MEDPAC | Medicare Payment Advisory Commission

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MEDICARE PAYMENT ADVISORY COMMISSION RELEASES REPORT TO CONGRESS ON MEDICARE PAYMENT POLICY

Washington, DC, March 12, 2026—Today, the Medicare Payment Advisory Commission (MedPAC) releases its March 2026 *Report to the Congress: Medicare Payment Policy*. The report presents MedPAC's recommendations for updating provider payment rates in fee-for-service (FFS) Medicare for 2027. The report reviews the status of the Medicare Advantage (MA) program (Medicare Part C), the Part D prescription drug program (Medicare Part D), and ambulatory surgical centers (ASCs). Finally, the report includes two additional congressionally mandated reports, one on the impact of recent changes to the home health prospective payment system and one on the performance of dual-eligible special-needs plans (D-SNPs).

| Fee-for-service payment rate update recommendations. MedPAC's payment update recommendations—required by law each year—are based on an assessment of payment adequacy in each setting that examines beneficiaries' access to and use of care, the quality of the care they receive, the supply of providers and their access to capital, and providers' costs and Medicare's payments.

For 2027, MedPAC recommends payment updates above current law for physicians and other health professional services; eliminating the update for outpatient dialysis services and hospice services; and reducing payments for skilled nursing facilities, home health agencies, and inpatient rehabilitation facilities.

For acute care hospitals, the Commission recommends the current-law payment update, combined with the Medicare Safety-Net Index (MSNI) described in our March 2023 report. The MSNI would target $1 billion in additional Medicare resources to hospitals that are important sources of care for low-income Medicare beneficiaries.

| Medicare Advantage. Each year, the Commission is required to report on the status of the MA program. MA gives beneficiaries the option of receiving benefits from private plans rather than from traditional FFS Medicare. The Commission strongly supports the inclusion of private plans in the Medicare program, and beneficiaries should be able to choose among Medicare coverage options. Overall, plan and beneficiary participation continues to indicate a robust MA program, though significant regional differences remain in enrollment and types of plans offered.

In 2025, the MA program included 5,492 plan options offered by 164 organizations, enrolled about 34.9 million beneficiaries (55 percent of Medicare beneficiaries with both Part A and Part B coverage), and paid MA plans an estimated $537 billion (not including Part D drug plan payments). In 2026, the average Medicare beneficiary has a choice of 39 plans, offered by an average of eight organizations. Medicare's capitated payments to MA plans are expected to average $16,242 per beneficiary per year in 2026, including rebate payments of $2,660 per beneficiary per year (on average). The average rebate amount has more than doubled since 2018. Plans use rebates to

provide supplemental benefits, which have the potential to address health challenges that many seniors face as they age and for which there is limited coverage under FFS Medicare. In 2026, conventional MA plans project using about 35 percent of their rebate funds to reduce cost sharing for enrollees, 22 percent for non-Medicare services, about 26 percent to enhance plans' Part D benefit, about 9 percent to reduce enrollees' Part B premiums, and about 8 percent for administrative expenses and profit. Relatively little is known about beneficiaries' use of these benefits or about their value. Starting in 2024, CMS began to improve and increase the amount of data that plans report regarding supplemental benefits. In our preliminary analysis of the newly collected data, we found that MA organizations spent roughly $24 billion in 2023 on non-Medicare services offered as supplemental benefits. This is the first time that information about plans' actual spending for supplemental benefits has been available.

The Commission estimates that Medicare spends approximately 14 percent more for MA enrollees than it would spend if those beneficiaries were enrolled in FFS Medicare, a difference that translates into a projected $76 billion in 2026. That difference varies by MA organization and stems largely from two factors: favorable selection of beneficiaries into MA and coding intensity. "Favorable selection" refers to the tendency of beneficiaries with lower spending than predicted by their risk score to enroll in MA. We estimate that, in 2026, favorable selection will increase MA payments by roughly 11 percent above what the program would have paid under FFS Medicare. "Coding intensity" refers to the tendency for MA plans to record more diagnosis codes for their enrollees, which causes risk scores and Medicare payments to be higher. We estimate that, due to higher coding intensity, MA risk scores will be about 4 percent higher than risk scores for similar FFS beneficiaries, even after accounting for the annual CMS coding adjustment.

