



# Medicare Advantage: How it Works, How it's Financed, and What's Next?

Center Forward Basics

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## Overview

Medicare Advantage, also known as Medicare Part C, is a core part of the Medicare program in which the federal government partners with private health insurance companies to provide benefits to those eligible for Medicare. In recent years, enrollment in the program has increased significantly, with over half of Medicare beneficiaries (about 54%) choosing Medicare Advantage over **"traditional" Medicare** in 2025.

Medicare Advantage was created with the goal of introducing competition and choice into the Medicare program, with the anticipated benefit of reducing costs and improving benefits for the enrollee. Medicare Advantage plans often offer additional benefits compared to traditional Medicare, such as lower **cost sharing** (often eliminating the need for a **Medigap** plan), dental, vision, and hearing coverage, prescription drugs, over-the-counter medications, transportation, and wellness programs.

## Legislative Framework

Private plans have been an option in Medicare since the 1970s after the passage of the [Social Security Amendments of 1972](#), but enrollment in private plans remained relatively low through the 1990s. The [Balanced Budget Act of 1997](#) established the Medicare+Choice program (Medicare Part C), laying the foundation for Medicare Advantage. The legislation introduced fixed payments to private plans and began adjusting payments based on how sick or healthy enrollees are.

The 2000s brought further changes with the [Medicare Modernization Act](#), which aimed to modernize Medicare and expand private plan participation in part by increasing and restructuring plan benchmarks. After a period of sustained growth in enrollment, the [Affordable Care Act \(ACA\)](#), enacted in 2010, reduced payments to Medicare Advantage plans to better align spending with traditional Medicare. The ACA also introduced quality-based bonuses to incentivize performance, updated risk adjustment, and adjusted for geographic variation. These changes gave CMS broad authority to make year over year changes to the program.

The program experienced rapid growth after 2010, rising from around 25% market share to around 54% over the next decade and a half.

## Financing the Medicare Advantage Program

The federal government pays Medicare Advantage plans a fixed amount per beneficiary per year under a risk-based contract, also known as capitated

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Center Forward brings together members of Congress, not-for-profits, academic experts, trade associations, corporations and unions to find common ground. Our mission: to give centrist allies the information they need to craft common sense solutions.

## Key Definitions:

- **Traditional Medicare:** Medicare is a health insurance program for people aged 65 and older, people under 65 with certain disabilities, and people of all ages with End-Stage Renal Disease (ESRD). Traditional Medicare may also be known as Medicare Fee-For-Service.
- **Cost Sharing:** The share of costs covered by your insurance that you pay out of your own pocket. This term generally includes deductibles, coinsurance, and copayments, or similar charges, but it doesn't include premiums, balance billing amounts for non-network providers, or the cost of non-covered services.
- **Medigap:** Medicare Supplement Insurance (Medigap) is extra insurance you can buy from a private health insurance company to help pay your share of out-of-pocket costs in traditional Medicare. Generally, you must have traditional Medicare to buy a Medigap policy.
- **Fee-For-Service:** A method in which doctors and other health

payments. In return for government payments, each plan agrees to assume the full risk of providing all care for that enrollee. This arrangement differs from traditional Medicare, which operates under a **fee-for-service model**. The rate the government pays to Medicare Advantage plans is determined by a series of **benchmarks, bids, and quality incentives**. Health insurance companies bid to enroll Medicare beneficiaries in their Medicare Advantage plans. That bid is based on companies' assessments of the costs of providing **Part A** and **Part B** services to the average beneficiary.

If a plan's bid is below the local benchmark, the difference between the bid and the benchmark is shared between the plan and the federal government. Plans receive a percentage of this difference, also known as a rebate, based on their quality rating, while the remaining portion is retained by Medicare as program savings. Plans must use these funds to lower premiums, reduce cost-sharing, or offer additional benefits. 98% or more individual MA plans offer vision, dental, and hearing benefits. Rebate dollars can also be used to pay for administrative expenses and expenses associated with providing additional benefits.

CMS uses quality ratings to measure all Medicare Advantage plans. The rating runs on a 1-5 star system. Depending on plan type, CMS will evaluate 2027 Medicare Advantage contracts using roughly 30–45 quality measures. This reflects the removal of 11 administrative and topped-out measures finalized in the 2027 Final Rule. A benchmark may be raised and the percentage of the rebate a plan will be able to receive will change according to the star rating, so plans are incentivized to score well. CMS estimates approximately 64% of Medicare Advantage beneficiaries are currently in contracts that will have four or more stars in 2026.

