United States Congress
Joint Economic Committee
Est. 1946

ISSUE BRIEF

The Part B Premium Pass-Through: Medicare Advantage Overpayments Inflate Premiums for All

March 10, 2026

Executive summary

- **Medicare Part B premiums are higher because Medicare Advantage (MA) is overpaid.** On average, covering a beneficiary in MA costs an estimated 120 percent of what it would cost in Traditional Medicare (TM). MA overpayments raise Part B spending, and because premiums are set to cover roughly one-quarter of expected costs, everyone in Part B pays more.

- **The Joint Economic Committee estimates MA overpayments increased Part B premiums by $212 per enrollee in 2025, totaling $13.4 billion in higher premiums.** Since 2016, MA overpayments have added an estimated $82 billion to Part B premiums. TM beneficiaries, who are not enrolled in MA, bore roughly $6 billion of that burden.

- **Higher Part B premiums reduce seniors' net Social Security benefits.** About 85 percent of the added premium burden falls on individuals, with the remainder falling on state and federal taxpayers. For most seniors, Part B premiums are withheld from Social Security checks. Therefore, increases in premiums directly reduce take-home benefits for seniors.

- **Seniors face a dramatic reduction in the affordability of Medicare Part B.** By 2035, per-person premiums are projected to double from $2,440 to about $5,000. Of that total, about $450 will be due to overpayments if they continue at the same rate. Aligning MA payments with TM would prevent unnecessary premium growth, increase the affordability of Medicare, and protect net Social Security checks.

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Introduction

Medicare Part B provides coverage for outpatient services including office visits, outpatient procedures, diagnostic tests, physician-administered drugs, and preventative services to nearly 64 million Americans. The Part B account of the Supplemental Medical Insurance Trust Fund is financed primarily through transfers from the general fund and premiums collected from enrollees. By law, the standard Part B premium is set each year to cover 25 percent of expected Part B spending per aged enrollee, with some individuals paying additional premiums.[1]

This financing design means that about 26 to 28 percent of any increase in Part B expenditure is passed on to beneficiaries as higher premiums; conversely, anything which reduces expenditure would lower premiums. As a result, from 2025 to 2026, the standard premium was raised from $185 per month to $203 per month (or $2,435 per year), reflecting an increase in the expected average cost per aged beneficiary from $8,880 to $9,739.[2] A key aspect of this financing mechanism is that while the standard Part B premium varies with income, it does not vary based on whether the individual receives Part B benefits through the fee-for-service Traditional Medicare (TM) program, or through Medicare Advantage (MA).

MA provides a bundled plan that combines both Part A and B coverage, as well as supplemental benefits that are not offered in the TM program. The original intention of MA was for payments to equal 95 percent of TM. If successful, this would create a sharing structure whereby privately provided Medicare plans compete and produce savings that would be shared between taxpayers, beneficiaries would benefit from more choice and lower premiums, and efficient insurers would be rewarded.

However, the same design features which promised taxpayers and TM beneficiaries a share of savings also work in reverse. If realized payments to MA are instead higher than what they would be for covering beneficiaries in TM, then this would increase the cost to taxpayers, as well as Part B premiums for both MA and TM beneficiaries.[3]

MA has achieved many valuable successes and now covers about 55 percent of Medicare enrollees, a share projected to keep rising. However, MA has not achieved the envisioned savings of costs equaling 95 percent of Traditional Medicare. Instead, the official estimate by the non-partisan Medicare Payment Advisory Commission (MedPAC) found that MA would be paid $84 billion more in 2025 than it would have cost to cover the same beneficiaries in TM, or an average of 120 percent of the cost of TM.

While the effect of MA overpayments on taxpayers and federal borrowing is generally recognized, the effect on Part B premiums has received less attention. This is despite the direct effect higher premiums impose by directly reducing take-home Social Security benefits and healthcare affordability for about 50 million Medicare beneficiaries. This effect is the focus of this brief.

[1] Social Security Act, 42 U.S.C. § 1395r (2018).
[2] The per enrollee costs including beneficiaries with disabilities was $9,238 in 2025 and is expected to reach $10,050 in 2026.
[3] Furthermore, the design also risks a self-reinforcing, upward cost spiral, whereby higher MA payments contribute to a coding "arms race" to increase risk-adjusted payments, or to provide more generous supplemental benefits that are targeted to attract enrollees with low expected expenditures (conditional on their risk score). This further increases MA payments relative to what they would be in TM.

In what follows, we analyze how MA overpayments impact Medicare premiums in detail. We estimate that in 2025, Part B premiums were, on average, about $212 higher per enrollee and $13.4 billion higher in total than they otherwise would have been. Over the past 10 years, this cumulatively amounts to $82 billion in additional premiums. The burden of higher premiums is primarily borne by individuals (84.9 percent), with state and federal taxpayers covering 9.1 and 6.0 percent, respectively.

A significant portion of the burden, approximately $6 billion, is borne by TM beneficiaries who are not using the MA program. These TM beneficiaries pay higher premiums to fund more expensive care for MA enrollees. Because Medicare Advantage penetration, plan availability, and popularity differ widely, the burden on TM beneficiaries varies substantially across regions.

To quantify how these premium burdens fall on TM beneficiaries, we provide an accompanying data product, the *Medicare Affordability Update*, which measures these burdens at state and congressional district levels. By capturing this geographic variation, the data product offers policymakers and the public a clear picture of how MA overpayments pass through to seniors' finances and state budgets.

Part B premium setting: the 25 percent rule and Medicare Advantage overpayments

By statute, the standard Part B premium is set to cover approximately 25 percent of expected Part B spending among aged enrollees.[4] As a result, about one-quarter of any increase in expected Part B spending for aged enrollees is mechanically reflected as an increase in the standard Part B premium. Because some beneficiaries pay income-related premiums (namely, an Income Related Monthly Adjustment Amount, or IRMAA), total premium financing, and thus the pass-through of spending increases, is expected to average about 26 to 28 percent of Part B costs over the next decade.

A recent example of this pass-through mechanism resulted from a surge in Part B spending on certain skin substitute products, from $256 million in 2019 to over $10 billion in 2024.[5] The Administration responded by changing how Medicare pays for skin substitutes under the Physician Fee Schedule. CMS estimates these policies will reduce gross fee-for-service (TM) spending by $19.6 billion in 2026 and stated that, absent the changes, the Part B premium increase would have been about $11 higher per month.[6]

The pass-through rate does not vary based on whether an individual receives Part B benefits through Traditional Medicare (TM) or Medicare Advantage (MA). Because MA payments per enrollee are

[4] Technically, the Social Security Act §1839 (42 U.S.C. §1395r(a)) sets the standard Part B premium for enrollees aged 65 and over by (i) defining the "monthly actuarial rate" as the amount the Secretary estimates is necessary such that the aggregate amount for the year "will equal one-half of the total of the benefits and administrative costs" estimated to be payable from the SMI Trust Fund for services performed and related administrative costs incurred with respect to those enrollees, and (ii) requiring the Secretary to promulgate a standard "monthly premium rate" that "is equal to 50 percent of" that actuarial rate. Because the actuarial rate is set to cover one-half of expected costs and the standard premium is set at one-half of that actuarial rate, the standard premium in effect finances 25 percent of expected Part B costs for enrollees age 65 and over. Social Security Act, 42 U.S.C. §1395r(a)(1), (a)(3) (2018).

[5] Office of Inspector General, U.S. Department of Health and Human Services, *Medicare Part B Payment Trends for Skin Substitutes Raise Major Concerns About Fraud, Waste, and Abuse, Office of Inspector General* (OEI-BL-24-00420, Washington: CMS, 2025), https://oig.hhs.gov/reports/all/2025/medicare-part-b-payment-trends-for-skin-substitutes-raise-major-concerns-about-fraud-waste-and-abuse/.

[6] "CMS Modernizes Payment Accuracy and Significantly Cuts Spending Waste," Centers for Medicare and Medicaid Services, October 31, 2025, https://www.cms.gov/newsroom/press-releases/cms-modernizes-payment-accuracy-significantly-cuts-spending-waste; "2026 Medicare Parts A & B Premiums and Deductibles," Centers for Medicare and Medicaid Services, November 14, 2025, https://www.cms.gov/newsroom/fact-sheets/2026-medicare-parts-b-premiums-deductibles.

estimated to average about 120 percent of what it would cost to cover the same beneficiaries in TM, these MA overpayments increase Part B spending and, in turn, raise Part B premiums for beneficiaries in both TM and MA.

In this brief, "MA overpayments" refers to the estimated difference between what the federal government spends to cover current MA enrollees and what it would have spent if those same beneficiaries were covered under TM. In other words, it is an estimate of how much higher MA payments are, on average, relative to TM for the same beneficiaries. This should not be confused with "improper payments," which refer to payments made incorrectly due to administrative errors, fraud, or failure to meet program requirements. MedPAC's current estimate is that MA costs are about 120 percent of TM, implying roughly $84 billion in overpayments in 2025.

