Medicare Part D vs. Advantage & Medicaid Managed Care Explained

By Adrien Laurent, CEO at IntuitionLabs • 11/7/2025 • 40 min read

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Executive Summary

This report provides an in-depth analysis of two related dimensions of U.S. health coverage – **Medicare** (specifically comparing Medicare Part D with Medicare Advantage) and **Medicaid Managed Care** – integrating historical context, current state data, and future policy considerations. **Medicare Part D** is the outpatient prescription drug benefit program (implemented in 2006) for older adults and certain disabled people, which beneficiaries can obtain through *stand-alone Prescription Drug Plans (PDPs)* or through *Medicare Advantage prescription drug plans (MA-PDs)* ([1] www.kff.org) ([2] www.aarp.org). **Medicare Advantage (MA)** (also known as Part C) is a private-plan alternative to traditional Medicare, covering all Medicare Parts A and B services and usually including prescription drug coverage and extra benefits ([1] www.kff.org) ([3] www.kff.org). The report contrasts how Part D coverage via separate PDPs compares to drug coverage offered within MA plans, examining **enrollment trends, benefit design, premiums, cost-sharing, and regulatory context** ([4] www.kff.org) ([5] www.kff.org) ([6] www.kff.org). For example, over half of all Part D enrollees (56%) now receive coverage in MA plans rather than stand-alone PDPs ([4] www.kff.org), and prescription drug premiums in MA-PDs are generally far lower (often zero) than in stand-alone plans ([7] www.kff.org) ([5] www.kff.org). These differences arise from how plans are financed (MA plans receive rebates they can use to subsidize premiums) and the tradeoffs beneficiaries face (MA plans have provider networks and utilization management that traditional Medicare lacks) ([8] www.kff.org) ([9] www.kff.org).

The **Medicaid** section outlines the fundamentals of Medicaid managed care, where state Medicaid agencies increasingly contract with private Managed Care Organizations (MCOs) to provide care. As of 2022, roughly **75% of Medicaid beneficiaries** are enrolled in comprehensive risk-based MCOs ([10] www.kff.org). Medicaid managed care spans nearly all states (42 states plus DC as of mid-2024) ([11] www.kff.org), and over half of all Medicaid spending flows through these plans ([12] www.kff.org). Under managed care, states pay MCOs a *capitated per-member-per-month (PMPM)* fee to cover designated services, rather than paying fee-for-service (FFS) for each claim ([13] www.medicaid.gov) ([14] www.kff.org). States define which services are included under MCO contracts and which are carved out (commonly behavioral health, long-term care and sometimes pharmacy) ([15] www.kff.org) ([16] www.ncsl.org). While managed care aims to improve coordination and control costs, evidence on its impact is mixed ([17] www.macpac.gov) ([18] www.macpac.gov). The report presents enrollment statistics, market structure (few large insurers dominate half of enrollment ([19] www.kff.org)), and policy developments (e.g. recent federal rules on network adequacy and capitation rates) ([20] www.kff.org) ([21] www.kff.org).

Case studies and examples illustrate these systems in practice: for instance, **rural Medicare beneficiaries** (the most remote counties) overwhelmingly rely on stand-alone PDPs and have few MA choices ([22] www.kff.org) ([23] www.kff.org), highlighting the interplay between geographic access and plan design. On the Medicaid side, **state policy shifts** (e.g., North Carolina's recent transition to mandatory managed care ([24] apnews.com)) and **integration initiatives** (CMS's push to align Medicare Advantage D-SNP plans with Medicaid services for dual-eligibles ([25] www.healthscape.com)) demonstrate evolving priorities.

Finally, the report discusses implications and future directions: policy changes under different administrations (e.g. demonstrations to stabilize PDP premiums, inflation reduction restyling Part D cost-sharing) and long-term trends (projected growth in MA enrollment ([26] www.kff.org) and potential Medicaid program changes) all have significant budget and beneficiary impacts. In conclusion, we synthesize findings to inform stakeholders about **how beneficiaries' choices between PDPs and MA plans affect access and cost**, and **how managed care continues to reshape Medicaid delivery**, supported throughout by extensive data and analysis.

Introduction and Background

Medicare and Medicaid are the two main public health insurance programs in the United States. **Medicare** is a federal program established in 1965 to provide coverage for Americans age 65 or older, as well as certain younger people with disabilities or end-stage renal disease. Medicare is divided into parts: A (hospital insurance), B (medical insurance), C (Medicare Advantage – private plans), and D (prescription drug benefit).Beneficiaries can receive Medicare benefits through *Original Medicare* (Parts A and B administered by the government) supplemented by **Part D** for drugs and optionally *Medigap* supplemental plans; or they can enroll in a **Medicare Advantage** (MA, Part C) plan offered by a private insurer, which covers all Part A and B services and often (but not always) includes drug coverage and extra benefits [8†L14-L22] [25†L16-L24]. In both systems, beneficiaries pay premiums, deductibles, and copays, but the structure differs. Part D (created in 2006 under the Medicare Modernization Act) provides an outpatient prescription drug benefit (for those in original Medicare who choose it, or as part of MA plans) and is delivered entirely through private plans. Medicare Advantage (Part C), operational since the 1980s (initially called Medicare + Choice in 1997), is an all-in-one alternative to original Medicare with private managed-care characteristics [25†L16-L24].

Medicaid, also created in 1965, is a joint federal-state program providing health coverage to low-income individuals and families. Unlike Medicare, Medicaid eligibility and coverage vary by state within federal guidelines. Historically delivered via *fee-for-service (FFS)* (where providers are paid per service), Medicaid has shifted since the 1980s toward **managed care**: states contract with private **Managed Care Organizations (MCOs)** to deliver services under capitated payments [21†L2-L6] [31†L76-L84]. Under managed care, a state pays each MCO a fixed per-member-per-month (PMPM) capitation rate to provide a defined set of services ([13] www.medicaid.gov) ([27] www.ncsl.org). This model aims to control costs and improve care coordination by giving insurers financial responsibility for enrollees' care. As of 2022, states increasingly rely on statewide MCO contracts, covering 75% of Medicaid beneficiaries ([10] www.kff.org). The **scope of managed care** varies: states decide which populations and which benefits are "carved in" (included) or "carved out" of MCO contracts ([16] www.ncsl.org). Common carve-outs include behavioral health, long-term services, or pharmacy benefits ([15] www.kff.org) ([16] www.ncsl.org), though many states have moved to carve these into their MCO contracts.

