Health Affairs Scholar
EMERGING & GLOBAL HEALTH POLICY
OXFORD

Medicare Advantage enrollees' reports of unfair treatment during health care encounters

Megan Mathews[1] , **Megan K. Beckett**[2], **Steven C. Martino**[3] , **Julie A. Brown**[2] , **Nate Orr**[2],
Sarah Gaillot[4], **Marc N. Elliott**[2],*

[1]RAND Corporation, Arlington, VA 22202, United States
[2]RAND Corporation, Santa Monica, CA 90401, United States
[3]RAND Corporation, Pittsburgh, PA 15213, United States
[4]Centers for Medicare & Medicaid Services, Baltimore, MD 21244, United States
*Corresponding author: RAND Corporation, Santa Monica, CA 90401, United States. Email: Elliott@rand.org

Abstract

We investigated unfair treatment among 1863 Medicare Advantage (MA) enrollees from 21 MA plans using 2022 survey data (40% response rate) in which respondents indicated whether they were treated unfairly in a health care setting based on any of 10 personal characteristics. We calculated reported unfair treatment rates overall and by enrollee characteristics. Nine percent of respondents reported any unfair treatment, most often based on health condition (6%), disability (3%), or age (2%). Approximately 40% of those reporting any unfair treatment endorsed multiple categories. People who qualified for Medicare via disability reported unfair treatment by disability, age, income, race and ethnicity, sex, sexual orientation, and gender/gender identity more often than those who qualified via age. Enrollees dually eligible for Medicare and Medicaid or eligible for a Low-Income Subsidy (DE/LIS) reported unfair treatment by disability, income, language/accent, race and ethnicity, culture/religion, and sex more often than non-DE/LIS enrollees. Compared with White respondents, racial and ethnic minority respondents more often reported unfair treatment by race and ethnicity, language/accent, culture/religion, and income. Female respondents were more likely than male respondents to report unfair treatment based on age and sex.

Key words: unfair treatment; Medicare Advantage; health equity; survey.

Introduction

Unfair treatment in the health care setting because of one's personal characteristics is one of many factors contributing to health disparities.[1] Unfair treatment by health care providers or hospitals is associated with worse quality of care and health outcomes, such as delayed treatment, limited access to care, and poor patient care experiences.[2-8] As such, unfair treatment may be an underlying cause of persistent health disparities in the United States, the eradication of which is a national priority.[9]

Assessment of unfair treatment is now instrumental to disparity-reduction efforts in hospitals.[10] Such assessment may be especially important for reducing health care disparities among people with Medicare.[11,12] Large portions of the Medicare population identify with racial and ethnic minority groups, prefer another language to English, have a disability, or have low income and assets.[13,14] Each of these characteristics is a potential basis for unfair treatment. However, no prior study has investigated rates of reported unfair treatment in this population.

Consistent with the broader interest in research to support hospital disparity-reduction efforts, the Centers for Medicare and Medicare Services (CMS) called for testing and the potential inclusion of a measure of unfair treatment in the Medicare Advantage (MA) and Part D Star Ratings program.[15,16] The Star Ratings program is used to measure and compare MA plans to one another using a rating scale from 1 to 5 stars calculated from nationally collected data across a variety of quality-of-care domains.[17]

The present study sought to fill a gap by testing, collecting, and exploring rates of reported unfair treatment in the Medicare population. We describe the prevalence of unfair treatment during health care encounters in the prior 6 months due to a range of personal attributes and how unfair treatment varies by enrollee characteristics in a sample of MA enrollees. To our knowledge, this is the first attempt to document the prevalence of unfair treatment in a national Medicare population.

