

The Medicare Advantage Shakeout:

A Survival Guide for Regional
Health Plans

Table of Contents

01	Executive Summary	4
	Your Star Ratings Are Dying.....	4
02	The MA Market Inflection Point	5
	The Financial Crisis Unfolding	5
	Star Ratings Volatility: The New Normal	9
	Market Segmentation: Winners and Losers	10
	Regional Plans: Caught in the Middle	11
03	The Winners' Formula: Driving Member-Level Behavioral Change	13
	The Real Competitive Advantage	13
	Lever 1: Patient Education and Health Literacy	14
	Lever 2: Ease of Access to Clinical Care.....	14
	Lever 3: Clinical Proximity and PCP Partnerships	15
	Lever 4: Individual Member-Level Engagement	17
	How Insurtechs Achieve Member Proximity	18
	Traditional Plan Challenge	19
	The Survey Season Problem and Behavioral Solution.....	20
04	Barriers Facing Regional Plans	21
	Legacy Systems and Operational Models.....	21
	Resource Constraints	22
	Cultural Resistance to Digital Transformation	23
	Knowledge Gaps About What Actually Improves Ratings	24
05	Strategic Options Analysis	26
06	Strategic Implementation Framework	30
	Quick Wins: Operational Improvements (0–6 Months).....	30

	Medium-Term: Member Education Programs (6–12 Months)	34
	Long-Term: Technology Platform and Data Capabilities (12–24 Months)	38
	Role of Predictive Analytics in Targeting Resources	42
07	The ROI of Star Rating Improvement	44
	Investment Requirements by Strategy	44
	Projected Star Rating Improvements	45
	Bonus Payment Opportunity	46
	Competitive Positioning Value	47
	Break-Even Analysis and Timeline	49
08	The Transformation Roadmap for Executive Leadership	50
	90-Day Immediate Actions	50
	12-Month Transformation Program	53
	Multi-Year Strategic Roadmap	56
	Key Decisions and Resource Allocation	57
09	Conclusion: The Path Forward	61
	The Moment of Decision	61
	The Regional Plan Advantage	61
	Success Factors	62
	The Choice Is Clear	63
10	About Invene	65
11	Bibliography	66

01 Executive Summary

01.1 Your Star Ratings Are Dying

The Medicare Advantage market is experiencing a fundamental restructuring. The average Medicare Advantage plan rating fell from 4.07 Stars in 2024 down to 3.92 Stars in 2025, with only 40% of contracts earning bonus-eligible ratings.^{1,2} This drop represents billions in lost quality bonus payments. A mere one percent drop in 4-Star contracts results in a loss of hundreds of millions in revenue across the industry. For individual plans, the difference between a 3.5-Star and a 4-Star rating can mean \$25 million to \$100 million in annual bonus losses.

This collapse exposed structural weaknesses that now threaten the viability of many plans. National plans are retrenching after years of aggressive expansion. Regional health plans struggle to maintain profitability amid margin compression.

The fundamental difference between winners and losers is their operational model.

Plans that succeed drive behavioral change at the individual member level. They personalize every interaction based on individual behavior patterns, barriers, and needs.

This white paper will discuss three key areas:

- The competitive landscape and market dynamics driving change
- Why member-centric operational models outperform traditional approaches
- A transformation roadmap for regional health plans choosing to compete rather than exit
blah

The window is closing. Plans that delay transformation will find themselves priced out by bonus-earning competitors or forced to sell at distressed valuations.

02 The MA Market Inflection Point

02.1 The Financial Crisis Unfolding

In 2024, Medicare Advantage (MA) shifted from a profitable growth opportunity to a money-losing business forcing insurers to cut back.

Three forces converged to destroy MA profitability:

1. Post-pandemic utilization, coupled with aging members, led to medical cost surges and higher-than-predicted claims. The delayed care from 2020 to 2021 materialized in 2023 to 2024 as complex, expensive cases. Plans built their 2024 bids assuming utilization would normalize. They were wrong.
2. CMS cut payments via the Risk Adjustment Model V28, which reduced funding for many chronic conditions. Although CMS projected a 3.7% revenue increase for 2025, it included a 0.16% drop in benchmark rates. This is the first such decrease in years, amid annual medical cost trends of 6% to 8%. Squeezed by rising costs and limited government payments, Medicare Advantage plans saw their margins disappear.
3. CMS tightened Star ratings by using the Tukey outlier deletion methodology, which raised the performance bar. Consequently, many plans experienced a drop in their overall Star ratings. Even plans that maintained the same quality metrics as the prior year often saw their overall Star ratings fall.

The strategic shift in MA

The following three tables compare the strategic shift in MA for the last year.

Table 1

Major National Players – Large-scale insurers with nationwide presence				
INSURER	MA ENROLLMENT	PROFITABILITY	STRATEGIC DIRECTION	KEY STRATEGIES
UnitedHealthcare (UHC)	9.4 million enrollees (2024), ~29% of MA market. Largest MA insurer nationwide.	Historically strong profits; facing 2024–2025 margin pressure from a spike in medical costs (~\$3.6B higher MA spend than expected). Still profitable but intensifying cost controls to counter rising outpatient utilization.	Generally expanding (national presence in all states), but selectively retrenching in high-cost areas — e.g. discontinuing certain broad-network PPO plans in 2024–2025, impacting ~600k members, to stabilize margins. Not exiting MA, but pruning unprofitable offerings.	Leverages unmatched scale and vertical integration (Optum) to spread risk and manage costs. Adjusting pricing and benefit design to reflect higher utilization trends. Deploying advanced analytics (AI) to detect fraud/waste and reduce unnecessary spend. Maintains focus on quality — keeps majority of members in ≥4-star plans (earning bonus payments) to bolster revenue.
Humana	Over 6 million enrollees, ~18% market share. Second-largest MA insurer.	Historically high MA profitability (e.g. \$2.5B net profit in 2023), but outlook worsening. A sharp Star Ratings drop will leave only ~25% of members in bonus-eligible plans (down from 94%) and could cost \$1–3B from 2025–2026 revenue, putting future profit at risk. Medical cost ratio rising toward ~90%, compressing margins.	Retrenching slightly to protect margins. After years of aggressive growth, now paring back certain plan offerings and extras for 2024 — expects to lose “hundreds of thousands” of members as it pulls back benefits/prices to preserve profit. Sued CMS over Stars methodology; focusing on core profitable segments.	Star rating recovery initiatives underway (major investments to improve scores). Diversifying contracts to avoid over-concentration of members in a few contracts (which hurt Stars). More disciplined bidding — prioritizing margin over membership growth to regain ~3% segment margin by 2027. Pushing operational efficiencies and care management to tame costs.
CVS/Aetna	~3.4–3.9 million MA enrollees (2023–24), ~12% share. Fast-growing third-place insurer.	Solid performance with 88% of members in ≥4-star plans (2024), which secures quality bonuses. Profit margins in MA are positive (CVS Health projects ~\$9 EPS in 2024) but modest, as the company absorbs integration costs. Facing the same cost trend uptick as peers — parent firm slightly dialed back 2024 earnings outlook.	Expanding ambitiously. Added 255 new counties for 2024 (now in 46 states) — the broadest Aetna MA footprint ever. Also making big strategic investments in care delivery (primary care clinics, home health) to strengthen its MA ecosystem. No signs of exit; doubling down on Medicare business through parent CVS’s vertical integration.	Vertical integration strategy: acquired Oak Street Health (primary care centers) and Signify Health (in-home assessments) to better control quality and costs for MA members. Aims to funnel Aetna seniors to Oak Street clinics, improving care coordination and retention. Expanding specialty plans (e.g., Dual-Eligible SNPs in 31 states) to grow in high-need, high-revenue segments. Leverages CVS’s retail footprint (pharmacies, MinuteClinics) for member engagement.
Elevance Health (Anthem BCBS)	~2.0 million MA enrollees, ~6% share. (Part of Blue Cross Blue Shield system.)	Moderate profitability: ~4–5% operating margins. Projects a ~90% medical loss ratio for 2025, indicating slim margins. Took a hit from Stars downturn — one large contract fell to 3.5-star, costing an estimated \$375M in lost bonuses. Overall MA earnings are positive but under pressure.	Restructuring portfolio for profitability. Exiting certain underperforming segments; discontinuing all standalone Part D drug plans and pulling out of some MA counties/plans (about 150k MA members affected). Refocusing on core markets and products (e.g. HMOs and SNPs) that drive better returns.	Emphasizing managed-care products: shifting mix toward HMO and Dual-SNP plans (which have tighter networks and care management). Taking a “disciplined” benefit design approach — scaled back plan offerings and adjusted pricing for 2026 bids to boost margins. Intensifying quality improvement after rating setbacks. Cutting losses in low-performing areas to concentrate resources on plans/regions with sustainable growth.
Cigna	~0.6–0.7 million MA enrollees, ~2% share. (Mid-tier national plan.)	Underperforming segment for Cigna. MA margins are below target (fell short of the 4–5% goal in 2023 and expected to remain <4% in 2024). Expansion costs and changes in CMS payment models have kept profits low. Additionally, a decline in star ratings and a recent \$172M risk-coding fraud settlement have weighed on financials.	After years of footprint expansion (doubled MA geographic reach from 2019 to 2023), Cigna sold its MA business to HCSC.	Cigna sold its MA business to HCSC.
Blue Cross Blue Shield (Regional Plans)	~4.6 million MA enrollees combined, ~14% market share (all independent BCBS plans including Anthem). Individual Blue plans are regional (e.g., Florida Blue, BCBS Michigan ~0.65M members each).	Mixed results; generally thin margins. Many Blues struggled with 2023 cost surges — e.g. Blue Cross MN’s operating profit in 2023 fell 40% (from \$173M to \$103M) amid MA cost pressures. Plans with small MA enrollment face scale challenges and some have incurred losses. One smaller Blue (BCBS Kansas City) cited insufficient membership and exited the MA market entirely after 2024.	Maintaining presence in core markets, with selective growth. Regional Blues typically stick to their states/counties (limited by BCBS association rules) — no national expansion. Some large Blues are growing their MA books (collectively Blues accounted for ~30% of MA enrollment growth in 2025) to defend local market share. However, if a market is not viable, a Blue plan may exit or retrench.	Local network leverage and niche focus. Blues capitalize on strong local provider relationships and brand loyalty. They often partner with area health systems and clinics to manage care for MA (sometimes integrating care management programs jointly). Many Blue plans target group retiree MA contracts and develop specialized plans (chronic condition SNPs, etc.) to serve high-need populations. The emphasis is on local expertise in benefit design and customer service to compete against national giants.

