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Understanding and taking risk in Medicare Advantage (MA)

Julie Wang, FSA, MAAA
Partner, Head of Health Practice
Oliver Wyman Health Actuarial
Julie.Wang@OliverWyman.com

Shannon Padayachy, FSA, FIA, CERA
Principal
Oliver Wyman Health Actuarial
Shannon.Padayachy@OliverWyman.com

Steven Lias, FSA, MAAA
Senior Manager
Oliver Wyman Health Actuarial
Steven.Lias@OliverWyman.com

Allie Ladwig
Consultant
Oliver Wyman Health Actuarial
Allie.Ladwig@OliverWyman.com

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For 2026 NAACOS Meeting

Agenda for NAACOS meeting

Section 1 [30 minutes] – Understanding Medicare Advantage (MA)
MA market context: volatility, plan exits/retractions, rate pressure, supplemental benefit changes, and why some plans continue to grow.
MA funds flow and bid mechanics: how premiums, benchmarks, rebates, admin costs, supplemental benefits, Stars, and plan assumptions can flow through to provider economics.

Section 2 [20 minutes] – Contracting Implications: Taking Risk in MA
Risk contract anatomy: common deal terms, financial levers, downside-risk exposure, MLR / Part D considerations, attribution, data, prior authorization, and quality reporting
Provider readiness: capabilities needed to forecast, monitor, mitigate, and manage MA risk.

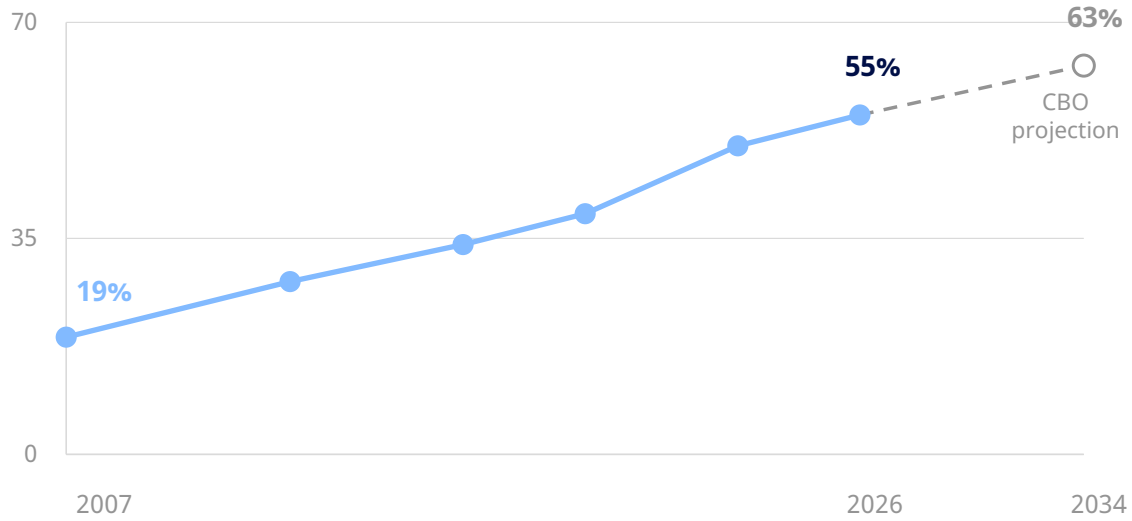
Understanding Medicare Advantage (MA)

01

MA market today: majority Medicare, concentrated share

PENETRATION

MA share of eligible Medicare beneficiaries



35M
MA enrollees in 2026

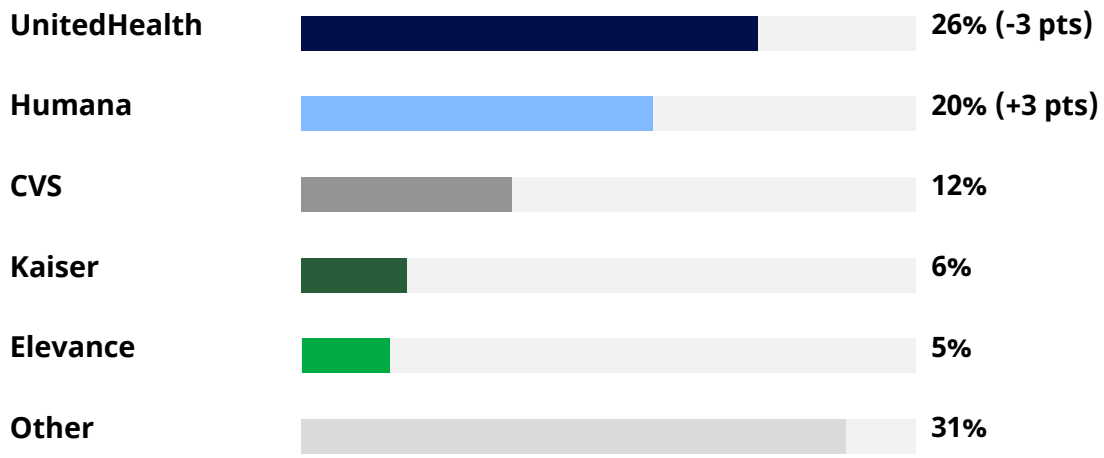
+3%
YoY enrollment growth

55%
of eligible Medicare beneficiaries

Growth has not stopped, but it has slowed — the market is no longer a broad-based expansion story.

