



Benchmark Reform in Medicare Advantage

Jeremy Nighohossian

Executive Summary

Government-run healthcare programs, by their nature, incorporate flawed incentives into their design. Medicare is beset with price controls, payment policies, and incentives that make it wasteful and even counter-productive. Consequently, numerous reforms are available that would both save taxpayer money and reduce market distortions. Given the multitude of options, reforms should endeavor to achieve both.

Medicare Advantage (MA) is a market-based option built within Medicare that, ideally, reduces both costs and distortions. However, because MA operates *within* the larger government framework and competes with the much more heavily regulated Original Medicare, it sometimes leads to results counter to policymakers' intent and the public's interest. As a result, policymakers have instituted a series of modifications and reforms that introduce further distortions into the system without addressing the targeted problems.

This brief lays out three potential reforms that would save taxpayers \$100 billion over ten years while also making the program less complex and more market driven.

- *Discontinue quality bonus payments.*
The Quality Bonus Program raises payments for plans depending on a government-determined quality rating. Ratings should be replaced with consumer-driven ratings as determined by market share.
- *Eliminate benchmark quartiles.*
Benchmarks are currently scaled up or down depending on the relative costs of Medicare beneficiaries in a given county: Counties with a higher average cost have their benchmarks scaled down; counties with lower average costs have their benchmarks scaled up. On net, these adjustments raise costs and also cause additional distortions. Modifying those adjustments could save \$119 billion. Removing them entirely could save \$203 billion.

- *Cut rebate levels across the board.*
Plan enrollees currently receive about 65 percent of the difference between the plans' costs and the benchmark in the form of enrollee benefits. Research suggests that rebates could be reduced without significantly harming MA enrollment. A reduction sufficient to save \$100 billion would reduce rebates by less than \$25 per month and affect enrollment only negligibly.

Taken together, these reforms represent an opportunity to make MA more straightforward and increase market-based discipline on plan payments while lowering costs to taxpayers.

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BACKGROUND

The system by which Medicare Advantage plans are paid is a patchwork of programs and corrections that have been added sporadically over the decades since the program's inception. Each piece was an attempt to reduce the inherent differences between a top-down, government-administered program and a bottom-up, market-driven program. Policymakers have been determined to design a system in which two fundamentally different approaches to insurance are equal across several dimensions.

PAYMENTS IN ORIGINAL MEDICARE

In the beginning, there was traditional, fee-for-service (FFS) Medicare. It encompassed hospital services (Part A) and outpatient

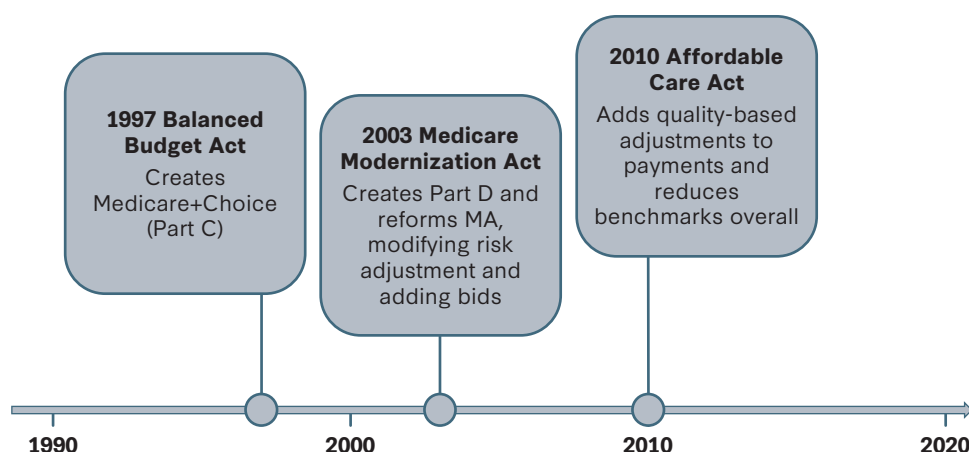
and physician services (Part B). Its payment structure has changed over the years. Starting in 1984, hospitals were paid according to diagnosis-related groupings (DRGs; Part A). In the 1990s, relative value units became the determining factor for paying physicians (Part B). Both are government-created accounting and allocation systems that determined a "price" for healthcare services that beneficiaries received.

