Health Policy Perspective

Escalating Growth of Spending on Medicare Advantage Plans: Save Medicare From Insolvency and Balance the Budget

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Background: The U.S. health care system faces escalating costs and inefficiencies, with Medicare projected to reach insolvency by 2036. Despite this, Medicare Advantage (MA) plans continue to receive preferential funding, resulting in overpayments, rising patient out-of-pocket expenses and limited accountability, instead of being a tool to achieve lower spending and increase quality. Physicians endure payment cuts, sequestration, and denied services, threatening access to care.

Objective: To analyze MA plans' growth, costs, and policy implications and assess their impact on Medicare solvency, physician reimbursement, and patient care quality.

Study Design: A comprehensive policy and financial analysis using data from Medicare Payment Advisory Commission, Centers for Medicare and Medicaid Services, Congressional Budget Office, peer-reviewed literature, and federal reports from 1997–2025.

Methods: We reviewed legislative history, financial trends, and quality metrics of Medicare and MA programs. Specific focus was placed on benchmarks, rebates, risk adjustments, favorable selection, coding intensity, and patient access barriers. Data on enrollment trends, geographic variation, and out-of-pocket costs were analyzed.

Results: MA enrollment grew from 6.9 million (16% of Medicare beneficiaries) in 2014 to 33.6 million (54%) in 2024. Payments to MA plans exceed fee-for-service (FFS) Medicare by 22%, translating to $84 billion annually, plus $15 billion in quality bonuses. Out-of-pocket maximums surged 859% since 1999, and inappropriate care denials affect 13%-18% of cases. Risk adjustment and coding practices inflate payments, undermining program sustainability.

Limitations: The present investigation relies on secondary data from government agencies and published literature; real-time administrative and clinical data from MA plans were unavailable due to reporting gaps.

Conclusion: Originally intended to reduce costs, MA plans have driven higher expenditures, limited access, and increased patient burdens. Policy reforms—including alignment of MA payments with FFS Medicare, elimination of favorable selection and upcoding incentives, and enforcement of coverage requirements—are critical to preserving Medicare solvency and ensuring equitable patient care.

Key words: Medicare Advantage, Medicare solvency, physician reimbursement, supplemental benefits, quality reporting, coverage denials, interventional pain management

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At a time when the United States (U.S.) health care system is approaching unsustainable levels (1), and Medicare faces potential insolvency within the next decade (2,3), Medicare Advantage (MA) plans continue to expand, receiving priority over physician payments and patient care, yet operating without meaningful accountability (2,4-6). The present state with meteoric rise of MA defies the sole purpose of MA plans as a tool to achieve lowered spending and increased quality (5-10). On November 1, 2024, the Centers for Medicare and Medicaid Services (CMS) finalized a rule (7) affecting physician payments that eliminated certain telehealth services, later revealed to cost $2 billion annually, and implemented a 2.8% cut to physician reimbursements. These cuts reflect the expiration of temporary payment boosts intended to soften prior reductions to the conversion factor: 3.75% in 2021, 3% in 2022, 2.5% in 2023, and a projected 2.93% for 2024. The final rule also incorporated a 0% update for budget neutrality and inflation, continuing the downward pressure on the conversion factor. Additionally, physicians remain subject to ongoing 2% sequestration cuts mandated by the Budget Control Act of 2011 (8), expected to last through 2034 to fund the Affordable Care Act (ACA) (3). The proposed final rule and its impact on physicians is described (11).

Although physicians narrowly avoided a 4% reduction under the Statutory Pay-As-You-Go (PAYGO) Act of 2010 (9), which requires deficit-increasing legislation to be offset by spending cuts, this reduction could be reinstated (12). While CMS claimed budgetary constraints justified physician cuts, on January 10, 2025, they proposed a 4.3% payment increase to MA plans, amounting to $21 billion in one year and nearly $210 billion over a decade, starting in 2026 (4). This comes from the $84 billion excess payments made in 2023 for favorable selection and risk adjustment mechanisms (2,5,13-15). Moreover, veterans covered by Veterans Administration (VA) plans have reportedly been double billed through MA plans by approximately $15 billion annually (16,17).

A particularly concerning consequence of the rising costs of MA is the impact on all Medicare beneficiaries. Higher MA spending drives up Part B premiums for everyone, including those in traditional fee-for-service (FFS) Medicare. The Medicare Payment Advisory Commission (MedPAC) estimates that due to inflated MA payments, Part B premiums will rise by about $13 billion in 2025, equivalent to approximately $198 more per beneficiary per year (2,17). Although Congress has yet to cut MA payments, signs of fiscal distress are growing. Biniek et al (18) previously warned that higher, faster-growing per-enrollee spending in MA exacerbates Medicare's solvency and affordability crisis.

MA, now a $450 billion annual program, was founded on the premise that private insurers could deliver Medicare benefits more efficiently. However, according to researchers and government officials, MA has added tens of billions of dollars to health care costs rather than generating savings. MedPAC has projected that in 2025, MA will cost Medicare $84 billion more, or 20% more per enrollee, than FFS.

In broader terms, U.S. health care spending reached $4.9 trillion in 2023, a 7.5% increase from 2022 (1). This equates to $14,570 per person and 17.6% of gross domestic product (GDP). For comparison, in 1970, health expenditure totaled $74.1 billion; by 2000, they reached $1.4 trillion; by 2023, they had more than tripled. On the individual level, average annual family premiums for employer coverage rose 7% to $25,572 in 2024.

Multiple drivers contribute to rising health care expenditures, but congressional control over Medicare and Medicaid plays a significant role. Out-of-pocket spending for individuals also continues to climb (1). Medicare, which provides coverage to seniors and people with disabilities, is one of the largest and fastest-growing components of the federal budget. According to MedPAC and the Congressional Budget Office (CBO), net Medicare spending is projected to reach $14 trillion over the next decade. The Medicare Hospital Insurance (HI) Trust Fund, Part A, which covers about 40% of Medicare or 20% of total health spending, is projected to become insolvent by 2036 (2,3).

Despite mounting evidence from MedPAC, CBO, investigative journalism, and peer-reviewed research identifying issues such as inappropriate utilization, service denials, lower quality of care, excessive cost-sharing, and systemic fraud and abuse, MA plans remain shielded from reform. Meanwhile, CMS continues to approve cuts to physician payments, compounding the instability of the entire Medicare system.

Evolution of Medicare Advantage (MA) Plans

The Balanced Budget Act (BBA) of 1997 (19) established Medicare's managed care program under Medicare+Choice. This program was later renamed "Medicare Advantage" through the Medicare Prescription Drug, Improvement, and Modernization Act

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(MMA), signed into law by President George W. Bush in 2003 (20). The MMA introduced an optional prescription drug benefit that could be purchased as a standalone plan or integrated into an existing Part C plan. This legislation helped evolve Medicare into its current structure comprising Parts A, B, C, and D.

Part A covers:

- Inpatient hospital stays
- Skilled nursing facility care
- Hospice care
- Some home health care

Part B includes:

- Physician services
- Outpatient care
- Medical supplies
- Preventive care

Part C provides bundled coverage through private insurers, combining benefits under Parts A, B, and often D, and may include additional services such as dental, vision, and over-the-counter items.

Part D consists solely of prescription drug coverage.

Table 1 shows the difference between traditional Medicare and MA Plans.

