AEP 2027 Outlook:

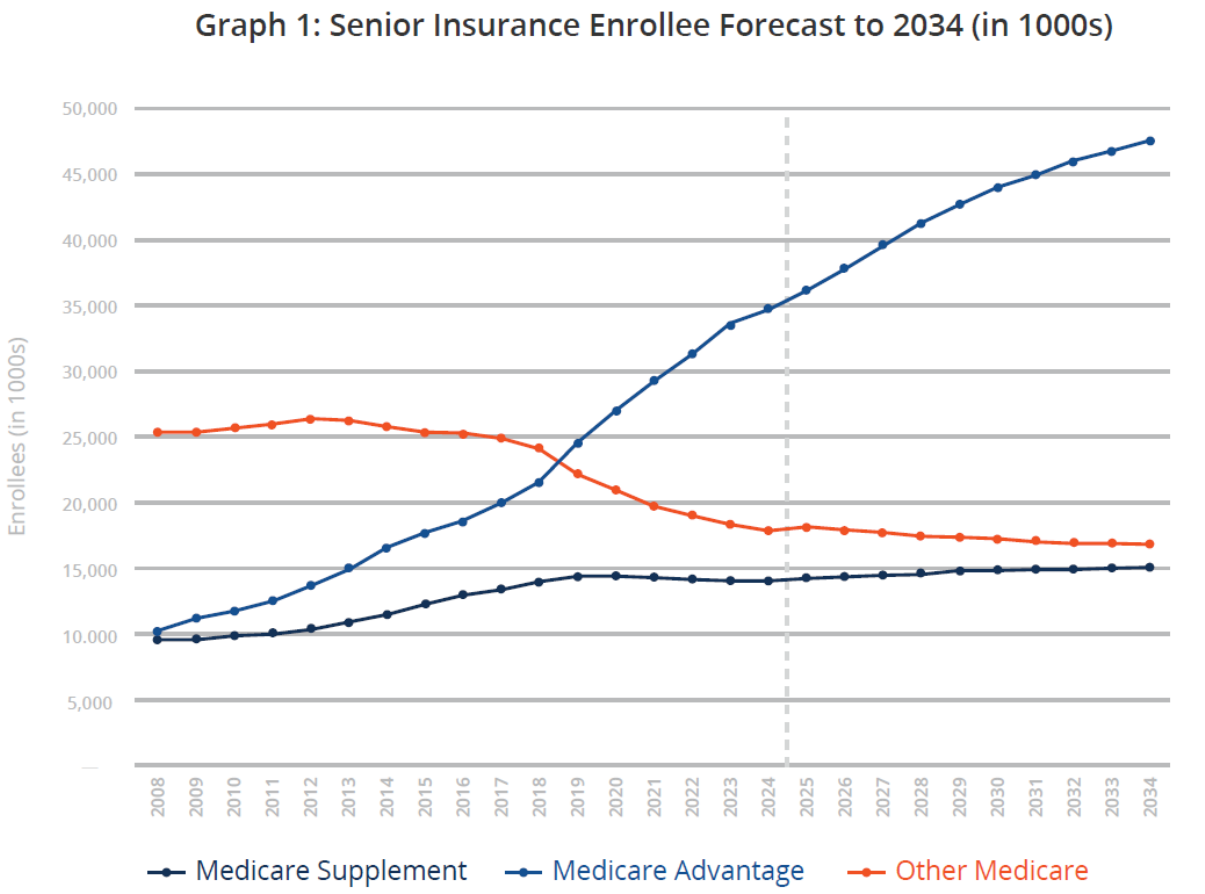
OPPORTUNITIES IN A DESTABILIZED MARKET

OPPORTUNITIES AMID DISRUPTION

The Medicare space is facing formidable, if not unprecedented, headwinds. The industry is seeing compressed margins, regulatory pressure, changing stakeholder expectations, technology advances and, more recently, negative public sentiment. However, there are still many opportunities for agents who adjust their businesses, leverage technology, and do right by their clients. This white paper provides a view of the private Medicare industry from multiple dimensions.

