Are Medicare Advantage Plans Forgetting to Close the Back Door? Provider-Sponsored Plans Lead in Medicare Advantage Member Retention

Mary Hsieh, Nate Smith, Narda Ipakchi

Background

Medicare Advantage (MA) plans have grown significantly in the last decade from 25 percent of the total Medicare eligible population in 2010 to 42 percent in 2021. While much of this growth occurred among national MA sponsors, provider-sponsored plans (PSP), plans that are either owned or have a strong affiliation with a provider, have also experienced significant growth. This type of health plan has offered providers a way to advance their population health management strategies and diversify their business while controlling the revenues from major government and non-government payors.

PSPs have the theoretical advantage of greater alignment with providers, local community presence and partnerships, greater integration of claims and clinical information, improved care coordination, and better accuracy in coding. The 15 top PSPs that we examine in this brief experienced a collective MA growth of 86% since 2010. This brief analyzes the differences in churn rates between the top five non-PSP MA orgranizations and 15 top PSP organizations, as determined by enrollment.

As MA gains greater popularity and acceptance among beneficiaries, MA plans have become increasingly competitive in terms of affordability (premium and cost sharing), provider network, and additional supplemental benefits. Despite the tremendous amount of resources that plans invest to attract new members, retention of members often takes a backseat.

MA plans need to pay attention to member churn rates to improve retention, as beneficiaries hold the power of choice and can make changes to their coverage annually during various enrollment periods.[1]

In an extremely competitive MA market, retention serves as a proxy for member satisfaction, directly affecting growth and revenue as well as MA plan operating cost and efficiencies.

Methods and Limitations

We used the 100 percent master beneficiary summary file (MBSF) for years 2016 through January 2021 to track beneficiary enrollment and churn in MA plans. Organizations were selected based on total enrollment within all MA contracts under the parent organization.[2] The

[1] The Annual Election Period (AEP) runs from October 15 to December 7 each year and is the annual timeframe Medicare beneficiaries can select to switch from one MA plan to another, switch from MA to Original Medicare, or switch from Original Medicare to MA. Medicare also offers an Open Enrollment Period (OEP) from January 1 – March 31 each year, during which individuals enrolled in MA can switch to a different plan or switch to Original Medicare. Depending on individual circumstances, some individuals may qualify for a Special Enrollment Period (SEP), which provides additional opportunities throughout the year to change coverage. This analysis includes AEP and OEP changes but does not include SEP changes.

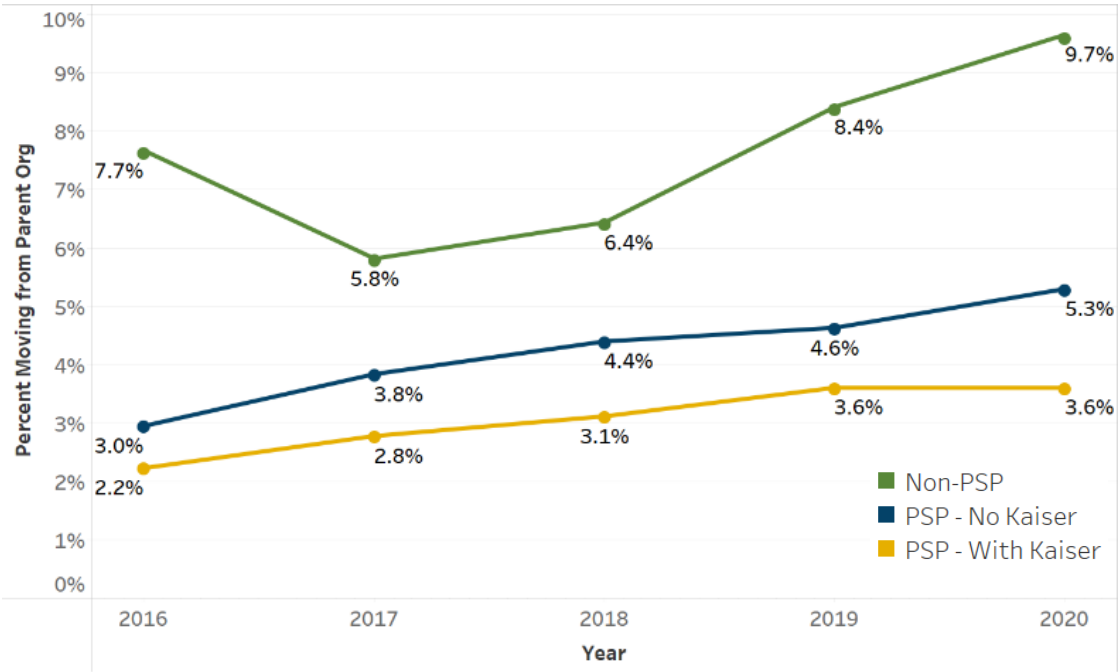
[2] The authors used August 2020 MA Enrollment Data. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-Enrollment-by-Contract

analysis was limited to 15 large PSPs and the five largest non-PSPs.[3]

We monitored movements (enrollment and switching) from one parent organization to another beginning January 2016. Enrollment in contracts that occured prior to any parent organization mergers and acquisitions are included in the analysis.

