MILLIMAN WHITE PAPER

Analysis of 2022 AEP enrollment results for Medicare Advantage plans

Characteristics of plans gaining and losing enrollment

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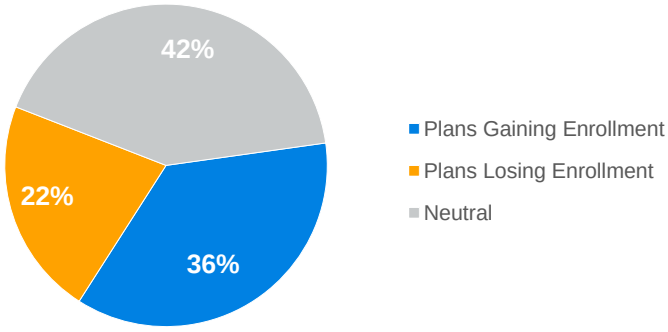
Medicare Advantage (MA) plan options, flexibilities, and competitiveness continue to evolve. This white paper looks at the characteristics of plans that gained or lost enrollment during the 2022 Annual Enrollment Period (AEP).

The number of MA plan offerings has grown significantly since the program's inception, particularly in the past few years.[1] Market competition for enrollment remains robust, driving Medicare Advantage organizations (MAOs) to continuously innovate their plan offerings to deliver the benefits beneficiaries want at attractive price points.

People eligible for Medicare can enroll in MA plans during the AEP, which runs from October 15 to December 7. The AEP is a crucial window for MAOs to gain market share and sustain long-term growth. The changes in enrollment during the AEP provide key insights into how plan offerings attract or deter beneficiaries. This white paper describes the result of a Milliman analysis of MA plans that gained or lost membership during 2022 AEP, with particular emphasis on key plan elements that may influence beneficiary plan selection behavior.

Figure 1 shows the distribution of enrollment for all plans we analyzed based on their 2022 AEP enrollment gains or losses. We identified an MA plan as an enrollment-gaining plan if it achieved at least 5% enrollment growth, with a minimum of 100 net beneficiaries gained, during the 2022 AEP. Conversely, we identified a plan losing enrollment as one experiencing at least a 5% enrollment decrease, with a minimum of 100 net beneficiaries lost, during 2022 AEP. Neutral plans, which are not the focus of this paper, neither gained nor lost a significant amount of membership during AEP.

FIGURE 1: ENROLLMENT GAINED AND LOST PLAN DISTRIBUTION



While some of the differences between plans that gained or lost enrollment may seem obvious, this analysis confirms evident market trends as well as highlights some less apparent trends impacting enrollment. The resulting enrollment changes during 2022 AEP leads to the following conclusions.

[1] Meredith Freed, Anthony Damico, and Tricia Neuman (November 2, 2021). Medicare Advantage 2022 Spotlight: First Look. Kaiser Family Foundation. Retrieved April 20, 2022, from https://www.kff.org/medicare/issue-brief/medicare-advantage-2022-spotlight-first-look/.

Plans that gained enrollment, on average:

- Charged significantly lower premiums
- Demonstrated higher supplemental benefit prevalence
- Offered richer limits and cost sharing on supplemental benefits
- Offered a higher Part B premium buy-down amount
- Charged lower primary care physician (PCP) copays
- Offered more value-based insurance design (VBID) options among dual special needs plans (D-SNPs), including the Part D low-income subsidy (LIS) reduction flexibility

Plans that lost enrollment, on average:

- Charged higher premiums
- Demonstrated lower supplemental benefit prevalence

On average, the following characteristics were similar between enrollment-gaining and enrollment-losing plans:

- Medicare-covered cost-sharing enhancements in aggregate had similar benefit value
- Maximum out-of-pocket (MOOP) limits and Part C deductibles were similar
- Average specialist copays were similar
- Senior Savings Model (SSM) plan participants were similarly prevalent

Our results and conclusions focus on general enrollment plans, i.e., excluding all special needs plans (SNPs) unless specifically stated otherwise. Refer to the "Methodology and Assumptions" section below for a comprehensive list of exclusions.