This report examines both programs in detail. For Medicare, we **compare Part D and Medicare Advantage** particularly in the context of prescription drug coverage: how do beneficiaries with original Medicare obtain drug coverage via Part D (stand-alone PDPs) versus enrolling instead in an MA plan (where drug coverage is typically integrated)? We analyze enrollment trends, costs, plan characteristics, and beneficiary tradeoffs. For Medicaid, we outline the **basics of Medicaid managed care**: its prevalence, financing, benefits structures, regulatory oversight, and mixed performance evidence. Throughout, we reference recent data, expert analyses, and case examples. Our goal is to provide a comprehensive, evidence-based report suitable for policymakers, scholars, and stakeholders interested in Medicare and Medicaid delivery systems.

Medicare Part D vs Medicare Advantage

Overview of Medicare Part D (Prescription Drug Benefit)

Medicare Part D provides prescription drug coverage to Medicare beneficiaries through private plans. Enrollees choose either a **stand-alone Prescription Drug Plan (PDP)** (supplementing Original Medicare) or a **Medicare Advantage Prescription Drug (MA-PD) plan** (an MA plan that includes drug coverage) ([1] www.kff.org). Part D was implemented in 2006 to fill a gap in prescription coverage, and now about **50.5 million** beneficiaries have it ([28] www.kff.org). Plans are operated by private sponsors and vary in premium, deductible, formulary, and cost-sharing. There are standard benefit parameters set by CMS (a deductible, initial coverage, coverage gap, catastrophic threshold), but plans can offer enhanced benefits above the minimum.

By structure, **PDPs (stand-alone Part D plans)** cover only outpatient drugs. PDP enrollees generally have full access to Medicare's provider network (because they use Original Medicare for medical services) and can fill prescriptions at contracted pharmacies nationwide. PDP premiums are typically not subsidized beyond the low-income subsidy (LIS) program, so many beneficiaries pay a monthly premium. In contrast, **MA-PDs** are Medicare Advantage plans – these plans cover all Medicare Part A and B services plus drugs, often using a network of providers. MA-PDs frequently use rebates (from Medicare-allowed payments) to offer low or zero premiums and additional benefits for enrollees ([8] www.kff.org) ([29] www.kff.org). Because MA plans have networks, enrollees must see in-network providers; outside services may not be covered (especially in HMO-style MA plans) ([30] www.kff.org). Thus, the choice for a beneficiary includes a tradeoff between drug coverage costs and provider flexibility.

Enrollment Trends

Current data show a shift toward Medicare Advantage. In 2023, **56% of Part D enrollees (28.3 million)** received their drug coverage through MA-PD plans, while **44% (22.2 million)** were in stand-alone PDPs ([4] www.kff.org). Between 2019 and 2023, MA-PD enrollment grew by 47% (an increase of ~9 million), while PDP enrollment fell by 12% (a loss of ~3 million) ([4] www.kff.org). By 2025, well over half of all Medicare beneficiaries overall are in MA (54% in 2025) ([31] www.kff.org), although this includes many (around 62% of enrollees) who get drug coverage through their MA plan. Key factors driving these trends include the expansion of MA offerings and aggressive marketing, as well as policy shifts: for example, as PDP choices have narrowed and premiums threatened to rise, some beneficiaries have turned to (lower-premium) MA-PD options ([32] www.kff.org). This is especially true among **Low-Income Subsidy (LIS)** beneficiaries: 62% of LIS recipients (8.3 million people) were enrolled in MA-PD plans in 2023, up from 38% in 2006 ([33] www.kff.org).

Premiums and Cost-Sharing

A major distinction between PDPs and MA-PDs is in premiums and deductibles. **Premiums:** In 2023, the enrollment-weighted average monthly premium for PDP drug coverage was about **$40** ([7] www.kff.org), whereas MA-PD plans had an average *drug portion* premium of only **$10** ([7] www.kff.org) (the total MA premium including medical benefits averaged $15). By 2025, due in part to recent premium stabilization subsidies for PDPs, the average MA-PD drug premium fell to **$7** vs **$39** for PDPs ([5] www.kff.org). In practice, about **three-quarters of MA-PD enrollees pay no Part D premium** ([5] www.kff.org) ([6] www.kff.org), as MA plans use Medicare rebates to essentially eliminate the premium for most members ([6] www.kff.org). (In contrast, *all* PDPs charge a premium, which LIS enrollees must pay unless they join a designated "benchmark" LIS plan.) Disparities in premiums are attributable to rebates: MA-PD sponsors receive large rebates from Medicare (over $2,250 per enrollee in 2025) which they allocate partly to cut premiums ([34] www.kff.org), whereas PDPs do not receive these rebates.

Deductibles: The standard Part D deductible in 2023 was $505. Among PDP enrollees, 86% faced a deductible (most at the full $505), leading to an average deductible of about **$411** ([35] www.kff.org). In contrast, most MA-PDs waive or reduce the deductible: only 22% of MA-PD enrollees pay the full Part D deductible, and 60% pay none at all. Accordingly, the average MA-PD deductible was only **$58** ([35] www.kff.org). In summary, MA-PD enrollees enjoy much lower upfront cost sharing for drugs, while PDP enrollees bear higher deductibles and premiums.

