

The Value of Medicare Advantage versus Fee-for-Service

Prepared for AHIP

November 12, 2025

Prepared by:
Wakely Consulting Group, LLC

Tim Courtney, FSA, MAAA
Principal and Senior Consulting Actuary

Executive Summary

In Chapter 11 of the MedPAC March 2025 Report to the Congress: Medicare Payment Policy,¹ MedPAC estimates that Medicare Advantage (MA) payments are 100% of FFS spending, before accounting for the effects of coding intensity and favorable selection. This finding is similar to estimates from recent prior years' reports; MedPAC's March 2024 report estimated MA payments are 101% of FFS spending, for example.

To assist AHIP in assessing the validity of MedPAC's comparative cost estimates for MA and FFS, Wakely Consulting Group, LLC an HMA company (Wakely) evaluated how accounting for the following specific aspects of the FFS and MA programs would affect results:

- The impact of applying the MA mandatory maximum out-of-pocket (MOOP) limit to FFS; and
- The impact of calculating MA benchmarks based only on beneficiaries eligible for both Medicare Parts A and B (i.e., same eligibility criterion for MA enrollment).

This report does not evaluate favorable selection or coding intensity.

In summary, our findings for these analyses are as follows:

1. If the traditional FFS program were required to implement a maximum out-of-pocket (MOOP) provision equivalent to the mandatory amount required under Medicare Advantage, the net liability to CMS would increase by 3.5% nationally. The impact of a MOOP provision generally increases as the expenses of a given classification of beneficiaries change, although not in all cases. In particular, we estimate that FFS costs for beneficiaries with ESRD status would increase by 7.6% with a \$8,300 MOOP in place.
2. Costs associated with non-ESRD FFS beneficiaries who are enrolled in both Parts A and B are about 6.1% higher than the total non-ESRD FFS population. If CMS used these costs to calculate Part C benchmarks, most Part C benchmark rates by county would increase by a similar percentage.

In its analysis of the impact of basing benchmarks on only those with both Parts A and B instead of counting beneficiaries with either Part A or B, MedPAC says "...our analysis of historical data shows that the projections have not systematically impacted our base comparison of MA spending with FFS payments." In the 2025 report, MedPAC references their analysis of this issue in their March 2023 Report to the Congress.² The analysis in the March 2023 report notes the following: "we use historical claims data to (1) calculate the average risk-standardized Part A and Part B spending separately for beneficiaries with

¹ <https://www.medpac.gov/document/march-2025-report-to-the-congress-medicare-payment-policy/>

² <https://www.medpac.gov/document/march-2023-report-to-the-congress-medicare-payment-policy/>

Part A and Part B coverage, Part A-only coverage, and Part B-only coverage by county, and to (2) make adjustments for beneficiaries with Medicare as a secondary payer.”

Wakely continues to maintain that adjusting for risk scores (i.e. the MedPAC reference to using risk-standardized spending) is not appropriate for this comparison and received confirmation from the CMS Office of the Actuary that no such risk adjustment or standardization occurs in the calculation of the United States per Capita Cost (USPCC) estimate. The Wakely analysis of FFS claims includes claims where Medicare is the secondary payer.

Table 1 summarizes the results of these analyses. These adjustments should be considered when comparing MA payments to FFS costs.

Table 1 - FFS Cost Estimates Under Alternative Conditions

Condition	Cost Difference vs. Current FFS
MOOP Applies to FFS	3.5%
Benchmarks use only beneficiaries with A and B Eligibility	6.1%
Combined effect of MOOP and Benchmark Change (1.035 x 1.061) -1	9.8%

Analysis and Results

Impact of a Maximum Out-of-Pocket Provision in FFS

Currently, the traditional FFS Medicare benefit does not include a provision to cap beneficiary out-of-pocket expenses. CMS requires all Medicare Advantage Organizations (MAOs) to include a MOOP limit for medical (i.e., Part C) services. Historically, CMS has defined a “mandatory” MOOP amount and a lower, “voluntary” amount. Plans offering a lower, voluntary MOOP were allowed increased flexibility with respect to cost sharing provisions for certain key services.

While MAOs must offer a MOOP provision at the mandatory level or less, the increased costs created by this requirement are classified as a Mandatory Supplemental benefit in the bid pricing tool (BPT).

In order to better understand how traditional Medicare FFS costs compare with those under Medicare Advantage, we analyzed how traditional FFS costs would change if the mandatory MOOP provision was applied.

Specifically, we looked at 2023 FFS costs from the 100% claim files and re-priced claims by beneficiary based on an assumption that out-of-pocket expenses could be no greater than \$8,300. The use of a \$8,300 MOOP is based on the mandatory MOOP amount in effect for MAOs in contract year 2023.

Based on our analysis, we found that 2023 FFS costs would be 3.5% higher if a MOOP of \$8,300 was implemented under traditional FFS.

