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Protect Medicare's Future: Hold Medicare Advantage Insurance Companies Accountable for Rising Health Care Costs

EXECUTIVE SUMMARY

The Medicare Advantage (MA) program — now covering more than 33 million older adults — was created to deliver higher-quality, more coordinated care at a lower cost. Yet unchecked corporate profiteering within the program has resulted in the program driving significant wasteful spending that undermines Medicare's promise to seniors and taxpayers. Policymakers must act swiftly to strengthen the fundamental design of MA's payment and quality system to ensure the health and financial security of millions of older adults and seniors, and the sustainability of Medicare itself.

A program that costs more and delivers less

Medicare Advantage has failed to deliver on its core promise. Since 2007, MA overpayments have drained nearly $600 billion from the Medicare program. In 2025 alone, taxpayers will spend $84 billion more to cover people in MA than if they were in traditional Medicare — an average 20% overpayment per enrollee. These excess payments drive up Part B premiums for all Medicare beneficiaries and push the Medicare Hospital Insurance Trust Fund closer to insolvency, projected as soon as 2033. And all that spending fails to deliver better care, with MA plans demonstrating inconsistent performance on health care quality and access compared with traditional Medicare.

IN 2025

Taxpayers spent

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covering people in MA vs traditional Medicare.

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Yet MA plans still **fail to deliver better care and access.**

Corporate health plans manipulate the system and drive consumer harm

MA insurers have built a business model that prioritizes profits at the expense of patients. Through systematic upcoding, deceptive marketing of supplemental benefits, and wrongful care denials, corporate health plans exploit flaws in the system to inflate their payments. Seniors are promised better care, but instead often face barriers, delays and denials. For example, there were nearly 90,000 inappropriate denials in 2019 alone, with 83% of appeals overturned in 2023. These practices hurt patients and drain taxpayer dollars.

6 Solutions to Restore Medicare Advantage's Promise

Policymakers must build on recent progress to rein in MA overpayments, stop industry abuses, and restore integrity and fairness to the program by:

- **Cracking down** on upcoding and corporate gaming through strong risk adjustment reform and full implementation of the bipartisan No UPCODE Act.
- **Modernizing** MA benchmarks and bidding to ensure taxpayer dollars reward efficiency and real quality improvement.
- **Reforming** the quality bonus program to be budget neutral and impose penalties for poor performance.
- **Tightening oversight** of vertically integrated insurers to stop them from hiding profits and violating medical loss ratio protections.
- **Expanding transparency** so the public and policymakers know whether MA plans deliver real value and access to care.
- **Investing in traditional Medicare** by adding dental, vision and hearing benefits and a cap on out-of-pocket costs — promoting healthy competition between MA and traditional Medicare to ensure beneficiaries have meaningful, high-quality choices.

A broken payment system and market power run amok

Every piece of the MA payment structure — benchmark and bidding, the quality bonus program, and risk adjustment — is designed to favor corporate health plans. Misaligned incentives mean plans are rewarded even when they fail to improve quality or efficiency, collecting billions in unwarranted overpayments. Meanwhile, just five insurance giants — UnitedHealthcare, Humana, CVS Health/Aetna, Elevance Health and Kaiser Permanente — control 80% of the market, limiting patient choices and using their size and increasing vertical integration to hide profits, avoid accountability, and squeeze patients and providers alike.

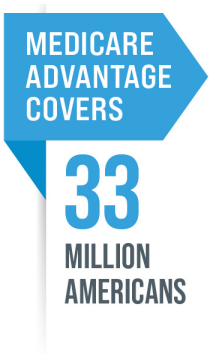
Voters want Congress and the president to act

An overwhelming majority of voters (91%) across the political spectrum want lawmakers to act to hold corporate health systems accountable for charging excessive health care prices. Older adults and taxpayers deserve a Medicare program that delivers value, not corporate windfalls.

Lawmakers must deliver on Medicare's promise

The promise of Medicare is simple: After a lifetime of work, every older adult deserves affordable, high-quality care they can count on. Corporate health systems are breaking that promise. Congress and the Centers for Medicare & Medicaid Services must act now to hold MA insurers accountable, restore fairness to the payment system, and protect the future of Medicare for today's seniors and generations to come.

