Executive Insights

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# Why Medicare Advantage Is Marching Toward 70% Penetration

Through over-reimbursement and under-reimbursement, Medicare Advantage — the first real "retail" health insurance market of scale — has consistently penetrated the Medicare marketplace over the past 20 years. And it shows no sign of slowing down.

For payers, that means finding ways to drive growth of their Medicare Advantage offering. For providers not already contracting with Medicare Advantage, it's time to bite the bullet and either figure out an effective business model or consider launching their own plan. For investors, this is a macro trend and as such, a long-term opportunity.

To be sure, the penetration rise has been measured at just 1.5 percentage points per year over the past 10 years. But accounting for recent trend and other market dynamics, L.E.K. Consulting's proprietary county-level projection model shows Medicare Advantage enrollment rising from roughly 20 million, or 35% penetration, at the end of 2017 to approximately 38 million, or 50% penetration, by the end of 2025. Nor will it stop there. Indeed, we believe that Medicare Advantage's march forward will continue apace until its penetration rate hits 70%.

Figure 1
Medicare Plan Finder comparison in Cook County, IL

| Metric | | MAPD | | Medicare Supplement | Original Medicare |
|---|---|---|---|---|---|
| | | HMO | PPO | Policy F | |
| Monthly premium* | | $0 | $0 | $111-$294 | $0 |
| Network breadth | | Plan doctors for most services | Any doctor but higher copay for OON | Any doctor | Any doctor |
| Out-of-pocket spending limit | | $3,400 | $10,000 IN and OON | None | None |
| Degree of care coordination | | High | Med | Low | None |
| Estimated annual cost | Health status: Excellent | $2,650 | $3,400 | $5,320 | $4,440 |
| | Health status: Poor | $5,470 | $6,760 | $13,360 | $14,150 |

Note: *Plan premium in addition to the Medicare Part B premium
Source: Medicare Plan Finder, L.E.K. analysis

*Why Medicare Advantage Is Marching Toward 70% Penetration* was written by **Bill Frack**, Managing Director, **Andrew Garibaldi**, Managing Director, and **Andrew Kadar**, Principal, in L.E.K. Consulting's Healthcare Services practice.

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## Driving the march

Medicare Advantage is one of the rare products in the U.S. healthcare system that not only satisfies the "triple aim" of healthcare improvement — that is, improving the experience of care and the health of populations while reducing per capita healthcare costs — but also appeals to the self-interests of three very powerful constituents that have been driving its march forward: consumers, health plans and the government.

- **Consumers like** Medicare Advantage plans because they offer predictability, additional benefits, care coordination and lower estimated total annual healthcare costs than are offered by either Original Medicare or Medicare Supplement plan options (see Figure 1)
- **Health plans** like Medicare Advantage plans because they make more money: Medicare Advantage plans yield higher nominal revenue and operating margin with per-member per-month (PMPM) revenue of $800-$1,200 and operating margin of $30-$60 PMPM vs. $180-$220 and $10-$18 for Medicare Supplement, respectively
- **Government** supports Medicare Advantage because it enables the effective deployment of cost trend management tools other than the fee schedule

## Slow and steady growth

Over the past 20 years, enrollment in Medicare Advantage plans has grown at a slow but steady pace (see Figure 2).

The sole aberration in consistent growth occurred between 1999 and 2002, when the Balanced Budget Act led to the loss of Medicare Advantage plan options for some 20% of the covered population. As a result, the proportion of Medicare beneficiaries with access to a Medicare Advantage plan — then known as Medicare+Choice — fell from 72% in 1999 to 61% in 2002. Enrollment dropped 21%.

