The Cost of Discrimination in Health Care: Evidence from Older Adults' Experiences and Medicare Spending

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Research bridging policy and practice

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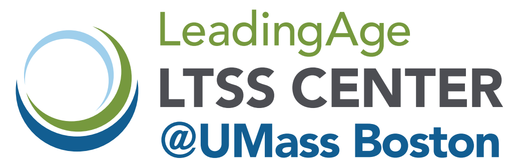

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Executive Summary

Discrimination in health care is not only a civil rights and equity concern, it is also associated with higher Medicare spending. Older adults who report experiencing discrimination during medical care are more likely to rely on high-cost services, particularly hospital care. Using nationally representative data from the Health and Retirement Study linked to Medicare claims from 2012 to 2022, this analysis examines how older adults' experiences of discrimination in medical settings are associated with health care utilization and costs. Nearly one in five older adults (19%) reported experiencing discrimination in health care in 2020/2022, an increase from 15.5% in 2012. Reports were especially high among non-Hispanic Black and Hispanic older adults and among individuals in poorer health. Age discrimination was the most commonly cited form (38.5%), followed by race/ethnicity (31.3%) and gender (14.5%).

Nearly one in five older adults (19%) reported experiencing discrimination in health care in 2020/2022, an increase from 15.5% in 2012.

These experiences were not isolated events. Older adults who reported discrimination were less satisfied with their care, less likely to report having a usual source of care, and more likely to say that their care preferences were not taken into account.

Importantly, discrimination was associated with substantially higher Medicare spending. Across the ten-year study period, average two-year total Medicare costs were consistently higher among older adults who reported discrimination compared to those who did not. For example, individuals reporting race/ethnicity-based discrimination had costs approximately 19% higher than those reporting no discrimination. These differences were driven primarily by inpatient spending, suggesting greater reliance on high-intensity, and potentially avoidable care.

After accounting for health status, income, insurance coverage, and demographic characteristics, older adults who reported discrimination had 31% higher odds of incurring above-average Medicare costs in subsequent years. Repeated experiences of discrimination were also associated with rising costs over time. Each reported experience of discrimination was linked to roughly $1,100 in additional Medicare spending, independent of aging and worsening health.

When scaled nationally, the fiscal implications are significant.

Excess Medicare spending attributable to health care discrimination reached an estimated $14.2 billion in 2022 alone and approximately $73.2 billion cumulatively between 2012 and 2022 (in 2022 dollars).

Expressed in 2025 dollars and scaled to current Medicare enrollment, the estimated excess cost over a two-year period rises to $17.4 billion, with cumulative excess spending approaching $89.6 billion.

These findings suggest that discrimination operates not only as an inequity within the health system but also as a structural inefficiency that contributes to avoidable public spending. They also underscore that health care discrimination should be understood not only as an equity or civil rights issue, but also as a health system performance and cost issue. Experiences of discrimination can undermine trust, reduce continuity of care, and contribute to delayed care, fragmented treatment, and higher downstream utilization. As a result, discrimination may carry measurable fiscal consequences for Medicare and the broader health system.

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Addressing discrimination, therefore, represents an opportunity to improve both patient experience and health system efficiency. Even modest improvements in patient-provider interactions and care continuity could yield meaningful reductions in excess health care spending.

Several policy levers could support these improvements:

Provider training and professional standards
Federal and state regulators could require periodic training on discrimination, implicit bias, and culturally responsive care as part of provider licensure, continuing medical education (CME), or Medicare participation requirements.

Accountability for patient-reported experiences
Health systems and payers could incorporate patient-reported measures of discrimination and respect in care into quality reporting and payment models (e.g., CAHPS-based metrics or value-based purchasing programs).

Strengthening continuity and relationship-based care
Delivery models that emphasize long-term patient–provider relationships, such as primary care medical homes or team-based care models, may help build trust and reduce perceived discrimination in clinical encounters.

Health system monitoring and transparency
Health systems could systematically track patients' experiences of discrimination and use these data to identify disparities, guide quality improvement efforts, and increase institutional accountability.

Given the magnitude of the estimated excess Medicare spending associated with discrimination, addressing these issues could yield both equity gains and meaningful cost savings for the health care system.

Introduction

Discrimination within health care settings is a pervasive and consequential problem that undermines patient trust, disrupts care-seeking behavior, and contributes to poorer health outcomes.[1] A growing body of research documents that a substantial share of U.S. adults perceive discrimination when interacting with physicians, hospitals, or other health care providers, with estimates ranging from roughly one in five to more than one in three adults depending on the population and measurement approach.[2, 3, 4] These experiences are rarely isolated events. Most individuals who report discrimination describe repeated encounters that shape their long-term relationship with the health care system.

Prior research demonstrates that perceived discrimination operates through multiple pathways to affect health. Experiences of disrespect, dismissal, or unfair treatment are associated with heightened psychological stress, delayed or forgone care, lower adherence to treatment recommendations, and reduced engagement with preventive services.[5, 6, 7, 8, 9, 10, 11, 12, 13] Over time, these mechanisms contribute to worse physical and mental health outcomes and greater reliance on acute, high-intensity care, including emergency department visits and hospitalizations.[6, 11, 12, 14, 15]

> This study is among the first to link specific forms of perceived discrimination among older adults to observed Medicare claims-based spending, providing new evidence on the system-level costs of discriminatory care experiences.

Importantly, discrimination in health care is not confined to a single domain. While racial and ethnic discrimination is the most frequently studied and reported form, research consistently shows that patients also experience discrimination based on age, gender, disability, weight, income, insurance status, language, mental health conditions, and other characteristics, often simultaneously and in intersecting ways. Older adults may be particularly exposed to discriminatory dynamics in health care. Ageism, multi-morbidity, disability, and frequent interactions with complex medical systems can heighten both opportunities for discriminatory treatment and its consequences. However, despite research on discrimination and health consequences, far less attention has been paid to the economic implications of discrimination, especially its downstream effects on health care utilization and public program spending.

