Medicare and Communities of Color originates from topics in *The Role of Private Health Plans in Medicare: Lessons from the Past, Looking to the Future*, the final report of the Study Panel on Medicare and Markets convened by the National Academy of Social Insurance. The brief also updates information from the Kaiser Family Foundation’s 1999 brief, *Faces of Medicare: Medicare and Minority Americans*. Medicare and Communities of Color is a factual presentation highlighting principal issues in Medicare’s interaction with people of color.1 A National Academy of Social Insurance study panel is examining how Medicare can be a leader in reducing racial and ethnic health disparities among its beneficiaries and the rest of the health system.

Medicare has improved access to care for aged or disabled beneficiaries by providing an entitlement to health care. Medicare is particularly important to people of color, who are more likely than their White counterparts to be uninsured before becoming eligible for Medicare. Despite Medicare’s achievements, evidence shows that beneficiaries of color continue to experience disparities in both health status and health outcomes.2 For example, nearly 70 percent of Black beneficiaries live with hypertension, compared with 50 percent of White beneficiaries.3 Beneficiaries of color are more likely to report lower incomes, and have less supplemental health coverage than White beneficiaries. In a study published in 2004, 28 percent of physicians treating Black Medicare patients reported difficulty providing their patients access to high quality care, as compared with 19 percent of physicians treating White patients.4 The study suggests that structural inequalities in the health care system lead to physicians’ difficulties. Beneficiaries of color also encounter significant difficulty in receiving certain health care treatments.

Medicare, as a social insurance health program, has the responsibility to seek to ensure that all beneficiaries receive the care they are entitled.

Reginald D. Williams II is Health Policy Research Assistant at the National Academy of Social Insurance.

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2 The health care system is an influential factor, although factors outside of health care are recognized determinants of health.


4 In this study, high quality health care is defined as a physician’s ability to access important health care services like referrals to specialists, non-emergency hospital admissions, and high quality diagnostic imaging and ancillary care. Bach, Peter, Hoangmai Pharm, Deborah Schrag, Ramsey Tate, and J. Lee Hargraves. 2004. “Primary Care Physicians Who Treat Blacks and Whites.” *Journal of the American Medical Association* 351(6):575–584.
Medicare's Race and Ethnicity

The face of Medicare is changing: people of color will become a more significant part of Medicare's population over the next generation. America is becoming more diverse, and demographic trends project a considerable change in the nation's racial and ethnic composition. Currently, people of color—Asian, Black, Latino, and Native American people—account for 6.5 million, or 18 percent of the Medicare population over the age of 65. By 2030, people of color will represent more than 25 percent of the population over the age of 65, or 18.6 million people. Figure 1 details the projected growth of communities of color in the elderly population.

Among Medicare's 5.5 million disabled beneficiaries under the age of 65, 1.8 million are beneficiaries of color: 17 percent are Black; 10 percent Latino; and 5 percent other (68 percent are White, non-Latino). Medicare's disabled population is at significantly higher risk for health problems and facing access barriers.

Historical Significance of Medicare

Since its inception, Medicare has significantly improved the lives of people of color. Medicare played a pivotal role in desegregating hospitals by requiring that hospitals comply with the Civil Rights Act of 1964. As a result,
the desegregation of more than 1,000 hospitals occurred in a period of less than four months.8 Medicare also provided a virtually universal entitlement to health insurance, and greatly increased access to care for all over the age of 65 and a substantial number of disabled persons, beginning in 1972. In 1963, before Medicare was created, people of color 75 years and older had an average of 4.8 visits a year to the doctor, compared with 7.5 for White people of the same age group. By 1971, beneficiaries of color saw the doctor at a rate comparable to White beneficiaries, 7.3, compared to 7.1 visits for White beneficiaries.9

Medicare continues to be important in improving access to care for people of color. In 2001, 30 percent of Latino people ages 55–64 are uninsured, but after age 65 only 5 percent are uninsured. Asian and Black beneficiaries have experienced similar gains in access to care after they become eligible for Medicare, as shown in Table 1.10

Medicare’s comprehensive collection of data has made significant contributions to documenting disparities. Medicare’s administrative data set, derived from claims, is a rich record of health information that allows researchers to analyze differences in health care utilization by race and ethnicity. The Medicare Current Beneficiary Survey, administered to a representative sample of beneficiaries, also provides a wealth of information. It is the only comprehensive source of information on the health status, health care use and expenditures, health insurance coverage, and socioeconomic and demographic characteristics of the entire spectrum of Medicare beneficiaries. Along with other sources, these data sets have been essential in evaluating the experiences of people of color in Medicare.