We further analyzed how costs would increase if a MOOP were in place according to different status markers such as dual, ESRD, institutionalized status and age group.

Table 2 summarizes the results of the different analyses.

Table 2 – Impact of \$8,300 MOOP on 2023 FFS Costs by Population Type

Population Group	MOOP Impact
Total FFS	3.5%
Total Dual	4.3%
Total Non-Dual	3.2%
Total non-ESRD	3.2%
Total ESRD	7.6%
<65	4.9%
65-69	3.4%
70-74	3.3%
75-79	3.3%
80-84	3.2%
85+	3.0%
Institutionalized	7.3%
Non-Institutionalized	2.9%

While MOOP impact generally rises with higher total spending, older age groups show smaller increases despite higher average costs. This reflects a larger share of Part A (lower coinsurance) spending among older beneficiaries, compared with higher Part B coinsurance (typically 20%) among younger groups.

Notably, the impact of MOOP is much higher than average for ESRD and Institutionalized beneficiaries. For ESRD beneficiaries, many of whom require regular dialysis treatment at 20% coinsurance, a \$8,300 MOOP would increase costs 7.6% for the Medicare program. This finding is particularly important when comparing the programs, because it is easy to ignore ESRD beneficiaries since MA bids are submitted on a non-ESRD basis. Plans are still required to make coverage available to ESRD members (members could proactively join MA plans beginning in

2021), so liabilities associated with these members impact MA plans. Any comparison of the MA program and FFS should include consideration for ESRD beneficiaries.

It is also worth noting that there are payment differences for ESRD vs. non-ESRD beneficiaries. Because there is no bid for ESRD beneficiaries, there is no rebate paid for these members, nor is there any quality bonus adjustment for qualifying plans. Instead, MA organizations are paid the full risk adjusted benchmark and are required to fund the MOOP along with any supplemental benefits offered by the plan.

Like the ESRD population, we found that the impact of a MOOP for institutionalized beneficiaries would also be well above the overall average. For these beneficiaries, whose medical needs are associated with high acute care costs, a \$8,300 MOOP would result in 7.3% higher FFS costs.

It is important to note that our analysis did not consider potential beneficiary behavioral changes as a result of a MOOP. It is likely that utilization of services would increase for beneficiaries after a MOOP was reached, so our estimates of MOOP impact in Table 2 should be viewed as a minimum amount.

Benchmark Development – Limiting to Beneficiaries Enrolled in Part A and Part B

Although MA beneficiaries must have both Part A and Part B, current FFS benchmarks reflect spending for all FFS beneficiaries, including those with only one part. In its March 2017 report titled “Report to the Congress: Medicare Payment Policy,” MedPAC recommended that CMS calculate benchmarks using only the FFS spending of beneficiaries enrolled in both Part A and Part B.

In the most recent reports from March 2024 and March 2025, MedPAC referenced its prior March 2022 analysis, which found that risk-adjusted FFS spending for beneficiaries enrolled in both Part A and Part B is about 1 percent higher than for all FFS enrollees. The more recent reports confirm that this finding remains consistent.

While we agree with the recommendation to develop benchmarks using only the population eligible for MA, we believe the appropriate measure of the impact of changing the benchmark calculation is to only look at the cost difference. The risk score adjustment is not needed since it is a nation-wide calculation, and risk scores calculated for beneficiaries with Part A only or Part B only coverage are not comparable to scores for those enrolled in both Part A and B.

For purposes of calculating the benchmark, FFS spending is developed by taking the sum of Part A per capita spending and Part B per capita spending. To support the estimated 1% difference in costs, MedPAC conducted the following analysis:

1. **Part A Spending Comparison:** MedPAC compared beneficiaries enrolled in both Part A and Part B to those enrolled in Part A only. Among those with both A and B, Part A spending was 8% higher and risk scores were 6% higher than for Part A-only enrollees. After adjusting for risk, costs were 2% higher for those with both Part A and Part B.

2. Part B spending comparison: Similar to Part A, MedPAC compared Part B costs and risk scores for beneficiaries enrolled in Part A and Part B vs. beneficiaries enrolled only in Part B. MedPAC found no difference in spend or risk scores for the two groups.
3. Blended result: The result of these two calculations was that beneficiaries enrolled in both Part A and B experienced risk-adjusted costs about 1% higher than the total FFS population. Note, we are unclear how MedPAC blended the two impacts to arrive at the 1%.

It is not necessary to adjust for a difference in risk scores because the CMS HCC risk model is developed using only beneficiaries enrolled in both Part A and Part B,³ and thus already reflects the higher average risk of those with both Part A and B. Therefore, it would be inappropriate to use risk scores produced by the model for beneficiaries who are only enrolled in Part A or only Part B since diagnoses will only be based on a subset of claims as compared with beneficiaries enrolled in both A and B. In addition, no risk adjustment is needed because the entire FFS population eligible for Medicare Advantage (i.e., those with both Part A and B eligibility) will be used as a cost basis and is therefore 1.00 definitionally.