BACKGROUND

The Centers for Medicare and Medicaid Services (CMS) contracts with private insurers to offer Medicare benefits through the MA program. Plans in the MA program are required to offer traditional Medicare benefits ("Medicare-covered" benefits or services) and can further enrich their benefit packages by offering additional benefits not covered by traditional Medicare, often called "supplemental benefits." These supplemental benefits are a key differentiator between MA plans and traditional Medicare, forming the foundation of the competitive nature of the MA marketplace.

"Core" supplemental benefits offered by MAOs typically include, but are not limited to, dental, vision, and hearing benefits. Less prevalent "non-core" benefits commonly include over-the-counter (OTC) benefit cards, fitness, chiropractic services, meals, and transportation benefits, among others.[2] MA plans commonly offer a Part D benefit, which is also a key differentiator among plans. Plan offerings will additionally vary based on the level of premium charged, deductible, MOOP, and provider network.

During AEP, Medicare-eligible beneficiaries will fall into one of these classifications:

- Remaining in traditional Medicare fee-for-service (FFS)
- Remaining in their current MA plan
- Leaving FFS or their existing MA plan coverage for a new MA plan
- Reverting to FFS from MA

This paper focuses on how MA plan enrollment fared during the 2022 AEP. We identified a plan as enrollment-gaining if it achieved at least 5% enrollment growth, with a minimum of 100 net beneficiaries gained, during the 2022 AEP. Conversely, we identified a plan losing enrollment as one experiencing at least a 5% enrollment decrease, with a minimum of 100 net beneficiaries lost during the 2022 AEP.

[2] Julia Friedman and Mary Yeh (April 1, 2022). Prevalence of Supplemental Benefits in the General Enrollment Medicare Advantage Marketplace: 2018 to 2022. Milliman Insight. Retrieved April 20, 2022, from https://www.milliman.com/en/insight/Prevalence-of-supplemental-benefits-in-the-general-enrollment-Medicare-Advantage.

Enrollment-gaining and enrollment-losing plans

BENEFICIARIES PREFER PLANS WITH LOWER PLAN PREMIUMS

Non-SNP enrollment-gaining plans on a nationwide basis only charge approximately $7 per member per month (PMPM) of premium on average compared to a nearly $27 PMPM average premium charged by enrollment-losing plans. This is largely driven by the substantial enrollment of MA beneficiaries in $0 premium plan offerings in recent years. The prevalence of $0 premium plan offerings nationwide in 2022 (about 60% of plans) continues to trend upward. About 50% of all $0 premium offers are identified as enrollment-gaining plans, while about 16% are identified as enrollment-losing.

Historically, plans with $0 premium have been more prevalent among health maintenance organization (HMO) plans but, for the first time in 2022, there are now more $0 premium preferred provider organization (PPO) plan offerings than premium plan PPOs. Because $0 premium plans have traditionally been limited to HMO plan types, beneficiaries choosing between a $0 premium HMO plan and a premium PPO plan with nearly identical benefits have been required to decide which they value more: a lower up-front premium with the HMO or greater provider flexibility with the PPO. The rise in $0 premium PPO plans may have essentially eliminated this dilemma, and now requires $0 premium HMO plans to surmount their PPO counterparts in supplemental benefits.

We observed differences in plan components among plans gaining and losing enrollment between national MA carriers and regional MA carriers. Anthem, Centene/WellCare, Cigna, CVS Health, Humana, Kaiser, and United are considered national carriers for this analysis, while all other organizations are considered regional carriers. National plans gaining enrollment have a significantly lower average premium than their regional counterparts, as Figure 2 shows. Notably, national enrollment-losing plans have an average premium only slightly higher than enrollment-gaining regional plans. This reality puts more pressure on regional carriers to differentiate their products from the national organizations' product offerings.

FIGURE 2: ENROLLMENT-GAINING AND ENROLLMENT-LOSING AVERAGE PLAN PREMIUMS PMPM

Average Plan Premiums	Plans Gaining Enrollment	Plans Losing Enrollment
National	$6.99	$26.57
National Carriers	$4.14	$17.48
Regional Carriers	$14.64	$47.10
HMO	$2.98	$12.33
PPO	$5.09	$27.21

PLANS GAINING ENROLLMENT OFFER MORE SUPPLEMENTAL BENEFITS

Supplemental benefit prevalence across all plans nationwide continues to trend upward, with well-established core benefits such as preventive and comprehensive dental, vision hardware, and hearing aids becoming "must have" offerings in nearly all regions and plan types.[3] As Figure 3 shows, these benefits, among others, indicate a clear gap between plans gaining and losing enrollment in terms of prevalence.

