

How Late 2025 and Early 2026 Earnings Calls Expose the Medicare Advantage Pullback, the Migration of Margin From Insurance to Services, and the Quiet Redistribution of Healthcare Profit Pools

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Abstract

- Focus: Late 2025 and early 2026 earnings calls across major payers and hospital operators
- Core idea: margins are not disappearing, they are moving across segments
- Key tensions: utilization vs pricing, insurance vs services, volume vs acuity
- Critical signals: Medicare Advantage pullback, PBM revenue quality, hospital revenue cycle strain -
- Who is winning: diversified platforms with services leverage
- Who is exposed: pure-play MA insurers and lower-scale hospital operators

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- Where narratives conflict across the stack

- What management teams are signaling vs what they are avoiding
- What this means for operators, builders, and investors

The setup: utilization it reset

The single most important thing buried across the industry because nobody wants to say it out loud, is that utilization went up and stayed there. That sounds obvious in retrospect. It spent roughly eighteen months telling itself that the transitory unwind of deferred care, a kind of once it cleared things would settle back into normalcy now. It got quietly retired somewhere between late 2023 calls, and nobody held a funeral.

What replaced it is messier and a lot less comfortable than the old assumptions. The senior population is using the system than the actuarial models expected. Cardiovascular procedures, orthopedics, and outpatient settings, and specialty drug utilization are all running at levels that make 2019 through 2022 pricing decisions look like they were made on a different planet. Part of this is demographic, with the leading edge of the boomer cohort now well into the high utilization zone. Part of it is behavioral, with supplemental benefit designs from the Medicare Advantage boom years having trained a generation of seniors to actually use their coverage. And part of it is pharmaceutical, with GLP-1 adjacent prescribing patterns and specialty pipeline launches pulling spend forward in ways that underwriting did not fully anticipate.

The earnings language tracks this shift if you read it with the right ear. The word normalization has mostly disappeared. What you hear now is calibration, recalibration, repricing, discipline, and the ever popular operating rigor. That is not accidental. Calibration implies the system is adjusting to a new steady state. Normalization implied the old steady state was coming back. Those are very different concepts and the word swap is doing real work.

The practical implication is that every business model in the stack that was sized for 2019 utilization economics has been quietly rebuilt, or is in the process of being rebuilt. That rebuild is the actual story of the last four quarters, and most of what follows is really just variations on it.



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Insurance margins: the illusion of recovery

At a headline level the payer numbers have stopped getting worse. MLRs are no longer expanding at the same pace. Some carriers are guiding to modest year over year improvement. If you squint, it looks like stabilization, maybe even the early innings of recovery. That is the surface.

Underneath it is not really recovery. It is a repricing exercise catching up to a cost base that shifted two years ago, combined with benefit design trims and network tightening that took out some of the worst unit economics. The underlying cost structure did not get better. The pricing got closer to the cost.

The cleanest illustration of where this leaves things sits inside CVS, where the insurance segment has produced quarterly losses even while the enterprise as a whole still generates billions in operating income. That is the whole story in one line. The underwriting engine is not the profit engine right now. It is being carried by everything around it. The insurance book is still functional, still servicing millions of lives, still generating massive revenue, but the margin contribution has effectively been redirected. Management can frame that as strategic integration, and they do, but the accounting reality is that one segment is subsidizing another.

Cigna shows a variation on the same pattern with different geometry. The stub healthcare segment, once adjustments for the Medicare divestiture are baked in, is stable to modestly growing. The scale and the growth both sit in Evernorth. But inside Evernorth the split between top line and bottom line is where the interesting tension lives. Revenue is expanding very quickly, driven by pharmacy volume, specialty pipeline, and care services. Operating income is growing too, but not at the same rate in the PBM core. That gap is meaningful. It tells you that some of the growth is lower quality than the revenue line suggests. Spread compression in traditional PBM economics is real and ongoing, even as specialty and care services do the heavy lifting on incremental margin.

