2025 Medicare Advantage Bids Are Over, Now What?

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September 5, 2024

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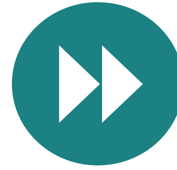
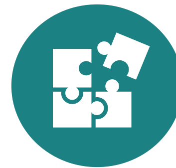
AGENDA

2025 Medicare Advantage Bid Year Review



Select Issues: Looking Forward to 2026 and Beyond



Emerging Regulatory Issues

Key Takeaways

Questions and Answers

TODAY'S EXPERTS

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2025 MEDICARE ADVANTAGE BID YEAR REVIEW

MEDICARE INDUSTRY HEADWINDS

Key Headwinds Impacting the MA Market

- Inflation Reduction Act's (IRA) impact on Part D
- Medicare Advantage risk score model changes
- Increased utilization
- Low Medicare Advantage benchmark growth rate
- Multiple Star ratings methodology changes
- Rebate reallocation rules and NAMBA volatility
- Part D is becoming a larger piece of the financial picture
- 2025 Final Rule impact on future of D-SNP opportunities
- Increased administrative requirements for VBID and SSBCI

Net Impact of Industry Headwinds

- Expect benefit degradation starting in 2025
- MA plans exiting select counties and markets
- Potential for increasing rate negotiation with providers and hospitals

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OBSERVATIONS FROM A CHALLENGING BID YEAR

Changes

Utilization Trends

- Higher utilization trends are continuing into 2024 and impacted 2025 bid assumptions

MA v28 Risk Score Model Change

- Impact is plan-specific, but impact can be significant
- New enrollee model cohorts seeing significant improvement, but still relatively less profitable than continuing enrollee cohorts

Part D

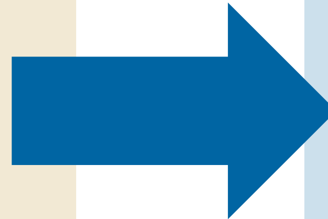
- Part D has become a larger piece of the pie due to benefit redesign and risk model changes
- New in 2025, these changes will increase plan liability and drastically increase the direct subsidy

TBC Challenges

- Several Wakely clients were significantly constrained by TBC rules

Competitive VBID Application

- New rules make it more challenging to submit application and also screen out new participation



Plan Responses

Benefit Degradation

- Extensive benefit degradations to balance out rate and utilization challenges
- Includes both core benefits, premiums and supplemental benefits

Product Portfolios

- Product terminations - Plans are terminating specific products (e.g., PPO in market where they currently offer both HMO and PPO)
- Increase in product consolidations with plans offering fewer options in a given market

Footprint Contraction

- Plans are exiting counties and even states due to underlying rates, historical utilization and cost experience, expected lack of competitiveness

Profitability

- Push for profitability versus growth especially in plans that have underperformed in the past or now facing potential losses

Growth Targets

- Plans are setting limited to no growth targets
- Some plans are projecting membership losses

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LOOKING FORWARD TO 2026 AND BEYOND

WHAT TO EXPECT: 2026 AND BEYOND

- **Expect continued revenue pressure from risk adjustment** model changes, lower-than-expected **revenue benchmark growth**, and Stars model changes
- Large disruptions in competitive landscape: supplemental benefits degradation, market exits, and strategic shifts
- Regulatory changes will require strategic nuance and strength in operations / compliance
- Impacts from Part D benefit changes and drugs included in the Medicare Drug Price Negotiation Program
- Will medical trends remain elevated? Increased focus on medical economics & population health will be critical

