MILLIMAN RESEARCH REPORT

State of the 2018 Medicare Advantage industry: Stable and growing

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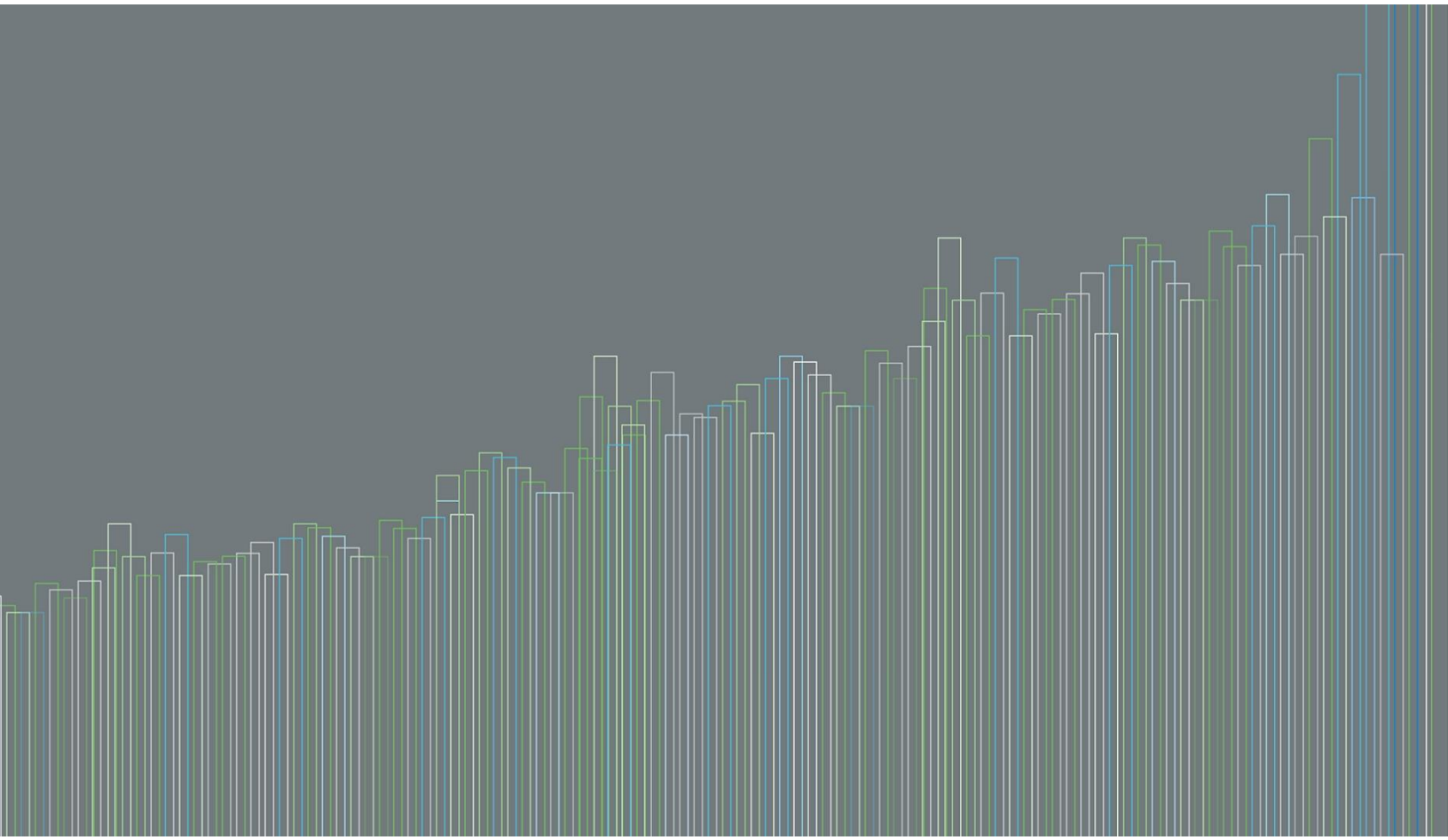

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I. Executive Summary

Medicare Advantage (MA) 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, otherwise known as Medicare Advantage organizations (MAOs). MAOs offer a number of different plan designs with differing benefit packages and premiums. 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).

Each MA benefit plan has an associated "value added," which is defined as the value of benefits provided to a specific plan's beneficiaries above traditional Medicare that are not funded through member premiums. This metric not only accounts for the value of non-Medicare-covered benefits and traditional Medicare cost-sharing reductions, but it is also offset by each plan's member premium. Therefore, two plans with identical benefits will have different value added amounts if their premiums vary. This report highlights changes in the MA value added from 2014 to 2018. We focus our analyses on the general enrollment and dual-eligible special needs plan (D-SNP) types nationwide, excluding Puerto Rico.

Various legislated and regulatory changes have impacted the federal government's funding of MAOs in recent years, including sequestration, the conclusion of the Quality Bonus Payment Demonstration, the Health Insurer Providers Fee (HIPF), and other regulatory changes. Additionally, the Patient Protection and Affordable Care Act (ACA) changed the methodology of calculating payment rates to MAOs beginning in 2012 and ended with the 2017 payment year. During much of that time, CMS payments to MAOs have been decreasing annually as a percentage of fee-for-service costs, and through 2016 this resulted in less value added to members over time. However, the MA market saw an increase in both 2017 and 2018 in these value added amounts:

- There was a moratorium on the HIPF in the 2017 plan year, allowing many MAOs that previously were assessed the fee to repurpose those dollars into improved plan benefits and/or lower member premiums, which directly contributes to an increase in value added.
- Despite the HIPF reinstatement for the 2018 plan year, the MA market saw a continued increase in value added year-over-year. Some contributing factors to this value added increase include:
  - For the last year of payment changes in 2017, the impact of the ACA funding cuts was relatively small compared to prior years.
  - MAO contracts with 4.0 or higher star ratings, which are measurements of quality, receive additional revenue dollars per member per month (PMPM) through bonus payments. Based on CMS's published 2018 Star Ratings Fact Sheet,[1] which summarizes the 2018 star ratings (to be used in the 2019 bid cycle), about 44% of Medicare Advantage prescription drug (MA-PD) plan contracts offered in 2018 (about 170 contracts) were at a 4.0 or higher star rating. Approximately 73% of MA-PD enrollees are currently enrolled in contracts that have 4.0 or higher star ratings, compared to 69% of enrollees in 2017. By achieving higher star ratings, MAOs have the ability to offer improved benefits to prospective enrollees, which in turn directly increases the value added metric.
- The MA program continues to be an attractive business opportunity for current and new MAOs. This is leading to a significant increase in the number of plans and MAOs available in 2017 and 2018 relative to prior years. Based on the data underlying this report, there was growth of 3.9% in the number of plans offered in 2017 (relative to 2016) and 14.6% in 2018 (relative to 2017). New MAOs typically enter the market with rich benefits and low member premiums, which overall contribute to the increasing value added.

