No Real Choices

How Medicare Advantage Fails Seniors of Color

PNHP

Physicians for a National Health Program

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Table of Contents

Executive Summary

The Medicare Advantage ("MA") program, through which health insurance corporations contract with the federal government to deliver Medicare benefits, offers enrollees few upfront costs, an out-of-pocket maximum, extra benefits, and a simple enrollment process. However, these advertised benefits show themselves to be hollow when carefully studied, revealing a program that compromises access, equity, and quality of care. Evidence from an exhaustive literature review and new research reveals that MA enrollees often encounter steep barriers to the physicians and hospitals people with complex conditions need for medically necessary care.

Contrary to claims from the insurance industry that MA is a solution to inequity, racial and ethnic minorities enrolled in MA continue to face many of the longstanding disparities that are common in American healthcare. The financial model of MA does little to mitigate existing inequities – and often exacerbates them by disproportionately offering communities of color inferior insurance products. At the same time, MA places a heavier burden on federal spending than Traditional Medicare (TM), which raises doubts about whether the program truly provides worthwhile returns for the people it is meant to serve.[1,2]

In this report, we demonstrate that communities of color that have been historically deprived of wealth accumulation and disposable income are unable to afford the premiums for supplemental insurance (e.g., "Medigap" and a separate Part D pharmacy benefit) that most people in TM depend upon to mitigate the unlimited coinsurance and hospital deductibles in TM. Like TM, MA also includes coinsurance and deductibles; unlike TM, MA includes a statutory maximum on out-of-pocket expenses, a pharmacy benefit, and a very low monthly premium, all without patients needing to pay for any supplemental insurance policies. In fact, MA plans that include these attractive features are widely available for less than $20 per month.[3] As the high cost of Medigap makes TM an unaffordable alternative to MA, under-resourced communities frequently have no meaningful choice but to enroll in more restrictive MA plans, ensnaring them in a bind we label the "**Gap Trap**."

In collaboration with Johns Hopkins University researchers, we conducted a cross- sectional analysis of more than 2,400 MA plans to determine whether these plans disproportionately enroll specific racial and ethnic groups, and to evaluate differences in plan quality across them based upon the CMS quality star rating system. Our findings reveal that 23.7% of MA plans disproportionately enroll Asian, Hispanic, and Black Americans, and that these populations tend to be enrolled in the most restrictive and lowest-performing MA plans. In our analysis, plans with the highest concentration of White enrollees averaged 4.3 out of 5 stars while plans with the highest concentrations of

1 Physicians for a National Health Program. Taking Advantage: How Corporate Health Insurers Harm America's Seniors. May 23, 2024.
2 Center for American Progress. Ending Overpayment in Medicare Advantage: A Proposal To Improve the Value of the Medicare Program. March 19, 2024.
3 National Council on Aging. What Are the Costs of Medicare Advantage? January 8, 2025.

Black, Hispanic, and Asian enrollees fell below the 4.0-star threshold required for quality bonuses, averaging 3.86, 3.75, and 3.70 stars, respectively.[4]

4 Andrew Anderson, Ji Mun Li, Darrell J. Gaskin, and Michael K. Meiselbach, Racial and Ethnic Sorting in Medicare Advantage Plan Enrollment (Working paper, Johns Hopkins Bloomberg School of Public Health, 2025), manuscript under review

Introduction

"Everyone deserves affordable high-quality health coverage and care regardless of the individual qualities that make us who we are, like our race, gender, disability, or health status," says AHIP,[5] the trade association for the health insurance industry. While insurers offering Medicare Advantage ("MA") have the resources and flexibility to improve health equity, the research reviewed in this report demonstrates that inequities persist without meaningful change. In some circumstances, we found that inequities are significantly worse between groups of people enrolled in MA as compared to those enrolled in TM.

MA is a federally funded program through which health insurers deliver benefits to older adults and people with disabilities. Their HMO and PPO products are an alternative to the government-administered TM program. Insurers in MA make the false promise of lowering costs and improving health outcomes. Our previous reports demonstrated that neither claim is justified.[6,7]

In this report we focus on how insurers offering MA fail to improve racial and ethnic health equity, with a particular focus on Black Americans. We center Black Americans in this analysis because they have been the subject of the most extensive equity research, making it possible to document with rigor the ways in which MA fails to mitigate inequities in healthcare.

At the same time, we want to be explicit that these inequities are not unique to Black Americans. Our data includes research on other racial and ethnic groups–including Hispanic, Asian, and Native American populations – but the evidence is far less developed. Available data suggest similar patterns of inequity exist across these groups, and future research must deliberately expand the lens to ensure their experiences are fully captured.

Through our analysis of existing research, we found that MA enrollees from marginalized communities face worse clinical outcomes, higher hospital readmission rates, and limited access to quality care. While the MA program offers insurers the flexibility to reduce cost sharing and ease access to care for vulnerable populations, they do not consistently do so. Rather than benefiting from that flexibility, the populations most vulnerable to harm are frequently only offered plans with the most restrictive design and lowest quality.

This report presents new research demonstrating that the insurance industry attracts Asian, Hispanic, and Black Americans into the most restrictive and lowest-performing MA plans and too often leaves them without the care they need. The report also explores some of the perverse incentives that are driving this injustice. Regardless of the reasons, any system that traps and harms people – particularly in ways that map onto centuries of racial injustice – cannot be a solution to health inequity.

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5 AHIP. Health Equity.

6 Physicians for a National Health Program. Our Payments, Their Profits: Quantifying Overpayments in the Medicare Advantage Program. October 4, 2023.

7 Physicians for a National Health Program. Taking Advantage: How Corporate Health Insurers Harm America's Seniors. May 23, 2024.

Many members of Congress have adopted a hands-off approach to MA. Some falsely believe that MA is instrumental to addressing inequity, possibly influenced by decades of industry-funded studies with significant flaws that perpetuate this belief. This report is intended to set the record straight and establish a foundation for long-needed fundamental reforms.

Two Faces of Medicare

President Lyndon Johnson described Medicare as "[...]the seeds of compassion and duty which have today flowered into care for the sick, and serenity for the fearful."[8] It was designed at a time when half of all older Americans had no health insurance. Insurers would either not cover them or would charge them premiums that were unaffordable. For several decades, Medicare guaranteed that the elderly and people with disabilities had affordable access to high quality healthcare.

With the passage of Medicare, older Americans found themselves in the enviable position of guaranteed access to care. Insurers now lobbied for access to this remunerative population. These efforts led to the passage of the Balanced Budget Act of 1997 through which Congress created Medicare Part C, originally named Medicare + Choice and later reformulated as MA.[9] This was intended as a market-based strategy to establish competition among multiple small insurers. However, the landscape has gradually consolidated into quite the opposite and is now dominated by a handful of large corporations.[10]

Insurance corporations have taken over coverage of more than half the people in our cherished public health program. Two very different models of Medicare have emerged: Traditional Medicare and Medicare Advantage.

Traditional Medicare

TM was designed to achieve the mission President Johnson articulated. Nearly all older adults are automatically enrolled into TM when signing up for Social Security. Enrollees have the freedom to receive care from any physician or hospital that accepts Medicare payments, without requiring referrals. Patients in TM face almost no bureaucratic barriers to the care they choose for themselves. For example, TM almost never requires prior authorization for covered services (one prior authorization for every 100 enrollees per year).[11] All enrollees participate in a single unified program with the same set of benefits and the same freedom to choose the care most appropriate for their circumstances.

This structure makes TM fundamentally equitable: every eligible person across the United States is assured of the same benefits.

The program's finances align directly with the health of the nation, ensuring that the financial returns from long term investments in public health flow back into the Medicare budget. By pooling such a large population, TM maximizes budgetary predictability and distributes the costs of high-expense medical care across millions of enrollees.

8 Truman Library Institute. "Signing Medicare into Law."
9 Medicare Rights Center, Medicare Advantage History: Legislative Milestones. 2023.
10 Nicole Zhu, Jeannie Fuglesten Biniek, Nolan Sroczynski, and Tricia Neuman, Most Medicare Advantage Markets are Dominated by One or Two Insurers. July 14, 2025.
11 Biniek, Jeannie Fuglesten, Nolan Sroczynski, Meredith Freed, and Tricia Neuman, Medicare Advantage Insurers Made Nearly 50 Million Prior Authorization Determinations in 2023. January 28, 2025.

The greatest challenge for people in TM is significant personal financial expenditures. Enrollees are responsible for a 20% coinsurance for most outpatient expenses, with no upper limit, and a $1,716 deductible (in 2026) for each benefit period in which they are hospitalized, potentially multiple times per year.[12]

To mitigate this, most TM enrollees obtain supplemental coverage, most commonly by personally paying a premium. For example, a 2025 "Plan G" Medigap policy typically limits out-of-pocket costs to $257 annually but averages nearly $2,000 per year in premiums.[13] Other Medigap options are available with varying premiums and out-of-pocket structures. Additionally, enrollees in TM who need prescription drug coverage must purchase a separate Part D plan,[14] adding another premium cost to the overall expense of enrolling in TM that people avoid when opting into MA.

Medicare Advantage

Historically, prepaid health plans held a minor place within Medicare since its enactment in 1965. As part of the 1997 Balanced Budget Act, Medicare Part C was created as a federally funded, commercially administered insurance program called "Medicare Plus Choice" and later reformulated as "Medicare Advantage" under the 2003 Medicare Modernization Act.[15] Since 2004, the share of enrollees in MA has more than quadrupled from 13% to 54% of all Medicare enrollees in 2025.[16,17] Unlike TM, MA is built on prepaid capitations to commercial enterprises whose business model depends on maximizing revenue and minimizing expenses, often at the expense of patient care.[18]

MA was originally proposed to cut Medicare costs; this has not been the case.[19] MedPAC estimated that payments to MA in 2025 were $84 billion higher than the same patients would have cost had they been enrolled in TM.[20] Our own 2023 analysis expanded upon the MedPAC findings by also considering the economic impact of county benchmarks, quality bonuses, and induced utilization (setting MA benchmarks based upon the average cost in TM where most people have Medigap). With these additional factors, we estimated the overpayments to MA at $140 billion.[21]

Besides financial loss, evidence shows harm to patients, physicians, and hospitals across the MA program coupled with failures to improve care.[22] MA plans consume between 11.1 to 20.5 million

12 CMS. Medicare and You 2026.
13 Worstell, Christian, What Is the Average Cost of Medicare Supplement Insurance Plan G? May 30, 2025.
14 KFF. The Trump Administration is Reducing Enhanced Support for the Part D Stand-Alone Drug Plan Market. July 28, 2025.
15 Medicare Rights Center, Medicare Advantage History: Legislative Milestones. 2023.
16 Lindsay Harris, Lori Achman, and Marsha Gold, Medicare Advantage and Medicare Beneficiaries: Monthly Tracking Report for August, 2004. September 7, 2004.
17 Nancy Ochieng, Meredith Freed, Jeannie Fuglesten Biniek, Anthony Damico, and Tricia Neuman, Medicare Advantage in 2025: Enrollment Update and Key Trends. July 28, 2025.
18 Physicians for a National Health Program. Taking Advantage: How Corporate Health Insurers Harm America's Seniors. May 23, 2024.
19 Jeannie Fuglesten Biniek, Juliette Cubanski, and Tricia Neuman, Higher and Faster Growing Spending Per Medicare Advantage Enrollee Adds to Medicare's Solvency and Affordability Challenges. August 17, 2021.
20 MedPAC. The Medicare Advantage program: Status report. March 2025.
21 Physicians for a National Health Program. Our Payments, Their Profits: Quantifying Overpayments in the Medicare Advantage Program. October 4, 2023.
22 Ibid

clinician hours annually on prior authorizations,[23] time that should be used for patient care. In 2025, nearly 10 million enrollees are in narrow networks excluding more than 75% of local doctors.[24] For some cancers, postoperative death rates are nearly twice as high in MA as TM, mainly due to care delays and limited access to centers of excellence.[25] Copayments, narrow networks, and prior authorizations create systemic barriers to care with dire consequences.