This study builds on existing research by examining not only how common health care discrimination is among older adults, but also how these experiences translate into patterns of health care use and Medicare spending. Using nationally representative data from the Health and Retirement Study (HRS) linked to Medicare claims from 2012 to 2022, the study assesses differences in outpatient, inpatient, and emergency department use between older adults who report discrimination and those who do not. It also estimates the extent to which discrimination independently contributes to higher health care costs after accounting for health status and sociodemographic factors.

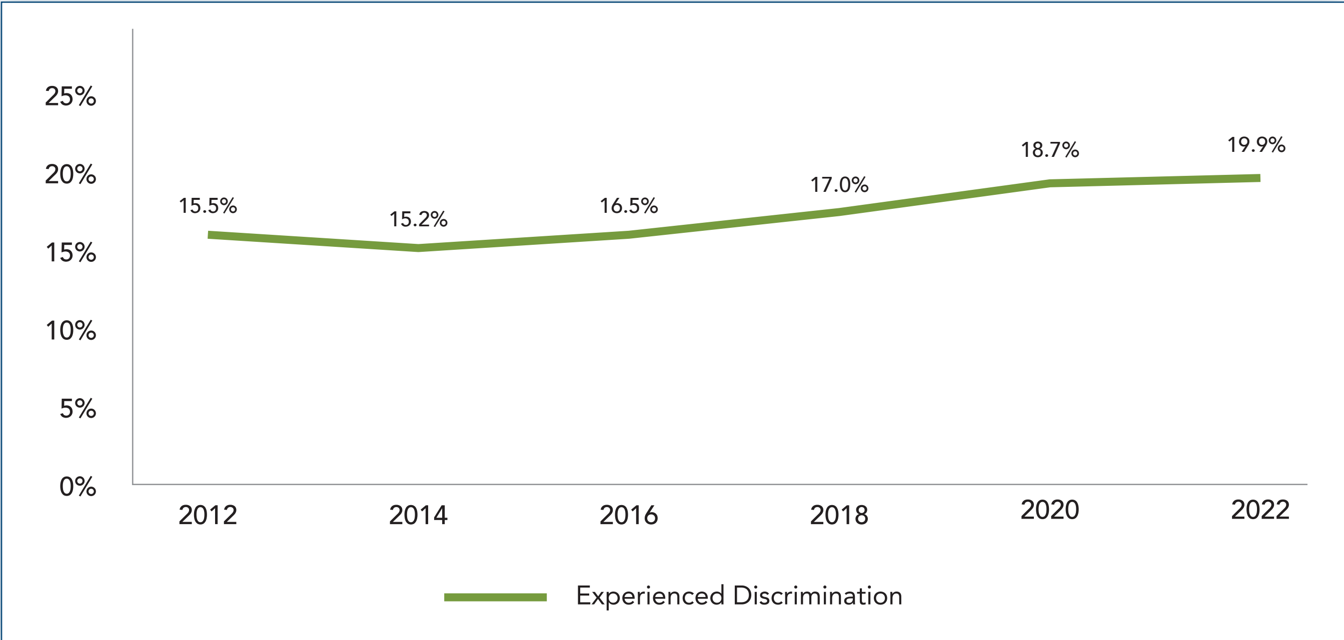
By translating patient-reported experiences of discrimination into concrete fiscal impacts, this report reframes discrimination not only as an equity and civil rights concern but also as a driver of inefficient, avoidable health care spending with significant implications for the Medicare program.

This study is among the first to link specific forms of perceived discrimination among older adults to observed Medicare claims-based spending, providing new evidence on the system-level costs of discriminatory care experiences.

Results

For details about the database and method used to analyze the data, see Appendix I. The most recent demographic characteristics of those who did and did not report experiencing discrimination can be found in Appendix II. The study sample includes 6,029 individuals, of whom 1,164 or 19% reported experiencing health care discrimination in either 2020 or 2022. As shown in Figure 1, rates of discrimination in the health care setting have increased steadily over the past decade. From 2012 to 2022, reported rates of discrimination in health care increased by 4.4 percentage points (Figure 1).

Figure 1.
Trends in Percentage of Adults Age 50+ Experiencing Discrimination



Not shown in the figure is that while health care discrimination is reported across all groups, it is more common among adults ages 65 to 74, individuals with lower income or poorer health, and people of color. The most prevalent forms of discrimination are age (38.5%), race/ethnicity (31.3%), and gender (14.5%). Among those reporting discrimination, adults ages 65–74 make up the largest share (53%), followed by those ages 75–84 (28%), with smaller shares among adults ages 50–64 and 85 and older (9% and 10%, respectively).

As shown in Figure 2, racial and ethnic disparities in reported health care discrimination persist and, in some cases, have widened over time. Reports among older adults who are non-Hispanic White remained essentially flat between 2012 and 2022 (14.7% to 14.4%), indicating no meaningful change and consistently lower exposure relative to other groups. In contrast, older adults who are non-Hispanic Black reported the highest levels of discrimination across all years, with rates increasing from 19% in 2012 to a peak of 22.9% in 2020 and remaining elevated at 21.9% in 2022.

The most prevalent forms of discrimination are age (38.5%), race/ethnicity (31.3%), and gender (14.5%).