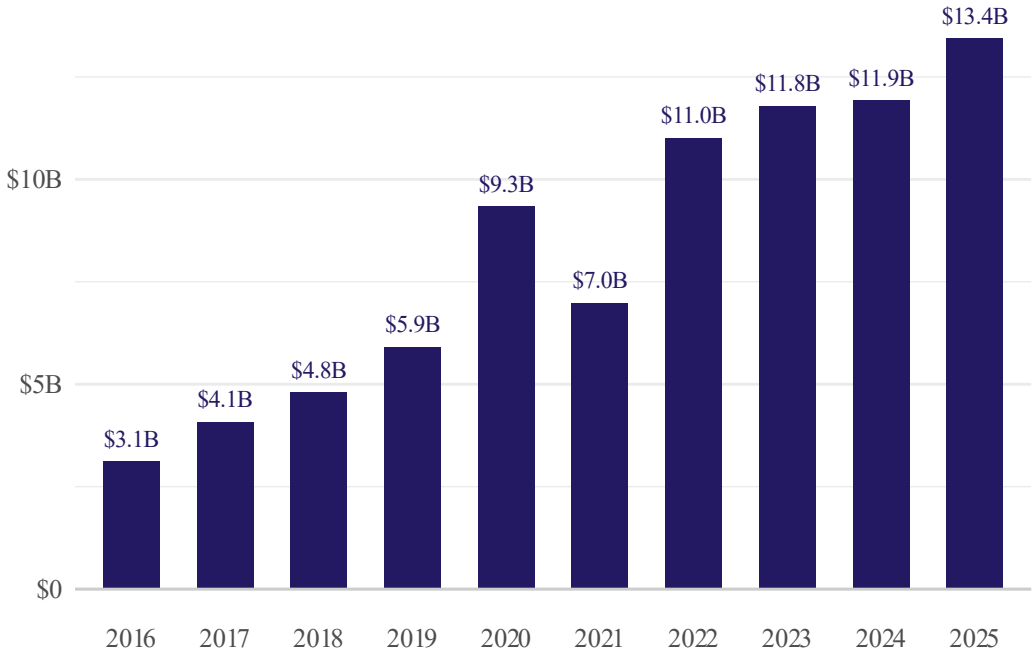
The calculation for the total additional or "excess" Part B premiums that are due to MA overpayments is the product of the total MA overpayments, the share of MA payments under Part B (since a portion of MA overpayments are for Part A services), and the share of Part B that is financed by premiums:

$$\begin{aligned} \$\text{ Additional Part B Premium} &= \$\text{MA Overpayments} \\ &\times \textit{percent} \text{ of MA payments under Part B} \\ &\times \text{percent of Part B financed by premiums} \end{aligned}$$

Applying this equation to data in 2025, this implies $\$84 \text{ billion} \times 60.6 \text{ percent} \times 26.4 \text{ percent} = \$13.4 \text{ billion}$ in higher total Part B premiums due to MA overpayments.[7] Figure 1 reports this estimated total excess burden by year. This total excess premium payment has more than quadrupled over the last decade. In 2025, the excess burden amounted to an average of $212 additional dollars per year for each Part B beneficiary. We will describe in later sections that this additional burden—and who pays for it—varies by income.

[7] The overpayment estimate of $84 billion is from MedPAC's March 2025 report. We use historical calculations of overpayment estimates for 2016-2025 from page 339 of the same report. We are aware that at the time this brief is being published, MedPAC has released a preliminary estimate of 2025 overpayments for their forthcoming 2026 report. This estimate, which is based on slightly updated data and methodology, is slightly lower at about $76 billion for 2025, but is not published as final at the time this report is going to print. If we were to use $76 billion in overpayments for our analysis this would modestly reduce the total additional premiums from $13.4 billion to $12.2 billion, and the average additional premiums per person from $212 to $192. Part B's share of MA spend is found by taking the complement of the Part A percentage of total in MA provided on page 169 of 2025 Trustees Report, and the aggregate premium financing share is from the values in Figure III.C2, Medicare Trustees Report. Note that the implied premium financing share is slightly higher, 26.73 percent, if one calculates it from the values of premium income, $154.8 billion, and total expenditures, $579.1 billion, from Table III.C4. in the same report. Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (Washington: MedPAC, 2025), 320. See chap. 11, "The Medicare Advantage program: Status Report." See the methodology section in Appendix A and the literature review on MA overpayments in Appendix B for more details on how overpayments for MA relative to TM are estimated, and for a review of estimates from this literature. It is important to note that MA overpayments are not to be confused with estimates of fraudulent, or improper payments.

Figure 1: Additional Medicare Premiums Due to MA Overpayments by Year



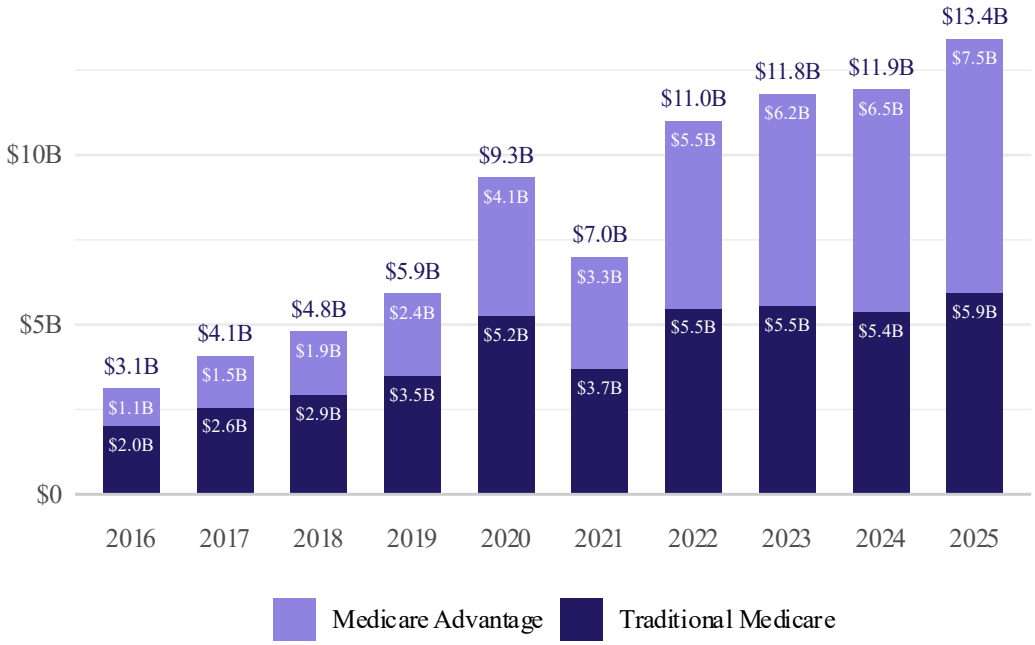
Source: Centers for Medicare and Medicaid Services;[8] JEC calculations

Who pays, who benefits? Medicare Advantage versus Traditional Medicare

Because Part B premiums are set nationally, higher Part B spending in MA raises premiums for all Part B payers, including beneficiaries who remain in TM. If TM accounts for about 44.2 percent of Medicare beneficiaries, a proportional allocation implies that TM beneficiaries and payers bore about $6 billion of the estimated $13.4 billion Part B premium increase in 2025. This split is shown in Figure 2 for each year from 2016 to 2025. In effect, TM beneficiaries help finance higher MA spending even though they do not receive MA's supplemental benefits.

[8] "Medicare Monthly Enrollment," Centers for Medicare and Medicaid Services, last modified February 19, 2026, https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/medicare-and-medicaid-reports/medicare-monthly-enrollment. See July 2025 data.

Figure 2: Additional Medicare Premiums due to MA Overpayments on TM and MA Enrollees by Year



Source: Centers for Medicare and Medicaid Services;[9] JEC calculations

Redistribution across states and congressional districts

The financing structure implies redistribution across states and congressional districts based on their relative MA and TM enrollment shares: states and districts that have more MA enrollees benefit more, while those with more TM enrollees pay relatively more for other people's benefits.

Figure 3 maps the total excess Part B premiums due to MA overpayments by congressional district. We calculate this total excess by district in two steps. First, we must account for the disparate portion of each district's enrollee population that would pay higher Part B premiums, namely the IRMAA enrollees. To do so, we divide the $13.4 billion national total of excess Part B premiums across our estimated enrollee population in each district, which amounts to about $193 per enrollee, then add an additional $240 each for those who have sufficiently high income to fit the IRMAA classification.[10] The total for district d is then calculated as:

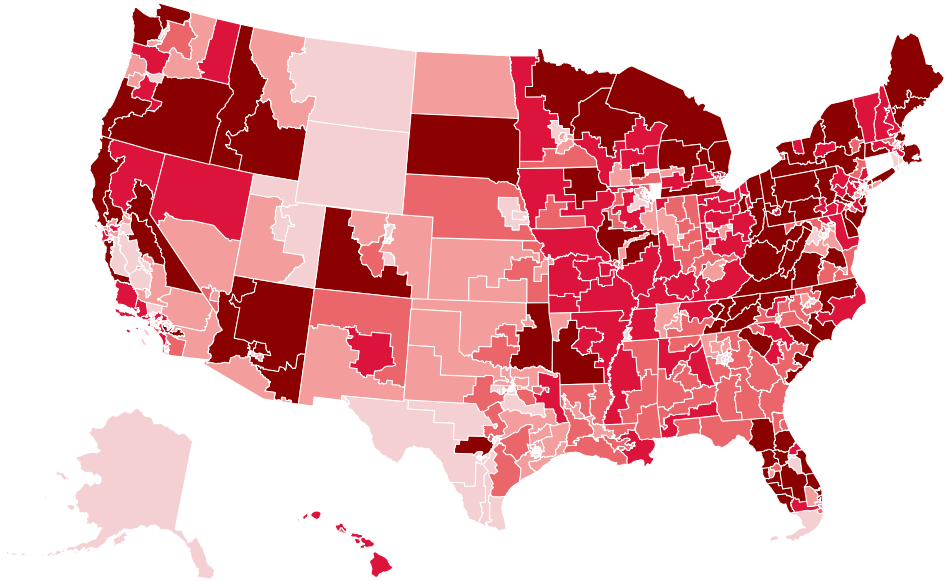
$$\$\ \text{Additional Part B premiums}_d = \$192.92 \times \text{total part B enrollment}_d + \$240.20 \times \text{IRMAA enrollment}_d$$

Figure 3 illustrates how in some regions of the country, the excess burden of greater Part B premiums due to MA overpayments is greater. For example, it is greater in Florida in part due to the state's relatively large share of seniors. Similarly, congressional districts with a higher concentration of high-income

[9] *Ibid.*
[10] The IRMAA additional payments are based on a graduated scale, but due to data limitations we use their average additional for our analysis. Moreover, IRMAA enrollee data is not available at the congressional district level, so we use a proxy. Further discussion of our apportionment and measurement is included in Appendix A.

retirees that pay IRMAA, such as certain districts in coastal areas including California and the Northeast, tend to bear a larger total excess burden.

