

MILLIMAN REPORT

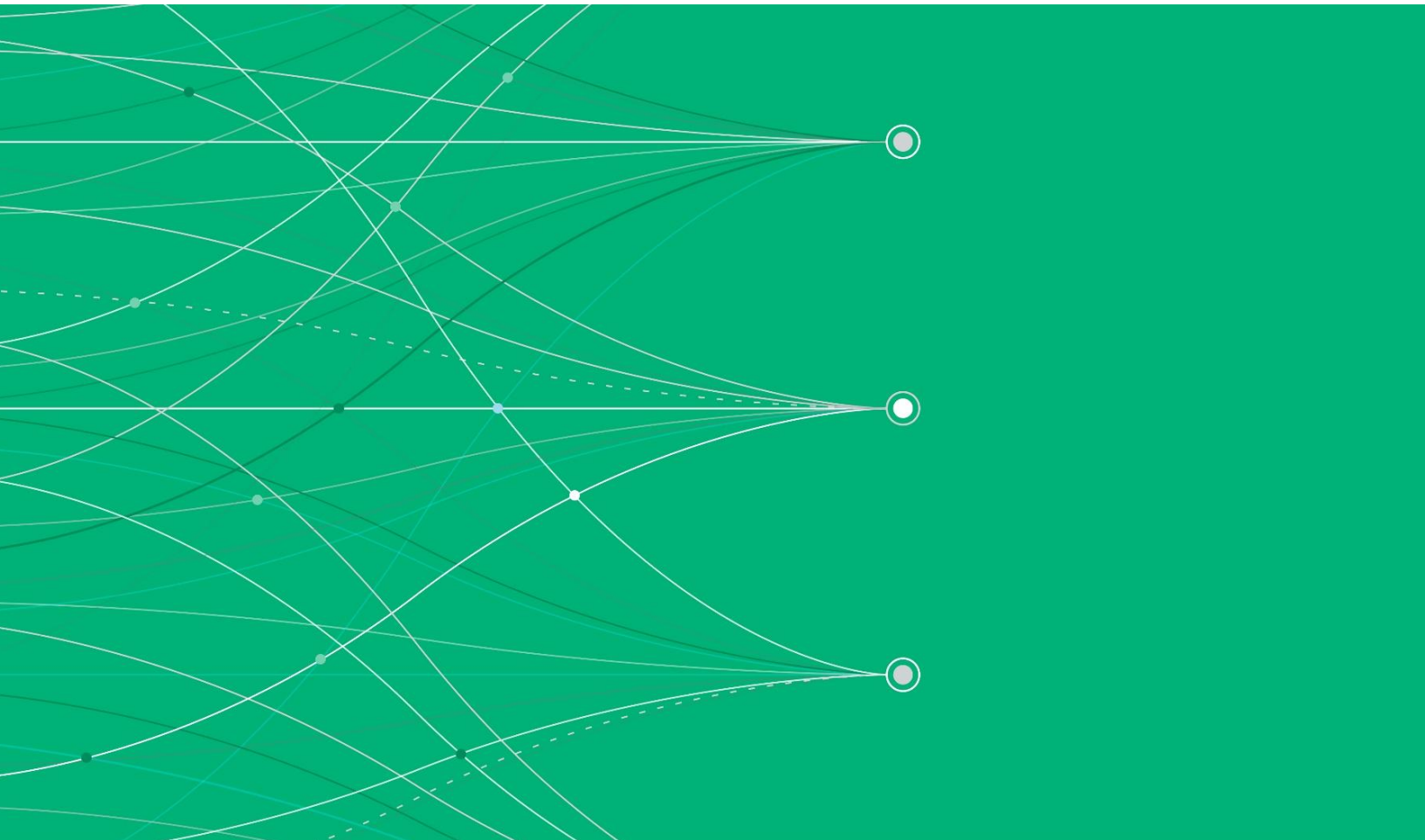
# Value of Medicare Advantage to the federal government: 2025

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## I. Executive summary

UnitedHealth Group (UHG) commissioned Milliman to analyze the value to the federal government of the Medicare Advantage (MA) program relative to Traditional Medicare for 2025. This is an update to a prior analysis completed in 2024.<sup>1</sup> In our analysis, we estimated the value of the MA program to the government (government value) by quantifying what is provided for each dollar of government spending paid to MA plans, compared to each dollar of government spending for Traditional Medicare.

In interpreting this report, it is important to consider that Traditional Medicare and MA are different approaches to delivering health care for beneficiaries over the age of 65 or under the age of 65 and disabled. These programmatic differences contribute in large part to the ways Traditional Medicare and MA deliver value to the government and beneficiaries.

Traditional Medicare, also known as “Original Medicare” or “Medicare Fee-for-Service,” is comprised of Medicare Part A and Part B, and covers a wide range of services, including hospital care, office visits, preventive services, and some medical supplies. Traditional Medicare does not cover prescription drugs, but beneficiaries may purchase prescription drug coverage separately (called Medicare Part D). Beneficiaries covered under Traditional Medicare may see any provider who accepts Medicare, resulting in broad access to most health care providers nationwide. As a fee-for-service program, Traditional Medicare reimburses providers for services rendered and mainly relies on plan design features such as deductibles and cost sharing to control unnecessary utilization.

MA, also called Part C, is a form of Medicare offered by private health insurers. MA plans are required to cover everything that Traditional Medicare covers, and often offer additional benefits, such as vision, dental, hearing, and may include prescription drug coverage.

Because MA is a managed care program, MA plans have managed care features that are not typically seen (or minimally seen) in Traditional Medicare. The primary goals of these features are to keep expected costs for Part A and Part B services at or below those of Traditional Medicare, to increase the quality of beneficiary care, and to help avoid unnecessary or duplicative services. Cost and care management strategies employed by MA plans include the following:

- Provider networks: Traditional Medicare beneficiaries are generally able to see any provider that accepts Medicare nationwide. MA plans may require beneficiaries to use providers specified by the plan.<sup>2</sup>
- Care coordination programs, such as chronic care management and case management for beneficiaries with acute or complex care needs.
- Utilization management programs (e.g., prior authorization<sup>3</sup>) that verify services ordered by providers are medically necessary and appropriate.
- Risk-sharing arrangements with providers, which promote value-based care by giving them incentives to optimize their patients’ use of clinical services or drive improvements against quality of care metrics.<sup>4</sup>

The use of managed care strategies is the primary difference between Traditional Medicare and MA. These strategies generate “savings” for Medicare Advantage Organizations (MAOs) that result in the MA program incurring less cost to provide Traditional Medicare benefits.<sup>5</sup> A portion of these savings is retained by the Centers for Medicare and Medicaid Services (CMS), and MAOs are required to use a portion of the savings to provide beneficiaries with additional benefits. Common additional benefits offered by MA plans include:

<sup>1</sup> Heinrich, A., Smetek, S., & Swanson, B. (2024, April). *Value of Medicare Advantage to the federal government*. Milliman. [https://edge.sitecorecloud.io/millimaninc5660-milliman6442-prod27d5-0001/media/Milliman/PDFs/2024-Articles/4-29-24\\_Value-of-MA-to-the-federal-government.pdf](https://edge.sitecorecloud.io/millimaninc5660-milliman6442-prod27d5-0001/media/Milliman/PDFs/2024-Articles/4-29-24_Value-of-MA-to-the-federal-government.pdf).

<sup>2</sup> Medicare (n.d.). *Understanding your Medicare Advantage Plan’s provider network*. <https://www.medicare.gov/Pubs/pdf/11941-Understanding-Your-Medicare-Advantage-Plan.pdf>.

<sup>3</sup> Traditional Medicare currently requires some prior authorizations, though only in very limited cases. A prior authorization demonstration on select Part B services is expected to begin in 2026, expanding services requiring prior authorization, though still impacting a much smaller set of services compared to most MA plans. Centers for Medicare and Medicaid Services. (2025, November 20). *Prior authorization demonstration for certain ambulatory surgical center ASC services*. Retrieved December 18, 2025, from <https://www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/prior-authorization-pre-claim-review-initiatives/prior-authorization-demonstration-certain-ambulatory-surgical-center-services>.

<sup>4</sup> Traditional Medicare has some value-based care through Accountable Care Organizations and Medicare Shared Savings Programs. Centers for Medicare and Medicaid Services. (2025, September 29). *Medicare Shared Savings Program Accountable Care Organizations updated Performance Year 2024 financial and quality Results*. <https://www.cms.gov/files/document/fact-sheet-ssp-py24-financial-quality-results.pdf>.

<sup>5</sup> The calculation of savings is discussed in Section II.

- **Lower cost sharing** for Parts A and B services compared to Traditional Medicare. 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 Traditional Medicare. 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 2025, the average MOOP for general enrollment (non-special needs plan) MA beneficiaries is approximately \$4,900.<sup>6</sup>
- **Supplemental benefits** not covered under Traditional Medicare. Examples of these benefits include dental, vision, hearing, over-the-counter (OTC) benefits, and nonemergency medical transportation.
- **Subsidized prescription drug coverage (Part D)**. Most MA plans include Part D coverage and use savings to reduce or eliminate their premiums, whereas Traditional Medicare beneficiaries must purchase drug coverage separately.
- **Subsidized Part B premiums**, where MA plans credit a specified monthly amount to a beneficiary's Social Security account. This is intended to offset the monthly Part B premiums, which are typically a reduction to a beneficiary's SS payment.<sup>7</sup>

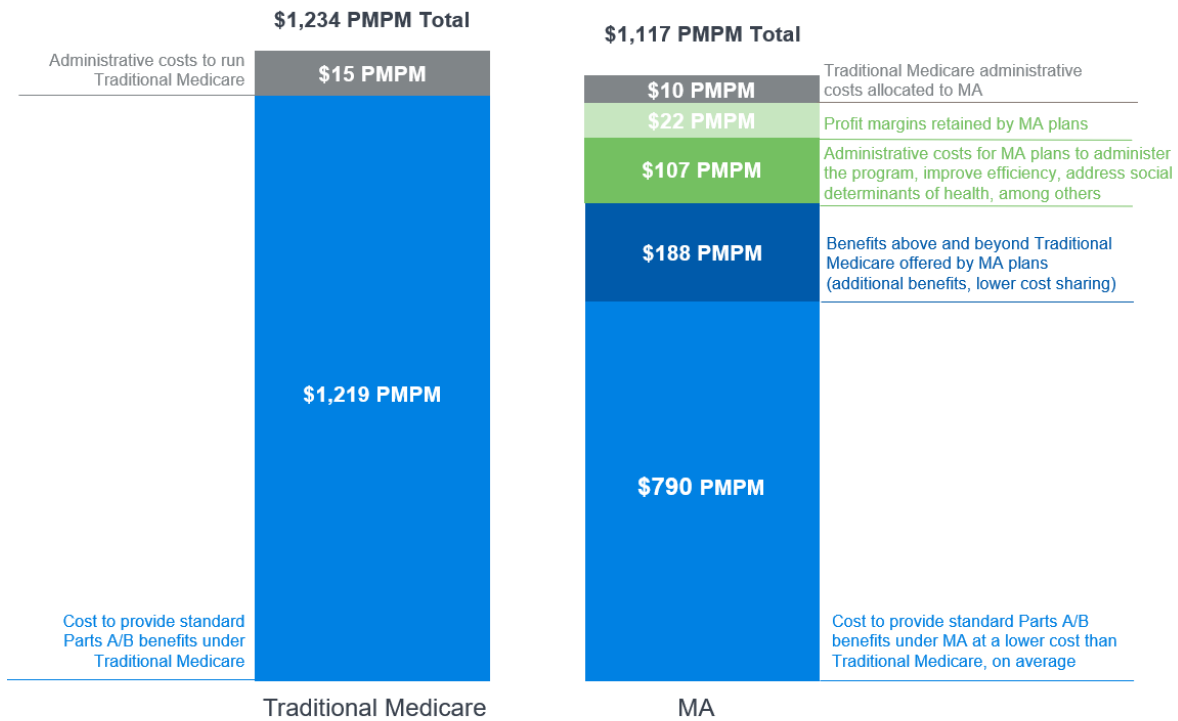
Our analysis shows that for beneficiaries in Traditional Medicare, for each dollar of government spending, almost 99% goes to expenses in Part A and Part B, with the remaining amount covering administrative costs. For beneficiaries enrolled in MA, approximately 71% of each dollar of government spending is for expenses for comparable Part A and Part B services, with an additional 17% of payments, generated through "savings" described above, for the reduction in cost sharing (RICS) and additional benefits as described above. The remaining 12% includes MA plan administrative costs (9%), which fund the various care management programs used by MA plans, Traditional Medicare administrative costs allocated to MA (1%), and profit margins (2%). The allocations of government payments for Traditional Medicare and MA, respectively, are shown in Figure 1, expressed as an average cost per member per month (PMPM).<sup>8</sup>

<sup>6</sup> Friedman, J., Cates J., & Phillips E. (2024, December 16). *State of the 2025 Medicare Advantage industry: General enrollment plan valuation and selected benefit offerings*. Milliman. <https://www.milliman.com/en/insight/state-of-medicare-advantage-general-enrollment-2025>.

