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Decades of Legislation Has Favored Medicare Advantage Over Traditional Medicare

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Introduction

As the Medicare program has become more privatized through growing enrollment in Medicare Advantage (MA), the traditional Medicare program has been neglected. Legislation passed over the last 20 plus years has generally favored enrollment in MA plans. A major course correction is needed to both strengthen traditional Medicare and better protect those enrolled in MA plans.

Background

As the nation honors Medicare's 60th anniversary, the reality is that program has become more privatized over time. Enrollment in private Medicare Advantage (MA) plans has more than doubled since 2010 to 54% of all Medicare beneficiaries, a number that is projected to grow to 64% by 2034.[2] This growth comes with significant costs for the program. Medicare pays more to MA plans for enrollees than their costs would be in traditional Medicare. According to the Medicare Payment Advisory Commission (MedPAC),[3] the federal government pays MA plans 20% more for MA enrollees than it pays for similar individuals in traditional Medicare, costing the Medicare program $84 billion in 2025 alone and leading to $13 billion more in Part B premiums paid by all Medicare beneficiaries, including those in traditional Medicare who accrue no benefit from MA plans at all. Despite these significant overpayments, MA plans do not produce better quality outcomes for enrollees,[4] and MA enrollees can face barriers and delays in care due to denials and premature termination of care that would otherwise be covered under traditional Medicare.[5]

The growing privatization of Medicare has come at the expense of the traditional Medicare program. In our market-driven health care system that relies on principles of competition, traditional Medicare cannot meaningfully compete with Medicare Advantage, given the unequal compensation drawn by the private plans, nor can it serve as an affordable and accessible

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backstop for beneficiaries who have significant health needs that are unmet by MA plans. On the whole, policymakers have not slowed this trend and have largely neglected traditional Medicare, tending to pass legislation that favors enrollment in Medicare Advantage. One notable exception was H.R. 3, *The Elijah Cummings Lower Drug Costs Now Act,* passed by the House in December 2019 but not taken up by the Senate. H.R. 3 would have reinvested significant savings from changes in Medicare drug payment policies into expanding traditional Medicare benefits, including adding oral, vision, and dental coverage for all beneficiaries, expanding rights to purchase Medigap coverage, and expanding eligibility for low-income assistance.

During the *Build Back Better* debate in 2021, these coverage expansions were briefly on the table again but did not survive. Congress did pass the *Inflation Reduction Act of 2022*, which included important provisions such as a cap on out-of-pocket Part D drug expenses and gave the Secretary of HHS the authority to negotiate prices of certain drugs, but savings generated by this bill were largely not invested back into traditional Medicare.

Medicare Legislation Has Mostly Favored Medicare Advantage Over Traditional Medicare

The following is a catalogue of some of the major Medicare-related legislation passed in the last 20 years (note that this is not a comprehensive list of all legislation impacting Medicare during this time period). Commentary has been put in text boxes when legislation has favored MA over traditional Medicare; this includes both added incentives for beneficiaries to enroll in MA plans and disincentives to remain in traditional Medicare. Regulations promulgated by the Centers for Medicare & Medicaid Services (CMS) tend to build on legislative changes. In recent years there has been some modest, but important, progress concerning oversight of MA plans. [6] However, regulatory action has also significantly favored the MA program over traditional Medicare.

- **The Medicare Prescription Drug, Improvement, and Modernization Act of 2003** (MMA, Pub. L. No. 108-173) began a major restructuring of the Medicare program, relying heavily on private insurance to deliver benefits through increased payments to Part C plans (renamed "Medicare Advantage") and increased beneficiary cost-sharing responsibilities.

While creating a new Part D prescription drug benefit, the MMA made such coverage available only through private plans, requiring those in traditional Medicare to purchase a stand-alone drug plan to add on to their Medicare and often "Medigap" coverage. This was in contrast to MA enrollees, who could get drug coverage through "one-stop shopping" with a Medicare Advantage-Prescription Drug Plan.

