Group Medicare Insights:
Plan quality, design and performance

A changing landscape:
Four trends that may impact Medicare Advantage in the years ahead

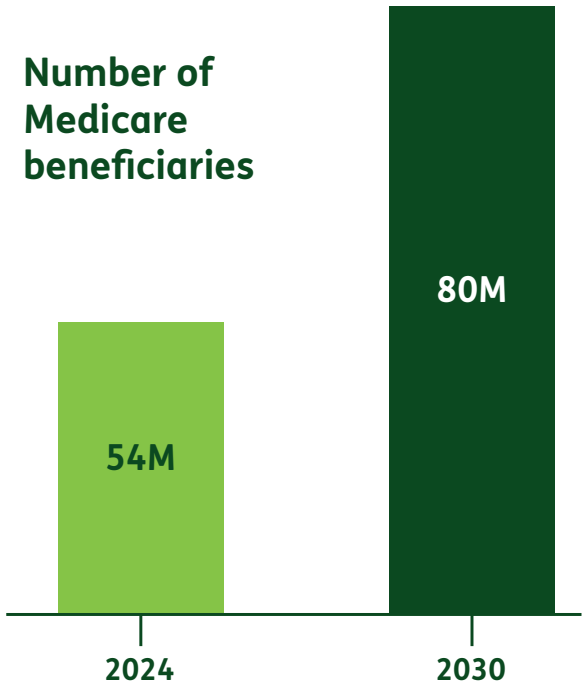
The year 2023 marked a turning point for Medicare Advantage: For the first time ever, more Americans (51%) were enrolled in a Medicare Advantage plan than in Original Medicare. In 2024, this number rose again, with 54% of the eligible Medicare population enrolled in a Medicare Advantage plan.[1] This trend is expected to continue, with one health policy organization projecting that 60% of the eligible population will be enrolled in Medicare Advantage by the end of this decade.[2] But as enrollment in Medicare Advantage grows, the landscape in which payers, providers, and plan sponsors operate is undergoing a period of rapid change.

This can be attributed to a few major trends, which have the potential to significantly impact the Medicare Advantage market in the near- and long-term. These include a changing regulatory environment, shifting demographics, primary care physician shortages and greater adoption of digital tools in the health-insurance industry.

This paper explores these trends and their significance for payers, plan sponsors, providers and members.

Trend #1: Shifting demographics, higher utilization and a changing regulatory environment

The senior population in the United States is growing fast—it is projected that by 2030, adults above the age of 65 will outnumber youth below the age of 18 for the first time in U.S. history.[3] The result is a rapidly growing Medicare-eligible population: As the baby boomer generation ages into Medicare, it's expected there will be an increase from 54 million beneficiaries today to over 80 million beneficiaries by 2030.[4]



A spike in Medicare Advantage members resulting from the growing senior population will drive higher utilization and an increased number of claims. Utilization will also be affected as more seniors grapple with complex and acute care needs. Medicare Advantage plans are already being impacted by this situation—utilization rates rose a staggering 8.1% in the fourth quarter of 2023, according to a survey conducted by AHIP.[5]

Payments provided by the federal government to Medicare Advantage plans have traditionally covered most of the costs borne by payers. In theory, this government funding should increase in proportion to higher utilization rates and a rise in claims.

However, this isn't happening in the Medicare Advantage market. Instead, funding increases from the Centers for Medicare & Medicaid Services (CMS) are misaligned with the uptick in utilization and the higher claims trend. Payers are left to figure out how they can contain costs while still providing the best possible product.

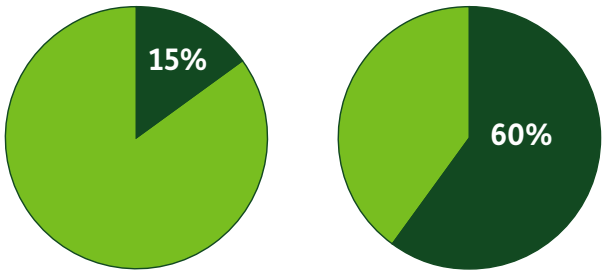
While a changing regulatory environment means a recalibration of what Group Medicare will look like going forward, it's important to keep in mind that any upcoming changes—such as premium hikes—won't erode the overall value of Group Medicare.

Group Medicare will continue to be the most cost-effective and highest-quality option for group plan sponsors. Other options may require plan sponsors to significantly erode benefits or move members to a Medicare secondary plan, which will likely lead to higher costs. Medicare Advantage also offers benefits and programs that are absent from traditional Medicare. This is why the value proposition of Group Medicare—especially from a financial perspective—will continue to be significantly better relative to other options available to group plan sponsors.

Trend #2: The impact of the Inflation Reduction Act on Medicare Part D

The Inflation Reduction Act (IRA) requires drug manufacturers to pay a rebate to the federal government if prices for drugs covered under Medicare Part D increase faster than the rate of inflation. While this regulatory change is intended to cap out-of-pocket costs and enhance affordability of prescription drugs for beneficiaries, it shifts liability to drug manufacturers and Part D plans. Under the IRA, Medicare Part D plans' share of costs will increase from 15% to 60% for both brand-name and generic drugs above the spending cap, while manufacturers will be required to provide a 20% price discount on brand-name drugs.[6]

Medicare Part D plans' share of costs



The IRA Part D changes will mean the liability for specialty-drug spend will increase significantly for high-cost claimants, creating financial pressure. Plan sponsors and insurers will need to work together to control these costs into the future.

