

Review of Key Academic Literature Assessing the Medicare Advantage Program

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This report synthesizes findings from the most rigorous research on the extent to which Medicare Advantage (MA) reduces health spending, increases federal expenditures, and produces better health outcomes for Medicare beneficiaries compared with Traditional Medicare (TM). The studies selected for this review employ advanced empirical methods to control for issues such as selection (e.g., healthier patients enrolling differentially in MA), which make it challenging to draw conclusions about the MA program.

Executive Summary

The MA program allows private insurers to offer government-subsidized health insurance coverage to Medicare beneficiaries. On average, MA plans spend less on health care services than TM does for comparable beneficiaries. However, despite lower spending on the core Medicare benefit, total government spending on MA enrollees exceeds what it would be if TM covered those enrollees. Approximately half of the higher spending goes toward more generous coverage in MA, including lower cost sharing and additional benefits such as dental and vision coverage. The remaining half of higher spending results from more intensive coding practices and “favorable selection”: MA plans attract enrollees who are less costly to insurers than their risk profiles, based on the federal government’s risk adjustment formula, would suggest. This partly reflects the tendency of healthier enrollees to be drawn to the MA program. It also reflects that MA beneficiaries are more likely than TM beneficiaries to be coded by their plans and providers—particularly plan-owned providers—as having comorbidities despite having functionally identical underlying health status. Notably, health maintenance organization (HMO) plans appear to save the federal government money after

¹ Daniel Stern’s contributions to this report were made in his personal capacity and the views expressed herein do not represent the views of his employer or any affiliated organizations.

accounting for favorable selection. Finally, while mortality substantially varies across MA plans, the government’s quality measurements—part of the Star Ratings system—are uncorrelated with an MA plan’s likelihood of lowering enrollee mortality.

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Key Findings

- **Key Finding 1—Medicare Advantage (MA) Plans Spend Less Per Person Than Traditional Medicare, After Controlling for Favorable Selection:** Per capita health care spending is lower in MA than TM because MA plans reduce high-cost care, such as inpatient admissions and post-acute care.
- **Key Finding 2—Medicare Advantage Plans Cost the Federal Government More Money Than If Enrollees Had Traditional Medicare:** Despite MA plans spending less per person, the federal government spends more to cover MA beneficiaries than it would if those beneficiaries were enrolled in TM. Approximately half of the higher spending goes toward the more generous benefits offered by MA plans, and the remaining half flows from more intensive coding practices and inadequate risk adjustment. If MA were limited to HMO plans, the federal government would likely save money.
- **Key Finding 3—Insurer Market Power Determines the Extent to Which Increases in Federal Payments to Medicare Advantage Plans Benefit Enrollees:** When the federal government increases payments to private insurers, research has found that approximately half of the increase accrues to enrollees in the form of more generous benefits or lower premiums. The share of higher payments passed through to MA plan enrollees depends on insurers' market power. In more competitive markets, a higher share of government payments is passed through as lower premiums and greater benefits.
- **Key Finding 4—There Is Extensive Variation in Patient Mortality Across MA Plans:** Mortality varies across MA plans as a function of plan design and the providers included in the network. Notably, the government's Star Ratings are uncorrelated with plan mortality.

Introduction

The Medicare program, introduced in 1965, provides near-universal health insurance coverage to approximately [62.6 million people](#) aged 65 and older, as well as [7 million people](#) under age 65 with a disability (“Medicare Beneficiaries by Type of Entitlement”).² When the program was first launched, the federal government was the sole purchaser of health care services for covered beneficiaries. Beginning in the 1980s, the program allowed private insurers to receive capitated payments from the federal government to offer insurance coverage to Medicare beneficiaries.

² As of [October 2025](#), 69.6 million people were enrolled in Medicare (“Medicare Monthly Enrollment: October 2025”).

Today, the Medicare Advantage (MA) program, which offers Medicare beneficiaries the option to enroll in private insurance plans, covers [35 million people](#) ([over 54%](#) of eligible Medicare beneficiaries) (Freed et al., 2025).³ The remaining 34 million receive coverage through the Traditional Medicare (TM) program.

Allowing publicly funded private insurers to offer insurance coverage to eligible enrollees broadens the options available to Medicare beneficiaries and allows participating private insurers to introduce care management to the program. The MA program’s design necessitates that private plans offer insurance coverage at least as comprehensive as TM and, in many cases, substantially more generous. MA plans often offer lower out-of-pocket costs and additional benefits, such as dental and vision coverage.