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- **The Medicare Improvements for Patients and Providers Act of 2008** (MIPPA, Pub. L. No. 110-275), primarily designed to address problems with the way Medicare pays physicians, also made modest improvements for beneficiaries, including reducing the cost-sharing for mental health services and increasing the asset limits for eligibility for programs that assist with Part B premiums and cost-sharing. In response to marketing misconduct surrounding the sale of MA plans, the bill also included a number of consumer protections and marketing restrictions for MA and Part D plans and agents/brokers selling such plans.

- **The Patient Protection and Affordable Care Act of 2010** (PPACA) **and the Health Care and Education Reconciliation Act of 2010** (HCERA), together known as the **Affordable Care Act** (ACA, Pub. L. No. 111-148, 111-152), included significant changes to the Medicare program, particularly with regard to reimbursement for Medicare Advantage plans and to providers. The ACA also provided system delivery mechanisms and demonstrations and pilot projects to improve coordination of care; other initiatives to improve quality of care; and initiatives to reduce unnecessary hospital readmissions. The law added Medicare coverage for an annual wellness visit, eliminated cost-sharing for most preventive services, added some consumer protections to Medicare Advantage, and phased out the Part D coverage gap for prescription drugs known as the "Donut Hole." The ACA strengthened Medicare's finances, in part, by changing how MA plans are paid. The aim was to reduce MA overpayments that averaged 114% of spending in traditional Medicare. But savings were used to expand health coverage outside of Medicare – a worthy goal, but such funds were not largely reinvested into strengthening traditional Medicare.

While the ACA temporarily brought MA spending levels closer to traditional Medicare, equal payment with traditional Medicare was never achieved,[7] and payments to MA plans are up to 20% more per person when compared with traditional Medicare.[8] The ACA also established the MA quality bonus program which contributes to current MA overpayments and, according to experts, has neither successfully improved quality in the MA program nor helped beneficiaries compare plans.[9]

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- **The Medicare Access and CHIP Reauthorization Act of 2015** (MACRA, Pub. L. No. 114-10) made several changes to the Medicare program, including revamping how Medicare pays physicians, further means-testing premiums for higher income beneficiaries, and changing who is eligible for certain Medigap policies.

In order to provide a "pay for" (a requirement to offset costs), MACRA prohibited new Medicare beneficiaries (those eligible starting January 1, 2020) from purchasing Medigap policies that cover the Part B deductible in traditional Medicare—known as "first dollar coverage." This restriction reduced the scope of coverage available in Medigap plans, making Medicare Advantage plans comparatively more attractive.

- **The 21st Century Cures Act**, signed into law in December 2016 (Pub. L. No. 114-255), was aimed largely at fostering access to new treatments and cures and improving health information technology.

The Act also removed the prohibition on people with end stage renal disease (ESRD) from enrolling in MA plans beginning in 2021. However, Congress failed to give these same individuals equal access to Medigap policies, creating unequal treatment based on health status.[10] The Act also restored expanded enrollment periods for MA plans (effective 2019), including a 3-month window for MA enrollees to switch plans. Notably, people in stand-alone Part D drug plans did not receive the same flexibility for switching plans. This change, supported by insurance agents/brokers and the health insurance industry,[11] favored MA enrollment by giving those in MA plans more flexibility to make changes to their coverage than those in traditional Medicare.

- **The Bipartisan Budget Act of 2018** (**BBA '18**, Pub. L. No. 115-123) removed the annual dollar cap on outpatient therapy and permanently fixed restrictions in the law that limited Medicare coverage and access for Speech Generating Devices (SGDs), which are a crucial means of communicating for people with ALS and other degenerative diseases.

