



Public
Programs
and Minorities

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A
Resource Kit
for Journalists

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May 2006

Medicare: Improving Health for a Growing Minority Population

Medicare Overview

Medicare provides health insurance to nearly 42 million Americans, the vast majority of whom are seniors over age 65. Individuals are automatically considered eligible for Medicare if they or their spouse are eligible for Social Security payments and have made payroll tax contributions for at least 10 years. Medicare also covers roughly 6.3 million people under age 65 who have permanent disabilities and who qualify for Social Security Disability Insurance (SSDI).

Medicare's Role in Communities of Color

Today, Medicare covers 3.9 million African Americans, 3.1 million Latinos, and 1.7 million other racial and ethnic minorities, including Asian/Pacific Islanders and American Indians/Alaska Natives. Overall, communities of color constitute slightly more than 20 percent of the entire Medicare population.¹ This number, however, will grow dramatically as the minority population in the U.S. continues to age. It is estimated that by 2030, 26 percent of Medicare beneficiaries age 65 and older will be racial and ethnic minorities.² Furthermore, according to the most recent Census projections, racial and ethnic minorities are expected to make up almost 40 percent of the elderly population in 2050.³

Medicare Structure

Medicare was enacted in 1965 as a federal entitlement program for seniors. Unlike other public health insurance programs such as Medicaid, there are no income requirements to qualify for Medicare. Almost anyone who qualifies for Social Security payments—including most seniors over 65 and a number of younger individuals with permanent disabilities—can enroll in Medicare regardless of income. Today, the program consists of four distinct “parts,” each of which offers different benefits and covers different types of medical services, as described below.

- **Medicare Part A (Hospital Insurance):** Almost anyone who has more than 10 years of Medicare-covered employment is entitled to Medicare Part A at no cost after they retire at age 65. Others can enroll, but they must pay a monthly premium that is calculated based on the number of years they made payroll tax contributions.

Medicare Part A helps pay for:

- hospital stays,
- skilled nursing home care,
- home health care, and
- hospice care.

Beneficiaries must pay a copayment or deductible when obtaining many of these services. The types of care beneficiaries need must also meet certain coverage criteria. For example, for hospital stays, the patient must need acute care that can be provided *only* in a hospital. In addition, the patient must pay a deductible (\$952 in 2006) and copayments for stays of longer than 60 days (\$238/day for days 61-90 and \$476/day for days 91-150).

- **Medicare Part B (Medical Insurance):** Unlike Part A, Medicare beneficiaries are not automatically enrolled in Part B. Instead, they must choose to enroll and pay the monthly premium (\$88.50 in 2006). However, 95 percent of eligible beneficiaries choose to enroll in the program, which pays for physician services, outpatient diagnostic tests, and certain medical supplies and equipment.

Similar to Part A, the medical insurance portion of Medicare also requires beneficiaries to pay deductibles and copayments for the services they use. In 2006, the annual deductible is \$124, and the copayment is generally 20 percent of Medicare's approved charge for the service.

It is important to note that Part B is not a comprehensive benefit package. For example, although Medicare covers many preventive services, including mammograms, diabetes screening tests, and prostate cancer screening tests, Part B does **not** pay for:

- routine checkups,
- eyeglasses or hearing aids,
- routine foot care, or
- most dental care.

