WHITE PAPER

What Drives Medicare Advantage Sales?

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The Impact of Benefit Richness on Plan Enrollment

The Medicare Advantage (MA) market landscape is rapidly changing and growing. Each year, MA organizations (MAOs) are entering new markets, expanding service areas, or offering new or enhanced benefits in order to gain market share.

This paper explores the various drivers of enrollment growth in the MA space. We evaluated the correlation between: 1) a health plan improving benefits or reducing member premium and 2) the subsequent enrollment change in that plan. Outside of benefits and member premiums, there are other factors that can contribute to enrollment growth. To gain insight into some of these factors, we interviewed Andrew Herman, a Medicare Advantage broker based in Tampa, FL, to learn about what other considerations drive member plan selection.

The considerations within this paper are broad generalizations. No one factor will drive plan selection for all members, and each market will have unique factors contributing to enrollment growth. Please feel free contact the authors to discuss how to analyze specific markets and plans.

Year-Over-Year Benefit Changes

We focused our research in this section on two key questions:

1. Can year-over-year increases in benefits or year-over-year reductions in member premiums translate to sales?
2. If so, which member benefits are most impactful?

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To answer these questions, we tracked 2019 and 2020 enrollment across credible[1], non-cross walked, nationwide General Enrollment MA plans and evaluated changes in enrollment in relation to changes in benefits. Each subsection below presents a few findings and key considerations for the observed relationship between enrollment and member premium, Out of Pocket Cost (OOPC), and non-Medicare covered supplemental benefits.

When we studied the impact of changing OOPC and non-Medicare covered supplemental benefits, we isolated our analysis to plans that did not change member premium. When we studied the impact of changing member premium, however, we did not limit our analysis to plans with constant OOPC and/or non-Medicare covered supplemental benefits. Essentially all plans changed OOPC year-over-year, and as a result, we could not exclude this impact from the member premium relationship. Please see the Appendix for further detail on the methodology we used.

Member Premium

The first year-over-year relationship we evaluated was the impact of changing member premiums. We found that the data shows a noticeable pattern of enrollment increases associated with member premium decreases (and vice versa). Figure 1 below shows average plan enrollment changes for the plans included in our study:

Figure 1: Average Plan Enrollment Change for Changes in Member Premium

	Change in Member Premium	
	Decrease	Increase
# of Plans	217	266
Average YoY Enrollment Change	7%	-8%
% of Plans with Enrollment Increase	47%	22%
% of Plans with Enrollment Decrease	53%	78%

For plans that decreased member premiums, 47% increased enrollment. However, only 22% of plans increased enrollment while increasing member premium. Though there is a strong correlation observed between member premium and enrollment, it is important to note that some plans experienced a membership decrease even after the plan lowered the member premium. As we will discuss in later sections of this paper, there are various other factors that contribute to membership changes outside of benefit differences.

