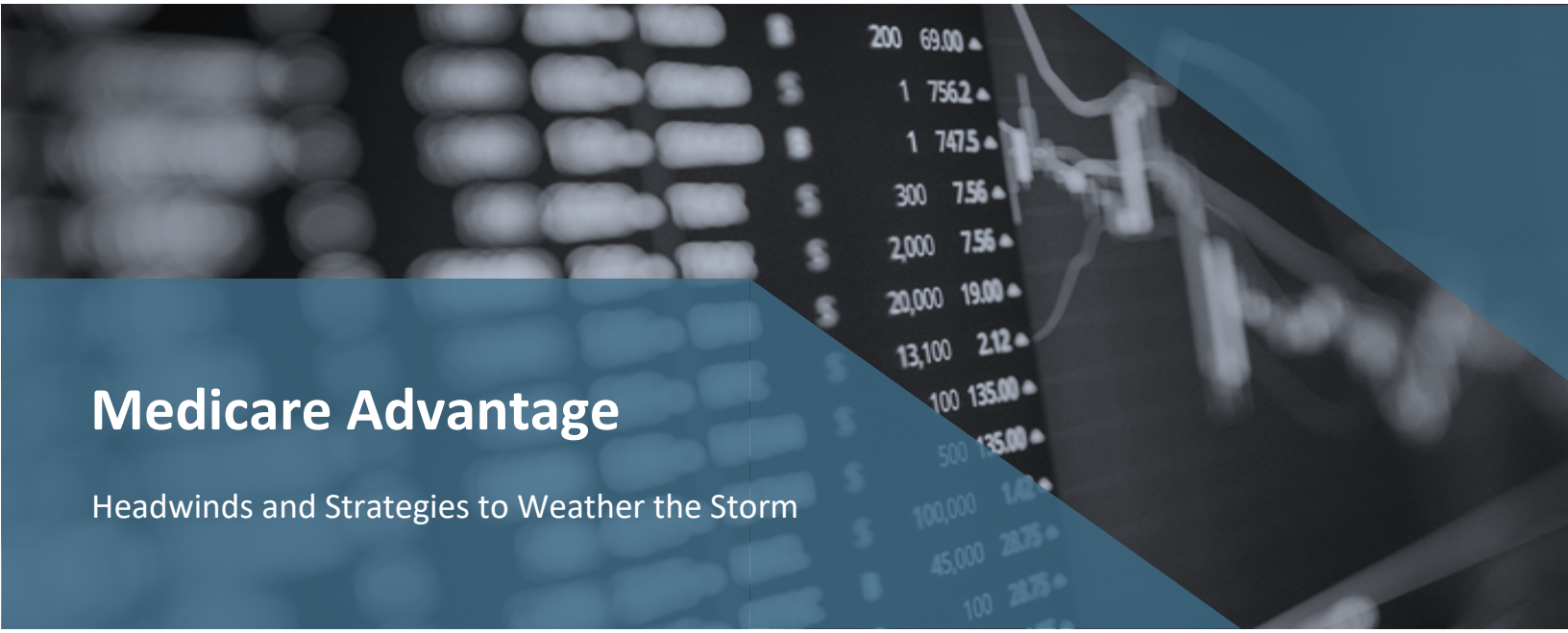


Medicare Advantage

Headwinds and Strategies to Weather the Storm

The Medicare Advantage market appears to be at a critical crossroads. The past few years have seen unprecedented enrollment growth, fueled by a rapidly increasing over 65 population and a favorable regulatory environment. The unprecedented growth from prior years has now slowed down and conflicting trends converging on Medicare Advantage organizations are expected to continue to result in more tempered growth going forward.

