Medicare

60 Years of Transformation

September 29, 2025 / Amy Dunn and Stephen Murphy

Segal

Agenda

History of Medicare

Evolution of Medicare Advantage Plans

- National and regional growth
- Emerging issues

Challenges facing the Medicare and Medicaid Systems

- Financial Solvency
- Provider Accessibility
- Affordability

History of Medicare

What is Medicare?

Medicare is a federally run program that provides health coverage to U.S. Citizens and permanent residents who are:

- Aged 65 or older
- Disabled; or Diagnosed with End Stage Renal Disease (ESRD)

Today, more than 67 million Americans receive some sort of coverage through Medicare

History of Medicare

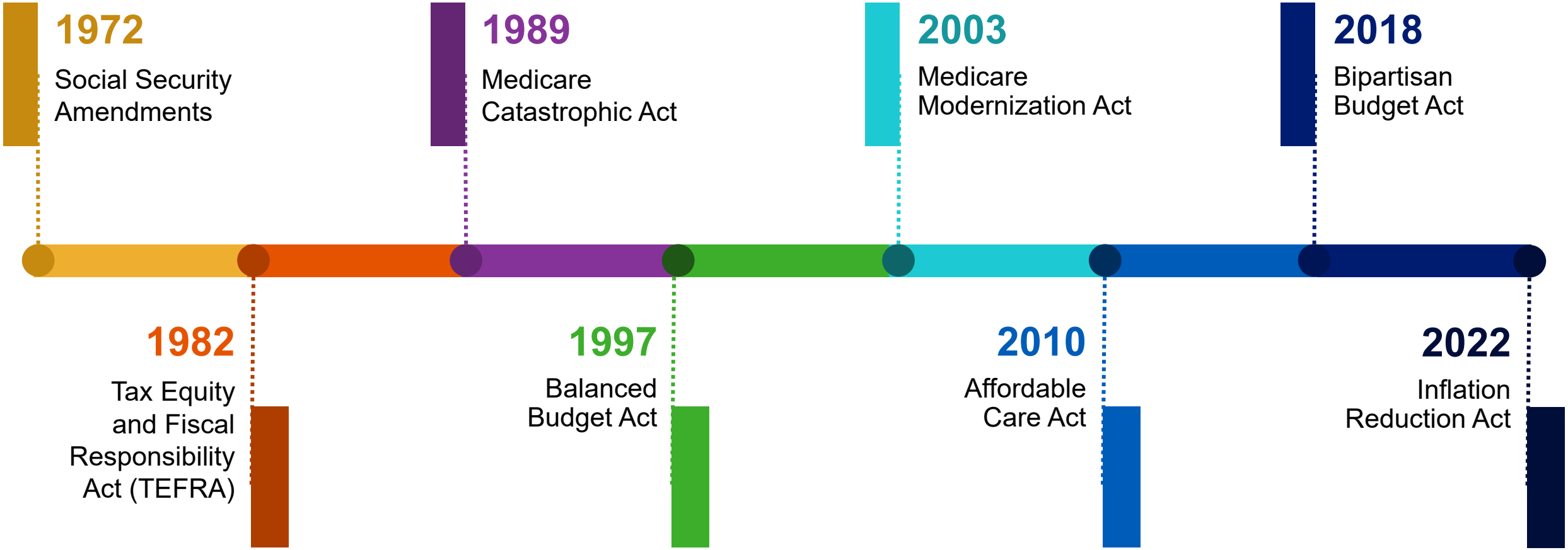
Medicare was signed into law in 1965, 60 years ago

