Session 8L, Future of Medicare Advantage: Trends of an Expanding Market

Moderator/Presenter:
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Presenters:
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David Hayes, FSA, MAAA
Gregory V. Sgrosso, FSA, MAAA
Session Goals and Learning Outcomes

- This session will address the current landscape of the Medicare Advantage market with a focus in future trends due to an increase in the Medicare eligible population.

- An emphasis will be placed on Medicare eligible enrollment due to the baby boomer population, Part C and D Medicare spending and cost trends, evolving creativity in provider contracting, and future benefit package and premium changes.

- With increased popularity in Medicare Advantage, additional oversight will be placed on future changes in policy and reducing the financial burden for beneficiaries.

- Attendees will be further prepared for current and future changes in the Medicare Advantage program.

- Attendees will gather additional insight into future trends in policy changes and cost spending and will be more equipped to adapt to changes in the marketplace.
To Participate, look for Polls in the SOA Event App or visit health.cnf.io in your browser

Find The Polls
Feature Under
More In The Event
App

Type health.cnf.io In Your
Browser
Poll: Of the following, which do you think will be the greatest focus in the Medicare Advantage industry in the future?
Of the following, which do you think will be the greatest focus in the Medicare Advantage industry in the future?
Medicare, we have a problem!
From Pyramid to Pillar: A Century of Change
Population of the United States

1960

85+
80-84
75-79
70-74
65-69
60-64
55-59
50-54
45-49
40-44
35-39
30-34
25-29
20-24
15-19
10-14
5-9
0-4

2060

Source: National Population Projections, 2017
www.census.gov/programs-surveys/popsproj.html
An Aging Nation
Projected Number of Children and Older Adults

For the First Time in U.S. History Older Adults Are Projected to Outnumber Children by 2035

Projected percentage of population

Adults 65+ 22.8% 23.5%
Children under 18 15.2% 19.8%

Projected number (millions)

2016 2020 2025 2030 2035 2040 2045 2050 2055 2060
49.2 73.6 78.0 76.4 94.7 79.8

Note: 2016 data are estimates not projections.

Source: National Population Projections, 2017
www.census.gov/programs-surveys/popproj.html

United States Census Bureau
Economics and Statistics Administration

Milliman
Poll: The US population is currently 326 million. When is it expected to exceed 400 million?
The US population is currently 326 million. When is it expected to exceed 400 million?
Enrollment Trends and Market Penetration
Medicare Advantage Historical Enrollment in Total

Figure 1
Enrollment in Medicare Advantage plans has steadily increased since 2004

Total Medicare Private Health Plan Enrollment, 1999-2017
(in millions)

<table>
<thead>
<tr>
<th>Year</th>
<th>Enrollment (in millions)</th>
<th>% of Medicare Beneficiaries</th>
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</thead>
<tbody>
<tr>
<td>1999</td>
<td>6.9</td>
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<td>13%</td>
</tr>
<tr>
<td>2004</td>
<td>5.3</td>
<td>13%</td>
</tr>
<tr>
<td>2005</td>
<td>6.8</td>
<td>16%</td>
</tr>
<tr>
<td>2006</td>
<td>8.4</td>
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<td>2012</td>
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<td>2015</td>
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<td>31%</td>
</tr>
<tr>
<td>2016</td>
<td>19.0</td>
<td>33%</td>
</tr>
</tbody>
</table>

NOTE: Includes MSAs, cost plans, demonstration plans, and Special Needs Plans as well as other Medicare Advantage plans. Excludes beneficiaries with unknown county addresses and beneficiaries in territories other than Puerto Rico.

# Medicare Advantage Historical Enrollment by Type

## Most Medicare Advantage enrollees are in HMOs

**Total Enrollment in Medicare Private Health Plans, by Plan Type, 2007-2017**

(in millions)

<table>
<thead>
<tr>
<th>Year</th>
<th>Other</th>
<th>PFFS plans</th>
<th>Regional PPOs</th>
<th>Local PPOs</th>
<th>HMOs</th>
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<td>2009</td>
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<td>2011</td>
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<td>11.9</td>
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<tr>
<td>2012</td>
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<td>14.4</td>
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<td>2014</td>
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<td>3.7</td>
<td>4.0</td>
<td>15.7</td>
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<td>2015</td>
<td>0.3</td>
<td>10.7</td>
<td>4.1</td>
<td>4.1</td>
<td>16.8</td>
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<tr>
<td>2016</td>
<td>0.6</td>
<td>11.3</td>
<td>4.9</td>
<td>4.9</td>
<td>17.6</td>
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<tr>
<td>2017</td>
<td>0.7</td>
<td>11.9</td>
<td>4.9</td>
<td>4.9</td>
<td>19.0</td>
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<table>
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<tr>
<th>% of Medicare Beneficiaries</th>
<th>2007</th>
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<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
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<th>2017</th>
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<td>22%</td>
<td>23%</td>
<td>24%</td>
<td>25%</td>
<td>27%</td>
<td>28%</td>
<td>30%</td>
<td>31%</td>
<td>31%</td>
<td>33%</td>
</tr>
</tbody>
</table>

**NOTE:** Other includes MSAs, cost plans and demonstrations. Includes Special Needs Plans as well as other Medicare Advantage plans. Excludes beneficiaries with unknown county addresses and beneficiaries in territories other than Puerto Rico.

