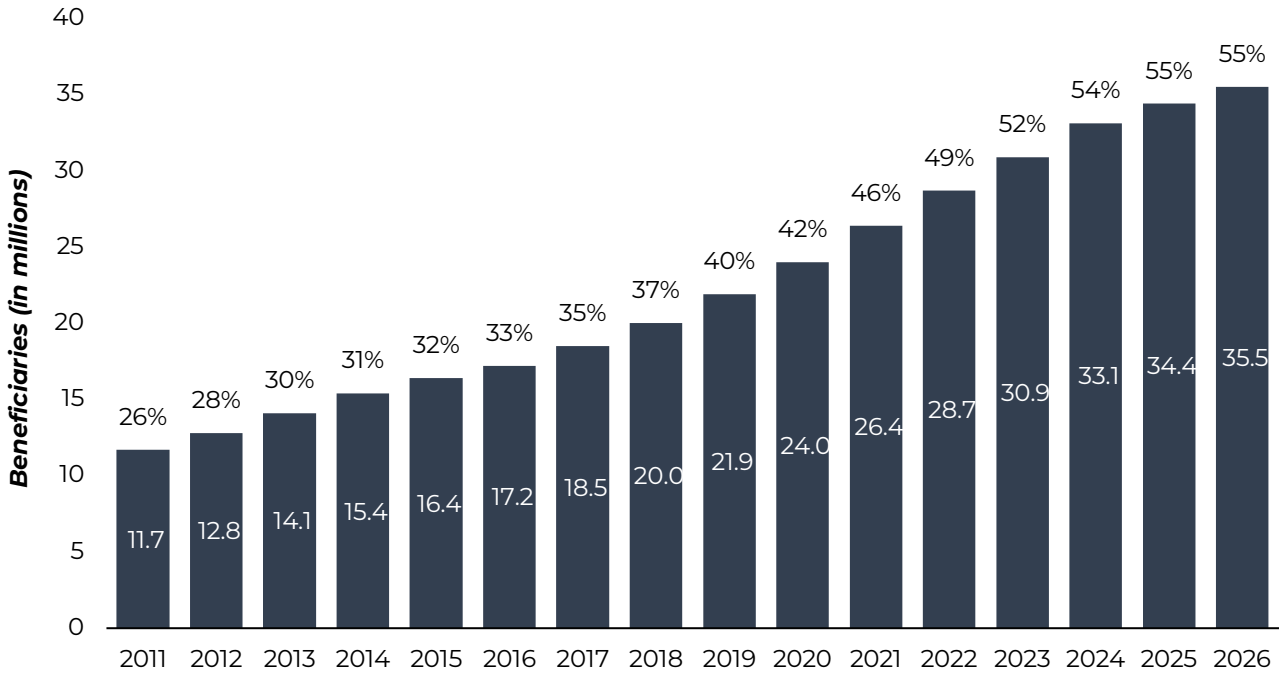
SECTION

9

Medicare Advantage

Chart 9-1 Enrollment in MA plans, 2011–2026

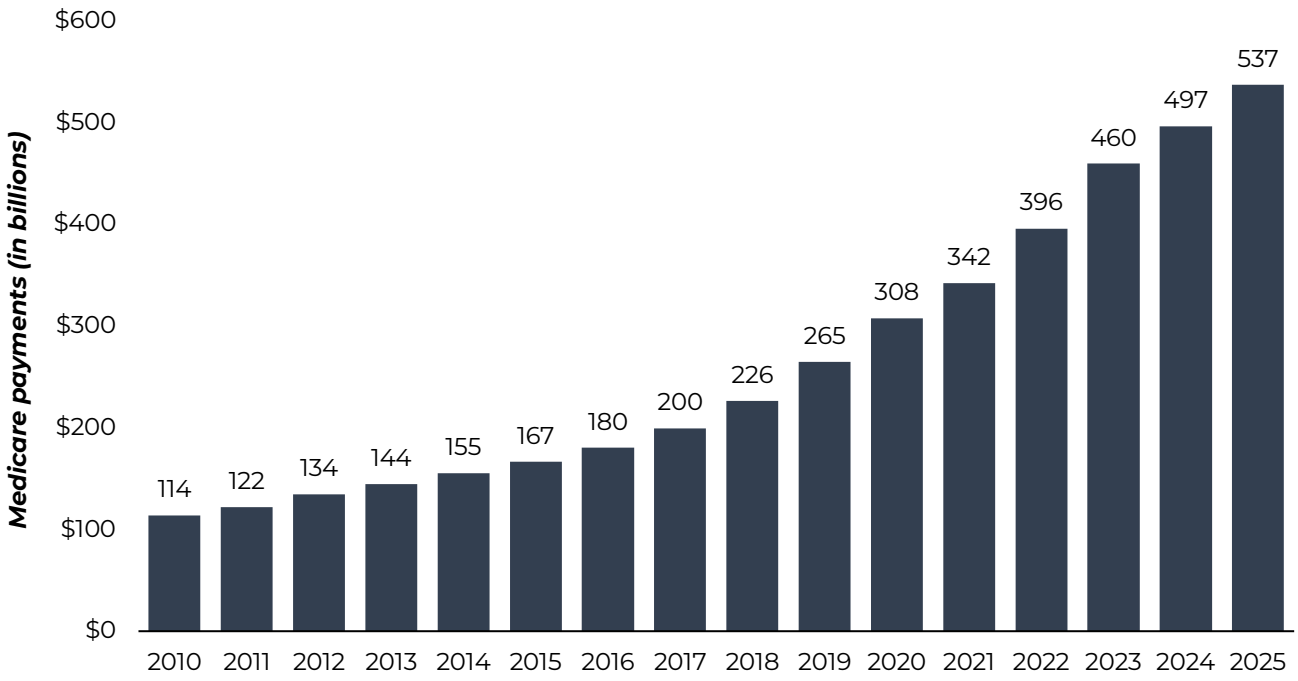


Note: MA (Medicare Advantage). Percentages indicate the share of total MA-eligible enrollment.

Source: Medicare enrollment data, February 2011–2026.

> In February 2026, enrollment in MA plans, which are paid on a risk-adjusted basis, reached 35.5 million, or 55 percent of all eligible Medicare beneficiaries (only beneficiaries enrolled in both Part A and Part B are eligible to enroll in an MA plan). An additional 1 percent of all Medicare beneficiaries with both Part A and Part B coverage are enrolled in other private plans such as cost plans and plans under the Program of All-Inclusive Care for the Elderly (PACE) (data not shown).

