2024 VBID benefit MA market landscape and 2025 VBID Model application considerations

Milliman

Executive Summary

Benefits offered through the Value-Based Insurance Design (VBID) Model program of the Centers for Medicare and Medicaid Services (CMS) have grown significantly in the Medicare Advantage (MA) market in recent years. In this paper, we outline benefits trends, the landscape of these benefits in the 2024 market, and insights for 2025 and beyond. Our key findings include:

1. Benefits are offered through VBID on dual-eligible special needs plans (D-SNPs), which enroll 93% of D-SNP beneficiaries in 2024. This is significantly more than chronic special needs plans (C-SNPs) and general enrollment plans (non-SNPs) with 25% and 21% VBID prevalence, respectively.
2. National Medicare Advantage organizations[1] (MAOs) are more likely to offer VBID benefits than regional MAOs across all market segments.
3. Food and utilities are the most commonly offered VBID benefits in 2024, again due to the prevalence of these benefits for D-SNP beneficiaries.
4. There may be opportunity to maximize disease-specific targeted benefit approaches through VBID in light of the new challenges introduced to health plans by the Inflation Reduction Act (IRA).

The VBID program requires a separate application beyond the standard MA bid filing and, new for calendar year (CY) 2025, will include a competitive application screening and a scoring process for all VBID applications.[2] The application deadline for the 2025 VBID program is April 12, 2024.

Background

The voluntary VBID Model for MAOs was announced in 2015 and implemented in the beginning of 2017. The program was recently extended through calendar year 2030. The VBID program is meant to reduce government Medicare expenditures and improve the quality and coordination of care for Medicare Advantage (MA) beneficiaries by allowing design flexibility for beneficiaries with a limited set of enrollee characteristics.[3] Prior to this initiative, MAOs were required to offer uniform benefits to all enrollees due to federal requirements. CMS first waived this uniformity requirement under the initial model for qualified MAOs in seven states to enrollees with a limited set of clinical conditions.[4] Since the implementation of the model, CMS has waived the uniformity requirement for all states and territories, expanded the list of allowed clinical conditions, and enabled MAOs to use additional eligibility criteria and interventions.

Beginning in January 2021, CMS introduced the Hospice Benefit component within the VBID Model (VBID-H) to evaluate the inclusion of the Part A Hospice Benefit. Without VBID-H, when a beneficiary in an MA plan elects hospice, fee-for-service (FFS) Medicare becomes financially responsible for a majority of the services and the plan retains responsibility for certain supplemental services. With VBID-H, the MA plan retains responsibility for all Original Medicare services, including hospice care.[5] Only 2% of beneficiaries in the market have VBID-H coverage on their plans in 2024. CMS recently announced that the VBID-H program will not continue in 2025.[6]

1 See discussion on page 3 below for the definition of national versus regional MAOs.

2 CMS (March 13, 2024). Medicare Advantage (MA) Value-Based Insurance Design (VBID) Model Application Screening and Scoring Process for Calendar Year (CY) 2025. Retrieved March 22, 2024, from https://www.cms.gov/files/document/vbid-cy225-application-screening-scoring.pdf.

3 CMS. Medicare Advantage Value-Based Insurance Design Model Extension Fact Sheet. Retrieved March 22, 2024, from https://www.cms.gov/priorities/innovation/vbid-extension-fs.

4 CMS. Findings at a Glance: Medicare Advantage (MA) Value-Based Insurance Design (VBID) Model: Evaluation of Model Year 1 (2017). Retrieved March 22, 2024, from https://www.cms.gov/priorities/innovation/Files/reports/vbid-yr1-evalrpt-fg.pdf.

5 CMS. VBID Model Hospice Benefit Component Overview. Retrieved March 22, 2024, from https://www.cms.gov/priorities/innovation/innovation-models/vbid/vbid-hospice-benefit-overview.

6 CMS. The Future of the Hospice Benefit Component of the Value-Based Insurance Design (VBID) Model. Retrieved March 22, 2024, from https://www.cms.gov/priorities/innovation/innovation-models/vbid/vbid-hospice-announcement.