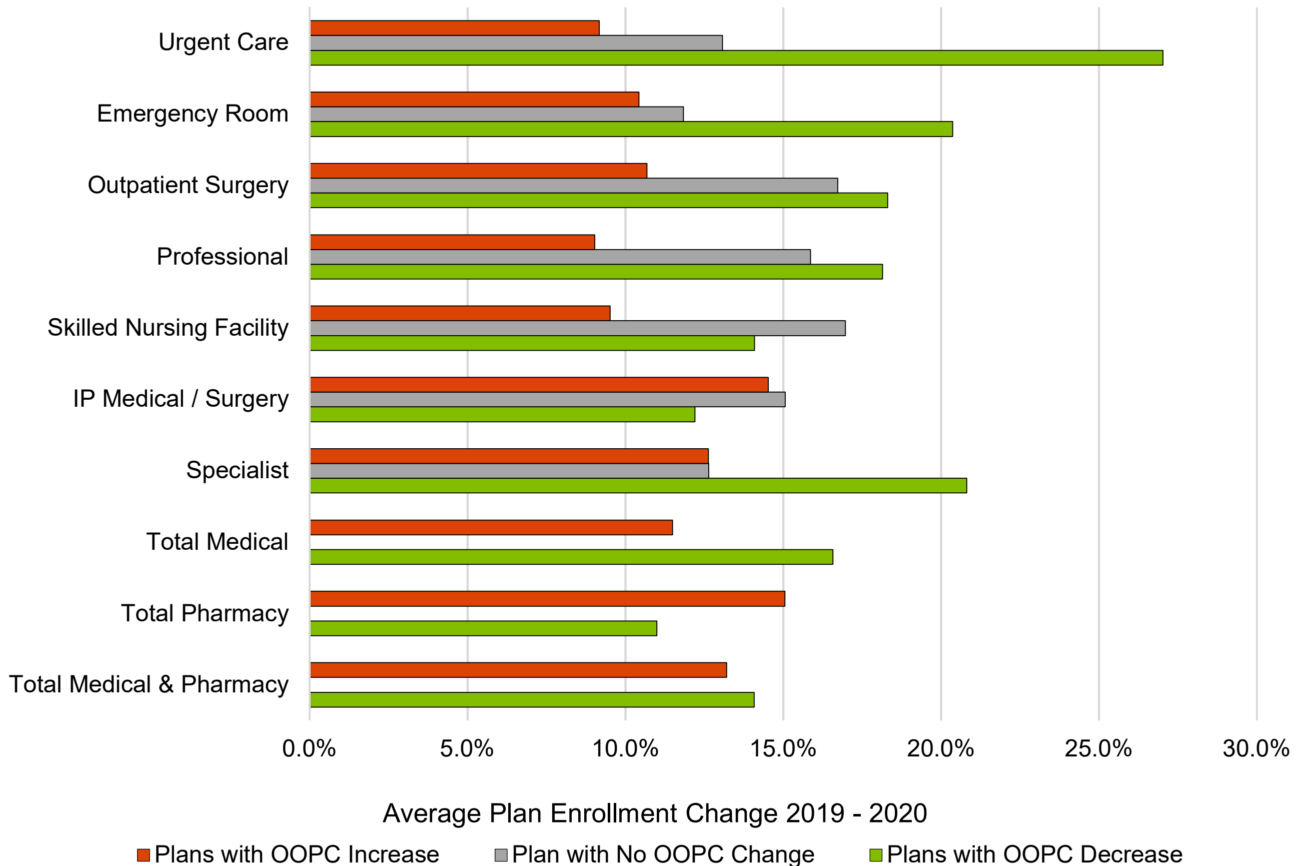
Out of Pocket Cost (OOPC)

The next relationship we evaluated was how enrollment varied with Out-of-Pocket Cost (OOPC) changes. We evaluated OOPC separately for total Medical, total Part D, and key service categories, including

[1] Defined as having greater than 2,000 members in 2019.

Urgent Care, Outpatient Surgery, and Professional. Figure 2 below shows the impact on average plan enrollment of increasing (i.e., adding copays/coinsurance) or decreasing (i.e., removing copays/coinsurance) OOPC. For most service categories, enrollment increased for plans that decreased OOPC more than it did for plans that increased OOPC.

Figure 2: Average Plan Enrollment Change for Changes in OOPC



Urgent Care, Emergency Room, Outpatient Surgery, Professional, and Specialist showed the most defined patterns. In these service categories, we saw a clear distinction in enrollment change between plans that improved benefits vs. those that weakened benefits. An important consideration for plans is that while lower Urgent Care or Emergency Room copays, for example, may be associated with greater enrollment increases, this benefit design may also incentivize members to receive care in more expensive settings or create an anti-selection dynamic within the plan. Plans should account for all factors related to member experience and behavior when developing a benefit design structure.