[1] CMS (November 1, 2017). 2018 Part C and D Medicare Star Ratings Data. Retrieved February 16, 2018, from https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/2018-Part-C-and-D-Medicare-Star-Ratings-Data-v11-01-2017-.zip (download).

The average change in member premium and value added PMPM is a decrease of $0.31 and an increase of $0.49, respectively, from 2014 to 2018, for all general enrollment beneficiaries nationwide, excluding Puerto Rico (PR). The average change in member premium and value added, for all dual-eligible beneficiaries nationwide, excluding PR, from 2014 to 2018, is an increase of $0.30 and $5.16 PMPM, respectively.

Enrollment growth is strong within this market, due to the popularity of the MA program and the continued aging of the Baby Boomer generation, with an increase of approximately 6% per year since 2014 as measured in this analysis. Nationwide, MA penetration is approximately 33.5% as of January 2018, which has been steadily increasing since 2014. Steady growth and increased market penetration is one indicator of the value offered by MA plans.

II. Background

CMS requires all MAOs to submit a bid for each plan offered by the first Monday in June. This bid 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 is 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 their bids each year, they must take into account historical costs, CMS revenue levels, anticipated market changes, and membership characteristics, which all impact how each 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 2017, CMS released benefit and premium information for all MA plans that are to be offered in 2018. As the MA market continues to evolve, it is important to analyze how the landscape of this program is changing over time.

This report highlights key changes in beneficiary premiums and benefits for the 2018 MA market, as well as the reasons for and the magnitude of the decrease in value added within the Medicare Advantage market between 2014 and 2016 and the increases in value added in 2017 and 2018, with a more detailed look at changes between 2017 and 2018. This report also aims to assist MAOs in making strategic decisions during 2019 bid preparations.

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 2019 benefit and premium decisions. Specifically, we focus on value added and premium in 2018, as well as on how they changed from 2014 to 2018, using publicly available information released by CMS.

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

The value added for dual-eligible special needs plans (D-SNPs) only measures the value of non-Medicare-covered benefits that are not funded through member premiums, e.g., dental, over-the-counter (OTC) drug card, etc., 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, i.e., non-employer group waiver plans (EGWPs), excluding standalone prescription drug plans (PDPs). We used publicly available membership information released by CMS from February of the corresponding year; for example, the membership used for reviewing 2014 data is the February 2014 membership. For the 2018 analysis, we utilized the January 2018 enrollment information as February information was not available when this report was developed.

The primary focus of this report is noninstitutionalized non-Medicaid plans and D-SNPs. The noninstitutionalized non-Medicaid plans are also referred to as general enrollment plans because they do not contain enrollment restrictions (with the noted exception of end-stage renal disease). D-SNPs for chronic (C-SNP) and institutionalized (I-SNP) conditions are less common in the MA market and are excluded from the results in this report, except where specifically stated. Additionally, we exclude Puerto Rico (PR) from the results, as PR contains a significant portion of D-SNP enrollment and the variance that is due to more extreme ACA funding cuts in PR skews the nationwide D-SNP results. For geographical consistency, we also exclude PR from the general enrollment plan analyses. The results also 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. Lastly, Medicare-Medicaid Plans (MMPs), which include around 370,000 members, were also excluded.

In addition, for the population we analyzed, there are about 2,450 unique general enrollment plans offered in 2018, with about 1,750 continuing to be offered from 2017. Roughly 400 plans offered in 2017 are no longer available in 2018. However, approximately 700 new plans will begin in 2018. Overall, there is a net increase of about 15% in the total number of individual general enrollment plans available in 2018 compared with 2017 (about 2,150 general enrollment plans were available in 2017). For comparison, between 2016 and 2017 there were approximately 300 plans that terminated with approximately 400 new plan offerings in 2017, for a net change of 3.9% in 2017. D-SNPs have stayed relatively flat through 2017 (approximately 50 entries and exits each year), with 2018 seeing approximately 100 net new plans entering the market.

IV. Results

GENERAL ENROLLMENT PLANS

Analysis: 2018 snapshot

This section provides an analysis of 2018 general enrollment plans and the market changes from 2017. The value added 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. Note that the buy-down of the Part B premium is included under "Change in Benefits" within this section of the report.

Region

The table in Figure 1 contains the 2018 value added and member premium for all general enrollment plans by region, on a per member per month (PMPM) basis. The change in these metrics from 2017 is also shown. The benefit change is measured as the value added change, excluding the change in premium. For example, nationwide there is a $4.94 increase in value added, with $2.01 of this due to decreased premiums. Therefore, there is a net increase in benefits of $2.93. This change is similar to last year in terms of value added, where the nationwide increase in value added was $5.38; however, the premium decrease at that time was $1.01. In 2018 it appears that the market has continued to decrease premiums relative to the prior year while still improving benefits for members.

FIGURE 1: MEDICARE ADVANTAGE AVERAGE PREMIUM AND VALUE ADDED AMOUNTS BY REGION

GENERAL ENROLLMENT PLANS

REGION	2018 VALUE ADDED	CHANGE IN VALUE ADDED	2018 PREMIUM	CHANGE IN PREMIUM	CHANGE IN BENEFITS	MEMBERSHIP DISTRIBUTION (%)
NORTHEAST	$51.75	$6.54	$54.30	-$3.36	$3.18	18%
MIDWEST	$72.01	$10.07	$38.55	-$4.04	$6.03	19%
SOUTH	$112.92	$5.14	$19.30	-$1.18	$3.96	37%
WEST	$90.88	-$0.21	$31.98	-$0.65	-$0.85	27%
NATIONWIDE	$88.41	$4.94	$32.56	-$2.01	$2.93	100%

As shown in Figure 1, general enrollment plans have an average value added of about $88 nationwide. However, this varies significantly by region, with the South and West regions having values that are higher than average with included lower member premiums, consistent with results seen in prior years. 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 added.

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 added 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 added, there are downward shifts in premium in all areas of the country, with larger decreases seen in the Northeast and Midwest regions. As mentioned above, there is about a $2 decrease in the average nationwide premium from 2017 to 2018. There is continued improvement of benefit offerings through richer benefits and offering of new non-Medicare-covered benefits relative to 2017 with the one noted exception of the West region, which experienced leaner benefits between 2017 and 2018.

Star rating

CMS uses information collected through member surveys, plan submissions, and providers to assign quality star ratings to MA and PDP contracts. Star ratings are intended to help beneficiaries compare plans based on their historical levels of quality. In addition, the ACA introduced a new payment methodology in 2012 that ties both benchmark revenue payments and rebate percentages (retained savings) to an MAO's overall star rating (Part C + Part D), incentivizing organizations to increase their star ratings.

