MILLIMAN RESEARCH REPORT

State of the 2020 Medicare Advantage industry: As strong as ever

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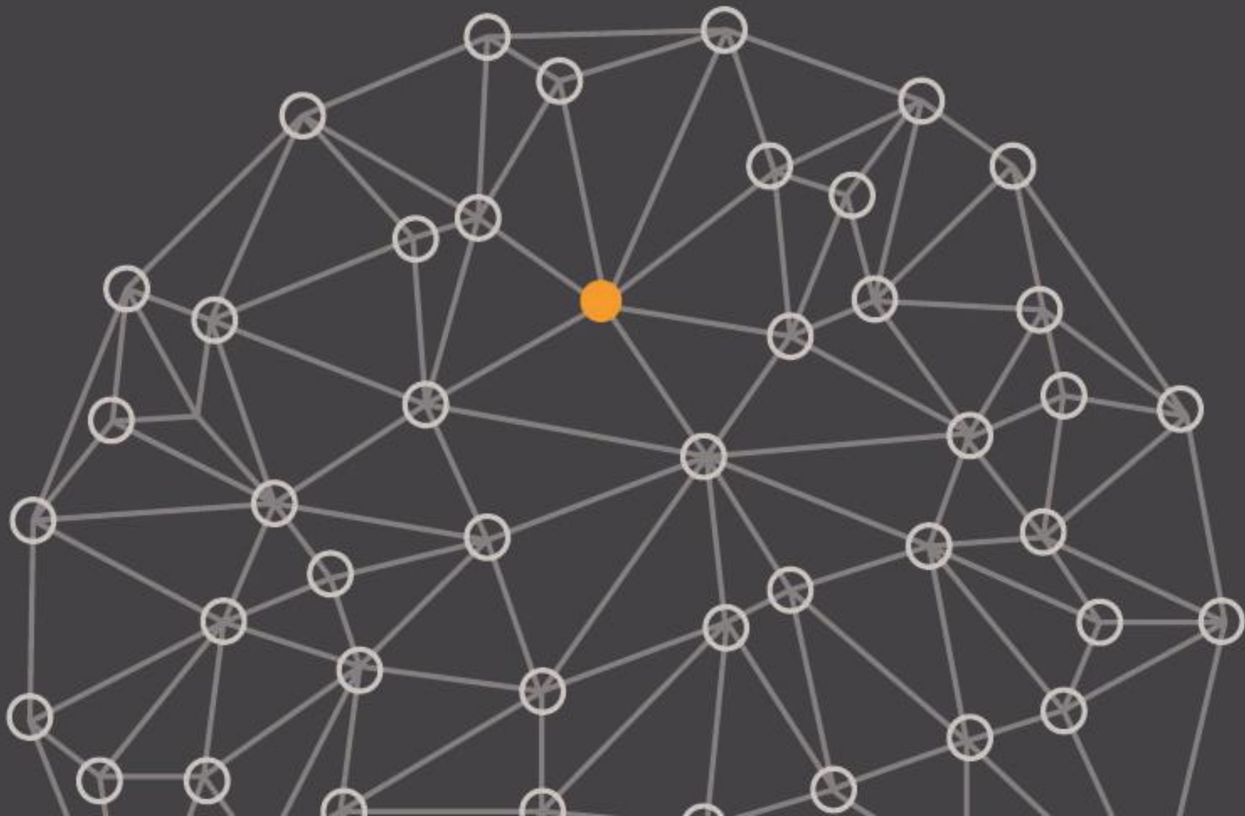

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I. Executive Summary

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 beyond traditional Medicare that are not funded through member premiums. This metric accounts for the value of non-Medicare-covered benefits, reductions in cost sharing to traditional Medicare, any buy-down of the Part B premium, and any additional premium the member is responsible for. 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 2016 to 2020. We focus our analyses on general enrollment and dual-eligible special needs plan (D-SNP) types nationwide, excluding any U.S. territories.

There has been strong growth in the Medicare Advantage program in 2020 relative to prior years, both in the number of plans available, as well as in value added increases. The value added changes include enhanced benefit offerings and decreases in member premium for both general enrollment and D-SNP plans.

- For all general enrollment beneficiaries nationwide, between 2016 and 2020, the average change in member premium was a decrease of $1.92 per member per month (PMPM) and a value added increase of $7.82 PMPM. For all dual-eligible beneficiaries nationwide between 2016 to 2020, member premium decreased $0.11 PMPM and value added increased $8.72 PMPM.
- There was a moratorium on the Health Insurance Providers Fee (HIPF) in the 2019 plan year, allowing the opportunity for many MAOs that previously were assessed the fee to use those dollars on improved plan benefits and/or lower member premiums, which directly contributes to an increase in value added. Despite the HIPF reinstatement in the bid development for the 2020 plan year, the MA market overall continued to increase value added by $5.66 for non-SNP and $8.87 for SNP plans, on average. MAOs used both improved benefit offerings and reduced premiums to increase the 2020 value added.
- The MA program continues to be an attractive market for current and new MAOs. This is leading to a significant increase in the number of plans and MAOs available each successive year of the program. The number of plans offered in 2019 (relative to 2018) grew 18.4% and then 16.3% in 2020 (relative to 2019), with 13 new MAOs entering the market in 2020.[1] New MAOs typically enter the market with rich benefits and low member premiums.

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 8% per year from 2016 to 2019 as measured in this analysis. Nationwide, MA penetration is approximately 34.8% of eligible Medicare Part A and B enrollees as of September 2019, and has been steadily increasing since 2016 (the first year of this study). Steady growth and increased market penetration is in part indicative of the value offered by MA plans.

[1] Jacobson, G., Freed, M., Damico, A., & Neuman, T. (October 24, 2019). Medicare Advantage 2020 Spotlight: First Look. Kaiser Family Foundation. Retrieved February 6, 2020, from https://www.kff.org/report-section/medicare-advantage-2020-spotlight-first-look-data-note/.

II. Background

CMS requires all MAOs to submit a bid for each plan they intend to offer in the following year by the first Monday in June. This bid estimates the cost to provide traditional Medicare benefits to beneficiaries projected to enroll in the plan for the coming year. A portion of any savings generated by the MAO (the savings is defined as the difference between the MAO's bid and the CMS-provided benchmark rate) is returned to the plan as a rebate, which can be used by the plan to provide benefits above and beyond traditional Medicare, such as reductions to cost sharing for Medicare services or coverage of non-Medicare services, such as dental, vision, or hearing benefits. 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 benchmark 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 releases information to assist beneficiaries in electing a plan for the coming year during the annual enrollment period. In October 2019, CMS released benefit and premium information for all MA plans that are to be offered in 2020.

