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Cain Brothers House Calls

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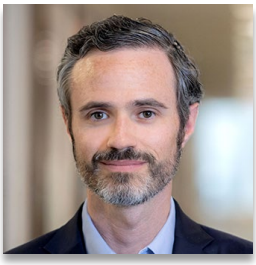

What's Happening to Medicare Advantage? A Panel Discussion

by Wyatt Ritchie, Mike Elizondo, Stacy Guffanti, and David W. Johnson

This is a companion article to an episode of "House Calls," a podcast from Cain Brothers, a division of KeyBanc Capital Markets, Inc. Listen to the audio version of the episode on Key.com, Apple Podcasts, Spotify, or your favorite podcast app.

Medicare Advantage (MA) is in the news. A once highly attractive, fast-growing market has whipsawed dramatically, leaving stakeholders uncertain about immediate prospects, longer-term consequences, and the future of the program. To discuss these developments, we enlisted leaders from Cain Brothers' managed care team, Managing Directors Mike Elizondo and Stacy Guffanti, along with our thought-leadership partner Dave Johnson of 4sight Health. Their discussion was facilitated by Wyatt Ritchie, Head of Cain Brothers.

The following is an edited and condensed version.

Why is Medicare Advantage in some turmoil today?

Mike Elizondo: To go back a little further than recent news, our team started to see pressures in the Medicare Advantage market around when direct contracting started. That was an attempt by CMS to take unmanaged populations and try to manage them with physician groups or providers outside of the Medicare Advantage program. Our suspicion was that CMS was really trying to get full claims data or full history for members in a pseudo-managed environment. Since then, we've seen changes to the V28 program that has ultimately brought down risk-adjusted government payments. With the recent news about star ratings, some of that is just a "back to normal" move in terms of the pandemic relief that many payers received and you're now seeing that naturally filter through the program. But we continue to see seniors select MA over traditional Medicare. Over the next ten years that's expected to grow close to 60%, so there's clearly a real value proposition there despite all the business headwinds. Providers and payers and their service providers have created a very desirable program.

Stacy Guffanti: Broadly speaking, the demographics are changing for who is going into Medicare Advantage. If you think back to when the program started, Medicare Advantage was more focused on a healthier population and wasn't marketed the way it has been over the past few years through the broker community. Now, you're getting a sicker population moving into the program leading to higher overall utilization and the need to manage medical costs. When you combine that with the reimbursement and risk adjustment pieces, it's a perfect storm for payers. That's why we're seeing such headwinds.

Dave Johnson: What's great about Medicare Advantage is that care management aspect. What's terrible is all the game playing that goes on upfront to figure out what the payment rate should be. And the government is trying to navigate between those two pulls. You can see the fault lines emerging with private administration of government-funded health insurance on the exchanges and some of the Medicaid managed care programs. Last year, the Mayo Clinic and United Health Group got into a pretty big skirmish when Mayo announced it would not provide anything other than emergent care to United's members who are part of the biggest MA plan in the country. That was quickly settled but it brings to mind the old African proverb, "When the elephants fight, the grass gets trampled." The fact that Mayo and UHC are going toe-to-toe on how to split federal dollars is indicative of some of the pressure between payers and providers which underlies some of the market activity we're seeing.

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What do recent events say about the government's underlying goals and objectives?

Stacy Guffanti: We need to think back on why MA was started. It was really about lowering costs and providing additional benefits that ultimately lead to better health outcomes. But effectively, it's led to more spending in Medicare. CMS is projected to pay between $500 and $600 billion in payments to private Medicare Advantage plans and that number continues to skyrocket. Part of that has been because of a big push to move members into MA plans. I think what CMS is doing right now is related both to its original purpose and its broader goal around moving all Medicare members into value. A lot of groups including private investors saw MA as a way to capture profit in Medicare. Now CMS is cracking down on that and taking a hard stance. It may take a couple years to play itself out but I don't see Medicare Advantage going away. I think it's a great program, but we need to go through a normalization period to get back to where CMS wants it to be.

Mike Elizondo: We also need to make sure we're delineating the various Medicare Advantage programs. The headlines are really about Part C, which is sort of standard retail Medicare Advantage. I absolutely think CMS wants to continue to support the D-SNPs, the chronic care SNPs, the institutional SNPs, the PACE programs. What they're really cracking down on, in my opinion, is the broader Part C population. In some respects, they created this beast by allowing supplemental benefits to be included more broadly within the bid process and by including medical costs in order to hit those MLR floors. Things like grocery cards and expanded ancillary benefits have added a lot of costs, and it's not clear, candidly, in a retail MA population how effective or necessary those supplementals have been. This is a program that was supposed to be lower cost than traditional Medicare. But there's a lot of data showing a fully loaded MA premium is over the benchmark rate, and that's not what it was designed to do.

Dave Johnson: It probably didn't help when Don Berwick and Rick Gilfillan published their two-part series in Health Affairs last year which basically said, we set up this program to manage the care of seniors more effectively but it doesn't work. We're paying too much and we can accomplish the same thing through all the various ACO programs. That was a remarkably influential policy article and it wouldn't surprise me if it was having an impact behind the scenes.

Do these changes signal a move away from Medicare Advantage toward other programs and tools?