Hospitals report the costs associated with caring for Medicare beneficiaries in annual cost reports to the Centers for Medicare and Medicaid Services (CMS), which determines overall spending for hospital reimbursements. Those total costs are then divided among the DRGs according to their resource intensity. Overall spending on outpatient and physician services is determined by congressional statute.

PAYMENTS IN MEDICARE ADVANTAGE

When Medicare+Choice (which later became Medicare Advantage) was created in 1997, the basic objective was to make private plans a viable alternative to traditional Medicare without systematically paying more. Policymakers then needed a way to determine how much Medicare should pay private plans. Broadly, payments were tied to the cost of covering comparable beneficiaries in traditional Medicare, with adjustments intended to account for differences in beneficiary characteristics and local costs. The major legislation related to MA and its payment structures can be seen in figure 1.

FIGURE 1 Major legislation related to Medicare Advantage



In a system where a private offering is competing with a public one, a payment system must meet three goals:

- Beneficiaries must have an incentive to switch to lower-cost private plans.
- Private plans must be able to afford to treat their enrollees.
- Taxpayers must not pay any more for the enrollees in private plans than they do for those who stay in traditional Medicare.

To achieve all three goals, Congress effectively defined the *benchmark*, the amount that traditional Medicare paid for a beneficiary, as the average cost, with adjustments for local demographic and geographic characteristics. Private plans would be paid according to that benchmark. Under this mechanism, and with private plans representing a minuscule proportion of total beneficiaries, private plans would have costs similar to those of traditional Medicare.

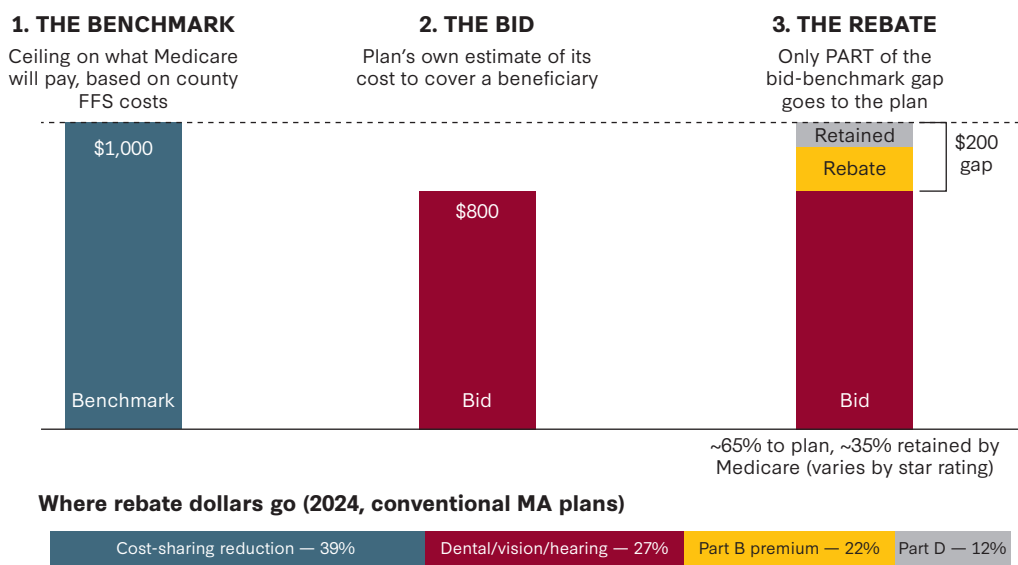
However, policymakers became concerned that private plans were attracting enrollees who cost less than the average traditional Medicare beneficiary.¹ This problem is called *favorable selection*. Tying plan payments to the cost of the average FFS beneficiary, when the enrollees the private plans covered are less costly than average, raises the overall costs of Medicare.

To address this problem, policymakers instituted risk adjustments based on the health of the enrollees. Risk adjustments are intended to reduce the financial advantage from favorable selection but also tend to make it more difficult for the plans to methodically appeal to the relatively less costly beneficiaries.