CMS historically allowed MAOs to offer rewards and incentives (RI) under the VBID Model for both medical and pharmacy services. Beneficiaries could receive some form of a cash equivalent given they meet the criteria for the benefit.[7] In the 2025 VBID Model Request for Application (RFA), CMS announced it will be discontinuing the Part C RI Program due to the ability to offer these flexibilities outside of this Model. The Part D RI program under the VBID Model will continue in 2025.[8]

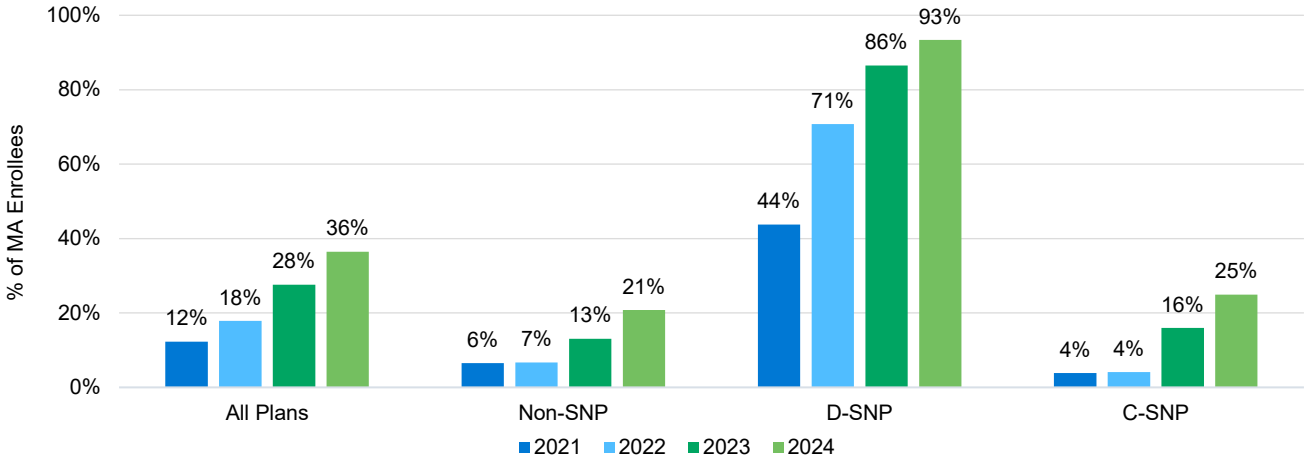
Similarly, Wellness and Health Care Planning (WHP) was included in the VBID Model to encourage discussions for beneficiaries' preference of care.[9] WHP is still required but will be discontinued in 2025 as a separate component given its widespread adoption by MAOs.[10]

The remainder of VBID discussion in this paper excludes VBID-H, RI, and WHP.

VBID participation grew significantly in recent years

The VBID program has seen four years of steady growth from 2021 to 2024, as shown in Figure 1.

FIGURE 1: PERCENTAGE OF BENEFICIARIES WITH VBID COVERAGE, 2021-2024[11]



Growth in VBID participation is evident in all plan types across the last four years. In 2021, 12% of all MA beneficiaries were enrolled in a plan with a VBID offering, which grew to 36% in 2024.

Special Supplemental Benefits for the Chronically Ill (SSBCI) is a separate CMS benefit program that allows for many of the same benefit flexibilities as VBID. SSBCI does not have the same application requirements as the VBID program, which can result in less administrative burden on the MAO. However, SSBCI is more limited than VBID in the following ways:

- SSBCI only allows chronic conditions as qualifying conditions to receive SSBCI benefits. In VBID, plans can use low socioeconomic status and geographic areas to qualify members for VBID benefits.
- SSBCI does not allow for any Part D benefit flexibilities.

7 CMS, VBID Model Hospice Benefit Component Overview, op cit.

8 CMS (December 13, 2023). Request for Applications for the Calendar Year 2025 Value-Based Insurance Design Model. Retrieved March 22, 2024, from https://www.cms.gov/files/document/vbid-cy25-rfa.pdf.

9 CMS. Request for Applications for the Calendar Year 2024 Value-Based Insurance Design Model. Retrieved March 22, 2024, from https://www.cms.gov/priorities/innovation/media/document/vbid-cy-2024-rfa.

10 CMS, Findings at a Glance, op cit.

11 Institutional special needs plans (I-SNPs) were not included in any figures because very few I-SNPs participate in the VBID program.

