Under Original Medicare (OM), Medicare pays providers a fixed rate for each service rendered to enrollees. Medicare Advantage (MA) has a different structure. Medicare pays MA plans a fixed monthly rate for each enrollee, and the plans pay providers to deliver care. Unlike OM, where payments are service-dependent, MA plans receive the same amount each month, regardless of how much care their enrollees use.

The Centers for Medicare & Medicaid Services (CMS) sets yearly MA payment rates through a complicated series of determinations and adjustments. The process begins with benchmarking, then moves to bidding and applying rebates before arriving at a final payment. As a result of problematic assumptions and calculations along the way, MA plan payments are systemically inflated. In 2023, Medicare will pay MA at least 6% more than OM for similar enrollees, translating to $27 billion in overpayments.

**The Benchmarking Process**

As part of the rate-setting process, CMS determines the maximum monthly payment a plan could receive for providing OM services. This “benchmark” is based on county-level per enrollee spending in OM and may be adjusted to incorporate additional considerations, such as plan service area, MA Star Ratings, and enrollee health status.

To develop MA benchmarks, CMS first calculates how much Medicare spends on OM enrollees in every U.S. county.
Using OM spending as the baseline may inflate MA plan payments. Research suggests people who initially choose OM are sicker and more costly than their MA counterparts, and that MA enrollees disproportionately switch to OM when their health needs and expenses grow. If these trends persist, MA payments will increasingly be based on inaccurate assessments, inappropriately raising MA payments, Medicare costs, and program misalignments.

**County Adjustments**

Based on these OM costs, CMS divides the counties into four categories and adjusts the benchmarks for each to encourage plan participation and enrollee access. For example, CMS increases benchmarks to make less profitable areas more attractive to plans while dialing back elsewhere to promote efficiency.

<table>
<thead>
<tr>
<th>County Category</th>
<th>Benchmark Calculation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Quartile (lowest OM costs)</td>
<td>OM cost + 15%</td>
</tr>
<tr>
<td>2nd Quartile</td>
<td>OM cost + 7.5%</td>
</tr>
<tr>
<td>3rd Quartile</td>
<td>OM cost</td>
</tr>
<tr>
<td>4th Quartile (highest OM costs)</td>
<td>OM cost - 5%</td>
</tr>
</tbody>
</table>

These add-ons can further inflate payment rates. They definitionally guarantee half of all U.S. counties have MA benchmarks above projected OM spending and that the average benchmark is higher than average OM spending. As a result of this approach, about half of MA enrollees live in counties where benchmarks exceed estimated OM costs by 7.5% or 15%.

**Quality Bonus Payments**

The MA Quality Bonus Program (QBP) also raises benchmarks—and thus payments—for certain plans. Under the program, CMS rates plans on a five-star system. The ratings are based on nearly 50 measures that track clinical processes and plan performance. Plans that receive at least four stars get a “bonus” in the form of a 5% benchmark increase. In “double bonus” counties (those with low OM spending and high MA enrollment) highly rated plans get a 10% increase.
<table>
<thead>
<tr>
<th>Plan Rating</th>
<th>Bonus Benchmark</th>
<th>Double Bonus (in qualifying counties)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 4.0</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>4.0 to 5.0</td>
<td>5%</td>
<td>10%</td>
</tr>
</tbody>
</table>

In 2012, quality bonus payments were established to reward plans based on quality and help beneficiaries meaningfully assess plan differences.

Evidence suggests the program is meeting neither objective. Ten years ago, 38% of MA enrollees were in plans with four or five stars. After years of plan gaming, including through contract consolidations that boosted bonus payments and masked underperformance, as well as generous policy choices by CMS, most recently in reaction to the COVID-19 emergency, this number reached a high of 90% in 2022 before settling at 72% in 2023. However, it is unclear if the surge in highly rated—and highly paid—plans is due to meaningful quality improvements or a Star Ratings system that is inaccurate, ineffective, and easily manipulated.

Although the QBPs relationship to plan quality is questionable, its effect on Medicare costs is not. Over the last seven years, the program has paid out nearly $50 billion in bonuses. These payments have increased exponentially, from $3 billion in 2015 to $12 billion in 2021. Since unlike other quality programs the QBP is not required to be budget-neutral, its potential to generate extra plan dollars, and Medicare costs, is limitless.

**Standard Benchmark**

After making these adjustments, CMS arrives at the standard benchmark for every county.

According to the Medicare Payment Advisory Commission (MedPAC), MA standard benchmarks in 2023 averaged 109% of projected OM spending.

