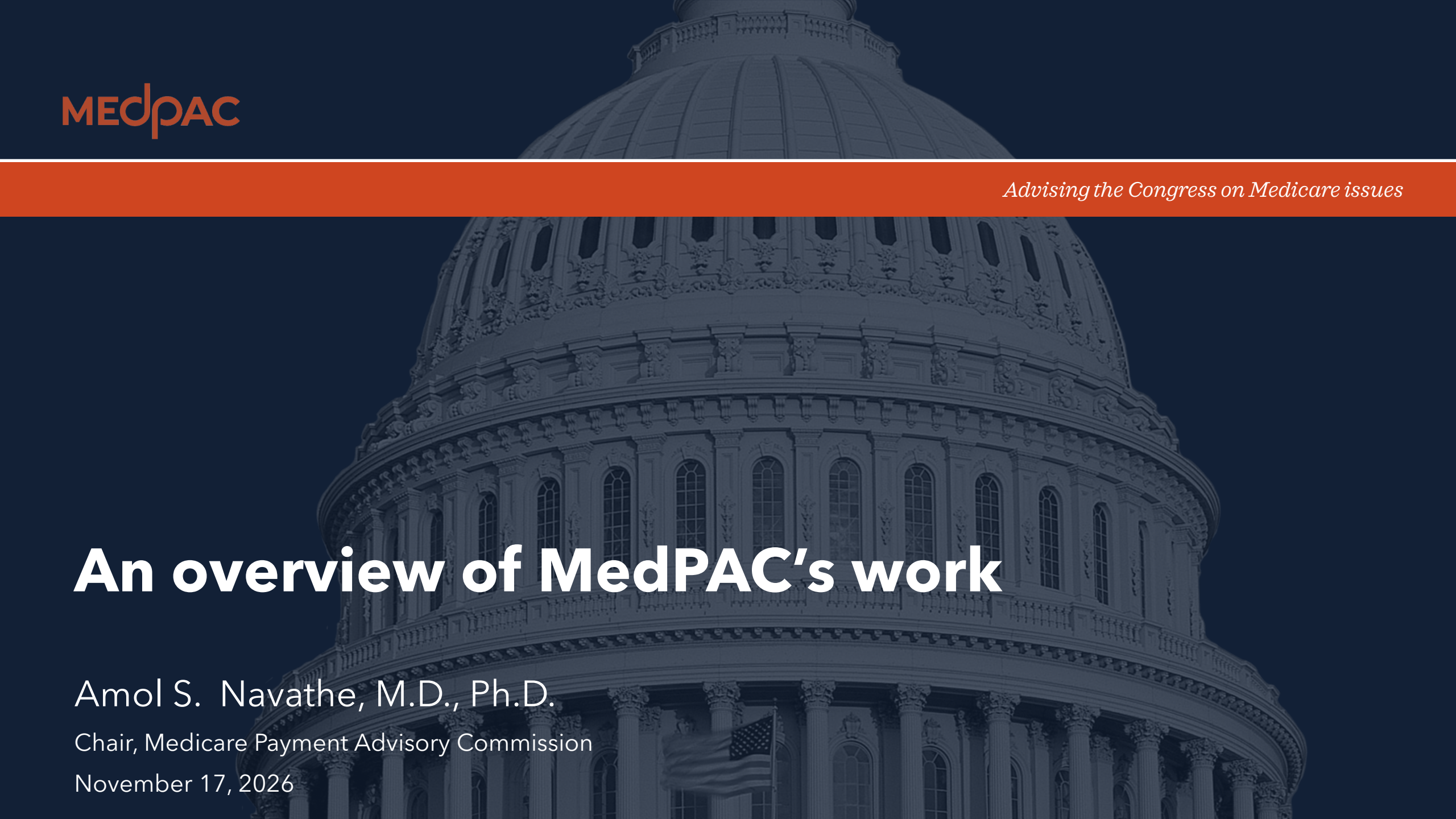


MEDPAC

Advising the Congress on Medicare issues

An overview of MedPAC's work

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Chair, Medicare Payment Advisory Commission

November 17, 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

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
  - Opportunities to simplify beneficiary enrollment process
  - Medicare's approach to clinician quality measurement and value
- Selected policy areas for discussion
  - FFS Medicare, including recent work the physician fee schedule
  - Medicare Advantage
  - Recent trends in cost sharing and spending under Part D

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

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).

