2027 Advance Notice: Examining the influence of fee-for-service Medicare spending trends on federal payments in Medicare Advantage

Commissioned by UnitedHealthcare

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CMS projects that average payments to Medicare Advantage organizations will increase by 0.09% in 2027[1] - essentially unchanged from 2026. But CMS expects fee-for-service (FFS) costs in the traditional Medicare benefit to rise by over 5%, creating a gap between FFS trend and MA payments.

The cost of healthcare in the U.S. has been a frequent topic of public discussion, as the federal government spent over one trillion dollars on Medicare in 2024.[2] This is projected to nearly double by 2033, and per capita Medicare spending trends are expected to grow by almost 6 percent per year over that time horizon.[3] UnitedHealthcare commissioned Milliman to analyze historical and projected Medicare trends and their impact on 2027 Medicare Advantage (MA) payment rates. This whitepaper aims to familiarize readers with what is driving the Advance Notice's FFS trends, what these assumptions imply about CMS' current expectations for healthcare trends heading into 2027, and how to understand the gap between expected MA payment trends and projected FFS cost trends.

Summary

The effective growth rate in the Advance Notice represents the year-over-year change in MA payment benchmarks. CMS projects 2027 FFS costs will be 5% greater than the projected 2026 costs from last year's final Rate Announcement, yet changes to the risk score model nearly fully offset this increase, resulting in a 0.09% change in payment rates from 2026 to 2027. As noted in the Advance Notice Fact Sheet, CMS expects risk scores, which directly affect MA payments, to increase by 2.45%, though it is unclear how much risk scores will increase due to an aging population versus pure coding intensity.

Underlying the growth rate are CMS's estimated changes in annual Medicare claim costs. We observe the following key drivers of projected trends:

- CMS projected trend in Part A costs is 3.0% in 2026 and 4.7% in 2027. Inpatient claims are a majority of Part A costs, and inpatient claim trends are projected to decrease in future years relative to recent historical experience. A major driver of this change is a large deceleration in utilization trends, though CMS does not explain what is driving this deviation from historical utilization patterns.
- CMS projected trend in Part B costs is 1.4% in 2026 and 5.9% in 2027. Significant adjustments to skin substitutes had a large effect on the Part B growth rate, but excluding this impact results in a more stable Part B trend of 6% in 2026 and 7% in 2027. One major source of uncertainty in Part B trends is a scheduled 2.0% reduction in physician fees. While this cut is currently slated to occur in 2027, Congress has intervened to prevent similar scheduled physician fee cuts in nearly every year since 2021. If such an intervention occurs again and is accounted for in projected costs, the growth rate would increase by about 0.4%.
- Healthcare cost trends are comprised of changes to utilization, mix of services, unit costs, and specific policy adjustments. Of these components, unit costs and policy changes are known in advance and therefore simpler to estimate, whereas utilization and mix

[1] 2027 Advance Notice Fact Sheet, does not include an adjustment for underlying coding trend in MA.
[2] Historical National Health Expenditure Accounts for 1960-2024, Table 19.
[3] Projected National Health Expenditures for 2024-2033, Table 17.

are more challenging to predict. We tested holding utilization and mix constant with the average observed trends from the last two years, which would result in a 1.9% increase in projected 2027 total costs relative to the projections in the Advance Notice.

Changes between the Advance Notice and final Rate Announcement are common, and incorporating more recent data may change projected payment rates. MA plans should monitor whether CMS decides to phase in the new risk score model or modify the "sources of diagnoses" provision, which currently accounts for a 1.53% reduction in payments, and compare CMS projections against their own expectations of future costs to determine what types of benefit changes or other adjustments are necessary for 2027.

Dissecting the Headline Number

There are several moving parts that comprise the 0.09% projected trend for Medicare Advantage, but they can generally be thought of as having two main elements – changes in spending for the FFS population and payment policies focused more explicitly on MA. Equally important is the difference between cost trend and payment growth rates, a critical distinction in the discussion that follows. Cost trend reflects the current best estimate of year over year utilization and cost per service changes. The effective growth rate trends represent the change in MA payment benchmarks from one year to the next, calculated as current 2027 CMS estimates compared to previous 2026 CMS estimates that were used in determining 2026 MA benchmarks. The effective growth rate will include both the estimated 2026 to 2027 cost trend, plus any restatements to the 2026 cost estimates as of the Advance Notice.

