Medicare Advantage Part C Revenue: Challenges Ahead

By Tim Courtney, FSA, MAAA
Senior Consulting Actuary, Wakely Consulting, Inc.

The Centers for Medicare & Medicaid Services (CMS) recently issued a press release announcing modest premium increases in the Medicare Advantage (MA) program for 2013 and a prediction that MA enrollment will increase by 11% in 2013. Health and Human Services Secretary Kathleen Sebelius said "Thanks to the Affordable Care Act, the Medicare Advantage and Prescription Drug programs have been strengthened and continue to improve for beneficiaries".

Will modest premium increases and increasing MA enrollment continue in the years ahead? The answer depends on many factors including the impact of the Affordable Care Act (ACA) payment reforms in 2014 and beyond, plan star ratings, medical cost trends, administrative efficiency, and regulatory changes to mention just a few. This article primarily focuses on one of these factors – the impact of ACA payment reforms on Part C revenue trends over 2014 through 2017.

Brief History of the MA Payment formula and Subsequent Reforms under ACA and the Quality Bonus Payment Demonstration

Medicare Prescription Drug, Improvement and Modernization Act of 2003

The basic elements of the current MA payment scheme were established with the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003. The formula for payment is:

> MA Payment = (Risk Score x 1.00 Bid) – MA Basic Member Premium + Rebate,
> *where MA Basic Member Premium = Max{1.00 Bid – 1.00 Benchmark,0}*
> *where Rebate = Max{(Risk-Adjusted Benchmark - Risk-Adjusted Bid) x (Rebate %),0}*

The risk-adjusted bid represents a plan's estimate of the cost to cover the standard Medicare benefit for the anticipated characteristics of the plan's covered population. The risk score is based on a prospective model driven by prior year diagnoses. Beginning in 2010, a "coding difference" adjustment was introduced based on a CMS study concluding that MA risk scores needed to be reduced by 3.41% to achieve a 1.00 average risk score across all of Medicare (i.e. the fee-for-service and MA programs).

The benchmark was set by CMS and was based on the fee-for-service (FFS) estimate of Medicare costs by county; although many counties had benchmarks higher than the FFS estimate due to historical "minimum updates", and "floors", which increased benchmarks beyond FFS levels. Finally, the rebate percentage was fixed at 75% and represented the proportion of dollars plans were required to spend on extra benefits or reduced cost sharing, provided the bid was below the benchmark.

The Patient Protection and Affordable Care Act of 2010

The Patient Protection and Affordable Care Act (ACA) of 2010 kept the same formula as MMA, but altered the determination of the benchmark, reduced the rebate percentage, and mandated minimum increases to the coding difference adjustment beginning in 2014. The goals of the ACA reforms were to gradually bring MA payments closer to FFS levels and to provide incentives for plans to improve patient outcomes through a quality bonus payment system tied to star ratings.

Under the ACA, benchmarks would be migrated to a new calculation as follows:

County Benchmark = FFS Cost Estimate x (Applicable Percentage + Quality Bonus)

The applicable percentage varied based on a county's ranking in one of four quartiles, while the quality bonus added a fixed percentage if a plan achieved a star rating of 4 or more. Certain "double bonus" counties that met CMS criteria received two times the bonus percentage. The table below summarizes these provisions for non-double bonus counties.

	Original ACA: Applicable Percentage + Quality Bonus			
		Qualifying Plan (Star Rating of 4 or More)		
County Ranking by Quartile	**Star Rating less than 4**	**2012**	**2013**	**2014+**
100% (Highest)	95.0%	96.5%	98.0%	100.0%
75%	100.0%	101.5%	103.0%	105.0%
50%	107.5%	109.0%	110.5%	112.5%
25% (Lowest)	115.0%	116.5%	118.0%	120.0%

Starting in 2012, a transition began between the benchmark calculation under MMA (also called "pre-ACA") and ACA. The transition was two, four, or six years, depending on the county. Generally, the bigger the difference between the pre-ACA benchmark and the FFS county estimate, the longer the transition period.

The rebate percentage under ACA was reduced from the pre-ACA value of 75% to 50%, 65%, or 70%, depending on a plan's star rating. Similar to the benchmark calculation, a phase-in period was established over three years. The table below shows the percentages by star rating and transition rules.

