

Beneficiary Experiences with Medicare Advantage Supplemental Benefits



People with Medicare have the choice to get coverage through Original Medicare or private Medicare Advantage (MA) plans. Original Medicare allows enrollees to choose any participating provider and rarely has prior authorization barriers, but it has coverage gaps and no out-of-pocket maximum for hospital or physician services. MA plans have more access barriers, including limited provider networks and more frequent utilization management, but they do cap enrollee costs and offer extra or “supplemental” benefitsⁱ—at least on paper.

Those considering MA can find plan comparisons complex and burdensome. For many, the sheer number of plans, along with outdated decision-making tools and insufficient plan data, create barriers to active, informed coverage choices.ⁱⁱ

The recent explosion of supplemental benefit offerings has further complicated the landscape. There is often not enough standardization or detail available to prospective enrollees,ⁱⁱⁱ including about efficacy and delivery, making shopping for the right plan even more of a struggle.^{iv}

Medicare’s Outdated Structure Drives Interest in MA and Supplemental Benefits

Many people with Medicare find supplemental benefits attractive. In 2022, 24% of those who chose MA did so because of these offerings.^v Callers to the Medicare Rights Center’s national helpline identify Medicare’s coverage gaps and the related issue of Medicare affordability as their prime drivers toward MA. For some, supplemental benefits may appear to offer a solution.^{vi} Similarly, people seeking cost predictability may turn to MA, which, unlike OM, caps enrollee expenses. At \$9,350 for 2025 this ceiling is far too high; an estimated 95% of people will have costs that remain below it.^{vii} Nevertheless, the perceived certainty is a draw for some.^{viii}

Struggles With Affordability

Medicare costs, and beneficiary struggles with those costs, are growing. In 2012, 21% of helpline callers had questions about how to afford Medicare premiums, cost sharing, or prescription drugs.^{ix} In 2023, 41% of callers did.^x

Rising health care costs are to blame,^{xi} and people with Medicare have a significant and disproportionate health spending burden: On average, 14% of their household income (\$7,000 in 2022) goes to health-related expenses, twice as high as non-Medicare households.^{xii}

Many people with Medicare simply cannot afford these costs. In 2024, half of all Medicare beneficiaries lived on \$43,200 or less per year, and one in four had savings below \$18,950.^{xiii}

These high and rising costs have a significant impact on beneficiary access to care. In recent years, one in three people with Medicare reported they delayed or went without care due to cost,^{xiv} while one in five older adults had some form of medical debt.^{xv}

Coverage Gaps

Original Medicare covers visits to hospitals and doctors' offices, durable medical equipment for use in the home, and optional prescription drug coverage. But what Medicare doesn't cover can come as an unwelcome surprise.^{xvi} For example, Medicare does not cover comprehensive dental, hearing, or vision care, has treatment and settings gaps for behavioral health care, puts limits on durable medical equipment, and does not cover long-term care.^{xvii}

Many enrollees face additional costs as a result. While people with higher incomes may be able to purchase separate insurance for missing benefits, or buy a Medigap to reduce financial exposure, others cannot afford to do so.

For people with very low incomes, Medicaid—through Medicare Savings Programs (MSPs)—can help cover Medicare payments and coverage gaps.^{xviii} The programs can be a lifeline, but are chronically underenrolled, in part due to overly strict eligibility thresholds and burdensome paperwork requirements that make it hard to get and keep coverage.^{xix}

Enter Supplemental Benefits

Supplemental benefits can be “optional,” meaning enrollees can choose to add them to their plans for an extra cost, or they can be “mandatory” with no ability for enrollees to save money by opting out.^{xx} Mandatory benefits can reduce beneficiaries’ Medicare costs, be primarily health related, or—since 2020—address social determinants of health for enrollees with chronic conditions through Special Supplemental Benefits for the Chronically Ill (SSBCI).^{xxi}

Regardless of classification, these added benefits are extremely variable from plan to plan and year to year and usually have cost limitations or service exclusions. For example, a plan’s supplemental dental benefits may cover most types of procedures, but only up to a certain dollar amount—effectively capping coverage. Others may limit the benefit by only covering routine cleanings, not dentures or root canals.^{xxii}

Plans may also offer supplemental benefits like gym memberships that typically appeal to younger, healthier beneficiaries,^{xxiii} favorably skewing their risk pool—and the overall MA population—toward lower-cost enrollees.^{xxiv} By contrast, they do not generally offer benefits that may appeal to those with higher needs, such as offsets for long-term care expenditures and durable medical equipment for use outside the home.