Figure 2.
Trends in Percentage of Adults Age 50+ Experiencing Discrimination Race/Ethnicity

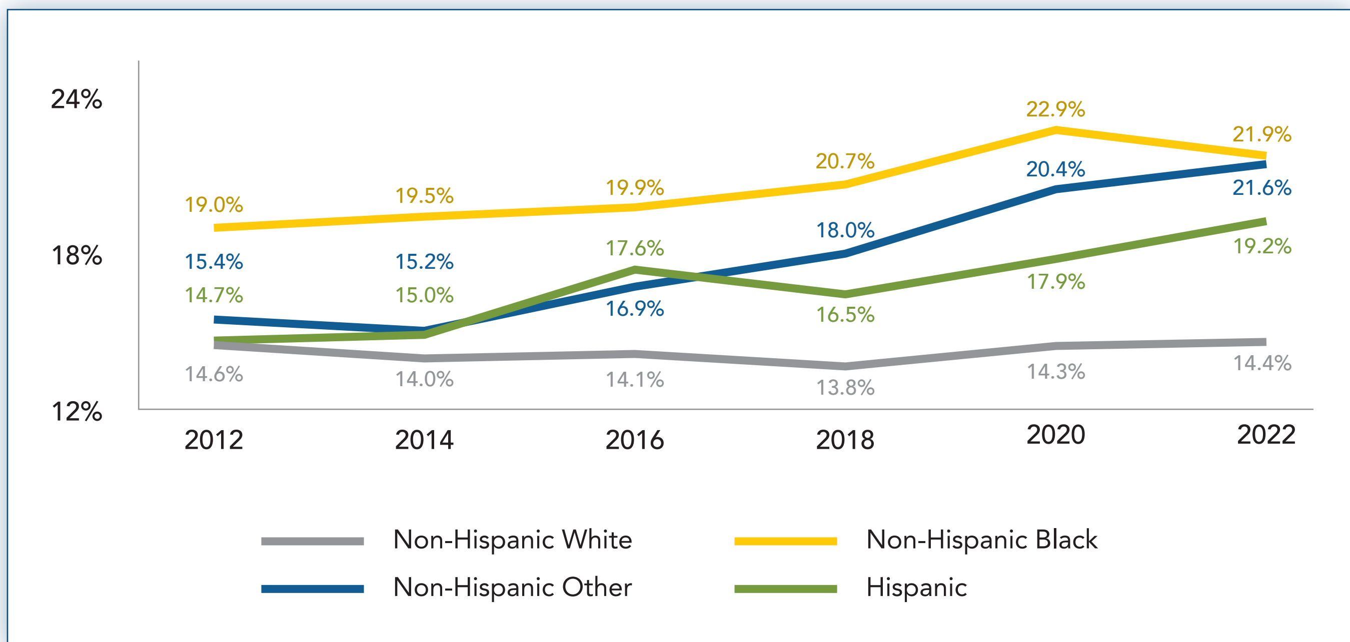


Figure 3 shows that older adults categorized as non-Hispanic Other experienced the steepest growth in reported discrimination, rising from 15.4% to 21.6% (+6.2 percentage points), while older adults who are Hispanic also saw a notable increase over the study period, from 14.6% in 2012 to 19.2% in 2022 (+4 percentage points).

Older adults who are non-Hispanic Black reported the highest levels of discrimination across all years.

Figure 3.
The Percent Change Between 2012 and 2022 of Adults Age 50+ Experiencing Discrimination by Race/Ethnicity

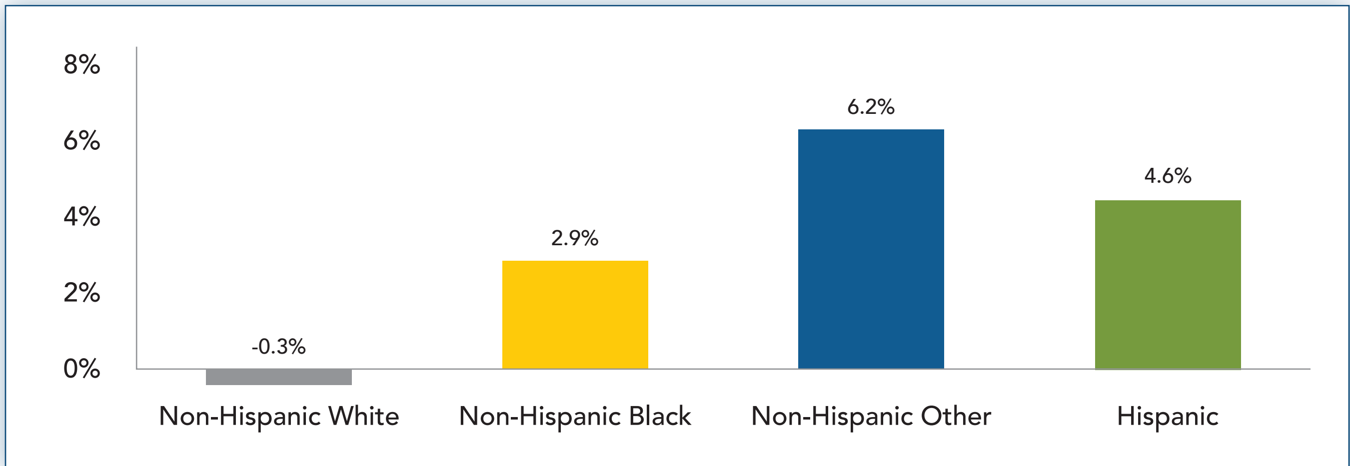
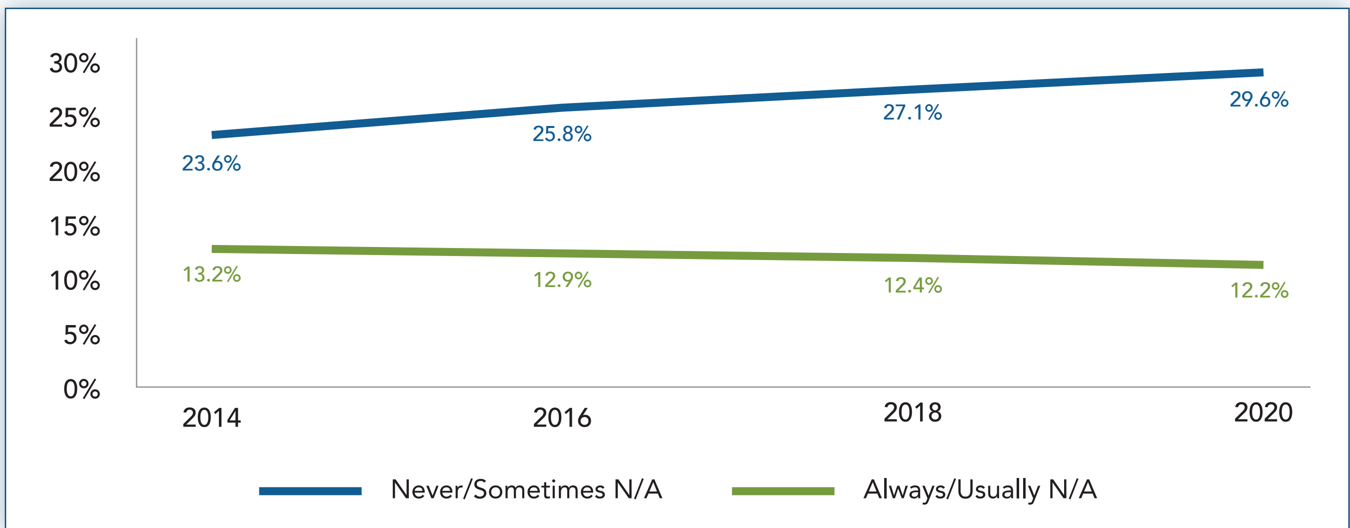