Table 1. *Coverage and beneficiary costs in traditional Medicare and Medicare Advantage (MA), 2024.*

Traditional Medicare Coverage	**Medicare Advantage**
1. No restrictions on receiving medically necessary, covered services.	1. For nonemergent care, enrollees generally are restricted to "in network physicians, hospitals, and other providers in their service area.
2. Access to specialists and services without referrals or prior authorization	2. Plan may require primary care physician referral to see a specialist and may subject services to prior authorization or other utilization management.
3. Part A and Part B cover most medically necessary services and supplies in hospitals, physicians' offices, and other health care facilities but do not cover long-term care services, eye exams, and most dental care.	3. Plans must cover all medically necessary Pert A and Part B services. Plans may cover extra services that traditional Medicare does not, such as dental, vision, transportation, and gym memberships.
4. In most cases, enrollees do not need approval (or prior authorization for traditional Medicare) to cover their services or supplies.	4. In many cases, enrollees may need to get approval (prior authorization) from their plan before it covers certain services or supplies.
5. Enrollees can join a separate Medicare drug plan to get drug coverage (Part D).	5. Medicare drug coverage (Part D) is included in most plans. In most types of Medicare Advantage plans, enrollees cannot join a separate Medicare drug plan.
Costs 6. After beneficiary pays Part B deductible ($257), covered services require paying 20 percent coinsurance. Beneficiary pays hospital deductible ($1,676) for an inpatient admission.	6. Out-of-pocket expenses vary by plan and are not standardized. They are variable from $8,850 to $13,300 (average $8,850). Copays may vary from $30 to $785 per episode of service.
7. Enrollees pay a monthly Part B premium (standard, $185). Monthly premiums to join a prescription drug plan (Part D) average $46.50.	7. Monthly premiums for MA plans with prescription drug coverage average $17. Among MA recipients, 8% choose plans without drug coverage. Enrollees in MA prescription drug (MA-PD) plans also pay a monthly Part B premium.
8. Traditional Medicare does not limit out-of-pocket expenses. Most traditional Medicare beneficiaries have supplemental coverage, by paying monthly premiums to purchase Medigap coverage through Medicaid, through retiree coverage, or private plans ($138/month) and part D plan($55.50)	8. Plans have an annual maximum out-of-pocket limit, after which enrollees pay nothing, although the limit may vary for in-network, and out-of-network services. Maximum out-of-pocket limits may vary by MA plan so enrollees should use the Medicare Pian Finder to research options.[a] Enrollees cannot purchase supplemental coverage.

Adapted from: Lieberman SM, Mayes R. Inside the meteoric rise of Medicare Advantage. *Health Aff (Millwood)* 2025; 44:906-914 (5).
Source: Centers for Medicare and Medicaid Services. Compare original Medicare and Medicare Advantage [internet]. Baltimore (MD): CMS; [cited 2025 Jun 16]. Available from https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/your-coverage-options/compare-original-medicare-medicare-advantage; and CMS. Fact sheet: Medicare Advantage and Medicare prescription drug programs to remain stable as CMS implements improvements to the programs in 2025 [Internet]. Baltimore (MD): CMS; 2024 Sep 27 [cited 2025 Jun 16]. Available from: https://www.cms.gov/newsroom/fact-sheets/medicare-advantage-and-medicare-prescription-drug-programs-remain-stable-cms-implements-improvements. ahttps://www.medicareplanfinder.com.

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Type of Medicare Advantage (MA) Plans

The primary MA plan types are health maintenance organizations (HMOs), local preferred provider organizations (PPOs), and regional PPOs. Additional classifications spanning these types include Special Needs Plans (SNPs) and employer group plans. SNPs offer tailored benefit structures for specific groups such as dual eligibles (Medicare and Medicaid), institutionalized beneficiaries, or those with certain chronic conditions. All SNPs must operate as either HMO or PPO plans. Employer group plans, by contrast, are limited to Medicare beneficiaries affiliated with union or employer groups with contracts with MA insurers (2).

Covered Benefits

MA plans must cover all traditional Medicare services under Part A (hospital care, hospice, skilled nursing, and certain home health services) and Part B (physician visits, outpatient care, durable medical equipment, mental health services, and ambulance transport). In 2024, approximately 89% of MA plans included Part D drug coverage. Additionally, most MA plans offer extra benefits such as dental cleaning, hearing aids, and eyeglasses (21-26).

In 2020, MA plans could include a wide range of telehealth services within their core benefit offerings. Some plans offer access to gym memberships, meal delivery, acupuncture, or caregiver support.

Traditional Medicare, by contrast, has several key coverage gaps (21-26). It does not cover basic dental care, hearing aids, eyeglasses, or long-term care and requires beneficiaries to pay cost-sharing for most services. Moreover, prescription drug coverage is not included, requiring beneficiaries to purchase a separate Part D plan if desired. These Part D plans are offered exclusively through private insurers; no public or government-run alternative exists.

Related to these coverage limitations, many beneficiaries enrolled in traditional Medicare purchase additional insurance. Medigap or Medicare Supplement plans help cover the out-of-pocket costs left by traditional Medicare, such as the 20% copayment for Part B services. Some Medigap policies may also include services not covered by original Medicare, such as dental or vision care (27).

Private insurance companies sell Medigap plans. Premiums for these plans are paid in addition to the Medicare Part B premium and, if applicable, the Part D premium for drug coverage. In most states, Medigap insurers are obligated to issue policies to any qualifying applicant only during designated enrollment windows, outside of which they may deny coverage or adjust premiums based on the applicant's health history. These protections are known as "guaranteed issue" rights. Notably, federal law prohibits the sale of Medigap policies to individuals enrolled in MA plans.

Managed Care

Nearly all MA enrollees are subject to prior authorization requirements for coverage of specific treatments or services, an administrative control that traditional Medicare does not generally impose. Prior authorization allows MA plans to approve or deny coverage based on CMS covered procedures, but instead MA plans ignore CMS contracted requirement of regular Medicare coverage of all CPT codes, except those with a CMS noncoverage statement. MA plans arbitrarily utilize their own proprietary commercial insurance non-CMS clinical guidelines and standards of care. For services that the MA plans do not require preapproval, the MA plans still have the authority to assess medical necessity retroactively.

Concerns have long existed regarding the frequency and validity of such denials, whether made before care is provided or after payment is requested (2,21,23-26,28-39). A 2022 government report (39) examined denials from a sample week in June 2019 at 15 MA plans and found that 13% of denied services should have been approved under Medicare rules. Extrapolated over a year, this would amount to roughly 85,000 inappropriate denials of care. The report also found that 18% of payment denials were erroneous, translating to 1.5 million wrongful payment denials annually among those plans. These findings suggest a systemic pattern of excessive denial rates in some MA plans. However, it is also essential to recognize that inappropriate or excessive care, long documented in traditional Medicare, can be equally costly and harmful. Both denied and unnecessary care present risks to patients and increase systemic inefficiencies.

Access to Providers

Traditional Medicare offers beneficiaries nationwide access to any doctor or hospital that accepts Medicare, which includes the vast majority of physicians and nearly all hospitals. In contrast, MA enrollees must seek care from a defined provider network established by each plan. These networks vary widely depending on insurer and region.

A 2017 analysis revealed that, on average, MA

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networks included fewer than 46% of all Medicare-participating physicians within a given county. The CMS announced plans to increase oversight of these networks beginning in 2024, in response to findings that some plans had not met required "network adequacy" standards in prior years.

There remains debate over whether narrower or broader provider networks lead to better outcomes. While narrower networks may facilitate better cost control and coordinated care, broader networks are often viewed as enhancing choice. Despite these nuances, consumers frequently lack access to accurate, user-friendly information when comparing provider networks. Provider directories are usually outdated and inconsistently formatted, limiting transparency. Furthermore, many beneficiaries do not evaluate networks for post-acute care services, such as home health or skilled nursing, which they may unexpectedly require later.

Out-of-Pocket Costs

All MA enrollees are responsible for paying the standard Medicare Part B premium, $174.70 per month in 2024, with higher-income individuals paying more. A minority of MA plans cover part or all of this premium. Additionally, most MA plans charge an extra monthly premium, typically including Part D drug coverage. In 2024, the average MA plan with Part D coverage cost $17 per month, while 8% choose plans with no coverage.

Since 2011, MA plans have been required to cap enrollees' out-of-pocket costs for services covered under Parts A and B. In 2024, the maximum allowable out-of-pocket cost was $8,850 for in-network services in HMOs and PPOs (when only in-network providers are used), and $13,300 for combined in- and out-of-network services in PPOs. However, recent trends show a surge in cost-sharing amounts, with outpatient surgical copayments rising to between $450 and $785, compared to traditional levels of $100 to $250.

Some MA plans offer out-of-pocket limits below the federally mandated ceiling to attract enrollees. For 2025, the average in-network out-of-pocket maximum is projected to be $9,350 (22).

In contrast, traditional Medicare has no cap on out-of-pocket hospital or doctor service costs. Many beneficiaries purchase Medigap (supplemental) coverage to manage expenses predictably. In 2020, the average monthly premium for Medigap was $138; in 2024, the average premium for a standalone Part D plan was $55.50.