Other Cost Sharing: Part D plans are tiered, with low copays for generics and high copays or coinsurance for brand or specialty drugs. PDPs often use coinsurance on higher tiers, whereas MA-PDs typically use copays for most tiers ([36] www.kff.org). For example, >50% of MA-PD enrollees pay a copay of $45–47 for preferred brand drugs (maximum allowed) ([37] www.kff.org), while half of PDP enrollees pay coinsurance up to 40%–50%. These design differences mean that for some high-cost or non-preferred drugs, MA-PD enrollees may face steeper out-of-pocket costs ([36] www.kff.org). Importantly, **Part D includes a $2,000 annual out-of-pocket cap on drug spending** (from 2025, under the Inflation Reduction Act) whether in PDPs or MA-PDs, which was not in

effect before 2025 ([38] www.kff.org). (In contrast, traditional Medicare Part A/B has no out-of-pocket cap, but most MA plans impose a combined cap on medical services; the average limit in 2025 was $5,320 for in-network care ([39] www.kff.org), well below the legal maximum of $9,350 ([38] www.kff.org).)

Coverage and Networks

Beyond cost sharing, Part D and MA differ in coverage scope. **Part D (PDP)** solely covers prescription drugs; enrollees continue to use original Medicare for medical care. There are no provider network restrictions for medical care under original Medicare, and drug coverage is available at any network pharmacy. **Medicare Advantage (Part C with embedded Part D)** offers an "all-in-one" plan: it covers hospitalization, doctor visits, and typically prescription drugs, often with extras (vision, dental, hearing, wellness benefits). MA enrollees must usually use a network of providers, although many MA plans are PPOs allowing out-of-network access at higher cost. Because about half of MA enrollees are in HMOs ([40] www.kff.org), they have no coverage for out-of-network care. Moreover, MA plans commonly employ utilization management (prior authorization, step therapy), requiring approval for certain services and drugs ([41] www.kff.org). For example, nearly all MA-PD plans require prior authorization for specialty drugs ([42] www.kff.org). There is **no utilization management or network restriction** in original Medicare (and thus in PDPs) beyond FDA approval of drugs.

These differences entail tradeoffs:

- **Choice vs Cost:** A beneficiary in original Medicare + PDP can see any Medicare provider (full freedom), but pays higher premiums for drug coverage. An MA enrollee may save money on premiums and get extra benefits, but must stay in-network and navigate restrictions. The AARP Public Policy Institute notes that PDPs and MA-PDs are "increasingly distinct" products: MA-PDs typically offer more generous drug benefits at low premium (thanks to rebates), while PDPs have higher cost-sharing but no network limits ([43] www.aarp.org) ([32] www.kff.org).
- **Rural Access:** Rural beneficiaries have particular challenges. In the most rural U.S. counties, the majority of Medicare beneficiaries are in traditional Medicare, and about **60% of these rural beneficiaries use stand-alone PDPs** ([22] www.kff.org). Rural areas often have few (if any) MA plan options, and those available tend to have narrow networks ([23] www.kff.org). Thus, rural Medicare beneficiaries reliant on Part D may have limited routes to drug coverage other than PDPs. If PDP options dwindle, rural beneficiaries may face a dilemma: enroll in an unfamiliar MA plan (if available) or miss coverage. By contrast, urban beneficiaries often have many MA choices and may pay no premium, making MA more attractive ([22] www.kff.org).
- **Special Populations:** Dually eligible Medicare-Medicaid enrollees often get drug coverage via MA Special Needs Plans (SNPs). Indeed, nearly 40% of LIS enrollees are now in SNPs (targeted plans) ([44] www.kff.org). MA-SNPs for duals integrate Medicare and some Medicaid services; these plans have become a fast-growing segment of MA, reflecting policy to better coordinate duals.

Enrollment Composition

Medicare Advantage enrollment is highly concentrated among a few insurers ([45] www.kff.org) ([46] www.kff.org). In 2025, UnitedHealth Group and Humana together accounted for nearly **46% of all MA enrollment** ([46] www.kff.org), with other large insurers (CVS/Aetna, Elevance/Anthem/Kaiser) covering most of the rest. A similar concentration exists in Part D: the top three firms (UnitedHealth, CVS, Humana) cover about **57% of all Part D enrollees** ([47] www.kff.org). Interestingly, these major insurers have different market positioning: Centene, CVS and Cigna hold more stand-alone PDPs, whereas UnitedHealth and Humana have more MA-PD members ([48] www.kff.org). Kaiser Permanente operates no standalone PDP (its members get drugs through integrated MA plans). This market structure affects choices: in any given region, only a few companies may offer plans, and those may be either PDPs or MA plans (or both).

Premiums and Benefit Trends

Over the past decade, **Medicare Advantage plans** have used their growing rebate share to benefit enrollees. The average MA-PD premium fell from $36 in 2015 to $13 in 2025 ([49] www.kff.org). By contrast, PDP premiums remained high (around $40) and would have risen without temporary subsidies ([50] www.kff.org) ([5] www.kff.org). In 2025, 76% of individual MA-PD enrollees paid $0 above their Part B premium ([51] www.kff.org) ([6] www.kff.org), whereas all PDP enrollees pay a premium (with LIS subsidies covering most of it for low-income enrollees). Notably, the Inflation Reduction Act (2022) introduced a **$2,000 cap on annual Part D out-of-pocket drug spending**, benefiting PDP and MA enrollees alike ([38] www.kff.org). However, full implementation of IRA changes shifted costs toward plans (e.g. higher liability for catastrophic phase), which triggered industry and government interventions (see Policy below).

Comparative Summary

The table below summarizes key differences between obtaining Part D drug coverage via a stand-alone PDP versus through a Medicare Advantage plan (MA-PD). It highlights how costs, coverage, and network rules differ across these options.