Data and methods

Data sources

As part of a field test of the MA Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey conducted in July through October 2022, 4712 enrollees from 21 MA plans were randomized to 2 survey administration mode protocols: (1) Web-Mail-Telephone or (2) Mail-Telephone. In the Web-Mail-Telephone protocol, a pre-notification letter was mailed which included the web survey URL and PIN code, followed by an invitation to the web survey by email (when available) or mail, with follow-up by a second reminder invitation. Mail administration was attempted for all web

nonresponders, with follow-up by a second mailing attempt; phone administration was attempted with all mail nonresponders. In the Mail-Telephone protocol, a pre-notification letter was mailed followed by an initial mailing and follow-up by a second mailing attempt. A second questionnaire was mailed to nonrespondents 4 weeks after the initial survey mailing; phone administration was attempted with all mail nonresponders. The response rate (response rate = completes/[total sampled—post-sampling ineligibles]) was 40% (1863 respondents); the mode of survey administration was not pertinent to the present study. Administrative enrollment data were also extracted from the CMS Integrated Data Repository.[18]

Unfair treatment measure

We developed a brief measure of unfair treatment during health care encounters. The development process began with a literature scan of existing, publicly available measures of unfair or insensitive treatment of patients in health care settings. We adapted the equitable treatment measure from CAHPS Cultural Competency Survey items,[19] which asked about unfair treatment in the past 12 months due to race or ethnicity or insurance type. To align with other MA CAHPS items, we shortened the recall period to the past 6 months—a reference period that was selected based on multiple rounds of testing during the development of the MA CAHPS survey[20] and asked about broader categories of unfair treatment. Iterative rounds of cognitive testing were conducted in English and Spanish to test, revise, and re-test the item wording and response list to ensure that they were understood and interpreted as intended. The resulting question, shown in Table 1, asked, "In the last 6 months, did anyone from a clinic, emergency room, or doctor's office where you got care treat you in an unfair or insensitive way because of any of the following things about you?" Respondents answered this question with regard to the following 10 personal characteristics: "health condition, disability, age, culture or religion, language or accent, race or ethnicity, sex (female or male), sexual orientation, gender or gender identity, or income." We include in our denominator anyone who answered any of the items in this set (all but 39 did so, ~2%). We imputed "No" for missing responses

among those who answered some but not all unfair treatment items, as respondents often misunderstand long sequences of yes/no items as a "check-all-that-apply" format.[21] We created a summary measure of any unfair treatment to denote whether a respondent endorsed at least 1 unfair treatment item.

Approximately 2% of respondents (*n* = 39) did not answer any of the unfair treatment question and were removed from analysis (*n* = 1824 respondents; excludes 2.1% missing responses).

Analysis

We calculated rates of unfair treatment overall and by the following enrollee characteristics: disability status, operationalized as original entitlement for Medicare via disability; low-income status, operationalized as dual-eligibility for Medicare and Medicaid or Low-Income Subsidy eligibility (DE/LIS eligible); race and ethnicity; age; and sex. Chi-square tests were performed to evaluate statistically significant differences (*P* < .05) by enrollee characteristics for each unfair treatment category. This study was approved by the RAND Human Subjects Protection Committee.

Limitations

This study had several potential limitations. First, our data were limited to MA enrollees from 21 health plans and may not by generalizable to the broader population of Medicare enrollees or to the general adult population. The 21 plans that participated had sufficient enrollment to allow for oversampling of respondents for this study beyond the sample needed for their participation in the national MA CAHPS survey. Enrollees in smaller plans are therefore underrepresented in our sample. Second, the sample size provided adequate (80%) power for a 2-sided test with alpha = .05 to detect differences of 1.0%–1.7% from the overall average for a 20% subgroup when the overall prevalence of an unfair treatment category was 3%–9%; smaller differences, which may nonetheless have important implications, may not have been detected. Power was not sufficient to compare individual racial and ethnic groups; the experiences of individual groups may differ substantially, which may be apparent when larger scale data become available. Third, unlike some such measures, the measure of unfair treatment used in this study did not attempt to assess the impact of unfair treatment on those who experience it. Fourth, our measure does not attempt to assess potential causes of unfair treatment, including patient–provider concordance by race and ethnicity or other provider characteristics. The CMS's goal of developing this measure of unfair treatment is to hold plans accountable for this aspect of care, rather than to assess the role of individual providers. Fifth, while respondents are required to report on events over a 6-month period, evidence suggests that recall is good for patient experiences over such an interval[20]; events of unfair treatment may be especially salient.[22,23] Sixth, we did not explicitly screen for utilization in the past 6 months, which could, in principle, underestimate the rate of unfair treatment. However, 90% of those responding to this item reported utilization in the past 6 months outside of emergency department and urgent care settings; the remaining 10% reported similar rates of unfair treatment and may have been referencing care in emergency department or urgent care settings.