UNDERSTANDING CHANGES TO FFS SPENDING

MA payment benchmarks are anchored to FFS costs, making FFS trends a core driver of MA revenue. However, through the bid process, the MA program encourages plans to achieve costs below these FFS-based benchmarks, since savings—when achieved—are shared between reducing Medicare program costs and providing MA plans with rebates that fund supplemental benefits and lower premiums.

Average per-person FFS spending drives a 4.97% increase in 2027 MA payments

Per capita spending is usually the largest contributor to payment rate changes, and 2027 is no exception. But this roughly 5% growth rate runs counter to headlines of continuing high healthcare spending trends[4], and understanding the components of this value is key to evaluating the adequacy of proposed payment rates.

Roughly a third of that increase is attributable to changes in the FFS population

The FFS population is not fixed – as newer enrollees who are typically healthier have generally been more likely to enroll in MA in recent years, the overall age and illness burden of the FFS population has shifted. Since payment rates are anchored to the FFS population in the bid year, CMS' payment formula adjusts raw cost trends to account for the expected change in FFS risk scores between the current year and the bid year – worth between 1.5% and 2.5% depending on the source[5]. While changes to the risk adjustment model and the effects of the ongoing shift to electronic health records complicate a precise measurement, actual medical inflation – the change in the cost and use of healthcare for a population on an apples to apples basis – is smaller than the top-line payment growth rates. Put another way, payment growth locks in on the average FFS enrollee, but that average enrollee is a different – older and more costly – person.

Recent changes to payment for skin substitutes are a driver – and an example of the challenges in trend estimation

In response to significant increases in spending for skin substitutes in 2024 and 2025, payments for skin substitutes in FFS Medicare were revised downward by approximately 90% for 2026. This drives a $24 PMPM decrease in projected costs for physician administered drugs since last year's rate announcement – nearly 2% of total FFS costs. The effect on trends was even more pronounced – the upward revision of 2025 experience by $14 means the downward shift in cost for the experience period that will drive 2027 bids was roughly 3% of total costs for this single line item.

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[4] *Medicare membership, rising costs drag on health insurers' Q4 2025 earnings* | S&P Global (retrieved February 25, 2026) https://www.spglobal.com/market-intelligence/en/news-insights/articles/2026/2/medicare-membership-rising-costs-drag-on-health-insurers-q4-2025-earnings-98747579

[5] In the Advance Notice Fact Sheet, CMS indicates that trend in the normalization using the 2026 risk model would have been worth 1.5%, while CMS calculations in the Advance Notice using the 2017 risk score model show annual risk score trend from 2021-2025 at 2.51%. Annual risk score trend using 2021-2025 data and the proposed 2027 risk score model show annual risk trend of 1.89%.

RISK ADJUSTMENT POLICY CHANGES PULL RATES ALMOST ALL THE WAY BACK TO ZERO

Beyond the strict cost aspects, program policy changes influence payments as well. Some changes – such as anticipated effects of changes to star ratings and annual payment rebasing – are expected to have a limited effect on overall MA payment levels in 2027 on a nationwide basis. But two risk adjustment policy changes, described below, are expected to reduce payments to MA organizations.

The new risk model will drive a 3.3% drop in MA payments

While all of the different iterations of the CMS-HCC risk adjustment model are designed to ensure MA organizations are paid for the relative risk of their enrollees compared to FFS, not all risk adjustment models produce the same estimate of that relativity. CMS estimated the new risk model proposed in the Advance Notice is expected to reduce MA payments by 3.32%, with roughly half of that driven by expected coding trends and the change in the FFS population discussed earlier. The other half represents an apples-to-apples reduction in payments for MA members compared to the 2024 model, which itself delivered a significant reduction in payments over the model it replaced.[6]

Unlinked chart review records take some diagnoses off the table, driving another 1.5% decrease

The bulk of the remaining reduction in MA payments is related to the exclusion of diagnoses from chart review records that are unlinked to a patient encounter. This change in particular follows years of focus on this issue from MedPAC and others and drives another 1.53% reduction in MA payments.[7]

How does MA coding improvement fit in, and will it align with CMS expectations?

