HEALTHCARE INDUSTRY GROUP

Medicare Advantage at an Inflection Point: From Coding Arbitrage to Value Competition

The Trump administration's 2027 Medicare Advantage (MA) Advance Notice triggered an immediate market response—one that underscores how deeply investors understand the implications of this policy shift.[1]

Within hours of the proposal's release, Medicare Advantage–exposed equities sold off sharply:

- **Humana:** Down ~20% at the open[1]
- **UnitedHealth Group:** Down high-teens following the rate proposal and weaker 2026 guidance[1]
- **CVS / Aetna, Elevance, Centene:** Down ~10%–13%[1]

This was not a routine reaction to a modest rate update. The equity markets are signaling that the core earnings model underpinning Medicare Advantage, particularly the ability to offset medical cost pressure through coding intensity, is being structurally impaired.

Nearly flat benchmark rates combined with a proposed exclusion of *unlinked chart reviews* from risk adjustment represent the most consequential reset of the program in more than a decade. CMS is deliberately moving MA away from revenue growth driven by documentation arbitrage toward a model that forces plans to compete on true clinical value, medical cost control, and beneficiary experience.[2,3]

For payers, the message is unambiguous: The arms race around risk score optimization is ending. The next era of Medicare Advantage will reward operational discipline—not financial engineering.

WHAT CHANGED AND WHY IT MATTERS

1 FLAT RATES ARE A POLICY SIGNAL, NOT A BUDGET ACCIDENT

CMS proposed a 0.09% average net payment increase for 2027, far below the 4%–6% increase anticipated by the street, based on underlying medical cost trends.[3] While CMS actuaries still project ~2.5% payment growth after coding, the topline signal is unmistakable: Regulators are no longer willing to underwrite margin protection through generous benchmarks.[3]

This comes amid:

- Persistent evidence of MA overpayments measured in the tens of billions annually.
- Intensifying Congressional, DOJ, and media scrutiny of payer practices.
- A broader political narrative focused on taxpayer protection and program integrity.

Flat rates, in this context, are leverage. They constrain the system while CMS simultaneously tightens the rules governing how plans generate revenue.

2 EXCLUDING UNLINKED CHART REVIEWS IS THE REAL SHOCKWAVE

The proposed exclusion of diagnoses derived from chart reviews not tied to an actual beneficiary encounter is the most impactful element of the rule.

Chart reviews—retrospective mining of medical records to identify undocumented diagnoses—are:

- Not permitted in traditional Medicare.
- One of the largest drivers of MA overpayments.
- Estimated to have generated ~$24 billion in excess payments in 2023 alone.[4,5]

Under the proposal:

- Diagnoses must be connected to a documented clinical encounter to count toward risk scores.
- "Drive-by" coding exercises, health risk assessments, and unanchored reviews lose financial value.
- Plans with heavier reliance on retrospective coding will be disproportionately impacted.

This change compounds the margin pressure already introduced by V28, which is fully phased in by 2026 and has already compressed risk score uplift across the industry.

