Structured Inefficiency: The Impact of Medicare Reform On African Americans

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Summary – *Recent passage of H.R. 1, the Medicare Prescription Drug, Improvement and Modernization Act, has created a need to better understand the complexities of the new law upon underserved populations. This paper summarizes key aspects of the legislation including the prescription drug benefit and the expanded support for private insurers and analyzes their likely effect on African American seniors—a vulnerable Medicare population. Prescription drug and other reforms are assessed in relation to minority health disparities and other concerns related to health care access, cost and quality.*

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Introduction

On December 8, 2003 President George W. Bush signed the Medicare Prescription Drug, Improvement, and Modernization Act into law. Touted as the most sweeping change to Medicare since its passage in 1965, provisions in the legislation include a new Part D prescription drug benefit for seniors effective in 2006, a drug discount card that seniors can buy in the interim, substantial subsidies and other incentives to private insurers, and a Part B asset test for high income individuals among other reforms. The Congressional Budget Office estimates the legislation will cost $395 billion over the next ten years.

As the American public begins to digest the bill's economic, philosophical and programmatic implications, it is imperative to better understand how the new law affects special populations—particularly African Americans who have a unique relationship to the U.S. health system. Due to a number of factors, rooted in social, political, and economic inequities, African Americans are less likely than whites to have access to quality, consistent, and affordable health care and education over a lifetime. As a result, they are more likely to experience high rates of disability, morbidity and mortality related to chronic conditions such as Type 2 diabetes, heart disease, stroke, kidney disease, and high blood pressure. Indeed, this reality is reflected in statistics that show 43 percent of African American Medicare beneficiaries describing their health as poor or fair, compared to only 26 percent of whites.[1]

The poorer health status of African American seniors is compounded by their lower socioeconomic status (SES). While 40 percent of all Medicare beneficiaries have incomes below 200 percent of the federal poverty level, 65 percent of African American beneficiaries fall below 200 percent of the poverty level and 33 percent have incomes that fall below the poverty level itself.[2] Given their poorer health and economic status, it is perhaps not surprising that a recent study found that African American seniors are *more than twice* as likely as whites to report being unable to afford filling at least one prescription in the previous year.[3] A significant part of this gap in access could be attributed to the presence of chronic conditions, SES factors like education and income, and a lack of supplemental health coverage that would help offset the costs of prescription drugs.[4]

While Medicare has been an important source of health coverage for African American seniors for almost forty years, it is evident that the need for a prescription drug benefit has been long overdue. An analysis of the recently passed law, however, raises serious questions about the adequacy of the prescription drug benefit passed and the impact of other enacted reforms.

Analytical Framework

Three primary questions guide this analysis. First, do the provisions of the new legislation increase African American's access to health care and prescription drugs? In other words, will the benefits be affordable and readily available? Second, does the legislation increase the quality of health care provided to African Americans? Since African Americans experience severe health disparities, it would seem logical that reforms would address a major quality of care issue for a significant percentage of the Medicare population. Furthermore, as questions of unequal treatment in the health system arise and are substantiated, it is important to ensure that reforms account for the need to support culturally competent care and other equalizing health measures.[5] Finally, does the legislation's fiscal structure promote the best interests of African American seniors and the African American community at large?

The Medicare Prescription Drug Benefit

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173), adds a prescription drug benefit to the Medicare coverage options beginning in 2006. Starting approximately in June 2004, Medicare beneficiaries may purchase a prescription drug discount card from private companies that negotiate reduced prices with pharmaceutical companies. The card can cost up to $30 per year, although states may opt to pay that fee for beneficiaries. Most Medicare beneficiaries may obtain the card, excepting those that currently receive prescription drug coverage through Medicaid.

In 2006, enrollees will be offered a minimum of two prescription drug plans administered by the lowest competitive bidders. At least one of these plans must be a stand-alone drug benefit plan that is not incorporated into a medical insurance plan. If no plans bid in a region, Medicare will provide a fallback plan. A tax-free subsidy incentive is offered to employer-based plans that continue to offer coverage to retirees, though it doesn't cover the full cost of providing that care.

