Medicare Advantage enrollment: Growth expectations for new organizations

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Introduction

Enrollment growth is one of the most important considerations in the early years of a start-up Medicare Advantage (MA) organization (MAO). Indeed, it might be the most important consideration. Enrollment impacts an MAO's revenue and profitability and is a key driver to becoming successful.[1] For these reasons, enrollment projections are a critical component of a new MAO's financial pro forma. However, enrollment assumptions are often difficult to develop, especially for a new MAO without any prior experience.

To better inform enrollment expectations for new MAOs, we analyzed historical enrollment experience for parent organizations new to the MA market from 2007 to 2018. We summarized results annually from an MAO's initial start-up year to its seventh year of operations (where available) and segmented this experience by population type and size. This past experience may be useful in developing future projections for new MAO enrollment growth.

1 See Appendix A for a discussion of enrollment impacts.

Results

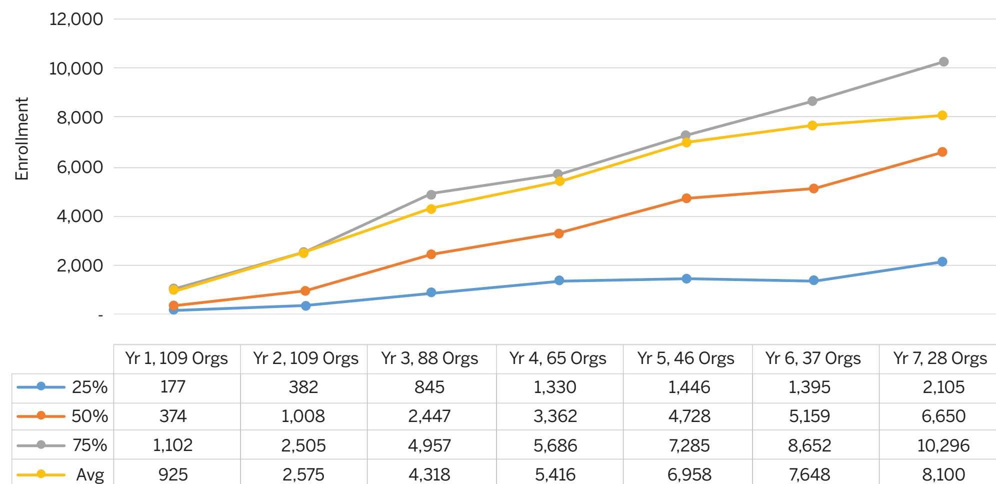
We reviewed 2007 to 2018 enrollment by duration across 109 parent organizations entering the MA market between 2007 and 2017.[2] We calculated the average enrollment as well as the 25th, 50th, and 75th percentiles for each duration year. Note it is important to consider the credibility of each data point. As we separated the data into various segments, the number of organizations and corresponding credibility of each data point decreased.

ENROLLMENT INCREASED WITH MATURITY, BUT VARIED WIDELY

Average enrollment increased consistently as organizations matured, as shown in Figure 1. Average enrollment nearly tripled from year 1 to year 2. The Centers for Medicare and Medicaid Services (CMS) restricts new organizations from expanding their service areas and plan types in their second year. The observed enrollment growth in year 2 suggests organizations grew their membership within their initial footprint and plan types. New organizations are permitted to expand their service areas in year 3 and beyond with CMS approval. Subsequent average enrollment continued to increase, with the average enrollment in year 7 reaching nearly nine times the initial enrollment.

2 We excluded organizations with only one year of experience, which limits the analysis to only organizations entering the MA market through 2017.

FIGURE 1: ENROLLMENT BY DURATION



	Yr 1, 109 Orgs	Yr 2, 109 Orgs	Yr 3, 88 Orgs	Yr 4, 65 Orgs	Yr 5, 46 Orgs	Yr 6, 37 Orgs	Yr 7, 28 Orgs
25%	177	382	845	1,330	1,446	1,395	2,105
50%	374	1,008	2,447	3,362	4,728	5,159	6,650
75%	1,102	2,505	4,957	5,686	7,285	8,652	10,296
Avg	925	2,575	4,318	5,416	6,958	7,648	8,100

Initial enrollment varied widely, with smaller organizations (represented by the 25th percentile) achieving average enrollment of 177 members and larger organizations (represented by the 75th percentile) achieving average enrollment of 1,102 members in the first year. This gap between the 25th and 75th percentiles was maintained as organizations matured, with enrollment at both percentiles increasing with duration.