Churn was defined as a beneficiary switching from one contract to another at any point during the year, so long as the change ended up with the beneficiary enrolled in a different parent organtization than the previous. We do not examine switches from MA to traditional FFS or switches that do not change the parent organization.

Figure 1 : MA Churn Between 2016 and 2020 – Top PSPs vs Top 5 Non-PSPs



NOTES: Excludes beneficiaries ever enrolled in cost plans, employer group waiver plans, special needs plans (SNPs), Medicare-Medicaid plans (MMPs), medical savings accounts (MSAs), and programs of all-inclusive care for the elderly (PACE). The numerator is total number of unique beneficiaries who switched from the parent organization in each year. The denominator is the total number of unique beneficiaries enrolled in each year. Average churn is enrollment weighted.

[3] **PSPs included:** Capital District Physicians' Health Plan, Geisinger Health System, Health First, Healthfirst, Henry Ford Health System, Intermountain Health Care, Kaiser Foundation, Marshfield Clinic Health System, Presbyterian Healthcare Services, Providence Health & Services, Spectrum Health System, Trinity Health, Triton Health Systems, and UPMC Health System.
Non-PSPs included: Anthem, Centene/WellCare, CVS Health, Humana, and UnitedHealth Group

The study is limited to beneficiaries who enrolled in standard MA plans (92 percent of all MA plans). Beneficiaries enrolled in one of the following plan types during the study period were excluded from the analysis: Special Needs Plan (SNP), Employer Group Waiver Plan, Cost plan, Medical Savings Account (MSA), Programs of All-Inclusive Care for the Elderly (PACE), and Medicare-Medicaid Plans (MMP).

Findings

We examined annual churn rates for PSP and non-PSP categories between 2016 and 2020 (Figure 1). As Kaiser Permanente (KP) is such a large PSP, we examined churn for the PSP category including and not including the organization. In 2016, only 3 percent of the enrollees in a PSP (without KP) switched, whereas 7.7 percent switched among the top non-PSPs. In 2020, 5.3 percent of beneficiaries switched from a PSP (without KP) compared to 9.7 percent who switched from a non-PSP in 2020 (Figure 1).[4]

Over the study period of 2016 to 2020, the average enrollee churn rate from one MA plan for the largest five non-PSP MA plans was nearly twice that of the 15 large PSPs.

In addition to the above discrete annual churn rates by overall plan category (PSP vs. non-PSP), we also measured the total percentage of unique beneficiaries who switched over the entire the study period (2016-2020). We refer to this as aggregate churn (Figure 2). We found considerable variation among individual sponsors across both PSP and non-PSP categories. Among non-PSPs, the percentage of unique beneficiaries who switched to another parent organization between 2016 to 2020 ranged from approximately 17.5 percent to 33.6 percent. While PSPs, on average, had lower churn, performance also varied across individual organizations from under 8 percent to 33.6 percent over the same period.

Implications

The significant difference in churn rates between the top PSPs and top non-PSPs sponsors shows that, on average, the PSPs studied generally have lower churn to another MA plan than non-PSPs.

Across the board, enrollee switching rates between MA plans increased towards the end of the study period, potentially reflecting the increasingly competitive market and the impact of reinstating the Open Enrollment Period

Revenue and Repuational Implications: Churn is often a proxy of consumer satisfaction. In recent years, CMS has placed greater emphasis on the weighting of Consumer Assessment of Health Plan Satisfaction (CAHPS) measures in calculating a plan's Star performance, rewarding plans that do well in the underlying CAHPS measures. MA plans who perform at a 4-Star or above qualify for additional revenues that can be