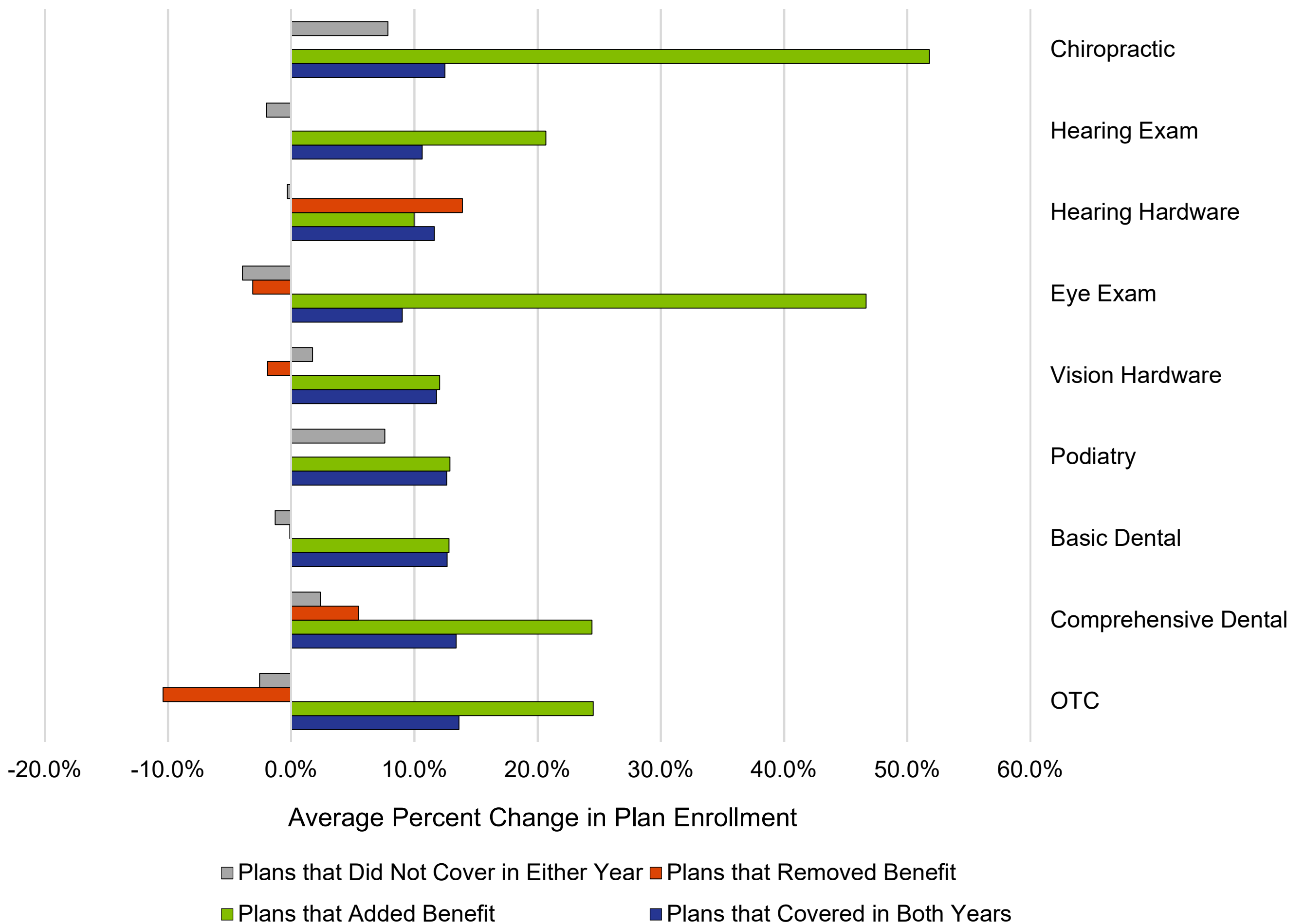
We also found that more plans saw an enrollment increase when they increased their Part D OOPC, rather than the opposite. This counter-intuitive relationship suggests that the total Part D OOPC calculated value was not a key factor in determining plan choice. When evaluating Part D plan options, members also focus on whether their drugs are on the formulary, pharmacy access, and brand loyalty.

Additionally, the Part D OOPC metric that is developed by CMS, which incorporates plan formulary within the calculation, may vary (and potentially significantly) from actual member cost-sharing for some members. Individual member cost is dependent on the specific drugs prescribed to that member, which is likely different than the aggregate OOPC drug mix. Members are more likely to select a plan based on costs for their drugs specifically. Further, when members select a particular plan for rich medical benefits or other reasons, they may overcome formulary challenges by exploring drug alternatives with their physician or by utilizing pharmacy discount coupons that provide a lower out of pocket cost compared to using the plan's drug benefit.

