

# Estimated Impact to MA Plan Rebates and Payments from the No UPCODE Act

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## Summary:

The Better Medicare Alliance (BMA) commissioned BRG to estimate the effects of the No UPCODE Act on Medicare Advantage (MA) plan payments and enrollment. The No UPCODE Act would make three key changes to the MA payment system: using two years of diagnostic data in the MA risk adjustment model; excluding diagnoses from chart reviews and health risk assessments; and requiring the Centers for Medicare & Medicaid Services (CMS) to evaluate coding differences between MA and Traditional Medicare (TM).

BRG estimates the combined effect of the No UPCODE Act would reduce per-member rebates by 43%-58% and total payments to Medicare Advantage plans by 9%-20% from 2027 to 2035. The proposal would likely lead to higher out-of-pocket costs when seeking care and reduced supplemental benefits such as dental & vision coverage. Alternately, MA plans could continue to offer the same level of benefits, but enrollees would need to pay a new premium of approximately \$2,663 per year, or \$222 per month. While BRG did not estimate the impact of individual policies, our model suggests eliminating chart reviews would account for more than half of the impact on rebates and total payments.

BRG also estimates by 2035 nearly 6 million fewer beneficiaries would enroll in MA plans, a decrease of 12% relative to current expectations. In 2035 MA plans would cover approximately 52% of the total Medicare population compared to the 51% covered by MA plans in 2025.

**Table 1: Estimated Change in Average MA Rebate Per Member**

	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Per Year	\$0	-\$1,070	-\$1,234	-\$1,425	-\$1,638	-\$1,809	-\$1,996	-\$2,238	-\$2,437	-\$2,663
Per Month	\$0	-\$89	-\$103	-\$119	-\$136	-\$151	-\$166	-\$187	-\$203	-\$222
% change	0.0%	-42.8%	-46.1%	-49.0%	-52.2%	-53.6%	-55.0%	-56.1%	-57.0%	-57.8%

**Table 2: Estimated Change in MA Payments**

	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Total (\$b)	\$0.0	-\$63.3	-\$85.0	-\$109.9	-\$136.7	-\$160.8	-\$186.0	-\$216.3	-\$243.4	-\$272.5
% change	0.0%	-9.2%	-11.3%	-13.2%	-15.0%	-16.3%	-17.4%	-18.4%	-19.2%	-19.9%
PMPY	\$0	-\$1,303	-\$1,428	-\$1,586	-\$1,772	-\$1,900	-\$2,046	-\$2,249	-\$2,392	-\$2,563
PMPM	\$0	-\$109	-\$119	-\$132	-\$148	-\$158	-\$171	-\$187	-\$199	-\$214

Note: Change in total payments is not equivalent to estimated impact on Federal spending.

## Background

Payments to Medicare Advantage plans depend on three components: bids that plans submit to CMS, benchmarks CMS sets on a county-level basis, and risk scores that predict beneficiaries' expected healthcare costs.

The difference between plans' bids and Medicare's benchmarks determine a base payment from CMS to the plan for an enrollee with average expected health costs. CMS determines base payments by comparing county benchmarks to a plan's standardized bid, which reflects the plan's estimated cost of providing Medicare benefits to an enrollee of average health in the county. If a plan's bid is above the benchmark, CMS pays the plan the benchmark amount, and the plan must charge enrollees a premium equal to the difference between the bid and the benchmark. If a plan's bid is less than the benchmark, CMS pays the plan its bid plus a rebate that is a percentage of the difference between the bid and the benchmark. Both the benchmark and the rebate percentage are also modified to reflect a plan's average quality score, with higher quality plans earning higher benchmarks and rebate percentages.

When calculating the rebate, CMS uses the plan's risk-adjusted bid (that is, the plan's bid adjusted for the health of its expected enrollee population, not its standardized bid) and the risk-adjusted benchmark (calculated by assuming a beneficiary of average risk multiplied by the plan's expected average risk score). Plans must use the rebate primarily to reduce Part B or Part D premiums or cost sharing, or to offer additional benefits such dental care or transportation to medical appointments.

CMS assigns a risk score to each beneficiary. The base payment is multiplied by this risk score determine what Medicare pays for each specific beneficiary to a plan to cover the Medicare Part A and B benefits. Risk scores are calculated using the MA Risk Adjustment model. The model uses diagnoses from the previous year and demographic information to predict each beneficiary's expected spending in the coming year, assigning coefficients to each "hierarchical condition category" (HCC) to account for that HCC's contribution to the next year's expected costs. The coefficients are determined using Medicare FFS beneficiaries' experience. Finally, risk scores are "normalized" so that a score of 1.0 reflects the health care spending of the average beneficiary in Medicare Fee-for-Service (FFS), with higher risk scores indicating higher than expected health care spending and vice versa.

Diagnoses included in risk score calculations are documented by plans and submitted to CMS. Plans submit encounters to CMS to document the diagnoses. Encounters may come from different sources, including medical claims, chart reviews, and health risk assessments (HRA). Generally, risk scores increase with the number and severity of the diagnoses submitted. Higher risk scores lead to both higher A/B payments and higher rebate payments (by increasing the difference between the risk adjusted benchmark and bid). This creates an incentive for plans to invest in documenting diagnoses that does not exist in FFS Medicare. CMS applies an across-the-board reduction to risk scores called the coding intensity factor (CIF) to adjust for the difference in coding intensity across the MA and FFS populations. The CIF has a statutory minimum of 5.91%.

