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# Health Care and Public Health Policy: Racial and Ethnic Health Inequities

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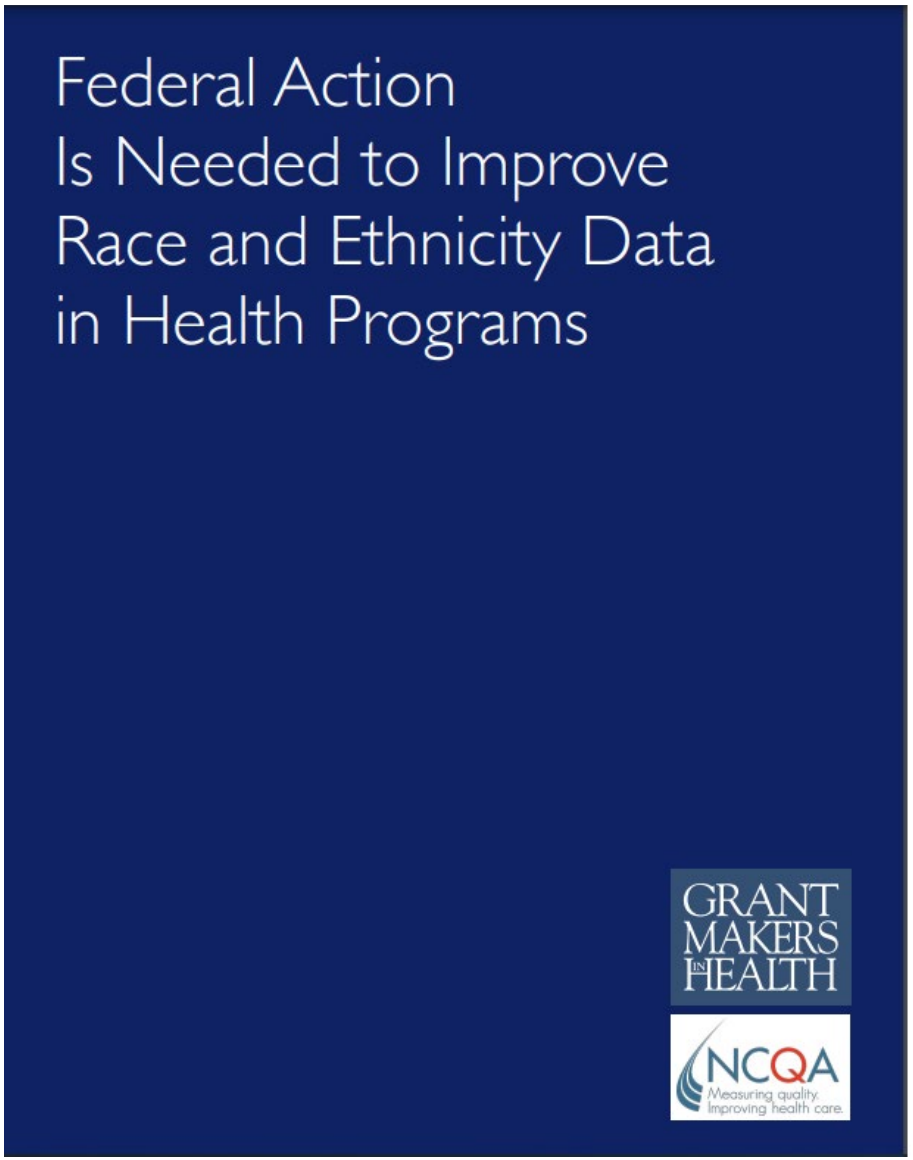
NASEM Committee on the Review of Federal Policies that Contribute to Racial and Ethnic Health Inequities

August 3, 2022

- **Data**
- **Coverage**
  - Filling the Medicaid Coverage Gap
  - Potential loss of coverage following the end of the Public Health Emergency (PHE)
- **Addressing Payment Disparities**
- **Budget Neutrality Requirements for Section 1115 Waivers**
- **Liens**

