

MedPAC Holds April 2026 Meeting

On April 9 and 10, 2026, the Medicare Payment Advisory Commission (MedPAC) held a public meeting, which included the following sessions:

- Improving payment incentives in Medicare,
- Analysis of regional benchmarks and benchmark-plan availability in the Part D PDP market,
- Preferred networks and pharmacy access in Part D,
- Estimated association between Medicare Advantage (MA) enrollment and hospitals' and post-acute care providers' finances, and
- Information sources that beneficiaries use to make Medicare enrollment decisions.

The full agenda for the meeting and presentations for the sessions are available [here](#).

IMPROVING PAYMENT INCENTIVES

In this session, MedPAC focused on evaluating payment incentives in Medicare's payment approaches, focusing on standalone fee-for-service (FFS), alternative payment models (APMs), and MA. Staff analyzed the drivers of Medicare's \$1.1 trillion in annual spending, noting that volume and intensity of services are the leading drivers of projected Part B spending growth.

MedPAC staff reviewed how current payment systems' incentives can influence service volume and intensity—such as FFS encouraging higher service volume and MA encouraging more intensive diagnostic coding.

The Commission presented recommendations to shift the program towards a framework that rewards high-quality, efficient care. Key recommendations for each payment system included:

- **FFS Medicare:** Overhauling the benefit system design by allowing for varied cost-sharing and an out-of-pocket maximum, increasing payment rates for hospitals and clinician services while decreasing them for post-acute care providers, and improving the process by which payment rates are set.



- **APMs:** Operating a smaller number of cohesive APMs and a single accountable care organization (ACO) model with separate tracks for different-sized providers and mandatory episode-based payments, revising methods for calculating ACO spending targets without periodically reducing them, and revising spending target calculations to reduce coding incentives and favorable selection.
- **MA:** Expanding the geographic markets used for plan payment areas, recalibrating benchmarks, strengthening risk adjustment to curb coding intensity, and overhauling the quality bonus program.

Commissioner Discussion

The prevailing view was that “unfettered” FFS Medicare is financially unsustainable. Commissioners noted that paying for individual items or services incentivizes increased volume and intensity without rewarding provider accountability or care coordination. They contrasted this with MA, noting that stand-alone FFS lacks robust managed care tools—such as prior authorization, utilization management, and narrow provider networks—which can lead to tradeoffs in quality and access. Because FFS serves as the foundational layer for benchmarks and fee schedules across the entire program, the Commission recognized that modernizing its benefit design is essential to curbing inefficient spending across all three payment approaches.

In response to the spending analysis, Commissioners noted that drug spending—the fastest-growing component of Part B—requires a distinct policy approach. Because Medicare acts as a “price taker” rather than a “price setter” across all models, traditional utilization incentives are often less effective in this area. Additionally, Commissioners emphasized that “aging within Medicare”—specifically the transition of beneficiaries into the 80 years or older demographic—is a critical spending driver distinct from general enrollment growth. This shift also highlights a growing disconnect between the complex clinical needs of an aging population and a delivery system that remains tethered to fragmented, single-provider payment models.

While modernizing FFS is critical, Commissioners also identified systemic challenges that can hinder the effectiveness of value-based approaches like MA and APMs. Specifically, they observed that a lack of awareness among both providers and patients regarding their participation in APMs may prevent the program from achieving its full benefits. They suggested that participation should be streamlined and mandatory so that beneficiaries clearly understand when they are enrolled. Furthermore, they noted that the effectiveness of capitated models, such as MA, depends on a time horizon; if beneficiaries are not expected to remain with a plan long-term, the incentive to invest in their long-term health is diminished. Finally, the Commission questioned whether the complexity of managed models delivers actual savings to taxpayers, raising

concerns that "improved value" is often offset by high administrative costs and "gaming" of the system.

In closing, the Chair emphasized that the purpose of this work is to clarify the conceptual roles of these different models without vilifying any specific approach. The final report on these payment incentives will be included in the June 2026 report to Congress.

