Medicare Advantage Funding Cuts and the Impact on Beneficiary Value

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Prepared by:
Milliman, Inc.

Brett L. Swanson, FSA, MAAA
Consulting Actuary

Eric P. Goetsch, FSA, MAAA
Principal and Consulting Actuary

15800 Bluemound Road
Suite 100
Brookfield, WI 53005
USA
Tel +1 262 784 2250
Fax +1 262 923 3680

milliman.com

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I. EXECUTIVE SUMMARY

The Medicare Advantage program is a government-sponsored program that offers an alternative to traditional fee-for-service (FFS) Medicare where benefits are provided to Medicare beneficiaries by private health plans. The cost of the program is funded in large part by the federal government, with the revenue received by private plans based on laws, regulations, and an underlying bidding process established, regulated, and overseen by the Center for Medicare and Medicaid Services (CMS).

Various legislated and regulatory changes have impacted the federal government's funding of Medicare Advantage plans, including the American Taxpayer Relief Act (ATRA), sequestration, the conclusion of the Quality Bonus Payment Demonstration, and other regulatory changes. Additionally, the Patient Protection and Affordable Care Act (ACA) changed the methodology of calculating payment rates to Medicare Advantage Organizations (MAOs, or "plans") beginning in 2012. Since that time, CMS payments to MAOs have been decreasing annually, resulting in less "value add" to members over time. "Value add" is defined as the value of benefits provided to a plan's beneficiaries above traditional Medicare that are not funded through member premiums. This metric not only accounts for the value of non-Medicare covered benefits and traditional Medicare cost-sharing reductions, but it is also offset by each plan's member premium. Therefore, two plans with identical benefits will have different value adds if their premiums vary.

Overall, Medicare Advantage value add for beneficiaries has been decreasing every year from 2012 to 2015. This is also true for Medicare Part C (medical) and Medicare Part D (prescription drugs) separately, but the drivers of each are different. For Part C, benefit value and premiums have been decreasing every year, but benefit value has been decreasing faster than premium, resulting in a decrease in value add every year. For Part D, benefit values have not decreased as sharply as Part C, but premiums have increased each year even as benefit levels have fallen.

The cumulative change in average annual premium and average annual value add, for all general enrollment beneficiaries nationwide, from 2012 to 2015 is $18.96 and -$180.24, respectively. The cumulative change in average annual premium and average annual value add, for general enrollment beneficiaries nationwide while excluding the impact of member migration for continuing plans, from 2012 to 2015 is $157.32 and -$295.20, respectively.

The funding pressures faced by MAOs continue to mount, resulting in an increase in the number of counties not serviced by Medicare Advantage general enrollment plans. In total, there were 55 counties, 79 counties, 169 counties, and 211 counties nationwide not serviced by general enrollment Medicare Advantage plans in 2012, 2013, 2014, and 2015, respectively.

The Medicare Advantage market will continue to evolve with the increased pressure on MAO revenue resulting from the ACA, ATRA, sequestration, the end of the Quality Bonus Payment Demonstration, and other regulatory changes. General enrollment plan beneficiaries have generally seen a reduction in benefit value and an increase in premium amounts since the implementation of the ACA.

As Medicare Advantage plans and beneficiaries continue to operate in the 2015 plan year, it is also important to be aware of further changes currently scheduled to occur in 2016. Many of these changes will put continued pressure on revenue payments to MAOs and, consequently, possibly on beneficiaries as well through additional benefit reductions and premium increases.

II. OVERVIEW

CMS requires all MAOs to submit a bid by the first Monday in June that estimates the cost to provide traditional Medicare benefits to an "average risk" Medicare beneficiary for the coming year. A portion of any savings generated by the MAO (the savings defined as the difference between the benchmark payment rate and the bid) is returned to the plan as a rebate, which can be used by the plan to provide benefits above and beyond traditional Medicare, such as reductions to cost-sharing on Medicare services or coverage of non-Medicare services such as dental. If a plan's total estimated cost to provide traditional Medicare and supplemental benefits (including administrative costs and profit margin) is greater than the amount of revenue received from CMS through the base revenue and rebate, the difference is funded through premiums charged to the plan's members.

This report highlights key changes in beneficiary premiums and benefits over time as well as the reasons for and the magnitude of the decrease in the value add within the Medicare Advantage market between 2012 and 2015. We summarize the components of the ACA and subsequent legislated actions driving the downward pressure on payments to MAOs. Plans have been combatting these reductions the best they can prior to making benefit and premium changes; however, it was inevitable some changes would need to be made that impact beneficiaries. We summarize the changes that are contributing to the decline of beneficiary value within Medicare Advantage.

There are a variety of plan types that are offered through the Medicare Advantage program, including general enrollment plans and Special Needs Plans (SNPs). As the name suggests, SNPs have restrictive enrollment criteria that are limited to individuals with special needs. Specifically, Dual SNPs are limited to members that are eligible for both Medicare and Medicaid benefits, Institutional SNPs are limited to nursing home eligible enrollees, and Chronic SNPs are limited to members with certain chronic conditions. This report includes results on a nationwide basis and focuses on general enrollment plans since the benefit considerations and premiums charged by SNPs are influenced by other mechanisms such as the Low Income Benchmarks. Additionally, we excluded stand-alone prescription drug plans (PDPs), Providers for All Inclusive Care for the Elderly (PACE) plans, Medicare cost plans, Medical Savings Account plans, Employer Group Waiver Plans, and Dual Demonstration (a.k.a. Medicare-Medicaid) plans.

