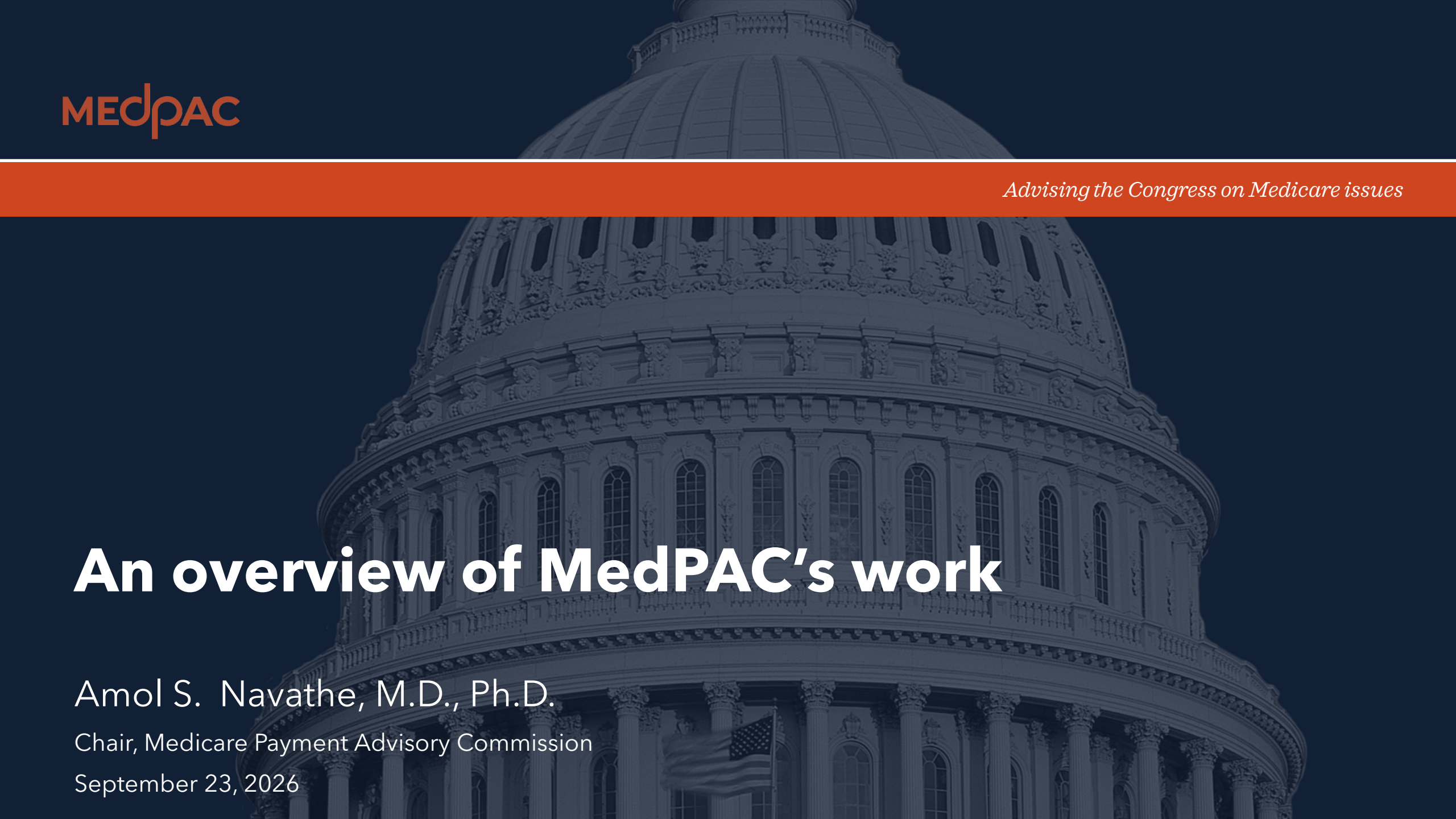

MEDPAC

Advising the Congress on Medicare issues

An overview of MedPAC's work

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Chair, Medicare Payment Advisory Commission

September 23, 2026

MedPAC's mission and structure

- Provide independent, nonpartisan policy and technical advice to the Congress on issues affecting the Medicare program
- Seven public meetings during the year
- Transparency is integral to MedPAC's work: Public comments, meeting transcripts, presentations, annual analytic agendas, and other products are all available on MedPAC's website
- MedPAC's principles of Medicare payment
  - Payments should be sufficient to support beneficiary access to high-quality health care in an appropriate clinical setting
  - Providers should have incentives to supply appropriate and equitable care in an efficient manner
  - Medicare payments should reflect efficient care delivery, thereby ensuring that the program's fiscal burden on beneficiaries and taxpayers is not greater than necessary

Priorities for future work

MedPAC's upcoming analytic agenda includes a broad range of topics

- Planned and ongoing analysis
  - Accuracy in the physician fee schedule
  - Trends in utilization and spending for Part B drugs and hospice
  - Payments for software as a medical service and prescription digital therapeutics
  - Access to care for rural beneficiaries
  - The average generosity of medical benefits in MA relative to FFS
- Selected policy areas for 2026 - 2027
  - Recent trends in cost sharing and spending under Part D
  - Opportunities to simplify beneficiary enrollment process
  - Medicare's approach to clinician quality measurement and value