Whether traditional Medicare or MA is more cost-effective for an individual depends on multiple factors: their health status and care needs, the type and cost of supplemental coverage, MA plan benefits and network structures, and overall health care utilization.

Quality of Care

Ensuring quality care in MA is a critical function of CMS. Since 2006, CMS has used a star-rating system to assess plan performance. Ratings are based on nearly 100 metrics covering clinical quality, patient experience, and administrative efficiency. Over 40 measures are used to calculate an overall star rating for each MA contract, on a scale from 1 to 5. These ratings are available to beneficiaries via the Medicare Plan Finder tool and are meant to guide plan selection.

Beginning in 2012, as mandated by the ACA, CMS has linked the star ratings to its Quality Bonus Program (QBP). Under this system, MA contracts with ratings of 4 stars or higher receive financial bonuses reflected in benchmark increases and higher rebate percentages. Plans rated below 5 stars can still improve enrollment via a once-per-year special enrollment period, allowing switching to a 5-star plan outside the standard enrollment window.

Despite these incentives, the share of MA contracts receiving quality bonuses has declined. In 2025, 41% of rated contracts qualify for bonuses, down from 44% in 2024 and 51% in 2023. The proportion of MA enrollees in bonus-status plans decreased from 75% in 2024 to 69% in 2025. During the COVID-19 public health emergency (PHE), CMS temporarily relaxed quality reporting requirements, leading to a spike in average star ratings from 4.06 in 2021 to 4.37 in 2022. These leniencies ended in 2023; the average star rating dropped to 3.95 in 2025. The share of beneficiaries enrolled in 5-star plans has also fallen sharply from 27% in 2022 to just 3% in 2025.

Quality in Medicare Advantage (MA)

The MedPAC has long recognized the potential of MA to innovate and deliver higher-quality care at lower cost. However, the current system of quality measurement and reporting has significant shortcomings. MedPAC has concluded that the system fails to provide a consistent and reliable basis for comparing plan performance (2). Despite these flaws, the quality measures continue to drive substantial payments, with the QBP increasing MA spending by approximately $15 billion annually.

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Beneficiary satisfaction with both MA and traditional FFS Medicare remains high. In 2023, Consumer Assessment of Healthcare Providers and Systems surveys (CAHPS) showed broadly similar results between the two groups. For example, MA and FFS enrollees reported nearly identical scores for "getting needed care and seeing specialists" (MA: 81, FFS: 80) and "care coordination" (both scored 86). MA scores slightly exceeded FFS in categories such as "customer support," "health plan rating" and "health care quality rating," while FFS slightly outperformed MA on flu vaccine uptake. These results suggest that, on average, enrollees in both programs report comparable experiences, though differences may exist depending on specific plans or regions.

However, a growing body of literature documents persistent and escalating problems associated with MA plans (28-39).

Escalating Medicare Advantage (MA) Growth

Since their introduction, Medicare program components have undergone numerous modifications. Pursuant to the Deficit Reduction Act of 2005 (DRA), CMS began adjusting MA enrollee risk scores downward to account for differences in coding practices between MA plans and traditional Medicare (13-20,40). These payment reductions and risk-score adjustments were expected to decrease the number of MA plans and limit beneficiary enrollment. In 2010, the CBO projected MA enrollment would decline from 24% of beneficiaries in 2010 to 14% by 2020 (41). Similarly, the CMS Office of the Actuary projected a 50% decline in MA enrollment by 2017 under these payment changes, relative to prior-law projections (42). Instead, the ACA ushered in a substantial transformation of the MA program (2,3,5,40-44).

When the ACA was enacted, it was widely anticipated that MA enrollment would decline due to payment reductions, which were expected to lead to benefit cuts and premium increases (40-44). Instead, MA enrollment has steadily climbed since the ACA's implementation. In 2011, then-Chairman of the House Budget Committee, Paul Ryan, cited projections from the CBO and the CMS, predicting that MA enrollment would fall to 7.4 million by 2017, a 50% decrease from what would have been expected without the ACA's payment adjustments. Contrary to these forecasts, MA enrollment grew to 17.3 million by 2017, comprising 33% of the Medicare population. These concerns proved unfounded and ultimately contributed to surging MA spending, which now exceeds spending for FFS Medicare enrollees by 22%. As of 2024, MA enrollment reached 33.6 million beneficiaries, or 54% of the Medicare population.

In 2020, CMS expanded MA plan flexibility to offer additional supplemental benefits to keep beneficiaries healthier. However, these modest additions, such as transportation or meal delivery, coincided with significant increases in copayments and deductibles. While such benefits were promoted as innovations, MA plans used the opportunity to increase out-of-pocket spending. Between 1999 and 2025, average out-of-pocket costs surged from $976 to over $9,350, a rise of 859%. Patient copays for services increased from $0-$250 per service to $250-$750 per service. These rising costs are in addition to cost-sharing obligations for Part B drug benefits.

Despite these trends, MA enrollment and plan availability continue to grow. By 2024, more than half of eligible beneficiaries were enrolled in an MA plan. For 2025, the average Medicare beneficiary can access 42 different plans offered by eight national organizations. Rebates used to fund supplemental benefits remain at historically high levels. From July 2023 to July 2024, MA enrollment increased by 2 million (6%), reaching 33.6 million enrollees, even as the total number of MA-eligible beneficiaries grew by just 2%. As a result, MA's share of eligible Medicare beneficiaries rose from 52% in 2023 to 54% in 2024 (Fig. 1).

Enrollment in MA has more than doubled since 2010. Beneficiaries are drawn to MA plans by the promise of lower premiums, cost-sharing reductions, additional non-Medicare benefits, and a cap on out-of-pocket spending. For some beneficiaries whose care needs are met within network policies, MA may offer lower total financial liability compared to FFS Medicare with Medigap coverage (25). However, publicly available data also show that some high-needs MA enrollees face greater financial burdens than those in FFS Medicare, particularly due to higher cost-sharing for in-network and out-of-network care compared to the fixed costs of Medigap premiums (26,27).

Geographic Variations in Growth

MA enrollment patterns show variation across urban and rural areas. In 2024, 56% of eligible urban Medicare beneficiaries were enrolled in MA, compared to 47% in rural areas. Notably, MA enrollment in rural areas grew more quickly by 8% compared to a 6% increase in urban areas. Enrollment patterns by plan type also differ geographically. In rural areas, 39% of MA beneficiaries are in HMOs, compared to 59% in urban

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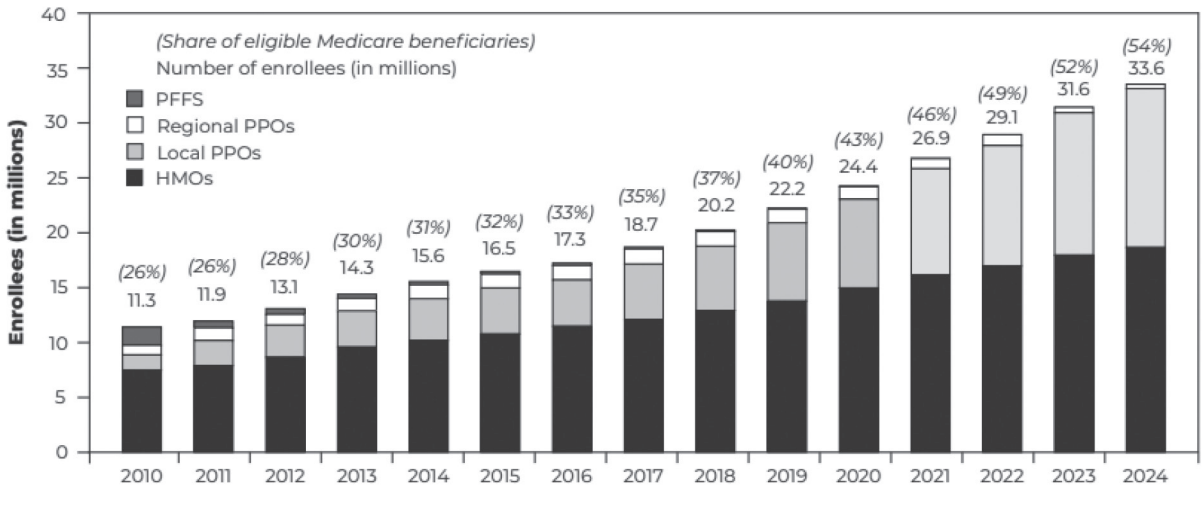


Fig. 1. *The share of eligible Medicare beneficiaries enrolled in Medicare Advantage has more than doubled since 2010.*

Note: PFFS (private fee-for-service), PPO (preferred provider organization), HMO (health maintenance organization). Beneficiaries must have both Part A and Part B coverage to enroll in a Medicare Advantage plan; therefore, beneficiaries who have Part A only or Part B only are not included in this figure.
Source: MedPAC analysis of CMS enrollment files, July 2010 to July 2024

areas. Conversely, 58% of rural MA enrollees are in local PPOs, compared to 40% in urban areas.

