Star rating changes: How Medicare Advantage plans react

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Medicare Advantage organizations (MAOs) can have widely different responses to changes in revenue due to changes in star rating.

MAO contract-specific star ratings are based upon various metrics that measure an MAO's performance and quality of care, and in turn determine what applicable increase, if any, is applied to the revenue from the federal government. A star rating of 4.0 and higher results in an approximate 5% quality bonus payment (QBP), and those contracts, which go from a 4.0 star rating or higher to a 3.5 star rating or lower, find their federal revenue reduced approximately 5%.

Many MAOs are confined by competitive pressures in their market, and are unable or reluctant to make large benefit changes or premium changes in a single year. Some years have had large revenue changes not attributed to a star rating change in a given year, such as the elimination or re-introduction of the Health Insurance Providers Fee (HIPF),[1] which may have allowed an MAO to prevent large benefit reductions and possibly premium increases due to a decrease in star rating. Changes also vary by Medicare Advantage (MA) plan type and the size of the MAO or if the MAO is trying to maintain a $0 premium on specific plans. This paper provides insight into plans' benefit and premium changes made alongside revenue changing due to a star rating change, and measures the change in value added through benefits and premium changes provided to beneficiaries.

We analyzed general enrollment plans that experienced one of two star rating changes:

- Plans that saw their star rating move from a 3.5 or lower star rating to 4.0 or higher. We refer to these as "Increased Revenue" plans. As noted above, this change in star rating results in an approximate 5% increase (or up to 10% in qualifying counties) in federal revenue relative to the prior time period.
- Plans that saw their star rating move from a 4.0 star rating or higher to 3.5 or lower. We refer to these as "Decreased Revenue" plans. Again, this change in star rating results in an approximate 5% decrease in federal revenue relative to the prior time period.

This analysis was measured from one plan year to the next for the following calendar year (CY) time periods:

- CY2016 to CY2017
- CY2017 to CY2018
- CY2018 to CY2019
- CY2019 to CY2020

We measured changes made to an MA plan's benefit offerings using a "value added" metric. Value added is defined as the value of benefits provided to a specific plan's beneficiaries above and beyond traditional Medicare fee-for-service (FFS) benefits, not funded through beneficiary premiums.

The table in Figure 1 shows the average value added change for Increased Revenue and Decreased Revenue plans, as compared to all general enrollment plans, in each of the four years analyzed.

FIGURE 1: VALUE ADDED CHANGES FOR MEDICARE ADVANTAGE PLANS WITH STAR RATING CHANGES, PMPM CHANGE BY YEAR

Year	All General Enrollment Plans[2]	Decreased Revenue Plans	Increased Revenue Plans
2016 to 2017	$7.38	-$4.56	$15.23
2017 to 2018	$5.19	-$4.87	$5.71
2018 to 2019	$13.05	$8.36	$19.21
2019 to 2020	$5.66	$0.58	$6.78
Four-year Average	**$7.82**	**-$0.12**	**$11.73**

[1] Doucet, M., Yahnke, J. now Friedman, J. (April 2013). https://www.milliman.com/-/media/Milliman/importedfiles/uploadedFiles/insight/healthreform/pdfs/aca-health-insurer-fee.ashx

[2] Friedman, J.M., Swanson, B.L., Yeh, M.G., & Cates, J.J. (February 2020). State of the 2020 Medicare Advantage Industry: As Strong as Ever. Milliman Research Report. Retrieved October on 2, 2020, from https://us.milliman.com/-/media/milliman/pdfs/articles/state_of_the_2020_medicare_advantage_industry.ashx.

Key takeaways from this analysis include:

- As seen in Figure 1, the changes in value added relative to the market average in each year are directionally consistent with the change in star rating for these plans. The mix of plans included in each year of the analysis vary from year to year. However, the overall four-year average still results in relativities to the overall market that align with the directionality of the expected revenue streams for each star rating change.
  - Decreased Revenue plans averaged about $8 per member per month (PMPM) less of benefit or premium improvements relative to the market average for all general enrollment plans over the last four years, while Increased Revenue plans averaged approximately $4 PMPM more of benefit or premium improvements relative to the general enrollment overall market average in the last four years.
  - In three of the four years of the analysis, Decreased Revenue plans decreased their value added more relative to the market average than Increased Revenue plans increased value added.
  - On an absolute basis, Decreased Revenue plans averaged about $0 PMPM of benefit or premium improvements over the last four years, while Increased Revenue plans averaged nearly $12 PMPM more of benefit or premium improvements in the last four years.
- Increased Revenue plans tend to add more benefits than Decreased Revenue plans remove. Competitive pressures for Decreased Revenue plans may make them look to be more efficient with administrative expenses and medical management practices, or may necessitate a reduction in margin, to make up for lost revenue in order to continue offering key benefits or to maintain beneficiary premiums.
- Moratoriums of HIPF in CY2017 and CY2019 had a large positive effect on increasing the change in value added in each of those years, in particular for the Increased Revenue plans.