Non-Medicare Covered Supplemental Benefits

The final year-over-year relationship we examined was the impact that Supplemental Benefits—such as vision, dental, and over-the-counter items (OTC) have on year-over-year enrollment changes. This analysis focused on situations where a plan either added the supplemental benefit in 2020 or removed the benefit in 2020. Figure 3 below shows our findings.

Figure 3: Average Plan Enrollment Change for Changes in OOPC



We note that due to small sample size, we do not show the average percent change in enrollment for plans that removed the benefit in the Chiropractic, Hearing Exam, or Podiatry categories. Furthermore, due to the low sample size, readers should use caution in drawing conclusions from the average percent change in enrollment for plans that added the benefit in the Chiropractic and Eye Exam categories.

For a majority of the supplemental benefits evaluated, we observed a noticeable difference in enrollment change between plans that added the benefit vs. those that removed it. Comprehensive dental and OTC drug cards showed the most meaningful enrollment change. Plans not currently offering these benefits could consider adding them in order to increase enrollment.

Another interesting relationship we found is that the year-over-year membership increase was greater for plans which covered the supplemental benefits in both years compared to plans that did not cover the benefit either year. The higher membership growth in plans with richer supplemental benefits supports our observation that supplemental benefits are valuable to a member's plan selection.

Relationship of Benefit Richness and Enrollment

While we have focused on year-over-year benefit and premium changes thus far, our research in this section focuses on the relationship between plan value and enrollment, as observed in 2020 for three core-based statistical areas (CBSAs). Prior to completing the analysis, we anticipated there would be both a strong relationship between the richness of benefits that a plan offers and the plan's enrollment/market share and this relationship would be consistent across regions. Our assumption was that plans that provided reduced cost-sharing, lower member premiums, or enhanced supplemental benefits would attract more membership and therefore have higher market share.

To examine this relationship, we selected three CBSAs geographically dispersed across the country with relatively high Medicare Advantage penetration rates. The CBSAs we chose span the following markets: Tampa, FL, Cleveland, OH, and Los Angeles, CA. To approximate plan value, we developed a proxy for average member net out of pocket expense, defined as:

$$Medical\ OOPC + Dental\ OOPC + Part\ D\ OOPC + Plan\ Premium - Part\ B\ Premium\ Buydown$$

We examined the relationship between this value and the plan enrollment (within the CBSA counties only) for 2020 plans. We separated HMO/HMOPOS and PPO plans, and made exclusion as noted in the *Appendix* section. As anticipated, there is a generally positive relationship observed between the proxy net expense value and plan enrollment across each market. However, the correlation is not as strong as we expected, as shown by the R-squared values[2] in Figure 4.

