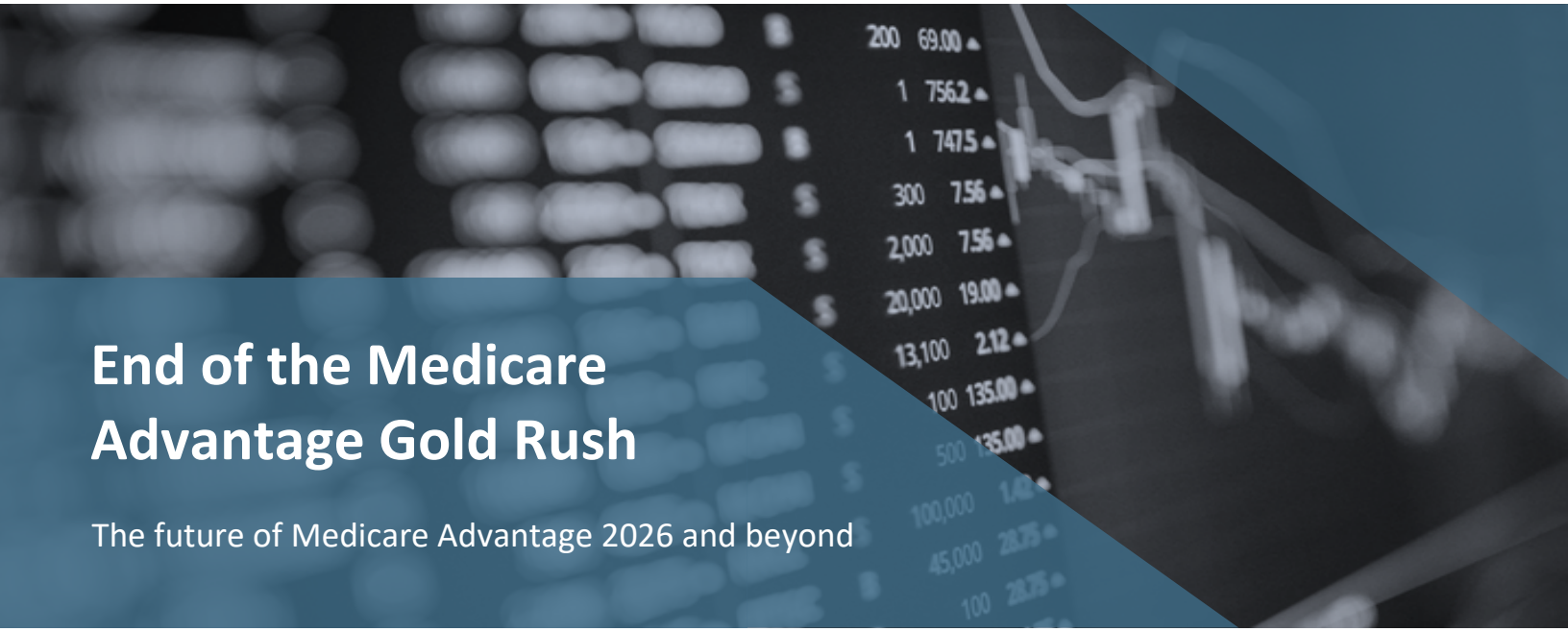

End of the Medicare Advantage Gold Rush

The future of Medicare Advantage 2026 and beyond

Medicare Advantage (MA) plans have long been a cornerstone of growth and profitability for major insurers, buoyed by generous federal reimbursements, aggressive medical services coding strategies, and enticing member benefits. However, the landscape is shifting dramatically. As we approach 2026, a confluence of rising healthcare costs, regulatory reforms, and evolving market dynamics is challenging the sustainability of these plans. Once seen as a golden opportunity for payers/insurers, the MA market is now entering a period of recalibration, prompting insurers to rethink their strategies, streamline offerings, and prioritize long-term viability over rapid expansion. This article explores the forces reshaping Medicare Advantage, and the strategic pivots insurers must make to thrive in the years ahead.

Key Challenges to MA Profitability

Enrollment in MA plans continues to rise, reaching 33 million in 2025, while profit margins declined from 6.5% in 2020 to 3.2% in 2025. This underscores the growing tension between membership growth and sustainability.

Escalating Medical Costs and Utilization:

- **Higher utilization of services:** Insurers underestimated the surge in healthcare services, including outpatient procedures and medical pharmacy use, after the COVID-19 pandemic. This increased medical spending has negatively affected profit margins.

- **Medical inflation:** The rising cost of healthcare, including treatments, is outpacing increases in Federal government benchmark payments, squeezing plan profitability. (more on this below)
- **Aging population:** As more older adults enroll using higher than expected levels of healthcare services, costs naturally increase for insurers, eroding profit margins.

Federal Funding Changes:

- **Lower benchmark rates:** Benchmark payments, the maximum amount the Centers for Medicare & Medicaid Services (CMS) pays to a plan, have been lower than expected, reducing revenue for insurers.
- **Risk-adjustment model updates:** The new version of the risk-adjustment model (v28) calculates payments based on member health status. Insurers that previously maximized risk scores through aggressive medical service coding practices are now seeing payments fall because those coding practices do not apply to measures of member health status now used to calculate risk adjusted payment.
- **Reduced overpayments:** Federal measures are cracking down on practices that artificially inflate payments, such as upcoding, leading to less revenue for insurers. There is far greater scrutiny on coding aided by artificial intelligence (AI) and the ability to detect aberrant and/or suspicious patterns.

