



Medicare Advantage Competition at the Local Level:

A Case Study of Birmingham, Alabama

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Medicare Advantage Competition at the Local Level: A Case Study of Birmingham, Alabama

Executive Summary

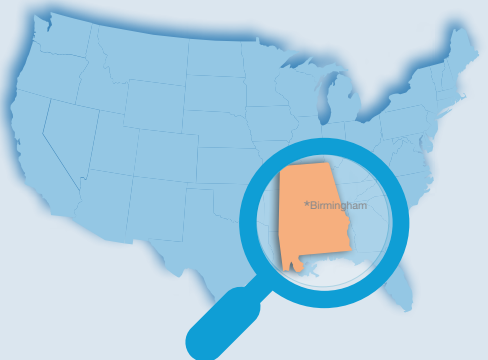
Ideally, market competition gives Medicare Advantage Organizations (MAOs) incentive to improve the accessibility, affordability, and quality of care they provide. Beneficiaries cite lower out-of-pocket (OOP) costs and coverage of supplemental benefits that traditional Medicare (TM) does not provide as reasons for enrolling in Medicare Advantage (MA), and many say they are satisfied with their plans. However, just one or two MAOs account for the majority of plan enrollment in many markets, which can dampen the positive effects of competition. Competition can also play out in ways that policymakers may not have intended. For example, in previous work, MPI heard from regional and local plans that MA payment incentives have led to competition in revenue-generating activities that have high administrative burden and low clinical value, such as aggressively capturing diagnosis codes. One goal for policymakers is to find approaches to MA policy that harness beneficial elements of competition and limit undesirable effects or outcomes that do not justify their costs.

In this case study, MPI looks at factors that have led to relatively more competition among MAOs in one local market: Birmingham, Alabama. MPI selected Birmingham because of the variety of MAOs that compete there, none of which dominate the market. At the same time, Alabama's commercial health insurance market has been considered one of the least competitive. MPI sought to understand:

- What factors promote MA competition in Birmingham?
- Why might the competitiveness of a market's MA sector differ from its commercial sector?
- In what ways do MA plans compete? Have those ways benefited Medicare enrollees and taxpayers?

To inform this work, MPI conducted stakeholder interviews with representatives from five MAOs with plans in the Birmingham area. We combined what we learned from their perspectives with analysis of CMS data on plan enrollment, benefits, quality ratings, and financial performance.

The Medicare Policy Initiative ([MPI](#)) was established in 2024, and is part of the Center on Health Insurance Reforms ([CHIR](#)) at Georgetown University's McCourt School of Public Policy. MPI is a nonpartisan source of evidence on ways to deliver more value and meaningful choices to Medicare beneficiaries while making Medicare's insurance programs sustainable for the long term. Our team conducts policy research, assesses and develops reform options, and translates evidence into actionable information for policymakers through technical assistance, education, and expert convenings.



Birmingham's MA market is relatively competitive

In 2024, 90% of Medicare beneficiaries across the nation lived in a county where half or more of MA enrollment was in plans offered by just one or two MAOs. Relative to several metropolitan areas with similarly-sized populations, Birmingham's market is less concentrated. Rather than one or two companies, five or more MAOs have competed there over the past decade, and at least four have consistently had double-digit shares of enrollment. Other MAOs have entered and exited as well. Currently, eight MAOs compete for most enrollees in the market.

What factors promote MA competition in Birmingham?

Several factors explain Birmingham's relative competitiveness. The first three listed below are related to structural features of the market, while the last two factors are the result of policy choices.

- **Many Medicare beneficiaries with a high share enrolling in MA plans.**

The Birmingham metropolitan area is home to nearly a quarter of a million Medicare beneficiaries and has been accepting of managed care with consistently high MA penetration over the past ten to fifteen years. In 2026, 67% of eligible beneficiaries in the area were enrolled in MA—much higher than 55% nationally.

- **High income disparity and chronic disease burden.**

Relative to other states, Medicare beneficiaries in Alabama have poorer rankings of healthy lifestyles and higher disparities between low and high-income older adults for certain quality indicators. MAOs have responded by introducing plans with low copays, OOP limits, and supplemental benefits not covered in TM. Special Needs Plans (SNPs) that are only open to beneficiaries dually eligible for Medicare and Medicaid (D-SNPs) have been a particular area of growth in the Birmingham market.

- **Large employers use MA plans for retiree benefits.**

Over the past decade, rather than wrapping supplemental coverage around TM, two relatively large public sector employers moved their retiree health

benefits into MA plans open only to their retirees. That has drawn MAOs to compete for those employer-group contracts.

- **Upward adjustments to MA benchmarks.**

For several Birmingham-area counties, Medicare adjusts MA benchmarks (the maximum amount that Medicare will pay plans for each enrollee) upward to encourage plans to operate there (called benchmark quartile adjustments). Higher payment benchmarks encourage more plan entry and appear to provide MAOs with enough resources to offer many plans at no additional premium beyond that for Part B.

- **Lack of managed Medicaid has allowed broad D-SNP entry.**

Alabama does not contract with comprehensive Medicaid Managed Care Organizations (MCOs) to deliver benefits. In some states, an MAO can only enroll dually eligible individuals in a D-SNP if that plan is operated by the same parent company as the state's MCO. Because Alabama has no such requirement, there are fewer hurdles for MAOs to offer D-SNPs there.

Why is its MA market more competitive than its commercial market?

In contrast, studies describe Alabama as having the least competitive commercial health insurance market in the country. Several features explain this distinction:

- **Interdependence of a dominant health system and a dominant commercial insurer.**

The University of Alabama at Birmingham (UAB) Medicine, the area's largest health system, and Blue Cross Blue Shield of Alabama (BCBSAL), the state's dominant commercial insurer, have a stable, interdependent relationship that may deter other insurers from entering Birmingham's market for commercial employer coverage. Employers want a broad network that includes UAB Medicine, and UAB needs BCBSAL's large patient volume. By comparison, rival health insurers have looked to the state's MA market as relatively wide open for competition.

- **Individual coverage rather than group coverage.**

Employers periodically select one or a few insurers to provide commercial health coverage for blocks of workers. For most MA plans, Medicare beneficiaries enroll as individuals and have an annual opportunity to change plans, which drives more competition.

- **MA payment rates to providers are constrained by TM's rates.**

MA plans typically pay providers rates that are lower than commercial rates and closer to those of TM. Under law and regulation, hospitals must accept TM rates as payment for out-of-network services, which effectively caps what MAOs pay to in-network providers as well. Lower payment rates make the business case stronger for MAOs to enter the market.

How do MAOs compete in Birmingham's MA market?

Competition in the Birmingham area has led to some outcomes that benefit MA enrollees but may have also played out in unintended ways. What follows are some of the dimensions by which MAOs compete.

- **Certain market segments are more competitive than others.**

MAOs have differing market strategies and mixes of MA products they offer. Birmingham's segment of MA plans open to all Medicare beneficiaries has long been its largest and has the most competitors. The area's D-SNP segment has also grown to include many MAOs, while its employer-group segment and those for other types of SNPs have fewer competitors.

- **An orientation toward health maintenance organizations (HMOs) over preferred provider organizations (PPOs).**

HMOs typically require members to get care through stricter networks of providers and often have lower OOP costs. Members of PPOs can obtain care both in- and out-of-network but usually pay more for that flexibility. Among MA plans open to all Medicare beneficiaries in the Birmingham area, 64% of enrollees are in HMOs, compared with 61% nationally.

Several interviewees said their MAOs have had a longstanding orientation toward HMOs over PPOs because they believe HMOs allow them to better coordinate care. Still, MAOs continue to offer PPOs in the area because some MA enrollees value out-of-network flexibility.

- **Differing approaches to provider networks and payments can affect competitiveness.**

MAOs' payment agreements with providers can directly affect not only the cost of care but also progress toward clinical quality goals and the thoroughness of diagnosis coding. Those factors, in turn, can affect plan payments and the competitiveness of benefits and premiums. Some MAOs aim to use value-based contracts to help align payer and provider incentives. However, not all providers are willing to accept arrangements that involve sharing risk. Birmingham-area MAOs told us they use a broad set of payment arrangements across providers, but we heard of a fee-for-service orientation paired with quality awards more often than shared risk.

- **Higher star ratings and quality bonuses.**

The MA payment system pays rebates to plans for a portion of the difference between Medicare's benchmarks and plans' bids. Plans that receive four or more stars in CMS's star ratings system receive quality bonuses that raise their benchmarks and increase their rebates. Plans use rebates to provide supplemental benefits to their enrollees such as lower premiums and cost sharing for medical and drug benefits or extra benefits that TM does not cover. Plans we spoke with were focused on "closing gaps" in clinical care to obtain four or more stars. All interviewees said that their MAOs either require providers to regularly report data that feeds into quality reporting, directly access data through shared applications, or place or assign clinicians with providers to coordinate and collect data and address questions related to coding of diagnoses. In 2026, among Birmingham-area non-employer group enrollees, 83% are in plans that earned quality bonuses, well above the national average of 68%.

- **Passing along rebates to enrollees.**

The magnitude of MA rebates has increased dramatically in recent years and has averaged over \$200 per member, per month (PMPM) nationally since 2023, with similar levels in the Birmingham market. Competition among Birmingham-area MAOs has clearly benefited MA enrollees by leading plans to pass along rebates through lower premiums, cost sharing, and extra benefits. At the same time, MAOs also compete through certain benefits less clearly linked to health. SNP enrollees were the focus of what one interviewee called “aggressive competition” through “cash-like” benefits such as allowances for over-the-counter (OTC) health-related products. MAOs likely compete more intensely for SNP enrollees because rebates for and profitability of those members is higher. In 2026, the Birmingham market has:

- **Broad enrollment in zero-premium plans and some access to plans with Part B buydowns.**

Nearly all MAOs in the area offer plans that charge no premium beyond Medicare’s Part B premium. Among plans open to all Medicare beneficiaries, zero-premium plans account for 88% of enrollment compared with 76% nationally. Additionally, among open-enrollment plans, about 39% of enrollees are in plans that help pay a portion of their members’ Medicare Part B premium—higher than the national average of 31%.

