Health Policy Review

The Escalating Growth of Spending on Medicare Advantage Plans: A 2026 Update on Controlling Costs, Preserving Medicare Solvency, and Balancing the Federal Budget

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Background: In September/October 2025, Manchikanti et al. published an analysis showing that Medicare Advantage (MA) spending growth was outpacing traditional fee-for-service (FFS) Medicare, driven by favorable selection, risk-adjustment coding intensity, and quality bonus payments, and warned that this trajectory threatened both Medicare's Hospital Insurance (HI) trust fund solvency and physician payment stability. Frantz et al. also published a leadership perspective describing promises and challenges of Medicare Advantage. In the year since, MA now covers more than half of all Medicare beneficiaries, Centers for Medicare & Medicaid Services (CMS) has undertaken the largest Risk Adjustment Data Validation (RADV) audit expansion in program history, a federal court has struck down CMS's ability to extrapolate audit findings across whole contracts, and a separate court has found CMS exceeded its statutory authority in administering the Quality Bonus Program (QBP). Despite these changes, MA plans continue to be rewarded by both parties, with corresponding, rather devastating cuts to physician payments.

Objective: To update 2025 analysis with developments through mid-2026, quantify the current scale of MA overpayment using the most recent Medicare Payment Advisory Commission (MedPAC) and Medicare Trustees data, summarize the regulatory and legal actions taken to control MA spending since publication of the original article, examine quality of care, access, out-of-pocket costs, and prior authorization/non-coverage practices including specific implications for interventional pain management and provide updated, actionable recommendations to control MA cost growth, preserve Medicare solvency, and contribute to balancing the federal budget.

Methods: Narrative update drawing on the 2025 and 2026 Medicare Trustees Reports, MedPAC's March 2025 and subsequent 2026 status reports, CMS rate announcements and audit policy releases, and contemporaneous legal and policy analyses from the Committee for a Responsible Federal Budget (CRFB), Kaiser Family Foundation (KFF), the Center on Budget and Policy Priorities, and Health Affairs Forefront, current through August 2026.

Results: MA now enrolls over half of Medicare beneficiaries and is projected to cost $615 billion in 2026, approximately 14% ($76 billion) more than equivalent FFS spending, with MedPAC's coding-intensity estimate revised to 10.3% above FFS following full phase-in of the 2024 CMS-Hierarchal Condition Category (HCC) (V28) risk-adjustment model. The QBP will pay plans $13.4 billion in 2026 despite MedPAC's finding that star ratings do not reliably reflect care quality, a conclusion reinforced by a May 2026 federal court ruling that CMS exceeded its statutory authority in setting 20 star-rating measures. CMS's May 2025 expansion of RADV audits to all approximately 550 eligible MA contracts was substantially undermined by a September 2025 court ruling barring extrapolation of audit-sample findings across a contract's full enrollee population, though CMS confirmed in January 2026 it would continue the audit rollout. The Committee for a Responsible Federal Budget projects $1.2 to $1.3 trillion in cumulative MA overpayments over 2026–2035, a reduction of roughly one-third from earlier projections but still the largest identified source of Medicare overpayment. Despite these developments, the 2026 Medicare Trustees Report confirms Hospital Insurance trust fund insolvency in 2033, with the 75-year actuarial shortfall widening to 0.56% of payroll and total unfunded obligations rising to $65.3 trillion.

Conclusion: One year after our original analysis, the fundamental problem persists: MA spending growth continues to outpace the value delivered, and reforms enacted or attempted to date the V28 risk-model phase-in, RADV audit expansion, and quality-bonus scrutiny have been partially offset by litigation, incomplete implementation, and continued benchmark and quality-bonus design flaws. Federal oversight data released in the past year show that some of MA's apparent cost and utilization advantages coincide with denial and non-appeal patterns that its own regulators describe as concerning, and prior-authorization burden historically associated with MA is now migrating into traditional FFS Medicare for core interventional pain procedures. At the same time, interventional pain physicians have experienced cuts in payments (45%) without inclusion of sequester cuts. Achieving durable Medicare solvency, a balanced federal budget, and genuinely improved beneficiary access will require the risk-adjustment, benchmark, quality-bonus, and prior-authorization-transparency reforms detailed in this update, sustained through legislative and regulatory follow-through rather than administrative action alone.

