

## MedPAC Releases March 2025 Report to Congress

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Each March, the Medicare Payment Advisory Commission (MedPAC) is required to report to Congress on the Medicare fee-for-service (FFS) payment systems, the Medicare Advantage (MA) program, and the Medicare prescription drug program (Medicare Part D). In this report, MedPAC provides payment update recommendations for Medicare FFS payment systems and status updates on ambulatory surgical centers (ASCs), the MA program, and the Part D program. The report was released on March 13, 2025, and can be found [here](#).

### MEDPAC DISCUSSES RELEVANT CONTEXT FOR MEDICARE PAYMENT POLICY

National healthcare spending in the United States continues to outpace economic growth, with both overall healthcare and Medicare expenditures rising significantly. In 2023, total U.S. healthcare spending reached \$4.9 trillion (17.6 percent of GDP), with Medicare spending accounting for \$1.0 trillion (3.7 percent of GDP).

Medicare spending is projected to double within the next decade, driven primarily by an aging population, increased utilization of services, and the growing enrollment in Medicare Advantage (MA) plans.

#### Medicare's Financial Outlook

- Medicare spending will continue to grow by 7 to 8 percent per year over the next decade, and will cause Medicare spending to nearly double from \$1.0 trillion in 2023 to \$1.9 trillion in 2032.
- The Part A trust fund is now projected to be covered until 2035 according to the Congressional Budget Office. This estimate has been extended following the COVID-19 pandemic, due to higher-than-expected Medicare payroll tax revenues combined with lower-than-expected utilization of inpatient services.
- As the entire baby-boom generation reaches Medicare eligibility by 2029, the number of Medicare beneficiaries will grow to 75 million. The ratio of workers that finance Medicare through payroll and income taxes versus the number of

beneficiaries will continue to decline, from 4.5 workers/beneficiary in 2023 to 2.5 workers/beneficiary by 2029.

### Drivers of Medicare Spending Growth

- Health care spending grew 7.5 percent in 2023, driven by higher coverage, service use, and drug costs, with future growth expected to outpace GDP. Implementation of the Inflation Reduction Act of 2022 (IRA) increased Medicare spending due to increased benefits part of Part D, limiting of beneficiary cost sharing for insulins, and requiring coverage for applicable vaccines with no cost sharing.
- 20.3 million additional Americans gained health coverage between 2020 and 2023. 5.8 million of those purchased marketplace plans, while 15.5 million gained coverage through Medicaid.
- Part B spending has grown from 44 percent of Medicare spending in 2014 to an estimated 49 percent in 2024; and is projected to reach 53 percent by 2032 as care shifts from inpatient to outpatient settings. This shift has been driven by technological advancements and Medicare policy changes, increases reliance on general tax revenues, reducing funds for other priorities.
- Recent FDA approvals allow Medicare Part D to cover GLP-1 drugs for certain conditions, which is expected to increase access and spending. Potential savings from improved health outcomes remain uncertain.
- Provider consolidation has continued to increase. The number of “super” concentrated hospital systems, (where a single dominant hospital system accounts for the majority of hospital discharges in a designated area), grew from 47 percent to 57 percent between 2003 and 2017. Additionally, by 2021, 52 percent of all physicians are affiliated with a health system.
- The shift toward MA continues. As of 2025, 54 percent of Medicare beneficiaries now enrolled in MA plans, up from 34 percent in 2018. MedPAC estimates that in 2025, Medicare will spend 20 percent more for MA enrollees than if those beneficiaries were on Fee-For-Service Medicare.
- Service volume and intensity per beneficiary are rising and projected to rise in the coming years by an average of 2.8 percent per year

### Impact on Beneficiaries

- Premiums and cost sharing are taking up a larger share of retirees' incomes. In 2024, these costs consumed 26 percent of the average Social Security benefit, up from 17 percent in 2004.
- While most Medicare beneficiaries continue to have access to care, some populations—especially dual-eligible beneficiaries and those with low incomes—experience greater financial strain. Disabled beneficiaries under 65 and those receiving partial Medicaid benefits report higher difficulty affording out-of-pocket costs.