Year	Pre-ACA/ ACA Weight	<3.5 stars	≥3.5, <4.5 stars	≥4.5 stars
2012	⅔/⅓	66.7%	71.7%	73.3%
2013	⅓/⅔	58.3%	68.3%	71.7%
2014+	0%/100%	50.0%	65.0%	70.0%

In addition to the benchmark and rebate changes, a mandated minimum increase in the coding difference adjustment was also established according to the following schedule.

Year	Minimum Increase	Implied Coding Difference Adjustment Factor
2012	0.00%	3.41%
2013	0.00%	3.41%
2014	1.30%	4.71%
2015	0.25%	4.96%
2016	0.25%	5.21%
2017	0.25%	5.46%

Note that ACA sets the minimum incremental changes in 2014 through 2017. The final coding difference adjustment factor in future years will be higher if the minimum increase is exceeded in any year.

Quality Bonus Payment Demonstration

In November 2010, CMS proposed to waive the ACA rules for determining quality bonus payments in favor of a national quality bonus payment (QBP) demonstration to be in effect from 2012 through 2014. This proposal was later affirmed in the April 4, 2011 Rate Announcement and Final Call Letter. The QBP demonstration increased quality bonus payments and lowered the star-rating threshold to qualify for quality bonus. No changes were made to risk adjustment or to the rebate percentage.

The table below shows how each component of the payment formula is calculated under the original pre-ACA formula, ACA, and QBP demonstration.

Medicare Advantage Part C Payment By Component			
Component	**Pre-ACA**	**ACA**	**Quality Bonus Payment Demonstration 2012-2014**
Risk Score	Part C risk score x coding difference adjustment	Part C risk score x mandated minimum coding difference adjustment	Part C risk score x mandated minimum coding difference adjustment
Benchmark	USPCC cost by county x growth rate, with periodic re-basing to FFS minimum	Blend of: Pre-ACA, FFS x (Applicable Percentage + Quality Bonus)	Blend of: Pre-ACA **x (1+ Quality Bonus),** FFS x (Applicable Percentage + Quality Bonus)
Benchmark Maximum	None	Blended Benchmark can be no higher than Pre-ACA Benchmark	Blended Benchmark can be no higher than Pre-ACA Benchmark**, except no maximum for plans with 3 stars or more**
Applicable Percentage	None	95%, 100%, 107.5%, 115%; varies by "quartile"	95%, 100%, 107.5%, 115%; varies by "quartile"
Quality Bonus	None	If 4 Stars or higher, then: 2012: 1.5% 2013: 3.0% 2014+: 5.0%	**For 2012 - 2014: 3 Stars: 3.0% 3.5 Stars: 3.5% 4-4.5 Stars: 4.0% (5% in 2014) 5 Stars: 5.0%**
Rebate %	75%	Phased-in blend of 75% and: >=4.5 Stars: 70% 3.5 or 4 Stars: 65% <=3 Stars: 50%	Phased-in blend of 75% and: >=4.5 Stars: 70% 3.5 or 4 Stars: 65% <=3 Stars: 50%

Bold items represent change versus ACA

The most important differences between ACA and the QBP demonstration were the application of the quality bonus to the pre-ACA benchmark and the quality bonus definition.

During 2012 and 2013, MA payments under the QBP demonstration are much higher as compared with the original ACA language for plans with a star rating of 3 or more. Figure A below compares risk-adjusted benchmarks under ACA and the QBP demonstration with the pre-ACA benchmarks and FFS costs.