Key words: Medicare Advantage, IPM, interventional techniques, Medicare insolvency, Hospital Insurance trust fund, risk adjustment, RADV audit, quality bonus program, federal budget, health policy

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In September/October 2025, Manchikanti et al. published an analysis in Pain Physician documenting the escalating growth of Medicare Advantage (MA) spending and its threat to Medicare's Hospital Insurance (HI) trust fund solvency and to physician payment stability, including within interventional pain management (1-3). We estimated that MA overpayments relative to traditional fee-for-service (FFS) Medicare totaled approximately $44 billion annually from favorable selection, $40 billion from risk-adjustment coding discrepancies, and $15 billion from duplicative coverage of veterans already eligible for Veterans Administration benefits, and we called for structural reform of MA payment policy as a component of any credible plan to preserve Medicare and reduce the federal deficit. Also in 2025, Frantz et al. (4) published a leadership perspective in the Journal of American College of Radiology, describing provisions and challenges of MA. At the same time, interventional pain physicians have experienced a 45% cut in payments since 2001 without inclusion on of yearly 2% sequester cut, with MA plans reaping benefits with favorable policies from both parties (2,3,5-7).

In the year since that publication, MA enrollment has surpassed 50% of the Medicare population for the first time, and both regulatory and judicial developments have materially reshaped the oversight landscape for MA payment integrity. This update reviews those developments through August 2026, incorporates the newly released 2026 Medicare Trustees Report, and revises our policy recommendations accordingly (8-13).

The Continuing Escalation of MA Spending

Medicare Payment Advisory Commission's (MedPAC's) 2026 analysis estimates total MA payments of approximately $615 billion for the year, with MA payments running approximately 14% (about $76 billion) above what equivalent beneficiaries would have cost the program in traditional FFS Medicare (Table 1) (14-16). This figure is lower than MedPAC's 2024 estimate of a 22% ($83 billion) payment excess (17), a reduction attributable primarily to the completed phase-in of the 2024 CMS- Hierarchal Condition Category (HCC) risk-adjustment model ("V28"), which Centers for Medicare & Medicaid Services (CMS) designed specifically to reduce the influence of diagnosis-coding intensity on plan payments (18). MedPAC's coding-intensity estimate for 2026 stands at 10.3% above FFS, down from a revised 12.5% for 2025 and an earlier estimate of 16.4% (19,19A). This represents genuine, measurable progress but coding intensity remains well above the 5.9% minimum statutory adjustment CMS is required to apply, meaning a substantial share of the coding-driven overpayment persists even after V28's full implementation (16,20).

Figure 1 places the current overpayment estimate in historical context. Methodological differences across the cited analyses (GAO 2008, ASPE 2021, MedPAC 2023–2026) limit direct year-over-year comparability, but the pattern across two decades is consistent: MA has been paid above equivalent FFS spending in every rigorous federal or congressional-advisory estimate since the program's modern form was established, notwithstanding its statutory original purpose of reducing Medicare spending through managed-care efficiency (10,14-17,21,21A).

Quality Bonus Program: Persistent Design Flaws, Now With Judicial Confirmation

The Quality Bonus Program (QBP), which raises MA benchmark payments for plans rated 4 stars or higher

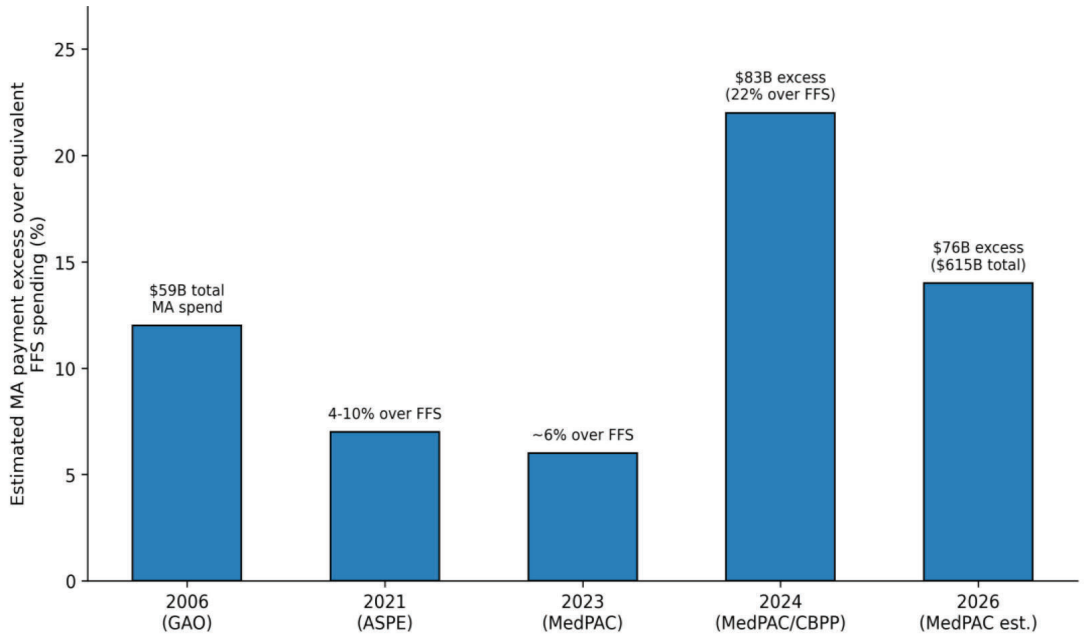


Fig 1. *Estimated Medicare Advantage payment excess relative to equivalent traditional fee-for-service Medicare spending, as reported in successive federal and congressional-advisory analyses, 2006–2026. Methodologies differ across sources (GAO, ASPE, MedPAC) and are not directly comparable year-over-year; the figure illustrates the persistence of a measurable MA payment premium over FFS across nearly two decades rather than a single continuous trend line.*

