

Medicare and Communities of Color

By Reginald D. Williams II

Introduction

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.

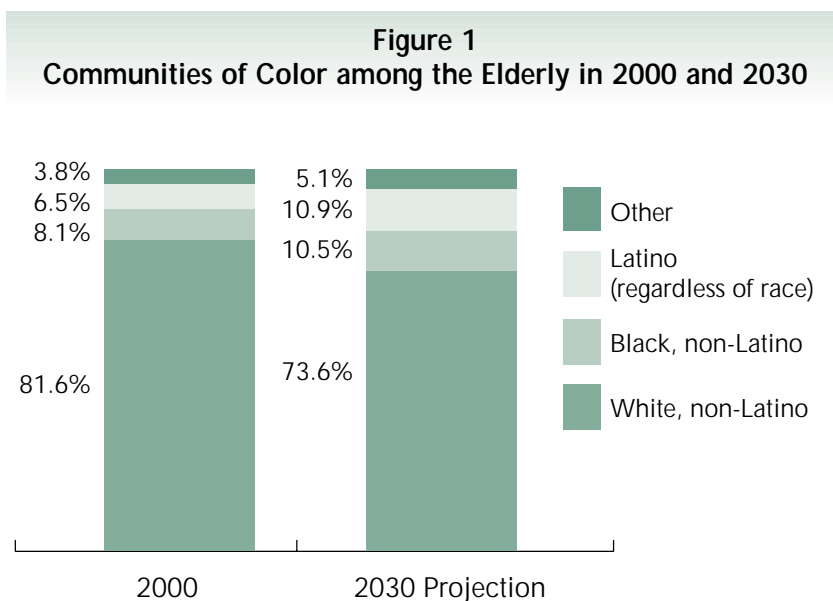
Medicare has improved access to care for aged or disabled beneficiaries by providing an entitlement to health care. Medicare is particularly important to people of color, who are more likely than their White counterparts to be uninsured before becoming eligible for Medicare. Despite Medicare's achievements, 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.

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- 1 See, e.g., Buto, Kathleen, Martha Priddy Patterson, William Spriggs, and Maya Rockeymoore, eds. 2004. *Strengthening Community: Social Insurance in a Diverse America*. Washington, DC: Brookings Institution Press, for further discussion of these issues.
- 2 The health care system is an influential factor, although factors outside of health care are recognized determinants of health.
- 3 Centers for Medicare and Medicaid Services (CMS). 2004. 2000 Medicare Current Beneficiary Survey (MCBS). Baltimore, MD: CMS.
- 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.⁵ 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.⁶ 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).⁷ Medicare's disabled population is at significantly higher risk for health problems and facing access barriers.

NOTE: Other includes American Indians, Asians and Pacific Islanders who are all non-Latino. Figure 1 is an update of information first presented in Kaiser Family Foundation (KFF). 1999. *Faces of Medicare: Medicare and Minority Americans*. Menlo Park, CA: KFF.

Source: Centers for Medicare and Medicaid Services (CMS). 2004. 2000 Medicare Current Beneficiary Survey (MCBS). Baltimore, MD: CMS and United States Census Bureau. 2000. Projections of the Total Resident Population by 5 year Age Groups, Race, and Hispanic Origin with Special Age Categories: Middle Series, 2025 to 2045. Washington, DC: United States Census Bureau.

Historical Significance of Medicare

Since its inception, Medicare has significantly improved the lives of people of color. Medicare played a pivotal role in desegregat-

ing hospitals by requiring that hospitals comply with the Civil Rights Act of 1964. As a result,

- 5 In this paper, "(beneficiaries, communities, or people) of color" describes racial and ethnic groups traditionally referred to as minorities. Communities of color include the following races: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, and the ethnicity designation of Hispanic or Latino.
- 6 United States Census Bureau. 2000. Projections of the Total Resident Population by 5 year Age Groups, Race, and Hispanic Origin with Special Age Categories: Middle Series, 2025 to 2045. Washington, DC: United States Census Bureau.
- 7 CMS Office of Research, Development and Information: Data from the Medicare Current Beneficiary Survey (MCBS) 2000 Access to Care Files.