# Data!!!





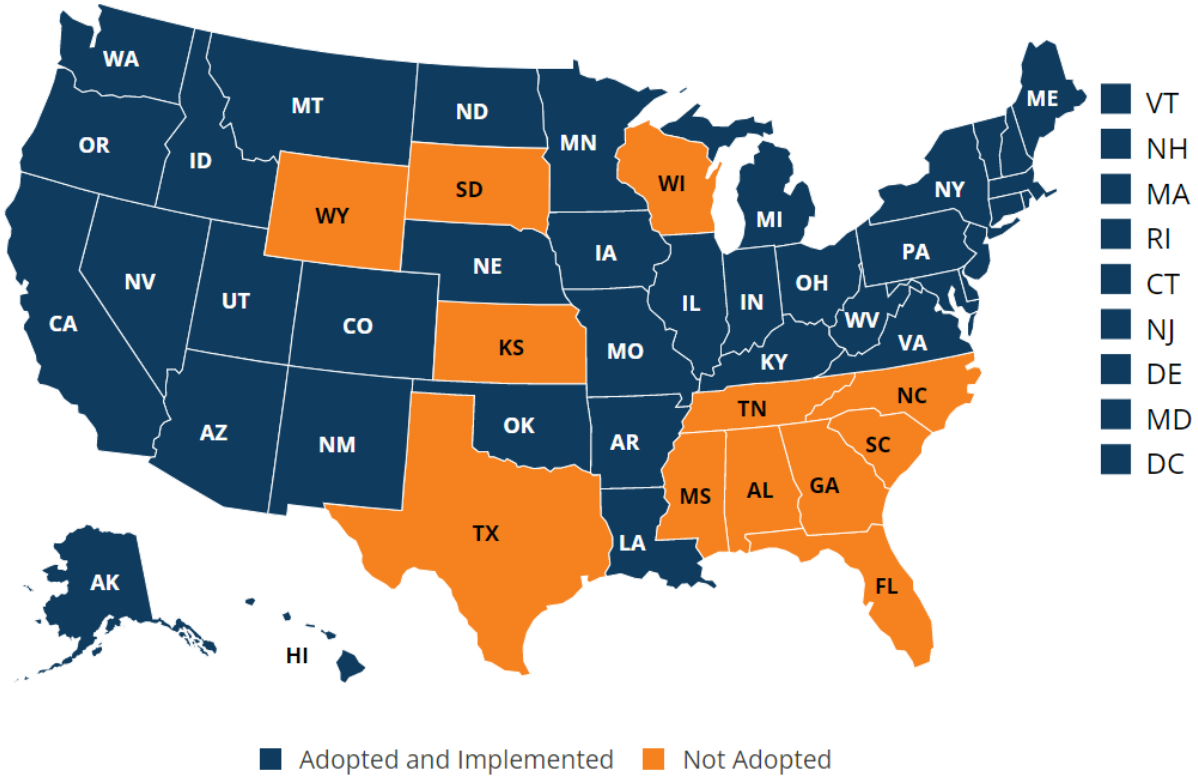

See, https://www.gih.org/wp-content/uploads/2021/10/GIH-Commonwealth-Fund-federal-data-report-part-1.pdf.