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

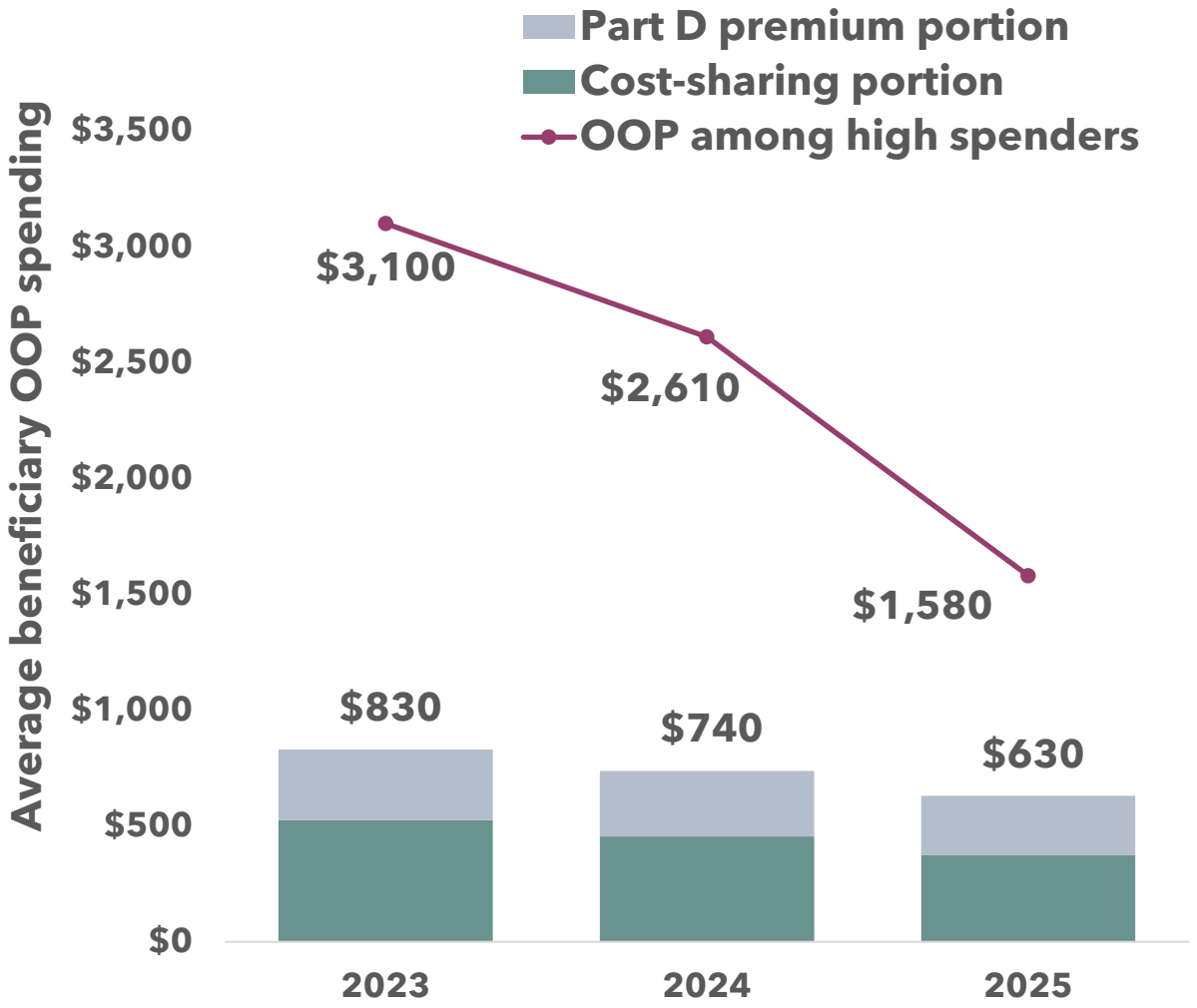
Medicare Part D: Market structure and stability

Emerging challenges in Part D

- The benefit redesign reduced cost sharing and improved affordability for enrollees with high drug spending
- These changes have increased Part D benefit spending
  - Temporary policies to reduce premiums also increase Medicare spending
- Continued growth in benefit costs after these policies phase out could lead to substantial increases in enrollee premiums
- Higher benefit costs and premiums may affect the long-term stability of the Part D market, especially for PDPs

Note: PDP (stand-alone prescription drug plan).

Non-LIS enrollees' OOP spending declined from 2023 to 2025 (inflation-adjusted)