As the impact of the IRA is felt in the Group Medicare Advantage market, it will be important to keep members informed about changes that will have a trickle-down effect on them. In the near- to long-term future, there will be financial pressures to maintain the rich benefits that plan sponsors can realistically offer to Group Medicare members.

Trend #3: A growing physician shortage will fuel the rise of value-based care

A shortage of doctors and nurses has left many Americans without primary care providers (PCPs). According to a report by the National Association of Community Health Centers, more than 100 million people in the U.S. don't have a PCP.[7] Meanwhile, another study revealed that only 43% of American adults said they have a relationship with a doctor or healthcare facility that has lasted at least five years.[8] This situation is likely to worsen in the coming years: The Association of American Medical Colleges projects the U.S. will face a shortage of up to 86,000 physicians by 2036.[9]

A shortage of doctors and nurses has left many Americans without PCPs

86,000
Fewer physicians by 2036

PCPs play a quarterback role in the healthcare system, ensuring members receive an integrated care experience, which is tied to improved health outcomes. The PCP's role includes coordinating healthcare services, such as referrals to specialists and keeping up-to-date with a member's changing healthcare needs and any adverse health events, such as a visit to an emergency room. Without a

PCP performing this critical coordinating and gatekeeping role, patients lose access to an integrated care experience.

A holistic approach that places the member and their PCP at the center of the care model helps address access to care issues associated with a shortage of PCPs. This is why Medicare Advantage organizations encourage members and physicians to move to a value-based care (VBC) model.

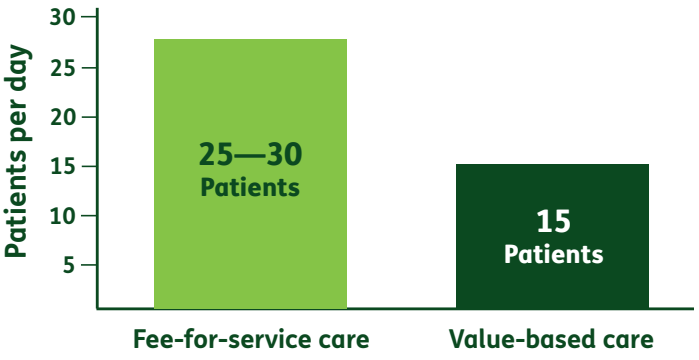
VBC is the best way to enable integrated care, going beyond physical well-being to encompass social, behavioral and functional health. The VBC model weaves together different pieces of the healthcare puzzle to treat the whole person. There is greater emphasis on patient outcomes in a VBC model because physicians are paid and incentivized based on the quality of the care provided rather than the number of patients seen.

Against this background, Humana's goal is to get as many members as possible attributed to VBC physicians. Currently, 70% of Humana's individual Medicare Advantage prescription drug (MAPD) members are aligned with VBC providers. The goal is to boost this even more while also increasing the number of providers in a VBC contract arrangement. To help achieve this, Humana partners with physicians to educate and support them with tools and resources.

On a macro level, greater uptake of a VBC model may help address the shortage of PCPs by reducing physician burnout. Physicians who participate in a VBC practice tend to have a better experience and see fewer daily patients: In a fee-for-service practice, a physician might see 25 to 30 patients a day (or more), whereas in a VBC practice a physician will see about 15 patients per day on average. When physicians have higher levels of job satisfaction, it's easier to retain talent.

70% of Humana's MAPD members are aligned with VBC

As we look toward the coming years, more physicians are likely to adopt or transition to VBC because they can provide a better quality of care, healthcare costs are lower, members and physicians have a better experience (members spend more time with doctors and physician burnout is reduced) and the incentive structure rewards physicians for improving health outcomes for patients.



Trend #4: Greater adoption of digital health tools

Digital tools help facilitate a coordinated, more cohesive and patient-centric healthcare experience by making it easier for providers, payers, plan sponsors and members to share health information, ensuring members get the most out of their Medicare Advantage benefits. In the coming years, greater adoption of digital health tools is expected, along with an expansion of partnerships between health technology companies and Medicare Advantage carriers.

To illustrate this point, consider that Humana was one of the first insurers to partner with Epic, a cloud-based electronic health record (EHR) company, to develop solutions that improve provider interoperability. The goal was to make it easier for physicians to exchange data to better enable collaboration and coordination. Humana has since partnered with other EHR companies too.

From a member perspective, digital tools allow for greater control over the healthcare experience while making it easier to feed information into the system. Any data provided empowers physicians to improve quality of care by supplying them with information and insights that enable them to better support their patients.

The final word

While an evolving landscape means payers like Humana will need to implement changes that impact plan sponsors and members, one thing that will remain consistent is the focus on providing the best possible product and the highest level of support for providers and members. This will be especially true as the Medicare Advantage population continues to grow.

The trends cited in this paper may present some challenges, however, they also present opportunities for payers to work with plan sponsors and physicians to shape Medicare Advantage in a way that will continue to provide tremendous value to all stakeholders for years to come.

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