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Centers for Medicare & Medicaid Services (CMS)
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted electronically via regulations.gov

RE: Advance Notice of Methodological Changes for Calendar Year (CY) 2027 for Medicare Advantage Capitation Rates and Part C and Part D Payment Policies ("Advance Notice") — AHIP Comments

Dear Director Klomp and Director Lazio:

Thank you for your dedicated stewardship of the Medicare program and commitment to ensuring Medicare meets the needs of seniors and people with disabilities while delivering value and accountability to taxpayers. We appreciate the opportunity to provide comments on the Advance Notice.

Health plans are honored to serve 35 million Medicare beneficiaries who have chosen to enroll in Medicare Advantage (MA) and nearly 57 million enrolled in Part D drug coverage. MA provides beneficiaries superior value, enhanced benefits, more coordinated care and better health outcomes compared to fee-for-service (FFS). MA beneficiaries save an average of more than $4,100 annually in premiums and out-of-pocket costs compared to those in FFS.[1] MA is particularly important for millions of beneficiaries with chronic diseases, who access more preventive care and experience fewer preventable admissions and readmissions – all while saving money.

We share CMS's commitment to a competitive, innovative market with strong program integrity. Health plans support thoughtful, data-driven reforms to the MA risk adjustment system and welcome other steps to strengthen and modernize Medicare for beneficiaries.

We respectfully submit that, if finalized as proposed, the Advance Notice risks undermining CMS's goal of providing beneficiaries with stable, affordable choices during the annual enrollment period. At a time of sharply rising medical costs and high utilization of medical

[1] https://media.milliman.com/v1/media/edge/images/millimaninc5660-milliman6442-prod27d5-0001/media/Milliman/PDFs/2026-Articles/1-16-26_Comparison-of-beneficiary-costs-across-Medicare-coverage-options.pdf.

services, the combined effect of the proposed policy changes and growth rates will not keep pace with the cost of caring for seniors in 2027. Unless the Final Notice prioritizes stability and closes the gap between the proposed flat funding and the expected increase in Medicare costs next year, tens of millions of beneficiaries could see fewer choices, reduced supplemental benefits, higher premiums and higher out-of-pocket costs when they renew their MA coverage in October 2026.

An analysis of potential impacts of the Advance Notice conducted by Wakely[2] found that monthly premiums could increase by $23 – or more than $550 annually for the typical senior couple – to maintain current levels of benefits. Plans seeking to preserve $0-premium options could see 50% cuts to important supplemental benefits, such as dental or vision, and a $1,000 increase in seniors' out-of-pocket cost exposure.

Flat funding amid sharply rising costs for 2027 would compound the instability seniors have experienced following policies enacted prior to 2025. A new study found that 2.9 million enrollees incurred "forced disenrollments" in 2026 due to plan terminations in their areas.[3] In addition, average premiums rose 24%, and supplemental benefits were reduced due to policies enacted in prior years.

We believe CMS can both accomplish its policy objectives and avoid disruption for America's seniors when they choose their 2027 plans starting this October by:

- Closing the substantial gap between proposed program funding and the expected cost of caring for seniors in 2027. We note that National Health Expenditure data released in January projects growth in Medicare spending of 8.9% for 2026-2027, while CMS projects FFS-only trend to increase 5.1% next year.

- Phasing-in proposed risk adjustment policies beginning in 2028, consistent with past CMS practice for major methodological updates.

In the attached comments, we offer detailed recommendations in support of these objectives.

We appreciate your consideration of our perspective. Please contact me any time we can be of assistance.

Sincerely,

Mike Tuffin
President & Chief Executive Officer

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[2] https://ahiporg-production.s3.amazonaws.com/documents/Potential-Impact-to-Benefit-Design_AdvanceNotice-Proposals-02.23.2026.pdf.

[3] Mark K. Meiselbach et al., *Forced Disenrollments Among Medicare Advantage Beneficiaries Following 2026 Plan Exits*, JAMA (Feb. 18, 2026), doi:10.1001/jama.2026.0028.

AHIP Detailed Comments on CY 2027 Advance Notice

Summary of Key Issues and Recommendations:

Medicare Advantage. AHIP supports CMS's efforts to update the MA risk adjustment model with more recent data and to impose limits on the use of diagnoses from chart reviews that are not linked to encounter data submissions. However, **the combined effect of the proposed changes in 2027 and lower than expected projected growth rates would reduce program funding well below the level needed to keep pace with the real cost of caring for Medicare beneficiaries unless changes are made in the Final Rate Announcement.**

The impacts would be uneven across states and populations. An analysis from Wakely Consulting Group (Wakely)[4] estimates that roughly 70% of MA enrollees live in areas that will see cuts in payments to plans. The most negatively impacted states include Oklahoma, Kansas, West Virginia, Alabama, and North Dakota. Rural counties on average would see lower growth rates than the national average. The impacts in certain areas under the Final Rate Announcement could be significantly worse, e.g., because of local adjustments to rates.

MA beneficiaries have experienced coverage losses, premium increases, and benefit reductions in recent years.[5] For example, since 2024, the number of general enrollment MA plan options has fallen by 14%, or nearly 600 plans. In 2026 alone, 32 MA plans exited counties and 15 carriers exited the MA program altogether. A new study found that 2.9 million enrollees incurred "forced disenrollments" in 2026 due to plan terminations in their areas, reflecting a trend of greater coverage disruption that began in 2025.[6] Average premiums in 2026 rose 24%. And supplemental benefits were scaled back – including benefits for meals, nutrition, and transportation that support the Administration's Make America Healthy Again agenda.[7]

Wakely modeled the potential impacts for beneficiaries in MA plans if the proposals are finalized in the Final Rate Announcement. Wakely estimates a nationwide cut of about 15% in the rebate dollars that plans use to reduce member premiums and cost sharing and offer supplemental benefits. The beneficiary impact of the cuts could be dramatic, although specific impacts will vary depending on the approach that each plan uses in response to the cuts.[8] Wakely's modeling found that with a loss of rebate dollars of this magnitude, beneficiaries in plans that prioritize maintaining benefits could see monthly premiums rise by $23. Beneficiaries in plans that prioritize keeping member premiums as low as possible could see significant benefit reductions, such as a 50% decrease in comprehensive dental and vision eyewear coverage, a $1,000 increase in the out-of-pocket cost maximum, and a 50% decrease in other supplemental benefits.

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[4] See: https://ahiporg-production.s3.amazonaws.com/documents/CY2027-Advance-Notice-Summary-and-Analysis-Wakely-02.19.2026.pdf.
[5] See: https://ahiporg-production.s3.amazonaws.com/documents/202602_AHIP_IG_Medicare_Advantage_Landscape_2026.pdf.
[6] Mark K. Meiselbach et al., *Forced Disenrollments Among Medicare Advantage Beneficiaries Following 2026 Plan Exits*, JAMA (Feb. 18, 2026), doi:10.1001/jama.2026.0028.
[7] See: https://bettermedicarealliance.org/blog-posts/2026-medicare-advantage-data-reveal-shifts-in-benefit-design/.
[8] See: https://ahiporg-production.s3.amazonaws.com/documents/Potential-Impact-to-Benefit-Design_AdvanceNotice-Proposals-02.23.2026.pdf.

To allow CMS to accomplish its policy objectives on risk adjustment without disrupting coverage for seniors in 2027 or undermining other health policy goals, **we urge CMS to take the following steps to ensure that funding in the Final Rate Announcement reflects rising medical costs:**

- **Revise and delay risk adjustment implementation**. Make technical adjustments outlined below to the updated risk adjustment model and the chart review proposal and delay their effective dates to 2028. These changes will ensure a more orderly implementation, avoid inappropriate payment cuts for chronic illnesses that would occur under the proposed model, and minimize benefit cuts for seniors.
- **Phase in the risk adjustment proposals** over a period of years, consistent with CMS precedent for major risk adjustment changes.
- **Ensure data used in setting growth rates are updated and reflect realistic estimates of expected cost trends**. Consider phasing in the impacts of certain policy changes to further support payments in the Final Rate Announcement that more closely meet funding needs.
- **Calculate MA benchmarks based only on fee-for-service (FFS) Medicare beneficiaries who are eligible for MA** – those enrolled in both Medicare Parts A and B.

Below we also provide feedback on the Star Ratings program, including potential future new measures and methodological changes.

Part D. The environment for Part D for 2027 bidding will be extremely complex and uncertain. Plans continue to have to implement major statutory changes to the benefit. The Part D risk adjustment model (even with proposed updates) still does not adequately reflect those changes. CMS plans to begin demonstrations that could have major impacts on the program, including the BALANCE (Better Approaches to Lifestyle and Nutrition for Comprehensive Health) Model for coverage of GLP-1s. CMS has not clarified whether it intends to continue the stand-alone PDP premium stabilization demonstration. And risk adjustment changes designed to reduce PDP premiums will increase costs for MA plans offering Part D coverage. Wakely found that the proposed Part D risk adjustment model will increase Part D premiums for MA-PD plans by about $6.00 to $10.00. This can put additional pressure on MA plan affordability.

The average premium for available PDP plans nationally increased 15% to $43.54 in 2026,[9] even with CMS's decision to continue the PDP stabilization demonstration for 2026. The number of available PDPs has declined significantly in recent years, with fewer PDP plan options available today than at any point since Part D's inception.[10] To avoid further reductions in choice and competition, and help stabilize bids and premiums across MA-PDs and PDPs in 2027, **we urge that CMS:**

- **Consider narrowing risk corridors**, e.g., as part of the BALANCE Model design, to address the significant degree of uncertainty that can drive higher Part D bids and taxpayer costs.

[9] See: https://ahiporg-production.s3.amazonaws.com/documents/202602_AHIP_IG_Medicare_Prescription_Drug_Coverage.pdf.
[10] See: https://www.kff.org/medicare/a-current-snapshot-of-the-medicare-part-d-prescription-drug-benefit/.

- **Clarify the future of the premium stabilization demonstration for 2027**.
- **Delay implementation of the proposed chart review limits** and take steps to improve the proposed RxHCC model and its accuracy.

Attachment I. Preliminary Estimates of the National Per Capita MA Growth Percentage and the National Medicare Fee-for-Service Growth Percentage for Calendar Year 2027

Section B. 2027 Growth Percentage Estimates

For 2027, CMS projects that MA non-ESRD benchmarks will increase by 4.97% on average, reflecting projected growth of 5.10% for FFS USPCCs and 4.04% for total USPCCs. By comparison, the non-ESRD FFS growth trend in the CY 2026 Final Rate Announcement was 8.81%.

Supporting documents published with the Advance Notice[11] show a variety of adjustments made to both Part A and Part B cost trend estimates since the CY 2026 Final Rate Announcement. They include significant drops in estimated inpatient utilization trends for 2026 and 2027, and significant adjustments to costs for Part B physician-related services driven in part by a payment policy change for skin substitutes finalized in the CY 2026 Physician Fee Schedule (PFS) final rule.[12]

Discussion and Recommendations: AHIP has significant concerns with the estimated growth percentages and the underlying data supporting them.

- National Health Expenditure data released in January estimate the Medicare growth rate at 8.9% from 2026-2027,[13] and there are indications that Medigap carriers are experiencing higher claims.[14] By contrast, the Advance Notice estimates the FFS-only growth trend at 5.1% for 2027. While the methodologies and populations for the various estimates differ, we urge CMS to be more transparent in explaining why the Advance Notice estimate trends are so much lower.
- Wakely calculates that the CY 2027 MA-only growth rate (based on the CMS data for the FFS-only growth rate and the total growth rate) is only 3.2%.[15] That is considerably lower than the estimated FFS-only trend of 5.1%. CMS does not explain how it determined MA costs would be growing at such a small rate and considerably below FFS costs. Without additional transparency, this raises concerns about the accuracy of these and other CMS growth rate calculations.
- The restatements of prior CMS spending estimates, based on data through the 2nd quarter of 2025 for Part A claims and the 3rd quarter of 2025 for Part B and MA claims, are reducing

[11] See: https://www.cms.gov/files/document/trends-supporting-2027-growth-rates.pdf.
[12] See: https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2026-medicare-physician-fee-schedule-final-rule-cms-1832-f.
[13] See: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2025.00545#.
[14] See: https://www.telosactuarial.com/blog/2026-med-supp-rate-increases-q1.
[15] See: https://ahiporg-production.s3.amazonaws.com/documents/CY2027-Advance-Notice-Summary-and-Analysis-Wakely-02.19.2026.pdf.

the 2027 growth rates. They estimate major reductions in cost trends in 2026 compared to prior estimates.

- The average non-ESRD FFS trend from 2023-2025 is about 6.8%. For 2026, the trend is only 2.0%.
- CMS estimates cost growth in 2026 for inpatient costs will decline from 5.71% to 2.02% and for skilled nursing facility costs will decline from 9.58% to 7.18%. Wakely notes these amounts "are much lower than recent experience."[16] One component of inpatient cost growth, utilization growth, will be only 1.43% in 2026, compared to the 2023-2025 average of 3.16%. In addition, CMS expects the inpatient utilization trend to be 0.64% for 2027.
- Part B growth trends will also decline significantly, from 9.06% in 2025 to 1.36% for 2026.
- A major contributor to the Part B and overall FFS decline in growth rates reflects CMS estimates that Part B payments for skin substitute procedures will drop by nearly 90 percent due to the change in methodology under the CY 2026 PFS final rule. Wakely estimates that this single adjustment to the 2026 FFS USPCC lowers the overall effective growth rate for 2027 by about 2.8 percentage points.[17]

AHIP strongly urges CMS to finalize an effective growth rate that more closely reflects likely Medicare utilization trends and cost experience and minimizes disruptive cuts that will harm MA enrollees. It is critical that the Final Rate Announcement:

- **Incorporate the full year of 2025 expenditure data to calculate the growth rate**, to the greatest extent possible.
- **Address widespread questions about the credibility of utilization assumptions and overall trend** by releasing additional details about the sources and analyses.
- **Consider ways to mitigate the full impact of the skin substitute adjustment in a single year, such as phasing it in over several years, to protect beneficiaries from higher costs and reduced benefits in 2027.** We support CMS's efforts to reduce unnecessary, wasteful spending in the Medicare program. However, CMS is proposing to reduce FFS costs to this degree without first having data validating the accuracy of CMS estimates about the impact of the PFS change. A phase-in would allow for appropriate adjustments in future years once data becomes available. In addition, we understand that skin substitute impacts, along with those for the durable medical equipment and rural emergency hospital adjustments, are highly uneven at the county level. CMS should clarify if the skin substitute payment changes will be reflected in the costs used to derive AGAs, as this would add to the variability of the local impacts. Further complicating the issue, skin substitute expenditures are incorporated into the proposed 2027 MA risk model, lowering relative coefficients and payments for many prevalent clinical conditions for Medicare beneficiaries (see a detailed discussion of this issue in Section G of this letter). The interaction of these two issues could significantly compound the overall negative payment impact for MA plans depending on the health status of their populations and levels of skin substitute use by their enrollees and FFS beneficiaries in their service areas.