## MEDPAC PROVIDES PAYMENT UPDATE ANALYSIS AND RECOMMENDATIONS

To assess payment adequacy and provide payment update recommendations for Medicare FFS, MedPAC considers all available indicators of payment adequacy and the most recently available data. Due to data lags, the most recent complete data MedPAC has is from 2023. To arrive at payment update recommendations, MedPAC considers the following payment adequacy indicators: beneficiaries' access to care, quality of care, access to capital, and Medicare payments and providers' costs. The table below summarizes MedPAC's payment update recommendations and rationale.

| Payment System                             | Payment Update Recommendation                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Rationale and Expected Changes                                                                                                                                                                                                                                                                                                                                                                              |
|--------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                            | <i>Italicized text quotes MedPAC's recommendations</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                             |
| Hospital inpatient and outpatient services | <p><i>The Congress should:</i></p> <ul style="list-style-type: none"> <li>• <i>for 2026, update the 2025 Medicare base payment rates for general acute care hospitals by the amount specified in current law plus 1 percent; and</i></li> <li>• <i>redistribute existing disproportionate-share-hospital and uncompensated-care payments through the Medicare Safety-Net Index (MSNI)—using the mechanism described in [MedPAC's] March 2023 report—and add \$4 billion to the MSNI pool.</i></li> </ul> | <p>Indicators of overall payment adequacy were mixed, as were indicators of quality care. Hospital costs exceeded FFS Medicare payments. Those treating more low-income Medicare patients faced greater financial difficulties.</p> <p>MedPAC's analysis indicates that the combination of both recommendations would increase FFS Medicare base payment rates 2.2 percentage points above current law.</p> |

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| Physician and other health professional services | <p><i>The Congress should:</i></p> <ul style="list-style-type: none"> <li>• <i>for calendar year 2026, replace the current-law updates to Medicare payment rates for physician and other health professional services with a single update equal to the projected increase in the Medicare Economic Index minus 1 percentage point; and</i></li> <li>• <i>enact the Commission's March 2023 recommendation to establish safety-net add-on payments under the physician fee schedule for services delivered to low-income Medicare beneficiaries</i></li> </ul> | <p>Physician payment indicators reflect adequate or better access to care for Medicare beneficiaries than private insurance. However, despite recent increases in physician payment, costs are expected to grow faster than payment rate updates.</p> <p>As the MEI is projected to increase by 2.3 percent in 2026, MedPAC's analysis indicates the Commission's first recommendation would produce a 1.3 percent increase in payment rates. The recommended safety-net add-on policy would separately increase the average fee schedule revenue for clinicians by 1.7 percent.</p> |
| Outpatient dialysis facility                     | <p><i>For calendar year 2026, the Congress should update the 2025 Medicare end-stage renal disease prospective payment system base rate by the amount determined under current law.</i></p>                                                                                                                                                                                                                                                                                                                                                                    | <p>Most indicators for outpatient dialysis services are generally positive.</p> <p>Based on MedPAC's analysis of current law, the base payment rate is expected to increase by 1.7 percent in 2026.</p>                                                                                                                                                                                                                                                                                                                                                                              |
| Skilled nursing facility (SNF) services          | <p><i>For fiscal year 2026, the Congress should reduce the 2025 Medicare base payment rates for skilled nursing facilities by 3 percent.</i></p>                                                                                                                                                                                                                                                                                                                                                                                                               | <p>MedPAC recommends a payment reduction to more closely align payments with costs, noting that the FFS Medicare margin for freestanding SNFs is projected to be 23 percent in 2025.</p> <p>Based on MedPAC's analysis, current law is expected to increase payment rates by 2.9 percent in FY 2026.</p>                                                                                                                                                                                                                                                                             |
| Home health care services                        | <p><i>For calendar year 2026, the Congress should reduce the 2025 Medicare base payment rates for home health agencies by 7 percent.</i></p>                                                                                                                                                                                                                                                                                                                                                                                                                   | <p>MedPAC has found that FFS Medicare payments are significantly higher than costs, projecting a 19 percent margin for providers in 2025.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                        |

