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# Medicare Advantage Overpayments Under the Microscope

The Medicare Advantage (MA) program has grown to cover over 55% of eligible Medicare beneficiaries, with approximately 34.9 million enrollees in 2025 and 5,492 plan options offered by 164 organizations.[1] As MA's market share has expanded, so too has the federal government's financial exposure. In its March 2026 Report to the Congress, the Medicare Payment Advisory Commission (MedPAC) estimated that Medicare will spend approximately $76 billion more on MA enrollees in 2026 than it would have spent if those same beneficiaries were enrolled in Traditional fee-for-service (FFS) Medicare – a difference of roughly 14%, out of projected total MA payments of $615 billion.[2] That estimate, combined with a new congressional analysis of the downstream premium effects of MA overpayments and a January 2026 proposal by the Centers for Medicare & Medicaid Services (CMS) to hold MA payment rates nearly flat for 2027, has placed the program squarely at the center of an intensifying policy debate. This *Health Capital Topics* article examines the sources of these excess payments, the regulatory and enforcement landscape, and the powerful industry lobbying apparatus that may complicate efforts to address them.

## MedPAC's March 2026 Report

Each year, MedPAC compares total Medicare spending on MA enrollees with what the program would have spent if those same individuals were enrolled in Traditional FFS Medicare, adjusting for health status, geographic distribution, and coding differences. The Commission identified two primary drivers of the $76 billion gap: favorable selection and coding intensity.[3] MedPAC noted that, before accounting for either factor, MA spending would actually have been approximately $3 billion *lower* than FFS spending for similar beneficiaries, suggesting that the excess payments are entirely attributable to these two systemic distortions.[4]

Favorable selection (the larger of the two factors) occurs when beneficiaries who enroll in MA plans turn out to be healthier and less costly than their risk scores predict. MA plan designs, including the use of prior authorization and comparatively narrower provider networks, tend to attract beneficiaries who use fewer medical services than their counterparts in Traditional Medicare. MedPAC projected that favorable selection will increase MA payments by roughly 11% above what the program would have paid under FFS Medicare in 2026, accounting for approximately $57 billion of the $76 billion in excess payments.[5]

Coding intensity, often referred to as "upcoding", reflects the tendency for more diagnostic codes to be recorded for MA enrollees, which inflates risk scores and thereby increases per-beneficiary payments from the federal government. MedPAC estimated that MA risk scores in 2024 were approximately 14% higher than scores for similar FFS beneficiaries due to higher coding intensity.[6] For 2026, the Commission projected that the gap narrowed to approximately 10%, driven by the completed phase-in of CMS's V28 risk adjustment model.[7] After CMS's statutory minimum coding pattern adjustment of 5.9%, MedPAC estimated that MA risk scores remain roughly 4% higher than they would have been in FFS, resulting in approximately $22 billion of the $76 billion in excess payments.[8] MedPAC's $76 billion estimate is notably lower than the $84 billion projected for 2025 in the Commission's prior report, a reduction the Commission attributes to the V28 model's intended effect of reducing coding intensity by an estimated 2.9 percentage points in each year of its three-year phase-in.[9]

MedPAC further reported that Medicare's capitated payments to MA plans are expected to average $16,242 per beneficiary per year in 2026, including an average of $2,660 per beneficiary per year in rebate payments that fund supplemental benefits.[10] Plans project allocating those rebates as follows: approximately 26% to reduce enrollee cost sharing, 38% for non-Medicare services, 19% to enhance Part D benefits, 7% to reduce Part B premiums, and 10% for administrative expenses and profit.[11] The average rebate amount has more than doubled since 2018 and now accounts for approximately 15% of total MA payments.[12] The Commission also estimated that the MA quality bonus program will add approximately $16 billion to MA payments in 2026, with 64% of MA enrollees expected to be in plans qualifying for bonus payments.[13] The Commission also noted significant heterogeneity in coding intensity across plans: 16% of MA enrollees were in plans with coding intensity below CMS's adjustment threshold, while eight MA organizations had average coding intensity over 20% above FFS levels.[14] If current overpayment trends continue, the Committee for a Responsible Federal Budget has projected that MA overpayments could total $1.2 trillion over the next decade.[15]


