MEDPAC

Advising the Congress on Medicare issues

Association between changes in Medicare Advantage enrollment and hospital finances

Jeff Stensland and Brian O'Donnell

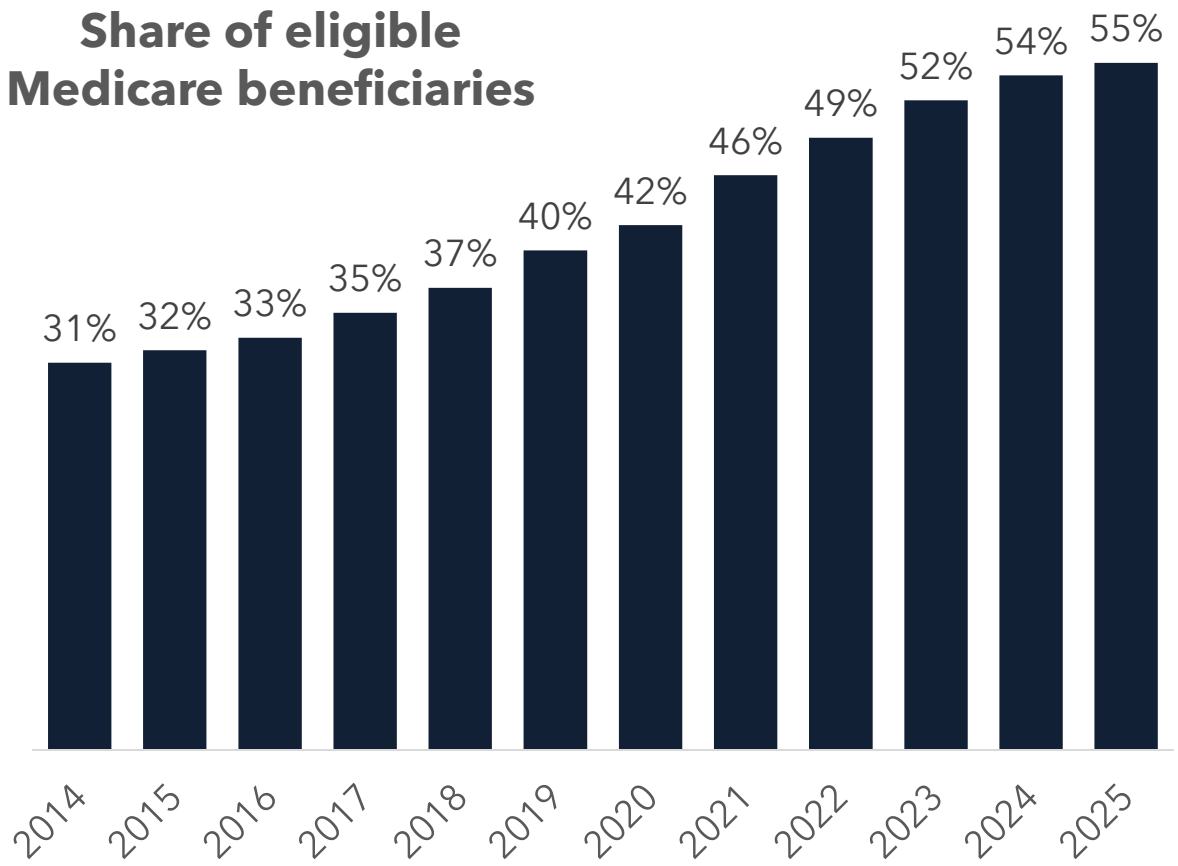
September 5, 2025

Presentation roadmap

1. Background on MA enrollment, prior research, and plan incentives
2. Association between MA enrollment changes and hospital revenues, costs, and profit margins
3. Topic for further exploration: Association between MA enrollment changes and uncompensated care payments per discharge
4. Discussion and next steps

Note: MA (Medicare Advantage).

Share of Medicare beneficiaries enrolled in MA has increased rapidly, 2014–2025



- From 2014 to 2025, the share of Medicare beneficiaries enrolled in MA has grown from 31% to 55%
- Growth is driven by multiple factors, including:
  - Beneficiaries' preferences for additional benefits, out-of-pocket spending limits, reduced cost sharing, integration of Part D drug benefits
  - Employers increasingly offer retiree health benefits through MA plans

Note: MA (Medicare Advantage). Beneficiaries must have both Part A and Part B coverage to enroll in MA; therefore, beneficiaries who have Part A only or Part B only are not included in this figure.

Source: Medicare Payment Advisory Commission. 2025. *A data book: Health care spending and the Medicare program*. Washington, DC: MedPAC.
Freed, M., T. Neuman, M. Rae, et al. 2024. *Medicare Advantage has become more popular among the shrinking share of employers that offer retiree health benefits*. Washington, DC: KFF.

