2019 Medicare Advantage Growth Outlook

Leverage supplemental benefits for Medicare Advantage growth
Executive summary
Eliminate product selection hurdles to drive growth using supplemental benefits

Expanding growth opportunities drive greater competition.
Medicare Advantage (MA) plan enrollments have grown steadily and now covers one-third of all Medicare beneficiaries. While health plans are eager to take advantage of the favorable reimbursement and relaxed benefits policies under MA plans, the recently expanded open enrollment period and increased number of products available to consumers further stiffens plan competition for enrollees.

Traditional growth strategies reaching limits.
Traditional plan levers for product differentiation using price and quality are reaching their limits as close to 90% of MA enrollees have access to zero-premium plans and 74% are enrolled in 4+ star-rated plans. In contrast, only 7% of plan products offer supplemental benefits.

Alleviate product selection challenges to drive growth using supplemental benefits.
But despite this untapped opportunity, plans leave enrollees to face a number of challenges as they select MA products with supplemental benefits. Enrollees don’t know their own future non-medical needs and find benefit information confusing—yet products with supplemental benefits have robust utilization restrictions.

To drive enrollment growth using supplemental benefits, plans must simplify the product selection process by alleviating the challenges MA enrollees face as they select and use their benefits. Plans must narrow the list of products enrollees have to choose from and pare down the tasks needed to use their benefits.

Two solutions to enrollee challenges during enrollment in supplemental benefits.

<table>
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<th>Plan solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unknown future benefit needs</td>
<td>1 Narrow products options for members using historical data. Use publically available and plan-collected data on past health care utilization, overall costs, and socioeconomic needs to recommend a tailored selection of products.</td>
</tr>
<tr>
<td>Confusing benefit information</td>
<td>2 Reduce tasks required for members to use benefits. Absorb the complex member tasks necessary to use benefits, so that enrollees must complete only a few simple steps.</td>
</tr>
</tbody>
</table>

Source: Health Plan Advisory Council interviews and analysis.
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Defining the growth opportunities

- The influx of Medicare-eligible seniors and high rates of enrollee satisfaction have driven steady growth in MA enrollment.
- While changing regulatory policies offer favorable margin growth opportunities, they’ve also resulted in intensified competition among plans for enrollees.
Medicare Advantage continues record growth

Popularity is driven by satisfaction with low costs and expansive benefits

Medicare Advantage (MA) now accounts for more than one-third of the Medicare population, and record growth is expected to continue over the next decade. Experts project that 40% of the seniors will be enrolled in MA plans by 2025.

**MA enrollment to nearly double by 2025**

*Total enrollment and percentage of total Medicare population*

The rapid increase of MA penetration is partly driven by the surge in demand from the increasing population of baby boomers—roughly 10,000 people have been turning 65 every day since 2011. In addition, enrollees continue to choose MA over traditional Medicare, citing satisfaction with services covered and overall low cost of care. Unlike traditional Medicare, MA plans typically combine additional benefits such as prescription drug coverage into a single plan with low, predictable costs. This is attractive to seniors living on fixed incomes.

**Factors driving MA enrollment growth**

- **Influx of MA-eligible seniors**
  - Baby boomers have turned 65 every day since 2011

- **Satisfaction with benefits**
  - 86% Of MA enrollees are satisfied with benefits covered

- **Satisfaction with costs**
  - 80% Of MA enrollees are satisfied with costs of MA plans

As plans think about expanding and entering the MA markets, they must confront the consumer expectations and needs of the baby boomer population who may have a different approach to health care decisions than the previous generation. For example, data suggests that boomers make health care decisions more independently than previous generations. They are less likely to rely on physician recommendation and more apt to seek a second opinion elsewhere. Plans therefore must invest in other drivers of satisfaction, for example, remote access to physician-experts to increase options for second opinions.
There’s a significant opportunity to grow margins

Plans are forced to lean on performance revenue amid fluctuating rates

Alongside the increase in the number of Medicare-eligible seniors, MA also offers a significant margin opportunity. Payment rate increases have fluctuated over the past few years, but quality bonus payment revenue has risen steadily.