## The No UPCODE Act

The No Unreasonable Payments, Coding, or Diagnoses for the Elderly (No UPCODE) Act, S.1105, would make three changes to MA payment policy:

1. The MA Risk adjustment model would use two years of diagnostic data instead of one, with the elongated lookback applying to both the creation of the HCC coefficients using FFS data as well as calculating risk scores data submitted by MA plans.
2. The model would exclude diagnoses collected from chart reviews or health risk assessments when calculating MA risk scores for payment purposes.
3. CMS would be required to evaluate and publish the impact on risk scores for differences in coding patterns between MA and FFS, and ensure that the coding intensity factor (CIF) adjustment fully accounts for these differences. The Act reinforces that the adjustments could be made at a plan or contract level.

The proposal would not remove the current 5.91% CIF floor. While the Act's provisions would take effect in 2026, the impact would likely start in 2027, given the timing of MA rate setting.

## Data Sources

2025 Medicare Trustees Report. Available at <https://www.cms.gov/oact/tr/2025>.

2021-2023 Medicare Advantage Plan Payment files Available at <https://www.cms.gov/medicare/health-drug-plans/plan-payment-data>.

MedPAC "Medicare Advantage Program: Status Report" Jan 2025. Available at <https://www.medpac.gov/wp-content/uploads/2025/01/Tab-M-MA-status-report-January-2025-SEC.pdf>.

MedPAC "Report to the Congress: Medicare and the Health Care Delivery System", Chapter 2, June 2025. Available at [https://www.medpac.gov/wp-content/uploads/2025/06/Jun25\\_MedPAC\\_Report\\_To\\_Congress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2025/06/Jun25_MedPAC_Report_To_Congress_SEC.pdf).

Jacobs, Paul. "In-Home Health Risk Assessments and Chart Reviews Contribute to Coding Intensity in Medicare Advantage". Health Affairs, July 2024. Available at <https://www.healthaffairs.org/doi/10.1377/hlthaff.2023.01530>.

Curto, Vilsa et al. "Coding intensity variation in Medicare Advantage". Health Affairs Scholar. Jan 2025. Available at <https://academic.oup.com/healthaffairsscholar/article/3/1/qxae176/7958334>.

Congressional Budget Office. "Options for Reducing the Deficit: 2025 to 2034". Dec 2024. Available at <https://www.cbo.gov/publication/60557>.

## Assumptions and Methodology

Baseline estimates for MA enrollment, bids, rebates, and payments were first developed using the 2025 Medicare Trustees Report. We combined these estimates with state-level estimates developed using the 2021-2023 MA Plan Payment files, which also provided baseline risk scores. Our baseline estimates account for the recent shift to version 28 of the MA risk model and assume MA risk scores will grow 2% per year, consistent with recent experience under version 28.

We first estimated the impact of using 2 years of diagnoses in the risk model, which would impact both the individual coefficients of the risk model as well as the scores of individual enrollees in MA plans. We estimate these changes would slow the growth of MA risk scores in the first 3-4 years after the new policy, as initially there would be less opportunity for MA plans to identify uncaptured diagnoses from enrollees. We also estimate that, over time, plans would find new ways to identify and capture diagnoses, such that the impact in the final year of our analysis is significantly less than the first year.

We next evaluated the impact of eliminating diagnoses from either HRAs or chart reviews. Researchers have consistently found that MA plans are able to increase risk scores by 7%-8% relative to FFS scores, with higher impacts found in local PPO plans as well as among the full dual eligible population. We assumed the No UPCODE Act would immediately eliminate these gains, and that plans would not be able to recapture any of these losses.

Finally, to evaluate the effects of the third provision of the No UPCODE Act regarding CMS's evaluation and publication of the full coding differences between MA and FFS, we relied on research that demonstrated the overall estimated risk scores differed by 15%-17%, with higher effects in local HMOs and provider-owned plans. Since a portion of this difference would already be eliminated by the restrictions of HRAs and chart reviews, and since CMS would still be required to implement a minimum 5.91% coding intensity factor, we estimate on average plans would see an additional 1-3% additional reduction in risk scores, with higher impacts on local HMO plans. We also assume this impact would be one-time in nature.

Given the mechanics of the MA bidding process, we assumed the lower risk scores would lead to lower benchmarks while having no initial impact on MA bids. This results in lower rebates, the primary outcome variable in our analysis. The impact on rebates varies by plan type and year, based on the factors described above.