Figure A

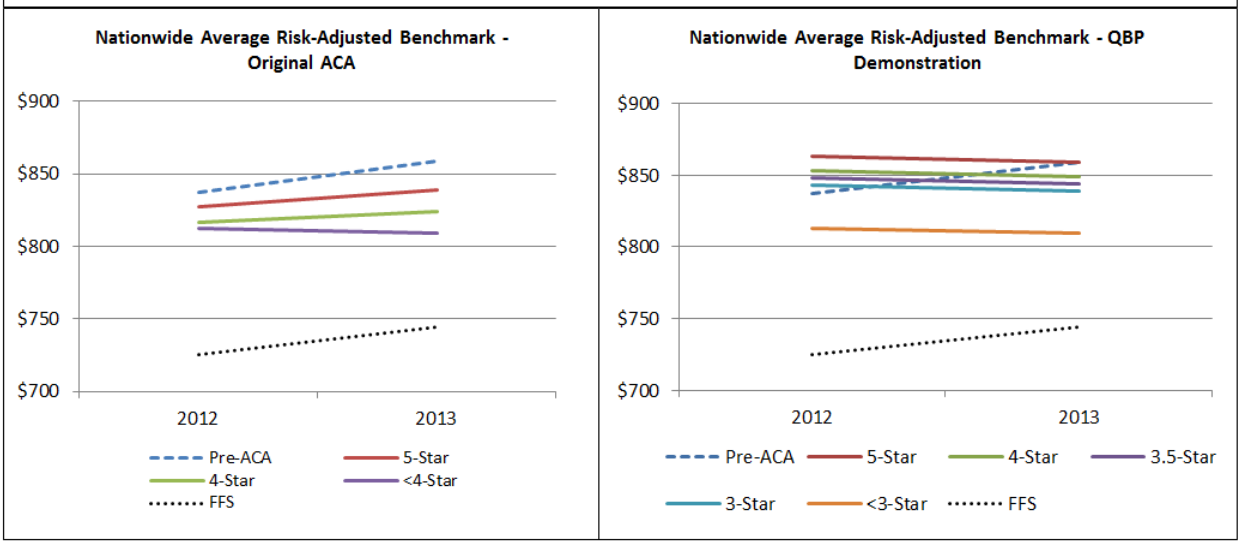


Figure A shows that MA plans with 3 stars or more had higher payments under the QBP demonstration than they would have under original ACA. In addition, 2012 payments under the QBP demonstration for those same plans actually exceeded pre-ACA levels due to the application of the quality bonus payment to the pre-ACA benchmarks.

Part C Payments in 2014 through 2017

Over the next four MA contract years (2014 through 2017), the transition to full implementation of ACA payment reforms will take place; however it will not be a uniform transition by year due to the expiration of the QBP demonstration and the beginning of mandated coding difference adjustment increments in 2014.

Below is a discussion of the impact of Part C payment reforms on benchmark and revenue trends on a national, regional, and plan-specific level.

Any such discussion must address the important issue of mandated reductions to physician payments. The Balanced Budget Act (BBA) of 1997 implemented the Sustainable Growth Rate (SGR) system, which included a mechanism to adjust future physician payments under Medicare to be consistent with targeted levels, subject to certain limits. This mechanism has dictated payment decreases in every year from 2002 through 2011, but the decrease has been overridden by Congress in every year except 2002. Due to these overrides, the cumulative reduction has become very large.

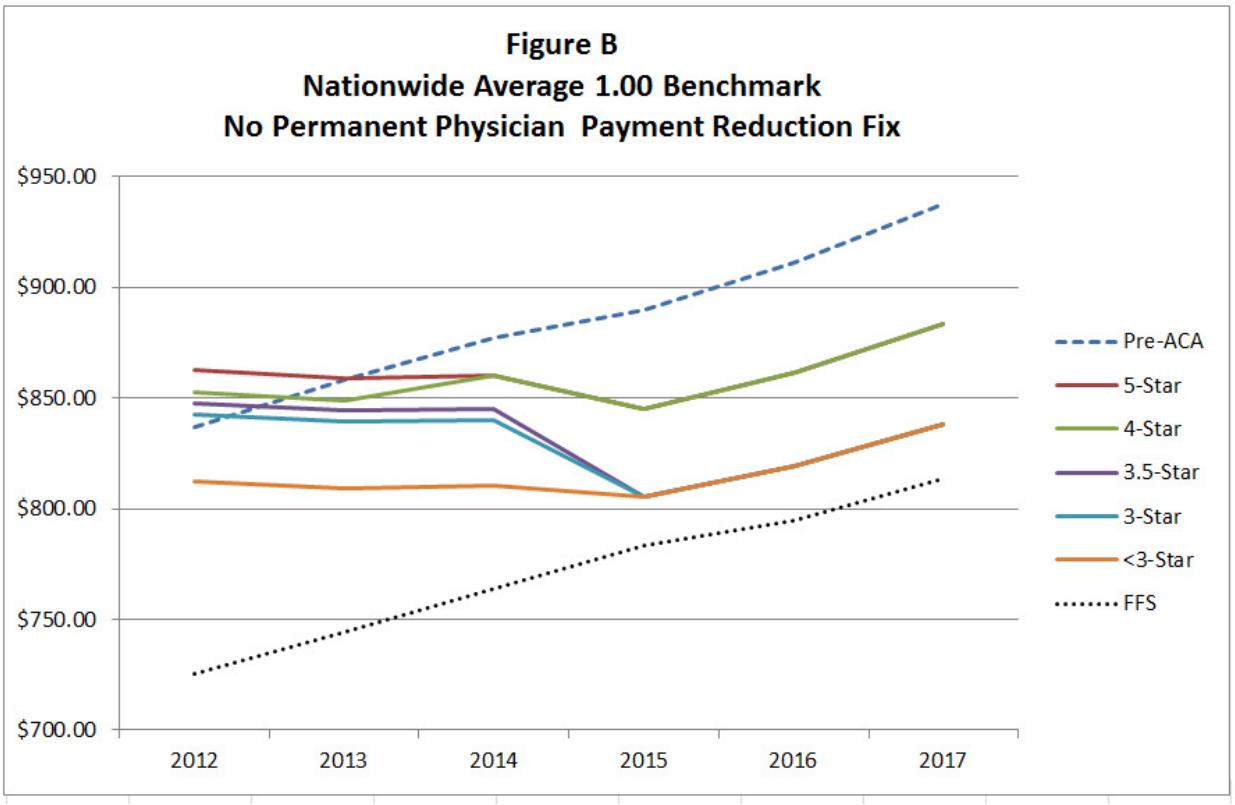
Since Medicare county benchmarks are based on estimated National Per Capita Growth Rate, the mandated BBA reductions directly impact benchmarks. For example, the growth rates underlying 2013