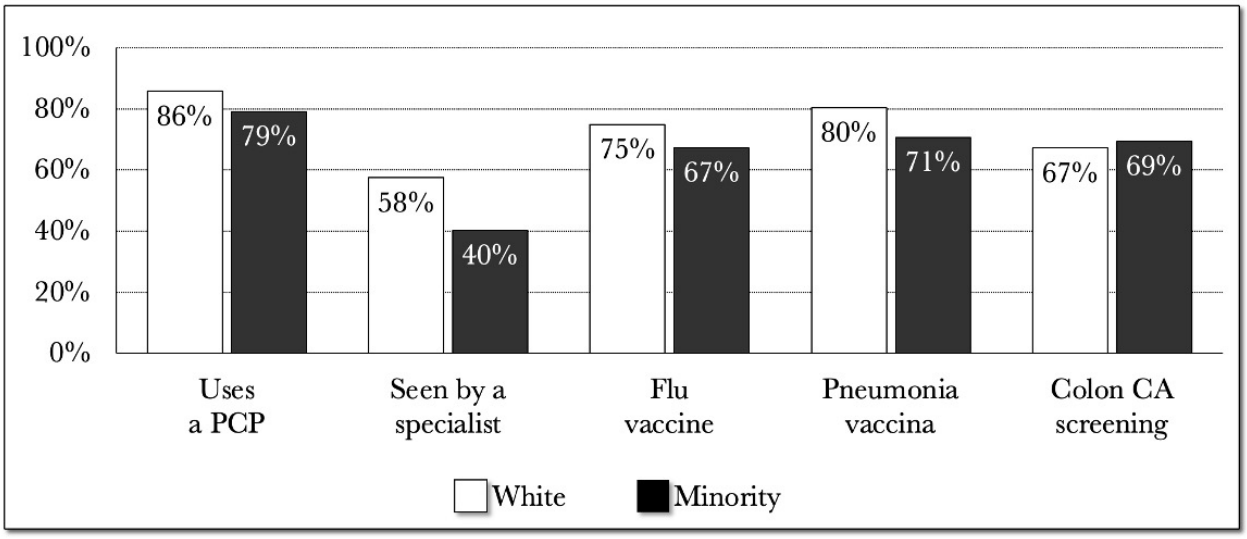
In addition to administrative burdens and narrow networks, investigative reporting reveals troubling practices. According to a 2025 investigation by The Guardian, UnitedHealth Group, the largest healthcare conglomerate in the U.S., secretly paid nursing homes bonuses to cut hospital transfers, saving money and boosting revenues based on their star rating, while risking residents' health. In several documented cases, patients who needed immediate hospital care did not receive it, and at least one suffered permanent brain damage as a result of delayed transfer. Internal communications show that UnitedHealth supervisors tracked nursing home "budgets" for allowable hospital admissions, effectively rationing care.[26]

These problems compound existing racial inequities. One study demonstrated that Black MA enrollees (more so than Hispanic or Asian/Pacific Islander enrollees) face significantly higher rates of preventable hospitalizations compared to White enrollees, with even worse disparities in lower-rated plans. This study suggests that providing more consistent access to higher-rated plans could help reduce these disparities.[27]

In summary, while TM continues to embody President Johnson's original promise of equitable, universal access, MA is eroding those basic guarantees.

23 Physicians for a National Health Program. Taking Advantage: How Corporate Health Insurers Harm America's Seniors. May 23, 2024.
24 Aditi P. Sen et al. Physician Network Breadth and Plan Quality Ratings in Medicare Advantage. JAMA Health Forum. Published Online: July 30, 2021. 2021;2;(7):e211816. doi:10.1001/jamahealthforum.2021.1816
25 Mustafa Raoof, Philip H.G. Ituarte, Sidra Haye, Gretchen Jacobson, Kevin M. Sullivan, Oliver Eng, Jae Kim, and Yuman Fong, Medicare Advantage: A Disadvantage for Complex Cancer Surgery Patients. November 10, 2022.
26 George Joseph, Revealed: UnitedHealth Secretly Paid Nursing Homes to Reduce Hospital Transfers. May 21, 2025.
27 Sungchul Park, Rachel M. Werner, and Norma B. Coe, Association of Medicare Advantage Star Ratings With Racial and Ethnic Disparities in Hospitalizations for Ambulatory Care Sensitive Conditions. December 2022.

Chart 1: Utilization of healthcare services in MA[28]



28 Johnston KJ, Hammond G, Meyers DJ, Joynt Maddox KE, Association of Race and Ethnicity and Medicare Program Type With Ambulatory Care Access and Quality Measures. August 17, 2021.

The Equity Illusion

Diversity is not Equity

Recent history outside of health care shows that higher representation of minority populations does not equate to equity. In 2006, subprime mortgages were issued to 26% of White homebuyers, 47% of Hispanic homebuyers, and 53% of Black homebuyers.[29] In 2022, 4% of White Americans received payday loans, compared to 6% of Hispanic Americans and 12% of Black Americans.[30] Subprime mortgages and payday loans were disproportionately marketed to communities of color despite banks knowing this would make them more vulnerable to debt traps and foreclosures. These financial products were revealed as predatory practices and are not solutions to racial inequity. In these contexts, greater diversity does not necessarily mean greater equity.

The failure of diversity as proof of equity can also be documented in healthcare. Lower-income enrollees from minority racial and ethnic backgrounds are significantly more likely to select MA plans. As we demonstrate below, this is not because these plans offer superior care, but because financial limitations leave people in lower income groups with no choice.

One study notes that between 2009 and 2018, MA enrollment among Black individuals grew by 66% (from 23% to 38%), while Hispanic enrollment rose by 43% (from 33% to 48%). But growth of enrollment was steepest among enrollees in the most disadvantaged neighborhoods, where enrollment increased from 25% to 40% – a 60% relative increase compared to 42% in the least disadvantaged areas. Yet despite this rapid growth, racial and ethnic minority enrollees are disproportionately concentrated in lower-quality plans and are offered fewer high-quality plan options. For example, Hispanic enrollees are significantly more likely to enroll in zero-premium plans (53.3%), which tend to offer narrower networks, higher cost-sharing for out-of-network care, and fewer high-quality provider options.[31] These patterns emphasize that financially vulnerable beneficiaries often choose MA because cost barriers leave them with no real choice – forcing them to trade affordability for low quality care.[32]

Although MA has a higher percentage of diverse populations (29%) compared to TM (19%), with 54% of all Medicare enrollees from diverse backgrounds choosing MA in 2021[33] versus 46% of MA enrollment overall that year,[34] this does not mean that the program is fulfilling its promise of improving equity. Insurers often cite these enrollment numbers as proof they are closing health equity gaps, but closer inspection shows the evidence does not support this claim.

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29 Algernon Austin, Subprime Mortgages Are Nearly Double for Hispanics and African Americans. June 10, 2008.
30 Tammy Worth, Kansas Coalition Pushing Payday Loan Reform. November 22, 2022.
31 David J. Meyers, Vincent Mor, Momotazur Rahman, and Amal N. Trivedi, Growth in Medicare Advantage Greatest Among Black and Hispanic Enrollees. June 2021.
32 Christopher L. Cai, Sonia Iyengar, Steffie Woolhandler, David U. Himmelstein, Kavya Kannan, and Lisa Simon, Use and Costs of Supplemental Benefits in Medicare Advantage, 2017-2021. January 14, 2025.
33 AHIP, Increasingly Diverse Segment of Americans Choosing Medicare Advantage. January 10, 2024.
34 MedPAC, A Data Book: Health Care Spending and the Medicare Program. July 2021.

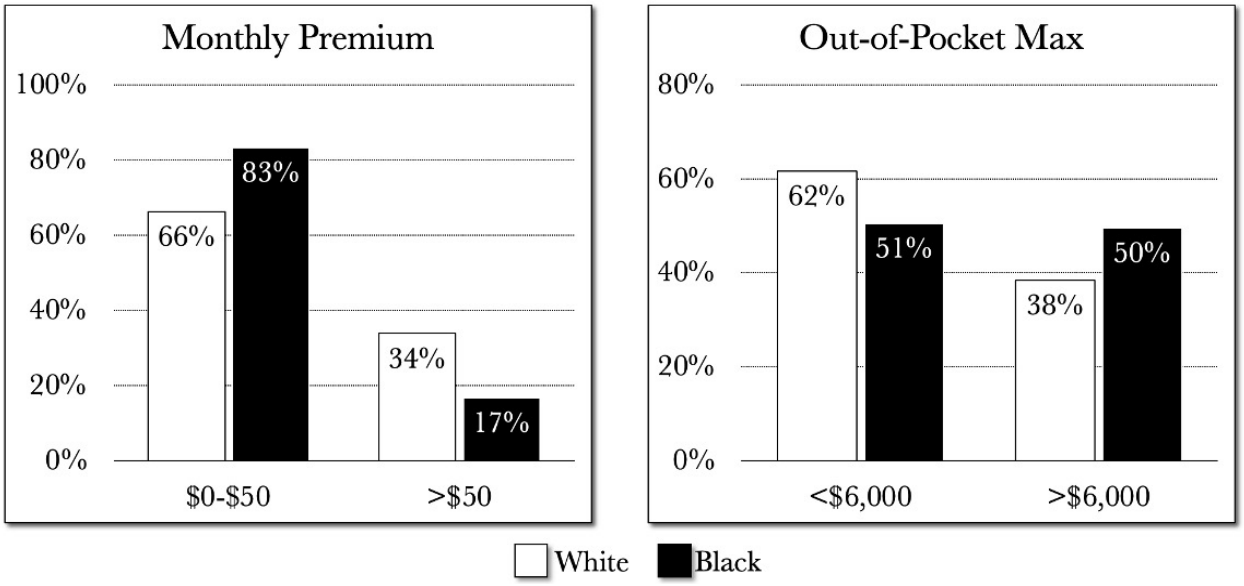
Insurers use strategic tools to attract people of color into MA plans,[35,36] particularly among lower-income beneficiaries. These individuals typically have complex health needs which are expected to generate billions in profit for health insurers in the coming years, despite being a group that typically racks up expensive health care bills."[37] Insurers argue that increased funding to MA plans is justified, however, that funding is inconsistently applied towards meaningful improvements in plan quality.[38,39]

In fact, subjective experiences and healthcare measures are often worse for minority MA dual beneficiaries, suggesting that the plans are of lower quality.[40] According to a 2021 report from the CMS Office of Minority Health: "With just one exception, racial and ethnic minority beneficiaries reported experiences with care that were either worse than or similar to the experiences reported by White beneficiaries." The disparities are even more pronounced in clinical care measures. The same study reported that API enrollees fared worse than White enrollees on six measures, Black enrollees had poorer results on 14 clinical measures, and Hispanic enrollees had worse outcomes on 16 measures. Black, Asian, and American Indian enrollees in MA had significantly worse clinical outcomes than White enrollees.[41] These findings emphasize that inequities in MA are not confined to one group – they span across racial and ethnic minority populations.

