AHIP
Guiding Greater Health

Medicare Advantage Leads to Savings for Seniors and Taxpayers

February 2026

Executive Summary

Medicare Advantage (MA) delivers high-value, affordable care for older adults and people with disabilities, resulting in substantial savings compared to traditional fee-for-service (FFS) Medicare.

In contrast to other studies comparing MA and FFS, which focus exclusively on health care expenditures in Medicare, AHIP's analysis considers the **full range of health care expenditures for Medicare beneficiaries,** including payments from public programs—Medicare, Medicaid, Veterans Affairs, and Tricare, as well as any employer-sponsored or privately purchased supplemental coverage. Focusing on all sources of payment provides a more comprehensive picture of health care expenditures for Medicare beneficiaries because 89% of FFS beneficiaries and 41% of MA beneficiaries have at least one other supplemental insurance in addition to Medicare.[1] AHIP's analysis draws on a robust, nationally representative dataset of Medicare beneficiaries from 2021 through 2023, to estimate the overall health care related expenditures, including premiums and out-of-pocket spending, related to medical, dental, vision, and hearing care.

To ensure a fair comparison, the study employed propensity score matching, a statistical tool that creates matched groups of beneficiaries enrolled in MA and FFS who are similar across critical demographic and socioeconomic factors like age, sex, race, ethnicity, income, dual-eligibility status, number of chronic conditions, rural vs. urban geographic setting, and Census region, as well as measures of quality of care like self-reported general health, overall satisfaction with quality of care, access to medical care, and difficulties paying for medical bills. By holding these characteristics constant, the analysis offers a rigorous assessment of whether MA genuinely reduces overall health care costs while maintaining access to high quality care services. Similar to other recent work,[2] AHIP's study concludes that, compared to FFS Medicare, MA delivers higher-value care at lower costs.

Using different methodology than Inovalon's recent work, this analysis validates Inovalon's findings. It provides compelling evidence that Medicare Advantages (MA) delivers superior value compared to traditional fee-for-service (FFS) Medicare, saving nearly $6,300 per beneficiary while improving outcomes and patient experience.

Key Findings:

1. **The MA program delivers considerable savings to the health care system by reducing the cost of care for Medicare beneficiaries.** Annual health care expenditures per MA beneficiary from 2021-2023, on average, were almost $6,300 lower than the per beneficiary costs for their FFS peers.
2. **MA also provides substantial savings to enrollees by reducing their out-of-pocket costs and insurance premiums.** On average, during that same three-year window, MA beneficiaries saved nearly $1,100 a year in out-of-pocket costs and nearly $2,100 in insurance premiums compared to a matched set of similar FFS beneficiaries.
3. **Study results do not indicate that savings in MA arise from reduced benefits or compromised care quality.** In this matched sample, FFS and MA beneficiaries reported similar satisfaction levels regarding overall care, specialist access, and out-of-pocket costs.
4. **For Medicare enrollees from underserved populations and those with complex needs (i.e., veterans, individuals from racial and ethnic minority communities, enrollees with low incomes, individuals residing in rural areas, those without a college degree), MA enhanced access by making care more affordable.** On average, MA enrollees saved approximately $700 to $1,600 in out-of-pocket costs and $1,300-$1,900 in insurance premiums. Overall, total annual health care expenditures for these enrollees were $4,700-$10,000 lower than their peers in traditional FFS Medicare.
5. **The value advantage of MA over FFS perhaps is most evident when it comes to beneficiaries with chronic diseases.** Total annual spending on MA beneficiaries with diabetes, rheumatoid arthritis, and chronic obstructive pulmonary disease, on average, was $5,400-$9,000 less than their FFS counterparts. These MA beneficiaries also spent $800-$1,400 less in annual out-of-pocket costs, and $1,700-$2,100 less on annual insurance premiums.

These findings can help inform policymakers about the potential benefits of supporting and strengthening the MA program—particularly regarding benefit design flexibility, risk adjustment accuracy, and quality measurement.