**Risk Score**

CMS then upwardly adjusts the benchmark calculation based on health risk, paying plans more for higher-cost enrollees.
Intended to predict and cover plan expenses more accurately and mitigate plan incentives to enroll only healthy beneficiaries, risk adjustment instead encourages plans to maximize documentation of sicker, older enrollees. If a plan can increase its risk score, it can increase its Medicare payment. This practice is called “upcoding” and it regularly leads to substantial MA overpayments, potentially costing Medicare an extra $600 billion over the next decade. Although CMS is statutorily required to lower plan risk scores by a minimum amount each year, this base rate (5.9%) has been unchanged since 2018 and is not keeping pace with MA coding practices. MedPAC estimates that in 2021, risk scores for MA enrollees were 11% higher than they should have been, inflating MA payments by $17 billion and clearly exposing the inadequacy of a 5.9% adjustment.

**Risk-Adjusted Benchmark (RAB)**

After all these factors—OM costs, county adjustments, quality bonuses, and risk scores—are combined, CMS finally arrives at a plan-specific risk-adjusted benchmark (RAB). This is the maximum payment an MA plan can receive.

Because of the inflationary flaws within each of its components, the benchmark sharply diverges from the OM costs it is meant to reflect; it sets the MA payment floor too high. The upshot is that Medicare has overpaid MA plans relative to OM every year since 2003, when the current payment system was established.

**Using the Benchmark to Determine Plan Payment**

**Bidding**

With the benchmark in mind, MA plans then submit bids to CMS. The bid is meant to represent how much money the plan estimates it will need to cover Part A and B benefits for the average enrollee in the coming year, including administrative costs and profits. The relationship between the bid and the relevant RAB largely determines the plan’s monthly payment:

- A plan bidding at or above the RAB receives a per-enrollee payment equal to the benchmark. Enrollees must make up the difference, if any, through higher premiums.

- When a plan bids below the RAB, it receives the bid amount plus a share of the difference in the form of a rebate. Plans must generally use these dollars to provide additional services or lower enrollee costs.
### Rebates

The cost and coverage enhancements that MA plans must spend their rebates on can include lower cost sharing, reduced premiums, and supplemental benefits like dental coverage. However, plans may keep some rebates from quality bonus payments to cover administrative expenses and as profit. Historically, plans invested most of their enrollee-facing rebate dollars in lowering member costs. But allocations for additional benefits are growing.

<table>
<thead>
<tr>
<th>Plan Bid</th>
<th>Base Payment</th>
<th>Rebate (% of difference)</th>
<th>MA Premium?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Above the RAB</td>
<td>RAB</td>
<td>0%</td>
<td>Required</td>
</tr>
<tr>
<td>At the RAB</td>
<td>RAB</td>
<td>0%</td>
<td>Not required</td>
</tr>
<tr>
<td>Under the RAB</td>
<td>Bid</td>
<td>50-70% (average 65%)</td>
<td>Not required</td>
</tr>
</tbody>
</table>

Since the MA payment methodology yields inflated benchmarks, most plans can and do comfortably bid significantly below these targets and receive unnecessarily generous rebates in return, dollars they use to fund attractive supplemental benefits that drive enrollment and overpayment.

MA bids are historically low relative to OM spending, but benchmarks remain well above the OM threshold. This gap is widening each year: In 2017, benchmarks were 106% of OM spending and the average plan bid was 90%. By 2023, OM payments had grown to 109% while bids had fallen to 83%.

Rebate amounts range from 50% to 70% of the difference between the plan’s bid and the RAB, depending on the plan’s Star Rating—higher stars result in higher rebates. In 2021, as in prior years, the average rebate was near the top of this range, around 65%.

Under this approach, Star Ratings increase already inflated plan rebates, worsening the problem of MA overpayment. Further, allowing Star Ratings to affect both QBP and rebate payments gives the program disproportionate influence, adding to plan gaming incentives and questions about the system’s quality measurement capabilities.
Conclusion

The plan payments that emerge from the benchmark and bidding processes are meant to reflect OM spending and lower Medicare costs, but the payments fall short on both counts.\textsuperscript{xxiii} As shown above, much of this is by design.

This methodology has consequences. Per person, Medicare spending is higher and growing faster for MA beneficiaries than for those with OM.\textsuperscript{xxiv} The resulting overpayments reward insurers with greater profits but penalize all beneficiaries through higher Part B premiums and taxpayers through increased costs. Absent correction, these impacts will only deepen.

Although MA was intended to reduce Medicare expenditures through competition and efficiencies, its formula—premised on flawed assumptions and misalignments that fuel inaccurate overpayments at every turn—prevents any savings from accruing.


\textsuperscript{vi} Id.


Id.


