MEDPAC

Advising the Congress on Medicare issues

The Medicare Advantage program: Status report

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Presentation roadmap

1. Overview of Medicare Advantage enrollment, plan availability, and market structure
2. MA rebates and supplemental benefits
3. Update on MA plan payments
4. Enrollees with ESRD: Medicare payments, enrollment trends, and MA plan costs

MedPAC's MA status report

- The Commission is required by law to report on the status of the MA program in March of each year, including a review of:
  - Payment policies, risk adjustment methods, the impact of risk selection, mechanisms for promoting quality, access to care, and other issues
- We examine MA enrollment trends, plan availability for the coming year, plan generosity, and Medicare spending

Note: MA (Medicare Advantage).

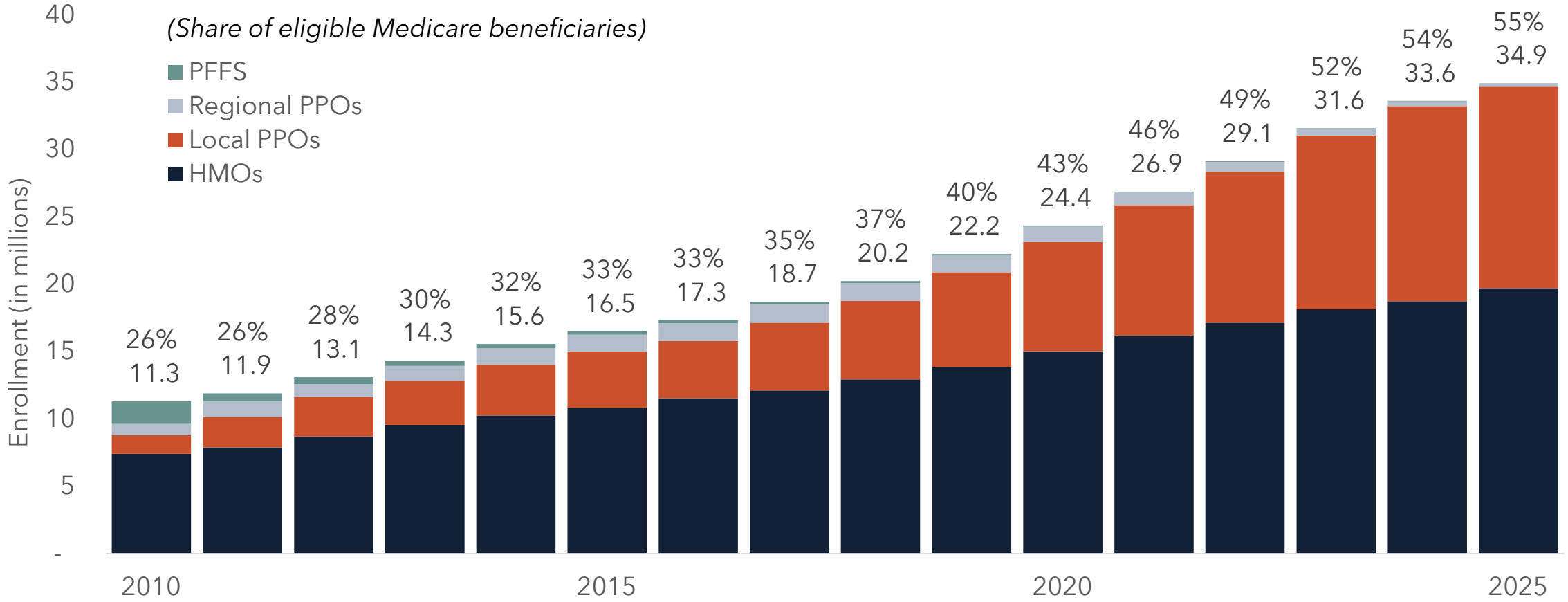
The Commission supports the inclusion of private plans in Medicare

- Beneficiaries in MA receive benefits from private plans rather than the FFS program
- For beneficiaries, the primary trade-off is access to the lower premiums, cost sharing reductions and additional benefits MA plans provide versus a broader choice of providers and fewer constraints on utilization in FFS
  - MA benefits often offer better protection against high OOP spending
- MedPAC has recommended important reforms to improve Medicare's policies for paying and overseeing MA plans

Note: MA (Medicare Advantage), FFS (fee for service), OOP (out of pocket).

MA enrollment, plan availability, and market structure

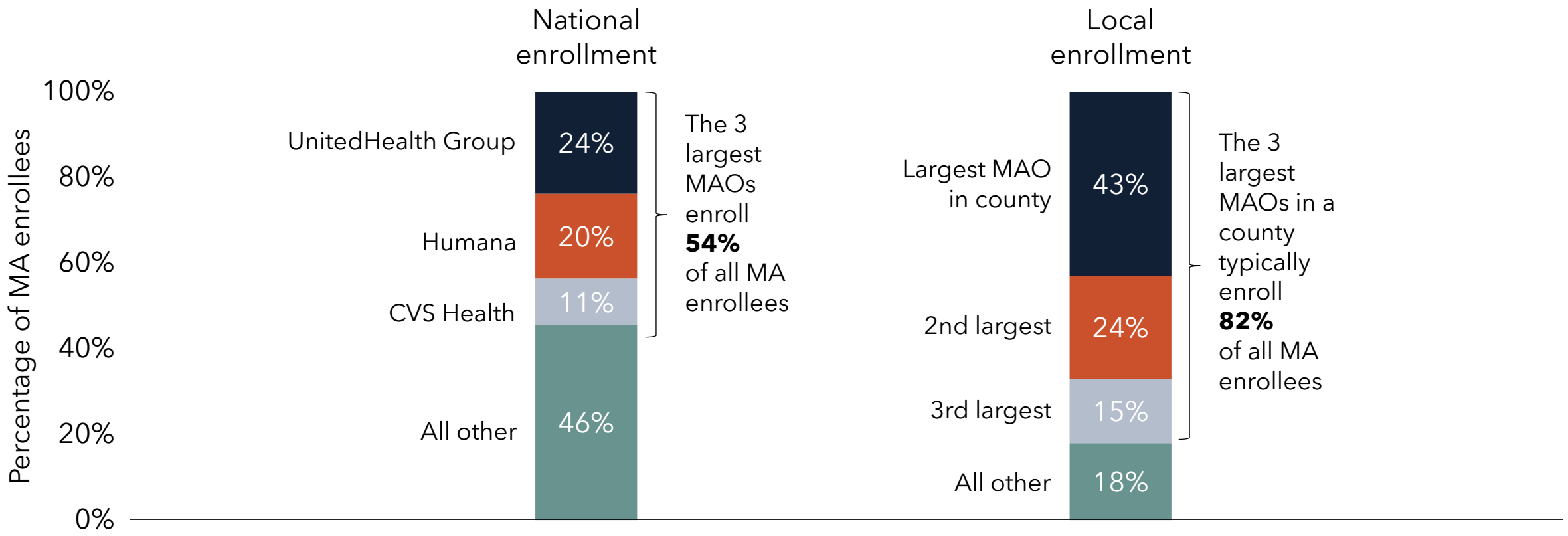
In 2025, 55% of eligible beneficiaries enrolled in MA plans



Note: MA (Medicare Advantage), PFFS (private fee-for-service), PPO (preferred provider organization), HMO (health maintenance organization). Beneficiaries must have both Part A and Part B coverage to enroll in an MA plan, so beneficiaries who have Part A only or Part B only are not included in this figure.

Source: MedPAC analysis of CMS enrollment files, July 2010–2025.

MA enrollment is highly concentrated at the national and local level



Note: MAO (Medicare Advantage organization). Employer plans and special-needs plans are excluded.
Source: MedPAC analysis of CMS July 2025 enrollment data.