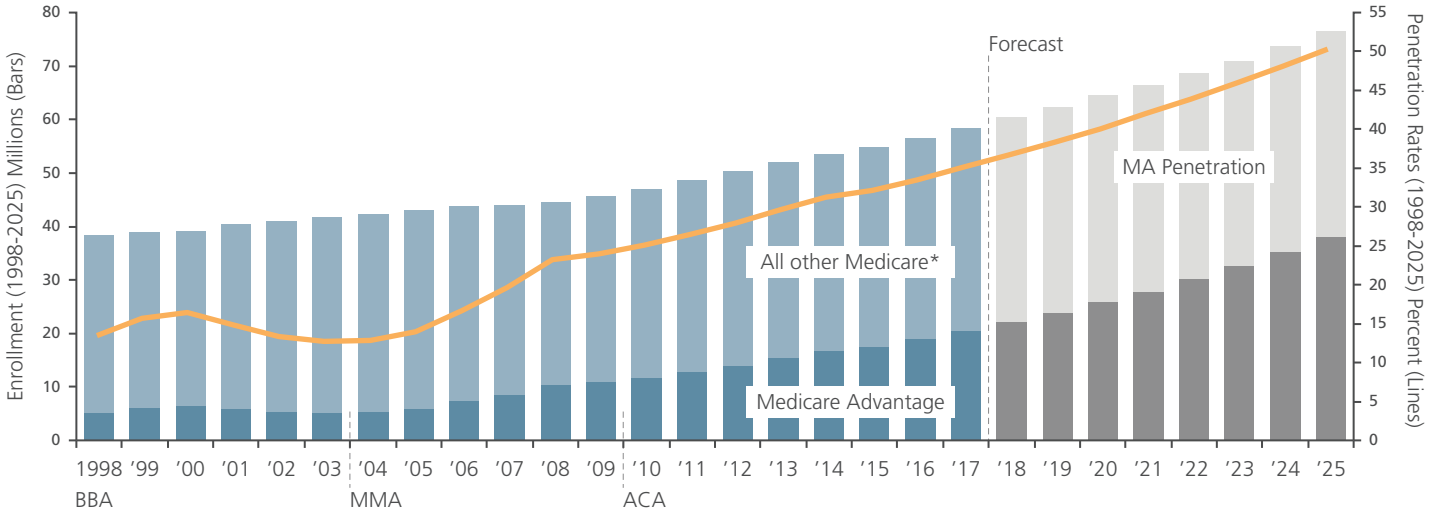
As soon as access was restored by way of the 2003 Medicare Modernization Act, penetration quickly reverted back to the trend line. Indeed, even the reimbursement cuts that resulted from the Affordable Care Act — which reduced average Medicare Advantage reimbursement from underlying fee-for-service costs plus 12% in 2011 to parity with underlying fee-for-service costs by 2017[1] — have not impacted the steady growth.

## Headed for 70% penetration

We expect Medicare Advantage to continue its slow but steady growth, reaching 60% to 70% penetration sometime between 2030 and 2040.

We base our forecast on a number of factors, among which are that several urban and rural counties not only have already achieved a Medicare Advantage penetration rate of 55%-65%, but their penetration rates continue to grow at a weighted-average 1.0 percentage point per year (see Figure 3).

Figure 2
L.E.K. Medicare Advantage enrollment trend and projection




Notes: *Includes enrollment in Original Medicare and Medicare Supplement; excludes Puerto Rico and U.S. territories
Source: CMS, KFF, Mark Farrah Associates, NAIC, L.E.K. analysis

Figure 3
Top 20 counties by penetration*

| # | State Name | County Name | 2017 | | MA Penetration | | | Percent Rural |
|---|---|---|---|---|---|---|---|---|
| | | | Eligibles | Enrolled | 2012 | 2017 | Annual PPT | |
| 1 | Florida | Miami-Dade | 444,059 | 290,539 | 55.0% | 65.4% | 2.1% | 0.4% |
| 2 | Pennsylvania | Beaver | 41,147 | 26,644 | 65.5% | 64.8% | -0.1% | 25.8% |
| 3 | New York | Monroe | 148,835 | 96,338 | 61.7% | 64.7% | 0.6% | 6.4% |
| 4 | Pennsylvania | Westmoreland | 89,559 | 57,654 | 65.5% | 64.4% | -0.2% | 25.4% |
| 5 | Wisconsin | Calumet | 7,784 | 4,883 | 58.0% | 62.7% | 1.0% | 27.5% |
| 6 | Pennsylvania | Allegheny | 254,834 | 159,534 | 61.7% | 62.6% | 0.2% | 2.5% |
| 7 | Pennsylvania | Armstrong | 16,922 | 10,593 | 62.7% | 62.6% | 0.0% | 67.5% |
| 8 | Pennsylvania | Cambria | 35,525 | 22,060 | 59.8% | 62.1% | 0.5% | 32.0% |
| 9 | Pennsylvania | Washington | 48,994 | 30,144 | 61.7% | 61.5% | 0.0% | 30.8% |
| 10 | Oregon | Clackamas | 78,085 | 47,866 | 57.6% | 61.3% | 0.7% | 18.1% |
| 11 | Pennsylvania | Indiana | 18,428 | 11,225 | 55.5% | 60.9% | 1.1% | 60.1% |
| 12 | Pennsylvania | Butler | 39,377 | 23,876 | 56.6% | 60.6% | 0.8% | 42.0% |
| 13 | North Carolina | Stokes | 10,390 | 6,213 | 54.6% | 59.8% | 1.0% | 75.7% |
| 14 | Michigan | Ottawa | 47,126 | 28,154 | 51.9% | 59.7% | 1.6% | 20.3% |
| 15 | Wisconsin | Outagamie | 30,959 | 18,445 | 53.6% | 59.6% | 1.2% | 24.7% |
| 16 | Oregon | Polk | 16,708 | 9,852 | 55.9% | 59.0% | 0.6% | 19.9% |
| 17 | Louisiana | Jefferson | 83,912 | 49,297 | 52.8% | 58.8% | 1.2% | 1.1% |
| 18 | Florida | Osceola | 53,304 | 31,295 | 47.2% | 58.7% | 2.3% | 7.8% |
| 19 | Oregon | Multnomah | 119,120 | 69,940 | 54.0% | 58.7% | 0.9% | 1.3% |
| 20 | Pennsylvania | Lawrence | 22,105 | 12,958 | 57.5% | 58.6% | 0.2% | 40.3% |
| | Average (weighted by enrollment) | | | | 57.7% | 62.8% | 1.0% | 10.8% |