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

Table 1
Health Insurance Coverage Status by Selected Characteristics, 2001

	Percentage Uninsured	
	Ages 55–64	Ages 65 and Older
White, non-Latino	11%	0.2%
Black, non-Latino	17%	1%
Latino	30%	5%
Asian and Pacific Islander, non-Latino	20%	6%

Source: United States Census Bureau. 2002. Health Insurance Coverage Status and Type of Coverage by Selected Characteristics in 2001 from Current Population Survey, March Supplement. Washington, DC: Government Printing Office.

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

8 Quadagno, Jill. 2000. “Promoting Civil Rights through the Welfare State: How Medicare Integrated Southern Hospitals.” *Social Problems* 47(1):68–89. And Smith, David. 2004. *Disparities in Treatment: the Healthcare Struggle to End the Racial Segregation of Care*, presented at The Harvard University Civil Right Project and Interfaculty Program on Health Systems Improvement Roundtable on Racial and Ethnic Disparities in Healthcare Treatment: The Policy, Legal, and Research Agenda. Unpublished.

9 Centers for Medicare & Medicaid (then the Health Care Financing Administration). 2000. *Medicare 2000: 35 Years of Improving Americans’ Health and Security*. Baltimore, MD: CMS

10 United States Census Bureau. 2002. Health Insurance Coverage Status and Type of Coverage by Selected Characteristics in 2001 from Current Population Survey, March Supplement. Washington, DC: Government Printing Office.

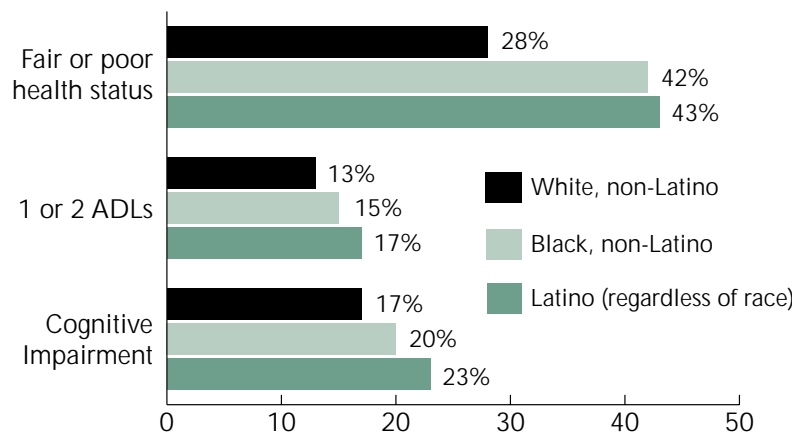
White beneficiaries. Black and Latino beneficiaries are also more likely to report that they need help with at least one activity of daily living (ADL), such as eating, bathing, dressing, using the toilet, and getting in and out of bed—tasks necessary for independence. In addition, 23 percent of Latino 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.¹¹ 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.

Figure 2
Measures of Health Status by Race and Ethnicity, 2000



NOTE: The cognitive impairment measure combines the self-reported conditions of Alzheimer’s disease and mental disorder from the Medicare Current Beneficiary Survey. When the individual is unable to respond, caregivers provide the information. The figure is an update of information first presented in Kaiser Family Foundation (KFF). 1999. *Faces of Medicare: Medicare and Minority Americans*. Menlo Park, CA: KFF.

Source: Centers for Medicare and Medicaid Services (CMS). 2004. 2000 Medicare Current Beneficiary Survey (MCBS). Baltimore, MD: CMS.