INTRODUCTION



More than 33 million Americans depend on Medicare Advantage (MA) plans for their health care coverage.[1] Yet, there are significant questions about whether these plans are delivering the quality of care and cost savings they have promised, and there is a lot of evidence that demonstrates big insurance companies are exploiting the MA payment system for financial gain at the expense of our nation's older adults. As policymakers and health advocates work to create a more affordable and equitable health care system, they must focus on reforming Medicare Advantage and specifically work to redesign a payment system so that it better ensures program integrity and accountability. The following policy explainer serves as a primer on the program's current challenges as well as the most promising opportunities for transforming MA for the benefit of patients, families and taxpayers, now and into the future.

Snapshot of a Medicare Advantage program in crisis

First created in 1997, the MA program was designed as an alternative to traditional fee-for-service Medicare (also referred to as traditional Medicare or TM), offering older adults the option to receive most of their Medicare benefits for hospital and medical services (Medicare parts A and B) — and later, prescription drugs (Medicare Part D) — through a more streamlined, tailored and sometimes lower-cost private health plan.[2] These private health plans entice consumers to enroll with assurances of improved care coordination and additional benefits beyond those covered under traditional Medicare as part of the MA program's foundational objectives to enhance the quality of care delivered in Medicare at a lower cost to taxpayers and the federal government.[3] But the Medicare Advantage program has yet to demonstrably achieve those goals, failing to generate federal savings or to meaningfully improve health care quality for Medicare beneficiaries.[4]

In large part, the program's failures stem from a misalignment between the business interests of MA insurers and the interests of both the patients they serve and the taxpayers who support the Medicare program. Many insurers are deliberately manipulating flaws in the MA payment system in ways that undermine the health and financial well-being of our nation's older adults as well as the federal government.[5] These harmful practices include systematic "upcoding" of patient diagnoses that do not reflect the actual care that beneficiaries are receiving, manipulation of the quality bonus program and star rating system, predatory and deceptive marketing schemes to prospective

Many insurers are deliberately manipulating flaws in the MA payment system in ways that undermine the health and financial well-being of our nation's older adults as well as the federal government.

beneficiaries, and overly aggressive and medically inappropriate care denials, among others.[6] Collectively, these practices deprive beneficiaries of access to medically necessary care when they need it most, drive higher Part B premiums, and contribute to hundreds of billions of dollars in wasteful federal spending — putting the financial solvency of the Medicare trust funds at risk.[7]

With more than half of eligible Medicare beneficiaries now enrolled in MA — and the program being predicted to grow to cover nearly two-thirds of all Medicare beneficiaries by 2034 — there is an urgent need to fundamentally reform the Medicare Advantage program, including by improving government oversight of MA plans and cracking down on insurers' corporate coding abuses and overpayments.[8]

High costs, questionable quality and limited access to care

Medicare Advantage is an expensive taxpayer investment. Since 2007, inflated spending in the MA program has cost the federal government nearly $600 billion.[9] As program enrollment increases, so does the level of overspending. **In 2025 alone, Medicare is projected to pay 20% more to cover enrollees in MA than it would spend if those same beneficiaries were enrolled in traditional Medicare — a difference that amounts to $84 billion in extra spending in just one year.**[10] Because the MA program is funded through a combination of the Medicare Hospital Insurance (Part A) Trust Fund and the Supplementary Medical Insurance (Part B) Trust Fund, this wasteful spending is a direct threat to Medicare sustainability. This is particularly perilous given that the Medicare trustees project that the Part A trust fund will become insolvent by 2033.[11] Moreover, this higher MA spending results in higher Part B premiums for *all* Medicare beneficiaries, whether or not they are enrolled in an MA plan.[12] For example, **Part B premiums for enrollees in TM and MA increased by a staggering $13 billion in 2024 alone as a direct result of MA overspending.**[13]

This high cost of health care delivered through Medicare Advantage is especially egregious given its inconsistent performance on health care quality and access compared with traditional Medicare.[14] For example, TM outperforms MA on key quality measures such as ensuring patients undergoing cancer treatment receive care in highly rated hospitals, skilled nursing facilities and home health agencies,

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and minimizing hospital readmissions among patients initially hospitalized for heart attack, congestive heart failure or pneumonia.[15] Research even shows that TM outperforms MA on the overall use of high-value care, including preventive care.[16]