benchmarks include an assumption that physician fees will decrease by -30.8% in 2013. At the same time, the growth rate also reflects a positive restatement of the prior year trend to recognize the override of the physician payment reduction in 2012.

The projections presented in this article assume that the historical pattern of assumed physician payment decreases in the current year together with restatement of prior years (due to congressional override) will continue. It is an important caveat, however, that if the BBA mandates to physician payments are ever permanently eliminated, the growth rate for the subsequent year would be much higher. For example, if the BBA payment reduction were eliminated for 2014, we estimate that the 2014 growth rate would be 4.5 to 5 points higher than if the reduction were assumed as usual.

Nationwide Projections

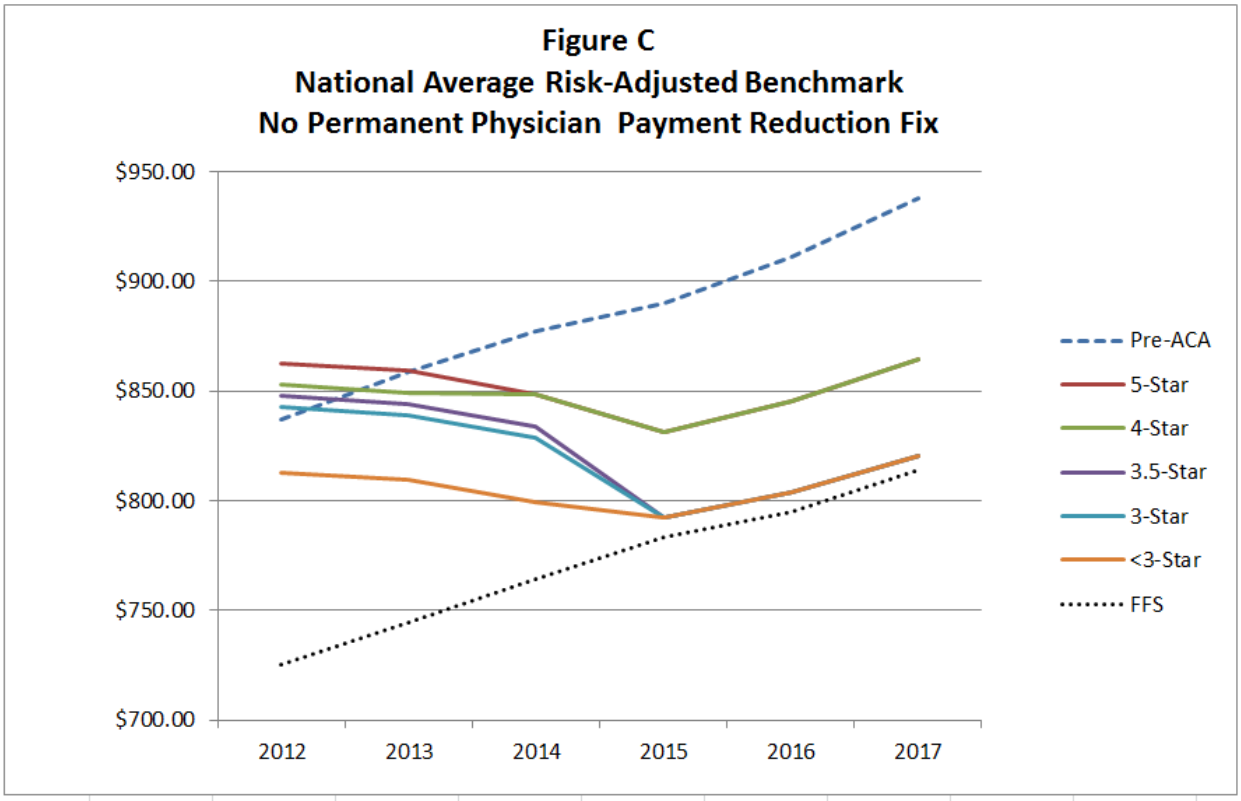
Figure B below shows estimated nationwide standardized (i.e. 1.00) benchmarks from 2012 through 2017. Enrollment is based on MA membership by county as of March 2012 and trends are based on the 2012 Medicare Trustees report, adjusted to reflect the historical pattern of assumed physician payment reductions and subsequent restatements when the reductions do not occur.



