Medicare Advantage: Myth vs. Fact

BETTER MEDICARE ALLIANCE

As the dominant Medicare choice for beneficiaries, the Medicare Advantage program is overwhelmingly popular with seniors because it provides high-quality, affordable health care with better outcomes compared to Fee-for-Service (FFS) Medicare. Despite the program's success, ongoing criticism remains, including proposals to cut Medicare Advantage. This would cause widespread disruption for millions of seniors who rely on Medicare Advantage, with plan closures, higher costs and reduced benefits.

Here are the facts:

Promoting Accurate Risk Adjustment

CLAIM: Medicare Advantage plans inflate risk scores so beneficiaries appear sicker than those enrolled in Fee-for-Service Medicare.

> **FACT:** Accurate, complete diagnosis coding is fundamental to how Medicare Advantage works, with benefits to patients as well as plans. The Medicare Advantage risk adjustment model relies on qualified health professionals to document beneficiaries' diagnoses in order to determine prospective, capitated payments. Ensuring diagnoses are complete and accurate allows plans to manage care appropriately and cover more than 35 million beneficiaries' health needs. Unlike Fee-for-Service Medicare, Medicare Advantage is specifically designed to manage the holistic health of a beneficiary, resulting in a more efficient use of Medicare dollars and better, high-quality and coordinated care for seniors.

> **FACT:** Medicare Advantage is a highly regulated program with accountability mechanisms designed to ensure diagnosis and payment accuracy, including strict documentation requirements and Risk Adjustment Data Validation (RADV) audits. Since 2025, CMS has significantly expanded the frequency and volume of RADV audits and has announced plans to audit all eligible Medicare Advantage contracts each payment year.

CLAIM: MedPAC estimates that coding intensity will contribute billions of dollars in excess Medicare Advantage payments in 2026.

> **FACT:** Coding intensity in the Medicare Advantage program is a much more nuanced picture, and CMS's own actions show the issue is being actively addressed. Unlike payment in Fee-for-Service, Medicare Advantage plans receive risk-adjusted payments based on enrollees' diagnoses. Because FFS Medicare providers have less financial incentive to document all conditions, Medicare Advantage enrollees can appear sicker by comparison, a difference known as coding intensity.

> **FACT:** CMS has taken various actions to address coding intensity. Congress requires CMS to apply a 5.9% reduction to Medicare Advantage risk scores to account for this gap, and CMS has reaffirmed that level in both the CY 2026 and CY 2027 Rate Announcements. Additionally, CMS announced plans for a major expansion of its audit program in May 2025, scaling from about 60 plans per year to all eligible Medicare Advantage plans annually. CMS plans to deploy AI-assisted coding tools and expand its medical coder workforce to accelerate reviews. Further, starting in CY2027, CMS finalized a policy excluding diagnoses not tied to a specific patient encounter from risk score calculations.

> **FACT:** CMS has estimated that improper payments in FFS Medicare totaled approximately $28.8 billion in FY 2025 — a 6.55% improper payment rate — compared with $23.7 billion (6.1%) in Medicare Advantage. However, MedPAC's analysis also found that coding intensity's impact on Medicare Advantage payments has fallen sharply from roughly 10% in 2022 to about 4% in 2026 following full phase-in of CMS's updated risk adjustment model,

undercutting the claim that upcoding remains a widespread, uncorrected problem. Additionally, CMS published a peer-reviewed analysis in 2026 estimating the uncorrected coding differential for 2022 at just 1.5–2%, substantially lower than MedPAC's estimates.

FACT: If CMS were to increase the coding intensity adjustment beyond the current 5.9% level, Medicare beneficiaries could face reductions in benefits and increased out-of-pocket costs. CMS has carefully weighed this issue and reaffirmed the current adjustment level while pursuing reforms that address these coding differences.

Closing Care Gaps with In-Home Health Assessments

CLAIM: Health risk assessments and chart reviews are used to add diagnosis codes and provide little to no value to the beneficiary.

FACT: In-home health assessments, also known as health risk assessments, are an important component of the Medicare program as they provide in-home care to improve health outcomes and address chronic disease earlier. These assessments identify gaps in care and collect detailed information that informs a beneficiary's personalized care plan to improve overall health and promote independence. They address gaps in care and work to eliminate risk factors that may not even be evident in a doctor's office, including connecting beneficiaries to community resources if necessary.

Driving High-Value, Affordable Health Care

CLAIM: Despite being created to deliver efficiencies and cost-savings to the Medicare program, Medicare Advantage drives up costs and does not result in savings.

FACT: Medicare Advantage provides measurably better value for beneficiaries, the government, and taxpayers through reduced cost-sharing, maximum out-of-pocket limits and extra supplemental benefits that do not exist in Fee-for-Service Medicare, along with reduced spending on Medicare-covered services.

FACT: According to a July 2026 analysis by ATI Advisory, Medicare Advantage beneficiaries spend $2,824, or 36%, LESS on annual out-of-pocket costs and premiums compared to Fee-for-Service Medicare and that gap has widened over time. Medicare Advantage beneficiaries are about half as likely to face a significant cost burden (12%) as those in Fee-for-Service Medicare (24%), and this savings advantage holds across income levels, racial and ethnic groups, geography and chronic condition burden. Through supplemental benefits, Medicare Advantage provides enhanced coverage of Medicare-covered benefits, such as reduced cost-sharing and lower premiums, while providing benefits and services NOT covered by Fee-for-Service Medicare. Nearly all (98%) of plans provide some combination of dental, vision or hearing coverage for beneficiaries, and 59% of plans offered in 2026 are zero-dollar premium plans, meaning beneficiaries only pay the Part B premium that all Medicare beneficiaries pay and do not pay an additional premium for their Medicare Advantage plan.

FACT: In addition to lower beneficiary costs in Medicare Advantage, research finds that, on average, per beneficiary government spending is lower in Medicare Advantage compared to Fee-for-Service. A recent Milliman analysis found that federal payments to Medicare Advantage plans run about 9% lower than the government's cost for comparable beneficiaries in Fee-for-Service. Medicare Advantage delivers more value to the government for every dollar spent in Medicare Advantage compared to Fee-for-Service Medicare, with financial protections leading to beneficiary savings and extra services delivered through supplemental benefits.

Updated as of August 12, 2026. Sources: U.S. Code Title 42 § 1395w-23; CMS Medicare Advantage audit strategy (May 2025); Albanese et al. analysis of Medicare Advantage coding pattern differences (January 2026); ATI Advisory analysis commissioned by Better Medicare Alliance (July 2026); Milliman "Value of Medicare Advantage to the Federal Government" (2025 data, published January 2026).