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State of the 2016 Medicare Advantage industry changes as a result of continued rate pressure

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I. EXECUTIVE SUMMARY

The Medicare Advantage (MA) 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 Centers for Medicare and Medicaid Services (CMS).

Various legislated and regulatory changes have impacted the federal government's funding of MA plans, including the American Taxpayer Relief Act (ATRA), sequestration, the conclusion of the Quality Bonus Payment Demonstration, and other regulatory actions. 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 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 general enrollment beneficiaries has been decreasing every year from 2012 to 2016 (this report only focuses on 2013 to 2016). This is also true for Medicare Part C (medical) and Medicare Part D (prescription drugs) separately, but the drivers of each are slightly different. For Part C, benefit value has been decreasing every year while premiums are for the most part increasing annually, with both of these changes together resulting in a decrease in value add every year. For Part D, benefit values have not decreased as significantly as Part C, but premiums have increased at a rate faster than the Part C premium increases each year.

The average change in member premium and value add per member per month (PMPM), for all general enrollment beneficiaries nationwide, from 2013 to 2016, is $3.40 and -$10.30, respectively. The average change in member premium and value add, for all dual-eligible beneficiaries nationwide, excluding Puerto Rico (PR), from 2013 to 2016, is -$1.11 and $0.96 PMPM, respectively.

The Medicare Advantage market will continue to evolve with 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.

II. BACKGROUND

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 bid and the benchmark rate) is returned to the plan as a rebate, which can be used by the plans 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.

As MAOs prepare to submit these bids each year, they must take into account historical costs, CMS revenue levels, anticipated market changes, and membership characteristics, which all impact how a plan's costs and benefits will change in the coming year. After all bids are submitted and reviewed, CMS subsequently releases information to assist beneficiaries in electing a plan for the coming year during the annual enrollment period. In October 2015, CMS released benefit and premium information for all MA plans that are to be offered in 2016. As the MA market continues to evolve through the ACA, it is important to analyze how the landscape of this program is changing as the various provisions of the ACA and other programs are implemented.

This report highlights key changes in beneficiary premiums and benefits for the 2016 MA market as well as the reasons for and the magnitude of the decrease in value add within the Medicare Advantage market between 2013 and 2016, with a more detailed look at changes between 2015 and 2016. We summarize the components of the ACA and subsequent legislated actions driving the downward pressure on payments to MAOs. This report also aims to assist MAOs in making strategic decisions during 2017 bid preparations.

As a result of the ACA, the funding mechanism for the MA program is shifting to include a greater reliance on estimated Medicare FFS costs and a plan's quality rating. This results in varied levels of payment changes across the country, as well as reducing the portion of "savings" that the MAO is allowed to retain (aka "rebates") to fund additional member benefits that traditional Medicare does not cover without the need to charge additional member premium. In addition to the rate pressure that has been introduced by the ACA, in 2016, MAOs also face a number of new pressures on the funding they receive from the government compared with prior years. In the 2016 bid year, these new pressures include:

- An increase in the MA coding pattern adjustment applied to 2016 payments, which reflects "differences in coding patterns between MA plans and traditional Medicare to the extent that the Secretary [CMS] has identified such differences."[1] This adjustment is a further reduction in Part C risk scores of 5.41% (5.21% from ACA plus 0.2% from ATRA) in 2016 and increases by 0.25% each year through 2018, when it will be 5.91%.

- Starting in 2012, the ACA requires that the county payment rates transition from the pre-ACA amount to the ACA amount. During the transition period, the blend of the "pre-ACA amount" and the "ACA amount" is used to create the final county rates. Counties are subject to either a two-, four-, or six-year transition period, which began in 2012 and will be complete in 2017. Roughly 20% of the counties in the United States are blending county payment rates in 2016.
- In addition to the blended payment rates, payment levels are capped at pre-ACA levels. This means that if, under the new payment rate system, the ACA payment rate calculated is higher than what it would have been prior to the ACA, the payment rate is set to the pre-ACA rate.

[1] Code of Federal Regulations, Title 42, Chapter IV, Subchapter B, Part 422, Subpart G, Section 422.308. Retrieved February 9, 2016, from http://www.ecfr.gov/cgi-bin/text-idx?SID=64ed48e3cca2724cff132de8166251a4&mc=true&node=sp42.3.422.g&rgn=div6#se42.3.422_1308.

- Prior to ACA, rebates as a percentage of savings were 75% for all contracts, but have decreased to 70% for contracts with 4.5 or more stars, 65% for contracts with 3.5 to 4.0 stars, and 50% for contracts with less than 3.5 stars in 2014. Contracts must have a 4.0 quality star rating or higher in order to qualify for a quality bonus payment of 5% (which brings these contracts to a total of 75%). It is worth noting that new contracts without a star rating (where the parent company does not have an established star rating under another contract) and contracts considered low enrollment receive a 3.5% bonus payment in 2016.
- The introduction of the health insurer fee (HIF) starting in 2014, a new premium tax introduced as part of the ACA. The HIF is an additional expense that can increase an MAO's non-benefit expenses by 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). Please note that Bill H.R. 2029, signed into law on December 18, 2015, put a moratorium on the 2017 HIF; therefore, based on current law, no HIF will be collected in 2017.
- Last, we mention a few other impactful items that affect health plans within and outside Medicare Advantage. A minimum loss ratio of 85% (evaluated at the contract level for Medicare Advantage) and cuts to MA government payments that are due to sequestration of 2%, which began April 1, 2013, both result in restrictions to health plans for the amount of revenue they are ultimately allowed to keep.

Because of the competitiveness within the MA market, MAOs typically offset the impact of any revenue reductions or cost increases, like those mentioned above, with improved efficiencies (e.g., administrative and more concentrated provider networks) and reduced retention margins to the extent possible. The various approaches and tactics to try to offset these payment reductions typically impact beneficiary value in the long run. Some of these include, but are not limited to:

- Increased medical management, which in turn leads to lower utilization of high-cost services and more efficient (i.e., lower-cost) administrative services.
- Reducing provider reimbursement levels by renegotiating provider contracts as well as the development of narrower networks.
- Lowering profit margins in order to remain competitive in all aspects of the market.
- Encouraging their providers to capture diagnoses both through prospective approaches (e.g., educating providers and developing prompt documentation) and retrospective approaches (e.g., performing chart reviews and creating suspect lists) in order to have these diagnoses codes reflected in the CMS Hierarchical Conditions Categories (CMS-HCC) risk model and, therefore, directly increase plan revenue for the coming calendar year.
- Leadership teams at managed care organizations (MCOs) are constantly trying to ensure that the MAO's performance in the 47 star rating measures (some of which change from year to year) is as good as it can be to maximize the opportunity for the MAO to attain the highest possible star rating, which, as discussed above, has a direct impact on the county benchmarks and rebate percentages the plan receives. While a higher star rating can mean more revenue, it can also mean higher costs to implement the programs and strategies to raise the contract's star rating.