This report highlights key changes in member premiums and benefits for the 2020 MA market, as well as the contributing factors for, and the magnitude of, the increase in value added within the MA market each year from 2016 to 2020. This report also aims to assist MAOs in making strategic decisions during 2021 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 2021 benefit and premium decisions. Specifically, we focus on value added and premium in 2020, as well as on how they changed from 2016 to 2020.

Value added for general enrollment plans is defined as the benefits provided to a plan's beneficiaries above traditional Medicare that are not funded through member premiums. This metric accounts for the value of non-Medicare-covered benefits, traditional Medicare cost-sharing reductions, any buy-down of the Part B premium, and any additional member premium.

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, vision, hearing, or 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., no 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 2016 through 2019 service years. For 2020, we utilized the September 2019 enrollment, which takes into account any plans that applied a crosswalk into 2020, because 2020 enrollment was not available at the time of the analysis.

The primary focus of this report is non-institutionalized non-Medicaid (NINM) plans and D-SNPs. The NINM 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 (ESRD). Please note that ESRD beneficiaries will be permitted to enroll in general enrollment plans starting in 2021. SNPs for members with chronic conditions (C-SNPs) and institutionalized members (I-SNPs) are less common in the MA market and are excluded from the results in this report, except where specifically stated. Additionally, we exclude all U.S. territories from the results. The results also exclude medical savings account (MSA) plans, Medicare Cost Plans (Cost), Part B-only plans, 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 375,000 members, were also excluded.

In addition, for the population we analyzed, there are about 3,400 unique general enrollment plans offered in 2020, with about 2,600 continuing to be offered from 2019. This excludes plans in U.S. territories and also counts each segment of a particular plan as a unique plan in this plan count. This is a significant increase from prior years and represents the most MA plans ever available in the market for beneficiaries to choose from. Roughly 350 plans offered in 2019 are no longer available in 2020, though members in these plans may have been automatically moved to another plan in 2020. However, approximately 800 new plans will begin in 2020. Overall, there is a net increase of about 15.5% in the total number of individual general enrollment plans available in 2020 compared with 2019 (about 2,950 general enrollment plans were available in 2019). For comparison, between 2018 and 2019 there were approximately 350 general enrollment plans that terminated with approximately 850 new plan offerings in 2019, for a net change of 19% in 2019. D-SNP plan offerings also continue to increase each year, with approximately 100 entries and 50 exits each year, leading to a net increase of 16% over 2019 and a total of about 550 D-SNPs available in 2020.

IV. Results

GENERAL ENROLLMENT PLANS

Analysis: 2020 snapshot

This section provides an analysis of 2020 general enrollment plans and the market changes from 2019. 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 2020 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 2019 is also shown. The benefit change is measured as the value added change, excluding the change in premium. For example, nationwide there is a $5.66 increase in value added, with $0.63 of this due to decreased premiums. Therefore, there is a net increase in benefits of $5.03. This change is smaller than last year in terms of value added, where the nationwide increase in value added was $13.05. The 2019 market saw a large increase in benefit value of $9.29 (including the Part B buy-down) due in part to the moratorium on the 2019 Health Insurer Providers Fee (HIPF) and insurers repurposing those funds directly back into benefits for the consumer, along with a significant premium decrease of $3.76. In 2020, the market has continued with a small decrease in premiums and expansion of benefits relative to 2019, despite the return of the HIPF for 2020.

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

GENERAL ENROLLMENT PLANS						
REGION	2020 VALUE ADDED	VALUE ADDED CHANGE FROM 2019	2020 PREMIUM	PREMIUM CHANGE FROM 2019	BENEFITS VALUE CHANGE FROM 2019	2020 MEMBERSHIP DISTRIBUTION (%)
Northeast	$79.23	$4.60	$44.32	-$1.23	$3.37	17%
Midwest	$98.00	$4.43	$35.59	-$0.87	$3.55	20%
South	$143.16	$4.71	$15.87	$0.09	$4.80	36%
West	$126.34	$9.47	$27.87	-$1.46	$8.01	26%
Nationwide	$118.56	$5.66	$27.92	-$0.63	$5.03	100%

As shown in Figure 1, general enrollment plans have an average value added of about $119 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 includes the overall benefit package and considers the expected medical spending of the average beneficiary, the member premium is equally important to members because it is a fixed monthly cost and many beneficiaries are sensitive to premium changes.

Underlying the change in value added, there are downward shifts in premium in all areas of the country with the exception of the South region, which realized a very small increase in average premium, and with larger decreases seen in the Northeast and West regions. This could be driven by more offerings of $0 premium plans, or by members choosing plans with lower premiums. As mentioned above, there is a $0.63 PMPM decrease in the average nationwide premium from 2019 to 2020. There is continued improvement of benefit offerings through richer benefits and offering of new non-Medicare-covered benefits relative to 2019 in all regions.

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 Patient Protection and Affordable Care Act (ACA) introduced a 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 MA value added and premium information stratified by overall star rating. This figure compares the distribution of plans that were bucketed into the corresponding 2019 star rating (used in the 2020 bids) to the 2020 star rating (to be used in the 2021 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 calculate 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 reflecting 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	2020 VALUE ADDED	VALUE ADDED CHANGE FROM 2019	2020 PREMIUM	PREMIUM CHANGE FROM 2019	BENEFITS VALUE CHANGE FROM 2019	2020 MEMBERSHIP DISTRIBUTION (%)
New Contract	$136.46	$11.44	$14.23	-$0.11	$11.33	0.9%
Low Enrollment	$122.12	$18.38	$11.11	-$10.10	$8.28	0.2%
<3.0 *	$159.39	$102.06	$8.70	-$35.48	$66.57	0.1%
3.0	$108.12	$13.95	$22.58	-$5.35	$8.60	3%
3.5	$98.22	$5.74	$27.80	$0.24	$5.98	16%
4.0	$114.11	$0.21	$28.46	$4.28	$4.49	41%
4.5	$130.24	-$0.11	$26.33	-$9.72	-$9.82	28%
5.0	$136.92	$13.71	$33.27	-$6.01	$7.70	11%
Total	$118.56	$5.66	$27.92	-$0.63	$5.03	100%

* Note that results for star ratings less than 3.0 are highly volatile due to the very low enrollment and plan mix underlying this category and therefore are deemed not credible.

