How Medicare Advantage Plans Market to Veterans—and Why It Matters for VA Spending

Melissa Hafner, MPP; Robyn Elkins, MA; Juana Ruiz, BS; Susan Joy, MA, MPH

Why Medicare Advantage Plans Want to Enroll Veterans

Many veterans aged 65 and older are eligible to receive health benefits from the Veterans Health Administration (VHA) as well as Medicare. Federal health programs such as Medicare and Medicaid have rules that determine "payer precedence"—that is, which program pays first when an individual has more than one type of coverage. No such rule exists, however, between Medicare and the VHA. This lack of a payer precedence rule raises significant risks for duplicative payments in Medicare Advantage (MA) plans. Recent research has shown that between 2019 and 2023, VHA spending on care for veterans enrolled in MA plans grew by 77%, even as veteran enrollment in MA plans also increased, suggesting that MA plans are not serving as a substitute for VHA care.[1] One study estimated that Medicare paid $1.32 billion in 2020 for MA enrollees with VHA benefits who received no services from their MA plan, and there is likely to be significant excess spending for other veterans who used a mix of VHA- and MA-funded services.[2]

MA plans are privately operated health plans that receive a prospective monthly payment from Medicare for each enrolled member (whether they use health services or not), and the monthly payment is adjusted up or down based on the individual's health status. Therefore, MA enrollees who can use other sources of coverage to pay for their care are more profitable for the plan. If a veteran is enrolled in an MA plan but receives most of their care through the VHA, the MA plan does not pay for those services and retains more of the revenue from the monthly payment. Given this payment structure, MA organizations have an incentive to enroll veterans in their MA plans to receive the monthly payment and steer them to VHA-financed care. Because there is no payment reconciliation between MA and VHA, however, the government can end up paying for the same care twice—once through the prospective monthly payment to the MA plan and again for the VHA services.

Recent research has examined plan-level differences between veteran-targeted plans and other MA plans, finding that veteran-targeted plans had benefit designs that likely would be attractive to veterans who obtain some of their care through the VHA, thus making them lower cost enrollees for

[1] Trivedi, A. N., Jiang, L., Meyers, D. J., Schwartz, A. L., Kizer, K. W., & Yoon, J. (2025). Spending by the Veterans Affairs Health Care System for Medicare Advantage enrollees. *JAMA Health Forum, 6*(12), e255653. doi:10.1001/jamahealthforum.2025.5653

[2] Ma, Y., Phelan, J., Jeong, K. Y., Tsai, T. C., Frakt, A. B., Pizer, S. D., Garrido, M. M., Dorneo, A., & Figueroa, J. F. (2024). Medicare Advantage plans with high numbers of veterans: Enrollment, utilization, and potential wasteful spending. *Health Affairs*, *43*(11). https://www.healthaffairs.org/doi/10.1377/hlthaff.2024.00302

the MA plan.[3] For example, veteran-targeted MA plans are far less likely to offer Medicare Part D drug coverage (a benefit typically offered through the VHA) and more likely to offer $0 premiums. From the perspective of the veterans who enroll in MA, these plans are an additional source of health coverage at little to no cost. These plans raise concerns, however, about wasteful spending to the extent that they duplicate coverage available through the VHA or includes incentives—such as higher copays or deductibles in MA—that encourage veterans to seek care through the VHA.

In addition to tailoring their benefits, MA organizations may be employing marketing strategies to appeal to veterans. We sought to better understand the features of marketing materials used by veteran-targeted plans and how those features might attract veterans who are likely to use the VHA for most of their care.

Analysis Approach

Using the 2026 CMS Landscape file,[4] we identified veteran-targeted plans by using a set of key terms included in the names of MA plans: *courage*, *eagle*, *freedom*, *honor*, *liberty*, *patriot*, *salute*, *valiance*, *valor*, and *veteran*.[5] This approach yielded 51 veteran-targeted plans in 46 states. Between January and March 2026, we collected publicly available marketing materials from the websites and social media accounts of MA organizations, veteran groups, or agents and brokers (Appendix A includes a detailed methodology). We coded the marketing materials to analyze:

- the channels that MA organizations use when marketing to veterans,
- affiliations with veteran organizations (e.g., American Legion),
- imagery and language,
- highlighted benefits and services,
- cost sharing that might appeal to veterans, and
- references to specific VHA-MA benefit coordination or concierge services that may help steer enrollees to seek care from the VHA.

Findings

Among 26 of the 51 plans, we identified 69 marketing materials aimed at veterans. Among the remaining 25 plans, we found only general advertisements, summaries of benefits, or a plan website, but these results contained no references to veterans.