Of further concern is the bait and switch that many MA beneficiaries experience under the promise of access to additional benefits not otherwise available in traditional Medicare (known as supplemental benefits), as well as guarantees of reduced cost sharing for some medical services.[17] While traditional Medicare is not authorized to provide certain widely popular and medically necessary services — including comprehensive dental, vision and hearing services — private MA plans can elect to cover a broad array of medical and nonmedical benefits tailored to meet the needs of older Americans. But while MA insurers tout these expansive supplemental benefits as a key marketing tool to lure seniors into the MA program, they also aggressively and often inappropriately restrict access to those benefits through care denials and prior authorizations that prevent older adults from accessing the very care they enrolled to receive.[18] For example, MA insurers *wrongfully* denied nearly 90,000 prior authorization requests in 2019 alone.[19] And in 2023, 83% of MA care denials that were appealed were successfully overturned after being determined to have wrongfully denied access to medically necessary care.[20]

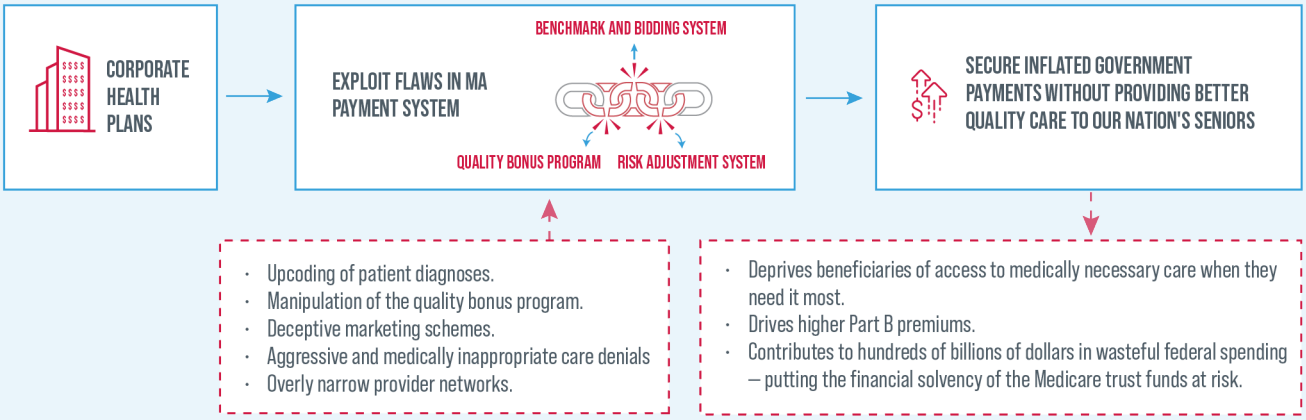
Taken together, high and rising MA program costs, mixed performance on health care quality, and widespread wrongful care denials are symptoms of a broken MA system that is failing to meet the needs of our nation's seniors, taxpayers and the federal government.

A flawed business model that conflicts with the interests of our nation's seniors

Over the last 60 years, the role of health insurers and the business of health insurance has changed dramatically.[21] What started as a system of independent local health plans with a mission to provide high-quality, affordable health care to communities has radically shifted into a multitrillion-dollar industry in which large health insurance corporations are laser-focused on increasing their revenues and profits while doing everything they can to minimize their costs and expenditures.[22,23,24] MA insurers are no exception, adopting a core business model that leverages the MA program to maximize Medicare payments from the federal government while minimizing the costs they incur for providing care to older adults.[25] As a result, insurers make nearly double the profit per enrollee in the MA market than they do in the commercial market, draining our nation's federal health care resources.[26]

A key strategy of these large insurance corporations is to manipulate the Medicare payment system to secure inflated payments from Medicare, including through the systematic upcoding of patient diagnoses that often do not reflect the actual care that beneficiaries receive, all while restricting patient access to care through the use of narrow provider

Medicare Advantage Insurers Exploit the System at the Expense of Our Nation's Seniors



networks and prior authorization to reduce insurers' health care spending.[27] MA insurers are able to pocket a growing portion of those inflated payments as profits, while using the remaining portion to offer low-value benefits that sound attractive to persuade Medicare patients to enroll in their plans.[28] This business model is costly and wasteful for the federal government and bad for the health and well-being of our nation's older adults.[29]

Weaknesses in the MA payment system

Payments to Medicare Advantage insurers should reflect the actual cost and value of delivering medically necessary care, not how cleverly health plans can game the Medicare payment system. MA insurers should generate revenue because they provide comprehensive health care coverage, meaningful access to critical health care services, and measurable improvements in patient health outcomes for the patients they serve. Yet, this is not how the MA program currently operates, in part because the MA payment system is rife with misaligned incentives.