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|                                                  |                                                                                                                                                   | According to MedPAC's analysis, current law is expected to produce a 2.4 percent increase in payment rates in 2026.                                                                                                                                                                         |
| Inpatient rehabilitation facility (IRF) services | <i>For fiscal year 2026, the Congress should reduce the 2025 Medicare base payment rate for inpatient rehabilitation facilities by 7 percent.</i> | MedPAC recommends a payment reduction to more closely align payments with costs, noting that the FFS Medicare margin for IRFs is projected to be 16 percent in 2025.<br><br>The IRF base payment rate is expected to grow by 2.6 percent in 2026 based on MedPAC's analysis of current law. |
| Hospice services                                 | <i>For fiscal year 2026, the Congress should eliminate the update to the 2025 Medicare base payment rates for hospice.</i>                        | With a projected aggregate margin of 8 percent in 2025, matched with positive indicators regarding access to care and capital, MedPAC's analysis recommends eliminating the 2.5 percent increase current law is expected to produce in FY 2026 payment rates.                               |

## MEDPAC PROVIDES A STATUS UPDATE ON THE MEDICARE PRESCRIPTION DRUG PROGRAM (PART D)

In 2024, the Medicare Part D program provided prescription drug coverage to over 54 million beneficiaries, with payments through Prescription Drug Payments (PDPs) and Medicare Advantage Prescription Drug plans (MA-PDs) totaling \$128.2 billion dollars. Medicare covered \$68.2 billion of that amount in subsidies for basic benefits and \$43.9 billion for low-income subsidies (LIS). Part D enrollees paid \$16.1 billion in premiums for basic benefits and \$18.8 billion in cost sharing, while employers providing drug coverage to their retirees paid \$0.5 billion. Sentiment surveys and focus groups found overall high satisfaction with the Part D program.

The passage of the Inflation Reduction Act (IRA) of 2022 has led to significant changes in the Part D program. Between 2022 and 2025, out-of-pocket (OOP) cost limits for insulin and vaccines, as well as inflation rebates for drug manufacturers, have gone into effect. However, 2025 has seen further changes and implementation of the full Part D benefit redesign outlined in the IRA, which has caused meaningful change in the Part D space. These changes shift liability between various stakeholders in the program,

reducing beneficiary cost sharing while increasing plan and Medicare liability (the latter through changes to subsidies). Negotiated prices for drugs selected for the Medicare Drug Price Negotiation Program (MDNP) will go into effect in 2026 for the first cycle of the program.

Before the 2025 provisions went into effect, in July 2024, CMS reacted to uncertainty regarding potential enrollment shifts due to changes in individual plan premiums for PDPs caused by IRA provisions and created the Part D Premium Stabilization Program. Launched at the same time plan sponsors received bid information about 2025, this voluntary demonstration lowers participating PDP premiums by up to \$15, requires participating PDPs to limit the annual increase in their total premiums to no more than \$35, and provided additional loss protections. Almost all PDPs elected to join the demonstration, which the Congressional Budget Office estimates cost \$5 billion in 2025.

In this chapter, MedPAC provides their preliminary analysis on the impacts of these new provisions.

### **Main Impacts of the IRA in 2025 on Part D**

- **Concern about the long-term stability of the PDP market:** MedPAC commissioners expressed concern regarding the long-term stability of the PDP market given diverging trends in the PDP and MD-PD markets. Premiums charged by PDPs tend to be higher on average than MA-PDs and the number of benchmark plans has continued to decline. Additionally, PDP enrollees' benefit costs are higher than their MA-PD counterparts, and PDPs have higher average gross costs combined with lower risk scores than MA-PDs.
- **Cost-sharing for patients under the Part D benefit redesign:** Lower cost sharing for patients through IRA provisions will make medications more affordable but may increase premiums and Medicare subsidy costs. Overall uncertainty has driven up the amount and variation in plan bids.
- **Impact of IRA on pharmaceutical manufacturers:** IRA changes are likely to affect future pharmaceutical company revenues, which may affect future research and development investment decisions. Estimates of the impact of these changes have varied widely. Congressional Budget Office research projects this effect will be limited, while other research shows a greater impact. For the DPNP and inflation rebates policy specifically, the Commission has not made recommendations related to either of these policies. However, the Commission notes that negotiated prices that go into effect in 2026 may drive additional changes in the pharmaceutical supply chain. MedPAC asserts that the

IRA and subsequent policy changes are “likely to interact in a way that complicates our understanding of the impact of any given policy in isolation.”

