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CHAPTER 3 OF THE
CHAIRMAN'S VIEWS

The Fiscal and Economic Health of Medicare

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CHAIRMAN DAVID SCHWEIKERT

CHAPTER 3: THE FISCAL AND ECONOMIC HEALTH OF MEDICARE

Healthcare spending has significantly impacted the nation's fiscal outlook, and policymakers must address rising healthcare costs in Medicaid and Medicare. This chapter will focus on Medicare and the Medicare Advantage program, where there are significant successes, challenges, and opportunities going forward.

Medicare's apparent trilemma

Medicare is at a crossroads. Since 1960, health expenditure growth in the United States has outpaced economic growth in every decade. As the baby-boom generation retires, Medicare enrollment and spending are rising. Hospital Insurance (HI) expenditures are projected to outgrow income, while increases in general-revenue transfers for Supplementary Medical Insurance (SMI) are placing increasing strain on the Federal budget.[134]

The HI trust fund, which relies on payroll taxes, is projected to be depleted by the end of October 2032, at which point payments would be cut roughly 12 percent absent legislative action.[135] The SMI trust fund, which covers Medicare Parts B and D, is automatically financed by general revenues and premiums, making it fiscally balanced but heavily reliant on taxpayer transfers. The Boards of Trustees that oversee these trust funds

[134] Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *The 2025 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* (Centers for Medicare and Medicaid Services, 2025), Figure III.B1, Table III.C4, pp. 53, 89.

[135] Committee for a Responsible Federal Budget, "Medicare Hospital Insurance Trust Fund," accessed April 2026, https://www.crfb.org/our-work/projects/medicare-hospital-insurance-trust-fund.

note that SMI costs will continue growing faster than GDP, placing increasing pressure on the Federal budget.[136]

For beneficiaries, this is an affordability story. As emphasized by recent Joint Economic Committee research, by law, Part B spending is passed through to beneficiary premiums, which are now expected to double over the next decade to about $5,000 per senior.[137] Because these premiums are typically withdrawn directly from Social Security checks, higher Medicare spending shows up not only in Federal ledgers but also in lower net monthly income for more than 50 million seniors. The affordability challenge makes the fiscal challenge even harder to solve.

Medicare Advantage (MA) plays a pivotal role in this context. With over half of Medicare beneficiaries enrolled in MA, the program is already popular, and projections indicate it could approach two-thirds of beneficiaries within the next decade.[138] However, despite its popularity, misaligned incentives have prevented the program from consistently delivering lower-cost care for taxpayers and the Medicare trust funds.[139] Instead, MA currently costs the government more per enrollee than Traditional Medicare (TM, also called fee-for-service Medicare), adding to Federal budget deficits, Part B premiums, and pressure on the HI

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[136] See "Implications of SMI Cost Growth" in Boards of Trustees, *The 2025 Annual Report of the Boards of* Trustees, p. 36.
[137] U.S. Congress Joint Economic Committee, "The Part B Premium Pass-Through: Medicare Advantage Overpayments Inflate Premiums for All" (March 10, 2026), Appendix D, Figure 9, p. 25, https://www.jec.senate.gov/public/index.cfm/republicans/2026/3/jec-brief-finds-medicare-advantage-overpayments-causing-increased-premiums-for-all-seniors.
[138] Congressional Budget Office, "Medicare," Details About Baseline Projections for Selected Programs (February 2026), p. 3, https://www.cbo.gov/system/files/2026-02/51302-2026-02-medicare.pdf.
[139] Medicare Payment Advisory Commission, "The Medicare Advantage program: Status report," chap. 12 in *Report to the Congress: Medicare Payment Policy* (2026), p. 343.

trust fund.[140] Thus, overpayments in MA directly amplify both fiscal strain and beneficiary affordability concerns.

Medicare's financing challenges are of a scale that can no longer reasonably be managed through automatic premium increases, growing general-revenue transfers, and trust-fund drawdowns alone. As a result, the next decade is increasingly likely to be seen as presenting an *apparent trilemma* among three goals: affordability for seniors, fiscal solvency, and access to new technologies and medical innovation.

The current system has been very effective at incentivizing and promoting medical innovation. However, policymakers must recognize that policy has too often failed to translate new technologies into lower costs for seniors or the Federal budget. If costs continue to escalate, policymakers will face growing pressure and may mistakenly pursue blunt cost-control strategies that protect the Treasury in the short run while weakening the incentives that drive medical progress. This would mean fewer new cures and treatments, not only for Americans but also for the world. The U.S. market has an outsized role in financing medical innovation worldwide, accounting for approximately 53 percent of global prescription drug sales revenues in 2022.[141]

However, while these three goals may appear mutually incompatible, they are not—there is a way out. Market forces can reduce Medicare costs in ways that benefit seniors and all taxpayers. As we argue in this chapter, the main vehicle for doing so is MA reform that realigns incentives so that insurers compete

[140] U.S. Congress Joint Economic Committee, "The Part B Premium Pass-Through."
[141] Sonal Parasrampuria and Stephen Murphy, *Comparing U.S. and International Market Size and Average Pricing for Prescription Drugs, 2017-2022*, National Institutes of Health, Office of the Assistant Secretary for Planning and Evaluation (December 2024), https://www.ncbi.nlm.nih.gov/books/NBK611829/.

by improving health and delivering care at lower real cost. MA has important design flaws, but it should be reformed rather than discarded. Neither markets nor innovation will be sufficient to achieve these goals if the payment system continues to reward rent seeking and subsidy capture rather than efficiency gains.

In the following sections, we show the scale of the problems caused by MA overpayments, how they arose, and why addressing them is crucial for both fiscal sustainability and beneficiary affordability. Chairman David Schweikert recently introduced legislation, H.R. 3467, which contains key reforms that would build a considerably more economically and fiscally efficient MA program.[142]

The fiscal cost of the misaligned Medicare Advantage payment system

Medicare Advantage should be the part of Medicare where private provision, innovative care management, and technology lower costs for both beneficiaries and all taxpayers. While MA has delivered important benefits for enrollees (a point which this chapter returns to), taxpayer savings relative to Traditional Medicare have not materialized. Instead, the evidence shows that Medicare still pays more for MA enrollees than it would if those same beneficiaries were covered in TM. The Medicare Payment Advisory Commission (MedPAC) estimates that Medicare will spend 14 percent more on MA enrollees in 2026 than it would spend if those same beneficiaries were in TM. This difference, about $76 billion, is referred to as MA *overpayments*.

The following analysis is based on MedPAC's estimate for several reasons. First, MedPAC produces the estimate with the explicit

[142] *To amend title XVIII to reform the Medicare Advantage program*, H.R. 3467, 119th Cong. (2025), https://www.congress.gov/bill/119th-congress/house-bill/3467.

intention of answering the taxpayer-focused question: how much does Medicare spend, on average, to cover MA enrollees relative to what it would spend if those same enrollees were instead covered in TM? This is, with one caveat, the appropriate question to ask and represents the best available evidence to policymakers on the taxpayer question.[143]

Second, although that question may seem straightforward, much of the confusion surrounding comparisons of MA and TM costs arises because small changes in the econometric specification, especially in the variables the model seeks to hold constant, can shift the analysis away from the taxpayer question and cause otherwise similar studies to answer fundamentally different questions.[144]

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[143] The caveat being the quasi-experimental literature that suggests greater MA penetration may generate spillover effects that reduce spending for non-MA patients, including those covered by TM, a channel MedPAC does not incorporate. Notably, Baicker, Chernew, and Robbins (2013) find that hospital spillovers offset about 12 percent of the associated increase in MA payments. See also Afendulis, Chernew, and Kessler (2017) and Feyman, Pizer, and Frakt (2021). These effects do not displace MedPAC's estimate as the appropriate baseline for the taxpayer-payment comparison used here, but they remain a potentially important omitted channel that warrants more explicit evaluation, including by MedPAC where the relevant spillovers can be credibly bounded or estimated. Baicker, Katherine, Michael E. Chernew, and Jacob A. Robbins, "The Spillover Effects of Medicare Managed Care: Medicare Advantage and Hospital Utilization," *Journal of Health Economics* 32, no. 6 (2013): 1289–1300; Christopher C. Afendulis, Michael E. Chernew, and Daniel P. Kessler, "The Effect of Medicare Advantage on Hospital Admissions and Mortality," *American Journal of Health Economics* 3, no. 2 (2017): 254–79; Yevgeniy Feyman, Steven D. Pizer, and Austin B. Frakt, "The Persistence of Medicare Advantage Spillovers in the Post-Affordable Care Act Era," *Health Economics* 30, no. 2 (2021): 311–27.