Medicare fee-for-service

Medicare fee-for-service (FFS)

- Traditional Medicare operates under a FFS payment system
  - Medicare pays health care professionals and facilities based on the services they provide using established payment systems
    - Very limited utilization management, can incentivize more high- and low-value care
    - Can be challenging to get prices "right"
  - Beneficiaries are not required to stay within a network of providers
  - Beneficiaries (or their supplemental insurance plans) are responsible for cost sharing
    - No upper limit exists on the amount of Medicare cost-sharing expenses a beneficiary may incur
- MedPAC has recommendations to improve FFS payment accuracy and value

Payment adequacy framework



Beneficiaries' access to care

- Capacity and supply
- Volume of FFS Medicare
- Patient experiences from surveys and focus groups



Quality of care

- FFS Medicare risk-adjusted measures
- Patient experience scores



Access to capital

- All-payer margin
- Borrowing costs
- Investment income



FFS Medicare payments and costs

- Growth in input costs
- FFS Medicare margin
- Projected FFS Medicare margin

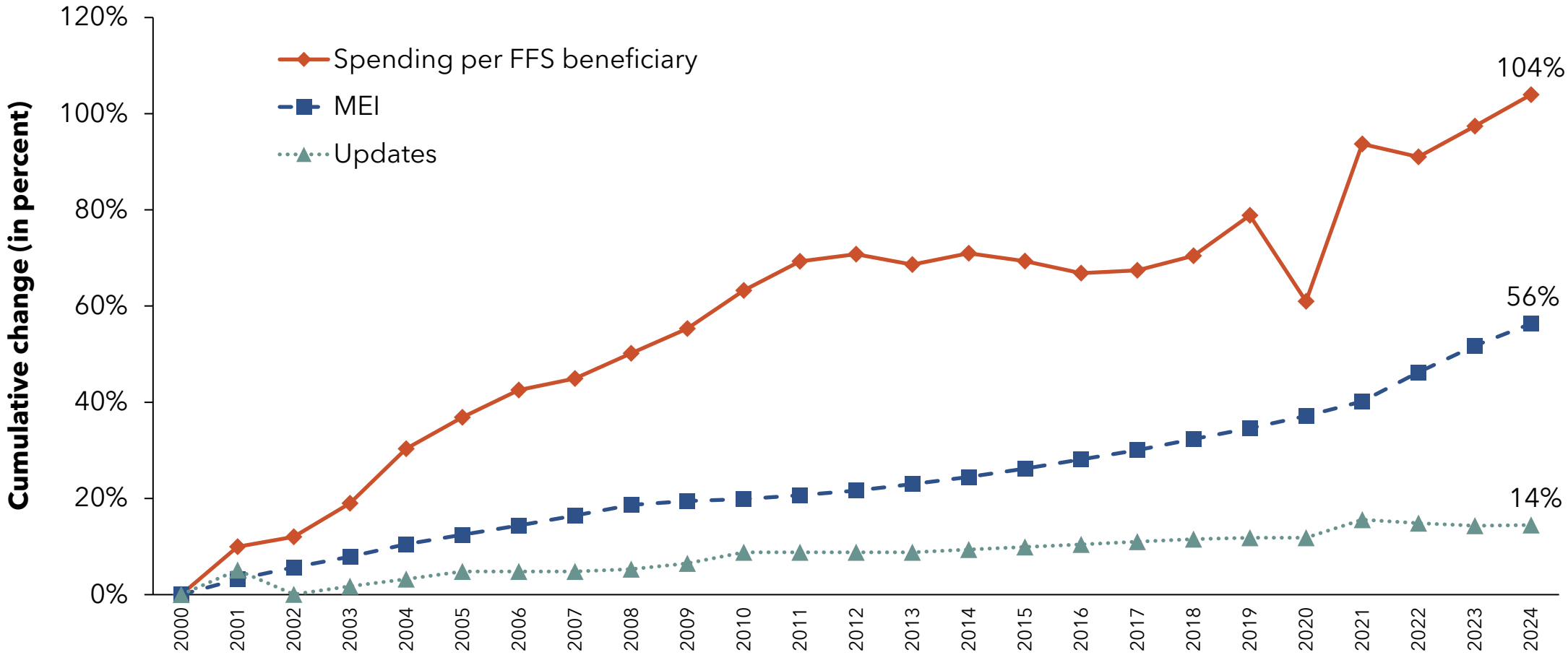
Update recommendation

Note: FFS (fee-for-service).

2026 FFS Medicare payment update recommendations for 2027

Sector	Recommendation
Hospital inpatient and outpatient services	Current law plus $1 billion through the MSNI
Physician and other health professional services	Current law plus 0.5%
Skilled nursing facility services	Minus 4%
Home health care services	Minus 7%
Inpatient rehabilitation facility services	Minus 7%
Outpatient dialysis services	No update
Hospice services	No update

Physician fee schedule spending per FFS beneficiary grew substantially faster than the MEI or fee schedule payment updates, 2000–2024



