Guide to Equity in Medicare

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ABOUT THIS GUIDE

This guide equips advocates with key information about Medicare, including an overview of the system's inequities, and highlights the policy and accountability levers that can advance equity.

This guide is part of a larger project on inequities and policy levers in the US health care system. For the complete guide, visit urbn.is/4054rNQ.

The other topics covered include the following:

- behavioral health care system
- Children's Health Insurance Program
- health care for the uninsured
- Indian Health Service
- Marketplace insurance
- Medicaid
- Medicaid-Medicare
- pharmacy services
- Veterans' Affairs

OVERVIEW

Medicare is a federal health insurance program for people ages 65 and older, people under the age of 65 who receive disability benefits, and those with permanent kidney failure (or end-stage renal disease) or amyotrophic lateral sclerosis (ALS, also known as Lou Gehrig's disease). Older people are automatically enrolled or become eligible to enroll in Medicare when they apply for Social Security retirement benefits. There are four "parts" of Medicare, each covering different health care services and governed by different rules.

Original Medicare, also known as traditional or fee-for-service Medicare, includes coverage of hospital services (Medicare Part A) and medical services (Medicare Part B). Part A covers inpatient hospital stays, short-term skilled nursing facility stays, hospice care, and some home health care services and is free for people who worked and paid Medicare taxes for at least 10 years. Medicare Part B covers doctors' visits, outpatient services, home health care, durable medical equipment, and certain preventive services. People pay a monthly premium for Part B coverage based on their income.

Medicare Parts C and D are administered by private health plans that contract with the Medicare program. Coverage, premiums, and out-of-pocket costs vary by health plan. Medicare Part C, or Medicare Advantage, combines Part A and Part B coverage and may include prescription drug coverage. Medicare Part D covers prescription drugs and some vaccines. People have to sign up for Original Medicare Parts A and B before enrolling in Parts C and/or D.

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POPULATION

Over 66.6 million people are enrolled in Medicare, with slightly over half (51 percent) enrolled in Original Medicare and 49 percent enrolled in Medicare Advantage plans (Part C coverage). Over three-quarters of Medicare

beneficiaries (76 percent) also have Part D prescription drug coverage. Of all Medicare beneficiaries, about 18 percent are also enrolled in Medicaid (also known as dual enrollees).

Most Medicare beneficiaries (77 percent) were between 65 and 84 years old, while 13 percent were younger than 65, and 10 percent were older than 85. In terms of race and ethnicity, most Medicaid beneficiaries are white (72.8 percent); 10 percent are Black; 9.5 percent are Hispanic/Latinx; 4.5 percent are Asian, Native Hawaiian, and Pacific Islander; 0.4 percent are American Indian/Alaska Native; and 2.7 percent identify as multiple races.

Compared with beneficiaries enrolled in Original Medicare (Parts A and B), those enrolled in Medicare Advantage are more likely to have incomes below the federal poverty level, be older, have lower levels of education, and be in poorer health. In addition, Medicare Advantage beneficiaries are disproportionately Black and Latino and more likely to be dually enrolled in Medicaid.

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PROVIDERS AND SERVICE DELIVERY

Most Medicare beneficiaries report ease of access to care and satisfaction with care, including ease of finding a provider and short wait times for appointments. This is likely because nearly all physicians serving adults in the US accept Medicare, including those practicing in private practices, community health centers, hospitals, and other health care settings. However, some Medicare beneficiaries experience difficulties finding a new primary care provider, likely driven by growing shortages of primary care physicians in the US.

In the Original Medicare program, the federal government pays fee-for-service rates to physicians, hospitals, and other providers and facilities for services delivered to beneficiaries. In the Medicare Advantage program, the federal government contracts with health plans that receive fixed payments for delivering Medicare services, but providers participating in the Medicare Advantage plans are often paid on a fee-for-service basis. Medicare reimbursement rates to providers are, on average, higher than Medicaid but lower than reimbursement by commercial payers.