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[3] Dorneo, A., Ma, Y., Garrido, M. M., Pizer, S. D., Shafer, P. R., Tsai, T. C., Frakt, A. B., & Figueroa, J. F. (2025). Characteristics and benefit design of veteran Medicare Advantage Affinity Plans. *JAMA Health Forum, 6*(3), e250159. https://jamanetwork.com/journals/jama-health-forum/fullarticle/2831837

[4] Centers for Medicare and Medicaid Services. *Prescription drug coverage - General information. CY2026 Landscape (202603)*. https://www.cms.gov/medicare/coverage/prescription-drug-coverage

[5] See Footnote 2 for previous research that identified the set of key words frequently used in veteran-targeted MA plans.

Plan websites and social media are the most common sources for veteran-targeted marketing materials.

Most materials appeared on plans' websites (54%) or social media channels (26%), with the remainder distributed through veteran-affiliated groups or marketing intermediaries, such as agents or brokers. For example, we identified several web-based TV advertisements featuring a veteran who also serves as a broker and a live TV spot aired during the annual enrollment period that featured an MA organization executive. Similarly, one MA plan's broker handbook notes that the plan has an online store that includes marketing materials designed specifically for veterans. In addition, content from MA organizations' social media accounts shows that these organizations host or support veteran-focused events to reach these beneficiaries.[6]

Exhibit 1. Sources of Veteran-Targeted Marketing Materials

Marketing channel	Number (percentage) of marketing materials (*n* = 69)
Carrier web page	37 (54%)
Carrier social media	17 (25%)
Other social media (e.g., agent or broker veteran affiliated organization)	3 (4%)
Video or television placement	6 (10%)
Other marketing materials	5 (7%)

Veteran affiliated groups and patriotic imagery are common features of marketing materials.

We identified seven out of 51 plans (14%) that mentioned affiliations with veteran-related groups, such as USAA, the American Legion, Veterans of Foreign Wars, and AMVETS (American Veterans). Across these seven plans, we found 23 marketing materials that included such references. Emphasizing strong relationships with veteran groups may help plans position themselves as allies to veterans—for example, by stating that they are recommended by veterans' service organizations (VSOs). Referencing these organizations in marketing materials could help lend legitimacy to plans' claims about their ability to serve veterans and suggest that other veterans have had positive experiences with the plan.

In addition to receiving endorsements from VSOs, MA organizations used marketing materials to show their commitment to supporting veterans in other aspects of life beyond health care. For example, some highlighted their efforts to support veteran-related causes, such as fundraising initiatives to support veteran meal programs. In another case, an MA organization reported being the founding

[6] We included social media results in our analysis if they were clearly marketing related, such as mentioning the plan name or showing plan employees engaging in marketing during an event. We did not include social media results with more general messaging (e.g., observance of Veterans Day or general veteran appreciation).

sponsor of the HonorCare program, described as a "health care initiative designed to support Medal of Honor recipients and their families." Similarly, some MA organizations highlighted their commitment to helping veterans in other ways, such as being a "top military-friendly employer" and emphasizing targeted hiring initiatives aimed at employing veterans. Others mentioned their sponsorship of large-scale social events for veterans.

We identified 42 instances of patriotic imagery in 19 (37%) of the plans analyzed. The American flag appeared most frequently (20 instances across 11 plans). Plans also commonly depicted individuals wearing caps that identified military service (e.g., "Vietnam veteran" or "veteran"), appearing 18 times across 14 plans. Images of individuals in military uniforms were less common (nine instances across five plans). Additional patriotic imagery—including individuals saluting, a battleship, and individuals wearing shirts indicating military service—appeared less frequently.

This use of patriotic imagery is reflected in marketing strategies publicly shared by the firms that designed these campaigns. We identified two examples of plans' marketing strategies posted online by the firms responsible for the campaigns. The strategies emphasize "military values" such as service, trust, and respect as well as "iconography associated with serving our country." One marketing strategy stated that the campaign generated more than 1,000 enrollments in 2025 and more than $11 million in gross revenue for the plan.

Veteran-targeted plans emphasize supplemental benefits and behavioral health care.

Supplemental benefits were frequently highlighted across the marketing materials for the plans analyzed. Dental benefits appeared 32 times across 17 plans, vision or eyewear benefits appeared 30 times across 17 plans, and hearing benefits appeared 22 times across 13 plans. Materials also mentioned over-the-counter medication benefits or allowances, which appeared 12 times across 11 plans. Plans included additional benefits—such as fitness and gym access and transportation to medical visits or Department of Veterans Affairs (VA) sites—though these benefits appeared less frequently. Transportation to VA sites could encourage enrollees to seek care through the Veterans Health Administration (VHA) rather than through the MA plan, potentially reducing costs for the MA organization.