MARKET SHARE

2026 MA enrollment by parent organization



46%
share held by UHG + Humana

8
avg. parent orgs. available

28%
counties where top 2 have 75%+ share

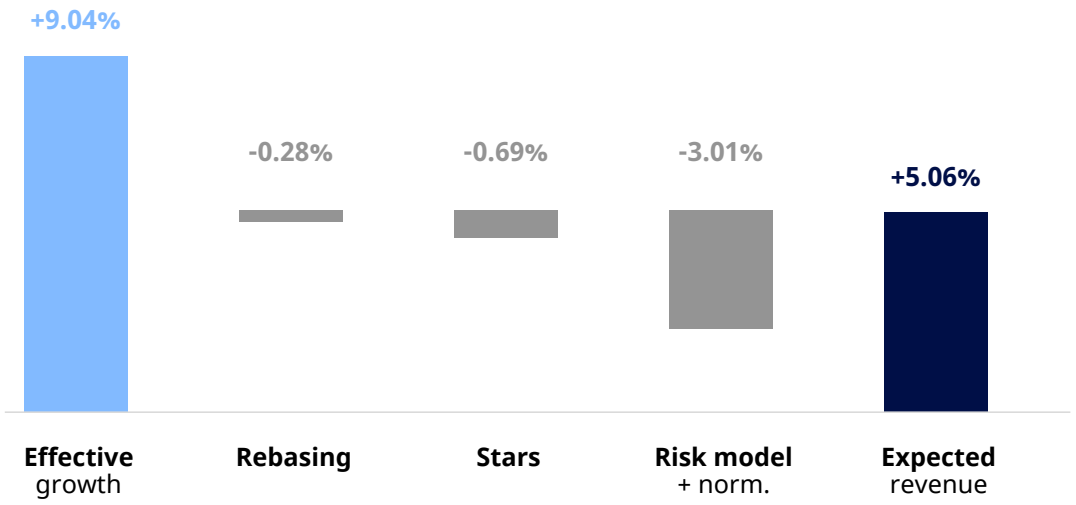
Share is shifting inside a concentrated market: Humana grew while UnitedHealth contracted in 2026.

Source: KFF, Medicare Advantage in 2026: Enrollment Update and Key Trends; CMS enrollment files; CBO projections as cited by KFF.

Pressure points: rates, benefits, and utilization controls

RATE PRESSURE

CY2026 MA payment drivers



A headline rate increase does not fully translate to plan economics once risk model, Star and local cost pressures are reflected.

BENEFIT PRESSURE

>7%
decline in value added in 2026

$7
PMPM lower non-Medicare supplemental value

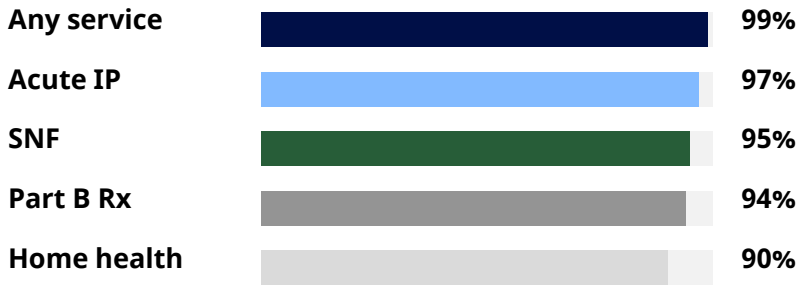
231
fewer $0 MA-PD premium plans

KFF still finds 75% of individual MA-PD enrollees pay no supplemental premium in 2026, but OTC, meal, transportation, bathroom safety and remote technology benefits are less prevalent.

Average in-network MOOP: $5,421; PPO combined in/out-of-network MOOP: $9,825.

MANAGEMENT TOOLS

Share of MA enrollees in plans with prior authorization



Provider implication: expect tighter UM and benefit-driven member behavior.

Source: CMS 2026 MA and Part D Rate Announcement; KFF 2026 premiums/OOP/supplemental benefits/prior authorization; Milliman 2026 GE MA plan valuation update.

Market reset: local exits and fewer plan options

MEMBER DISRUPTION

2.6M
individual MA-PD enrollees in terminated plans for 2026

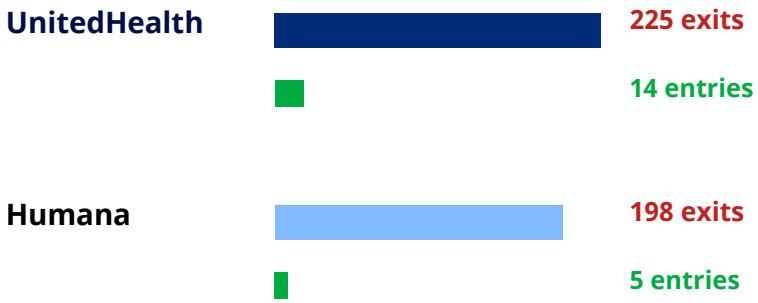
1.3M
enrollees in plans affected by consolidation

Plan exit	→	**Member reselects**
Consolidation	→	**Auto-mapped**

For providers, denominator movement can change attribution, plan mix and network leverage before any contract term changes.

FOOTPRINT PRUNING

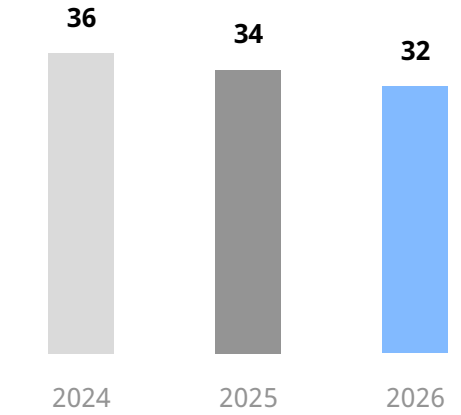
County exits vs. entries in 2026



Carrier decisions are local: margin, utilization, Stars and strategy determine where plans stay or leave.

