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Fact Sheet: Does Medicare Advantage Save the Government Money?

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Medicare Advantage (MA) is a program that allows private health insurance companies to provide Medicare benefits to eligible beneficiaries. A motivator for the implementation of the MA program was to leverage private sector efficiencies to provide Medicare benefits at a lower cost than Traditional Medicare (TM). The hope was that MA would 1) provide high quality care, 2) reduce out of pocket costs to beneficiaries, and 3) reduce overall spending on Medicare.

While MA enrollees do enjoy lower out of pocket costs, there is continued debate amongst government oversight bodies, researchers, and health plans about whether MA is fulfilling its promise to save the federal government and taxpayers money. Current data show that that the MA program overall ***does not save money***. In fact, reliable analyses to date show that the U.S pays ***more*** on average for an enrollee in MA than they do for a similar beneficiary in TM. While this finding has been contested by some, this fact sheet reviews the various evidence and outlines the increased transparency and reporting needed to 1) assess reasons for the differences, and 2) address any overpayment or parity issues that exist between MA and TM.

In this fact sheet:

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- What is the debate?
- How do MA plans try to reduce their spending?
- What is the evidence that spending for MA enrollees is higher than for comparable TM enrollees?
- What is the evidence that MA is not more expensive for the federal government?
- How can we bridge the gap between these narratives?

Why does this matter?

- **Medicare is a large part of the overall US federal budget**—in 2024 the U.S spent $910 billion on Medicare, accounting for 13 percent of all U.S spending.
- **Increased MA enrollment could increase overall federal spending**. Medicare beneficiaries are increasingly choosing MA. As of 2024 over half were enrolled in MA. If MA costs more, then any increase in MA enrollment could have a major impact on overall Medicare spending.
- **It is important to have fairness and parity between MA and TM**. Comparing the two programs is difficult because MA beneficiaries get extra supplemental benefits while TM beneficiaries do not. This is despite the fact that both groups pay Part B premiums that fund these benefits.
- **Cost containment in Medicare is a bipartisan issue**. Most policymakers support identifying ways to reduce Medicare spending while maintaining the current level and quality of benefits and sustaining the program for future generations.

What is the debate?

The MA program allows Medicare beneficiaries to get their health care via managed care plans such as a Health Maintenance Organization or a Preferred Provider Organization. It is often assumed that managed care will result in lower overall health care spending. But there is disagreement about whether MA is lowering or increasing overall federal spending on the Medicare program.

On the one hand, research by the Medicare Payment Advisory Commission (MedPAC)—an independent and bipartisan Congressional agency tasked with monitoring and advising Congress on Medicare payment—has concluded that the federal government is spending more on beneficiaries who select MA than on similar beneficiaries enrolled in TM. A growing body of research from health economists supports this conclusion.

In contrast, some researchers say that the comparisons between TM and MA conducted by MedPAC have not compared equivalent populations. Additionally, others have argued that comparisons need to take into account the "spillover" effect, where utilization management practices in MA change TM provider behavior, resulting in lower spending and reduced hospital use for all Medicare beneficiaries

Finally, others concede that federal spending on MA is higher ***but justified*** due to the value offered to enrollees in the form of extra supplemental benefits and lower out of pocket costs. Some also argue that because MA covers a lower-income, higher-needs population than TM, this justifies the higher federal spending.

How do MA plans try to reduce their spending?

Managed care health plans attempt to reduce spending by managing their enrollees' utilization of care. They use strategies such as limiting beneficiaries to specific "in network" providers (compared to TM beneficiaries who can seek care from any Medicare provider in the US). They also apply utilization management techniques such as requiring prior authorization and denying claims to reduce use of high-cost care and reduce duplication of services such as tests and treatments. (See MPI's Prior Authorization Fact Sheet).

To encourage enrollment in MA plans despite narrower networks and additional utilization management requirements, MA plans offer their enrollees other incentives. This includes lower cost sharing, including low or no premiums, lower co-payments/co-insurance and caps on their out-of-pocket spending, compared to TM. Moreover, MA plans offer extra benefits that are not available in TM such as limited dental, vision and hearing services and non-medical benefits that are expected to improve health (e.g., gym memberships, groceries). Lower cost-sharing and extra benefits increase MA spending relative to TM spending.

MA and TM are paid differently which can make it difficult to compare spending across the two programs

- **Traditional Medicare uses a "fee-for-service" (FFS) payment model**. This means that the federal government (through the Centers for Medicare and Medicaid Services, or CMS) pays providers (doctors, hospitals, etc.) each time they provide care for a Medicare beneficiary using a fee schedule that establishes what the reimbursement rate is for each service.
- **Medicare Advantage plans are paid a capitated rate** (i.e., a fixed amount per member, per month, or PMPM) for providing Medicare Part A and Part B benefits. This amount is "risk adjusted" meaning that enrollees are assigned to higher or lower payment groups based diagnoses that plans uncover through health risk assessments, utilization data and chart review. In addition to this, MA plan payment is further determined through CMS benchmarks based on TM spending, plan bids, rebates, enrollee premiums and quality bonuses. More detailed explanations of how MA plans are paid are available from MedPAC and The Commonwealth Fund.

Different payment systems result in different financial incentives

Fee-for-Service payments in traditional Medicare can result in providers earning more income when they provide a greater volume of services (e.g., more visits, tests, and procedures), even if those services are unnecessary. However, Medicare's Alternative Payment Models, episode payments, and payment bundles can mediate this incentive.