Chart 9-2 Medicare payments to MA plans, 2010–2025



Note: MA (Medicare Advantage). The figures above do not include Medicare Medical Savings Account plans, cost-reimbursed plans, Medicare–Medicaid demonstration plans, and the Program of All-Inclusive Care for the Elderly (PACE). Dollar amounts are nominal figures, not adjusted for inflation.

Source: MedPAC estimates based on the reports of the Boards of Trustees of the Medicare trust funds, 2020–2025.

> The Medicare program paid MA plans an estimated $537 billion in 2025 to cover Part A and Part B services for MA enrollees.

> From 2019 to 2025, total estimated payments to MA plans more than doubled on a nominal basis, reflecting in part the increase in the number of beneficiaries enrolled in MA (see Chart 9-1).

Chart 9-3 MA plans available to almost all Medicare beneficiaries, 2019–2026

	Share of Medicare beneficiaries living in counties with plans available					Average plan offerings per beneficiary
	CCPs					
	HMO or local PPO (local CCP)	Regional PPO	Any CCP	PFFS	Any MA plan	
2019	97	74	98	38	99	23
2020	98	73	99	36	99	27
2021	98	72	99	34	99	32
2022	99	74	99	35	99	36
2023	99	74	99	29	>99.5	41
2024	>99.5	74	>99.5	30	>99.5	43
2025	>99.5	68	>99.5	29	>99.5	42
2026	99	60	99	26	99	39

Note: MA (Medicare Advantage), CCP (coordinated-care plan), HMO (health maintenance organization), PPO (preferred provider organization), PFFS (private fee-for-service). These data do not include plans that have restricted enrollment (special-needs plans, employer plans) or are not paid based on MA rates (cost plans and certain demonstration plans). For 2019 through 2021, "share of Medicare beneficiaries" includes beneficiaries who do not have both Part A and Part B coverage (i.e., includes all Medicare beneficiaries). As of 2022, "share of Medicare beneficiaries" includes only beneficiaries with both Part A and Part B coverage (i.e., MA-eligible beneficiaries).

Source: MedPAC analysis of plan bid data from CMS, 2019–2026.

> There are four types of MA plans, three of which are CCPs. Local CCPs include HMOs and local PPOs, which have comprehensive provider networks and limit or discourage use of out-of-network providers. Local CCPs may choose which individual counties to serve. Regional PPOs cover one or more entire states and have networks that may be larger than those of local PPOs. CCPs accounted for 99 percent of Medicare private plan enrollees as of February 2026 (data not shown). Since 2011, PFFS plans are required to have networks in areas with two or more CCPs. In other areas, PFFS plans are not required to have networks and enrollees are free to use any Medicare provider.

> Since 2006, almost all Medicare beneficiaries have had MA plans available (not all data shown). In 2026, local CCPs are available to 99 percent of eligible Medicare beneficiaries, and regional PPOs are available to 60 percent of beneficiaries.

> The number of plans from which beneficiaries may choose in 2026 is slightly lower than recent years. In 2026, beneficiaries can choose from an average of 39 plans operating in their counties and have access to plans offered by an average of eight insurers (latter data not shown).

Chart 9-4 Changes in enrollment vary among major plan types

Plan type	Total enrollees (in thousands)					Percent change 2025–2026
	2022	2023	2024	2025	2026	
Local CCPs	27,878	30,291	32,667	34,142	35,295	3%
Regional PPOs	756	534	385	235	163	–31
PFFS	48	37	32	38	36	–5

Note: CCP (coordinated-care plan), PPO (preferred provider organization), PFFS (private fee-for-service). Local CCPs include health maintenance organizations (HMOs) and local PPOs.

Source: CMS health-plan monthly summary reports, February 2022–2026.

> Almost all Medicare Advantage (MA) enrollees (over 99 percent) choose local CCPs (HMOs or local PPOs), which limit or discourage use of out-of-network providers. Though network requirements may be less restrictive in regional PPOs and PFFS plans, enrollment in both types of plans declined between 2022 and 2026. From 2025 to 2026, enrollment in regional PPOs fell by 31 percent.

> Combined enrollment in the three types of plans grew by 3 percent from February 2025 to February 2026 (data not shown). Enrollment in local CCPs grew by 3 percent over the past year, and special-needs plans (SNPs) accounted for more than three-quarters of this growth (latter data not shown). Local PPO enrollment remained stable from 2025 to 2026 (data not shown). Most enrollment growth among HMOs (79 percent) occurred in SNPs (data not shown).

Chart 9-5 MA and cost-plan enrollment by state and type of plan, 2026

State or territory	All MA-eligible beneficiaries (in thousands)	Distribution (in percent) of beneficiaries by plan type					
		HMO	Local PPO	Regional PPO	PFFS	Cost	Total
U.S. total	64,022	32%	23%	0%	0%	0%	55%
Alabama	1,052	31	35	0	0	0	66
Alaska	108	0	2	0	0	0	2
Arizona	1,429	41	15	0	0	0	56
Arkansas	644	18	32	1	0	0	51
California	6,580	50	6	0	0	0	56
Colorado	988	38	18	0	0	0	56
Connecticut	710	26	36	0	0	0	62
Delaware	237	16	19	0	0	0	35
Florida	4,964	39	22	1	0	0	62
Georgia	1,869	20	40	0	0	0	60
Hawaii	273	18	43	0	0	0	61
Idaho	385	32	17	0	0	0	49
Illinois	2,254	18	30	0	0	0	48
Indiana	1,321	22	32	1	0	0	55
Iowa	661	20	18	0	0	2	40
Kansas	560	15	21	0	0	0	36
Kentucky	930	28	31	1	0	0	60
Louisiana	895	47	14	0	0	0	61
Maine	361	37	26	0	0	0	63
Maryland	1,024	14	14	0	0	0	28
Massachusetts	1,360	25	14	0	0	0	39
Michigan	2,174	24	43	0	0	0	67
Minnesota	1,117	3	49	0	0	8	60
Mississippi	612	21	27	1	0	0	49
Missouri	1,271	34	24	0	0	0	58
Montana	251	5	26	0	1	0	32
Nebraska	366	18	18	0	0	1	37
Nevada	564	45	12	0	0	0	57
New Hampshire	322	11	23	0	0	0	34
New Jersey	1,628	12	34	0	0	0	46
New Mexico	434	25	30	0	0	0	55
New York	3,695	38	20	0	0	0	58
North Carolina	2,165	36	25	0	0	0	61
North Dakota	141	0	23	0	0	15	38
Ohio	2,412	39	22	0	0	0	61
Oklahoma	755	22	24	0	0	0	46
Oregon	898	37	21	0	0	0	58
Pennsylvania	2,791	31	27	0	0	0	58
Puerto Rico	704	95	1	0	0	0	96
Rhode Island	227	55	11	0	0	0	66
South Carolina	1,195	14	35	0	0	0	49
South Dakota	189	0	25	0	0	13	38
Tennessee	1,413	37	20	0	0	0	57
Texas	4,544	37	22	1	0	0	60
Utah	443	37	23	0	0	0	60
Vermont	156	0	13	0	0	0	13
Virgin Islands	19	0	29	0	0	0	29
Virginia	1,574	28	15	0	0	0	43
Washington	1,437	36	18	0	0	0	54
Washington, DC	82	12	29	0	0	0	41
West Virginia	428	10	47	0	0	3	60
Wisconsin	1,287	29	27	0	0	3	59
Wyoming	122	0	15	0	0	0	15

