Healthcare Disparities for those that are 65 years and older

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Abstract:

For those that are 65 years of age and older, they are unfortunately experiencing disparities in healthcare. Overall, Medicare is a good solution to provide medical coverage for those that no longer are able to receive it through their employer. Although, the changes that have been enacted have not been at the same pace as the rising population of older individuals in the United States. This age group can have several barriers to accessing healthcare, such as finding locations where their insurance is accepted. In addition, providers that do accept Medicare may have to see more patients than their counterparts that are private or cash only due to the stringent requirements in documentation as well as lower reimbursement rates. This can, in turn, reduce the quality of care during a visit as it may be shortened. Furthermore, the shortage of geriatric providers is only adding to the disparity. If there are not enough providers that have the special training tailored to this population, the accessibility of quality care is diminished. The U.S. can help bridge the gap between those that are 65 years and older and quality healthcare by reassessing reimbursement rates between Medicare and providers as well as recruiting more recently graduated physicians to the specialty of Geriatric Medicine. If providers can be paid as much as their more lucrative counterparts, it can increase the number of providers that tailor to the older population, reducing the disparities that exist for them.

Objectives:

The objective of this project is to share the disparities that individuals over 65 years old in the United States experience when trying to utilize their healthcare as well as provide ideas of improvement.

Methods:

This was carried out through a literature review.

Discussion:

Medicare was made into law on July 30, 1965 by President Lyndon B. Johnson as an amendment to an existing act (known as the Social Security Act). In the years leading up to it, there were many that opposed the idea of a federal healthcare system that supported the elderly. As the society got older, the rising need for a public program increased as most of the individuals obtained their health insurance through their employer. The issue was that once they stopped working, older Americans would lose their healthcare coverage (1). When originally signed in 1965, Medicare was funded by both employer and employee contributions. This structure still holds almost 60 years later, with the addition of other sources of income like interest paid on trust fund investments (2). Additionally, there are two funds through the United States Treasury: Hospital Insurance Trust Fund and Supplementary Medical Insurance Trust Fund, both covering different aspects of the Medicare program (3).

To qualify for Medicare, there are generally three requirements: be 65 years or older, disabled, or have a terminal disease that prevents you from being able to obtain coverage through an employer. Additionally, this program is mainly available to those that are U.S. citizens, but if an individual has been residing in the United States legally for five years up until enrollment, they are also able to qualify (4).

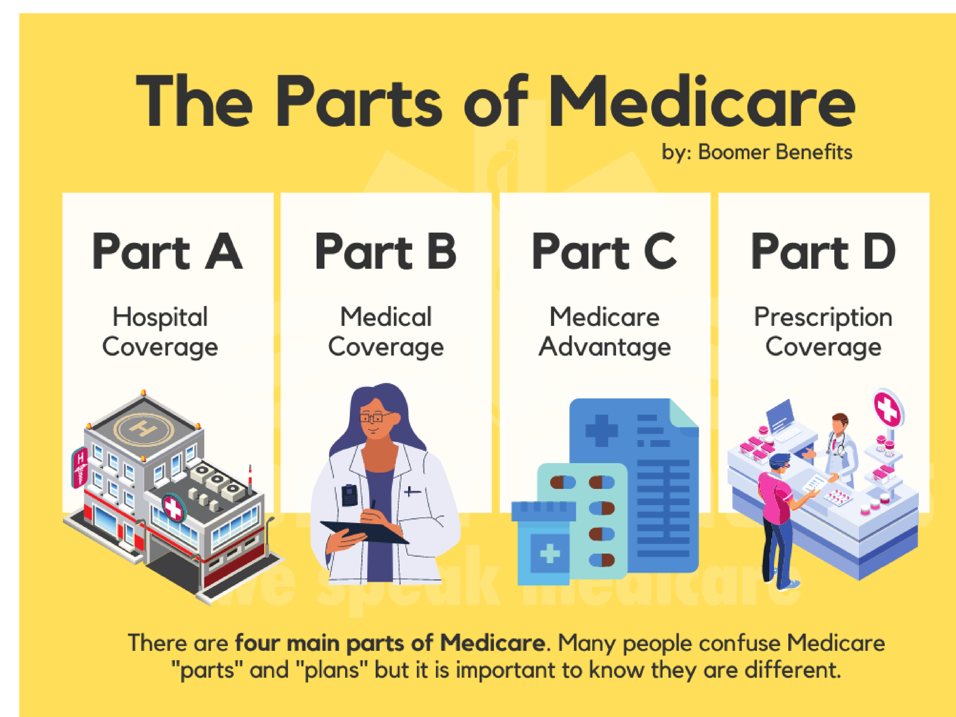

Figure 1. *The four parts of Medicare (left).* Part A covers in-patient costs, Part B covers out-patient services, Part C is comparable to a private insurance option, and Part D covers prescription drug costs (5, 14).

In 1965, the population of the United States was 189,703,283 people (6). About 9.6% were older than 65, which is about 18,211,515 people. As of 2022, the population of the U.S. was 338,289,857 people and 17.1% were older than 65, which is about 57,847,565 (6). Since 1965, there has been a 7.5% increase in population aged 65 or above, as well as an overall increase in how many individuals are occupying the States. In addition, the original budget in 1965 allotted for Medicare was around 10 billion dollars (7). In 2022, around $755 billion was spent for the program (8). Overall, there have been dramatic increases in how much of the population is made up of both those that are 65 years and older as well as how much money is being spent to provide coverage for all of these individuals. The issue that arises is whether this spending will be sustainable as the older population increases as well as if the program itself is providing sufficient care for those that are using it.