- **Primary care copays and OOP caps.**

Nearly all Birmingham-area plans charge \$0 copays for primary care visits. Unlike TM, all MA plans must include a cap on OOP spending. Most plans in the market offer maximum OOPs of between \$4,500 and \$7,000 for in-network services compared to the maximum allowable amount in MA of \$9,250.

- **Other uniform benefits not covered by TM.**

Nearly all plans cover preventive dental, vision, and hearing benefits for enrollees. MPI did not analyze the networks of those providers, which can be limited. Allowances towards eyeglasses and hearing aids are common, but few plans in the market include more comprehensive dental benefits. In 2023, many Birmingham-area MAOs spent \$20 to

\$40 PMPM on dental benefits, with wider variation in spending for other categories. OTC cards are a common benefit that interviewees described as “useful for marketing,” but their connection to member health was less clear. OTC allowances across plans in the area vary widely between \$15 per quarter and \$300 per quarter.

- **Special Supplemental Benefits for the Chronically Ill (SSBCI).**

Area MAOs target supplemental benefits towards specific needs of individual low-income and medically complex members through SSBCI authority. In the Birmingham market, the most commonly offered SSBCIs include allowances for general supports (such as help paying utility bills), food and produce, and transportation assistance.

Tradeoffs observed from competition in Birmingham’s market

The MA program was designed around competition and in many ways has benefited MA enrollees. At the same time, our case study of the Birmingham market highlights a number of policy tradeoffs.

- **Quartile adjustments to county benchmarks.**

Under MA’s payment system, CMS ranks each county’s benchmark (based on average TM spending) into quartiles. To encourage more plan offerings and enrollment, Medicare pays lower-spending counties (such as in the Birmingham area) benchmarks that are adjusted above average TM spending. That policy is one factor behind Birmingham’s higher degree of competitiveness. At the same time, nationwide, a disproportionate share of MA enrollees lives in counties with upward benchmark adjustments, which contributes to higher Medicare program spending. Policymakers may want to weigh whether the current degree of beneficiary access to MA plans and their supplemental benefits warrants higher Medicare spending or whether changes to benchmark adjustments would better balance program goals between access and Medicare’s sustainability.

- **Broad D-SNP entry associated with lack of comprehensive Medicaid managed care.**

Because Alabama does not use MCOs or aligned enrollment in D-SNPs, more MAOs have been able to enter that market relative to other states. Broader choice among D-SNPs likely leads MAOs to compete for enrollees on the basis of supplemental benefits. If D-SNP members qualify for and use those benefits, this can enhance their health. Still, there is limited visibility into which supplemental benefits dually eligible enrollees use. This makes it difficult to evaluate whether the value of robust D-SNP competition outweighs the tighter care coordination that other states' approaches may provide. Policymakers may want to consider increased transparency into enrollees' use of supplemental benefits.

- **MAO focus on star ratings and quality bonuses, despite unclear value of the quality bonus program.**

Interviewees described close attention to their performance on quality measures for star ratings. Nationally, however, analysts suggest that, despite at least \$13 billion in annual payments, CMS's quality bonus program has neither improved quality nor meaningfully helped beneficiaries choose among plan options. Policymakers may want to consider whether alternative approaches could better help beneficiaries compare plans and provide MAOs with incentives to improve quality of care more effectively at lower cost to taxpayers.

- **Not all supplemental benefits are closely tied to member health.**

One result of Birmingham-area competition is that MA enrollees there benefit from lower OOP costs and extra coverage not provided in TM. Supplemental benefits such as \$0 copayments for primary care visits and preventive dental benefits have clearer ties to members' overall health. However, other types of benefits such as OTC allowances—which reportedly have been a focus in MAO competition—have a more tenuous relationship to health and may be more of a marketing tool. Given concerns about Medicare's financial sustainability, policymakers may want to weigh whether use of rebates for benefits that are not clearly associated with member health are in the broader interest of those who fund the MA program through taxes and Medicare premiums.

- **Concern about benefit instability and variation.**

For 2026, interviewees said most of their plans' benefits had remained stable from the previous year, but in the wake of higher benefit spending and payment uncertainties, MAOs have pulled back selectively on less common benefits. Plan representatives seemed aware that year-to-year instability of benefits can affect the plan's relationship with its members. Likewise, in separate work, MPI's advisory group of beneficiaries enrolled in MA plans voiced concerns about year-to-year instability of supplemental benefits and wide variation in benefits across plans, which makes comparing their options difficult. Policymakers may want to consider weighing the flexibility that MAOs now have in designing supplemental benefits with beneficiaries' desire for more stability and easier comparisons among their plan options.

Summary

The Birmingham metropolitan area has robust competition among MAOs, particularly among MA plans open to all Medicare beneficiaries and among D-SNPs. In a community with high chronic disease burden and income disparity, competing MAOs pass along payment rebates that lower enrollees' OOP costs and provide benefits not included in TM such as preventive dental, vision, and hearing coverage. At the same time, policymakers may want to weigh whether certain avenues of competition such as through OTC allowances less clearly tied to member health meet the MA program's policy objectives. A goal for MA policy is to promote competition and its desirable outcomes with steps that limit competition's unintended effects and help ensure the long-term financial sustainability of the Medicare program.

Medicare Advantage Competition at the Local Level: A Case Study of Birmingham, Alabama

The Medicare Advantage (MA) program was designed to provide Medicare benefits to enrollees through private health plans. Competition among MA organizations (MAOs) was intended to give plans incentive to improve quality, constrain growth in premiums and cost sharing, and pass along payment rebates through supplemental benefits that enrollees would not otherwise receive in traditional Medicare (TM). [Beneficiaries say they enroll in MA for its lower out-of-pocket \(OOP\) costs and supplemental benefits](#), and [many are satisfied with their plans](#). Over time, though, [MA enrollment has grown more concentrated](#) both nationally, among a few large health plans, as well as within local markets, resulting in beneficiaries having fewer MAOs to choose among. Greater concentration of enrollment can reduce competitive pressure and weaken the positive features of the MA program's design. As [MPI's previous work on local and regional MAOs](#) has shown, competition can also sometimes lead to unintended or less desirable results, such as unsupported coding of enrollee diagnoses to boost payments, inappropriate use of prior authorization, or misleading marketing practices. A goal for policymakers is to find approaches to MA policy and payment that harness beneficial elements of competition and limit undesirable effects or outcomes that do not justify their costs.

For most types of MA plans, MAOs can select individual counties in which they want to operate. For that reason, local factors—especially the characteristics of Medicare beneficiaries and providers who live and operate in a given area—are centrally important for understanding which MAOs choose to enter a specific market and that market's relative competitiveness.

Research questions

By using a case study approach, MPI sought to understand the factors that affect MA competition within a specific market. Our goal for this research was to understand what can increase or sustain MA competition and its positive outcomes, as well as recognize its less desirable results. MPI sought to address the following:

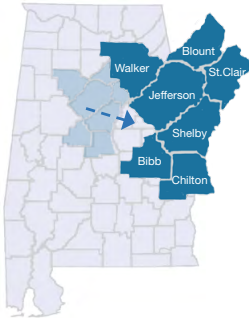
- What factors promote MA competition within a market?
- Why might the competitiveness of a market's MA sector differ from its commercial sector?
- In what ways do MA plans compete? Have those ways benefited Medicare enrollees and taxpayers?

Methodology

To select a market for this case study, MPI compared enrollment market shares of MAOs in several different metropolitan statistical areas (MSAs). We sought out markets that were less concentrated and that had a mixture of large, publicly traded MAOs as well as local or regional plans and newer entrants—Birmingham fit those criteria. (See Text Box 1 for background on the Birmingham market.)

MPI conducted key informant interviews with representatives from five MAOs. To recruit interview subjects, we reached out to all MAOs currently operating in that market as well as major health systems in the area. We conducted semi-structured interviews with representatives of the five MAOs that were willing to participate; those plans account for more than two-thirds of the Birmingham MSA's current MA enrollment. We combined findings from those interviews with analysis of publicly available data on plan enrollment, benefits, quality ratings, and financial performance.

1 BACKGROUND ON THE BIRMINGHAM MARKET



The Birmingham MSA is made up of seven counties: Bibb, Blount, Chilton, Jefferson (where the city of Birmingham is located), St. Clair, Shelby, and Walker. In 2025, [the MSA had a population of nearly 1.2 million, 17% of which was age 65 or older](#)—somewhat lower than the national share of nearly 19%. The Birmingham market includes the largest urban area in the state and makes up roughly one-quarter of Alabama’s population. Formerly reliant on iron and steel production, today major employers in the area include health and life science organizations, state and local governments, financial service firms, and manufacturing.

The greater Birmingham area has proportionately:

- A larger share of white (62%) and black (26%) individuals compared with national averages of 56% and 12%, respectively; and
- Smaller shares of Hispanic (6%) and Asian (1%) individuals compared with national averages of 20% and 6%, respectively.
- In 2024, 13% of greater Birmingham area residents lived in poverty, slightly above the national average of 12%.

In 2024, about 16% of Alabama’s population had health insurance coverage through Medicare, including both beneficiaries with traditional Medicare and MA enrollees. Other sources of coverage for the state population included [employers \(47%\), Medicaid \(20%\), military and veterans’ programs \(2%\), and individual \(non-group\) sources including Affordable Care Act plans \(7%\)](#). In 2024, [just over 8% of Alabamans were uninsured](#), roughly the same share as the national average.

[Alabama did not implement Medicaid expansion under the Affordable Care Act](#) and has [some of the most restrictive eligibility criteria for Medicaid in the country](#). The state does not contract with comprehensive Medicaid managed care plans.

Instead, it pays Medicaid providers on a largely fee-for-service basis and operates the [Alabama Coordinated Health Network \(ACHN\)](#)—a single coordinated care management delivery system that links providers, patients, and community resources in each of the state’s seven regions. [Primary care providers can earn higher payment rates for participating in the ACHN and are eligible for performance-based quality bonuses](#).

