NATIONAL HEALTH LAW PROGRAM

Protect Medicaid Funding

Health Disparities

Issue #6

Medicaid provides a long-term investment in health that helps people succeed. It increases the diagnosis and early treatment of chronic conditions, enhances educational achievement and future earnings for covered children, and reduces health care disparities.[1] Medicaid coverage is tailored to the unique needs of low-income individuals and families, but still costs less per enrollee than employer-based insurance.[2] Despite Medicaid's proven success and efficient use of funds, opponents repeatedly seek to cut or cap funding for the program. These proposals seriously jeopardize the health and financial security of the 97 million people who benefit from Medicaid each year.[3] Medicaid's core consumer protections make the program work for enrolled populations, including children, parents, pregnant women, low-income workers, older adults, and persons with disabilities. This fact sheet examines why Medicaid is so important for communities experiencing health disparities and how they would be harmed by Medicaid funding caps.

Why Medicaid is important for communities experiencing health disparities:

- **Medicaid protects communities of color.** Medicaid is an important source of health coverage for people of color, who represent 58% of non-elderly Medicaid enrollees.[4] Medicaid coverage is particularly critical for people of color because they are more likely to be living with certain chronic health conditions, such as diabetes, which requires ongoing screening and services.[5]

- **Medicaid protects rural communities.** Higher proportions of individuals in rural areas live in poverty than do individuals in metropolitan areas, and thus a higher percentage of rural individuals (21%) are enrolled in Medicaid compared to metropolitan individuals (16%).[6] In addition, working adults in rural communities are less likely to have access to employer-based health insurance.[7] Medicaid provides federal funding to support coverage for rural communities and in doing so, helps sustain a healthy workforce.

- **Medicaid protects communities with disabilities.** Although insurance markets historically discriminated against people with disabilities, Medicaid has provided reliable coverage to lower income people with disabilities, with no pre-existing condition exclusions or other barriers. Medicaid has also pioneered the development of home and community based services that allow individuals with disabilities to receive care in their homes, instead of more expensive institutional care.

- **Medicaid protects health security in states.** Federal Medicaid dollars provide states with increased funding to help meet new community health threats as they arise, such as obesity or opioid epidemics. Medicaid funding is also specifically designed to ensure that when the economy falters and low-wage people of color and rural workers lose their jobs, states can get more federal funding to meet the increased needs.

- **Medicaid supports safety-net health centers for communities experiencing health disparities.** Medicaid requires states to include coverage of Federally Qualified Community Health Center and Rural Health Clinic services and pays the centers special rates to help sustain the care they provide to underserved communities.[8]

How funding caps would harm communities experiencing health disparities:

- **Funding caps would hurt communities experiencing health disparities.** Funding caps result in reduced federal funding for state Medicaid programs. States would be forced to cut back on Medicaid, and communities experiencing health disparities would be among the most impacted. For example, with funding caps states would be more likely to reject or reverse new Medicaid expansions, meaning there would be no source of coverage for many low-income populations experiencing health disparities, such as people of color and rural communities. States would be especially likely to cut expensive services relied on by persons with disabilities. Finally, states would likely also pursue policies such as high premiums and cost-sharing that shift costs onto low-income communities experiencing health disparities, who may not be able to afford their health care.

- **Funding caps would put state health security in jeopardy.** Under a funding cap, states get a predetermined federal payment for future years, meaning states would not have enough money if health care needs increase. For example, the number of Americans living with diabetes is predicted to increase by 54% between 2015 and 2030.[9] Under a cap, states would not get support for these new costs, which disproportionately impact people of color. In addition, under a block grant, if the economy falters and people of color or rural workers lose their jobs, states get no additional federal funding to help cover increases in the uninsured.

- **Funding caps would undermine flexibility to address community health priorities.** Funding caps would make it impossible for states to implement or continue initiatives that address the social determinants of health or make strategic investments in preventive care and community health that save long-term costs. Funding caps might also force states to reduce the enhanced Medicaid rates paid to public and rural health clinics that care for underserved communities, including individuals without insurance.