DEMOGRAPHICS AND PROJECTIONS

According to Omaha-based actuarial consulting firm **Telos Actuarial**, about 40 million individuals in the next 10 years are expected to turn 65 and the Medicare population is expected to grow from 67.6 million to 80.5 million beneficiaries. As nearly 13 million more individuals will be added to the Medicare program, this represents a 19% increase. Beyond 2034, another 3 million beneficiaries are projected to be added by 2040. Projected enrollments by product type are listed here, with MA-PD plans projected to continue to grow the most.



Source:
https://static1.squarespace.com/static/62743ad114b54d6e9e8ff613/t/687ea5698729f44f73dae85c/1753130346095/The+Future+of+Medicare+Supplement+-2025.pdf

The demographics alone are compelling and suggest that the industry will continue to grow despite a number of headwinds. The dual-eligible enrollments (those on Medicare and Medicaid), which are key to call centers, will likely decline, however.

LEGISLATION

The **Inflation Reduction Act** (IRA), signed into law Aug. 16, 2022, had a major impact on standalone Part D with carriers increasing premiums and ceasing agent commissions. This likely removed incentives for consumers to avoid high-cost drugs, such as GLP-1s, which are driving prescription drug costs higher, according to conversations with national carriers. Major legislation passed with the new administration includes the **One Big Beautiful Bill Act** (OBBBA), which deeply affects Medicaid (primarily the Affordable Care Act market), but not Medicare.

There are a number of proposals to increase Medicare Advantage oversight and reform, including risk adjustments, upcoding of conditions carriers apply using Health Risk Assessments to maximize reimbursements (**S. 1105**) and prior authorization (**HR 3514/S.**

4532). In addition, Congressional advisory groups such as MedPAC, Paragon and Commonwealth have issued reports questioning compensation to agents as creating churn and steering clients to a plan that maximizes compensation to the plans that pay more. Smaller carriers also claim the larger carriers have an unfair advantage in paying agents fees above Fair Market Value regulated amounts.

The **2025 Trustees of the Social Security and Medicare trust funds report** projected that the Hospital Insurance Trust Fund — which pays for Medicare Part A and some in-home care and for hospice care — will only be able to pay 100% of total scheduled benefits until 2033. At that point, that fund's reserves will become depleted and only able to pay 89% of total scheduled benefits, unless Congress acts.

Additionally, the Trump administration could issue rules that would impact Medicare in 2027 after the midterm elections, assuming Republicans remain in control of Congress. The Medicare Advantage program is very popular with seniors, and elected officials generally support the program, particularly Republicans. Even so, Republicans' desire to weed out fraud, waste and abuse could lead to other changes.

As of mid-June 2026, there doesn't appear to be any proposed legislation that threatens the private market. Medicare is often referred to as the third rail of politics, and prior funding challenges have always been met by Congress on a bipartisan basis. The move by President Trump to implement "Most Favored Nation" drug pricing — which seeks to match the costs of prescription drugs in the United States to the lowest price offered in other developed nations — may or may not have a material impact.

Regulatory Environment

In the industry's most highly watched legal matter, a Centers for Medicare and Medicaid Services (CMS) rule issued in April 2024 would have limited Medicare Advantage program administrative payments, standardized compensation payments and restricted contracts with third-party marketing organizations other industry organizations argued that these changes to the compensation rules would limit consumer education and access to Medicare products, reduce market competition and increase overall costs for consumers. A Texas judge in July 2024 issued a stay preventing CMS from implementing a portion of its regulation until a final decision was issued. On Aug. 18, 2025, the same judge issued an opinion that's a clear win on the industry organizations' challenges to the most critical portions of the CMS rule.