MA plans available to nearly all Medicare beneficiaries; number of choices is stable

Plan Availability	2025	2026
Share of beneficiaries with access to:		
Any MA plan	>99.5%	99%
$0 premium plan with Part D	99	98
Avg. number of choices (beneficiary weighted)	42	39
Avg. number of insurers (beneficiary weighted)	8	8

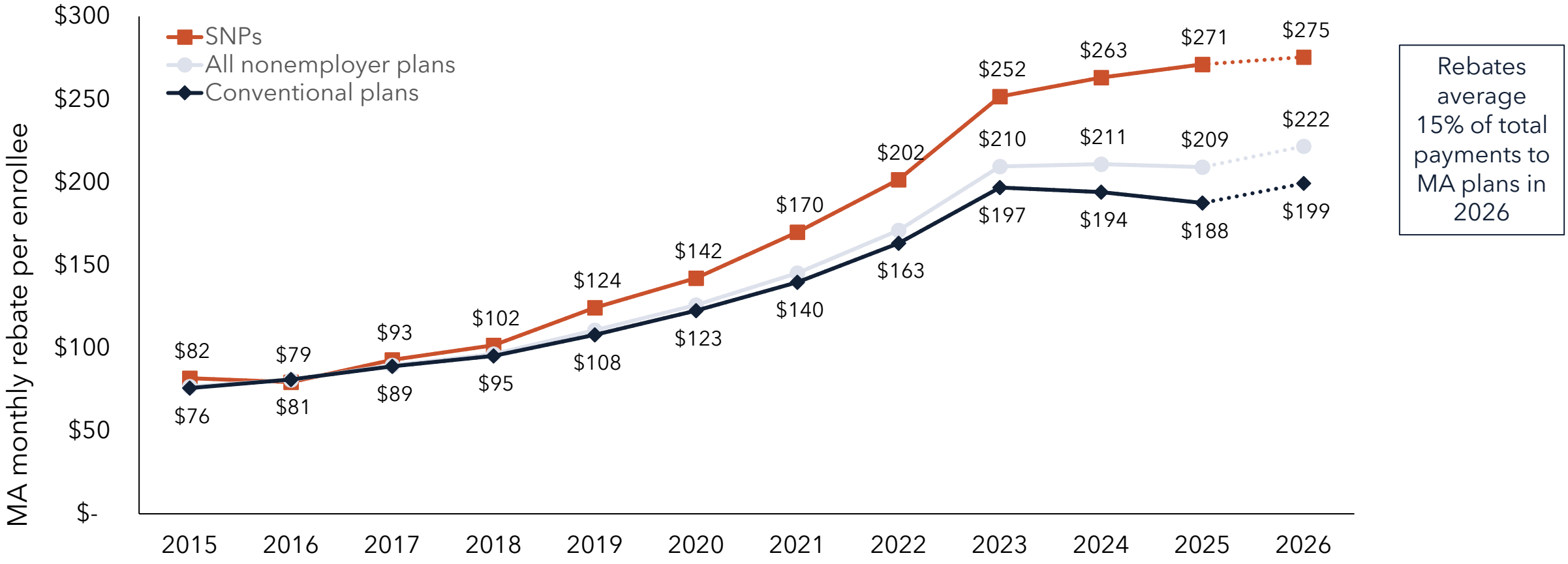
- Beneficiaries continue to have many plans available to them in 2026
- 98% of beneficiaries have a D-SNP in their county
- Number of plan choices is slightly lower than 2025, number of insurers is stable

Note: MA (Medicare Advantage), D–SNP (dual-eligible special-needs plan). Plan availability does not include special-needs plans and employer plans.

Source: MedPAC analysis of CMS bid and enrollment data.

MA rebates and supplemental benefits

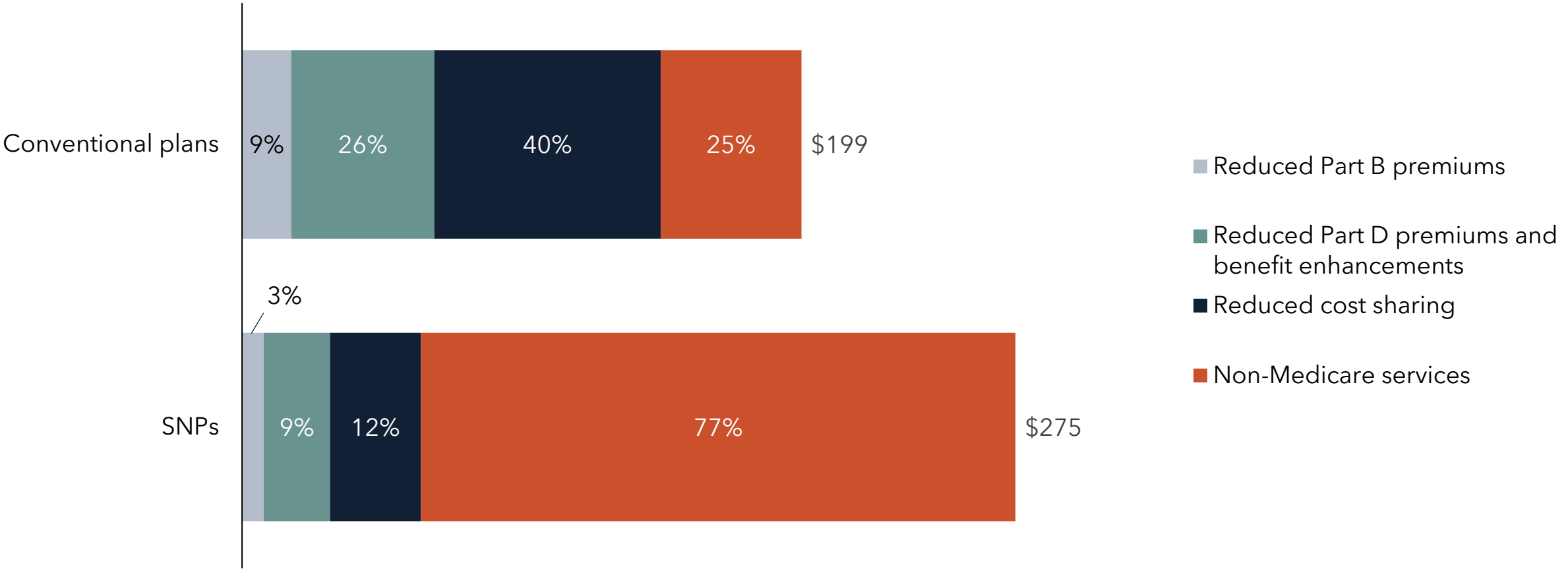
MA rebates projected to reach historic high in 2026



Note: SNP (special-needs plan), MA (Medicare Advantage). Excludes employer plans and plans that do not offer a prescription drug benefit. Projected growth in rebates from 2025 to 2026 exceeds consumer price index growth for that period.

Source: MedPAC analysis of data from CMS on plan bids, 2015–2026.

MA plans offer reduced cost-sharing, lower premiums, and additional services financed by rebate



Note: SNP (special-needs plan), MA (Medicare Advantage). Excludes employer plans.
Source: MedPAC analysis of data from CMS on plan bids, 2026.

MA plans spent nearly $24 billion on non-Medicare services in 2023

Benefit category	Total spending (billions)	Percent
Dental	$6.6	28%
Non-primarily health related	5.8	24
Over the counter	4.4	18
Vision	1.8	7
Transport	0.9	4
Fitness	0.7	3
Hearing	0.7	3
Meals	0.6	3
All other	2.5	10
Total	**23.9**	**100%**

- Supplemental benefits can address health challenges that many seniors face as they age
- For 2023, MAOs are newly required to report how much they spend on the non-Medicare services offered as supplemental benefits
- MAOs spent nearly $24 billion on such benefits in 2023
  - Dental benefits and non-primarily health related benefits accounted for more than half of reported spending

Note: MA (Medicare Advantage). Includes spending reported by contracts for health maintenance organizations (HMOs), local and regional preferred provider organizations (PPOs), and private fee-for-service (PFFS) plans.

Source: MedPAC analysis of MA medical loss ratio data from CMS, 2023.