Table 2

Insurtech & Mid-Size Players – Technology-driven and emerging competitors				
INSURER	MA ENROLLMENT	PROFITABILITY	STRATEGIC DIRECTION	KEY STRATEGIES
Devoted Health (Insurtech)	227K MA members (mid-2024), up from 142K in Dec 2023 — <1% share. Rapid growth (expanded from 5 states to 13 states in one year). Targeting ~20 states by 2025.	Not yet profitable. As a venture-backed startup, Devoted has operated at a loss for 5+ years. It continues to lose money as it scales (funded by large VC rounds – e.g. raised \$287M in 2024). The company's medical costs still exceed premiums, but the gap is narrowing as it grows.	Aggressively expanding, Devoted is in growth mode, entering new states and counties at a fast clip. It grew from 5 states to 13 by 2023 and plans to be in 20 states by 2025. Rather than retrench, it's relying on investor funding to reach sustainable scale. No indications of exit; instead pursuing nationwide expansion.	Tech-driven, integrated care model. Devoted built its own care delivery arm (Devoted Medical – virtual and in-home teams) to closely manage seniors' health. Its proprietary platform ("Orinoco") integrates data and workflows across insurance and care delivery, aiming to improve preventive care coordination. The focus is on high member satisfaction and quality — Devoted achieved a 4.6-star average rating (94% of members in 4-star or 5-star plans), maximizing bonus revenues. It competes by offering rich supplemental benefits and concierge-like service (Devoted "Guides") to attract and retain members.
Clover Health (Insurtech)	~103K MA members (Q1 2025), ~0.3% share — up 30% YoY from ~79K. Markets concentrated in select states (e.g. NJ, GA, TX).	Historically unprofitable, but making progress. Clover burned cash for years; its medical loss ratios were >100% in early years, improving to ~86% in 2023–2024. In mid-2024 it posted its first ever profitable quarter on an adjusted basis, and by Q1 2025 nearly broke even on a GAAP basis. Still had full-year net losses in 2022–2024, but markedly smaller.	Tempered expansion: focus on stabilization. Clover at one point expanded to 9+ states, but it has slowed expansion to concentrate on improving margins in its existing markets. The strategy has shifted from "growth at all costs" to achieving sustainable operations. Clover is still growing membership but any new market entries are cautious.	Data and physician-centric approach. Clover's hallmark is its AI-powered platform "Clover Assistant", which it provides to network physicians. This tool uses data to prompt providers on care gaps and coding opportunities during visits, intended to both improve care and capture accurate risk adjustments. The company also embraced open networks and low out-of-pocket costs to attract members. Now, to improve profitability, Clover is tightening utilization management and focusing on high-value care coordination.
Alignment Health-care (Insurtech)	~189K MA members (end of 2024); 223.7K by Q2 2025 (~0.6% share). Strong growth (membership +58% in 2024). Operates in CA, FL, NV, AZ, NC and growing.	Not yet consistently profitable, but nearing break-even. Alignment has spent heavily to grow, incurring losses each year — however, it achieved its first quarterly net income (\$15.7M) in Q2 2025. Its medical benefit ratio (~86–87%) is relatively controlled for an insurtech, reflecting effective cost management. With revenue ~\$2.7B in 2024, its net loss has narrowed substantially.	Expanding steadily with a focused footprint. Alignment continues to enter new counties (and potentially new states) where it can partner deeply with provider groups. It grew ~58% in 2024 and projects strong growth into 2025. Unlike peers, Alignment is pure-play MA (no ACA or Medicaid lines), allowing full focus on Medicare. No retrenchment — the company signals confidence in growing "market-plus" even as others pull back.	Care model innovation and selective risk management. Alignment positions itself as a "contrarian" to legacy insurers' playbook — rather than relying on aggressive coding or broad networks, it focuses on identifying the sickest patients and managing their care closely. Its proprietary "AVA" platform and Care Anywhere program integrate virtual and in-home care to coordinate treatment for polychronic seniors. Alignment places "maniacal" emphasis on Star ratings and preventive care. It engages in deep value-based partnerships with physicians and IPAs, sharing data and incentives to keep patients out of the hospital.
Centene	~1.6 million MA enrollees, about 5% share. Large multi-line insurer also in Medicaid and ACA.	Stable margins but facing challenges. Centene reported solid profits from its Medicare business in 2023 but results softened in 2024. Higher medical costs particularly in 2024 and the impact of lower star ratings have pressured margins. Centene's overall approach has been to manage profitability while slowly growing enrollment, but recent headwinds mean it is taking a more careful stance on MA profitability.	Stable but cautious approach. Centene did not massively scale back like some others but it is disciplining its expansion. It slightly reduced MA membership around 6% fewer enrollees in 2025 to drop unprofitable counties and plans. Centene sees MA as a key part of its diversified portfolio, Medicaid and marketplace remain committed but has turned more selective in its growth.	Focus on operational efficiency. Centene is emphasizing better integration of care for MA members using its Medicaid expertise and managing complex populations to handle high need MA populations. It is also tightening utilization management and expanding value-based contracts with providers to control costs. Aiming to stabilize MA margins at 2% to 3% through administrative efficiencies and better network management.
Molina Healthcare	~0.25 million MA enrollees, about 1% share. Small but growing in Medicare.	Modest segment, limited track record. Molina has historically been Medicaid focused and only recently started growing its MA presence. A smaller player, margins in MA are still developing. Molina indicated in 2024 that its MA business was on track but is not yet a major profit driver. It is more of a growth experiment than a core moneymaker.	Gradual expansion. Molina is not retrenching; in fact, it is looking to slowly grow its MA as part of its efforts to diversify beyond Medicaid. In 2025, Molina added some plans in new markets, for example California expansion. The strategy is to build scale in Medicare over time, though it remains cautious given the challenging environment.	Dual eligibles specialization. Molina is leaning into serving dual eligible beneficiaries, Medicaid plus Medicare, where its experience with low income populations is an advantage. It is also focusing on integrated care models and value-based contracts to manage costs. Molina is leveraging its existing care management infrastructure built for Medicaid to manage high needs seniors.

Table 3

Specialized & Regional Players – Focused insurers with niche or geographic strategies				
INSURER	MA ENROLLMENT	PROFITABILITY	STRATEGIC DIRECTION	KEY STRATEGIES
Oscar Health (Insurtech)	Minimal MA presence; primarily focused on ACA marketplace. <1% MA share.	Not a significant MA player. Oscar is mainly focused on individual marketplace plans (ACA exchanges) and is still working toward profitability in that segment. Its MA business is negligible.	Limited involvement in MA. Oscar has experimented with some MA products but has not made Medicare a core focus. The company's strategy is to perfect its model in the under-65 market before potentially expanding to seniors.	N/A for MA profitability strategies. Oscar's strengths (tech-first, consumer-friendly design) could theoretically apply to MA, but it has not yet committed significant resources there.
Bright Health (Status: Exited/Bankrupt)	Former MA player; exited market. Previously ~0.1 million enrollees.	Severe losses; bankruptcy. Bright Health lost hundreds of millions trying to scale rapidly in MA. It filed for bankruptcy in 2024 and sold off its MA business to other insurers. The company failed to achieve profitability and could not sustain operations.	Complete exit. Bright Health is no longer operating as an MA insurer. Its contracts were sold or terminated. This is a cautionary tale of over-expansion without a sustainable model.	N/A. Bright's aggressive growth strategy (rapid multi-state expansion) backfired. It underpriced plans, faced adverse selection, and couldn't manage medical costs. The company's downfall illustrates the risks of chasing growth without operational fundamentals.
Kaiser Permanente	~1.9 million MA enrollees (~6% share). Integrated health system with insurance arm.	Strong profitability. Kaiser has some of the best MA margins in the industry due to its integrated model (owns clinics and hospitals). Its business is profitable and stable, though it faces the same industry headwinds (rising costs, star rating changes).	Steady growth in existing markets. Kaiser does not expand geographically as aggressively as others; it operates only in about 8 states where it has clinics. But within those markets, its growth has exceeded MA enrollment steadily. Kaiser's strategy is to leverage its integrated delivery system to attract seniors who want coordinated care.	Vertical integration advantage. Kaiser controls the entire care delivery chain (insurance, primary care, specialists, hospitals). This allows tight cost control and high quality care, leading to strong star ratings (often 4 stars+). Kaiser uses its brand reputation for integrated care to attract MA members. It focuses on preventive care and chronic disease management to keep costs down. The model is sustainable because Kaiser can manage utilization directly.
Geisinger Health Plan	~0.15 million MA enrollees (<1% share). Regional integrated health system (Pennsylvania).	Solid margins. Like Kaiser, Geisinger benefits from owning its delivery system. Its MA business is profitable within its limited footprint. Geisinger faces challenges from small scale but offsets this with operational efficiency.	Maintaining regional presence. Geisinger is not expanding outside Pennsylvania. It focuses on serving its existing community with high-quality integrated care. The plan is stable but not growing rapidly due to geographic limits.	Integrated care model. Geisinger uses its owned clinics and hospitals to provide coordinated care for MA members. It achieves strong quality outcomes (4+ star ratings) through care coordination. The strategy is to be a trusted local option in its market, emphasizing quality over scale.
SCAN Health Plan	~0.28 million MA enrollees (~1% share). Regional nonprofit MA-only insurer (California).	Moderate profitability. SCAN is a nonprofit organization focused solely on seniors (MA and supplemental insurance). It operates with modest margins but is financially stable. SCAN has some of the same star rating and cost pressures but remains committed to its mission.	Stable in California market. SCAN is not aggressively expanding outside its core California (and Arizona) footprint. It focuses on serving seniors in those markets with a mission-driven approach. Growth is modest but steady.	Member-centric, nonprofit model. SCAN emphasizes high-touch member services and care management. It invests heavily in care coordination and social services (for example, transportation and programs to maintain independence). SCAN achieves good star ratings (4+) through these efforts. As a nonprofit, it reinvests margins into member benefits and quality improvement rather than maximizing profit.

02.2 Star Ratings Volatility: The New Normal

Table 4 shows reasons MA enrollment has slowed despite more seniors aging into eligibility:

Table 4

Medicare Advantage Enrollment Dropoff Causes – Reasons MA enrollment has slowed despite more seniors aging into eligibility		
MECHANISM	DESCRIPTION / EFFECT	SUPPORTING EVIDENCE
Diminishing pool of converts	Most “low-hanging fruit” — those dissatisfied with Traditional Medicare, or attracted by supplemental benefits — have already moved to MA. The remaining Traditional Medicare population tends to be more resistant or has entrenched preferences.	Analysts note that as MA penetration surpasses 50%, further expansion becomes more incremental.
Higher acquisition cost & risk	New enrollees (or switchers) are more likely to be higher risk, sicker, or more cost-intensive. Thus the cost of enrolling additional members (in claims, marketing, underwriting adjustments) goes up, weakening the business case for aggressive outreach.	One metaphor used: “MA enrollment has turned into a game of hot potato” — no insurer wants to grab too large a share of high-utilization members.
Benefit rollback and less “extras” appeal	As insurers trim supplemental benefits (dental, vision, non-emergency transport, wellness perks) to preserve margins, the attractiveness of MA versus Traditional Medicare diminishes for marginal enrollees. Some of them simply stay put.	Analysts cite “worse benefits and fewer plans available” as a cause for slower growth in 2025.
Plan exit / contraction by major insurers	When major insurers shrink offerings or withdraw from certain counties or states, fewer MA options exist for some beneficiaries, thus reducing conversions in those geographies.	Humana, Aetna, and others signaled contraction of their MA footprint heading into 2025.
Choice overload & decision friction	Beneficiaries face many MA plan options with similar advantages and small differences. This complexity can lead some to default to Traditional Medicare or delay switching.	Some advocacy reports argue that insurers “flood” the market with highly similar plans, which confuses consumers and may deter enrollment.
Regulatory, marketing and oversight constraints	Tighter CMS rules on enrollment marketing, benefit standardization, and plan design make it more difficult to aggressively recruit new members.	There’s growing regulatory scrutiny of marketing practices and demands for “meaningful difference” requirements.
Switching inertia & satisfaction	Many beneficiaries are complacent or satisfied with their existing Medicare coverage (Traditional or MA). If they feel the benefit differential is diminishing, the incentive to switch reduces.	Behavioral inertia is often underappreciated in health insurance choice models; qualitative commentary cites this in the MA context.

The 4-Star threshold is crucial for Medicare Advantage plans. Below 4 Stars, plans lose CMS quality bonus payments. Achieving 4 Stars or more yields a significant 4%-5% revenue boost, equating to about \$37M annually for a plan with 100,000 members.³

That revenue difference compounds. High-Star plans capture disproportionate enrollment growth during the Annual Election Period. Plans stuck at 3.5 Stars watch members migrate to 4-Star competitors, shrinking the membership base that generates premium revenue.

The optimal target for most plans is 4.0 to 4.5 Stars. This is high enough to capture bonus payments and competitive positioning, yet low enough to avoid extreme adverse selection.

Table 5 shown below compares the response of various player categories to the changes in the MA market:

Table 5

CATEGORY	NATIONAL PLANS (UHC, HUMANA, CVS, ELEVANCE, CIGNA/HCSC)	REGIONAL BLUES	INSURTECHS (DEVOTED, CLOVER, ALIGNMENT, ETC.)
Scale & Market Share	UHC/Humana dominate ~47% of market. Expansion has slowed — pruning counties, cutting unprofitable plans. Interviews echo this; Justin noted nationals are “cutting down service areas” after years of aggressive growth.	Limited to state/geography, collectively ~14%. Scale issues make it harder to absorb star volatility and MLR shocks. Sarah highlighted regional strength in local retention and PCP ties.	Still <1% share. Growth-first mindset, but reliant on VC funding. Devoted expanded from 5 to 13 states in a year, but still burning cash.
Profitability Trends	Profits compressed by higher MLRs (UHC +2.3 pts; Humana warned of star bonus losses costing billions). Mark emphasized executives often misunderstand stars and see it as “just a survey” — leading to under-investment in long-term strategies.	Margins thin. Some (e.g., BCBS MN) saw 40% drop in MA profit in 2023. Smaller Blues like KC exited MA due to insufficient membership. Sarah reinforced that retention and provider relationships, not brute-force scale, are what protect margins.	Still unprofitable, but trending toward breakeven (Clover, Alignment). Justin predicted the breakthrough will come when predictive analytics ties directly into personalized, AI-driven outreach.
Stars & Quality	Stars volatility hit hardest here (Humana plunged from 94% to 25% of members in 4-star+ plans). Mark warned that chasing 5-star can backfire — attracting high-risk, high-churn populations.	Quality performance varies widely. Blues with strong provider alignment can sustain 4-star, but many sit at 3.5-star. Resource constraints limit large-scale star rating recovery campaigns.	Devoted has highest star scores (94% in 4-star/5-star). Alignment emphasizes star-centric care journeys. Clover uses tech for coding and care prompts. Interviews highlight: predictive analytics can triage member interventions (who’s at risk vs. who just needs nudges).
Provider Alignment	Often weaker, especially in broad PPO markets. Reliance on data/outreach vs. PCP engagement. Interviews stressed this gap; Sarah and Mark both said gaps close in the office, not in analytics dashboards.	Strength lies here. Deep community ties and local provider loyalty. Can integrate predictive insights more naturally. Mark highlighted value-based contracting as “huge, but underutilized” lever.	Alignment/Devoted integrate directly with clinics and provider groups. Clover pushes AI tools (Clover Assistant) to influence PCP behavior. Justin observed 5-star plans often succeed by embedding in communities and provider locations.
Strategic Direction	Retrenchment, pruning for profitability. UHC/Humana cutting counties, CVS rebalancing. Cigna exited entirely (sold to HCSC).	Holding ground in local markets. Some retreat (exits if nonviable), others cautiously expand SNPs.	Growth-focused. Devoted and Alignment expanding; Clover stabilizing. Betting on innovation, not brute force.
Innovation & Outreach	Heavy investment in analytics, but still reliant on broad cohorts. Struggle with personalization at scale. Justin noted: nationals still waste money on “millions of mailers, 70% garbage”.	More personalized, but resource-constrained. Some success embedding staff in provider offices (Sarah’s model).	Innovation-first. Alignment’s AVA platform + Care Anywhere, Devoted’s concierge model, Clover’s AI coding assistant. Justin predicted the future is AI-driven personalized journeys at scale.