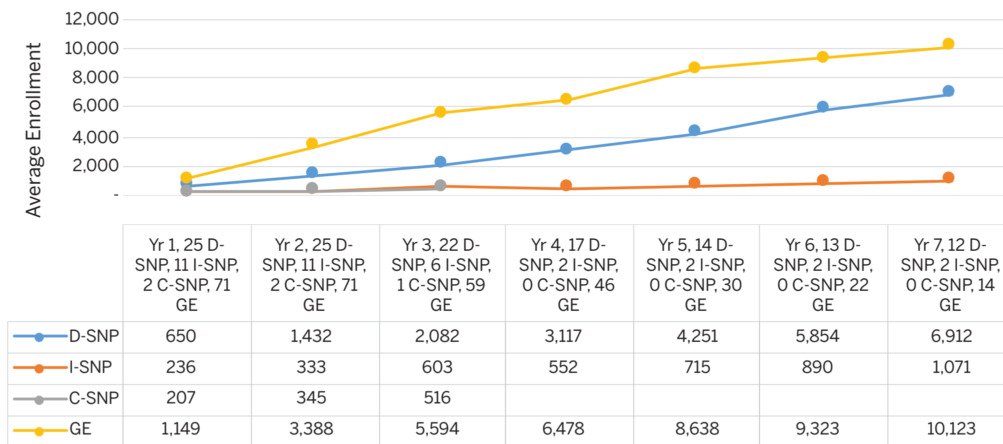
GENERAL ENROLLMENT ORGANIZATIONS ACHIEVED THE LARGEST INITIAL ENROLLMENT

General enrollment (GE) organizations achieved the highest initial enrollment, as shown in Figure 2, and were significantly larger than Dual Special Needs Plan (D-SNP), Institutional Special Needs Plan (I-SNP), and Chronic Special Needs Plan (C-SNP) organizations. Average enrollment for all population types increased with maturity. GE and D-SNP organizations realized average enrollment in year 7 that was roughly nine and 11 times their initial enrollment, respectively. I-SNP and C-SNP organizations achieved much lower initial enrollment, likely due to highly targeted population approaches. Both I-SNP and C-SNP organizations more than doubled enrollment from the initial year to third year, and I-SNP organizations more than quadrupled enrollment by the seventh year.

SMALL ORGANIZATIONS ACHIEVED SIGNIFICANT GROWTH WITH MATURITY

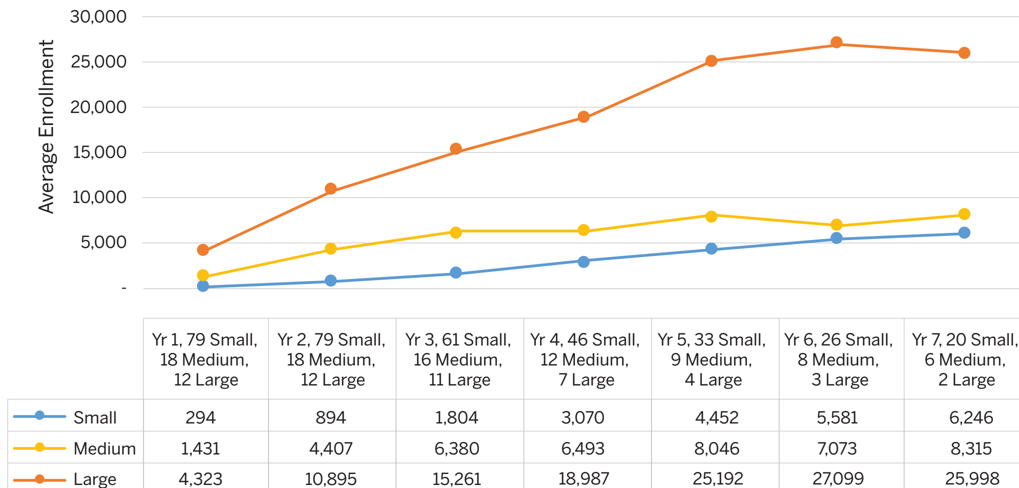
Small organizations increased average enrollment by a factor of over 20 from year 1 to year 7. Medium and large organizations increased average enrollment at a much slower rate of about sixfold, with large organizations experiencing a slight tapering of average membership in year 7. These differing growth rates result in average enrollment for small organizations nearly catching up to average enrollment for medium organizations by year 7. Large organizations, while growing at a slower rate, achieved an average year 7 enrollment that is about four and three times the average enrollment of small and medium organizations, respectively.

