Unintended Consequences: Examining How Medicare Advantage Payment Policies Encourage Aggressive Marketing to Veterans and Duplicative Spending

Aditi Pathak and Susan Joy

Introduction

Veterans are a popular marketing focus for large Medicare Advantage (MA) organizations. Many organizations offer plans with words like "valor," "patriot," and "honor" in their plan names.[1,2] As a result, the number of MA plans with veteran enrollment exceeding 20% has increased in recent years, growing from 147 to 294 between 2016 and 2022.[3] By 2024, more than 1 million veterans—or about 1 in 4 veterans eligible for Medicare—were enrolled in MA plans and were eligible for health benefits through the Department of Veterans Affairs (VA).[3,4] Coupled with aggressive marketing to veterans, the rapid growth of MA plans with high levels of veteran enrollment raises concerns about potential duplicative and wasteful federal spending because MA plans receive full payment even when veterans get care through the VA.[5,6]

KEY FINDINGS

- An MA payment policy designed to prevent underpayment to MA plans in counties where many veterans get care through the VA may instead motivate plans to market aggressively and enroll veterans in these counties to increase plan revenues.
- Counties with the highest VA/DoD benchmark adjustment factors have a greater concentration of veteran-targeted MA plan offerings than counties with low-adjustment values, consistent with the adjustment factor influencing plan marketing decisions.
- MA plans are sensitive to marginal changes in benchmark generosity when choosing where to offer plans as modest differences in VA/DoD adjustment factors are associated with veteran-targeted plan availability.

The role of MA payment policy in influencing MA plans to enroll veterans. MA plans receive fixed per-beneficiary, per-month—or capitated—payments to provide all Medicare-covered services regardless of the actual amount or cost of care they receive. Veterans dually eligible for Medicare and VA health benefits can simultaneously access care from both federal health programs. However, the VA is prohibited from receiving Medicare fee-for-service (FFS) reimbursement or billing MA plans for care provided to veterans. When dually eligible veterans enroll in MA plans but continue to get care through the VA, the arrangement can result in duplicative spending because MA plans continue to receive the full capitated payment even if they do not pay for any services. The fiscal consequences are substantial: Between 2011 and 2020, the VA spent $78 billion on health services for veterans also enrolled in MA,[7] creating opportunities for MA plans to maximize revenue by aggressively targeting veterans to enroll.

Recent evidence has suggested that veteran-targeted MA plans are experiencing rapid enrollment growth and that veterans enrolled in these MA plans are more likely to access care through the VA; these patterns are consistent with rising duplicative federal spending.[8] Most research has focused on examining veteran enrollment, spending, and cost shifting across MA plans and the VA. However, the role of MA payment policy in creating incentives for plans to market aggressively to veterans is understudied. MA county benchmarks—the maximum amount Medicare will pay an MA plan per enrollee to provide Medicare-covered benefits before accounting for risk factors—are based on traditional FFS Medicare spending for beneficiaries in each county and include a VA/Department of Defense (DoD) adjustment factor. The adjustment is intended to prevent MA plans from being underpaid if they operate in counties where a large proportion of veterans or military beneficiaries receive health services through the VA or DoD, reducing county-level spending in traditional FFS Medicare. The VA/DoD factor adjusts benchmarks upward in counties with lower average Medicare FFS spending for veterans, implicitly assuming that beneficiaries with VA/DoD benefits will not enroll in MA plans, or if they enroll, they will receive all covered care through the MA plan.[9,10]

The adjustment applies uniformly to all MA plans operating in a county, regardless of whether the plans enroll veterans or coordinate care with VA or DoD providers. High VA/DoD adjustment factors may send a signal to MA plans to target veterans in these counties because they generate lower Medicare-covered spending on average—either because they substitute VA services for Medicare-covered care or because they may be healthier than similar non-veteran beneficiaries. As a result, the VA/DoD adjustment may create incentives for plans to target veterans for enrollment, as higher benchmarks coupled with lower expected Medicare spending can generate higher revenue per veteran enrollee for MA plans.

This study explored whether VA/DoD benchmark adjustments may unintentionally encourage MA plans to strategically target veterans for enrollment in counties with higher adjustments to increase revenue. Researchers identified veteran-targeted MA plans using a validated method based on veteran-related keywords in plan names (valor, patriot, honor, courage, eagle, freedom, liberty, salute, valiance, and veteran). Researchers examined the relationship between the level of the VA/DoD adjustment and proportion of veteran-targeted plans among all MA plans across counties. Researchers studied the relationship while accounting for other factors that may influence whether MA organizations offer a veteran-targeted plan in a county such as proportion of veterans in each county and the level of VA health care spending (see Study Data and Methods on page 7 for more information).