The district court vacated the fixed fee and the contract-terms restriction, concluding that:

(1) both provisions exceed CMS's statutory rulemaking authority;
(2) both provisions are arbitrary and capricious, and
(3) vacatur is the appropriate remedy.

Because U.S. District Judge Reed O'Connor went beyond his preliminary injunction order and ruled that CMS exceeded its statutory authority, the decision should go a long way to ensure that CMS cannot simply use a new rulemaking process to pass a similar rule.

In separate matters, the Department of Justice (DOJ) has filed suit against several top carriers, along with three prominent call centers. All named parties are defending against the lawsuit. Much of the issue surrounds the use of co-op marketing funds. One carrier is further challenged by DOJ on overcharging by upcoding health conditions to maximize reimbursement, impacting its publicly traded stock price significantly. Carriers prior authorization methods have also drawn political fire.

Carrier Reimbursement

Lower reimbursement rates have resulted in carrier plan closures and plan exits from many geographies. Expect 2024 to go down as the year when MA-PD benefits were the richest. Most carriers are reducing geography and benefit designs on MA-PD plans, the first contraction in the 20 years of the MA-PD industry. Reimbursement rates went up to 5.06% for 2026, pleasing many carriers, but that doesn't make up for the cuts they received in 2024 and 2025, which fell far short of medical trend. Reimbursement for 2027 increased essentially by 4.5% which indicates fewer plan disruptions in 2027 compared to 2026.

CMS announced a significant expansion of its auditing efforts of Medicare Advantage carriers to ensure that proper coding of health conditions is documented. CMS had fallen several years behind in its Accelerated Risk Adjustment Data Validation, and the perception is carriers have received more reimbursement than what is justified and lawful.

The Premium Stabilization Demonstration was enacted in 2025 to help absorb Part D prescription drug sticker shock for consumers caused by passage of the Inflation Reduction Act. On July 28, 2025, CMS announced a pullback on the subsidy, setting the stage for continued disruption and higher consumer premiums for Part D in 2026. In response, carriers in 2025 suppressed electronic enrollment methods and discontinued commissions in MA-PD markets that carriers plan to discontinue in 2026. Demonstration programs generally last for three years so the future of Part D is questionable. There are five carriers remaining in the market and only one carrier pays partial commissions in selected states. Agents are conflicted on providing drug plan reviews for clients when no compensation is available.

Medigap and the Birthday Rule

The trend of consumerism is growing, with more states — both red and blue — adopting the "birthday rule." **The birthday rule** allows policyholders an open enrollment period each year surrounding their date of birth without the fear of being turned away due to health conditions. While the opportunity for beneficiaries to change plans without underwriting sounds like a good thing, it actually comes with unintended adverse consequences that

will ultimately affect the very consumers these policies are meant to help. First, if carriers are forced to take on high utilization clients on a guaranteed issue basis, they pass those costs along to their other policyholders in the form of higher premiums. Second, carriers reduce agent commissions significantly. if agents aren't going to get paid commission on the business, consumers do not have ready access to the help and advice they need.

To the point about higher premiums, large rate increases have been filed by leading carriers, with some reaching 40% annual increases in premiums paid by consumers. This is due in part to higher than expected medical utilization following the pandemic. In addition to high rate increases, we also have seen a number of Medicare Supplement carriers and reinsurers leave the market, including Swiss Re:, Manhattan Life, Lumico, Allstate, US Fire and others.

Recent conversations with leading carriers indicate that medical utilization remains higher than anticipated and hasn't stabilized. This cycle should moderate as Part B claims for orthopedic procedures such as knee and hip replacements that were delayed during the pandemic come down. A new phenomenon is the behavior of new retirees who are frequently putting off medical procedures until they go on Medicare. In the past, it was more likely a person about to retire would get procedures done while still on group insurance.