- Dual-eligible special needs plans (D-SNPs) have the largest percentage of beneficiaries (93%) in plans that offer VBID in 2024. MAOs can select low socioeconomic status as the eligibility criteria for a beneficiary to receive VBID benefits, and dual-eligible beneficiaries are likely to meet this criteria. This means D-SNPs can effectively offer VBID benefits—which cannot be offered as mandatory supplemental benefits under the MA program—to all beneficiaries. It also allows for offering Part D flexibilities to all beneficiaries, such as reducing Part D cost sharing for low-income beneficiaries without forfeiting CMS subsidies.
- Chronic and disabling condition special needs plans (C-SNPs) increased participation in the program from 4% of beneficiaries in 2021 to 25% of beneficiaries in 2024. Similar to D-SNPs, C-SNPs can effectively offer VBID benefits to all beneficiaries by selecting the same eligibility requirements to receive VBID benefits as to enroll in the C-SNP. C-SNPs may be more likely to use SSBCI to provide Part C benefit flexibilities to their beneficiaries, however, because through SSBCI they can qualify all beneficiaries using chronic conditions and avoid the administrative burden of the VBID application. The existence of the SSBCI program may explain why C-SNPs have less VBID coverage compared to D-SNPs.
- **VBID coverage for non-SNP plans was less than 10% of beneficiaries in 2021 and 2022, but more than doubled to 21% in 2024.** Non-SNP plans can enroll a wide range of beneficiaries given that there is no additional qualifying enrollment factor, as is the case with SNPs. MAOs offering non-SNPs may question whether the cost of adding VBID coverage is worth the gain to a potentially small portion of their beneficiaries. Due to the ability to target Part D benefit flexibilities under VBID, which is unique to this demonstration program, non-SNP plans may see value in utilizing this flexibility through VBID to target specific high-cost and high-incidence disease states for many MA beneficiaries, such as diabetes or chronic obstructive pulmonary disease (COPD).

Figures 2 and 3 show the same information as Figure 1 but split the view into national and regional carriers. National players are defined as those that have more than 500,000 beneficiaries in total (including all enrollment types), and regional players are the remainder.[12]

FIGURE 2: PERCENTAGE OF BENEFICIARIES WITH VBID COVERAGE FOR NATIONAL CARRIERS, 2021-2024

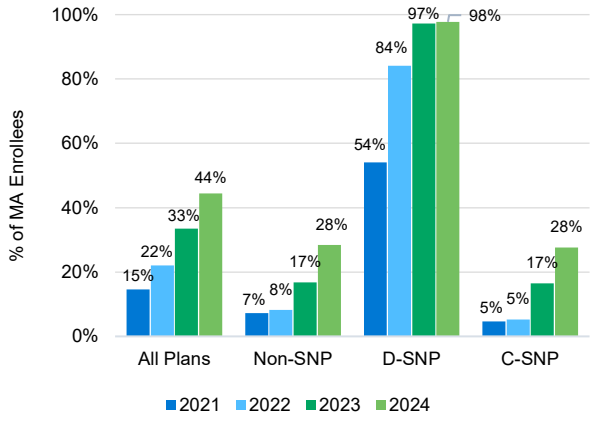
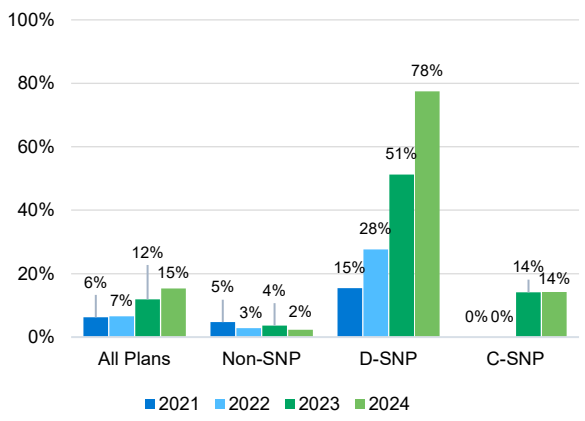


FIGURE 3: PERCENTAGE OF BENEFICIARIES WITH VBID COVERAGE FOR REGIONAL CARRIERS, 2021-2024



Figures 2 and 3 show that, for each plan type and year, national carriers offer VBID coverage to a higher percentage of beneficiaries than regional carriers.