Note: MA (Medicare Advantage), HMO (health maintenance organization), PPO (preferred provider organization), PFFS (private fee-for-service). Cost plans are not MA plans; they submit cost reports rather than bids to CMS. "U.S. total" does not include beneficiaries residing in foreign areas. Sum of beneficiaries by state does not equal U.S. total due to rounding. We report MA enrollment as a share of MA-eligible beneficiaries (Medicare beneficiaries with both Part A and Part B coverage).

Source: CMS enrollment and population data, February 2026.

Chart 9-6 MA enrollment patterns, by age, dual-eligibility status, and ESRD status, June 2024

	All MA-eligible beneficiaries		FFS		MA		MA enrollment as a share of total MA-eligible category
	Enrollment, in millions	Share of total	Enrollment, in millions	Share of total	Enrollment, in millions	Share of total	
Total	60.5	100%	27.6	100%	32.8	100%	54%
Aged (65 or older)	53.7	89	24.8	90	28.8	88	53
Under 65	6.8	11	2.8	10	4.0	12	58
No dual eligibility	49.1	81	23.8	86	25.3	77	51
Aged (65 or older)	46.1	76	22.5	81	23.6	72	51
Under 65	3.0	5	1.3	5	1.7	5	57
Full dual eligibility	8.0	13	3.1	11	4.9	15	59
Aged (65 or older)	5.3	9	1.9	7	3.4	10	62
Under 65	2.8	5	1.2	4	1.5	5	53
Partial dual eligibility	3.3	6	0.7	3	2.6	8	78
Aged (65 or older)	2.3	4	0.5	2	1.8	6	80
Under 65	1.0	2	0.3	1	0.8	2	75
Enrollment subcategories, all ages							
ESRD	0.4	1	0.2	1	0.2	1	50
Beneficiaries with partial dual eligibility							
QMB only	1.7	3	0.4	1	1.3	4	77
SLMB only	1.0	2	0.2	1	0.8	2	79
QI	0.6	1	0.1	<1	0.5	1	79

Note: MA (Medicare Advantage), ESRD (end-stage renal disease), FFS (fee-for-service), QMB (qualified Medicare beneficiary), SLMB (specified low-income beneficiary), QI (qualifying individual). Data for 2025 were not available as of the date of analysis. MA category does not include cost plans, plans under the Program of All-Inclusive Care for the Elderly (PACE), and Medicare–Medicaid Plans participating in CMS's financial alignment demonstration. MA-eligible beneficiaries are Medicare beneficiaries with both Part A and Part B coverage. Dually eligible beneficiaries are eligible for Medicare and Medicaid. Data exclude Puerto Rico because enrollment data undercount dual-eligibility categories. In 2024, Puerto Rico had about 654,000 Medicare beneficiaries enrolled in MA plans, and about 302,000 were enrolled in dual-eligible special-needs plans. Figures may not sum to totals due to rounding.

Source: MedPAC analysis of 2024 CMS enrollment data.

> Medicare beneficiaries with Medicaid benefits are more likely to enroll in MA than beneficiaries without Medicaid. Beneficiaries who have full dual eligibility for Medicare and Medicaid (i.e., those who have coverage of their Medicare out-of-pocket costs (premiums and cost sharing) as well as coverage for services such as long-term care services and supports) are less likely to enroll in MA plans than beneficiaries with "partial" dual eligibility (i.e., those who receive assistance only with Medicare premiums and, in some cases, with cost sharing). Fully dual-eligible beneficiaries have coverage through state Medicaid programs, including certain QMBs (i.e., QMB-Plus) and certain SLMBs (i.e., SLMB-Plus) who also have Medicaid coverage for services. Beneficiaries with partial dual eligibility (such as QIs or SLMBs) have coverage for Medicare premiums or premiums and Medicare cost sharing (such as QMBs).

> MA plan enrollment among dually eligible beneficiaries continues to increase. In 2024, 59 percent of fully dual-eligible beneficiaries were in MA plans (up from 58 percent in 2023), and 78 percent of partially dual-eligible beneficiaries were in MA plans (up from 76 percent in 2023) (2023 data not shown). QI and SLMB-only beneficiaries have the highest rates of MA enrollment among partially dual-eligible beneficiaries (79 percent). About 51 percent of Medicare beneficiaries who are not dually eligible for Medicaid were enrolled in an MA plan.

> A substantial share of the dually eligible population (35 percent; data not shown) are under the age of 65 and entitled to Medicare on the basis of disability or ESRD. Beneficiaries under age 65 who are fully dual eligible are less likely than aged fully dual-eligible beneficiaries to enroll in MA (53 percent vs. 62 percent, respectively). A higher share of MA enrollees are fully dual eligible compared with fee-for-service enrollees (15 percent vs. 11 percent, respectively).

> ESRD beneficiaries had higher rates of MA enrollment in 2024 (50 percent) compared with 2023 (47 percent; data not shown).

Chart 9-7 MA plan benchmarks, bids, and Medicare program payments relative to what FFS spending would have been, 2026

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

Note: MA (Medicare Advantage), FFS (fee-for-service). "Benchmarks" are the maximum Medicare program payments for MA plans and incorporate plan quality bonuses. The "overall estimate" of benchmarks, bids, and payments as a share of FFS spending incorporates all three components of the Commission's methodology for comparing payments: a base comparison of MA payments with FFS spending that standardizes for differences in risk scores and geography but does not account for the effects of coding intensity and favorable selection; an adjustment to that base comparison for favorable selection; and 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 enrolled in employer plans and beneficiaries with end-stage renal disease (ESRD). Components may not sum to totals due to rounding. More details on our coding and selection analyses are found in the Chapter 12 Technical Appendix of our March 2026 report to the Congress. Components of the benchmark and payment columns do not sum to the total due to rounding.
* Estimates of benchmarks and bids relative to FFS spending do not include employer plans or enrollees with ESRD because MA plans do not submit bids for those enrollees.