ANALYSIS OF REGIONAL BENCHMARKS AND BENCHMARK-PLAN AVAILABILITY IN THE PART D PDP MARKET

In this session, the Commission reviewed issues surrounding Prescription Drug Plans (PDPs) for beneficiaries eligible for low-income premium subsidy amounts (LIPSA). MedPAC staff focused on analyzing benchmark plans, which are stand-alone basic PDPs with premiums at or below a given region's LIPSA. The number of benchmark plans has been declining across regions, with only 11 percent of low-income subsidy (LIS) beneficiaries having more than four plans to choose from. Not only does a lack of benchmark options reduce beneficiary choice, but it also concentrates enrollment among a small number of plans.

Due to these changes, LIS enrollees have shifted from choosing PDPs to Medicare Advantage Prescription Drug Plans (MA-PDs). Staff identified three reasons for the declining number of regional benchmark plans, with the third reason identified as most influential:

1. The number of basic PDP offerings determines the number of benchmark plans.
2. LIS plan-enrollment distribution across MA-PDs and PDPs affects the weighting of plan premiums used to determine a region's benchmark.
3. As basic premiums for PDPs increase relative to those of MA-PDs, the number of benchmark plans tends to decline.

In Part 1 of the discussion, Commissioners highlighted that less benchmark PDP availability has reduced the accessibility of affordable drugs for low-income beneficiaries. They also questioned whether growth in enhanced MA-PD plans could discourage the enrollment of LIS beneficiaries, to which MedPAC staff responded that there is no evidence of selection and that variation arises from drug mix rather than from plan types.

Commissioners also discussed benchmarks and the opportunity to rebid during the session. MedPAC staff clarified that plans have limited flexibility once benchmarks are set, and that MA-PDs can adjust rebate buy-downs, but PDPs can only qualify through a de minimis policy if close to the benchmark. Finally, commissioners raised concerns

about the lack of transparency in manufacturer rebate negotiations and requested further analysis of the process.

During the second half of the discussion, a commissioner requested more information about which groups contributed to the Part D plan, and how much drug manufacturers provide in discounts and rebates. Additionally, commissioners expressed that structural and affordability concerns are pushing LIS beneficiaries away from PDPs and leading them towards MA-PDs, despite their true plan preferences. Finally, several commissioners described how structural misalignment in benchmark development excludes MA-PDs. Some agreed that future analysis should explore whether benchmark plans can be separated to eliminate cross-plan incentive distortion, whether LIS weighting could be modified, or if MA-PDs could be allowed to qualify as benchmark plans.

Chairman Michael Chernew concluded the session with a summary about the potential benefits and challenges of separating PDP markets from the formulas that create benchmark plans. While there are key differences, Chairman Chernew asserts that separating them is challenging because there is significant integration between PDPs and MA plans. However, the decision to separate plans for the purpose of analysis is ultimately left to MedPAC staff. Overall, there was shared support for continued MedPAC investigation into Part D evolution.

PHARMACY TRENDS IMPACTING MEDICARE PART D

In this session, MedPAC evaluated the shifting retail pharmacy landscape and its implications for Part D networks and beneficiary access. Staff found that retail pharmacy closures have accelerated sharply since 2022, with chain pharmacies increasingly driving this trend—accounting for 62 percent of all closures in 2025, a dramatic rise from 25 percent in 2021. However, MedPAC noted that the decline in retail pharmacies has not led to a corresponding increase in mail-order pharmacy utilization.

In a review of Part D pharmacy networks and use of “preferred” networks, MedPAC found that despite recent closures, Part D networks in 2025 continued to offer broad coverage of approximately 90 percent within PDP regions. Pharmacy networks modestly favor chain pharmacies. Preferred networks may create price variances across pharmacies while posing tradeoffs for pharmacies and beneficiaries. Patients may see lower out-of-pocket costs, while pharmacies may have to weigh trade-offs between lower reimbursement and higher prescription volume. MedPAC also identified that modest increases in PDP network participation rates may mask “network churn,” in which pharmacies enter and exit the network.