We reviewed the data also by categorizing the results into $0 premium and non-$0 premium cohorts for both Increased Revenue and Decreased Revenue plans. More detail behind these results can be reviewed in Appendix A (Increased Revenue plans) and Appendix B (Decreased Revenue plans).

- For Increased Revenue non-$0 premium plans, the largest reduction in premiums, on a PMPM basis, tended to be from national MAOs. These sponsors tended to adjust premiums more so than smaller MAOs when they receive additional revenue due to reaching the 4.0 or higher star rating. The relationship between premium decreases and benefit enhancements is much more uniform for national MAOs relative to plans sponsored by smaller MAOs, which tend to make benefit enhancements before reducing premiums.
- Enticement benefits of dental, vision, and over-the-counter (OTC) drug card, as well as Part D benefits, tended to be added or enhanced the most for Increased Revenue plans, and these same benefits are reduced less on Decreased Revenue plans, especially for $0 premium plans.
  - Decreased Revenue non-$0 premium plans tended to remove supplemental benefits more than their $0 premium counterparts. In fact, $0 premium Decreased Revenue plans generally added supplemental benefits while reducing enhanced coverage of Medicare-covered benefits. Decreased Revenue non-$0 premium plans would generally achieve this by removing or reducing dental or OTC coverage. Both benefits have high penetration of the MA market.[3]
  - Decreased Revenue $0 premium plans, and to a lesser degree, Decreased Revenue non-$0 premium plans, tended to reduce enhanced coverage of Medicare-covered benefits. In particular, cost sharing on outpatient services would increase.
    - The Centers for Medicare and Medicaid Services (CMS) places specific cost-sharing limits on various MA benefits including but not limited to inpatient hospitalization, skilled nursing services, emergency care, urgently needed care, and physician services. Outpatient surgery and ambulatory surgical care, both outpatient services, are thus not restricted by any specific cost-sharing limits. Because these benefits are likely not top of mind when individuals make plan decisions, they are popular choices when MAOs need to look to areas to make benefits leaner.

As shown in the table in Figure 2 below, in the last four years, approximately 70% to 80% of Increased Revenue plans have increased year-over-year value added.

FIGURE 2: VALUE ADDED CHANGES FOR MEDICARE ADVANTAGE PLANS WITH STAR RATING CHANGES, DISTRIBUTION BY STAR RATING CHANGE

	Decreased Revenue Plans		Increased Revenue Plans	
Year	Increased Value Added	Reduced Value Added	Increased Value Added	Reduced Value Added
2016 to 2017	39.5%	60.5%	81.4%	18.6%
2017 to 2018	30.5%	69.5%	73.4%	26.6%
2018 to 2019	66.7%	33.3%	81.2%	18.8%
2019 to 2020	53.3%	46.7%	75.9%	24.1%

[3] Ibid

For Increased Revenue plans, the results tend to be similar to the PMPM value added in that the vast majority of Increased Revenue plans have positive value added. These results are even more pronounced in the two years of the HIPF moratorium, CY2017 and CY2019. The percentage of Decreased Revenue plans that increased their value added amounts is higher than what otherwise may be expected, particularly from CY2018 to CY2019 and CY2019 to CY2020. Specifically, in each of these years, the percentage of Decreased Revenue plans with positive value added is greater than 50%, with CY2019 reaching close to 67% with the HIPF moratorium.