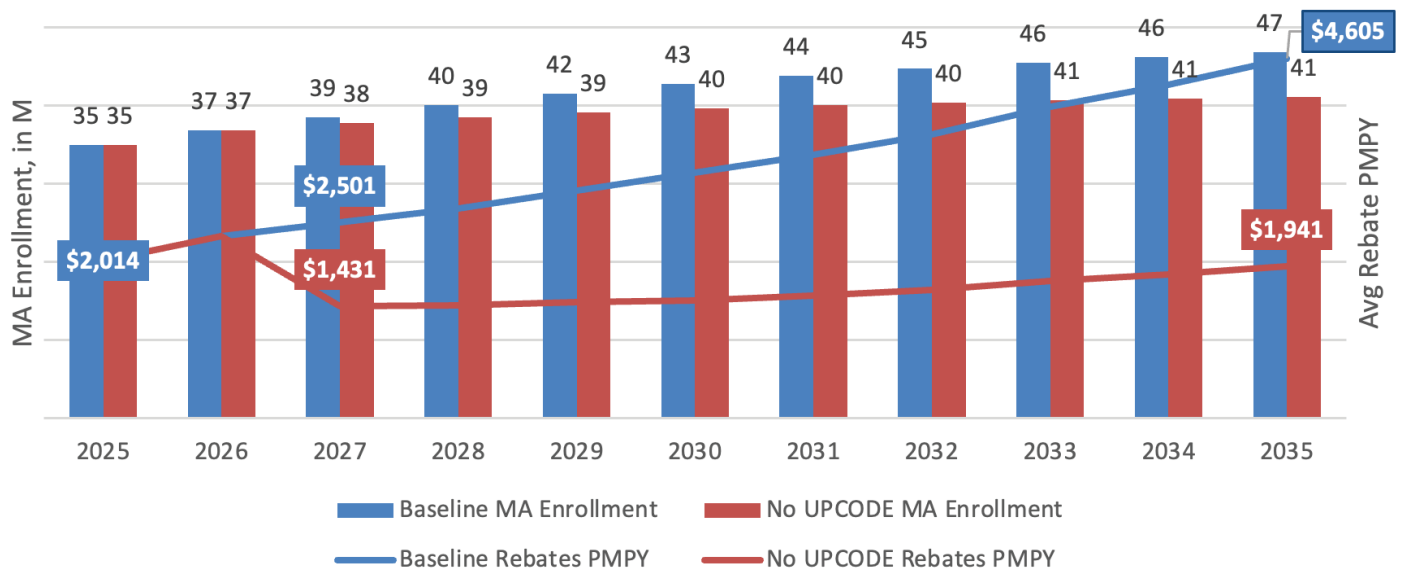
We next estimated the potential impact on MA enrollment due to lower rebates. Lower rebates to MA plans would take the form of reduced benefits to enrollees such as higher cost share for physician visits, hospital stays, or Part D drugs or less generous or complete elimination of dental, hearing, or vision benefits. Alternately, MA plans could continue to offer these benefits, but the enrollee would be required to pay for them via a new premium. In either case, Medicare beneficiaries would likely find MA plans less appealing in the future under the No UPCODE Act than under current expectations, which we estimate would reduce enrollment. We applied different reductions in enrollment growth based on plan type and year, tied to our expected change in rebates.

Finally, there is historical evidence that plans make efforts to reduce their bids in order to maintain rebates for enrollees. While it is unclear how much more opportunity plans have to reduce bids, especially with less opportunity to fully capture beneficiary risk scores, we did assume that MA plans would find ways in the first few years of the No UPCODE Act to maintain 25% of the potentially lost rebate value.

## Analysis

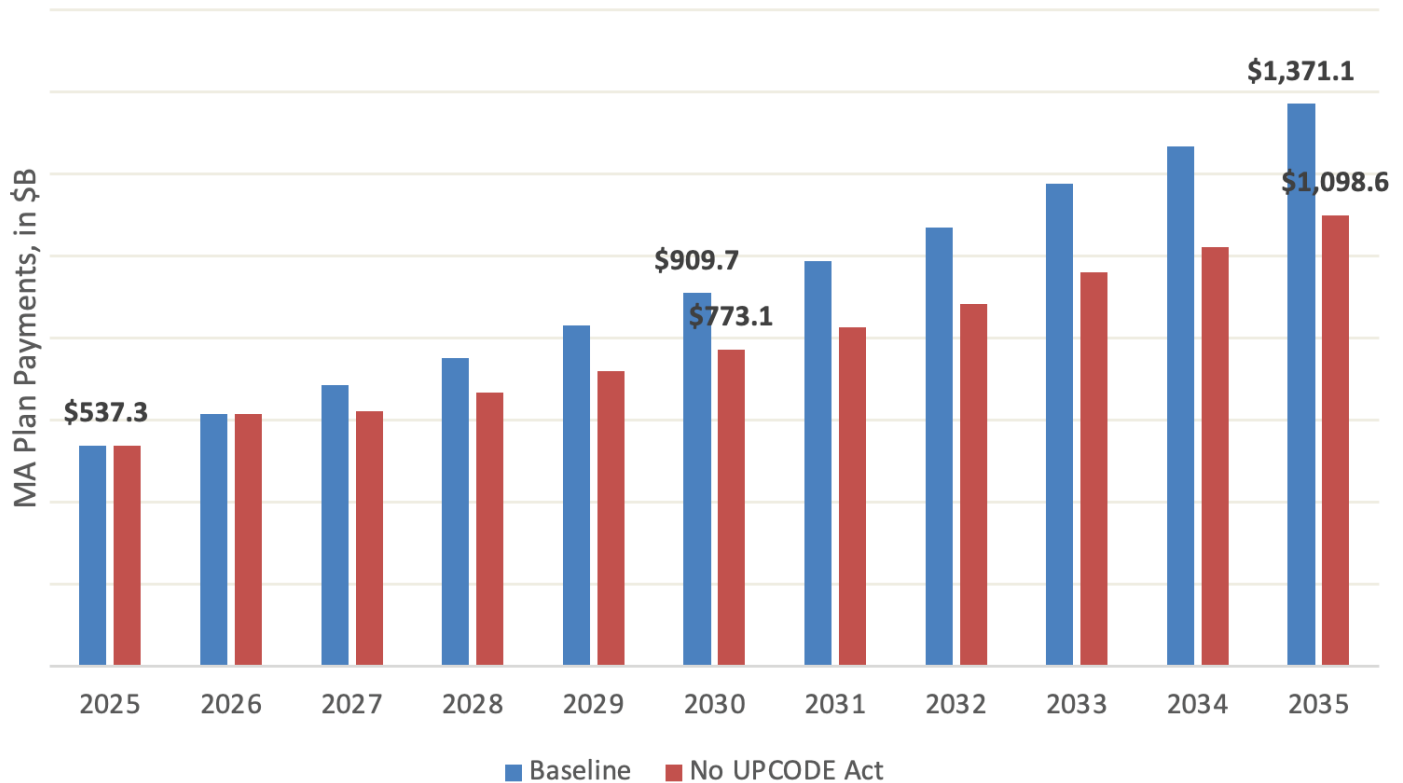
We estimate that, by 2035, MA enrollment would be about 13% lower under the No UPCODE Act than it would otherwise, covering 41 million beneficiaries instead of the 47 million under current forecasts (Figure 1). This drop in enrollment is due to lower rebates per enrollee, which we estimate will be \$1,941 per member in 2035, or nearly 58% lower than the current estimate of \$4,605.