Note: FFS (fee-for-service), MEI (Medicare Economic Index). MEI data are from the new version of the MEI (based on data from 2017) and include updated total-factor productivity data. Spending per FFS beneficiary is based on incurred spending under the physician fee schedule. The graph shows updates to payment rates in nominal terms. Fee schedule updates do not include Merit-based Incentive Payment System adjustments or bonuses for participating in advanced alternative payment models. One-time payment increases of 3.75% in 2021, 3.0% in 2022, 2.5% in 2023, and a weighted average of 1.25% and 2.93% for 2024 are included.

Source: MedPAC analysis of Medicare regulations, CMS market basket data, and reports from the Boards of Trustees of the Medicare trust funds.

MedPAC work on the adequacy and accuracy of the physician fee schedule

- Recommendation to replace the dual PFS updates based on A–APM participation with an update based on a portion of MEI growth (2025)
- 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.

Medicare Advantage

The Medicare Advantage program

- The Medicare Advantage (MA) program allows beneficiaries to receive their Medicare benefits through private plans
  - For beneficiaries, the primary trade-off is access to the supplemental benefits MA plans provide versus a broader choice of providers and fewer constraints on utilization in FFS
- Plans must offer the basic Medicare benefit (Parts A and B)
  - About 92% of enrollees in plans that also cover prescription drugs (Part D)
  - Nearly 100% of plans offer extra benefits: Reduced cost sharing, supplemental services
  - Some plans charge a premium for extra benefits (in addition to the Part B premium)
- MA plans are paid a monthly capitated amount for each enrollee
  - Amount varies by geography, enrollee health conditions, and plan quality rating
- The Commission strongly supports including private plans in the Medicare program