Medicare Advantage (MA) Rebates and Supplemental Benefits in 2025

In 2025, MA rebates remain near record highs. These rebates must fund supplemental benefits, such as reduced cost sharing, lower premiums, and coverage for services not included in Parts A or B, like dental, vision, hearing, and fitness programs. Some rebate dollars are also allocated to plan administrative costs and profit.

For nonemployer MA plans, the average rebate 2025 reached $210 per enrollee per month, up slightly from $209 in 2024. These figures exclude employer plans, which do not submit bids and receive payments based on prior-year nonemployer plan bidding behavior and county benchmarks. Rebates comprise 17% of total plan payments, consistent with 2024 levels. For conventional MA plans (excluding employer plans and SNPs), the average rebate in 2025 is $188 per month, or $2,255 annually. After subtracting administrative costs and profit projections, this amounts to $2,075 in benefits. While slightly lower than the $196 monthly rebate in 2023 (Fig. 2), this level remains nearly double that of 2018. SNPs continue to receive higher rebates, averaging $267 per member per month in 2025, with the gap between SNP and conventional plan rebates widening steadily since 2019. This increase parallels rising SNP enrollment and higher coding intensity among Medicaid-eligible MA enrollees.

As MA rebate spending grows, it becomes increasingly important for policymakers to understand how these funds are used and whether enrollees utilize the supplemental benefits they finance. Although plans are required to submit encounter data for these services, current reporting has proven unreliable. Medicare lacks sufficient data to evaluate how much is spent on each type of benefit, who uses the benefits or whether use varies by demographic or geographic factors. This lack of transparency makes it difficult to assess the actual value of these benefits or the cost-effectiveness of Medicare's spending. The MedPAC continues investigating MA rebates and supplemental benefits and will release additional analyses in future reports and presentations.

Escalating Cost of Medicare Advantage (MA) Plans Threatening Medicare Solvency

Traditional Medicare and MA can be compared across several dimensions, including the benefits provided, quality of care, patient outcomes, and costs.

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Fig. 2. *MA rebates for conventional plans and SNPs have more than doubled since 2017.*

Note: MA (Medicare Advantage), SNP (Special Needs Plan). Employer group plans and plans not offering Part D coverage are omitted. The plan rebate is the monthly amount the plan provides as premium-free supplemental benefits per beneficiary. Rebate dollar amounts are based on the national average and reflect plan risk scores in plan bids, but do not reflect payment adjustments for sequestration. Data for 2010 to 2020 differ slightly (by less than $2, on average) from the amounts we reported in previous years, which did not account for plans' adjustments for beneficiaries with Medicare as a secondary payer.
Source: MedPAC analysis of data from CMS on plan bids.

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However, policymakers have focused predominantly on cost comparisons between traditional Medicare and MA, as the original rationale for involving private insurers in Medicare was to reduce costs without compromising, if not improving, the quality of care. Despite this intent, earlier and more recent research has consistently found that MA plans cost the government and taxpayers more than traditional Medicare on a per-beneficiary basis (45,46).

Why Do Medicare Advantage (MA) Plans Cost More, and How Are They Paid?

As of 2024, MA payments were projected to be 22% higher than traditional FFS Medicare spending. Benchmarks for MA are set at 132% of FFS spending, while the average plan bid is about 101%. Administrative costs and profits account for 14% of MA expenditure, undercutting potential cost savings. The total excess MA payments compared to FFS Medicare amount to $84 billion, with another $15 billion (3.2%) allocated for quality bonuses (Fig. 3). According to MedPAC, MA payments, including rebates used for supplemental benefits, significantly exceed what would have been spent had the same beneficiaries remained in FFS Medicare. This continues a longstanding pattern of higher spending levels under Medicare's managed care payment policies. Even without adjusting for favorable selection or coding intensity, MedPAC estimates that payments to MA plans have generally been on par with historical FFS spending for beneficiaries with both Part A and Part B coverage.

Capitation

MA plans are paid a fixed amount per enrollee annually through risk-based contracts (Fig. 4) (47). This payment model, known as capitation, requires plans to manage all care for a set payment, assuming full financial risk. While this structure allows plans the flexibility to innovate in care delivery, various adjustments and bonuses layered onto the base rate complicate the system. Although beneficial in certain respects, these mechanisms contribute significantly to the higher costs

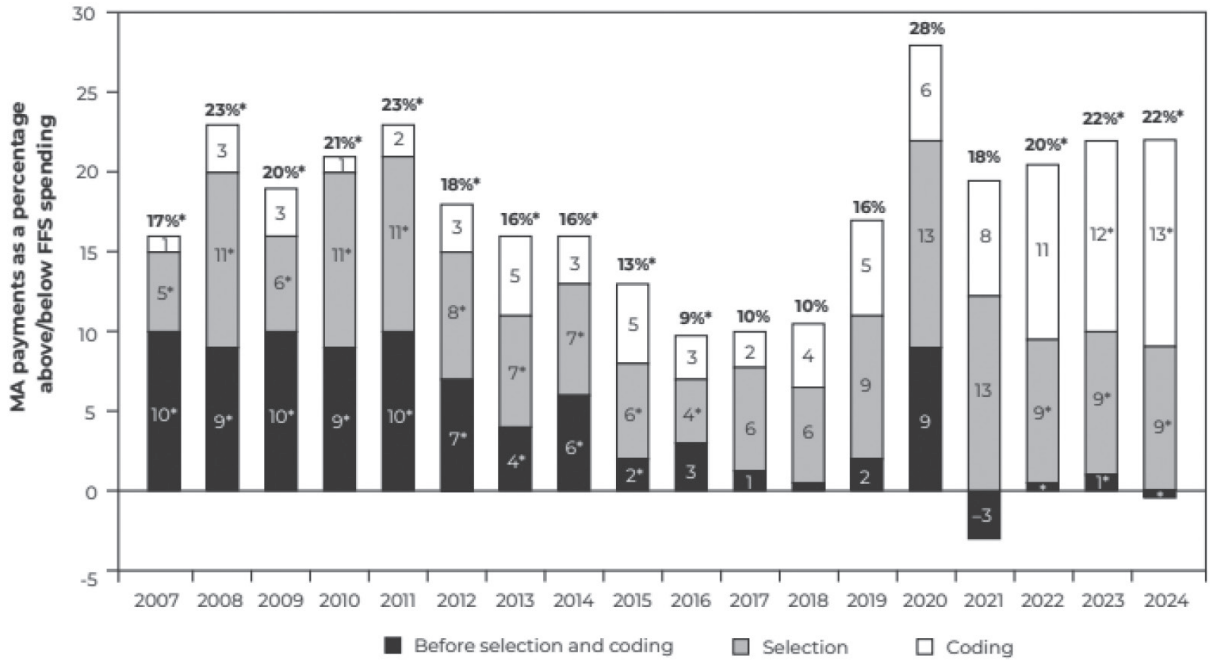


Fig. 3. *Higher Medicare Advantage payments relative to what estimated spending would have been in FFS, 2007-2024.*

Source: MedPAC Report to Congress: Medicare Payment Policy, March 2024.