UnitedHealth looks cleaner on the surface mostly because Optum is enormous and the segment reporting structure allows the services strength to mask the insurance pressure. The insurance pressure is still there. It is just being absorbed inside a larger system. The 2024 medical cost pressure stories, the 2025 guidance revisions, and the ongoing commentary around the individual senior lives with higher than expected cost trend all point to the same underlying dynamic the rest of the sector is dealing with. Optum is not making that dynamic go away. It is providing enough offsetting profit contribution that the consolidated numbers stay investor friendly.

Elevance sits in a somewhat similar place, with Caredon doing more of the work each quarter. Humana, because the services arm is smaller relative to the insurance book, shows the pressure more rawly. The variance across carriers in how painful the current environment looks is largely a function of how much services leverage is sitting next to the insurance book. That is not a coincidence. That is the structural story.

The industry level takeaway is simple to state and slightly awkward to live with. Insurance margins did not magically recover on the back of some endogenous improvement in the business. They stabilized because pricing caught up, benefits were trimmed, networks were tightened, acquisition costs were pulled back, and supplemental design was rationalized. The cost structure underneath is not fundamentally different than it was when MLRs were blowing out. It just has a bigger revenue number on top of it.

Medicare Advantage: from growth engine to controlled burn

For most of the last decade Medicare Advantage was the easiest growth story anywhere in healthcare. Enrollment compounded at rates that would make a SaaS founder jealous, risk adjustment methodology supported margin, supplemental benefit escalation drove market share wars, and public markets rewarded whoever could show the fastest lives growth. That era is visibly over. Not winding down. Over.

The earnings language now leans into discipline, which is the polite industry word for walking away from members. Plans are exiting geographies, trimming or eliminating supplemental benefits that drove prior enrollment gains, pulling back on broker channel aggression, and being much more selective about which segments of the senior population they want to grow in. The 2026 plan year filings, read in aggregate, show benefit reductions that would have been unthinkable three years ago. Dental, vision, OTC allowances, transportation, grocery cards, the whole supplemental stack that defined the competitive dynamic in 2019 through 2022 is being scaled back or eliminated across large swaths of the market.

Humana is the most transparent about this because it has to be. As the most MA concentrated of the major publicly traded insurers, the pressure shows up in its numbers without anywhere to hide. The messaging centers on recalibration and return to margin, but the actions are sharper than the words. Benefit designs are being cut. Growth is being traded explicitly for per member profitability. The company is basically telling the market it would rather shrink into a more profitable

book than grow into a less profitable one. That is the right strategy. It is also a complete inversion of the playbook that drove valuation for a decade.

The variance across players in how they can absorb this shift is where the two speed market really shows up. A company with a large services arm can tolerate compressed insurance margin because it is monetizing the same lives through pharmacy, specialty distribution, care delivery, behavioral, and analytics. The insurance book becomes a customer acquisition channel for a broader platform. A pure play MA insurer does not have that option. Its insurance margin is its margin. When that compresses, everything compresses. That is why the smaller and more concentrated MA names have had such a brutal stretch relative to the diversified platforms, even when the underlying medical cost trend they are fighting is roughly similar.

Risk adjustment methodology is the other overhang. The V28 transition phase in, combined with increased audit activity and the ongoing debate about coding intensity, is putting downward pressure on risk scores at exactly the moment cost trend is elevated. Plans that built their margin on aggressive coding are getting squeezed from both sides, with costs going up and risk adjusted revenue going down. That is not a temporary mismatch. That is a structural reset of the economics of the product.

The part none of the calls really address head on is what this means for the supplemental benefit arms race as a competitive dynamic. If everyone is trimming benefits at roughly the same time, the relative competitive position does not change that much. The senior who was getting a three hundred dollar OTC card is now getting a hundred and fifty, but so is everyone else in the market. The question is whether enrollment behavior responds to the absolute level of benefits or the relative level. Early signals suggest absolute matters more than the industry wants to admit, which would imply disenrollment pressure as seniors shop around looking for the benefit levels they got used to. That shows up in the 2026 AEP data, and it is a tension that is going to define the next twelve to eighteen months.