For More Information

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- **Differences in Medicaid, Medicare, and commercial health insurance payments**: Cindy Mann and Adam Striar, "How Differences in Medicaid, Medicare, and Commercial Health Insurance Payment Rates Impact Access, Health Equity, and Cost," New York: The Commonwealth Fund, August 17, 2022.

FINANCING

Medicare is primarily financed by the federal government using general revenues and payroll tax revenues collected from employers and employees by the Federal Social Security Administration. Other sources of Medicare funding include taxes on Social Security benefits, payments from states, and earned interest. Funding for Medicare totaled $888 billion in 2021, representing about 12 percent of the federal budget.

About 15 percent of Medicare funding comes from premiums paid by beneficiaries. In addition to paying premiums, most beneficiaries also have out-of-pocket health care expenses such as copayments, deductibles, coinsurance premiums, and costs for any uncovered services. Beneficiaries enrolled in Original Medicare can purchase private supplemental insurance (also known as Medigap) to help pay for copays, deductibles, and sometimes services that Original Medicare does not cover.

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BARRIERS TO ACCESSING COVERAGE AND HEALTH CARE

While Medicare may be the closest to universal insurance for people 65 and older, enrollees face multiple barriers to accessing comprehensive coverage and health care services. The major barriers include the following:

Program Complexity

Navigating the complex Medicare system can be challenging for many beneficiaries who must understand rules, coverage, and cost sharing under various parts; when and how to enroll; decide between Original Medicare or Medicare Advantage; and select from sometimes dozens of private plans that are heavily marketed in the Medicare Advantage market. These challenges can result in beneficiaries experiencing gaps in coverage or inadequate coverage, missing out on financial assistance that may be available to people with low incomes, or facing late enrollment penalties and higher premiums. The Medicare Advantage program mitigates some of this complexity by providing more streamlined access to all services under just one plan compared with separate programs under Original Medicare, which likely explains the growing popularity of Medicare Advantage plans.

Affordability

Cost and affordability are among the top concerns for many Medicare beneficiaries who often have fixed incomes but may be experiencing growing health care needs as they age. For example, the Original Medicare does not have an out-of-pocket maximum, while the Medicare Advantage out-of-pocket maximum threshold is $8,850 for in-network services. Most Medicare Part D prescription drug plans have annual coverage limits ($5,030 in 2024). This coverage gap (or "donut hole") means beneficiaries who exceed the limit have out-of-pocket costs for needed medications. While nearly all beneficiaries in Original Medicare have some supplemental coverage to protect them from catastrophic medical expenses (including Medigap, employer insurance, or Medicaid), about 1 in 10 Medicare beneficiaries have no other coverage. Several public programs offer financial assistance to Medicare beneficiaries

with limited resources, including Medicare Savings Programs and Part D low-income subsidies. But many Medicare beneficiaries are unaware of these programs and do not enroll despite being eligible for assistance. In a recent survey, over one in five Medicare beneficiaries said they delayed or forewent health care because of cost concerns.

Patient Story: Cost Barriers in Medicare

Jane was a helpline client with a cancer diagnosis. Her illness required that she receive a weekly shot covered under Medicare Part B; however, Jane's coinsurance of over $1,500 per shot was completely unaffordable. She called to inquire about a Medicare Savings Program (MSP) and Medicaid to assist with her costs. Her income appeared to be in the range of the Qualified Medicare Beneficiary (QMB) level of the Medicare Savings Program, which pays for Medicare premiums and protects enrollees from being billed for Medicare deductibles, coinsurances, and copayments. With QMB, Jane would not owe the weekly coinsurance for her cancer treatment. MSP enrollment would also automatically enroll Jane in the federal Extra Help program for help paying prescription drug costs.

—Excerpted from Medicare Trends and Recommendations: An Analysis of 2022 Call Data from the Medicare Rights Center's National Helpline, New York: Medicare Rights Center, October 2023.