<sup>7</sup> Nelson, P., Hamilton, J., & Heinrich, A. (2023, April). *Is the Part B premium buydown here to stay? 2023 landscape and considerations for 2024*. Milliman. [https://www.milliman.com/-/media/milliman/pdfs/2023-articles/4-26-23\\_part-b-premium-buydown.ashx](https://www.milliman.com/-/media/milliman/pdfs/2023-articles/4-26-23_part-b-premium-buydown.ashx).

<sup>8</sup> The terms member and beneficiary are used interchangeably throughout this report.

**FIGURE 1: 2025 TRADITIONAL MEDICARE VS. MA GOVERNMENT PAYMENT ALLOCATION, \$ PMPM<sup>†</sup>**



<sup>†</sup> Traditional Medicare is weighted using February 2025 MA enrollment by county. Government payments for MA, attributed to additional benefits in this figure, include allocations to reduce the 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 is included in Figure 3. Totals may not equal the sum of components due to rounding.

Government payments to MA plans in 2025 are estimated to be approximately 91% of—or 9% lower than—government costs for Traditional Medicare, as shown in Figure 1. Government payment differentials shown for 2025 are larger than prior versions of this report. The larger differential is primarily driven by the CMS 2024 HCC risk score model and the 2025 MA benchmarks. The CMS 2024 HCC (or v28) risk score model, which, on average, results in higher risk scores for Traditional Medicare and lower risk scores for MA,<sup>9</sup> continues to be phased in for 2025, impacting MA payment rates to plans, which are adjusted for risk scores. In addition, 2025 Traditional Medicare cost estimates (underlying the 2025 MA payment rates) were restated after the 2025 MA payment rates had already been finalized. The Traditional Medicare costs included in this analysis align more closely with the restated estimates, whereas the MA payment rates are based on the 2025 payment rates as is.

We used information published by the Medicare Payment Advisory Commission (MedPAC) to derive average 2025 projected profit margin (2.0%), projected medical loss ratio (88.3%<sup>10</sup>), and 2025 MA rebates generated through savings (\$208 PMPM).<sup>11</sup> Of total MA rebates, the value of reduced cost sharing and additional benefits is \$188 PMPM: \$59 PMPM for the RICS, \$82 PMPM for the value of additional benefits expected to be used, \$10 PMPM for the reduction in Part B premium, and \$37 PMPM for the reduction in Part D premium.<sup>12</sup> Extrapolated to the approximately 28 million beneficiaries enrolled in individual MA plans in 2025, this equates to \$63.0 billion annually in additional benefits.

Figure 2 summarizes the estimated total program costs expressed as a PMPM, separately for the government and the beneficiary, for Traditional Medicare and MA. The total government costs shown in Figure 2 are consistent with the totals from Figure 1.

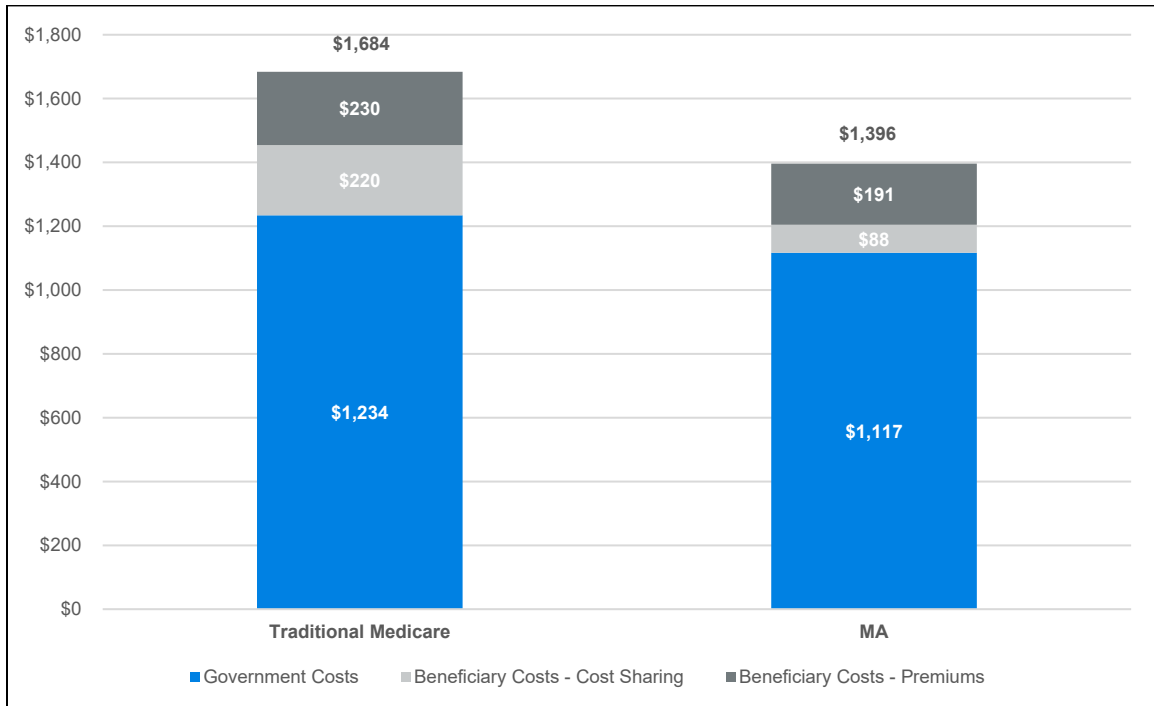
<sup>9</sup> Pipich, R., Cross, K., & Rothschild, M. (2023, February). *High-level impacts of the proposed CMS-HCC risk score model on Medicare Advantage payments for 2024*. Milliman. [https://media.milliman.com/v1/media/edge/images/millimaninc5660-milliman6442-prod27d5-0001/media/Milliman/PDFs/2023-Articles/2-28-23\\_2024-Proposed-CMS-HCC-Model-Impact.pdf](https://media.milliman.com/v1/media/edge/images/millimaninc5660-milliman6442-prod27d5-0001/media/Milliman/PDFs/2023-Articles/2-28-23_2024-Proposed-CMS-HCC-Model-Impact.pdf).

<sup>10</sup> The medical loss ratio is calculated using Figure 1, excluding Traditional Medicare administrative costs to MA. The minimum required loss ratio for MA plans is 85.0%.

<sup>11</sup> MedPAC (2025, June). *Report to the Congress: Medicare and the health care delivery system*. [https://www.medpac.gov/wp-content/uploads/2025/06/Jun25\\_MedPAC\\_Report\\_To\\_Congress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2025/06/Jun25_MedPAC_Report_To_Congress_SEC.pdf).

<sup>12</sup> Values do not include retention amounts for administrative cost and profit margin.

**FIGURE 2: 2025 COMBINED GOVERNMENT AND BENEFICIARY COSTS IN TRADITIONAL MEDICARE VS. MA, \$ PMPM<sup>‡</sup>**



<sup>‡</sup> Traditional Medicare is weighted using February 2025 MA enrollment by county. The Traditional Medicare beneficiary costs include the cost sharing collected for Part A and Part B services, the standard Part B premium, and the average standalone prescription drug plan (PDP) 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 supplemental benefits and Part D-related out-of-pocket costs. Traditional Medicare beneficiary costs may be funded through other coverages, such as Medicaid, employer coverage, or Medigap plans, which may or may not include additional beneficiary premiums. Those impacts are excluded from our analysis. Totals may not equal the sum of components due to rounding.

Figure 2 shows that the value of total program costs for 2025 in MA are 83% of those in Traditional Medicare (\$1,396 PMPM vs. \$1,684 PMPM), and beneficiary costs in MA are 62% of those in Traditional Medicare (\$279 PMPM vs. \$450 PMPM). Care and cost management strategies in the MA managed care program help reduce government costs and beneficiary costs. The benefit structure of the MA program also drives lower MA beneficiary costs through reductions in Part A and Part B cost sharing and a MOOP, providing beneficiaries with choices among various plans, each offering a varying set of additional benefits that may suit a beneficiary’s specific needs.

For every dollar of total program costs (excluding Part D premiums, which are included in Figure 2), government payments cover 75.3 cents, with the Traditional Medicare beneficiary paying the remaining 24.7 cents. Government payments for MA cover 80.7 cents of total program costs (excluding Part D premiums) with the MA beneficiary paying the remaining 19.3 cents.<sup>13</sup>

Figure 2 also includes beneficiary premiums—the standard Part B premium (\$185 per month in 2025<sup>14</sup>, which all Medicare beneficiaries must pay regardless of coverage option), the average MA premium (\$17 per month in 2025), the average standalone prescription drug plan (PDP) premium for Traditional Medicare (\$45 per month in 2025<sup>15</sup>), and the average Part B premium giveback for MA (\$10 per month in 2025). Note that many MA plans offer a \$0 MA premium, where in 2025, 99% of MA beneficiaries have access to at least one Medicare Advantage Prescription Drug (MA-PD) plan with a \$0 premium.<sup>16</sup> Since Traditional Medicare does not include prescription drug coverage, we included

<sup>13</sup> 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.  
<sup>14</sup> Centers for Medicare and Medicaid Services. (2024, September 27). *Medicare Advantage and Medicare Prescription Drug Programs to remain stable as CMS implements improvements to the programs in 2025*. <https://www.cms.gov/newsroom/fact-sheets/medicare-advantage-and-medicare-prescription-drug-programs-remain-stable-cms-implements-improvements>.  
<sup>15</sup> Cubanski, J., & Damico, A. (2024, November 22). *Medicare Part D in 2025: A first look at prescription drug plan availability, premiums, and cost sharing*. KFF. <https://www.kff.org/medicare/issue-brief/medicare-part-d-in-2025-a-first-look-at-prescription-drug-plan-availability-premiums-and-cost-sharing/>.  
<sup>16</sup> Freed, M., Fuglesten Biniek, J., Damico, A., & Neuman, T. (2024, November 15). *Medicare Advantage 2025 spotlight: First look at plan premiums and benefits*. KFF. <https://www.kff.org/medicare/issue-brief/medicare-advantage-2025-spotlight-a-first-look-at-plan-premiums-and-benefits/>.

premiums for the most common drug coverage selected, which is a PDP. This premium is higher than the average premium for MA coverage.<sup>17</sup>

Because Traditional Medicare has higher beneficiary out-of-pocket costs than MA for Part A and Part B services, most Traditional Medicare beneficiaries obtain supplemental coverage to cover these out-of-pocket costs, whether through a Medigap plan, employer-sponsored coverage, or Medicaid.<sup>18</sup> 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. Beneficiaries may choose Traditional Medicare plus Medigap for its broad networks, minimal utilization management, or predictability of out-of-pocket costs.

MedPAC recently stated government payments to MA plans are significantly higher than Traditional Medicare spending, which the Commission estimated to be driven by additional risk score coding and beneficiary selection differences beyond what is captured in the 5.9% CMS statutory minimum coding pattern adjustment (i.e., MA beneficiaries may have lower spending than their risk scores predict).<sup>19</sup> We performed a sensitivity analysis to test a range of reasonable risk score coding differences, beyond the 5.9% adjustment, by reducing Traditional Medicare costs by 5% and 10%. This analysis showed that even with 10% lower Traditional Medicare costs for Part A and Part B services, MA's cost management strategies still produce lower total program costs than Traditional Medicare.