Figure 3: Additional Medicare Premiums due to MA Overpayments by Congressional District in 2025



Source: Centers for Medicare and Medicaid Services;[11] JEC calculations

The excess premiums due to MA overpayments are also incurred by TM beneficiaries, who do not participate in MA plans, but still pay the higher premiums since Part B premiums are uniform. The map in Figure 4 shows the total excess burden due to MA overpayments incurred by TM beneficiaries only. We calculate this by scaling our estimated total MA overpayment excess burden for each district by the share of Medicare Part B enrollees in the district who are enrolled in TM.

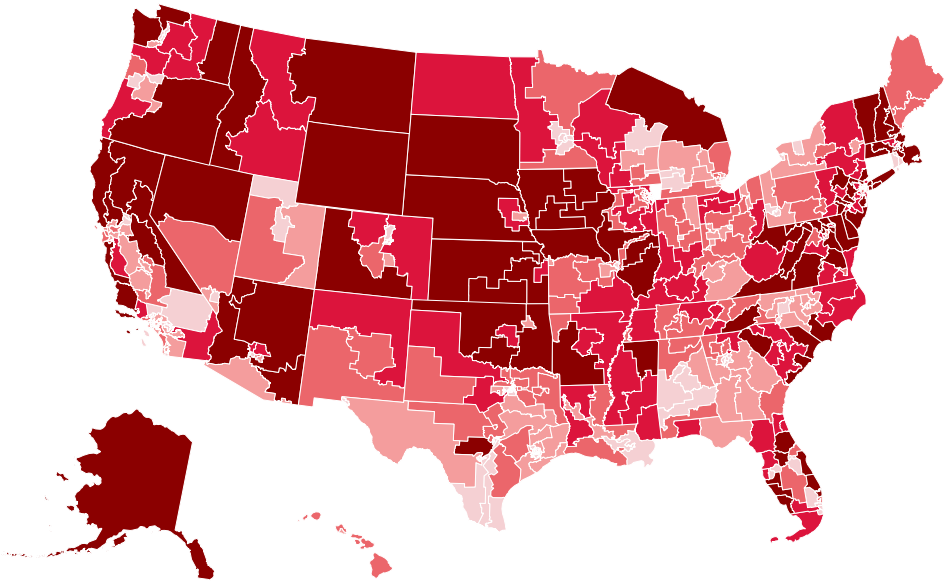
Consider the state of Wyoming, where only about 21 percent of its approximately 121,000 Medicare beneficiaries are enrolled in MA. Collectively, individuals and public payers in the state will pay an estimated $25.4 million in excess premiums during 2025, with $21 million being paid by, or on behalf of, TM beneficiaries. In effect, this means that Traditional Medicare beneficiaries collectively pay about $770 in excess premiums for every one Medicare Advantage beneficiary in the state.

Next, consider Minnesota, where Medicare Advantage enrollment is relatively high, at about 65 percent. For every 10 Medicare Advantage enrollees in the state, there are only about 5.5 Traditional Medicare enrollees. As a result, fewer Traditional Medicare beneficiaries are paying the national Part B premium increase without being enrolled in Medicare Advantage. In effect, this means that Traditional Medicare beneficiaries collectively pay about $114 in excess premiums for every one Medicare Advantage beneficiary in the state.

[11] "Medicare Monthly Enrollment," Centers for Medicare and Medicaid Services.

Taken together, Wyoming and Minnesota illustrate how national premium setting and local enrollment patterns create geographic redistribution. In Wyoming, where Medicare Advantage enrollment is low, most beneficiaries remain in Traditional Medicare and thus pay the higher Part B premiums without receiving any of the supplemental benefits funded by the higher MA payments. In contrast, in Minnesota, where MA enrollment is high, fewer beneficiaries are in Traditional Medicare paying the higher premiums without benefit, while more are in MA potentially benefiting from the overpayments. In other words, Wyoming's TM-borne burden per MA enrollee is about 6.8 times that of Minnesota's ($770 divided by $114 is about 6.8). If payment levels between Medicare Advantage and Traditional Medicare were aligned, states like Wyoming, with a large share of TM beneficiaries who are paying more without receiving MA benefits, would see greater relief. Conversely, areas like Minnesota, with high MA penetration, would experience a smaller reduction in burden. See Table 1 in Appendix D for a state-level summary.

Figure 4: Additional Medicare Premiums due to MA Overpayments Borne by TM Enrollees by Congressional District in 2025



Source: Centers for Medicare and Medicaid Services;[12] JEC calculations[13]

[12] "Medicare Monthly Enrollment," Centers for Medicare and Medicaid Services.
[13] Map includes total excess burden due to MA overpayments borne by TM enrollees, whether funded privately or through taxpayer-funding, such as via Medicaid.

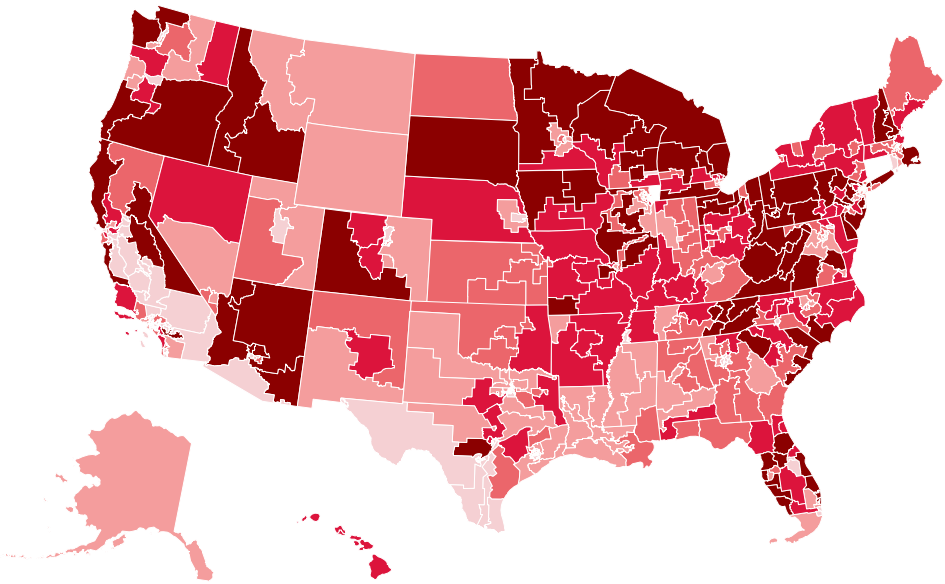
Individual burden

Most commonly, Medicare Part B premiums are paid out of cash flows that would otherwise be received as income and are therefore financed by beneficiaries themselves. The primary exception is that roughly 18 percent of enrollees receive subsidized premiums through public assistance programs. In these cases, premiums are paid by taxpayers, typically in full through Medicaid. This occurs through six eligibility pathways, which we describe in detail later in this analysis. Because the individual burden can be calculated as the total burden minus the public burden, we start with that and express it here as:

$$\text{Individual burden} = \text{total burden} - \text{public burden}$$

Using this, we estimate the excess burden on individuals due to MA overpayments to have been $11.5 billion in 2025, or about 85 percent of the total additional premiums. This primarily represents a reduction in take-home-benefits for the nearly 70 percent of beneficiaries who have premiums withheld from Social Security benefits. In 2021, 43.2 million, or about 68 percent of Medicare Part B enrollees, had their Part B premiums withheld directly from their Social Security benefit checks.[14] In addition, some have premiums deducted from Railroad Retirement (0.5 million), or Civil Service Retirement benefits, and some are billed directly by Medicare.[15] We show how the burden borne by individuals varies by congressional district in Figure 5.

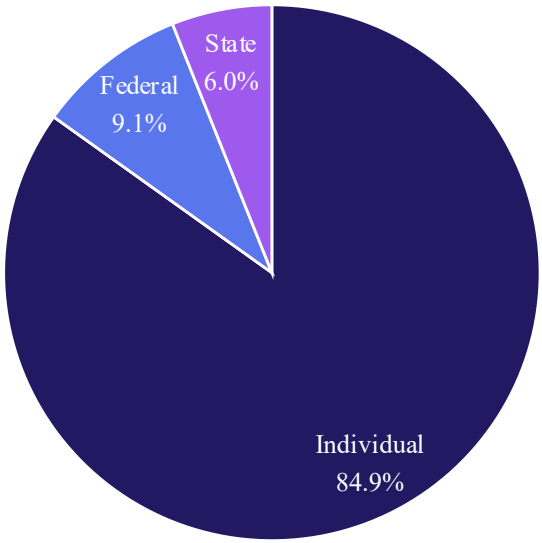
Figure 5: Additional Medicare Premiums due to MA Overpayments Borne by Individuals by Congressional District in 2025



Source: Centers for Medicare and Medicaid Services;[16] JEC calculations

[14] Paulette C. Morgan, "Medicare Part B: Enrollment and Premiums" (CRS Report R40082, Washington, 2022), 14-15, https://www.congress.gov/crs_external_products/R/PDF/R40082/R40082.55.pdf.
[15] *Ibid.*
[16] "Medicare Monthly Enrollment," Centers for Medicare and Medicaid Services.

Figure 6: Incidence of Additional Medicare Premiums in 2025



Source: Centers for Medicare and Medicaid Services;[17] JEC calculations

Figure 6 shows that in 2025, the vast majority (84.9 percent) of the premium increase associated with MA overpayments was born privately.