Prior research on effects of MA growth on hospitals is limited and mixed

- MedPAC site visits: Hospitals report that MA plans result in higher costs and lower revenues
- Hospital industry analyses suggest that MA patients have lower payment-to-cost ratios than FFS patients
- Academic research has been limited, mixed, and focused on rural areas
  - One study found MA growth was associated with improved financial conditions for rural hospitals
  - Another found MA growth reduced inpatient days at rural hospitals and increased inpatient days at urban hospitals

Note: MA (Medicare Advantage), FFS (fee-for-service).

Source: Henke, R. M., K. R. Fingar, L. Liang, et al. 2023. Medicare Advantage in rural areas: Implications for hospital sustainability. *American Journal of Managed Care* 29, no. 11 (November): 594–600.
Cataife, G., and S. Liu. 2025. Medicare Advantage penetration and the financial distress of rural hospitals. *Health Economics Review* 15, no. 1 (February 12): 9.
American Hospital Association. 2025. The growing impact of Medicare Advantage on rural hospitals across America. https://www.aha.org/guidesreports/growing-impact-medicare-advantage-rural-hospitals-across-america.

MA plans have an incentive to manage utilization, which could reduce volume and shift care to lower-paid settings

- MA plans have multiple tools to reduce volume or shift care to lower-paid settings
  - Provider networks
  - Utilization management (e.g., prior authorization)
- MA plan tools
  - When used appropriately, may promote more efficient care and better outcomes (e.g., avoiding high-cost settings by better managing care)
  - When misused, may lead to beneficiaries having difficulty accessing needed care and additional administrative burdens on providers

Note: MA (Medicare Advantage).

MA plans have an incentive to reduce their payments per patient to providers

- MA plans often have an incentive to negotiate rates below FFS rates
  - MA payment rates are similar to FFS rates for hospital inpatient services
  - But MA payment rates in other sectors may be above or below FFS rates
- MA plans have an incentive to reduce payments in other ways:
  - Reclassifying patients (e.g., downgrading a hospital admission to an observation stay, reporting a lower severity level of admission)
  - Denying claims for lack of medical necessity

Note: MA (Medicare Advantage), FFS (fee-for-service).

Source: Maeda, J., and L. Nelson. 2017. *An analysis of private-sector prices for hospital admissions*. Congressional Budget Office working paper 2017-02. Washington, DC: CBO.
Vabson, B., A. L. Hicks, and M. E. Chernew. 2025. Medicare Advantage denies 17 percent of initial claims; most denials are reversed, but provider payouts dip 7 percent. *Health Affairs* 44, no. 6 (June): 702–706.

Incentives may differ when MA plans are financially integrated with providers

- Many hospitals are financially integrated with an MA plan (i.e., they have common ownership)
- With non–financially integrated hospitals, MA plans may have an incentive to:
  - Reduce volume
  - Reduce payment rates
  - Downgrade inpatient admissions to observation stays
- With financially integrated hospitals, MA plans have different incentives:
  - Weaker incentive to reduce volume
  - No incentive to reduce payment rates
  - Among teaching hospitals, incentive to code stays as inpatient admissions rather than observation stays
- Incentives associated with financial integration could vary across sectors

Note: MA (Medicare Advantage).

Estimating how MA plans' incentives may affect hospitals' finances

- MA plan incentives may affect providers' finances through many channels
- Our approach estimates the aggregate effect of these incentives on:
  - All-payer revenue (which includes FFS and MA revenue)
  - All-payer costs
  - All-payer profit margins
- Some effects may be offsetting
  - E.g., if MA reduces hospitals' patient volume, we would expect to see reductions in both revenues and costs
- We also estimate whether the effects of MA enrollment changes are different for hospitals that are financially integrated with an MA plan

Note: MA (Medicare Advantage), FFS (fee-for-service).

Estimated associations between changes in MA enrollment and hospital revenues, costs, and profit margins

Overview of Commission's preliminary research approach

- Used hospital cost-report data to obtain revenue, costs, and profit margins from 2013 to 2023
- Examined all-payer revenue, costs, and profit margins
  - MA-specific financial data are not available on hospital cost reports
- Used MA penetration (i.e., the share of eligible beneficiaries enrolled in MA) in each hospital's county to measure exposure to MA
- Examined both IPPS hospitals and CAHs
- Identified hospitals that were financially integrated with an MA plan using AHRQ's Compendium of U.S. Health Systems

Note: MA (Medicare Advantage), IPPS (inpatient prospective payment systems), CAH (critical access hospital), AHRQ (Agency for Healthcare Research and Quality).

Overview of Commission's preliminary research approach *(continued)*

- Used linear regression models to examine how changes in county-level MA penetration were associated with changes in hospital finances
  - Included hospital fixed-effects, meaning estimates reflect changes within each hospital from 2013 to 2023
  - Included year fixed-effects to control for national trends
  - Included controls for county-level demographic factors that were changing during the study period
- Associations we estimate could be due to the causal effects of MA on finances or effects of factors omitted from our models (due to a lack of data) that could affect both MA enrollment and hospital finances

Note: MA (Medicare Advantage).