Table 2
Five Most Common Chronic Conditions by Race and Ethnicity among Medicare Beneficiaries, listed with Percentages, 2000

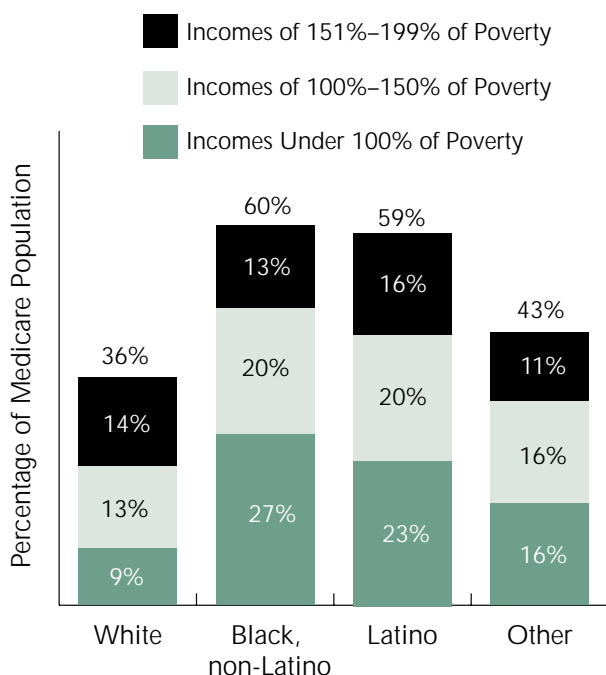
	White, non-Latino	Black, non-Latino	Latino
Arthritis	57%	61%	56%
Hypertension	55%	69%	59%
Heart Disease	40%	35%	32%
Diabetes	–	28%	24%
Osteoporosis/broken hip	19%	–	15%
Skin cancer	19%	–	–
Other type of Cancer	–	16%	–

NOTE: The presence of dashes (–) notes only that, for this group, this chronic condition was not among the top five.

Source: Centers for Medicare and Medicaid Services (CMS). 2004. 2000 Medicare Current Beneficiary Survey (MCBS). Baltimore, MD: CMS.

11 Centers for Medicare and Medicaid Services (CMS). 2004. 2000 Medicare Current Beneficiary Survey (MCBS). Baltimore, MD: CMS.

Figure 3
Poverty among the Medicare Population, 1999



NOTE: The federal poverty level was \$8,240 for an individual and \$11,060 for a couple in 1999.

Source: Kaiser Family Foundation (KFF). 2001. *Medicare Chart Book, Second Edition*. Menlo Park, CA: KFF.

age 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. Of the 7 million dual eligibles, 2.4 million 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.

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.

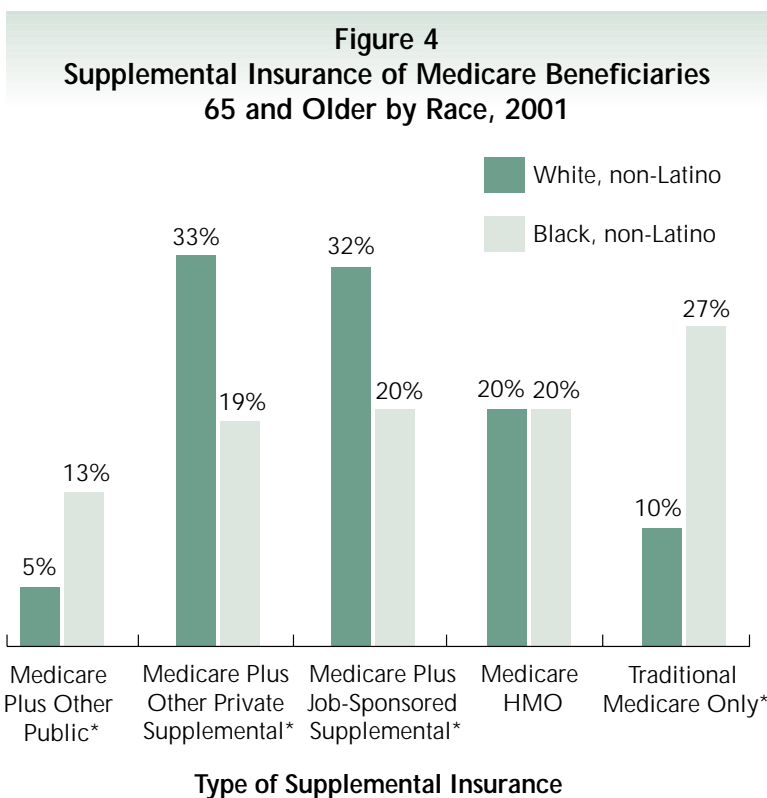
Medicaid provides supplemental coverage to many beneficiaries of color. Medicaid, a joint federal and state program for qualified low-income people, typically provides comprehensive supplemental coverage to low-income Medicare beneficiaries. The poorest Medicare beneficiaries are dually eligible for Medicare and Medicaid. Medicaid assistance wraps around Medicare cover-