Services businesses: where the margin actually went

If there is one through line across every major payer call, it is that services are doing the work. Optum, Evernorth, and the CVS Health Services segment are not diversification anymore. They are the core earnings engines. The margin that used to sit in insurance has been relocated one layer up in the stack, into the services businesses that sit adjacent to or inside the same enterprise.

Evernorth is worth walking through because its segment reporting is relatively clean and the dynamics are visible. Top line growth is being driven by pharmacy volume, with specialty continuing to be the fastest growing component, and by care services including the Express Scripts and Evernorth Care businesses. Operating income growth is positive but materially slower than revenue growth in the PBM core. That gap is spread compression. Pass through pricing models, transparent rebate arrangements, and ongoing employer pressure on PBM economics are all grinding at the traditional margin structure. Specialty pharmacy and care services are carrying a disproportionate share of incremental operating income, which is where the higher quality growth actually is.

CVS Health Services shows a similar shape with more noise. The segment is highly profitable on an adjusted basis. It is also where the significant goodwill impairment charges tied to care delivery assets have landed, most visibly on the Oak Street side. That is the part that makes the vertical integration narrative complicated. The strategic logic, which is that owning primary care for seniors gives the insurance arm more control over cost and quality, is sound in theory. The economics of acquiring those assets at 2021 valuations and integrating them into a much larger system have been mixed. Some of the acquired capital is performing. Some of it is being written down. When you read the adjusted numbers you see the performing part. When you read the GAAP numbers and the impairment disclosures, you see both.

The distinction matters because it changes how to think about the returns on vertical integration strategy at the sector level. If the services margin that is replacing insurance margin is partially financed by writing down the assets that were supposed to generate it, the net economics are softer than the adjusted numbers suggest. That does not make the strategy wrong. It makes the strategy more expensive than the adjusted framing implies, and it raises the bar for whether the promised long term synergy benefits materialize.

Optum is the benchmark here because it has operated at scale the longest. Optum Health, Optum Rx, and Optum Insight each show different margin profiles and different growth trajectories. Optum Rx looks a lot like Evernorth on the PBM side, with pharmacy volume growth outpacing operating income growth. Optum Health is a mixed bag, with value based care arrangements performing unevenly across geographies and populations. Optum Insight is the quietly interesting one, because the technology and revenue cycle component has relatively clean high margin growth that does not carry the same cyclical exposure as the insurance or care delivery components. That is where the infrastructure tax on the rest of the system shows up, and it is showing up reliably.

The industry level point is that the services wrapper around the insurance book is not a hedge. It is where the margin is. But not all services are equal. PBM core economics are compressing. Specialty pharmacy economics are holding up but under ongoing pressure. Care delivery economics are mixed and carry real integration risk. Data and technology services are the highest quality component, with the caveat that they are smaller in absolute dollars. Reading the services story as a monolith misses the texture. The texture is what matters.

Hospitals: strong volumes, stubborn economics

On the provider side the first read of the data looks positive. Volumes are up. Acuity is up. Revenue per adjusted admission is up. Same facility revenue growth is running at rates that would historically drive meaningful margin expansion. The margin expansion has not really shown up, or has shown up much less than the top line would suggest.

The reason is a cost base that reset in 2021 and 2022 and has not reset back. Contract labor is well off its peak, which gets called out on every call as a tailwind, but base wages stepped up permanently. Nursing compensation, tech compensation, and the compensation structure for the scarce clinical roles are all at levels that are not reverting. Supply costs, particularly for implants and specialty pharmaceuticals used in the inpatient and outpatient settings, are elevated and sticky. Professional fees for hospital based physician services, especially anesthesia and emergency medicine, have stepped up as the staffing companies in those spaces work through their own economic issues.

HCA, because it is the largest and most operationally sophisticated of the for profit hospital operators, shows the cleanest version of this dynamic. Same facility revenue growth is strong, acuity is favorable, and management commentary is generally constructive. Margins are improving but the rate of improvement is slower than the top line growth would historically predict. That gap is the cost base.