- **While VBID participation increased for national non-SNPs from 2021 to 2024, participation decreased for regional non-SNPs.** National players appear more willing to offer VBID benefits to potentially small portions of their beneficiaries than regional plans. This may be because nationals are already investing time and resources into the VBID application and approach for their D-SNPs, making it less administratively burdensome to add VBID benefits to select non-SNP plans in their portfolios. Many regional MAOs may have a small or no D-SNP footprint and, given this, are not willing to carry the administrative burden of the VBID application and process.

12 Centene/WellCare, CIGNA, CVS/AETNA, Elevance Health Inc., Humana, Kaiser, and UnitedHealth Care are national players for this analysis due to their total enrollment counts.

- **Both national and regional plans are highly penetrated in the VBID program for their D-SNP plan offerings.** In the D-SNP market, nearly all plans offered by national MAOs offer VBID coverage in 2024. Regional carriers have seen significant growth in coverage, from 15% in 2021 to 78% in 2024, starting to catch up to VBID prevalence in the national D-SNP market.
- **National C-SNPs have steadily increased VBID coverage from 2022 to 2024, while regional carriers held coverage steady in 2023 and 2024.** This is a case of different organizations utilizing VBID for their beneficiaries in each year, as regional C-SNPs also did not offer VBID until 2023. National carriers may have more experience than regionals with the VBID application and greater ability to handle the administrative burden of applying for and maintaining the standards of the program.

Food and utilities remain the most common Part C VBID offerings in 2024

MAOs can offer both medical and drug flexibilities in benefit offerings to their beneficiaries through the VBID program. Medical non-primarily health-related benefit enhancements can be categorized into either additional services or reductions in cost sharing. A reduction in medical cost sharing can be on Medicare-covered benefits or mandatory supplemental benefits. In the 2024 market, a wide variety of additional services that extend beyond those traditionally found in supplemental benefits are offered.

Figure 4 displays the percentage of beneficiaries with the different types of medical VBID benefits in 2024.