12 Medicare Payment Advisory Commission (MedPAC). 2004. *Report to the Congress: New Approaches in Medicare*. Washington, DC: MedPAC.

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).¹³ 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.¹⁴ 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.¹⁵

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.¹⁶ For example, eye examinations for M+C enrollees with



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

Source: Reed, Marie, J. Lee Hargraves, and Alwyn Cassil. 2003. "Unequal Access: African-American Medicare Beneficiaries and the Prescription Drug Gap." *Center for Studying Health System Change (HSC) Issue Brief 64*. Washington, DC: HSC.

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.

14 Kaiser Family Foundation (KFF). 2004. *Medicare Fact Sheet: Medicare Advantage*. Menlo Park, CA: KFF

15 Thorpe, Kenneth, Adam Atherly, and Kelly Howell. 2002. *Medicare+Choice: Who Enrolls? A Study Commissioned by the Blue Cross and Blue Shield (BCBS) Association*. Washington, DC: BCBS Association.

16 King, Kathleen and Mark Schlesinger, eds. 2003. *The Role of Private Health Plans in Medicare: Lessons from the Past, Looking to the Future*. Washington, DC: National Academy of Social Insurance.

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.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-

Table 3
Common Preventive Screenings,
Race and Ethnicity, 2000

	Female Beneficiaries Who Received Mammograms	Male Beneficiaries Screened for Prostate Cancer
White, non-Latino	54%	64%
Black, non-Latino	51%	58%
Latino	47%	55%

NOTE: Screenings for prostate cancer reflect male beneficiaries who reported receiving a PSA blood test, digital exam, or both.

Source: Centers for Medicare and Medicaid Services (CMS). 2004. 2000 Medicare Current Beneficiary Survey (MCBS). Baltimore, MD: CMS.

17 Schneider, Eric, Alan Zaslavsky, and Arnold Epstein. 2002. "Racial Disparities in the Quality of Care for Enrollees in Medicare Managed Care." *Journal of the American Medical Association* 287(10): 1288–1294.

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.

18 Asch, Stephen, Elizabeth Sloss, Christopher Hogan, Robert Brook, and Richard Kravitz. 2000. "Measuring Underuse of Necessary Care among Elderly Medicare Beneficiaries Using Inpatient and Outpatient Claims." *Journal of the American Medical Association* 284(18): 2325–2333. And Eggers, Paul, and Linda Greenberg. 2000. "Racial and Ethnic Differences in Hospitalization Rates Among Aged Medicare Beneficiaries, 1998." *Health Care Financing Review* 21(4): 91–105.

19 King, Kathleen and Mark Schlesinger, eds. 2003. *The Role of Private Health Plans in Medicare: Lessons from the Past, Looking to the Future*. Washington, DC: National Academy of Social Insurance.

20 Canto, John, Jeroan Allison, Catarina Keefe, Contessa Fincher, Robert Farmer, Padmini Sekar, Sharina Person, and Norman Weissman. 2000. "Relation of Race and Sex to the Use of Reperfusion Therapy in Medicare Beneficiaries with Acute Myocardial Infarction." *New England Journal of Medicine* 342(15): 1094–1100.

Medicare Brief

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