[16] See: https://ahiporg-production.s3.amazonaws.com/documents/CY2027-Advance-Notice-Summary-and-Analysis-Wakely-02.19.2026.pdf
[17] Id.

Attachment II. Changes in the Payment Methodology for Medicare Advantage and PACE for CY 2027

Section B. Calculation of Fee-for-Service Cost

CMS is proposing to make two adjustments to the FFS experience data used in the development of FFS USPCCs for the CY 2027 ratebook:

- Rural Emergency Hospital (REH) Payments: The Consolidated Appropriations Act of 2021 established REHs to deliver emergency hospital, observation, and other services to Medicare patients on an outpatient basis. Starting January 2023, REHs were eligible to receive enhanced Medicare payments in the form of increased outpatient prospective payment system (OPPS) rates and additional facility payments. CMS is proposing to incorporate these payments into the 2023 and 2024 FFS experience data used to establish USPCCs and MA benchmarks.
- Proposed Exclusion of Significant, Anomalous, and Highly Suspect Billing Activity: In 2023, CMS identified a concerning rise in claims for certain urinary catheter supplies. An investigation found that these claims were fraudulent, and in 2024, CMS finalized a policy to remove these expenditures from the Medicare Shared Savings Program (MSSP) benchmark calculation.[18] CMS is proposing to make corresponding adjustment to the 2023 FFS experience data to exclude these payments.

Discussion and Recommendations: While AHIP supports making necessary technical adjustments to the FFS data used to calculate FFS costs and MA benchmarks, we are concerned about the impacts of making multiple overlapping adjustments all at once. With regard to the anomalous billing adjustments, we are concerned about the variable impact across counties. According to the anomalous claim expenditure data CMS released with the Advance Notice, some counties will be significantly more impacted than others, due to where the anomalous billing occurred and the magnitude of the proposed adjustments. **We recommend CMS carefully evaluate the impact of these adjustments on MA benchmarks, identify any unintended consequences that could harm access or affordability to MA in those areas, and take steps to mitigate that impact by phasing in the adjustments over time.**

B3. AGA Methodology

CMS proposes to continue to determine rates in Puerto Rico based only on FFS enrollees with both Part A and Part B coverage, but to not use this calculation method nationwide. As discussed below, CMS also has the option to adopt the Puerto Rico-specific calculation method nationwide.

Discussion and Recommendations: AHIP strongly supports the continuation of the policies CMS has adopted for Puerto Rico in prior Rate Notices, including the adjustment to the calculation of benchmarks for Puerto Rico to reflect only claims data for beneficiaries

[18] "Medicare Program: Mitigating the Impact of Significant, Anomalous, and Highly Suspect Billing Activity on Medicare Shared Savings Program Financial Calculations in Calendar Year 2023," (89 FR 79152).

enrolled in both Parts A and B. As explained below, the MA program is critically important in Puerto Rico and inadequate benchmarks could jeopardize that coverage.

In addition, we urge nationwide adoption of the policy in Puerto Rico that excludes Part A-only beneficiaries in calculating MA benchmarks. Sixteen percent of FFS beneficiaries had only Part A coverage with no Part B in 2023 and the percentage is growing. In some geographies, the percentage of FFS beneficiaries with Part A-only coverage is significantly higher; almost 30 counties in the US had 25% or more Part A-only beneficiaries in 2024.[19]

AHIP has longstanding concerns that the current methodology outside of Puerto Rico includes spending data for FFS beneficiaries who only have Part A coverage, even though they are ineligible to enroll in MA. This methodology has material negative impacts on MA benchmarks and is inappropriately limiting the funding available for MA beneficiaries.

First, the plain language of the statute excludes Part A-only beneficiary costs from benchmarks. Under section 1876(a)(4) of the Social Security Act, Part A-only beneficiaries are excluded from the calculation of adjusted average per capita cost (used in calculating the base payment amount for MA benchmarks). In addition, section 1853 of the Social Security Act generally requires that capitated payments, as modified through the risk adjustment program, be designed to ensure actuarial equivalence between MA and FFS. Using claims experience from FFS beneficiaries who are not eligible to enroll in MA does not appropriately estimate what would have been paid for the same beneficiary had they remained in FFS. In releasing data for public use, even CMS has noted that per capita spending for beneficiaries enrolled in only Part A "cannot be compared directly to spending for beneficiaries that are enrolled in both Part A and Part B."[20]

Second, data clearly demonstrate that it is inappropriate for Part A-only beneficiaries to be included in setting MA benchmarks. A recent Wakely analysis[21] shows the large difference in Part A spending for those enrolled in Part A only versus those enrolled in Parts A and B, and the implications for the data used in calculating benchmarks.

- The 2023 per member per month (PMPM) Part A cost for FFS enrollees with Part A and Part B coverage was $432.65, while the PMPM Part A cost for FFS enrollees solely with Part A was only $73.01.
- Wakely finds that overall non-ESRD FFS costs would be 6.1% higher if CMS used only beneficiaries enrolled in both Parts A and B rather than the total non-ESRD FFS population.

Third, even if CMS continues to disagree that it is required to exclude Part A-only enrollee data, it clearly has the authority to make this adjustment and should do so to ensure appropriate benchmarks in the MA program. CMS has excluded Part-A only enrollees in calculating benchmark rates for Puerto Rico since 2012. In the 2020 Final Rate Announcement,

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[19] AHIP internal analysis of CMS FFS Data (2015-2024), available at: https://www.cms.gov/medicare/payment/medicare-advantage-rates-statistics/ffs-data-2015-2024.
[20] "Medicare Data for the Geographic Variation Public Use File: A Methodological Overview." CMS, February 2023, accessed at: https://data.cms.gov/sites/default/files/2023-02/d30ee401-edd4-4d41-a631-69d95356dc2d/Geographic%20Variation%20Public%20Use%20File%20Methods%20Paper.pdf.
[21] See: https://www.ahip.org/resources/the-value-of-medicare-advantage-versus-fee-for-service.

CMS implicitly acknowledged the ability to make this change when it indicated it was considering revising MA rates based on data from beneficiaries with both Parts A and B. Most recently, in the CY 2026 Final Rate Announcement, CMS said it would "continue to analyze this issue and consider whether any adjustments" to bring the rest of the country in line with Puerto Rico "may be warranted in future years."[22]

CMS has noted that Puerto Rico needs the adjustment to "produce a more accurate projection of FFS costs per capita." This is clearly correct. However, more accurate projections of FFS costs are equally important and necessary throughout the country. As noted above, including Part A-only enrollees produces a less accurate projection of FFS costs for those eligible to enroll in MA. There is no justification for CMS failing to extend nationwide its policy in Puerto Rico of excluding Part A-only FFS enrollee costs.

B4. Adjustments for Medicare Shared Savings Program and Innovation Center Models and Demonstrations, and Advanced Alternative Payment Models

Consistent with prior years, CMS proposes several changes to the calculation of the Average Geographic Adjustments (AGAs) used to determine the county benchmarks. CMS indicates that these changes are primarily associated with adjusting the FFS claims data for shared savings and losses of alternative payment models, including accountable care organizations, bundled payment demonstrations, and other Center for Medicare and Medicaid Innovation (Innovation Center) payment models. CMS proposes limiting the adjustment for Innovation Center models to the models listed in Table II-4 of the Advance Notice. CMS further proposes to continue excluding from FFS costs certain payments made through Innovation Center models when those payments are not funded from the Medicare Part A or B Trust Funds. CMS will adjust AGAs to account for incentive payments made to physicians and other eligible clinicians who are eligible for such payments through participation in advanced alternative payment models (A-APMs).

Discussion and Recommendations: AHIP supports CMS's general policy to account for the increasing share of FFS payments made through models and other payment methods outside standard payment systems by adjusting AGAs to reflect such spending. **We are concerned, however, that CMS continues to exclude from FFS cost calculations Innovation Center payments that do not come directly from the Medicare trust funds.** We are not aware of any statutory basis for excluding these costs from the calculation of MA benchmarks. Similar to CMS's policy (discussed above) of including certain enrollees ineligible for MA in calculating benchmarks, the exclusion of these funds means CMS is not determining the cost of providing a benefit to MA enrollees that is comparable to what it would be if the benefit were provided to such enrollees under the FFS program. This should be the key test in setting MA benchmarks, not the source of FFS funding. **As the Innovation Center expands the scope and range of alternative payment models that diverge from traditional FFS payment methods, a growing share of FFS spending may be excluded from MA benchmarks.**

In particular, we are concerned that CMS excludes advance payment of shared savings paid to providers under Innovation Center models. To the extent these advance payments are reconciled

[22] Announcement of Calendar Year (CY) 2026 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies.

against actual provider experience after the end of the model performance period and additional payments from the Part A or B Trust Funds are made, they are part of the overall payments made to providers through the Innovation Center and should be reflected in MA benchmarks. Further, excluding these payments makes assessments of FFS spending and subsequent comparisons of MA and FFS costs less accurate.

We recommend that CMS reconsider its policy of excluding models in its adjustment of the AGAs to the extent the models involve payments such as bonuses and care management fees funded through the Innovation Center. In particular, CMS should include advance shared savings payments made as part of Innovation Center models in calculating historical FFS experience, similar to the adjustments CMS makes to reflect A-APM incentive payments. We also ask that CMS publish in the Rate Notice the annual amounts paid to FFS providers through the Innovation Center but not included in benchmark calculations. CMS should specify these amounts each year to allow stakeholders to understand the impact that Innovation Center model funding mechanisms have on FFS cost estimates and MA benchmarks.

B5. Additional Adjustment to FFS per Capita Costs in Puerto Rico

CMS is considering whether to apply an adjustment to the FFS experience for beneficiaries in Puerto Rico to reflect the nationwide propensity of beneficiaries with zero claims, as it has done in the CYs 2017-2026 Rate Announcements.

Discussion and Recommendations: The MA program is critically important in Puerto Rico. We understand that as of February 2026, 85% of all Medicare beneficiaries in Puerto Rico are enrolled in MA plans. A substantial number of these beneficiaries have low incomes and enroll in MA to receive more care coordination and affordable Part D coverage, which otherwise may not be accessible due to the statutory prohibition on providing Part D low-income subsidies (LIS) to beneficiaries in the territories.

AHIP strongly supports the continuation of the policies CMS has adopted in prior Rate Notices, including: an adjustment to account for the large number of Puerto Rico beneficiaries with no Part A or B claims. This adjustment remains necessary to help plans in Puerto Rico maintain benefits for the low-income populations they serve.

At the same time, we remain seriously concerned about the large gap in MA benchmarks between Puerto Rico and the mainland. The MA program is a critical and cost-effective means for providing comprehensive coverage to low-income populations in Puerto Rico. Inadequate benchmarks can jeopardize that coverage, as well as limit resources for provider payments that could be used to help address critical workforce shortages on the Island. While MA plans in Puerto Rico need to allocate more rebate dollars to address the lack of LIS coverage and other program differences, they face similar costs for prescription drugs as the national market and work within the same labor market. We also understand that the implementation of the v28 risk model had a higher-than-average impact in Puerto Rico given the prevalence of chronic conditions among beneficiaries living on the Island. We urge CMS to consider recommendations from multiple stakeholders in Puerto Rico to address these concerns, such as a county benchmark floor that would prevent the type of significant gaps we have seen in Puerto Rico compared to

other geographies. Further, if CMS changes its policy and excludes Part A-only beneficiaries from benchmark calculations nationwide as discussed in Section B3 above, CMS should ensure that AGAs are applied in a way that prevents a reduction in benchmarks levels in Puerto Rico. **We also urge CMS to consider creating a technical working group involving CMS staff, MA plans in Puerto Rico, and other key stakeholders that can develop longer term solutions that will ensure accessible, high quality and affordable care for seniors in Puerto Rico.**

B7. Proposed consolidation of files published with the CY 2027 Medicare Advantage Ratebooks

CMS proposes to consolidate a number of supporting data files the agency releases as part of the annual ratebook development process. These files help actuaries and other interested stakeholders understand components of FFS costs and identify trends for purposes of developing bids for the coming year.

Discussion and Recommendations: AHIP supports CMS efforts to streamline the number of data files released and make the files easier to use as part of the bid development process. We believe the data file consolidations proposed in the Advance Notice are reasonable. At the same time, we emphasize that any decisions about future changes to data files must recognize the need for CMS to be transparent about how FFS costs are calculated. **We urge CMS to default to more data sharing whenever feasible, and to seek input from plan actuaries when evaluating potential changes.**

Section C. Additional Adjustments

C2. Organ Acquisition Costs for Kidney Transplants

As required by the 21st Century Cures Act, CMS describes a methodology for excluding costs related to kidney acquisitions from MA benchmarks. In 2021, CMS began removing kidney acquisition costs from MA benchmarks, and in 2023 CMS adopted a new approach for the development of the exclusion amounts to incorporate variations in the way provider payments are calculated by Medicare Administrative Contractors (MACs). In the CY 2026 Final Rate Announcement, CMS finalized a change to the way that kidney acquisition costs are determined for hospitals participating in the Maryland Total Cost of Care Model, similar to modifications made previously regarding how GME costs are carved out for Maryland hospitals. This change reduced benchmarks in most Maryland counties.[23]

Discussion and Recommendations: AHIP remains concerned about the impact of these changes on benchmarks in most Maryland counties. The share of Medicare beneficiaries in Maryland enrolled in MA (24% as of February 2026) is already well below the national average due, in part, to the Total Cost of Care Model that prevents MA plans from negotiating with inpatient

[23] The proposed change would impact benchmarks in counties outside of Maryland as well, because the payments are attributed to the county of residence for individuals receiving services. However, the impact to non-Maryland counties appears minimal.

facilities to reduce costs and improve care. **We urge CMS to re-evaluate this policy and consider ways to improve access to the quality care and benefits offered by MA.**

Section F. MA Employer Group Waiver Plans (EGWP)

CMS proposes to maintain the current payment methodology for EGWPs in 2027. Under that approach, CMS waives the bidding requirements that apply to non-EGWP plans and instead determines EGWP rates based on average bid-to-benchmark ratios using 2026 bids. In response to requests from stakeholders, CMS provides preliminary bid-to-benchmark ratios for EGWPs in the Advance Notice, noting that the ratios are not final and could differ from final ratios used to determine EGWP rates for 2027.

