BETTER MEDICARE
ALLIANCE

POLICY WHITE PAPER · 2026

MedPAC's Spending Comparison Undercounts the Value of Medicare Advantage

> *A fair comparison with Fee-for-Service has to look at the full picture.*

Better Medicare Alliance | September 2026

BETTERMEDICAREALLIANCE.ORG

Introduction

The Medicare Payment Advisory Commission (MedPAC), an independent agency that provides the U.S. Congress with analysis and policy advice on the Medicare program, has concluded that the federal government spends more per beneficiary in Medicare Advantage than in Fee-for-Service Medicare.[1] That conclusion is widely cited and directly informs federal payment policy, yet the analysis could be strengthened by a broader view of program costs and benefits. A growing body of research applies these broader methodological frameworks, including analyses examining the cost implications of required Medicare Advantage benefits,[2] studies using pre-enrollment health status to assess selection,[3] and peer-reviewed evidence on multi-year cost avoidance.[4] The conclusions of the MedPAC and other spending analyses are meaningfully impacted by decisions about what counts as a program cost, which populations are compared, and over what time horizon spending is measured.

The MedPAC analyses could be made more comprehensive by incorporating additional program impacts and the enhanced benefit structure offered by the Medicare Advantage program. For example, the MedPAC analysis excludes potential programmatic savings to Part D and Medicaid stemming from the Medicare Advantage program. Additionally, the analysis relies on comparison groups that do not fully account for important population, programmatic, and policy differences, focusing on beneficiaries who switch between Fee-for-Service Medicare and Medicare Advantage, estimating what their spending would have been had they remained in Fee-for-Service Medicare. Finally, the MedPAC analysis does not empirically incorporate the benefits that Medicare Advantage plans provide that Fee-for-Service Medicare does not offer, most notably a maximum out-of-pocket (MOOP) limit and often reduced or $0 cost share for primary care and other office visits. These analytic decisions make Medicare Advantage appear more costly to the federal government than it is.

MedPAC and policymakers should consider a broader set of analyses, including those that take a more expansive view of federal spending, account for the value of benefits Medicare Advantage plans are required to provide, assess the long-term effects of care management, and construct comparison groups based on more nuanced data. These perspectives are essential to reflect the true value of Medicare Advantage for the federal government beneficiaries. Relying too heavily on analyses that only look at one aspect of the program (e.g. Medicare Parts A and B spending) misses important program nuances (e.g. Medicare is buying more with the dollars than in Fee-for-Service Medicare and spending less on Part D). There are concrete opportunities to improve future analyses by incorporating new methodological considerations that reflect the scope of underlying differences between the two programs and populations.

The impact of getting these comparisons right is substantial. Medicare Advantage now covers more than half of all Medicare beneficiaries nationally, with 35 million individuals choosing to receive their Medicare coverage through Medicare Advantage in 2026.[5] The federal government is projected to spend almost $588 billion on the program this year.[6] As policymakers weigh further reforms to the program, the policy conclusions drawn from spending comparisons will directly shape the coverage available to those 35 million beneficiaries.

Opportunities to More Accurately Capture the Value of the MA program

SCOPE OF SPENDING

MedPAC's analyses focus on a specific view of federal spending, assessing Medicare Parts A and B payments and comparing plan bids and benchmarks to estimated Fee-for-Service Medicare spending. This captures core program spending but does not account for all federal spending associated with beneficiaries enrolled in each program. In particular, this approach excludes Part D spending, Medicaid spending for dual eligible beneficiaries, and other federal expenditures that interact with Medicare coverage. As a result, the MedPAC comparison provides a useful but incomplete view of total federal outlays associated with Medicare Advantage and Fee-for-Service Medicare.