MedPAC has commented on the issue of risk adjustment and USPPC cost estimates as they relate to beneficiaries eligible for Part A only or for Part B only. More specifically, they stated *“because enrollees with only Medicare Part A or only Medicare Part B are healthier than beneficiaries with both Medicare Part A and Part B, CMS makes this calculation using risk-standardized spending estimates, which account for the differences in health status”*.

Wakely submitted a question in June 2025 to the Office of the Actuary on this issue. Below is the question and response we received:

Question: We are not aware of any risk adjustment that occurs in the benchmark calculation (other than in the average geographic adjustment (AGA) calculation). Can you confirm whether there is any step in calculation of the USPPC where there is an adjustment for risk standardization? If so, how does CMS calculate a Part A or Part B only score, given the risk adjustment model is calibrated to Part A and Part B only members?

Response: That is correct, the tabulation of the USPPCs includes no adjustment for risk standardization.

Wakely independently calculated the cost difference with the 2023 100% FFS data. We found that Part A spending was 15.4% higher for beneficiaries that were enrolled in Part A and B compared to those only enrolled in Part A. This compares to the 8% in MedPAC’s older study. We believe one cause of the cost differential increasing is that MA penetration has been increasing over time, leaving fewer beneficiaries in FFS. Since beneficiaries must be eligible for both Part A and B, those with Part A only enrollment comprise a greater percentage of the total

³ <https://www.cms.gov/files/document/report-congress-risk-adjustment-medicare-advantage-december-2021.pdf>, page 9.

remaining in FFS. Using 2023 FFS data, about 16% of beneficiaries with Part A coverage are enrolled with Part A only, and without Part B.

For Part B spend, we also found there was no material difference between the two populations. Combining the impact based on overall cost, the total non-ESRD FFS spend is 6.1% higher for those enrolled in Part A and Part B vs those enrolled in Part A and/or Part B.

Table 3 shows 2023 FFS costs PMPM by Part A and B eligibility type.

Table 3 – 2023 FFS Costs by Eligibility

Eligibility	Part A	Part B	Total
A and B	\$432.65	\$571.98	\$1,004.63
A Only	\$73.01		\$73.01
B Only		\$495.80	\$495.80
All Beneficiaries	\$375.04	\$572.04	\$947.08
A and B/All	15.4%	0.0%	6.1%

Data and Methodology

The analyses in this report are based on 2023 FFS costs and membership from the 100% claims and enrollment files. We used logic consistent with CMS's definition of dual, institutional and ESRD members. Age was calculated as of January 2023. Our analysis excludes Hospice members.

Members may switch dual, institutional, or ESRD status throughout the year. For purposes of classifying beneficiaries into appropriate categories, we took the most recent status and assumed it applied for the entire year.

The impact of the MOOP was calculated at a member level. The revised paid amounts equal the original allowed amount minus the minimum of the member's annual cost share and \$8,300. Our analysis is limited to members who were enrolled in both Parts A and Part B.

MA membership and risk score information was sourced from the Virtual Research Data Center (VRDC). This data represents nationwide 2023 MA beneficiaries.

The benchmark analysis comparing FFS spending for beneficiaries enrolled in Part A and Part B vs Part A and/or Part B relied on the 2023 100% FFS cost and membership files. We separately calculated the Part A PMPM and the Part B PMPM consistent with how CMS calculates Medicare Advantage benchmarks.

Limitations

All model assumptions and resulting estimates included in this report involve inherent uncertainty. Users of the results should be qualified to use it and understand the results and inherent uncertainty. Actual results may vary, potentially materially, from our estimates. Wakely based this analysis primarily on CMS published data, which are subject to revision over time. It is the responsibility of AHIP to review the assumptions carefully and notify Wakely of any potential concerns.

Responsible Actuaries

I, Tim Courtney am the actuary responsible for this communication. We are Members of the American Academy of Actuaries. I am a Fellow in the Society of Actuaries. I meet the Qualification Standards of the American Academy of Actuaries to issue this report.

Conflict of Interest

Wakely provides actuarial services to a variety of clients throughout the health industry. Our clients include commercial, Medicare, and Medicaid health plans, the federal government and state governments, medical providers, and other entities that operate in the domestic and international health insurance markets. Wakely has implemented various internal practices to reduce or eliminate conflict of interest risk in serving our various clients. Except as noted here, Tim Courtney is financially independent and free from conflict concerning all matters related to performing the actuarial services underlying this analysis. In addition, Wakely is organizationally and financially independent to AHIP.

Subsequent Events

There are no known relevant events subsequent to the date of information received that would impact the results of this report.

Contents of Actuarial Report

This document and the supporting exhibits/files constitute the entirety of the actuarial report and supersede any previous communications on the project.