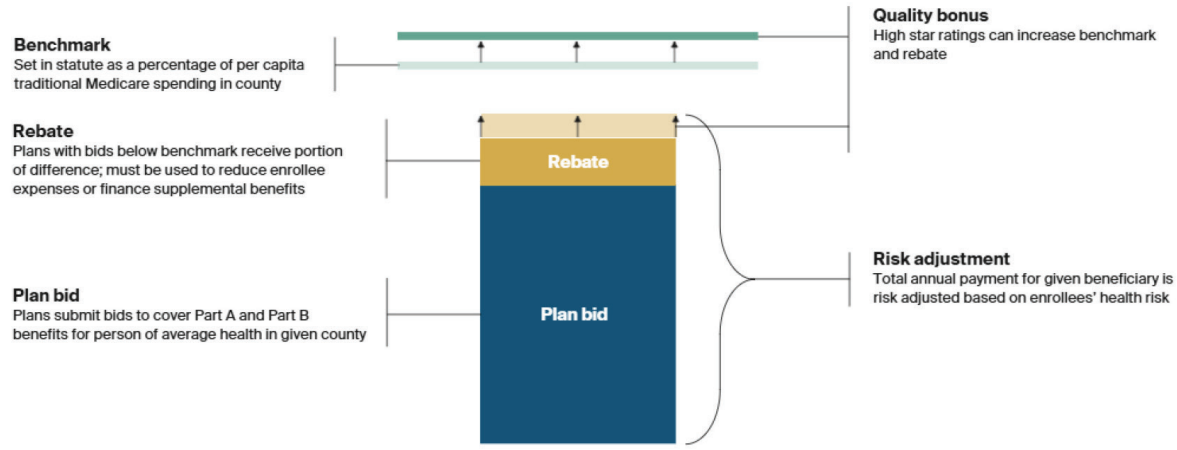


Fig. 4. *Medicare Advantage payments are based on a system of benchmarks, bids, and quality incentives.*

Source: Christina Ramsay, Gretchen Jacobson, Steven Findlay, and Aimee Cicciello, Medicare Advantage: A Policy Primer, 2024 Update (Commonwealth Fund, Jan. 2024). https://doi.org/10.26099/69fq-dy83

of MA compared to traditional Medicare. Moreover, all Medicare beneficiaries must pay a premium to support MA plans, further inflating system-wide costs.

Benchmarks

Benchmarks set the upper limit on what the federal government will pay MA plans and are established

as a percentage of local traditional Medicare spending, ranging from 115% to 95%. In counties with lower FFS spending, benchmarks are set higher (e.g., 115%), while in higher-spending counties, they are set lower (e.g., 95%). SNPs and other MA plans are paid according to the same benchmark methodology.

Bids

MA plans submit annual bids estimating the cost of providing Part A and B services to an average beneficiary. In 2022, according to MedPAC, 92% of these bids were below traditional Medicare spending and the county-specific benchmarks.

Rebates

When a plan's bid falls below the local benchmark, as is typical, the plan retains part of the savings as a rebate. This rebate represents shared savings between the government and the MA plan. Plans must use these rebate funds to reduce premiums, lower cost-sharing or offer additional benefits not covered by traditional Medicare. Rebates can also cover administrative expenses and profit margins. Rebates and bids are adjusted based on enrollees' health status, providing higher rebates for sicker, costlier beneficiaries. In 2023, average rebate payments for added benefits reached $196 per monthly enrollee (48). If a plan's bid exceeds the benchmark, the plan may charge additional premiums for core benefits, supplemental benefits, and Part D coverage.

Quality Adjustments

Plan quality ratings also influence benchmarks and rebate amounts:

- Plans with four stars or more receive a 5% bonus on benchmarks; in some counties, this rises to 10% in some counties. The ACA limits benchmarks, including quality bonuses, to what they would have been pre-ACA, which can restrict the bonus impact.
- Rebate percentages vary by quality: 50% for plans with ≤ 3 stars, 65% for plans with 3.5 or 4 stars, and 70% for plans with 4.5 or 5 stars.

Risk Adjustment

Bids and rebates undergo risk adjustment to reflect the health status of enrollees. This mechanism helps prevent plans from selecting only the healthiest individuals and avoiding sicker ones. Risk scores predict each enrollee's expected cost relative to the average Medicare beneficiary (score = 1.0). For example, a chronically ill, elderly patient may score above 1.0, while a young, healthy individual would score below 1.0. Accurate coding incentivized by this system helps insurers better manage care needs and improve services. Traditional Medicare lacks similar incentives, as about one-third of beneficiaries each year do not have an office visit where health data can be captured.

However, there are concerns about "upcoding" plans inflating diagnoses to make patients appear sicker and trigger higher payments (Fig. 5) (49,50). Critics argue this skews costs, while insurers claim their coding is more thorough. In response, Congress mandated CMS to reduce risk scores by 3.4% starting in 2010 and 5.9% from 2018 onward. Though CMS administrators have the authority to increase the reduction, none have done so. Some experts now advocate for completely redesigning the MA risk adjustment process. Recent research suggests that MA enrollees are not sicker than their FFS counterparts (51). Correcting for overpayments could save $600 billion between 2023 and 2031.

Medical Loss Ratios

Since 2014, MA and Part D plans must maintain a minimum medical loss ratio (MLR) of 85%, meaning that no more than 15% of their total revenue can be spent on administrative costs and profit. This rule aims to cap overhead and ensure that most funds go toward patient care. If a plan fails to meet this requirement, it must remit payments to CMS. Failure for three consecutive years bars the plan from enrolling new beneficiaries; failure for five years can lead to termination of the plan.

Margins tend to be higher in plans serving dual-eligible beneficiaries and those with chronic conditions. Institutional SNPs also typically have higher margins, though these declined in 2020, likely due to the COVID-19 pandemic.

Following the ACA, MA enrollment has grown rapidly, by 71% since 2010, reaching 20.4 million people (34% of Medicare beneficiaries) by 2018 and climbing to 54% by 2024. State-level enrollment varies widely, ranging from 2% to 63%, with 30 states reporting that over half of their Medicare population is enrolled in MA.

Higher Payments to Medicare Advantage (MA) Plans Stem from Favorable Selection and Coding Intensity

Favorable selection and differences in coding intensity significantly increase payments to MA plans

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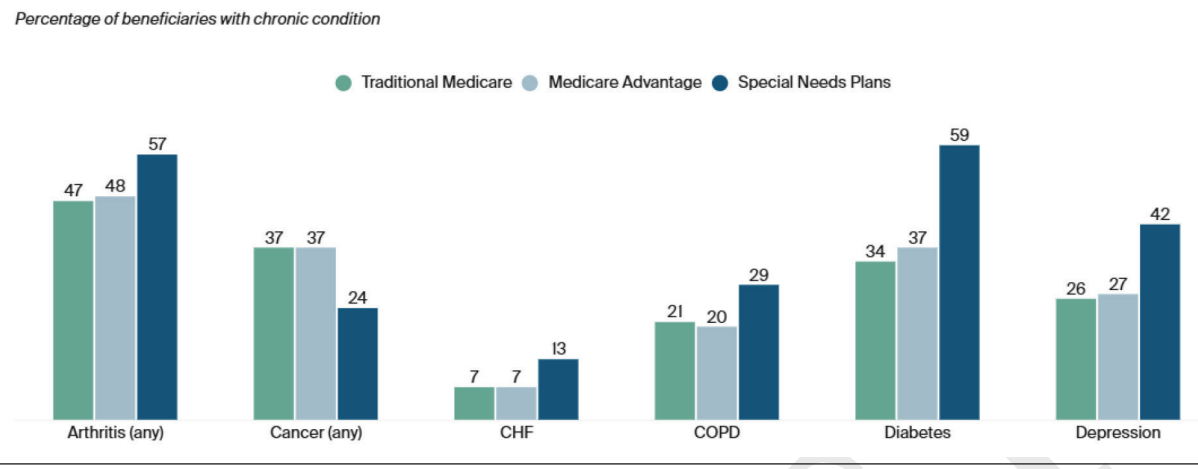


Fig. 5. *The prevalence of many chronic conditions is similar for enrollees in traditional Medicare and Medicare Advantage, after separating Special Needs Plans.*