The table in Figure 2 shows the value added and premium information in the MA industry stratified by overall star rating. This figure is comparing the distribution of plans that were bucketed into the corresponding 2017 star rating (used in the 2018 bids) to the 2018 star rating (to be used in the 2019 bids). There is roughly a three-year delay in receiving a star rating. The "Low Enrollment" designation applies to contracts that do not have sufficient enrollment and corresponding data in the three years prior to evaluate and create a star rating. Contracts that have entered the market in the past three years will be classified as "New Contract." It is important to note that New Contracts receive benchmark revenue payments that reflect a bonus payment of 3.5%, unless the new 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. Low Enrollment contracts also receive benchmark payments that reflect a bonus payment of 3.5%.

FIGURE 2: MEDICARE ADVANTAGE AVERAGE PREMIUM AND VALUE ADDED AMOUNTS BY STAR RATING

GENERAL ENROLLMENT PLANS

STAR RATING	2018 VALUE ADDED	CHANGE IN VALUE ADDED	2018 PREMIUM	CHANGE IN PREMIUM	CHANGE IN BENEFITS	MEMBERSHIP DISTRIBUTION (%)
NEW CONTRACT	$106.40	$20.36	$19.51	-$18.84	$1.52	0.4%
LOW ENROLLMENT	$42.39	-$67.34	$37.52	$10.02	-$57.32	0.3%
<3.0	$117.47	$14.82	$17.80	$5.06	$19.88	0.4%
3.0	$94.96	$24.45	$18.74	-$16.32	$8.13	4%
3.5	$77.52	$11.82	$34.33	-$1.04	$10.78	22%
4.0	$85.42	-$14.42	$30.53	$4.96	-$9.46	45%
4.5	$116.26	$31.51	$30.34	-$10.61	$20.90	19%
5.0	$65.75	-$10.72	$51.37	$4.49	-$6.23	8%
TOTAL	$88.41	$4.94	$32.56	-$2.01	$2.93	100%

Figure 2 demonstrates there is not a strong correlation between the 2018 value added or change in value added and the star rating. However, contracts with star ratings of 5.0 have significantly higher premiums than contracts with lower star ratings. Additionally, New Contracts without a star rating have a significantly higher value added than the total (average). This result was similar to what was observed for prior years, indicating that New Contracts often enter the market with significantly richer benefits and lower 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 may include HMOs with a point of service (POS) option (meaning access to out-of-network benefits, and noted below as HMO-POS plans), private fee-for-service plans (PFFS), and preferred provider organizations (PPOs), which include local (LPPO) and regional (RPPO) variations. Please note that the value added 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: MEDICARE ADVANTAGE AVERAGE PREMIUM AND VALUE ADDED AMOUNTS BY PLAN TYPE

GENERAL ENROLLMENT PLANS

PRODUCT TYPE	2018 VALUE ADDED	CHANGE IN VALUE ADDED	2018 PREMIUM	CHANGE IN PREMIUM	CHANGE IN BENEFITS	MEMBERSHIP DISTRIBUTION (%)
HMO	$109.91	$3.55	$24.02	-$1.22	$2.33	65%
HMO-POS	$60.60	$7.79	$58.77	-$3.32	$4.46	6%
LPPO	$51.87	$11.81	$48.19	-$6.40	$5.41	20%
RPPO	$37.69	-$6.65	$39.51	$3.19	-$3.46	8%
PFFS	-$13.49	-$12.13	$64.78	$4.24	-$7.89	1%
TOTAL	$88.41	$4.94	$32.56	-$2.01	$2.93	100%

The table in Figure 3 demonstrates that HMOs generally have the highest value added for general enrollment plans, while PFFS plans generally have the lowest value added, which is consistent with prior year results. Note that a negative value added indicates PFFS plans have lower value added than traditional Medicare. Among general enrollment plans, HMOs are the most popular product type, with roughly 65% of the membership. Product types appear to be experiencing varied rate pressures, with some having the ability to mitigate the year-over-year impact on beneficiary value added. RPPO and PFFS plans appear to be forced to give up more value added in 2018 relative to 2017, which is mostly due to large decreases in benefit value relative to the HMO, HMO-POS, and LPPO product types. HMOs have the lowest premium, which is consistent with also having the greatest amount of value added, and also can be seen with every year of data underlying these results.

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 achieving lower administrative costs than smaller local carriers. Carrier size is defined below, based on publicly available MA membership for each year across all plans on a nationwide basis, as described below in the Methodology section:

- Mega: 250,000 or more members. This group contains the large national insurers Aetna, Anthem, CIGNA, Humana, Kaiser, UnitedHealth Group, and WellCare.
- Large: 50,000 or more members but under 250,000 members.
- Medium: 5,000 or more members but under 50,000 members.
- Small: 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 added and premium results for general enrollment plans by carrier size.

FIGURE 4: MEDICARE ADVANTAGE AVERAGE PREMIUM AND VALUE ADDED AMOUNTS BY CARRIER SIZE

GENERAL ENROLLMENT PLANS

CARRIER SIZE	2018 VALUE ADDED	CHANGE IN VALUE ADDED	2018 PREMIUM	CHANGE IN PREMIUM	CHANGE IN BENEFITS	MEMBERSHIP DISTRIBUTION (%)
MEGA	$95.58	$3.69	$23.32	-$1.20	$2.49	68%
LARGE	$74.09	$6.84	$52.88	-$2.55	$4.28	21%
MEDIUM	$70.61	$6.92	$51.97	-$3.20	$3.72	10%
SMALL	$73.31	$5.58	$48.00	-$3.84	$1.74	0.4%
TOTAL	$88.41	$4.94	$32.56	-$2.01	$2.93	100%

Based on the results shown in Figure 4, small, medium, and large carrier sizes provide a lower value added for general enrollment beneficiaries compared with mega carriers. Mega carriers provide the greatest amount of value added, the lowest overall premium, and the smallest changes in both value added and premium from 2017, and they contain the majority of January 2018 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 added 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 and their behavior in the MA market.