Figure 2 demonstrates an increase in value added as star ratings rise from 3.5 to 5.0 stars. Historically, the 4.5 star rating value added has been higher than the 5.0 star rating value added, but the opposite is true in 2020. This is driven by a decrease in benefit value for 4.5 stars, and an increase in benefits in 5.0 stars, in addition to premium reductions. The 4.5 star benefit change is mainly driven by UnitedHealth Group, which has a significant number of members in the 4.5 star category, and which reduced benefit offerings significantly in 2020 for these members. However, the majority of UnitedHealth Group's members are in 4.0 star plans, and that subset of members will experience a much improved set of benefits in 2020. The 5.0 star benefit change is driven mainly by Kaiser Permanente, which has a significant number of members relative to other 5.0 plans, and which also dramatically improved its benefit value from 2019 to 2020. Additionally, Figure 2 shows that New Contracts without a star rating have higher levels of value added than the total (average). This result is similar to what was observed for prior years, indicating that New Contracts often enter the market with significantly richer benefits and lower premiums, likely in an attempt to gain more market presence.

Product type

MAOs can offer various product types, including health maintenance organizations (HMOs), which may include a point-of-service (POS) option (meaning access to out-of-network benefits, and noted below as HMO-POS plans), private fee-for-service (PFFS) plans, and preferred provider organizations (PPOs), which include local (LPPO) and regional (RPPO) variations. The value added measure only evaluates in-network benefits for contracted providers. 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	**2020 VALUE ADDED**	**VALUE ADDED CHANGE FROM 2019**	**2020 PREMIUM**	**PREMIUM CHANGE FROM 2019**	**BENEFITS VALUE CHANGE FROM 2019**	**2020 MEMBERSHIP DISTRIBUTION (%)**
HMO	$141.29	$7.42	$20.38	$0.16	$7.59	59%
HMO-POS	$106.45	$36.69	$37.37	-$25.23	$11.46	11%
LPPO	$86.21	-$0.08	$37.60	-$1.23	-$1.30	23%
RPPO	$55.29	$3.04	$42.82	$3.87	$6.91	6%
PFFS	-$6.83	-$9.66	$73.48	$8.58	-$1.09	1%
Total	$118.56	$5.66	$27.92	-$0.63	$5.03	100%

The table in Figure 3 demonstrates that the HMO product type generally has the highest value added for general enrollment plans, while the PFFS product type generally has the lowest value added, which is consistent with prior year results. Note that a negative value added indicates the PFFS product type has lower value added than traditional Medicare. Among general enrollment plans, the HMO product type is the most popular product type, with roughly 59% of the membership; the HMO-POS product type is gaining market share as well. 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. The PFFS product type appears to be forced to give up more value added in 2020 relative to 2019, and the LPPO product type very slightly more as well, which for the PFFS product type is mostly due to large increases in premium relative to the HMO, HMO-POS, and LPPO product types. The 2019 HMO products changing to HMO-POS products in 2020 with the addition of out-of-network benefits are driving the large shifts in value added and premium from 2019 to 2020 for the HMO-POS product type. These new HMO-POS products, many of which are offered by UnitedHealth Group and WellCare, have significantly higher value added amounts and lower premiums, on average, than HMO-POS products in existence in 2019. The HMO product type has 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. 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 Anthem, Cigna, CVS Health Corporation, 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 large, medium, and small 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	2020 VALUE ADDED	VALUE ADDED CHANGE FROM 2019	2020 PREMIUM	PREMIUM CHANGE FROM 2019	BENEFITS VALUE CHANGE FROM 2019	2020 MEMBERSHIP DISTRIBUTION (%)
Mega	$127.27	$3.86	$19.83	$0.12	$3.98	71%
Large	$95.39	$9.06	$48.22	-$2.51	$6.55	19%
Medium	$100.37	$11.19	$46.77	-$2.08	$9.11	10%
Small	$119.43	$17.59	$31.72	-$4.73	$12.86	0.5%
Total	$118.56	$5.66	$27.92	-$0.63	$5.03	100%

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. 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, though mega carriers had the smallest increase in value added from 2019 to 2020. Mega carriers provide the greatest amount of value added, the lowest overall premium, the smallest change in value added from 2019, and they contain the majority of September 2019 cross-walked membership.

Benefit offerings

In addition to differences by various plan characteristics, it is important to understand how specific benefits affect the value added and premium metrics within the MA marketplace. In an environment of increased revenue pressure, plans will generally increase premium, 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 deductibles.

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

GENERAL ENROLLMENT PLANS						
PART C AND D DEDUCTIBLES	2020 VALUE ADDED	VALUE ADDED CHANGE FROM 2019	2020 PREMIUM	PREMIUM CHANGE FROM 2019	BENEFITS VALUE CHANGE FROM 2019	2020 MEMBERSHIP DISTRIBUTION (%)
Both > $0	$49.68	$3.49	$24.84	-$8.30	-$4.81	1%
Part C Only > $0	$78.80	$4.47	$12.73	-$10.88	-$6.41	1%
Part D Only > $0	$96.14	$1.43	$29.54	$1.18	$2.61	49%
Both = $0	$144.05	$7.80	$26.75	-$2.00	$5.80	49%
Total	$118.56	$5.66	$27.92	-$0.63	$5.03	100%

Figure 5 shows that the vast majority of beneficiaries (98%) choose plans with no Part C deductible. This result shows that beneficiaries have a clear preference for plans without a Part C deductible, likely because it removes uncertainty about cost-sharing amounts. MAOs also recognize this beneficiary preference, as only 5.6% of unique general enrollment MA plans included a medical deductible in 2020. Additionally, plans without medical deductibles generally offer a richer overall benefit package, as evidenced through the value added for these plans (Part D Only > $0 and Both = $0 in Figure 5 above). 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 2020, 49% of general enrollment plans offer a $0 premium. This is a slight increase from 2019, when 45% of general enrollment plans offered a $0 premium. The membership distribution had a slight increase from 56% to 57% in plans offering a $0 premium, confirming that paying no additional premium is attractive to members.