Part A:
primarily covers hospitalization

Part B:
covers physician services

Original Medicare (Parts A and B) Does Not Cover

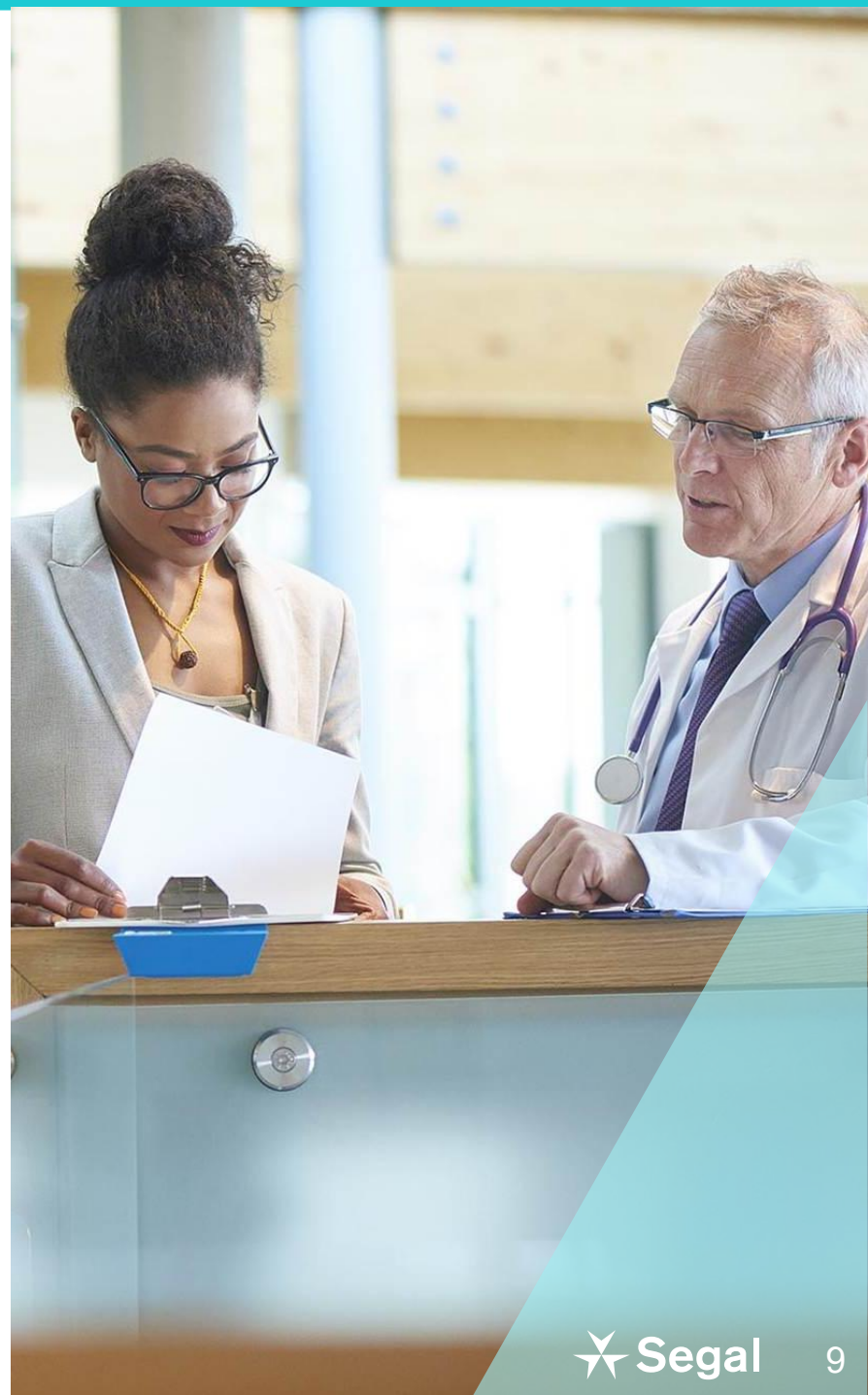
Key Legislative Moments



Evolution of Medicare Advantage

Evolution of Medicare Advantage

- The laws passed in 1972 expanded Medicare contracts to HMOs (known as prepaid plans) to provide Part A and Part B on a capitated basis
  - Plans could choose to be paid on a reimbursement basis or a “risk sharing” basis
- HMOs were required to provide the same services as Original Medicare
- These Medicare “HMO” demonstrations had mixed success



Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)

1 **Key takeaway**

formally expanded the use of risk contracting to pay providers

2 **Key takeaway**

The new rules provided a glimpse of the forthcoming Medicare Advantage program and the move toward the use of “risk adjustment”

3 **Key takeaway**

TEFRA’s rules also allowed for individuals to disenroll with a month’s notice, leading to losses to the Medicare program

However, plans were required to use payments in excess of projected costs for additional benefits beyond Original Medicare

Medicare Part C was formally established in 1997

1 **Key takeaway**

Enables beneficiaries to receive Medicare benefits through private health plans who contract with the Centers for Medicare and Medicaid.