The stated intent of the MA payment system is to incentivize MA insurers to compete on the cost, quality and efficiency of the coverage they offer to enrollees relative to other MA insurers and to traditional Medicare.[30] If MA insurers offer Medicare coverage at a lower cost than average TM spending, particularly while achieving high-quality scores (that is, high star ratings), they are financially rewarded.[31] However, **flaws in each of the three components of the MA payment system — the benchmark and bidding system, the quality bonus program, and the risk adjustment system — have allowed MA insurers to inflate their payments from the federal government without meaningfully and consistently providing better quality care to our nation's seniors.**[32]

The benchmark and bidding system: An outdated approach that fails to ensure appropriate payment in an evolving coverage landscape

The Centers for Medicare & Medicaid Services (CMS) sets monthly payments to MA plans based on a comparison between MA plan bids (that is, the plan's best guess of how much it will cost to cover Medicare Part A and Part B benefits for an average MA enrollee) and benchmarks based on TM (that is, the cost of providing Part A and Part B services for the average enrollee in TM).[33] This benchmark and bidding system provides the core around which all MA payments flow. The way that CMS determines specific benchmarks has changed over the years, largely in efforts to increase access to MA plan choices, and particularly in certain communities with historically fewer plan options and ultimately lower program participation. As the MA program has evolved, so too has the need to evolve the benchmarking system. However, the changes needed to modernize the benchmarking system have not kept pace with the growth of the MA program and ultimately have led to misaligned payments that do not reflect the true cost of care.

Prior the Affordable Care Act, MA benchmarks were set at a uniform rate above traditional Medicare costs, which spurred growth in access to MA across the country, but that growth was uneven.[34] The result was that MA plans became widely available in some areas of the country but remained unavailable in others, particularly in low-spending, often rural regions of the country where the benchmarks were not attractive enough to incentivize plans to enter the market.[35] The Affordable Care Act addressed this issue by establishing the quartile-based benchmark system, which sets MA payment caps relative to local fee-for-service costs, paying plans up to 115% of fee-for-service in the lowest-spending areas, 107.5% in the second quartile, 100% in the third quartile, and just 95% in the highest-spending areas.[36] By boosting benchmarks in low-cost areas and capping them in high-cost areas, this new quartile-based benchmark payment system helped to encourage plans to expand nationwide, including into rural and low-cost regions; to create more access to MA across geographies; and to control federal spending growth in more expensive areas.[37]

While this approach was initially successful, the MA program ultimately outgrew it. Plans became widely available and accessible across the nation, with the average beneficiary now having access to 42 different MA plans and nearly 100% of eligible beneficiaries having access to at least one zero-dollar premium plan with drug coverage.[38] Incentives that were once driving better access are now misaligned in a saturated MA coverage market, instead creating arbitrary geographic inequities that funnel excess payments to historically low-cost areas where MA plans are rewarded above the actual cost of care, while failing to meaningfully drive efficiency and higher-value care in high-cost regions.[39]

Exactly how does that play out? In low-spending areas, benchmarks are set well above traditional Medicare costs (up to 115%), allowing MA plans to capture excess federal dollars without demonstrating added value. Higher MA payments are therefore driven into areas of the country where TM spending is low and health care utilization is less, whether due to having healthier populations or greater health system efficiencies.[40] This happens despite the fact that most plans bid below TM spending in these areas. As a result, payments to MA plans are 9% higher than the TM spending in those areas.[41]