With the combination of legislative pressures and plans' approaches to mitigate these pressures, nationwide plans are inevitably having to make changes that impact the value to the beneficiary.

III. OVERVIEW

In this report, we analyze various aspects of the MA market to aid MAOs in understanding the current market environment as they prepare to make 2017 benefit and premium decisions. Specifically, we focus on value add and premium in 2016, as well as how they changed from 2013 to 2016, using publicly available information released by CMS.

For the analyses contained within this report, we define "value add" as the 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 is also offset by each plan's member premium. Therefore, two plans with identical benefits will have different value adds if their premiums vary.

The value add for Dual Special Needs Plans (D-SNPs) only measures the value of non-Medicare-covered benefits that are not funded through member premiums (e.g., dental, vision, hearing) because these types of plans often provide Medicare-covered services without member cost sharing through coordinated efforts with each state's Medicaid program.

All results presented below represent the individual MA market—that is, non-employer group waiver plans (EGWPs), excluding standalone prescription drug plans (PDPs)—using membership information released by CMS from September 2015. In all cases, plans that are new to the MA market in 2016 are not included in the summaries, as all results are weighted using the September 2015 membership. Plans new to the 2016 market had zero membership at that time. We utilized only plans that remained in the market in 2016.

The primary focus of this report is noninstitutionalized non-Medicaid plans, which are also referred to as general enrollment plans because they do not contain enrollment restrictions (with the noted exception of end-stage renal disease), and MA Special Needs Plans for D-SNPs, specifically offered to beneficiaries eligible for both Medicare and Medicaid. Special Needs Plans for chronic and institutionalized conditions are less common in the MA market and are excluded from the results in this report, except where specifically stated. Additionally for D-SNPs, we narrow down the results to exclude PR in most of the analyses, as PR contains a significant portion of D-SNP enrollment and the variance that is due to more extreme funding cuts in PR skews the nationwide D-SNP results compared with the remainder of the United States. The results exclude medical savings account (MSA) plans, Medicare Cost Plans (Cost), and Program of All-Inclusive Care for the Elderly (PACE) plans, all of which account for a very small portion of the individual membership. Medicare-Medicaid Plans (MMP), which include around 380,000 members, were also excluded.

In addition, for the population we analyzed, there are about 2,100 unique general enrollment plans offered in 2016, with about 1,650 continuing to be offered from 2015. Roughly 360 plans offered in 2015 are no longer available. However, approximately 450 new plans will begin in 2016. Overall, there is a net increase of about 4% in the overall number of individual general enrollment plans available in 2016 compared with 2015 (about 2,010 general enrollment plans were available in 2015). For comparison, between 2014 and 2015 there were approximately 500 plans that terminated with approximately this same amount of new plan offerings in 2015, for a net change of 0% in 2015. D-SNPs have stayed relatively flat, with between 50 and 70 plans entering and exiting the market each year from 2014 through 2016, maintaining roughly 350 plans each year.

IV. RESULTS

GENERAL ENROLLMENT PLANS

Analysis: 2016 snapshot

This section provides an analysis of 2016 general enrollment plans and the market changes from 2015. The value add and member premium results are split into various subcategories, such as region, star rating, product type, carrier size, and certain benefit offerings. See Appendix A for a mapping of each state to the regions used in this report.

Region

The table in Figure 1 contains the 2016 value add and member premium for all general enrollment plans by region, on a per member per month (PMPM) basis. The change in these metrics from 2015 is also shown. The benefit change is measured as the value add change, excluding the change in premium. For example, nationwide there is a $5.13 decrease in value add, with $3.17 of this due to increased premiums. Therefore, there is a net decrease in benefits of $1.96. This change is markedly smaller than last year, where the nationwide decrease in value add was $15.33 and the premium increase was $5.50.

Figure 1:
State of the 2016 Medicare Advantage Industry
Medicare Advantage Average Premium and Value Add Amounts by Region
General Enrollment Plans

Region	2016 Value Add	Change in Value Add	2016 Premium	Change in Premium	Change in Benefits	Membership Distribution
Northeast	$34.59	-$6.19	$64.57	$4.32	-$1.86	20%
Midwest	$52.76	-$3.49	$51.99	$3.86	$0.37	17%
South	$103.00	-$6.13	$23.34	$2.33	-$3.80	35%
West	$84.49	-$3.38	$35.64	$2.84	-$0.54	27%
PR	$119.99	-$13.30	$7.48	$3.39	-$9.91	2%
Nationwide	**$76.19**	**-$5.13**	**$39.43**	**$3.17**	**-$1.96**	**100%**

As shown in Figure 1, general enrollment plans have an average value add of about $76 nationwide. However, this varies significantly by region, with the South, West, and PR regions having values that are higher than average with included lower member premiums. Both the South and West regions have historically seen payment rates higher than managed medical costs in comparison with the other regions of the country, which contributes to the higher amounts of value add, and is consistent with the results seen in prior years. Puerto Rico is seeing a large value add decrease relative to other areas of the country, though the change in premium is only slightly over the national average. Because PR makes up such a small proportion of general enrollment plans, we elected to keep it included as part of the nationwide analysis for these plans.

In addition to the total value of supplemental benefits offered to beneficiaries, MAOs must continually evaluate the member premium charged to beneficiaries in their plans. While the value add looks at the overall benefit package and considers the expected medical spending of the average beneficiary, the member premium is equally important to members because this is a fixed monthly cost.

Underlying the change in value add, there is continued shifting of costs to the beneficiary through benefit reductions and premium increases from 2015 to 2016. Most regions see relatively similar decreases in benefits, as shown above, resulting from similar decreases in value add and increases in member premium, with the noted exception that the Midwest region appears to have seen a slight benefit increase.

Star rating

MA uses information collected through member surveys, plan submissions, and providers to assign quality star ratings to MA and PDPs, and this is intended to help beneficiaries compare plans based on their historical levels of quality. In addition, the ACA introduced a new payment methodology that ties both benchmark revenue payments and rebate percentages (retained savings) to an MA organization's star rating, incentivizing organizations to increase their star ratings.

The table in Figure 2 shows the value add and premium information in the MA industry stratified by star rating. There is roughly a three-year delay in receiving a quality star rating. The "low enrollment" star rating applies to contracts that do not have enough enrollment and corresponding data three years prior to evaluate and create a quality star rating. Contracts that have entered the market in the past two years will be classified as "new contract." It is important to note that new contracts and "low enrollment" contracts receive benchmark revenue payments that reflect a bonus payment of 3.5%, unless the contract's parent organization has an established star rating, in which case that parent's average star rating is used for the benchmark and rebate calculations.