In a 2025 [Commonwealth Fund scorecard of state health system performance](#), Alabama ranked 42nd. Alabama had somewhat [better performance on indicators of avoidable hospitalizations as well as prevention and treatment, but poorer performance in rankings of healthy lifestyles and income disparity](#). The state’s population has higher rates than the national average of adults who are obese, smoke, or who report that they are in fair or poor health, and higher rates of breast and colorectal cancer deaths. Alabama ranked near the bottom of states for [disparities between lower and higher-income Medicare beneficiaries age 65 or older on indicators such as 30-day hospital readmission rates and primary care’s share of total health care spending](#).

Birmingham's MA market is relatively competitive

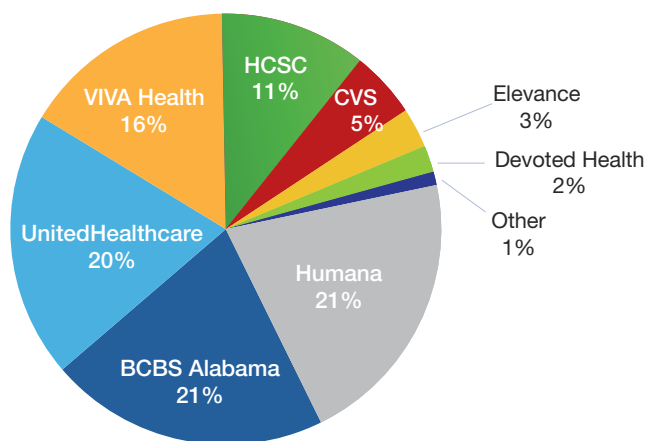
Nationwide, in 2024, 90% of Medicare beneficiaries lived in a county where half or more of MA enrollment was in plans offered by one or two MAOs—a level of concentration that has grown more pronounced over time. By comparison, the Birmingham market has a long history of more MA competition, with at least five MAOs competing each year over the past decade. Although Blue Cross Blue Shield of Alabama (BCBSAL) historically has led the pack, UnitedHealthcare (UHC), VIVA Health, and Cigna, have also maintained fairly similar shares of enrollment. (VIVA Health is owned by the area's dominant health system, University of Alabama Birmingham (UAB) Medicine. In 2025, Health Care Service Corporation (HCSC) purchased Cigna's MA business and markets under the HealthSpring brand.) Historically, Humana had a relatively smaller market share than the others, but in 2024 it signed an agreement to bring UAB Medicine's providers into its network, which has led to more enrollment. Plan representatives from several MAOs that

we interviewed described entering the Birmingham area with a primary focus on the MA market.

In 2026, eight MAOs compete for most enrollees in the market and three (Humana, BCBSAL, and UHC) each hold about one-fifth shares (Figure 1). VIVA Health and HCSC also hold double-digit market shares.

Over the past decade, other MAOs have entered and exited the market. For example, in 2022, Centene's Medicare subsidiary Wellcare joined with local health system Ascension-St. Vincent's to launch MA plans. Ascension phased out its partnership with Wellcare in 2024 reportedly due to disputes over prior authorization denials and delays in payment, and UAB Medicine purchased St. Vincent's (see Text Box 2 on Birmingham's health care providers). Wellcare exited the Birmingham market by 2025.

Figure 1. In 2026, eight MAOs compete for most of the Birmingham-area's enrollees



Notes: MA (Medicare Advantage), MAO (Medicare Advantage Organization). Other includes Simpra Advantage, Elevance Health, and Blue Cross Blue Shield of Michigan.

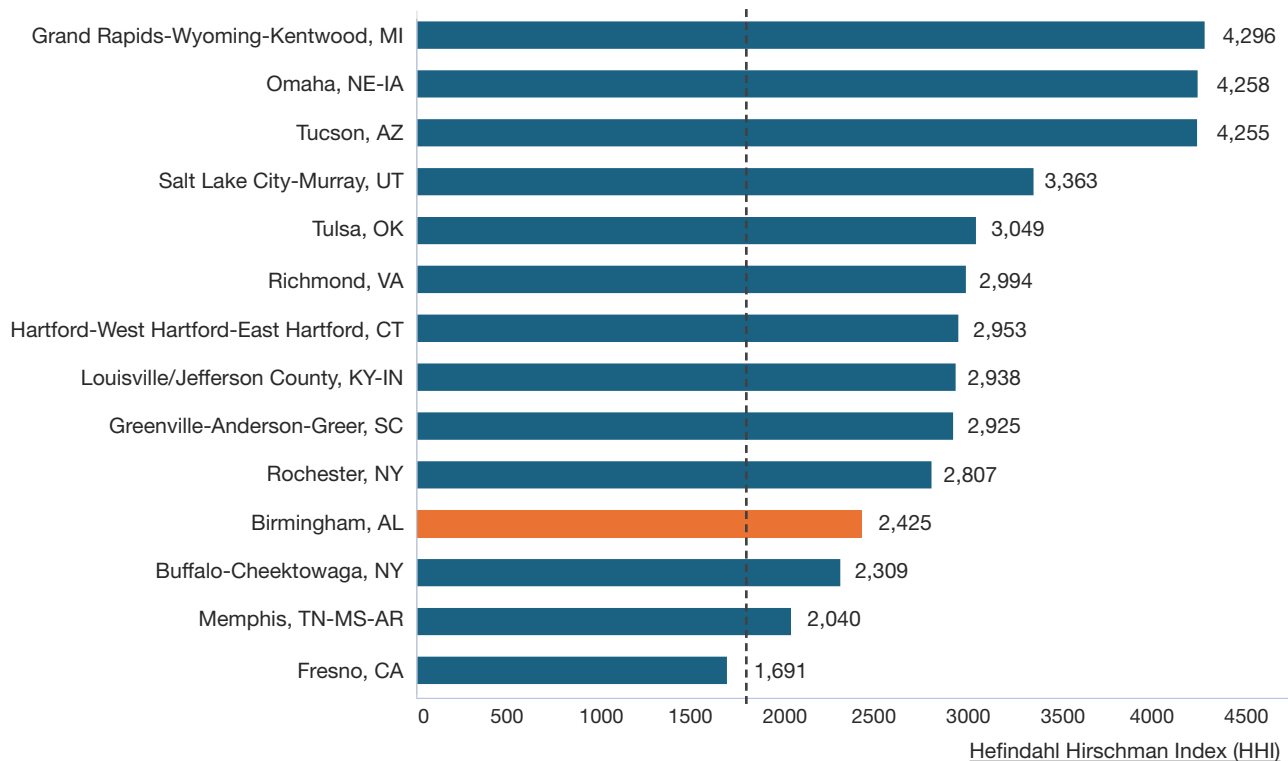
Source: MPI based on CMS [MA enrollment data](#) released in February 2026.

Two start-up MAOs have entered Birmingham's market over the past decade but only one remains. Formed with the intention of disrupting older insurance models through better automation, [Bright Health used consumer-oriented online tools and partnered with integrated health systems—specifically Brookwood Baptist in Birmingham—to provide care through narrow networks. The company expanded quickly into markets](#) (including Birmingham in 2018) but did not win much enrollment or achieve reliable profitability, exited Alabama at the end of 2021, and [announced the sale of its remaining MA plans elsewhere in 2023](#). A second technology-oriented start-up MAO, Devoted Health, entered the Birmingham market in 2023. Its “payvider” (integrated payer and provider) business model [assigns health care navigators](#)

[to members, offers virtual access to care through an in-house medical group, and provides clinical support for its network of local providers](#). Devoted has expanded its geographic footprint rapidly and, in 2026, [operates in 29 states including Alabama](#).

To get a sense of how Birmingham's market compares with other similarly-sized MSAs, Figure 2 shows [estimates of their MA market concentration using the Herfindahl-Hirschman Index \(HHI\)](#). In 2024, while nearly all of the markets we examined had HHIs above the 1,800 threshold that [federal agencies consider “highly concentrated,”](#) Birmingham's HHI was lower than many of its peers and fell around the lowest quartile of HHIs calculated from nearly four hundred moderately-sized MSAs.

Figure 2. Birmingham's MA market is less concentrated than many similarly-sized MSAs



Note: HHI (Herfindahl-Hirschman Index), MA (Medicare Advantage), MSA (metropolitan statistical area). Based on [federal merger guidelines](#), values of 1,800 and higher are considered highly concentrated. A monopoly would have an HHI of 10,000.

Source: MPI based on 2024 data from Jose Guardado and Carol Kane, 2025. [Competition in health insurance: A comprehensive study of U.S. markets. 2026 update](#). American Medical Association Policy Research Perspectives. June. Peer MSAs identified from [U.S. Census Bureau](#).

2 BIRMINGHAM'S HEALTH CARE PROVIDERS

Birmingham's provider market is and has long been dominated by the [University of Alabama at Birmingham \(UAB\) Medicine](#), a nonprofit integrated health system. Statewide, UAB Medicine includes [15 hospitals, 135 care sites, and is affiliated with about 4,500 physicians](#). The system's anchor facility—1,400-bed UAB Hospital—is the fifth largest in the nation, Alabama's leading academic medical center, and [employs about 1,650 physicians](#), including many of the Birmingham area's specialists.

UAB Medicine has been building new facilities and consolidating with other providers in the Birmingham area. [In 2024, UAB Medicine purchased all of the care sites of its largest competitor, St. Vincent's, from Ascension](#), including five hospitals, a freestanding emergency department, imaging facilities, and other facilities. The deal also meant that UAB absorbed clinics that were part of St. Vincent's large multispecialty physician group. UAB Medicine has also [continued to purchase physician groups](#).

UAB Medicine's largest remaining competitor in the Birmingham market is [Baptist Health](#) (formerly known as Brookwood Baptist), a health system with five hospitals and an affiliation with Baptist Medical Group, which has [a multispecialty group practice with over 60 locations](#). Previously, Brookwood Baptist operated as a joint venture between for-profit Tenet Healthcare and not-for-profit Baptist Health. [In 2024, Tenet sold its majority stake to not-for-profit Orlando Health](#). Orlando Health appears interested in expanding its presence in the state. Earlier this year, it [announced plans to acquire a system](#) located in a metropolitan area to the east of Birmingham.

Other hospitals that serve the Birmingham community include for-profit Grandview Medical Center, operated by Community Health Systems, that focuses primarily on elective and commercially-insured care, Children's Hospital of Alabama, and the Birmingham Veterans Affairs (VA) Medical Center, which is part of the broader Birmingham VA Health Care System. [Grandview plans to expand its footprint of ambulatory surgical centers in the Birmingham area](#).