Introduction

Over 35 million seniors and people with disabilities–that is, more than half of the eligible Medicare population–choose Medicare Advantage (MA).[3] This demonstrates its growing popularity among individuals seeking high quality care and better outcomes at lower costs.[4]

The published literature underscores the value of MA. For example, a JAMA-published study concluded that MA plans lowered health care costs by steering their members towards high-value services and reducing the number of low-value services.[5] Harvard researchers, meanwhile, found that MA plans outperformed Fee-for-Service (FFS) Medicare on all preventive and chronic care clinical quality metrics, including cancer and diabetes screening, and monitoring patients on persistent medications, helping to reduce disease risk by detecting illnesses at an early stage.[6] Furthermore, a 2022 study documented that, compared to FFS beneficiaries, MA enrollees had lower rates of inpatient and emergency department admissions, avoidable emergency department visits, and 30-day readmissions.[7] More recently, **Inovalon's April 2025 study found that, compared to people in MA with similar demographic, clinical, and social risk factors, FFS enrollees experienced:**

- 53% higher inpatient costs
- 52% more emergency department visits
- 40% more hospital admissions
- 126% higher hospital 30-day readmission rates, and
- 71% higher preventable hospitalizations.[8]

These studies provide clear evidence that MA offers higher care quality and exceptional value compared with FFS Medicare. However, they focus primarily on the medical claims paid for by Medicare and do not account for expenses of other types of insurance. In 2022, 89% of FFS beneficiaries and 41% of MA beneficiaries had at least one other supplemental insurance in addition to Medicare.[9]

This study adds to those other studies by considering all health expenditures - including premiums and out-of-pocket expenses paid by enrollees, and amounts from payers – and considering all sources of payments - Medicare, Medicaid, other public insurance programs (e.g. Veteran Affairs, Tricare), and employer sponsored or individually purchased supplemental insurance. In addition to medical claims, the analysis also included dental, vision and hearing claims.

AHIP's analysis focused on three measures of cost of health care:

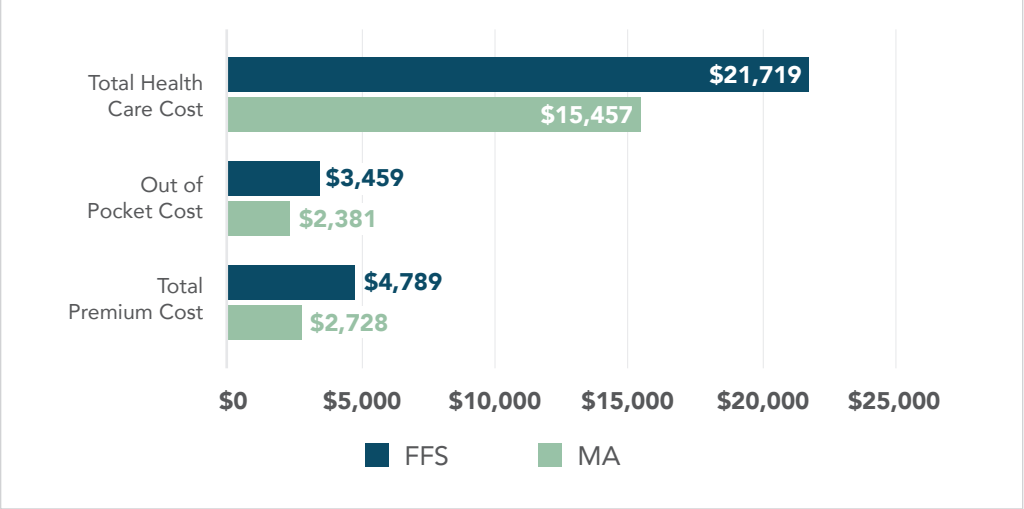
- Total Health Care Cost, which measures the average annual cost of health care related expenses per beneficiary, including out-of-pocket costs, Medicare and Medicaid payments, and any additional public, employer-sponsored or individual supplemental insurance payments
- Out of Pocket Cost, which measures the average annual out-of-pocket cost for health care related expenses per beneficiary
- Total Premium Cost, which measures the average annual expenditure for Parts A, B, C, and D premiums, as well as premiums for any supplemental insurance per beneficiary.

To account for demographic and socioeconomic differences between beneficiaries enrolled in MA and FFS, AHIP researchers employed propensity score matching to create matching cohorts for the analysis. It matched cohorts on age, sex, race and ethnicity, income, full or partial-dual eligibility, number of chronic conditions, urban/rural residence, and Census region. In addition to demographic variables, the analysis matched MA and FFS beneficiaries on self-reported general health, overall satisfaction with quality of care, access to medical care, and difficulties paying for medical bills to ensure comparable quality of care in both programs. AHIP researchers repeated the matching process for beneficiaries from underserved populations and those with diabetes, chronic obstructive pulmonary disease (COPD), and rheumatoid arthritis (RA) to create separate matching cohorts (see Appendix for a detailed methodology).