Recommendation: AHIP appreciates CMS publishing preliminary bid-to-benchmark ratios for 2027, which facilitates MA plan engagement with employers as they develop EGWP offerings and bids. **We reiterate our prior recommendation that CMS exclude negative margin plans from the calculation of estimated bid-to-benchmark ratios for EGWPs.**

Section G. CMS-HCC Risk Adjustment Model

From 2024 to 2026, CMS phased in a new Part C risk adjustment model, version 28 (v28) of the clinical classification of hierarchical condition categories (HCCs). The v28 model included significant changes to the diagnoses and HCCs in the model and resulted in major cuts in MA risk adjustment payments. For 2026 alone, the last year of the 3-year phase-in, the fact sheet for the CY 2026 Rate Announcement estimated a 3 percent reduction in MA risk adjustment payments.

For CY 2027, CMS is proposing to make the following changes and technical updates to v28:

- Remove the specified coefficient constraints applied to HCC 328 Chronic Kidney Disease, Moderate (Stage 3B) and HCC 329 Chronic Kidney Disease, Moderate (Stage 3, except 3B).
- Recalibrate the model using more recent FFS data years (from 2018 diagnoses predicting 2019 expenditures to 2023 diagnoses predicting 2024 expenditures.)
- Update the denominator year used in determining the average per capita predicted expenditures to create relative factors in the model, changing from payment year 2020 to payment year 2024.
- Exclude diagnoses from audio-only services to align with the MA diagnosis submission policy.

If finalized, CMS estimates the CY 2027 impact on MA risk scores, relative to CY 2026, will be -3.32 percent.

Discussion and Recommendations: AHIP supports CMS's plans to update the risk model with more current data and make other appropriate technical adjustments. However, we have several significant concerns.

We appreciate that CMS has demonstrated how inaccurate many recent public assertions of MA coding intensity have been through its recently-published analysis of coding differences between MA and FFS.[24] CMS used the methodology for assessing coding intensity that has been used in "other widely cited analyses", most notably by MedPAC, but applied it to the v28 model. CMS found that after accounting for the 5.9 percent coding intensity adjustment, MA coding was only 1.5 to 2 percent higher. We welcome CMS's analysis. However, we are concerned that the combined effect of the model changes and the proposal regarding diagnoses from unlinked chart reviews discussed in Section L below would cut MA risk adjustment payments by nearly 5 percent on average - much more than the assessed coding differences.

We are also very concerned about the policy implications of proposed changes to the risk adjustment model that would re-weight the model's demographic and disease coefficients.

Scope of Changes

Our analysis indicates that in most model segments, coefficients are declining for the most prevalent populations and disease groups. For example:

- Wakely found that payments for Non-Dual Aged beneficiaries – the largest segment – will decrease 5.72%.[25]
- Payments in disabled beneficiary segments will decrease more than for corresponding non-disabled segments.
- The new model makes cuts in payments for many chronic conditions that can benefit from care coordination and disease management. Lung Disease and Kidney Disease will see major payment cuts under the new model of 15.5% and 24.9%, respectively, averaged across model segments.[26] These cuts can have significant impacts on special needs plans (SNPs) that enroll populations with higher rates of chronic disease prevalence than the general Medicare population.[27]

Drivers of Changes and Policy Implications

CMS does not discuss the drivers of these significant impacts or the policy implications. We are concerned that CMS is proposing significant changes without a detailed discussion of these important issues.

It appears that a key factor is the significant growth in FFS spending on skin substitutes. According to CMS, Medicare Part B spending on skin substitutes rose from $252 million in 2019 to over $10 billion in 2024, a nearly 40-fold increase. Unlike CMS's decision to remove those costs from benchmark calculations, CMS has included those costs when calibrating the proposed risk model. As noted in the Wakely report, HCCs related to skin ulcers, which have commonly

[24] See: https://academic.oup.com/healthaffairsscholar/article/4/1/qxag010/8430651.
[25] This is based on Wakely's aggregated client experience, which could differ from national averages.
[26] Based on analysis provided to AHIP by MAST Health Policy Solutions.
[27] See: https://www.commonwealthfund.org/publications/issue-briefs/2021/oct/medicare-advantage-vs-traditional-medicare-beneficiaries-differ; https://www.kff.org/medicare/a-closer-look-at-the-growing-role-of-special-needs-plans-in-medicare-advantage/.

been treated with skin substitutes, will see increases ranging on average from 17% to more than 95%.[28]

AHIP supports using updated data whenever possible, but CMS is choosing to use utilization and cost data that the agency acknowledges reflects wasteful spending that will not reflect actual costs in the payment year. Moving forward with the model using these inflated high skin substitute spending levels would introduce significant biases in the model. The coefficients of most other chronic illnesses would be artificially low while payments for skin substitute procedures (which MA plans already control better than FFS) will be artificially high. This will lead to significant underpayments for many chronic diseases in 2027. This raises questions about the model's predictive power and accuracy for MA costs in 2027 and whether it meets the basic statutory actuarial equivalence requirement in section 1853 of the Social Security Act. Moreover, it is misaligned with CMS's goals to provide appropriate incentives for MA plans to improve their management of chronic illnesses that are prevalent in the Medicare population. Given the infrequency with which CMS has historically updated the risk model, these misallocations could continue to distort risk adjusted payments for years to come.

We urge CMS not to finalize the proposed updated model for 2027. Instead, **we recommend that CMS:**

- **Recalibrate the model to remove wasteful spending** from its calculations so that it aligns with changes being made in CMS policies and benchmark calculations and improves the predictive strength of the model.
- **Be transparent with MA plans and share detailed analyses and plan-specific impacts of risk model changes before re-proposing the model in a subsequent Advance Notice** (e.g., for CY 2028), to better ensure issues and unintended consequences can be identified and mitigated *before* the updated model is finalized. We have previously offered specific recommendations on steps CMS should take when designing and implementing major risk adjustment reforms, and we refer to our recent comment letter on the CY 2027 MA and Part D Policy & Technical Changes proposed rule, where we outline our recommendations in detail. This should include at least a 60-day comment period for risk adjustment changes.
- When CMS does implement the changes, **we recommend that the changes be phased-in over several years** to limit negative impacts on MA beneficiaries.

Section J. Medicare Advantage Coding Pattern Difference Adjustment

For CY 2027, CMS is proposing to apply the statutory minimum MA coding adjustment factor of 5.90%. The coding adjustment factor is applied to the risk scores for all MA enrollees to reflect differences in the likelihood that any individual diagnosis is reported in MA relative to original Medicare.

Recommendation: AHIP supports the agency's decision to maintain, and not exceed, the statutory minimum adjustment.

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[28] See: https://ahiporg-production.s3.amazonaws.com/documents/CY2027-Advance-Notice-Summary-and-Analysis-Wakely-02.19.2026.pdf.

Section L. Sources of Diagnoses for Risk Score Calculations

CMS proposes to continue the policy first adopted in the CY 2022 Rate Announcement to calculate risk scores for payment using only risk adjustment-eligible diagnoses from encounter data and FFS claims. In addition, CMS proposes to exclude diagnoses from audio-only services and diagnoses from unlinked chart review records (CRRs) from the calculation of Part C risk scores. CMS estimates that the exclusion of unlinked CRRs will lower average Part C risk scores by 1.53 percent in 2027, as compared with 2026.

Discussion and Recommendations: A risk adjustment system that ensures an MA plan's payments reflect the health risks of its population is critical to the MA program. We share CMS's goal of improving MA risk adjustment, including addressing questions that have been raised about the appropriateness of diagnoses submitted under particular coding practices and circumstances, while ensuring MA plans can continue to use the tools they need to ensure they have complete information about the health of their enrollees.

We support CMS's proposal to exclude unlinked CRR diagnoses from risk score calculation. However, plans need time to implement operational changes in response to the proposal. In addition, there are circumstances under which operational challenges outside a plan's control could severely limit the ability for plans to ensure CRRs are linked to encounter data records. Given the diagnoses in CRRs must still comply with CMS risk adjustment requirements, CMS should not impose limits that would risk the ability of plans to submit legitimate diagnoses which recognize the costs of providing care for enrollees, helping to keep coverage affordable and available to the Medicare population.

Accordingly, we recommend the following modifications to the proposal. We believe the proposal, as modified, would achieve CMS's goals for ensuring appropriate risk adjustment payments while limiting potential adverse beneficiary impacts.

- **Establish a CY 2028 implementation date.** MA plans have worked with their providers to improve the completeness and accuracy of MA encounter data over time. However, the proposal would attach significant new policy and business considerations in connection with encounter data and chart reviews. Clinical encounters affecting 2027 payments are taking place now, in 2026. MA plans that have a process in place that includes the use of CRR diagnoses from unlinked chart reviews will need lead time to implement process changes in response to the new policy and assess the costs and likely impacts for bidding purposes. For example, plans might consider negotiating contract changes with providers, and the providers and plans may need to upgrade certain systems and processes. The implications of this change could also extend to care management practices and activities that rely on chart reviews. In order to allow MA organizations time to make these assessments and operational changes, we urge CMS to have the proposal take effect in 2028.
- **Permit an exception for new enrollees to the plan**. It is our understanding that CRRs are typically linked to encounter data records. However, there are circumstances where this can be challenging. When a beneficiary first enrolls into an MA plan, the plan may not have access to the enrollee's medical encounter claims from the prior year, even if they were

submitted by the enrollee's previous plan and would otherwise be a valid encounter with which a CRR could be linked. We believe an exception to allow unlinked CRR diagnosis submissions for new-to-plan enrollees is appropriate to ensure accurate capture and reporting of their clinical diagnoses and health care needs.

Attachment III. Benefit Parameters for the Defined Standard Benefit and Changes in the Payment Methodology for Medicare Part D for CY 2027

Section D. Part D Risk Sharing

CMS proposes to retain existing Part D risk corridors for CY 2027. CMS indicates that it is not appropriate to widen the risk corridors, based on its analysis of Part D risk sharing amounts from CYs 2008 to 2023 that showed that risk sharing amounts continue to vary significantly in aggregate from year to year and among Part D sponsors in any given year.

Departing from its approach utilized in the CY 2026 Advance Notice, CMS does not outline a timeframe for release of the CY 2027 premium stabilization and/or risk corridor parameters for standalone plans participating in the voluntary Part D Premium Stabilization Demonstration. In a footnote on page 79 of the CY 2027 Advance Notice, CMS states that after announcing the voluntary demonstration for CY 2025 "[t]he demonstration design allowed for CMS to continue the demonstration for subsequent years, with parameters in each subsequent year to be determined based on market conditions."

Discussion and Recommendations: **We strongly support not widening Part D risk corridors,** particularly given the bidding and market uncertainties associated with ongoing implementation of the statutory benefit redesign provisions and the new BALANCE (Better Approaches to Lifestyle and Nutrition for Comprehensive Health) Model and GUARD (Guarding U.S. Medicare Against Rising Drug Costs) Model scheduled for implementation in 2027. **CMS should instead consider using its demonstration authority to narrow the risk corridors for both MA-PDs and PDPs,** e.g. as part of the BALANCE Model design, to address the significant degree of uncertainty that can drive higher Part D bids and taxpayer costs. To further address these uncertainties and help to stabilize bidding and premiums, we also urge that CMS clarify the future of the Part D Premium Stabilization Demonstration for CY 2027 before the bid submission deadline.

AHIP appreciates and supports the Administration's goals of lowering prescription drug costs for seniors and taxpayers. We welcome the opportunity to work with CMS on solutions that will improve affordability, ensure access to drugs, retain choice and competition, and secure the long-term stability of the Part D program.

Section F. RxHCC Risk Adjustment Model

CMS made multiple changes to the RxHCC risk adjustment model in 2025 and 2026 to account for statutory changes in the Part D benefit. CMS is proposing further updates for 2027, including, for example, incorporating adjustments for manufacturer discounts and maximum fair prices (MFP); updating the data years used to calibrate the model using 2023 diagnoses and 2024

expenditure data; updating the denominator year to 2024; and excluding diagnoses from audio-only services and diagnoses submitted on unlinked chart review records. In addition, CMS proposes to use separate continuing enrollee model segments for beneficiaries in MA-PD plans and PDPs.

Discussion and Recommendations: We appreciate CMS's continued work to update the RxHCC model to reflect ongoing changes to the Part D benefit and account for the different risk profiles of segments of Part D enrollees. However, **we have a number of concerns regarding the proposed RxHCC model and its accuracy in predicting costs for CY 2027**:

- It does not adequately reflect changes in utilization and behavior under the current benefit design, including for specialty drugs.
- It does not account for the MFPs of selected drugs announced in November 2025 for initial price applicability year 2027.
- The proposal to exclude diagnoses from unlinked chart reviews fails to provide adequate implementation time for Part D plans or provide appropriate exceptions for operational challenges, such as when a plan does not have claims/encounter data for new members switching from another Part D plan. (We discuss this issue in more detail in our comments relating to the source of diagnoses for the MA risk model, in Attachment II, Section L above.)

We recommend that CMS delay implementation of the unlinked chart review provision until 2028, and allow "new to plan" exceptions, consistent with our recommendations for the MA risk adjustment model. We also urge CMS to incorporate data that better reflects expected costs under the current model design in future versions of the model. Without such changes, the RxHCC model will add uncertainty into bidding that can translate into more year-over-year disruption and higher government and premium costs. It is vital that CMS prioritize recalibration of the model to best reflect projected Part D costs.

We also reiterate our recommendation that CMS engage in a more collaborative, transparent way with plan sponsors when considering future significant updates to the risk adjustment model, such as the proposal for segmentation of the risk model for MA-PDs and PDPs. As Wakely notes, the average risk scores for MA-PDs would decline 2.6% from 2026 to 2027, but the coefficients under the proposed model for various segments would change much more dramatically. For example, the model cuts payments for continuing aged non-low income enrollees by 3.37% while increasing the payments for new non-low income enrollees by 20.30%.[29] Other segments also see significant changes. Using technical expert panels, providing longer timeframes for stakeholder analysis and comments, and sharing estimated plan-specific impacts, would better enable CMS to receive constructive and meaningful feedback on the changes, and allow for the type of analyses needed to ensure stable, appropriate program payments and access to care for enrollees.

[29] See: https://ahiporg-production.s3.amazonaws.com/documents/CY2027-Advance-Notice-Summary-and-Analysis-Wakely-02.19.2026.pdf.

