# No Real Choices

## How Medicare Advantage Fails Seniors of Color

Physicians for a National Health Program has developed a report detailing the impact of Medicare "Advantage" (MA) on racial health inequities, funded by Arnold Ventures.

Using data-driven critical analysis, we assessed MA insurers' claims that their plans promote equity. Corporate insurers congratulate themselves for enrolling millions of seniors of color, but avoid talking about the significant drawbacks to MA plans and the ways in which seniors can feel trapped by subpar coverage. Beneath the glossy promises, research reveals that **MA often exacerbates inequity**—especially for Black, Hispanic, and Asian enrollees.

### Key Findings

**Systemic Disparities:** When studying MA plans, we found that plans serving a higher proportion of people of color had lower quality ratings.

**The "Gap Trap":** Many seniors from under-resourced communities cannot afford Medigap or standalone Part D prescription drug coverage and are therefore stuck with MA plans that limit access to specialists and high-performing hospitals.

**Higher Denial Rates:** One study found that MA prior authorization requests were denied 23% of the time for Black seniors vs. 15% for their white counterparts.

**False Economy:** Despite promises of efficiency, MA's payment structure increases federal spending while delivering poorer outcomes and deeper inequities.

Medicare Advantage's lower upfront costs appeal to historically marginalized seniors, who enroll in plans that provide less care and impose higher long-term costs—both to patients and to taxpayers. **Rather than closing gaps, MA often reproduces them.**

Our report highlights the need to ensure that federal programs, like MA, which perpetuate racial and economic disparities, be removed and replaced with a truly equitable system that benefits all Americans.

PNHP physicians for a national health program

Read the report

# Solutions to Deliver Equity for America's Seniors

## Expose the truth about equity

Policymakers, providers, and the public must recognize that high enrollment of people of color in MA is not evidence of equity, but of structural barriers and financial entrapment.

## Return to Medicare's original promise of equity and universality

Reforms must eliminate geographic variations in plan offerings and ensure that comparably high quality options are available in every community.

## End the "Gap Trap" by introducing a low out-of-pocket maximum

Strengthening Traditional Medicare by establishing a low limit on out-of-pocket expenses would remove the pressure that forces low-income enrollees—disproportionately Black and Hispanic—into corporate plans with restrictive networks and inferior care.

## Match the actuarial value of MA benefits in TM

By providing the same level of coverage and supplemental benefits in the public program, we can eliminate the false choice that pushes marginalized populations into MA and ensure that all beneficiaries–regardless of race, ethnicity, or income–have access to high-quality care.

## Improve TM by redeploying overpayments to MA

We can close the Gap Trap by creating a $5,000 out-of-pocket maximum in TM (similar to the most common MA plans) and adding vision and hearing benefits to TM at a comparable actuarial value to MA. MedPAC's conservative estimate of $84 billion in annual overpayments to MA is more than adequate to fund these improvements to TM.

## Explore new models for determining how much MA plans are paid

Today's risk-adjustment model is failing—and creating strong incentives for insurers to upcode. Researchers have found that by incorporating additional data sources alongside the current Hierarchical Condition Categories, we can be more predictive of true health outcomes (mortality, hospitalizations, drug use); reduce both under-compensation and over-compensation of MA plans; and redistribute payments toward underserved populations.

## Learn from models that already deliver equity

When benefits are structured fairly, outcomes can be more equitable. Studies show that Black Americans with chronic kidney disease on dialysis survive longer than matched White Americans, thought to be due to universal, traditional Medicare coverage for dialysis patients.