MA delivers high-quality care at lower costs than FFS

MA delivers considerable savings to the health care system by lowering the cost of health care for Medicare beneficiaries. AHIP's analysis found that, on average, annual health care expenditures per MA beneficiary from 2021-2023 were almost $6,300 lower compared to their FFS peers (Figure 1). In addition, on average, MA beneficiaries saved nearly $1,100 a year in out-of-pocket costs and $2,100 in insurance premiums compared to a matched set of similar FFS beneficiaries.

Figure 1. Average Annual Health Care Expenditures of Beneficiaries Enrolled in MA vs FFS

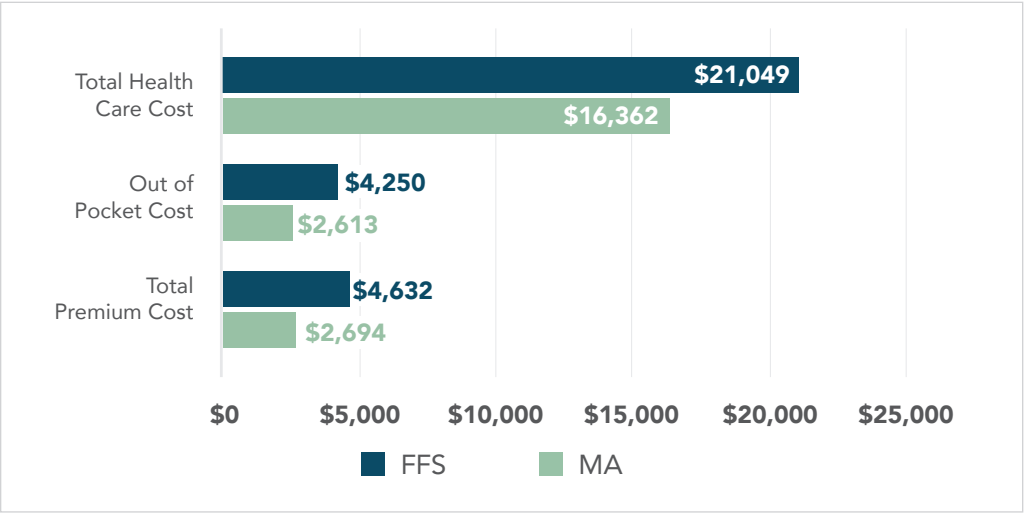


MA lowers cost of care for underserved populations

Veterans. United States veterans comprise a population of men and women who have faced extraordinary health risks while serving their country and who consequently face clinically complex health care needs.[10] When they become age-eligible, although they may still receive services through the Veterans Health Administration (VHA) many veterans enroll in Medicare. Veterans who rely on Medicare experience shorter wait times to receive care and have higher usage of outpatient services compared to those who rely only on VHA services.[11]

Veterans who chose MA, on average, saved $1,600 in out-of-pocket costs and $1,900 in insurance premiums. Total annual health care expenditures for veterans in MA was $4,700 less than veterans enrolled in FFS (Figure 2).

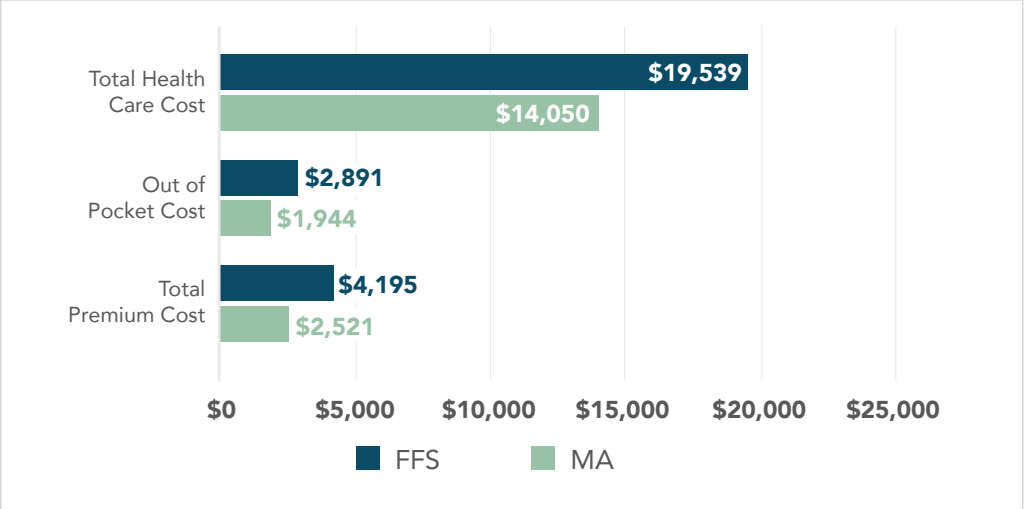
Figure 2. Average Annual Health Care Expenditures of Veterans Enrolled in MA vs FFS



Rural residents. Over 60 million Americans live in rural areas. Compared to their more urban counterparts, rural residents tend to be older, in poorer health, and face greater access challenges.[12] Rural populations also are more likely than urban residents to worry about and struggle to pay their medical bills.[13]

MA helps beneficiaries residing in rural areas afford care by lowering their out-of-pocket expenses. Among rural residents, those enrolled in MA saved on average approximately $900 in out-of-pocket costs and $1,700 in insurance premiums. Total annual health care expenditures for rural MA enrollees was $5,500 less than for their rural peers in FFS (Figure 3).