02.3 Market Segmentation: Winners and Losers

The Medicare Advantage market’s fundamental shift from growth to profitability has created distinct winners and losers across different plan types. This transformation is reshaping competitive dynamics in ways that favor some players while devastating others.

- **National Plans:** Retrenchment After Overexpansion, see Table 1.
- **Insurtechs:** Winning Stars Despite Unprofitability
- **Regional Health Plans:** Holding Ground but Struggling

Insurtechs

Three advantages of Insurtechs:

1. **Digital-first member engagement:** Members interact through mobile apps they use daily. The plan becomes a health partner rather than a distant insurance administrator.
2. **Direct clinical integration:** Consider these examples. Alignment and Devoted integrate directly with clinics and provider groups. Clover pushes tools to PCPs that surface quality

gaps during patient visits. 5-Star plans often succeed by embedding in communities and provider locations.

3. **AI-driven personalization:** Insurtechs know which members need human outreach and which respond to automated nudges. They don't waste resources on one-size-fits-all campaigns.

Regional Health Plans

Regional Blue Cross Blue Shield plans collectively hold 14% of the MA market.⁴ But they face the worst of both worlds: too small to absorb volatility like nationals and too resource-constrained to innovate like insurtechs. Scale issues make it harder to absorb Star volatility and MLR shocks. A small Star rating drop for regional plans impacts disproportionately compared to plans with millions of members.

Yet regional plans possess an undervalued asset: local market knowledge and provider relationships. However, they lack the data infrastructure and operational capabilities to make them work effectively. Retention and provider relationships, not brute-force scale, are what protect margins.

Most regional plans sit at 3.5 Stars. They perform adequately on clinical measures but struggle with member experience scores due to limited resources, like slower tech investment approvals and reduced staff. This keeps them from launching comprehensive Star rating recovery campaigns.

02.4 Regional Plans: Caught in the Middle

Regional health plans face an existential crisis. They lack the scale to compete with nationals on cost structure. They lack the resources to match insurtech innovation. Caught in the middle, their model is outpaced by market evolution at both extremes.

Regional plans are going to die unless they play to their strengths. They need a clear strategy. They've got to know whether they're trying to shrink, grow, or go after more profitable members.

Yet as MA enrollment expands, scale has become both an asset and a burden. Large national carriers struggle to maintain personalization across millions of members. But regional plans, though smaller, often achieve higher Stars performance by focusing on local provider partnerships and community presence. In this environment, agility and intimacy have become competitive differentiators.

Three paths exist: transform, partner, or exit. Status quo guarantees slow decline as star ratings drift lower and margins compress.

The decision cannot wait. Each quarter of delay means another CAHPS survey season missed, another year of preventive care gaps unclosed, and another cohort of members who disenroll to competitors with better ratings.

Regional plans that choose transformation have advantages that insurtechs lack:

- Deep community relationships
- Provider trust built over decades
- Existing member bases that reduce customer acquisition costs
- Strong local brands that carry weight in their market

These advantages create a clear path to competitive differentiation for regional plans willing to transform, rather than merely improve.

03 The Winners' Formula: Driving Member-Level Behavioral Change

03.1 The Real Competitive Advantage

Patient education represents only part of the solution. Traditional tactics focus on one-way information transfer such as:

- Plans send brochures
- Make phone calls
- Conduct webinars

Members receive information but may not act on it.

The real competitive advantage lies in driving behavioral change in individual members by removing barriers that prevent them from receiving care. Market leaders recognize that a member may know she needs a mammogram but lacks transportation to the imaging center. Another knows he should refill his diabetes medication but can't afford the copay. A third wants to see a specialist but can't navigate the referral process.

Winning plans identify barriers at the individual member level and systematically remove them. They do not send out mass reminders about declining colon cancer rates for those who get their colonoscopy. Instead, they investigate specific solutions, like why Jane Doe missed her dialysis appointment, whether she needs transportation, if she's experiencing side effects, or if her housing situation changed.

This member-level focus requires four levers working together:

1. **Patient education:** Provides knowledge
2. **Access to care:** Removes logistical barriers
3. **Clinical partnerships:** Enables intervention at the point of care
4. **Individual engagement:** Personalizes every interaction based on member behavior patterns

Plans that pull all four levers change behavior. Plans that pull only one or two levers waste money on programs that show minimal impact.

03.2 Lever 1: Patient Education and Health Literacy

Patient education works when it reaches the right member at the right time through the right channel. Generic education programs fail to drive behavioral change.

Effective education requires four elements:

1. **Segmentation by health literacy level:** A universal approach to health education is ineffective due to diverse member needs. For instance, while healthcare professionals easily grasp clinical information on diabetes management, members with limited English proficiency require visual aids and explanations in their native language. Therefore, a one-size-fits-all approach to materials will not succeed across all segments.
2. **Culturally competent delivery:** Effective member engagement requires culturally and linguistically appropriate outreach. For instance, one plan boosted low CAHPS response rates among non-English speakers by deploying community health workers who communicated in preferred languages using culturally sensitive methods, imagery, and examples relevant to each community's health practices and beliefs.

This approach led to increased response rates among targeted populations, and more significantly, uncovered care gaps that previous English-only initiatives had overlooked.

3. **Timely intervention:** Education delivered 6 months before a screening is forgotten by the time the appointment comes around. Education delivered two weeks before, along with appointment scheduling assistance, drives completion.
4. **Actionable next steps:** Effective education should offer clear next steps, not leave members to navigate care on their own. Plans that map out specific steps achieve significantly higher completion rates. For instance, a provider could explain that a care coordinator will call the following day to schedule a procedure and arrange transportation.

The best education integrates with clinical workflows. Members trust their doctors more than their health plans. Education delivered by PCPs during appointments is retained far more than mailers or phone calls from plan staff at a later date.

03.3 Lever 2: Ease of Access to Clinical Care

Knowing you need care differs from being able to access it.

A member may understand that preventive screenings reduce cancer risk. But if appointment wait times run 3 months, she's unlikely to schedule. If the nearest in-network imaging center is 45 minutes away and she lacks transportation, the screening won't happen. If she needs to call the PCP office 5 times to get through, she gives up.

Access barriers kill quality performance regardless of education efforts. The difference is active scheduling assistance versus passive instruction.

These four access improvements can lead to significant quality gains.

1. **Appointment availability monitoring:** Track wait times for primary care, specialists, and diagnostic procedures. Hold providers accountable for access standards in network contracts. Route members to providers with availability rather than letting them wait months.
2. **Same-day and next-day options:** Provide urgent care and virtual visits to prevent gaps when members need care quickly. For example, a diabetic with a foot wound needs to be seen immediately, not scheduled 3 weeks out when the patient might potentially lose the foot.
3. **Centralized scheduling assistance:** Make it easy on members by having them leave the office with their specialist appointment already scheduled, which can be readily achieved with automation or bringing in a software vendor.

Some plans now use quality coordinators embedded within provider offices. These coordinators handle scheduling, data validation, and outreach under the provider's brand, boosting care gap closure rates and freeing clinicians to focus on patient care. Plus in-office coordinators are more effective than running centralized campaigns. This hybrid model blends plan analytics with provider trust, producing immediate gains in both Stars and satisfaction. The embedded approach eliminates the friction of members calling separate plan numbers or navigating different systems. Everything happens seamlessly within the trusted provider relationship.

4. **Removing administrative barriers:** Prior authorization delays, referral requirements, and claims issues frustrate members. Each administrative hurdle increases the likelihood a member abandons care. Another issue is overcommunication. Members often receive 5 or 6 messages within a week all urging them to take unrelated actions. Instead of improving satisfaction, this constant pressure triggers disengagement and survey fatigue. The most successful plans simplify the member journey, guiding people through one meaningful step at a time.

03.4 Lever 3: Clinical Proximity and PCP Partnerships

Health plans must get closer to patients. For traditional plans, that means getting closer to primary care physicians who see patients regularly.

Clinical encounters, not health plan outreach, drive improvements in quality metrics. A PCP who identifies a care gap during a visit can order the screening, schedule the appointment,

and reinforce the importance face-to-face. The PCP carries more weight than a letter arriving from the health plan provider 6 weeks later.

PCPs resist health plan initiatives that add work without adding value. They embrace initiatives that make their jobs easier while improving outcomes.

Several strategies work:

Pre-visit chart preparation

Staff review upcoming appointments 2 to 3 days in advance, identify care gaps, confirm specialist notes have arrived, and line up orders. The PCP enters the exam room with a complete picture and can address all the gaps during the visit.

Point-of-care technology

Real-time alerts during the visit prompt the physician to address gaps before the patient leaves. A point-of-care tool, like a skin over the EMR, lets them see HCC and quality gaps while seeing the patient.

Every patient visit represents a narrow window of influence. High-performing plans ensure each visit addresses multiple objectives, like risk coding, identifying care gaps, and member education, rather than treating each area as separate workflows. This integrated model provides more value for the patient without taking up more time and resources.

Unified gap reporting across plans

Almost all PCPs contract with multiple health plans, each sending separate gap lists with different formats and requirements. A family medicine practice might receive 5 different spreadsheets showing mammography gaps, one from each plan they contract with. The administrative burden of reconciling these lists often means that no one care gap gets prioritized.

Collaborative gap reports draw the provider's attention. Instead of 5 separate lists, the practice receives one comprehensive report showing all mammography gaps across all patients, regardless of payer.

Performance-based incentives

Longitudinal relationships matter most. Members who stay with the same PCP for years complete more preventive care, manage chronic conditions better, and report higher satisfaction, marking the strongest predictor of consistent high Star performance.

Regional plans benefit from continuity of care, a key differentiator. High member retention leads to better predictive accuracy, operational stability, superior preventive care, and higher CAHPS scores because provider-member trust is already established.

Plans should focus on retention and continuity rather than constant member and provider network churn. This reinforces why real improvement happens inside provider offices, not through plan outreach. The therapeutic relationship itself becomes the foundation for quality performance, which produces a better Star rating.

03.5 Lever 4: Individual Member-Level Engagement

Population health management fails because populations do not behave uniformly. Averages mask individual variations and hide the specific barriers each member faces. This creates a fundamental challenge for health plans trying to improve outcomes and explains why generic population methodologies consistently underperform. Winning plans abandon broad-brush tactics and know their members individually. They track behaviors, identify patterns, and personalize interventions based on what works for each person.

The shift from population-level focus to member-level focus changes everything:

Population Approach	"Colon cancer screening rates are 62%. Let's send 50,000 members a mailer about screening importance."
Member-level Approach	"Jane Doe is 67, has never completed a colonoscopy, and has a family history of colon cancer. She has declined screening twice when her PCP recommended it. Let's have a care coordinator call her to understand her barriers. She's typically afraid of procedures. So we'll arrange for a nurse to explain what to expect and offer to have her daughter accompany her."

Effective member engagement relies on orchestration, not volume. High-performing plans coordinate messages across channels and departments, ensuring each interaction builds logically on the last, rather than bombarding members with disconnected outreach. Members feel understood rather than managed, which improves responsiveness and drives higher CAHPS scores.

This coordination requires real-time detection. Traditional plans review data monthly or quarterly. By the time they identify a member who missed an appointment, weeks have passed and the moment for intervention has closed.

Insurtechs monitor daily. When Jane Doe misses her dialysis appointment Tuesday morning, the care team knows by Tuesday afternoon. They call immediately to understand what happened and help reschedule, which prevents small issues from becoming major gaps.

Beyond reactive monitoring, predictive identification catches problems before they occur. Rather than waiting for Jane to miss an appointment, models predict she's at high risk of non-completion based on transportation barriers, work schedule conflicts, and past no-show patterns. The care team reaches out proactively to arrange transportation and flexible scheduling.

These capabilities require modern technology infrastructure. Care coordinators cannot manually track hundreds of members. They need systems that bring to light the right member at the right time with the right context to enable effective outreach.

03.6 How Insurtechs Achieve Member Proximity

Insurtechs built digital infrastructure that creates daily touchpoints with members. The health plan is not a distant entity that members interact with twice a year. It's a daily health partner accessed through mobile apps that members check regularly.

Devoted offers concierge-style service through dedicated care teams.⁵ Members call their team directly rather than navigating phone trees. The team knows their medical history, social situation, and preferences. Continuity builds trust that enables more effective interventions.

Clover developed the Clover Assistant, an AI tool designed to integrate with physicians' EHRs. This tool identifies quality gaps and documentation opportunities during patient visits.⁶ The tool doesn't add work but reduces it. Physicians don't have to toggle between systems or manually search for missing data. The Clover Assistant runs in the background, presenting real-time prompts and prepopulated fields based on the patient's record and type of visit. This turns quality documentation from an administrative burden into a natural part of the clinical workflow. It helps physicians gather the necessary information for quality metrics and risk adjustment during patient interactions.

Alignment built the AVA platform for automated member engagement combined with Care Anywhere for flexible access.⁷ Members use the app to schedule virtual visits, refill prescriptions, access care navigation support, and receive personalized health recommendations. The app becomes the primary care interface.

This is the competitive moat of the future: AI-driven personalized journeys at scale. Insurtechs exemplify this well. They use tech to deliver individualized experiences that feel high-touch while operating at population scale.