FIGURE 2: AVERAGE ENROLLMENT BY DURATION AND POPULATION TYPE



	Yr 1, 25 D-SNP, 11 I-SNP, 2 C-SNP, 71 GE	Yr 2, 25 D-SNP, 11 I-SNP, 2 C-SNP, 71 GE	Yr 3, 22 D-SNP, 6 I-SNP, 1 C-SNP, 59 GE	Yr 4, 17 D-SNP, 2 I-SNP, 0 C-SNP, 46 GE	Yr 5, 14 D-SNP, 2 I-SNP, 0 C-SNP, 30 GE	Yr 6, 13 D-SNP, 2 I-SNP, 0 C-SNP, 22 GE	Yr 7, 12 D-SNP, 2 I-SNP, 0 C-SNP, 14 GE
D-SNP	650	1,432	2,082	3,117	4,251	5,854	6,912
I-SNP	236	333	603	552	715	890	1,071
C-SNP	207	345	516				
GE	1,149	3,388	5,594	6,478	8,638	9,323	10,123

FIGURE 3: AVERAGE ENROLLMENT BY DURATION AND SIZE



	Yr 1, 79 Small, 18 Medium, 12 Large	Yr 2, 79 Small, 18 Medium, 12 Large	Yr 3, 61 Small, 16 Medium, 11 Large	Yr 4, 46 Small, 12 Medium, 7 Large	Yr 5, 33 Small, 9 Medium, 4 Large	Yr 6, 26 Small, 8 Medium, 3 Large	Yr 7, 20 Small, 6 Medium, 2 Large
Small	294	894	1,804	3,070	4,452	5,581	6,246
Medium	1,431	4,407	6,380	6,493	8,046	7,073	8,315
Large	4,323	10,895	15,261	18,987	25,192	27,099	25,998

Please see appendices B-G for additional summaries of historical experience by organization type.

Methodology

We summarized publicly available enrollment and plan information released by CMS from January 2007 through December 2018. We created a database with experience for 109 parent organizations containing the following:

- Parent organization.
- Parent organization start date: Based on the start date for the first contract offering for the parent organization.
- Calendar year.
- Duration year: The number of years since the MAO first began (i.e., year 1 = initial year).
- Average enrollment: Calculated as the average for each calendar year from 2007 through 2018.
- Population type: Identified as a parent organization consisting of primarily D-SNP, C-SNP, I-SNP, or GE in its first year. (This means an organization identified as primarily GE may also offer SNPs. Similarly, organizations identified as primarily D-SNP, C-SNP, or I-SNP population types may also offer GE plans.)
- Size: "Large" parent organizations have at least an average of 2,500 members in their first year of operations. "Medium" parent organizations have between 1,000 and 2,499 average members in their first year of operations. "Small" parent organizations have fewer than 1,000 average members in their first year of operations.