Our analysis also did not address selection differences between Traditional Medicare and MA beyond population and geographical differences. We used MA enrollment by county as weights when aggregating total Traditional Medicare costs. We also removed Part A-only and Part B-only members and costs from Traditional Medicare. To be enrolled in MA, the beneficiary must be enrolled in both Part A and Part B, so this ensured our comparison between programs was appropriate.

In summary, the managed care structure of the MA program allows MA to provide value to the government with lower total costs than Traditional Medicare, as shown in Figure 1. MA plans must offer at least the same coverage as Traditional Medicare, usually with various additional benefits as well, and they do this at a lower overall cost to both the government and the beneficiary.

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<sup>17</sup> Centers for Medicare and Medicaid Services. (2024, September 27). *Medicare Advantage and Medicare Prescription Drug Programs to remain stable as CMS implements improvements to the programs in 2025*. <https://www.cms.gov/newsroom/fact-sheets/medicare-advantage-and-medicare-prescription-drug-programs-remain-stable-cms-implements-improvements>.

<sup>18</sup> Ochieng, N., Cubanski, J., & Neuman, T. (2024, September 23). *A snapshot of sources of coverage among Medicare beneficiaries*. KFF. <https://www.kff.org/medicare/issue-brief/a-snapshot-of-sources-of-coverage-among-medicare-beneficiaries/>.

<sup>19</sup> MedPAC (March 2025). *Report to the Congress: Medicare payment policy*. [https://www.medpac.gov/wp-content/uploads/2025/03/Mar25\\_MedPAC\\_Report\\_To\\_Congress\\_SEC-1.pdf](https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_MedPAC_Report_To_Congress_SEC-1.pdf).

## II. Background

UHG commissioned Milliman to analyze the value to the federal government of the MA program relative to Traditional Medicare for 2025. In our analysis, we estimated the value of the MA program to the government (government value) by quantifying what is provided for each dollar of government spending paid to MA plans, compared to each dollar of government spending for Traditional Medicare. Additional sources of value, such as care coordination, provider risk sharing, and care management programs, generate implicit cost differences, but are not directly quantified in our analysis.

### General background on Medicare

Medicare is government-sponsored health care 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 outpatient and physician services). Part A is funded through the Medicare Hospital Insurance (HI) Trust Fund, which is financed primarily by payroll taxes.<sup>20,21</sup> Part B (and similarly Medicare Part D) is funded through the Medicare Supplemental Medical Insurance (SMI) Trust Fund, which largely comprises payments from the General Fund of the Treasury and Part B beneficiary premiums.<sup>22</sup>

### Medicare coverage options

Those eligible for Medicare can choose to receive health care coverage through Traditional Medicare or an MA plan.

All Medicare beneficiaries, regardless of the coverage selected, must pay a premium for Part B services, which is \$185 per month in 2025.<sup>23</sup> Higher-income beneficiaries may pay higher premiums and lower-income beneficiaries may pay lower premiums than the standard monthly amount.

The most popular Medicare coverage options in the market today are as follows:

- **Traditional Medicare:** Beneficiaries selecting Traditional Medicare can receive services from any doctor or hospital that accepts Medicare (i.e., no network restrictions and limited prior authorization restrictions) and they must pay standard cost sharing. Only Part A facility services and Part B ambulatory services are covered under Traditional Medicare, with prescription drug coverage purchased separately. Traditional Medicare is also known as Standard Medicare or Medicare Fee-for-Service.
- **Medigap:** Beneficiaries with Traditional Medicare 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. Medigap premiums can be based on the beneficiary’s own characteristics, such as age, gender, health status, tobacco use, and geography, depending on the state of issue.<sup>24</sup> These plans help cover out-of-pocket costs that Traditional Medicare does not cover (cost sharing borne by the beneficiary). However, unless the beneficiary is within the open enrollment period (six months after turning 65) or if the beneficiary recently lost other coverage, these plans do not have guaranteed issue. In other words, outside the protected enrollment period, a Medigap insurer may deny coverage or impose higher premiums with a preexisting condition coverage waiting period.<sup>25</sup>

There are several types of Medigap plans, designated by letters A through N, which represent different plan designs.<sup>26</sup> Plan G is the most popular and most comprehensive Medigap plan actively sold on the market, covering all out-of-pocket costs for Part A and Part B services except the Part B deductible, which is \$257 for 2025.<sup>27</sup> The other plan types offer leaner coverage with lower premiums. In 2023, state level average Medigap premiums ranged from \$191 to \$267 per month,<sup>28</sup> which are paid in exchange for lower out-of-pocket costs. Medigap premiums also cover administrative costs and profit loads, as well as increased costs related to induced utilization

<sup>20</sup> 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.

<sup>21</sup> Medicare. (n.d.). *How is Medicare funded?* Retrieved July 21, 2025, from <https://www.medicare.gov/about-us/how-is-medicare-funded>.

<sup>22</sup> Social Security Administration. (n.d.). *Financial status of the Social Security program*. <https://www.ssa.gov/history/reports/gspan17.html>.

<sup>23</sup> Centers for Medicare and Medicaid Services. (2024, November 8). *2025 Medicare Parts A & B premiums and deductibles*. <https://www.cms.gov/newsroom/fact-sheets/2025-medicare-parts-b-premiums-and-deductibles>.

<sup>24</sup> Freed, M., Ochieng, N., Cubanski, J., & Neuman, T. (2024, October 18). *Key facts about Medigap enrollment and premiums for Medicare beneficiaries*. KFF. <https://www.kff.org/medicare/key-facts-about-medigap-enrollment-and-premiums-for-medicare-beneficiaries/>.

<sup>25</sup> Medicare Interactive. (2025, March 31). *Medigap purchasing details: Enrollment periods, guaranteed issue, and more*. Retrieved July 21, 2025, 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>.

<sup>26</sup> Medicare. (n.d.). *Compare Medigap Plan benefits*. Retrieved July 21, 2025, 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.

<sup>27</sup> Centers for Medicare and Medicaid Services. (2024, November 8). op cit.

<sup>28</sup> Freed, M., Ochieng, N., Cubanski, J., & Neuman, T. (2024, October 18). op cit.

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, or vision, which must be obtained separately. Beneficiaries who choose MA are not eligible to purchase a Medigap plan.

- **MA:** Private insurers, also known as MAOs, contract with CMS to offer privately managed plans covering at least the equivalent of Part A and Part B (otherwise known as Part C). These managed care plans can either be Part C only (MA only) or, more commonly, both Part C and Part D (MA-PD). Throughout this paper, when we refer to MA plans, this includes both MA-only and MA-PD plans, unless otherwise specified. The MA program is an alternative to Traditional Medicare, and beneficiary premiums for MA-PD coverage vary from \$0 to approximately \$250 per month in 2025, with an average of \$17 per month.<sup>29</sup> Notably, approximately 67% of MA-PD plans offer benefits for a \$0 premium, covering 75% of MA beneficiaries.<sup>30,31</sup> If an MA plan has a premium, 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).

MAOs manage costs to below Traditional Medicare levels through several utilization and cost management strategies, such as maintaining provider networks, requiring more prior authorizations than Traditional Medicare, and engaging providers in risk sharing arrangements to incentivize value-based care. Keeping costs lower than Traditional Medicare allows savings to be generated (discussed below), so that MA cost sharing for Part A and Part B services can be reduced relative to Traditional Medicare, and additional benefits not covered by Traditional Medicare, known as supplemental benefits, can be offered. Supplemental benefits vary by plan and include services such as dental, hearing, vision, OTC benefit cards, and non-emergency medical transportation benefits, among many others.

MAOs are paid through capitated payments from CMS, so the management and coordination of care is crucial for success.

- **PDPs:** Traditional Medicare and Medigap do not provide drug coverage. To obtain prescription drug coverage, these beneficiaries must select a PDP or have some alternative coverage, such as Veterans Administration benefits or employer-provided insurance.

PDP organizations contract with CMS to provide standalone Part D plans covering only prescription drug benefits, mainly for Traditional Medicare beneficiaries (including those who enroll in Medigap plans). PDP premiums in 2025 range from \$0 to \$190 per month, with an average of \$45 per month.<sup>32</sup>

MA plans typically include Part D benefits, as noted above.

A beneficiary must enroll in Part D once eligible for Medicare, either through an MA-PD plan or a PDP (or other equivalent employer-sponsored coverage), to avoid facing premium penalties from CMS.

### MA payments and differences relative to Traditional Medicare costs

MA is funded through a combination of government payments to MA plans and beneficiary premiums. Government payments to MA plans consist of two components: bids and rebates. They are developed as follows.

#### MA bids

Every year, CMS requires each MA plan to develop and submit a bid amount, which estimates the cost 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 average benchmark is based on CMS published county level benchmarks for the forthcoming year, which are intended to estimate the regional costs of care for Traditional Medicare (with other adjustments outside the scope of this report). The benchmarks may also be adjusted from Medicare’s star rating system. Plans with a star rating of 4.0 or higher (out of 5.0) receive a slightly higher benchmark.

<sup>29</sup> Centers for Medicare and Medicaid Services. (2024, September 27). *Medicare Advantage and Medicare Prescription Drug Programs to remain stable as CMS implements improvements to the programs in 2025*. <https://www.cms.gov/newsroom/fact-sheets/medicare-advantage-and-medicare-prescription-drug-programs-remain-stable-cms-implements-improvements>.

<sup>30</sup> Freed, M., Fuglesten Biniek, J., Damico, A., & Neuman, T. (2024, November 15). *Medicare Advantage 2025 spotlight: First look at plan premiums and benefits*. KFF. <https://www.kff.org/medicare/issue-brief/medicare-advantage-2025-spotlight-a-first-look-at-plan-premiums-and-benefits/>.

<sup>31</sup> Milliman analysis of CMS 2025 landscape files. See <https://www.cms.gov/medicare/coverage/prescription-drug-coverage>.

<sup>32</sup> Cubanski, J., & Damico, A. (November 22, 2024). *Medicare Part D in 2025: A first look at prescription drug plan availability, premiums, and cost sharing*. KFF. <https://www.kff.org/medicare/issue-brief/medicare-part-d-in-2025-a-first-look-at-prescription-drug-plan-availability-premiums-and-cost-sharing/>.

Every month, the government will pay the MAO the bid amount up to the average benchmark for each member in each plan. This process is intended to align a portion of the MAO payments with the costs of Traditional Medicare.

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

If a plan estimates the bid to be 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. As noted above, plans with a star rating of 4.0 or higher receive a higher benchmark, which results in larger “savings” for those plans. A portion of the savings is retained by the government (approximately 34% in 2025) and the remainder (approximately 66%, called the “rebate”) is retained by the MAO, but must be used to reduce Part A and Part B cost sharing through lower copays and/or a plan-specific MOOP, to fund the expected cost of additional benefits beyond what Traditional Medicare covers, and/or to subsidize Part D and/or Part B premiums. MAOs aim to manage costs for Part A and Part B services so the estimated bid results in 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 (through a lower bid payment) and delivers more value to beneficiaries by offering additional benefits for the same cost—that is, every dollar spent in MA is used for more benefits than the same dollar in Traditional Medicare.

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 the average difference between the benchmark and bid (savings) in 2025 was \$314 PMPM, where, on average, the government retained \$106 PMPM and the MA plan received the remaining \$208 PMPM as a rebate.

### Traditional Medicare costs vs. MA payments

There are three key differences in government payments to MA and Traditional Medicare in 2025.

#### 1. Estimated 2025 benchmarks

The 2025 MA plan payments are based on the 2025 MA benchmarks, which were set based on the estimated non-ESRD Traditional Medicare costs in the 2025 Rate Announcement. CMS restated the 2025 Traditional Medicare costs upward by 4.3% in the 2026 Rate Announcement, driven by updated claims trends.<sup>33</sup> MA plan payments for 2025 were not restated. Therefore, MA plan payments are lower than estimated 2025 Traditional Medicare costs before any consideration for cost management strategies. This is consistent with public comments made through various earnings calls by national carriers highlighting higher medical trends emerging in 2025.<sup>34,35,36</sup>

In our analysis, we did not adjust for this but rather compared actual 2025 government payments to MA plans to estimated 2025 Traditional Medicare costs.

