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"Medicare Advantage: Past Lessons, Present Insights, Future Opportunities"

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Chairmen Buchanan, Schweikert, and Smith, Ranking Members Doggett, Sewell, and Neal, and members of the subcommittees, thank you for inviting me here today to discuss the present and future of Medicare Advantage (MA). My name is Matthew Fiedler, and I am a health economist and the Joseph A. Pechman Senior Fellow in Economic Studies at the Brookings Institution.[1]

My testimony makes five main points:

- **Covering a beneficiary under MA costs an estimated 20% more than covering the same person under traditional Medicare, generating $84 billion in additional payments in 2025.** Most of these additional costs are financed by taxpayers, but around 15% (roughly $13 billion) is financed via higher Part B premiums. Those higher premiums apply to all Medicare beneficiaries, not just beneficiaries who are enrolled in MA.

  MA plans are paid more mostly because of problems with the program's risk adjustment system. Risk adjustment aims to align payments to plans with their enrollees' health care needs, as predicted by their health conditions and other characteristics. However, the current system overstates the needs of MA enrollees because MA plans report more diagnoses for their enrollees than would be reported for the same enrollees if they were enrolled in traditional Medicare, where there is typically much less incentive to record additional diagnoses; this makes MA enrollees look more costly than they actually are. MA plans also attract beneficiaries who, on average, need less care than the risk adjustment model predicts based on their diagnoses, a phenomenon called "favorable selection."

- **Paying an MA plan an additional dollar delivers much less than a dollar of value to enrollees.** Research finds that when policymakers increase the benchmarks used to determine payments to MA plans, insurers respond by raising the prices they charge to deliver the base Medicare benefit. As a result, only part of the resulting increase in payments to plans (evidence suggests about 50 cents) finances extra benefits, such as reduced premiums, reduced cost-sharing, or coverage for services that Medicare does not cover (e.g., dental services). It is unclear how insurers use the amounts that are not passed through to beneficiaries, but at least part is likely captured as profits or spent on marketing.

- **Reforming MA payment could free up resources to meet other needs, allow policymakers to enhance Medicare's benefits, or both.** Because so much money paid to MA plans does not generate value for beneficiaries, reforming those payments could offer

[1] The views expressed in this testimony are my own and should not be attributed to the staff, officers, or trustees of the Brookings Institution.

policymakers a range of potentially appealing options. For example, the savings could finance a substantial increase in the overall value of Medicare benefits without a net increase in program costs. They could also be used to reduce the deficit or invest in other priorities. Or policymakers could take a middle path: increase Medicare's generosity to some degree while still reserving some savings to meet other needs.

- **A sensible goal for MA payment reform would be to align payments to MA plans with the cost of covering comparable enrollees under traditional Medicare.** Under such a system, beneficiaries would tend to choose MA in cases where MA could offer better coverage at the same cost and remain in traditional Medicare otherwise. This would maximize the quality of the coverage beneficiaries received for a given federal outlay.

  To achieve this goal, the most important step would be to fix the MA program's broken risk adjustment system. Doing so would require multiple reforms, but one worthwhile step would be for lawmakers to more clearly specify the methodology that the Centers for Medicare and Medicaid Services (CMS) should use to calculate the "coding intensity adjustment" used to offset MA plans' more intensive diagnosis coding; this adjustment is currently much too small. Lawmakers could also direct CMS to create a parallel adjustment aimed at favorable selection. Fully aligning MA payments with traditional Medicare costs would also require reforms to the program's underlying benchmark formula.

- **The opportunities presented by MA payment reform show that it is possible to sharply reduce federal health care spending without increasing uninsurance.** Congress recently passed legislation expected to cut spending on Medicaid and the Marketplaces by around $1 trillion over a decade and increase the number of uninsured by more than 10 million people. By contrast, MA reform could generate hundreds of billions of dollars in savings over ten years without increasing uninsurance and while maintaining the overall generosity of the Medicare program. And MA reform is far from the only option for generating substantial health care savings without compromising access to care.

The remainder of my testimony examines these points in greater detail.