**Figure 1: Estimated Change in MA Enrollment and Per Member Per Year (PMPY) Rebates**



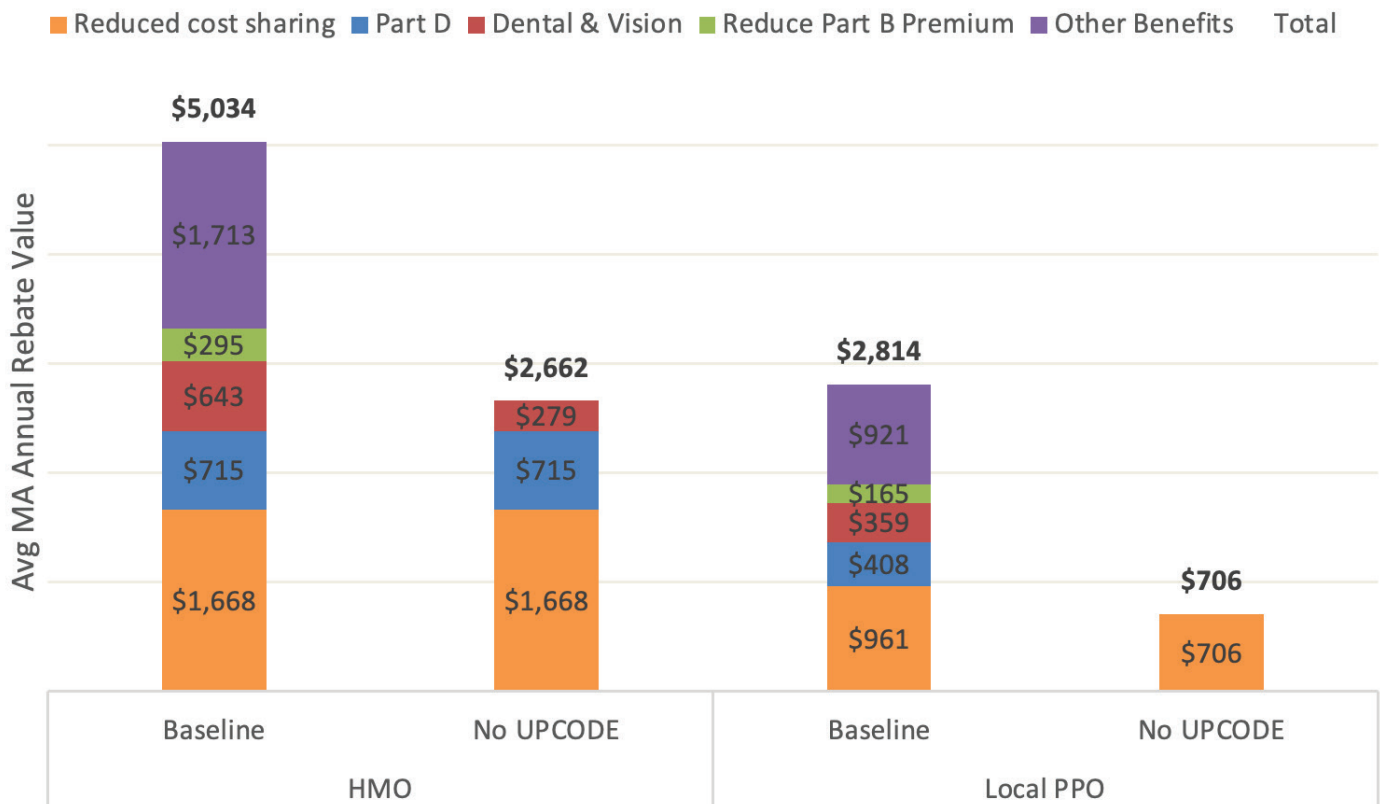
Due to the combination of lower rebates and lower enrollment, we estimate total MA plan payments would be nearly 20% lower by 2035 (Figure 2). We also estimate the cumulative decrease in plan payments due to the No UPCODE Act over the next 10 years would be nearly \$1.5 trillion.

