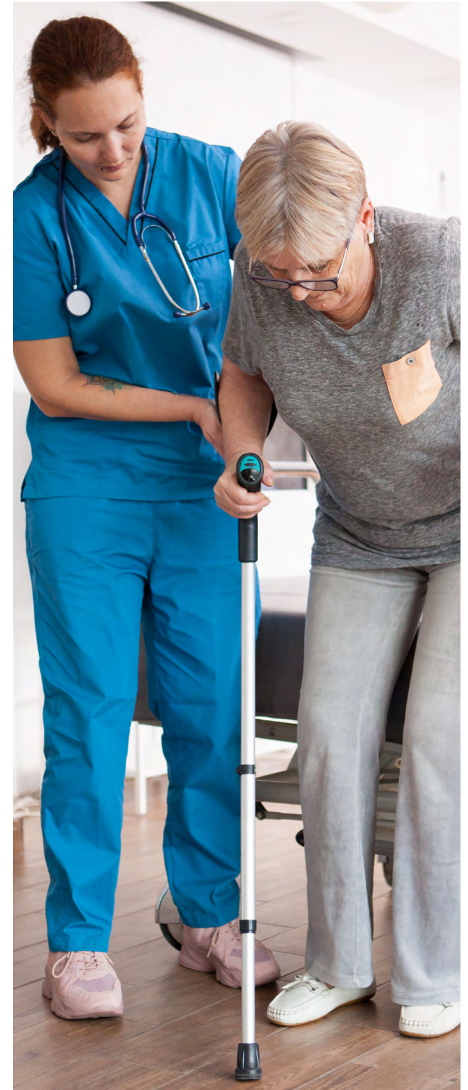
2024 Annual Health Care Trends Report

Regulatory complexities

Shifting membership, declining quality and rising risk increase momentum for value-based arrangements and consumer-centric care

Changes in how and where consumers access coverage have a significant impact on utilization, cost and market share. As of 2024, 14 million individuals have been disenrolled from Medicaid and will transition to state exchanges, employer coverage or abandon the health system.[1] Medicare currently covers nearly 70 million individuals and another 4 million will turn 65 this year.[2,3] Enrollment in state exchanges continues to grow significantly, with over 21 million individuals gaining coverage in 2024.[4]



In addition to these adjustments, as well as the impact of the Inflation Reduction Act, recent policy changes are putting pressure on health care systems to accelerate the shift to value-based care (VBC). Some estimates project that 90 million lives will be in VBC models by 2027.[5] The shift to VBC continues to gain momentum. However, this level of business realignment is not an overnight process and requires careful navigation to move from the traditional fee-for-service model to value-based care.

Forces driving regulatory decisions in 2024

CMS has posted final rules for Medicare, prescription drugs (Part D), Star Ratings and the integration of Medicare and Medicaid for the contract year 2025.[6] Medicare Advantage and Part D continue to promote competition, increase access to care, include behavioral health services, and protect individuals from inappropriate marketing and prior authorization.

In light of rising drug costs, the rule protects consumers from being guided based on broker or agent financial incentives. As the cost of new and existing drugs continues to rise, it is structured to make sure Medicare drug plans remain affordable to consumers.

Optum

Another mandate from CMS regarding Star Ratings and quality bonus payments is for health care organizations to recognize underlying conditions and limit disease progression. This expectation will bring data analytics, coding and risk adjustment into even sharper focus.

CMS is working to integrate Medicaid and Medicare policies, as they share common goals of controlling costs and eliminating fraud, waste and abuse. The innovation generated through the Center for Medicare and Medicaid Innovation (CMMI) can be used to inform Medicaid policy as well. This keeps health equity at the forefront.

In fact, CMS mandates that Medicare Advantage plans incorporate a health equity expert in their utilization management committees and conduct an annual analysis of prior-authorization policies to address potential disparities in access to care for enrollees with disabilities or limited income and resources.

The new rule mandates that Medicare Advantage plans provide personalized mid-year communications to enrollees regarding any unused supplemental benefits. This is to guarantee that the substantial federal investment of over $65 billion annually in these benefits aligns with the needs of beneficiaries.[7]

Medicare's predictability and the guidance from CMS drive not only Medicare but also Medicaid, making it crucial for health leaders to actively engage, provide input and participate in the cross-functional stakeholder discussions to address cost, access and quality in health care models.