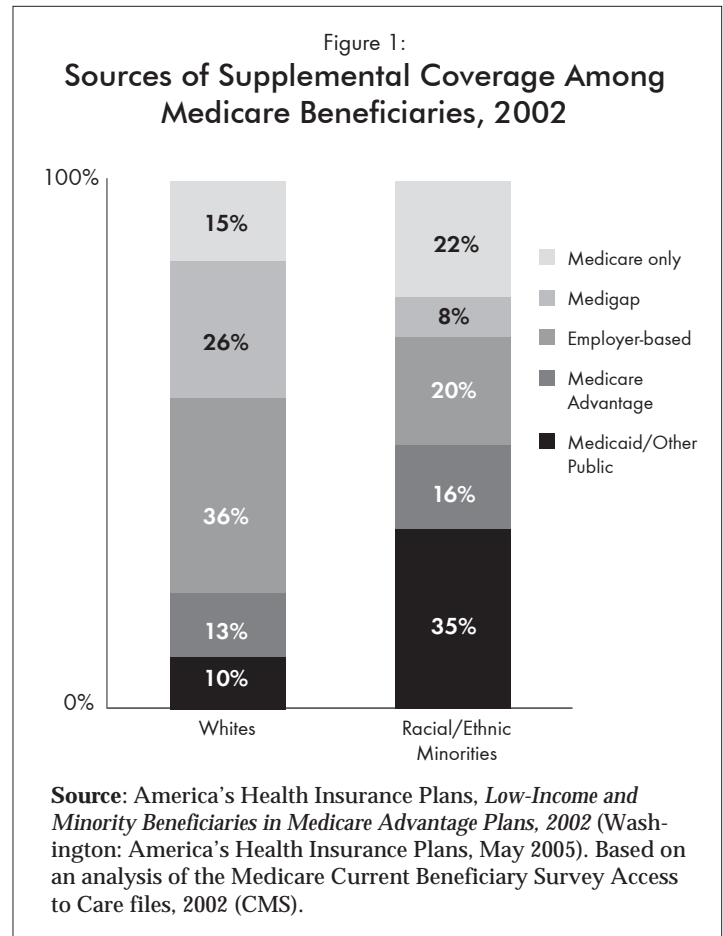
Because there are notable gaps in coverage, many elderly individuals rely on additional insurance options to fill these gaps. Most beneficiaries receive supplemental coverage through either employer-sponsored plans or so-called Medigap plans, which are private insurance plans specifically designed to fill the holes in coverage left by traditional Medicare. Those with poverty-level incomes often can enroll in Medicaid, the public health insurance program for those with low incomes that provides much more comprehensive benefits than traditional Medicare, and with less cost-sharing.

The gaps in Medicare coverage hit racial and ethnic minorities the hardest. While only 12 percent of all beneficiaries rely entirely on Medicare for health insurance coverage, the

percentage doubles for racial and ethnic minorities; for 23 percent of African Americans and 25 percent of Latinos, Medicare is their only source of coverage. What's more, African American and Latino beneficiaries are roughly three times as likely as whites to use Medicaid to supplement Medicare, making them among the most vulnerable Medicare beneficiaries.⁴

- Medicare Part C (Managed Care Plans):** Also called “Medicare Advantage” (formerly Medicare+Choice), Medicare Part C was designed to restructure the options available to Medicare beneficiaries. Historically, these private plans (primarily HMOs) have provided Part A and B benefits to enrollees. With the introduction of Part D in 2006, the plans also have the option of including standard prescription drug coverage as part of their benefits package. Today, approximately 12 percent of beneficiaries are enrolled in Medicare Advantage plans.⁵ The remaining 88 percent have traditional fee-for-service Medicare coverage in which Medicare pays for services as the costs are incurred by beneficiaries. Medicare Advantage is expected to play an increasingly important role in the next several years, with 16 to 30 percent of beneficiaries expected to enroll in such plans by 2013.⁶

- Medicare Part D (Prescription Drug Benefit):** Beginning on January 1, 2006, beneficiaries who have enrolled in Part D have prescription drug coverage provided by private plans that contract with Medicare. Before this date, beneficiaries did not have access to prescription drugs through Medicare and either had to rely on other sources of coverage or had to pay all costs out of pocket. Like Part B, the drug benefit is optional for almost all Medicare beneficiaries, and it includes premiums and cost-sharing provisions. Those who wish to enroll must select either a stand-alone prescription drug plan (PDP) or a Medicare Advantage plan with a prescription drug benefit. Because Part D is still in its infancy, it is unclear how many racial and ethnic minorities have chosen to enroll and what impact the benefit has had on communities of color.



