Received: 6 May 2024 | Revised: 2 August 2024 | Accepted: 17 August 2024

DOI: 10.1111/jgs.19183

BRIEF REPORT

Journal of the American Geriatrics Society

Telehealth availability and use among beneficiaries in Traditional Medicare and Medicare Advantage

Sungchul Park PhD[1,2] | Hye-Young Jung PhD[3] | Jiani Yu PhD[3]

[1]Department of Health Policy and Management, College of Health Science, Korea University, Seoul, Republic of Korea

[2]BK21 FOUR R&E Center for Learning Health Systems, Korea University, Seoul, Republic of Korea

[3]Department of Population Health Sciences, Weill Cornell Medical College, New York, New York, USA

Correspondence
Sungchul Park, Department of Health Policy and Management, College of Health Science, Korea University, BK21 FOUR R&E Center for Learning Health Systems, Korea University, 145 Anam-ro, Seongbuk-gu, Seoul 02841, Republic of Korea.
Email: sungchul_park@korea.ac.kr

Abstract

Background: Medicare Advantage (MA) plans must cover all telehealth services offered by Traditional Medicare (TM), but have flexibility to provide additional telehealth services. It is not known whether these flexibilities are associated with telehealth availability and use. In this study, we examined differences in telehealth availability and use between TM and MA beneficiaries.

Methods: This cross-sectional study analyzed beneficiaries who participated in the 2021 Medicare Current Beneficiary Survey. Our primary outcomes were telehealth availability and use, assessed both overall and by modality (telephone only, video only, and both). Our key independent variable was full-year enrollment in MA versus TM. Differences in outcomes between TM and MA beneficiaries were estimated using logistic regression models that adjusted for beneficiary characteristics. The analysis of telehealth availability included all beneficiaries in the sample, while the analysis of telehealth use was limited to those offered telehealth services. In a secondary analysis, we examined differences between TM and MA beneficiaries in the availability of technology that may enable telehealth use and experience using the internet to seek information.

Results: Among 8130 Medicare beneficiaries, MA beneficiaries were 2.9 (95% CI: 0.6–5.2) percentage points more likely to have a provider who offered telehealth services than TM beneficiaries, including both telephone and video options. However, MA beneficiaries were 3.5 (−6.7, −0.4) percentage points less likely to use telehealth services than TM beneficiaries. Video-only options were used less frequently among MA beneficiaries compared to those in TM (−2.7 [−5.1, −0.3]). Despite lower telehealth use, MA beneficiaries had comparable or higher rates of technology access and internet experience compared to TM beneficiaries.

Conclusion: Our findings suggest that greater access to telehealth services among MA beneficiaries did not translate into greater telehealth use. Future research is warranted to explore the underlying mechanisms behind lower use of telehealth services among MA beneficiaries.

KEYWORDS

Medicare Advantage, telehealth availability, telehealth use, Traditional Medicare

INTRODUCTION

In response to the COVID-19 pandemic, the Medicare program implemented a rapid expansion of telehealth benefits. This expansion was facilitated by temporary regulatory waivers, including relaxed geographic limitations for telehealth provision beyond rural areas and allowing telehealth to be delivered in patients' homes.[1] Evidence suggests that telehealth availability and use among Traditional Medicare (TM) beneficiaries dramatically increased during the onset of the pandemic.[2–5] However, by 2022, the proportion of TM beneficiaries using telehealth services decreased to approximately 15%.[6]

While prior work has largely focused on telehealth use delivered to TM beneficiaries, nearly half of the Medicare population is covered by Medicare Advantage (MA) plans.[7] Growth in overall telehealth use may be more pronounced among MA enrollees, as MA plans have been permitted by Congress to cover telehealth services in a patient's home and in both rural and nonrural areas, as early as 2018.[8] Therefore, MA plans have had up to 2 years to develop telehealth offerings and promote telehealth use among enrollees prior to the expansion of telehealth flexibilities for TM beneficiaries.[8]

During the COVID-19 public health emergency, MA plans were required to cover all telehealth services offered by TM, with the added flexibility to provide additional telehealth services as part of the basic benefit package or as a supplemental benefit, potentially encompassing telemonitoring and direct-to-consumer telehealth visits.[9] These features may contribute to coverage of more telehealth offerings and overall higher telehealth availability for beneficiaries in MA compared to TM. In 2021, 94.0% of MA plans offered supplemental telehealth benefits.[10] These basic and supplemental benefits for telehealth may vary among MA plans, but are integral components of plans and have been cited as a primary reason for beneficiaries' choice of MA plan enrollment.[11] Despite support for increased telehealth offerings for MA beneficiaries versus TM beneficiaries, it remains unclear whether more comprehensive coverage of telehealth services among MA beneficiaries translates into greater telehealth use.