Medicare Advantage Group Enrollment

**Figure 3**

About one in five Medicare Advantage enrollees are in group plans and enrollment in group plans has doubled since 2008.

**Distribution of Medicare Advantage Enrollees, by Plan Type, 2017**

- Group Plans: 19%
- Individual Plans, Open For General Enrollment: 69%
- Special Needs Plans: 12%

**Total Medicare Advantage Enrollment, 2017 = 19.0 Million**

**Total Enrollment in Group Plans, 2008-2017 (in millions)**

- 2008: 1.7
- 2009: 1.8
- 2010: 1.9
- 2011: 2.1
- 2012: 2.3
- 2013: 2.5
- 2014: 3.0
- 2015: 3.1
- 2016: 3.2
- 2017: 3.7

**NOTE:** Numbers may not sum to total due to rounding. Excludes beneficiaries with unknown county addresses and beneficiaries in territories other than Puerto Rico.

**SOURCE:** Authors' analysis of CMS Medicare Advantage enrollment files, 2008-2017.
Medicare Enrollment and Growth Rate (2010-2026) (enrollment in millions)
Poll: What region of the US has the highest penetration of Medicare Advantage plans?
What region of the US has the highest penetration of Medicare Advantage plans?
Medicare Advantage by State

Figure 4

Enrollment in Medicare Advantage plans varies across states

Share of Medicare Beneficiaries Enrolled in Medicare Private Health Plans, by State, 2017

NOTE: Includes MSAs, cost plans and demonstrations. Includes Special Needs Plans as well as other Medicare Advantage plans. Excludes beneficiaries with unknown county addresses and beneficiaries in territories other than Puerto Rico. SOURCE: Authors’ analysis of CMS State/County Market Penetration Files, 2017.
Medicare Advantage Penetration by State

Figure 5

Medicare Advantage penetration varies widely across large metropolitan counties in 2017

Five Counties with the Lowest and Five Counties with the Highest Penetration Rate, among Counties with at least 100,000 Beneficiaries

- Lake, IL (Waukegan) 11%
- Montgomery, MD (Rockville) 11%
- Baltimore, MD 14%
- Fairfax, VA 14%
- Plymouth, MA (Brockton) 16%
- National Average 33%
- Erie, NY (Buffalo) 58%
- Multnomah, OR (Portland) 58%
- Allegheny, PA (Pittsburgh) 62%
- Monroe, NY (Rochester) 65%
- Miami-Dade, FL (Miami) 65%

NOTE: Excludes beneficiaries with unknown county addresses or in territories other than Puerto Rico. 109 counties had at least 100,000 beneficiaries in 2017. Estimates for Baltimore County (13%) and Baltimore City (17%) were averaged. Counties’ seats are denoted in parentheses when different from county name.

Market Concentration

- UnitedHealthcare and Humana together account for 41 percent of enrollment in 2017
- Enrollment continues to be highly concentrated among a handful of firms
- In 17 states, one company has more than half of all Medicare Advantage enrollment – an indicator that these markets may not be very competitive.
Medicare Advantage by Entity

Figure 6

More than half of all Medicare Advantage enrollees are in plans offered by three firms or affiliates

Medicare Advantage Enrollment, by Firm, 2017

Total Medicare Advantage Enrollment, 2017 = 19.0 Million

NOTE: All other insurers includes firms with less than 2% of total enrollment. BCBS are BlueCross and BlueShield affiliates and excludes Anthem BCBS plans. Anthem includes BCBS plans and other plans. Percentages may not sum to 100% due to rounding.

Market Concentration by State

Figure 7

In most states, three firms or affiliates account for more than three-quarters of Medicare Advantage enrollment

*Combined Market Share of the Three Firms or Affiliates with the Largest Number of Medicare Advantage Enrollees by State, 2017*

[source: Authors’ analysis of CMS State/County Market Penetration Files, 2017.]
Aging of the US Population

The Number of 65-Plus Americans Is Projected to Grow Rapidly

POPULATION 65 YEARS AND OLDER, 1900-2050

Source: U.S. Census Bureau, compiled by the U.S. Administration on Aging, 2008.
Aging of the US Population by Decade

Figure 2

The aging of the population and rising health care costs are contributing to the growth in Medicare spending over time

*U.S. population ages 65 and older, 2010-2050*

Special Needs Plans

- Types of Special Needs Plans
  - D-SNP, C-SNP and I-SNP

- Eligibility Requirements
  - Who can enroll?

- Benefit Designs Strategy and Formulary Development
  - How do the benefits differ from a typical MA-PD plan?