Quality bonus payments introduced by the Affordable Care Act (ACA) in 2010 are tied to the plan’s average star rating on consumer satisfaction and performance metrics. Plans that receive a rating of four stars or higher can increase their payments by up to 5%. CMS has continued to offer quality bonuses to high-performing plans, and over time, most plans have improved their star ratings and enrolled more beneficiaries. This has led to an overall increase in performance revenue received by MA plans—between 2015 and 2018, bonus payments to plans increased from $3.0 billion to $6.3 billion.

MA plans therefore have a significant opportunity to grow their margins, but also face relentless pressure to achieve a four- or five-star rating to continue receiving performance bonuses.

MA market share is dominated by just a few firms

Despite the attractive profit margin potential, entering the MA market can be challenging. The MA market is highly consolidated nationwide. In every state but Oregon, three firms or affiliates control more than half of the MA market share. And in 48 states, three firms control 75% or more. This is a significant barrier to entry for plans interested in launching new MA products or expanding their current offerings geographically.

**Combined market share of the three firms or affiliates with the largest number of Medicare enrollees by state, 2017**

![Map showing market share distribution](image)

<table>
<thead>
<tr>
<th>Market Share</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;50%</td>
<td>1</td>
</tr>
<tr>
<td>51%-74%</td>
<td>11</td>
</tr>
<tr>
<td>75%-89%</td>
<td>23</td>
</tr>
<tr>
<td>≥90%</td>
<td>15 and Washington DC</td>
</tr>
</tbody>
</table>

MA markets attract established and new carriers

However, there was a marked increase in the number of MA products offered and the number of new firms offering such products in 2019. Eighteen percent more products were available for enrollees to choose from nationwide, and 14 firms offered an MA product for the first time. Among the new carriers, one firm received venture capital funding, while two were launched by provider systems.

Increased participation in the MA market will likely increase plans’ need to distinguish themselves and communicate the unique aspects of their products to remain competitive.

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**Established and new carriers offer more products in 2019**

- **18%** Increase in number of plan product offerings available to consumers, 2018-2019<sup>1</sup>
- **7 ➤ 14** New carriers offering MA products in 2019, up from 7 in 2018

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<sup>1</sup> 2019 CMS PBP Filings Analysis.

Loosened restrictions extend benefit flexibility

Plans can design products to attract enrollees and address social needs

Plans can now leverage flexible benefits to members, potentially differentiating the product.

In 2018, CMS authorized plans to offer supplemental benefits that address social determinants of health and design disease-specific benefits for enrollees with chronic or high-risk conditions. Plans can adjust cost-sharing for health care services related to a member’s health conditions, and also add benefits to address social determinants of health. For example, plans can now offer reduced copays for enrollees with diabetes or provide transportation to primary care appointments.

Policy changes to benefits offered by Medicare Advantage plans for 2019

<table>
<thead>
<tr>
<th>Value-based benefit design</th>
<th>Supplemental benefit expansion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plans can design disease-specific benefits for enrollees with chronic or high-risk conditions</td>
<td>Supplemental benefits can cover services that diagnose, prevent, or improve effects of health conditions</td>
</tr>
<tr>
<td>Reduced copays for diabetic enrollees</td>
<td>Transportation to primary care appointments</td>
</tr>
<tr>
<td>Additional tobacco cessation sessions for enrollees with COPD</td>
<td>Temporary and portable mobility ramps for in-home safety</td>
</tr>
</tbody>
</table>

Expect future benefit expansion and relaxation of restrictions

Plans should expect a continued relaxation of benefit restrictions as CMS intends to continue to foster innovative benefit designs in the MA market through such policies. For instance, telehealth coverage can be offered by MA plans only as a supplemental benefit at present. But in 2020, MA plans will be able to offer it as part of a basic benefits package as well. Plans will also be able to offer telehealth services to all plan members regardless of where they live, unlike in traditional Medicare where CMS restricts telehealth to certain rural sites.

Additionally, CMS has further widened the scope of supplemental benefits MA plans can offer to chronically ill enrollees in 2020. MA plans will have the ability to offer a “non-primarily health related” items or services to chronically ill enrollees if it can improve or maintain the health or overall function of the enrollee as it relates to the chronic disease.

