Wakely
An HMA Company

Wakely.com

CY2027 Potential Benefit Impact from Proposed Changes in the Advance Notice

Written By
Tim Courtney, FSA, MAAA
Rachel Stewart ASA, MAAA

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.

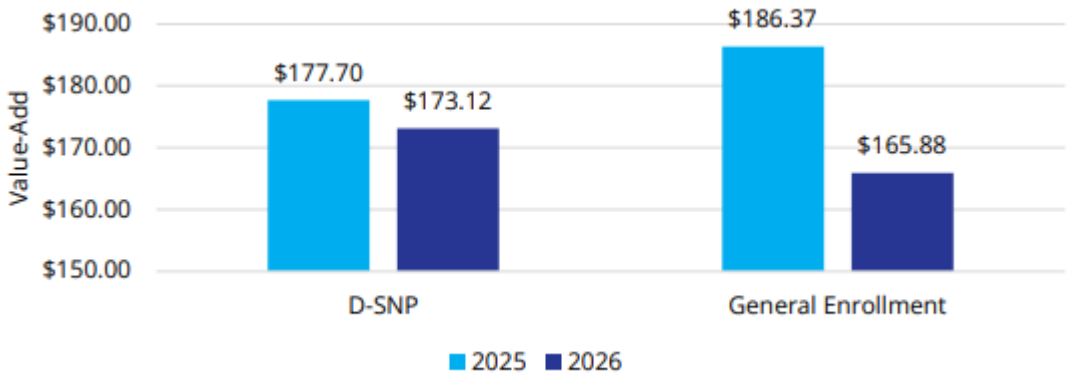
[4] https://www.wakely.com/wp-content/uploads/2026/01/The-Value-Shift-How-Medicare-Advantage-Benefits-Are-Evolving-for-2026-1.pdf

- 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.

LIMITATIONS

The assumptions and resulting estimates included in this report and produced by the model are inherently uncertain. Users of the results should be qualified to use it and understand the results and the inherent uncertainty. Actual results may vary, potentially materially, from our estimates. It is the responsibility of AHIP to review the assumptions carefully and notify Wakely of any potential concerns.

RESPONSIBLE ACTUARIES

We, Rachel Stewart, and Tim Courtney, are the actuaries responsible for this communication. We are Members of the American Academy of Actuaries. Rachel is an Associate of the Society of Actuaries, and Tim is a Fellow in the Society of Actuaries. We meet the Qualification Standards of the American Academy of Actuaries to issue this report.

CONFLICT OF INTEREST

Wakely provides actuarial services to a variety of clients throughout the health industry. Our clients include commercial, Medicare, and Medicaid health plans, the federal government and state governments, medical providers, and other entities that operate in the domestic and international health insurance markets. Wakely has implemented various internal practices to reduce or eliminate conflict of interest risk in serving our various clients. Except as noted here, we, Rachel Stewart and Tim Courtney, are financially independent and free from conflict concerning all matters related to performing the actuarial services underlying this analysis. In addition, Wakely is organizationally and financially independent to AHIP.

CONTENTS OF ACTUARIAL REPORT

This document contains the results, assumptions, and methods used in our analysis, and satisfies the ASOP 41 reporting requirements. Reliance on this report is at AHIP's discretion. Wakely understands that AHIP may post and issue the Report publicly, including but not limited to sharing the Report with its members and may, at AHIP's sole discretion, publish the Report on the ahip.org website. In addition, Wakely understands and anticipates that AHIP may quote portions of the Report in separate AHIP authored documents. Wakely requests the opportunity to review these citations before publication and such approval shall be provided no later than two business days from Wakely's receipt of such citations.

This document and the supporting exhibits/files constitute the entirety of the actuarial report and supersede any previous communications on the project.

Tim Courtney, FSA, MAAA	Rachel Stewart, ASA, MAAA
Principal and Senior Consulting Actuary	Senior Consulting Actuary
727-259-7480	(727) 259-7478
timc@wakely.com	rachel.stewart@wakely.com

Founded in 1999, Wakely Consulting Group, an HMA Company, is well known for its top-tier healthcare actuarial consulting services. With nine locations nationwide, Wakely boasts deep expertise in Medicare Advantage, Medicaid managed care, risk adjustment and rate setting, market analyses, forecasting, and strategy development. The firm's actuaries bring extensive experience across all sectors of the healthcare industry, collaborating with payers, providers, and government agencies.

Wakely.com