A Third of Counties Have Seven or More Veteran-Targeted MA Plans

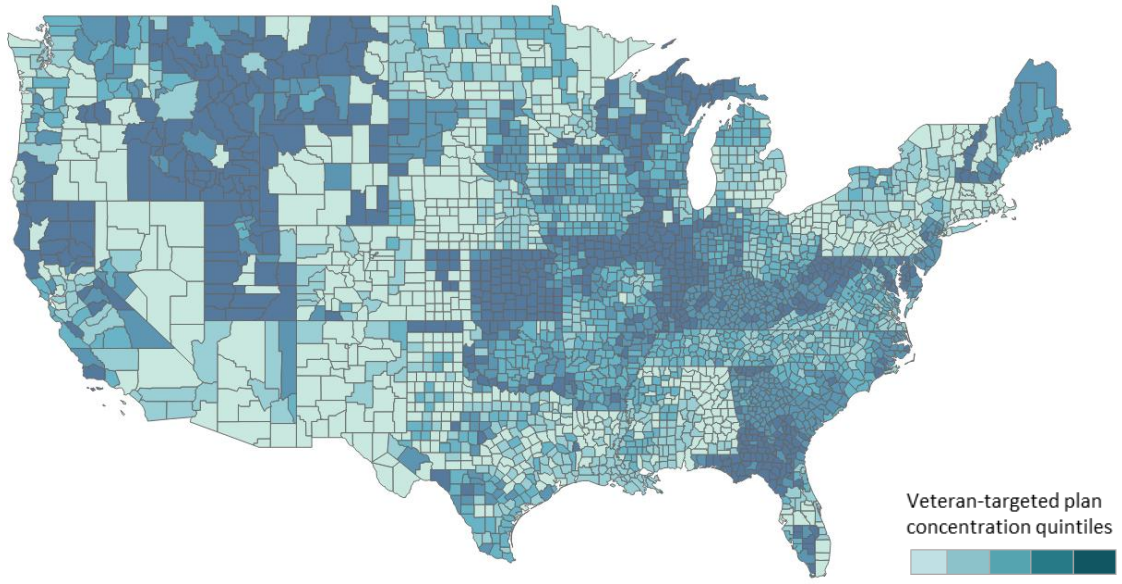
Of the 3,065 counties in the analysis, approximately 95% have at least one veteran-targeted MA plan. On average, counties have 42 MA plans overall (SD = 23.1) and five veteran-targeted MA plans (SD = 2.9). Among all counties, 19.4% have between zero and two veteran-targeted MA plans, whereas 21.7% of counties have three or four such plans. Another 23.6% of counties offer five or six veteran-

targeted plans. Notably, the largest proportion of counties, 35.2%, fall into the highest category, in which seven or more veteran-targeted MA plans are available to beneficiaries.

Veteran-Targeted Plan Concentration Varies Widely Across Counties

Although most counties have five or more veteran-targeted plans, there is substantial variation across counties in veteran-targeted plan concentration, which is the proportion of all MA plans in the county that are veteran-targeted plans. Exhibit 1 shows the geographic variation in the distribution of veteran-targeted plan concentration. The median veteran-targeted plan concentration is 12%, and approximately 1% of the counties have a veteran-targeted plan concentration of at least 40%.

Exhibit 1. Variation in Veteran-Targeted Plan Concentration



Note. Map obtained from Centers for Medicare & Medicaid Services Medicare Advantage (MA) landscape file, 2026. The map shows quintiles of veteran-targeted plan concentration, or the proportion of MA plans in each county that are veteran-targeted plans.

Higher VA/DoD Adjustments Create Incentives to Offer Veteran-Targeted Plans

Exhibit 2 shows modest but meaningful variation in the VA/DoD adjustment factor across counties. The median county receives a 1.3% benchmark increase; most counties range from 0.5% to 2.3%. The bottom third, or low-tercile, counties cluster near a neutral adjustment (typically 0.3%), some even below 1.0, slightly reducing benchmarks. Medium-tercile counties hover near 1.5% with minimal variation, whereas high-tercile counties have larger adjustments (median 3.0%, top quarter at 3.8% or higher). Adjustments in the high-tercile counties can meaningfully affect capitation payments, potentially impacting plan entry and continuity in areas with larger veteran populations. To illustrate, in a county where the benchmark would otherwise be $1,250, a 3% VA/DoD adjustment would increase benchmarks by $37.50 per beneficiary per month—or $450 per beneficiary per year, all other factors in the benchmark calculation remaining constant.

