

Every Bid Everywhere All at Once: A 2027 MA and Part D Debrief

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Resubmission and Desk Review

Jennifer Carioto

2027 bid season featured unprecedented resubmission cycles for some

Driven by star rating and regulatory guidance changes



Timing is based on typical bid timeline

Strategic implications of QBP recalculation for 2027 Medicare Advantage bids



Competitive market effects

- 2027 bids were developed based on expected competitor Star Ratings and benefit strategies
- Competitors receiving QBP increases may resubmit bids and use additional rebate dollars through richer benefits and/or lower premiums
- Market competitiveness may shift during annual enrollment period (AEP)



Financial flexibility with additional QBP revenue

- Enhanced supplemental benefits
- Reduced member cost sharing
- Lower premiums
- Improved plan margins



Margin recovery opportunity

- Some organizations may prioritize margin improvement rather than benefit enhancements
- May reduce the number of negative or near-zero margin bids



Contract-level optimization

- QBP increases apply at the contract level and may affect multiple PBPs
- Creates flexibility to:
 - Reallocate value across plans and markets
 - Reduce the need for plan terminations
 - Introduce new plans

CMS Part C and D desk review focus areas vary by plan, assumptions, and bid year

The categories below represent common areas of inquiry observed across recent CMS desk reviews and are illustrative rather than exhaustive

01

Benefit pricing and cost sharing

- Effective copay and coinsurance calculations
- Induced utilization factors
- MOOP development (C)
- Supplemental benefit pricing (C)
- Benefit phase allocation (D)
- BPT/PBP consistency

03

Projection assumptions and trends

- Utilization and unit cost trends
- Emerging experience adjustments
- Provider reimbursement changes and area factors (C)
- Medical management program impacts (C)
- Formulary adjustments (D)
- Historical actual-to-expected analyses

05

Experience, manual rates and credibility

- Experience and/or manual rate development
- Source population selection and comparability of source plans
- Credibility weighting
- Risk normalization

02

Rebates, Federal Reinsurance & Subsidies (D)

- Rebates development
- LICS (Low Income Cost Sharing Subsidy)
- Federal reinsurance
- Manufacturer Discount Program (MDP)

04

Risk Scores, Population Changes and Enrollment Mix

- Risk score projections
- Coding intensity adjustments
- Enrollment projections
- Population change factors
- Morbidity assumptions
- DE/Non-DE (C) & LI/ NLI population differences

06

Reconciliation and documentation

- BPT/PBP/supporting file reconciliation
- Formula and calculation support
- Hardcoded values and audit trails
- Compliance with bid instructions
- Assumption validation

Common CMS inquiries related to non-benefit expenses (NBEs)

Desk review question vary by plan, assumptions, and bid year

NBE Development Methodology and Assumptions

- Staffing assumptions
- Vendor costs
- Marketing and sales expenses
- Reinsurance expenses
- NBE trend assumptions
- Administrative cost build-up by category
- M3P bad debt support

Expense Allocation Methodologies

- MA vs. Part D allocation
- Contract and plan-level allocation
- Revenue-based allocation methods
- Direct vs. indirect administrative expenses

Actual-to-Expected Analysis and Historical Projection Accuracy

- Why NBE was historically under- or over-projected
- Analysis required under Appendix B.39.1
- How lessons learned from historical experience were incorporated into the current bid

Documentation and Reconciliation

- Support for specific workbook values
- Line-item development exhibits
- Reinsurance documentation
- Audit trails and calculation support

CMS NBE reviews primarily assess whether administrative expenses are reasonable, appropriately allocated, and adequately supported.

Voluntary bid resubmission following revised CMS TBC guidance

CMS rebate reallocation optional resubmission



Initial CMS guidance

- Margin flexibility would only be considered after **evaluating non-OOPC benefit reductions** – both Medicare-covered and non-Medicare-covered Mandatory Supplemental Benefits (MSBs)
- Use the OOPC model to identify benefit changes that could reduce plan value without materially affecting OOPC
- CMS explicitly stated there was **no flexibility to exceed the TBC limit**

Plan implications

- Removal of *all* non-OOPC supplemental benefits alone would not fully resolve the TBC issue
- Concerns regarding **member disruption and market competitiveness** from further benefit reductions