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

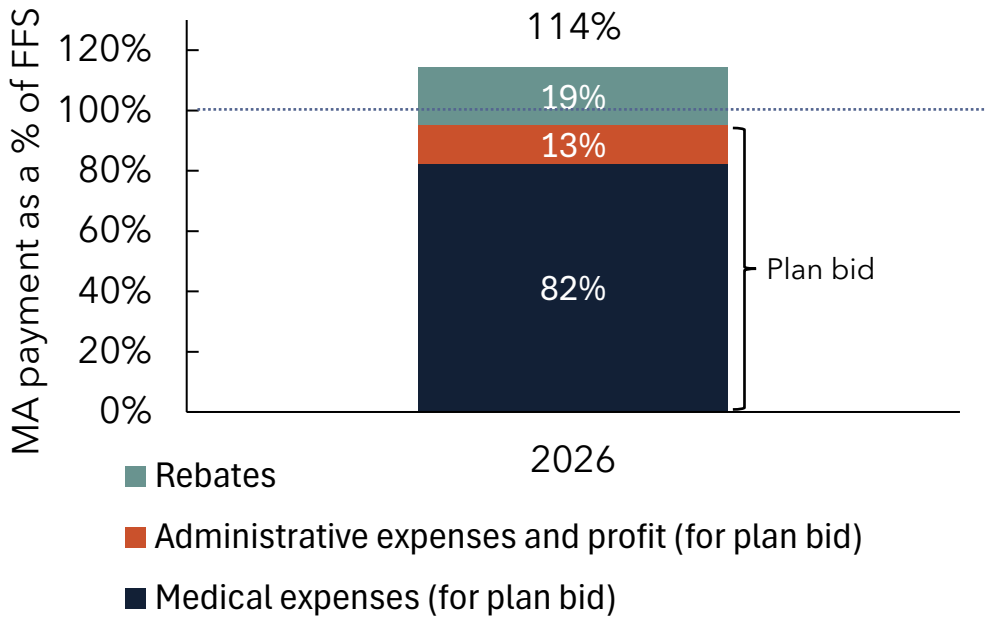
Note: MA (Medicare Advantage), FFS (fee-for-service). The "overall" estimate of benchmarks, bids, and payments as a share of FFS spending incorporates all three components of MedPAC's methodology for comparing payments: (1) a base comparison of MA payments to FFS spending that standardizes for differences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

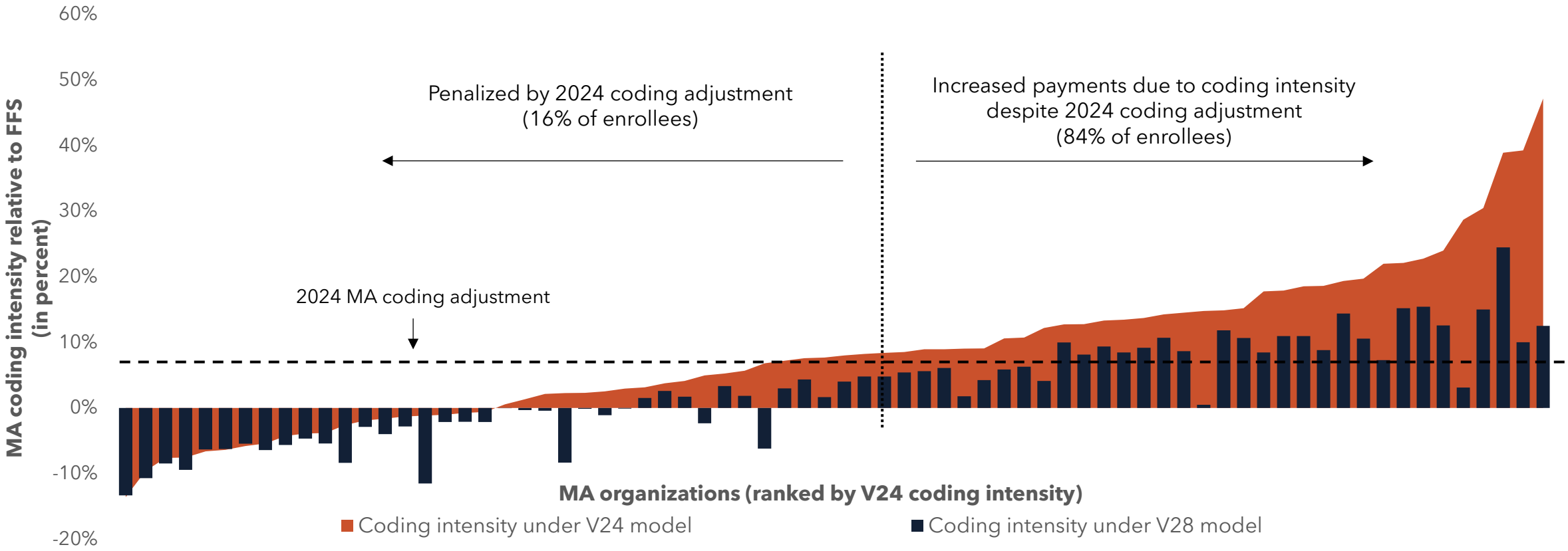
- MedPAC's analysis indicates plans reduce their enrollees' medical expenses by 18 percent below what they would have been in FFS
  - Consistent with existing literature (Huckfeldt et al. 2026; Inovalon 2025; Jung et al. 2025; Teigland et al. 2025)
- Without adjustments for coding and selection, unrealistically 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.