Preliminary and subject to change

Update on MA plan payments

Medicare's payments to MA plans

- Payment to plan = base rate × average risk score
- Base rate is based on plan bids, benchmarks, and quality scores
  - A bid is the amount each plan expects it will cost to cover Part A and Part B services
  - Benchmarks range from 115% of FFS in lowest-FFS-spending counties to 95% of FFS in highest-spending counties (4 quartiles of counties)
    - Can be increased by 5% or 10% as a quality bonus for plans achieving 4 or more stars
- Nearly all plans bid below their benchmark
  - Plans receive a base payment equal to their bid plus a "rebate," which is a percentage (varying by quality score) of the difference between bid and benchmark

Note: MA (Medicare Advantage), FFS (fee-for-service). If a bid is greater than the benchmark, Medicare pays the benchmark and the enrollee pays a premium to make up the difference. However, this scenario is rare.

MA plan payment policy: Risk adjustment

- Risk scores are a beneficiary-specific index of predicted spending relative to national average spending (a 1.0 risk score)
  - Based on beneficiary demographic characteristics and diagnoses
  - Increase MA plans' base payment rates for enrollees expected to have higher spending and decrease rates for enrollees expected to have lower spending
  - Used to standardize the FFS spending estimates that are used for county benchmarks
- The risk model is developed using data for FFS beneficiaries; spending predictions are distorted when MA enrollee tendencies differ from FFS
  - Coding intensity results from MA diagnostic coding patterns that differ from FFS
  - Favorable selection results from MA enrollees having spending tendencies that differ from the average FFS beneficiary, independent of coding intensity

Note: MA (Medicare Advantage), FFS (fee-for-service).

Comparing spending on MA and FFS Medicare

- Each year, the Commission compares spending on MA to what Medicare would have spent if MA enrollees were instead enrolled in FFS
- Account for differences in health status, including favorable selection, diagnostic coding differences, geographic distribution, and Medicare service coverage (e.g., hospice)
- Relative to FFS, spending on MA varies due to:
  - Payment policies unrelated to risk adjustment
  - Intensity of MA coding relative to FFS
  - Favorable selection of beneficiaries into MA

Note: MA (Medicare Advantage), FFS (fee-for-service).

Inclusion of the ESRD population in our MA to FFS spending comparisons

- In response to commissioner interest, we now estimate what FFS spending would have been for MA enrollees with ESRD
  - Account for the differences in how payments are set for the dialysis, kidney transplant, and post-transplant populations
- For 2026, payments to MA plans for enrollees with ESRD are a projected 12% above what FFS spending would have been
  - Estimated before the effects of coding and selection: 3%
  - Estimated effect of coding intensity: 9%
  - Estimated effect of favorable selection: 0%
- The ESRD population has a small effect on overall MA estimate (6% of MA payments in 2026)

Note: MA (Medicare Advantage), FFS (fee-for-service).

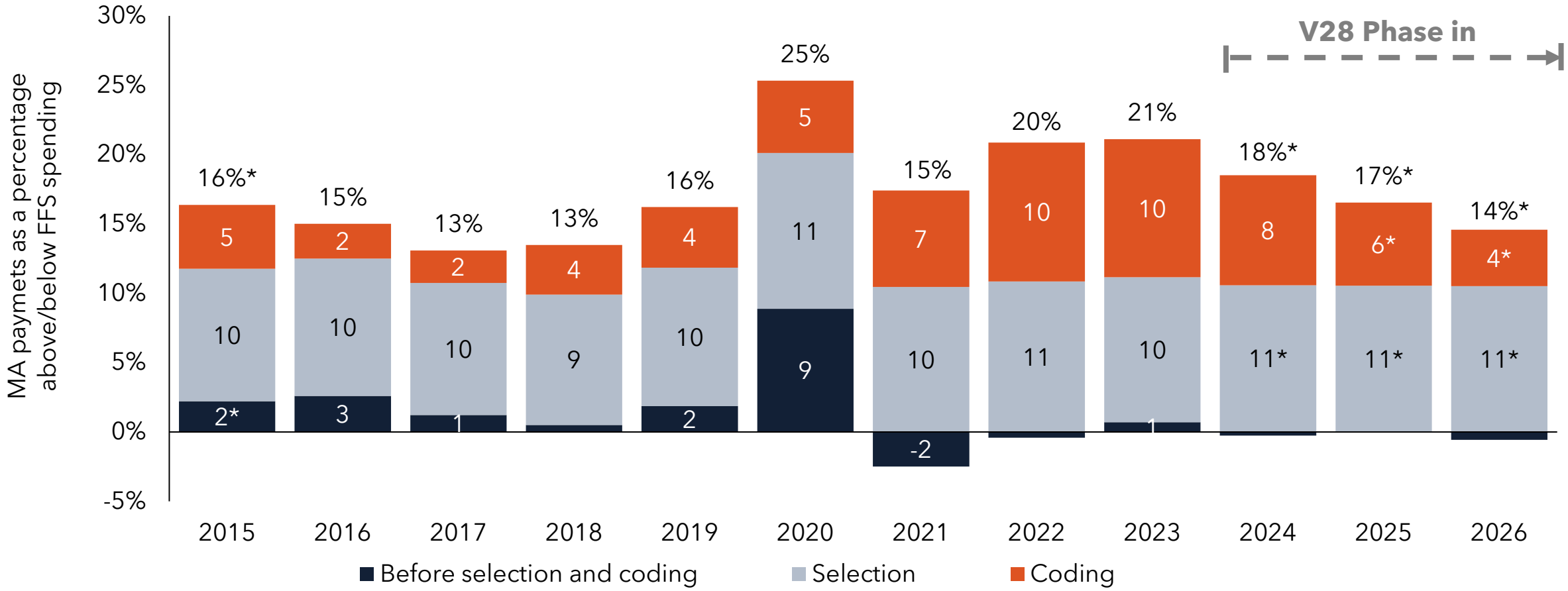
Estimated effects of coding and selection push MA benchmarks, bids, and payments higher relative to what spending would have been in FFS

	Share of FFS spending in 2026		
	Benchmarks	**Bids**	**Payments**
Overall	124%	95%	114%
Estimated before coding and selection	107	83	99
Estimated coding effect (net of CMS coding adjustment)	+4	+3	+4
Estimated selection effect	+12	+9	+11

Note: MA (Medicare Advantage), FFS (fee-for-service). The "overall" estimate of benchmarks, bids, and payments as a share of FFS spending incorporates all three components of MedPAC's methodology for comparing payments: (1) a base comparison of MA payments to FFS spending that standardizes for differences in risk scores and geography but does not account for the effects of coding intensity and favorable selection; (2) an adjustment to that base comparison for favorable selection; and (3) an adjustment for coding intensity. The values in the "estimated before coding and selection" row reflect estimates using only the base comparison, without adjusting for the effects of coding intensity and favorable selection. The values in the third and fourth rows are the additive adjustments to the base comparison for the effects of coding and selection. Estimates of payments include beneficiaries with end-stage renal disease. More details on our methodology can be found in the chapter and in the technical appendix. Components may not sum to totals due to rounding.

Source: MedPAC analysis of data from CMS on plan bids, enrollment, benchmarks, FFS expenditures, and risk scores.