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

> Since 2006, plan bids have partly determined the Medicare payments that plans receive. Plans bid to offer Part A and Part B coverage to Medicare beneficiaries (Part D coverage is bid separately). The bid includes plans' expected medical expenses, plus their administrative costs and profit that are not found in plan claims or provider incentive payments. CMS bases the Medicare payment for a private plan on the relationship between its bid and its applicable benchmark.

> The benchmark is a bidding target in each county and is set by means of a statutory formula based on percentages (ranging from 95 percent to 115 percent) of CMS's projections of each county's per capita, risk-standardized FFS Medicare spending. Plans with quality ratings of 4 or more stars typically have their benchmarks raised by up to 5 percent (and up to 10 percent in some counties).

> The risk-adjustment model used by Medicare to adjust payments to plans is based on FFS data and therefore reflects the expected spending and diagnostic-coding patterns in FFS Medicare. The model accounts for differences in demographics and recorded diagnoses. The Commission's comparisons use that risk-adjustment model as a starting point to standardize MA and FFS spending. However, Medicare's risk-adjustment model does not account for the effects of coding intensity (i.e., the extent to which the same beneficiary could have more diagnoses recorded in MA, and thus a higher risk score, than they would in FFS Medicare) or favorable selection (i.e., the extent to which the risk-adjustment model used to standardize spending overpredicts spending for MA enrollees even for beneficiaries who have diagnoses coded with the same level of intensity). Therefore, the Commission's final comparisons of MA payments and FFS spending incorporate adjustments for coding and selection to account for those ways in which Medicare's risk-adjustment model overstates what FFS spending would have been for MA beneficiaries.

(Chart continued next page)

Chart 9-7 MA plan benchmarks, bids, and Medicare program payments relative to what FFS spending would have been, 2026 (continued)

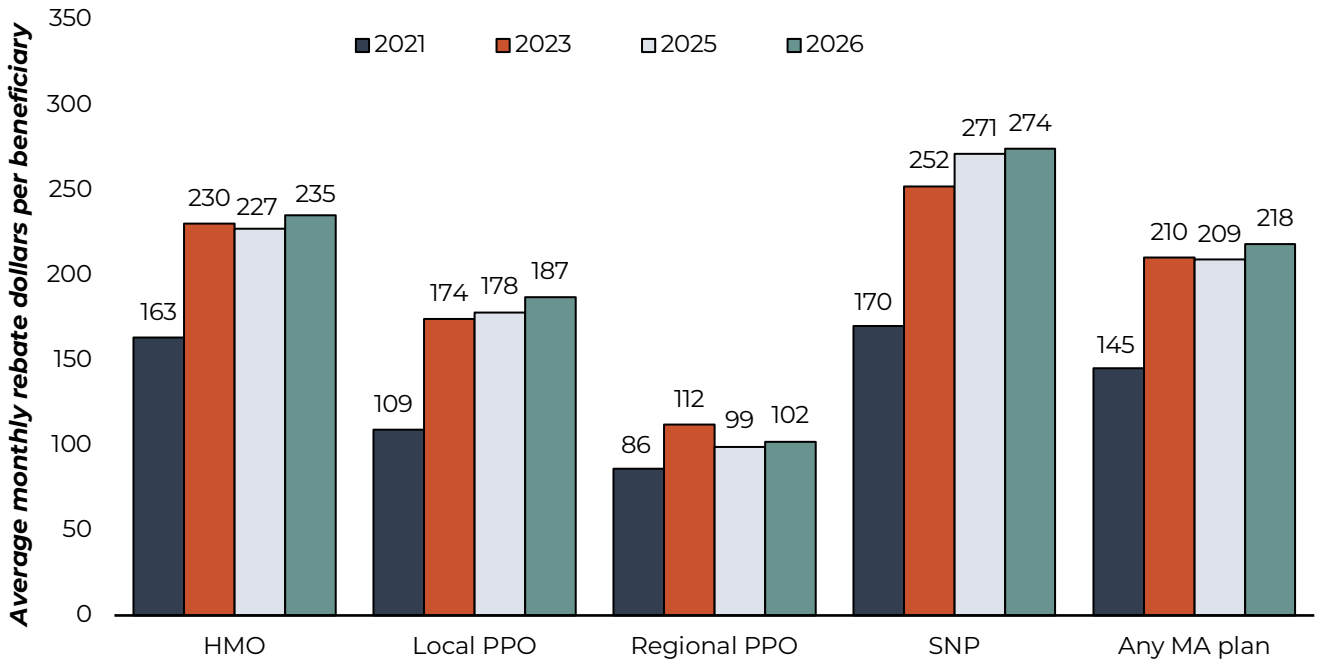
> If a plan's bid is below the benchmark, the plan receives its bid plus a "rebate," defined by law as a percentage of the difference between the plan's bid and its benchmark. The percentage is based on the plan's quality rating, and it is typically 65 percent or 70 percent. After accounting for administrative expenses and profit, plans must return rebates to enrollees in the form of lower cost sharing, supplemental benefits not covered by FFS Medicare, or lower premiums. (If a plan's bid is above the benchmark, then the plan receives the benchmark amount as payment from Medicare and enrollees have to pay an additional premium that equals the difference; however, bidding over the benchmark is rare. For 2026, virtually all plans bid below their benchmarks.)

> Using CMS's projections of FFS spending that do not fully account for the effects of coding or selection, we estimate that benchmarks will be an average of 107 percent of FFS spending in 2026. After accounting for the effects of coding and selection, we estimate that MA benchmarks in 2026 will average 124 percent of what FFS spending would have been for MA beneficiaries.

> Plans have generally bid below benchmarks since the current system began, and the difference between bids and benchmarks has grown. We estimate plans' enrollment-weighted bids to be 77 percent of benchmarks in 2026 (data not shown). We estimate plans' enrollment-weighted bids to be 95 percent, on average, of FFS spending for 2026. Not accounting for coding or selection, plan bids are estimated to average about 17 percent below FFS spending.