Figure 2:
State of the 2016 Medicare Advantage Industry
Medicare Advantage Average Premium and Value Add Amounts by Star Rating
General Enrollment Plans

Star Rating	2016 Value Add	Change in Value Add	2016 Premium	Change in Premium	Change in Benefits	Membership Distribution
New Contract	$112.93	-$0.80	$3.68	-$0.08	-$0.89	0%
Low Enrollment	$89.97	-$5.24	$22.83	$1.86	-$3.38	1%
2.5	$95.80	-$11.53	$14.15	$0.61	-$10.92	1%
3.0	$73.04	-$1.81	$32.90	$4.34	$2.52	7%
3.5	$81.19	-$3.25	$26.28	$1.73	-$1.52	23%
4.0	$85.63	-$7.17	$35.51	$4.10	-$3.07	36%
4.5	$57.16	-$5.51	$59.51	$3.50	-$2.00	23%
5.0	$72.29	-$3.10	$47.50	$2.01	-$1.09	10%
Total	**$76.19**	**-$5.13**	**$39.43**	**$3.17**	**-$1.96**	**100%**

Figure 2 demonstrates that there is not a strong correlation between the 2016 value add or change in value add and the star rating. However, plans with star ratings of at least 4.0 have significantly higher premiums than plans with lower star ratings. Additionally, plans without a star rating (aka "new contract" or "low enrollment") have a significantly higher value add, with a modest decrease in the amount between 2015 and 2016. This result was similar to what was observed for prior years, indicating that newer plans often enter the market with significantly richer benefits and are more reluctant to reduce benefits and/or increase premiums in an attempt to gain more of a market presence.

Product type

MAOs can offer various product types, including health maintenance organizations (HMOs), which can include HMOs with a place of service (POS) option (meaning access to out-of-network benefits, and noted below as HMO-POS plans), private fee-for-service plans (PFFSs), and preferred provider organizations (PPOs), which include local (LPPO) and regional (RPPO) variations. Please note that the value add methodology does not value the out-of-network benefits. HMO, HMO-POS, PFFS, and LPPO plans are collectively referred to as local plans (HMOs and PPOs are also known as local coordinated care plans) and are only offered in individual counties chosen by the plan. On the other hand, RPPOs serve a CMS-defined region, usually comprising an entire state or multistate area, and rely on revenue partially developed through a competitive bidding process.

Figure 3:
State of the 2016 Medicare Advantage Industry
Medicare Advantage Average Premium and Value Add Amounts by Plan Type
General Enrollment Plans

Product Type	2016 Value Add	Change in Value Add	2016 Premium	Change in Premium	Change in Benefits	Membership Distribution
HMO	$97.71	-$4.80	$28.55	$2.42	-$2.37	64%
HMO-POS	$58.27	-$8.45	$61.64	$5.69	-$2.76	8%
LPPO	$21.61	-$8.20	$73.16	$5.28	-$2.92	16%
PFFS	$8.46	-$8.09	$58.27	$5.65	-$2.44	2%
RPPO	$55.63	$0.52	$33.59	$2.10	$2.62	10%
Total	**$76.19**	**-$5.13**	**$39.43**	**$3.17**	**-$1.96**	**100%**

The table in Figure 3 demonstrates that HMOs generally have the highest value add for general enrollment plans, while PFFS plans generally have the lowest value add. In prior years, the rank of value add by product type was identical to 2016, with the exception that we now identify HMO-POS plans separately from HMO plans. Among general enrollment plans, HMOs are the most popular product type, with roughly 64% of available membership. Product types appear to be experiencing varied rate pressures and/or the ability to mitigate the year-over-year impact on beneficiary value add, with LPPOs, HMO-POSs, and PFFS plans forced to give up more value add in 2016 relative to 2015, which is mostly due to larger increases in premium relative to the HMO and RPPO product types. HMOs have the lowest premium, which is consistent with also having the greatest amount of value add. RPPO plans also have 2016 member premiums at a level similar to the HMO plans.

Carrier size

The MA market is populated with organizations of varying size, ranging from large national carriers offering hundreds of plans across the country to local carriers with a handful of plans in local markets. In the MA product environment, carrier size can be a determinant of numerous factors contained in the cost and benefit development, such as administrative costs, medical care management, and desired profit margin. Often, large national carriers are able to achieve increased economies of scale and are thereby capable of including lower administrative costs than smaller local carriers. Publicly available MA September 2015 membership across all general enrollment plans and D-SNPs on a nationwide basis was used to define carrier size, as follows:

- Mega: More than 250,000 members. This group contains the large national insurers Aetna, Anthem, CIGNA, Humana, Kaiser, UnitedHealth Group, and WellCare.
- Large: More than 50,000 members but under 250,000 members.
- Medium: More than 5,000 members but under 50,000 members.
- Small: More than zero members but under 5,000 members.

Note that independent Blue Cross Blue Shield carriers are included in both the large and medium categories, rather than the mega category, as they are considered separate organizations and, therefore, individually do not meet the membership thresholds for the mega carrier category.

The table in Figure 4 contains the value add and premium results for general enrollment plans by carrier size.

Figure 4:
State of the 2016 Medicare Advantage Industry
Medicare Advantage Average Premium and Value Add Amounts by Carrier Size
General Enrollment Plans

Carrier Size	2016 Value Add	Change in Value Add	2016 Premium	Change in Premium	Change in Benefits	Membership Distribution
Mega	$86.44	-$3.94	$26.95	$2.33	-$1.62	61%
Large	$59.51	-$6.53	$59.95	$3.89	-$2.63	26%
Medium	$60.31	-$7.76	$57.75	$5.31	-$2.44	13%
Small	$83.04	-$5.49	$41.21	$5.47	-$0.01	1%
Total	**$76.19**	**-$5.13**	**$39.43**	**$3.17**	**-$1.96**	**100%**

Based on the results shown in Figure 4, large and medium carriers provide a lower value add for general enrollment beneficiaries compared with mega and small carrier sizes. Small carriers tend to be newer start-ups (as it takes time to gather membership) and, as discussed in the star rating section, newer plans often enter the market with significantly richer benefits and are more reluctant to reduce benefits and/or increase premiums in an attempt to gain more of a market presence, which is evidenced here by the very small change in value add for this carrier size. Mega carriers provide the other greatest amount of value add, the lowest overall premium, and the smallest changes in both value add and premium from 2015, and they contain the majority of September 2015 membership. It is worth noting that the majority of mega carriers are for-profit organizations, whereas more than half of large carriers are not-for-profit organizations.

Benefit offerings

In addition to plan characteristic changes, it is important to understand how benefits affect the value add and premium metrics within the MA marketplace. In an environment of increased revenue pressure, plans will generally increase premium or reduce benefits, or use some combination of the two. Therefore, it is necessary to view benefit differences alongside plan characteristics to fully understand how benefits affect members in the MA market.

The table in Figure 5 shows the value add and premium differences for plans with and without a deductible.