How much does the federal government pay Medicare Advantage plans?

The federal government determines payments to MA plans using a three-step bidding process. First, it establishes "benchmark" payment amounts that equal a percentage of the expected cost to cover an average-risk traditional Medicare (TM) beneficiary in each county.[2] The percentage varies based on the level of TM spending in a county and a plan's quality performance.

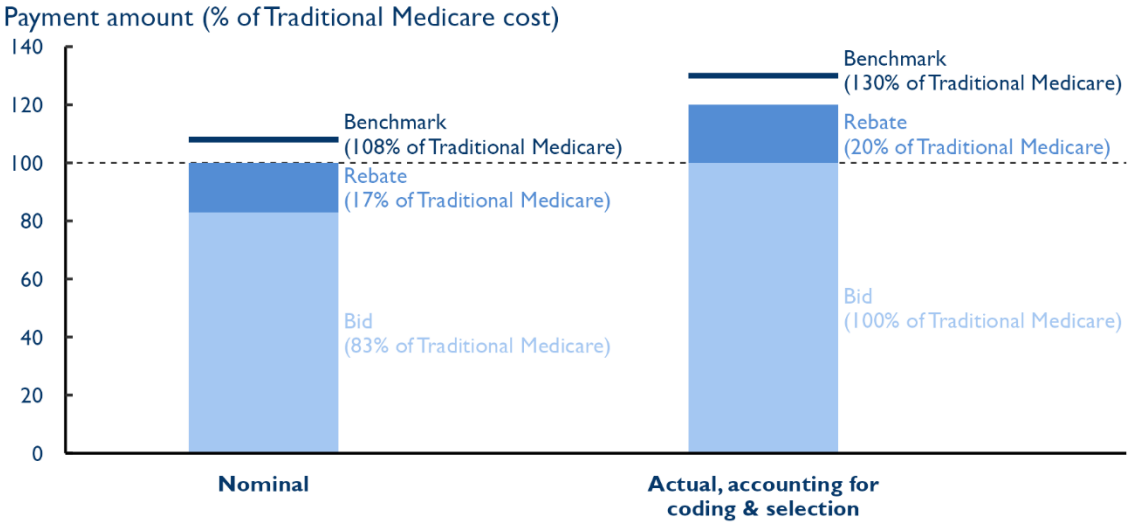
Next, insurers submit "bids" to CMS that represent the prices they will charge to deliver the TM benefit package. When the bid is below the benchmark (as is almost always the case in practice), the plan is then paid its bid plus a "rebate" equal to a portion of the difference between the bid and the benchmark.[3] Insurers are required to use the rebate to offer benefits beyond those offered in TM, such as lower cost-sharing, lower premiums, or coverage for additional services.

[2] Benchmarks are subject to a cap equal to the greater of: (1) traditional Medicare spending in the area; and (2) an amount based on the benchmark in effect under the rules used before enactment of the Affordable Care Act.

[3] In other cases, CMS pays the plan the benchmark amount, and enrollees pay the excess as an additional premium.

Importantly, payments to MA plans are then "risk-adjusted" to account for differences between MA enrollees and the average TM enrollee reflected in payment benchmarks. To do so, CMS uses information on each enrollee's health conditions and other characteristics to calculate a "risk score" for the enrollee that represents the expected (relative) cost of covering that enrollee. Payments to each MA plan are then adjusted upward or downward based on how the average risk score of the plan's enrollees compares to the average risk score in TM.

Figure 1. Medicare Advantage Plan Payments, 2025



Source: MedPAC (2025)

As shown in Figure 1, this system nominally pays MA plans roughly at parity with TM. In reality, however, risk adjustment overstates the expected cost of MA enrollees, which pushes payments to MA plans well above TM levels. The risk adjustment system faces two main challenges:

1. *Intensive diagnosis coding by MA plans:* To calculate risk scores for MA enrollees, CMS relies on enrollee diagnosis data submitted by MA insurers themselves. Insurers have strong incentives to increase how many diagnoses they report to CMS, and they use a range of strategies to do so, including encouraging providers to report more diagnoses on claims, reviewing enrollee medical records to identify diagnoses, and encouraging enrollees to undergo health assessments that document diagnoses (MedPAC 2024).

