GREAT MINDS AND ONE BALD GUY

FROM INSIGHTS TO IMPACT

Season 1: Episode 1

Episode Title: Weathering the Storm: Shifting Market Dynamics Impacting the 2025 Medicare AEP

Meet the Experts
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TODD: Mike, to better understand how the past years may have contributed to the current marketplace dynamics, can I ask you to give a brief explanation of the history of Medicare and the institution of the MA plans and cost plans?

MIKE: Medicare was born out of social programs that were instituted in the mid-1960s to provide healthcare coverage for senior citizens in the country. The original premium for Medicare was $3, and the deductible was $40. So, that gives you a sense of where we've started. Where we are today is a bit more complicated. Along the way, our healthcare industry has changed dramatically, and Medicare has tried to keep pace with the evolution of care. Then, in the late '70s and into the '80s, we started introducing the concept of managed care. And that's where cost plans were born, and those plans really took hold in the early 2000s, particularly in the Upper Midwest. Medicare Advantage, as we know it today, started in the early 90s with the CHOICE program, and then through the Medicare Modernization Act in the early 2000s, is really when what we would refer to as Part C, or Medicare Advantage was born. And subsequently, Part D and the prescription drug plans were introduced. Today, we have a program in Medicare that provides fee-for-service from an original Medicare perspective. And some people choose to supplement that, while others are choosing to assign those benefits to a private insurance company, which is what we call Medicare Advantage. And so, we've seen Medicare grow from the humble beginnings of the first Medicare beneficiary to have their red, white, and blue card–which was former President Harry Truman–to millions of Americans who are utilizing this very vital program.

TODD: Tom, I'd like to ask you to kind of talk about the onset of the CMS oversight, and how that has progressed from the start until now, and if you can touch on some of the boomer demographics that influenced the evolution of this oversight.

TOM: Going back a decade now, we've seen CMS implement more and more regulations over how we do business in the Medicare space. The agent community has adapted to, and in many cases, supported changes that bring continuity to the market and that limit the reach of bad actors. But, there's also been some overreach, particularly in areas like scope of appointments; the 48-hour rule; and more recently, call recordings. Some of these rules have been put in place in response to problems CMS saw in the call center, but they tend to hit the independent agent harder and in more difficult ways over time. The NABIP Minnesota chapter has been very active, both at the state level and the national level, in lobbying for things on behalf of Minnesota seniors and all the agents who support them. However, the wheels can turn very slowly in DC. There is a bill that's been introduced that is designed to give the independent agents some relief and that will redefine what's called

a TPMO, a third-party marketing organization–which is often what the advertisers we see on TV are–to take independent agents out of that definition. And with that, I think we'll see some relief on CMS rules that have made doing business as an agent more challenging. In regard to the Boomer influence, not only are we seeing upwards of 10,000 people a day who are turning 65, but because people are living longer, the 75 to 80-year-old demographic also continues to grow, as is the 85-plus demographic.

TODD: Kris, can you talk about the type of plans now available to seniors as they age in, and as they can switch during AEP?

KRIS: Minnesota has a pretty rich offering when it comes to healthcare options. The high-level products that are offered are obviously the Medicare Advantage prescription drug plans, and there's subsets of products underneath those that are HMOs and managed care PPOs, where you have a two-tier product system. We also have cost plans, and Medicare Advantage private fee-for-service options. So there's a plethora of different options for Minnesotans. We even have some specialized plans, like CSNPs or DSNPs, and dual plans like MSHO. For the majority of those plans, the beneficiary will basically assign their original Medicare benefits over to the carrier who then gets a reimbursement amount. The individual doesn't lose their original Medicare benefits, they are just assigned to the carrier that the individual chose to work with. Medicare cost plans are a little different. For carriers, the costs they incur are reimbursed from the federal government. So, you have original Medicare first on the Medicare Part A side, in which the carrier pays kind of like a supplement. And on the Part B side, the carrier takes on all, all risk and financial liability initially for making those payments, and then they submit those costs back to CMS and for reimbursement. You also have Medicare Part D, which was introduced in 2006, in conjunction with the Medicare Modernization Act. Medicare Part D works really well with Medicare supplements, which have been around a long time. Through the years since 2006, we've seen high deductible F plans come into the market, as well as plans N and plans KL. I call it the alphabet soup of Medicare supplement plan offerings.