To address this gap in knowledge, we used a nationally representative sample of Medicare beneficiaries and conducted two analyses. First, we examined differences in telehealth availability and use between TM and MA beneficiaries. We hypothesized that compared to TM beneficiaries, MA beneficiaries had greater access to telehealth services, but had fewer telehealth visits. This is particularly relevant because socially vulnerable populations, who often face challenges in technology access and experience, are more likely to enroll in MA plans.[12,13] As a secondary analysis, we examined differences in available technology for telehealth use and experience using the internet to search for information between TM and MA beneficiaries. We hypothesized that compared to TM beneficiaries, MA beneficiaries had less equipment availability and internet experience.

Key points

- Medicare Advantage plans must cover all telehealth benefits included in Traditional Medicare, but may also provide additional telehealth benefits.
- This cross-sectional study found that compared to Traditional Medicare beneficiaries, Medicare Advantage beneficiaries had greater access to telehealth services, but had fewer telehealth visits.
- This difference in telehealth use was not associated with patient-level technology barriers such as equipment availability and internet experience.

Why does this paper matter?

Many Medicare Advantage plans provide supplemental telehealth benefits that could potentially improve access to care and well-being. However, our findings suggest that more comprehensive coverage of telehealth services among Medicare Advantage beneficiaries did not translate into greater telehealth use, suggesting that the full advantages of these benefits may not be realized due to low take-up. Furthermore, this difference was not associated with patient-level technology barriers, implying that other patient factors or practice/clinician factors may play a significant role in influencing telehealth use among Medicare Advantage beneficiaries.

METHODS

Data

This cross-sectional study used data from the 2021 Medicare Current Beneficiary Survey (MCBS) Public Use Files.[14] The MCBS is a panel survey of a nationally representative sample of the Medicare population. The data collects beneficiary-level information on demographic, socioeconomic, healthcare utilization, and health status

characteristics through administrative records and three survey rounds annually. We used the Public Use Files, which are limited versions of the data made available to the public. The 2021 dataset was the first to include telehealth-related information in the Public Use File.

Study population

We first identified all community-dwelling Medicare beneficiaries with full-year enrollment in either TM or MA ($n = 10{,}308$). Then, we excluded those with missing telehealth information ($n = 1964$) and those with missing data on other variables ($n = 214$). Our final sample comprised 8344 Medicare beneficiaries with full-year enrollment in either TM or MA.

Measures

Our primary outcomes were binary measures of telehealth availability and use. First, we assessed the availability of telehealth services (defined by a "yes" response to "Does your usual provider offer telephone or video appointments?"). Second, we evaluated the use of telehealth services (defined by a "yes" response to "Since July 1, 2021, have you had an appointment with a doctor or other health professional by telephone or video?"). We assessed telehealth availability and use both overall and by modality (telephone only, video only, and both). Furthermore, we investigated several secondary outcomes. These included three binary measures of equipment availability that may enable telehealth use (owning or use a computer, smartphone, or tablet) and three binary measures of internet experience (ever using the internet to get information, using the internet to look up health information, and ever accessing the official website for Medicare information).

Our primary independent variable was full-year enrollment in MA versus TM. We adjusted for differences between TM and MA beneficiaries using characteristics based on the Andersen behavioral model of healthcare utilization, which has been widely used in studies of healthcare services.[15] The model posits that health care use is determined by predisposing, enabling, and need factors. Thus, we categorized the individual-level characteristics into three categories: predisposing factors (age, sex, and self-reported race/ethnicity), enabling factors (education, family income, Medicare-Medicaid dual-eligibility, and non-metropolitan residence), and need factors (comorbidities [acute myocardial infarction, congestive heart failure, stroke, cancer, dementia, depression, and diabetes], and functional limitations).

Statistical analyses

We first compared sample characteristics between TM and MA beneficiaries using chi-square tests for categorical variables and analysis of variance tests for continuous variables. To estimate adjusted differences in outcomes between TM and MA beneficiaries, we used a logistic regression model that controlled for the individual-level characteristics described above. We then used predictive margins to calculate the mean adjusted values of the outcomes for TM and MA beneficiaries while holding constant all other variables except enrollment in MA versus TM, allowing us to compare the outcome of interest between TM and MA enrollees. Then, we estimated the differences in outcomes between TM and MA beneficiaries. The analysis of telehealth availability included all beneficiaries in the sample, while the analysis of telehealth use was limited to those offered telehealth services.

