INDUSTRY EBOOK

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Medicare Supplement at a Tipping Point

Why “the insurer pays when Medicare pays” no longer works, and how fraud, waste and abuse claims management can restore stability.

A CO-BRANDED PUBLICATION FROM

ClaimQI™
CLAIMS INTELLIGENCE

WHITE PINE
ACTUARIAL CONSULTING

AT A GLANCE

A product seniors depend on is under financial strain.

Medicare Supplement carriers face record medical trend, negative margins and an influx of higher-cost members. Most still pay every claim Medicare approves. The data says that assumption is expensive, and that carriers have more control than they think.

−8.1%

Average 2024 profit margin on open Med Supp blocks[1]

$28.8B

Medicare Fee-for-Service payments found improper in the 2025 reporting year, 6.55% of the total[3]

1 in 10

Medicare Advantage enrollees in non-employer HMO and PPO plans facing a forced plan exit in 2026[2]

$4B+

Medicare payments suspended in a single catheter fraud scheme, while supplemental payers kept paying the cost sharing[4]

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SECTION 1

Complementary coverage and full access

Medicare Supplement is one of the most common types of insurance in the United States. Commonly known as Medigap or "Med Supp," it pays some or all of the cost sharing associated with Medicare on behalf of the beneficiary.

Because the member's cost sharing under Medicare is around 20% of total medical costs and has no limit, this insurance is important to the financial well-being of America's seniors. Med Supp allows for a frictionless Medicare experience: plans have no networks and no formal care management programs such as prior authorization, so seniors can receive care from any provider that accepts Medicare.

This stands in contrast to Medicare Advantage, which has grown in popularity over the last 20 years. Under Medicare Advantage, the federal government pays insurance companies to administer health coverage for seniors. These plans often carry low or no premium beyond Medicare Part B, but they come with access limitations based on provider networks, contracting, and prior authorization requirements on select services.

~20%

of total medical costs is the member's share under Original Medicare, with no annual limit

5.6M

covered lives and $14.8 billion of in-force premium reported by Med Supp carriers for 2024[1]

Two paths for Medicare beneficiaries

How Med Supp and Medicare Advantage differ for the member

	MEDICARE SUPPLEMENT	MEDICARE ADVANTAGE
Provider access	Any provider that accepts Medicare	Limited by plan network and contracting
Prior authorization	None	Required on select services
Member premium	Roughly $50 to over $200 per month	Often low or $0 beyond Part B
Who pays claims	Medicare first, then the Med Supp carrier pays cost sharing	The plan, funded by federal payments

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SECTION 2

Unprecedented cost trends and margin pressure

It is no surprise that many seniors prefer Med Supp, especially those in rural areas who need access to the providers and facilities near home. With premiums ranging from $50 to over $200 per month, Med Supp has long been perceived as the more expensive option.

Recent developments have sent the product into a state of disequilibrium. High medical trends have produced financial losses for carriers, with the average profit margin on open Med Supp blocks at −8.1% in 2024,[1] along with exceptionally high premium increases.

Those rate increases have taken Med Supp from expensive to unaffordable for many seniors, causing excessive lapsation and a loss of financial security.