Components of legislated actions driving the downward pressure on payments to MAOs

1. **County benchmarks now being based on fee-for-service costs and quality star ratings**

   The funding mechanism for the Medicare Advantage program has been shifting since 2012 (and will continue through 2017) to include a greater reliance on estimated Medicare FFS costs and a plan's quality rating. This results in varied levels of annual payment changes across the country, but the aggregate net impact has been lower county benchmarks year over year. Lower county benchmarks result in lower "savings," of which the MAO is allowed to retain a portion (a.k.a. rebates) to fund additional member benefits that traditional Medicare does not cover without the need to charge additional member premium.

2. **Payment rate caps limiting the positive impact of bonuses**

   Beginning in 2015, the final benchmark for a county is capped at the level of the county's pre-ACA benchmark amount, which ensures that all ACA county benchmarks are less than or equal to the pre-ACA county benchmarks. In many instances, this cap results in no star rating quality bonuses, thus removing the payment increases that are rewarded to plans based on higher quality as measured by the star rating program.

3. Lower Part C rebate percentages

Prior to ACA, rebates as a percentage of savings were 75% but have subsequently decreased to 70% for plans with 4.5 or more stars, 65% for plans with 3.5 to 4.5 stars, and 50% for plans with less than 3.5 stars by 2014. For example, if a plan's bid was $900 against a $1,000 benchmark, the pre-ACA rebate was $75 (75% of the difference between the $1,000 benchmark and the $900 bid). All else equal, the post ACA rebate for a 5.0 star plan (5.0 stars is the highest rating achievable under the star rating system) is decreased to $70 (70% of the difference between the benchmark and bid), a reduction of $5 which could have otherwise been used to provide additional beneficiary value.

4. Minimum loss ratios limit retention amounts

Beginning in 2014, plans were required to have a minimum loss ratio of 85%. With 15% allowed for retention, plans with larger administrative cost margins (typically smaller plans with smaller economies of scale) have less opportunity for reasonable long term profit margins. Any plan not exceeding the minimum loss ratio must pay a rebate. Unlike some other health insurance markets, this rebate is not returned to the member, but is retained by CMS.

5. Minimum Medicare Advantage coding intensity adjustment

A Medicare Advantage coding intensity adjustment is applied to payments which reflects "differences in coding patterns between Medicare Advantage plans and providers under Part A/B to the extent that the Secretary has identified such differences." The ACA, combined with the impact of the ATRA, extended the application of the Medicare Advantage coding intensity adjustment through 2019, increasing the minimum adjustment 0.25% each year until 2017, when a minimum reduction in Part C risk scores will be 5.90%. All else equal, this mandated increase in the Medicare Advantage coding intensity adjustment decreases the revenue received from the government by a commensurate amount.

6. Health Insurer Fee

A new premium tax introduced as part of the ACA, the health insurer fee, started in 2014. The health insurer fee is an additional expense that can increase an MAO's non-benefit expenses up to approximately 3.0%, depending on the MAO. Smaller MAOs and not-for-profit MAOs will be assessed a smaller fee (or no fee).

7. Sequestration cuts

Due to the budget sequestration in 2013, in which automatic spending cuts to particular categories of the US federal government kicked in as a result of the proposed budget exceeding budget caps, all Medicare Advantage payments made to MAOs were reduced 2% beginning April 1, 2013.

Plans' approaches to offset Medicare Advantage payment reductions prior to making changes that impact beneficiary value

1. **Increased medical management leading to lower utilization and more efficient (i.e., lower cost) administrative services**

   In 2009, prior to the implementation of the ACA, Medicare Advantage payments to plans averaged approximately 114% of traditional Medicare costs[1]. In that environment, even operating at FFS utilization levels (i.e., little to no medical management), there was sufficient additional revenue to cover administration costs and maintain a reasonable profit. As the ratio of Medicare Advantage plan payments to traditional Medicare costs approaches 100% in 2017, MAOs must obtain more utilization savings via medical management to allow for administrative costs and profit.

2. **Reducing provider reimbursement levels**

   MAOs are looking to renegotiate their provider contracts to reduce direct reimbursement (e.g., reimburse at a lower percentage of the Medicare fee schedule), transfer risk to providers (e.g., through capitation or risk sharing arrangements), or create incentives to lower unnecessary utilization.

3. **Better diagnoses capture leading to higher risk scores**

   Through both prospective approaches (e.g., educating providers and developing prompt documentation) and retrospective approaches (e.g., performing charts reviews and creating suspect lists), MAOs can capture more of the diagnoses reflected in the CMS-HCC risk model and directly increase plan revenue for the next calendar year. However, to the program in aggregate, such actions are offset by reductions in overall payments from CMS to the extent risk score improvements exceed the minimum MA coding intensity adjustment.

4. **Better performance measures leading to higher star ratings**

   Ensuring that the MAO's performance in the 46 star rating measures is as good as it can be maximizes the opportunity for the MAO's highest possible star rating, which has a direct impact on the county benchmarks for the plan measure, keeping in mind that the performance measure captured in a given year does not impact plans revenue for approximately three years.

5. **Lowering profit margins**

   Many MAOs have had no other options but to lower their profit margins to very low levels in order to remain competitive. In some situations, profit margins have temporarily become negative. In these cases, CMS requires supporting documentation on how the MAO will bring the plan to profitability over the next two to five years. If positive profitability can't be supported in the next two to five years, then the plan offering is required to be terminated.

