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WHITE PAPER

Understanding Selection Risk Under BALANCE:

Evidence from Recent MA Data

Robert Lang, FSA, MAAA

Josh Thyen, ASA, MAAA

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SUMMARY

This paper summarizes GLP-1 eligibility and financial performance using 2022–2024 Medicare Advantage (MA) experience data to better understand the pending 2027 "Better Approaches to Lifestyle and Nutrition for Comprehensive hEalth" (BALANCE) program and potential selection risks from participation or nonparticipation in the program. The analysis focuses on three primary metrics: eligibility prevalence, the relationship between risk scores and claims, and cohort-level financial results in the form of medical loss ratios (MLR).

Several key observations from this analysis include:

- The proportion of members eligible for GLP-1s has increased over the study period.
- Members who would be newly eligible under BALANCE represent a small share of the total GLP-1-eligible population based on historical diagnosis data. However, potential under-coding of obesity and body mass index (BMI) diagnoses are likely to contribute to underestimation of the truly eligible population under BALANCE.
- GLP-1 utilizers over the study period have higher MA risk scores and lower medical claims on average than their GLP-1-eligible, non-utilizing counterparts; We still report some Part D information but note that, while interesting, the utilization patterns are from a pre-Inflation Reduction Act (IRA) dataset and this dynamic may shift as a result of the 2027 Part D program parameters.
- The population that would be newly eligible under BALANCE tend to have lower risk scores but somewhat elevated claims costs that result in MLRs between 93 and 97%; however, this is before accounting for any new GLP-1 utilization and the 2027 Part D benefit parameters.

Although these results provide interesting directional insight into population dynamics under BALANCE, Medicare Advantage Organizations considering participation should consider further analysis to fully assess financial impact in a post-IRA environment and to evaluate how coding practices and utilization patterns may evolve as the program is implemented.

BALANCE BACKGROUND

The Center for Medicare and Medicaid Innovation (Innovation Center) announced the BALANCE initiative in late 2025 with the intention of expanding access to GLP-1 therapies and related interventions for members with obesity and associated comorbidities. The Centers for Medicare & Medicaid Services (CMS), which leads the Innovation Center, later released a Request for Applications (RFA) in March 2026 for Part D plan sponsors. The RFA provided several key clarifications, including:

- Coverage criteria standards patients must meet to be eligible
- Payment effectuation, including the creation of a Facilitated Direct and Indirect Remuneration DIR (FAD) field in the Prescription Drug Event (PDE) report
- Participation thresholds required to be met for the program to move forward for Medicare Part D in 2027

Given the newly released coverage standards and detailed indicator requirements, it is important to evaluate not only how eligibility is expanding, but also how newly eligible members compare with beneficiaries who are already eligible in terms of cost and risk profile.

This paper assesses those relationships using recent experience data and to identify any insights that may inform future program participation strategy or plan design. For purposes of interpreting results, it is worth clarifying that this study does not attempt to adjust for program changes in 2027 such as shifts in plan liability, risk model changes, or changes in net drug cost.

ANALYSIS RESULTS

Prevalence Rates and Eligibility

We conducted this study using Wakely's de-identified MA dataset, which contains more than 13 million member months annually. The study draws on detailed CY2022–2024 MA claims data, supplemented with standardized CMS files, including monthly membership report (MMR) and Medicare Advantage organization (MAO-004) submissions. We limited the data to a consistent plan cohort across all three years in order to reduce noise and variability of the results. Unless otherwise specified, results referencing MA are specifically for the Medicare Part C program.

The first metric analyzed was the prevalence of members who currently are eligible for GLP-1s, whether those members use a GLP-1, and whether members who meet the BALANCE eligibility standards are already eligible under the current standards (see Table 1).

