



The Benefits of Medicare Advantage for Black Americans

NATIONAL CAUCUS AND CENTER
FOR BLACK AGING

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Foreward

The National Caucus & Center on Black Aging (NCBA) was founded in 1970 to ensure the socioeconomic concerns and challenges of Older Black and African Americans were addressed at the 1971 White House Conference on Aging. Over the course of the last half century, the health care system has become more robust and more equitable; however, African American and Black immigrant older adults still lag behind. Today, nearly two-in-three single Black older adults are economically insecure, with a median income roughly half of white seniors.¹ Two-thirds of African American and Black immigrant older adults live in a high poverty neighborhood—with a median income that is roughly half that of white seniors.² And African American and Black older adults continue to experience chronic conditions such as diabetes, heart disease, and cancer at rates higher than their peers.³

Medicare Advantage (Medicare Part C) was created in 1997 with the goal, in part, of improving care coordination for seniors and expanding access to services not covered under traditional Medicare.⁴ Now 25 years old, we can see how Medicare Advantage has benefitted elderly minorities. Today, roughly half of Black seniors are enrolled in Medicare Advantage, a number that has accelerated in recent years.⁵ And these plans are working. Medicare Advantage enrollees were more likely than those in traditional Medicare to report having a usual source of care. They were also more likely to receive preventive care services, such as annual wellness visits and routine checkups, screenings, and vaccines.⁶

African American and Black immigrant Americans have many options when choosing how to get their health coverage. Depending on their physical needs and income, individuals may qualify for an array of different programs offered through the federal government and Medicare Advantage plans.

NCBA hopes this brief helps seniors and caregivers navigate this complicated set of options and helps policymakers understand the importance of Medicare Advantage to minority seniors and their families.



Sincerely,
Karyne Jones
NCBA President and CEO

Executive Summary

Recognizing that Medicare Advantage plans are proving to be increasingly popular among African American and Black immigrant beneficiaries (hereafter referred to as “Black beneficiaries” or “Black older adults”) and other minority groups, this report is intended to provide a critical understanding of why and how these plans are benefitting older Black Americans and how Medicare Advantage plans might offer coverage that better meets the specific needs of Black beneficiaries as compared to the coverage and benefits offered by traditional Medicare.

After identifying and analyzing the specific needs and considerations of the Black beneficiary population, findings from the report show that Medicare Advantage offers several unique elements that—while potentially advantageous to beneficiaries across demographic groups—may be particularly meaningful to, and aligned with the needs of Black beneficiaries including:

- **Lower costs and greater savings.** Due in part to greater flexibility on cost and coverage policies, and required maximum out-of-pocket (OOP) limits, Medicare Advantage has a 35 percent lower rate of cost burden as compared to traditional Medicare.⁷ Further, compared to their counterparts enrolled in traditional Medicare, Black MA beneficiaries report an average of \$1,270 in costs savings.⁸ Black Medicare beneficiaries are more likely to experience economic insecurity than their white counterparts, have a significantly lower average household income, and are twice as likely to report cost as a barrier to accessing health care. This means that the health care cost savings that Medicare Advantage plans are able to deliver beneficiaries are likely to be particularly meaningful to this population and may factor into older Black adults’ decision to choose MA plans over traditional FFS Medicare.
- **Coverage of supplemental benefits.** Unlike traditional Medicare, nearly all MA plans (99 percent) offer coverage of supplemental benefits such as vision, dental, hearing, telehealth and/or wellness, and in recent years MA plans have expanded their supplemental benefit coverage to include programs designed to address social determinants of health (SDOH).⁹ This element of MA may be particularly supportive for Black beneficiaries as it: provides an additional cost saving mechanism for a group with higher rates of cost-related deferment of medical care, offers more comprehensive services to a population contending with health disparities and chronic conditions at higher rates than other racial groups and

includes SDOH programs for a group disproportionately impacted by systemic barriers to care.

- **The availability of Special Needs Plans (SNPs) and overall, more coordinated and consistent access to care and medicines.** SNPs—which are a part of Medicare Advantage—are tailored Medicare Advantage plans designed to meet the unique health care needs of some of the most vulnerable Medicare beneficiaries, including those that are dually-eligible for Medicare and Medicaid, have certain conditions, or are institutionalized.¹⁰ These plans have shown to be especially important to low-income populations and beneficiaries of color. While Black beneficiaries make up only eight percent of the traditional Medicare population and 11 percent of the total MA population, they comprise nearly 30 percent of the total enrollment in SNPs.¹¹ The disproportionate enrollment in SNPs by Black Medicare beneficiaries reflects the specific needs of this population. In addition to SNPs, Medicare Advantage offers services and programs to coordinate care which is an especially important benefit for Black beneficiaries who often face disproportionate barriers to care and are more likely to be managing one or more chronic conditions.
- **Improved health outcomes.** Research and large-scale comparative analyses directly comparing Medicare Advantage and traditional Medicare show that Medicare Advantage outperforms traditional Medicare across a range of health outcome categories and metrics. Medicare Advantage, for example, was found to have a 43 percent lower rate of avoidable hospitalizations compared to traditional Medicare—among groups with complex chronic conditions the gap is even greater, with Medicare Advantage’s avoidable hospitalization rate being 57 percent lower than the rate for traditional Medicare.¹² Because of the systemic disparities and the higher burden of disease that Black Americans face, the improved health outcomes associated with Medicare Advantage plans may be particularly advantageous and meaningful for Black beneficiaries.¹³