Figure 5:
State of the 2016 Medicare Advantage Industry
Medicare Advantage Average Premium and Value Add Amounts by Deductible
General Enrollment Plans

Part C and D Deductibles	2016 Value Add	Change in Value Add	2016 Premium	Change in Premium	Change in Benefits	Membership Distribution
Both > $0	$38.23	-$4.72	$40.10	$1.38	-$3.34	<1%
C Only > $0	$27.34	-$9.78	$57.80	$5.56	-$4.22	1%
D Only > $0	$60.96	-$4.89	$36.52	$3.36	-$1.52	45%
Both = $0	$90.37	-$5.24	$41.52	$2.97	-$2.28	53%
Total	**$76.19**	**-$5.13**	**$39.43**	**$3.17**	**-$1.96**	**100%**

Figure 5 shows that the vast majority of beneficiaries (98%) choose plans with no Part C deductible. This result shows that beneficiaries have a clear preference for plans without a Part C deductible because it removes uncertainty surrounding cost-sharing amounts. MAOs also recognize this pattern, as fewer and fewer plans are being offered under MA that include medical deductibles—in 2014, 6.2% of all unique general enrollment plans offered plans with Part C deductibles greater than $0, whereas 2.1% and 1.5% of general enrollment plans offered plans with medical deductibles in 2015 and 2016, respectively. Additionally, plans without deductibles generally offer a richer overall benefit package, as evidenced through the value adds for these plans. Please note that Figure 5 does not distinguish between plans that offer medical benefits only (MA Only) and plans that offer both medical and pharmacy benefits (MA-PD).

In 2016, general enrollment plans have maximum out-of-pocket (MOOP) levels ranging from $0 to $6,700 per year. CMS identifies each plan as either meeting the voluntary or the mandatory MOOP. Plans with a voluntary MOOP limit member out-of-pocket costs to $3,400 or less per calendar year, while plans with a mandatory MOOP have a limit between $3,401 and $6,700. Plans with a voluntary MOOP are generally given greater flexibility regarding cost-sharing requirements for individual service lines because the member will reach the MOOP quicker than in a plan with a mandatory MOOP. The table in Figure 6 shows nationwide value add and premium information by MOOP type.

Figure 6:
State of the 2016 Medicare Advantage Industry
Medicare Advantage Average Premium and Value Add Amounts by MOOP
General Enrollment Plans

Maximum Out-of-Pocket	2016 Value Add	Change in Value Add	2016 Premium	Change in Premium	Change in Benefits	Membership Distribution
Voluntary	$102.36	-$4.58	$46.68	$3.16	-$1.42	22%
Mandatory	$68.65	-$5.25	$37.34	$3.18	-$2.07	78%
Total	**$76.19**	**-$5.13**	**$39.43**	**$3.17**	**-$1.96**	**100%**

Figure 6 shows that a majority of beneficiaries choose plans with the mandatory MOOP between $3,401 and $6,700. This is a slight increase from last year, when 75% of beneficiaries chose mandatory MOOPs. This is likely driven by their preferences for plans with lower premiums.

Historical analysis: Past four years

This section provides an analysis of a four-year lookback from 2013 to 2016 for general enrollment plans. We measured the value add by county of each general enrollment Medicare Advantage benefit plan in the country for each year from 2013 to 2016, including the value of traditional Medicare cost-sharing reductions, supplemental benefits, and reductions that are due to member premium. The results below are provided on a per member per month (PMPM) basis and use the membership levels by plan from September 2015 to develop the weighted averages across all plans for the given year that remained in the market in 2016.

Benefit values

The table in Figure 7 contains the nationwide average "benefit values," which are calculated as the difference between the value of benefits offered within the Medicare Advantage plans compared with 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 offered. The Part D column reflects the Part D member premium needed to pay for the Part D benefit levels within each plan.

Figure 7:
State of the 2016 Medicare Advantage Industry
Medicare Advantage National Average Benefit Value
General Enrollment Plans

Year	Enrollment	Inpatient	Outpatient	Physician	Other Medicare-Covered	Other Non-Medicare-Covered	Total Part C	Part D	Overall Total
September 2015 Membership Base									
2013	7,423,243	$18.67	$16.24	$29.14	$8.51	$19.74	$92.30	$42.31	$134.61
2014	8,199,821	$17.48	$15.15	$27.85	$7.36	$18.59	$86.43	$39.49	$125.92
2015	9,638,718	$16.20	$14.53	$24.26	$6.63	$17.31	$78.92	$37.42	$116.34
2016	9,676,041	$15.35	$13.65	$23.61	$5.93	$17.93	$76.47	$38.16	$114.63
Year-over-Year Change									
2013 to 2014	776,578	-$1.19	-$1.09	-$1.29	-$1.15	-$1.15	-$5.87	-$2.82	-$8.69
2014 to 2015	1,438,897	-$1.28	-$0.62	-$3.59	-$0.73	-$1.29	-$7.51	-$2.07	-$9.57
2015 to 2016	37,323	-$0.85	-$0.88	-$0.64	-$0.69	$0.62	-$2.45	$0.74	-$1.71

The cumulative change in total annual benefit value, for all general enrollment beneficiaries nationwide, from 2013 to 2016, is -$239.76. This is calculated by taking the monthly 2016 total benefit value of $114.63 minus the monthly 2013 total benefit value of $134.61 multiplied by 12 (12 months per year).

Figure 7 illustrates that benefit values have been decreasing every year from 2013 to 2016 for every benefit category, with the exception of non-Medicare-covered services and Part D from 2015 to 2016.

Premium and value add amounts

The table in Figure 8 contains the nationwide average value add amounts, which are calculated as the difference between the benefit values from Figure 7 and the corresponding nationwide average member premiums. Again, 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 contributes to the total value add.

Figure 8:
State of the 2016 Medicare Advantage Industry
Medicare Advantage National Average Premium and Value Add Amounts
General Enrollment Plans

		Part C			Part D			Total			
Year	Enroll-ment	Benefit Value	Pre-mium	Value Add	Benefit Value	Pre-mium	Value Add	Benefit Value	Part B Buy-Down	Pre-mium	Value Add
September 2015 Membership Base											
2013	7,423,243	$92.30	$18.73	$73.57	$42.31	$10.48	$31.82	$134.61	$1.68	$29.22	$107.08
2014	8,199,821	$86.43	$18.28	$68.15	$39.49	$12.49	$27.00	$125.92	$1.49	$30.76	$96.64
2015	9,638,718	$78.92	$19.95	$58.97	$37.42	$16.31	$21.11	$116.34	$1.23	$36.26	$81.32
2016	9,676,041	$76.47	$21.46	$55.02	$38.16	$17.97	$20.19	$114.63	$0.98	$39.43	$76.19
Year-over-Year Change											
2013 to 2014	776,578	-$5.87	-$0.45	-$5.42	-$2.82	$2.00	-$4.82	-$8.69	-$0.20	$1.55	-$10.44
2014 to 2015	1,438,897	-$7.51	$1.67	-$9.18	-$2.07	$3.82	-$5.89	-$9.57	-$0.25	$5.50	-$15.33
2015 to 2016	37,323	-$2.45	$1.51	-$3.95	$0.74	$1.66	-$0.92	-$1.71	-$0.25	$3.17	-$5.13