Both the rebate and the bid amount are “risk adjusted” to account for beneficiaries' health status. Payment is determined in part by each beneficiary's risk score, which reflects the expected cost of each enrollee relative to the cost of the average Medicare beneficiary. Risk adjustment is intended to eliminate the incentive for Medicare Advantage plans to select the healthiest, lowest-cost beneficiaries and avoid enrolling the sickest, highest-cost beneficiaries. It is also designed to ensure plans are appropriately compensated for enrolling individuals with greater health needs. Some analysts and oversight bodies have raised concerns that certain plans may engage in practices that exaggerate the poor health status of beneficiaries for additional adjustments to the compensation, referred to as “upcoding”. CMS applies a statutory minimum coding intensity adjustment (currently 5.9%) to account for differences between traditional Medicare and Medicare Advantage, and conducts audits through the Risk Adjustment Data Validation (RADV) program, which has been expanded in recent years.

Each year, the Centers for Medicare & Medicaid Services (CMS) releases a Medicare Advantage **payment rate adjustment**. In the final Calendar Year 2027 Rate Announcement, CMS projected that Medicare Advantage plans will receive an average payment increase of 2.48%, significantly lower than the 2026 finalized rate of 5.06%. This increase was higher than the earlier proposed update of 0.09%, however, some stakeholders note that the final rate update may

care providers are paid for each service performed. Examples of services include tests and office visits.

- **Benchmarks:** The maximum payment from the government to a Medicare Advantage plan set in statute as a percentage of traditional Medicare spending in a given county, ranging from 95 percent to 115 percent. For counties with relatively low traditional spending, benchmarks are set higher than average spending for traditional Medicare. For counties with relatively high spending, benchmarks are set slightly lower than traditional Medicare
- **Bids:** Under Medicare advantage a bid is the plan's estimated cost of providing Medicare-covered services.
- **Quality Incentives:** In Medicare Advantage, quality incentives offer increased payments for plans with higher quality care. Plans with a high star rating indicate higher quality and receive a larger payment from the federal government.
- **Medicare Part A:** Hospital insurance.
- **Medicare Part B:** Outpatient medical insurance.
- **Payment Rate Adjustment:** Medicare Advantage (MA) payment rate adjustment is the annual process where the Centers for Medicare & Medicaid Services (CMS) modifies the capitation payments made to health insurance companies under Medicare Advantage. It uses a risk adjustment model to set accurate, predictable, and actuarially sound payments while mitigating unnecessary cost growth.
- **Prior Authorization:** Approval from a health insurance company

still lag behind underlying medical cost and utilization trends, which could continue to place pressure on plan benefit offerings and premiums in future years.

## Look Ahead

Medicare Advantage continues to evolve, with recent signs of plan consolidation and benefit adjustments following changes in payment policy. In 2026, the average number of Medicare Advantage plans available to a Medicare enrollee was 32, slightly below the 2024 peak of 36. Some organizations have exited certain markets or reduced plan offerings, creating isolated markets. Approximately 2.6 million individuals experienced plan exits or benefit reductions by the end of 2025; however, nearly all (about 99%) had at least one alternative plan available in 2026, and more than two-thirds were able to transition to another plan offered by the same insurer. In this context, recent policy discussions have largely focused on **prior authorization** and program costs relative to traditional Medicare.

Medicare Advantage plans use prior authorization to approve certain higher-cost services, including inpatient hospital stays, skilled nursing facility care, and some specialty treatments. Prior authorization is intended to be used as a tool to promote appropriate, evidence-based care and manage costs. While most requests are approved, some stakeholders have raised concerns about administrative burden, delays in care, and outside sources other than a medical professional holding approval authority, prompting ongoing regulatory and industry efforts to streamline processes. CMS has also introduced recent initiatives to improve prior authorization in partnership with Medicare Advantage plans, including requirements for faster decision timelines, greater transparency, and expanded use of electronic prior authorization to reduce burden and improve access.

Estimates of Medicare Advantage (MA) spending relative to traditional Medicare vary depending on methodology. The Medicare Payment Advisory Commission (MedPAC) estimates that the U.S. government spends approximately 14% more on Medicare Advantage beneficiaries than it would in traditional Medicare. This difference translates to a projected \$76 billion in additional spending in 2026. The Commission acknowledges that a portion of these increased payments to Medicare Advantage plans is used to provide more generous supplemental benefits and better financial protection for Medicare Advantage beneficiaries, in addition to coding practices.

While this represents a substantial difference, some analyses have found that when accounting for differences in program design, such as the inclusion of an annual maximum **out-of-pocket limit** in Medicare Advantage, overall costs may be comparable to or lower than traditional Medicare on a beneficiary-equivalent basis. A portion of payments to Medicare Advantage plans is also used to provide enhanced benefits and reduce cost sharing for beneficiaries, which are not typically covered under traditional Medicare. As a result, comparisons of spending between the two programs depend heavily on how benefits, risk, and enrollee protections are accounted for.

