Medicare Policy in 2025: Analysis of P.L. 119-21

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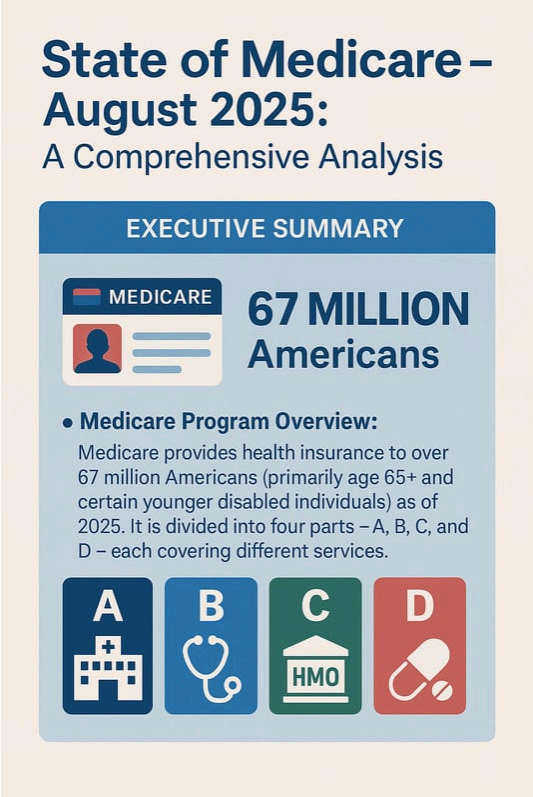

State of Medicare – August 2025: A Comprehensive Analysis

Executive Summary

- **Medicare Program Overview:** Medicare provides health insurance to over **67 million** Americans (primarily age 65+ and certain younger disabled individuals) as of 2025. It is divided into four parts – **A, B, C, and D** – each covering different services. Part A (Hospital Insurance) covers inpatient care, Part B (Medical Insurance) covers outpatient/physician services, Part C (Medicare Advantage) offers a private plan alternative, and Part D covers prescription drugs. Eligibility generally begins at 65 (with earlier eligibility for disabilities/ESRD), and each part has specific enrollment rules and cost-sharing structures. Providers and insurers participating in Medicare must adhere to federal standards for access, quality, and billing.

- **Major 2025 Legislative Changes (Public Law 119-21):** In July 2025, the **One Big Beautiful Bill Act (OBBB)** was enacted (P.L. 119-21), implementing budgetary changes through the budget reconciliation process. This law extended certain tax provisions and modified federal spending on healthcare programs. It introduced **policy modifications**, including implementing Medicaid work requirements and funding caps, blocking a planned expansion of Medicare Savings Programs, and *potentially* triggering across-the-board Medicare payment cuts (via sequestration) due to deficit impacts medicareadvocacy.org. The changes affect coverage for low-income seniors and nursing home residents, while also impacting Medicare's fiscal outlook.

- **Medicare Advantage Developments:** Medicare Advantage (Part C) enrollment has continued to rise in 2025, now encompassing **54%** of Medicare beneficiaries. Enrollment growth has slowed somewhat (4% growth from 2024 to 2025), but MA remains on track to cover a majority of beneficiaries in coming years. **Payment to MA plans** averages about 20% higher per enrollee than Traditional Medicare, adding an estimated **$84 billion** in extra spending in 2025. Policymakers are scrutinizing these costs, and CMS has issued new regulations for 2025 to improve plan accountability – including **standardized broker commissions** (to curb biased marketing), stricter oversight of **prior authorization** and network adequacy (especially for behavioral health), and requirements for more transparency around supplemental benefits. Plans are innovating with extra benefits (e.g. dental, vision, transportation) and specialized care programs, but also face pressure to contain costs and maintain quality networks.

- **Prescription Drug Reforms (Part D):** The **Inflation Reduction Act of 2022** ushered in significant drug pricing reforms now taking effect. In 2025, Medicare **caps Part D out-of-pocket spending at $2,000** annually, eliminating the unlimited cost exposure that existed previously. This cap is projected to benefit about 11 million enrollees by substantially reducing their pharmacy costs. Additionally, drug manufacturers are now required to pay Medicare **inflation rebates** if they raise drug prices faster than inflation, tempering price hikes. Medicare is also preparing to **negotiate prices** for high-cost drugs (with the first negotiated prices for 10 drugs to take effect in 2026). Part D plans have adjusted to these changes with slight premium increases (capped by a stabilization program) and modifications to formularies and cost-sharing designs. Moreover, Part D now provides **insulin at no more than $35/month and free recommended vaccines**, improving affordability for beneficiaries.

- **Medicare Financial Outlook:** Medicare's finances face mounting strain. The **Hospital Insurance (Part A) Trust Fund** is now projected to become insolvent in **2033**, three years sooner than previously estimated. Insolvency means the fund will only be able to pay ~89% of Part A costs unless changes are made. The acceleration is due in part to higher spending (e.g., inpatient care and Medicare Advantage payments) and slower revenue growth. Parts B and D (Supplementary Medical Insurance), which are funded by general revenues and premiums, remain solvent by design but their **cost growth outpaces inflation**, increasing pressure on beneficiaries and taxpayers – in 2024, premiums and cost-sharing for Part B/D consumed about **26% of the average Social Security benefit**. The 2025 budget law's deficit increases risk triggering a 4% Medicare spending sequester, though Congress is expected to avert that medicareadvocacy.org. To ensure long-term sustainability, policymakers are considering options like raising revenue (e.g., payroll taxes), reducing overpayments (particularly in Medicare Advantage), and delivery system reforms to improve efficiency.

Keywords: Medicare 2025, Medicare Advantage, Part D reform, Public Law 119-21, Medicare Trust Fund, Medicare insolvency, OBBB Act, inflation rebate, out-of-pocket cap, Medicare enrollment trends.

Introduction

Medicare is the nation's largest public payer for health care, serving older adults and people with disabilities. As of mid-2025, Medicare covers roughly one-fifth of all U.S. health care spending and about **12% of the federal budget**. Its importance to beneficiaries, providers, and taxpayers means that any change in Medicare's structure or financing has wide-ranging implications. This report provides an in-depth review of the **state of Medicare in August 2025**, a time marked by significant policy shifts and emerging challenges. It begins with a detailed overview of Medicare's four parts – A, B, C, and D – including how each part is structured, who is eligible, how enrollment works, what is covered, and what obligations providers or plans must fulfill.

Subsequently, the report analyzes major legislative developments, focusing on **Public Law 119-21 (enacted 2025)**, which introduced changes to health programs as part of a budget reconciliation package. We discuss the provisions affecting Medicare, implementation details, as

well as anticipated impacts on stakeholders and timelines. Following that, we turn to **Medicare Advantage (Part C)**, examining recent trends in enrollment, payment, plan innovation, and regulatory changes that are reshaping the Medicare Advantage landscape. We also delve into **prescription drug coverage (Part D)** reforms – highlighting how new policies on drug pricing (inflation rebates, out-of-pocket caps, and forthcoming price negotiations) aim to reduce costs for both beneficiaries and the Medicare program.

Finally, we assess Medicare's **financial outlook**, including the solvency of its trust funds and the program's fiscal trajectory. We incorporate the latest projections from the 2025 Medicare Trustees Report and other analyses to understand the sustainability of Medicare in the coming decade. Throughout the report, **charts and tables** are provided to illustrate key points – such as enrollment growth in Medicare Advantage and Medicare's spending trends – and extensive references to official sources (CMS, CBO, Trustees), legislative texts, and expert analyses are included to support the findings.

Medicare Part A (Hospital Insurance)

Coverage & Benefits: Medicare Part A covers inpatient hospital care, short-term skilled nursing facility (SNF) care, home health care related to a hospital stay, and hospice care for the terminally ill. For inpatient hospital stays, Part A helps pay for semi-private room, meals, general nursing, and related services and supplies. It also covers inpatient care in a SNF (following a qualifying hospital stay), limited home health visits, and hospice care (including support services for the patient and family). *Notably, Part A does not cover long-term custodial nursing home care beyond skilled rehabilitation needs.* Beneficiaries typically face a **deductible** for each hospital benefit period ($1,600 in 2023; slightly higher in 2025 due to inflation) and **coinsurance** for extended hospital or SNF stays (e.g., no copay for the first 60 hospital days, then a copayment per day for days 61–90, etc.). Hospice care under Part A generally has minimal cost-sharing.

Eligibility & Enrollment: Most people become entitled to Part A when they turn 65, provided they (or their spouse) have paid Medicare payroll taxes for at least 10 years (40 quarters). This entitles them to **premium-free Part A**. Individuals under 65 can also qualify for Part A after 24 months of receiving Social Security Disability Insurance (SSDI) benefits, or immediately upon diagnosis of End-Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis (ALS). Enrollment in Part A is usually automatic at age 65 for those already receiving Social Security benefits; others may need to sign up through Social Security. If a person or their spouse lacks 40 quarters of contributions, they can **buy into Part A** by paying a monthly premium (which in 2025 is roughly $506 for those with under 30 quarters, pro-rated lower for 30–39 quarters). There are specific enrollment periods (e.g., Initial Enrollment Period around one's 65th birthday, Special Enrollment Periods for those working past 65 with employer coverage, etc.), and late enrollment can result in a premium penalty.

Financing: Part A is financed mainly through the **Hospital Insurance Trust Fund**, which draws primarily from payroll taxes under the Federal Insurance Contributions Act (FICA). Employers and employees each pay 1.45% of wages (for a total of 2.9%), and higher-income earners pay an additional 0.9% Medicare tax on earnings above $200,000 (individual) or $250,000 (married) kff.org. In 2023, payroll taxes accounted for about 88% of Part A revenue kff.org. The trust fund is also fed by other sources like taxes on Social Security benefits, interest on trust fund investments, and premiums from people who buy Part A. Providers are paid under prospective payment systems – for example, hospitals receive a fixed payment per admission based on Diagnosis-Related Groups (DRGs), adjusted for factors like location and patient complexity.

Provider Participation & Obligations: Hospitals, SNFs, home health agencies, and hospice organizations must meet Medicare's **Conditions of Participation** to receive Part A payments. This includes compliance with health and safety standards, staffing requirements, and agreeing to **Medicare's payment rates**. Providers that accept Medicare (virtually all acute-care hospitals do) **must not charge beneficiaries more than allowed cost-sharing** and must submit claims to Medicare on the patient's behalf. For instance, a hospital cannot balance-bill a Medicare patient beyond the fixed deductible or coinsurance amounts. Providers are also subject to documentation requirements (e.g., a physician order and plan of care is needed for home health services under Part A). Importantly, because Part A services are typically **institutional**, beneficiaries usually do not have to actively select providers as long as they go to a Medicare-certified facility. That facility and its practitioners will bill Medicare directly. Hospitals and other Part A providers are paid on an assignment basis (accepting Medicare's payment as payment in full). In the case of hospice, providers must ensure that the patient elects the Medicare hospice benefit, at which point Medicare covers virtually all hospice services related to the terminal illness with very limited cost-sharing (like small copays for outpatient drugs and respite care). Providers under Part A are incentivized to contain costs due to the prospective payment; if they can provide care for less than the DRG payment, they may keep the difference (and conversely, they bear losses if costs exceed the payment), while maintaining quality under oversight such as Medicare quality reporting programs.

Medicare Part B (Medical Insurance)

Coverage & Benefits: Medicare Part B covers a broad range of **outpatient medical services**. This includes physician services (office visits, surgical services, etc.), outpatient hospital care, preventive services (such as screenings, annual wellness visits, and vaccinations like flu shots), diagnostic tests (e.g., X-rays, MRIs, blood tests), durable medical equipment (wheelchairs, walkers, home oxygen, etc.), ambulance services, and many other medically necessary services not covered by Part A. Part B also covers limited outpatient prescription drugs (for example, infused or injected drugs given in a clinic) and certain home health visits not preceded by a hospital stay. Preventive services under Part B are often covered **with no cost-sharing** (for those recommended by the U.S. Preventive Services Task Force), while most other Part B services require the beneficiary to pay a **20% coinsurance** after meeting an annual **Part B**

deductible ($226 in 2023; approximately $240 in 2025). There is **no cap on out-of-pocket spending** in Part B, which is why many beneficiaries obtain supplemental coverage (Medigap, retiree insurance, or Medicaid) to cover the 20% coinsurance.

