Medicare Advantage: Myth vs. Fact

BETTER MEDICARE ALLIANCE

As the dominant Medicare choice for beneficiaries, the Medicare Advantage program is overwhelmingly popular with seniors because it provides high-quality, affordable health care with better outcomes compared to Fee-for-Service Medicare. Despite the program's success, ongoing criticism remains, including proposals to cut Medicare Advantage. This would cause widespread disruption for millions of seniors who rely on Medicare Advantage, with plan closures, higher costs and reduced benefits.

Here are the facts:

Promoting Accurate Risk Adjustment

CLAIM: Medicare Advantage plans inflate risk scores so Medicare Advantage beneficiaries appear sicker than beneficiaries in Fee-for-Service Medicare.

> **FACT:** The Medicare Advantage risk adjustment model relies on qualified health professionals to accurately diagnose beneficiaries in order to determine prospective, capitated payments. Ensuring diagnoses are complete and accurate allows plans to manage care appropriately and cover more than 34 million beneficiaries' health needs. Unlike Fee-for-Service Medicare, Medicare Advantage is specifically designed to manage the holistic health of a beneficiary, resulting in a more efficient use of Medicare dollars and better, high-quality and coordinated care for seniors. Medicare Advantage is a highly regulated program with accountability mechanisms to ensure diagnosis and payment accuracy, including strict documentation requirements and regular audits.

CLAIM: MedPAC estimates that upcoding will result in about $40 billion in excess payments in 2025.

> **FACT:** The MedPAC estimate is based on a fundamentally flawed analysis that does not account for under-coding in Fee-for-Service, among other issues. Accurate clinical diagnosis and coding, or documenting a beneficiary's health status, is fundamental to effective care management. Unlike payment in Fee-for-Service, the Medicare Advantage payment model relies on accurately diagnosing a beneficiary to determine prospective, capitated payments that are adjusted based on the health status of beneficiaries. If a beneficiary is chronically ill or sick and requires ongoing care, plans receive higher payments as their health care costs will be higher. Similarly, plans receive lower payments for healthier beneficiaries as their health care costs are lower. There are also established mechanisms to ensure Medicare Advantage diagnoses are accurate and are assessed through the Risk Adjustment Data Validation audit process. Annual HHS reports also find that Fee-for-Service Medicare consistently records higher improper payment rates than Medicare Advantage.

> **FACT:** CMS has the authority to increase this adjustment and has determined the current 5.9% minimum uniform adjustment is sufficient. The coding intensity adjustment should be approached carefully. First, there are various methodologies that should be examined to appropriately balance and account for differences between Medicare Advantage and Fee-for-Service. Second, there are mechanisms currently in place that ensure coding is appropriate. Any increase to the coding intensity adjustment is a cut to Medicare beneficiaries and could lead to fewer benefits and higher out-of-pocket costs, which they cannot afford.

Closing Care Gaps with In-Home Health Assessments

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CLAIM: Health risk assessments and chart reviews are used to add diagnosis codes and provide little to no value to the beneficiary.

FACT: In-home health assessments, also known as health risk assessments, are an established component of the Medicare program and an important way to provide in-home care to improve health outcomes and address chronic disease earlier. In-home health assessments identify gaps in care and collect detailed information that informs a beneficiary's personalized care plan to improve overall health and promote independence. They are comprehensive clinical care models where a qualified health professional provides a clinical primary care visit and ensures there is an appropriate follow-up care plan, identifies and addresses gaps in care and works to eliminate risk factors that may not even be evident in a doctor's office, including connecting beneficiaries to community resources if necessary.

Driving High-Value, Affordable Health Care

CLAIM: Despite being created to deliver efficiencies and cost-savings to the Medicare program, Medicare Advantage drives up costs and does not result in savings.

FACT: Analyses and critics fail to account for the additional value Medicare Advantage delivers to the beneficiary, government and taxpayers in the form of reduced cost-sharing, maximum out-of-pocket limits and extra supplemental benefits that do not exist in Fee-for-Service Medicare, along with reduced spending on Medicare-covered services.

Medicare Advantage beneficiaries spend $2,541 LESS on annual out-of-pocket costs and premiums compared to Fee-for-Service Medicare. Additionally, Medicare Advantage beneficiaries report a 31% lower rate of cost burden on average than those enrolled in Fee-for-Service Medicare. Through supplemental benefits, Medicare Advantage provides enhanced coverage of Medicare-covered benefits, such as reduced cost-sharing and lower premiums, while providing benefits and services NOT covered by Fee-for-Service Medicare. Nearly all (97%) of plans provide some combination of dental, vision or hearing coverage for beneficiaries, and a majority of plans offered in 2025 are zero-dollar premium plans, meaning beneficiaries only pay the Part B premium that all Medicare beneficiaries pay and do not pay an additional premium for their Medicare Advantage plan.

In addition to lower beneficiary costs in Medicare Advantage, research finds that, on average, per beneficiary government spending is lower in Medicare Advantage compared to Fee-for-Service, with Medicare Advantage covering Medicare-covered services for 31% less than Fee-for-Service. Together, Medicare Advantage delivers more value to the government for every dollar spent in Medicare Advantage compared to Fee-for-Service Medicare, with financial protections leading to beneficiary savings and extra services delivered through supplemental benefits.