expected impacts of new supplemental benefit offerings on quality and total cost of care? On enrollee satisfaction and engagement? Do these vary by chronic condition category and/or benefit offering?

8. What other mechanisms could policymakers consider to support health plans and other stakeholder efforts to address non-medical needs in order to improve overall health and contain spending?

Methodology

HMA analyzed data from two publicly available data sources published by CMS to evaluate access, availability, and adoption of newly available supplemental benefits.

1. *Plan Benefit Package (PBP) Data*. CMS publishes this data on a quarterly basis. It provides detailed information regarding approved MA and Part D benefits for all MA and Part D organizations that submit a bid. HMA analyzed the "PBP Benefits – 2020, Quarter 2" data files which reflect 2020 plan benefit offerings available to MA enrollees as of the date of publication of this issue brief. We used this data source to identify the plans and plan types that offer one or more of the newly available MA supplemental benefits and which specific benefit or benefits are offered. For purposes of plan counts, we defined a plan as a unique contract-plan-segment, and excluded Medicare-Medicaid plans (MMPs), Cost plans, MSAs, and PACE.

2. *Medicare Advantage Plan-Level Enrollment Data*. CMS publishes these files monthly. 2020 MA enrollment is based on the February 2020 enrollment data release. This data source was used to summarize enrollment counts in MA plans (SNP and non-SNP) that offer newly available supplemental benefits. Data is not available for a small number of plans with fewer than 11 enrollees; these plans are excluded from the analysis.