   MedPAC (2025) estimates that because of these efforts, a given enrollee is assigned a risk score 10% higher when enrolled in MA rather than TM (even after netting out the "coding intensity" adjustment that CMS makes to MA risk scores). Other research using different methods similarly concludes that an identical beneficiary is assigned a much higher risk score when enrolled in MA rather than TM (e.g., Geruso and Layton 2020)

2. *Favorable selection into MA:* Many factors that influence enrollees' health care spending are not captured in risk scores, so some enrollees end up spending more than predicted by their risk scores, while others spend less. In practice, people who turn out to have lower-than-predicted spending are more likely to choose MA than TM, a phenomenon commonly referred to as "favorable selection." This may be at least partly because enrollees who need less care are more willing to tolerate the narrower networks and tighter utilization controls present in MA relative to TM (Graves et al. 2020; Ochieng et al. 2023).

MedPAC (2025) estimates that favorable selection of enrollees into MA causes the risk adjustment system to overstate the expected cost of MA enrollees by 11%. Once again, other research, including research using different methods, has also found that MA enrollees are strongly favorably selected (e.g., Curto et al. 2019; Lieberman et al. 2023).

The right side of Figure 1 illustrates how the MA payment system works after accounting for these shortcomings of the program's risk adjustment system. Benchmarks are set at around 130% of TM costs, while insurer bids average approximately 100% of TM costs. As a consequence, total payments to MA plans—including rebate payments—exceed TM costs by 20%. This 20% differential equates to an estimated $84 billion in additional payments in 2025.

Most of this amount is financed by taxpayers. However, a portion is financed via higher Part B premiums. Part B premiums are set to cover 25% of Part B costs, and Part B currently accounts for around 61% of total payments to MA plans according to the 2025 Medicare Trustees Report. This implies that roughly 15% of the additional payments are financed via premiums, amounting to around $13 billion in 2025. Notably, these higher premiums apply to all Medicare beneficiaries, not just beneficiaries enrolled in MA. Part B premiums are typically paid by beneficiaries directly but are sometimes paid by an employer or by Medicaid on a beneficiary's behalf.

How much value do payments to Medicare Advantage plans generate for beneficiaries?
One important question is how much value these additional payments generate for MA enrollees. Evidence suggests that, at least at the margin, paying an additional dollar to an MA plan delivers much less than a dollar of value to the Medicare beneficiaries enrolled in MA.

Research finds that when the federal government raises MA payment benchmarks, insurers increase their bids, thereby increasing what insurers are paid to deliver the base Medicare benefit. Based on this evidence, I estimate that of each additional dollar the federal government pays to MA plans, only around 50 cents of that dollar finances additional benefits, with the remainder reflecting higher prices for delivering the base benefit. An appendix provides additional details.

The next question is how much value that spending on additional benefits produces for enrollees. In principle, this amount could be higher or lower than 50 cents. However, when examining the post-2010 period, Pelech and Song (2025) estimate that lower premiums or cost-sharing account for almost all of the benefits plans add when benchmarks rise; Chernew et al. (2023) find something similar. This suggests that the 50 cents that plans spend on additional benefits when the MA benchmarks rise likely generates around 50 cents of value for enrollees.[4]

If only 50 cents of each additional dollar paid to MA plans is spent on additional benefits, a natural question is where the other 50 cents end up. While evidence on this question is incomplete, some may be captured by insurers as higher profits. Some may also be dissipated through higher

[4] In particular, 50 cents of lower premiums and cost-sharing is unlikely to be worth much *less* than 50 cents to beneficiaries (with the caveat being that some funds allocated to reduced cost-sharing likely reflects increases in utilization, administrative costs, or plan profits that enrollees may value at less than their cost). In principle, funds allocated to reducing cost-sharing could generate *more* than a dollar of benefit to enrollees per dollar spent by reducing enrollees' exposure to financial risk or increasing utilization of high-value care. However, the fact that plans devote some of the additional funds to lower premiums suggests that plans do not see such opportunities; if they did, they would likely seize them to better compete for enrollees. While plans might shy away from offering benefits that they fear would lead them to attract high-risk enrollees or that enrollees undervalue (e.g., Abaluck and Gruber 2011; Stockley et al. 2014), it is not clear that these considerations are important here.