[1] Medicare Payment Advisory Commission, *Report to the Congress Medicare Payment Policy* (March 2009)

Inevitable changes that need to be made that impact beneficiary value

1. Narrower networks

While MA Plans seek to structure provider networks to encourage better health care outcomes at a lower overall cost, moving to narrower networks allows for the MAO to be more cost efficient. However, having fewer providers in the network may result in some members losing access to their current providers.

2. Higher cost sharing and out-of-pocket maximums

The impact of higher cost sharing and out-of-pocket maximums is at the point of service. As a result, those individuals receiving services more regularly would be most impacted by these changes. In addition, if cost sharing gets high enough, it may trigger some individuals to not seek needed medical care to avoid paying the cost sharing.

3. Higher premiums

MA plans may need to increase premiums in order to maintain the same level of benefits. Although premium increases affect all members, those individuals not receiving services on a regular basis would likely be most discouraged by higher premiums as they don't directly feel the benefit of the coverage they are receiving for that premium as much as those utilizing services on a routine basis.

4. Fewer non-Medicare covered supplemental benefits

Medicare Advantage plans often cover benefits that are not covered by traditional Medicare. This includes benefits such as, but not limited to, preventive dental services, routine eye exams, glasses and contacts, non-emergency transportation, routine hearing exams, hearing aids, and coverage of over-the-counter prescription drugs. As funding of the Medicare Advantage program decreases, MAOs must consider removing the coverage of some of these benefits, thereby reducing the affordability and access of these services for some Medicare beneficiaries.

5. Forced migration to other plans

In some situations, one of the prior four changes may be a change that, for a variety of reasons, an individual cannot accept. In those situations, the individual will either look for another plan or move back to traditional Medicare. This results in disruptions for the beneficiary, which could include the need to enroll in a new plan, becoming accustomed to a new benefit design and premium structure, being subject to a different network of physicians, and changes to the administrative process (i.e., customer service numbers, billing information, etc.) due to having a different MAO plan sponsor.

III. RESULTS

Using our industry leading *Health Cost Guidelines®* and other Milliman tools, Milliman measured the actuarial value ("value add") by county of each general enrollment Medicare Advantage benefit plan in the country for each year from 2012 to 2015, including the value of traditional Medicare cost sharing reductions, supplemental benefits, and reduced by the member premium. The results below are provided on a per member per month basis.

Table 1 contains the nationwide average "benefit values," which are calculated as the difference between the value of benefits offered within the Medicare Advantage plans compared to the value of benefits offered in traditional Medicare. The total Part C benefit value column is the sum of the benefit values of the prior five columns: inpatient, outpatient, physician, other Medicare covered, and non-Medicare covered. For the Medicare covered benefits, it is a measure of how much lower the cost sharing is within the Medicare Advantage plans versus traditional Medicare. For the Other Non-Medicare Covered benefits, it is a measure of the value of the additional benefits being offered. The Part D column reflects the Part D member premium needed to pay for the Part D benefit levels within each plan.

The first set of results, labeled "September," uses the membership levels by plan from September of the prior year to develop the weighted averages across all plans for the given year (including all plans offered in a given year). The next sets of results, labeled "Continuing with Migration" and "Continuing without Migration," use the membership from September 2014 and September 2011, respectively, to develop, for each year, the weighted averages across "continuing plans." Continuing plans are those that have been offered every year from 2012 to 2015. The purpose of including both of these sets of results is to help illustrate the impact of migration on benefit value, member premium, and value add. The "Continuing with Migration" results are those assuming the membership mix among plans as of September 2014 is the same membership mix among plans every year (i.e., that the three years of migration is reflected in full every year). It is worth noting that the membership increases slightly over time due to the expansion of service areas for continuing plans. The "Continuing without Migration" results are those assuming the membership mix among plans as of September 2011 is the same membership mix among plans every year (i.e., that there was no migration). It is worth noting that the membership decreases slightly over time due to the contraction of service areas for continuing plans.

Table 1
Medicare Advantage National Average Benefit Value

Year	Enrollment	Inpatient	Outpatient	Physician	Other Medicare Covered	Other Non-Medicare Covered	Total Part C	Part D	Overall Total
September									
2012	7,844,543	$15.87	$15.99	$27.10	$7.37	$11.65	$78.00	$32.01	$110.00
2013	8,620,690	$14.65	$15.20	$26.91	$6.86	$10.29	$73.91	$31.90	$105.81
2014	9,110,400	$13.39	$14.12	$25.02	$5.86	$11.43	$69.82	$29.64	$99.47
2015	8,770,762	$12.88	$13.88	$23.51	$5.64	$12.55	$68.46	$28.16	$96.62
Continuing With Migration									
2012	7,617,231	$15.98	$15.72	$27.58	$7.52	$11.60	$78.40	$32.45	$110.85
2013	7,768,213	$15.24	$14.99	$27.52	$7.21	$10.38	$75.34	$32.74	$108.08
2014	7,865,558	$14.01	$14.07	$25.98	$6.06	$11.98	$72.10	$30.16	$102.26
2015	7,865,681	$13.07	$13.93	$23.62	$5.68	$12.59	$68.89	$28.24	$97.13
Continuing Without Migration									
2012	5,854,271	$16.61	$15.95	$28.12	$7.78	$11.58	$80.03	$32.59	$112.62
2013	5,794,959	$16.10	$15.44	$28.37	$7.37	$10.21	$77.48	$32.89	$110.37
2014	5,713,148	$14.75	$14.60	$26.88	$6.36	$12.05	$74.64	$30.32	$104.96
2015	5,640,178	$14.06	$14.58	$25.00	$6.08	$12.90	$72.62	$28.94	$101.56

