MILLIMAN CLIENT REPORT

Value of Medicare Advantage to the federal government

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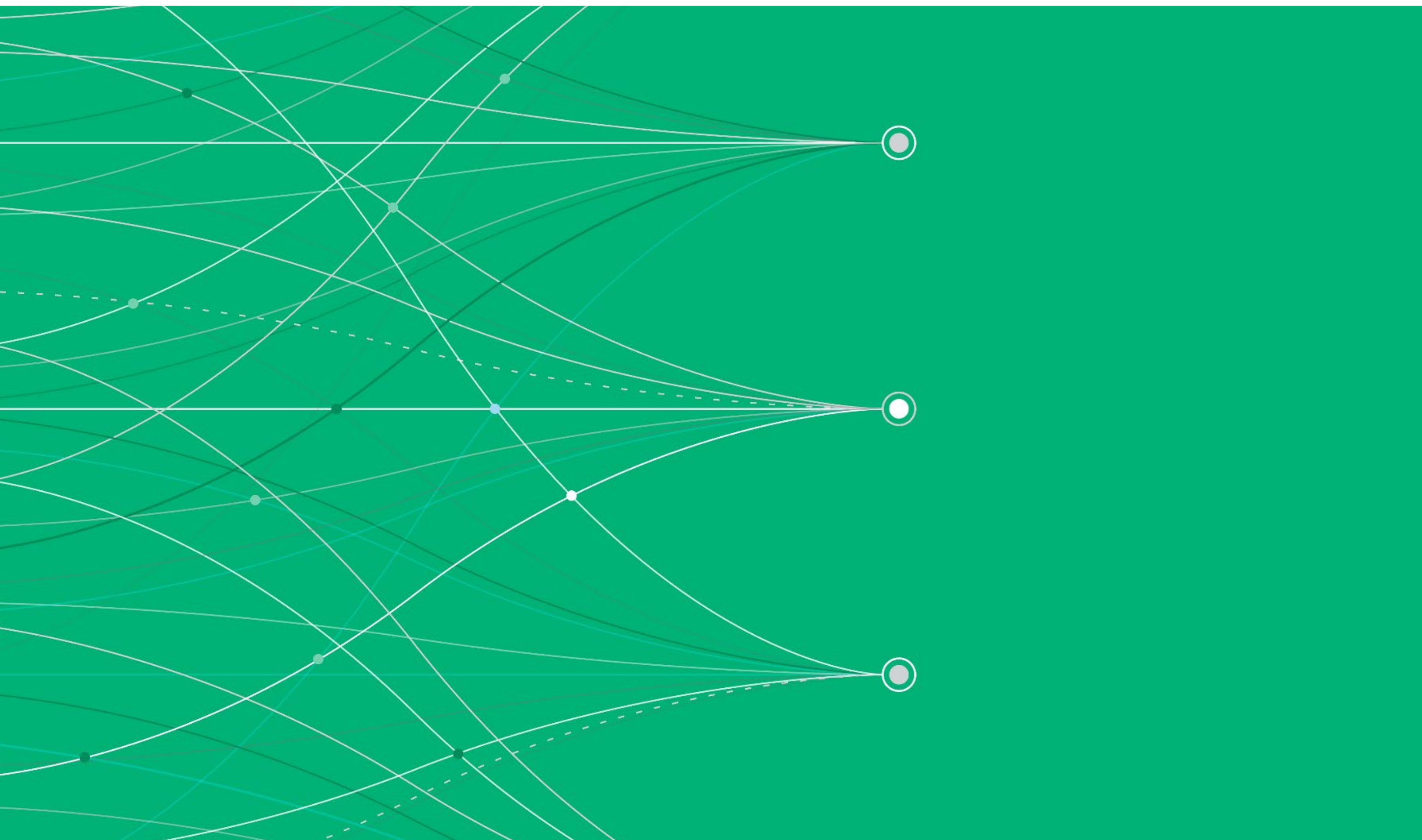

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I. Executive Summary

UnitedHealth Group (UHG) commissioned Milliman to analyze the value to the federal government (government) of the Medicare Advantage (MA) program relative to Medicare fee-for-service (FFS). In our analysis, we estimated the value of the MA program to the government (government value) by quantifying what can be provided for each dollar of government spending paid to MA plans. We then compared this to the same dollar of government spending for services provided under Medicare FFS for beneficiaries.[1]

Under statute, coverage for MA services and cost sharing for Part A and Part B services, in aggregate, must be at least actuarially equivalent to (equal to or richer than) the coverage and cost sharing under Medicare FFS.[2] The structure of the MA program requires health maintenance organizations (HMOs) and preferred provider organizations (PPOs) to have provider networks in place, requiring beneficiaries to use providers specified by the plan.[3] However, MA plans may also set up care and cost management strategies, such as the following:

- Care coordination programs, such as chronic care management and case management.
- Utilization management programs (e.g., prior authorization).
- Risk-sharing arrangements with providers.

The goal of these strategies is to not only ensure that beneficiaries receive high-quality care but also to manage beneficiary care to keep expected costs for Part A and Part B services at or below Medicare FFS. Medicare FFS includes some prior authorization requirements,[4] though these requirements impact a much smaller set of services compared to most MA plans.

The reduction in Part A and Part B costs under MA creates "savings," which MA plans are required to use toward additional benefits. Common additional benefits provided through savings include:

- **Lower cost sharing** for Parts A and B services compared to Medicare FFS. The same hospital and physician services (Parts A and B) are covered at a lower cost to the beneficiary, typically in the form of copayments (fixed dollar amounts) instead of coinsurance (percentage of charge amounts).
- **A maximum out-of-pocket (MOOP) spending limit,** which is not included in Medicare FFS. This is required for MA plans and is one of the most important features to beneficiaries of MA. This limits an MA beneficiary's medical out-of-pocket spending to a specified maximum amount, with the plan covering 100% of medical costs above that threshold. In 2024, the average MOOP for general enrollment (non-special needs plan) MA beneficiaries is approximately $4,750.[5]
- **Supplemental benefits** not covered under Medicare FFS. Non-exhaustive examples of these benefits include dental, vision, hearing, over-the-counter (OTC) benefits, and nonemergency medical transportation.
- **Subsidized prescription drug coverage (Part D)**, where Medicare FFS beneficiaries must purchase drug coverage separately.

[1] We used Medicare FFS risk scores and data from the CMS 5% sample for the MA portion of the analysis to normalize for part of the population differences between programs. Other differences may still exist in the underlying populations.

[2] Girod, C. & Kolli, S. (April 2018). Medicare Advantage and Part D: Compliance for Actuaries. Milliman White Paper. Retrieved March 23, 2024, from https://www.milliman.com/-/media/milliman/importedfiles/uploadedfiles/insight/2018/medicare-advantage-part-d-actuaries.ashx.

[3] Medicare. (January 2023). Understanding your Medicare Advantage Plan's provider network. Retrieved March 23, 2024, from https://www.medicare.gov/Pubs/pdf/11941-Understanding-Your-Medicare-Advantage-Plan.pdf.

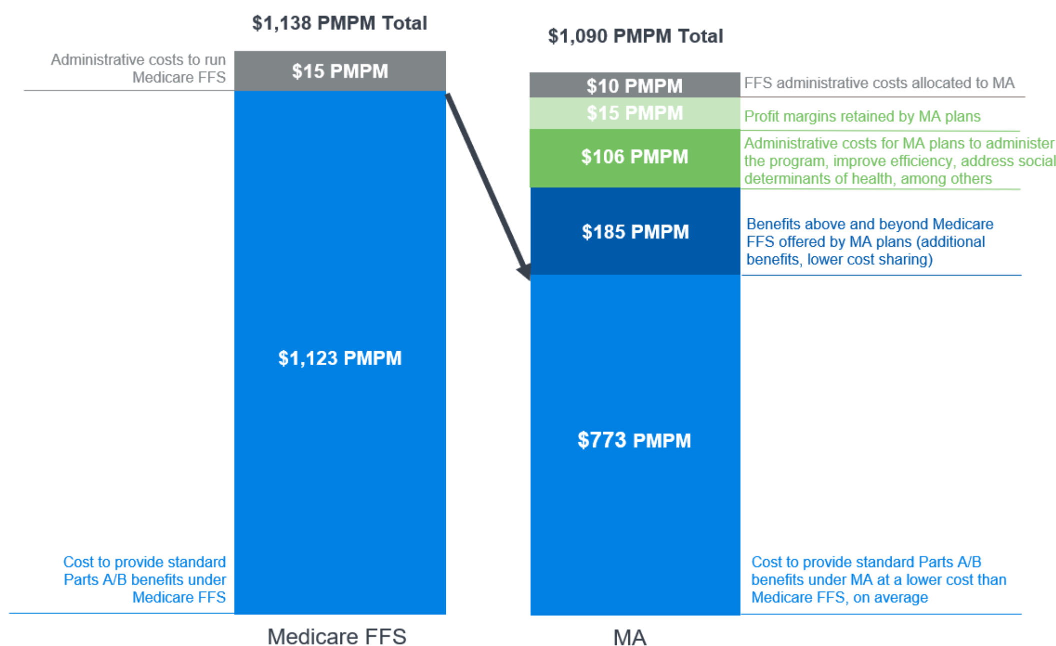
[4] CMS. Prior Authorization and Pre-Claim Review Initiatives. Retrieved March 23, 2024, from https://www.cms.gov/research-statistics-data-systems/medicare-fee-service-compliance-programs/prior-authorization-and-pre-claim-review-initiatives.

[5] Friedman, J. & Yeh, M. (January 16, 2024). State of the 2024 Medicare Advantage Industry: General Enrollment Plan Valuation and Benefit Offerings. Milliman White Paper. Retrieved March 23, 2024, from https://www.milliman.com/en/insight/state-of-the-2024-medicare-advantage-industry-general-enrollment#:~:text=Medicare%2Dcovered%20benefit%20changes%20vary%20by%20benefit%20type&text=The%20average%20MOOP%20increased%20from,approximately%201%25%20relative%20to%202023.