Pharmacy network composition and churn may impact patient access. As pharmacy closures reduce the number of retail pharmacies available for Part D contracting, plans may alter their network composition (e.g., ownership type or location), increasing the likelihood of gaps in beneficiary access in areas with fewer providers and in rural regions where access to preferred pharmacies is already narrower. Ongoing closures may further jeopardize access by driving network churn, where instability disrupts the continuity of care for long-term pharmacist-beneficiary relationships.

Commissioner Discussion

Several commissioners emphasized the value of pharmacists and the need to fairly compensate them for their work, noting a significant opportunity to treat them as active members of the care team to help control Part D costs and ensure appropriate medication use. One Commissioner suggested that interviewing pharmacy store managers could be helpful, as they might better understand the operational realities and insights that corporate-level data might miss.

A commissioner highlighted that pharmacies are often strained by GPO purchasing costs and PBM reimbursement rates; in some cases, pharmacies reportedly lose money when dispensing generic drugs. Commissioners also identified other areas of interest when identifying reasons behind recent closures: whether there is a correlation between PBM "clawbacks" and the 2024 reversal in independent pharmacy growth, whether recent chain closures are due to changes in the drug-delivery business or to a failed business strategy to transform retail pharmacies into primary care hubs, and the role of vertical integration in changing pharmacy dynamics.

Regarding access, Commissioners noted that pharmacies with preferred status may not always guarantee the lowest prices for the beneficiary and may reflect the plan's contracting strategy. They raised questions about whether chain closures are concentrated in low socioeconomic status (SES) communities or are occurring uniformly across regions. Finally, further analysis was requested regarding out-of-pocket (OOP) cost disparities for rural beneficiaries, as well as additional analysis on how mail orders could help substitute for closures.

Moving forward, MedPAC plans to continue monitoring pharmacy networks and beneficiary access, convene focus groups with pharmacists in the next cycle, and conduct additional analyses to examine the effects of pharmacy closures on medication access.

ESTIMATED ASSOCIATION BETWEEN MA ENROLLMENT AND HOSPITALS' AND POST-ACTUE CARE PROVIDERS' FINANCES

In this session, MedPAC staff analyzed the impact of increasing rates of MA enrollment, which has grown from 30 percent to 55 percent between 2013-2025, on the finances of

hospital and post-acute care providers. MedPAC staff presented the results of a comprehensive regression using all-payer hospital data to capture the net effect of all potential ways MA can be associated with provider finances. Findings suggest that there is no statistically significant association between MA penetration and all-payer operating margins, with a 10 percent-point increase in market MA penetration associated with a 0.5 percent reduction in all-payer revenue and a 0.9 percent decrease in all-payer costs. Furthermore, no statistically significant association was found between MA penetration and the all-payer margins of skilled nursing facilities (SNFs). Home health agencies (HHAs) and MA accounted for a smaller share of inpatient rehabilitation facility (IRF) use than overall MA penetration, while MA and FFS patients differed in their clinical mix. Throughout their presentation, MedPAC staff repeatedly emphasized that the regression results should only be considered associations due to limitations.

Commissioner discussion was divided into two parts. During the first discussion, commissioners agreed that MedPAC staff had overemphasized the limitations of their regression and suggested that, when included in the June 2026 report, there should be less reiteration of the study's limits. Additionally, a commissioner raised concerns about how MA plans can pay in network providers less than 100 percent of the allowable amount for traditional Medicare, as opposed to out-of-network providers in a PPO, to whom MA plans are required to give the full amount. Commissioners also discussed the complaint that MA plans are implementing medical management through increased denials and prior authorization (PA), which may be inappropriate and harmful. Staff presented that there are now more denials than ever, but 80-90 percent eventually get overturned. While the trend delays care, treatment is typically ultimately received.

