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Hospitals – US

Growth in Medicare Advantage will increase risks of lower revenue

Summary

Hospitals will face rising risks to reimbursement, particularly from an uptick in denial of claims, as US seniors increasingly opt for health coverage under Medicare Advantage (MA) plans rather than traditional Medicare. By 2030, when all baby boomers have turned 65, we expect approximately 60% of Medicare enrollees to be covered by an MA plan. The shift to MA will increase healthcare providers' reliance on large commercial insurers, elevating the insurers' influence and negotiating strength. New rules from Centers for Medicare & Medicaid Services (CMS) have the potential to mitigate some of the challenges posed by MA growth.

» **Risks to hospital revenue will rise with MA expansion.** MA plans, which are managed by large insurers, present greater challenges to revenue capture than traditional Medicare, as hospitals cite an uptick in claim denials and delays in care authorization. Hospitals with broad scale and more essential roles will be best positioned to counter these issues. However, hospitals of varied sizes and types are terminating MA contracts.

» **Declining profitability of MA plans presents an additional threat to hospital revenue.** Insurers have begun to see a decline in profitability from MA plans, which have been a valuable source of earnings for them. To help offset lower MA earnings, insurers could, in addition to service denials, turn to reducing costs by restricting provider networks or becoming more aggressive when negotiating MA and commercial rates.

» **Hospitals' reliance on largest insurers will grow, giving insurers greater negotiating power.** UnitedHealth, Humana, Aetna and Elevance (formerly Anthem) now cover about 65% of MA patients, in addition to dominating the commercial market. Hospitals will thus become increasingly reliant on these big payers. Payer positioning in contract negotiations will further challenge healthcare providers, especially in markets dominated by one or two insurers.

» **New rules from CMS have the potential to alleviate challenges posed by MA.** CMS rules implemented in January 2024 seek to ensure that MA plans provide access to care in line with traditional Medicare. If adhered to, the rules would likely alleviate some of the risks to revenue presented by MA expansion, including pre-authorization for treatment and downgrading of admissions to observation stays.

Risks to hospital revenue will rise with MA expansion

As the US population ages, more patients will migrate from commercial health insurance plans to Medicare. Traditional Medicare has typically offered hospitals lower reimbursement rates than commercial plans. However, the rising popularity of Medicare Advantage, which is cheaper than buying a Medicare supplemental plan and typically includes drug, dental or vision services which are not included in traditional Medicare, presents an additional risk to health provider revenues. MA enrollment is likely to account for about 60% of all Medicare membership by 2030 compared with about 31% in 2016.

Although MA reimbursement may not always align with traditional Medicare, issuers have not cited MA rates as a significant issue. Rather, they point to more frequent claim denials under MA than traditional plans. A recent report by the American Hospital Association and Syntellis (a management and data solutions firm serving healthcare, higher education and financial institutions) found that between January 2022 and July 2023, MA denials increased by 55.7% compared with a 20.2% jump in commercial insurance denials. Claim denials often involve denial of inpatient admission status and a downcoding to an observation stay, which is considered an outpatient service and reimbursed at a much lower rate than an admission. Such moves also expose hospitals to greater levels of bad debt, since patients are typically burdened with higher out of pocket expenses.

Denials are part of a broader set of MA-related measures cited by issuers that will contribute to revenue leakage for hospitals. These include delays or denials of pre-authorization for treatment; delays in approving post-acute care (resulting in longer-than-necessary stays and reduced bed capacity); and introducing changes to coverage language in MA contracts that result in lower reimbursement.

Many hospitals are seeking to limit MA claim denials, including through active discussions with payers and finding ways to improve revenue cycle management. This includes ensuring proper claim documentation and detailed review of each denial. Hospital systems with broad scale or that are essential for local or regional healthcare networks will have more leverage to counter increased denial practices.

Higher levels of claim denials have contributed to a number of hospitals and health systems deciding to terminate MA contracts with certain private insurers. As of January 1, these include WellSpan Health in Pennsylvania, out of network with Humana; Genesis Healthcare System in Ohio, out of network with Elevance Health (formerly Anthem) and Humana; and WakeMed in North Carolina, out of network with Humana.