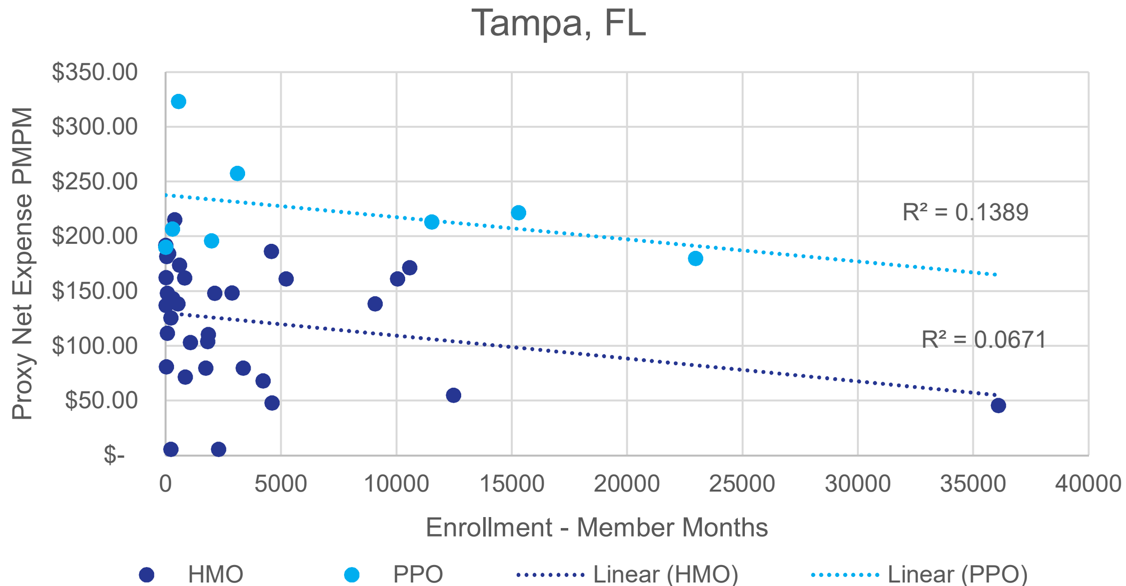
[2] R-squared is the coefficient of determination. In this context, it represents the amount of variation in enrollment that can be explained by the average proxy net expense PMPM. The maximum R-squared value is 1.0 (meaning that *all* of the variation in enrollment is explained by the average proxy net expense PMPM).

Figure 4: Proxy Net Expense PMPM by CBSA

	HMO/HMOPOS		PPO	
CBSA	Average Proxy Net Expense PMPM[3]	R^2	Average Proxy Net Expense PMPM[2]	R^2
Cleveland	$216.60	0.0582	$266.61	0.0284
Los Angeles	$148.04	0.0484[4]	$343.24	N/A[5]
Tampa	$97.03	0.0671	$204.80	0.1389

A graph showing the relationship between enrollment and proxy net expense for Tampa, FL, is below in Figure 5.

Figure 5: Tampa, FL HMO Plan Enrollment and Proxy Net Expense PMPM



The weak correlation between the proxy net expense PMPM and enrollment indicates there are other factors at play in members' plan selection decisions, which we discuss below in the section *Additional Considerations for Enrollment Growth*. Plans should consider these additional factors, along with their benefit strategies, when developing a plan design.

Another aspect of this analysis was to examine differences in the average benefit offering for a MA plan in each of the regions selected. As shown in the table above, the member proxy net expense PMPM

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[3] Enrollment weighted average

[4] One large HMO plan removed in order to better reflect the relationship in the rest of the market. The inclusion of this plan reduces the R-squared value to .0022.

[5] Includes only one plan

varies significantly between our selected markets, with Cleveland approximately twice as high as Tampa (indicating that the average MA benefits that an enrollee would receive in Tampa are much richer than in Cleveland). This demonstrates that the competitive landscape and overall benefit levels vary widely across the country. To further examine these differences, we compared the prevalence of select supplemental benefits across the CBSAs. We considered the following supplemental benefits: basic and comprehensive dental, vision hardware, OTC, hearing aids, transportation, and Part B premium buydown. Figure 6 shows the percentage of plans by market offering any level of supplemental benefit as a mandatory offering (at no additional premium to the member).

Figure 6: Prevalence of Mandatory Supplemental Coverage by Market

CBSA	Basic Dental	Comprehensive Dental	Vision Hardware	OTC	Hearing Aids	Transportation	Part B Buydown
Cleveland	90%	41%	82%	73%	90%	39%	0%
Los Angeles	79%	75%	98%	81%	88%	75%	13%
Tampa	100%	93%	93%	85%	88%	63%	27%

As shown above, some benefits are common across all markets, including basic dental, vision hardware, OTC, and hearing aids. Plans can assume these benefits are a given in most markets and count on including them within their benefit package. Other benefits, such as transportation and Part B buydown, vary significantly by market. These more unique benefits might influence a member's plan selection. This highlights the competitive differences across the country and the need for MAOs to examine each plan's unique market dynamics separately.

Key Benefit Change Findings

Overall, the short answer to our initial question of whether benefits drive sales is: **it depends**. The data does reinforce some intuitive relationships: increases in benefits lead to increases in enrollment, and richer plan benefits tend to have greater enrollment. However, we do see many examples where the opposite is true.