### Health Status of Beneficiaries of Color

In many ways, beneficiaries of color differ from White beneficiaries. Over 40 percent of Black and Latino beneficiaries perceive their health status as fair or poor, compared with 28 percent of

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White beneficiaries. Black and Latino beneficiaries are also more likely to report that they need help with at least one activity of daily living (ADL), such as eating, bathing, dressing, using the toilet, and getting in and out of bed—tasks necessary for independence. In addition, 23 percent of Latino and 20 percent of Black beneficiaries have some type of cognitive impairment, such as Alzheimer’s disease, dementia or other forms of diminished mental capacity, compared to 17 percent of White beneficiaries. Figure 2 displays the poorer health status of Black and Latino beneficiaries compared to White beneficiaries.

The burden of chronic conditions falls more heavily on some beneficiaries of color. Diabetes ranks among the top five chronic conditions among only Black and Latino beneficiaries. Cancer of all types (except skin cancer) is in the top five only for Black beneficiaries. Table 2 displays the top five chronic conditions of beneficiaries by race and ethnicity.

**Low-incomes and Beneficiaries of Color**

Beneficiaries of color are more likely than their White counterparts to have low incomes, often reflecting persisting inequalities in education and employment. Low-income beneficiaries tend to report poorer health status and have more health problems than higher income counterparts. Low-income beneficiaries are also less able to afford Medicare’s premiums and coinsurance requirements. Figure 3 displays poverty among communities of color in Medicare Population.

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Disparities in Supplemental Health Insurance Coverage

Beneficiaries of color are more likely than White beneficiaries to rely solely on Medicare coverage, as beneficiaries of color are also less likely to have private supplemental coverage in the form of individually purchased Medigap or employer-sponsored retiree coverage. Supplemental insurance coverage helps with Medicare premiums and cost sharing. In addition, it usually provides access to prescription drugs and other services not covered by Medicare. Figure 4 details supplemental coverage by race.

Medicaid provides supplemental coverage to many beneficiaries of color. Medicaid, a joint federal and state program for qualified low-income people, typically provides comprehensive supplemental coverage to low-income Medicare beneficiaries. The poorest Medicare beneficiaries are dually eligible for Medicare and Medicaid. Medicaid assistance wraps around Medicare coverage and provides services not covered by Medicare, including prescription drugs, and long-term care. Other low-income Medicare beneficiaries who are not entitled to full Medicaid benefits receive financial assistance with Medicare premiums and cost sharing through the Medicare Savings Program (MSP). About seven million dual eligibles receive full Medicaid benefits or financial assistance through the MSP. A significant number are beneficiaries of color: 21 percent are Black beneficiaries; 15 percent Latino; and 7 percent other, compared with 57 percent White, non-Latino.12

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) will provide an opportunity for many low-income beneficiaries to receive some financial relief from their health care costs. In 2004 and 2005, beneficiaries with incomes below 135 percent of poverty, an amount equal to $12,564 a year for a single person and $16,848 for a couple in 2004, will receive assistance of up to $600 per year for prescription drugs. In 2006, full-benefit, dual-eligible beneficiaries will be required to receive prescription drug benefits from Medicare, instead of Medicaid, but will receive subsidies for drug coverage. Other low-income beneficiaries who do not currently have drug coverage will receive drug subsidies on a sliding scale.

Currently, all beneficiaries except full dual eligibles must apply to receive this benefit. The voluntary enrollment policy may pose a significant barrier to beneficiaries who have historically been less likely to enroll for such assistance.

The MMA also provides about $14 billion in new funding to encourage private health plans to participate in the Medicare Advantage program (formerly Medicare+Choice). Analyses have shown that Medicare’s private plans have provided significant assistance to communities of color and low-income beneficiaries by acting as a safety net for beneficiaries whose income and assets are too high to qualify for Medicaid, but who don’t have retiree health benefits, and cannot afford other supplemental coverage. Medicare’s private plans enroll 11 percent of all Medicare beneficiaries. Among Medicare beneficiaries who live in areas served by Medicare+Choice (M+C) plans and do not have retiree or individual Medigap coverage, beneficiaries of color show a strong preference for M+C. Within this category, Medicare’s private health plans enroll 40 percent of Black and 52 percent of Latino beneficiaries, compared with 39 percent of White beneficiaries.

Despite the improved access to care that Medicare’s private plans provide to beneficiaries, the plans are not a panacea for beneficiaries of color. Increased access to care through private plans has not eliminated the historical disparities in use of services and quality of care observed in the fee-for-service Medicare program. For example, eye examinations for M+C enrollees with

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**Figure 4**

Supplemental Insurance of Medicare Beneficiaries 65 and Older by Race, 2001

<table>
<thead>
<tr>
<th>Type of Supplemental Insurance</th>
<th>White, non-Latino</th>
<th>Black, non-Latino</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Only</td>
<td>5%</td>
<td>13%</td>
</tr>
<tr>
<td>Medicare Plus Other Public*</td>
<td>19%</td>
<td>33%</td>
</tr>
<tr>
<td>Medicare Plus Other Private Supplemental*</td>
<td>20%</td>
<td>19%</td>
</tr>
<tr>
<td>Medicare Job-Sponsored Supplemental*</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Medicare HMO</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>Traditional Medicare Only*</td>
<td>27%</td>
<td>27%</td>
</tr>
</tbody>
</table>