Where Potential Meets Reality: Beneficiary Experiences

Gaps in Medicare coverage and affordability mean that people who are trying to stretch their dollars and still meet their health care needs may be drawn to MA’s “extra” benefits.

But for some enrollees, their expectations and reality do not align. Every year, Medicare Rights hears from people who are having problems choosing and using their supplemental benefits, including the stories below. From misunderstanding the scope of these benefits, to prioritizing them even when a plan does not otherwise meet their needs, to being misled by plan representatives about the benefits available to them, the beneficiary experience with supplemental benefits points to significant problems.

The Part B Premium Buydown or “Giveback Benefit”

One of the more aggressively marketed MA supplemental benefits is the Part B premium buydown, generally called the “giveback benefit” by plans.^{xxv} This benefit allows plans to pay for all or part of an enrollee’s Part B premium.

But many Medicare beneficiaries with low incomes are already eligible for a Medicare Savings Program, which would cover their entire Part B premium as well as triggering other cost-saving

coverage.^{xxvi} Unfortunately, MSP application processes are notoriously complex, and many eligible people are not enrolled.^{xxvii}

These vignettes illustrate how beneficiaries may turn to MA to make up for administrative burden:

Heard on the Helpline:

The Part B Premium Buydown or “Giveback Benefit”

Ms. LM is a “partial dual” because she is eligible for the Qualified Medicare Beneficiary (QMB) MSP which would pay her Part B premium as well as other Medicare cost sharing. But she was having trouble reenrolling in the MSP after being sent the incorrect paperwork by the Medicaid office. She enrolled in an MA plan with a premium giveback to partially compensate for her inability to access the MSP that she was entitled to.

While the giveback may appear to be a relatively straightforward benefit, enrollees still can run into issues:

Heard on the Helpline:

The Part B Premium Buydown or “Giveback Benefit”

Ms. LB joined an MA plan with Part B premium giveback benefits. Before enrolling, the broker told her the giveback benefit would take effect immediately. After enrolling, however, the Part B premium continued to be deducted from her Social Security benefit. When Ms. LB called the plan directly, she learned it would not take effect for 120 days. This was an unanticipated financial hardship.

Flex Cards and Other Cash-Like Benefits

Another popular supplemental benefit allows plans to give enrollees prepaid flex or debit cards or other cash-like benefits to use for various necessities like groceries, utilities, and rent.^{xxviii} As the caller experiences below indicate, this benefit is also associated with a great deal of marketing.

Heard on the Helpline:

Flex Cards and Other Cash-Like Benefits

Ms. KM, who is dually eligible, has an MA plan with a monthly over-the-counter (OTC) benefit allowance, which she can use to purchase health-related items. She has been receiving repeated solicitations from another insurer, offering her a plan with a higher monthly allowance. She spoke with one of our helpline counselors and determined the MA plan on offer would have higher cost sharing for the services she often uses and therefore would not be a good fit for her. But the solicitations have not stopped. Ms. KM shared this is not a one-off; she receives frequent solicitations from numerous MA plans.

Other enrollees have reported an inability to access their benefit.

Heard on the Helpline:

Flex Cards and Other Cash-Like Benefits

Ms. VB, who is dually eligible, enrolled in an MA plan with a card that she could use for groceries, OTC items, and utilities. She did not receive the card until many months after signing up. When she finally did, the card didn't work, even after repeated calls to the plan.

Perhaps the most troubling issue with flex cards is their potential to interfere with recipient access to critical assistance. In our casework, we have encountered variances among public benefits administrators as to whether MA flex cards qualify as “income” for program eligibility purposes. This is a fundamental issue, as such a categorization could put enrollees over the limit for income-dependent programs like the Supplemental Nutrition Assistance Program (SNAP) or Section 8 housing vouchers from the Department of Housing and Urban Development (HUD).^{xxix}

Some federal agencies have attempted to offer guidance. In March, HUD explained that only benefits used to pay for rent and utilities count as income.^{xxx} The administrator of the Centers for Medicare & Medicaid Services (CMS) stated in January 2025 that “While CMS does not have statutory or regulatory authority to regulate how other federal agencies categorize supplemental benefits, we have made it clear that debit cards are not benefits themselves, but rather a mechanism for MA plans to make payments for plan covered items and services.”^{xxxi}

While welcome, these clarifications have not ended confusion, concern, or potential harms because agencies still have the potential to count flex cards as income.