In the second discussion round, conversations about denials continued. Commissioners expressed concern that physicians may appeal and win a denial but are not reimbursed for the administrative work required of the appeal process. Consolidation and cross-subsidization were cited as reasons for increasing rates of denials. Concerns were also raised about the fact that MA plans and hospitals are not aligned, and that MedPAC staff need to establish a network adequacy standard for MA IRFs. Finally, commissioners asked that data on MA penetration be further stratified by facility, that the impacts of MA expansion on nursing staff be studied more carefully, and that staffers explore mechanisms for improved cost reporting. Overall, streamlining authorization, reducing unnecessary administrative burden for providers, and strengthening provider alignment to create partnerships between plans and providers were three key guidelines offered to ground future work.

At the end of the session, the Chair stated that though there tends to be emphasis on the impact of MA revenue, costs adjust. Grounding the research in the literature was highlighted as a strength of the MedPAC research presented. Finally, while MedPAC

staff gave careful consideration to understanding regression outcomes as impacted by confounders, it was strongly suggested that if there was a major MA impact on physician finances, the effects would be clear. Suggestions from commissioners will be incorporated into the June 2026 report to Congress.

INFORMATION SOURCES USED FOR MEDICARE ENROLLMENT DECISIONS

In this session, MedPAC examined the information sources Medicare beneficiaries use when making enrollment decisions. Beneficiaries consider financial protection, access to care, and the availability of extra benefits when choosing between FFS Medicare and MA, but researchers have found that individuals have difficulty understanding insurance concepts and are prone to various decision-making biases when selecting health plans. When comparing coverage options, beneficiaries often rely on multiple sources, including CMS-provided tools such as Medicare.gov, the Medicare & You handbook, and the 1-800-MEDICARE helpline; free, individualized counseling through the State Health Insurance Assistance Program (SHIP); and insurance agents and brokers.

More than half of beneficiaries use multiple sources of information when making enrollment decisions. Among beneficiaries in FFS Medicare, 45 percent are not receiving help, 30 percent rely on insurance agents, 14 percent consult friends and family, 5 percent rely on SHIP, 5 percent use Medicare.gov or the Medicare hotline, and 3 percent derive information from advertisements. Among MA enrollees, 37 percent do not receive help, 31 percent rely on insurance agents, 20 percent turn to friends and family, 4 percent rely on SHIP, 9 percent use Medicare.gov or the Medicare hotline, and 7 percent derive information from advertisements.

MedPAC staff also reviewed MA marketing sources and trends, finding that beneficiaries are exposed to marketing from MA plans and third-party marketing organizations (TPMOs) through mail, phone calls, and television advertising, with television advertising highlighted as a prominent source. Some marketing materials suggest that beneficiaries may miss out on benefits if they do not enroll in MA. Rates of “rapid disenrollment” from MA plans, defined as leaving within the first three months, tripled between 2017 and 2022. The marketing landscape has also changed with the growth of field marketing organizations (FMOs) and TPMOs, including the use of call centers and lead generators. CMS is considering revisions to TPMO definitions and oversight and recently issued a request for information on ways to modify the current regulatory definition of TPMOs to delineate roles and requirements.

CMS provides several information sources to support beneficiary decision-making, including the 1-800-MEDICARE helpline and the Medicare.gov website. Medicare.gov includes the Medicare & You handbook and the Plan Finder tool. Plan Finder has been updated to include provider directory information. Limitations, including inaccuracies

in provider directories and limited information on MA supplemental benefits, have been identified. Additionally, beneficiaries seeking Medigap coverage often must contact insurers directly to obtain an accurate premium quote and/or buy a policy.