These intuitive relationships exist more strongly for certain benefits than others. In particular, changes in member premium tend to have a greater effect on enrollment than cost-sharing changes. That said, decreases in cost-sharing for certain benefits, such as Urgent Care, Emergency Room, Outpatient Surgery, Professional, and Specialist, correlate with enrollment increases more than other benefits.

Within the realm of supplemental benefits, the data suggests that OTC and dental benefits have the strongest relationship with member enrollment shifts. Since OTC benefits are not as common in all rating areas, adding an OTC benefit may provide plans with a competitive advantage. The addition or removal of these benefits, compared to other supplemental benefit offerings, appear to have a larger influence on member plan choice.

It is important to consider that a variety of reasons may contribute to a plan's decision to add or remove a supplemental benefit. These drivers, such as a Star Rating change, may also contribute to member plan selection decisions. We discuss the implications of Star Rating changes as well as other considerations for member enrollment within the next section.

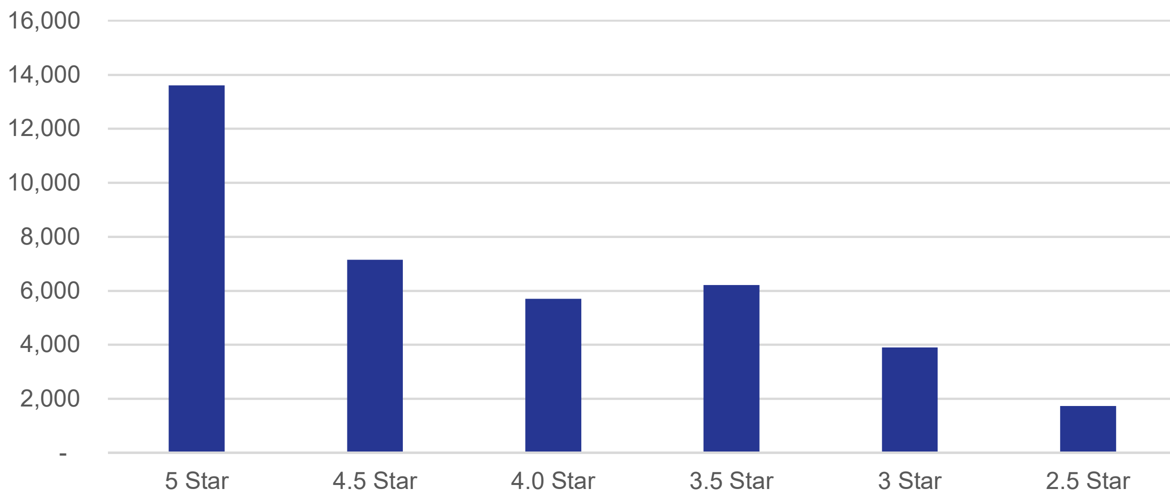
Additional Considerations for Achieving Enrollment Growth

The Impact of Star Rating

Another aspect of this analysis was to look at the impact of Medicare Star Ratings on enrollment. Our goal was to understand if Star Rating influenced member plan selection. To do this, we analyzed if plans took the change in revenue from gaining or losing Star Ratings from one year to the next to improve/reduce benefits or decrease/increase member premium.

In general, unless a member is choosing between a 5.0 Star plan and a 2.0 Star plan, we assumed that Star Ratings do not directly impact member enrollment. However, when comparing average plan size (based on 2020 enrollment) against payment year 2020 Star Ratings, we saw a very clear correlation in that plans with high-quality ratings are larger on average than plans with low-quality ratings. See figure 7 below for a summary of the average 2020 plan enrollment and Marketing Year 2020 Star Ratings.

Figure 7: Average Plan Size for 2020 Marketing Year Star Ratings



There are likely confounding factors skewing the results shown above. For example, MAOs with large enrollment are also likely to have more resources to devote to improving Star Ratings. This can be said for more established contracts as well, but likely not as much for newer contracts which tend to have lower enrollment and perform worse on Star Ratings overall. A contributing factor for the higher average plan size for 5.0 Star plans may be that 5.0 Star plans are allowed to market year-round, not only during the Open Enrollment period. This is likely to impact average plan enrollment for 5.0 Star plans.