Conversely, the report also found that several shortcomings of traditional FFS Medicare may also be uniquely misaligned with the needs of the Black Medicare population. Weaknesses examined in the following report include: higher OOP costs and no annual cap on spending, little-to-no-care coordination and a lack of benefits that directly address social determinants of health (SDOH), care that is often wasteful and unnecessary, and limited accountability for quality within the program’s open networks.

As Medicare Advantage continues to be the preferred coverage choice for beneficiaries of color as well as those who classify as low income and medically complex, it’s critical that beneficiaries and decision makers alike have a comprehensive understanding of the role MA plans play in supporting these marginalized groups.



Introduction

Medicare Overview

More than 62 million people, including 54 million older adults and 8 million younger adults with disabilities, rely on Medicare for their health insurance coverage.¹⁴ Americans eligible for Medicare benefits have the option of either enrolling in the federally run traditional fee-for-service (FFS) Medicare program or selecting a plan from Medicare Advantage, which are alternative plans offered by Medicare-approved plan options.¹⁵

While traditional Medicare has been in place since 1965, Medicare Advantage was not created until 1997. Since its inception 25 years ago, Medicare Advantage enrollment has steadily increased. Today, nearly half (46 percent) of all eligible Medicare beneficiaries are enrolled in Medicare Advantage plans.¹⁶ These numbers are even higher among beneficiaries of color; 49 percent of Black Americans eligible for Medicare are enrolled in Medicare Advantage and racial minorities make up a

“As Medicare Advantage plans prove to be increasingly popular among Black beneficiaries and other minority groups, it’s critical to understand why and how these plans are benefitting older Black Americans and how the introduction of this plan over 25 years ago has impacted and continues to impact communities of color.”

larger share of the Medicare Advantage population than they do in fee-for-service Medicare (32% vs 21% in 2019).¹⁷ Further, enrollment in Medicare Advantage by older Americans of color is projected to continue to grow. Between 2013 and 2019 alone, enrollment in Medicare Advantage among minority beneficiaries grew 111 percent.¹⁸

As Medicare Advantage plans prove to be increasingly popular among Black beneficiaries and other minority groups, it's critical to understand why and how these plans are impacting older Black Americans.

Understanding the Unique Profile and Considerations of Older Black Americans

To better understand the increasing popularity of Medicare Advantage compared to traditional Medicare among older Black Americans, it is critical to recognize and understand the key demographic factors that impact the Black Medicare population. Important considerations include:

INCOME

Multigenerational racial and economic inequality has led to persistent inequities with regard to economic opportunity for Black Americans. As a result, the poverty rate among Black Americans is nearly 2.5 times the rate among white Americans and is also the highest rate across all racial groups.¹⁹ Older Black Americans, specifically 64 percent of single Black seniors and 34 percent of senior Black couples, experience economic insecurity at higher levels than older white Americans (47 and 21 percent for white singles and couples, respectively report economic insecurity). Older Black households also have a higher likelihood of falling into the category of Extremely Low Income (ELI) renter households than any other racial cohort.²⁰ Moreover, the

SNAPSHOT: KEY DATA ON INCOME DISPARITIES AMONG BLACK OLDER ADULTS

Assets & Inherited Wealth

More than 55 percent of white Americans can count on proceeds from property, investments, annuities, and other assets, compared to 26% of Black Americans.

Retirement Savings

While 65 percent of white Americans have retirement savings with an average balance of \$50,000, only 44% of Black Americans have savings for their post-work years, with an average of \$20,000 in retirement accounts.

Social Security & Pensions

For 35% of older Black married couples and 58% of unmarried older Black Americans, Social Security accounts for most, if not all, of their regular income. Without those benefits, the poverty rate among Black Americans nearly triples from 18% to 51%.