We explored what the government value may have looked like under revised MA benchmarks in Section IV below. Government costs under the estimated revised MA benchmarks would have been approximately 3.2% higher, assuming the MA bid payments remain fixed (except when the bid was projected to be greater than the benchmark), with this change leading to increases in savings and rebates.

#### 2. Risk adjustment

Risk adjustment is intended to compensate MA plans for bearing the risk of higher-cost beneficiaries and removing the incentive for MAOs to avoid certain costly populations when providing coverage and designing plans.

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 risk-adjusted for the relative health status of the enrolled population. Risk scores are based on basic demographic information, such as age, gender, and type of member (non-dual-eligible, dual-eligible, institutionalized), and also take into

<sup>33</sup> Centers for Medicare and Medicaid Services. (2025, April 7). *Announcement of calendar year (CY) 2026 Medicare Advantage (MA) capitation rates and Part C and Part D payment policies* [Note]. <https://www.cms.gov/files/document/2026-announcement.pdf>.

<sup>34</sup> UnitedHealth Group (2025, July 29). *Earnings conference call: Second quarter 2025 remarks*. <https://www.unitedhealthgroup.com/content/dam/UHG/PDF/investors/2025/UNH-Q2-2025-Remarks.pdf>.

<sup>35</sup> CVS Health Corp. (2025, July 31). *Q2 2025 earnings call*. [https://s206.q4cdn.com/752775519/files/doc\\_events/2025/07/1/CVS-Health-Q2-2025-Earnings-Transcript.pdf](https://s206.q4cdn.com/752775519/files/doc_events/2025/07/1/CVS-Health-Q2-2025-Earnings-Transcript.pdf).

<sup>36</sup> Elevance Health. (2025, July 17). *Q2 2025 Elevance Health Inc earnings call*. [https://s202.q4cdn.com/665319960/files/doc\\_financials/2025/q2/ELV-USQ\\_Transcript\\_2025-07-17.pdf](https://s202.q4cdn.com/665319960/files/doc_financials/2025/q2/ELV-USQ_Transcript_2025-07-17.pdf).

account medical diagnosis codes recorded for the enrolled population. At a very basic level, the more unique diagnosis codes present, and the more intensive those diagnoses are (e.g., with complications vs. without complications), the higher the risk score.

In Traditional Medicare, government payments to providers have historically largely been based on the services performed (i.e., fee-for-service) and not on the diagnosis of a beneficiary (with certain exceptions for inpatient services). As such, providers outside an inpatient setting historically had the incentive for procedure codes on a claim to be accurate but had limited incentive to ensure the proper diagnoses were accurately coded. This has changed with the rise of Accountable Care Organizations (ACOs). As of January 2025, 53.4% of people with Traditional Medicare are under an accountable care relationship with a provider.<sup>37</sup> These shared savings programs increase provider incentives to ensure all proper diagnosis codes are submitted, which impacts risk scores and thus the payments and shared savings received. These same providers also serve MA beneficiaries, where MA plans also have an incentive to ensure all proper diagnosis codes are submitted because they impact the MA risk scores, which in turn adjust government payments received and, ultimately, impact MA plan revenue.

Since MA plans want to ensure diagnosis codes are fully and accurately recorded, they have administrative processes in place to collect and document this information. As a result, for a beneficiary in MA and a beneficiary in Traditional Medicare 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. Recent studies from MedPAC suggest the actual coding pattern difference exceeds the standard CMS 5.9% adjustment.<sup>38,39</sup> If the actual coding pattern difference exceeds this 5.9% adjustment, payments to MA plans may exceed payments for Traditional Medicare for enrollees of similar demographic and health statuses. MedPAC estimates this actual coding difference in 2025 may be as high as 16%, or 10% in excess of the statutory MA coding pattern adjustment.<sup>40</sup> We performed sensitivity tests, discussed in Section IV, which explored the impact of this potential difference in payment.

For payment year 2024, CMS implemented a new risk score model (2024 HCC, or v28) with updated underlying diagnoses and calibrated data. Using the 2023 enrollment underlying this analysis, the new risk score model is estimated to reduce risk scores across Traditional Medicare and MA by approximately 2.7%, increasing Traditional Medicare by 1.2% and decreasing MA by 6.0%.<sup>41</sup> Ultimately, CMS allowed the model to be phased in over a three-year period, where for 2025, two-thirds of the weight for projected risk scores would be on the new risk score model (2024 HCC, or v28), and the remaining one-third on the prior risk score model (2020 HCC, or v24). The phase-in leads to an approximate 4.0% reduction in 2025 MAO revenue compared to risk scores calculated exclusively on the prior risk score model. The model change impacts different populations and plan types differently. Our analysis incorporated 2025 risk scores calculated on the blended model basis using weights prescribed for the 2025 payment year.<sup>42</sup>

### 3. Population differences

The benchmarks for MA plans are developed by CMS using estimated Traditional Medicare expenses. More specifically, costs are estimated based on all beneficiaries enrolled in Traditional Medicare, 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 Traditional Medicare (approximately 15% of the total Traditional Medicare population as of 2023) tend to be younger and are less likely to have multiple health conditions than the average Medicare beneficiary,<sup>43</sup> 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.

<sup>37</sup> Centers for Medicare and Medicaid Services (2025, January 15). *CMS moves closer to accountable care goals with 2025 ACO initiatives*. <https://www.cms.gov/newsroom/fact-sheets/cms-moves-closer-accountable-care-goals-2025-aco-initiatives>.

<sup>38</sup> MedPAC (March 2025). *Report to the Congress: Medicare payment policy*. [https://www.medpac.gov/wp-content/uploads/2025/03/Mar25\\_MedPAC\\_Report\\_To\\_Congress\\_SEC-1.pdf](https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_MedPAC_Report_To_Congress_SEC-1.pdf).

<sup>39</sup> Committee for a Responsible Federal Budget (2023, July 17). *New Evidence Suggests Even Larger Medicare Advantage Overpayments*. <https://www.crfb.org/blogs/new-evidence-suggests-even-larger-medicare-advantage-overpayments>.

<sup>40</sup> MedPAC (March 2025). *op cit*.

<sup>41</sup> We used 2023 Medicare Advantage and Traditional Medicare risk scores trended to 2025 from the Chronic Conditions Warehouse (CCW) Virtual Research Data Center (VRDC). We calculated member level risk scores under both the 2020 HCC and 2024 HCC models, applying the respective normalization factors for each.

<sup>42</sup> This is consistent with the methodology used by MedPAC when calculating excess coding.

<sup>43</sup> Tarazi, W., Welch, P., Nguyen, N., Bosworth, A., Sheingold, S., De Lew, N., & Sommers, B.D. (2022, March 2). *Medicare beneficiary enrollment trends and demographic characteristics. Issue Brief*. Office of the Assistant Secretary for Planning and Evaluation. <https://aspe.hhs.gov/reports/medicare-enrollment>.

In our analysis, we removed claims from Part A-only and Part B-only beneficiaries when calculating Traditional Medicare costs to ensure our comparison to an MA beneficiary was appropriate. This increased the Traditional Medicare costs by approximately 4%.

If Part A-only and Part B-only beneficiaries were included in the Traditional Medicare costs, total government payments to MA plans (including bid payments and rebates) would be approximately 94% of Traditional Medicare government costs. This is slightly lower than recent MedPAC research.<sup>44,45</sup>

There are other sources of payment differences between Traditional Medicare 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 Traditional Medicare expenditures per 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 Traditional Medicare areas and higher for lower-cost Traditional Medicare areas. The membership-weighted average multiplier is 1.05 for 2025, whereas the dollar-weighted average multiplier is 1.04. Higher multipliers in lower-cost Traditional Medicare areas help incentivize MA plans to participate in low-cost counties where the opportunity for an MA plan to manage beneficiary costs below Traditional Medicare levels may be more difficult.
- **QBPs:** Medicare’s star rating system measures an MAO’s performance and the quality of services provided to its beneficiaries, such as 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 and rebate percentages. MAOs with star ratings of 4.0 or above (out of 5.0) receive a 5% increase to benchmarks and retain 65% of the savings between the bid and benchmark in the form of a rebate. In our analysis, we estimated approximately 76% of beneficiaries in 2025 are enrolled in an MA plan with a star rating of 4.0 or higher.<sup>46</sup>
- **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:** Although 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 Traditional Medicare costs and the prior year’s trended applicable amount. This cap methodology prevents payments to MA plans, which would otherwise be based on Traditional Medicare costs, from increasing above payment rates prior to the ACA. Benchmark payments to plans would be approximately 0.8% higher in 2025 without the benchmark cap.

<sup>44</sup> MedPAC (March 2025). *Report to the Congress: Medicare payment policy*. [https://www.medpac.gov/wp-content/uploads/2025/03/Mar25\\_MedPAC\\_Report\\_To\\_Congress\\_SEC-1.pdf](https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_MedPAC_Report_To_Congress_SEC-1.pdf).

<sup>45</sup> We used 2023 Medicare Advantage and Traditional Medicare risk scores and claims trended to 2025 from the Chronic Conditions Warehouse (CCW) Virtual Research Data Center (VRDC). We accounted for differences in risk score and geography to normalize for part of the population differences between programs. Other differences may still exist in the underlying populations.

<sup>46</sup> Milliman analysis of CMS enrollment files. See <https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-advantagepart-d-contract-and-enrollment-data/ma-state/county-penetration/ma-state/county-penetration-2025-07>.

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

We used reports from MedPAC and CMS, calendar year 2023 eligibility and claims data from CMS’s Research Identifiable Files (RIFs), and Milliman’s Medicare modeling suite of tools to estimate plan and county-specific costs and to assist in the development of the components of Medicare program payments, both to Traditional Medicare and MA. Specifically, we estimated the following:

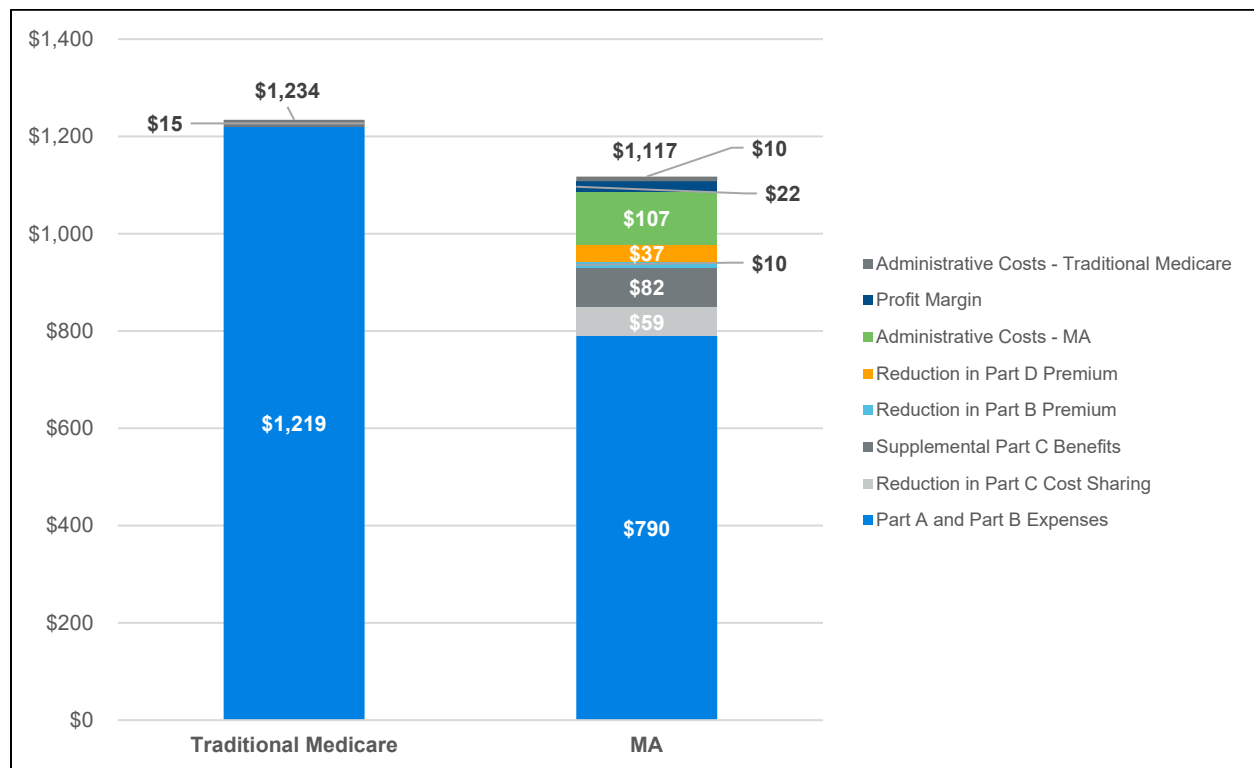
- Claim costs for Part A and Part B services under both Traditional Medicare and MA
- Beneficiary cost sharing for Part A and Part B services under both Traditional Medicare and MA
- Rebates earned by MA plans and how these rebates are allocated across additional benefits
- Average premiums paid by MA beneficiaries for Part C and Part D coverage

Through estimating the components of government payments for each program, we compared the overall value of government payments in 2025 between Traditional Medicare and MA.<sup>47</sup> For Traditional Medicare, government payments are for Part A and Part B claim expenses, 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 borne by the MAO), as well as the rebate payments (which cover the cost of the additional benefits provided, assuming the bid is projected below the benchmark), including administrative costs for both Traditional Medicare and the MAO, as well as profit margin.