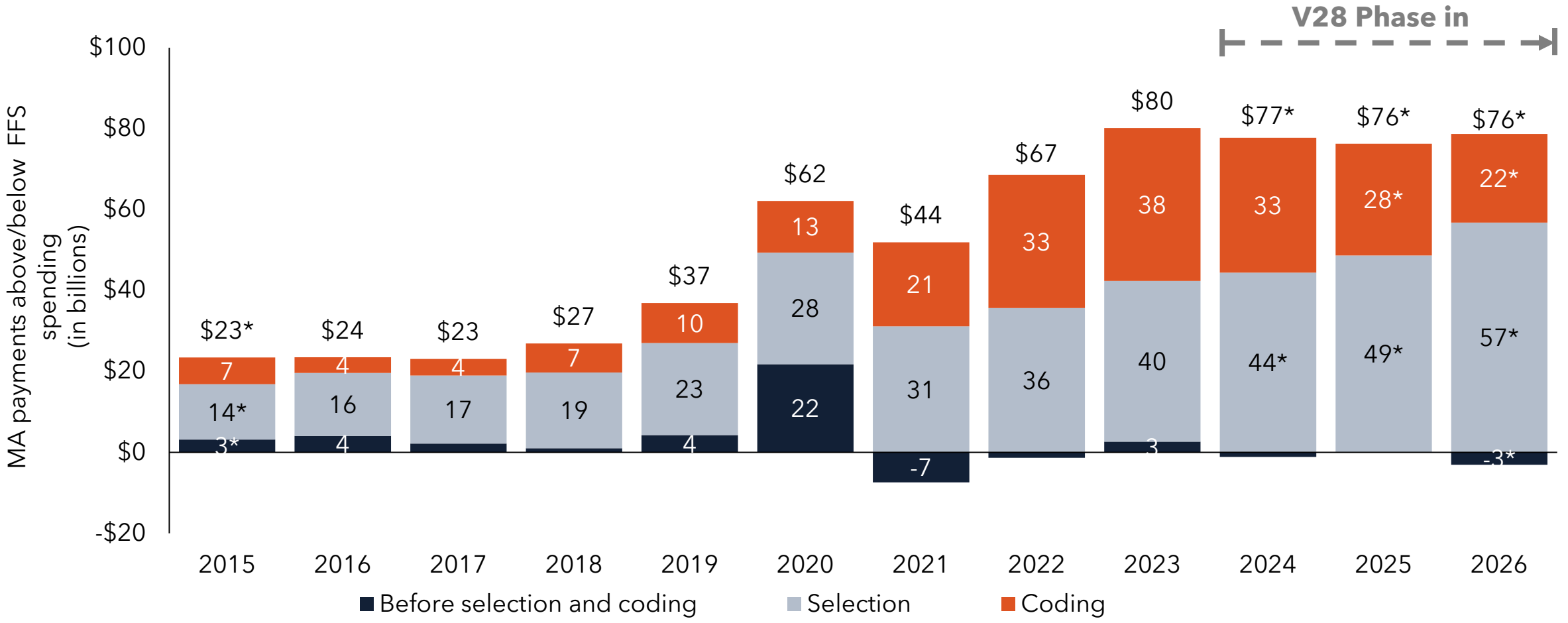
V28 reduced coding intensity in recent years; MA payments still exceed what spending would have been in FFS



Note: MA (Medicare Advantage), FFS (fee-for-service). Components may not sum to totals due to rounding. Estimates from 2016 through 2023 use actual MA and FFS data. Unidentified values indicate less than 0.5%.
* Specified values used projected data.

Source: MedPAC analysis of Medicare enrollment, Medicare claims spending, and risk-adjustment files.

MA payments $76 billion above what spending would have been in FFS in 2026



Note: MA (Medicare Advantage), FFS (fee-for-service). Components may not sum to totals due to rounding. Estimates from 2016 through 2023 use actual MA and FFS data. Unidentified values indicate less than $3 billion.
* Specified values used projected data.

Source: MedPAC analysis of Medicare enrollment, Medicare claims spending, and risk-adjustment files.

Changes to estimated MA and FFS spending comparison reflect the full implementation of V28 and data updates

- This year's projected MA to FFS spending comparison for 2026 (14 percent) is lower than last year's projection for 2025 (20 percent)
- Updates to coding intensity estimate account for the difference
  - Incorporating new data lowered the projected 2025 overall estimate from 20 percent (last year) to 17 percent (this year)
  - Projecting from 2025 to 2026 further lowers the overall estimate to 14 percent due to the final phase in of the V28 risk model (from two-thirds in 2025 to 100 percent in 2026)
- Other updates for newer data and methodological improvements had very small effects on recent estimates

Note: MA (Medicare Advantage), FFS (fee-for-service).

V28 risk model corresponded with reduced payments, stable supplemental benefits, and high plan availability

- The Commission supported the V28 risk model to mitigate higher payments from coding intensity
- After the V28 model was introduced, from 2024 to 2026:
  - MA payments decreased relative to FFS, due to lower coding intensity
  - Supplemental benefits, measured by rebate levels, were stable
  - Plan availability remained high and stable
- Bid data suggest plans adapted to lower payment rates by lowering projected costs and bids; in 2026 we estimate:
  - MA plans' bids are 5% below FFS spending
  - MA plans' projected medical expenses are 18% below FFS spending

Note: MA (Medicare Advantage), FFS (fee-for-service).

Base comparison accounts for payment policies unrelated to risk adjustment

- Base comparison of MA and FFS spending captures the effects of:
  - Plan benchmarks, including the Part A-only population that are used for benchmarks
  - MA-eligibility, which does not include the Part A–only population
  - Distribution of MA enrollment among county quartiles
  - Share of MA enrollment in plans receiving a quality bonus benchmark increase
  - Plan bidding that is below payment benchmarks
- Compare MA payments and FFS spending adjusted to have MA risk profile
  - Years with historical data available: Use actual payments (including nonclaims FFS spending), risk scores, and enrollment for beneficiaries with both Part A and Part B
  - Other years: Use estimates based on MA bid data and CMS's projections of local-area risk-standardized FFS spending
  - Estimates from these two methods are within 1 percentage point (nonpandemic years)
- MA payments are similar to FFS spending for most recent years before accounting for coding intensity and favorable selection

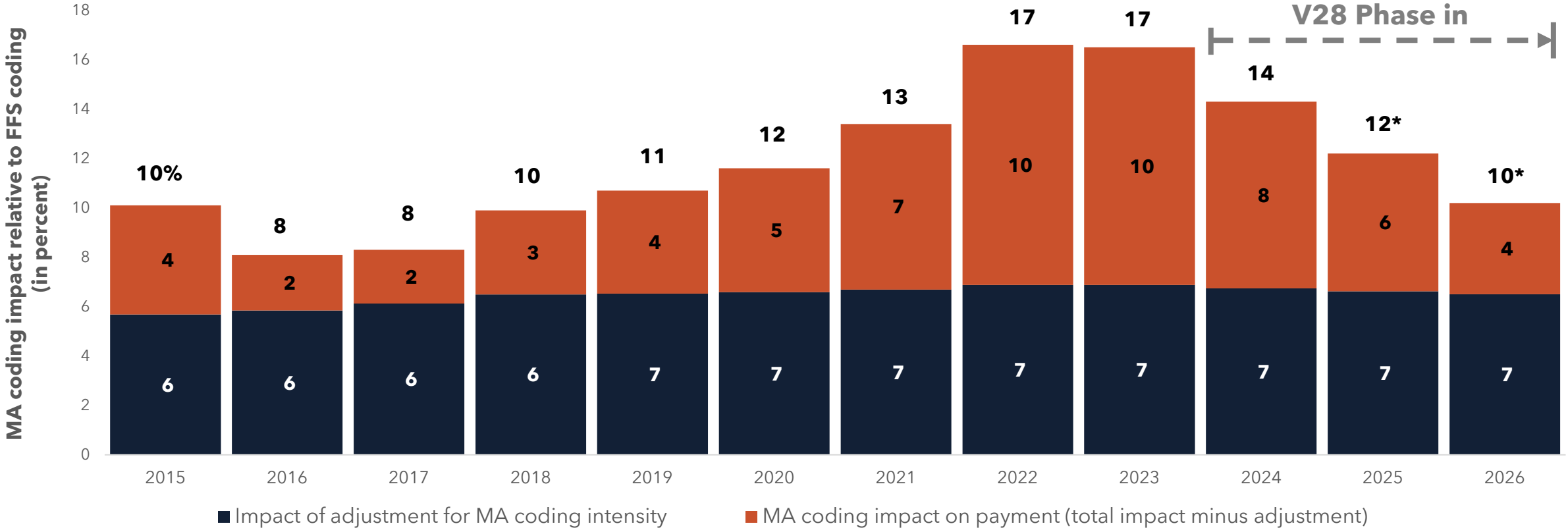
Note: MA (Medicare Advantage), FFS (fee-for-service).