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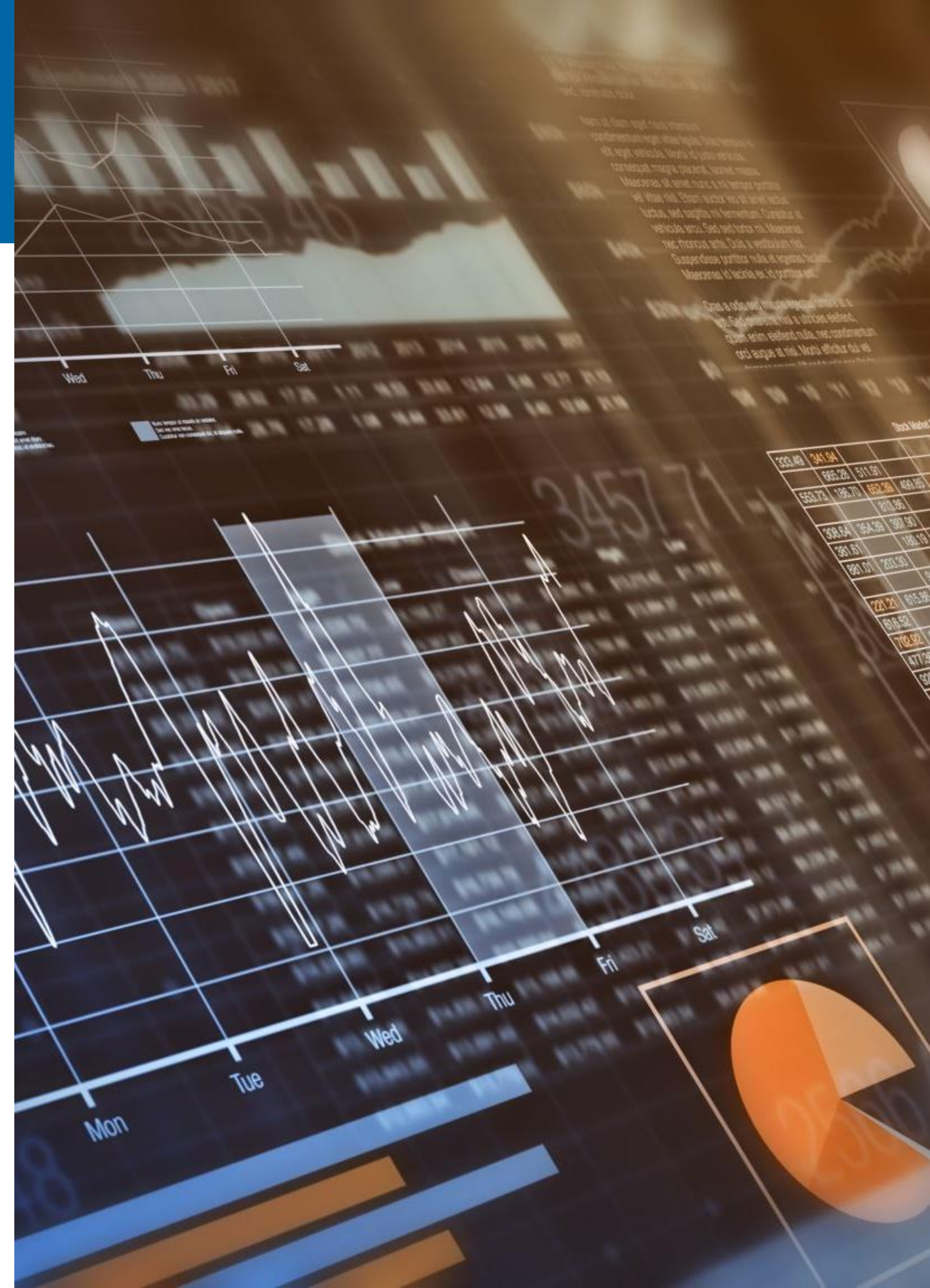
SUPPLEMENTAL BENEFITS: MEMBER INSIGHTS

- Product planning in the 2026 bids will require benefit analytics to drive appropriate member selection, product portfolio, and benefit refinements
- Analyze supplemental benefit experience over multiple years to uncover insights that lead to optimal decisions for your plans

Analytical methods for discovering actionable insights:

- Split the financial and medical data by members that utilize certain supplemental benefits versus those that don't
- Create multi-year studies on these member cohorts to assess the impacts of these benefits on member selection, health status, and behaviors. For example:
  - After a transportation benefit was added to a Dual Special Needs Plan (D-SNP), are loss ratios for members utilizing transportation decreasing? Are members more engaged in their care?
  - After a dental benefit limit was added or significantly increased, what types of members selected the plan? What types of members left the plan? Does this align with the product strategy?