Member app ecosystems create continuous engagement. Members who open the app daily to check benefits, schedule appointments, or refill medications maintain an ongoing connection with the plan. When the plan needs to close a care gap or improve adherence, members already trust the communication channel.

03.7 Traditional Plan Challenge

Traditional health plans built operational models for a different era. Infrastructure built for claims and service calls cannot offer personalized engagement.

Four structural barriers block transformation:

1. **Legacy systems designed for batch processing:** Claims systems run overnight cycles. Data integration happens monthly. By the time operational staff see updated information, it's weeks old. Real-time intervention requires real-time data pipelines that traditional plans lack.
2. **Population health management mindset:** Organizational culture focuses on cohorts and segments rather than individuals. Analytics teams produce reports on population trends. Care management programs target high-risk groups. The infrastructure to identify and intervene with individual members in real-time doesn't exist.
3. **Call center operations, not relationship management:** Members dial 1-800 numbers and reach whichever representative happens to answer. Each call starts from scratch. Continuity doesn't exist. Compare this to Devoted's model where members call their dedicated care team who knows them.
4. **Provider fragmentation and outcomes:** PCPs contract with 5–15 health plans, creating a significant barrier to adopting plan-specific technology. Because these tools only apply to a fraction of their patients, they face workflow resistance and low adoption. A quality improvement tool that only helps 10% of patients won't get used.

Traditional plans cannot drive adoption the way insurtechs can as they design their networks, partnerships, and tech around shared infrastructure from the start. Their care teams and affiliated providers operate within a single coordinated system, which makes it easier to embed tools into daily workflows. Traditional plans, by contrast, depend on independently managed provider networks where no single system or workflow standard exists.

These barriers are real but not insurmountable. Regional plans can transform. It requires executive commitment, significant technology investment, organizational restructuring, and 24 to 36 months of sustained effort.

03.8 The Survey Season Problem and Behavioral Solution

Effective CAHPS improvement requires year-round focus on the member experience. Yet survey timing enables specific interventions. Plans can identify members likely to receive surveys (random sampling but stratified by demographic characteristics) and ensure those members experience exceptional service in the months leading up to when the survey goes out.

More importantly, plans can boost survey response rates through targeted outreach. Members who feel valued and engaged are more likely to complete surveys. Pre-survey communication that explains why the survey matters and encourages participation increases response rates up to 29%.⁸

Plans must equip their provider partners with specific techniques that enhance member experience during office visits. Plans should encourage providers to personalize interactions by documenting member details in their EMR's FYI section. When staff ask about grandchildren or personal interests, members overlook longer wait times and rate their experience higher.

Plans should also promote transparent communication during appointments. When providers narrate their actions by explaining, "Now I'm checking your blood pressure to see if your medication is working well," it reduces patient anxiety and builds confidence in the thoroughness of the care received.

The operational model that drives individual behavioral change is the same operational model that improves Star ratings. Plans do not need separate strategies for quality metrics and member satisfaction. Both require individualized knowledge of members, understanding their barriers, and tailoring interventions to boost engagement.

04 Barriers Facing Regional Plans

04.1 Legacy Systems and Operational Models

Regional health plans run on technology infrastructure built for a different time. Core systems date to the 1990s and early 2000s. Overall, these plans process claims efficiently but cannot support real-time member engagement.

Data lives in silos. Claims data in one system and clinical data from HIEs in another. Member service interactions in a third. Call center notes in a fourth. EHR data, when available, is located in a fifth. No unified view exists so care coordinators toggle between multiple screens to understand a member's situation.

Integration projects take 12 to 18 months and cost millions. Each system speaks a different data format. APIs either don't exist or don't work reliably. Data extracts run on batch schedules rather than in real-time. The best-case scenario is overnight processing, where you see yesterday's data each morning. Older systems update only weekly or monthly, leaving care managers working with severely outdated information. Real-time data feeds that enable real-time intervention remain aspirational.

Most regional plans structure their operations around claims processing, network management, customer service, and compliance, which create functional silos that fragment member experience. These plans lack dedicated teams responsible for end-to-end member journeys. Care gap closure happens in isolation across clinical, operational, and engagement departments without coordination or shared accountability.

Many underperforming regional plans struggle from fundamental misalignment. Internal silos between quality, operations, and member services cause each function to act independently, even though every decision shapes the member's experience and ultimately affects Star results.

This fragmented operational model worked when health plans were claims payers focused on processing payments and managing networks. It fails under value-based care arrangements where plans must actively drive quality outcomes. Medicare Advantage plans face particular pressure to close care gaps and capture accurate risk coding to optimize both Star ratings and revenue. These requirements demand coordinated action across clinical, operational, and engagement teams rather than siloed departmental responses.

Technology debt compounds over time. Each year of delayed modernization makes transformation harder and more expensive. Data accumulates in legacy formats. Business logic gets

embedded in outdated code no one fully understands. Staff builds manual workarounds that become dependencies. Eventually, the cost and risk of replacement seems prohibitive.

But the cost of not replacing grows faster. Every quarter, insurtechs pull further ahead with modern infrastructure that enables capabilities that traditional plans cannot match. The tech gap becomes an operational gap that becomes a quality gap that becomes a competitive gap which threatens the survival of regional plans.

04.2 Resource Constraints

Regional plans face resource disadvantages on two fronts: against nationals who have scale, and against insurtechs who have VC funding.

Regional scale disadvantages versus nationals, manifest in three ways:

1. **Risk absorption capacity:** A bad flu season or unexpected utilization spike can severely impact a smaller plan's margins, while a large national plan absorbs the same dollar loss with minimal margin impact. Star rating volatility hits small plans harder since one CAHPS measure dropping from 4-Star to 3-Star performance can drop the overall rating. Nationals with dozens of contracts can offset weak performers with their strong performers.
2. **Negotiating power:** National plans have greater leverage than regional plans when negotiating contracts for PBMs, data vendors, and tech partnerships. Vendors typically offer substantial discounts to plans with millions of members that smaller plans cannot match. Thus, competing on price is extremely difficult due to these cost structure differences.
3. **Investment capacity:** Nationals can invest hundreds of millions in tech modernization and analytics capabilities, while regional plans work with budgets that are often an order of magnitude smaller. This absolute dollar gap means nationals can deploy capabilities that regional plans simply cannot afford to build.

Regional innovation disadvantages versus insurtechs manifest in three ways:

1. **Capital access:** Insurtechs can raise \$100 million to \$500 million in VC funding to finance innovation before achieving profitability. They can spend 3 to 5 years building member engagement platforms and achieving product-market fit without needing positive unit economics. In contrast, regional plans cannot operate at losses for 3 years while building their capabilities.
2. **Talent acquisition:** Software engineers and data scientists choose startups over traditional health plans. Compensation packages include equity that could be worth millions if the company succeeds and sells.
3. **Decision-making velocity:** Insurtechs deploy new features weekly. Regional plans take months to approve projects, navigate compliance reviews, and coordinate IT resources.

By the time a regional plan implements a new product offering, insurtechs have iterated the same capability three times.

These resource constraints are real but not deterministic. Regional plans must acknowledge they cannot outspend nationals or out-innovate insurtechs. They must win through operational focus, provider relationships, and local market knowledge.

04.3 Cultural Resistance to Digital Transformation

Regional plan leadership teams built their careers in traditional insurance operations. These executives mastered claims processing, actuarial modeling, network contracting, and regulatory compliance during the decades when health plans functioned as claims payers rather than care partners.

Digital transformation, member engagement platforms, and predictive analytics represent unfamiliar territory for these leaders. Most regional plan CEOs and COOs lack experience with technology-driven business models. This knowledge gap creates reflexive skepticism about digital initiatives and their return on investment. Regional plans chronically underinvest in digital transformation strategies because most leadership teams don't have the experience to confidently evaluate tech-driven business models.

The challenge is to balance immediate operational demands against long-term strategic investments. This resource allocation dilemma explains why many plans struggle with sustained quality improvement despite recognizing its importance. The three-year lag between Stars investments and bonus revenue creates a fundamental tension with quarterly financial pressures and annual budget cycles.

This timing mismatch reveals why Stars performance requires a different investment framework than traditional health plan operations. Stars measure whether operational models successfully drive member behavioral change, making them indicators of current organizational effectiveness rather than future potential.

Beyond leadership skepticism, digital transformation efforts face resistance throughout the organization. Staff fear automation will cause job displacement. This triggers predictable pushback when AI-driven care management threatens care coordinators. Self-service portals could reduce call center headcount. The truth is that digital transformation often eliminates certain roles. Plans should address these concerns with honesty and transparency to make the transformation smoother.

Meanwhile, most plans have "change-fatigue". These plans have spent the last 15 years adapting to multiple regulatory changes: ACA implementation, evolving risk adjustment models, shifting Star rating methodologies, prior authorization requirements, interoperability man-

dates, and endless CMS policy updates which have consumed resources. This makes teams reflexively resistant to proposals for major transformation. The familiar refrain becomes predictable: “We’re too busy dealing with regulatory compliance.”

This resistance extends beyond health plans to their provider networks. Physician offices resist new tech and processes for similar reasons. They have endured waves of EHR implementations, value-based payment models, and quality reporting programs. Each initiative added more work for them without the obvious value.

Overcoming cultural resistance requires executive sponsorship that transcends verbal support. In a recent Deloitte Center for Health Solutions survey, 61% of executives identified C-suite collaboration with IT leaders as the number one success driver for technology transformation.⁹ The CEO must visibly champion transformation by attending project meetings. Leaders must remove obstacles when teams get stuck. They must hold other leaders accountable for progress. Transformation initiatives fail when executives delegate them to middle management without maintaining personal investment.⁹

04.4 Knowledge Gaps About What Actually Improves Ratings

Most health plans misallocate resources because they don’t understand the root causes of low Star ratings.

Frequently, plans underperform because of misreading data. Teams often treat every quality measure as equally important, overlooking CMS weighting and performance thresholds. As a result, effort is misallocated toward low-impact metrics while the high-value measures that move Stars remain neglected.

Regional plans overinvest in clinical interventions that produce minimal Star rating improvement. Disease management programs show clinical benefit but with limited Star rating impact. Plans need to address and prioritize the experience measures that carry the most weight.

These same plans underinvest in member experience improvements that would generate positive returns. Call center quality improvements cost a fraction of clinical programs but directly impact three high-weight CAHPS measures.¹⁰

Plans also overlook valid exclusions that could legitimately improve their ratings. Exclusions are both appropriate and necessary. Members in hospice care, for example, are not expected to complete preventive screenings. Excluding them removes impossible-to-close gaps and allows plans to focus resources on members who can actually benefit from interventions. Yet many plans fail to systematically document these valid exclusions, artificially suppressing their measure performance and wasting resources on outreach that can never succeed.

Regional plans have provider relationships for value-based care but lack the infrastructure to execute effectively. Many plans have incentive savings, but it's hard to calculate without proper data, which can lead to over or underpayment. Without adequate data systems, they cannot measure performance accurately or share results transparently with providers, and without operational capabilities, they cannot support providers with real-time gap lists and actionable insights. The relationships exist, but the tools to leverage them do not.

The knowledge gap extends to understanding how different measures interact and reinforce each other. Improving medication adherence, for example, helps Part D ratings while simultaneously driving better chronic disease control in Part C. Improved care transitions lower readmissions and boost member experience scores.

Effective post-discharge follow-up is crucial for improving multiple healthcare measures simultaneously. Plans that understand this connection can focus on high-impact interventions that yield broad improvements. Conversely, plans that fail to recognize these interdependencies often scatter their efforts across numerous single-measure initiatives, leading to fragmented and ultimately less effective results.

Focus matters as much as resources. Regional plans with limited budgets must concentrate resources on initiatives that drive the largest Star rating improvements. Spreading resources across every possible intervention guarantees mediocre results.

05 Strategic Options Analysis

Regional health plans can choose from four strategic choices.

Option A-Stay the course (High Risk): Maintain current operations for cash flow without improvements until bankruptcy.

Option B-Exit Medicare Advantage Market: Exiting makes strategic sense for plans who can't get their MLR low enough or do it profitably.

Option C-Transform to Compete (Recommended Path):

<p>What It Means</p>	<p>Fundamental operational transformation to match insurtech capabilities. Modernize tech infrastructure. Rebuild operational model around individual member engagement. Implement predictive analytics to target resources effectively.</p>
<p>Investment Required</p>	<p>\$15M to \$60M over 3 years, varying by plan size and starting point.</p> <p>Detailed investment breakdown:</p> <ul style="list-style-type: none"> • Year 1: \$5M to \$20M (quick wins, pilot programs, initial technology) • Year 2: \$8M to \$30M (scale programs, full technology deployment) • Year 3: \$2M to \$10M (optimization, continuous improvement)
<p>Timeline</p>	<p>18 to 36 months to full implementation. Quick wins deliver results in 6 to 12 months. Full transformation takes 24 to 36 months.</p>
<p>Expected Outcomes</p>	<p>0.5 to 1.0 Star rating improvement over 3 years. Margin recovery as plan crosses 4-Star threshold and captures bonus payments. Improved member retention and competitive positioning.</p>

Critical success factors

Executive commitment: The C-Suite must visibly champion the transformation, not delegate it to middle management. The board must understand this is a multi-year investment and provide patient capital rather than demanding immediate returns.

Phased implementation with quick wins: Plans should generate momentum by starting with operational improvements that show results within 6 to 12 months. These early successes maintain organizational commitment during the more challenging phases of the transformation.