TODD: Mike, is it kind of safe to say that CMS reimbursement rates have not kept up with inflation?
MIKE: The cost of healthcare is just skyrocketing, people are living longer, and technology advancements, while beneficial to patients, is expensive. And, unfortunately, the industry as a whole, is not keeping up in terms of money coming in the door vs. money going out the door. We're seeing that correction in the Medicare space now as the band-aid is being ripped off across the country

TODD: Tom, do you know where the initial, Part D reimbursement amount was set at, and then how the IRA changed that number?

TOM: Fundamentally, what the Inflation Reduction Act did was it lowered the maximum out of pocket cost for those highest utilizers of prescription drugs from $5,000 down to $2,000. The net result of that, however, was the other 9 out of 10 people who were used to very low premiums and zero copays on their generic drugs ended up paying more. That was pretty disruptive to the marketplace. On the standalone PDP side, that was anticipated to affect rates so much that Medicare came in with what they call a demonstration project, and they refunded the standalone Part Ds to lower premiums. That's a 3-year program that, in itself, is a bandaid to a bigger problem. In addition, Medicare transferred costs to the carriers.

MIKE: The IRA, while probably virtuous in intention, is definitely providing relief to some folks, but it's really causing stress in other places. And, what I would advocate for is a harder look at what we're trying to do, which is to really bend the cost curve of what the healthcare industry is costing, carriers, agents, and most importantly, beneficiaries. What we're seeing is just more cost shifting, as carriers, Part D, standalone PDP companies, and the industry as a whole is adjusting.

TOM: The other factor that comes into play here is pharmaceutical costs. Ten years ago, pharmaceutical costs were about 10 cents on the dollar or 10%. Today, that's grown to 25% of every healthcare dollar, which is an

added pressure on utilization and which may be the biggest factor, overall. All of these things together have created this perfect storm, which has put the pressure on the market.

TODD: Kris, can you talk a little bit about how the plans are distributed, both by the insurance companies and independent agents, and then a little about the commission load, when this started, where they were then, and we'll talk about where they are now, too.

KRIS: This is another area where Minnesota is a little different from the national average, where nationally you probably see agent/brokers being involved in about 50% of all Medicare sales. In Minnesota, that percentage is between 70% and 80%. So, our market's been heavily reliant on the expertise of the agent/broker channel, while nationally, you see a lot of call centers, call center activity, or maybe the carrier call center, and sales call centers being utilized. In regard to the commission load, CMS sets fair market value on commissions, which stems from the MIPA guidance in 2009 that was intended to limit bad actors. So compensation is really set, and I think there's a race to the top where everybody pays fair market value, or you're really not in the market. And those fair market values are set by CMS every year.

TODD: Minnesota is a state that's used to paying a premium for their plans, and the cost plan offered a really nice hybrid option. In a lot of our counties in Minnesota, it's still the only plan in play. With that being said, Mike, can you talk about things like STAR plans and how they affect your reimbursement rates, along with all the factors you've already talked about that are pressuring the plans to stay viable.

MIKE: First, on the cost side, one common question we get is, why can't you have cost and MA together? I think it's important for us to note that it's one or the other, and CMS says you can either have a cost plan or a Medicare Advantage in any given geography or county. Medica offers the nation's largest cost plan, and we feel like that provides a ton of value in rural settings. We will hitch our wagon to that, and continue to serve those populations. In regard to your question about the economics, finances, and the impact of STAR ratings, which came out of the Medicare Modernization Act as a measure for beneficiaries to make informed decisions. What it's morphed into over the years is a tool that is tied to financial measures. Generally speaking, there are four different categories: quality of care, member experience, administration, and pharmacy.If thresholds are met, carriers receive bonus payments for beneficiaries who are in a plan that is, for instance, a 5-star plan or a 4-star plan. Now, I am a big fan of STARS, because it rewards quality; however, the complexity of getting to this point has been burdensome