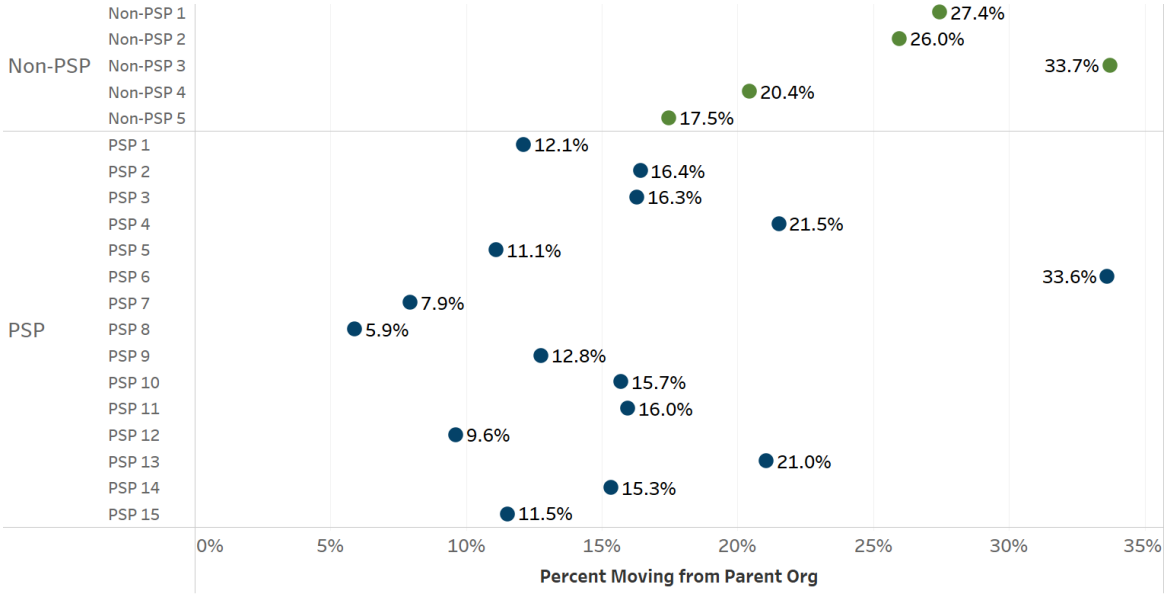
[4] Beginning in 2019, the OEP enabled individuals to make a change to their coverage between January 1 and March 31 if they are unhappy with their selection following the Annual Election Period.

used to develop more attractive products and benefits. Lower plan-to-plan churn may favorably position PSPs for higher Medicare Stars performance, all other factors being equal.

membership to the competition may pass the benefits of the coding efforts to the competitor since risk scores travel with the member.

Cost Implications: Retaining members for longer

Figure 1: Percent of Total Membership Churn Between 2016 and 2020, by Parent Organization



NOTES: Excludes beneficiaries ever enrolled in cost plans, employer group waiver plans, special needs plans (SNPs), Medicare-Medicaid plans (MMPs), medical savings accounts (MSAs), and programs of all-inclusive care for the elderly (PACE). The numerator is total number of unique beneficiaries who switched from the parent organization between 2016 and 2020. The denominator is the total number of unique beneficiaries enrolled between 2016 and 2020.

As CMS moves toward greater emphasis on consumer experience in the Star ratings, those MA plans with the ability to keep members satisfied and retain them over a longer period will also enjoy greater reputational advantage. Further, plans with five stars have the ability to enroll members year round, while other non 5-Star plans rely on limited enrollment periods.

Moreover, CMS pays MA plans on a risk-adjusted basis, and plans who retain their enrollees preserve the value of the investments made on accurately coding diagnoses. MA plans that lose

periods provides plans with predictable and stable revenue streams, as MA plans are reimbursed on a per member per month basis. MA plans devote significant resources to attracting and enrolling new members. The ability to retain members also enables plans to realize this administrative investment over the course of the enrollee's membership. As mentioned above, the ability to retain members over time also maximizes the resource investments on improving coding practices for MA plans, improving both revenues and cost.

With greater focus on CAHPS in Medicare Star ratings, MA organizations have an even greater imperative to focus efforts on member satisfaction to improve member retention.

In a crowded and competitive Medicare Advantage market, all MA plan growth strategies need to incorporate a strong strategy to retain the membership.

Future Research

Further research is needed to understand a number of key questions driving member churn including the underlying variations across sponsors. Factors that may impact churn rates include a plan's member experience, provider network, core and supplemental benefits, cost-sharing or premium, ability to access benefits and services, etc. All these factors also contribute to member satisfaction and engagement and ultimately may impact member retention in a crowded and competitive market.

Questions? Contact Mary Hsieh at mhsieh@healthmanagement.com