FIGURE 6: MEDICARE ADVANTAGE MEMBERSHIP AND PLAN DISTRIBUTION BY PREMIUM RANGE

GENERAL ENROLLMENT PLANS						
PREMIUM RANGE	2020 MEMBERSHIP DISTRIBUTION	2019 MEMBERSHIP DISTRIBUTION	CHANGE IN MEMBERSHIP DISTRIBUTION	2020 PLAN DISTRIBUTION	2019 PLAN DISTRIBUTION	CHANGE IN PLAN DISTRIBUTION
$0.00	56.9%	55.7%	1.1%	49.1%	44.7%	4.5%
$0.01 - $20.00	5.3%	5.3%	0.0%	6.1%	5.8%	0.4%
$20.01 - $50.00	17.2%	18.0%	-0.8%	20.3%	21.6%	-1.3%
$50.01 - $100.00	13.9%	13.9%	0.0%	14.9%	17.0%	-2.2%
$100.00+	6.7%	7.0%	-0.2%	9.6%	11.0%	-1.4%
Total	100.0%	100.0%		100.0%	100.0%	

In 2020, general enrollment plans have maximum out-of-pocket (MOOP) levels ranging from $0 to $6,700 per year. 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. CMS identifies each plan as either meeting the voluntary or the mandatory MOOP. Plans with a voluntary MOOP generally have 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 7 shows nationwide value added and premium information by MOOP type.

FIGURE 7: MEDICARE ADVANTAGE AVERAGE PREMIUM AND VALUE ADDED AMOUNTS BY MOOP

GENERAL ENROLLMENT PLANS						
MAXIMUM OUT-OF-POCKET	2020 VALUE ADDED	VALUE ADDED CHANGE FROM 2019	2020 PREMIUM	PREMIUM CHANGE FROM 2019	BENEFITS VALUE CHANGE FROM 2019	2020 MEMBERSHIP DISTRIBUTION (%)
Voluntary	$173.68	$9.80	$27.11	-$1.35	$8.45	25%
Mandatory	$100.17	$3.66	$28.19	-$0.39	$3.27	75%
Total	$118.56	$5.66	$27.92	-$0.63	$5.03	100%

Figure 7 shows that a majority of beneficiaries choose plans with the mandatory MOOP between $3,401 and $6,700, despite the fact that plans with a voluntary MOOP have both a higher value added and a slightly lower premium than mandatory MOOP plans in 2020. 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 2016 to 2020 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 2016 to 2020, 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 PMPM basis and use the membership levels by plan from February of each specific year for 2016 through 2019 service years to develop the weighted averages across all plans for the given year. For the 2020 analysis, we utilized the September 2019 enrollment information, which takes into account any plan crosswalks into 2020, as February 2020 information was not available when this report was developed.

Benefit values

The table in Figure 8 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. Medicare-covered benefits are measured by how much lower the cost sharing is within the Medicare Advantage plans versus traditional Medicare. Non-Medicare-covered benefits are measured by the value of the additional benefits offered, such as dental, OTC drug card, vision, acupuncture, etc. The Part D column reflects the amount of MA rebate needed to pay for the Part D benefit levels within each plan, as Part D is not offered under traditional Medicare.

FIGURE 8: MEDICARE ADVANTAGE NATIONAL AVERAGE BENEFIT VALUE

GENERAL ENROLLMENT PLANS								
YEAR	INPATIENT	OUTPATIENT	PROFESSIONAL	OTHER MEDICARE-COVERED	OTHER NON-MEDICARE-COVERED	PART C SUBTOTAL	PART D	TOTAL
Five-Year Analysis								
2016	$15.83	$19.40	$23.70	$6.70	$16.63	$82.25	$39.66	$121.91
2017	$15.47	$19.34	$23.93	$6.72	$18.26	$83.72	$44.50	$128.22
2018	$15.14	$19.75	$24.68	$6.71	$19.07	$85.35	$45.66	$131.01
2019	$15.50	$20.04	$26.96	$6.88	$24.13	$93.51	$46.17	$139.67
2020	$15.38	$20.49	$28.91	$6.90	$26.23	$97.91	$46.80	$144.71
Year-Over-Year Change								
2016 to 2017	-$0.36	-$0.06	$0.23	$0.02	$1.63	$1.47	$4.85	$6.31
2017 to 2018	-$0.33	$0.41	$0.75	-$0.01	$0.81	$1.63	$1.16	$2.79
2018 to 2019	$0.36	$0.28	$2.28	$0.17	$5.06	$8.15	$0.51	$8.66
2019 to 2020	-$0.11	$0.45	$1.95	$0.02	$2.10	$4.40	$0.64	$5.04

Figure 8 illustrates that benefit values have cumulatively increased from 2016 through 2020 for all service categories with the exception of Inpatient, which over time has not experienced material change. Other Non-Medicare-Covered has experienced the largest increases over time. This is due to an increase in the prevalence of Non-Medicare-Covered benefits offered by plans, such as transportation, visitor/travel, and meal delivery.

Premium and value added amounts

The table in Figure 9 contains the nationwide average value added amounts, which are calculated as the difference between the benefit values from Figure 8 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, while MAOs have the option of reducing beneficiaries' Medicare Part B premiums, most plans do not offer that benefit. To the extent that the Part B premiums are reduced, this too contributes to the total value added.

FIGURE 9: 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
2016	$82.25	$19.18	$63.07	$39.66	$16.41	$23.25	$121.91	$0.95	$35.59	$87.27
2017	$83.72	$17.01	$66.71	$44.50	$17.56	$26.94	$128.22	$1.00	$34.57	$94.66
2018	$85.35	$15.81	$69.54	$45.66	$16.51	$29.15	$131.01	$1.15	$32.32	$99.85
2019	$93.51	$14.65	$78.85	$46.17	$13.90	$32.26	$139.67	$1.78	$28.55	$112.89
2020	$97.91	$14.23	$83.68	$46.80	$13.69	$33.11	$144.71	$1.77	$27.92	$118.56
Year-Over-Year Change										
2016 to 2017	$1.47	-$2.17	$3.64	$4.85	$1.15	$3.70	$6.31	$0.04	-$1.03	$7.38
2017 to 2018	$1.63	-$1.20	$2.83	$1.16	-$1.05	$2.21	$2.79	$0.15	-$2.25	$5.19
2018 to 2019	$8.15	-$1.16	$9.31	$0.51	-$2.60	$3.11	$8.66	$0.63	-$3.76	$13.05
2019 to 2020	$4.40	-$0.42	$4.82	$0.64	-$0.21	$0.85	$5.04	-$0.01	-$0.63	$5.66

Figure 9 illustrates that, overall, value added has been increasing for Part C and Part D since 2016. The 2019 market saw a large increase in value added, mostly due to a significant increase in the benefit value (including the Part B buy-down) of $9.29 due to the moratorium on the 2019 Health Insurer Providers Fee (HIPF) and insurers repurposing those funds directly back into benefits for the consumer.