Figure 4 illustrates a growing divergence in reported health care discrimination based on whether individuals feel their care preferences are taken into account. Among individuals who report that their preferences are *never or only sometimes* respected, experiences of discrimination increased steadily from 24% in 2014 to 29.6% in 2022, a significant (25%) increase in the rate of reported discrimination. In contrast, individuals who report that their preferences are *always or usually* considered experienced consistently lower rates of reported discrimination, remaining relatively flat over time at between 12% and 13% over the period. The disparity between these two groups widened markedly over time.

Individuals who report that their preferences are always or usually considered experienced consistently lower rates of reported discrimination.

Figure 4.
Trends in Percentage of Adults Age 50+ Experiencing Discrimination by whether Care Preferences are Taken into Account



An important question is the extent to which discrimination affects overall health care costs, which we examine using Medicare claims costs. Figure 5 shows that across the 10-year observation period, average 2-year total health care costs are consistently higher among individuals who reported experiencing health care discrimination compared with those who reported no discrimination. Adjusting costs to 2022 dollars, individuals reporting no discrimination averaged $12,674 in total 2-year Medicare costs. In contrast, those reporting any form of discrimination had higher Medicare costs than those reporting no discrimination. For example, those experiencing racial/ethnic-based discrimination had costs that were 19% higher ($15,090) than those not experiencing discrimination. When discrimination is based on appearance, costs were 9% higher ($13,783), compared to costs when no discrimination is reported.

Average 2-year total health care costs are consistently higher among individuals who reported experiencing health care discrimination.

Figure 5.
Average 2-Year Total Medicare Claims Costs (Inpatient and Outpatient) by Discrimination Status between 2012-2022

