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Preparing for Medicare Advantage's Make-or-Break Moment

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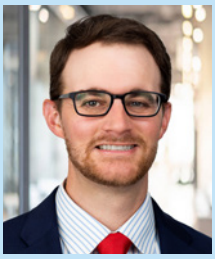

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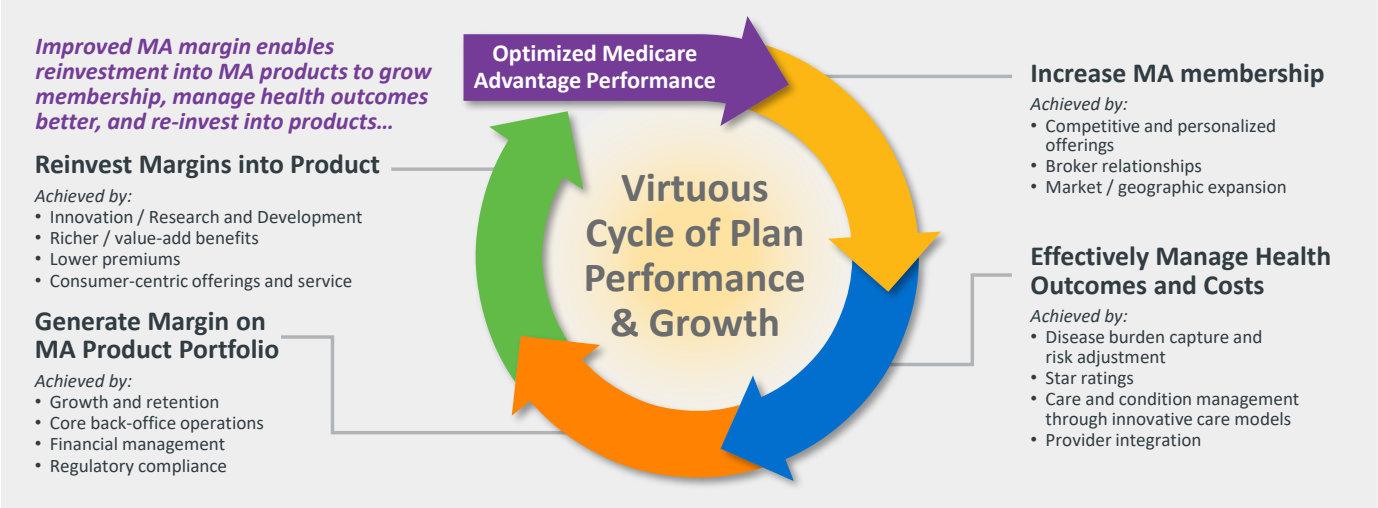
In recent years, the Medicare Advantage (MA) program enjoyed both rapid membership growth and positive attention from healthcare organizations and advocates. As of the beginning of 2024, 33.4 million Americans were enrolled in MA, up 7% from 2023. More than half of all Medicare-eligible individuals are now enrolled in MA.

Interest and growth in MA has been buoyed by a number of factors: a growing eligible population as Baby Boomers continue to age into Medicare eligibility; affordable benefit packages with low or zero monthly premiums; regulatory changes providing for more flexibility in plan and member design; consumer-centric programs and care models tailored to the needs of beneficiaries; increased marketing and sales efforts through direct mailings, telemarketing, and online advertising.

The program has also delivered meaningful value to members, who are more likely than traditional Medicare beneficiaries to have an annual income less than $40,000. In addition, the average monthly premium for Medicare beneficiaries enrolled in an MA plan has dropped by almost one-third in the last four years, reaching $18 per month in 2023.

Ideally, success in MA can take the form of a virtuous cycle: an improved margin on MA for a plan enables reinvestment in related products to grow membership and better manage health outcomes, which leads to further reinvestment (Figure 1). Sustained success is contingent on meaningful collaboration between payers and providers.

Figure 1: *The Virtuous Cycle of MA Success*



MA Hits Headwinds

However, after several high-growth years, payers and providers are currently confronting multiple MA-related challenges. Many providers have recently posted losses as their contractual yields decrease and authorizations for care have become more restrictive. The bar for risk adjustment and Star Ratings is also rising. Only 6% of plans received a 5-star rating from the Center for Medicare & Medicaid Services (CMS) for 2024, down from 22% in 2023. CMS also recently confirmed plans for rate cuts in 2025, with critics arguing that benefits for beneficiaries may become more limited. Providers are also reeling from related bureaucratic headaches.

As a result of these concerns, some providers are going out of network from MA plans, while some have asked CMS to investigate administrative denials. Nineteen percent of health system chief financial officers stopped accepting one or more MA plans in 2023—and 61% either plan to do so in 2024 or are considering doing so—according to a recent survey by the Healthcare Financial Management Association and Eliciting Insights.

Current MA members also have expressed concerns with the program's trajectory. While roughly two-thirds of MA and traditional Medicare beneficiaries recently surveyed by the Commonwealth Fund said their coverage has met their expectations, MA members were more likely to report delays in care while awaiting prior approval (22% vs. 13%) or difficulty affording care due to copayments or deductibles (12% vs. 7%).

