



Published in final edited form as:

JAMA Intern Med. 2026 July 01; 186(7): 861–868. doi:10.1001/jamainternmed.2026.1237.

Federal Enforcement Actions Against Medicare Advantage Plans from 2010 to 2023

Zihan Chen, MPP¹, Amal N. Trivedi, MD, MPH^{1,2}, Hayden Rooke-Ley, JD³, Jeffery Marr, PhD¹, David J. Meyers, PhD¹

¹Department of Health Services, Policy and Practice, Brown University School of Public Health, Providence, RI

²Center of Innovation in Long-term Services and Supports for Vulnerable Veterans, Providence VA Medical Center, Providence, Rhode Island

³Center for Advancing Health Policy through Research, Brown University School of Public Health, Providence, RI

Abstract

Importance: Medicare Advantage (MA) plans continue to grow, enrolling over half of Medicare beneficiaries and receiving over \$494 billion in annual federal payment. Therefore, robust oversight is essential to monitor plans' compliance with federal standards and initiate enforcement actions when necessary to ensure program integrity and protect beneficiaries.

Objective: To examine Centers for Medicare and Medicaid Services (CMS) enforcement actions against MA contracts and characteristics of contracts and beneficiaries impacted by enforcement actions.

Design, Setting, and Participants: This is a cross-sectional study of CMS enforcement actions against MA contracts that were Preferred Provider Origination or Health Maintenance Organization from 2010 to 2023. Data were analyzed from May 2025 to January 2026.

Exposures: Enforcement actions, including civil money penalties, suspension of enrollment, and contract termination.

Main outcomes: The number of enforcement actions and contracts affected; average monetary penalties per MA enrollee.

Results: There were 844 enforcement actions against MA contracts from 2010 – 2023. Most enforcement actions were monetary penalties (n=737, 87.3%), with far fewer enrollment suspensions (n=99, 11.7%) and contract terminations (n=8, 0.9%). Forty-two percent of MA contracts received an enforcement action during the study period. Most of enforcement actions originated from program audit (n=544, 64.5%). Enforcement activity varied widely across years: in 2012, 19% of contracts received monetary penalties while only 1% of contracts received such penalties in 2019. Financial penalties peaked at \$6.50 per enrollee in 2019 and remained under \$3

Correspondence to: David Meyers, 121 South Main Street, Providence, RI 02912, david_meyers@brown.edu.

Disclaimer: The views expressed in this article are those of the authors and do not necessarily reflect the position or policy of the Department of Veterans Affairs or the US government.

in other years. Compared with contracts that did not receive enforcement actions, contracts that were terminated had lower star ratings (mean [SD] stars, 2.5 [0.5] vs 3.6 [0.6]) and enrolled a much lower share of White beneficiaries (44.7% vs 68.7%); suspended contracts enrolled more dually eligible beneficiaries (28.9% vs 18.8%).

Conclusion and Relevance: This study found that federal enforcement actions against Medicare Advantage plans were highly variable from year-to-year and imposed modest fines. Enforcement actions may be relatively modest in magnitude, raising concerns about their effectiveness in deterring noncompliance. The design of oversight and enforcement actions warrant further evaluation to determine what amount of enforcement actions are needed to protect patients and ensure plans meet federal standards.

Introduction

Medicare Advantage (MA) plays an increasingly important role in covering health services for older adults, making it essential to understand how MA plans are regulated. MA operates as private alternatives to the traditional Medicare program under federal contracts to deliver Medicare-covered benefits. These plans now enroll over half of Medicare beneficiaries and receive over \$494 billion in annual federal payments.¹ Because MA plans are paid on a capitated basis, they have financial incentives to contain costs through mechanisms such as prior authorization or narrow provider networks. These strategies may have been effective in reducing utilization as MA was associated with lower rates of acute care and low-value care, and with shorter post-acute care use.^{2–5} However, concerns have been raised regarding these strategies' potential to delay or restrict access to medically necessary care and increase administrative burdens for patients and providers.^{6–10} Government and Kaiser Family Foundation reports have also highlighted marketing practices that may mislead consumers.^{11–13} These issues emphasize the importance of government monitoring and enforcement to maintain MA program integrity and compliance and safeguard beneficiaries' access to necessary care.

Federal agencies, and sometimes state agencies, oversee MA plans through routine monitoring, audits, and enforcement actions.¹⁴ State regulators license MA organizations to operate as risk-bearing entities. CMS conducts program audits of organizations on a rotating cycle within three to five years to assess compliance with operational and beneficiary protection requirements such as internal compliance programs and inappropriate denials or delays of covered services.^{15–17} MA organizations are selected based on CMS's annual risk assessment that incorporates prior audit findings, star ratings, enrollment growth, and other factors.¹⁸ In addition to program audits, CMS also conducts financial audits that focuses on compliance with payment requirements such as maximum out-of-pocket limits, routine monitoring that assesses medical loss ratios, as well as ad hoc reviews.¹⁹ When CMS identifies noncompliance, it may issue warning letters or require corrective action plans. In more serious cases, CMS can impose formal enforcement actions, including civil money penalties, enrollment and marketing suspensions, and, in the most severe cases, contract terminations.^{20,21} Enforcement actions are a cornerstone of regulatory policy and are widely used in other parts of the health care system, such as nursing homes and hospitals, to address

poor quality of care or regulatory noncompliance.^{22–24} However, little is known about the patterns and regulatory strength of CMS enforcement actions specific to MA plans.