In high-spending regions, benchmarks are set to 95% of traditional Medicare, but the downward pressure on costs at this level is undermined because plans can still inflate payments through risk adjustment coding and can capture generous rebates without creating greater efficiencies.[42] Under the quartile-based benchmark system, plans in areas of the country where TM spending is higher can game the system by strategically bidding below inflated benchmarks, which results in the federal government paying a disproportionately higher rebate to these plans.[43] And while MA plans are required by law to use these rebate dollars to provide additional benefits and/or lower cost sharing to beneficiaries, MA plans channel a shrinking share of those rebates into meaningful benefits for enrollees.[44] In fact, evidence suggests that plans actually retain a significant share of these rebate dollars in the form of higher profits, with consumers receiving less than half of the rebate in new benefits or cost sharing, and in many cases as little as 12.5% of the increased MA plan payments.[45]

Fundamentally, the quartile-based benchmark payment system skews plan growth toward low-cost areas and allows plans in high-cost areas to profit without delivering true efficiency gains — driving distortions in federal spending while failing to reduce overall Medicare costs. Simply put, the quartile-based benchmark system is outdated and needs reforms that are more reflective of the true cost of providing care and that drive greater efficiency and higher-value care to our nation's seniors.

The quality bonus program

After the benchmark and bidding process, CMS further adjusts MA plan payments based on the quality of care and coverage provided to their enrollees using a five-star rating system under the umbrella of a quality bonus program (QBP). This system measures plan performance on a large number of clinical quality, patient experience and administrative performance measures.[46] However, despite the fact that 80% of MA plans now achieve quality bonus payments (meaning they receive a rating of four stars or higher), the evidence is clear that quality bonus payments do not drive meaningful or consistent improvements in plan quality.[47] There are a number of problems with the QBP, including:[48]

- **Quality is scored at the overarching contract level, even for contracts that cover large and disparate areas through multiple MA plans and plan designs.** This means star ratings assigned to an individual MA plan do not necessarily reflect the quality a beneficiary would receive, since the ratings are based on quality scores averaged across *multiple* MA plans

included under one contract.[49] MA insurers have actually gamed this flaw by combining their lower-performing MA plans and contracts into contracts with higher star ratings in order to inflate their QBP payments without actually improving health care quality or coverage.[50] Between 2012 and 2016 alone, this gaming drove an estimated $1.1 billion in extra Medicare payments to MA plans.[51]

- **Differences in enrollee social risk are not adequately accounted for when calculating star ratings, which skews plan performance on driving meaningful quality improvements.** Ultimately, plans may still be disincentivized to enroll beneficiaries with social risk factors and relatedly higher health care needs and spending, and some plans even engage in discriminatory behavior such as adverse selection in order to maintain their high star ratings and QBP payments.[52]
- **There are both too many measures and not enough of the right measures to fully account for plan performance and to hold plans accountable for driving quality improvement.** For instance, the QBP is missing many externally validated measures used to assess clinical quality, such as measures assessing mortality rates and hospital readmissions, while the QBP's "administrative measures" do not hold MA insurers accountable for inappropriate care denials that run contrary to Medicare coverage requirements or for overly restrictive and narrow provider networks.[53]
- **Performance targets are set at inconsistent levels, making it challenging for plans to know how quality ratings impact QBP payments and failing to incentivize meaningful improvements in plan performance.** Targets for each quality measure are set based on the relative performance of other plans, which are adjusted annually and often have minimal differences between performance targets that give an MA insurer a three-star rating versus a four-star rating and so on.[54]
- **The QBP is not budget neutral.** It only provides bonus payments and does not include financial penalties for poor performance, failing to balance the substantial rewards it provides to plans and failing to more effectively hold plans accountable for improving health care quality.[55]

Wasteful spending under the QBP is significant. In 2025 alone, Medicare paid MA plans an *additional* $15 billion through the quality bonus program despite little evidence to demonstrate commensurate improvements in health care quality being delivered by these plans.[56]

The risk adjustment system

In the final component of MA payment, CMS uses a risk adjustment model to increase or decrease base payments to MA insurers based on the characteristics and diagnoses of each enrolled patient, to account for differences in health care costs between healthier and

sicker enrollees.[57] One of the major goals of risk adjustment is to prevent insurers from engaging in adverse selection and other discriminatory business practices that maximize plan profit by failing to cover patients most in need of health care.[58] However, the current risk adjustment model is prone to significant MA plan gaming, where plans use certain billing and coding practices to make their enrollees appear sicker and more expensive relative to traditional Medicare beneficiaries in order to generate a higher reimbursement from the federal government.[59] This systematic upcoding occurs despite the fact that MA enrollees actually tend to be healthier and less costly to cover overall than those in TM.[60]