[3] Ibid.

FIGURE 3: SUPPLEMENTAL BENEFIT PREVALENCE

Enrollee-Weighted Benefit Prevalence	Plans Gaining Enrollment	Plans Losing Enrollment
Comprehensive Dental	92%	71%
Preventive Dental	97%	88%
Vision Hardware	97%	89%
Hearing Hardware	96%	91%
Over-the-Counter Drug Card	91%	76%
Combo/Flex Benefit4	81%	53%

Not all supplemental benefit offerings showed a higher prevalence among enrollment-gaining plans. Some benefits with high market saturation are offered by both enrollment-gaining and enrollment-losing plans. This includes vision and hearing exams, worldwide emergency room (ER), and annual physical exams. Acupuncture is one of the few supplemental benefits where enrollment-losing plan prevalence (44%) is higher than enrollment-gaining plan prevalence (37%).

We observed that enrollment-gaining plans on average have a higher Part B premium buy-down of about $9.50 PMPM compared to the enrollment-losing plans' average of about $1.00 PMPM. When considering gaining and losing plans explicitly offering a Part B premium buy-down, the enrollment-gaining plan average is approximately $74 PMPM compared to enrollment-losing plans' average of $45 PMPM. Enrollment-gaining plans offered lower PCP copays of nearly $1.70 PMPM compared to an average of almost $4.60 PMPM for enrollment-losing plans. Other Medicare-covered services were not clearly differentiated among plans.

NON-UNIFORM BENEFIT PREVALENCE IN D-SNP PLANS IS HIGHER AMONG PLANS GAINING ENROLLMENT

Benefit packages offered non-uniformly across a plan's membership (i.e., only offered to qualifying beneficiaries) include:

- VBID plans
- Uniformity Flexibility (UF)
- Special Supplemental Benefits for the Chronically Ill (SSBCI)
- Part D Senior Savings Model (SSM[5])

These flexibilities have gained market traction since their inception and are considered an attractive benefit for qualifying beneficiaries, as further discussed in the "Non-uniform Benefit Offerings" section below.

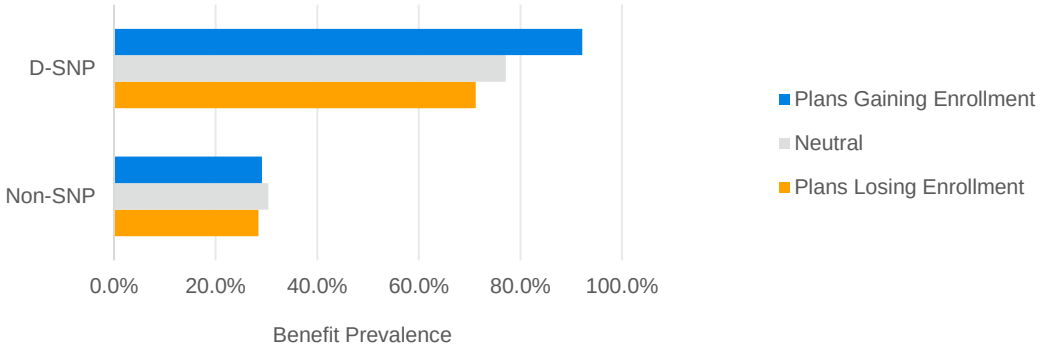
Among non-SNPs, we did not observe a distinguishable difference between enrollment-gaining and enrollment-losing plans offering these flexibilities. However, D-SNPs gaining enrollment exhibited a higher prevalence of offering at least one non-uniform benefit package (i.e., VBID, UF, and/or SSBCI, but not SSM as D-SNPs cannot offer this flexibility).

Figure 4 shows the non-uniform package prevalence between non-SNPs and D-SNPs gaining and losing enrollment.