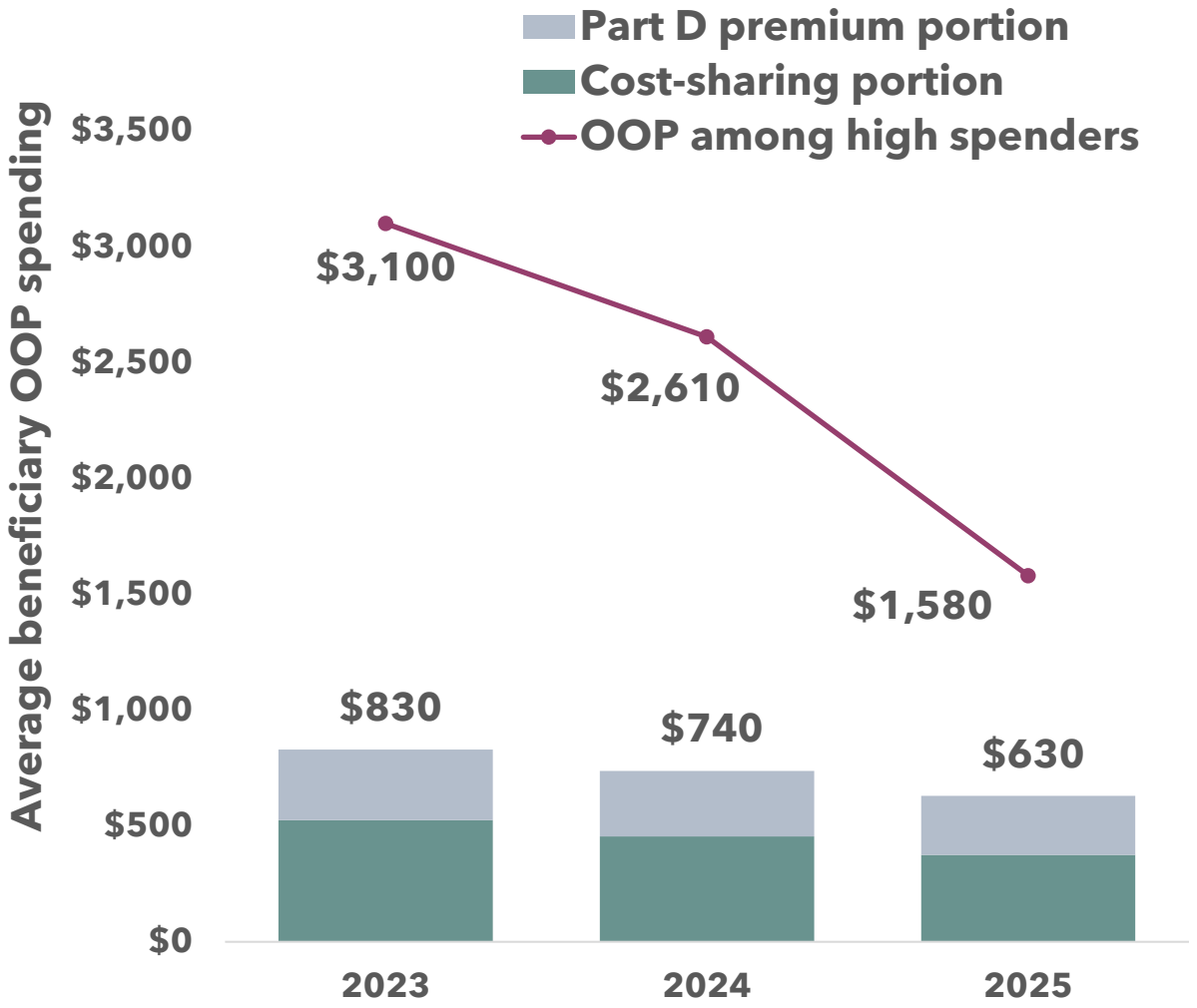
Medicare Part D: Market structure and stability