Medicare's Potential to Reduce Racial and Ethnic Health Disparities

As the single largest purchaser of health care in the U.S., Medicare has tremendous potential to reduce racial and ethnic disparities in health. In fact, the origins of the Medicare program are rooted in a federal effort to improve health care within the African-American community. By law, hospitals were required to comply with the Civil Rights Act of 1964 in order to receive payments for Medicare patients, a move that catalyzed the desegregation of hospitals during the 1960s. In the 40 years since then, however, an overwhelming body of evidence has shown that racial and ethnic minorities continue to receive lower quality care and suffer from worse health outcomes compared to whites. Because Medicare provides coverage for almost all racial and ethnic minorities over 65—as well as many individuals with permanent disabilities, regardless of age—it can play a powerful role in closing the health gaps that exist between minority populations and whites.

Despite having near-universal coverage for the elderly population under Medicare, numerous studies have shown that racial and ethnic elderly minorities are more likely to suffer from a greater number of illnesses and to report being in fair or poor health.⁷ For example, according to a 2002 survey of Medicare beneficiaries:

- 30 percent of African Americans and 28 percent of Latinos on Medicare had diabetes, compared to 18 percent of non-Latino whites.
- 71 percent of African Americans on Medicare had hypertension, compared to 57 percent of Latinos and 59 percent of non-Latino whites.
- 32 percent of Latinos on Medicare had cognitive or mental impairments, compared to 25 of non-Latino whites and 20 percent of African Americans.⁸

These disparities may be due to the fact that compared to their white peers, African American and Latino beneficiaries are much less likely to have had insurance coverage before enrolling in Medicare. By the time they become eligible for and enroll in Medicare, certain conditions may have progressed and worsened.

Disparities in health care persist among Medicare beneficiaries despite the fact that the same standard Medicare benefits are supposed to be provided to all beneficiaries (unlike private health insurance plans and state Medicaid programs). While some evidence suggests that disparities might have narrowed among elderly Medicare beneficiaries in recent years, treatment gaps nevertheless persist.⁹ For example:

- Less than half of African Americans and Latinos over 65 received a flu shot, and only about a third received a pneumonia vaccination in 2002. This compares with 68 percent of elderly whites who received the flu shot and 59 percent who received the pneumonia vaccination.¹⁰

- Elderly Latinos with Medicare coverage were roughly one-third as likely as whites the same age to undergo total hip replacement surgery, an operation that can reduce pain and improve physical function for patients with severe osteoarthritis.¹¹
- Compared to white Medicare patients, elderly African Americans with early stage lung cancer were less likely to undergo surgery and more likely to die within five years of diagnosis.¹²
- Elderly African American, Latino, and Asian cancer patients living in nursing homes were less likely to receive pain treatment than their white peers.¹³
- Elderly African Americans, Latinos, and Asian and Pacific Islanders were more likely than elderly whites to suffer from infections that were caused by medical care.¹⁴

While modest efforts have emerged over the last few years to address these inequalities—for example, beginning in late 2003, health care plans started to receive race and ethnicity data on their Medicare enrollees with the requirement that they conduct at least one project on disparities—quality improvement has been uneven at best.¹⁵

“ . . . among persons enrolled in Medicare . . . there have been no meaningful, consistent reductions in the gaps in care between black enrollees and white enrollees. ”¹⁶

More can and needs to be done to reduce health

disparities among the Medicare population. Since the program already reaches more than 7 million racial and ethnic minorities—and this number is only expected to grow—Medicare is uniquely positioned to address the problem of health care disparities by ensuring that all beneficiaries have access to high-quality care.

A Key Emerging Issue: The Prescription Drug Benefit

One of the most radical transformations to the Medicare program in its 40-year history took effect on January 1, 2006, with the implementation of the prescription drug benefit. Also called Medicare Part D, the benefit was enacted as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Beginning in November 2005, beneficiaries were given the option of enrolling in a private prescription drug plan or joining a Medicare Advantage plan that offered drug coverage.