Revised CMS guidance

- **Bids were resubmitted to align with final CMS guidance** referring to Appendix E 11.1.1 of the CY2027 bid instructions
- Revised guidance: *The resubmitted bids may use MA gain/loss margin flexibility to the extent necessary to meet TBC compliance*
- Additional bid revisions were required to maintain compliance with CMS rebate reallocation instructions and bid review requirements

Part D and the NAMBA Story

Matthew Hayes



The Post-Redesign Reality is Cost Keeps Climbing

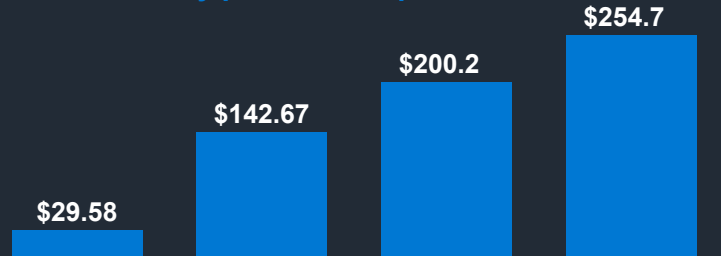
	CY2024	CY2025	CY2026	CY2027
National Average Monthly Bid Amount	\$64.28	\$179.45	\$239.27	\$296.05
Base Beneficiary Premium	\$34.70	\$36.78	\$38.99	\$41.33
Direct Subsidy (Bid Less Base Premium)	\$29.58	\$142.67	\$200.28	\$254.72
Direct Subsidy, Year-over-Year Change	—	+382%	+40%	+27%

Four straight years of escalation

The redesign moved support into the up-front bid, and with base premium growth capped at 6%, nearly every extra dollar lands in the direct subsidy.

CY2027 landed near \$255 PMPM, about \$10 to \$15 below what most plans priced to — and the stabilization demo ends after CY2026.

Direct subsidy per member per month



CMS announced the end of the Part D Premium Stabilization Act for CY2027, which will push additional premium to PDP plans, particularly for those plans already with higher premium levels

National average monthly bid amounts are as announced by CMS each July. The CY2027 base beneficiary premium reflects the 6% statutory growth cap applied to the CY2026 amount. Direct subsidy amounts are shown as the national average monthly bid amount less the base beneficiary premium, before risk adjustment; actual plan payment varies with each enrollee's Part D risk score.

Where a Subsidy Shortfall Goes

Only two levers absorb 2027 variance between projected and actual direct subsidy. The other three are locked for 2027 bids, but lower funding puts them on the table for 2028.

AVAILABLE FOR 2027 — absorbs subsidy variance		LOCKED UNTIL THE 2028 PRICING YEAR — longer-term responses to lower funding		
 Member Premium	 Rebate Reallocation	 Formulary Position	 Utilization Management	 Market Footprint
A standalone PDP with no rebate pool passes the subsidy gap straight into the monthly premium. Most visible to members, and the fastest to move enrollment.	MA-PD only. Part C rebate dollars buy the Part D premium back down, so the cost lands on supplemental benefits and cost sharing instead.	2028 could bring fewer brands per class, more exclusive arrangements, harder rebate negotiations, and moves in tier and specialty coinsurance.	2028 could bring expanded prior authorization, step therapy, and quantity limits on the high-cost categories where plan liability concentrates.	2028 could bring consolidated offerings or region exits, moving members from exited plans into a different formulary.

What this means: for 2027, subsidy variance shows up only in premium and rebate decisions. Moving forward this may push plans to consider ways to manage high-cost members through leaner formularies, tighter UM, and leaving higher cost markets

Projecting the NAMBA Is one of the Trickiest Numbers in the Bid

The national average monthly bid amount is set by every other plan's pricing, not by yours, and it is published in July, nearly two months after bids are filed. A miss flows straight through the direct subsidy to premium and margin. These are the moving parts that make the projection hard.

