2027 Medicare Advantage Advance Notice Analysis

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Summary

The Better Medicare Alliance (BMA) commissioned BRG to estimate certain effects of the Centers for Medicare & Medicaid Services' (CMS) 2027 "Advance Notice of Methodological Changes for Calendar Year (CY) 2027 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies" ("Advance Notice" or AN). BMA asked BRG to examine how (1) CMS's fee-for-service (FFS) Medicare spending estimates impact payments to MA plans and (2) the risk model changes in the 2027 AN impact payments to MA plans.

BRG finds that:

- Payments to MA plans would increase by around $12 per member per month (PMPM), or $144 annually, for every additional 1 percent added to the 2027 effective growth rate.
- The risk model changes proposed in the AN (not including elimination of unlinked charts) would reduce total payments to MA plans by $27 PMPM, or $324 annually, from what they would be otherwise.

Growth Rate Background

CMS annually estimates total FFS spending to determine how much to increase MA benchmarks. These spending estimates reflect CMS's current forecast of FFS cost growth for the next two years and retroactive adjustments to prior years based on additional claims data. The net increase factor for the upcoming payment year, which incorporates all of these changes, is called the effective growth rate (EGR).

The primary application of the EGR is to adjust the annual US per capita cost (USPCC), which represents CMS's overall estimate of FFS costs, adjusted for aspects not covered under the MA benefit (e.g., hospice). When CMS publishes its annual estimated change in plan payment, with either the AN or rate announcement (RA), it also uses the change in EGR to estimate change in plan bids. However, while the USPCC is updated by the total EGR, estimated plan bids are usually increased by a slightly lower amount, as CMS has found historically that plan bids grow more slowly than FFS costs.

The EGR is a major factor in determining benchmarks and thus projected total payments to MA plans. CMS used FFS data through the first half of 2025 to project AN growth rate trends. CMS's Office of the Actuary (OACT) published a fact sheet showing dozens of past and future spending trends to provide transparency into its calculation of the EGR. The document includes projections of future utilization and prices, assumptions that are inherently uncertain. OACT typically modifies these assumptions in the RA and future years to reflect updated data as it becomes available.

The EGR also includes Medicare FFS policy changes that may not be representative of MA plans' experience. For example, this year's EGR includes downward revisions for Medicare FFS's new payment methodology for skin substitutes and home healthcare in 2026, which impacts 2027 payments too. Prior BRG research has demonstrated that MA plans did not have the same significant growth in skin substitute payments as traditional Medicare, so the plans likely will not benefit from lower-cost trend due to a downward adjustment in these payments.

The retroactive adjustments made to the EGR can be either positive or negative; for the 2027 estimate, CMS decreased its estimates for the last ten years, whereas a year ago CMS had increased its estimates for nine of the prior ten years. While these changes keep the USPCC and plan benchmarks as close to FFS spending as possible, they can cause issues with MA plans that do not have the ability to "rebid" prior years, resulting in plan cost growth that can exceed the EGR if there are enough prior-period downward adjustments.

The EGR does not include other adjustments to payments due to policy or model updates, such as this year's proposed hierarchical condition category (HCC) model revision and elimination of diagnoses from unlinked chart reviews. The EGR also does not include changes in payments due to increases or decreases in plan risk scores.