[144] A taxpayer-focused analysis asks what Medicare would have spent if the same beneficiaries had instead been enrolled in TM, which requires adjusting for pre-enrollment differences among the beneficiaries who select into MA and quantifying the extent to which differences in diagnosis coding intensity raise MA beneficiaries' risk scores relative to those of otherwise similar beneficiaries in TM, thereby increasing risk-adjusted payments. By contrast, if a model quantifies structural differences between the two programs such as an out-of-pocket cap, it is no longer asking what MA costs relative to TM *as it actually exists*, rather what a hypothetical comparison would look like with a redesigned, more similar benefit structure. Further, if a model credits MA for supplemental benefits or lower cost sharing, it is typically asking

Third, while estimates in the broader academic literature vary by data source, method, and period, our reading is that MedPAC's findings are broadly consistent with a wide range of research.[145]

MedPAC estimates that Medicare will make $76 billion in additional payments to MA plans in 2026, driven primarily by favorable selection and coding intensity. Favorable selection, which MedPAC estimates adds $57 billion, arises because beneficiaries who choose MA tend to have lower medical spending than their risk scores predict. Coding intensity, which MedPAC estimates adds $22 billion, arises because MA insurers have stronger incentives than providers in TM to document diagnoses aggressively, thereby raising risk-adjusted payments.[146] In other words, the central problem is that the payment system rewards insurers for attracting enrollees whose costs fall below what the risk-score model predicts and for investing in diagnosis documentation that makes those enrollees appear sicker, for payment purposes, than they would in TM.

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whether MA delivers more benefits to beneficiaries per government dollar spent. Only the former question is directly informative about MA's cost to taxpayers. For more, see Medicare Policy Initiative, *A Policymaker's Guide to Interpreting Studies That Compare Medicare Advantage and Traditional Medicare Payment*, Center on Health Insurance Reforms, Georgetown University McCourt School of Public Policy (March 2026), https://georgetown.app.box.com/s/1wdsnmajuxd6jtborl1u7ao6qebq8n7m.

[145] For a review of the literature on MA overpayments, see U.S. Congress Joint Economic Committee, "The Part B Premium Pass-Through," pp. 21–24; Zack Cooper et al., *Review of Key Academic Literature Assessing the Medicare Advantage Program*, Health Care Affordability Lab at Yale (March 9, 2026), https://cdn.prod.website-files.com/682cf1c625625bb1fcf9efa1/69b961a3e45c6f07cccdda22_20260309%20Review%20of%20Key%20Academic%20Literature%20Assessing%20the%20Medicare%20Advantage%20Program%20(1).pdf; Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (2026), pp. 377–8.

[146] The two components sum to more than $76 billion because MedPAC estimates that, absent favorable selection and coding intensity, MA would be paid about $3 billion less than TM for otherwise similar beneficiaries. Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (2026), pp. 377–8.

There are several reforms that address overpayments, but to better harness MA's underlying pro-competition, pro-innovation structure, the focus of this chapter is on fundamental reforms to the program's incentives. To put the scale of potential savings in perspective, this chapter includes counterfactual exercises that consider the fiscal, tax, and premium effects of achieving payment parity, that is, a situation in which covering a beneficiary through MA costs the Medicare program the same as covering that same beneficiary through TM.

However, two points are worth emphasizing. First, the goal of MA reform should not merely be payment parity. By realigning incentives and harnessing market forces, MA can be reformed to provide the same or better healthcare at *lower* cost to both beneficiaries and taxpayers, as was originally intended.[147] Second, counterfactual exercises involving the *financial outcome* of payment parity should not be understood as an endorsement of any particular policy for achieving payment parity, except when the chapter explicitly does so by highlighting policies that would reduce wasteful resource use on capturing higher payments, rather than delivering lower cost care by making beneficiaries healthier.

MA plans are paid based on a capitated amount reflecting their enrollees' average risk score.[148] MA provides a bundled plan that must cover both Part A and B coverage. For 2025, total MA payments are divided between the Hospital Insurance (Part A) trust fund and the Supplementary Medical Insurance (Part B)

[147] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (2026), p. 345; Sandy Christensen to Interested Parties, "Medicare+Choice Provisions in the Balanced Budget Act of 1997," November 12, 1997, Congressional Budget Office, p. 6, https://www.cbo.gov/sites/default/files/105th-congress-1997-1998/reports/1997_11_12_choice.pdf.
[148] Boards of Trustees, *The 2025 Annual Report of the Boards of Trustees*, pp. 160–65.

account, with about 60 percent attributed to Part B.[149] As a result, the $76 billion in overpayments mechanically flow through Medicare's financing structures in distinct ways. The additional expenditure for the Part A trust fund is $30 billion, and for the Part B account it is $46 billion.[150]

These additional expenditures present distinct timing challenges for each trust fund. On the Part A side, the effects are not felt immediately by beneficiaries, but they still matter now because they increase the rate at which the HI trust fund is depleted.

On the Part B side, the impact is gradual and ongoing. Because the SMI account is balanced annually via premiums and general revenue, rising MA costs steadily increase both. Thus, beneficiaries already see the effects of higher premiums, while Federal transfers rise in tandem. The following sections track these channels. First, we examine how the additional cost to Part A accelerates trust fund depletion and increases payroll taxes necessary for solvency once depleted, and then we examine how Part B premiums and borrowing increase over time.

Medicare Advantage overpayments' Part A incidence

Under current law, the HI trust fund is financed primarily through payroll taxes on earnings, supplemented by taxation of Social Security benefits, premiums, and other minor income sources. As discussed, the HI trust fund will be depleted in late 2032.[151]

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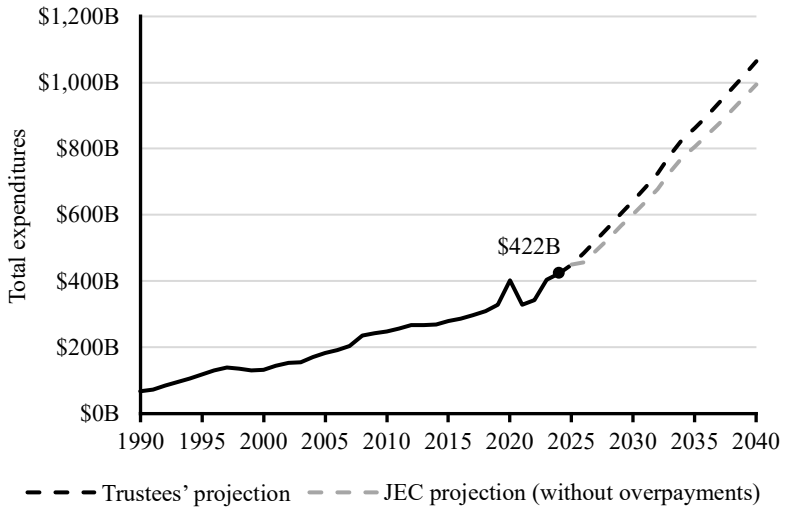
[149] JEC calculations; Boards of Trustees, *The 2025 Annual Report of the Boards of Trustees*, Table IV.C2, p. 163.
[150] JEC calculations.
[151] Boards of Trustees, *The 2025 Annual Report of the Boards of Trustees*, p. 5.

Figure 3-1: Total Expenditures from the Hospital Insurance Trust Fund



Source: Boards of Trustees;[152] JEC calculations

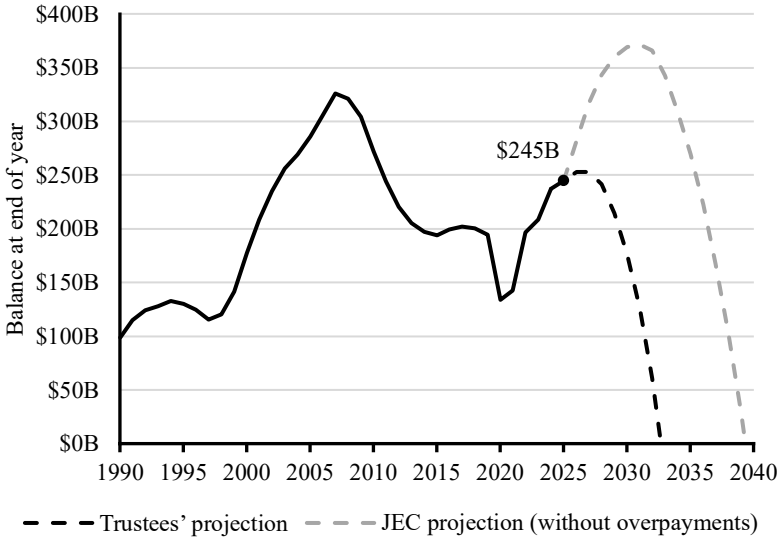
To illustrate the impact MA overpayments have on the HI trust fund's solvency, JEC calculates that eliminating MA overpayments in 2026 would reduce Part A expenditures by about $30 billion, rising to about $56 billion in 2035. JEC estimates this reduction would be enough to extend the HI trust fund's solvency by approximately six to seven years.[153] The estimate assumes that MA payments would otherwise continue to exceed TM costs by

[152] Boards of Trustees, *The 2025 Annual Report of the Boards of Trustees*, Table III.B4, p. 56.