The Bid System

With the 2003 Medicare Modernization Act, the payment system was modified to infuse additional market dynamics by requiring private plans to bid to participate in Medicare Advantage. The elements of the MA bidding system are portrayed in figure 2. The bid was

FIGURE 2 The Medicare Advantage payment system with bidding by plans



Notes: The benchmark, bid, and rebate columns represent the author's illustration of how the payment system works. Numbers are examples.

Source: The distribution of dollars bar chart is sourced from Medicare Payment Advisory Commission (MedPAC), "Supplemental Benefits in Medicare Advantage," chap. 2 in *Report to the Congress: Medicare and the Health Care Delivery System* (June 2025), <https://www.medpac.gov/document/june-2025-report-to-the-congress-medicare-and-the-health-care-delivery-system>.

the plan's expected cost of covering the average enrollee for that plan, after adjusting for risk factors. For example, if a plan expected the risk-adjusted average enrollee to cost \$1,000 per year in healthcare services, they would submit that figure to CMS.

CMS's payment to the plan would be calculated primarily based on that bid and the benchmark. If the bid was above the benchmark, Medicare would pay the plan the benchmark, and the plan or the enrollees would have to make up the difference. This prevented Medicare from paying more for these MA beneficiaries.

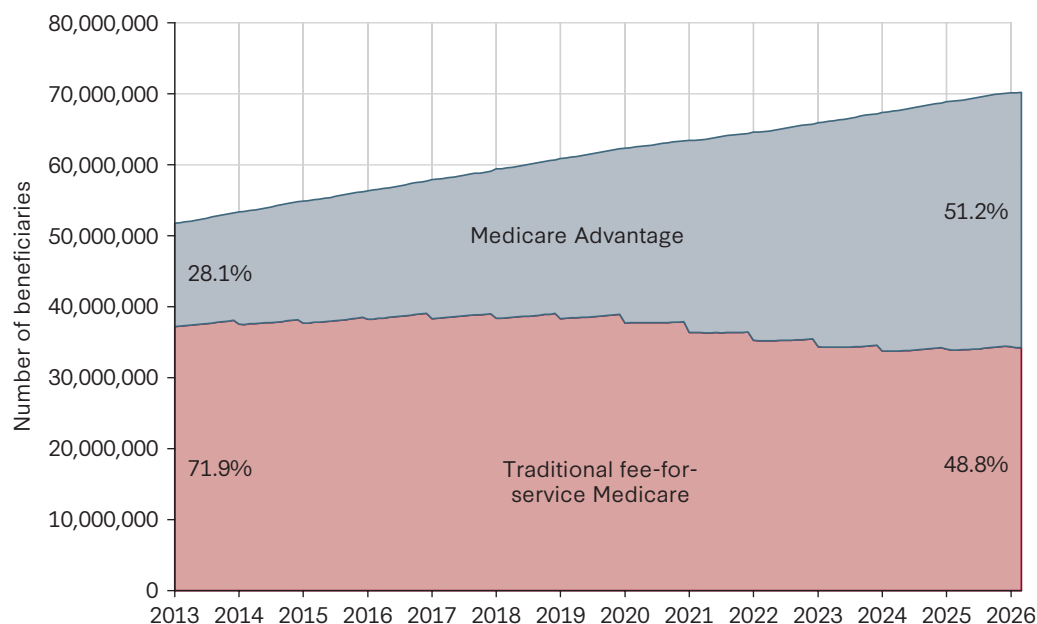
If the plan bid below the benchmark, however, the difference would be split. Part of the

difference would go to the plan as a "rebate." And the remainder would accrue to taxpayers/Medicare. By law, the rebate had to go to supplemental benefits or reduce cost sharing or premiums for the enrollee, not cover the plan's medical costs. Rebates often were used to cover the enrollee's Part B premiums, which every Medicare beneficiary must pay whether they are in MA or Original Medicare, and Part D premiums, which covered prescription drugs. Originally, the rebate was set at 75 percent of the difference between the bid and the benchmark.