2 **Key takeaway**

Introduced a new risk adjustment model

3 **Key takeaway**

Introduced the annual enrollment period

4 **Key takeaway**

Opened program to PPOs and Fee for Service plans

5 **Key takeaway**

Initially popular, the program saw a slowdown in growth

Medicare Modernization Act of 2003

1 **Key takeaway**

changes to MA program

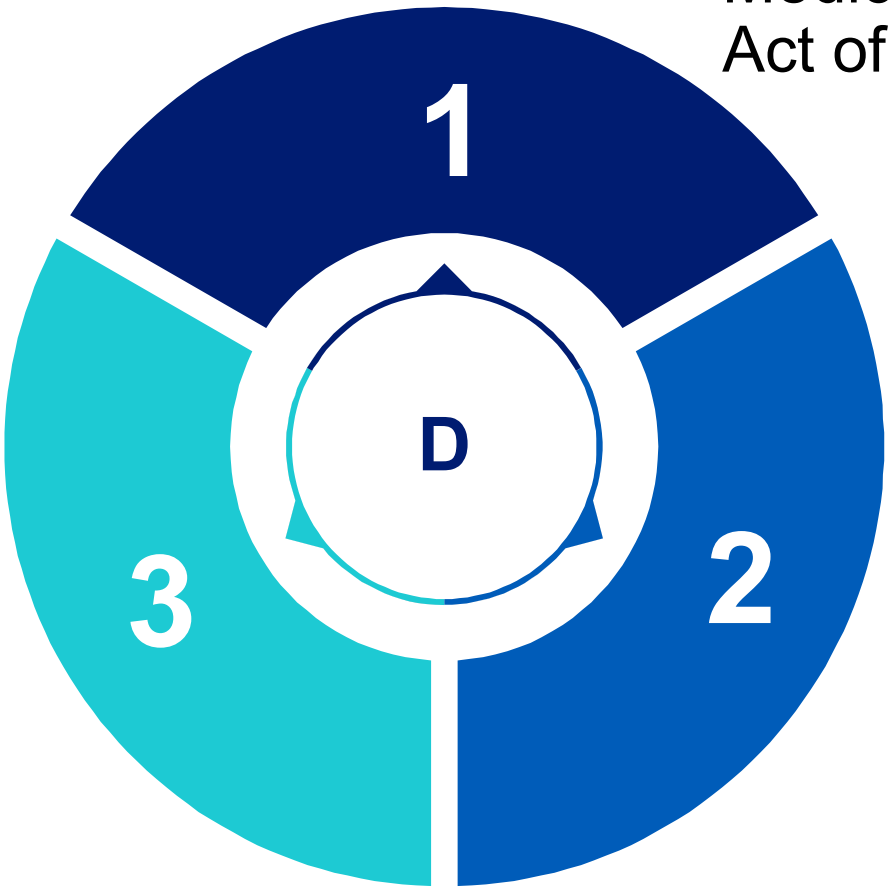
- Raised payment rates for Medicare Advantage Plans to attract more participation
- Established regional PPOs
- Established Special Needs Plans (SNPs)
- Updated benchmarks and introduced the competitive bidding process

2 **Key takeaway**

These reforms led to a sharp growth in plan participation

Medicare Part D

Established through the Medicare Modernization Act of 2003



Provides outpatient prescription drug benefits

Large reform of Part D program introduced in 2022 as part of the Inflation Reduction Act

Affordable Care Act of 2010

Key Takeaway

- Increased the amount of preventive services covered with no cost sharing
- Gradually reduced the Part D “donut hole”
- Introduced Medicare Advantage payment reforms
- Introduced Accountable Care Organizations and introduced the Center for Medicare and Medicaid Innovation (CMMI) to test alternative payment demonstrations
- Introduced Value Based Purchasing

Inflation Reduction Act

Key takeaway

Historic changes to Part D Plans

- Drug Price Negotiation
- Out-of-Pocket Insulin Cap of $35/month
- Out-of-Pocket Maximum Cap of $2,000
- Elimination of cost sharing for adult vaccines and catastrophic coverage
- Expanded low-income subsidies
- Limited increases to the base Part D premium

Growth of Medicare Advantage Plans

National and Regional Growth

National Growth

- MA enrollment is still growing, but at a slower pace than previously seen
- MA enrollment grew from 19% to 54% between 2007 and 2025
- Enrollment is highly concentrated among a small number of parent organizations
- CBO projects MA will cover 64% of beneficiaries by 2034