Technology modernization: Legacy systems must be replaced or substantially modified. While expensive and risky, this step is unavoidable. Delaying modernization creates compounding technical debt. Systems become harder to maintain, integrate, and eventually replace. Each year of delay widens the competitive gap, while escalating total modernization costs exponentially more, which makes immediate action the most cost-effective strategy.

Success outlook

Successful health plan transformations suggest that organizations with strong executive commitment and adequate investment typically achieve their objectives. Failure consistently traces back to inconsistent leadership support, underfunding transformation initiatives, or organizational resistance that derails implementation. The most successful transformations maintain momentum through early wins while building toward comprehensive change.

This path requires courage

Leadership must commit to a multi-year transformation before seeing definitive results. The board must provide patient capital through the investment period. The organization must embrace uncomfortable change and the new ways of working. But this is the only path that preserves independence while creating a sustainable competitive position against better-funded national plans and agile insurtechs.

Option D: Partnership and M&A Strategies:

What It Means	Leverage external capabilities and capital to accelerate transformation or achieve scale.
Investment Required	Highly variable depending on partnership structure. Tech partnerships may require \$3M to \$10M in initial implementation plus ongoing fees. M&A requires substantial capital for acquisition or acceptance of dilution for sellers.
Timeline	Partnerships can be implemented faster than building—6 to 18 months versus 24 to 36 months. M&A timelines vary based on complexity and regulatory approval requirements.

Partnership models

Tech vendor partnerships: Contract with specialized vendors for member engagement platforms, predictive analytics, and care management tools. This approach offers faster implementation than building internally (6 to 18 months versus 24 to 36 months) and requires lower upfront investment since ongoing vendor fees replace large capital expenditures. The tradeoff is potential vendor lock-in and limited ability to customize solutions for specific plan needs.

Clinical enablement partnerships: Plans partner with provider enablement companies that embed staff directly in primary care practices to drive quality improvement. This is a proven model where shared-risk arrangements align financial incentives between the plan and the enablement partner, ensuring both parties benefit from improved outcomes.

Data analytics partnerships: Outsource predictive modeling and decision support to external analytics firms instead of developing in-house capabilities. This offers faster value and access to specialized expertise, which is hard for regional plans to secure, but it creates reliance on outside partners for key strategic functions.

M&A considerations

Acquire insurtech capabilities or talent: Plans can purchase small insurtechs or technology companies to gain both proven platforms and experienced talent. This requires significant capital and carries integration risk, as health plan operations and startup cultures often clash during the merger process.

Merge with other regional plans for scale: Multiple regional or MA plans can combine to achieve economies of scale, spreading technology investments across a larger membership base. This strategy requires regulatory approval and involves complex integration of different systems, processes, and cultures.

Be acquired by a national plan or private equity: Regional plans can sell to larger players with deeper resources to fund transformation. This provides liquidity to current owners but requires accepting loss of independence. Staff and members must adapt to a new organization with different priorities, decision-making processes, and culture.

When this makes sense

For plans lacking capital for full transformation, partnership and M&A are the best options, due to their access to external capabilities. Acquisition is appealing for non-strategic markets if premium valuation is offered. Mergers make sense when the scale benefits and synergies justify the organizational complexity.

However, partnership is not a substitute for strategic clarity. Plans must still decide what outcomes they're trying to achieve and how partnerships accelerate progress toward those goals. Partnerships that do not deal with their strategic confusion waste money and delay the inevitable reckoning.

06 Strategic Implementation Framework

06.1 Quick Wins: Operational Improvements (0–6 Months)

Plans can quickly improve operations and demonstrate transformation value without major tech investments. These initiatives, relying on process optimization and staff development, show results within 6 months.

Regional plans improve rapidly via consolidation, not program expansion. Unifying Star Ratings leadership under one executive for analytics, provider coordination, and member outreach, streamlines operations and aligns fragmented departments.

Call Center and Customer Service Excellence	
Target impact	0.1 to 0.2 Star improvement on customer service measures (C21, D07) within 6 to 12 months. Customer service carries high weight in Star calculations, so this improvement flows through to overall ratings.
Investment	\$200K to \$500K for training programs, speech analytics tools, and process redesign.

CAHPS directly tracks customer service quality. Plans with excellent call center operations score higher on customer service measures than plans with poor operations.¹¹

High-performing plans should implement CAHPS-aligned training for all customer-facing staff. Representatives receive training on the specific behaviors that CAHPS measures: answering calls quickly, providing accurate information, showing empathy, resolving issues on first contact, and following up when promised.

Top plans use protocols to prioritize first-call resolution, aiming for over 80% to boost member satisfaction and cut call volume.

Call scripts that help representatives sound caring and personal, rather than scripted, drive better outcomes. Representatives, who reference previous interactions and recall the specifics of a member, create the perception of personalized service.

Real-time coaching, driven by speech analytics, immediately improves call outcomes. By identifying frustrated callers, supervisors can intervene quickly, helping representatives resolve issues before calls escalate.

Member Service Standards	
Target impact	Reduces complaint rates (measure C16/D09) by 15% to 25% within 6 months. Each avoided complaint improves the complaints measure.
Investment	Minimal. Requires process changes and accountability but no tech investment.

CMS accessibility compliance is key to excellent member service. Plans must offer TTY services for hearing-impaired members and language services for non-English speakers during all hours. Tracking compliance rates and addressing gaps immediately prevents service failures.

Service standards include responding to member inquiries within 24 hours, returning calls the same business day, and resolving complaints within 48 hours or providing status updates for complex issues. Measuring compliance and holding teams accountable ensures consistency.

When internal grievance logs show member dissatisfaction, reaching out personally to understand issues and resolve them prevents complaints from becoming formal CTM complaints that impact Star ratings.

Provider Network Optimization	
Target impact	0.2 to 0.3 Star improvement on access measures (C19, C20) within 12 months. Access measures are high-weight CAHPS measures.
Investment	\$500K to \$2M for scheduling assistance staff and network monitoring tools.

Systematic monitoring of appointment availability requires surveying members about wait times, calling provider offices to check availability, and tracking which providers maintain 2-week appointment availability versus those with 2-month backlogs.

Network contracts must hold providers accountable through appointment availability standards such as primary care within 2 weeks, specialists within 4 weeks, and urgent care same-day. Monitoring compliance and removing or lowering the tier of non-compliant providers maintains network quality.

Appointment scheduling assistance eliminates barriers by deploying staff to help members schedule appointments rather than providing phone numbers and instructing members to call independently.

Pre-scheduling specialist appointments while members are still at PCP offices ensures continuity of care. Referral coordinators schedule appointments and confirm with members before they leave the office.

Exclusion Hygiene and Documentation	
Target impact	0.2 to 0.3 Star improvement on affected measures within 3 to 6 months. Exclusions provide immediate improvement without changing clinical care. They simply remove inappropriate denominator cases from measures.
Investment	\$200K to \$500K for chart review resources and provider training.

Systematic review of member records identifies valid exclusions, including advanced illness, frailty conditions, or other valid reasons to exclude members from quality measures. Documenting statin intolerance for members unable to take cholesterol medications eliminates impossible-to-close gaps from multiple measures. As mentioned earlier: Hospice enrollment at any point during the year enables exclusion from every HEDIS measure.

Provider training on documentation for exclusions can close a common gap. Many exclusions are legitimate but undocumented in ways CMS recognizes. Clinical notes may mention hospice but lack specific terminology and codes that trigger exclusion logic.

Calendar-Based Quality Initiatives	
Target impact	Optimizing timing improves resource efficiency. The same resources deployed at the right time yield 30% to 50% better results than random timing throughout the year.
Investment	Minimal. Requires coordination and planning but no additional budget.

Aligning initiatives with the calendar optimizes impact: focus early year on patient follow-through, and late year on documentation and exclusions to affect rates within 30–45 days.

Q1-Q2

Timely completion of member actions, such as preventive screenings, chronic disease management visits, and medication adherence, is crucial. These interventions require members to schedule and attend appointments, and complete their care. Initiating these actions early allows sufficient time for completion before measurement deadlines.

Pre-CAHPS season

By proactively engaging with members, plans can significantly enhance their experience leading up to survey season. Addressing grievances promptly, providing personalized attention to members who have recently had negative experiences, and utilizing community health workers for non-English speaking populations are all effective strategies for improving survey outcomes.

CAHPS survey season

To maximize participation in survey response optimization programs, it is crucial to educate members on the significance of their feedback. Offering varied response methods and proactive follow-up for non-responders significantly increases both response rates and overall scores.

Q3-Q4

Quick wins deliver immediate impact and complement year-round focus rather than substituting for it. Updated exclusions and post-visit documentation promptly adjusts denominators or numerators. These adjustments can shift measures within 30 to 45 days, avoiding the need for extended member engagement.

06.2 Medium-Term: Member Education Programs (6–12 Months)

Member education programs require more investment than quick wins but deliver sustainable impact. These programs change member behavior in ways that improve both quality metrics and experience scores.

Stratified Education Strategies	
Investment	\$2M to \$5M annually for dedicated staff (community health workers, health coaches, care coordinators) and program development.

One-size-fits-all education fails. Different member segments need different approaches:

High-risk clinical + low engagement

Intensive care management and education are required for these members. Dedicated care coordinators who build long-term relationships boost engagement. Home visits target members unresponsive to calls. Addressing social determinants (e.g., transportation, food insecurity) proactively removes barriers to engagement.

Low health literacy

To improve comprehension, use plain-language materials that avoid medical jargon. Visual aids and videos work better than text-heavy documents. Health coaches, who explain concepts and ensure comprehension before moving forward, increase understanding.

Non-English speakers

Deploy community health workers who are culturally competent and share the language to increase response rates within these targeted populations. This approach also revealed care gaps that previous English-only campaigns had completely missed.

New enrollees

Effective onboarding education is crucial for new members to understand their benefits, provider networks, and how to access care. A member's initial 90 days significantly influence their overall perception of the plan.

Coordinated provider engagement

Effective preventive care, medication adherence, and chronic disease management programs succeed when providers consistently reinforce these messages. Incentive models should reward comprehensive quality behaviors, not isolated metrics. Plans integrating Stars, risk adjustment, and cost-control via shared savings or clear dashboards boost PCP engagement and performance improvement.

When providers grasp the direct link between quality metrics and financial outcomes, they transition from passive recipients to active partners in member education. For instance, a PCP that is aware that better diabetes care closure rates boost their shared savings will proactively discuss A1C testing during visits. This reinforces the same message the health plan communicates through member mailings. Such alignment transforms education from a plan-driven campaign into a coordinated effort between the plan and provider, offering members seamless, consistent guidance from their trusted care team.

Multi-Channel Communication Infrastructure	
Investment	\$3M to \$8M for tech platform, staff, and content development.

Plans should reach members through multiple channels based on their preferences and needs:

Digital-first for tech-savvy members

Tech-savvy members expect seamless digital experiences by enabling benefit lookups, care gap notifications, and appointment scheduling in a single platform. Text messaging works effectively for time-sensitive communications like appointment reminders and medication refill alerts, while personalized emails deliver ongoing health tips and preventive care reminders based on individual health profiles.

Human-touch for elderly and low-tech populations

Many Medicare Advantage members still favor traditional communication and require individualized support to navigate healthcare. For those not using digital platforms, phone outreach is the main channel, complemented by printed mailings for crucial benefit and care details. Home visits are often necessary for complex situations, which helps to overcome obstacles such as mobility issues or cognitive impairments that prevent office-based interactions.

Community-based outreach for vulnerable populations

Building trust with underserved populations, who often harbor skepticism towards healthcare institutions, can be achieved by fostering strong community ties through partnerships with local health centers, senior centers, and faith-based organizations. These trusted community venues serve as ideal locations for health education and outreach. This reduces barriers to participation. Furthermore, community health workers who have existing relationships within these neighborhoods can effectively bridge cultural and linguistic divides that traditional outreach efforts may overlook.

Provider-integrated for clinical touchpoints

The most effective member education occurs during clinical encounters when members are already focused on their health. Training PCP office staff to deliver consistent education messages during appointments and check-in processes leverages the trust relationship members have with their healthcare providers. This approach has education feeling like part of coordinated care rather than separate health plan marketing.

Pre-CAHPS Survey Engagement	
Target impact	Improving survey response rates by 5–10% enhances measure stability, ratings, and satisfaction scores by increasing participation from engaged, satisfied members.
Investment	\$3M to \$8M for tech platform, staff, and content development.

CAHPS surveys administered late Q1 measure the prior year’s experience. Plans cannot change what has already happened. But they can influence who responds and how they think about their experiences.

Effective CAHPS engagement begins with member education campaigns launched in January: “Look for your survey in the mail and please complete it! Your feedback helps us improve your health plan.” Success requires explaining why the survey matters and demonstrating how responses directly drive plan improvements.

Broad campaigns alone produce limited results. But predictive models identify members who are likely and unlikely to respond, enabling targeted outreach through their preferred channels. Phone calls from familiar care coordinators, strategic text reminders, and completion incentives significantly improve response rates among these critical populations.

Community health workers are crucial for engaging non-English speakers, as they offer language-concordant outreach. This approach effectively addresses both linguistic and cultural barriers that can hinder survey participation, ultimately leading to improved survey response rates among historically underrepresented groups.

Care Gap Closure Programs	
Target impact	0.3 to 0.5 Star improvement across multiple clinical quality measures (C01-C04, C09-C11) within 12 to 18 months.
Investment	\$3M to \$10M for care coordination staff, point-of-care technology, and provider engagement programs.