The cumulative change in average annual premium, for all general enrollment beneficiaries nationwide, from 2013 to 2016, is an increase of $122.52. This is calculated by taking the average monthly 2016 premium of $39.43 minus the average monthly 2013 premium of $29.22, multiplied by 12. The cumulative change in average annual value add (which includes the change in the Part B premium buy-down), for all general enrollment beneficiaries nationwide, from 2013 to 2016, is -$370.68. This is calculated by taking the average monthly 2016 value add of $76.19 minus the average monthly 2013 value add of $107.08 multiplied by 12.

Figure 8 illustrates that, overall, value add has been decreasing every year from 2013 to 2016. This is also true for Part C and Part D separately.

Part D benefit design and premium

The table in Figure 9 contains various information regarding changes in the Part D benefit design, premium, and benefit value over time for general enrollment MA-PD plans. It is worth noting that the values in Figure 9 are slightly different than the corresponding values in other tables, as Figure 9 only includes plans that offer Part D benefits. Other tables assume that plans that do not offer Part D benefits (e.g., "MA Only" plans) effectively have a Part D premium, benefit, and value add of $0.

Figure 9:
State of the 2016 Medicare Advantage Industry
Medicare Advantage National Average Part D Benefit Design
General Enrollment Plans

Year	Enrollment	Part D Deductible	Part D Premium	Part D Benefit Value
September 2015 Membership Base				
2013	7,082,163	$19.56	$10.99	$44.35
2014	7,854,643	$25.59	$13.03	$41.22
2015	9,274,264	$91.35	$16.95	$38.89
2016	9,311,442	$122.55	$18.67	$39.65
Year-over-Year Change				
2013 to 2014	772,480	$6.02	$2.04	-$3.12
2014 to 2015	1,419,621	$65.77	$3.92	-$2.33
2015 to 2016	37,178	$31.20	$1.72	$0.76

Figure 9 illustrates 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, and again from 2015 to 2016. 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 allow for a Part D deductible from $0 up to the "Defined Standard" Part D deductible ($360 in 2016), 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 benefit tiers. As previously mentioned, Part D premiums have increased every year while benefit value has decreased almost every year, leading to the decreasing value add of Part D benefit every year.

Part C benefit design and premium

The table in Figure 10 contains information regarding changes in the Part C benefit design over time for general enrollment plans. This includes both MA-PD and MA-only plans.

Figure 10:
State of the 2016 Medicare Advantage Industry
Medicare Advantage National Average Part C Benefit Design
General Enrollment Plans

All Members				PCP Copay		PCP Coinsurance		SCP Copay		SCP Coinsurance	
Year	Enrollment	Out-Of-Pocket Max	Deductible	Enrollment	Copay	Enrollment	Coinsurance	Enrollment	Copay	Enrollment	Coinsurance
September 2015 Membership Base											
2013	7,423,243	$4,321	$13.29	7,402,373	$9.37	20,870	18.45%	7,400,172	$28.26	23,071	19.30%
2014	8,199,821	$4,824	$8.01	8,172,993	$9.49	26,828	18.80%	8,170,057	$30.66	29,764	19.46%
2015	9,638,718	$5,052	$4.46	9,596,101	$9.97	42,617	19.24%	9,595,569	$33.21	43,149	19.63%
2016	9,676,041	$5,264	$5.02	9,653,222	$9.67	22,819	18.02%	9,643,949	$34.31	32,092	20.00%
Year-over-Year Change											
2013 to 2014	776,578	$503	-$5.28	770,620	$0.13	5,958	0.34%	769,885	$2.40	6,693	0.16%
2014 to 2015	1,438,897	$228	-$3.55	1,423,108	$0.47	15,789	0.44%	1,425,512	$2.55	13,385	0.17%
2015 to 2016	37,323	$212	$0.56	57,121	-$0.29	-19,798	-1.22%	48,380	$1.09	-11,057	0.37%

Figure 10 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. While primary care physician (PCP) cost sharing has remained relatively steady from 2013 to 2016, specialty care physician (SCP) copays have increased every year.

Non-Medicare-covered benefits

The table in Figure 11 contains the percentage of membership in general enrollment plans that offer various non-Medicare benefits, including preventive dental, vision exams and hardware, nonemergency transportation (NEMT), hearing exams and aids, and over-the-counter (OTC) drug cards.

Figure 11:
State of the 2016 Medicare Advantage Industry
Medicare Advantage Membership With Access To Non-Medicare Covered Benefits
General Enrollment Plans

Year	Enrollment	Preventive Dental	Vision Exams	Vision Hardware	NEMT	Hearing Exams	Hearing Aids	OTC Drug Card
September 2015 Membership Base								
2013	7,423,243	39.6%	93.6%	64.4%	62.1%	44.3%	23.8%	21.8%
2014	8,199,821	40.9%	88.4%	55.6%	55.7%	50.6%	21.6%	24.4%
2015	9,638,718	48.9%	92.0%	62.7%	61.5%	42.3%	20.9%	27.4%
2016	9,676,041	53.7%	92.8%	65.9%	69.5%	45.5%	20.6%	27.4%
Year-over-Year Change								
2013 to 2014	776,578	1.3%	-5.3%	-8.8%	-6.4%	6.3%	-2.2%	2.6%
2014 to 2015	1,438,897	8.0%	3.6%	7.2%	5.9%	-8.2%	-0.7%	3.0%
2015 to 2016	37,323	4.8%	0.8%	3.2%	8.0%	3.1%	-0.3%	0.0%

In general, Figure 11 illustrates that there has been an increase in the number of general enrollment plans offering non-Medicare benefits from 2013 to 2016, with the exception of hearing aids, which have shown a slight decrease in coverage over the years. The inclusion of the "enticement benefits" does come with an associated expense to the plan and may result in higher member premiums charged by the plan, which are generally offset with other benefit reductions.

D-SNPs

Analysis: 2016 snapshot

This section provides an analysis of 2016 D-SNPs and the changes in these plans from 2015. The value add and premium results are split into various subcategories, such as region, star rating, product type, carrier size, and membership type. With the exception of the results by membership shown in Figure 16 below, the analyses in this section only contain D-SNPs and exclude institutionalized (I-SNP) and chronic (C-SNP) Special Needs Plans.

