Medicare Advantage Payment Accuracy

Evidence on Coding, Selection, and Program Integrity

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Testimony of David J. Meyers before the Joint Economic Committee on June 24, 2026

CAHPR CENTER FOR ADVANCING HEALTH POLICY THROUGH RESEARCH

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[1]The opinions and conclusions expressed in this testimony are the author's alone and do not necessarily reflect those of Brown University, the Brown University School of Public Health, or any of the research sponsors.
[2]Dr. Meyers is also a part-time senior advisor for the Center for Medicare and Medicaid Innovation. This testimony is the author's alone and does not necessarily reflect the views of CMMI, CMS, or the Federal government.
[3]The Center for Advancing Health Policy through Research (CAHPR) at the Brown University School of Public Health is dedicated to generating research that informs policies aimed at reducing costs, improving patient well-being, and driving meaningful transformations in U.S. health care delivery. Our work focuses on the design of insurance plans and their interactions within the health care market, employing a unique approach that integrates quantitative policy analysis with legal evaluation. This combined methodology helps identify the most effective legal and regulatory changes to create a significant impact. While this testimony is not a research publication, it is informed by relevant research conducted by CAHPR and its affiliates.

Chairman Schweikert, Vice Chairman Schmitt, Ranking Member Hassan and members of the committee, thank you for the opportunity to testify today on the evidence regarding payment accuracy and program integrity in Medicare Advantage, and the policy options available to address these issues.

My name is David Meyers. I am an Associate Professor in the Department of Health Services, Policy, and Practice at the Brown University School of Public Health. My research focuses on Medicare Advantage payment policy, risk adjustment, and the impacts of provider and insurer consolidation on program spending. The remarks I deliver today are in my personal capacity as a researcher studying Medicare Advantage payment and program integrity, and are informed by several recent studies from my colleagues and me examining risk score coding, plan payment, and consolidation in the program.

My remarks today highlight the evidence on payment accuracy and program integrity in Medicare Advantage. Today, I will focus on three core areas:

1. How Medicare Advantage is paid, and the scale of the gap between MA payments and the underlying cost of beneficiary care;
2. The specific, evidence-based mechanisms that drive this gap, including coding intensity, vertical integration between physicians and MA-aligned practices, favorable selection, duplicative VA spending, quality bonus design, and broker compensation; and
3. Policy options Congress could consider to improve payment accuracy and strengthen program integrity in Medicare Advantage.

Over the last two decades, the Medicare Advantage program has grown increasingly large and complex, now enrolling over 55% of all Medicare beneficiaries. Medicare Advantage alone comprises over 7% of the total federal budget,[4] and while it was originally designed to save money, in the program's history it has never once cost less in delivering care than Traditional Medicare.

Given that the program takes such a large share of federal spending, oversight is essential. As I will discuss today, there is roughly $100 billion in potentially wasteful or unnecessary spending in the program each year. This includes a combination of differences in coding intensity and favorable selection, as well as other duplicative spending and spending that is questionable in its usefulness for Medicare beneficiaries and the American taxpayer. This does not include an additional $30 billion annually spent on programs of questionable utility including the non-budget neutral star ratings, and broker payments.

My testimony today focuses on documenting where, and by how much, Medicare Advantage payments diverge from the actual cost of beneficiary care. This is a distinct question from whether any particular behavior meets the legal threshold for fraud, which is a determination for other bodies to make. Rather, these issues represent a form of leakage or healthcare waste and abuse, in which more federal funding is being diverted to insurance companies and away from taxpayers in ways that are likely unintended.

[4] KFF. *Medicare 101: How Much Does Medicare Spend and How Is the Program Financed?* October 8, 2025. https://www.kff.org/medicare/health-policy-101-medicare/?entry=table-of-contents-how-much-does-medicare-spend-and-how-is-the-program-financed.

While healthcare fraud is an important problem, I am more concerned about issues of waste and abuse where the insurers that operate Medicare Advantage plans take advantage of the current rules to extract additional funds from the system. It is worth placing this leakage into context. The roughly $100 billion in potentially excess payments each year exceeds CMS's estimates of total Medicare and Medicaid improper payments, about $70 billion in 2025. This has a cost to Medicare beneficiaries: as work conducted by this committee has found, increased payments to Medicare Advantage plans have shifted at least $13 billion in additional spending directly onto beneficiaries through Part B premium increases.[5]

In order for the Medicare Advantage program to meet its essential purpose and potential to care for our nation's elderly, it is essential to address these issues of payment accuracy, integrity, and waste. It is critical for Congress and CMS to take proactive steps to address these payment challenges.

Background: How Medicare Advantage Is Paid

In the Medicare Advantage program, private plans are paid by CMS to cover the needs of beneficiaries in a given year. These payments are risk adjusted and capitated[6]–providing a set amount per beneficiary per month adjusted for the beneficiary's health risks. If a plan is able to keep spending low, they are able to make a profit, while if spending is higher, the plan absorbs the loss. These capitated base payments are calculated based on historical Traditional Medicare spending in a given county with several adjustments applied (the "benchmark").[7] Benchmarks are the maximum amount that Medicare can pay for a Medicare Advantage beneficiary by law and serve as a bidding target for Medicare Advantage plans. Plans bid for the benefits they plan to offer. If the bid is above the benchmark, the plan must charge an additional part C premium, while if the bid is less than the benchmark, the plan keeps a portion of the difference as a rebate, which they can further invest into benefits. Most plans bid below the benchmark. To ensure that plans spend most of their payments on patient care, all MA plans are subject to a statutory Medical Loss Ratio (MLR) of 85% meaning that no more than 15% of payments should be spent on overhead or profit.[8]

Importantly, the capitated payment plans received are risk-adjusted. Under a capitated model without risk adjustment, there could be a concern that plans will try to avoid more costly patients. As a result, having a well functioning risk adjustment system is imperative to the success of the program and ensuring that higher need beneficiaries are adequately cared for. There are challenges however, as I will discuss below, with the ways in which CMS currently calculates risk.

III. Evidence on Payment and Program Integrity Issues in Medicare Advantage

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[5] Joint Economic Committee, United States Congress. *JEC Brief Finds Medicare Advantage Overpayments Causing Increased Premiums for All Seniors*. March 10, 2026. https://www.jec.senate.gov/public/index.cfm/republicans/2026/3/jec-brief-finds-medicare-advantage-overpayments-causing-increased-premiums-for-all-seniors.