Notes: Medicare Advantage plans, as shown, do not include Special Needs Plans (SNPs). CHF = congestive heart failure; COPD = chronic obstructive pulmonary disease, emphysema, and/or asthma. Across all listed chronic conditions, differences between SNPs and other types of Medicare coverage are significantly different, p<.05. Data represent community-dwelling beneficiaries. Beneficiaries in SNPs were determined using plan identifiers reported in the Medicare Current Beneficiary Survey.
Data: Analysis of the Medicare Current Beneficiary Survey, 2018, as cited in Gretchen Jacobson et al., Medicare Advantage vs. Traditional Medicare: How Do Beneficiaries' Characteristics and Experiences Differ? (Commonwealth Fund, Oct. 2021).
Source: Christina Ramsay, Gretchen Jacobson, Steven Findlay, and Aimee Cicciello, Medicare Advantage: A Policy Primer, 2024 Update (Commonwealth Fund, Jan. 2024). https://doi.org/10.26099/69fq-dy83

compared to what Medicare would spend under traditional FFS. Before accounting for coding differences, favorable selection has consistently led to risk scores for MA enrollees that overstate their expected costs in FFS, inflating MA payments by an estimated 11%, or $44 billion in 2025. On top of that, diagnostic coding practices in MA further exaggerate differences in health status between MA and FFS enrollees, contributing another estimated 10%, or $40 billion, in added payments above FFS in 2025. Combined, these factors result in MA payments projected to total $538 billion in 2025, or approximately $507 billion when excluding projected payments for enrollees with end-stage renal disease (ESRD).

MedPAC derived these estimates using CMS's projections for MA enrollment and average per capita payments. Accounting for favorable selection and coding intensity, Medicare is projected to spend 20% more on MA enrollees than it would have if the same individuals were enrolled in FFS Medicare. This amounts to a projected $84 billion excess payment, or 17% of total payments to MA plans (excluding ESRD payments) in 2025. These higher payments correspond with MedPAC's projections of plan rebates in 2025, which are also estimated to be 20% of FFS spending and 17% of total payments to MA plans. The magnitude of overpayments varies widely across MA organizations, mainly due to differences in coding intensity and other plan-specific factors. It is important to note that these additional payments do not equate to plan profits or administrative costs. Instead, they are used primarily to fund supplemental benefits and enhanced financial protections that attract beneficiaries and increase plan revenue.

These estimates begin with projected total payments to MA plans in 2025. These payments equal 100% of CMS's projected FFS spending (Table 2). Plan benchmarks and bids are projected at 108% and 83% of FFS spending, respectively. However, to accurately compare MA and FFS costs, it is necessary to account for differences in population characteristics, specifically coding intensity and favorable selection.

Coding intensity refers to the more comprehensive documentation of diagnoses for MA enrollees, which results in higher risk scores than if the same individuals were enrolled in FFS. Favorable selection reflects the tendency of beneficiaries with lower actual medical costs relative to their risk scores to enroll in MA, mean-

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Table 2. *Medicare Advantage payments were estimated to be substantially above FFS spending due to the effects of coding intensity and favorable selection.*

	Share of FFS spending in 2025		
	Benchmarks	**Bids**	**Payments**
Overall estimate	130%	100%	120%
Estimated before coding and selection	108*	83*	100
Estimated coding effect	+10	+8	+10
Estimated selection effect	+11	+9	+11

Note: MA (Medicare Advantage), FFS (fee-for-service). The "overall estimate" of benchmarks, bids, and payments as a share of FFS spending incorporates all three components of the Commission's methodology for comparing payments: a base comparison of MA payments with FFS spending that standardizes for differences in risk scores and geography but does not account for the effects of coding intensity and favorable selection; an adjustment to that base comparison for favorable selection; and an adjustment for coding intensity. The values in the "estimated before coding and selection" row reflect estimates using only the base comparison, without adjusting for the effects of coding intensity and favorable selection. The values in the third and fourth rows are the additive adjustments to the base comparison for the effects of coding and selection. Estimates do not include beneficiaries with end-stage renal disease. More details on our methodology can be found later in this chapter and the technical appendices. Components may not sum to totals due to rounding. * Estimates of benchmarks and bids relative to FFS spending do not include employer plans.
Source: MedPAC analysis of data from CMS on plan bids, enrollment, benchmarks, FFS expenditures, and risk scores.

ing that, absent any intervention, these beneficiaries would have lower standardized spending than the FFS average. MedPAC has refined its methods to estimate these effects more precisely in current and historical comparisons.

Adjusting for favorable selection and coding intensity increases projected plan benchmarks, bids, and payments relative to FFS spending. In 2025, benchmarks are projected to equal 130% of FFS spending, suggesting Medicare could spend up to 30% more for beneficiaries in MA than if those same individuals were in FFS. Actual MA payments are expected to be 120% of FFS spending because most MA plans bid below benchmark levels.

After adjusting for coding intensity and selection, projected bids in 2025 equate to 100% of FFS spending, indicating that MA plans, on average, estimate their costs to provide standard Medicare benefits are equivalent to those of FFS Medicare. Nonmedical expenses, including administrative costs and profits, are projected to represent 13% of plan bids.

Historical analysis of MA and other private plan payment structures over the past 40 years suggests that these arrangements have not yielded program-wide savings. Evaluations of pre-1985 Medicare demonstrations found private plan payments were 15% to 33% higher than FFS spending (29). Between 1985 and 2004, risk adjustment remained inadequate, and studies estimated private-plan payments exceeded FFS spending by 5% to 7% throughout the late 1980s and mid-1990s (30,31,52).

As shown in Fig. 6, from 2007 through 2025, payments to MA plans have consistently been at least 8% higher than FFS spending for similar beneficiaries. Between 2011 and 2017, this gap narrowed from 23% to 16%, mainly due to benchmark reductions under the ACA. However, once these benchmark changes were fully implemented in 2017, MA payments rose again relative to FFS, driven primarily by coding intensity and favorable selection.

Figure 7 illustrates how much more Medicare pays MA plans than it would have if the same beneficiaries were enrolled in FFS, expressed in actual dollar amounts. In this calculation, MedPAC excluded payments for ESRD beneficiaries, who are accounted for separately and are projected to comprise about 6% of total MA payments in 2025. Thus, the estimated $84 billion in MA overpayments for 2025 does not include ESRD-related spending. MA payments for ESRD enrollees are based on a separate model with different base payments and risk adjustments. MedPAC plans to address comparative analysis for this subgroup in future reporting.

The methodology for estimating the difference between MA and FFS payments comprise three components. First, a base comparison is calculated using standardized FFS spending that adjusts for geography and average risk scores but excludes adjustments for coding and selection. Second, an estimate is developed for favorable selection, which is then used to adjust the base comparison. Third, the effect of coding intensity is estimated and used to change the comparison further. Historical data are used to estimate the impact of each component for the most recent years available, 2022 for the base and selection components and 2023 for coding intensity. Projections for each component extend through 2025, offering Congress the most current available estimates. These projections carry inherent uncertainty and updated comparisons for each year will be provided as data becomes available. Additional methodological details for these calculations can be found later in the chapter and the accompanying technical appendices.