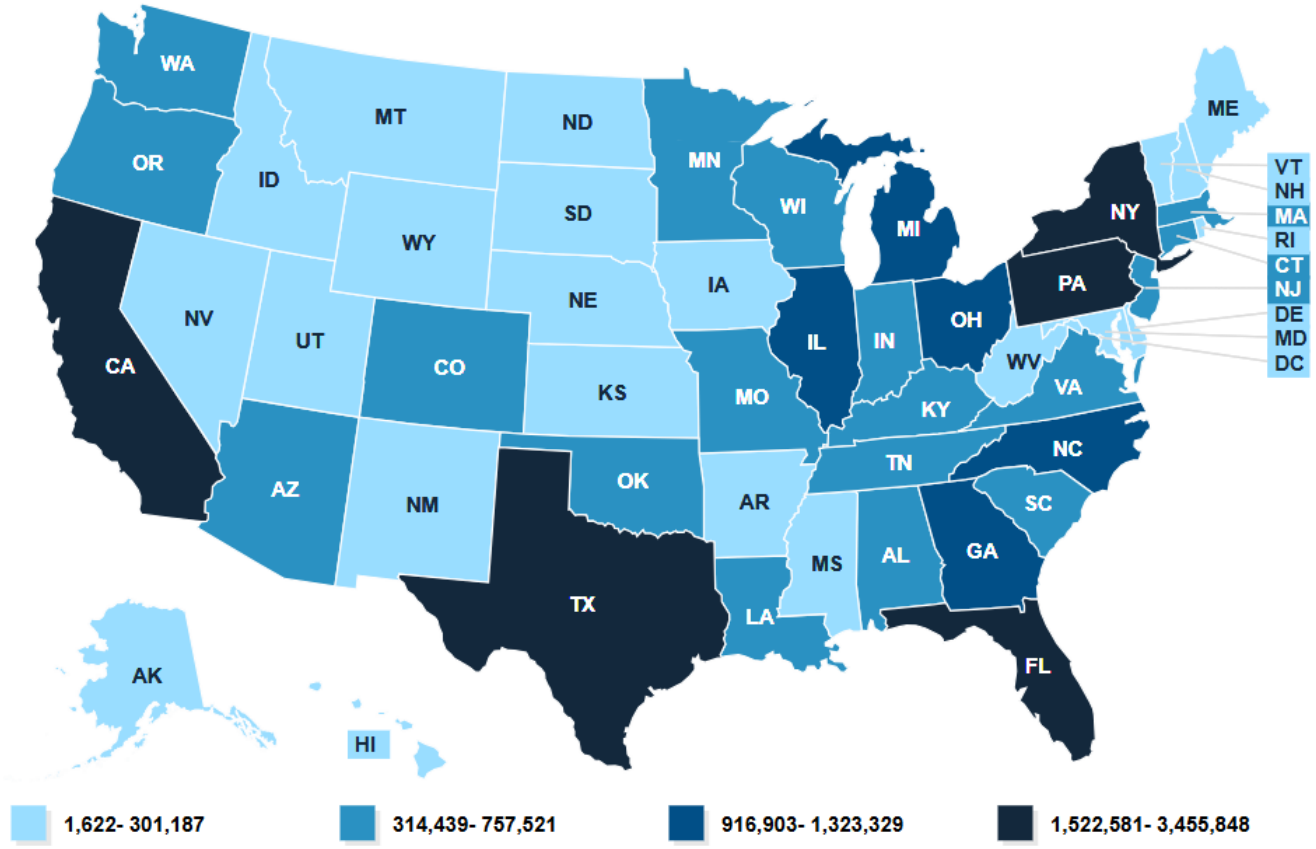
Regional Growth

- In the most rural counties, 58% Medicare Beneficiaries are covered by traditional Medicare
- Rural Californians have disproportionately low MA enrollment
- Provider choice remains very limited in rural areas, and specialty practices

Source: https://www.kff.org/medicare/medicare-advantage-enrollment-update-and-key-trends/

Medicare Advantage Enrollment Prevalence

California leads the country in Medicare Advantage Enrollment with nearly 3.5M enrollees, followed by Florida (2.9M) and Texas (2.5M)

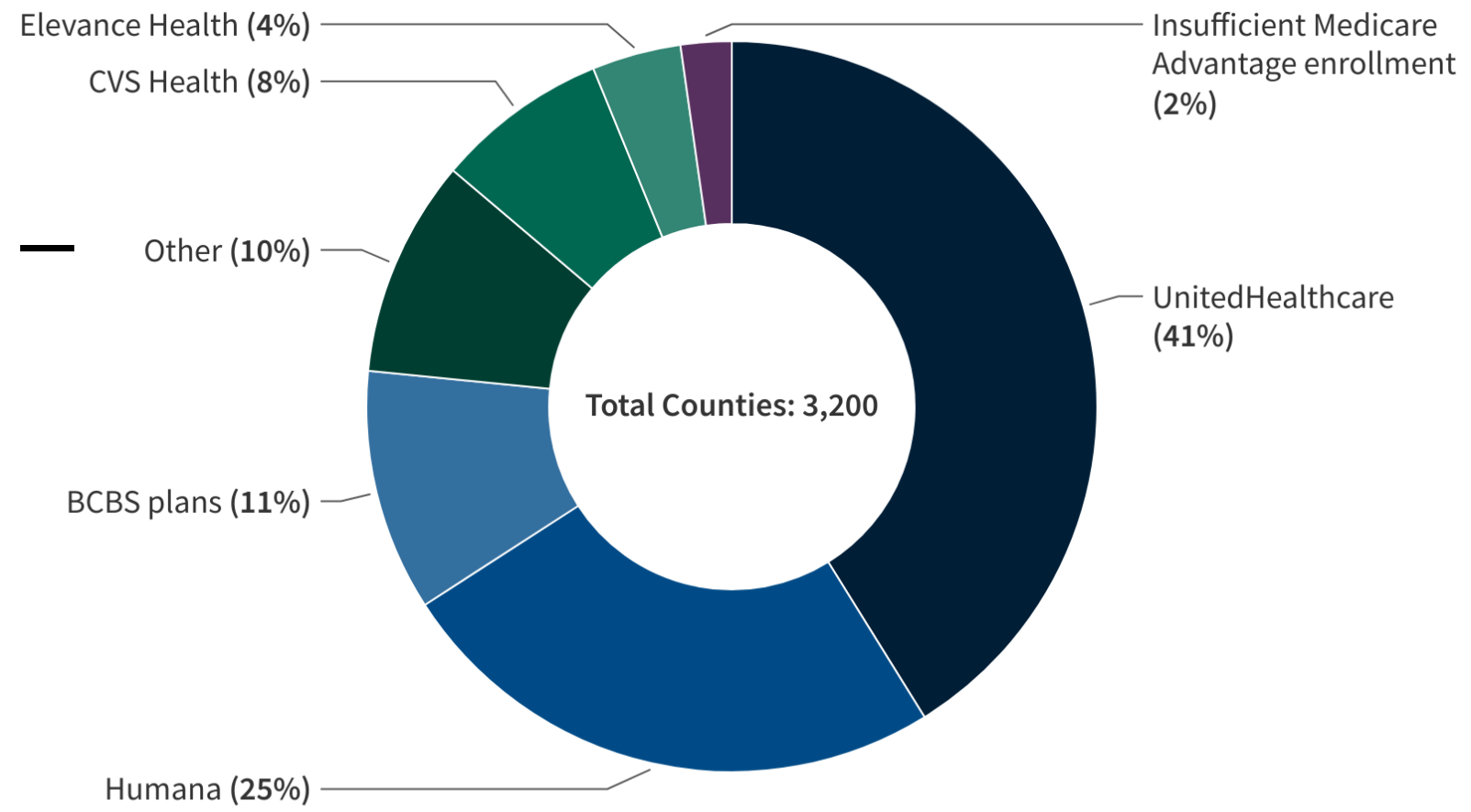


Source: https://www.kff.org/state-category/medicare/medicare-advantage/enrollment/