This narrower focus is especially salient for beneficiaries with complex needs. For dual eligible beneficiaries, comparisons limited to Medicare Parts A and B do not capture the full federal spending picture, because Medicaid also finances a substantial share of their care. Likewise, analyses that exclude Part D spending may miss differences in prescription drug use and management between Medicare Advantage and Fee-for-Service Medicare. Medicare Advantage-Part D plans integrate medical and drug coverage, while Fee-for-Service Medicare beneficiaries may enroll in standalone Part D plans. The average Part D total premium for Medicare Advantage beneficiaries with drug coverage is substantially lower than for standalone Part D plans, reflecting plan design differences and negotiating leverage.[7] Whether total federal Part D outlays per beneficiary differ between Medicare Advantage and Fee-for-Service Medicare populations, and how they interact with medical cost comparisons, is not systematically examined in current studies.

Savings associated with Medicare Advantage plan enrollment can also accrue to Medicaid, driven by dual-eligible special needs plans (D-SNPs) and dual eligible individuals enrolled in other Medicare Advantage plans. Through Medicare Advantage's care and utilization management programs, the beneficiary cost sharing liability (which is covered by Medicaid) may be lower than for those enrolled in Fee-for-Service Medicare. In addition, through the MOOP threshold imposed by Medicare Advantage plans, costs above the MOOP are transferred from Medicaid to the Medicare Advantage plan. Using 2020 Fee-for-Service Medicare data, 2.5 percent of Fee-for-Service Medicare beneficiaries would have exceeded the 2023 mandatory Medicare Advantage MOOP of $8,300 with average annual out-of-pocket costs of approximately $15,000. These mechanisms help drive savings to Medicaid.[8]

Few existing studies explicitly incorporate these broader components of spending into their primary estimates. This makes it difficult to assess whether observed differences in Part A and B spending alone understate, overstate, or accurately reflect Medicare Advantage's net impact on total federal outlays. Future analyses could provide a more comprehensive perspective by clearly specifying the spending viewpoint used (for example, Medicare-only versus combined Medicare and Medicaid) and incorporating Part D and relevant Medicaid costs where feasible. This would help policymakers interpret existing findings in the context of the full range of federal costs and potential savings associated with each program.

DIFFERENCES BETWEEN THE MEDICARE ADVANTAGE AND FEE-FOR-SERVICE MEDICARE ENROLLED POPULATIONS

Differences between the populations enrolled in Medicare Advantage and Fee-for-Service Medicare should be accounted for in any comparison of federal spending across the two programs. Analyses should capture the full scope of updated risk score methodology and the underlying differences between populations who change enrollment to Medicare Advantage versus remaining in Fee-for-Service Medicare. Medicare Advantage and Fee-for-Service Medicare beneficiaries differ in ways that are directly relevant to utilization and spending, and the Centers for Medicare & Medicaid Services (CMS) recently implemented policy changes to refine the risk adjustment model. These differences influence patterns of service use, enrollment decisions, and spending independent of program design, making careful adjustment essential to any assessment of relative federal outlays.

v28 Risk Adjustment Model

CMS leadership conducted an analysis in early 2026 that finds smaller differences in coding between Medicare Advantage and Fee-for-Service Medicare than those identified by MedPAC.[9] Members of CMS leadership recalculated the payment year 2022 national average enrollment-weighted risk scores for Medicare Advantage and Fee-for-Service Medicare using the newly implemented v28 risk adjustment model and a demographic-only risk adjustment model. They estimated the difference in risk scores due to health status using the demographic estimate of coding intensity (DECI) methodology, the same methodology used by MedPAC. This analysis finds an estimated 1.5-2.0 percent “uncorrected” coding in Medicare Advantage relative to Fee-for-Service Medicare in 2022, significantly lower than MedPAC’s 2025 finding of 10 percent in its 2025 report and 4 percent in its 2026 report.

The CMS leadership analysis notes that the implementation of the Hierarchical Condition Categories (HCC) risk adjustment model version 28 (v28) made several changes expected to meaningfully reduce coding intensity. In its March 2026 report, MedPAC similarly notes that declining differences in Medicare Advantage and Fee-for-Service Medicare coding intensity were driven by the completed phase-in of the v28 risk model. However, MedPAC’s analysis still applies an estimated impact of the full phase-in of v28 for 2026, using the coding-intensity growth trend (+0.7 percentage points) based on the post-pandemic trend for the V24 model.