> Altogether, we estimate that MA payments are 14 percent higher than what Medicare would have spent to cover the same group of enrollees in FFS Medicare. That estimate incorporates adjustments for the effects of coding and selection. Before accounting for those effects, we estimate that payments to MA plans are about 99 percent of FFS spending.

Chart 9-8 Average monthly rebate payment, by plan type, 2021–2026



Note: HMO (health maintenance organization), PPO (preferred provider organization), SNP (special-needs plan), MA (Medicare Advantage). Employer group waiver plans are excluded. SNPs are a subset of HMO and PPO plans. Enrollment weights are based on months of enrollment for MA enrollees without end-stage renal disease (ESRD) since plans do not receive rebates for members with ESRD. We use data on plans' actual enrollment to calculate the enrollment weights. The enrollment data used as weights for 2025 and 2026 are adjusted using ESRD enrollment projections from plans' bids. In previous years, MedPAC used the enrollment projections from plan bids as weights for all years that were analyzed. As a result, estimates of average rebates for 2021, 2023, and 2025 reported in previous data books are slightly different from the estimates reported here. Dollar amounts are nominal figures, not adjusted for inflation.

Source: MedPAC analysis of bid data from CMS.

> The average rebate payment, which plans receive from Medicare to provide additional benefits that are not covered under Medicare Part A and Part B, is an important summary measure of plan generosity. Plans are awarded rebates for bidding below their benchmarks. The rebates must be returned to the plan members in the form of supplemental benefits (after accounting for plan margins and administrative costs). The extra benefits can include lower cost sharing, supplemental benefits not covered by Medicare, or lower premiums. The average rebate for all plans slightly increased on a nominal basis to $218 per month per beneficiary for 2026.

> HMOs have had higher rebates than PPOs because they tend to bid lower than PPOs. Average rebates for HMOs are $235 per month per beneficiary for 2026.

> Local PPOs' rebates have risen sharply, reaching $187 per month per beneficiary for 2026.

> In recent years, rebates grew particularly rapidly for SNPs, a subset of HMOs and PPOs that offer benefit packages tailored to specific populations (beneficiaries who are dually eligible for Medicare and Medicaid, are institutionalized, or have certain chronic conditions). Average rebates for SNPs rose to $274 per month in 2026 (up from $170 per month in 2021). The relatively large rebates for SNPs coincide with historically higher reported margins than conventional MA plans (data not shown) and higher relative coding intensity for beneficiaries who are dually eligible for both Medicare and Medicaid (see Chart 9-9).

Chart 9-9 Impact of diagnostic coding intensity on MA risk scores was larger for enrollees eligible for partial or full Medicaid benefits, 2024

Beneficiary group	Coding intensity relative to FFS Medicare
All MA enrollees	14.7%
New enrollees	N/A
Long-term institutional	9.8
No Medicaid benefits	13.5
Partial Medicaid benefits	25.9
Full Medicaid benefits	18.4

Note: MA (Medicare Advantage), FFS (fee-for-service), N/A (not applicable). Coding-intensity estimates are reported before accounting for the application of the coding-intensity adjustment that reduced MA risk scores by 5.9 percent in 2024. Enrollees with end-stage renal disease (ESRD) are excluded. In this analysis, we first determined whether a beneficiary was a new enrollee, then we determined long-term institutional status (based on the presence of a 90-day Minimum Data Set assessment for nursing home residents), and then Medicaid eligibility. New enrollees have a risk score based only on demographic factors and therefore do not exhibit diagnostic coding intensity. Analysis uses the demographic estimate of coding intensity (DECI) method, which is the MA-to-FFS CMS hierarchical condition (HCC) risk-score ratio divided by the MA-to-FFS demographic risk-score ratio, estimated separately for each beneficiary group. MedPAC's DECI estimate for all MA enrollees accounts for differing shares of MA and FFS enrollment across the beneficiary groups by weighting MA enrollment for each group to calculate overall average MA and FFS CMS–HCC risk scores and demographic risk scores. See Appendix 12-C of our March 2026 report to the Congress for more information about our analysis using the DECI method.

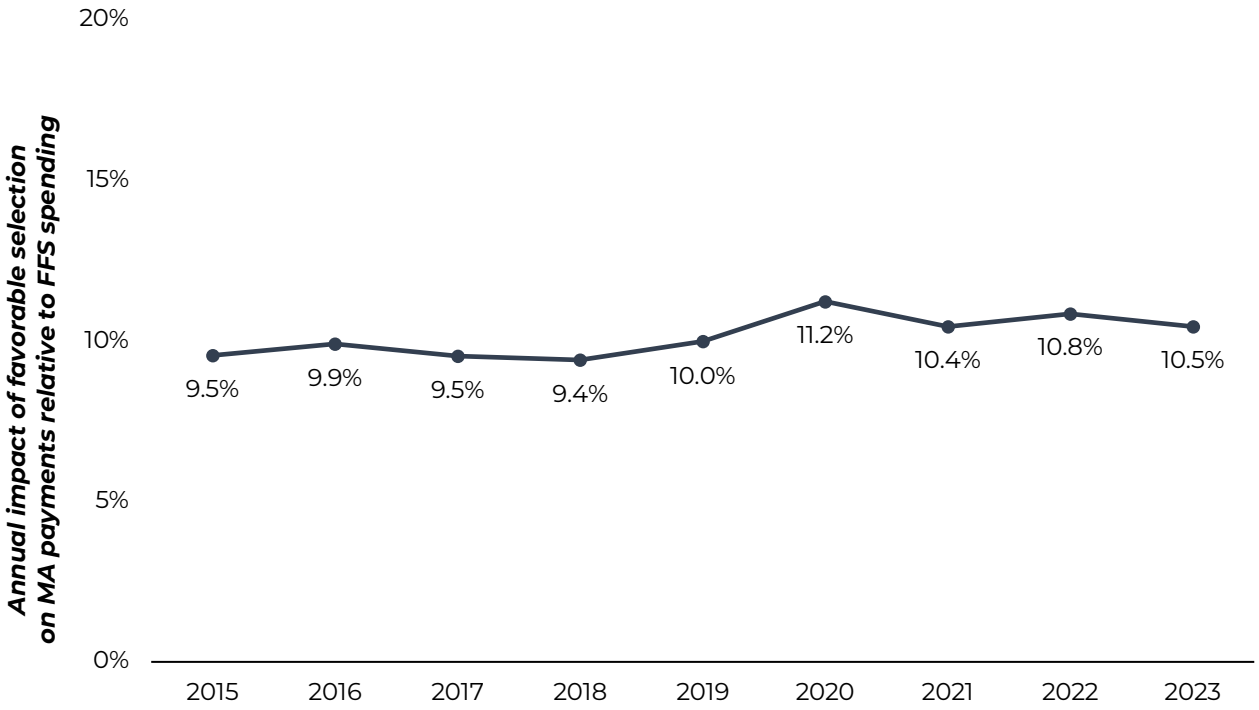
Source: MedPAC analysis of CMS enrollment and risk-score files, 2023 and 2024.

