CAHPR CENTER FOR ADVANCING HEALTH POLICY THROUGH RESEARCH

School of Public Health
BROWN UNIVERSITY

Honorable Elizabeth Warren Honorable Lloyd Doggett
United States Senate United States House of Representatives
Washington, DC 20510 Washington, DC 20515

Re: Response to Request to Estimate Spending Impact of Proposed Saving MEDICARE Act

Dear Representative Doggett:

We are writing in response to your June 15, 2026, request regarding an estimate on the potential spending impact of proposed legislation to address potential excess spending on care in Medicare Advantage plans (MA).

Per your request, researchers affiliated with the Center for Advancing Health Policy through Research (CAHPR)[1] at the Brown University School of Public Health[2] have estimated the potential impact of proposed legislation that aims to strengthen Medicare Advantage program integrity by curbing diagnosis-code upcoding, reforming benchmark payment calculations, cutting ineffective bonus spending, and tightening audit oversight and enforcement timelines.

Compared to current baseline trends in spending among this population, we estimate that over a ten-year period from 2028–2037, this could reduce Medicare spending by approximately $2,520.9B. We describe the primary assumptions used in this calculation below.

Please don't hesitate to contact us if you have further questions.

Sincerely,

David Meyers, PhD
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Associate Professor
Brown University School of Public Health

Andrew Ryan, PhD
Director, CAHPR
Professor
Brown University School of Public Health

[1] The Center for Advancing Health Policy through Research (CAHPR) at the Brown University School of Public Health is a nonpartisan research center dedicated to generating research that informs policies aimed at reducing costs, improving patient well-being, and driving meaningful transformations in U.S. health care delivery. Our work focuses on the design of insurance plans and their interactions within the health care market, employing a unique approach that integrates quantitative policy analysis with legal evaluation. This combined methodology helps identify potential effective legal and regulatory changes. While this is not a research publication, it is informed by relevant research conducted from the center.

[2] The opinions and conclusions expressed in this analysis are the author's alone and do not reflect those of Brown University, the Brown University School of Public Health or any of the research sponsors.

Background

The Saving MEDICARE Act includes a series of provisions intended to reduce Medicare spending by modifying Medicare Advantage (MA) payment policies and addressing duplicate payments associated with veterans who receive care through the Department of Veterans Affairs (VA). This analysis estimates the potential impact of these provisions on federal spending over the 2028–2037 budget window.

We used projections from the 2025 Medicare Trustees Report and estimates from the published literature to model the effects of favorable selection, risk upcoding, benchmark payments associated with the county quartile system, quality bonus payments, and VA reimbursement policies. We then estimated the savings associated with individual provisions of the legislation and the overall reduction in federal spending.