Table 1. *Mechanisms of Medicare Advantage overpayment and their current estimated cost.*

Mechanism	Estimated annual/decade cost	Source	Status as of mid-2026
Favorable selection (healthier-than-average enrollees)	~$44 billion/yr (2025 estimate)	MedPAC / original 2025 article	Persistent; not addressed by V28 risk model alone
Coding intensity / risk-score "upcoding"	10.3% higher risk scores than FFS (2026 est., down from 12.5% in 2025 and 16.4% in earlier estimate)	MedPAC 2026	V28 (2024 CMS-HCC) model fully phased in for CY2026; statutory minimum coding-intensity adjustment (5.9%) still far below estimated actual intensity
Quality Bonus Program (QBP) payments	$13.4 billion (2026), up from $12.7B (2025) and $3B (2015)	KFF / MedPAC	68% of MA enrollees in bonus-qualifying plans (2026); MedPAC: star ratings do not reliably reflect quality
Benchmark design (rates set above FFS in many counties)	Contributes to overall 14% (2026) / 22% (2024) payment excess	MedPAC	Structural; unchanged by recent rate announcements
Duplicative coverage (e.g., VA-eligible beneficiaries)	~$15 billion/yr (2025 estimate)	Original 2025 article	No coordinated federal fix identified as of mid-2026
Aggregate MA overpayment vs. equivalent FFS	$76 billion (2026, 14% of $615B total MA payments); $1.2–1.3 trillion projected over 2026–2035	MedPAC 2026 / CRFB Jan 2026	Projection revised down ~34% from prior CRFB estimate due to V28 phase-in, but remains the largest identified source of Medicare overpayment

on CMS's 5-star scale, will cost the program at least $13.4 billion in 2026, more than four times its 2015 cost of approximately $3 billion (15,22). Sixty-eight percent of MA enrollees are in bonus-qualifying plans for 2026, down modestly from 75% in 2025 (15). MedPAC has repeatedly found that the star-rating system "does not provide a reliable basis for evaluating quality across MA plans in meaningful ways" and has produced "unwarranted bonus payments" (17).

This finding received unexpected judicial reinforce-

ment in May 2026. Clover Health, an MA organization covering more than 100,000 beneficiaries, successfully challenged its 2026 star rating in federal court after CMS's rating cost the company an estimated $120 million in 2027 payments. Judge Lisa Wood ruled that CMS exceeded its statutory authority in using 10 of the star-rating measures underlying Clover's score and failed to follow required notice-and-comment rulemaking procedures for an additional 10 measures, vacating Clover's 2026 rating and ordering CMS to recalculate it (23). While the ruling directly affects only one plan, it establishes a legal precedent that may invite similar challenges across the industry and raises a direct question about the legal soundness of the measure-setting process underlying the entire $13.4 billion 2026 QBP payment total (22,23).

RADV Audits: The Largest Enforcement Expansion Yet, Partially Undercut by the Courts

In May 2025, CMS announced the most significant expansion of Risk Adjustment Data Validation (RADV) audits in the program's history, moving from auditing approximately 60 MA contracts to all roughly 550 eligible contracts on an annual basis, with an explicit goal of clearing the backlog of audits for payment years 2018 through 2024 by early 2026 (24). This expansion directly targets the coding-intensity and favorable-selection mechanisms responsible for the majority of estimated MA overpayment (Table 1).

However, in September 2025 within weeks of our original article's publication a federal court ruled that CMS could not extrapolate RADV audit findings from a sample of an MA contract's enrollees across that contract's entire enrolled population without applying a previously used FFS Adjuster, a methodological requirement CMS had eliminated in its 2023 RADV final rule (1,25). Because extrapolation is what allows a finding of, for example, a 5% error rate in a sample to translate into a proportional overpayment recovery across an entire multi-billion-dollar contract, this ruling substantially weakens CMS's practical ability to recover the overpayments its own audits identify, even as the underlying audit activity continues. CMS confirmed in a January 27, 2026 memorandum that it intends to proceed with expanded RADV audits, including new audits for payment year 2020, while the litigation remains pending on appeal (Table 2) (25,26).