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

FIGURE 5: MEDICARE ADVANTAGE AVERAGE PREMIUM AND VALUE ADDED AMOUNTS BY DEDUCTIBLE

GENERAL ENROLLMENT PLANS

PART C AND D DEDUCTIBLES	2018 VALUE ADDED	CHANGE IN VALUE ADDED	2018 PREMIUM	CHANGE IN PREMIUM	CHANGE IN BENEFITS	MEMBERSHIP DISTRIBUTION (%)
BOTH > $0	$29.29	$4.42	$44.56	-$3.51	$0.91	2%
C ONLY > $0	$36.88	-$1.72	$42.77	$3.17	$1.44	1%
D ONLY > $0	$73.77	$7.19	$30.98	-$2.18	$5.00	52%
BOTH = $0	$109.54	$3.62	$33.52	-$1.89	$1.73	45%
TOTAL	$88.41	$4.94	$32.56	-$2.01	$2.93	100%

Figure 5 shows that the vast majority of beneficiaries (97%) 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 offered under MA that include medical deductibles—in 2014, 5.7% of all unique general enrollment plans offered plans with Part C deductibles, whereas 4.6% of general enrollment plans offered plans with medical deductibles in 2018. Additionally, plans without medical deductibles generally offer a richer overall benefit package, as evidenced through the value added for these plans (D Only > $0 and Both = $0 in Figure 5 above). 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). The results assume that MA Only plans effectively have a Part D premium, benefit, and value added of $0.

In 2018, 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 added and premium information by MOOP type.

FIGURE 6: MEDICARE ADVANTAGE AVERAGE PREMIUM AND VALUE ADDED AMOUNTS BY MOOP

GENERAL ENROLLMENT PLANS

MAXIMUM OUT-OF-POCKET	2018 VALUE ADDED	CHANGE IN VALUE ADDED	2018 PREMIUM	CHANGE IN PREMIUM	CHANGE IN BENEFITS	MEMBERSHIP DISTRIBUTION (%)
VOLUNTARY	$134.62	$9.18	$30.12	-$7.92	$1.27	24%
MANDATORY	$73.92	$0.33	$33.33	-$0.42	-$0.10	76%
TOTAL	$88.41	$4.94	$32.56	-$2.01	$2.93	100%

Figure 6 shows that a majority of beneficiaries choose plans with the mandatory MOOP between $3,401 and $6,700, despite the fact that plans that have a voluntary MOOP have both a higher value added and a lower premium than mandatory MOOP plans in 2018. The differences in value added between voluntary MOOP and mandatory MOOP are largely driven by service area and are not necessarily a function of positive member selection.

Historical analysis: Past five years

This section provides an analysis of a five-year lookback from 2014 to 2018 for general enrollment plans. We measured the value added by county for each general enrollment Medicare Advantage benefit plan in the country for each year from 2014 to 2018, 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 February of each specific year to develop the

weighted averages across all plans for the given year. For the 2018 analysis, we utilized the January 2018 enrollment information as February information was not available when this report was developed.

Benefit values

The table in Figure 7 contains the nationwide average "supplemental 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, Professional, Other Medicare-Covered, and Other 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, such as dental, OTC drug card, vision, acupuncture, etc. The Part D column reflects the Part D member premium needed to pay for the Part D benefit levels within each plan, as Part D is not offered under traditional Medicare.

FIGURE 7: MEDICARE ADVANTAGE NATIONAL AVERAGE BENEFIT VALUE

GENERAL ENROLLMENT PLANS

YEAR	INPATIENT	OUTPATIENT	PROFES-SIONAL	OTHER MEDICARE-COVERED	OTHER NON-MEDICARE-COVERED	TOTAL PART C	PART D	OVERALL TOTAL
FIVE-YEAR ANALYSIS								
2014	$15.62	$21.17	$22.63	$6.94	$15.54	$81.91	$36.99	$118.89
2015	$14.72	$17.74	$20.95	$6.51	$18.34	$78.26	$36.01	$114.27
2016	$13.88	$15.87	$20.99	$5.84	$18.65	$75.22	$37.50	$112.72
2017	$13.43	$15.91	$21.39	$5.86	$20.30	$76.90	$40.15	$117.05
2018	$13.05	$16.25	$22.51	$5.82	$21.25	$78.88	$40.97	$119.85
YEAR-OVER-YEAR CHANGE								
2014 TO 2015	-$0.90	-$3.43	-$1.69	-$0.43	$2.80	-$3.64	-$0.98	-$4.62
2015 TO 2016	-$0.84	-$1.87	$0.04	-$0.67	$0.30	-$3.04	$1.49	-$1.55
2016 TO 2017	-$0.45	$0.04	$0.41	$0.02	$1.65	$1.67	$2.65	$4.32
2017 TO 2018	-$0.38	$0.33	$1.12	-$0.04	$0.95	$1.99	$0.82	$2.81

The cumulative change in total annual benefit value, for all general enrollment beneficiaries nationwide, from 2014 to 2018, is $11.52. This is calculated by taking the monthly 2018 total benefit value of $119.85 minus the monthly 2014 total benefit value of $118.89 multiplied by 12 (12 months per year).

Figure 7 illustrates that benefit values have cumulatively increased from 2014 through 2018 for Other Non-Medicare-Covered and Part D but cumulatively decreased for all other service categories over the same time period.

Premium and value added amounts

The table in Figure 8 contains the nationwide average value added amounts, which are calculated as the difference between the benefit values from Figure 7 above and the corresponding nationwide average member premiums. Again, value added 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, but that is not utilized frequently by most plans. To the extent that the Part B premiums are reduced, this too contributes to the total value added.

FIGURE 8: MEDICARE ADVANTAGE NATIONAL AVERAGE PREMIUM AND VALUE ADDED AMOUNTS

GENERAL ENROLLMENT PLANS

	PART C			PART D			TOTAL			
YEAR	BENEFIT VALUE	PREMIUM	VALUE ADDED	BENEFIT VALUE	PREMIUM	VALUE ADDED	BENEFIT VALUE	PART B BUY-DOWN	PREMIUM	VALUE ADDED
FIVE-YEAR ANALYSIS										
2014	$81.91	$19.74	$62.17	$36.99	$14.06	$22.93	$118.89	$1.36	$33.79	$86.46
2015	$78.26	$19.67	$58.59	$36.01	$16.58	$19.43	$114.27	$1.23	$36.25	$79.24
2016	$75.22	$19.17	$56.05	$37.50	$16.41	$21.09	$112.72	$0.96	$35.58	$78.10
2017	$76.90	$17.01	$59.89	$40.15	$17.56	$22.59	$117.05	$1.00	$34.57	$83.48
2018	$78.88	$15.95	$62.93	$40.97	$16.61	$24.36	$119.85	$1.12	$32.56	$88.41
YEAR-OVER-YEAR CHANGE										
2014 TO 2015	-$3.64	-$0.06	-$0.13	-$0.98	$2.52	-$3.50	-$4.62	-$0.13	$2.46	-$7.22
2015 TO 2016	-$3.04	-$0.50	-$2.54	$1.49	-$0.17	$1.67	-$1.55	-$0.27	-$0.67	-$1.15
2016 TO 2017	$1.67	-$2.16	$3.83	$2.65	$1.15	$1.50	$4.32	$0.04	-$1.01	$5.38
2017 TO 2018	$1.99	-$1.06	$3.04	$0.82	-$0.95	$1.77	$2.81	$0.12	-$2.01	$4.94

The cumulative change in the average annual premium, for all general enrollment beneficiaries nationwide, from 2014 to 2018, is a decrease of $14.76. This is calculated by taking the average monthly 2018 premium of $32.56 minus the average monthly 2014 premium of $33.79, multiplied by 12. The cumulative change in average annual value added (which includes the change in the Part B premium buy-down), for all general enrollment beneficiaries nationwide, from 2014 to 2018, is $23.40. This is calculated by taking the average monthly 2018 value added of $88.41 minus the average monthly 2014 value added of $86.46 multiplied by 12.