Exhibit 2. Variation in VA/DoD Adjustment Factor

County-level VA/DoD adjustment factor, by tercile	Mean	25th percentile	Median	75th percentile
Low (*n* = 1,202 counties)	0.1%	-0.1%	0.3%	0.6%
Medium (*n* = 1,202 counties)	1.5%	1.2%	1.5%	1.8%
High (*n* = 1,201 counties)	3.4%	2.5%	3.0%	3.8%
All counties	1.5%	0.5%	1.3%	2.3%
PBPM change in benchmark, all counties	$18.75	$6.25	$16.25	$28.75

Note. VA/DoD = Department of Veterans Affairs/Department of Defense; PBPM = per beneficiary, per month. Data are from Centers for Medicare & Medicaid Services Medicare Advantage Rate Calculation File, 2026.

Counties With the Highest Adjustments Differ in Ways That May Compound Incentives

Exhibit 3 presents statistics of county-level characteristics stratified by terciles of the VA/DoD adjustment factor. Mean adjustment factors rise from 0.1% in the low tercile to 3.5% in the high tercile, indicating increasingly generous benchmark adjustments that raise potential MA plan revenues.

As expected, counties with high VA/DoD adjustments have a larger veteran presence (7.04% vs. 6.09% in low-adjustment counties; $p < .001$). A higher share of veterans in the overall county population may also suggest a larger and more readily identifiable market for veteran-targeted MA plans, strengthening incentives for MA organizations to offer veteran-targeted plans in the county. Counties with high VA/DoD adjustment also have substantially higher VA per-capita expenditures; nearly half of the counties fall in the top spending quartile, which may signal greater reliance on VA services and create opportunities for MA plans to coordinate or substitute care through veteran-targeted offerings. At the same time, high-adjustment counties tend to have fewer MA plans overall (36.0 vs. 47.2 in low-adjustment counties; $p < .001$), implying less competition and potentially greater scope for plan differentiation through veteran-targeted plan designs.

Exhibit 3. Variation in County Characteristics, by Terciles of VA/DoD Adjustment Factor

County characteristic	Tercile of VA/DoD adjustment factor			Total
	Low adjustment	Medium adjustment	High adjustment	
Mean of VA/DoD adjustment factor	0.1%	1.5%	3.5%	1.5%
Veteran characteristics				
% Veterans	6.09%	6.32%	7.04%	6.48%
VA per capita expenditures (quartiles)				
1	48.6%	19.6%	6.9%	25.0%
2	28.7%	30.3%	16.0%	25.0%
3	14.3%	32.2%	28.5%	25.0%
4	8.4%	17.9%	48.7%	25.0%
VA hospital in county	2.5%	4.5%	5.5%	4.2%
MA availability				
Number of MA plans	47.2	44.1	36.0	42.4
High MA penetration (>median)	47.5%	50.5%	52.4%	50.1%
Demographics				
Rural	49.5%	62.4%	73.4%	61.8%
Age 65 and over	19.2%	20.4%	22.0%	20.5%
Population living under federal poverty level	14.1%	14.6%	15.3%	14.7%

Note. VA/DoD = Department of Veterans Affairs/Department of Defense; MA = Medicare Advantage. Data are from Centers for Medicare & Medicaid Services MA Rate Calculation File (VA/DoD adjustment factor) and Area Health Resource File (county characteristics). Column percentages reported. All county characteristics had p values < .001 for tests comparing means (t-test) or distribution (chi-square) across terciles of VA/DoD adjustment factor.