Quality of Care in Medicare Advantage: A Mixed and Contested Evidence Base

A comprehensive claim underlying MA's continued expansion is that private plan management delivers better care than traditional FFS Medicare, justifying its higher cost. The evidence for this claim is genuinely mixed, and the direction of the mixing matters. A widely cited 2021 systematic review of 48 studies found that MA outperformed traditional Medicare on utilization-oriented metrics more preventive care visits, fewer hospital admissions and emergency department visits, shorter hospital and skilled nursing facility lengths of stay but found no consistent trend favoring MA on patient experience, hospital readmission rates, mortality, or racial and ethnic disparities in care (27). The review's authors explicitly cautioned that available evidence might not fully account for selection bias, unobserved differences in beneficiaries' social risk, or the same risk-adjustment and coding-intensity distortions documented in Table 1, since many of the more favorable comparisons rely on MA encounter data subject to the identical upcoding incentives that drive overpayment (27).

More recent analyses present a similarly divided picture. A 2019 study in Annals of Internal Medicine found hospital readmission rates were, in some analyses, higher rather than lower in MA compared with traditional Medicare (28) directly at odds with newer industry-sponsored and claims-based analyses (including a 2026 full-risk MA cohort study and analytics-vendor-sponsored research) reporting substantially lower MA readmissions (29). A parallel Kaiser Family Foundation (KFF) literature review found MA enrollees experienced lower hospital readmission rates and higher rates of return to the community in some studies, but traditional Medicare outperformed MA on other measures, including care in the highest-rated hospitals for cancer treatment and in the highest-quality skilled nursing facilities and home health agencies (30). Taken together, the strongest and most consistent quality advantage documented for MA is in utilization and preventive-service metrics that are also the metrics most directly rewarded by the risk-adjustment and quality-bonus payment structures described above a pattern that warrants caution in attributing the advantage to superior clinical management rather than to the measurement and payment incentives themselves (7,27,31). In fact, MedPAC has concluded that the current quality measurement and reporting system is flawed, offering no reliable basis for comparing performance across plans (32-40). Nonetheless, these measures drive $15 billion annually in QBP. Studies comparing MA and traditional FFS show

Table 2. *Timeline of regulatory and legal developments affecting MA payment oversight, 2024–2026.*

Date	Action	Effect on MA spending oversight
Nov 1, 2024	CMS finalizes physician fee schedule rule eliminating certain telehealth flexibilities	Later estimated to cost ~$2 billion annually; unrelated cost pressure compounding MA/FFS payment asymmetry
Jan 10, 2025	CMS proposes 4.3% MA payment increase (~$21 billion, 2026)	Signaled continued growth trajectory ahead of final rate announcement
Apr 7, 2025	CMS finalizes 2026 MA/Part D Rate Announcement: average 5.06% payment increase; completes 3-year phase-in of V28 (2024 CMS-HCC) risk model	Full V28 phase-in modestly reduces coding-intensity-driven overpayment relative to prior projections
May 2025	CMS announces expansion of RADV audits to all ~550 eligible MA contracts annually (from ~60) and plan to clear PY2018–PY2024 backlog by early 2026	Most significant enforcement expansion in program history; intended to recover diagnosis-coding overpayments
Sep 2025	Federal court rules CMS cannot extrapolate RADV sample findings across an MA contract's full enrollee population without the previously used FFS Adjuster	Materially weakens CMS's ability to recover overpayments at scale from audit findings; under appeal
Sep/Oct 2025	Original article published: Manchikanti et al., Pain Physician 2025;28(5):359-376	Establishes baseline overpayment estimates ($44B favorable selection, $40B risk adjustment, $15B duplicative VA coverage) and calls for reform
Jan 27, 2026	CMS issues HPMS memo confirming continued RADV rollout (PY2020 audits) despite pending litigation	Signals CMS intent to proceed with audit expansion notwithstanding legal uncertainty
Jan 2026	CRFB revises MA overpayment projection to $1.2–1.3 trillion over 2026–2035 (down ~34% from earlier estimate)	Reflects V28 phase-in benefit, but confirms overpayment remains in the trillion-dollar range over the decade
May 2026	Judge Lisa Wood rules CMS exceeded statutory authority on 10 Quality Bonus Program star-rating measures and failed notice-and-comment rulemaking on 10 more (Clover Health v. CMS); vacates Clover's 2026 star rating	First successful legal challenge to QBP measure-setting process; raises broader questions about the $13.4 billion 2026 QBP payment total
Jun 2026	2026 Medicare Trustees Report: HI trust fund insolvency confirmed for 2033 (Q2); 75-year shortfall rises to 0.56% of payroll; unfunded obligations rise to $65.3 trillion	Confirms no improvement in Medicare's underlying fiscal trajectory despite MA payment reforms enacted to date

no significant difference in overall quality of care. In some cases, complication rates may be higher among MA enrollees than those in FFS Medicare (32-40).