# Coverage

# 12 States Have Yet to Expand Medicaid



## Medicaid Expansion Status by State

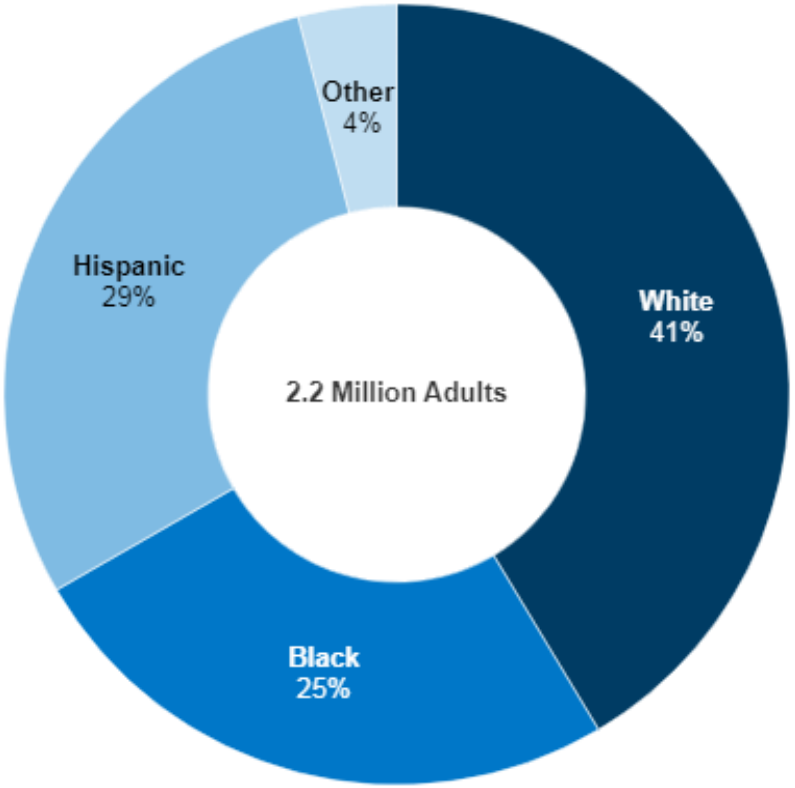



### Medicaid Expansion Incentive

The American Rescue Plan includes a two-year, five percentage point increase in the Medicaid matching rate (FMAP) for "traditional" eligibility groups for new expansion states

Source: Status of State Medicaid Expansion Decisions: Interactive Map, 2021.