Table 1. Use of GLP-1 Drugs Among Currently Eligible and BALANCE-Eligible MA Members

	2022		2023		2024	
	Members	Prevalence	Members	Prevalence	Members	Prevalence
Total Population	462,407		479,298		481,030	
Currently Eligible	163,011	35%	187,891	39%	191,166	40%
GLP1 Users	19,303	12%	27,249	15%	31,057	16%
Non-GLP1 Users	143,708	88%	160,642	85%	160,109	84%
BALANCE-Eligible	201,466	44%	234,451	49%	238,070	49%
Currently Ineligible	43,157	21%	52,328	22%	52,471	22%
Already Eligible	158,309	79%	182,123	78%	185,599	78%

Over the three-year sample period, several notable observations emerged:

- The percentage of people currently eligible increased by 5%, with the percentage of members who would be eligible under BALANCE increasing proportionally.
- The primary shift in growth occurred between 2022 and 2023, with marginal growth between 2023 and 2024.
- The percentage of GLP-1 utilizers increased proportionally with the percentage of members that were eligible.

These findings might suggest that a general worsening of morbidity among the population over the study period. While it's possible that the growth in eligibility is partially caused by a degradation in population morbidity, it is also likely that a simultaneous increase in coding efforts is occurring that could be directly attributed to societal interest in GLP-1 medications. This possibility may explain the growth in the eligible populations between 2022 and 2024 and suggests a historical propensity for under-coding, particularly for diagnoses related to obesity and BMI. These diagnoses are generally understood to have been under-coded due to their non-inclusion in the MA Risk Adjustment calculation.

Risk Score and Claim Cost

The second set of metrics analyzed included medical risk scores, along with medical costs on a net and normalized basis across the following cohorts: 1) currently eligible members split into GLP-1 utilizers and non-utilizers, 2) members who would be newly eligible under BALANCE, and 3) all other members not meeting the GLP-1 eligibility criteria, who were placed in the ineligible cohort.

As discussed previously, results are reported without adjustment and represent the true costs incurred during the given timeframe. No adjustments have been made to account for the post-IRA landscape or future BALANCE GLP-1 pricing considerations (see Table 2).

Table 2. Experience Across Eligible, Newly Eligible, and Ineligible MA Populations

		Currently Eligible		Newly Eligible Under BALANCE	Ineligible Population	Total Population
		GLP-1 Utilizers	Non-Utilizers			
2022	Medical Risk Score	1.617	1.456	1.006	0.881	1.108
	MA Claim Costs (Norm)	$822	$973	$952	$788	$882
	Total MA Claim Costs	$1,329	$1,416	$957	$695	$978
	Inpatient	$443	$560	$277	$211	$339
	Outpatient	$352	$367	$309	$203	$272
	Professional	$298	$281	$219	$154	$207
	Other MA Claims	$236	$208	$152	$127	$160
2023	Medical Risk Score	1.605	1.492	1.001	0.862	1.137
	MA Claim Costs (Norm)	$848	$1,011	$952	$797	$913
	Total MA Claim Costs	$1,361	$1,508	$953	$687	$1,038
	Inpatient	$423	$581	$261	$190	$345
	Outpatient	$370	$391	$301	$207	$290
	Professional	$312	$298	$217	$153	$219
	Other MA Claims	$257	$238	$174	$136	$182
2024	Medical Risk Score	1.591	1.505	1.013	0.877	1.154
	MA Claim Costs (Norm)	$889	$1,101	$1,025	$846	$981
	Total MA Claim Costs	$1,415	$1,657	$1,038	$742	$1,131
	Inpatient	$433	$635	$285	$199	$373
	Outpatient	$381	$421	$322	$222	$312
	Professional	$324	$324	$233	$163	$237
	Other MA Claims	$278	$276	$197	$158	$211

Based on this summary, we have the following key observations:

- The higher risk scores among currently eligible GLP-1 utilizers do not correspond to higher claims costs relative to non-users, who have lower risk scores but higher claim costs.

  - GLP-1 utilizers have the lowest net claims costs after normalizing using MA risk scores for all GLP-1 eligible populations under BALANCE.
  - This relationship is consistent across all three years.
  - Note: Post-IRA, this relationship may change as plan sponsors accept more Part D liability.
- Net claims costs for the utilizer cohort are materially lower in inpatient and outpatient spending in all years than for the non-utilizing eligible population but higher in professional and other medical.
- The newly eligible population has significantly lower risk scores and claims costs relative to the currently eligible population.