PLAN SUPPLY

Avg. MA-PD options



3,373
individual MA plans in 2026

-9%
vs. 2025 plan count

Choice remains broad, but fewer options and more churn are showing up in many states.

Source: KFF, Medicare Advantage 2026 Spotlight: A First Look at Plan Offerings; CMS Landscape files; Oliver Wyman CCA market environment materials.

Growth pockets: SNPS, value positioning, and targeted expansion

SNP ENGINE

23%
of MA enrollment is in SNPs

85%
of 2025-26 net MA growth came from SNPs

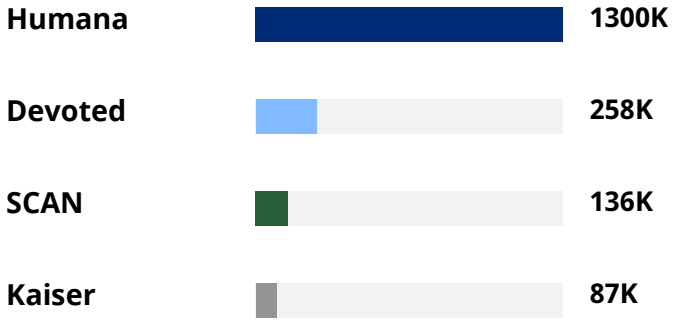
+45%
C-SNP enrollment growth

D-SNPs still dominate SNP enrollment (78%), but C-SNPs are the faster-growing specialty segment.

SNP enrollment mix in 2026

WINNERS

2025–2026 enrollment gains



Among the largest insurers, Humana and Kaiser grew; selected challengers also captured meaningful membership.

WHY GROWTH WORKS

1. Product has a purpose
SNP focus, Part B buydowns and targeted benefits

2. Geography is selective
County-level expansion rather than blanket growth

3. Operating model differentiates
Provider partnerships, tech-enabled care and care management

Provider lens:
Growth plans may be attractive partners, but risk terms need to reflect tighter benefits, PA and attribution churn.

Source: KFF, Medicare Advantage in 2026: Enrollment Update and Key Trends; Milliman 2026 GE MA plan update.

How is the MA benchmark developed?

MA benchmarks – using fee-for-service as a baseline

What is a benchmark?

- The *benchmark* is the **maximum monthly amount Medicare will pay** an MA enrollee in a county.
- It represents Medicare's projected **cost to cover an average beneficiary under Original Medicare** (Parts A & B) in that area.