- **Subsidized Part B premiums,** where MA plans credit a specified monthly amount to a beneficiary's Social Security (SS) account. This is intended to offset the monthly Part B premiums, which are typically a reduction to a beneficiary's SS payment.[6]

The conclusions from our analysis are consistent with this market dynamic, where "savings" are created and used for providing additional benefits. In other words, each dollar spent by the government on MA provides beneficiaries with lower cost sharing and additional benefits than they would otherwise receive under Medicare FFS. Our analysis shows that, for beneficiaries in Medicare FFS, for each dollar of government costs almost 99% goes to expenses in Part A (hospital services) and Part B (physician services), with the remaining amount covering administrative costs. In contrast, for beneficiaries in MA, about 71% of each dollar of government costs goes to expenses for comparable Part A and Part B services. The remaining 29% of the payments, generated through "savings" described above, go to the reduction in cost sharing and additional benefits as described above, as well as to cover MA plan administrative costs and profit margins. The allocation of government payments for Medicare FFS and MA, respectively, are shown in Figure 1.

FIGURE 1: MEDICARE FFS VS. MA GOVERNMENT PAYMENT ALLOCATION (2024), $ PMPM†



† Medicare FFS is weighted using January 2024 MA enrollment by county. Government payments for MA attributed to additional benefits in this figure include allocations to reduce Part D premium for beneficiaries. Part D costs are otherwise excluded from government payments in this figure. More detail on the allocation of government payments for Part D are included in Figure 3 below. Totals may not equal the sum of components due to rounding.

We estimated the value of reduced cost sharing and additional benefits for MA beneficiaries in 2024 to be $185 per member per month (PMPM): $51 for the reduction in cost sharing for Medicare-covered services and $134 for the value of additional benefits not covered by Medicare FFS.[7] Extrapolated to the approximately 27 million beneficiaries enrolled in individual Medicare Advantage plans, this equates to $59.9 billion annually in additional benefits.

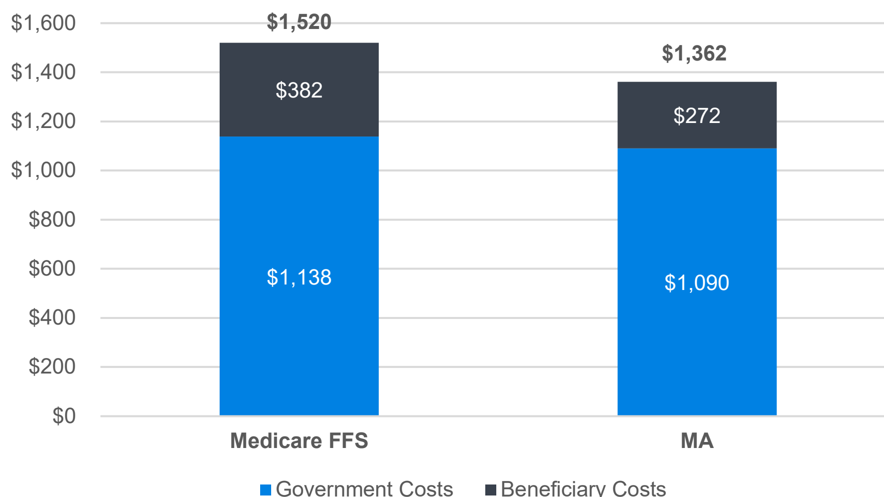
[6] Nelson, P., Hamilton, J., & Heinrich, A. (April 2023). Is the Part B Premium Buydown Here to Stay? 2023 Landscape and Considerations for 2024. Milliman White Paper. Retrieved March 23, 2024, from https://www.milliman.com/-/media/milliman/pdfs/2023-articles/4-26-23_part-b-premium-buydown.ashx.

[7] Values do not include retention amounts for administrative cost and profit margin.

Even though MA plans have utilization controls and cost containment strategies in place, which may reduce beneficiary choice of providers and utilization, Medicare Advantage remains a very popular program. As of January 2024, slightly over 50% of Medicare-eligibles (approximately 33.5 million) enrolled in an MA plan.[8,9,10]

Figure 2 summarizes our estimates of total program costs, separately for the government and the beneficiary, for Medicare FFS and MA coverage. The total government costs shown in Figure 2 are consistent with the totals from Figure 1.

FIGURE 2: GOVERNMENT AND BENEFICIARY COSTS IN MEDICARE FFS VS. MA, $ PMPM‡



‡ Medicare FFS is weighted using January 2024 MA enrollment by county. The Medicare FFS beneficiary costs include the cost sharing collected for Part A and Part B services and the standard Part B premium. The MA beneficiary costs include cost sharing for medical coverage, the standard Part B premium, and Part C and Part D premiums, but exclude other Part D-related out-of-pocket costs. Medicare FFS beneficiary costs may be funded through other coverages, such as Medicaid, employer coverage, or Medigap plans, which may or may not include additional beneficiary premium. Those impacts are excluded from our analysis. Totals may not equal the sum of components due to rounding.

Figure 2 suggests that MA offers significant value to the government when comparing total program costs across both programs.[11] Care and cost management strategies in MA help reduce government costs as well as beneficiary costs. The additional benefits of Part A and Part B cost-sharing reductions and a MOOP for beneficiaries in MA also contributes to lower MA beneficiary costs. Many MA plans are able to offer these benefits at $0 additional premium to the beneficiary. In 2024, 99% of Medicare Advantage beneficiaries have access to at least one Medicare Advantage Prescription Drug (MA-PD) plan at $0 premium.[12]

[8] Milliman analysis of CMS enrollment files. See https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/mcradvpartdenroldata/ma-state/ma-state/county-penetration-2024-01.

[9] Total enrollment in MA plans includes employer group waiver plans (EGWPs), Medicare-Medicaid plans (MMPs), Cost plans, MSA plans, and PACE plans, all of which are excluded from our analysis.

[10] CMS. Contract Summary 2024 01. Retrieved March 23, 2024, from https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/mcradvpartdenroldata/monthly/contract-summary-2024-01.

[11] We used Medicare FFS risk scores and data from the CMS 5% sample for the MA portion of the analysis to normalize for part of the population differences between programs. Other differences may still exist in the underlying populations.

[12] Freed, M., Damico, A., Biniek, J., & Neuman, T. (November 15, 2023). Medicare Advantage 2024 Spotlight: First Look. KFF. Retrieved March 23, 2024, from https://www.kff.org/medicare/issue-brief/medicare-advantage-2024-spotlight-first-look/.

For every dollar spent on Part A and Part B services, government payments cover 84.4 cents for Medicare FFS beneficiaries and 90.4 cents for MA beneficiaries, with the Medicare FFS beneficiary and MA beneficiary paying the remaining 15.6 cents and 9.6 cents, respectively.[13] This is consistent with Figure 2, where beneficiaries under MA have lower cost sharing on these services.

Because Medicare FFS has higher beneficiary out-of-pocket costs than MA for Part A and Part B services, most Medicare FFS beneficiaries obtain supplemental coverage to cover these out-of-pocket costs, whether through a Medigap plan, employer-sponsored coverage, or Medicaid.[14] However, Medigap does not offer coverage for supplemental benefits typically seen in MA plans, such as subsidized prescription drug coverage, vision, and dental, and charges a premium for all plan types and coverages.

Some recent studies have estimated that government payments to MA plans are significantly higher than Medicare FFS spending, which the authors estimate to be driven by additional risk score coding differences and selection differences beyond the 5.9% CMS proposed statutory minimum coding pattern adjustment.[15] Our analysis did not address risk score coding differences beyond the 5.9% CMS proposed statutory minimum. To account for the possibility that government payments to Medicare FFS and MA may not be directly comparable due to risk score coding differences, we performed a sensitivity analysis by reducing Medicare FFS costs by 5% and 10%. This analysis showed that, even with both 5% and 10% lower Medicare FFS costs for Part A and Part B services, MA is still less expensive in total program costs than Medicare FFS.

Our analysis also did not address selection impacts. To account for some of the population and geographical differences between Medicare FFS and MA, we used MA enrollment by county as weights when aggregating total Medicare FFS costs. We also applied an adjustment to Medicare FFS costs because published FFS rates include beneficiaries that enroll in Medicare Part A only or Part B only, but, to be enrolled in MA, the beneficiary must be enrolled in both Part A and Part B.

In summary, MA offers significant value to the government through lower total costs, as shown in Figure 1. MA plans must offer at least the same coverage as Medicare FFS, usually offering significant additional benefits as well, and they are able to do this at a lower overall cost to both the government and the beneficiary.[16] Through the additional benefits offered, MA provides choices among various plans, each offering a varying set of additional benefits that may suit a beneficiary's needs.

[13] Some beneficiaries have additional coverage such as Medicaid coverage, employer-sponsored coverage, or a Medigap plan. In these cases, the beneficiary's supplemental coverage may pay for some or all of the cost sharing.

[14] Ochieng, N., Clerveau, G., Cubanski, J., & Neuman, T. (December 13, 2023). A Snapshot of Sources of Coverage Among Medicare Beneficiaries. KFF. Retrieved March 23, 2024, from https://www.kff.org/medicare/issue-brief/a-snapshot-of-sources-of-coverage-among-medicare-beneficiaries/.

[15] MedPAC. (March 2024). Report to the Congress: Medicare Payment Policy. Retrieved March 23, 2024, from https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_MedPAC_Report_To_Congress_SEC.pdf.

[16] We used Medicare FFS risk scores and data from the CMS 5% sample for the MA portion of the analysis to normalize for part of the population differences between programs. Other differences may still exist in the underlying populations.

II. Background

UnitedHealth Group (UHG) commissioned Milliman to analyze the value to the federal government (government) of the Medicare Advantage (MA) program relative to Medicare fee-for-service (FFS). In our analysis, we estimated the value of the MA program by quantifying the value of services provided by MA plans compared to the value of services provided under Medicare FFS. Additional sources of value, such as care coordination, provider risk sharing, and care management programs, generate implicit cost differences in our estimates, but are not directly quantified in our analysis.

GENERAL BACKGROUND ON MEDICARE

Medicare is government-sponsored healthcare coverage for people over the age of 65 and/or those who meet other specific criteria related to disease burden and disability status. Medicare was enacted with the signing of the Social Security Amendments Act of 1965 and consists of two parts: Part A, the hospital benefit entitlement, and Part B, coverage for supplemental ambulatory medical care (typically physician services). Expenses for Part A are funded through the Medicare Hospital Insurance (HI) Trust Fund, which is financed primarily by payroll taxes.[17,18] In comparison, expenses for Part B (along with Medicare Part D) are funded through the Medicare Supplemental Medical Insurance (SMI) Trust Fund, which is comprised largely of Part B beneficiary premiums and general revenues.[19]

THE BASICS OF MEDICARE COVERAGE OPTIONS

Those eligible for Medicare can choose to receive their Medicare benefits either through Medicare FFS or an MA plan.