Although the specific benefit design varies by plan and region, the standard benefit requires that Medicare enrollees pay a monthly premium, annual deductible, and copayment for their covered drugs. The standard benefit structure has three tiers of coverage: 1) partial coverage (which pays for 25 percent of the first \$2,500 in drug costs); 2) no coverage (the coverage gap or so-called “doughnut hole,” which is the \$2,850 gap after the initial coverage limit when the beneficiary usually must pay all drug costs); and 3) catastrophic coverage (which covers 95 percent of all drug costs that exceed \$5,100).

In 2006, the average premium for a private drug plan is \$32.20. The maximum annual deductible is \$250, after which point Medicare pays 25 percent of prescription drug costs until the beneficiary reaches the “doughnut hole.” After the beneficiary pays a total of \$3,600 in out-of-pocket drug expenses, Medicare pays 95 percent of all drug costs above the catastrophic threshold (\$5,100 in 2006).¹⁷

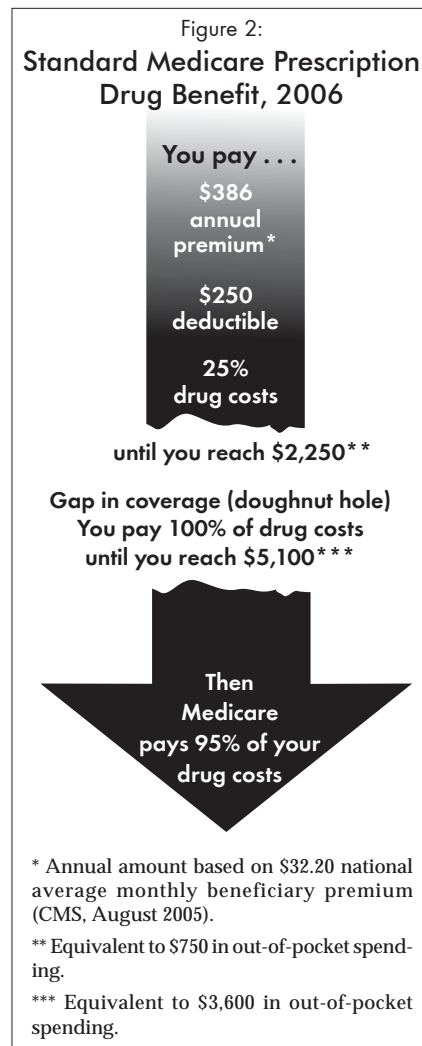
Medicare beneficiaries have an overwhelming number of choices to make when selecting a prescription drug plan. Most states offer between 40 and 49 plans, with a few offering more than 50. Each plan also has its own benefit structure—premiums, deductibles, drug prices, and the list of covered drugs can differ significantly from plan to plan. Beneficiaries who decide to enroll must choose a plan by May 15, 2006 or face a potentially substantial penalty for late enrollment.

While millions of Americans in Medicare now have to decide if the prescription drug benefit is right for them, that decision looms even larger for many racial and ethnic minorities. Among Medicare beneficiaries, 43 percent of African Americans and 37 percent of Latinos went without drug coverage for part or all of 2002. Many of them will have access to affordable drug coverage for the first time through the Medicare drug benefit.¹⁸ The benefit structure, however, is extraordinarily complex. It is even more confusing for those who qualify for low-income assistance, a population that includes nearly two-thirds of all African-American and Latino Medicare beneficiaries.¹⁹ Outreach is critically important for this population so that they understand the implications of the new benefit and how it will affect them if they enroll.

The following sections provide a brief discussion of some of the most pressing areas of concern with implementation of the Medicare prescription drug benefit and its impact on communities of color.

- **Dual Eligibles**

More than 6 million Medicare beneficiaries have extremely low incomes that qualify them for Medicaid, the nation’s public health insurance program for the poor. These individuals are often referred to as “full dual eligibles” because they qualify for



both programs, meaning they have access to the additional benefits provided through Medicaid, such as long-term care. Medicaid also pays Medicare's premiums and cost-sharing for the dual eligible population.

