CHAMBER HILL

INSIGHTS

MedPAC Meeting on MA Enrollment and Hospital Finances

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On September 5, 2025, the Medicare Payment Advisory Commission (MedPAC) convened for the second day of its September meeting. Staff presented findings on the relationship between shifts in Medicare Advantage (MA) enrollment and hospital finances. Commissioners responded positively to the analysis and offered suggestions to strengthen and expand the research.

ASSOCIATION BETWEEN CHANGES IN MA ENROLLMENT AND HOSPITAL FINANCES

MedPAC staff examined how rising MA enrollment is affecting hospitals' finances. Between 2014 and 2025, MA enrollment grew from 31% to 55% of Medicare beneficiaries, driven by beneficiary preferences for added benefits and employer retiree coverage shifts. Hospitals have expressed concern that MA patients often generate lower payment-to-cost ratios than fee-for-service (FFS) patients, and MA plans actively use tools like prior authorization and narrow networks to manage utilization, which can reduce hospital volumes or shift care to lower-paid settings. Additionally, MA plans negotiate rates, downgrade admissions, and deny claims in ways that can reduce hospital revenue.

Using 2013–2023 cost report data, MedPAC found that higher MA penetration is not significantly associated with changes in hospital profit margins, but it is linked to declines in both revenues and costs (about 1.3% and 1.2% for every 10-percentage-point increase in MA penetration). Effects differ by ownership: financially integrated hospitals did not experience significant revenue or cost declines, while non-integrated hospitals did. Critical Access Hospitals saw no statistically significant effects, partly due to cost-based reimbursement and MA per diem structures. Another emerging issue is uncompensated care (UC) payments—because MA plans often mirror FFS add-ons, a decline in FFS discharges raises the UC payment per discharge, potentially increasing hospitals' UC payments as MA grows.

Overall, the findings suggest that MA growth shifts financial dynamics but does not broadly erode hospital profit margins, with effects moderated by whether hospitals are integrated with MA plans. Policymakers may need to consider integration differences and downstream effects on FFS-related payments when evaluating MA's hospital impact

COMMISSIONER DISCUSSION

The Commissioners' discussion focused on the financial and operational impacts of MA growth on hospitals, with particular attention to integration, utilization management, and methodological considerations.

Several Commissioners raised questions about how new services and prior authorization denials affect hospital operations, emphasizing that, while hospitals often maintain profit margins, they must divert resources to manage administrative burdens. Concerns were also raised about retiree health plan enrollees in MA, the role of broker incentives, and whether beneficiaries and taxpayers are truly getting value for money under the current system.

Others highlighted the importance of examining differences between financially integrated and non-integrated hospitals, noting the leverage and pricing differentials created by integration. Commissioners suggested expanding the analysis to include dollar amounts, stratifications based on MA market characteristics, and thresholds in penetration levels. They also encouraged looking at other sectors, such as post-acute care and skilled nursing facilities, where effects may differ. There was recognition that hospitals owning MA plans tend to be larger and structurally different, and that regional market dynamics and timing of MA penetration may produce varying effects. Overall, while the analysis was well received, Commissioners urged refinement with more current data, stratified analyses, and a clearer picture of how MA growth translates into real-world financial pressures and adaptations by providers.

We trust you found this summary useful. Please reach out to us with any questions.