- Coordinating Care
  - Network Access and care management

- Trends in the Industry
  - Are SNP plans becoming more popular?
D-SNP Distribution by State

Figure 4: D-SNP Plans by State, 2016

*Data from the Centers for Medicare & Medicaid Services SNP Comprehensive Report – July 2016*
Dual – Eligible Special Needs (D-SNP)

- Medicaid Eligibility Categories?
  - QMBs, QMB+, SLMBs, SLMB+, QDWIs
- Types of DSNP plans
  - All Dual
  - Zero-cost sharing
  - Dual-Eligible Subsets
  - Partial-Dual plans
  - FIDE-SNP
  - DSNP lookalike
- Benefit Designs and Flexibility
  - Medicare-FFS benefits
  - Formulary designs
- Focus on Care Coordination
- Challenges for Insurers
Chronic Condition Special Needs (C-SNP)

- Eligibility requirements for these members
- Application of a C-SNP plan
- Types of C-SNP plans?
  - 15 types of Condition-specific plans
  - Single Condition
  - Multi-Condition with comorbidity groupings
- Tailored Benefit Designs
- Challenges for Insurers
Institutional Special Needs (I-SNP)

• Background and Eligibility

• Type of Member Enrolled
  • LTC facility, SNF, NH, ICF
  • At home or needing institutional levels of care

• Facility Contracts and Requirements

• Level of Care Assessments
Cost Trends
Poll: Medicare Advantage medical cost trends have averaged ____% per year over the past 10 years.
Medicare Advantage medical cost trends have averaged ____% per year over the past 10 years.
State of the Medicare Advantage Industry

- Health Insurer Providers Fee (HIPF)
  - Gone in 2017, back in 2018, gone again in 2019
- 44% of contracts in 2018 had 4 or more stars
- 73% of enrollees in 2018 were in plans with 4 or more stars
  - Up from 69% in 2017
- Plans' Growth – 3.9% from 2016 to 2017
  - 14.6% from 2017 to 2018
  - Average enrollee growth has been 6% per year since 2014
  - MA penetration is at 33.5% in 2018 – has been increasing since 2014
- $2 average nationwide premium decrease from 2017 to 2018
- HMOs most popular product (65%) with lowest premiums
- 97% choose plans with no Part C deductible
- 76% of members choose a mandatory MOOP between $3,401 and $6,700
Medicare Part C Utilization per 1,000 Trends (2011-2018)

<table>
<thead>
<tr>
<th>Year</th>
<th>Inpatient Hospital</th>
<th>Skilled Nursing Facility</th>
<th>Home Health</th>
<th>Outpatient Hospital</th>
<th>Physician</th>
<th>Other Part B</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>-2.3%</td>
<td>0.5%</td>
<td>-3.1%</td>
<td>4.2%</td>
<td>2.4%</td>
<td>0.0%</td>
<td>0.4%</td>
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<td>2012</td>
<td>-4.2%</td>
<td>-2.9%</td>
<td>-4.3%</td>
<td>5.1%</td>
<td>0.5%</td>
<td>0.8%</td>
<td>-0.8%</td>
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<tr>
<td>2013</td>
<td>-4.2%</td>
<td>-0.9%</td>
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<td>-1.7%</td>
<td>-1.1%</td>
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<tr>
<td>2014</td>
<td>-2.9%</td>
<td>-1.4%</td>
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<td>0.9%</td>
<td>-0.7%</td>
<td>0.1%</td>
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<tr>
<td>2015</td>
<td>-0.7%</td>
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<td>2.1%</td>
<td>6.2%</td>
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<td>2.8%</td>
<td>1.9%</td>
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<tr>
<td>2016</td>
<td>-0.8%</td>
<td>-5.0%</td>
<td>-0.2%</td>
<td>5.7%</td>
<td>0.2%</td>
<td>1.1%</td>
<td>0.6%</td>
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<tr>
<td>2017</td>
<td>-1.8%</td>
<td>-0.7%</td>
<td>0.8%</td>
<td>4.7%</td>
<td>2.5%</td>
<td>0.5%</td>
<td>0.9%</td>
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<td>2018</td>
<td>-0.9%</td>
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<td>1.5%</td>
<td>3.1%</td>
<td>0.5%</td>
<td>0.8%</td>
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### Medicare Part C Cost per Service Trends (2011-2018)

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<tbody>
<tr>
<td>Inpatient Hospital</td>
<td>1.3%</td>
<td>3.4%</td>
<td>6.3%</td>
<td>3.0%</td>
<td>1.9%</td>
<td>0.6%</td>
<td>1.7%</td>
<td>3.0%</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>9.6%</td>
<td>-8.5%</td>
<td>2.9%</td>
<td>2.6%</td>
<td>2.7%</td>
<td>3.2%</td>
<td>4.1%</td>
<td>2.6%</td>
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<tr>
<td>Home Health</td>
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<td>0.0%</td>
<td>1.5%</td>
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<td>Outpatient Hospital</td>
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<tr>
<td>Physician</td>
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<tr>
<td>Other Part B</td>
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<tr>
<td>Total</td>
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<td>1.7%</td>
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<td>1.5%</td>
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Medicare Part C Allowed Per Member Per Month Trends (2011-2018)