Plans positioned supplemental services as a key feature for VA beneficiaries, likely because VHA coverage of these services varies by eligibility. For example, the VHA covers dental benefits for beneficiaries with a service-connected dental disability or condition or who meet other specific criteria, although VA beneficiaries may be able to buy dental insurance at a reduced cost through the VA Dental Insurance Program.[7] Similarly, the VHA covers routine eye exams and preventive vision testing but does not cover eyewear unless the beneficiary has a compensable service-connected disability or vision problems related to illness or injury for treated through the VHA.

[7] U.S. Department of Veterans Affairs. (2026). *VA dental care*. https://www.va.gov/health-care/about-va-health-benefits/dental-care/

Beyond highlighting supplemental benefits, a smaller subset of materials focused on veterans' specific health needs. Among the limited number of materials that referenced specific health conditions (*n* = 9), all focused on mental and behavioral health—most commonly suicide prevention and post-traumatic stress disorder. Research has shown that behavioral health conditions are prevalent and growing among veterans[8,9] and that veterans continue to face barriers to accessing behavioral health care through the VHA, despite the expansion of Community Care, a policy change that was intended to expand access to behavioral health care delivered by clinicians and hospitals outside the VA health care system.[10,11]

Although these veteran-targeted marketing materials emphasized access to behavioral health care that may appeal to veterans who face challenges obtaining such care through VHA benefits, research has shown that MA plan enrollees face similar barriers. One study found that enrollees with behavioral health conditions faced higher out-of-pocket costs than those enrolled in traditional Medicare,[12] while another found that beneficiaries accessed more mental health services after leaving MA plans, suggesting limitations in MA plans' mental health benefits or provider networks.[13]

In contrast to the emphasis on behavioral health, physical health conditions were rarely mentioned in the marketing materials reviewed. Although some materials included imagery of individuals using canes or wheelchairs—possibly acknowledging higher rates of disability among veterans—services related to disability, such as physical therapy, occupational therapy, or rehabilitation, were not highlighted.

Low or $0 cost sharing may help attract veterans because of variability of VHA costs.

In our sample of veteran-targeted plans, 16 of 51 plans (31%) included information about cost sharing in their marketing materials. Across all materials reviewed, 34 included references to cost sharing. These materials were released by a roughly even mix of health maintenance organizations (HMOs; *n* = 16) and preferred provider organizations (PPOs; *n* = 18). Most highlighted $0 premiums and free preventive care, such as primary care provider (PCP) visits and dental, hearing, and vision screenings. A smaller number mentioned $0 deductibles, and some listed copay amounts for several different

[8] Gates, M. A., Holowka, D. W., Vasterling, J. J., Keane, T. M., Marx, B. P., & Rosen, R. C. (2012). Posttraumatic stress disorder in veterans and military personnel: Epidemiology, screening, and case recognition. *Psychological Services, 9*(4), 361–382.
[9] Liu, Y., Collins, C., Wang, K., Xie, X., & Bie R. (2019). The prevalence and trend of depression among veterans in the United States. *Journal of Affective Disorders, 245*, 724–727. https://www.sciencedirect.com/science/article/abs/pii/S0165032718319013?via%3Dihub
[10] Vanneman, M. E., Roberts, E. T., Li, Y., Sileanu, F. E., Essien, U. R., Mor, M. K., Fine, M. J., Thorpe, C. T., Radomski, T. R., Suda, K. J., & Gellad, W. F. (2025). Experiences with VA-purchased community care for US veterans with mental health conditions. *JAMA Network Open, 8*(5), e2511548. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2834351
[11] Rasmussen, P., & Farmer, C. M. (2023). The promise and challenges of VA community care: Veterans' issues in focus. *Rand Health Quarterly, 10*(3), 9. https://www.rand.org/pubs/periodicals/health-quarterly/issues/v10/n3/09.html
[12] Park, S., Meyers, D., Jimenez, D. E., Gualdrón, N., & Le Cook, B. (2024). Health care spending, use, and financial hardship among traditional Medicare and Medicare Advantage enrollees with mental health symptoms. *American Journal of Geriatric Psychiatry*. https://doi.org/10.1016/j.jagp.2024.01.014
[13] Liu, A., Ayers, B., & Meiselbach, M. (2025). Mental health care use after leaving Medicare Advantage for traditional Medicare. *American Journal of Managed Care, 31*(12), 765–771. https://www.ajmc.com/view/mental-health-care-use-after-leaving-medicare-advantage-for-traditional-medicare

services. Similarly, some marketing materials highlighted reductions in enrollees' Part B premiums through a "buyback."[14]

Some materials did not provide explicit information on cost-sharing details but instead included broader claims about lowering enrollees' costs. For example, one plan website noted that enrollees could combine VA and MA benefits in a way that minimizes out-of-pocket costs. Another proposes an MA-only plan as the "final piece in your coverage puzzle" for enrollees whose needs were largely met by existing plan or benefits.