Limited Access to Care

Medicare may not cover some services, including long-term care services and supports (such as nursing home care). Some acute care services, such as dental, vision, and hearing, are excluded from Original Medicare but may be covered by some Medicare Advantage plans as supplemental benefits. Provider shortages and low provider reimbursement may hamper access to behavioral health services for some Medicare beneficiaries, though Congress recently made changes to address these barriers, including expanding the type of providers who can provide mental health and substance use services to Medicare beneficiaries and improving access to telehealth counseling. Furthermore, Medicare Advantage enrollees may have more restricted access to care because of the requirement to see in-network providers and obtain referrals or prior authorization for some services. A recent investigation found inappropriate denials of services by Medicare Advantage plans, posing barriers to timely and appropriate care for beneficiaries and adverse health effects and causing financial concerns for providers.

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DISPARITIES

There are documented disparities in Medicare, though a full understanding of these disparities is limited by the low quality and completeness of Medicare's race and ethnicity data. For example, Black and Hispanic Medicare beneficiaries are more likely than white beneficiaries to report poor health and challenges with accessing health care services, have fewer doctor visits but more emergency department visits and hospitalizations, and have higher rates of chronic health conditions such as diabetes.

Compared with older Medicare beneficiaries, those who are under age 65 with disabilities are more likely to report challenges enrolling in the program and accessing needed care, including because services are not covered or denied by their health plan. In addition, Medicare beneficiaries with disabilities report lower satisfaction with care and high rates of affordability and cost concerns than older Medicare beneficiaries.

Similarly, studies examining utilization and experiences with care among Medicare Advantage enrollees found that Black and Hispanic/Latinx enrollees were more likely to have worse outcomes than white enrollees.

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OVERSIGHT AND ACCOUNTABILITY

Congress is the primary source of accountability for the Medicare program, run by the Centers for Medicare & Medicaid Services (CMS) under the US Department of Health and Human Services. Among its core functions, CMS is

responsible for ensuring high-quality care for Medicare beneficiaries, including by ensuring its contractors, such as providers, Medicare Advantage plans, and state agencies, properly administer Medicare. In addition, CMS develops program and payment policies, provides guidance, develops health and safety standards for hospitals and health care facilities, investigates fraud, and collects and analyzes data to monitor program performance.

Major entities, programs, and tools support Medicare's oversight, accountability, and transparency, including the following:

- **Conditions of Participation** are health and safety standards that all health care facilities must comply with to participate in Medicare. Accreditation organizations, such as the Joint Commission, Commission on Accreditation of Rehabilitation Facilities, and others, assess and rate health care facilities on compliance with the Medicare standards.
- Dubbed "the investigative arm of Congress" and "the congressional watchdog," the **Government Accountability Office** aids Congress in improving the performance of federal programs, including Medicare, by conducting independent research and providing recommendations.
- The **Office of Inspector General** within the US Department of Health and Human Services assists CMS with oversight of all Medicare programs through investigations, evaluations, and financial audits.
- The **Medicare Payment Advisory Commission (MedPAC)** conducts research and analysis and advises Congress on the Medicare program.
- The **Medicare appeals process** allows beneficiaries to appeal coverage and payment decisions. CMS operates two Beneficiary and Family Centered Care-Quality Improvement organizations to assist beneficiaries in addressing complaints and appeals.
- The federal government funds the **State Health Insurance Assistance Program** and provides locally-based navigation assistance to Medicare beneficiaries and their families, including understanding and selecting from available coverage options.
- **Beneficiary assistance and advocacy organizations,** such as Medicare Rights Center, AARP, National Council on Aging, Area Agencies on Aging, and others, advocate for programs and policies to improve access to and quality of care for Medicare beneficiaries and often assist beneficiaries in navigating Medicare and resolving issues.
- **Quality assessment and reporting programs** are designed to assist consumers in making informed decisions about health plans and health care providers in the Medicare program, though there is little evidence suggesting consumers use and find these data helpful or that they strengthen accountability in the program. These include quality reporting programs that require hospitals and other health care facilities and providers to report data on selected quality measures to CMS annually. Patient experience surveys assess patients' experiences with their health care providers and plans. Five-star quality rating systems report how health plans and providers perform overall on quality and patient experience measures.