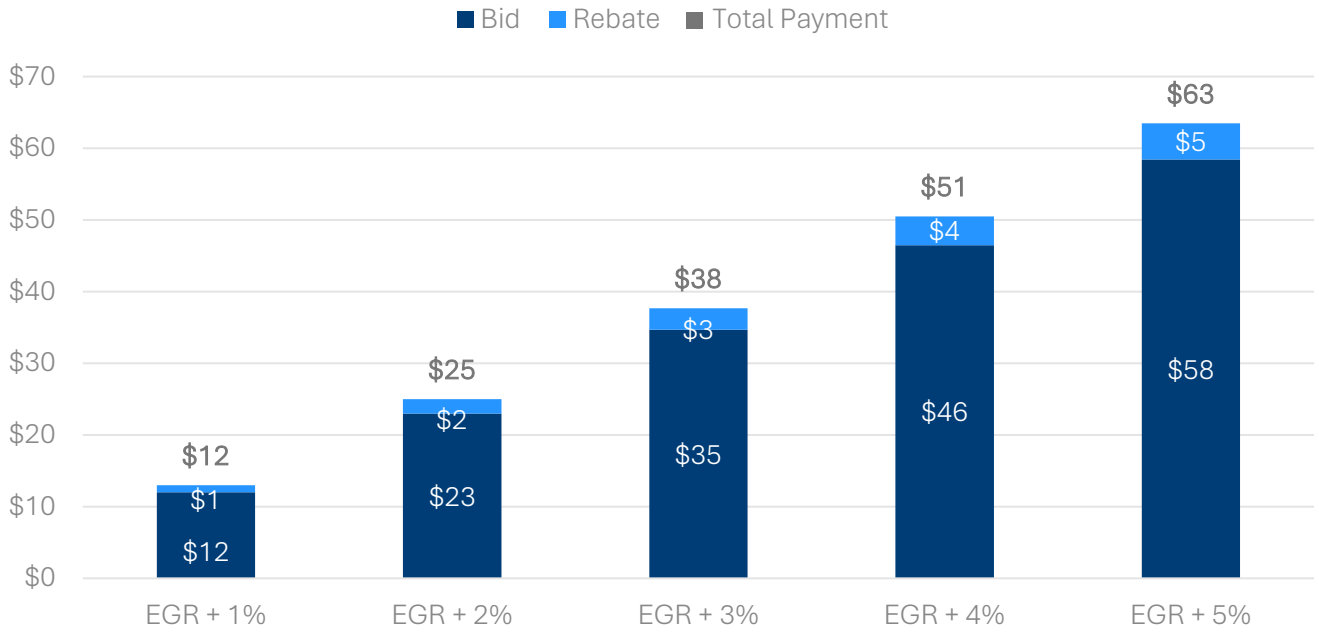
The current EGR estimate for payment year 2027 is 4.97 percent. Regardless of whether it is positive or negative, low or high, an EGR lower than MA plans' expectations of medical trend will apply financial pressure in the same manner as a payment cut.

Growth Rate Analysis

Some stakeholders have argued that CMS's 2027 AN growth rate projections underestimate trends in utilization and spending. Our modeling shows small changes in the EGR can have significant impacts on total plan payment. We find that a change of 1 percentage point in the 2027 EGR would change total plan payments by roughly $12 PMPM, while a 5-percentage-point shift would change payments by approximately $63 PMPM. If CMS's EGR lags medical trend, the drop in total payments from what they otherwise would be would apply financial pressure to plans akin to a payment cut, with total payments falling by $144 annually with a 1 percent change and $756 annually with a 5 percent change.

Figure 1 illustrates how changes of 1 to 5 percent in the EGR translate into differences in total 2027 PMPM payments for MA plans.

Figure 1: Impact on 2027 Total PMPM Payments to MA Plans from EGR Changes



Source: BRG MA Payment Model.
Note: Total Payment = Bid + Rebate; totals may not add due to rounding.