Last year, we projected that, in 2025, Medicare would spend 20 percent more on MA enrollees than on similar enrollees in FFS Medicare. The lower projected payment difference for 2026 primarily stems from two factors: the completed phase-in of a new risk model (called Version 28, or V28) designed to reduce differences in coding, and the availability of new risk-score data, which show slower growth in MA risk scores in recent years (described further below). The Commission has supported implementation of the V28 risk model. Our lower estimated payment difference indicates that V28 is having the intended effect of reducing the impact of differences in MA and FFS diagnosis coding on payments. Altogether, our estimates suggest that, on average, plans were able to maintain their level of rebates in 2026 by adjusting their bids—and, in fact, average rebates are projected to reach a record high, despite the complete phase-in of the V28 risk model.

The Commission acknowledges that a portion of the increased payments to MA plans is used to provide more generous supplemental benefits and better financial protection for MA enrollees and provides information about the scope of spending that goes to offering those benefits. The benefits from MA's higher cost relative to FFS are subsidized by the taxpayers and beneficiaries who fund Medicare, increasing fiscal strain on the program. The Commission estimates that Part B premiums, paid by all Medicare beneficiaries, will be about $11 billion higher in 2026 because of these higher payments.

The Commission holds the goal of meaningful and transparent competition in MA to create incentives for plans to improve quality and reduce costs for beneficiaries and taxpayers. Over the past several years, the Commission has made several recommendations to improve the program. These recommendations call for the Congress and CMS to make reforms to address imbalances related to coding intensity, replace the quality bonus program, establish more equitable benchmarks, and improve the completeness of encounter data.

This report provides an update to the Commission's March 2021 analysis of Medicare payments and MA plan costs for enrollees with end-stage renal disease (ESRD). Our analysis finds that, overall, finances appear to have improved for both MA plans and dialysis facilities with increasing MA enrollment. Between 2018 and 2023, Medicare payments to MA plans grew faster, on average, than

plans' reported medical costs for enrollees with ESRD. While MA plans roughly broke even on medical costs for these enrollees in 2018, by 2023 Medicare payments to plans exceeded their medical costs by an average of 12 percent. Most MA plans charge the maximum allowable 20 percent coinsurance for dialysis, affecting about 90 percent of enrollees with ESRD in conventional plans and D-SNPs in 2022, though enrollees may receive protection from the maximum out-of-pocket limit ($9,250 in 2026) that MA plans are required to offer. On average, MA plans pay more than FFS Medicare rates for dialysis services. In 2022, MA plan prices for dialysis were 22 percent higher than FFS Medicare rates, down from 28 percent higher in 2020.

| Part D. In 2025, the Medicare prescription drug program (Part D) paid for outpatient prescription drug coverage for more than 55 million beneficiaries. In 2024, Part D expenditures totaled $148.3 billion. Of this amount, Medicare paid $90.3 billion in subsidies for basic benefit costs and $41.3 billion in extra financial support for enrollees receiving the low-income subsidy (LIS). Plan enrollees paid the remaining $16.7 billion in plan premiums for basic benefits. Over time, Part D enrollment has shifted from prescription drug plans (PDPs) to Medicare Advantage Prescription Drug plans (MA-PDs).

The recent redesign of the Part D program includes key elements of the Commission's 2020 recommendations, including changes intended to restore plan incentives to manage drug spending by reducing the role of Medicare reinsurance payments while increasing the role of capitated direct-subsidy payments. However, the elimination of cost sharing above the annual out-of-pocket threshold and the lowering of that threshold, while improving affordability, likely created significant utilization uncertainties because plans lack cost-sharing tools to manage spending once beneficiaries reach the threshold.

An analysis of recent trends in Part D bids finds that the national average bid rose by 180 percent in 2025 and by another 33 percent in 2026. These sharp increases reflect a multitude of factors—the financial shift from cost-based federal reinsurance to the capitated monthly payment, the impact of the Part D redesign that simultaneously reduced beneficiary cost sharing and capped growth in beneficiaries' basic premiums, expected increases in drug utilization from reduced cost sharing liability, and the overall trend in drug spending, which has continued to rise. Using bid data, we estimate that shifts in financing from beneficiaries (premiums and cost sharing) and Medicare (reinsurance and the low-income cost sharing subsidy) to plans accounted for over 80 percent of the increase in bids in 2025. In contrast, projected increases in drug spending explained most of the growth in bids for 2026 (over 70 percent).