The Commission anticipates the initial year of data on IRA changes will provide an incomplete picture of the effects of the IRA on the Part D program. MedPAC will continue to monitor the IRA’s impact on the Part D program and its stakeholders beyond the initial years of implementation.

### **Recent Trends**

MedPAC staff added a note in this section highlighting that recent trends may not be as useful in forecasting future behaviors given the wide-ranging impact of the IRA.

- **Shift from PDPs to MA-PDs:** Beginning in 2020, the number of enrollees in PDPs has declined as people shift to MA and associated MA-PDs. PDP enrollees comprised 53 percent of Part D enrollees in 2020. This share has fallen 10 percent over the last four years to just 43 percent in 2024. MedPAC staff describe this change to differences in benefits between the two programs, as well as specific plan characteristics and needs for LIS beneficiaries.
- **Breakdown of Part D spending has shifted:** Program spending has shifted increasingly to cost-based payments, with Medicare payments for monthly capitated direct subsidies falling an average of nearly 20 percent from 2019 to 2023. MedPAC staff ascribe this decline to the increased use of generic drugs by Part D enrollee, growth in manufacturer rebates, and a rise in pharmacy fees that offset basic benefit plan costs. Concurrently, Medicare’s cost-based reinsurance payments have risen 8.2 percent per year on average from 2019 to 2023, as the number of beneficiaries reaching the catastrophic phase of Part D’s benefit (removed as of 2025) increased. MedPAC staff are concerned about how this realignment in spending created misaligned plan incentives, including a growth in post-sale rebates that has shifted more costs to Medicare’s LICs subsidy and to beneficiaries who paid a coinsurance that did not reflect these rebates.
- **Overall Part D price sales growth slowed by generics:** High generic penetration has helped moderate the growth in overall Part D prices at the point of sale. Despite a nearly 50 percent increase in the prices for all drugs and biologics between 2014 and 2023, decreases in generic prices (which account for 90 percent of all prescriptions) have helped slow overall price growth.
- **Future savings will need to come from biosimilars and drug price negotiation:** MedPAC staff projects the uptake of biosimilars and the new Medicare DPNP will affect Part D prices. With the share of generic prescriptions

remaining flat since 2017, any efforts to moderate Part D drug prices will need to come through an increase in biosimilar use and savings achieved through price negotiations.

### **Pharmacy Trends**

- **Integration of Pharmacy Benefit Managers (PBMs) has mixed effects:** PBMs that are vertically integrated with insurers and pharmacies may increase efficiency through lower transaction costs throughout their supply chain, however these changes also diminish price transparency. Lack of transparency can increase costs for enrollees and taxpayers, especially given CMS's lack of visibility into costs for integrated organizations.
- **Vertical integration may create conflicts of interest:** Vertical integration in PBMs may cause conflicts of interest both internally and externally. For example, internally pharmacy owners face incentives to increase the volume of drugs dispensed. Externally, in highly concentrated PBM markets, vertical integration may incentivize anticompetitive behavior such as elevating prices for competing plans.
- **Concern about preferential pharmacies:** MedPAC staff noted a mix of both positive and negative research regarding designated preferential pharmacies. On one hand, these pharmacies may be more effective in encouraging generic drug use. However, concerns persist regarding preferred pharmacies overall given disparities in beneficiary access, and a potential need for increased cost-sharing subsidies. For beneficiaries receiving low-income subsidies, there are no additional financial incentives to choose preferred pharmacies, which would leave the Part D program to fill the gap.
- **Impacts of the change to the definition of "negotiated price":** Effective January 1, 2024, Part D plans' payments to their network pharmacies, must include all possible pharmacy price concessions so that the point of sale (POS) price is the lowest possible reimbursement a pharmacy network may receive for a particular drug. The change was expected to increase price transparency for pharmacies and beneficiaries and improve long-term revenue predictability. However, in the initial months of 2024, it was anticipated that pharmacies may experience cashflow shortages due to obligations to pay price concessions (pharmacy DIR) from 2023 while simultaneously receiving lower reimbursement for prescriptions filled in 2024. In late 2023, CMS sent a letter to Part D sponsors and PBMs encouraging them to make cash flow arrangements with network pharmacies to pay for these changes. The National Community Pharmacists Association stated these measures were not effective in addressing issues for independent pharmacies. MedPAC also highlighted pharmacy closures, noting