[6] Fuse Brown, Erin C., Travis C. Williams, Roslyn C. Murray, David J. Meyers, and Andrew M. Ryan. "Legislative and Regulatory Options for Improving Medicare Advantage." *Journal of Health Politics, Policy and Law* 48, no. 6 (2023): 919–50. https://doi.org/10.1215/03616878-10852628.

[7] Social Security Act § 1853, codified at 42 U.S.C. § 1395w-23

[8] Social Security Act § 1857(e)(4), codified at 42 U.S.C. § 1395w-27(e)(4)

Coding intensity and risk score accuracy

Because capitated payments are tied to the documented health status of each enrollee, Medicare Advantage plans face a direct financial incentive to record diagnoses more intensively than occurs under Traditional Medicare. The same beneficiary, with the same underlying health status, can generate a substantially higher payment in MA simply by virtue of having more conditions documented. This is often called differential coding intensity or upcoding,[9] and current estimates on the spending impact of these coding differences range from $22 to $30 billion in additional payments a year.[10,11]

Sometimes these differences in coding intensity constitute outright fraud. In January of this year, five Kaiser Permanente affiliates agreed to pay $556 million—the largest Medicare Advantage risk-adjustment settlement to date—to resolve allegations that they pressured physicians to add unsupported diagnoses to patients' records, and the Justice Department has reached similar settlements in recent years with Cigna, Independent Health, and Aetna.[12,13]

However, diagnosis coding does need not rise to the level of fraud to represent waste or leakage from the payment system. If a patient receives a diagnosis that technically can be substantiated in their medical chart, but that does not reflect their actual care needs, it can still lead to a higher-than-necessary payment to the insurer. For example, as reported by the US Senate Judiciary committee, United Health Group used a specific medical device to aggressively capture additional codes for peripheral artery disease.[14] As a result of these tests, the condition could now be substantiated in a beneficiary's medical records, however in most cases they were not captured in the course of regular care by the beneficiary's doctors and did not factor into any of their healthcare needs. Regardless of if the diagnoses are fraud, spending on such conditions is still potentially wasteful.

Two mechanisms of risk upcoding in particular have been the focus of sustained research and oversight attention. The first is the health risk assessment, an in-home visit conducted primarily to capture

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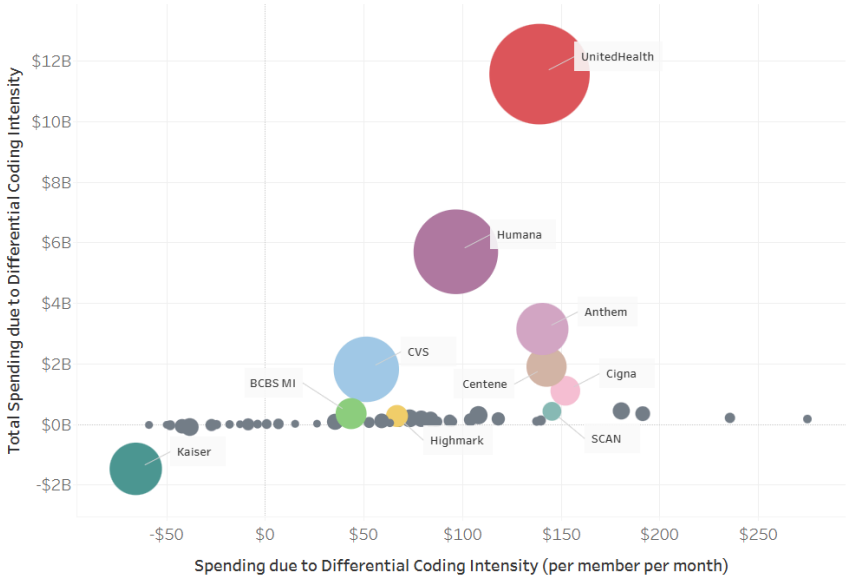
[9] Geruso, Michael, and Timothy Layton. "Upcoding: Evidence from Medicare on Squishy Risk Adjustment." *Journal of Political Economy* 128, no. 3 (2020): 984–1026. https://doi.org/10.1086/704756.
[10] MedPAC. *March 2026 Report to the Congress: Medicare Payment Policy*. 2026. https://www.medpac.gov/document/march-2026-report-to-the-congress-medicare-payment-policy/.
[11] Meyers, David J, Jay, Andrew Ryan, et al. "Medicode: The Medicare Advantage Coding Intensity Report Card." Brown University Center for Advancing Health Policy Through Research, n.d. https://doi.org/10.26300/60AA-ZT74.
[12] Muoio, Dave. "Kaiser Permanente to Pay $556M to Settle Medicare Advantage Fraud Claims." *Fierce Healthcare*, January 14, 2026. https://www.fiercehealthcare.com/payers/kaiser-permanente-pay-556m-settle-medicare-advantage-fraud-claims.
[13] United States Department of Justice. *Medicare Advantage Provider Independent Health to Pay Up To $98M to Settle False Claims Act Suit*. December 20, 2024. https://www.justice.gov/archives/opa/pr/medicare-advantage-provider-independent-health-pay-98m-settle-false-claims-act-suit.
[14] Grassley, Chuck. *Grassley Report Details UnitedHealth's Record of Appearing to Game the Medicare Advantage System, Turning Risk Adjustment into Its Own Business*. January 12, 2026. https://www.grassley.senate.gov/news/news-releases/grassley-report-details-unitedhealths-record-of-appearing-to-game-the-medicare-advantage-system-turning-risk-adjustment-into-its-own-business.

additional diagnoses rather than to deliver care.[15,16] The second is the chart review, a retrospective examination of a beneficiary's medical record that adds diagnosis codes, frequently without any associated clinical encounter.[17] Research indicates that together these two practices contribute as much as $15 billion per year in additional risk-adjusted payments.[18] While the HHS Office of the Inspector General[19,20] has highlighted these issues in several reports, CMS has done little to address these known challenges beyond a recent rule change to remove "unlinked" chart reviews, or those that don't correspond to an actual patient visit from risk score calculation.[21]

Importantly, coding intensity varies significantly across different plans in the program. My team has documented that several specific companies drive most differences in coding intensity in the program[22] (see Figure 1). This presents a challenge, as a one-size-fits-all approach that impacts all plans evenly may harm plans that are not engaging in these activities at the same rate.