Capitated payment in Medicare Advantage gives plans a financial incentive to:

- reduce enrollees' use of care, especially "low-value" services where the costs or risks of the care outweigh the benefits. But it can also incentivize plans to inappropriately deny necessary services.
- enroll lower cost, healthier beneficiaries (called "favorable selection")—though risk adjustment mediates this incentive.

Risk adjustment in Medicare Advantage can also incentivize plans to engage in a practice called "upcoding" in which they uncover every possible diagnosis via approaches like health risk assessments and chart review to produce the highest possible PMPM payment from CMS—including diagnoses for which they are not currently providing care.

What is the evidence that spending for MA enrollees is higher than for comparable TM enrollees?

MedPAC, the Government Accountability Office, the US Department of Health and Human Services Office of Inspector General, Members of Congress, and a wide variety of research organizations have provided evidence that the federal government pays MA plans considerably more than what the same beneficiaries would cost under TM. For 2025, MedPAC estimates that CMS will pay 20 percent more for MA enrollees, for a total cost of $84 billion.

Research shows that upcoding and favorable selection are major drivers of increased spending in MA.

MedPAC estimated that favorable selection and upcoding increased the federal government's payments to MA by 20 percent. Other researchers have estimated that upcoding alone (not including the effects of favorable selection) resulted in higher payments to MA plans of up to $20 billion per year, though others suggested far lower amounts. Research also shows that there is wide variation in the degree to which MA plans upcode, with larger MA sponsors upcoding more than many of the smaller plans. For this reason some argue that proposals to address upcoding by reducing all plans' risk scores uniformly unfairly penalizes smaller plans.

Federal audits and investigations have produced evidence of MA overpayment.

An Office of the Inspector General investigation found that MA plans received $9.2 billion in risk adjustment payments based on diagnoses that plans found through chart review and health risk assessments, rather than care the plan actually provided. Additionally, CMS's 2022 Risk Adjustment Data Validation (RADV) audits, in which they review the coding in small random sample of plans, identified several diagnoses that were commonly miscoded, and found that about 21 percent of insurers had coding errors. Most of these audits resulted in penalties

anywhere from hundreds of thousands to millions of dollars being repaid to the federal government. In 2023, CMS increased the scope of the RADV audit program to help CMS recoup funds. The U.S. Department of Justice has also brought numerous False Claims Act cases against MA plans for fraudulent diagnosis coding, including against large insurers like UnitedHealth Group and Cigna.

The MA Quality Bonus Program (QBP) is a source of higher payment to MA plans.

The QBP pays plans bonuses for better star ratings. But unlike other Medicare pay-for-performance programs, the QBP does not include any monetary penalties for poor performance, and it therefore cost the federal government over $11 billion in 2024. Research suggests that the QBP is overly generous, awarding bonuses to plans with average performance. MA plans also complain that the QBP scores can be manipulated and can arbitrarily create large changes in plan revenue from year to year. Several MA sponsors have successfully sued CMS to improve their star ratings and increase their payments. Researchers and MedPAC have suggested various ways to reform the QBP program.

What is the evidence that MA is not more expensive for the federal government?

Some industry stakeholders argue that MedPAC's recent estimates of higher spending in MA relative to TM fail to take into account several factors.

- **Comparing beneficiaries with similar coverage**
  Comparisons between MA and TM spending are often criticized because they include TM beneficiaries who only have Part A or only Part B benefits. These beneficiaries may have artificially low spending because they have another source of coverage (in most cases, an employer). A Milliman analysis sponsored by an MA trade group suggests that MA is paid about the same as TM when you focus only on beneficiaries enrolled in both Part A and Part B and also include TM's administrative costs. However, that analysis did not consider the federal government's costs for administering the MA program.

- **Spillover Effect**
  Economists have shown regions with a higher proportion of MA enrollees (i.e., high MA penetration) are associated with reduced costs and lower utilization in TM, suggesting spillover effects from MA to TM. These effects are not included in MedPAC's comparisons of MA and TM costs. More research is needed to determine the total savings associated with this phenomenon.

- **MA plans bid below TM "benchmarks"**
  Every year CMS creates county "benchmarks" which are estimates of the total cost of providing Medicare benefits for TM enrollees in that county. MA plans then submit a "bid" that reflects their estimated costs of providing benefits. Some argue that because most plans bid below the benchmark, it indicates a potential for cost savings. In reality it does not produce cost savings because the federal government pays MA plans more than their bid—including risk adjustment payments and a rebate for some of the difference between the plan's bid and the benchmark. Plans with higher star ratings recoup more of this difference. Plans then use rebate funds to pay for extra supplemental benefits.

How can we bridge the gap between these narratives?

In order to clarify policymakers' understanding of whether MA is overpaid or paid appropriately, and to refine approaches to fixing any payment issues, it is important to increase the accuracy and granularity in what MA plans report about their spending and the benefits they provide. For example, policymakers and regulators need:

- More complete MA utilization data that allows better comparisons between TM and MA.
- More information on ownership structures and vertical integration and its effect on MA spending.
- More granular reporting on the cost and utilization of MA supplemental benefits.
- Transparent data on the criteria used by MA plans to determine who can access supplemental benefits.
- More research on the quality of care, denial rates, and effectiveness of supplemental benefits would help policymakers understand whether there is a justification for higher payment to MA plans; and whether supplemental benefits should be added to TM to increase fairness and parity.

For further reading: Policy proposals to address MA payment, including a variety of proposed changes to the benchmark/bidding system, risk adjustment, coding intensity adjustments, and the quality bonus program, are available in MPI's Compendium of Medicare Advantage and Part D Proposals.

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