Since MA plan payments are risk adjusted primarily by the numbers and types of diagnoses reported by MA plans on behalf of their enrollees (for example, plans are paid more to cover enrollees with relatively more diagnoses or diagnoses linked to higher care and treatment costs), MA plans have a strong financial incentive to identify and record as many diagnoses as possible among their enrolled beneficiaries.[61] Most concerningly, some MA plans go as far as assigning patient diagnoses that are not even supported by the patient's medical record, relying on sham health risk assessments and chart reviews to support their diagnosis claims.[62]

These coding practices allow MA insurers to receive higher risk-adjusted payments, often without delivering additional care or coverage to beneficiaries, even in the cases of patients with chronic diseases and comorbidities who truly need that additional care.[63] These coding abuses of the risk adjustment system further inflate Medicare payments to MA plans, costing Medicare an additional $40 billion every year.[64]

Vertical integration fuels overpayments and undermines medical loss ratio requirements

These overpayments driven by a broken MA payment system have been supercharged by dramatic consolidation between health insurers (horizontal integration) as well as between insurers and health care provider groups and other health care entities (vertical integration), which has resulted in nearly 80% of the Medicare Advantage market being controlled by just five large insurance corporations: UnitedHealthcare, Humana, CVS Health/Aetna, Elevance Health (formerly Anthem) and Kaiser Permanente.[65] As of 2024, nearly all beneficiaries (95%) live in counties with highly concentrated MA markets.[66] This means that while Medicare beneficiaries may seemingly have access to more MA plan choices, these plans are mostly controlled by the same five dominant health insurer parent companies, which actually reduces meaningful plan choices for beneficiaries.[67] This unchecked consolidation undermines healthy competition and allows MA insurers to focus on minimizing their costs and expenditures to the detriment of improving health care quality, making care delivery more efficient, or lowering premiums and offering more benefits.[68]

This extreme market consolidation has left the MA program even more vulnerable to MA insurers' harmful practices, including corporate coding abuses and exploitation. For example, rapid

increases in vertical integration have occurred over the last 10 years, with MA insurers purchasing provider groups and other health care entities, such as hospitals, pharmacy benefit managers and pharmacies. Through these vertically integrated systems, insurers can more aggressively engage in upcoding by financially incentivizing their providers to capture and submit as many potential medical conditions as possible — making their patients appear sicker and more expensive than they really are — thereby inflating their Medicare payments.[69] For instance, UnitedHealthcare — now the largest employer of physicians in the United States, with over 90,000 employed or affiliated nationwide — offers lucrative bonuses and manufactures internal competitions between physicians, complete with a "doctor leaderboard" and prizes, as a way to financially incentivize and pressure their providers to code as many diagnoses as possible among their Medicare Advantage patients.[70] As a result, vertically integrated plans like those offered by UnitedHealthcare generate significantly higher overpayments due to upcoding as compared with MA plans that are not vertically integrated.[71]

The threats posed by vertical integration do not end there. Unchecked consolidation in the MA market has allowed insurers to undermine medical loss ratio (MLR) requirements, one of the few tools policymakers have to ensure taxpayer dollars are spent on patient care rather than insurer profits, marketing or executive salaries.[72] Plans that directly employ providers can more easily steer a greater percentage of their Medicare payments to their profit margins instead of toward patient care by gaming medical loss ratio requirements. MLR requirements are critical patient protections put in place under the Affordable Care Act to ensure the majority of premium dollars (85%) are spent on health-related expenses and not an insurance company's administrative costs or profits.[73] However, because provider practices are not subject to MLR requirements, once a plan acquires a provider group, the insurance plan can then pay the providers above market rates and report that amount as a medical cost even though those payments ultimately result in additional profit for the parent company beyond what the MLR requirement would allow.[74] In other words, when MA insurers vertically integrate with providers and related businesses, they can shift profits into those entities and make medical spending look higher on paper, allowing them to meet MLR requirements while retaining excess revenue.[75] Large insurance corporations use this strategy to maximize their revenues and profits by diverting a larger and larger share of their Medicare payments toward their profit margins and away from patient care. In fact, some estimates suggest that vertically integrated plans could be spending as little as 70% of their premium dollars on patient care.[76] **This unchecked vertical integration allows for insurers to subvert MLR rules and directly undermines the purpose of the MLR rule and its ability to ensure that taxpayer dollars are spent on patient care rather than insurer profits.**