Some of the research on Hispanic enrollees in MA plans is unclear. Hispanic enrollees face worse access to care relative to White enrollees in TM but similar access relative to White enrollees in MA. Hispanic-White disparities in delaying care due to cost and reporting problems paying medical bills appeared narrower in MA relative to TM.[42] Another study comparing Hispanic versus non-Hispanic White enrollees suggested the gaps in quality of care were smaller in MA than in TM for all outcomes.[43] It is worth acknowledging that while some research suggests that TM fares worse for some minority demographics, there is still a significant observable difference in quality and accessibility of care compared between people of color and White enrollees within TM.[44]

35 Alignment Healthcare, Alignment Healthcare Caters to Growing Hispanic Senior Community with Launch of the One, a $0 Premium Medicare Advantage Plan, for 2022. October 6, 2021.
36 Fierce Healthcare, New UnitedHealthcare "Medicare Explicado" DVD Educates Hispanics About Medicare and Medicaid Benefit Options. November 16, 2011.
37 Caitlin Owens, Major Shift: Health Insurers Are Suddenly Coveting Sicker Patients. February 14, 2024.
38 Gangopadhyaya A, Zuckerman S, Rao N, Assessing the Difference in Racial and Ethnic Disparities in Access to and Use of Care Between Traditional Medicare and Medicare Advantage. March 9, 2023.
39 Paul N. Van de Water, Growth in Medicare Advantage Raises Concerns. January 10, 2025.
40 Weech-Maldonado R, Elliott MN, Adams JL, Haviland AM, Klein DJ, Hambarsoomian K, Edwards C, Dembosky JW, Gaillot S, Do Racial/Ethnic Disparities in Quality and Patient Experience Within Medicare Plans Generalize Across Measures and Racial/Ethnic Groups? March 11, 2015.
41 RAND Health Care, Racial, Ethnic, & Gender Disparities in Health Care in Medicare Advantage. April 2021.
42 Hames AG, Tipirneni R, Switzer GE, Ayanian JZ, Kullgren JT, Racial/Ethnic Disparities in Cost-Related Barriers to Care Among Near-Poor Beneficiaries in Medicare Advantage vs Traditional Medicare. October 23, 2024.
43 Jeah Jung, Hansoo Ko, Roger Feldman, Caroline S. Carlin, and Ge Song, Gaps in Quality of Care Not Consistent Between Traditional Medicare, Medicare Advantage for Racial and Ethnic Groups. March 2024.
44 Kenton J. Johnston et al. Association of race and ethnicity and Medicare program type with ambulatory care access and quality measures. JAMA Network. 2021;326;(7):628-636. doi:10.1001/jama.2021.10413

Chart 2: Characteristics of MA plans by race (2016 data)[45]



The inequities run deeper when we examine quality outcomes. Historically, Black enrollees in Medicare managed care plans have consistently received lower-quality care than their White counterparts. A 2002 study of HEDIS performance data found that Black enrollees had significantly lower rates of preventive screenings, follow-up care, and essential treatments, even after adjusting for confounders.[46] Although an older study, its conclusions establish a trend that has continued for decades. A 2024 study demonstrated that nearly one in ten MA enrollees report experiencing unfair treatment in healthcare settings, with the highest prevalence among those with disabilities, lower incomes, and racial and ethnic minorities.[47]

Additional research shows that, on a national level, Black MA enrollees continue to experience significant disparities in managing blood pressure, cholesterol, and glucose, with little to no improvement over time.[48] Similarly, MA plans serving socioeconomically disadvantaged populations tend to perform worse on key health measures (blood pressure, diabetes, and cholesterol control) compared to those serving wealthier populations.[49]

These disparities are also evident in hospital outcomes. Black MA enrollees experience higher rates of readmission compared to their White peers. In New York State, Black MA enrollees were 64% more likely than White enrollees to be readmitted to a hospital within 30 days after surgery,

45 Sungchul Park et al. Association of Medicare Advantage star ratings with racial and ethnic disparities in hospitalizations for ambulatory care sensitive conditions. Med Care 2022 Dec 1;60(12):872-879. doi: 10.1097/MLR.0000000000001770. Epub 2022 Nov 10.

46 Sungchul Park, Rachel M. Werner, and Norma B. Coe, Racial and Ethnic Disparities in Access to and Enrollment in High-Quality Medicare Advantage Plans. March 27, 2022.

47 Megan Mathews, Megan K. Beckett, Steven C. Martino, Julie A. Brown, Nate Orr, Sarah Gaillot, and Marc N. Elliott, Medicare Advantage Enrollees' Reports of Unfair Treatment During Health Care Encounters. May 29, 2024.

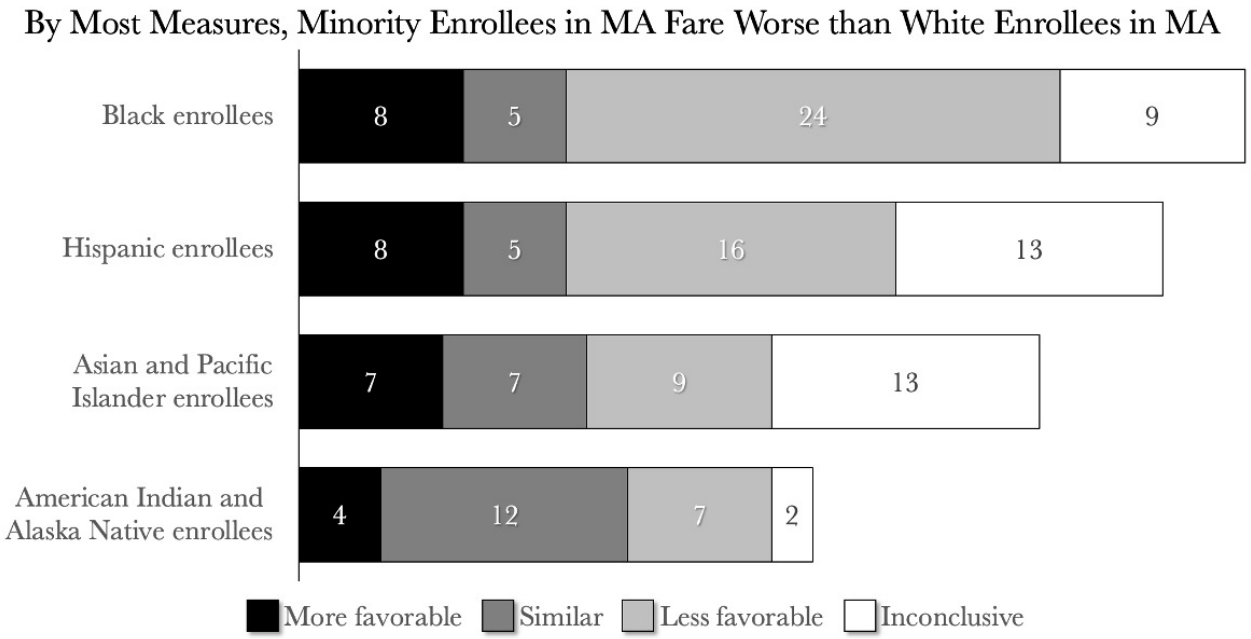
48 Ayanian JZ, Landon BE, Newhouse JP, and Zaslavsky AM, Racial and Ethnic Disparities Among Enrollees in Medicare Advantage Plans. December 11, 2014.

49 Fierce Healthcare, New UnitedHealthcare "Medicare Explicado" DVD Educates Hispanics About Medicare and Medicaid Benefit Options. November 16, 2011.

compared to a 33% disparity among TM enrollees.[50] These findings indicate that risk-reduction strategies adopted by MA plans have failed to equitably reduce readmissions, potentially stemming from inadequate post-discharge care coordination and network restrictions that disproportionately affect Black patients.

We do not suggest that MA plans should be completely responsible for fixing the deep-rooted issues causing health inequity. However, we document that their claims to address these issues are not supported by the overwhelming evidence indicating that MA plans often preserve, and in some cases worsen, these problems.

Chart 3: A review of MA outcomes data in minority enrollees vs White enrollees[51]



50 Yue Li, Xi Cen, Xueya Cai, Caroline P. Thirukumaran, Jie Zhou, and Laurent G. Glance, Medicare Advantage Associated With More Racial Disparity Than Traditional Medicare For Hospital Readmissions. July 2017.
51 Nancy Ochieng, Jeannie Fuglesten Biniek, Juliette Cubanski, and Tricia Neuman, Disparities in Health Measures By Race and Ethnicity Among Beneficiaries in Medicare Advantage: A Review of the Literature. December 13, 2023.

Link Between MA Prior Authorization, Physician Shortages, and Inequity

Compounding these inequities are barriers created by prior authorization (PA). While insurers argue that PA ensures appropriate use of resources, abundant evidence shows that prior authorization frequently delays or denies necessary care, especially costly care for older adults with chronic or complex conditions.

A 2022 Office of Inspector General (OIG) report found that 13% of prior authorization denials[52] in MA would have been approved under TM, demonstrating that insurers routinely deny MA patients care they would otherwise have received in the public program. The same report found that 18% of payment denials for services already provided also would have been covered under TM. The scope of this problem has drawn congressional scrutiny. A 2024 KFF analysis revealed that 99% of MA enrollees[53] are in plans requiring prior authorization for at least one service. The most frequently affected areas include high-value services such as advanced imaging, durable medical equipment, and post-acute care, with some plans even requiring PA for chemotherapy and skilled nursing facility admissions – critical services where delays can have life-altering consequences.