While it is clear Increased Revenue plans are able to offer additional benefits beyond the market average, it does not appear that MA beneficiaries are basing their choice of plan solely on the star rating and associated benefits of lower cost sharing and reduced premium. Over the last two years of changes analyzed, CY2018 through CY2020, approximately 2.3 million people enrolled in Decreased Revenue plans while only 1.6 million enrolled in Increased Revenue plans. This is important to note because it emphasizes star rating and the assumed importance of benefit and premium improvement are not the only drivers for beneficiaries to enroll in a particular plan. Other drivers may include a plan's breadth of network, brand affinity, and ability to drive market share.

Methodology and assumptions

To perform these analyses, we relied on detailed information on MA plan benefit offerings from 2016 through 2020 and their respective premiums and star ratings released by CMS. We also used publicly available MA enrollment information for February of each year to develop enrollment-weighted averages by plan grouping. The various groupings we analyzed include:

- Plan year
- $0 premium plans
- Non-$0 premium plans
- Plan type e.g., health maintenance organization (HMO), preferred provider organization (PPO)
- MAO size

The values presented reflect plans available in each respective year. The information released by CMS includes detailed cost-sharing information by service category, enrollee premium, service area, supplemental benefits covered, star rating, and enrollment by plan.

For these analyses, we define value added as the benefits provided to a plan's beneficiaries above traditional Medicare. This metric accounts for the value of supplemental benefits provided to a plan's beneficiaries and is offset by the amount of premium charged to the plan's beneficiaries and any buy-down of the Part B premium. Therefore, two plans with identical benefits will have different value added amounts if their premium amounts differ. The value added metrics are defined as:

- Part C Value Added = Estimated value of supplemental Part C benefits - Part C beneficiary premium
- Part D Value Added = Estimated value of supplemental Part D benefits (indicated Part D premium) – Part D beneficiary premium
- Total Value Added = Estimated value of supplemental Part C benefits + Estimated value of Part D benefits + Buy-down of Part B premium – Part C and Part D beneficiary premiums

We used the Milliman MACVAT® (which summarizes the previously mentioned information released by CMS as well as the value added metric) to identify plans that either received a 4.0 star rating or higher after receiving a lower star rating in the previous year (Increased Revenue plans) or received a 3.5 star rating or lower after receiving a higher star rating in the previous year (Decreased Revenue plans). We reviewed this for CY2016 to CY2017, CY2017 to CY2018, CY2018 to CY2019, and CY2019 to CY2020. We note the overall star rating of the previous year informs the star rating the contract will assume for the coming bid year, e.g., the 2015 overall star rating impacted revenue for CY2016.

We included all individual plans-- e.g., non-employer group waiver plan (EGWP) MA prescription drug (MAPD) plans. Prescription Drug Plans (PDPs), Medical Savings Account (MSA) plans, Medicare-Medicaid Plans (MMP), Program for All Inclusive Care of the Elderly (PACE) plans, Part B only plans, and Cost and Special Needs Plans (SNPs) were excluded. SNPs generally have a large portion of dual-eligible enrollment (i.e., beneficiaries who are eligible for both Medicare and Medicaid). Medicaid pays the cost sharing for these beneficiaries and reimburses the MAOs for the enrollee premium, up to the low-income premium subsidy (LIPSA), which CMS publishes annually and varies by region. Therefore, because the MAOs often target the LIPSA as the plan premium amount, the premium amount is not a true function of the revenue available to the plan and thus, we did not include these plans when doing the annual comparisons. We also did not include any plans from Puerto Rico.

Caveats, limitations, and qualifications

Adam J. Barnhart, Julia M. Friedman, and Peter T. Kissinger are 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 report is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices.

The material in this report represents the opinion of the authors and is not representative of the view 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 report is designed to provide an analysis of the relationship between Medicare Advantage plan revenue based on star rating and the benefits offered by the plan. This information may not be appropriate, and should not be used, for other purposes. We do not intend this information to benefit any third party that receives this work product. Any third-party recipient of this report that desires professional guidance should not rely upon Milliman's work product, but should engage qualified professionals for advice appropriate to its specific needs. Any releases of this report to a third party should be in its entirety.

The credibility of certain comparisons provided in this report may be limited, particularly where the number of plans in certain groupings is low. Some metrics may also be distorted by premium and benefit changes in a few plans with particularly high enrollment.

In preparing our analysis, we relied upon public 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

Plans moving to a 4.0 star rating or higher after being at 3.5 or below (Increased Revenue plans)

We further broke our analysis down between $0 premium plans and non-$0 premium plans to identify any differences between the two groups that cross the 4.0 star rating threshold. Over the last four years, the value added change has been slightly greater for non-$0 premium plans when compared with $0 premium plans that reach a 4.0 star rating or higher. The table in Figure 3 below lists the value added for each of these types of plans over the last four years.