Promising solutions underway to strengthen the MA program

The Medicare program represents a long-standing promise to our nation's seniors that after a lifetime of work, they will have guaranteed access to affordable, high-quality health care. Medicare is a pillar of economic and health security for older adults, ensuring they are not left to shoulder the burden of rising medical costs alone. To keep that 60-year-old promise to our seniors, whether they are enrolled in traditional Medicare or Medicare Advantage, and to ensure the health and financial well-being of future generations, federal policymakers must act now to ensure Medicare's program integrity and long-term sustainability.

The good news is that elements of MA reforms are already underway at CMS — the result of bipartisan support in Congress and through Democratic and Republican administrations alike. Examples include:

- **Implementation of a more accurate risk adjustment model.** In 2024, CMS began implementing a new risk adjustment model (2024 CMS-HCC Risk Adjustment Model) to mitigate MA insurers' systematic upcoding.[77] This updated model will be fully phased in by 2026 and will reduce the value in the risk adjustment model of targeted diagnoses that are prone to inflated coding and drive wasteful Medicare spending — or remove these diagnoses all together.
- **Strengthened MLR reporting requirements.** In the Contract Year 2026 Policy and Technical Changes proposed rule, CMS proposed to restrict vertically integrated MA insurers from reporting certain financial incentives that are used to drive upcoding as "medical spending" for the purposes of MLR reporting. If implemented, this provision would help to reduce the financial incentive for vertically integrated MA insurers and their providers to inflate Medicare payments by capturing and submitting as many potential medical conditions as possible.[78]
- **Enhanced risk adjustment data validation (RADV) audits.** In 2023, CMS finalized enhanced RADV audits of Medicare Advantage insurers' coding practices. These audits involve CMS reviewing a sample of diagnoses billed by MA insurers to check if the diagnoses are supported by beneficiaries' medical records and then clawing back any improper payments associated with unsupported diagnoses.[79]
- **Additional guardrails against inappropriate care denials.** In 2024, CMS codified strengthened patient protections against inappropriate care denials by requiring MA insurers to cover medically necessary care for standard TM benefits, including Part A and Part B benefits, when they meet TM coverage requirements.[80] For services where there is no standard TM coverage guidance to follow, MA insurers now to have make public the evidence and rationale for making determinations about medical necessity when deciding to approve or deny coverage for any such service.[81]

- **Restrictions against misleading marketing practices.** In 2024, to combat misleading marketing by MA insurers and their brokers and agents, CMS finalized new beneficiary protections, including placing limits on advertisements, marketing calls and events, as well as additional requirements on agents to explain coverage options more fully.[82]
- **Improved transparency and quality of MA encounter data.** In early 2024, CMS published new guidance clarifying that MA insurers are required to include utilization and payment information for supplemental benefits offered to beneficiaries in MA encounter data submissions.[83] This is a critical step to promoting true transparency in the MA program and allowing CMS, as well as researchers and the public, to evaluate the extent to which the supplemental benefits offered by MA insurers are providing value to beneficiaries' health and health care.[84]

Key policy reforms to rein in wasteful MA overpayments and strengthen health care quality

These approaches represent meaningful progress. But reining in MA overpayments and fixing the broken financial incentives that allow MA insurers to drive wasteful spending and limit access to high-quality care will require multipronged policy solutions, reforming the MA payment system as well as the underlying financial incentives that are at odds with the interests of patients and families. In the short term, policymakers should focus on implementing policies that rein in wasteful MA overpayments, including cracking down on upcoding practices, stopping inappropriate care denials, and increasing transparency into the value and access of supplemental MA benefits. In the long term, policymakers should redesign the economic incentives of the MA payment system to be aligned with the needs of older adults. Congress and CMS should work to reorient the MA program to the goal we all have — improved health care for ourselves and our families that is affordable and economically sustainable.