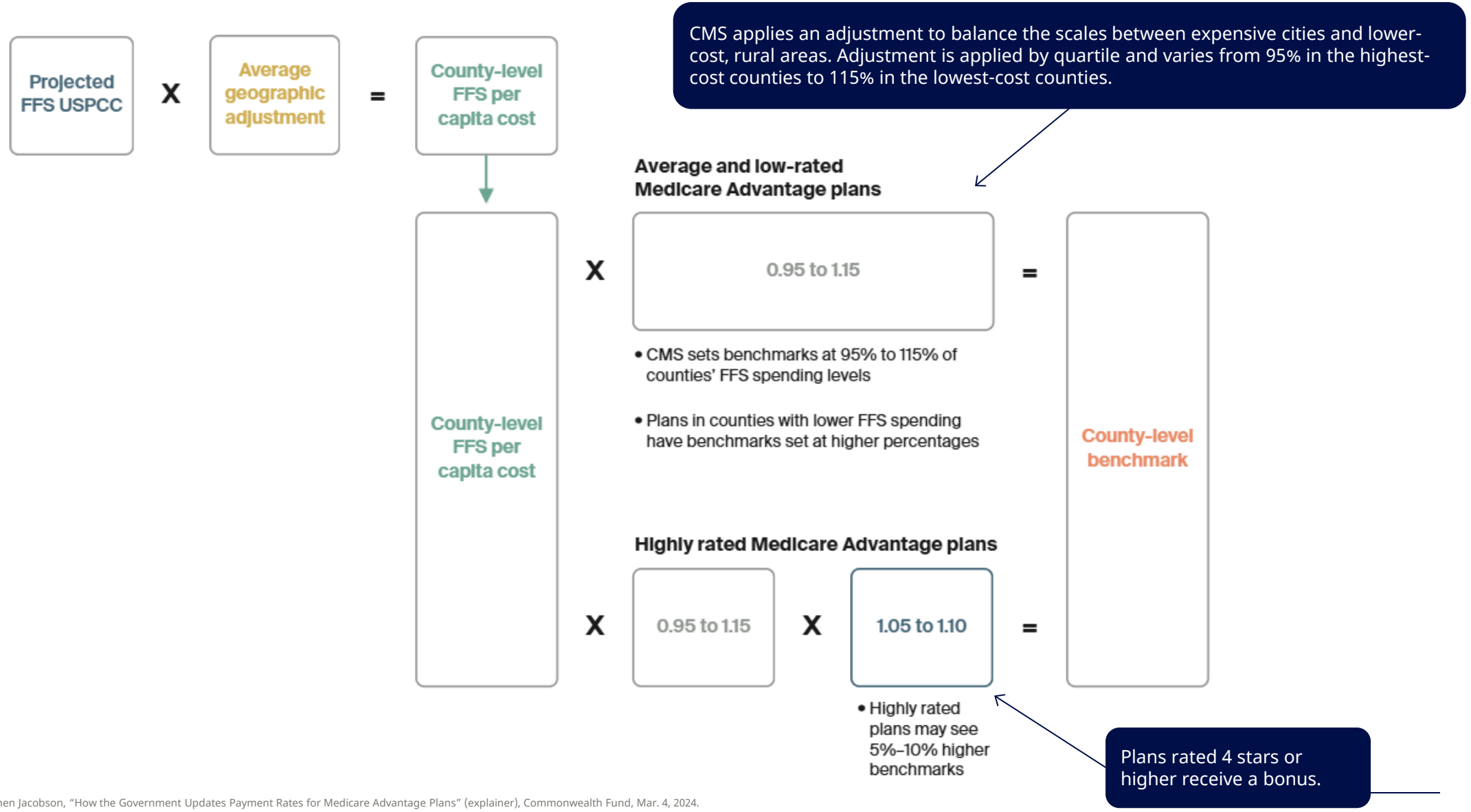
FFS spending as basis

- Medicare uses **local fee-for-service (FFS) spending as the baseline** for benchmarks. Each county's historical FFS cost per person is calculated.
  - This reflects what Medicare spends on average for a beneficiary's Parts A and B services in that county.

MA Ratebook

- Each year, CMS projects the upcoming year's **national FFS cost per capita**.
- It is then **adjusted by a geographic factor** to obtain the county level projected FFS cost for the year.
- The resulting figure is used to set the **MA benchmark** for that county which then forms the MA rate book.

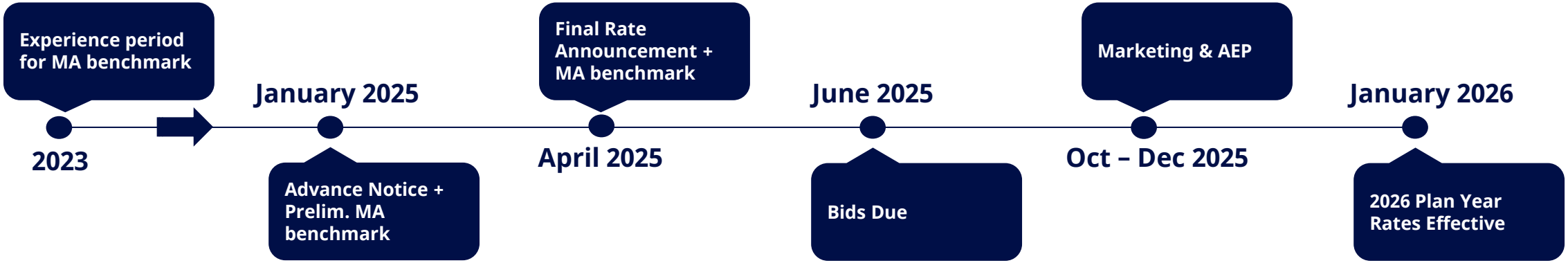
MA benchmarks – county-level development and variation by star



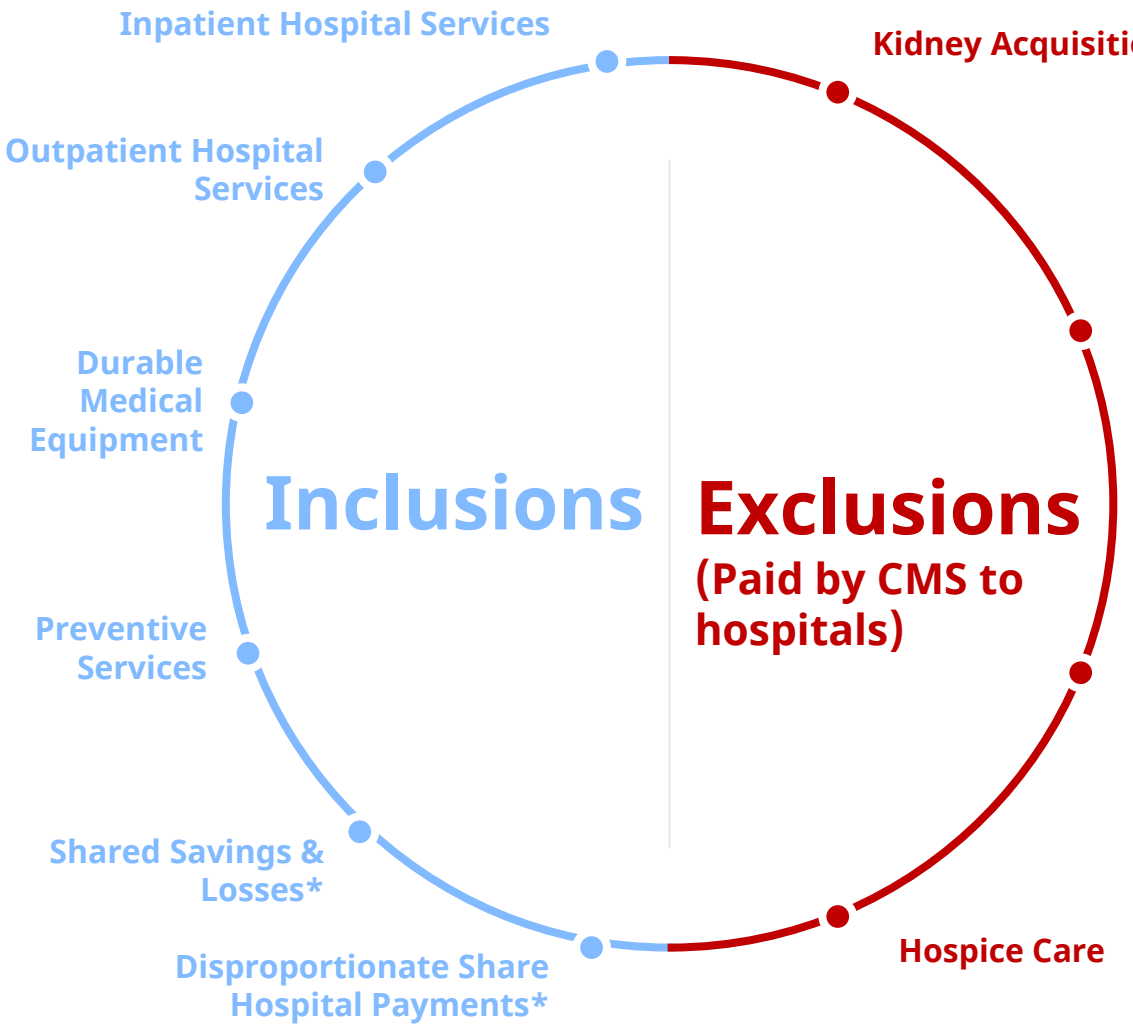
Source: Christina Ramsay and Gretchen Jacobson, "How the Government Updates Payment Rates for Medicare Advantage Plans" (explainer), Commonwealth Fund, Mar. 4, 2024.