FIGURE 3: VALUE ADDED CHANGES FOR MEDICARE ADVANTAGE PLANS WITH STAR RATING CHANGES, PMPM BY PLAN PREMIUM AMOUNT

	Increased Revenue Plans	
Year	$0 Premium Plans	Non-$0 Premium Plans
2016 to 2017	$14.37	$16.56
2017 to 2018	$5.11	$7.15
2018 to 2019	$18.64	$19.67
2019 to 2020	$4.22	$10.58

$0 PREMIUM PLANS

Within the Increased Revenue $0 premium plan grouping, plans tended to add value to their beneficiaries by enhancing or increasing the number of non-Medicare covered benefits that are offered to their beneficiaries over the four years of changes analyzed. To isolate specific benefit changes, we reviewed CY 2019 to CY 2020 benefit changes for these plans. In particular, plans within this grouping added or enhanced numerous benefits, such as OTC drug card and transportation benefits. These plans have also added value by enhancing professional visits, primarily through reduced copays for primary care visits, specialty care visits, and mental health services. Plans also leveraged reducing Part D copays and deductibles as another way to add significant value for their beneficiaries.

The table in Figure 4 below shows the breakdown of the value added change for Increased Revenue $0 premium plans by major service category.

We also looked for value added patterns between different plan types, particularly HMO plans, HMO – Point-of-Service (HMO-POS) plans, Local PPO (LPPO) plans, and Regional PPO (RPPO) plans. For Increased Revenue $0 premium plans over the last four years, the vast majority of plans, approximately 82%, are HMO plans. Around 10% of the plans, over the four years analyzed, were HMO-POS plans and the remaining were split between LPPO and RPPO plans. HMOs are typically better able to achieve a $0 premium by offering a limited network and greater management of costs due to control of said network. HMOs are also generally better able to engage in risk-sharing contracts with their network providers, providing an incentive to the providers to optimize the quality metrics underlying the star rating.

NON-$0 PREMIUM PLANS

The Increased Revenue non-$0 premium plans have the option of reducing premium with the additional revenue in addition to improving other benefits. On average, these plans elected to use about 25% of the total value added change to improve premium with the remainder going toward improved benefits. For three of the four years that were analyzed, at least 20% of Increased Revenue non-$0 premium plans raised their premiums, reaching as high as 30% of plans from CY2017 to CY2018 and 26% of plans from CY2019 to CY2020.

FIGURE 4: VALUE ADDED CHANGES FOR MEDICARE ADVANTAGE PLANS WITH STAR RATING CHANGES, INCREASED REVENUE $0 PREMIUM PLANS, CHANGES BY MAJOR SERVICE CATEGORY

Year	Total Value Added Change	Inpatient Change	Outpatient Change	Professional Change	Other Change	Non-Medicare-Covered Value Added Change	Part D Value Added Change	Part B Premium Buy-down Change
2016 to 2017	$14.37	$0.03	$1.01	$1.84	$0.42	$5.06	$5.92	$0.09
2017 to 2018	$5.11	-$0.07	-$0.09	$1.70	$0.24	$2.39	$0.91	$0.01
2018 to 2019	$18.64	$2.09	$0.77	$5.09	$1.25	$6.21	$2.41	$0.83
2019 to 2020	$4.22	-$0.17	$0.59	$1.14	$0.20	$1.98	$0.22	$0.26

Plans that had the largest reductions in premiums, on a PMPM basis, tended to be from national MAOs, such as UnitedHealth Group, Humana, and Centene. These sponsors tended to adjust premiums more so than smaller MAOs when they receive additional revenue from reaching the 4.0 or higher star rating. While the plans sponsored by national MAOs enhance their benefit offering as well, the relationship between premium decreases and benefit enhancements is much more uniform than plans sponsored by smaller MAOs, which tend to make benefit enhancements before reducing premiums.

The table in Figure 5 below shows the breakdown of the value added change for Increased Revenue non-$0 premium plans by major service category.