Do Changes in Star Rating Result in Plan Benefit Changes?

The other consideration we looked at was whether plans increasing in Star Rating from one payment year to the next would utilize the additional revenue generated from Star Rating improvement and invest in either benefits or member premium, resulting in greater enrollment growth. For this analysis, we looked at plans' payment year star ratings for 2018 and 2019 compared to their 2018 and 2019 enrollment changes, as well as plans' payment year 2019 and 2020 star ratings compared to their 2019 and 2020 enrollment changes. We separated plans into five categories: Improved Star Rating, Stable Star Rating, Deteriorated Star Rating, 3.5 to 4.0 Star Improvement, and 4.0 to 3.5 Star Deterioration. Our hope was that we would see benefit improvements and member premium reductions in general across the "Improved Star Rating" bucket, and an even stronger trend of benefit improvement in the 3.5 to 4.0 Star Improvement, as these are the plans that will be receiving an extra 5% Quality Bonus Payment.

Within our analysis, we did not see a consistent theme with enrollment growth, benefit change, or member premium change across each of the Star Rating categories. We did not see a clear pattern of contracts improving in Star Rating, putting that additional revenue towards enhanced benefits or reduced member premium more often than contracts with deteriorated Star Ratings. This suggests that plans most often set their benefits and premium relative to the market and take any changes in Star-related revenue as changes to profit, rather than feeding these through to the member's benefits/premium. This could also suggest that plans are hesitant to drastically change benefits or member premium based on Star Rating changes that may only last one year.

Additional Considerations for Enrollment Growth

The majority of this paper has focused on the impact that benefits and member premiums have on enrollment growth and enrollment changes. Beyond these factors, however, there are many other considerations that determine what plan a member will select and how much enrollment growth a plan will have. The section below discusses these additional considerations that were not directly analyzed or isolated within this whitepaper and analysis.

We interviewed Medicare Advantage broker Andrew Herman, based in Tampa, FL, to learn about factors beyond benefits that impact member plan selection. The considerations in this section reflect his opinions and are generalizations. No one solution will fit all members.

Provider Network

Provider network and network composition is an important factor when a member is selecting a plan. If a member has an existing primary care physician and/or specialist that they have a strong relationship with, they are likely to select their Medicare Advantage plan based on whether or not that physician is in the plan's network. Members who see a specialist might be hesitant to select a plan that requires a referral before seeing their specialist.

Changes to a plan's provider network, especially if made unexpectedly mid-year, create member abrasion, and have the potential to drive members away from a plan. Network confusion and a lack of clear information about which providers are in-network are common, especially related to dental networks. This has prompted some plans to offer "discounted prices" or "stipend amounts" that members can use at any dental provider. Well trained, knowledgeable customer service staff can also help reduce this confusion and member frustration.

Marketing and Brand Recognition

Marketing campaigns and brand recognition play a large role in enrollment growth. A member may be more likely to select an organization that they are familiar with or one that they had coverage with prior to becoming Medicare eligible. Additionally, providers may have favorable opinions about certain plans due to prompt payment practices or other factors. Members value the opinions of their doctors, and this may drive plan selection in some cases. Finally, members may perceive large carriers—along with their brand recognition and typically larger networks—to be a "safer bet" than some smaller or newer carriers just joining the market.

Member materials can also lead to confusion and member frustration. Some seniors prefer to receive printed materials for key documents such as the Provider and Pharmacy Directories and the Evidence of Coverage (EOC). However, when allowable by CMS, many plans opt for summarizing benefit and plan information on their website only, rather than providing printed materials. For seniors, receiving a postcard with a link to an insurer's website may be a turn-off.

Plan sponsors also compete by providing monetary incentives to members for completing various wellness and preventive procedures. In the wake of COVID-19 this year, one plan sponsor in Tampa mailed its members a care package containing face masks and other supplies. Consumers appreciated the surprise mailings which will likely will lead to improved member retention.