Association of changes in MA enrollment and changes in revenue, costs, and profits

Association with a 10 percentage point increase in MA penetration	
Profit margin (percentage points change)	–0.1% (0.2%)
All-payer revenues	–1.3%* (0.2%)
All-payer costs	–1.2%* (0.6%)

Note: * Revenue and cost differences are statistically significant using a $p < .05$ criterion. Standard errors are in parentheses.

On average, across all IPPS hospitals:

- **Profit margins:** No significant association with changes in MA penetration
- **Revenue and costs:** Are 1.3% and 1.2% lower, respectively, when MA penetration is 10 percentage points higher

Note: MA (Medicare Advantage), IPPS (inpatient prospective payment systems).
Source: MedPAC analysis of Medicare cost reports and enrollment data from CMS.

Association of changes in MA enrollment and changes in revenue, costs, and profits *(continued)*

Association with a 10 percentage point increase in MA penetration

	Base effect	Additional effect if financially integrated
Profit margin (percentage point change)	0.0% (0.2%)	–0.4% (0.2%)
All-payer Revenue	–2.0%** (0.6%)	2.6%** (0.7%)
All-payer cost	–1.9%** (0.6%)	3.3%** (0.6%)

Note: ** For revenues and costs, base effects and additional effects on integrated providers are statistically significant at the p<.01 level of significance. The combined effects are not statistically significant for integrated providers. Standard errors in parentheses.

Some associations differ depending on integration with an MA plan

- **Nonintegrated:** Lower revenues and costs
- **Financially integrated:** No statistically significant association between changes in MA enrollment and revenues or costs

No difference in associations for profit margins

Note: MA (Medicare Advantage). To calculate the effect of a 10 percentage point increase in MA penetration on financially integrated hospitals, sum the base effect and the additional effect of financial integration (i.e., the first and second columns in the table on this slide).

Source: MedPAC analysis of Medicare cost reports and enrollment data from CMS.

Critical access hospitals: No statistically significant association with revenues, costs, or profit margins

- No statistically significant association between MA enrollment changes and:
  - Revenues
  - Costs
  - Profit margin
- Potential explanations (discussed further at the Commission's April 2025 public meeting)
  - If CAH volume declines, payment per unit increases due to cost-based reimbursement
  - MA patients have longer lengths of stay; per diem payments by MA plans could, in part, offset any reduction in inpatient volume

Note: MA (Medicare Advantage), CAH (critical access hospital).

Topic for further exploration: High MA growth could increase a hospital's uncompensated care payments

- About 80% of IPPS hospitals are DSH hospitals that receive add-on payments to cover a portion of their uncompensated care costs
- Payments are made as an add-on to each FFS discharge
- We have heard MA plans usually pay the same FFS add-on for each MA discharge

Note: MA (Medicare Advantage), IPPS (inpatient prospective payment systems), DSH (disproportionate share), FFS (fee-for-service).

An above-average decline in FFS discharges increases the uncompensated care add-on per discharge

- When MA plans pay hospitals based on the FFS pricer, the formula for the Medicare Advantage UC payments is approximately:

  MA discharges x (FFS UC payments/historic average of FFS discharges)
- As MA discharges increase, MA UC payments increase
- As FFS discharges decrease, MA UC payments increase
- We estimate that for every 10-perentage-point shift from FFS to MA in a county, UC payments per FFS and MA discharge increase by about 13 percent relative to the national average change.

Note: FFS (fee-for-service), UC (uncompensated care), MA (Medicare Advantage).

Limitations

- We examine associations, not causal relationships
  - May be missing variable that are related to both MA enrollment changes and changes in hospital revenues
  - Some of the association between MA growth and hospital finances may be driven by these factors that are omitted from our regression models
  - Integrated hospitals may differ in multiple ways from unintegrated hospitals
- We have an imprecise measure of how integrated a hospital is with an MA plan. Even integrated hospitals will often serve patients from other MA plans. Therefore, our effect of integration will be imprecise.
- There is heterogeneity among hospitals; effects of MA growth may differ among subgroups of hospitals

Note: MA (Medicare Advantage).

Summary

- On average, we estimate that increases in MA enrollment are:
  - Not associated with a statistically significant change in hospital profit margins
  - Associated with lower hospital revenues and costs
- Effects on providers' finances may differ by ownership status
  - MA plans have limited financial incentives to reduce volume or payment rates at financially integrated hospitals
    - Financially integrated hospitals do not experience large revenue changes when MA grows
    - Non–financially integrated hospitals experience revenue and cost declines
  - Financial integration between MA plans and providers could also be important in other sectors (e.g., clinicians, ASCs, home health)
- MA enrollment changes may have unexpected effects on FFS and MA payment rates (e.g., uncompensated care payments per discharge)

Note: MA (Medicare Advantage), ASC (ambulatory surgical center), FFS (fee-for-service).

Discussion and next steps

- Questions or clarifications?
- Feedback on additional future work?

MEDPAC

Advising the Congress on Medicare issues

Medicare Payment Advisory Commission

meetingcomments@medpac.gov

www.medpac.gov

@medicarepayment