While the 0.09% projected trend for MA is intended to represent an apples-to-apples comparison of payments for current MA enrollees, CMS notes in the Advance Notice Fact Sheet that they expect MA risk scores to increase by 2.45% relative to 2026. While a risk score change of this magnitude would reflect a payment rate increase, it is unclear the degree to which this estimate reflects the effects of the aging population and an increasing illness burden in the MA population or an expectation that MA organizations will simply identify additional diagnoses for the same population.

The remainder of this whitepaper discusses this breakdown in more detail, with a focus on the specific FFS trends driving payment rate changes, as well as structural and circumstantial factors that may result in changes to these estimates in the rate announcement and in actual payments to MA organizations for 2027 plan offerings.

US Per Capita Costs (USPCCs), Actuarial Equivalence, and Payments

Payments in MA are complex, but the core payment dynamic is built around the concept of actuarial equivalence – the idea that the federal government should spend at most the same amount of money on a FFS enrollee as an MA enrollee with an equivalent illness burden. The payment structure outlined by Congress to accomplish this objective has three main pieces:

- **The average cost of a FFS enrollee**
  MA payments are anchored on the average US Per Capita Cost – with a number of additional adjustments that tend to, on average, reduce overall payment growth in MA. Changes from one year to the next are essentially FFS trends.
- **Relative health spending based on the health status of an MA enrollee compared to the average FFS enrollee**
  The risk score model is used to compensate MA plans based on the relative risk of their enrolled populations compared to the average Medicare member. The CMS risk model is specifically designed to produce an overall 1.0 risk score for a specific base payment year. CMS then calculates historical risk scores for the total FFS population to estimate how quickly FFS risk scores are changing and predict the average FFS risk score in the bid year. The risk score produced by the model is designed to measure costs relative to 1.0 in the base year (aligning with the average FFS spending in that year). To maintain that same connection with average FFS spending in the bid year, the risk score produced by the model is divided by this estimate of average FFS risk score in the bid year – the normalization factor – to predict the cost of that enrollee relative to the average FFS cost.
- **The increased number of diagnoses an MA enrollee will receive relative to an equivalent FFS enrollee**
  MA plan revenue can heavily depend on the diagnoses that are recorded for individual enrollees. This gives MA organizations an incentive to ensure more complete diagnosis coding relative to FFS – a concept called coding intensity. In recent years, CMS has

[6] Per the fact sheet accompanying the 2024 rate announcement, shifting from full effect of the 2024 model to a 1/3 phase in increased MA payments by about 1%, suggesting the 2024 risk model itself accounted for a 1.5% reduction in risk scores.
[7] MedPAC March 2025 Report to the Congress – Chapter 11, https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_Ch11_MedPAC_Report_To_Congress_SEC.pdf.

held this factor steady at a 5.9% reduction in MA risk score, suggesting that the portion of additional diagnoses captured by MA would generate about 6% more revenue than the diagnoses for FFS members of the same illness burden level.

There are a number of details that also affect payments, such as star ratings and geography, though the nationwide average effects of these are expected to be minor for 2027 on a nationwide basis.

Looking more deeply at FFS trends in the 2027 Advance Notice

The effective growth rate of 4.97% is the most important number in the Advance Notice for understanding the trajectory of Medicare payments. It reflects CMS's projection of what FFS Medicare will spend in 2027, adjusted for the geographic and enrollment composition of the MA program. This section breaks that number down into its service category components, identifies key drivers and anomalies, and shows what CMS's published values imply about medical cost trends heading into 2027.