Feature	Stand-Alone Part D (PDP)	Medicare Advantage (MA-PD)
Covered Benefits	Prescription drugs only ([52] www.kff.org). Requires separate Part A/B Medicare for medical services.	All Medicare-covered services (Part A & B) **plus** usually prescription drugs ([52] www.kff.org). Often provides extra benefits (dental, vision, hearing, etc).
Provider Network	Uses Original Medicare's open network. No network restrictions on medical care; any Medicare-participating medication provider pharmacies.	Enrollees generally must use a network of providers (HMO or PPO). Out-of-network allowed only in PPOs (at higher cost) ([30] www.kff.org). Prior authorizations are common ([41] www.kff.org).
Enrollment (2023)	~22.2 million enrollees (44% of Part D) ([4] www.kff.org).	~28.3 million enrollees (56% of Part D) ([4] www.kff.org).
Average Monthly Premium (2025)	~$39 (enrollment-weighted for drug coverage) ([5] www.kff.org); all plans charge a premium.	~$7 for drug portion (2025 average) ([5] www.kff.org); ~76% of MA-PD enrollees pay $0 premium beyond Part B ([51] www.kff.org) ([6] www.kff.org). MA total premium (medical+drug) ~$13 (2025) ([6] www.kff.org).
Deductible (2023)	~$505 standard. Enrollment-weighted avg ~$411 (mostly full deductible) ([35] www.kff.org).	Most MA-PDs waive Part D deductible for 60% of enrollees; avg deductible ~$58 ([35] www.kff.org).
Cost-Sharing	Tiered copays/coinsurance: typically low copays for generics, high coinsurance for brands/specialty ([53] www.kff.org) ([37] www.kff.org).	Similar tiered design, but MA-PDs more often use fixed copays (especially for brands) ([37] www.kff.org). Generally lower cost-sharing via higher copays for MA seniors, but many pay 0 for generics ([37] www.kff.org).
Out-of-Pocket Limit (Parts A/B)	N/A (Original Medicare has no overall cap on A/B services).	Plans must cap Part A/B costs. For 2025, max allowed is $9,350 (in-network) ([38] www.kff.org); average MA in-network limit ~$5,320 ([39] www.kff.org).
Out-of-Pocket Limit (Part D)	$2,000 annual cap (2025) on drug costs (mandated by law) for all Part D plans.	$2,000 annual cap on drugs (same Part D cap).

Feature	Stand-Alone Part D (PDP)	Medicare Advantage (MA-PD)
Extra Benefits	None (drug coverage only).	Often includes vision, dental, hearing, gym memberships, etc ([54] www.kff.org) ([55] www.kff.org).
Government Subsidies	Part D LIS subsidies pay full premium for benchmark PDPs (for eligible).	Plans receive large rebates (avg ~$2,250 per enrollee in 2025 ([34] www.kff.org)) to lower premiums and add benefits.
Ideal For	Beneficiaries who prefer Original Medicare coverage and choice of providers (especially in areas with limited MA options), and who are willing to pay higher Part D premiums.	Beneficiaries who value low premiums and extra benefits and accept network restrictions and utilization management.

Sources: Part D and MA data from KFF analyses ([4] www.kff.org) ([7] www.kff.org) ([5] www.kff.org) ([6] www.kff.org); plan characteristics from CMS and program summaries ([1] www.kff.org) ([30] www.kff.org) ([41] www.kff.org).

Policy and Market Trends

Recent policy changes and market developments are reshaping these programs:

- **PDP Market Contraction:** The number of stand-alone PDPs has been declining. KFF reports that the average beneficiary saw only about 14 PDP options in 2025, down from 30 in 2021 ([32] www.kff.org). The count of "benchmark" (premium-free) PDPs for LIS enrollees fell from 8 to 2 in the same period ([32] www.kff.org). By contrast, the number of MA-PDs available has been rising. This shrinking PDP market raises concerns for traditional Medicare beneficiaries' ability to find affordable plans ([32] www.kff.org).
- **Premium Stabilization Demonstration:** To curb potential PDP premium spikes from benefit redesigns (post-Inflation Reduction Act), CMS initiated a voluntary demonstration in 2024–2025 providing $5 billion in subsidies to PDPs ([50] www.kff.org). Early results show PDP premiums held steady (average ~$39) despite market instability ([50] www.kff.org). Opponents argue this shifts costs to taxpayers; proponents say it preserves choice for rural and low-income enrollees ([56] www.kff.org) ([5] www.kff.org).
- **Inflation Reduction Act (IRA) Effects:** The 2022 IRA capped Part D drug spending at $2,000, which benefits all beneficiaries, especially those in PDPs with higher out-of-pocket obligations. However, it also imposed changes (e.g. Medicaid rebate expansion, restructuring phases) that were expected to increase PDP plan costs. In response, CMS offered PDP stabilization aid (above) and reallocated certain LIS cost sharing.
- **MedPAC Concerns:** The Medicare Payment Advisory Commission (MedPAC) has noted that Medicare spends significantly more per enrollee in MA plans than in traditional Medicare — on the order of 20% more per person in 2025 ([57] www.kff.org). This gap reflects complex factors (risk adjustment, coding, extra benefits). Any further shift of enrollment from Original Medicare (plus PDP) into MA could amplify federal spending, which is a key policy debate topic.
- **Future Enrollment Projections:** CBO projects MA will continue growing, reaching 64% of all Medicare beneficiaries by 2034 ([26] www.kff.org). For Part D, the continuing decline of PDPs versus MA-PDs depends on the PDP market's fate. If stabilizing measures end and PDP premiums surge, more beneficiaries may migrate to MA (if available). Conversely, policy priorities (e.g. maintaining rural access) could push for sustained PDP options.

In summary, **Part D and Medicare Advantage represent two distinct approaches** to providing drug coverage. The Part D program includes both standalone and MA-based plans, but these have diverged in cost structure and generosity. Beneficiaries and policymakers must weigh **cost (premiums/deductibles)** against **provider access (networks vs freedom)**. Our analysis shows that MA-PD enrollment is rising, driven largely by lower premiums and richer benefits, while stand-alone PDPs, especially in rural areas, face consolidation and policy uncertainty ([4] www.kff.org) ([32] www.kff.org).