Though tempting, we hesitate to conclude that GLP-1 utilization is directly associated with lower inpatient spending compared with the rest of the eligible cohort. A more detailed study assessing causation is required to formulate any concrete conclusions. What seems clear, though, is that the cohort that would become eligible for GLP-1s under the BALANCE model appears to have limited opportunities for medical savings because their costs are already materially lower than the currently eligible cohort. Although their costs are higher than the non-eligible cohort, it seems unreasonable to believe they can fully close the gap to offset the cost of GLP-1s, which will cost approximately $245 per month under BALANCE.

An additional consideration related to potential medical cost savings are provider risk-sharing arrangements. While in some instances these arrangements include both medical and drug costs, drug costs are sometimes carved out. In such cases, plans participating in BALANCE would be responsible for additional Part D liability associated with increased GLP-1 utilization, but would share a significant portion of medical savings (if any) back to the providers under these arrangements. Each plan sponsor should carefully consider their risk-sharing arrangement dynamics and the portion of their membership covered under them when considering BALANCE participation.

Current MLR

Finally, we analyzed MA MLR by year, split into the same cohorts as the summary above (see Table 3).

Table 3. MA MLR by Eligibility Cohort

	Currently Eligible		Newly Eligible Under BALANCE	Ineligible Population	Total Population
	GLP-1 Utilizers	Non-Utilizers			
2022 MA MLR	86.2%	97.7%	99.0%	80.0%	89.5%
2023 MA MLR	84.8%	97.7%	95.0%	77.7%	89.0%
2024 MA MLR	86.9%	103.8%	99.4%	80.8%	93.5%

For this study, MLR was calculated using all MA CMS revenue (MA risk-adjusted bid and MA rebates) and member premiums allocated to MA in the denominator, along with total net medical expenses.

Given the results outlined in the risk score and claim cost section, it makes sense that we would observe lower MLRs for the GLP-1 utilizer subset of the currently eligible cohort because their risk scores are higher and costs are lower in all periods. When comparing the MLR components across all three years, the primary drivers of the lower GLP-1 utilizer MLR consistently stemmed from lower inpatient claims costs relative to the non-utilizer cohort.

Another key comparison is in the high MLRs for the population that would be newly eligible for BALANCE. Notably, their MLRs are among the highest in all years studied. However, their inpatient expenses are less than $100 PMPM higher than the ineligible cohort. If GLP-1 usage is expected to generate medical savings (particularly for avoidable inpatient spend) and the ineligible cohort represents a reasonable target for inpatient spend, then it does not appear there is sufficient opportunity to achieve medical savings that cover the elevated plan liability of the GLP-1 drug cost if the GLP-1s inpatient (IP) claims costs aren't significantly higher. Therefore, if CMS revenue does not increase sufficiently to cover the cost of the GLP-1 usage, then it is likely that MLRs for this cohort would not improve in the short term once provided access to GLP-1 prescriptions.

Finally, we note again that these MLRs reflect the Medicare program during each of the respective years for the Part C benefit only. Given the evolving nature of the Part D program due to the impact of the IRA over the past few years, Part D was not explicitly reported in this analysis to avoid conflating historical experience with future expectations. Though it may be reasonable to conclude that the Part C MLRs for the GLP-1 utilizing population will continue to remain lower, we cannot conclude that their overall MLR (Part C and Part D combined) will be lower in a post-IRA environment because of material shifts in Part D liability to the plan sponsors. Rather, these MLRs are most appropriately used for comparing cohort to cohort

within a given year rather than drawing direct conclusions regarding cohort profitability in the future.

Although these observations and their consistency across a three-year sample size are interesting, further analysis is needed to adequately inform any decision-making about whether to participate in the BALANCE program. Potential future considerations to expand upon include translating data to include Part D expenses on a consistent post-IRA basis, factoring in BALANCE cost impact resulting from reduced GLP-1 cost and Facilitated DIR, the prevalence of under-coding BMI and how that may change in a post-BALANCE environment, and longitudinal analysis of GLP-1 impact on long-term patient cost of care.