Low or $0 cost sharing is generally appealing to enrollees, but for veterans, whose VHA benefits may vary, it may function as an additional layer of no-cost coverage. Eligibility for VHA benefits, and associated cost sharing, depend on a veteran's "priority grouping," which factors in military service history, disability rating, income level, Medicaid eligibility, and other benefits they may be receiving (for example, VA pension benefits).[15] Notably, as of 2024, nearly half of veterans enrolled in VHA care were in the top two priority groups, meaning they had little or no cost sharing when obtaining health care through the VHA.[16]

Some MA plans with low or $0 cost sharing may also require, or offer small financial incentives for, health risk assessments obtained through home visits or annual wellness visits. During these visits, providers collect information on enrollees' health status, health risks, and daily activities. Research has shown that MA plans use information obtained from these visits to collect diagnosis codes that enable enrollees to receive higher risk-adjusted payments from CMS.[17,18]

Veteran-targeted MA plans may use care coordination or other benefits to encourage reliance on VA care.

A subset of veteran-targeted marketing materials (15%) emphasized assistance with navigating VA and MA benefits or framed MA coverage as low-cost "wrap-around" insurance rather than as comprehensive coverage of Medicare Part A and Part B services. These materials often highlighted supplemental benefits—such as urgent care, dental, or vision—while downplaying the full range of services that MA plans are required to cover. For example, one plan's materials stated that "[T]he VA encourages you to sign up for Medicare as soon as you can if you think you'll need health care outside

[14] Lankford, K. (2024, September 29). *What is a Social Security Medicare premium refund?* AARP. https://www.aarp.org/medicare/social-security-medicare-premium-refund/
[15] U.S. Department of Veterans Affairs. *VA priority groups*. https://www.va.gov/health-care/eligibility/priority-groups/
[16] Minhas A. (2026). *Share of veterans enrolled in the VA health care system from 2018 to 2024, by priority groups*. Statista. https://www.statista.com/statistics/1369584/veterans-enrolled-in-the-va-healthcare-system-in-the-us/?srsltid=AfmBOootn_xWvC4OFq69-MrdO9IiixHS0YBcAfQ-2GSfzFcTCzPWkmQN.
[17] Office of Inspector General, U.S. Department of Health and Human Services. (2024). *Medicare Advantage: Questionable use of health risk assessments continues to drive up payments to plans by billions*. Report number: OEI-03-23-00380. https://oig.hhs.gov/reports/all/2024/medicare-advantage-questionable-use-of-health-risk-assessments-continues-to-drive-up-payments-to-plans-by-billions/
[18] Jung, J., Feldman, R., & Carlin, C. (2023). Coding intensity through health risk assessments and chart reviews in Medicare Advantage: Does it explain resource use? *Medical Care Research and Review, 80*(6), 641–647. https://journals.sagepub.com/doi/10.1177/10775587231191169

of their system," positioning the MA plan primarily as a complement to VA care rather than as a full source of coverage.

Several marketing materials also described navigation or coordination services related to VA systems. For example, one video message stated, "We can help steer a veteran toward economic stability, stable housing, even access to healthcare through VA," while another plan described hosting events where veterans could learn about receiving care through a local Veterans Home. Although such services are not inherently inappropriate, they may create opportunities for MA organizations to influence where enrollees seek care after enrollment. This incentive is notably absent in traditional Medicare because beneficiaries with coverage through both programs can choose to receive care funded directly by either program on a fee-for-service basis, no health insurance intermediary benefits from steering the beneficiary to one program or the other.

In some cases, benefit design appeared to encourage reliance on VHA-financed care. For example, one plan offered unlimited transportation to VA facilities but limited transportation to non-VA medical facilities to 20 one-way rides, a structure that could incentivize enrollees to obtain care through the VHA rather than through MA provider networks.

Overall, these materials tended to emphasize the role of MA plans in filling gaps in provider availability or offering supplemental benefits, rather than reinforcing that MA plans are required to cover all Medicare Part A and Part B services. By framing MA coverage primarily as wrap-around support, the materials implicitly suggested that veterans would continue to receive most of their care through the VHA. This de-emphasis on physical health care may further reinforce the positioning of MA plans as supplemental coverage, with the implicit assumption that veterans will obtain most physical health services through the VHA.