[15] James, Hannah O., Beth A. Dana, Momotazur Rahman, et al. "Medicare Advantage Health Risk Assessments Contribute Up To $12 Billion Per Year To Risk-Adjusted Payments." *Health Affairs* 43, no. 5 (2024): 614–22. https://doi.org/10.1377/hlthaff.2023.00787.
[16] Weaver, Christopher, and Anna Wilde Mathews. "Medicare Paid Insurers Billions for Questionable Home Diagnoses, Watchdog Finds." *Wall Street Journal*, October 24, 2024. https://www.wsj.com/health/healthcare/medicare-insurers-extra-payments-72d09393?eafs_enabled=false.
[17] Meyers, David J., and Amal N. Trivedi. "Medicare Advantage Chart Reviews Are Associated With Billions in Additional Payments for Some Plans." *Medical Care* 59, no. 2 (2021): 96–100. https://doi.org/10.1097/MLR.0000000000001412.
[18] Jacobs, Paul D. "In-Home Health Risk Assessments And Chart Reviews Contribute To Coding Intensity In Medicare Advantage." *Health Affairs* 43, no. 7 (2024): 942–49. https://doi.org/10.1377/hlthaff.2023.01530.
[19] Office of Inspector General. *Some Medicare Advantage Companies Leveraged Chart Reviews and Health Risk Assessments To Disproportionately Drive Payments*. OEI-03-17-00474. 2021. https://oig.hhs.gov/reports/all/2021/some-medicare-advantage-companies-leveraged-chart-reviews-and-health-risk-assessments-to-disproportionately-drive-payments/.
[20] Office of Inspector General. *Medicare Advantage: Questionable Use of Health Risk Assessments Continues To Drive Up Payments to Plans by Billions*. OEI-03-23-00380. 2024. https://oig.hhs.gov/reports/all/2024/medicare-advantage-questionable-use-of-health-risk-assessments-continues-to-drive-up-payments-to-plans-by-billions/.
[21] "2027 Medicare Advantage and Part D Rate Announcement." *Federal Register* 91 (April 6, 2026): 17384.
[22] Meyers et al., "Medicode: The Medicare Advantage Coding Intensity Report Card."

Figure 1: Differential Coding Intensity Across Patent Organizations



Notes: Figure from medicoding.org representing differences in coding intensity across MA contracts using 2021 data projected to 2025 dollars.

A common defense of these practices holds that Medicare Advantage is not overcoding at all but coding accurately, and that the real problem is undercoding in Traditional Medicare, where fee-for-service providers have little financial incentive to document every condition a patient has. There is some truth to the premise. Traditional Medicare coding is almost certainly less complete than it could be, but addressing undercoding in Traditional Medicare would not resolve the overpayment problem in Medicare Advantage. This is because Medicare Advantage payment increases with coding intensity while the cost of care does not, so a beneficiary coded more completely in Medicare Advantage than in Traditional Medicare is overpaid regardless of whether those codes are more accurate than what would have been captured in traditional Medicare. Moreover, risk adjustment incentives in Traditional Medicare in value-based programs such as Accountable Care Organizations have reduced the undercoding in Traditional Medicare.

To address issues of coding intensity, CMS recently implemented the V28 risk adjustment model, which changes how risk is calculated for several conditions. Work from my team,[23] MedPAC,[24] and CMS have found that the V28 model has been effective in addressing a portion of the risk score differences, and had a particular impact on the plans that inflated risk to the highest degree, but in my view this is likely to only be a temporary success. It has not changed the fundamental challenge of risk adjustment that insurers are paid more when more diagnoses are recorded. Insurers are capable of moving faster than CMS in optimizing for the payment model, and unless additional changes are made to address differences in coding intensity, Medicare Advantage overpayments are likely to persist.

[23] Marr, Jeffrey, Andrew M. Ryan, and David J. Meyers. "Exposure to the New Medicare Advantage Risk Adjustment Model Varies across Insurers." *Health Affairs Scholar* 4, no. 5 (2026): qxag092. https://doi.org/10.1093/haschl/qxag092.
[24] MedPAC, *March 2026 Report to the Congress*.

Vertical integration between physician practices and Medicare Advantage plans

A recent trend contributing to payment integrity issues in the Medicare Advantage program is the vertical integration of insurers and providers. This integration takes two primary forms: there is a growing trend of health systems developing their own Medicare Advantage products,[25] and there is also a trend of insurance companies acquiring provider practices.[26] While advocates of these integrations argue that they improve care coordination between payers and providers, there is little evidence to support these claims.[27] Instead, there has been some evidence of two potential payment impacts: increased risk coding, and potential Medical Loss Ratio (MLR) gaming.[28]

My team and other colleagues at Brown have recently conducted several studies that have found that when insurance companies acquire providers, we see large increases in captured risk scores (Figure 2). In one study, we find that when physicians begin to work for companies integrated with insurance companies, risk scores increase about 25% after two years and rise to over 35% by five years, with no meaningful differences in patient characteristics, disease burden, or quality of care.[29] In another study that looked specifically at physicians acquired by United Healthcare, we saw similar increases over time.[30] These increases are likely driven by changes in how codes are captured in medical charts, as well as increased financial incentives for providers to increase coding intensity. This type of vertical integration creates a particular challenge for CMS's ability to assess wasteful spending. The primary tool at CMS's disposal are risk adjustment data validation (RADV) audits, which compare diagnosis codes reported by plans against what can be substantiated in a beneficiary's medical charts. When providers and payers are vertically integrated, there will likely be less distance between the medical chart and what gets reported, limiting the effectiveness of this crucial enforcement tool. Further, litigation has halted CMS's attempt to extrapolate the coding error rates detected in RADV audit samples to the entire plan's codes, limiting the reach of RADV audits pending CMS's appeal.[31]

Figure 2: Change in HCC Risk Scores after vertical integration

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[25] Bejarano, Geronimo, David J. Meyers, Meredith B. Rosenthal, and Jeffrey Marr. "Hospital–Medicare Advantage Vertical Integration and Medical Loss Ratios." *Health Affairs Scholar* 4, no. 4 (2026): qxag085. https://doi.org/10.1093/haschl/qxag085.