In 2016, PR's federal funding will see a greater rate of decrease from 2015 rates as compared with the rest of the nation. Consequently, we have excluded PR from the Dual Eligible population specific results, except for Figure 12 below, so as to not skew the results.

Region

The table in Figure 12 contains the value add and premium results for D-SNPs by region. See Appendix A for a mapping of states to these regions.

Figure 12:
State of the 2016 Medicare Advantage Industry
Medicare Advantage Average Premium and Value Add Amounts by Region
Dual-Eligible Special Needs Plans

Region	2016 Value Add	Change in Value Add	2016 Premium	Change in Premium	Change in Benefits	Membership Distribution
Northeast	$34.62	-$1.08	$34.81	$1.02	-$0.06	23%
Midwest	$38.33	$2.71	$26.70	-$1.16	$1.54	6%
South	$55.31	$3.81	$21.73	-$1.98	$1.82	37%
West	$39.50	-$0.36	$26.71	$0.09	-$0.27	20%
PR	$37.57	-$24.46	$0.61	$0.61	-$23.85	13%
Nationwide	**$43.89**	**-$1.96**	**$23.32**	**-$0.47**	**-$2.43**	**100%**
Nationwide*	**$44.84**	**$1.45**	**$26.76**	**-$0.64**	**$0.81**	**87%**

* Nationwide average excluding Puerto Rico.

The D-SNPs results in Figure 12 demonstrate slight decreases in the value add metric from 2015 in the Northeast and West regions, while having larger increases in the Midwest and South regions. As previously noted, PR saw a large decrease in value add. Because nearly all D-SNPs target premiums are consistent with the Part D low-income benchmark (LIB), the change in premium seen in Figure 12 varies, as the LIBs were not all consistently increasing or decreasing. It is important to note that PR does not have a LIB and, therefore, typically the 2016 premiums for these plans are $0; however, a few plans had premiums of over a dollar in 2016, contributing to the small overall premium value displayed in Figure 12. Otherwise, there was a modest increase in the value of services not covered by Medicare when excluding PR.

Star rating

The table in Figure 13 contains the value add and premium analysis by plan star rating for D-SNPs (note that "new contract" and "low enrollment" applies again to contracts with insufficient information on which to base a star rating).

Figure 13:
State of the 2016 Medicare Advantage Industry
Medicare Advantage Average Premium and Value Add Amounts by Star Rating
Dual-Eligible Special Needs Plans, Excluding Puerto Rico

Star Rating	2016 Value Add	Change in Value Add	2016 Premium	Change in Premium	Change in Benefits	Membership Distribution
New Contract	$51.61	-$0.71	$32.80	$0.29	-$0.43	0%
Low Enrollment	$27.08	-$2.73	$31.05	$2.54	-$0.19	1%
2.5	$52.11	$4.48	$23.46	-$3.74	$0.74	4%
3.0	$46.34	$6.88	$23.24	-$5.20	$1.68	19%
3.5	$37.89	$1.22	$27.74	-$1.21	$0.01	24%
4.0	$49.55	-$0.81	$30.52	$1.93	$1.12	24%
4.5	$44.34	$1.67	$24.45	-$0.15	$1.52	8%
5.0	$49.56	-$7.87	$22.99	$7.35	-$0.52	6%
Total	**$44.84**	**$1.45**	**$26.76**	**-$0.64**	**$0.81**	**87%**

Based on this information, there isn't a strong relationship between star rating and value add, with the noted exception that new plans continue to offer high value add as a means to generate a greater market presence.

Product type

The table in Figure 14 contains the value add and premium information by product type for D-SNPs.

Figure 14:
State of the 2016 Medicare Advantage Industry
Medicare Advantage Average Premium and Value Add Amounts by Plan Type
Dual-Eligible Special Needs Plans, Excluding Puerto Rico

Product Type	2016 Value Add	Change in Value Add	2016 Premium	Change in Premium	Change in Benefits	Membership Distribution
HMO	$44.89	$0.40	$27.73	$0.08	$0.48	79%
HMO-POS	$11.47	$1.27	$33.80	$0.00	$1.27	1%
LPPO	$26.21	-$1.52	$38.74	$2.61	$1.09	<1%
RPPO	$48.50	$13.33	$14.71	-$8.86	$4.47	7%
Total	**$44.84**	**$1.45**	**$26.76**	**-$0.64**	**$0.81**	**87%**

The HMO product saw a modest increase in its value add from 2015 to 2016, which is also consistent with prior years. Although HMO-POS plans are a small portion of the D-SNP market, their 2016 value adds vary dramatically from HMO plans. Note that the value add analysis presented in this paper only values in-network benefits, therefore the value of out-of-network benefits found in HMO-POS plans is not considered here. RPPO plans significantly increased their value adds over the prior year, which is largely due to a decrease in member premium. However, LPPO plans decreased their value adds over the prior year.

Carrier size

The table in Figure 15 contains the value add and premium information by carrier size for D-SNPs.

Figure 15:
State of the 2016 Medicare Advantage Industry
Medicare Advantage Average Premium and Value Add Amounts by Carrier Size
Dual-Eligible Special Needs Plans, Excluding Puerto Rico

Carrier Size	2016 Value Add	Change in Value Add	2016 Premium	Change in Premium	Change in Benefits	Membership Distribution
Mega	$52.88	$3.09	$22.00	-$1.88	$1.21	52%
Large	$34.35	-$2.98	$35.44	$2.54	-$0.45	15%
Medium	$32.41	$0.67	$33.16	$0.39	$1.06	17%
Small	$24.20	-$1.26	$30.62	-$0.64	-$1.91	2%
Total	**$44.84**	**$1.45**	**$26.76**	**-$0.64**	**$0.81**	**87%**

As indicated in Figure 15, small carriers generally provide the lowest level of value add to D-SNP beneficiaries compared with other carrier sizes, while mega carriers provide the highest level of value add. These results are largely consistent with prior years. D-SNPs are typically under increased financial pressure because they must be offered with no member premium (after applying the Part D low-income premium subsidy). Keeping this in mind, it seems reasonable that the mega and large carriers are able to offer a greater level of enticement benefits, which is due to lower administrative costs among other things.

Because D-SNPs target the Part D LIB when bidding, the premiums are mostly driven by each region's LIB. However, there appears to be some efficiency, as the mega carriers are able to offer lower premiums across nearly all regions. As previously mentioned, D-SNP carriers can offer plans at or below the LIB because both cases result in no realized beneficiary premium.

