MEDPAC | Medicare Payment Advisory Commission

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

Washington, DC, March 13, 2025—Today, the Medicare Payment Advisory Commission (MedPAC) releases its March 2025 *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 2026, providing additional resources to acute care hospitals and clinicians who furnish care to Medicare beneficiaries with low incomes, and eliminating certain Medicare coverage limits on stays in freestanding inpatient psychiatric facilities. The report reviews the status of ambulatory surgical centers (ASCs), the Medicare Advantage (MA) program (Medicare Part C), and the Part D prescription drug program (Medicare Part D).

| 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.

MedPAC recommends payment updates above current law for acute care hospitals and physicians and other health professional services; the current law payment update for outpatient dialysis providers; and payment reductions relative to current law for hospice providers, skilled nursing facilities, home health agencies, and inpatient rehabilitation facilities.

To maintain adequate access to care for Medicare beneficiaries, we also recommend that the Congress enact the Commission's March 2023 recommendation to establish permanent safety-net add-on payments for clinician services furnished to FFS Medicare beneficiaries with low incomes. The Commission determines that providing additional financial support is warranted because low-income beneficiaries face greater challenges accessing care. We estimate that the recommended safety-net add-on policy would increase average payments under the fee schedule by 1.7 percent, with increases varying for different clinicians by specialty and share of services furnished to beneficiaries with low incomes. When combined with our recommended update for the physician fee schedule (a 1.3 percent update), we estimate overall payments would increase by 3 percent.

For hospital services, the Commission recommends using the Medicare Safety-Net Index (MSNI) described in our March 2023 report to redistribute existing disproportionate share hospital and uncompensated care payments and increase those payments by $4 billion. The MSNI funds would target additional Medicare resources toward hospitals that are important sources of care for low-income Medicare FFS and MA beneficiaries.

| Medicare Advantage. Each year, the Commission is required to report on the status of the MA program. The program 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 that beneficiaries should be able to choose among Medicare coverage options. Overall, plan and beneficiary participation continues to indicate a robust MA program.

In 2024, the MA program included 5,678 plan options offered by 175 organizations, enrolled about 33.6 million beneficiaries (54 percent of Medicare beneficiaries with both Part A and Part B coverage), and paid MA plans an estimated $494 billion (not including Part D drug plan payments). In 2025, the average Medicare beneficiary has a choice of 42 plans (offered by an average of eight organizations), and the average enrollee in a conventional MA plan has $2,075 in supplemental benefits available. On average, conventional plans project using about 38 percent of these funds to reduce cost sharing for enrollees, 25 percent for non-Medicare services, about 23 percent to enhance plans' Part D benefit, and about 6 percent to reduce enrollees' Part B premiums. Although Medicare pays plans $2,255 annually per beneficiary for supplemental benefits (including $180 for plan administrative expenses and profit), there is currently no reliable information about the extent of beneficiaries' use of these benefits and their value. The average rebate amount, which finances extra benefits, has more than doubled since 2018 among conventional plans and, in 2025, accounts for a projected 17 percent of payments to MA plans.

The Commission estimates that Medicare spends approximately 20 percent more for MA enrollees than it would spend if those beneficiaries were enrolled in FFS Medicare, a difference that translates into a projected $84 billion in 2025. 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 2025, 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 10 percent higher than risk scores for similar FFS beneficiaries, even after accounting for the annual CMS coding adjustment.

The Commission acknowledges that a portion of these increased payments to MA plans are used to provide more generous supplemental benefits and better financial protection for MA enrollees. However, 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 $13 billion higher in 2025 because of higher MA spending.

The Commission remains committed to including private plans in the Medicare program and allowing beneficiaries to choose among Medicare coverage options, including the alternative delivery systems that private plans can provide. However, the Commission is concerned that current Medicare policy to pay MA plans and incentivize high-quality care does not serve beneficiaries or taxpayers, and requires reform. 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.

| Part D. In 2024, the Medicare prescription drug program (Part D) paid for outpatient prescription drug coverage for more than 54 million beneficiaries. In 2023, Part D expenditures totaled $128.7 billion. Of this amount, Medicare paid $68.2 billion in subsidies for basic benefit costs, $43.9 billion in financial support for enrollees receiving the low-income subsidy (LIS), and $0.5 billion in retiree drug subsidies. Plan enrollees paid the remaining $16.1 billion in plan premiums for basic benefits. In addition, enrollees also paid $18.8 billion in cost sharing.

The passage of the Inflation Reduction Act of 2022 (IRA) resulted in many changes to the Part D program, including a redesign of Part D's benefit structure. This redesign 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. Changes taking place in 2025 are expected to have wide-ranging impacts on Part D plan sponsors, enrollees, and participants in the pharmaceutical supply chain. The national average plan bid rose by nearly 180 percent in 2025. Variation in bids submitted by Part D plans was likely driven by plans' uncertainty and differing assumptions regarding the effects of the IRA on benefit costs, for which plans now bear a substantial portion of the insurance risk. The Premium Stabilization Demonstration that CMS implemented for 2025 reduced some of the largest premium increases among the PDPs but will increase program spending by an estimated $5 billion in 2025, and large variations in premiums remain. The Commission will continue monitoring the implementation of changes in Part D.

Part D enrollment continues to shift from PDPs to MA-PDs. In 2024, PDPs accounted for less than 43 percent of all Part D enrollees, down from 53 percent in 2020. Due in part to MA-PDs' ability to use Part C rebates to lower Part D premiums, the average PDP premium in 2025 (weighted by 2024 enrollment) is estimated at $44, while the average MA–PD premium (including both special needs plans and conventional plans) is $14. In 2023, about 532,000 enrollees filled a prescription for which a single claim was sufficient to put them into the catastrophic phase of the Part D benefit, up from just 33,000 enrollees in 2010.

| Eliminating Medicare's coverage limits on stays in freestanding inpatient psychiatric facilities. Fee-for-service Medicare's coverage of treatment in freestanding psychiatric facilities (IPFs) is subject to certain limitations, including a 190-day lifetime limit on days in IPFs and a reduction in the number of covered inpatient psychiatric days available during the initial benefit period for new Medicare beneficiaries who received care from a freestanding inpatient psychiatric facility on or in the 150 days prior to their date of Medicare entitlement.

As of January 2024, about 40,000 beneficiaries exhausted their coverage in freestanding IPFs since their initial enrollment in Medicare. An additional 10,000 beneficiaries were within 15 days of the 190-day limit. In 2023, 75 percent of beneficiaries at or near the 190-day limit were disabled and 84 percent had low incomes. We found that, on average, beneficiaries affected by the limit had 2.2 fewer days of covered inpatient psychiatric care than beneficiaries in the comparison group of beneficiaries not affected by the limit, indicating that overall covered days for inpatient psychiatric services would likely increase if the limit were removed.

In this report, the Commission recommends that Congress eliminate the 190-day limit on covered days in freestanding impatient psychiatric facilities and the reduction in the number of covered inpatient psychiatric days available during the initial benefit period. Continued work to ensure that Medicare beneficiaries are receiving high-quality inpatient psychiatric care and are appropriately transitioned to the community upon discharge is critically important. The Commission will continue to monitor the access and quality of care for beneficiaries who use these services.

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.