Legislation passed in Minnesota may be a solution considered by other states. The bill permits the insurance carrier to levy a surcharge in situations where a Medicare beneficiary exercises guarantee issue. Other states may follow suit and determine how large of a surcharge will be permitted. In addition, ancillary product designs complementing the High Deductible G plan may help provide another pricing point for consumers beyond traditional plans G and N.

Carrier Actions in a Period of Market Contractions

An estimated 1.5 to 2 million MA-PD clients experienced a service area reduction or plan termination in 2026. There was a cascading effect in certain markets where carriers tried to suppress enrollments by cutting commissions and reducing enrollment methods. For plan filing in June of 2026, CMS requested carriers to disclose their commission plan for 2027. CMS also cautioned the carriers on suppressing plan information and enrollments and that it would monitor carrier actions for 2027 plan year.

Several large carriers took defensive actions shortly after the record-setting AEP of 2024, including Aetna, Elevance (Anthem), Cigna and Wellcare. Humana dropped 28% of plans in 2025, CVS/Aetna 26% and UnitedHealthcare (UHC) 15%, according to an OliverWyman analysis of CMS data. Most notable were the changes at UnitedHealthcare, the nation's largest MA-PD carrier. UHC announced in July 2025 that it planned to drop several Medicare Advantage plans that collectively cover more than 600,000 people, disrupting the market, particularly in rural areas. Because so many were PPO plans, a significant number

of in-force cases had to be rewritten as HMO plans with UHC or be switched to another carrier. For plan year 2026, most Medicare Advantage plans degraded benefits and the market shifted from traditionally seeking larger market share to seeking to improve profitability. Humana's plans emerged as increasing market share in 2026, more than it had budgeted and I suspect we'll see benefits degraded in 2027 by Humana to be more on par with the industry.

Some regional carriers have exited or reduced commissions in the Medicare market because of financial concerns. Most notably, Minnesota-based nonprofit health plan UCare reported an operating loss of $504 million in 2024. MA-PD publicly traded stocks such as UHC, Anthem and CVS/Aetna were beaten down by losses but show signs of recovery in 2026. The growth market for 2026 is Chronic Special Needs Plans (C-SNPs), as it was the only plan type showing expansions for 2026. The trend for C-SNPs is expected to continue in 2027. Following a period of unprecedented growth, the distribution market for Affordable Care Act (ACA) individual health insurance plans faces instability. The enhanced ACA subsidies introduced during the pandemic expired at the end of 2025. The potential end of those subsidies as well as rising health care costs and increasing utilization of high-priced drugs are some of the main factors driving ACA Marketplace insurers to raise premiums on average by about 20% in 2026. This disruption in the ACA markets will drive a trend for distributors to re-engage with Medicare products.

TECHNOLOGY AND DISTRIBUTION

As quoting and enrollment tools have advanced to help agents work more efficiently, SMS has led the industry with its technology, including Lead Advantage Pro® and Medicare Insurance Direct®. Today, robust agency management systems (AMS) are moving beyond generic customer relationship management (CRM) systems to help agents further streamline their operations, manage client data and compliance, and enhance productivity. In addition, applied use of artificial intelligence (AI) is moving rapidly. There is great interest in AI's potential applications and pursuing the best AI and AMS solutions for agents. A growing trend is carriers introducing Benefit Activation processes where the agent engages the client post enrollment for scheduling a wellness visit with their provider, completing a Health Risk Assessment, signing up for mail order pharmacy, etc. The role of the agent expands and the likelihood of engagement with the Medicare beneficiary increases due to the relationship with the agent. As Quality Stars is shifting away from metrics to outcomes, the agent can influence the beneficiary perhaps more than a call from a carrier.

Distribution

Due to quality of business and lower marketing support, a number of call centers now have less of an impact on the market. Together Health, creators of the Joe Namath commercials is no longer in the Medicare space. GoHealth, the nation's largest call center, filed for Chapter 11 bankruptcy in mid-2026. Publicly traded call centers like eHealth and

SelectQuote have struggled with their stock prices in the last two years. The NAIFA Medicare Collective published Gold Standards for call centers as the industry works to better police itself.