What Moves the NAMBA

Pharmacy trend

Risk score coding

Patent expirations and the new drug pipeline

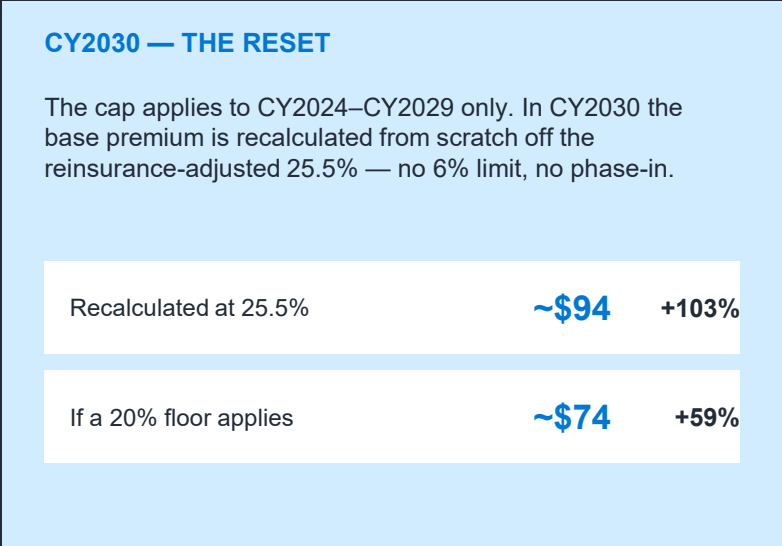
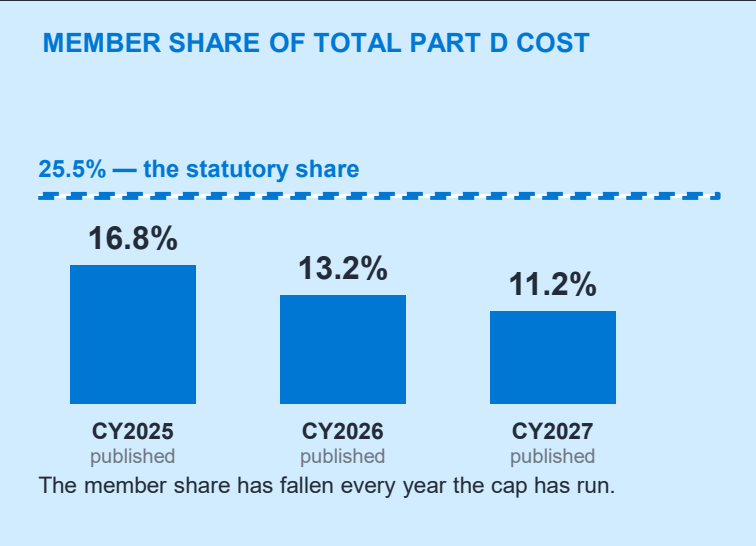
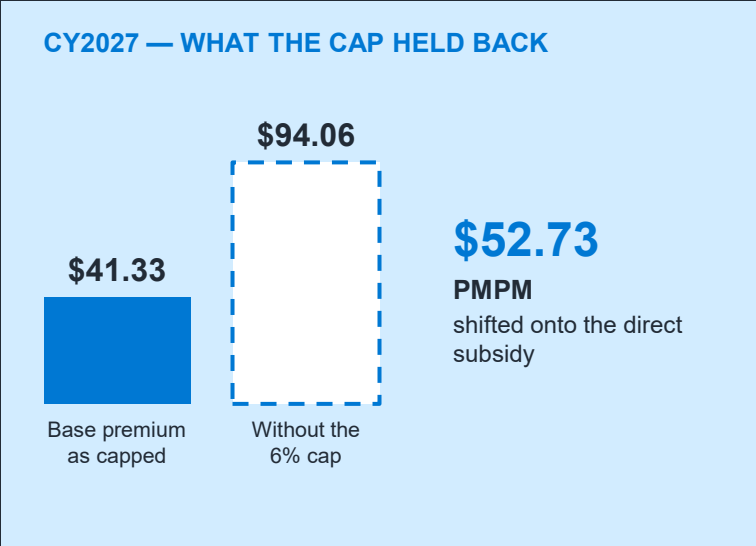
Member migration

Emerging experience

Bidder behavior on plan exits

The 2030 Cliff : When the Premium Cap Disappears

The base beneficiary premium has risen exactly 6% every year since CY2024. In CY2027 members fund about 11% of the basic benefit rather than the 25.5% the statute contemplates. The cap applies through CY2029 only — in CY2030 the base premium is recalculated from scratch, with no phase-in.