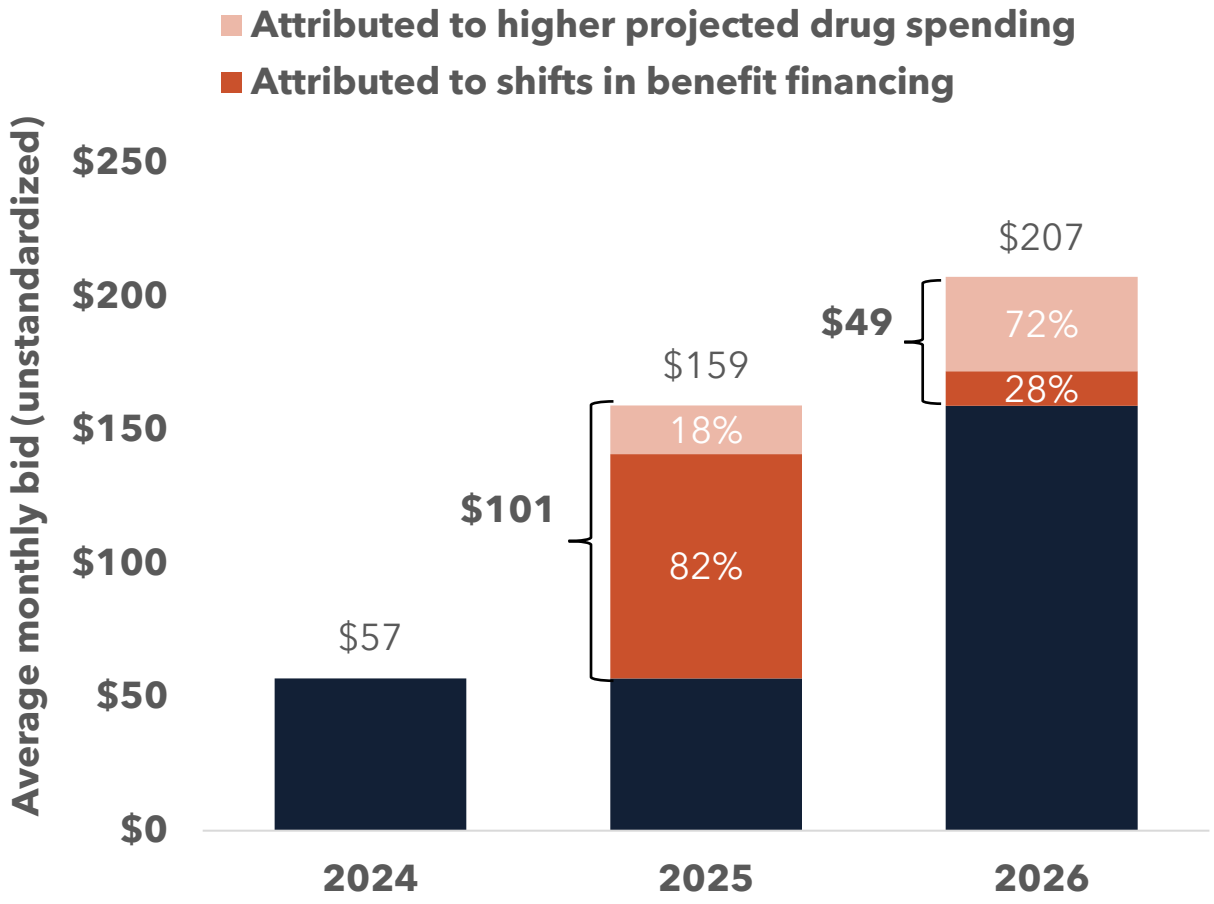


- OOP spending declined by $200 (25%), on average, from 2023 to 2025
  - Cost sharing declined by 30%
  - Premium spending by 16%
- Among high-spenders, OOP spending declined by 50%
- Over the same time, program spending per enrollee increased by 30% (data not shown)

Note: LIS (low-income subsidy). OOP (out-of-pocket), "Beneficiary OOP spending" is the sum of cost sharing plus and total Part D premiums paid OOP. "OOP among high spenders" is the average OOP spending among the top 10 percent highest-spending enrollees. Figures exclude LIS beneficiaries and those enrolled in employer group waiver plans. Spending reflects gross spending before retrospective rebates and discounts.

Source: MedPAC analysis of Part D prescription drug event (preliminary for 2025) and landscape data from CMS.

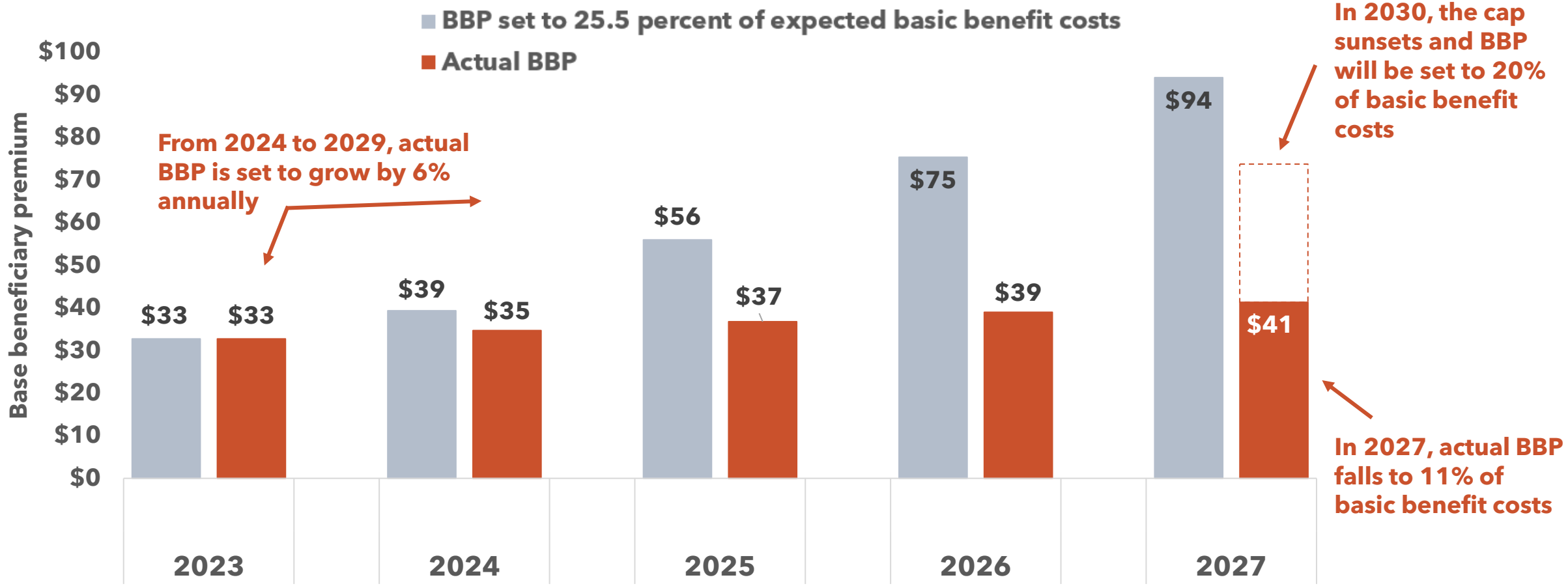
Plan liability (Part D bids) rose due to shifts in financing and higher spending