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<td>Skilled Nursing Facility</td>
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<td>1.7%</td>
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<td>3.4%</td>
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<td>Home Health</td>
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<td>Outpatient Hospital</td>
<td>6.7%</td>
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<td>6.5%</td>
<td>3.8%</td>
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<tr>
<td>Physician</td>
<td>3.2%</td>
<td>-0.7%</td>
<td>-10.5%</td>
<td>1.4%</td>
<td>2.9%</td>
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</tr>
<tr>
<td>Other Part B</td>
<td>2.2%</td>
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<td>-0.7%</td>
<td>0.3%</td>
<td>5.7%</td>
<td>2.9%</td>
<td>2.3%</td>
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<td>2.2%</td>
<td>3.6%</td>
<td>1.1%</td>
<td>2.4%</td>
<td>2.8%</td>
</tr>
</tbody>
</table>
Medicare Part D Spending

Annual Medicare Part D spending, in $ billions

- Retiree drug subsidy
- Reinsurance
- Low-income subsidy
- Direct subsidy
- Premiums

Medicare Part D Rebates

*Medicare Part D rebates as a percent of total drug costs:*

Medicare Part D Spending Growth Rate

Average annual growth in Medicare Part D per enrollee spending, actual and projected:

- **Actual: 2007-2013**: 2.4%
- **Actual: 2013-2016**: 4.4%
- **Projected: 2016-2026**: 4.7%

SOURCE: Kaiser Family Foundation analysis of Medicare spending data from the 2017 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, Table V.D1; 2017 Expanded and Supplementary Tables and Figures.
Trends in Medicare Future Spending

Figure 7
Medicare spending is expected to increase at a faster rate between 2015 and 2025 than it did between 2010 and 2015

<table>
<thead>
<tr>
<th>Total Medicare spending</th>
<th>Medicare per capita spending</th>
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<tbody>
<tr>
<td>2010-2015: 4.4%</td>
<td>2010-2015: 1.4%</td>
</tr>
<tr>
<td>2015-2025: 7.1%</td>
<td>2015-2025: 4.3%</td>
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</tbody>
</table>

SOURCE: Kaiser Family Foundation analysis of Medicare spending data from Board of Trustees.
Trends in Medicare Part D Spending

Figure 8

Spending on Part D prescription drug coverage is projected to grow faster than on other Medicare-covered benefits

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Part A</th>
<th>Part B</th>
<th>Part D</th>
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<tbody>
<tr>
<td>2015</td>
<td>$12,744</td>
<td>$5,019</td>
<td>$5,522</td>
<td>$2,203</td>
</tr>
<tr>
<td>2025</td>
<td>$19,405</td>
<td>$6,901</td>
<td>$8,642</td>
<td>$3,861</td>
</tr>
</tbody>
</table>

Per beneficiary spending:

SOURCE: Kaiser Family Foundation analysis of Medicare spending data from the 2016 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds (Table V.D1)
Medicare Spending Trends

Figure 4

Actual and Projected Net Medicare Spending, 2010-2027

Actual Net Outlays (in billions)

Projected Net Outlays (in billions)

<table>
<thead>
<tr>
<th>Year</th>
<th>Actual</th>
<th>Projected</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>$446</td>
<td>$450</td>
</tr>
<tr>
<td>2011</td>
<td>$480</td>
<td>$501</td>
</tr>
<tr>
<td>2012</td>
<td>$466</td>
<td>$506</td>
</tr>
<tr>
<td>2013</td>
<td>$492</td>
<td>$513</td>
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<tr>
<td>2014</td>
<td>$505</td>
<td>$522</td>
</tr>
<tr>
<td>2015</td>
<td>$540</td>
<td>$544</td>
</tr>
<tr>
<td>2016</td>
<td>$588</td>
<td>$588</td>
</tr>
<tr>
<td>2017</td>
<td>$590</td>
<td>$847</td>
</tr>
<tr>
<td>2018</td>
<td>$584</td>
<td>$872</td>
</tr>
<tr>
<td>2019</td>
<td>$648</td>
<td>$895</td>
</tr>
<tr>
<td>2020</td>
<td>$698</td>
<td>$996</td>
</tr>
<tr>
<td>2021</td>
<td>$754</td>
<td>$1,079</td>
</tr>
<tr>
<td>2022</td>
<td>$824</td>
<td>$1,159</td>
</tr>
<tr>
<td>2023</td>
<td>$872</td>
<td></td>
</tr>
<tr>
<td>2024</td>
<td>$895</td>
<td></td>
</tr>
<tr>
<td>2025</td>
<td>$996</td>
<td></td>
</tr>
<tr>
<td>2026</td>
<td>$1,079</td>
<td></td>
</tr>
<tr>
<td>2027</td>
<td>$1,159</td>
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</table>

