Medicare Advisers Urge Payment Changes to Rein In Program Costs

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Summary by Bloomberg AI

- The Medicare Payment Advisory Commission issued a report analyzing the financial health of the Medicare program and outlining steps to ensure its continued viability.
- The commission identified factors behind the program's rising costs, including fraud, improper payments, and misaligned payment incentives, and estimated that Medicare costs could double again by 2032.
- MedPAC recommended that Congress improve the accuracy of fee-for-service payments and highlighted the Centers for Medicare & Medicaid Services' efforts to rein in improper spending, including the use of fraud prevention systems.

A key Medicare panel that advises Congress issued a report Monday analyzing the financial health of the federal insurance program, outlining steps policymakers can take to ensure its continued viability.

The Medicare Payment Advisory Commission focused much of its 2026 report to Congress on the issue of spending on the federal health program. The panel underscored fraud, improper payments, and misaligned payment incentives as factors behind the Medicare program’s rising costs.

The commission estimates that the federal government doubled its yearly spending on the Medicare program from 2010 to 2023, increasing from $500 billion to $1 trillion. If current spending rates hold, Medicare costs could double again, reaching nearly **$2 trillion** by 2032.

The report echoes many of the same concerns the Trump administration has voiced about increased spending on programs such as Medicare and Medicaid. Republicans in 2025 pushed through changes to Medicaid to reduce enrollment and spending, and the administration has taken aggressive steps to root out fraud in the programs.

MedPAC highlighted the misaligned incentives that underpin traditional Medicare's fee-for-service payment system. The report said the payment method "financially rewards providers who furnish more care than might be necessary," leading to increased Medicare spending and beneficiary costs as a result.

The commission also identified the use of payment systems with different data sources and formulas, resulting in Medicare paying more for the same service depending on the site of care.

MedPAC recommended that Congress improve the accuracy of these fee-for-service payments by updating Medicare law to slightly increase rates for select hospital services, while modestly decreasing payments for outpatient dialysis, hospice services, and acute care services, which tend to have healthy profit margins.

Improper Payments

MedPAC also analyzed the financial impact of improper payments on overall Medicare spending. These payments come in the form of overpayments, underpayments, payments for ineligible services or recipients, and payments lacking sufficient documentation to determine appropriateness.

Although some improper payments result from fraud, the report notes that most are due to insufficient documentation or other errors. In total, the Medicare program spent approximately $56.7 billion on improper payments in 2025.

The advisers stopped short of issuing direct fraud recommendations; however, they did highlight the Centers for Medicare & Medicaid Services' efforts to rein in improper spending, including the use of fraud prevention systems to identify suspicious billing patterns before payments are made.

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