MA coding generates increased payments in 2026

- Differences in diagnostic coding between FFS and MA
  - FFS: Little incentive to code diagnoses
  - MA: Financial incentive and infrastructure to code more diagnoses
- MedPAC's estimates of coding intensity
  - Uses the DECI method, accounting for Medicaid eligibility and institutional status
  - Projects estimates for 2025 and 2026 based on the annual coding-intensity trend and an updated estimate of the impact of the V28 risk model
    - We estimate coding intensity to be about 8.8 percentage points lower under V28 (when fully phased in) before accounting for plan behavior
- 2026 MA risk scores are projected to be 10% higher (before coding adjustment) than scores would be if MA enrollees were instead enrolled in FFS Medicare

Note: MA (Medicare Advantage), FFS (fee-for-service), DECI (demographic estimate of coding-intensity).

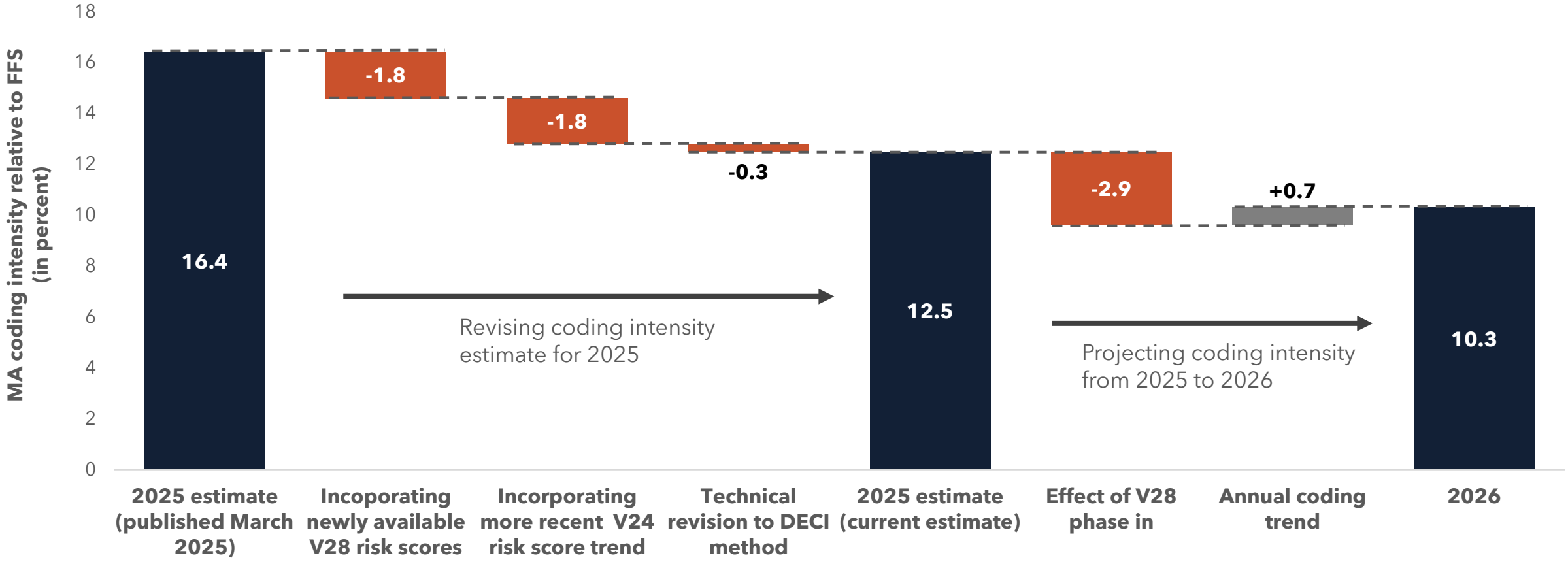
V28 has reduced estimated MA coding intensity



Note: MA (Medicare Advantage), FFS (fee-for-service). Estimates account for differences between MA and FFS populations in age, sex, Medicaid eligibility, and institutional status. New enrollees are constrained to have no coding intensity. Dark blue shows the effect of the coding adjustment, which is calculated as the MA coding-intensity estimate relative to FFS, multiplied by the coding adjustment. For 2026, we calculate 1.10 × 5.9 percent = 0.065 or about 7 percent. Components may not sum to totals due to rounding. * For 2025 and 2026, we projected coding intensity based on the annual trend under the V24 model from 2023 through 2024 (+0.7% in each year) and then accounted for the phase-in of the V28 risk-adjustment model (-2.9% in each year).

Source: MedPAC analysis of CMS enrollment and risk-score files.

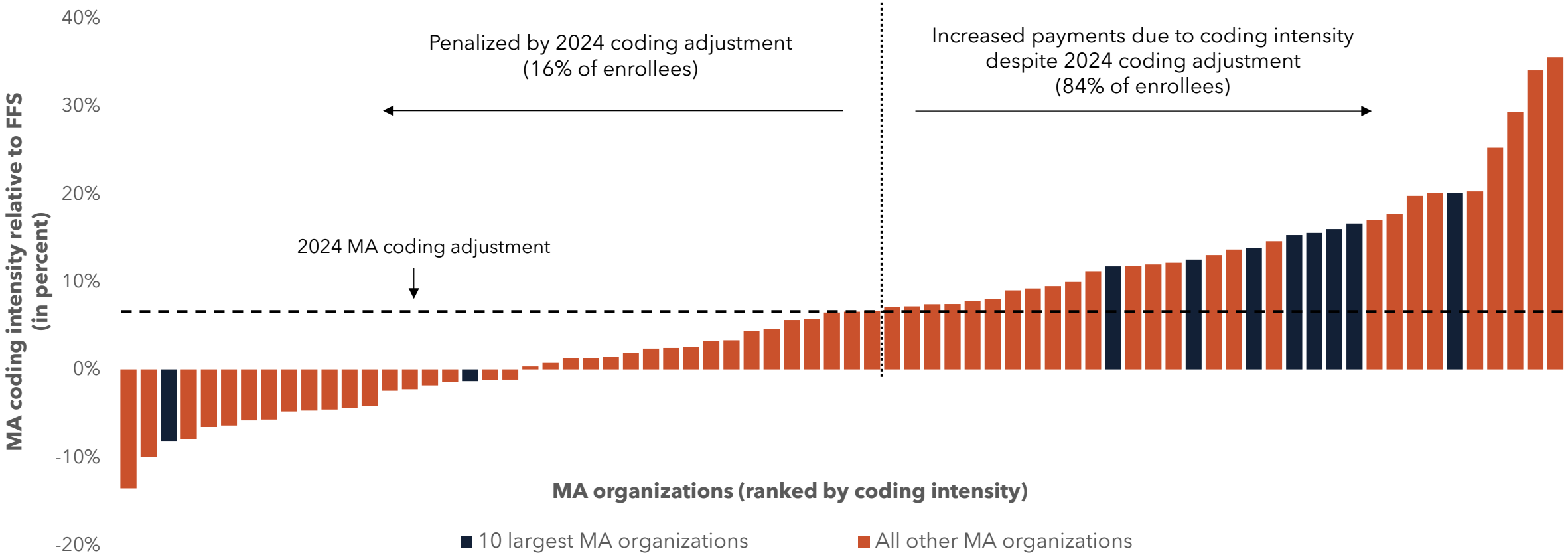
Updating coding intensity estimate for 2025 for new data and other factors; projecting for 2026



Note: MA (Medicare Advantage), FFS (fee-for-service), DECI (demographic estimate of coding intensity). In our March 2025 report, we projected coding intensity from the most recent year of available data, 2023, to 2025. For this report, new data are available, and we have updated our method of projecting coding intensity. This figure reconciles the difference in coding intensity estimates for 2025 due to new data and other factors and explains the projection assumptions for 2026. These estimates are for MA enrollees without end-stage renal disease.

Source: MedPAC analysis of CMS enrollment and risk-score files.