To more fully realize that vision, policymakers should pursue key reforms such as:

Strengthening the risk adjustment system against industry gaming to prevent MA insurers from wrongfully billing diagnoses at a higher rate than in TM in order to inflate their Medicare payments without providing additional care or coverage. Coding reforms drafted in the bipartisan No Unreasonable Payments, Coding, Or Diagnoses for the Elderly (No UPCODE) Act would rein in abuses used by MA insurers to inflate their payments, including sham health risk assessments and chart reviews, and save up to $1.5 billion over 10 years, according to the Congressional Budget Office.[85]

Improving the MA benchmark and bidding system to ensure MA insurers are only financially rewarded for bidding at or below their true costs and to promote healthy competition between MA plans and TM. Potential benchmark reforms could include

calculating benchmarks using a blend of national and county-level TM spending as well as initiating long-term reforms that test setting MA benchmarks using an administrative benchmark approach by taking a base payment rate and increasing it year over year using a fixed administrative factor or through competitive bidding.[86]

Holding MA insurers accountable for delivering high-quality care and coverage by strengthening the quality bonus program. Reforms include making quality bonus payments budget neutral, incorporating financial penalties where appropriate, and setting higher performance targets not based on average plan performance.[87] These QBP reforms, including making the QBP budget neutral, would save an estimated $12 billion annually, or $120 billion over 10 years.[88]

Mitigating the harms related to vertically integrated plans and ensuring health care dollars are spent on the health and health care of our nation's families. Reforms could include strengthening MLR reporting requirements to ensure vertically integrated plans report their overall MLR for both their insurance plan and their provider group(s) at the parent company level for their Medicare beneficiaries. Other reforms could include requiring vertically integrated plans to report their transfer prices (that is, the prices they are paying their affiliated and employed providers) as well as establishing pricing benchmarks to ensure these plans are paying similar fair market rates to their affiliated and employed providers as they do to unaffiliated providers.[89]

Promoting meaningful transparency into the MA program by requiring MA insurers to submit high-quality and complete encounter data to CMS. Lawmakers and the public need to be able to understand the extent to which the MA program is fulfilling its obligations to deliver affordable and quality care. Greater transparency into MA encounter data is also critical to better understand the use of prior authorization in the MA program and the marketing of supplemental benefits. Transparency is the foundation of appropriate program regulation and oversight, and it would inform meaningful and targeted policy solutions to remove unnecessary barriers to accessing key services, to reform prior authorization processes to improve the efficiency and transparency of patient care, and to eliminate prior authorization for services with strong evidence for being of low value to patients.

Investing in improvements to traditional Medicare such as adding a standard dental, vision and hearing benefit and an out-of-pocket maximum to improve meaningful competition between Medicare Advantage and traditional Medicare. Healthy competition can drive improvements to cost efficiency, quality, access and innovation in the care delivered to *all* Medicare beneficiaries. This includes creating stronger incentives to control health care costs and close the payment gaps between the two programs, increasing beneficiary choices, and raising the standard of health care quality across the entire Medicare program.

MA insurers continue to engage in harmful practices to receive higher government payments, consolidate and offer unreliable coverage — and ***the health and health care of millions of current Medicare beneficiaries and all future generations hang in the balance.***

Conclusion

As millions of people transition into retirement, now more than ever, Medicare serves a critical role in the care and coverage of our nation's families. Yet, older adults are increasingly enrolling in plans run by MA insurers whose business interests are in direct conflict with the health and financial well-being of Medicare beneficiaries. With each year that passes, MA insurers continue to engage in harmful practices to receive higher government payments, consolidate and offer unreliable coverage — and the health and health care of millions of current Medicare beneficiaries and all future generations hang in the balance.

The American people want policymakers to take action. An overwhelming majority of voters (91%) across the political spectrum want lawmakers to act to hold corporate health plans and health systems accountable for driving unaffordable health care.[90] Specifically, 8 in 10 voters support policies to prohibit Medicare Advantage insurance companies from exaggerating patients' health risks to get paid more and to require MA plans to improve data reporting transparency and take responsibility for their spending of taxpayer money.[91]

Now is the time to reform the MA payment system and hold big MA health insurance corporations accountable to patients and taxpayers. Only then can we ensure that the Medicare program is sustainable and that all Medicare beneficiaries receive high-quality care and coverage that meet their needs no matter which coverage option they choose.

Endnotes

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MCR2025-28