There are long-running debates over whether the public sector (e.g., TM) or private firms are more efficient at delivering government-sponsored services (e.g., Medicare). An extensive literature also addresses the MA program (Ochieng and Biniek, 2022). However, evaluating the MA program is challenging because Medicare enrollees can choose whether to enroll in MA or TM and may switch their enrollment. Healthier enrollees, for example, may be differentially drawn to MA plans relative to TM. Conversely, MA plans may differentially select lower-cost enrollees or aggressively code beneficiary health status, making savings appear artificially high. This lack of random assignment means that simply observing differences in spending and outcomes between MA and TM beneficiaries can be misleading (Brot et al., 2025).

Rather than synthesizing all studies that have assessed the MA program, this review focuses on a subset that has taken the most empirically rigorous approaches to studying the program over the last 25 years. Importantly, these papers account for the fact that patients can choose whether to enroll in an MA plan or the TM program—an essential factor in accurate evaluation. As a result, this review provides an overarching view of the MA program, rather than assessing the merits of particular risk-adjustment formulas or other specific program revisions over time.

Background on Medicare Advantage

Traditional Medicare covers hospital, outpatient, and physician services. Beneficiaries may purchase a Part D plan for prescription drug coverage. The Medicare program offers coverage with an actuarial value of approximately 80% and includes deductibles in Parts A and B, a 20% coinsurance rate and no out-of-pocket maximum (42 U.S.C. §§ 1395e, 1395l; Bailey, 2014). In practice, approximately 90% of TM enrollees are either exempt from cost sharing because they are dual-enrolled in Medicaid or enrolled in supplemental insurance—namely, a Medigap plan or

³ In [January 2026](#), 35.5 million beneficiaries were enrolled in a Medicare Advantage plan, representing 51% of the total Medicare population and 54% of beneficiaries eligible to enroll in Medicare Advantage (“Monthly Contract and Enrollment Summary Report: Contract Summary, January 2026”).

employer-sponsored plan—that limits their cost sharing (Ochieng et al., “A Snapshot of Sources,” 2025). The TM program provides limited care management.

In the 1980s, the federal government began experimenting with allowing Medicare beneficiaries to enroll in private health maintenance organizations (HMOs) subsidized by the Medicare program (McGuire et al., 2011). Enrollment grew in the 1990s, and the program was formally enacted and expanded as Medicare Part C in 1997, later renamed and reformed as Medicare Advantage (MA) in 2003 (Blumenthal et al., 2015; McGuire et al., 2011; Patel and Guterman, 2017). MA enrollment has steadily increased since the program’s introduction. In 2003, 13% of Medicare beneficiaries were enrolled in an MA plan (Ochieng et al., “Medicare Advantage in 2025,” 2025; Patel and Guterman, 2017). By 2025, 34 million MA beneficiaries comprised approximately 54% of Medicare enrollment, and the CBO estimates this will increase to 64% by 2034 (Ochieng et al., “Medicare Advantage in 2025,” 2025).

In the MA program, a health insurer is responsible for administering and financing the health care coverage for its beneficiaries. In exchange, the insurer is paid a capitated rate per enrollee and may retain any savings net of payments for health care services, creating incentives to reduce the cost of care. Since plan year 2014, plans are also subject to a minimum medical loss ratio, requiring that 85% of premium dollars be spent on services and quality improvement activities for enrollees (42 U.S.C. § 1395w-27(e)(4)).

MA plans are generally required to cover all medically necessary services covered under TM, including hospital benefits under Medicare Part A and medical benefits under Medicare Part B (42 U.S.C. § 1395w-22; Medicare.gov “Compare Original Medicare & Medicare Advantage”; Ramsay et al., 2024). However, plans have some flexibility within these bounds (“Medicare Program; Contract Year 2024 Policy and Technical Changes,” CMS-4201-F). Beneficiaries may purchase outpatient prescription drug coverage either as a standalone plan to complement TM coverage or as part of an MA plan. While insurers do offer standalone MA plans, 89% of MA plans in 2024 offered Part D benefits combined with medical and hospital coverage (Ramsay et al., 2024).

Medicare sets benchmark base payment rates using total TM spending for each county. Plans then submit bids representing their expected base per capita health care costs in the counties they cover. If a plan’s bid exceeds the benchmark, it receives the benchmark as the capitation rate and must cover the difference by charging enrollees a premium. If the bid falls below the benchmark (92% of bids in 2022), the plan receives its bid plus a portion of the difference as a rebate (Ramsay et al.,

2024).⁴ The federal government pays this fixed base payment per member per month to cover its enrollees and adjusts it for each enrollee according to age, sex, and health status.⁵

Plans must use rebates to lower premiums or out-of-pocket costs, or to provide coverage for health-related services not otherwise required by Medicare. This includes dental, hearing, and vision benefits, and may also include other health, wellness, and lifestyle benefits such as over-the-counter medication discounts, non-emergency medical transportation, or grocery shopping services (Gupta et al., 2025).