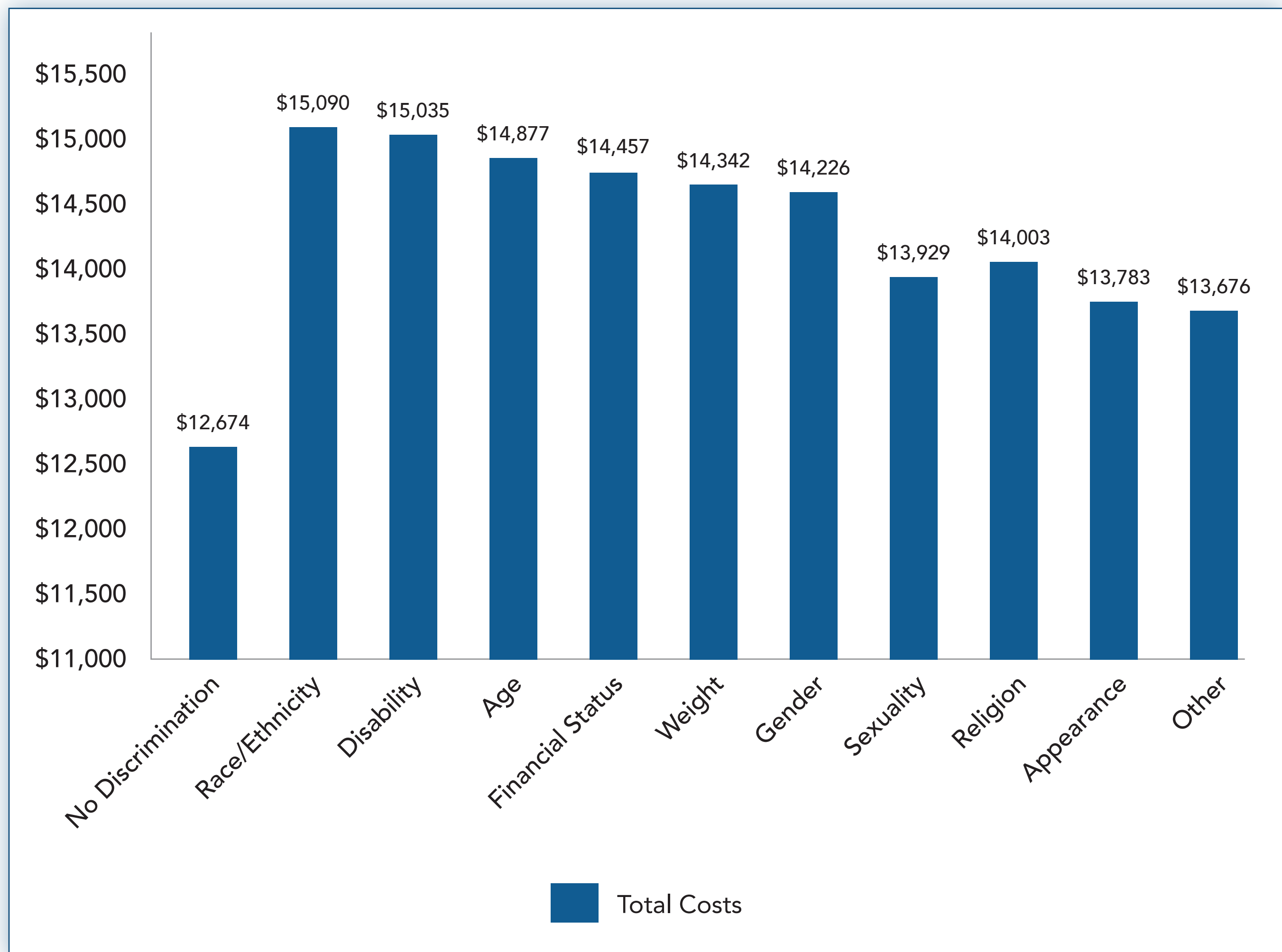
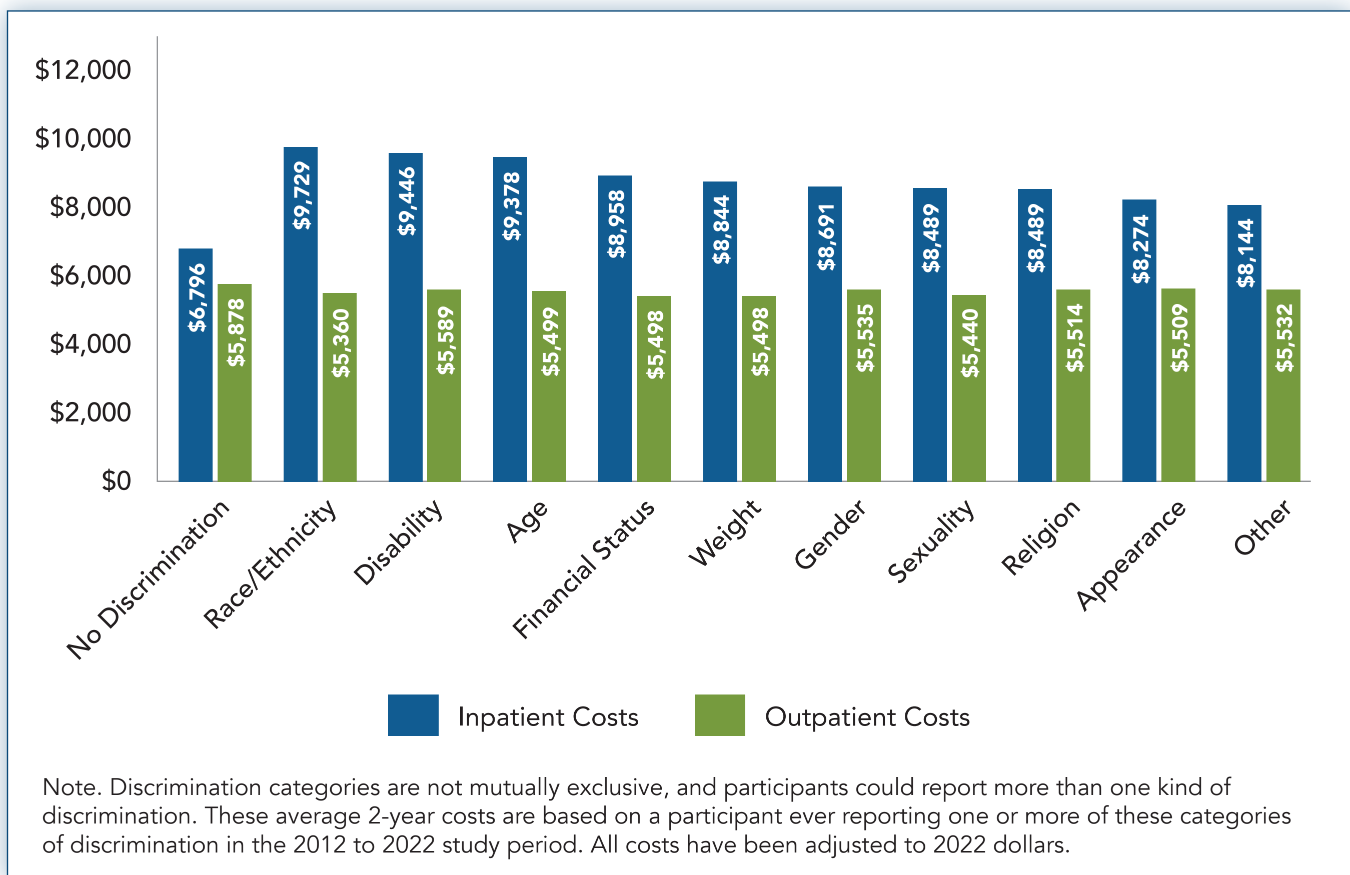


Figure 6 shows that differences in average 2-year Medicare costs by discrimination status are driven primarily by inpatient spending, with comparatively little variation in outpatient costs. Across all discrimination categories, older adults who reported experiencing discrimination incurred substantially higher 2-year average inpatient costs than those reporting no discrimination; $6,796 in the no-discrimination group compared to at least $8,144 among those who experienced discrimination – a roughly 20% difference. Average 2-year inpatient spending was highest among those reporting race/ethnicity-based discrimination ($9,729). Although inpatient costs decline modestly across other discrimination types, they remain elevated across all categories. In contrast, outpatient costs are relatively stable, clustering between approximately $5,360 and $5,590 regardless of discrimination status.

