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AETNA'S $117.7-MILLION LESSON FOR MA PLANS AND PART D SPONSORS

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On March 11, the U.S. Department of Justice (DOJ) announced that Aetna agreed to pay $117.7 million to resolve False Claims Act (FCA) allegations tied to its Medicare Advantage (MA) diagnosis coding practices.[1] The settlement ranks among the largest MA risk-adjustment resolutions to date and is particularly significant given that DOJ has identified MA risk-adjustment fraud as an aggressive enforcement priority.

The Aetna case turns on two distinct theories of liability. The first involves a 2015 internal chart review program; the second involves morbid obesity diagnosis codes submitted from 2018 through 2023. Both theories carry compliance implications that extend well beyond this case.

There is a third dimension to this case that has received little attention. Recent Food and Drug Administration (FDA) approvals have opened Medicare coverage pathways that will make certain GLP-1 drugs available for obesity-related indications, which began in July 2026.[2] These coverage pathways rely on the same diagnosis infrastructure that DOJ alleged Aetna spent years manipulating.

DOJ's enforcement theories here have real consequences for compliance programs, especially as the coverage of GLP-1s will likely be accompanied by intense scrutiny of obesity diagnosis data across the MA ecosystem.

United States ex rel. Thomas v. Aetna

Under MA, the Centers for Medicare & Medicaid Services (CMS) pays private insurers a fixed monthly amount per enrollee, which can be adjusted upward based enrollees' perceived health status on paper. According to the data, the sicker the patient looks, the more the insurer collects. That payment structure creates an obvious incentive to make patients appear sicker than they actually are. According to DOJ, Aetna acted on that incentive in two distinct ways.

The first involves a chart review program Aetna ran in 2015. Aetna paid outside coders to review patient medical records and identify diagnoses that those records could support. When those reviews found new diagnoses, Aetna submitted them to CMS and collected higher payments.[3] But when those same reviews found that previously submitted codes lacked support, DOJ alleged that Aetna did not make adequate changes. DOJ's position is that Aetna used its own review process to find money while deliberately ignoring what it owed back.

The bulk of the financial settlement is related to this allegation. Aetna agreed to pay $106 million to resolve DOJ's chart-review theory. Notably, the chart review allegations were not part of the qui tam complaint; DOJ appears to have developed that theory through its own investigation and review of CMS data.

The second theory covers payment years 2018 through 2023. According to DOJ, Aetna submitted morbid obesity diagnosis codes for patients whose recorded body mass index (BMI) was inconsistent with that diagnosis. In some cases, the codes appear to have been drawn from patients' problem lists—the running log of diagnoses maintained in an electronic health record—rather than from a current physician assessment. A patient who was once obese or coded as obese remained coded as morbidly obese for years, generating additional payments even if the patient's condition had changed.

This part of the case came to light through a qui tam complaint filed in January 2024 by a former Aetna risk-adjustment coding auditor who will receive over $2 million from the settlement. Aetna did not admit liability. A company spokesperson told *The Wall Street Journal* that Aetna disagreed with DOJ's "industry-wide allegations," meaning Aetna thinks any number of its competitors could be engaging in similar practices.[4] In effect, Aetna is saying everyone is speeding on this highway, and they were the ones stopped and ticketed.

In addition to denying liability, Aetna also declined to enter into a corporate integrity agreement with the U.S. Department of Health and Human Services Office of Inspector General (OIG).[5] These agreements are negotiated compliance oversight arrangements that often accompany large FCA settlements. As a result, OIG reserved the right to exclude Aetna from federal healthcare programs for the alleged conduct and has indicated that Aetna will face heightened scrutiny from the agency for 10 years.

The MA enforcement environment

The Aetna settlement is the latest in a series of large MA risk-adjustment resolutions, and the signals from the government suggest more are coming. For example, DOJ representatives have stated publicly that MA fraud would be a focus of aggressive FCA enforcement efforts. Additionally, during his Senate confirmation hearing, CMS Administrator Mehmet Oz pledged to take direct action against upcoding. That commitment has bipartisan support in Congress; the No Unreasonable Payments, Coding, or Diagnoses for the Elderly Act—also known as the No UPCODE Act, introduced in March 2025—would prohibit MA plans from using diagnoses derived from chart reviews and health risk assessments for risk adjustment purposes.[6] The Congressional Budget Office estimated the bill could save $124 billion over 10 years.[7]

The scale of the problem explains the attention it receives. The Medicare Payment Advisory Commission (MedPAC) estimated that, in 2024, MA coding intensity increased MA risk scores by a net 13% and generated approximately $50 billion in higher payments to MA plans.[8] MedPAC separately estimated that total Medicare payments to MA plans were $83 billion higher than what Medicare would have spent for the same beneficiaries in fee-for-service Medicare, or 22% above fee-for-service spending. CMS has also begun using more current data to calculate risk scores, a technical shift that reflects the agency's concern about stale or unsupported diagnoses. Taken together, these developments describe an enforcement environment with institutional momentum.