Actual Cost of Living

Older Black adults are at a decided disadvantage in navigating ordinary living expenses like housing, utilities, transportation, health care, and even food. The AARP Foundation reports that 23.2% of older Black Americans are food insecure, "unable to afford or readily access a diet of fresh, nutritious foods," compared to 6.2% of older white Americans.

median income is significantly higher for white Medicare enrollees (\$30,050) than it is for Black Medicare enrollees (\$17,350).²¹

HEALTH DISPARITIES AND UNIQUE HEALTH NEEDS

Systemic racial and health inequities have disproportionately exposed older Black Americans to significant health disparities and put the population at higher risk for developing and facing higher risk of complications and death related to chronic health conditions such as diabetes, kidney disease, heart disease, COVID-19, and cancer.²² According to one study published in 2021, compared to white adults in the U.S., Black Americans are more than eight times more likely to be diagnosed with HIV, more than five times as likely to be hospitalized with hypertension, and 3.5 times more likely to be diagnosed with end-stage renal disease (a condition commonly associated with diabetes).²³ Additionally, the most recent data from the Department of Health and Human Services (HHS) show that Black Americans with diabetes have significantly higher rates of adverse health outcomes related to the disease than white Americans with diabetes and are twice as likely to die from the disease than their white counterparts.²⁴

ACCESS TO HEALTH CARE

One of the primary factors driving the disproportionately high burden of disease among older Black Americans as compared with older white adults, is disparities in access to high quality health care. Despite a growing awareness of the barriers to care that communities of color are more likely to contend with, large racial and cultural inequities driven by issues both inside and outside of the health system persist.²⁵ One key driver of inequitable access to care for older Black Americans is cost, with Black Medicare beneficiaries being twice as likely than their white counterparts to report cost as a barrier to accessing needed care and nearly a quarter of Black beneficiaries reporting difficulty with paying medical bills.²⁶ Research also shows that Black Americans are less likely to have a usual source of care for preventive services, more likely to contend with discrimination when dealing with medical professionals, and more often receive suboptimal care in health system settings compared to white Americans.²⁷ Black Medicare beneficiaries, for example, wait an average of 22.5 minutes longer at the emergency room than white beneficiaries.²⁸

FAMILY AND CAREGIVING STRUCTURE

Another important dynamic to consider relates to non-traditional family structures that, while not exclusive to Black communities, tend to be more common among Black and other minority groups. Of relevance is the prevalence of grandfamilies and kinship care, which describes a family unit in which grandparents or other adult family

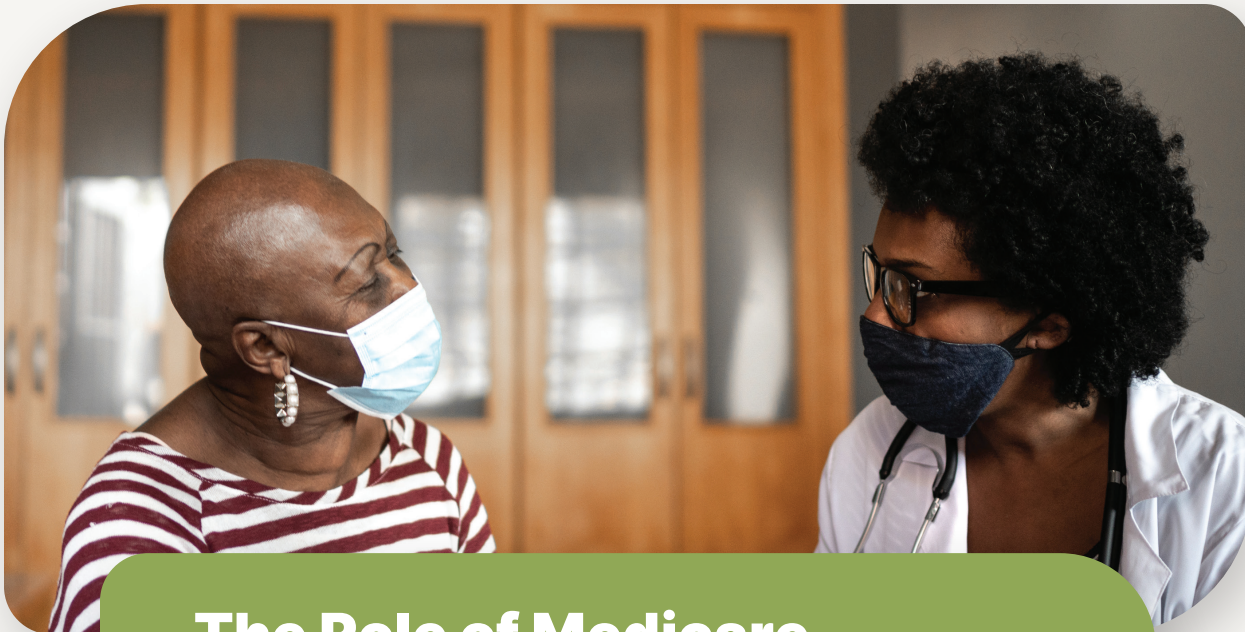
members act as heads of household and raise minor-aged children in the absence of biological parents in the home.²⁹ In the U.S., Black children are more likely than children of other races to be raised by someone other than their biological parent.³⁰ While only 14 percent of children in the U.S. are Black, 25 percent of children living in grandfamilies are Black.³¹ Further, among Black American grandparents (aged 60+) who are living with their grandchildren, 35 percent report being responsible for the basic needs of one or more minor-aged grandchild—the general population average is significantly lower, hovering at around 20 percent.³²