Like nearly all MSAs in the United States, Birmingham's hospital market is highly concentrated, with [UAB Medicine accounting for 53% of inpatient admissions in 2024 and Orlando Health for 32%](#). According to one recent analysis, in 2024, [Birmingham's HHI puts it in a category considered "highly concentrated."](#) Birmingham's hospital HHI was similar to the nationwide average calculated from hundreds of moderately-sized MSAs and was on the higher end of HHIs relative to peer MSAs with similarly-sized populations (Figure 3).

Historically, with the exception of UAB, health systems in the Birmingham market [employed fewer physicians relative to other markets and Birmingham had more small, independent practices](#).^{*} While hospital-based health systems have hired physicians and purchased practices, interviewees noted that the Birmingham area still has many independent primary care practices and groups. Some of those groups are organized into independent practice associations (IPAs) that let physicians retain ownership while collectively negotiating with insurers, participating in value-based care arrangements, and pooling resources to reduce administrative overhead. For example, [in 2020, 115 primary care physicians from five smaller IPAs formed Iron City, reportedly the state's largest physician-led IPA](#).

^{*} For another source of information about hospital market concentration, see [Yale's Health Care Affordability Lab](#), which shows similar estimates for the Birmingham market.

^{**} Center for Studying Health System Change, 2013. *Alabama's pass on Medicaid expansion leaves Birmingham's uninsured with weak safety net*. Community report no. 7 for the Robert Wood Johnson Foundation. October.

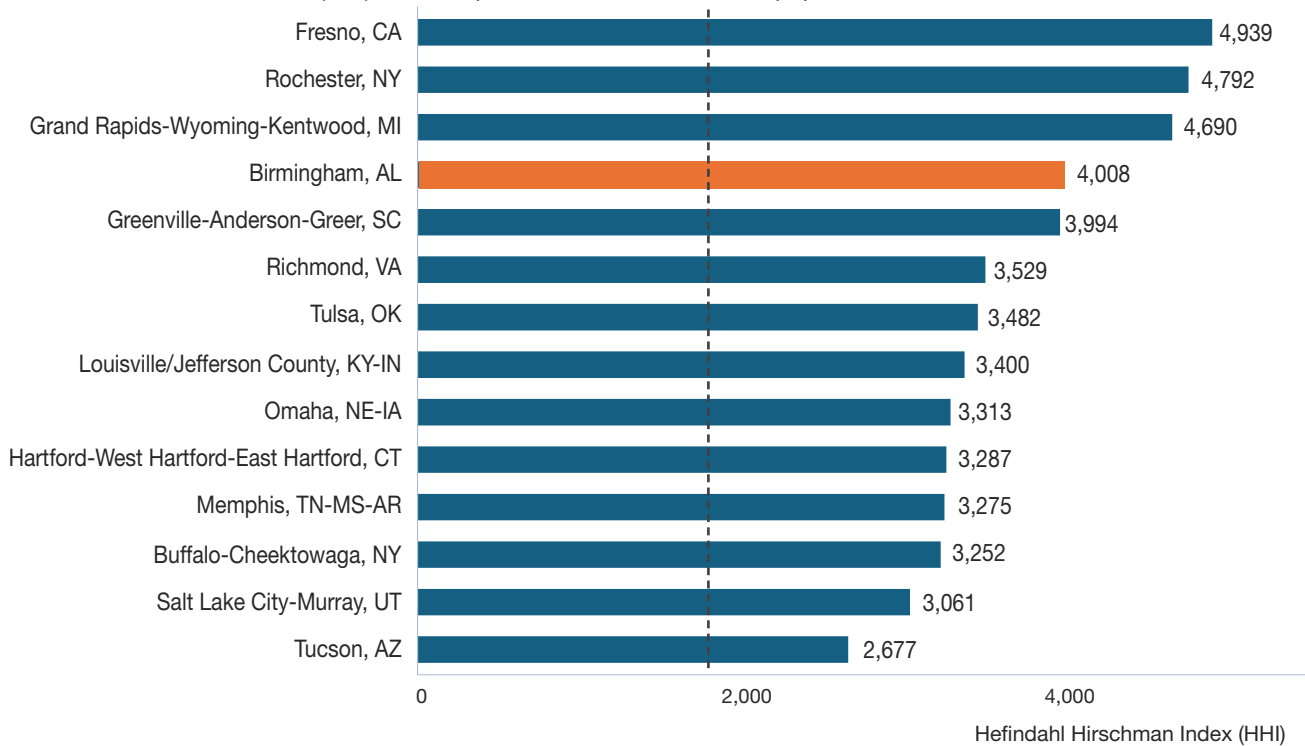
Over the past 10 to 15 years, private equity (PE) firms have also rolled up smaller physician practices in the Birmingham market, [particularly for specialties such as gastroenterology and dermatology](#). PE-backed platforms such as [Complete Health](#) have also [purchased primary care practices in Birmingham](#).

Rather than rolling up existing practices, a separate strategy of some PE firms has been to set up new primary care facilities and hire local physicians. [ArchWell Health, a senior-focused primary care company that was originally launched by a PE firm and then later sold to UnitedHealth Group](#), is one example.

Figure 3. Birmingham's hospital market is more concentrated than several similarly-sized peers

Hospital Market Concentration: Birmingham vs. Peer MSAs

Herfindahl-Hirschman Index (HHI) for metropolitan statistical areas with population 1.0M - 1.4M



Notes: HHI (Herfindahl-Hirschman Index), MA (Medicare Advantage), MSA (metropolitan statistical area). Based on [federal merger guidelines](#), values of 1,800 and higher are considered highly concentrated. A monopoly would have an HHI of 10,000.

Source: MPI based on 2024 data from Jose Guardado, 2026. [Competition in hospital markets: 2026 update](#). American Medical Association Policy Research Perspectives. June. Peer MSAs identified from [U.S. Census Bureau](#).

What factors promote MA competition in Birmingham?

Several reasons explain Birmingham's relative competitiveness. The first three factors described below are related to the market's structural features while the remaining two are the result of policy choices.

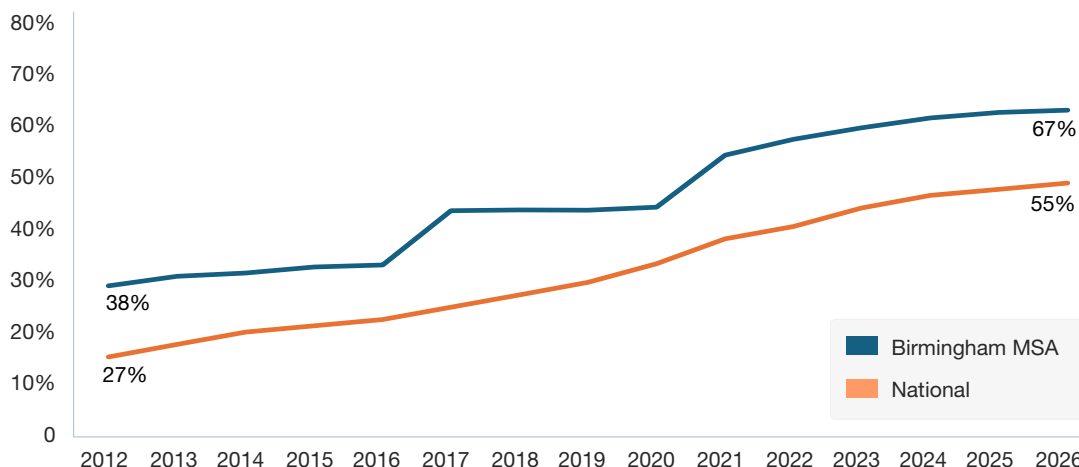
Many Medicare beneficiaries with a high share enrolling in MA plans

The Birmingham metropolitan area is home to nearly a quarter of a million Medicare beneficiaries. One interviewee described the market as having a “big eligibility base that’s attractive to plans.”

Both the state of Alabama and the Birmingham MSA have been accepting of managed care with consistently high MA penetration over the past ten to fifteen years.

Statewide, as of February 2026, among about 1.1 million eligible Medicare beneficiaries, [61% were enrolled in MA](#)—well above the [national average of 55%](#). Within the Birmingham MSA, about 167,000 beneficiaries (67%) are enrolled in MA plans and the area has been consistently higher than the national average (Figure 4).

Figure 4. Consistently higher shares of Medicare beneficiaries in the Birmingham MSA have enrolled in MA plans compared to national shares



Notes: MA (Medicare Advantage), MSA (metropolitan statistical area).

Source: MPI. Birmingham shares from analysis of CMS [MA enrollment data](#) by ZAHealth. National shares from Meredith Fried et al., 2026, [Medicare Advantage in 2026: Enrollment Update and Key Trends](#). KFF. June 5.