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)

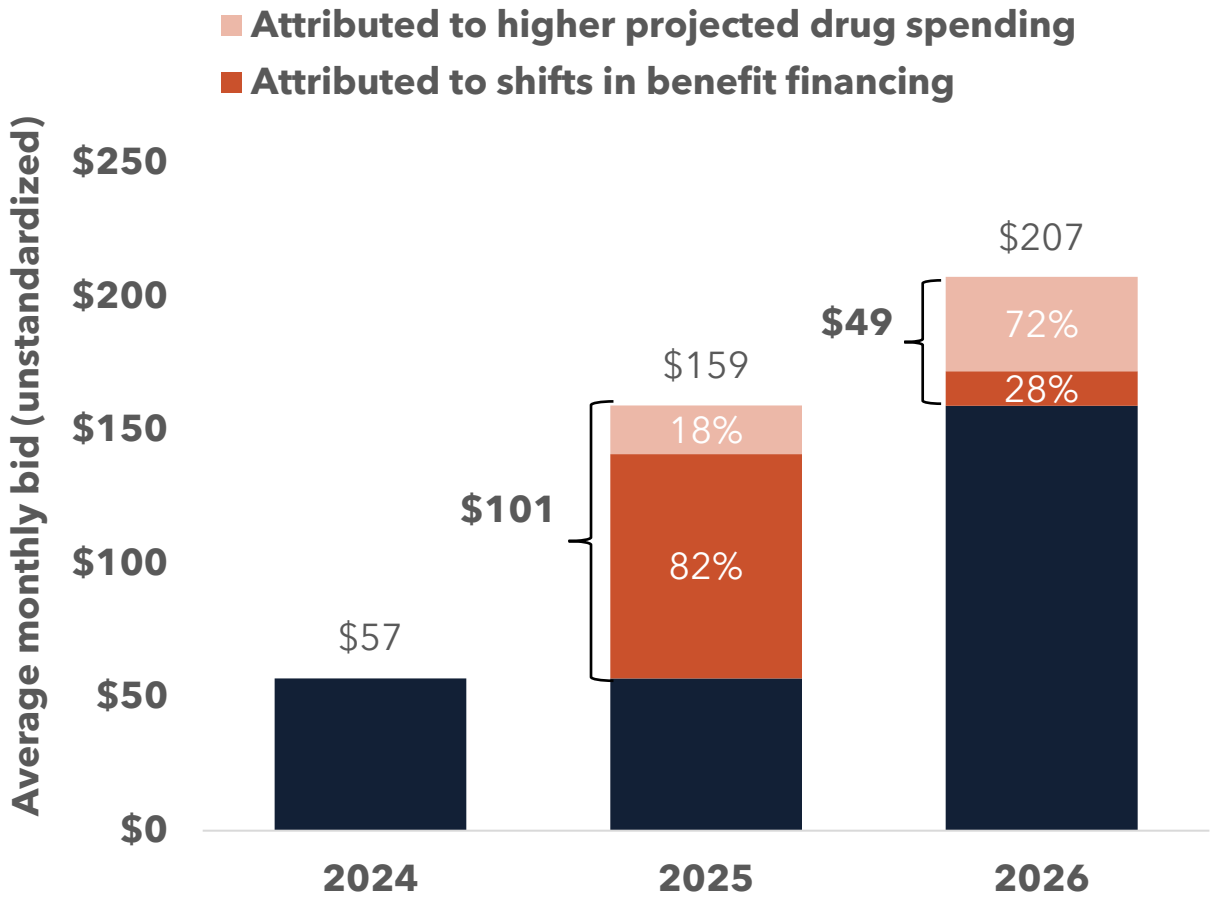


- OOP spending declined by $200 (25%), on average, from 2023 to 2025
  - Cost sharing declined by 30%
  - Premium spending by 16%
- Among high-spenders, OOP spending declined by 50%
- Over the same time, program spending per enrollee increased by 30% (data not shown)

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