We created the database described above from the following CMS data files:

- Monthly Enrollment by Contract files:[3] We summarized January 2007 through December 2018 enrollment. We calculated the enrollment for each contract as the sum of the individual and Employer Group Waiver Plan (EGWP) enrollment. We excluded the following contract types: Prescription Drug Plans (PDP), Programs of All-Inclusive Care for the Elderly (PACE), Cost, Medicare-Medicaid Plan (MMP), Medical Savings Account (MSA), and Private Fee-for-Service (PFFS).
- SNP Data files:[4] We used these files to identify enrollment on select plans including D-SNP, C-SNP, and I-SNP. We defined all other enrollment as GE. We aggregated this information to the parent organization level, and then assigned an overall population indicator to each parent organization with 90% or more of its first year enrollment assigned to D-SNP, C-SNP, or I-SNP. Otherwise, we identified the parent organization as GE at initial start-up.

We reviewed the CMS files for completeness and reasonableness and made several assumptions in preparing our summarized database:

- We included parent organizations beginning operations between January 2007 and December 2017 and having more than one year of experience.[5] We accounted for parent organizations changing names over the analysis period (e.g., merged with another organization) by mapping the prior parent organization name to the new parent organization name.
- We assumed enrollment equal to zero for contracts with fewer than 10 members in a given month (identified by an asterisk in the source CMS files).
- Population type information was available starting in May 2007 in the source CMS files. Therefore, we assumed the January 2007 through April 2007 population type was equal to the May 2007 population type.
- We removed experience for four outlier parent organizations.[6]

Conclusion

Our analysis demonstrates it is possible to achieve sizeable enrollment early on. However, there is a wide range around historical enrollment experience at all durations. Consideration needs to be given to the type of population the plan is targeting when forecasting year 1 enrollment and subsequent growth. Organizations beginning their operations with significant enrollment stand to gain a larger market share in the coming years than organizations initially coming to market with smaller enrollment.

The historical experience presented in this analysis may assist potential entrants into the MA market in developing enrollment assumptions for pro forma statements, state licensure applications, and internal budgets. MA entrants should have realistic expectations of enrollment projections, as we have often observed new MAOs projecting large starting enrollment and subsequent enrollment growth that do not materialize. Successful MAOs will set realistic enrollment assumptions and implement organizational activities, target premiums, and benefit plans supporting these enrollment targets. This sounds simple but, in practice, complete alignment across an MAO is required to project and achieve sizeable and realistic enrollment growth.

3 CMS. Monthly Enrollment by Contract. Retrieved May 2, 2019, from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-Enrollment-by-Contract.html.

4 CMS. Special Needs Plan (SNP) Data. Retrieved May 2, 2019, from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Special-Needs-Plan-SNP-Data.html.

5 All organizations involved in MA before 2007 (including some national organizations) and organizations starting January 2018 and later are excluded. Experience for organizations terminating operations during the experience period is included.

6 Three organizations exhibited enrollment growth of more than 3,000% in a year and one organization converted a significant amount of its prior Cost plan membership to its new MA contract.

Caveats, qualifications, and limitations

Kelly S. Backes and Julia M. Friedman are consulting 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 paper is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices.

The material in this paper 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 paper is designed to provide historical Medicare Advantage enrollment experience and discussion of enrollment impacts on Medicare Advantage organization performance. It may not be appropriate, and should not be used, for other purposes.

The validity of certain comparisons provided in this paper may be limited, particularly where the number of organizations, enrollment, and/or credibility in data segments is low. Additionally, future enrollment performance for any one organization will vary from the historical experience provided in this report.

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.

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Appendix A

Why is enrollment growth important?

There are a number of reasons why enrollment growth is an important factor in achieving ultimate profitability. Outlined below are a few important considerations for start-up MAOs.

LOWERS ADMINISTRATIVE COSTS ON A PER MEMBER PER MONTH (PMPM) BASIS

New MAOs typically have very high initial start-up administrative costs in the first few years of operations. This oftentimes results in losses in the early years when fixed expenses are high and enrollment has not yet reached a level to support the expenses. As enrollment increases, these fixed administrative costs—which CMS refers to as non-benefit expense (NBE)—can be spread over a larger enrollment base. For example, a fixed cost of $500,000 for building occupancy expenses is more palatable when spread over 100,000 member months, or 8,333 average members ($5 PMPM), than over 10,000 member months, or 833 average members ($50 PMPM). This provides a significant incentive for new MAOs to develop attractive products and employ targeted marketing efforts to try to quickly increase enrollment.