In addition, we are concerned that the overall reduction in MA-PD risk scores could make Part D coverage more expensive for MA plans at the same time the other provisions of the Advance Notice could have significant adverse and disruptive impacts on MA benefits if finalized. **We urge CMS to consider this dynamic as it assesses potential changes to include in the Final Rate Announcement.**

Section G. Normalization Factors for the RxHCC Models

Following the approach used in 2025 and 2026, CMS proposes to calculate separate normalization factors for MA-PD plans and PDP plans in 2027. In addition, CMS proposes to continue calculating Part D normalization factors using a multiple linear regression methodology that includes a flag to indicate whether a risk score originates from before or after the onset of the COVID-19 period. Risk scores reflecting dates of service before 2020 would be flagged as being "pre-COVID-19", while risk scores reflecting dates of service in 2020 and after would be flagged as being in the "post-COVID-19" period.

Discussion and Recommendations: We are concerned that CMS is proposing to use the same methodology implemented in 2026 that calculates normalization based on the projected risk score for 2027 rather than the trend between the model's denominator year and payment year. This methodology is inconsistent with traditional approaches to determining normalization as described on page 93 of the Advance Notice, which states that "[t]he normalization factor is a projection of the underlying risk score trend to the payment year and is applied by dividing each individual risk score in the payment year by the relevant normalization factor." As Wakely notes in its analysis, the proposed approach increases the normalization factor for MA-PDs from 1.098 to 1.109 and reduces the normalization factor for PDPs from 1.018 to 1.005.[30] Given the proposal to use separate continuing enrollee model segments for beneficiaries in MA-PD plans and PDPs in the proposed RxHCC model, **we recommend that CMS return to using the traditional approach of calculating normalization based on the expected trend between the model's denominator year and the model's payment year.**

Attachment IV. Updates for Part C and D Star Ratings

Section B. Reminders for 2027 Star Ratings and Beyond

In the Advance Notice, CMS provides relevant reminders and the complete set of measures and updates for 2027 Star Ratings. We have the following comments and recommendations:

- **Deadline for complaints data review request**. CMS includes deadlines for plans to request CMS review of their data (complaints, appeals and Part D patient safety measures) for 2027 and 2028 Star Ratings.

  Discussion and Recommendations: We appreciate CMS's announcement through the Advance Notice of the deadlines for plans to request CMS review of their data for 2027 and

[30] See: https://ahiporg-production.s3.amazonaws.com/documents/CY2027-Advance-Notice-Summary-and-Analysis-Wakely-02.19.2026.pdf.

2028 Star Ratings. However, the March 31st deadline for complaints data requests is being set much earlier than in prior years (e.g., deadlines for the 2025 Star Ratings were June 28, 2024 and May 30, 2025 for 2026 Star Ratings). We understand that the previous deadlines provided plans with adequate lead time to assess whether they need to submit a data review request or not and that the March deadline will be operationally burdensome to meet. **We recommend that CMS extend the deadline (e.g., at least 30 days or more) for plans to request review of their complaints data for 2027 and 2028 Star Ratings**.

- **Medication Therapy Management (MTM) Program Completion Rate for CMR measure.** CMS indicates that it plans to return this measure (that is on the display page for 2027 and 2028 Star Ratings) as a new measure for 2029 Star Ratings (measurement year 2027).

  Discussion and Recommendations: We have several concerns about this approach. MTM eligibility criteria were expanded effective January 1, 2025. This expansion could create significant challenges for supporting quantifiable health outcomes such as improved adherence, reduced adverse events, or improved control of chronic conditions. We recognize the important role that MTM plays in medication safety, adherence, and care coordination. We also recognize that Part D's MTM requirements are intended to achieve the important goals of reducing the risk of adverse events (such as drug-to-drug interactions) and enhancing medication optimalization and adherence programs. However, we believe it is critical to study the impact of these changes before reinstating this measure in Star Ratings. The ability of Part D's MTM program to provide improved outcomes is, at best, yet to be proven, and at worst, could actually impede a plan's ability to deliver more personalized and effective care coordination services to vulnerable beneficiaries. CMS should engage in a more holistic assessment of the MTM measure and collaborate with the Pharmacy Quality Alliance (PQA) and other stakeholders to accelerate the development, testing, and evaluation of a patient-centered, outcome-based MTM measure. **We therefore continue to recommend that CMS retain the MTM Program Completion Rate for CMR measure on the display page for the 2029 Star Ratings and until CMS can adequately assess this measure as well as a possible alternative**.

Section C. Measure Updates for 2027 Star Ratings

In the Advance Notice, CMS includes a table that displays all of the measures that will be used to calculate the 2027 Star Ratings. The table also reflects which measures will be used for calculating the improvement measures and categorical adjustment index (CAI). For the 2027 Star Ratings, CMS has also added a column to the table that reflects which measures would be included in the calculations for the Health Equity Index (HEI). However, CMS indicates that the agency has proposed to remove the HEI and to continue implementation of the historical reward factor for 2027 Star Ratings via the MA and Part D proposed rule for 2027.[31] If this proposal is finalized, the 2027 Star Ratings will not include the HEI reward.

Discussion and Recommendations: **As indicated in AHIP's comments in response to the MA and Part D proposed rule for 2027, we support CMS's decision to not move forward**

[31] 90 FR 54894, November 28, 2025.

with effectively substituting the HEI for the reward factor starting with 2027 Star Ratings. Since the measurement period for the HEI has already passed, we also continue to urge CMS to hold plans harmless for 2027 given that they invested significant resources and developed quality strategies based on current rules.

Section G. Changes to Existing Star Ratings Measures for the 2027 Measurement Year and Beyond

In the Advance Notice, CMS solicits feedback on changes to existing Star Ratings measures including the following:

- **Plan All-Cause Readmissions measure**. CMS indicates that the National Committee for Quality Assurance (NCQA) is considering making changes to the Plan All-Cause Readmissions measure, which is used in the Star Ratings program. One of the changes being considered is the inclusion of denied claims to the measure specifications. The rationale for this change is to ensure the continued validity of the measure. By including denied claims, both the denominator (index hospital stay) and the numerator (readmission) events would be captured more comprehensively. This change is considered substantive and would be proposed through future rulemaking. Additionally, the updated measure would be moved to the display page for at least two years before being reinstated in the Star Ratings.

  Discussion and Recommendations: While we appreciate NCQA's goal to maintain the validity of this measure by including denied claims, it is important that both NCQA and CMS thoroughly test this change to understand its impact on plan performance before updating the measure specifications. Denials can occur for various reasons, including administrative and clinical ones, and can also be modified and resubmitted for approval or appealed during the measurement period. Including such claims risks double-counting events if a denied claim is later approved or if a denied claim for an inpatient stay is resubmitted and paid as an outpatient service. Additionally, it is unclear how NCQA and CMS would exclude claims that were initially denied due to clerical errors.

  We recommend that NCQA and CMS conduct validity testing and a dry run of the Plan All-Cause Readmissions measure with the revised specifications before proposing the revision for the Healthcare Effectiveness Data and Information Set (HEDIS) and subsequently for Star Ratings. Furthermore, NCQA should publish the results of the validity testing to show how the measure performs with and without the inclusion of denied claims. This would enable stakeholders to assess the potential benefits and risks of including denied claims.

- **Transitions of Care measure**. CMS indicates that NCQA plans to develop a new electronic clinical data system (ECDS) reported version of the Transitions of Care (TRC) measure, with measure testing slated for 2026 and updates to be implemented for the 2028 measurement year. CMS intends to monitor NCQA’s testing activities to determine if any updates to the measure technical specifications are substantive and would therefore need to be proposed through rulemaking. Additionally, NCQA is considering shortening the timeframe for patient engagement after discharge and medication reconciliation indicators from 30 to 14 days.

Discussion and Recommendations: In our comments on the MA and Part D proposed rule for CY 2027, we expressed concerns about the rapid pace at which NCQA is transitioning measures to the ECDS reporting method. Plans continue to face challenges with this reporting method due to issues such as data availability and interoperability. Smaller practices or providers in rural areas, in particular, may struggle to share data electronically with plans, leading to increased burdens on both the plan and provider in calculating the measure.

We urge CMS to focus on ways to improve ECDS reporting. **One important step that CMS can take, in conjunction with the Assistant Secretary for Technology Policy/Office of the National Coordinator for Health Information Technology (ASTP/ONC), is to add applicable data exchange requirements to the ONC Health IT Certification Program.** This will ensure that developers of certified electronic health records (EHRs) align their products with current quality measures, allowing data to be more easily captured, extracted, and exchanged as part of a provider's workflow. It will aid in the transition to digital quality measures and reduce the measurement burden on both plans and providers.

In the meantime, given the complexity of the TRC measure, which involves multiple indicators and data sources, we recommend that NCQA and CMS work closely with plans to identify potential reporting challenges using ECDS. A comprehensive transition timeline is also essential to ensure that plans can successfully report the updated measure. Prematurely requiring ECDS-only reporting could increase the measurement burden on all parties and unfairly penalize plans for factors beyond their control. NCQA should not transition the TRC measure to ECDS-only until the challenges with reporting through this method have been addressed. **We also recommend that CMS collaborate with NCQA to conduct validity testing for the TRC and other Stars measures to ensure consistent results between measures reported through traditional methods and those reported via ECDS.**

Additionally, we are concerned about NCQA's proposal to shorten the follow-up timeframe from 30 to 14 days. **We strongly support maintaining the 30-day patient follow-up timeframe for the TRC measure**, as beneficiaries may need more time to schedule follow-up visits due to factors outside their control, such as cases where providers have limited availability for appointments.

- **Diabetes Care – Blood Sugar Controlled measure**. CMS indicates that NCQA is developing an ECDS-reported version of this measure for the 2027 measurement year. Before its implementation, NCQA is conducting feasibility testing for the ECDS measure. Based on the findings, NCQA plans to maintain the current hybrid measure in HEDIS alongside the ECDS measure during a two-year transition period, covering measurement years 2027 and 2028. The hybrid measure will then be replaced with the new ECDS-only measure in 2029.

  Discussion and Recommendations: As noted above, we are concerned that plans continue to face challenges in reporting ECDS measures. Therefore, **we recommend that CMS**

consider a longer transition period to ensure the feasibility and validity of the ECDS-only version for this measure and other measures in Star Ratings.

Section H. Efforts to Simplify and Refocus the Measure Set to Improve the Impact of the Star Ratings Program

CMS seeks feedback on new measures or measurement concepts that would disincentivize unnecessary, inappropriate, or low-value care. Additionally, CMS solicits input on the addition of new measures focused on the clinical appropriateness of care and measures related to medical errors or misdiagnoses.

Discussion and Recommendations: We agree with CMS on the importance of reducing waste and improving quality of care. MA plans have been leaders in working with contracted providers and utilizing evidence-based tools to reduce low-value or clinically inappropriate care.[32] While the structure of the MA payment system already provides incentives for plans to achieve these goals, we appreciate CMS's interest in exploring additional incentives to improve the value of care. However, when considering any new Stars measures, **we urge CMS to ensure they are consistent with the guiding principles for new measures that CMS has previously articulated**.[33] They include, among other things, that new measures be developed by consensus-based organizations; reflect the prevalence of conditions and the importance of health outcomes in the Medicare population; be a true reflection of plan quality and enrollee experience; rely on data that is accurate, complete, and reliable; and measure improvement under the plan's control.

CMS could leverage existing resources such as NCQA and PQA for these potential new measures. CMS should also consider whether these measures should be included in the Universal Foundation of measures across CMS quality programs.[34] We also recommend that CMS work with the developers and stewards of measures used in Star Ratings to utilize the consensus-based entity (CBE) measure endorsement process to ensure that new quality measures in the Star Ratings are meaningful, reliable, valid, and feasible.

Section K. Potential Methodological Enhancements for Future Years

CMS seeks feedback on potential methodological changes for Star Ratings to make the performance calculations "easier to understand and implement." One approach that CMS suggests is using percentile distribution to determine measure-specific performance cut points instead of using the clustering methodology that is currently used for non-Consumer Assessment of Health Providers and Systems (CAHPS) measures.

Discussion and Recommendations: We appreciate CMS's interest in simplification of Star Ratings methodologies. We agree that the complexity creates a host of challenges, including increased uncertainty and difficulty for plans to validate results.

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[32] See: https://www.ahip.org/resources/medicare-advantage-vs-traditional-fee-for-service-medicare-different-populations-different-outcomes.
[33] 83 FR 16440, April 16, 2018.
[34] See: https://www.cms.gov/medicare/quality/cms-national-quality-strategy/universal-foundation.

However, we have concerns with CMS's suggestion to use percentile distribution. It is critical that CMS ensure any replacement methodology would be evidence-based; lead to results that are credible and predictable; identify true differences in quality among plans; and avoid inappropriate year-to-year swings that cause disruption for beneficiaries. We encourage CMS to partner with MA plans, including through the use of a technical expert panel, to develop the details of a percentile distribution methodology and to analyze its impacts. That analysis should include simulations and a transparent methodology that are shared with each MA plan through confidential contract-level feedback reports. A detailed proposal combined with plan-level impacts will enable AHIP and our member plans to provide meaningful and constructive comments about this approach.

AHIP also urges CMS to consider returning to the use of pre-determined measure-level performance cut points. Pre-determined cut points would enable MA plans and their network providers to better manage their care and health improvement efforts. It would also be the most effective way for CMS to improve predictability, stability, and transparency under the Star Ratings program. In particular:

- It reduces the burdens on providers who contract with multiple plans and might otherwise face varying and conflicting quality performance metrics for the same quality measures.
- It helps plans and their network providers assess the effectiveness of their efforts to improve quality of care, health outcomes, and reduce costs while maintaining high performance and rating levels.
- It creates quality improvement aims and "stretch goals" to incentivize plans to increase efforts to support healthy aging, such as nutrition and well-being.
- It empowers consumer choice, as consumers increasingly rely on categorical ratings and scores to inform their decisions. This clarity is particularly beneficial during open enrollment periods when beneficiaries are evaluating their Medicare plan coverage options. For instance, a beneficiary with diabetes may prioritize choosing a plan with high Star Ratings on diabetes care measures.
- It has greater methodological transparency and helps plans and their network providers understand the goals for each Star Ratings measure more clearly.