- We decomposed increases in average Part D bids using unadjusted spending projections reported by plans
  - In 2025, most of the increase in bids was attributed to the IRA's shifts in benefit financing
  - In 2026, most of the increase was attributed to higher expected drug spending
  - In both years, bids also reflected uncertainty regarding utilization growth under the redesigned benefit
- In 2027, plan bids continued to grow, by 24%, on average (data not shown)*

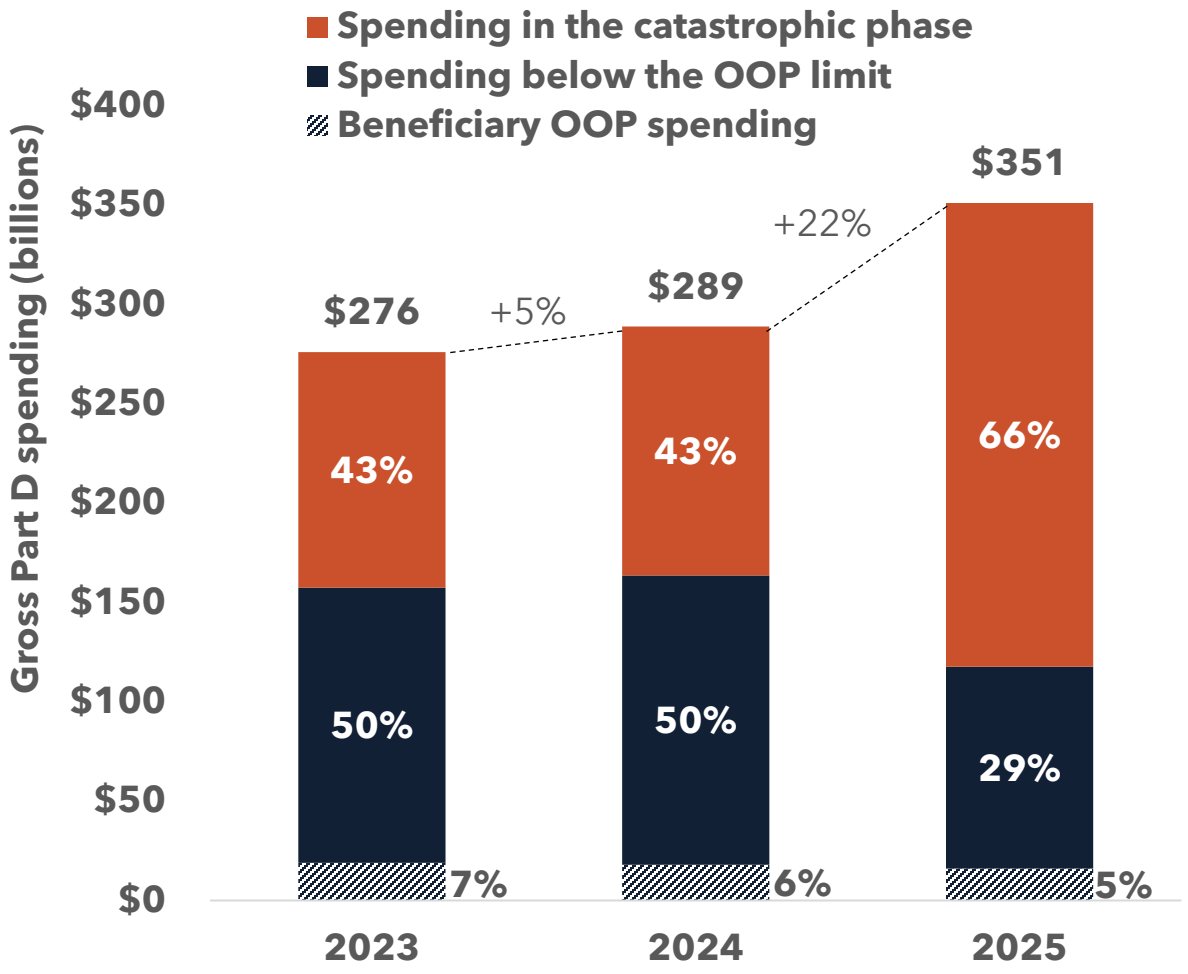
Note: IRA (Inflation Reduction Act of 2022). The dark bottom parts of the bars represent the average bid for 2024 and the prior year's average bids for 2025 and 2026. Figure excludes special-needs plans since their bids are not included in the calculation of the national average monthly bid amount. We used unadjusted spending amounts since this is how plans build their bids. For more information on how we attributed bid growth to shifts in benefit financing vs. higher projected drug spending, see March 2026 Report to the Congress (Chapter 13) https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch13_MedPAC_Report_To_Congress_SEC.pdf.
* https://www.cms.gov/newsroom/fact-sheets/medicare-part-d-2027-national-average-monthly-bid-amount-information
Source: Part D bid pricing tool data from CMS.