Access to Care and Out-of-pocket Expenses: Lower Averages, Uneven Reality

MA's average out-of-pocket (OOP) costs are theoretically lower than traditional Medicare's for the typical beneficiary. A 2024 USC Schaeffer Center analysis found this OOP advantage was driven primarily by MA plans' use of prior authorization and narrower provider networks to control utilization, which allows plans to bid below CMS benchmarks and return the resulting rebates to enrollees as reduced cost sharing; supplemental benefits (dental, vision, hearing) accounted for only about 15% of the OOP difference (41). For 2026, the average MA in-network OOP limit is $5,421 (combined in- and out-of-network: $9,825), with PPO limits ($6,592) exceeding HMO limits ($4,636); traditional Medicare has no OOP limit at all absent supplemental Medigap coverage (42).

This averaged advantage, however, is generated by the same mechanisms prior authorization and network restriction that create access friction for beneficiaries who need extensive specialty or interventional care, precisely the population for whom an OOP cap matters most. A beneficiary whose request for a covered service is denied, delayed pending peer-to-peer review, or never submitted because a specialist is out-of-network does not accrue the OOP costs that would have appeared in a claims-based average, but also does not receive the care. The population-level statistic of "lower average OOP costs" is therefore not a clean measure of affordability; it is partly a downstream artifact of the same utilization-management apparatus responsible for the prior authorization and denial patterns detailed below. In reality, MA plans are required to provide a benefit package that is at least equivalent to that offered by traditional Medicare. Despite this requirement, OOP costs for MA plans Parts A and B have increased substantially, from $976 in 1999 to $8,707 in 2024, reflecting a 792% increase over 25 years (1).

In its March 2025 report to Congress, MedPAC found that payments to MA plans were 22% higher than traditional FFS Medicare spending. Administrative costs and profits represent 14% of total MA expenditures, undermining claims of cost efficiency. These excessive payments translate to $84 billion annually in spending above FFS levels, with another $15 billion (3.2%) allocated for quality bonuses. Policy changes could produce significant savings: canceling the proposed 4.3% payment increase for 2026 would save $21 billion annually ($210 billion over ten years); eliminating duplicate coverage for veterans already served by the VA would save $15 billion annually ($150 billion over ten years); addressing favorable selection would yield $44 billion in annual savings ($440 billion over ten years); and reforming risk adjustment could generate $40 billion annually ($400 billion over ten years).

OOP maximums under MA have increased sharply. In 2024, the in-network maximum reached $8,850, a 792% increase from 1999. The combined in-network and out-of-network maximum reached $13,300, a 1,262% increase (Fig. 1).

A Wall Street Journal investigation published on December 2, 2024, reported that MA plans received $44 billion in unnecessary payments between 2018 and 2021, averaging $15 billion per year, much of which went unused by insurers (43). A separate investigation published on November 11, 2024, revealed that the sickest patients, particularly those in their final year of life, are more likely to switch from MA to traditional Medicare. This transition shifts high-cost care to taxpayers and reduces insurers' liability (44).

OOP costs for MA enrollees can be prohibitively high. Patients may face charges of up to $750 per visit, often exceeding the reimbursement rates for interventional pain procedures and ambulatory surgical services.

Prior Authorization and Claim Denials: Scale and Consequences

MA insurers made nearly 53 million prior authorization determinations in 2024 (45,45A), compared with minimal prior authorization use in traditional FFS Medicare over the same period. Two June 2026 reports from the Department of Health and Human Services (HHS) Office of Inspector General (OIG) quantified the consequences in post-acute care specifically (Table 3). Among 19 large MA organizations reviewed, skilled nursing facility (SNF) admission requests were denied 12% of the time (ranging from 0.4% to 23% across plans); when the 18% of denials that were appealed reached review, Medicare Advantage Organizations (MAOs) overturned 95% of their own denials in the enrollee's favor (46). Denial rates were substantially higher for long-term acute care hospital (LTCH) admissions (65% overall, with the three largest (MAOs) denying at the highest rates) and inpatient rehabilitation facility (IRF) admissions (54% overall, ranging from 4% to 66% by plan); appealed denials in these categories were overturned 36% and 43% of the time, respectively (47). Individual insurers showed marked variation: one large plan denied 80% of LTCH admission requests, while smaller plans with fewer enrollees and requests posted even higher denial rates in some categories (48).