Figure 2: Estimated MA Plan Payments Under Baseline and No UPCODE Act



The reduction in MA rebates would result in fewer benefits for enrollees. MedPAC currently estimates that MA plans spend nearly 2/3 of their rebate dollars on reducing cost sharing for traditional Medicare services or Part D drugs, and another 1/6 of rebate dollars providing dental or vision benefits to enrollees. Using the expected cost growth of each of these services, we estimate that by 2035 the average HMO plan would be able to maintain current levels of cost sharing and Part D enhancements, but the dental and vision coverage would need to be reduced, along with all other additional benefits. For local PPO plans, we estimate plans would need to increase cost sharing for traditional Medicare benefits and eliminate all other benefits. Alternately, plans could continue to offer the same level of benefits, but enrollees would need to pay a new premium of approximately \$2,663 per year, or \$222 per month.

Figure 3: MA Supplemental Benefit Use in 2035 Under Baseline and No UPCODE Act



The impact of the No UPCODE Act would vary by state, largely due to the variation in the types of plans beneficiaries are choosing along with the current variation in risk scores. MA enrollees and plans in Upper Plains States would be most negatively impacted, generally due to greater penetration of local PPOs in this region, with rebates dropping more than 65% and total plan payments dropping more than 14% relative to current expectations.

Our model estimates the combined impact of all policies included in the No UPCODE Act, using assumptions grounded in the Data Sources section of this paper. Because the policies interact with each other, we present individual impacts as ranges to demonstrate the relative impact of each policy:

**Rebates:** Within our model, eliminating chart reviews accounted for over 50% of the change in rebates in 2027, a share that grew in 2035. Applying differential coding intensities accounted for 20-25% of the in rebates in 2027, a share that fell in 2035. Using 2 years of diagnoses and eliminating HRAs each accounted for 10-15% of the change in rebates in 2027, shares that both grew in 2035.

**Total Payments:** Within our model, eliminating chart reviews accounted for 55 to 60% of the change in total payments in 2027 and 2035. Applying differential coding intensities, using 2 years of diagnoses, and eliminating HRAs each accounted for 10-15% of the change in rebates in 2027. By 2035, applying differential coding accounted for a smaller share of the change in total payments, eliminating HRAs accounted for a larger share, and using 2 years of diagnoses accounted for the same share.

Figure 4: Estimated Percentage Change in 2035 MA Rebate PMPM by State Due to No UPCODE Act