Affordable Care Act Reforms

During the 2000s, Medicare Advantage continued to grow. As part of the 2010

FIGURE 3 Enrollment in Medicare and Medicare Advantage, 2013–2026



Source: Medicare Payment Advisory Commission (MedPAC), *A Data Book: Health Care Spending and the Medicare Program* (July 2026), https://www.medpac.gov/wp-content/uploads/2026/07/July2026_MedPAC_DataBook_SEC.pdf.

Affordable Care Act (ACA), the benchmarks were reformed considerably.

Several major changes involved the rating system, which CMS had developed after the 2003 Medicare Modernization Act. The ACA reduced the size of the rebates from 75 percent for all plans. Now plans would receive 50 percent, 65 percent, or 70 percent depending on the plan's rating. The ACA also instituted the Quality Bonus Program (QBP) in which higher-rated plans would see their benchmarks increased.²

The benchmarks were modified in a second way as well, based on Medicare beneficiary costs. The ACA created a benchmark-scaling

system in which benchmarks were scaled up or down based on average costs in the county the plan served. Counties with lower average costs in traditional Medicare saw their benchmarks scaled up to attract more plans. Counties with higher average costs saw their benchmarks scaled down. On the whole, though, the adjustments increased benchmarks for counties.³

After the reforms, Medicare Advantage grew even more, as seen in figure 3. In 2011, enrollees in MA represented 26 percent of all Medicare beneficiaries, but by 2026, more people were enrolled in MA than in traditional Medicare.

REFORMS

The goal of any reform should be to minimize distortion and maximize market-based operation of the system, without increasing the potential for abuse and wasteful spending. In this case, *market-based* means that consumers choose plans freely and are incentivized to choose plans that offer the best value, while plans are incentivized to attract consumers by providing low-cost, high-quality coverage. Because this program is run by the government, reforms should also be careful to avoid subsidizing wasteful spending by any of the actors.

Reform of Medicare Advantage is additionally complicated because it comprises two fundamentally different systems that somehow need to be comparable. Private plans try to control costs by minimizing unnecessary care, while traditional Medicare is much less restrictive, both in provider choice and in the services it covers. Therefore, enrollees in these two systems are difficult to compare, and whether one “pays more” than the other is challenging to discern.

The reforms that follow meet all the goals because they both remove complexity from the system and reduce overdesign while maintaining incentives.

ELIMINATE THE QUALITY BONUS PROGRAM

As part of the ACA, benchmarks are increased for plans that receive four- or five-star ratings from CMS. These ratings are based on a range of measures that are meant

to capture clinical quality, enrollee experience, and customer service. However, these criteria are bureaucratic and top-down, not consumer driven, and they are arguably unnecessary. Research finds that the star ratings do not measure what matters the most to enrollees and do not improve quality.⁴ While the government can remain free to rate plans according to its criteria, the rating that matters more is the number of consumers who choose the plans (or decide to exit them). Additional ratings systems are unnecessary.

Paragon Health Institute estimated that ending the Quality Bonus Program would save \$170 billion over ten years.⁵ MedPAC estimated that the QBP costs \$16 billion per year.⁶

ELIMINATE THE QUARTILE SYSTEM

Also as part of the ACA, benchmarks are scaled up or down depending on whether the county is a low-cost or a high-cost county. Counties with average FFS Medicare costs in the bottom 25 percent have their benchmarks set at 115 percent of FFS spending, which correspondingly increases the rebates paid to plans. Counties that fall between the 25th and 50th percentiles have benchmarks set at 107.5 percent. The third quartile receives neither an increase nor a decrease, and the highest-cost counties—those in the top quartile—receive benchmarks reduced by 5 percent.

The intent was to encourage more plans to compete for enrollees in low-cost counties, but because the benchmark increases are larger than the decreases, the overall result is an upward-adjusted benchmark.

This approach also ignores several important factors. For one, costs may vary between areas for economic reasons that apply to private plans as well, which the adjustments don't capture. For example, a county's population may be healthier in ways not accounted for in the risk adjustment. If so, scaling the benchmarks may just raise overall costs, reduce plan competition, or create other adverse consequences.