Dental Coverage

In our experience, dental coverage is the most popular supplemental benefit. For our helpline callers, the most frequent questions revolve around policy restrictions.

Heard on the Helpline:

Dental Coverage

Ms. SO called on behalf of her husband, who had enrolled in an MA plan with a \$2,000 dental benefit. His broker advised him that he was eligible for an extra \$2,000 in dental coverage (\$4,000 total). However, after receiving expensive dental work, he learned his specific procedure was excluded from the policy. The plan only covered \$2,000 of his \$3,700 bill, leaving him responsible for the balance.

Coverage for dental implants is a particularly attractive draw.

Heard on the Helpline:

Dental Coverage

Mr. EG, who is dually eligible, wants to switch from his MA plan to another company's offering because the new plan said it will cover dental implants.

But there can be a catch.

Heard on the Helpline:

Dental Coverage

Ms. EM remained in an MA plan that was not covering her medical services because of the plan's dental benefit, which she understood would pay for her dental implant. However, Ms. EM then received a denial for the implant and learned that it was not a covered service.

Ms. CW needed dental implants for a long time. She enrolled in an MA plan solely because the plan representative said it would cover her procedure, but the plan then denied coverage.

For 2021, the average annual limit for dental coverage for plans with extended benefits was \$1,300.^{xxxii} Dental implants often exceed coverage limitations for MA dental benefits, with an average cost of \$3,000–\$7,000 for a single implant.^{xxxiii}

Vision and Hearing Coverage

Like dental care, vision and hearing services are medically necessary for healthy aging but generally excluded from Medicare coverage. When people choose MA to unlock this coverage, they can run into similar limitations.

Heard on the Helpline:

Vision and Hearing Coverage

Mr. RR and his wife, both dually eligible, enrolled in an MA plan to access vision and hearing benefits. Mr. RR wanted to use his \$350 optometry allowance to take advantage of a deal from an in-network provider offering two pairs of glasses for \$90. The plan refused his request because the allowance was only intended to cover one pair of glasses. Ms. RR, who enrolled for the hearing aid allowance, was also disappointed. The only hearing aid model the plan covered was outdated and not appropriate for her.

Ms. NR, who is dually eligible, wanted to switch to a different MA plan for its hearing aid benefit. However, in working with our helpline counselors, she learned her hearing loss required an advanced hearing aid the plan did not cover.

Non-Emergency Medical Transportation (NEMT)

Many people with Medicare struggle to get themselves to routine medical appointments due to lack of transportation. Original Medicare provides limited NEMT, but some MA plans may offer it as a supplemental benefit. For those who are dually eligible, Medicaid is also an option. It generally covers some NEMT, though the service can vary from state to state.^{xxxiv} And when NEMT is covered by both programs, beneficiaries may lose out.

Heard on the Helpline:

Non-Emergency Medical Transportation (NEMT)

Ms. MP, who is dually eligible, enrolled in an MA plan from OM after a representative came to her assisted living facility and promoted the plan's NEMT benefits. With OM, Ms. MP was able to get transportation through Medicaid and was satisfied with the service. She was surprised to learn she was giving it up by enrolling in an MA plan with transportation coverage. She has also found the plan's service difficult to work with, from scheduling problems to reimbursement delays.

Even where there is not a conflict between the programs, people with MA may struggle to access effective or sufficient NEMT.

Heard on the Helpline:

Non-Emergency Medical Transportation (NEMT)

Ms. LJ, who is dually eligible, had an MA plan that covered a limited number of NEMT rides each year. She requested and was granted an additional 30 rides. Later, an agent from the insurance company called and offered to switch her into an MA plan with even more rides as well as a prepaid card to buy groceries. Ms. LJ changed plans but never received the grocery card. When she tried to use the transportation benefit, she was told she had exhausted her annual ride allotment.

Discussion

As these examples show, although supplemental benefits may be appealing, they are not without risk.

Foundationally, many people choose MA for supplemental benefits because Medicare has gaps in coverage and inadequate financial protections that expose beneficiaries to potentially limitless out-of-pocket costs. And many who would be protected through MSPs face barriers to enrollment. Some MA insurers exploit this dynamic in the name of marketing, often to the detriment of the beneficiary. Modernizing Medicare cost protections and eliminating coverage gaps would lessen some of these opportunities. Short of such expansions, better beneficiary decision-making tools and information, as well as stronger guardrails, like enhanced oversight of plans and brokers, could improve the current landscape.

