KODA HEALTH

EXECUTIVE GUIDE · OCTOBER 2026

A GUIDE FOR MEDICARE ADVANTAGE PLANS

Advance care planning and medical loss ratio

Most plans treat advance care planning as a quality initiative. It is also one of the few levers that lowers claims cost and raises member satisfaction at the same time.

90%

MA aggregate MLR in 2024

9.6%

Median health benefit cost growth, 2025

~25%

of Medicare spending in the last year of life

EXECUTIVE SUMMARY

Margin is compressed, and the easy levers are mostly pulled.

MA plans' aggregate MLR hit 90% in 2024, tighter than every other line of business except Medicaid managed care. Health benefit costs then grew another 9.6% in 2025, while administrative cost-cutting had already run its course.

One lever most plans haven't used yet: reducing unwanted, low-value utilization in the single most expensive phase of care, the last year of life.

Advance care planning, built as infrastructure rather than a one-time conversation, cuts that utilization by giving patients the care they actually asked for. **Lower cost and higher satisfaction rarely move together. This one does.**

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01 · WHAT MLR MEANS TODAY

Running well above the floor, and moving the wrong direction

Medical loss ratio is the share of premium spent on medical claims and quality improvement versus administration and profit. The ACA set the MA floor at 85%. Fall short, and the difference is rebated to CMS.

MA still produces the highest gross margin per enrollee of any line of business. But the ratio is the tightest it's been. Benefit costs rose a median 9.6% in 2025 while per-member admin costs barely moved.

That leaves the claims side. Not denying claims, which erodes Stars and trust fast, but **reducing the volume of care members receive and didn't actually want.**

LINE OF BUSINESS	MLR 2024	MARGIN / ENROLLEE
Medicaid managed care	91%	$608
Medicare Advantage	**90%**	**$1,655**
Group market	88%	$846
Individual market	85%	$987

Source: KFF analysis via Becker's Payer Issues

Stars, quality bonus payments, and retention

A different mechanism than MLR, but moving in the same direction. CMS is shifting Star Ratings weight toward member-reported outcomes through the Health Outcomes Survey (HOS). Small shifts in Stars now translate directly into revenue.

~40%

STARS WEIGHT FROM SURVEY MEASURES BY 2029

$12.7B

PROJECTED QBP SPENDING, 2025

23%

ANNUAL PLAN SWITCHING RATE

$2–3M

PER RETENTION POINT, 100K-MEMBER BOOK

HOS doesn't ask members to rate a program. It asks whether they feel supported, whether their health improved, whether they can do what they want to do.

Members remember a small number of moments. A well-run advance care planning conversation, someone asking what matters most, being there when a decision got hard, is one of the moments members actually remember.

ONE CAPABILITY, BOTH SIDES OF THE P&L

Cost side

Lower claims from fewer unwanted hospitalizations and ICU days

Revenue side

Higher bonus-payment eligibility and retained premium

03 · THE HIDDEN CONNECTION

A meaningful share of the claims behind that 90% is care patients didn't choose.

None of it shows up as waste on a claims report. It shows up as a hospitalization, an ICU day, a procedure, indistinguishable from care a patient actively wanted.

An unwanted intubation.

A fourth hospitalization in six months for a condition the patient had already decided to manage differently.

An ICU stay because nobody in the building knew a POLST existed.

Advance care planning, done well, is the mechanism that separates preference-concordant care from care nobody asked for. The connection gets missed because most ACP is measured as a single conversation or a signed form, not as infrastructure that catches the moment a patient's situation changes.

04 · WHAT THE DATA SUPPORTS

Not all ACP shows savings. That distinction matters more than the topline numbers.

A SINGLE BILLED CONVERSATION

+$1,635

higher adjusted monthly cost

A study of 18,484 seriously ill MA beneficiaries found billed ACP encounters linked to higher cost and more hospitalizations. The authors attributed it to confounding: sicker patients are more likely to have ACP billed.

Ashana et al., JAMA Network Open, 2019

COMPREHENSIVE, ONGOING PROGRAMS

$13,916

savings per patient engaged in ACP

Infrastructure that keeps watching after the first conversation, catching the moment preferences or condition change, is what reduces avoidable utilization. Comprehensive programs also show 24.5% lower total cost of care and 1.6x the rate of appropriate hospice use.

SOURCE	PROGRAM	FINDING
Patel et al., JAMA Oncology, 2018	Lay health worker-led ACP, patients with cancer	**76.7%** hospice use vs 48.3% for controls, nearly 1.6x the rate in the final 30 days
Aledade, AJMC, 2022	ACO-wide ACP program	**$13,916** savings per patient engaged in ACP
WellSpan / Bhatia et al., NEJM Catalyst, 2021	Health system ACP program, real-world use	**24.5%** lower total cost of care, driven by reduced ICU stays
Koda ACP (data on file)	Population-level ACP infrastructure	See outcomes below

KODA POPULATION-LEVEL OUTCOMES

87
Net Promoter Score

79%
fewer terminal hospitalizations

33%
fewer ICU admissions

51%
higher hospice utilization

42%
lower total cost of care

05 · PATIENT-DRIVEN, NOT DENIAL OF CARE

High NPS and cost containment aren't opposing goals.