For all analyses, we used survey weights to adjust the sample characteristics to be nationally-representative. We also accounted for the complex survey design in standard error estimation. Data were analyzed using Stata statistical software version 16.1 (StataCorp). Reported p-values were two-sided, and $p < 0.05$ represented statistical significance.

RESULTS

Our final sample included 8130 Medicare beneficiaries (representing a weighted sample of 38,855,761 beneficiaries), including 4134 TM beneficiaries and 3996 MA beneficiaries (Table 1). Compared to TM beneficiaries, MA beneficiaries were more likely to be older, be non-Hispanic Black or Hispanic, have lower levels of education and family income, qualify for both Medicare and Medicaid, have more comorbidities (acute myocardial infarction, stroke, dementia, depression, diabetes), and less likely to reside in non-metropolitan areas. Our final sample closely resembled the original MCBS sample among TM and MA beneficiaries in terms of characteristics, with the exception of metropolitan residence. After excluding those without telehealth information, we observed a lower proportion of individuals living in non-metropolitan areas.

Among 8130 Medicare beneficiaries, 5547 beneficiaries (68.2%) were offered telehealth services (Table 2). MA beneficiaries were 2.9 (95% CI: 0.6–5.2) percentage points more likely to have a provider who offered telehealth services than TM beneficiaries. However, MA beneficiaries were 3.5 (95% CI: −6.7, −0.4) percentage points less likely to use telehealth services than TM

TABLE 1 Sample characteristics of Medicare beneficiaries, 2021 Medicare current beneficiary survey data.

Characteristic	TM ($n = 4134$)	MA ($n = 3996$)	*p*-value
Age			0.003
<65	15.5	16.4	
65–74	37.8	34.1	
≥75	46.7	49.5	
Female	48.5	43.5	0.000
Race/ethnicity			0.000
Non-Hispanic White	80.2	66.9	
Non-Hispanic Black	7.2	12.5	
Hispanic	7.2	15.4	
Non-Hispanic other	5.4	5.1	
Education			0.000
Less than high school	9.7	18.0	
High school	28.1	31.8	
More than high school	62.3	50.3	
Family income			0.000
≤100% of FPL	11.5	19.8	
100%–199% of FPL	19.2	29.3	
≥200% of FPL	69.4	50.9	
Residence in non-metropolitan area	24.0	15.6	0.000
Dual eligibility for Medicare and Medicaid	15.0	25.8	0.000
Comorbidities			
Acute myocardial infarction	8.8	9.7	0.006
Congestive heart failure	5.8	6.3	0.142
Stroke	9.6	10.4	0.022
Cancer	19.9	19.1	0.698
Dementia	2.9	4.0	0.042
Depression	25.6	28.6	0.022
Diabetes	29.0	36.2	0.000
Functional limitations			0.066
No functional limitation	56.5	54.5	
IADLs only	16.1	15.5	
1–2 ADLs	17.8	19.9	
3+ ADLs	9.6	10.1	

Abbreviations: ADL, activities of daily living; FPL, federal poverty level; IADL, instrumental activities of daily living; MA, Medicare Advantage; TM, Traditional Medicare.

beneficiaries. Among specific types of telehealth services, MA beneficiaries had greater access to both telephone and video telehealth options with an adjusted difference of 3.6 (95% CI: 1.0–6.1) percentage points, but used video-only options less frequently than TM beneficiaries with an adjusted difference of −2.7 (95% CI: −5.1, −0.3) percentage points. There were no statistically significant differences in other outcomes.

Despite lower telehealth use, MA beneficiaries had comparable or higher rates of access to technologies that may enable telehealth use and experience with the internet relative to TM beneficiaries (Table 3). MA beneficiaries were 3.0 (95% CI: 0.8–5.1) percentage points more likely to use a smartphone, 2.0 (95% CI: 0.1–3.8) percentage points more likely to ever use the internet to obtain information, and 4.3 (95% CI: 1.6–6.9) percentage points

TABLE 2 Differences in telehealth availability and use between TM and MA beneficiaries, 2021 Medicare current beneficiary survey data.