[153] JEC calculations use projections from the 2025 Medicare Trustees Report and assume MedPAC's current 14 percent MA overpayment estimate persists. Because that estimate is measured relative to TM costs, payment parity implies a 12.28 percent reduction in MA payments, calculated as 0.14/1.14, which is applied to projected HI expenditures for MA beneficiaries beginning in 2026. The scenario carries forward higher end-of-year HI trust-fund balances, credits additional interest income using projections of nominal interest rates of 4.125 percent for 2026–2034 and 4.135 percent thereafter. The calculation holds enrollment, utilization, plan bidding, taxable payroll, non-interest income, and other factors constant.

14 percent and credits the resulting higher trust-fund balances with additional interest income.

Figure 3-2: Hospital Insurance Trust Fund Balance



Source: Boards of Trustees;[154] JEC calculations

To further translate the fiscal effects of MA payment parity into economic terms, consider the following thought experiment: if the HI trust fund were exactly solvent, how much could payroll tax rates be reduced while maintaining the trust fund's solvency, and what would the economic effects be?

To answer this hypothetical, let E_t denote HI expenditures in year t, let TP_t denote the HI trust fund's taxable payroll (the tax base for the payroll tax), and let τ_t denote the regular Medicare payroll tax rate. This analysis focuses on the regular Medicare tax under the *Federal Insurance Contributions Act* (FICA), which is

[154] Boards of Trustees, *The 2025 Annual Report of the Boards of Trustees*, Table III.B4, p. 56.

currently 1.45 percent for employees and 1.45 percent for employers, for a total tax rate of 2.90 percent.[155] The additional 0.9 percent Medicare surtax levied on individuals with incomes above $200,000 and married couples with incomes above $250,000, and the revenue it generates, is held constant. Revenues from all other sources, including premiums, are also held constant. Let B_t denote HI revenue from all other sources. The financing identity under maintained solvency is therefore,

$$E_t = \tau_t TP_t + B_t$$

Holding B_t fixed, a reduction in expenditures of ΔE_t allows for a reduction in the payroll tax rate that maintains solvency:

$$\Delta\tau_t = \frac{\Delta E_t}{TP_t}$$

As discussed, the additional expenditure for the Part A trust fund due to MA overpayments is $30 billion. Taxable payroll can be recovered by rearranging ratios provided in the Trustees' Report, estimated to be approximately $13 trillion.[156] This implies that MA payment parity could be used to reduce the 2.90 percent regular Medicare tax by $30 billion divided by $13 trillion, or

[155] *Federal Insurance Contributions Act*, 26 U.S.C. §§ 3101, 3111 (2024).
[156] JEC calculations; Boards of Trustees, *The 2025 Annual Report of the Boards of Trustees*, pp. 46–78. Table III.B1 shows total revenue in Calendar Year 2024 of $451 billion and $7 billion interest income for total 2024 non-interest income of $444 billion. Table III.B7 shows a 2024 income ratio of 3.41 percent. The report describes this ratio as "the non-interest income (from payroll taxes, taxation of OASDI benefits, premiums, general fund transfers for uninsured persons, and monies derived from the fraud and abuse control program) […] expressed as percentages of taxable payroll," where "[t]axable payroll is the total amount of wages, salaries, tips, self-employment income, and other earnings subject to the HI payroll tax." Dividing these two implies the 2024 payroll tax base was approximately $13 trillion.

approximately 0.23 percentage points.[157] Assuming a labor supply elasticity consistent with the Congressional Budget Office's (CBO) range of between 0.1 to 0.3, this tax reduction would yield an employment effect equivalent to between 51,000 and 154,000 additional workers.[158]

Medicare Advantage overpayments' Part B incidence: rising premiums and reduced Social Security checks

The remaining incidence of MA overpayments, about $46 billion, falls on the Part B account of the SMI trust fund. Because Part B is financed through a combination of beneficiary premiums and government contributions, this translates to roughly $33.7 billion in increased contributions from the Federal government and about $12.2 billion in higher Part B premiums.[159] Under Chairman Schweikert's leadership, the Committee has made understanding this burden on seniors, most of whom have Part B premiums deducted automatically from their Social Security checks, a

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[157] The Committee for a Responsible Federal Budget alternatively estimated in January 2026 that a 0.1 percentage point increase in the payroll tax would raise about $13.5 billion per year. This would imply a 0.22 percentage point estimated reduction in the payroll tax from MA payment parity, which is very close to our estimate.

[158] A 0.23 percentage point reduction in the tax rate increases workers' after-tax wages by about (0.0023) / (1 − 0.27) = 0.32 percent, where 27 percent is an estimate of the average marginal federal tax rate on labor income. See Congressional Budget Office, *Marginal Federal Tax Rates on Labor Income: 1962 to 2028* (January 2019), p. 1, https://www.cbo.gov/publication/54911. The labor supply substitution elasticity measures the percentage change in labor supply resulting from a 1 percent change in the after-tax wage, holding income constant. In CBO's assessment, income effects tend to be small, so we ignore them. See Congressional Budget Office, *How the Supply of Labor Responds to Changes in Fiscal Policy* (October 2012), https://www.cbo.gov/publication/43674. CBO's review of the empirical literature finds substitution elasticities ranging from 0.1 to 0.3. See Robert McCleeland and Shannon Mok, "A Review of Recent Research on Labor Supply Elasticities," CBO Working Paper 2012-12 (October 25, 2012), p. 4, https://www.cbo.gov/publication/43675. Applying this range to the 0.32 percent increase in after-tax wages implies a labor supply increase of 0.032 to 0.096 percent. Multiplying by a total employment of about 161 million in 2024, this corresponds to between 51,000 and 154,000 additional workers. See Bureau of Labor Statistics, *Employment Situation, March 2026*, April 3, 2026, p. 4, https://www.bls.gov/news.release/archives/empsit_04032026.pdf.

[159] JEC calculations.

central focus. The following section revisits and extends our recent findings using new data.

In March 2026, the JEC published an issue brief titled "The Part B Premium Pass-Through: Medicare Advantage Overpayments Inflate Premiums for All," which quantified a major, yet largely overlooked, way MA overpayments affect seniors: by increasing Part B premiums.[160] Because Part B premiums are set to finance roughly one-quarter of expected Part B costs, higher MA payments raise premiums for everyone in Part B. In 2025 alone, the Committee estimated that MA overpayments increased Part B premiums by about $212 per enrollee, or about $13.4 billion in total.

Since the publication of "The Part B Premium Pass-Through," MedPAC has published a new estimate of the MA overpayment rate that addresses several long-standing methodological critiques, including the full phase-in of the V28 risk model, updated risk-score data, and the inclusion of the end-stage renal disease (ESRD) population in its MA-versus-FFS comparisons. As shown in Figure 3-3, the estimated excess premium burdens are very similar in the two sets of estimates. The updated estimate is modestly lower in 2025 but slightly higher in other years, and the average difference between the estimates is less than 4 percent over the past decade.

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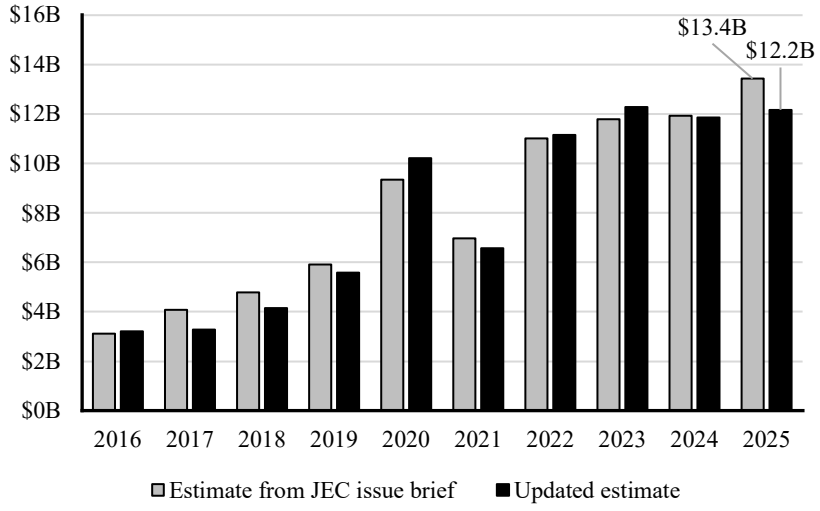
[160] U.S. Congress Joint Economic Committee, "The Part B Premium Pass-Through;" Christopher Weaver and Anna Wilde Mathews, "Seniors Paid Billions in Extra Premiums Due to Alleged Medicare Overpayments," *The Wall Street Journal,* updated March 10, 2026, https://www.wsj.com/health/healthcare/seniors-paid-billions-in-extra-premiums-due-to-alleged-medicare-overpayments-d41f5d79.