Heightened Regulatory Oversight:

- **Tighter rules on benefits:** Regulatory changes are placing greater scrutiny on risk-adjustment payments and tightening the Star Ratings program, making it harder for plans to offer competitive supplemental benefits and differentiate themselves through cost.
- **Prior authorization and denials:** Increased public outcry and regulatory action regarding prior authorization delays and denials have prompted CMS to enact new rules. Insurers must now meet more stringent timelines and guidelines. Further, CMS policy changes have led to more accountability for MA plans, including greater oversight of marketing and quality.

Market and Operational Pressures:

- **Competition for members:** Intense competition for members forced some insurers to pursue a "growth-at-any-cost" strategy by offering generous benefits, which is now proving financially unsustainable in the new environment.
- **Unprofitable plan types and markets:** Less-managed products, such as PPO plans, tend to have higher and less predictable costs. As a result, many insurers are exiting these plans and pulling out of unprofitable geographic areas.
- **Provider pushback:** Hospitals and other providers are growing frustrated with slow payments and high denial rates from MA plans. Some are refusing to accept certain plans or requiring higher reimbursement rates.

Insurer Near Term Responses

Insurers are addressing financial pressures in the Medicare Advantage (MA) market by pursuing a "margin-first" strategy, retreating from less profitable areas, and adjusting benefits.

Strategic Retrenchment and Focus on Profitable Segments:

Exiting certain markets and plans: Humana expects to lose up to 500,000 members by the end of 2025 as it exits unprofitable markets. Similarly, UnitedHealth Group is dropping over 100 MA plans, affecting more than 600,000members, particularly in less-managed PPO offerings.

Emphasis on more profitable special needs plans (SNPs):

While cutting general enrollment plan, many insurers are expanding their offerings for special needs plans, such as Dual-Eligible SNPs (D-SNPs) and Chronic Condition SNPs (C-SNPs).

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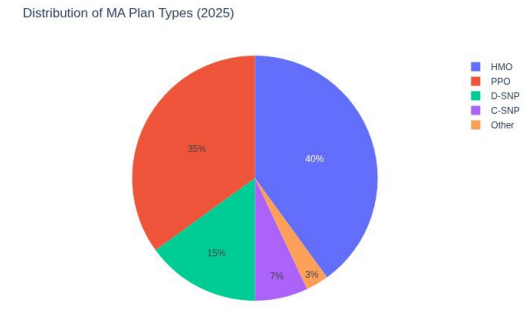
These plans serve specific populations and are generally more profitable. This is because these plans receive higher per capita payments due to higher expected health care needs to these populations. The MA risk adjustment system also pays more for enrollees with higher number of diagnoses and health conditions.

Implications for Medicare beneficiaries

- Reduced "extra" benefits that previously distinguished MA from traditional Medicare
- Fewer zero-premium options and potentially higher out-of-pocket costs
- Less market competition in some counties as insurers exit



HMO plans have dominated at 40%, followed by PPOs at 35% - moving into 2025, Special Needs Plan (D-SN) and C-SNP) account for 22%, reflecting insurers' strategic pivot toward more profitable segments.

<u>Adjusting Supplemental Benefits</u>:

Insurers are making significant cuts to extra benefits to control costs, moving away from features that heavily influenced enrollment in the past.

- **Scaling back flex cards:** For 2025, over half of seniors with a flex card benefit will experience a decrease or removal of their allowance. These cards, which provide flexible spending for out-of-pocket costs, are a prime target for cuts.
- **Revising dental coverage:** Insurers are decreasing or removing dental allowances for many plans, though core dental, vision, and hearing benefits are still widely offered.
- **Overall reductions:** Insurers are re-evaluating and/or eliminating benefits that are not directly health-related, such as alcohol, tobacco, and certain cosmetic procedures. Additionally, benefits like grocery stipends and transportation are being scrutinized to ensure they have a clear health purpose.

<u>Risk Adjustment Adaptation</u>:

Insurers are refining their strategies for risk adjustment—the process used to calculate plan payments based on member health status—due to regulatory changes by the Centers for Medicare & Medicaid Services (CMS).

- **Adopting the V28 model:** Insurers and providers are adapting their coding practices to fully implement CMS's new V28 risk adjustment model, which will determine 100% of risk scores by 2026. This requires careful documentation of specific conditions, as many old codes no longer count.
- To ensure accurate payment, insurers are focusing on data analytics and provider engagement to improve clinical documentation. This helps to accurately reflect the health of their patient population.

Changes in risk adjustment model:

***CMS** is completing a three-year phase of its 2024 CMS-HCC risk adjustment model for MA plans, meaning 100% of risk scores will be calculated using the new model starting in 2026. Key changes include restructuring condition categories using ICD10 vs ICD9, removing some diagnostic codes and adding new ones – changes designed to improve payment accuracy and promote more precise clinical documentation. (CMS also plans to begin phasing in an encounter data-based risk adjustment model as early as 2027.)*

In our follow-up article on this topic, we will delve further into long-term optimization strategies for Medicare Advantage Plans that will help to maximize opportunities via steps insurers and health plans can take now to mount a more strategic, agile response. DataWell has experts in many of the areas for both short term and longer-term optimization (including plan design, member and provider engagement, data management and integrity to name a few) and would be happy to engage in a conversation to evaluate and discuss possibilities for ongoing success.

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