- **Medicare FFS:** Beneficiaries with Medicare FFS can receive services from any doctor or hospital that accepts Medicare. Only Part A facility services and Part B ambulatory services are covered under Medicare FFS. As such, to obtain prescription drug coverage, FFS beneficiaries must select a standalone prescription drug plan (PDP) or have some alternative coverage, such as Veterans Administration (VA) benefits or employer-provided insurance. All beneficiaries (including those enrolled in Medigap and MA) pay a premium for Part B services, which is $174.70 per month in 2024.[20] Higher-income beneficiaries may pay higher premiums and lower-income beneficiaries may pay lower premiums than the standard monthly amount.
- **Medigap:** Beneficiaries with Medicare FFS can purchase supplemental “wraparound” coverage known as Medigap (or Medicare Supplement) through private insurance companies for an additional monthly premium beyond the standard Part B premium. These plans help cover out-of-pocket costs Medicare FFS does not cover (otherwise borne by the beneficiary). However, unless the beneficiary is within the open enrollment period (six months after turning 65) or the beneficiary recently lost other coverage, these plans do not have guaranteed issue. In other words, outside of the protected enrollment period, a Medigap insurer may deny coverage or impose higher premiums with a preexisting condition coverage waiting period.[21]

  There are several types of Medigap plans, designated by letters A through N, which represent different benefits and coverage types.[22] Plan G is currently the most popular and comprehensive Medigap plan actively sold on the market, though there are other plan types offering leaner coverage with lower premiums.

[17] Additional funding for Part A comes from income taxes paid on Social Security benefits, interest income on trust fund investments, and Part A premiums from those who are not eligible for premium-free Part A.

[18] Medicare. How is Medicare funded? Retrieved March 23, 2024, from https://www.medicare.gov/about-us/how-is-medicare-funded.

[19] Cubanski, J. & Neuman, T. (January 19, 2023). What to Know About Medicare Spending and Financing. KFF. Retrieved March 23, 2024, from https://www.kff.org/medicare/issue-brief/what-to-know-about-medicare-spending-and-financing/#:~:text=Part%20A%2C%20which%20covers%20inpatient,employees%20(1.45%25%20each).

[20] U.S. Railroad Retirement Board. (October 2023). Medicare Part B Premium and Deductible Increase in 2024. Retrieved March 23, 2024, from https://rrb.gov/Newsroom/NewsReleases/MedicarePartBPremium#:~:text=The%20Centers%20for%20Medicare%20%26%20Medicaid,the%202023%20deductible%20of%20%24226.

[21] Medicare Interactive. Medigap Purchasing Details: Enrollment Periods, Guaranteed Issue, and More. Retrieved March 23, 2024, from https://www.medicareinteractive.org/get-answers/medicare-health-coverage-options/supplemental-insurance-for-original-medicare-medigaps/medigap-purchasing-details-enrollment-periods-guaranteed-issue-and-more.

[22] Medicare. Compare Medigap Plan Benefits. Retrieved March 23, 2024, from https://www.medicare.gov/health-drug-plans/medigap/basics/compare-plan-benefits. Three states, Massachusetts, Minnesota, and Wisconsin, have different standardized plans through federal waivers.

Typically, Medigap plans have premiums ranging from $50 to $300,[23] which are paid in exchange for lower out-of-pocket (OOP) costs; Plan G covers out-of-pocket costs for all Part A and Part B services other than the Part B deductible, which is $240 for 2024.[24] Medigap premiums also cover administrative costs and profit loads, as well as significantly higher utilization resulting from reduced cost sharing barriers (i.e., first dollar coverage), and the lack of cost and utilization management strategies.

Medigap plans do not provide coverage for additional benefits, such as prescription drug coverage, dental, and vision, which must be obtained separately. Beneficiaries who choose MA are not eligible to purchase Medigap plans.

- **Medicare Advantage:** MAOs contract with CMS to offer privately managed insurance plans covering the equivalent of Part A and Part B (otherwise known as Part C), and frequently Part D (prescription drug) services. These plans can either be Part C only (Medicare Advantage only, or MA only) or both Part C and Part D (MA-PD). Throughout this paper, we refer to MA plans that include both MA-only and MA-PD plans, unless otherwise specified. The MA program is an alternative to Medicare FFS, and beneficiary premiums for MA-PD coverage vary from $0 to over $200 per month in 2024, with an average of $18.50.[25] Notably, about 66% of MA-PD plans offer benefits for $0 premium, which covers about 68% of MA beneficiaries.[26,27] If a premium is required, it is in addition to the standard Medicare Part B premium discussed above (which may be partially subsidized depending on the plan the beneficiary is enrolled in). In many cases, cost sharing for Part A and Part B services are reduced and additional benefits not covered by Medicare FFS are offered, known as additional or supplemental benefits. Supplemental benefits vary widely and include services, such as dental, hearing, vision, over-the-counter (OTC) benefit cards, and nonemergency medical transportation (NEMT) benefits, among many others. MAOs, through capitated payments from CMS, manage and coordinate the care of the beneficiaries enrolling in their plans.
- **Prescription drug plans:** Part D benefits are typically bundled with MA-PD coverage, but PDP organizations may also contract with CMS to provide standalone Part D plans covering only prescription drug benefits, mainly for Medicare FFS beneficiaries (including those who enroll in Medigap plans). Premiums for PDPs in 2024 range from $0 to $195 per month, with an average of $48 per month.[28,29] A beneficiary must enroll in either an MA-PD plan that provides both medical and drug coverage or a PDP plan (or other equivalent employer-sponsored coverage) to avoid facing future premium penalties from CMS.

[23] Medigap.com. Average Cost of Medigap Insurance Plans. Retrieved March 23, 2024, from https://www.medigap.com/faqs/average-cost-of-medigap-insurance-plans/.

[24] U.S. Railroad Retirement Board. (October 2023), op cit.

[25] CMS. (September 26, 2023). Medicare Advantage and Medicare Prescription Drug Programs to Remain Stable in 2024. Press release. Retrieved March 25, 2024, from https://www.cms.gov/newsroom/press-releases/medicare-advantage-and-medicare-prescription-drug-programs-remain-stable-2024.

[26] Medicare Advantage 2024 Spotlight: First Look, KFF, op cit.

[27] CMS. CY2024_Landscape_Files_Final_20240205. Retrieved March 25, 2024, from https://www.cms.gov/files/zip/cy2024landscapefilesfinal20240205.zip (ZIP file download). Summarized from the MA-PD landscape files for 2024 benefits.

[28] Cubanski, J. & Damico, A. (November 8, 2023). Medicare Part D in 2024: A First Look at Prescription Drug Plan Availability, Premiums, and Cost Sharing. KFF. Retrieved March 25, 2024, from https://www.kff.org/medicare/issue-brief/medicare-part-d-in-2024-a-first-look-at-prescription-drug-plan-availability-premiums-and-cost-sharing/.

[29] CMS. CY2024_Landscape_Files_Final_20240205, op cit. Summarized from the PDP landscape files for 2024 benefits.

A PRIMER ON MA PAYMENTS AND DIFFERENCES RELATIVE TO FFS COSTS

Medicare Advantage is an alternative to Medicare FFS where private health insurers offer Medicare benefits through managed care plans. Medicare Advantage plans are paid through a combination of government payments and beneficiary premiums.

Government payments to MA plans consist of two components: bids and rebates. They are developed as follows.

Bids

Each year, CMS publishes benchmarks by county for the forthcoming year that are intended to estimate the regional costs of care for Medicare FFS, with other adjustments outside the scope of this report. For each MA plan each year, CMS requires a bid to be developed and submitted, estimating the costs to cover Part A and Part B services, including administrative costs and profit margin. This bid amount is compared to the average membership weighted benchmark across the plan's service area. The government will pay the plan the bid amount up to the average benchmark. This process is intended to align a portion of the MA payments with the costs of Medicare FFS. The benchmark used in the savings calculation is also impacted by Medicare's star rating system. Plans with a star rating of 4.0 or higher (out of 5.0) receive a higher benchmark. This higher benchmark results in larger rebates for plans, as discussed below, enabling them to offer even more benefits.

In addition, the bid and the benchmark are risk-adjusted for the health status of expected enrollees in the plan.

If a plan submits a bid above the benchmark, the excess cost is paid through beneficiary premiums. In other words, the payment to an MAO from the government is capped at the benchmark amount.

Rebates

If the bid amount is less than the average benchmark, "savings" are created through the difference between the benchmark and the bid. A portion of the savings is retained by the government (approximately 34.7% in 2024) and the remainder (called the "rebate") must be used by plans to reduce Part A and Part B cost sharing through lower copays and/or a plan-specific MOOP, to offer additional benefits beyond what Medicare FFS covers, or to subsidize Part D and/or Part B premiums, as described in the Executive Summary above. MAOs aim to manage costs of Part A and Part B services so their plans have rebate dollars to offer additional benefits, which makes their plans more attractive to potential beneficiaries. Successfully managing Part A and Part B costs reduces the cost to the government and delivers more value to beneficiaries for the same expenditure amount by offering additional benefits—that is, every dollar for MA is used for more benefits than for the same dollar for Medicare FFS.

The proportion of savings that becomes a rebate (the rebate percentage) is also determined by Medicare's star rating system, where higher star ratings lead to higher rebate percentages.

From our analysis, we estimated for 2024 that the average difference between the benchmark and bid was $316 per member per month (PMPM), where, on average, the government retained $109 PMPM and the MA plan received the remaining $206 PMPM as a rebate.

Medicare FFS costs vs. MA payments

There are two key differences in government payments to MA and Medicare FFS that frequently receive attention.

Risk adjustment

The first key difference is risk adjustment, which is intended to compensate MA plans for bearing the risk of higher-cost beneficiaries while removing the incentive for MAOs to avoid certain costly populations when providing coverage and designing plans. It is argued risk adjustment can increase payments to MAOs in excess of the risk borne.