Table 1. Unfair treatment item question wording and prevalence.

In the last 6 months, did anyone from a clinic, emergency room, or doctor's office where you got care treat you in an unfair or insensitive way because of any of the following things about you?

	Yes	No	Prevalence
a. Health condition	☐	☐	6.3%
b. Disability	☐	☐	2.9%
c. Age	☐	☐	2.0%
d. Culture or religion	☐	☐	1.0%
e. Language or accent	☐	☐	1.2%
f. Race or ethnicity	☐	☐	1.0%
g. Sex (female or male)	☐	☐	0.9%
h. Sexual orientation	☐	☐	0.4%
i. Gender or gender identity	☐	☐	0.4%
j. Income	☐	☐	1.0%
ANY RESPONSE			9.4%

We imputed "No" for respondents who answered some but not all unfair treatment items as it is common
for respondents to misunderstand long sequences of similar items as a "check-all-that-apply" format.[24]
Approximately 2% of respondents (*n* = 39) did not answer any of the unfair treatment questions and were
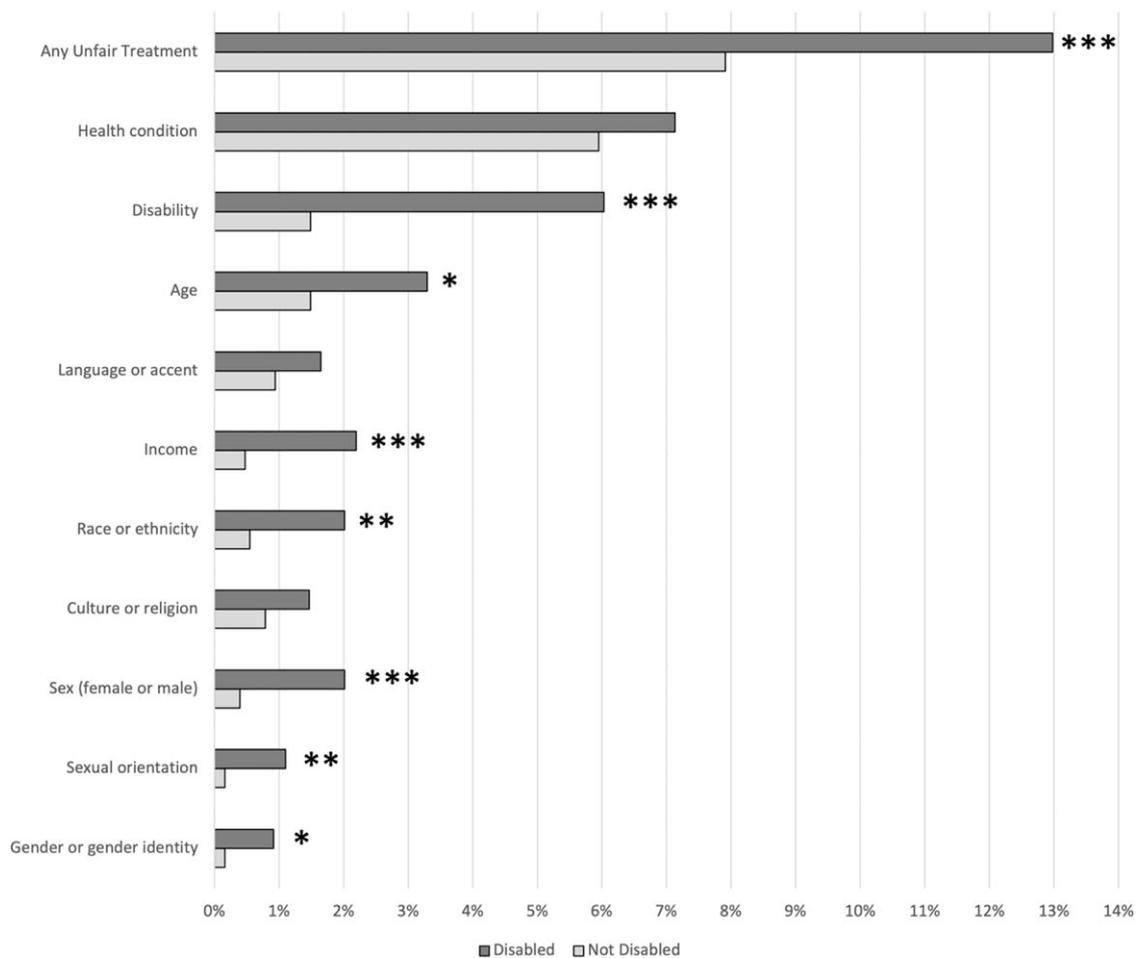removed from analysis. *n* = 1824 respondents; excludes 2.1% missing responses.