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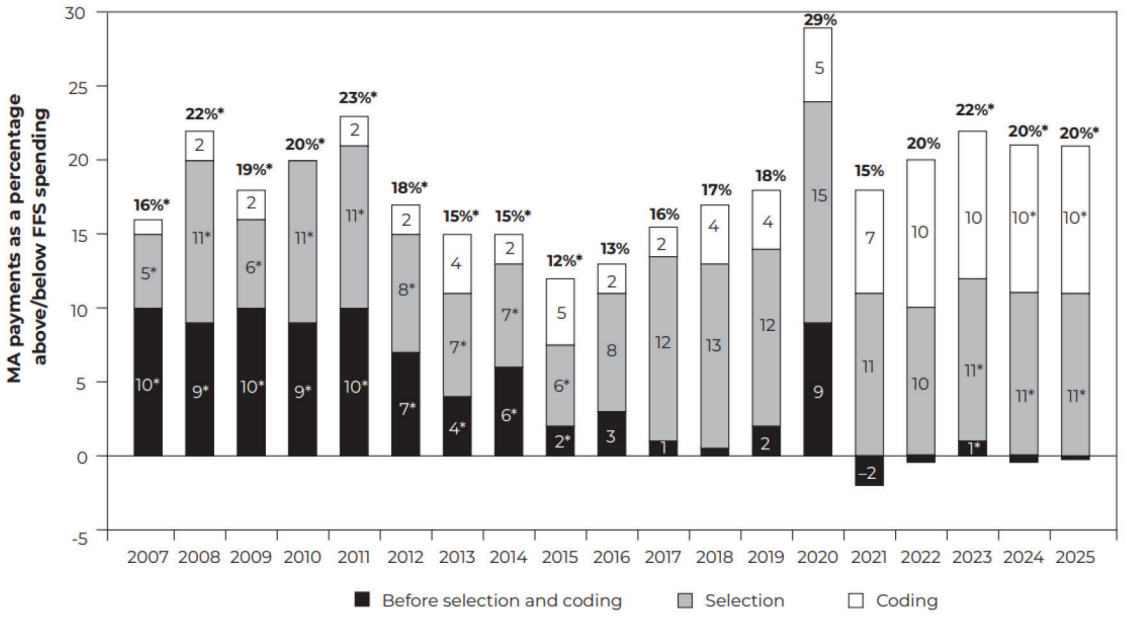


Fig. 6. *Higher Medicare Advantage payments relative to what estimated spending would have been in FFS since 2007.*

Note: MA (Medicare Advantage), FFS (fee-for-service). Estimates of MA payments relative to what spending would have been in FFS before selection and coding are less than 0.5% for 2018, 2022, 2024, and 2025. Estimates of coding-related MA payments are less than 0.5% for 2007 and 2010. We exclude MA payments for beneficiaries with end-stage renal disease. Components may not sum to totals due to rounding. * Specified values were derived from projected data (for 2023 to 2025) or earlier methodologies for estimating each component (for 2007 to 2015). Values without an asterisk were estimated using historical data and the current and most comprehensive version of the methodology for estimating each component. See text for details.
Source: MedPAC analysis of Medicare enrollment, Medicare claims spending, and risk-adjustment files.

Medicare Advantage (MA) Benefit Package and Cost Limitations

MA plans are required to provide a benefit package that is at least equivalent to that offered by traditional Medicare. Despite this requirement, out-of-pocket costs for Medicare Parts A and B have increased substantially, from $976 in 1999 to $8,707 in 2024, reflecting a 792% increase over 25 years.

In its March 2025 report to Congress, MedPAC found that payments to MA plans were 22% higher than traditional FFS Medicare spending. Administrative costs and profits represent 14% of total MA expenditures, undermining claims of cost efficiency. These excessive payments translate to $84 billion annually in spending above FFS levels, with another $15 billion (3.2%) allocated for quality bonuses. Policy changes could produce significant savings: canceling the proposed 4.3% payment increase for 2026 would save $21 billion annually ($210 billion over ten years); eliminating duplicate coverage for veterans already served by the VA would save $15 billion annually ($150 billion over ten years); addressing favorable selection would yield $44 billion in annual savings ($440 billion over ten years); and reforming risk adjustment could generate $40 billion annually ($400 billion over ten years).

Out-of-pocket maximums under MA have increased sharply. In 2024, the in-network maximum reached $8,850, a 792% increase from 1999. The combined in-network and out-of-network maximum reached $13,300, a 1,262% increase (Fig. 8).

A *Wall Street Journal* investigation published on December 2, 2024, reported that MA plans received $44 billion in unnecessary payments between 2018 and 2021, averaging $15 billion per year, much of which went unused by insurers (10). A separate investigation published on November 11, 2024, revealed that the sickest patients, particularly those in their final year of life, are more likely to switch from MA to traditional Medicare. This transition shifts high-cost care to taxpayers and reduces insurers' liability (53).

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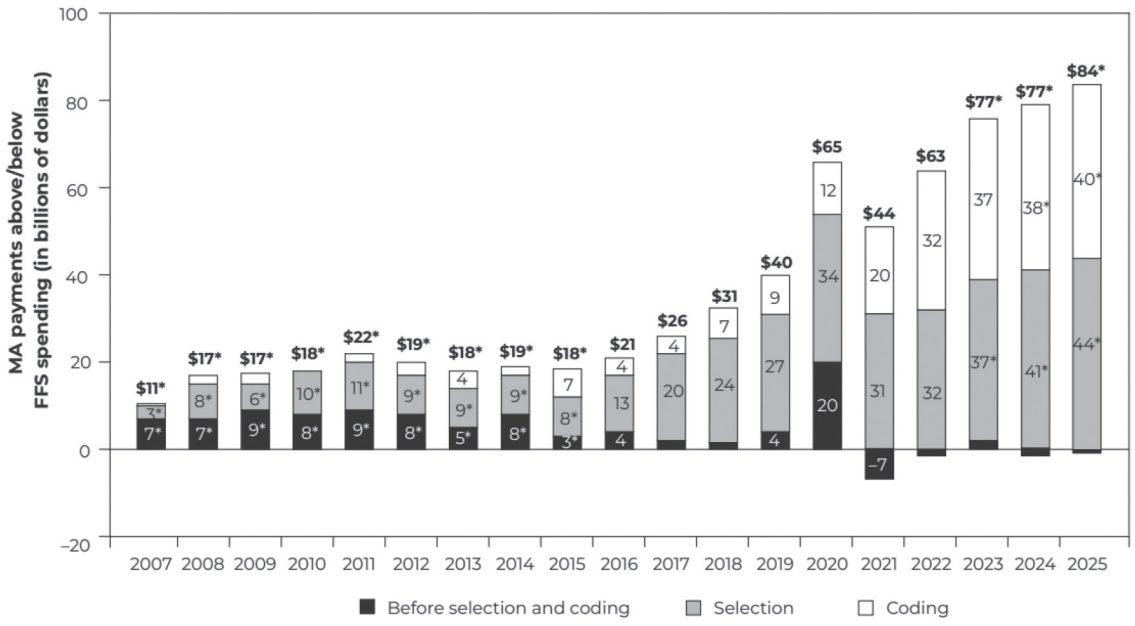


Fig. 7. *Higher Medicare Advantage payments relative to what estimated spending would have been in FFS since 2007.*

Note: MA (Medicare Advantage), FFS (fee-for-service). Estimates of MA payments relative to what spending would have been in FFS before selection and coding are less than $3 billion for 2017, 2018, 2022, 2023, 2024, and 2025. Estimates of coding-related MA payments are less than $3 billion for 2007, 2008, 2009, 2010, 2011, 2012, and 2014. We exclude MA payments for beneficiaries with end-stage renal disease. Components may not sum to totals due to rounding.
*Specified values were derived from projected data (for 2023 to 2025) or earlier methodologies for estimating each component (for 2007 to 2015). Values without an asterisk were calculated using historical data and the methodology's current and most comprehensive version for evaluating each component. See text for details.
Source: MedPAC analysis of Medicare enrollment, Medicare claims spending, and risk-adjustment files.

Out-of-pocket costs for MA enrollees can be prohibitively high. Patients may face charges of up to $300 per visit, often exceeding the reimbursement rates for interventional pain procedures and ambulatory surgical services.

Enrollment in MA has surged. By 2024, 32.8 million beneficiaries, or 54% of the eligible Medicare population, were enrolled in MA, up from 6.9 million (16%) in 2014. This reflects a 120% increase in enrollment over a decade, with a 6% increase occurring between 2023 and 2024 alone.

Though MA plans are promoted as delivering higher-quality care at reduced cost, these promises have eroded. MedPAC has concluded that the current quality measurement and reporting system is flawed, offering no reliable basis for comparing performance across plans. Nonetheless, these measures drive $15 billion annually in Quality Bonus Payments. Studies comparing MA and traditional FFS show no significant difference in overall quality of care. In some cases, complication rates may be higher among MA enrollees than those in FFS Medicare.

Despite marketing claims, MA plans are still legally required to cover all Medicare-approved services (all CPT codes except those with a non-coverage statement) and provide a benefit package equivalent to traditional Medicare.

Issues in Interventional Pain Management

MA plans often deny necessary interventional pain procedures without appropriate clinical justification Such denials conflict with federal requirements that MA plans cover all services included under traditional Medicare. Congressional oversight is needed to ensure full compliance with coverage mandates.