Public burden borne by taxpayers

There are several groups whose Part B premiums are paid by public funds, mostly by Medicaid through the Medicare Savings Program (MSP). We quantify excess premiums paid by state and federal governments, which we call the "public burden." To do this, we divide the population into three mutually exclusive measures of taxpayer-subsidized enrollees: enrollees with jointly (state and federal) subsidized Part B premiums, enrollees with state-only subsidized Part B premiums, and enrollees with federal-only subsidized Part B premiums. We then use state-specific Federal Medical Assistance Percentages (FMAPs) to divide the excess burden on the jointly subsidized enrollees into state and federal excess burdens. FMAP is the federal matching rate for Medicaid spending: for each dollar of eligible Medicaid expenditure, the federal government pays a share rate that varies by state, and the state pays the remainder.[18] The state-only and federal-only subsidized enrollees are assumed to have their excess premiums fully covered by state taxpayers and federal taxpayers, respectively.
Thus, denoting by "standard excess premium" the increased premium cost due to MA overpayments, our formulas are, for state s:

$$\begin{aligned}&\$\ \text{State total excess burden due to MA overpayments}_s\\ &\quad = \text{Jointly subsidized enrollees}_s \times \text{standard excess premium} \times (1 - \text{FMAP}_s)\\ &\quad + \text{State-only subsidized enrollees}_s \times \text{standard excess premium}\end{aligned}$$

[17] "Medicare Monthly Enrollment," Centers for Medicare and Medicaid Services.
[18] Social Security Act, 42 U.S.C. § 1396a(a)(10)(E) (2018).

$$\begin{aligned}\$\ \text{Federal total excess burden due to MA overpayments}_s \\ = \ &\text{Jointly subsidized enrollees}_s \times \text{standard excess premium} \\ + \ &\text{FMAP}_s\ \text{Federal-only subsidized enrollees}_s \times \text{standard excess premium}\end{aligned}$$

We describe how we calculate the terms of these equations, jointly subsidized enrollees_s, state-only subsidized enrollees_s, and federal-only subsidized enrollees_s, as well as the FMAP parameters, in Appendix A.

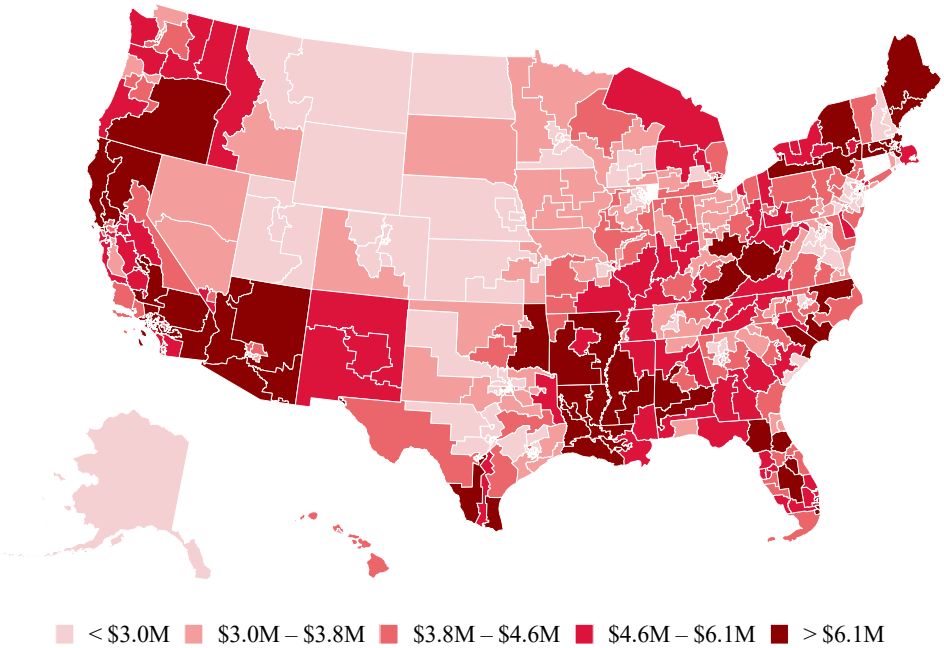
By summing up the state and federal total excess burdens, calculated using our formulas, across states, we arrive at our estimates for the national aggregate excess burdens due to MA overpayments on taxpayers, split by state taxpayers and federal taxpayers. Figure 6, already introduced, shows the incidence of the premium burden is primarily borne by individuals (84.9 percent), followed by federal (9.1 percent), and state (6.0 percent) taxpayers.

Moreover, we calculate the total public excess burden due to MA overpayments at the congressional district level, by summing the state and federal excess burdens at the congressional district level, using estimated measures of enrollments at the congressional district level.[19] Estimates from this calculation are mapped in Figure 7.

Figure 7 shows that congressional districts with high public-sector burdens appear clustered in southern states, including Louisiana, Mississippi, Arkansas, and parts of Texas. This pattern is consistent with a larger share of seniors in these areas receiving premium support through Medicaid. It is similarly noteworthy that the public burden in midwestern states, many of which have few or even at-large, congressional districts, appear to have relatively low public burdens, which is a result of lower safety net participation among seniors.

[19] In fact, because the total public excess burden does not depend on the split across the three groups, nor does it depend on FMAP, we calculate the total public excess burden at the congressional district level more succinctly by estimating the total publicly subsidized enrollment and multiplying by the standard excess premium.

Figure 7: Additional Medicare Premiums due to MA Overpayments Borne by the Public by Congressional District in 2025



Source: Centers for Medicare and Medicaid Services;[20] JEC calculations

Conclusion

Over the next decade, per-person Part B expenditures are projected to nearly double, from around $9,100 in 2025 to over $18,000 in 2035. Because the standard Part B premium is set to cover 25 percent of expected costs, baseline premiums are expected to nearly double as well, from about $2,200 per year in 2025 to about $4,500 in 2035. Average premiums are expected to grow even more. Under these projections, premiums will rise sharply for seniors who rely on Medicare.

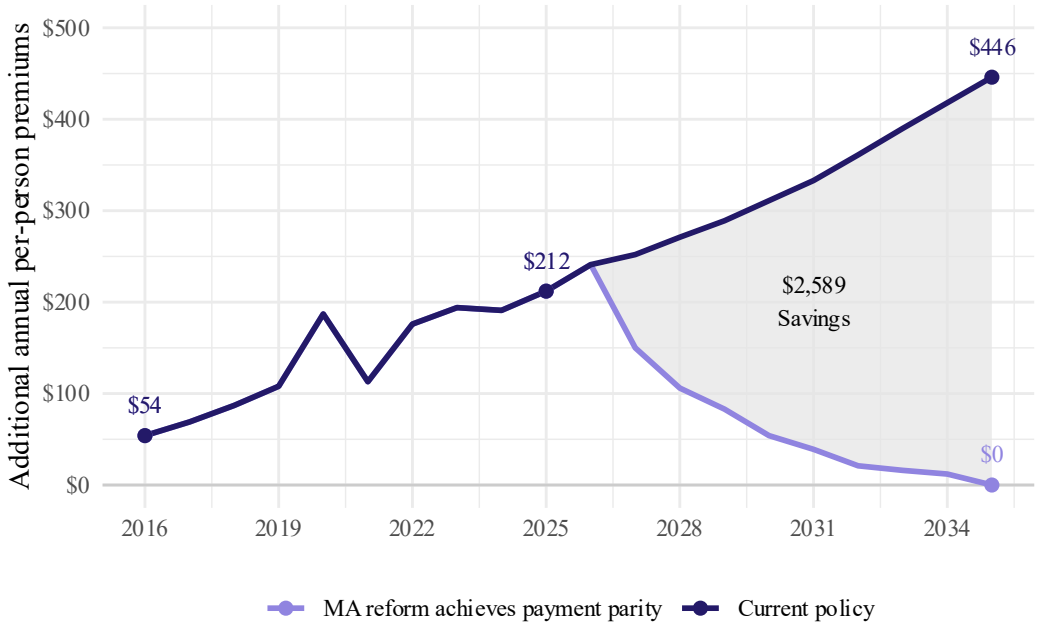
In addition to the near doubling in projected spending per person in Part B, the other factors that produce the excess premiums detailed in this brief are projected to increase as well. Part B is projected to grow faster than Part A, thereby increasing Part B's share of Medicare spending, and finally, the share of Part B costs financed through premiums is expected to rise, as more beneficiaries pass the thresholds for income adjusted premiums. These trends are shown in Figure 9 in Appendix D and mean that, as Part B costs rise, more of that cost will show up as higher premiums.

It is therefore imperative for policymakers to act to prevent premiums from gradually eating away at seniors' social security checks. One concrete, fiscally sustainable approach is to align Medicare Advantage payment levels with Traditional Medicare. This would directly address what may appear to be a modest per-beneficiary amount, $212 per year, but which has already amounted to $82 billion in excess Part B premiums over the past decade. And, looking ahead, the per-beneficiary amount may no longer be so modest. If Medicare Advantage continues to be paid at 120 percent of Traditional Medicare as Part B spending doubles, the additional premium burden would rise to roughly $450 per beneficiary per year in 2035 (shown in Figure 8).

[20] "Medicare Monthly Enrollment," Centers for Medicare and Medicaid Services.

However, even though every contributing factor mentioned is projected to grow, the excess burden from Medicare Advantage overpayments we document are not inevitable. They ultimately result from a policy choice to pay more for Medicare Advantage than for Traditional Medicare. Aligning Medicare Advantage payment levels with Traditional Medicare would directly limit this avoidable premium growth and protect the Social Security benefits of 50 million Part B beneficiaries. Reform that gradually achieves payment parity could save each senior approximately $2,600 over the next decade.

Figure 8: Projection of Additional Part B Premiums Under Current Policy Versus Payment Parity



Source: Medicare Payment Advisory Commission;[21] Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds;[22] Congressional Budget Office;[23] JEC calculations

[21] Medicare Payment Advisory Commission, *Report to the Congress*, 338-339. See chap. 11, "The Medicare Advantage program: Status Report."
[22] Boards of Trustees, *2025 Annual Report*, 163, 187, 201. See Table III.C2, "Premium Income as a Percentage of Part B Expenditures;" Table V.B3, "Medicare Enrollment;" and Table IV.C2, "Medicare Payments to Private Health Plans, by Trust Fund."
[23] Data for Baseline Projections of Medicare Program, Congressional Budget Office, June 2024, https://www.cbo.gov/system/files/2024-06/51302-2024-06-medicare.pdf.