Premiums are likely to rise sharply when the basic premium growth cap is sunset



Note: BBP (base beneficiary premium).
Source: MedPAC analysis of BBP amounts in CMS's announcements of Part D national average monthly bid amount.

Gross spending increased sharply, with two-thirds of Part D spending above the OOP limit, in 2025



- High growth in spending to $351B
- Beneficiary OOP share fell to 5%
- Catastrophic spending as a share of total spending grew to 66%
  - Redesigned benefit was expected to increase spending in this phase
  - Majority of spending in 2025 not subject to any cost sharing

Note: OOP (out-of-pocket), Spending is gross spending before retrospective rebates and discounts. "Spending in the catastrophic phase" occurs when enrollees reach the OOP limit in the year. "Spending below the OOP limit" excludes beneficiary OOP spending shown in the bottom portion of the bars. See Figure 13-1 of the March 2026 Report to the Congress for how the benefit is financed below and above the OOP limit.

Source: MedPAC analysis of Part D prescription drug event data (preliminary for 2025) and Part D enrollment data from CMS.

Understanding the drivers of spending growth is important

- Underlying price and utilization trends for specialty drugs
- Eliminating cost sharing in the catastrophic phase likely accelerated spending growth in 2024
- The IRA strengthened plan incentives to manage spending but may also limit plans' ability to manage spending
  1. TrOOP policy: Supplemental benefits counting as TrOOP lowers the effective OOP limit and may increase spending
  2. Benefit design: Lower OOP limit combined with high deductible and 25% coinsurance compress initial coverage phase and may increase spending

Note: IRA (Inflation Reduction Act of 2022), TrOOP (true out of pocket), OOP (out-of-pocket).
Source: https://www.cms.gov/oact/tr/2024, https://www.cms.gov/oact/tr/2025, https://www.cms.gov/oact/tr/2026; https://www.milliman.com/en/insight/moop-2025-part-d-beneficiaries-spending; https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_Ch12_MedPAC_Report_To_Congress_SEC.pdf, Changes in Medication Use After Medicare Part D Annual Out-of-Pocket Spending Caps | Health Policy | JAMA Health Forum | JAMA Network.

Opportunities to simplify the beneficiary enrollment process

Medicare beneficiaries make complex enrollment decisions

- Last year, the Commission began analyzing the complexity of the Medicare enrollment process, the enrollment decisions that beneficiaries face, and the information sources that beneficiaries use to navigate those decisions
  - Enrollment requirements and time frames can be confusing and may have lifelong implications
  - Beneficiaries weigh various factors when choosing between FFS Medicare and MA, including financial protection, access to care, and the availability of extra benefits
- Building on prior work, the Commission intends to continue to examine opportunities to simplify the beneficiary enrollment experience and better support beneficiaries as they enroll in Medicare

Medicare's approach to clinician quality measurement and value

MedPAC's focus on improving Medicare's quality measurement

- Supports Medicare's measurement of the quality of care furnished by providers to:
  - Monitor performance
  - Inform patients and payers
  - Encourage the provision of high-quality care
- The Commission has recommended redesigns of FFS quality payment programs for clinicians, hospitals, skilled nursing facilities and the MA quality bonus program

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

Measuring and paying for clinician quality is especially challenging

- MedPAC recommended eliminating MIPS in March 2018 due to its design flaws
- This cycle, the Commission plans to assess whether Medicare's quality measurement and value-based payment programs are improving quality and providing value for the Medicare program
  - Begin with a focus on clinician quality measurement programs
  - Future cycles may consider other programs

Note: MIPS (Merit-based Incentive Payment System). MIPS is pay-for-performance programs for clinicians not in advanced-alternative payment models. MIPS is an individual clinician-level payment adjustment based on quality, cost, advancing care information, and clinical practice improvement activities.

Recent work on Medicare Advantage

MedPAC's approach to improving Medicare

- MA and FFS are each essential parts of the Medicare program
- Must improve each for better value for beneficiaries and taxpayers
- We have discussed FFS improvements that:
  - Improve payment accuracy (Payment incentives in the PFS)
  - Increase fairness across geographic areas and populations (Reduce cost sharing for outpatient services in CAHs, develop a Medicare safety-net index)
  - Increase efficiency across payment systems (Expand site-neutral payment policy)
  - Improve incentives for efficient care (Support value-base payment programs)
- We have discussed MA improvements that:
  - Improve competition (Measure quality, choice at local market level)
  - Increase fairness between plans (Address remaining coding differences)
  - Reduce administrative burden for plans, CMS (Reform QBP)
- We have also discussed improvements across programs including issues related to the complexity of the beneficiary enrollment process

Note: MA (Medicare Advantage), FFS (fee-for-service), PFS (Physician Fee Schedule), CAH (Critical Access Hospital), CMS (Centers for Medicare and Medicaid Services), QBP (Quality Bonus Payment).