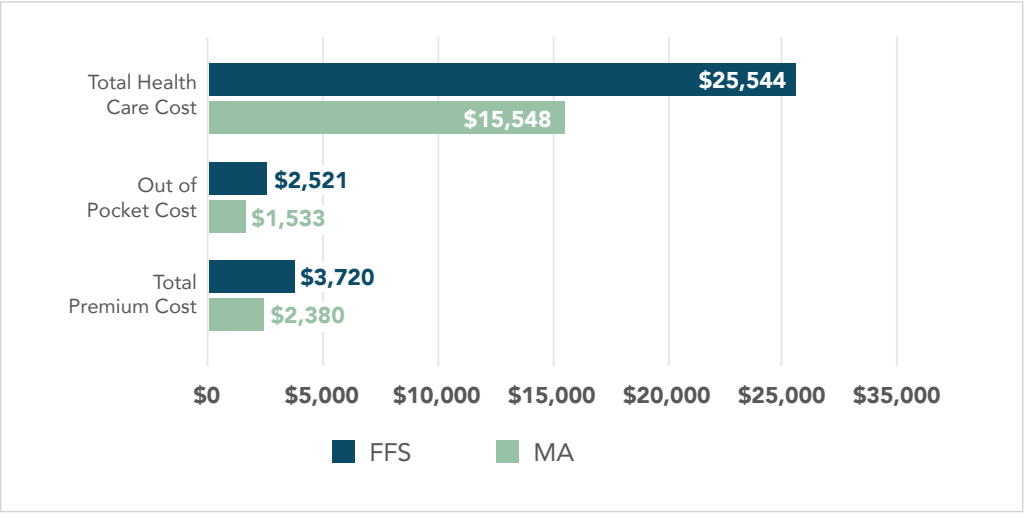
Figure 3. Average Annual Health Care Expenditures of Beneficiaries Residing in Rural Areas Enrolled in MA vs FFS



Enrollees with low incomes. Low-income beneficiaries with incomes below 200% of the federal poverty level (FPL) often have poorer health and higher prevalence of chronic diseases resulting in higher health care utilization and costs.[14] AHIP's research also indicated that this subpopulation experiences higher health care costs compared to the general population. At the same time, most low-income beneficiaries were dually enrolled in Medicaid and Medicare and consequently faced lower cost-sharing and out-of-pocket costs.

Compared with FFS, the average annual health care expenditures were $10,000 lower, the average out-of-pocket costs were almost $1,000 lower, and the average insurance premiums were $1,300 lower for low-income MA enrollees (Figure 4).

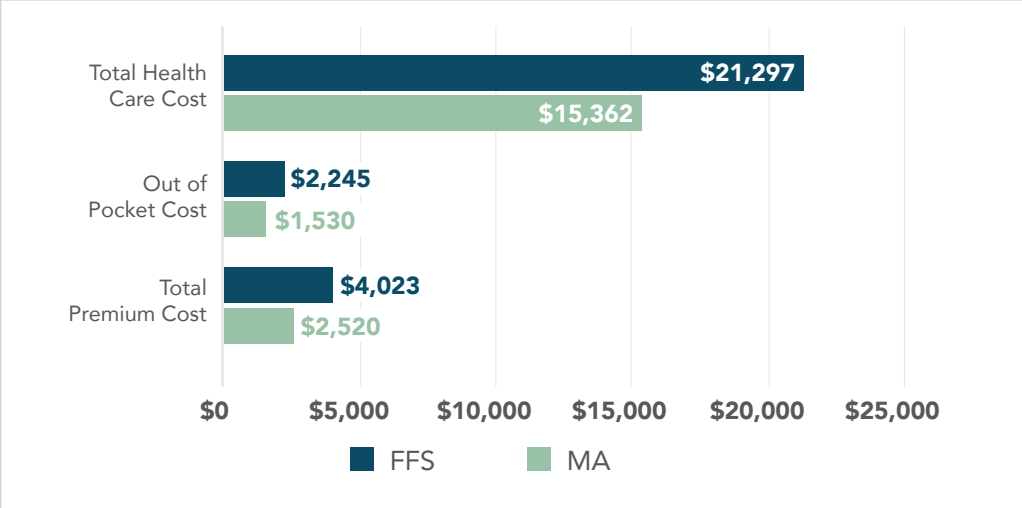
Figure 4. Average Annual Health Care Expenditures of Low Income Beneficiaries (< 200% FPL) Enrolled in MA vs FFS