Grandfamilies and kinship care structures can be immensely beneficial and constructive (particularly for the children involved). Yet data demonstrate that grandfamilies are not equitably supported, which can be especially difficult considering these families often undergo unique lifestyle changes and resource redistribution. This can be particularly challenging for older adults with health conditions, limited income, and logistical constraints (e.g., limited transportation, living space, or financial resources).³³ Research on grandfamilies, for example, has shown that caregivers are frequently unable to attend to their own health care needs due to a lack of daycare, scheduling challenges, and strained financial situations.³⁴

Notably, these unique caregiving structures have an outsized impact on women, with women in caregiving roles being twice as likely than non-caregivers to end up living in poverty.³⁵ As a result, Black caregivers report outsized financial impacts due to this caregiving responsibility including: limited ability to save, leaving bills unpaid, and/or taking on more debt.³⁶ This only exacerbates a broader trend, as Black women with lower incomes tend to incur more out of pocket health care costs than Black men.³⁷ Additionally, according to the National Committee to Preserve Medicare and Social Security, women live longer than men and are likely to suffer from three or more chronic conditions, including arthritis, hypertension, osteoporosis; more women than men suffer from physical limitations and cognitive impairments that limit their ability to live independently.³⁸

Research on grandfamilies has shown that caregivers are frequently unable to attend to their own health care needs due to a lack of daycare, scheduling challenges and strained financial situations.

Understanding this unique profile and demographics provides an important foundation for understanding why and how Medicare Advantage might be better positioned than traditional Medicare to serve and support Black Medicare beneficiaries.



The Role of Medicare Advantage in Supporting Older Black Americans

Both traditional fee-for-service Medicare and Medicare Advantage offer important health benefits to adults ages 65 years and older. Additionally, data show that populations enrolled in traditional FFS Medicare and Medicare Advantage are clinically similar and have comparable functional impairments and support needs.³⁹ Still, despite these similarities, the programs differ in several key areas and the benefits, costs, access, care structures, and health outcomes have a range of implications for beneficiaries.

While enrollment in Medicare Advantage has grown rapidly over the past decade across demographic groups, the share of Black Medicare eligible adults enrolling in Medicare Advantage has been particularly pronounced. In 2022, 46 percent of all Medicare eligible adults chose Medicare Advantage Plans. Among older Black adults this number was even higher at 49 percent and between 2013 and 2020 minority enrollment in Medicare Advantage grew by 111 percent, according to research conducted by Milliman.⁴⁰ Furthermore, a December 2021 Centers for Medicare and Medicaid Services (CMS) report found “substantial progress in the reduction of inequities in the patient experience for Black beneficiaries” in Medicare Advantage.⁴¹ Given the unique profile and needs of the Black Medicare eligible population,

detailed in the previous section, there are several reasons why Black beneficiaries may benefit particularly from, and be more inclined to, enroll in Medicare Advantage over traditional Medicare.⁴² Detailed below are distinct aspects of Medicare Advantage that may be driving the increased enrollment in these plans and potentially better positioning Medicare Advantage to support Black beneficiaries.

Lower Costs and Greater Savings

Research continues to demonstrate that Medicare Advantage plans play a key role in shielding financially vulnerable populations from high out-of-pocket medical costs.⁴³ Across beneficiaries, Medicare Advantage has a 35 percent lower rate of cost burden as compared to traditional Medicare.⁴⁴ Further, according to a study conducted by Avalere:

- Inpatient hospital costs were as much as 23 percent lower among high-need, high-cost populations in MA relative to fee-for-service Medicare and,
- Part D drug costs were 38 to 44 percent lower among MA plan enrollees compared to costs for those enrolled in traditional Medicare.⁴⁵

These cost savings can be attributed to a variety of factors but two components distinct to Medicare Advantage are particularly notable:

- **Greater flexibility on cost and coverage policies.** Compared to traditional Medicare, MA plans can offer more flexible cost and coverage policies and may offer deductible and cost sharing policies that are more financially beneficial to enrollees. For example, nearly seven in 10 Medicare Advantage enrollees are in plans with no additional premiums (outside of the premium they would otherwise pay for traditional Medicare), despite having coverage of supplemental benefits not covered by traditional Medicare⁴⁶
- **Maximum annual out of pocket limits.** In addition to often providing additional benefits and reduced cost sharing, Medicare Advantage plans are required to place a cap on annual out-of-pocket

The cost savings that Medicare Advantage plans deliver beneficiaries are likely to be particularly meaningful to Black beneficiaries and may factor into older Black adults' decision to choose MA plans over traditional FFS Medicare. Indeed, Black Medicare Advantage enrollees see an average of \$1,270 in cost savings a year compared to their counterparts in traditional Medicare.