Eligibility & Enrollment: Anyone who is **eligible for Part A** (whether premium-free or by purchase) is also eligible to enroll in Part B. In fact, Part B enrollment is required if one wants to enroll in Part A premium-free at 65 (unless still working with employer insurance, etc.), and it is also a prerequisite for Part C (Medicare Advantage). Enrollment in Part B is voluntary, and about 91% of all Medicare beneficiaries are enrolled in Part B (some choose to defer it if they have other coverage). If a beneficiary does not enroll in Part B when first eligible and lacks other creditable coverage, a **late enrollment penalty** (10% for each 12-month period of delay) may be added to their premium. Initial enrollment is typically at the same time as Part A. There are Special Enrollment Periods (SEP) for those who delay Part B due to employer-sponsored insurance, and a General Enrollment Period (Jan–Mar each year) for others who missed signing up, with coverage effective in July (rules as of 2025). Recent regulatory changes have aimed to simplify Part B enrollment and eliminate prior waiting periods, but the 2025 budget law placed a moratorium on implementing some of those streamlining measures (this is discussed in a later section).

Financing & Premiums: Part B is funded through the **Supplementary Medical Insurance (SMI) Trust Fund**, which, unlike Part A, does not have a dedicated payroll tax. About **71%** of Part B costs are financed by general revenues (federal income taxes), and about **27%** by beneficiary premiums (the remaining ~2% from sources like interest and fees) kff.org. Each year, Part B premiums are set to cover roughly 25% of the expected average costs for an aged beneficiary, and the government's general fund contributes the rest. In 2024, the standard monthly Part B premium is $174.70; for 2025 it is projected to increase modestly (exact figure determined in late 2024). High-income beneficiaries pay **income-related monthly adjustment amounts (IRMAA)** on top of the standard premium – for example, individuals with income above $103,000 (in 2025) pay higher premiums scaled up to 3.4 times the standard premium for the top bracket kff.org. Part B also has an annual deductible (which was $226 in 2023, indexed upward each year). General tax revenue financing means Part B does not face insolvency; however, it does trigger a Medicare funding warning if general revenue exceeds a threshold (which it has in recent years), indicating growing reliance on the federal budget.

Provider Payment & Obligations: Part B pays healthcare providers under various fee schedules and payment systems. The largest is the **Physician Fee Schedule** for doctors and practitioners, which assigns relative value units (RVUs) to services and is updated by Medicare annually. Medicare-participating providers **accept assignment**, meaning they agree to accept Medicare's approved amount as full payment (Medicare pays 80%, patient 20%). Over 95% of doctors who see Medicare patients are participating providers. Providers who do not accept assignment can charge patients up to **15% over Medicare's approved amount** (this is the **limiting charge** for unassigned claims), but this is relatively rare and not allowed in some states. For certain services like lab tests, Medicare pays 100% under Part B's Clinical Lab Fee Schedule (no patient cost).

Part B providers (e.g., physicians, physician assistants, nurse practitioners, therapists, medical equipment suppliers) must enroll in Medicare and meet program standards (for example, physicians must have a valid license and cannot be excluded due to fraud sanctions). They must also **avoid balance billing** beyond the allowed amounts and **submit claims** to Medicare. Moreover, providers are subject to quality reporting programs under Part B (such as MIPS – the Merit-based Incentive Payment System), which can adjust payments based on performance. Part B also covers services like **ambulance transport and durable medical equipment (DME)**; suppliers of DME must be Medicare-certified and often participate in competitive bidding programs in certain areas. In summary, Part B establishes a contractual-like obligation: providers adhere to Medicare rules and billing limits, and in return Medicare provides timely, standardized payments for services rendered.

Medicare Part C (Medicare Advantage)

Medicare Part C, or Medicare Advantage, is an alternative way for beneficiaries to receive their Medicare benefits through **private health plans** approved by Medicare. To enroll in Part C, a person must first be entitled to Part A and enrolled in Part B, and must reside in a plan's service area (most people join during their initial Medicare enrollment at 65 or during annual enrollment periods). Medicare Advantage plans include **health maintenance organizations (HMOs)**, **preferred provider organizations (PPOs)**, and other plan types that contract with networks of healthcare providers. These plans are required to cover all services that Original Medicare (Parts A and B) would cover, **at minimum**, and often provide additional benefits such as dental, vision, hearing, and wellness programs that are not covered by Original Medicare. Most Medicare Advantage plans also bundle in Part D prescription drug coverage.

Financing and Structure: Medicare Advantage is not financed by a separate trust fund; instead, the government pays each plan a **capitated monthly amount** for each enrollee. Funding for an enrollee's Part A benefits comes from the HI Trust Fund and Part B (and D) benefits from the SMI Trust Fund, effectively routing Medicare's funding through the plan kff.org. In 2023, nearly half of all Part A spending was for beneficiaries in Medicare Advantage plans rather than in Original Medicare kff.org. Beneficiaries enrolled in Part C must continue to pay the Part B premium, and many plans charge an additional plan premium (although a large share of MA plans have $0 premiums beyond Part B). Plans often have different **cost-sharing structures** (e.g., copays for doctor visits instead of the 20% coinsurance under Part B) and an annual limit on out-of-pocket costs, which Original Medicare lacks. In 2025, all Medicare Advantage plans are required to limit enrollees' in-network maximum out-of-pocket spending (MOOP) to $8,300 or less for Part A and B services, providing a protective cap.

Eligibility and Enrollment: Enrollment in Medicare Advantage is optional. Beneficiaries can choose to enroll in a private MA plan if one is available in their area. Nationwide, the average beneficiary has dozens of plan choices, offered by various insurance companies. Enrollment typically occurs when first eligible for Medicare or during the **Annual Election Period** (Oct 15 –

Dec 7 each year, for coverage starting Jan 1). There is also an **Open Enrollment Period** (Jan 1 – Mar 31) when existing MA enrollees can switch plans or return to Original Medicare. Certain qualifying events (moving, qualifying for extra help, etc.) may trigger Special Enrollment Periods. As of 2025, more than 34 million people (over 54% of Medicare beneficiaries) are in Medicare Advantage, reflecting its growing popularity. Medicare Advantage plans can include specialized plans such as **Special Needs Plans (SNPs)** tailored for people with Medicaid dual eligibility, chronic conditions, or those in institutions.

Coverage and Extra Benefits: By law, Medicare Advantage plans must cover all Part A and Part B services that Original Medicare covers (excluding hospice, which remains covered by Part A even for MA enrollees). Many plans offer additional benefits as a means of competition – common extras include routine dental care, eyeglasses, hearing aids, gym memberships, transportation to medical appointments, and over-the-counter item allowances. These supplemental benefits are funded through plan rebates (if a plan's bid to Medicare is below benchmark, the savings must be used on extra benefits or lower premiums for enrollees). In recent years, Medicare Advantage has also expanded allowed supplemental benefits to address **social determinants of health**. For example, certain chronically ill enrollees might get meal deliveries or home air quality equipment as a benefit. Plans have flexibility in package design, and beneficiaries should compare how each plan covers their needs (for instance, one plan may cover comprehensive dental care while another might not). Importantly, **urgent and emergency care** is covered by MA plans anywhere in the U.S., even outside the plan's service area, as required by law.

Provider Networks and Obligations: Unlike Original Medicare, which allows beneficiaries to use any provider nationwide that accepts Medicare, Medicare Advantage plans typically use **network** providers. Enrollees usually must get care from the plan's contracted doctors and hospitals (except emergencies or urgently needed care) to have full coverage. Providers who participate in Medicare Advantage must **contract** with the plan and adhere to its utilization rules and quality standards. For example, an MA plan may require prior authorization for certain procedures or referrals to see specialists (especially in HMOs), and network providers are generally required to obtain the plan's approval where applicable. Medicare Advantage plans are obligated by CMS to have **adequate networks** of providers (including primary care and specialists) within certain time-and-distance standards, to ensure enrollees have reasonable access to care. Plans must credential providers and can terminate providers for failing to meet quality or performance metrics (with notice to affected enrollees).

Providers in MA networks bill the plan (not Medicare directly) for services, and they typically **accept the payment terms negotiated in their contract** as payment in full. Out-of-network coverage depends on plan type: HMO plans usually *do not cover* non-emergency services from out-of-network providers at all (enrollees would pay full cost), whereas PPO plans may allow out-of-network use with higher cost-sharing. MA plans must also follow **marketing rules and consumer protections** set by Medicare: for instance, they must provide clear information about benefits and costs, and are now required to use standardized** communication about certain

benefits (to avoid misleading enrollees regarding supplemental benefits). They also must have an appeals process for denials that is aligned with Medicare's requirements, including independent review. In summary, Part C gives beneficiaries the option to receive care through managed care arrangements, with potentially lower out-of-pocket costs and extra benefits, but with **trade-offs in provider choice** and additional rules (like prior authorization) that both providers and patients must navigate. Recent regulatory changes (elaborated in the Medicare Advantage developments section) are strengthening oversight of how plans use tools like prior authorization to ensure they do not unduly restrict necessary care.

Medicare Part D (Prescription Drug Coverage)

Medicare Part D provides **outpatient prescription drug coverage** through private plans. Individuals on Medicare can get Part D by either joining a stand-alone **Prescription Drug Plan (PDP)** (which supplements Original Medicare) or by enrolling in a Medicare Advantage plan that includes drug coverage (an MA-PD). Part D is **voluntary**, but there are late-enrollment penalties to encourage timely enrollment. As of 2024, about **53 million** Medicare beneficiaries are enrolled in Part D plans (including both PDPs and MA-PDs), representing roughly 80% of all Medicare beneficiaries. (Most others have creditable drug coverage through sources like the VA or employer retiree plans.) Part D has dramatically improved access to medications for seniors and disabled beneficiaries since its inception in 2006.

Enrollment and Plan Choice: Part D plans are offered by private insurers and vary by region; beneficiaries choose a plan during their Initial Medicare Enrollment or during the Annual Open Enrollment Period (Oct 15 – Dec 7). In 2025, the average Medicare beneficiary can choose from **48 plans** with drug coverage, including around 14 stand-alone PDPs and additional MA-PD options. The number of stand-alone PDPs has been declining (464 PDPs nationwide in 2025, down 35% from the year prior), as more beneficiaries opt for MA-PD plans. Beneficiaries receiving the Part D **Low-Income Subsidy (LIS)** ("Extra Help") have their premiums and cost-sharing reduced or eliminated; about 3 million Part D enrollees get full LIS benefits as of 2024. Plans that qualify as **benchmark plans** offer basic coverage with premiums at or below a regional threshold so that LIS recipients can enroll with no premium. In 2025, there are fewer benchmark plans available than ever before (only 90 plans nationally), meaning some low-income enrollees have fewer $0 premium options and may need to switch plans to avoid paying premiums.

Coverage and Formularies: All Part D plans must cover a wide range of prescription drugs that Medicare beneficiaries commonly need, **including most drugs in certain protected classes** (notably, nearly all antidepressants, antipsychotics, anticonvulsants, immunosuppressants for transplant, anticancer drugs, and HIV/AIDS drugs must be covered). A plan's list of covered drugs is called its **formulary**, and plans have significant flexibility in formulary design as long as these minimum requirements are met. Formularies categorize drugs into **tiers** with different cost-sharing: for example, a typical plan might have tiers for preferred generics, generics,

preferred brands, non-preferred brands, and specialty drugs kff.org. Lower tiers have small copayments (or $0 for some generics), whereas higher tiers might have significant coinsurance (e.g., 25% or more for specialty medications). Plans can also manage utilization with tools like **prior authorization, step therapy,** and **quantity limits**, though such utilization management is not permitted for drugs in the protected classes in most cases.

The standard Part D **benefit structure** (defined by law) has four phases (note: these are being reformed as of 2025 – see below):

1. **Deductible** – in 2025, plans can have a deductible up to $545 (many plans set the maximum; some waive it for lower tiers).
2. **Initial Coverage** – after the deductible, the enrollee pays 25% coinsurance and the plan pays 75% until total drug costs reach a certain threshold.
3. **Coverage Gap** – historically, after reaching the threshold, enrollees entered the "donut hole" coverage gap where they paid a higher share. However, the ACA gradually closed this gap, and as of 2020 enrollees pay 25% in the gap (with manufacturer discounts for brand drugs covering 70%).
4. **Catastrophic Phase** – after an enrollee's *out-of-pocket spending* exceeds the annual out-of-pocket threshold (around $7,400 in total drug spend for 2023, which equated to about $3,100 in true out-of-pocket costs), they enter catastrophic coverage. Before 2024, in catastrophic phase Medicare paid 80%, plans 15%, and the enrollee continued to pay 5% coinsurance *with no upper limit*.