This study addresses this gap with three key objectives. First, we examined the types and trends of enforcement actions taken against MA plans using a novel dataset obtained under a Freedom of Information Act request to CMS. Second, we assessed the strength of these sanctions. Third, because enforcement actions may reflect operational challenges, regulatory burden, or quality issues within plans, we compared contract characteristics across types of enforcement actions. In addition, because high-need or racial and ethnic minority beneficiaries experience higher disenrollment rates and more restricted access to high-quality plans, we examined the characteristics of enrollees most affected by different types of sanctions.^{25–27}

Methods

Study Data and sample

We obtained a list of all CMS enforcement actions from 2010 to 2023 through a Freedom of Information Act (FOIA) request. Each enforcement action record included the type of action, referral source, enforcement date, and affected contracts. Specifically, there were three types of enforcement actions: civil money penalty (monetary penalties), suspension of enrollment and marketing (suspensions), and contract terminations (terminations). Referral sources of enforcement actions were grouped into program audit, financial audit, formulary & coverage determination, appeals, and grievances, medical loss ratio, financial insolvency, star rating requirements, and others. Appendix Table 1 presents detailed descriptions of referral sources. Each referral source warrants multiple categories of enforcement actions. For example, a program audit (a referral source) can lead to both monetary penalties and suspensions. Monetary penalties are often assessed in aggregate across multiple contracts under the same MA organization, which occasionally includes standalone prescription drug plans. We assumed each contract/plan accounted for an equal share of the penalty and excluded drug plans from the analysis.

We linked the enforcement data to CMS data on all Health Maintenance Organizations (HMO) and Preferred Provider Organizations (PPO) MA contracts between 2010 and 2023. We used CMS star ratings, plan benefit files, and the 100% sample of Medicare Master Beneficiary Summary File data, to identify characteristics of contracts and enrollees. The final analytical sample included characteristics of contracts and associated enforcement actions on the contract-year-type of enforcement level.

Measures of Contract and Beneficiary Characteristics

Characteristics were chosen based on their relevance to oversight design, operational complexity, quality performance, and beneficiary experience identified from prior literature. We included contract structures – whether the contract had special needs plans, had a health maintenance organization designation, and plan premiums—as these factors may be related to differences in compliance requirements, oversight intensity, operational challenges, and financial health that could result in enforcement actions. We used MA star rating as a

measure of quality performance which is used as a basis for contract termination and may be indirectly reflected in enforcement actions.²¹ We measured beneficiary compositions as enrollees' age, sex, race and ethnicity, and dual enrollment in Medicaid to identify which populations were most affected by sanctions. We also included the state to assess geographic concentration of sanctions.

Statistical Analysis

We first summarized the number of enforcement actions, and the number of contracts and enrollees affected overall and by year. We then analyzed the distribution of per-enrollee monetary penalties among contracts that received the penalty across MA parent organizations. The dollar amount was adjusted to the 2023 levels using Consumer Price Index. Enforcement actions were also examined in relation to contract characteristics to describe the contexts in which different types of enforcement were observed. Additionally, we analyzed the variation in the proportion of contracts receiving enforcement actions across MA parent companies to assess the concentration and extent of enforcement actions within organizations. Analyses were performed in R and STATA version 18. This study met the STROBE reporting guideline and was determined to be exempt by the Brown University Institutional Review Board. Informed consent was waived because the data were deidentified.

Results

From 2010 to 2023, we identified 1,173 unique MA contracts and 844 enforcement actions. The most common type of enforcement was monetary penalties (n=737, 87.3%), followed by suspension (n = 99, 11.7%), and termination (n = 8, 0.9%; Table 1). The most common source of enforcement actions was program audit (n=544, 64.5%), followed by "other" (n=130, 15.4%; "other" may include incompliance with marketing or annual notice of change requirements; see details in Appendix Table 1). Specifically, terminations were attributable to persistent low star ratings, financial insolvency, or failure to improve from previous suspensions (Appendix Table 2). Among all MA contracts, 42.0 percent of them had ever received an enforcement action: 38.3% received monetary penalties, 8.4% were suspended, and 0.7% were terminated. Twenty percent of contracts (n=240) received more than one enforcement action over the study period.

The annual proportion of contracts affected by enforcement actions fluctuated substantially over time and were clustered within program audit cycles (Figure 1). Comparing the highest annual rate of monetary penalties within each cycle in panel A, the peak proportion declined modestly over time: from 19.2% during the first audit cycle, to 17.8% in the second cycle, 14.6% in the third, and 15.1% in the fourth. Suspensions followed a similar and more pronounced downward trend. The proportion of suspended contracts peaked at 8.8% in 2010 during the first cycle, but the highest suspension rates declined to 4.2% in the second cycle, 1.8% in the third, and just 0.1% in the fourth. The number of enrollees affected presented with a similar variability across time. At the peak level, 0.7 per 1000 enrollees were affected by termination, 75.4 per 1000 affected by suspension, and 351.0 per 1000 affected by monetary penalties.

Figure 2 presents the magnitude of monetary penalties across years. Among contracts that were penalized, the highest monetary penalties per enrollee was \$6.50 in 2019; in other years, it remained under \$3. At the parent organization level, the maximum penalty did not exceed \$50 per enrollee in most years (Appendix Figure 1).