Features of the Prescription Drug Benefit:

Means testing determines the plan structure:

- Standard Benefit (above 150% FPL)*
  - $250 annual deductible
  - Unfixed premium, estimated to be $35
  - 75% coverage up to a cap of $2,250
  - Zero coverage between $2,250 and $5,100
  - Catastrophic coverage at $3,600 out-of pocket, or $5,100 total drug spending
  - 5% copayment above catastrophic level
- Low-income Benefit (<100% FPL)
  - Full subsidies for premiums and deductibles
  - $1 and $3 copays for individuals with assets under $6,000 and couples with assets under $9,000
  - No doughnut hole, or coverage gap
  - Complete catastrophic coverage
- Low-income Benefit (100–135% FPL)
  - Full subsidies for premiums and deductibles
  - $2 and $5 copays for individuals with assets under $6,000 and couples with assets under $9,000
  - No doughnut hole, or coverage gap
  - Complete catastrophic coverage
- Low-income Benefit (135-150% FPL)
  - Unfixed sliding scale premium
  - $50 deductible
  - 15% copays in the doughnut hole up to the catastrophic coverage level
  - $2 and $5 copays for individuals with assets under $10,000 and couples with assets under $20,000 after catastrophic is reached.

* Federal Poverty Level
Source: House Ways and Means Committee, *Summary of Medicare Conference Agreement* 11/21/03

While employers are not prohibited from offering supplemental benefits to Medicare beneficiaries, the plan is structured to provide a strong financial disincentive for them to do so. As a result, many retirees could still end up with less generous drug coverage than they had previously through employer-based plans.

The features of the benefit plan are determined by means testing, a complete upheaval of the traditional social insurance nature of Medicare. The payment format is set by the poverty status of each beneficiary. Individuals above 150 percent of the federal poverty level qualify for the standard benefit structure, while individuals below this level qualify for the low-income benefit structure. The standard benefit has a set deductible of $250, an unfixed premium, and 75% coverage up to $2,250 of total drug spending. At this point, beneficiaries face a doughnut hole, or period of zero drug coverage, until total drug spending reaches $5,100. Adding insult to injury, a minute provision of the new law prohibits Medigap insurers (who offer supplemental plans to Medicare recipients) from offering coverage for the doughnut hole[6] or any other cost-sharing measures. As a result, beneficiaries without employer-based supplemental insurance will face a substantial coverage gap. Under the standard plan, many recipients will be worse off than before, including those in poor health and those that will lose generous employer-based coverage when the Medicare drug benefit becomes available.

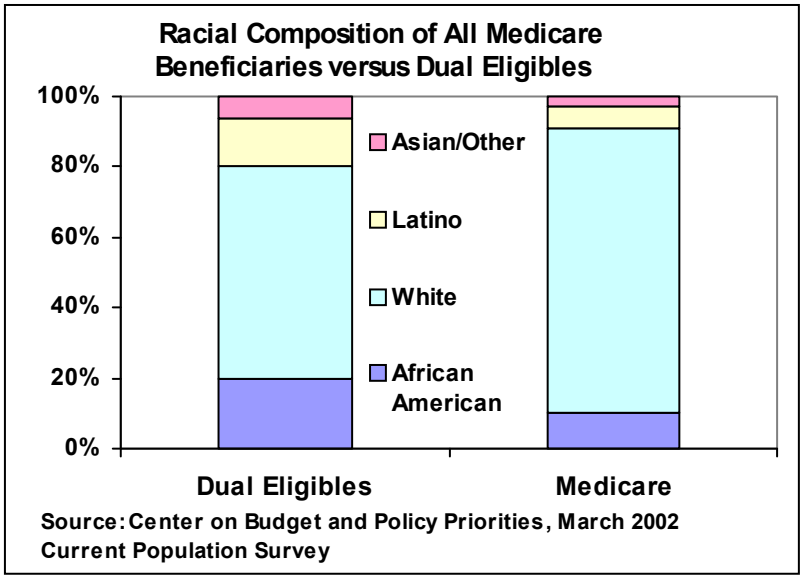
At first glance, the low-income benefit appears to be beneficial, at least for those below 150% of the federal poverty limit who qualify for this price structure. For those below 135% of the federal poverty level, there is no premium or deductible and there are low co-payments that are applicable through the doughnut hole or coverage gap. For those between 135% and 150% of the federal poverty level, there is a $50 deductible, a sliding scale premium, and a 15% co-insurance that is also applicable through the doughnut hole or coverage gap. This low-income plan is certainly more desirable than the standard plan. However, while the low-income plan offers inexpensive costs at present, the Medicare bill contains cost-containment provisions that allow coinsurance costs to rise as the costs of pharmaceuticals increase. This provision is coupled with a non-negotiation clause, which prevents Medicare from negotiating lower prescription drug prices with pharmaceutical companies. As a result, costs to all beneficiaries are expected to escalate in the coming years.