#### Government payments PMPM for Traditional Medicare vs. MA

Figure 3 summarizes the components of government payments in 2025 for Traditional Medicare and MA.

FIGURE 3: 2025 TRADITIONAL MEDICARE VS. MA GOVERNMENT PAYMENT COMPONENTS, \$ PMPM



Note: Totals may not equal the sum of components due to rounding. Traditional Medicare is weighted using February 2025 MA enrollment by county.

<sup>47</sup> We used 2023 Medicare Advantage and Traditional Medicare risk scores and claims trended to 2025 from the Chronic Conditions Warehouse (CCW) Virtual Research Data Center (VRDC). We accounted for differences in risk score and geography to normalize for part of the population differences between programs. Other differences may still exist in the underlying populations.

Government payments to MA plans in 2025 were estimated to be approximately 91% of—or 9% lower than—government costs for Traditional Medicare when accounting for risk score and population differences.

This differential is partly driven by program differences between Traditional Medicare and MA—Traditional Medicare is fee-for-service based, whereas MA is a managed care program. A managed care structure employs care and cost management strategies, including provider networks, prior authorizations, and value-based care arrangements.<sup>48</sup> These strategies are minimally present in Traditional Medicare. Quantifying the impact of these strategies is outside the scope of this analysis.

The government cost differential is larger than in prior studies. Two key drivers of this difference are:

- As discussed in Section II, CMS implemented a new risk score model (2024 HCC, or v28) for payment year 2024 with updated underlying diagnoses and calibrated data, which is to be phased in over a three-year period. For 2025, two-thirds of the weight for projected risk scores is on the new risk score model, and the remaining one-third on the prior risk score model (2020 HCC, or v24). The v28 risk score model, on average, reduces MA risk scores and increases Traditional Medicare risk scores (though it impacts different populations and plan types differently).<sup>49</sup> Our analysis incorporated 2025 risk scores calculated on the blended model basis using weights prescribed for the 2025 payment year.<sup>50</sup> This continued phase-in increases the difference between government payments for Traditional Medicare and MA compared to prior studies, all else equal, because MA plan payments are risk adjusted.
- Another key component driving the higher differential than prior studies is the 2025 MA payment rate levels. The 2025 MA payment rates were published in the 2025 Final Rate Announcement, which was released in April 2024. The 2025 payment rates are based on 2025 estimates for Traditional Medicare costs at the time of publication. More recently, in the release of the 2026 Final Rate Announcement, CMS revised projected 2025 Traditional Medicare costs upward by 4.3% from the initial estimate in the 2025 Rate Announcement. This revision was driven by updated claims trends that were higher than initially projected.<sup>51</sup> The benchmarks included in our analysis reflect the actual benchmarks paid to MA plans, based on the 2025 estimates from the 2025 Final Rate Announcement, and the Traditional Medicare costs used in this analysis align more closely with the restated 2025 estimates. We explored what the government value may have looked like using MA benchmarks that align more closely with current trends, as shown in Section IV. When increasing 2025 benchmarks approximately 4.3% (consistent with the Traditional Medicare cost restatement), we observed that government costs under MA would have been approximately 93% of government costs for Traditional Medicare in 2025, assuming 2025 bids remain the same and the increase in benchmarks would directly lead to increases in MA rebates.

As shown in Figure 3, each dollar spent by the government on MA provides funding for Part A and Part B services, as well as funding for benefits and services not covered through Traditional Medicare, including additional administrative expenses incurred by MA plans and profit margin. We estimate approximately \$899 PMPM is for the bid payments, and \$208 PMPM is for the rebate payments (earned through savings). The bid payments include administrative costs, some of which are to help with cost management strategies, as well as profit margins. The rebate payments are used to reduce Part C cost sharing, Part D premiums, and Part B premiums, as well as provide supplemental benefits, such as dental, vision, and hearing. A portion of rebates is also used to cover administrative costs and profit margins allocated to these benefits through the bid mechanics. However, rebates do not always cover 100% of the additional benefits listed—plans may charge their beneficiaries premiums or cost sharing to cover the remainder of expected incurred costs, which are not reflected in Figure 3.

In 2025, the average government payments to MA for Part A and Part B services (excluding rebate payments for Part D and supplemental benefits) were estimated to be approximately 78% of the payments to Traditional Medicare for Part A and Part B expenses. In other words, in 2025, MAOs offer Part A and Part B services equivalent to Traditional Medicare, cover administrative costs and profit margins, and reduce beneficiary cost sharing, at an approximately 22% lower cost than Traditional Medicare.

<sup>48</sup> Some strategies are currently employed in Traditional Medicare, such as prior authorizations and value-based care, though on a more limited basis than MA.

<sup>49</sup> Pipich, R., Cross, K., & Rothschild, M. (2023, February). *High-level impacts of the proposed CMS-HCC risk score model on Medicare Advantage payments for 2024*. Milliman. [https://media.milliman.com/v1/media/edge/images/millimaninc5660-milliman6442-prod27d5-0001/media/Milliman/PDFs/2023-Articles/2-28-23\\_2024-Proposed-CMS-HCC-Model-Impact.pdf](https://media.milliman.com/v1/media/edge/images/millimaninc5660-milliman6442-prod27d5-0001/media/Milliman/PDFs/2023-Articles/2-28-23_2024-Proposed-CMS-HCC-Model-Impact.pdf).

<sup>50</sup> This is consistent with the methodology used by MedPAC when calculating excess coding.

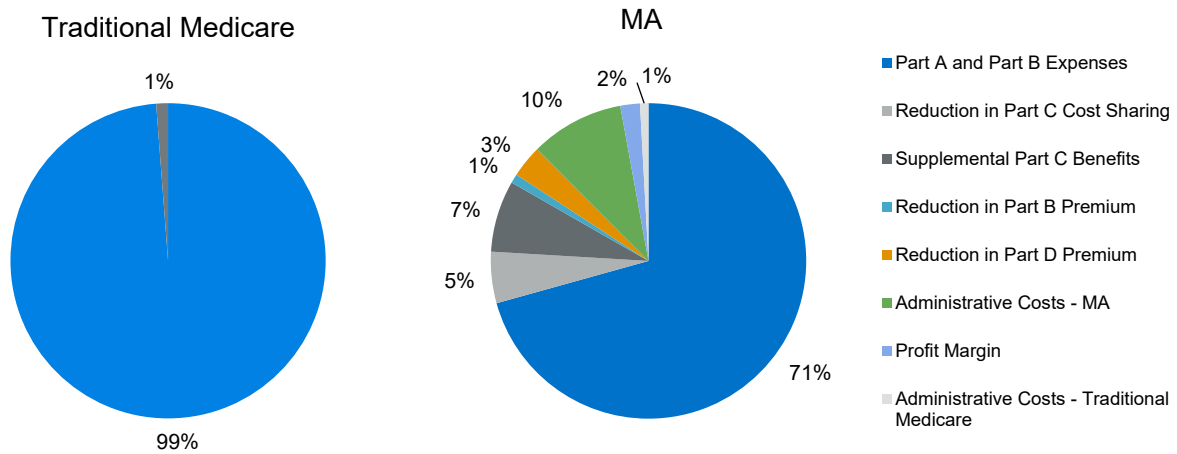
<sup>51</sup> Centers for Medicare and Medicaid Services. (2024, April 1). *Announcement of calendar year (CY) 2025 Medicare Advantage (MA) capitation rates and Part C and Part D payment policies*. <https://www.cms.gov/files/document/2025-announcement.pdf>.

In other public analyses, such as recent MedPAC reports,<sup>52</sup> costs to administer the Traditional Medicare program are excluded from government costs. In our analysis, we included administrative costs paid directly by the government for both Traditional Medicare and MA based on reported administrative costs from the 2025 Medicare Trustees report.<sup>53</sup> MAOs also incur additional expenses to administer their MA plans, described later in this report.

**Distribution of government payments to Traditional Medicare vs. MA**

Figure 4 shows the distribution of the components of the government’s payments for Traditional Medicare versus MA as a percentage of the total.

**FIGURE 4: 2025 DISTRIBUTION OF TRADITIONAL MEDICARE AND MA GOVERNMENT PAYMENTS, %**



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

For Traditional Medicare, approximately 99% of government payments are for Part A and Part B service costs, with the remaining 1% for administrative costs. For MA, 71% of government payments are for Part A and Part B service costs, since these managed care plans have methods to manage costs and utilization. The remaining 29% of the government payments are for enhanced coverage for MA beneficiaries through lower cost sharing (5%), supplemental benefits (7%), and reduced premiums for Part B (1%) and Part D (3%), as well as administrative costs (11%) and a profit margin (2%). Part of the MA administrative costs help drive lower Part A and Part B service costs, such as care management program costs.