Stacy Guffanti: I personally don't see Medicare Advantage going away. I think there will be multiple programs for seniors – and there will be a sorting out of who should be in which plan. Sicker populations moved into Medicare Advantage and plans haven't done what they needed to do to actually control those costs. But the pitch to those seniors was you don't need to pay anything but you will get all of these additional benefits. So they signed up without really knowing what they signed up for and now they're kind of stuck in the middle between the provider and the payer. I think we're going to see a lot of frustrated seniors out there in the next year especially with a lot of plans exiting markets, and seniors are going to be very confused about what's happening. Will they still choose MA or will they go back to traditional Medicare?

Mike Elizondo: I think open enrollment this year is going to be in stark contrast to what we've seen over the past few years, not only in terms of the benefits offered but the number of plans in the market. So, there will be a whipsaw on choice in 2025 that will likely continue into 2026. We've seen how "administrative excellence" has been rewarded in these programs in the past, but now CMS is saying, you need to be managing costs not just earnings.

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Dave Johnson: Administrative excellence might be the best euphemism I've heard for profiteering. We know a managed population will outperform an unmanaged population every day of the week, but we actually have to do the work. Sometimes in health care, we forget that there are human beings at the end of these transactions. There's an enormous opportunity in really making the journey easier for the people that are ultimately consuming these products and services. If there's a silver lining here, that's where it could reside.

How should managed care companies be thinking about their markets?

Mike Elizondo: I think a lot of it has to do with scale. It takes a lot of infrastructure to run these plans effectively and it takes really strong provider relationships in that market. These programs work well when you're able to get the doctors, the health systems, and the health plans to play nicely in the sandbox together. Markets where there are multiple plan choices with multiple benefit designs will be too expensive for plans to recruit members. So I think they'll pick their spots and make investments where they can become really dense and relevant in certain geographies.

Stacy Guffanti: I agree. You can't be successful without scale. And now the question is can we actually make money at a very local level? So, it's about being very disciplined and saying, if we can't make money, we need to exit. And on the flip side, we're also seeing more and more providers want to exit Medicare Advantage networks. Members tend to follow their providers. Next year, we'll have a bit more clarity but it's going to take a couple years to play out.

What has been the impact on providers?

Stacy Guffanti: An interesting statistic I read recently said that 19% of health systems have discontinued at least one MA plan and 61% are considering dropping an MA plan or dropping MA entirely. Payers are pushing down on the system side, and there's a lot of conflict going on around claims, prior authorizations, and delays in payment while they work through the administrative piece. I don't think that was CMS's intent but it will be interesting to watch.

Dave Johnson: This may be a bit Pollyannaish but I think many providers are still overly wedded to fee-for-service and hospital-centric treatment. Companies like Humana have been at this for a couple decades now and they're getting better at care management which puts many providers in a somewhat precarious position. So, when Humana is managing a member's care from soup to nuts and the member trusts them and Humana has got great tech, at what point does Humana win the hearts and minds of the consumer? Ultimately, I think the winners should be those that do a better job of value-based care delivery and consumerism. At least that's the hope.

Mike Elizondo: This is also impacting risk-based providers that focused almost exclusively on MA over the past 10 to 15 years. We've come out of a posture of "close out your round, go to your next round immediately, finance your way through growth." That's not the market we're in anymore. On top of that we've got top line revenues being squeezed. So if you do the math, you've got $100 for a member and 85% of that is supposed to go to care. But if that $100 goes to $90 or $80, there are a lot fewer dollars to go around. It's going to be interesting over the next few years to see who is weeded out. Similar to the payers, those providers are going to need to pick their spots where they're going to be really successful. Many of the risk-taking groups will look to a higher acuity Medicare population instead of the retail Part C population and focus a lot more on the dual eligible population and the chronic care special needs plan members. There are just more dollars flowing around there so it will be easier to invest in health.

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What will be the impact on consumers?

Stacy Guffanti: Over the next couple years, I expect there will be a lot of frustration amongst seniors that in the short term could drive members out of MA and into other CMS programs.

Mike Elizondo: On a broader scale, I agree that we'll see benefit reductions but in some markets, certain payers might make investments in their benefit designs. From a business standpoint, this could be a once-in-a-lifetime opportunity to get some density in very important markets.

Stacy Guffanti: I agree, and I think ultimately it gets back to provider-payer alignment. I also think that investments in primary care will continue. The more successful payers will go where they have a clear strategy as it relates to primary care to avoid inpatient admissions.

What will MA markets look like over the next 5 years?

Mike Elizondo: I compare this to the ACA exchanges when they started in 2014. If you look at ACA markets now, they're great markets. Lots of investment from many payers including ones that were historically single line businesses. I think the MA market is also going to be healthier over the long term. I think we'll see more acute beneficiaries ending up in Medicare Advantage and CMS will continue to tinker with traditional Medicare and with pilots as a check on MA. But I think MA will be the predominant program for the vast majority of Medicare beneficiaries in the future.

Stacy Guffanti: I agree. I also think the Medicaid side is going to become more important and we'll need to integrate benefits between the two programs and get people into the right programs to ultimately control costs. A lot of what we're seeing in MA is driven by very sick populations which require more services than MA is providing. They need long-term care services, which go through Medicaid. Certain states have done a better job of integrating those than others, but I don't see how we lower costs without those two programs coming together.

Dave Johnson: Whole-person health is well underway. Some of the transparency we're getting now on negotiated rates in the commercial space is going to enable market setting rates for routine procedures. And administrative excellence is going to become less and less a part of the equation which is good for the country and ultimately good for consumers.

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