What to watch — this is current law and requires no action from Congress to happen. A roughly 60% to 100% single-year jump in the base beneficiary premium in an election-adjacent year is the most likely trigger for Congress to reopen Part D. Plan for the reset; expect the politics to arrive first.

Sources: CMS Part D bid announcements CY2024–CY2027

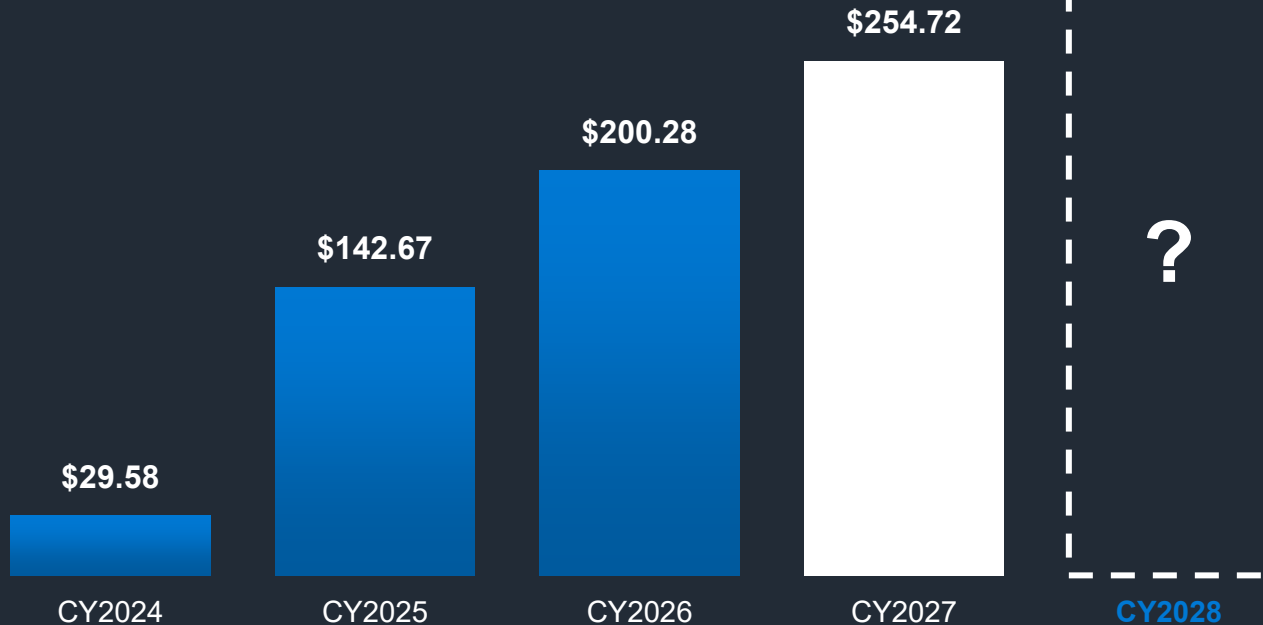
The Bigger the Direct Subsidy Gets, the Bigger the Miss

Harder to project every year, and far more expensive to get wrong

DIRECT SUBSIDY PMPM

More than 8x higher than
CY2024

WIDER RANGE



8.6x

growth in the direct subsidy in four years, and still climbing

\$1.48 → \$12.74

PMPM impact of a 5% projection miss, CY2024 versus CY2027 — the same error, nine times the dollars

A bigger subsidy means a wider miss — build CY2028 pricing and rebate strategy around a range, not a point

Star Ratings

Rachel Ferguson



What Is Changing in Star Ratings

The measure set, the math, and the moving target

The measure set

- Continued shift away from administrative measures toward clinical outcomes
- Patient experience, complaints and access weights cut from 4 to 2 for 2026 ratings
- 11 measures removed in the CY2027 final rule, most beginning with 2029 ratings
- Health equity index dropped; the historical reward factor continues

The methodology

- Tukey outlier deletion fully embedded in cut point calculation
- Guardrails cap year-over-year cut point movement where applicable; CAHPS, improvement and new measures are exceptions
- Improvement measures carry weight 5
- Small-denominator contracts remain exposed to single-case volatility