[4] Julia Friedman and Mary Yeh (March 14, 2022). Combo Benefits: Understanding the Landscape of This Innovative Medicare Advantage Benefit in 2022. Milliman Insight. Retrieved April 20, 2022, from https://jp.milliman.com/en-GB/insight/combo-benefits-understanding-the-landscape-of-this-innovative-medicare-advantage-benefit-in-2022.

[5] Kevin Pierce and Josh Collins (March 24, 2022). To Participate or Not to Participate? 2023 Considerations and 2022 Landscape for the Part D Senior Savings Model. Milliman Insight. Retrieved April 20, 2022, from https://www.milliman.com/en/insight/to-participate-or-not-to-participate-considerations-and-landscape-for-the-part-d-ssm.

FIGURE 4: NON-UNIFORM BENEFIT PREVALENCE BY SNP STATUS



Additionally, we observed the prevalence of SSM across non-SNPs was consistent between enrollment-gaining and enrollment-losing plans. Because non-uniform benefit offerings target specific populations with certain conditions or socioeconomic statuses, it may not be appropriate to determine a plan's success during AEP solely based on total enrollment changes.

MOOP, DEDUCTIBLE, AND OTHER BENEFITS HAVE LESS IMPACT ON MEMBER CHOICE

While a lower MOOP may be a desirable plan feature to a beneficiary, we observed the average MOOP among enrollment-gaining plans ($5,089) is slightly higher than that of plans losing enrollment ($4,937). Much of this is driven by the large portion of national PPO enrollment-gaining plans, which on average have higher MOOPs than enrollment-gaining HMO plans.

In addition to the MOOP, we observed other plan features that did not have a distinguishable pattern between enrollment-gaining and enrollment-losing plans and may not be key drivers in beneficiary plan choice.

- Part C deductibles are largely uncommon in the MA marketplace and did not show a significant differential between enrollment-gaining and enrollment-losing plans.
- Average specialist copays were commonly lower for enrollment-gaining plans. However, the difference compared to enrollment-losing plans is relatively minor.
- Medicare-covered benefits are not as impactful to beneficiary choice as supplemental benefits.

Measuring value of MA plans

Within the Milliman Medicare Advantage Competitive Value Added Tool (Milliman MACVAT®), a user can easily use the proprietary value added metric to measure the relative value of MA plans. The value added metric measures the PMPM richness of services above and beyond traditional Medicare for MA plans. Value added measures allow for objective evaluations of the relative value of MA plan offerings (i.e., plans with the highest value added level can be considered the most competitive on average). Milliman's proprietary rating models make this data comparable by calculating a value added metric for every plan. "Value added" is defined using the formula shown in Figure 5.

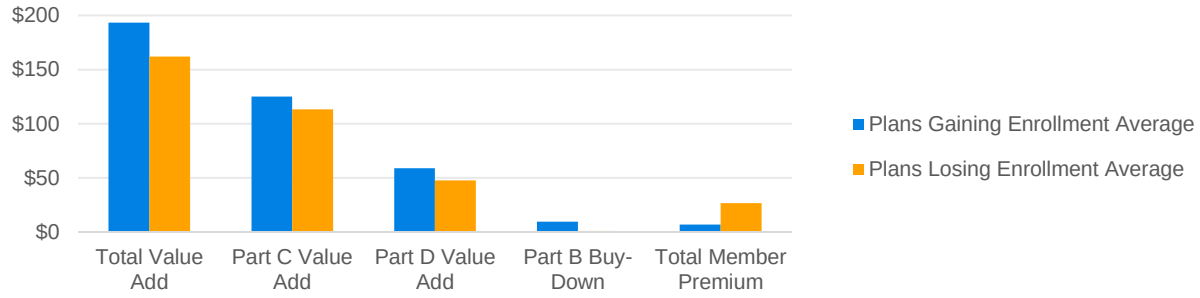
FIGURE 5: MILLIMAN MACVAT VALUE ADDED CALCULATION

Total Value Added = Estimated value of supplemental Part C benefits + Estimated value of Part D benefits + Buy-down of Part B premium − Member Part C & Part D premiums

Milliman MACVAT value added among enrollment-gaining and enrollment-losing plans

Enrollment-gaining plans have higher value added levels driven by richer supplemental benefits and lower premiums. Evaluating enrollment-gaining and enrollment-losing plans in the context of value added provides insight into how these plans' benefit offerings may contribute to membership growth and earning potential of the plans. We observe enrollment-gaining plans provide, on average, about $31 PMPM more value to beneficiaries than their enrollment-losing counterparts.