Furthermore, the new bill revokes some of the federal matching payments available to states for wrap around Medicaid coverage of prescription drugs that dual eligibles presently enjoy. Wrap-around coverage treats Medicare as the primary payer, but allows Medicaid to supplement the benefits offered, fill coverage gaps, and subsidize copayments. According to the U.S. House of Representatives Ways and Means Committee conference report, Medicaid can offer supplemental coverage of classes of prescribed drugs not included in the Medicare plan, such as over-the-counter drugs, but cannot supplement covered

medications. Dual eligibles and other low-income beneficiaries will face benefit cutbacks and cost increases, making them worse off under this new plan.

Issues for African Americans

African Americans represent a disproportionate number of low-income Medicare beneficiaries, and therefore are overrepresented among dual eligibles, or individuals that qualify for coverage through both Medicare and Medicaid. While African Americans make up about 10 percent of all Medicare beneficiaries, they comprise 20 percent of dual eligibles. For this reason, African American Medicare recipients are particularly vulnerable to clauses of the new policy that are detrimental to lower-income populations.



For example, the loss of federal matching funds for Medicaid wrap-around coverage will be particularly damaging to African Americans who are dually eligible for Medicare and Medicaid. Although the low-income benefit plan offers assistance to beneficiaries in the form of reduced payment scales and uninterrupted coverage, the new plan will still be more costly to dual eligible seniors who currently receive a more generous prescription drug package through their state Medicaid drug assistance programs. At such extremely low income levels, an increase of even a few dollars can result in cutbacks in medical care and treatment, since beneficiaries may be unable to produce the extra money that is required.

Additionally, dual eligibles that participate in their state Medicaid drug assistance programs have become accustomed to accessing the drugs that they need from a pharmacy of their choice. The new prescription drug plans may include a smaller network of pharmacies that these seniors can use. This could result in reduced access if pharmacies are not conveniently located in neighborhoods where these seniors are used to filling their prescriptions.

Other concerns for low-income African Americans include the absence of real cost containment provisions in the law that prevent premiums, deductibles and other costs from rising exponentially. Given the steady increase in the cost of

prescription drugs, deductibles could skyrocket in the coming years, leading to lost coverage for beneficiaries who cannot afford to pay them. This problem is exacerbated by the non-negotiation clause of the bill, which prevents Medicare from using its large market share to negotiate lower costs with pharmaceutical companies. Without negotiation, there will be no measure to check the rising costs of prescription drugs, premiums, and deductibles will be forced upward. This is a threat to low-income, working and middle class retirees on a fixed income—particularly those who lack supplemental coverage from outside insurance.

African Americans are less likely than whites to have supplemental employer-based or private insurance. A Henry J. Kaiser Family Foundation report[7] noted that 58 percent of African American Medicare recipients have no supplemental insurance beyond Medicaid, compared to just 21 percent of whites. Of particular concern is the doughnut hole for Medicare recipients above 150 percent of poverty. Without assistance to cover this gap, African American beneficiaries lacking other supplemental insurance may be forced into a risky period of non-coverage. Furthermore, African Americans are more likely to reach the coverage gap faster than whites due to their poorer health status.

Another serious concern for African Americans is the limitations of the preferred drug lists, or formularies offered by prescription drug plans (PDP). As currently structured, consumers would be unable to learn about the types of drugs offered on insurers preferred drug lists prior to joining a PDP. Furthermore, plans are allowed to change the types of drugs included in their formularies at will even though enrollees are only allowed to change their plan coverage once a year. The law also allows insurers to vary the cost-sharing amount paid to beneficiaries by drug type or class.

Concerns for African American Medicare Beneficiaries:

- The loss of a federal match for selected Medicaid wrap-around coverage leads to reduced drug benefits for dual eligibles.
- Means testing weakens Medicare, by turning it into a social welfare program that is vulnerable to future attack.
- While the low-income benefit plan offers inexpensive coverage at present, costs to recipients are expected to rise steadily—a real threat to those on a fixed income.
- The non-negotiation clause prevents Medicare from securing deals with pharmaceutical companies to provide drugs at lower costs to beneficiaries.
- Pharmacy networks created by private plans may reduce access to convenient pharmacies.
- The doughnut hole leaves many African American beneficiaries above 150% of poverty with a large coverage gap that cannot be filled with Medigap.
- Drug formularies are subject to change and may not cover drugs important to African Americans.

The types of drugs offered through a plan formulary are very important for African Americans as medical science has determined that the level of responsiveness to specific drugs can vary significantly based on racial and ethnic categories.[8] For example, African Americans with high blood pressure have been shown to have different responses than whites to

antihypertensive drugs like Beta-blockers.[9] Thus, health outcomes and the quality of care for African Americans could be severely compromised by formulary restrictions. While the legislation allows for appeals to the drug formulary, this process would be onerous and could also jeopardize health outcomes with the time and effort needed to pursue this option. In addition, the possibility of varying cost-sharing amounts charged to beneficiaries by drug type or class could have an adverse effect on African Americans struggling to afford their share of payments for unique and/or costly medication needs (e.g. patients with End Stage Renal Disease).