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POLICIES AND ACTIONS THAT COULD LESSEN BARRIERS AND DISPARITIES

CMS has, over the years, attempted to protect integrity and increase oversight of the Medicare program, but oversight does not necessarily translate to enforcement or holding entities accountable for change and improvement. For example, a recent report by the Office of Inspector General on Medicare Advantage showed prior authorization outcomes indicate that better guidance and oversight of Medicare Advantage plans are needed to ensure beneficiary access to care. While Medicare has pioneered value-based payment approaches to improve the quality of care and better outcomes, the results of these programs are mixed, and some may have contributed to health disparities. For example, Medicare's hospital value-based programs have been found to disproportionately penalize safety-net hospitals that care for high proportions of Black patients.

The following policies and strategies could reduce barriers and advance health equity in the Medicare program:

Enhancing Enrollment Education and Assistance

- Streamlining and simplifying Medicare coverage options and rules could reduce the program complexity and confusion among beneficiaries, improve access to comprehensive care, and enhance program oversight.
- Improving consumer education and enrollment assistance resources, such as by enhancing online plan comparison tools and increasing funding for State Health Insurance Assistance Programs, would assist beneficiaries in making informed decisions about their coverage options and avoid mistakes, which in turn could promote better access to all needed services and minimize financial burdens.

Reducing Beneficiary Financial Burdens

- Protecting beneficiaries from high medical bills could be accomplished by lowering out-of-pocket maximum thresholds for Medicare Advantage plans and establishing out-of-pocket maximums in Original Medicare.
- Improving access to and enrollment in available financial assistance programs could be accomplished by enhancing outreach and education efforts, simplifying enrollment, removing asset tests, and increasing income limits.

Improving Access to Care

- Improving the comprehensiveness of benefits under Original Medicare would improve access to services currently not covered, such as hearing, vision, and dental services, and eliminate differences between coverage offered by Medicare Advantage and Original Medicare.
- Improving access to care in Medicare Advantage could be accomplished by strengthening network plan adequacy requirements, adding guidance and oversight over the prior authorization process, and streamlining appeals of denials.

Incorporating Equity Considerations in Oversight and Accountability

- Improving the quality and completeness of Medicare beneficiary race and ethnicity data, as well as data on other demographic characteristics such as language or sexual orientation, would allow CMS to identify disparities and develop more effective policies and strategies to advance equity.
- Requiring stratified reporting by race/ethnicity and other key characteristics in quality improvement programs, consumer surveys, value-based payment initiatives, and other efforts would similarly allow CMS

to identify and hold providers and Medicare Advantage plans accountable for addressing identified disparities.

- Requiring that all Medicare Advantage plans convene community advisory boards consisting of members, providers, consumer advocates, and other interested stakeholders would improve governance and meaningfully engage beneficiaries in policy and program development, evaluation, and oversight.

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GLOSSARY

Accountability is an assurance that an individual or organization is evaluated on its performance or behavior related to something for which it is responsible.

An **appeal** is a request to a health insurer to review a decision that denies a benefit or payment for health care services or medications.

The **federal poverty level** is a measure of income issued every year by the Department of Health and Human Services. Federal poverty levels are used to determine your eligibility for certain programs and benefits, including savings on Marketplace health insurance and Medicaid and CHIP coverage.

Federal subsidies are cash assistance available to purchase health coverage at reduced or no cost for people with incomes below certain levels.

Fee-for-service is a traditional type of insurance payment in which the health plan will reimburse the medical provider directly for each covered medical expense after services are delivered.

Health disparities are preventable differences in disease, health status, or opportunities to achieve optimal health experienced by socially disadvantaged racial, ethnic, and other population groups and communities.

Health equity is the state in which everyone has a fair and just opportunity to attain their highest level of health.

Prior authorization is a required approval from a health plan before a patient receives a service or fills a prescription in order for the service or prescription to be reimbursed.

Quality measures are tools that help assess or quantify health care processes, outcomes, patient experiences, and organizational structures and/or systems associated with providing high-quality health care.

Value-based payments attempt to improve quality of care and reduce health care costs by linking provider payments to specific metrics or goals (such as improving rates of patients screened for depression). The amount of payment providers receive depends on their performance on selected metrics.

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