As discussed previously, part of government payments to MA plans are through bid payments, which reflect projected costs for Part A and Part B services in the expected service area. These bid payments are also adjusted for the relative health status of the expected enrolled population, estimated through risk scores. Risk scores are based on basic demographic information such as age and gender and type of member (non-dual-eligible, dual-eligible, institutionalized), as well as medical diagnosis codes recorded for the enrolled population. At a very basic level, the more unique the diagnosis codes, and the more intensive those diagnoses are (e.g., with complications vs. without complications), the higher the risk score.

In Medicare FFS, providers are paid largely based on the services they perform (i.e., fee-for-service) and not on the diagnosis of a beneficiary, with certain exceptions for Inpatient services. As such, providers outside of an Inpatient setting have the incentive for procedure codes on a claim to be accurate but have limited incentive to ensure the proper diagnoses are accurately coded. These same providers also serve MA beneficiaries, but MA plans have an incentive to ensure that all of the proper diagnosis codes are submitted. These diagnosis codes are important because they impact the MA risk scores, which adjust government payments received and, ultimately, MA plan revenue.

MA plans make a concerted effort to ensure their beneficiaries' full lists of diagnoses are properly and accurately recorded. In other words, for a beneficiary in MA and a beneficiary in Medicare FFS with similar demographic and health statuses, the beneficiary in MA will likely have a higher risk score, all else equal. CMS adjusts for this difference by reducing MA risk scores by 5.9% through an "MA coding pattern adjustment," which was established by Congress. Some studies suggest the actual coding pattern difference exceeds the standard CMS 5.9% adjustment.[30,31] If the actual coding pattern difference exceeds this 5.9% adjustment, payments to MA plans may exceed payments for Medicare FFS for enrollees of similar demographic and health statuses. The Medicare Payment Advisory Commission (MedPAC) estimates this actual coding difference may be as high as 19%, or 13% in excess of the statutory MA coding pattern adjustment.[32] We performed sensitivity tests, discussed later in this report, to explore the impact of this potential difference in payment.

For bid year 2024, CMS implemented a new risk score model with updated underlying diagnoses and calibrated data. It was estimated the new risk score model would reduce MAO revenue by approximately 3.4% in aggregate.[33] Ultimately, CMS allowed the model to be phased in over a three-year period, where, for 2024, one-third of the weight for projected risk scores would be on the new risk score model, and the remaining two-thirds on the existing risk score model. With the phase-in, this would lead to an approximate 1.1% reduction in MAO revenue. The model change impacts each population and plan type differently. Our analysis incorporates 2024 risk scores calculated on the new blended model basis.

Population differences

The second key difference is the population used for developing the FFS benchmark rates, which is argued to reduce payments to MAOs.

The benchmarks for MA plans are developed by CMS and are calculated using estimated Medicare FFS payments. More specifically, costs are estimated based on all beneficiaries enrolled in Medicare FFS, including those with Part A-only or Part B-only coverage. In contrast, MA beneficiaries must be enrolled in both Part A and Part B to enroll in an MA plan. Generally, Part A-only beneficiaries in Medicare FFS (approximately 12% of the total Medicare FFS population) tend to be younger and are less likely to have multiple health conditions than the average Medicare beneficiary,[34,35] which could lead to lower Part A costs than the Part A costs of beneficiaries enrolled in both Part A and Part B. The inclusion of these lower-cost Part A-only beneficiaries in the benchmark calculations is likely to reduce payments to MA plans.

In our analysis, we adjusted Medicare FFS costs to remove the estimated impact of Part A-only and Part B-only beneficiaries. This adjustment ensured that our comparison of a Medicare FFS beneficiary to an MA beneficiary was more appropriate. This adjustment increased the Medicare FFS costs by 5.5%.

[30] MedPAC. (March 2024). Report to the Congress, op cit.

[31] Committee for a Responsible Federal Budget. (July 17, 2023). New Evidence Suggests Even Larger Medicare Advantage Overpayments. Retrieved March 25, 2024, from https://www.crfb.org/blogs/new-evidence-suggests-even-larger-medicare-advantage-overpayments.

[32] MedPAC. (March 2024). Report to the Congress, op cit.

[33] Pipich, R., Cross, K., & Rothschild, M. (February 2023). High-Level Impacts of the Proposed CMS-HCC Risk Score Model on Medicare Advantage Payments for 2024. Milliman White Paper. Retrieved March 25, 2024, from https://www.milliman.com/-/media/milliman/pdfs/2023-articles/2-28-23_2024-proposed-cms-hcc-model-impact.ashx.

[34] Data.CMS.gov (2021). CMS Program Statistics – Medicare Total Enrollment. Retrieved March 25, 2024, from https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/medicare-and-medicaid-reports/cms-program-statistics-medicare-total-enrollment.

[35] ASPE Office of Health Policy. (March 2, 2022). Medicare Beneficiary Enrollment Trends and Demographic Characteristics. Issue Brief. Retrieved March 25, 2024, from https://aspe.hhs.gov/sites/default/files/documents/f81aafbba0b331c71c6e8bc66512e25d/medicare-beneficiary-enrollment-ib.pdf.

Other differences

There are other sources of payment differences between Medicare FFS and MA that are embedded in the structure of the MA program. They include county quartiles, quality bonus payments (QBPs), counties eligible for "double bonuses," and Affordable Care Act (ACA) benchmark payment caps, summarized as follows:

- **County quartiles**: Each year, CMS ranks counties based on total FFS expenditures per FFS beneficiary, splits the counties into quartiles, and applies a multiplier to the county-level benchmark payments based on the quartile in which the county falls. The multipliers by quartile are 0.95, 1.00, 1.075, and 1.15, where multipliers are lower for higher-cost FFS areas and multipliers are higher for lower-cost FFS areas. The membership and dollar-weighted average multiplier is 1.04 for 2024. Higher multipliers in lower-cost FFS areas help incentivize MA plans to participate in low-cost counties, where the opportunity for an MA plan to manage beneficiary costs below Medicare FFS levels may be more difficult.
- **Quality bonus payments (QBPs)**: Medicare's star rating system measures an MAO's performance and the quality of services provided to its beneficiaries, including medication adherence, health outcomes, and health plan member satisfaction, which are collected and measured each year. MAOs are awarded star ratings based on the results. These star ratings translate into bonus payments, known as QBPs, in the form of an increase to benchmarks, discussed previously. MAOs with star ratings of 4.0 or above (out of 5.0) receive a 5% increase to benchmarks. In our analysis, we estimate nearly 75% of beneficiaries in 2024 are enrolled in an MA plan with a star rating of 4.0 or higher.[36]
- **Double-bonus counties**: Some plans will receive a multiplier on the QBPs if they operate in "double-bonus" counties. To be a double-bonus county, the county must meet certain requirements, but generally it is highly populated, has high MA enrollment, and has lower-than-average costs.
- **ACA benchmark payment caps:** While QBPs and double-bonus counties can increase payments to MA plans, benchmark payments (including bonuses) are capped at the "applicable amount." The "applicable amount" is the greater of a county's Medicare FFS costs and the prior year's trended applicable amount. This cap methodology prevents payments to MA plans, which would otherwise be based on Medicare FFS costs, from increasing above payment rates prior to the ACA.

Despite these differences, our analysis determined total government payments to MA plans (including bid payments and rebates) are approximately 101% of Medicare FFS government costs, where government payments include costs for Part A-only and Part B-only beneficiaries, which is consistent with recent MedPAC research.[37,38] Government payments to MA plans are approximately 96% of Medicare FFS government costs when excluding Part A-only and Part B-only Medicare FFS beneficiaries. Both estimates exclude Medicare FFS administrative costs.

[36] Milliman analysis of CMS enrollment files. See https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/mcradvpartdenroldata/ma-state/ma-state/county-penetration-2024-01.

[37] MedPAC. (March 2024). Report to the Congress, op cit.

[38] We used Medicare FFS risk scores and data from the CMS 5% sample for the MA portion of the analysis to normalize for part of the population differences between programs. Other differences may still exist in the underlying populations.

III. Estimating government value: A comparison of payments, benefits, and services

We used reports from MedPAC and CMS to connect publicly available information to Milliman's Medicare modeling suite of tools to estimate plan and county-specific costs, as well as to assist in the development of the components of Medicare program payments, both to Medicare FFS and MA. Specifically, we estimated the following:

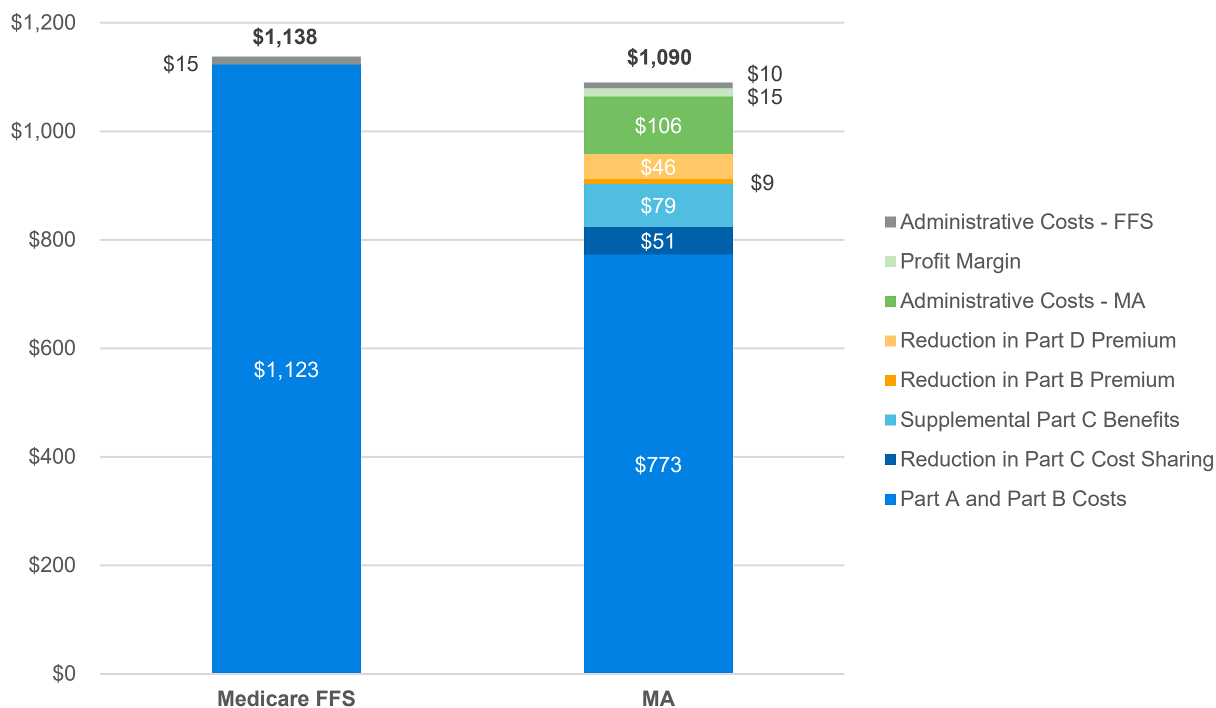
- The claim costs for Part A and Part B services under both Medicare FFS and MA
- The beneficiary cost sharing for Part A and Part B services under both Medicare FFS and MA
- The rebates earned by MA plans and how these rebates are allocated across additional benefits
- The average premiums paid by MA beneficiaries for Part C and Part D coverage