The following characteristics are shaping the market:

- **Enrollment trends:** Half of Medicare-eligible individuals are now in Medicare Advantage plans. The market grew by 1.7 million beneficiaries (+5.4%), slowing down from the previous year's record growth of 2.7 million (+9.4%). Notably, for-profit carriers like United, Humana, and Aetna collectively captured 1.4 million new members: 86% of the total market's growth.
- **Plan options and preferences:** The number of plan options are roughly flat from the previous year, with the average senior having access to 44 plans. Preferred provider organizations (PPOs) have increased, constituting 43% of all plans offered, up from 31% in 2019.
- **Market dynamics and quality:** Medicare Advantage enrollment and social vulnerability are related. Counties with higher vulnerability scores show greater penetration rates (53%) compared to counties with lower scores (45%). Meanwhile, quality remains a concern as plans struggle to maintain quality scores. Average star ratings continued their decline and this year approximately one-quarter of beneficiaries are enrolled in a plan with less than four stars.
- **Market outlook:** In the current environment, lower than average rate increases, post pandemic spikes in utilization, and a tighter risk adjustment model have contributed to slowing the momentum that has driven historic growth. The margin and operational pressures of these changes were felt in 2024 and will intensify in 2025.

Moving forward, in addition to the slow down in growth, there are other changes afoot that will present challenges for Medicare Advantage plans moving forward. Understanding the nature and direction of these changes are important for plans and providers in terms of taking action to maintain the viability of their Medicare Advantage offerings.

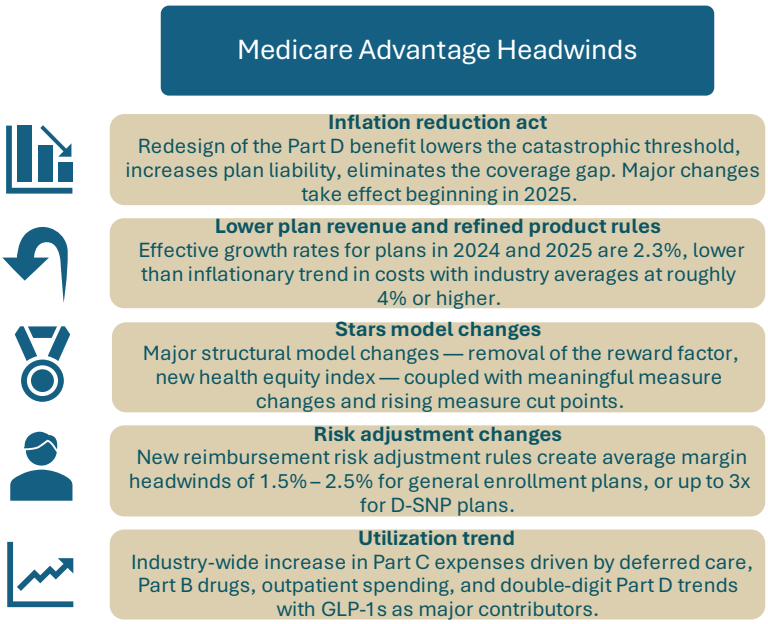
How the regulatory environment is shaping the future, introducing challenges for Medicare Advantage plans

Legislative changes being made to the program are deliberate and intended to address perceived flaws in the current set of rules and regulations governing these plans. There is mounting concern over the cost of the program. It's more than a question of solvency, but rather skepticism around the value for dollars spent – an estimated $462 Billion in 2024.

This skepticism has grown in spite of all the effort that Medicare Advantage and provider organizations have put forth to improve quality ratings year over year, introducing new health equity and social determinants of health programs, plus helping members get the care they need during the pandemic.

An example to illustrate this apparent divide (between what plans are doing to make improvements in an effort to fuel growth versus value perceived) is the broad introduction and expansion of supplemental benefits as a strategy to grow membership. Relaxation of eligibility rules have enabled insurers to cover everything from gasoline cards and groceries to utility bills. While these benefits can favorably address social determinants of health for very targeted populations, their widespread deployment as a tactic to grow membership comes at a time of increased scrutiny over funding for the Medicare Advantage program overall.