A plan's rebate is determined by its Star Rating under the quality bonus payment (QBP) system. Star Ratings aggregate a plan's quality based on approximately 50 different quantitative quality measures from multiple sources.⁶ Under QBP, plans with a 4-Star Rating or higher receive a 5% increase in their county benchmark (or 10% for plans in "double-bonus counties," where Medicare aims to attract more plan offerings and encourage competition on quality). Plans then receive between 50% and 70% of the difference between their bid and the benchmark as a rebate, depending on their rating (Ramsay et al., 2024).

Medicare Advantage Enrollment Reduces Utilization Relative to Traditional Medicare

Two studies—Curto et al. (2019) and Brot et al. (2025)—analyze the extent to which MA plans reduce spending relative to TM. Collectively, these studies show that, for comparable enrollees, MA lowers health spending by approximately 10%. Both studies highlight that MA plans achieve these savings by lowering hospitalizations and elective procedures. These findings echo Afendulis et al. (2017) and Duggan et al. (2018), who also show that MA enrollment lowers hospitalizations.

Curto et al. (2019) found that, after accounting for underlying differences between MA and TM beneficiaries, MA reduces health care spending by 9% compared with TM. The authors used beneficiary risk scores to account for health status differences between MA and TM enrollees and further controlled for differential selection and coding by using county-level risk-adjusted mortality rates in MA and TM as a proxy for health status. They show that lower spending resulted

⁴ The federal government paid MA plans an estimated \$86 billion in rebates in 2025 (MedPAC Report to Congress, June 2025), an increase from the \$12 billion in 2014 (Medicare Trustees Annual Report, May 2024). Over that period, the average monthly rebate increased from approximately \$75 to \$210 (MedPAC Report to Congress, March 2025).

⁵ For each Medicare beneficiary, the Centers for Medicare & Medicaid Services (CMS) builds a risk score based on age, gender, and existing medical conditions diagnosed in the prior year. Diagnoses are grouped into hierarchical condition categories (HCCs), and payments per beneficiary are adjusted by their HCCs. CMS pays plans their bid rates, which are then risk-adjusted for each enrolled individual.

⁶ For a list of quality measures included in the Star Ratings, see Centers for Medicare & Medicaid Services, 2025 Medicare Advantage and Part D Star Ratings, Oct. 10, 2024, <https://www.cms.gov/newsroom/fact-sheets/2025-medicare-advantage-and-part-d-star-ratings>

from MA patients using less care, particularly less expensive care. On average, MA enrollees experienced fewer inpatient and skilled nursing facility stays than TM beneficiaries, had fewer emergency department and specialist visits, were more likely to be discharged home instead of to post-acute care, and were more likely to have outpatient instead of inpatient surgery. They also found equivalent reductions in “low-value care,” namely imaging and diagnostic tests, and “high-value care,” such as preventive care.

Brot et al. (2025) use novel data to track individuals’ health care utilization and spending before and after they turn 65 and enroll in either MA or TM. This approach allows them to account for differences in enrollees’ health care costs based on their medical spending and underlying health status before they enrolled in the Medicare program. They find that enrollment in MA reduces health care utilization by approximately 6% compared with TM in the first year of Medicare enrollment. Like Curto et al. (2019), they show that utilization reductions come primarily from inpatient and post-acute care. Enrollment in MA lowered preventable hospitalizations but also lowered some other medically recommended services, including breast cancer screenings for women and blood sugar screening for diabetics. Reduced utilization was found to be concentrated among beneficiaries of HMO MA plans, while beneficiaries enrolled in preferred provider organization (PPO) MA plans experience increases in utilization compared with TM. Approximately 56% of MA enrollees participate in an HMO plan (MedPAC, 2025).

Duggan et al. (2018) also found that MA enrollment reduces hospitalizations. They focus on what happens to MA beneficiaries after their plans exit the market and found that hospitalizations increased by approximately 60%, with larger increases for nonemergency hospitalizations that persisted for extended periods after enrollees switched to TM. The authors attributed this increase to previously enrolled MA plans limiting access to nearby hospitals and reducing elective admissions.