POTENTIALLY SATISFIES CMS ENROLLMENT THRESHOLDS

Plans[7] covering fewer than 500 enrollees for a non-SNP and fewer than 100 members for a SNP for three or more consecutive years may be terminated by CMS. MAOs setting and achieving enrollment targets above these CMS thresholds will avoid potential CMS termination.

MAY INCREASE REVENUE VIA THE OVERALL QUALITY STAR RATING

MAOs receive the majority of their revenue from the federal government. The amount of this federal revenue is based on a number of factors, including the MAO's estimated revenue requirement to provide traditional Medicare services (also known as the MA bid), service area, risk score, and overall quality star rating. A new MAO is assigned the "New Contract" star rating for the first three years of operations, with a 3.5% bonus payment (7% bonus payment in qualifying counties) in its federal revenue calculation. In the fourth year, an MAO's star rating will be calculated based on its own experience only if the minimum requirements for a specified number of star rating measures are met, many of which are related to enrollment.[8] An MAO's star rating could result in a 5% bonus payment (10% bonus payment in qualifying counties) for 4.0 and higher stars (out of 5.0) and a 0% bonus payment for less than 4.0 stars. If the minimum requirements for star rating measures are not met, the MAO will be assigned the "Low Enrollment" star rating, which results in a 3.5% bonus payment (7% bonus payment in qualifying counties). The urgency to increase enrollment to potentially achieve bonus payments is further exacerbated by the fact that the star rating for a given year is determined by the enrollment and experience from roughly three years prior. Therefore, new MAOs are incentivized to increase enrollment quickly to best position themselves for the possibility of achieving a 5% bonus payment as soon as possible.[9]

NEW MA ORGANIZATIONS CANNOT EXPAND SERVICE AREAS IN YEAR 2

CMS has issued guidance that organizations new to MA "will not be permitted to expand their service areas or product types until the organization has accumulated at least 14 months of performance experience."[10] Therefore, for new entrants into the market, this is an important consideration when planning enrollment targets for the first few years of operations.

MAY STABILIZE CLAIMS FLUCTUATIONS

An MAO with a large membership base will generally experience less variation in medical and pharmacy costs year to year, per the law of large numbers. As enrollment grows, medical and pharmacy costs are expected to stabilize. This allows for less variation in profit margin year to year, reduces the cost associated with purchasing reinsurance coverage, and improves the accuracy of pro formas and internal budget development.

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7 In this context, "plan" is defined at the plan benefit package level, not the organization level.

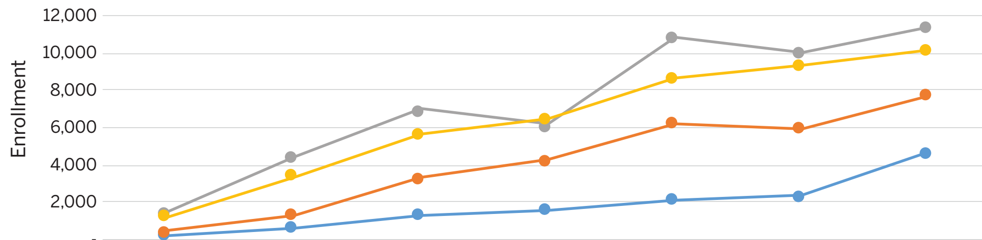
8 CMS. Part C and D Performance Data. Retrieved May 2, 2019, from https://www.cms.gov/medicare/prescription-drug-coverage/prescriptiondrugcovgenin/performancedata.html.

9 Higher star ratings will also result in higher rebate percentages used in the federal revenue calculation (in addition to the bonus payment).

10 Amy Larrick Chavez-Valdez, Director of the Medicare Drug Benefit and C and D Data Group, & Kathryn A. Coleman, Director of the Medicare Drug and Health Plan Contract Administration Group (February 7, 2018). CMS memorandum: 2019 Application Cycle Past Performance Review Methodology Final.