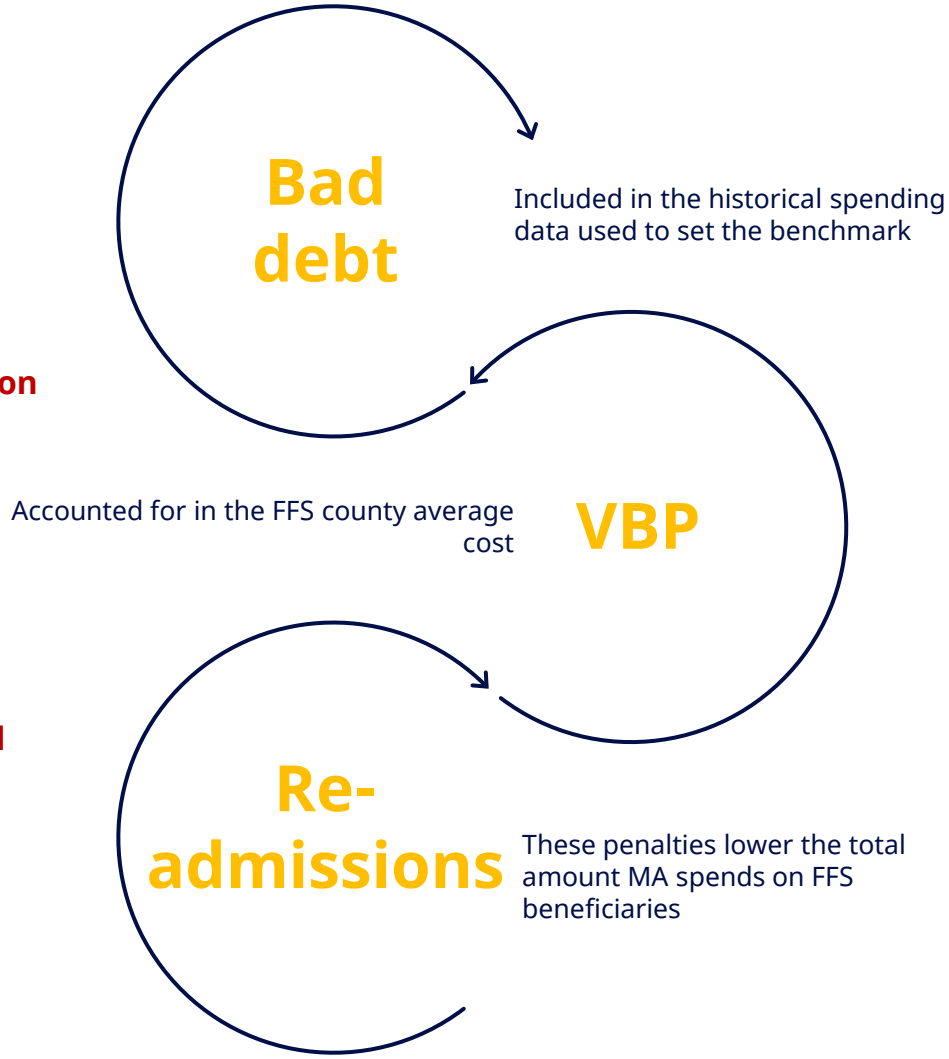
How MA benchmarks are refreshed/rebased every year

- The annual MA rating cycle for the following contract year includes three key milestones:
  - Advance Notice in January/February
  - Final Rate Announcement/rate book in April
  - Bids due in June
- CMS Office of the Actuary (OACT) is anticipated to project the US per capita cost (USPCC) for the upcoming contract year using **most recent data**
  - For example, the 2026 MA benchmark is projected based on FFS cost data through 2024
- County-level geographic factor development uses **multi-year rolling averages**
  - For example, the geographic factors used in the 2026 MA benchmark were based on a 5-year average from 2019 to 2023
- This methodology implies that emerging **cost shocks are delayed in impacting MA benchmarks and negotiations**



MA benchmarks include nearly all standard Part A and Part B medical expenditures, but exclude certain high-cost and specialized items





* While CMS handles the final payment, the historical FFS baseline includes these costs to reflect the actual cost of care in those areas.

How does the MA plan P&L function?