A final related concern is the question of what happens to working and middle-income beneficiaries who fail to pay the required premium amount. This scenario would likely be a non-issue for the many beneficiaries who have their premiums automatically deducted from their Social Security checks. However, others who do pay directly—primarily those enrolled in private insurance plans—but fail to meet premiums for their creditable prescription drug coverage could be dropped from their plans and face higher fees if and when they seek to re-enroll. The Congressional Budget Office estimates that approximately half of all beneficiaries will reach the doughnut hole but less than 18 percent will have drug costs high enough to ever regain coverage at catastrophic levels.[10] Thus, some beneficiaries may calculate that it is in their best interest to drop coverage after reaching the doughnut—but their attempts at cost-savings will result in more expensive coverage upon their return and the possibility (if its in the same year) of having their benefits "re-rack" which means that program credits for their paid deductible and out-of-pocket drug spending could be erased.

Other Medicare Reform Issues

There are a number of provisions outside of the prescription drug benefit that will also have a direct impact on African American beneficiaries and the future viability of the Medicare program.

Medicare Part B Deductible Increase

Since 1991, the Medicare Part B deductible has been set at $100 per year. The new law increases the deductible to $110 in 2004 and pegs the Part B deductible to the rate of inflation thereafter. Combined with the expected increases in prescription drug co-pays, premiums, and deductibles, the inflationary increases in Medicare Part B deductible will likely make it even harder for African American beneficiaries with modest means to meet their share of future costs.

Kidney Disease Provisions

Provisions related to those with End Stage Renal Disease (ESRD) are important to African Americans who comprise 29 percent of the treated population and

have a prevalence rate that is 4.4 times higher than whites.[11] Traditionally, beneficiaries with ESRD get dialysis and other necessary services through Medicare Part B, which covers 80 percent of these outpatient services. Beneficiaries usually pay for the cost of the other 20% through Medigap or other private supplemental insurance. Many low-income ESRD beneficiaries have been able to cover the additional cost through supplemental Medicaid coverage.

It is important to note that individuals who have already developed ESRD are not allowed to join HMOs, however those who develop it while participating in a private plan can maintain their coverage. In the past, concerns have been raised about the amount of cost-sharing ESRD beneficiaries have been required to bear under Medicare Plus Choice. Because ESRD patients have to dialyze up to three times per week, co-pays for each visit can become exorbitant. Thus, rising co-pays, premiums and deductibles can place a serious financial burden on African American ESRD patients—many of whom are dual eligibles and have only modest Social Security income from which to contribute.

With the retirement of the baby boom generation and the increase in the incidence of diabetes in the general population—but particularly with African Americans—the ESRD population is expected to grow exponentially in the future. While the new law standardizes ESRD payments to private insurers and provides a modest increase in reimbursements to ESRD facilities, there are significant questions about whether these provisions adequately address the growing needs of this very costly subpopulation of the Medicare program.

Private Insurers and Risk

The legislation offers expansive financial and structural incentives in an attempt to attract and retain Health Maintenance Organizations (HMO) and Preferred Provider Organizations (PPO) operating in the Medicare program. Called Medicare Advantage (MA), this initiative gives a new name to the failed Medicare Plus Choice experiment of the 90's in which HMOs dropped out of the program at alarming rates due to unprofitable operations.[12]

Seeking to avoid the mistakes of the past, Medicare Advantage gives preferential treatment to HMOs and PPOs by providing payment rates that will be 25 percent higher than those paid to the traditional Medicare fee-for-service program and establishing "risk corridors" and a stabilization fund to limit private insurers exposure to market risk. While the subsidies will no doubt increase the strength of private insurers, they—along with other structural factors—will place HMOs and PPOs in a stronger position to induce more beneficiaries to join their programs—at the expense of the traditional Medicare program.
The new bill provides an unprecedented amount of financial assistance to private insurers that will have the effect of diverting precious resources away from the traditional fee-for-service Medicare plan. Instead of using federal funds to prop up private insurers, this money could have been used to improve upon traditional

Medicare--where more than 85% of beneficiaries receive their care. The preferential financial treatment of private insurers also establishes an unfair competition between the private plans and traditional Medicare that begins—not in 2010 (when a formal demonstration competition is set to start) but in 2006 when the changes in the law take effect. Traditional Medicare is set up for failure because government-subsidized private plans will lure beneficiaries away with offers of more generous benefits leaving the traditional program struggling to make ends meet while still covering the most expensive beneficiaries whom private plans refuse to accept. Not only does this approach pave the way for the privatization of Medicare, it also unfairly sets up beneficiaries who will be left holding the ball when the generous initial benefits offered by private plans are curtailed in the future as costs rise and government subsidy amounts decrease.

