

The Medicare Advantage 'quagmire' facing hospitals

By: Alan Condon – Becker's Hospital Review
Tuesday, September 15th, 2026

Medicare Advantage now [covers](#) more than 51% of eligible beneficiaries, but for a growing number of health systems, participating in the program has become a lose-lose proposition: stay in and absorb mounting losses, or exit and hand competitors an enrollment lane in the fastest-growing segment of Medicare.

The tension between those two options has left much of the industry, in the words of Margaret Anderson, president of Health Alliance Plan by Henry Ford Health, "[in a bit of a quagmire.](#)"

Over the past three years, [Becker's](#) has reported on roughly 90 hospitals and health systems that have terminated some or all of their commercial Medicare Advantage contracts. In 2026 alone, at [least 30 systems](#) have gone out of network with one or more MA plans, including Rochester, Minn.-based Mayo Clinic, Chapel Hill, N.C.-based UNC Health and Sioux Falls, S.D.-based Avera Health.

About 1 in 10 MA enrollees, or 2.9 million people, will be forced to disenroll from their plan this year as insurers exit markets, according to a *JAMA* study [published](#) Feb. 18.

The economics driving the retreat have hardened. And even health systems that remain committed are being forced to rethink their strategies.

The wave that won't crest

The list of hospitals and health systems walking away from MA contracts stretches across nearly every region of the country.

San Diego-based Scripps Health [exited](#) nearly all of its commercial MA contracts in January 2024, affecting about 32,000 beneficiaries across five health plans. Rochester, Minn.-based Mayo Clinic [ended](#) most of its Humana and UnitedHealthcare MA contracts this January. Renton, Wash.-based Providence took 15 California hospitals [out of network](#) with UnitedHealthcare MA. Allentown, Pa.-based Lehigh Valley Health Network [followed the same route](#) on Jan. 26.

The reasons are consistent across every exit: denial rates, prior authorization burdens, delayed payments and reimbursement levels that no longer cover the cost of care.

At Providence, MA plans are 70% more likely than traditional Medicare to deny claims for incomplete medical records and twice as likely to deny on medical necessity grounds, Providence President and CEO Erik Wexler [told Becker's](#) in January. Requests for additional documentation run 7.5 times higher, and the system has recorded a 73% increase in payment denials and underpayments.

“When it comes to UnitedHealthcare or any other commercial payer, if we are not seeing fair performance in how we are paid for the care we provide, and if denials and delays are not within a reasonable sphere of performance, then we are not going to continue working with that commercial payer,” Mr. Wexler said. “It’s time for us to reset the way the program works. It’s essential for the federal government and Congress to get involved in correcting this deterioration in performance by commercial payers.”

St. Louis-based Ascension, another large Catholic system, is among the organizations rethinking how — and whether — to continue participating with certain MA payers.

“Congress created Medicare Advantage to deliver better benefits, broader coverage and lower costs for seniors,” Ascension President and CEO Eduardo Conrado told [Becker’s](#). “Too often, that is not what patients experience.

“Instead, they face delays and denials that get in the way of timely care. Despite significant growth, Medicare Advantage has not delivered better health outcomes or greater system efficiency. Our data shows that Medicare Advantage plans are 70% more likely than traditional Medicare to deny claims due to incomplete medical records and twice as likely to deny based on medical need.”

The sunk-cost trap

For many systems, the harder question is not whether MA is broken but [whether they can afford to leave](#).

Scripps CFO Brett Tande describes the dilemma as a classic sunk-cost problem. Systems have spent years building infrastructure, care management teams and contracting capabilities around Medicare Advantage. Walking away means writing off much of that investment and betting that volume will hold up.

“Insurance is actually a low-margin business,” Mr. Tande told [Becker’s](#) in February. “Medicare Advantage insurance is, at best, a 2% to 3% margin business, and that’s when you run it with prior auth and other practices many of us find caustic.”

Scripps was losing about \$75 million a year on the contracts it exited, according to President and CEO Chris Van Gorder. More than two years later, the system has not reported a quarterly loss, ratings agencies that downgraded it in late 2023 have signaled

potential upgrades, and inpatient volumes have largely held steady.

But few systems have Scripps' market leverage.

"For the average hospital, that's a much scarier proposition," Mr. Tande said. "But I still think you're going to see more systems exit, because continuing to absorb losses isn't sustainable. At some point, the decision has to change."

The exit path also carries hidden costs for patients.

Barry Arbuckle, PhD, president and CEO of Fountain Valley, Calif.-based MemorialCare Health System, [warned](#) that seniors who try to leave MA and buy Medigap coverage after their initial enrollment window often face medical underwriting, higher premiums or outright denial. With 93% of adults 65 and older living with at least one chronic condition, the affordability gap can be severe.

That leaves many systems boxed in: losing money on MA contracts while their patients face similarly narrow options if they try to switch back.

Why Henry Ford Health is doubling down

Not every system is retreating. Henry Ford Health is [doubling down](#).

Medicare Advantage enrollment at Health Alliance Plan by Henry Ford Health [surged](#) 45.8% year over year to 132,566 members as of June 30, up from 90,935 a year earlier. The plan has retained 92% of its existing membership while adding roughly 40,000 members.

Ms. Anderson attributes the growth to a strategy Henry Ford has spent years building around network scale, affordability and tight payer-provider integration. Health Alliance Plan recently expanded its MA network across Michigan's Lower Peninsula,

where about 96% of providers are now in network. The system offers an MA product built exclusively around Henry Ford Health's network of 12 hospitals, about 550 care sites and more than 5,000 physicians, with \$0 primary care copays and lower out-of-pocket costs on selected services.

Integration also cuts administrative fat on both sides. Henry Ford Health's administrative loss ratio sits below 11%, allowing more premium revenue to flow to benefits, according to Ms. Anderson. Prior authorizations are also negotiated in partnership with the provider network with the aim of eliminating them where possible.

The financial picture reflects both sides of the expansion. Healthcare premium revenue at Henry Ford Health rose 26.1% year over year to \$1.7 billion in the first six months of 2026, driven primarily by MA growth. Provider expenses climbed faster, up 34.4% to \$1 billion, producing an 86.9% medical loss ratio. Ms. Anderson said the system is targeting a 1% margin on the business, not a source of outsized profit.

"As a regional plan and an integrated delivery system, we're here for the long term. We are not a payer that's going to be in and out of counties, degrading benefits or doing service area reductions," Ms. Anderson said. "These are the communities where we practice and live, so we have a commitment to the communities that we serve in Michigan."

The Henry Ford approach echoes the case SCAN Group CEO Sachin Jain, MD, made to [*Becker's*](#) in 2024: MA works when systems commit to full-risk arrangements and invest in managing population health, rather than treating MA as a lower-paying version of traditional Medicare.

"The greatest opportunity that health systems have is to actually enter into full-risk arrangements in which they assume full risk for

a population of patients and focus on keeping them healthy rather than managing them when they're sick," Dr. Jain said. "To be successful in MA, there needs to be an exquisite performance in both stars program as well as appropriate coding. When health systems engage in both, they have the opportunity to perform well."

Whether that model spreads or remains the exception may shape how much longer the current wave of exits continues. For a program that now [covers more than 35 million seniors](#), the stakes of getting the answer wrong keep rising.

Ms. Anderson, from her seat inside a health system that has answered by leaning in, is not optimistic that the broader picture improves soon.

"I hope that we continue to think about how we invest in this population," she said. "I believe very strongly in Medicare Advantage. It needs funding, and unfortunately, we're going in the opposite direction."