FIGURE 4: PERCENTAGE OF BENEFICIARIES WITH MEDICAL VBID COVERAGE IN 2024

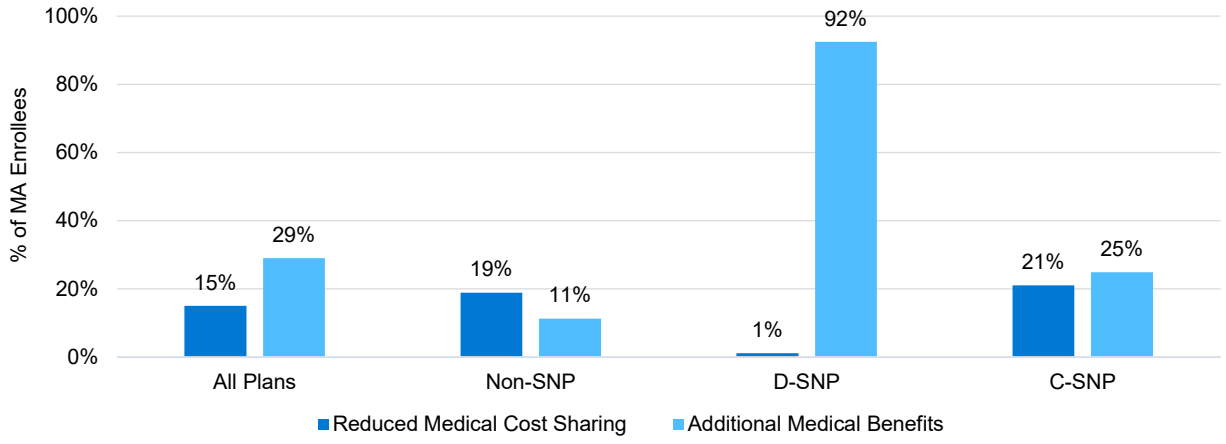


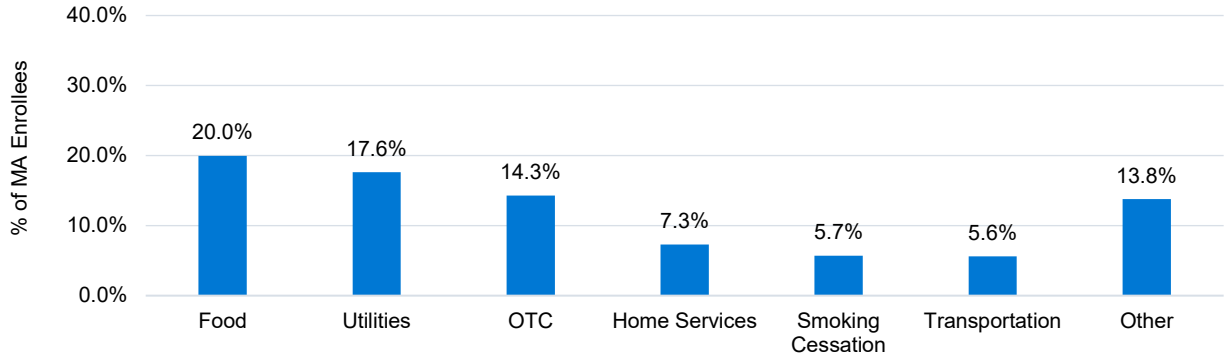
Figure 4 shows coverage for a VBID medical benefit by plan type and in total. Reduced cost-sharing coverage for Medicare-covered services rather than non-Medicare-covered services accounted for the majority of "reduced medical cost sharing" coverage.

- Across all plans, reduced medical cost sharing is offered to 15% of beneficiaries in 2024. Reduced medical cost sharing is very rarely offered on D-SNPs, because these beneficiaries typically do not pay their own cost sharing out of pocket; Medicaid covers this in most cases. D-SNP plan sponsors recognize that offering reduced cost sharing through VBID would not provide any additional value for the beneficiary.

Additional medical benefits are more common than reduced medical cost sharing across the market, with the exception of general enrollment plans, where members are generally responsible for any medical cost sharing. Additional medical benefits are covered for 92% of D-SNP beneficiaries in 2024.

Figure 5 shows the additional services offered through VBID benefits in 2024 with at least 5% of beneficiaries in plans providing the benefits.

FIGURE 5: PERCENTAGE OF BENEFICIARIES WITH VBID COVERAGE FOR ADDITIONAL BENEFITS IN 2024[13]



The benefit offerings with at least 5% coverage, shown in Figure 5, have not changed since 2023. Plans often offer their beneficiaries multiple VBID benefits through a combined benefit limit, and beneficiaries can spend their dollar allowance however best suits their needs. Additionally, in 2024 some plans offered creative new VBID offerings, including genetic testing kits, mental health and wellness smartphone applications, nonfood groceries, supplemental physical therapy, and wellness boxes,[14] but all of these benefits have less than 1% market prevalence.

Through the VBID program, plans can offer reduced cost sharing on medications dispensed through the Part D program to beneficiaries. The reduction in drug cost-sharing benefit should be viewed differently for low-income (LI) versus non-low-income (NLI) members due to the differences in how these beneficiaries pay for their Part D benefits.

NLI BENEFICIARIES

- VBID benefits designed for NLI beneficiaries will typically provide reduced cost sharing for a subset of drugs, as these beneficiaries typically pay the actual tier cost sharing for medications.
- A benefit targeted at NLI beneficiaries would typically state the new copay for the specific drugs included. MAOs can use this to target a specific class of drugs or conditions, with the idea that the VBID reduction in cost sharing would improve beneficiary adherence and provide better disease management. The ability to reduce cost sharing for a given drug without changing formulary placement or cost sharing for an entire tier provides an option for MAOs to make more detailed adjustments to their plans without compromising other features, such as rebates through their pharmacy benefit manager (PBM) contracts. Reducing cost sharing on target drugs can also improve drug adherence and thus star ratings.