Racial and ethnic minorities make up a disproportionate percentage of dual eligibles. In fact, African Americans and Latinos are roughly six times more likely than whites to be eligible for both Medicaid and Medicare.²⁰ Because of their disproportionate representation, any effort to reduce racial and ethnic disparities in health must also address the needs of this population.

The introduction of prescription drug coverage under Medicare Part D has important implications for Medicare beneficiaries who are also enrolled in Medicaid. More than a third of all African Americans and Latinos in Medicare received prescription drug coverage through Medicaid before January 2006, compared to one out of 10 white beneficiaries. As of January 1, 2006, however, Medicaid no longer pays for prescription drugs for dual eligibles. Instead, dual eligibles now must be enrolled in a private drug plan financed through Part D.

Despite the fact that this change affects more than 2 million Medicare beneficiaries from communities of color, there has been relatively little outreach to minorities regarding the change in benefit. The transition from Medicaid to Medicare for prescription drug coverage also has been mired with problems. Thousands of beneficiaries showed up to the pharmacy in January to discover that they were unable to fill their prescriptions due to administrative complications. Fortunately, more than 30 states have stepped up since January to smooth the transition by spending millions of dollars for emergency supplies of drugs. This is not, however, a permanent solution, and many low-income Medicare beneficiaries now face new copayments and greater restrictions on the prescriptions they can fill.

- **Low-income Beneficiaries**

Racial and ethnic minorities are disproportionately represented among low-income Medicare beneficiaries: 64 percent of African American and 62 percent of Latino beneficiaries have incomes below 150 percent of the federal poverty level (\$19,245 for a family of two in 2005), compared to 32 percent of white beneficiaries.²¹ Many of these individuals qualify for subsidies that will help them pay for premiums and cost-sharing, depending on their incomes and assets (see Table 1 on page 8). However, of the estimated 5.7 to 7 million people who could qualify for the low-income subsidy, only about 1.2 million had been approved as of January 2006. What's even more discouraging, only about one-fourth of those approved for the subsidy had enrolled in a Part D plan during the first month of the program.²² That amounts to barely 5 percent of eligible low-income beneficiaries who are now receiving extra help for their prescription drug coverage.

Table 1:
Medicare Prescription Drug Benefit Subsidies for Low-Income Beneficiaries, 2006

Low-Income Subsidy Level	Monthly Premium	Annual Deductible	Copayments
Full-benefit dual eligibles Income <100% of poverty (\$9,570/individual; \$12,830/couple)	\$0	\$0	\$1/generic \$3/brand-name; no copays after total drug spending reaches \$5,100
Full-benefit dual eligibles Income ≥ 100% of poverty	\$0	\$0	\$2/generic \$5/brand-name; no copays after total drug spending reaches \$5,100
Institutionalized full-benefit dual eligibles	\$0	\$0	No copays
Individuals with income <135% of poverty (\$12,920/individual; \$17,321/couple) and assets <\$6,000/individual; \$9,000/couple)	\$0	\$0	\$2/generic \$5/brand-name; no copays after total drug spending reaches \$5,100
Individuals with income 135%-150% of poverty (\$12,920-\$14,355/individual; \$17,321-\$19,425/couple) and assets <\$10,000/individual; \$20,000/couple	sliding scale up to \$32.50*	\$50	15% of total costs up to 5,100; \$2/generic \$5/brand-name thereafter

Note: *\$32.50 is the national monthly Part D base beneficiary premium for 2006. Poverty level dollar amounts are for 2005. Additional assets of up to \$1,500/individual and \$3,000/couple for funeral or burial expenses are permitted.

Source: Kaiser Family Foundation summary of Medicare prescription drug benefit low-income subsidies in 2006.