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SUPPLEMENTAL BENEFITS: MEMBER INSIGHTS

Perform multi-year analyses on financials and medical utilization by member cohorts to uncover insights

Loss Ratios for HMO Members that use dental vs. HMO Members that don't use dental[1]

Year	Dental Non-Utilizers	Dental Utilizers	Difference
2021	92.1%	87.5%	-4.6%
2022	89.2%	85.5%	-3.7%
2023	93.6%	89.7%	-3.9%

Lower MLRs for dental utilizers; appears that dental utilizers are healthier, but we need to dig deeper to understand the drivers

[1]Data is based on a credible sample of over 50k MA lives; Loss Ratio includes member-level claims (Medical, Rx, and Supplemental) and revenue (risk adjusted bid, Rx revenue, and supplemental rebates)

ER Visits/1000 for HMO Members that use dental vs. HMO Members that don't use dental[2]

Year	Dental Non-Utilizers	Dental Utilizers	Difference %
2021	1,812	1,441	-20.5%
2022	1,799	1,480	-17.7%
2023	1,888	1,498	-20.7%

Dental utilizers had **significantly lower ER utilization** on average, even after normalizing both cohorts' data to a 1.0 risk score basis; also, the % of dental utilizers who had 5 or more ER visits per year was 6.8%, compared to 9.9% for non-utilizers

Member engagement appears to be stronger among dental utilizers, as they tend to visit the ER much less and there are far fewer ER overutilizers (indicating a higher coordination of care)

[2]Data is based on a credible sample of over 50k MA lives; ER utilization metrics were normalized to a 1.0 average risk score within each cohort

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WHAT CAN MA PLANS DO?

- **Example actions to be taken:**
  - Compile a list of members to contact for annual wellness visit reminders, prioritizing members who have high utilization in supplemental benefits, but who have no PCP visits
  - Determine which plans may need stronger member outreach/education about supplemental benefits, to enhance member engagement
- **Compile a list of desired benefit changes for 2026 to align with product strategy and company objectives**
- **Determine which supplemental benefits have lower-than-expected utilization**
  - Try to understand the cause, and formulate a solution (e.g., operational challenges that can be fixed, benefit value is too low from the member's perspective and should be increased, etc.)
- **Negotiate vendor contracts to reduce plan costs**
- **Add benefit limits and/or prior authorization of these benefits; ensure that benefits are incorporated into care management activities**

RISK ADJUSTMENT OPTIMIZATION: END TO END COVERAGE IS CRITICAL

- Optimizing the full spectrum of Risk Adjustment processes will be critical to sustaining revenue going forward
- How do plan risk scores compare to market? Newly available data allows for MA risk score benchmarking
- Risk adjusted revenue in Part D increases to $142.67 PMPM in 2025; increased focus is needed on RxHCC processes:
  - Update suspecting and recapture logic for RxHCCs
  - Update education for providers and coders
  - Revisiting value-based arrangements to incorporate changes
  - Reassessing coding guidelines
  - Incorporating RxHCC encounter data quality checks