Gray = >30% rural

Note: *Does not include Puerto Rico or Minnesota
Source: Mark Farrah, L.E.K. analysis

## Medicare Advantage vs. Original Medicare

Where will the penetration come from? Much of it will come from Original Medicare, which could decrease more than 20 points, from 40% to 10%-20% penetration (see Figure 4).

Seniors with Original Medicare will likely find their 20% coinsurance responsibility more burdensome as healthcare expenses continue to increase. According to the Kaiser Family Foundation, expenditures for physician and other professional services increased approximately 5.4% per year from 2000 to 2014, while expenditures on prescription drugs and other medical nondurables increased 6.2% per year. If healthcare costs continue to increase, a senior on Original Medicare could be responsible for significantly increased out-of-pocket spend.

Ongoing increases in age-related chronic conditions will likely convince seniors and soon-to-be seniors that they need the degree of care management Medicare Advantage plans provide. The number of seniors with multiple chronic conditions increased by approximately eight percentage points from 2000 to 2010, according to the Centers for Disease Control and Prevention. Meanwhile, United Health Foundation notes that the population about to turn 65 is seven percentage points more likely to be obese and six percentage points more likely to have diabetes than those who turned 65 in 1999.

L.E.K. conducted a proprietary study and found that roughly 20% of seniors exhibit behavioral factors that would suggest that a Medicare Advantage plan would be their best-fit product; however, they end up defaulting to Original Medicare. These seniors exhibit "concerned but uninformed" tendencies — in other words, they are often worried about their health but aren't proactive about seeking health or plan information. As such, they are likely to respond positively to outreach and guidance, as they are unlikely to have made a conscious and well-informed decision to remain in Original Medicare (which is why they can also be referred to as "defaulters").

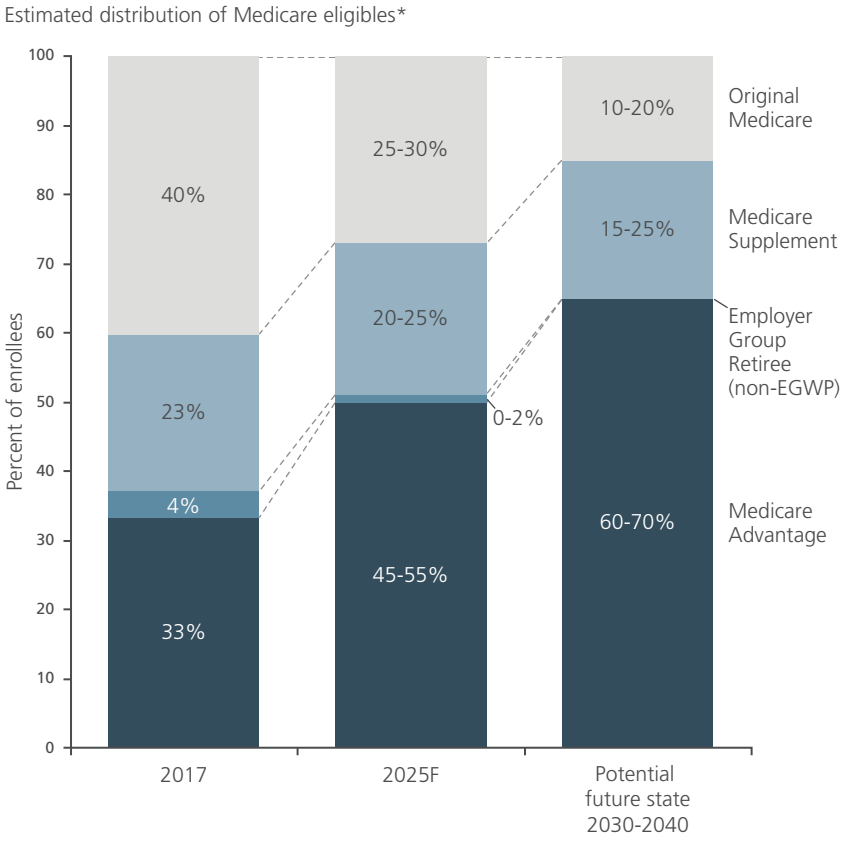
## Medicare Advantage vs. Medicare Supplement