**NOTE:** The presence of an asterisk (*) note that the Black/White comparison is statically significant at p<.05.


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13 Medicare Advantage, private plans in Medicare, will include: health maintenance organizations (HMOs), preferred provider organizations (PPOs), regional PPOs, provider-sponsored organizations (PSOs), private fee-for-service (PFFS) plans, and medical saving accounts (MSA) coupled with high deductible insurance programs.


diabetes, beta-blocker use after heart attacks, and follow-up care after hospitalizations for mental illness show that beneficiaries of color receive a significantly lower quality of care when compared with White beneficiaries.\textsuperscript{17}

**Disparities in Health Care Services in Fee-For-Service Medicare**

Regardless of dramatic improvements in access to care that Medicare provides at age 65, persisting disparities remain in preventive, primary, and surgical care for beneficiaries of color. In fee-for-service Medicare, the unequal use of medical services and lower quality of care for communities of color compared to White beneficiaries is well documented, even when the factors of insurance status and socio-economic status are taken into account. Simply put, race matters.

Significant differences exist among beneficiaries in receiving key diagnostic and preventive screenings. Beneficiaries of color are less likely than White beneficiaries to receive common preventive measures such as mammography, prostate exams, and flu shots. Table 3 shows these disparities in use of mammograms and prostate cancer screening by race and ethnicity. Historically, Black beneficiaries have been less likely than White beneficiaries to get flu shots, although the gap has narrowed in recent years. In 1991, the rate of flu immunizations for Black beneficiaries was only 59 percent of the White beneficiaries’ rate. This improved to 74 percent by 2000.

Disparities are also evident in primary care. Beneficiaries of color are less likely to report having a physician’s office as a usual source of care than their White counterparts. Beneficiaries of color also disproportionately rely on emergency rooms and urgent care clinics or report having no usual source of care. Beneficiaries of color are also less satisfied with their care. Fourteen percent of Black beneficiaries report being very satisfied with their general care, compared with 31 percent of White and 25 percent of Latino beneficiaries.

Delayed treatments and preventable hospitalizations for avoidable medical conditions are also more common among beneficiaries of color, whether the cause is patient lifestyle, physician attitudes, or other institutional and systemic factors. For example, among Black beneficiaries, inade-

\begin{table}[h!]
\centering
\begin{tabular}{|l|c|c|}
\hline
 & Female Beneficiaries & Male Beneficiaries \\
& Who Received & Screened for \\
Mammograms & Prostate Cancer \\
\hline
White, non-Latino & 54\% & 64\% \\
Black, non-Latino & 51\% & 58\% \\
Latino & 47\% & 55\% \\
\hline
\end{tabular}
\caption{Common Preventive Screenings, Race and Ethnicity, 2000}
\end{table}

quate diabetes management leads to more treatments for glaucoma, hospitalizations for hypoglycemic comas, and non-traumatic lower limb amputations.18

Beneficiaries of color are less likely to receive angioplasty, bypass surgery, and proper follow-up care after cardiac episodes. Black beneficiaries’ angioplasty rates are about 60 percent of their White counterparts, bypass surgery rates are 50 percent lower for Black beneficiaries, and Black beneficiaries receive follow-up care after hospitalizations for a cardiac problem at only 80 percent of the rate for White beneficiaries.19 Black beneficiaries are even less likely to receive routine therapy that restores blood flow to vital organs and tissues after a heart attack.20

What causes these disparities? The Institute of Medicine’s 2002 report, Unequal Treatment, concluded that disparities are caused by a complex web of factors based in “historical and contemporary inequities” that involve participants throughout the many layers of the health care system, including patients, health care professionals, administrative and bureaucratic processes, and the health marketplace itself. The report found that personal bias, discrimination, and racism are powerful contributing factors to the unequal treatment of communities of color in America’s health care system.

Conclusion

Medicare’s historical impact on improving access to care for communities of color is unprecedented, and it is a leader in the collection of data on racial and ethnic health disparities. Over the years, Medicare has made efforts to support communities of color and to address racial and ethnic health disparities in Medicare, but significant health disparities remain in both Medicare and the greater American health care system. As communities of color become a larger part of Medicare’s population, addressing their needs and reducing health disparities will become more important to the program’s success. A National Academy of Social Insurance study panel is examining how Medicare, as the nation’s largest purchaser and regulator of health care, can be a leader in reducing racial and ethnic health disparities among its beneficiaries and the rest of the health system.


This brief is the eleventh in a series on Medicare. It is drawn from topics discussed in The Role of Private Health Plans in Medicare: Lessons from the Past, Looking to the Future, the final report of the Study Panel on Medicare and Markets convened by the National Academy of Social Insurance. The report was published in November 2003. This brief was supported by a grant from The Robert Wood Johnson Foundation.

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