marketing spending—such as higher broker commissions—as plans compete more intensively for now-more-lucrative enrollees (Duggan et al. 2016). In principle, a plan could use some to improve the base Medicare benefit, such as by broadening networks or relaxing utilization controls, which could have benefits for enrollees. However, Duggan et al. (2016) look carefully for effects in this vein and find no evidence that these higher payments translate into higher utilization, greater enrollee satisfaction, or improvements in self-reported health status, which suggests that any changes in this vein that do occur are likely generating relatively little value for enrollees.

The potential of Medicare Advantage payment reform

Paying MA plans a dollar to deliver substantially less than a dollar of value to Medicare beneficiaries is clearly a poor use of public funds. The MA payment system is thus ripe for reform.

The best use of the resulting savings depends on policymakers' values and priorities. (Those values and priorities would also dictate which ways of redeploying the savings would ensure that reform was an improvement on the status quo. Because each additional dollar paid to MA plans does produce *some* value for Medicare beneficiaries, it is possible to imagine uses of the savings from reforming MA payment that would generate even less value than the status quo.)

Nevertheless, it is instructive to consider a few illustrative options. One option would be to reinvest the savings within the Medicare program. For example, policymakers could reduce cost-sharing under the base Medicare benefit (e.g., by adding an annual limit on out-of-pocket spending), buy down the Part B or D premiums, or add coverage for services that Medicare does not currently cover (e.g., dental services). Importantly, these types of benefit enhancements would typically benefit MA and TM enrollees alike, leaving TM enrollees much better off, while at least partially offsetting any benefit reductions that MA enrollees saw due to MA payment reductions. If well-designed, this approach could markedly increase the overall generosity of the Medicare program without increasing program costs on net.

Another option would be to use the savings from MA payment reform to reduce the federal deficit or finance other policy initiatives. Or policymakers could choose to combine these options. Indeed, because of the deep inefficiency of the status quo, it would likely be feasible to craft reforms that held Medicare beneficiaries harmless or made them better off overall while also freeing up substantial budgetary resources for other purposes.

Charting a path for reform

If policymakers want to reform MA payment, the next question is how. A sensible goal would be to align payments to MA plans with the cost of covering comparable enrollees in TM. In such a system, beneficiaries would tend to enroll in MA when MA could offer better coverage at the same cost as TM and stay in TM otherwise, thereby maximizing the return to program spending.[5]

Achieving this goal would require two types of reforms:

[5] As emphasized by Glazer and McGuire (2017), there are rationales for deviating from a "level playing field" payment approach. However, it is not clear whether they imply that MA should be paid more or less than TM on net. For example, if greater MA enrollment creates "spillover" savings in TM by causing providers to shift toward less-intensive practice styles (e.g., Chernew et al. 2008; Baicker, Chernew, et al. 2013), that could rationalize paying MA plans more than TM. On the other hand, if MA plans' intensive marketing efforts caused some beneficiaries to enroll in MA even when TM would better serve their interests, that could rationalize paying MA plans less than TM. I view a "level playing field" approach as a reasonable starting point, pending further research and analysis.

1. *Fix the MA risk adjustment system.* The first—and most important—step would be to fix the MA risk adjustment system. As shown in Figure 1, if MA risk adjustment were appropriately compensating for differences in enrollee risk between MA and TM, then MA payments would already be roughly in line with TM costs, at least on average.

   A first step toward fixing risk adjustment would be to make technical improvements to the structure of the risk adjustment model and the data used to calculate risk scores. Others have identified many promising reforms in this vein that merit serious consideration (e.g., McWilliams 2025a; 2025b; MedPAC 2025). In my view, one particularly appealing reform is improving the risk adjustment data validation audits that CMS uses to address improper diagnosis coding by MA plans; CMS has taken important steps in this direction during the prior and current administrations, but there is still more to be done. Another is adding a reinsurance component to the MA risk adjustment system, similar to the one that already exists in the individual and small group market risk adjustment systems.