Medicare Advantage Enrollment Concentration Among Insurers – Nationally

In More Than Half of All Counties, UnitedHealthcare (41%) or Humana (25%) Was the Largest Medicare Advantage Insurer

Percent of counties where the given firm had the highest share of enrollment in Medicare Advantage in 2024



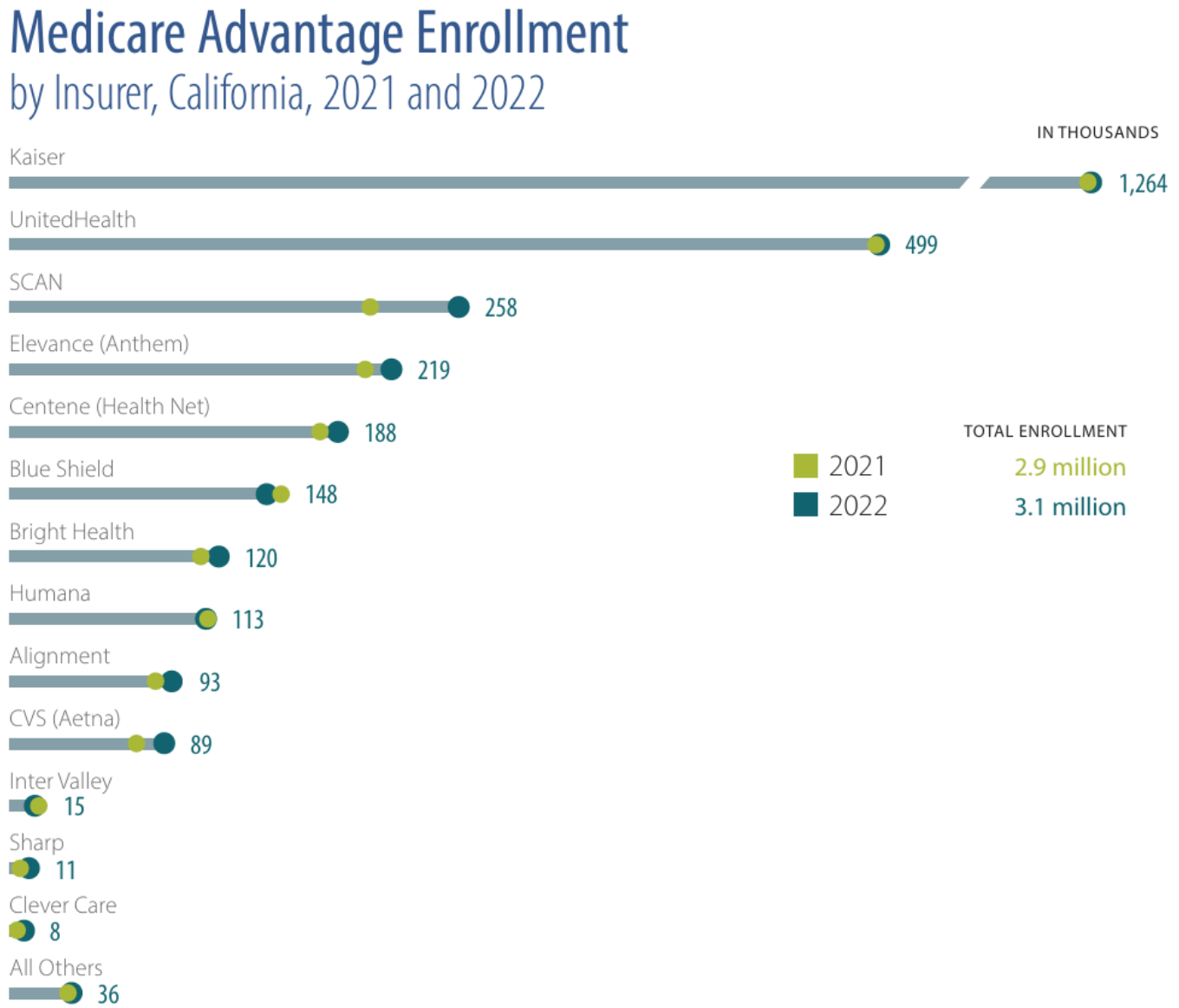
Note: Insurers representing less than 2% of counties were rolled up into the category of "Other."

Source: KFF Analysis of CMS Medicare Advantage Enrollment Files, 2010-2024

Medicare Advantage Enrollment Concentration Among Insurers – California

"Market penetration for Medicare Advantage was significantly lower in northern counties, while the southern parts of California often saw enrollment rates above 55 percent."