Bottom-line Estimate

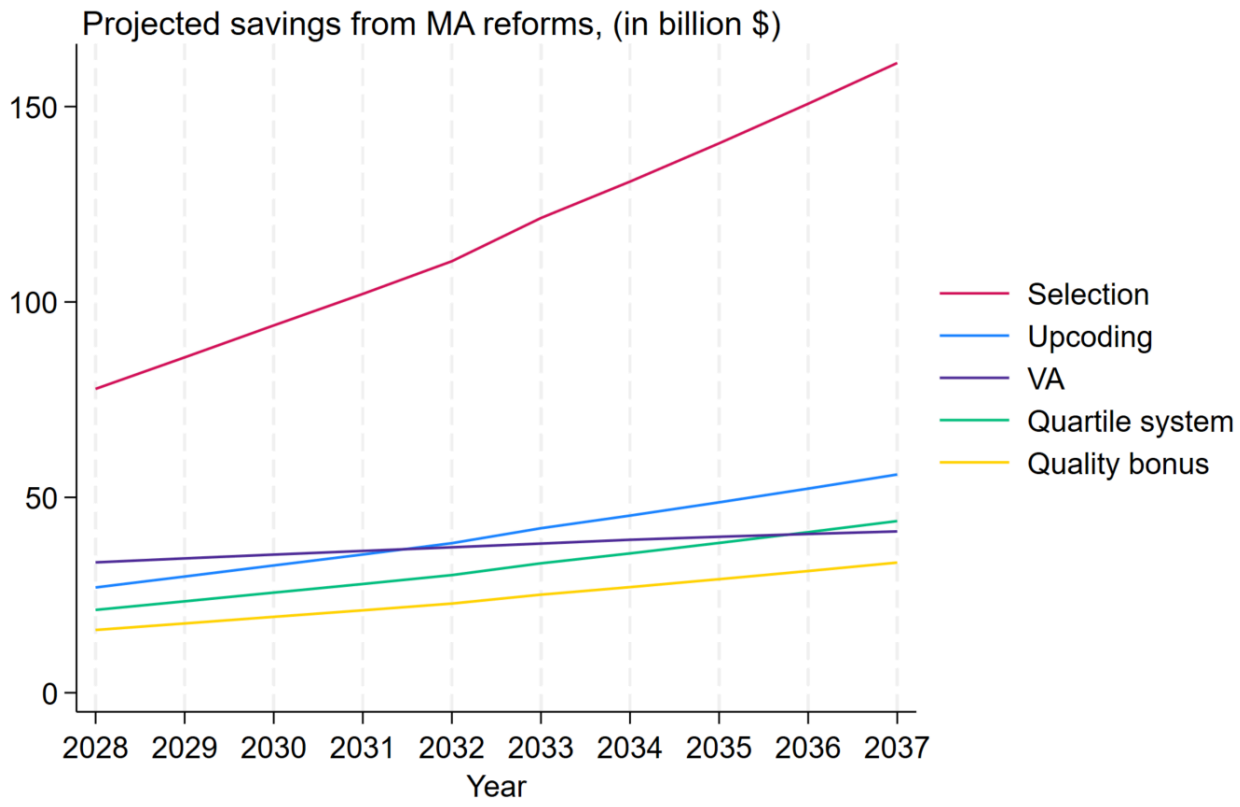
We estimate that the Saving MEDICARE Act would reduce Medicare spending by approximately $2.5 trillion over the 2028–2037 budget window (**Table 1**). The largest source of savings would result from addressing favorable selection in MA ($1.17 trillion), followed by eliminating risk upcoding ($407 billion), permitting recovery of VA spending for dually enrolled veterans ($376 billion), eliminating benchmark increases associated with the county quartile system ($320 billion), and ending quality bonus payments ($243 billion). Provisions related to oversight and enforcement may generate additional savings but were not quantified.

Figure 1 displays the projected annual savings associated with each provision over the 2028–2037 budget window. Because MA enrollment and spending per beneficiary are projected to increase over time, annual savings increase throughout the projection period.

Table 1. Estimates of the impact of components of the Saving MEDICARE Act on Medicare spending over 2028-2037 budget window

Component	Total Savings Over 10 Year Budget Window, ($B)
Preventing upcoding	407.2
Improving benchmark payments	
Addressing favorable selection	1,174.8
Eliminating quartile payment system	320.3
Eliminating frivolous payments	
Ending Quality Bonus Payments	242.8
Eliminating VA double payment	375.8
Enhancing oversight	N/A
Total	2,520.9

Figure 1. Projected savings of components of the Saving MEDICARE Act on Medicare spending over each year of 2028-2037 budget window



How We Estimated The Impact Of MA Provisions

To estimate the impact of provisions affecting MA payments, we used projections from the 2025 Medicare Trustees Report on MA enrollment and spending per beneficiary for Medicare Parts A and B. We used Trustees projections through 2034 and extended them through 2037 using the average annual growth rate observed in the Trustees Report. All estimates were generated for the 2028–2037 budget window and assume implementation beginning January 1, 2028.

Modeling the impact of MA payment adjustments on spending per beneficiary

We approximated MA spending per beneficiary as a function of underlying expected medical spending and four payment adjustments: favorable selection, risk upcoding, benchmark payments associated with the county quartile system, and quality bonus payments. Specifically, we modeled MA spending per beneficiary as:

MA spending per beneficiary = expected spending × (1 + favorable selection) × (1 + risk upcoding) × (1 + quartile adjustment + quality bonus)

This equation did not account for county-level payment adjustments, which we assumed would be largely budget neutral. Parameter values were obtained from published analyses and are summarized in Table 2. We assumed a favorable selection effect of 12 percent based on estimates reported by MedPAC. The quartile adjustment was based on estimates from Murray et al.,[1] and the quality bonus effect was based on estimates reported by Dixit et al.[2]