Program Selection

MedPAC leverages a “switcher” analysis to assess whether favorable selection (disproportionate enrollment of healthier, lower-cost beneficiaries) occurs in beneficiary choices between Medicare Advantage and Fee-for-Service Medicare. The MedPAC analysis relies on the observed spending gap for beneficiaries in the single year before they switch into Medicare Advantage, which is used to estimate how that gap might evolve over time for other beneficiaries who have switched enrollment. It is not possible to observe what a switcher would have spent had they stayed in Fee-for-Service Medicare, so MedPAC applies the trajectory of a comparable group who did stay in Fee-for-Service Medicare instead. The comparison group is selected almost entirely based on two variables, dual eligible status and mortality. These are crude and limited proxies for the clinical complexity that drives how spending patterns change over time.

This analysis provides a time-limited view of beneficiary spending, as it only assesses Medicare Advantage beneficiaries’ spending in the year before they switch from Fee-for-Service Medicare to Medicare Advantage. The favorable selection among “switchers” identified by MedPAC may diminish over time as people continue to stay enrolled and may experience worsening health after entering Medicare

Advantage. While MedPAC presents a longitudinal analysis, the constructing of trajectories of risk scores and spending in the Fee-for-Service Medicare population and applying those trajectories longitudinally to "switchers" does not sufficiently assess the ways in which beneficiaries' characteristics, risk scores, and spending may change over time in each program.

Future analyses could be strengthened by incorporating broader measures of beneficiary complexity. Doing so would improve the reliability of comparative estimates and provide a clearer picture of whether observed spending differences reflect the programs themselves, the populations they serve, or both.

BENEFIT STRUCTURE

Medicare Advantage plans offer important beneficiary financial protections and additional benefits that are not present in Fee-for-Service Medicare. The provision of this coverage increases the cost of the benefit package under Medicare Advantage. While MedPAC acknowledges the additional benefits that Medicare Advantage plans provide, the analysis does not incorporate the dollar value of these benefits or attempt to estimate the cost of providing them under Fee-for-Service Medicare. This means the MedPAC findings do not make an apples-to-apples comparison of the programs, nor do they reflect the true value provided by Medicare Advantage to beneficiaries and the federal government.

Unlike the Fee-for-Service Medicare program, where beneficiary out-of-pocket costs are unlimited, Medicare Advantage plans are required to provide meaningful spending protections. For example, Medicare Advantage plans are required to apply a MOOP cap on beneficiary spending ($9,250 is the in-network maximum in 2026, but many plans offer lower caps). If these same protections were offered in Fee-for-Service Medicare, federal spending would increase significantly. One study considered the cost of providing a MOOP limit to Fee-for-Service Medicare and estimated program spending would increase by 3.5 percent.[10] Other researchers have compared the programs in terms of costs to beneficiaries rather than the government, finding lower out-of-pocket costs for Medicare Advantage beneficiaries.[11] [12]

Additionally, Medicare Advantage plans offer supplemental benefits that fill in some of the coverage gaps that exist in Fee-for-Service Medicare and often provide lower cost share for medical services. For example, despite the clinical benefit of routine dental care including reducing hospital readmissions following surgery, Fee-for-Service Medicare does not provide dental coverage. Nearly all Medicare Advantage plans offer dental coverage, in addition to hearing aids and other critical services and benefits. The additional value provided through Medicare Advantage program costs relative to Fee-for-Service Medicare is not always considered in comparison studies.

Future studies should consider the value of these components of Medicare Advantage when comparing the two Medicare programs. Analyses should assess the dollar value of reduced out-of-pocket spending and supplemental benefits in Medicare Advantage. Fee-for-Service Medicare spending numbers used in program comparisons should include what it would cost the program to provide these benefits to Fee-for-Service Medicare beneficiaries. This would provide an apples-to-apples comparison that accurately reflects the value beneficiaries receive from the Medicare Advantage program.