Appendix A: Methodology for Excess Part B Premium Calculations

In the main text, we describe how we calculate the aggregate Part B premium increase due to Medicare Advantage (MA) overpayments, estimating that premiums were, for example, $13.4 billion higher in 2025 due to MA overpayments. We perform this calculation similarly for other years.

In 2025 there were 63.48 million people on Medicare Part B.[24] Thus, the average excess premium per Part B enrollee in 2025 was:

$$\frac{\$13.4 \text{ billion}}{63.48 \text{ million}} = \$212 \text{ excess premium burden due to MA overpayments}$$

However, Medicare Part B enrollees do not all pay the same premiums. To better estimate congressional district excess premium burdens due to MA overpayments, we divide enrollees into three groups and determine the average excess premium burden for each of the three groups. We detail our approach next.

Calculating average excess Part B premiums by income group

While $212 is the average excess premium burden, to calculate how much each enrollee pays to cover the cost of overpayments in Medicare Advantage requires information about income. This is because Medicare Part B premiums depend on income.

- If an enrollee's income is sufficiently low, they will qualify for Medicaid or a State program, which will pay the standard premium.
- If an enrollee's income is moderate, they will pay the standard premium out of their private income, usually via Social Security withholding.
- If an enrollee's income is sufficiently high, they will pay the standard premium plus an income-related monthly adjustment amount (IRMAA).[25] In 2025, 5.1 million enrollees paid an IRMAA.[26]

In 2025, Medicare collected $154.8 billion in total Part B premiums, which includes $140.9 billion in standard premiums paid by, or on behalf of, Part B beneficiaries, and $14.1 Billion in additional payments from IRMAA beneficiaries (above and beyond the $11.3 billion those same IRMAA beneficiaries paid in standard premiums).

Distributing the $154.8 billion across total Part B enrollment of 63.48 million means an average premium payment of $2,438.5. Distributing the $140.9 billion across 63.48 million total enrollees means, on average, $2,220 in annual premiums were paid via the standard premium. These averages include both private and taxpayer-funded payments. Distributing the $14.1 billion of additional payments from IRMAA across the 5.1 million IRMAA beneficiaries means, on average, they paid an additional $2,765 annually. Thus, IRMAA enrollees paid, on average, $\$2{,}220 + \$2{,}765 = \$4{,}985$ in Part B premiums.

[24] Boards of Trustees, *2025 Annual Report,* 187. See Table V.B3, "Medicare Enrollment."
[25] Social Security Administration, *Medicare Premium Refund Request (Application)* (SSA-44, Baltimore: SSA, 2026), https://www.ssa.gov/forms/ssa-44.pdf.
[26] Boards of Trustees, *2025 Annual Report,* 205. See Table V.E3, "Part B Income-Related Premium Information."

The increase in Part B premiums due to MA overpayments was $212, on average. Dividing this by the average premium, $2,438.5, means the average premium increase was 8.69 percent. Allocating this proportionally to the standard and IRMAA average premiums, we obtain:

- Standard Premium Increase due to MA overpayment: $2{,}220 \times 8.69 \text{ percent} \approx \$193 / \text{year}$
- Average Increase per IRMAA beneficiary: $\$4{,}985 \times 8.69 \text{ percent} \approx \$433.20 / \text{year}$

In our calculations, we assume that all IRMAA-paying beneficiaries pay the same increment due to MA overpayments. In fact, the additional IRMAA payments are charged on a graduated scale that increases with income.[27] However, we only estimate total IRMAA enrollment at the congressional district level, using methods to be detailed shortly. Consequently, in our calculations we treat the IRMAA enrollees as a homogenous group, all of whose members pay $433.20 greater Medicare Part B premiums in 2025 due to MA overpayments. Other enrollees pay (either privately or through taxpayer subsidies) the standard premium increment, i.e., $193 more. This is an approximation to a more complicated premium schedule.

Note that enrollees with incomes that are sufficiently low will qualify for Medicaid or a State program, and therefore typically not pay their Medicare Part B premiums. In these cases, taxpayers cover their premium payments: the excess burden is not lessened, it is merely transferred from private enrollees to taxpayers.

Measurement of IRMAA-paying beneficiaries

To measure excess premiums for IRMAA beneficiaries we would ideally be able to employ data including the amounts of IRMAA premiums collected (or the number of individuals in each IRMAA bracket which would let us calculate collections), at every geographic level of interest. However, no public data sources provide this data at a sub-state geographic level, thus making allocation to congressional districts impossible.

To overcome this data limitation, we employ data from the American Community Survey (ACS). The ACS provides a measure at the Congressional District level of the number of households above the age of 65 with incomes above $250,000 and households above 65 with incomes below $250,000. We use this data to calculate the share of households who are above 65 with incomes above $250,000, which we use as a proxy for the share of beneficiaries in a congressional district who pay IRMAA. We chose this approach due to its geographic granularity, which allows us to allocate excess premiums to congressional districts within each state. We expect this to be a reasonably good proxy for the IRMAA population as the first threshold for IRMAA for a married couple filing jointly was $212,000 or greater in 2025.

[27] The income-related monthly adjustment amount (IRMAA) tiers set the beneficiary's total monthly premium to cover 35 percent, 50 percent, 65 percent, 80 percent, or 85 percent of expected Part B costs. In 2025, Medicare Advantage overpayments raised average Part B expenditures by an estimated $802 per beneficiary, therefore the per-person premium increase in each IRMAA tier was approximately: 35%: $282 per year ($23.39/month); 50%: $401 ($33.41/month); 65%: $521 ($43.44/month); 80%: $642 ($53.46/month); 85%: $682 ($56.80/month).
In 2026, the corresponding modified adjusted gross income (MAGI) thresholds are: 35 percent if MAGI is >$109,000 and ≤$137,000 (individual) or >$218,000 and ≤$274,000 (married filing jointly); 50 percent if >$137,000 and ≤$171,000 (individual) or >$274,000 and ≤$342,000 (joint); 65 percent if >$171,000 and ≤$205,000 (individual) or >$342,000 and ≤$410,000 (joint); 80 percent if >$205,000 and <$500,000 (individual) or >$410,000 and <$750,000 (joint); and 85 percent if ≥$500,000 (individual) or ≥$750,000 (joint). For married filing separately (and lived with spouse at any time during the year), CMS lists: 80 percent if MAGI is >$109,000 and <$391,000, and 85 percent if ≥$391,000. See "2026 Medicare Parts A & B Premiums and Deductibles," Centers for Medicare and Medicaid Services, November 14, 2025, https://www.cms.gov/newsroom/fact-sheets/2026-medicare-parts-b-premiums-deductibles.

Estimating congressional district Medicare enrollee totals by group

To calculate the district-level excess Medicare Part B premiums due to MA overpayments, and the excess burdens for subgroups (e.g., Traditional Medicare beneficiaries only), we require estimates of total Medicare enrollment in several subgroups of the program, for each congressional district. For example, we need measures of enrollees in Traditional Medicare only, and we need measures of those enrolled in Part B but not concurrently enrolled in Medicaid. We require other subgroups as well for our analysis.

Unfortunately, the data available to us does not contain group-level estimates for many enrollment types by congressional district. In many cases, we instead have the following: congressional district-level data on total Medicare enrollment (the sum of Part B and non-Part B enrollment), county-level data on Medicare enrollment by group and total Medicare enrollment, and national totals for Medicare enrollment by group. We use these datasets to estimate the Medicare enrollments by group that we require.

We provide mathematical details for our approach below. In short, we first estimate the shares of total Medicare enrollment in each group by allocating county-level estimates to congressional districts using population weights.[28] We then multiply the estimated shares by the (known) congressional district-level data on total Medicare enrollments to obtain a preliminary estimate of the congressional district population count in each group. Finally, we multiply all congressional district group-level totals by a constant factor in order to match national aggregate totals in each group, arriving at our final estimates.

The result of our calculations is an estimate of the total Medicare population in each of our required groups, for each congressional district. For the population weights, we use block-level data from the 2020 decennial census and 2024 redistricting files.[29]

Step 1. We estimate the shares of total Medicare enrollment in each group by allocating county-level estimates to congressional districts using population weights.

Where c denotes county, d congressional district, and i group, let the following denote the data series that we observe:

p_{ic} = number of enrollees in county c, group i
T_c = total number of Medicare enrollees in county c (both Part B and non-Part B included)
pop_d = total population in congressional district d
pop_{cd} = total population in the intersection of congressional district d and county c

We then estimate r_{id}, the estimated district d share of group i (out of total Medicare enrollment),

$$r_{id} = \sum_c \frac{pop_{cd}}{pop_d} \times \frac{p_{ic}}{T_c}$$

[28] "Cross walking" county level observations to congressional districts can be accomplished in various ways. See Andreas Ferrara, Patrick A. Testa, and Liyang Zhou, "New Area- and Population-based Geographic Crosswalks for U.S. Counties and Congressional Districts, 1790–2020," NBER Working Paper no. 32206 (2024), https://doi.org/10.3386/w32206. For this project, we use population weights, allocating county data to a congressional district based on the population shares of the congressional district in each county.

[29] We constructed the weights using Census data and verified our estimates by comparison with those from "Geocorr 2022 Applications," Missouri Census Data Center, University of Missouri, accessed February 27, 2026, https://mcdc.missouri.edu/applications/geocorr2022.html.

The summation is over all counties, or equivalently only counties with $pop_{cd} > 0$ (since otherwise the term in the sum would be zero). Note that the denominator is the total number of people enrolled in Medicare; thus r_{id} is an estimate of the share out of *all* Medicare enrollees in congressional district d that are in group i (not an estimate of the share out of, for example, Part B enrollees only).

To give a concrete example, consider the case where:

1. A congressional district is populated equally by 2 counties.
2. County A has a share of group 1 of 80 percent;
3. County B has a share in group 1 of 20 percent.