> Payments to MA plans are risk adjusted to account for differences in expected health spending. Risk adjustment increases payments to plans for enrollees with higher expected Medicare spending. An enrollee's risk score is based on demographic information and diagnoses that plans submit to CMS. Documenting additional diagnosis codes raises plan enrollees' risk scores, which increases the rebates that plans use to provide extra benefits to enrollees. Plans that document relatively more diagnosis codes therefore have a competitive advantage over other plans. In contrast, the payment policies in FFS Medicare offer relatively little incentive to code all diagnoses. This difference in coding incentives results in higher risk scores when a beneficiary enrolls in MA than if the same beneficiary had enrolled in FFS Medicare. As a result of higher MA coding intensity, the Medicare program pays more, on average, when a beneficiary enrolls in MA than it would if the same beneficiary were in FFS Medicare. This phenomenon is true both for beneficiaries who have higher-than-average and lower-than-average spending.

> In 2024, for beneficiaries without ESRD, MA risk scores on average were an estimated 14.7 percent higher than risk scores for comparable FFS beneficiaries due to coding intensity. Those higher risk scores were partially offset by CMS's coding-intensity adjustment, which reduced MA risk scores by 5.9 percent. See Appendix 12-C of our March 2026 report to the Congress for information about coding intensity for MA enrollees with ESRD.

> MA enrollees without ESRD who were eligible for full or partial Medicaid benefits had higher coding intensity relative to FFS than enrollees who were not eligible for Medicaid. Coding intensity for MA enrollees who were eligible for partial Medicaid benefits was 25.9 percent higher than for FFS beneficiaries who were eligible for partial Medicaid benefits. Coding intensity for MA enrollees who were eligible for full Medicaid benefits was 18.4 percent higher than for FFS beneficiaries who were eligible for full Medicaid benefits. By contrast, coding intensity for MA enrollees who were not eligible for Medicaid was 13.5 percent higher than their FFS counterparts, and coding intensity for MA enrollees with long-term institutional status was 9.8 percent higher than their FFS counterparts.

Chart 9-10 Estimated impact of favorable selection, 2015–2023



Note: MA (Medicare Advantage), FFS (fee-for-service). Estimates include both beneficiaries with and without end-stage renal disease (ESRD). Estimates for beneficiaries without ESRD were constructed using the Commission's comprehensive method for estimating favorable selection. Estimates for beneficiaries with ESRD were constructed using the Commission's simple method. Selection occurs when Medicare's risk-adjustment model overpredicts spending for MA enrollees when setting county benchmarks, even for beneficiaries with similar coding intensity. See Appendix 12-B of our March 2026 report to the Congress for more information about our analysis of favorable selection.

Source: MedPAC analysis of Medicare enrollment (2006–2023), Medicare claims spending (2007–2023), and risk-adjustment files (2007–2023).

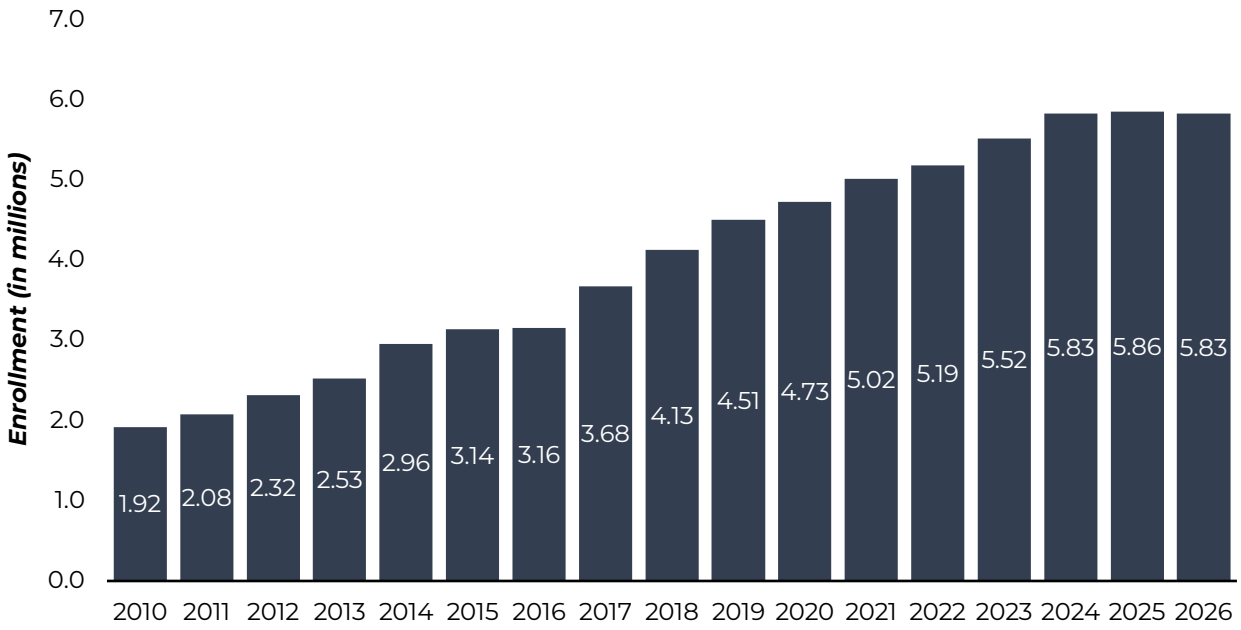
> When setting MA benchmarks and paying plans for each enrollee, CMS implicitly assumes that if MA enrollees were in FFS Medicare, their average Medicare spending would be equal to that of current FFS enrollees in the same county after adjusting for differences in risk scores. "Favorable selection" refers to the tendency for Medicare's risk-adjustment model to—on average—overpredict the spending that the MA-enrolled population would have had if they were enrolled in the FFS program, even for beneficiaries with similar coding intensity. Favorable selection can occur due to unmeasured differences in health status but can also result from factors such as differences in beneficiaries' propensities to seek care for reasons that are unrelated to their health.