Figure 8 illustrates that, overall, value added increased in both 2017 and 2018, whereas prior to 2017 value added was decreasing. This is also true for Part C. For Part D, the results indicate consistent small increases in the value added from 2015 through 2018.

Part C benefit design and premium

The table in Figure 9 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 9: MEDICARE ADVANTAGE NATIONAL AVERAGE PART C BENEFIT DESIGN

GENERAL ENROLLMENT PLANS

	ALL MEMBERS			PCP COPAY		PCP COINSURANCE		SCP COPAY		SCP COINSURANCE	
YEAR	ENROLL-MENT	OUT-OF-POCKET MAX	DEDUC-TIBLE	ENROLL-MENT	COPAY	ENROLL-MENT	COIN-SURANCE	ENROLL-MENT	COPAY	ENROLL-MENT	COIN-SURANCE
FIVE-YEAR ANALYSIS											
2014	10,209,990	$4,920	$13.57	10,186,534	$10.55	23,456	18.29%	10,176,402	$32.65	33,588	19.48%
2015	10,871,409	$5,115	$10.35	10,818,202	$10.44	53,207	19.08%	10,816,703	$34.33	54,706	19.69%
2016	11,540,223	$5,293	$10.55	11,488,032	$9.66	52,191	19.91%	11,476,982	$35.12	63,241	20.00%
2017	12,178,620	$5,302	$12.46	12,156,437	$9.29	22,183	20.00%	12,132,623	$35.50	45,997	20.00%
2018	12,819,621	$5,270	$14.15	12,786,793	$8.55	32,828	20.00%	12,769,699	$35.42	49,922	19.90%
YEAR-OVER-YEAR CHANGE											
2014 TO 2015	661,419	$194.29	-$3.22	631,668	-$0.11	29,751	0.79%	640,301	$1.68	21,118	0.21%
2015 TO 2016	668,814	$177.94	$0.20	669,830	-$0.78	-1,016	0.79%	660,279	$0.79	8,535	0.31%
2016 TO 2017	638,397	$9.07	$1.91	668,405	-$0.38	-30,008	0.09%	655,641	$0.38	-17,244	0.00%
2017 TO 2018	641,001	-$31.25	$1.69	630,356	-$0.74	10,645	0.00%	637,076	-$0.08	3,925	-0.10%

Figure 9 illustrates an increase in the maximum out-of-pocket limit each year through 2017 with a slight decrease in 2018, reflecting that individuals' overall potential cost burden has been increasing annually from 2014 to 2018. 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 decreased every year from 2014 to 2018, specialty care physician (SCP) copays have increased almost every year, although there are small average changes in the later years. Coinsurance on both of these benefits remains a fairly unpopular benefit design.

Part D benefit design and premium

The table in Figure 10 contains various information regarding changes in the Part D deductibles, premium, and benefit value over time for general enrollment MA-PD plans. It is worth noting that the values in Figure 10 are slightly different from the corresponding values in other tables, as Figure 10 only includes plans (and corresponding enrollment) that offer Part D benefits. As mentioned previously, 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 added of $0.

FIGURE 10: MEDICARE ADVANTAGE NATIONAL AVERAGE PART D BENEFIT DESIGN

GENERAL ENROLLMENT PLANS

YEAR	PART D DEDUCTIBLE	PART D PREMIUM	PART D BENEFIT VALUE
FIVE-YEAR ANALYSIS			
2014	$25.08	$14.64	$38.54
2015	$97.60	$17.21	$37.37
2016	$129.06	$16.98	$38.82
2017	$132.30	$18.10	$41.39
2018	$132.74	$17.07	$42.11
YEAR-OVER-YEAR CHANGE			
2014 TO 2015	$72.53	$2.56	-$1.17
2015 TO 2016	$31.46	-$0.22	$1.45
2016 TO 2017	$3.24	$1.12	$2.57
2017 TO 2018	$0.44	-$1.03	$0.72

Figure 10 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 “Enhanced Alternative” plan design, which allows for a Part D deductible from $0 up to the “Defined Standard” Part D deductible ($405 in 2018), 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 cost-sharing tiers. The average Part D premium has varied since 2014, although within a very small range, and benefit values have continued to increase since 2015, despite an increasing Part D deductible being included in many plans.

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 and comprehensive dental, vision exams and hardware, nonemergency transportation (NEMT), hearing exams and aids, and OTC drug cards. Please note that the other non-Medicare-covered measurement category used in the summaries above includes many more benefits than the ones outlined in Figure 11, which summarizes only the most popular and visible benefits. Other non-Medicare-covered benefit examples not included in Figure 11 are non-Medicare-covered podiatry, acupuncture, and worldwide emergency room (ER) coverage, to name a few.

FIGURE 11: MEDICARE ADVANTAGE MEMBERSHIP WITH ACCESS TO NON-MEDICARE-COVERED BENEFITS

GENERAL ENROLLMENT PLANS

YEAR	ENROLLMENT	PREVENTIVE DENTAL	COMPRE-HENSIVE DENTAL	VISION EXAMS	VISION HARDWARE	NEMT	HEARING EXAMS	HEARING AIDS	OTC DRUG CARD
FIVE-YEAR ANALYSIS									
2014	10,209,990	38.7%	19.8%	86.0%	53.5%	18.6%	58.2%	39.4%	22.6%
2015	10,871,409	47.5%	23.2%	92.1%	59.5%	19.9%	61.3%	43.2%	26.2%
2016	11,540,223	52.1%	25.3%	93.2%	63.7%	20.5%	69.7%	47.6%	27.7%
2017	12,178,620	55.5%	26.9%	93.1%	63.4%	20.6%	75.3%	57.4%	40.0%
2018	12,819,621	58.7%	29.9%	93.6%	68.7%	20.6%	82.6%	66.6%	41.4%
YEAR-OVER-YEAR CHANGE									
2014 TO 2015	669,830	8.7%	3.5%	6.1%	6.1%	1.3%	3.1%	3.8%	3.6%
2015 TO 2016	668,814	4.7%	2.1%	1.1%	4.2%	0.6%	8.4%	4.4%	1.5%
2016 TO 2017	638,397	3.4%	1.5%	-0.1%	-0.3%	0.1%	5.7%	9.8%	12.2%
2017 TO 2018	641,001	3.2%	3.0%	0.5%	5.3%	0.0%	7.2%	9.2%	1.4%

In general, Figure 11 illustrates an increase in the number of general enrollment plans offering non-Medicare benefits from 2014 to 2018. 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: 2018 snapshot

This section provides an analysis of 2018 D-SNPs and the changes in these plans from 2017. The value added 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 I-SNPs and C-SNPs. Consistent with general enrollment plans, the buy-down of the Part B premium is also included in the "Change in Benefits" part of this section of the report. Note that the value added 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.

