NEW RULE:

Not Business as Usual

5 Key Updates to the 2025 Final Rule that Health Plans Need to Consider

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For Medicare Advantage (MA) plans, the work in front of them may look like it's about continuing to balance the same priorities they always have—member acquisition and retention, risk adjustment, Medical Loss Ratio (MLR) and Star Ratings. But the April 4th publication of The Centers for Medicare and Medicaid Services (CMS) 2025 Final Rule shows that succeeding in MA means that plans will need to think differently...again.

It Starts with the Final Rate Notice

To appreciate the Final Rule, we need to start with the Final Rate Notice that was published a few days earlier. In it, CMS cut benchmark payments to health plans by 0.16%. There has been disagreement in the payer community about what that cut means practically, but even amidst CMS' sunny forecast that plans will see a 3.7% increase in overall revenues in 2025, the real headline is that the Medicare Trust Fund will save $9.2B in 2025. Those savings will come largely from changes in the risk model that amount to a 2.45% reduction in Hierarchical Condition Categories (HCC) payments.

As we head toward 2025, there are 5 key updates made in the Final Rule that MA plans will need to consider to maintain success in the years to come.

1 Member Experience Comes at a Price

As healthcare utilization and costs have risen (seemingly due to members catching up on care missed during the pandemic), CMS is holding firm on their decision to enact cuts, creating increased pressure on plan margins. To combat this, plans will pull back on supplemental benefits that have proven popular and become the norm in recent years.

Medicare Advantage plans from major nationals to smaller regionals have declared their intent to reduce ancillary benefits like vision, caregiver support, and food and produce allowances as they prepare their bids for 2025. And a recent analysis by McKinsey noted that "With the number of plan options increasing every year, the market may have reached a saturation point, leading to benefit designs that evolve from a buffet to a curated menu."[1]

Benefit Reductions May Not be the Answer

Wholesale benefit reductions should not be the long-term answer. Icario's experience with plans in the government space indicates a strong and irreversible trend toward consolidation of member identification, copay, RxBin, supplemental benefits and critical rewards and incentives on a single card. These steps reflect broader trends toward creating a health plan member experience that looks and feels more akin to DoorDash than traditionally sterile healthcare experiences. Particularly in an environment of high inflation, members have come to expect $0 premiums, transportation benefits and gym memberships. Health plans have recognized the marketing appeal and used it to attract members.

Moreover, plans would be wise to proceed cautiously with benefit cuts. Average voluntary member attrition (as measured by Star Measure C26) has steadily increased from 12% in 2020 to 19% in 2024. Even if economic pressures push plans to focus on margin over membership growth, member satisfaction and retention will remain key to MA plan success and profitability.

MA member acquisition costs now regularly exceed $2,000 per member[1], so keeping members until they become profitable (a 4-year endeavor for most MA plans) must remain a focus.

2 CMS Has Also Noticed the Supplemental Benefit Trend

As plans balance competing priorities, the Final Rule articulated an additional requirement that will have implications for both the benefits offered and their communication to members. Recognizing the market appeal of supplemental benefits and that, "plans have reported that enrollee utilization of many of these benefits is low," the Final Rule articulated a specific set of criteria for personalized member outreach to remind the beneficiary what they bought and what has gone unused within the year.

> ***"Beginning January 1, 2026, MA organizations must mail a mid-year notice annually, but not sooner than June 30 and not later than July 31 of the plan year, to each enrollee with information pertaining to each supplemental benefit available through the plan year that the enrollee has not accessed, by June 30 of the plan year."***

This level of complexity and personalization as well as the requirement that the notice be printed and sent will be difficult for plans to achieve. Particularly in an environment where member abrasion is a key concern, plans will need to balance this additional requirement against the many other member touchpoints they need to make each year. By Icario's estimates, health plans send more than 250 individual communications to their members each year.

Moreover, fulfilling the letter of the law—simply complying with the requirement of an annual mailing—may not be in plans' best interests, and it might not be possible. The Final Rule has additional provisions stating:

> ***"Furthermore, we proposed that each notice must include the scope of the supplemental benefit(s), applicable cost sharing, instructions on how to access the benefit(s), applicable information on the use of network providers for each available benefit, list the benefits consistent with the format of the EOC, and a toll-free customer service number including, as required, a corresponding TTY number, to call if additional help is needed."***

Continued communications about member benefits as part of an orchestrated, omni-channel campaign will be more effective both at meeting CMS requirements and at creating member health, good will and profitability.

3 Risk Adjustment is Critical, But Agents and Brokers Likely Won't Complete HRAs

Another way in which the Final Rule and the Final Rate Notice have coincided is the new, blended approach to calculating risk scores in 2025. They'll calculate 1/3 of the risk score using a model from 2020 and 2/3 of the risk score using the 2024 model. This results in the 2.45% reduction in the risk model mentioned above.

In many cases, MA plans rely on Health Risk Assessment (HRA) surveys to help them capture those risk scores, particularly for new members to their plans.

More than 11,000 Baby Boomers turn 65 every day in America. Between 2024 and 2027, that means 4.1 million new Medicare beneficiaries per year.