Outcomes	Adjusted estimates (95% CI)[a]		
	TM beneficiaries	MA beneficiaries	Difference among MA beneficiaries relative to TM beneficiaries
Availability of telehealth ($n = 8369$)[b]			
Any telehealth	66.9 (65.2, 68.6)	69.8 (68.3, 71.3)	2.9 (0.6, 5.2)
Telephone only	12.1 (10.9, 13.2)	12.3 (11.1, 13.5)	0.3 (−1.4, 1.9)
Video only	8.1 (7.1, 9.1)	7.0 (6.0, 7.9)	−1.1 (−2.5, 0.3)
Both telephone and video	41.3 (39.5, 43.1)	44.9 (43.1, 46.6)	3.6 (1.0, 6.1)
Use of telehealth ($n = 5395$)[c]			
Any telehealth	48.5 (46.3, 50.7)	44.9 (42.7, 47.1)	−3.5 (−6.7, −0.4)
Telephone only	21.2 (19.3, 23.1)	21.1 (19.3, 22.8)	−0.2 (−2.7, 2.4)
Video only	17.6 (15.8, 19.3)	14.8 (13.2, 16.5)	−2.7 (−5.1, −0.3)
Both telephone and video	9.3 (8.0, 10.6)	8.7 (7.4, 9.9)	−0.7 (−2.5, 1.1)

Abbreviations: MA, Medicare Advantage; TM, Traditional Medicare.

[a]Logistic regression models were used to generate estimates while adjusting for individual-level characteristics (age, sex, race/ethnicity, education, family income, Medicare-Medicaid dual eligibility, residence in non-metropolitan area, comorbidities, and functional limitations). From the regression results, we calculated the mean adjusted values of the outcomes for TM and MA beneficiaries while holding constant all other variables, allowing us to compare the outcome of interest. For all analyses, we used survey weights to adjust the sample characteristics to be representative of the Medicare population.

[b]The analysis of telehealth availability included all beneficiaries in the sample. Telehealth availability was determined by a "yes" response to the question "Does your usual provider offer telephone or video appointments?"

[c]The analysis of telehealth use was limited to those offered telehealth services. Telehealth use was determined by a "yes" response to "Since July 1, 2021, have you had an appointment with a doctor or other health professional by telephone or video?"

TABLE 3 Differences in equipment availability and internet experience between TM and MA beneficiaries with access to telehealth services, 2021 Medicare current beneficiary survey data.

Outcomes	Adjusted estimates (95% CI)[a]		
	TM beneficiaries	MA beneficiaries	Difference among MA beneficiaries relative to TM beneficiaries
Equipment availability ($n = 5395$)[b]			
Own or use computer	75.6 (73.9, 77.3)	73.1 (71.4, 74.8)	−2.5 (−4.9, 0.1)
Own or use smartphone	79.9 (78.4, 81.5)	82.9 (81.5, 84.3)	3.0 (0.8, 5.1)
Own or use tablet	52.7 (50.5, 54.8)	50.9 (48.7, 53.0)	−1.8 (−4.9, 1.3)
Internet experience ($n = 5395$)[b]			
Ever use the internet to get information	82.2 (80.9, 83.5)	84.2 (82.9, 85.4)	2.0 (0.1, 3.8)
Use the internet to look up health information	65.2 (63.3, 67.2)	69.5 (67.7, 71.3)	4.3 (1.6, 6.9)
Ever access the official website for Medicare information	54.2 (52.1, 56.3)	51.4 (49.2, 53.5)	−2.9 (−5.9, 0.2)

Abbreviations: MA, Medicare Advantage; TM, Traditional Medicare.

[a]Logistic regression models were used to generate estimates while adjusting for individual-level characteristics (age, sex, race/ethnicity, education, family income, Medicare-Medicaid dual eligibility, residence in non-metropolitan area, comorbidities, and functional limitations). From the regression results, we calculated the mean adjusted values of the outcomes for TM and MA beneficiaries while holding constant all other variables, allowing us to compare the outcome of interest. For all analyses, we used survey weights to adjust the sample characteristics to be representative of the Medicare population.

[b]The analysis of telehealth use was limited to those offered telehealth services.

more likely to use the internet to look up health information compared to TM beneficiaries. No significant differences were observed in other outcomes.

DISCUSSION

In this nationally representative analysis of Medicare beneficiaries, we found that MA beneficiaries were more likely to have a provider who offered telehealth services, but were less likely to utilize telehealth services than TM beneficiaries. These findings align with prior evidence suggesting that MA beneficiaries have lower rates of telehealth use for behavioral health services than TM beneficiaries (9% vs 16%).[16] Given that behavioral health constitutes a substantial portion of telehealth services, this may contribute to differences in telehealth use between MA and TM beneficiaries. We found that these differences in telehealth use were not associated with patient-level technology barriers, as MA beneficiaries did not have differential access to computers, phones and tablets, nor differences in their experience using the internet to look for information, compared to TM beneficiaries.