– Tejaswita Karve
Senior Director, Star Ratings
Optum

Regulatory environment: Progress, challenges and what to watch

Membership moves have put tens of millions of lives in flux, as well as disrupting the business strategies of the health organizations who serve them. To effectively manage rising costs associated with regulatory adjustments, health care organizations must reassess their revenue streams and prioritize cost containment. They can do this by expanding telehealth services, adopting automation, upskilling health care professionals, forming strategic partnerships, and transitioning toward VBC models and more sophisticated risk-adjustment models.

Reimbursement has been stagnant or down for Medicare Advantage plans and the number of Medicare Advantage Plans shrank for the first time in 10 years.[8] Despite this overall contraction, most major payers have expanded plan offerings, hinting at a concentrated market. But this changing landscape continues to challenge payers to shore up margins and meet market and regulatory scrutiny.

As redetermination moves consumers off Medicaid, employers will feel pressure to pick up the cost of these premiums for their employees. Already stretched with rising labor costs, they will be looking to their health partners for creative solutions. Furthermore, regulatory changes are prompting health care leaders to reevaluate and modify their business models and reimbursement structures. It is critical for leaders to proactively manage the fast-paced financial and operational disruption caused by shifts in membership and policy changes.

Recent CMS policies emphasize the importance of a patient-centered experience. One that addresses individual needs and preferences, while also tracking and analyzing consumer behaviors throughout their entire health care journey.

Local culture, beliefs, ethnicity, economics and demographics guide an individual's approach toward their health. What works in Boston may not work in Atlanta, and what works in Atlanta may not work in Oregon. CMS recognizes this and has put rules and incentives in place. It expects health organizations to be flexible enough to respond to these dynamics at the individual and community level.

As the regulatory environment continues to progress, innovators can focus on specific use cases for AI, maximizing the investment in electronic medical records (EMRs), promoting environmental sustainability and finding new ways to make a positive impact on each community.

Moving forward in this regulatory environment

Expect membership disruption in every line of business.

Revisit revenue streams with a heightened focus on cost containment.

Identify the counsel that can shorten the timeline on the shift to risk and understand the levers that drive success.

Understand the risk in the populations you serve. Ready your organization with specialized services, technologies, care coordination and attention to SDOH.

Ensure data analytics, coding and risk adjustment models are able to embrace SDOH and drive action at the member level.

Use this insight to build a consumer-centric experience for every individual.

Develop processes for identifying fraud, waste and abuse that do not interfere with the patient/provider relationship.

Why the time to act is now

As the largest and most predictable payer, Medicare leads change in the industry. Its guidance is the beacon for transformation and health organizations will need to keep pace. Based on recent policy adjustments, speed and accuracy in the shift to value provides the best opportunity to mitigate costs and ensure long-term sustainability. Innovation and collaboration between payers and providers is necessary to better manage care transitions, address social drivers of health and identify predictive indicators of disease and costs.

Regulatory environment sources

1. Corallo B, Diana A, Tolbert J, Mudumala A, Rudowitz R. Unwinding of Medicaid continuous enrollment: Key themes from the field. KFF. Jan. 10, 2024.
2. CMS. Medicare Monthly Enrollment.
3. Ansberry C. America has never had so many 65-year-olds. They're redefining the milestone. *The Wall Street Journal.* Feb. 6. 2024.
4. The White House. Record marketplace coverage in 2024: A banner year for coverage. Jan. 24, 2024.
5. Neha Patel N, Singhal S. What to expect in US health care in 2024 and beyond. McKinsey & Co. Jan. 5, 2024.
6. CMS. Contract Year 2025 Medicare Advantage and Part D Final Rule (CMS-4205-F). April 4, 2024.
7. CMS. Biden-Harris Administration finalizes rule expanding access to care and increasing protections for people with Medicare Advantage and Medicare Part D. April 4, 2024.
8. Kaiser Family Foundation. AIS Directory of Health Plans. Baltimore Health Analytics.

optum.com

Optum is a registered trademark of Optum, Inc. in the U.S. and other jurisdictions. All other brand or product names are the property of their respective owners. Because we are continuously improving our products and services, Optum reserves the right to change specifications without prior notice. Optum is an equal opportunity employer.

© 2024 Optum, Inc. All rights reserved. WF13199504 05/24