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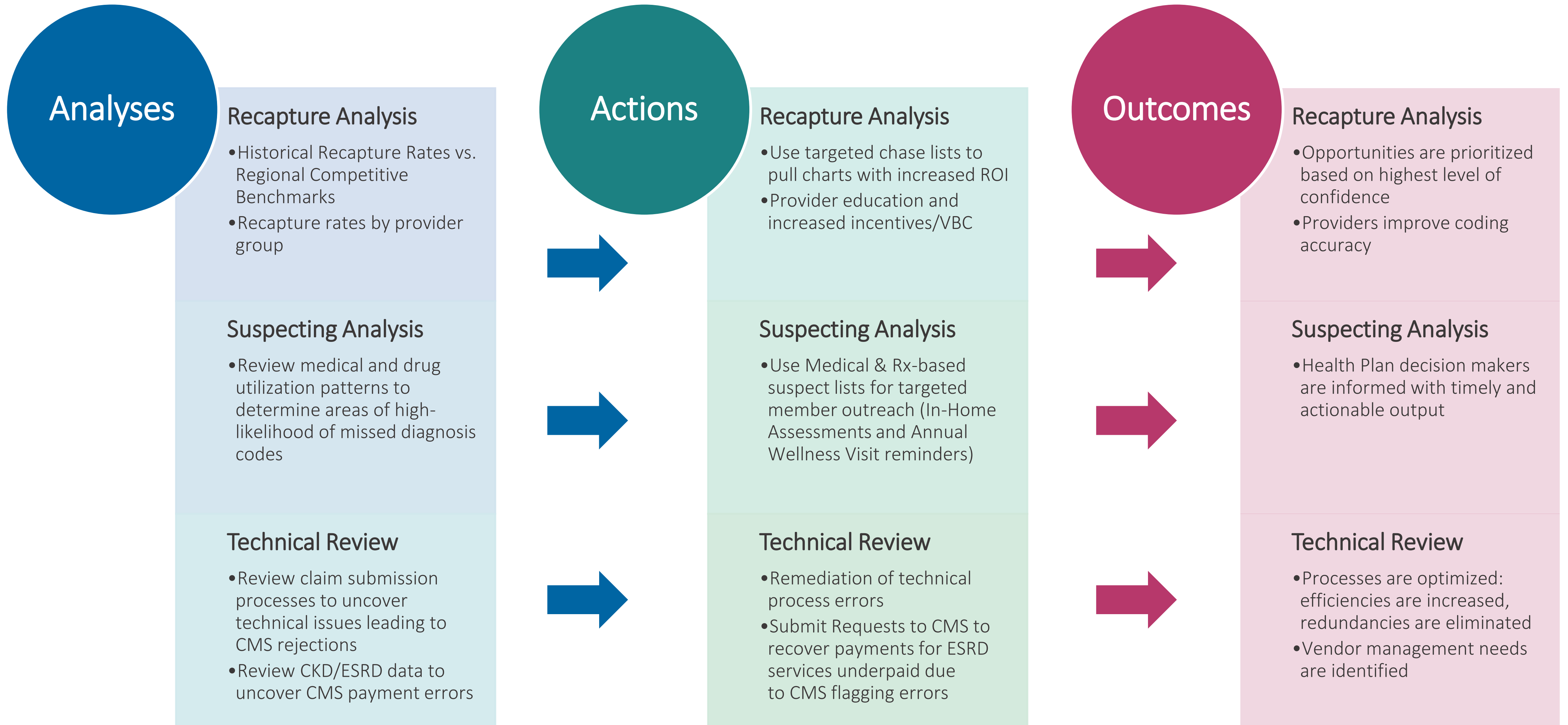
RISK ADJUSTMENT OPTIMIZATION: ANALYSES, ACTIONS, & OUTCOMES



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THREE MAJOR CHANGES COMING IN STARS

- Patient Experience and Access measures decreasing in weight, leveling the playing field among measures
- 2024 is the first year to inform the new Health Equity Index reward, scheduled to replace the reward factor in the 2027 Star Ratings (2028 Payment Year)
- The first hybrid Star rating measure is transitioning to electronic reporting which historically renders much lower rates

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WHAT SHOULD PLANS DO?

Analyze your predictions under the new changes

- Recalibrate to new weighting
- Adjust Q3/Q4 interventions and 2025/2026 plans

Take action:

- Update provider incentive programs to align focus
- Consider vendors who can help with gap closure
- Beef up your internal controls for administrative measures – these are within your control
- Review PBM performance – do you need updated contract terms?
- Capitalize on Interoperability rules to access clinical data, improve rates and gain competitive advantage

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EMERGING REGULATORY ISSUES

DRIVERS OF CHANGE IN THE 2025 MEDICARE ADVANTAGE ENVIRONMENT

Revenue

- Low 2025 rate adjustment
- Full transition to v28 HCC Model
- Varied impact of Stars changes
- Recalibration of Stars ratings

Medical Trend

- Continued high medical trend
  - Largely driven by utilization

2025 Product and Market Changes

- Rebate Reallocation
- Elimination of Duals/LIS quarterly SEP
- Pending broker compensation changes
- Benefit degradation
- Footprint reductions and product exits