We found large differences in characteristics of contracts and their enrollees across enforcement types (Table 2). Terminated contracts had the lowest average star rating of 2.5, compared to 3.1 stars for suspended contracts and 3.6 stars for contracts receiving monetary penalties or no enforcement actions. The average monthly premium was \$2.42 for terminated contracts, much lower than the \$26.99 for suspended contracts, \$31.40 for contracts with monetary penalties, and \$34.10 for contracts with no enforcement actions. Suspended contracts had the highest share of beneficiaries dually enrolled in Medicaid (28.9%) compared to other contracts (terminated contracts, 18.7%; monetary penalty contracts, 19.4%; no enforcement contracts, 18.8%). Suspended contracts also had the highest share of enrollees who were Black (17.3%). Contracts that were terminated enrolled the highest proportion of beneficiaries who were Hispanic (36.3%) and the lowest proportion of enrollees who were White (44.7%).

At the parent organization level, Arcadian Management Services Inc. and Aetna were most likely to receive suspension and monetary penalties, respectively (Appendix Figure 2). Universal American Corp., Health Net, Inc., and Aetna, were among the top MA organizations to receive both suspension and monetary penalties. There was significant geographic variation in the population affected by enforcement actions (Appendix Figure 3). MA enrollees in southern states, as well as in Ohio, were the most heavily impacted by suspension of enrollment and monetary penalties on MA contracts.

Discussion

This study evaluated patterns of enforcement actions on Medicare Advantage contracts and characteristics of affected contracts and enrollees between 2010 and 2023. We found that about half of MA contracts had ever received an enforcement action. There were large annual fluctuations in the number of enforcement actions during the study period. Monetary penalties were the most common type of enforcement, but their magnitudes were modest, ranging from \$0.2 to \$6.5 per enrollee. There were also considerable differences in characteristics of contracts and enrollees affected across types of enforcement actions. Among all contracts, terminated contracts had the lowest star ratings and premiums, and the highest share of enrollees who were Hispanic. Suspended contracts enrolled higher proportions of dual eligible and Black beneficiaries compared to other contracts.

The year-to-year variability in enforcement actions may reflect the cyclical structure of CMS's program audit process rather than uniform enforcement activity over time. Enforcement actions were heavily clustered within program audit cycles, consistent with our finding that most sanctions originate from audits and are often imposed in the middle of each cycle. This pattern highlights the central role of program audits in identifying noncompliance and suggests that other forms of routine or ad hoc oversight contribute relatively fewer enforcement actions. Program audits are a key mechanism for protecting

patients' rights and access to care, particularly given Medicare Advantage (MA) plans' extensive use of prior authorization and their high rates of inappropriate denials.^{6,9,28} Although each audit cycle typically covers approximately 90% of MA enrollees, only 20–50% of parent organizations are included, mostly because Medicare Advantage enrollment is concentrated among a relatively small number of large parent organizations.^{17,18,29,30} Future research should investigate the optimal frequency and coverage of Medicare Advantage program audits, which likely depends on multiple factors, including the administrative costs to the government, how plans respond to audits, and the effectiveness of enforcement actions. Understanding these dynamics is critical for designing an effective audit schedule.

Monetary penalties were modest relative to the revenue MA plans retained after claims expenses: the highest penalty imposed was \$6.5 per enrollee, substantially lower than gross margins of \$1,815 per enrollee in the same year.³¹ This small penalty amount is by design. CMS has the authority in statute to apply penalties for up to \$47,596 per-enrollee per-violation in 2025.³² However, their current methodology of calculating monetary penalty set a limit far below this maximum, which CMS stated to be sufficient to encourage compliance.³³ For example, in 2019, CMS per-enrollee methodology capped fines of up to \$424 for the most serious violations—such as inappropriate delays or denials of urgently needed care with prior offenses. It also set an aggregate cap for per-enrollee penalties on the basis of the size of an MA organization.³³ An MA organization with three million or more enrollees—the largest firms covering most beneficiaries—could be fined no more than \$2 million per violation, which equates to less than \$0.67 per enrollee. While excessively large penalties could unfairly burden plans, penalties setting this low may be unlikely to have meaningful corrective or deterrent effects.

Suspension of enrollment and marketing could be a more effective policy lever, although it was used infrequently during the study period. Suspension may be more effective than monetary penalties because it incentivizes contracts to correct noncompliance to release the sanction; it is less disruptive than termination, because it restricts contract's abilities to enroll new beneficiaries but allows for other normal business operations. The design of enforcement could also be strengthened by escalating sanctions for repeat violations or failures to correct deficiencies. However, this was rarely observed in our study: only two suspended contracts were ultimately terminated for failure to improve, and it was unclear whether any prior monetary penalties triggered more serious sanctions. In 2023, CMS began using an organization's past record of notice for noncompliance (not enforcement actions) as a basis for denying applications for new contracts or service areas.³⁴ Moving forward, CMS could consider prior sanctions—particularly monetary penalties—when reviewing new applications or determining whether to suspend or terminate a contract.