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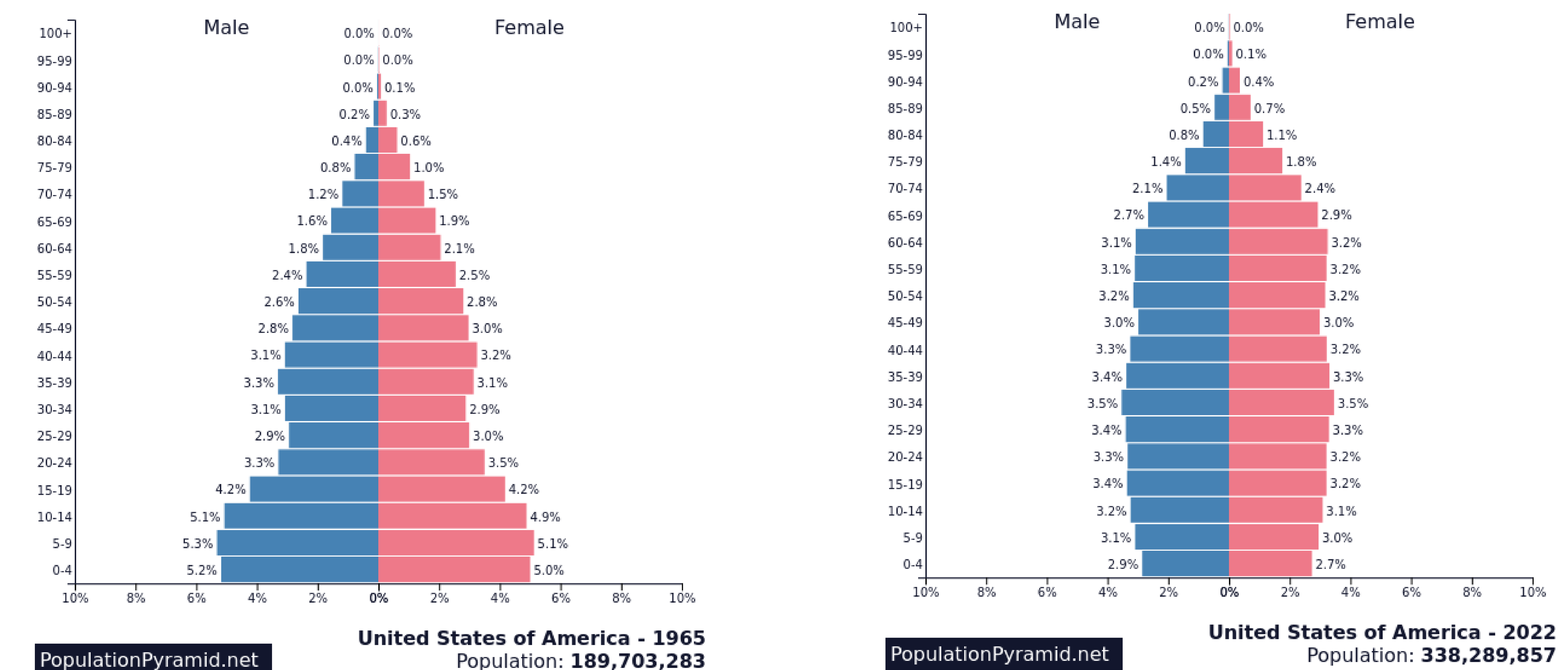

Figure 2. *Population Pyramids of the United States in 1965 (left) and 2022 (right).* There has been an overall shift in shape from the two years. Unlike in 1965 where the younger population heavily outnumbered the older population, in 2022 it started to transition to where the older population is outnumbering the younger population (6).

When an individual turns 65 years old, there are typically two options that they can pursue: enroll in Medicare if they qualify or keep their private insurance that is through their employer. Once they are no longer working, then they must opt in for Medicare Coverage (at least Part A and Part B to avoid a penalty) (9). Medicare is similar to private insurance companies, but there are some differences. With Medicare, not all doctors will accept the insurance. Medicare does not reimburse physicians as much as private insurances do, which means that they do not make as much money with Medicare patients. To add to this, Medicare has stricter regulations that must be met so that they can get reimbursed, making it more difficult for the provider to be reimbursed (10). With some providers not accepting Medicare, it can make healthcare harder to access for these individuals using it. Additionally, as the reimbursement rates are lower, providers must see more patients in order to make more money. This can affect the quality of care during a visit, limiting the amount of time the provider can spend with the patient.

Insurance is not the only factor that can contribute to the disparities of healthcare for the older population. With the increasing older population, the number of physicians that are specialized in geriatric care are not increasing as well. From 2000 to 2010, there was a 17% decrease in this specialty, which poses a huge disparity for this group (11). Historically, those that pursue geriatric medicine do not get compensated as much as their peers who choose higher earning specialties, which contributes to the shortage (12). In addition, older individuals usually have more comorbidities compared to the younger individual, making it more difficult to provide care that is effective (13). As geriatric physicians are trained to handle the complexity that comes with treating those that are 65 years and older, the low number that represent how many are practicing is concerning. These factors limit the access to high quality healthcare that the older individual needs.

There are a couple areas of improvement that can help bridge the gap between the older population and the ability to receive quality healthcare. The reimbursement schedules between Medicare and providers can be restructured so that it is cost-effective for the U.S. Treasury, supportive to providers that incentivize the acceptance of Medicare, as well as ensuring quality healthcare to the elderly. There can be an effort to attract more recently graduated physicians to the specialty of Geriatric Medicine so that the shortage can be decreased. Overall, those that are 65 years and older are experiencing disparities in healthcare, and there needs to be changes made so that this can be resolved.

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