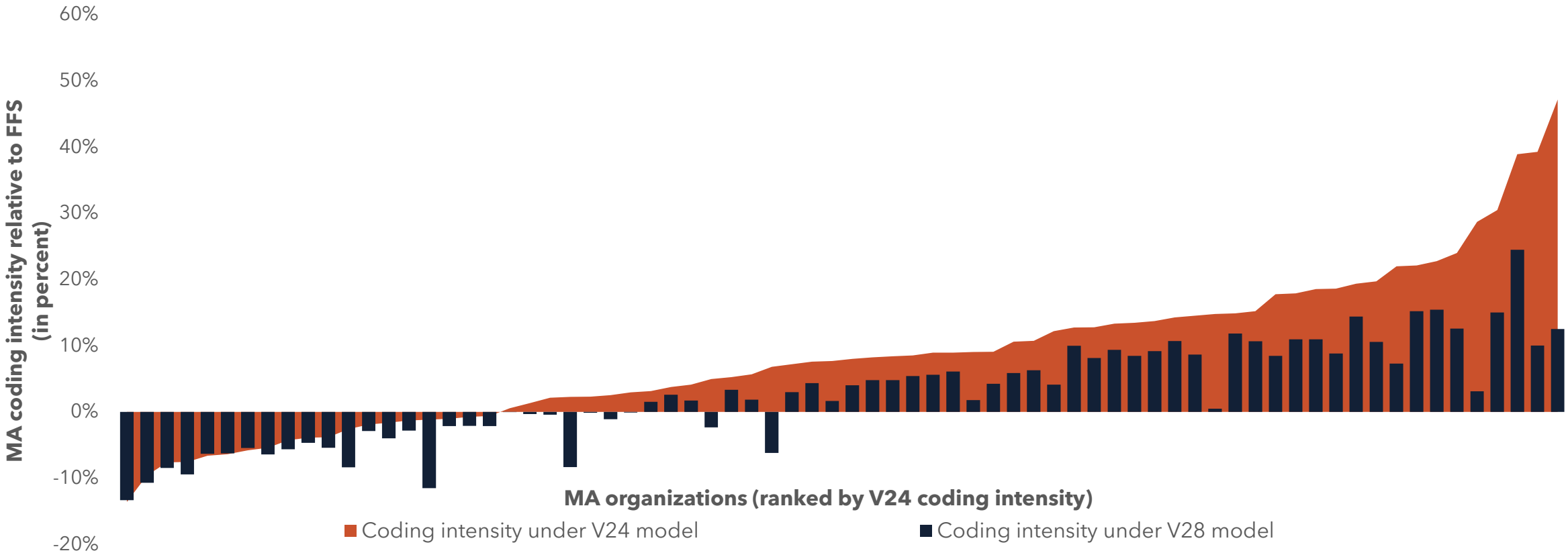
Coding intensity generates payment differences across MA organizations



Note: MA (Medicare Advantage), FFS (fee-for-service). All estimates are for 2024 and account for any differences between MA and FFS populations in age, sex, Medicaid eligibility, and institutional status. New enrollees are constrained to have no coding intensity because their risk scores are not based on diagnostic coding. Beneficiaries residing in Puerto Rico, enrolled in a chronic-condition special-needs plan, or with end-stage renal disease are excluded from the analysis, as well as organizations with fewer than 25,000 enrollees.

Source: MedPAC analysis of CMS enrollment and risk-score files.

The V28 model reduced estimated coding intensity and improved risk adjustment fairness, 2024



Note: MA (Medicare Advantage), FFS (fee-for-service). All estimates account for any differences in age, sex, Medicaid eligibility, and institutional status between MA and FFS populations. New enrollees are constrained to have no coding intensity because their risk scores are not based on diagnostic coding. Beneficiaries residing in Puerto Rico, enrolled in a chronic-condition special-needs plan, or with end-stage renal disease are excluded from the analysis, as well as organizations with fewer than 25,000 enrollees. This figure shows coding intensity for V24 and V28 risk scores and does not reflect the blending of the two risk models used for paying MA plans in 2024.

Source: MedPAC analysis of CMS enrollment and risk-score files.

MA coding intensity: Results from several new studies consistent with MedPAC's estimates

- One study controlled for mortality and removed HCCs with large MA and FFS differences; estimated coding intensity to be 8.4% in 2014
- Another study used the DECI method to produce estimates of 10.1% for 2016 to17.4% for 2021; estimated V28 effect of −7.3% for 2021
- A study analyzing FFS to MA switchers found rapidly increasing risk scores and estimated coding intensity to be 18.6% for 2021
- Three studies produced parent organization estimates similar to ours
- A review of medical records and lab data found prevalence of certain chronic conditions to be more similar between MA and FFS than HCC data suggests

Note: MA (Medicare Advantage), HCC (hierarchical condition category), FFS (fee-for-service), DECI (demographic estimate of coding intensity).

Sources: [1]Curto, V. E., E. Politzer, T. S. Anderson, et al. 2025. Coding intensity variation in Medicare Advantage. *Health Affairs Scholar* 3, no. 1 (January): qxae176. [2]Kronick, R., F. M. Chua, R. Krauss, et al. 2025a. Are fewer diagnoses better? Assessing a proposal to improve the Medicare Advantage payment system. *Health Affairs* 44, no. 1 (January): 66–74. [3]Jacobs, P. D., and T. J. Layton. 2025. Identifying coding intensity in Medicare Advantage through switchers. *Health Services Research* (April 28): e14628. [4]Kronick, R., F. M. Chua, R. Krauss, et al. 2025. Insurer-level estimates of revenue from differential coding in Medicare Advantage. *Annals of Internal Medicine* (April 8). [5]Medicode Medicare Advantage coding intensity report card. 2025. *MA plans are projected to receive at least $30 Billion in additional payments due to differential coding intensity in 2025*. www.medicoding.org. [6]Oseran, A. S., R. Aggarwal, J. Figueroa, et al. 2025. Prevalence of chronic medical conditions among MA and traditional Medicare beneficiaries. *Annals of Internal Medicine*178, no. 3 (March): 327–335.

Background on favorable selection

- Every beneficiary (FFS and MA) has a risk score that predicts what their spending will be in the next year based on demographics and diagnoses (hierarchical condition categories, or HCCs)
- Risk models are imperfect; there is a distribution of actual spending for individuals with each risk score
- Some beneficiaries have spending that is lower than expected, others have spending that is higher than expected
- Favorable selection can occur if beneficiaries with lower-than-expected spending on average choose MA over FFS
  - Favorable selection can occur at any risk score because it is the difference between expected spending and actual spending

Note: FFS (fee-for-service), MA (Medicare Advantage).

MA plan and beneficiary incentives may produce favorable selection

- Absent any intervention from plans, favorable selection in MA occurs if spending for MA enrollees is systematically lower than their risk scores predict
- MA plan features may contribute to favorable selection
  - Plan networks and prior authorization
  - Higher cost sharing for most services compared with Medigap
- Beneficiary preferences may contribute to favorable selection
  - Perception of MA networks and prior authorization may influence choice of coverage
  - Beneficiaries who seek more care may prefer FFS with supplemental insurance
  - Beneficiaries who seek less care and extra benefits may prefer MA

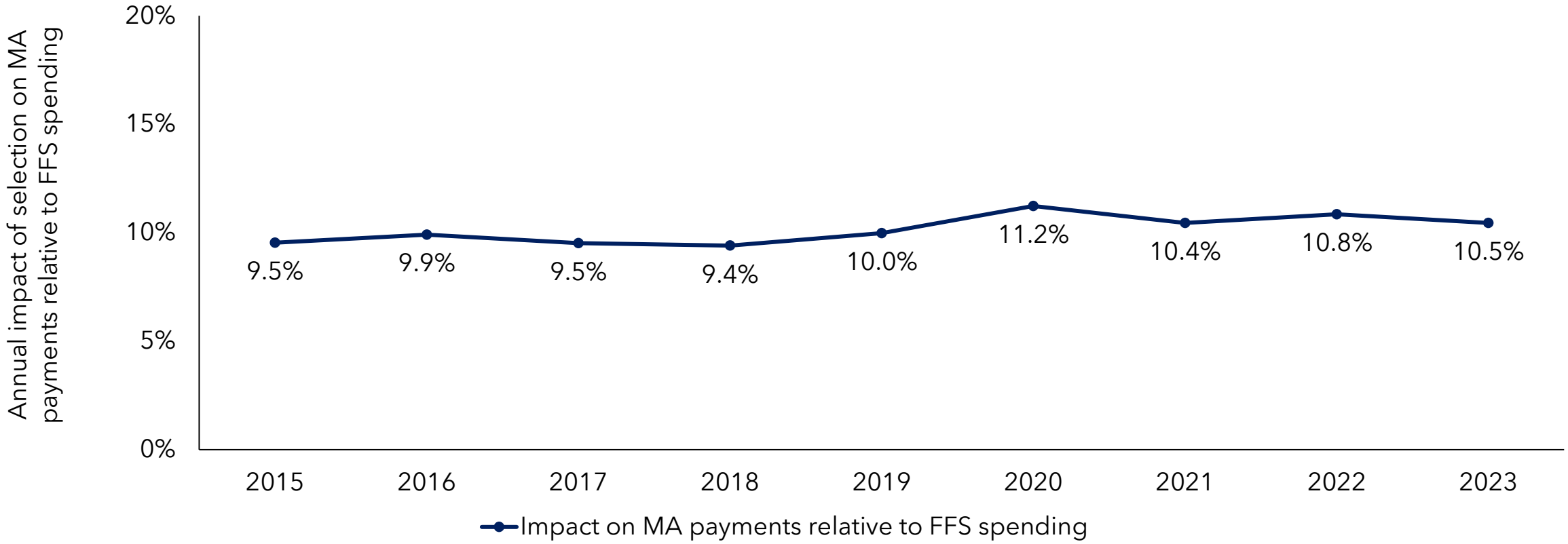
Note: MA (Medicare Advantage), FFS (fee-for-service).