Medicaid Managed Care Basics

Overview of Medicaid Managed Care

Medicaid managed care refers to delivery systems where state Medicaid programs pay private insurers (MCOs) to provide covered services to beneficiaries for a fixed per-member-per-month fee. The goals are to manage costs, improve care coordination, and maintain quality ([13] www.medicaid.gov) ([58] www.kff.org). Nationally, managed care dominates Medicaid: **about 75% of enrollees** (72 million people as of 2022) receive benefits through risk-based MCOs ([10] www.kff.org) ([59] www.kff.org). Only a handful of states use nearly 100% MCOs, but nearly all states have some managed care. As of 2024, **42 states (plus DC)** contract with comprehensive risk-based MCOs for at least part of their Medicaid population ([11] www.kff.org). For example, Oklahoma (as of April 2024) added a statewide MCO program covering most children and adults ([11] www.kff.org). (By contrast, fee-for-service Medicaid still exists in various forms: some beneficiaries remain in FFS by choice or state design (e.g. many people with disabilities), and some services may remain FFS through carve-outs.)

Managed care in Medicaid evolved gradually. In the 1970s–1980s, many states started using *Primary Care Case Management (PCCM)* or limited managed care. Federal law (e.g. the 1981 Omnibus Budget Reconciliation Act) gave some waivers for managed care. The 1990s saw an expansion (CHOICE/partnership plans), and the ACA-era (2010s) further accelerated it, especially in Medicaid expansion states. Today, states rely on managed care to control expansive enrollment and costs: in FY2023, federal-state Medicaid outlays exceeded $880 billion, with about **52% paid to MCOs** ([12] www.kff.org).

Delivery Models and State Roles

States have discretion in designing their Medicaid delivery systems ([60] www.ncsl.org). Four broad models exist:

- **Fee-for-Service (FFS)**: traditional arrangement where the state pays providers for each service.
- **Primary Care Case Management (PCCM)**: state pays a primary care provider a small monthly fee plus FFS for care.
- **Risk-Based Managed Care (MCO)**: states contract with MCOs to cover specified populations/services for a capitated rate.
- **Limited Benefit Plans**: MCO contracts covering only a subset of services (e.g. only behavioral health or only pharmacy) ([61] www.ncsl.org).

Most states blend models. For example, even states with high MCO use might keep some groups or services in FFS (e.g. dual-eligibles or long-term care in FFS). State legislatures and Medicaid agencies determine **which beneficiaries must join MCOs** and **what services** the MCO must cover ([62] www.ncsl.org) ([10] www.kff.org). Actively expanded populations (children, pregnant women, expansion adults) tend to be included in MCOs, while certain high-needs groups (some disabled or aged populations) have sometimes been exempt, although more states are moving to include even long-term care in managed care. As of 2022, about 30 MCO states covered 75% or more of children and of non-elderly adults in managed care ([63] www.kff.org); fewer states had 75% or more of aged/disabled enrollees in managed care, but that share is rising.

Regardless of model, the **state is ultimately responsible**. Even under MCO arrangements, states set rules and rates and must ensure network adequacy, quality, and access ([64] www.macpac.gov) ([20] www.kff.org). States often update MCO contracts through RFPs and adjust capitation rates annually with actuaries to reflect costs

and utilizations. NCSL notes that state legislatures often play roles in oversight, setting statutory standards for MCO operations and funding ([62] www.ncsl.org).

Capitation and Payment

A defining feature is **capitated payment**. Under risk-based managed care, "the state Medicaid agency pays each contracted MCO a per member per month fee, called a capitated payment, to cover the costs of all benefits and provider payments for the Medicaid beneficiaries assigned to the MCO model" ([27] www.ncsl.org). These capitation rates are supposed to be **actuarially sound** – set via actuarial analyses of expected costs, and adjusted for the health status (risk adjustment) of enrolled populations ([27] www.ncsl.org) ([14] www.kff.org). For example, CMS requires that rates cover "all reasonable, appropriate, and attainable costs" ([14] www.kff.org), and states must justify rates to CMS. The federal requirement of *actuarial soundness* (42 CFR 438.4) formalizes this. States also may apply **inflation and utilization updates**, risk corridors, and medical loss ratio (MLR) requirements (e.g. ensuring that at least 85% of capitation is spent on medical care) ([14] www.kff.org) ([65] www.kff.org). If an MCO's actual costs exceed payments, the plan absorbs the loss (hence the term "risk-based" managed care). Conversely, if an MCO spends less than the capitation, it generally keeps the surplus (subject to certain MLR or risk-sharing rules).

For historical context, mandatory managed care took off after the Balanced Budget Act of 1997 expanded state flexibility (through waivers) and created financial incentives. Today, federal law provides two main paths for states to enroll groups in managed care: Section 1932 of the Social Security Act (state plan amendments) and Section 1115 waivers (flexible demonstration projects). Each has specific rules, but both ultimately lead to MCO programs. Section 1932 is more streamlined for broad mandates, whereas 1115 waivers have been used for staggered transitions or special populations. Regardless of path, **states retain authority to adjust which beneficiaries or services are included in managed care**, with CMS approval.

Enrollment and Expenditures

Nationwide, Medicaid managed care enrollment has grown steadily. As of July 2022, about 72 million Medicaid enrollees were in risk-based MCOs ([59] www.kff.org). This was roughly 75% of total Medicaid population ([10] www.kff.org). For example, most of ACA-expansion adults (in expansion states) and low-income parents are covered by MCOs ([63] www.kff.org). Enrollment growth spiked during COVID (due to the pause on disenrollments), and even after the unwind, Medicaid enrollment remains about 8 million higher than pre-pandemic ([66] www.kff.org), implying continued high absolute MCO draft.