Figure 1. Rate of unfair treatment and disability status. Significance levels: *.01 ≤ *P* < .05, **.001 ≤ *P* < .01, and ***P* < .001 indicate significant difference between groups. *n* = 1824 respondents.

Results

Comparison of respondent characteristics with the MA population

Most respondents were 65–79 years old (65%), female (63%), not DE/LIS eligible (56%), without disabilities (70%), White (67%), and had a high school degree but not a 4-year college degree (58%) (see Appendix Table 1). Respondents were similar to those sampled and to all MA CAHPS respondents in a larger national survey.

Prevalence of unfair treatment

As shown in Table 1, rates of unfair treatment based on different characteristics ranged from 0.4% to 6.3%, with 9.4% of respondents reporting any unfair treatment; the proportion reporting any unfair treatment among the 90% of patients who reported any health care utilization in the prior 6 months (9.6%) was similar to the rate among all respondents (9.4%; *P* = .50 for those with and without reported utilization). The most commonly endorsed unfair treatment category was health condition (6.3%), followed by disability (2.9%) and age (2.0%). Unfair treatment by culture or religion, language or accent, race or ethnicity, sex, and income were each reported by approximately 1% of respondents. Unfair treatment due to sexual orientation and gender or gender identity were each reported by less than 1%.

Of respondents who reported any unfair treatment, 38% endorsed multiple unfair treatment categories. As shown in Appendix Table 2, respondents who reported multiple categories of unfair treatment most often endorsed health condition (69%), followed by disability (66%), age (43%), language or accent (29%), and culture or religion (26%). Respondents most commonly reported unfair treatment based on health condition and disability jointly, accounting for 57% of the instances in which a person cited multiple categories of unfair treatment. An additional 12% of those instances involved reports of unfair treatment based on health condition, disability, and age. Other combinations were endorsed by 3% or less of respondents who cited multiple categories of unfair treatment.