Furthermore, the operating norms of HMOs have distinct racial implications that must be considered if private insurers are positioned to play a greater role in providing care to America's seniors. As private, for-profit corporations Health Maintenance Organizations have traditionally sought to achieve greater profit margins by targeting healthier, low-cost clientele and imposing strict controls over access to specialists and utilization of high-cost medical procedures. As mentioned previously, low income and African American seniors tend to be in poorer health—disproportionately suffering from chronic conditions that can be costly to treat. Additionally, African American seniors tend to reside in geographical clusters corresponding to racially stratified residential patterns.[13] As a result, there is a possibility that racial discrimination can occur through a process of "medical redlining"—private insurers seeking to avoid adverse selection in their risk pools by cherry picking preferred participants based on health status and medical history, establishing operations in areas where the density of high cost (i.e. low-income and minority enrollees) is lower, or a combination of both.

As it happens, several provisions built into the new legislation reduce incentives for private insurers to behave in a discriminatory fashion as they somewhat alleviate the consequences of adverse selection. The requirement for MA plans to cover one or more entire regions (instead of locales) gives them an opportunity to establish diverse risk pools across wider geographic areas. The creation of risk corridors, in which insurers are responsible for only a narrow margin of losses before government steps in to share the expenses, and a stabilization fund, providing additional government payments to insurers who incur losses, could alleviate historical disincentives for private insurers to enroll high-risk (e.g. unhealthy, high cost) beneficiaries. Because these subsidies guarantee private insurers a base of financial support upon which they can maintain a decent profit margin despite high cost enrollees, they are likely to lower disincentives for HMOs and PPOs to establish operations even in geographically unprofitable areas.

While this situation may afford more African American seniors greater access to HMOs, it could have a negligible effect on disparate pricing as the law allows insurers to employ traditional risk adjustment techniques that could set higher prices for premiums, deductibles, and co-pays in regions where African Americans are concentrated. To complicate matters, if the stability of the traditional Medicare program is jeopardized in a future where private insurers reign, African American beneficiaries on a fixed-income would be at the mercy of plans that view their health status and ability to pay as a threat to their profit margin. Thus, pricing tools and other cost-saving methods used by private plans could result in a reversal of the tremendous strides in health care access and quality made by African American seniors after the Medicare program was created.

Physician Choice

Traditional fee-for-service Medicare enables beneficiaries to choose from any physician who accept Medicare payments. HMOs and PPOs, however, would restrict access to physicians by creating a limited physician network from which enrollees must select. These limitations could adversely affect African American beneficiaries who may prefer physicians that are not included in the network or that get dropped from the plan.

The expanded role of HMOs and PPOs may have a related effect: the increased marginalization of African American physicians. Many black doctors have expressed concerns about discriminatory treatment from private insurance networks.[14] Indeed, studies have found that physicians who treat disproportionately poor and minority patients—as African American physicians typically do—could face exclusion from HMO networks.[15] Other studies have shown that minority physicians are less successful in obtaining hospital admissions and referrals to specialists in managed care settings.[16]

Lack of physician choice creates real quality of care concerns as it minimizes or negates the ability of African American beneficiaries to receive reliable, culturally competent care—important factors for improving minority health outcomes.

Quality of Care

While studies show that African Americans have greater access to care under Health Maintenance Organizations, a number of analyses have demonstrated that their increased access does not translate into improved quality of care, compared to non-minority populations.[17] Indeed, poorer health outcomes have been a persistent problem for minorities enrolled in Medicare and HMOs.[18]

Given the body of evidence illustrating the existence of minority health disparities, it seems logical that structural changes to the program should incorporate provisions that seek to eliminate these disparities in the Medicare

population. While the new legislation does not explicitly address minority health disparities, it does include several provisions that could facilitate the study and possible adoption of program features geared toward eliminating these disparities.