Part C benefit design and premium

The table in Figure 10 contains information regarding changes in the Part C benefit design over time for general enrollment plans for primary care physician (PCP) and specialist care physician (SCP) copays and coinsurance cost-sharing types. This includes both MA-PD and MA Only plans.

FIGURE 10: MEDICARE ADVANTAGE NATIONAL AVERAGE PART C BENEFIT DESIGN

GENERAL ENROLLMENT PLANS										
			PCP COPAY		PCP COINSURANCE		SCP COPAY		SCP COINSURANCE	
YEAR	TOTAL ENROLL-MENT	OUT-OF-POCKET MAX	ENROLL-MENT	COPAY	ENROLL-MENT	CO-INSURANCE	ENROLL-MENT	COPAY	ENROLL-MENT	CO-INSURANCE
2016	11,548,011	$5,293	11,498,150	$9.66	67,712	19.47%	11,484,770	$35.12	78,466	19.62%
2017	12,179,993	$5,302	12,157,810	$9.29	55,288	17.34%	12,133,996	$35.50	75,376	18.14%
2018	12,919,343	$5,271	12,884,610	$8.54	68,263	18.00%	12,866,860	$35.42	81,592	18.26%
2019	14,139,389	$5,050	14,091,362	$6.84	78,471	18.40%	14,074,100	$33.84	90,574	18.66%
2020*	14,203,085	$4,889	14,131,097	$5.35	99,078	19.00%	14,117,881	$33.04	107,370	19.09%
2016 to 2017	631,982	$8.34	659,660	-$0.37	-12,424	-2.14%	649,226	$0.38	-3,090	-1.48%
2017 to 2018	739,350	-$30.77	726,800	-$0.75	12,975	0.66%	732,864	-$0.08	6,216	0.12%
2018 to 2019	1,220,046	-$220.53	1,206,752	-$1.70	10,208	0.40%	1,207,240	-$1.59	8,982	0.39%
2019 to 2020*	63,696	-$161.32	39,735	-$1.49	20,607	0.60%	43,781	-$0.80	16,796	0.43%

* September 2019 enrollment cross-walked to 2020 is used for 2020 enrollment.

Figure 10 illustrates an increase in the maximum out-of-pocket limit from 2016 to 2017, and a sizable decrease each year from 2017 to 2020. PCP cost sharing has decreased every year from 2016 to 2020, and SCP copays have decreased every year from 2017 to 2020. Coinsurance on both of these benefits remains a fairly unpopular benefit design.

Because 2020 membership is based off of 2019 membership cross-walked to 2020 plans, the change between 2020 and 2019 does not reflect any changes in member selection between plans.

Part D benefit design and premium

The table in Figure 11 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 11 are slightly different from the corresponding values in other tables, as Figure 11 only includes plans (and corresponding enrollment) that offer Part D benefits.

FIGURE 11: 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			
2016	$129.09	$16.99	$41.05
2017	$132.28	$18.10	$45.88
2018	$132.70	$16.96	$46.92
2019	$122.02	$14.26	$47.35
2020	$119.07	$14.02	$47.94
Year-Over-Year Change			
2016 to 2017	$3.19	$1.11	$4.83
2017 to 2018	$0.42	-$1.14	$1.05
2018 to 2019	-$10.68	-$2.70	$0.43
2019 to 2020	-$2.95	-$0.24	$0.58

Figure 11 illustrates increases in the Part D benefit value each year. In particular, there is an increase in the average Part D deductible from 2016 to 2018, and a steeper decrease from 2018 to 2020. The decrease from 2018 to 2019 is driven by a few carriers with large market share decreasing Part D deductibles on many of their plans. The average Part D premium has decreased since 2017. Note that this is the Part D premium reduced by MA rebates, and may not correlate directly to the benefit value.

Non-Medicare-covered benefits

The table in Figure 12 contains the percentage of membership in general enrollment plans that offer various non-Medicare benefits, including preventive and comprehensive dental, vision exams and hardware, non-emergency medical transportation (NEMT), hearing exams and aids, OTC drug cards, fitness benefits, and meal benefits. Note that the other non-Medicare-covered measurement category used in Figure 8 above includes many more benefits than the ones outlined in Figure 12, which summarizes only the most popular and visible benefits. Other non-Medicare-covered benefit examples not included in Figure 12 are non-Medicare-covered podiatry, acupuncture, and worldwide emergency room (ER) coverage, to name a few.

FIGURE 12: 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	FITNESS BENEFIT	MEAL BENEFIT
Five-Year Analysis											
2016	11,548,011	52.1%	25.3%	93.2%	63.7%	20.5%	69.7%	50.1%	27.7%	78.5%	21.7%
2017	12,179,993	55.5%	26.9%	93.1%	63.4%	20.6%	75.3%	61.8%	39.9%	81.8%	21.3%
2018	12,919,343	58.9%	30.0%	93.6%	68.8%	20.6%	82.6%	71.0%	41.5%	83.8%	22.3%
2019	14,139,389	68.1%	43.6%	95.5%	76.4%	29.5%	83.5%	80.4%	60.0%	88.6%	38.5%
2020*	14,203,085	75.9%	56.4%	96.2%	82.3%	31.4%	85.7%	84.9%	70.3%	90.0%	43.5%
Year-Over-Year Change											
2016 to 2017	631,982	3.4%	1.5%	-0.1%	-0.3%	0.1%	5.7%	11.6%	12.2%	3.27%	-0.4%
2017 to 2018	739,350	3.4%	3.1%	0.5%	5.4%	0.0%	7.2%	9.3%	1.6%	2.08%	1.0%
2018 to 2019	1,220,046	9.3%	13.6%	1.9%	7.5%	8.9%	0.9%	9.4%	18.5%	4.79%	16.2%
2019 to 2020*	63,696	7.8%	12.9%	0.7%	6.0%	1.9%	2.3%	4.5%	10.3%	1.34%	5.0%

* September 2019 enrollment cross-walked to 2020 is used for 2020 enrollment.

In general, Figure 12 illustrates an increase in the number of general enrollment plans offering non-Medicare benefits from 2016 to 2020, with fairly significant increases seen for dental, OTC drug cards, and meals in 2019 and 2020. The inclusion of "enticement benefits" does come with associated expenses to the plan and may result in higher member premiums.