The estimated r_{1d} for this congressional district is then 50 percent ($= 0.50 \times 80\% + 0.50 \times 20\%$).

Step 2. Multiply the estimated shares from Step 1 by the (known) congressional district-level data on total Medicare enrollments to obtain a preliminary estimate of the congressional district population count in each group.

Let

$T_d = \text{total number of Medicare enrollees in district } d$
$p_{id} = \text{number of enrollees in district } d, \text{group } i \text{ (unobserved)}$

We observe T_d in the data, and use it to produce a preliminary estimate of p_{id} as follows

$$p_{id}^{\text{prelim}} = r_{id} \times T_d$$

Because r_{id} is an estimate of the share out of all Medicare enrollees in the congressional district that are in group i, multiplying this by T_d appropriately scaling this up from a share to a total.

For example, if we observe a congressional district that has 100,000 Medicare enrollees, and we estimated via Step 1 that 20 percent of these enrollees would be in group 1, then we estimate that 20,000 group 1 enrollees are in the district.

Step 3. We multiply all congressional district group-level totals by a constant factor in order to match national aggregate totals in each group, arriving at our final estimates.

We observe national aggregates for each group,

$$p_i = \text{number of enrollees in group } i, \text{nationwide}$$

However, the analogous national aggregate p_i^{sum} obtained by summing over congressional districts via our approach,

$$p_i^{\text{sum}} = \sum_d p_{id}^{\text{prelim}}$$

does not necessarily equal p_i, the true national aggregate. We therefore adjust our preliminary estimates p_{id}^{prelim} so that our final estimates total to the national aggregate, with our final estimate for p_{id} as follows,

$$p_{id} = \frac{p_i}{p_i^{\text{sum}}} \times p_{id}^{\text{prelim}}$$

Thus, $\sum_d p_{id} = p_i$ is assured for each i: the sum of our congressional district estimates across the country are equal to the known national totals. For example, if p_i is 3 percent larger than p_i^{sum} for a given group i, then we would in this step multiply all of our congressional district estimates p_{id}^{prelim} by 1.03 to arrive at our final estimates for p_{id}.

We use p_{id} for our estimates of the counts of Medicare enrollees in each group for our analysis.

Enrollment group calculations for public excess burden

To calculate the public excess premium burden due to MA overpayments, we divide the population into three mutually exclusive measures of taxpayer subsidized enrollees: enrollees with jointly (state and federal) subsidized Part B premiums, enrollees with state-only subsidized Part B premiums, and enrollees with federal-only subsidized Part B premiums. This section describes how we calculate each group.

The first group, Enrollees with Jointly Subsidized Part B, includes enrollees that are either Qualified Medicare Beneficiaries (QMB) or Specified Low-Income Medicare Beneficiaries (SLMB).[30] Within these categories, beneficiaries are further designated into "Only" or "Plus" subgroups. "Only" subgroups receive assistance solely through a Medicare Savings Program to cover their Part B premium (and, in the case of QMB, cost-sharing), but do not qualify for full Medicaid benefits, while "plus" refers to individuals who qualify for full Medicaid benefits in addition to premium assistance. Thus,

$$\begin{aligned}\text{Enrollees with Jointly Subsidized Part B Premiums} \\ = \text{ QMB Only} + \text{QMB Plus} + \text{SLMB Only} + \text{ SLMB Plus}\end{aligned}$$

Enrollees in this group have standard Part B premiums paid on their behalf by taxpayers, and in the case of Medicaid, the burden is financed jointly by state and federal governments according to each state's Federal Medical Assistance percentage (FMAP). We thus split the burden for this group between state and federal taxpayers based on each state's FMAP.[31]

The second group, Enrollees with Federal-Only Subsidized Part B Premiums, consists of nearly 600,000 enrollees in the Qualified Individuals (QI) category. CMS data provides this combined as a single variable with Qualified Disabled Working Individuals (QDWI) enrollees who do not receive subsidized Part B

[30] More details on these and the following variables can be found in the data dictionary provided in Appendix B.
[31] FMAP is the federal matching rate for Medicaid spending: for each dollar of eligible Medicaid expenditure, the federal government pays a share rate that varies by state and the state pays the remainder (1−FMAP). Each state has a separate FMAP based on the state's average per capita income relative to the national average, with a statutory minimum of 50% and maximum of 83%. The simple (unweighted) average FMAP across the 50 states is about 60% (so the average state share, 1−FMAP, is about 40%). Because higher-income states receive lower FMAPs by design, they finance a larger share (1−FMAP) of each dollar of excess premiums than lower-income states. We use state FMAP values from KFF, to calculate the relative burdens for each state as well as the federal government from these jointly subsidized enrollees (KFF, 2026).

premiums, and thus introduces some measurement error. However, this error is very small as the count of individuals in QDWI is reported to be quite small (1,733 individuals as of 2019).[32]

$$\text{Enrollees with Federal-Only Subsidized Part B Premiums} = \text{QDWI QI BENES}$$

The third measure, Enrollees with State-Only Subsidized Part B Premiums, is based on the CMS variable that captures Other Full-Dual Benefit Medicaid beneficiaries that are entitled to Medicare Part A and/or entitled to Part B, and qualify for full Medicaid benefits, but not through the QMB, SLMB, or QI groups. Enrollees in this measure generally have their Part B premiums paid for by their state when the state has a buy-in agreement with CMS that includes all Medicaid eligibility groups.[33] Thus,

$$\begin{aligned}\text{Enrollees with State-Only Subsidized Part B Premiums} \\ = \text{Other Full-Dual Benefit Medicaid Beneficiaries} \\ - \text{Dual Benefit Medicaid} \times \text{State Has a Buy-In Agreement with CMS}\end{aligned}$$

As of January 2025, this applied to 28 jurisdictions (27 states, and Washington D.C.), and about 829,000 enrollees.[34] Importantly, when states pay premiums on behalf of enrollees in this group, the payments are generally not eligible for federal financial participation (FFP), and are thus borne entirely by state budgets.

Medicare Advantage Part B premium givebacks (rebates)

Medicare Part B "premium givebacks," also referred to as premium rebates, are a newer type of Medicare Advantage supplemental benefit. While givebacks have been a common benefit for Part D premiums, an increasing number of MA plans have started to offer them for Part B. Meiselbach et al. explored trends related to Part B givebacks and their associations with plan enrollment. They found a notable increase in MA plans offering Part B givebacks, with 3.4 million beneficiaries receiving an average of $77 per month across 18.7 percent of MA plans in 2024.[35] The rebates contributed a reported $3.12 billion in annual MA program costs.[36]

Since Part B premium givebacks reduce premium costs, and therefore excess premiums borne by MA enrollees, we would like to include a produce an estimate of excess premiums for MA enrollees that is net of these rebates. Unfortunately, data limitations prevented us from doing this at the same geographic

[32] Centers for Medicare and Medicaid Services, *Medicare-Medicaid Dual Enrollment: Ever-Enrolled Trends Data Brief, 2006 through 2019* (Baltimore: CMS, 2020), 14, https://www.cms.gov/files/document/medicaremedicaiddualenrollmenteverenrolledtrendsdatabrief.pdf.
[33] We write that states "generally" pay Part B premiums for these enrollees because there are a few minor exceptions, including that states do not pay premiums in the first month of Part B enrollment due to timing rules. Further, the measure may include a small percentage of beneficiary-months where the beneficiary is only enrolled in Part A, thus slightly overstating the number of Part B enrollees have premiums paid on their behalf through this mechanism. See Centers for Medicare and Medicaid Services, *State Payment of Medicare Premiums* (100-24, Baltimore: CMS, 2025). See chap. 1, "Program Overview and Policy."
[34] This includes the following jurisdictions: AK, AL, AR, AZ, CA, CO, DE, DC, FL, GA, HI, IA, IN, KS, MD, MI, MS, NC, NJ, NM, NV, OH, OR, SC, UT, VA, WA, WY. See Centers for Medicare and Medicaid Services, *State Payment of Medicare Premiums* (100-24, Baltimore: CMS, 2025). See chap. 1, "Program Overview and Policy," Appendix 1. D.
[35] Mark K. Meiselbach et al., "Medicare Advantage Part B Premium Givebacks and Enrollment," *JAMA Health Forum* 6, no. 6 (2025), e251215, https://doi.org/10.1001/jamahealthforum.2025.1215.
[36] *Ibid.*

levels as our other measures. Specifically, CMS suppresses state and county enrollment data when fewer than 11 enrollees are in a plan and county combination.[37] This leads to missing data on Part B givebacks for approximately a third of counties across the United States. Therefore, our estimates for excess premiums among MA enrollees are gross figures, but we note that alternative data sources may be used in future work to estimate givebacks for the counties with missing values.