> The inequities are tangible: one study found that prior authorization requests from White enrollees were denied about 15% of the time, while Black enrollees faced denials 23% of the time.[54]

This limitation on access to care is further compounded by the shortage of clinicians, projected to grow to 86,000 physicians by 2036.[55] At the same time, more than 77.2 million people live in primary-care Health Professional Shortage Areas (HPSAs).[56] These shortages are not evenly distributed; majority-Black communities are more likely to face inadequate primary-care supply.[57]

One of the primary causes of this shortage is physician burnout, which results in early retirements and reductions in clinical hours. Nearly one in three physicians have expressed an intention to leave practice within two years, citing burnout as a primary reason.[58] Burnout is driven by excessive administrative burden, and prior authorization consistently ranks among the top contributors. In 2024, 89% of physicians reported prior authorization increases burnout.[59]

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52 Office of Inspector General, Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care. April 2022.
53 Meredith Freed, Jeannie Fuglesten Biniek, Anthony Damico, and Tricia Neuman, Medicare Advantage in 2024: Premiums, Out-of-Pocket Limits, Supplemental Benefits, and Prior Authorization. August 8, 2024.
54 Boris Vabson, Andrew L. Hicks, and Michael E. Chernew, Medicare Advantage Denies 17 Percent of Initial Claims; Most Denials Are Reversed, But Provider Payouts Dip 7 Percent. June 2025.
55 AAMC, The Complexities of Physician Supply and Demand: Projections From 2021 to 2036. March 2024.
56 Bureau of Health Workforce, Health Resources and Services Administration, U.S. Department of Health & Human Services, Second Quarter of Fiscal Year 2025: Designated HPSA Quarterly Summary. 2025.
57 Darrell J. Gaskin, Gniesha Y. Dinwiddie, Kitty S. Chan, and Rachael R. McCleary, Residential Segregation and the Availability of Primary Care Physicians. April 2012.
58 Jennifer A. Ligibel, Nicolette Goularte, Jennifer I. Berliner, Steven B. Bird, Chantal M. L. R. Brazeau, Susannah G. Rowe, Miriam T. Stewart, and Mickey T. Trockel, Well-Being Parameters and Intention to Leave Current Institution Among Academic Physicians. December 15, 2023.
59 American Medical Association, 2024 AMA Prior Authorization Physician Survey. 2024.

Because nearly all MA enrollees are in plans that rely on prior authorization, increased diversity in MA could magnify these pressures among people of color. Unlike TM, where prior authorization is uncommon, insurers' heavy reliance on utilization management tools in MA increases clinician workload and frustration, accelerating burnout and workforce attrition. This leads to fewer practicing physicians and longer patient wait time. These negative effects are most severe in minority communities, where enrollment in MA is higher and where many live in areas already known to be shortage zones.

Link Between Quality Incentives and Equity

The Quality Bonus Program (QBP) is the Centers for Medicare and Medicaid Services' (CMS) system of awarding bonus payments to MA plans.[60] On the surface, the QBP seems a straightforward way to measure and reward higher quality MA plan performance.

Even as imperfect as they are, the star ratings are clinically meaningful for patients. They measure plan performance on cancer screening, hospital readmissions, emergency room aftercare, diabetes, hypertension, heart disease, osteoporosis, and chronic pain. They include measurements of customer service, care coordination, member turnover, timeliness of PA appeals, etc.

The star ratings also have significant financial implications for MA plans. The MA payment structure includes a "rebate" that allows plans to retain a variable portion of the difference between the CMS cost benchmark and the plan's submitted bid to CMS. As star ratings increase, plans can keep a larger share, increasing from 50% up to 75%[61] of the bid-benchmark gap. CMS also provides an additional bonus of 5% of capitated payments to MA plans that achieve at least 4.0 stars. This bonus can increase to 10%, known as a "double bonus"[62] for insurers operating in certain large metropolitan areas within counties characterized by both below-average per-person TM spending and high MA adoption. However, restricting double-bonus eligibility to counties with below-average TM spending tends to funnel resources into healthier, wealthier communities. Since Black enrollees are 35% less likely than White enrollees to reside in counties that qualify,[63] these double bonuses disproportionately benefit communities with larger White populations, thereby exacerbating racial inequities.

Plans often use these extra funds to enhance supplemental benefits or reduce out-of- pocket costs -- desirable enhancements especially in underserved areas. The current system thus shifts resources away from the neediest communities, with potential negative impacts on equity. The availability of particular MA plans varies geographically. In addition, the CMS quality bonus payment system more frequently benefits Whiter, wealthier communities as compared to poorer communities and communities of color.

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60 Laura Skopec, Robert Berenson. The Medicare Advantage Quality Bonus Program: High cost for uncertain gain. Urban Institute Health Policy Center. June 2023.
61 Christina Ramsay & Gretchen Jacobson. How the Government Updates Payment Rates for Medicare Advantage Plans. March 4, 2024.
62 Jeannie Fuglesten Biniek, Anthony Damico, & Tricia Neuman. Medicare Advantage Quality Bonus Payments Will Total at Least $12.7 Billion in 2025. June 12, 2025.
63 Adam A. Markovitz, John Z. Ayanian, Anupama Warrier, and Andrew M. Ryan, Medicare Advantage Plan Double Bonuses Drive Racial Disparity in Payments, Yield No Quality or Enrollment Improvements. September 2021.

> "If MA plans of equally high quality served Wayne and Lapeer residents [two Detroit-area counties], the one serving more Black enrollees would receive only half as many quality bonus dollars."[64]

Studies indicate that Black, Asian, and Hispanic enrollees in MA are less likely to be enrolled in higher-quality plans and more likely to be enrolled in low-quality plans as compared to White enrollees. 53% of Black, 42.2% of Asian, and 59.9% of Hispanic enrollees were in plans rated 4 stars or above, compared with 69.8% of White enrollees.[65] Conversely, 34.9% of Black, 36.8% of Asian, and 27.7% of Hispanic enrollees were in plans rated 3.5 stars or below, compared with just 22.4% of White enrollees.[66] This is significant because enrollment in lower-quality plans means that minority enrollees are systematically denied the higher standards of care and benefits that White enrollees more often receive.

A 2022 CMS report found that racial and ethnic disparities persist across numerous clinical quality measures.[67] Further research demonstrates inequities in quality of care between enrollees of color versus White enrollees regarding behavioral health care,[68] emergency department use,[69] outcomes in preventive care, hospitalizations, mental health treatment, and access to highly rated plans.[70]

These disparities in MA plan characteristics do not result from poor consumer choices but instead reflect geographic differences in plan availability. Counties with higher unmet social needs were found to have a lower likelihood to access of high-quality plans, with vulnerable markets averaging 1.1 fewer 4-star or higher plans than less disadvantaged areas.[71] While Black, Hispanic, and Asian enrollees have lower enrollment in higher quality plans than White enrollees, these differences shrink dramatically once county- level plan offerings are taken into account. For example, the gap for Black enrollees decreases from −9.1 to −0.5 percentage points, for Asian/Pacific Islander enrollees from −15.9 to −5.0, and for Hispanic enrollees from −12.7 to 0.6.

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64 David Meyers et al. Growth in Medicare Advantage greatest among Black and Hispanic enrollees. Health Aff (Millwood). 2021 Jun;40(6):945-950. doi:10.1377/hlthaff.2021.00118.
65 Ibid
66 David J. Meyers, Emmanuelle Belanger, Nina Joyce, John McHugh, Momotazur Rahman, and Vincent Mor, Analysis of Drivers of Disenrollment and Plan Switching Among Medicare Advantage Beneficiaries. February 25, 2019.
67 CMS, Disparities in Health Care in Medicare Advantage by Race and Ethnicity. April 2022.
68 Joshua Breslau, Marc N. Elliott, Amelia M. Haviland, David J. Klein, Jacob W. Dembosky, John L. Adams, Sarah J. Gaillot, Marcela Horvitz-Lennon, and Eric C. Schneider, Racial And Ethnic Differences In The Attainment Of Behavioral Health Quality Measures In Medicare Advantage Plans. October 2018.
69 Jeah Jung et al. Gaps in quality of care not consistent between Traditional Medicare, Medicare Advantage for racial and ethnic groups. Health Affairs Vol 43 No 3. March 4, 2024. https://doi.org/10.1377/hlthaff.2023.00428
70 Nancy Ochieng et al. Racial and ethnic health inequities and Medicare. KFF. February 2021.
71 Hansoo Ko, Ghaida Alsadah, and Gilbert Gimm. Association of Social Vulnerability and Access to Higher Quality Medicare Advantage Plans. June 2025.

When focusing specifically on counties that offer a 5-star plan, Black enrollees are more likely than White enrollees to choose the higher-rated option by 3.2 percentage points.[72] Therefore, when *offered* higher quality plans, Black enrollees are *more* likely to choose plans with higher ratings. Rather than choosing poorly, Black MA enrollees are limited to the inferior choices that are available in their communities.

MA plans operate under a managed care model that limits enrollees to a specific network of providers, often excluding high-quality hospitals and specialists. This is particularly stark in MA plans with closed-network HMO models, but even when MA plans built as PPO models allow for non-network care, the higher coinsurance requirements still place an unequal burden.[73,74]

> Unlike TM, which offers broad access to physicians and hospitals, MA plans often restrict enrollees to narrow provider networks.

There is growing evidence that racial concordance among patients of color and their physicians results in better health outcomes such as higher life expectancy, increased willingness to receive preventative care, and lower infant mortality rates. However, Black and Hispanic physicians are underrepresented in MA networks. One study analyzing racial concordance found that 20% of Black and Hispanic enrollees had no available same-race physicians included in their MA network. Additionally, only 43.2% of Black physicians and 44% of Hispanic physicians were included in a given enrollee's county as compared to 51.1% of White physicians.[75] This discrepancy limits access to culturally competent care, reinforcing barriers to preventive services and widening existing disparities.

Cost of Care and the "Gap Trap"

TM has no upper cap on out-of-pocket expenses, making supplemental coverage a crucial safeguard against financial risk. For those without Medicaid or retiree benefits from a union or former employer, Medigap coverage can be very expensive, especially for communities of color who face longstanding barriers to wealth accumulation. Consequently, Black enrollees in both MA and TM face greater cost-related obstacles to care compared to White enrollees.[76]

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72 Park S, Werner RM, Coe NB. Racial and ethnic disparities in access to and enrollment in high-quality Medicare Advantage plans. Health Serv Res. 2023 Apr;58(2):303-313. doi: 10.1111/1475-6773.13977. Epub 2022 Apr 9. PMID: 35342936; PMCID: PMC10012240.

73 Medicare, Preferred Provider Organizations (PPOs).

74 Medicare Options 360, Medicare HMO vs PPO.

75 David J. Meyers, Eunhae Grace Oh, Maricruz Rivera-Hernandez, Momotazur Rahman, and Amal N. Trivedi, Medicare Advantage Networks Include Few Black Or Hispanic Physicians, Making Concordant Care Inaccessible For Many. January 2025.

76 Gangopadhyaya A, Zuckerman S, Rao N. Assessing the difference in racial and ethnic disparities in access to and use of care between Traditional Medicare and Medicare Advantage. Health Serv Res. 2023 Aug;58(4):914-923. doi: 10.1111/1475-6773.14150. Epub 2023 Mar 25. PMID: 36894493; PMCID: PMC10315374.

59% of Black and 67% of Hispanic Medicare-eligible adults are enrolled in an MA plan.[77] This pattern is driven largely by financial necessity. 40% of Black and Hispanic Medicare enrollees are near-poor, with incomes between 101% and 250% of the federal poverty level (FPL). These individuals may not be eligible for Medicaid supplemental insurance[78,79,80] and often are unable to afford necessary care. MA's cap on out-of- pocket expenses and additional benefits leaves them with no affordable alternative.[81] This pattern, which we call the "**Gap Trap**," forces low-income older adults into MA.