However, major **Part D redesign** measures from the Inflation Reduction Act are in motion. In 2024, the 5% coinsurance in catastrophic phase is eliminated (enrollees pay $0 after hitting the threshold). And starting in 2025, Part D will have a true **annual out-of-pocket cap of $2,000** for each enrollee. This fundamentally changes the above structure by ending enrollee cost-sharing above that amount. Plans and Medicare will cover 100% of drug costs beyond $2,000 (with new cost-sharing arrangements involving plan liability and manufacturer price discounts in the catastrophic phase). These reforms are detailed later in this report under drug pricing reforms, but in essence, **no Part D enrollee will pay more than $2,000 out-of-pocket in 2025 for covered drugs**, which is a significant protective benefit.

Financing: Part D is financed through the SMI Trust Fund, similar to Part B. General federal revenues cover about **73–75%** of Part D program costs, and enrollee premiums cover roughly **14–15%** (on average, base beneficiary premium $36.78 in 2025). Additionally, states contribute financing for Part D through monthly payments to Medicare (often called the "clawback") for dual-eligible beneficiaries, accounting for about 12–13% of Part D revenues. High-income Part D enrollees also pay an IRMAA surcharge on their premiums, ranging from about $12 to $76 extra per month in 2025, depending on income, which effectively increases the percentage of cost they cover kff.org. Notably, Medicare's subsidy for Part D includes **reinsurance payments** to plans for high-cost enrollees. In 2024, Medicare (taxpayer) reinsurance covered 80% of catastrophic drug costs; in 2025, this share will drop (Medicare's share reduces to 20% for brand drugs in catastrophic, as plans and manufacturers take on more). Part D spending has

been growing and is projected at about $137 billion in 2025 (before rebates), roughly 15% of total Medicare outlays.

Plan and Pharmacy Obligations: Part D plan sponsors must meet CMS requirements for formulary breadth, ** pharmacy access**, and beneficiary protections. They must contract with a sufficient number of pharmacies in their service area, including standard retail pharmacies, and offer convenient access (with rules ensuring rural and urban access standards). Many plans have **preferred pharmacy networks** offering lower co-pays if used. Plan sponsors also have to operate **Medication Therapy Management (MTM)** programs to assist enrollees with multiple chronic conditions and high drug costs, in order to optimize their medication regimens. Plans are required to handle **exceptions and appeals**: if a drug is not on the formulary or is restricted, enrollees and their doctors can request an exception for coverage, and if denied, appeal to independent reviewers. Part D plans must comply with formulary review by CMS (each year CMS reviews and approves plan formularies for adequacy and nondiscrimination). They also report data on coverage determinations and appeals to ensure compliance.

Pharmacies participating in Part D networks must accept the plan's reimbursement rates as payment in full (aside from any enrollee copay) and cannot charge extra. Part D's structure also involves **manufacturers**: for example, in the coverage gap, manufacturers of brand-name drugs are required to provide a 70% discount which counted toward the enrollee's out-of-pocket threshold (this is adjusted in 2025 with the new discounts in catastrophic phase). Providers (prescribers) in Part D mainly interact by prescribing medications, but they may need to assist in prior authorizations or formulary exception justifications as required by plans. In terms of program integrity, Part D sponsors must have compliance programs to prevent fraud and abuse (such as improper prescribing or pharmacy billing). Overall, Part D's obligations for plans and providers aim to balance cost management with ensuring beneficiaries have access to necessary medications. Recent improvements – like capping insulin at $35/month and making adult vaccines free – illustrate how the program is evolving to provide better value and protection to enrollees.

2025 Legislative Update: Public Law 119-21 (Budget Reconciliation Act)

On July 4, 2025, **H.R. 1 – the "One Big Beautiful Bill Act" (OBBB)** became **Public Law 119-21**. This legislation was advanced through the budget reconciliation process, which focused primarily on taxing and spending provisions. The law's objectives included extending certain tax provisions from 2017, funding various priorities, and addressing federal deficits while adhering to reconciliation rules that mandated budgetary impacts. To offset costs, the law introduced **spending modifications**, with a focus on health care programs like Medicaid, Marketplace subsidies, and to a lesser degree, Medicare.

Key Provisions Affecting Medicare and Health Programs

Medicaid and ACA Changes: Although Medicare is the focus of this report, the context of P.L. 119-21 includes massive changes to **Medicaid** and the Affordable Care Act (ACA) insurance Marketplaces, which indirectly affect many low-income seniors and people with disabilities (including those also on Medicare). Notable Medicaid provisions include:

- **Medicaid Work Requirements:** OBBB requires many adult Medicaid beneficiaries to complete **80 hours per month of work or community engagement** to maintain coverage, with states losing federal funds for non-compliance. CBO estimated this could cut millions from Medicaid rolls. Work requirement policies in Arkansas and other states have previously shown that large numbers lost coverage due to reporting hurdles rather than gaining employment.
- **Frequent Eligibility Re-Determinations:** States must increase the frequency of Medicaid eligibility checks (some as often as every 6 months). Historically, such frequent checks lead to coverage losses *even among eligible individuals* (so-called "administrative churn").
- **Funding Mechanism Restrictions:** The law **prohibits new provider taxes** or rate assessments that states often use to fund their Medicaid share, and phases down existing provider taxes over several years. It also limits certain supplemental payments in Medicaid managed care. These changes force states to either find alternative funding or cut services. Justice in Aging projected that **optional benefits** like Home and Community-Based Services (HCBS) are likely targets for state cuts due to these funding constraints.
- **Eligibility and Enrollment Rule Rollback:** A 2024 CMS rule intended to streamline Medicaid and CHIP enrollment (e.g., by simplifying documentation and expanding automatic renewals) is put on hold through 2034. This preserves onerous paperwork requirements that cause eligible people (including low-income seniors) to lose coverage.
- **Long-Term Care Eligibility Tightening:** Effective 2028, the law lowers the allowable home equity for Medicaid nursing home coverage to $1000,000 (no inflation indexing) from a higher level (about $688,000–$1,038,000 in 2025, varying by state). This means individuals with home equity above the new cap will not qualify for Medicaid long-term care unless they sell or borrow against their homes, which could particularly hit older adults in regions with high home values.
- **ACA Subsidy Cliff:** P.L. 119-21 allows the enhanced ACA premium tax credits (enacted in 2021) to expire at the end of 2025 without extension. This will significantly raise premiums for millions of Marketplace enrollees in 2026 unless new legislation intervenes. CBO projected about **5 million people** would lose health insurance as a result of the subsidy rollback alone.

These Medicaid/ACA provisions, taken together, represent modifications of roughly $900 billion in federal Medicaid spending over 10 years, affecting insurance coverage levels. This broader context matters for Medicare because changes in Medicaid or Marketplace coverage may affect care patterns and medical debt, impacting hospitals and providers that also serve Medicare patients.

Medicare-Specific Provisions: While the law's Medicare changes were not as sweeping as Medicaid's, several targeted provisions will impact Medicare beneficiaries and providers:

- **Medicare Savings Programs (MSP) Rule Freeze:** The law imposes a *nine-year moratorium* (through 2034) on implementing a recent rule designed to increase enrollment in Medicare Savings Programs. MSPs (including QMB, SLMB, QI) help low-income Medicare beneficiaries by paying their Part B premiums and cost-sharing. The 2024 streamlining rule would have automatically identified and enrolled more eligible people (by aligning MSP criteria with Medicaid MAGI rules, for instance). By blocking this, the law effectively **prevents an estimated 1.3 million low-income seniors and people with disabilities from gaining this financial assistance**. These individuals will continue to pay Part B premiums (deducted from Social Security) and co-pays they cannot afford, likely causing some to forgo care or medications. CBO tallied this as a cost *savings* of $66 billion over 10 years – which from the beneficiary perspective represents $66 billion more in out-of-pocket costs borne by vulnerable populations.

- **Nursing Home Staffing Standards Delay:** The law blocks a recently finalized Medicare/Medicaid regulation that would set minimum staffing requirements in nursing homes. Specifically, it prohibits CMS from implementing or enforcing the **national nursing home minimum staffing rule** (proposed in 2024) until September 30, 2034. That rule would have required facilities to have a Registered Nurse on duty 24/7 and to meet certain nurse-to-resident ratios. By halting it, the law removes a federal mandate aimed at improving care quality. Proponents of the rule argued adequate staffing is critical to prevent neglect; CMS had cited evidence that understaffing leads to higher risks of injuries, infections, and deaths. With the moratorium, nursing homes – especially those that struggle to staff – avoid federal penalties for low staffing, but **resident advocates warn** that this will perpetuate substandard conditions. An estimated 13,000 lives *per year* could be lost due to inadequate staffing, according to analyses mentioned by advocacy groups. (It's noted that parts of the staffing rule were already challenged in court by the nursing home industry, but P.L. 119-21 preemptively stops the rule's enforcement even if it survives legally).

- **Medicare Payment Sequestration (PAYGO):** Because the OBBB increases the deficit by roughly **$3.4 trillion** over 10 years (mainly due to foregone tax revenue), it triggers the **Statutory Pay-As-You-Go Act** of 2010. That law requires that new legislation not increase the deficit over 5- and 10-year windows, or else automatic cuts ("sequestration") are applied to certain mandatory programs. Medicare by statute can only be cut a maximum of 4% via this mechanism. Absent congressional waiver, starting in **FY2026 Medicare payments to providers would be reduced by 4%**. Over 2026–2034, this would mean about a **$500 billion reduction in Medicare outlays** medicareadvocacy.org. In practical terms, a 4% cut would hit Part A and B provider payments and Part D plan payments (but not affect beneficiary premiums or cost-sharing directly). This threat is taken seriously by providers (who already operate under a separate 2% Medicare sequestration since 2013), but in the past Congress has **consistently acted to waive PAYGO sequestration for Medicare**. Indeed, the expectation in 2025 is that lawmakers will avert these cuts as the impacts (e.g., across-the-board hospital and physician pay cuts) would be politically and practically untenable. The OBBB itself did not include such a waiver (as that would violate Senate reconciliation rules), so a separate legislative action is needed by end of 2025. The uncertainty, however, adds financial caution for providers and Medicare Advantage plans bracing for potential payment slowdowns.

- **Medicare Drug Price Negotiation Limitations:** The Inflation Reduction Act's new drug price negotiation program (set to begin in 2026) was slightly pared back by P.L. 119-21. The law **exempts "orphan drugs"** – drugs that have FDA orphan designation for rare diseases and have no non-orphan indications – from being selected for Medicare price negotiation. Originally, even orphan drugs could be picked if they met the criteria (top spending and beyond a certain years on market) unless they only had one orphan indication. This exemption potentially shields some very high-cost drugs (for rare diseases) from future price discounts under Medicare. While intended to protect innovation for rare conditions, it could also encourage manufacturers to seek orphan status to avoid negotiation. This carve-out means Medicare's ability to **restrain costs for certain expensive therapies** (some costing hundreds of thousands per patient) is limited, possibly shifting more cost to the program and beneficiaries. Aside from this, the law did not overturn the IRA's negotiation authority, which is scheduled to proceed for other drugs.

In summary, Public Law 119-21 represents a shift in health policy implementation, emphasizing modified spending approaches and revised program eligibility criteria. The law focuses on budgetary adjustments and program administration changes. CBO estimates indicated changes in insurance coverage across Medicaid and ACA markets, and Medicare's Chief Actuary noted that the deficit impact could affect the Part A Trust Fund's projected solvency date.

Expected Impact on Stakeholders

- **Medicare Beneficiaries:** Directly, the changes to MSP enrollment will affect a subset of Medicare beneficiaries – primarily **low-income seniors**. Over a million low-income beneficiaries may not receive assistance with premiums and co-pays, which could lead to difficult choices between affording health care vs. other necessities. Indirectly, Medicare beneficiaries could feel impacts from the Medicaid and ACA modifications: for example, an older adult whose younger family members experience Medicaid changes may face greater family financial strain or lose access to spousal Medicaid nursing home coverage. If state Medicaid programs modify **optional benefits like dental, vision, hearing (which Medicare doesn't cover)**, dual-eligible Medicare beneficiaries could find those services harder to access, affecting their overall health.