Most plans manage member satisfaction and MLR as separate priorities, sometimes competing ones. ACP is one of the few levers that moves both at once, because it is patient-driven rather than utilization-restricting.

THE MYTH

Keep members happy, or keep spend down. Pick one.

Every dollar saved has to come from care someone wanted, so savings and satisfaction trade off.

THE REALITY

The costliest care is often care members never wanted.

Remove that, and spend falls while satisfaction rises. Nothing is withheld.

Cost containment members resent

The usual tools save money by restricting access. Each one draws down NPS, CAHPS scores, and retention, which then cost the plan on the revenue side.

Denials

Spend drops on the claim. The member remembers who said no.

Narrow networks

Lower unit cost, fewer choices, more members shopping at open enrollment.

Prior auth friction

Delays and paperwork land on members and their physicians, then show up in CAHPS.

How ACP moves both at once

1

Members say what they want

A guided conversation records goals, values, and treatment preferences.

2

Care follows those wishes

Preferences sit in the EHR, so the care team acts on them in a crisis.

3

Unwanted care drops

Fewer hospitalizations and ICU stays the member never wanted, and earlier hospice.

87

KODA NPS

Satisfied members who got the care they actually wanted cost less. Not because care was withheld, but because it was aligned.



> Because we've talked about it, it eliminates that fear. To have someone knowledgeable to guide you is really valuable.

HEALTH PLAN MEMBER, 75 · COMPLETED HER PLAN ALONGSIDE HER HUSBAND

Why this matters for MLR

ACP as infrastructure doesn't deny or delay care. It identifies what a patient wants, documents it where a clinician can find it at 2 a.m., and makes sure someone revisits it as the patient's situation changes.

The claims that drop are high-cost, end-of-life admissions and ICU days, the numerator of MLR. Meanwhile, patients and families report feeling more in control and less blindsided, which protects Stars and retention. That is a different conversation to bring to a Star Ratings committee than a typical utilization management initiative.

TRADITIONAL UM	ACP INFRASTRUCTURE
Denies or delays care	**Delivers the care patients asked for**
Plan decides what's appropriate	**Patient preferences lead**
Erodes Stars and member trust	**87 NPS alongside utilization reductions**
Savings at the cost of satisfaction	**Savings and satisfaction together**

06 · COMMON OBJECTIONS

Questions we hear from plan leadership

"Isn't this a documentation requirement we already meet?"

Most plans track ACP as completion rate: was the form signed. That single-layer version doesn't show savings. The infrastructure version tracks whether the document still matches the patient's current situation, and whether anyone would know if it didn't.

"Won't reducing utilization push our MLR below 85%?"

No. MA plans run a 90% aggregate MLR, five points above the floor. The risk isn't a rebate. It's margin compression from rising cost trend with no admin room left to cut. Reducing unwanted utilization protects margin without approaching the threshold.

"Isn't this a provider-side initiative?"

A health system can run a documentation workflow. Tracking every attributed member, not only patients who walk through one hospital's doors, is a different scope, and a better fit for a plan that already holds population-level data.

07 · HOW KODA COMPASS WORKS FOR MA PLANS

Watching every enrolled member continuously, not on a scheduled check-in

Koda Compass surfaces the moment a member's situation changes enough to need a new conversation, at a population scale a single health system workflow can't reach.

01

Ingest signals

ADT, lab, pharmacy, and referral data across the attributed population catch meaningful changes in condition.

02

Route targeted outreach

KodaCares Patient Advocates reach out only where a conversation is actually needed, not a blanket call campaign.

03

Guide and complete the plan

A Koda patient advocate guides the member and family, then the completed plan is shared with the member's doctor.

04

Check in monthly

Monthly check-ins for up to 12 months as health changes.

05

Report outcomes

NPS, hospitalization and ICU trend, hospice enrollment, and total cost of care, ready for a Stars or quality committee.

One capability that protects margin and improves member experience

01 MA plans run a 90% aggregate MLR with admin cost-cutting largely exhausted. Utilization is the remaining lever, and it has to be pulled carefully.

02 Unwanted, low-value care in the last year of life, roughly a quarter of Medicare spending, is invisible on a claims report today.

03 A single ACP conversation doesn't reduce cost. Ongoing ACP infrastructure does, with $292 to $9,500 per patient in documented savings.

04 It raises patient satisfaction rather than trading against it, a combination most cost levers don't offer.

05 This is a population-level initiative a health plan is positioned to run, not only a provider-side documentation task.

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Sources: KFF analysis via Becker's Payer Issues; Sherlock Company 2026 benchmark; KFF; healthinsurance.org; Ashana et al., JAMA Network Open (2019); Patel et al., JAMA Oncology (2018); Aledade, AJMC (2022); WellSpan / Bhatia et al., NEJM Catalyst (2021); Koda Compass data on file.