The OIG's own assessment of these findings is notable for its directness: "the extremely high overturn rate indicates that some enrollees were initially denied medically necessary care and raises concerns about

Table 3. *Medicare advantage prior authorization denial and appeal-overturn rates by service category.*

Service category	Denial rate	Appeal rate	Overturn rate on appeal	Source
Skilled nursing facility (SNF) admission	12% (range 0.4–23% across MAOs)	18%	95%	OIG, June 2026 (OEI-09-24-00331)
Long-term acute care hospital (LTCH) admission	65% overall (3 largest MAOs highest)	36%	36%	OIG, June 2026 (OEI-09-24-00330)
Inpatient rehabilitation facility (IRF) admission	54% overall (range 4–66% across MAOs)	31%	43% (range 14–86% across MAOs)	OIG, June 2026 (OEI-09-24-00330)
All MA prior authorization determinations (2024)	— (~53 million total determinations)	—	>80% of all appealed denials overturned	KFF analysis of CMS data, 2026
Interventional pain management procedures (ESI, RFA, SCS)	5.9% (2023) → 7.4% (2025), trending higher in 2026	Not separately reported	Not separately reported	Industry billing-data analysis, 2026

Post-acute care figures reflect June 2024 data reported to HHS OIG by the 19 largest Medicare Advantage organizations (>200,000 enrollees each). IPM figures reflect industry billing-data analysis and are not directly comparable in methodology to the OIG figures.

denials that were not appealed" (46). This concern is amplified by the low overall appeal rates as low as 18% for SNF denials meaning the great majority of denials, including many that OIG's own data suggest were likely inappropriate, are never challenged and never corrected. The OIG further found that nursing home residents were denied SNF-level care at nearly four times the rate of non-resident enrollees, concentrating this risk among an especially vulnerable population (47).

Non-coverage Policies and Regulatory Response

MA plans are required to provide a benefit package, that is at least equivalent to traditional Medicare. However, beyond individual claim denials, MA plans retain latitude in how they define "medically necessary" care and structure non-coverage policies, and area regulators have attempted to address with limited success. A Biden Administration rule would have required MA plans to conduct a "health equity analysis" of the effects of their prior authorization policies on enrollees with social risk factors, beginning with plan year 2025; the Trump Administration announced in June 2025 that it would not enforce this requirement (45). A separate, still-pending requirement will, beginning in 2026, require insurers to publicly post all items and services subject to prior authorization along with their approval, denial, and appeal-approval rates a transparency measure that, if implemented, would for the first time allow beneficiaries and physicians to compare plans on this dimension before enrollment rather than discovering coverage restrictions only after a denial (45).

Implications for Interventional Pain Management

These access and coverage pressures bear directly on interventional pain management (IPM). Industry billing-data analysis reports that MA plans denied 7.4% of prior authorization requests for pain management procedures in 2025, up from 5.9% in 2023, a 25% relative increase in two years, with 2026 data trending higher still (49). The procedures carrying the greatest denial risk are precisely the core IPM procedures at issue throughout this journal's guideline literature: epidural steroid injections (CPT 62320–62327), radiofrequency ablation (CPT 64625), and spinal cord stimulator placement (CPT 63650–63688) (49).

A distinct and, for interventional pain physicians, more consequential development is that the prior authorization burden historically associated with MA specifically is now migrating into traditional FFS Medicare. Facet joint interventions including medial branch blocks, radiofrequency ablation, and intra-articular injections have required prior authorization in FFS Medicare since July 1, 2023, and implanted spinal cord stimulators have required it since July 1, 2021 (50). Most significantly, CMS launched its Wasteful and Inappropriate Service Reduction (WISeR) model on January 1, 2026 in six states (Arizona, New Jersey, Ohio, Oklahoma, Texas, and Washington), introducing prior authorization requirements for 17 outpatient procedures in traditional FFS Medicare, explicitly including epidural steroid injections and nerve stimulators; claims submitted without prior authorization in participating states are routed to prepayment review, with cases performed without authorization risking zero reimbursement (50).

This convergence has two implications for the arguments advanced in this article and its companion analysis of physician payment reform in interventional pain management (2,5,6). First, the traditional framing of MA prior authorization as a cost and access burden distinct from FFS Medicare is eroding for IPM specifically; physicians should not expect that steering patients toward traditional Medicare will avoid administrative friction for these procedures going forward. Second, the WISeR-driven prior authorization requirements arrive on top of, not instead of, the 33% general and 41% interventional-pain-specific real-terms reimbursement decline since 2001 already documented in our companion article (2,5,6); the administrative cost of obtaining authorization typically requiring peer-to-peer review for initial denials and resubmission when authorizations expire after 60 to 90 days compounds a payment environment already under severe strain, without any corresponding relief on the payment side. Implementation of new Ambulatory Surgery Model (ASM) is devastating keeping more Advantage for MA plans and a disadvantage for physicians treating low back pain (7).