LI BENEFICIARIES

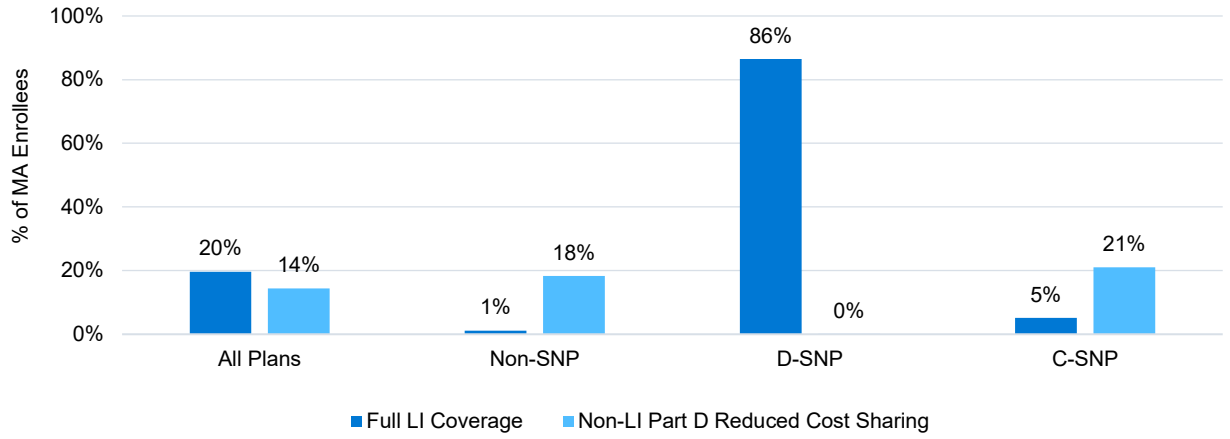
- VBID benefits designed for LI beneficiaries will typically waive or reduce Part D low-income cost sharing, as these beneficiaries typically pay much lower cost sharing, no more than $1.55 for non-applicable (generally generic) drugs and $4.60 for applicable (generally brand) drugs in 2024 for beneficiaries who qualify for the full low-income cost sharing subsidy (LICS).
- While the LI copays may seem small relative to typical Part D copays, offering zero-dollar cost sharing is a substantial benefit to low-income beneficiaries given their income status. MAOs can attract LI beneficiaries with this benefit by addressing the cost-sharing barrier to filling scripts. Importantly, this is done without forfeiting the LICS payment to the MAO. This approach makes it an attractive solution both for the LI member, who will pay little or no cost sharing for their medications, ideally improving adherence, and it allows the plan a financially advantageous solution to this benefit enhancement rather than through an enhanced alternative (EA) plan design approach, where the plan would lose the benefit of the LICS payment.

13 The “Other” grouping contains more than 30 types of benefits. The most prevalent benefits included are provider-referred, pet care, pest control, social needs benefit, and personal care.

14 These benefits are custom entries in the Plan Benefit Package and a definition of the benefit is not available.

Figure 6 shows the coverage for a VBID drug benefit split by different plan types and in total. Partial LI coverage was less than 1% and was excluded for this reason.

FIGURE 6: PERCENTAGE OF BENEFICIARIES WITH DRUG VBID COVERAGE IN 2024



We observe the following in Figure 6.

- D-SNPs offer full LI cost-sharing coverage to 86% of beneficiaries in 2024, dominating the market.
- Non-SNPs and C-SNPs are more likely to offer NLI Part D reduced cost sharing, at 18% and 21% coverage, respectively, in 2024. Non-SNPs are less likely to enroll LI beneficiaries. C-SNPs may favor the drug-specific Part D reduced cost sharing because their chronic condition population may highly utilize a certain class of drugs for which they can reduce cost sharing.

2025 VBID Model considerations

THE 2025 VBID APPLICATION WILL BE SUBJECT TO ADDITIONAL SCRUTINY

In the 2024 VBID Model RFA, CMS stated, “Model Participation selection is not competitive. CMS does not intend to set a maximum number of qualified MAOs participating in the Model test.”[15] In the 2025 RFA, this language changed to "Model participation selection *may be* competitive. CMS *reserves the right to set a maximum number of qualified MAOs, PBPs, enrollee population, or other limits* on participating in the Model test."[16] While CMS has previously stated it has the ability to reject any application, with the goal of protecting the Medicare program, this new language implied that applications may be compared against each other. On March 13, 2024, CMS released a memorandum via the Health Plan Management System (HPMS)[17] indicating how it intends to review applications and that it will apply a competitive scoring rubric in order to compare applications. Another paper in this VBID series will provide more insight into the implications, considerations, and open questions on the CY 2025 VBID RFA and this associated memorandum.