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2027 Medicare Advantage Advance Notice

Summary and Analysis

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Table of Contents

EXECUTIVE SUMMARY

On January 26, 2026, the Centers for Medicare & Medicaid Services (CMS) released the CY2027 Advance Notice for Medicare Advantage (MA) and Part D, along with an accompanying Fact Sheet. The comment period for the Advance Notice ends February 25, 2026. AHIP has retained Wakely to provide a financial summary report of the information presented in the Notice. The key highlights of our analysis are:

- The CY2027 fee-for-service (FFS) growth rate is 5.10%.
    - While CMS has estimated the CY2025 per capita costs to be higher than what was projected in the CY2026 Rate Announcement, the CY2026 and CY2027 per capita costs are restating down. Notably, the average non-ESRD FFS trend from 2023-2025 is about 6.8%, but for 2026, CMS is only estimating a trend of 2.0%.
    - The CY 2027 FFS growth rate of 5.1% is 372 basis points lower than the final 2026 growth rate of 8.81%. Moreover, we calculate the MA-only growth rate for CY 2027 to be 3.2%, which is around 200 basis points lower than the CY 2027 FFS growth rate and more than 70% lower than our estimate of the CY 2026 MA-only growth rate of 11.9%.
    - The CY 2027 FFS growth rate reflects provisions from the CY 2026 Physician Fee Schedule, which includes a significant negative adjustment reflecting a change in how CMS pays for skin substitutes procedures. In addition, CMS has adjusted for Rural Emergency Hospital payments and anomalous durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) claims. However, even when those changes are taken into account, the rationale for the decline is not fully explained. In addition, those changes do not explain the significant reduction in projected MA-only costs.

- The proposed Part C risk adjustment model is expected to decrease plan risk adjusted benchmark payment by about -4.85% overall. This is a result of:
    - Updated model calibration using 2023 diagnosis codes and 2024 expenditures (compared with 2018/2019),
    - the removal of encounters submitted from chart reviews with no linked claim in the calculation of the risk score,
    - and the updated FFS normalization factor. CMS is proposing to continue to use the multiple linear regression methodology to calculate FFS normalization.
    - There is significant variation in impacts from the proposed risk adjustment model across model segments. The most prevalent population type, Non-Dual Aged beneficiaries, will see a decrease of 5.72%. Payments in disabled

beneficiary segments will decrease more than for corresponding non-disabled segments.

- We estimate the year-over-year change in normalized MA-PD Part D risk scores of -2.6%.
    - CMS is proposing a revised 2027 RxHCC risk adjustment model that reflects updates for the Inflation Reduction Act (IRA) as well as changes in Part D benefit parameters. In addition, CMS is proposing to use separate model segments for Medicare Advantage Prescription Drug (MAPD) plans and Prescription Drug Plan (PDP) plans.
    - CMS proposes to continue to use separate RxHCC FFS normalization factors for MA plans that include Part D coverage (MA-PD) and PDP markets as well as use the multiple linear regression.

- After accounting for all changes, we estimate that the nationwide average change in the blended risk adjusted benchmark will be -0.29% in CY 2027. In addition, the reduction in Part D risk adjustment payments will, on average, increase the required costs for MA plans offering Part D coverage.

- We also note that the skin substitute fee schedule, DMEPOS and REH adjustment is highly uneven at the county level. When AGA rebasing occurs in the Final Rate Announcement, the impacts are likely to vary significantly across states and counties.

GROWTH RATE AND EXPECTED AVERAGE MA PAYMENT CHANGE FOR 2027

Estimated MA Payment Change for 2027

The CY 2027 FFS growth rate, which is the primary driver of the Part C benchmark rates, is 5.10%. The total (FFS and MA) growth rate is 4.04%. The FFS growth rate is 372 basis points (bps) lower than the final 2026 growth rate.

Table 1 compares these growth rate estimates.

Table 1 – CMS Projected Growth Rate

Component	CY2027 (2027 Advance Notice)	CY2026 (2026 Final Announcement)	Difference
Non-ESRD FFS	5.10%	8.81%	-3.72%
Non-ESRD Total	4.04%	10.72%	-6.68%

The total (MA + FFS) United States per capita costs (USPCC) growth rate is less than the FFS growth rate. This will increase the number of counties that are impacted by the Pre-ACA benchmark cap.

CMS published estimated enrollment figures in the CY2026 Final Rate Announcement. We used these amounts along with the estimated non-ESRD Total and non-ESRD FFS USPCC amounts in the CY2027 Advance Notice to back into an MA-only USPCC amount. (I.e. This assumes the non-ESRD Total USPCC is a weighted average of the MA-only UPSCC and the non-ESRD FFS USPCC.) Using these figures, we calculated the MA-only growth rate to be 3.2%.

CMS published a comparison of its most current non-ESRD cost projections with those in the 2026 Final Announcement. Table 2 below shows the restatement in the CMS USPCC estimates for 2023 through 2028. We note the following:

- The 2025 non-ESRD FFS USPCC is restating up 1.94% from the CY2026 Final Rate Announcement.
- The non-ESRD FFS USPCCs are restating down from the CY2026 Final Rate Announcement for years 2026-2028. This has a direct impact on the 2027 growth rate.
- The MA only USPCCs are also restating down for all years.

The drivers of these restatements are discussed further below.

Table 2 - Restatement in Estimated non-ESRD USPCC Cost Projections (Current/Prior)

Year	Total (FFS + MA)	FFS	MA
2028	-1.7%	-0.3%	-2.5%
2027	-1.8%	-0.8%	-2.5%
2026	-1.3%	-0.3%	-1.9%
2025	-0.2%	1.9%	-1.8%
2024	-0.7%	-0.9%	-0.6%
2023	-0.2%	-0.3%	-0.2%

CMS published a document titled "trends-supporting-2027-an-growth-rates.pdf" which includes the service category level cost development of the USPCCs. The 1.94% increase to the 2025 non-ESRD FFS USPCCs (as compared to the CY2026 Final Rate Announcement) is due to an increase in both Part A and Part B Trends. Table 3 displays the published trends from the CY2026 Rate Announcement as compared with the trends in the Advance Notice.

The increase to 2025/2024 Part A trends is driven by higher-than-expected spending through Q2 2025 for inpatient and skilled nursing facility (SNF). The increase to the Part B trends is largely driven by physician admin Rx, although we note there are increases in several service categories.

Table 3 – 2025/2024 non-ESRD FFS Trends

	CY27 Advance Notice	CY26 Final Rate Announcement
Part A	6.27%	3.59%
Part B	9.06%	5.86%

The average non-ESRD FFS trend from 2023-2025 is about 6.8%. For 2026, CMS is estimating a significant decrease in trend, to 2.0%. Table 4 displays the Part A and Part B estimated trends as displayed in the CY2027 Advance Notice for years 2023 – 2028.

Table 4 – non-ESRD FFS Trends included in CY2027 Advance Notice

	Part A	Part B	Total
2023/2022	2.74%	8.25%	6.0%
2024/2023	3.62%	8.49%	6.5%
2025/2024	6.27%	9.06%	8.0%
2026/2025	2.96%	1.36%	2.0%
2027/2026	4.70%	5.90%	5.4%

- CMS notes that actual spending through June 2025 for inpatient and SNF exceeded amounts projected in the 2026 Rate Announcement. The respective PMPM trends (CY2025/CY2024) for inpatient and SNF are estimated to be 5.71% and 9.58%. However, the estimated PMPM trends for CY2026/CY2025 are estimated to be 2.02% and 7.18% which are much lower than recent experience.
    - The average inpatient utilization trend from 2023-2025 is 3.16%. The inpatient utilization trend for 2026 is expected to be 1.43% and for 2027 is expected to be 0.64%. This does not align with recent experience.
    - For CY2026, CMS fully phased in the technical update to remove IME and DGME costs attributable to MA enrollees from the non-ESRD FFS UPSCC amounts. The impact of moving from 52% phase in for CY2025 to 100% phase in for CY2026 is about -2.0% on the overall IP trend.
- The decrease in Part B trends from 9.06% in 2025 to 1.36% for 2026 is primarily driven by a decrease in trend for Physician Fee schedule, OP hospital, and DME. In addition, a significant portion of the decrease in Part B trend is driven by a change in CMS payment policy for "skin substitute" procedures. Beginning in 2026, CMS will pay for these procedures under the Physician Fee Schedule as "incident-to supplies." Previously, they were paid as biologicals, with payments up to $2,000 per square centimeter. CMS estimates spending for these

products will decrease by nearly 90%.[1] The Physician Admin Rx trend for 2026 is -28.19%. This negative trend is driven by the skin substitute reimbursement changes.
- The drop in DME utilization trend from 10.82% to 4.28% is driven by the anomalous DMEPOS claims removal.

The impact of the skin substitute reimbursement change on the overall trend is about -2.8%. That is, if we replaced Physician Admin Rx expenditures in the USPCC calc for 2027 as was displayed for 2026, the overall trend for CY2027 would increase to 4.8%. While the impact of skin substitutes is material on the overall trend and growth rate, even when we normalize for this the estimated trends for 2027 are still lower than we've seen in recent years.

For CY2027, CMS is proposing two adjustments to 2023 and 2024 FFS expenditures:

- Rural Emergency Hospitals (REH) receive payment rates that are 5% higher than the Hospital Outpatient Prospective Payment System (OPPS) rates for specified services. Starting in CY2023, REH facilities receive additional facility payments in 12 monthly installments which are not included in the National Claims History (NCH). CMS is proposing to adjust the 2023 and 2024 FFS experience to reflect these additional payments.
- CMS proposes excluding anomalous durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) claims with Healthcare Common Procedure Coding System (HCPCS) codes A4352 and A4353 from 2023–2024 experience.
- With the Advance Notice, CMS released the proposed adjustments for 2023 and 2024 at the county level. We note that the adjustments vary drastically by county. (E.g., the DMEPOS adjustment ranges from $0 to $200 per capita for CY2023.)

Other important items to note about the development of the USPCCs:

- The USPCC projections used data through Q22025 for Part A claims and Q32025 for Part B and Medicare Advantage.
- As in prior years, CMS makes considerations for:
    - COVID-19
    - Part B Provisions of the IRA

[1] https://www.cms.gov/newsroom/press-releases/cms-modernizes-payment-accuracy-significantly-cuts-spending-waste

    - 340B-Acquired Drug Payment Policy for Calendar Years 2018-2022.
- Technical adjustment to remove MA-related IME and DGME costs
    - In 2024, CMS began a three-year phase-in to remove the MA-related IME and DGME costs from the historical and projected non-ESRD USPCCs. In CY 2026, the technical adjustment was fully phased in. For CY2027, CMS will continue to remove these expenditures which is expected to have minimal impact on the change in non-ESRD USPCCs (US Per Capita Costs).

Wakely Analysis – Estimated Impact of Growth Rates

Wakely estimates that the nationwide average change in blended standardized (non-risk adjusted) MA Benchmarks from 2026 to 2027 will be 4.77% and the nationwide average change in the blended risk adjusted benchmark will be -0.29%.

Table 5 presents the components of these changes.

Table 5 – Estimated Change in MA Payment – 2026 to 2027*

Component	Wakely Estimated Annual Change	CMS Fact Sheet
Effective Growth Rate	4.89%	4.97%
Rebasing/Re-pricing (AGA)	0.00%	0.00%
Change in Star Ratings	-0.19%	-0.03%
Total Benchmark Change	**4.77%**	**4.94%**
MA Coding Pattern	0.00%	0.00%
Risk Model (FFS Normalization & Risk Model Change)	-4.83%	-4.85%
Total Risk Score Change	**-4.83%**	**-4.85%**
Total	**-0.29%**	**0.09%**

Wakely estimates are based on nationwide MA enrollment by county as of December 2025 and published 2026-star ratings. Wakely estimates are multiplicative, while the CMS estimates in the fact sheet are additive.

Below is a brief definition of each of the elements in Table 5.

Effective Growth Rate. This is the combined impact of the FFS growth rate (5.10%), changes to the applicable percentage, and the benchmark cap.

Applicable Percentage

The applicable percentage varies according to a county's quartile ranking. The 2027 county quartiles are determined by the 2026 FFS rates. We estimate a slight decrease due to a shift in county quartiles.

Benchmark Cap

The ACA formula requires that the final blended benchmark can be no greater than the pre-ACA benchmark. The impact of this cap can change year-to-year as plans Star Ratings change, and as the Total growth rate – formally referred to as the National Per Capita Medicare Growth Percentage (NPCMGP) – varies from the FFS trend. The proposed 2027 Total growth rate of 4.04% is lower than the FFS growth rate of 5.10%, which can contribute to a positive year over year impact. (i.e. the cap applies to fewer plans than before). The impact of benchmark caps by county varies depending on a contract's Star Rating.

Using benchmarks for plans with 4+stars, we estimate the number of counties that hit the benchmark cap will increase from 1,117 in 2026 to 1,217 in 2027. The MA enrollment weighted average dollar impact of the cap for 4+ star plans is -$6.95 in 2026 and -$8.72 in 2027.

Star Rating/Quality Bonus. This is the difference in quality bonus impact on benchmarks due to star rating changes between 2026 and 2027. The Wakely estimate is more negative than the amount published in the Fact Sheet. The Wakely estimate reflects 2025 star ratings published in December 2024, and 2026 star ratings published in October 2025. The estimate uses static enrollment (December 2025) and excludes terminated and new plans. It is possible that the CMS estimated the impact of Star Rating changes includes both changes in the ratings as well as change in enrollment by plan, although CMS does not provide a description of its method in the Fact Sheet.

Change in Coding Pattern Adjustment. The PY2027 coding pattern adjustment is -5.90%, which is the minimum adjustment required by the Affordable Care Act. This is the same adjustment used in PY2026.

Part C FFS Normalization Factor and Risk Model Revision. For CY2027 CMS is proposing to update the v28 model using 2023 diagnoses and 2024 expenditures (as compared to 2019/2020 in the 2024 CMS-HCC v28 model). Consistent with last year, CMS is using the multiple linear methodology to calculate the FFS normalization factor. The proposed PY2027 FFS Normalization factor is 1.058. In addition, CMS is proposing to eliminate chart review encounters that are unlinked to a prior claim record in the risk score calculation. More details on these changes are discussed below.

Geographic Impacts

As has been the case in past years, the change in benchmarks can vary significantly depending on geographic area and plan Star Rating.

Table 6 shows the top five and bottom five growth rates by State (these changes include changes due to Star Rating, double bonus status, applicable percentage, and benchmark cap) as estimated by Wakely. About 68% of MA enrollees reside in a region that is expected to have a negative change in risk adjusted benchmark payment. We also note that rural counties, as defined by CMS, estimate a lower average growth rate than nationwide (4.51% vs 4.77%). Rural counties are defined as "Not in Metro Area" from the rate data released in the Part C bid pricing tool (BPT).