# Race/Ethnicity of Adults in the Coverage Gap



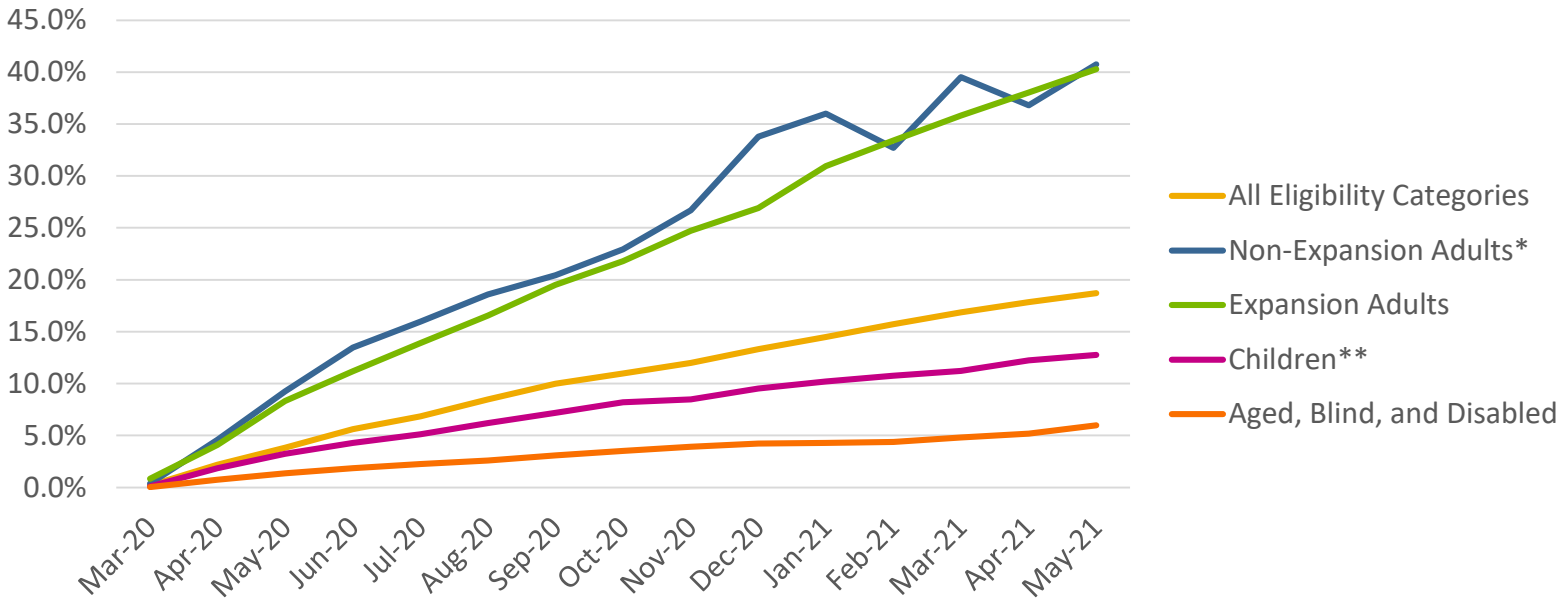

NOTE: Totals may not sum to 100% due to rounding. Nonelderly includes individuals ages 0 to 64. Other includes Asian, American Indian Alaska Native, and Native Hawaiian and Other Pacific Islander people, along with people of multiple races. Hispanic people may be of any race but are categorized as Hispanic; other groups are all non-Hispanic.
SOURCE: KFF analysis of 2019 American Community Survey. • PNG

# Coverage at Risk When the PHE Ends



**Medicaid enrollment has grown sharply due to the economic downturn as well as continuous coverage requirements.