> Differences in average 2-year Medicare costs by discrimination status are driven primarily by inpatient spending.

Figure 6.
Average 2-Year Inpatient and Outpatient Costs by Discrimination Status between 2012-2022



Note. Discrimination categories are not mutually exclusive, and participants could report more than one kind of discrimination. These average 2-year costs are based on a participant ever reporting one or more of these categories of discrimination in the 2012 to 2022 study period. All costs have been adjusted to 2022 dollars.

In order to capture the independent effect of experiencing discrimination on health care costs, we estimated statistical models that examine whether discrimination reported in one survey wave is associated with higher costs in subsequent years. Results from the model indicate that experiences of health care discrimination are independently associated with a higher

likelihood of incurring above-average Medicare costs in subsequent years (Appendix III). Above-average costs are defined as total Medicare spending above the sample mean in the follow-up wave (2020 or 2022), adjusted to 2022 dollars.

> **Beneficiaries who reported discrimination had 31% higher odds of having above-average total Medicare costs in the following two-year measurement period.**

After adjusting for 2018 or 2020 sociodemographic characteristics, health status, and insurance factors, beneficiaries who reported discrimination had 31% higher odds of having above-average total Medicare costs in the following two-year measurement period. Several health-related factors were also strong predictors of elevated costs, including poor or fair self-rated health, a higher number of chronic conditions, and dual eligibility for Medicare and Medicaid. Notably, having a usual source of care was protective, reducing the odds of high costs by 26%, underscoring the importance of continuity and stable access to care. Racial and ethnic disparities persisted even after adjustment, with non-Hispanic Black and Hispanic beneficiaries significantly more likely to experience high subsequent costs relative to non-Hispanic White beneficiaries.

> **Each study wave (two-year period) in which a beneficiary reported discrimination was associated with an increase of approximately $1,100 in additional Medicare costs.**

Additional regression model results showed that repeated experiences of health care discrimination are associated with meaningful cumulative increases in Medicare spending over time (Appendix IV). Holding baseline demographic characteristics constant and accounting for changes in health status between 2012 and 2022, each study wave (two-year period) in which a beneficiary reported discrimination was associated with an increase of approximately $1,100 in additional Medicare costs over the study period (all dollar values adjusted to 2022 dollars). In contrast, greater continuity of care was protective: each study wave in which a beneficiary reported having a usual source of care was associated with a reduction of roughly $780 in total costs.

Age and worsening health status were strong drivers of cost growth, with increases in chronic conditions, transitions into poor or fair health, and smoking associated with substantial rises in spending. Changes in dual eligibility status were also linked to higher costs, reflecting the complex care needs of beneficiaries who become dually eligible over time. Taken together, these findings suggest that discriminatory experiences contribute to sustained cost growth beyond what would be expected from aging and health deterioration alone, while consistent access to care may mitigate long-term increases in Medicare spending.

Discussion and Policy Implications

This study adds to a growing body of evidence demonstrating that discrimination in health care settings is both prevalent and consequential for older adults. Consistent with prior national studies, approximately one in five older adults reported experiencing discrimination, with particularly high rates among racial and ethnic minority populations.[16, 17, 18, 19] Age discrimination emerged as the most commonly reported form, underscoring the central role of ageism in shaping older adults' health care experiences.

Importantly, this analysis moves beyond documenting the extent to which discrimination is experienced, to quantifying the cost burden associated with discriminatory care experiences. Even after adjusting for health status, income, insurance coverage, and demographic characteristics, discriminatory experiences were associated with significantly higher Medicare spending, particularly through increased inpatient utilization. These findings are consistent with theoretical and empirical work suggesting that discrimination operates through stress pathways, the erosion of trust, and disruptions in care-seeking behavior that may contribute to poorer health outcomes and more costly care.[19, 20, 21]

The strong association between discrimination and failures of patient-centered care further reinforces this interpretation. Prior studies have shown that feeling unheard or disrespected by providers is associated with lower adherence to treatment recommendations, reduced engagement in preventive care, and worse physical and mental health outcomes.[22, 23, 24, 25, 26, 27, 28, 29] Our findings suggest that these dynamics may also have significant downstream cost implications, particularly when they contribute to avoidable hospitalizations.

Across the 10-year study period, both the prevalence of reported discrimination and the aggregate cost burden increased steadily. When these findings are applied nationally, the number of older adults reporting discrimination rose from 10 million in 2012 (15.5%) to 12.9 million in 2022 (19.9%) at a corresponding level of adjusted 2-year excess costs of $11 billion (2012) and $14.2 billion (2022). Cumulatively, the total adjusted excess Medicare costs attributable to discrimination over the 2012-2022 period were approximately $73.2 billion (2022 dollars). This upward trajectory reflects both rising prevalence and the compounding effects of discrimination-related care disruptions over time.

When these same models are expressed in 2025 dollars and scaled to 2025 Medicare enrollment levels, the adjusted excess cost per beneficiary rises to $1,271 over two years. The estimated excess cost for a single two-year wave reaches $17.4 billion. Over the full 2012-2022 period, the total inflation-adjusted excess Medicare spending attributable to health care discrimination is approximately $89.6 billion (2025 dollars).

The estimated excess cost for a single two-year wave reaches $17.4 billion. Over the full 2012-2022 period, the total inflation-adjusted excess Medicare spending attributable to health care discrimination is approximately $89.6 billion (2025 dollars).