Medicare Trust Fund Solvency: No Improvement Despite Reform Efforts

The 2026 Medicare Trustees Report, released in June 2026, confirms that the HI (Part A) trust fund remains on track for insolvency in the second quarter of 2033 the same year projected in the 2025 report, though the Trustees note this consistency masks offsetting effects: higher MA enrollment and spending pushed the projection earlier, while lower Part A base-year spending pushed it later, netting to an unchanged insolvency

date (8,9,11,12). More concerning, the 75-year actuarial shortfall widened from 0.42% of taxable payroll in the 2025 report to 0.56% in the 2026 report, and the present value of Medicare's total unfunded obligations over 75 years rose from $60.3 trillion to $65.3 trillion (9,11). Upon insolvency, current law requires an automatic reduction in Part A payments to approximately 89% of scheduled levels an 11% across-the-board cut that the Trustees project would grow to 16% by 2040 in the absence of legislative action (8,9).

Gross Medicare spending is projected to rise from 3.9% of gross domestic product (GDP) in 2025 to 6.5% by 2050, nearly doubling as a share of the economy over the next 25 years even before accounting for MA-specific overpayment (9). The persistence of the 2033 insolvency date despite the V28 risk-model phase-in and RADV audit expansion underscores that administrative reforms to MA payment policy, while directionally correct, have not been sufficient in scale or speed to alter Medicare's underlying fiscal trajectory.

Updated Recommendations

Building on our 2025 recommendations (1), and informed by the regulatory and legal developments of the past year, we propose the following updated priorities:

1. Legislative correction of the RADV extrapolation ruling. Congress should codify CMS's statutory authority to extrapolate RADV audit findings across a contract's full enrollee population without requiring the FFS Adjuster, closing the loophole exposed by the September 2025 court ruling and restoring CMS's practical ability to recover identified overpayments at scale (25).
2. Full statutory alignment of the coding-intensity adjustment with measured intensity. With MedPAC estimating actual coding intensity at 10.3% above FFS for 2026 against a statutory minimum adjustment of only 5.9%, Congress should raise the statutory floor to track MedPAC's or CMS's own measured intensity annually, rather than relying on a fixed minimum enacted years before the V28 model existed (16,19,20).
3. Redesign or elimination of the QBP. Given MedPAC's repeated findings that star ratings do not reliably measure quality, combined with the May 2026 judicial finding that CMS exceeded its statutory authority in setting rating measures, Congress and CMS should pursue a fundamental redesign of the QBP potentially budget-neutral bonus financing, third-party-validated quality measures, or outright elimination rather than incremental measure adjustments that remain vulnerable to the same legal and methodological challenges (17,22,23).
4. Benchmark reform to eliminate above-FFS payment floors. Counties where MA benchmarks are set above local FFS spending should be transitioned toward FFS-indexed benchmarks or competitive bidding, addressing the structural, not merely administrative, driver of MA overpayment (16).
5. Sustained funding and staffing for RADV audit completion. CMS's stated goal of auditing all ~550 eligible contracts annually will fail without adequate medical-coder staffing and resolution of the pending appeal; Congress should appropriate dedicated funding for audit completion independent of the broader CMS budget cycle (24,25).
6. Protection of physician payment stability during MA reform. As documented in our companion analysis of physician payment reform in interventional pain management, MA payment growth has coincided with a 33% real-terms decline in general Medicare physician reimbursement since 2001 (45% for interventional pain physicians specifically); any MA savings realized through the reforms above should be explicitly weighed against, and where appropriate redirected toward, stabilizing physician payment rates rather than deficit reduction alone (2,5,6).
7. Mandatory, standardized prior authorization transparency reporting, enforced without exception. CMS should enforce, rather than decline to enforce, both the pending 2026 requirement that insurers publicly report prior authorization approval, denial, and appeal-overturn rates by service category, and the shelved health-equity analysis requirement, so that physicians and beneficiaries can compare plans' authorization burden before enrollment rather than discovering it only after a denial (45).
8. A statutory prior authorization off-ramp for interventional pain management and other high-overturn service categories. Given OIG's finding that appealed denials are overturned in the substantial majority of cases across post-acute care categories, and rising MA and now FFS (WISeR) denial rates for core IPM procedures, CMS should adopt "gold-carding" provisions exempting physicians and facilities with demonstrated high prior-authorization approval rates from further authorization

requirements for the same procedures, reducing administrative burden without loosening medical necessity standards (46,47,49,50).

The Good, the Bad, and the Ugly of Medicare Advantage

Having reviewed both the payment-integrity data underlying MA's cost to the federal budget and the quality, access, and utilization-management evidence underlying its value to beneficiaries, it is useful to summarize where the program genuinely succeeds, where it falls structurally short, and where its own oversight bodies have documented outcomes that are difficult to characterize as anything other than harmful.

