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INSIGHTS

MedPAC Sessions on Medicare Advantage and Dual-Eligible Special-Needs Plans

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On January 16, 2026, the Medicare Payment Advisory Commission (MedPAC) met to see presentations and discuss findings on the Medicare Advantage (MA) program and Dual-Eligible Special-Needs Plans (D-SNPs). The information from the presentations and discussion will be included in the March 2026 report to Congress.

THE MA PROGRAM: STATUS REPORT

MedPAC staff offered a comprehensive overview of the MA program. MedPAC staff shared that in 2025, MA plans enrolled 55% of eligible beneficiaries, with the beneficiaries having an average of 42 plans to choose from. They also predicted that MA rebates will reach a historic high in 2026, which they said could help in reducing cost sharing as well as providing beneficiaries supplemental benefits such as dental and vision services. MedPAC staff also noted that MA spending has been greater than traditional Medicare Fee-for-Service (FFS) spending, which may be attributed to upcoding. They also noted that the new V28 reduced coding-intensity model appears to help control MA costs while maintaining stable supplemental benefits and MA plan availability. It is expected that the V28 model will continue to reduce MA coding intensity effects in coming years.

The Chair opened Commissioner discussion by sharing that he thinks about MA plans as an indirect way to provide access to care. He differentiated this from more direct ways MedPAC examines, such as hospital payments and the post-acute care space.

Multiple Commissioners were interested in the excess administrative expenses expected with MA plans, seeking clarification on how administrative costs are accounted for in the medical-loss ratio and how savings can be passed on to beneficiaries.

There was also interest in the V28 service model due to its relative newness. MedPAC staff clarified that there are plans to compare the effects of the V24 model to the V28 model to see if there are code discrepancies between the models and that the V28 model uses Medicare FFS data to periodically update the model calibration. Some Commissioners raised concerns that the model is affecting MA plans that have not been found to be upcoding and wondered if there was a way to make plan-specific adjustments in those cases. MedPAC staff shared that such changes would need to be a change in policy, not just a change in the data model.

One Commissioner requested that in the future MedPAC take a closer look at other Medicare populations, such as those with permanent disabilities, as much of the previous and current work focuses on the older adult population.

There were also broad concerns from the Commissioners about the profit margin of MA plans, especially when compounded with concerns about MA plans having a much higher spending amount per beneficiary than those enrolled in Medicare FFS. It was suggested that future work could provide a clear breakdown of how money flows through MA plans, as well as taking a closer look at the star rating system which some Commissioners believe is helping to accelerate payment rates. Receiving clearer data from reliable sources was highlighted as a need from staff and Commissioners. It was also suggested that the use of supplemental benefits and clear beneficiary-level data could be helpful to the Commission. Another thought was that the Commission needs to understand how supplemental benefits are used to market MA plans and how beneficiaries shop for plans.

The Commissioners shared a wide variety of ideas about how to transform the MA space to work better for beneficiaries. These included flexible spending accounts to allow supplemental benefits to be purchased directly, going back to encounter-based coding, revisiting out-of-pocket maximum policies to contain costs, and reconsidering whether the quality payment system should be budget-neutral. Another suggestion made was to streamline the plan choices and create better materials to explain the differences between types of care plans.

Overall, the Commissioners shared the sentiment that MA plans are somewhat overfunded, and that program changes are needed to ensure quality care is still delivered while costs are contained.

MANDATED REPORT: D-SNPS

MedPAC staff began the session with an overview of D-SNPs, sharing that nearly half of dually eligible beneficiaries are enrolled and use has tripled over the last decade. MedPAC staff shared how each type of D-SNP plan had various results on Healthcare Effectiveness Data and Information Set (HEDIS) quality measures, which can make it difficult to directly compare across plan types. It was also noted that look-alike plans offer an alternative to D-SNPs and Chronic Condition Special-Needs plans (C-SNPs) are becoming more popular in the market.

The Commissioners questioned how integration for D-SNPs can be best measured, but MedPAC staff shared that the plan providers are very aware of the quality incentives that relate to higher payments and will focus their efforts on those measures, which can make it difficult. One Commissioner shared that they were not surprised that there is no correlation between increased integration and broad quality measures, stating that integration is not the only or strongest way to create value for challenged populations.

Multiple Commissioners had questions about D-SNP marketability to beneficiaries and would like to see some qualitative data from plans and beneficiaries in the future. MedPAC staff shared that current reports indicate that care coordination benefits are hard to explain to beneficiaries so many beneficiaries still make their plan decisions on supplemental benefit access.

There was conversation about the ability to join C-SNPs in the middle of the year which MedPAC staff

clarified was not a new policy. MedPAC staff also explained that the rationale is that they are specific, specialized plans for those with health needs and the policy is in place to provide beneficiaries access to specialized plans for those with health needs as soon as possible.

There was also worry that these plans help with the cherry-picking of beneficiaries, leaving other plans with lower patient populations resulting in fewer plan offerings.

The discussion ended with the Commissioners agreeing that the wide variety of plan options can make the process of picking one difficult to navigate, and some streamlining would be helpful. However, it was also agreed that this must be balanced with providing a variety of plan specifications so each beneficiary can find one that best suits their needs.

We trust you found this summary useful. Please reach out to us with any questions.