> The estimated effect of favorable selection was substantial in every year during the 2015 to 2023 period, indicating that the risk model overpredicted the spending that the MA population would have incurred in the FFS program by between about 9 percent and 11 percent.

> On net, favorable selection persisted throughout the study period even as a larger share of Medicare beneficiaries enrolled in MA (see Chart 9-1).

> In 2023, the effect of favorable selection alone resulted in MA payments that were 10.5 percent above what would have occurred in the FFS program.

Chart 9-11 Enrollment in employer group MA plans, 2010–2026



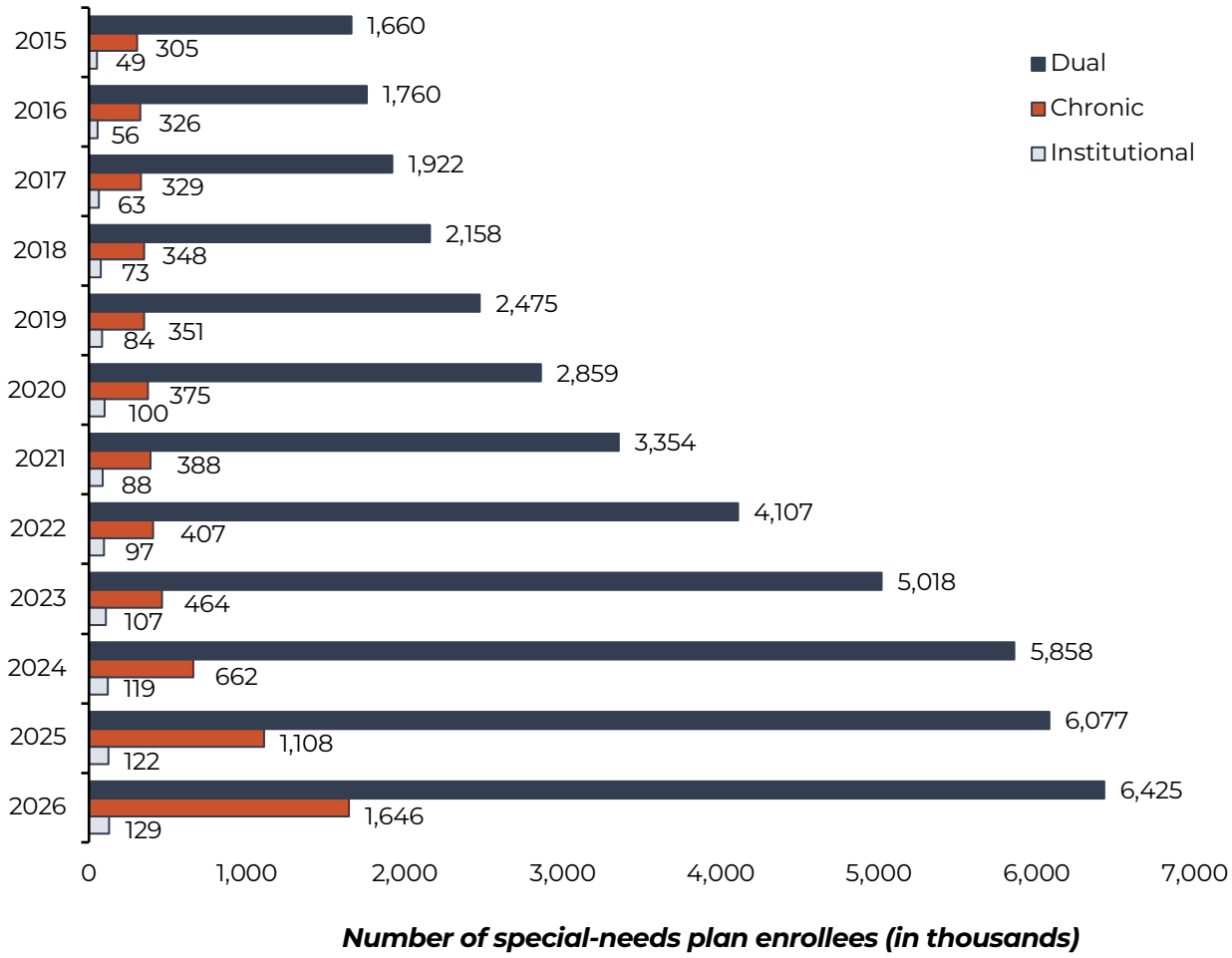
Note: MA (Medicare Advantage).

Source: CMS enrollment data, February 2010–2026.

> While most MA plans are available to any Medicare beneficiary residing in a given area, some MA plans are available only to retirees whose Medicare coverage is supplemented by their former employer or union. These plans are called employer group plans. Such plans are usually offered through insurers and are marketed to groups formed by employers or unions rather than to individual beneficiaries.

> As of February 2026, about 5.8 million enrollees were in employer group plans, or about 16 percent of all MA enrollees. Employer plan enrollment decreased by less than 1 percent from 2025 but has more than doubled since 2013.

Chart 9-12 Number of enrollees in special-needs plans, 2015–2026



Source: CMS special-needs plans comprehensive reports, February 2015–2026.

> Special-needs plans (SNPs) offer benefit packages that are tailored to specific populations. Dual-eligible SNPs enroll only beneficiaries dually entitled to Medicare and Medicaid, chronic condition SNPs enroll only beneficiaries who have certain chronic or disabling conditions, and institutional SNPs enroll only beneficiaries who reside in institutions or are nursing home certified.

> The vast majority of SNP enrollees are in dual-eligible SNPs (D–SNPs). Enrollment in D–SNPs has more than tripled since 2015, exceeding 6 million—about 18 percent of all MA enrollees—in 2026.

> Enrollment in chronic condition SNPs (C–SNPs) has grown at varying rates as plan requirements have changed, but it has generally risen annually since 2015. In 2026, about 1.6 million beneficiaries (about 5 percent of all MA enrollees) were enrolled in C–SNPs.

> Enrollment in institutional SNPs increased to its highest level ever in 2026 but accounts for less than 1 percent of all MA enrollees.

> The number of SNPs increased by 19 percent from February 2025 to February 2026 (data not shown). D–SNPs increased by 12 percent, I–SNPs decreased by 5 percent, and the number of C–SNPs increased by 46 percent (data not shown).