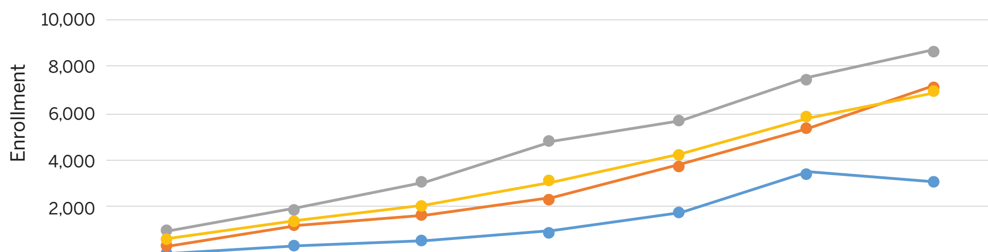
Appendices B through D: Enrollment by year for general enrollment, D-SNP, and I-SNP organizations

APPENDIX B: ENROLLMENT BY YEAR FOR GENERAL ENROLLMENT ORGANIZATIONS



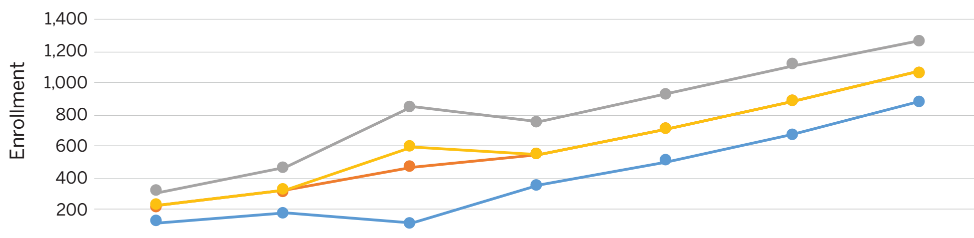
	Yr 1, 71 Orgs	Yr 2, 71 Orgs	Yr 3, 59 Orgs	Yr 4, 46 Orgs	Yr 5, 30 Orgs	Yr 6, 22 Orgs	Yr 7, 14 Orgs
25%	190	609	1,285	1,589	2,152	2,352	4,683
50%	437	1,345	3,311	4,222	6,224	5,978	7,737
75%	1,422	4,468	7,013	6,178	10,891	10,081	11,454
Avg	1,149	3,388	5,594	6,478	8,638	9,323	10,123

APPENDIX C: ENROLLMENT BY YEAR FOR D-SNP ORGANIZATIONS



	Yr 1, 25 Orgs	Yr 2, 25 Orgs	Yr 3, 22 Orgs	Yr 4, 17 Orgs	Yr 5, 14 Orgs	Yr 6, 13 Orgs	Yr 7, 12 Orgs
25%	84	369	604	965	1,806	3,469	3,118
50%	364	1,268	1,718	2,412	3,793	5,374	7,216
75%	1,056	1,980	3,090	4,831	5,705	7,531	8,724
Avg	650	1,432	2,082	3,117	4,251	5,854	6,912

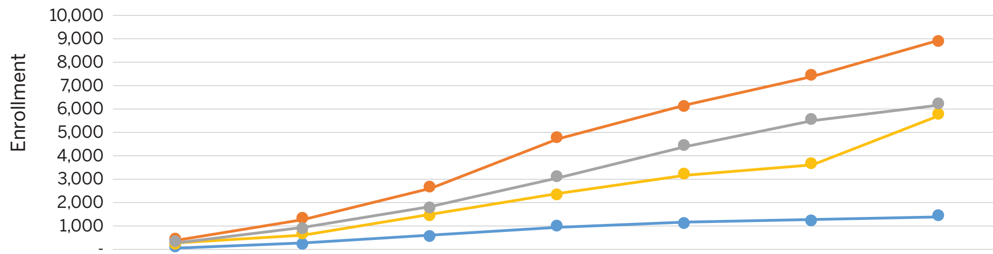
APPENDIX D: ENROLLMENT BY YEAR FOR I-SNP ORGANIZATIONS



	Yr 1, 11 Orgs	Yr 2, 11 Orgs	Yr 3, 6 Orgs	Yr 4, 2 Orgs	Yr 5, 2 Orgs	Yr 6, 2 Orgs	Yr 7, 2 Orgs
25%	120	179	117	356	502	669	877
50%	226	322	471	552	715	890	1,071
75%	311	462	845	749	929	1,111	1,265
Avg	236	333	603	552	715	890	1,071