- **Healthcare Providers:** Hospitals, physicians, and other providers anticipate **higher uncompensated care loads** as millions lose Medicaid or exchange plan coverage. Emergency departments may see more uninsured patients. Nursing homes avoiding mandated staffing may have short-term relief in labor costs, but could face continued scrutiny over care quality and possibly more lawsuits or state-level regulations in absence of the federal rule. For Medicare providers specifically, the specter of a 4% Paygo cut is concerning – it would compound the existing 2% sequester, totaling a 6% reduction in 2026. While likely to be waived, the uncertainty might cause providers to be cautious in expenditures and investments. If the cut were to happen even briefly, it could affect Medicare participation in the short run. Additionally, some physicians may see changes in their Medicare patient populations based on the new eligibility criteria, potentially affecting practice revenue. Rural and safety-net hospitals are also at risk: Medicaid cuts reduce their revenue (since Medicaid expansion populations shrink), and if Medicare eventually enforces cuts or if more uninsured turn to ER care, these hospitals' finances could worsen.

- **Insurers and Plans: Medicare Advantage organizations** came out relatively unscathed in P.L. 119-21 – the law did not directly cut MA benchmarks or risk adjusters (despite some bipartisan calls to address MA overpayments). In fact, by removing the ACA enhanced marketplace subsidies after 2025, the law could indirectly push some near-retirees (age 64) to consider Medicare enrollment if they lose affordable ACA coverage, potentially *increasing* Medicare (and MA) enrollment slightly. However, insurers who offer Medicaid managed care and Marketplace plans will see enrollment drops and revenue losses in those lines. For Part D plan sponsors, the orphan drug exemption from negotiation could be a double-edged sword: on one hand, it preserves manufacturer revenues (and thus perhaps maintains broad drug availability), but it also means plans won't benefit from negotiated lower costs on some high-priced drugs, which could keep Part D spending (and premiums) higher than otherwise. Insurers also are wary that the law's massive deficit increase might create pressure for future **Medicare payment reforms** – for instance, MA plans worry that MedPAC and others will double down on proposals to trim plan payments to extend the trust fund, which could be enacted in future years to offset the law's debt impact.

- **State Governments:** States will shoulder new administrative burdens and costs due to the Medicaid changes. They must implement work requirement tracking systems, more frequent eligibility verifications, and adjust to reduced federal matching funds via provider taxes. Many state officials expressed concern that the law "forces states to impose burdensome red-tape" and essentially shifts costs to states. Some states may respond by tightening Medicaid eligibility or cutting provider payments to stay within budgets, which can have spillover effects on the healthcare workforce and infrastructure that also serves Medicare patients. States also might see increased demand for state-funded or charitable health programs as federal coverage recedes. Conversely, a few states that ideologically align with the work requirements may welcome the law, seeing it as an opportunity to reduce Medicaid rolls and costs.

Implementation Timeline and Transition

The OBBB's provisions phase in on various schedules:

- **Immediately Effective (July 2025):** Medicaid work requirements became available for states to adopt October 2025 (with some needing waiver approvals). The ban on implementing the Medicare MSP rule and the Nursing Home staffing rule took effect upon enactment (July 2025). The new Medicare eligibility criteria began immediately upon enactment.

- **2026:** By mid-2026, SSA will review current Medicare beneficiaries based on the new eligibility criteria and send appropriate notices for any coverage changes effective January 1, 2027. Medicare's potential sequester cuts (4%) would activate in early 2026 if not addressed through legislative action. Also in 2026, ACA marketplace enrollees will be notified of subsidy modifications for the 2027 plan year.

- **2027:** Medicare coverage changes based on new eligibility criteria take effect on **January 1, 2027**. There is an 18-month implementation window that allows for potential legislative adjustments to these provisions.

- **2028 onwards:** The **Medicaid provider tax cap reduction** starts in FY2028, gradually lowering the allowable tax rate by 0.5% per year until 2032. The home equity asset test for Medicaid long-term care takes effect January 1, 2028. Medicaid coverage re-determination rules and work requirements will likely be in effect in multiple states by 2026–2028, so coverage loss impacts will ramp up through those years. ACA enhanced subsidies fully expire end of 2025, so 2026 open enrollment (late 2025) will already reflect higher premiums, with coverage impact most seen in 2027.

- **2030–2034 sunsets:** Many provisions of OBBB are written to expire by 2034 to comply with budget rules (which typically require changes not to show costs beyond the 10-year window). The MSP and nursing home staffing rule moratoria both end September 30, 2034, presumably with the expectation that future Congresses might extend or revisit them. The work requirement authority also sunsets after 2030 unless renewed.

During these transitions, federal agencies and stakeholders are navigating implementation challenges. CMS must issue guidance to states on implementing work requirements and other Medicaid changes, while also adapting Medicare enrollment systems to the new eligibility criteria. Educational organizations are increasing outreach efforts to inform beneficiaries about changes and available assistance programs, particularly encouraging low-income seniors to utilize any available state pharmacy assistance if they lose MSP help. The **healthcare industry** is also adjusting; providers are training staff on new eligibility verification processes and preparing for potential changes in patient populations.

In conclusion, Public Law 119-21 is poised to **reshape the landscape of public health coverage** in the U.S., including Medicare. Its implementation is staggered and complex, and while it achieves significant federal savings on paper, it raises serious concerns about access to care for vulnerable populations. The full impact on Medicare will unfold over the coming years, against the backdrop of the program's other ongoing changes, as discussed in the next sections.

Recent Developments in Medicare Advantage (Part C)

Medicare Advantage – the private-plan arm of Medicare – continues to grow and evolve in 2025, with important implications for beneficiaries, insurers, and Medicare's finances. Below we examine the latest **enrollment trends**, updates in **payment and reimbursement policies**, plan **innovations**, and **regulatory shifts** affecting Medicare Advantage.

Enrollment Trends and Market Dynamics

Enrollment in Medicare Advantage (MA) has been on an upward trajectory for two decades, and in 2025 it reached a new milestone. **More than half (54%) of eligible Medicare beneficiaries are enrolled in a Medicare Advantage plan**. This translates to approximately 34.1 million people out of ~63 million total Medicare beneficiaries. MA enrollment as a share of Medicare has jumped from 19% in 2007 to 54% in 2025, reflecting steady growth each year.

However, the **pace of growth has slowed slightly**. Between 2024 and 2025, MA enrollment grew by about 1.3 million beneficiaries (around a 4% increase), compared to a 7% growth rate the year before. Some analysts note that as MA has already captured the majority of beneficiaries in many counties, the remaining growth may be naturally slower. The Congressional Budget Office projects MA enrollment will continue rising to around 64% of all Medicare beneficiaries by 2034.

One notable trend is the **rising enrollment in Special Needs Plans (SNPs)**, which are MA plans tailored for specific high-need populations. In 2025, **21% of MA enrollees** are in SNPs, up from about 19% the year before. Within SNPs, those for dual-eligibles (D-SNPs, serving people on both Medicare and Medicaid) make up the lion's share (over 80% of SNP enrollment). But growth has been especially rapid in **Chronic Condition SNPs (C-SNPs)** – plans designed for individuals with particular chronic illnesses like diabetes or heart failure. C-SNP enrollment surged by more than 70% from 2024 to 2025. This suggests that insurers are expanding offerings for specific chronic conditions and that beneficiaries with those conditions find value in the tailored benefits (such as focused care management) these plans provide. Institutional SNPs (I-SNPs, for long-term nursing home residents) remain a small niche (under 3% of SNP enrollment) and saw flat growth.

The **MA market remains highly concentrated among a few insurance organizations**. As of 2025, two companies – UnitedHealth Group and Humana – together account for about **46% of all MA enrollees nationwide**. UnitedHealth Group is the market leader, and between 2024 and 2025 it achieved the largest absolute enrollment gain (adding roughly 505,000 MA members). Humana, historically the second-largest MA insurer, saw a slight **decline** of about 297,000 enrollees year-over-year. This could be due to strategic retrenchment in certain markets or increased competition; for instance, Humana announced an exit from some employer group MA contracts and certain counties. Meanwhile, other players like **Elevance Health** (formerly Anthem) had significant growth (~249,000 enrollees gained). Market entries and exits also shaped local plan landscapes – in 2025, **three new insurers** entered the MA market, while **eight insurers exited**. Major insurers expanded into some new counties and withdrew from others, leading to some beneficiaries having to switch plans. It's reported that about **5% of MA enrollees** in individual plans (around 1.4 million people) had their plan *terminate* or consolidate for 2025, requiring them to transition to a different plan.

Despite a slight drop in the sheer number of plan choices (the average beneficiary has 42 plan options in 2025, down from 43 in 2024), **choice remains robust**. Nearly one-third of Medicare beneficiaries live in counties with over 50 MA plan options. Some reduction in plan offerings may be due to insurer mergers of plan offerings (to reduce duplicative plans) or response to payment changes, but the market "appears to be relatively stable," with the average beneficiary still having dozens of options. The **composition of plan types** has slowly shifted: local PPOs (Preferred Provider Organizations) have grown to represent 43% of all MA plans in 2025 (up from 24% in 2017), while HMOs have declined from 71% to 56% of plans in that period. Regional

PPOs are only ~1% of plans now. This indicates insurers see opportunity in offering PPOs (which give slightly more out-of-network flexibility) even though HMOs remain common.

From a beneficiary perspective, **premiums remain low in many MA plans**. The vast majority of enrollees choose plans with $0 additional premium (aside from the Part B premium). For 2025, the average MA-PD premium (if including those who do pay one) is around $15–$18 per month, a slight uptick from prior years, but about half of MA-PD enrollees are still in zero-premium plans. Many MA plans continue to compete on extra benefits and out-of-pocket costs rather than charging a premium.

Payment and Reimbursement Updates

Medicare Advantage's growth has drawn heightened scrutiny to how Medicare pays plans. In general, Medicare **spends more per person in MA** than it would if the same beneficiaries were in Traditional Medicare – an excess that has grown significantly over time. In 2025, **Medicare payments to MA plans are about 20% higher per enrollee** than spending for similar beneficiaries under fee-for-service Medicare. This translates into an additional **$84 billion in federal spending** for the year. A decade ago (2015), the "MA payment gap" was around $18 billion, so the divergence has skyrocketed. The higher payments partly finance the richer benefits and lower cost-sharing that MA plans offer (which attract enrollees), but also raise concerns about efficiency and potential overpayments (e.g., through risk coding practices).

Risk Adjustment and Coding Intensity: One driver of higher payments is how MA plans report enrollee diagnoses which determine risk scores. Plans are incentivized to document all health conditions (through health risk assessments, etc.) because sicker patient codes raise their capitation payments. MedPAC and others have noted that MA enrollees' risk scores tend to be significantly higher (over 8% higher in 2020) than equivalent FFS beneficiaries due to **coding intensity**. In response, CMS in early 2023 finalized a new **risk adjustment model (V28)** for 2024 that refines how diagnoses map to risk scores. The update aimed to remove some diagnosis codes that plans were potentially gaming (like unspecified diabetes) and re-calibrate condition categories. The industry was concerned this model change would effectively cut MA payments by reducing risk scores. After vigorous lobbying, CMS decided to **phase in the new model over three years (2024–2026)** to mitigate immediate impacts. Thus, for 2025, MA payments reflect a blend of the old and new risk models. This phased approach gives plans time to adjust, but it signals a policy intent to curb excess payments from aggressive coding. The **expected result** is a slight moderation in MA payment growth, though aggregate payments still rise due to growth in baseline costs and quality bonus payments.

Benchmarks and Quality Bonuses: MA plan payments are based on county-level **benchmarks** (a percentage of FFS spending) and plan bids. For 2025, benchmarks increased roughly 2–3% on average, and most plans bid below the benchmark to provide extra benefits via rebates. The **Quality Bonus Program** continues to reward plans with 4 or 5 stars with a bump in benchmarks. Over 70% of MA enrollees are in plans that earned bonus status for 2025, which raises overall

payments. There is ongoing debate about whether the star ratings genuinely reflect quality or are too easy to achieve (thus inflating costs). No legislative changes to the bonus system occurred in 2025, but MedPAC has recommended restructuring it.