The cumulative change in total annual benefit value, for all general enrollment beneficiaries nationwide, from 2012 to 2015 is -$160.56. This is calculated by taking the monthly 2015 total benefit value ($96.62) minus the monthly 2012 total benefit value ($110.00) multiplied by 12 (12 months per year). The cumulative change in total annual benefit value, for general enrollment beneficiaries nationwide while excluding the impact of member migration for continuing plans, from 2012 to 2015 is -$132.72. This is calculated by taking the monthly 2015 total benefit value ($101.56) minus the monthly 2012 total benefit value ($112.62) multiplied by 12.

Table 1 illustrates that benefit values have been decreasing every year from 2012 to 2015 for every benefit category, with the exception of non-Medicare covered services. Our conclusion is that, although downward revenue pressure has caused MAOs to lower their overall plan benefits every year, they continue to add more non-Medicare benefits since these benefits are often the “enticement” benefits MAOs need to attract individuals to their plan.

Table 2 contains the nationwide average “value add” amounts, which are calculated as the difference between the benefit values from Table 1 and the corresponding nationwide average members premiums. In other words, “value add” is defined as the value of benefits provided to a plan’s beneficiaries above traditional Medicare that are not funded through member premiums. Additionally, MAOs have the option of reducing the Part B premiums that are charged to Medicare beneficiaries. To the extent that the Part B premiums are reduced, this too adds to the total value add.

Table 2
Medicare Advantage National Average Premium and Value Add Amounts

		Part C			Part D			Total			
Year	Enrollment	Benefit Value	Premium	Value Add	Benefit Value	Premium	Value Add	Benefit Value	Part B Buy-Down	Premium	Value Add
September											
2012	7,844,543	$78.00	$24.23	$53.76	$32.01	$12.32	$19.68	$110.00	$1.30	$36.56	$74.75
2013	8,620,690	$73.91	$22.91	$51.00	$31.90	$13.59	$18.31	$105.81	$1.07	$36.50	$70.38
2014	9,110,400	$69.82	$21.61	$48.21	$29.64	$15.13	$14.51	$99.47	$1.10	$36.74	$63.82
2015	8,770,762	$68.46	$21.36	$47.11	$28.16	$16.78	$11.38	$96.62	$1.24	$38.14	$59.73
Continuing With Migration											
2012	7,617,231	$78.40	$18.36	$60.05	$32.45	$9.57	$22.88	$110.85	$1.45	$27.93	$84.38
2013	7,768,213	$75.34	$18.83	$56.50	$32.74	$10.09	$22.66	$108.08	$1.32	$28.92	$80.48
2014	7,865,558	$72.10	$19.06	$53.04	$30.16	$12.41	$17.75	$102.26	$1.19	$31.47	$71.98
2015	7,865,681	$68.89	$22.11	$46.79	$28.24	$17.34	$10.90	$97.13	$1.10	$39.45	$58.79
Continuing Without Migration											
2012	5,854,271	$80.03	$25.20	$54.83	$32.59	$11.64	$20.95	$112.62	$1.01	$36.84	$76.79
2013	5,794,959	$77.48	$26.19	$51.29	$32.89	$12.80	$20.09	$110.37	$0.85	$38.99	$72.23
2014	5,713,148	$74.64	$26.76	$47.88	$30.32	$16.13	$14.19	$104.96	$0.62	$42.89	$62.69
2015	5,640,178	$72.62	$29.45	$43.17	$28.94	$20.50	$8.43	$101.56	$0.59	$49.95	$52.19

The cumulative change in average annual premium, for all general enrollment beneficiaries nationwide, from 2012 to 2015 is $18.96. This is calculated by taking the average monthly 2015 premium ($38.14) minus the average monthly 2012 premium ($36.56) multiplied by 12. The cumulative change in average annual premium, for general enrollment beneficiaries nationwide while excluding the impact of member migration for continuing plans, from 2012 to 2015 is $157.32. This is calculated by taking the average monthly 2015 premium ($49.95) minus the average monthly 2012 premium ($36.84) multiplied by 12. The cumulative change in average annual value add, for all general enrollment beneficiaries nationwide, from 2012 to 2015 is -$180.24. This is calculated by taking the average monthly 2015 value add ($59.73) minus

the average monthly 2012 value add ($74.75) multiplied by 12. The cumulative change in average annual value add, for general enrollment beneficiaries nationwide while excluding the impact of member migration for continuing plans, from 2012 to 2015 is -$295.20. This is calculated by taking the average monthly 2015 value add ($52.19) minus the average monthly 2012 value add ($76.79) multiplied by 12.

Table 2 illustrates that, overall, value add has been decreasing every year from 2012 to 2015. This is also true for Part C and Part D separately, but the drivers of each are different. For Part C, benefit value and premiums have been decreasing every year, but benefit value has been decreasing faster than premium, resulting in a decrease in value add every year. For Part D, benefit values have not decreased as sharply as Part C, but premiums have increased each year, even as benefit levels have fallen.