Changing cut points

- Industry gains raise the bar even when your own scores hold
- Unchanged performance can earn fewer Stars when thresholds tighten
- Longer-range plans must be priced before future cut points are known
- About half of the measure-level draft 2027 thresholds became harder (CMS draft cut points, September 2026)

Star Ratings Changes, 2026–2029

What CMS proposed and finalized

Rating year	What changes	Planning implication
2026	KED plus Improving or Maintaining Physical Health and Mental Health added; patient experience, complaints and access weights cut from 4 to 2	One new measure and two returning, respecified measures; member experience carries less of the rating
2027	Two new Part D medication-safety measures (opioid/benzodiazepine overlap; anticholinergic polypharmacy); Functional Status Assessment returns; physical and mental health weights rise from 1 to 3; Pain Assessment, MRP and MTM CMR completion leave	Part D measure mix shifts; health equity index not adopted and the historical reward factor continues
2028	Part D adherence becomes case-mix adjusted; first removals take effect (call-center interpreter and TTY, Part C Statin Therapy for Patients with Cardiovascular Disease)	Adherence results less comparable with prior years; early removals begin to shift relative influence
2029	Most of the 11 finalized removals take effect; depression screening and follow-up added; MTM CMR completion returns; Diabetes Care – Eye Exam retained	Fewer measures, so each one carries greater relative influence

Sources: CY2027 Medicare Advantage and Part D final rule, CMS, April 2026; CMS 2026 and 2027 Star Ratings measure lists. Removal from Star Ratings does not end reporting or oversight obligations.

Clover challenged CMS's authority to use certain measures

Clover Insurance Company v. HHS, Southern District of Georgia, May 27, 2026

What the district court held

- Ten measures exceeded CMS authority; the court read the statute to limit ratings to HEDIS, HOS and CAHPS data
- Ten more were procedurally invalid because CMS skipped notice and comment
- Authority defects and procedural defects may call for different remedies

What CMS did next

- Recalculated Clover from 3.5 to 4.5 stars
- Recalculated 2027 quality bonus payment ratings for certain MA contracts
- Held plans harmless and reopened bids through June 29
- Appealed to the Eleventh Circuit in July

What is still unresolved

- Appeal pending; timing and outcome uncertain
- The ruling decided Clover's case; it is not yet a program-wide conclusion
- The nondelegation claim, aimed at contractor-driven appeals measures, was left undecided

Sources: Clover Insurance Co. v. HHS, No. 2:25-cv-00142 (S.D. Ga. May 27, 2026); Clover SEC filing describing the 2027 QBP rating recalculation, June 2026

Stars, Revenue, and the Bid

How ratings enter the bid

- At 4.0 stars and above, the quality bonus adds five percentage points to the applicable benchmark, subject to caps and qualifying-county provisions
- Rebate share rises with the rating: 50% below 3.5 stars, 65% at 3.5–4.0, 70% at 4.5–5.0
- Together these set the dollars available for supplemental benefits

What the difference is worth

- Illustration: \$50 PMPM of savings retained at 65% leaves \$32.50 PMPM for benefits
- Crossing 4.0 stars turns on the benchmark bonus; crossing 4.5 lifts retention to 70%
- A higher benchmark is not by itself added benefit funding or margin
- Rebates apply to MA-PD contracts, not stand-alone PDPs

The timing problem

- Bids are filed in June; draft cut points follow in September and ratings in October
- Many annual measures carry a roughly three-year lag from performance to payment
- 2026 performance can affect CY2029 payment through bids filed in June 2028
- Longer-range planning, not the next bid, carries the uncertainty

Upcoming Decisions and Planning Dates

Dates that move a 2027 or 2028 rating



Legislative watch: H.R. 8375, as introduced, would add a compliance and coverage-protection domain and expand data sources — proposal only.

Before the 2028 Cycle Begins

Start earlier

- Build the scenario range off the Advance Notice
- Document assumptions as you price them
- Reconcile the pricing tool, the PBP and the certification before you file

Own these four things

- Project each contract's 2027 and 2028 ratings across a range of cut points
- Quantify dollar exposure for contracts sitting near 4.0 and 4.5 stars
- Assign ownership for the 2027 measurement and data-submission work
- Confirm which retired measures still carry reporting obligations

Q&A



Thank you

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