FROM USPCC GROWTH TO THE EFFECTIVE GROWTH RATE

The effective growth rate starts with the USPCC: the average monthly cost of a FFS beneficiary. CMS publishes separate Part A and Part B USPCCs, which increased 7.04% and 3.91% respectively for 2027 compared to previous 2026 estimates, yielding a total FFS USPCC growth rate of 5.10%. The total USPCC, which incorporates managed care per-capita costs (increasing 3.27% from previous 2026 estimates), produces a growth rate of 4.04%. The effective growth rate of 4.97% is a blend between the FFS USPCC and total USPCC growth rates, with the majority of county benchmarks driven by the FFS USPCC growth rate and a smaller portion driven by the total USPCC growth rate.

FIGURE 1: NON-ESRD FFS USPCC SUMMARY, 2027 ADVANCE NOTICE

Source: CMS Office of the Actuary, 2027 Advance Notice (February 2026)

	PRIOR YEAR PMPM ESTIMATE: CY 2026	CURRENT PMPM ESTIMATE: CY 2027	GROWTH RATE
FFS Part A USPCC	$465.49	$498.28	7.04%
FFS Part B USPCC	$765.03	$794.95	3.91%
Total FFS USPCC	**$1,230.52**	**$1,293.23**	**5.10%**
Managed Care Per Capita	$1,376.30	$1,421.24	3.27%
Total USPCC	$1,309.71	$1,362.64	4.04%
Effective Growth Rate			**4.97%**

PART A: HIGH GROWTH RATE MASKS DROP IN PROJECTED TRENDS

Part A costs are projected to be 7.04% higher in 2027 compared to last year's estimates for 2026, driven primarily by inpatient hospital spending ($393 PMPM, up 7.04% from previous 2026 estimates) and skilled nursing facility costs ($87 PMPM, up 7.38% from previous 2026 estimates). This significant growth rate is partly driven by an under-projection of 2026 costs in last year's Rate Announcement ($465.49 PMPM, now restated to $475.91). CMS projected trend in Part A costs is lower—3.0% in 2026 and 4.7% in 2027. For inpatient care, CMS projects some deceleration in unit cost growth (2.50%, down from 3.05% in 2024) but assumes a sharp pullback in utilization trends - from 3.23% in 2025 to just 0.64% in 2027. CMS did not explain what is driving this significant slowdown of inpatient utilization trends relative to prior years.

In Figure 2, we break down the components of the CMS trends, isolating the traditional components of true claims trend (utilization, unit cost, and case mix) from all other adjustments that go into the final projected trends, such as the phase out of MA medical education payments. The subtotal in Figure 2 shows a clear decrease in projected trends (4% to 5% from 2025-2027) relative to the historical observed trends (6.5% to 7% from 2023-2025), driven largely by the steep drop in CMS expected utilization trends.

FIGURE 2: PART A ANNUAL TRENDS, 2023-2027

Source: CMS Office of the Actuary, Trends Supporting the 2027 Advance Notice Growth Rates

PART A SERVICE CATEGORY	2024 / 2023	2025 / 2024	2026 / 2025	2027 / 2026
Utilization	3.0%	2.9%	1.5%	0.8%
Unit Cost	3.1%	2.9%	2.5%	2.6%
Case Mix	0.4%	1.0%	0.9%	0.7%
Subtotal	**6.6%**	**7.0%**	**4.9%**	**4.1%**
All Other	-2.8%	-0.7%	-1.8%	0.6%
Total Part A	**3.6%**	**6.3%**	**3.0%**	**4.7%**

PART B: THE DOMINANT SOURCE OF UNCERTAINTY

Part B costs are projected to grow 3.91% in 2027 compared to previous 2026 estimates - materially slower than Part A. But this headline figure is misleading on its face. Part B now represents approximately 61% of total FFS USPCC ($795 of $1,293 PMPM), making it the dominant driver of overall spending levels. The lower Part B growth rate masks enormous variation across service categories: outpatient hospital trends remain elevated at 9.3%, while physician fee schedule spending is nearly flat at 0.9%. Most importantly, the Part B aggregate is being substantially depressed by a single payment policy change in physician-administered drugs that distorts the underlying trend picture.