High income disparity and chronic disease burden

With Alabama's above-average rates of income disparity and chronic disease (see Text Box 1), another major source of growth has been enrollment in special needs plans (SNPs). At 23%, current enrollment in SNPs that are only open to beneficiaries dually eligible for Medicare and Medicaid (D-SNPs) is now on par with [the national average](#), but has been a particular area of growth in the Birmingham market (Figure 5). Other categories include [institutional SNPs \(I-SNPs\)](#) for residents of nursing

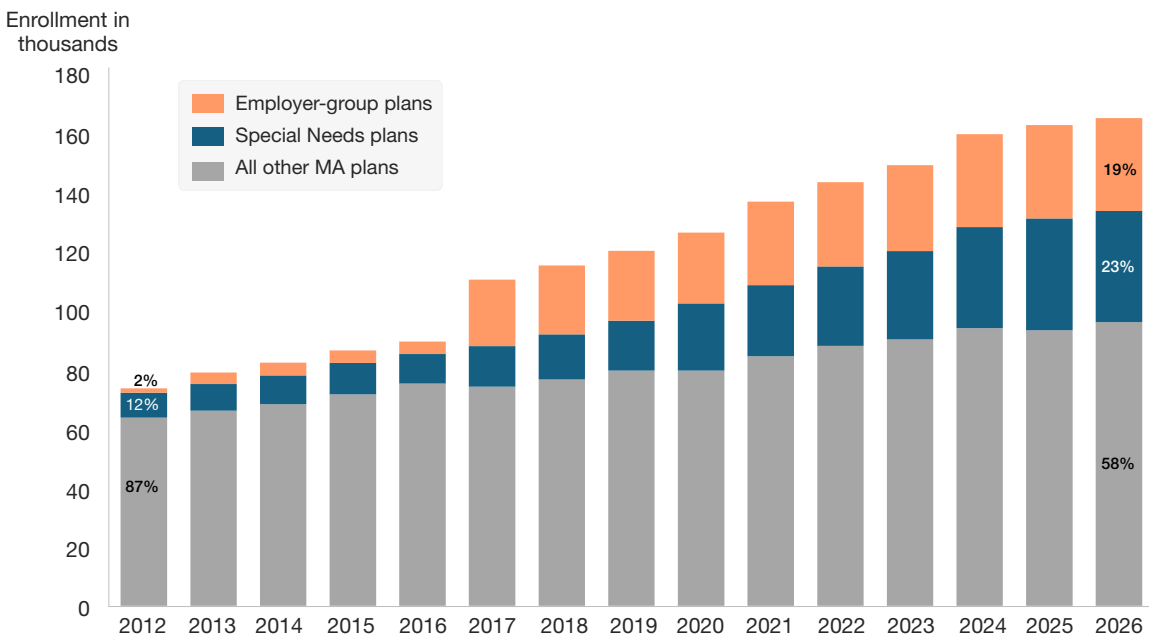
facilities, and [chronic condition SNPs \(C-SNPs\)](#) for beneficiaries with certain complex care needs. Dually eligible beneficiaries make up significant shares of the enrollees in all three categories. We estimate that roughly one-third of MA enrollees in the Birmingham market receive [Part D's low-income subsidy](#), a proxy that slightly overstates the share of enrollees who are dually eligible for Medicare and Medicaid.

Large employers use MA plans for retiree benefits

Between 2012 and 2026, MA enrollment in the Birmingham market grew at a rapid clip of nearly 6% annually. Nationally, aging of the U.S. population has been an important factor behind growth in MA enrollment over the past 10 to 15 years. For Alabama and Birmingham specifically, an additional source of growth has been a move by state public-sector employers to set up employer-group MA plans. In 2017, the Alabama [Public Education Employees' Health Insurance Plan \(PEEHIP\)](#) moved its benefits for Medicare-eligible retirees from its self-insured health benefit for active workers to

[an MA employer-group plan](#), initially administered by UHC. The PEEHIP employer group alone accounts for nearly all of the jump in enrollment observed in 2017 (Figure 5). The Alabama State Employees Insurance Board SEIB followed suit in 2020, [establishing its own employer-group MA plan](#). UHC and Humana have been the main competitors for those contracts, with [Humana currently operating plans for both](#) groups. In 2026, 19% of Birmingham's MA enrollees are in employer groups, higher than the [national average of 16%](#).

Figure 5. Enrollment in special needs plans and employer-group plans has grown fastest in the Birmingham market



Note: MA (Medicare Advantage).

Source: MPI based on analysis of CMS [MA enrollment data](#) by ZAHealth.

Upward adjustments to MA benchmarks

A benchmark is the maximum amount that Medicare will pay plans for each MA enrollee and is based on levels of TM spending in the county where their enrollees live. Under [MA's payment system](#), CMS ranks each county's benchmarks into quartiles, and then applies quartile multipliers of 95%, 100%, 107.5%, or 115%. To encourage plans to operate in all parts of the country, lower-spending counties have their benchmarks adjusted upward. To encourage plans to share efficiencies with Medicare, the highest-spending counties have their benchmarks adjusted downward. Because the

Birmingham area's TM spending is lower than other parts of the country, its benchmarks are adjusted upward. Weighted by enrollment, the Birmingham MSA had 2026 benchmarks that were about 105% of average TM spending and that is one factor behind Birmingham's higher degree of competitiveness. At the same time, nationwide, a [disproportionate share of MA enrollees lives in counties with higher benchmark adjustments](#), which contributes to higher [Medicare program spending above levels in TM](#).

Lack of Medicaid managed care has allowed broad D-SNP entry

Although capitated contracts with Medicaid managed care organizations (MCOs) are the dominant approach states use to provide Medicaid coverage, Alabama does not contract with comprehensive MCOs. Nationwide, [all D-SNPs must meet minimum CMS requirements for coordinating with state Medicaid programs](#), such as [following a model of care that specifies required elements of care coordination with the state and notifying the state of admissions to inpatient facilities](#). However, some states that use comprehensive MCOs additionally require that D-SNPs have exclusively aligned enrollment, meaning that the plan can only enroll dually-eligible

individuals who receive Medicare and Medicaid benefits from plans operated by the same parent company. Because it does not use comprehensive MCOs, Alabama has no such requirement, and there are fewer hurdles for MAOs to offer D-SNPs. Having greater numbers of D-SNPs may lead MAOs to compete on the basis of the supplemental benefits they can pass along to enrollees. In turn, this benefits enrollees to the extent they have access to and use those supplemental benefits. However, D-SNP enrollees' care may be less coordinated relative to exclusively aligned models in other states.

Birmingham's market for commercial insurance is far less competitive than its MA market

In Alabama's market for commercial health benefits, nonprofit [Blue Cross Blue Shield of Alabama](#) (BCBSAL) has long been the dominant company. [One study of 2024 data found Alabama to be the state with the least competitive commercial health insurance market in the country](#). That year, [BCBSAL covered 83% of enrollment in commercial HMOs, PPOs, and exchange plans in the Birmingham MSA while its closest competitor, UnitedHealth Group, had 8%](#). BCBSAL's market position is especially strong among PPOs, which are popular among employer groups. [The company states](#) that

it has some of the lowest employer premiums in the country and the widest provider network. BCBSAL's name recognition and the breadth of its provider network likely appeal to employers that need to attract and retain workers. For that same reason, employers may be reluctant to switch carriers over time and disrupt employees' access to care, which helps maintain BCBSAL's stability as the market leader. Its dominant position also helps reinforce BCBSAL's ability to keep a broad provider network because providers need to be included in it to maintain their patient populations.

A health insurer with such a dominant market position should have considerable bargaining leverage to negotiate favorable payment rates with providers. However, [providers have also been consolidating and bolstering their negotiating leverage, which may temper payers' market power](#). One metric of relative pricing power is the ratio of commercial payment rates to rates paid in traditional Medicare. In 2017, [commercial payers in Alabama \(of which BCBSAL was dominant\) paid an average of 98% of Medicare rates for professional services—the lowest rates in the country—compared with 122% nationally, and 101% in the Birmingham MSA](#). A more recent study estimated that for 2025, commercial payment rates relative to Medicare rates [averaged 163%](#)

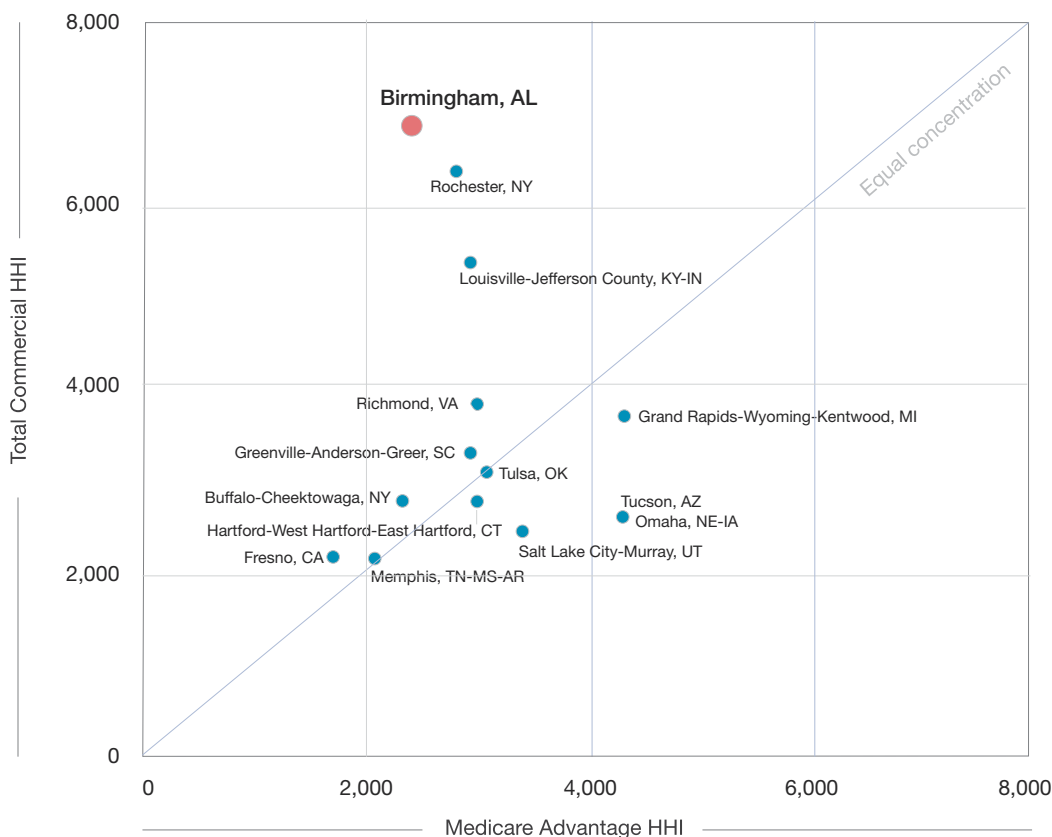
[in Alabama: 181% for inpatient services, 191% for hospital outpatient services, and 138% for professional services](#). The same study estimated national average ratios at 196% overall: 209% inpatient, 263% outpatient, and 148% for professional services.

In 2024, Birmingham's HHI for its commercial health enrollment (which combines group and individual plans) was much more highly concentrated than its HHI for its MA market (Figure 6). By comparison, most peer MSAs with similarly-sized populations had more comparable commercial and MA market concentration as shown by falling closer to Figure 6's 45-degree line.