Enrollees from racial and ethnic minority populations. Beneficiaries from racial and ethnic minority populations disproportionately choose MA over traditional FFS Medicare. In 2022, 63% of African American Medicare beneficiaries and 61% of Hispanic Medicare beneficiaries were enrolled in MA plans.[15]

MA beneficiaries from racial and ethnic minority populations experienced lower health care costs compared to their FFS-enrolled peers. Annual health care expenditures per MA beneficiary were $5,900 lower for racial and ethnic minority beneficiaries (Figures 5). On average, racial and ethnic minority MA beneficiaries saved nearly $700 a year in out-of-pocket costs and $1,500 in insurance premiums.

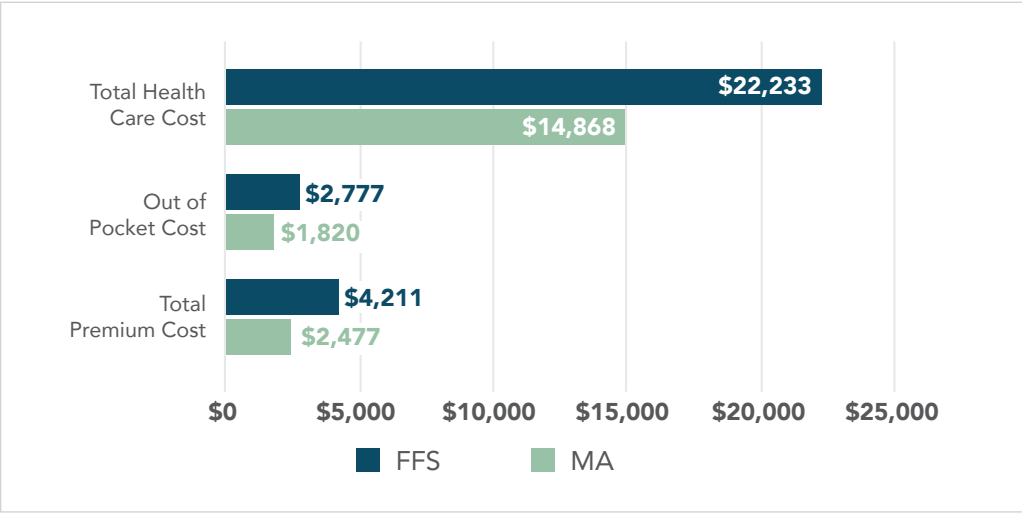
Figure 5. Average Annual Health Care Expenditures of Racial and Ethnic Minority Beneficiaries Enrolled in MA vs FFS



Education levels. Compared to college educated patients, those with high school degree or less are more likely to rate their health as poor, to have multiple comorbidities, to experience functional limitation,[16] and experience higher lifetime risks of heart attacks or other major cardiovascular diseases.[17]

MA helps beneficiaries without college by lowering their out-of-pockets costs and premiums. MA beneficiaries without college degrees, on average, saved approximately $1,000 in out-of-pocket costs and $1,700 in insurance premiums. Their total annual health care expenditures were $7,400 lower than their peers in traditional FFS Medicare (Figure 6).

Figure 6. Average Annual Health Care Expenditures of Beneficiaries Without a College Degree Enrolled in MA vs FFS