Table 2 also illustrates that migration among plans provides upward pressure to the value add metric as individuals tend to migrate to plans with lower premiums and better value. Comparing the “Continuing with Migration” results to the “Continuing without Migration” results shows lower member premiums and higher value add when considering migration. This comparison also shows that individuals tend to migrate to plans that have slightly lower benefits in exchange for the much lower premium, creating the improvement in the value add.

Table 3 contains various information regarding changes in the Part D benefit design, premium, and benefit value over time for MA-PD plans.

Table 3
Medicare Advantage National Average Part D Benefit Design

Year	Enrollment	Initial Coverage Limit	Part D Deductible	Part D Premium	Part D Benefit Value
September					
2012	7,438,918	$3,060	$15.59	$13.00	$33.75
2013	8,231,595	$3,103	$18.31	$14.23	$33.41
2014	8,733,608	$2,932	$22.87	$15.78	$30.92
2015	8,416,200	$3,031	$91.14	$17.48	$29.35
Continuing With Migration					
2012	7,274,265	$3,073	$17.03	$10.02	$33.98
2013	7,420,868	$3,120	$15.52	$10.56	$34.27
2014	7,517,942	$2,952	$21.25	$12.98	$31.55
2015	7,518,065	$3,039	$91.83	$18.14	$29.55
Continuing Without Migration					
2012	5,540,276	$3,099	$14.06	$12.30	$34.44
2013	5,483,831	$3,153	$14.35	$13.53	$34.76
2014	5,406,455	$2,970	$16.42	$17.05	$32.04
2015	5,340,313	$3,056	$80.15	$21.65	$30.56

Table 3 illustrates relative stability in the initial coverage limit between 2012 and 2015, but increases in the Part D deductible each year. In particular, there is a dramatic increase in the average Part D deductible from 2014 to 2015. This is partially attributable to a significant number of plans changing their benefit type from a “Basic Alternative” or an “Enhanced Alternative” plan design which allows for a Part D deductible from $0 up to the “Defined Standard” Part D deductible ($320 in 2015) to an “Actuarial Equivalent” plan design which mandates that the Part D deductible be equal to the “Defined Standard” Part D deductible. Additionally, a number of plans have introduced Part D deductibles that only apply to a subset of prescription drugs which also contributes to the dramatic increase in the average Part D deductible. As previously

mentioned, Part D premiums have increased every year while benefit value has decreased every year, leading to the decreasing value add of Part D benefit every year, as shown in Table 2. The "Continuing with Migration" results show lower Part D premiums and higher Part D benefit values than the "Continuing without Migration" results, indicating that over time individuals are migrating to plans that have lower Part D premiums and higher Part D benefit values than their existing plan. It is worth noting that the values in Table 3 are slightly different than the corresponding values in other tables, as Table 3 only includes plans that offer Part D benefits. Other tables assume plans that do not offer Part D benefits (e.g., "MA Only" plans) have a Part D premium and value add of $0.

Table 4 contains various information regarding changes in the Part C benefit design over time. This includes both MA-PD and MA-only plans.

Table 4
Medicare Advantage National Average Part C Benefit Design

		All Members			PCP Copay		PCP Coinsurance		SCP Copay		SCP Coinsurance	
Year	**Enroll-ment**	**Out-Of-Pocket Max**	**Deduc-tible**	**Network Size**	**Enroll-ment**	**Copay**	**Enroll-ment**	**Coinsur-ance**	**Enroll-ment**	**Copay**	**Enroll-ment**	**Coinsur-ance**
September												
2012	7,844,543	$4,316	$11.93	8,384	7,829,571	$10.47	14,972	18.67%	7,827,388	$28.08	17,155	19.24%
2013	8,620,690	$4,413	$19.48	8,799	8,606,916	$9.60	13,774	17.82%	8,606,276	$28.92	14,414	19.17%
2014	9,110,400	$4,924	$14.11	9,111	9,094,008	$10.29	16,392	16.89%	9,083,413	$32.17	26,987	19.53%
2015	8,770,762	$5,077	$2.93	8,744	8,742,887	$9.90	27,875	18.78%	8,742,318	$33.58	28,444	19.38%
Continuing With Migration												
2012	7,617,231	$4,337	$6.22	7,545	7,602,385	$10.53	14,846	17.74%	7,600,029	$28.36	17,202	18.05%
2013	7,768,213	$4,320	$14.56	7,869	7,753,214	$9.28	14,999	17.74%	7,752,228	$28.88	15,985	18.89%
2014	7,865,558	$4,889	$7.08	8,446	7,850,559	$9.91	14,999	17.74%	7,842,345	$31.92	23,213	19.24%
2015	7,865,681	$5,074	$2.04	9,011	7,842,605	$10.03	23,076	18.53%	7,842,468	$33.57	23,213	19.24%
Continuing Without Migration												
2012	5,854,271	$4,305	$5.80	7,589	5,847,728	$10.06	6,543	18.09%	5,846,339	$27.57	7,932	18.42%
2013	5,794,959	$4,279	$9.41	7,962	5,788,645	$8.82	6,314	18.03%	5,788,492	$27.87	6,467	18.37%
2014	5,713,148	$4,828	$6.15	8,663	5,707,078	$9.46	6,070	17.95%	5,694,799	$30.67	18,349	19.42%
2015	5,640,178	$4,955	$0.99	8,820	5,628,196	$9.33	11,982	18.96%	5,621,829	$31.79	18,349	19.42%

Table 4 illustrates an increase in the maximum out-of-pocket limit each year, reflecting that individuals' overall potential cost burden is increasing annually. A Part C deductible has been a fairly unpopular cost sharing feature where most Medicare Advantage plans have opted for a $0 deductible. The Part C deductible continues to decline over time. While primary care physician (PCP) cost sharing has remained relatively steady from 2012 to 2015, specialty care physician (SCP) copays have increased every year. This is likely due to MAOs believing it is more important to members to maintain PCP cost sharing levels in an effort to maintain membership.