Table 6 – States with Highest and Lowest Expected Benchmark Change

Rank	State	Benchmark Change	Risk Adjusted Change [1]
Mean	**All**	**4.77%**	**-0.29%**
1	UT	7.1%	1.9%
2	MA	7.1%	1.9%
3	OH	7.1%	1.9%
4	NH	6.6%	1.5%
5	ID	6.5%	1.4%
47	ND	3.3%	-1.7%
48	AL	3.2%	-1.7%

49	WV	3.2%	-1.8%
50	KS	3.1%	-1.8%
51	OK	2.5%	-2.4%

[1] We assumed a -4.89% total risk score change to every state. Actual impacts due to the proposed risk score changes will vary significantly by plan.

Table 7 shows the benchmark changes for states with the highest MA enrollment, ranked in descending order. The top three states reflect an expected benchmark change that is lower than average.

Table 7 - Expected Benchmark Changes for Top MA Enrollment States

State	Benchmark Change	Risk Adjusted Change [1]
CA	4.8%	-0.3%
FL	4.2%	-0.8%
TX	5.3%	0.2%
NY	4.7%	-0.4%
PA	5.4%	0.3%
OH	7.1%	1.9%

[1] We assumed a -4.89% total risk score change to every state. Actual impacts due to the proposed risk score changes will vary significantly by plan.

Please note that the estimated benchmark changes do not include any changes due to repricing or rebasing to the average geographic adjustment factors (AGA). AGA factors are calculated by taking a five-year average of cost relativities (county/nationwide) divided by a five-year weighted average of risk scores. The CY2027 AGA factors will be based on data years 2020-2024.

Each year, CMS reprices the cost data to reflect the most current fee schedule. That is per capita costs from 2020-2024 will be repriced on the FY2026 fee schedule. In addition, the risk scores are based on the payment year model (i.e. the proposed 2027 CMS v28 model).

There could be a significant shift in the AGA factors due to:

- The removal of anomalous DMEPOS claims. CMS is proposing to remove identifiable fraudulent DMEPOS claims for data years 2023 and 2024. This is reflected in the USPCCs published with the advance notice and will also have an impact for data years 2023 and 2024 in the AGA factor calculation. For CY2023, the county level per capita costs range from $0-$200 and for CY2024, the amounts range from $0-$50. In areas where there was more DMPOS fraudulent spend than nationwide average, there could be a decrease to AGA factors.
- The inclusion of the REH payments. Rural counties that have eligible emergency hospitals will have an increase in per capita costs which will likely increase the AGA factors.
- It is unclear if the change in Medicare reimbursement applicable to skin substitute procedures will be reflected in the re-priced 2020-2024 historical costs used to derive the AGAs. CMS does not reprice Part B drugs as a part of the AGA adjustments. Since these procedures will be paid under the Physician Fee Schedule beginning 1/1/2026, it is unclear how the AGAs will be affected. The impact of the Physician Admin Rx reimbursement could have varying impact depending on the mix services underlying the Part B per capita costs.

The impact of the proposed 2027 CMS-HCC model. An increase in risk scores would mean a decrease to AGA factors.

ESRD Growth Rate

The proposed CY2027 FFS Dialysis-only ESRD USPCC growth rate is 6.17%. This compares to the CY2026 growth rate of 6.79%. Table 8 displays the growth rate history over the last five years. The lower growth rates for CY2024 and CY2025 were driven by significant downward restatements of greater than 5%.

Table 8 – FFS ESRD Dialysis Only USPCC Growth Rates

Year	Growth Rate
2027	6.2%

2026	6.8%
2025	1.8%
2024	2.3%
2023	9.6%

Table 9 displays the FFS ESRD USPCC restatements included in the Notice. Similar to the non-ESRD rates, the 2024 cost estimate is positively restating.

Table 9 – FFS ESRD Dialysis Only USPCC Restatements

Year	Current	Prior	Current/Prior
2028	$11,603	$11,498	0.90%
2027	$11,013	$10,934	0.70%
2026	$10,486	$10,373	1.10%
2025	$10,084	$9,814	2.80%
2024	$9,275	$9,139	1.50%
2023	$8,705	$8,706	0.00%

Note, the anomalous DMEPOS adjustment will also impact the ESRD rates. This could have a variable impact on the state rates.

Employer Group Waiver Plan (EGWP) Bid to Benchmark Ratios

For PY2027 the bid to benchmark ratios will be based on 2026 MA bids and weighted by February 2026 enrollment. The historical bid to benchmark ratios are provided in the table below, as well as the preliminary ratios for PY2027 which use January 2026 enrollment. The average preliminary 2027 bid to benchmark ratio increased about 20 basis points from the average 2025 ratio. This could indicate that MA cost trends are outpacing MA payments.

Table 10 – EGWP Bid to Benchmark Ratio

Quartile	PY2024 (2023 B2B)	PY2025B (2024 B2B)	PY2026 (2025 B2B)	PY2027 (2026 B2B)
0.950	78.5%	78.5%	78.8%	78.6%
1.000	77.2%	76.7%	77.7%	77.8%
1.075	76.6%	76.1%	77.2%	77.8%
1.150	76.8%	76.5%	77.6%	77.7%
Average	77.3%	77.0%	77.8%	78.0%

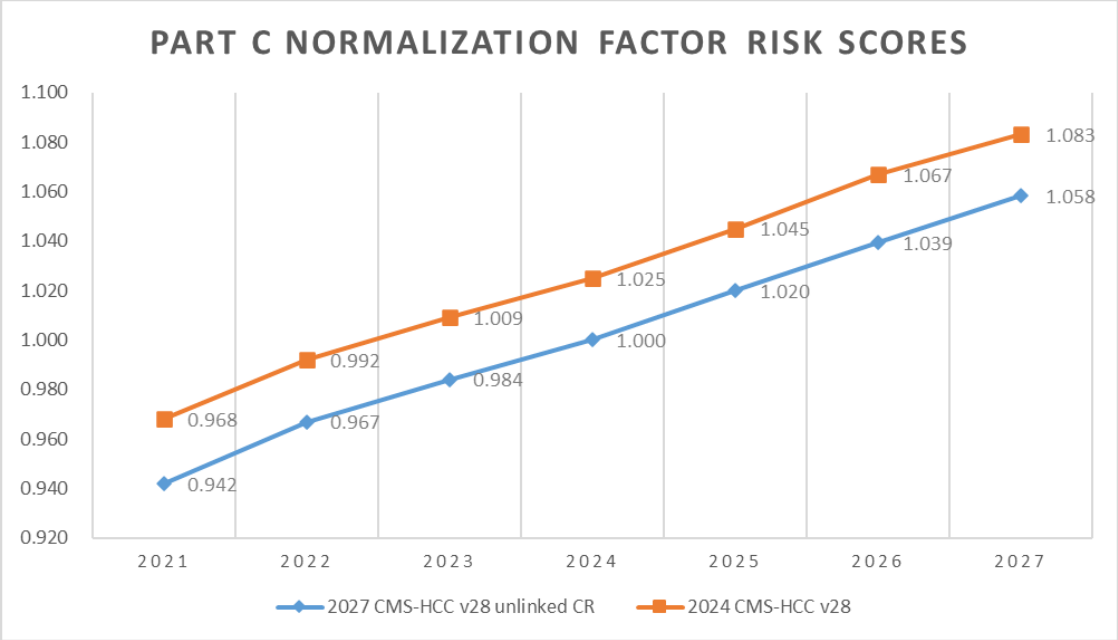
PART C RISK ADJUSTMENT MODEL, SOURCES OF DIAGNOSES FOR CY 2027, AND FFS NORMALIZATION

Following the completion of a three-year phase in of the 2024 CMS-HCC model for CY2026, CMS is again proposing a revision for CY2027 with the 2027 CMS-HCC model. The proposed model will use the same hierarchical condition categories (HCCs), version 28 (v28) of the clinical classification of HCCs, and demographic variables as the 2024 CMS-HCC model. The proposed 2027 CMS-HCC model will deviate from the 2024 CMS-HCC model in the following ways:

1. The model will be calibrated on 2023 diagnoses used to predict 2024 expenditures.
2. Diagnoses from audio-only services and diagnoses from unlinked chart review records will be excluded from the calculation of risk scores for Part C beneficiaries

CMS proposed to continue using the multiple regression model to set the FFS normalization factor for CY2027. The model was first introduced for CY2025 to improve accuracy related observed volatility in risk scores caused by the COVID-19 pandemic. The regression model added a variable that was 0 for pre COVID years (2020 and prior) or 1 for all subsequent years (2021 and after). CMS now has sufficient historical data that the COVID variable is always 1, so the model acts as a liner regression model, as in years prior to 2025. Figure 1 compares the normalization factors risk scores published in the CY2026 and CY2027 Advance Notice for the two models.

Figure 1: Part C Normalization Factor Risk Scores, 2021-2027



Note: The 2027 value for the 2024 CMS-HCC model was derived based on CMS commentary in the Fact Sheet that the change in normalization would have been -1.5%.

Figure 1 shows that the trend patterns of the two models are very similar. One key difference is that the 2026 to 2027 change in FFS normalization factor is -1.5% for 2024 CMS-HCC versus -1.9% for 2027 CMS-HCC (i.e. derived as the annualized trend implied by the 1.058 factor).

Implications of the Proposed Model Change and FFS Normalization Factors

In the January 26, 2026 Fact Sheet[2] supporting the Advance Notice, CMS notes that the combined effect of the change in risk adjustment models and FFS normalization 2027 Part C scores is -3.32% (i.e. risk scores will be reduced by an additional 3.32% as compared with CY2026). CMS further notes that the impact of excluding unlinked chart reviews from 2027 CMS-HCC risk score calculations will result in an additional decrease in scores relative to 2026 of -1.53%.

The implication of the Fact Sheet estimates is that the updated model will reduce risk scores about 1.45% on average. Table 11 shows our estimates of component changes in risk adjustment going from 2024 CMS-HCC for CY2026 to 2027 CMS-HCC with unlinked chart reviews excluded for CY2027.

Table 11 Estimated Components of Part C Risk Model Revision and Normalization Change 2026 to 2027

Component	2027/2026
FFS Normalization Change - 2024 CMS-HCC	-1.50%
Incremental Normalization Change for 2027 CMS-HCC	-0.37%
Model Change	-1.45%
Risk Model Revision and Normalization	**-3.32%**

Taken together with CMS's estimate that excluding unlinked chart reviews reduces CY2027 risk scores an additional 1.53%, the total change in scores from CY2026 to CY2027 is -4.85%. The contribution of the updated data years for the 2027 CMS-HCC model is about -3.0% (-1.45% model change plus -1.53% unlinked chart review impact).

We conducted additional analysis comparable to CMS estimates in the Fact Sheet on aggregated Wakely client data. We found that Wakely clients on average will experience a reduction in Part C risk scores of 3.95%, with similar results by component, as compared with CMS. Table 12 shows this comparison.

Table 12 – Comparison of Risk Score Change Wakely Data versus CMS – 2026 to 2027

[2] https://www.cms.gov/newsroom/fact-sheets/2027-medicare-advantage-part-d-advance-notice

Component	Wakely Data	CMS
Model Revision & FFS Normalization	-2.43%	-3.32%
Unlinked Chart Reviews	-1.56%	-1.53%
Total	**-3.98%**	**-4.85%**

The results in Table 13 illustrate that there are variances in how the risk model changes affect different plans. The model revision varies considerably by model segment (e.g. dual/non-dual, aged/disabled, and other differentiators) and coefficient changes by HCC vary significantly, so plans with a higher concentration of members will certain conditions may see different results than the national average. These differences are discussed in more detail below.

Within the Wakely client data, we saw a modest amount of variation in the impact of the model revision and FFS normalization across plans. Table 13 shows results for selected percentiles.

Table 13 – Model Revision & FFS Normalization Change by Percentile, Wakely Data

Percentile	2027/2026
10	-4.8%
25	-4.1%
50	-3.1%
75	-1.8%
90	0.9%

We further analyzed the impact of the Model Revision and FFS normalization by risk model segment for the Wakely client data set and found significant variation. The most prevalent population type, Non-Dual Aged beneficiaries, will see a decrease of 5.72%. New Enrollee scores are expected to increase by 0.5%, and Institutional members will on average see scores that are 11.5% higher in CY2027 versus CY2026. Table 14 shows results by model segment.

Table 14 – Model Revision & FFS Normalization Change by Model Segment, Wakely Data

Model Segment	2024 CMS-HCC Model - Normalized CY2026	2027 CMS-HCC Model (Excl Unlinked CRR) - Normalized CY2027	2027/2026
Full Dual Benefit Aged	1.541	1.502	-2.53%
Full Dual Benefit Disabled	1.251	1.199	-4.15%

Non-Dual Benefit Aged	0.974	0.918	-5.72%
Non-Dual Benefit Disabled	1.085	1.004	-7.43%
Partial Dual Benefit Aged	1.172	1.084	-7.56%
Partial Dual Benefit Disabled	1.130	1.024	-9.32%
New Enrollee	0.755	0.760	0.57%
Institutional	2.436	2.723	11.79%
Total	**1.127**	**1.100**	**-2.43%**

The changes by model segment in Table 14 illustrate how changes to HCC coefficients have varying effects depending on population types. Because some coefficients go up and some go down, the mix of conditions by model segment will result in different risk score effect by segment. An example of this is that the coefficients for Pressure Ulcers increased dramatically (see analysis and Table 15 below) in the new model. Institutional populations will have a much higher incidence rate of these conditions and so will be disproportionately affected.

Analysis of Coefficient Changes

It is beyond the scope of this report to analyze or validate CMS coefficient calculations in 2027 CMS-2027 model; however, we have several observations regarding the change in coefficients from the 2024 CMS-HCC model.

First, almost all continuing enrollee demographic coefficients decreased in the 2027 CMS-HCC model, indicating that the HCCs had more predictive strength in the new model. In Table 15, we display the change in demographic coefficients for model segments with factors for those age 65 and over.