**

## Median Growth in State Medicaid/CHIP Enrollment, from February 2020




*E.g., parents and pregnant women
**Includes children enrolled in Medicaid and CHIP
Note: The number of states reporting data varies by month

*Source:* Manatt analysis of state Medicaid enrollment databases.

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# The "Perfect Storm"



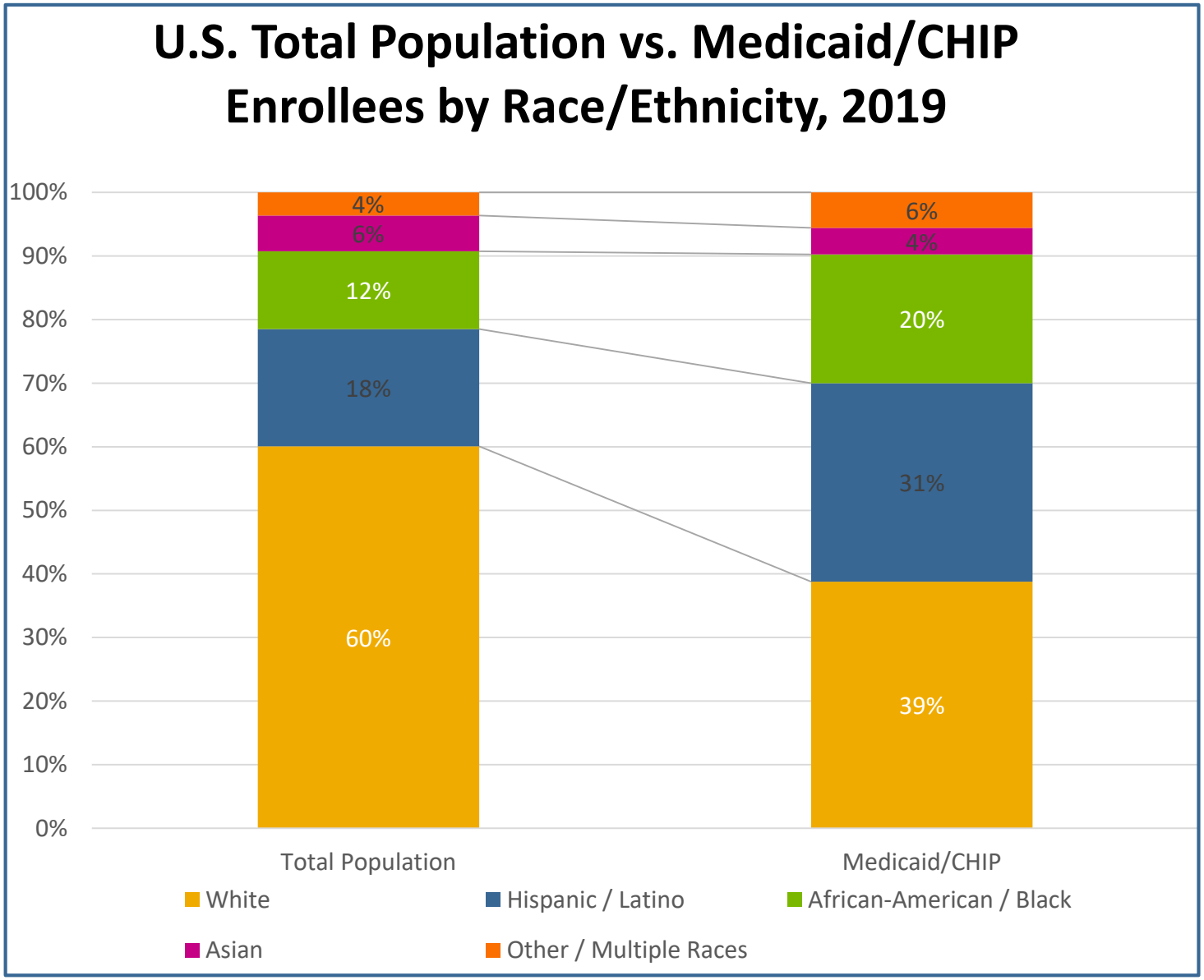
## Most People Likely Remain Eligible for Coverage (Medicaid, Marketplace or CHIP) but There is a High Risk of Coverage Loss