Figure 3-3: Additional Medicare Premiums Due to MA Overpayments



Source: JEC calculations[161]

From about $3.2 billion in 2016, excess premiums rose to over $12.2 billion in 2025, roughly a fourfold increase in nominal terms and about threefold after adjusting for inflation.[162] This growth reflects not only MA overpayments and the increasing popularity of MA but also other underlying trends, most notably the rapid growth in Part B spending per person. Looking forward, if the current overpayment rate of 14 percent persists, then current projections for MA payments, Part B spending, and the Part B premium-financing share imply that excess premiums would reach $29.9 billion annually by 2035.[163]

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[161] U.S. Congress Joint Economic Committee, "The Part B Premium Pass-Through;" Centers for Medicare and Medicaid Services, "Medicare Monthly Enrollment," last modified February 19, 2026, https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/medicare-and-medicaid-reports/medicare-monthly-enrollment.
[162] U.S. Congress Joint Economic Committee, "The Part B Premium Pass-Through."
[163] JEC calculations. These calculations are arguably conservative as the current overpayment rate of 14 percent is unusually low by historical standards due to the

Importantly, higher premiums are not confined to MA enrollees. Part B premiums are set nationally, so beneficiaries in TM pay them too. The JEC estimates that roughly $5.5 billion of the 2025 premium increase was borne by TM beneficiaries who may never enroll in MA and therefore do not receive its supplemental benefits. For most seniors, these higher premiums are withheld directly from Social Security checks, reducing take-home benefits month after month.

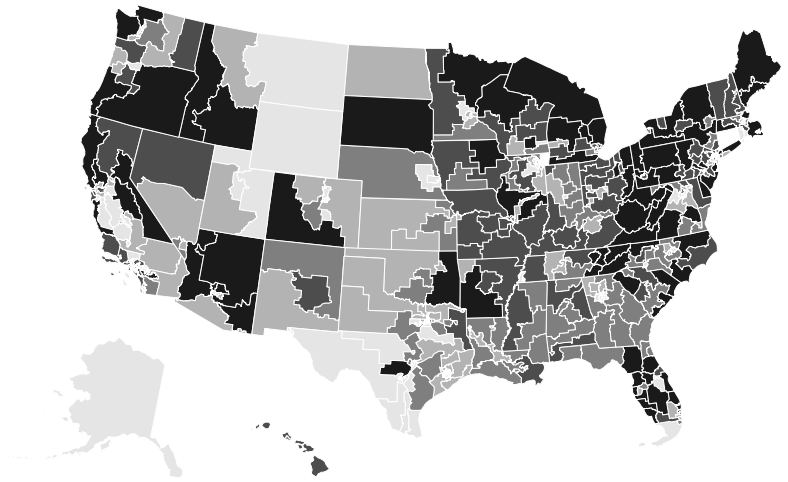
The Committee also developed a companion data product, the Medicare Affordability Tracker, which quantifies these premium burdens in each state and congressional district and reveals important economic dynamics of MA.[164] The tracker makes clear that MA overpayments are borne by seniors and taxpayers across the country, and it shows how that burden varies with local enrollment patterns and subsidy rates, which is an important consideration given the underlying cross-subsidization from TM to MA. That geographic variation is especially relevant in rural America. In 2024, only 42 percent of Medicare beneficiaries in the most rural areas were enrolled in MA, compared with 56 percent in urban areas, meaning many rural states and districts remain

recent introduction of the V28 risk-score model. If we instead calculated future excess premiums by applying the average MA overpayment rate from the past ten years, 16.9 percent, excess premiums would reach approximately $35 billion annually in 2035. See Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (2026), p. 377. The other data are from the 2025 Trustees Report, including projections for 2025 to 2034. This includes total payments to MA plans and the Part A and Part B shares of those payments. Boards of Trustees, *The 2025 Annual Report*, Table IV.C2, Figure III.C2, pp. 90, 163. For 2035, we extrapolate linearly from the Trustees' forecast of 2025 to 2034 data to maintain consistency.

[164] U.S. Congress Joint Economic Committee, "Medicare Affordability Tracker," https://www.jec.senate.gov/public/index.cfm/republicans/mat/.

more exposed to the higher national Part B premium and stand to benefit disproportionately from reform.[165]

Figure 3-4: Additional Medicare Premiums due to MA Overpayments by Congressional District, 2025



Source: JEC calculations[166]

Consider the state of Wyoming, where only about 21 percent of Medicare beneficiaries are enrolled in MA. In 2025, individuals and public payers in the state are estimated to have paid about $25 million in excess premiums, with roughly $20 million borne by or on behalf of TM beneficiaries. In effect, TM beneficiaries in Wyoming collectively pay about $770 in excess premiums for every one MA beneficiary in the state.[167] If MA payment levels were brought to (or closer to) parity with TM, states such as

[165] Nancy Ochieng et al., "Key Facts About Medicare Beneficiaries in Rural Areas," KFF, June 11, 2025, https://www.kff.org/medicare/key-facts-about-medicare-beneficiaries-in-rural-areas/.
[166] U.S. Congress Joint Economic Committee, "The Part B Premium Pass-Through."
[167] U.S. Congress Joint Economic Committee, "Wyoming Medicare Affordability Update," https://www.jec.senate.gov/public/index.cfm/republicans/mat/wy-mau/.

Wyoming, where relatively few beneficiaries are enrolled in MA and many remain exposed to the higher national Part B premiums, would see especially large relief.

This affordability problem is set to intensify. The Committee's issue brief found that per-person Part B expenditures are projected to rise from roughly $9,100 in 2025 to more than $18,000 in 2035. Because the standard premium is tied to those costs, baseline premiums are projected to rise from about $2,200 to about $4,500 per year, and average premiums rise further still. If MA continues to cost the Medicare program substantially more than TM does, the additional premium burden will grow as Part B spending grows and reach roughly $395 per beneficiary each year by 2035. That burden is not inevitable. It reflects a policy choice of maintaining a flawed payment system that pays more for MA than for TM. Pro-competitive, pro-innovation policies that align payment levels would directly limit this avoidable premium growth, protecting the Social Security benefits of roughly 50 million Part B beneficiaries.

Taken together, the tracker shows not only where the costs of the current system fall, but also how large the gains from reform could be. Because roughly 80 percent of Americans live in urban areas, where MA enrollment is higher, a Medicare Advantage program that delivers on its potential to improve care and lower costs through greater efficiency could generate enormous economic benefits for households and taxpayers alike.[168]

[168] U.S. Census Bureau, "Nation's Urban and Rural Populations Shift Following 2020 Census," updated March 10, 2023, https://www.census.gov/newsroom/press-releases/2022/urban-rural-populations.html.

Medicare Advantage overpayments' Part B incidence: increased Federal borrowing

Premiums are only one channel through which MA overpayments in Part B affect the economy. Because Part B is financed through a combination of beneficiary premiums and government contributions, the same excess costs that raise premiums also raise Federal outlays. In trust-fund accounting, the SMI trust fund is automatically balanced, with premiums and government contributions reset each year to cover expected costs. However, this automatic balance does not make the added cost disappear. It means instead that higher Part B costs require larger Federal financing flows and, unless offset elsewhere, increase deficits and borrowing.