Special Needs Plans population categories

There are three different population types for MA SNPs, which make up roughly 14% of total MA enrollment based on publicly available MA September 2015 membership by plan type data, excluding PR. They are:

- Dual: Beneficiaries enrolled in these plans are eligible for both Medicare and Medicaid. These plans are referred to as Dual-Eligible SNPs, or D-SNPs, and they are the most common type of Special Needs Plan, with about 11.4% of total MA enrollment.
- Chronic: Beneficiaries enrolled in these plans have a severe or disabling chronic condition, such as chronic heart failure or diabetes. These plans are known as C-SNPs and contain about 2.6% of the MA enrollment. The enrollment in these plans is a relatively equal mix of dual-eligible and general enrollment beneficiaries.
- Institutional: Beneficiaries who live in an institution such as a nursing home or who require nursing care in the home qualify for institutional plans, known as I-SNPs. These plans are a small percentage of the total, about 0.3%. The enrollment in these plans is largely made up of dual-eligible beneficiaries.

The table in Figure 16 contains the value add and premium information split by type of SNP plan.

Figure 16:
State of the 2016 Medicare Advantage Industry
Medicare Advantage Average Premium and Value Add Amounts by SNP Population
Special Needs Plans, Excluding Puerto Rico

SNP Type	2016 Value Add	Change in Value Add	2016 Premium	Change in Premium	Change in Benefits	Membership Distribution
D-SNP	$44.84	$1.45	$26.76	-$0.64	$0.81	11%
C-SNP	$143.34	-$4.37	$13.97	$8.51	$4.14	3%
I-SNP	$103.82	-$2.89	$32.21	$5.16	$2.26	<1%
Total	**$64.01**	**$0.30**	**$24.54**	**$1.15**	**$1.45**	**14%**

The three population types shown in Figure 16 have very different membership needs and costs. Recall that the value add for D-SNPs only includes the value of services not covered by Medicare and does not include the possible Medicare-covered services cost-sharing reductions, as dual members do not perceive any value in cost-sharing reductions. However, the value add includes Medicare-covered services cost-sharing reductions for I-SNPs and C-SNPs, as these plans do enroll some general enrollment beneficiaries who perceive value in cost-sharing reductions, relative to the D-SNP enrollees. This contributes to the overall differences in value add between I-SNPs and C-SNPs compared with that for D-SNPs, which is consistent with the results in prior years. Additionally, many C-SNP plans are not tailored toward dual-eligibles and, therefore, do not necessarily target LIBs. There was a concerted effort by the C-SNPs, which are tailored toward general enrollment beneficiaries, to target a $0 premium in 2015, resulting in a significantly lower average premium; however, this may not have been sustainable as there was more than a 260% increase in 2016 premium.

Historical analysis: Past four years

This section provides an analysis of a four-year lookback from 2013 to 2016 for D-SNPs. Using the same methodology as for the general enrollment plans, Milliman measured the value add by county of each D-SNP Medicare Advantage benefit plan in the country for each year from 2013 to 2016, including the value of supplemental benefits and reduced by the member premium. Because dual-eligible members typically do not pay cost sharing in D-SNPs (cost sharing is typically covered by the state's respective Medicaid plan), and because plans typically target the Part D LIB, the value add for the member can be found in the value of the supplemental non-Medicare-covered benefits.

The results below are provided on a PMPM basis and use the membership levels by plan from September 2015 to develop the weighted averages across all plans for the given year that remained in the market in 2016.

Benefit values

The table in Figure 17 contains the nationwide average "benefit values," which are calculated as the difference between the value of benefits offered within the Medicare Advantage plans compared with 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.

Figure 17:
State of the 2016 Medicare Advantage Industry
Medicare Advantage National Average Benefit Value
Dual-Eligible Special Needs Plans, Excluding Puerto Rico

Year	Enrollment	Inpatient	Outpatient	Physician	Other Medicare-Covered	Other Non-Medicare-Covered	Total Part C	Part D	Overall Total
September 2015 Membership Base									
2013	1,158,504	$0.33	$0.00	$0.00	$0.00	$45.50	$45.84	$26.17	$72.01
2014	1,218,927	$0.49	$0.00	$0.00	$0.00	$45.23	$45.72	$26.34	$72.06
2015	1,263,808	$0.32	$0.00	$0.00	$0.00	$43.14	$43.46	$27.26	$70.73
2016	1,263,845	$0.34	$0.00	$0.00	$0.00	$43.13	$43.47	$28.13	$71.60
Year-over-Year Change									
2013 to 2014	60,423	$0.15	$0.00	$0.00	$0.00	-$0.27	-$0.12	$0.17	$0.05
2014 to 2015	44,881	-$0.16	$0.00	$0.00	$0.00	-$2.09	-$2.26	$0.92	-$1.33
2015 to 2016	37	$0.02	$0.00	$0.00	$0.00	-$0.01	$0.00	$0.87	$0.87

The cumulative change in total annual benefit value, for all D-SNP beneficiaries nationwide, from 2013 to 2016, is -$4.92. This is calculated by taking the monthly 2016 total benefit value of $71.60 minus the monthly 2013 total benefit value of $72.01 multiplied by 12 (12 months per year).

Figure 17 illustrates that benefit values have been fluctuating each year from 2013 to 2016, but while a slight downward trend is seen in the Part C benefits, a slight upward trend is seen in the Part D benefits. For D-SNPs, note that the Inpatient column is slightly greater than $0, and the Outpatient, Physician, and Other Medicare-Covered columns all reflect a $0 benefit value. As the reader may recall, the value add for D-SNPs only measures the value of non-Medicare-covered benefits that are not funded through member premiums (e.g., dental, vision, hearing) because these types of plans often provide Medicare-covered services without member cost sharing, through coordinated efforts with each state's Medicaid program. Within the Inpatient bucket, we also include the value of covering additional inpatient days beyond 90 days and lifetime reserve days (a non-Medicare-covered benefit), which is why this amount is greater than $0.

Non-Medicare-covered benefits

The table in Figure 18 contains the percentage of membership in plans that offer various non-Medicare benefits, including preventive dental, vision exams and hardware, NEMT, hearing exams and aids, and OTC drug cards.

Figure 18:
State of the 2016 Medicare Advantage Industry
Medicare Advantage Membership With Access To Non-Medicare-Covered Benefits
Dual-Eligible Special Needs Plans

Year	Enrollment	Preventive Dental	Vision Exams	Vision Hardware	NEMT	Hearing Exams	Hearing Aids	OTC Drug Card
September 2015 Membership Base								
2013	1,158,504	89.6%	89.4%	81.1%	55.9%	63.5%	67.2%	67.1%
2014	1,218,927	88.1%	89.9%	82.7%	46.2%	61.9%	68.3%	65.8%
2015	1,263,808	81.1%	86.5%	86.6%	70.3%	68.8%	71.7%	68.8%
2016	1,263,845	84.1%	84.2%	84.9%	73.7%	66.1%	72.5%	70.3%
Year-over-Year Change								
2013 to 2014	60,423	-1.5%	0.5%	1.6%	-9.7%	-1.6%	1.0%	-1.3%
2014 to 2015	44,881	-7.0%	-3.4%	3.9%	24.1%	6.9%	3.4%	3.0%
2015 to 2016	37	3.0%	-2.2%	-1.7%	3.4%	-2.8%	0.8%	1.5%

Figure 18 illustrates that there has been an increase in the percentage of plans that offer the various enticement benefits, with the noted exception of preventive dental and vision exams, where these two benefits have been offered less over time.

