Medicare Advantage Can Harm Health Care Services Credit Quality

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Key Takeaways

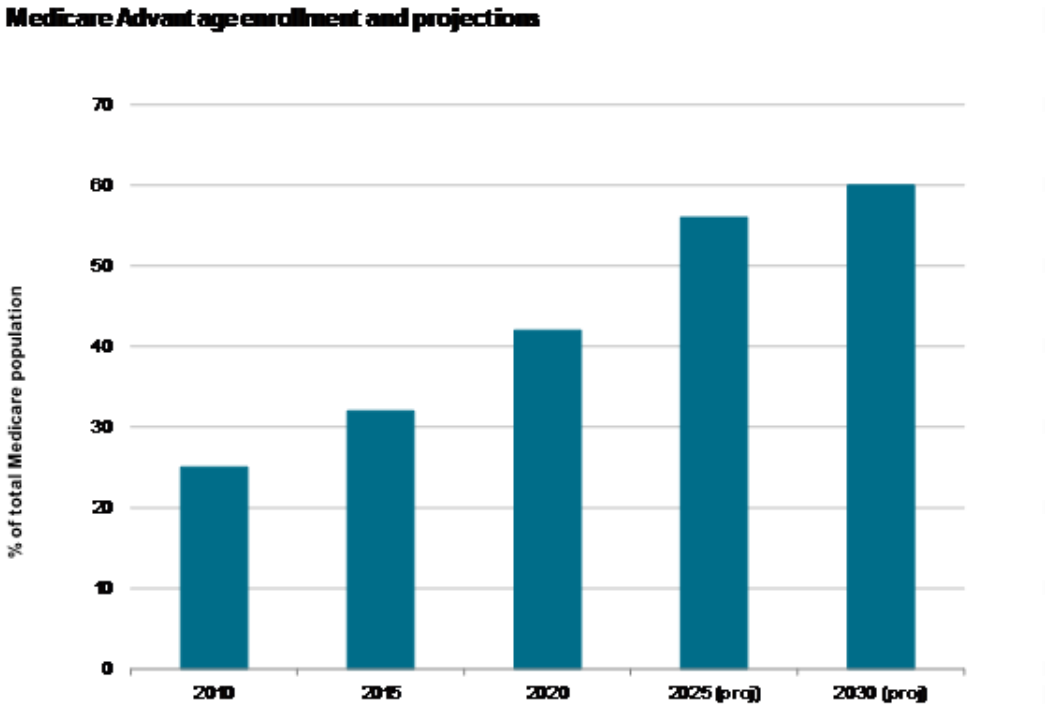
- The Medicare Advantage (MA) program recently achieved a milestone in covering more than 50% of total Medicare beneficiaries.
- This development could have an adverse impact on margins and thus be a negative credit factor for certain health care service companies, the most stressed segment within S&P Global Ratings' rated for-profit health care universe. We believe hospitals are the most negatively affected health care services subsector.
- We expect health care service providers to see future rate pressure from MA plans implementing strategies to preserve their margins from higher utilization, and regulatory changes.
- In 2024 the Centers for Medicare & Medicaid Services (CMS) implemented rules that could help health care service providers, though the extent of the benefit is unclear.

Medicare Advantage coverage has ballooned over the past several years, growing to 52% of the total Medicare population in 2023 from 43% in 2020 and only 26% in 2010. This growth poses challenges to health care service providers' credit quality, given growing risks to reimbursement from MA plans relative to traditional Medicare, as well as the payment risk and higher complexity around prior authorization requirements. S&P Global Ratings believes hospitals are the most vulnerable subsector because Medicare is typically at least a third of their revenue, and because a large percentage of their admissions are unplanned (they come through the emergency room), which limits the hospital's ability to verify the insurance treatment of provided services on a prospective basis.