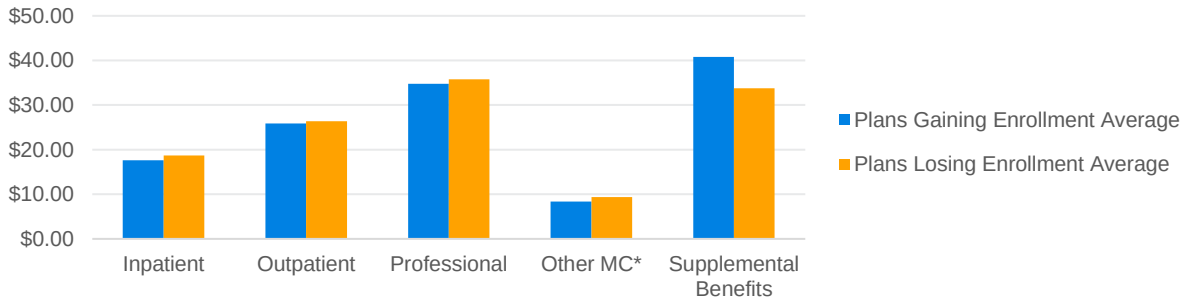
FIGURE 6: VALUE ADDED COMPARISON OF ENROLLMENT-GAINING AND ENROLLMENT-LOSING PLANS



While high-level averages provide a general sense of how overall plan richness impacts beneficiary decisions, drilling down to the value of more specific benefit categories gives a better view of the key drivers of these differences. Medicare-covered services have a slightly higher value added level for enrollment-losing plans than enrollment-gaining plans. This means enrollment-losing plans, on average, buy down Medicare-covered services to richer levels than enrollment-gaining plans. This is not to say richer benefits for Medicare-covered services are associated with poorer enrollment performance but may instead suggest there are more efficient uses for these resources,[6] as discussed below.

Alternatively, there is seemingly a large gap between the value added level of supplemental benefits favoring enrollment-gaining plans. While the total Medicare-covered benefit value shows less than a $1 PMPM difference between enrollment-gaining and enrollment-losing plans, there is more than a $7 PMPM difference on supplemental benefits. This suggests plans aiming to gain enrollment may consider using additional rebates and savings generated from Medicare-covered services to expand supplemental benefit coverage rather than buying down cost sharing on Medicare-covered services.

FIGURE 7: VALUE ADDED COMPARISON BY TYPE



* Other Medicare-covered (MC) services under traditional Medicare, e.g., ambulance, durable medical equipment (DME), etc.

[6] Kelly Backes, Greg Herrle, and Douglas Rodrigues (November 2019). Medicare Advantage: Strategies to Increase Plan Revenue. Milliman White Paper. Retrieved April 20, 2022, from https://www.milliman.com/en/insight/medicare-advantage-strategies-to-increase-revenue.

To summarize, the main takeaways from our value added analysis by enrollment-gaining and enrollment-losing plans are:

- Lower member premiums make up over 50% of the difference between the average value added level of enrollment-gaining and enrollment-losing plans
- Supplemental benefits appear to be the largest driver of benefit value differences
- Medicare-covered benefits do not appear to be a key driver of beneficiary plan choice