[26] Rooke-Ley, Hayden, Soleil Shah, and Erin C. Fuse Brown. "Medicare Advantage and Consolidation's New Frontier — The Danger of UnitedHealthcare for All." *New England Journal of Medicine* 391, no. 2 (2024): 97–99. https://doi.org/10.1056/NEJMp2405438.

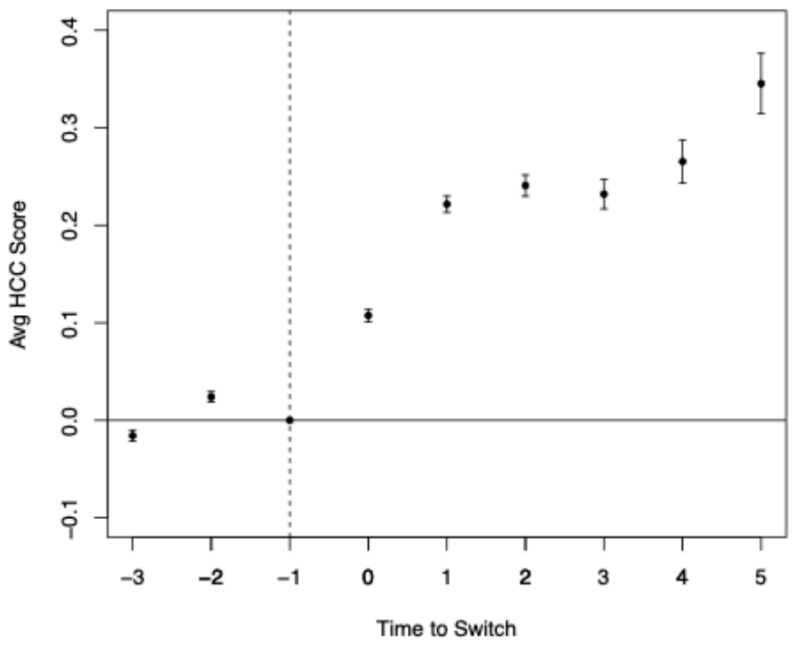
[27] Rooke-Ley, Hayden, Anika Shah, Corrie Mook, and Erin Fuse Brown. *Health Care Conglomerates: Policy and Legal Options for Addressing Vertical Integration*. May 2026. https://doi.org/10.26300/3ASF-MQ68.

[28] Fuse Brown, Erin C., Hayden Rooke-Ley, and Christopher M. Whaley. "Comments on the Contract Year 2026 Policy and Technical Changes to the MA Program (CMS-4208-P) - RFI on Medical Loss Ratio (MLR) and Vertical Integration." January 27, 2025. https://cahpr.sph.brown.edu/sites/default/files/documents/CMS_MLR_Vertical%20Integration.pdf.

[29] Meyers, David J., Jay Shroff, Yashaswini Singh, and Christopher Whaley. *Corporate Practice of Medicine: Vertical Alignment and Medicare Advantage Risk Coding*. October 2025. https://doi.org/10.26300/AMM6-VH76.

[30] Marr, Jeffrey, Christopher M. Whaley, and Xiaoxi Zhao. *From Payer to Provider: Impacts of Insurer Vertical Expansion into Physician Services*. April 14, 2026. https://doi.org/10.26300/9XTE-NH94.

[31] Humana Inc. v. Becerra, No. 4:24-cv-00909-O (N.D. Tex. Sept. 25, 2025); appeal docketed, Humana Inc., v. Kennedy, No. No. 25-11293 (5th Cir., Nov. 21, 2025), https://litigationtracker.law.georgetown.edu/litigation/humana-inc-et-al-v-kennedy-et-al/



Notes: Figure from author's working paper and follows changes in recorded HCC scores after a physician practice is acquired or vertically aligns with an insurer.

A second potential concern arises from the medical loss ratio (MLR). As I noted above, Medicare Advantage plans must spend at least 85 percent of their payments on patient care, with the remainder available for administration and profit—a requirement meant to limit how much of each premium dollar a plan retains. When an insurer also owns the physician practices that deliver that care, however, this constraint can be substantially weakened. Payments from the insurer to its own affiliated providers count as medical spending in the numerator of the MLR, even though the profit those practices earn stays within the same company. An integrated insurer therefore, has an incentive to pay its captive providers above the market rate: doing so inflates reported medical spending, helps the plan satisfy the MLR and avoid issuing rebates, and yet imposes no genuine economic cost, because the money never actually leaves the company. Recent evidence is consistent with precisely this dynamic. In a 2025 study,[32] my Brown University colleague Dan Arnold and his coauthor found that UnitedHealthcare pays providers affiliated with its Optum division roughly 17 percent more than it pays comparable non-Optum providers. Vertical integration can be used to subvert the statutory MLR requirements that Congress implement, allowing for additional leakage of payment from the system away from actual patient care.

Favorable selection

Perhaps the largest single contributor to the gap between Medicare Advantage payments and the cost of care is not coding at all, but a phenomenon called favorable selection. MedPAC estimates that in 2025, favorable selection increased Medicare Advantage payments by roughly 11 percent above what the

[32] Arnold, Daniel R., and Brent D. Fulton. "UnitedHealthcare Pays Optum Providers More Than Non-Optum Providers." *Health Affairs* 44, no. 11 (2025): 1395–403. https://doi.org/10.1377/hlthaff.2025.00155.

program would have paid under Traditional Medicare.[33] It is not only MedPAC that finds these results: other research has found favorable selection estimates of similar magnitude when comparing the health of those who enroll in Medicare advantage compared to Traditional Medicare.[34,35,36]

In plain terms, favorable selection occurs when the beneficiaries who enroll in Medicare Advantage are, on average, healthier and less costly than their risk scores predict, while those who remain in Traditional Medicare are comparatively more expensive. Because MA payment benchmarks are built from the average spending of Traditional Medicare enrollees, a plan that attracts beneficiaries who are cheaper than that average is paid as though it were covering a typical beneficiary, while in fact covering a healthier one. The clearest evidence of this pattern comes from beneficiaries who switch from Traditional Medicare to MA: at the same risk score, those who switch have systematically lower prior spending than those who stay behind.[37] The extent of overpayment due to favorable selection is growing as more beneficiaries enroll in Medicare Advantage.[38]

While favorable selection is not necessarily fraudulent or nefarious, it represents a substantial payment inefficiency in the program as it implies that the benchmarks are currently being set at rates that are higher than they should be to reflect accurate payment in the program.