Second, the incentives are arguably backward. Some might argue that high-cost counties need higher benchmarks to promote competition and lower costs and that low-cost counties have less room for cost containment and might require fewer plans to compete to reach the point of diminishing returns.⁷

Third, there is also the issue of quartile "cliffs." For counties that are near any of the cutoff points—25th percentile, 50th percentile, etc.—uncontrollable variations in FFS beneficiaries can move them from one quartile to another and create drastic changes in the benchmarks.⁸ The abrupt change of quartile is particularly problematic for counties that jump into a higher quartile and abruptly see a much

lower benchmark. The plan then has to determine how to adjust its premium rebates and supplemental benefits. Plans likely understand this risk and build it into their bids and payments prospectively, raising costs all around.

In 2021, MedPAC estimated that overhauling the benchmark quartile system and replacing it with a more uniform benchmark 2 percent below FFS costs would save about \$10 billion to \$12 billion per year. Given the growth in Medicare and Medicare Advantage, that would be closer to \$20 billion per year today.⁹

Using more recent data, fully eliminating the quartile program would likely save about \$203 billion over ten years. A smaller reform, one that shifted the benchmarks slightly so they average out to 100 percent instead of 104.75 percent, would save \$244 billion.

Table 1 shows the savings from different modifications of the quartile system. The "flat" scenario removes the quartile system entirely. The second scenario reduces the benchmark bonuses so they are centered around 100 percent. The final scenario,

TABLE 1 SAVINGS FROM MODIFICATIONS TO THE QUARTILE BENCHMARK SYSTEM

Quartile scaling scenario	Scaling factor				10-year savings
	High-cost quartile	Second quartile	Third quartile	Low-cost quartile	
Flat	100%	100%	100%	100%	\$203B
Centered around 100%	90.6%	95.4%	102.5%	109.7%	\$244B
Narrowed	95%	100%	105%	107.5%	\$119B

Source: Author's calculations.

“narrowed,” gives the less costly counties smaller benchmark bonuses than today.

ACROSS-THE-BOARD REBATE CUT

Rebates are essential to the system because they serve as the primary financial incentive for beneficiaries to choose MA plans. Because rebates get larger as the bids shrink (i.e., as plans reduce costs), beneficiaries’ incentives to choose plans correspond to lower costs.

Prior to the ACA, the rebate was set at 75 percent of the difference between the bid and the benchmark. As mentioned above, the ACA called for rebates to be either 50 percent, 65 percent, or 70 percent, depending on the plan’s star rating. As of 2026, the average rebate was 65 percent. In dollar terms, this amounts to \$218 per member per month in 2026.¹⁰

However, arguably, the incentive to beneficiaries would be sufficient if rebate levels were 50 percent or 40 percent. Presumably, the government could reduce rebate levels without significantly harming overall enrollment. In fact, there is likely a level at which rebates can be set that reduces total costs to taxpayers, accounting for the payments themselves, effects on enrollment, and the incentives for plans to reduce costs.

While that point is not known, and is probably not knowable, research has examined how the rebates relate to penetration, or the share of eligible Medicare beneficiaries enrolled in Medicare Advantage. In a 2014 study, researchers determined that a \$10 per member per month reduction in rebates

reduced overall penetration by 0.2 percentage points.¹¹

Using this finding, we can determine what rebate reduction will save \$100 billion over ten years, while accounting for the loss in enrollment. That figure is \$22.72 per member per month.¹² Currently, the average rebate is \$218 per member per month. So the reduction would be 10.4 percent of the rebate. Such a change would reduce the overall rebate percentage from 65 percent to 59 percent with minimal effect on penetration or the generosity of the enrollee benefits.¹³

CONCLUSION

Medicare Advantage was designed to let private plans compete on cost and quality while ensuring that taxpayers pay no more than they would under traditional Medicare. Over nearly three decades, that original design has been overtaken by a series of corrections—including risk adjustment, competitive bidding, geographic scaling, and quality bonuses—that each responded to real problems but that, together, have made the system unwieldy.

The reforms outlined in this brief share a common thread: Each would remove administrative complexity and use simpler, market-driven incentives. They represent a meaningful opportunity to reduce MA’s complexity and cost without abandoning the program’s basic premise: that private plans, competing on a level playing field with clear rules, can deliver better value than a government-designed program.