MedPAC analysis indicates MA plans experience favorable selection

- MedPAC estimated that favorable selection led to higher payments than FFS (March 2025)
- Updates to methodology
  - Better account for dual-eligibility status in our estimates
    - Improves modeling of changes in selection during MA enrollment
    - Improves modeling of beneficiaries who enrolled upon initial eligibility
  - Technical updates to improve the comparability between our MA study population and FFS comparison groups
  - Include the estimated selection effect for beneficiaries with ESRD

Note: MA (Medicare Advantage), FFS (fee-for-service).

Estimated impact of favorable selection, 2015–2023



Note: MA (Medicare Advantage), FFS (fee-for-service).
Source: MedPAC analysis of Medicare enrollment, Medicare claims spending, and risk-adjustment files.

MedPAC's estimates of favorable selection are largely consistent with other researchers'

- MedPAC's approach generalizes estimates to the entire MA population based on "switchers" from FFS to MA
  - Adjusts for differences between MA switchers and other MA enrollees by assigning selection percentages based on enrollees' year of entry, dual-eligibility status, and mortality status
- Other research provides support for prevalent favorable selection across the entire MA population
  - Beneficiaries who switch from FFS to MA: 13% to 14% selection effect (Lieberman et al. 2023; Jacobson et al. 2019; Newhouse et al. 2015)
  - Newly eligible beneficiaries directly enrolling in MA:
    - 13% pre-MA selection for a sample of commercially insured beneficiaries (Tiegland et al. 2023)
    - 23% pre-MA selection for Medicaid enrollees (Pelech et al. 2025)

Note: MA (Medicare Advantage), FFS (fee-for-service).

Source: Lieberman, S. M., et. al 2023. *Medicare Advantage enrolls lower-spending people, leading to large overpayments.* White Paper. June. Jacobson et al. 2019. *Do people who sign up for Medicare Advantage plans have lower Medicare spending?* Washington, DC: Kaiser Family Foundation. Newhouse, J. P., et al. 2015. *How much favorable selection is left in Medicare Advantage?* American Journal of Health Economics 1, no. 1 (Winter): 1-26. Teigland, C. et al. 2023. Harvard-Inovalon Medicare study: *Utilization and efficiency under Medicare Advantage vs. Medicare fee-for-service.* White Paper. September. Pelech, D., R. Ding, J. Guo, et al. 2025. *Favorable selection among dually enrolled beneficiaries in private Medicare plans*. Health Affairs 44, no. 10 (October): 1256–1265.

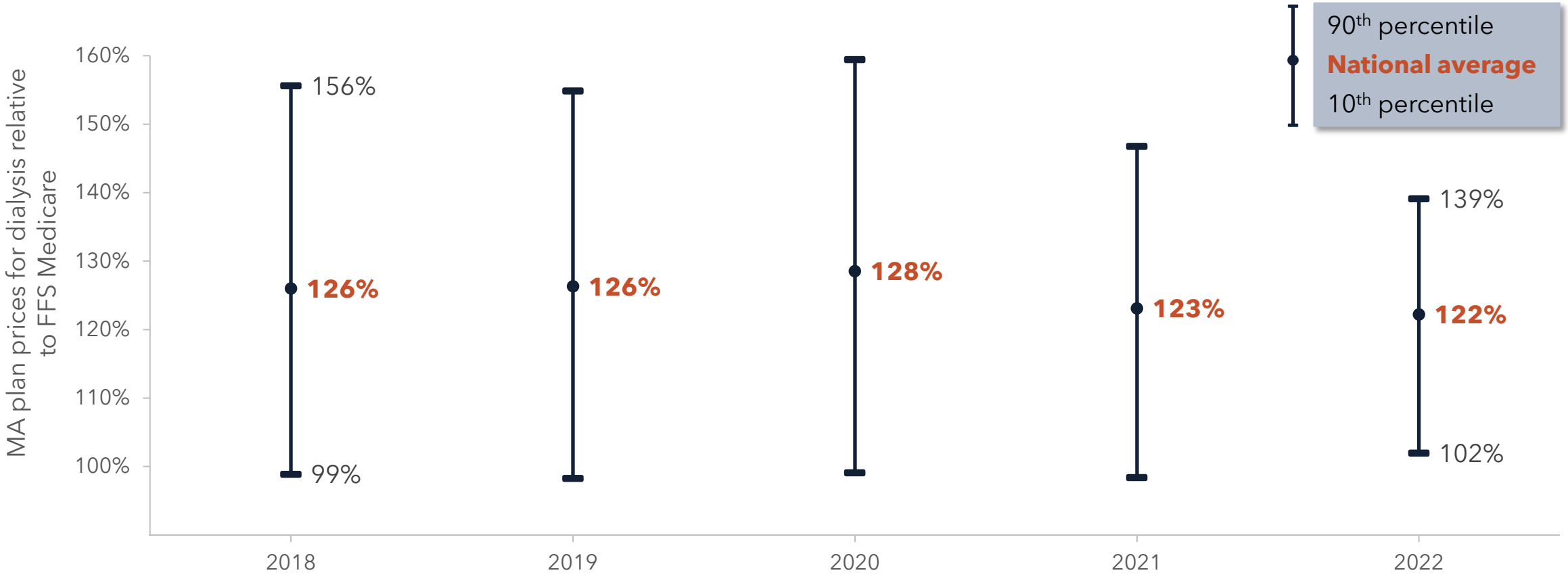
Enrollees with ESRD: Medicare payments, enrollment trends, and MA plan costs

MA for beneficiaries with ESRD

- Individuals with ESRD have been entitled to Medicare Part A and Part B benefits since 1972, but were mostly prohibited from joining MA plans
- Beginning in 2021, the 21st Century Cures Act allows all beneficiaries with ESRD to sign up for MA plans
  - MA enrollment grew significantly among beneficiaries with ESRD, from 27% in December 2020 to 55% in December 2024
- In the 2021 report to the Congress, MedPAC assessed:
  - MA plan prices for dialysis
  - MA enrollment trends by coinsurance amounts
  - MA plan costs and revenues for individuals with ESRD in 2018
- For the 2026 report to the Congress, we updated each of these analyses with additional years of data

Note: ESRD (end-stage renal disease), MA (Medicare Advantage).

Most MA contracts paid more per dialysis treatment than FFS Medicare rates



Note: FFS (fee-for-service), MA (Medicare Advantage). The dots represent the national average of MA contract prices for dialysis relative to FFS Medicare. The bars represent treatment volume-weighted MA contract prices for dialysis services relative to FFS Medicare at the 10th and 90th percentile. Estimated MA prices have been adjusted to account for differences in age and wage index.