In 2025, MA overpayments increased Part B costs by about $46 billion.[169] Of that amount, the Federal government financed roughly $33.7 billion directly through larger Federal contributions and about $1.2 billion through federally subsidized premiums, totaling about $35 billion in additional Federal outlays for Part B that year.[170]

We extend those outlays through the ten-year period from 2026 to 2035 to assess the resulting borrowing impacts.[171] Over the

[169] JEC calculations, as discussed in "The financial cost of the misaligned Medicare Advantage payment system."
[170] JEC calculations, as discussed in "Medicare Advantage overpayments' Part B incidence: rising premiums, reduced Social Security checks." Of the $33 billion in Medicare Advantage overpayments financed by the SMI trust fund and not by individuals' Part B premiums, the JEC estimates a portion is financed through public funds, mostly by Medicaid through the Medicare Savings Program. U.S. Congress Joint Economic Committee, "The Part B Premium Pass-Through."
[171] For the premium estimates, see U.S. Congress Joint Economic Committee, "The Part B Premium Pass-Through." Calculations of borrowing estimates below use MedPAC's updated 2025 overpayment estimate, which produces slight differences in the 2025 premium and Federal contribution amounts, if compared to the issue brief. For debt-service calculations, see Congressional Budget Office, *The Budget and*

decade, excess Part B payments increase Federal outlays directly by $573 billion and add an additional $93 billion in debt-service costs, for a total deficit increase of about $665 billion. To put this in perspective, $665 billion amounts to roughly 14.1 percent of the $4.7 trillion in new ten-year debt approved during the Biden Administration. In other words, the Part B premium and borrowing impact of MA overpayments is large even on the scale of recent Federal debt expansion.[172]

To put the opportunity costs of these overpayments in perspective, consider that the CBO estimated that authorizing coverage of GLP-1 medications to treat obesity for nearly 30 million Medicare beneficiaries would add a net cost of roughly $35 billion from 2026 to 2034.[173] In other words, the Federal government spent as much on MA overpayments through Part B in 2025 alone as CBO estimated Medicare coverage of GLP-1 medications for obesity would cost for nearly a decade.

This illustrates the potentially foregone economic benefits when scarce Federal dollars finance excess MA payments. Those excess payments partly finance the increased generosity of MA's supplemental benefits, instead of potentially higher-value prevention. Obesity increases the prevalence of costly chronic conditions, reduces mobility, and raises long-term medical

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Economic Outlook: 2026 to 2036 (February 2026), https://www.cbo.gov/publication/61882. Calculations assume no change in revenues, a mid-year timing factor (0.5), and a blended interest rate where the 3-month Treasury bill is given a 35 percent weight, and the 10-year note is given a 65 percent weight. This produces an effective rate that ranges from 3.83 percent (in 2026) to 3.97 percent (in 2031).

[172] Committee for a Responsible Federal Budget, "How Much Did President Biden Add to the Debt?" April 3, 2025, https://www.crfb.org/blogs/how-much-did-president-biden-add-debt.

[173] Congressional Budget Office, *How Would Authorizing Medicare to Cover Anti-Obesity Medications Affect the Federal Budget?* (October 2024), https://www.cbo.gov/publication/60441.

spending. The opportunity cost has become even more striking as GLP-1 prices have recently fallen sharply. CBO's 2024 analysis cited prices of roughly $1,100 to $1,300 for a four-week supply before discounts and other payments. That range is about four to five times the $245 net monthly price at which participating manufacturers will soon provide eligible GLP-1 drugs through the Medicare GLP-1 Bridge.[174]

The polarized views on MA: a reconciliation of financial and economic efficiencies

Under current payment rules, MedPAC estimates that it is currently 14 percent more costly to the Federal government when a Medicare beneficiary enrolls in MA than in TM. That extra cost, $76 billion, has been almost entirely driven by two dynamics: favorable selection, which has been found to increase the financial cost by $57 billion, and coding intensity, which has been found to account for $22 billion.[175]

Favorable selection refers to the dynamic that the beneficiaries who choose MA tend to have lower medical expenditures than their risk scores predict. Coding intensity refers to the phenomenon that MA insurers are incentivized through the risk adjustment system to document diagnosis codes more aggressively than those beneficiaries would have been coded in TM. This increases the risk scores of their beneficiaries, and thereby the risk-adjusted payments the insurers receive.

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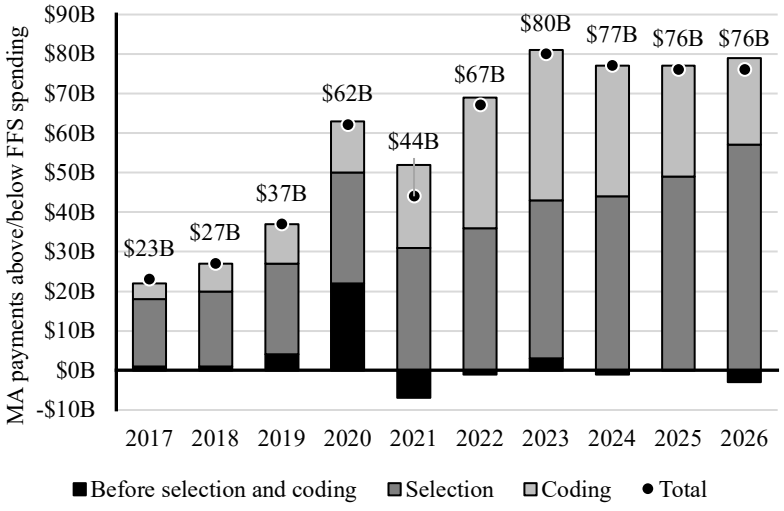
[174] Centers for Medicare and Medicaid Services, "Medicare GLP-1 Bridge," last modified April 8, 2026, https://www.cms.gov/medicare/coverage/prescription-drug-coverage/medicare-glp-1-bridge.

[175] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (2026), p. 377; Medicare Payment Advisory Commission, "The Medicare Advantage program: Status Report," chap. 11 in *Report to the Congress: Medicare Payment Policy* (2025), p. 320.

Figure 3-5: Effect of Coding and Selection on MA Overpayments



Source: Medicare Payment Advisory Commission[176]

That additional cost estimate, however, represents an estimate of *financial inefficiency*, not an analysis of *economic efficiency*. The financial question, what the Federal government pays, and the questions of economic efficiency are separate, and should be treated as such. It is entirely possible for MA to be both *less* financially efficient from the perspective of the Federal government as a payer, and *more* economically efficient from the perspective of consumers or producers.

Economic efficiency has two components: productive efficiency, and allocative efficiency. From the perspective of productive efficiency, the question is whether MA delivers better outcomes using the same amount of real resources, or alternatively, equal outcomes using fewer real resources. From the perspective of

[176] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (2026), Figure 12-6, p. 378.

allocative efficiency, the question is whether MA delivers greater beneficiary value relative to the real resources used.

The analysis that follows therefore separates the financial and economic questions by first asking whether the underlying forces that are driving coding intensity and favorable selection reflect genuine efficiency gains, or wasteful rent seeking. We argue that the evidence for real economic efficiency is weak. An important share of overpayments is dissipated through rent-seeking expenditures devoted to documenting greater apparent sickness, increased churn, and capturing the subsidies, rather than improving health or reducing real resource costs. In fact, an underlying theme is how often the payment structures reduce the incentives for those economically efficient investments in health. Overall, the dynamics behind coding intensity and favorable selection are unlikely to be economically efficient and are better understood as a combination of fiscal transfers and wasteful rent-seeking.

However, our review of the literature on the overall productive and allocative efficiencies of MA indicates MA has greater overall productive efficiency than TM, especially in adopting specific cost-cutting technologies. In this regard, we find clear evidence in favor of the program's efficiencies, indicating that private provision of Medicare services through MA is reducing real healthcare costs. This evidence further motivates reform of the program to better align public and private incentives so that private innovation benefits taxpayers as well as beneficiaries.

Coding intensity, favorable selection, and economic efficiency

Gordon Tullock's seminal analysis of rent seeking illuminates the concept of economic efficiency in MA. Tullock's key insight is that when policy creates a valuable transfer, firms devote real

resources to securing it, and those expenditures can be socially wasteful because they are spent not to create wealth, but instead to capture or defend the transfer.[177] This can create a situation in which, from the payer's (in this case, the government's) perspective, an industry is overpaid, a characterization that appears foreign from the industry's perspective, because a meaningful share of the excess payments is not retained as profit but is instead dissipated through wasteful rent-seeking to capture those rents.

Applied to MA, the relevant question is how the additional payments attributable to coding intensity and favorable selection are generated and used. Some of those payments may go to financing productive diagnosis-capture activities that improve care management or sorting of beneficiaries across plans that better align consumer needs to insurance coverage.[178] Others may finance diagnosis-capture efforts that raise payments without improving health or reducing future resource use. The remainder reflects a transfer from the Federal government to insurers that redistributes resources but does not represent a net social cost.