Encounter Data and Audits: CMS has been shifting toward using **encounter data** (detailed records of services provided) to calibrate payments, instead of solely insurer-reported summaries. For 2025, CMS increased the weight of encounter data in risk score calculation, aiming for more accuracy. Additionally, after years of delay, CMS finalized a rule to apply extrapolation in **Risk Adjustment Data Validation (RADV) audits** starting with the 2018 payment year. This means CMS will recoup improper payments from plans based on sampled chart audits without a "fee-for-service adjuster" that plans had lobbied for. Essentially, if an MA plan is found to have overstated diagnoses, CMS can now collect an extrapolated refund for the contract – potentially recovering hundreds of millions in overpayments going forward. Plans criticized this as punitive, but CMS and watchdogs view it as necessary to hold plans accountable and save Medicare funds.

Plan Margins and Reimbursements to Providers: In MA, plans negotiate rates with providers. Often, these rates are around 100% of Medicare FFS rates, though for some services and in some markets plans pay less (or sometimes more, especially for value-based arrangements). As MA enrollment grows, providers' revenue mix changes. For instance, primary care practices in some areas now get over half their patients as MA members, paid by capitated or contract rates rather than directly by Medicare. Some MA plans (particularly integrated systems or those contracting via Accountable Care-like arrangements) pay providers capitations or shared savings arrangements. **Reimbursement updates for providers within MA** are not dictated by Medicare's annual fee schedule changes – they depend on contract terms. If Traditional Medicare increases physician fees by 1%, MA plans are not obligated to do the same, though competitive pressures in provider networks often lead them to keep pace to ensure access.

Looking ahead, the **OBBB Act's** impact on MA payments is indirect but notable: by worsening Medicare's fiscal outlook, it could put pressure on lawmakers to find savings, and the MA program's excess payments are a clear target. Already, groups like MedPAC and the Committee for a Responsible Federal Budget highlight trimming MA "overpayments" as a solution to extend the Part A trust fund. Thus, while 2025 itself didn't bring major legislative cuts to MA, the climate is shifting toward **payment reform in MA** to enhance efficiency and equity with FFS Medicare.

Plan Innovations and Benefit Design

Medicare Advantage plans in 2025 continue to innovate in benefit design to attract and manage enrollees, particularly through supplemental benefits and care management programs:

- **Expanded Supplemental Benefits:** Virtually all MA plans offer benefits beyond Medicare's standard coverage. According to KFF, more than 99% of plans include extras like **vision, hearing, and dental coverage** in 2025. These benefits can range from modest (e.g., an annual eye exam and $200 for glasses) to comprehensive (e.g., extensive dental coverage up to $2,000). Additionally, plans often cover transportation to medical appointments, OTC drug allowances, and fitness programs (SilverSneakers gym memberships remain very popular).

- **Special Supplemental Benefits for the Chronically Ill (SSBCI):** Since 2020, CMS allows MA plans to offer non-primarily health related benefits to chronically ill enrollees who can benefit. By 2025, many plans have taken up this option. Examples include meals (e.g., 10–14 home-delivered meals after a hospitalization or for those with nutrition insecurity), **pest control**, **air conditioning/heating** installation for conditions like asthma, and **transportation not just to medical visits but to places like grocery stores**. For 2025, CMS tightened oversight by requiring that these SSBCI offerings have a **reasonable expectation of improving health or function** for the targeted chronic population. Plans must collect evidence or data to substantiate that their novel benefits (say, a food pantry benefit for diabetics) indeed help outcomes, and they cannot market SSBCI in a misleading way (i.e., they must clarify that such benefits are only for eligible enrollees, not everyone in the plan).

- **Telehealth and Technology:** MA plans have embraced **telehealth** more broadly than Traditional Medicare. Even as the public health emergency ended, MA plans in 2025 continue to offer telehealth visits as a covered benefit, sometimes with lower copays than in-person visits. Plans are also using remote patient monitoring tools (e.g., providing members with devices like blood pressure cuffs or glucose monitors that upload readings to care managers). Some plans have introduced smartphone apps for members to chat with care coordinators or AI symptom checkers. These digital health investments aim to manage chronic conditions better and differentiate plan offerings.

- **In-Home Services:** Many MA plans now offer in-home support services for eligible members. This could include a certain number of hours of in-home caregiver support, home safety assessments (to prevent falls), or even home modifications (installing grab bars, wheelchair ramps for those with mobility limitations). Under SSBCI, some plans cover **personal care services** (help with activities of daily living) for chronically ill members who don't yet qualify for Medicaid long-term care. For example, an MA plan might provide 20 hours of in-home personal care per year for someone with a severe chronic illness to help avoid institutionalization.

- **Care Management and Coordination:** MA plans increasingly emphasize care coordination as a selling point. They often assign high-risk enrollees a **case manager** (usually a nurse or social worker) who can help coordinate appointments, follow up after hospital discharges, and ensure medication adherence. Some plans have specialized programs like **transitional care teams** that proactively reach out to members after a hospital stay to arrange follow-up doctor visits or home health, seeking to reduce readmissions.

- **Value-Based Insurance Design (VBID):** MA plans are experimenting with VBID through a CMS Innovation Center model that allows tailoring cost-sharing or extra benefits for certain populations. For instance, a plan might waive co-pays for insulin and podiatry visits for members with diabetes to encourage better management. The **VBID Model** in 2025 also allows MA plans to offer healthy food and transportation benefits to targeted enrollees. Plans that are part of the VBID demo can even offer hospice services within the plan (as opposed to carving them out to Original Medicare), which a number of plans are testing to provide more seamless end-of-life care.

- **Network and Delivery Innovations:** Some MA plans are tightly integrating with provider groups – for example, partnering with primary care chains focused on seniors (like Oak Street Health or ChenMed) to offer enriched primary care. These clinics often provide longer appointments, on-site labs/pharmacy, and even activities for seniors. Plans advertise these as a way to get more personalized care. Additionally, **telehealth-only plans (Direct Contracting Entities now rebranded as ACO REACH for Traditional Medicare, but some analogous arrangements exist in MA)** have not taken off in MA yet, but plans do compete on having renowned hospitals or health systems in-network. In some areas, integrated delivery system plans (like Kaiser Permanente) leverage their model to provide coordinated care and often achieve high quality ratings, attracting members.

Overall, plan innovation in MA for 2025 continues to focus on **holistic benefits** – addressing medical, dental, vision, and social needs – which is a distinct advantage of MA over Original Medicare. However, these extras come at the cost of **utilization controls**; thus, plans balance richer benefits with managing how enrollees use services.

Regulatory and Policy Shifts

Regulators at CMS have been active in refining rules for Medicare Advantage to protect consumers and improve equity and transparency. Several important rules and updates took effect for contract year 2024 and 2025:

- **Marketing Oversight and Broker Compensation:** In response to a spike in complaints about aggressive and misleading marketing (especially from third-party brokers and call centers), CMS implemented stricter regulations. For 2024 and beyond, all marketing materials must include a disclaimer when fewer than all plans are represented, and the infamous television ads with celebrity spokespeople have been curtailed. Moreover, starting with the Fall 2023 enrollment season for 2024, agents are required to record sales calls and follow new scripts. Building on that, CMS released a 2025 final rule that **levels the compensation structure** for brokers across MA and Part D plans. Previously, some plans or companies offered brokers higher commissions or bonuses for enrolling a beneficiary in their plan, which could incentivize steering. Now, the rule sets **fixed compensation amounts** (with a slight increase in the base rate) that must be the same regardless of which plan the beneficiary chooses. For example, if the fair market value commission is set to $715 for a new enrollment (hypothetical figure for 2025 including the one-time $100 increase), an agent will get that amount whether they enroll someone in Plan A or Plan B, eliminating a financial bias. Also, insurers cannot offer gifts or bonuses tied to enrollment numbers beyond these set amounts. This is intended to ensure that brokers help beneficiaries find the *best* plan for their needs, rather than the one that pays the agent the most.

Additionally, CMS cracked down on **Third-Party Marketing Organizations (TPMOs)** – companies that collect leads and often bombard beneficiaries with calls. New rules prohibit TPMOs from selling beneficiaries' contact information without **express written consent** and require more transparency in online lead forms. This should reduce the "flood" of cold calls that many seniors received after entering their info in online Medicare plan searches.

- **Network Adequacy & Access to Services:** CMS updated **network adequacy** requirements to include certain provider types. Notably, for 2024, CMS added **Outpatient Behavioral Health** as a specific category that plans must have in network. This category covers mental health and substance use disorder providers such as therapists, counselors, psychiatrists, and opioid treatment programs. Plans must contract with enough behavioral health providers and even must include at least one provider who offers tele-behavioral health services to count toward the requirement. This change reflects a push for better mental health access, recognizing that previously, some MA plans had sparse mental health networks. CMS is also independently evaluating how often MA enrollees get approved or denied for services; an April 2022 OIG report found some plans were inappropriately denying care, which has fueled these network and prior auth reforms.

- **Supplemental Benefit Utilization:** Starting in 2024, plans are required to **proactively notify enrollees** mid-year about their unused supplemental benefits. For instance, if by July an enrollee hasn't used their dental benefit or their free gym membership, the plan must send a notice listing those unused benefits and instructions on how to access them. This was because CMS found many enrollees were unaware of benefits they technically had. Plans must provide details like scope of the benefit, any cost-sharing, how to use it, and a contact number. This rule should help enrollees get more value (e.g., actually get those new glasses or preventative dental exam the plan offers).

- **Prior Authorization Reform:** Prior authorization (PA) in MA has been a contentious issue. There were high-profile reports of MA plans requiring PA for services that would clearly be covered under Traditional Medicare, effectively creating barriers to care. CMS's 2024 rule (effective Jan 2024) requires MA plans to **follow Traditional Medicare's coverage rules** more closely – meaning they cannot deny coverage for a service that is medically necessary under Medicare coverage guidelines. Also, **PA approvals must remain valid for the entire course of treatment** (an MA plan can't force a provider to keep re-authorizing a series of treatments once initially approved). For 2025, CMS went further to ensure PA processes are not discriminatory. The final rule requires each MA organization to establish a **Utilization Management Committee** with a **health equity expert**. This committee must conduct an annual analysis of PA outcomes by subsets of enrollees (like comparing PA approval rates for those receiving low-income subsidies vs. others, or by race/ethnicity if data available). The results must be made public, shining light on any disparities. The goal is to identify if certain groups are disproportionately denied and rectify that. Another rule in the 2025 final policy is giving **enrollees more say in care planning**: if an MA plan **terminates coverage of a service** mid-treatment (like decides to end coverage of skilled nursing facility days), the enrollee is assured the right to appeal that decision just as they would under Original Medicare, which CMS clarified in regulations.

- **Star Ratings and Consumer Information:** CMS adjusted some Star Rating measures to emphasize outcomes and patient experience. For example, **member experience** (from CAHPS surveys) now has a greater weight in determining a plan's star rating. In 2022 and 2023, member experience measures got quadruple weight; this continues in 2024, meaning plans cannot get high stars without good beneficiary feedback. The disastrous decline in 5-star plans from 2022 to 2023 (as CAHPS was re-weighted) has somewhat reversed as plans put more focus on member satisfaction. CMS also restarted use of its **"Consumer Warning" icon (the alert on Plan Finder for plans with recent sanctions or poor performance)** after pausing some enforcement during the pandemic.

- **Competitive Practices:** A subtle but important 2025 change is CMS addressing **anti-competitive consolidations**. The rule includes a requirement that **brokers be paid the same commission regardless of plan** (discussed above) and also addresses "look-alike" D-SNP issues. Specifically, CMS lowered the threshold for when a regular MA plan is considered a D-SNP "look-alike" (a plan with >70% dual-eligible enrollment) to discourage MA plans from trying to enroll high numbers of duals outside of SNP contracts. This pushes more coordination by having duals in actual D-SNPs that integrate with Medicaid.