Appendix B: Variables from CMS and ACS data used in analysis

Source	Variable	Definition
CMS	Total Medicare Part B Beneficiaries B_TOT_BENES	Count of Medicare beneficiaries enrolled in Supplementary Medical Insurance (or Part B)
	Original Medicare Part B Beneficiaries B_ORGNL_MDCR_BENES	Count of Original Medicare beneficiaries enrolled in Supplementary Medical Insurance (or Part B)
	Medicare Advantage and Other Health Plan Part B Beneficiaries B_MA_AND_OTH_BENES	Count of Medicare Advantage and Other Health Plan Beneficiaries enrolled in Supplementary Medical Insurance (or Part B)
	Qualified Medicare Beneficiaries Only Beneficiaries QMB_ONLY_BENES	Count of Qualified Medicare Beneficiaries who are entitled to Medicare Part A, have income up to 100 percent of the federal poverty level and resources that do not exceed three times the limit for supplementary security income (SSI) eligibility with adjustments for inflation and are not otherwise eligible for full-benefit Medicaid coverage. Medicaid pays their Part A premiums, if any, and Medicare Part B premiums.
	Qualified Medicare Beneficiaries with Full-Benefit Medicaid QMB_PLUS_BENES	Count of Qualified Medicare Beneficiaries with full-benefit Medicaid that meet the QMB-related eligibility requirements and the eligibility requirements for a separate categorical Medicaid eligibility group covered under the state plan. These individuals are entitled to all benefits available to a QMB, as well as the full range of Medicaid benefits applicable to the separate eligibility group for which they qualify.
	Specified Low-Income Medicare Beneficiaries Only Beneficiaries SLMB_ONLY_BENES	Count of Specified Low-Income Medicare Beneficiaries without other Medicaid who are entitled to Part A and have income between 100 and 120 percent of the federal poverty level, and resources that do not exceed three times the limit for supplementary security income eligibility with adjustments for inflation. Medicaid pays only the Medicare Part B premiums.
	Specified Low-Income Medicare Beneficiaries with Full-Benefit Medicaid SLMB_PLUS_BENES	Count of Specified Low-Income Medicare Beneficiaries with full-benefit Medicaid who meet the SLMB-related eligibility requirements and the eligibility requirements for a separate categorical Medicaid eligibility group covered under the state plan. In addition to coverage for Medicare

[37] Data for monthly enrollment by contract/plan/state/county for November 2025, Centers for Medicare and Medicaid Services, accessed February 27, 2026, https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-advantagepart-d-contract-and-enrollment-data/monthly-enrollment-contract/plan/state/county/monthly-enrollment-cpsc-2025-11. See “Read me” text file.

		Part B premiums, these individuals receive full-benefit Medicaid coverage.
	Qualified Disabled and Working Individuals/Qualifying Individuals QDWI_QI_BENES	Qualified Disabled and Working Individuals are eligible for premium-free Part A by virtue of qualifying for Social Security Disability Insurance (SSDI) benefits but lose those benefits and subsequently premium-free Medicare Part A, after returning to work. QDWIs have income that does not exceed 200 percent of the federal poverty level, have resources that do not exceed two times the SSI resource standard and are not otherwise eligible for Medicaid. Medicaid pays Medicare Part A premiums only. Qualifying Individuals are entitled to Part A and have income of at least 120 but less than 135 percent of the federal poverty level, resources that do not exceed three times the limit for SSI eligibility with adjustments for inflation and are not eligible for any other eligibility group under the state plan. QIs receive coverage for their Medicare Part B premiums, to the extent their state Medicaid programs have available slots.
	Other Full-Benefit Medicaid Beneficiaries OTHR_FULL_DUAL_MDCD_BENES	Other Full-Benefit Medicaid beneficiaries are entitled to Medicare Part A and/or entitled to Part B, and qualify for full Medicaid benefits, but not the QMB or SLMB groups.
ACS	B27006_001 through B27006_056	Population with Medicare coverage by sex and age.
	B19037_001	Total number of households.
	B19037_053	Number of households with a householder aged 65 years or more.
	B19037_069	Number of households with a householder aged 65 years or more and a household income of $200,000 or more in 2022 inflation-adjusted dollars.

Appendix C: Methodology and literature on Medicare Advantage overpayments

The key building block that this brief and data release are built upon is the estimate provided by the Medicare Payment Advisory Commission ("MedPAC") that the Medicare Advantage ("MA") program was overpaid 120 percent relative to the fee-for-service ("FFS," also referred to as "Traditional Medicare" or "TM") program in 2025. As discussed, this overpayment estimate reflects the difference in Medicare spending that would occur if MA enrollees were instead covered under the FFS program. MedPAC most recently estimated that this added $84 billion in federal costs in 2025.

The overpayments are attributed to two categories: coding intensity and favorable selection.

Coding intensity

"Coding intensity" accounts for the differing financial incentives to document medical conditions ("diagnoses") between Medicare Advantage and the fee-for-service program. MedPAC utilizes the demographic estimate of coding intensity ("DECI") for its estimations of MA overpayments. The method assumes fee-for-service enrollees have comparable health after controlling for demographic

characteristics including age, sex, Medicaid eligibility, and institutional status. Upon these assumptions, MedPAC creates four risk scores:

- A national average based on demographic characteristics for FFS beneficiaries;
- A national average based on demographic characteristics for MA beneficiaries;
- A national average based on the demographic characteristics and medical diagnostic coding with the Centers for Medicare and Medicaid Services's (CMS) hierarchical condition category (HCC) scores; and
- A national average based on the demographic characteristics and medical conditions with HCC scores.

MedPAC takes these four scores and creates a ratio of two ratios, as described below:

$$\text{Coding Intensity} = \frac{\frac{\text{National average MA CMS HCC risk score}}{\text{National average FFS CMS HCC risk Score}}}{\frac{\text{National average MA demographic only risk score}}{\text{National average FFS demographic only risk Score}}}$$

Alternate coding intensity estimates produce similar results to the DECI method. While there is natural variation in estimated coding intensity depending on the setting, research design, geographic area, and period, our review of the literature strongly supports using MedPAC's estimated overpayment figures as the key building block in our analysis.

Geruso and Layton found enrollees in private Medicare plans have risk scores 6 to 16 percent higher than if they were enrolled in FFS Medicare between 2006-2011.[38] Curto et al. evaluated coding intensity between FFS and MA using mortality rates, which is consistently and reliably measured, and estimated coding inflation at 8.4 percent in 2014, compared to 7.2 percent by MedPAC and to a range of 4.6 to 20 percent by other sources.[39] Jacobs and Layton estimated coding intensity led to 18.6 percent higher risk scores amongst enrollees who switched from FFS to MA coverage compared to those who remained in FFS in 2021.[40] The differential in risk scores between FFS and MA increases with continuous MA enrollment: Hayford and Burns noted it was associated with an additional 1.2 percent increase per year.[41] Jacobs noted MA risk scores were 7.4 percent higher in 2021 when data from in-home health risk assessments and chart reviews were included.[42]

The DECI method's estimations are a basis for improving the measurement of coding intensity. The Center for Advancing Health Policy Through Research (CAHPR) at Brown University developed a "report card" derived from the DECI method to compare coding intensity at the plan, contract, and state

[38] Michael Geruso and Timothy Layton, "Upcoding: Evidence from Medicare on Squishy Risk Adjustment," *Journal of Political Economy* 12, no. 3 (2020): 984-1026, https://doi.org/10.1086/704756.
[39] Vilsa E. Curto et al., "Coding intensity variation in Medicare Advantage," *Health Affairs Scholar* 3, no. 1 (2025), qxae176, https://doi.org/10.1093/haschl/qxae176.
[40] Paul D. Jacobs and Timothy J. Layton, "Identifying Coding Intensity in Medicare Advantage Through Switchers," *Health Services Research* 60, no. 5 (2025), e14628, https://doi.org/10.1111/1475-6773.14628.
[41] Tamara Beth Hayford and Alice Levy Burns, "Medicare Advantage Enrollment and Beneficiary Risk Scores: Difference-in-Differences Analyses Show Increases for All Enrollees On Account of Market-Wide Changes," *Inquiry* 55 (2018), 46958018788640, https://doi.org/10.1177/0046958018788640.
[42] Paul D. Jacobs, "In-Home Health Risk Assessments and Chart Reviews Contribute To Coding Intensity In Medicare Advantage," *Health Affairs* 43, no. 7 (2024), https://doi.org/10.1377/hlthaff.2023.01530.

level.[43] Scholars built upon the DECI method to refine estimates: Kronick et al. considered MedPAC's estimate and qualified the DECI method's assumptions, asserting MA contracts may attract beneficiaries of different health and demographic characteristics.[44] Using these different assumptions, they found MA risk scores to be 0.19 points higher in 2021 compared to if the beneficiaries were in FFS, resulting in an estimated $33 billion in plan payments.[45] Ghoshal-Datta, Chernew, and McWilliams note MedPAC estimates fail to account for the incomplete documentation of medical conditions in FFS Medicare.[46] This lapse in persistent coding may contribute 2.85 percentage points to the 2020 differential between FFS and MA risk scores and may cost up to $8.1 billion in Medicare spending.[47]

Favorable selection

"Favorable selection" accounts for the phenomenon of Medicare beneficiaries who have lower-than-expected medical expenditures preferring to enroll in a Medicare Advantage plan over fee-for-service Medicare. Since 2023, MedPAC has utilized a novel and comprehensive approach to estimating favorable selection by estimating the following:

- Spending that the FFS program would have incurred for the MA-enrolled population had they been enrolled in the FFS program (FFS equivalent spending); and
- FFS spending that the Medicare payment system predicted for that population (risk model predicted spending)

MedPAC takes the spending estimates for MA beneficiaries with at least two years of prior enrollment data in the FFS program, or individuals who switch from FFS to MA (38 percent of non-ESRD MA enrollees in 2021), and calculates the following ratio:

$$\text{Favorable Selection} = \frac{\text{FFS equivalent spending}}{\text{risk model predicted spending}}$$

For individuals who directly enrolled into MA upon initial Medicare eligibility (33 percent) or had less than two years of prior FFS enrollment data (29 percent), MedPAC uses a selection ratio based on beneficiaries who have at least two years of prior FF
S enrollment, joined the MA program the same year, and have the same mortality status.