The projections in Figure B do not tell the full revenue picture because they ignore the impact of the reduced rebate percentage and the coding difference factor increase. It is not practical to generalize a

nationwide impact of the reductions to the rebate percentage; however, it is possible to analyze the impact of the coding pattern adjustment.

Making an assumption that risk scores keep pace with FFS normalization but do not increase such that coding pattern changes in 2014-2017 are offset, Figure C below shows a slightly different pattern of benchmarks versus Figure B, as shown below.



Even though Figure C only captures two of three ways in which payment reform impacts Part C revenue (benchmarks and coding difference, but not rebate percentage), a few key points can be made:

- Risk-adjusted benchmark trends in 2014 and 2015 will be negative if plans maintain their star ratings.
- The expiration of the QBP demonstration in 2015 causes a significant decrease in risk-adjusted benchmarks for 3-star and 3.5-star plans.
- Risk-adjusted benchmarks for plans with less than 3 stars are nearly the same as FFS costs. In fact, they will likely be lower than FFS because actual FFS costs will almost certainly be based on higher trends than shown here if the physician payment reduction is not eliminated.

The table below shows the nationwide annual trend estimates in risk-adjusted benchmarks according to plan star rating.

Annual Trend in Risk-Adjusted Benchmark						
Trend Year	**Pre-ACA**	**5-Star**	**4-Star**	**3.5-Star**	**3-Star**	**<3-Star**
2013/2012	2.6%	-0.4%	-0.4%	-0.4%	-0.4%	-0.4%
2014/2013	2.2%	-1.2%	-0.1%	-1.2%	-1.2%	-1.2%
2015/2014	1.5%	-2.0%	-2.0%	-4.9%	-4.4%	-0.9%
2016/2015	2.4%	1.7%	1.7%	1.4%	1.4%	1.4%
2017/2016	2.9%	2.3%	2.3%	2.0%	2.0%	2.0%

Below is a brief synopsis of the key revenue drivers over the next four bid years:

2014

- Coding difference factor will change from 3.41% to at least 4.71%.
- Plans with 4 and 4.5 star ratings will see an increase in the quality bonus percentage from 4% to 5%.
- Rebate percentage no longer blended with pre-ACA value of 75%.
- Counties on a four or six year transition schedule continue to have benchmarks blended with pre-ACA values, though the weight decreases on pre-ACA.

2015

- QBP demonstration expires.
- Plans with a star rating of 3 or 3.5 no longer get a quality bonus. Risk-adjusted benchmarks will decrease by 4.5% to 5% (due to decreased benchmarks and coding difference factor) for these plans.
- Quality bonus no longer applies to the pre-ACA benchmark.
- Blended benchmarks are capped at pre-ACA level, regardless of star rating.
- Benchmarks for all two and four year transition counties are now based entirely on ACA formulas.
- Coding difference must increase by at least 0.25% versus 2014.