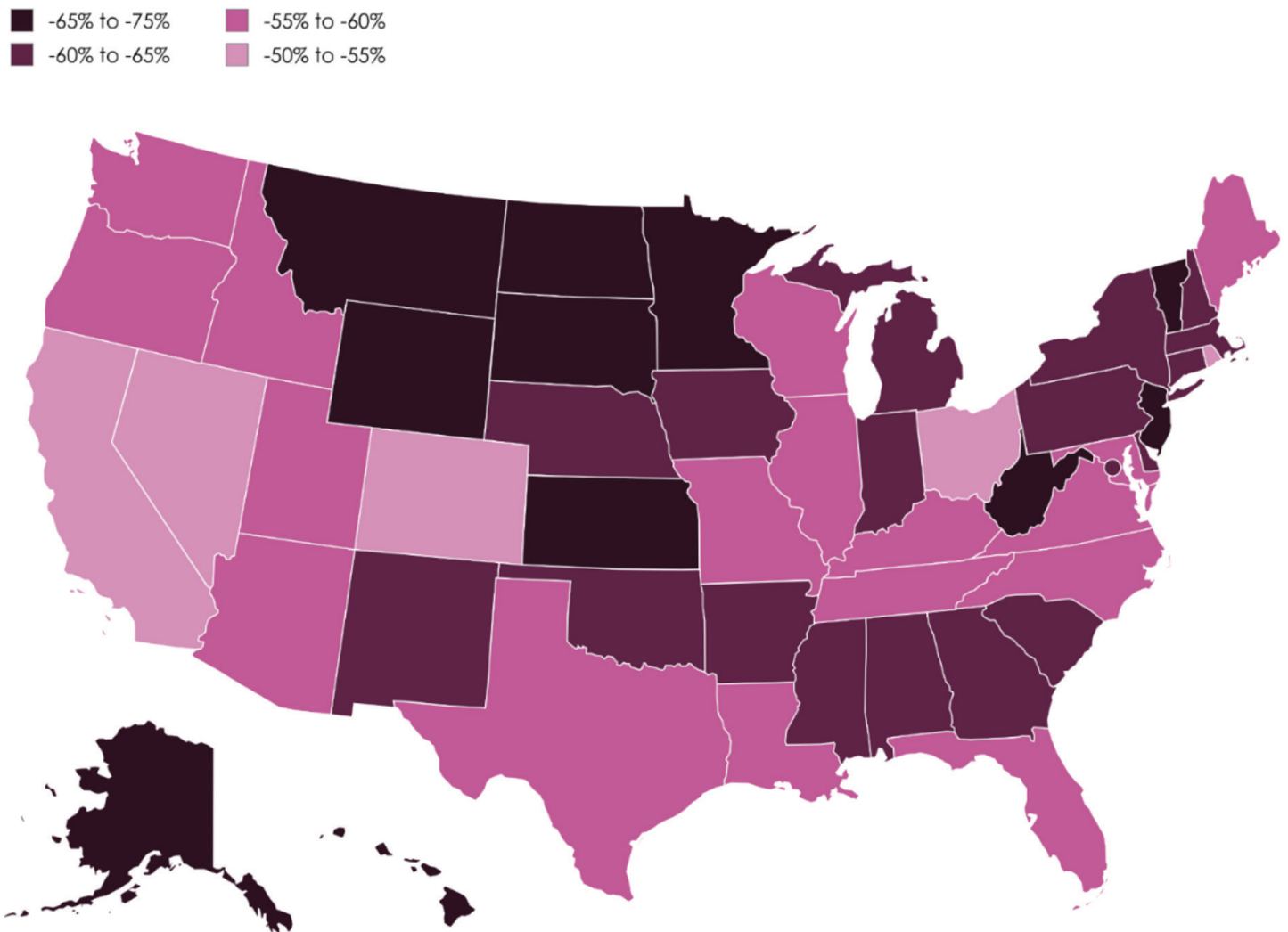
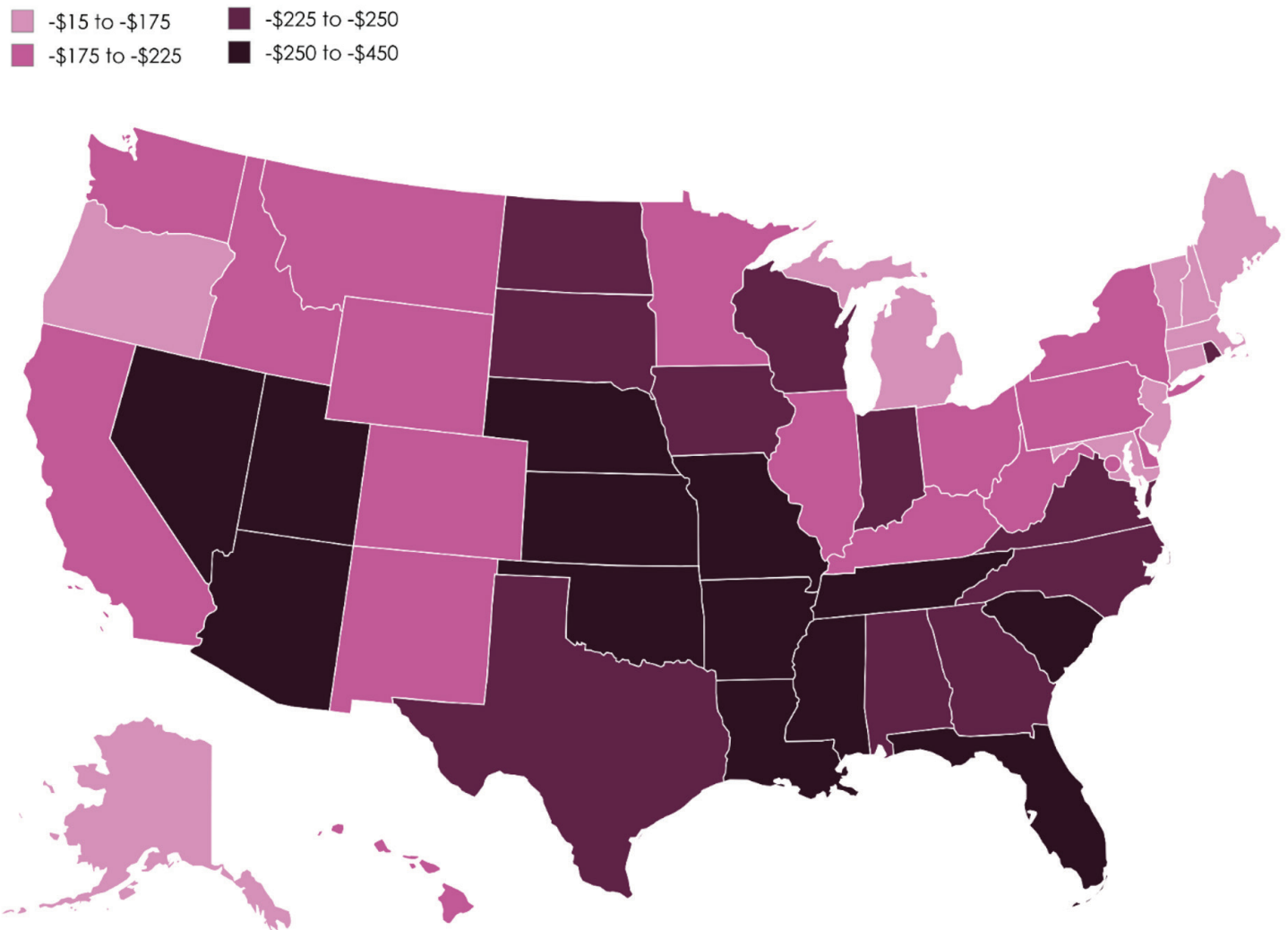
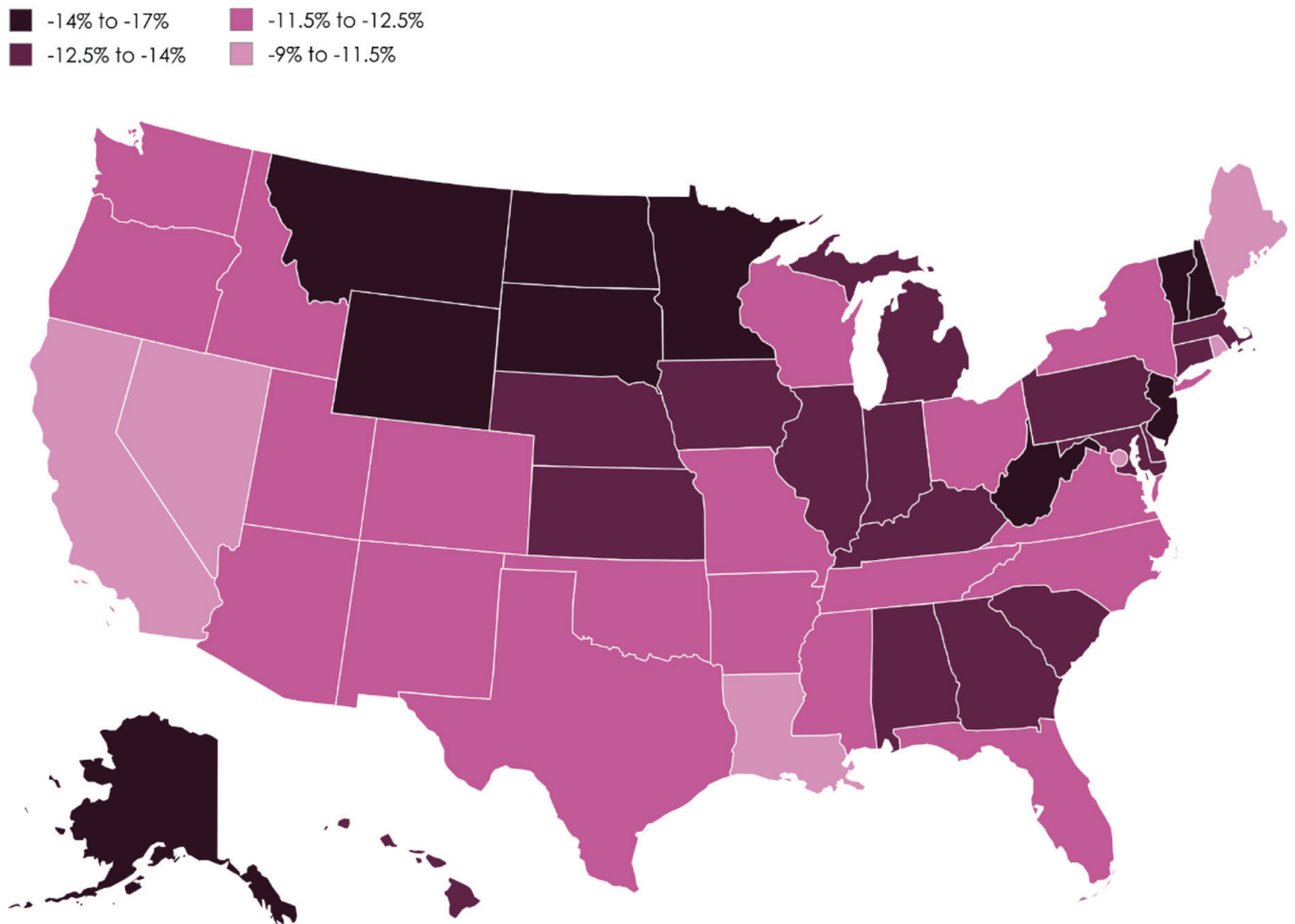