Our findings suggest that other patient or practice/clinician factors may influence telehealth use among MA beneficiaries.[17,18] For instance, providers may be less motivated to provide telehealth services to MA beneficiaries, given the strong financial incentives in a managed care environment to prioritize cost efficiency and reduce unnecessary care.[19] This may depend, however, on whether providers see telehealth as a cost-saving appropriate form of care that substitutes for or complements in-person care. Therefore, if telehealth is seen as low-value care in certain contexts, capitated MA plans may seek to restrict the provision of telehealth to MA beneficiaries.

We also found that compared to TM beneficiaries, MA beneficiaries were more likely to be Black or Hispanic.[12,13] Recent research has shown that even after controlling for geographic, demographic, and clinical factors, Black and Hispanic TM beneficiaries were less likely to receive telemedicine than White beneficiaries.[20] These differences may be attributed to differences in clinical need or preferences for telehealth versus in-person care, as well as systematic barriers to care that might limit access to telehealth services. Thus, further research is warranted to explore the underlying mechanisms for the lower use of telehealth services among Black or Hispanic Medicare beneficiaries.

Our findings have important policy implications. The Medicare Payment Advisory Committee estimates that MA plans receive approximately 6% more per beneficiary than the cost of covering similar beneficiaries in TM, amounting to about $27 billion in 2021.[21] This highlights the importance of ensuring that these additional payments translate into enhanced benefits for MA enrollees.[22,23] We found that some of the increased payments may indeed contribute to better benefits, but the full advantages of these benefits may not be realized due to low take-up among MA beneficiaries. In particular, given that MA beneficiaries are more likely to be racial and ethnic minorities, and may experience greater social vulnerability, these findings that MA beneficiaries have lower telehealth take-up have important implications for health equity. Further research is warranted to identify the underlying mechanisms driving lower telehealth use among MA beneficiaries, including disentangling patient preferences for telehealth from structural barriers to telehealth use.

Our study has several limitations. First, we relied on survey data, which may introduce self-reporting error and bias into our findings. Second, we used MCBS data collected during the COVID-19 pandemic, which may have influenced responses. However, prior research has indicated that these impacts are minimal.[14] Third, we assumed that Medicare beneficiaries had telehealth access and use at the time of the interview. However, there may be a discrepancy between the timing of the interview and the actual occurrence of telehealth access and use. Fourth, we controlled for a comprehensive set of potential confounders, but unobserved characteristics, such as those related to selection into MA plans, may still pose a potential limitation. Because our findings are associations and not causal, they should be interpreted cautiously.

CONCLUSION

Many MA plans provide supplemental and basic telehealth benefits that could potentially improve access to care. However, our study found that although MA beneficiaries were more likely to have a provider who offered telehealth, they had relatively fewer telehealth visits compared to TM beneficiaries. While this difference was not found to be associated with access to technology or internet experience, future research is warranted to explore underlying mechanisms behind relatively lower use of telehealth among MA beneficiaries.

AUTHOR CONTRIBUTIONS

Dr. Park had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis. *Concept and design*: All authors. *Acquisition, analysis, or interpretation of data*:

All authors. *Drafting of the manuscript*: All authors. *Critical revision of the manuscript for important intellectual content*: All authors. *Statistical analysis*: Park. *Obtained funding*: None. *Administrative, technical, or material support*: Park. *Supervision*: Park.

CONFLICT OF INTEREST STATEMENT

Dr. Jung reports grant funding outside the submitted work from the National Institute on Aging and honoraria from Brown University and Chung-Ang University.

SPONSOR'S ROLE

None.

FINANCIAL DISCLOSURE

None.

