January 18, 2024

Medicare Advantage (MA) Monthly Enrollment

Prior Auth Final Rules Save $15 B Over Ten (2026)

Relevant Companies

Our Take & Next Up

CVS (gains) and Centene (loses) in MA enrollment figures released yesterday by the Centers for Medicare and Medicaid Services (here **).** Takeaways from January 2024 enrollment files (all analyses are of individual enrollment and are based on summaries of county level enrollment files from December 2023 to January 2024) can be found below. Also yesterday after the close CMS released its Prior Authorization (PA) final rule that applies to MA, Medicaid, Exchange plans.

Key Points

MA enrollment is up 2%. Overall MA enrollment only +2.3%, but there are major differences in terms of winners and losers. The top 3 account for 57.4% of enrollees, up from 56.8% in December 2023.

- CVS +22% enrollment increase in MA vs. December 2023.
- United's enrollment in MA is flat.
- Humana is +1.2%.
- Elevance's enrollment declined by 2.5%.
- Centene declined by 11%.
- Cigna dropped by 1.6%.

Among organizations with between 100 and 500 thousand MA lives in January 2024, the winners and losers are below.

- Winners include Devoted Health (+41%), MHH Healthcare (+19.5%) Alignment Healthcare (+22.5%), Health Care Service Corporation (+14.9%).
- Losers include Bright Health (-11%), California Physicians' Service (-12%).

For the standalone PDP market, overall enrollment declined by 2%. Large decreases for CVS (-22%), Humana (-17%), and Cigna (-12%). United's PDP enrollment was down by 2%. Centene had an increase of +34%, and now has over 1/3 of PDP enrollment, whereas it had one-quarter of PDP enrollment in December.

In tandem CMS released its Prior Authorization rule ($15 B in savings/ten) late yesterday (MA, Medicaid MCOs, Exchange, CHIP). The rule improves the electronic exchange of health information and prior authorization processes for medical services. The policies will improve processes and reduce burden on patients, providers, and payers.

Beginning primarily in 2026, impacted payers will be required to send PA decisions within 72 hours for expedited (i.e., urgent) requests and seven calendar days for standard (i.e., non-urgent) requests for medical items and services. For some payers, this new timeframe for standard requests cuts current decision timeframes in half. The rule also requires all impacted payers to include a specific reason for denying a prior authorization.

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