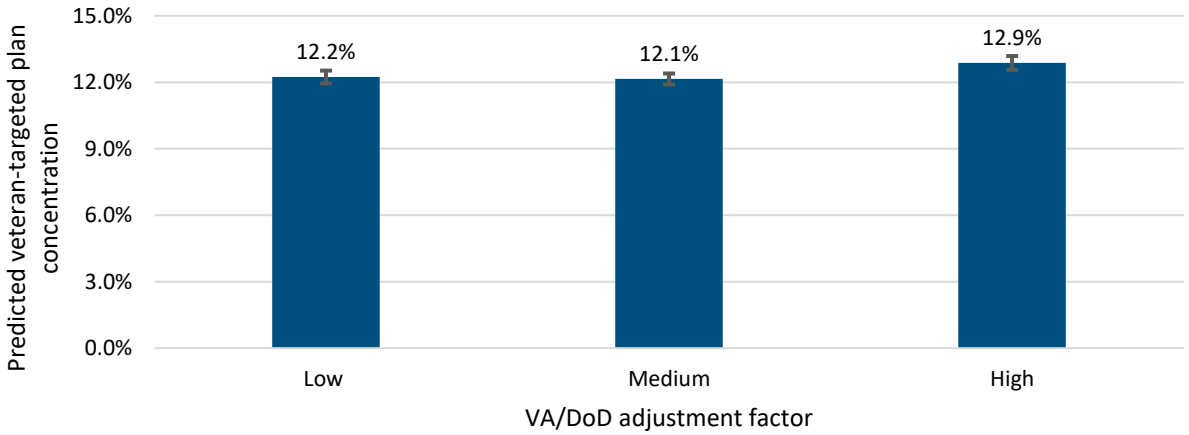
MA Organizations Offer More Veteran-Targeted Plans in High-Adjustment Counties

Estimates show that counties with high VA/DoD adjustment factors (top tercile) had a predicted veteran-targeted plan share of 12.9%, compared with 12.2% in bottom-tercile counties (see Exhibit 4). The estimates show a difference of 0.6 percentage points (p = .007), which represents a 4.8% relative increase over the bottom-tercile baseline. Based on the average number of MA plans in high-

adjustment counties (*n* = 36) this implies approximately 0.2 additional veteran-targeted plan offerings per high-adjustment county, or roughly 214 additional county-contract offerings across all high-adjustment counties nationally (*n* = 1,201). Given the average geographic footprint of veteran-targeted plans—approximately 56 counties per contract—this corresponds to roughly four additional unique plan contracts.

To contextualize the economic significance of the findings, it is important to note that veteran-targeted plans are already widely available, with 95% of counties having at least one veteran-targeted plan and more than a third of the counties having seven or more veteran-targeted MA plans. Comparing the number of plans to enrollee ratio for all MA plans (5,093 plans across 35.7 million MA enrollees)[11] and for veteran-targeted MA plans (285 plans across 1.3 million veteran enrollees in MA), there are 50% more veteran-targeted plans per enrollee, which also suggests a high baseline level of veteran targeting in the MA market. Furthermore, the absolute differences in the VA/DoD adjustment factor across counties are modest—ranging from a median 0.3% benchmark increase in low-adjustment counties to 3.0% in high-adjustment counties. Despite this, the payment differential appears to be associated with differences in veteran-targeted plan availability, suggesting that MA plans are potentially sensitive to marginal changes in benchmark generosity when deciding where to offer plans. Hence, while modest in absolute terms, the estimates reflect the strong incentive embedded in the VA/DoD adjustment factor for MA plans to target veterans.

Exhibit 4. Predicted Veteran-Targeted Plan Concentration



Note. VA/DoD = Department of Veterans Affairs/Department of Defense. Data are from analyses of Centers for Medicare & Medicaid Services (CMS) Medicare Advantage (MA) Landscape File 2026, CMS MA Rate Calculation File 2026, and Area Health Resource File 2023-2024. The exhibit shows predicted veteran-targeted plan concentration and 95% confidence intervals across terciles of the VA/DoD adjustment factor values. Estimates from fractional logistic regression weighted by the number of MA plans in the county.

Policy Implications

The findings raise important questions about whether the VA/DoD adjustment factor is functioning as intended. The adjustment was designed to account for lower observed traditional FFS Medicare

spending among veterans and military beneficiaries who may receive care through the VA or DoD, under the assumption that these MA enrollees would receive all Medicare-covered services through their MA plan. However, the observed association between higher VA/DoD adjustment values and greater veteran-targeted plan concentration—despite an already high baseline level of veteran-targeted plan availability—suggests that the adjustment may also operate as a geographic signal that influences where plans market to veterans. Because the adjustment raises payments in areas where veterans' Medicare spending is lower, it may create unintended incentives for MA organizations to target veterans in higher-revenue counties, potentially contributing to duplicative federal spending when the enrollees continue to use VA-funded services. These findings suggest that the Centers for Medicare & Medicaid Services (CMS) should revisit both the purpose of the adjustment and the methodology used to construct the VA/DoD adjustment factor.