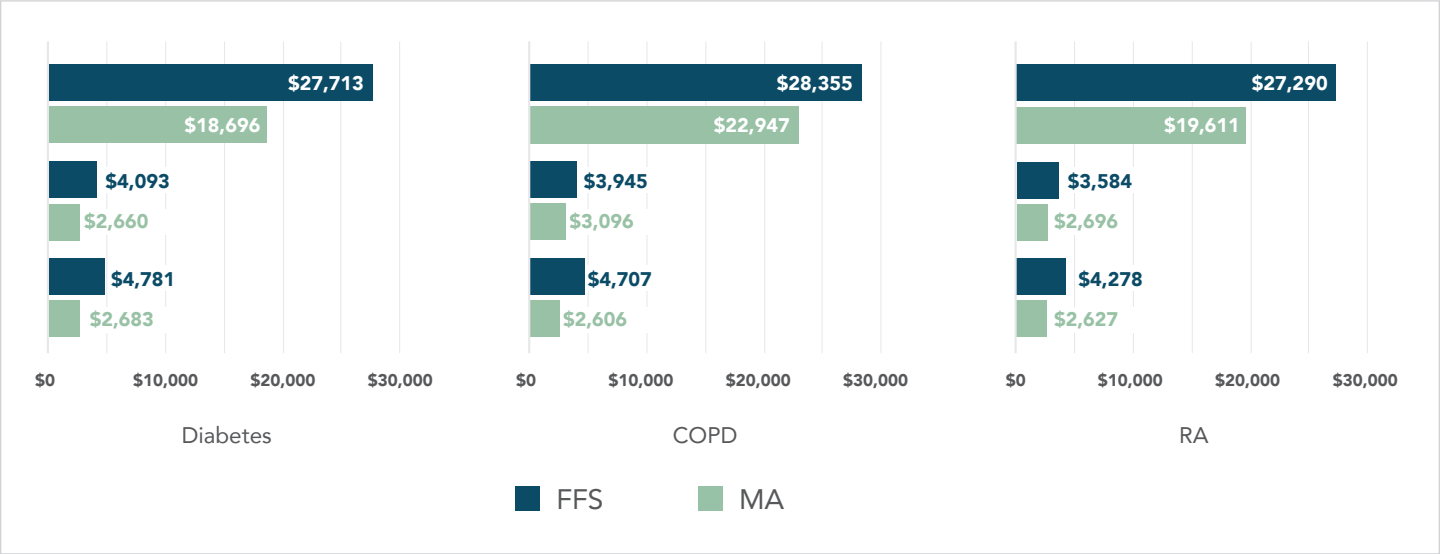


MA lowers cost of care for beneficiaries with chronic diseases

Chronic diseases— such as diabetes, cancer and heart disease—account for most illnesses, disability, and death in the U.S.[18] They require continuous and costly treatment, making them a leading driver of cost; indeed, they are responsible for 90% of the $4.9 trillion spent on health care in U.S. each year.[19] In the sample AHIP studied, total health care expenses for beneficiaries with diabetes, COPD, and RA, on average, were between 20% and 25% higher than those for the FFS Medicare population.

The value advantage of MA over FFS is most evident when it comes to beneficiaries with chronic diseases. Among those beneficiaries with chronic diseases, total annual health care expenditures, on average, were significantly lower for those enrolled in MA rather than traditional FFS Medicare— $9,000 less for those with diabetes, $5,400 less for those with COPD, and $7,700 less for those with RA (Figure 7). Additionally, beneficiaries with chronic diseases enrolled in MA plans, on average, spent significantly less than their counterparts in FFS on out-of-pocket annual costs (i.e., among those with diabetes: $1,400 less; with COPD: $800 less; those with RA: $900 less). They also spent less on average on annual insurance premiums (i.e., among those with diabetes and COPD: $2,100 less; those with RA: $1,700 less).

Figure 7. Average Annual Health Care Expenditures of Beneficiaries with Diabetes, COPD, and RA Enrolled in MA vs FFS



Millions of Americans, including veterans, minorities, lower income and rural residents, and patients with chronic diseases actively choose MA because it offers the highest quality care more efficiently and affordably than FFS. With better wrap-around services and care coordination, MA enrollees are making the best choice for their wallet and their health care needs.

As this study suggests, MA offers significant benefits to Medicare enrollees. These findings, coupled with the growing body of similar research, should help policymakers better understand the potential benefits of the MA program.

Appendix

Methodology

Data for this study came from the 2021-2023 Medicare Current Beneficiary Survey (MCBS), which is a continuous, multi-purpose longitudinal survey of a nationally representative sample of the Medicare population.[20] It contains information on beneficiary demographics; insurance coverage; health care cost, quality, and access; and patient satisfaction. It combines the survey-reported utilization and expenditure data directly from the beneficiary (including out-of-pocket costs, copayments, and services not covered by Medicare) with linked Medicare administrative claims data (FFS claims and MA encounter data). This linkage and reconciliation of survey and claims data allows for a more complete and accurate picture of the total cost burden of all health services used by beneficiaries, including Medicare-covered services and those not covered, offering detailed insights not available from administrative data alone.