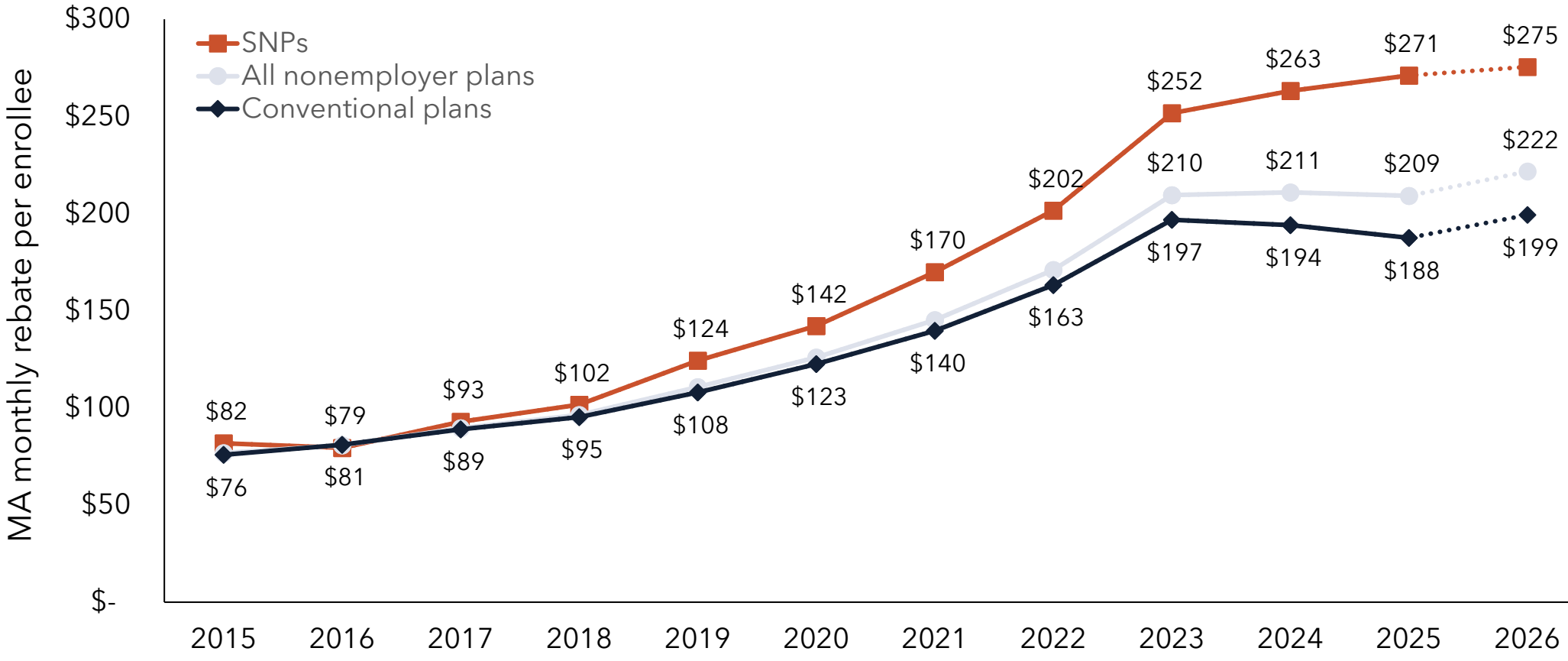
MA plans available to nearly all Medicare beneficiaries; number of choices is stable

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
- Regional variation in offerings

Note: MA (Medicare Advantage), D-SNP (dual-eligible special-needs plan). Plan availability excludes special-needs plans and employer plans.
Source: MedPAC analysis of CMS bid and enrollment data.

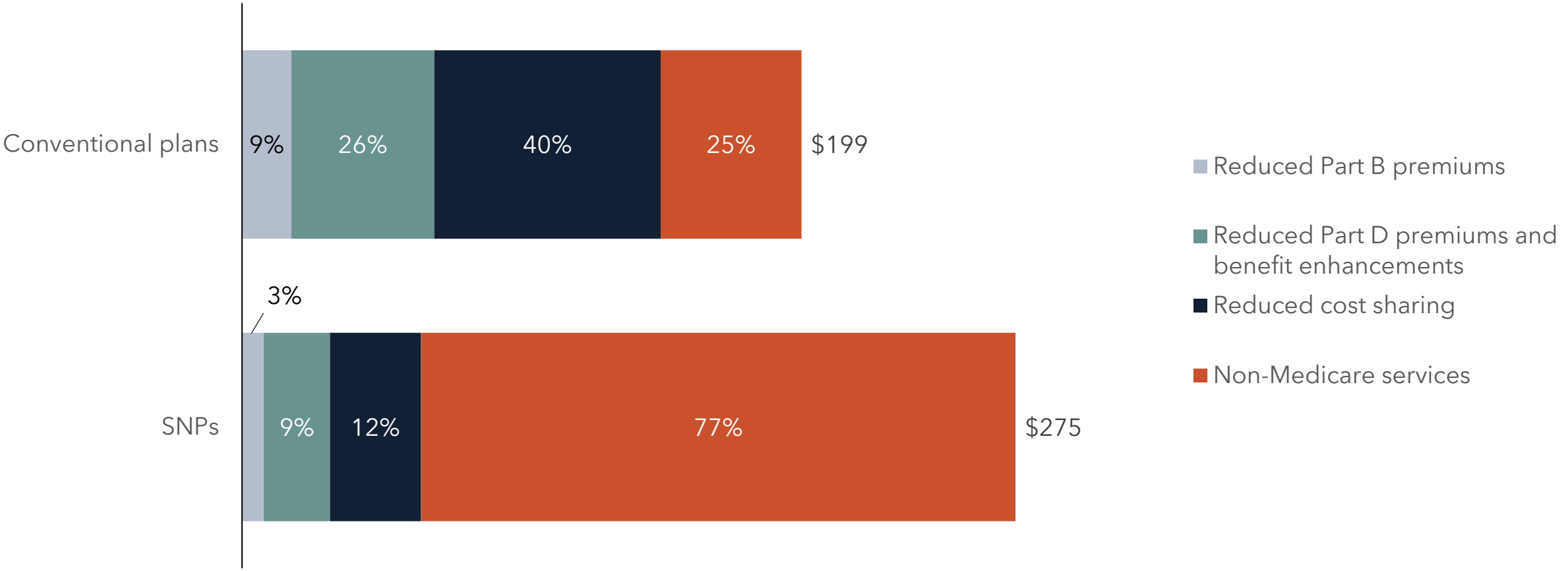
MA rebates have grown substantially over the past decade