Through estimating the components of government payments for each program, we can compare the overall value of the government payments between Medicare FFS and MA.[39] For Medicare FFS, government payments are for Part A and Part B services and the amount the government spends to administer the program. For MA, government payments are comprised of the bid payments (which cover Part A and Part B expenses), as well as the rebate payments (which cover the cost of the additional benefits provided, assuming the bid is projected below the benchmark), both including administrative costs for Medicare FFS and the MAO as well as profit margin.

GOVERNMENT PAYMENTS PMPM FOR MEDICARE FFS VS. MA

Figure 3 summarizes the components of government payments within Medicare FFS and MA. While government payments are overall similar between programs, each dollar spent by the government on MA provides Part A and Part B covered services, as well as lower cost sharing for beneficiaries and additional benefits not found in Medicare FFS.

FIGURE 3: MEDICARE FFS VS. MA GOVERNMENT PAYMENT COMPONENTS, $ PMPM



Note: Totals may not equal the sum of components due to rounding. Medicare FFS is weighted using January 2024 MA enrollment by county.

[39] We used Medicare FFS risk scores and data from the CMS 5% sample for the MA portion of the analysis to normalize for part of the population differences between programs. Other differences may still exist in the underlying populations.

As shown in Figure 3, payments to MA comprise a wide range of benefits not covered under Medicare FFS. Rebates earned by MA plans through savings are used to reduce Part C cost sharing, Part D premiums, and Part B premiums, as well as to provide additional supplemental benefits such as dental, vision, and hearing. A portion of rebates is also used to cover administrative costs and profit margins. However, rebates do not always cover 100% of the benefits listed—sometimes plans may charge their beneficiaries premiums or cost sharing to cover the remainder of costs, which are not reflected in Figure 3.

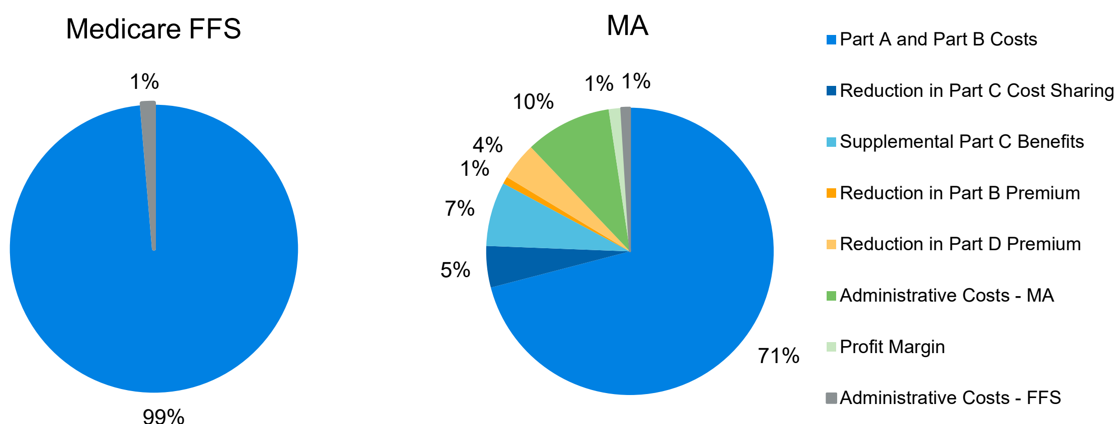
In 2024, the average government payments to MA for Part A and Part B services (including administrative costs and profit margins allocated to Part A and Part B services, otherwise known as the bid, as well as rebates allocated to reduce Part A and Part B cost sharing) are expected to be approximately 83% of the payments to Medicare FFS Part A and Part B costs. In other words, MAOs can offer Part A and Part B services equivalent to Medicare FFS, as well as cover administrative costs and profit margins and reduce beneficiary cost sharing, at an approximately 17% lower cost than Medicare FFS.

In other public analyses,[40] costs to administer claims are excluded from FFS payments. In our analysis, we included administrative costs paid directly by the government for both Medicare FFS and MA based on reported administrative costs from the 2023 Medicare Trustees report.[41] However, MA plans still incur additional expenses to administer the MA plan, described later in this report.

DISTRIBUTION OF GOVERNMENT PAYMENTS TO MEDICARE FFS VS. MA

Figure 4 shows the distribution of the components of the government's payments as a percentage of the total.

FIGURE 4: DISTRIBUTION OF MEDICARE FFS AND MA GOVERNMENT PAYMENTS, %



Note: Totals may not equal the sum of components due to rounding.

For Medicare FFS, approximately 99% of government payments are for Part A and Part B service costs, where the remaining 1% is for administrative costs. In contrast, for MA about 71% of government payments are for Part A and Part B service costs, as MA plans have methods to manage costs and utilization. The remaining 29% of the government payments are for enhanced coverage for MA beneficiaries to provide lower cost sharing, additional benefits, and reduced premiums for Part B and Part D while still covering plan administrative expenses and a profit margin.

[40] MedPAC. (March 2024). Report to the Congress, op cit.

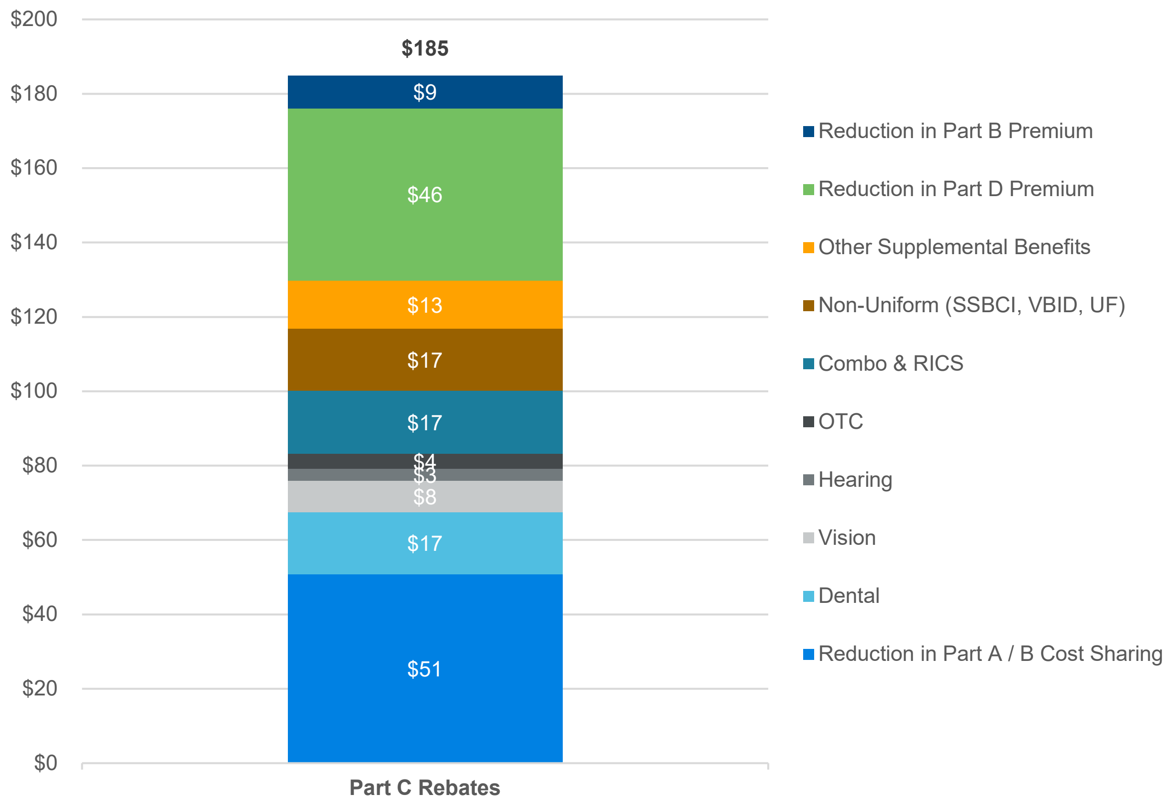
[41] See the full 2023 Medicare Trustees report at https://www.cms.gov/oact/tr/2023 (retrieved March 25, 2024).

ADDITIONAL MA BENEFITS PROVIDED THROUGH PART C REBATES

As shown in Figure 4, 17% of government payments to MA plans are for reduced cost sharing, supplemental benefits not covered under Medicare FFS, and Part B and Part D premium reductions, which are funded through rebates generated from savings. These benefits have been an important differentiator (both from Medicare FFS and other MA plans) since the program's inception; they are so prevalent that plans may have difficulty gaining enrollment if they do not offer them.

The graph in Figure 5 summarizes how these Part C rebates are allocated to the various additional benefits. The portion covered by beneficiary premiums is not included in Figure 5.

FIGURE 5: ALLOCATION OF PART C REBATES, $ PMPM



Note: Totals may not equal the sum of components due to rounding.