Unfair treatment by disability status

As shown in Figure 1, MA enrollees who qualified for Medicare via disability benefits more often reported unfair treatment than those who qualified via age (13.0% vs 7.9%). Those who qualified for Medicare via disability were at least 5 times more likely to report unfair treatment by sex (2.0% vs 0.4%), sexual orientation (1.1% vs 0.2%), and gender or gender identity (0.9% vs 0.2%); 4 times more likely to report unfair treatment by disability (6.0% vs 1.5%), income (2.2% vs 0.5%), and race or ethnicity (2.0% vs 0.5%); and twice as likely to report unfair treatment by age (3.3% vs 1.5%) as those who qualified via age (*P* < .05 for all differences).
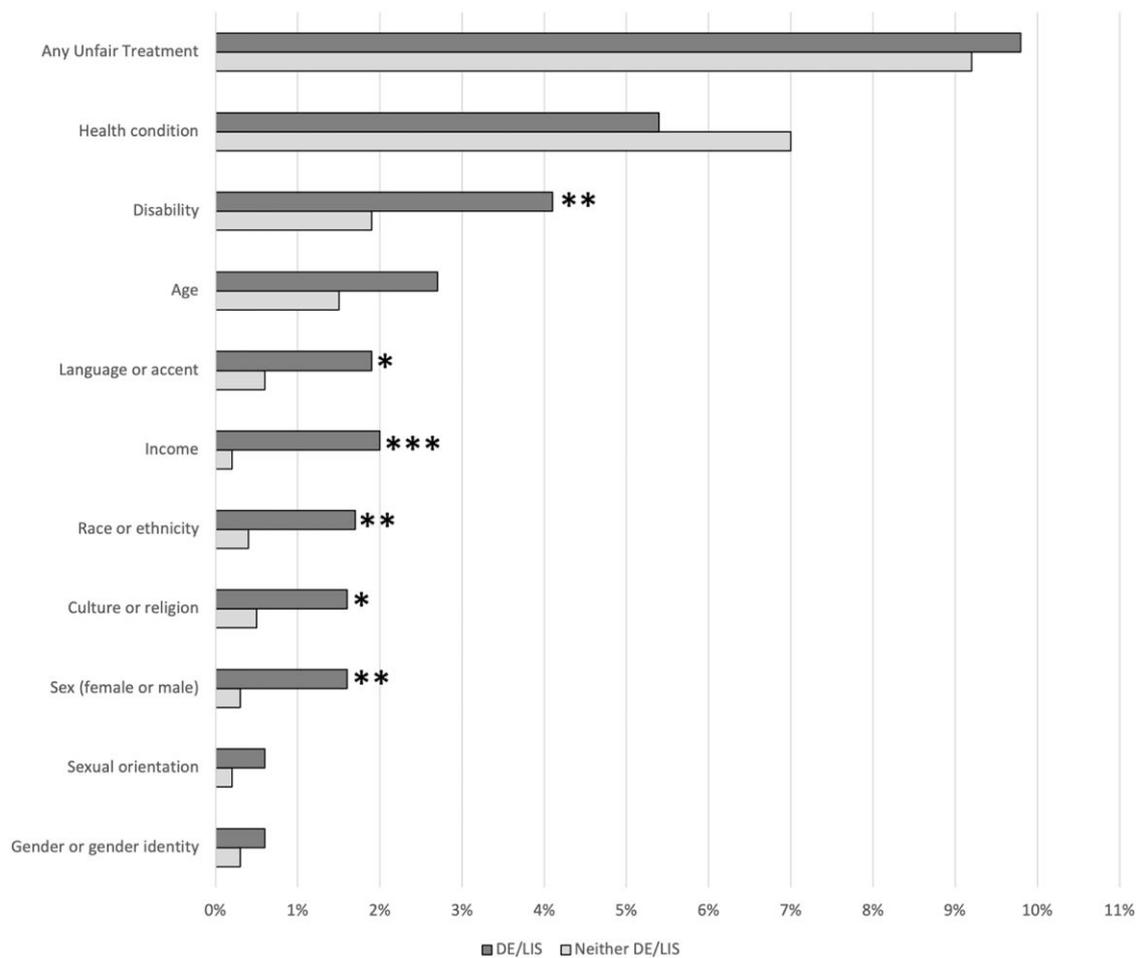
Figure 2. Rate of unfair treatment and DE/LIS status. Significance levels: *.01 ≤ *P* < .05, **.001 ≤ *P* < .01, and ***P* < .001 indicate significant difference between groups. *n* = 1824 respondents. Abbreviation: DE/LIS, eligible for a Low-Income Subsidy.

Unfair treatment by DE/LIS status

While DE/LIS eligible enrollees reported experiencing unfair treatment of any kind at rates similar to those of non-DE/LIS enrollees, they were 10 times more likely to report unfair treatment by income (2.0% vs 0.2%), 4 times more likely to report unfair treatment by race or ethnicity (1.7% 0.4%), 3 times more likely to report unfair treatment by language or accent (1.9% vs 0.6%) and culture or religion (1.6% vs 0.5%), and twice as likely to report unfair treatment by disability (4.1% vs 1.9%) as other enrollees (Figure 2) (*P* < .05 for all differences).

Unfair treatment by race and ethnicity

Racial and ethnic minority respondents were grouped to ensure adequate statistical power. Medicare Advantage enrollees who identified with racial and ethnic minority groups were 8 times more likely to report unfair treatment by income (2.4% vs 0.3%) and approximately 4 times more likely to report unfair treatment by language or accent (2.4% vs 0.6%), race or ethnicity (2.1% vs 0.6%), and culture or religion (2.1% vs 0.6) than White MA enrollees (see Figure 3). Conversely, White MA enrollees were nearly twice as likely as other enrollees to report unfair treatment by health condition (7.5% vs 4.1%).