2016

- Benchmark calculations for counties on a six-year transition schedule move from a pre-ACA weight of 33.3% in 2015 to 16.7% in 2016.
- Coding difference must increase by at least 0.25% versus 2015.

2017

- All benchmarks now based entirely on ACA formulas.
- Coding difference must increase by at least 0.25% versus 2016.

Regional Projections

There is significant variation in the year-to-year impact of ACA and QBP reforms in different counties. There are three main causes of this variation:

1. Differences between pre-ACA benchmarks and the FFS rates adjusted by the applicable percentage.
2. Transition schedule.
3. Double-bonus status.

These variables make it challenging to generalize about regional trends. Below are risk-adjusted benchmark trend averages for the five states with the highest increase in 2015 and the five states with the lowest. Trends are shown for 4/4.5 star plans as well as 3/3.5 star plans since these are likely to be the most common ratings in 2015. Note that trends for individual counties within a state will vary.

Risk-Adjusted Benchmark Trend - 4.0/4.5 Star Plans				
State	**2014**	**2015**	**2016**	**2017**
FL	6.4%	0.6%	3.1%	3.9%
CT	5.9%	0.6%	2.9%	3.7%
ND	7.0%	0.4%	2.9%	3.8%
NV	7.5%	0.3%	2.8%	3.7%
MD	6.2%	-0.2%	2.7%	3.6%
NM	5.1%	-3.5%	2.0%	2.9%
DC	3.0%	-3.9%	-0.1%	1.1%
LA	2.4%	-4.4%	-0.6%	0.3%
HI	3.8%	-4.7%	0.8%	1.7%
PR	-0.4%	-7.6%	-4.0%	-3.5%

Risk-Adjusted Benchmark Trend - 3.0/3.5 Star Plans				
State	**2014**	**2015**	**2016**	**2017**
ND	6.1%	-1.5%	3.0%	3.8%
MT	5.9%	-1.7%	3.0%	3.8%
NV	6.3%	-2.2%	3.1%	3.9%
SD	5.7%	-2.3%	3.0%	3.8%
ME	4.8%	-2.3%	3.2%	4.0%
LA	1.4%	-6.1%	-1.4%	-0.7%
NY	2.0%	-6.2%	0.6%	1.5%
UT	3.7%	-6.3%	3.2%	4.0%
HI	2.3%	-7.0%	-0.4%	0.4%
PR	-1.3%	-8.6%	-4.8%	-4.4%

Although many other comparisons could be made, it should be clear from the above tables that trends in risk-adjusted benchmarks vary significantly across the country.

Plan-Level Projections

While it is useful to analyze the impact of ACA and QBP demonstration reforms on Part C revenue at a high level, the real impact needs to be assessed at the plan, or Plan Benefit Package (PBP), level. The elements of ACA and QBP payment reforms are fixed, but plans can control several other factors in order to meet member premium, benefit level, and profit goals. Payment reform over the next few

years will likely present the biggest challenge yet of plans' ability to affect these controllable factors in order to maintain an acceptable balance of these three goals.

In order to illustrate the revenue projection process and what it implies for these "controllable" factors, we use a hypothetical PBP in the Philadelphia area. We ignore Part D here to isolate Part C reform, but it should be noted that all MA plans must offer at least one plan with basic Part D benefits.

Our hypothetical plan currently has a 3.5-star rating, and covers beneficiaries in three Philadelphia-area counties, with the following characteristics:

State	County Name	Projected CY13 Members	Applicable %	Transition Period	Double Bonus County?
PA	DELAWARE	260	97.5%	6	YES
PA	MONTGOMERY	380	100.0%	2	YES
PA	PHILADELPHIA	980	95.0%	6	NO

Note that the 2012 applicable percentage for Delaware county was based on the highest-cost quartile in 2012, which equates to 95%; however, in 2013, it was ranked in the second-highest quartile, which implies an applicable percentage of 100%. When a county changes ranks, the applicable percentage for the year in which the change occurs will be a straight average of the current and prior years, so in this case, (95% + 100%)/2 = 97.5%. In 2014, the applicable percentage will move to 100%, assuming the ranking stayed as the second highest quartile.

In 2012 and 2013, the plan had no member premium and benefits better than Medicare in the form of reduced cost sharing and additional benefits like dental care. Administrative expenses represented 11% of total revenue, while profit was 3%.