[1] Harvey W. Kaufman et al., *Surge in Newly Identified Diabetes among Medicaid Patients in 2015 within Medicaid Expansion States under the Affordable Care Act*, 38 DIABETES CARE 833 (2015) (Medicaid coverage improves diabetes screening and treatment initiation); DAVID W. BROWN ET AL., NAT'L BUREAU OF ECON. RESEARCH, MEDICAID AS AN INVESTMENT IN CHILDREN: WHAT IS THE LONG-TERM IMPACT ON TAX RECEIPTS? 20 (2015), http://www.nber.org/papers/w20835 (Medicaid improves long-term outcomes for children); Thomas C. Buchmeuller et al., *Effect of the Affordable Care Act on Racial and Ethnic Disparities in Health Insurance Coverage* 106 AM. J. PUB. HEALTH 1416, 1420 (2016) (Medicaid expansion reduced health care disparities).

[2] TERESA COUGHLIN ET AL., KAISER COMM'N ON MEDICAID & THE UNINSURED, WHAT DIFFERENCE DOES MEDICAID MAKE? 4, 7 (2013), http://kaiserfamilyfoundation.files.wordpress.com/2013/05/8440-what-difference-does-medicaid-make2.pdf (Employer-based coverage would cost 28% more than covering the same low-income individual with Medicaid).

[3] CONG. BUDGET OFFICE, DETAIL OF SPENDING AND ENROLLMENT FOR MEDICAID FOR CBO'S MARCH 2016 BASELINE (2016), https://www.cbo.gov/sites/default/files/51301-2016-03-Medicaid.pdf. Though 97 million individuals enrolled in Medicaid over the course of 2015, the average monthly enrollment was 76 million. *Id*. This underscores the importance of Medicaid as a source of coverage for individuals who temporarily lose coverage, such as individuals between jobs.

[4] KAISER FAMILY FOUND., DISTRIBUTION OF THE NONELDERLY WITH MEDICAID BY RACE/ETHNICITY (2015), http://kff.org/medicaid/state-indicator/distribution-by-raceethnicity-4.

[5] American Indians/Alaska Natives (15.9%), Non-Hispanic blacks (13.2%), Hispanics (12.8%), and Asian Americans (9%) make up the populations with the highest rates of diagnosed diabetes, compared to 7.6% of Non-Hispanic whites. U.S. DEP'T OF HEALTH & HUM. SERVS., CTRS. FOR DISEASE CONTROL & PREVENTION, NAT'L CTR. FOR CHRONIC DISEASE PREVENTION & HEALTH PROMOTION, NATIONAL DIABETES STATISTICS REPORT 2014, http://www.cdc.gov/diabetes/pubs/statsreport14/national-diabetes-report-web.pdf.

[6] KAISER FAMILY FOUND., THE AFFORDABLE CARE ACT AND INSURANCE COVERAGE IN RURAL AREAS (2014), https://kaiserfamilyfoundation.files.wordpress.com/2014/05/8597-the-affordable-care-act-and-insurance-coverage-in-rural-areas1.pdf.

[7] *Id. See also* NAT'L POVERTY CENTER, NAT. POVERTY CENTER WORKING PAPER SERIES: #11-16 - THE GEOGRAPHY OF EXCLUSION: RACE, SEGREGATION AND CONCENTRATED POVERTY 6-7 (2011), http://npc.umich.edu/publications/u/2011-16%20NPC%20Working%20Paper.pdf ("With the exception of Appalachia, which is overwhelmingly white in racial composition (Pollard 2004), racial and ethnic populations are heavily concentrated in geographically isolated rural regions of the United States.").

[8] GEO. WASH. U., SCH. OF PUB. HEALTH & HEALTH SERVICES, QUALITY INCENTIVES FOR FEDERALLY QUALIFIED HEALTH CENTERS, RURAL HEALTH CLINICS, AND FREE CLINICS: A REPORT TO CONGRESS 1-2 (2012), http://www.healthit.gov/sites/default/files/pdf/quality-incentives-final-report-1-23-12.pdf.

[9] Rowley William R. et al., *Diabetes 2030: Insights from Yesterday, Today, and Future Trends*, POPULATION HEALTH MGMT. 1 (2016), http://online.liebertpub.com/doi/pdfplus/10.1089/pop.2015.0181.