On spending, managed care commands a majority of funds. In FY2023, of the $880+ billion in Medicaid program expenditures ([12] www.kff.org), ~52% went to MCO payments ([12] www.kff.org). (The rest goes to fee-for-service providers, direct federal costs, administrative expenses, etc.) The share of spending on MCOs varies by state – in states where most beneficiaries are in MCOs, 60+% of dollars flow through MCOs. For instance, KFF notes that in three-quarters of MCO states, at least 40% of Medicaid dollars were paid to MCOs ([67] www.kff.org). As states add higher-need groups (e.g. aged/disabled, long-term care) into managed care, the share of dollars to MCOs continues to rise.

A striking fact is market concentration: **Five large companies cover half of all Medicaid MCO enrollees** ([19] www.kff.org). Centene, UnitedHealth Group, Elevance (Anthem), Molina, and Aetna/CVS each run Medicaid plans in multiple states; their combined enrollment exceeds 50% of all Medicaid managed care business ([19] www.kff.org). All five are Fortune 500 firms, mostly publicly traded. In 2022, 63% of MCO enrollment was accounted for by just 16 multi-state parent companies ([68] www.kff.org). This is relevant because beneficiary

choice in managed care is often limited to the plans each state contracts with, and usually a small number of insurers dominate.

Benefit Design and Carve-Outs

Covered Benefits: Medicaid managed care plans must at least provide all standard Medicaid state plan services (mandatory and optional benefits) for populations included in the MCO. However, states often choose to *carve out* certain services from MCOs. Common carve-outs historically include behavioral health, pharmacy, and long-term services/supports (LTSS) like nursing home care ([15] www.kff.org) ([16] www.ncsl.org). When carved out, those services continue under fee-for-service (or under a separate limited benefit plan or pre-paid inpatient health plan). Carve-outs are used when states feel special attention is needed for expensive or specialized benefits, or when pediatric behavioral/mental health needs coordination. As KFF notes, in 2024 about 31 of 42 MCO states reported the pharmacy benefit was included in MCO contracts, but 8 states carved it out ([15] www.kff.org). Some states even use hybrid models (e.g. a single statewide pharmacy benefit manager with risk-sharing ([69] www.kff.org)). Carving services **into** managed care means the MCO is responsible (and at risk) for those costs, whereas carving out means the state bears the costs in FFS.

Additional Services: Besides state-plan services, MCOs can offer *"in lieu of"* and *"value-added"* services – extra supports not in the state plan, paid out of the plan's capitation. These often include care coordination, transportation, nutrition, home-visiting, or housing supports. Federal rules allow MCOs to provide certain non-traditional services ("in lieu of" the standard care) as long as they are cost-effective ([70] www.macpac.gov). These innovations aim to improve outcomes (e.g. addressing social determinants) but cannot be counted in setting capitation rates.

Network and Access

Under managed care, MCOs contract with provider networks. Unlike Original Medicare's open-access model, network adequacy is a key concern ([71] www.macpac.gov) ([72] www.macpac.gov). Federal regulations require states to ensure MCO networks meet provider-to-enrollee ratio standards, as well as geographic access and timely appointment wait-time standards (recently strengthened under a 2024 CMS rule ([73] www.kff.org)). If networks are too narrow, beneficiaries risk inadequate access, especially specialists. Indeed, MACPAC notes that studies find mixed results: some beneficiaries in MCOs face access problems, especially for mental health or specialists, while others gain better preventive care ([18] www.macpac.gov). For example, a 2011 state survey found two-thirds of states reported at least occasional access issues in MCOs (dental, psychiatry, etc.), but many also saw primary care access improve ([74] www.macpac.gov). The underlying challenge is that capitated payments create an incentive (if rates are low) for plans to curb service use ([75] www.macpac.gov); conversely, states enforce network rules to mitigate it ([72] www.macpac.gov) ([73] www.kff.org).

The network aspect also creates continuity concerns: if an MCO changes its provider contracts, beneficiaries may lose their doctors. One study found that, among Medicaid MCOs in 14 states, 12% of primary care physicians exited MCO networks each year, and 34% left over five years ([76] www.macpac.gov). Plans with narrow networks saw even higher turnover ([76] www.macpac.gov). This turnover can disrupt care. Moreover, MACPAC notes that MA programs (for Medicare) also see access issues with prior authorization and networks; similar pressures affect Medicaid MCOs when states expand managed care to complex populations, such as dual eligibles with specialized needs ([77] www.macpac.gov) ([78] www.macpac.gov).

Access to Care and Quality

Federal law imposes specific quality and access requirements on Medicaid MCOs that do not apply to state-operated FFS Medicaid ([79] www.macpac.gov) ([21] www.kff.org). MCOs must meet network adequacy standards, have adequate timeliness, and undergo periodic External Quality Review (EQR) to assess performance. States often require accreditation, HEDIS reporting, and maintenance of medical loss ratios. KFF points out that the 2024 CMS managed care rule further strengthens timely access (e.g. establishing maximum wait-times for routine appointments) ([73] www.kff.org). However, states vary in how aggressively they enforce standards, leading to mixed beneficiary experiences.

Empirical studies of outcomes are inconclusive. MACPAC's review notes *no definitive evidence* that managed care uniformly improves or worsens access/quality ([17] www.macpac.gov). Some research suggests MCOs can improve preventive care and care management, while other evidence finds gaps remain, especially for specialty services ([80] www.macpac.gov) ([18] www.macpac.gov). For example, pediatric studies found no consistent change in access for children with special needs under managed care ([80] www.macpac.gov). Conversely, one Children's Hospital analysis found Medicaid-insured children with Type 1 diabetes in managed care had *fewer* readmissions than those in FFS ([81] www.macpac.gov), implying better ambulatory management. States themselves often perceive managed care as improving access to primary care (the most cited benefit in a 2011 survey ([82] www.macpac.gov)), even as they report occasional problems with specialists.

Beneficiary satisfaction with Medicaid MCOs tends to be moderate. A 2015 Texas study found MCO members were generally satisfied and that key metrics met or exceeded standards ([83] www.macpac.gov). On the other hand, the HHS Office of Inspector General (2014) found that over half of "secret shopper" calls to providers found no availability for new Medicaid appointments ([74] www.macpac.gov). Long waits (median 2 weeks, some over a month) and difficulty finding network providers were common issues ([74] www.macpac.gov). Geographic and provider shortages, particularly in rural areas, exacerbate access concerns ([84] www.macpac.gov).

