Protect Medicaid Funding Issue #11: Health Inequities
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Introduction

Medicaid helps people live healthier and more economically secure lives. It increases the diagnosis and early treatment of chronic conditions, enhances educational achievement and future earnings for covered children, reduces health care inequities, and provides comprehensive, high-quality, and cost-effective care.[1] Medicaid coverage is tailored to the unique needs of individuals and families with low incomes, but still costs less per beneficiary than private insurance.[2] Medicaid's core beneficiary protections make the program work for enrolled populations, including children, parents, pregnant people, low-income workers, older adults, and persons with disabilities. Despite Medicaid's proven success and efficient use of funds, detractors repeatedly seek to cut or cap funding for the program. These proposals seriously jeopardize the health and financial security of the over 80 million people who benefit from Medicaid and CHIP.[3]

This fact sheet examines why Medicaid is important for communities experiencing health inequities and how they would be harmed by Medicaid funding caps.

Why Medicaid is Important for Communities Experiencing Health Inequities

Medicaid protects communities of color. Medicaid is an important source of health coverage for people of color, who represent 60% of non-elderly Medicaid beneficiaries.[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 urban areas, and thus a higher percentage of rural individuals

(24%) are enrolled in Medicaid compared to urban individuals (22%).[6] In addition, working adults in rural communities are less likely to have access to private insurance (58%) than those in urban communities (66%).[7] Medicaid provides federal funding to support coverage for rural communities and in doing so, helps sustain a healthy workforce.

Medicaid protects people with disabilities. Although insurance markets historically discriminated against people with disabilities, Medicaid provides 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 (HCBS) 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 the COVID-19 pandemic, obesity epidemic, and opioid epidemic. 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 increased needs.

Medicaid supports safety-net health centers for communities experiencing health inequities. Medicaid requires states to include coverage of Federally Qualified Community Health Center (FQHC) and Rural Health Clinic (RHC) 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 Inequities

Funding caps would hurt communities experiencing health inequities. Funding caps result in reduced federal funding for state Medicaid programs. States would be forced to cut back on Medicaid and communities experiencing health inequities 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 and underserved populations experiencing health inequities, such as people of color and rural communities. States would be especially likely to cut expensive services relied on by people with disabilities. Finally, states would also likely pursue policies such as premiums and cost-sharing that shift costs onto low-income and underserved communities experiencing health inequities, 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 78% between 2014 and 2030 and 172% between 2014 and 2060.[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.

ENDNOTES

[1] Robin Rudowitz et al., Kaiser Fam. Found., *10 Things to Know about Medicaid* (Jun. 30, 2023), https://www.kff.org/mental-health/issue-brief/10-things-to-know-about-medicaid/; MACPAC, *Access in Brief: Children's Experience in Accessing Medical Care* (Nov. 2021), https://www.macpac.gov/wp-content/uploads/2016/06/Access-in-Brief-Childrens-Experiences-in-Accessing-Medical-Care.pdf.

[2] Heidi Allen et al., *Comparison of Utilization, Costs and Quality of Medicaid vs. Subsidized Private Health Insurance for Low-Income Adults*, 4 JAMA NETWORK OPEN (2021), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2774583 (". . .overall health care spending was more than 80% higher among Marketplace-eligible adults than among Medicaid-eligible adults. This difference was no longer significant when claims were adjusted to Medicaid prices, indicating that the cost differences were driven by higher prices for the same services in the Marketplace compared with Medicaid.").*See also* Ark. Ctr. for Health Improvement, *Arkansas Health Care Independence Program ("Private Option") Section 1115 Demonstration waiver Interim Report* (Jun. 16, 2016), https://achi.net/wp-content/uploads/2018/10/Arkansas-Health-Care-Independence-Program-Section-1115-Demonstration-Waiver-Interim-Report-June-2016.pdf (noting a 78.3% difference between the commercial and Medicaid per patient per month payments).

[3] CMS, *May 2024 Medicaid & CHIP Enrollment Data Highlights* (Aug. 30, 2024), https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html.

[4] Kaiser Fam. Found., Distribution of the Nonelderly with Medicaid by Race/Ethnicity (2022), https://www.kff.org/medicaid/state-indicator/medicaid-distribution-nonelderly-by-raceethnicity/.

[5] American Indians/Alaska Natives (13.6%), non-Hispanic Blacks (12.1%), Hispanics (11.7%), and non-Hispanic Asians (9.1%) make up the populations with the highest rates of diagnosed diabetes, compared to 6.9% of non-Hispanic Whites. HHS, CDC, Nat'l Diabetes Prevention Prog., *CDC 2022 National Diabetes Statistics Report* (May 15, 2024), https://www.cdc.gov/diabetes/data/statistics-report/index.html.

[6] Julia Foutz et al., Kaiser Fam. Found., *The Role of Medicaid in Rural* Areas (April 25, 2017), https://www.kff.org/medicaid/issue-brief/the-role-of-medicaid-in-rural-america/ (In some states, the differences in Medicaid coverage rates are even larger when comparing rural areas to urban areas. In California and Hawaii, the Medicaid coverage rates in rural areas is sixteen and thirteen percentage points higher respectively than the rates in urban areas. In Arizona, Arkansas, and Florida, the Medicaid coverage rates in rural areas is about ten percentage points higher than the rates in urban areas.)

[7] *Id; see also* Rural Health Info. Hub*, Rural Health Disparities,* https://www.ruralhealthinfo.org/topics/rural-health-disparities *;see also* Daniel T. Lichter et al., Nat'l Poverty Ctr., *National Poverty Center Working Paper Series #11-16—The Geography of Exclusion: Race, Segregation, and Concentrated Poverty,* 6-7 (May 2011), https://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 minority populations are heavily concentrated in geographically isolated rural regions of the United States.").

[8] George Washington Univ. Sch. Of Pub. Health & Health Servs., *Quality Incentives for Federally Qualified Health Centers, Rural Health Clinics, and Free Clinics: A Report to Congress,* 1-2 (Jan. 23, 2012), https://www.healthit.gov/sites/default/files/pdf/quality-incentives-final-report-1-23-12.pdf; Medicaid & CHIP Payment & Access Comm'n, *Medicaid Payment Policy for Federally Qualified Health Centers* (Dec. 2017), https://www.macpac.gov/wp-content/uploads/2017/12/Medicaid-Payment-Policy-for-Federally-Qualified-Health-Centers.pdf.

[9] Ji Lin et al., *Projection of the Future Diabetes Burden in the United States Through 2060*, 16 POPULATION HEALTH METRICS 9 (2018), https://pophealthmetrics.biomedcentral.com/articles/10.1186/s12963-018-0166-4.