Related work by Afendulis et al. (2017) reinforced these findings by comparing counties just above and below the population threshold for elevated urban floor payment rates to MA plans to understand how increased MA penetration affects beneficiary health care utilization. They found that enrollment in an MA plan in a county with elevated payment rates led to approximately a 22% reduction in the likelihood of hospitalization.

Finally, Baicker and Robbins (2015) showed that reduced utilization extends to TM beneficiaries in areas with high MA penetration. They studied differences in several utilization measures across counties with higher and lower MA penetration and found that higher MA penetration led to fewer hospitalizations and hospital days, less invasive treatments, and more physician visits for TM beneficiaries. Specifically, a 10% increase in MA penetration in an area was associated with a 4.5% decrease in per-patient hospitalization costs among all Medicare beneficiaries.

Medicare Advantage Plans Cost the Federal Government More Money Than If Enrollees Had Traditional Medicare

Although MA plans spend less per beneficiary on health care services than TM, Brot et al. (2025) show that the aggregate cost to the Medicare program of enrolling an individual in MA exceeds the cost of enrolling that individual in TM. This study echoes MedPAC reports showing that federal government spending on MA beneficiaries is higher than it would be if those beneficiaries were covered under TM (March 2025 Report to the Congress, 2025).

Brot et al. (2025) focus on MA plans from 2012 to 2021. They replicate the MA payment formulas and use insurer bid data to show that MA plans cost the federal government approximately 15% more than if the same individuals were enrolled in TM. These findings are similar in magnitude to MedPAC estimates projecting that, in 2025, Medicare spending on MA beneficiaries will be approximately 20% higher (\$84 billion) than it would be if those beneficiaries were covered by TM (March 2025 Report to the Congress, 2025).

Brot et al. (2025) also identify the sources of higher federal spending on MA plans, factoring in savings from reduced health care utilization under MA. First, MA plans offer more generous cost sharing and additional benefits relative to TM, which accounts for approximately half of the additional spending. Second, favorable selection—whereby MA plans attract healthier patients than TM conditional on risk—accounts for the remaining half. They observe that MA enrollees are approximately 11% less costly to insure than their risk scores would suggest. Absent the additional benefits and favorable selection of beneficiaries, they conclude that MA plans would likely reduce federal government spending.

These findings are similar to the results of Brown et al. (2014), who found that, even after the implementation of condition-based risk adjustment in 2004, MA plans continued to enroll beneficiaries who were more profitable, conditional on risk score. They concluded that favorable selection resulted in payments to MA plans approximately 9% higher than they would have been if those beneficiaries were covered under TM. Geruso and Layton (2020) similarly found that more intensive coding practices in MA, compared with TM, increased MA beneficiary risk scores by between 6% and 16% compared with what those scores would have been under TM.⁷ Likewise, recent research by Grasley and Guido (2025) shows that when primary care physicians are acquired

⁷ Brown et al. (2014) and Geruso and Layton (2020) accounted for favorable selection by studying changes in Medicare patient populations before and after major Medicare Advantage policy revisions. Brown et al. identified changes in average risk scores and expenditures conditional on risk scores among MA beneficiaries before and after the introduction of risk adjustment in 2004. Geruso and Layton compared county-level average risk scores, including both MA and TM beneficiaries, before and after implementation of the Medicare Modernization Act of 2003, which substantially increased national MA enrollment. They showed that average risk scores across the entire Medicare population increased, implying that enrolling in MA boosted beneficiaries' risk scores.

by a large payer, the MA risk scores of their patients substantially increase, thereby increasing the capitated payments the payer receives.

As MedPAC notes, MA plans may capture more diagnoses than would be expected under TM through chart reviews—whereby plans retroactively review beneficiaries’ medical charts to identify diagnosis codes incorrectly excluded from or included on medical claims (a process not used in TM)—and through health risk assessments (HRAs), which are annual reviews of patients’ health needs conducted as part of an annual wellness visit (March 2025 Report to the Congress, 2025). The US Department of Health and Human Services Office of Inspector General estimated that HRAs alone generated \$7.5 billion in additional payments to MA plans in 2023 (Carter, 2024).

Insurer Market Power Determines the Extent to Which Increases in Federal Payments to Medicare Advantage Plans Benefit Enrollees

Research shows that insurers’ market power determines the extent to which increases in federal spending on MA plans are passed through to enrollees in the form of lower premiums or more generous benefits. Song et al. (2013) found that a \$1 increase in county benchmarks results in a \$0.53 increase in MA plan bids, suggesting that MA plans have market power because, in a perfectly competitive market, plans would bid their costs and would not adjust their bids in response to benchmark changes.⁸

Duggan et al. (2016) compared the benefit generosity of MA plans operating in counties just above the population threshold for additional reimbursement under the urban floor payment rate with that of MA plans in counties just below the threshold that did not receive this additional reimbursement. They found that only approximately one-eighth of the increased reimbursement was passed through to beneficiaries in the form of more generous coverage.