Market Characteristics

Medicaid MCO markets are mixed public-private. States contract with a mix of for-profit, non-profit, and even government agencies to serve as MCOs. As of 2022, 282 different state Medicaid MCOs were active ([19] www.kff.org). However, only 16 parent organizations operate plans in multiple states, covering 63% of enrollment ([19] www.kff.org). Five big corporations handle half of all enrollment (Centene, UHG, Elevance, Molina, Aetna/CVS) ([19] www.kff.org); together with four others (CVS, Kaiser, etc), a handful of companies dominate. States sometimes partner with university or local health systems to serve harder-to-reach groups, but these are few. This concentration can limit competition, though it also ensures large insurers have capacity to handle huge Medicaid rolls.

In many states, Medicaid managed care is integrated with Children's Health Insurance Program (CHIP), meaning CHIP beneficiaries (kids in low-income families) are often in the same MCOs as Medicaid kids. In about half of states, Medicaid and CHIP are "aggregated" under one plan type ([85] www.kff.org).

Financial and Operational Challenges

Recent years have presented challenges in Medicaid managed care financing. During the COVID-19 Public Health Emergency (PHE), states paused Medicaid disenrollments, causing enrollment jumps. As of Oct 2024, Medicaid rolls were 8 million higher than pre-pandemic ([66] www.kff.org). This has created uncertainty in utilization patterns. According to KFF, MCOs have raised concerns that existing capitation rates (set under old assumptions) may not cover the increased risk and utilization of a larger, older/more complex enrollment ([86] www.kff.org). Some states are negotiating rate increases or adjusting risk scores to mitigate MCO losses.

On the federal side, proposals to cut Medicaid funding (through block grants or per-capita caps) could dramatically alter managed care dynamics by shifting costs to states. Meanwhile, the 2024 federal managed care rule (CMS 2024) introduces stricter standards on access and payments ([21] www.kff.org), though its future is uncertain given political shifts ([73] www.kff.org). Under the previous (Trump) administration, CMS had relaxed some network requirements ([87] www.kff.org), highlighting that Medicaid MCO regulations can vary widely across administrations.

Table 2: Fee-for-Service vs. Managed Care in Medicaid

Feature	Fee-for-Service Medicaid	Managed Care (Risk-Based MCO)
Provider Payment	State pays providers fee-for-service per claim submitted. Providers receive full payment for covered services (no direct financial risk).	State pays MCO a fixed *capitated* per-member-per-month (PMPM) payment to cover specified services ([13] www.medicaid.gov) ([14] www.kff.org). The plan then pays providers.
Financial Risk	Costs are borne by the state (and federal govt). Utilization determines spending.	MCO bears risk: if actual costs exceed capitation, the plan loses money; if costs are lower, plan retains surplus (subject to any MLR rules) ([88] www.macpac.gov) ([13] www.medicaid.gov).
Provider Network	Any qualified provider who accepts Medicaid can serve enrollees. Beneficiaries have freedom to see any provider (subject to prior authorization rules).	Enrollees limited to the MCO's contracted network (or in PPOs, limited access out-of-network). Network adequacy requirements apply ([71] www.macpac.gov); narrow networks can restrict choice.
Covered Benefits	All mandatory and state-plan optional benefits, plus any covered services. State directly administers all covered services ([27] www.ncsl.org).	MCO is contracted to provide a defined set of Medicaid benefits. Most state-plan services are included, but some (e.g., behavioral health, LTC, drugs) may be carved out of the MCO contract ([15] www.kff.org) ([16] www.ncsl.org). Additional "in lieu of" services may be offered by plans.
Quality Oversight	State ensures providers meet standards; general monitoring by state agencies. No specific federal managed-care quality reviews.	MCOs must meet federal and state access/quality standards (e.g. timeliness, network adequacy) and undergo regular External Quality Reviews and reporting (NCQA/URAC, CMS audit) ([70] www.macpac.gov) ([21] www.kff.org).
Administration	State agency handles eligibility, claims processing, provider payment. (Usually more state staff and systems needed).	MCO handles day-to-day operations under state contract. State oversees contract compliance but offloads claims processing/authorization to plans ([27] www.ncsl.org).
Enrollee Types	State typically covers all eligibles (especially aged/disabled not in MCO). Some states allow opt-out for certain groups.	States often mandate children, pregnant women, expansion adults, and some adults to MCOs. ([63] www.kff.org) Duals and LTC often managed in special plans or transitioned with caution.
Example Challenges	May lack coordination of care; unpredictable costs from year to year.	Network adequacy issues, potential access delays (e.g. specialist referrals) ([71] www.macpac.gov) ([74] www.macpac.gov); sometimes lower administrative overhead for state.

Sources: State Medicaid plan requirements and payment rules ([13] www.medicaid.gov) ([27] www.ncsl.org); KFF and MACPAC analyses of managed care design and impacts ([15] www.kff.org) ([71] www.macpac.gov).

Case Studies and Examples

- **North Carolina's Transition (2021)**: North Carolina implemented mandatory managed care for most Medicaid recipients in July 2021. Under this reform, **providers moved from fee-for-service to capitated payments** ([24] apnews.com). During the change, enrollment swelled to 2.9 million (due to COVID) but is expected to decline post-pandemic ([89] apnews.com). Interviews with NC officials have highlighted initial challenges: some providers shocked by payment cuts, others adjusting to the new risk model ([90] apnews.com). Nevertheless, NC's example shows the trend: even large southern states are committing fully to managed care.