(OOP) spending, guaranteeing that beneficiaries will not spend over a set amount per year out-of-pocket on health care expenses. No such cap exists within traditional Medicare.

As detailed in [previous sections](#), Black Medicare beneficiaries are more likely to experience economic insecurity than their white counterparts, have a significantly lower average household income, and are twice as likely to report cost as a barrier to accessing health care. This means that the cost savings that Medicare Advantage plans are able to deliver beneficiaries are likely to be particularly meaningful to this population and may factor into older Black adults' decision to choose MA plans over traditional FFS Medicare. Indeed, Black Medicare Advantage enrollees see an average of \$1,270 in cost savings a year compared to their counterparts in traditional Medicare.⁴⁷ To that end, the significant cost savings achieved by MA plans may very well play an important role in supporting a minority population with statistically lower incomes and more complex medical needs.

Coverage of Supplemental Benefits

Another way Medicare Advantage drives cost savings and more comprehensive and supportive patient care is through the coverage of supplemental benefits. Nearly all Medicare Advantage Plans (99 percent) offer coverage of supplemental benefits not covered by traditional Medicare such as dental, vision, hearing, telehealth, wellness, and/or fitness.⁴⁸ Traditional Medicare, on the other hand, does not offer any of these benefits and requires that beneficiaries purchase separate supplemental insurance to have these services covered or pay the full price out of pocket.⁴⁹ This difference has proven to have real world impacts for beneficiaries; according to a 2022 study, beneficiaries in traditional Medicare with no supplemental coverage had higher rates of cost-related problems than beneficiaries enrolled in Medicare Advantage plans.⁵⁰

In recent years, Medicare Advantage has gone even further to provide broader supplemental support to beneficiaries, expanding coverage to include a range of benefits that aim to address social determinants of health, which disproportionately impact beneficiaries of color. For example, 40 percent of Black Medicare beneficiaries report systemic barriers to food access, compared to 16 percent of white beneficiaries.⁵¹ Many MA plans have extended supplemental coverage to include benefits that address food insecurity, provide transportation services for those in need, and improve wellness and safety through community-based programming.⁵²

While Medicare Advantage's comprehensive coverage of benefits could be advantageous for older Americans across demographic groups, this component of Medicare Advantage may especially support the unique needs of older Black adults for a variety of reasons including the ability to:

- Provide another cost saving mechanism for a group at higher risk of economic instability and that reports higher rates of deferring medical care due to costs;
- Offer more comprehensive “whole-person” health care services to a population burdened by health disparities, with higher rates of chronic conditions and higher risks of developing complications related to these conditions;
- Help address adverse impacts related to social determinants of health for a group disproportionately impacted by these factors;⁵³ and
- Deliver more streamlined medical care for a group that faces systemic barriers to accessing care and unique family structures that can make cumbersome medical administration particularly burdensome.

More Coordinated, Consistent Access to Care and Medicines

Broader coverage of supplemental benefits is just one way Medicare Advantage offers more streamlined, coordinated, and comprehensive care. Outside of supplemental benefit coverage, several unique aspects of Medicare Advantage encourage, incentivize, and make “whole-patient” care possible in a way that is fundamentally different from traditional Medicare.