The law requires the Institutes of Medicine of the National Academies of Science (IOM) to complete a report within a year of enactment that specifies how health care performance measures can be improved upon. Given IOMs experience crafting the path-breaking "Unequal Treatment" study, their recommendations should include sustained attention to program design recommendations related to the elimination of health disparities.[19] The new law also requires Medicare Advantage organizations to maintain an "ongoing quality improvement program" that improves the quality of care for HMO/PPO enrollees. The provision gives specific instruction for private insurers to improve upon chronic care management—a provision that could benefit African Americans but fails to address this matter from the perspective of racial disparities. Perhaps most importantly, the law contains a Health Care Quality Demonstration Program that permits the Secretary of Health Human Services to approve projects that improve patient care quality including one that would examine, "the appropriate use of culturally and ethnically sensitive health care delivery." Several other miscellaneous studies included in the new law provide opportunities to consider how to build program features that reduce and eliminate minority health disparities.

Health Savings Accounts

Touted as a new way to help Americans save for future health needs, H.R. 1 establishes health savings accounts. These accounts have a preferential tax structure that allows for tax-free contributions and withdrawals. While the tax advantages seem great, these accounts would only be available to those individuals with high-deductible private health insurance—in other words, disproportionately wealthy and white populations.

Additional questions arise as to whether these accounts are being positioned to serve an expanded role in a future where Medicare is privatized (like proposals to create private accounts in the Social Security program). Accordingly, these accounts could lead to a future where individuals are expected to carry a heavier responsibility for their medical care—relieving private employers and the government from their historic role in this area.

The End of Medicare

Contained within the legislation is a premium support demonstration program that is designed to test the economic efficiency of private insurers versus the traditional Medicare program. The demonstration project, set to begin in 2010, would set up a competition between traditional Medicare and MA HMO/PPOs in six regions. Even though the stated goal of the project is to determine which health care delivery structure provides the greatest efficiency, there are significant concerns that this provision will pave the way toward the privatization of Medicare.

There are a number of reasons why a demonstration project of this nature makes little sense from a structural perspective. The primary reason is that private insurers will have an unfair and artificial advantage in the competition due to the generous governmental subsidies and other benefits provided to them. Higher reimbursement rates, discretionary pricing arrangements, incentive payments for prescription drug coverage bids, risk corridors, and stabilization funds are all forms of corporate welfare that are likely to give private insurers the appearance of greater efficiency upon completion of the demonstration project. Traditional Medicare would be disadvantaged because it would not enjoy the benefits of these preferential arrangements and also because it will continue to serve as a provider of last resort to beneficiaries in extremely poor health who cannot join or are dropped from private plans due to costly chronic conditions.

African Americans should be wary of efforts to undermine the social insurance nature of the Medicare program. Historically, it was implementation of the Medicare program nearly 40 years ago that erased Jim Crow era health care practices in the South.[20] For the first time ever, all U.S. hospitals had to disband segregated facilities in order to be eligible to receive millions of dollars in federal Medicare funds.[21] Subsequently, African American seniors enjoyed increased access and quality of care than they had previously been accustomed.

Practically speaking, social insurance programs have traditionally operated in an egalitarian fashion where everyone is literally “in it together.” Unlike social welfare programs that are means tested by income to determine eligibility, social insurance programs are viewed not as a hand out but as a benefit earned and paid for by individuals through a working lifetime of Federal Insurance Contribution Act (FICA) payroll tax contributions matched by their employers.

Thus, American society has traditionally supported social insurance programs while ridiculing social welfare programs in which recipients collect costly benefits that are by and large viewed as unearned. For this reason, introducing upper and lower income means testing into the Medicare program represents a fundamental departure from the philosophy of social insurance and could very well threaten the future popularity of Medicare. This would be detrimental to African Americans and all beneficiaries in the long run as it could eliminate a

social good that is vitally important to the economic stability of middle class and low-income families.