- Large number of people to renew: almost all 88.3 million enrollees.
- States required to turn first to data- based sources of information but systems capacity varies across states
- When data can't confirm eligibility states will rely on paper applications mailed to last known address. But many people have moved during the PHE
  - High risk of influx of returned mail and procedural closures
- Needed follow up may be limited in some states
  - Significant state staff shortages
  - Some states are poised to move quickly
- Transfers (Medicaid to Marketplace or CHIP) are another risk point

**See:** S. Sugar, et al., *Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic*, ASPE, April 2021. Available at: https://aspe.hhs.gov/sites/default/files/private/pdf/265366/medicaid-churning-ib.pdf; *The Return of Churn; State Paperwork Barriers Caused More than 1.5 Million Low-Income People to Lose Their Medicaid Coverage in 2018.* Families USA, April 2019. Available at: https://familiesusa.org/wp-content/uploads/2019/09/Return_of_Churn_Analysis.pdf ; April 2022 Medicaid and CHIP Enrollment Snapshot

# Coverage Losses Likely to Disproportionately Impact People of Color



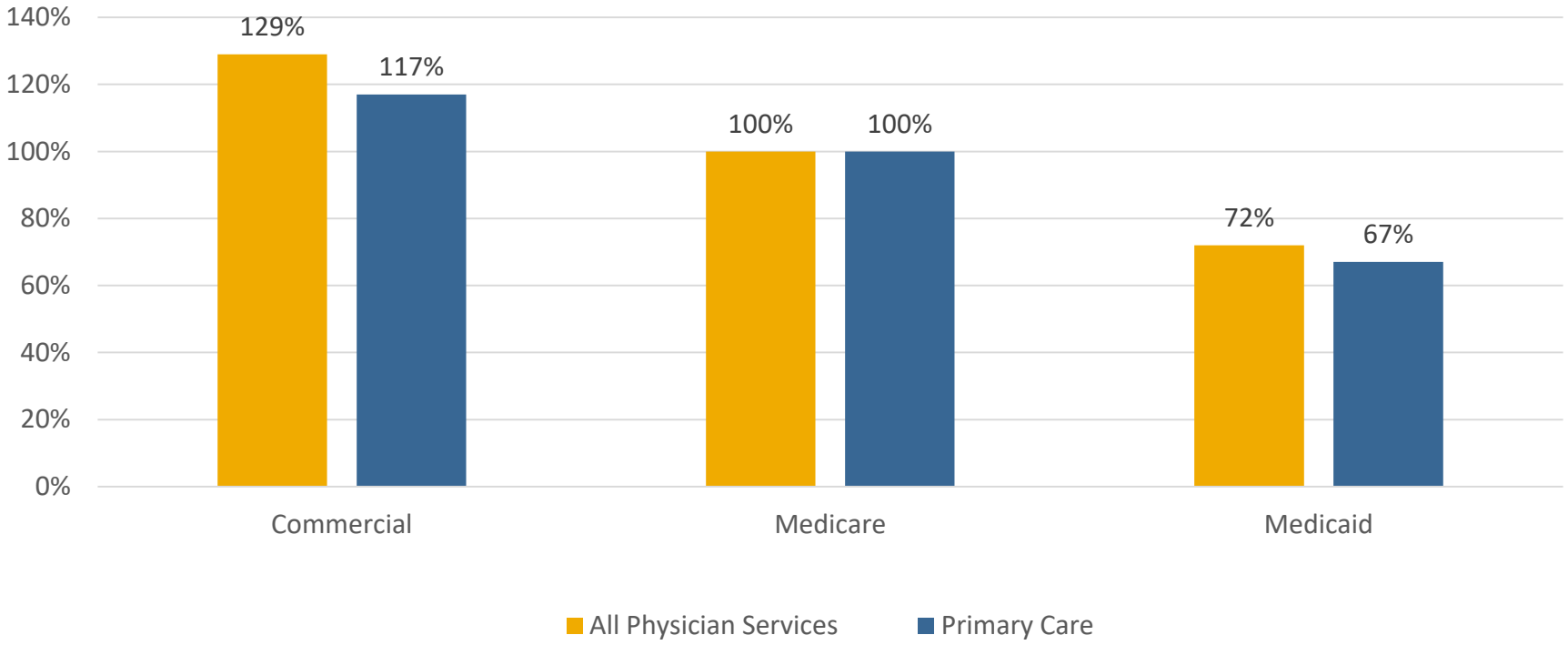



**Sources:** CMS, March 8, 2022, All-State Medicaid and CHIP Call. SHADAC, State Health Compare; Buettgens, M., and Green, A., "What Will Happen to Medicaid Enrollees' Health Coverage after the Public Health Emergency?" Urban Institute, March 9, 2022, https://www.urban.org/research/publication/what-will-happen-medicaid-enrollees-health-coverage-after-public-health-emergency.