Unfair treatment by sex

Male and female respondents reported similar rates of unfair treatment, with 2 exceptions. Female respondents were more than twice as likely to report unfair treatment by age (2.6% vs 1.0%) and 13 times as likely to report unfair treatment by sex (1.3% vs 0.1%) (see Appendix Figure 1) (*P* < .05 for both differences).

Discussion

In this study, we found that almost 1 in 10 MA enrollees reported experiencing unfair treatment in a health care setting. This finding is consistent with the small number of studies that have investigated this issue among older adults.[19,24,25] However, our summary measure incorporated more categories of unfair treatment than measures used in other studies and used a shorter recall period.

The most commonly reported categories of unfair treatment were health condition and disability. Reported unfair treatment varied strongly by enrollee characteristics, with a much greater prevalence among those with disabilities and limited income and assets. Racial and ethnic minority enrollees were more likely than White enrollees to report unfair treatment based on race and ethnicity, language or accent, culture or religion, and income. While some variation in unfair treatment categories varied by a corresponding enrollee characteristics
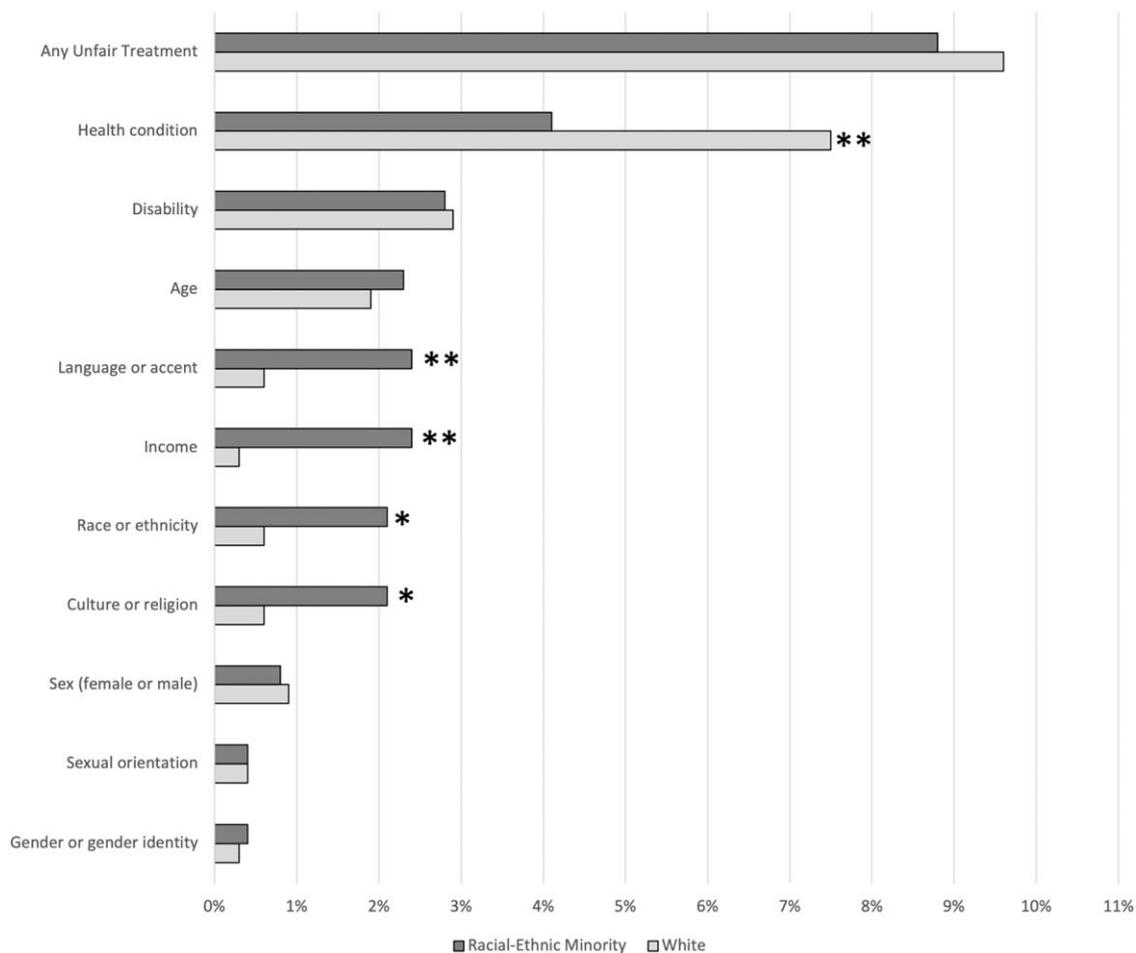
Figure 3. Rate of unfair treatment and respondent race and ethnicity. Significance levels: *.01 $\leq P <$ .05 and **.001 $\leq P <$ .01 indicate significant difference between groups. $n = 1824$ respondents.