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**The Premium Pass-Through Effect**

In a report released on March 10, 2026 (days before MedPAC's March report), the Joint Economic Committee (JEC) detailed how MA overpayments directly increase Medicare Part B premiums for all beneficiaries.[16] Per statute, the standard Part B premium is set to cover approximately 25% of expected Part B spending per enrollee.[17] Because MA overpayments increase overall Part B spending, the excess cost is mechanically passed through to all Part B beneficiaries in the form of higher monthly premiums, regardless of whether the individual is enrolled in MA or Traditional Medicare.[18]

The JEC estimated that MA overpayments increased Part B premiums by $212 per enrollee in 2025, totaling $13.4 billion in additional premiums across all 63.5 million Part B beneficiaries.[19] The Committee calculated this figure using MedPAC's $84 billion overpayment estimate for 2025, multiplied by Part B's 60.6% share of MA payments and the 26.4% share of Part B costs financed by premiums.[20] Traditional Medicare beneficiaries, who do not receive the supplemental benefits offered by most MA plans, shouldered approximately $6 billion of that financial burden.[21] Since 2016, cumulative excess premiums attributable to MA overpayments have totaled an estimated $82 billion.[22] Approximately 84.9% of the excess premium burden falls on individuals – most of whom have premiums withheld directly from Social Security checks – with the remainder paid by federal taxpayers (9.1%) and state taxpayers (6.0%).[23]

JEC Chairman David Schweikert stated that "between aggressive upcoding, questionable quality bonuses, and structural overpayments in Medicare Advantage, seniors who stay in traditional Medicare are effectively subsidizing the system."[24] Looking ahead, the JEC projected that per-person Part B premiums are on track to nearly double from approximately $2,440 to $5,000 by 2035.[25] Approximately $450 of that amount (per beneficiary per year) would be attributable to continued MA overpayments if current payment policies remain unchanged.[26] The Committee recommended aligning MA payment levels with Traditional Medicare, estimating that gradually achieving payment parity could save each senior approximately $2,600 over the next decade.[27] The standard monthly Part B premium has already risen from $185 in 2025 to $202.90 in 2026.[28]

**CMS's January 2026 Advance Notice: A Proposed Nearly Flat Payment Increase**

These findings from MedPAC and the JEC come against the backdrop of CMS's Calendar Year 2027 Advance Notice, released on January 26, 2026. CMS proposed a net average year-over-year payment increase of just 0.09% (approximately $700 million in additional MA payments), a figure far less than the 5.06% update finalized for the prior year.[29] When accounting for estimated risk score trend growth of 2.45% driven by coding practices and population changes, the expected average change in total payments would be approximately 2.54%.[30]

Among the most consequential proposals in the Advance Notice is a plan to exclude diagnosis information from unlinked chart review records, i.e., diagnosis data not associated with a specific beneficiary encounter, from risk score calculations beginning in 2027.[31] CMS estimates that this proposal alone would reduce Part C payments by approximately $7.2 billion.[32] CMS Administrator Dr. Mehmet Oz stated that the proposed policies are designed to help "ensure beneficiaries continue to have affordable plan choices and reliable benefits, while protecting taxpayers from unnecessary spending."[33] A final rate decision is expected by early April 2026.

