

## POPULATION HEALTH FORUMS

### Medicare at Fifty Years: Its Effect on Disparities

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Edith Mitchell, MD, FACP, is a renowned researcher, clinician, leader, and advocate in cancer prevention, treatment, and disparities. She is member of the [Cancer Moonshot<sup>SM</sup> Blue Ribbon Panel](#) and is a decorated General in the Air Force. As Dr. Nash said when he introduced Dr. Mitchell, "She's been an important fixture at Jefferson for a long time and is a national powerhouse...there is no better person to help us understand...not only the progress we've made...but identifying the challenges in making sure that we deliver care, we narrow the gap and decrease disparity."

"How many people in the audience have worked with a parent or a friend to sort through Medicare paperwork?" "And how many people are Medicare-wannabe -- in other words, someone who plans to live long enough to receive Medicare?" This how Dr. Mitchell opened the Forum, driving the point home that we are all impacted by Medicare in some way.

Dr. Mitchell first provided an overview of Medicare history, reminding the audience that the program was first administered by the U.S. federal government in 1966. July 1, 2016 marked 50 years since the birth of Medicare. It was initially set up for Americans aged 65 and older, who have worked and paid into the system, and younger people with disabilities. January 1, 1966 was when enrollment occurred. There has been a steady and significant increase Medicare

enrollment since it was first implemented. By 2014, 15.6% of Americans were covered. She emphasized that, since then, the overall survival for Americans has increased – which means we can expect the number of Medicare enrollees to continue to increase.

Dr. Mitchell pointed out some of the key important historical markers of the Medicaid program:

- President Nixon signed the Social Security Amendments in 1972, which made more individuals eligible for Medicare.
- The establishment of the Health Care Financing Administration was created to administer both Medicare and Medicaid programs.
- President Clinton signed the Balanced Budget Act of 1997; this extended the financial solvency of the Hospital Insurance Trust fund to 2010.
- Creation of the Children's Health Insurance Program (CHIP).
- Clinton signed the Balanced Budget Refinement Act (BBRA) in 1999.
- Changing the name HCFA (Healthcare Financing Administration) to Centers for Medicare and Medicaid Services (CMS) in 2001.

Dr. Mitchell explained that additions to Medicare coverage over the years included benefits such as Medicare coverage to individuals with End Stage Renal Disease; hospice care, and coverage for younger people with ALS.

Dr. Mitchell's interest in Medicare was ignited by research she conducted on racial differences in cancer. She explained differences in how cancer care is covered by insurance, comparing white patients to

black patients. For example, commercial insurance may be the dominant form of coverage for cancer treatment in white younger patients (ages 40-64); whereas Medicaid and Medicare play a significant role in payments for black patients undergoing cancer treatment.

Medicare was a major force in racial desegregation of health facilities. As part of the Civil Rights Act, any institutions receiving federal funds were required to comply as a condition of their participation in the Medicare program. Hospitals integrated their staffs, waiting rooms and wards; admission rates for blacks rose; and disparities in access to hospital services for people of all ages began to narrow. Dr. Mitchell explained that the impact of the Civil Rights Act on hospitals became one of the major areas of integration, with little resistance.

Mitchell described current eligibility criteria for Medicare benefits. Persons 65 years of age and older, and legal residents of the U.S. for at least 5 years are eligible for Medicare. People with disabilities under 65 are eligible if they receive Social Security Disability Insurance, and specific medical conditions may afford eligibility. Medicare Part B is optional and may provide coverage for various outpatient services, tests, and medical equipment. Part C (Medicare Advantage) typically includes a monthly premium and may include prescription drugs, dental care, and vision care, etc. Part D covers prescription plans.

Mitchell went on to discuss MACRA (Medicare and CHIP Reauthorization Act), which was signed into law in 2015. She explained that MACRA streamlines and balances existing Medicare quality reporting programs into the Merit-Based Payment Incentive System (MIPS)

and provides financial incentives for providers who move into alternative payment models. It also helps to extend CHIP and funding for community health centers.

The future of the Affordable Care Act and Medicare is uncertain, explained Dr. Mitchell. Despite the number of adults that have gained coverage through the ACA and Medicare expansion, various proposals in Congress could impact some of the successful benefits of these programs.

Dr. Mitchell was then joined by Ronald Myers, DSW, PhD for the Grandon Society

workshop. Dr. Myers is the Director of the Division of Population Science and Center for Health Decisions (CHD) at Thomas Jefferson University. His areas of expertise include patient adherence to cancer screening, physician follow-up of abnormal cancer screening test results, informed decision making in cancer susceptibility testing, and cancer disparities research.

Using the context of the current political and economic challenges of healthcare, Dr. Myers discussed the framework of the collective impact learning model which is actually used at Jefferson for cancer patients

and overall can improve health and reduce disparities. He emphasized the importance of thinking about solutions beyond legislation, and to think about an institutional approach to improve care. Patient engagement is a big focus of Dr. Myers' work. Dr. Mitchell added to the exchange by examining the idea of incentivizing patients.

Both speakers provoked a lively audience discussion on Medicare, quality, and costs.