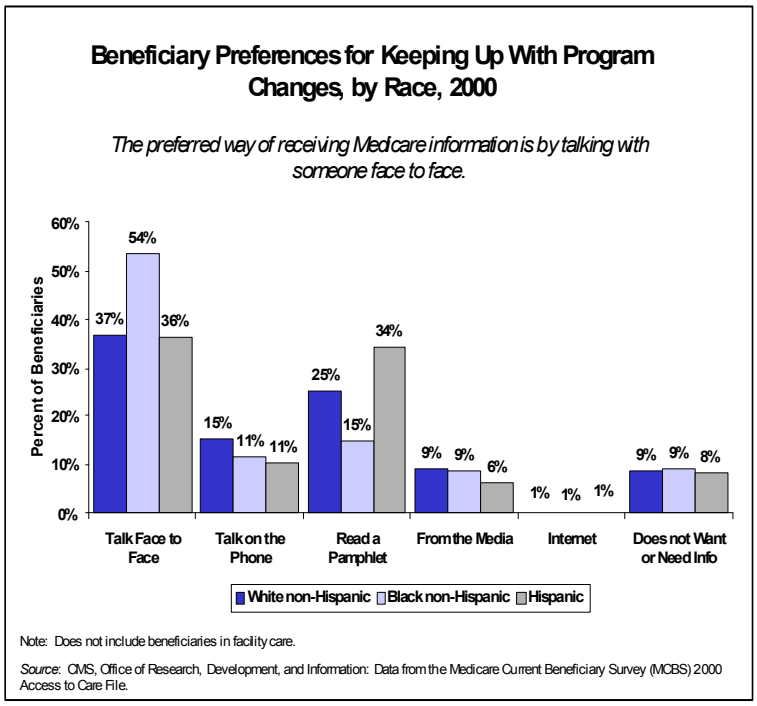
Positive Benefits

There are several aspects of the Medicare Prescription Drug, Improvement and Modernization Act that will have a positive impact on African American Medicare beneficiaries. They include:

- Preventive Health Screenings: While Medicare currently covers diabetes self management training, home testing strips and the blood glucose monitors that diabetics need in order to manage their disease, Medicare has not traditionally covered the tests needed to screen for diabetes. H.R. 1 establishes that Medicare will now pay for diabetes screening tests for those at risk for diabetes. The new law also covers an initial physical exam for new beneficiaries and screening tests for cardiovascular disease. Each of these new preventive benefits will be important to African Americans who suffer disproportionately from complications related to Type 2 diabetes and cardiovascular disease.

- Federally Qualified Health Centers (FQHC's): Serving low-income communities where minorities are disproportionately located, FQHC's provide an important source of health care for low-income African Americans. In addition to a safe harbor provision that would allow FQHC's to receive donations and other contributions from private and nonprofit sources without penalty, FQHC's would also receive wrap-around payments to provide full coverage for reimbursement shortfalls that occur when private insurance plans pay less than what the FQHC-provided services cost.

- Beneficiary Outreach Demonstration Program: The bill establishes a demonstration



Note: Does not include beneficiaries in facility care.

Source: CMS, Office of Research, Development, and Information: Data from the Medicare Current Beneficiary Survey (MCBS) 2000 Access to Care File.

program requiring Medicare specialists to conduct outreach at Social Security offices in at least 6 areas. Centers for Medicare and Medicaid Services (CMS) survey data illustrates that African Americans are most likely to prefer receiving information about program changes through personal communication. With African Americans already more likely to report little knowledge about the Medicare program, it becomes even more important to conduct aggressive outreach targeted to this population.

- Disproportionate Share (DSH) Payments Increased: Currently, hospitals that serve a disproportionate share of low income patients with special needs receive federal DSH payments to help cover the costs of uncompensated care. The new law effectively increases DSH payments by 16 percent in 2004. States that have received lower DSH payments in the past will receive a 16 percent increase annually for five years. This provision provides much needed relief to hospitals that serve low-income communities with high-uninsured populations—especially those hospitals located in poor, urban areas where African Americans are disproportionately concentrated.

- Federal Reimbursement for Undocumented Workers: The law makes $250,000,000 available each year from 2005-2008 to disburse (by formula) allotments to providers in states that furnish emergency health services to undocumented workers. The six states serving the highest number of undocumented workers will receive an additional $83,000,000 per year to cover costs.

- Citizens' Health Care Working Group: The Agency for Health Care Quality and Research will convene a Citizen's Health Care Working Group comprised of 15 individuals, 14 of whom will be appointed by the U.S. Comptroller General. In addition to health care experts, working group members are to include representatives of the uninsured, chronically ill, and disabled among other groups. The working group will be charged with holding hearings on topics that include state and local strategies for expanding health coverage and will be responsible for producing a final report entitled, "The Health Report to the American People."

Policy Recommendations

In light of the shortcomings of the new Medicare structure, lawmakers should seek to make the following amendments to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003:

- **Contain soaring prescription drug costs by allowing Medicare to negotiate lower drug prices.** Medicare should be permitted to use its large market share to negotiate lower prescription drug prices with

pharmaceutical companies. Medicaid and the veterans' benefits programs have been allowed to do this, with the result of lowering federal spending on these programs. This is particularly prudent during this time of fiscal shortfalls and given the soaring price of pharmaceuticals.

- **Eliminate unfair subsidies and other advantages provided to Medicare Advantage plans so that traditional Medicare can compete on a level basis.** Higher reimbursement rates, discretionary pricing arrangements, incentive payments for prescription drug coverage bids, risk corridors, and stabilization funds are government subsidized windfalls that give private insurers an unfair advantage that should be leveled if an honest competition with traditional Medicare is to take place.