Non-uniform benefit offerings

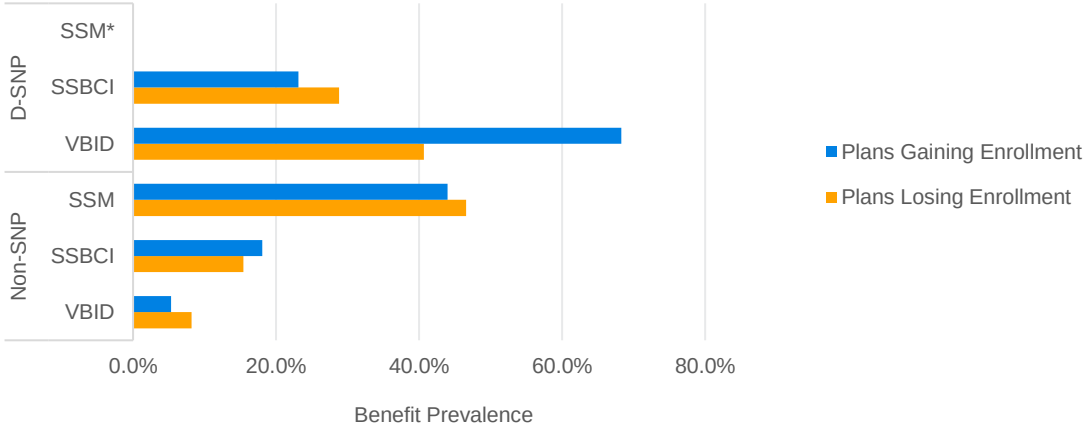
INCREASED OFFERINGS OF NON-UNIFORM BENEFITS

In 2018 and 2019, CMS expanded the range of benefits that could be offered to all enrollees under the "primarily health related" definition of supplemental benefits, allowing plans to offer different cost-sharing levels or additional benefits, including SSBCI, to specific subsets of their enrollees ("uniformity flexibility").[7] This allows MA organizations to reduce cost sharing for certain uniformly offered benefits, or additionally offer supplemental benefits to enrollees meeting specific medical criteria. In 2022, the top targeted disease states for plans offering Uniformity Flexibility package(s) were diabetes, congestive heart failure (CHF), and chronic obstructive pulmonary disease (COPD).[8]

Additionally, CMS provided guidance on April 24, 2019, that allows plans to offer benefits that are both not primarily health related and offered non-uniformly to eligible chronically ill enrollees. The main requirement for these benefits is that the "item or service has a *reasonable* expectation of improving or maintaining the health or overall function of the chronically ill enrollee."[9]

As previously mentioned, non-uniform benefit prevalence shows a distinguishable difference among D-SNP enrollment-gaining and enrollment-losing plans, but not among their non-SNP counterparts. As Figure 8 shows, VBID offerings among D-SNPs largely drive this difference, and SSBCI offerings are less prevalent among D-SNP plans gaining enrollment.

FIGURE 8: SSM, SSBCI, AND VBID BENEFIT PREVALENCE



* D-SNP plans are not eligible to participate in SSM.

[7] Johnson, Nicholas & Polakowski, Michael (February 2019). Medicare Advantage: Changes and Updates to Enhanced Benefits. SOA Health Watch, no. 88, p. 30. Retrieved April 20, 2022, from https://www.soa.org/globalassets/assets/library/newsletters/health-watch-newsletter/2019/february/hsn-2019-iss88-johnson.pdf.

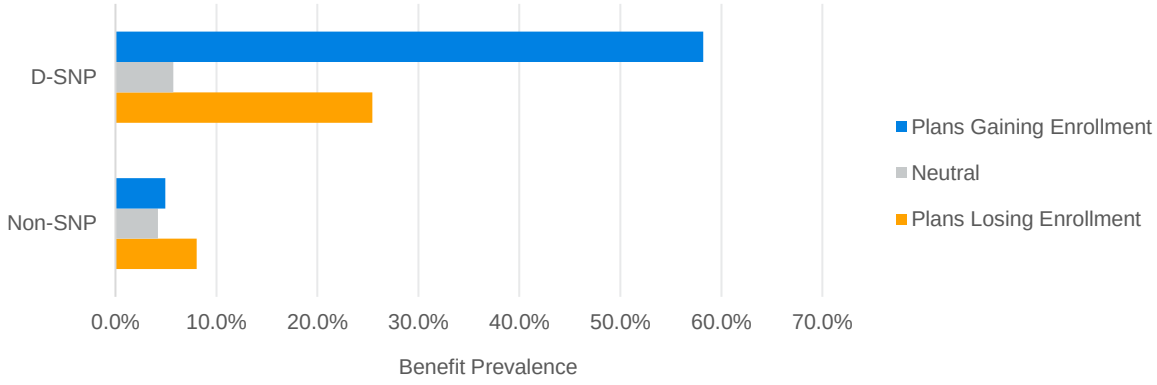
[8] Catherine M. Murphy-Barron, Eric Buzby, and Sean Pittinger (February 2022). Overview of Medicare Advantage Supplemental Healthcare Benefits and Review of Contract Year 2022 Offerings. Milliman Brief. Retrieved April 20, 2022, from https://www.milliman.com/en/insight/Overview-of-MA-supplemental-healthcare-benefits-review-2022-offerings.