MedPAC's methodology for estimating favorable selection is consistent with current research, if not comparatively conservative. Curto et al. showed spending per MA beneficiary was 9 to 30 percent lower than spending per FFS beneficiary in 2010 and attributed this difference to utilization, not prices.[48] Teigland et al. found that individuals who directly enrolled into MA between 2015 to 2019 had 12 to 13

[43] "MediCode: Medicare Advantage Coding Intensity Report Card," Brown University Center for Advancing Health Policy Through Research, accessed February 27, 2026, https://doi.org/10.26300/60aa-zt74.
[44] Richard Kronick et al., "Insurer-Level Estimates of Revenue from Differential Coding in Medicare Advantage," *Annals of Internal Medicine* 178 (2025): 655-662, https://doi.org/10.7326/ANNALS-24-01345.
[45] *Ibid.*
[46] Niru Ghoshal-Datta, Michael E. Chernew, and J. Michael McWilliams, "Lack Of Persistent Coding In Traditional Medicare May Widen The Risk-Score Gap with Medicare Advantage," *Health Affairs* 43, no. 12 (2024), https://doi.org/10.1377/hlthaff.2024.00169.
[47] *Ibid.*
[48] Vilsa Curto et al., "Health Care Spending and Utilization in Public and Private Medicare," *American Economic Journal: Applied Economics* 11, no. 2 (2019): 302-332, https://doi.org/10.1257/app.20170295.

percent lower risk-adjusted spending compared to FFS beneficiaries, while MedPAC reported 4 to 9 percent for enrollees who switched from FFS to MA during the same period.[49] Lieberman and Ginsburg estimated favorable selection led to 14.4 percent in overpayments over the same period as Teigland et al.[50] Xu et al. reported that switching from FFS to MA amongst beneficiaries more than tripled between 2006 and 2022, while switching from MA to FFS decreased.[51] Relatedly, Meyers et al. noted Medicare Advantage beneficiaries with higher needs had significantly higher disenrollment rates from the program into FFS compare to MA beneficiaries with lower needs.[52] Newhouse et al. used a different measure of favorable selection and found beneficiaries who initially enrolled in Medicare Advantage had a "hazard rate" 30 percent less than those of new FFS beneficiaries, while beneficiaries who switched from FFS to Medicare Advantage had a "hazard rate" 20 percent lower than FFS beneficiaries between 2008 to 2012.[53] MedPAC acknowledges that modeling favorable selection in Medicare Advantage involves uncertainty due to primarily observing individuals with at least two years of FFS data before entering the MA program, and this is accounted for in their conservative estimates.

[49] Christie Teigland et al., "Harvard-Inovalon Medicare study: Utilization and Efficiency under Medicare Advantage vs. Medicare fee-for-service," white paper (Inovalon, 2025), https://www.inovalon.com/resource/harvard-inovalon-medicare-study-utilization-and-efficiency-under-medicare-advantage-vs-medicare-fee-for-service/; Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (Washington: MedPAC, 2025), 382.
[50] Steve M. Lieberman, Paul Ginsburg, and Samuel Valdez, "Medicare Advantage enrolls lower-spending people, leading to large overpayments," Schaeffer Center White Paper Series (Leonard D. Schaeffer Institute for Public Policy and Government Service, University of Southern California, June 13, 2023), https://doi.org/10.25549/n153-9a66.
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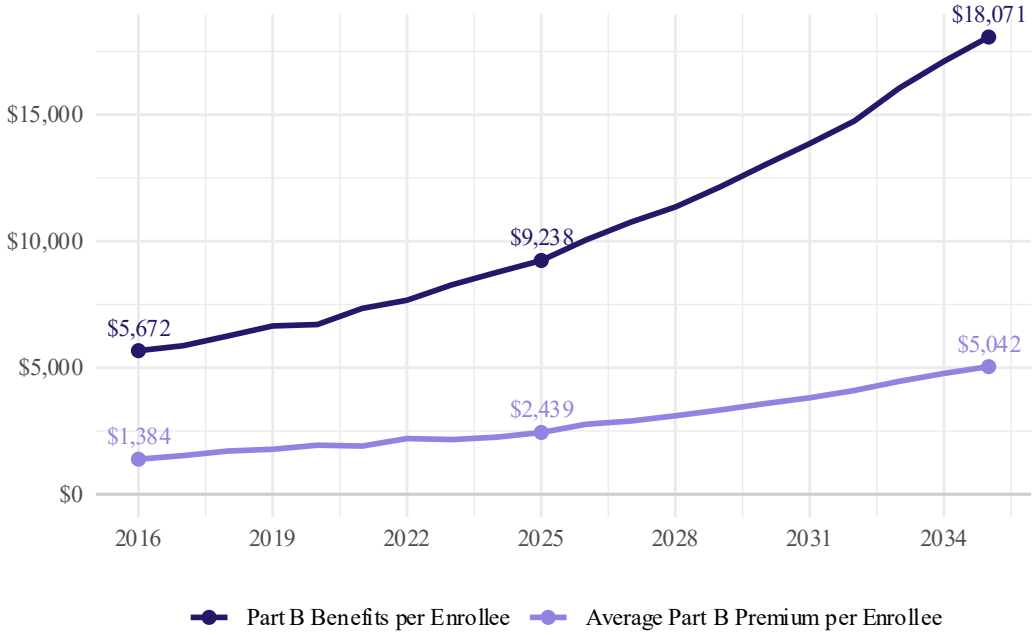
Appendix D: Additional analyses and projections

Figure 9: Projection of Medicare Part B Premiums



Source: Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds;[54] JEC calculations[55]

[54] Boards of Trustees, *2025 Annual Report*, 201. See Table V.D1, "HI and SMI Average Incurred per Beneficiary Costs."
[55] Annualized Part B Premiums, accounting for premium financing measures.

Table 1: Additional Premiums due to MA Overpayments by State

State	Total Part B (millions)	Total TM (millions)	Paid by TM per MA beneficiary	Burden on individuals (millions)	Burden on taxpayers (millions)	State burden (millions)	Federal burden (millions)
Alaska	$23.7	$21.7	$2,369	$20.9	$2.8	$1.4	$1.4
Alabama	$216.5	$75.3	$110	$173.4	$43.1	$13.5	$29.5
Arkansas	$129.0	$64.7	$203	$103.8	$25.3	$8.6	$16.7
Arizona	$299.2	$134.0	$171	$250.4	$48.8	$19.8	$29.1
California	$1,460.6	$641.8	$176	$1,119.6	$341.0	$176.7	$164.2
Colorado	$212.1	$90.8	$162	$187.2	$24.9	$15.9	$9.0
Connecticut	$154.6	$57.2	$130	$116.9	$37.6	$18.4	$19.2
Dist. of Columbia	$19.2	$11.4	$341	$12.6	$6.6	$2.5	$4.1
Delaware	$49.8	$32.1	$387	$43.4	$6.3	$2.9	$3.5
Florida	$1,042.2	$409.5	$138	$866.7	$175.6	$77.6	$97.9
Georgia	$385.5	$154.0	$139	$311.8	$73.6	$36.4	$37.2
Hawaii	$63.8	$24.5	$147	$54.1	$9.8	$4.9	$4.8
Iowa	$133.7	$79.0	$296	$117.0	$16.6	$8.1	$8.5
Idaho	$78.0	$36.3	$178	$69.2	$8.8	$2.6	$6.2
Illinois	$473.4	$247.1	$231	$418.4	$55.1	$25.0	$30.0
Indiana	$266.6	$122.2	$172	$221.8	$44.8	$18.6	$26.1
Kansas	$113.6	$72.3	$358	$100.6	$13.1	$6.4	$6.7
Kentucky	$189.6	$79.0	$145	$160.4	$29.2	$7.6	$21.5
Louisiana	$182.5	$71.0	$131	$140.7	$41.8	$12.0	$29.7
Massachusetts	$297.3	$178.5	$333	$235.2	$62.1	$30.6	$31.5
Maryland	$227.0	$160.0	$536	$197.7	$29.3	$14.2	$15.2
Maine	$74.4	$27.5	$122	$56.2	$18.2	$6.9	$11.3
Michigan	$440.6	$145.4	$101	$374.6	$66.1	$26.6	$39.5
Minnesota	$228.6	$80.7	$113	$209.0	$19.6	$9.3	$10.3
Missouri	$258.1	$108.4	$148	$228.8	$29.3	$9.8	$19.5
Mississippi	$123.2	$64.7	$224	$94.3	$28.8	$7.9	$20.9
Montana	$51.6	$34.9	$434	$47.6	$4.0	$1.4	$2.6
North Carolina	$444.4	$174.2	$134	$375.3	$69.2	$28.8	$40.4
North Dakota	$28.7	$17.6	$326	$26.6	$2.1	$1.0	$1.1
Nebraska	$74.3	$46.8	$349	$68.0	$6.3	$2.6	$3.7
New Hampshire	$68.1	$41.0	$325	$63.6	$4.5	$2.0	$2.4
New Jersey	$357.6	$193.8	$262	$315.7	$41.9	$20.4	$21.5
New Mexico	$90.9	$41.8	$178	$70.4	$20.5	$8.6	$11.9
Nevada	$118.7	$50.9	$160	$102.1	$16.6	$6.7	$9.9
New York	$794.7	$333.6	$157	$609.5	$185.3	$87.6	$97.7
Ohio	$491.0	$190.8	$130	$412.0	$79.0	$37.3	$41.7
Oklahoma	$153.3	$83.5	$245	$132.9	$20.5	$6.6	$13.9
Oregon	$185.8	$76.9	$147	$152.7	$33.1	$16.1	$17.0
Pennsylvania	$576.8	$237.3	$146	$498.7	$78.1	$31.9	$46.2

Rhode Island	$47.8	$16.0	$107	$41.6	$6.2	$2.5	$3.7
South Carolina	$245.6	$124.5	$213	$211.3	$34.3	$13.2	$21.1
South Dakota	$38.9	$23.0	$303	$35.7	$3.2	$1.5	$1.7
Tennessee	$290.8	$124.7	$156	$252.8	$38.0	$13.6	$24.4
Texas	$949.6	$385.4	$145	$823.4	$126.1	$47.7	$78.5
Utah	$93.8	$38.7	$150	$86.0	$7.8	$3.8	$4.0
Virginia	$340.9	$192.9	$285	$300.4	$40.5	$21.9	$18.6
Vermont	$32.7	$21.7	$416	$28.8	$3.9	$1.5	$2.4
Washington	$304.1	$139.4	$181	$259.4	$44.7	$21.6	$23.1
Wisconsin	$258.9	$100.0	$128	$234.0	$24.8	$9.4	$15.4
West Virginia	$85.6	$34.8	$138	$71.3	$14.2	$3.3	$10.9
Wyoming	$24.9	$19.6	$758	$22.7	$2.2	$1.2	$0.9

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