

Highlights of the Medicare Advantage landscape by race and ethnicity

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This report evaluates the general enrollment Medicare Advantage (MA) plans available to individuals of different racial and ethnic groups in the United States. We examined plan options available to individuals aged 65 and over belonging to five different racial or ethnic groups from 2016 to 2020.

Our analysis shows differences exist in average plan characteristics, such as star rating and premium. The magnitude and direction of the differences vary by racial or ethnic group, and the geographic concentration of racial or ethnic groups is a key driver of this variance.

Background

Prior research has shown that access to healthcare services varies by geography and that racial and ethnic minorities often experience reduced access compared to other populations.¹ Access to healthcare services is highly correlated to access to health insurance,² and so we set out to determine whether there are similar differences in access to health insurance—specifically for MA plans—for racial and ethnic minorities. This paper focuses specifically on the number and characteristics of MA plans available to individuals aged 65 and over who are white, Black, Hispanic or Latino (H/L), Asian or Pacific Islander (A/PI), or American Indian or Alaska Native (AI/AN).

MA plans are offered in almost every county throughout the United States, and the plan options available are specific to each county. Anyone living in one of those counties who is eligible for Medicare can enroll regardless of race or ethnicity. This analysis

looks at the MA program across the nation, and reflects the fact that certain racial or ethnic groups live in parts of the United States that have different MA plan options available. This paper explores the impact of geography on the number and average characteristics of plans available to each racial or ethnic group, but does not study other potential drivers of plan availability, such as income or health status. The results of this analysis should not be interpreted to imply a specific bias in the MA program.

Enrollment data based on race and ethnicity in MA plans is not publicly available. Instead, our analysis calculates average plan metrics for each county using total plan enrollee data, and then weights the average results for each county together using age-65-and-over census data by race and ethnicity to calculate metrics of the nationwide average plan available to an individual of each race or ethnicity. We examined a number of different metrics, including factors impacting plan revenue, cost sharing, benefits offered, and number of plans available. We observed larger differences between racial and ethnic groups in overall star rating, total premium, maximum out-of-pocket cost, and number of plans available from 2016 to 2020, which are presented below.

Results

PLAN AVAILABILITY

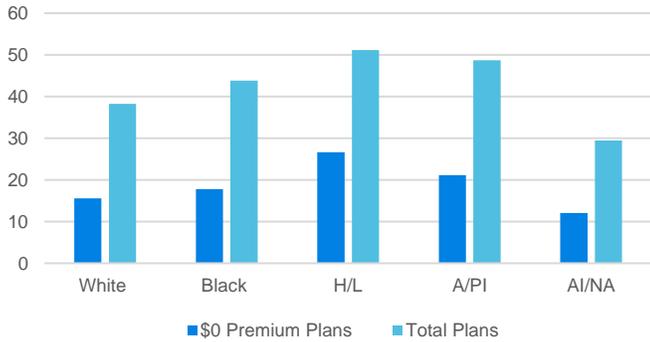
We evaluated the average count of 2020 MA plans available, including general enrollment and special needs plans (SNPs), to an MA enrollee of each racial or ethnic group. Additionally, we calculated the average count of zero-dollar premium plans available, as these plans improve accessibility to the MA program and are a large driver of MA enrollment.³ Figure 1 displays the results, which show that the average Black, H/L, and A/PI enrollee has more MA plan offerings available than the average white enrollee. AI/AN enrollees have the lowest number of MA plans available, on average. All racial and ethnic groups have a similar percentage of plan offerings at a zero-dollar premium, except for H/L, whose percentage of zero-dollar plan offerings is about 10% higher.

¹ Agency for Healthcare Research and Quality. Disparities in Health Care Quality Among Racial and Ethnic Minority Groups: Selected Findings From the 2010 National Healthcare Quality and Disparities Reports. Retrieved December 13, 2020, from <https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrd10/nhqrd10/minority.pdf>.

² National Center for Health Statistics (February 2017). Health Insurance and Access to Care. NCHS Fact Sheet. Retrieved December 13, 2020, from https://www.cdc.gov/nchs/data/factsheets/factsheet_hi.ac.pdf.

³ Piper, B.J. & Gabe, M.L. (April 2019). Hang on Tight! Why Maintaining a Zero-Dollar MA-PD Premium Plan Is Worth the Effort. Milliman White Paper. Retrieved December 13, 2020, from <http://assets.milliman.com/ektron/zero-dollar-ma-pd-premium-plan.pdf>. Note that author M.L. Gabe is now M.G. Yeh.