KRIS: STAR ratings is kind of like taking a test, right? You think you know the rules, and you take the test, and you get a 5-star, right? Then the next year, the government comes in and changes those rules and makes it a lot harder to get that 5-star. Not saying that there's not value in that, but I think at some point in time, the pressure's too high for carriers. Or are there just certain things that can't be attained? So it gets harder and harder to achieve the 4 or 5 star level. And, that has an impact on the funding to the carrier, because the higher the star rating they have, the higher the funding they get. So three-star, I mean, you're hurting, right? You're kind of limping along. CMS doesn't usually look at carriers well who have a 3-star rating, they want to see them go up. That leads to a lot of time, energy, and resources being put into increasing Star ratings.

MIKE: That's a great segue into the latter part of your question, Todd, which is, about the pressures that we're seeing. So, each county in the United States there is a benchmark rate that CMS says, here's what it's going to cost the average person from a fee-for-service or original Medicare perspective. And the math behind those calculations is significant. But we take that benchmark, or that capitation amount, and then we start bidding based on that amount by county. Some counties are 100% counties, some counties are 95% counties, so there are counties within our service area that, out of the gate, we're receiving 95% of that benchmark. There are things like risk adjustment that carriers use to try to influence payments, but in the end, when we look at money coming in the door and what's going out the door, the margins are razor thin. There is also what we call the benefit arms race, where you see carriers across the nation, coming out of COVID and low utilization and we see that cost curve bending the other way, and the benefits that have been implemented are no longer keeping pace with utilization. I think that one piece right there explains about 80-90% of the situation we're in: benefits versus utilization is not matching up.

TODD: Kris, considering the effect of the IRA on Part D, do you believe that's also creating some of this perfect storm?

KRIS: There were a lot of changes to Part D and really what it boils down to is, with the capped out-of-pocket amount, the risk goes to the carrier. So, what do they do? They reduce benefits, or they minimize their formulary. Through the years, you saw a pretty good formulary on Medicare Part D plans, and I think the fear is if you have the out-of-pocket capped at $2,000, you have a capped amount of what this a standard Part D plan increase can be year over year. So, for example, if it's 6% capped, but you need 10% to keep up the pace with the pharmaceutical costs or the utilization, that risk goes on to the carrier. As a result, they're going to have more limited formularies, the costs are going to go up, and you're just going to see overall changes on the Part D.

TODD: To put this in perspective, in the beginning, reimbursement rates were somewhere in the $1,000 range as the national average. In the last 6 years, that has only increased by $100, roughly. On the average, each half of a star rating allows for another 5% of that standard, reimbursement rate. So, if you start at 3 stars, getting to a 5-star can get you quite a bit more dollars against that reimbursement. But if you have networks charging you at 100% of that, and you're getting billed at the highest operational level, that puts carriers at a deficit of north of $150 per member per month. That's a lot to digest, and I don't think a lot of agents know that. I don't think a lot of clients know that. The good news is, we have an advent of some new products for agents to be able to work their way out of the storm. Tom, can you talk about some of the other products that are starting to come out, or things that are being generated to support agents as they start to see diminished commissions and such?

TOM: We're looking at a series of ancillary products through which agents can generate additional revenues. Depending on your state, there are hospital indemnity plans, home healthcare products, short-term care plans, and long-term care plans. I also think we're probably going to see a bit of rebalancing between Medicare Advantage and Medicare supplement sales. And so, here in Minnesota, because we have community rates where it's one price for all ages, we've seen that tip the scale in favor of Medicare Advantage plans. But the introduction of the Medicare Plan N, which has some co-pays, is putting the price point for those Medicare supplement plans at a little lower rate. I think the lowest plan in Minnesota is $161. Now, that's an underwritten plan. But I think, you know, it goes to show that, when we have high-end Medicare Advantage plans we may see a shift or rebalancing in those markets. I do think it's important for agents to take a look of their client base to understand where their risk tolerance and how these options might factor into their business.

TODD: Because there are some government programs that have also create new opportunities, Tom, do you want to talk a little bit about DSNP, MCHO, CSNP, and stand-alone Part D?