For 2013, the plan's expected revenues and expenses PMPM are as follows:

	Component	Formula/Basis	2013
A	1.00 Benchmark	Per CMS & County Mix	$899.85
B	Risk Score	Plan population	0.950
C	Risk-adjusted Benchmark	A x B	$854.85
D	1.00 Bid	E/B	$842.11
E	Risk-adjusted Bid	Plan Estimate	$800.00
F	MA Basic Premium	Max{ D-A, $0 }	$0.00
G	Savings	Max{ C - E, $0 }	$54.85
H	Rebate %	ACA Rebate % for 3.5-star plan	68.3%
I	Rebate	G x H	$37.48
J	Member Premium	Affected by CMS revenue, benefits and plan profits	$0.00
K	**TOTAL REVENUE**	**E -F + I + J**	**$837.48**
L	Medical Claim Expense - Medicare Benefits	Plan Estimate	$688.00
M	Medical Claim Expense - Additional Benefits	Plan Estimate	$32.20
N	**Medical Claim Expense - Total**	**L + M**	**$720.20**
O	**Administrative Expense**	**11% x K**	**$92.12**
P	**Gain/(Loss)**	**K - N - O**	**$25.16**
Q	**Gain/(Loss) as % of Revenue**	**P/K**	**3.0%**

Looking ahead to 2014 and 2015, it will be challenging for the plan to maintain 2013 member premium, benefit, and profit levels.

This challenge is the result of several factors. First, benchmarks will be decreasing, particularly in 2015, due to the loss of the quality bonus (which was a double bonus in two of the three counties). The table below shows the calculation of projected benchmarks for 2013 through 2015 assuming no change to the plan's star rating.

	County	Membership	Pre-ACA Benchmark	FFS	Applicable %	Quality Bonus	Pre-ACA x (1+Quality Bonus [1])	FFS x (Applic % + Quality Bonus)	Pre-ACA Transition Weight	Blended Benchmark	Percent Change in Blended Benchmark
2013	DELAWARE	260	$915.64	$744.73	97.50%	7.00%	$979.73	$778.24	66.67%	$912.57	
	MONTGOMERY	380	$821.39	$740.49	100.00%	7.00%	$878.89	$792.32	0.00%	$792.32	
	PHILADELPHIA	980	$984.45	$788.50	95.00%	3.50%	$1,018.91	$776.67	66.67%	$938.16	
	TOTAL	1,620								**$899.85**	
2014	DELAWARE	260	$931.97	$760.83	100.00%	7.00%	$997.20	$814.09	50.00%	$905.65	-0.8%
	MONTGOMERY	380	$835.58	$756.51	100.00%	7.00%	$894.07	$809.46	0.00%	$809.46	2.2%
	PHILADELPHIA	980	$1,002.08	$805.55	95.00%	3.50%	$1,037.16	$793.47	50.00%	$915.31	-2.4%
	TOTAL	1,620								**$888.93**	**-1.2%**
2015	DELAWARE	260	$943.53	$773.54	100.00%	0.00%	$943.53	$773.54	33.33%	$830.20	-8.3%
	MONTGOMERY	380	$846.25	$769.71	100.00%	0.00%	$846.25	$769.71	0.00%	$769.71	-4.9%
	PHILADELPHIA	980	$1,012.47	$816.90	95.00%	0.00%	$1,012.47	$776.05	33.33%	$854.86	-6.6%
	TOTAL	1,620								**$830.93**	**-6.5%**

[1] Quality Bonus not applicable in 2015 and beyond

Second, the rebate percentage will be further reduced in 2014 as the ACA formula becomes fully phased in.

Third, the coding difference factor will change from 0.9659 (1-.0341) to at most 0.9529 (1-.0471) in 2014, per ACA.

The table below shows 2014 and 2015 revenues and expenses, similar to the table above, assuming that the plan wishes to maintain its 3% profit goal, and so allows member premiums to increase and additional benefits to decrease.