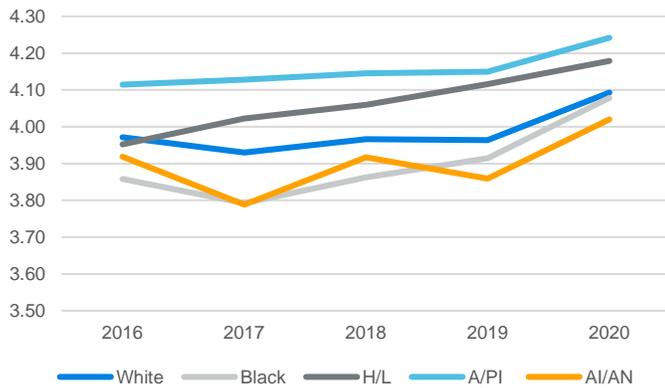
FIGURE 1: AVERAGE COUNT OF 2020 PLANS AVAILABLE TO MA ENROLLEES



STAR RATING

Figure 2 shows the average overall star rating of available MA plans by racial or ethnic group from 2016 to 2020. The average star rating for MA plans offered to A/PI and H/L individuals are higher than the average star ratings for plans offered to Black, white, and AI/AN individuals. These results are generally consistent with Centers for Medicare and Medicaid Services (CMS) findings, which examined differences in 2017 Healthcare Effectiveness Data and Information Set (HEDIS) Clinical Care measures by racial or ethnic group.⁴

FIGURE 2: AVERAGE OVERALL STAR RATING BY RACE/ETHNICITY

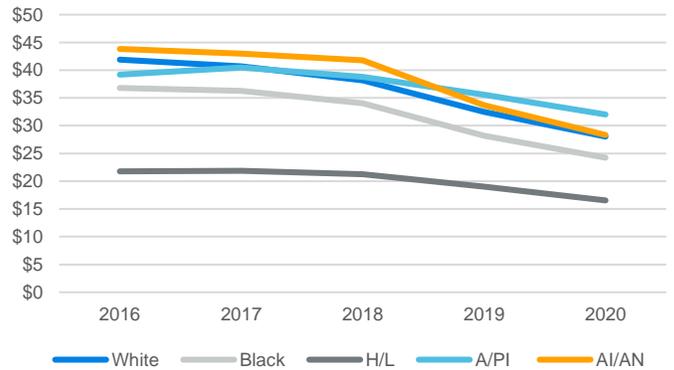


PREMIUM

Figure 3 shows the average total member premium of plans available to each racial or ethnic group from 2016 to 2020. Plans available to white, A/PI, and AI/AN individuals have similar average premiums, while the average premium is lower for Black and lowest for plans available to H/L individuals. The relatively

low premium for plans available to H/L individuals is driven by the high proportion of H/L individuals residing in Southern California and South Florida, where CMS payment rates to health plans are higher than average and, as a result, many of the general enrollment plans offered have no member premium.

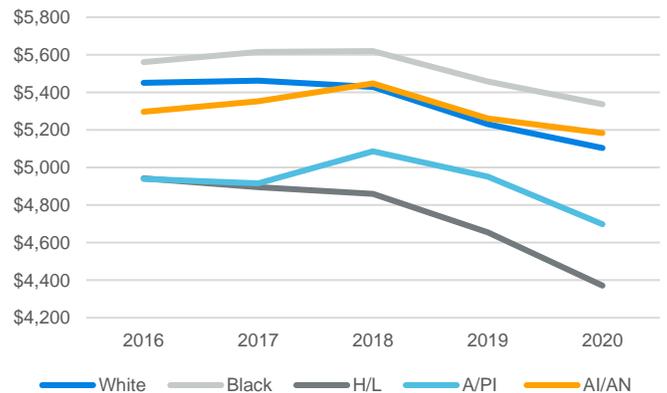
FIGURE 3: AVERAGE TOTAL PREMIUM BY RACE/ETHNICITY



MAXIMUM OUT-OF-POCKET COST

Figure 4 shows the average maximum out-of-pocket cost (MOOP) of the plans available to each racial or ethnic group from 2016 to 2020. The average MOOP is highest for plans available to Black individuals, and lowest for plans available to H/L and A/PI individuals. The average MOOP has trended down over time for all racial and ethnic groups, though most significantly for plans available to H/L individuals. This MOOP trend for H/L is driven by populations in Southern California and South Florida, similar to premiums discussed previously.

FIGURE 4: AVERAGE MOOP BY RACE/ETHNICITY

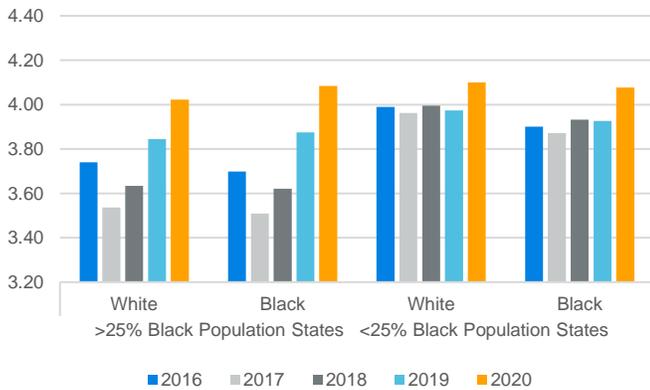


⁴ CMS (April 2019). Racial, Ethnic, and Gender Disparities in Health Care in Medicare Advantage. Retrieved December 13, 2020, from <https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/2019-National-Level-Results-by-Race-Ethnicity-and-Gender.pdf>.

