FACTFILE

JUNE 2023

healthleaders

As Medicare Advantage continues to grow, providers should be ready to execute a well-considered strategy

Medicare Advantage is expected to have a monumental year in 2023.

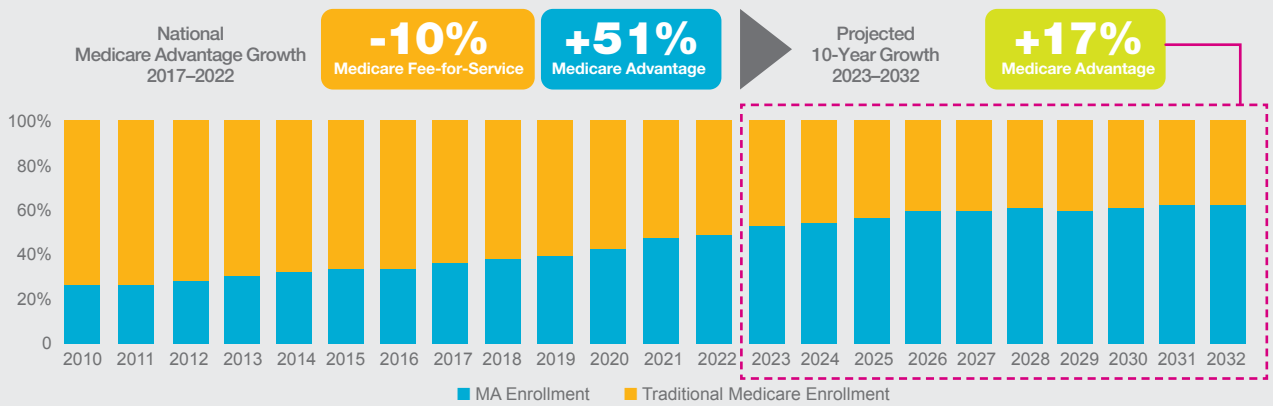
Congressional Budget Office (CBO) projections indicate 2023 will be the year Medicare Advantage (MA) penetration surpasses the symbolic majority threshold of 50%. Furthermore, major regulatory changes are set to be enacted or finalized that will inevitably impact both plan sponsors and providers.

Providers should expect Medicare Advantage to become a large part of their payer mix.

In just the past six years Medicare Advantage enrollment has grown by approximately 10 million beneficiaries or about 51%, while traditional Medicare enrollment growth has declined over the same period.

And in just the past four years MA penetration has gone up nearly 10% nationally. According to the CBO, that growth trajectory is expected to continue, rising to 61% penetration by 2032. Additionally, Medicare Advantage federal spending is already at $427 billion, which is approximately 55% of federal Medicare spending.

Medicare Advantage & Traditional Medicare Enrollment, Past & Projected



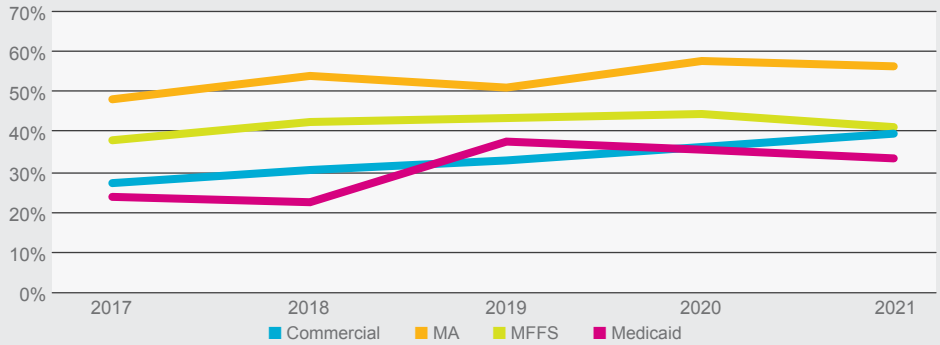
Source: Sg2 analysis of CMS Medicare Enrollment Dashboard and KFF analysis Medicare Chronic Conditions (CCW) Data Warehouse from 5% of beneficiaries, 2010–2017; CCW data from 20% of beneficiaries, 2018; and Medicare Enrollment Dashboard 2019–2022. Enrollment numbers from March of the respective year. Projections for 2023 to 2030 are from the May Congressional Budget Office (CBO) Medicare Baseline for 2022.

As a provider, what should I be prepared for with Medicare Advantage?

Medicare Advantage's rapid growth can be attributed to an aging population comprised of beneficiaries willing to trade restrictions on provider networks for extra benefits. In addition to aging beneficiaries, managed care plans are attracted to Medicare Advantage because of its ability to make a substantial margin, almost double compared to their other lines of business. When it comes to Medicare Advantage plans, what should providers expect if they decide to participate? One certainty is that they can anticipate more payments tied to alternative payment models (APMs) under Medicare Advantage than they will experience in other payer segments.