While MA helps enrollees avoid the high cost of Medigap premiums, it provides weaker protection against actual healthcare expenses -- posing the greatest risk for those in fair or poor health, who most need comprehensive coverage. In TM, there is almost no difference between Black and White enrollees (25% and 27%) as to whether they are forced to delay or skip care due to cost. However, for comparably unwell people in MA, 35% of White and 50% of Black enrollees report cost-related problems accessing care.[82]

If MA plans were designed to promote equity, they would reduce cost-sharing and out-of- pocket limits for low-income enrollees. The high cost of Medigap coverage leaves many financially limited to MA plans, undermining true equitable access by limiting enrollees' ability to choose the coverage that best meets their needs.[83]

Link between MA, Hospital Closures, and Equity

Hospital closures are among the most severe and consequential results of MA insurers' denied and discounted payments to providers, and they disproportionately affect communities of color.[84] TM provides stability by reliably and quickly reimbursing a predictable amount at an established fee schedule, combined with rural protections like Critical Access,[85] Sole Community,[86] and Medicare Bad Debt Reimbursement.[87] These safeguards do not carry over to MA. In contrast, MA insurers pay hospitals at rates as much as 15 percent below TM level while also imposing higher rates of

77 Minority Health Institute, Inc., Medicare Advantage's Role in Improving Health Equity for Seniors of Color. March 2024.
78 Medicaid, Seniors & Medicare and Medicaid Enrollees.
79 Medicare, Medicare Savings Programs.
80 National Council on Aging, Medicare Savings Programs Eligibility and Coverage. May 14, 2025.
81 Hames, Alexandra G et al. Racial/ethnic disparities in cost-related barriers to care among near-poor beneficiaries in Medicare Advantage vs traditional Medicare. The American Journal of Managed Care vol. 30,10 e297-e304. 1 Oct. 2024, doi:10.37765/ajmc.2024.89622
82 Jeannie Fuglesten Biniek, Nancy Ochieng, Juliette Cubanski, and Tricia Neuman, Cost-Related Problems Are Less Common Among Beneficiaries in Traditional Medicare Than in Medicare Advantage, Mainly Due to Supplemental Coverage. June 25, 2021.
83 Nancy Ochieng, Juliette Cubanski, Tricia Neuman, Samantha Artiga, and Anthony Damico, Racial and Ethnic Health Inequities and Medicare. February 16, 2021.
84 Grace Niewijk, Rising Hospital Closures Disproportionately Affect Disadvantaged Communities. April 26, 2024.
85 CMS, Information for Critical Access Hospitals. August 2025.
86 MedPAC, Summary of Medicare's Special Payment Provisions for Rural Providers and Criteria for Qualification. June 2001.
87 Jason D. Buxbaum, Ari D. Ne'eman, and Cyrus M. Kosar, Eliminating Bad Debt Reimbursement to Hospitals Serving Traditional Medicare Beneficiaries. August 11, 2025.

denials, extensive prior authorization requirements, and leaving them without access to the rural protections described above.[88]

As enrollment in MA grows, these differences have a profound effect on hospital finances. Between 2018 and 2023, the share of rural hospitals with more MA inpatient days than TM nearly tripled, and more than half of rural counties now have MA penetration exceeding 50%.[89] In these markets, each additional percentage point of MA enrollment increases hospitals' exposure to lower reimbursement, delayed or denied claims, and uncompensated patient cost-sharing. The Center for Healthcare Quality and Payment Reform estimates that more than 700 rural hospitals are now at risk of closure, with underpayment by private plans, including MA, as the leading driver. In their words, "The primary reason hundreds of rural hospitals are at risk of closing is that private insurance plans are paying them less than what it costs to deliver services to patients…Congress should require that MA plans pay small rural hospitals adequately."[90]

> Closures in rural areas have especially stark consequences for Black, Hispanic, and Native American older adults, who are overrepresented in the counties at highest risk. Research consistently finds that rural closures disproportionately affect communities with higher concentrations of racial and ethnic minority residents, amplifying existing inequities in access to care.[91,92]

The pattern may also apply to urban communities. Because Black and Hispanic individuals are more likely to enroll in MA, urban hospitals that serve predominantly minority populations also obtain a larger portion of their revenue from MA plans. Like rural hospitals, they lose the stabilizing effect of predictable Medicare reimbursement and supplemental payments that are essential for their survival. This situation can be especially challenging for many safety-net and teaching hospitals, which are already under financial strain. Research shows that safety-net hospitals care for a disproportionate number of low-income and minority patients, provide higher levels of uncompensated care, and consistently operate on thinner margins than non-safety-net institutions.[93]

MA's reimbursement structure does not simply impose administrative burdens on hospitals; it undermines the financial stability of the institutions most critical to underserved populations. When hospitals close, the inequities are profound and enduring. Entire communities lose immediate access to care, travel distances and wait times increase, and health outcomes worsen. Because closures cluster in rural and urban communities of color, MA contributes to racial and geographic inequity in the most fundamental measure of access: whether a hospital stays open at all.

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88 Ibid

89 American Hospital Association, The Growing Impact of Medicare Advantage on Rural Hospitals Across America.

90 Center for Healthcare Quality and Payment Reform, Rural Hospitals at Risk of Closing. August 2025.

91 Tarun Ramesh and Emily Gee, Rural Hospital Closures Reduce Access. September 2019.

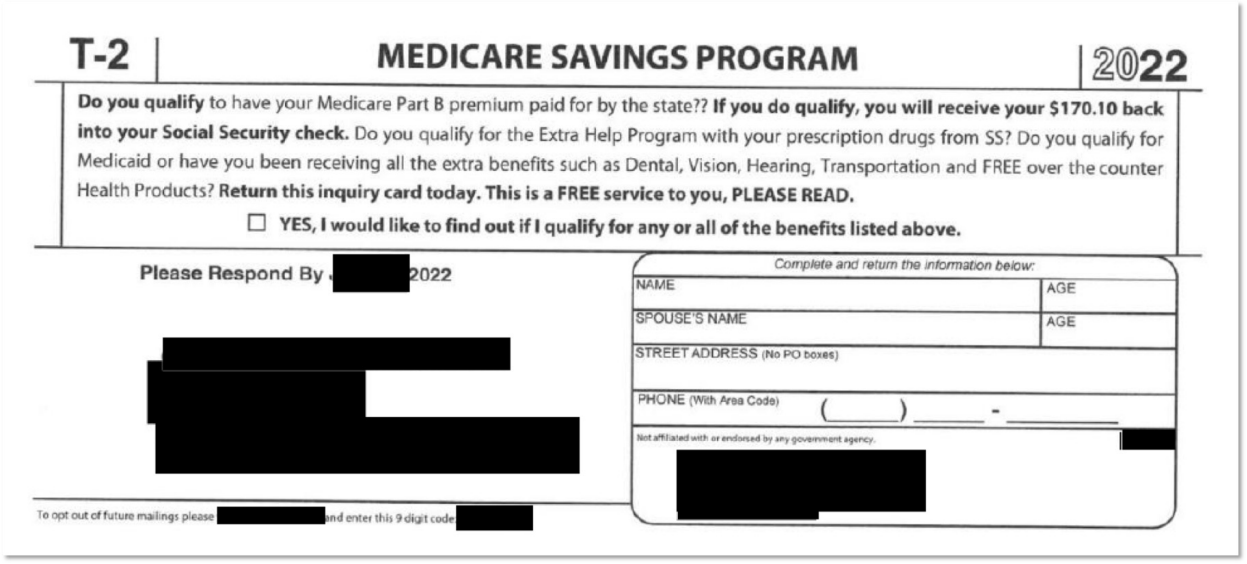
92 Tracey T. Stansberry, Patricia N. E. Roberson, and Carole R. Myers, U.S. Rural Hospital Care Quality. November 4, 2023.

93 Lukas K. Gaffney and Kenneth A. Michelson, Analysis of Hospital Operating Margins. April 3, 2023.

Misleading Marketing of MA

Deceptive Sales Tactics

A 2023 Senate Finance Committee report[94] documented how seniors are misled by sales tactics they described as "deceptive" or "overwhelming." For example, some agents assured seniors that their doctors were covered under new plans, only for them to later discover their physicians were out-of-network. Others received mailers designed to mimic official government correspondence, when in fact they were advertisements. Celebrity-driven television ads claimed seniors were missing out on benefits or even higher Social Security payments, pushing them toward call centers run by plan agents or brokers. Most troubling, there were reports of vulnerable seniors and people with disabilities having their plans switched without consent.



T-2 | MEDICARE SAVINGS PROGRAM | 2022

Do you qualify to have your Medicare Part B premium paid for by the state?? **If you do qualify, you will receive your $170.10 back into your Social Security check.** Do you qualify for the Extra Help Program with your prescription drugs from SS? Do you qualify for Medicaid or have you been receiving all the extra benefits such as Dental, Vision, Hearing, Transportation and FREE over the counter Health Products? **Return this inquiry card today. This is a FREE service to you, PLEASE READ.**

☐ **YES, I would like to find out if I qualify for any or all of the benefits listed above.**

Please Respond By [redacted] 2022

[redacted]

To opt out of future mailings please [redacted] and enter this 9 digit code [redacted]

Complete and return the information below:

NAME | AGE

SPOUSE'S NAME | AGE

STREET ADDRESS (No PO boxes)

PHONE (With Area Code) (_____) _____ - _____

Not affiliated with or endorsed by any government agency. [redacted]

[redacted]

Paper Benefits that Fail to Deliver

Deceptive marketing and a lack of affordable alternatives drive enrollment in MA. In 2022, insurers spent an estimated $6 billion[95] on advertising campaigns – many of them misleading[96] – aimed at attracting seniors with promises of extra benefits.

MA plans frequently advertise supplemental benefits not covered under TM, such as dental, vision, hearing aids, fitness programs, or pharmacy discounts, but these benefits are often limited, fragmented, or difficult to access. They also come with hidden costs like narrow provider networks

94 Majority Staff of the U.S. Senate Committee on Finance, Deceptive Marketing Practices Flourish in Medicare Advantage.
95 Brandon Novick. Medicare Advantage and deceptive marketing. Center for Economic and Policy Research. November 7, 2023.
96 Majority Staff of the U.S. Senate Committee on Finance, Deceptive Marketing Practices Flourish in Medicare Advantage.