Region

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

FIGURE 12: MEDICARE ADVANTAGE AVERAGE PREMIUM AND VALUE ADDED AMOUNTS BY REGION

DUAL-ELIGIBLE SPECIAL NEEDS PLANS

REGION	2018 VALUE ADDED	CHANGE IN VALUE ADDED	2018 PREMIUM	CHANGE IN PREMIUM	CHANGE IN BENEFITS	MEMBERSHIP DISTRIBUTION (%)
NORTHEAST	$57.09	$9.40	$33.95	-$3.61	$5.79	27%
MIDWEST	$55.59	$7.38	$28.39	$1.45	$8.84	8%
SOUTH	$69.42	$7.00	$21.19	-$1.85	$5.16	46%
WEST	$54.66	$6.19	$28.71	-$1.66	$4.53	19%
NATIONWIDE	$62.19	$7.64	$26.64	-$2.06	$5.58	100%

The D-SNP results in Figure 12 demonstrate increases in the value added metric from 2017 in all regions, with the largest increase in the Northeast region. The South, which represents about 46% of the membership, has the highest value added metric; all other areas have comparable value added amounts. In the Midwest, a premium increase reduces the larger changes in benefits for this area relative to other regions, whereas all other regions are seeing a reduction in premium going into 2018. Because nearly all D-SNPs target premiums that 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.

Star rating

The table in Figure 13 contains the value added and premium analysis by plan star rating for D-SNPs (as mentioned above, New Contract and Low Enrollment apply again to contracts with insufficient information to calculate a star rating).

FIGURE 13: MEDICARE ADVANTAGE AVERAGE PREMIUM AND VALUE ADDED AMOUNTS BY STAR RATING

DUAL-ELIGIBLE SPECIAL NEEDS PLANS

STAR RATING	2018 VALUE ADDED	CHANGE IN VALUE ADDED	2018 PREMIUM	CHANGE IN PREMIUM	CHANGE IN BENEFITS	MEMBERSHIP DISTRIBUTION (%)
NEW CONTRACT	$49.83	$21.85	$30.28	-$3.38	$18.47	1.2%
LOW ENROLLMENT	$59.23	$15.10	$26.39	-$2.52	$12.59	0.5%
<3.0	$43.45	-$9.87	$30.64	$8.83	-$1.03	2%
3.0	$55.07	$7.17	$31.50	$3.54	$10.72	13%
3.5	$65.28	$13.68	$26.56	-$2.37	$11.31	41%
4.0	$66.69	$8.57	$25.45	-$4.79	$3.78	24%
4.5	$58.66	-$0.25	$22.00	-$4.45	-$4.70	14%
5.0	$53.33	-$1.84	$31.75	$2.40	$0.56	5%
TOTAL	$62.19	$7.64	$26.64	-$2.06	$5.58	100%

Based on the information in Figure 13, there is not a strong relationship between star rating and value added. Interestingly, in the D-SNP environment, New Contract plans have a significantly lower value added amount than many other star rating categories.

Product type

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

FIGURE 14: MEDICARE ADVANTAGE AVERAGE PREMIUM AND VALUE ADDED AMOUNTS BY PLAN TYPE

DUAL-ELIGIBLE SPECIAL NEEDS PLANS

PRODUCT TYPE	2018 VALUE ADDED	CHANGE IN VALUE ADDED	2018 PREMIUM	CHANGE IN PREMIUM	CHANGE IN BENEFITS	MEMBERSHIP DISTRIBUTION (%)
HMO	$61.13	$6.98	$27.49	-$1.64	$5.34	88%
HMO-POS	$47.63	$17.34	$30.39	-$2.62	$14.72	1%
LPPO	$73.73	$3.90	$14.65	-$4.70	-$0.81	3%
RPPO	$71.42	$15.62	$21.37	-$5.48	$10.15	8%
PFFS	N/A	N/A	N/A	N/A	N/A	N/A
TOTAL	$62.19	$7.64	$26.64	-$2.06	$5.58	100%

The HMO product, which represents 88% of the membership, experienced an increase in its value added from 2017 to 2018; however, its change was significantly lower than what the smaller HMO-POS and RPPO product types saw. The increase in the HMO-POS and RPPO plans is due to both a decrease in member premium and a significant increase in the value of the benefits offered. Although the LPPO has the lowest value added increase, it does have the highest value added level. Note that the value added analysis presented in this paper only values in-network benefits; therefore, the values of the out-of-network benefits found in HMO-POS, LPPO, and RPPO plans are not considered here.

Carrier size

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

FIGURE 15: MEDICARE ADVANTAGE AVERAGE PREMIUM AND VALUE ADDED AMOUNTS BY CARRIER SIZE

DUAL-ELIGIBLE SPECIAL NEEDS PLANS

CARRIER SIZE	2018 VALUE ADDED	CHANGE IN VALUE ADDED	2018 PREMIUM	CHANGE IN PREMIUM	CHANGE IN BENEFITS	MEMBERSHIP DISTRIBUTION (%)
MEGA	$67.20	$7.68	$22.64	-$2.42	$5.26	68%
LARGE	$59.32	$7.70	$35.74	-$1.55	$6.14	17%
MEDIUM	$42.53	$5.42	$34.94	$0.62	$6.04	13%
SMALL	$40.07	$2.84	$29.23	$0.63	$3.47	1%
TOTAL	$62.19	$7.64	$26.64	-$2.06	$5.58	100%

As indicated in Figure 15, and directionally consistent with the general enrollment results, small carriers generally provide the lowest level of value added to D-SNP beneficiaries compared with other carrier sizes, while mega carriers provide the highest level of value added. These results are very similar to those in prior years. D-SNPs are typically under increased financial pressure because they must be offered with no member premium (net of 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. 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 15% of total MA enrollment based on publicly available MA January 2018 membership by plan type data, excluding PR. They are:

1. 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 12.2% of total MA enrollment.
2. 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 2.2% of the MA enrollment. The enrollment in these plans is a relatively equal mix of dual-eligible and general enrollment beneficiaries.
3. 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 0.5%. The enrollment in these plans is largely made up of dual-eligible beneficiaries.