NOTES

1. Jason Brown, Mark Duggan, Ilyana Kuziemko, and William Woolston, "How Does Risk Selection Respond to Risk Adjustment? New Evidence from the Medicare Advantage Program," *American Economic Review* 104, no. 10 (2014): 3335–64, <https://www.aeaweb.org/articles?id=10.1257%2Faer.104.10.3335>.
2. The Quality Bonus Program, created by the ACA, raises benchmarks (and therefore rebates) for plans rated four stars or higher.
3. Prior to the ACA, it should be noted, many counties saw benchmarks that were more than 120 percent of average fee-for-service costs. The ACA reform was designed to solve that problem.
4. Adam A. Markovitz, John Z. Ayanian, Devraj Sukul, and Andrew M. Ryan, "The Medicare Advantage Quality Bonus Program Has Not Improved Plan Quality," *Health Affairs* 40, no. 12 (2021): 1918–25, <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2021.00606>.
5. Joe Albanese, *Improving Medicare Through Medicare Advantage*, Paragon Health Institute (February 2024), <https://paragoninstitute.org/medicare/improving-medicare-through-medicare-advantage>.
6. Medicare Payment Advisory Commission (MedPAC), *Report to the Congress: Medicare Payment Policy* (March 2026), https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_MedPAC_Report_To_Congress_SEC.pdf.
7. Medicare Payment Advisory Commission (MedPAC), "Rebalancing Medicare Advantage Benchmark Policy," chap. 1 in *Report to the Congress: Medicare and the Health Care Delivery System* (June 2021), <https://www.medpac.gov/document/june-2021-report-to-the-congress-medicare-and-the-health-care-delivery-system/>.
8. MedPAC, *Report to the Congress: Medicare Payment Policy*.
9. MedPAC, "Rebalancing Medicare Advantage."
10. Medicare Payment Advisory Commission (MedPAC), "Medicare Advantage," chap. 9 in *A Data Book: Health Care Spending and the Medicare Program* (July 2026), <https://www.medpac.gov/document/july-2026-data-book-health-care-spending-and-the-medicare-program/>.
11. Lauren Hersch Nicholas, "Will Medicare Advantage Payment Reforms Impact Plan Rebates and Enrollment?," *American Journal of Managed Care* 20, no. 11 (2014): 917–24, <https://www.ajmc.com/view/will-medicare-advantage-payment-reforms-impact-plan-rebates-and-enrollment>.
12. Estimate based on author's calculations, which use current enrollment, penetration, and per member per month (PMPM, the standard unit for measuring MA capitated payments) amounts and are adjusted for inflation since the paper was published (see note 12). The author also conducted a similar analysis using more recent rebate data, which generated similar estimates.
13. Michael E. Chernew, Keaton Miller, Amil Petrin, and Robert J. Town, "Reducing Medicare Advantage Benchmarks Will Decrease Plan Generosity, but Those Effects Will Likely Be Modest," *Health Affairs* 42, no. 4 (2023): 479–87, <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2022.01031>.



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Preferred citation: Jeremy Nighohossian, "Benchmark Reform in Medicare Advantage," Healthcare Policy Working Group, Hoover Institution, October 2026.

ABOUT THE AUTHOR



JEREMY NIGHOHOSSIAN

Jeremy Nighohossian, PhD, is a senior fellow and economist at the Competitive Enterprise Institute, where he studies healthcare competition, antitrust, and federal and state reimbursement policy. He previously worked at FTI Consulting's Center for Healthcare Economics and Policy, specializing in healthcare antitrust and disputes. He holds a doctorate in economics from Texas A&M University and a chemical engineering degree from the University of Illinois.

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**Hoover Institution
Stanford University**
434 Galvez Mall
Stanford, CA 94305-6003
650-723-1754

**Hoover Institution
in Washington**
1399 New York Ave. NW, Ste. 500
Washington, DC 20005
202-760-3200

**Hoover Institution
in Texas**
3889 Maple Ave., Ste. 600
Dallas, TX 75219
hoovertexas@stanford.edu