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At the same time, the BBA contained a number of provisions that improve or expand services and coverage in Medicare Advantage only, which once again favored MA over traditional Medicare. This bill included provisions of the bipartisan Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act, which aimed to improve MA coverage for individuals with chronic conditions. These provisions included:

- *Expansion of supplemental benefits in MA – beginning in 2020, supplemental benefits offered by MA plans are no longer limited to being "primarily health related" but instead must only have a reasonable expectation of improving or maintaining the health or overall function of chronically ill enrollees.*[12]

- *Expansion of access to telehealth services available to enrollees of MA plans, including offering such services as a basic benefit.*

- The global COVID-19 pandemic led to wide-ranging changes in Medicare policy in 2020 and 2021, most of which expired along with the end of the declared Public Health Emergency in May 2023. Legislation included the **Consolidated Appropriations Act, 2021** (Pub. L. No. 116-260), which included key provisions of the Beneficiary Enrollment Notification and Eligibility Simplification (BENES) Act. Beginning in 2023, that legislation reduces some of the delay in coverage when enrolling during the general enrollment period (GEP) or in the later months of the initial enrollment period (IEP).

- **The Inflation Reduction Act** (IRA, Pub. L. No. 117-169) was signed into law on August 16, 2022. Among other things, the IRA makes a number changes to the Part D prescription drug benefit that are being phased in over several years, including an out-of-pocket cap of $2,000 in 2025, elimination of cost-sharing for vaccines covered under Part D (2023), expansion of eligibility for the Part D low-income subsidy (2024), other measures that limit the growth in the cost of drugs and Part D premiums, and a $35 cap per month on insulin charges under Medicare (2023). In addition, for the first time, the Secretary of HHS has the authority to negotiate the prices for certain high-cost drugs for Medicare beneficiaries, with negotiated prices effective in 2026.

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An unintended consequence of the IRA, though, could lead to erosion of the stand-alone Part D drug plan (PDP) market, diminishing the ability of those in traditional Medicare to afford drug coverage. This would shift more people into MA plans which are better positioned to absorb cost increases of Part D plan sponsors given significant overpayments to MA plans.[13]

- **The Consolidated Appropriations Act, 2023** (CAA, Pub. L. No. 117-328) was signed into law on December 29, 2022. The CAA contains a number of health provisions relating to Medicare, including a two-year extension of some telehealth flexibilities related to the COVID-19 public health emergency (through December 2024), expanding access to mental health and substance use disorder treatment (including coverage of marriage and family therapist services and mental health counselor services under Part B beginning January 2024), coverage of compression garments for treatment of lymphedema under Part B as durable medical equipment (DME) starting January 2024, and permanent Medicare Part B coverage for in-home intravenous immune globulin services (IVIG) beginning January 2024.

- **H.R. 1, the "One Big Beautiful Bill" Act** (OBBB, Pub. L. No: 119-21) was signed into law on July 4, 2025. Among other things, the bill targets the Medicaid program through mechanisms that will reduce enrollment, including new "community engagement" mandates (work requirements) for certain individuals in order to maintain coverage; more frequent eligibility redeterminations; elimination of coverage for certain groups of lawfully present immigrants; and restrictions on states' ability to generate additional Medicaid funding through provider taxes. Medicare-specific provisions include:

    - <u>Termination of Eligibility and Coverage for Certain Lawfully Present Non-Citizens</u> – upon enactment, restricts eligibility for new Medicare applicants to U.S. citizens or nationals, lawful permanent residents (green card holders), certain Cuban/Haitian entrants, and Compacts of Free Association (COFA) migrants. This provision immediately eliminates Medicare eligibility for all other new applicants who are lawfully present immigrants, including asylees, refugees, people with Temporary Protected Status, people granted withholding of removal, trafficking survivors, survivors of domestic violence, and individuals granted humanitarian parole for a

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period of at least 1 year. By July 4, 2026, the Commissioner of the Social Security Administration must identify existing Medicare beneficiaries who do not meet the new immigration criteria. These individuals must be notified "as soon as practicable" and "in a manner designed to ensure such individual's comprehension" that their Medicare coverage will be terminated as of 18 months after enactment of the OBBB (January 2027). This represents a significant departure from longstanding policy. While undocumented immigrants have never been eligible for Medicare, lawfully present individuals who meet the requisite work history requirements through SSA have been eligible for Medicare coverage.