The main points in the memo are as follows:

- **CMS is not considering exception requests as part of the CY 2025 application process**. If the application fails to meet any of the criteria outlined in the memorandum, the MAO cannot reapply to the VBID program for 2025, Given the prevalence of D-SNP plan participation in the VBID program, as discussed above, the application process and scoring will be critical for MAOs to pass in order to remain competitive in the market.

15 CMS, Request for Applications for the Calendar Year 2024, op cit.

16 CMS (December 13, 2023), Request for Applications for the Calendar Year 2025, op cit. Emphasis added.

17 CMS (March 13, 2024), Medicare Advantage (MA) Value-Based Insurance Design (VBID), op cit.

- **The VBID program is now a competitive bid application process**. CMS is expecting those MAOs that submit a VBID application to strictly adhere to the requirements published in this memorandum in the initial application. CMS will quantify the completeness or appropriateness of the application through a scoring rubric.
- CMS will score each application based on the categories outlined in Figure 7. An MAO will be denied participation in the VBID model if either or both of the following apply:
  - The Application Content section receives a score lower than 24
  - The Potential for Savings section receives a score lower than 36

FIGURE 7: CMS APPLICATION SCORING

SCORING CATEGORY	MATERIALS TO REVIEW	MAXIMUM POINTS	PASSING SCORE
Application Content			
Permissibility of Application Proposals	VBID App Spreadsheet: Tables 5.1.1-6.3.1	10	24
Support for Quality Improvement	Financial memo and related documents	10	
Health Equity Plan	VBID App Spreadsheet: Tab 4, All applicable questions	10	
Innovation	VBID App Spreadsheet: Tables 5.1.1-6.3.1	10	
Potential for Savings			
Value of VBID Benefits and/or VBID RI Programs	Financial memo and related documents	20	36
Expectation of Medical Cost Savings	Financial memo and related documents	20	
Support for Savings	Financial memo and related documents	20	

- New in the CY 2025 VBID RFA is the ability for MAOs to use the Area Deprivation Index (ADI); CMS's goal is for MAOs to use ADI to reach additional beneficiaries in underserved areas as a targeting criteria, as opposed to the only current non-condition-dependent targeting method of socioeconomic status. *The Innovation scoring category is based on the use of this targeting method of place of residence in the most underserved ADI areas*, as well as whether proposals are uniquely authorized by the model. A separate paper in this series introduces considerations around ADI that plans should take into account as they consider using this target methodology.
- **Each item will be scored one of three ways, based only on the information available in the original application**, as shown below, with the exception of "Support for Quality Improvement," "Support for Savings," and "Value of VBID Benefits and/or VBID Rewards and Incentives (RI) Programs." It is unclear at this time how many points would be assigned to "acceptable" or "poor" applications, or how an MAO can achieve "exceptional" within each category of the application.
  - Exceptional (all available points)
  - Acceptable
  - Poor (minimum available points)
- Within the "Support for Quality Improvement" and "Support for Savings" sections of the application, MAOs are now required to demonstrate how they can drive medical cost decreases through their VBID applications while excluding savings driven by reduced bid margin.
- This statement is an important consideration as, in past applications, MAOs could utilize the basic bid mechanics of additional supplemental benefits, which require a larger rebate and larger savings shared with CMS, to justify increased savings to the government. This approach may no longer be sufficient as the only source of savings to qualify.

- **CMS is using a quintile ranking system to score the value of the VBID or VBID Rewards and Incentives (RI) benefit offerings.** The "Value of VBID Benefits and/or VBID RI Programs" will rank the per member per month (PMPM) and per engaged beneficiary per month (PEBPM) value of VBID benefits and/or VBID RI programs and sort acceptable applications into quintiles at the parent organization application level. Applications where the value of the VBID benefits and/or VBID RI programs are not supported in other sections of the application will not be sorted into quintiles but will be assigned 0 points in this category. By using quintiles, CMS is signaling that the highest valued PMPM and PEBPM quintiles will likely receive the most points within this section and the lowest valued PMPM and PEBPM quintiles will likely receive the least points within this section. However, there are many open questions as to how CMS will aggregate these savings across MAOs and across Plan Benefit Packages (PBPs), and how that quantification may impact the ultimate scoring of this section.