- **Medication Access for Duals**: Historically, many dually eligible (Medicare+Medicaid) individuals receive Medicare drugs via the Low-Income Subsidy in PDPs. However, CMS has encouraged enrollment of duals into **D-SNPs** to align benefits. By 2025, 83% of special needs plan enrollees are duals ([91] www.kff.org), and most duals in MA (57%) are in D-SNPs ([92] www.kff.org). This aligns with CMS's goal (through the 2025 final rule) to integrate Medicare and Medicaid coverage (see below).

- **Medicaid MCO Coverage of Long-Term Care**: Many states originally excluded long-term care (LTC) from MCOs. However, states like California and New York have moved toward managed LTSS. Evaluations of these programs (e.g., Cal MediConnect) suggest mixed results: some gains in care coordination offset by network issues. (A 2016 OIG study found challenges in Cal MediConnect's integration of benefits.) Nevertheless, the national trend is more LTC in MCO, driven by budget pressures and the desire to manage the high costs of nursing home care.

- **Rural Medicaid**: Rural beneficiaries may face provider shortages in either FFS or MCO contexts. Some states partner with Critical Access Hospitals or Rural Health Clinics to meet network adequacy. In Arizona's program, for instance, some tribal communities contract with managed care, raising cultural and network considerations. While data is sparse, anecdotal reports suggest managed care can either improve rural access (via telehealth or transportation benefits) or worsen it if local providers opt out of plans.

Implications and Future Directions

Medicare (Part D vs MA): Future changes hinge on coordinating cost and access. If stand-alone PDPs continue to shrink, policymakers may need to ensure rural and LIS populations aren't forced into MA involuntarily. Conversely, any attempt to adjust MA payments (to narrow Medicare cost gaps) could alter plan offerings or premium levels. The "demonstration" subsidies for PDPs (effective through 2025) may be extended or modified, pending federal budgets and policy priorities. The Inflation Reduction Act's drug cap remains a landmark shift; monitoring its budgetary and clinical impacts will be essential.

Medicaid Managed Care: Key future issues include: how to incorporate new federal rules (2024/25 CMS rules on network/access), what to do about MCO financial solvency (especially after pandemic enrollment drops), and how to balance carve-outs (e.g., Texas recently proposed carving behavioral health back into MCO vs keeping it separate). The prevailing move seems to be *more* services into managed care (some states are even piloting global capitations covering all Medicaid spending). However, debates continue over whether this actually reduces costs or just shifts them. Legislative proposals (at both state and federal levels) around Medicaid block grants or work requirements could dramatically affect managed care viability.

Quality measurement and accountability will grow in focus. KFF notes that 2024's final rule on managed care access may be challenged by new administrations ([21] www.kff.org). In Congress, oversight and audits (GAO, state auditors) will likely scrutinize both Part D and Medicaid MCO spending. For duals, CMS's push to align Medicare and Medicaid implies future models where a single plan coordinates all services, potentially simplifying care for beneficiaries – but also requiring complex contracting between states and federal Medicare programs ([25] www.healthscape.com).

Overall, **Medicare Part D and Medicaid managed care are evolving rapidly** under demographic pressures and policy changes. Our analysis demonstrates the critical differences in design and outcomes between private-plan and traditional models, with important consequences for costs and coverage. The deep citations and data

herein provide an evidence base for stakeholders to understand these dynamics and contribute to informed policy and consumer decisions.

Conclusion

This comprehensive report has examined how Medicare Part D and Medicare Advantage differ in coverage, costs, and market dynamics, and has explained the fundamentals of Medicaid managed care. We find that Medicare beneficiaries now often choose between *Original Medicare + Part D* and *Medicare Advantage (with Part D)*, and that this choice involves tradeoffs: stand-alone PDPs offer network freedom at higher out-of-pocket cost, while MA-PDs offer lower premiums and extra benefits at the expense of provider choice ([7] www.kff.org) ([30] www.kff.org). The data show a continuing shift toward MA-PDs for drug coverage ([4] www.kff.org) driven largely by these cost factors. Policymakers are now grappling with how to preserve access for vulnerable groups (rural, poor) if traditional PDP markets contract ([32] www.kff.org).

On the Medicaid side, managed care is the **default delivery model** in most of the country ([10] www.kff.org). We have detailed how states design these programs – paying MCOs capitated rates, defining benefits and populations, and monitoring quality ([27] www.ncsl.org) ([15] www.kff.org). Despite decades of use, the evidence on managed care's effect on costs and quality remains mixed ([17] www.macpac.gov) ([18] www.macpac.gov). What is clear is that managed care has become the largest single channel of Medicaid spending (over half of Medicaid dollars in 2023) ([12] www.kff.org), and that a few large insurers dominate the field ([19] www.kff.org). Thus, decisions by these companies and state contracts have wide impact on care for low-income Americans.

Looking ahead, changes in law and policy will further shape these programs. The expansion of Medicare Advantage, ongoing Part D reforms (IRA, potential demo extensions), and rules for network adequacy will influence beneficiary experiences. Similarly, Medicaid managed care will evolve under pressures like the end of continuous enrollment, state budget constraints, and federal regulatory initiatives. Of particular note is the drive to **better integrate care for dual eligibles**, aiming to synchronize Medicare and Medicaid coverage – a step that could reshape both systems.

In sum, **Medicare Part D vs Medicare Advantage** and **Medicaid managed care** are distinct yet interrelated parts of the U.S. health system. Each involves complex tradeoffs between cost control and beneficiary choice. This report's evidence-based analysis, bolstered by extensive citations, aims to clarify these tradeoffs. As legislators, regulators, insurers, and beneficiaries navigate future decisions, the data and perspectives provided here should inform choices that balance affordability, access, and quality across these critical public programs.

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Dashboard & Visualization: Interactive business intelligence dashboards, real-time KPI monitoring, and custom data visualization solutions for pharmaceutical insights.

AI Consulting & Training: Comprehensive AI strategy development, team training programs, and implementation guidance for pharmaceutical organizations adopting AI technologies.

Contact founder Adrien Laurent and team at https://intuitionlabs.ai/contact for a consultation.

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