When severe sanctions are necessary, their benefits and costs should be balanced. Effective oversight and enforcement should deter violations and incentivize improvement while avoiding unnecessary disruption to beneficiaries and insurers.³⁵ Severe sanctions such as terminations may create unintended harms by forcing beneficiaries to switch to other MA plans or to traditional Medicare, potentially resulting in changes to benefits, provider networks, and out-of-pocket costs.^{10,35–37} Our analysis also found that suspensions and terminations disproportionately affected Black and Hispanic beneficiaries - populations that

already face barriers to accessing high-quality plans.^{25,38} This indicates that minority populations may bear a greater share of the adverse consequences of these two types of sanctions. To mitigate these harms, CMS could consider pairing more frequent, risk-based audits with enhanced support on compliance and quality improvement for plans serving high-need populations. When severe sanctions are unavoidable, enhanced transition safeguards—such as continuity-of-care protections and clearer beneficiary communication—may help reduce disruptions for vulnerable enrollees. Additionally, we found that terminated plans had substantially lower premiums. Taken together with the overrepresentation of Hispanic beneficiaries in these plans, these patterns could reflect strategic plan behavior such as aggressive pricing and marketing, or alternatively, operational challenges in serving markets with higher medical and social risks. Future research is warranted to understand the underlying drivers of severe sanctions.

Enforcement actions can influence consumer decisions about MA plans. The most direct example is contract termination, which removes persistently low-quality or financially unstable plans from the market. Previous studies on MA initiated terminations found that beneficiaries switched to higher-quality options and experienced better health outcomes.^{35,39} In addition, CMS grants beneficiaries a special enrollment period to disenroll from a sanctioned MA plan, although it's unclear how often this may occur and consumers are generally reluctant to switch plans.^{40,41} Transparency is another avenue: CMS could make enforcement actions visible on its plan comparison website, helping beneficiaries factor them into their decision-making. Finally, sanctions and program audit findings may capture dimensions of plan quality not reflected in the existing star rating system, suggesting they could add meaningful value to how plan performance is assessed.

This study has several limitations. The primary limitation of this study is the potential for incomplete or inaccurate information in the FOIA data. However, we conducted a random check of 10 enforcement actions reported on the CMS website (which publicly lists enforcement actions since 2020) and found that the FOIA data matched accurately.⁴² Second, the reported monetary penalty amounts may be imprecise because we could not determine the exact portion attributable to Medicare Advantage contracts in some cases. Third, the FOIA data did not include enforcement actions that arise from Risk Adjustment Data Validation audit or noncompliance with network adequacy requirements, or terminations of D-SNP “look-alikes”. Finally, this study is associational in nature, and while we identify the types of plans and beneficiaries most affected by enforcement actions, these characteristics are not necessarily causally linked to enforcement actions. Observed differences in contract characteristics across enforcement actions may reflect a combination of contracts' underlying risks of noncompliance and exposure to regulatory oversight, formal criteria for triggering specific sanctions, sociodemographic and health status of enrollees, and broader market conditions.

Conclusion

In this study of CMS enforcement actions against MA contracts from 2010 to 2023, we found substantial variations in the volume of enforcement actions and consistently modest monetary penalties. Our findings highlight the central role of program audits in identifying

noncompliance, while also revealing potential structural limitations of the current oversight framework.

As MA plans now enroll more than half of the Medicare population and continue to expand, these results point to several regulatory and research priorities. First, CMS may need to reconsider the frequency and coverage of program audits to reduce any gaps in oversight, as well as the design of monetary penalties to balance effectiveness and regulatory burden. Second, greater public visibility of enforcement actions or incorporating enforcement actions into the star rating system may strengthen incentives for compliance and inform consumers' choices. Third, future research should examine how different types of enforcement actions affect plan behavior, beneficiary experiences, and health equity, as well as whether stronger penalties could better reduce noncompliance and protect beneficiaries.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

Grant funding:

This study was funded by U.S. National Institute on Aging (grant P01AG027296)

References

1. Ochieng N, Freed M, Biniek J, Damico A, Neuman T. Medicare Advantage in 2025: Enrollment Update and Key Trends. KFF. July 28, 2025. Accessed September 20, 2025. <https://www.kff.org/medicare/medicare-advantage-enrollment-update-and-key-trends/>
2. Roy I, Hutchins F, Rose L, et al. Postacute Care Use and Outcomes Among Medicare Advantage vs Traditional Medicare Beneficiaries. *JAMA Netw Open*. 2025;8(10):e2540347. doi:10.1001/jamanetworkopen.2025.40347 [PubMed: 41160023]
3. Agarwal R, Connolly J, Gupta S, Navathe AS. Comparing Medicare Advantage And Traditional Medicare: A Systematic Review. *Health Affairs*. 2021;40(6):937–944. doi:10.1377/hlthaff.2020.02149 [PubMed: 34097516]
4. Boudreau E, Schwartz R, Schwartz AL, et al. Comparison of Low-Value Services Among Medicare Advantage and Traditional Medicare Beneficiaries. *JAMA Health Forum*. 2022;3(9):e222935. doi:10.1001/jamahealthforum.2022.2935 [PubMed: 36218933]
5. Beckman AL, Frakt AB, Duggan C, et al. Evaluation of Potentially Avoidable Acute Care Utilization Among Patients Insured by Medicare Advantage vs Traditional Medicare. *JAMA Health Forum*. 2023;4(2):e225530. doi:10.1001/jamahealthforum.2022.5530 [PubMed: 36826828]
6. Biniek JF, Sroczynski N, Freed M, Neuman T. Medicare Advantage Insurers Made Nearly 50 Million Prior Authorization Determinations in 2023. KFF. January 28, 2025. Accessed August 1, 2025. <https://www.kff.org/medicare/issue-brief/nearly-50-million-prior-authorization-requests-were-sent-to-medicare-advantage-insurers-in-2023/>
7. Cahan E Medicare Advantage Has Become Notorious for Prior Authorization—CMS and Lawmakers Are Taking Action. *JAMA*. 2024;332(12):948–951. doi:10.1001/jama.2024.13383 [PubMed: 39212960]
8. 2024 AMA Prior Authorization Physician Survey. American Medical Association. Accessed August 1, 2025. <https://www-ama-assn-org.revproxy.brown.edu/system/files/prior-authorization-survey.pdf>
9. Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care. 2022. Accessed August 1, 2025. <https://oig.hhs.gov/reports/all/2022/some-medicare-advantage-organization-denials-of-prior-authorization-requests-raise-concerns-about-beneficiary-access-to-medically-necessary-care/>