Part C rebate dollars are allocated to the various additional benefits as follows:

- Reductions in beneficiary cost sharing (including the impact of the MOOP) for Part A and Part B services: 28% of the total rebate, or $51 PMPM
- Addition of supplemental benefits: 43% of the rebate, or $79 PMPM, comprised of:
  - Dental:[42] $17 PMPM
  - Vision exams and hardware: $8 PMPM
  - Hearing exams and hardware: $3 PMPM
  - OTC benefit card:[43] $4 PMPM
  - Combo and reduction in cost sharing (RICS):[44] $17 PMPM
  - Nonuniform benefits, such as Special Supplemental Benefits for the Chronically Ill (SSBCI), Value-Based Insurance Design (VBID), and uniformity flexibility:[45] $17 PMPM
  - All other Part C supplemental benefits: $13 PMPM
- Reductions in Part D premiums: 25% of the rebate or $46 PMPM
- Reductions in Part B premiums: 5% of the rebate or $9 PMPM

These PMPMs represent the costs expected to be incurred under each MA plan's benefit design for the respective population (i.e., non-SNP, D-SNP, etc.).

The prevalence of supplemental benefits has increased significantly since 2017. In 2023, for general enrollment plans (non-special needs plans), 97% and 91% of beneficiaries are enrolled in plans offering preventive and comprehensive dental benefits, respectively, 99% are in plans offering vision exams, 96% are in plans offering vision hardware, and 97% are in plans offering hearing hardware (i.e., hearing aids).[46] Other supplemental benefits offered in plans covering over 75% of beneficiaries are fitness, OTC benefit cards, and meal delivery. These additional benefits may also assist beneficiaries in maintaining their health by providing coverage for services that may otherwise be skipped or delayed until something more acute needs to be addressed.

There are several other supplemental benefits, though not nearly as common, that are offered across MA plans today, such as nonemergency transportation services. Many benefits are now addressing nonmedical needs that impact beneficiary health, such as food or grocery cards, bathroom safety devices, and utility bill payments.[47] None of these additional benefits are available through the government for Medicare FFS beneficiaries.

[42] This represents dental benefits not under a shared dollar limit. Several carriers have a shared dollar limit across preventive and comprehensive, which are considered combo benefits. As such, part of the dental costs are included in the "Combo & RICS" grouping in Figure 5. See https://www.milliman.com/en/insight/state-of-the-2024-medicare-advantage-industry-general-enrollment (retrieved March 25, 2024).

[43] This represents just the standalone OTC benefit. In 2024, several carriers included OTC in other supplemental benefit categories, mainly combo or flex cards, included in the "Combo & RICS" grouping in Figure 5. See https://www.milliman.com/en/insight/state-of-the-2024-medicare-advantage-industry-general-enrollment (retrieved March 25, 2024).

[44] Friedman, J., Yeh, M., & Yen, I. (January 2023). 2023 Combined Benefits in Medicare Advantage: Tracking Benefit Strategy and Options. Milliman White Paper. Retrieved March 25, 2024, from https://www.milliman.com/-/media/milliman/pdfs/2023-articles/1-20-23_2023-combined-benefits-in-medicare-advantage.ashx.

[45] Murphy-Barron, C., Buzby, E.A., & Pittinger, S. (March 2023). Overview of Medicare Advantage Supplemental Healthcare Benefits and Review of Contract Year 2023 Offerings. Milliman Brief. Retrieved March 25, 2024, from https://www.milliman.com/-/media/milliman/pdfs/2023-articles/3-29-23_2023-ma-supplemental-benefits_milliman-brief-2.ashx.

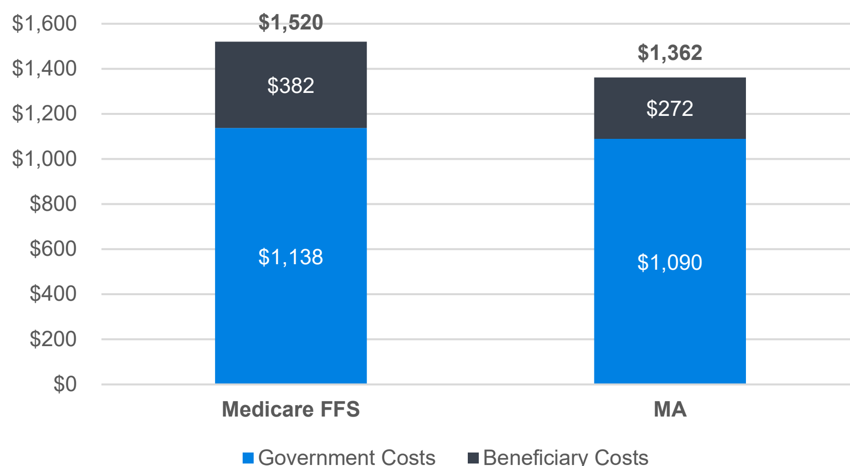
[46] Laktas, J., Yeh, M., & Friedman, J. (March 2023). Prevalence of Supplemental Benefits in the General Enrollment Medicare Advantage Marketplace: 2019 to 2023. Milliman White Paper. Retrieved March 25, 2024, from https://www.milliman.com/en/insight/prevalence-supplemental-benefits-general-enrollment-ma-marketplace-2023.

[47] Ibid.

TOTAL GOVERNMENT AND BENEFICIARY COSTS FOR MEDICARE FFS VS. MA

Figure 6 summarizes the total program costs, or the costs for the government and beneficiary, under both Medicare FFS and MA.

FIGURE 6: GOVERNMENT AND BENEFICIARY COSTS IN MEDICARE FFS VS. MA, $ PMPM†



† Medicare FFS is weighted using January 2024 MA enrollment by county. The Medicare FFS beneficiary costs include the cost sharing collected for Part A and Part B services and the standard Part B premium. The MA beneficiary costs include cost sharing for medical coverage, the standard Part B premium, and Part C and Part D premiums, but exclude other Part D-related out-of-pocket costs. Medicare FFS beneficiary costs may be funded through other coverages, such as Medicaid, employer coverage, or Medigap plans, which may or may not include additional beneficiary premium. Those impacts are excluded in our analysis. Totals may not equal the sum of components due to rounding.

As shown in Figure 6, beneficiary costs are significantly lower under MA than Medicare FFS, which is driven by two attributes specific to MA plans: reduced cost sharing and the inclusion of a maximum out-of-pocket spending limit (MOOP).

Under statute, Part A and Part B cost sharing for MA beneficiaries, in aggregate, must be actuarially equivalent to the cost sharing under Medicare FFS.[48] In other words, benefits must be overall the same or better under MA compared to Medicare FFS. We observed this in our analysis, where for every dollar of government costs for Part A and Part B services, government payments cover 84.4 cents for Medicare FFS and 90.4 cents for MA beneficiaries, with the Medicare FFS and MA beneficiary paying the remaining 15.6 cents and 9.6 cents, respectively.

The MOOP, which is required for all MA plans, limits an MA beneficiary's medical cost exposure within a calendar year to a specified amount. After this specified threshold, the plan covers the full costs of all claims. In 2024, the average MA MOOP for general enrollment (non-special needs plan) MA beneficiaries was $4,750.[49] The average cost-sharing reduction from the in-network MOOP on general enrollment (non-special needs plan) MA beneficiaries is approximately $12.50 PMPM. Medicare FFS does not offer such spending limits for its beneficiaries. Using 2020 Medicare FFS data, 2.5% of FFS beneficiaries would have exceeded the 2023 mandatory MA MOOP of $8,300[50] with average annual out-of-pocket costs of approximately $15,000.[51]

[48] Girod, C. & Kolli, S. Medicare Advantage and Part D: Compliance for Actuaries, op cit.

[49] Friedman, J. & Yeh, M. (January 16, 2024), op cit.

[50] See https://www.federalregister.gov/documents/2022/04/14/2022-07642/medicare-program-maximum-out-of-pocket-moop-limits-and-service-category-cost-sharing-standards (retrieved March 25, 2024).

[51] Mike, D., Nelson, P., & Schliesmann, B. (September 2023). Average Annual Beneficiary Healthcare Costs for Various Medicare Coverage Options 2023. Milliman Client Report. Retrieved March 25, 2024, from https://www.milliman.com/-/media/milliman/pdfs/2023-articles/9-27-23_average-annual-beneficiary-health-care-costs-for-various-medicare-coverage-options-2023.ashx.

In addition to lower cost sharing and additional benefits, many MA plans can provide this coverage for no additional premium. Notably, 99% of Medicare Advantage beneficiaries have access to at least one MA-PD plan at $0 premium (excluding the Part B premium that is mandatory for all Medicare beneficiaries).[52] As mentioned previously, in 2024 the average MA premium is $18.50, the impact of which is included in Figure 6 above.[53]

In addition, Figure 6 shows that the total program costs, or the combined average costs across the government and beneficiary, are lower under MA than in Medicare FFS.[54] This demonstrates that MA plans are providing Part A and Part B coverage, as well as additional benefits, at a lower total cost than the cost of Medicare FFS coverage for only Part A and Part B services.

CHOICE AND POPULARITY

Medicare FFS alone may not provide enough coverage in the eyes of most seniors. In fact, in 2021 97% of noninstitutionalized Medicare beneficiaries had some form of supplemental medical coverage, whether MA, Medigap, supplemental coverage through an employer, or Medicaid.[55]

Within MA, the average total out-of-pocket costs are lower than total out-of-pocket costs under Medicare FFS with Medigap and Part D coverage. For 2023, average out-of-pocket costs for premiums and cost sharing for Medicare beneficiaries not receiving subsidies due to income was estimated to be $3,396 under MA, $5,597 for Medicare FFS with PDP coverage (65% greater than MA), and $6,200 for Medicare FFS with PDP and Medigap (Plan G) coverages (83% greater than MA).[56] Out-of-pocket medical costs can be a significant portion of a beneficiary's annual income, particularly in the Medicare population. In 2023, half of Medicare beneficiaries had annual incomes below $36,000.[57] In addition, in 2020 a greater percentage of MA beneficiaries were low-income (34%) compared to Medicare FFS beneficiaries (31%).[58,59] With the significant cost difference among Medicare coverage options, for some beneficiaries MA may be the only affordable option providing adequate financial protection for healthcare costs, in addition to supplemental benefits offered under most MA plans, making MA a popular choice.[60] For example, MA has dual-special needs plans (D-SNPs) that are geared toward low-income beneficiaries. Popular supplemental benefits in these plans are general supports for living (i.e., utilities and rent), healthy food and grocery cards, and reductions in Part D copays to $0, all of which cover nearly 90% of D-SNP beneficiaries.[61]

Average total out-of-pocket costs are lower in MA partly due to the mechanics of the program, where MAOs manage Part A and Part B costs to below estimated Medicare FFS levels through care and cost management strategies. Lower MA costs then generate rebates MAOs must use to "give back" to the beneficiary through lower Part A and Part B cost sharing (relative to Medicare FFS) and supplemental benefits. However, in return, those beneficiaries must accept certain plan requirements such as seeking care within the plan's provider network[62] and adhering to utilization management programs (such as prior authorizations). Provider risk sharing has also become increasingly

[52] Medicare Advantage 2024 Spotlight: First Look, KFF, op cit.