Figure 6. Birmingham's MA market is far less concentrated than its commercial market

Health Insurance Market Concentration: Birmingham vs. Peer MSAs

Comparison of Total Commercial HHI and Medicare Advantage HHI across peer metropolitan markets



Notes: HHI (Herfindahl-Hirschman Index), MA (Medicare Advantage), MSA (metropolitan statistical area). Based on [federal merger guidelines](#), values of 1,800 and higher are considered highly concentrated. A monopoly would have an HHI of 10,000.

Source: MPI based on 2024 data from Jose Guardado and Carol Kane, 2025. [Competition in health insurance: A comprehensive study of U.S. markets. 2025 update](#). American Medical Association Policy Research Perspectives. June. Peer MSAs identified from [U.S. Census Bureau](#).

Why is Birmingham's MA market more competitive than its commercial market?

Several key factors help to explain the difference in concentration between Birmingham's MA and commercial markets.

BCBSAL's stable interdependence with UAB helps maintain its dominant commercial position.

Competitiveness in the commercial insurance market relies heavily on insurers' relationships with local employers and their leverage at building networks with local providers. By virtue of being the major academic medical center in the state with a large physician group that includes many of the area's specialists, UAB Medicine is the most important provider group for commercial insurers in the Birmingham market. Likewise, UAB needs BCBSAL's large patient volume for its hospitals, clinics, and other facilities. That stable, interdependent relationship, along with the state and regulatory influence those important entities have, is likely self-reinforcing. BCBSAL's network in the Birmingham market is likely broader than potential competitors in the commercial insurance market could set up, and UAB has little incentive to offer lower rates to a competitor when BCBSAL brings so much patient volume. At the same time, with deterred entry into Alabama's commercial market, insurers have looked to the state's Medicare market as relatively wide open for competition.

More individual coverage rather than group coverage drives greater competition.

Most MA plans enroll members individually and members can change plans on an annual basis during Medicare's annual enrollment period. In contrast, employers select one or a few insurers to cover all their workers and dependents, so large numbers of enrollees move as a block. To the extent that employers compete among insurers to administer their health benefits, they tend to award contracts less frequently than annually, both because of the complexity of those competitions and because employees value stability in their benefits. This structural difference allows greater opportunity for MAOs to compete.

MA payment rates to providers are constrained by TM's rates.

In the commercial market, insurers with less market power likely have more difficulty negotiating payment rates with providers that are low enough to allow them to be competitive with BCBSAL. However, the same is not true in the MA market. Past research has shown that MA payments are generally lower than commercial rates and closer to those of TM. Under law and regulations, hospitals must accept TM rates as payment for out-of-network services, which effectively caps what MAOs pay to in-network providers as well. Medicare pays MA plans based on benchmarks that are largely set based on average TM spending. MAOs have noted that they cannot afford to pay rates that are much higher because they must compete with TM as well as with other MA plans. In turn, some providers argue that certain MAOs use prior authorization and deny payment in ways that effectively lower their payment rates below those of TM. Lower payment rates make the business case stronger for MAOs to enter the market.



How do MAOs compete in Birmingham's MA market?

In MPI's stakeholder interviews, plan representatives described the Birmingham market as "highly competitive" and "saturated." With about two-thirds of the area's Medicare beneficiaries already enrolled in MA, competition among MAOs has reportedly gotten closer to becoming a zero-sum game, "trading lives" during the annual enrollment period, as one interviewee put it. But how exactly do they compete? We examined some of dimensions by which MA competition has played out to see both results that have been positive for MA enrollees as well as other effects that may be less desirable.

► More competition in certain market segments than others

MAOs have differing market strategies and mixes of MA products they offer, tailoring some plans to segments of beneficiaries to help them continue to expand enrollment. Certain MAOs are leaders in specific market segments, while the markets for plans open to all Medicare beneficiaries and that for D-SNPs are relatively more competitive (Table 1).

- **General-enrollment plans.** With more than 94,000 enrollees (57% of total enrollment in the MSA), Birmingham's market for general-enrollment MA plans is its largest and most competitive. In 2026, seven MAOs offer plans open to all Medicare beneficiaries. BCBSAL has the largest market share (36%), but VIVA Health, UHC, HCSC, and Humana also have shares of 10% or more.
- **D-SNPs.** Seven MAOs offer D-SNPs in the market, covering more than 31,000 enrollees (19% of total enrollment in the MSA). Several MAOs offer more than one D-SNP in order to charge cost sharing amounts tailored to categories of eligibility, i.e., lower cost sharing for enrollees who receive less generous cost-sharing assistance through the Medicare Savings Program (MSP), administered through the state Medicaid agency.

- **Employer group plans.** In 2026, under 32,000 Medicare beneficiaries in the Birmingham area are enrolled in employer-group plans (about 19% of total enrollment in the MSA). About 65% of those individuals are enrolled in Humana plans. Periodic competitions for employer groups can lead to large swings in market shares because retirees and their dependents move as a block. For example, in 2025, before Humana won the most recent PEEHIP contract, its share of the employer group MA market was only about 9% while UHC's was 69%.
- **C-SNPs.** Although [nationwide, MAOs have offered C-SNPs broadly](#), fewer MAOs have entered the Birmingham area with C-SNPs. In 2026, three MAOs (UHC, HCSC, and Devoted Health) operate a total of 5 C-SNPs with a combined enrollment of about 6,000 members (about 4% of total enrollment in the MSA). Prior to 2026, UHC was the only MAO offering C-SNPs in the market. In interviews, some MAO representatives noted a decision to focus on D-SNPs rather than C-SNPs because of more uncertainty about the expected costs of serving a C-SNP population, lower provider engagement in the market to support the care management model, and uncertainty about [whether CMS would place future restrictions on enrollment in C-SNPs](#).
- **I-SNPs.** Just two organizations offer I-SNPs in the Birmingham market: UHC and Simpra Advantage, an MAO sponsored by 17 group owners of nursing facilities. Statewide, in 2026, Simpra operates plans in more than 100 facilities across Alabama and has about 2,700 I-SNP enrollees. In the Birmingham area, I-SNPs have about 750 members.

Table 1. Birmingham-area MA enrollment is less concentrated in general enrollment plans and D-SNP segments than for employer-groups, C-SNPs, and I-SNPs

MAO	All MA plans combined	General enrollment plans	D-SNPs	Employer-group plans	C-SNPs	I-SNPs
Humana	21%	10%	16%	65%		
BCBS of Alabama	21%	36%				
UHC	20%	14%	35%	13%	75%	44%
VIVA Health	16%	21%	23%			
HCSC	11%	14%	12%		13%	
CVS Health/Aetna	5%	4%	8%	7%		
Elevance	3%			15%		
Devoted Health	2%	2%	6%		12%	
Simpra Advantage	<0.5%		<0.5%			56%
Other*	<0.5%			1%		
Total	100%	100%	100%	100%	100%	100%
Enrollment	163,710	94,109	31,202	31,680	5,972	747
Percent of total MSA enrollment	100%	57%	19%	19%	4%	<0.5%
HHI	1,708	2,243	2,271	4,650	5,995	5,065

Notes: MA (Medicare Advantage), MAO (Medicare Advantage organization), D-SNP (dualy-eligible special needs plan), C-SNP (chronic condition special needs plan), I-SNP (institutionalized special needs plan), BCBS (Blue Cross Blue Shield), HCSC (Health Care Service Corporation), UHC (UnitedHealthcare), HHI (Herfindahl-Hirschman Index). The HHI is calculated as the sum of squared market shares. HHIs of >1,800 are considered highly concentrated under [2023 Department of Justice/Federal Trade Commission merger guidelines](#). A monopoly would have an HHI of 10,000.

* BCBS of Michigan and Highmark.

Source: MPI based on CMS [MA enrollment data](#) released in February 2026.

► An orientation toward HMOs over PPOs

HMOs typically require members to get care through stricter networks of providers and often have lower OOP costs. Members of PPOs can obtain care both in- and out-of-network but usually pay more for that flexibility. In 2026, overall, 56% of Birmingham's MA enrollees are in HMO plans and 44% are in PPOs. However, about two-fifths of the area's PPO enrollment is in employer groups. Excluding those members, 64% of Birmingham MA members are enrolled in HMOs [compared with 61% nationally](#). Two MAOs (HCSC and VIVA Health) use HMO structures almost exclusively, while others (including BCBSAL and Simpra Advantage) only offer PPOs in the market.

Several interviewees said that their MAOs have had a longstanding orientation towards HMOs over PPOs in the Birmingham market, noting they believe its population has been more open to HMOs than other parts of the country. In the opinion of some, HMOs allow plans to better coordinate care than PPOs and offer stronger engagement with both members and

providers. HMO providers may be better able to stay engaged with their patients when those members are not seeking care out of network.

Some MA enrollees continue to value the out-of-network flexibility that PPOs provide. For beneficiaries who have had employer coverage while working, PPOs may feel more familiar as they enter retirement. However, one interviewee noted that, given growing consolidation in the area's provider market, network differences between HMOs and PPOs have narrowed because plans need to include major health systems and groups within their network. In their opinion, this reduces the value of PPOs. A representative of a different plan pointed out that, [consistent with a broader national trend for 2026](#), their MAO had intentionally thinned its PPO offerings. That move was part of an effort to be more deliberate in managing care by encouraging members to stay aligned with primary care providers. A reduction in PPOs may also have selection effects by reducing the number of more costly members.

► Differing approaches to provider networks and payments can affect competitiveness

MAOs' payment agreements with providers can directly affect not only the cost of care but also progress toward clinical quality goals and the thoroughness of diagnosis coding. Those factors, in turn, can affect plan payments and the competitiveness of benefits and premiums. While some MAOs aim to use value-based arrangements to manage care, not all providers are willing to accept arrangements that involve sharing risk.