FIGURE 3: PART B ANNUAL TRENDS BY SERVICE CATEGORY, 2023-2027

Source: CMS Office of the Actuary, Trends Supporting the 2027 Advance Notice Growth Rates

PART B SERVICE CATEGORY ANNUAL TRENDS	2024 / 2023	2025 / 2024	2026 / 2025	2027 / 2026
Physician Fee Sched.	4.4%	2.9%	4.9%	0.9%
Outpatient Hospital	9.2%	11.3%	10.1%	9.3%
Phys. Admin Drugs	28.7%	23.7%	-28.2%	7.3%
DME	10.2%	12.9%	5.7%	5.4%
Carrier Lab	8.9%	2.4%	5.6%	10.8%
Other Carrier	-6.5%	7.2%	6.9%	6.7%
Intermediary Lab	2.9%	3.5%	2.5%	5.9%
Other Intermediary	8.3%	5.0%	6.3%	4.8%
Home Health (B)	2.1%	3.6%	3.9%	10.2%
Claims Loading	-0.9%	-1.7%	1.4%	5.9%
Total Part B	**8.5%**	**9.1%**	**1.4%**	**5.9%**

Normalizing for Skin Substitutes

In response to a rapid escalation in billing for synthetic skin substitutes in 2024 and 2025, the 2026 Physician Fee Schedule rule and the 2026 Outpatient Prospective Fee Schedule rule changed payment methodology for these biological products, reducing projected spending by roughly 90%. The effect of this change on Part B trends is dramatic: projected 2027 physician-administered drug spending, which includes skin substitutes, was $117 PMPM in the 2026 Rate Announcement but appears as $91 PMPM in the 2027 Advance Notice, a reduction of $26 PMPM.

This creates an artificial hump-and-valley pattern in Part B trends. The 2025 base year appears elevated because actual skin-substitute billing came in 12.1% higher than the 2026 Rate Announcement (which relied on experience through the end of 2024) anticipated. Then 2026 appears suppressed because CMS models the full regulatory reduction. As a result, the 2027 Part B growth rate of 3.91% substantially understates the underlying trend in non-drug medical services.

Removing physician-administered drugs from Part B reveals a more stable - and more elevated - trajectory. Part B excluding physician-administered drugs grew at 6.7% from 2024 to 2025, 7.0% from 2025 to 2026, and 5.7% from 2026 to 2027. These growth rates tell a fundamentally different story than the headline figure (3.91%): underlying Part B medical costs are growing at closer to 6% annually, consistent with broader U.S. healthcare spending trends.

FIGURE 4: PART B TRENDS WITH AND WITHOUT PHYSICIAN-ADMINISTERED DRUGS, 2024-2027

Source: CMS Office of the Actuary, Trends Supporting the 2027 Advance Notice Growth Rates. Part B ex-Drugs calculated by authors.

	2024 / 2023	2025 / 2024	2026 / 2025	2027 / 2026
Total Part B	8.5%	9.1%	1.4%	5.9%
Phys. Admin Drugs	28.7%	23.7%	-28.2%	7.3%
Part B ex-Drugs	5.7%	6.7%	7.0%	5.7%

Outpatient Hospital: The Structural Cost Driver

While skin substitutes dominate the Part B narrative, the most consequential structural trend may be elsewhere. Outpatient hospital spending has grown from $165 PMPM in 2021 to a projected $271 PMPM in 2027 - a 64% increase in six years - and CMS projects continued growth above 9% annually. The driver is not unit cost inflation, which CMS estimates at a modest 2.30% for 2027, but rather volume and intensity trends running at 7.43%. This reflects a sustained structural shift in where and how care is delivered, as procedures continue to migrate from inpatient to outpatient settings and site-of-service differentials widen. While actual annual outpatient hospital trends have been growing at an increasing rate over each of the last several years, peaking at 11.3% in 2025, CMS projects these trends will begin to decelerate in 2026 (10.1%) and again in 2027 (9.3%).