From a policy perspective, these results reinforce the importance of addressing discrimination as a health system performance issue, not solely an equity or civil rights concern. Interventions aimed at reducing bias, strengthening communication, and promoting continuity of care, such as provider training, accountability for patient-reported experiences, and models that emphasize relationship-based care, may yield both equity gains and cost savings. Given the magnitude of the estimated excess Medicare spending attributable to discrimination, even modest improvements in patient experiences could have substantial fiscal implications.

> Addressing discrimination is central to improving the value, sustainability, and equity of publicly financed health care.

More broadly, this study contributes to a growing body of research showing that discrimination can function as a structural inefficiency within the health care system. By translating discriminatory experiences into concrete cost estimates, this analysis underscores that addressing discrimination is central to improving the value, sustainability, and equity of publicly financed health care. Future research should examine how specific policy levers, such as payment reforms, quality measurement, and patient engagement initiatives, can mitigate discriminatory experiences and reduce their long-term economic consequences.

APPENDIX I: Study Data And Methods

This study uses data from the Health and Retirement Study (HRS), a nationally representative longitudinal panel study of U.S. adults age 50 and older, conducted by the University of Michigan, linked to Centers for Medicare & Medicaid Services (CMS) Medicare claims data. The HRS has collected biennial data since 1998 (each wave represents a two-year time period) and includes detailed information on sociodemographic characteristics, health status, economic conditions, family and social supports, and health behaviors, as well as selected physical measurements and laboratory test results. To ensure representativeness, the HRS oversampled African American and Hispanic respondents.

The variables used in this analysis are drawn from multiple HRS data sources, including the core HRS survey, harmonized data files produced by the RAND Center for the Study of Aging, and the HRS Leave Behind Questionnaire (LBQ). The LBQ is administered to rotating half-samples of respondents in each wave and includes key measures of perceived discrimination. One-half of the HRS sample first received the LBQ in 2006, and the other in 2008, with repeat administration every four years thereafter, allowing for repeated measurement of discrimination experiences over time.

- The LBQ includes the following questions specific to health care settings: "In your day-to-day life, how often did you receive poorer service or treatment than other people from doctors or hospitals - almost every day; at least once a week; a few times a month; a few times a year; less than once a year; or never?"
- "What do you think were the reasons why these experiences happened to you - ancestry or national origin, gender, race, age, religion, weight, physical disability, physical appearance, sexual orientation, financial status, or other?" (Respondents may select more than one reason.)

Using data from the 2012 to 2022 HRS waves, linked to Medicare claims, we pooled LBQ responses to construct a measure indicating whether respondents ever reported experiencing discrimination in the health care system during the observation period. Medicare claims data were then used to examine subsequent health care utilization and spending outcomes through 2022. The analytic sample includes 6,029 respondents who completed the HRS core survey, responded to the relevant LBQ discrimination and sociodemographic questions at baseline (2012 or 2014) and at least one follow-up period, were age 50 or older, enrolled in Medicare, and had available claims data between 2012 and 2022. Although most of the study sample was age 65 or older (age of Medicare eligibility), a small percentage (6.6%) of the sample fell into the 50 to 64 age group (the youngest age was 54), representing those who had Medicare before age 65 due to long-term disabilities or severe health conditions.

We examined self-reported experiences of health care discrimination and associated Medicare spending for total, inpatient, outpatient, and emergency department care. We compared spending patterns between older adults who reported experiencing discrimination and those who did not and estimated differences in health care utilization and costs associated with

reported discrimination using multivariable regression models that adjust for health status and sociodemographic characteristics. Analyses include descriptive statistics, bivariate comparisons, and both cross-sectional and longitudinal regression models.

Findings from this analysis address the following research questions, based on responses from adults age 50 and older in the 2012 and 2014 HRS waves (baseline), with follow-up both four years later (2016 and 2018, respectively) and eight years later (2020 and 2022, respectively), linked to Medicare claims data:

1. What percentage of older adults report experiencing any discrimination in the health care system and what are the most prevalent forms of discrimination and trends over time for specific sub-groups in the population?

2. Do older adults (and sub-populations) who report experiencing discrimination in the health care system feel that they are being listened to less often by their providers, do they have lower health care satisfaction, and are they less likely to have a usual source of care compared to their counterparts who don't report discrimination?

3. Do older adults who report experiencing discrimination in the health care system have higher Medicare claims costs compared to their counterparts who don't report discrimination, and what is the "excess cost" (if any) that can be ascribed to discrimination in the health care system?

4. Are particular types of discrimination (e.g. age, gender, race, etc.) associated with higher Medicare claims costs than others and for whom is this true?

APPENDIX II:

Table 1. Characteristics of HRS Respondents by Experience of Discrimination 2020/2022 Age 50+ Older Adults (Completed LBQ) (N=6,029)

Variables (at wave of LBQ Completion)	Any Health Care Discrimination 2020/2022 (N=1,164)	No Health Care Discrimination 2020/2022 (N=4,865)
Age (Mean)	72.6	73.7
50 to 64	8.9%*	6.1%
65 to 74	53.0%*	48.9%
75 to 84	28.3%*	35.5%
85+	9.8%	9.5%
Gender		
Female	59.9%*	57.2%
Male	40.1%*	42.8%
Race/Ethnicity		
Non-Hispanic White	65.3%*	74.3%
Non-Hispanic Black	21.8%*	16.2%
Non-Hispanic Other	3.2%	2.6%
Hispanic	9.7%*	6.9%
Education Years (Mean)	13.6	13.9
Marital Status		
Married/Partnered	52.5%*	58.1%
Widowed	23.2%	22.2%
Divorced/Separated	18.4%*	15.2%
Never Married	5.9%	4.5%
Financial Characteristics		
Household Income (Median)	$42,030*	$59,900
$0 to $29.9K	34.7%*	32.2%
$30K to $74.9K	39.9%*	38.5%
$75K and over	25.4%*	29.3%
Net Wealth (Median)	$206,750*	$395,000
Below FPL	9.8%*	5.9%
Retired	71.5%	71.9%