MA enrollees have more opportunities to switch products

Plans must guarantee a seamless experience throughout the plan year

Aside from the growing competition in the MA market, the second—and likely larger—looming challenge for plans is the increased ability for enrollees to switch between products.

CMS recently expanded the open enrollment period (OEP). Now for the first time since 2010, enrollees can switch products during the first three months of every calendar year. They can switch from one MA plan to another, or disenroll from their MA plan and return to original Medicare and a stand-alone Part D drug plan. Enrollees with buyer’s remorse, who decide that they don’t like their plan or have a negative experience, are able to make changes during this period.

However, according to the Deft member experience survey,1 most enrollees (68%) are not aware of the OEP. Among the 28% of MA enrollees who are aware of the OEP, only 5% report that they are loyal to their plan. As consumers learn about their switching opportunities, plans will likely soon see increased shopping activity during this time of the year.

Consumers deemed to be at risk2 of switching products reported negative experiences, like receiving a higher than expected bill or finding out that a drug they filled was no longer covered. Plans should remain vigilant about providing a seamless experience throughout the year or risk losing enrollees to competitors.

Majority of surveyed MA enrollees not aware of OEP

Percent of surveyed enrollees aware of OEP

<table>
<thead>
<tr>
<th></th>
<th>n=1,200 MA enrollees, 2018 Deft Survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aware of OEP but not loyal to the plan</td>
<td>23%</td>
</tr>
<tr>
<td>Aware of OEP and loyal to plan</td>
<td>5%</td>
</tr>
<tr>
<td>Not aware of OEP</td>
<td>70%</td>
</tr>
</tbody>
</table>

Potential impact of member experience frictions on switching decisions

Percentage of enrollees at risk of switching by type of experience driving desire to switch

- I was billed higher than expected: 20%
- Drug I filled is no longer covered: 16%


1) Deft Member Experience Survey of 1,200 enrollees.
2) Considered by Deft researchers to be at risk of changing plans due to their awareness of OEP and experiences that may cause dissatisfaction.
Current strategies for growth reaching limits

- Health plans that offered supplemental benefits experienced greater enrollment growth than plans that did not.
- But supplemental benefits remain largely untapped, as most plans continue to rely on standard strategies—low-cost, high-quality products—which are reaching their limits.
Supplemental benefits are linked to enrollment growth

Benefits with fewer restrictions and predictable needs drive enrollment growth

The recently expanded ability to offer supplemental benefits presents a new frontier for product differentiation, but most plans struggle to make the case investment.

To determine how offering supplemental benefits can impact enrollment growth, we compared the change in enrollment between plan products that offered supplemental benefits for plan year 2019 with those that did not (controlling for price and plan quality variation in our analysis).

Drivers of plan enrollment growth in 2019

The results showed that enrollment grew at a higher rate for products with supplemental benefits, but growth differed by type of benefit offered.

**INSIGHT 1**

Products with supplemental benefits grew their membership at a higher rate than those without. Enrollment for products with supplemental benefits in 2019 was 32%, which is 11 percentage points more than products without supplemental benefits.

**INSIGHT 2**

Supplemental benefits that enrollees can easily anticipate using, such as transportation, attracted more enrollees. Those with robust restrictions such as meal and OTC benefits did not have a significant effect on enrollment.

Average rate of enrollment growth for products with and without supplemental benefits in 2019

n=210 state-issuer combinations

<table>
<thead>
<tr>
<th>Products with supplemental benefits</th>
<th>Products without supplemental benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollment rate: 32%</td>
<td>Enrollment rate: 21%</td>
</tr>
<tr>
<td>Difference: +11 pts</td>
<td></td>
</tr>
</tbody>
</table>

Average increase in number of enrollees by type of supplemental benefit offered in 2019

n=210 state-issuer combinations

<table>
<thead>
<tr>
<th>Benefit Type</th>
<th>Increase in Number of Enrollees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transportation</td>
<td>1,866</td>
</tr>
<tr>
<td>Dental</td>
<td>878</td>
</tr>
<tr>
<td>Nicotine Replacement Therapy (NRT)</td>
<td>69 (920)</td>
</tr>
</tbody>
</table>

Features:

- **Benefits members can easily anticipate using**
- **Benefits with robust utilization restrictions**

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1) Plan product type offering within a state (e.g., Humana PPO GA).
2) Analysis controlled for price and star ratings. P-values statistically significant except meal benefits.