A PAYMENT STRUCTURE THAT ENCOURAGES AND SUPPORTS WHOLE-PATIENT HEALTH

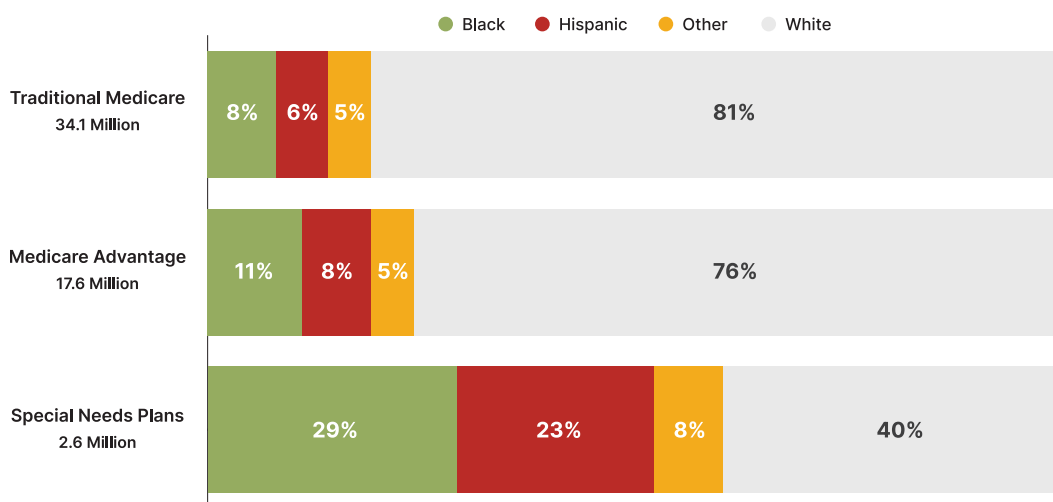
First, compared to the FFS payment model of traditional Medicare, the payment structure of Medicare Advantage is fundamentally better positioned to support a comprehensive, whole patient approach to care. Under the FFS model, payment is made to providers based on the individual cost of the specific services provided.⁵⁴ Conversely, Medicare Advantage plans receive monthly payments from CMS that are based on estimated costs of coverage for a wide range of medical services such as doctors’ visits, hospital stays, and other benefits, and also account for the health of the beneficiary population to ensure the plans have enough resources to cover patients with high health needs. The process that this payment method requires necessitates that MA plans consider the patient’s comprehensive needs and anticipate any supplemental or additional needs patients with particular conditions might have to support their care journey.⁵⁵ According to one analysis, this model “enables plans to offer care management interventions that help meet the complex care needs of vulnerable beneficiaries in ways that achieve positive health outcomes.”⁵⁶

The availability of customized Special Needs Plans (SNPs) serves as one example of how this model serves patients. SNPs—a part of Medicare Advantage—are tailored Medicare Advantage plans designed to meet the unique health care needs of some of

the most vulnerable Medicare beneficiaries, including those that are dually-eligible for Medicare and Medicaid, have certain conditions, or are institutionalized.⁵⁷ SNPs tailor their benefits, provider choices, and drug formularies to best meet the specific needs of the groups they serve, which can make it much easier for beneficiaries to navigate care and access the services and providers they need.⁵⁸ In addition to offering benefits customized to beneficiaries' unique needs, many of these plans also offer extra condition-specific benefits or programs and access to care coordinators that can support beneficiaries in more seamlessly managing their conditions.⁵⁹

In 2022, more than 4.6 million MA beneficiaries were enrolled in SNPs.⁶⁰ Moreover, SNPs have shown to be particularly important to low-income beneficiaries and beneficiaries of color. While Black beneficiaries make up only eight percent of the traditional Medicare population and 11 percent of the total MA population, they comprise nearly 30 percent of the total enrollment in SNPs.⁶¹ The disproportionate enrollment in SNPs by Black Medicare beneficiaries reflects the specific needs of this population, as older Black adults are more likely to be managing multiple chronic conditions and often face structural and social barriers that can make accessing and coordinating care more burdensome.

Black beneficiaries are more likely to be enrolled in MA and In Particular Special Needs Plans



A MODEL BUILT AROUND COORDINATED AND TAILORED CARE

In addition to SNPs, Medicare Advantage offers beneficiaries the option to enroll in an array of other coordinated care plans. As well as providing yet another cost saving mechanism for beneficiaries (these plans often have lower OOP costs), coordinated care plans also offer a streamlined way for patients to receive the care they need and in many instances are designed and tailored to ensure patients are able to more easily access the specific care they need for their individual health status and conditions.⁶² Notably, of the more than 24 million beneficiaries enrolled in MA in 2020, 21.6 million enrolled in a plan that integrates Medicare's inpatient and outpatient services with a prescription drug benefit.⁶³

While more integrated, coordinated care and whole-patient care can be beneficial to all beneficiaries, this aspect of MA plans may be especially supportive of the specific needs and disparities that Black beneficiaries contend with. For example, as previously outlined, Black Americans are less likely than their white Americans to have a usual source of care and to receive consistent, recommended preventive services. That said, research has shown that older Black adults are more likely to have a usual source of care and to report receiving routine health care services, including mammograms, flu shots, blood pressure screenings, and cholesterol checks, when enrolled in Medicare Advantage as compared to FFS Medicare.⁶⁴ Additionally, like the supplemental benefit coverage detailed above, coordinated, whole patient care may also provide an additional meaningful cost-saving tool, more optimal care for a group with higher health risks and needs, and more easily navigable care for those who face a range of barriers standing in the way of receiving adequate, timely, and high-quality care.