SUMMARY

Original Medicare was signed into law July 30, 1965, and the current environment is perhaps as destabilized as it's ever been. We can assume the Medicare Trust Funds will be secure, as no politician is willing to risk their career on seeing the program fail. Expect 2027 to be disruptive again, but less than 2026, with many MA-PD consumers seeking to change plans due to service area reductions, plan terminations and benefit reductions. Medicare Supplement has yet to stabilize in terms of utilization, and the birthday rule will likely extend to additional states. So more rate increases are likely, which we expect will suppress consumer interest in this plan choice. Part D has become a product desert and the uncertainty surrounding the Premium Stabilization Demonstration funding is

The demographics alone will continue to fuel industry growth despite the headwinds. All told, the industry is in a cycle, but the demographics alone spell opportunity in the private Medicare market. It will continue to be an ever-changing business that favors distribution that focuses on education and doing the right thing for clients.

Recommendations to CMS to Help Stabilize the Market

Part D

- Utilize Maximum Out-of-Pocket calculation instead of True Out-of-Pocket Cost, which includes manufacturer's discounts and rebates. It is highly unlikely that Congress passed the IRA legislation understanding the differences in how the $2,000 out-of-pocket costs are calculated.
- Evaluate how risk scores are determined, permitting pharmacy data to improve accuracy and
timeliness, not just relying on medical records.
- Require commissions and enrollment methods be adhered to once CMS approves the product.

Medicare Advantage

- Redefine third-party marketing organization designation (TPMO) to differentiate the various players in the market and their regulatory requirements.
- Seek retention programs that should be expected of call centers. No call centers should be focused exclusively on customer acquisition.
- Stabilize the market for 2027 by ensuring adequate carrier reimbursement while cracking down on upcoding and any fraudulent activities.

Medicare Supplement

- Increase the number of plan choices, as it has been 15 years since modernized plans occurred. With recent high premium increases, Plans G and N are unaffordable for many consumers.
- Reexamine plan choices including providing ancillary products to help reduce the out-of-pocket cost of a High Deductible G plan.
- Allow carriers to levy a surcharge in guaranteed issue situations such as the birthday rule. Minnesota recently passed legislation as a possible model to consider in other states.

ABOUT THE AUTHOR:

As Senior Vice President, Med Solutions, Dwane McFerrin, CLU®, CFP®, RHU®, CLTC®, LLIF, has helped position Senior Market Sales® (SMS) as a market leader selling Medicare Advantage and Part D in addition to Medicare Supplement. He is responsible for the strategic direction of the Medicare product line, carrier relationships and a team of marketing consultants who support sales in excess of 725,000 new business applications into Medicare-related products annually.

Dwane has more than 30 years of experience in executive-level positions in the insurance industry. Prior to joining SMS, he was Vice President of Marketing at Mutual of Omaha and a Senior VP of Agency at Physicians Mutual Insurance Company. He has a strong background in the senior market, sales management, association and worksite marketing, client development and lead generation.

In 2020, the Omaha Association of Health Underwriters (OAHU) presented Dwane its Underwriter of the Year Award recognizing distinguished service to the association and the industry. In 2026, Dwane received NABIP's Spirit of Freedom award for legislative advocacy. Dwane served as Chair for eight years on NABIP's Medicare Working Group, served a two-year term on the Omaha AHU Board of Directors and served on NABIP's mental health task force and prescription drug task force. He also is a founding member of the NAIFA Medicare Collective. A frequent industry speaker, Dwane is respected as a thought leader in the Medicare space.

Dwane holds a Master of Science Degree in Industrial/Organizational Psychology from the University of Nebraska at Omaha, a Bachelor of Arts from Central College and LIMRA's Leadership Institute Fellow designation. Dwane also served as an adjunct professor at Bellevue University's MBA Capstone Class.