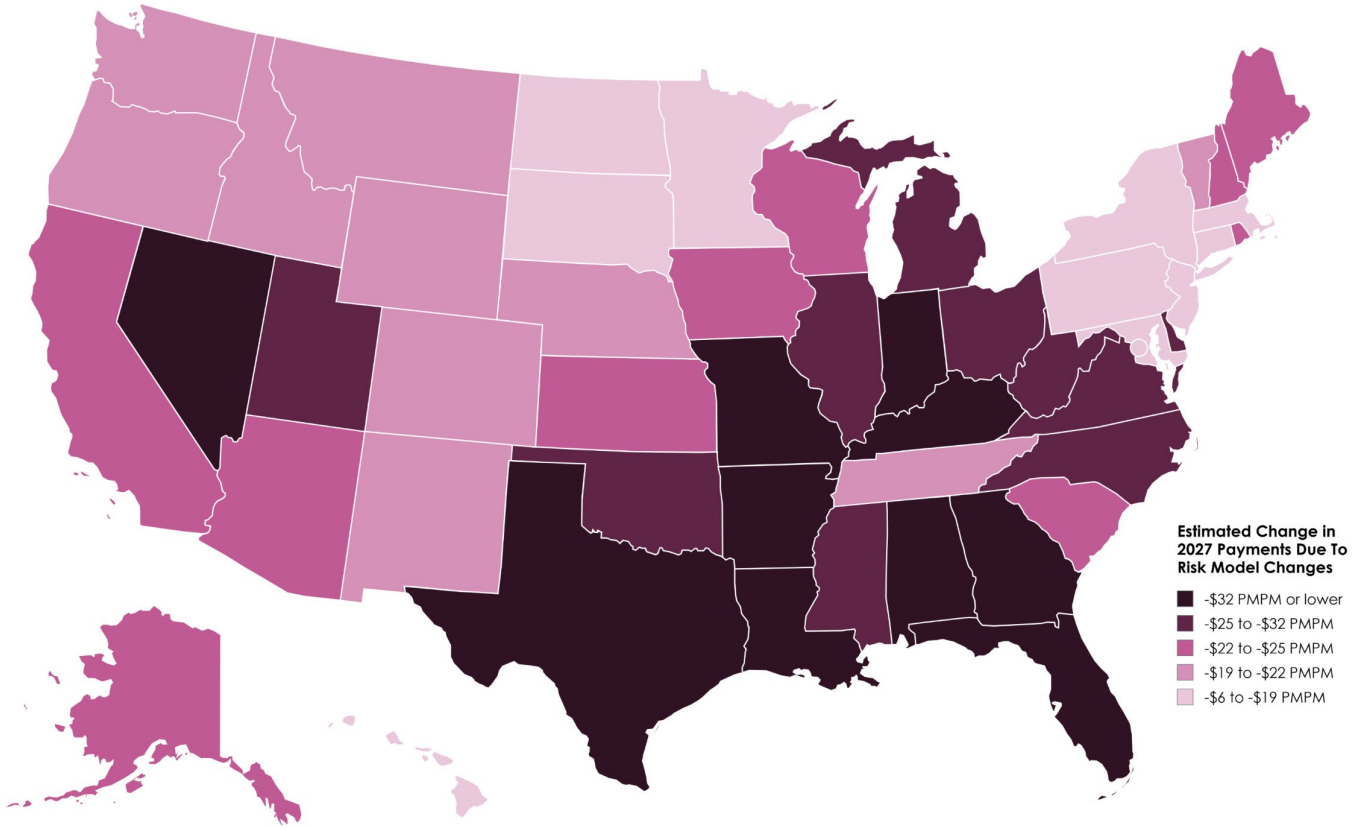
2027 Risk Model Changes Background

The 2027 AN includes changes to the CMS-HCC Risk Adjustment Model for MA plans. The model determines how a beneficiary's health status adjusts how much CMS pays an MA plan to insure the beneficiary, with sicker beneficiaries warranting higher payments and healthier beneficiaries warranting lower payments. CMS has proposed to calibrate the model for 2027 using recent underlying FFS data (updated to 2023 diagnoses and 2024 expenditures from 2018 diagnoses and 2019 expenditures). The proposed model also includes refinements to ensure diagnoses from audio-only encounters are not factored into the calibration; and updates how risk scores for people with chronic kidney disease impact payment to MA plans.

Risk Model Analysis

We estimate the risk model changes proposed in the 2027 AN will lower total payments to MA plans by $27 PMPM, or $324 annually, versus what they would otherwise be without the proposed revisions. Figure 2 shows the impact on a state-by-state basis. Our calculations did not include the impact of CMS's proposed exclusion of diagnoses from unlinked chart reviews, which may affect risk scores but is not a change to the risk model itself.

Figure 2: Estimated Change in 2027 Total PMPM Payments by State Due to Risk Model Revisions



Source: BRG MA Payment Model.
Note: Estimated change does not include impact from eliminating unlinked charts.

Implications for Policymakers

CMS's estimate of the EGR is integral in determining payments to MA plans. The growth rate projections rely on assumptions that are inherently uncertain and revised as new data emerges and policies are introduced and implemented.