Systematic care gap closure requires seamless coordination between health plans and providers across three critical touchpoints: before, during, and after clinical encounters.

To transform routine appointments into comprehensive care opportunities, staff begin pre-visit preparation 2 to 3 days in advance. This involves reviewing upcoming visits, identifying care gaps from claims and clinical data, confirming the availability of specialist notes and lab results, and preparing any necessary physician orders.

Point-of-care interventions offer PCPs real-time access to gap lists during patient visits. This allows for immediate action while members are actively engaged in their care. The integration of AI solutions presents new opportunities to enhance these alerts through predictive insights and automated workflows.

Immediate post-visit follow-up is crucial for addressing incomplete actions. For instance, if a patient departs without scheduling a mammogram, staff will contact them the following day to facilitate the scheduling of the appointment. Similarly, if prescriptions are not filled, staff will reach out to pharmacies and then to members to understand any barriers, ensuring all opportunities for care are maximized.

When members understand why preventive care is crucial for their health, these interactions become more than just transactional reminders. Instead of merely sending appointment notifications, explaining the importance of screenings, such as how a colonoscopy can prevent colon cancer, significantly increases completion rates. Members are more likely to act when they grasp the direct benefit to their specific health needs, rather than just receiving scheduling instructions.

Effective programs prioritize building lasting relationships over one-off interventions. Integrating risk adjustment documentation and quality gap closure into unified workflows enhances provider engagement and reduces administrative load across various initiatives.

06.3 Long-Term: Technology Platform and Data Capabilities (12–24 Months)

Modernizing technology unlocks capabilities unattainable with older systems. This requires the largest investment and longest timeline but provides the foundation for sustainable competitive advantage.

Data Infrastructure Modernization	
Timeline	12 to 18 months for initial implementation. Ongoing investment required for maintenance and expansion.
Investment	\$5M to \$15M for data warehouse, integration platform, and data engineering resources.

Modern data infrastructure begins with an enterprise data warehouse that integrates all canonical data sources: HEDIS, CAHPS, claims, pharmacy, enrollment, complaints, appeals, and member service interactions. This unified foundation eliminates data silos that fragment decision-making across departments.

Moving from overnight batch processing to real-time data streaming fundamentally transforms operations, enabling immediate intervention with current information instead of reacting to weeks-old data, thereby improving member and provider engagement.

Integrating with HIEs, provider EHRs, and external APIs yields more comprehensive, timely data than claims alone. EHR clinical data allows faster, more complete gap identification, bypassing claims delays. Hospital ADT feeds allow immediate post-discharge outreach for maximum intervention effectiveness.

Automated data quality monitoring and validation are vital for system reliability, tracking completeness, accuracy, and timeliness. Immediate alerts for poor data quality or failed sources prevent bad decisions and ensure the integrity needed for real-time intervention.

Member Engagement Platform	
Timeline	12 to 18 months for full deployment.
Investment	\$5M to \$15M for technology platform, implementation services, and ongoing licenses.

Effective member engagement requires a unified view of each member’s complete relationship with the plan.

A comprehensive CRM system consolidates critical information such as:

- Claims history
- Clinical conditions
- Recent member service interactions
- Open complaints
- Scheduled appointments

Successful personalized communication platforms boost engagement by tailoring outreach to individual member preferences (text, calls, mobile apps, or home visits) instead of using a uniform approach, which can produce engagement fatigue.

Integrating with CAHPS survey vendors allows plans to import results, proactively identify dissatisfied members, and track response rates by demographic. This turns survey data from a compliance task into actionable intelligence for operational improvement.

Real-time member sentiment tracking during call center interactions can identify and flag dissatisfied members, enabling immediate intervention to prevent formal complaints or disenrollment.

Analytics and Prediction Capabilities	
Timeline	6 to 12 months for initial models. Ongoing investment in model refinement and new use cases
Investment	\$3M to \$10M for analytics platform, data science resources, and model development.

Predictive models are shifting healthcare from reactive to proactive. Risk and care gap models forecast member needs within 90 days, enabling timely intervention. CAHPS non-responder models use demographics and behavior to target outreach, improving survey response rates and representativeness. Care gap closure scoring focuses intensive resources on members most likely to respond, while using light-touch nudges for the self-motivated. Member satisfaction and disenrollment models identify at-risk members for retention efforts, protecting revenue and reducing acquisition costs.

For analytics to be useful, they must drive clinical action. Models must integrate into staff workflows. Given that physicians cannot tackle 50 care gaps in a 15-minute visit, models identify the top 3 most crucial gaps to target for achievable interventions.

Provider Enablement Technology	
Timeline	6 to 12 months for initial deployment.
Investment	\$2M to \$5M for technology and implementation.

Provider enablement tech must integrate seamlessly into clinical workflows to avoid added burden. EMR overlays display care gaps and HCC opportunities within the physician's existing EHR view during visits, eliminating interruptive separate logins or screens.

Tools addressing only 10% of a PCP's patients are rarely adopted long-term. Comprehensive gap lists and aggregated worklists covering a provider's entire contracted membership across multiple payers offer value to a practice's complete operations, unlike single-plan limited tools.

Automated systems enhance care coordination by tracking specialist referrals, confirming appointments, and immediately alerting care coordinators when members fail to follow through, enabling timely intervention.

Performance dashboards provide vital feedback, showing providers' quality metrics, impact on Star Ratings, and attainment of value-based payments. They connect clinical actions to financial results.

For successful technology adoption, immediate and visible value is crucial. Technology, by itself, can create barriers to adoption. However, when technology is combined with embedded staff support, engagement increases because providers experience immediate benefits rather than added work. Physicians require tangible proof that new tools simplify their workflows instead of making them more complex.

The most effective approach combines digital capabilities with human support, proving that technology plus relationship building delivers better results than either approach alone.

06.4 Role of Predictive Analytics in Targeting Resources

Predictive analytics allows for efficient resource allocation. Regional plans must use models to identify members who most urgently need intensive care management, as they cannot afford to deploy it for everyone.

Core Use Cases for Predictive Models

CAHPS non-responder risk: Models predict which members won't complete surveys based on demographics (age, language, education), engagement history (past survey participation, portal usage), and barriers (tech access, health literacy). This data enables targeted outreach to high-risk non-responders to boost response rates where they matter most.

Member satisfaction prediction: Real-time member interactions predict CAHPS scores before survey season through call center sentiment analysis, complaint patterns, and service interactions. Identifying dissatisfied members enables intervention before the CAHPS survey, when satisfaction can still be influenced.

Care gap closure propensity: Prediction models identify members likely to complete recommended care with outreach. Some members close gaps independently, while others require extensive support. Maximizing return on investment involves focusing resources on members with a moderate propensity. These members need support but will respond to intervention.

Medication adherence risk: Pharmacy claims reveal refill patterns that predict which members will become non-adherent before they miss refills. Members who previously missed refills or who expressed cost concerns during calls are at high risk, and who will need proactive intervention with adherence support, financial assistance, or medication therapy management.

Disenrollment prediction: Disenrollment risk during annual election periods is heightened by recent complaints, service issues, premium increases, and benefit changes. To mitigate this, early identification of at-risk members allows for retention interventions. These interventions include personalized outreach from care coordinators, education on benefits, and service recovery efforts for members who have had negative experiences.

Implementation Principles

Successful patient engagement relies on flawless operational execution. It is crucial for plans to operationalize predictive capabilities by training staff, redesigning workflows, and ensuring systems facilitate real-time member interaction before widespread implementation. Deploying sophisticated models into unprepared organizations wastes investment and breeds cynicism when predictions don't translate into meaningful member outreach.

Predictions that live in separate reporting systems don't change behavior. Care coordinators need gap lists embedded in their CRM. PCPs need alerts within their EHR. Call center representatives need risk scores on their screen during every member interaction. If staff must switch between systems to access predictions, they won't use them consistently.

A prediction that a member will become non-adherent in 90 days enables proactive intervention. A prediction that a member is already non-adherent is just retrospective reporting dressed up as analytics. Timing determines whether predictions drive action or simply document what has already happened.

Predictions that staff don't understand get ignored, especially when they contradict with staffs' own experience. Staff who understand the reasoning will act on recommendations.

Models that identify the top 3 most important gaps for each patient enable focused intervention that actually gets completed. Comprehensive gap lists overwhelm providers and accomplish nothing.

Models degrade over time as member populations and behaviors change. Monitor prediction accuracy on a monthly basis. Retrain models quarterly with new data. What worked last year may not work this year as member demographics shift and market conditions change and evolve.

To achieve a high degree of personalization, the future of predictive analytics involves determining the most effective message, channel, and timing for each member's intervention. However, plans should prioritize mastering foundational analytics before attempting this advanced level of sophistication.

07 The ROI of Star Rating Improvement

07.1 Investment Requirements by Strategy

Transformation requires substantial investment over three years. Align the investment to plan size and starting point.

Quick Wins (0–6 months): \$800K–\$2M

- **Staff training programs and process improvements:** \$200K to \$500K
- **Call center optimization and speech analytics:** \$200K to \$500K
- **Documentation and exclusion hygiene programs:** \$200K to \$500K
- **Provider engagement initiatives:** \$200K to \$500K

These investments quickly pay for themselves within six months, through a reduction in complaints, higher survey scores, and improvements in exclusion-driven measures.

Medium-Term (6–12 months): \$4M–\$11M

- **Member engagement programs and community health worker staff:** \$1M to \$3M annually
- **Multi-channel communication infrastructure:** \$1M to \$3M
- **Care management program expansion:** \$1M to \$3M
- **Initial technology platform investments:** \$1M to \$2M

These investments deliver measurable Star rating improvements within six to 12 months that justify continued investment.

Long-Term (12–24 months): \$17M–\$50M

- **Enterprise data warehouse and integration:** \$5M to \$15M
- **Member engagement platform:** \$5M to \$15M
- **Predictive analytics capabilities:** \$3M to \$10M
- **Provider enablement technology:** \$2M to \$5M
- **Organizational change management:** \$2M to \$5M

The range reflects plan size. A 50,000-member regional plan invests at the low end. A 500,000-member plan invests at the high end. Technology costs will scale with complexity more than membership size, but implementation and change management scale with membership.

Total 3-Year Investment: \$15M–\$60M

This represents 3% to 5% of revenue for a typical MA plan. The investment pays for itself with bonus payments. Falling below 4 Stars costs 4–5% of revenue annually in lost bonus payments. For a \$500M plan, the transformation investment (\$15M to \$25M) equals approximately one year of lost bonus revenue, making the ROI compelling if Star rating improvements are achieved and sustained.

07.2 Projected Star Rating Improvements

Conservative Scenario (70% probability):

Year 1: +0.2 Stars from quick wins and operational improvements

- Call center training improves customer service measures
- Exclusion hygiene improves clinical quality measures
- Provider network optimization improves access measures
- Pre-CAHPS engagement improves survey response rates

Year 2: +0.3 Stars from member education programs and initial technology deployment

- Community health worker outreach improves experience scores for underserved populations
- Care gap closure programs improve clinical quality measures
- Member engagement platform enables personalized interventions
- Point-of-care tools drive gap closure during visits

Year 3: +0.2 Stars from full platform implementation and optimization

- Predictive analytics optimizes resource allocation
- Integrated workflows improve efficiency and effectiveness
- A strong culture of continuous improvement sustains gains
- Provider partnerships mature and deliver full value

Total: +0.7 Stars over 3 years

Aggressive Scenario (30% probability):

Year 1: +0.3 Stars

Year 2: +0.4 Stars

Year 3: +0.3 Stars

Total: +1.0 Star over 3 years

The aggressive scenario requires flawless execution, favorable market conditions, and a lack of regulatory headwinds. Rare but achievable for plans with strong fundamentals and exceptional execution.

Star rating improvements compound over time. Year 1 improvements establish the foundation. Year 2 improvements build on that foundation. By Year 3, the operational model transformation delivers sustained competitive advantage.

07.3 Bonus Payment Opportunity

Calculate return on investment through three lenses: direct bonus payments, member retention value, and competitive positioning benefits.

Example: 100,000 Member Regional Plan

Current state: 3.5 Stars (no bonus payments)

Target state: 4.0 Stars after transformation

Average premium: \$1,200/member/month

Annual premium base: \$144M

Bonus calculation:

- **Quality Bonus Payment at 4 Stars:** 4% of revenue
- 4% of \$144M = \$5.76M additional annual revenue
- **3-year bonus total:** \$17.3M
- **Less:** 3-year investment of \$20M (mid-range for 100K member plan)
- **Net financial position:** Break-even in Year 4, then \$5.76M/year ongoing

The break-even analysis looks unattractive until you consider the alternative. A plan that stays at 3.5 Stars loses competitive position to plans at 4+ Stars. Members migrate during annual

election periods. The membership base shrinks 5% to 10% annually, reducing revenue by \$7M to \$14M per year. After 3 years, the plan is 15% to 27% smaller with declining margins.

The investment in transformation doesn't just generate bonus payments; it prevents competitive decline and membership erosion.

The Affordable Care Act requires MA plans to maintain minimum Medical Loss Ratios, at least 85% of premium revenue must go toward clinical services and quality improvement rather than administrative costs or profit. Plans that fall below this threshold must issue rebates to members. Quality improvement programs help plans meet MLR requirements while simultaneously improving Star ratings, creating a dual financial benefit that strengthens the business case for transformation.