The inclusion or exclusion of UAB Medicine in Birmingham MAOs' networks has been an important element of competition. Interviewees described how historically, UAB Medicine only contracted fully with a select payer group while the remaining MAOs built networks with Birmingham's other major hospitals (St. Vincent's, Brookwood, and Grandview) and physician practices. VIVA Health, which is owned by UAB, and BCBSAL, with its longstanding ties to UAB through the commercial sector, have long included all of UAB's providers in their MA networks. Interviewees described ties to UAB as a competitive advantage and part of those MAOs' local identity that has helped build brand loyalty. [Cigna HealthSpring \(now HCSC\) and Humana included some UAB providers such as UAB Medical West in their networks, but previously not UAB's flagship hospital.](#) Despite this, MAOs other than BCBSAL and VIVA were able to remain competitive by establishing networks with Birmingham's other providers. More recently, now that Ascension-St. Vincent's system has joined with UAB Medicine, a broader set of MAOs includes UAB providers more fully in their networks. However, some interviewees voiced concern about maintaining network adequacy in the future if the Birmingham area becomes a two-health system market (UAB and Orlando Health).

Plan representatives said their MAOs use a broad set of payment approaches across providers ranging from fee for service (FFS) to shared savings to risk sharing to full capitation. As the dominant system, UAB Medicine likely has the most market leverage over payment, and one interviewee described UAB's negotiation position this way: "I wouldn't say you have

to take whatever price they're asking, but I wouldn't say that they're at the forefront of risk-based deals. You know, they are an academic institution. At the end of the day, they tend to be a bit more FFS-focused and less on the value-based piece, so I think it's kind of typical of what you would see with a lot of the academic institutions." Other points of negotiation relate to MAOs' prior authorization requirements and past payment disputes.

Another interviewee said they thought that in general, across all providers, Alabama has been slower to adopt value-based care than other states. The majority of payment arrangements for their MAO are on a FFS basis but paired with "upside-only" awards that providers can earn based on quality measures such as rates of annual wellness visits or colonoscopy or mammogram screenings.

Some plan representatives noted more opportunity for risk-sharing arrangements with newer companies that focus on primary care. A few MAOs use bundled payment models for specialties such as orthopedics, but interviewees said that sharing risk with primary care practices drives broader changes in care. A common approach we heard is to place MAO-employed or contracted nurses or other clinicians within larger network practices or assign them to a group of smaller practices to interact with physicians, collect data for quality measures, address questions related to diagnosis coding, and coordinate with the MAO's risk adjustment staff. Interviewees noted that collecting data for coding and quality measures is harder with independent practices than health systems because they have fewer resources. For health systems, MAOs use common platforms or portals to communicate, collect data, obtain pre-approval for admissions, and facilitate payment. However, for smaller providers, MAOs must rely on more in-person meetings to exchange information and review trends in member care. One plan representative described this model as "high-touch and not very scalable." Another said their plan's longstanding relationships with IPAs had been important; they noted a distinct performance gap between providers where they have those relationships and others where they do not.

MPI analyzed CMS data for plan payments and contract-level medical loss ratios (MLRs, the share of revenues spent on medical costs rather than administrative costs and profits) for MAOs that operate in the Birmingham MSA. In 2024, MAOs that operated general-enrollment MA prescription drug plans had fairly similar bids to provide Part A and Part B benefits to an enrollee of average health (see Appendix Table 1). There was somewhat more variation in competitors' average risk scores than their bids and, in turn, in each MAOs' risk-adjusted payments. Differences in the relative health of each plan's enrollees affect average risk scores, as can [differences in MAOs' tendencies to code diagnoses more completely](#). In 2024, MAOs had MLRs that ranged between about 87% and 94% for contracts that included Birmingham-area plans (see Appendix Table 2). While none of the MAOs had medical claims higher than their revenues, we cannot determine whether they covered their administrative costs.

► Higher star ratings and quality bonuses

Under the [MA payment system](#), when plans bid below payment benchmarks (that are based on TM spending levels) Medicare pays the plan its bid plus a portion of the difference between the benchmark and its bids. Plans receive a larger portion of that difference (called a rebate) depending on their quality scores as measured through CMS's star rating system (where one star is poor and five is excellent). Plans that receive four or more stars receive quality bonuses that raise their benchmarks and increase their rebates. Plans must use rebate dollars to provide supplemental benefits for their enrollees, which can take the form of lower premiums and cost sharing for Part A and Part B medical benefits or Part D drug benefits, or extra benefits that TM does not cover. In recent years, the magnitude of rebates has increased dramatically, from a national average of \$76 PMPM in 2015 to about [\\$210 PMPM or more since 2023](#). In 2024 (the latest year of data available), all MA plans in the Birmingham area excluding employer groups received weighted average rebates of \$205 PMPM, just below the national average of \$210 PMPM (see Appendix Table 1).

CMS's star ratings have understandably been a focus of competition for Birmingham-area MAOs because they directly affect plans' payments, rebates, and supplemental benefits. All plan representatives we spoke with said that their MAOs either require providers to regularly report data that feeds into quality reporting, directly access data through shared applications, or place or assign clinicians with providers to coordinate and collect data. Interviewees described these measures as mechanisms for managing care but also ways to close star gaps, i.e., achieve a rating of four or more stars to obtain MA quality bonuses.

In 2026, among Birmingham-area non-employer group enrollees, 83% are in plans that earned quality bonuses, well above [the national average of 68%](#). Following [CMS's recent recalculations of star ratings released in July 2026](#), 88% of enrollees are currently in plans with four or more stars, indicating that their plans will receive quality bonuses for the 2027 benefit year.*

► Passing along rebates to enrollees

[Studies of MA plans' behavior](#) have found that more competition is associated with [larger plan rebates, lower enrollee premiums, and lower cost sharing](#). It appears that competition among Birmingham-area MAOs has led them to pass along rebates to their members through lower premiums and cost sharing and more generous supplemental benefits. Those results are desirable because they clearly benefit plan members. Most MAOs we spoke with noted that they had not changed the generosity of their benefits much between 2025 and 2026. However, one interviewee described the offerings of competitors in certain categories of supplemental benefits as "aggressive" and hard to sustain over time. In addition, some MAO representatives noted that not all supplemental benefits are closely

* BCBSAL's plans newly qualify for quality bonuses in 2027. The updated ratings also increase stars for VIVA Health and certain HCSC and UHC plans in the Birmingham area, which will give those MAOs higher rebate payments to use for supplemental benefits in 2027.

linked to member health, which raises questions about whether such benefits make the best use of Medicare's finances. The following are some of the ways in which Birmingham-area plans are using rebates in 2026.

- **Broad enrollment in zero-premium plans.**

Nearly all MAOs in the Birmingham market offer at least one plan with no premium beyond Medicare's Part B premium. (The only exception is Simpra Advantage, which has a high-acuity member population, primarily in I-SNPs.) By comparison, many Medicare beneficiaries in TM pay for private Medigap policies that can cost [on the order of \\$200 per month](#), and they may pay a premium for a stand-alone Part D prescription drug plan as well. In 2026, 70% of the area's non-employer group MA enrollees are in plans that charge no premium. For non-employer group, non-SNP enrollment, more than 85% of Birmingham-area MA enrollees are in zero-premium plans, higher than the [2026 national average of 76%](#). Among the beneficiaries in MA plans that do charge premiums, about two-thirds are enrolled in D-SNPs. In most cases, the MSP pays that premium on behalf of the member because they are dually eligible for Medicare and Medicaid.

- **Competition through plans that help pay for Part B premiums.**

In 2026, more than a quarter of Birmingham's non-employer group MA enrollees are in plans that help members pay for a portion of their Medicare Part B premium of \$202.90 per month (called a "Part B buy down"). Six MAOs offer such plans. Among non-employer group, non-SNP plans, about 39% are in plans that help pay a portion of their members' Medicare Part B premium—[higher than the national average of 31%](#). Although some plans only cover nominal amounts, the median amount across area plans is \$20 per month, with one plan offering \$185 per month. Interviewees said that buy downs, when combined with other benefit design elements such as a higher OOP maximum, can be especially useful for attracting enrollees

who are newer to Medicare and expect to use relatively fewer health care services. A small share of Birmingham's enrollment is in Part B buy-down plans that do not include Part D prescription drug coverage, which may appeal to individuals who have drug benefits elsewhere such as through the Department of Veterans Affairs.

- **Until recently, escalating supplemental benefits.**

Consistent with rising rebates, interviewees described several years of competitive escalation in supplemental benefit offerings. One plan representative felt competition had led to an "arms race of supplementals" to attract enrollees. In the interviewee's opinion, some MAOs were offering benefits with tenuous connections to members' health and drew CMS scrutiny for "spending money too loosely." Nationwide, as spending escalated and some MAOs have faced revenue pressures, [plans have pulled back selectively on certain benefits](#). At the same time, plan representatives that we spoke with seemed mindful that enrollees get confused or angered by changes to supplemental coverage. One interviewee noted, "You know, you can't promise it or guarantee it, but I think we would pride ourselves in general of saying, can we offer this benefit, and can it hold? . . . You don't want to create a big whiplash."

For general-enrollment plans, MAOs commonly use rebates for lowering prescription drug premiums and copays, lowering copays for primary care and specialist visits, and providing fitness benefits. Unlike TM, all plans include a cap on OOP spending. Most plans in the market offer maximum OOPs of between \$4,500 and \$7,000 for in-network services compared to CMS's [maximum allowable amount of \\$9,250](#). In 2026, nearly all plans in the Birmingham market charge \$0 copays for primary care visits, [as do the vast majority nationwide](#).

[Consistent with nationwide trends](#), nearly all Birmingham-area plans cover preventive dental, vision, and hearing benefits. Interviewees cited those three categories of services not covered under TM—especially dental benefits—as contributing towards managing their

enrollees' overall health. An [initial year of reporting](#) from MLR data suggests that in 2023, many Birmingham-area MAOs spent \$20 to \$40 PMPM on dental benefits, with wider variation in spending for other categories of benefits. Allowances towards eyeglasses and hearing aids are common among area plans, but few include more comprehensive dental benefits, likely out of concern about adverse selection. In 2026, cards for over-the-counter (OTC) health-related products are a common and highly visible benefit useful for marketing, but allowances across plans vary widely between \$15 per quarter and \$300 per quarter. OTC cards are an example of a “cash-like” benefit where plan representatives thought its ties to member health were more tenuous. One interviewee heard comments from former members such as, “I’ve been with y’all a long time, I love y’all, but I can’t afford not to (switch plans).”