Duplicative payments for dually-enrolled veterans

A further source of waste arises for veterans who are simultaneously enrolled in Medicare Advantage and eligible for care through the Veterans Health Administration. When a veteran is enrolled in both Traditional Medicare and the VHA, only one program pays for any given service, preventing duplicate federal payment. Under Medicare Advantage, this safeguard disappears: the plan receives its full, risk-adjusted capitation payment, calculated on the assumption that it will cover all of the beneficiary's Medicare-covered care, even when the VHA actually delivers and pays for most of that care. The federal government therefore, pays twice for the same veterans, once through the VHA appropriation and again through the MA capitation rate, while the plan remains responsible for little more than its supplemental

[33] Newhouse, Joseph P., Mary Price, J. Michael McWilliams, John Hsu, and Thomas G. McGuire. "How Much Favorable Selection Is Left in Medicare Advantage?" *American Journal of Health Economics* 1, no. 1 (2015): 1–26. https://doi.org/10.1162/ajhe_a_00001.
[34] Ryan, Andrew M., Zoey Chopra, David J. Meyers, Erin C. Fuse Brown, Roslyn C. Murray, and Travis C. Williams. "Favorable Selection In Medicare Advantage Is Linked To Inflated Benchmarks And Billions In Overpayments To Plans." *Health Affairs* 42, no. 9 (2023): 1190–97. https://doi.org/10.1377/hlthaff.2022.01525.
[35] Crow, Samantha, and Matthew Fiedler. *Will Medicare Advantage's Rise Strengthen or Weaken Favorable Selection?* Brookings, 2025. https://www.brookings.edu/articles/will-medicare-advantages-rise-strengthen-or-weaken-favorable-selection/.
[36] Curto, Vilsa, Liran Einav, Amy Finkelstein, Jonathan Levin, and Jay Bhattacharya. "Health Care Spending and Utilization in Public and Private Medicare." *American Economic Journal: Applied Economics* 11, no. 2 (2019): 302–32. https://doi.org/10.1257/app.20170295.
[37] Lieberman, Steve M., Paul Ginsburg, and Samuel Valdez. *Medicare Advantage Enrolls Lower-Spending People, Leading to Large Overpayments*. USC Leonard D. Schaeffer Institute for Public Policy & Government Service, 2023. https://doi.org/10.25549/n153-9a66.
[38] Ryan et al., "Favorable Selection In Medicare Advantage Is Linked To Inflated Benchmarks And Billions In Overpayments To Plans."

benefits. However, the VHA is statutorily barred from recouping payment from Medicare as it does with commercial health insurance plans for veterans with dual forms of coverage.[39]

The scale of this duplication is large and growing. In work my colleagues and I first published in 2024,[40] we estimated that the VHA spent more than $78 billion caring for MA-enrolled veterans between 2011 and 2020. Our most recent analysis finds that this spending has continued to accelerate: from 2019 to 2023, the VA spent $86.9 billion on care for veterans enrolled in MA plans, with annual spending rising from $12.8 billion in 2019 to $22.7 billion in 2023—a 77% increase.[41] The number of dually enrolled veterans receiving VA care grew from roughly 1.0 million in 2019 to nearly 1.3 million in 2023, and by 2023 this spending equaled about 19% of the VA's entire health care appropriation, up from roughly 15% in 2019. The fastest growth occurred in the more expensive community care program, where VA spending rose 221% over the period—even as MA plans continued to receive full federal payments intended to cover the same care, an arrangement that effectively functions as an implicit public subsidy to MA insurers. Under modest assumptions about continued growth, we have projected that the VHA could spend on the order of $357 billion between 2026 and 2035 caring for beneficiaries whom MA plans are simultaneously being paid to cover.

Table: Projected spending on dual VHA and MA beneficiaries

Year	Estimate of VHA/MA Beneficiaries Who Use Care	Estimate of Total Spend per Beneficiary	Total VHA Spend
2026	1,553,466	$20,159.13	$31,316,521,835.03
2027	1,535,103	$21,066.29	$32,338,920,553.95
2028	1,515,769	$22,014.28	$33,368,561,640.32
2029	1,494,608	$23,004.92	$34,383,340,116.93
2030	1,470,541	$24,040.14	$35,352,002,620.89
2031	1,444,775	$25,121.95	$36,295,552,750.28
2032	1,418,010	$26,252.44	$37,226,226,776.05
2033	1,391,426	$27,433.79	$38,172,078,259.70
2034	1,365,621	$28,668.32	$39,150,050,796.20
2035	1,340,902	$29,958.39	$40,171,256,230.06
Total			$357,774,511,579.40

The rising dual enrollment growth among veterans, along with the increasing prevalence of Medicare Advantage affinity plans targeting veterans, points to a systemic inefficiency. By enrolling veterans who rely on the VHA for most or all of their care, Medicare Advantage plans can collect substantial federal payments, creating a significant risk of duplicative spending. Legislative policy changes would be

[39] Center for Advancing Health Policy through Research (CAHPR). *Potential Excess Federal Spending on Dual Medicare Advantage and Veterans Health Administration Enrollees*. 2024. https://doi.org/10.26300/CCDE-T257.
[40] Meyers, David J., Aaron L. Schwartz, Lan Jiang, Jean Yoon, and Amal N. Trivedi. "Spending by the Veterans Health Administration for Medicare Advantage Dual Enrollees, 2011-2020." *JAMA* 332, no. 16 (2024): 1392. https://doi.org/10.1001/jama.2024.18073.
[41] Trivedi, Amal N., Lan Jian, David Meyers, Aaron L. Schwartz, Kenneth W. Kizer, and Jean Yoon. "Spending by the Veterans Affairs Health Care System for Medicare Advantage Enrollees." *JAMA Health Forum* 6, no. 12 (2025): e255653. https://doi.org/10.1001/jamahealthforum.2025.5653.

required to close this loophole, to ensure more efficient use of federal resources while enabling the VHA to recoup payments from Medicare Advantage insurers.