We also see future risks to providers if at some point CMS addresses the MA program's higher-than-expected spending. According to a March 2024 MedPAC report to Congress, "Medicare payments to MA plans in 2024 (including rebates that finance extra benefits) are projected to total $83 billion more than if MA enrollees were enrolled in traditional Medicare." MedPAC also noted that payments to MA plans average about 122% of the expected spending if MA enrollees were in traditional fee-for-service Medicare. Additionally, MedPAC also

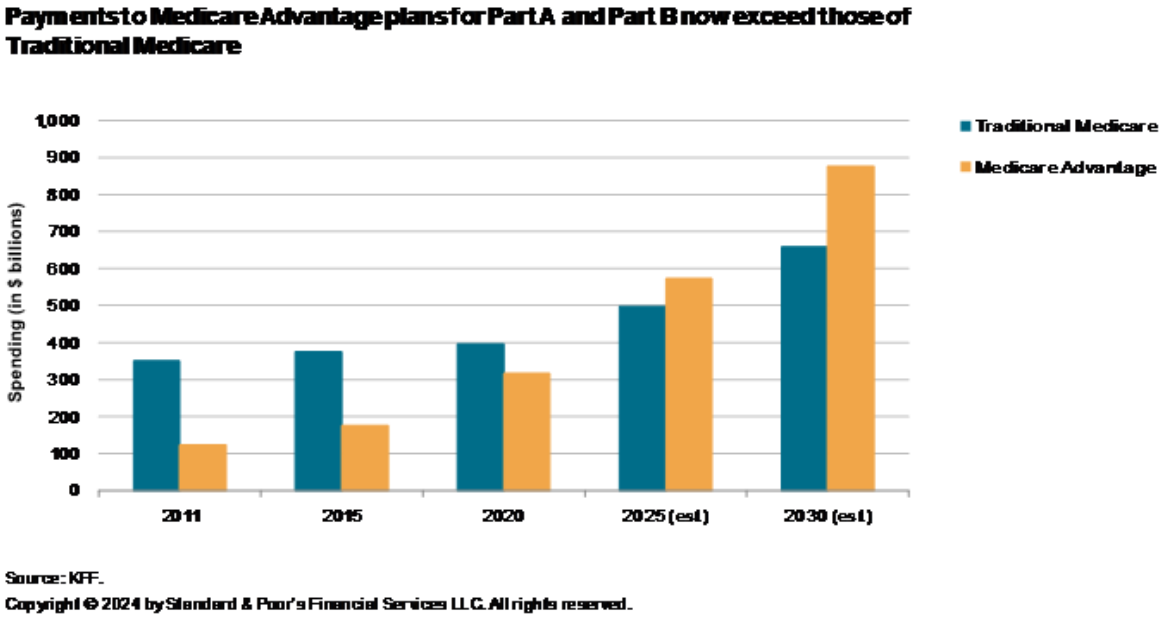
estimates Medicare beneficiaries will pay $13 billion more in Medicare Part B premiums. Given this was not the original intention, we speculate any future changes to the program to lower spending would ultimately hurt health care service providers.

Chart 1



Source: KFF

Chart 2



Quick Overview Of Medicare Advantage

Traditional Medicare is a public program operated by the government. It includes Part A (inpatient services) and Part B (outpatient services). Medicare Advantage plans exist as Medicare Part C, created as part of the Balanced Budget Act of 1997 (BBA) and renamed Medicare Advantage as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, which established Medicare Part D. MA is operated by private plans and covers all services Medicare covers plus extra benefits, such as dental, vision, prescription drugs, gym memberships, etc.

MA plans are required to submit a bid to CMS that includes an estimate of the costs of providing Medicare Part A and B benefits to beneficiaries in the upcoming year. Typically plans bid below the CMS benchmark and are then paid a rebate, the purpose of which is to either lower out-of-pocket costs or fund supplemental benefits (e.g. vision care or dental). The rate structure includes a risk adjustment that considers the differences in the health of the population (disease statues, etc.). Plans can also receive bonus payments based on quality of performance (as measured by the Star Ratings system).

The notable difference between traditional Medicare and MA is how CMS pays for care and how beneficiaries access it. Within traditional Medicare, enrollees can go to their provider of choice and CMS pays the provider on a fee-for-service basis. Typically, enrollees purchase a supplemental plan to provide coverage for services not covered. Within Medicare Advantage, CMS pays private insurers a fixed "capitated rate" per enrollee. Then the insurance company manages the delivery of care to its subscribers.

About 55%-60% of MA plans are health maintenance organizations (HMOs), which require enrollees to receive care from providers in their network, require referrals for specialty care, and have limited out-of-network benefits. The remaining 40% or so are preferred provider organization (PPO) plans that also have a physician network but don't require specialist referrals.