# Payment Disparities

# Average Relative Physician Payment Rates, Across Payers



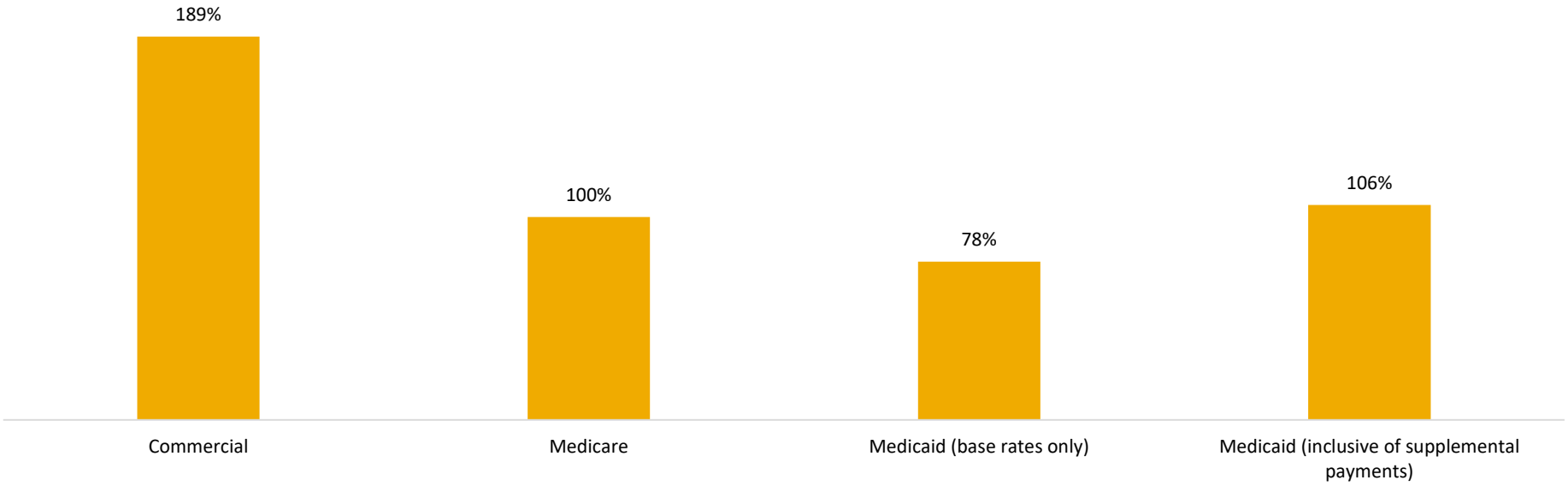



**Notes:** Medicaid figures reflect Medicaid fee-for-service rates only (i.e., figures do not account for payments to managed care plans). Commercial to Medicare and Medicare to Medicaid comparisons are derived from different sources using different methodologies. Accordingly, figures should only be considered high-level approximations. Relative rates may vary considerably across different commercial contracts, services, and states.

**Sources:** Commercial to Medicare comparison - https://www.cbo.gov/system/files/2022-01/57422-medical-prices.pdf; Medicare to Medicaid comparison - https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2020.00611.

# Average Relative Inpatient Hospital Payment Rates, Across Payers



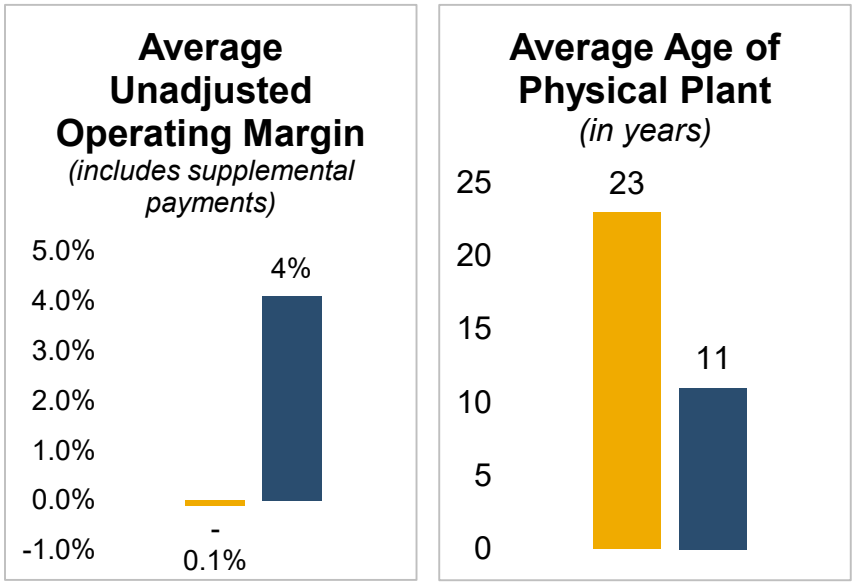



**Notes:** Medicaid figures reflect Medicaid fee-for-service rates only (i.e., figures do not account for payments to managed care plans). Commercial to Medicare and Medicare to Medicaid comparisons are derived from different sources using different methodologies. Accordingly, figures should only be considered high-level approximations. Relative rates may vary considerably across different commercial contracts, services, and states. Note that not all states pay and not all hospitals receive supplemental payments.