Additionally, certain Medicare Administrative Contractors (MACs), including Noridian and Palmetto, have issued unauthorized National Coverage Determinations

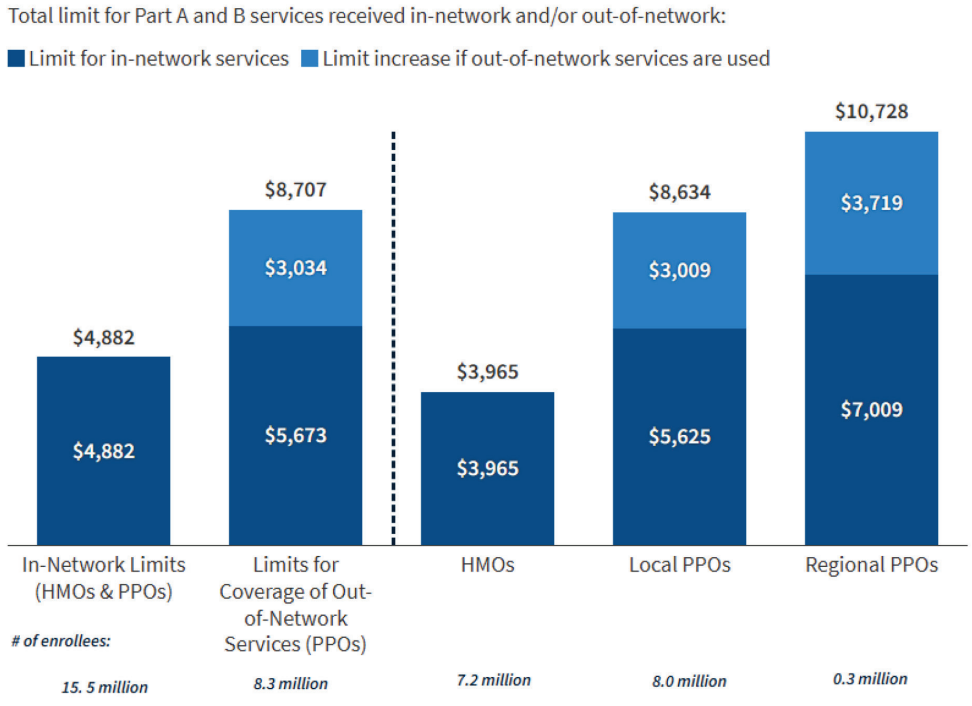


Fig. 8. *Average Medicare Advantage plan out-of-pocket limits, weighted by plan enrollment, 2024.*

Note: Excludes SNPs, employer group health plans, PACE plans, cost plans, and HMOPOS plans. HMOPOS plans include about 5.0 million enrollees; about 85% do not have an out-of-network out-of-pocket limit, about 10% have a combined out-of-pocket limit, and about 5% have separate in-network and out-of-network out-of-pocket limits. About 1% of local PPO enrollees have separate in-network and out-of-network out-of-pocket limits.
Source: KFF analysis of CMS Medicare Advantage Enrollment and Landscape Files, 2024.

(NCDs) restricting procedures like percutaneous adhesiolysis, despite extensive clinical evidence supporting their efficacy and safety. These actions exceed the MACs' authority and contradict established Medicare policy.

Unjustified Denials and Reimbursement Issues

MA plans frequently deny coverage by claiming that treatments are "experimental" or "investigational," by citing the absence of NCDs or Local Coverage Determinations (LCDs), or by denying appeals with inadequate justification, often referring providers to generic online information. These plans may also violate contractual agreements by pushing providers out of the network, thereby restricting patient access and burdening providers.

Medicare Advantage (MA) Plans: Compliance with Federal Law

According to Chapter 4 of the Medicare Managed Care Manual, failure to provide required services under an MA plan constitutes discrimination under federal law. This includes violations of the ACA, the Civil Rights Act, the Age Discrimination Act, the Americans with Disabilities Act (ADA), and the Genetic Information Nondiscrimination Act.

MA plans are prohibited from denying or conditioning enrollment based on health status, claims history, genetic information, or payment source. Noncompliance with these legal protections may result in enforcement action against plans that discriminate, particularly against those requiring specialized care.

Lack of Local Medicare Coverage Policies

LCDs are not required for all procedures; they are typically developed for high-volume, high-cost services. However, the absence of LCDs for many procedures providers request leads to inconsistent reimbursement policies across MA plans. This often forces providers

to either absorb the cost or deny essential care to patients.

In contrast, Medicare FFS reimburses these same procedures regardless of whether LCDs exist, revealing inconsistencies and inequities between the two programs.

Policy Proposals

Congress should consider adopting policy recommendations from the CBO, MedPAC, and other expert bodies to sustain Medicare and ensure appropriate access to care across both traditional and MA plans.

Medigap Regulations Provide Protections for Beneficiaries, Substituting Major Disadvantages of Medicare Advantage (MA) Plans

The traditional Medicare benefit package requires beneficiaries to pay substantial out-of-pocket expenses for most types of care. Cost-sharing includes deductibles for inpatient care and 20% coinsurance for Part B services, with no cap on total out-of-pocket spending. To manage these gaps in coverage, most beneficiaries obtain supplemental insurance. This supplemental coverage may come from an employer, Medicaid, or the government. Other options include individually purchased MA plans, which replace traditional Medicare coverage or individually purchased Medigap plans, which supplement traditional Medicare.

Approximately 80% of traditional Medicare beneficiaries who lack other forms of supplemental coverage purchase Medigap insurance. Medigap plans typically cover a significant portion of Medicare cost-sharing, although beneficiaries must pay a premium for this protection. Medigap is crucial in mitigating financial risk for enrollees not enrolled in MA plans (54-56).

Despite its importance, Medigap is underutilized. It is also largely controlled by the same insurers that offer MA plans, which may contribute to a systemic push directing seniors toward MA. Generally, Medigap is perceived to offer:

- Lower overall costs,
- Fewer administrative burdens (e.g., no pre-authorizations), and
- Better access to care.

Sun et al (54) highlights that guaranteed issues and community rating regulations for Medigap plans are essential in protecting beneficiaries who wish to disenroll from MA plans. These protections prevent insurers from denying coverage or charging higher premiums based on health status. To strengthen beneficiary options, policymakers may consider increasing public education and requiring insurers to sell MA plans to offer Medigap coverage.

Budgetary Savings

Budgetary savings could be realized through several key measures: canceling the proposed 4.3% payment increase for 2026 would save $21 billion annually ($210 billion over ten years); eliminating overlapping payments for veterans already covered by the VA would save $15 billion per year ($150 billion over ten years); implementing risk adjustment reforms would yield $40 billion annually ($400 billion over ten years); and addressing favorable selection would save $44 billion per year ($440 billion over ten years).

In addition to aligning MA payments with FFS Medicare and using savings to offset sequestration cuts, Congress should legislate co-insurance reforms to improve affordability, such as capping copays and deductibles at $100 per occurrence.

MA plans must be held accountable for fully covering all Medicare-approved services to ensure compliance with federal requirements (all CPT codes, except those with non-coverage statements). Congress should also standardize the issuance of LCDs across Medicare carriers to promote consistency in coverage. Moreover, Medicare carriers should be barred from independently issuing non-coverage policies; these decisions should remain under the sole purview of CMS and the Medicare Evidence Development & Coverage Advisory Committee (MEDCAC).

Conclusion

MA plans, created to lower costs and improve care, now place heavy financial strain on Medicare, taxpayers, and beneficiaries. Overpayments, fueled by favorable selection, aggressive coding, and inflated benchmarks, jeopardize Medicare's long-term stability as premiums and out-of-pocket costs climb. Findings from MedPAC, CBO, and federal investigations highlight systemic inefficiencies, questionable care denials, and inequitable reimbursements. Without reforms to payment structures, risk adjustment, and oversight, unchecked MA growth will deepen Medicare's fiscal crisis, limit access, and erode trust. Swift, evidence-based policy action is critical to safeguard Medicare's future.

Author Contributions

The article was designed by LM, ADK, and MRS.

All authors contributed to the preparation of this

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article, reviewed and approved the content with the final version.

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