

# Concerns Mount Over MA Among Rural Providers, Patient Advocates

Mar 3, 2026, 6:42 PM EST

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(Inside Health Policy)

Rural hospitals and patient advocates are separately voicing their concerns over the behavior of Medicare Advantage plans, including persistent upcoding and market exits, the latter of which forced about 3 million seniors to find another plan in 2026, according to a recent study. Consumers advocates want Congress to beef up original Medicare and both groups want action on two bipartisan bills that would ban upcoding and address network adequacy issues.

In 2025, about 55% of Medicare beneficiaries were enrolled in a Medicare Advantage plan. These plans receive capitated payments from the government and are known to attract beneficiaries with a variety of benefits not offered in traditional Medicare, including dental, vision, hearing, transportation and more.

MA plans are also known for higher coding intensity than FFS, meaning they often find more diagnosis for enrollees to boost their risk scores to glean higher pay. According to the Medicare Payment Advisory Commission (MedPAC), the government will spend \$76 billion more on MA enrollees than if they'd signed up for original Medicare in 2026.

But researchers found in a study published Wednesday (Feb. 18) in *JAMA Network* that sharply more insurers are dropping their MA plans and now about one in ten MA beneficiaries in 2026 were forced leave their plan due these contract terminations or service area reductions.

“Disruptions are more common among beneficiaries enrolled in PPO plans, plans offered by smaller carriers, and those living in rural areas,” Mark Meiselbach, study co-author and Johns Hopkins Bloomberg School of Public Health assistant professor, said on LinkedIn about the report. “These findings highlight the potential for significant coverage disruptions and raise important questions about continuity of care and market dynamics in Medicare Advantage.”

The study bolsters the issues patient advocates and rural providers made at recent industry conferences this year.

Families USA's Health Action Conference included a special session on MA this year, and panelists encouraged patient advocates to push for Congress to put traditional Medicare on par with MA by setting an out-of-pocket cap and by offering additional benefits like dental, vision and hearing.

To further level the playing field, MA's risk adjustment model must stop being based on individual assessments and instead broadly take into account the patient's health like Medicare does, suggested panelist Brendan Rose, AARP's Government Affairs Director.

"Some insurance carriers have entire employee teams of folks dedicated to prior authorization denials [and] training folks how to up code more effectively," Rose said at the Jan. 22 panel.

Rose reiterated AARP's support the No UPCODE Act, sponsored by Senate health committee chair Bill Cassidy's (R-LA) and ranking Democrat Jeff Merkley (OR), that would save up to \$270 billion over the next decade by reforming the MA risk adjustment model.

Cassidy's bill faced strong opposition as Better Medicare Alliance argued in December the bill would sharply reduce MA benefits, increase seniors' out-of-pocket costs, and lead to nearly 6 million fewer enrollees by 2035.

**Beneficiary advocates must find a way to counter the rallying cry MA plans are sending their beneficiaries to oppose these bills, Rose said.**

"[Groups that represent the insurance carriers] send notes or emails out to Medicare Advantage enrollees and say, 'Hey, Dan, guess what? Congress is about to cut \$200 billion from Medicare, and they're going to kill your benefit package. You better reach out to your member of Congress and tell them to protect Medicare,'" Rose said. "And, that is the message that folks in Congress get every time there's an effort to rein in MA or further regulate. And I think that that's the fundamental call, is figuring out how to counter that messaging so that we can be more effective at advocating with Congress."

MA plan marketing and compare tools also need to be reformed, panelist Medicare Rights Center Federal Policy Director Lindsey Copeland said.

“[A] lot of people when they are approaching Medicare eligibility are hearing a lot from MA plans,” Copeland said. “They are not hearing anything from the federal government. That's because the federal government is currently not required to reach out to beneficiaries or soon-to-be beneficiaries during that window.”

Rural providers are facing their own problems with MA plans, alleging low reimbursement rates delayed payments and market exits. While the new report backs up provider concerns about the market exits, researchers have yet to identify the data that show the financial issues MA plans are causing.

At the National Rural Health Association's Policy Institute Feb. 12, experts said the data is not there to support the anecdotal evidence that MA plans are hurting rural providers. Instead, researchers say MA has little impact on rural providers' finances and when it does, there's a small bump in hospital profits.

“Empirical studies find that Medicare Advantage is not bad and sometimes even good, and so that does not really align with [anecdotal reports],” Mark Holmes, director at the University of North Carolina's Cecil G. Sheps Center for Health Services Research, told rural advocates at a Feb. 12 panel discussion.

Holmes acknowledged more research needs to be done and some data hidden in a “black box.” He and Medicare Payment Advisory Commission analyst Brian O'Donnell suggested hospitals try to perform a cost report so researchers can construct an MA-specific margin that will help them determine pay.

While data tries to catch up, rural providers are feeling the pinch.

Panelist Mary Ellen Pratt, CEO of the Louisiana critical access hospital (CAH) St. James Parish Hospital, said her hospital has seen a decline in revenue due to an MA contract termination last year by Humana.

Pratt said Humana sent St. James Parish Hospital a termination notice in June 2024 that didn't include a reason for the action. While Humana eventually decided to extend

its contract with the hospital for the remainder of 2024, the hospital still faced a significant financial cliff since 52% of patients relied on Humana.

“The fact that Humana ended up extending our notice until the beginning of the calendar year was really important to us, because that way we got to our patients before open enrollment, and we [had] a full open enrollment timeframe to work with them on it,” Pratt said.

In the six months St. James Parish Hospital had to prepare for Humana’s contract termination, the hospital worked with the state and local agents to communicate to patients what the MA plan’s termination would mean for them and what to do next. Pratt also said she cut staff and some of the hospital’s payroll.

Humana accounted for 18% of the hospital’s revenue but St. James Parish Hospital is expecting a 4% decline in revenue as of January.

“It was a ton of work to get this accomplished, and we still feel extremely vulnerable,” Pratt said.

Pratt said she spoke to Senate Health Committee Chair Bill Cassidy (R-LA) about solving MA network inadequacy. Last September, Cassidy introduced a bill, the “Ensuring Access to Essential Providers Act of 2025” (S. 2793), which would require MA plans to cover certain services at essential community providers. Sen. Ben Ray Lujan (D-NM) is a co-sponsor on the bill.

“Part of what I was doing [in D.C.] this week is really trying to get some legislative change to that network adequacy guidance and rules that would disallow a plan to do this kind of thing in a community where they represent 50% of the enrollees in the sole community hospital,” Pratt said on Feb. 12.