Some industry experts are warning senior citizens about the costs associated with switching back to traditional Medicare after enrolling in MA plans. Their concerns are creating political and regulatory scrutiny.

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Collaborating for Value

Despite current challenges, many providers and health plans believe they need to continue to participate in and/or prioritize MA, given the program's scale and overall benefits to their organizations and the communities they serve.

For instance, the success of MA risk contracts predicated on collaborating around delivering healthcare value suggests a possible path forward.

According to a JAMA study of more than 300,000 Medicare Advantage beneficiaries, members in value-based care MA arrangements with risk for both payers and providers had lower rates of inpatient admission, emergency department visits, and readmissions. In addition, CMS's robust risk scoring model ensures that providers are paid fairly for the true cost of providing care to the populations they serve.

Percent of premium contracts, where payers delegate a share of the premium to providers to manage, are predictable, align payer and provider interests, easy to understand, and increasingly common.

In addition, the high cost of caring for Medicare enrollees makes the population health focus on VBC arrangements economical. Medicare members have the highest utilization of any insurance class, so intensive services like care management, disease management, and care coordination are more likely to have a positive return on investment.

Successful VBC arrangements share several core tenets, grounded in the need for close collaboration between participating parties (Figure 2).

However, VBC arrangements are not the only option. Value-centric collaborations can take on a wide range of forms, depending on the amount of risk providers are willing to assume and the partnerships' risk-related capabilities. The full continuum of value-centric collaborations runs the gamut from shared savings contracts with no downside risk for providers to full vertical integration into a single organization (Figure 3).

Figure 2: *Core Tenets Of Successful Payer-Provider Value-Based Care Models*

1 **Joint Oversight**	Joint governance, strategic alignment, and strategic planning through management / leadership collaboration
2 **Aligned & Meaningful Incentives**	Both sides sharing in risk and reward that is material enough to incent behavior change
3 **Joint Capability Deployment**	Leverage each others' unique strengths, co-invest in innovation, provider enablement, data-sharing, PHM capabilities, etc.
4 **Market Differentiation**	Partnership establishes unique elements and provides members/ patients value they can only get through the partnership

Figure 3: *Understanding the Continuum of Value-Based Care Arrangements*

	FFS	Common VBC Models			VBC-Driven Partnerships			
Partnership (Payment) Model	**Fee For Service**	**Shared Savings (Upside Only)**	**Shared Risk (Up and Downside)**	**Global Capitation**	**Joint Venture Risk-Based Entity (RBE)**	**Joint Insurance Product**	**Joint Provider Asset**	**Vertical Integration**
	Increasing Provider risk assumption and capability needs *Increasing Provider's opportunity for value creation and capture*							
Description	Provider is paid for each distinct service rendered on a transactional basis	Provider can earn upside payment based on total cost of care savings and quality performance	Provider is at risk for upside or downside payment based on total cost of care savings and quality performance	Provider assumes capitated risk (% of premium) and delegated capabilities for defined population	Risk-bearing entity jointly developed and owned by Provider and Payer that manages % of premium	Insurance plan or product jointly developed and owned by Provider and Payer	Payer and provider jointly agree to own a provider asset	Payer and Provider combining into a single organization which integrates care and coverage

Looking Into the Crystal Ball: Three Future State Scenarios

As the MA market confronts new headwinds after years of growth and favorable attention, we anticipate three possible future state scenarios. These possibilities can be applied to both the outlook nationally, as well as the actions of payers and providers within specific markets.

Scenario 1: A renewal of growth

In this scenario, better sense prevails, and plans and providers collaborate to address the core issues facing the program. A pause/adjustment in the market is followed by a period of renewed growth. From a national standpoint, this scenario is contingent on neutral to favorable regulatory treatment.

Scenario 2: Uneasy stabilization

In this scenario, contention is partially resolved through some degree of collaboration between payers and providers. This scenario is also dependent on neutral to favorable regulatory treatment.

Scenario 3: Implosion

In this scenario, high levels of contention continue, and more providers go out of network. Middle-income Medicare members opt out of MA and go back to traditional Medicare when feasible. This scenario accounts for heightened regulatory pressure on risk adjustment and utilization management practices, which further pressures margins.

Conclusion

Despite MA's recent, publicly documented challenges, the program now accounts for more than half of all Medicare beneficiaries—a patient population that every healthcare organization must engage in some form or fashion.

As providers and payers decide how to approach the program—and each other—amid uncertainty and contention, the path forward can appear unclear. However, healthcare leaders seeking to emerge from the current environment of MA contention have an opportunity to shape the future of MA and will play a major role determining which of the three scenarios outlined in this article comes to fruition.

Ultimately, organizations must be able to develop a business model that both delivers quality care and manageable per capita costs—and critically, find ways to work through today's pressing concerns with other MA stakeholders and partners.

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