MA plan revenue from CMS is determined by a complex "bid-to-benchmark" process, adjusted for the health of the members

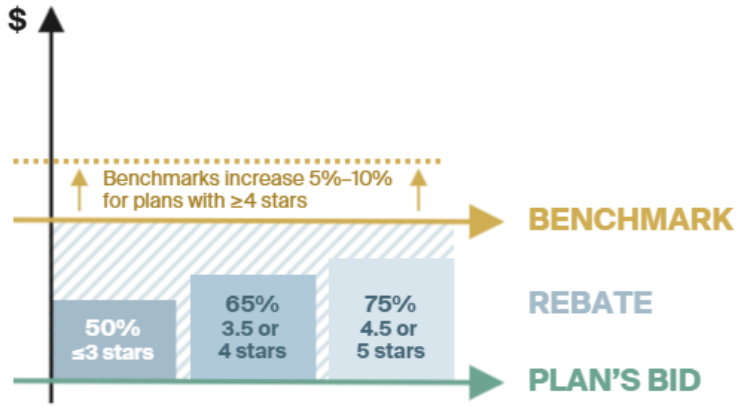
1

CMS sets a **benchmark**, the maximum amount the federal government will pay plans per enrollee per county.

2

A plan submits a **bid**, its estimated costs of covering the Medicare Parts A and B services for the average enrollee in each county.

*Both the benchmark and the bid amount are **risk adjusted** to account for enrollees' health status.*



3

If a plan bids below the benchmark, it receives a portion of the difference in the form of a **rebate**. This can range from 50 percent to 70 percent, depending on the plan's quality star rating.

Plans must use the rebate to lower out-of-pocket costs for enrollees or finance extra benefits.

Base Rate
The less of bid amount and benchmark; risk adjusted

Rebate
required to be spent on member benefits; not risk adjusted

MA plan revenue

Coding Intensity
Risk score reduction to adjust for MA coding difference vs. FFS

Risk Score
Accounts for members' ages, genders, and documented medical diagnoses.

Normalization
Ensures the average expected risk score in payment year remains at 1.0 vs. model calibration year.

Source: Christina Ramsay and Gretchen Jacobson, "How the Government Updates Payment Rates for Medicare Advantage Plans" (explainer), Commonwealth Fund, Mar. 4, 2024.

MA plan expenses are complex with margins being challenged lately

Medical Expenses

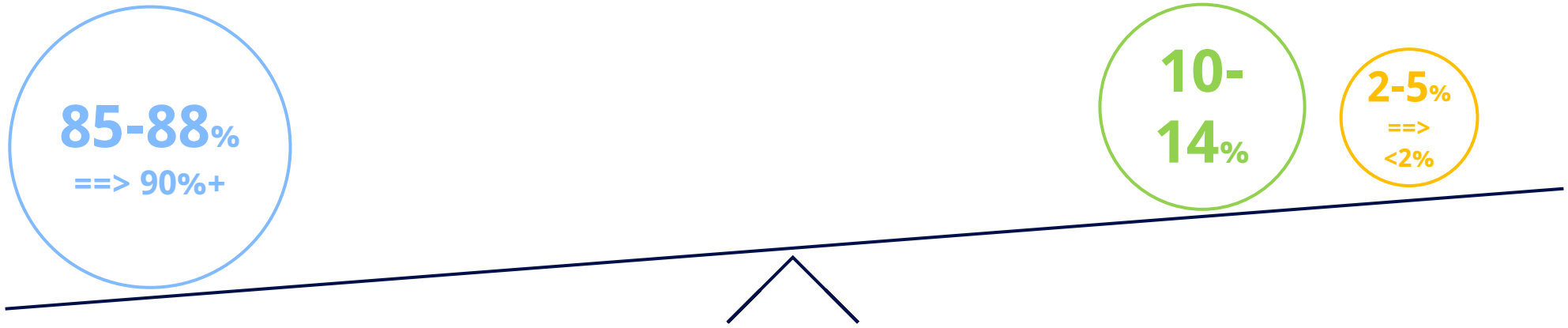
- **Medicare-covered medical services -** hospital stays, doctor visits, drugs, etc.
- **Extra expenses due to enriched benefits** compared to traditional Medicare on these core medical services
- **Non-Medicare covered benefits -** dental, vision, hearing, OTC, transportation, etc.
- **Expenses to improve care quality –** health risk assessment, VBC cost

Admin expenses

- Sales, marketing, broker fee
- Claims operations
- Member engagement
- Network management
- Managed care operations
- Care navigation/support
- Corp. functions (finance, IT, etc.)

Net margin

- **Historical average at 2-4%**
- Recent revenue and medical/Rx cost headwinds put many plans in the **negative margin territory**
- **MA plans pulling back** to prioritize profitability



Contracting implications:
taking risk in MA

02

Taking risk starts with knowing which levers providers actually control

RISK VALUE CHAIN

1. Plan revenue	2. Contract economics	3. Performance denominator	4. Operating model
Benchmark, bid, Stars, risk score, rebates, Part D subsidy	% premium / MLR, gain/loss share, quality gates, settlement	Attribution logic, rosters, carveouts, member churn	Care management, UM, quality, risk coding, governance

PROVIDER LENS

PROVIDER-CONTROLLABLE / SHARED

- Avoidable IP, ED, SNF and home health utilization
- Care transitions, readmissions and site-of-care
- Primary / specialty access and chronic-care management
- Quality gaps, member engagement and compliant risk documentation

LIMITED PROVIDER INFLUENCE

- Part D expense, rebates, direct subsidy, formulary and tiering
- Supplemental benefits: dental, vision, OTC, meals, transport
- Plan admin / vendor fees, broker / marketing and corporate allocations
- Plan decisions: bids, Stars, benefit richness, PA rules and exits