To estimate the remaining coding-related overpayment in MA, we relied primarily on recent analyses by MedPAC.[3,4] Prior to implementation of the CMS-HCC V28 risk adjustment model, MedPAC estimated that differential coding increased MA risk scores by approximately 16 percent relative to traditional Medicare, resulting in roughly 10 percent higher payments after accounting for the statutory coding intensity adjustment. More recently, MedPAC estimated that the transition to V28 substantially reduced excess coding by removing many diagnosis codes that were particularly susceptible to differential coding practices. In its March 2026 Report to Congress,[3] MedPAC estimated that the residual payment effect of coding intensity under the fully phased-in V28 model is approximately 4 percent. This estimate is broadly consistent with analyses from CMS and other researchers showing that V28 reduced coding intensity by roughly 7–9 percentage points relative to the prior V24 model. Because the Saving MEDICARE Act would take effect after implementation of V28, we used MedPAC's 4 percent estimate as the baseline level of residual coding-related overpayment available to be addressed by additional policy reforms. We assumed that these reforms, together, would eliminate the residual 4 percent upcoding.

Calculating projected savings

Using these assumptions, we estimated expected spending absent payment adjustments and calculated the excess spending attributable to each payment provision. This was performed using the Shapley method for statistical decomposition. We then projected the savings associated with eliminating these payment adjustments over the 2028–2037 budget window.

Table 2. Modeled Assumptions about the effect of MA payment features on spending

			Shapley factors	
Factor contributing to overpayment	**Assumed effect on excess MA spending**	**Source**	**Contribution**	**Share**
Favorable selection	12%	MedPAC 2026[4]	12.58 pp	54.8
Risk upcoding	4%	MedPAC 2026[3]	4.36 pp	19.0
Quartile adjustment	3.17%	Murray et al.[1]	3.43 pp	14.9
Quality bonus	2.4%	Dixit et al.[2]	2.60 pp	11.3
Total			22.97%	100%

To estimate the impact of the provision permitting the Department of VA to recover costs from MA plans for services delivered to dually enrolled veterans, we used projections of the number of veterans enrolled in both VA health care and MA and projections of VA spending per beneficiary derived from a prior budget analysis.[5]

We multiplied projected enrollment by projected spending per beneficiary to estimate total VA spending attributable to dually enrolled veterans during the 2028–2037 budget window and treated these expenditures as potential savings under the legislation.

Limitations

This analysis has several limitations. First, we assumed that changes in MA payment policy would not affect beneficiary enrollment decisions. Reductions in MA payments could affect plan participation, premiums, or enrollment, although the net effect on federal spending is uncertain because beneficiaries who leave MA would enroll in traditional Medicare.

Second, the estimates rely on a limited number of published studies and policy analyses. The magnitude of favorable selection, coding intensity, benchmark payments, and quality bonus

payments remains subject to uncertainty, and alternative assumptions would produce different estimates. For instance, our analysis assumes that the impact of v28 would persist over the budget time window. If plans find ways to circumvent v28 and increase coding intensity over time, our estimates will be overly conservative. Third, the analysis assumes that the effects of current MA payment policies remain constant over time. Changes in program rules, market conditions, beneficiary characteristics, or insurer behavior could alter the impact of these payment provisions during the budget window. Relatedly, the analysis assumes that policy changes are fully implemented and achieve their intended effects. Actual savings could differ if implementation is delayed, incomplete, or generates behavioral responses by plans, providers, or beneficiaries.

Fourth, uncertainty increases over the projection period. Estimates of future savings depend on projections of MA enrollment and spending per beneficiary, both of which become less certain farther into the future. Finally, the estimated savings associated with VA reimbursement provisions depend on assumptions regarding the amount of spending attributable to dually enrolled veterans and the extent to which these expenditures would be recoverable from MA plans.

References

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3. Medicare Payment Advisory Commission. *March 2026 Report to the Congress: Medicare Payment Policy*. MedPAC; March 2026. Accessed June 24, 2026. https://www.medpac.gov/document/march-2026-report-to-the-congress-medicare-payment-policy/

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5. Meyers DJ, Ryan A. Response to Request to Estimate Spending Impact of Proposed VA/MA Legislation. Center for Advancing Health Policy Through Research, Brown University School of Public Health; June 20, 2025. Accessed June 24, 2026. https://drive.google.com/file/d/1aEJ57x_EnAYds2jCG8eHwAhC-kVZPAmb/view?usp=sharing

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