DATA AND METHODOLOGY

Data

We leveraged Wakely's de-identified MA dataset for this study. This robust dataset includes over 13 million member months per year. This report uses detailed calendar year (CY) 2022–2024 MA claims data as well as standardized CMS files including MMR, PDE, and MAO-004 files.

To reduce any impacts on the results that could arise from differences in plan type or geographical mix across years, the data were limited to a consistent plan cohort across all three years, leading to the sample of 159 plans shown in Table 4.

Table 4. Member Counts, 2022–2024

Year	Plan Count	Members
2022	159	462,407
2023	159	479,298
2024	159	481,030

Risk scores are based on MMR-reported values and are based on the parameters specific to each payment year, which vary from year to year. As a result, comparisons are primarily made for each year rather than across years, although overall trends and relationships were analyzed across the entire three-year sample.

Wakely performed high-level reasonability tests on the data but did not independently audit the data.

Methodology

Based on the RFA released by CMS, members were grouped into the following cohorts for this analysis:

- Currently eligible for GLP-1s:
  - Indicators include type 2 diabetes, established cardiovascular disease with obesity, and obstructive sleep apnea (OSA) with obesity.
  - For the purposes of this study, this cohort was further split into those utilizing GLP-1s and those not utilizing GLP-1s.
- Becoming GLP-1 eligible under BALANCE criteria[1]

The eligibility cohorts were identified using MAO-004 submissions and claim level diagnosis codes to flag members meeting either the current or proposed criteria standards. GLP-1 utilization was tagged using PDE data based on GLP-1 NDCs present.

CAVEATS

This analysis is based on CY 2022–2024 MA experience. As noted, Wakely performed high-level reasonability tests on the data but did not independently audit the data. The following limitations should be considered when interpreting the findings.

Data Scope and Representativeness

- The study includes a consistent cohort across all three years, resulting in a fixed sample of 159 plans. While this approach improves year-over-year comparability, it may not fully represent the broader MA market or reflect emerging coding or utilization trends more broadly. Not all states / regions are represented; limitations in this regard may affect results.

Coding Practices and Under-Diagnosis Reporting

- The analysis relies heavily on diagnosis codes from MAO-004 and claims data. Historical under-coding of obesity and BMI likely leads to underestimation of the true BALANCE-eligible population.

[1] Centers for Medicare & Medicaid Services. Better Approaches to Lifestyle and Nutrition for Comprehensive hEalth (BALANCE) Model: Request for Applications, Part D Plan Sponsors. Last modified March 2026. Available at: https://www.cms.gov/priorities/innovation/files/balance-part-d-plans-rfa.pdf.

- Coding intensity of relevant diagnoses may have increased over the study period given heightened societal interest in GLP-1 medications, complicating interpretation of prevalence trends.

Risk Score Comparability

- Risk scores are based on the parameters specific to each payment year, which vary from year to year. As a result, comparisons should primarily be made within each year rather than across years due to differences in underlying risk models, which limits the ability to draw longitudinal conclusions about risk evolution or morbidity shifts.

GLP-1 Impact Interpretation

- Although GLP-1 utilizers are shown to have lower inpatient and outpatient costs, the analysis cannot establish causation.
- The newly eligible BALANCE cohort exhibits lower baseline costs, limiting potential for medical savings. However, future utilization patterns, adherence, and clinical outcomes remain uncertain.

Future Program Uncertainty

- The BALANCE program's operational details—including coding expectations, utilization management, and the impact of Facilitated DIR—may evolve before 2027 implementation.
- Member behavior, provider adoption, and plan design responses could materially shift eligibility, utilization, and cost patterns beyond what historical data can capture.

About the Authors

Robert Lang, FSA, MAAA
Senior Consulting Actuary
Robert.Lang@Wakely.com

Josh Thyen, ASA, MAAA
Consulting Actuary
Joshua.Thyen@Wakely.com

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