GEOGRAPHIC FACTORS

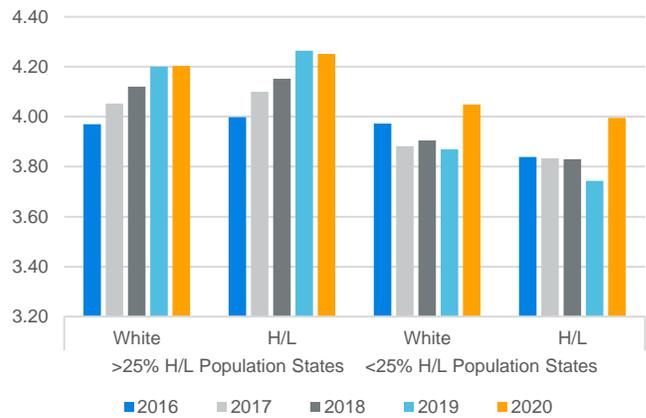
The geographic concentration within a state of each racial or ethnic group plays a role in the average MA plan available to that group. We considered the impact of geographic concentration for Black and H/L individuals, the two nonwhite racial or ethnic groups with the highest population share in the country. We examined states where the state-wide population is over 25% Black (Alabama, Georgia, Louisiana, Maryland, Mississippi, South Carolina, and Washington, D.C.), and compared them to the rest of the country, where the state-wide population is less than 25% Black. Figure 5 contains this comparison of star ratings for plans available to Black and white individuals, separately for states with Black populations greater than 25% and less than 25%. Plans in states with Black populations over 25% had notably lower average star ratings from 2016 to 2019; however, in 2020, the average star rating for plans in these states moved significantly closer to the nationwide average.

FIGURE 5: AVERAGE STAR RATING BY REGION FOR WHITE AND BLACK



Similarly, we examined states where the state-wide population is over 25% H/L (Arizona, California, Florida, Nevada, New Mexico, Puerto Rico, and Texas), and compared them to the rest of the country, where the state-wide population is less than 25% H/L. Figure 6 contains this comparison of star ratings for plans available to H/L and white individuals, separately for states with H/L populations greater than 25% and states with H/L populations less than 25%. Plans in states with H/L populations over 25% had higher star ratings than plans in the rest of the country. The average star ratings of plans available to H/L individuals in states with H/L populations over 25% are greater than the average star ratings for plans available to white individuals in the same region.

FIGURE 6: AVERAGE STAR RATING BY REGION FOR WHITE AND H/L



The geographic concentration of A/PI individuals also contributes to disparities seen between plans available to the A/PI population and plans available to the white population. Thirty-two percent of the A/PI population in the country resides in California, a state where the average plan has a higher star rating and lower MOOP than the average nationwide plan.

Methodology and assumptions

We used publicly available data to support our analysis. We used MA plan enrollment data for February 2016 through February 2020 published by CMS.⁵ We used 2018 five-year American Community Survey (ACS) data to gather population counts by racial and ethnic group in each county.⁶ We used population aged 65 and over as a proxy for the Medicare-eligible population. We recognize that detailed race/ethnicity data for MA enrollees is available through the CMS Innovator Research program and that data might produce different results. Star rating, premium, and benefit information was summarized from the Milliman MACVAT®. We calculated metrics for the average general enrollment plan within each county by weighting on plan enrollment within the county in each year. We calculated metrics for the average plan available to each racial or ethnic group by weighting each county’s average plan by the 65-and-over population of the racial or ethnic group residing in each county.

⁵ CMS. Monthly Enrollment by Contract/Plan/State/County. Retrieved December 13, 2020, from <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-Enrollment-by-Contract-Plan-State-County>.

⁶ U.S. Census Bureau. American Community Survey: Data Tables and Tools. Retrieved December 13, 2020, from <https://www.census.gov/acs/www/data/data-tables-and-tools/>.

Caveats, limitations, and qualifications

This report is intended to summarize availability and characteristics of MA plans available to racial and ethnic groups from 2016 through 2020. This information may not be appropriate, and should not be used, for other purposes. We do not intend this information to benefit, and assume no duty of liability to, any third party that receives this work product. Any third-party recipient of this report that desires professional guidance should not rely upon Milliman's work product, but should engage qualified professionals for advice appropriate to its specific needs.

In preparing this analysis, we relied upon publicly available data from CMS and the ACS. If the underlying data or information is inaccurate or incomplete, the results of the analysis may likewise be inaccurate or incomplete. The opinions included here are those of the authors and not necessarily those of Milliman. Adam Barnhart and Mary Yeh are actuaries for Milliman, members of the American Academy of Actuaries, and meet the qualification standards of the Academy to render the actuarial opinion contained herein. To the best of our knowledge and belief, this information is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices.



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