Percent of Federal Outlays

<table>
<thead>
<tr>
<th>Year</th>
<th>GDP</th>
<th>Federal Outlays</th>
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<tbody>
<tr>
<td>2010</td>
<td>3.0</td>
<td>12.9</td>
</tr>
<tr>
<td>2011</td>
<td>3.1</td>
<td>13.3</td>
</tr>
<tr>
<td>2012</td>
<td>2.9</td>
<td>13.2</td>
</tr>
<tr>
<td>2013</td>
<td>3.0</td>
<td>14.2</td>
</tr>
<tr>
<td>2014</td>
<td>2.9</td>
<td>14.4</td>
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<td>14.6</td>
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<td>3.2</td>
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<tr>
<td>2017</td>
<td>3.1</td>
<td>14.7</td>
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<tr>
<td>2018</td>
<td>2.9</td>
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<tr>
<td>2019</td>
<td>3.1</td>
<td>14.8</td>
</tr>
<tr>
<td>2020</td>
<td>3.3</td>
<td>15.1</td>
</tr>
<tr>
<td>2021</td>
<td>3.4</td>
<td>15.4</td>
</tr>
<tr>
<td>2022</td>
<td>3.7</td>
<td>16.3</td>
</tr>
<tr>
<td>2023</td>
<td>3.6</td>
<td>16.1</td>
</tr>
<tr>
<td>2024</td>
<td>3.8</td>
<td>15.9</td>
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<td>2025</td>
<td>4.0</td>
<td>16.7</td>
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<td>2026</td>
<td>4.1</td>
<td>17.1</td>
</tr>
<tr>
<td>2027</td>
<td></td>
<td>17.5</td>
</tr>
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</table>

NOTE: All amounts are for federal fiscal years; amounts are in billions and consist of mandatory Medicare spending minus income from premiums and other offsetting receipts.

SOURCE: Congressional Budget Office, An Update to the Budget and Economic Outlook, 2017 to 2027 (June 2017).
Medicare Spending by Sponsor (1987-2016) (amounts in billions)
Medicare Spending (1987-2016)
Annual Percentage Change

ACA Reduces Medicare Spending

Figure 3

The Affordable Care Act helped to reduce Medicare spending growth in the years following its enactment.

<table>
<thead>
<tr>
<th>Total Medicare spending</th>
<th>Medicare per capita spending</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.0%</td>
<td>7.4%</td>
</tr>
<tr>
<td>4.4%</td>
<td>1.4%</td>
</tr>
</tbody>
</table>


SOURCE: Kaiser Family Foundation analysis of Medicare spending data from Boards of Trustees.
What if the ACA was Repealed?

Figure 4
Repealing the ACA would increase Medicare spending by more than $800 billion over 10 years

Amounts in $ billions:

<table>
<thead>
<tr>
<th>Year</th>
<th>without ACA repeal</th>
<th>with ACA repeal</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>$588</td>
<td>$611</td>
</tr>
<tr>
<td>2017</td>
<td>$592</td>
<td>$626</td>
</tr>
<tr>
<td>2018</td>
<td>$590</td>
<td>$634</td>
</tr>
<tr>
<td>2019</td>
<td>$654</td>
<td>$712</td>
</tr>
<tr>
<td>2020</td>
<td>$701</td>
<td>$770</td>
</tr>
<tr>
<td>2021</td>
<td>$755</td>
<td>$837</td>
</tr>
<tr>
<td>2022</td>
<td>$849</td>
<td>$949</td>
</tr>
<tr>
<td>2023</td>
<td>$874</td>
<td>$987</td>
</tr>
<tr>
<td>2024</td>
<td>$897</td>
<td>$1,023</td>
</tr>
<tr>
<td>2025</td>
<td>$995</td>
<td>$1,148</td>
</tr>
</tbody>
</table>

SOURCE: Congressional Budget Office, Budget and Economic Outlook: 2017 to 2027 (January 2016), Table 1-2; Budgetary and Economic Effects of Repealing the Affordable Care Act (June 2015), Table 4.
Medicare Advantage Premiums

- The average MA-PD enrollee pays a monthly premium of about $36 in 2017, about $1 per month less than in 2016.
- Average premiums range from $28 per month for HMO enrollees to $55 per month for local PPO enrollees and $41 per month for regional PPO enrollees.
- In 2017, as in prior years, most Medicare beneficiaries (81%) had a choice of at least one “zero premium” MA-PD.
  - Among MA-PD enrollees with access to a zero premium plan, only about half (52%) are enrolled in such a plan.
  - More than one-quarter (26%) of MA-PD enrollees with access to a zero premium plan are in plans with premiums of $50 per month or more, including 10 percent with premiums of $100 per month or more.
Figure 11

Weighted average monthly premiums for Medicare Advantage Prescription Drug plan enrollees vary across the country

Ten States with the Lowest and Ten States with the Highest Average Monthly Premiums, 2017

NOTE: Excludes SNPs, employer-sponsored group plans, demonstrations, PACE plans, and plans for special populations. Includes only Medicare Advantage plans that offer Part D benefits. Excludes beneficiaries with unknown county addresses and beneficiaries in territories other than Puerto Rico. SOURCE: Authors’ analysis of CMS’s Landscape Files and March Enrollment files for 2017.
Medicare Advantage Out-of-Pocket Limits