Overall, the regulatory trajectory for Medicare Advantage is toward **greater transparency, fairness, and alignment with Original Medicare standards**. CMS under current leadership has frequently stated that while MA is popular, it must not *overstep* or offer less access than Traditional Medicare. The changes in 2024–2025 reflect that philosophy: ensuring MA enrollees get what they're entitled to (no more, but also no less), and that plans compete on value rather than on cherry-picking or marketing tricks.

Figure 1: Growth of Medicare Advantage Enrollment (2007–2025). More than half of Medicare beneficiaries are enrolled in MA plans by 2025, up from 19% in 2007. The trend line (blue) shows steady growth in MA enrollment, while Traditional Medicare enrollment (orange) has plateaued, leading MA to become the new majority coverage.

Prescription Drug Pricing Reforms (Medicare Part D)

The past few years have brought the most significant changes to Medicare's drug benefit since its inception. The **Inflation Reduction Act (IRA) of 2022** introduced a suite of reforms to reduce prescription drug costs for Medicare and beneficiaries. By August 2025, many of these changes are either in effect or imminent. Additionally, Medicare is implementing new programs around drug price inflation rebates and preparing to negotiate drug prices for the first time. In this section, we detail the **Part D drug pricing reforms**, including the inflation rebate provision, the new out-of-pocket cap, formulary and benefit design changes, and the outlook as Medicare's role in drug pricing evolves.

Inflation Rebate Program

Starting in 2023, drug manufacturers face a new requirement: if they raise the price of drugs faster than the rate of inflation, they must pay a rebate to Medicare for those excess increases. This **Inflation Rebate Program** applies to drugs under Part D (as well as Part B drugs separately). The policy is akin to the Medicaid Drug Rebate Program's inflationary component but is brand new to Medicare.

CMS moved swiftly to implement this. By late 2024, CMS issued **final rules** clarifying how rebates will be calculated and collected. The rebate amount is essentially the difference between a drug's price increase and what the increase would have been had it matched inflation (using CPI-U as the benchmark), multiplied by Medicare units sold. Already, the first set of Part D drugs

subject to rebates have been identified – for example, certain widely-used drugs that had substantial price hikes in late 2022 and 2023. The **savings from this provision are two-fold**: it discourages companies from large annual price hikes (or else face financial penalties), and any collected rebates will go into the Medicare Trust Funds, indirectly helping Medicare's finances.

One real-world impact observed: In early 2023, several pharmaceutical companies notably **kept price increases in the single-digit percentages**, often below inflation, a departure from past practice of common 10%+ annual hikes. While overall drug inflation still outpaces general inflation in some cases, the threat of rebates seems to be exerting a restraining influence. For beneficiaries, the inflation rebate doesn't directly lower pharmacy counter prices (that will come from other provisions), but it slows the growth of those prices over time. Notably, due to how Part D plan bids work, eventually slower price growth should translate to lower premiums and cost-sharing than they otherwise would be.

CMS's November 2024 final rule also spelled out the process: manufacturers will be invoiced for rebates starting in 2025 for price increases that occurred in 2023. There's a lag because data needs to be collected and validated. By 2025, Medicare will publicly report which drugs had price hikes above inflation. This transparency might also shame some companies and further deter large increases.

$2,000 Out-of-Pocket Cap and Benefit Redesign

Perhaps the most impactful change for Medicare beneficiaries is the new **annual out-of-pocket (OOP) spending cap of $2,000** in Part D, effective **January 1, 2025**. This addresses a longstanding problem: Part D did not originally have a true out-of-pocket maximum – enrollees with very high drug costs (for instance, expensive cancer medications or multiple brand-name drugs for chronic diseases) could end up spending thousands per year even after reaching the catastrophic phase, since they kept paying 5% coinsurance on each refill with no limit.

Under the IRA changes:

- In 2024, that 5% coinsurance in the catastrophic phase was **eliminated**, so enrollees pay $0 after hitting the OOP threshold (approximately $3,250 out-of-pocket, which excludes manufacturer discounts in the gap).
- In 2025, a firm cap of $2,000 is established for out-of-pocket spending. This cap is lower than what the catastrophic threshold would have been and does **include** the previously required 5% coinsurance.

With this reform, once a beneficiary has paid $2,000 in a year for Part D covered drugs (counting what they pay out-of-pocket, including the deductible, copays/coinsurance in initial coverage, and any payments in the gap), they pay nothing further for the rest of the year. An estimated **approximately 1.4 million Part D enrollees** had annual out-of-pocket costs above $2,000 in recent years; they will all see their expenses reduced, in many cases dramatically. In total, about **11 million enrollees** are projected to benefit over the next decade from the cap and other Part D

changes combined. This includes those who will now be more likely to adhere to medications because they no longer face catastrophic costs.

To illustrate, consider an example: In 2025, Mrs. Smith has several conditions – cancer, rheumatoid arthritis, and high cholesterol. She takes an expensive cancer drug and a biologic for arthritis. By mid-year, under the old system, she might have spent $5,000 out-of-pocket and would still owe 5% of tens of thousands in drug costs through December. Under the new system, as soon as she spends $2,000, her Part D plan covers **100%** of further drug costs (with Medicare covering a portion via reinsurance and manufacturer discounts applicable in the catastrophic phase for brand drugs). Mrs. Smith's *personal* drug spending stops at $2,000. This is a profound financial relief and offers peace of mind that drug costs won't bankrupt patients or force choices like rationing doses.

Part D's structure behind the scenes is also being **redesigned** in 2025:

- The catastrophic phase cost distribution shifts: Part D plans, which used to only bear 15% of costs in catastrophic, will now cover 20% for brand drugs and 60% for generics, with Medicare's reinsurance covering the remainder. Drug manufacturers will also, starting in 2025, provide a **20% discount on brand-name drug prices in the catastrophic phase** (this is a new **Manufacturer Discount Program** replacing the coverage gap discount). In the initial phase, manufacturers will give a 10% discount on brands once the deductible is met. These discounts count toward the OOP cap.
- Because plans are taking on a larger share of catastrophic spending risk, the IRA created a **temporary premium stabilization program** capping Part D premium increases to 6% per year for 2024–2029. Plans also have the ability to spread the costs via a "smoothing" mechanism for premium revenue.

In practice for 2025, **Part D premiums are rising modestly**, but with the stabilization, no PDP's base premium could increase by more than $35 from 2024. Some plans did implement that maximum allowed increase (especially those expecting a lot of high-cost enrollees hitting the cap). The **base beneficiary premium** (a weighted measure) rose about 6% to $36.78. Many MA-PD plans, which historically often had $0 drug premiums, have started adding small drug deductibles or charging modest premiums as well, to offset the new obligations. We also see some plans increasing **coinsurance on expensive drugs** or tightening formularies, but they must still abide by coverage rules.

CMS also finalized a requirement that Part D plans offer **"flexible monthly payment options"** (the so-called OOP smoothing). This allows enrollees who expect to hit the $2,000 cap early in the year (say they have one drug that costs $5,000 in January) to opt into paying their cost-sharing in equal installments throughout the year, rather than $2,000 upfront in January. For 2025, plans had to at least have a system to accommodate this for those who ask, and by 2026 it becomes more automated. This addresses the cash-flow issue and helps people on fixed incomes manage expenses.

Insulin, Vaccines, and LIS Improvements

Some quick wins of the IRA were already realized in 2023:

- **Insulin Copay Cap:** Since January 2023, all Part D plans cannot charge more than **$35 for a 30-day supply of any covered insulin**. This cap dramatically reduced costs for insulin-dependent beneficiaries. Anecdotally, people who were paying $100+ per insulin vial per month saw immediate savings. Plans also cannot apply a deductible to insulin. (In 2026, similar $35 caps will apply to Part B-covered insulin used in pumps.)

- **Vaccines at $0:** As of 2023, all adult vaccines recommended by ACIP and covered under Part D must be provided **with no cost-sharing**. This fixed a pain point where, for instance, the shingles vaccine (Shingrix) could cost a beneficiary $100 per dose under Part D if they hadn't met the deductible. Now, vaccines like shingles, Tdap, and others are free. Uptake of the shingles vaccine among seniors is expected to climb significantly thanks to this change.

- **Expanded Low-Income Subsidy:** In 2024, the IRA made the full Low-Income Subsidy available to individuals up to 150% of poverty (eliminating the partial subsidy category). This means more people qualify for zero premiums and minimal copays. This was a quieter change but important for low-income near-poor beneficiaries who previously had to pay some premium.

By 2025, these provisions are well in force. Plans have adjusted formularies accordingly – for example, ensuring a broad range of insulin products are on formulary (plans can't circumvent the cap by dropping insulins; CMS requires they cover insulin in all formulary classes that include it). Vaccine coverage is standardized, which simplifies pharmacy billing (no more Part D vaccine admin fees for patients).

Formulary and Pricing Strategies

With Medicare taking a stronger hand in drug pricing, Part D plans are also adapting their strategies:

- **Formulary Changes:** The average Part D formulary in 2025 covers about 89% of all drugs on the market (similar to previous years). Plans still must cover at least two drugs per class and all drugs in the protected classes. However, plans have increasingly moved drugs to higher tiers with coinsurance. In 2025, a larger share of MA-PDs are using coinsurance (instead of fixed copays) for higher-cost drug tiers. For example, expensive specialty drugs might have 25% or 33% coinsurance on a specialty tier. With the $2,000 cap coming, some plans might not fear high coinsurance as much, since they know the enrollee's exposure is limited and Medicare will pick up the rest.

- **Specialty Tier Adjustments:** CMS allowed plans to have two specialty tiers starting in 2022 (a preferred and a non-preferred specialty tier). Some plans have implemented this by 2025 to negotiate better prices: they put certain expensive drugs (say certain brand biologics where they got a discount) on a "Preferred Specialty" tier at 25% coinsurance, and others on a higher tier at 33%. This gives enrollees an incentive to use the drugs the plan got cheaper. With negotiation on the horizon (which will initially focus on some very high-spend drugs), plans may leverage those lower prices by preferring negotiated drugs on formularies.

- **Price Negotiation Prep:** Medicare's forthcoming **Drug Price Negotiation Program** (another IRA piece) will have its first negotiated prices effective in 2026 for 10 Part D drugs. In August 2023, CMS announced the list of 10 drugs (which included anticoagulant Eliquis, diabetes drugs like Jardiance, etc.). In 2025, manufacturers of those drugs are in talks with CMS about what a "fair" price will be. Part D plans are preparing to implement those prices in 2026. While not directly a 2025 change, the industry in 2025 is abuzz with speculation: will some manufacturers refuse to negotiate (incurring a big excise tax penalty)? Will negotiations produce, say, 40-60% price cuts? Those answers come in 2024–2025. The OBBB's **orphan drug exemption** for negotiation means that some drugs that might have been picked in later years (like a very high-cost rare disease drug) won't be eligible, potentially keeping their prices high. But the initial 10 drugs for 2026 were mostly common drugs, none of which are orphan-only, so the first round proceeds unaffected. Plans are supportive of negotiation because it will reduce their costs (Medicare will set the price which all plans pay). If anything, plans in 2025 might be slightly de-emphasizing aggressive formulary restrictions on those drugs in anticipation that relief is coming via Medicare's price setting.

- **Plan Bids and Premiums:** The Part D premium stabilization means that for 2025, **stand-alone PDP premiums** rose modestly to an average of $45 (enrollment-weighted), though actual average paid premium is expected lower as people switch to cheaper plans. Some PDPs that would have spiked premiums due to the cap were reined in by the $35 limit on increases. However, the trend of **consolidation of PDPs** has continued – fewer PDPs means each remaining one may have a broader risk pool. Many insurers trimmed their plan offerings, often dropping the higher-premium plans and nudging members to cheaper ones. This aligns with a long-term trend: since 2010, the number of PDPs has fallen by more than half while MA-PD enrollment grew.

- **Pharmacy Networks and Negotiated Prices:** 2025 also sees heightened focus on what Part D plans pay pharmacies. There's been an issue with DIR (Direct and Indirect Remuneration) fees that plans/claw back from pharmacies after the sale. A CMS rule took effect in 2024 requiring those fees to be reflected at point of sale. As a result, some plans lowered their negotiated prices but eliminated retroactive pharmacy fees, improving price transparency for pharmacies and potentially for customers (lower negotiated price means slightly less cost before reaching cap). Pharmacies have welcomed this change, though some worry plans adjusted by lowering reimbursement. CMS is monitoring whether pharmacy access remains robust.