3 SCALE IS NO LONGER AN AUTOMATIC ADVANTAGE

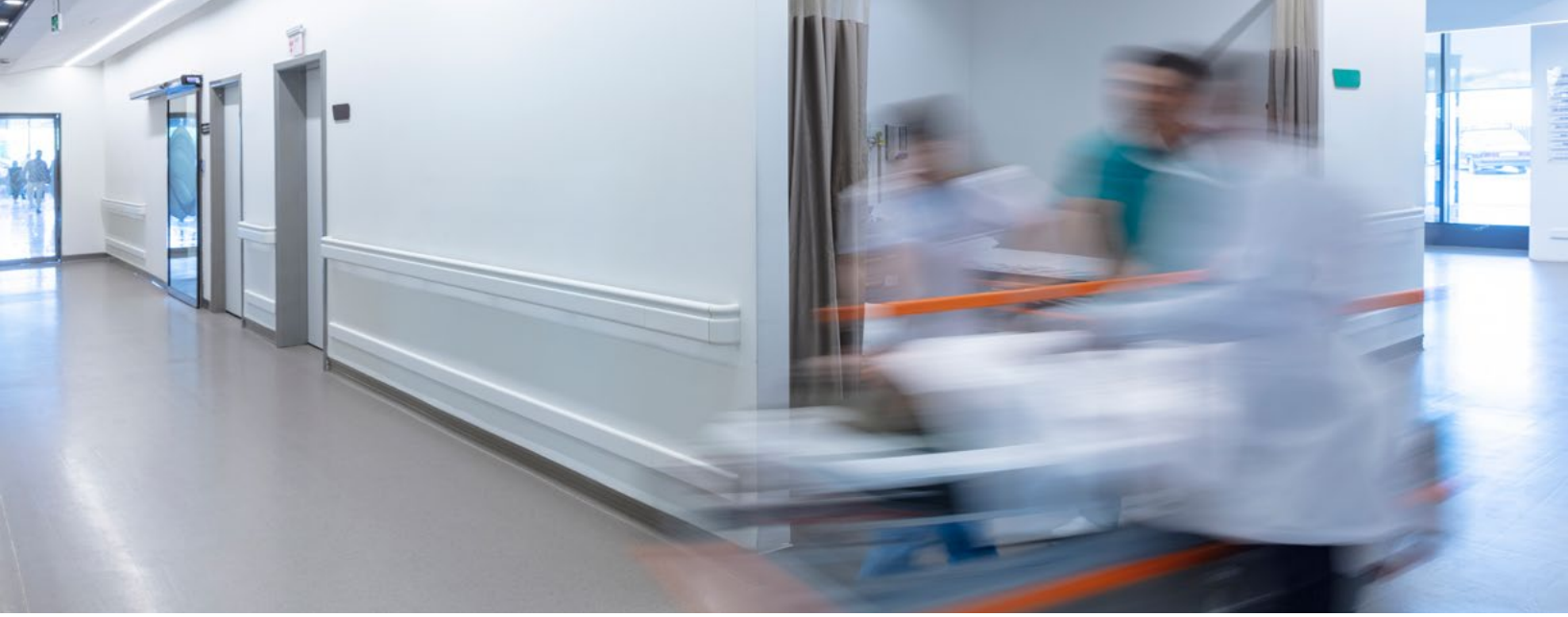
CMS explicitly framed the proposal to level the playing field regardless of plan size or resources.[2,3] That language matters.

Large nationals, particularly UnitedHealthcare, have historically leveraged scale to build industrialized coding operations, including home-based assessments and large clinical coding workforces. While all major carriers participate to varying degrees, exposure is uneven.

Under the proposed framework:

- Scale-driven coding arbitrage becomes less valuable.
- Fixed-cost infrastructures built around risk optimization face diminishing returns.
- Regional and nonprofit plans that relied less on aggressive chart reviews may be relatively advantaged.

In effect, CMS is shifting competitive advantage away from who can *code best* toward who can *manage care best*.



IMPLICATIONS FOR MEDICARE ADVANTAGE ECONOMICS

MARGIN COMPRESSION IS STRUCTURAL, NOT TEMPORARY

Taken together, flat rates + chart review exclusion + V28 create a multi year margin reset:

- Less ability to offset medical trend through coding.
- Higher sensitivity to utilization growth, especially post-acute and pharmacy.
- Increased pressure on benefit richness and supplemental offerings.

Carrier warnings about benefit cuts should be taken seriously—but also understood as part of a familiar lobbying playbook. The deeper reality is that MA margins were inflated by a system CMS now views as misaligned with program intent.

BENEFIT DESIGN WILL GET SHARPER—AND NARROWER

Plans will be forced to:

- Reprice benefits with greater precision.
- Reassess the ROI of supplemental benefits untethered to measurable outcomes.
- Exit underperforming counties and products more aggressively.

The elevated churn and plan switching already observed for 2026 is likely a preview of what's ahead.

CARE MANAGEMENT MUST FINALLY CARRY ITS WEIGHT

With coding tailwinds fading, sustainable performance will depend on:

- Prospective clinical engagement.
- Effective chronic condition management.
- Pharmacy and utilization control (particularly GLP-1s, specialty drugs, and post acute spend).

In short, MA economics will increasingly resemble managed care fundamentals, rather than regulatory optimization.

WHAT PLANS SHOULD DO NOW

The market reaction makes clear that this is not a policy risk to be managed through advocacy alone. Plans need to act now to reposition their operating models for a post-arbitrage MA environment.

1 REBASE FINANCIAL PLANS WITHOUT CODING TAILWINDS

Plans should immediately re-underwrite their multi-year MA forecasts assuming:

- Lower sustainable risk score lift.
- Reduced ROI from retrospective chart reviews.
- Continued regulatory tightening beyond 2027.

Margin plans that rely on "coding catch-up" to close gaps will not hold.

2 WIND DOWN UNLINKED CHART REVIEW INFRASTRUCTURE

Organizations with industrialized chart review operations should do the following:

- Quantify exposure by product, geography, and member cohort.
- Begin de-scaling vendor and internal resources tied to unanchored reviews.
- Shift remaining efforts toward encounter based documentation integrity and compliance.

The objective is not less accurate coding, but defensible, care-anchored coding.