**Industry Pushback and the MA Lobbying Apparatus**

The MA industry has mounted a significant campaign in response to both MedPAC's findings and CMS's proposed rate. CMS reported receiving nearly 47,000 comments on the 2027 Advance Notice, a record-breaking figure.[34] However, KFF Health News found that approximately 82% of the comments (of the approximately 16,400 posted comments as of the date of the investigation) were identical to a template letter posted on the website of Medicare Advantage Majority, a secretive advocacy group that does not disclose its funders.[35] The organization has spent over $3.1 million on hundreds of Facebook advertisements since September 2024.[36]

Insurer-backed lobbying organizations have also mobilized. The Better Medicare Alliance (BMA), whose founding members include UnitedHealth Group, Humana, and Aetna, along with the Healthcare Leadership Council, have criticized MedPAC's methodology, endorsed a Wall Street Journal editorial calling for MedPAC to be defunded, and supported legislation that would dictate how the Commission's staff conducts research.[37] In 2022, BMA reported expenses of $23.1 million, including over $14 million on advertising and promotion, and the organization has previously run Super Bowl advertisements depicting proposed MA payment changes as harmful cuts to seniors' benefits.[38] BMA's spokesperson has also mobilized beneficiaries to write letters and make phone calls, stating that roughly 3 million seniors were "forced to find new coverage" in 2026 because plans either closed or exited certain markets.[39]

MedPAC's findings have also been characterized by industry groups as relying on flawed analysis. BMA's senior vice president of public affairs stated that MedPAC's estimates "do not accurately reflect Medicare Advantage spending, nor do they even attempt to capture the superior value of the program to beneficiaries and taxpayers." The Healthcare Leadership Council called the JEC's report "the latest example of a recurring reliance on MedPAC's false narrative regarding MA's payment rate compared to Traditional Medicare."[40] Market analysts observe, however, that the MA industry's lobbying efforts have historically produced results: CMS has frequently finalized higher rates than initially proposed, creating an expectation among


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insurers that the political process will yield more favorable outcomes.[41]

**Enforcement Trends: Following the Money**

Government regulation and enforcement often follow the money, and the scale of MA spending, which reached $537 billion in 2025, with projections of $615 billion for 2026, has attracted increasing scrutiny from federal investigators.[42] UnitedHealth Group, the nation's largest MA insurer, is currently the subject of both criminal and civil investigations by the Department of Justice (DOJ) related to its Medicare billing practices.[43] The investigations reportedly focus on whether the company inflated diagnoses through in-home health risk assessments and chart reviews to trigger additional government payments to its MA plans.[44]

The DOJ's pursuit of UnitedHealth reflects a broader pattern of escalating MA enforcement. On March 11, 2026, the DOJ announced that CVS's health insurer Aetna agreed to pay $117.7 million to resolve False Claims Act allegations that it submitted incorrect diagnoses for MA members to inflate its risk adjustment payments.[45] The government alleged that Aetna operated a chart review program in which coders identified new diagnosis codes not supported by actual medical documentation, and that between 2018 and 2023, Aetna knowingly submitted untruthful diagnosis codes for morbid obesity for individuals whose body mass indices indicated they were not actually obese.[46] Separately, Elevance Health is facing CMS sanctions over issues with its risk adjustment data.[47] Curbing upcoding has emerged as an area of bipartisan consensus, with the Senate Judiciary Committee, chaired by Senator Chuck Grassley (R-Iowa), launching inquiries into MA billing practices.[48] MedPAC's own data underscores the stakes: eight of the ten largest MA organizations had coding intensity that was at least 5 percentage points higher than CMS's coding adjustment in 2024, and eight MA organizations had average coding intensity at least 20% above FFS levels.[49]

**Conclusion**

The convergence of MedPAC's $76 billion overpayment estimate, the JEC's analysis of premium pass-through effects, CMS's proposed nearly flat rate increase, and escalating DOJ enforcement activity reflects a moment of heightened scrutiny for the MA program. Despite data revealing potentially massive overpayments driven by favorable selection and upcoding (which flow downstream to all Medicare beneficiaries through higher Part B premiums), the industry's formidable lobbying apparatus suggests that meaningful payment reform will face significant political headwinds.

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