Outside of premium changes, similar to the $0 premium plans, the Increased Revenue non-$0 premium plans added benefit value primarily by adding or enhancing supplemental benefits, enhancing Medicare-covered professional cost sharing, and enhancing Part D benefits. Particularly for CY2019 to CY2020, many of the plans driving the change in the non-Medicare covered value added numbers enhanced or added nearly all of what are considered "core" non-Medicare benefits: non-Medicare covered vision exams and an allowance for vision hardware, non-Medicare covered hearing exams and hearing aids, OTC drug coverage, supplemental dental coverage, or meal benefits. Additionally, reducing Part D cost sharing, particularly for Tier 1 and Tier 2 prescription drugs, was a popular way for these plans to enhance benefits.

For Increased Revenue non-$0 premium plans over the last four years, similar to $0 premium plans, approximately 48% are HMO plans. Around 11% of the plans, over the four years analyzed, are HMO-POS plans, about 39% are LPPO, and the rest are RPPO plans. As noted earlier, HMOs are generally better able to engage in risk-sharing contracts with their network providers, providing an incentive to the providers to optimize the quality metrics underlying the star rating.

FIGURE 5: VALUE ADDED CHANGES FOR MEDICARE ADVANTAGE PLANS WITH STAR RATING CHANGES, INCREASED REVENUE NON-$0 PREMIUM PLANS, CHANGES BY MAJOR SERVICE CATEGORY

Year	Total Value Added Change	Premium Change	Inpatient Change	Outpatient Change	Professional Change	Other Change	Non-Medicare-Covered Value Added Change	Part D Value Added Change	Part B Premium Buy-down Change
2016 to 2017	$16.56	-$3.20	$0.18	$1.12	$2.45	$0.19	$1.74	$7.66	$0.01
2017 to 2018	$7.15	-$1.45	-$0.01	$0.56	$0.81	$0.05	$3.29	$1.00	$0.00
2018 to 2019	$19.67	-$7.93	-$0.03	$0.65	$3.91	-$0.48	$4.86	$2.83	$0.00
2019 to 2020	$10.58	-$2.66	-$0.55	$0.87	$2.23	$0.06	$3.89	$1.41	$0.00

Appendix B

Plans moving to 3.5 Star rating or below after being at 4.0 or higher (Decreased Revenue plans)

As shown in the table in Figure 6, Decreased Revenue non-$0 premium plans tend to have larger shifts in value added than their $0 premium counterparts. A large amount of the difference can be attributed to the change in the premium amount, a lever that $0 premium plans do not have available to them. For the most recent two years of changes analyzed, the aggregate change of these Decreased Revenue plans has been positive value added, despite losing the 5% revenue bonus. However, the change in value added for these two years was lower than the average increase for general enrollment plans. The HIPF moratorium likely played a role in the CY2018 to CY2019 positive value added.

FIGURE 6: VALUE ADDED CHANGES FOR MEDICARE ADVANTAGE PLANS WITH STAR RATING CHANGES, PMPM CHANGE BY PLAN TYPE

	Decreased Revenue Plans	
Year	$0 Premium Plans	Non-$0 Premium Plans
2016 to 2017	-$1.79	-$7.26
2017 to 2018	-$4.09	-$5.28
2018 to 2019	$6.58	$10.35
2019 to 2020	$0.00	$1.89

$0 PREMIUM PLANS

Similar to the Increased Revenue $0 premium plans, the Decreased Revenue $0 premium plans continued enhancing non-Medicare covered benefits despite their known loss in revenue. Over the two most recent years, these plans also increased the value added on Medicare covered professional benefits while reducing beneficiary benefits in other Medicare-covered categories as shown in the table in Figure 7. The HIPF moratoriums in CY2017 and CY2019 obscure some of the changes that may have occurred absent them and relative revenue increases.

The decreases in Medicare covered benefits were offset by small increases in non-Medicare covered benefits in most years driven by plans adding or enhancing OTC drug card benefits, adding non-Medicare covered hearing and vision benefits, adding non-emergency transportation benefits, and adding or expanding meal coverage. With the exception of CY2018 to CY2019, which was a HIPF moratorium year, these plans saw benefit increases across the board, while the Part D benefits have stayed near flat or were reduced for these Decreased Revenue $0 premium plans.