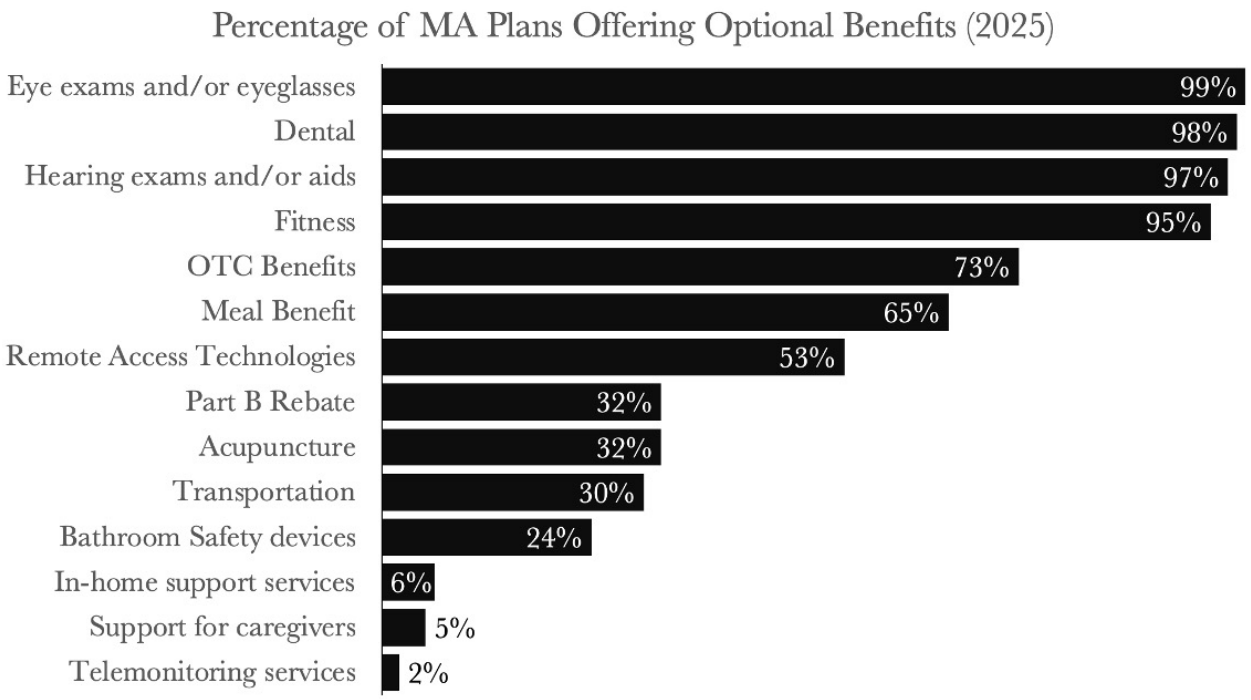
and restrictive prior authorization requirements. Without robust networks or transparent coverage details, these so-called "extras" can fail to deliver meaningful improvements in health and may not be functionally available at all. For example, one analysis of some of the more popular supplementary benefits identified that MA enrollees typically save an average of $20 on eyeglasses, $22 on durable medical equipment like hearing aids, and $23 per dental visit compared to those in TM.[97] These are national averages; by definition, some plans are more generous, others more restrictive. It is difficult for consumers to access enough information to inform personal decisions on this level of detail.

For example, dental benefits in MA often limit coverage to a network so limited that patients must pay entirely out of pocket unless they are able to travel prohibitively long distances. Such dental plans often limit coverage to an annual cap as low as $1,000 (well below the cost of more than the most basic dental procedures),[98] require a 50% coinsurance for anything beyond preventive care, and include exclusions or waiting periods for certain procedures.[99,100] Because wealthier enrollees are more able to pay out-of-pocket when such benefits fall short, MA's "paper benefits" widen health disparities.

Insurers can determine which supplemental benefits to include when designing an MA plan and more consistently include features that would attract healthier members (e.g., fitness club memberships). They are less likely to offer benefits which support people with serious health concerns, such as support for caregivers, in-home services, and bathroom safety devices.[101]

97 Christopher L Cai et al. Use and costs of supplemental benefits in Medicare Advantage, 2017-2021. JAMA Network Open. Vol 8 No 1. 2025;8;(1):e2454699. doi:10.1001/jamanetworkopen.2024.54699
98 Dental Depot, Affordable Dental Care: Costs, Insurance & Smart Savings.
99 Carly Plemons, Do Medicare Advantage Plans Cover Dental Services? July 25, 2024.
100 Luke Pisarcik, Medicare Advantage Dental Benefit Compare Tool 2024 Insights. November 27, 2023.
101 Meredith Freed, Jeannie Fuglesten Biniek, Anthony Damico, and Tricia Neuman, Medicare Advantage 2025 Spotlight: A First Look at Plan Premiums and Benefits. November 15, 2024.

Chart 4: Breakdown of Optional Benefits in MA Plans[102]



Confounded Industry Research

Much of the research promoted by the insurance industry to present MA as an equity solution is deeply flawed. The industry's trade association, AHIP, cites studies purporting improved outcomes for MA enrollees, yet these studies often rely on diagnostic coding data that has been artificially inflated through "upcoding." To boost capitation payments, MA insurers use aggressive strategies to capture more diagnostic codes than are typically recorded in TM. This practice not only generates billions in unjustified revenue for insurers, draining $40 billion[103] in taxpayer funds in a single year, but also skews risk profiles, making enrollees seem sicker on paper then they are. Research comparing outcomes for genuinely sicker populations against genuinely healthier, upcoded populations can lead to misleading conclusions.

A common tool used in such analyses is the Charlson Comorbidity Index (CCI), which predicts mortality risk based on diagnostic codes. While widely used in health research, the CCI and similar tools are particularly vulnerable to distortion[104] in the MA context, where diagnostic inflation is rampant. Because MA plans systematically capture more diagnoses than are recorded in TM, the CCI makes MA enrollees look far sicker than they are. This allows insurers to claim that their plans are managing more complex populations and producing better outcomes, when in fact the apparent gains are statistical artifacts. For example, an MA enrollee who receives more diagnostic codes during a health risk assessment will have a higher CCI score than a similar TM enrollee,

102 Nancy Ochieng et al. KFF. Medicare Advantage in 2025: Premiums, Out-of-Pocket Limits, Supplemental Benefits, and Prior Authorization. July 28, 2025.
103 MedPAC, The Medicare Advantage Program: Status Report, March 2025.
104 Moiz Bhai and Danny R. Hughes, Estimating Self-Selection in Medicare Advantage. April 2024.

even if their true health status is no different. The result is that studies using unadjusted diagnostic coding data systematically overstate the effectiveness of MA.

One example of confounded data generating uninterpretable conclusions was recognized in a study commissioned by industry's advocacy group Better Medicare Alliance (a 501(c)(4) advocacy coalition that promotes MA), which acknowledges that "...differences between MA and FFS and submission of data may introduce limitations. MA plans and FFS providers may differ in diagnostic coding patterns, which may hinder the accuracy of matching MA and FFS beneficiaries on clinical profiles. MA plans have an incentive to thoroughly identify beneficiary diagnoses, while FFS providers may not. Utilization metrics were chosen to mitigate the impact of these differences; however, differences in coding patterns could affect the matching procedure itself."[105]

A study by Kronick and Welch illustrates the magnitude of this problem: between 2004 and 2013, average MA risk scores rose sharply from 90% to 109% of FFS risk scores,[106] driven not by increases in morbidity but by inflated coding. Other peer-reviewed research documents risk score inflation ranging from 8% to over 20%[107] annually, with some insurers boosting scores by an additional 12.8%[108] through manipulated health risk assessments. Higher recorded illness levels make it appear that these plans are managing sicker populations more effectively, even when no real health gains have occurred.

CMS is continually trying to address this and is now on version 28 of their risk adjustment factor ("RAF") scoring methodology, with further iterations likely.[109] Regardless of any ultimate improvements in accuracy and predictability, decades of flawed data will remain a rich source for distorted and misleading research.

This confounds research that relies on unadjusted claims data and enables MA proponents to present inflated performance metrics as genuine improvements. In short, what appears to be higher quality care is often just the result of diagnostic inflation.

The consequences of all of this are stark: disenrollment rates spike among MA enrollees in their final year of life, when their need for care is greatest. Enrollees in their final year of life are more than twice as likely to leave MA plans and return to TM: 4.5–4.6% of those in their last year of life disenrolled, compared to just 1.7–2.0% of other enrollees.[110]

The very populations most drawn to these plans have the fewest real resources for essential care, reinforcing inequities rather than closing them.

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105 John Barkett, Ruth Tabak, and Caden Riley, Black, Hispanic, and Asian American/Pacific Islander MA Beneficiaries Receive More Primary Care and Less Potentially Avoidable Care Than Similar Beneficiaries in Traditional Medicare. April 2025.

106 Richard Kronick and W. Pete Welch, Measuring Coding Intensity in the Medicare Advantage Program. 2014.

107 Vilsa E. Curto, Eran Politzer, Timothy S. Anderson, John Z. Ayanian, Jeffrey Souza, Alan M. Zaslavsky, and Bruce E. Landon, Coding Intensity Variation in Medicare Advantage. January 2025.

108 Hannah O. James, Beth A. Dana, Momotazur Rahman, Daeho Kim, Amal N. Trivedi, Cyrus M. Kosar, and David J. Meyers, Medicare Advantage Health Risk Assessments Contribute Up To $12 Billion Per Year To Risk- Adjusted Payments. May 2024.

109 Michael Stearns, Melissa James, and Kimberly Rykaczewski, How CMS-HCC Version 28 Will Impact Risk Adjustment Factor (RAF) Scores. February 27, 2023.

110 United States Government Accountability Office, Beneficiary Disenrollments to Fee-for-Service in Last Year of Life Increase Medicare Spending. June 2021.

PNHP & Johns Hopkins Research

Quantitative Research

These inequities set the stage for our collaboration with researchers at Johns Hopkins University, where we sought to examine whether the structure of MA itself reinforces racial and ethnic disparities. Using 2023 Medicare Beneficiary Summary Files linked to MA/Part D Contract and Enrollment Data, as well as 2023 County Health Rankings, the Hopkins researchers conducted a cross-sectional study of 2,489 MA plans across all 50 states and the District of Columbia.[111] Analyses were carried out at the plan–race level with race-stratified linear probability models, allowing an assessment of how plan characteristics interact with county-level demographics such as racial composition, segregation, income, and provider supply.

The researchers identified plans as outliers when they enrolled a racial or ethnic group at least 10 percentage points above the local average, ranked among the top 5% for that group, and showed this pattern in more than one county. The industry refers to these outlier plans as "affinity plans". By these criteria, the Hopkins researchers identified 623 affinity plans (270 Black, 126 Hispanic, 78 Asian, and 149 White). Together, nearly one in four MA plans (23.7%) met the affinity criteria for at least one racial or ethnic group.[112]

The findings revealed striking disparities. Plans with highly concentrated Black enrollees had significantly lower star ratings than non-affinity plans serving Black enrollees (mean 3.86 vs. 4.04) and operated across more counties (mean 224.7 vs. 64.0). Hispanic- and Asian-concentrated plans followed a similar pattern, with lower quality ratings compared to non-affinity plans. In sharp contrast, White-concentrated plans had higher star ratings (mean 4.31 vs. 4.01).[113]

Taken together, the plans disproportionately serving Black, Hispanic, and Asian beneficiaries tend to be of lower quality and more restrictive, while plans disproportionately serving White beneficiaries tend to be of higher quality. Far from advancing equity, these patterns perpetuate disparities in access and outcomes.

The table below summarizes one of the major findings of the new research from Johns Hopkins.

111 Andrew Anderson, Ji Mun Li, Darrell J. Gaskin, and Michael K. Meiselbach, Racial and Ethnic Sorting in Medicare Advantage Plan Enrollment (Working paper, Johns Hopkins Bloomberg School of Public Health, 2025). Manuscript under review.
112 Ibid
113 Ibid

Table 5: Racial and Ethnic Sorting in Medicare Advantage Plan Enrollment[114]

	White-concentrated MA plans	Black-concentrated MA plans	Hispanic-concentrated MA plans	Asian-concentrated MA plans
Average CMS Quality Star Rating (out of 5 possible)	4.30	3.86	3.75	3.70

This methodology focused on the most pronounced cases of racial enrollment imbalances, likely just the tip of the iceberg, and may represent patterns that extend more broadly.