(eg, more unfair treatment by sex for women than men), there was also variation by characteristics with a less direct correspondence; for example, women were more likely than men to report unfair treatment based on their age. The fact that women were more likely than men to report unfair treatment based not only on their sex but also on their age may reflect the enduring phenomenon of gendered ageism.[26]

Unfair treatment may be an important contributor to the health care disparities that have been observed among people with Medicare.[27] A recent study found that unfair treatment and anticipation of future unfair treatment can lead to disruptions in health care,[28] potentially exacerbating health disparities.

The CMS plans to include a measure of unfair treatment as a display measure in the MA and Part D Star Ratings program starting with the 2025 Star Ratings and to provide detailed information to individual plans.[15] Routine collection of this information would allow monitoring of trends in reported unfair treatment and help identify opportunities to promote equitable care.

Acknowledgments

Supplementary material
Supplementary material is available at *Health Affairs Scholar* online.

Funding

Conflicts of interest
Please see ICMJE form(s) for author conflicts of interest. These have been provided as supplementary materials.

Notes
1. Davis BA. Discrimination: a social determinant of health inequities. *Health Aff Forefront*. 2020.
2. Bazargan M, Cobb S, Assari S. Discrimination and medical mistrust in a racially and ethnically diverse sample of California adults. *Ann Fam Med*. 2021;19(1):4-15. https://doi.org/10.1370/afm.2632
3. Cummings L. *Listening to Black Californians: How the Health Care System Undermines Their Pursuit of Good Health*.

California HealthCare Foundation; 2022:1-39. https://www.chcf.org/wp-content/uploads/2022/09/ListeningBlackCalifornians.pdf

4. Shavers VL, Fagan P, Jones D, et al. The state of research on racial/ethnic discrimination in the receipt of health care. *Am J Public Health*. 2012;102(5):953-966. https://doi.org/10.2105/AJPH.2012.300773

5. Van Houtven CH, Voils CI, Oddone EZ, et al. Perceived discrimination and reported delay of pharmacy prescriptions and medical tests. *J Gen Intern Med*. 2005;20(7):578-583. https://doi.org/10.1111/j.1525-1497.2005.0123.x

6. Han X, Call KT, Pintor JK, Alarcon-Espinoza G, Simon AB. Reports of insurance-based discrimination in health care and its association with access to care. *Am J Public Health*. 2015;105(Suppl 3):S517-S525. https://doi.org/10.2105/ajph.2015.302668

7. Colen CG, Ramey DM, Cooksey EC, Williams DR. Racial disparities in health among nonpoor African Americans and Hispanics: the role of acute and chronic discrimination. *Soc Sci Med*. 2018;199:167-180. https://doi.org/10.1016/j.socscimed.2017.04.051

8. Sorkin DH, Ngo-Metzger Q, De Alba I. Racial/ethnic discrimination in health care: impact on perceived quality of care. *J Gen Intern Med*. 2010;25(5):390-396. https://doi.org/10.1007/s11606-010-1257-5

9. Office of Disease Prevention and Health Promotion. Healthy People 2030. Accessed September 29, 2023. https://health.gov/healthypeople

10. Chapman EN, Kaatz A, Carnes M. Physicians and implicit bias: how doctors may unwittingly perpetuate health care disparities. *J Gen Intern Med*. 2013;28(11):1504-1510. https://doi.org/10.1007/s11606-013-2441-1

11. Martino SC, Mathews M, Dembosky JW, Haviland AM, Elliott MN. Disparities in health care in Medicare Advantage associated with dual eligibility or eligibility for a low-income subsidy and disability. 2023. Accessed October 3, 2023. https://www.cms.gov/files/document/2023-disparities-health-care-medicare-advantage-associated-dual-eligibility-or-eligibility-low.pdf