Conclusion

This analysis shows that a sample of MA plans use targeted marketing strategies designed to appeal to veterans who are likely to rely on the VHA for care. Across marketing materials, these plans commonly emphasize patriotic imagery, affiliations with veterans' service organizations, low or $0 cost sharing, supplemental benefits that may fill gaps in VHA coverage, and services framed as helping veterans navigate or coordinate VHA care. Collectively, these features position MA coverage as low-cost "wrap-around" insurance rather than as a comprehensive alternative to VA-financed care.

Although such marketing may be attractive to veterans—particularly those seeking additional coverage at little or no cost—it raises important questions for federal spending and program oversight. By enrolling veterans who continue to receive most of their care through the VHA, MA plans may collect prospective Medicare payments while bearing limited responsibility for care delivery. Moreover, although the overall number of veteran-targeted plans is small relative to all MA plans, previous research has shown that overall spending on these plans may still be substantial. In the absence of a

payer-precedence rule between Medicare and the VHA, this dynamic creates ongoing risks of duplicative federal spending and misaligned incentives across programs.

These findings underscore the need for closer attention to how MA plans market to veterans and how those messages frame the role of MA coverage relative to VHA benefits. Greater transparency in marketing materials, clearer communication about the scope of MA plan responsibilities, and closer monitoring of veteran-targeted plans may help ensure that enrollment decisions are well informed and that Medicare payments more accurately reflect care delivered. As veteran enrollment in MA continues to grow, addressing and understanding these issues will be increasingly important for protecting both veteran beneficiaries and federal health care spending.

Appendix A. Methodology

Plan Sampling Approach

To identify veteran-targeted Medicare Advantage (MA) plans, in October 2025 we obtained the 2026 CMS Landscape file, which includes 174 MA plan names by state and county.[19] We used a set of key terms included in plan names—*courage*, *eagle*, *freedom*, *honor*, *liberty*, *patriot*, *salute*, *valiance*, *valor*, and *veteran*—to identify veteran-targeted MA plans, which resulted in 129 plans.[20] We note that multiple contract identification numbers (plan IDs) can be assigned to the same plan name (that is, the same plan can have different IDs in different counties and states). Although the benefit designs of these plans may vary across contract IDs, we hypothesize that the choice to use a single plan name means that the MA organization will use the same marketing materials for that plan name across multiple contract IDs and that beneficiaries may search for the plan by name. Because the same plan may be offered in multiple counties and states under the same name, we deduplicated the list based on parent company and plan name, resulting in a list of 51 veteran-targeted plans in 46 states.

Data Collection

Between January and March 2026, we conducted general web searches for publicly available marketing materials from the websites and social media accounts of MA organizations, veteran groups, and agents and brokers. First, we entered the plan name and parent organization name in Google (e.g., "United AARP Medicare Advantage Patriot"). Next, we reviewed all results tabs ("All," "Images," "Videos," and "News") for marketing materials such as brochures, social media posts, advertisements, flyers, videos, or web pages associated with a specific plan.

We saved marketing materials if they included the plan name and mentioned veterans, alluded to veterans' service (e.g., "*For those who have served* . . .") or included other patriotic references. If multiple social media posts or flyers contained identical content, we saved only one version. We included plan summaries of benefits only if they included references to veterans or Veterans Health Administration (VHA) care. We were unable to determine the posting date of certain materials, especially web pages. We included materials such as benefit descriptions if they were no more than 1 year old. We included social media posts up to 5 years old. If we found no results that mentioned veterans for a plan, we saved a screen shot of the general results for documentation purposes. This process resulted in a list of 69 marketing materials from 26 plans.

[19] The file includes 138,344 plan-county-state combinations and 174 unique plan names. Centers for Medicare and Medicaid Services. *CY2026 Landscape (202603)*. https://www.cms.gov/medicare/coverage/prescription-drug-coverage

[20] See Footnote 2 for previous research that identified the set of key words frequently used in veteran-targeted MA plans.

Coding and Analysis

We developed an Excel-based coding sheet to categorize themes and features included in the marketing materials:

- type of marketing material (web, social media, video, etc.),
- affiliations with veteran organizations (e.g., American Legion),
- imagery and language,
- highlighted benefits and services,
- cost sharing, and
- references to specific VHA-MA benefit coordination or concierge services that may help steer enrollees to seek care from the VHA.

We documented the presence of any of these features along with a description to support content analysis. We then calculated the frequency of each feature (see Exhibit 1) and summarized the plan features emphasized, as well as the language, imagery, and affiliations used to appeal to veterans.

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