[53] CMS. (September 26, 2023), Medicare Advantage and Medicare Prescription Drug Programs to Remain Stable, op cit.

[54] We used Medicare FFS risk scores and data from the CMS 5% sample for the MA portion of the analysis to normalize for part of the population differences between programs. Other differences may still exist in the underlying populations.

[55] Naber, J. (May 2022). Medicare Beneficiary Out-of-Pocket Cost Exposure for Part B Drugs and Services. Milliman Brief. Retrieved March 25, 2024, from https://www.milliman.com/-/media/milliman/pdfs/2022-articles/5-25-22_medicare_part_b_beneficiary_out_of_pocket_costs.ashx.

[56] Mike, D., Nelson, P., & Schliesman, B. (September 2023), Average Annual Beneficiary Healthcare Costs, op cit.

[57] KFF. (February 5, 2024). Low Incomes, Little Savings: Many Medicare Beneficiaries Have Modest Financial Resources to Draw Upon in Retirement. Retrieved March 25, 2024, from https://www.kff.org/medicare/press-release/low-incomes-little-savings-many-medicare-beneficiaries-have-modest-financial-resources-to-draw-upon-in-retirement/#:~:text=Key%20takeaways%20from%20the%20analysis,incomes%20below%20%2436%2C000%20per%20person.

[58] MedPAC. (July 2023). Data Book: Healthcare Spending and the Medicare Program. Retrieved March 25, 2024, from https://www.medpac.gov/wp-content/uploads/2023/07/July2023_MedPAC_DataBook_SEC.pdf.

[59] We considered those with incomes less than 150% of the federal poverty level (FPL) to be low-income. This is consistent with the definition used in the Part D program for those eligible for Part D low-income subsidies. See https://www.cms.gov/files/document/lis-memo.pdf (retrieved March 25, 2024).

[60] Impacts quoted represent beneficiaries on average. For a beneficiary in an MA plan that reaches the MOOP, Medigap may be a better option.

[61] Friedman, J. & Yeh, M. (January 16, 2024), op cit.

[62] MA plans establish provider networks based on the provider's cost and willingness to engage in the care management protocols established by the plan.

popular over the past few years, where MA plans include providers in the management of beneficiary care (and therefore costs) through these financial arrangements. MA plans also leverage care coordination, such as chronic care management, case management, and other programs, to reduce costs both through providing holistic care to beneficiaries and preventing certain services deemed unnecessary or duplicative by the plan and steering beneficiaries to less costly sites of care. These care and cost management strategies help MA plans reduce costs for Part A and Part B services.

Provider networks and utilization management programs may be perceived to be restrictive, but enrollment in MA has continued to grow significantly. Even in the last decade, MA enrollment has more than doubled, from about 15 million beneficiaries in 2014 to over 33 million beneficiaries in 2024, increasing from 31% of overall 2014 Medicare enrollment to over a 50% share of 2024 Medicare enrollment.[63,64,65] This demonstrates that Medicare beneficiaries value the additional benefits and lower cost sharing offered by MA and actively continue to enroll in MA instead of Medicare FFS.

Because MA continues to increase in popularity, so does the competitiveness of the market. MA offers a wide array of choices among plans. In 2024, the average MA beneficiary can choose from 43 plans.[66] Each MA plan offers a varying set of additional benefits that may suit a beneficiary’s needs.

ADMINISTRATIVE COSTS

MAOs must factor in additional costs to administer the plan (also called non-benefit expense, or NBE). As such, MAOs have higher administrative costs compared to Medicare FFS. Examples of these costs MAOs must consider are the following (though this list is not exhaustive):

- Expenses for care management and utilization management programs
- Expenses for claim adjudication
- Expenses for beneficiary enrollment
- Expenses for marketing materials
- Expenses to set up and administer provider networks
- Administrative fees paid to vendors
- Salaries for marketing and sales staff
- Commissions to brokers
- Expenses for quality improvement activities (which improve the health and experience of beneficiaries, driving improvement in star ratings)

MA plans allocate approximately 10.3% of government payments to administrative costs, which are included in both the bid and the rebates, as discussed previously. While data is not readily available for MA plans, a study estimated commercial health plans spend approximately 6% of total administrative costs on quality improvement activities and approximately 15% on cost containment activities.[67] Please note that some of these additional costs, such as costs for care management and utilization management programs, help MA plans reduce benefit expenses for Medicare-covered services, as seen in Figure 3 above.

[63] Ochieng, N. et al. (August 9, 2023). Medicare Advantage in 2023: Enrollment Update and Key Trends. KFF. Retrieved March 25, 2024, from https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-enrollment-update-and-key-trends/.

[64] Milliman analysis of CMS-published January 2024 MA State/County Penetration data from https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-advantagepart-d-contract-and-enrollment-data/ma-state/county-penetration (retrieved March 25, 2024).

[65] Total enrollment in MA plans includes employer group waiver plans (EGWPs), Medicare-Medicaid plans (MMPs), Cost plans, MSA plans, and PACE plans, all of which are excluded from our analysis.

[66] Medicare Advantage 2024 Spotlight: First Look, KFF, op cit.

[67] AHIP. (September 6, 2022). Where Does Your Health Care Dollar Go? Retrieved March 25, 2024, from https://www.ahip.org/resources/where-does-your-health-care-dollar-go.

Medicare FFS does have administrative costs, though significantly less than MA. According to the Medicare Trustees report, approximately $10.4 billion, or 1.3% of expenditures, was allocated to administrative expenses, which are government expenses for both the Medicare FFS and MA programs.[68] The administrative costs are funded through both the Hospital Insurance (HI) Trust Fund and supplementary medical insurance (SMI) account and include costs for "the payment of benefits, the collection of taxes, fraud and abuse control activities, and experiments and demonstration projects designed to determine various methods of increasing efficiency and economy in providing health care services."[69] Some of these categories are expenses for MA as well, such as fraud and abuse control activities and expenses for demonstration projects (some of which are utilized in the MA program). As such, we also included an additional 1.3% for MA administrative costs for Part A and Part B services under the assumption that the government's costs are proportional to the population enrolled in each. The allocation of the $10.4 billion across programs was not provided in the Medicare Trustees report.

Despite higher administrative costs in MA, the total government payment PMPM is still lower compared to Medicare FFS.

CONCLUSIONS

MA provides significant value to the government. We summarize below the key conclusions from this analysis in our evaluation of the difference in payments between the Medicare FFS and MA programs.

- Care and cost management strategies play a critical role in the MA program, helping to increase quality of beneficiary care as well as reduce both costs through providing holistic care to the member and costs of certain services deemed unnecessary or duplicative. This allows MA plans to offer the same coverage as Medicare FFS at lower costs for Part A and Part B services. The savings seen from these cost reductions allow MA plans to return a portion back to the beneficiary through providing lower out-of-pocket costs and additional benefits. Approximately 71% of each dollar of government payments to MA is used for Part A and Part B costs, with another 5% used to reduce beneficiary cost sharing, compared to 99% of each dollar of government payments to Medicare FFS covering just Part A and Part B services.
- Part A and Part B services, reduced cost sharing, and additional benefits, as well as administrative costs and profit margins, are provided at a lower total cost to the government compared to Medicare FFS offering just Part A and Part B coverage,[70] as shown in Figure 3 above.
- Because MAOs can provide reductions in cost sharing through rebates, MA beneficiaries have lower out-of-pocket costs compared to Medicare FFS beneficiaries. Government payments for Part A and Part B services to MA, which are bid payments plus a portion of the rebates, become a larger proportion of total costs than in Medicare FFS. Specifically, for every dollar spent on Part A and Part B services, government payments cover 84.4 cents for Medicare FFS beneficiaries and 90.4 cents for MA beneficiaries, with the Medicare FFS beneficiary and MA beneficiary paying the remaining 15.6 cents and 9.6 cents, respectively.[71]
- Rebates generated through savings are used to provide cost-sharing reductions and additional benefits not offered in either Medicare FFS or Medigap. These rebates account for 17% of the government's dollar, as shown in Figure 4 above. Figure 5 above summarizes the average PMPM breakdown of these costs. There are several additional benefits, such as dental, vision, and hearing coverage, that provide significant value to beneficiaries.
- MA plans provide reductions in cost sharing and a number of additional benefits frequently at no additional cost to members. While some MA plans require a premium (the average MA premium for 2024 is $18.50[72]), 99% of Medicare Advantage beneficiaries have access to at least one MA-PD plan at $0 premium (excluding the Part B premium that is mandatory for all Medicare beneficiaries).[73]

[68] See the full 2023 Medicare Trustees report at https://www.cms.gov/oact/tr/2023 (retrieved March 25, 2024).

[69] Ibid.

[70] We used Medicare FFS risk scores and data from the CMS 5% sample for the MA portion of the analysis to normalize for part of the population differences between programs. Other differences may still exist in the underlying populations.

[71] Some beneficiaries have additional coverage, such as Medicaid coverage, employer-sponsored coverage, or a Medigap plan. In these cases, the beneficiary's supplemental coverage may pay for some or all of the cost sharing.

[72] CMS. (September 26, 2023), Medicare Advantage and Medicare Prescription Drug Programs to Remain Stable, op cit.

[73] Medicare Advantage 2024 Spotlight: First Look, KFF, op cit.