LONGITUDINAL COST AVOIDANCE

MedPAC's approach captures only direct spending through CMS's payments to Medicare Advantage organizations and predicts spending comparisons over a one-year timeframe. It does not consider how differences in preventive care and care coordination provided by Medicare Advantage plans may shape spending trajectories over multiple years. This is particularly limiting because Medicare Advantage is associated with higher rates of preventive care and care coordination activities whose cost-reduction effects may not materialize for several years. For example, Medicare Advantage beneficiaries are more likely to receive an annual wellness visit (AWV) than those in Fee-for-Service Medicare.[13]

Differences in preventive screenings, AWVs, chronic disease monitoring, supplemental benefits, and care management may not immediately translate into lower spending through direct Medicare Advantage payments, but may reduce avoidable emergency department use, hospitalizations, and post-acute care over time. Research has found that Medicare Advantage beneficiaries with complex or high-need conditions experience substantially lower rates of avoidable hospitalization than comparable Fee-for-Service Medicare beneficiaries.[14] Additionally, evidence suggests that greater Medicare Advantage penetration is associated with spillover effects into the Fee-for-Service Medicare population, lowering total Medicare spending (Medicare Advantage and Fee-for-Service Medicare) per capita.[15] [16]

As a result, analyses that focus only on a single year of spending may not fully capture the downstream effects of Medicare Advantage's care model on total federal outlays. As Medicare Advantage covers a growing portion of the Medicare population, and beneficiaries enroll earlier and remain in the program longer, the risk of overlooking the longitudinal cost avoidance in a single year comparison grows. Applying longitudinal approaches that consider population and program experiences over multi-year periods would better account for program impacts over time.

Conclusion

MedPAC provides a valuable analysis that could be improved by incorporating a broader view of federal spending, benefits to enrollees, care management effects, risk adjustment updates, and underlying population differences. Current MedPAC analyses understate the value Medicare Advantage delivers, both to the federal government and to the beneficiaries it serves. Future comparisons should, at a minimum, incorporate Part D and Medicaid costs into the federal spending picture, account for the full value of benefits Medicare Advantage plans are required to provide, assess long-term cost avoidance impacts, and take a more representative view of population comparisons. Addressing these gaps would show that Medicare Advantage delivers more value at lower net cost to the federal government than current analyses reflect. Federal payment rates built on incomplete analyses put the coverage of the 35 million beneficiaries enrolled in Medicare Advantage at risk.

Sources

[1] Chapter 12: March 2026 Report to the Congress: Medicare Payment Policy

[2] Microsoft Word - Value of MA _Response to MedPAC_11.12.2025.docx

[3] INOV_MA-vs-FFS-Outcomes-Study_5.28.25-v1.0.0.pdf

[4] ELV_PPI_MA_Penetration_Medicare_Spending.pdf

[5] Medicare Advantage Enrollment Grew by About 1 Million People, Mainly Due to Special Needs Plans | KFF

[6] 2026 Medicare Trustees Report

[7] Medicare Advantage and Medicare Prescription Drug Programs Expected to Remain Stable in 2026 | CMS

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

[9] An updated analysis of coding pattern differences in Medicare Advantage - PMC

[10] Microsoft Word - Value of MA _Response to MedPAC_11.12.2025.docx

[11] Medicare Beneficiary Spending 2025 - Better Medicare Alliance

[12] Value to the federal government of Medicare Advantage

[13] Medicare Beneficiary Spending 2025 - Better Medicare Alliance

[14] Comparison of Health Care Utilization by Medicare Advantage and Traditional Medicare Beneficiaries With Complex Care Needs - PMC

[15] ELV_PPI_MA_Penetration_Medicare_Spending.pdf

[16] Geng, F. et al. (April 2023). Increased Medicare Advantage Penetration Is Associated With Lower Post-Acute Care Use for Traditional Medicare Patients. Health Affairs.