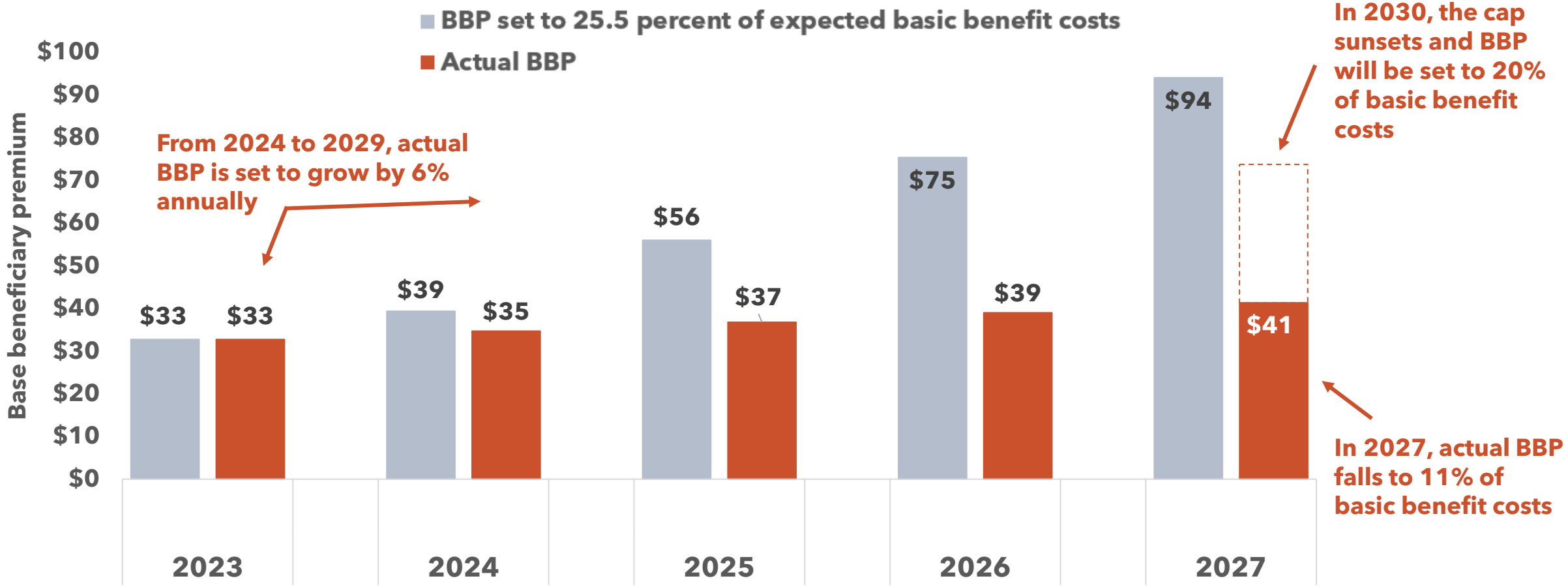
- We decomposed increases in average Part D bids using unadjusted spending projections reported by plans
  - In 2025, most of the increase in bids was attributed to the IRA's shifts in benefit financing
  - In 2026, most of the increase was attributed to higher expected drug spending
  - In both years, 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