Comparison of Traditional and Medicare Advantage Plans

	Traditional Medicare	**Medicare Advantage**
Provides extra benefits (e.g. dental, eyeglass, gym, etc.)	No	Yes
Restricted provider networks	No	Often
Zero-premium options	No	Yes
Requires separate Medigap / Part D policies	Yes	No
Prior authorization requirements for some services	No	Sometimes

Drivers Of MA Enrollment Growth

Many factors have contributed to the tremendous growth of Medicare Advantage plans, including:

- Additional benefits not offered under traditional Medicare, such as dental coverage, gym memberships, reduced cost sharing, and debit cards for over-the-counter purchases.
- Many MA plans are marketed as zero-premium products. This makes them appear financially attractive to enrollees, especially as premiums for stand-alone Part D prescription drug plans continue to rise. And
- Annual out-of-pocket limits, unlike traditional Medicare.

Another significant driver is the relative simplicity and streamlined benefits offered by MA plans. Unlike traditional Medicare, which may require additional purchases of Medigap and Part D plans, MA plans consolidate coverage into a single package. MA plans typically promote integrated care models that coordinate various types of services and providers. For seniors with complex health needs, the promise of coordinated care and potential cost savings is a significant draw.

Aggressive consumer marketing (TV, mail, etc.) is also a big contributor to this growth. Brokers receive higher commissions for selling Medicare Advantage plans than they receive for selling traditional Medicare supplemental plans, including Medigap and Part D plans.

Reluctance to leave MA plans is bolstered by concerns over potential denial of Medigap coverage for preexisting conditions under traditional Medicare. Lastly, many beneficiaries are either not fully aware of or understand the potential tradeoffs associated with MA plans, such as restricted provider networks and the requirement for prior authorizations that could delay treatment.

Why MA Growth Is A Headwind For Providers

Health care providers generally see lower margins on MA-covered patients relative to those covered by traditional Medicare. While the current differential is small, the underlying problems are significant.

Preauthorization requirements and claims denials increase costs to health care providers.

As MA plans are paid a capitation rate, they are incentivized to tightly control utilization of health care services. One key strategy for this is to require prior authorization from the insurer that the service or prescription will be covered by the plan. The preauthorization and denial rates are high, and cause providers to absorb additional costs to refile a claim and add uncertainty about how much they

will be paid, or if they will be paid at all. Smaller providers don't have the resources to fight claim denials and, in some cases--especially in rural areas--providers have terminated contracts with MA plans in response, and in some instances were forced to close their locations.

These headwinds have even gotten the attention of very large providers. In a well-publicized example, Scripps, a large not-for-profit health system in San Diego, terminated its contract with Medicare Advantage plans effective Jan. 1, 2024.

Reimbursement rates and timing of payments

Although current reimbursement rates are not much different than those of traditional Medicare, we believe it is unlikely to remain this way. As MA plans dealing with their own struggle to preserve margins, providers already face rate pressure. However, if already elevated utilization rates remain high for an extended period we would expect payors to further squeeze payments to providers. Overall, we expect these challenges coupled with further expansion of MA as a percentage of total Medicare beneficiaries will continue to pressure margins on the Medicare portion of the provider payor mix.

The rates providers receive is only one consideration. Providers may incur other, often unreimbursed expenses such as additional administrative costs when a claim is denied, or higher care costs when the prior authorization process drives up lengths of stay, or when hospitals treat patients that seek emergency care only to have the care denied, or paid at a much lower rate. Moreover, many MA plans pay providers on a longer cycle than traditional Medicare does, extending the time it takes to get paid. This is exacerbated by higher claims denial rates that require providers to refile denied claims, further delaying payment. This situation can hurt cash flow and liquidity.

What's Next For Medicare Advantage?