The "Continuing with Migration" values in Table 4 show slightly higher maximum out-of-pocket values, PCP copays, and specialist copays compared to the "Continuing without Migration" results, which means while individuals are migrating to plans that have lower premiums and higher value add in general, the maximum out-of-pocket, PCP copay, and specialist copays of the plan they are migrating to are higher. This is consistent with the Table 2 results, which indicate that finding plans with lower premiums is a priority over finding plans with richer benefits in terms of to where beneficiaries migrate.

Table 4 also illustrates that the preferred network size has fluctuated over time and there is no conclusive evidence in our data that individuals have migrated to plans that have narrower networks over time.

Table 5 contains the percentage of membership in plans that offer various non-Medicare benefits, including preventive dental, vision exams and hardware, non-emergency transportation, hearing exams and aids, non-Medicare podiatry, and OTC drug cards.

Table 5
Medicare Advantage Membership With Access To Non-Medicare Covered Benefits

Year	Enrollment	Preventative Dental	Vision Exams	Vision Hardware	Non-Emergency Medical Transportation	Hearing Exams	Hearing Aids	Non-Medicare Covered Podiatry	Over-The-Counter Drug Card
September									
2012	7,844,543	40.6%	86.5%	55.3%	17.8%	64.2%	35.3%	34.4%	23.2%
2013	8,620,690	41.4%	90.1%	60.5%	20.0%	61.8%	44.6%	34.0%	22.1%
2014	9,110,400	38.8%	87.5%	48.9%	19.2%	57.8%	51.2%	36.4%	21.7%
2015	8,770,762	45.3%	91.9%	60.8%	21.1%	67.2%	49.3%	37.2%	23.9%
Continuing With Migration									
2012	7,617,231	37.3%	89.7%	53.6%	20.5%	64.5%	36.8%	36.4%	22.1%
2013	7,768,213	39.2%	94.5%	60.9%	23.0%	64.3%	49.3%	35.3%	21.4%
2014	7,865,558	37.8%	91.3%	52.8%	20.3%	59.3%	55.9%	38.6%	21.5%
2015	7,865,681	44.5%	92.9%	60.8%	21.6%	68.4%	50.9%	39.0%	22.8%
Continuing Without Migration									
2012	5,854,271	37.5%	89.7%	55.9%	19.2%	68.4%	40.8%	38.8%	21.3%
2013	5,794,959	39.1%	95.3%	63.0%	22.1%	68.4%	51.3%	38.0%	20.2%
2014	5,713,148	38.1%	94.4%	55.3%	21.1%	64.1%	59.1%	41.3%	19.9%
2015	5,640,178	45.3%	94.2%	63.4%	22.5%	72.1%	54.0%	42.2%	22.4%

In general, Table 5 illustrates that there has been an increase in the number of plans offering non-Medicare benefits from 2012 to 2015. This is consistent with the increase in non-Medicare benefit value over time, as shown in Table 1, and confirms the importance of maintaining and adding these “enticement” benefits to attract individuals to their plan even as Medicare Advantage revenue decreases. However, when comparing the percentage of beneficiaries with access to various non-Medicare benefits for almost all years and all benefits between “Continuing with Migration” to the “Continuing without Migration,” the “Continuing without Migration” is greater than the “Continuing with Migration” (the one noted exception is OTC Drug Card). This suggests that, while plans continue to increase the prevalence of these “enticement benefits,” members are in fact more inclined to gravitate toward plans without these benefits over time. The inclusion of the “enticement benefits” comes with an associated expense to the plan and may result in higher member premiums charged by the plan. This migration towards plans without the “enticement benefits” is consistent with the finding above that members gravitate towards plans with slightly lower benefits in exchange for the much lower premium.

Table 6a represents a distribution of the count of plans within each preferred provider network size category whereas Table 6b represents a distribution of the membership within each preferred provider network size category. The "Average Size" calculated in each table assumes a midpoint value for each preferred provider size category (i.e., 1,500 is the assumed size for the category "1,001 – 2,000") and a size of 25,000 for the category "20,000+."