Physician Fees: Policy Risk in a Scheduled Cut

At the other extreme, physician fee schedule spending is projected to grow just 0.9% in 2027 - the slowest rate of any major service category. The reason is straightforward: CMS's projection incorporates a scheduled 2.0% reduction to the Medicare physician conversion factor, reflecting the end of a 2026-only payment increase under current law. This cut, if it takes effect, would be a primary restraint on Part B growth. But Congress has intervened to prevent or partially offset a scheduled physician fee cut in almost every year since 2021, so assuming this reduction occurs may not be appropriate. Standing federal guidance requires actuaries to make their best estimate of the likelihood of passage of another payment increase, and it is likely that many actuaries will include an estimate of some degree of increase given the frequency of recent extensions. If a similar intervention occurred in 2027, the effective growth rate in the Advance Notice would underrepresent actual costs. Without the 2.0% physician fee schedule reduction, the effective growth rate would have been 5.32%.

WHAT CMS'S PUBLISHED TRENDS IMPLY ABOUT MEDICAL COSTS IN 2027

Taken together, CMS's service-category projections paint a nuanced picture. Inpatient utilization assumptions are unprecedentedly low, while SNF and home health trends remain elevated. The physician fee schedule trend is substantially a function of a scheduled cut that

Congress may delay again. And the headline Part B growth rate of 3.91% is an artifact of the skin substitute anomalous claims, resulting in changes in payment policy, not evidence that underlying medical costs are moderating.

There are a number of assumptions underlying projected trends, all of which have a direct impact on MA payment rates. It is challenging to unpack the difference between the growth rate and trends, and the drivers of trend that are true claim cost trends versus policy changes. However, once trends are broken down into their components, projecting each component forward is more straightforward. Policy changes such as the skin substitute adjustment are generally known and quantifiable, and unit cost changes are set by CMS. This leaves utilization and mix of service trends as the most challenging items to predict.

To sensitivity test alternative utilization and mix assumptions, using data published by CMS, we held projected utilization trends constant with average historical trends from 2023 to 2025 and re-projected 2027 PMPMs. This is shown in Scenario 1 of Figure 5 below. While CMS assumes a deceleration of trends in several service categories, holding those trends constant with the most recent trend levels would produce a total projected PMPM of $1,317.82, which is 1.9% higher than the projected PMPM in the Advance Notice. In Scenario 2, we apply an additional sensitivity test, building on Scenario 1 but also assuming Congress intervenes to avoid the 2% reduction in physician fees in 2027. This increases the projected PMPM further. While historical trends are certainly not always the best indicator of future trends, we use this sensitivity test to measure the impact of CMS's expected changes in utilization patterns relative to recent history.

FIGURE 5: SENSITIVITY TESTING OF CMS PROJECTED 2027 PMPMS

	PART A	PART B	TOTAL	SCENARIO IMPACT
CMS Projected 2027 PMPM	498.28	794.95	1,293.23	
Scenario 1: Assume Constant Volume & Mix Trend from Historical	515.34	802.48	1,317.82	1.9%
Scenario 2: Scenario 1 plus Removal of PFS Reduction	515.34	807.38	1,322.72	2.3%

As noted above, utilization and mix trends are among the most difficult to predict. We adjusted utilization and mix trends for the service categories for which CMS reported utilization and mix trends (inpatient, SNF, Part A and Part B home health, physician fee schedule, outpatient hospital, and DME). There is also volatility in the CMS projections for other service categories and for the "Other" trend component, however we did not test the impact of these assumptions as there is not enough information in the published CMS data to understand what is driving these trends.

How Likely Are These Projections to Change?

The projections described above represent CMS's best estimates as of late January — roughly 11 months before the start of the 2027 payment year. History shows that these estimates can change materially between the Advance Notice and the Rate Announcement, and that even CMS's understanding of what has already happened continues to evolve.