10. Meyers DJ, Rahman M, Trivedi AN. Narrow Primary Care Networks in Medicare Advantage. *J GEN INTERN MED*. 2022;37(2):488–491. doi:10.1007/s11606-020-06534-2 [PubMed: 33469747]
11. Deceptive Marketing Practices Flourish in Medicare Advantage. U.S. Senate Committee on Finance. Accessed January 29, 2026. <https://www.finance.senate.gov/imo/media/doc/Deceptive%20Marketing%20Practices%20Flourish%20in%20Medicare%20Advantage.pdf>
12. Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency. Federal Register. May 9, 2022. Accessed February 14, 2026. <https://www.federalregister.gov/documents/2022/05/09/2022-09375/medicare-program-contract-year-2023-policy-and-technical-changes-to-the-medicare-advantage-and>
13. Biniek JF, Cottrill A, Sroczynski N, et al. How Health Insurers and Brokers Are Marketing Medicare. KFF. September 20, 2023. Accessed September 15, 2025. <https://www.kff.org/medicare/how-health-insurers-and-brokers-are-marketing-medicare/>
14. Medicare Advantage Oversight Mechanisms. Published online 2024. Accessed August 1, 2025. <https://bettermedicarealliance.org/wp-content/uploads/2024/08/Medicare-Advantage-Oversight-Mechanisms-2024-.pdf>
15. Program Audits | CMS. Accessed August 4, 2025. <https://www.cms.gov/medicare/audits-compliance/part-c-d/program-audits>
16. Medicare Managed Care Manual Chapter 11 - Medicare Advantage Application Procedures and Contract Requirements. Accessed August 4, 2025. <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c11.pdf>
17. 2019 Part C and Part D Program Audit and Enforcement Report. Medicare Parts C and D Oversight and Enforcement Group; 2020. Accessed July 8, 2025. <https://www.cms.gov/files/document/2019-program-audit-enforcement-report.pdf>
18. 2014 Part C and Part D Program Audit and Enforcement Report. Medicare Parts C & D Oversight and Enforcement Group; 2015. Accessed July 8, 2025. <https://www.cms.gov/files/document/2014annualreportpdf>
19. 2023 Part C and Part D Program Audit and Enforcement Report. Medicare Parts C and D Oversight and Enforcement Group; 2024. Accessed July 8, 2025. <https://www.cms.gov/files/document/2023-program-audit-enforcement-report.pdf>
20. 42 CFR 422.752 -- Basis for imposing intermediate sanctions and civil money penalties. Accessed January 29, 2026. <https://www.ecfr.gov/current/title-42/part-422/section-422.752>
21. 42 CFR 422.510 -- Termination of contract by CMS. Accessed January 28, 2026. <https://www.ecfr.gov/current/title-42/part-422/section-422.510>
22. Harrington C, Tsoukalas T, Rudder C, Mollot RJ, Carrillo H. Variation in the Use of Federal and State Civil Money Penalties for Nursing Homes. *The Gerontologist*. 2008;48(5):679–691. doi:10.1093/geront/48.5.679 [PubMed: 18981284]
23. Jiang J (Xuefeng), Jiang M, Bai G Enforcing Hospital Price Transparency: Lessons From CMS Actions. doi:10.1377/forefront.20241202.645014
24. Stevenson DG, Cheng AK. Nursing home oversight during the COVID-19 pandemic. *Journal of the American Geriatrics Society*. 2021;69(4):850–860. doi:10.1111/jgs.17047 [PubMed: 33577714]
25. Park S, Werner RM, Coe NB. Racial and ethnic disparities in access to and enrollment in high-quality Medicare Advantage plans. *Health Services Research*. 2023;58(2):303–313. doi:10.1111/1475-6773.13977 [PubMed: 35342936]
26. Martino SC, Mathews M, Damberg C, et al. Voluntary Disenrollment from Medicare Advantage Plans Is Higher Among Racial and Ethnic Minorities. *Health Serv Res*. 2020;55(Suppl 1):54–55. doi:10.1111/1475-6773.13403 [PubMed: 31835283]
27. Meyers DJ, Belanger E, Joyce N, McHugh J, Rahman M, Mor V. Analysis of Drivers of Disenrollment and Plan Switching Among Medicare Advantage Beneficiaries. *JAMA Intern Med*. 2019;179(4):524–532. doi:10.1001/jamainternmed.2018.7639 [PubMed: 30801625]