● Education and Outreach

Without appropriate outreach to Medicare beneficiaries, particularly those from communities of color, the implementation of the prescription drug benefit will be a missed opportunity to reduce health disparities among the Medicare population. Unfortunately, in October 2005, more than 60 percent of seniors admitted that they did not understand the Medicare drug benefit well, and only 14 percent reported that they understood the benefit very well.²³

While the availability of Part D has become familiar to Americans, specific details about the benefit are available primarily through an online government-run Web site at www.medicare.gov. The site, which allows users to view detailed information about available drug plans, is designed to make choosing a plan simpler by offering side-by-side price comparisons. The Medicare Prescription Drug Plan Finder tool on the site even allows visitors to list the medications they are currently taking so that they can tailor their plan choices to their individual circumstances.

The vast majority of seniors, however, do not use the Internet and probably never will see the tools available on the Web site. What's more, elderly African Americans are even less likely to use the Internet—according to a 2004 survey of seniors, only 11 percent of African Americans age 65 and over reported using the Internet, compared

to 22 percent of non-Hispanic whites and 21 percent of English-speaking Hispanics.²⁴ As late as October 2005—one month before the sign-up period for Part D began—most Medicare beneficiaries said that they had never heard of www.medicare.gov, and barely one out of 20 reported that they had ever visited the site.²⁵

Conclusion

Although racial and ethnic minorities in Medicare have access to the same coverage as whites, they continue to fare worse on measures of prevention, treatment, and overall health status. While much of the health gap can be attributed to disparities in income and education—factors that also have been shown to have a profound effect on health—the fact remains that Medicare can do more to improve health within communities of color.

The introduction of Medicare Part D in January presents a remarkable opportunity to address the problem of health disparities in minority communities. The Part D benefit, for instance, provides significant financial assistance to low-income populations that could increase their access to prescription drugs. This assistance is particularly important to minorities who previously lacked drug coverage because of its high cost. Journalists can play an important role in reaching out to and educating communities of color about the drug benefit, particularly as the May 15 enrollment deadline rapidly approaches.

The Part D benefit has the potential to reduce disparities beyond expanding access to drug coverage. Currently, more than half of all beneficiaries who are eligible for Medicaid or other low-income assistance are not enrolled in these programs.²⁶ These programs help beneficiaries pay some or all of their Medicare premiums and deductibles, thus reducing two major barriers to access. By making a concentrated effort to inform minority groups about Medicare Part D and its associated low-income assistance, it is possible to further expand access to insurance coverage by encouraging eligible individuals to apply for help that is already available to them.

Because virtually all individuals over 65 are enrolled in Medicare—and because one out of five beneficiaries belongs to a racial or ethnic minority group—the Medicare program can use its significant stature as a federal insurance program to address the problem of health disparities. By reaching out to minority populations and making it much easier for low-income minorities to enroll in financial assistance programs, Medicare can begin to reduce the health gap among this population and pave the way for broader improvements.