For example, standardized, accurate, and easy to compare information about supplemental benefits should be embedded in Medicare Plan Finder. Users should be able to filter plans by benefit to zero in on exactly what they need.

Moreover, the plans themselves should be standardized and of high quality, and plan proliferation should be curbed to allow beneficiaries to directly compare benefits and costs among a reasonable number of plans. This could help people make coverage decisions that better suit their circumstances, as could greater education about the consequences, including the trade-offs between OM and MA. Boosting federal oversight could help reduce avoidable harms; because coverage decisions that overly weight or rely on incorrect information about supplemental benefits can lead to enrollment choices that undermine beneficiary health and financial security, accuracy in all beneficiary-facing tools and communications is paramount.

The more fundamental question may be whether supplemental benefits bring value to the Medicare program and its enrollees. As the Medicare Payment Advisory Commission (MedPAC) noted in 2022, and which remains true, the expanded availability of supplemental benefits has not been accompanied by additional transparency: “[Currently] we have no data about [supplemental benefit] use nor information about their value,”^{xxxv} including how much MA plans spend on specific benefits, how they market them, who is eligible for them, who is actually receiving them, and what the enrollee experience has been. Again in 2025, MedPAC noted that “policymakers do not have good information about whether the spending provides good value to MA enrollees and the taxpayers who fund the program.”^{xxxvi}

More must be done to collect and analyze information about supplemental benefits, including the enrollee experience. It should ultimately be on insurers to demonstrate how the benefits they use public dollars to design, sell, and administer are functioning. Perhaps they are valuable additions to health coverage or, perhaps, they are more valuable to MA plans as marketing tools that provide little real net value for the people targeted by them or for the Medicare program that bears the cost.

ⁱ Meredith Freed, *et al.*, “Medicare Advantage in 2024: Premiums, Out-of-Pocket Limits, Supplemental Benefits, and Prior Authorization” (August 8, 2024), <https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2024-premiums-out-of-pocket-limits-supplemental-benefits-and-prior-authorization/>.

ⁱⁱ Medicare Rights Center, “Medicare Advantage Proliferation: Too Much of a Complicated Thing” (July 23, 2025), <https://www.medicarerights.org/policy-documents/medicare-sustainability-ma-proliferation>.

ⁱⁱⁱ Julie Carter & Rachel Gershon, “Clearer Choices: Why Medicare Advantage Enrollees Need Better Information On Supplemental Benefits” (June 13, 2025), <https://www.healthaffairs.org/content/forefront/clearer-choices-why-medicare-advantage-enrollees-need-better-information-supplemental>.

^{iv} See, e.g., U.S. Government Accountability Office, “Medicare Advantage: Plans Generally Offered Some Supplemental Benefits, but CMS Has Limited Data on Utilization” (January 31, 2023), <https://www.gao.gov/products/gao-23-105527>; Jeannie Fuglesten Biniek, *et al.*, “Gaps in Medicare Advantage Data Limit Transparency in Plan Performance for Policymakers and Beneficiaries” (April 25, 2023), <https://www.kff.org/medicare/issue-brief/gaps-in-medicare-advantage-data-limit-transparency-in-plan-performance-for-policymakers-and-beneficiaries/>.

^v Faith Leonard, *et al.*, “Traditional Medicare or Medicare Advantage: How Older Americans Choose and Why” (October 17, 2022), <https://www.commonwealthfund.org/publications/issue-briefs/2022/oct/traditional-medicare-or-advantage-how-older-americans-choose>.

^{vi} Sarah Murdoch, *et al.*, “Medicare Trends and Recommendations: An Analysis of 2023 Call Data from the Medicare Rights Center’s National Helpline” (January 2025), <https://www.medicarerights.org/pdf/2023-helpline-trends-report.pdf>.

^{vii} 42 CFR § 422.100(f)(4)(iv)(A).

^{viii} Faith Leonard, *et al.*, “Traditional Medicare or Medicare Advantage: How Older Americans Choose and Why” (October 17, 2022), <https://www.commonwealthfund.org/publications/issue-briefs/2022/oct/traditional-medicare-or-advantage-how-older-americans-choose>.