Out-of-pocket limits for Medicare Advantage Prescription Drug plan enrollees have increased between 2011 and 2017

NOTE: Excludes special needs plans (SNPs) and employer group health plans. Percentages may not sum to 100% due to rounding. In 2017, plans with 4% of enrollees were missing information about out-of-pocket limits. Includes only Medicare Advantage plans that offer Part D benefits. SOURCE: Authors’ analysis of CMS Medicare Advantage enrollment and landscape files, 2011-2017.
Part D Deductibles

Figure 13

Average Part D deductibles for Medicare Advantage Prescription Drug plan enrollees have increased, 2011-2017

NOTE: Excludes special needs plans (SNPs) and employer group health plans. SOURCE: Authors’ analysis of CMS Medicare Advantage enrollment and landscape files, 2011-2017.
Market Strategy Trends
Poll: What is the biggest external influence that will directly impact the Medicare Advantage program going forward?
What is the biggest external influence that will directly impact the Medicare Advantage program going forward?

- The 2020 Election: 12%
- RepealReplace of ACA: 16%
- CBO projection of the Medicare Trust: 8%
- Baby Boomers: 62%
- Other: 3%
The PCP Conundrum

- 1500 patients is a fair upper limit for a PCP to get to know his/her patients over many years
- 1000 leads to getting better care
- PCP needs 2500 patients and around 25 visits per day to cover overhead and income around $175,000
- MA program limits number of patients per physician to 400
  - Good care
  - Increased patient satisfaction
  - Keep the total cost of care lower than local and national levels

- Clearly, this leads to the current shortage we are seeing of the number of PCPs
# State of the Medicare Advantage Industry

## Figure 9: Medicare Advantage National Average Part C Benefit Design

### General Enrollment Plans

<table>
<thead>
<tr>
<th>Year</th>
<th>All Members</th>
<th>PCP Copay</th>
<th>PCP Coinsurance</th>
<th>SCP Copay</th>
<th>SCP Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Enrollment</td>
<td>Out-of-Pocket Max</td>
<td>Deductible</td>
<td>Enrollment</td>
<td>Copay</td>
</tr>
<tr>
<td>2014</td>
<td>10,209,990</td>
<td>$4,920</td>
<td>$13.57</td>
<td>10,186,534</td>
<td>$10.55</td>
</tr>
<tr>
<td>2015</td>
<td>10,871,409</td>
<td>$5,115</td>
<td>$10.35</td>
<td>10,818,202</td>
<td>$10.44</td>
</tr>
<tr>
<td>2016</td>
<td>11,540,223</td>
<td>$5,293</td>
<td>$10.55</td>
<td>11,488,032</td>
<td>$9.66</td>
</tr>
<tr>
<td>2017</td>
<td>12,178,620</td>
<td>$5,302</td>
<td>$12.46</td>
<td>12,155,437</td>
<td>$9.29</td>
</tr>
<tr>
<td>2018</td>
<td>12,819,621</td>
<td>$5,270</td>
<td>$14.15</td>
<td>12,786,793</td>
<td>$8.55</td>
</tr>
</tbody>
</table>

### Five-Year Analysis

### Year-Over-Year Change

<table>
<thead>
<tr>
<th></th>
<th>Enrollment</th>
<th>Out-of-Pocket Max</th>
<th>Deductible</th>
<th>PCP Enrollment</th>
<th>PCP Copay</th>
<th>PCP Coinsurance</th>
<th>SCP Enrollment</th>
<th>SCP Copay</th>
<th>SCP Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014 TO 2015</td>
<td>661,419</td>
<td>$194.29</td>
<td>-$3.22</td>
<td>631,668</td>
<td>-$0.11</td>
<td>29,751</td>
<td>0.79%</td>
<td>640,301</td>
<td>$1.68</td>
</tr>
<tr>
<td>2015 TO 2016</td>
<td>668,814</td>
<td>$177.94</td>
<td>$0.20</td>
<td>669,830</td>
<td>-$0.78</td>
<td>-1,016</td>
<td>0.79%</td>
<td>660,279</td>
<td>$0.79</td>
</tr>
<tr>
<td>2016 TO 2017</td>
<td>638,397</td>
<td>$9.07</td>
<td>$1.91</td>
<td>668,405</td>
<td>-$0.38</td>
<td>-30,008</td>
<td>0.09%</td>
<td>655,641</td>
<td>$0.38</td>
</tr>
<tr>
<td>2017 TO 2018</td>
<td>641,001</td>
<td>-$31.25</td>
<td>$1.69</td>
<td>630,356</td>
<td>-$0.74</td>
<td>10,645</td>
<td>0.00%</td>
<td>637,076</td>
<td>-$0.08</td>
</tr>
</tbody>
</table>