Table 6a
Count of Contract - Plan - Segment by Provider Network Size

	September				Continuing Plans			
Network Size	**2012**	**2013**	**2014**	**2015**	**2012**	**2013**	**2014**	**2015**
<1000	19.4%	16.6%	20.6%	22.6%	17.3%	14.6%	12.7%	13.5%
1001-2000	15.5%	16.6%	16.3%	14.7%	16.8%	16.2%	14.8%	13.3%
2001-3000	8.2%	8.2%	7.0%	8.3%	9.4%	8.4%	7.6%	9.0%
3001-4000	8.9%	7.9%	6.9%	6.8%	9.7%	9.7%	10.0%	9.4%
4001-5000	7.4%	7.0%	6.8%	5.6%	8.6%	9.0%	7.5%	6.8%
5001-6000	4.5%	5.3%	6.3%	4.8%	5.8%	5.4%	6.6%	5.6%
6001-7000	2.6%	2.3%	2.8%	3.1%	3.4%	2.8%	3.5%	4.1%
7001-8000	3.3%	4.2%	4.8%	4.3%	4.4%	5.0%	6.1%	4.6%
8001-9000	2.3%	2.4%	2.2%	3.7%	3.4%	3.0%	2.4%	4.1%
9001-10000	2.9%	2.7%	2.7%	2.6%	2.1%	2.1%	3.0%	2.8%
10001-11000	1.2%	1.6%	0.9%	1.3%	1.6%	2.1%	1.5%	1.9%
11001-12000	0.2%	0.3%	0.6%	0.9%	0.2%	0.5%	0.8%	1.1%
12001-13000	1.4%	2.8%	3.0%	3.3%	1.4%	1.4%	2.5%	3.2%
13001-14000	1.0%	1.5%	1.2%	1.3%	1.3%	1.7%	1.4%	1.5%
14001-15000	0.8%	0.9%	0.8%	0.1%	1.0%	1.2%	1.0%	0.1%
15001-16000	1.0%	2.1%	1.2%	1.2%	0.9%	3.0%	0.8%	0.9%
16001-17000	0.0%	0.3%	0.3%	0.0%	0.0%	0.3%	0.5%	0.1%
17001-18000	0.7%	0.7%	1.7%	1.2%	0.5%	0.7%	2.8%	1.7%
18001-19000	0.8%	1.8%	2.5%	2.9%	1.4%	2.6%	4.4%	5.2%
20000+	12.3%	11.6%	9.9%	10.4%	9.7%	9.1%	8.8%	9.9%
Unavailable	5.2%	3.1%	1.4%	0.7%	1.4%	1.4%	1.4%	1.4%
Average Size	**6,779**	**7,186**	**6,806**	**6,838**	**6,323**	**6,902**	**7,414**	**7,605**

**19001-20000 is omitted from CMS files*

Table 6b % of Membership by Provider Network Size												
	September Enrollment				Continuing With Migration				Continuing Without Migration			
Network Size	**2012**	**2013**	**2014**	**2015**	**2012**	**2013**	**2014**	**2015**	**2012**	**2013**	**2014**	**2015**
<1000	9.9%	8.1%	7.4%	8.5%	10.8%	9.4%	8.0%	7.7%	10.0%	8.6%	7.8%	7.9%
1001-2000	13.0%	11.7%	11.2%	11.9%	14.0%	12.7%	11.4%	10.6%	14.4%	12.9%	11.6%	10.3%
2001-3000	9.1%	8.0%	5.9%	7.6%	8.9%	7.2%	5.3%	7.6%	8.9%	7.4%	5.0%	8.0%
3001-4000	13.2%	11.4%	12.3%	12.4%	14.2%	13.6%	14.2%	12.9%	13.8%	12.6%	13.8%	12.4%
4001-5000	7.7%	11.3%	9.7%	10.5%	8.3%	13.4%	11.2%	10.7%	8.6%	13.7%	10.8%	10.9%
5001-6000	5.9%	5.0%	7.9%	4.6%	6.5%	4.7%	7.0%	4.4%	6.4%	4.5%	7.3%	5.3%
6001-7000	3.5%	3.3%	3.3%	3.7%	3.8%	3.0%	3.3%	3.9%	3.4%	3.0%	3.7%	4.7%
7001-8000	2.6%	3.5%	4.1%	3.4%	3.2%	4.3%	4.9%	3.2%	3.2%	4.1%	4.4%	3.2%
8001-9000	4.2%	3.9%	1.6%	2.9%	4.7%	3.3%	1.8%	2.9%	5.4%	4.3%	2.1%	2.9%
9001-10000	2.5%	2.4%	3.6%	2.2%	1.6%	2.4%	3.5%	2.4%	1.5%	1.5%	2.4%	2.3%
10001-11000	1.9%	3.3%	2.2%	3.5%	2.9%	3.9%	2.5%	3.7%	2.0%	3.5%	1.9%	2.5%
11001-12000	1.0%	0.4%	0.3%	1.4%	0.8%	0.4%	0.3%	1.6%	1.2%	0.5%	0.2%	2.1%
12001-13000	1.3%	1.4%	2.2%	2.8%	1.2%	0.7%	1.7%	2.6%	0.8%	0.8%	1.9%	2.5%
13001-14000	1.3%	2.2%	1.4%	1.3%	0.8%	1.7%	1.3%	1.4%	0.9%	2.2%	1.0%	1.1%
14001-15000	2.0%	1.3%	1.8%	0.0%	2.1%	1.2%	1.5%	0.0%	2.4%	2.0%	2.6%	0.0%
15001-16000	0.7%	0.8%	1.2%	0.9%	0.3%	0.9%	1.2%	1.0%	0.5%	0.9%	0.7%	0.7%
16001-17000	0.0%	0.7%	0.6%	0.2%	0.0%	0.7%	0.4%	0.3%	0.0%	0.6%	0.2%	0.2%
17001-18000	0.5%	0.8%	1.2%	2.0%	0.3%	0.5%	1.1%	2.1%	0.3%	0.4%	1.0%	2.6%
18001-19000	0.9%	1.4%	6.6%	4.7%	0.9%	1.7%	7.1%	5.2%	1.1%	1.5%	9.1%	6.0%
20000+	17.2%	17.2%	14.7%	14.7%	14.1%	13.7%	11.6%	15.3%	13.8%	13.7%	11.6%	13.9%
Unavailable	1.8%	1.9%	0.9%	0.6%	0.7%	0.7%	0.7%	0.7%	1.3%	1.1%	0.8%	0.6%
Average Size	**8,384**	**8,799**	**9,111**	**8,744**	**7,545**	**7,869**	**8,446**	**9,011**	**7,589**	**7,962**	**8,663**	**8,820**

**19001-20000 is omitted from CMS files*

As previously mentioned, there is no conclusive evidence based on the information contained in Table 6a and 6b that individuals have migrated to plans that have narrower networks over time. In fact, the "Average Size" based on the count of continuing plans increases every year suggesting that continuing plans are adding providers to the networks over time more so than removing providers from their networks.