Supplemental benefits are largely untapped

Markets are saturated with low-cost products from high-quality plans

Most MA plans currently rely on low-cost policies and high star ratings to drive retention and enrollment growth. Yet these strategies are reaching their limits, as close to 90% of enrollees have access to zero-premium plans and 74% are enrolled in 4+ star-rated plans.

Conversely, only 7% of enrollees have access to products with supplemental benefits—far below members’ interest in these products, considering the opportunity to reduce out-of-pocket costs and meet additional needs. Given the vast number of plan options MA enrollees can choose from, plans can use supplemental benefits to craft unique products that stand out to members.

### DRIVERS OF ENROLLMENT

**Low premiums**

Members more likely to switch when faced with higher premium increase.

**Plan quality**

Members in higher rated plans less likely to switch.

### IMPACT ON ENROLLEE BEHAVIOR

**Share of MA enrollees voluntarily switching plans**

*By increase in monthly premiums, 2013-2014*

<table>
<thead>
<tr>
<th>Premium Increase</th>
<th>2013-2014 Enrollees</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0-$9.99</td>
<td>11%</td>
</tr>
<tr>
<td>$10-$19.99</td>
<td>11%</td>
</tr>
<tr>
<td>$20-$29.99</td>
<td>21%</td>
</tr>
<tr>
<td>$30-$39.99</td>
<td>24%</td>
</tr>
<tr>
<td>$40+</td>
<td>29%</td>
</tr>
</tbody>
</table>

**Share of MA enrollees voluntarily switching plans**

*By star rating of 2013 plan, 2013-2014*

<table>
<thead>
<tr>
<th>Star Rating</th>
<th>2013-2014 Enrollees</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 or 2.5</td>
<td>14%</td>
</tr>
<tr>
<td>3 or 3.5</td>
<td>12%</td>
</tr>
<tr>
<td>4 or 4.5</td>
<td>9%</td>
</tr>
<tr>
<td>5</td>
<td>3%</td>
</tr>
</tbody>
</table>

### CURRENT PLAN PERFORMANCE

**90%**

Of MA enrollees have access to zero-premium plans

**74%**

Of MA enrollees in 4+ MA-PD\(^1\) plan, 2019

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### Extra benefits

Members value supplemental benefits.

### Consumers willing to switch to products with supplemental benefits

*Member proclivity to switch to MA plan with listed benefit*

- **Dental**: 82%
- **Vision**: 72%
- **Gym**: 47%
- **Transportation**: 25%

**7%**

Of MA enrollees have access to plans with new supplemental benefits in 2019

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Source:

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Most plans are slow to embrace newly allowed benefits

By relying on strategies that have reached their limits, most plans are losing out on opportunities to drive growth using supplemental benefits. In 2019, only 41% of plans offered products with any supplemental benefits. Among health plans offering the supplemental benefits, most expanded in areas that were previously allowed, such as over-the-counter drugs (OTC). Few plans delved into the newly allowed benefits. The one exception was nicotine replacement therapy (NRT), which was most likely because of NRT’s potential ROI. A number of studies have shown the NRT can nearly double the chances of quitting smoking1 and improve health outcomes2 in the long run.

Distribution of types of supplemental benefits offered in 2019

Percentage of plans offering benefit type (among plans offering any supplemental benefits)

<table>
<thead>
<tr>
<th>Benefit Type</th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>OTC drugs</td>
<td>36%</td>
<td>63%</td>
</tr>
<tr>
<td>Meals</td>
<td>42%</td>
<td>19%</td>
</tr>
<tr>
<td>NEMT3</td>
<td>28%</td>
<td>39%</td>
</tr>
<tr>
<td>Home safety devices</td>
<td>2%</td>
<td>5%</td>
</tr>
<tr>
<td>NRT</td>
<td>47%</td>
<td></td>
</tr>
<tr>
<td>Caregiver support</td>
<td></td>
<td>13%</td>
</tr>
<tr>
<td>In-home support</td>
<td></td>
<td>3%</td>
</tr>
<tr>
<td>Social worker phone line</td>
<td></td>
<td>2%</td>
</tr>
<tr>
<td>Palliative care</td>
<td></td>
<td>1%</td>
</tr>
</tbody>
</table>

Even though most plans were initially enthusiastic about the ability to expand supplemental benefits, a few logistical hurdles deterred many from offering any of the new benefits.