Finally, Cabral et al. (2018) used the creation of separate rural and urban payment floors (Pub. L. 106-554; 42 U.S.C. § 1395w-23(c)(1)(B)), which increased MA payments in approximately 70% of counties, to study how benefits respond to plan payment increases. They found that approximately half of the value of the increases was passed through to beneficiaries in the form of lower premiums or more generous benefits. This pass-through rate is higher than that observed in Duggan et al. (2016), although this difference may reflect the distinct MA reimbursement increases studied in the two papers. Notably, they also found that pass-through is lower in less competitive markets and

⁸ In a perfectly competitive market, price equals marginal cost. Here, price refers to a plan’s bid, and marginal cost refers to the cost of providing health care coverage to the marginal enrollee. An exogenous increase in a county’s benchmark should not affect the cost of providing health care coverage to the marginal enrollee. Therefore, plans responding to exogenous benchmark increases by increasing their bids implies they are not pricing at marginal cost. To be sure, although no market is *perfectly competitive*, this finding is notable because MA plan market power may directly impact the fiscal efficiency of the MA program.

higher in more competitive markets. A key takeaway from both studies is that increases in MA reimbursement are not passed through to enrollees on a dollar-for-dollar basis.

Identifying the Impact of Medicare Advantage Enrollment on Quality and Mortality

The prevailing literature has not found marked differences in outcomes for enrollees in MA and TM (Ochieng and Fuglesten Biniek, 2022). Among the literature reviewed in this report, Brot et al. (2025) find that MA beneficiaries are less likely to be admitted for avoidable hospitalizations. However, their study also finds modestly lower rates of screenings for breast cancer and blood sugar among diabetics.

Afendulis et al. (2017) also studied the effect of MA enrollment on mortality and found that, relative to TM, MA enrollment in counties with elevated payment rates led to lower mortality. While the mortality effects are statistically and economically significant, the study design does not allow the authors to determine whether the effect reflects better care management by private plans or more generous coverage for MA beneficiaries resulting from higher payment rates in those specific counties.

Abaluck et al. (2021) studied whether mortality rates differ across MA plans and whether these differences are causal rather than driven by patient characteristics and selection. They found significant variation in observed (i.e., raw, unadjusted) MA plan mortality rates; the best plans have mortality rates approximately 23% lower than lower-quality plans. They also found that observed mortality rates are strong predictors of causal mortality rates, namely, certain plans do appear to reduce mortality rates for their enrollees. Lower mortality rates were also found in plans that spent more on care through higher premiums, offered more generous prescription drug coverage, or exhibited higher medical loss ratios. Crucially, the authors determined that an MA plan's Star Ratings—quality scores published by the Centers for Medicare & Medicaid Services that do not incorporate mortality rates—are not correlated with a plan's mortality effects.

Conclusion

There is a vast literature studying the differences in performance of TM and MA plans.⁹ However, since enrollees decide whether to enroll in MA or TM, determining the “causal effect” of MA is challenging. MA, for example, may appear to spend less on enrollees because of genuine differences in care delivery or because it attracts differentially healthy enrollees. In this report, we synthesize

⁹ See, for example, Ochieng and Fuglesten Biniek (2022), a Kaiser Family Foundation report that reviewed findings from 62 studies.

results from a small number of studies that use more advanced empirical techniques enabling the assessment of MA's "causal effect."

Four studies (Afendulis et al., 2017; Brot et al., 2025; Curto et al., 2019; Duggan et al., 2018) show that MA plans lead to lower health care spending than TM. MA plans appear to lower health spending primarily by reducing hospitalization rates relative to TM. These savings are concentrated in HMO plans. There is limited evidence on the impact of MA enrollment on quality, although Afendulis et al. (2017) find that MA enrollment leads to lower mortality.

Notably, even though MA lowers health spending, it raises overall Medicare program spending. Subsidies to MA plans finance more generous benefits (e.g., lower cost sharing and vision and dental coverage), and MA plans tend to attract healthier enrollees due to enrollee preferences and because enrollees, conditional on their true health status, appear more likely to have medical claims coded with comorbidities.

There are substantial differences in mortality across MA plans that reflect differences in plan design; plans that spend more tend to have lower mortality. Notably, plans with lower mortality do not necessarily have higher Star Rating quality scores.

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