IV. METHODOLOGY

We relied on detailed Medicare Advantage plan benefit offerings for 2012 through 2015 and their respective premiums released by CMS in performing the analyses contained in this report. We also used publicly available Medicare Advantage enrollment information for September 2014 to develop member weighted averages by state, region, star rating, product type, carrier size, and plan type, and for nationwide totals from the plan-level detail released by CMS. The information released by CMS includes detailed cost-sharing information by service category, member premium, service area, supplemental benefits covered, and enrollment by plan.

For the analyses contained within this report, we define value add as the value of benefits provided to a plan's beneficiaries above traditional Medicare. This metric not only accounts for the value of supplemental benefits, but it is also offset by each plan's member premium. Therefore, two plans with identical benefits will have different value adds if their premiums vary.

Part C Value Add = Estimated value of supplemental Part C benefits - Member Part C premium.

Part D Value Add = Estimated value of Part D benefits (a.k.a. indicated Part D premium) - Member Part D premium.

Total Value Add = Estimated value of supplemental Part C benefits + Estimated value of Part D benefits + Buy-down of Part B premium - Member Part C and Part D premiums.

The value add for all plans excludes over-the-counter (OTC) drug cards because limited information is released by CMS and plans may have varying restrictions on this benefit's use. Other items that are excluded from the value add analysis include comprehensive dental coverage (CMS does not provide enough detail on this benefit), at-home adaptation services, orthodontics, and adult day care.

Except for when otherwise noted, we included all general enrollment individual (i.e., non-EGWP) Medicare Advantage plans, excluding PDP, SNP, MSA, Dual Demonstration, PACE, and Cost plans. This analysis includes the vast majority of all individual general enrollment plans.

The estimated value of the Part C and Part D benefits is evaluated using Milliman's internal pricing models, calibrated to county-specific 2015 FFS costs with consistent medical management and population base assumptions for each county. This information is used in conjunction with plan-specific star rating information and benchmark revenue information released by CMS to determine the value add for each plan.

IV. CONCLUSIONS

The Medicare Advantage market will continue to evolve with the increased pressure on MAO revenue resulting from the ACA, ATRA, sequestration, the end of the Quality Bonus Payment Demonstration, and other regulatory changes. General enrollment plan beneficiaries have generally seen a reduction in benefit value and an increase in premium amounts since the implementation of the ACA.

As Medicare Advantage plans and beneficiaries continue to operate in the 2015 plan year, it is also important to be aware of further changes currently scheduled to occur in 2016. Many of these changes will put continued pressure on revenue payments to MAOs and, consequently, possibly on beneficiaries as well through additional benefit reductions and premium increases. They include:

- The Medicare Advantage coding pattern adjustment will increase from 5.16% in 2015 to a minimum of 5.41% in 2016. This results in a 0.25% decrease in payments to MAOs, if all else remains equal.
- In the development of 2014 Part C risk scores, CMS released a new HCC risk model that will ultimately reduce Part C risk scores for Medicare Advantage beneficiaries by about 2.5%. This change was phased in at 33% for the 2015 bid development and may be fully phased in for the 2016 plan year. This change will affect MAOs differently, depending on the underlying risks of each plan's enrolled beneficiaries.
- The benchmark revenue payments will continue to be phased in to being fully based on each county's FFS rates as a result of the ACA. All counties designated as two-year and four-year phase-in counties will fully use the ACA benchmarks in 2015, but any six-year phase-in counties will continue to see changes to the payment benchmarks in 2016.
- The health insurance tax (HIT) will increase slightly from 2015 to 2016. This will impact MAOs differently depending on size, premiums collected, and not-for-profit status.

V. QUALIFICATIONS, CAVEATS, AND LIMITATIONS

We, Brett Swanson and Eric Goetsch, are actuaries for Milliman, members of the American Academy of Actuaries, and meet the qualification standards of the Academy to render the actuarial opinion contained herein. To the best of our knowledge and belief, this report is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices.

The material in this report represents the opinion of the authors and is not representative of the views of Milliman. As such, Milliman is not advocating for, or endorsing, any specific views contained in this report related to the Medicare Advantage program.

The information in this report is designed to provide key information surrounding Medicare Advantage funding cuts and the impact on beneficiary value. It may not be appropriate, and should not be used, for other purposes.

The credibility of certain comparisons provided in this report may be limited, particularly where the number of plans and/or enrollment in counties or states is low. Some metrics may also be distorted by premium and benefit changes in one or two plans with particularly high enrollment.

In completing this analysis we relied on information from CMS, which we accepted without audit. However, we did review it for general reasonableness. If this information is inaccurate or incomplete, conclusions drawn from it may change.