- Moratorium on Medicare Savings Program (MSP) Improvements – imposes a nine-year prohibition on implementing key provisions of a final rule published by CMS on September 21, 2023 (88 Fed. Reg. 65230). This rule was specifically designed to streamline eligibility and enrollment processes for MSPs, which provide crucial assistance with Medicare premiums and cost-sharing for lower-income beneficiaries. The Congressional Budget Office (CBO) estimates that this moratorium will generate over $66 billion in savings over 10 years. The "savings" will be achieved by preventing eligible beneficiaries from accessing assistance programs designed to make Medicare more affordable.

- Blocking Nursing Facility Staffing Standards – prohibits CMS from implementing a final rule issued in 2024 (89 Fed Reg 408706), which established national minimum staffing requirements for nursing facilities to promote quality care. Notably, while portions of this rule have already been vacated by federal courts, the Trump Administration continues to defend the rule (as of July 2025).

- Limiting Medicare Drug Price Negotiation – the Inflation Reduction Act of 2022 (Pub. Law No. 117-169) granted the Secretary of HHS authority to negotiate prices for certain high-cost drugs used by Medicare beneficiaries, with the first negotiated prices taking effect in 2026. Section 71203 of the OBBB carves out certain "orphan drugs" (developed to treat rare diseases) from this process, effectively limiting Medicare's ability to control costs for some of the most expensive medications.

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Conclusion

While legislation over the last 20 years or so has made some improvements to traditional Medicare, it has, on balance, generally favored enrollment in MA. The Medicare program is long overdue for a course correction that will meaningfully preserve and strengthen the traditional Medicare program and allow it to serve as a counterweight to the private program.

If policymakers had the will, reining in overpayments to MA plans alone could fund a significant expansion of traditional Medicare; these expansions would accrue to the benefit of all Medicare beneficiaries, including those in MA plans, by creating a new, enhanced baseline of coverage.[14] As long as MA remains an option in Medicare, we must also ensure that those currently in MA plans have adequate access to care. This requires more rigorous oversight of the insurance industry and more pathways for MA enrollees to return to traditional Medicare when they choose.

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[1] Note: this Issue Brief is adapted from the Center for Medicare Advocacy's "Statement on the 60th Anniversary of Medicare" (July 29, 2025), available at: https://medicareadvocacy.org/wp-content/uploads/2025/07/Statement-on-Medicares-60th.pdf.

[2] See KFF, "Medicare Advantage in 2025: Enrollment Update and Key Trends" (July 2025), available at: https://www.kff.org/medicare/issue-brief/medicare-advantage-enrollment-update-and-key-trends/.

[3] MedPAC, "Report to Congress" (March 2025), available at: http://www.medpac.gov/wp-content/uploads/2025/03/Mar25_Ch11_MedPAC_Report_To_Congress_SEC.pdf.

[4] See, e.g., The Commonwealth Fund, "Medicare Advantage: A Policy Primer" (January 2024), available at: https://www.commonwealthfund.org/publications/explainer/2024/jan/medicare-advantage-policy-primer; see also KFF "Beneficiary Experience, Affordability, Utilization, and Quality in Medicare Advantage and Traditional Medicare: A Review of the Literature" (Sept. 2022), available at: https://www.kff.org/medicare/report/beneficiary-experience-affordability-utilization-and-quality-in-medicare-advantage-and-traditional-medicare-a-review-of-the-literature/.

[5] See, e.g., HHS, Office of Inspector General (OIG), "Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care" (April 2022), available at: https://oig.hhs.gov/reports/all/2022/some-medicare-advantage-organization-denials-of-prior-authorization-requests-raise-concerns-about-beneficiary-access-to-medically-necessary-care/.