Figure 5: Estimated Dollar Change in 2035 MA Rebate PMPM Due to No UPCODE Act



**Figure 6: Estimated Change in 2035 MA Plan Payments by State Due to No UPCODE Act**



**Table 3: Estimated Percentage Change to 2035 MA Enrollment, Rebates and Payments Due to No UPCODE Act**

State	% Change Vs Baseline, 2035		
	Enrollment	Rebate PMPM	Total Payments
Alabama	-12.9%	-60.9%	-22.2%
Alaska	-16.1%	-76.8%	-19.4%
Arizona	-11.6%	-55.0%	-22.1%
Arkansas	-11.8%	-60.4%	-22.0%
California	-10.5%	-50.5%	-19.2%
Colorado	-11.8%	-54.4%	-21.7%
Connecticut	-13.0%	-62.1%	-19.4%
Delaware	-13.6%	-63.5%	-22.2%
District of Columbia	-11.3%	-61.0%	-17.9%
Florida	-11.8%	-57.5%	-22.9%
Georgia	-13.1%	-63.6%	-21.9%
Hawaii	-13.2%	-66.5%	-22.5%
Idaho	-11.6%	-55.6%	-22.6%
Illinois	-13.6%	-59.6%	-22.2%
Indiana	-12.8%	-60.9%	-22.0%
Iowa	-12.7%	-61.5%	-22.8%
Kansas	-13.7%	-66.1%	-25.1%
Kentucky	-12.8%	-58.2%	-20.9%
Louisiana	-11.2%	-56.0%	-21.8%
Maine	-11.5%	-55.3%	-20.4%
Maryland	-12.9%	-57.4%	-18.9%
Massachusetts	-12.9%	-61.9%	-20.6%
Michigan	-13.6%	-61.8%	-21.3%
Minnesota	-14.4%	-70.5%	-23.6%
Mississippi	-11.7%	-62.0%	-21.8%
Missouri	-12.2%	-57.5%	-22.4%