Small changes in the EGR can have significant impacts on plan payment. Our modeling shows a 1 percent understatement of the EGR would lower total payments to MA plans by $144 per beneficiary per year, with the opposite being true if an overstatement occurred.

When plans' actual cost experience exceeds CMS's FFS projections, MA plans experience financial pressure in the same manner as a payment cut. That pressure can lead to changed bids, reduced rebates, and less-generous supplemental benefits for beneficiaries. CMS's proposed changes to the CMS-HCC risk-adjustment model will add financial pressure to plans in 2027. Our modeling suggests the proposed risk model changes would cut payments by $324 per beneficiary per year compared to what plans would receive without the proposed revisions. Together, uncertainty in the growth rate assumptions and new risk model adjustments could substantially reduce plan funding from what it would otherwise be and limit the benefits available to MA enrollees.

Appendix: Estimated State Impact from Risk Model Revisions

State	Estimated Change *			State	Estimated Change *	
	2027 PMPM	2027 Total Payment ($M)			2027 PMPM	2027 Total Payment ($M)
Alabama	-$38	-$268.8		Montana	-$21	-$20.7
Alaska	-$24	-$0.3		North Carolina	-$27	-$362.7
Arizona	-$23	-$209.8		North Dakota	-$19	-$6.8
Arkansas	-$36	-$135.7		Nebraska	-$19	-$30.1
California	-$24	-$895.0		Nevada	-$47	-$182.5
Colorado	-$22	-$135.4		New Hampshire	-$22	-$26.5
Connecticut	-$18	-$78.0		New Jersey	-$16	-$102.2
Delaware	-$30	-$25.4		New Mexico	-$21	-$58.6
District of Columbia	-$12	-$4.6		New York	-$6	-$143.7
Florida	-$55	-$1,946.7		Ohio	-$29	-$434.3
Georgia	-$32	-$370.0		Oklahoma	-$31	-$124.2
Hawaii	-$17	-$29.9		Oregon	-$19	-$115.4
Idaho	-$20	-$49.20-		Pennsylvania	-$18	-$333.9
Illinois	-$25	-$247.50		Rhode Island	-$22	-$38.0
Indiana	-$32	$-273.40		South Carolina	-$25	-$169.1
Iowa	-$22	-$66.90		South Dakota	-$14	-$7.6
Kansas	-$25	-$57.5		Tennessee	-$19	-$187.1
Kentucky	-$39	-$205.6		Texas	-$33	-$963.9
Louisiana	-$39	-$258.6		Utah	-$27	-$84.9
Maine	-$24	-$62.7		Vermont	-$19	-$2.0
Maryland	-$16	-$44.5		Virginia	-$27	-$204.2
Massachusetts	-$14	-$82.6		Washington	-$20	-$187.4
Michigan	-$25	-$300.0		West Virginia	-$31	-$68.9
Minnesota	-$11	-$72.5		Wisconsin	-$22	-$187.7
Mississippi	-$30	-$113.0		Wyoming	-$21	-$6.0
Missouri	-$35	-$292.4				

*Estimated change does not include impact from eliminating unlinked charts.

Source: BRG MA Payment Model. BRG's MA Payment Model estimates spending, utilization, the impact of quality measures, and patient morbidity at the national, state, and county levels. Key metrics and inputs in our model include total and PMPM payment; beneficiary financial exposure to premiums, deductibles, and cost sharing; FFS PMPM costs, star rating, quality bonus, and benchmarks; premium and zero-premium plans; and chronic conditions, raw and normalized risk scores (RAF), and individual HCC prevalence rates under risk adjustment models V24 and V28. The model integrates data primarily from the CMS Chronic Conditions Data Warehouse with 100 percent MA encounter, FFS, enrollment and eligibility, Medicaid enrollment, encounter, claims, and nursing home assessment data; CMS data sources for benchmark, star bonus, FFS trend, rebate and plan payment, RAF, and enrollment data; risk score V24 and V28 algorithms and FFS normalization and coding intensity adjustments; proprietary BRG plan survey data and internal BRG industry expertise; and publicly available reports from academics and independent analysts.