   However, even an expansive set of changes of this type would likely fall short of fully addressing MA's coding intensity and favorable selection problems. To address what remains, policymakers could increase the coding intensity adjustment that CMS applies to risk scores and create a similar adjustment to account for favorable selection.

   While CMS already has the authority to apply an adequate coding intensity adjustment and may have the authority to create a favorable selection adjustment, legislative action would be more likely to achieve the desired outcome. CMS has kept the coding intensity adjustment at the statutory minimum level even in the face of clear evidence that this adjustment is too small to fully offset higher coding intensity in MA. To avoid similar problems going forward, Congress could direct CMS to use a specific methodology to calculate each adjustment (e.g., a methodology similar to the one currently used by MedPAC). This approach would allow the adjustments to evolve over time in response to changes in market conditions, while still limiting the discretion that has allowed CMS to consistently apply inadequate coding intensity adjustments in the past.

2. *Revisit the program's underlying benchmark methodology.* While fixing risk adjustment is the most important step, fully equalizing payments between MA and TM would also require revisiting the underlying rules governing MA benchmarks. A straightforward approach would be to eliminate the current "quartile" system and instead set benchmarks at a fixed multiple of TM costs in all areas.[6]

   Policymakers would then have a few different options for addressing the MA quality bonus program. They could, if they wished, retain the program in its current form and account for quality bonuses when setting the multiplier described above. Alternatively, they could replace the program with a budget-neutral program that increased benchmarks for high-performing plans and reduced them for low-performing plans. Or they could eliminate it entirely in light of evidence from other settings that the administrative costs generated by these types of pay-for-performance systems swamp any quality gains (Fiedler 2023).

[6] The appropriate percentage would depend on how rebates were calculated. If rebates continued to equal a fraction of the difference between the bid and benchmark, then aligning MA and TM payments would require a percentage above 100%. If the rebate percentage were increased to 100%, then the appropriate percentage would equal 100%.

The approach outlined above would continue to base MA benchmarks on the cost of covering enrollees under TM. One alternative approach, often referred to as "competitive bidding," would be to set benchmarks based on MA plan bids (e.g., Lieberman et al. 2018; Hartnett et al. 2023; Ginsburg and Lieberman 2024). For example, some such proposals would set county benchmarks as a specified percentage of the average risk-standardized bid in a prior year.

An important advantage of competitive bidding approaches is that the overall level of payments to MA plans would no longer depend on the accuracy of the risk adjustment system since benchmarks would now be based on bids that already reflect MA coding and selection patterns. On the other hand, competitive bidding would generally fail to achieve payment parity between MA and TM because plan bids need not align with TM costs, either on average or on a county-by-county basis. As such, competitive bidding might do a worse job of steering beneficiaries toward the form of coverage that served them most efficiently than the approach described here. Further, competitive bidding would not eliminate the need for effective risk adjustment since risk adjustment would still play an essential role in ensuring a level playing field *among* competing MA plans.

Comparing alternative approaches to reducing federal health care spending

In closing, I want to make one broader point about alternative ways of reducing federal health care spending. Congress recently enacted legislation that is expected to cut around $1 trillion over ten years from Medicaid and the Marketplaces (CBO 2025). Those savings will be achieved mainly by removing millions of people from Medicaid and the Marketplaces, of whom more than 10 million will become uninsured.[7] Together with the impending expiration of enhancements to the premium tax credit first enacted in 2021 and recent administrative actions by CMS, the United States is on track to unwind nearly three-quarters of the decline in the uninsured rate since 2013, the year before the Affordable Care Act's main coverage provisions took effect (Fiedler 2025).

Research on the effects of insurance coverage shows that the people becoming uninsured will experience significant negative consequences. They will have worse access to health care (Wherry and Miller 2016; Ghosh et al. 2019; Duggan et al. 2022). They will be less financially secure (Baicker, Taubman, et al. 2013; Zewde et al. 2019; Brevoort et al. 2020). And they will experience worse health outcomes, including a higher risk of death (Levy and Buchmueller 2025).