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 were 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.

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

	Share of total			MA enrollment as a share of total MA-eligible category
	All MA-eligible beneficiaries	FFS	MA	
Total	100%	100%	100%	54%
Aged 65 or older	89	90	88	53
Under 65	11	10	12	58
No dual eligibility	81	86	77	51
Full dual eligibility	13	11	15	59
Partial dual eligibility	6	3	8	78
Enrollment subcategories, all ages				
ESRD	1	1	1	50

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

Each year, the Commission compares spending on MA to what Medicare would have spent if MA enrollees were instead enrolled in FFS

- MedPAC's estimate that Medicare spends more on MA enrollees is a purely fiscal calculation and accounts for the ways the enrollee populations differ between programs including:
  - Favorable selection
  - Diagnostic coding differences
  - Geographic distribution
- MA and FFS also offer different benefits which are important to beneficiaries but not part of the fiscal calculation
- Calculation also accounts for other aspects of MA payment including bidding behavior, benchmarks, and QBP adjustments

Note: MA (Medicare Advantage), FFS (fee-for-service), QBP (quality bonus program).

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

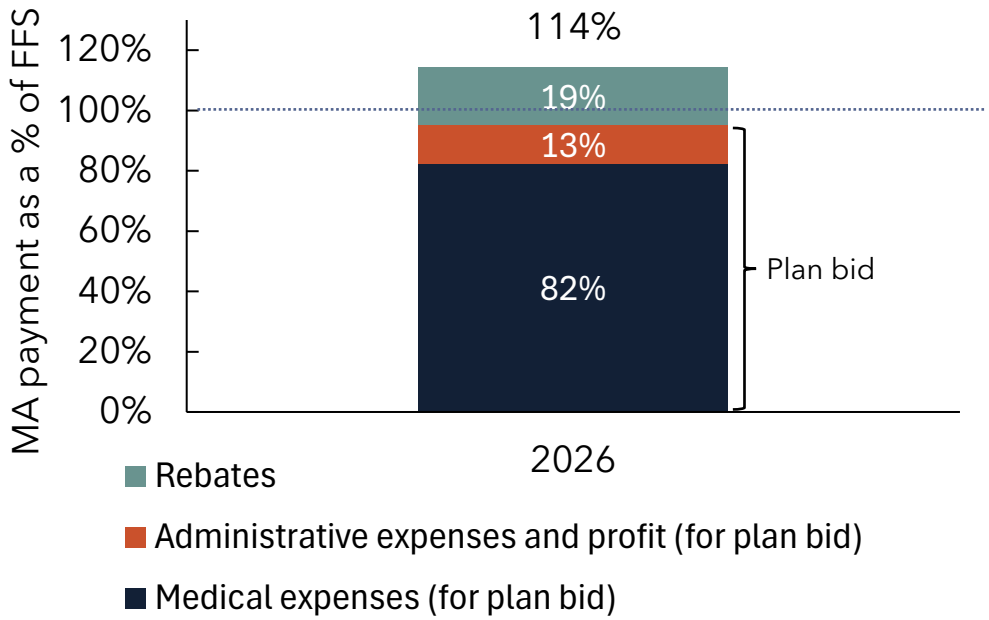
Note: MA (Medicare Advantage), FFS (fee-for-service). The "overall" estimate of benchmarks, bids, and payments as a share of FFS spending incorporates all three components of MedPAC's methodology for comparing payments: (1) a base comparison of MA payments to FFS spending that standardizes for differences 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.

MA bids and rebates are consistent with both plan efficiencies and higher payments from coding and selection