There may be other indirect sources of savings to the government driven by MA plans, though not directly addressed in this analysis. These sources may include the following:

- **Spillover savings in Medicare FFS** resulting from the presence of MA. Studies have shown that, in areas with greater MA penetration, Medicare FFS beneficiaries have lower hospital costs and fewer “post-acute care services” such as care in nursing homes.[74] In other words, markets with high MA penetration may exhibit a spillover effect, reducing costs for Medicare FFS beneficiaries and producing additional savings for the government.
- **Savings to Medicaid**, which is funded by a combination of state and federal dollars. Savings may be driven by dual-eligible special needs plans (D-SNPs) and dual-eligibles in other MA plans. Medicaid typically covers cost sharing for low-income Medicare beneficiaries. Through MA’s care and utilization management programs, the beneficiary cost sharing (which is covered by Medicaid) may be lower than for those enrolled in Medicare FFS. In addition, through the MOOP threshold imposed by MA plans, costs above the MOOP are transferred from Medicaid to the MA plan. Using 2020 Medicare FFS data, 2.5% of FFS beneficiaries would have exceeded the 2023 mandatory MA MOOP of $8,300[75] with average annual out-of-pocket costs of approximately $15,000.[76] These mechanisms help drive savings to Medicaid, which constitute indirect savings to the government.

[74] Geng, F. et al. (April 2023). Increased Medicare Advantage Penetration Is Associated With Lower Post-Acute Care Use for Traditional Medicare Patients. Health Affairs. Retrieved March 25, 2024, from https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2022.00994#:~:text=Increased%20Medicare%20Advantage%20Penetration%20Is,Traditional%20Medicare%20Patients%20%7C%20Health%20Affairs.

[75] See https://www.federalregister.gov/documents/2022/04/14/2022-07642/medicare-program-maximum-out-of-pocket-moop-limits-and-service-category-cost-sharing-standards (retrieved March 25, 2024).

[76] Mike, D., Nelson, P., & Schliesman, B. (September 2023), Average Annual Beneficiary Healthcare Costs, op cit.

IV. Sensitivity testing

As discussed throughout this report, there are arguments about whether payments to Medicare FFS and MA are still comparable, even after adjusting for underlying population differences.

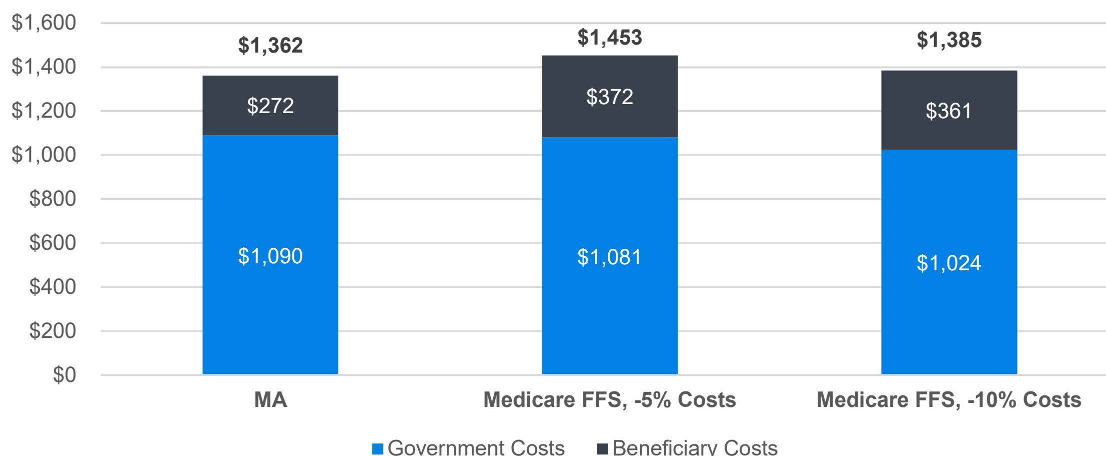
MedPAC recently estimated that 2024 government payments to MA plans will be, on average, 122% of FFS spending, which they estimated to be driven by additional risk score coding differences and selection impacts.[77] Analyzing the validity of the outcomes of that report are outside the scope of this paper.

As discussed previously, using the same risk scores for each respective population would not be appropriate because there are risk score coding differentials due to the mechanics of the MA program, and coding diagnoses on risk scores is not as critical in Medicare FFS. We accounted for this differential in our analysis by adjusting the MA risk scores down by the 5.9% CMS MA coding pattern adjustment. MedPAC estimates this actual coding difference may be as high as 19% (inclusive of the 5.9%).[78] If actual coding differences exceed the 5.9% published CMS estimate, then MA government payments would be higher relative to Medicare FFS.

In addition, some studies suggest there is a selection difference in the populations, where beneficiaries select coverage based on their anticipated healthcare needs. In other words, Medicare beneficiaries selecting MA plans may tend to spend less in healthcare costs, not seeing provider networks and prior authorizations as a barrier to receiving the medical services they need. On the other hand, those with more medical needs may see this as a barrier, opting for Medicare FFS, with or without Medigap (or other supplemental coverage), where the care and cost management programs are much more limited. Because MA payments are based on Medicare FFS spending, MedPAC estimates this selection impact could increase MA payments by 9%.[79]

To test whether each of these factors could impact our overall conclusions, we conducted a high-level sensitivity test on our analysis. We reduced Medicare FFS costs by 5% and 10%. Figure 7 summarizes the government payments and beneficiary costs under each scenario.

FIGURE 7: GOVERNMENT AND BENEFICIARY COSTS IN MEDICARE FFS VS. MA ($ PMPM), -5% AND -10% MEDICARE FFS COST SCENARIOS†



† Medicare FFS is weighted using January 2024 MA enrollment by county. The Medicare FFS beneficiary costs include the cost sharing collected for Part A and Part B services and the standard Part B premium. The MA beneficiary costs include cost sharing for medical coverage, the standard Part B premium, and Part C and Part D premiums, but exclude other Part D-related out-of-pocket costs. Medicare FFS beneficiary costs may be funded through other coverages, such as Medicaid, employer coverage, or Medigap plans, which may or may not include additional beneficiary premium. Those impacts are excluded in our analysis. Totals may not equal the sum of components due to rounding.

Under both scenarios, total program costs for Medicare FFS are higher than for MA. While government payments under Medicare FFS would be less than MA, the beneficiary costs are significantly higher.

[77] MedPAC (March 2024). Report to the Congress, op cit.

[78] Ibid.

[79] Ibid.

V. Methodology and data sources

We estimated Medicare FFS payments using cost and enrollment information published by CMS. We used MA membership by county from January 2024 published by CMS as weights when aggregating Medicare FFS costs, excluding indirect medical education (IME) costs and kidney acquisition costs (KACs). We used risk scores consistent between Medicare FFS and MA plans in a given service area to adjust for some differences in health status between the programs, and adjusted MA for the 5.9% CMS MA coding pattern adjustment. Additionally, we adjusted Medicare FFS costs upward to remove the inclusion of Part A-only and Part B-only beneficiaries in the published rates, which tend to have lower overall Medicare costs.

We estimated government administrative expenses for both Medicare FFS and MA using information published in the 2023 Medicare Trustees report.

We used detailed publicly available information for all MA plans from CMS to inform benefit designs, premiums, and star ratings. We used this information, along with proprietary Milliman pricing tools, to calculate imputed bids and supplemental benefit costs for all contract-year (CY) 2024 MA plans under the current MA payment methodology, which supported our estimate of total MA costs.

To calculate imputed bids, we estimated plans' net medical costs using benefit designs for all plans and calculated expected costs for each plan's service area using proprietary Milliman pricing tools. The estimated net medical cost and assumptions for administrative costs and profit margin for each plan are combined with the plan's star rating and benchmark revenue rates released by CMS (adjusted for estimated risk scores) to calculate the plan's imputed rebate. We then estimated the distribution of the plan's rebate based on the cost-sharing reductions, supplemental benefits offered, and Part D and Part B buy-downs. Plan type and geography were factors in developing the medical cost estimates and other assumptions. Other assumptions include administrative expenses and profit margins.

Part D estimates include government payments to reduce beneficiary premiums, which are used to provide enhanced drug coverage, including $0 low-income copays through the Value Based Insurance Design (VBID) program and non-Part D drug coverage.

The analysis excludes all employer group waiver plans (EGWPs), Program of All-inclusive Care for the Elderly (PACE) organizations, Medical Savings Account (MSA) plans, Medicare Cost plans (1876 and 1833), and Medicare-Medicaid Plans (MMPs). However, we include all MA-PD and MA-only plans (offering only Part C coverage) that are not in one of the excluded plan types.

VI. Caveats and Limitations

The authors of this report are employees of Milliman, Inc. Ali Heinrich, Sam Smetek, and Brett Swanson are members of the American Academy of Actuaries and meet the qualification standards of the American Academy of Actuaries to perform the analysis supporting this report.

Milliman does not intend to benefit and assumes no duty of liability to parties that receive this work product. Any third-party recipient of this work product that desires professional guidance should not rely upon Milliman's work product, but should engage qualified professionals for advice appropriate to its own specific needs. Milliman is not advocating for, or endorsing, any specific policy changes to the Medicare FFS or Medicare Advantage programs in this report.

Milliman has developed certain models to estimate the values included in this report. The intent of the models was to illustrate cost differences between Medicare Advantage and Medicare FFS. We have reviewed the models, including their inputs, calculations, and outputs, for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP).

The models rely on data and information as input to the models. We relied upon certain data and information from CMS and MedPAC for this purpose and accepted it without audit. There is no single comprehensive source that estimates the value of various benefits provided by MA plans, and limited granularity is available in terms of the various payment streams that MA plans receive and how those payments are used. As such, we connected these publicly available aggregate totals to plan and region-specific costs to estimate the cost for MA plans to provide traditional Medicare benefits, the difference between Medicare FFS and MA costs for these services, rebates earned by MA plans for these savings, how these rebates are allocated to supplemental benefits, and the value of the MA benefit. To the extent the data and information relied upon is not accurate, or is not complete, the values provided in this report may likewise be inaccurate or incomplete.

The figures presented in this report are designed to provide information regarding the estimated relative value of the Medicare Advantage and Medicare FFS programs for 2024 based on publicly available benefit, premium, and enrollment data, as well as our estimates of Medicare-covered service costs, drug costs, risk scores, supplemental benefit costs, and other related items. Future healthcare costs are highly uncertain and will likely vary from our current estimates and will depend on the demographic characteristics and health statuses of enrolled beneficiaries, a plan's geography, and other factors.

The models, including all input, calculations, output, and this report, may not be appropriate and should not be used for any other purpose.

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