**Additional MA benefits provided through Part C rebates**

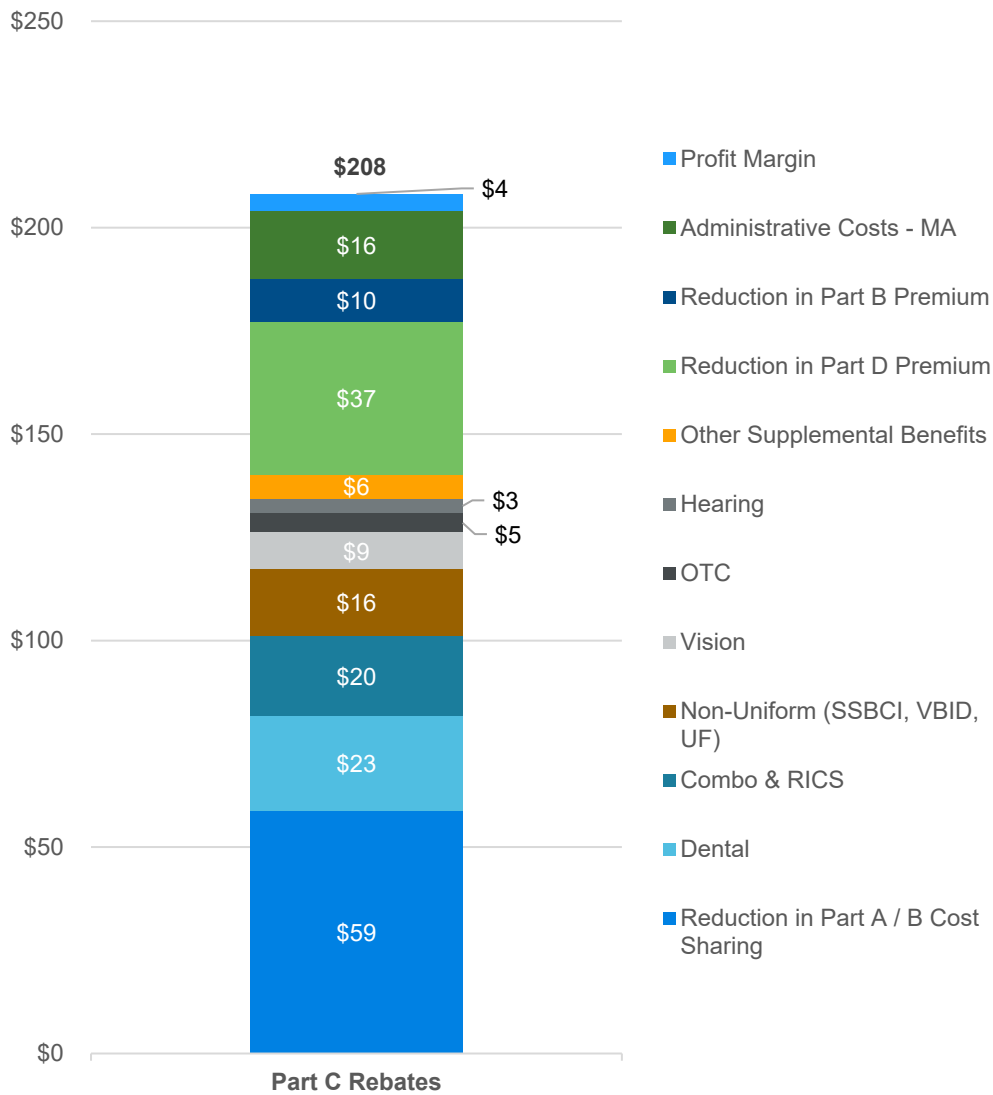
As shown in Figure 4, 17% of government payments to MA plans are for the portion of rebates that fund reduced cost sharing, expected costs for supplemental benefits not covered under Traditional Medicare, and Part B and Part D premium reductions. Cost sharing reductions and supplemental benefits have been an important differentiator, both from Traditional Medicare and other MA plans, since the program’s inception; they are so prevalent that plans may have difficulty gaining enrollment if not offered.

Figure 5 provides more detail on how Part C rebates are allocated. The portion of supplemental benefit costs covered by beneficiary premiums or cost sharing is not included in Figure 5.

<sup>52</sup> MedPAC (March 2025). *Report to the Congress: Medicare payment policy*. [https://www.medpac.gov/wp-content/uploads/2025/03/Mar25\\_MedPAC\\_Report\\_To\\_Congress\\_SEC-1.pdf](https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_MedPAC_Report_To_Congress_SEC-1.pdf).

<sup>53</sup> See the full 2025 Medicare Trustees report at <https://www.cms.gov/oact/tr/2025>.

FIGURE 5: 2025 ALLOCATION OF PART C REBATES, \$ PMPM



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

Part C rebate dollars reflect the expected costs of 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 \$59 PMPM
- Supplemental benefits: 39% of the rebate, or \$82 PMPM, comprise:
  - Dental: \$23 PMPM
  - Combo benefits and RICS:<sup>54</sup> \$20 PMPM
  - Non-uniform benefits, such as Special Supplemental Benefits for the Chronically Ill (SSBCI), Value-Based Insurance Design (VBID), and uniformity flexibility (UF):<sup>55</sup> \$16 PMPM
  - Vision exams and hardware: \$9 PMPM

<sup>54</sup> Yeh, M., & Yen, I. (2024, April 3). *2024 combined benefits in Medicare Advantage: Tracking benefit strategy and options*. Milliman. <https://www.milliman.com/en/insight/2024-combined-benefits-medicare-advantage-tracking-benefit-strategy>.

<sup>55</sup> Murphy-Barron, C., Buzby, E., & Pittinger, S. (2023, March 29). *Overview of Medicare Advantage supplemental healthcare benefits and review of Contract Year 2023 offerings*. Milliman. <https://www.milliman.com/en/insight/ma-supplemental-healthcare-benefits-review-cy2023>.

- OTC benefit card:<sup>56</sup> \$5 PMPM
- Hearing exams and hardware: \$3 PMPM
- All other Part C supplemental benefits: \$6 PMPM
- Reductions in Part D premiums: 18% of the rebate or \$37 PMPM
- Reductions in Part B premiums: 5% of the rebate or \$10 PMPM
- Administrative costs allocated to the above benefits<sup>57</sup>: 8% of the rebate, or \$16 PMPM
- Profit margin allocated to the above benefits<sup>57</sup>: 2% of the rebate, or \$4 PMPM

The prevalence of supplemental benefits has increased significantly over the last decade. 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).<sup>58</sup> Other supplemental benefits offered in plans covering over 75% of beneficiaries are fitness, OTC benefit cards, and meal delivery. Conventional wisdom suggests that 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.

Several other supplemental benefits, though not nearly as common, are offered across MA plans today, such as non-emergency transportation services or post inpatient meals. Many benefits are now addressing nonmedical needs that impact beneficiary health, such as food or grocery cards, bathroom safety devices, and utility bill payments.<sup>59</sup> None of these additional benefits are available through Traditional Medicare.

#### **Total government and beneficiary costs for Traditional Medicare VS. MA**

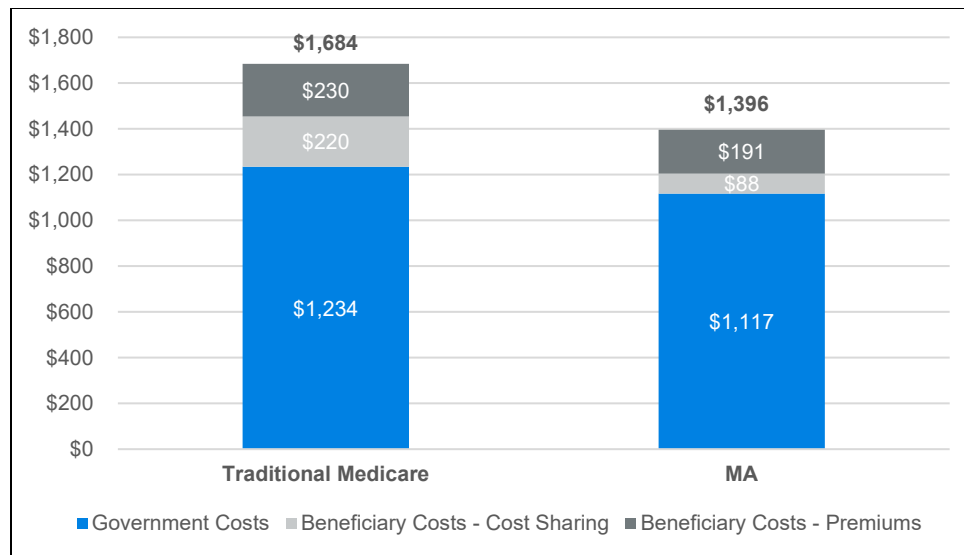
Figure 6 summarizes the total program costs, or the costs for the government and beneficiary, under both Traditional Medicare and MA.

<sup>56</sup> This represents just the standalone OTC benefit. In 2025, 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-medicare-advantage-general-enrollment-2025>.

<sup>57</sup> This represents the portion of administrative costs and profit margins allocated to supplemental benefit costs, as calculated in the CMS bid forms.

<sup>58</sup> Laktas, J., Yeh, M., & Friedman, J. (2023, March 21). *Prevalence of supplemental benefits in the general enrollment Medicare Advantage marketplace: 2019 to 2023*. Milliman. <https://www.milliman.com/en/insight/prevalence-supplemental-benefits-general-enrollment-ma-marketplace-2023>.

<sup>59</sup> Ibid.

FIGURE 6: 2025 COMBINED GOVERNMENT AND BENEFICIARY COSTS IN TRADITIONAL MEDICARE VS. MA, \$ PMPM<sup>†</sup>

<sup>†</sup> Traditional Medicare is weighted using February 2025 MA enrollment by county. The Traditional Medicare beneficiary costs include the cost sharing collected for Part A and Part B services, the standard Part B premium, and the average standalone PDP premium. The MA beneficiary costs include cost sharing for medical services, the standard Part B premium, and Part C and Part D premiums, but exclude other supplemental benefit and Part D-related out-of-pocket costs. Traditional Medicare 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.

Figure 6 shows that the total program costs for 2025, or the combined average costs across the government and beneficiary, are estimated to be lower under MA than in Traditional Medicare.<sup>60</sup> Notably, all three components under MA are lower than under Traditional Medicare, resulting in an approximately \$290 PMPM difference. Combined government and beneficiary costs in MA are 83% of those in Traditional Medicare (\$1,396 PMPM vs. \$1,684 PMPM), and beneficiary costs in MA are 62% of those in Traditional Medicare (\$279 PMPM vs. \$450 PMPM).

Beneficiary costs in Figure 6 are significantly lower under MA than Traditional Medicare, which is partially driven by differences in the structure of the programs, with key differences as follows (though this list is not exhaustive):

- MA plans typically have reduced cost sharing for Part A and Part B services.** Under statute, Part A and Part B cost sharing for MA beneficiaries, in aggregate, must be actuarially equivalent to or less than the cost sharing under Traditional Medicare.<sup>61</sup> In other words, benefits must be overall the same or better under MA compared to Traditional Medicare. We observed this in our analysis, where for every dollar of Part A and Part B claim expenses, government payments cover 75.3 cents for Traditional Medicare and 80.7 cents for MA beneficiaries, with the Traditional Medicare and MA beneficiary paying the remaining 24.7 cents and 19.3 cents, respectively. (Note, this includes Traditional Medicare administrative costs but excludes Part D/PDP premiums.)
- All MA plans are required to have a MOOP.** The MOOP 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 2025, the average MA MOOP for general enrollment (non-special needs plan) MA beneficiaries was \$4,900,<sup>62</sup> which reduces cost sharing by approximately \$14.50 PMPM on average across all beneficiaries. Traditional Medicare does not have spending limits for its beneficiaries. Using 2023 Traditional Medicare data trended to 2025, 5.3% of non-dual eligible Traditional Medicare beneficiaries would have exceeded the 2025 maximum MA MOOP of \$9,350,<sup>63</sup> with average annual out-of-pocket costs of approximately \$18,600.<sup>64</sup>

<sup>60</sup> We used 2023 Medicare Advantage and Traditional Medicare risk scores and claims trended to 2025 from the Chronic Conditions Warehouse (CCW) Virtual Research Data Center (VRDC). We accounted for differences in risk score and geography to normalize for part of the population differences between programs. Other differences may still exist in the underlying populations.

<sup>61</sup> Girod, C., & Kolli, S. (2018, April 30). *Medicare Advantage and Part D: Compliance for actuaries*. Milliman. <https://firm.milliman.com/en/insight/Medicare-Advantage-and-Part-D-Compliance-for-actuaries>.

<sup>62</sup> Friedman, J., Cates, J., & Phillips, E. (2024, December 16). *State of the 2025 Medicare Advantage industry: General enrollment plan valuation and selected benefit offerings*. Milliman. <https://www.milliman.com/en/insight/state-of-medicare-advantage-general-enrollment-2025>.

<sup>63</sup> Federal Register. (2022, April 14). *Medicare program; maximum out-of-pocket (MOOP) limits and service category cost sharing standards*. <https://www.federalregister.gov/documents/2022/04/14/2022-07642/medicare-program-maximum-out-of-pocket-moop-limits-and-service-category-cost-sharing-standards>.

<sup>64</sup> Heinrich, A. & Scherer K. (2026 January). *Comparison of annual beneficiary health care costs across Medicare Advantage options: 2025*. <https://www.milliman.com/en/insight/2025-beneficiary-value-unitedhealth>

3. **Part D coverage is included in MA plans at lower premium levels, on average.** In addition to lower cost sharing and additional benefits, many MA plans can provide coverage for no additional premium. Notably, 99% of MA beneficiaries have access to at least one MA-PD plan with a \$0 premium (excluding the Part B premium that is mandatory for all Medicare beneficiaries).<sup>65</sup> As mentioned previously, in 2025 the average MA monthly premium is \$17 for Part C and Part D coverage<sup>66</sup>, compared to the average monthly PDP premium of \$45<sup>67</sup> that Traditional Medicare beneficiaries would pay to receive Part D coverage.