AHIP's analysis of MCBS survey data included non-institutionalized beneficiaries who were enrolled in Medicare Part A and Part B for the full year and had Medicare as their primary insurance. It excluded enrollees who: 1) switched midyear between MA and FFS, 2) terminated their coverage during the year, or 3) qualified for Medicare due to end-stage renal disease. AHIP only used information it obtained from administrative data to determine participation in Part A, Part B, MA, and Medicaid. The team marked beneficiaries as enrolled in either FFS or MA based on continuous enrollment in the same program for 12 months.

AHIP's researchers grouped continuous variables (i.e., age, income, income poverty ratios) into discrete categories. They used the Chronic Conditions file to calculate the number of chronic conditions for each beneficiary and dropped from the analysis any MCBS record that contained "unknown" or "refused" data values.

The main outcome variables were the following:

- Total Annual Health Expenditure: all health care related expenses paid on behalf of the beneficiary within a year, including out-of-pocket costs, Medicare and Medicaid payments, and any additional public, employer-sponsored or individual supplemental insurance payments. This included all medical, prescription drug, dental, vision, and hearing expenditures.
- Total Out of Pocket Expenditure: all out-of-pocket expenses paid by the beneficiary for medical, prescription drug, dental, vision, and hearing benefits.
- Total Premium Cost: sum of all premiums paid, either by the beneficiary or a third party on their behalf, for Parts A, B, C, and D plans, as well as any additional public, employer-sponsored or individual supplemental insurance. Due to availability of premium data, this variable is a CMS estimate.

AHIP adjusted all outcome variables for inflation to 2023 dollars using Consumer Price Index (CPI) data, published by the U.S. Bureau of Labor Statistics (BLS).[21]

AHIP also employed propensity score matching to construct matching cohorts of FFS Medicare and MA enrollees to account for socioeconomic, demographic, and health status differences between the populations enrolled in the two programs. Compared to FFS Medicare, AHIP documented that MA enrollees are more urban, racially diverse, lower income, and more likely to have chronic disease diagnoses compared with FFS beneficiaries.[22] AHIP assigned the cohorts in a one-to-one match using logistic regression based on the following demographic and socio-economic variables: age, sex, race and ethnicity, income, full or partial-dual eligibility, number of chronic conditions, urban/rural residence, Census region, self-reported general health, overall satisfaction with quality of care, access to medical care, and difficulties paying for medical bills. This process resulted in a final study cohort of 7,309 matched pairs of enrollees.

After weighting, all cohorts exhibited similar demographic characteristics (Table A1). AHIP tested the balance of covariates before and after matching using standardized differences. The cohorts appeared to be balanced after propensity score matching (Figure A1).

For the analysis of health care costs of the underserved populations, AHIP repeated propensity score matching for those populations. This resulted in a study cohort of 1,121 matched pairs of veteran beneficiaries, a cohort of 1,419 matched pairs of beneficiaries who were rural residents, a cohort of 2,527 matched pairs of low -income beneficiaries, a cohort of 1,139 matched pairs of beneficiaries from racial and ethnic minority populations, and a cohort of 2,861 matched pairs of beneficiaries without a college degree.