By contrast, reforming MA payment could generate hundreds of billions in savings for the federal government over a ten-year period—while maintaining or even increasing the overall generosity of the Medicare program. Nor is MA payment reform the only source of health care savings that would do little or no harm to Americans' ability to access care. Adopting site-neutral payment for ambulatory services in Medicare, reforming the tax exclusion for employer-provided coverage, or taking steps to rein in high hospital prices in commercial insurance could all generate substantial federal savings without meaningfully harming access to care (Hoagland et al. 2025).

Appendix

This appendix presents the evidence and calculations underlying the estimate presented in the main text that each additional dollar paid to MA plans finances around 50 cents of spending on additional benefits. My starting point is evidence on how changes in benchmarks affect plan bids. The Congressional Budget Office (2022) has previously estimated that when benchmarks rise, plan

[7] The CBO estimate cited above indicated that the legislation would cause 11.8 million people to lose coverage, but removal of certain provisions likely reduced that to between 10 and 11 million in the final bill.

bids rise by an amount equivalent to around 50% of the increase in benchmarks. Fiedler (2021) undertakes a review of the research literature that reaches a similar conclusion, and Chernew et al. (2023) produce a similar estimate using data for a more recent time period.

The MedPAC estimates cited in the main text imply that rebates currently average around 66.7% of the difference between bids and benchmarks. Thus, this bidding response implies an increase in rebate payments around 33% (= 0.667 x [1-0.5]) as large as the increase in benchmarks. Thus, of the marginal dollar paid to plans, 60 cents (=100 x 0.5 / [0.5+0.33]) go to higher bid payments, and the remaining 40 cents go to rebates that finance additional benefits.

These estimates may modestly understate how much of the marginal dollar paid to plans finances additional benefits. When plans use rebate dollars to reduce cost-sharing, that increases how much health care enrollees use. But under the rules of the MA bidding process, plans account for that utilization in their *bids;* rebate dollars cover only the "mechanical" costs of reduced cost-sharing.[8]

To obtain an estimate of the increase in plan liability attributable to increased utilization, observe that the total change in plan liability due to a change in actuarial value can be written as

$$\frac{\mathrm{d}}{\mathrm{d}\nu}[\nu pq] = pq[1 + \nu\epsilon],$$

where ν is actuarial value, q is utilization, p is price of care per unit, and ϵ is the semi-elasticity of utilization with respect to actuarial value. This equation implies that the increase in plan costs attributable to increased utilization is $\nu\epsilon$ times as large as the mechanical cost.

The Congressional Budget Office (2020) reports estimates of the semi-elasticity of utilization with respect to plan actuarial value based on a review of prior studies. Taking the simple average across the estimates reported in their Exhibit 5-1 for non-drug categories yields an estimate of $\epsilon = 1.3$. The actuarial value of an MA plan must exceed the actuarial value of TM, which is currently around 84%,[9] but by definition cannot exceed 100%. This implies that the additional plan cost attributable to the additional utilization is between 1.1 and 1.3 times the mechanical cost.

The estimates in Table 4 of Pelech and Song (2025) imply that 18% of the marginal rebate dollar was devoted to reducing cost-sharing for Part A and B services during the post-2010 period. Putting this all together implies that for each additional dollar that the federal government pays to MA plans, between 8 cents (= 40 cents x 0.18 x 1.1) and 9 cents (= 40 cents x 0.18 x 1.3) finances additional Part A and B utilization attributable to reduced cost sharing. In total, then, when plan payment rises by a dollar, the amount plans devote to additional benefits rises by 48-49 cents.

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[8] For additional discussion of this point, see MedPAC (2017) or CMS' bidding instructions to plans.

[9] This figure was calculated using data from the 2026 MA Rate Announcement. Specifically, I divided the monthly actuarial value of Medicare deductible and coinsurance for 2026 by the United States per capita cost for that year.

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