Improved Health Outcomes

In addition to—and likely in large part due to—the cost, coverage, care, and accessibility benefits detailed above, research and large-scale comparative analyses have shown that Medicare Advantage outperforms traditional Medicare across a range of health outcome categories and metrics. Medicare Advantage, for example, was found to have a 43 percent lower rate of avoidable hospitalizations compared to traditional Medicare—among groups with complex chronic conditions the gap is even greater, with Medicare Advantage's avoidable hospitalization rate being 57 percent lower than the rate for traditional Medicare.⁶⁵ Studies examining hospital readmission have also consistently found lower readmission rates among MA plan beneficiaries than among their counterparts enrolled in traditional Medicare.⁶⁶

As discussed in the previous section, MA plan beneficiaries are more likely to have a usual source of care and to receive preventative services. This increased likelihood of usual care and preventive services helps contribute to a population

that, in general, is healthier and receiving more of the care they need. Compared to the traditional Medicare population, those enrolled in MA plans have 49 percent and 11 percent higher vaccination rates for pneumonia and flu, respectively; among high-need, high-cost beneficiaries these gaps are even more pronounced.⁶⁷ MA plans have also shown to outperform traditional Medicare in disease management. According to a report published in 2022, among beneficiaries with diabetes, Medicare Advantage enrollees were more likely than those in traditional Medicare to be prescribed guideline-recommended therapy, use medication for their condition, and perform better on clinical care measures such as diabetic eye exam screening.⁶⁸ Similarly, MA beneficiaries with heart disease were found to be more likely to receive guideline-recommended therapies in ambulatory settings than their counterparts in traditional Medicare. Further despite having a higher likelihood of receiving more consistent and higher quality of care, when compared to traditional Medicare beneficiaries, MA enrollees have been shown to have fewer medical visits overall, suggesting reduced need for medical services over the long run and better health overall.⁶⁹

Research has consistently demonstrated that Black Americans contend with overall worse health status due in large part to systemic issues including limited access to culturally competent care, racial biases in medical care, and socioeconomic disadvantages, among other factors.⁷⁰ As a result (and as outlined in the [first section](#) of this report) Black Americans are generally at higher risk for a range of conditions such as heart diseases, stroke, cancer, asthma, influenza and pneumonia, diabetes, and HIV/AIDS.⁷¹ Because of these systemic disparities and the higher burden of disease that Black Americans face, the improved health outcomes associated with Medicare Advantage plans may be particularly advantageous and meaningful for Black beneficiaries.



Shortcomings of Traditional Fee-For-Service Medicare

While traditional FFS Medicare provides important benefits to more than 36 million Americans—representing a little more than half of all Medicare eligible adults—the program has some key shortcomings and it's important that consumers and decision makers understand the implications of these weaknesses, particularly as it relates to vulnerable populations, including older Black adults.

Traditional Medicare lacks many of the components that potentially position Medicare Advantage to better support the specific needs of Black beneficiaries, and recognizing how these shortcomings may impact the nearly 6 million Black Medicare eligible adults living in the U.S., is critical.⁷²

Higher Out-of-Pocket Costs and No Annual Cap on Spending

Unlike Medicare Advantage, traditional FFS Medicare does not have any ceiling on out-of-pocket costs for covered services, and while the program promises to cover all medical care, it explicitly excludes any coverage for dental, vision, hearing, or long-term care.⁷³ With no OOP limit and zero coverage for supplemental benefits, beneficiaries enrolled in traditional Medicare are at greater risk of being exposed to high medical costs than those enrolled in Medicare advantage. Indeed, data show that one-fourth of traditional Medicare beneficiaries are underinsured, defined as

spending at least 10 percent of total annual income on medical services, excluding premiums.⁷⁴ According to research, the risks associated with underinsurance are highest for those with low incomes and those managing multiple chronic conditions—findings that are especially relevant to Black beneficiaries given the population's unique profile and needs.⁷⁵

Compared to other racial groups, Black Medicare beneficiaries on average have a greater risk of chronic conditions and associated complications and have higher rates of poverty and income instability, which means they are more likely to need more frequent and more expensive medical care than other groups and also more likely to have difficulty paying for the care they need. To that end, traditional Medicare enrollees' higher exposure to financial risk related to potential OOP costs and underinsurance and a lack of coverage for supplemental benefits may be profoundly detrimental to older Black adults, demonstrating the important role that MA plans may play for many Black beneficiaries.

Little-To-No Care Coordination

While Medicare Advantage plans operate under a capitated payment system in which plans are paid a fixed, prospective amount every month to cover care for each beneficiary, traditional Medicare is a fee-for-service program. Fundamentally, a FFS model rewards high volume and high cost services, as clinicians and hospitals are paid based on the number and cost of the services they provide rather than the quality of care provided and reported patient outcomes. This means there is very little incentive for coordinated care, and as a result, within FFS models, patient care is inconsistent and siloed—some patients receive too much care, some not enough, and others might even receive the wrong care.⁷⁶