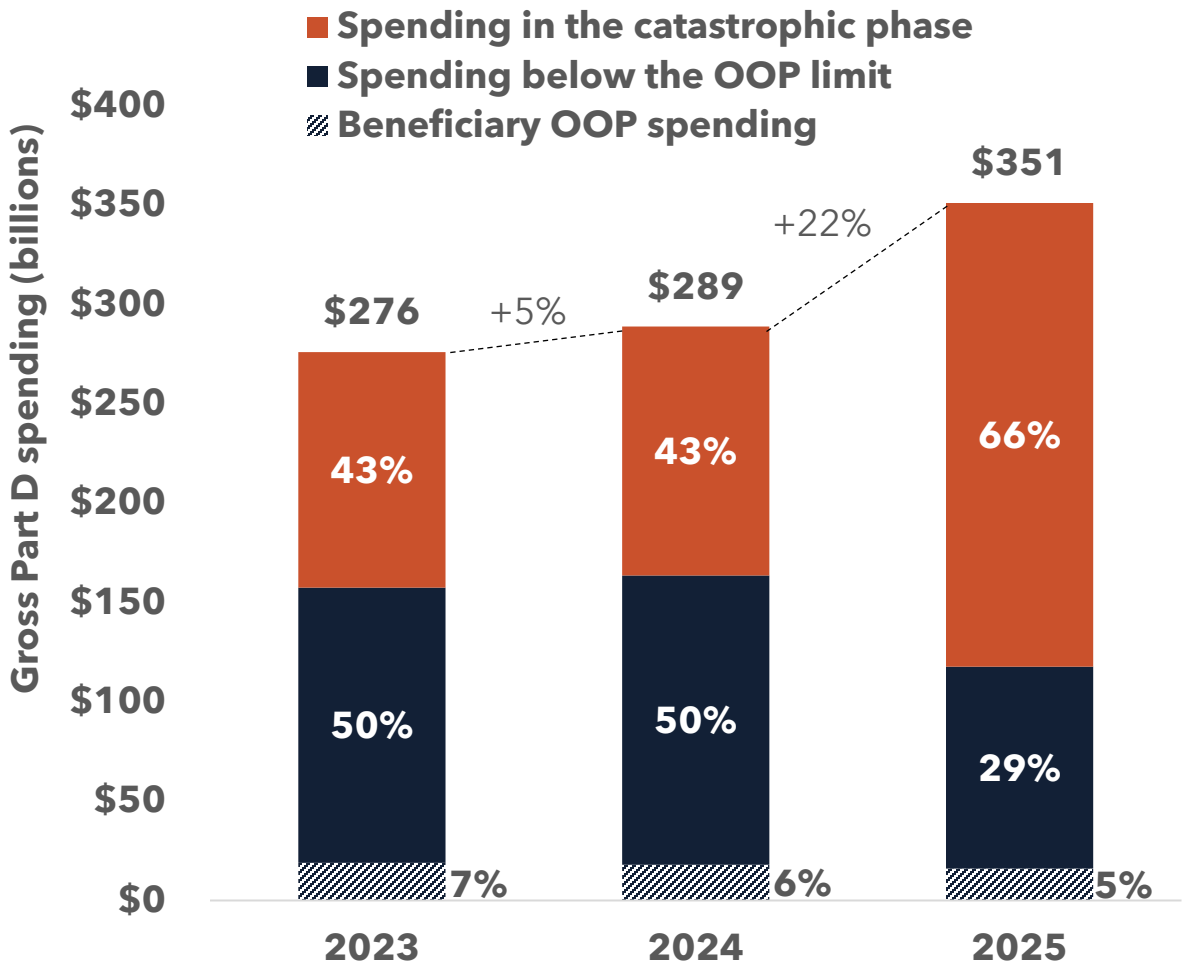
Source: Part D bid pricing tool data from CMS.

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.



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