Source: https://www.newsweek.com/california-counties-see-drastically-different-medicare-advantage-enrollment-1937995



Notes: Enrollment as of December. Medicare Advantage is Medicare's managed care plan. *All others* includes plans with fewer than 7,000 Medicare enrollees in December 2022. *Humana* includes Arcadian Health Plan; *Centene (Health Net)* includes WellCare (formerly Easy Choice); *Bright Health* includes Central Health Plan and Universal Care. For details on groupings, see California Health Insurers Enrollment Almanac, 2023 — Data, available at "California Health Insurers, Enrollment - 2023 Edition." Total enrollment in 2022 increased by 5%, or 145,000, over 2021. See Appendix H for details, including market share.

Source: https://www.chcf.org/wp-content/uploads/2024/10/HealthInsurersAlmanac2024.pdf

Challenges Facing The Medicare and Medicaid Systems

Emerging Issues

Overpayment concerns

Prior authorization

Denials of service and slow care approvals

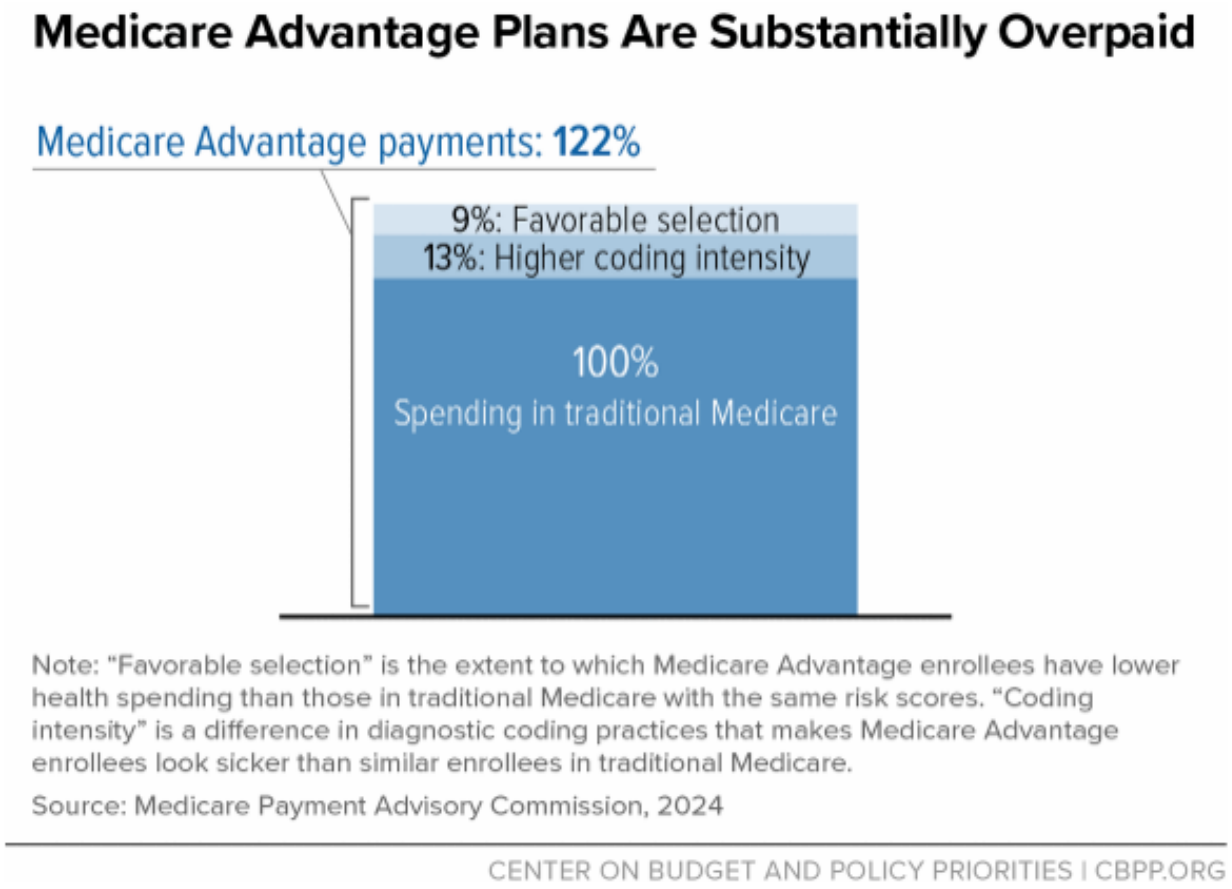
Upcoding

Example 1: A doctor includes a diagnosis that isn't actively being treated.

A patient with a history of prostate cancer, who is in remission, could be coded as having active prostate cancer, even though they haven't needed treatment in years. This adds a high-risk diagnosis that boosts payment, even though it doesn't reflect the patient's current health condition or spending.

Example 2: Making a common condition sound more serious.

A patient with uncomplicated diabetes might be labeled as having diabetes with chronic kidney problems based on a minor lab finding that wasn't clinically significant or noted by the treating physician. This moves the patient into a higher-paying risk group.