that they could have negative impacts for beneficiaries, and that impacts of pharmacy closures would likely vary regionally.

## **MEDPAC PROVIDES A STATUS REPORT ON MEDICARE ADVANTAGE, HIGHLIGHTING CONCERNS ABOUT SPENDING AND CONSOLIDATION**

As of 2024, Medicare Advantage (MA) program enrollment sits at 33.6 million beneficiaries, having grown from just 37 percent of eligible Medicare beneficiaries in 2018 to an all-time high of 54 percent. The average beneficiary now has a choice of 42 different plans, and in 2025, MA plans are projected to receive \$538 billion in Medicare payments. MedPAC staff estimate spending on these MA beneficiaries is 20 percent higher than if these beneficiaries elected for traditional fee-for-service (FFS) Medicare, a difference of \$84 billion. This estimate is composed of \$44 billion due to higher MA coding intensity (even after CMS's annual coding adjustment), and \$40 billion due to favorable selection by beneficiaries into MA plans. Additionally, the commission highlighted additional elevated payments in MA plans due to benchmark payment policies that set rates higher than FFS in certain areas, payments made through the quality bonus payment program, and a substantial increase in MA rebates. MedPAC staff also expressed concern about growing consolidation within MA.

### **Risk Adjustment and Coding Intensity**

- Coding intensity refers to the level of documented medical conditions that are part of a patient's record. Beneficiaries with more complex conditions receive higher rates of reimbursement due to their higher risk and associated medical status.
- In 2025, MedPAC projects that MA risk scores will be 16 percent higher than those of comparable FFS beneficiaries due to higher coding intensity. CMS applies a 5.9 percent reduction to MA risk scores to partially adjust for this difference (annual coding adjustment), but MedPAC estimates that even after this, MA risk scores will stay approximately 10 percent higher.
- MedPAC, at the request of the House Committee on Appropriations, analyzed differential diagnostic coding in MA and FFS Medicare, finding incomplete coding is more common in FFS than in MA.
- Coding intensity varies significantly across MA organizations, with some plans exceeding the CMS annual coding adjustment by a wide margin. MedPAC estimates that coding intensity differs by up to 26 percentage points across the largest MA organizations.

### **Favorable Selection**

- Favorable selection refers to the discrepancy (on average) between a beneficiary's expected spending (based on their individual health and geographic characteristics) if they were in FFS Medicare versus MA.
- This phenomenon occurs for a variety of reasons, medical and non-medical, including unmeasured medical conditions and specific care preferences.
- MedPAC research found that even for beneficiaries with high risk scores, FFS spending would be less than if they enrolled in MA.

### **Quality in Medicare Advantage**

- 69 percent of MA enrollees are in plans that receive quality bonus payments; however, MA and FFS beneficiaries report similar levels of satisfaction with care.

### **Rebates**

- MA rebates are used by plans in a variety of ways, including:
  - Administrative costs and profits,
  - Lower premiums,
  - Lower cost sharing, and
  - Vision, hearing, dental, or fitness benefits.
- Rebates for MA plans have doubled on average since 2018, and now account for 17 percent of total plan payments.