We can provide a decomposition as,

$$\Delta\text{Payments} = C_P + C_R + \Pi$$

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[177] Gordon Tullock, "The Welfare Costs of Tariffs, Monopolies, and Theft," *Economic Inquiry 5*, no. 3 (1967): 224–32, https://doi.org/10.1111/j.1465-7295.1967.tb01923.x.
[178] Bruce E. Landon et al., "A Comparison of Relative Resource Use and Quality in Medicare Advantage Health Plans Versus Traditional Medicare," *The American Journal of Managed Care* 21, no. 8 (2015): 559–66, https://pmc.ncbi.nlm.nih.gov/articles/PMC6365159/; Bruce E. Landon et al., "Utilization of Services in Medicare Advantage versus Traditional Medicare since the Passage of the Medicare Modernization Act," *Health Affairs* 31, no. 12 (2012): 2609–17, https://doi.org/10.1377/hlthaff.2012.0179; Steven M. Liberman, Paul B. Ginsburg, and Samuel Valdez, "Favorable Selection Ups The Ante On Medicare Advantage Payment Reform," *Health Affairs Forefront* (2023), https://doi.org/10.1377/forefront.20230606.520135.

where $\Delta\text{Payments}$ is the increase in MA payments attributable to dynamics underlying coding intensity and favorable selection, C_P is real resource use devoted to productive activities including productive diagnosis capture, C_R is real resource use devoted to unproductive activities including diagnosis capture for rent-seeking purposes, and Π is the residual transfer to plans. The corresponding welfare effect of the incentives under MA is,

$$\Delta W = B_P - C_P - C_R$$

where B_P is the value of the productive benefits to consumers. Note that Π does not enter the welfare effect because pure transfers are, in this standard framework, wasteful spending from the perspective of the government as a payer, who faces the financial efficiency question as opposed to economic efficiency. On the point of economic efficiency, they are neutral—firms gain a dollar for each dollar the government loses, netting to zero efficiency effect.

MedPAC has estimated that two mechanisms, Health Risk Assessments (HRAs) and chart reviews, account for roughly half of additional payments from coding intensity in recent years.[179] An HRA is a prospective evaluation, often conducted during an in-home visit or structured questionnaire, in which a clinician or vendor collects information on a beneficiary's conditions and may identify new diagnoses that can be submitted for risk adjustment. A chart review is a retrospective process in which a plan or its contractor reviews a patient's medical record to identify diagnoses that were documented by a provider but not submitted on a claim or encounter. The plan or its contractor then submits these

[179] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (2026), p. 401. The commission attributes 53 percent of coding intensity to HRAs and chart reviews in 2022 and 47 percent in 2023.

previously unsubmitted diagnoses, which increases the beneficiary's risk score.

While HRAs and chart reviews may be used as part of good care management to prevent future medical expenditures, available evidence suggests that a substantial share of the payments from diagnosis coding through these channels is not tied to additional care, findings that indicate HRAs and chart reviews are channels that serve more as revenue generators than they do as tools for care management. Specifically, Jung et al. found that 46.6 percent of payments generated by HRAs and 36.1 percent of payments generated by chart reviews were not associated with any increased resource use.[180] They further estimated that such payments increased from $4.7 billion in 2016 to $9.9 billion in 2019. Jacobs reports similar estimates, rising to $15 billion in additional payments by 2021.[181]

It is also unclear whether favorable selection generates real benefits to consumers. It may partly reflect efficient matching, with beneficiaries receiving lower-premium, network-based coverage they value. However, the selection literature also warns that imperfect risk adjustment can induce plans to design benefits, networks, formularies, and marketing strategies to attract beneficiaries whose costs are low relative to their risk scores.[182]

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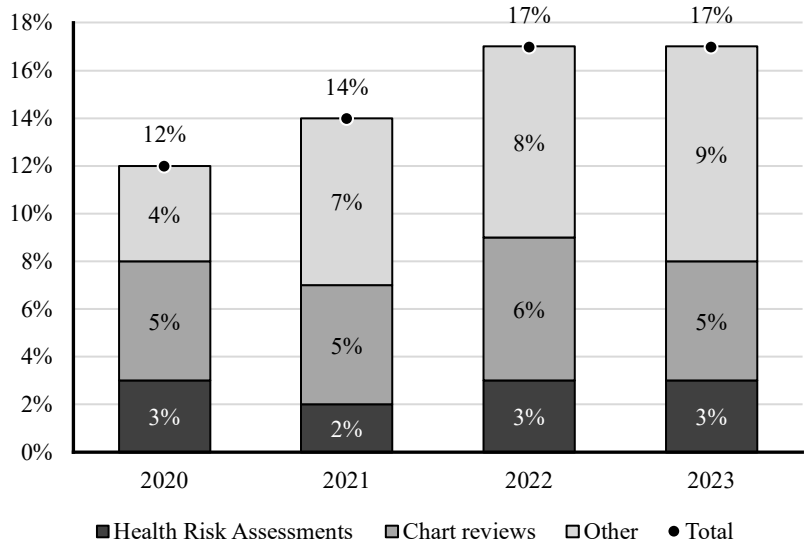
[180] Jeah Jung, Roger Feldman, and Caroline Carlin, "Coding Intensity Through Health Risk Assessments and Chart Reviews in Medicare Advantage: Does It Explain Resource Use?" *Medical Care Research and Review* 80, no. 6 (2023): 641–47, https://doi.org/10.1177/10775587231191169.

[181] Paul D. Jacobs, "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.

[182] Michael Geruso and Timothy J. Layton, "Selection in Health Insurance Markets and Its Policy Remedies," *Journal of Economic Perspectives* 31, no. 4 (2017): 23–50, https://doi.org/10.1257/jep.31.4.23.

Taken together, the evidence on coding intensity and favorable selection suggests that B_P is likely modest, that is, of overpayments, consumers receive only a modest portion of the benefits due to the incentives in MA. It is unclear whether the increased payments due to coding intensity primarily raise Π, increasing MA plan profits as a pure transfer from the government to firms, or are instead dissipated in Tullock-style rent-seeking efforts (C_R), resulting in a welfare loss. Overall, however, it seems likely that $B_P - C_P$ is modest, and C_R may also be modest, and therefore ΔW is small, possibly negative. In short, in addition to being a drain on government resources, the incentives identified that cause MA to be more expensive than TM are unlikely to be economically efficient.

Figure 3-6: Contributors to MA Coding Intensity



Source: Medicare Payment Advisory Commission[183]

[183] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (2026), Figure 12-14, p. 401.

Technology, telehealth, and Medicare Advantage efficiencies

Coding intensity and favorable selection create specific incentives that add substantial amounts to Medicare's cost and are unlikely to have meaningful economic efficiency gains. However, these aspects, as significant as they are, are only a modest portion of the MA program overall. Importantly, MA involves private insurance companies that, despite many misaligned incentives, still face competitive, profit-maximizing pressures to reduce costs, and therefore adopt cost-reducing technologies.

To provide a broad estimate of the savings, using 2010 claims from three large MA insurers, Curto et al. (2019) find that MA insurer revenues were about 30 percent higher than their healthcare spending, yet adjusted healthcare spending per enrollee in MA was 9 to 30 percent lower than in TM.[184] This illustrates a critical point: MA can use fewer resources internally due to private sector competition while still costing the Medicare program more due to poor program design.

Using national MA encounter data and standardized TM prices, Jung, Carlin, and Feldman (2025) find adjusted total resource use was 12.8 to 17.5 percent lower in MA than TM from 2016 to 2019, with better measured quality on several claims-based indicators.[185] Other analysis by Afendulis, Chernew, and Kessler (2017) used "urban floors" as an instrument for MA enrollment. These are minimum benchmarks for MA plans in counties that are part of metropolitan statistical areas with a population of 250,000 or more. The authors found that the induced expansion of MA

[184] Vilsa Curto et al., "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.
[185] Jeah Jung, Caroline Carlin, and Roger Feldman, "Medicare Advantage Has Lower Resource Use and Better Quality of Care Than Traditional Medicare," *American Journal of Health Economics* 11, no. 4 (2025), https://doi.org/10.1086/730436.

reduced market-wide hospitalization and mortality levels, and these findings are a clear indication that MA can and does improve important health outcomes.[186]

One such example in MA is the use of prior authorization, the requirement that a patient or provider get approval before a product or service is provided. Prior authorization is unpopular, but the economic evidence shows why insurers keep using it. Brot-Goldberg et al. find in Medicare Part D that prior authorization reduced drug spending by nearly $10 for every $1 of administrative cost.[187] A study of a national MA insurer found that its use of predictive algorithms led to a 13 percent decline in skilled nursing facility length of stay, driven by large reductions in longer stays, with no observed change in readmissions or mortality.[188]

The lesson is not that seniors or doctors need more bureaucracy, but that private insurers can now use better prediction and care management to lower healthcare costs by identifying those who need more care. The technology for smarter prior authorization is available today and has the potential to reduce low-value care and paperwork burdens, rather than add to them. The current Administration is embracing this development. HHS and CMS have secured voluntary commitments from all major health insurers to streamline prior authorization through standardized