**Milliman**

56
State of the Medicare Advantage Industry

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

**GENERAL ENROLLMENT PLANS**

<table>
<thead>
<tr>
<th>YEAR</th>
<th>ENROLLMENT</th>
<th>PREVENTIVE DENTAL</th>
<th>COMPREHENSIVE DENTAL</th>
<th>VISION EXAMS</th>
<th>VISION HARDWARE</th>
<th>NEMT</th>
<th>HEARING EXAMS</th>
<th>HEARING AIDS</th>
<th>OTC DRUG CARD</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>10,209,990</td>
<td>38.7%</td>
<td>19.8%</td>
<td>86.0%</td>
<td>53.5%</td>
<td>18.6%</td>
<td>58.2%</td>
<td>39.4%</td>
<td>22.6%</td>
</tr>
<tr>
<td>2015</td>
<td>10,871,409</td>
<td>47.5%</td>
<td>23.2%</td>
<td>92.1%</td>
<td>59.5%</td>
<td>19.9%</td>
<td>61.3%</td>
<td>43.2%</td>
<td>26.2%</td>
</tr>
<tr>
<td>2016</td>
<td>11,540,223</td>
<td>52.1%</td>
<td>25.3%</td>
<td>93.2%</td>
<td>63.7%</td>
<td>20.5%</td>
<td>69.7%</td>
<td>47.6%</td>
<td>27.7%</td>
</tr>
<tr>
<td>2017</td>
<td>12,178,620</td>
<td>55.5%</td>
<td>26.9%</td>
<td>93.1%</td>
<td>63.4%</td>
<td>20.6%</td>
<td>75.3%</td>
<td>57.4%</td>
<td>40.0%</td>
</tr>
<tr>
<td>2018</td>
<td>12,819,621</td>
<td>58.7%</td>
<td>29.9%</td>
<td>93.6%</td>
<td>68.7%</td>
<td>20.6%</td>
<td>82.6%</td>
<td>66.6%</td>
<td>41.4%</td>
</tr>
</tbody>
</table>

**FIVE-YEAR ANALYSIS**

**YEAR-OVER-YEAR CHANGE**

<table>
<thead>
<tr>
<th>FROM</th>
<th>TO</th>
<th>ENROLLMENT CHANGE</th>
<th>PREVENTIVE DENTAL CHANGE</th>
<th>COMPREHENSIVE DENTAL CHANGE</th>
<th>VISION EXAMS CHANGE</th>
<th>VISION HARDWARE CHANGE</th>
<th>NEMT CHANGE</th>
<th>HEARING EXAMS CHANGE</th>
<th>HEARING AIDS CHANGE</th>
<th>OTC DRUG CARD CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>2015</td>
<td>669,830</td>
<td>8.7%</td>
<td>3.5%</td>
<td>6.1%</td>
<td>6.1%</td>
<td>1.3%</td>
<td>3.1%</td>
<td>3.8%</td>
<td>3.6%</td>
</tr>
<tr>
<td>2015</td>
<td>2016</td>
<td>668,814</td>
<td>4.7%</td>
<td>2.1%</td>
<td>1.1%</td>
<td>4.2%</td>
<td>0.6%</td>
<td>8.4%</td>
<td>4.4%</td>
<td>1.5%</td>
</tr>
<tr>
<td>2016</td>
<td>2017</td>
<td>638,397</td>
<td>3.4%</td>
<td>1.5%</td>
<td>-0.1%</td>
<td>-0.3%</td>
<td>0.1%</td>
<td>5.7%</td>
<td>9.8%</td>
<td>12.2%</td>
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<tr>
<td>2017</td>
<td>2018</td>
<td>641,001</td>
<td>3.2%</td>
<td>3.0%</td>
<td>0.5%</td>
<td>5.3%</td>
<td>0.0%</td>
<td>7.2%</td>
<td>9.2%</td>
<td>1.4%</td>
</tr>
</tbody>
</table>
## State of the Medicare Advantage Industry

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

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

- This may be considered by plans that do not want to make major changes to their offerings. An example would be a plan that does not want to offer a Chronic Special Needs Plan but still feels like they have an advantage over the management of specific conditions.

- Conditions that are currently being considered are those that may affect a relatively healthy population but still require regular medication, for example high cholesterol and high blood pressure.

- Another benefit some plans are considering is specific DME items for diabetic patients.

- Plans are still awaiting clearer guidance and documentation from CMS around uniform flexibility and therefore they make time to take advantage of this provision.

- Large health plans may have dedicated teams built around ensuring requirements are well defined and met.

- If several plans take advantage of it, this provision may gradually replace VBID.

- Provider sponsored plans could target conditions/benefits that they specialize in.

- Overall feedback was carriers are definitely considering opportunities, but some reluctance for 2019.
Recent Medicare Program Enhancements

• Medicare Diabetes Prevention Program
  • Purpose of the program
  • Description of the program and eligibility
  • Costs to Insurers

• Flexible Benefit Designs
  • Subset population within a plan
  • Common benefit designs

• Supervised Exercise Therapy for Symptomatic Peripheral Artery Disease (SET for PAD)
  • Intent and description of the program
  • Costs and benefits offered
Health Plan Considerations around the Expansion of the Definition of Supplemental Benefits

- Some Institutional Special Needs Plans may be interested in offering limited benefits related to long-term care (LTC). These benefits may include help with activities of daily living such as bathing and dressing. They may also involve subsidization of nursing room stays.
  - LTC is expensive => MA plans increase premiums => anti-selection spiral with no underwriting/prem classes

- Other benefits that have been suggested\(^1\) include:
  - Providing air conditioners for beneficiaries with asthma
  - Providing discounted access to health groceries
  - Having meals delivered to beneficiaries’ homes
  - Transportation to doctors’ offices
  - Fall prevention

- Large health plans may have dedicated teams built around ensuring requirements are well defined and met.