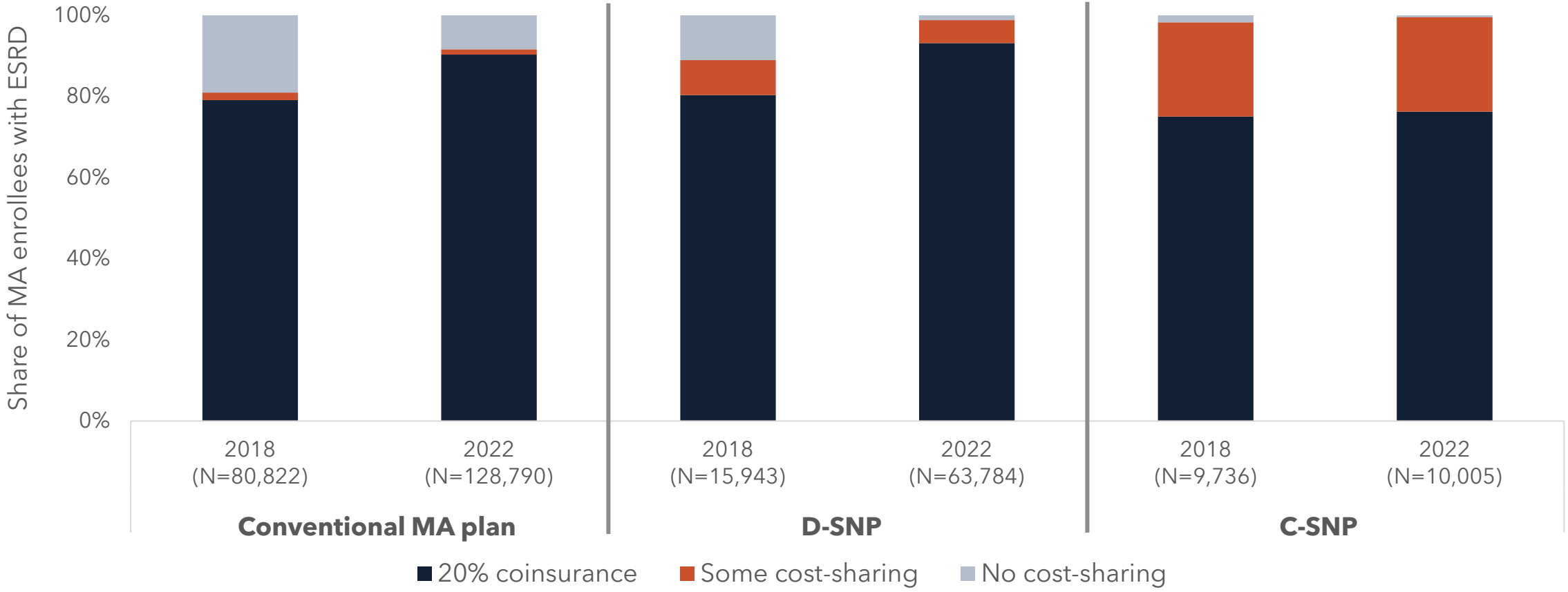
Source: MedPAC analysis of FFS claims, MA encounter data, and MA plan benefits package files, 2018-2022.

Potential drivers of higher MA plan prices for dialysis services relative to FFS rates

- Overall, consolidation in the dialysis market may contribute to higher MA prices for dialysis than FFS Medicare rates
- But the drop in MA prices for dialysis in 2021 and 2022 could have been driven by:
  - Growing MA enrollment by beneficiaries with ESRD, which may have increased MA plans' negotiating leverage
  - Removal of network adequacy requirements for outpatient dialysis facilities

Note: ESRD (end-stage renal disease), FFS (fee-for-service), MA (Medicare Advantage). Estimated MA prices have been adjusted to account for differences in age and wage index.
Source: MedPAC analysis of FFS claims, MA encounter data, and MA plan benefits package files, 2018-2022.

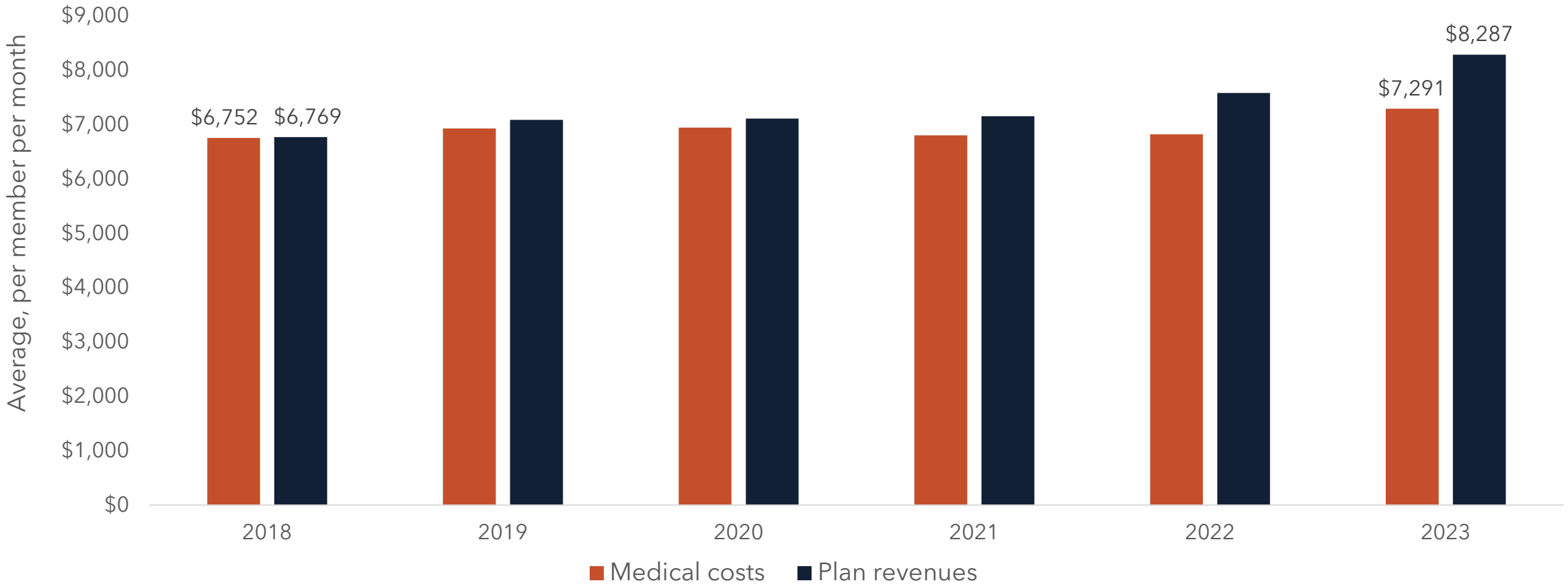
The share of MA enrollees with ESRD in plans with maximum allowed coinsurance for dialysis increased



Note: MA (Medicare Advantage); ESRD (end-stage renal disease); SNP (Special Needs Plan); C-SNP (Chronic or Disabling Condition SNP); D-SNP (Dual-Eligible SNP). The bars represent MA enrollment by beneficiaries with ESRD, by plan coinsurance amounts.

Source: Data compiled by MedPAC from MA encounter data, MA plan benefits package files, and CMS SNP data, 2018-2022.

MA plan revenues for enrollees with ESRD grew faster, on average, than plans' reported medical costs



Note: ESRD (end-stage renal disease), MA (Medicare Advantage). The orange bars represent average per member per month (PMPM) medical costs, and the dark blue bars represent average PMPM plan revenues.

Source: MA 2020-2025 bid pricing tool data including 2018-2023 cost and revenue information.

Faster growth in Medicare's payments to MA plans for enrollees with ESRD relative to plans' reported costs

- Average PMPM plan revenues may be rising faster than plan medical expenses due to:
  - Lower negotiated payment rates, over time, for dialysis
  - Efficient care delivery
  - Concentrated MA enrollment growth in states with above-average ESRD payment rates
  - Growth in spending among beneficiaries with ESRD who remain in FFS

Note: ESRD (end-stage renal disease), FFS (fee-for-service), MA (Medicare Advantage), PMPM (per member per month).

Next steps

- Commissioner questions
- March 2026 report to the Congress
  - MA status report
  - Technical appendix

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