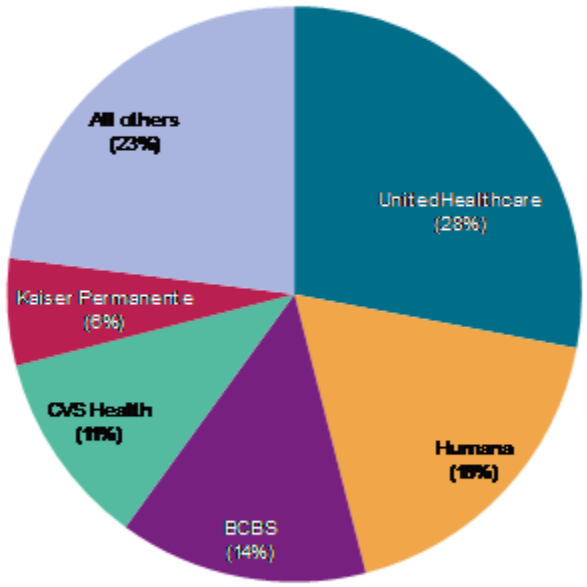
Weaker MA rates from the new risk model being implemented in 2024-2026 and MA Star Rating changes are making for a very challenging operating environment for payors in MA. We believe insurers still see MA as a strong long-term growth opportunity, given favorable demographics and rising MA penetration. Baby Boomers are aging into the Medicare program and increasingly choosing MA over government-run fee-for-service (FFS) Medicare, as reflected in the tremendous enrollment growth vs. traditional Medicare. Moreover, strong

bipartisan political support for the MA program should ensure policies supportive of MA growth.

Insurers are being challenged to make a profit in the MA segment. Public insurers have targeted an average margin of 3%-5%, though most will struggle to achieve this. Looking ahead, insurers recently submitted their 2025 bids and have highlighted the need to reprice their MA products, adjust product benefits, cut supplemental benefits, and exit less-profitable products and geographic markets to remain competitive in this market. Thus, we expect insurers to prioritize margin over membership, and we expect large insurers will use their scale and market clout to limit provider rate increases over what will prove to be a challenging contract negotiation season.

Chart 3

Medicare Advantage enrollment is concentrated in few plans
Based on 2022 total enrollment of 28.4 million



Source: Peter G. Peterson Foundation.

Utilization in MA has been up since the second quarter 2023 as seniors returned to receiving normalized levels of care post-pandemic, so the sector is experiencing pent-up demand combined with improved provider capacity. Moreover, companies have invested heavily in product benefits (to gain market share) and in marketing those benefits, which may be driving higher utilization. While most insurers have noted higher-than-expected use of outpatient services, most particularly in orthopedic and cardiac care, inpatient utilization trends are also up, possibly in response to a change in provider behavior in anticipation of a regulatory change known as the "two-midnight rule," effective Jan. 1, 2024, where some payors saw increases in claims for short-stay hospital visits, likely related to a decrease in observation visits.

Based on second quarter results from public insurers, we believe some companies did not capture 100% of higher utilization trends into their 2024 pricing assumptions. Overall, we think if higher utilization is coming from pent-up demand, utilization should eventually normalize (decrease). Based on the second quarter earnings reports from the large for-profit hospital companies, utilization remains quite high. Hence, it's quite possible that utilization will stay at a higher baseline over the longer term.

What's Next For Providers?

In 2024, CMS implemented two new rules that should benefit health care providers, especially hospitals.

Two-midnight rule: Originally implemented in 2014 for traditional Medicare, the "two-midnight rule" was expanded to MA plans in 2024. It requires that patients be admitted as an inpatient if the clinician says the patient requires hospital care beyond two midnights, as opposed to being held under observation status as outpatient. This should increase reimbursement to providers, as hospitals are reimbursed more for an inpatient than for an observation stay. Prior to the rule, a far higher percentage of MA patients were considered in observation status when compared with traditional Medicare or commercially insured patients. In 2023, 22.3% of MA patients were in observation status for two days or more compared with 8.7% for Medicare and 11.3% for commercial. StataSphere reported that this rule could affect over 20% of MA patients and it was a contributor to a strong 3.9% year-over-year (YOY) increase in hospital admissions in March 2024, and 5.1% YOY decrease in outpatient admissions. However, it remains to be seen whether MA plans will recoup the higher expenses associated with greater inpatient admissions through lower reimbursement rates to hospitals in future rate negotiations.

Streamlined preauthorization: In January 2024, CMS finalized a rule to streamline the prior authorization process, which includes improving the electronic exchange of health information. Starting in 2026 certain payors must include a specific reason when denying requests, publicly report certain prior authorization metrics, and provide decisions within 72 hours for urgent requests and seven calendar days for standard requests. This should theoretically provide more certainty for providers around payment terms and reimbursement, though hospitals may benefit less given the emergent nature of most admissions.