Before laying out some of the strategies and actions health plans and provider organizations might pursue to shore up the future viability of their offerings, let's take a snapshot look at the regulatory challenges being faced, as summarized in this exhibit:



Source: Oliver Wyman Analysis

Given these headwinds, here are some suggested steps payers can take to prepare

Redefine the product portfolio and right-size benefits.

The average Medicare Advantage beneficiary in 2024 has access to approximately 45 plans, with 4,400 options available nationally (PwC analysis). Given the wide choice and similarity in offerings, it will be critical for health plans to tailor their portfolios so that their products can be perceived as high value.

In light of the current environment, health plans should consider refocusing their efforts from "growth" to "insurance fundamentals, including a deeper dive into understanding which plans both can help drive growth and balance insurance

risk. Health plans need to continuously measure profitability at a product level to help determine the optimal mix of no-, low- or high-premium plans as well as HMOs and PPOs, in addition to the range of benefits offered.

Medical Expense Management

Fundamentals here include a renewed focus on building a health care delivery model that ensures equitable access to high-quality, cost effective care while paying attention to insurance risk related to populations served. Basics include:

- Stratifying the population based on health (physical and mental), utilization and social factors
- Manage high utilization conditions and procedures with more effective care coordination including steerage of less acute cases to lower levels of care
- Analysis to further strategic investments in existing population health programs, with an emphasis on all levers of performance (inclusive of member and provider satisfaction)
- Take further steps to share accountability with providers through risk-based contracting models

Evaluation breadth of provider network through the lens of managing performance

Network breadth is a key way payers have attempted to make their plans more competitive. A majority of both Medicare Supplement and original Medicare beneficiaries cite a leading reason for not choosing an Medicare Advantage plan related to accessing specialist care and doctors. The strong growth of PPO plans demonstrates that many beneficiaries prefer choice and plans that help bridge the gap between narrow HMO networks and fee-for-service or Medicare supplemental coverage. However, in order to continue efforts to “right side” networks, moving more toward value based provider contracting (shared risk) is an important consideration. A recent JAMA study showed that in Medicare Advantage plans with risk-based contracting, inpatient, ER, and readmission rates were lower.

Drive clarity and investments toward improving Medicare Advantage Star Ratings

Payers can build financial headroom by improving performance on CMS’s annual Medicare Advantage Star Ratings. CMS continues to evolve the way it calculates its ratings, going beyond Healthcare Effectiveness Data and Information Set (HEDIS), quality measures and Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys as it institutes aggressive threshold scores. Mature plans are building effective strategies to engage Low Income Subsidy (LIS), Dually Eligible (DE), and disabled enrollees to help improve performance on the Health Equity Index (HEI).

Benchmark supplemental benefits to meet market parity

Supplemental benefits that most payers offer — such as vision, hearing, fitness and dental — are required to remain at parity with the market. However, payers who have expanded into a broader range of supplemental benefits (as noted previously in this article) to enhance competitiveness, should take a step back and further evaluate the cost/benefit and value of these enhanced benefits.

Given an anticipated reduction in payments to payers that have historically helped to fund these benefits, payers should consider right-sizing (e.g., based on utilization or member social and clinical needs) to free up funds for other plan enhancements or to help improve total beneficiary cost in leading products.

Administrative and operational expense optimization

Rising administrative costs associated with Medicare Advantage Plans are likely to come under more intense scrutiny. For example, CMS plans to implement a new rule in 2026 requiring payers to provide a condensed, streamlined prior authorization process. Technology and data management investments, process improvements and automation, including predictive modeling and generative AI, offer the prospect of promising strategic levers to manage administrative spending.

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Risk adjustment optimization

Risk adjustment methodology refinement presents another opportunity for payers to capture revenue while effectively managing CMS rebates. Increasing the accuracy and completeness of risk scores through comprehensive risk score coding, as well as documentation and submission of risk data, may result in higher risk scores for the managed population and thereby higher risk-adjusted revenue payments from CMS.

In summary, strong analytics along with continued investment in member experience and provider networks may be key to help strengthen payers' performance in a competitive and evolving regulatory environment.

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