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

FIGURE 16: MEDICARE ADVANTAGE AVERAGE PREMIUM AND VALUE ADDED AMOUNTS BY SNP POPULATION

SPECIAL NEEDS PLANS

SNP TYPE	2018 VALUE ADDED	CHANGE IN VALUE ADDED	2018 PREMIUM	CHANGE IN PREMIUM	CHANGE IN BENEFITS	MEMBERSHIP DISTRIBUTION (%)
D-SNP	$62.19	$7.64	$26.64	-$2.06	$5.58	12.2%
C-SNP	$165.30	$7.89	$10.18	-$0.32	$7.57	2.2%
I-SNP	$108.55	$8.42	$30.42	-$0.13	$8.29	0.5%
TOTAL	$78.99	$6.81	$24.31	-$1.58	$5.23	15%

The three population types shown in Figure 16 have very different membership needs and costs. Recall that the value added for D-SNPs only includes the value of services not covered by Medicare and does not include the cost-sharing reductions for Medicare-covered services, as dual members do not perceive any value in cost-sharing reductions. However, for I-SNPs and C-SNPs, the value added includes cost-sharing reductions for Medicare-covered services, 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 added between I-SNPs and C-SNPs compared with that for D-SNPs, which is consistent with the results in prior years. Both C-SNPs and I-SNPs kept their premiums relatively flat from 2017 to 2018, which is consistent with the results seen in the general enrollment plan market.

Historical analysis: Past five years

This section provides an analysis of a five-year lookback from 2014 to 2018 for D-SNPs. Using the same methodology as for the general enrollment plans, Milliman measured the value added by county of each D-SNP Medicare Advantage benefit plan in the country for each year from 2014 to 2018, including the value of supplemental benefits reduced by the member premium. Because dual-eligible members usually 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 added for the member is developed based upon the value of the supplemental non-Medicare-covered benefits.

The results below are provided on a per member per month (PMPM) basis and use the membership levels by plan from February of each specific year to develop the weighted averages across all plans for the given year. For the 2018 analysis, we utilized the January 2018 enrollment information as February information was not available when this report was developed.

Benefit values

The table in Figure 17 contains the nationwide average "benefit values," which are calculated as the difference between the value of supplemental 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, Professional, Other Medicare-Covered, and Non-Medicare-Covered.

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: MEDICARE ADVANTAGE NATIONAL AVERAGE BENEFIT VALUE

DUAL-ELIGIBLE SPECIAL NEEDS PLANS

YEAR	INPATIENT	OUTPATIENT	PROFESSIONAL	OTHER MEDICARE-COVERED	OTHER NON-MEDICARE-COVERED	TOTAL PART C	PART D	OVERALL TOTAL
FIVE-YEAR ANALYSIS								
2014	$0.80	$0.13	$3.20	$0.00	$39.29	$43.42	$23.53	$66.95
2015	$0.53	$0.13	$3.24	$0.00	$42.46	$46.35	$24.88	$71.24
2016	$0.47	$0.13	$3.24	$0.00	$43.13	$46.97	$25.71	$72.69
2017	$0.49	$0.14	$3.33	$0.00	$51.69	$55.65	$27.54	$83.19
2018	$0.53	$0.14	$3.22	$0.00	$56.11	$60.00	$28.82	$88.82
YEAR-OVER-YEAR CHANGE								
2014 TO 2015	-$0.27	$0.00	$0.04	$0.00	$3.17	$2.94	$1.35	$4.29
2015 TO 2016	-$0.06	-$0.00	$0.00	$0.00	$0.68	$0.62	$0.83	$1.45
2016 TO 2017	$0.02	$0.00	$0.09	$0.00	$8.56	$8.67	$1.83	$10.50
2017 TO 2018	$0.04	$0.00	-$0.11	$0.00	$4.42	$4.35	$1.27	$5.62

The cumulative change in total annual benefit value, for all D-SNP beneficiaries nationwide, from 2014 to 2018, is $262.44. This is calculated by taking the monthly 2018 total benefit value of $88.82 minus the monthly 2014 total benefit value of $66.95 multiplied by 12 (12 months per year).

Figure 17 illustrates gains in the overall benefit value each year since 2014 in the D-SNP market. Both Part C and Part D benefit values have increased every year during that time. As the reader may recall, the value added 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. For Inpatient, the benefit value represents covering additional inpatient days beyond 90 days and lifetime reserve days (a non-Medicare-covered benefit). For Outpatient, the benefit value reflects the inclusion of the enhanced worldwide ER benefit. The benefit value for Professional represents the physical exams and immunizations not covered by Medicare, as well as non-covered chiropractic services and podiatry services.

Non-Medicare-covered benefits

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

FIGURE 18: MEDICARE ADVANTAGE MEMBERSHIP WITH ACCESS TO NON-MEDICARE-COVERED BENEFITS

DUAL-ELIGIBLE SPECIAL NEEDS PLANS

YEAR	ENROLLMENT	PREVENTIVE DENTAL	COMPRE-HENSIVE DENTAL	VISION EXAMS	VISION HARDWARE	NEMT	HEARING EXAMS	HEARING AIDS	OTC DRUG CARD
FIVE-YEAR ANALYSIS									
2014	1,261,403	87.8%	75.4%	86.8%	90.7%	69.9%	57.5%	57.7%	61.4%
2015	1,374,174	82.7%	74.9%	86.9%	87.5%	72.3%	70.3%	68.6%	68.3%
2016	1,469,623	86.3%	81.4%	85.2%	85.7%	74.8%	74.8%	68.4%	73.7%
2017	1,624,820	88.5%	87.7%	90.5%	91.1%	78.6%	83.1%	78.0%	82.2%
2018	1,837,115	87.3%	88.2%	90.2%	92.1%	82.0%	84.9%	80.0%	87.3%
YEAR-OVER-YEAR CHANGE									
2014 TO 2015	25,103	-5.1%	-0.5%	0.1%	-3.2%	2.4%	12.8%	11.0%	7.0%
2015 TO 2016	95,449	3.6%	6.6%	-1.7%	-1.7%	2.5%	4.5%	-0.2%	5.3%
2016 TO 2017	155,197	2.2%	6.2%	5.3%	5.4%	3.8%	8.3%	9.6%	8.5%
2017 TO 2018	212,295	-1.2%	0.5%	-0.3%	1.0%	3.4%	1.8%	2.0%	5.1%

Figure 18 illustrates an increase in the percentage of D-SNP plans that offer the various enticement benefits, with the noted exception of preventive dental and vision exams, where these two benefits have been offered slightly less in the most recent years. There was a significant increase in the percentage of plans offering these benefits from 2016 to 2017.