With well over 50% of eligible seniors enrolling in MA, continuing to evaluate and improve the program will likely remain a top priority in Congress for years to come. The program offers an alternative to traditional Medicare for many Medicare-eligible individuals, but concerns about healthcare costs, long-term sustainability, and access to care may complicate further discussions.

that may be required before you get a service or fill a prescription in order for the service or prescription to be covered by your plan.

- **Out-Of-Pocket Limit:** The most you have to pay for covered services in a plan year. After you spend this amount on deductibles, copayments, and coinsurance for in-network care and services, your health insurance plan pays 100% of the costs of covered benefits.

## Link to Additional Resources

- AHA: [Skyrocketing Hospital Administrative Costs, Burdensome Commercial Insurer Policies Impacting Patient Care](#)
- AHIP: [Medicare Advantage Demographics](#)
- AHIP: [Medicare Advantage Leads to Savings for Seniors and Taxpayers](#)
- AHIP: [Fewer Options, Higher Costs Due to Consecutive Years of Inadequate Rates](#)
- AHIP: [Market Signals Indicate Long-Term Threats to Affordability, Plan Choices for Seniors](#)
- AHIP: [Medicare Advantage Delivers Higher-Quality Care at a Lower Cost than Fee-for-Service Medicare](#)
- AHIP: [New Analysis Shows Medicare Advantage Outperforms Fee-for-Service Medicare in Improving Patient Outcomes, Delivering Care at a Lower Cost](#)
- AHIP: [Prior Authorization: Selectively Used & Evidence-Based](#)
- AHIP: [The False Tell on MLR “Gaming”](#)
- Better Medicare Alliance: [Analysis of the 2026 Medicare Advantage Plan Landscape](#)
- Better Medicare Alliance: [Medicare Beneficiary Spending Brief 2025](#)
- Better Medicare Alliance: [New Battleground Polling Shows Seniors Strongly Oppose Medicare Advantage Cuts, Underscoring Broad Concern Over No UPCODE Act](#)
- Better Medicare Alliance: [State of Medicare Advantage 2025](#)
- CMS: [Medicare Advantage Part D Star Ratings](#)
- CMS: [Star Ratings Fact Sheet](#)
- Center for Medicare Advocacy: [Overpayments to Medicare Advantage in 2026: \\$76 Billion](#)
- Commonwealth Fund: [How Risk Adjustment Affects Payment For Medicare Advantage Plans](#)
- Commonwealth Fund: [Medicare Advantage: A Policy Primer](#)
- Commonwealth Fund: [What Do Medicare Beneficiaries Value About Their Coverage?](#)
- Federation of American Hospitals: [FAH letter of support MA Prompt Pay Act 2025](#)
- Federation of American Hospitals: [STATEMENT of the Federation of American Hospitals to the U.S. House Committee on Ways and Means “Hearing with Health Insurance CEOs”](#)
- Federation of American Hospitals: [STATEMENT of the Federation of American Hospitals to the U.S. House of Representatives Committee on Ways and Means Re: “Medicare Advantage: Past Lessons, Present Insights, Future Opportunities”](#)
- Health Affairs: [How Insurers That Own Providers Can Game The Medical Loss Ratio Rules](#)
- Health Affairs: [Medicare Advantage At 25 Years: Reclaiming A Public Purpose](#)
- Health Affairs: [Inside The Meteoric Rise Of Medicare Advantage](#)
- HealthScape Advisors| [Medicare Advantage 2026: Enrollment depicts industry at a crossroads](#)
- HHS Office of the Inspector General: [Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care,](#)
- Inovalon: [Medicare Advantage vs. Traditional Fee-for-Service Medicare: Different Populations, Different Outcomes](#)
- KFF: [Medicare Advantage 2026 Spotlight: A First Look at Plan Premiums and Benefits](#)
- KFF: [Medicare Advantage Insurers Made Nearly 53 Million Prior Authorization Determinations in 2024](#)
- KFF: [A Snapshot of Sources of Coverage Among Medicare Beneficiaries](#)
- MedPAC: [MA Payment Basics](#)
- MedPAC: [MedPAC 2026 Report to Congress](#)
- MedPAC: [MedPAC 2024 Report to Congress](#)

- NORC at the University of Chicago: [Analysis of Hospital Discharges to PAC Settings Among Medicare Beneficiaries](#)
- Premier Inc.: [Claims Adjudication Costs Providers \\$25.7 Billion - \\$18 Billion is Potentially Unnecessary Expense](#)
- Premier Inc.: [Trend Alert: Private Payers Retain Profits by Refusing or Delaying Legitimate Medical Claims](#)