

Protect and Strengthen Medicare

Medicare and Health Equity



The Problem

Medicare eligibility translates into meaningful gains in health equity. But the COVID-19 pandemic in particular has demonstrated that racial, ethnic, gender, LGBTQ+ status, disability status, and income disparities in health outcomes and access to care remain. For example, Medicare beneficiaries **most likely to report** difficulty getting vision, dental, or hearing care include individuals with low incomes, those in fair or poor health, and Black and Hispanic enrollees. Many LGBTQ+ individuals have **significant challenges** finding able and willing providers, and those over age 50 in particular experience pronounced **health disparities**. In our experience, transgender people in particular may struggle to access appropriate care, including gender affirming care, in Medicare. This lack of access can magnify inequities, put beneficiary health at risk, and lead to more costly and invasive treatments later.

Background

For the past 50 years, Medicare has filled a vital role in helping older adults and people with disabilities afford high-quality care. The program has been especially important in **reducing health and access inequity for people 65 and older**. But people with Medicare still face **systemic issues** that perpetuate and even exacerbate disparities. **Life expectancy at age 65** has improved since Medicare's enactment but is lower for Black adults than White or Hispanic adults. Among Medicare beneficiaries, people of color are more likely to report being in relatively poor health, have higher prevalence rates of some chronic conditions, such as hypertension and diabetes than White beneficiaries; they are also less likely to have one or more doctor visit, but have higher rates of hospital admissions and emergency department visits than White beneficiaries. Women have longer average lifespans, but fewer resources when they retire.

Older adults who experienced discrimination based on their race or ethnicity were **nearly twice as likely** to have a mental health diagnosis, such as depression or anxiety, than their peers. They were also significantly more likely to feel socially isolated, have multiple chronic conditions, and experience financial hardship—underscoring the importance of access to appropriate, affordable, and trusted care.

Moreover, the ongoing opioid public health emergency has had a **disproportionately devastating** impact on Black, Indigenous, and other communities of color. Today, Black men ages 65 and older **die of drug overdose at a seven-times higher rate** than White men of the same age. Access to treatment varies by race and ethnicity as well; in recent years beneficiaries of color with opioid use disorder (OUD) were less likely than White beneficiaries to receive medications for OUD in **outpatient settings** or following opioid-related **emergency department visits**.

There are significant income disparities for Medicare beneficiaries. On average, Black and Hispanic Medicare beneficiaries have fewer years of formal education and lower median per capita income, savings, and home equity than White beneficiaries, and women have lower income and savings than men. Before the COVID-19 pandemic, half of all beneficiaries—nearly 30 million people—lived on \$29,650 or less per year, and one quarter lived on \$17,000 or less. But the numbers were not evenly split across populations. Women had median incomes of \$27,750, compared to a median income of \$32,050 for men. White beneficiaries had median incomes of \$33,700, while half of Black beneficiaries had incomes of \$23,050 or less, and the median for Hispanic beneficiaries was even lower at \$15,600.

Assets show the same troubling pattern. One fourth of all Medicare beneficiaries had savings below \$8,500 in 2019, and 12% had no savings or were in debt.

These numbers are crucial given the prevalence of significant health issues in the Medicare population and the program's relatively high out-of-pocket costs, especially when compared to Medicaid. Medicare Advantage has caps on out-of-pocket expenses, but they are too high for many beneficiaries. The Inflation Reduction Act (IRA) of 2022 will cap Part D costs at \$2000 starting in 2025 and should help to bring down list prices through negotiation. However, Original Medicare still lacks a cap and medical prices continue to rise. In 2016, half of all traditional Medicare beneficiaries **spent at least 12% of their total per capita income on health care** and the average out-of-pocket spend for traditional Medicare beneficiaries was \$5,460.

Expenses are even higher for services that Medicare does not cover at all, including most dental, hearing, and vision care, a comprehensive suite of long-term services and supports, and some mental health and substance use disorder care.

Possible Solutions

- **Create Caps.** Establish universal, affordable out-of-pocket caps in traditional Medicare and Medicare Advantage.
- **Improve Availability.** Expand eligibility and access for programs that help those with lower incomes, including eliminating asset limits and raising income limits and aligning them across programs.
- **Curb MA Overpayment.** Reduce Medicare Advantage overpayments that allow MA plans to overcharge the Medicare program through inappropriate risk adjustment and gaming. This drives up premiums for all beneficiaries, overburdens the Medicare trust fund, and takes money from taxpayers' pockets.
- **Improve Data Collection.** Collect robust data, including intersectional data that may reveal inequitable treatment for certain communities, to inform all legislative, regulatory, and experimental model choices to pinpoint inequities and disparities in the current system or to track how new policies and models may affect underserved populations. Closely monitor and respond to any reports or evidence of discrimination in MA plan design, administration, and operation.
- **Eliminate Gaps.** Close the gaps in coverage by passing legislation providing comprehensive oral, vision, and hearing coverage within Medicare Plan B, strengthening the Medicare home health benefit, and modernizing the coverage of substance use disorders and mental health within the program.
- **Increase Access.** Increase access to providers by increasing Medicare payment for underenrolled specialties and enhancing requirements for MA network adequacy. This effort should focus on mental health and substance use disorder care; cultural competence and sensitivity; language access; and disability access, including equipment for diagnosis and treatment.