28. Anderson KE, Darden M, Jain A. Improving Prior Authorization in Medicare Advantage. *JAMA*. 2022;328(15):1497–1498. doi:10.1001/jama.2022.17732 [PubMed: 36190725]
29. 2017 Part C and Part D Program Audit and Enforcement Report. Medicare Parts C and D Oversight and Enforcement Group; 2018. Accessed September 21, 2025. <https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/Downloads/2017ProgramAuditEnforcementReport.pdf>
30. 2021 Part C and Part D Program Audit and Enforcement Report. Medicare Parts C and D Oversight and Enforcement Group; 2022. Accessed July 8, 2025. <https://www.cms.gov/files/document/2021-program-audit-enforcement-report.pdf>
31. Ortaliza J, Biniek JF, Hinton E, Neuman T, Rudowitz R, Cox C. Health Insurer Financial Performance in 2023. KFF. July 2, 2024. Accessed January 27, 2026. <https://www.kff.org/medicare/health-insurer-financial-performance/>
32. Civil Money Penalty Calculation Methodology Update. Published online May 15, 2025. Accessed October 7, 2025. <https://www.cms.gov/files/document/hpmsmemo2025cmppenaltyupdate05152025.pdf-0>
33. Civil Money Penalty Calculation Methodology. Published online June 21, 2019. Accessed October 7, 2025. <https://www.cms.gov/medicare/compliance-and-audits/part-c-and-part-d-compliance-and-audits/downloads/2019cmpmethodology06212019.pdf>
34. Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency. Federal Register. May 9, 2022. Accessed August 5, 2025. <https://www.federalregister.gov/documents/2022/05/09/2022-09375/medicare-program-contract-year-2023-policy-and-technical-changes-to-the-medicare-advantage-and>
35. Dixit MN, Trivedi AN, Meyers DJ. Contract Termination and Insurance Enrollment Among Medicare Advantage Beneficiaries. *JAMA Network Open*. 2024;7(8):e2428267. doi:10.1001/jamanetworkopen.2024.28267 [PubMed: 39163045]
36. Special Enrollment Periods | Medicare. Accessed September 22, 2025. <https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods>
37. Crook HL, Zhao AT, Saunders RS. Analysis of Medicare Advantage Plans' Supplemental Benefits and Variation by County. *JAMA Netw Open*. 2021;4(6):e2114359. doi:10.1001/jamanetworkopen.2021.14359 [PubMed: 34160609]
38. Meyers DJ, Mor V, Rahman M, Trivedi AN. Growth In Medicare Advantage Greatest Among Black And Hispanic Enrollees. *Health Affairs*. 2021;40(6):945–950. doi:10.1377/hlthaff.2021.00118 [PubMed: 34097525]
39. Abaluck J, Caceres Bravo M, Hull P, Starc A. Mortality Effects and Choice Across Private Health Insurance Plans. *The Quarterly Journal of Economics*. 2021;136(3):1557–1610. doi:10.1093/qje/qjab017 [PubMed: 34475592]
40. Rivera-Hernandez M, Blackwood KL, Moody KA, Trivedi AN. Plan Switching and Stickiness in Medicare Advantage: A Qualitative Interview With Medicare Advantage Beneficiaries. *Med Care Res Rev*. 2021;78(6):693–702. doi:10.1177/1077558720944284 [PubMed: 32744130]
41. Medicare Managed Care Manual: Medicare Advantage Enrollment and Disenrollment. Accessed September 23, 2025. <https://www.cms.gov/files/document/cy-2024-ma-enrollment-and-disenrollment-guidance.pdf>
42. Part C and Part D Enforcement Actions | CMS. Accessed May 2, 2025. <https://www.cms.gov/medicare/audits-compliance/part-c-d/part-c-and-part-d-enforcement-actions>

Key Points

Question:

How is the federal government overseeing Medicare Advantage plans using enforcement actions?

Findings:

From 2010 to 2023, most enforcement actions were monetary penalties (87.3%), with far fewer enrollment suspensions and contract terminations. Average monetary penalties peaked at \$6.5 per enrollee in 2019 and remained under \$3 in other years.

Meaning:

The magnitude of enforcement actions appears modest, raising concerns about their effectiveness in protecting patients and ensuring that plans meet federal standards.