THE ADVANCE NOTICE IS A STARTING POINT

The Rate Announcement, published approximately two months after the Advance Notice, incorporates updated claims data and responds to public comment. In recent years, the gap between the two has been significant. The 2024 Rate Announcement more than tripled the Advance Notice's published bottom line, from 1.03% to 3.32%, as CMS softened the impact of its risk model transition in response to industry feedback. In 2025, the bottom line was essentially unchanged. But the 2026 Rate Announcement told perhaps the most dramatic story: the effective growth rate was revised upward from 5.93% to 9.04% — a 3.11 percentage-point increase in a two-month window, reflecting billions of dollars in updated cost estimates as actual claims replaced projections. Since the initial publication of a top-line payment growth estimate in 2015, 2024 is the only year that cost trends and payment rates were not updated in the Rate Announcement, with an average increase of about 0.7% to cost trends and about 1.2% to MA payment as estimates incorporate new information – more claims, final payment rules, and feedback received during the comment period.

CMS'S VIEW OF THE PAST CHANGES TOO

It is not only forward-looking projections that shift. Each time CMS publishes a new set of cost estimates, it revises its view of what prior years actually cost. The 2027 Advance Notice provides a revealing window: CMS now estimates that total FFS spending in 2025 is approximately $23 per member per month higher than it projected in the 2026 Rate Announcement — a 1.94% upward revision to the current year, driven by emerging claims experience in inpatient costs and physician-administered drugs. Conversely, the 2024 estimate was revised downward by roughly $10 PMPM, meaning the growth rate from 2024 to 2025 is even steeper than previously understood.

CMS's projections rely on claims experience through mid-2025 and actuarial judgment about how that experience extends through 2027. Milliman analysis of more recent data through October 2025[8] shows that observed 2025 trends are above 10%, which is notably higher than the trends in the Advance Notice. In periods of rapid change — new drug approvals, regulatory interventions, shifting utilization patterns — the distance between historical patterns and future patterns could grow, and with it the risk that published rates vary significantly from actual costs.

WHAT TO WATCH FOR IN THE 2027 RATE ANNOUNCEMENT

The Rate Announcement is expected in early April 2026. Several factors will determine how the final 2027 payment rates differ from the Advance Notice.

The effective growth rate revision could be a significant variable. For 2026, CMS revised the EGR upward by 3.11 percentage points between the Advance Notice and Rate Announcement. While a revision of that magnitude is not typical, any material change in CMS's cost estimates — driven by actual second half of 2025 claims experience — will flow directly through to the bottom line. The trajectory of skin substitute billing in the second half of 2025, and any early indicators of how the 2026 regulatory change is affecting prescribing and claims patterns, will be particularly influential.

The risk score model changes may be modified. In past years, CMS has phased in new risk score models, rather than implementing fully in one year. The sources of diagnoses provision may also be modified. At 1.53 percentage points of downward payment impact, this is the largest new policy element in the Advance Notice — without it, the published payment change would be approximately 1.62%.

Congressional action on physician fees remains uncertain. The 2027 Advance Notice incorporates a scheduled 2.0% reduction to the Medicare physician conversion factor. Congress has intervened to prevent or partially offset this cut in each of the past several years, and a similar intervention would raise both physician fee schedule spending and the effective growth rate.

The MA industry will be waiting with great anticipation to see if any changes are incorporated in the final Rate Announcement. As plans prepare their 2027 bids, reconciling their own projected trends with changes in payment rates will be a primary focus, as plans determine what type of benefit changes or other adjustments are needed to balance changes in plan-specific costs with the CMS established payment rates.

Caveats, Limitations, and Qualifications

This report was prepared by Milliman for UHC. UHC may share this information with external parties with Milliman’s prior written consent. We do not intend this information to benefit, and assume no duty or liability to, any third party that receives this work product. The report is intended to present a summary of factors affecting the change in MA payment rates as proposed in the CY 2027 Advance Notice. It is not intended, and should not be used, for any other purpose. Milliman does not intend to benefit any third-party recipient.

In preparing this analysis, we relied on information published by CMS. We accepted this information without audit but reviewed the information for general reasonableness. Our results and conclusions may not be appropriate if this information is not accurate.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Jason Karcher and Brian Larsen are members of the American Academy of Actuaries, and they meet the qualification standards for performing the analysis in this paper.

[8] Based on FFS claims trends observed in the CMS Accountable Care Organizations Realizing Equity, Access, and Community Health (ACO REACH) Model.