Tenet shows a slightly different picture because of USPI. The ambulatory surgery center portfolio is genuinely high margin and growing, and it pulls the consolidated margin profile up in a way that masks some of the hospital side pressure. Stripping USPI out, the pure hospital margin story looks a lot more like Community Health Systems and HCA.

Community Health Systems is worth calling out because the numbers are unvarnished in a way that is useful. Same store revenue growth has been positive, but admissions

have been flat to slightly down in several recent quarters. That tells you that pricing, case mix, and supplemental payment programs are doing most of the work. It is not bad. It is lower quality than volume driven growth, and it depends on the durability of the supplemental payment structures, which is not guaranteed.

The supplemental payment dynamic is its own topic and does not get enough attention in the calls. State directed payment programs, Medicaid supplemental arrangements, and various 1115 waiver structures are material contributors to reported margin for a lot of hospital systems, particularly those with higher Medicaid and uninsured exposure. Those programs get renewed or restructured on state level timelines, and the federal posture toward them has been shifting. A material change in the supplemental payment environment would move provider margin noticeably. The calls mostly treat this as background noise, which it is not.

Payer mix is the other thing quietly eating into the volume story. The continued shift from commercial to Medicare, driven by demographics and by employer plan changes, is compressing average reimbursement per case even as acuity and volume both trend up. Medicare Advantage now represents a majority of Medicare eligible lives in many markets, which means hospital reimbursement is increasingly set by MA contract rates rather than traditional Medicare. Those rates vary by plan and by contract vintage, and the tension between hospitals and MA plans over reimbursement, prior authorization, and claims adjudication is visible in the contracting commentary across calls. Several large health systems have publicly exited MA contracts with specific plans, which is a new dynamic and worth watching.

The hospital margin story right now is an operational grind. Incremental improvement is possible and is happening. The idea of snapping back to 2019 margins at the sector level is not supported by anything in these calls.

Revenue cycle: the silent margin battlefield

Almost every provider call touches revenue cycle, but usually as a side note rather than a central theme. That framing is wrong. Revenue cycle is where a large share of the unresolved margin battle is actually being fought.

Denial rates are up, and the composition of denials is shifting toward more clinically complex reasons that take longer to overturn. Prior authorization requirements are expanding across both commercial and Medicare Advantage books, and the administrative friction is rising in ways that are not fully captured in any single line item. Collections are getting harder as high deductible plan penetration continues

and patient out of pocket obligation grows. Average days in accounts receivable have drifted up across most of the large publicly traded systems, even as they have invested heavily in revenue cycle technology and offshoring.

The actuarial reality is that the cost of getting paid has risen faster than the cost of providing care in many systems. That is a striking statement and the data in these calls roughly supports it. Hospital systems are seeing more complex patients, generating more revenue per case, and spending more to capture that revenue. The net margin benefit is muted because the administrative cost layer is growing.

This is also where the disconnect between payer and provider narratives is most visible. Payers talk about medical cost trend management, which on the earnings call sounds like pricing discipline and utilization management. Providers experience the same thing as more denials, more documentation requirements, more prior authorization loops, and more back end friction in getting paid for care that has already been delivered. Both narratives are describing the same underlying activity. They are framed in opposite moral terms, and both framings contain real information.

For anyone building in this space, and several of the calls mention deals or investments in revenue cycle technology and services without ever quite using the phrase, this is one of the most structurally durable problem areas in healthcare. It is not a transient issue waiting for a policy fix. It is getting more complex each year as payer rules proliferate, as more care moves to risk based and value based contracting structures that require new kinds of documentation, and as the underlying clinical acuity of the patient population increases. The vendor landscape around it is fragmented, which is both the opportunity and the challenge. Whoever consolidates durable workflow across the denial management, prior authorization, and patient financial experience stack captures an enormous amount of value, and the large incumbents know it, which is why the strategic activity in this category has been quietly intense.

Noteworthy that Optum Insight, Waystar, R1, and the private equity owned middle layer of revenue cycle services have all been in various stages of repositioning over the last twelve months. Some of that is public, some of it is not. The point is that the capital is flowing where the friction is, and the friction is here.