Integrated quality, MRA, and care management programs deliver compounding ROI. Each closed care gap improves HCC accuracy, lowers medical costs, and boosts Stars ratings. Plans that treat these as interdependent initiatives achieve sustainable margin recovery. This is measurable in both lower MLR and increased CMS bonus revenue.

Quality improvement reduces medical costs through several mechanisms:

- Preventive care prevents expensive acute episodes
- Chronic disease management reduces complications and hospitalizations
- Medication adherence prevents disease progression
- Care coordination reduces duplicative services and readmissions

The Star rating bonus payments represent only part of the financial benefit. MLR improvements from better population health compound the return.

07.4 Competitive Positioning Value

Beyond direct bonus payments, transformation delivers strategic advantages that create long-term value:

Member retention improvement

Currently, 8% to 12% of members switch plans during the annual election period. High-Star plans retain 90% to 95% of members. Low-Star plans retain 75% to 85%. The difference is 100 to 250 basis points of annual churn.

For a 100,000-member plan, reducing churn from 12% to 8% retains 4,000 members. At \$14,400 annual premium per member, that's \$57.6M of retained revenue.

Enrollment growth during Annual Election Period

Medicare Plan Finder displays quality icons for 4+ Star plans. These icons drive 10–15% higher enrollment from new-to-Medicare beneficiaries and switchers.

For a 100,000-member plan, 10% incremental enrollment growth is 10,000 members. At \$14,400 annual premium, that's \$144M of new revenue. Even at 90% MLR, this generates \$14M of additional margin.

Provider network stability

Providers prefer contracting with high-performing plans. Low-Star plans face provider resistance, network adequacy challenges, and higher contract rates. High-Star plans negotiate favorable terms and maintain broad, stable networks.

Regulatory standing

Plans below 3 Stars face regulatory scrutiny, potential sanctions, and enrollment freezes. Plans at 4+ Stars enjoy regulatory goodwill and lower compliance risk. The avoided cost of regulatory intervention—like legal fees, consultant fees, and staff time—is substantial.

Premium pricing flexibility

High-Star plans justify premium pricing through superior quality and member experience. Low-Star plans face pressure to discount premiums to compete. The ability to maintain or increase premiums while competitors discount creates 50 to 100 basis points of margin advantage.

Acquisition value

For plans considering eventual sale or merger, Star ratings directly impact valuation multiples. The sustained participation of major carriers in Stars-driven initiatives validates these returns. Even incremental improvements translate into measurable gains across retention, enrollment growth, and bonus stability. This demonstrates that quality and financial performance are inseparable.

These benefits don't show up in year-one ROI calculations but compound over time to create sustainable competitive advantage worth hundreds of millions.

07.5 Break-Even Analysis and Timeline

100,000 Member Plan:

- **Total investment:** \$20M over 3 years
- **Annual bonus payment at 4 Stars:** \$5.76M
- **Break-even point:** Month 42 (mid Year 4)
- Cumulative cash flow turns positive in Year 4

The financial case strengthens when including member retention value, enrollment growth, and competitive positioning benefits. The full value created is not accurately reflected by the ROI of bonus payments alone.

Risk factors that reduce returns:

- Execution failures that deliver <0.5 Star improvement
- Investment cost overruns exceed 30%
- Timeline delays exceed 12 months
- Regulatory changes that reduce QBP rates
- Competitive market dynamics that prevent enrollment growth

Many plans hesitate to modernize because foundational investments lack immediate ROI. Yet, improvements like data integration, AI orchestration, and predictive targeting determine whether a plan can sustain future Star gains. Treating infrastructure as a cost rather than a multiplier keeps organizations trapped in reactive cycles that erode both margins and member experience.

Plans should model downside risks, ensuring the strategy holds even with disappointing financial returns. Transformation may be vital for survival, even if the financial ROI is marginal.

08 The Transformation Roadmap for Executive Leadership

08.1 90-Day Immediate Actions

The first 90 days will determine whether transformation succeeds or becomes another failed initiative. The C-suite must act decisively to build momentum, secure commitment, and demonstrate early results.

Month 1: Assessment and Strategy Development

Week 1–2: Diagnostic analysis

- Pull Star ratings performance for the past 3 years by measure
- **Identify the top 5 improvement opportunities using this framework:**
 - Measure weight (prioritize weight 3+ measures)
 - Current performance gap to 4-Star threshold
 - Addressability (Can you realistically improve this?)
 - Timeline (How quickly can improvement happen?)

For example, a plan at 3.2 Stars on medication adherence (weight 3, high addressability, 6 to 12 month timeline) should prioritize it over a measure where they are already at 4 Stars.

- **Assess organizational readiness:**
 - Technology infrastructure maturity
 - Staff capabilities and capacity
 - Provider relationship strength
 - Financial resources available
 - Leadership commitment level

Week 3–4: Benchmarking and business case development

- Benchmark against insurtechs in your market
- Analyze what they do differently in member engagement

-
- Calculate financial opportunity from Star rating improvement
 - Identify which quick wins can be implemented in 6 months
 - Draft business case for board presentation

Secure executive sponsorship: The CEO must visibly champion this work. The board must understand this is a multi-year investment before seeing returns. The CFO must commit the capital. This cannot be a COO solo project.

Month 2: Quick Wins Launch

Implement operational improvements that show results within 6 months:

Call center CAHPS-aligned training begins immediately since every member interaction affects future survey responses. Rather than waiting for perfect training materials, health plans should use CMS CAHPS questions to train representatives on the specific behaviors members will evaluate during survey season.

Exclusion hygiene documentation review requires assigning dedicated staff to systematically review charts for hospice, advanced illness, and statin intolerance. This initiative delivers immediate measure improvements by removing inappropriate cases from quality denominators.

Provider network access monitoring starts with surveying 20 high-volume providers by calling their offices to check appointment availability. This assessment identifies which providers maintain 2-week access versus those with 2-month backlogs, enabling immediate focus on the worst offenders that drive member dissatisfaction.

Proactive, real-time complaint resolution drives member retention. When members complain, same-day or next-day resolution prevents issues from escalating to the CMS CTM system that directly impacts Star ratings. This approach treats complaints as opportunities for service recovery rather than administrative burdens.

Establish weekly Star ratings improvement team meetings:

- COO leads personally for the first 90 days, CEO should attend meetings frequently either in person or virtually
- **Cross-functional team:** clinical, operations, IT, member services, provider relations
- Review progress on quick wins weekly
- Remove obstacles that slow implementation
- Maintain urgency and accountability

Month 3: Multi-Year Roadmap Development

Develop a detailed 3-year transformation roadmap:

Investment requirements by year:

- **Year 1:** Quick wins + pilot programs + foundational technology
- **Year 2:** Scale member engagement + full technology deployment
- **Year 3:** Optimization + advanced capabilities

Detailed implementation timelines with milestones require project management discipline. Plans must assign owners, set deadlines, and track progress to ensure accountability across interconnected workstreams.

Plans should identify technology requirements:

- Data warehouse and integration platform
- Member engagement and CRM system
- Predictive analytics capabilities
- Provider enablement tools

Each major technology capability requires a strategic decision between building internal solutions or purchasing from established vendors. Plans must evaluate their technical resources, timeline constraints, and long-term maintenance capabilities when making these build-versus-buy decisions. Major technology purchases necessitate formal RFP processes that typically span 6 to 12 months from initial requirements definition through final contract award. This makes early planning essential to avoid project delays.

Proactive procurement prevents delays. Issue RFIs in Months 1–2 for vendor identification, followed by RFPs in Months 3–4. Complete evaluations by Month 6 to start implementation in Months 7–9.

For board approval, comprehensive business cases must include:

- **3-year investment:** \$15M to \$60M depending on plan size
- **Expected Star rating improvement:** 0.5 to 1.0 Stars
- **Financial return:** bonus payments + retention + growth
- **Competitive necessity:** What happens if we don't transform?

Board presentation must convey urgency: This is not optional. The market has changed. Status quo guarantees decline. Transformation is the only path to sustained competitiveness.

08.2 12-Month Transformation Program

Q1 (Months 1–3): Foundation

Complete quick wins implementation:

- Call center training and quality monitoring in place
- Exclusion documentation generating 0.1 to 0.2 Star improvement
- Provider access issues identified and resolution underway
- Real-time complaint resolution reducing CTM complaints

Measure early results:

- Customer service measure trending up based on quality monitoring scores
- Improvements in clinical quality measures due to exclusion documentation
- Member satisfaction improving based on complaint reduction

Target: Achieve 0.1 to 0.2 Star improvement from operational fixes alone. This proves transformation can work and builds organizational confidence.

Pilot member education program with high-risk population:

- Select 5,000 high-risk members with multiple care gaps
- Deploy intensive care management with education
- Measure completion rates and cost per closed gap
- Refine approach based on pilot results

Select and begin implementing member engagement technology:

- Evaluate current CRM and member engagement platform
- Renegotiate contract for CRM or issue RFP for new one
- Evaluate vendors and select solution
- Begin implementation project (6 to 9 month timeline)
- Establish data integration requirements

Establish provider partnership framework:

- Identify 3 to 5 high-performing provider groups for deep partnership
- Negotiate value-based arrangements
- Deploy embedded staff to support care gap closure
- Implement point-of-care tech for gap alerting

Q2 (Months 4–6): Scale

Deploy member education programs across all segments:

- Stratified approaches by health literacy, language, and risk level
- Multi-channel communication based on member preferences
- Community health worker deployment for underserved populations
- New member onboarding programs

Implement multi-channel communication infrastructure:

- Member portal and mobile app if not already deployed
- Text messaging platform for appointment reminders and health tips
- Email campaigns for targeted education
- Maintain phone and mail for members who prefer traditional channels

Launch pre-CAHPS survey engagement campaign (if timing aligns):

- Q1 is pre-CAHPS season
- If in Q2, prepare for next year's campaign
- Identify likely non-responders using predictive models
- Plan outreach strategy for Q1 next year

Begin data infrastructure modernization project:

- Data warehouse implementation underway
- API integrations with key data sources
- Real-time data pipeline development
- Data quality monitoring implementation

Expand provider enablement pilots:

- Scale embedded staff model to additional provider groups
- Deploy point-of-care gap alerting tools
- Aggregate data across multiple payers for unified worklists
- Measure impact on gap closure rates and provider satisfaction

Q3 (Months 7–9): Optimize

Measure mid-year progress and refine strategies:

- Review Star ratings projection based on YTD measure performance

-
- Identify which interventions are working and which are not
 - Double down on successful programs
 - Pivot or stop underperforming programs

Deploy predictive analytics for care gap prioritization:

- Implement models that predict gap closure propensity
- Integrate predictions into care coordinator workflows
- Focus resources on members most likely to respond to intervention
- Measure improvement in resource efficiency

Implement real-time member sentiment tracking:

- Deploy speech analytics for call center
- Track complaint patterns and dissatisfaction signals
- Route at-risk members for proactive intervention
- Prevent issues from escalating to formal complaints

Expand successful pilot programs:

- Scale member education programs that showed strong results
- Expand provider partnerships to additional groups
- Deploy tech capabilities broadly after successful pilots

Prepare for annual HEDIS submission:

- Ensure data quality and completeness
- Conduct mock audit to identify potential issues
- Document exclusions and data sources properly
- Submit on time with no errors

Q4 (Months 10–12): Sustain

Document and close remaining care gaps before measurement cutoff:

- Focus on gaps that can be closed in 30 to 45 days
- Prioritize high-weight measures
- Deploy intensive outreach for members close to completing gaps
- Ensure documentation is complete and submitted properly

Conduct year-end exclusion review:

-
- Final sweep for valid exclusions before measurement period ends
 - Ensure documentation meets CMS requirements
 - Submit updated information before deadlines

Plan for next year's CAHPS survey season:

- Analyze this year's results and identify improvement opportunities
- Develop enhanced pre-survey engagement strategy
- Build predictive models for non-responder targeting
- Plan community health worker deployment

Measure full-year impact on Star ratings (visible October following year):

- Project Star rating based on YTD measure performance
- CMS releases official ratings in October
- Analyze performance vs. targets
- Celebrate successes and learn from shortfalls

Develop Year 2 priorities based on results:

- What worked? Do more of it.
- What didn't work? Fix or stop it.
- What new opportunities emerged?
- What resources are needed for Year 2?

08.3 Multi-Year Strategic Roadmap

Year 1: Foundation and Quick Wins

- **Target:** +0.2–0.3 Stars
- **Investment:** \$5M–\$20M depending on plan size
- Operational excellence through process improvements
- Pilot member education programs with measurable results
- Initial technology platform deployment and integration
- Provider partnership framework established

Year 2: Scale and Integration

- **Target:** +0.3–0.4 Stars (cumulative +0.5–0.7)

-
- **Investment:** \$8M-\$30M
 - Full member engagement platform deployment
 - Predictive analytics operationalized across all use cases
 - Provider enablement expansion to majority of network
 - Comprehensive data integration with real-time pipelines
 - Advanced member segmentation and personalization

Year 3: Optimization and Innovation

- **Target:** +0.2–0.3 Stars (cumulative +0.7–1.0)
- **Investment:** \$2M–\$10M
- AI-driven personalization at scale
- Advanced predictive capabilities for all major use cases
- Full provider partnership model with value-based arrangements
- Industry-leading member experience and quality outcomes
- Sustainable competitive advantage established

Star rating improvements compound. Year 1 establishes foundation. Year 2 builds on that foundation. Year 3 sustains gains and optimizes for maximum impact. Plans that expect immediate dramatic results will be disappointed. Plans that commit to multi-year transformation achieve sustainable competitive advantage.