Qualitative Analysis

In addition to the quantitative analysis, we partnered with Johns Hopkins University researchers to conduct a qualitative study. The aim was to better understand how race and socioeconomic status shape the experiences of Black Medicare beneficiaries enrolled in MA. Our original design called for two in- person focus groups with Black enrollees aged 65–70: one in Baltimore City and one in Prince George's County. These sites were chosen intentionally to compare experiences across communities with different levels of wealth. Each group was to include ten participants, balanced by gender, with exclusions for dual eligibles and those with supplemental commercial coverage.

However, recruitment challenges forced us to modify this plan. Ultimately, we were able to conduct one in-person focus group in Prince George's County, but with only four participants. The Baltimore City focus group could not be completed as designed and was replaced with phone interviews. To ensure sufficient participation, the eligibility criteria were broadened to include beneficiaries in both MA and TM, as well as dual eligibles and those with supplemental insurance. We also expanded the geographic scope to allow Black Medicare beneficiaries from anywhere in Maryland or Washington, D.C. to participate. Four phone interviews have been completed under these expanded criteria.

Despite these limitations, common themes emerged across the Prince George's County focus group and the phone interviews. Many participants expressed uncertainty about their plan type, as well as confusion and concern that their coverage did not extend to all the services they needed. Our limited findings emphasize the importance of further qualitative research–particularly studies that explicitly examine how socioeconomic status influences the experiences of people of color in MA plans.

"Why isn't [Medicare accepted] across the board? Why is it just got to be in certain areas?" - *Participant 1*

"You ain't got no choice. You can't go to wherever you want to go." - *Participant 3*

114 Ibid

Solutions

If Medicare is to truly serve as a tool for equity, the system must deliver equitable results, not just misleading research and marketing. As the insurance industry's advocacy organization AHIP states, "Everyone deserves affordable high-quality health coverage and care regardless of the individual qualities that make us who we are, like our race, gender, disability, or health status."[115] Our findings highlight that urgent reforms are necessary to ensure fair treatment for all enrollees.

Expose the truth about equity

The first step is honesty. Policymakers, providers, and the public must recognize that high enrollment of people of color in MA is not evidence of equity but of a lack of affordable alternatives. Transparency in data, marketing practices, and plan quality is essential to dismantle misleading narratives.

Return to Medicare's original promise of equitable, universal access to care

Reforms must eliminate geographic variations in plan offerings that enroll people of color into lower-quality plans with narrower networks. Ensure that comparably high quality options are available in every community.

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

TM must be strengthened by establishing a low limit on out-of-pocket expenses. This would remove the pressure that forces low-income enrollees – disproportionately Black and Hispanic – into MA plans with restrictive networks and inferior care. In 2024, the average MA plan included an out-of-pocket maximum of $4,882 for in-network services and $8,707 for both in-network and out-of-network care in PPOs.[116] By one actuarial estimate, a $5,000 maximum in TM would cost CMS $39 billion per year[117] – less than half of MedPAC's estimate of $84 billion in annual overpayments for MA enrollees in 2025.[118] Other estimates suggest the overpayments in MA may be as high as $140 billion, more than three times as high as the estimate for parity in out-of-pocket payments.[119]

Although we would prefer a far lower out-of-pocket maximum in TM, even one set at $5,000 would make TM more competitive with MA while also reducing overall spending in health care. Premiums for Medigap supplemental policies become less expensive as those insurers would not be liable for expenses above the $5,000 maximum, which would help mitigate the Gap Trap.

115 AHIP. Health Equity.
116 Meredith Freed et al. Medicare Advantage in 2024: Enrollment Update and Key Trends. KFF. August 8, 2024.
117 Physicians for a National Health Program. Our Payments, Their Profits: Quantifying Overpayments in the Medicare Advantage Program. October 4, 2023.
118 MedPAC, Medicare Payment Policy. March 2025.
119 Physicians for a National Health Program. Our Payments, Their Profits: Quantifying Overpayments in the Medicare Advantage Program. October 4, 2023.

Match the actuarial value of MA benefits in TM

The actuarial value of benefits offered in MA should be matched in TM. By providing the same level of coverage and supplemental benefits in the public program, we can eliminate the unfair choice that pushes marginalized populations into MA and ensure that all beneficiaries–regardless of race, ethnicity, or income–have the same access to comprehensive, equitable care.

The resources required to address both the "Gap Trap" and the TM benefit shortfalls could come from redeploying the overpayments to MA

MedPAC estimates annual overpayments for MA enrollees in 2025 amounted to $84 billion.[120] Other estimates suggest the overpayments in MA may be as high as $140 billion.[121]

According to a 2023 actuarial analysis,[122] closing the Gap Trap by creating a $5,000 out-of-pocket maximum in TM (a close match to the most common market offerings of MA) would cost CMS roughly $39 billion per year. Adding audiology and optometry benefits to TM at a comparable actuarial value of those programs in MA would cost CMS $21 billion. Even MedPAC's conservative estimate of $84 billion is more than adequate to begin to level the playing field between TM and MA and end the "Gap Trap."

Explore new models for determining how much MA plans are paid

Today's risk-adjustment model is failing. Under the current MA risk-adjustment model, Hierarchical Condition Categories (HCCs), the more severe diagnoses a plan documents, the higher their risk score, and therefore the higher the federal payment the plan receives. In turn, this creates strong incentives for insurers to upcode. Researchers have found that a variety of alternative approaches, for example incorporating additional data sources with HCCs, were more predictive of true health outcomes (mortality, hospitalizations, drug use), reduced both under-compensation and over-compensation of MA plans, and redistributed payments toward underserved populations, including enrollees with disabilities and more Black enrollees.[123]

Approaches like these and others[124,125] merit further exploration to reduce incentives for upcoding, promote equity, ensure that payments are aligned with actual care needs, and establish a more accurate basis for future research.

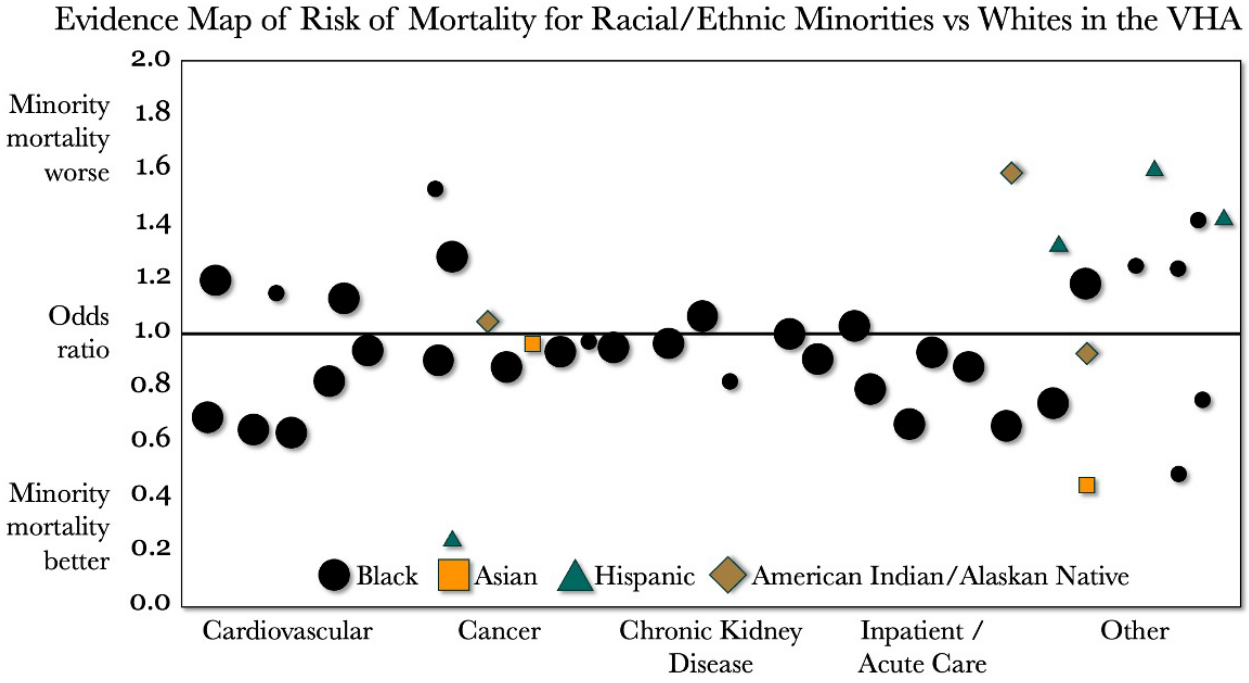
120 MedPAC, Medicare Payment Policy. March 2025.
121 Physicians for a National Health Program. Our Payments, Their Profits: Quantifying Overpayments in the Medicare Advantage Program. October 4, 2023.
122 Ibid
123 J. Michael McWilliams et al. Use of patient health survey data for risk adjustment to limit distortionary coding incentives in Medicare. Health Affairs Jan 2025. https://doi.org/10.1377/hlthaff.2023.01351
124 Ibid
125 Ibid

Learn from models that already deliver equity

A 2009 review found that most studies show that Black Americans with chronic kidney disease on dialysis survive longer than matched White Americans,[126] an outcome thought to be due to universal coverage of dialysis patients by the same insurance, largely TM.[127]

A similar pattern has been identified in another large equal-access public program: The Veterans Health Administration. A literature review of racial disparities in the VHA concluded that "Most studies compared mortality between Black and White veterans and found similar or lower mortality for Black veterans… Although there is a lot of research on Black veterans, more research is needed for other racial/ethnic minority groups, including American Indian and Alaska Native, Asian, and Hispanic veterans."[128]

Chart 6: Evidence Map of Risk of Mortality for Racial/Ethnic Minorities vs Whites in the Veterans Health Administration[129]



- *Marker size indicates strength of evidence*
- *Each marker is a different diagnostic category*
- *More details are available at the citation*

126 Keith Norris, Rajnish Mehrotra, and Allen R. Nissenson, Racial Differences in Mortality and End-Stage Renal Disease. August 1, 2009.
127 Eunhae Grace Oh, Joan F. Brazier, Emily A. Gadbois, Denise A. Tyler, Laura M. Keohane, David J. Meyers, Momotazur Rahman, Kevin H. Nguyen, and Amal N. Trivedi, Dialysis Facility Participation In Medicare Advantage Networks Was Highest For Large Dialysis Organizations In 2021. March 2025.
128 Kim Peterson, Johanna Anderson, Erin Boundy, Lauren Ferguson, Ellen McCleery, and Kallie Waldrip, Mortality Disparities in Racial/Ethnic Minority Groups in the Veterans Health Administration: An Evidence Review and Map. March 2018.
129 Ibid

Conclusions

Despite industry claims to the contrary, racial and ethnic health disparities in the United States are not being reduced by Medicare Advantage. The existing literature and our new research in collaboration with Johns Hopkins University collectively demonstrate that racial minority enrollees in MA suffer from worse clinical outcomes and face barriers accessing best quality care. These disparities stem from factors such as restrictive networks and misaligned financial incentives that fundamentally oppose public health priorities. While MA insurers continue to falsely portray themselves as champions of health equity, their dependence on deceptive data and misleading marketing contradicts this claim. As policymakers consider reforms to Medicare, it is critical to adopt rigorous equity analyses and to endorse policy solutions that prioritize patient well-being.