Market Dynamics

The considerations above include many generalizations about plan selection within the MA market. However, determinations of how a member selects a plan and which plans see the greatest enrollment growth vary significantly by market, as was seen in the *Relationship of Benefit Richness and Enrollment* section above. The level of competition within a market is also likely to determine how impactful a richer set of benefits and lower member premiums are on member enrollment. In markets with robust or increasing competition, MA brokers, who generally are familiar with all plans and steer clients towards plans having the highest value and suitability to the member, may influence enrollment trends.

Finally, MA members are known for being "stickier," or less likely to change plans, than younger commercial populations. This dynamic can help plans retain the enrollment they have but may make it difficult to attract members away from their current MA plan. One year of increased member premium or benefit cuts may not result in significant enrollment lapse, but consecutive years of benefits cuts or premium increases, poor customer service, or negative provider network changes are likely to drive

member aversion. Since the MA demographic group tends to be more resistant to change, plan selection at time of Medicare eligibility is paramount. Members who have a good experience with customer service and benefit delivery during their first year may stay with the carrier for many years or for life.

Appendix: Limitations and Methodology

This analysis focused on the impact of year-over-year benefit and star rating changes on plan enrollment as well as the correlation between a plan's benefit/premium richness and their market share. Our subset was limited to General Enrollment Individual Medicare Advantage plans. We excluded special needs plans from the analysis because their specific member needs vary greatly from the general enrollment population, as do their plan designs. We excluded Employer Group Waiver plans (EGWP) as these benefits differ for each group offering and are not readily and publicly available. Any plans that cross-walked membership between years were also eliminated from the analysis to mitigate any confounding impact on the changes we sought to analyze. In addition, we excluded any plan/county combinations that had enrollment below the ten-member threshold required by CMS to protect PHI. All sections of this paper utilized a subset of the data with the aforementioned qualifications.

The first portion of this paper discusses the impact of plan benefit changes from 2019 to 2020 on those plans' enrollment in the same years. To isolate the impact of Out of Pocket Cost (OOPC) and non-Medicare covered Supplemental benefits on plan enrollment, we excluded plans for which Part B Buy-down and member premium changed from 2019 – 2020. Total plans included was approximately 750. However, when quantifying the impact of member premium changes on plan enrollment changes, plans with changes to OOPC and/or non-Medicare covered Supplemental benefits are included in our analysis. Total plans included was approximately 1,200. The *Relationship of Benefit Richness and Enrollment* portion of this paper utilizes a 'point-in-time' view of proxy net expense PMPM and enrollment for 2020. We did not consider changes over time for this section. In addition to the plan exclusions mentioned in the first paragraph, this section also excluded PFFS and RPPO plan types. The definition of the proxy net expense PMPM is the sum of Medical, Dental, and Part D OOPC, plus plan premium, less part B premium buydown. These OOPC values reflect the values produced when running a plan's PBP through the CMS OOPC calculator. We added the plan premium to our proxy net expense as it reflects an additional cost to the member each month. Part B premium buydown, if any, was reduced from the proxy net expense as it reflects a reduction in total monthly medical expenses for a member.

We studied the Star Rating portion for both 2018-2019 changes and 2019-2020 changes in plan enrollment, premium, and plan benefits. Plan benefits were analyzed using total OOPC from the CMS OOPC calculator. We calculated total OOPC as a sum of the Dental, Medical, and Part D OOPC values. We did not analyze each individual subset of OOPC in this section. In addition, we excluded any plans that did not have a reported star rating in either year of comparison. This excludes plans that are too new or too small to have a star rating in the given year. Within this comparison, we compared a plan's *payment year* star rating[6] with the associated benefit changes for that year.

[6] This is the year that the Star Rating would impact the plan's CMS revenue.

The OOPC Model underwent changes between the 2019 and 2020 plan years. To normalize for these model changes, we adjusted the 2019 OOPC values, so their enrollment weighted average equaled that of the 2020 OOPC values. We used the same methodology for the 2018-2019 data analyzed.

Any inferences drawn from this analysis should consider the plans used in this research and the corresponding limitations described above.

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