^{ix} Charlotte Sutton, *et al.*, “Medicare Trends and Recommendations: An Analysis of 2012 Call Data from the Medicare Rights Center’s National Helpline” (last accessed February 26, 2025), <https://www.medicarerights.org/pdf/2012-helpline-trends-report.pdf>.

^x Sarah Murdoch, *et al.*, “Medicare Trends and Recommendations: An Analysis of 2023 Call Data from the Medicare Rights Center’s National Helpline” (January 2025), <https://www.medicarerights.org/pdf/2023-helpline-trends-report.pdf>.

^{xi} Centers for Medicare & Medicaid Services, “Fact Sheet: 2025 Medicare costs” (December 2024), <https://www.medicare.gov/publications/11579-medicare-costs.pdf>.

^{xii} Nancy Ochieng, *et al.*, “Medicare Households Spend More on Health Care Than Other Households” (March 14, 2024), <https://www.kff.org/medicare/issue-brief/medicare-households-spend-more-on-health-care-than-other-households/>.

^{xiii} Alex Cottrill, *et al.*, “Income and Assets of Medicare Beneficiaries in 2024” (August 25, 2025), <https://www.kff.org/medicare/income-and-assets-of-medicare-beneficiaries/>.

^{xiv} Karen Politz, *et al.*, “KFF Survey of Consumer Experiences with Health Insurance” (July 15, 2023), <https://www.kff.org/private-insurance/poll-finding/kff-survey-of-consumer-experiences-with-health-insurance/>.

^{xv} Alex Cottrill, *et al.*, “What are the Consequences of Health Care Debt Among Older Adults?” (July 26, 2024), <https://www.kff.org/medicare/issue-brief/what-are-the-consequences-of-health-care-debt-among-older-adults/>.

^{xvi} Dena Bunis, “10 Things Medicare Doesn’t Cover” (October 8, 2024), <https://www.aarp.org/health/medicare-insurance/info-2018/services-not-covered.html>.

^{xvii} Centers for Medicare & Medicaid Services, “Long-term care” (last accessed November 13, 2025), <https://www.medicare.gov/coverage/long-term-care>.

^{xviii} Medicare Interactive, “Medicare Savings Program basics” (last accessed March 26, 2025), <https://www.medicareinteractive.org/get-answers/cost-saving-programs-for-people-with-medicare/medicare-savings-programs-qmb-slmb-qj/medicare-savings-program-basics>.

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- ^{xxi} Public Law 115–123, § 50322. Expanding Supplemental Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees; Anne Tumlinson, *et al.*, “The CHRONIC Care Act of 2018: Advancing Care for Adults with Complex Needs” (March 2018), http://www.thescanfoundation.org/sites/default/files/chronic_care_act_brief_030718_final.pdf.
- ^{xxii} Nancy Ochieng, *et al.*, “Medicare Advantage in 2025: Premiums, Out-of-Pocket Limits, Supplemental Benefits, and Prior Authorization” (July 28, 2025), <https://www.kff.org/medicare/medicare-advantage-premiums-out-of-pocket-limits-supplemental-benefits-and-prior-authorization/>.
- ^{xxiii} Shefali S. Kulkarni, “Gym Memberships In Medicare Advantage Plans Cater To Healthy Seniors” (January 11, 2012), <https://kffhealthnews.org/news/gym-memberships-in-medicare-advantage-plans-cater-to-healthy-seniors/>.
- ^{xxiv} For more on favorable selection, see our companion piece of MA marketing, brokers, and agents; see also Committee for a Responsible Federal Budget, “New Evidence Suggests Even Larger Medicare Advantage Overpayments” (July 17, 2023, updated February 2, 2024), <https://www.crfb.org/blogs/new-evidence-suggests-even-larger-medicare-advantage-overpayments>.
- ^{xxv} For more on Part B buydown marketing, see our companion piece on MA marketing, brokers and agents.
- ^{xxvi} Medicare Interactive, “Medicare Savings Program basics” (last accessed November 13, 2025), <https://www.medicareinteractive.org/understanding-medicare/cost-saving-programs/medicare-savings-programs-qmb-slimb-qi/medicare-savings-program-basics>.
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- ^{xxix} Center for Medicare Advocacy, “Issue Brief: Medicare Advantage ‘Flex Cards’ and Public Benefits” (March 18, 2025), <https://medicareadvocacy.org/issue-brief-medicare-advantage-flex-cards-and-public-benefits/>.
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