Star Ratings and the Quality Bonus Program

Outside of risk adjustment, another significant source of payment inefficiency in the MA program is in the Star Ratings program. The Star Ratings program and the Quality Bonus Program built on it are meant to help beneficiaries compare plans and to reward high performers.[42] Plans whose contracts reach four or more stars on a five-star scale receive a bonus that raises their benchmark and increases the rebate share they retain, and in certain high-penetration counties, that bonus is doubled, for up to ten percent, rewarding a plan's geography as much as its quality. Unlike most Medicare quality initiatives, the program is not budget-neutral: the bonuses are additional federal dollars layered onto already-elevated benchmarks rather than a redistribution among plans.

As designed, this is supposed to be a beneficiary-facing tool, helping beneficiaries select higher-quality plans. However, because almost every plan is rated highly, the ratings do little to distinguish among options: roughly 75 percent of MA enrollees were in a bonus-receiving plan in 2025, and the average contract rating in 2026 was 3.98 stars, just below the four-star threshold.[43] The signal is further muddied by the fact that ratings are assigned to multistate "contracts" rather than to the individual plan a beneficiary enrolls in, allowing insurers to average weak and strong offerings together, and by the fact that most beneficiaries never consult the ratings at all. Meanwhile, the cost is high and growing: KFF estimates bonus payments reached at least $12.7 billion in 2025,[44] more than quadruple the figure from a decade earlier—spending whose link to better care is weak, as work I've done as well as others has found little evidence that the program improves plan quality or that the bonuses are reliably reinvested in members' benefits.[45,46,47,48]

Recent litigation challenging the star rating methodology is making this worse rather than better. In Clover Insurance Company v. HHS, decided in the Southern District of Georgia on May 27, 2026, the court held that CMS had improperly included 20 measures in the plan's rating and ordered a recalculation, finding both that some measures lacked statutory authorization and that the agency had skipped required

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[42] Brown et al., "Legislative and Regulatory Options."
[43] Fuglesten Biniek, Jeannie, Anthony Damico, and Tricia Neuman. *Medicare Advantage Quality Bonus Payments Will Total at Least $12.7 Billion in 2025*. KFF, 2025. https://www.kff.org/medicare/medicare-advantage-quality-bonus-payments/.
[44] Fuglesten Biniek, Jeannie. *How Medicare Pays Medicare Advantage Plans: Issues and Policy Options*. KFF, 2025. https://www.kff.org/medicare/how-medicare-pays-medicare-advantage-plans-issues-and-policy-options/.
[45] Meyers, David J., Momotazur Rahman, Ira B. Wilson, Vincent Mor, and Amal N. Trivedi. "The Relationship Between Medicare Advantage Star Ratings and Enrollee Experience." *Journal of General Internal Medicine* 36, no. 12 (2021): 3704–10. https://doi.org/10.1007/s11606-021-06764-y.
[46] Meyers, David J., Amal N. Trivedi, and Andrew M. Ryan. "Flaws in the Medicare Advantage Star Ratings." *JAMA Health Forum* 6, no. 1 (2025): e244802. https://doi.org/10.1001/jamahealthforum.2024.4802.
[47] Anderson, Andrew, and Mark K. Meiselbach. "Fluctuating Star Ratings and Medicare Advantage Bonuses." *JAMA Health Forum* 6, no. 10 (2025): e254398. https://doi.org/10.1001/jamahealthforum.2025.4398.
[48] Ryan, Andrew M., Baris Gulseren, John Z. Ayanian, Adam A. Markovitz, David J. Meyers, and Erin Fuse Brown. "Association Between Double Bonuses and Clinical and Administrative Performance in Medicare Advantage." *JAMA Health Forum* 3, no. 9 (2022): e223301. https://doi.org/10.1001/jamahealthforum.2022.3301.

notice-and-comment rulemaking procedures for others.[49] Though formally limited to Clover, the ruling could call into question nearly half of all rating measures. The agency's response compounds the fiscal problem: CMS will recalculate bonus ratings only for plans whose scores would rise, while those whose scores would fall keep the higher rating. That one-directional adjustment can only push payments up and it is likely that further suits could add to this. In recent years, other recalculations of the ratings have invariably led to higher payments to plans. Without change from Congress, the star ratings are likely to remain a major source of spending in the program, with minimal demonstrated value.

Medicare Advantage broker compensation

Another potential area of inefficiency is the broker-and-agent market. Insurance brokers and agents play an important role in the Medicare Advantage market. The choices facing a new enrollee are genuinely complex, and there are dozens of plans in a typical county, each with its own networks, formularies, and supplemental benefits. An independent broker can help a beneficiary sort through them. However, there are serious concerns that the way brokers are paid may conflict with steering beneficiaries toward the plans that best fit their needs, and that broker fees are large enough to represent meaningful resources diverted from members' benefits.

Until recently, there were no national estimates of how much MA plans spend on brokers. In a study my colleagues and I published in JAMA Internal Medicine, drawing on a dataset obtained through the Freedom of Information Act, we provide the first such quantitative estimates—and they are substantial. Broker spending more than doubled in under a decade, from $3.9 billion in 2014 to $10.1 billion in 2022, while the share of new enrollees referred by a broker rose from 35.8 percent to 43.7 percent.[50] Most striking, the large majority of this spending is not tied to any enrollment decision at all: in 2022, 73.6 percent of broker payments were renewal fees, paid simply for a beneficiary remaining in the same plan, and the share of enrollees generating such a fee climbed from 50.1 percent to 69.4 percent. The bulk of broker compensation, in other words, rewards retention rather than the work of helping someone find a better plan. And because these figures exclude bonus payments tied to enrollment targets, which we could not observe, they likely understate the true total.