Health plan challenges to offering supplemental benefits in 20194

1) Stead LF, et.al., 2008.
2) Wu D and Sin DD, 2011.
3) Non-emergent medical transportation.
4) Responses from long term quality alliance (LTQA) survey of a selection of MA plans.

Plans rely on robust usage restrictions to contain costs

Most meal benefits include copays, authorization, and low coverage limits

For the plans that immediately offered the new supplemental benefits, many were conservative with their offerings to mitigate risk.

For example, of those that offered meal benefits, 90% required copays and authorization for those benefits. Additionally, these plans often attached low quantitative limits to the number of meals and days of coverage for enrollees using the benefits.

Most plans require authorization and copays for meal benefits

Percentage of plan products requiring copay and authorization or meal benefits in 2019

n=895 plan products

- 90% Of plan products with meal benefits require copay
- 91% Of plan products with meal benefits require authorization

Meal benefit limits, 2019

Average benefit allowances

- 46 Maximum meals per coverage period
- 22 Days per coverage period

Most OTC benefit coverage amounts are relatively low and don’t carry over

Among plans that offered OTC drug benefits, the benefit amounts were relatively low—averaging between $10 and $25 each month.

Most plans also chose to offer nicotine replacement therapy under the OTC benefit, further reducing the amount of money consumers requiring NRT can spend on other OTC purchases.

Finally, most OTC benefits had “use it or lose it” limits. Only 20% of plans allowed benefits to carry over from month to month.

While restrictions on eligibility and use make actuarial sense, they may have adverse effects on uptake of products with supplemental benefits—and ultimately lead to negative member experiences.

OTC benefit coverage amounts are relatively low

Average OTC coverage amounts in 2019

n=994 plan products

- Every month: $25
- Every 3 months: $30

OTC benefit features, 2019

- 91% Plans cover NRT under OTC benefit
- 20% Plans allow unused OTC benefits to carry over

Unlocking MA growth potential using supplemental benefits

- Enrollees experience challenges during enrollment that inhibit product selection, especially not knowing their future non-medical needs and confusing benefit information.
- To drive enrollment growth using supplemental benefits, plans must alleviate those challenges by paring down tasks needed to select and use MA products.
Confusing options dissuade benefit selection and use

Consumers struggle to select, understand, and use supplemental benefits

MA plans investing in supplemental benefits must devise a comprehensive strategy to design benefits that attract enrollees without harming their experience. While there are many strategic marketing and financing considerations, plans intending to offer these benefits must address two major challenges enrollees experience as they select MA products with supplemental benefits. **Enrollees don’t know their own future benefit needs and find benefit information confusing.** Further still, enrollees have to choose from numerous product options and interpret the vast restrictions on use and eligibility.

Each year, members face new health care events that they are unable to predict in the year prior. For example, 61% of individuals incurring the highest health care costs in a given year were not the highest cost individuals in the prior year. And yet, the available tools members use most frequently to compare and choose plans that best meet their needs are unreliable. In an assessment by the National Council on Aging (NCOA), the Medicare Plan Finder tool scored a D on ability to provide customized plan choices as enrollees cannot input personal information on income or health history.¹

While most plans are aware that a significant share of enrollees do not understand benefit information, supplemental benefits come with a host of new restrictions and limitations on when and how enrollees can use them—exacerbating the existing challenges. For example, 42% of seniors cannot correctly describe a deductible or calculate their coinsurance when given a scenario and multiple choice answers to choose from, even though 90% of meal benefits require copays.