**MedPAC makes several recommendations related to MA. Recommendations are not formal recommendations that were voted upon by the Commission for this report, but reiterate some formal recommendations the Commission has included in previous reports:**

- Congress should direct the Secretary to develop a risk-adjustment model using FFS and MA diagnostic data, excluding health risk assessments, and apply a coding adjustment for differences between FFS and MA plans.
- MedPAC recommends that Congress should set accuracy thresholds for MA encounter data, apply payment withholds and refunds, and offer a voluntary direct submission option for non-compliant organizations.
- Congress should replace the MA quality-bonus program with a value-incentive program focusing on local-market quality and equitable rewards and penalties

- The existing MA benchmark policy should be replaced with one that appropriately accounts for both local and national FFS spending and modifies existing specific existing benchmark regulations.

## **MEDPAC PROVIDES A STATUS REPORT ON AMBULATORY SURGICAL CENTERS, REITERATES RECOMMENDATION THAT ASCS BE REQUIRED TO SUBMIT COST DATA**

Ambulatory Surgical Center Services (ASCs) provide same-day surgical procedures for patients who do not require overnight hospitalization. The Commission's status report highlighted four areas: growing ASC supply and service volume in 2023, stable quality reporting measure results, rising Medicare payments, and the need for ASC cost data submission.

ASCs continued to grow in 2023, with the number of Medicare-certified facilities increasing by 2.5 percent to 6,308 ASCs (compared to the 2.2 percent annual average growth from 2018-2022). During 2023, 250 new ASCs opened, while 95 closed or merged, resulting in a net increase of 155. Service volume per Medicare FFS beneficiary rose by a meaningful 5.7 percent in 2023, driving a 2.2 percent increase in aggregate ASC services. This growth was fueled by an increase in high-volume and complex procedures like colonoscopies, cataract surgeries, total knee arthroplasties and total hip arthroplasties. Most ASCs are for-profit (95.3 percent) and located in urban areas (93.8 percent), with an uneven geographic distribution of facilities across states. ASCs offer several advantages over hospital outpatient departments (HOPDs), including lower patient cost-sharing, shorter non-operative times, better locations, easier scheduling, and greater physician autonomy. However, according to MedPAC staff's research, ASCs are less likely to serve Medicare beneficiaries who were dually eligible for Medicaid, those aged 85+, or those under 65 eligible due to disability.

The ASC Quality Reporting Program requires ASCs to submit quality data to avoid a 2 percent payment reduction, with performance on these measures not affecting payments. The program currently includes four claims-based measures tied to unplanned hospitalizations across different specialties. Between 2018 and 2023, ASCs showed significant improvements in the ASC-12 measure, (7-day hospital visit rate after outpatient colonoscopy), which saw its national average decrease from 12.2 percent to 9.8 percent. However, performance across the remainder of the ASC quality measure set remained unchanged over the same period. CMS has added several new measures that are scheduled to begin data collection in 2025 and will affect ASC payment updates in 2027. The Commission recommends expanding these outcome quality measures to more services; specifically, (1) surgical-site infections (SSIs) at ASCs, (2) specialty-specific clinical guidelines to assess whether services provided in ASCs are appropriate, and (3) a claims-based outcome measure for cardiology.

In 2023, ASCs received \$6.8 billion in Medicare payments, including both FFS Medicare spending (\$5.4 billion) and beneficiary cost-sharing (\$1.4 billion). Payments per FFS beneficiary rose by 15.4 percent in 2023, almost double the 2018-2022 average of 7.8 percent. This increase in 2023 was driven by a 3.9 percent increase in the conversion factor, 5.7 percent rise in per capita volume, and a 5.0 percent increase in the average relative weight of services. Despite ASCs across the nation offering over 3,700 procedures, Medicare revenue for these facilities is highly concentrated, with 59 procedures accounting for 75 percent of total revenue. However, since ASCs do not submit cost reports, it is not possible to assess the financial status of all ASCs.

The Commission has consistently recommended that Congress require ASCs to submit cost data. This would help establish payment rates that more accurately reflect ASC costs. Unlike other facilities, ASCs are not currently required to provide cost data, which means their payment rates are primarily based on hospital outpatient prospective payment system (OPPS) weights that may not accurately reflect their cost structures. The lack of ASC specific cost data incentivizes ASCs to focus on high margin procedures, which narrows their services. While collecting this data would impose an administrative burden on ASCs, the Commission argues this is feasible given small businesses and health facilities already submit cost data.

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