Endnotes

- ¹ Kaiser Family Foundation, *A Profile of African Americans, Latinos, and Whites with Medicare: Implications for Outreach Efforts for the New Drug Benefit* (Washington: Kaiser Family Foundation, November 2005), available online at <http://www.kff.org/minorityhealth/7435.cfm>.
- ² Marsha Lillie-Blanton, Osula Evadne Rushing, and Sonia Ruiz, *Key Facts: Race, Ethnicity & Medical Care, Update June 2003* (Menlo Park, CA: Kaiser Family Foundation, 2003), available online at <http://www.kff.org/minorityhealth/upload/Key-Facts-Race-Ethnicity-Medical-Care-Chartbook.pdf>.
- ³ Estimate based on an analysis of the U.S. Census Bureau's "U.S. Interim Projections by Age, Sex, Race, and Hispanic Origin," available online at <http://www.census.gov/ipc/www/usinterimproj/>, accessed on November 29, 2005.
- ⁴ Kaiser Family Foundation, *The Faces of Medicare: Medicare and Minority Americans* (Washington: Kaiser Family Foundation, July 1999).
- ⁵ Kaiser Family Foundation, *Medicare at a Glance* (Menlo Park, CA: Kaiser Family Foundation, September 2005).
- ⁶ Kaiser Family Foundation, *Medicare Chartbook, Third Edition* (Washington: Kaiser Family Foundation, Summer 2005).
- ⁷ Kaiser Family Foundation, *The Faces of Medicare: Medicare and Minority Americans*, op. cit.
- ⁸ Kaiser Family Foundation, *A Profile of African Americans, Latinos, and Whites with Medicare: Implications for Outreach Efforts for the New Drug Benefit*, op. cit.
- ⁹ Amal Trivedi, Alan Zaslavsky, Eric Schneider, et al., "Trends in the Quality of Care and Racial Disparities in Medicare Managed Care," *New England Journal of Medicine* 353 (August 18, 2005), pp. 692-700.
- ¹⁰ American Lung Association, *Lung Disease Data in Culturally Diverse Communities: 2005* (New York: American Lung Association, February 2005).
- ¹¹ Agustin Escalante, Jane Barrett, Inmaculada del Rincon, et al., "Disparity in Total Hip Replacement Affecting Hispanic Medicare Beneficiaries," *Medical Care* 40 (June 2002), pp. 451-460.
- ¹² Marsha Lillie-Blanton, Osula Evadne Rushing, and Sonia Ruiz, *Key Facts: Race, Ethnicity & Medical Care, Update June 2003*, op. cit.
- ¹³ Ibid.
- ¹⁴ Sheila Leatherman and Douglas McCarthy, *Quality of Health Care for Medicare Beneficiaries: A Chartbook, Focusing on the Elderly Living in the Community* (New York: Commonwealth Fund, May 2005).
- ¹⁵ Amal Trivedi, Alan Zaslavsky, Eric Schneider, et al., "Trends in the Quality of Care and Racial Disparities in Medicare Managed Care," op. cit.
- ¹⁶ Ashish K. Jha, Elliott S. Fisher, Zhonghe Li, et al., "Racial Trends in the Use of Major Procedures among the Elderly," *New England Journal of Medicine* 353 (August 18, 2005), p. 690.
- ¹⁷ Kaiser Family Foundation, *Medicare: The Medicare Prescription Drug Benefit* (Washington: Kaiser Family Foundation, September 2005).
- ¹⁸ Kaiser Family Foundation, *A Profile of African Americans, Latinos, and Whites with Medicare: Implications for Outreach Efforts for the New Drug Benefit*, op. cit.
- ¹⁹ Ibid.
- ²⁰ Leighton Ku and Matthew Broaddus, *The Six Million Medicare Beneficiaries Excluded from Prescription Drug Benefits under the Senate Bill are Disproportionately Minority* (Washington: Center on Budget and Policy Priorities, September 2003).
- ²¹ Kaiser Family Foundation, *A Profile of African Americans, Latinos, and Whites with Medicare: Implications for Outreach Efforts for the New Drug Benefit*, op. cit. In 2002, the federal poverty level was \$8,860 for an individual and \$11,940 for a couple.
- ²² Kaiser Family Foundation, *Medicare: Low-Income Assistance under the Medicare Drug Benefit* (Washington: Kaiser Family Foundation, September 2005).
- ²³ Kaiser Family Foundation and Harvard School of Public Health, *The Medicare Drug Benefit: Beneficiary Perspectives*

tives Just Before Implementation (Menlo Park, CA: Kaiser Family Foundation, November 2005).

²⁴ Susannah Fox, *Older Americans and the Internet* (Washington: Pew Internet and American Life Project, March 2004), available online at http://www.pewinternet.org/pdfs/PIP_Seniors_Online_2004.pdf.

²⁵ Kaiser Family Foundation and Harvard School of Public Health, op. cit.

²⁶ June Eichner and Bruce C. Vladeck, "Medicare As a Catalyst for Reducing Health Disparities," *Health Affairs* 24 (March/April 2005), pp. 365-375.

For more information on Families USA's Minority Health Initiatives,
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