MA adoption is expanding

Median not-for-profit hospital gross revenues derived from MA grew 53% from 2018 to 2022, according to Moody's 2022 medians, and will continue to grow as the number of baby boomers eligible for Medicare tops out in 2030. Based on CMS forecasts of Medicare enrollment and our expectation for MA penetration, MA enrollees will make up about 60% of the total Medicare population in 2030 (see Exhibit 1). According to the US Census Bureau, since 2010, about 10,000 people turn 65 every day. By 2030, all baby boomers will be at least 65 years old, the age they become Medicare eligible.

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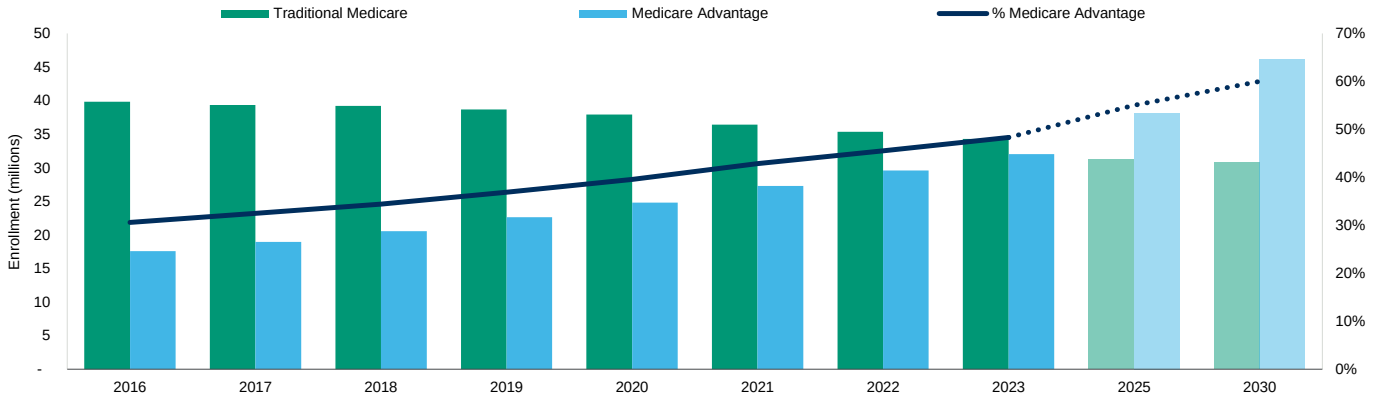
Exhibit 1

MA continues to take market share from traditional Medicare



Sources: Centers for Medicare & Medicaid Services and Moody's Ratings

Declining profitability of MA plans presents additional threat to hospital revenue

Profitability from MA products, a valuable source of earnings for private insurers, has declined, according to our estimates. To help offset lower earnings from MA plans, insurers could, in addition to service denials, turn to reducing costs by restricting provider networks or becoming more aggressive when negotiating MA and commercial rates. This would lead to additional downward pressure on revenue for hospitals.

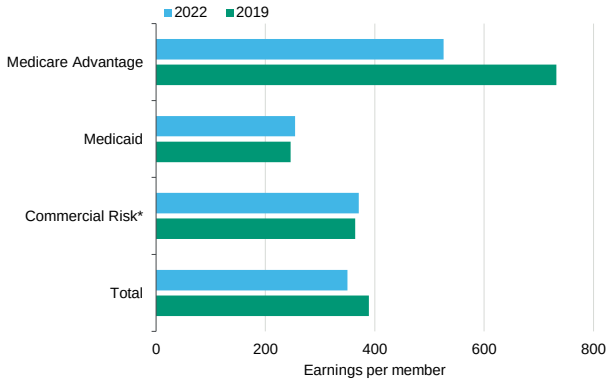
As shown in Exhibit 2, earnings per MA member dropped about 28% between 2019 and 2022 based on our rated health insurers, although at $526 they were still over 40% higher than commercial risk ($371) and more than double that of Medicaid members ($254) in 2022. Insurers have attributed softer 2023 earnings to higher use of medical services. For example, Humana cited this trend in its recent earnings announcement. Higher use rates would typically be beneficial for hospitals, but that benefit is being eroded by the increase in claim denials and other measures.

As shown in Exhibit 3, insurers will soon be hit by a decline in their core reimbursement rates for MA, which will fall by 1% beginning in 2024. This core rate, which is determined by CMS, includes that agency's phase-in of a new risk adjustment model aimed at paying plans more accurately by simplifying and eliminating about 2,000 diagnosis codes.