DUAL-ELIGIBLE SPECIAL NEEDS PLANS

Analysis: 2020 snapshot

This section provides an analysis of 2020 D-SNPs and the changes in these plans from 2019. 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 17 below, the analyses in this section only include 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, OTC cards) because these types of plans often provide Medicare-covered services without member cost sharing, through coordinated efforts with each state's Medicaid program. That is, we only measure the additional value of services not covered by Medicare and do not value the cost-sharing reductions for Medicare-covered services, as dual-eligible beneficiaries do not perceive any value in cost-sharing reductions.

Region

The table in Figure 13 contains the value added and premium results for D-SNPs by region. See Appendix A for a mapping of states to these regions.

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

DUAL-ELIGIBLE SPECIAL NEEDS PLANS						
REGION	2020 VALUE ADDED	VALUE ADDED CHANGE FROM 2019	2020 PREMIUM	PREMIUM CHANGE FROM 2019	BENEFITS VALUE CHANGE FROM 2019	2020 MEMBERSHIP DISTRIBUTION (%)
Northeast	$63.25	$9.30	$31.74	-$2.35	$6.95	26%
Midwest	$71.73	$12.74	$26.88	-$3.51	$9.22	10%
South	$81.49	$7.77	$22.06	-$1.97	$5.80	47%
West	$55.32	$8.29	$28.25	-$2.42	$5.88	16%
Nationwide	$71.52	$8.87	$26.08	-$2.32	$6.55	100%

The D-SNP results in Figure 13 demonstrate increases in the value added metric from 2019 in all regions, with the largest increase in the Midwest region. The South, which represents about 47% of the membership, has the highest value added metric, while the West has the lowest, similar to results from prior years. All regions are seeing reductions in premium going into 2020. 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 13 varies, as the LIBs were not all consistently changing at the same rate.

Star rating

The table in Figure 14 contains the value added and premium analysis by plan star rating for D-SNPs (as mentioned above, New Contract and Low Enrollment apply to contracts with insufficient information to calculate a star rating).

FIGURE 14: MEDICARE ADVANTAGE AVERAGE PREMIUM AND VALUE ADDED AMOUNTS BY STAR RATING

DUAL-ELIGIBLE SPECIAL NEEDS PLANS						
STAR RATING	2020 VALUE ADDED	VALUE ADDED CHANGE FROM 2019	2020 PREMIUM	PREMIUM CHANGE FROM 2019	BENEFITS VALUE CHANGE FROM 2019	2020 MEMBERSHIP DISTRIBUTION (%)
New Contract	$51.59	-$9.18	$27.43	-$1.04	-$10.22	1.4%
Low Enrollment	$57.97	$12.10	$31.75	$4.04	$16.14	1.4%
<3.0 *	$37.32	-$7.59	$25.00	-$8.01	-$15.60	0.001%
3.0	$60.59	$11.22	$27.74	-$3.96	$7.26	7%
3.5	$62.35	-$1.77	$27.64	-$2.04	-$3.81	20%
4.0	$76.97	$13.16	$26.16	-$1.03	$12.13	43%
4.5	$74.34	$7.15	$25.63	-$0.49	$6.66	20%
5.0	$73.91	$8.28	$19.77	-$6.27	$2.01	7%
Total	$71.52	$8.87	$26.08	-$2.32	$6.55	100%

* Note that results for star ratings less than 3.0 are highly volatile due to the very low enrollment and plan mix underlying this category and therefore are deemed not credible.

Based on the information in Figure 14, plans with 4.0 stars and above offer significantly higher value added than plans with 3.5 stars or below.

Product type

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

FIGURE 15: MEDICARE ADVANTAGE AVERAGE PREMIUM AND VALUE ADDED AMOUNTS BY PLAN TYPE

DUAL-ELIGIBLE SPECIAL NEEDS PLANS						
PRODUCT TYPE	2020 VALUE ADDED	VALUE ADDED CHANGE FROM 2019	2020 PREMIUM	PREMIUM CHANGE FROM 2019	BENEFITS VALUE CHANGE FROM 2019	2020 MEMBERSHIP DISTRIBUTION (%)
HMO	$71.52	$9.23	$26.74	-$2.37	$6.86	83%
HMO-POS	$72.96	$22.20	$23.21	-$4.35	$17.85	3%
LPPO	$66.35	$3.71	$19.85	-$1.40	$2.31	4%
RPPO	$73.24	$5.48	$24.03	-$0.96	$4.52	10%
PFFS	N/A	N/A	N/A	N/A	N/A	N/A
Total	$71.52	$8.87	$26.08	-$2.32	$6.55	100%

The HMO product, which represents 83% of the membership, experienced an increase in value added from 2019 to 2020; however, its change was significantly lower than what the HMO-POS product type saw. The increase in the HMO-POS product type is due to both a decrease in member premium and a significant increase in the value of the benefits offered. The LPPO product type has the lowest value added increase and the lowest value added overall. 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 product types are not considered here.

Carrier size

The table in Figure 16 contains the value added and premium information by carrier size for D-SNPs. Please refer to the "General Enrollment: Carrier Size" section above for a discussion of the determination of carrier size.

FIGURE 16: MEDICARE ADVANTAGE AVERAGE PREMIUM AND VALUE ADDED AMOUNTS BY CARRIER SIZE

DUAL-ELIGIBLE SPECIAL NEEDS PLANS						
CARRIER SIZE	2020 VALUE ADDED	VALUE ADDED CHANGE FROM 2019	2020 PREMIUM	PREMIUM CHANGE FROM 2019	BENEFITS VALUE CHANGE FROM 2019	2020 MEMBERSHIP DISTRIBUTION (%)
Mega	$76.70	$8.25	$23.31	-$2.45	$5.80	74%
Large	$69.32	$14.50	$34.56	-$2.02	$12.47	11%
Medium	$48.62	$7.76	$33.93	-$1.79	$5.97	14%
Small	$29.86	-$7.59	$31.18	$1.87	-$5.71	1%
Total	$71.52	$8.87	$26.08	-$2.32	$6.55	100%

As indicated in Figure 16, and consistent with prior years, 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. 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).

Because D-SNPs target the Part D LIB when bidding, the premiums are mostly driven by each region’s LIB. Mega carriers have the largest concentrations of membership in areas with lower LIBs, which contributes to their low premiums relative to other carriers. D-SNP carriers can offer plans at or below the LIB because both cases result in no realized member premium.