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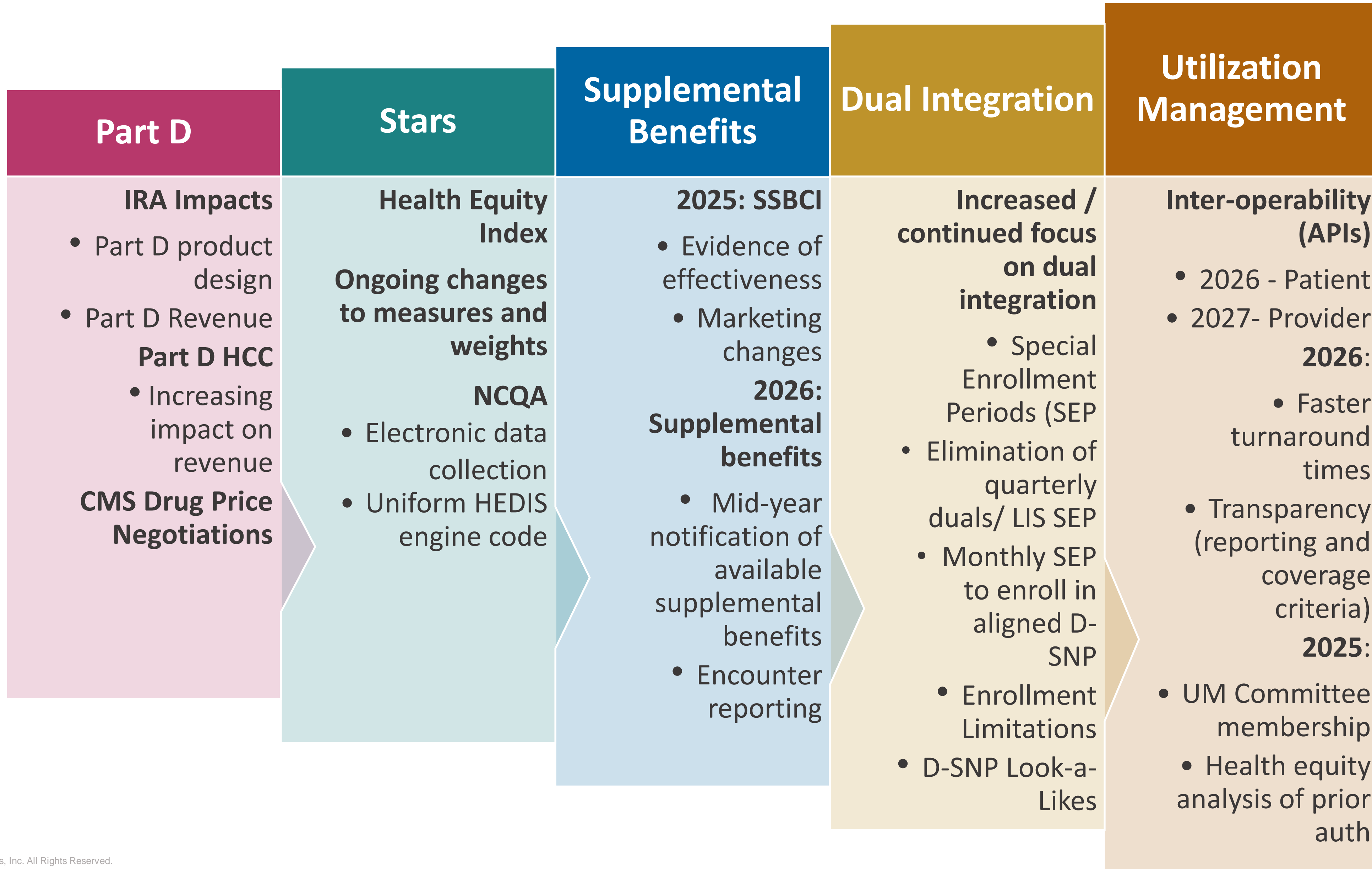
EMERGING ENVIRONMENTAL AND REGULATORY CHANGES



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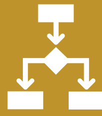
Key Takeaways

Bids are never really "over"

2025+ is going to be a challenging year for Medicare Advantage plans

Bids evolving from technical and financial focus to incorporate more business and operational planning



Medicare Advantage Plans have and will continue to make difficult decisions over the coming years

Start planning **now** to understand implications and plan for upcoming regulatory changes

HOW CAN WE HELP?

Our depth and breadth of experience has helped an incredibly diverse range of healthcare industry leaders.

Questions?

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WHO IS HMA?

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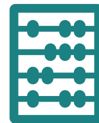

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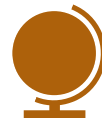

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