TOM: Across the country, since 2024, we've seen a surge in CSNP plans, and in some markets those have become the best-selling products. It's our general take that carriers do have financial incentives to help people who are diabetic or who have heart conditions, for example, to better manage their care, and so we would anticipate that CSNP or chronic special needs plans will continue to grow. The DSNP market remains strong, as well. Here in Minnesota, we have also the MSHO plans that are designed to provide better benefits to people with lower income.

TODD: I'm going to ask Tom a very, very loaded question, and that is… What happened to UCare? And why do other nationals seem to not be supporting the Minnesota market?

TOM: Companies across the country are facing financial pressures, and even the big players are looking at markets differently, and there's been a big shift away from PPO-style plans that typically have richer benefits. Whether it's based on know a formulary change or different co-pays, we'll see plans across the country that go through growth that's probably much higher than what they would normally want to do.That growth factor is maybe the only other thing we haven't talked about, and that there are these layers of risk

KRIS: With regional carriers like Blue Cross, Health Partners, and UCARE, we're within the bounds of the state of Minnesota, and we're at that capitated rate that Mike talked about, which comes with admin burdens and financial pressures. But what's unique in Minnesota is you have one carrier that completely exited the market, and that leaves at 158,000 to 200,000 members, who have to find a new home, and Tom was talking about how that influx of volume and risk is high. One carrier I talked to said, no carrier can handle growth of 158,000 in one year. It's just, unprecedented, and it puts a lot of pressures on all carriers that are left standing in the market.

TODD: I'd like to ask Tom, where do you think we are now, as far as the trade winds, the current administration, and where they're talking about going?

TOM: The disruptions in the market are definitely getting national attention, and conversations are increasing about how we bring healthcare providers, insurance carriers, agent distribution, and CMS together to look for solutions that will better stabilize the market. In the Medicare supplement world, if losses go up, companies can go to the state, refile rates, and keep those plans whole. But in a market like Minnesota, where we have an 11th hour surprise with UCare pulling out of the state completely, carriers can't go back and refile those plans.

MIKE: Medicare is a big ship with a small rudder, and the calendar was at odds with carriers, where we had to hit the submit button and there's really no turning back.

TODD: Kris, where do you see some things coming on the horizon that might be working?

KRIS: My perspective is all about the agent of brokers, and I encourage every agent and broker out there to look at cross-selling. Look at hospital indemnity. Look at dental, vision, and cancer policies–anything you can–because there are going to be some agents who will walk away from the business because they can't financially weather the storm, or walk away from their clientele and focus maybe on other parts of their business. And, there are those that are going to help their members through it. So, as you're having conversations with your clients who have to switch, talk about those other products so you can financially support yourself and weather the storm through 2026. I also think the introduction of DSNPs or CSNPs in the state of Minnesota will hopefully help offset some pressures on the regional carriers and entice national carriers to come back in with those products.

TODD: From a legislative advocacy piece, or for an agent, Tom, what would you advise people to do?

TOM: Well, we do have some very strong associations in Minnesota with NAIFA and NABIP, so follow what they are putting out and look for opportunities to learn and take action to voice your concerns. In addition, the proposed Independent Broker's Time Act is designed to clearly define who these third-party marketing organizations are, and make sure that agents are not lumped in with offshore call centers or lead generators that are on TV. Agents and agencies across Minnesota can reach out to their legislators in support of that bill.

Todd Villeneuve: All right, well, I thank each and every one of you for your time today. I'm blessed to call you my friends and colleagues, and also people that I can actually get the right answer from sometimes. I want to thank everybody for hanging with us for 90 minutes. Hopefully this was informative. I'll leave you with the fact that the head of health distribution at Integrity and CMS have conversations because of the, you know, 660,000 agents they represent at Integrity. And the current administration felt they didn't get in place in time to make any significant changes for this fall. But they are heralding the fact that the broker is the most important link in that distribution of information to the client. They are agreeing with that. Early odds, things were… it was a little iffy, but they are now changing our 100% part of the agent, understanding the agent prop in this distribution process. So. There are the winds of change. But with that, there's some… there is some light at the end of the tunnel here. Hang in there, ask for help. If you need ideas, guys, call us. Thanks, everybody, on the panel. Have a fantastic day.

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