08.4 Key Decisions and Resource Allocation

Technology: Build, Buy, or Partner?

Build

Appropriate if you have strong internal IT capability and unique requirements that vendor solutions do not address. Provides maximum control and customization. Requires significant investment and 24 to 36 month timeline. High risk of delays and cost overruns.

Buy

Appropriate if standard solutions exist and speed to market matters more than customization. Vendor platforms deliver 80% of needed functionality. Implementation takes 6 to 12 months versus 24 to 36 for build. Lower risk but higher ongoing costs and vendor lock-in.

Partner

Appropriate if you lack internal resources and want to leverage external expertise. Partnerships provide capabilities without capital investment. Shared-risk arrangements align incentives. Requires finding high-quality partners and managing relationships effectively.

Recommendation for most regional plans

Partner for speed and expertise. Selectively build for unique differentiators. This hybrid approach accelerates transformation while maintaining strategic control.

Staffing Strategy

Hire new capabilities:

- Member engagement specialists and community health workers
- Data engineers and analytics talent
- Provider relationship managers
- Change management specialists

Retain and retrain existing staff:

- Change management is critical to transformation success
- Existing staff have institutional knowledge that's valuable
- Invest in training programs rather than wholesale replacement
- Help staff transition to new roles rather than eliminating positions

Partner with external consultants for expertise gaps:

- Subject matter experts for transformation program design
- Technology implementation partners
- Interim leaders to drive specific initiatives
- Training and change management support

Invest in analytics talent or partner with analytics firms:

- Building internal data science team takes 18 to 24 months
- Partnering with analytics firms provides immediate capability
- **Consider hybrid:** partner initially, hire selectively over time

Provider Relationship Strategy

Owned or employed provider models give maximum control over care delivery and quality improvement. Some regional plans acquire or build medical groups. This requires substantial capital and operational expertise in provider practice management.

To become a preferred partner and encourage providers to recommend more patients to your plan, focus on strengthening relationships with top-performing provider groups. This is crucial as PCPs will become more selective due to developing strong plan relationships. Offer value-based contracts that include upside opportunities and deploy enablement resources designed to reduce provider administrative burden.

Enable providers with technology and support resources:

- Point-of-care gap alerting tools
- Embedded staff to handle care coordination
- Aggregated data across multiple payers
- Performance feedback and quality improvement support

Regional plans have provider relationships that nationals lack. Use this advantage. Structure value-based arrangements that align financial incentives with quality outcomes. Share savings when providers help improve Star ratings. Create true partnerships rather than transactional relationships.

Funding Sources

Operational budget reallocation:

- Redirect spending from low-value programs to transformation
- Eliminate ineffective member outreach campaigns
- Replace offshore staff with technology
- Consolidate redundant systems and vendors
- Use savings to fund initial investments

Board-approved strategic investment:

- Present comprehensive business case showing ROI
- Request multi-year capital allocation
- Treat as strategic investment, not annual operating budget
- Secure board commitment before starting

Potential private equity or strategic investor:

-
- Consider minority investment from PE firm with healthcare expertise
 - Provides capital and operational support
 - Requires accepting outside influence and governance
 - Appropriate for plans needing substantial capital¹²

Revenue from initial Star rating improvements to fund later phases:

- Year 1 improvements generate some bonus revenue
- Use incremental revenue to fund Year 2 investments
- Reduces required upfront capital
- Creates self-funding cycle if execution succeeds

09 Conclusion: The Path Forward

09.1 The Moment of Decision

The Medicare Advantage market will not stabilize at current profitability levels. Regulatory pressure continues. CMS tightens Star rating methodology annually. Risk adjustment models reduce revenue. Medical costs rise faster than payment rates. Without intervention, revenue and margins will continue to decline as CMS tightens payment benchmarks and medical costs outpace reimbursement increases.

National plans are consolidating their operations to focus on areas that offer profitable density. Insurtechs capture market share through operational excellence. Regional plans sit in the middle: too small for national scale advantages and too resource-constrained for insurtech innovation.

Status quo is not viable. Star ratings drift lower as competitors improve. Members migrate during annual election periods. Margins compress until the plan becomes too small to sustain operations. Exit or distressed sales become inevitable outcomes.

The window for transformation is closing. Each year of delay allows competitors to build larger advantages. Plans that wait until a crisis hits, lack the time and resources to transform successfully. By the time the problem is undeniable, the solution is unaffordable.

Plans that delay decision-making will face three bad options in 24 to 36 months:

1. Emergency transformation attempts that fail due to insufficient time
2. Distressed sale at valuation multiples 40% to 60% below the current market
3. Managed wind-down and market exit with substantial reputational damage

The C-Suite must force the strategic conversation now while options still exist.

09.2 The Regional Plan Advantage

Regional plans possess competitive advantages that insurtechs cannot easily replicate.

Local market knowledge

Local market knowledge is made up of a deep understanding of community needs, demographics, provider landscape, and competitive dynamics. National plans lack this granular local knowledge. Insurtechs must build it from scratch.

Provider relationships built over decades

Primary care physicians trust regional plans. They have existing contracts, operational relationships, and shared history. Provider relationships and member retention protect margins more effectively than scale alone.

Member loyalty and trust in local brand

Regional brands carry credibility in their communities. Members view them as local organizations rather than distant national corporations. This trust creates retention advantages and reduces member acquisition costs.

Ability to move faster than national plans once committed

National plans require consensus across multiple regions and stakeholder groups. Decision-making takes 6 to 12 months. Regional plans can make decisions in weeks and implement in months if leadership commits.

Opportunity to adopt insurtech best practices without VC pressure

Insurtechs operate under pressure for hockey-stick growth to satisfy investors. Regional plans can transform at a sustainable pace focused on profitability rather than valuation multiples.

These advantages create opportunity. Regional plans that transform can achieve competitive parity with insurtechs while leveraging local strengths insurtechs lack.

09.3 Success Factors

Five factors determine transformation success:

Executive commitment

The CEO, CFO, and COO must champion transformation visibly and consistently. This cannot be delegated to middle management. The board must provide patient capital and support through a multi-year journey.

Provider partnerships

Successful plans work through PCPs rather than around them. The most effective approach enables providers to drive quality improvement rather than competing with them for member relationships. This collaboration model leverages the trust relationships providers already have with members while aligning incentives for shared quality outcomes.

Member-centric focus

Transformation requires driving individual behavioral change rather than managing populations through broad interventions. Plans must know members as individuals, understand their specific barriers to care, and personalize interventions based on what works for each person's unique circumstances and preferences.

Technology enablement

Modern platforms enable personalization at scale. Legacy systems cannot support required capabilities. Technology investment is not optional; it's foundational to competitive survival.

Patience and persistence

Transformation takes time. Leadership must maintain commitment through inevitable setbacks and slow periods.

Plans that excel at all five factors achieve sustainable competitive advantage. Plans weak in any area struggle to complete transformation successfully.

09.4 The Choice Is Clear

Regional health plans face a stark choice.

Transform

Fundamental operational change to match the insurtech member-centric model requires \$15M to \$60M investment over 3 years. This approach delivers 0.5 to 1.0 Star improvement and establishes a sustainable competitive position that enables independence and profitability in the evolved market.

Exit

Plans that acknowledge their inability to compete profitably can wind down operations over 12 to 24 months, redeploy resources to other lines of business, and maintain their reputation through orderly transition rather than prolonged decline.

No middle path exists between these options. Incremental improvements within legacy operational models will not generate the Star rating improvements required for competitive survival. Half-hearted transformation attempts that lack full executive waste resources and fail to deliver meaningful results.

The competitive advantage isn't technology alone or scale alone. Success requires an operational model that drives individual member behavioral change through personalized engagement, clinical proximity, and execution excellence.

Insurtechs proved this model works by achieving 4 to 5 Star ratings consistently despite being unprofitable and small. The question for regional plans is whether leadership has the will to transform operations to match insurtech effectiveness while leveraging the local market advantages insurtechs lack.

The playbook exists. The technology is available. The financial case is compelling for plans that execute well. Leadership commitment remains the only variable that determines success or failure.

Plans that transform within the next 12 to 18 months will thrive in the evolved market. Plans that delay transformation will face increasingly limited options and unfavorable outcomes as competitive pressures intensify.

Regional plans that solve this operational challenge will survive and prosper. Those that don't will join the growing list of MA market exits. The moment of decision is now.

About Invene

Invene is a boutique consultancy that helps mid-market and enterprise healthcare companies build AI-driven solutions with measurable P&L impact. Invene has partnered with 20 of the Fortune 100, supported 22 FDA clearances, and delivered over 400 products. Clients include payers, providers, MedTech, pharma, life sciences, and HealthTech innovators.

The firm specializes in transforming complex software ideas into secure, compliant digital products. Through a phased, R&D-informed approach, Invene helps clients reduce risk, identify high-leverage opportunities, and accelerate from concept to launch.

Invene's core capabilities include:

- **AI & Machine Learning:** Predictive analytics, natural language processing, anomaly detection, ensemble modeling, computer vision, and medical image analysis
- **Clinical Systems & Digital Health:** EMR integration, clinical workflow optimization, remote monitoring (RTM/RPM), digital therapeutics, and patient portal modernization
- **Cloud & Enterprise Infrastructure:** Data warehouse architecture, cloud migration, unified data access, edge computing, and platform consolidation
- **Product Engineering & SaMD:** HIPAA-compliant applications, Software as a Medical Device (SaMD), connected health devices, and medical-grade integration middleware

From rapid AI prototypes to full-scale platforms, Invene helps healthcare organizations translate vision into outcomes.

Bibliography

- 1 **Centers for Medicare & Medicaid Services.** *Fact Sheet: 2025 Medicare Advantage and Part D Star Ratings.* Official CMS document confirming the average weighted Star Rating for MA-PD plans is 3.92 in 2025, down from 4.07 in 2024, and only seven contracts earned 5 Stars. 2024. <https://www.cms.gov/files/document/fact-sheet-2025-medicare-advantage-and-part-d-star-ratings.pdf>
- 2 **Health Management Associates.** 2025 Medicare Advantage Star Ratings. Confirms only seven MA plans received 5-Star ratings in 2025. 2024. <https://www.healthmanagement.com/blog/2025-medicare-advantage-star-ratings/>
- 3 **Kaiser Family Foundation (KFF).** *Medicare Advantage Quality Bonus Payments.* Estimates total bonuses at least \$12.7 billion in 2025; notes bonuses can reach hundreds of millions for large plans, with per-member bonuses around 5% of benchmarks. 2024. <https://www.kff.org/medicare/issue-brief/medicare-advantage-quality-bonus-payments/>
- 4 **Kaiser Family Foundation (KFF).** *Medicare Advantage in 2024: Enrollment Update and Key Trends.* 2024. <https://www.kff.org/medicare/medicare-advantage-in-2024-enrollment-update-and-key-trends/>
- 5 **Devoted Health.** About Us. 2024. <https://www.devoted.com/about-us/>
- 6 **Clover Health.** Clover Assistant. 2020. <https://www.cloverassistant.com>
- 7 **Alignment Health.** Members. 2018. <https://www.alignmenthealth.com/members>
- 8 **Scantron Corporation.** *Improving Survey Response Rates: Four Tactics to Increase Participation.* 2012. <https://scantron.com/wp-content/uploads/2018/08/4TipsImproveResponseRate-1.pdf>
- 9 **Deloitte Center for Health Solutions and Scottsdale Institute.** Health care C-suites align on tech transformation. Survey of 43 health system executive leaders finding that 61% of respondents reported “C-suite alignment and collaboration” as the top driver of successful technology initiatives in health systems, with 80% including it among the top 3 drivers. 2025. <https://www.deloitte.com/us/en/insights/industry/health-care/c-suite-aligns-for-health-system-tech-transformation.html>
- 10 **Health Management Associates.** *Consumer Assessment of Healthcare Providers Systems (CAHPS): Improving Member Experience.* 2021. <https://www.healthmanage->

[ment.com/insights/spotlight/consumer-assessment-of-healthcare-providers-systems-cahps-improving-member-experience/](https://www.mckinsey.com/insights/spotlight/consumer-assessment-of-healthcare-providers-systems-cahps-improving-member-experience/)

- 11 **McKinsey & Company.** *New Stars ratings for Medicare Advantage prioritize customer experiences.* 2020. <https://www.mckinsey.com/~media/McKinsey/Industries/Healthcare%20Systems%20and%20Services/Our%20Insights/New%20stars%20ratings%20for%20Medicare%20Advantage%20prioritize%20customer%20experiences/new-stars-ratings-for-medicare-advantage-to-prioritize-customer-experiences.pdf>
- 12 **Alignment Healthcare.** Alignment Healthcare Announces \$115 Million Equity Investment from Warburg Pincus. Example of plan taking minority or growth capital from private equity or strategic growth investors. 2017. <https://www.alignmenthealth.com/newsroom/blog-posts/alignment-healthcare-announces-115-million-equity>

Thank you

Start with data readiness, build your business case, and implement predictive modeling with ethical frameworks. The rewards are substantial: millions in bonus payments, improved member outcomes, and market leadership in an increasingly competitive landscape.

Get In Touch
Book a Discovery Call Today

 invene.com

 linkedin.com/company/invene

 invene.com/contact-us