ORCID

Sungchul Park https://orcid.org/0000-0002-7546-9685
Jiani Yu https://orcid.org/0000-0002-7518-6220

REFERENCES

1. Department of Health and Human Services. *Certain Medicare Beneficiaries, Such As Urban and Hispanic Beneficiaries, Were More Likely Than Others to Use Telehealth During the First Year of the COVID-19 Pandemic*. Accessed September 3, 2024. https://oig.hhs.gov/oei/reports/OEI-02-20-00522.asp
2. Samson L, Tarazi W, Turrini G, Sheingold S. *Medicare Beneficiarie's Use of Telehealth Services in 2020—Trends by Beneficiary Characteristics and Location*. Department of Health and Human Services; 2021.
3. Chang M-H, Moonesinghe R, Truman BI. Telehealth availability and usage among Medicare beneficiaries during the COVID-19 pandemic, October and November 2020. *J Public Health Manag Pract*. 2022;28(1):77-85.
4. Suran M. Increased use of Medicare telehealth during the pandemic. *Jama*. 2022;327(4):313.
5. Patel SY, Mehrotra A, Huskamp HA, Uscher-Pines L, Ganguli I, Barnett ML. Variation in telemedicine use and outpatient care during the COVID-19 pandemic in the United States. *Health Aff*. 2021;40(2):349-358.
6. Centers for Medicare and Medicaid Services. *Medicare Telehealth Trends Report*. Centers for Medicare and Medicaid Services; 2023.
7. *Medicare Advantage in 2022: Enrollment Update and Key Trends*. Kaiser Family Foundation; 2022. Accessed September 3, 2024. https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-enrollment-update-and-key-trends/
8. Grabert LM, McCormack G, Trish E, Wagner KL. Fostering flexibility: how Medicare Advantage potentially accelerated telehealth benefits. *Inquiry*. 2024;61:00469580241238671.
9. Neuman P, Jacobson GA. Medicare Advantage checkup. *N Engl J Med*. 2018;379(22):2163-2172.
10. Park S, Langellier BA, Meyers DJ. Adoption of telehealth benefits by Medicare Advantage plans in 2020 and 2021. *J Gen Intern Med*. 2022;37(3):686-688.
11. Leonard F, Jacobson G, Haynes LA, Collins SR. *Traditional Medicare or Medicare Advantage: How Older Americans Choose and Why*. Commonwealth Fund. 2022. Accessed September 3, 2024. https://www.commonwealthfund.org/publications/issue-briefs/2022/oct/traditional-medicare-or-advantage-how-older-americans-choose
12. Meyers DJ, Mor V, Rahman M, Trivedi AN. Growth in Medicare Advantage greatest among Black and Hispanic enrollees. *Health Aff*. 2021;40(6):945-950.
13. Park S, Meyers DJ, Rivera-Hernandez M, Bustamante AV. Medicare Advantage enrollment by immigration and English proficiency status. *Am J Manag Care*. 2023;29(9):e280-e283.
14. *Medicare Current Beneficiary Survey 2021: Data User's Guide*; 2022.
15. Andersen RM. Revisiting the behavioral model and access to medical care: does it matter? *J Health Soc Behav*. 1995;36(1):1-10.
16. U.S. Department of Health and Human Services. *Telehealth Was Critical for Providing Services to Medicare Beneficiaries During the First Year of the COVID-19 Pandemic*. U.S. Department of Health and Human Services Office of Inspector General; 2022.
17. Rodriguez JA, Betancourt JR, Sequist TD, Ganguli I. Differences in the use of telephone and video telemedicine visits during the COVID-19 pandemic. *Am J Manag Care*. 2021;27(1):21-26.
18. Ganguli I, Orav EJ, Hailu R, et al. Patient characteristics associated with being offered or choosing telephone vs video virtual visits among Medicare beneficiaries. *JAMA Netw Open*. 2023;6(3):e235242.
19. Beckman AL, Frakt AB, Duggan C, et al. Evaluation of potentially avoidable acute care utilization among patients insured by Medicare Advantage vs Traditional Medicare. *JAMA Health Forum*. 2023;4(2):e225530.
20. Marcondes FO, Normand S-LT, Le Cook B, et al. Racial and ethnic differences in telemedicine use. *JAMA Health Forum*. 2024;5(3):e240131.
21. The Medicare Payment Advisory Committee. *Chapter 11: The Medicare Advantage Program: Status Report (March 2023 Report). The Medicare Payment Advisory Committee*; 2023.
22. Park S, Meyers DJ, Trivedi AN. Association of Medicare Advantage enrollment with financial burden of care. *Ann Intern Med*. 2024;177(7):882-891.
23. Park S, Berkowitz SA. Financial hardship among Traditional Medicare and Medicare Advantage enrollees with and without food insecurity. *J Gen Intern Med*. 2024.

How to cite this article: Park S, Jung H-Y, Yu J. Telehealth availability and use among beneficiaries in Traditional Medicare and Medicare Advantage. *J Am Geriatr Soc*. 2025;73(2):545-551. doi:10.1111/jgs.19183