87%

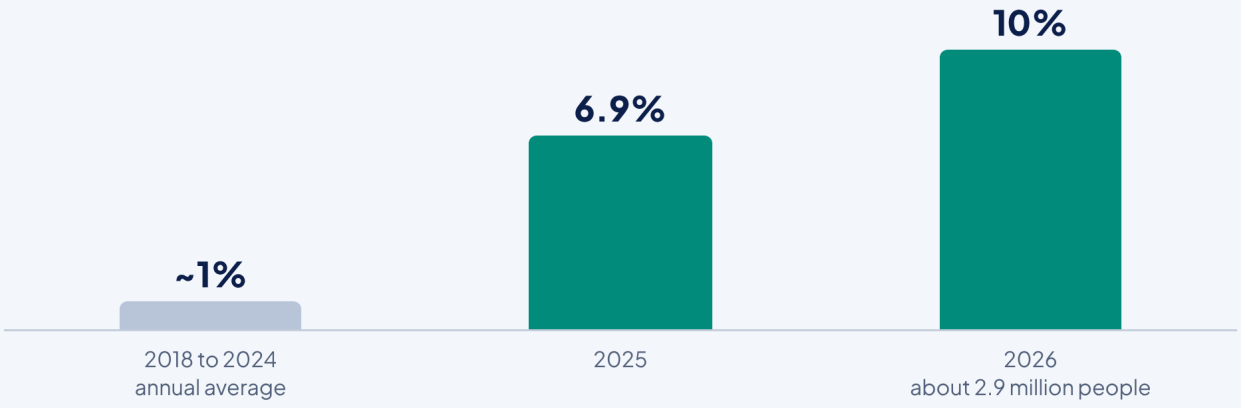
average 2024 loss ratio on open blocks, with individual carriers ranging from 66% to 102%[1]

11%

average 2024 lapse rate on open blocks, and 16% on closed blocks[1]

Medicare Advantage plan exits have jumped tenfold

Share of enrollees in non-employer HMO and PPO plans forced to leave their plan because it exited the market



Source: Meiselbach et al., JAMA, February 2026.[2]

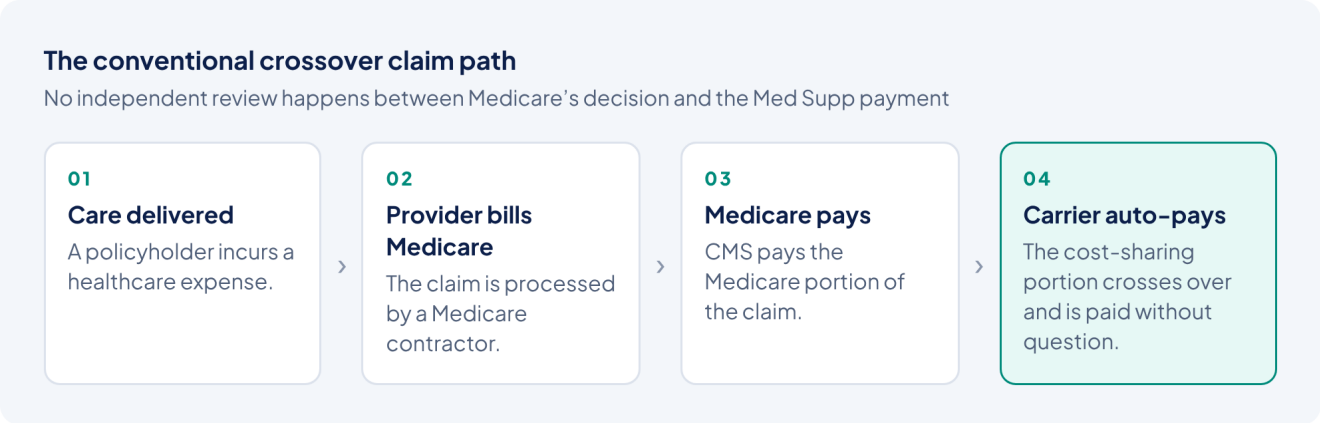
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Plan exits push higher-cost members into Med Supp

To compound matters, Medicare Advantage plan exits reached record levels in 2025 and 2026. When members experience a plan exit, they receive a Guaranteed Issue right to buy a Med Supp plan without going through underwriting. The members with the most medical conditions are the most likely to exercise that right, which drives up the overall morbidity and cost of the Med Supp block.

With these forces making Med Supp less budget-friendly for seniors, insurers are struggling to keep members on plans and strengthen margins. That calls for a change in how insurers think about Med Supp claims.

> **The long-established view has been that "the insurer pays when Medicare pays." At the current tipping point, payers need to step outside that thinking.**



Ensuring that dollars are not wasted or spent unnecessarily lowers claim costs and loss ratios. It also brings a new challenge: keeping the Med Supp experience frictionless for members while doing so.