Limitations & Next Steps

A limitation of our study is that some of the evidence we cited on inequity among racial and ethnic groups within MA was inconsistent. Overall, research suggests that people of color in MA fare worse than White enrollees, but some analyses reported that MA showed no observable difference and occasionally modest advantages for other minority groups compared to White enrollees. Additionally, some cited literature holds that MA had the same, or in some cases, better health outcomes for enrollees of minority groups as compared to TM. This variation highlights the need for a more comprehensive and systematic analysis to definitively understand how MA affects different racial and ethnic communities across a wide range of measures.

While existing evidence strongly suggests that MA worsens inequities, significant literature gaps remain:

- More research is needed on the long-term health outcomes of minority enrollees in MA compared to those in TM, particularly regarding the effects of restrictive networks and utilization management tools.
- Little research has examined the long-term financial burden of MA on minority enrollees, including how prior authorization delays, denials, and high out-of-pocket costs shape financial stability.
- Research has heavily focused on differences between Black and White enrollees within MA plans, but there is limited comparative work on how Black enrollees fare in MA versus TM.
- Our quantitative research with Johns Hopkins University demonstrated disproportionate enrollment patterns; however, there is little analysis on the reasons behind these patterns. More study is needed.
- Socioeconomic status as an independent factor influencing experiences in MA versus TM has not been thoroughly examined, especially among people of color.

Addressing these gaps is essential for understanding how Medicare policy can either perpetuate or reduce racial inequities–and for ensuring that future reforms are based on evidence.

Appendix

The Roots of Today's Health Disparities

This report was produced in direct response to the misleading guidance being circulated by insurers, policymakers, and lobbyists that MA improves care for communities of color. We believe that a comprehensive understanding of racial and ethnic health inequities requires knowing the history of how health care has treated marginalized communities.

Colonial Era to 1865: Health Care as Property Protection: From the founding of this country through the end of the Civil War, health care for Black Americans was never about healing; it was about profit. Enslaved people received only the most rudimentary care necessary to maintain their economic value to White slaveowners. Physicians during this period were often called upon not to save lives and reduce suffering, but to restore labor productivity. Medical experiments on enslaved people were common and brutal, frequently performed without consent or analgesia, and based on the racist belief that Black bodies did not feel pain in the same way as White bodies.[130] This approach to health established the foundation for a system that regarded Black life in economic, rather than humane or moral terms. When slavery ended, the fragile safety net that had been solely designed to safeguard capital, vanished. Freed Black Americans were left with little to no access to healthcare and were predominantly excluded from the burgeoning systems of hospitals and medical institutions. This transition from coerced care to deliberate neglect did not mark the end of racist medical violations; they merely transitioned into different forms.

1900–1930s: Codifying Segregation: The early 20th century marked a turning point in how the American medical system was formalized–and how its foundations were intertwined with discriminatory values. In 1910, the Flexner Report, commissioned by the Carnegie Foundation and authored by Abraham Flexner, purported to standardize medical education in the U.S. and Canada. While reforming medical education by standardizing it around a science-based model, it was founded on racist and sexist biases that caused lasting damage to diversity in the medical field. The report recommended closing many schools that failed to meet the new standards, disproportionately affecting institutions that trained Black Americans and women. In 2020, the Association of American Medical Colleges (AAMC) officially renamed its prestigious Abraham Flexner Award, citing Flexner's "racist and sexist views, pejorative language, and unsubstantiated statements" as reasons for the change. Of the seven Black medical schools operating at the time, only two– Howard and Meharry–remained open after Flexner's recommendations. Flexner suggested that Black physicians were inferior to White physicians in ability and intellect. He argued that Black doctors should be trained as "sanitarians" rather than fully-trained physicians or surgeons, and should focus on preventing infectious diseases in the Black community to prevent the spread of diseases to

130 Kyere E., Enslaved People's Health Was Ignored from the Country's Beginning, Laying the Groundwork for Today's Health Disparities. July 30, 2020.

White Americans.[131,132] Ultimately, the Flexner report advanced the agenda of White, male physicians, severely limiting the Black medical workforce.

Health care access was also shaped by geography. Redlining, a policy created in the 1930s by the Home Owners' Loan Corporation (HOLC), denied loans and investment to neighborhoods deemed "high risk", which almost always meant Black communities. Redlining didn't just limit economic mobility; it had profound health consequences, with those in redlined areas having a higher incidence of health issues.[133] Racial inequities were literally built into the physical and institutional landscape of American cities.

1932–1972: The U.S. Government's Betrayal at Tuskegee: The Tuskegee Study of Untreated Syphilis, conducted by the U.S. Public Health Service, is one of the most glaring examples of medical racism in American history. From 1932-1972, researchers in Macon County, Alabama, enrolled 600 Black men, mostly impoverished sharecroppers – 399 of whom had syphilis – into a study under the false promise of free medical care. What the men were not told was that they would not be treated, even after penicillin became widely available in the 1940s.[134] For four decades the U.S. government allowed these individuals to endure suffering and death, solely for the purpose of studying the natural progression of the disease. In a moment of chilling cruelty, Public Health Service physician Dr. Thomas W. Murrell reflected on the study by writing, "Perhaps here, in conjunction with tuberculosis, will be the end of the negro problem. Disease will accomplish what man cannot."[135] Tuskegee was not an outlier. It reflected the deep-rooted belief that Black lives were expendable – and that Black suffering was acceptable if it served White institutions. That belief continues to echo in today's healthcare structures.

The Rise of Segregated and Fragmented Care: As American health infrastructure grew in the 20th century, it did so along explicitly racial lines. Black Americans were systematically excluded from the benefits of New Deal programs such as Social Security, which initially denied coverage to agricultural and domestic workers – jobs held predominantly by Black Americans.[136] When employer-based health insurance took hold in the 1940s and 1950s, it favored unionized and white-collar jobs, locking many Black workers out of coverage entirely.

Even those with insurance were often denied access to White hospitals and clinics. The 1946 Hill-Burton Act, which funded hospital construction across the country, allowed facilities to remain segregated under the guise of "separate but equal."[137] By 1959, 30% of Southern hospitals refused Black patients entirely and 50% maintained segregated wards.[138] It took the organizing and resistance of thousands – not just legislation – to force compliance with civil rights law.

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131 Wright-Mendoza J., The 1910 Report That Disadvantaged Minority Doctors. May 3, 2019.
132 Savitt, Todd, Abraham Flexner and the Black Medical Schools. 1992. September 2006.
133 Ramsay C., Pinnell P., Rees L., Simpson H., Unequal Treatment: The Stark Reality of Healthcare Inequality in the UK. March 24, 2023.
134 Centers for Disease Control and Prevention, About the Untreated Syphilis Study at Tuskegee. September 4, 2024.
135 Washington, HA, Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present. 2006.
136 Interlandi, J., Why Doesn't the United States Have Universal Health Care? The Answer Has Everything to Do With Race. August 14, 2019.
137 Largent, E. A., Public Health, Racism, and the Lasting Impact of Hospital Segregation. 2018.
138 P. Preston Reynolds. The Federal Government's Use of Title VI and Medicare to Racially Integrate Hospitals in the United States, 1963 Through 1967. Am Jnl of Public Health. Vol 87 No 11. Pgs 1850-1858, November 1997.

In 1965, when Medicare and Medicaid were introduced, they were designed to preserve this fragmentation.[139] Medicare Part A, funded through payroll taxes, provided hospital care to all seniors. Although the Civil Rights Act barred federal funding of programs that discriminated by race, Congress did not allocate the proper resources to enforce the act.[140]

Medicare Part B (covering outpatient services) was made optional and based on premiums which inherently discriminates against lower-income communities and allows segregation in physician offices to persist.

Medicaid, created under the pretext of "states' rights," grants states broad authority to restrict eligibility, disproportionately excluding Black Americans. Even in states with fewer restrictions, Medicaid has been chronically underfunded, weakening its capacity to address inequities.

Instead of closing racial gaps in care, this fragmented system has only deepened them.

The Modern Machinery of Racial Harm: Although MA is promoted as offering increased choice and affordability, it has instead created a two-tiered system of care where individuals with limited resources and complex health conditions often only have access to the lowest- quality MA plans. Currently, MA plans serving a higher proportion of Black enrollees are more likely to receive lower ratings, restrict provider networks, and deny care more frequently.

The consequences of this disparity became painfully clear during the COVID-19 pandemic. Data show that Black Americans experienced a staggering threefold increase in premature years of life lost compared to White Americans.[141] These negative outcomes were not solely due to comorbidities or lifestyle factors – they were the direct result of unequal access to care, employment conditions that increased exposure, and a fragmented, privatized system that failed to respond fairly during the crisis.

Equity Deferred: The promise of equity remains unfulfilled. A 2024 report from the Kaiser Family Foundation documents the ongoing health disparities between Black and White Americans. The data are alarming: life expectancy for Black Americans is more than four years shorter than for Whites (72.8 vs. 77.5 years). Black individuals are more likely to be uninsured (10% vs. 7%) and more likely to go without care because of cost (14% vs. 11%). They are also more likely to report their health as fair or poor (21% vs. 16%) and face significantly higher rates of infant and maternal mortality–more than double and triple, respectively, the rates experience by White Americans.[142] These outcomes are not difficult to anticipate; they are the predictable result of a system that has long regarded Black lives as expendable and Black suffering as acceptable collateral.

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140 U.S. Commission on Civil Rights, Federal Title VI Enforcement to Ensure Nondiscrimination in Federally Assisted Programs. June 1996.
141 McGough M, Lo J, Amin K, Artiga S, Hill L, and Cox C, Racial Disparities in Premature Deaths During the COVID-19 Pandemic. April 24, 2023.
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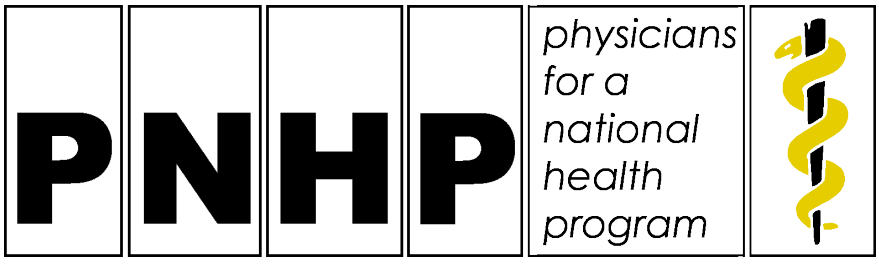

Physicians for a National Health Program (pnhp.org) is a nonprofit research and education organization whose more than 25,000 members support single-payer Medicare for All reform.