Exhibit 2

Health insurers' earnings from MA have declined

Based on Moody's rated entities

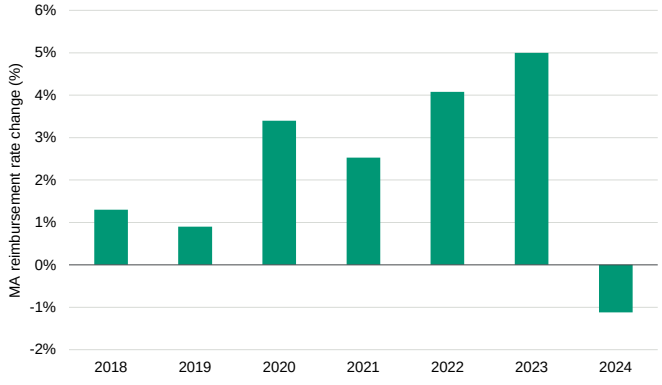


* excludes administrative services only (ASO) members of 89,792 and 87,980 in 2022 and 2019, respectively, or approximately twice the amount of commercial risk members.

Sources: Moody's Ratings surveys and company reports

Exhibit 3

MA insurers' core reimbursement rates will decline in 2024



Reimbursement rates include effective base rate, star rating change, and risk model revision and normalization; MA risk score trend excluded.

Sources: Centers for Medicare & Medicaid Services and Moody's Ratings

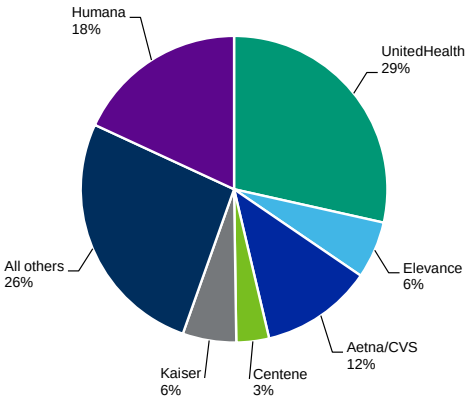
MA insurers are under further pressure stemming from scrutiny by the Department of Justice (DOJ) related to allegations of overbilling. In October 2023, Cigna agreed to pay about $172 million to settle DOJ allegations that it submitted inaccurate diagnosis data to receive higher payments for its MA members.

Hospitals' reliance on largest insurers will grow, giving insurers greater negotiating power

Growth in MA membership will be concentrated in the largest plans, increasing healthcare providers' reliance on these insurers, which already dominate commercial plans. This will give insurers still greater power in negotiating contracts, especially in markets dominated by one or two companies. As shown in Exhibit 4, the four largest national health insurers – UnitedHealth, Humana, Elevance Health and Aetna – capture close to 19-20 million, or about 65% of total MA members.

Exhibit 4

MA market share is concentrated among the largest insurers, with UnitedHealth and Humana in the top spots



As of January 1, 2024

Sources: Centers for Medicare & Medicaid Services and Moody's Ratings

Moreover, MA players with lower scale will likely exit the market, making the biggest plans even larger. For example, Cigna, which has significantly smaller scale in the MA market at about 600,000 members, announced in January 2024 its plan to sell its Medicare business, including its MA plans to Health Care Service Corp for $3.7 billion.

New CMS rules have the potential to alleviate challenges posed by MA

New oversight rules from CMS seek to ensure that MA plans provide access to care in line with traditional Medicare. It is too early to determine the impact of these changes, but if adhered to, they would reduce some of the risks to provider revenue presented by MA expansion, including downcoding of admissions to observation stays and in the area of pre-authorization of treatment.

Addressing concerns that MA plans were impeding access to care, CMS finalized rules effective January 1 that require MA coverage determination to align more closely with what is currently covered under traditional Medicare. Favorably for hospitals, CMS is requiring that insurers follow the "two-midnight benchmark", which is an inpatient admission criterion outlined in the federal code specific to admissions. It requires the admitting physician to expect, at the time of admission, that the patient will need inpatient care that "crosses two midnights". The new rules, however, will still allow MA plans to review the claim to determine if the care was reasonable based on the medical record.

The new rules also address pre-authorization requirements for care, requiring that MA plans allow for an appeal process that matches traditional Medicare and that they publicly report data on prior authorization denials and approvals.

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