12. Martino SC, Elliott MN, Dembosky JW, et al. Disparities in health care in Medicare Advantage by race, ethnicity, and sex. 2023. Accessed October 3, 2023. https://www.cms.gov/files/document/disparities-health-care-medicare-advantage-race-ethnicity-and-sex.pdf-0

13. Ali A, Scior K, Ratti V, Strydom A, King M, Hassiotis A. Discrimination and other barriers to accessing health care: perspectives of patients with mild and moderate intellectual disability and their carers. *PLoS One*. 2013;8(8):e70855. https://doi.org/10.1371/journal.pone.0070855

14. De PK. Beyond race: impacts of non-racial perceived discrimination on health access and outcomes in New York City. *PLoS One*. 2020;15(9):e0239482. https://doi.org/10.1371/journal.pone.0239482

15. Centers for Medicare & Medicaid Services. Advance Notice of Methodological Changes for Calendar Year (CY) 2024 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies 2023. Accessed October 4, 2023. https://www.cms.gov/files/document/2024-advance-notice-pdf.pdf

16. Centers for Medicare & Medicaid Services. Announcement of Calendar Year (CY) 2023 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies 2022. Accessed October 11, 2023. https://www.cms.gov/files/document/2023-announcement.pdf

17. Centers for Medicare & Medicaid Services. Part C and D Performance Data. 2024. Accessed October 4, 2023. https://www.cms.gov/medicare/health-drug-plans/part-c-d-performance-data

18. Centers for Medicare & Medicaid Services. Integrated Data Repository (IDR). Accessed September 29, 2023. https://www.cms.gov/about-cms/information-systems/idr

19. Weech-Maldonado R, Carle A, Weidmer B, Hurtado M, Ngo-Metzger Q, Hays RD. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) cultural competence (CC) item set. *Med Care*. 2012;50(9 Suppl 2):S22-S31. https://doi.org/10.1097/MLR.0b013e318263134b

20. Schnaier JA, Sweeny SF, Williams VS, et al. Special issues addressed in the CAHPS™ survey of Medicare managed care beneficiaries. *Med Care*. 1999;37(3 Suppl):MS69-MS78.

21. Stevens AC, Courtney-Long EA, Okoro CA, Carroll DD. Peer reviewed: comparison of 2 disability measures, behavioral risk factor surveillance system, 2013. *Prev Chronic Dis*. 2016;13:E106.

22. Kanouse DE, Hanson LR. *Negativity in Evaluations*. Morristown, NJ: General Learning Press; 1972.

23. Rozin P, Royzman EB. Negativity bias, negativity dominance, and contagion. *Pers Soc Psychol Rev*. 2001;5(4):296-320.

24. Doty MM, Horstman C, Shah A, Ayo-Vaughan M, Zephyrin LC. How discrimination in health care affects older Americans, and what health systems and providers can do. 2022. Accessed October 11, 2023. https://www.commonwealthfund.org/publications/issue-briefs/2022/apr/how-discrimination-in-health-care-affects-older-americans#:~:text=Older%20adults%20in%20the%20United%20States%20are%20more,with%20their%20peers%20in%2010%20other%20high-income%20countries

25. Nguyen TT, Vable AM, Glymour MM, Nuru-Jeter A. Trends for reported discrimination in health care in a national sample of older adults with chronic conditions. *J Gen Intern Med*. 2018;33(3):291-297. https://doi.org/10.1007/s11606-017-4209-5

26. Rochon PA, Kalia S, Higgs P. Gendered ageism: addressing discrimination based on age and sex. *Lancet*. 2021;398(10301):648-649.

27. Skopec L, Gonzalez D, Kenney GM. *Most Adults Who Feel Treated or Judged Unfairly by Health Care Providers Report Adverse Consequences*. Urban Institute; 2021.

28. Gonzalez D, Karpman M, Kenney GM, McDaniel M. To what extent are parents and children exposed to bias and unfair treatment in health care? 2023. Accessed October 4, 2023. https://www.urban.org/sites/default/files/2023-07/To%20What%20Extent%20Are%20Parents%20and%20Children%20Exposed%20to%20Bias%20and%20Unfair%20Treatment%20in%20Health%20Care.pdf