CONTRACT RESPONSE

- Define a core medical risk pool by service category / DOFR
- Default carveout for Part D; cap or carve out supplemental benefits
- Fixed PMPMs or caps for admin / payer-service fees
- Annual bid / benefit review plus material-change reopeners

***Core message*: MA downside risk is an operating commitment, not just an actuarial settlement. Hidden exposure usually sits in attribution, data, carveouts and governance.**

Risk contract anatomy: define economics, exposure and settlement before accepting downside

ECONOMIC TERMS

Revenue / funding	% of premium, benchmark proxy, risk score, Star impact
MLR basis	Which costs count; admin, quality and payer services treatment
Gain/loss share	Upside/downside %; quality gates; settlement timing
Part D / Rx	Whether Rx risk, rebates, direct subsidy or RxHCCs are in scope
Reconciliation	Payer workbook, member-month detail, audit and dispute rights

EXPOSURE CONTROLS

Caps and corridors	Limits on downside exposure and asymmetric risk
Stop-loss / high cost	Protection for catastrophic members or outlier events
Population carveouts	New members, DSNP/partial benefit, ESRD, hospice, OOA
Benefit carveouts	Supplemental benefits, payer-managed programs, Part B Rx
Material change	Reopeners for plan exits, benefit changes, Stars or rate shocks

85%

minimum MA / Part D MLR

plan-level rule that may be referenced in risk contracts

Provider ask: require the payer to show the same calculation logic used for settlement, including adjustments, exclusions and timing.

Risk deals are simplifying – core medical claims stay in the performance pool, while Part D, supplemental benefits and payer-run programs are increasingly carved out, capped, or priced separately.

Source: CMS Medical Loss Ratio requirements; CMS CY2026 Part D redesign instructions

Why MA risk can feel harder than MSSP risk

The issue is often not the care model; it is the benchmark, population size and payer-specific execution layer.

1. BENCHMARK STARTING POINT

MSSP / CMS-VBC

Benchmark is built from assigned beneficiaries' FFS spending experience, trended / risk adjusted under one CMS methodology.

Unmanaged FFS benchmark

MA MLR DEAL

Provider target often starts from managed plan revenue / bid economics, not the full county benchmark.

Managed plan top line

2. SAVINGS CAN BE PRE-BAKED

Illustrative math

FFS / MA benchmark = 100

plan bid below benchmark

MA plan revenue ~85–90

provider MLR target

claims target already lower

Translation: the ACO may need to create additional savings against a top line where the MA plan has already bid below benchmark.

3. SMALLER POOLS + PAYER VARIATION

- MSSP pools FFS beneficiaries across CMS assignment; MA contracts are payer-by-payer and often smaller.
- Smaller MA attributed populations create more random volatility from a few high-cost members or churn.
- Each payer can differ on attribution, PA, network, care gaps, data feeds and settlement workbooks.
- Same care-management infrastructure can underperform financially if the target, data or population is not comparable.

VBC implication: MA is not just MSSP with a payer wrapper; plan bids, rebates/benefits and admin convert the FFS benchmark into a managed top line before provider risk is applied, so providers should not expect MSSP-like profitability from the same operations.

Source: CMS MA bid / benchmark / rebate payment materials; CMS Shared Savings Program financial and assignment methodology resources; MCC Contracting Playbook

Align on a glide path: risk should increase only as controls mature

RISK GLIDE PATH

1 FFS + quality incentives
Build payer data and reporting

2 Upside-only shared savings
Test attribution and cost model

3 Limited downside with corridors
Price manageable exposure

4 Full TCOC risk / capitation
Operate mature risk engine

DECISION GATES

Data reliability	Timely, complete, machine-readable files tied to settlement.
Attribution stability	Roster logic understood; disputes resolved before settlement.
Financial transparency	Premium / MLR / settlement logic can be reproduced.
Operating maturity	Care model, quality, risk and admin routines active.
Governance discipline	Monthly council and quarterly JOC have decision rights.

***Glide path principle*: scale downside only after evidence shows the provider can manage the attributed population and reproduce the economics.**

Provider readiness: capabilities needed to forecast, monitor, mitigate and manage MA risk

FORECAST	MONITOR	MITIGATE	MANAGE
• Revenue bridge • Medical/Rx trend model • Risk score and Star scenarios • Payer benefit / market changes	• Monthly membership + attribution • Claims, MLR and settlement variance • Quality / care gap status • Prior auth and denial friction	• Care management for high-risk members • Leakage and site-of-care management • Care gap closure + supplemental data • Coding completeness with compliance guardrails	• Owner matrix and JOC cadence • Escalation paths and issue log • Dashboard and performance narrative • Annual reset / renegotiation evidence

READINESS THRESHOLD

Do not take material downside unless each key term has a named owner, data feed, cadence, performance metric and escalation path. Otherwise, the provider is accepting actuarial risk without operating control.

How do MA plans reimburse hospitals?