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SECTION 3

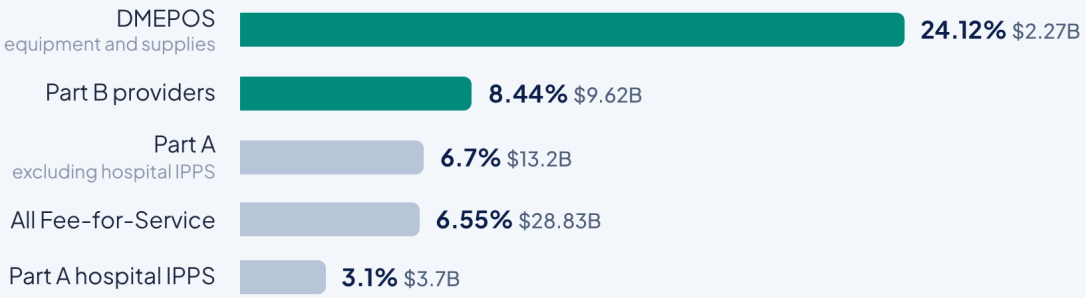
An expensive mindset and miss

Insurers typically assume that when Medicare pays its portion of a claim, the service complied with the Medicare policy rules that govern medical necessity and procedures. A second common misconception is that a claim from a fraudulent source would never be marked for Med Supp payment. Both assumptions are costly and most often inaccurate. A significant number of claims marked for payment do not follow Medicare's policies and rules.

The scale of the exposure is measurable. CMS's Comprehensive Error Rate Testing (CERT) program found that 6.55% of Medicare Fee-for-Service payments, $28.83 billion, were improper under Medicare coverage, coding, billing or documentation requirements in the 2025 reporting year. The exposure is more concentrated in the areas that directly generate Med Supp cost sharing.[3]

Improper payment rates are highest where Med Supp pays most often

Medicare Fee-for-Service improper payment rate by claim type, 2025 reporting year



Source: CMS, 2025 Medicare Fee-for-Service Supplemental Improper Payment Data.[3] Dollar figures are projected improper payments.

These figures are not fraud estimates. They show something equally important: Medicare payment alone is not evidence that a claim satisfied Medicare's payment requirements.

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Medicare's fraud controls protect Medicare's dollars

Additionally, billions of dollars in fraudulent claims are paid by Med Supp carriers each year. When Medicare identifies a provider as a suspected fraud scheme, the legal process takes months and sometimes years. During that time the provider's claims are still processed. The Medicare portion is held and released only if the provider is cleared. The Med Supp portion, in most cases, is auto-paid by the carrier.

Even a fraudulent provider who knows the Medicare portion will be withheld still has reason to file fake claims in order to collect the Med Supp portion.

Many carriers believe they are powerless to challenge these claims and must "pay around Medicare." That belief is widespread, long-standing and not factually correct.

CARRIERS HAVE RIGHTS

Med Supp carriers can deny or recover claim payments that do not meet Medicare coverage requirements or are fraudulent.

The Government Accountability Office (GAO) reported in 2026 that when Medicare places a provider under payment suspension for credible information of potential fraud, it still fully processes that provider's claims. Those claims continue to appear as approved in the system used to communicate with supplemental payers. CMS began sharing limited payment-suspension information with supplemental payers only in December 2025.[4]

Case in point: the urinary catheter scheme

What GAO found when it reviewed one Medicare fraud scheme

$4B+
in Medicare payments suspended

15
providers placed under payment suspension

$10s of millions
in cost sharing that private payer representatives estimate supplemental plans may still have paid

A carrier needs its own fraud controls, its own provider monitoring, and its own defensible process for determining when payments should not be made.

Source: U.S. Government Accountability Office, GAO-26-107799.[4]

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The traditional model exposes Med Supp twice

The financial asymmetry continues after a fraud case is resolved. Government recoveries do not make the Med Supp carrier whole.

EXPOSURE ONE

At payment

A questionable Medicare-approved claim crosses over and the carrier pays the beneficiary cost sharing.

EXPOSURE TWO

At recovery

The government recovers its own losses through settlement or judgment. The carrier receives no share unless it separately pursues its own recovery rights.