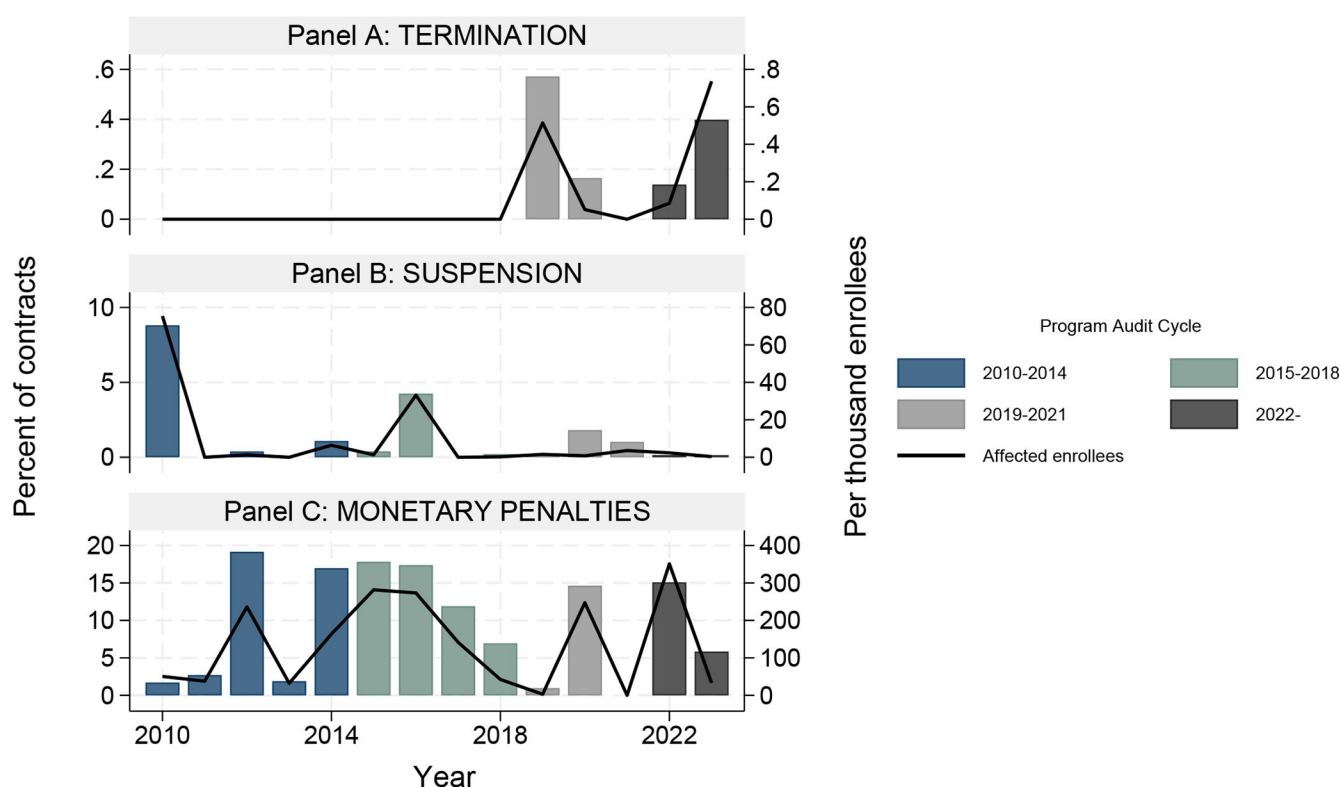


FIGURE 1.

Proportion of Medicare Advantage contracts and enrollees affected by enforcement actions, 2010 – 2023

The bar graph shows the percent of contracts affected by enforcement actions, which was calculated using the number of contracts receiving each type of enforcement action divided by the total number of contracts that were health maintenance organizations or preferred provider organizations in each year.

The line graph shows the number of enrollees affected by enforcement actions, which was calculated using the number of enrollees in contracts receiving each type of enforcement action divided by the total number of enrollees (in thousands) among contracts that were health maintenance organizations or preferred provider organizations.

Audit cycle years were assigned based on CMS annual Part C and Part D Program Audit and Enforcement Reports. CMS reports indicate that the first audit cycle ended in 2014 and that the third audit cycle began in 2019. In the 2021 report, CMS summarized audit coverage over a three-year period from 2019 to 2021; therefore, we treated 2021 as the end of the third audit cycle. Although the third audit cycle may have extended beyond 2021, none of the CMS reports after 2019 explicitly reference audit cycle boundaries.