### Member characteristics and product experience hurdles that make MA enrollment and use difficult

<table>
<thead>
<tr>
<th>Member Characteristics</th>
<th>Product Experience Hurdles</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Unknown future benefit needs</strong></td>
<td><strong>Confusing benefit information</strong></td>
</tr>
<tr>
<td>Members don’t know which benefits to select since they can’t anticipate their future needs in the plan coverage year</td>
<td>Quantitative limits, cost-sharing, and restrictions are hard to understand and deter members from using plan benefits</td>
</tr>
<tr>
<td><strong>61%</strong> Of top spenders in a given year were not the top spenders in the prior year²</td>
<td><strong>42%</strong> Of seniors cannot correctly describe a deductible or calculate coinsurance</td>
</tr>
<tr>
<td><strong>D</strong> Score on ability of Medicare Plan Finder Tool to provide customized list of plan options as assessed by NCOA</td>
<td><strong>90%</strong> Of MA plans with meal benefits required authorization and copay to use the benefit</td>
</tr>
</tbody>
</table>

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¹) National Council on Aging review on Medicare Plan Finder Tool features needed to support online enrollment choices.  

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Two imperatives to alleviate consumer hurdles during product selection

To successfully drive growth using supplemental benefits, plans must **narrow the list of product options** and **reduce the number of tasks required to use those products**.

Acting on these imperatives will reduce the effort required for enrollees to select plans with supplemental benefits that suit their needs and reduce the fatigue while using these benefits. In addition to driving growth, this shift in strategy will help ensure that members are satisfied with their MA product throughout use.

**Imperatives for solving common consumer challenges during enrollment**

**CHALLENGE 1**
*Future benefit needs unknown*

**IMPERATIVE 1**

- **Narrow product options for members using historical data**

While members don’t know their future needs, health plans have access to data that can help members better predict care. Plans can use this to make the product selection easier.

Most plans have access to historical data on enrollee health care utilization, chronic care needs, and sometimes even non-medical needs. This data is often available in claims data or collected during care management programs, home visits, and other interactions between plans and members. Plans can then use this data to make meaningful recommendations on the most appropriate MA products for an enrollee’s future needs.

**CHALLENGE 2**
*Benefit information is confusing*

**IMPERATIVE 2**

- **Reduce tasks required for members to use benefits**

After selecting the most appropriate products for members, health plans should then focus on reducing the confusion and difficulty around using the different types of benefits.

With increased benefit restrictions, consumer difficulties in understanding and using their benefits are becoming even tougher. Plans should address any difficulties enrollees face as they use their benefits since members can switch products during the reinstated open enrollment period. Plans must therefore ensure that member experiences while using supplemental benefits are frictionless. And plans can do so by limiting the number of tasks a member needs to complete before using a given benefit.

Source: Health Plan Advisory Council interviews and analysis.
Humana is using data to help enrollees estimate their out-of-pocket drug costs during drug plan selection to get them to choose the best plan options. Understanding and comparing out-of-pocket costs is just one of the many complicated steps during MA product selection. And Humana can use the same data elsewhere during product selection (e.g., comparing products with supplemental benefits).

Humana’s Rx Calculator chooses a list of the top most suitable MA products for the members by using historical data on enrollee medical needs and care utilization. The tool is integrated with CMS’s Blue Button 2.0, which houses up to four years of Medicare claims and prescription drug use data.

During the drug plan enrollment process, Humana requests for member approval to use Blue Button data. Upon approval, the tool incorporates Blue Button data on the enrollee’s health care utilization, including current drug prescriptions, chronic disease history, and history of hospitalizations.

Humana’s tool uses this data to determine the most appropriate MA-PD or Part D-only plan for the enrollee. It’s important to note that enrollees can print a comparison of up to three plans, helping them focus on their best options. They can also save their drug list for future use in the tool. In addition to providing accurate plan recommendations, Humana’s Rx Calculator also provides estimates for future prescription costs without requiring members to manually enter health care utilization and prescription use history.

While Humana currently uses this tool to recommend the most appropriate drug benefit plan, other plans can similarly apply this data along with external data on social determinants of health needs to predict member needs for supplemental benefits.

Since launching Rx Calculator with Blue Button 2.0 integration, Humana has received positive feedback from members and agents. During the 2019 Annual Election Period (AEP), there were more than 30,000 uses of the tool by both sales agents and enrollees.