The Good

For some beneficiaries, MA delivers real, tangible value that traditional Medicare does not: an out-of-pocket spending cap that FFS Medicare lacks absent supplemental Medigap coverage, frequently zero-premium plan options, and supplemental benefits such as dental, vision, and hearing coverage unavailable under original Medicare (41,42). The strongest and most consistently replicated quality findings favor MA on utilization-oriented measures, arguably more preventive care visits, fewer emergency department visits and hospital admissions, shorter lengths of stay (27) and a 2026 full-risk MA cohort analysis found favorable results on 16 of 20 quality and efficiency measures relative to FFS (29). MA disproportionately serves lower-income and diverse beneficiary populations, for whom the OOP cap and $0-premium options may represent meaningful financial protection unavailable elsewhere in Medicare (17).

The Bad

Despite some genuine benefits for individual enrollees, the program's aggregate cost to Medicare remains structurally excessive: $76 billion in estimated overpayment for 2026 alone and $1.2 to $1.3 trillion projected over the coming decade (Table 1), even after the most significant risk-adjustment model reform in the program's history. The quality advantage claimed for MA is considerably less conclusive than commonly represented once encounter-data-based and industry-sponsored studies are separated from independent survey- and vital-statistics-based research; readmissions, mortality, and patient experience show no consistent MA advantage across the highest-quality available evidence, and MA underperforms traditional Medicare in access to the highest-rated cancer hospitals, skilled nursing facilities, and home health agencies (27,30,34). The same prior authorization and network-restriction tools that produce MA's lower average out-of-pocket costs simultaneously generate the delay, denial, and administrative burden documented throughout this update the favorable and unfavorable findings are, to a substantial degree, two faces of the same underlying mechanism rather than independent phenomena.

The Ugly

The starkest findings in this update come directly from federal oversight bodies rather than external critics. OIG's own June 2026 data show MA organizations denying more than half of inpatient rehabilitation requests and nearly two-thirds of long-term acute care hospital requests, then overturning 36–95% of those denials on the rare occasions they are appealed a pattern OIG itself describes as raising concern that "some enrollees were initially denied medically necessary care," with low appeal rates meaning the great majority of likely-improper denials are never corrected at all (46,47). Nursing home residents, an especially vulnerable population with limited capacity to navigate an appeal, were denied SNF-level care at nearly four times the rate of other enrollees (47). A federal court has now found, separately, that CMS exceeded its statutory authority in administering the very QBP measures underlying $13.4 billion in 2026 payments (23), while a different court ruling has left CMS able to identify overpayments through RADV audits but substantially unable to recover them at scale (26). And the administrative mechanism most associated with MA prior authorization is now expanding into traditional FFS Medicare through the WISeR model, targeting the same core interventional pain procedures (epidural steroid injections, radiofrequency ablation, spinal cord stimulation) already facing rising MA denial rates, layering new administrative burden onto a physician-payment environment already reduced by 41% in real terms for interventional pain specifically since 2001 (2,5-7,49,50). Considered together, these are not isolated administrative frictions; they represent oversight bodies documenting, in the government's own words, a pattern in which some of the financial and quality advantages attributed to Medicare Advantage may be manufactured in part by care that should have been authorized and was not.

Limitations

This is a narrative policy update, not a systematic review; source selection prioritized primary federal sources (CMS, MedPAC, the Medicare Trustees, Congressional Research Service) supplemented by nonpartisan policy analyses (CRFB, KFF, CBPP) rather than an exhaustive literature search. Dollar and percentage estimates cited here originate from multiple organizations using different methodologies and base years and are not directly additive; Table 1 and Fig. 1 present them side by side for context rather than as a single reconciled estimate. The RADV extrapolation ruling and the Clover Health QBP ruling were both under appeal or recent as of this writing (August 2026) and their ultimate resolution may alter the practical impact described here. All figures should be verified against primary sources immediately prior to submission, given the pace of regulatory and judicial change in this area.

Conclusion

One year after our original analysis, MA spending growth remains the single largest identified driver of avoidable Medicare cost and a direct contributor to the HI trust fund's projected 2033 insolvency. The past year has brought the most significant MA payment-integrity reforms in the program's history full phase-in of a redesigned risk-adjustment model, the largest audit expansion ever undertaken, and the first successful legal challenge to the QBPs measure-setting authority yet the Trustees' own 2026 projections show no improvement in Medicare's underlying fiscal trajectory. Sustained, legislatively durable reform of risk adjustment, benchmark design, and quality-bonus financing, rather than administrative action alone, will be required to convert this year's regulatory and judicial momentum into a genuine and lasting saving for Medicare and the federal budget.

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