Special needs plans population categories

There are three different population types for MA SNPs, which make up roughly 17% of total MA enrollment based on publicly available MA September 2019 membership. They are:

1. Dual (D-SNP): Beneficiaries enrolled in these plans are eligible for both Medicare and Medicaid. These D-SNP plans are the most common type of special needs plan, with about 13.9% of total MA enrollment.
2. Chronic (C-SNP): Beneficiaries enrolled in these plans have severe or disabling chronic conditions, such as chronic heart failure or diabetes. These plans account for about 2.0% of the MA enrollment. The enrollment in these plans is a relatively equal mix of dual-eligible and general enrollment beneficiaries.
3. Institutional (I-SNP): Beneficiaries who live in an institution such as a nursing home, or who require nursing care in the home, qualify for 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 17 contains the value added and premium information split by type of SNP.

FIGURE 17: MEDICARE ADVANTAGE AVERAGE PREMIUM AND VALUE ADDED AMOUNTS BY SNP POPULATION

SPECIAL NEEDS PLANS						
SNP TYPE	2020 VALUE ADDED	VALUE ADDED CHANGE FROM 2019	2020 PREMIUM	PREMIUM CHANGE FROM 2019	BENEFITS VALUE CHANGE FROM 2019	2020 MEMBERSHIP DISTRIBUTION (%)
D-SNP	$71.52	$8.87	$26.08	-$2.32	$6.55	13.9%
C-SNP	$186.90	$17.59	$9.13	-$0.16	$17.44	2.0%
I-SNP	$141.78	$14.52	$29.50	-$2.12	$12.40	0.5%
Total	$88.02	$9.42	$24.10	-$1.91	$7.52	17%

The three population types shown in Figure 17 have very different membership needs and costs. As stated above, 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. All SNP types have slight decreases in premium from 2019 to 2020, 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 2016 to 2020 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 2016 to 2020, 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 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 2020 analysis, we utilized the September 2019 enrollment information as February information was not available when this report was developed.

Benefit values

The table in Figure 18 contains the nationwide average “supplemental 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.

Non-Medicare-covered benefits are measured by 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 18: 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								
2016	$0.49	$0.13	$3.76	$0.29	$33.02	$37.70	$25.46	$63.15
2017	$0.52	$0.14	$3.85	$0.29	$40.95	$45.74	$28.58	$74.32
2018	$0.56	$0.14	$3.73	$0.29	$46.31	$51.03	$30.10	$81.13
2019	$0.94	$0.15	$3.77	$0.29	$57.71	$62.86	$28.12	$90.98
2020	$0.96	$0.15	$5.28	$0.30	$63.89	$70.57	$27.03	$97.60
Year-Over-Year Change								
2016 to 2017	$0.02	$0.00	$0.09	$0.00	$7.93	$8.05	$3.12	$11.17
2017 to 2018	$0.04	$0.01	-$0.11	$0.00	$5.36	$5.29	$1.52	$6.81
2018 to 2019	$0.38	$0.00	$0.03	$0.00	$11.41	$11.83	-$1.98	$9.84
2019 to 2020	$0.02	$0.01	$1.51	$0.00	$6.17	$7.71	-$1.09	$6.63

Figure 18 illustrates gains in the overall benefit value each year since 2016 in the D-SNP market. Part C benefit values have increased every year during that time, while Part D benefit values increased from 2016 to 2018, and decreased from 2018 to 2020, though the changes are small. 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 and podiatry services.

Non-Medicare-covered benefits

The table in Figure 19 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, OTC drug cards, fitness benefits, and meal benefits.

FIGURE 19: MEDICARE ADVANTAGE MEMBERSHIP WITH ACCESS TO NON-MEDICARE-COVERED BENEFITS

DUAL-ELIGIBLE SPECIAL NEEDS PLANS											
YEAR	ENROLL-MENT	PREVENTIVE DENTAL	COMPRE-HENSIVE DENTAL	VISION EXAMS	VISION HARDWARE	NEMT	HEARING EXAMS	HEARING AIDS	OTC DRUG CARD	FITNESS BENEFIT	MEAL BENEFIT
Five-Year Analysis											
2016	1,469,875	86.3%	81.4%	85.2%	85.7%	74.8%	74.8%	68.6%	73.7%	54.3%	16.9%
2017	1,624,840	88.5%	87.7%	90.5%	91.1%	78.6%	83.1%	78.0%	82.2%	66.8%	26.9%
2018	1,866,921	87.2%	88.2%	90.2%	92.1%	82.0%	85.0%	80.1%	87.4%	71.0%	35.8%
2019	2,177,048	85.4%	87.5%	89.8%	91.4%	83.7%	83.2%	81.6%	96.9%	79.6%	65.6%
2020*	2,369,807	92.3%	89.6%	90.2%	92.9%	81.9%	84.8%	83.5%	98.1%	84.7%	76.4%
Year-Over-Year Change											
2016 to 2017	154,965	2.2%	6.2%	5.3%	5.4%	3.8%	8.3%	9.4%	8.5%	12.6%	10.0%
2017 to 2018	242,081	-1.3%	0.5%	-0.2%	1.0%	3.4%	1.9%	2.1%	5.2%	4.2%	8.9%
2018 to 2019	310,127	-1.8%	-0.7%	-0.5%	-0.6%	1.7%	-1.8%	1.4%	9.5%	8.6%	29.7%
2019 to 2020*	192,759	6.9%	2.1%	0.4%	1.5%	-1.8%	1.5%	1.9%	1.2%	5.2%	10.9%

* September 2019 enrollment cross-walked to 2020 is used for 2020.

Figure 19 illustrates an increase in the percentage of D-SNP plans that offer the various enticement benefits from 2016 to 2020, though some benefits have slight decreases between years during this timeframe. Because 2020 membership is based off of 2019 membership cross-walked to 2020 plans, the change between 2020 and 2019 does not reflect any changes in member selection between plans.

V. Methodology

In performing the analyses contained in this report, we relied on detailed MA plan benefit offerings for 2016 through 2020 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 2020, which uses September 2019 enrollment, taking into account any plans which applied a crosswalk into 2020, because February 2020 enrollment was not yet available) 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. The value added metrics are defined as:

- 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.

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 when otherwise noted, we included all individual (i.e., non-EGWP) Medicare Advantage plans, excluding PDP, MSA, MMP, PACE, Part B only, and Cost plans. This analysis includes the vast majority of all individual general enrollment plans and D-SNPs. We excluded all U.S. territories 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 2020 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 have published regarding the state of the 2014, 2016, and 2018 Medicare Advantage industry.[2] Values represented in this paper are calibrated to county-specific 2020 FFS costs and include additional benefits not measured in the previous reports, such as fitness and meals benefits (for which benefit detail was not previously available). Prior papers reflect results calibrated to county-specific 2014, 2016, and 2018 FFS costs, respectively. Therefore, comparisons between years are only relative as stated within each report, and not directly between each report.