In the four years of data analyzed, we found three years with reductions in the Medicare-covered outpatient supplemental value, and the one year with a positive change was nearly flat. These decreases in outpatient supplemental value added are primarily due to increases in outpatient surgery and ambulatory surgical cost-sharing amounts. They tend to be popular benefits for plans to increase beneficiary cost sharing when a benefit reduction is necessary. As mentioned in the body of the report, CMS places specific cost- sharing limits on various MA benefits including, but not limited to: inpatient hospitalization, skilled nursing services, emergency care, urgently needed care, and physician services. Because outpatient surgery and ambulatory surgical care are not restricted by any specific cost-sharing limits and because these benefits are not necessarily top of mind when individuals are making plan decisions, they are popular choices when plans need to look for areas to make benefits leaner.

FIGURE 7: VALUE ADDED CHANGES FOR MEDICARE ADVANTAGE PLANS WITH STAR RATING CHANGES, DECREASED REVENUE $0 PREMIUM PLANS, CHANGES BY MAJOR SERVICE CATEGORY

Year	Total Value Added Change	Inpatient Change	Outpatient Change	Professional Change	Other Change	Non-Medicare-Covered Value Added Change	Part D Value Added Change	Part B Premium Buy-down Change
2016 to 2017	-$1.79	-$0.88	-$0.91	-$1.89	$0.34	$0.29	$0.24	$1.03
2017 to 2018	-$4.09	-$0.29	-$0.89	-$0.87	$0.07	$0.77	-$2.89	$0.02
2018 to 2019	$6.58	$0.46	$0.06	$2.42	$0.42	$2.18	$1.04	$0.00
2019 to 2020	$0.00	-$0.57	-$1.60	$0.29	$0.00	$1.42	$0.41	$0.06

Also similar to the Increased Revenue $0 premium plans, the majority of the Decreased Revenue $0 premium plans are HMO plans. HMO plans made up approximately 68% of the plans analyzed over the four-year period and about 69% of the population. LPPO plans constituted 15% of the plans analyzed, followed by HMO-POS plans, RPPO plans, and a small number of Private FFS (PFFS) plans.

NON-$0 PREMIUM PLANS

Decreased Revenue non-$0 premium plans had large decreases in value added in the first two years of the analysis, followed by a large increase in value added in the third year (likely due to the HIPF moratorium), and then a reduced, but still positive value added in the fourth year of the analysis. Unlike the $0 premium plans, non-$0 premium plans tended to be less focused on maintaining positive value added amounts for non-Medicare covered benefits as shown in the table in Figure 8 below. These plans generally made large changes to premium to make up lost revenue or account for additional revenue in the case of the HIPF moratorium years.

Also, while the benefit changes are fairly consistent among major categories, less emphasis is placed on enhancing non-Medicare covered benefits, compared with the Decreased Revenue $0 premium plans. In fact, a number of plans removed or reduced supplemental benefits, including removing dental benefits, lowering OTC drug card benefit limits or eliminating the benefit altogether, and lowering hearing benefits, when reviewing CY2019 to CY2020 data.

Similar to the Increased Revenue non-$0 premium plans, there is a wider range of plan types of Decreased Revenue non-$0 premium plans relative to Decreased Revenue $0 premium plans. While HMO plans still comprise about 47% of the plans analyzed, about 26% of the plans were LPPO plans, approximately 15% were HMO-POS plans, and the remaining plans were split between RPPO and LPPO plans.

FIGURE 8: VALUE ADDED CHANGES FOR MEDICARE ADVANTAGE PLANS WITH STAR RATING CHANGES, DECREASED REVENUE NON-$0 PREMIUM PLANS, CHANGES BY MAJOR SERVICE CATEGORY

Year	Total Value Added Change	Premium Change	Inpatient Change	Outpatient Change	Professional Change	Other Change	Non-Medicare-Covered Value Added Change	Part D Value Added Change	Part B Premium Buy-down Change
2016 to 2017	-$7.26	$4.91	-$0.87	-$1.32	-$1.08	$0.62	-$1.44	$1.74	$0.00
2017 to 2018	-$5.28	$3.80	-$1.15	$0.24	-$0.21	-$0.53	$0.00	$0.17	$0.00
2018 to 2019	$10.35	-$6.03	-$0.08	-$0.17	$1.70	$0.11	$3.02	-$0.26	$0.00
2019 to 2020	$1.89	-$0.91	-$0.16	$0.59	$1.04	-$0.55	-$0.21	$0.28	$0.00