Table 15 – Change in Demographic Coefficients – 2024 CMS-HCC to 2027 CMS-HCC

Demographic Category	Non Dual, Aged	Full Dual, Aged	Partial Dual, Aged	Institutional	Total
Female 65-69	-3.6%	-12.2%	-13.7%	-1.9%	-6.2%
Female 70-74	-4.3%	0.2%	-13.0%	-3.4%	-3.6%
Female 75-79	-3.4%	-6.4%	-9.5%	2.1%	-4.3%
Female 80-84	-3.4%	-2.6%	-10.8%	-2.0%	-3.5%
Female 85-89	-6.9%	-8.9%	-4.9%	1.5%	-7.1%
Female 90-94	-7.5%	-5.6%	-15.9%	-4.0%	-7.3%

Female 95+	-6.6%	1.9%	-12.1%	-13.5%	-4.9%
Male 65-69	2.1%	-12.4%	-8.3%	-4.1%	-2.1%
Male 70-74	-0.3%	-5.1%	1.7%	0.8%	-1.4%
Male 75-79	-7.8%	0.6%	-7.6%	-15.9%	-5.8%
Male 80-84	-2.5%	0.8%	-16.8%	-4.8%	-2.4%
Male 85-89	-4.1%	-7.5%	-12.0%	-0.7%	-5.2%
Male 90-94	-8.9%	-6.5%	-24.0%	1.6%	-8.8%
Male 95+	-8.6%	-1.7%	-41.8%	-10.1%	-8.4%

Second, we observed a consistent and significant increase in the coefficients for pressure ulcers. These increases are likely caused by the updating of expenditure year to 2024, when skin substitute reimbursement was much higher than in 2020 (the denominator year for 2024 CMS-HCC model). As such, this highlights a disconnect between the process used to recalibrate the risk adjustment model versus the development of the growth rate and projected costs for the contract year. In this case, the risk scores are affected by increased costs for skin substitutes observed in 2024; whereas, the CY2027 growth rate will reflect the known change in reimbursement for these procedures that is expected to dramatically reduce associated payments.

Table 16 – Change in Pressure Ulcer Coefficients – 2024 CMS-HCC to 2027 CMS-HCC

HCC	Description	Non Dual, Aged	Full Dual, Aged	Partial Dual, Aged	Full Dual, Disabled	Average
379	**Pressure Ulcer of Skin with Necrosis Through to Muscle, Tendon, or Bone**	77.4%	115.3%	142.4%	141.8%	95.5%
380	**Chronic Ulcer of Skin, Except Pressure, Through to Bone or Muscle**	43.5%	78.1%	36.1%	68.3%	53.7%
381	**Pressure Ulcer of Skin with**	33.7%	57.1%	44.0%	43.0%	40.4%

	Full Thickness Skin Loss					
382	**Pressure Ulcer of Skin with Partial Thickness Skin Loss**	14.9%	22.7%	26.2%	13.6%	17.0%
383	**Chronic Ulcer of Skin, Except Pressure, Not Specified as Through to Bone or Muscle**	23.5%	41.9%	56.1%	11.7%	27.8%

Third, there was a consistent shift in the coefficients for the two HCCs related to Stage 3 chronic kidney disease. The most populous model segments say consistent increases to HCC 328, (Chronic Kidney Disease, Moderate Stage 3B) and decreases to HCC 329 (Chronic Kidney Disease, Moderate Stage 3, Except 3B).

Table 17– Change in Chronic Kidney Disease Stage 3 Coefficients– 2024 CMS-HCC to 2027 CMS-HCC

HCC	Description	Non Dual, Aged	Full Dual, Aged	Partial Dual, Aged	Full Dual, Disabled
328	**Chronic Kidney Disease, Moderate (Stage 3B)**	48.0%	12.1%	7.1%	48.0%
329	**Chronic Kidney Disease, Moderate (Stage 3, Except 3B)**	-50.4%	-56.0%	-68.6%	-50.4%

PART D RISK ADJUSTMENT MODEL, SOURCES OF DIAGNOSES FOR CY 2027, AND FFS NORMALIZATION

For CY2027, CMS is again proposing to revise the Part D risk adjustment model. The update for CY2027 will use updated diagnosis and cost data and similar changes to sources of diagnoses as proposed for the CY2027 Part C model.

CMS is proposing to update the RxHCC models by incorporating the following changes, many of which are related to Part D benefit changes imposed by the IRA:

- Updated underlying data based on diagnoses from 2023 FFS claims and MA encounter data records and gross drug costs from 2024 prescription drug event (PDE) files.
- Increased CY2027 manufacturer discounts for drug manufacturers. In CY 2027, manufacturer discounts for applicable drugs were increased for specified manufacturers and specified small manufacturers. For specified manufacturers, the updated discounts apply to drugs dispensed to low-income subsidy (LIS) beneficiaries, with plan liability set at 70% in the initial coverage phase and 75% in the catastrophic phase. For specified small manufacturers, these same discount levels apply to drugs dispensed to all beneficiaries.
- Updates to reflect National Drug Control (NDC) codes for adult vaccines and insulins applicable as of May 2025.
- Adjustments to gross drug costs to account for the maximum fair price drugs of the selected drugs for Initial Price Applicability Year (IPAY) 2026 as part of the Medicare Drug Price Negotiation Program

Beyond these updates, CMS is also proposing two important and new changes to the Part D risk adjustment model for CY2027:

1. Exclude diagnoses from audio-only services and unlinked chart review records (same as the Part C model).
2. Calculate separate coefficients for all continuing enrollee model segments into MA-PD and PDP markets. Demographic coefficients are the same for both markets.

Based on an aggregation of HPMS scores across Wakely MA-PD clients, we found that the year over year change in normalized MA-PD Part D risk scores of the proposed 2027 CMS-RxHCC models is -2.6%. These estimates are based on the CY2024 data provided by CMS and normalized according to the proposed normalization factors for CY2027. It is important to note that our Wakely client experience reflects the MA-PD Part D risk adjustment model only.

The decrease in normalized MA-PD Part D risk scores will put pressure on plans to increase premiums or reduce benefit richness. To put the estimated normalized risk score change of -2.6% into perspective, we tested a range of assumptions across the following dimensions:

- CY2027/CY2026 national average Part D bid increase of 0%, 10% and 33% (same increase as 2026 versus 2025)

- Pan-specific variation of how the plan's Part D defined standard costs compared with the national average. We tested no difference, 10% higher, 20% higher, 10% lower, and 20% lower.

In addition to these assumptions, we assumed the national basic beneficiary premium would increase by the maximum allowed by the IRA, or +6%. Finally, we assumed risk scores would trend at 1.6% annual, which is assumed to be two-thirds of the +2.45% CMS estimated Part C risk score increase for MA plans.

Based on these assumptions, we found that the change in Part D risk adjustment model will result in an increase in plan-specific basic Part D premiums of about $6.00 to $10.00 as compared with no change to the risk model. In other words, plans would have to allow premiums to increase by this amount, scale back on A/B supplemental benefits and/or reduce profits to account for this change. To the extent that the national average impact is more/less of a decrease than Wakely clients, the increase basic premium pressure will be higher/lower, respectively.

As with the revised Part C model, we again observe modest variation in normalized Part D score changes from 2026 to 2027 across all plans. Table 18 shows the changes by select percentile.

Table 18 – Range of Normalized MA-PD Part D Risk Score Change – 2026 to 2027

Percentile	2027/2026
10	-6.3%
25	-3.9%
50	-1.5%
75	0.5%
90	3.0%

Table 19 shows the impact of the proposed model by risk model segment and in total for the Wakely MA-PD client sample.

Table 19 – Average Normalized MA-PD Part D Risk Score Change – 2026 to 2027

Model Segment	2026 RxHCC Model (22/23 Calibration) Encounter Data, and FFS	2027 RxHCC Model (23/24 Calibration) Encounter Data, and FFS	2027/2026
Continuing Enrollee Non-Low Income Aged	0.511	0.494	-3.37%
Continuing Enrollee Low Income Aged	1.433	1.351	-5.68%
Continuing Enrollee Non-Low Income Non-Aged	0.926	0.966	4.40%
Continuing Enrollee Low Income Non-Aged	2.656	2.594	-2.35%
Continuing Enrollee Institutional w/Non-Aged Interactions	1.682	1.853	10.21%
New Enrollee Community Non-Low Income (ESRD)	1.111	1.313	18.19%
New Enrollee Community Non-Low Income (non ESRD)	0.453	0.545	20.30%
New Enrollee Community Low Income (non ESRD)	1.280	1.332	4.10%
New Enrollee Community Low Income (ESRD)	2.026	2.025	-0.04%
New Enrollee Institutional (non ESRD)	1.900	2.060	8.46%
New Enrollee Institutional (ESRD)	1.974	2.138	8.31%
Total	**1.000**	**0.974**	**-2.60%**

It is notable that the changes to the Part D model result in much higher coefficients for New Enrollee model segments, particularly for the non-low income, non-ESRD population.

RxHCC FFS Normalization

The RxHCC FFS normalization factor for CY2027 reflects the following:

- An additional year of data (2020 through 2024).
- Continuation of the multiple linear regression model introduced in CY2026, recalibrated for the updated data years.
- Continuation of separate FFS normalization factors for MA-PD and PDP, but now based on risk scores calculated with the separate continuing enrollee coefficients.

Since the risk score data for RxHCC models lags one year behind Part C, the multiple linear regression model will have a non-zero coefficient for the COVID-19 flag (β_2) since the 2020 score is 0, or non-COVID.

Table 20 shows the Part D risk scores for the proposed RxHCC model, while Table 21 shows the multiple regression model coefficients based on historical scores.

Table 20 – Historical and Projected Risk Scores for Proposed 2027 RxHCC Model

Year	2027 RxHCC MAPD	2027 RxHCC PDP	2027 RxHCC Total
2020	0.932	1.036	0.987
2021	0.912	0.973	0.942
2022	0.958	0.989	0.972
2023	0.982	0.991	0.986
2024	1.010	0.987	1.000
2027 Projected	**1.109**	**1.005**	**1.060**

Table 21 – Multiple Regression Coefficients

	2027 Proposed RxHCC Model		
	MA-PD	PDP	Overall
Intercept (β_0)	--63.304	-7.852	-36.989
Average Change in FFS Risk Scores (β_1)	0.0318	0.0044	0.0188
COVID-19 Flag (β_2)	-0.046	-0.062	-0.059
Proposed 2027 normalization factor	1.109	1.005	1.060

As was the case with the derivation of the RxHCC FFS normalization factor for CY2026, CMS is again calculating the MA-PD and PDP factors by simply taking the projected 2027 risk score to be the FFS normalization factor.

Given that CMS is now using separate models for MA-PD and PDP (although demographic factors are the same), it does not seem appropriate to derive normalization factors across the two segments. Instead, the normalization should account only for the expected trend between the denominator year and the payment year for each model separately.

Adopting the trend-only approach would result in the following FFS normalization factors:

- MA-PD – 1.098
- PDP – 1.018

LIMITATIONS

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CY2027 Potential Benefit Impact from Proposed Changes in the Advance Notice

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Table of Contents

EXECUTIVE SUMMARY

Medicare Advantage (MA) plans receive monthly payments from the federal government for each enrolled beneficiary. These payments fund both the plan's estimated cost of providing Medicare benefits (its "bid") and, where the government benchmark exceeds the bid, a "rebate" that the plan must spend on supplemental benefits, reduced cost sharing, or lower member premiums. Each year, CMS publishes an Advance Notice proposing payment changes for the following year. This report analyzes those planned changes and models the likely impact on plan benefits and member premiums for 2027.

On January 26, 2026, the Centers for Medicare & Medicaid Services (CMS) released the 2027 Advance Notice, which details planned changes to the Part C and Part D capitation and risk adjustment methodology for calendar year (CY) 2027. The growth rate and risk model changes together resulted in a substantially lower estimated benchmark trend than the industry was expecting. In the CY 2027 Advance Notice CMS Fact Sheet,[1] CMS estimates risk adjusted Part C benchmark revenue will change on average by +0.09%. This near-flat payment update is significantly lower than the 2026 rate of +5.06%. The decrease is driven largely by proposed changes to the risk adjustment model that offset the underlying growth in healthcare costs.

As this report shows, based on experience with benefit reductions that took place in 2026, Wakely estimates that the Advance Notice could lead to a projected 15% decline in average plan rebate dollars from 2026 to 2027.

We modeled how these reductions might impact benefits and premiums for a typical plan under two approaches: The first assumes the plan prioritizes maintaining benefits while allowing premiums to increase. The second assumes the plan will instead prioritize keeping member premiums as low as possible while removing benefits.

From a nationwide perspective, we observed the following:

- If plans prioritize benefits, member premiums would increase by $23.
- Conversely, a plan that prioritized keeping a $0 premium could see changes such as a 50% decrease in other supplemental benefits, a 50% decrease in comprehensive dental

[1] https://www.cms.gov/newsroom/fact-sheets/2027-medicare-advantage-part-d-advance-notice

and vision eyewear coverage %, and a $1,000 increase in the out of pocket cost maximum.

It is important to note that nationwide policy changes have varying impact based on individual plan characteristics and geographic location. In addition, this report only considers the estimated changes to plan payments for Part C. It is possible that Part D claim trend pressures and risk adjustment changes could also create headwinds for plans.

BACKGROUND

On April 7, 2025, CMS finalized the CY 2026 growth rate and risk adjustment model changes in the CY2026 Rate Announcement[2] and estimated the change in risk adjusted Part C benchmark revenue to be +5.06%. However, the CMS fact sheet percentage change does not account for other revenue considerations like risk score coding trend, Part D changes and bid and rebate revenue. In a recent publication discussing the observed changes in 2026 premiums, supplemental benefits and plan value,[3] Wakely estimated the 2026 plan value-add amount decreased from 2025. That is, although CMS estimated an average of +5.06% to risk adjusted Part C benchmark revenue, Wakely estimated that from 2025 to 2026, the average plan value-add decreased by 11.0% for general enrollment plans and by 2.6% for Dual special needs plans (DSNP). Note, value-add is an estimated value of plan benefit designs including the combination of Part C Medicare-covered reduction in cost sharing, Part C supplemental benefits, Part D prescription drug coverage, member premium, and Part B premium reduction.

Given the decrease to plan value-add when the CY2026 CMS Fact Sheet estimated change in revenue was 5.06%, the CY2027 CMS Fact Sheet estimated change of 0.09% could indicate additional reduction in benefits.