SECTION 4

The missed opportunity

It is remarkable that the practice of paying around every claim Medicare pays has gone on for as long as it has.

Had the practice changed across the industry several years ago, Med Supp claims and premiums would likely be 5% lower than they are today. The double-digit rate increases of recent years would have been lower, and the damaging shock lapses that followed would have been softened.

Unless a carrier identifies and pursues its own recoveries, the Med Supp dollars paid on these claims remain a permanent loss to the block, and ultimately a cost passed to policyholders.

5%

estimated reduction in Med Supp claims and premiums had the industry stopped paying around Medicare several years ago

Authors' estimate

> **Lower claims would have meant lower rate increases, and fewer seniors priced out of their coverage.**

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SECTION 5

A new beginning

The good news is that Med Supp carriers now have an opening to better manage claims and costs and to mitigate unprecedented medical cost trends. By introducing processes that monitor claims and proactively flag those that are improper or fraudulent, carriers can stabilize rate changes, relieve compressed margins, and restore Med Supp's purpose as a predictable and stable option for Medicare beneficiaries.

Until now, Med Supp plans and payers have lacked claims management programs and tools. The ability to identify and manage improper payments, including fraud, waste and abuse, is essential for Med Supp blocks to return to equilibrium. The objective is a Med Supp claims-intelligence function that can do three things:

ONE

Recognize

when Medicare's payment decision, fraud action or recovery process does not fully protect the supplemental payer.

TWO

Translate

those signals into actionable controls the carrier can apply and defend.

THREE

Prevent

avoidable claim dollars from becoming permanent premium pressure for seniors.

Claims management on Med Supp products is what must happen to keep the product viable and affordable in the years ahead.

SOURCES

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3. Centers for Medicare & Medicaid Services. CERT Reports and 2025 Medicare Fee-for-Service Supplemental Improper Payment Data. cms.gov (accessed September 30, 2026).
4. U.S. Government Accountability Office. Medicare: CMS's Use of Data Analytics to Identify and Prevent Fraud. GAO-26-107799, March 30, 2026. gao.gov (accessed September 30, 2026).

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LET'S TALK

Protect the Medigap dollar.

The time has come for Medicare Supplement carriers to 'claim control of their claims.' With loss ratios spiraling out of control, and so many costs that are fraudulent or not within Medicare's rules, now is clearly the time to fix these issues. Find out what a claims-intelligence review could mean for your block. Conduct a simple, no obligation, HIPAA-compliant and IT-free Proof of Concept to review historical claims. In minutes you can see what your company is missing.

ClaimQI™
CLAIMS INTELLIGENCE

ABOUT CLAIMQI, INC.

ClaimQI, Inc. is a healthcare claims intelligence company delivering fraud, waste, and abuse (FWA) prevention for health plans across Medicare Advantage, Medigap, Medicaid, and self-funded commercial markets. Rather than leading with claims scoring on probabilistic risk and statistical anomaly detection, ClaimQI validates every claim against deterministic coverage rules, codes, and policy language, producing defensible, citation-backed determinations that avoid AI-inherent risks. ClaimQI's underlying AI/LLM methodology, which produces this citation-driven output while keeping claims data itself out of the AI model, is the subject of a pending U.S. patent application. ClaimQI was founded by health plan executives with a combined 50 years in health plan leadership, claims, compliance, and Special Investigations Unit (SIU) operations. ClaimQI is headquartered in Omaha, Nebraska. Learn more at **www.ClaimQI.ai**.

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ABOUT WHITE PINE ACTUARIAL CONSULTING

White Pine Actuarial Consulting brings two decades of health actuarial experience to today's challenging US health coverage environment. The company focuses on the Medicare Advantage, Medicare Supplement, and ACA lines of business. White Pine Actuarial frequently works on projects for software companies, anti-fraud work in the healthcare space, and expert witness work. The company appreciates the challenge of finding solutions for atypical problems companies experience. White Pine Actuarial is headquartered in Austin, TX.

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