MA reimbursements often reference Medicare FFS reimbursement

MA reimbursements are negotiated between payors and providers

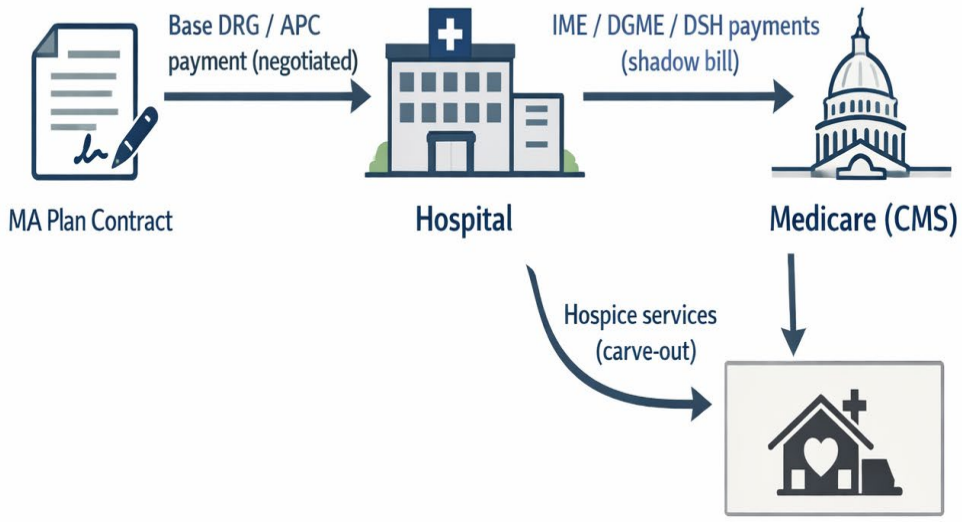
MA reimbursement often **reference Medicare FFS IPPS/OPPS/PFS reimbursement mechanism**, with plan/provider-specific multipliers, such as DRG × 102% or fixed per diem rates.

Indirect Medical Education (IME), Direct Graduate Medical Education (DGME), and Disproportionate Share Hospital (DSH) add-ons are typically excluded from MA plan payments; hospitals must **submit shadow claims to CMS** to receive these funds.

Some organ acquisition costs are excluded from MA plan payments

- **Kidney acquisition**: CMS explicitly exclude these from the MA benchmark development effective 2021 (exception: PACE)
- **Other organs' acquisition**: still included in the MA benchmark

Hospitals should **negotiate contracts accounting for these exclusions** and **clarify "100% of Medicare" definitions** to avoid underestimating total revenue from MA patients.



340B repayment with MA plans

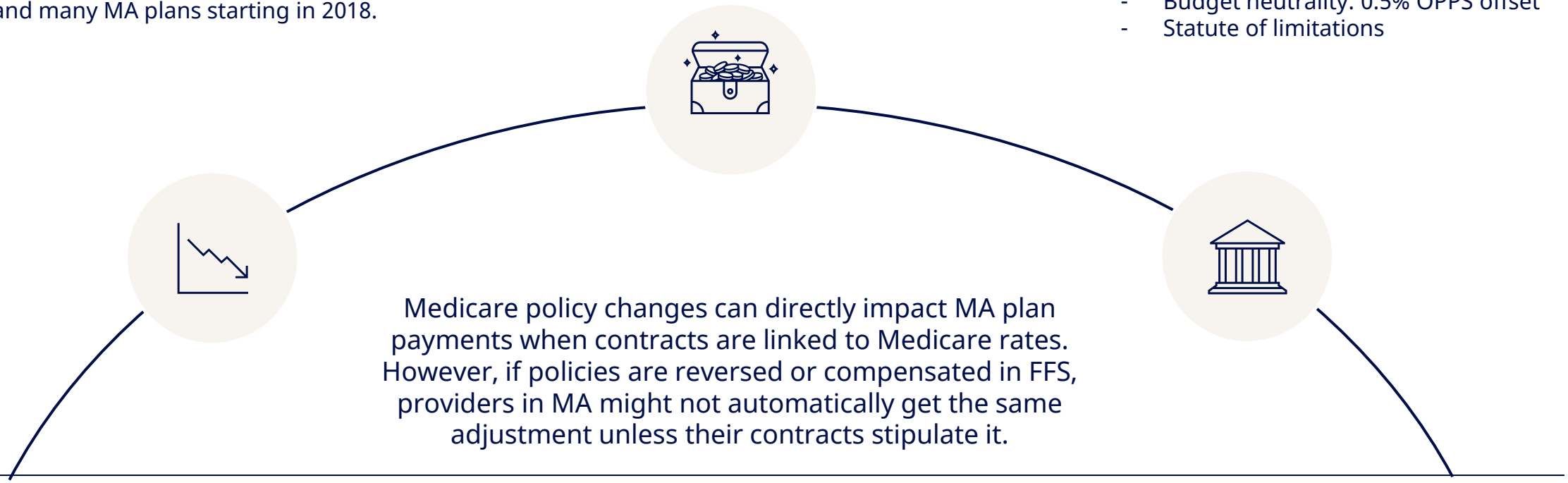
In 2018, Medicare cut 340B hospital drug payments to ASP - 22.5% (average sale prices minus 22.5%) to reduce what it viewed as overpayment (historically this payment was ASP+6%).

When Medicare lowered 340B drug rates, **MA plans followed suit and paid 340B hospitals at the reduced rate as well**. This significantly lowered reimbursement for 340B drugs under both FFS and many MA plans starting in 2018.

In 2022, the Supreme Court struck down Medicare's 340B cuts. **Medicare in 2023 moved to repay 340B hospitals the shortfall for 2018-2022 under FFS**. However, CMS explicitly told MA plans it "cannot interfere" in private MA-provider contracts, meaning **it did not require MA plans to repay the 340B difference.**

Some hospitals have sued MA plans to recover those drug payment losses from 2018-2022.

- Favorable contract language: "**Medicare allowable**" , "Medicare rules"
  - **Out-of-network hospitals** in favor
- Arbitration
- MA plans arguments:
  - Not in the MA benchmark
  - Budget neutrality: 0.5% OPPS offset
  - Statute of limitations



Medicare policy changes can directly impact MA plan payments when contracts are linked to Medicare rates. However, if policies are reversed or compensated in FFS, providers in MA might not automatically get the same adjustment unless their contracts stipulate it.

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