[2] 2014 paper: Swanson, B.L. et al. (February 28, 2014). State of the 2014 Medicare Advantage Industry. Milliman Research Report. Retrieved February 6, 2020, from https://www.milliman.com/en/Insight/state-of-the-2014-medicare-advantage-industry.

- 2016 paper: Freidman, J.M., et al. (February 2016). State of the 2016 Medicare Advantage Industry Changes as a Result of Continued Rate Pressure. Milliman Research Report. Retrieved February 6, 2020, from https://www.milliman.com/en/Insight/state-of-the-2016-medicare-advantage-industry-changes-as-a-result-of-continued-rate-pressu.
- 2018 paper: Freidman, J.M., et al. (February 28, 2018). State of the 2018 Medicare Advantage Industry: Stable and Growing. Milliman Research Report. Retrieved February 6, 2020, from http://us.milliman.com/insight/2018/State-of-the-2018-Medicare-Advantage-industry-Stable-and-growing/.

VI. Conclusions

General enrollment beneficiaries have seen an increase in value added of about 5% and a decrease of about 2% in premium amounts in 2020, relative to 2019. In 2020, D-SNP beneficiaries will also see a significant increase of 12% in value added and a decrease in premium (largely driven by changes in LIB amounts) of about 8%, relative to 2019. The market experienced a surge in the number of new plans available to beneficiaries and 13 new MAOs entered the market as well.[3] 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 2021 plan year, it is important to be aware of issues occurring in 2021, which will undoubtedly have an impact on market offerings. They include:

- Medicare Advantage plans will be allowed to actively enroll Medicare-eligible individuals with end-stage renal disease (ESRD) as of January 1, 2021. This change has the potential to impact MAOs as the behavior, claims costs, and CMS revenue payments for ESRD beneficiaries can vary significantly from non-ESRD beneficiaries.[4]
- Expected continuation by CMS of flexibility in benefit design through Value-Based Insurance Design (VBID), Uniformity Flexibility (UF), and Special Supplemental Benefits for the Chronically Ill (SSBCI).
- The Prescription Drug Pricing Reduction Act (PDPRA) of 2019 proposes sweeping changes to the Medicare Part D program that, if enacted, will likely impact all stakeholders beginning in 2021.[5] All else equal, MAOs may need to "revise alternative benefit designs, implement tighter formulary controls, or employ new strategies to manage catastrophic claim costs and address increased liability and risk exposure," which may increase the Part D value added for beneficiaries, but potentially at the cost of reduced Part C benefit offerings or increased member premiums.
- As of the publication of this paper, based on the Further Consolidated Appropriations Act, 2020 (HR 1865), the HIPF will be eliminated for the 2021 fee year and beyond. This will provide a reprieve to many MAOs of regulatory financial pressure and should allow them to expand supplemental benefit offerings further.
- Price transparency continues to be a hotly debated issue in Congress. While there are no known specifics as to how this may impact the Medicare program, an example of the possible impacts is the discussion surrounding moving drug rebates from post point of sale to point of sale.

In general, while many significant changes are being proposed that may impact the market, we expect the universe of offerings available in the MA market to continue to expand for 2021, both from current 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.6 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 now and in the future.

[3] Jacobson, G. et al., Medicare Advantage 2020 Spotlight: First Look, op cit.

[4] Backes, K.S., Kroening, K.N., Rodrigues, D.I., & Yilmaz, G. (January 16, 2020). Medicare Advantage: Eight Critical Considerations for Every Organization as ESRD Eligibility Expands in 2021. Milliman White Paper. Retrieved February 6, 2020, from https://www.milliman.com/insight/Medicare-Advantage-Eight-critical-considerations.

[5] Amend, J. et al. (August 15, 2019). A New Part D Benefit Design? Prescription Drug Pricing Reduction Act Proposes Major Changes to Part D. Milliman Research Report. Retrieved February 6, 2020, from https://us.milliman.com/insight/A-new-Part-D-benefit-design-Prescription-Drug-Pricing-Reduction-Act-proposes-major-chang.

[6] Backes, K.S., Herrle. G.J., & Rodrigues, D. (November 2019). Medicare Advantage: Strategies to Increase Plan Revenue. Milliman White Paper. Retrieved February 6, 2020, from https://us.milliman.com/en/insight/Medicare%20Advantage%20Strategies%20to%20increase%20revenue.

VII. Qualifications, caveats, and limitations

Julia M. Friedman, Brett L. Swanson, Mary G. Yeh, and Jordan J. Cates 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 Medicare Advantage market in 2020. 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
Midwest	IA
Midwest	IL
Midwest	IN
Midwest	KS
Midwest	MI
Midwest	MN
Midwest	MO
Midwest	ND
Midwest	NE
Midwest	OH
Midwest	SD
Midwest	WI
Northeast	CT
Northeast	MA
Northeast	ME
Northeast	NH
Northeast	NJ

Region	State
Northeast	NY
Northeast	PA
Northeast	RI
Northeast	VT
South	AL
South	AR
South	DC
South	DE
South	FL
South	GA
South	KY
South	LA
South	MD
South	MS
South	NC
South	OK
South	SC

Region	State
South	TN
South	TX
South	VA
South	WV
West	AK
West	AZ
West	CA
West	CO
West	HI
West	ID
West	MT
West	NM
West	NV
West	OR
West	UT
West	WA
West	WY

State	Region
AL	South
AK	West
AZ	West
AR	South
CA	West
CO	West
CT	Northeast
DE	South
DC	South
FL	South
GA	South
HI	West
ID	West
IL	Midwest
IN	Midwest
IA	Midwest
KS	Midwest

State	Region
KY	South
LA	South
ME	Northeast
MD	South
MA	Northeast
MI	Midwest
MN	Midwest
MS	South
MO	Midwest
MT	West
NE	Midwest
NV	West
NH	Northeast
NJ	Northeast
NM	West
NY	Northeast
NC	South

State	Region
ND	Midwest
OH	Midwest
OK	South
OR	West
PA	Northeast
RI	Northeast
SC	South
SD	Midwest
TN	South
TX	South
UT	West
VT	Northeast
VA	South
WA	West
WV	South
WI	Midwest
WY	West

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