This means providers entering into Medicare Advantage contracts need to have the underlying value-based care infrastructure required to succeed in APMs. The good news is that for providers well positioned for success in Medicare Advantage APMs, they can apply this investment infrastructure towards other payer segments that are increasingly adopting APMs.

Percentage of Payments Tied to APMs | National, 2017–2021



Source: Data from Health Care Plan Learning and Action Network website. Accessed March 2023. https://hcp-lan.org/

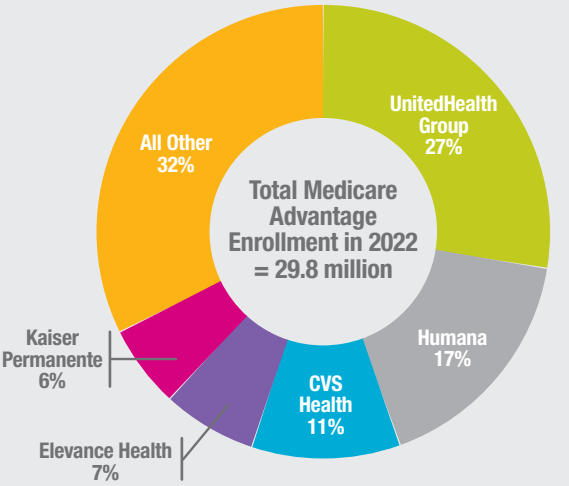
Medicare Advantage's growth may not always benefit providers

Providers should be aware that, while Medicare Advantage plan options are abundant from a beneficiary perspective, the MA industry is becoming more and more concentrated. Over half of the MA market is controlled by three insurance companies, all of which are for-profit. Providers should expect the big three to continue to get bigger in terms of MA. Humana recently announced plans to exit the commercial employer group market and focus on MA, while other plans, such as Elevance, look to grow their MA market share through acquisitions, as was the case with its recently announced acquisition of Blue Cross Blue Shield of Louisiana.

The increasing market concentration of the MA industry is an important trend for providers to pay attention to locally, as it can often lead to greater contract negotiation power for payers in the form of reimbursement rates that drop below 100% of Medicare, the aggressive use of prior authorization or other tactics.

Source: Sg2 analysis of Clarivate Medicare Advantage enrollment data, July 2022.

National Medicare Advantage Market Share by Enrollment, July 2022



Pioneer

Develops competencies to run own health plan

- Maximum upside, maximum downside
- Significant capital requirements
- Growing an MA plan alone is challenging
- Many providers have struggled/failed

Partner

Partners with payer(s) in co-branded or other value-based structures

- Limits financial exposure and leverages payer expertise in administration services
- Potential animosity with non-partnered payers depending on structure and strategy
- Ability to maximize value-based competencies to net better financial results than fee-for-service (FFS) alone

Price Taker

Contracts with most plans in the market

- Negotiates FFS rates, if able
- Risk of being left out of networks as other competitors partner
- Revenue loss with decreasing reimbursement and limited upside

Your Medicare Advantage strategy may vary by plan.

Provider MA strategies run along a spectrum ranging from being a fee-for-service–based "price taker" that goes out of network when reimbursement drops below an acceptable threshold, to building your own provider-sponsored MA plan.

Plenty of "pioneers" have formed a provider-sponsored health plan only to unwind it years later due to failed strategic and financial expectations. On the other end of the spectrum, many price takers have decided to go out of network. But despite all the public relations campaigns painting the MA plan as failing to provide reasonable reimbursement rates, that strategy can backfire leaving the provider without the volume of patients required to sustain long-term operations.

Build your strategy.

These examples are cautionary tales and reminders that formulating and implementing any Medicare Advantage strategy is challenging work. Failing to take the necessary time to develop a dynamic approach to Medicare Advantage may have your organization feeling like David going against an MA Goliath that is only expected to get bigger over time.

Given the anticipated growth in MA along with looming regulatory changes related to risk adjustment, star ratings, and utilization management, as a provider you need to be prepared with an intentional and thoughtful Medicare Advantage strategy.

About Vizient, Inc.

Vizient, Inc., the nation's largest health care performance improvement company, serves more than 50% of the nation's acute care providers, which includes 97% of the nation's academic medical centers, and more than 20% of ambulatory care providers. Vizient provides expertise, analytics and advisory services, as well as a contract portfolio that represents more than $130 billion in annual purchasing volume. Vizient's solutions and services improve the delivery of high-value care by aligning cost, quality, and market performance. Headquartered in Irving, Texas, Vizient has offices throughout the United States. Learn more at www.vizientinc.com.