	Component	2013	2014	2015
A	1.00 Benchmark	$899.85	$888.93	$830.93
B	Risk Score	0.950	0.937	0.935
C	Risk-adjusted Benchmark	$854.85	$833.12	$776.72
D	1.00 Bid	$842.11	$865.64	$897.70
E	Risk-adjusted Bid	$800.00	$811.29	$839.13
F	MA Basic Premium	$0.00	$0.00	$66.77
G	Savings	$54.85	$21.83	$0.00
H	Rebate %	68.3%	65%	65%
I	Rebate	$37.48	$14.19	$0.00
J	Member Premium	$0.00	$25.00	$75.00
K	**TOTAL REVENUE**	**$837.48**	**$850.48**	**$847.36**
L	Medical Claim Expense - Medicare Benefits	$688.00	$707.23	$721.65
M	Medical Claim Expense - Additional Benefits	$32.20	$24.20	$7.90
N	**Medical Claim Expense - Total**	**$720.20**	**$731.43**	**$729.55**
O	**Administrative Expense**	**$92.12**	**$93.55**	**$93.21**
P	**Gain/(Loss)**	**$25.16**	**$25.50**	**$24.60**
Q	**Gain/(Loss) as % of Revenue**	**3.0%**	**3.0%**	**2.9%**
R	CMS Revenue (E + I - F)	$837.48	$825.48	$772.36
S	Change in CMS Revenue		-1.4%	-6.4%

As the table above illustrates, the plan is only able to achieve the 3% profit target through a combination of increased monthly member premiums and scaled back additional benefits.

The 2014 and 2015 member premium and additional benefit changes under these assumptions are very dramatic, and could very well mean the plan's offering is not competitive versus other MA plans; however the plan can attempt to change some of the controllable factors to return to a more attractive offering. These controllable factors include:

- Star rating
- Medical expense trend
- Administrative expenses
- Process for coding and submitting diagnoses that drive risk score

- Profit level

Scenario testing one or more of these factors will create a wide range of financial results for the plan. Below is one possible scenario, where the plan is able to increase its star rating to 4.0 in 2014, and improve its diagnosis coding such that the risk score keeps pace with not only the FFS normalization factor published by CMS, but also the change in coding difference factor from 2014 to 2015.

The table below shows the results.

	Component	2013	2014	2015
A	1.00 Benchmark	$899.85	$906.53	$873.73
B	Risk Score	0.950	0.950	0.950
C	Risk-adjusted Benchmark	$854.85	$861.21	$830.05
D	1.00 Bid	$842.11	$865.64	$883.29
E	Risk-adjusted Bid	$800.00	$822.36	$839.13
F	MA Basic Premium	$0.00	$0.00	$9.56
G	Savings	$54.85	$38.85	$0.00
H	Rebate %	68.3%	65%	65%
I	Rebate	$37.48	$25.25	$0.00
J	Member Premium	$0.00	$0.00	$25.00
K	**TOTAL REVENUE**	**$837.48**	**$847.61**	**$854.57**
L	Medical Claim Expense - Medicare Benefits	$688.00	$707.23	$721.65
M	Medical Claim Expense - Additional Benefits	$32.20	$21.70	$13.20
N	**Medical Claim Expense - Total**	**$720.20**	**$728.93**	**$734.85**
O	**Administrative Expense**	**$92.12**	**$93.24**	**$94.00**
P	**Gain/(Loss)**	**$25.16**	**$25.44**	**$25.72**
Q	**Gain/(Loss) as % of Revenue**	**3.0%**	**3.0%**	**3.0%**
R	CMS Revenue (E + I - F)	$837.48	$847.61	$829.57
S	Change in CMS Revenue		1.2%	-2.1%

With the star rating and risk score changes, the above table shows that the plan is able maintain a $0 premium in 2014, with an increase to only $25 in 2015. Also, the additional benefit cuts are not as

severe as the baseline case. Note that other combinations of member premium and additional benefit levels are possible.

Conclusion

The reforms in the 2010 Affordable Care Act set out to reduce Part C payments to Medicare Advantage Organizations; however the impact of these reductions has not been felt yet due to the Quality Bonus Demonstration. As the ACA reforms continue to phase in for 2014, and the QBP demonstration expires in 2015, MA plans will face unprecedented Part C revenue reductions, barring any regulatory change or new demonstration. Looking beyond 2015, the revenue outlook for MA plans should stabilize, and by 2017 should behave more like the year-to-year changes experienced prior to 2011.

In order to emerge successfully from these upcoming challenges, plans will need to focus with more diligence than ever on changing factors it can control like the star rating, expense trend, administrative expenses, and diagnosis coding. Plans that are not able efficiently manage these factors will struggle to maintain a competitive plan offering. More than ever, it could make the difference between being a successful MA plan and one that is not in the MA market at all.