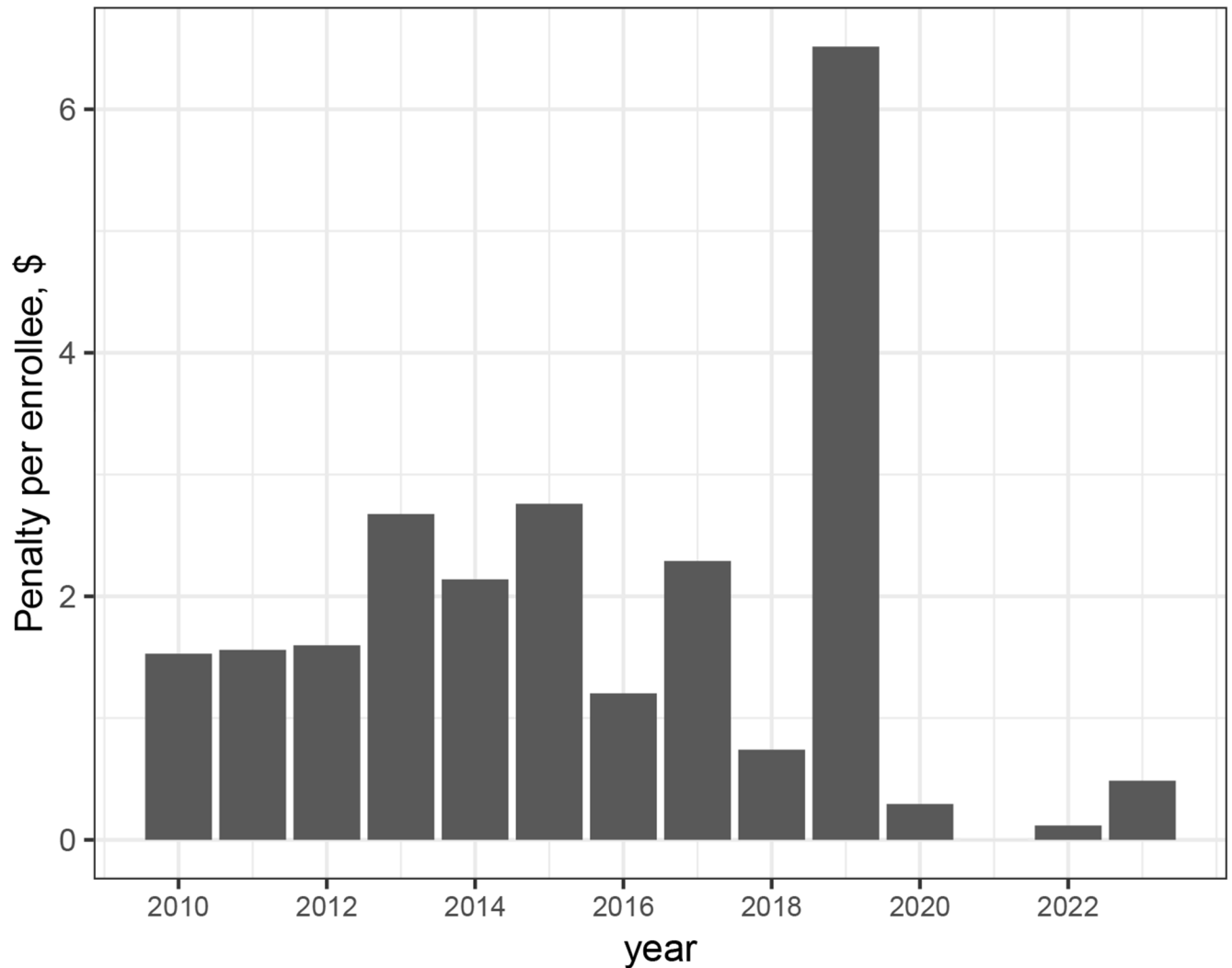


FIGURE 2.

Average monetary penalty per enrollee, 2010 – 2023

Each bar represents the average civil money penalty (monetary penalties) per enrollee among MA contracts receiving a monetary penalty in the year. It is calculated by dividing the total amount of monetary penalties by the number of enrollees in a contract with monetary penalties in the year. This is the same as first calculate the per-enrollee penalties at the MA organization level and then calculate the average of per-enrollee penalties across organizations weighted by their number of enrollees. All monetary values were inflation-adjusted to 2023 levels.

Table 1.
Distribution of Medicare Advantage Enforcement Actions by Type and Referral Source, 2010 - 2023

Type of enforcement or referral source	Enforcement Actions		Affected Contracts	
	No.	%	No.	%
<i>Total</i>	844	100	1173	100
Types of Enforcement				
Civil Money Penalty	737	87.3	449	38.3
Suspension	99	11.7	98	8.4
Termination	8	0.9	8	0.7
Never received enforcement			680	58.0
Referral Source of Enforcement				
Program Audit	544	64.5	403	34.4
Other ^a	130	15.4	123	10.5
Financial Audit	120	14.2	108	9.2
Formulary & Coverage Determination, Appeals, and Grievances	30	3.6	30	2.6
Medical Loss Ratio	9	1.1	9	0.8
Financial Insolvency	8	0.9	8	0.7
Star Rating	3	0.4	3	0.3

^a“Other” includes noncompliance with CMS’ marketing requirements, untimely and inaccurate annual notice of change, failure to improve from previous suspensions, and so on. Please see Appendix Table 1 for detailed information regarding each source of referral.

TABLE 2.
Contract characteristics ^a by type of enforcement, 2010-2023

	All	Termination	Suspension	Monetary penalty	No Enforcement ^b
N, contract-years	7946	8	99	737	7,102
N, contracts	1173	8	98	449	1,172
Plan Structures					
Has SNP, %	49.4	75.0	44.4	51.6	49.3
HMO, %	71.8	62.5	79.8	68.9	72.0
Premium (sd) ^c	33.73 (37.49)	2.42 (3.77)	26.99 (33.80)	31.40 (37.38)	34.10 (37.55)
Zero premium ^d , %	39.8	93.3	52.0	44.5	39.1
Quality Performance					
Star (sd)	3.6 (0.6)	2.5 (0.6)	3.1 (0.6)	3.6 (0.6)	3.6 (0.6)
Missing star, %	29.8	12.5	37.4	11.3	31.6
Beneficiary Composition^e					
Mean Age, y	72.9	70.1	71.6	72.6	73.0
Female, %	56.5	53.6	57.6	56.2	56.6
Dual, %	19.0	18.7	28.9	19.4	18.8
Beneficiary Composition: Race and ethnicity^e					
Asian, %	3.6	1.5	3.1	3.6	3.6
Black, %	12.1	15.6	17.3	13.8	11.8
Hispanic, %	13.7	36.3	15.2	13.8	13.6
White, %	68.4	44.7	63.3	66.7	68.7

SNP: Special needs plans. HMO: Health maintenance organization.

^aContract and enrollee characteristics are calculated based on the contract's enrollment and characteristics in the year of its enforcement actions. The unit of analysis is contract-year.

^bThe column of "No Enforcement" includes all contracts that did not receive an enforcement action in a given year between 2010 and 2023.

^cWe calculated premiums as the average of plan premiums under the contract weighted by plan enrollment.

^dZero premium was defined as the proportion of enrollees in a zero-premium plan under the contract.

^eBeneficiary composition was weighted by the number of enrollees.