3 DOUBLE DOWN ON MEDICAL COST MANAGEMENT

With revenue levers constrained, cost becomes decisive. High-performing plans will refocus on:

- Utilization management modernization.
- Post-acute and site-of-care optimization.
- Pharmacy economics, particularly specialty drugs and GLP-1s.
- Targeted chronic condition programs with measurable impact.

Care management must now earn its keep.

4 REPRICE BENEFITS AND RATIONALIZE FOOTPRINTS

Expect continued contraction.
Winning plans will do the following:

- Reprice supplemental benefits with sharper ROI discipline.
- Exit structurally unprofitable counties and populations.
- Simplify benefit designs to reduce administrative and clinical leakage.

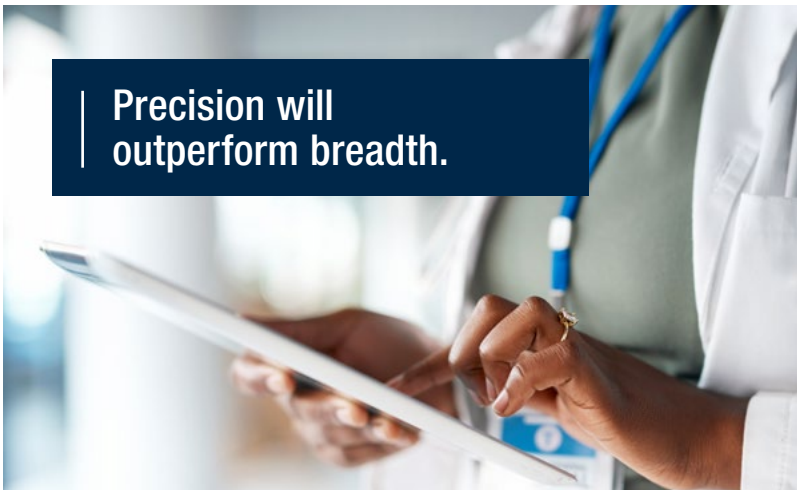
Precision will outperform breadth.

5 PREPARE LEADERSHIP AND BOARDS FOR A NEW MA NARRATIVE

Finally, management teams must reset expectations internally:

- This is a structural margin reset, not a temporary policy cycle.
- Regulatory scrutiny is likely to intensify, not fade.
- Competitive advantage will come from execution, not scale alone.

Plans that acknowledge this early will move faster—and suffer less dislocation—than those waiting for relief that is unlikely to arrive.



BOTTOM LINE

The Trump administration's Medicare Advantage proposal is not anti-MA. It is anti-gaming.

By constraining rates and curbing unlinked chart reviews, CMS is attempting to restore credibility to the program and re-anchor competition around value delivered to beneficiaries—not documentation prowess.

For plans that have built durable care models, disciplined cost structures and authentic clinical engagement, this reset is survivable—and potentially advantageous.

For those dependent on coding intensity to manufacture margin, the warning shot has already been fired.

The Medicare Advantage market is entering its post-arbitrage era. The winners will be those prepared to operate accordingly.

SOURCES:

1. Singh, Pia and Constantino, Annika Kim. "Humana, UnitedHealth plunge 20% after Trump administration proposes keeping Medicare Advantage rates flat." *CNBC*. January 26, 2026, updated January 27, 2026.
2. Parduhn, Rebecca Pifer. "CMS proposes excluding chart reviews from MA risk scoring in 2027 payment rule." *Healthcare Dive*. January 27, 2026.
3. Centers for Medicare & Medicaid Services. Medicare Advantage and Part D Advance Notice. January 26, 2026.
4. Medicare Payment Advisory Commission (MedPAC). March 2024 Report to the Congress: Medicare Payment Policy. March 15, 2024.
5. Biniek, Jeannie Fuglesten. "How Medicare Pays Medicare Advantage Plans: Issues and Policy Options." *Kaiser Family Foundation (KFF)*. November 20, 2025.

CONTACT US

Craig Savage
Managing Director,
Health Plans and Managed Care Practice Leader

craig.savage@alvarezandmarsal.com

Follow A&M on:

ABOUT ALVAREZ & MARSAL

Founded in 1983, Alvarez & Marsal is a leading global professional services firm. Renowned for its leadership, action and results, Alvarez & Marsal provides advisory, business performance improvement and turnaround management services, delivering practical solutions to address clients' unique challenges. With a world-wide network of experienced operators, world-class consultants, former regulators and industry authorities, Alvarez & Marsal helps corporates, boards, private equity firms, law firms and government agencies drive transformation, mitigate risk and unlock value at every stage of growth.

To learn more, visit: **AlvarezandMarsal.com/healthcare**

ALVAREZ & MARSAL
LEADERSHIP. ACTION. RESULTS.℠