In sum, **Medicare Part D in 2025 is fundamentally more generous and more regulated on pricing than ever before**. Beneficiaries are already seeing tangible benefits: insulin is affordable, vaccines are free, and no one is facing astronomic out-of-pocket drug costs after the $2k cap. These changes address some of the biggest pain points that seniors faced under Part D. For Medicare's budget, the combination of negotiation (starting 2026) and inflation rebates is projected to save hundreds of billions over time, though those savings ramp up gradually and depend on implementation details. The Part D benefit redesign does increase Medicare's obligations in the catastrophic phase (since Medicare will pay 20% of drug costs it used to push to enrollees via coinsurance), but the law's other provisions more than offset that from a budgetary perspective.

Looking ahead, **challenges remain**: drug manufacturers are responding by shifting strategies (for example, launching drugs at even higher prices initially, knowing they can't raise them as easily later, or focusing on orphan drug designations). The negotiation program will likely face

legal challenges (already some companies filed lawsuits claiming it's unconstitutional, though none have succeeded to date). But as of August 2025, Medicare is on track to roll out the negotiation and is collecting data from manufacturers and others to set fair prices. Another area to watch is **Part B drugs** – the IRA's inflation rebate already started for Part B in 2023 (leading to some coinsurance reductions for 34 Part B drugs in April 2023), and negotiation will extend to Part B drugs in later rounds (2028 onward). Thus, Medicare's role in drug pricing is expanding beyond Part D, a development that could further reduce beneficiary spending and program costs.

In conclusion, the drug pricing reforms under Medicare Part D as of 2025 represent a historic shift: Medicare has begun to assert itself in the pharmaceutical market – capping patient costs, penalizing unjustified price hikes, and preparing to directly negotiate prices for the costliest medications. This is great news for beneficiaries who have struggled with medication affordability, and it marks a new era of Medicare being an active negotiator for value, not just a passive bill-payer. The success of these reforms will depend on vigilant implementation and potential adjustments (for instance, ensuring the $2,000 cap keeps pace with inflation after 2025; it will rise slightly each year). Early signs indicate improved medication adherence and reduced financial stress among seniors, which could in turn lead to better health outcomes – the ultimate goal of these policy changes.

Financial Outlook for Medicare Trust Funds

Medicare's financial health is an ever-present concern for policymakers. The program's funding comes from two main trust funds: the **Hospital Insurance (HI) Trust Fund**, which finances Part A, and the **Supplementary Medical Insurance (SMI) Trust Fund**, which finances Parts B and D. Unlike SMI, which is continuously funded by premiums and general revenue, the HI trust fund operates more like a typical insurance fund that can face insolvency if outlays consistently exceed dedicated revenues. In 2025, Medicare's fiscal outlook has seen some **deterioration** compared to recent years, prompting warnings about the need for reforms to ensure long-term solvency and sustainability.

Hospital Insurance (Part A) Trust Fund Solvency

The **HI Trust Fund** pays for Part A services (inpatient hospital, SNF, hospice, some home health). It is mostly fed by payroll taxes as described earlier. Each year, the Medicare Trustees report on the fund's status. The **2025 Trustees Report** projected that the HI trust fund will be **insolvent in 2033**, meaning that in 2033 the reserves will be fully depleted and annual income will fall short of expenses. This projection is **three years sooner** than the prior year's report, which had projected insolvency in 2036. The shortening of the trust fund's life is attributed to **higher-than-expected spending** in 2022–2024 on Part A services, particularly in **hospital inpatient and hospice care**, as well as higher payments to Medicare Advantage plans drawing

from the HI fund. In addition, the macroeconomic assumptions (slightly slower growth in payroll tax revenue) played a role.

At insolvency, Medicare Part A does not stop, but the program would only be able to pay out what it receives in payroll taxes that year – about **89% of Part A costs** in 2033, dropping to 86% by 2040 if no changes are made. This would legally necessitate an **11% cut** in payments to hospitals and other Part A providers in 2033, growing larger thereafter. Such an outcome would be unprecedented – *Congress has never allowed the HI fund to reach depletion* kff.org. In past instances when insolvency loomed (e.g., early 1980s, late 1990s), legislative actions were taken (like payroll tax increases or payment reforms) to push the date forward. The 2025 Trustees urge that to maintain full Part A benefits, lawmakers must enact solvency measures before 2033.

The Trustees quantify the long-term shortfall: over the 75-year horizon, the HI fund has an actuarial deficit of about **0.42% of taxable payroll** (or 0.18% of GDP). In practical terms, that means an immediate increase in the payroll tax from 2.9% to about 3.3% or an equivalent cut in spending (roughly 8-10%) would be needed to close the gap. If action is delayed, more drastic adjustments would be required as the insolvency date nears.

It's worth noting that **2024 and 2025 saw large cost increases** in certain Part A sectors:

- Hospital utilization rebounded post-pandemic. There were also higher case complexities and more costly technologies (e.g., new inpatient treatments).
- The hospice benefit has grown substantially, partly due to longer lengths of stay and more for-profit hospices.
- Medicare Advantage's effect: When an MA enrollee uses Part A services, the costs are covered by the plan, but the funding ultimately comes from the HI trust via plan payments. MedPAC has pointed out that MA plans' efficiencies haven't translated into proportionately lower payments. In fact, as noted, MA draws more from the trust fund than if those beneficiaries were in Original Medicare. In 2023, nearly half of Part A spending went to MA enrollees kff.org, so MA's payment policies significantly influence the HI fund. If MA costs per enrollee were equal to FFS, the trust fund would be more solvent. This has led experts to call for aligning MA payments with actual FFS spending levels or adjusting for coding intensity more strongly.

On the positive side, Part A spending will eventually face demographic leveling: The Baby Boom cohort (born 1946-1964) will fully age into Medicare by the early 2030s. Until then, Medicare enrollment is surging (~10,000 boomers turning 65 each day has been a stat for years). After 2030, enrollment growth slows, which somewhat eases pressure, but the **ratio of workers to beneficiaries** will remain lower than historically, straining the payroll tax base.

The **Budget Reconciliation Act of 2025 (P.L. 119-21)** indirectly affects solvency. By increasing deficits and debt, it raises federal interest costs and puts pressure on the overall budget. While Medicare's trust fund accounting is separate, in reality Congress's ability to shore up Medicare might be constrained by a worsened fiscal environment. Moreover, the law's extension of tax cuts means less revenue is flowing into Treasury; proposals to redirect some general revenue to

Medicare (one way to bolster HI) become harder when the general fund is in deficit. Some analysts argue that the $3.4 trillion added debt from OBBB could itself prompt automatic Medicare cuts via PAYGO (the 4% sequester) medicareadvocacy.org, but as discussed, that is likely to be waived. Nonetheless, the **Trustees explicitly mention** that current law projections assume those cuts won't occur, and if they did, it would extend the trust fund by a couple of years by reducing Part A spending. The uncertainty itself is not ideal for planning.

Supplementary Medical Insurance (Parts B and D) Outlook

Unlike Part A, the SMI trust fund (Parts B and D) does not face an insolvency risk because it's structured with automatic financing:

- Each year, Part B premiums and general revenue contributions are set to meet expected costs. If spending rises, premiums and general revenue simply rise in tandem.
- Part D is similarly funded with premiums (about 25%) and general revenue (75%) each year adjusted to plan bids.

However, this means the burden of Medicare **shifts to beneficiaries and taxpayers** as costs grow. In 2025, the Trustees continued to issue a warning that Medicare's reliance on general revenues is exceeding the 45% threshold (meaning more than 45% of Medicare's total outlays are funded by general tax revenue, which has been the case for several years in a row). This triggers a "Medicare funding warning" which legally requires the President to submit a proposal to Congress to reduce that dependency. In reality, such proposals (like those from President Bush in 2008 or Trump in 2020) have not been acted upon by Congress.

The **cost projections for Part B and D** are sobering:

- Part B spending is projected to grow around 6-7% annually over the next decade, driven by an aging population (more doctor visits, etc.), increases in volume and intensity of services, and expensive new technologies (e.g., gene therapies administered under Part B, like new Alzheimer's infusions).
- Part D spending growth might moderate slightly due to the drug pricing measures, but overall prescription drug spending is still expected to climb as new drugs enter the market. The trustees (pre-IRA) had projected Part D to grow ~4-5% annually; the IRA may reduce federal Part D spending growth a bit later in the decade.
- **Total Medicare spending** (Parts A, B, D combined) was 3.9% of GDP in 2022. It's projected to rise to 6.2% of GDP by 2050. In the "alternative scenario" where certain cost controls are less effective, it could reach nearly 9% of GDP by 2099, reflecting the uncertainty if healthcare costs per person continue to outpace GDP growth.

For beneficiaries, this translates into rising **Part B premiums and out-of-pocket costs**. The Trustees noted that as of 2024, an average beneficiary's Part B and D premiums plus cost sharing equated to about **26% of the average Social Security benefit**, up from 7% in 1980 and 19% in 2000. This share could climb to over 30% by 2040 if nothing changes, meaning

healthcare will consume an ever-larger portion of seniors' incomes. Such trends raise concerns about affordability and have spurred proposals like capping out-of-pocket costs in Parts A/B (some advocate a combined maximum OOP, similar to MA or Medigap protection, in Original Medicare).

Addressing Solvency and Sustainability

Given the above, what can be done to shore up Medicare's finances? Policy options typically fall into two buckets: **increase revenues** or **decrease spending** (or some combination):

Revenue Options:

- **Increase the Medicare payroll tax** for Part A. Even a modest hike can have a big impact over time. For example, raising the combined payroll tax rate from 2.9% to 3.5% (split between employers and employees) would more than cover the 75-year shortfall. The last payroll tax increase for Medicare was in 1986 (aside from the ACA's addition of the 0.9% surtax on high earners in 2013 kff.org). Politically, a broad-based tax increase may be challenging but has precedent.
- **Broaden the tax base**. Some have suggested dedicating other revenue streams to Medicare, such as a fraction of a VAT or taxes on income beyond wages (Medicare already taps some unearned income via ACA's 3.8% Net Investment Income Tax which supports Medicare's trust funds indirectly). Another idea is to redirect existing taxes; for instance, currently, about 15% of Social Security benefit taxes go to Medicare's trust fund. Congress could increase the portion allocated to Medicare.
- **General revenue transfers**. Congress could at any time allocate general funds to the HI trust fund. This was done in a small way in recent COVID relief bills (to compensate for payroll tax dips). Some experts advocate an automatic general revenue backstop for HI, but others warn that would unravel the notion of Medicare being self-funded and could lessen pressure to control costs.

Spending Options:

- **Reduce Provider Payments**. Medicare already tries to keep provider payment updates below private sector trends. The ACA cut annual hospital payment updates by a productivity factor; the Trustees now see hospital payments rising more slowly than input prices, squeezing margins. Further cuts (beyond current law) could harm provider participation. However, targeted reductions or alternative payment models (like ACOs, bundled payments) aim to get more value for each dollar.
- **Benefit/Eligibility Changes**. Raising the **Medicare eligibility age** from 65 to 67 (phasing in like Social Security's increase) is often proposed to improve solvency. However, it only directly helps Part A's finances modestly (saves a couple of years of outlays for those 65-66, but those people might then go on ACA or employer coverage, shifting costs). Also, since 65-66 year-olds are generally healthier, removing them worsens the risk pool of Medicare slightly. Another idea is adjusting benefits – e.g., introducing a combined deductible for Parts A/B and uniform coinsurance to discourage overuse; this could produce savings especially if coupled with Medigap reforms (like prohibiting first-dollar coverage which can increase utilization).

- **Increase Cost-Sharing or Premiums**. Already, higher-income beneficiaries pay more. Some suggest expanding IRMAA to more people by freezing the income thresholds, or requiring a contribution for Part A (which is currently premium-free for most). Another angle is to have a uniform minimum copay for services currently free (though preventive services being free is intended to encourage use). Politically, broad increases on beneficiaries are sensitive, as seniors are a powerful constituency.

- **Delivery System Reforms**: The ideal way to "save Medicare" is to **slow health care cost growth overall**. Initiatives like accountable care organizations (ACOs), value-based purchasing, reducing fraud and waste, promoting generic drugs and biosimilars, and focusing on prevention could yield significant savings if scaled up. For example, if the rate of per-beneficiary spending growth can be kept 1% below baseline each year, compounded over decades, the long-term projections improve dramatically. The Trustees alternative scenario shows if certain ACA payment cuts that are deemed possibly unsustainable are overridden, costs balloon. So ensuring those efficiency cuts stick (perhaps by aiding providers to be more productive) is key.