V. METHODOLOGY

We relied on detailed MA plan benefit offerings for 2013 through 2016 and their respective premiums released by CMS in performing the analyses contained in this report. We also used publicly available MA enrollment information for September 2015 to develop member weighted averages by year, region, star rating, product type, carrier size, and plan type, and for nationwide totals from the plan-level detail released by CMS. The values presented reflect plans ultimately available in the 2016 market. 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 benefits provided to a plan's beneficiaries above traditional Medicare. This metric not only accounts for the value of supplemental benefits but is also offset by each plan's member premium and any buy-down of the Part B 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 (aka 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

We note that for the D-SNP analyses, we exclude the value of traditional Medicare cost-sharing reductions, because these types of plans often provide Medicare-covered services without member cost-sharing through coordinated efforts with each state's Medicaid program.

The value add for all plans excludes at-home adaptation services, orthodontics, and adult day care, as well as a variety of benefits that are not mainstream and may only be offered by a handful of plans (such as wigs, nursing hotlines, compression stockings, and bathroom safety equipment, for example).

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

The estimated value of the Part C and Part D benefits is evaluated using Milliman's internal pricing models, including the Milliman Medicare Advantage Competitive Value Added Tool (Milliman MACVAT), which is available for external license, calibrated to county-specific 2016 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.

The values quoted in this report are not comparable with the similar paper we published regarding the state of the 2014 Medicare Advantage industry.[2] Values represented in this paper are calibrated to county-specific 2016 FFS costs and include additional benefits not measured in the 2014 report such as OTC drug card and comprehensive dental (for which benefit detail was not previously available), whereas the prior paper reflects results calibrated to county-specific 2014 FFS costs. Therefore, comparisons between years are only relative as stated within each report, and not directly between each report.

[2] Swanson, B.L., et al. (February 28, 2014). State of the 2014 Medicare Advantage Industry. Milliman Research Report. Retrieved February 9, 2016, from http://www.milliman.com/insight/2014/State-of-the-2014-Medicare-Advantage-industry/.

IV. CONCLUSIONS

The MA market will continue to evolve with the increased pressure on MAO revenue resulting from the ACA, sequestration, and other regulatory changes.

General enrollment beneficiaries will generally see a reduction in value add and an increase in premium amounts in 2016. Additionally, the nationwide average plan premium for general enrollment plans increases roughly 9%. D-SNP beneficiaries will generally see an increase in value add and a slight decrease in premium amounts in 2016, excluding PR, and the nationwide premium for D-SNPs (largely driven by changes in LIB amounts) will decrease approximately 2%. As MAOs will likely see additional cost and revenue pressure over the coming years, additional costs will likely be shifted to general enrollment and D-SNP beneficiaries through benefit reductions and to general enrollment beneficiaries through premium increases.

As MA plans and beneficiaries continue to look ahead to the 2016 plan year, it is also important to be aware of further changes occurring in 2017. Many of these changes will put continued pressure on revenue payments to MAOs and, consequently, possibly on beneficiaries as well. They include:

- The MA coding pattern adjustment will increase from 5.41% in 2016 to a minimum of 5.66% in 2017. This results in a 0.25% decrease to payments to MAOs, if all else remains equal.

- In a memo from CMS dated October 28, 2015, a new HCC risk model was proposed that will ultimately decrease Part C risk scores for plans with a large amount of non-full-dual enrollees and will result in large increases to Part C risk scores for plans with a significant enrollment of full-dual membership. It remains to be seen if this risk model will be implemented for 2017 or, if implemented, how it will be phased in. 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 2016, but any six-year phase-in counties will continue to see changes to the payment benchmarks in 2017.

- Cuts to Medicare Advantage payments that are due to sequestration are expected to remain.

The health insurance tax (HIT) will become $0 in 2017, which is due to H.R. 2029 placing a moratorium on the fee for 2017. This will impact MAOs differently, depending on size, premiums collected, and not-for-profit status, but health plans that previously found themselves having to pay this amount will realize a net gain from not having to pass this on to beneficiaries through the administrative expense load.

As shown in this report, nearly all plans are facing similar revenue and cost pressures in the current market. However, plans that are able to find ways to improve their cost-to-revenue relationships—through reduced administrative expenses and higher star ratings, to name a couple of ways—will have an advantage in the market. Furthermore, it is clear that Medicare beneficiaries are choosing plans with low premiums and will likely continue to do so at the expense of poorer benefits. With the continued entrance of new carriers and plans, it is evident these plans realize the importance of appealing to beneficiaries through both high value add and premiums consistent with the low end of premiums for existing plans.

V. QUALIFICATIONS, CAVEATS, AND LIMITATIONS

Brett Swanson and Julia Friedman 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 and attachments are complete and accurate and have 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 general status of the market in 2016. 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.

APPENDIX A

State of the 2016 Medicare Advantage Industry State and Region Mapping

Region	State	State	Region	Region	State	State	Region
Midwest	IA	AL	South	South	WV	PA	Northeast
Midwest	IL	AK	West	West	AK	PR	PR
Midwest	IN	AZ	West	West	AZ	RI	Northeast
Midwest	KS	AR	South	West	CA	SC	South
Midwest	MI	CA	West	West	CO	SD	Midwest
Midwest	MN	CO	West	West	HI	TN	South
Midwest	MO	CT	Northeast	West	ID	TX	South
Midwest	ND	DE	South	West	MT	UT	West
Midwest	NE	DC	South	West	NM	VT	Northeast
Midwest	OH	FL	South	West	NV	VA	South
Midwest	SD	GA	South	West	OR	WA	West
Midwest	WI	HI	West	West	UT	WV	South
Northeast	CT	ID	West	West	WA	WI	Midwest
Northeast	MA	IL	Midwest	West	WY	WY	West
Northeast	ME	IN	Midwest				
Northeast	NH	IA	Midwest				
Northeast	NJ	KS	Midwest				
Northeast	NY	KY	South				
Northeast	PA	LA	South				
Northeast	RI	ME	Northeast				
Northeast	VT	MD	South				
PR	PR	MA	Northeast				
South	AL	MI	Midwest				
South	AR	MN	Midwest				
South	DC	MS	South				
South	DE	MO	Midwest				
South	FL	MT	West				
South	GA	NE	Midwest				
South	KY	NV	West				
South	LA	NH	Northeast				
South	MD	NJ	Northeast				
South	MS	NM	West				
South	NC	NY	Northeast				
South	OK	NC	South				
South	SC	ND	Midwest				
South	TN	OH	Midwest				
South	TX	OK	South				
South	VA	OR	West				

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