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[6] Center for Medicare Advocacy, "Improvements to Medicare Advantage Oversight and Consumer Protections Must Be Preserved and Expanded" (April 2025), available at: https://medicareadvocacy.org/wp-content/uploads/2025/04/2025-Issue-brief-MA-Oversight-Protections.pdf.
[7] The Commonwealth Fund, "The Evolution of Private Plans in Medicare" by Yash M. Patel and Stuart Guterman (December 2017), available at: https://www.commonwealthfund.org/publications/issue-briefs/2017/dec/evolution-private-plans-medicare.
[8] See, e.g., KFF "Medicare Advantage in 2025: Enrollment Update and Key Trends" (July 2025), available at: https://www.kff.org/medicare/medicare-advantage-enrollment-update-and-key-trends/.
[9] See, e.g., Urban Institute, "The Medicare Advantage Quality Bonus Program" by Laura Skopec and Robert A. Berenson (June 2023), available at: https://www.urban.org/sites/default/files/2023-06/The%20Medicare%20Advantage%20Quality%20Bonus%20Program.pdf; see also, e.g., KFF "Medicare Advantage Quality Bonus Payments Will Total at Least $12.7 Billion in 2025" by Jeannie Fuglesten Biniek, Anthony Damico and Tricia Neuman (June 2025), available at: https://www.kff.org/medicare/medicare-advantage-quality-bonus-payments/.
[10] Note that federal law does not require Medigap (Medicare Supplemental Insurance plan) issuers to offer policies to individuals under 65, including those with End Stage Renal Disease (ESRD), even during open enrollment or guarantee issue periods. States have the ability to add to these federal rights. There are no restrictions on Medicare beneficiaries under 65 enrolling in Medicare Advantage plans. See, e.g., KFF "Medigap May Be Elusive for Medicare Beneficiaries with Pre-Existing Conditions" (Oct. 2024), available at: https://www.kff.org/medicare/medigap-may-be-elusive-for-medicare-beneficiaries-with-pre-existing-conditions/.
[11] Note: online resources cited to and accessed in December 2016 in a Cetner for Medicare Advocacy *CMA Alert* no longer appear to be available, including a National Association of Health Underwriters (NAHU) statement endorsing HR 2581 (formerly at: http://cqrcengage.com/nahu/medicareoep) and America's Health Insurance Plans (AHIP) statement endorsing H.R. 2488 (formerly at: https://www.ahip.org/strengthening-medicare-advantage-for-current-and-future-beneficiaries/); both bills would have made similar changes by reinstating the MA-OEP.
[12] Note that these BBA changes were accompanied by a number of regulatory changes that, among other things, expanded the scope of supplemental benefits as well as loosening certain restrictions on MA plans, including re: meaningful difference standards and uniformity requirements. See, e.g., Center for Medicare Advocacy, "Special Report: Recent Changes in Law, Regulations and Guidance Relating to Medicare Advantage and the Prescription Drug Benefit Program" (Sept. 2018), available at: https://medicareadvocacy.org/special-report-recent-changes-in-law-regulations-and-guidance-relating-to-medicare-advantage-and-the-prescription-drug-benefit-program/.
[13] See, e.g., "KFF The Uncertain Future of Medicare's Stand-Alone Prescription Drug Plan Market and Why It Matters" (July 2025), available at: https://www.kff.org/medicare/the-uncertain-future-of-medicares-stand-alone-prescription-drug-plan-market-and-why-it-matters/; see also, e.g., Center for Medicare Advocacy, *CMA Alert* "Scale Back of Demo Project Drives Higher Part D Plan Costs" (July 31, 2025), available at: https://medicareadvocacy.org/scale-back-of-demo-project-drives-higher-part-d-plan-costs/.
[14] See, e,g., *New England Journal of Medicine*, "The Opportunity Costs of Medicare Advantage Plan Rebates" by Cori Uccello, Gretchen Jacobson, and Melinda J.B. Buntin (October 2024), available at: https://www.nejm.org/doi/10.1056/NEJMp2405572.

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