[2] https://www.cms.gov/newsroom/fact-sheets/2026-medicare-advantage-and-part-d-rate-announcement

[3] https://www.wakely.com/wp-content/uploads/2026/01/The-Value-Shift-How-Medicare-Advantage-Benefits-Are-Evolving-for-2026-1.pdf

ANALYSIS AND FINDINGS

Wakely Analysis: Estimated Impact of Growth Rates and Proposed Risk Adjustment Model

The key revenue changes proposed in the Advance Notice include:

- The CY2027 non-ESRD FFS growth rate is 5.10%. This is 372 basis points lower than the final 2026 growth rate of 8.81%.
- The proposed Part C risk adjustment model is expected to decrease plan risk adjusted benchmark payment by about -4.85% overall. This is a result of:
    - Updated model calibration using 2023 diagnosis codes and 2024 expenditures (compared with 2018/2019),
    - the removal of encounters submitted from chart reviews with no linked claim in the calculation of the risk score,
    - and the updated FFS normalization factor. CMS is proposing to continue to use the multiple linear regression methodology to calculate FFS normalization.
- In addition, we estimate the year-over-year change in normalized MA-PD Part D risk scores of -2.6%.
    - CMS is proposing a revised 2027 RxHCC risk adjustment model that reflects updates for the Inflation Reduction Act (IRA) as well as changes in Part D benefit parameters. In addition, CMS is proposing to use separate model segments for Medicare Advantage Prescription Drug (MAPD) plans and Prescription Drug Plan (PDP) plans.
    - CMS proposes to continue to use separate RxHCC FFS normalization factors for MA plans that include Part D coverage (MA-PD) and PDP markets as well as use the multiple linear regression.

Wakely estimates that the nationwide average change in blended standardized (non-risk adjusted) MA Benchmarks from 2026 to 2027 will be 4.77% and the nationwide average change in the blended risk adjusted benchmark will be -0.29% before coding trend.

Table 1 Change in Blended Risk-Adjusted Benchmarks 2026 to 2027

Component	Wakely Estimated Annual Change
Effective Growth Rate	4.89%
Rebasing/Re-pricing (AGA)	0.00%
Change in Star Ratings	-0.19%
Total Benchmark Change	**4.77%**
MA Coding Pattern	0.00%
Risk Model (FFS Normalization & Risk Model Change)	-4.83%
Total Risk Score Change	**-4.83%**
Total	**-0.29%**

Wakely estimates are based on nationwide MA enrollment by county as of December 2025 and published 2026-star ratings. Wakely estimates are multiplicative, while the CMS estimates in the fact sheet are additive.

Following is a brief definition of each of the elements in Table 1.

Effective Growth Rate. This is the combined impact of the FFS growth rate (5.10%), changes to the applicable percentage, and the benchmark cap.

Applicable Percentage

The applicable percentage varies according to a county's quartile ranking. The 2027 county quartiles are determined by the 2026 FFS rates. We estimate a slight decrease due to a shift in county quartiles.

Benchmark Cap

The ACA formula requires that the final blended benchmark can be no greater than the pre-ACA benchmark. The impact of this cap can change year-to-year as plans Star Ratings change, and as the Total growth rate – formally referred to as the National Per Capita Medicare Growth Percentage (NPCMGP) – varies from the FFS trend. The proposed 2027 Total growth rate of 4.04% is lower than the FFS growth rate of 5.10%, which can contribute to a positive year over year impact. (i.e. the cap applies to fewer plans than before). The impact of benchmark caps by county varies depending on a contract's Star Rating.

Star Rating/Quality Bonus. This is the difference in quality bonus impact on benchmarks due to star rating changes between 2026 and 2027. The Wakely estimate is more negative than the amount published in the Fact Sheet. The Wakely estimate reflects 2025 star ratings published

in December 2024, and 2026 star ratings published in October 2025. The estimate uses static enrollment (December 2025) and excludes terminated and new plans. It is possible that the CMS estimated the impact of Star Rating changes includes both changes in the ratings as well as change in enrollment by plan, although CMS does not provide a description of its method in the Fact Sheet.

Change in Coding Pattern Adjustment. The PY2027 coding pattern adjustment is -5.90%, which is the minimum adjustment required by the Affordable Care Act. This is the same adjustment used in PY2026.

Part C FFS Normalization Factor and Risk Model Revision. For CY2027 CMS is proposing to update the v28 model using 2023 diagnoses and 2024 expenditures (as compared to 2019/2020 in the 2024 CMS-HCC v28 model). Consistent with last year, CMS is using the multiple linear methodology to calculate the FFS normalization factor. The proposed PY2027 FFS Normalization factor is 1.058. In addition, CMS is proposing to eliminate chart review encounters that are unlinked to a prior claim record in the risk score calculation. More details on these changes are discussed below.

Change in Bid and Rebate Amounts

The actual revenue change for individual Medicare Advantage plans will depend on the trend in bids, and will further vary depending on Star Rating, counties served, risk score trends, population changes, and many other factors.

Note, the CMS Fact Sheet only estimates the impact on risk-adjusted benchmark payments. To properly estimate the impact of the various MA payment components addressed in the Advance Notice, Medicare Advantage plans must consider the total effect on actual payments from CMS, which is not necessarily the same as the change in benchmarks.

As noted above, we estimate the change in risk-adjusted benchmarks to be -0.29%. If we include estimated changes in bid and rebate levels, then the impact on Part C revenue is 3.5%. This estimate is based on the following assumptions:

- Plans bid at 78% of the benchmark in 2026. This is based on the proposed bid-to-benchmark ratios for MA EGWP plans published in the 2027 Advance Notice.
- The MA trend for CY 2027 is 6.8%. This is based on the average of the 2025-2027 MA-only USPCC rate presented in the Advance Notice.
- Annual risk score coding trend is 2.45% for a static population. This is based on the CMS fact sheet. Note, in past years CMS has stated they estimate MA coding trend (used in fact sheet) using historical MA data. Given the changes in the Advance Notice, the 2027/2026 coding trend could vary significantly from historical years.

- average Star Ratings, which result in an average rebate percentage of 65.4% in 2026 and 65.2% for 2027.
- No consideration for sequestration.
- No consideration for change in Part D costs and revenue.

Table 2 shows the calculations underlying our estimates.

Table 2 - Estimated Change in Risk-Adjusted Bid and Rebate, 2026 to 2027

	2026	2027	2027/2026
1.0 MA Benchmark [1] [a]	$1,274.31	$1,335.05	4.77%
Raw Risk Adjustment Factor [2]	1.0000	1.0245	2.5%
Risk Score Model Change	1.0000	0.9589	-4.1%
Removal of Unlinked Chart Reviews	1.0000	0.9842	-1.6%
FFS Normalization	1.0669	1.0580	-0.8%
MA Coding Pattern Adjustment	0.9410	0.9410	0.0%
Total Risk Adjustment Factor (RAF) Adjustments [b]	0.8820	0.8599	-2.5%
Risk-Adjusted Benchmark [a] x [b] = [c]	$1,123.93	$1,148.08	2.1%
Assumed Risk-Adjusted Bid [3] [d]	$876.38	$936.31	6.8%
Savings (Benchmark less Bid) [c] – [d] = e	$247.55	$211.77	-14.5%
Rebate [4] [e] * Rebate % = [f]	$161.95	$138.04	-14.8%
Risk-Adjusted Bid + Rebate [d] + [f]	**$1,038.33**	**$1,074.35**	**3.5%**

[1] Based on nationwide average MA enrollment by county as of December 2025

[2] Assumed 1.0 risk scores with 2.45% trend based on CMS fact sheet

[3] 2026 Bid set at 78% of risk-adjusted benchmark. 2027 Bid assumes 6.8% trend.

[4] Rebate set at 65.4% for 2026 and 65.2% for 2027

As a reminder, the bid amount is the payment used to fund traditional Medicare benefits. The rebate is used to cover reductions to a/b cost sharing, add additional supplemental benefits and Part D coverage, and buy down member premiums. The estimated decrease in rebate

percentage of about 15% will have a direct impact on beneficiary cost sharing, supplemental benefits and member premium.

Additional Considerations

Geographical Variation

The number presented above reflects a nationwide average. Actual plan impact will vary depending on geographic area, star ratings and underling benefits and costs. As in past years, CMS did not yet reflect the rebasing and repricing for the Average Geographic Adjustment (AGA) factors in the Advance Notice. These updates may result in dramatically different changes in FFS benchmarks by county. We anticipate there could be increased volatility due to the adjustments for the anomalous durable medical equipment, prosthetics, orthotic supplies (DMEPOS), rural emergency hospitals (REH), and risk adjustment.

Part D Revenue

For CY2027, CMS is again proposing to revise the Part D risk adjustment model. The update for CY2027 will use updated diagnosis and cost data and similar changes to sources of diagnoses as proposed for the CY2027 Part C model. In addition, CMS is proposing to calculate separate coefficients for all continuing enrollee model segments into MA-PD and PDP markets. Demographic coefficients are the same for both markets.

As in past years when new risk models are proposed, CMS released risk scores for PY2026 based on the current 2025 CMS-RxHCC model and the 2026 CMS-RxHCC model.

Based on an aggregation of HPMS scores across Wakely MA-PD clients, we found that the year over year change in normalized MA-PD Part D risk scores of the proposed 2027 CMS-RxHCC models is -2.6%. These estimates are based on the CY2024 data provided by CMS and normalized according to the proposed normalization factors for CY2027. It is important to note that our Wakely client experience reflects the MA-PD Part D risk adjustment model only.

It is expected that the change in Part D risk adjustment model will result in an increase to the plan-specific basic premium levels. An increase to Part D premiums would require more rebate dollars allocated to Part D to cover the same benefits or a reduction in benefits to maintain premiums.

Hypothetical Plan Benefit and Premium Changes

In order to provide more concrete examples of how plans could be affected by payment cuts we modeled how these reductions in Part C revenue might impact benefits and premiums for a typical plan under two approaches: The first approach assumes the plan prioritizes maintaining benefits while allowing premiums to increase. The second approach assumes the plan will instead prioritize keeping member premiums as low as possible while removing benefits. While hypothetical, the amounts reflected below fall within a common range of assumptions for current plans.

Please note, this hypothetical modeling does not account for Total Beneficiary Cost Sharing (TBC) limits. We assume that CMS would make an adjustment to the TBC rules as they have done in the past for revenue changes.

Table 3 displays the potential impact to member benefits and premiums. Please note the baseline benefits are hypothetical and do not represent any particular plan. Other combinations of changes could also be made.

Table 3 – Potential Impact to Benefits and Premiums due to Advance Notice Proposals

	Baseline	Preserve Benefits	Minimize Member Premium
Total Member Premium	$0	$23	$0
IP Copay Per Day, Days 1-5	$100	$100	$100
OP Surgery	$150	$150	$150
Specialist Office Visit	$10	$10	$10
Maximum Out-of-Pocket	$5,000	$5,000	$6,000
Preventive Dental	100%	100%	100%

	Baseline	Preserve Benefits	Minimize Member Premium
Comprehensive Dental	50%	50%	25%
Vision - Eye Exams	1 /year	1 /year	1/year
Vision – Eyewear Allowance	$300	$300	$150
Part D Enhanced (PMPM)	$10	$10	$10
All Other (PMPM)	$24	$24	$12

From a nationwide perspective, we observed the following:

- If plans prioritize benefits, member premiums would increase by $23.
- Conversely, a plan that kept a $0 premium could see changes such as a 50% decrease in other supplemental benefits, decrease comprehensive dental and vision eyewear coverage by 50%, and increase out of pocket costs by $1,000.

2026 Plan Benefit Design Changes

In a recent Wakely publication discussing the observed changes in 2026 premiums, supplemental benefits and plan value[4], the estimated plan value-add amount decreased from 2025 to 2026.

Key findings include:

- The average member premium for general enrollment plans was $12.09 per member per month (PMPM) in 2025, compared with $14.77 PMPM in 2026 based on proxy 2026 enrollment, yielding a 22% increase in average member premium. While the average member premium increased between 2025 and 2026, the number of plans with a premium stayed relatively consistent at around 32% of plans.

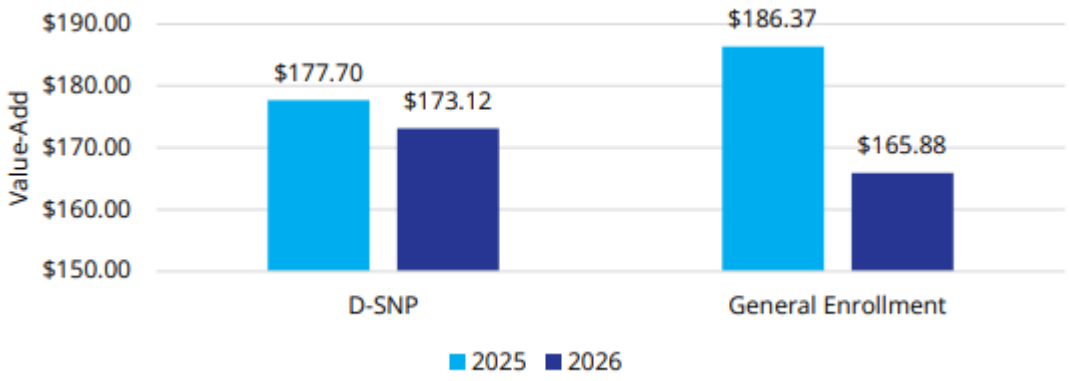
[4] https://www.wakely.com/wp-content/uploads/2026/01/The-Value-Shift-How-Medicare-Advantage-Benefits-Are-Evolving-for-2026-1.pdf

- The average Part B premium reduction increased from $15.43 PMPM in 2025 to $16.99 PMPM in 2026 for general enrollment plans based on proxy 2026 enrollment, an increase of roughly 10%. Like the member premium, the number of plans offering a Part B premium reduction stayed relatively consistent at 32% between 2025 and 2026.

- The average maximum out-of-pocket (MOOP) amount increased to $5,307 in 2026 from $5,128 in 2025 for general enrollment plans based on proxy 2026 enrollment, which is a 3.5% increase between the two years.

- The average plan value-add5 for general enrollment plans decreased roughly 11.0% between 2025 and 2026. Similarly, D-SNPs also saw a decrease in average plan value-add, but to a much smaller degree than general enrollment plans—only about 2.6%.

Table 4 – Change in Plan Value-add from 2025 to 2026



The value-add metric is a proprietary metric that Wakely developed to provide a comprehensive assessment of MA plan value. It can be used as a comparative metric to evaluate relative changes in plan. It includes the combination of Part C Medicare-covered reduction in cost sharing, Part C supplemental benefits, Part D prescription drug coverage, member premium, and Part B premium reduction.

Conclusion

In summary, a reduction to 2027 MA benchmarks or risk scores would lead to significant reductions in rebate dollars available to plans, resulting in a direct impact on member benefits

and out of pocket costs. In addition, a decrease in 2027 Part D risk scores will put additional pressure on MAO's to reduce Part D benefits or allocate more of their rebate dollars to cover Part D premium reductions. Given the reduction to benefits from 2025 to 2026, the proposals in the 2027 Advance Notice could indicate further benefit reductions.

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