Source: https://sph.brown.edu/news/2025-06-09/medicode

Prior Authorizations and Denial of Services

A Senate subcommittee investigated and reported in 2024 the practices of the three largest MA insurance companies — UnitedHealthcare, Humana and CVS — of "intentionally using prior authorization to boost profits by targeting costly yet critical stays in post-acute care facilities."

Source: https://www.aha.org/news/headline/2024-10-17-senate-report-scrutinizes-medicare-advantage-prior-authorization-denials-post-acute-care-services#:~:text=A%20report%20released%20Oct.,care%20hospitals%2C%20among%20other%20findings.

Challenges Provider Accessibility

1. **Medicaid is facing a significant reduction in provider participation**

2. **Medicare Advantage plans also have provider network issues**

3. **Original Medicare**

Provider Network Issues

MA has limited provider networks that can change, sometimes leaving beneficiaries unable to keep their doctors. [1]

- This is especially true as health care systems around the country increasingly stop accepting MA insurance contracts.
- Patients with traditional Medicare face no such limitations and can use any doctor who accepts Medicare.

[1] Source: https://www.kiplinger.com/retirement/medicare/problems-with-medicare-advantage-plans-keep-mounting#:~:text=Provider%20network%20drawbacks.,use%20of%20artificial%20intelligence%20tools.

At least 41 hospital systems have dropped out of 62 Advantage plans serving all or parts of 25 states since July [2024], according to Becker's Hospital Review. Over the past two years, separations between Advantage plans and health systems have tripled. [2]

[2] Source: https://fortune.com/well/2025/04/24/medicare-advantage-patients-leave-plan-health-system-breakup/

Challenges Financial Solvency

1. **Medicare Hospital Insurance Trust Fund**
2. **Federal Spending Growth**
3. **State budget pressures**
4. **Post-COVID Medicaid determinations**

Financial Solvency

The One Big Beautiful Bill Act (OBBB) cut over $1 trillion from health programs to extend tax cuts that were first enacted in 2017.

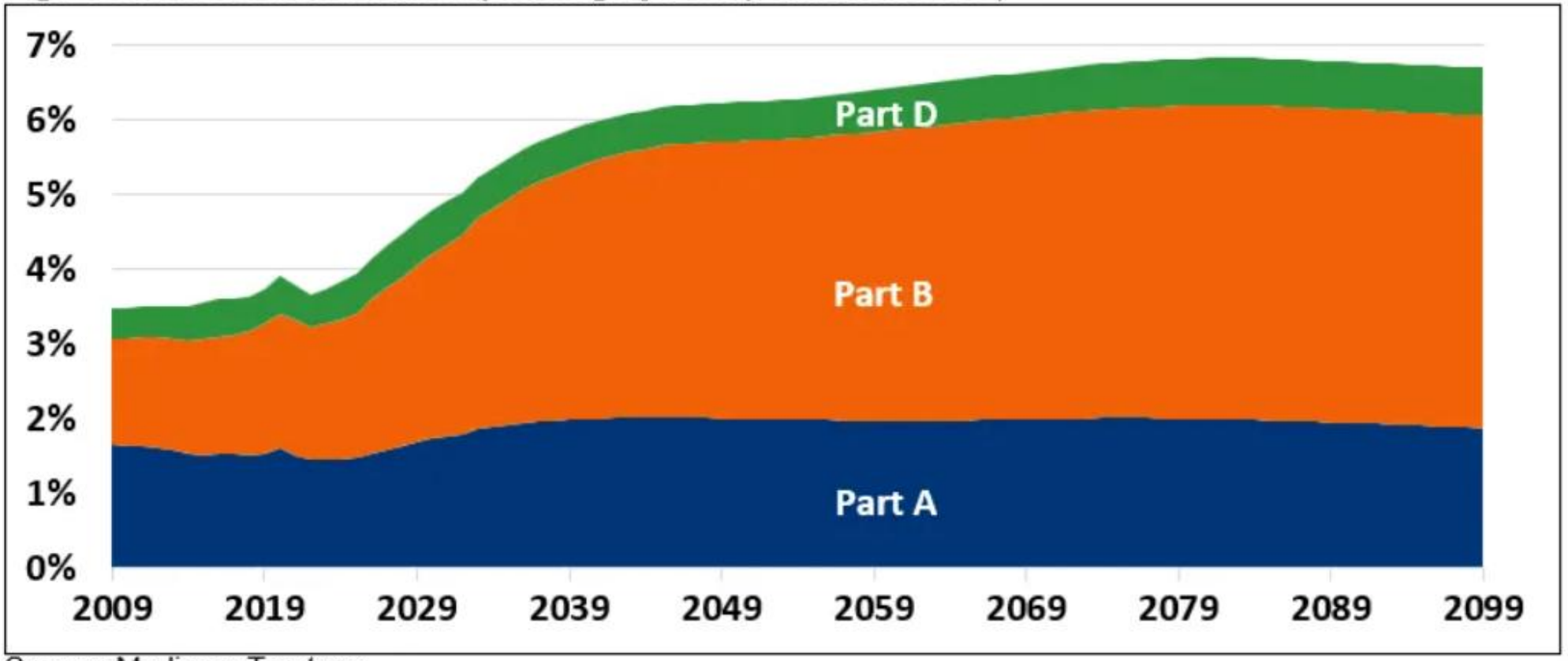
- Some of these cuts will speed up the timeline for when Medicare's Part A Trust Fund will become insolvent. If Congress takes no additional action, automatic spending cuts will be triggered, reducing Medicare funding by approximately $500 billion between 2026 and 2034.[1]
- To sustain Medicare for the long run, policymakers may consider adopting: [2]
  - reductions in payments to providers and plans or reductions in benefits, and
  - additional revenues, such as payroll tax increases or new sources of tax revenue