Value proposition to members

- Plan recommends products that fit member needs
- Accurate estimates for prescription costs
- Decrease in time required for selecting plan

Early program results

| Uses of Humana Rx Calculator by members and sales agents during 2018 Annual Election Period |
| 30K |

Positive member feedback and satisfaction while using the product

Make it easier to use OTC health plan allowance

Many Anthem-affiliated plan consumers can obtain OTC medications and health-related items through Walmart in stores, by phone, online, or in app

Plans must address any difficulties enrollees face as they actually use the benefit, because of the reinstated open enrollment period. Members can switch products within the first three month of coverage, so plans must guarantee a seamless experience using the supplemental benefits.

Anthem and Walmart jointly launched a program that enables Anthem MA enrollees to use their over-the-counter benefits to purchase OTC medications and health-related items (such as first aid supplies, support braces, and pain relievers) at Walmart’s 4,700 stores and online at Walmart.com.

The ability to shop for OTC products online is a remarkable departure from what most MA enrollees currently have to do. While most health plans understand that consumers value OTC benefits since they reduce out-of-pocket costs, if not well operationalized, OTC benefit programs can harm a member’s experience. Typically plans offer prepaid cards for OTC benefits through contracted vendors, but not every OTC product is eligible for coverage under CMS rules. This frustrates customers who don’t find out until they are at the pharmacy checkout line that the supplies in their shopping cart aren’t covered.

Anthem-Walmart OTC benefits shopping experience also leverages Walmart’s everyday low prices

To increase accessibility and guarantee a positive member experience, Anthem integrates OTC product eligibility information into Walmart's online portal and grants enrollees access to a microsite to purchase eligible OTC items. Enrollees are made aware of this option via email and through a “how to use your benefits” booklet that is sent to members through email or regular mail at the start of plan coverage.

The collaboration between Anthem and Walmart is expected to improve access to these OTC items and improve satisfaction by significantly reducing the effort required to make OTC purchases. Anthem has already noted an increase in the number of enrollees accessing the site for OTC benefits, as well as a marked increase in net promoter score (NPS).

Expected program results

- More Medicare consumers will be interested in enrolling in Anthem-affiliated plans
- Members will be more satisfied with Anthem-affiliated plans, likely improving NPS
- Members will be more likely to remain with Anthem-affiliated plans

Source: Anthem Inc., Indianapolis, IN; Health Plan Advisory Council interviews and analysis.
Conclusion

Supplemental benefits are poised to become inevitable competitive levers

Executives should consider each of the imperatives and accompanying case studies in this brief as lessons for designing products with supplemental benefits that can effectively lead to membership growth—as these benefits are poised to become the new competitive differentiators.

Driving enrollment growth will be difficult in the competitive MA market. But plans cannot afford to miss out on product differentiation using supplemental benefits, as growth strategies like lowering premiums and maintaining quality have limited returns.

To navigate the initial difficulties in offering these benefits, progressive plans eliminate the key challenges enrollees face during product selection to successfully drive their plan growth.

Two solutions to enrollee challenges during enrollment in supplemental benefits.

1. **Narrow products options for members using historical data.**
   Use publically available and plan-collected data on past health care utilization, overall costs, and socioeconomic needs to recommend a tailored selection of products.

2. **Reduce tasks required for members to use benefits.**
   Absorb the complex member tasks necessary to use benefits, so that enrollees must complete only a few simple steps.

Source: Health Plan Advisory Council interviews and analysis.
Additional resources on Medicare Advantage strategy

For more Health Plan Advisory Council resources on how to address other challenges in the Medicare Advantage line of business, refer to the publications below. All resources are available online at advisory.com.

- **The Medicare Advantage Stars Improvement Guide**
  A custom toolkit for improving stars performance

- **How to Give Providers the Data They Want**
  Three steps to better data sharing with providers to close care gaps

- **New Partnerships for Risk Adjustment Accuracy**
  Tactics to encourage provider and member behavior that supports your risk adjustment strategy

- **Top Three Insights on Medicare and Medicaid Consumers for Plans**
  Top insights from our national survey of consumers about what health care services they value most

Contact us at hpac@advisory.com for access to more resources on Medicare Advantage needs and priorities.
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