As these trends continue to play out, the Final Rule proposed changed compensation rules for brokers and agents, redefining compensation and eliminating anti-competitive practices related to paying agents premiums for activities like completing HRA surveys with members they are enrolling. Without compensation, brokers and agents weren't expected to continue to do the work of capturing these HRAs. A lawsuit against the Department of Health and Human Services brought by Americans for Beneficiary Choice and Council for Medicare Choice saw a Texas district court rule in July 2024 against the government and pause enforcement of the new rule.

With plans having made adjustments in response to the original Final Rule and given the uncertainty the court ruling has created, at least for this Annual Enrollment Period (AEP), Medicare Advantage plans will likely be in search of alternative routes through which they will complete new member HRAs. Digital, telephonic, in-home and paper surveys that have long been a staple of HRA completion will become increasingly important channels for MA plans, particularly those that have dual-eligible (DSNP) memberships that carry an additional burden of CMS requirements related to compliant outreach and HRA completion.

Plans acknowledge they need these HRA completions; it's not something they can do without. According to a May 2024 article published in Health Affairs, "44.4 percent of MA beneficiaries had at least one HRA. Among those with at least one HRA, HCC scores increased by 12.8 percent, on average, as a result of HRAs. More than one in five enrollees had at least one additional HRA-captured diagnosis, which raised their HCC score."[2]

4 Part D is Poised to Have a Big Impact on MA Plans

Another change that will create large economic impacts stemming from the Final Rule is the forthcoming change to the Medication Therapy Management (MTM) inclusion criteria. Three key provisions (that will go to the display measure side of Stars in 2025 and 2026 due to the weight of their impact) will expand the eligible membership for MTM. Specifically:

(1) add HIV/AIDS to the list of core chronic diseases, requiring plan sponsors to include all ten core chronic diseases identified by CMS in their targeting criteria; (2) require plan sponsors to include all Part D maintenance drugs and expressly state that Part D sponsors retain the flexibility to include all Part D drugs in their targeting criteria; and (3) revise the methodology for calculating the MTM cost threshold to be commensurate with the average annual cost of eight generic drugs (set at $1,623 for CY 2025).

These changes continue the reshuffling of relative importance among Star Measure domains. With the reduction of CAHPS measures from 4x weights to 2x weights, plans have already rethought their investment in member experience measures. Part D will carry about 15% of the overall plan Star Ratings, and HEDIS will be worth about 25%.

As with supplemental benefits and HRAs, health plan success related to this change in the Final Rule will be dependent largely upon member engagement. The average 2024 Star rating for MTM Program Completion Rate for Comprehensive Medication Review (CMR) was only 3.2. Plans will get a two-year respite from this measure, but when it returns, it will require the engagement of far more members at a higher expense to health plans in terms of both member outreach and benefit utilization. Plans should strategize now, while the measure is in display, for how they will solve for this expansion in 2027.

When the MTM measure returns as a full Star Measure in MY2027, the eligible population for MTM services will nearly double from 7% to 13%. CMS estimates annual costs for MTM services to be $193 million when these changes take effect.

5 CMS Doubles Down on Health Equity

The 2024 Final Rule codified the parameters around which the Health Equity Index (HEI) will replace the reward factor as a key incentive for health plans. While not a one-to-one replacement for the reward factor, the HEI represents CMS' decisive shift to identifying and rooting out inequalities in MA plans.

2025's Final Rule reasserts that intention by adding new requirements to how plans will need to apply health equity to their application of utilization management criteria. Specifically, the new provisions state that:

(1) at least one member of the UM committee has expertise in health equity, (2) the UM committee conducts plan-level annual health equity analysis of prior authorization policies and procedures used by the Medicare Advantage plan, and (3) the results of the analysis be made publicly available on the plan's website.

These compounding decisions related to health equity serve as a reminder that CMS is serious about enacting measures to ensure the even distribution of Medicare Advantage benefits across populations. Identifying members who will be counted in the denominator of the HEI is step number one. CMS committed to articulating which measures will be included in the evaluation at a future date, but plans should begin ensuring they have a solid understanding of their dual eligible membership, those qualifying for subsidies, and those with disabilities.

Health equity is another reason plans should move cautiously to ensure that supplemental benefits are in place to address members' most common barriers to care. According to the Commonwealth Fund, transportation, housing, and nutrition security benefits have the greatest impact for both health plans and members.

Finally, even members who don't have the added burden of social risk factors struggle to know what their benefits entail. And communicating with members who have housing or food obstacles can be a challenge. Enacting a multi-channel communication approach and ensuring they are written in a way that can overcome low levels of health literacy are keys to success.

Moving Into 2025 and Beyond

In the 2025 Final Rule, CMS made significant changes that represent a seismic shift in how Star Ratings will be determined over the next several years. The only practice that remains "Business as Usual" is the need to maintain a strong focus on member experience and retention. How that is achieved will require health plans to think and act differently. Investments in the essential expertise, programs and infrastructure will be key in ensuring plans remain not only compliant, but competitive in this new market landscape.

1. (2024, March 13). The future of Medicare Advantage. McKinsey & Company. https://www.mckinsey.com/industries/healthcare/our-insights/the-future-of-medicare-advantage#/

2. (2024, May). Medicare Advantage Health Risk Assessments Contribute Up To $12 Billion Per Year To Risk-Adjusted Payments. Health Affairs, 43(5). https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2023.00787?journalCode=hlthaff

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MK002-Rev2-07-24