Policy Of Auto-Enrolling Seniors In Medicare Advantage Could Backfire

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Mehmet Oz, administrator of the Centers for Medicare and Medicaid Services, during a healthcare affordability event in the Oval Office of the White House in Washington, DC, on Thursday, Apr. 23, 2026. CMS may soon change the default for newly eligible Medicare beneficiaries to Medicare Advantage rather than original Medicare. Photographer: Will Oliver/EPA/Bloomberg... More
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The Trump administration has said it's considering auto-enrolling newly eligible beneficiaries into either Medicare Advantage plans or Accountable Care Organizations. Should this policy go ahead, there are some things that could go wrong, including higher costs to the federal government and imposition of more care access restrictions on seniors and disabled folks, such as prior authorization and narrow physician and hospital networks.

Chris Klomp, director of Medicare, told *STAT News* that such auto-enrollment would be better than the current default into fee-for-service, original Medicare. But on multiple levels, this assertion is questionable. In terms of cost, the Medicare Payment Advisory Commission posted a report in March of this year that found that Medicare paid $76 billion more for Medicare Advantage patients in 2025 than it would have if those same patients had been enrolled in original Medicare. The increased payments to Medicare Advantage plans contribute to funding for the supplemental benefits these insurers provide.

And while Medicare Advantage plans offer low or even zero premium enrollment fees, their budget-conscious, profit-driven model places limits on

choices of doctors and hospitals as well as much more frequent use of prior authorization that can restrict patient access to certain prescription drugs, among other technologies.

What’s the Difference Between Traditional Medicare and Medicare Advantage?

Medicare serves roughly 68 million elderly and disabled Americans. At age 65, most Americans are currently automatically enrolled in Medicare to cover costs related to hospital and physician (as well as outpatient) services, known as Part A and Part B, respectively.

Often, each healthcare service is billed and reimbursed separately, hence the name “fee-or-service” Medicare. However, since 1983, Medicare has operated a diagnosis-related group-payment system that standardizes reimbursement rates for patient stays in the hospital, varying by disease and condition category.

Beneficiaries in traditional Medicare can also sign up for prescription drug coverage (Part D) through stand-alone plans that manage the pharmacy benefit.

Alternatively, those eligible for Medicare can enroll in Medicare Advantage, called Part C. Here, private insurers receive a set monthly fee per enrollee from the government to cover health services, including hospital, outpatient and physician services as well as in most plans, prescription drug coverage, all integrated under one insurer.

Attracted by low premiums and supplemental benefits such as vision and dental care not offered by traditional Medicare, the share of beneficiaries enrolling in Medicare Advantage has increased every year over the last two decades, along with a rise in the number of available plans. Medicare Advantage now enrolls more than 50% of the Medicare-eligible population.

How Seniors Could Be Affected by Change in Policy

At present, the default is traditional fee-for-service Medicare. Medicare Advantage is available to those who specifically select it. Now, however, the Trump administration is mulling reversing the default option and auto-enrolling beneficiaries in Medicare Advantage plans or an ACO. Once in a Medicare Advantage plan or ACO, enrollees would be stuck for three years before being able to transition to original Medicare.

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An ACO is a healthcare delivery model incentivized financially to provide more efficient care at a lower cost. Doctors, hospitals and other medical providers work together to provide coordinated care, often for those enrolled in traditional Medicare. The ACOs that Medicare beneficiaries could be auto-enrolled into are ones that participate in the Medicare Shared Savings Program. The Medicare Shared Savings Program is a voluntary initiative that aims to encourage healthcare providers to form ACOs to deliver cost-effective care to Medicare beneficiaries.

It’s unclear how the Centers for Medicare and Medicaid Services would determine whether a newly eligible beneficiary would be automatically enrolled in a Medicare Advantage plan or an ACO. In addition, among Medicare Advantage options, which differ considerably, it’s not clear which one would be picked as a default. Tricia Neuman, executive director for the Program on Medicare Policy at KFF, expressed her concerns to *MedPage* about whether the federal government would assign a new Medicare beneficiary a plan that allows them to continue treatment from their preferred physicians, or if there’s a risk they would be registered with an insurer that would force them to change doctors.

The Medicare Advantage program generally lowers out-of-pocket costs so long as beneficiaries stay within the designated network but often restricts choices

of doctors and healthcare providers. On the other hand, original Medicare offers broader physician and healthcare provider access and flexibility.

Furthermore, in stark contrast to traditional Medicare, involuntary disenrollments are a growing threat to Medicare Advantage plan recipients. A Johns Hopkins Bloomberg School of Public Health analysis found that approximately 10% of Medicare Advantage enrollees — roughly 2.9 million seniors — are being forced to find new coverage in 2026 as insurers exit markets. The average disenrollment rate for Medicare Advantage beneficiaries jumped from 1% in 2018-2024 to 7% in 2025, and then to 10% (nearly three million people) in 2026. In Vermont, 92% of enrollees had to find alternative plans or revert to original Medicare.

Growth in Medicare Advantage enrollment has been slowing recently. But contrary to predictions last autumn that there would be a decline, there was a slight increase in the numbers of people signing up: 34.4 million people enrolled in a Medicare Advantage plan in 2025, up from 33.4 million in 2024. Regardless, nearly every major insurer got rid of enrollees, with two exceptions: Humana and Kaiser Foundation Health Plan, which saw increases of 1.3 million beneficiaries and 64,000, respectively.

How Could the Administration’s Changes Affect Medicare Advantage Plans?

Recently, headwinds facing Medicare Advantage plans include rising medical costs and increased utilization of healthcare services and technologies by beneficiaries. The Inflation Reduction Act’s redesign of the outpatient drug benefit also presents challenges because it exposes payers to much greater cost liability, especially regarding high-cost beneficiaries.

But CMS has been helping Medicare Advantage weather the storm by way of a series of regulatory moves, including increasing payments to insurers and relaxing of regulations.

CMS finalized a 2027 payment rate increase of 2.48% to privately run Medicare Advantage plans that was far larger than the 0.09% rate initially proposed in January. In aggregate, this amounts to a $13 billion boost in federal government payments to private insurers to run health plans for people over 65 and certain individuals with disabilities. The higher rate is thought to help insurers stabilize their businesses as they face rising medical costs.

Last year, CMS decided upon a generous payment increase to Medicare Advantage plans of 5.1% for 2026. This constituted a $25 billion boost and differed substantially from the 2.2% increase proposed by the Biden administration in the waning days of its tenure.

CMS also loosened regulations with respect to the so-called star ratings system. Earlier this month, the agency eliminated 11 of the quality and care metrics Medicare Advantage plans are graded on including, among others, call center performance, appeals and complaints. The evaluations are designed to measure the quality and performance of health plans on the basis of patient satisfaction and the use of clinically appropriate tests and treatments. By lowering the number of metrics plans are held accountable for, this may generate close to $19 billion for insurers in bonuses over the next ten years.

And now, with a possible change on the horizon in the default option for newly eligible Medicare recipients to Medicare Advantage or an ACO, it's safe to assume that this administration's preference is to grow the Medicare Advantage market. Not only is this stipulated in Project 2025, a conservative blueprint on policy, prior to his assuming the administrator role at the CMS,

Oz declared he favored a Medicare Advantage for All healthcare system. This would extend beyond the confines of Medicare, suggesting a role for Medicare Advantage as a possible model for broader healthcare reform.

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