THIRD WAY

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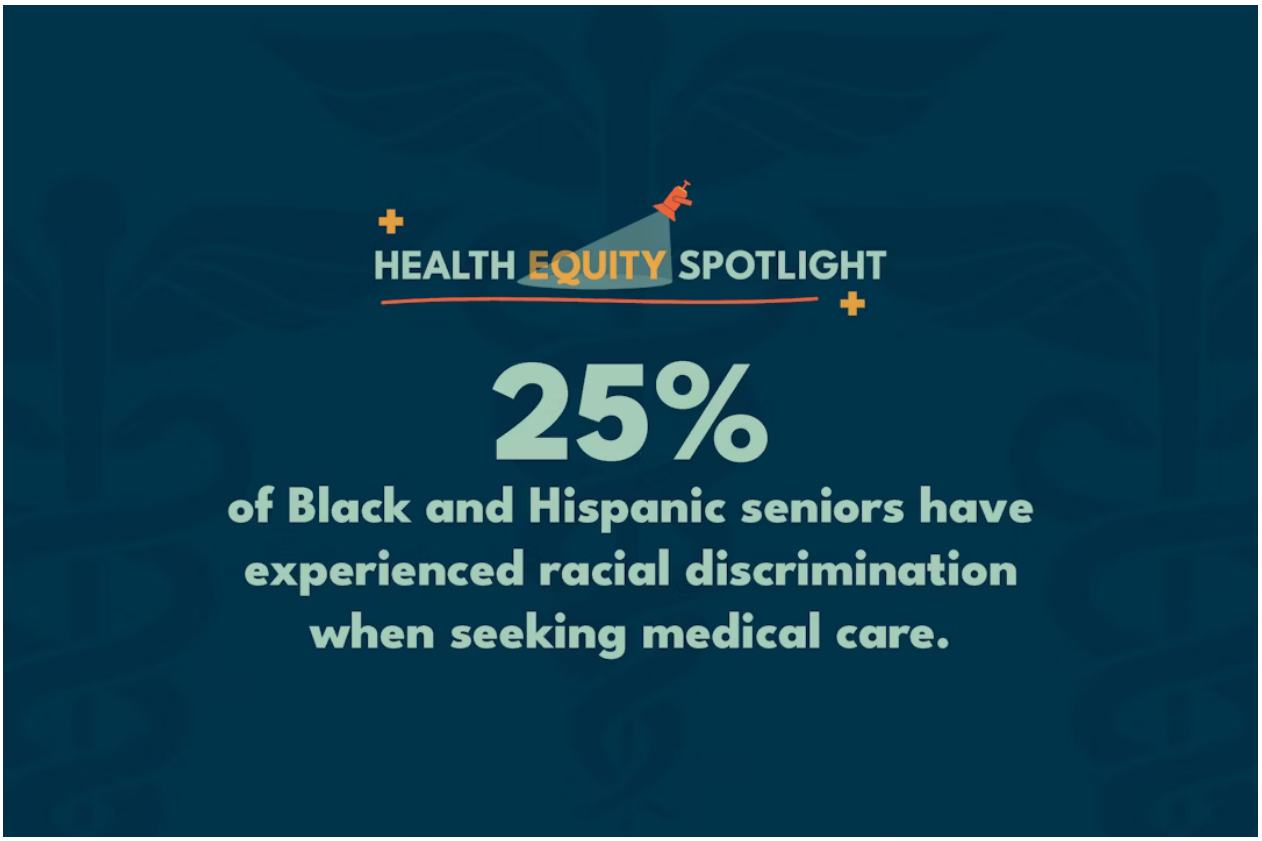
Making Health Care Equitable for Older Americans



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The current health care system isn't working for enough seniors of color. One in four Black and Hispanic seniors reported being treated unfairly or not having their health concerns taken seriously because of their race. And 27% of seniors who experienced racial discrimination said they didn't get the care they needed as a result.

These and other disparities have clear consequences for seniors' health and livelihood. The life expectancy of Black seniors is four years shorter than that of white seniors. Larger shares of Black and Hispanic Medicare beneficiaries reported being in fair or poor health than white beneficiaries—they see higher rates of hypertension, diabetes, heart disease, and more. People of color are more likely to develop chronic illnesses due to social and environmental factors, and these chronic illnesses are more likely to go unnoticed and progress when people skip routine care because of discrimination.

Medicare Advantage (MA) offers an opportunity to address some of these issues. Half of beneficiaries are on MA, a type of Medicare health plan offered by a private company that contracts with Medicare. Non-white seniors are also far more likely to enroll in one: more than half of Black and Hispanic seniors are enrolled in an MA plan, versus just 36% of white seniors. Why is this? Medicare Advantage plans tend to be more affordable than traditional Medicare plans because they have an out-of-pocket maximum. MA plans are also more comprehensive, including dental and vision insurance and additional benefits. They often have resources to address social determinants of health like access to nutritious food and safe homes.

Importantly, MA plans are held accountable for the quality of coverage they provide. The Centers for Medicare & Medicaid Services (CMS) uses a Star Rating System to assess MA plans and reward ones that perform well. Plans are given a 1-5 star rating based on five categories: member experience, customer service, plan performance, chronic conditions, and staying healthy. Plans with more stars receive quality bonuses, which can lower out-of-pocket costs or provide extra benefits to beneficiaries. If a plan fails to achieve at least three stars for three consecutive years, CMS can terminate their contract.

The Biden Administration recently introduced a major improvement to the Star Rating System: a Health Equity Index (HEI). The HEI would reward plans that provide excellent care to underserved populations by comparing health outcomes in populations with social risk factors—things like race and poverty—to those without. Plans are also required to provide culturally competent care and improve access to care for those with limited English proficiency. The addition of the HEI to the Star Rating System shows the Biden Administration is prioritizing patients and equity.

The Biden Administration can go even further. Each of the five categories of the Star Rating System should include an equity assessment. Today, a health plan gets credit under the star ratings if it meets a quality target for its group of enrollees. For example, if a plan succeeds in helping people with diabetes manage their disease, that counts toward their bonus. In the future, as better demographic data is available, each individual star rating should depend upon also meeting the quality targets for racial, ethnic, sexual identity, disability, and geographic subgroups. For diabetes management, that would mean the plan is succeeding across subgroups, not just for the average population.

Congress needs to do its part by fixing the parts of the Star Rating System that increase inequities. One type of quality payment known as double bonuses has had the unintended effect of providing fewer resources in areas with more Black beneficiaries. Black beneficiaries are less likely to live in counties that meet the eligibility requirements for these bonuses, so plans receive fewer quality bonus dollars and beneficiaries receive fewer benefits. Moreover, double bonuses have not had their intended effect of expanding coverage in areas with low Medicare Advantage enrollment. Congress also needs to make sure that the star ratings and quality bonus payments are optimally designed to get the biggest bang for their buck because beneficiaries may not be using the star ratings when

choosing a plan. The bonuses need to focus primarily on motivating plans directly to improve their performance.

Done right, the Medicare Advantage program can be a key part of improving health equity among older Americans. The Biden Administration and Congress are uniquely positioned to make these changes.