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Incomplete or ineffective compliance program as a liability

The chart-review theory in the Aetna settlement warrants particular attention from compliance professionals. DOJ's allegation is that Aetna conducted an internal review, observed results that required repayment to CMS, and chose not to act on them.

The FCA imposes liability not just for knowingly submitting false claims but for knowingly retaining money that should be paid or returned to the government. That obligation is sometimes called the "reverse false claim." According to DOJ, Aetna's chart reviews generated the knowledge, and the company's failure to act on that knowledge converted a coding practice into an FCA violation.

DOJ has long warned against "paper" compliance programs—programs that have been documented but do not meaningfully invest in identifying and remediating potential misconduct. In the FCA context, an incomplete or ineffective compliance scheme can bolster the government's case for scienter, providing proof that the company recklessly disregarded or deliberately ignored compliance risks. As a result, DOJ closely scrutinizes corporate compliance programs both in its investigations and when considering eligibility for cooperation credit and deferred or non-prosecution agreements. An organization that runs chart reviews or health risk assessments and finds unfavorable results but fails to document and act on them has given a potential relator a clear narrative: The company created a process to detect and correct problematic data but used it selectively to its financial advantage.

Compliance professionals running similar review programs should ask three questions:

1. Do your chart review protocols require deletion of unsupported codes, not just identification of new ones?
2. Is there documented supervision of what happens when a review produces an unfavorable finding?
3. Who in your organization sees those findings, and is there a record of what was decided?

A compliance program that captures only favorable results is not a compliance program in any meaningful sense. On the contrary, under DOJ's theory against Aetna, it served as useful evidence against the company.

The GLP-1 coverage wave and what it means for diagnosis data

FDA approval is typically the gateway for broad Medicare Part D coverage. FDA approval of a specific indication is the cleanest predicate for routine coverage; CMS and Part D plans then determine coverage terms and payment.

That sequence matters here because two 2024 FDA approvals opened specific Medicare coverage pathways for GLP-1 drugs that had not previously existed. Novo Nordisk's semaglutide, marketed as Wegovy, received FDA approval on March 8, 2024, for reducing cardiovascular risk in adults with established cardiovascular disease who are also overweight or obese.[9] Eli Lilly's tirzepatide, marketed as Zepbound, received FDA approval on December 20, 2024, for treating moderate to severe obstructive sleep apnea in adults with obesity. Both approvals made those uses eligible for coverage as medically accepted indications under Part D, subject to plan formulary and utilization management.

CMS then went further. In December 2025, it announced two programs to expand GLP-1 access to Medicare beneficiaries for weight loss itself, a use excluded from Medicare coverage under a long-standing statutory prohibition dating to the Medicare Modernization Act of 2003.[10] The first program, the Medicare GLP-1 Bridge, covers Wegovy and Zepbound for weight loss with a $50 monthly copay for eligible Part D enrollees.[11] Per CMS, the Bridge runs from July 1, 2026, through December 31, 2027. Eligibility requires a BMI of 35 or more or a BMI of 27 or more with qualifying comorbidities. A provider must submit prior authorization attesting that the patient meets those clinical criteria. That prior authorization rests on the diagnosis record—the same diagnosis record that has already attracted heightened DOJ scrutiny.

That does not mean a prior MA diagnosis code will automatically determine GLP-1 coverage. Prior authorization will involve current clinical criteria and provider attestation. But provider attestation will not fully answer the compliance question if the MA plan already knows or suspects that its historical obesity data is unreliable. For that reason, the relevant compliance question is not simply whether the patient has an obesity code; it is where the code came from, whether it remains clinically supported, and whether the organization has documented that review.

An estimated 14 million Medicare beneficiaries carry an obesity diagnosis.[12] Unsupported obesity codes submitted during the exact period covered by the Aetna settlement between 2018 and 2023 did not disappear when the risk-adjustment payment was collected. They remain in patient medical records and appear to be legitimate clinical diagnoses. If left uncorrected, they may now function as the documentation basis for drug coverage claims worth hundreds of dollars per patient per month.