This spending raises a structural concern. Brokers are compensated by the same insurers whose plans they recommend and owe no fiduciary duty to the beneficiary, leaving open the question of whether their compensation is calibrated to beneficiaries' needs or to insurers' enrollment and retention goals. CMS sought to address precisely this in a 2024 rule[51] that would have capped certain administrative payments and curbed volume-based incentives that could steer enrollees toward the plans paying brokers the most. But in August 2025 a federal court in Texas vacated the broker-compensation provisions, holding that CMS had exceeded its statutory authority—reasoning that the agency may regulate how compensation is

[49] Clover Insurance Company v. Department of Health and Human Services, No. 2:25-cv-00142 (S.D. Ga. May 27, 2026)
[50] Meyers, David J., Jay Shroff, Jeffrey Marr, Em Balkan, Andrew M. Ryan, and Amal N. Trivedi. "Trends in Broker Enrollment and Spending in Medicare Advantage." *JAMA Internal Medicine*, ahead of print, May 18, 2026. https://doi.org/10.1001/jamainternmed.2026.0864.
[51] Medicare Program; Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program for Contract Year 2024–Remaining Provisions and Contract Year 2025, 89 Fed. Reg. 30448 (Apr. 23, 2024), codified at 42 C.F.R. §§ 422.2274 and 423.2274.

used but may not, in effect, set the rates themselves.[52] As a result, the underlying compensation structure remains largely unchanged, and the incentives the rule was designed to correct remain in place. It is not clear that the amount of compensation being spent to brokers currently represents added value, or represents another source of leakage from the program.

Potential Policy Options to Address MA Payment Accuracy

Each of the mechanisms I have described points toward a corresponding policy response. In most cases, courts have determined that CMS cannot act on its own; the changes would require an act of Congress to grant CMS the requisite authority. None of these options requires reinventing Medicare Advantage. Most simply close specific, measurable gaps between what plans are paid and what beneficiary care actually costs. I group the options into six areas.

Addressing coding intensity

Because differential coding is both the most direct driver of overpayment and one of the most directly correctable, Congress could direct CMS to change how diagnoses are entered into risk-score calculations. Congress could require CMS to remove from risk scores any diagnosis derived from a chart review that is not corroborated by an actual clinical encounter, a change estimated to save more than $15.3 billion per year, and to likewise exclude diagnoses sourced solely from health risk assessments, for an additional estimated savings of more than $2.85 billion per year.[53] Congress could also direct CMS to replace the current uniform statutory coding adjustment—applied equally to all plans—with a variable coding-intensity adjuster that reduces payments specifically for plans coding disproportionately above a defined threshold, an approach estimated to save roughly $17.2 billion per year. While CMS currently has the authority to increase the statutory minimum adjuster from 5.9%, they have not chosen to at any point and may require a congressional mandate to do so.[54]

Introduced legislation illustrates how these changes might be structured. The No UPCODE Act (S. 1105) would, for example, require CMS to use two years of diagnostic data in risk adjustment, exclude chart-review- and health-risk-assessment-derived diagnoses from payment calculations, and require CMS to measure and account for coding differences between Medicare Advantage and Traditional Medicare. More comprehensive measures have also been introduced: H.R. 3467, the Medicare Advantage Reform Act introduced by Chairman Schweikert, would, among other changes, tie certain plan payments to encounter data subject to audit by the Secretary and require that such adjustments be made in a budget-neutral manner.

[52] Americans for Beneficiary Choice v. United States Department of Health and Human Services, No. 4:24-cv-00439-O (N.D. Tex. Aug. 18, 2025)
[53] Meyers et al., “Medicode: The Medicare Advantage Coding Intensity Report Card.”
[54] Fuse Brown, Erin C., Travis C. Williams, Roslyn C. Murray, David J. Meyers, and Andrew M. Ryan. *Legislative and Regulatory Strategies for Revitalizing Medicare Advantage*. 2023. https://doi.org/10.26300/7VEZ-V556.

Improve ownership transparency and strengthen the MLR to address vertical integration

Effective oversight of vertically integrated arrangements is currently constrained by the simple fact that the government cannot see them clearly.[55] No systematic national dataset identifies the corporate ownership and affiliation links between physician practices and MA plans;[56] in our own research, we had to assemble these linkages by hand. Congress could direct the establishment of such a dataset. With it in place, Congress could authorize CMS to adopt risk-adjustment methodologies that account for the measured coding differences observed specifically within integrated provider–insurer arrangements, where the documented effect on coding is larger than in independent practices.

Congress could also strengthen MLR rules and oversight to address MLR gaming by vertically integrated Medicare Advantage insurers and providers. Today, regulators have limited visibility into related party payments, affiliations and ownership structures, and whether these tactics are being used to game the MLR. Accordingly, Congress could begin by requiring insurers to report the type and amount of payments made to affiliated entities and extend CMS's authority to enforce the MLR and limit gaming, including by authorizing CMS to tighten MLR requirements to disallow insurer overpayments to related-parties from being used in calculating the MLR. To do so, Congress could provide CMS with express authority to craft an MLR enforcement mechanism for vertically integrated entities.

Beyond MLR reform, Congress should also act to improve transparency around ownership and managerial control within Medicare Advantage. Vertically integrated MA arrangements often involve complex ownership structures, including management services organization (MSO) arrangements, joint ventures, and other affiliation arrangements, that are not adequately captured in existing data systems like PECOS.

These structures can provide operational control and facilitate consolidation without triggering formal ownership reporting requirements, creating significant blind spots for CMS in its oversight of the MA program. Many vertical physician acquisitions are also too small to require notice to antitrust authorities under the Hart-Scott-Rodino Act, further limiting regulators' ability to monitor consolidation as it occurs.[57]

Congress could require provider organizations and MA plans to report full ownership, management, joint venture, and related-party arrangements to CMS, and direct the establishment of a centralized, publicly accessible national database of these relationships.

Such a requirement would complement the coding intensity and MLR reforms described above by giving regulators the foundational visibility they need to identify when consolidation is driving overpayments, gaming MLR rules, or otherwise distorting incentives within the MA program, before those harms become entrenched.[58]

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[55] Rooke-Ley et al., *Health Care Conglomerates.*
[56] Singh, Yashaswini, and Erin Fuse Brown. "The Missing Piece In Health Care Transparency: Ownership Transparency." *Health Affairs Forefront*, ahead of print, September 22, 2023. https://doi.org/10.1377/forefront.20230921.886842.
[57] Wollmann, Thomas. *How to Get Away with Merger: Stealth Consolidation and Its Effects on US Healthcare*. Working Paper. National Bureau of Economic Research, 2024. https://doi.org/10.3386/w27274.
[58] Singh and Fuse Brown, "Missing Piece in Health Care Transparency."