Where narratives conflict across the stack

Reading the calls side by side, rather than in isolation, is where the most useful insight comes out. The interesting moments are not where the stories agree. They are

where the stories should agree and do not.

Providers describe payer mix as favorable and pricing as constructive. Payers describe medical cost trend as elevated and rate increases to providers as moderate. Both of those statements cannot be fully true at the same time. If providers are getting paid meaningfully more per case and payers are not spending meaningfully more per case, the math does not close. The resolution is that both are partially true. Case mix acuity is shifting, so payers are spending more per case partly because the cases are more complex, not only because unit rates are higher. And providers are capturing a mix of rate, acuity, and supplemental payment that reads as favorable on their side without being purely a unit price story. But there is still real tension embedded in the gap, and that tension is where the 2026 and 2027 contract negotiation cycles are going to be painful.

The services story contains a similar tension. Payer calls emphasize growth in pharmacy and care services. The profitability of that growth varies widely by component. High revenue growth in PBM core with lower operating income growth means that growth is not as high quality as the top line suggests. Specialty pharmacy is better, but it is also where employer and regulatory scrutiny is most intense. Care delivery is the highest potential margin and the most capital intensive, and is where the integration risk has been most visible. If you read the services growth narrative as uniformly positive across the components, you miss the real picture. The real picture is a mix of durable margin, compressing margin, and potential margin that is still being built out with uneven execution.

The timing mismatch is the other recurring conflict. Providers are benefiting from higher acuity now, in current period results. Payers are repricing for it with a lag, through bid cycles, contract renewals, and benefit redesigns that take one to two years to fully manifest. During the lag, provider results can look strong while payer results look weak, even when the underlying economic reality is that both sides are converging toward a new equilibrium. The sector level earnings split between the two sides over the last six quarters reflects this lag effect as much as it reflects any real divergence in underlying performance.

The other conflict worth naming is between the vertical integration narrative and the segment level financial reality. The public narrative from the large diversified platforms is that vertical integration is working and delivering the long promised synergies. The segment data shows a more complicated picture, with some components performing well, some being actively restructured, and some being written down. That does not mean the strategy is failing. It means the strategy is

expensive and uneven, and investors who take the adjusted narrative at face value without digging into the segment reporting are missing the texture.

Conflicts like these are where the alpha is in reading these calls. Clean consistent narratives across the stack are rare in healthcare. Misalignment is the signal, and the misalignments pointing to the biggest structural shifts are the ones that show up repeatedly across multiple companies, not just in one.

What management teams are signaling vs what they are avoiding

Every management team shapes the narrative, and in healthcare that shaping is especially pronounced because the businesses are complex enough that the framing choices matter a lot.

When a management team talks about adjusted operating income without giving equivalent weight to impairment charges, that is signaling. When revenue growth gets prominent treatment but the associated margin compression only shows up in footnotes and analyst day decks, that is signaling. When the word transitory gets used more than once per call, that is almost always signaling.

Cigna is relatively good at structured disclosure. The segment breakouts are usable and the commentary generally lets you follow the story without heroic reconstruction. That is a compliment, not a setup for a criticism. When management teams structure their reporting to allow real analysis, it is easier for long term investors to get comfortable, and it is harder for short term narrative shifts to distort valuation.

CVS provides a lot of data but relies heavily on adjusted frameworks that remove some of the messier components of recent history. The company is not unusual in this, and management is navigating a genuinely difficult strategic position. But interpreting CVS requires more work than interpreting Cigna, and the adjusted to GAAP bridge is where a meaningful share of the real story sits.

UnitedHealth is a specific case, partly because of the scale and partly because of the current environment. The disclosures have become more structured under pressure, and the commentary around medical cost trend has become more specific over the last several quarters. That is investor demand forcing clarity. It is also an implicit acknowledgment that the prior framing was not sufficient given what was happening underneath.