Meanwhile, the future of Medicare Supplement, which is used to help pay some of the costs that Original Medicare doesn't cover, is less certain.

Medicare Supplement plans face headwinds similar to Original Medicare, such as higher medical costs and an increased desire for care coordination while offering a similar lack of strategic levers to manage healthcare spend. Seniors confronted with increases in premiums could be forced to look elsewhere.

Furthermore, a provision in the Medicare Access and CHIP Reauthorization Act (MACRA) bans Medicare Supplement insurers from selling any Medicare Supplement policy that covers the annual Medicare Part B deductible (i.e., first-dollar coverage) to new Medicare enrollees starting January 1, 2020. This impacts Plan C and Plan F offerings, the most popular Medicare Supplement choices today. The MACRA provision was designed to combat notoriously high healthcare utilization of Medicare Supplement members with first-dollar coverage and increase Medicare Supplement purchasers' "skin in the game." Analysts outline that the policy could change Medicare Supplement buying behaviors and potentially lead more seniors to choose a Medicare Advantage plan.

Figure 4
Where are the eligibles?




Note: *The number of original Medicare eligibles — individuals who are either currently or formerly entitled to or are enrolled in either Part A or Part B Original Medicare.
Source: L.E.K. analysis

## Dual eligibles and employer groups

As the Medicare Advantage market matures and its relative value proposition becomes clearer, two segments where Medicare Advantage penetration has historically lagged — dual eligibles and employer groups — are rapidly catching up.

"Dual eligibles" is a term used to encompass Medicare beneficiaries who also receive Medicaid assistance. Medicare Advantage penetration of dual eligibles, who represent roughly 20% of Medicare eligibles, has lagged MA penetration of overall seniors due to a lack of coordinated state offerings and managed care. However, states are moving aggressively to manage the cost of these high-needs populations. For example, dual demonstration plans are now available in 10 states, fully integrated dual eligible (FIDE) special-needs plans have increased enrollment at 11% per annum since 2012, and Programs of All-Inclusive Care for the Elderly (PACE) have increased enrollment programs at 10% per annum since 2012. States with mature dual eligibles managed care programs are also increasingly inclined to move to passive enrollment, which could rapidly accelerate penetration of this segment.

Retirees with employer health coverage are another group for whom Medicare Advantage penetration has lagged Medicare Advantage penetration of overall seniors. Approximately 20%-25% of seniors have group retiree coverage from their employer. This population is increasingly expected to join Medicare Advantage as employers transition from retiree drug subsidy (RDS) plans to Medicare Advantage employer group waiver plans (EGWPs) and as employers stop offering group retiree health coverage.

## Investing in long-term penetration growth

Medicare Advantage penetration has grown at a slow but steady pace over the past 25 years. As seniors increasingly eschew Original Medicare in favor of lower payments, better care management and more certainty in costs, with encouragement from both health plans and, albeit indirectly, the government, we expect that growth to continue — to 50% penetration by 2025 and, eventually, all the way to 70%.

With that in mind, payers will need to find ways to grow market share of their Medicare Advantage offering — for example, by expanding into new counties, investing in targeted sales to age-ins and adjusting product design to attract new members. And providers that have so far elected not to participate in Medicare Advantage will need to reconsider their stance and figure out a way to win with payers. Some may want to consider whether — and, if so, how — to develop provider-sponsored plans of their own. Investors, meanwhile, should be on the lookout for the vendors poised to support Medicare Advantage's continued growth — by offering payers superior care management, member engagement, sales and marketing, and other capabilities to boost growth and profitability. Medicare Advantage will soon become the predominant Medicare product offering. It's time to strike while the iron is hot.

[1]Source: CMS, Evercore ISI

## About the Authors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## About L.E.K. Consulting

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