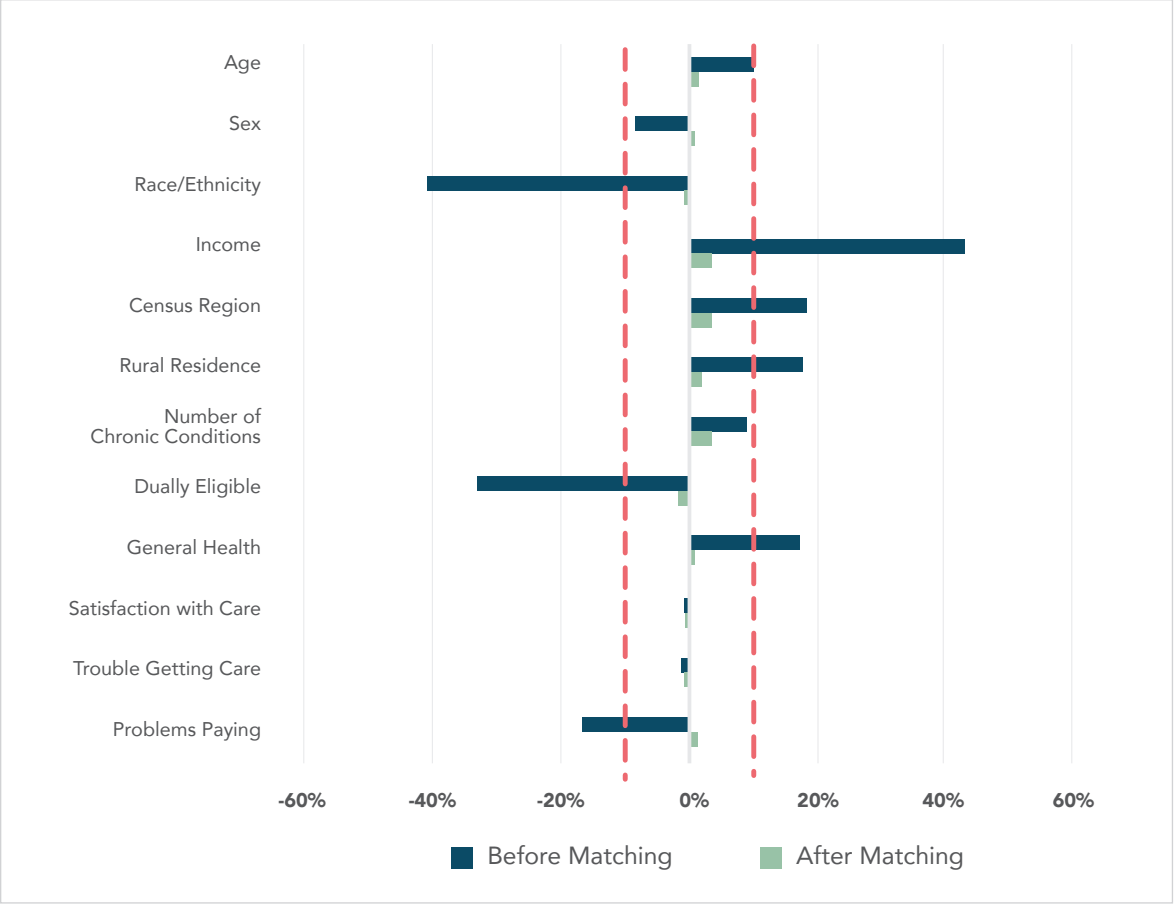
For the analysis of chronic disease health care costs, AHIP repeated propensity score matching with only the beneficiaries who had the given chronic disease. This resulted in a study cohort of 2,147 matched pairs of beneficiaries with diabetes, a cohort of 1,332 matched pairs of beneficiaries with COPD, and a cohort of 1,086 matched pairs of beneficiaries with RA.

Table A1. Characteristics of FFS and MA Cohorts Before and After Matching

Variables	Before Matching		After Matching	
	FFS	MA	FFS	MA
Dually Eligible	14%	28%	17%	18%
# of Chronic Conditions	1.51	1.61	1.53	1.51
Age				
Less Than 65	13%	16%	14%	15%
65 To <75	34%	33%	33%	33%
75 To <85	36%	34%	36%	36%
Over 85	17%	16%	17%	17%
Sex				
Female	53%	57%	55%	55%
Male	47%	43%	45%	45%
Race/Ethnicity				
White	84%	69%	82%	82%
Black	6%	13%	7%	7%
Hispanic	5%	14%	6%	7%
Asian	1%	1%	1%	1%
Other	4%	3%	4%	3%
Residence				
Rural	26%	18%	22%	21%
Urban	74%	82%	78%	79%
Income				
Less Than $20K	17%	30%	20%	22%
$20K To <$30K	11%	17%	13%	13%
$30K To <$50K	17%	18%	19%	20%
$50K To <$80K	20%	15%	20%	19%
More Than $80K	35%	20%	27%	27%
Federal Poverty Level (FPL)				
<= 100% FPL	11%	20%	13%	13%
>100% To 200% FPL	19%	30%	22%	24%
More Than 200% FPL	70%	50%	65%	63%
Census Region				
New England	4%	3%	4%	4%
Middle Atlantic	14%	13%	13%	13%
East North Central	15%	17%	17%	17%
West North Central	7%	5%	7%	6%

Variables	Before Matching		After Matching	
	FFS	MA	FFS	MA
South Atlantic	21%	24%	21%	22%
East South Central	8%	8%	8%	8%
West South Central	10%	9%	10%	9%
Mountain	12%	8%	9%	9%
Pacific	10%	13%	12%	12%
Beneficiaries' General Health				
Excellent or Very Good	55%	48%	53%	53%
Good	15%	21%	16%	17%
Fair or Poor	30%	31%	30%	30%
Satisfaction with care				
Satisfied with overall care quality	96%	96%	96%	96%
No trouble accessing care	93%	93%	94%	93%
Difficulties paying for medical bills	3%	7%	4%	4%

Figure A1. Standardized Differences Before and After Matching



Note: A standardized difference with an absolute value of less than 10% is generally regarded as negligible difference between the treatment and control groups.

Endnotes

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