



Medicare Advantage is an important and increasingly popular option, but the evidence is clear: insurers are overpaid.

PROBLEM: Medicare Advantage (MA) is an alternative to traditional Medicare (TM) run by private insurance companies that covered nearly 35 million beneficiaries last year, representing more than half of Medicare enrollment.¹ The MA program accounts for \$574 billion (or 54%) of total Medicare spending in 2026.² MA is rife with abuse and waste that is eroding the integrity and fiscal sustainability of the Medicare program, threatening the solvency of the Medicare Hospital Insurance Trust Fund, and costing Medicare beneficiaries and taxpayers billions of dollars every year. Reforms are urgently needed to curb overpayments and abusive practices in MA and to increase the value MA plans deliver to seniors and people with disabilities and taxpayers.

MA is intended to be more efficient than traditional Medicare, but it has never yielded aggregate savings to the Medicare program.³ A primary reason for this is MA plans' long history of abusing Medicare's payment system to overcharge taxpayers for the coverage plans provide. As a result, Medicare pays about 14% more for beneficiaries enrolled in MA compared to similar beneficiaries in traditional Medicare — a difference that will amount to a staggering \$76 billion in 2026 alone.⁴ These unchecked overpayments to MA insurers will also increase premiums for all Medicare beneficiaries — in both TM and MA — by about \$11 billion in 2026.⁵ In addition, MA plans too often delay needed care for Medicare beneficiaries and engage in deceptive marketing and other practices that require greater oversight.

SOLUTIONS: Congress and the Administration should enact the reforms below to reduce MA overpayments and improve accountability and competition among MA plans.

1. Reform MA Risk Adjustment and Address Upcoding

- a. Issue:** Many MA insurers engage in aggressive — and in some cases fraudulent — diagnosis coding to make their enrollees appear less healthy and generate higher Medicare payments to plans. Upcoding will account for \$22 billion in excess Medicare spending in 2026 alone.⁶
- b. Recommendations:**
 - i. Apply a higher coding adjustment factor** beyond the minimum established in statute to fully account for coding differences between MA and TM.⁷ This should be implemented in a way that accounts for coding variation across plans. Increasing the coding adjustment could reduce Medicare spending by up to \$1 trillion over 10 years.⁸
 - ii. Exclude Health Risk Assessments (HRAs) and all chart reviews** as sources of diagnoses for risk adjustment. These tactics are a major driver of upcoding and often result in additional reported diagnoses for which patients receive no follow-up care.⁹
 - iii. Develop a risk adjustment model that uses two years of diagnostic data** instead of one to improve coding accuracy by better capturing chronic conditions and reducing year-to-year variation in TM coding.¹⁰ Implementing this together with the exclusion of HRAs from risk adjustment could save \$124 billion over 10 years.^{11,i}
 - iv. In the longer term, policymakers should consider more fundamental changes to improve the risk adjustment model**, such as incorporating alternative data sources that insurers cannot manipulate.¹²

ⁱ Note: The ten-year savings estimate for applying a higher coding adjustment factor to fully account for coding intensity is interactive with the savings estimate for excluding HRAs and using two years of diagnostic data for risk adjustment.

2. Reform the Quality Bonus Program (QBP)

a. Issue: The QBP was established by the Affordable Care Act to incentivize quality improvement among MA plans, but there is little evidence that it provides meaningful quality information, has improved quality, or helps beneficiaries select a plan.^{13,14} Despite this failure to meet its intended goals, the QBP is still a major driver of spending in MA — bonus payments to plans have increased dramatically over the last decade, from \$3 billion in 2015 to over over \$12 billion in 2025.¹⁵

b. Recommendations:

- i. Make the QBP budget-neutral** to align with other Medicare quality programs, which are either budget-neutral or reduce spending. This would save between \$115-170 billion over 10 years.¹⁶
- ii. Evaluate quality at the plan and local market level** (rather than the contract level) to avoid MA organizations strategically consolidating plans to boost quality scores and to enable beneficiaries to make more informed choices about their coverage.
- iii. Reduce and simplify the existing quality measures** set to focus on prevention activities and patient-reported outcomes and experiences within their health plan to identify both poor- and high-performing plans.

3. Improve Transparency and Accountability for MA Insurers

a. Issue: There is a lack of basic data on MA and the care provided to Medicare enrollees in these plans, especially relative to data on TM. Better information is needed to improve program oversight and plan accountability

b. Recommendations:

- i. Ensure that people are getting access to covered services through their MA plan and crack down on plans inappropriately denying care.** Requiring plans to provide more detailed data on prior authorization and payment denials at the plan level is an important first step. Expanded reporting requirements around MA plan disenrollment would also improve the ability to understand patient experience and conduct appropriate oversight of this and other issues.
- ii. Improve the MA encounter data.** This should include regular assessments of the accuracy and completeness of the data reported by plans and penalties for noncompliance. In addition, additional payment information should be collected, including data on sub-capitation and quality-related payments. This is important for understanding the care delivery patterns provided by plans and whether plan payments to their provider networks are adequate.
- iii. Reduce and simplify the existing quality measures** set to focus on prevention activities and patient-reported outcomes and experiences within their health plan to identify both poor- and high-performing plans.
- iv. Expand reporting requirements around the use of supplemental benefits data,** including detailed, disaggregated payment and spending information to allow for assessments of the overall value of supplemental benefits.
- v. Increase transparency of ownership arrangements and financial transactions between related entities** to enable better understanding and oversight of vertical integration in the MA market. Enhanced transparency of these relationships is critical given evidence that vertical integration in MA further enables insurers to game the payment system and evade requirements (e.g., the Medical Loss Ratio requirements).
- vi. Enhance transparency around marketing of MA plans** to protect beneficiaries from misleading marketing tactics, unsolicited contact from brokers, and a lack of information that limits beneficiaries' ability to make informed decisions about their insurance coverage.



CONCLUSION: MA should be an option for Medicare enrollees and is an important part of the program. However, the substantial overpayments to insurance companies offering MA plans and abuse in the program indicates that Congress and the administration should take urgently needed action to protect beneficiaries and taxpayers by holding MA plans accountable, cracking down on fraud and abuse, and reducing excessive spending in the program. Policymakers should also consider longer-term strategies to more fundamentally improve the risk adjustment model and the benchmark system for setting payment rates.

ENDNOTES

- 1 https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_MedPAC_Report_To_Congress_SEC.pdf
- 2 <https://www.cbo.gov/system/files/2026-02/51302-2026-02-medicare.pdf>
- 3 https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_MedPAC_Report_To_Congress_SEC.pdf
- 4 Ibid.
- 5 Ibid.
- 6 Ibid.
- 7 https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/chapter-12-the-medicare-advantage-program-status-report-march-2016-report-.pdf
- 8 <https://www.cbo.gov/budget-options/60907>
- 9 <https://oig.hhs.gov/documents/evaluation/10028/OEI-03-23-00380.pdf>
- 10 https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/chapter-12-the-medicare-advantage-program-status-report-march-2016-report-.pdf
- 11 <https://www.cbo.gov/budget-options/60907>
- 12 <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2024.00569>
- 13 <https://www.urban.org/sites/default/files/2023-06/The%20Medicare%20Advantage%20Quality%20Bonus%20Program.pdf>
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- 15 <https://www.kff.org/medicare/medicare-advantage-quality-bonus-payments/>
- 16 <https://www.crfb.org/papers/employer-plans-medicare-advantage-flaw-quality-bonus-system>

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