STUDY DATA AND METHODS

Data. To identify veteran-targeted MA plans, researchers used the 2026 CMS MA landscape file, which contains information about all MA plans, including plan identifiers, plan names, county, and parent organization. County-level VA/DoD adjustment factors from the 2026 CMS MA rate calculation data were used to construct variables indicating upward adjustment to county-level MA benchmarks, implying stronger signals for MA plans to market aggressively to veterans in the county. Data from the 2023–24 Area Health Resource File (AHRF) were used to construct county-level variables for demographic composition, veteran characteristics, health care infrastructure and spending, and MA market penetration. The sample includes 3,065 counties that matched across the U.S. Department of Agriculture rural urban classification database, MA landscape files and rate calculation data, and AHRF. U.S. territories were excluded due to inconsistent availability of key MA payment adjustment variables and lack of comparability to county-level jurisdictions. Alaska was excluded because MA plans are offered statewide. Connecticut was excluded due to its municipal—cities, towns, and villages—rather than county structure.

Methods. Veteran-targeted health plans were identified with the method used by Dorneo et al. (2025),[2] which has demonstrated validity in identifying high-veteran enrollment plans, indicating reliability in identifying veteran-targeted plans. Specifically, a plan was classified as a veteran-targeted plan if the plan name included any of 10 keywords associated with veterans—valor, patriot, honor, courage, eagle, freedom, liberty, salute, valiance, and veteran. Researchers used publicly available information, including websites and marketing materials, to validate classification for specific types of plans. For example, since veteran-targeted plans are unlikely to offer prescription drug benefits,[Error! Bookmark not defined.] researchers validated plan classification by verifying the websites of MA plans that offered a Part D drug benefit. In addition, Dual Eligible Special Needs Plans, which enroll beneficiaries dually eligible for Medicare and Medicaid, were excluded from the

classification of veteran-targeted MA plans. Using this approach, 285 unique veteran-targeted plans were identified.

Researchers then constructed the outcome variable (veteran-targeted plan concentration) as the proportion of all MA plans in the county that were veteran-targeted plans. The outcome variable is measured at the county level and reflects unique veteran-targeted contract-county combinations. Because a single plan contract may be offered across multiple counties, the county-level measure reflects geographic availability of veteran-targeted MA plans rather than the number of unique plan contracts. The sample includes 16,074 contract-county combinations, corresponding to 285 unique plan contracts offered across an average of 56.4 counties each.

The VA-DoD adjustment factor is calculated as the ratio of standardized per-capita FFS spending among beneficiaries without VA/DoD eligibility to average per-capita FFS spending among all beneficiaries in the county. A factor above 1 indicates that beneficiaries eligible to receive services at VA/DoD facilities have lower Medicare FFS spending than the county average, and the benchmark is scaled upward accordingly. For example, if per-capita FFS spending is $10,200 among noneligible beneficiaries and $10,000 county-wide, the adjustment factor is 1.02 signifying a 2% upward adjustment. Because the factor directly scales the FFS rate used to set county benchmarks, it may create incentives for MA organizations to offer veteran-targeted plans in counties with a high VA/DoD adjustment factor. To capture this variation, researchers arranged the level of the VA/DoD adjustment factor across counties by terciles.

Because the outcome variable (veteran-targeted plan concentration) is a proportion bounded between 0 and 1, the analysis estimates county-level fractional logistic regression to test the relationship between the VA/DoD factor terciles and veteran-targeted plan concentration. Specifically, the specification includes two indicator variables representing the middle and highest terciles. The lowest tercile represents the reference category. Control variables included veterans as the percentage of total populations, quartiles of VA spending per enrollee, rurality, proportion of population over 65, and population living under federal poverty level. The total number of MA plans in the county was used as inverse probability weights to down weight counties where the outcome variable is imprecisely measured due to a low number of total MA plans offered.

The approach has three limitations. First, the analysis examines association and cannot establish a causal relationship between the VA/DoD adjustment and veteran-targeted plan concentration. Second, the analysis uses cross-sectional data that do not allow examination of entry of new veteran-targeted plans, which may be most sensitive to VA/DoD adjustments. Finally, veteran-targeted plans are identified using plan names and keywords, which may misclassify some plans if naming does not fully reflect actual targeting or enrollment patterns.

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