Medicare Advantage is a focal point. As previously detailed, MA costs more per enrollee. Policies to fix this could include: modifying the risk adjustment further, eliminating the quality bonus add-ons (as MedPAC has suggested a redesigned MA value incentive program), or setting benchmarks closer to 100% of fee-for-service (currently many counties have benchmarks at 115% of FFS for historically low-cost areas). If MA overpayments were eliminated, the Part A trust fund and Part B premiums would both see relief.

The 2025 Trustees Report prompted statements from many quarters (like the Arnold Ventures statement urging Congress to act on MA reforms and drug pricing). There's a sense that comprehensive Medicare legislation might emerge, especially as we near the insolvency date. Historically, big Medicare bills have happened when trust fund insolvency was within ~5 years (e.g., in 1983 for Social Security, in 1997 the Balanced Budget Act had Medicare cuts when insolvency was 4 years away). Now at 8 years out (2033), the window for proactive action is open. Some lawmakers have floated forming a bipartisan commission to propose Medicare (and Social Security) fixes, possibly after the 2024 election.

Impact of Public Law 119-21 on Long-Term Projections

As mentioned, P.L. 119-21 (the 2025 reconciliation) does not include direct Medicare savings to extend solvency – rather, it likely *worsens* it slightly. By speeding up trust fund exhaustion to 2033, it puts an onus on the next administration or two to address it. Interestingly, the law's deep Medicaid cuts could have some secondary Medicare effects: for example, if state Medicaid programs cut nursing home payments, some nursing facilities might close or refuse patients, potentially affecting availability of post-acute care for Medicare patients (which could raise hospital costs if discharges are delayed). Also, more uninsured among the 60-64 age group (due to ACA subsidy reduction) might mean some people enter Medicare at 65 in poorer health (having deferred care), which could increase Medicare spending for that cohort.

The **solvency issue is not just technical – it's about policy values.** Will we finance Medicare more from taxpayers (broadly sharing the load), from beneficiaries (through higher premiums or

cost-sharing), or from providers (accepting lower payments), or by transforming care delivery? Likely a mix of these will be required. The sooner changes are made, the more gradual they can be. For instance, a payroll tax increase now could be tiny and still compound to fill the gap, whereas waiting until 2030 might require a more drastic hike or benefit cut.

One "silver lining": Medicare's cost growth per person has actually been slower than private health insurance in the last decade. The ACA's reductions and the shift to value-based care have had some effect. The Trustees noted that if certain delivery system reforms (like ACOs) expand, we could see continued moderate growth. However, new expensive drugs and an aging population will counteract that.

In addition, **demographics beyond 2040** become more favorable: after 2050, the beneficiary growth flattens while the worker population can still grow with immigration and later retirement ages. So Medicare's toughest period might be 2025–2045, managing the Boomer bulge. Ensuring the program's solvency through that window is critical to avoid burdening younger generations or forcing abrupt cuts.

To put numbers in context: In 2023, Medicare benefit outlays were about $839 billion. By 2033, they will be well over $1.6 trillion annually if trends continue. The HI trust fund shortfall in 2033 was projected at around $55 billion (the gap between income and outgo that year). Bridging that isn't inconceivable in a $6 trillion federal budget – it's a matter of choices. If health care delivery can be made more efficient by even a few percentage points, and revenue adjusted slightly, Medicare can remain robust. Conversely, failure to act could lead to either automatic cuts or ad-hoc rationing which would undermine the program's guarantee.

Finally, it's important to highlight that **Medicare's financial challenges are fundamentally a reflection of broader health system challenges**: population aging and high per-capita healthcare costs. Solving Medicare solvency is intertwined with controlling healthcare inflation overall – through innovation, prevention, and tough choices about paying for new therapies. For instance, high-cost gene therapies cure diseases but cost $2 million per patient – Medicare will cover some of these under Part B or D, raising questions of how society will afford them for many. The drug pricing reforms are a step toward addressing that.

In conclusion, as of August 2025, Medicare's trust fund solvency warning bell is ringing louder. The next few years (leading up to 2030) likely present the last best opportunity to enact gradual changes. Whether through a bipartisan commission or budget deals, stakeholders broadly agree on the arithmetic (2033 insolvency) even if they differ on the solutions. The **commitment to Medicare's future** will be tested, but history shows that when push comes to shove, adjustments get made to uphold Medicare's promise. The hope among Medicare's champions is that any adjustments can strengthen the program *without* eroding the essential protections it provides to older Americans and people with disabilities.

Figure 2: Medicare Funding Sources (2023). Medicare is financed through a combination of general revenues, payroll taxes, and beneficiary premiums. Part A (Hospital Insurance) is

primarily funded by payroll taxes on earnings, whereas Part B and Part D draw about three-quarters of their financing from general federal revenue and the remainder from premiums (and state contributions for Part D) kff.org kff.org. Ensuring long-term solvency may require changes to these funding streams or cost structures.

Conclusion

In August 2025, Medicare stands at a pivotal juncture – a program **indispensable** to American healthcare, yet facing transformative changes and significant challenges. This report has examined Medicare's current state across its four parts and within the broader context of U.S. health policy. Several key themes emerge:

1. Evolving Benefits and Coverage: Medicare's coverage is more comprehensive today than ever. Parts A and B continue to provide the foundational hospital and medical benefits, while **Part C (Medicare Advantage)** has grown to serve the majority of beneficiaries, often with extra benefits like dental and vision care. **Part D** now offers improved drug coverage thanks to recent reforms – most notably the $2,000 annual cap on out-of-pocket drug spending that takes effect in 2025, which will alleviate financial burdens for millions. These enhancements reflect Medicare's ongoing commitment to improving affordability and access (e.g., free preventive vaccines and capped insulin costs). At the same time, the shift toward private plan delivery in MA raises questions about ensuring **equitable access and value** for the program's spending. CMS's new rules on marketing, network adequacy, and prior authorization demonstrate an effort to hold Medicare Advantage plans accountable so that beneficiaries get all medically necessary care without inappropriate barriers.

2. Legislative and Policy Developments: The enactment of **Public Law 119-21** in 2025 demonstrates how Medicare and other health programs undergo periodic policy adjustments. That law's measures – from Medicaid modifications and work requirements to Medicare eligibility criteria changes – have implications for coverage and care for various populations. The use of budget reconciliation for these changes highlights the procedural mechanisms available for healthcare policy modifications. Policy objectives focused on budget management intersect with practical impacts for patients and providers, contributing to ongoing discussions about the balance between fiscal sustainability and the **social insurance role** of Medicare/Medicaid. Moving forward, healthcare administrators must address implementation of these changes and monitor their effects during the transition period.

3. Medicare Advantage and Innovation vs. Oversight: The rapid expansion of Medicare Advantage reflects beneficiaries' attraction to out-of-pocket cost limits and extra benefits. It also reflects insurers' successful participation in Medicare's financing. The latest data showing MA enrollees now incur about 20% higher costs to Medicare than if they were in Original Medicare has heightened scrutiny on the program's payment model. Policymakers face the challenge of **recalibrating Medicare Advantage** to harness its innovative potential – such as

care management and flexibility – while eliminating inefficiencies or unfair advantages. The 2024–2025 CMS rules tightening marketing and requiring equitable prior authorization practices are steps indicating that **strong oversight is needed to protect beneficiaries' interests**. MA plans, for their part, are innovating with benefits addressing social determinants of health and chronic illness, which could improve outcomes. The coming years will likely bring further policy refinement: perhaps a new methodology for MA benchmark payments, integration of quality measures that truly differentiate plan performance, and expansion of value-based contracting with providers. The **lesson of 2025** is that Medicare Advantage's growth must be accompanied by robust monitoring to ensure it delivers **quality and cost-effectiveness** comparable to Traditional Medicare.

4. Drug Pricing Reforms as a Turning Point: The implementation of Part D reforms – inflation rebates, the out-of-pocket cap, and price negotiations – marks a historic shift in Medicare's role in the pharmaceutical marketplace. Medicare is no longer a passive payer of whatever prices the market sets; it is becoming an **active negotiator and regulator** of drug prices. Early signs (like slower price hikes for some drugs and high enrollment in the $35 insulin benefit) suggest these policies are making medicines more affordable and potentially bending the cost curve. However, long-term success will depend on execution details and industry response. It will be crucial for Medicare to maintain a balance: achieving lower costs while preserving incentives for genuine innovation (for example, safeguarding orphan drug development even as it closes loopholes that pharma might exploit to avoid negotiation). The drug pricing reforms enjoy broad public support and signify what is possible when political will aligns with beneficiary interest. They also set a precedent that could extend to other areas (e.g., possibly negotiating prices for high-cost Part B drugs or medical equipment in the future). Essentially, Medicare in 2025 has demonstrated that it can **adapt its policies to contemporary challenges**, addressing issues like exorbitant drug costs that were not foreseen when the program began.

5. Financial Sustainability and the Need for Proactive Measures: The financial outlook section of this report underscores a stark reality: Medicare's Part A trust fund is on a nine-year insolvency clock, and even if trust fund accounting is somewhat an artificial construct, it signifies that **expenditures are outpacing dedicated revenues by a widening margin**. Furthermore, the increasing share of Medicare spending coming from general revenues and beneficiary premiums raises concerns about intergenerational equity and affordability. The policy conversation is shifting from *whether* Medicare needs changes to *which* changes and when. In 2025, we see think tanks, bipartisan groups, and even private sector stakeholders (hospitals, insurers) acknowledging that reforms are needed to sustain Medicare for the next generation. Ideas range from raising the payroll tax or premiums for wealthy seniors, to delivery system reforms that reduce waste (e.g., site-neutral payments, where Medicare would pay the same for a service regardless of whether it's done in a hospital outpatient department or a freestanding clinic). The **sooner these discussions translate into policy**, the less disruptive adjustments will be. Fortunately, Medicare has a track record of periodic reforms (1983 DRG inpatient reform, 1997 payment cuts, 2010 ACA delivery reforms, etc.) that have extended its solvency and improved efficiency. The coming reform will likely need to be comparably

significant – perhaps a package combining revenue increases and spending moderation – to navigate the retirement of the baby boomers without compromising Medicare's guarantee of benefits.

In summary, Medicare in August 2025 is a program in **dynamic transition**. It is simultaneously expanding benefits (e.g., more drug coverage) and facing contraction in some respects (e.g., tighter eligibility for some groups), all while coping with the pressures of an aging population and rising medical costs. For healthcare policymakers, insurers, and providers, the imperative is to adapt to these changes and work collaboratively on solutions. Providers must adjust to new rules (like those on staffing or prior authorization) and continue improving quality under payment constraints. Insurers must innovate to deliver better care at lower cost or risk losing policy support for their current payment advantages. Policymakers must steer Medicare through partisan currents, preserving what works (high-quality care, broad access) and fixing what doesn't (inequities, inefficiencies, financing gaps).

Encouragingly, the Medicare program has proven resilient and capable of change. The **executive and legislative focus on Medicare in 2025** – from the reconciliation bill to CMS regulations – shows that the program remains at the center of health policy. The coming years will determine how successfully Medicare can balance the dual aims of **sustainability and adequacy** of benefits. The professional audience this report addresses – healthcare policymakers, insurers, providers – will be the ones crafting and implementing the next steps for Medicare. Their task is formidable: to ensure that Medicare at 65 (and now 60 years old as a program) can thrive for another generation, maintaining its promise to **beneficiaries** while evolving within the nation's economic and demographic realities.

The analyses and data presented here aim to inform that task. By understanding the current state of Medicare – its parts, recent reforms, legislative impacts, and fiscal status – stakeholders can make evidence-based decisions. Whether it's refining an aspect of Part D formulary, advocating for a particular solvency measure, or redesigning care models in Medicare Advantage, the decisions should be guided by the twin goals of improving health outcomes for beneficiaries and safeguarding the program's future. As of August 2025, Medicare is neither in crisis nor complacency: it is actively **transforming**, and with careful stewardship, it can continue to fulfill its role as a cornerstone of American health security for decades to come.

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