[9] CMS (April 24, 2019). Implementing Supplemental Benefits for Chronically Ill Enrollees. Retrieved April 20, 2022, from https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Downloads/Supplemental_Benefits_Chronically_Ill_HPMS_042419.pdf.

D-SNP PLANS VBID PACKAGES WAIVING OR REDUCING PART D LOW-INCOME COST SHARING

As a part of the VBID flexibility, plans are allowed to waive or reduce Part D cost sharing for beneficiaries eligible for the low-income subsidy (LIS) for any tier in any of the Part D cost corridors. This allows plans to offer LIS beneficiaries reduced cost sharing without losing any of the low-income cost-sharing subsidy (LICS) that the plan would receive under the uniform cost sharing. Many plans apply the cost-sharing waiver for all qualifying LIS levels, all tiers, and throughout all Part D cost corridors such that an LIS beneficiary essentially pays no cost sharing for their drug coverage. Figure 9 shows the plan prevalence among enrollment-gaining and enrollment-losing plans for this VBID flexibility.

FIGURE 9: LIS BUY-DOWN PREVALENCE UNDER VBID PROGRAM



Conclusion

Lower premiums, richer supplemental benefit offerings, and additional flexibility offerings were characteristics of plans gaining enrollment during the 2022 AEP. Enrollment-gaining plans on average had higher supplemental benefit prevalence and commonly included $0 premium plans, contributing to higher overall value added for their enrollees. Supplemental benefits appeared to be more impactful on beneficiary choice than enhanced Medicare-covered benefits.

VBID offerings are more prevalent among enrollment-gaining D-SNP plans, most notably the Part D LIS reduction offerings. Non-uniform benefits among non-SNP plans, including SSM, did not provide a distinguishable difference between enrollment-gaining and enrollment-losing plans, likely due to the beneficiary-targeting nature of these flexibilities.

With the MA market continuing to become more and more competitive each year, plans should consider what plan components and benefits drive member choice in order to obtain more market share during the next AEP.

Methodology and assumptions

To perform these analyses, we relied on detailed information of MA plan offerings for 2022 using the Milliman MACVAT. We also used publicly available MA enrollment information from February 2022 and December 2021 to develop enrollment-weighted averages and identify plans gaining or losing enrollment. The total enrollment change is based upon the February 2022 enrollment compared to the December 2021 enrollment (cross-walked to 2022 plan if applicable) and is inclusive of all counties in the service area of a given contract segment of the plan benefit package (PBP).

The values presented reflect plans available in 2022. The information released by CMS includes detailed cost-sharing information by PBP service category, enrollee premium, and enrollment by plan.

We included all individual plans, e.g., non-employer group waiver plans (EGWPs), Medicare Advantage plans with and without Part D coverage (MAPD and MA-only). We excluded standalone prescription drug plans (PDPs), medical savings account (MSA) plans, Medicare-Medicaid plans (MMPs), Program for All-Inclusive Care of the Elderly (PACE) plans, Part B-only plans, and Cost plans.

Caveats, Limitations, and Qualifications

Jordan Cates, Chandler Bentley, Julia Friedman, and Adam Barnhart 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 their 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 view 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 an overview of the 2022 Medicare Advantage landscape and the enrollment changes of associated plans gaining or losing enrollment as a result of the 2022 AEP. This information 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 in certain groupings is low. Some metrics may also be distorted by premium and benefit changes in a few plans with particularly high enrollment.

In preparing our analysis, we relied upon public 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.

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