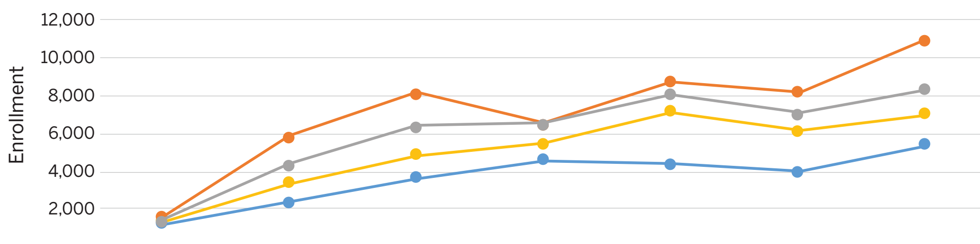
Appendices E through G: Enrollment by year for small, medium, and large organizations

APPENDIX E: ENROLLMENT BY DURATION FOR SMALL ORGANIZATIONS



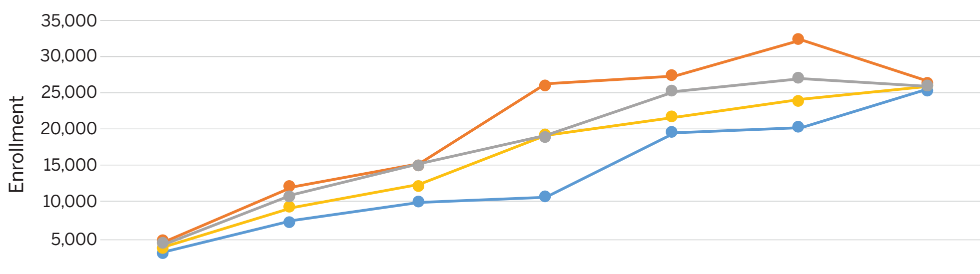
	Yr 1, 79 Orgs	Yr 2, 79 Orgs	Yr 3, 61 Orgs	Yr 4, 46 Orgs	Yr 5, 33 Orgs	Yr 6, 26 Orgs	Yr 7, 20 Orgs
25%	89	274	597	950	1,140	1,268	1,433
50%	251	616	1,455	2,379	3,187	3,663	5,760
75%	429	1,314	2,640	4,791	6,164	7,457	8,981
Avg	294	894	1,804	3,070	4,452	5,581	6,246

APPENDIX F: ENROLLMENT BY DURATION FOR MEDIUM ORGANIZATIONS



	Yr 1, 18 Orgs	Yr 2, 18 Orgs	Yr 3, 16 Orgs	Yr 4, 12 Orgs	Yr 5, 9 Orgs	Yr 6, 8 Orgs	Yr 7, 6 Orgs
25%	1,215	2,349	3,663	4,585	4,399	3,990	5,412
50%	1,379	3,342	4,852	5,448	7,132	6,089	6,986
75%	1,611	5,862	8,144	6,510	8,745	8,225	10,916
Avg	1,431	4,407	6,380	6,493	8,046	7,073	8,315

APPENDIX G: ENROLLMENT BY DURATION FOR LARGE ORGANIZATIONS



	Yr 1, 12 Orgs	Yr 2, 12 Orgs	Yr 3, 11 Orgs	Yr 4, 7 Orgs	Yr 5, 4 Orgs	Yr 6, 3 Orgs	Yr 7, 2 Orgs
25%	3,208	7,483	10,079	10,742	19,570	20,310	25,442
50%	3,883	9,395	12,339	19,270	21,730	24,013	25,998
75%	4,744	12,253	15,200	26,074	27,353	32,345	26,555
Avg	4,323	10,895	15,261	18,987	25,192	27,099	25,998