Strengthen RADV audit authority

Risk Adjustment Data Validation (RADV) audits are the program's principal backstop to recoup fraudulent risk coding in Medicare Advantage based on unsupported diagnoses, but their reach has been limited by the use of small annual samples that take years to adjudicate. Congress could restore and secure CMS's authority to audit the full population of RADV-eligible contracts and to extrapolate measured error rates across the contract, which is what gives such audits meaningful fiscal weight. This is especially salient now: in September 2025 a federal court vacated CMS's 2023 rule permitting extrapolation in Humana v. Becerra, on procedural grounds, with the administration's appeal now pending before the Fifth Circuit.[59] Rather than leave this authority to turn on the outcome of litigation, Congress could provide explicit statutory authority for extrapolation-based RADV audits and resolve the uncertainty.

Eliminate duplicative VA/MA spending

To address the duplicate payments for dually enrolled veterans, Congress could eliminate the statutory bar and authorize the Veterans Health Administration to seek reimbursement from Medicare Advantage plans for the care it provides to their enrollees, as the VHA already does from other insurers.[60] Legislation in the current Congress reflects this approach: the GUARD Veterans' Healthcare Act (H.R. 4077) would make precisely this change, which we estimate could reduce VHA spending by approximately $357.7 billion over the ten-year window from 2026 to 2035.

Reform the Quality Bonus Program

The most comprehensive reform would have Congress convert the Quality Bonus Program to a budget-neutral design, in which total bonus payments are offset by total penalties rather than added on top of benchmarks—an approach we estimated to save $14.1 billion in 2026 alone.[61] At a minimum, Congress could eliminate the double-bonus program, which rewards geography rather than performance, and direct CMS to reconfigure the Star Rating measures to rely less on insurer-self-reported data and more on independently verifiable outcomes.[62] These reforms have ample precedent: MedPAC has recommended replacing the Quality Bonus Program with a budget-neutral Medicare Advantage Value Incentive Program that would score a small set of measures, evaluate quality at the local rather than the contract level, account for social risk, and reward and penalize plans along a continuous scale rather than at a single cliff,[63] a model Congress could draw on directly.

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[59] Humana Inc. v. Becerra, No. 4:24-cv-00909-O (N.D. Tex. Sept. 25, 2025); appeal docketed, Humana Inc., v. Kennedy, No. No. 25-11293 (5th Cir., Nov. 21, 2025), https://litigationtracker.law.georgetown.edu/litigation/humana-inc-et-al-v-kennedy-et-al/

[60] CAHPR, *Potential Excess Federal Spending.*

[61] Dixit, Meehir N., Jay Shroff, David J. Meyers, and Andrew M. Ryan. "Estimating the Budgetary Impact of Reforms to the Medicare Advantage Quality Bonus Program." *JAMA* 334, no. 1 (2025): 83. https://doi.org/10.1001/jama.2025.4939.

[62] Mook, Corrie, Jeffrey Marr, and David Meyers. *Medicare Advantage at a Glance: Key Issues and Policy Considerations*. November 2025. https://doi.org/10.26300/E2GM-K117.

[63] MedPAC. *Report to the Congress: Medicare and the Health Care Delivery System*. 2020. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun20_ch3_reporttocongress_sec.pdf.

Address Medicare Advantage broker compensation

Finally, Congress could establish clearer statutory guardrails on broker compensation, with particular attention to the renewal-fee mechanism that, as our research shows, now accounts for the majority of broker spending despite corresponding to no beneficiary decision at all. This is an area where clear legislative direction is especially important, since CMS's 2024 attempt to tighten broker compensation administratively was vacated in court for exceeding the agency's authority. Legislation in the current Congress takes up the question directly: a bill introduced by Representative Ocasio-Cortez would direct the Secretary to establish a maximum compensation amount for agents, brokers, and other third parties representing for-profit Medicare Advantage insurers, and would redefine what counts as compensation so that insurers can no longer offer the bonuses, trips, and other perks that reward enrolling beneficiaries in particular plans.[64] A related bipartisan measure, the BROKERS TIME Act of 2025 (S. 2625), would refine how third-party marketing organizations are defined in order to better target predatory high-volume call centers while distinguishing them from local, licensed independent agents. Given the structural conflict of interest inherent in having brokers paid by the insurers whose plans they recommend, Congress could also consider directing additional resources to State Health Insurance Assistance Programs (SHIPs), which offer beneficiaries genuinely unbiased counseling but remain badly underfunded relative to the scale of broker spending they could help offset.

Conclusion

Taken together, the mechanisms I have described tell a consistent story. Across coding intensity, vertical integration, favorable selection, duplicative VA spending, the Quality Bonus Program, and broker compensation, Medicare Advantage is paid substantially more than the care it delivers actually costs—an excess over over $100 billion a year. To put that scale in perspective: this overpayment exceeds the combined improper-payment estimates for Traditional Medicare and Medicaid, and it far surpasses what is recovered from provider fraud across both programs in any year.

Only a small portion of this gap reflects conduct that rises to the level of fraud. The far larger share is waste that occurs within the rules of the program as they are currently written: payments that are legal and yet collectively divert tens of billions of dollars each year away from the Trust Fund, the taxpayers, and the beneficiaries who as the work of this committee has shown, bear higher Part B premiums as a result.

This matters not because Medicare Advantage lacks value, many beneficiaries appreciate the supplemental benefits and cost sharing protections it can provide, but because a payment system that systematically overpays is neither sustainable nor fair to the beneficiaries and taxpayers who fund it. The reforms I have outlined would maintain a robust Medicare Advantage program, while narrowing the gap between what plans are paid and what care costs. Most, however, will require Congress to act, either by granting CMS clear authority or by directing the agency to use the tools it already has.

Thank you for the opportunity to testify, and I look forward to your questions.

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[64] Ocasio-Cortez, Alexandria. *Ocasio-Cortez Proposes Bill to Limit Compensation for Representatives of Medicare Advantage Organizations*. June 10, 2026. https://ocasio-cortez.house.gov/media/press-releases/ocasio-cortez-proposes-bill-limit-compensation-representatives-medicare.