[1] Source: https://medicareadvocacy.org/impact-of-the-big-bill-on-medicare/
[2] Source: https://www.kff.org/medicare/faqs-on-medicare-financing-and-trust-fund-solvency/

Financial Solvency

- Part B continues to be the source of significant growth in spending.
- Some proposals to lower the growth are site-neutral payments and more MA oversight

Fig. 2: Total Gross Medicare Spending by Part (Percent of GDP)



Source: Medicare Trustees.

Medicare Income-Related Monthly Adjustment Amount (IRMAA)

- For higher income Medicare beneficiaries, Part B and Part D premiums include an additional charge based on the individual's modified adjusted gross income.
  - In 2025, Medicare individuals who earn over $106,000 per year are subject to IRMAA. ($212,000 per married couple)
- There is not a premium surcharge on Part A
- If an individual collects Social Security, the IRMAA amount is deducted directly from their Social Security benefits
- Medicare will announce the 2026 IRMAA amounts in the 4th quarter of 2025.
- The Medicare Trustees Report projected the Part B surcharges to increase by 1.04% and Part D surcharges may increase by close to 6%.

Medicare Income-Related Monthly Adjustment Amount (IRMAA)

Modified Adjusted Gross Income (MAGI)	Part B Premium	Part D Premium
Individuals less $106,000 Married $212,000 or less	2025 standard premium = $185.00	Plan premium
Individuals $106,000 up to $133,000 Married above $212,000 up to $266,000	Standard premium + $74.00	Your plan premium + $13.70
Individuals $133,000 up to $167,000 Married above $266,000 up to $334,000	Standard premium + $185.00	Your plan premium + $35.30
Individuals $167,000 up to $200,000 Married $334,000 up to $400,000	Standard premium + $295.90	Your plan premium + $57.00
Individuals $200,000 and less than $500,000 Married $400,000 and less than $750,000	Standard premium + $406.90	Your plan premium + $78.60
Individuals above $500,000 Married above $750,000	Standard premium + $443.90	Your plan premium + $85.80

Medicare Drug Price Negotiation Program

Negotiation eligible drugs include brand-name drugs and biologics

- The following are excluded from negotiation:
  - Drugs that have a generic or biosimilar available
  - Drugs less than 9 years (for small-molecule drugs) or 13 years (for biological products) from their FDA-approval or licensure date
  - Drugs that account for Medicare spending of less than $200 million in 2021
- Limits the total number of drugs to be negotiated to:
  - 10 Part D drugs in January 2026
  - 15 more Part D drugs in 2027
  - 15 more Part D or Part B drugs in 2028
  - 20 more Part D or Part B drugs in 2029 and later
- Manufacturers that do not follow the negotiation rules for the selected drugs will pay a tax and potential penalties
- Hope is that this will reduce long-term prescription drug trends, but it will likely take years to know the impact
- CMS estimates Medicare beneficiaries will save $1.5 billion when the first 10 Part D drugs take effect in 2026.
- The 15 drugs selected for the second round of price negotiation were used by 5.3 million Medicare beneficiaries between November 2023 and October 2024, potentially leading to much larger estimated cost savings in 2027.
- Since the law does not apply to the non-Medicare population, manufacturers may increase prices for those groups to offset decreases on Medicare

Medicare Drug Price Negotiation Program

For 2027…[the] 15 [targeted] drugs include the popular diabetes and obesity drugs Ozempic and Wegovy, along with other drugs used to treat asthma and chronic obstructive pulmonary disease, type 2 diabetes, prostate and breast cancer, and other conditions.

Drug name	Manufacturer	Used for	Total Gross Medicare Spending*	Number of Medicare Part D Users*
Ozempic; Rybelsus; Wegovy	Novo Nordisk	Type 2 diabetes; Type 2 diabetes and cardiovascular disease; Obesity/overweight and cardiovascular disease	$14.4B	2,287,000
Trelegy Ellipta	GlaxoSmithKline	Asthma; Chronic obstructive pulmonary disease	$5.1B	1,252,000
Xtandi	Astellas Pharma Inc.	Prostate cancer	$3.2B	35,000
Pomalyst	Bristol Myers Squibb	Kaposi sarcoma; Multiple myeloma	$2.1B	14,000
Ibrance	Pfizer	Breast cancer	$2B	16,000

Source: https://www.kff.org/medicare/faqs-about-the-inflation-reduction-acts-medicare-drug-price-negotiation-program/?entry=table-of-contents-how-many-and-which-types-of-drugs-qualified-for-price-negotiation-for-2027

Thank You