V. Methodology

In performing the analyses contained in this report, we relied on detailed MA plan benefit offerings for 2014 through 2018 and their respective premiums as released by CMS. We also used publicly available MA enrollment information for February of each year (with the exception of 2018, which uses January 2018) 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 available in each respective year. The information released by CMS includes detailed cost-sharing information by service category, member premium, service area, supplemental benefits covered, star rating, and enrollment by plan.

For the analyses contained within this report, we define value added as the benefits provided to a plan's beneficiaries above traditional Medicare. This metric not only accounts for the value of supplemental benefits, but it is also offset by each plan's member premium 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 Added = Estimated value of supplemental Part C benefits - Member Part C premium.
- Part D Value Added = Estimated value of Part D benefits (indicated Part D premium) - Member Part D premium.
- 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 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. Additionally, we also include the impact of a particular plan's formulary in the evaluation of the Part D and total value added metrics.

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. We excluded Puerto Rico from these results.

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 2018 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 added for each plan.

The values quoted in this report are not comparable with the similar papers we published regarding the state of the 2014 and 2016 Medicare Advantage industry.[2] Values represented in this paper are calibrated to county-specific 2018 FFS costs and include additional benefits not measured in the 2014 or 2016 reports, such as OTC drug card and comprehensive dental (for which benefit detail was not previously available). They also include the impact of the Part D formulary on the value added results. Prior papers reflect results calibrated to county-specific 2014 and 2016 FFS costs, respectively. 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 5, 2018, from http://www.milliman.com/insight/2014/State-of-the-2014-Medicare-Advantage-industry/.

Swanson, B.L., et al. (February 19, 2016). State of the 2016 Medicare Advantage Industry. Milliman Research Report. Retrieved February 5, 2018, from http://www.milliman.com/insight/2016/State-of-the-2016-Medicare-Advantage-industry-changes-as-a-result-of-continued-rate-pressure/.

VI. Conclusions

General enrollment beneficiaries have seen an increase in value added of approximately 6% and a decrease of about 6% in premium amounts in 2018, relative to 2017. D-SNP beneficiaries will also generally see an increase in value added and a decrease in premium amounts in 2018, relative to 2017, and the nationwide premium for D-SNPs (largely driven by changes in LIB amounts) will decrease by approximately 7%. As the market continues to expand, MAOs will likely recognize the importance of creating both general enrollment plans and D-SNPs in the market with strong enticement benefits in order to keep pace with market trends over the recent years.

As MA plans and beneficiaries continue to look ahead to the 2019 plan year, it is important to be aware of changes occurring in 2019, which will undoubtedly have an impact on market offerings. They include:

- As of the publication of this paper, based on HR 195, which was signed into law on January 22, 2018, there will be an additional moratorium on the HIPF for 2019—the fee for 2019 will be $0. This will likely provide another reprieve, relative to 2018, and allow MAOs to expand upon their benefit offerings for the 2019 service year.
- The Advance Notice issued by CMS on February 1, 2018, indicated a number of changes that could impact the breadth of benefits offered under MA plans. As of the publication of this paper, please note that these changes are proposed and not yet codified into regulations:
  - Removal of the meaningful difference requirement: The current regulations place limits, known as the "Part C meaningful difference" requirement, on the variety of plans that an MAO is allowed to offer in the same county. Similarly, there is a "Part D meaningful difference" requirement that currently limits the enhanced alternative (EA) benefit designs offered by the same MAO in the same region. This proposal would remove the requirement that MA plans offered by an MAO in the same county comply with these limits for Part C and would remove the EA requirement for Part D. CMS has concerns that the current meaningful difference requirement may be forcing MAOs to reduce the value of certain benefits to make each plan benefit package (PBP) comply with these artificial limits, and is also limiting the variety of plans that could be available in the market.
  - Flexibility in benefit design: CMS is proposing changes that would allow MAOs to offer varying Part C benefits to MA enrollees who meet specific medical criteria. This allowance would be separate from the Value-Based Insurance Design (VBID) program. Benefit changes may include:
    - Reductions in cost sharing for certain covered benefits
    - Specific tailored supplemental benefits
    - Differing deductibles
  - Additional options for plan segments: CMS has also proposed that MA plans can vary supplemental benefits in addition to premiums and cost sharing by segment of a plan.

In general, given the breadth of changes being proposed to expand the offerings available in the MA market for 2019 and the stability of the Medicare Advantage market, we expect a number of new plans coming to market in 2019, from both established and new MAOs. 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 MA market. It is evident that plans must realize the importance of appealing to beneficiaries through both high value added and low premiums to stay competitive in the MA market.

VII. 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 the general status of the market in 2018. It may not be appropriate, and should not be used, for other purposes. Milliman does not intend to benefit and assumes no duty of liability to parties who receive this information. Any recipient of this information should engage qualified professionals for advice appropriate to its own specific needs.

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 AND REGION MAPPING

REGION	STATE	STATE	REGION
MIDWEST	IA	AL	SOUTH
MIDWEST	IL	AK	WEST
MIDWEST	IN	AZ	WEST
MIDWEST	KS	AR	SOUTH
MIDWEST	MI	CA	WEST
MIDWEST	MN	CO	WEST
MIDWEST	MO	CT	NORTHEAST
MIDWEST	ND	DE	SOUTH
MIDWEST	NE	DC	SOUTH
MIDWEST	OH	FL	SOUTH
MIDWEST	SD	GA	SOUTH
MIDWEST	WI	HI	WEST
NORTHEAST	CT	ID	WEST
NORTHEAST	MA	IL	MIDWEST
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
SOUTH	AL	MA	NORTHEAST
SOUTH	AR	MI	MIDWEST
SOUTH	DC	MN	MIDWEST
SOUTH	DE	MS	SOUTH
SOUTH	FL	MO	MIDWEST
SOUTH	GA	MT	WEST
SOUTH	KY	NE	MIDWEST
SOUTH	LA	NV	WEST
SOUTH	MD	NH	NORTHEAST
SOUTH	MS	NJ	NORTHEAST
SOUTH	NC	NM	WEST
SOUTH	OK	NY	NORTHEAST
SOUTH	SC	NC	SOUTH
SOUTH	TN	ND	MIDWEST
SOUTH	TX	OH	MIDWEST
SOUTH	VA	OK	SOUTH
SOUTH	WV	OR	WEST
WEST	AK	PA	NORTHEAST
WEST	AZ	RI	NORTHEAST

STATE AND REGION MAPPING

REGION	STATE	STATE	REGION
WEST	CA	SC	SOUTH
WEST	CO	SD	MIDWEST
WEST	HI	TN	SOUTH
WEST	ID	TX	SOUTH
WEST	MT	UT	WEST
WEST	NM	VT	NORTHEAST
WEST	NV	VA	SOUTH
WEST	OR	WA	WEST
WEST	UT	WV	SOUTH
WEST	WA	WI	MIDWEST
WEST	WY	WY	WEST

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