State	% Change Vs Baseline, 2035		
	Enrollment	Rebate PMPM	Total Payments
Montana	-15.0%	-71.4%	-25.8%
Nebraska	-12.6%	-60.5%	-22.7%
Nevada	-11.0%	-51.9%	-22.3%
New Hampshire	-14.3%	-64.4%	-23.0%
New Jersey	-14.4%	-67.2%	-22.1%
New Mexico	-12.4%	-61.3%	-22.2%
New York	-11.9%	-60.8%	-19.0%
North Carolina	-12.3%	-57.2%	-21.8%
North Dakota	-15.8%	-75.7%	-27.0%
Ohio	-11.9%	-54.0%	-20.1%
Oklahoma	-12.4%	-60.6%	-22.6%
Oregon	-11.9%	-57.5%	-20.7%
Pennsylvania	-12.9%	-61.2%	-22.1%
Rhode Island	-10.5%	-52.4%	-21.0%
South Carolina	-13.0%	-64.3%	-23.7%
South Dakota	-15.4%	-74.6%	-27.6%
Tennessee	-12.0%	-58.0%	-22.0%
Texas	-12.2%	-55.8%	-20.7%
Utah	-11.6%	-55.2%	-23.0%
Vermont	-15.8%	-75.3%	-25.0%
Virginia	-11.7%	-55.8%	-21.7%
Washington	-11.9%	-58.4%	-22.2%
West Virginia	-14.4%	-68.6%	-22.0%
Wisconsin	-12.4%	-58.4%	-22.5%
Wyoming	-15.2%	-73.4%	-25.2%

**Table 4: Estimated Absolute Change to 2035 MA Enrollment, Rebates and Payments Due to No UPCODE Act**

State	% Change Vs Baseline, 2035		
	Enrollment (k)	Rebate PMPM	Total Payments (\$m)
Alabama	-116.7	-\$226	-\$5,717
Alaska	-0.4	-\$14	-\$11
Arizona	-120.8	-\$262	-\$6,863
Arkansas	-48.1	-\$282	-\$2,714
California	-510.7	-\$188	-\$27,352
Colorado	-86.9	-\$213	-\$4,281
Connecticut	-76.4	-\$160	-\$3,487
Delaware	-14.8	-\$189	-\$662
District of Columbia	-5.0	-\$190	-\$270
Florida	-464.2	-\$368	-\$32,848
Georgia	-185	-\$238	-\$9,357
Hawaii	-29.4	-\$184	-\$1,172
Idaho	-30.6	-\$204	-\$1,420
Illinois	-177.6	-\$185	-\$8,301
Indiana	-117.4	-\$230	-\$6,088
Iowa	-41.6	-\$232	-\$2,037
Kansas	-35.2	-\$283	-\$1,830
Kentucky	-88.8	-\$184	-\$4,199
Louisiana	-79.5	-\$280	-\$4,672
Maine	-34.6	-\$170	-\$1,501
Maryland	-50.5	-\$123	-\$2,267
Massachusetts	-84.2	-\$163	-\$3,678
Michigan	-253.6	-\$154	-\$10,818
Minnesota	-123.9	-\$178	-\$4,868
Mississippi	-43.2	-\$287	-\$2,433
Missouri	-116.4	-\$257	-\$6,467

State	% Change Vs Baseline, 2035		
	Enrollment (k)	Rebate PMPM	Total Payments (\$m)
Montana	-15.2	-\$204	-\$593
Nebraska	-20.8	-\$252	-\$1,114
Nevada	-46.7	-\$308	-\$3,176
New Hampshire	-23.6	-\$145	-\$913
New Jersey	-141.8	-\$170	-\$6,260
New Mexico	-38.4	-\$184	-\$1,617
New York	-329.5	-\$194	-\$16,932
North Carolina	-208.5	-\$245	-\$11,173
North Dakota	-8.3	-\$237	-\$346
Ohio	-221.2	-\$186	-\$11,235
Oklahoma	-55.2	-\$276	-\$3,104
Oregon	-82.9	-\$174	-\$3,773
Pennsylvania	-277.6	-\$218	-\$13,837
Rhode Island	-19.3	-\$233	-\$1,068
South Carolina	-96.9	-\$289	-\$5,176
South Dakota	-9.5	-\$246	-\$389
Tennessee	-126.1	-\$258	-\$7,098
Texas	-419.8	-\$234	-\$24,054
Utah	-39.8	-\$258	-\$2,188
Vermont	-10.7	-\$137	-\$344
Virginia	-101.6	-\$231	-\$5,312
Washington	-121.9	-\$220	-\$5,801
West Virginia	-44.5	-\$177	-\$1,980
Wisconsin	-120.6	-\$228	-\$5,924
Wyoming	-4.7	-\$204	-\$185

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