Health Plan Considerations around the Expansion of the Definition of Supplemental Benefits (continued)

- Supplemental benefits and making sure carriers are competitive.
  - Specifically mentioned were dental, fitness, meals, travel and OTC

- With incremental CMS funding, we would expect increased/enhanced supplemental benefits for 2019

- Some examples that were mentioned include:
  - Food programs
  - Food stamps
  - Pill boxes with electronic reminders and dispensing, utilizing bluetooth technology
  - Home safety devices
  - Wheel Chair ramps
  - Literacy programs
  - Transportation beyond physicians (i.e. grocery store)
  - Heat and A/C
  - Loneliness programs
  - Adult day care
  - Caregiver programs
  - Venture capital funding programs (Social Impact Investing)
    - Opioid treatment centers
Plan Changes to Part D Formularies

- Some plans target specific populations and tailor their formularies toward these populations. However, if considering this approach, care must be taken to avoid violation of CMS discrimination rules.

- Some plans also match lower (or zero) copays with medications that are tied to quality and adherence metrics.

- More incentives for preferred pharmacy networks if better rebates possible.
Non-Medicare Drug Coverage by Plans

- This may be centered on giving beneficiaries more choice. For example, beneficiaries may be provided with a catalog of OTC benefits from which they can choose what they want covered.

- Large pharmacies such as CVS and Walgreens would provide this coverage in order to get more customers into their stores.

- Other benefits offered may include generic Viagra (4 pills per month).
Overall Trends and Other Issues
New Initiatives Around Risk Adjustment

- Plans are starting to focus more on improving their EDS risk scores with the realization that they may have maximized what they can do with RAPS and that eventually, EDS will be fully implemented.

- Plans are seeking this improvement in risk scores by encouraging contact with patients whenever possible in order to take advantage of coding opportunities. For example, through annual wellness visits and providing rewards for filling out health risk assessments. In addition, in-office coders are increasingly being used.

- Some plans are also taking advantage of the extension of the 2017 payment year submission deadlines and are seeing improvement in their risk scores because of this.

- Other plans are reaching the point where they are maxed out on risk score coding and they aren’t expecting any big improvements going forward.
New Initiatives Around Risk Adjustment

Characteristics of CMS-HCC Model

- HCC's / Multiple Chronic Diseases
- Disease Interactions
- Diagnostic Sources
- Prospective in Nature
- Demographics
Risk-Sharing Agreements

• What is a risk-sharing agreement?
  • Variations by area of the country

• Types of risk sharing?
  • Percentage of HBR
  • Global capitation as percentage of MA bid
  • Partial capitation (services omitted)
  • Part C and Part D global capitation

• Actuarial Modeling of risk-sharing
  • What to consider?
  • Cost-projections and drivers

• Encounters versus FFS data

• Provider contracting and challenges faced
  • PSP plans with risk-sharing
Other Trends

- There are increased instances of provider risk sharing in which providers partner with health plans. This is seen as less risky by providers when compared to offering their own MA plans. Providers are becoming more savvy and could start pushing back for higher risk sharing terms.

- Growth in provider sponsored plans although some national hospital chains are selling off their plans due to high losses.

- Tiered networks are also being considered by more plans. In such networks, the “preferred” tier would have lower contracting rates and have enhanced member benefits.

- Some other ideas that have been discussed to increase revenue and reduce costs include:
  - Improving STAR and other quality ratings through increasing medication adherence, reducing falls and using in-home visits to reduce hospital and ER admissions.
  - Use of advance directives and palliative care in order to reduce high end-of-life costs
  - Educating members about the appropriate level of care
  - Moving out of high cost service areas
  - Improving utilization management, for example by hiring vendors that specialize in it
Medicare Advantage STAR Ratings

Figure 14

Almost two-thirds of Medicare Advantage enrollees are in contracts with ratings of 4 or more stars in 2017

Enrollment in Medicare Advantage Contracts, by Star Quality Rating, 2013-2017

<table>
<thead>
<tr>
<th>Year</th>
<th>5 Stars</th>
<th>4.5 Stars</th>
<th>4 Stars</th>
<th>3.5 Stars</th>
<th>3 Stars</th>
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<td>22%</td>
<td>66%</td>
<td>31%</td>
<td>11%</td>
<td>3%</td>
</tr>
</tbody>
</table>

NOTE: Excludes SNPs, employer-sponsored (i.e., group) plans, demonstrations, HCPCS, PACE plans, and plans for special populations. Totals may not add to 100% due to rounding. Less than 1% of enrollees were in plans with 2 stars in 2013 and 2014.

IT TAKES VISION.
Thank you

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