### Plan choices

In 2022, 95% of Medicare beneficiaries had some form of supplemental medical coverage, whether MA, Medigap, supplemental coverage through an employer, or Medicaid.<sup>68</sup> Out-of-pocket medical costs can be a significant portion of a beneficiary's annual income, particularly in the Medicare population. In 2024, half of Medicare beneficiaries had an annual income of \$43,200 or lower.<sup>69</sup> In addition, in 2024, 66% of all low-income Medicare beneficiaries enrolled in an MA-PD plan.<sup>70</sup>

Another recent Milliman study, also commissioned by UHG, found that the average total beneficiary out-of-pocket costs are lower under MA than total out-of-pocket costs under Traditional Medicare with Medigap Plan G and Part D coverage. In particular, for 2025, the average Medicare beneficiary not receiving subsidies due to income had estimated average out-of-pocket costs (premiums and cost sharing) of \$3,651 under MA, \$6,932 for Traditional Medicare with a PDP (90% greater than MA), and \$7,790 for Traditional Medicare with a PDP and Medigap Plan G (113% greater than MA).<sup>71</sup> Medicare beneficiaries must weigh these cost differences among Medicare coverage options with other components, such as provider choice, predictability of costs, supplemental benefits, and ease of accessing care.

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 expenses to below estimated Traditional Medicare levels through care and cost management strategies. Lower MA costs then generate rebates, as discussed previously, to provide lower cost sharing and supplemental benefits. However, in return, beneficiaries must accept certain plan requirements, such as seeking care within the plan's provider network<sup>72</sup> and adhering to utilization management programs (such as prior authorizations). Provider risk sharing has also become increasingly popular over the past few years, in which MA plans include providers in the management of beneficiary care (and therefore costs), incentivizing value-based care. 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. For SNPs in particular (for beneficiaries that tend to have the most costly and complex needs), each plan must have a Model of Care approved, which ensures the needs of each beneficiary are met through the care management programs.<sup>73</sup> These care and cost management strategies help MA plans reduce Part A and Part B expenses.

Although MA costs are lower on average, they may not be lower for all beneficiaries. Additionally, Traditional Medicare (particularly when paired with Medigap) has more predictable benefits, where Part A and Part B deductibles and beneficiary costs per day see small increases each year. MA plans may change benefits and premiums each year, subject to strict limits imposed by CMS. On the other hand, MA plans offer more choice in benefits, as benefit designs can vary by service category (e.g., physician visits, lab work) and benefit structure (e.g., copayment vs. coinsurance), allowing beneficiaries to select a plan that best fits their expected medical needs. Due to the competitiveness of the market, MA offers a wide array of choices among plans. In 2025, the average MA beneficiary can choose from 42 plans.<sup>74</sup>

<sup>65</sup> Freed, M., Fuglesten Biniek, J., Damico, A., & Neuman, T. (2024, November 15). *Medicare Advantage 2025 spotlight: First look at plan premiums and benefits*. KFF. <https://www.kff.org/medicare/issue-brief/medicare-advantage-2025-spotlight-a-first-look-at-plan-premiums-and-benefits/>.

<sup>66</sup> Centers for Medicare and Medicaid Services. (September 27, 2024). *Medicare Advantage and Medicare Prescription Drug Programs to remain stable as CMS implements improvements to the programs in 2025*. <https://www.cms.gov/newsroom/fact-sheets/medicare-advantage-and-medicare-prescription-drug-programs-remain-stable-cms-implements-improvements>.

<sup>67</sup> Cubanski, J., & Damico, A. (2024, November 22). *Medicare Part D in 2025: A first look at prescription drug plan availability, premiums, and cost sharing*. KFF. <https://www.kff.org/medicare/issue-brief/medicare-part-d-in-2025-a-first-look-at-prescription-drug-plan-availability-premiums-and-cost-sharing/>.

<sup>68</sup> Ochieng, N., Cubanski, J., & Neuman, T. (2024, September 23). *A snapshot of sources of coverage among Medicare beneficiaries*. KFF. <https://www.kff.org/medicare/a-snapshot-of-sources-of-coverage-among-medicare-beneficiaries/>.

<sup>69</sup> Cottrill, A., Cubanski, J., Neuman, T., & Smith, K. (2025, August 25). *Income and assets of Medicare beneficiaries in 2024*. KFF. <https://www.kff.org/medicare/income-and-assets-of-medicare-beneficiaries/>.

<sup>70</sup> MedPAC (2025, July). *A data book: Healthcare spending and the Medicare program*. [https://www.medpac.gov/wp-content/uploads/2025/07/July2025\\_MedPAC\\_DataBook\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2025/07/July2025_MedPAC_DataBook_SEC.pdf).

<sup>71</sup> Heinrich, A., & Scherer K. (2026 January). Comparison of annual beneficiary health care costs across Medicare Advantage options: 2025. <https://www.milliman.com/en/insight/2025-beneficiary-value-unitedhealth>

<sup>72</sup> MA plans establish provider networks based on the provider's cost and willingness to engage in the care management protocols established by the plan.

<sup>73</sup> Centers for Medicare and Medicaid Services. (2024, September 10). *Model of Care (MOC)*. <https://www.cms.gov/medicare/enrollment-renewal/special-needs-plans/model-care>.

<sup>74</sup> Freed, M., Fuglesten Biniek, J., Damico, A., & Neuman, T. (2024, November 15). *Medicare Advantage 2025 spotlight: A first look at plan offerings*. KFF. <https://www.kff.org/medicare/medicare-advantage-2025-spotlight-a-first-look-at-plan-offerings/>.

Enrollment in MA has continued to grow. In the last decade, MA enrollment has more than doubled, from approximately 16 million beneficiaries in 2015 to over 35 million beneficiaries in 2025, increasing from 32% of overall 2015 Medicare enrollment to over a 50% share of 2025 Medicare enrollment.<sup>75,76,77</sup>

### Administrative costs

Both Traditional Medicare and MA programs incur administrative costs. MAOs must factor in additional costs to administer the plan (also called non-benefit expenses or NBE). As such, MAOs have higher administrative costs compared to Traditional Medicare. Examples of these expenses for MAOs is as follows, 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 9.7% of government payments to administrative costs, which are included in both the bid and the rebates, as discussed previously. Although data is not readily available for the MA market, a study estimated commercial health plans spend approximately 6% of total administrative costs on quality improvement activities and approximately 16% on cost containment activities.<sup>78</sup> Even though MA plans incur additional expenses, such as costs for care management and utilization management programs, these activities help MA plans reduce benefit expenses for Medicare-covered services, as shown in Figure 3, offsetting the additional investment in administrative activities through reduced benefit expense.

The government also has administrative costs, though significantly less than MA. According to the Medicare Trustees report, approximately \$11.8 billion, or 1.2% of expenditures, was allocated to government administrative costs for both the Traditional Medicare and MA programs.<sup>79</sup> The administrative costs are funded through both the HI Trust Fund and 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.”<sup>80</sup> Some of these categories apply directly to MA as well, such as fraud and abuse control activities and demonstration projects. The allocation of the \$11.8 billion to Traditional Medicare versus MA was not provided in the Medicare Trustees report. As such, we also included an additional 1.2% 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.

Despite higher administrative costs in MA, the total 2025 costs incurred by the government are still lower compared to Traditional Medicare because these additional administrative expenses for managed care activities are offset by benefit expense savings.

### Conclusions

We summarize below the key conclusions in our evaluation of the difference in government payments between the Traditional Medicare and MA programs.

<sup>75</sup> Freed, M., Fuglesten Biniek, J., Damico, A., & Neuman, T. (2024, August 8). *Medicare Advantage in 2024: Enrollment update and key trends*. KFF. <https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2024-enrollment-update-and-key-trends/>.

<sup>76</sup> Milliman analysis of CMS enrollment files. See <https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-advantagepart-d-contract-and-enrollment-data/ma-state/county-penetration/ma-state/county-penetration-2025-07>.

<sup>77</sup> 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.

<sup>78</sup> AHIP (2024, October 24). *Where does your health care dollar go?* <https://www.ahip.org/resources/where-does-your-health-care-dollar-go>.

<sup>79</sup> See the full 2025 Medicare Trustees report at <https://www.cms.gov/oact/tr/2025>.

<sup>80</sup> Ibid.

- For 2025, Part A and Part B services, reduced cost sharing, additional benefits, administrative costs, and profit margins for MA are provided at a lower total cost to the government (approximately 91%) compared to Traditional Medicare that offers Part A and Part B coverage,<sup>81</sup> as shown in Figure 3.
- Care and cost management strategies employed by MA plans are a key factor in the government cost differential between Traditional Medicare and MA, enabling MA plans to offer the same coverage as Traditional Medicare at lower costs for Part A and Part B services. In addition to reducing costs, these strategies are also intended to help increase quality of beneficiary care and help avoid unnecessary or duplicative services, though quantifying this impact was outside the scope of this analysis.
- Government savings for 2025 are larger than prior studies. This is partly due to the following:
  - The continued phase-in of the CMS v28 risk model also drives a difference in government payments between MA and Traditional Medicare, and a difference compared to prior studies. The v28 risk model, on average, leads to lower risk scores for MA and higher risk scores for Traditional Medicare. 2025 MA plan revenue is approximately 4.0% lower than revenue using risk scores calculated exclusively on the prior risk score model.
  - 2025 MA benchmarks used in this analysis, and used for actual MA plan payments, were determined using estimated 2025 Traditional Medicare costs as of April 2024. In early 2025, CMS released restated estimated 2025 Traditional Medicare costs which were 4.3% higher in aggregate than what was used for the 2025 benchmarks. 2025 MA benchmarks and plan payments were not simultaneously restated. Traditional Medicare costs used in this analysis align closely with the restated CMS 2025 estimates. The absence of a restatement in actual 2025 MA payment rates drives part of the increased savings relative to prior studies. We estimated the magnitude of this impact in Section IV below.
- Approximately 71% of each dollar of government payments to MA is used for Part A and Part B costs, compared to 99% of each dollar in Traditional Medicare. A portion of MA administrative costs help drive the lower Part A and Part B costs through fees associated with cost management strategies.
- Managing Part A and B costs in MA also results in beneficiaries having lower out-of-pocket costs compared to Traditional Medicare beneficiaries. Combined government and beneficiary costs for Part A and Part B services (including beneficiary premiums for Part D coverage) for MA are 83% of those costs for Traditional Medicare (\$1,396 PMPM vs. \$1,684 PMPM). Beneficiary costs for MA are 62% of those for Traditional Medicare (\$279 PMPM vs. \$450 PMPM), as shown in Figure 6. In addition, this leads to government payments to MAOs for Part A and Part B services becoming a larger proportion of total costs than in Traditional Medicare. Specifically, for every dollar of Part A and Part B claim expenses, government payments fund 84.7 cents for Traditional Medicare beneficiaries and 90.6 cents for MA, with the Traditional Medicare beneficiary and MA beneficiary paying the remaining 15.3 cents and 9.4 cents, respectively.<sup>82</sup>
- A portion of government payments to MAOs also funds rebates for cost-sharing reductions and additional benefits not offered in either Traditional Medicare or Medigap. They account for 17% of the government's dollar to MA, as shown in Figure 4. Figure 5 summarizes the breakdown of the average rebate PMPM by additional benefit offered.
- MA plans provide various benefits not found in Traditional Medicare or Medigap, frequently at no additional cost to members. Although some MA plans require a premium (the average MA premium for 2025 is \$17<sup>83</sup>), 99% of MA beneficiaries have access to at least one MA-PD plan with a \$0 premium (excluding the Part B premium that is mandatory for all Medicare beneficiaries).<sup>84</sup>
- Both Traditional Medicare and MA incur administrative costs; however, these are significantly higher for MA due to the additional administrative activities required to run an MA plan. A notable portion of these costs is to employ cost management strategies, which allows MA plans to reduce costs below Traditional Medicare levels, thereby offsetting the additional investment in administration.

<sup>81</sup> We used 2023 Medicare Advantage and Traditional Medicare risk scores and claims trended to 2025 from the Chronic Conditions Warehouse (CCW) Virtual Research Data Center (VRDC). We accounted for differences in risk score and geography to normalize for part of the population differences between programs. Other differences may still exist in the underlying populations.