Chart 9-13 MA prior-authorization requests and outcomes, 2019–2024

Number (in thousands)

	2019	2020	2021	2022	2023	2024
Initial determination	35,882.7	30,707.0	37,787.2	45,705.2	48,809.2	51,122.5
Fully favorable	33,855.2	29,083.7	35,705.1	42,339.3	45,700.1	47,198.1
Partially favorable	403.6	303.2	412.6	822.1	585.9	1,054.4
Adverse	1,623.9	1,320.1	1,669.6	2,543.9	2,523.1	2,870.0
Reconsideration	150.7	167.3	229.1	334.3	361.6	450.3
Fully favorable	121.7	134.3	184.2	275.0	290.8	357.8
Partially favorable	1.2	1.7	2.5	2.9	4.4	5.1
Adverse	27.9	31.3	42.3	56.4	66.4	87.4

Percentage

	2019	2020	2021	2022	2023	2024
Initial determination	100%	100%	100%	100%	100%	100%
Fully favorable	94.3	94.7	94.5	92.6	93.6	92.3
Partially favorable	1.1	1.0	1.1	1.8	1.2	2.1
Adverse	4.5	4.3	4.4	5.6	5.2	5.6
Reconsideration	0.4	0.5	0.6	0.7	0.7	0.9
Fully favorable	80.7*	80.3*	80.4*	82.3*	80.4*	79.5*
Partially favorable	0.8*	1.0*	1.1*	0.9*	1.2*	1.1*
Adverse	18.5*	18.7*	18.5*	16.9*	18.4*	19.4*

Note: MA (Medicare Advantage). Percentages may not sum to 100 due to rounding.
* Due to small numbers, these percentages reflect reconsideration outcomes as a share of reconsiderations.

Source: MedPAC analysis of CMS Part C reporting requirements and MA enrollment data, 2019–2024.

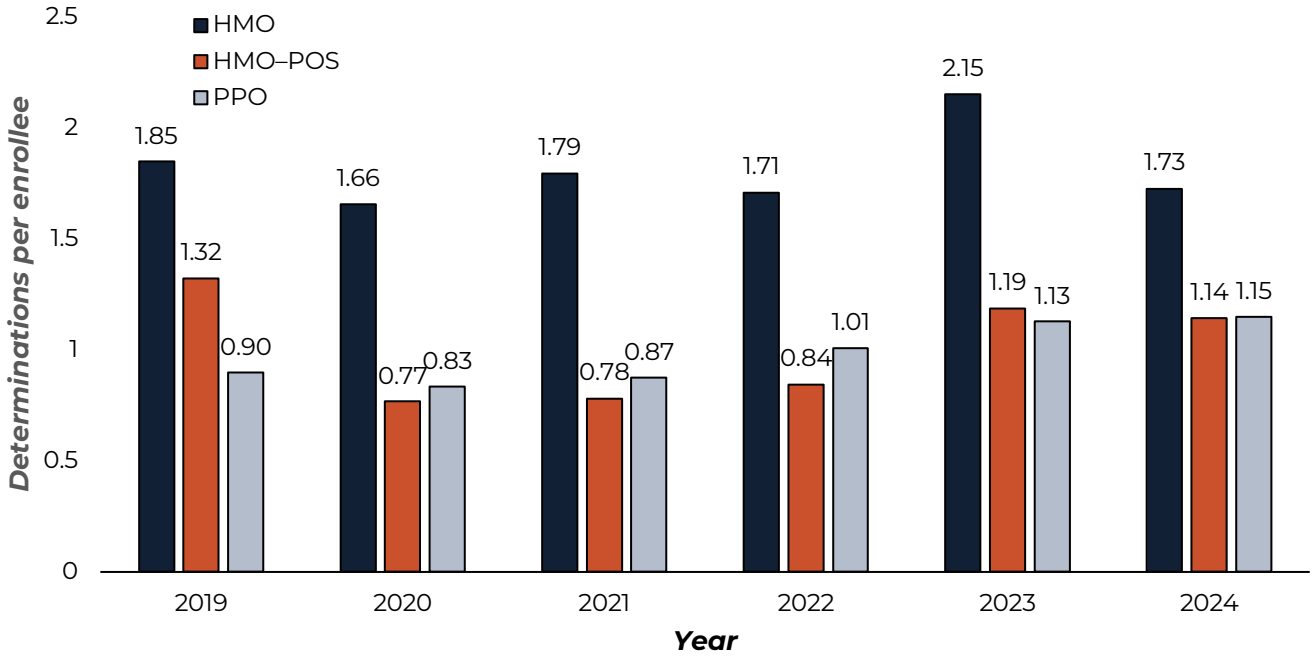
> Prior-authorization requests from enrollees and providers to MA plans have been increasing steadily over time in aggregate, from approximately 35.9 million requests overall in 2019 to over 51 million requests in 2024. The trend for per capita rate of prior authorizations has been less clear over time, with a rate of 1.49 in 2019 declining sharply to 1.25 in 2020, before rising steadily to a maximum of 1.55 in 2023 (data not shown). MA enrollees could expect about 1.38 prior authorizations per capita in 2024.

> Prior authorizations are overwhelmingly approved by MA organizations in the first instance, known as the initial determination (the outcome is fully favorable between 92 percent and 95 percent of the time, across 2019 to 2024).

> "Partially favorable" outcomes—such as a requirement for step therapy or the approval of a fraction of the number of requested days for a hospital stay—are rare, occurring in just over 1 percent of cases in 2023 but increasing to just over 2 percent of cases in 2024.

> Less than 1 percent of prior-authorization determinations are appealed. First-level appeals are reviewed by the MA organization in a process called "reconsideration." Reconsiderations were also overwhelmingly approved. Despite a large increase in the volume of reconsiderations—from 151,000 in 2019 to 450,000 in 2024—outcomes were fully favorable in about 80 percent of cases or above in recent years.

Chart 9-14 Per capita prior-authorization requests by plan type, 2019–2024



Note: HMO (health maintenance organization), HMO–POS (HMO point of service), PPO (preferred provider organization).

Source: MedPAC analysis of CMS Part C Reporting Requirements and MA enrollment data, 2019–2024.

> Prior authorization was more common for people enrolled in HMOs than for those enrolled in HMO–POS and PPO plans. HMOs processed, on average, 1.7 determinations per enrollee in 2024, compared to 1.1 determinations per enrollee in HMO–POS and PPO plans.

> There was a slight decline in prior authorizations per capita from 2023 across all plan types except PPOs, which exhibited a small increase from 1.13 to 1.15 initial determinations per enrollee. It is too early to determine whether this represents a peak in prior-authorization use by MA plans in 2023.