Hospital operators tend to emphasize same facility metrics, which is the right frame and is genuinely helpful. They often spend less time on the sustainability of

supplemental payment programs, the specifics of payer contracting disputes, and the long term implications of payer mix shifts, all of which are material to the forward margin profile. The language around labor is usually specific enough to be useful. The language around revenue cycle and administrative burden is usually general enough to be vague.

Across the entire set, the topic that gets the least structured discussion relative to its actual economic importance is administrative complexity and revenue cycle friction. Every participant is experiencing it. Very few are quantifying it in any useful way on the call. That gap between what is being lived operationally and what is being surfaced narratively is a useful place to focus attention, both for investment analysis and for anyone trying to build a business that addresses the problem.

What this means for operators, builders, and investors

Step back from the specifics and the picture is coherent. The industry is not losing margin. It is redistributing margin. The absolute pool of profit across the healthcare stack has not materially shrunk. It has moved, and it is continuing to move, and the direction of travel is reasonably clear if you squint past the quarterly noise.

Insurance is becoming less reliable as a standalone profit engine. Not unprofitable. Less reliable. The cyclical nature of medical cost trend, the structural shift in the senior population, the compression of Medicare Advantage economics, and the ongoing pressure on risk adjustment methodology all point to an insurance business that is more volatile and more capital intensive than the market assumed during the growth years. That does not make it a bad business. It makes it a different business than the one that was being valued in 2019 through 2022.

Services are becoming more central, but the services category is heterogeneous. Pharmacy benefit management in its traditional form is under long term margin pressure from transparency demands, employer sophistication, and regulatory scrutiny. Specialty pharmacy is a better position, with higher growth and more durable economics, though not immune to the same pressures. Care delivery is the highest potential return and the highest integration risk, and the experience of the last three years suggests that execution quality matters more than strategic positioning. Data, analytics, and revenue cycle technology services are the cleanest margin profile in the category, with the caveat that they are smaller in absolute dollars and require real operational scale to generate durable advantage.

Providers are recovering on volume and acuity, but constrained by a cost base that has reset and by an administrative environment that is getting more complex, not less. The good operators will keep grinding incremental margin improvement. The idea of a snap back to pre pandemic sector margins is not supported by anything visible in the current cycle. The weaker operators, particularly the smaller systems without the scale to invest in revenue cycle, labor productivity, and service line rationalization, are going to continue consolidating into larger platforms. That consolidation is itself a margin redistribution event, with value accruing to the acquirers who can integrate efficiently.

For operators inside the system, the implication is that diversification across the value chain is not optional if meaningful scale is the goal. A pure play insurance business, or a pure play hospital system, or a pure play PBM, is a harder business to run in the current environment than it was ten years ago. That does not mean every company should try to be vertically integrated. It means companies that are not vertically integrated need to have a clear answer to why their single segment positioning is durable, and that answer has to account for where the sector level margin is actually accumulating.

For builders, and this is where it gets interesting for anyone working in the early stage and growth stage ends of the market, the friction points in the stack are where durable businesses get made. Revenue cycle and administrative workflow sit at the top of that list. Specialty pharmacy infrastructure, particularly around patient support, benefits investigation, and prior authorization, is another. Care delivery enablement for the new value based contracting structures is a third, though the execution bar is high. Data infrastructure that actually connects clinical, financial, and utilization data in usable form is a fourth, and the existing incumbents have not solved it cleanly despite significant capital deployed.

For investors, the implication that gets most consistently missed is that segment level analysis matters more than consolidated analysis, and consolidated analysis matters more than narrative. The same company can have a weak insurance segment, a compressing PBM segment, a struggling care delivery investment, and a genuinely high quality data and technology business, all at the same time, and the consolidated adjusted earnings number will obscure most of that texture. Valuation that rests on consolidated adjusted numbers without a view on segment level durability is valuation that is going to be surprised by segment level transitions. There have been a lot of segment level transitions in healthcare recently. There are more coming.

The easy narratives have mostly broken. Growth is still there. Profit is still there. Both are just not sitting where they used to sit, and the disconnect between where they

used to sit and where they sit now is the single most important thing to internalize about reading these calls. Everything else flows from that.

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