Variables (at wave of LBQ Completion)	Any Health Care Discrimination 2020/2022	No Health Care Discrimination 2020/2022
Health		
Poor/Fair Health	33.0%*	22.8%
Depression	26.7%*	15.7%
Chronic Conditions (Mean)	3.0*	2.5
Impaired Cognition	0.6%	0.5%
Has Usual Source of Care	77.4%*	89.1%
Dual Eligible	11.8%*	6.9%
Care Preferences Taken into Account		
Never/Sometimes	31.5%*	16.6%
Always/Usually	68.5%*	83.4%
Healthcare Satisfaction		
Very/Somewhat Satisfied	80.8%*	88.7%
Neutral	12.6%*	8.2%
Very/Somewhat Dissatisfied	6.6%*	3.1%
Census Region		
Northeast	14.2%	15.4%
Midwest	19.7%	22.2%
South	41.3%	40.4%
West	24.8%	22.0%
Discrimination Type		
Race/Ethnicity	31.3%	N/A
Gender	14.5%	N/A
Age	38.5%	N/A
Religion	0.4%	N/A
Weight	4.3%	N/A
Disability	2.7%	N/A
Appearance	1.6%	N/A
Sexuality	0.2%	N/A
Financial Status	0.7%	N/A
Other	5.8%	N/A

* Indicates a statistically significant difference between groups at $p<0.05$

APPENDIX III:

Table 2. Lagged Variable Logistic Regression

Dependent Variable=Above Average (Mean) Total Costs in follow-up wave (2020/2022) (1=yes; 0=no) (N=5,247)		
Independent Variables (2018 or 2020 at LBQ Completion)	***Odds Ratio***	***Significance***
Reported Discrimination (2018 or 2020) (1=yes, 0=no)	1.31	0.02
Usual Source of Care	0.74	0.01
Age	1.02	0.00
Female	0.91	0.09
Non-Hispanic Black	1.28	0.00
Non-Hispanic Other	1.05	0.45
Hispanic	1.22	0.01
Education Years	1.01	0.08
Married/Partnered	0.84	0.04
Household Income $0 to $29.9k	1.16	0.04
Household Income $30k to $74.9k	1.07	0.06
Retired	1.02	0.67
Dual Eligible	1.35	0.01
Self-Rated Poor/Fair Health	1.79	0.00
Chronic Conditions Count	1.27	0.00
Depression	1.05	0.74
Current Smoker	1.14	0.06
Midwest Region	1.19	0.72
South Region	1.14	0.56
West Region	0.92	0.40

Note. Reference Groups: No Discrimination, No Usual Source of Care, Male, NH White, Non-Married (Divorced/Separated, Widowed, Never Married), Income $75k and over, Not Retired, Not Dual Eligible, Excellent/Good Health, Not Depressed, Non-Smoker, Northeast Region.

APPENDIX IV:

Table 3. Longitudinal OLS Linear Regression

Dependent Variable= Change in Total Costs from 2012 to 2022 (N=5,545)				
Independent Variables (Number of waves reported from 2012 to 2022 for key variables; change from 2012 to 2022 for health variables; all other demographics measured at baseline 2012)		***Coefficient***	**SE**	**Sig**
Discrimination Reported	(# of Waves)	1099.59	344.71	0.01
Usual Source of Care	(# of Waves)	-783.10	291.05	0.00
Age	(each additional year)	174.81	40.67	0.00
Female		-128.81	409.22	0.95
Non-Hispanic Black		387.26	210.39	0.08
Non-Hispanic Other		-972.55	1325.30	0.48
Hispanic		401.63	216.74	0.07
Education Years		-186.48	127.07	0.19
Married/Partnered		40.32	208.62	0.60
HH Income $0 to $29.9k		1245.97	1063.71	0.42
HH Income $30k to $74.9k		826.38	729.12	0.40
Retired		-361.96	561.09	0.53
Dual Eligible Status	(Change 2012 to 2022)	659.47	307.10	0.04
Self-Rated Poor/Fair Health	(Change 2012 to 2022)	1122.53	594.81	0.03
Chronic Conditions Count	(Change 2012 to 2022)	891.31	304.69	0.02
Depressed	(Change 2012 to 2022)	836.18	812.26	0.49
Smoker	(Change 2012 to 2022)	2162.39	819.17	0.00
Midwest Region		519.89	995.15	0.82
South Region		910.64	997.87	0.58
West Region		-573.11	767.25	0.71

Note. Reference Groups: No Discrimination, No Usual Source of Care, Male, NH White, Non-Married (Divorced/Separated, Widowed, Never Married), Income $75k and over, Not Retired, Not Dual Eligible, Excellent/Good Health, Not Depressed, Non-Smoker, Northeast Region

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Endnotes

1 Dixon et al., 2022
2 Nong et al., 2020
3 Rogers et al., 2015
4 Wang et al., 2024
5 Benjamins & Whitman, 2014
6 Cohen et al., 2022
7 Hawes et al., 2022
8 Lawrence et al., 2022
9 Klein & von dem Knesebeck, 2018
10 Rivenbark & Ichou, 2020
11 Tavares & Cohen, 2023
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13 Zhang et al., 2022
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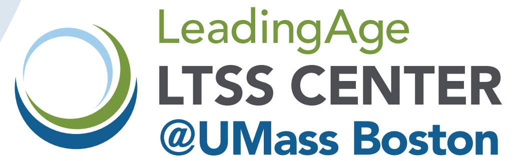

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