MAOs likely compete more intensely for SNP enrollees because the rebate dollars and profitability associated with those members is higher. In 2024, rebates for SNP enrollees in the Birmingham MSA averaged \$239 PMPM compared with \$196 PMPM for enrollees in other general-enrollment MA plans. One interviewee noted that because Medicare’s risk-adjusted payments for dually-eligible members are much higher than those of other members, they are more profitable to plans so long as their care is managed well. That individual’s MAO had lost ground to competitors and noted that in terms of profitability, it takes an average gain of more than two non-SNP enrollees to make up for the loss of one SNP member.

Plan representatives described making use of authority to target supplemental benefits towards the specific needs of individual low-income and medically complex members through [special supplemental benefits for the chronically ill](#) (SSBCI). One mentioned access to healthy food, lower copays for specialist visits and prescription fills, and transportation support for medical visits as benefits that their MAO uses the most for their SNPs. In 2026, across Birmingham market plans, the most commonly offered SSBCIs include allowances for general supports (such as help paying utility bills), food and produce, and transportation assistance.



Conclusion

Over the past decade, the Birmingham MSA has had robust competition among at least five and often more MAOs. A large eligibility base and payment benchmarks that are higher than average TM spending levels have made Birmingham an attractive market for MAOs to enter. The area's most competitive market segments are MA plans open to all Medicare beneficiaries and D-SNPs. Higher than average disease burden and income disparity as well as a lack of comprehensive MCO contracting in Alabama have led many MAOs to offer D-SNPs there.

Birmingham-area MAOs have focused attention on closing gaps in clinical measures to achieve four or more stars and earn quality bonuses. Those ratings and bonuses increase their MA payments and allow them to offer enrollees more generous supplemental benefits. However, even before recent legal complaints against CMS's star ratings, [numerous stakeholders \(including MAOs\)](#) have [pointed out the star rating system's inadequacies](#) and [questioned the effectiveness and cost of the quality bonus program](#). Policymakers may want to look for reforms to MA policy that could promote quality but that would have lower costs for taxpayers and beneficiaries who pay Medicare premiums.

MA's payment rebates have grown quickly in recent years, and competition in the Birmingham market has led to an escalation in supplemental benefits. This has had both more and less desirable outcomes. Rising benefits

have clearly made the individuals who enroll in those MA plans better off. Unlike Medicare beneficiaries in TM, most area MA enrollees pay zero medical and drug premiums, have no copays for primary care, and have their OOP costs capped at lower amounts. Some receive help paying for their Part B premiums. Although MPI did not examine the breadth of their provider networks, most Birmingham-area plans offer preventive dental, vision, and hearing benefits—services not covered by TM. As of yet, there is limited transparency into how widely enrollees use supplemental benefits and whether their value is commensurate with Medicare's considerable spending for plan rebates.

Other outcomes of MA competition are less desirable. For example, interviewees described recent heightened competition over “cash-like” benefits that are not clearly associated with member health. Nor is it clear that MAOs can maintain the [year-to-year stability of supplemental benefits that MA enrollees desire](#). Policymakers may want to consider weighing the flexibility that MAOs now have in designing supplemental benefits with beneficiaries' desire for more stability and easier comparisons among their plan options.

Appendix. Plan payments, risk scores, and medical loss ratios

MPI examined 2024 payment and 2023 medical loss ratio (MLR) data for MAOs operating in the Birmingham area to get a sense of the variation in the competitors' revenues and costs. Each MAO's standardized payment rate shown in Appendix Table 1 generally reflects their bid for providing Part A and Part B benefits to an enrollee of average health. MAOs' bids for general-enrollment MAPDs fell within a range of \$834 per member, per month (PMPM) to \$912 PMPM, or within plus or minus 6% of the Birmingham-area average. This suggests that in 2024, most had fairly similar revenue requirements. Simpra Advantage, whose members are entirely made up of I-SNP and D-SNP enrollees, had higher costs. Birmingham-area bids were about 2.5% higher than the nationwide averages for MAPDs (\$890 PMPM versus \$869 PMPM) and similarly higher across all types of MA plans except employer groups (\$893 PMPM compared to \$871 PMPM).

MAOs' average risk scores varied more than their standardized bids: Risk scores for general-enrollment MAPDs varied by plus or minus 10% relative to the Birmingham-area average. Average risk scores for the category "All MA plans except employer groups" varied more widely than those for "General-enrollment MAPDs" because each MAO has a different mix in the types of MA products they offer. Some MAOs offer many SNPs, for example, and members in those plans tend to have higher risk scores than enrollees in general MAPDs.

As described in the report, the Birmingham area has lower TM spending than other parts of the country, and CMS adjusts most benchmarks upward for counties that make up the Birmingham MSA. On an enrollment-weighted basis, for 2024, Birmingham-area benchmarks were about 4% higher than average TM spending. (They averaged 5% higher for 2026 payments.)

When a plan's bid is below its benchmark, Medicare pays MAOs their bid amount, adjusted by each member's risk score, plus a rebate—a portion of the difference between the benchmark and bid. In 2024, Medicare paid Birmingham-area general-enrollment drug plans an average of \$1,093 PMPM inclusive of an average rebate of \$198 PMPM (Appendix Table 1). Those amounts are very similar to nationwide averages of \$1,095 PMPM and \$195 PMPM. For all types of plans except employer groups, Medicare paid an average of \$1,208 PMPM including rebates of \$205 PMPM—below nationwide averages.

An MLR reflects the percentage of revenue spent on patient care (roughly, medical claims) rather than for administrative costs and profit. By law, [MAOs are required to maintain an MLR of 85% or above](#) for each contract and submit supporting data to CMS annually.* MPI examined the adjusted MLRs for MAOs operating MA contracts in the Birmingham area during 2023 (the latest year of data available).[†] Overall, in that year, those organizations spent an average of 89.7% of their revenue on medical claims (Appendix Table 2). That average is below the 2023 nationwide weighted average MLR of 90.8% across all MA contracts. MAOs' MLRs fell within a range of 87% to 94%. While none had an MLR above 100% (with medical claims greater than revenues), this does not mean necessarily that all Birmingham-area plans were profitable—that depends on each MAO's administrative costs. [According to one analyst](#), administrative costs nationwide average 8% of revenues, but those can vary considerably across organizations.

* [Some analysts](#) question the effectiveness of those regulations when large, vertically integrated health plans pay related businesses prices higher than competitive rates.

** CMS adjusts MLR data of smaller or new plans to reflect that their claims may be subject to more variability.

Appendix Table 1. Average risk scores, payment rates, and rebate amounts for general-enrollment MAPDs and all non-employer plans weighted by Birmingham-MSA enrollment, 2024

Birmingham-area MAOs	General-enrollment MAPDs				All MA plans except employer groups			
	\$PMPM				\$PMPM			
	Risk score	Standardized payment rate	Rebate	Risk-adjusted payment plus rebate	Risk score	Standardized payment rate	Rebate	Risk-adjusted payment plus rebate
BCBSAL	0.92	\$899	\$181	\$1,005	0.92	\$899	\$181	\$1,005
Cigna plans (now owned by HCSC)	1.10	\$910	\$211	\$1,214	1.19	\$897	\$228	\$1,291
CVS Health/Aetna	1.00	\$853	\$159	\$1,008	1.08	\$851	\$183	\$1,099
Devoted Health	0.90	\$834	\$230	\$981	0.99	\$853	\$258	\$1,104
Humana	1.06	\$874	\$189	\$1,120	1.12	\$866	\$200	\$1,173
Simpra Advantage	n/a	n/a	n/a	n/a	2.68	\$985	\$61	\$2,704
UHC	1.06	\$859	\$226	\$1,135	1.26	\$873	\$228	\$1,328
VIVA Health	1.07	\$912	\$201	\$1,174	1.16	\$928	\$200	\$1,278
Average of Birmingham-area MAOs	1.01	\$890	\$198	\$1,093	1.12	\$893	\$205	\$1,208
Nationwide average	1.04	\$869	\$195	\$1,095	1.17	\$871	\$210	\$1,225

Notes: MAPD (Medicare Advantage prescription drug plan), MSA metropolitan statistical area, MAO (Medicare Advantage organization), PMPM (per member, per month), BCBSAL (Blue Cross Blue Shield of Alabama), HCSC (Health Care Service Corporation), n/a (not applicable), UHC (UnitedHealthcare). Standardized payment rates reflect MAOs' bids of revenue requirements to deliver Part A and Part B services per month for an enrollee of average health. The category "All MA plans except employer groups" includes general-enrollment MAPDs, MA-only plans, and special needs plans. Risk-adjusted payment plus rebate may not sum to the product of risk score times standardized payment rate plus rebate due to rounding.

Source: MPI based on CMS [MA enrollment data](#) and [plan payment data](#).

Appendix Table 2. Average adjusted MLRs by MAO, weighted by Birmingham-MSA enrollment, 2023

Birmingham-area MAOs	Weighted average MLR
BCBSAL	94.0%
Centene	86.9%
Cigna plans (now owned by HCSC)	86.9%
CVS Health/Aetna	89.2%
Devoted Health	90.0%
Elevance	91.0%
Humana	91.3%
Simpra Advantage	88.0%
UHC	87.4%
VIVA Health	90.0%
Average of Birmingham-area MAOs	89.7%
Nationwide average	90.8%

Notes: MLR (medical loss ratio), MSA (metropolitan statistical area), MAO (Medicare Advantage organization), MAPD (Medicare Advantage prescription drug plan), MA (Medicare Advantage), BCBSAL (Blue Cross Blue Shield of Alabama), HCSC (Health Care Service Corporation), UHC (UnitedHealthcare). MLR is the percentage of revenue used for patient care (medical claims) rather than for administrative costs and profit. MAOs report MLR data to CMS at the contract level. The averages above only reflect contracts that had enrollment in the Birmingham MSA during 2023.

Source: MPI based on CMS [MA enrollment data](#) and [medical loss ratio data](#).

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About the Medicare Policy Initiative

The Medicare Policy Initiative is part of the Center on Health Insurance Reforms at Georgetown University's McCourt School of Public Policy. Our independent research and timely analysis guide federal policymakers in making common-sense reforms that deliver high quality, affordable coverage for seniors and people with disabilities.



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