The SHIP provides free, individualized Medicare counseling and community outreach through federal grant funding. In the second half of 2025, more than 10,000 counselors assisted nearly 1.2 million beneficiaries. The SHIP helps beneficiaries understand Medicare, compare plans, file appeals, and access supplemental benefits and Medicaid. SHIP funding declined by 26 percent (inflation-adjusted) between 2008 and 2025, while Medicare enrollment increased by approximately 53 percent over the same period. SHIP grantees report capacity constraints, particularly during the Annual Enrollment Period (AEP), and some programs stop accepting appointments due to high demand.

A scope interview with Administration for Community Living (ACL) staff that direct SHIP grantees, staff at the SHIP Technical Assistance (TA) Center, and counselors/staff from 7 grantees found that SHIP counselors assist beneficiaries with a wide range of Medicare needs and incomes levels, with common questions including MA coverage appeals, navigating supplemental benefits, and concerns about drug affordability; and provide in-person assistance and knowledge of local market conditions. However, SHIP counselors often have limited capacity for the number of appointments they can take during the AEP.

Insurance agents assist beneficiaries in comparing plan options and out-of-pocket costs. Agents often present tailored recommendations for available plans; one study found that large online agent tools included less than half of MA plans and less than two-thirds of Part D plans in a given market. In MedPAC's annual focus groups with beneficiaries, they reported positive and helpful experiences working with agents. Agents highlighted the importance of building a long-term relationship with their clients.

The Commission also discussed compensation. Insurance agent compensation includes compensation for MA and Part D enrollment and renewals. In 2026, maximum MA compensation was \$694 for initial enrollment and \$347 for renewals, compared to \$114 and \$57 for Part D. Agents may also receive administrative payments, bonuses, and other incentives. For Medigap policies, compensation is typically about 20 percent of the initial enrollment premium and 10 percent for renewals, with estimated payments based on the average annual Medigap premium. This is approximately \$520 initially and \$260 in subsequent years.

Some stakeholders have voiced concern that agents have financial incentives to steer beneficiary decision-making. Over five years, an agent could earn about \$624 more by enrolling a beneficiary in an MA-PD plan rather than a Medigap and Part D

combination. Insurance companies do not have to pay agent commissions for enrolling beneficiaries in plans and may stop paying commissions for some plans when sales exceed desired levels. Some insurers use “zero-dollar” commissions for enrollment in certain MA, Medigap, and Part D programs. This is a growing concern for state departments and agents regarding its effects on consumer access to plans.

Commissioner Discussion

Commissioners raised concerns about the complexity of the Medicare enrollment landscape and the extent to which beneficiaries can meaningfully navigate available information. A central theme was the growing influence of insurance agents and brokers, with discussion highlighting that while agents can provide valuable guidance, their compensation structures and plan-specific incentives may shape the information presented to beneficiaries. Commissioners also questioned the transparency of plan offerings, noting that beneficiaries may not realize they are only being shown a subset of available options.

There was also discussion around the adequacy and accessibility of unbiased resources, particularly the SHIP. Commissioners emphasized that while the SHIP plays a critical role in providing objective counseling, funding and capacity constraints limit its reach, especially during peak enrollment periods. This imbalance may further push beneficiaries toward broker-assisted enrollment.

In addition, commissioners discussed the role of marketing in influencing beneficiary decision-making, particularly in MA. Concerns were raised about the volume and tone of advertising, as well as the potential for messaging to mislead beneficiaries about their options or benefits. Some commissioners noted that these dynamics may contribute to suboptimal plan selection and higher rates of early disenrollment.

Finally, commissioners highlighted broader concerns about whether current tools, such as Plan Finder, provide sufficient clarity for beneficiaries to make informed choices. There was general agreement that improving transparency, simplifying comparisons, and strengthening access to unbiased guidance will be important areas for future policy consideration. An informational chapter on the topic will be included in MedPAC’s June 2026 report to Congress.

This Applied Policy® Summary was prepared by [Crystal Uba](#) with support from the Applied Policy team of health policy experts. If you have any questions or need more information, please contact her at cuba@appliedpolicy.com or 202-558-5272.