What compliance programs can do now

To be clear, no enforcement action has yet connected prior MA obesity upcoding to fraudulent GLP-1 coverage claims, as these programs are new. But the structural conditions for the wave are in place. The financial incentive is substantial, and in this major enforcement action, the diagnosis data underlying these new coverage determinations have been found unreliable. Compliance teams at MA plans should have treated July as a deadline. Auditing the provenance of obesity diagnoses in your patient population before GLP-1 claims begin flowing is the kind of proactive step that separates a compliance program from a liability.

In addition to auditing coding, the Aetna settlement identified two specific practices that generated liability, each with a compliance analog that organizations can examine today. Start with chart reviews and health risk assessments. The Aetna case turned in part on what the organization did with unfavorable findings from its own reviews. Every MA plan running these programs should be able to answer the three previously noted questions.

Morbid obesity coding warrants specific attention. Are submitted obesity codes supported by active physician diagnoses, or are they drawn from historical problem lists? Is BMI documentation in the medical record consistent with the submitted code? These are not complicated questions, but they are almost certainly the ones a DOJ investigator will ask if a relator claims these practices are unreliable.

On the GLP-1 question, the practical step is straightforward: Identify the obesity-coded patients in your population and determine whether those codes were generated through chart reviews or health risk assessments rather than direct clinical encounters. If the documentation does not support the diagnosis, it should have been corrected before July 1. A fraudulent code that generated a risk-adjustment overpayment in 2021 is a problem. The same code generating a GLP-1 drug claim in 2026 is a larger one.

Finally, consider your qui tam exposure. The Aetna case was brought by someone who worked inside the organization, understood the process, and documented what she saw. The question for compliance professionals is whether an employee with similar visibility would have a clear internal path to raise concerns, or whether their first call is to a relator's counsel.

Outside counsel can help assess exposure before a civil investigative demand arrives. Self-disclosure remains available. DOJ has historically treated organizations that come forward proactively more favorably than those identified through a relator or government audit.

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Conclusion

The Aetna settlement is significant for its size. It is more significant for what it describes. DOJ has now put a dollar figure on risk-adjustment practices that it views as capable of generating billions in annual overpayments across the MA program.

The chart review theory puts a heightened focus on a familiar FCA lesson. If operated selectively, an organization's own compliance infrastructure can become evidence

of knowledge, reckless disregard, or deliberate indifference. That is a lesson every compliance professional in the MA space should understand.

The GLP-1 coverage expansion adds a dimension that has received almost no attention. FDA approvals unlocked a Medicare coverage entitlement that launched in July and depends on the accuracy of obesity diagnoses in patients' medical records. Those records were the subject not just of the Aetna settlement but of ongoing enforcement actions across the industry.

But the conditions that create enforcement risk are present. There is a financial incentive, a compromised dataset, and a government payment system that depends on the accuracy of that data. Add in an insider who has no way to air this problem internally or whose warnings are ignored and not rewarded, and compliance programs that treat the Aetna settlement as someone else's problem may find themselves revisiting that judgment.

That is what the Aetna case illustrates. The relator was a coding auditor who understood the process, saw how decisions were made, and filed a federal complaint. She will receive more than $2 million. Aetna will pay $117.7 million. That is real money for any organization, especially those with the wherewithal to correct this problem before the wave crashes on its shore. CT

Endnotes

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Takeaways

- Aetna agreed to pay $117.7 million to resolve Medicare Advantage (MA) risk-adjustment allegations, signaling the continued U.S. Department of Justice's (DOJ) focus on upcoding and diagnosis-based overpayments.
- DOJ alleged Aetna identified unsupported diagnoses through chart reviews but failed to correct them, highlighting "reverse false claim" risks when unfavorable findings are ignored.
- MA plans face increasing scrutiny from DOJ, the Centers for Medicare & Medicaid Services, the U.S. Department of Health and Human Services Office of Inspector General, and Congress over risk-adjustment coding, particularly obesity and chart-review-derived diagnoses.
- Expanded Medicare coverage of GLP-1 drugs beginning in 2026 will rely on obesity diagnoses, increasing compliance risks tied to inaccurate or unsupported coding.
- Compliance programs should audit obesity diagnoses, document corrective actions, strengthen internal reporting channels, and ensure review processes address unfavorable findings as rigorously as favorable ones.