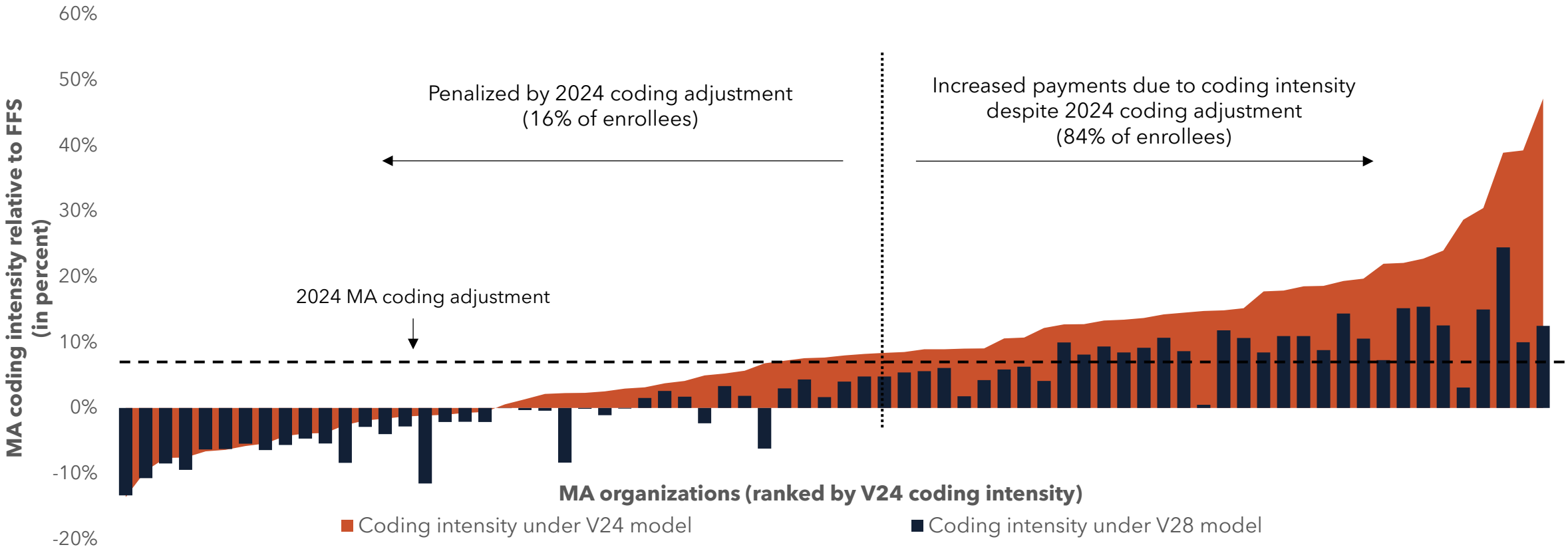
- MedPAC's analysis indicates plans reduce their enrollees' medical expenses by 18 percent below what they would have been in FFS
  - Consistent with existing literature (Huckfeldt et al. 2026; Inovalon 2025; Jung et al. 2025; Teigland et al. 2025)
- Without adjustments for coding and selection, unrealistically high levels of medical spending reductions are needed to explain rebate payments (Chernew et al. 2026)

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



Note: MA (Medicare Advantage), FFS (fee-for-service). Estimates of MA payments relative to what spending would have been in FFS incorporate all three components of the Commission's methodology for comparing MA payments with FFS spending: a base comparison of MA payments with FFS spending that standardizes for differences in risk scores and geography; an adjustment to that base comparison for favorable selection; and an adjustment for coding intensity. Components may not sum to totals due to rounding. Full note available in the June 2025 report to the Congress.

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.

MedPAC's recent work on the physician fee schedule

Concern: MEI growth is projected to exceed fee schedule updates by more than it did in the past

- MEI growth outpaced fee schedule updates by just over 1 percentage point per year for the two decades ending in 2020
- MEI growth likely substantially exceeded updates from 2020 to 2025
- From 2025 to 2034, the average annual difference between projected MEI growth and current-law fee schedule updates is larger than the two decades ending in 2020:
  - 1.5% per year for clinicians in A–APMs
  - 2.0% per year for clinicians not in A–APMs
- This larger gap between MEI growth and PFS updates could negatively affect access to clinician care in the future

Note: MEI (Medicare Economic Index), PFS (physician fee schedule), A–APM (advanced alternative payment model).

June 2025 recommendation to update PFS rates annually by a portion of MEI growth

- Replace the dual PFS updates based on A–APM participation with an update based on a portion of MEI growth
  - Key concept: Historical evidence suggests that a full MEI update has not been needed to maintain access to care
- Policymakers could consider a range of specific designs (e.g., update floors and ceilings)
- Updates based on a portion of MEI growth have multiple benefits:
  - Automatically adjust to changes in inflation
  - Improve predictability
  - Simple to administer
  - Balance beneficiary access with beneficiary and taxpayer financial burden

Note: PFS (physician fee schedule), MEI (Medicare Economic Index), A–APM (advanced alternative payment model).

MedPAC work on accuracy of the physician fee schedule

- Accuracy of RVUs is important because misvaluation has multiple effects
  - Can incentivize oversupply or undersupply of services
  - Can influence decisions about vertical consolidation
  - Non-Medicare payers base payments on misvalued codes
- Approaches to improve accuracy of relative payment rates (2025)
  - Update allocation of work, practice expense, and malpractice insurance RVUs
  - Improve the accuracy of global surgical payment codes
  - Improve the accuracy of relative payments for indirect practice expense*
- Recommendations to improve fee schedule accuracy (2006 and 2011)
  - Establish expert panel to assist CMS's review of RUC recommendations and regularly collect data from cohort of efficient practices

Note: RVU (relative value unit), Relative Value Scale Update Committee (RUC). *CMS implemented a policy consistent with this in its CY 2026 final rule.
Source: Medicare Payment Advisory Commission, 2025, *Report to the Congress*. Medicare Payment Advisory Commission, 2006, *Report to the Congress*. Medicare Payment Advisory Commission, 2011, Moving forward from the sustainable growth rate system.

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Questions?

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