Despite sharp increases in bids and expected spending for drugs covered under Part D, beneficiary premiums have grown more slowly. The average total PDP premium in 2026 (weighted by 2025 enrollment) is estimated at $44, up from $39 in 2025, while the average total MA-PD premium (including both special-needs plans and conventional plans) is $11, up from $9 in 2025, due in part to MA-PDs' ability to use Part C rebates to lower Part D premiums. Two policies have moderated premium increases by shifting spending to the program. First, the Inflation Reduction Act of 2022 (IRA) capped yearly growth in the base beneficiary premium (BBP) at no more than 6 percent. We estimate this provision increased Medicare's direct subsidy costs by about $10.5 billion in 2025 and $20 billion in 2026, respectively. Second, beginning in 2025, CMS implemented the Part D Premium Stabilization Demonstration to limit further yearly premium growth for participating PDPs. Estimates suggest Medicare will spend an additional $9 billion on Part D under this demonstration in 2025 and 2026.

| Ambulatory surgical centers. Ambulatory surgical centers (ASCs) continue to represent a growing and robust sector of outpatient care. In 2024, approximately 6,400 ASCs treated 3.4 million FFS Medicare beneficiaries, with total program spending and beneficiary cost sharing reaching $7.5 billion. The number of ASCs has grown by more than 2 percent annually since 2019, though their distribution varies widely across states. Medicare spending per FFS beneficiary on ASC services

increased rapidly, rising 9.4 percent annually from 2019 to 2023 and 15.9 percent from 2023 to 2024, with procedure volume per FFS beneficiary also increasing. Because Medicare payment rates are lower in ASCs than in hospital outpatient departments (HOPDs), care in ASCs generally lowers costs for both Medicare and beneficiaries, though increased service volume could offset the reduction in total FFS Medicare spending associated with a shift in the site of care.

| Mandated report: The impact of recent changes to the home health prospective payment system. The Bipartisan Budget Act (BBA) of 2018 required the elimination of therapy as a payment factor in the home health prospective payment system (PPS) in 2020 and shortening the unit of payment under the PPS from 60 days to 30 days. CMS implemented these changes through a new case-mix system known as the Patient-Driven Groupings Model (PDGM). The BBA of 2018 also mandated that the Commission assess the impact of the 30-day unit of payment in two reports: an interim report that we submitted in March 2022 and this final report due in March 2026.

Our analysis found no substantial changes in the probability of a FFS beneficiary using any home health care or in the average number of 30-day periods received by home health users associated with the PDGM in 2023. However, after adjusting for factors such as patient severity, the PDGM was associated with fewer home health visits per stay in 2023 (15.9 visits under PDGM compared with 18.8 visits without PDGM). That lower number of visits per stay in large part stemmed from a smaller number of therapy visits provided. The results for utilization, quality, and financial performance indicate that the implementation of the PDGM did not have an adverse impact on FFS Medicare beneficiaries and may have realigned therapy services to better reflect clinical need while maintaining quality of outcomes. The estimated effects presented in the analysis should be interpreted cautiously because implementation of the payment changes overlapped with the COVID-19 pandemic.

| Mandated report: Dual-eligible special-needs plans. The Bipartisan Budget Act of 2018 mandated that the Commission periodically study the performance of MA D-SNPs and other types of plans that serve dually eligible beneficiaries. This is our third report under the mandate. Dually eligible beneficiaries are more likely than non-dually eligible beneficiaries to be enrolled in MA plans (65 percent versus 51 percent in 2024), and the share of dually eligible beneficiaries enrolled in D-SNPs grew from 14 percent in 2014 to 46 percent in 2024.

MA plans performed better on some measures than Medicare-Medicaid Plans (MMPs), which were part of a demonstration that ended in 2025, but those differences could reflect structural differences between the two types of plans. These findings are consistent with our earlier mandated reports and with other Commission analyses that have examined the difficulties of assessing the quality and performance of MA plans.

The full report is available at MedPAC's website (http://www.medpac.gov).

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The Medicare Payment Advisory Commission is an independent, nonpartisan Congressional agency that provides policy and technical advice to the Congress on issues affecting the Medicare program. The Commission's goal is to achieve a Medicare program that ensures beneficiary access to high-quality care, pays health care providers and health plans fairly, rewards efficiency and quality, and spends tax dollars responsibly.