Because of the lack of coordination inherent to the FFS model, these programs often deal with major challenges related to limited access and underuse of many cost-effective and highly beneficial services (which in turn drives overuse of less effective and more costly services down the line).⁷⁷ This is due, in part, to the fact that FFS models drive up and expose patients to high costs, which means patients with limited financial resources and/or gaps in their insurance coverage are often forced to cut back or delay medically necessary care, treatments, and medications.⁷⁸ One-in-four diabetic patients report using less insulin than prescribed due to the high costs.⁷⁹ Importantly, although perhaps unsurprisingly, underuse has also been proven to be a major driver of racial disparities in health care.⁸⁰

A lack of emphasis on care coordination and a reliance on a fee-for-service model can discourage use of less expensive and more effective treatments, and lead to higher costs for the system and for patients, all of which can ultimately result in avoidable complications and poorer patient outcomes. These impacts can be harmful

to all Medicare beneficiaries, but as a population that deals with higher rates of chronic disease and income instability, unique family structures and socioeconomic profiles that can make coordinating care on their own more burdensome, and systemic barriers to accessing quality care, the shortcomings of the FFS Medicare model may have a disproportionately negative impact on Black beneficiaries.

Wasteful and Unnecessary Care

At the same time as promoting underuse of cost effective, highly beneficial and/or early intervention services, FFS models like that of traditional Medicare, simultaneously encourage overuse of less effective, lower value, and higher cost services. This is partly due to lack of care coordination and also a result of patients accessing preventive, high value, and cost-effective treatments at lower rates. When patients and providers are disincentivized from routine health care, preventive services, and early intervention care, patients are more likely to need care, services, and products that cost more money and often lead to less effective outcomes down the road.⁸¹ For example, one analysis of a disease management program for patients with congestive heart failure found that early-intervention and effective disease management saved \$4.4 million dollars over a two-year period by decreasing the need for costly hospital stays and expensive treatments for complications.⁸²

As a fee-for-service program, traditional Medicare does little to incentivize preventive care, which is often more effective and efficient, and as a result the care that is needed often comes later and requires more intensive and costly intervention.⁸³ In short, the FFS model can lead to overuse of less effective and more expensive care. Not only is overuse wasteful, it can also be harmful to patients—especially older adults who are often more vulnerable to medical complications—because it exposes them to more ineffective medical care and can lead to more time spent in medical facilities or undergoing unnecessary tests and treatments.⁸⁴ For example, 34 percent of knee replacements alone are not needed, which leads to approximately 14,000 patients suffering from infections, blood clots, heart problems, or some other health problem every year because of the procedure.⁸⁵

Limited Accountability for Quality within Open Networks

In traditional Medicare's FFS model, providers are paid for carrying out more services rather than being held accountable for treating patients within a fixed budget (as is the case within MA plans).⁸⁶ This means that medical providers aren't held accountable for the quality or efficiency of the care they provide.⁸⁷ Compared to managed care models, the FFS model does very little to incentivize accountability for health outcomes and lacks the infrastructure needed to support systematic measurement, and monitoring of access, and quality metrics.⁸⁸

While this lack of accountability can have consequences for all beneficiaries, it may be especially problematic for beneficiaries of color. For a group facing disproportionate barriers to accessing care, higher risks associated with chronic conditions, and overall worse health outcomes than other groups, a system that discourages efficient, effective, and coordinated care threatens to exacerbate health and access disparities among some of the most vulnerable populations relying on Medicare for health insurance coverage.

FFS Medicare vs. Medicare Advantage

	Fee For Service Medicare	Medicare Advantage
Provider Network	<i>Open</i> – Any willing clinician may participate	<i>Targeted</i> – Health plans contract with clinicians
Annual Premium	Lower premiums, on average	Somewhat higher premiums, on average, though low-income beneficiaries may access reduced premiums
Out of Pocket Costs	Higher, on average	Lower, on average
Total Annual Cost	Higher on average	Lower on average
Out of Pocket Cap	Beneficiaries must purchase supplemental coverage (“Medigap”)	Included
Supplemental Benefits	Beneficiaries must purchase supplemental coverage	Dental, vision, hearing and additional benefits to address SDOH included in most plans
Care Coordination	None	Included in most plans



Conclusion

Today, more than 46 percent of Medicare eligible adults are enrolled in Medicare Advantage plans. That number is even higher among people of color, with data showing that 49 percent of Black beneficiaries choose Medicare Advantage over traditional FFS Medicare. Medicare Advantage has several distinct components that may be particularly well suited for supporting the specific profile and needs of older Black Americans. Due to systemic biases, discrimination, and disparities, Black beneficiaries are more likely than other racial groups to live with chronic conditions, contend with income instability, face barriers to accessing quality health care, and live in unique family structures and environments that can come with specific constraints. As a result, while the greater cost savings, coordinated care, improved access to care, and better health outcomes associated with Medicare Advantage have the potential to benefit all Medicare enrollees, Black beneficiaries may find these factors particularly meaningful and well positioned to support their specific needs.

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