<sup>82</sup> 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.

<sup>83</sup> Centers for Medicare and Medicaid Services. (September 27, 2024). *Medicare Advantage and Medicare Prescription Drug Programs to remain stable as CMS implements improvements to the programs in 2025*. <https://www.cms.gov/newsroom/fact-sheets/medicare-advantage-and-medicare-prescription-drug-programs-remain-stable-cms-implements-improvements>.

<sup>84</sup> Freed, M., Fuglesten Biniek, J., Damico, A., & Neuman, T. (2024, November 15). *Medicare Advantage 2025 spotlight: First look at plan premiums and benefits*. KFF. <https://www.kff.org/medicare/issue-brief/medicare-advantage-2025-spotlight-a-first-look-at-plan-premiums-and-benefits/>.

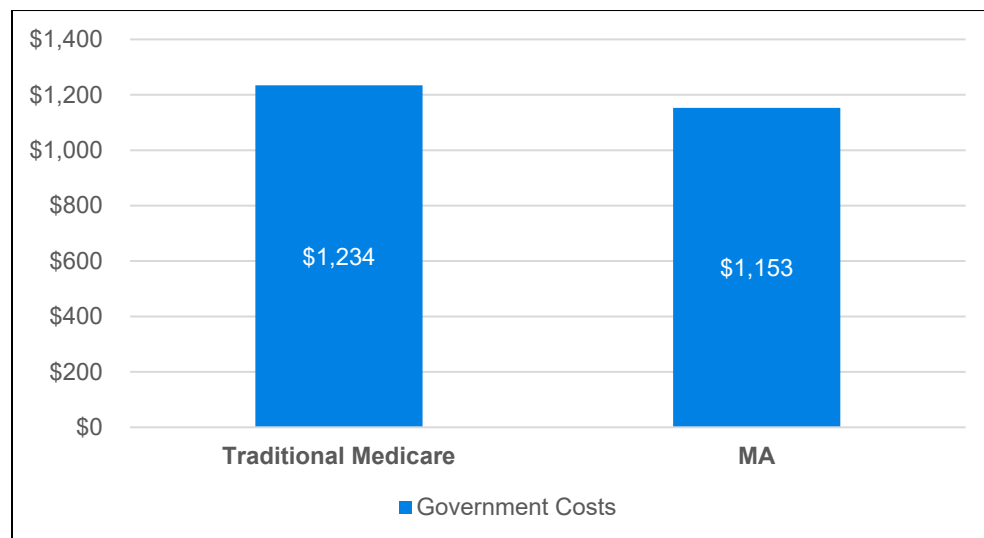
## IV. Sensitivity testing

We performed two sensitivity tests on our analysis: restated 2025 MA benchmarks and risk score coding differentials.

### Restated 2025 MA benchmarks

One year after 2025 MA benchmarks were established, when developing 2026 benchmarks, CMS revised projected 2025 non-ESRD Traditional Medicare costs upward by 4.3% from the initial estimate in the 2025 Rate Announcement. This restatement was driven by updated claims trends that were higher than initially projected.<sup>85</sup> The MA benchmarks included in our analysis reflect the original 2025 benchmarks, as these do not get restated when paying MA plans, and are lower than more recent projections of 2025 Traditional Medicare costs. This drives a portion of the government cost differential for 2025. We explored what the government value may have looked like using MA benchmarks that align more closely with current trends. When increasing 2025 benchmarks approximately 4.3% (consistent with the Traditional Medicare cost restatement), we observed government costs under MA would have been approximately 93% of government costs for Traditional Medicare in 2025, assuming 2025 bids remain the same and the increase in benchmarks would directly lead to increases in MA rebates.

FIGURE 7: GOVERNMENT COSTS IN TRADITIONAL MEDICARE VS. MA (\$ PMPM), 2025, 4.3% INCREASE TO 2025 MA BENCHMARKS<sup>†</sup>



<sup>†</sup> Traditional Medicare is weighted using February 2025 MA enrollment by county

### Risk score coding differential between MA and Traditional Medicare

MedPAC recently estimated that 2025 government payments to MA plans will be, on average, 120% of Traditional Medicare spending, which they estimated to be driven by additional risk score coding differences and selection impacts.<sup>86</sup> Analyzing the validity of the outcomes of that report is 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 stronger incentives in the MA program to capture diagnoses for risk scores, though incentives have increased recently for Traditional Medicare through the rise in popularity of ACOs. 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 has suggested the CMS adjustment may be inadequate and estimated the coding difference may be as high as 16% (inclusive of the 5.9%).<sup>87</sup> If actual coding differences exceed the 5.9% published CMS estimate, then MA government payments would be higher.

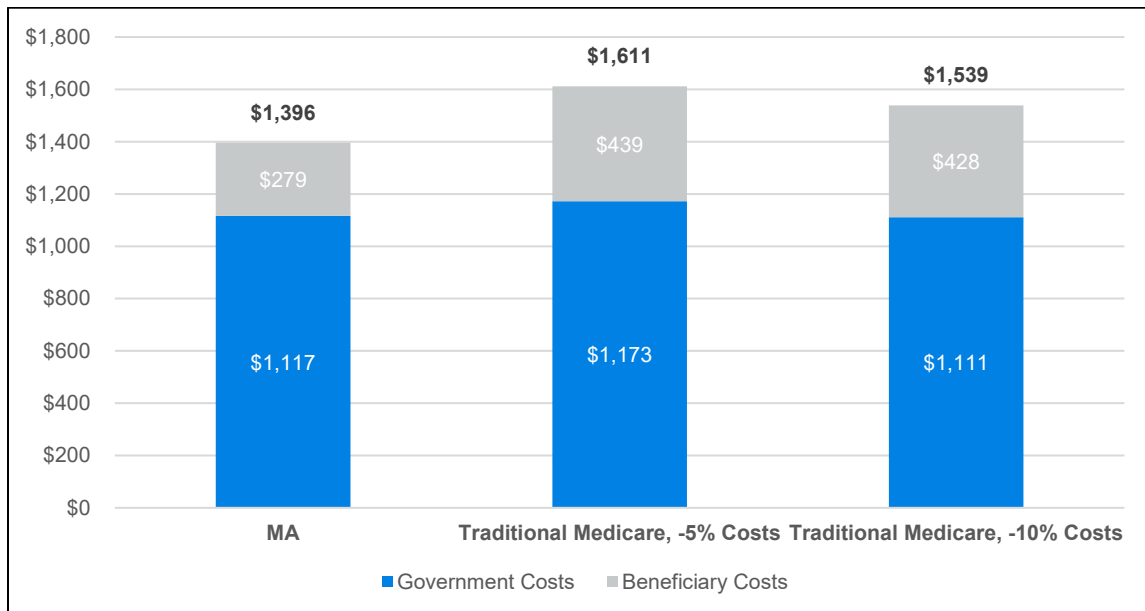
<sup>85</sup> Centers for Medicare and Medicaid Services. (2024, April 1). *Announcement of calendar year (CY) 2025 Medicare Advantage (MA) capitation rates and Part C and Part D payment policies*. <https://www.cms.gov/files/document/2025-announcement.pdf>.

<sup>86</sup> MedPAC (March 2025). *Report to the Congress: Medicare payment policy*. [https://www.medpac.gov/wp-content/uploads/2025/03/Mar25\\_MedPAC\\_Report\\_To\\_Congress\\_SEC-1.pdf](https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_MedPAC_Report_To_Congress_SEC-1.pdf).

<sup>87</sup> Ibid.

To test whether risk score coding differences beyond the 5.9% CMS MA coding pattern impact our overall conclusions, we conducted a high-level sensitivity test on our analysis. We reduced Traditional Medicare costs by 5% and 10% to test a range of reasonable risk score coding differences. Figure 8 summarizes the government payments and beneficiary costs under each scenario.

**FIGURE 8: COMBINED GOVERNMENT AND BENEFICIARY COSTS IN TRADITIONAL MEDICARE VS. MA (\$ PMPM), -5% AND -10% TRADITIONAL MEDICARE COST SCENARIOS<sup>†</sup>**



<sup>†</sup> Traditional Medicare is weighted using February 2025 MA enrollment by county. The Traditional Medicare beneficiary costs include the cost sharing collected for Part A and Part B services, the standard Part B premium, and the average standalone PDP 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 supplemental benefit and Part D-related out-of-pocket costs. Traditional Medicare 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 Traditional Medicare are higher than for MA. Although government payments under Traditional Medicare would be slightly less than MA in the 10% lower cost scenario, the beneficiary costs remain significantly higher.

In addition to coding differences, MedPAC suggests there is a selection difference in the populations, where beneficiaries select coverage based on their anticipated health care needs.<sup>88</sup> In other words, Medicare beneficiaries selecting MA plans could spend less in health care 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 Traditional Medicare with supplemental coverage, such as Medigap, where the care and cost management programs are much more limited. Because MA payments are based on Traditional Medicare spending, MedPAC estimates this selection impact could increase MA payments by 11%.<sup>89</sup> While this could be true, we were only able to account for demographic, diagnosis frequency and severity differences through risk adjustment using risk scores on a 2025 model basis.

<sup>88</sup> MedPAC (March 2025). *Report to the Congress: Medicare payment policy*. [https://www.medpac.gov/wp-content/uploads/2025/03/Mar25\\_MedPAC\\_Report\\_To\\_Congress\\_SEC-1.pdf](https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_MedPAC_Report_To_Congress_SEC-1.pdf).

<sup>89</sup> *Ibid.*

## V. Methodology and data sources

We estimated Traditional Medicare payments and MA costs using 2023 data from the Chronic Conditions Warehouse (CCW) Virtual Research Data Center (VRDC), projected to 2025. Enrollment data and risk score information were also obtained from the VRDC and supplemented with publicly available data from CMS. To aggregate Traditional Medicare costs, we applied county-level MA enrollment data from CMS's February 2025 enrollment files as weights. The analysis excluded Traditional Medicare costs associated with beneficiaries enrolled in only Part A or Part B and members with End-Stage Renal Disease (ESRD) or hospice status. We used 2023 risk scores projected to 2025 for both Traditional Medicare and MA and normalized all costs for risk scores. MA risk scores were adjusted for the 5.9% CMS MA coding pattern adjustment.

We estimated government administrative expenses for both Traditional Medicare and MA using information published in the 2025 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) 2025 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 2025 benefit designs for all plans adjudicated on 2023 data trended to 2025. 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 to cost-sharing reductions, supplemental benefits offered, and Part D and Part B buy-downs using information from MedPAC. Plan type and geography were factors in developing the medical cost estimates and other assumptions.

Part D estimates included government payments to MAOs to reduce beneficiary premiums, which are used to provide enhanced drug coverage, including \$0 low-income copays through the VBID program and non-Part D drug coverage.

The analysis excluded 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 included all MA-PD and MA-only plans (offering only Part C coverage) that are not in one of the excluded plan types.

We reviewed the March 2025 MedPAC report in conjunction with our analysis.<sup>90</sup> To review for reasonability, we adjusted MA payments at a high level by applying restated Traditional Medicare trends and removing Part A-only and Part B-only beneficiaries. These adjustments put MA on the same claim level and population basis to the claims and population underlying our Traditional Medicare estimate. After these high-level adjustments, the MA to Traditional Medicare government spending relativities underlying this analysis were consistent with Table 11-4 in the March 2025 MedPAC report (page 337) excluding additional coding and selection impacts. Valuing MedPAC's estimates for coding and selection impacts was outside the scope of this analysis.

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<sup>90</sup> MedPAC (March 2025). *Report to the Congress: Medicare payment policy*. [https://www.medpac.gov/wp-content/uploads/2025/03/Mar25\\_MedPAC\\_Report\\_To\\_Congress\\_SEC-1.pdf](https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_MedPAC_Report_To_Congress_SEC-1.pdf).

## VI. Caveats and limitations

The authors of this report are employees of Milliman, Inc. Ali Heinrich and Sam Smetek 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 Traditional Medicare or MA 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 MA and Traditional Medicare. 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 Traditional Medicare 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 MA and Traditional Medicare programs for 2025 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 health care 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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