- **Further limit the rising cost of premiums, deductibles and copays.** Pegging coinsurance payments to the rise in the cost of drugs and/or inflation places an undue burden on seniors with fixed Social Security incomes. Cost-sharing payments should be de-linked from these markers in an effort to provide much needed assistance to seniors. This could also be accomplished by redirecting government subsidies from private plans to beneficiaries to assist them with their cost sharing responsibilities.

- **Permit states to provide funds for premium, deductible, and copayment assistance for low-income beneficiaries that are not dual eligible.** This would aid low-income beneficiaries that do not qualify for Medicaid, while still preserving the social insurance nature of the federal Medicare program.

- **Guarantee all beneficiaries a standard drug benefit under the Medicare program.** Historically, private insurers have been unreliable health care providers for Medicare beneficiaries. While we have no experience with the new private drug plans, there are enough concerns with private insurers to build in a guaranteed system of prescription drug delivery. In order to guarantee drug coverage to all Medicare beneficiaries—but especially African Americans—the government should make the drug benefit available in all regions of the country through the traditional Medicare program.

- **Build program features designed to monitor and eliminate minority health disparities.** This would dramatically enhance the quality of care provided to minority beneficiaries since it would improve data collection procedures that would facilitate monitoring treatment and outcomes by race and an incentive system to reward physicians and plans that work to equalize health outcomes.

- **Require private plans to guarantee racial and ethnic diversity in their health care provider networks.** Plans should keep data on the

racial/ethnic composition of their physician networks and maintain provider diversity at levels that correspond to the racial and ethnic composition of the enrollee population. This provision will facilitate culturally competent care and contribute to improved quality of care for African Americans beneficiaries.

- **Extend the Social Security demonstration project to include outreach and education to other community-based settings where African American seniors congregate.** CMS survey data shows that 46 percent of African American reports that they have little or no knowledge about the Medicare program, compared to 27 percent of whites.[22] Given this discrepancy, it will be important for CMS to establish aggressive face-to-face outreach efforts that educate African Americans about program changes.

- **Expand the Citizen's Health Care Working Group to include representatives of minority communities and attention to health disparities.** The working group should reflect the diversity of America and should include sustained attention to health care issues from the perspective of racial and ethnic minorities. Although only 30 percent of the U.S. population, African Americans Hispanics and Asian Americans account for 52 percent of the nation's uninsured[23] and experience documented disparities in health care.

Conclusion

Medicare has provided more than 93 million seniors and disabled persons with access to quality health care and affordable coverage since its enactment in 1965.[24] Since its passage, life expectancy has increased by 20 percent, seniors have achieved near-universal access to care, and the quality of life has dramatically improved for many older Americans.[25]

While certain changes to the Medicare program, like the addition of a prescription drug benefit, have been long overdue, there are serious questions as to whether the changes enacted represent an optimal reform strategy: one that strengthens the fiscal solvency of the program while increasing health care access and quality.

Increased out-of-pocket costs, onerous asset tests, restricted prescription drug choices, and limited access to pharmacies and physicians are all factors likely to undermine health care access and quality for African American beneficiaries. The new law further destabilizes quality of care for this population by ignoring program changes that would help close minority health disparities and eschewing substantive provisions that would promote culturally competent care. Finally, the need to improve the Medicare program's fiscal stability has been subverted by

massive transfers of federal funds (subsidies) to private insurers who will likely pocket much of these taxpayer dollars through artificially derived profit margins. Given these factors, this analysis concludes that the reforms could do more harm than good to both African American beneficiaries and the Medicare program itself.

Officials at the Department of Health and Human Services are now charged with interpreting and implementing the legislation passed by Congress and signed into law by the President. It would be prudent for Administration officials to refine various provisions in this law to explicitly address many of the issues outlined in this analysis. Furthermore, it will be imperative that CMS launch extensive outreach efforts targeting African Americans who are already more likely to report knowing little or nothing about the Medicare program.[26] African American seniors are an important yet vulnerable group within the Medicare population. Program features designed to improve their access to and quality of care should be a fundamental concern to program administrators.

Finally, there are a myriad of problems with the new law that cannot be solved through regulatory adjustments made by the Administration. Foremost among them is the level of structured inefficiency that is built into the law in the name of encouraging free market enterprise. Congress must revisit the Medicare reform package to correct the law's more egregious aspects and produce a resulting bill that rewards true fiscal efficiency (e.g. low administrative costs), improved access to care and quality health care outcomes.

ENDNOTES

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