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[186] Afendulis et al., "The effect of Medicare Advantage on Hospital Admissions and Mortality."
[187] Zarek C. Brot-Goldberg et al., "Rationing Medicine Through Bureaucracy: Authorization Restrictions in Medicare," NBER Working Paper no. 30878 (January 2023), https://doi.org/10.3386/w30878.
[188] Jeffrey Marr, "Algorithmic decision-making in health care: Evidence from post-acute care in Medicare Advantage," *Journal of Health Economics* 104 (2025): 103055, https://doi.org/10.1016/j.jhealeco.2025.103055.

electronic submissions, reduced prior-authorization volume, and expanded real-time approvals by 2027.[189]

The *2026 Economic Report of the President* highlights the Administration's efforts to lead in the development of artificial intelligence and modernize the U.S.'s digital health ecosystem.[190] The CMS Interoperability Framework takes an important step toward deeper integration of digital health products into the U.S. healthcare system. It does so by advancing a market-oriented model based on voluntary, standards-based health data exchange among networks, EHRs, providers, payers, and patient-facing applications.[191]

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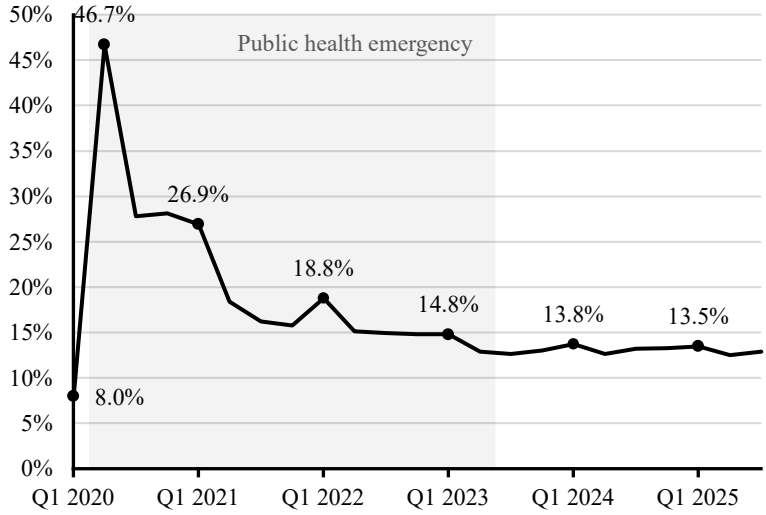
[189] U.S. Department of Health and Human Services, "HHS Secretary Kennedy, CMS Administrator Oz Secure Industry Pledge to Fix Broken Prior Authorization System," June 23, 2025, https://www.hhs.gov/press-room/kennedy-oz-cms-secure-healthcare-industry-pledge-to-fix-prior-authorization-system.htm. CMS is also testing aspects of this approach through the WISeR model, which uses enhanced technology to streamline the review of medical necessity for selected services in order to reduce inappropriate utilization, lower spending, expedite decisions, and ease provider administrative burden. Centers for Medicare & Medicaid Services, "WISeR (Wasteful and Inappropriate Service Reduction) Model," updated January 28, 2026, https://www.cms.gov/priorities/innovation/innovation-models/wiser.

[190] Executive Office of the President, Council of Economic Advisers, *Economic Report of the President* (2026), pp. 226–27, https://www.govinfo.gov/content/pkg/ERP-2026/pdf/ERP-2026.pdf.

[191] Centers for Medicare and Medicaid Services, "Interoperability Framework," last modified July 31, 2025, https://www.cms.gov/health-technology-ecosystem/interoperability-framework.

Figure 3-7: Telehealth Utilization in Traditional Medicare



Source: Centers for Medicare and Medicaid Services[192]

Another example of where MA appears to use technology to achieve savings and improve health outcomes is telehealth. Jiani Yu et al. (2025) provide evidence of positive results from telehealth access in MA. Using encounter data from a 20 percent random sample of MA enrollees, they find that high telehealth access was associated with a 13.4 percent decline in in-person office evaluation and management visits but no increase in total visits, suggesting telehealth substituted for in-person care rather than simply adding volume. They also find a 4.8 percent decline in total emergency department visits, with no increase in hospital admissions. This study suggests that telehealth in MA can reduce costs by improving access and ongoing outpatient management, which may keep some beneficiaries stable enough to avoid

[192] Centers for Medicare and Medicaid Services, "Medicare Telehealth Trends," last modified March 19, 2026, https://data.cms.gov/summary-statistics-on-use-and-payments/medicare-medicaid-service-type-reports/medicare-telehealth-trends.

emergency care.[193] Zaleski et al. (2025) provide similar evidence. In a large national MA plan, virtual-first care was associated with 10 to 24 percent lower episode spending for 6 of 11 common acute conditions, with no condition showing a significant cost increase. The study is observational, but it adds to the evidence that technology-enabled care can resolve many routine problems at lower cost.[194]

Crucially, TM currently pays for home-based telehealth at the same office-based physician fee schedule rate it would pay for an in-person visit, despite the potential for telehealth to reduce facility overhead. However, MA plans are not locked into that parity rule and therefore generally reimburse telehealth below office-based rates or otherwise use contract terms that prevent full in-person-rate payment.[195] Despite this, MA beneficiaries have been found to be more likely to have a provider who offered telehealth services, and have similar utilization rates as TM beneficiaries.[196] MA's flexibility to structure telehealth differently is a prime example for realizing cost savings from new technology.

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[193] Jiani Yu et al., "Utilization and quality among Medicare Advantage beneficiaries with high vs low access to telehealth," *Health Affairs Scholar* 3, no. 4 (2025): qxaf064, https://doi.org/10.1093/haschl/qxaf064.

[194] Amanda L. Zaleski et al., "An episode-based cost analysis of virtual-first versus in-person-first care to treat common acute conditions among members of a large national payor," *BMC Health Services Research* 25 (2025): 994, https://doi.org/10.1186/s12913-025-13154-1.

[195] Medicare Payment Advisory Commission, *Report to the Congress: Medicare and the Health Care Delivery System* (2023), p. 332, https://www.medpac.gov/document/june-2023-report-to-the-congress-medicare-and-the-health-care-delivery-system/.

[196] Sungchul Park, Hye-Young Jung, and Jiani Yu, "Telehealth availability and use among beneficiaries in Traditional Medicare and Medicare Advantage," *Journal of the American Geriatrics Society* 73, no. 2 (2025): 545–51; Sadiq Y. Patel et al., "Variation in telemedicine use and outpatient care during the COVID-19 pandemic in the United States: study examines variation in total US outpatient visits and telemedicine use across patient demographics, specialties, and conditions during the COVID-19 pandemic," *Health Affairs* 40, no. 2 (2021): 349–58.

Beyond telehealth, other categories of digital health can help transform the fiscal outlook in Medicare when paired with a properly realigned MA program. One example is wearable technology, which describes any product worn by a user that uses computing and sensors to collect and display real-time data.[197] In the healthcare context, these devices can monitor exercise activity, vital signs, medication adherence, and other health indicators. When beneficiaries choose to share these data with plans or providers, insurers can identify early warning signs and intervene before a manageable condition becomes a costly emergency-room visit, hospitalization, or complication.

The same data can also help beneficiaries set goals and monitor progress. Evidence suggests that the ability to set and monitor progress toward health targets, or "gamification," can be an important element in incentivizing healthy user behavior.[198] The close monitoring of health data and the modification of health behaviors allow the user to proactively improve their health and prevent future complications through healthier lifestyles and early detection.[199] In addition to changing health behaviors, wearables reduce friction in the provision of healthcare, leading to significant

[197] Serhat Burmaoglu et al., "Evolution Map of Wearable Technology Patents for Healthcare Field," chap. 14 in *Wearable Technology in Medicine and Health Care* (Academic Press, 2018): 275–90, https://doi.org/10.1016/B978-0-12-811810-8.00014-2.

[198] Lin Chen et al., "Effectiveness of mHealth-Based Gamified Interventions on Physical Activity in Older Adults: Systematic Review," *JMIR Aging* 8 (2025), https://doi.org/10.2196/78686; Alexander C. Fanaroff et al., "Effect of Gamification, Financial Incentives, or Both to Increase Physical Activity Among Patients at High Risk of Cardiovascular Events: The BE ACTIVE Randomized Controlled Trial," *Circulation* 149, no. 21 (2024): 1639–49, https://doi.org/10.1161/circulationaha.124.069531.

[199] Paolo Bonato, "Wearable Sensors and Systems: From Enabling Technology to Clinical Applications," *IEEE Engineering in Medicine and Biology Magazine* 29, no. 3 (2010): 25–36, https://doi.org/10.1109/memb.2010.936554.

cost reductions.[200] Altogether, this technology can increase efficiency and lower costs in healthcare, which presents an opportunity for transformative savings in Medicare.