THE 2025 VBID APPLICATION WILL REQUIRE MAOS OFFERING VBID TO INCLUDE CERTAIN SUPPLEMENTAL BENEFIT OFFERINGS

Additionally, CMS announced new criteria for MAOs to be included in the 2025 model. The 2025 RFA states that participating MAOs must "offer supplemental benefits to address health-related social needs in at least two of three health-related social needs areas: food, transportation and housing insecurity and/or living environment."[18] This new language affects plans that previously did not offer a range of benefits that meet this new criteria. While this could expand the offerings for MAOs in the program, it could also lead to some MAOs choosing to not participate. These benefits do not need to be offered as part of the VBID engagement specifically, but can also be offered under other flexibilities like SSBCI, or to all members in the plan.

THE INFLATION REDUCTION ACT COULD IMPACT VBID PROGRAM OFFERINGS

The changes to the Medicare Part D program from the Inflation Reduction Act (IRA)[19,20,21] could have ripple effects to the VBID program.

- The removal of member cost sharing in the catastrophic phase in 2024 and the change in 2025 benefit design will decrease costs to members and increase costs to plans. If a beneficiary already incurs lower costs under the Part D benefit in 2025, the VBID benefit can have less of an impact on beneficiaries. For beneficiaries taking high-cost scripts, the Medicare Prescription Payment Plan, which begins in 2025, allows for cost-sharing smoothing throughout the year, again reducing the immediate impact of the VBID benefit for these beneficiaries.
- The change in benefit structure will increase plan liability, which can affect a given MAO's decision to apply to the VBID program given the additional costs.
- While there are additional costs associated with VBID program participation, VBID benefits could drive savings through drug adherence and disease management. Plans may choose to continue to participate in VBID with this in mind.
- Furthermore, given the high prevalence of VBID in the market today, plans may apply to the program in 2025 to remain competitive with beneficiaries.

18 CMS (December 13, 2023). Request for Applications for the Calendar Year 2025, op cit.

19 Cline, M., Karcher, J., Klaisner, J., & Klein, M. (August 2022). Weathering the Reform Storm. Milliman Brief. Retrieved March 22, 2024, from https://www.milliman.com/en/insight/weathering-the-reform-storm.

20 Ally, A.J., Berman, M., Klein, M., & Pierce, K. (September 30, 2022). The Inflation Reduction Act Passed, Now What? Retrieved March 22, 2024, from https://www.milliman.com/en/insight/the-inflation-reduction-act-passed-now-what.

21 Berger, C., Engel, T., & Wanta, T. (August 30, 2023). Part D Redesign Under the Inflation Reduction Act. Milliman White Paper. Retrieved March 22, 2024, from https://www.milliman.com/en/insight/part-d-redesign-under-ira-potential-financial-ramifications.

Methodology

In performing this analysis, we relied on the 2024 Milliman MACVAT®. The Milliman MACVAT contains MA plan details and benefit offerings for 2021 through 2024, in addition to Milliman's proprietary measure of benefit richness, which includes VBID benefits. The Milliman MACVAT uses publicly available data released by CMS, which is then compiled, sorted, and summarized into a user-friendly format. We used the February enrollment from each applicable year (2021 through 2023), with the exception of 2024, for which we used the January 2024 enrollment.

This analysis excludes Prescription Drug Plans (PDPs), Medical Savings Account (MSA) plans, Medicare-Medicaid Plans (MMPs), the Program of All-Inclusive Care for the Elderly (PACE), Part B-only, and Cost plans.

Caveats and Limitations

Julia M. Friedman, Jordan T. Laktas, and Mary G. Yeh 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 information 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.

This report is intended to summarize the coverage within the VBID program. This information may not be appropriate, and should not be used, for other purposes. We do not intend this information to benefit, and assume no duty of liability to, any third party that receives this work product. Any third-party recipient of this report that desires professional guidance should not rely upon Milliman's work product, but should engage qualified professionals for advice appropriate to its specific needs.

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 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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