Lower-cost and more efficient chronic care in MA is another positive element. Regarding chronic care delivery costs, in a matched observational study of MA health maintenance organization (HMO) enrollees with diabetes or cardiovascular disease, Landon et al. (2015) report lower price-standardized resource use and higher quality in MA than in TM. For diabetes, spending was $5,223 in MA versus $6,413 in TM, and emergency department use was 567 versus 719 visits per 1,000 enrollees, suggesting that MA plans were delivering chronic care more efficiently rather than merely shifting costs.[201]

These positive elements are encouraging. Taken together, it appears MA is often more efficient than TM in the delivery of care, yet it remains more expensive for the government under current payment rules. The case for MA reform is therefore stronger than ever. Properly structured, MA can be the part of Medicare that drives technology and competition. It can better incentivize lower real healthcare costs and be the solution to Medicare's mounting pressures to maintain affordability for beneficiaries, sustainability for taxpayers, and innovation for the betterment of all—resolving the apparent trilemma. This is an argument for reform, not retreat. The answer is not to abandon a program that is misaligned, but to reform it to ensure private market forces work for both enrollees and taxpayers.

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[200] Itzik Fadlon et al., "Equity and Efficiency in Technology Adoption: Evidence from Digital Health," NBER Working Paper no. 32992 (September 2024), https://doi.org/10.3386/w32992.

[201] Landon et al., "A comparison of relative resource use and quality in Medicare Advantage health plans versus traditional Medicare."

Medicare Advantage reform

Realigning MA incentives can achieve all three goals: better protection for seniors, less pressure on the Federal budget, and a healthcare system in which Americans realize the benefits of new technologies that improve their health at lower cost. The imperative, then, is not merely to cut MA overpayments. It is to reform MA into what it was intended to be: a system in which competition and innovation improve health and lower costs at the same time.

H.R. 3467 would fundamentally realign the MA program by directly addressing the distorted incentives that lead to higher MA costs.[202] H.R. 3467 would save on the order of $200 billion over the ten-year window by eliminating payments for the quality-bonus program, which has repeatedly been found does not meaningfully improve quality. This reform would end the payment for diagnoses found exclusively through stand-alone HRAs and require the Centers for Medicare and Medicaid Services (CMS) to use a two-year diagnostic window,[203] aspects that alone conservatively would save the government around $155 billion over a ten-year budget window.[204]

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[202] H.R. 3467, 119th Cong. (2025).

[203] A two-year diagnosis window would also reduce wasteful pressure on insurers to repeatedly document chronic conditions every year to preserve revenue. In that sense, a two-year diagnostic window is not only a saver for taxpayers, but also a saver for plans insofar as it reduces the return to annual recoding activity that adds administrative cost without improving care.

[204] Congressional Budget Office, "Modify Payments to Medicare Advantage Plans for Health Risk," in *Options for Reducing the Deficit: 2025 to 2034* (December 2024), https://www.cbo.gov/budget-options/60907; Committee for a Responsible Federal Budget, "Budgets Offsets Bank," January 8, 2025, https://www.crfb.org/our-work/issues/budget-offsets-bank. See "Options for Medicare Savings and to Close the HI Shortfall." However, MedPAC found $15 billion in payments during the plan year 2023 for diagnoses only identified through HRAs. This implies the savings over a ten-year budget window would be larger.

Similarly, this reform would end payments found exclusively on retrospective chart reviews, a component of coding intensity that has grown significantly and accounted for $24 billion of payments to MA plans in 2023, or about 6 percent of MA payments that year. Notably, this is one area where CMS appears to have begun, albeit cautiously, to move in the Chairman's direction. In the 2027 Advance Notice, the agency proposed eliminating payment for diagnoses from unlinked chart reviews, a change the agency estimated would save $7.1 billion in 2027.[205]

Importantly, these reforms would do more than reduce overpayments; they would begin to correct a deeper distortion in MA.[206] The current system rewards plans for specializing in short-term coding gains, which can raise revenue quickly. Conversely, plans that invest in improving beneficiaries' long-term health are disadvantaged because they may not keep those enrollees long enough to realize the resulting reductions in costs. When the return to better health can be captured by a rival plan down the road, the

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[205] MedPAC estimates that about 42 percent of chart reviews are unlinked but found that 80 to 86 percent are likely linkable because the same beneficiary had an encounter record in the same data file with the same or overlapping dates of service. That suggests the practical savings from CMS's proposal would likely fall below the agency's already modest estimate of a 1.53 percent risk-score reduction, or $7.12 billion in 2027 to the Medicare Trust Funds. Michael E. Chernew to Mehmet Oz, comments regarding CMS-2026-0034, February 25, 2026, Medicare Payment Advisory Commission, https://www.medpac.gov/wp-content/uploads/2026/02/02252026_MedPAC_MA_Part-D-AN-CY-2027_comment-letter_v3_SEC.pdf; Chris Klomp and Jennifer Wuggazer Lazio to Medicare Advantage Organizations, Prescription Drug Plan Sponsors, and Other Interested Parties, "Advance Notice of Methodological Changes for Calendar Year (CY) 2027 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies," January 26, 2026, Centers for Medicare and Medicaid Services, https://www.cms.gov/files/document/2027-advance-notice.pdf.

[206] Christopher Weaver, Anna Wilde Matthews, and Tom McGinty, "UnitedHealth's Army of Doctors Helped It Collect Billions More From Medicare," *The Wall Street Journal,* December 29, 2024, https://www.wsj.com/health/healthcare/unitedhealth-medicare-payments-doctors-c2a343db; Tara Bannow et al., "Inside UnitedHealth's strategy to pressure physicians: $10,000 bonuses and a doctor leaderboard," *STAT News*, October 16, 2024, https://www.statnews.com/2024/10/16/united-health-optum-care-medicare-advantage-strategy-dashboard-emails-documents/.

market will tend to underinvest in prevention and long-term care management. This helps to explain the growing and encouraging interest in longer plan periods, such as the three-year terms proposed in H.R. 3467.[207]

A longer enrollment period would help to realign those incentives. By giving plans greater confidence that they will still be responsible for a beneficiary's costs in future years, a three-year term increases the return on investments that improve health gradually, such as better management of diabetes, hypertension, heart failure, and medication adherence. It also reduces the resources spent on the churn itself, for example on agents and broker fees, which are approaching $10 billion annually.[208] When beneficiaries frequently switch plans, insurers have weaker reason to make long-term investments whose returns may be captured by a competitor, and both beneficiaries and plans incur repeated search, onboarding, and administrative transition costs. These concerns are not theoretical. Dong et al. found that 15.6 percent of new MA enrollees had changed insurance within one year, 37.0 percent by three years, and 49.2 percent by five years.[209] In this sense, longer plan periods are a key step to shifting competition toward the more economically valuable task of keeping beneficiaries healthier at lower real cost over time.

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[207] U.S. House Committee on Ways and Means, "Six Key Moments: Hearing on Medicare Advantage: Past Lessons, Present Insights, Future Opportunities," July 24, 2025, https://waysandmeans.house.gov/2025/07/24/six-key-moments-hearing-on-medicare-advantage-past-lessons-present-insights-future-opportunities/.

[208] U.S. Senate Committee on Finance, *Pushing Medicare Advantage on Seniors: Unraveling the Complex Network of Marketing Middlemen* (March 25, 2025), https://www.finance.senate.gov/ranking-members-news/wyden-investigation-finds-rapid-growth-in-spending-on-marketing-middlemen-among-medicare-advantage-plans; David J. Meyers et al., "Trends in Broker Enrollment and Spending in Medicare Advantage," *JAMA Internal Medicine* (forthcoming).

[209] Jeffrey Dong et al., "Turnover Among New Medicare Advantage Enrollees May Be Greater Than Perceived," *The American Journal of Managed Care* 28, no. 10 (2022): 539–42. https://doi.org/10.37765/ajmc.2022.89251.

H.R. 3467 would also make MA the default enrollment option for new beneficiaries. Specifically, any individual who enrolls would by default be enrolled in the *lowest-premium* MA plan available in their area. Beneficiaries could opt into TM, or a different MA plan of their choice, but those who are enrolled would have a three-year term to their plan, with switching only permitted in cases of hardship. H.R. 3467 would therefore *expand* MA enrollment while also building aggressive price competition among MA plans to be the lowest-premium plan in an area. This would induce price competition far stronger than in the current system, and start driving premiums toward marginal costs. Given the evidence cited earlier that MA plans are, in fact, more efficient in production than TM, there are substantial efficiencies that this competition could reallocate to seniors and taxpayers.

The trilemma is no longer a distant warning, it is an imminent threat. Medicare Advantage reform that realizes the program's potential offers the best chance at achieving all three objectives: affordability for seniors, fiscal sustainability, and access to new technologies and medical innovation.