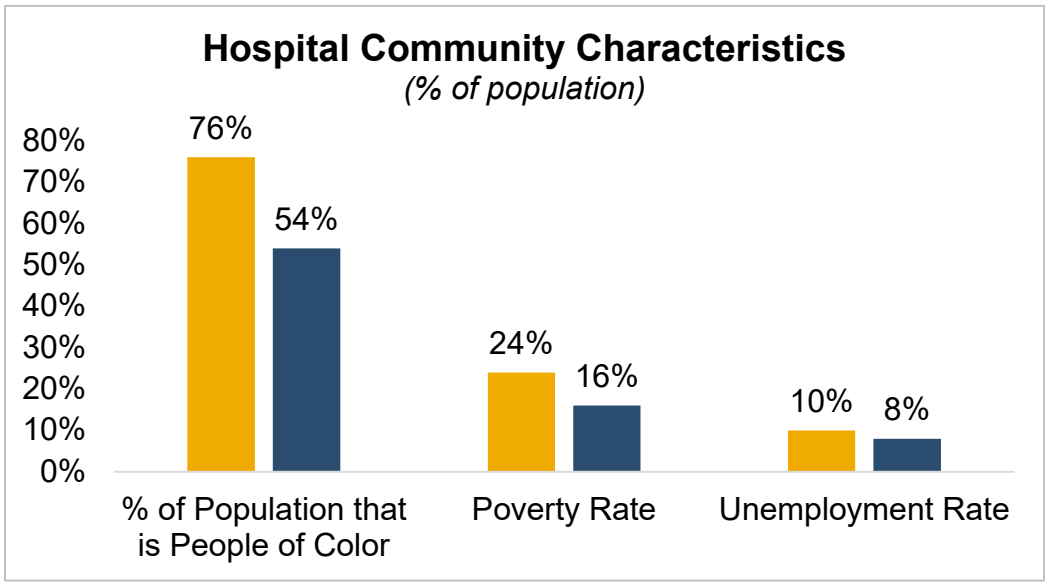
**Sources:** Commercial to Medicare comparison - https://www.kff.org/medicare/issue-brief/how-much-more-than-medicare-do-private-insurers-pay-a-review-of-the-literature/; Medicare to Medicaid comparison - https://www.macpac.gov/wp-content/uploads/2017/04/Medicaid-Hospital-Payment-A-Comparison-across-States-and-to-Medicare.pdf.

# For purposes of this analysis, safety net hospitals are defined as non-public facilities with at least 45% Medicaid/uninsured patients and no more than 20% commercial.

## Safety net hospitals have negative operating margins, and their facilities are twice as old as other NYC hospitals.




## Safety net hospitals serve poorer neighborhoods, which are home to greater proportions of communities of color.




Source: Based on Manatt analysis of hospital data available through the American Hospital Database, Institutional Cost Reports, data provided directly from safety net hospitals, and the New York City Community Health Profiles Database.

# Section 1115 Waivers

# Section 1115 Authority Budget Neutrality



- Under Section 1115 of the Social Security Act, the Secretary of HHS has broad, but not unlimited, authority to approve a state's requests to waive compliance with certain provisions of federal Medicaid law and authorize expenditures not otherwise permitted by law
- Such authority is allowed for an "experimental, pilot or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives" of the Medicaid program
- By longstanding practice, waivers must be budget neutral to the federal government
  - Federal Medicaid spending under the waiver can not exceed projected federal spending without the waiver
  - Policy is not set by statute or regulation

Source: Social Security Act (SSA) § 1115; *See* SSA § 1916(f) for cost sharing waiver limitations.
∗ HHS may only waive provisions in SSA § 1902.;

# Innovative State Section 1115 Requests

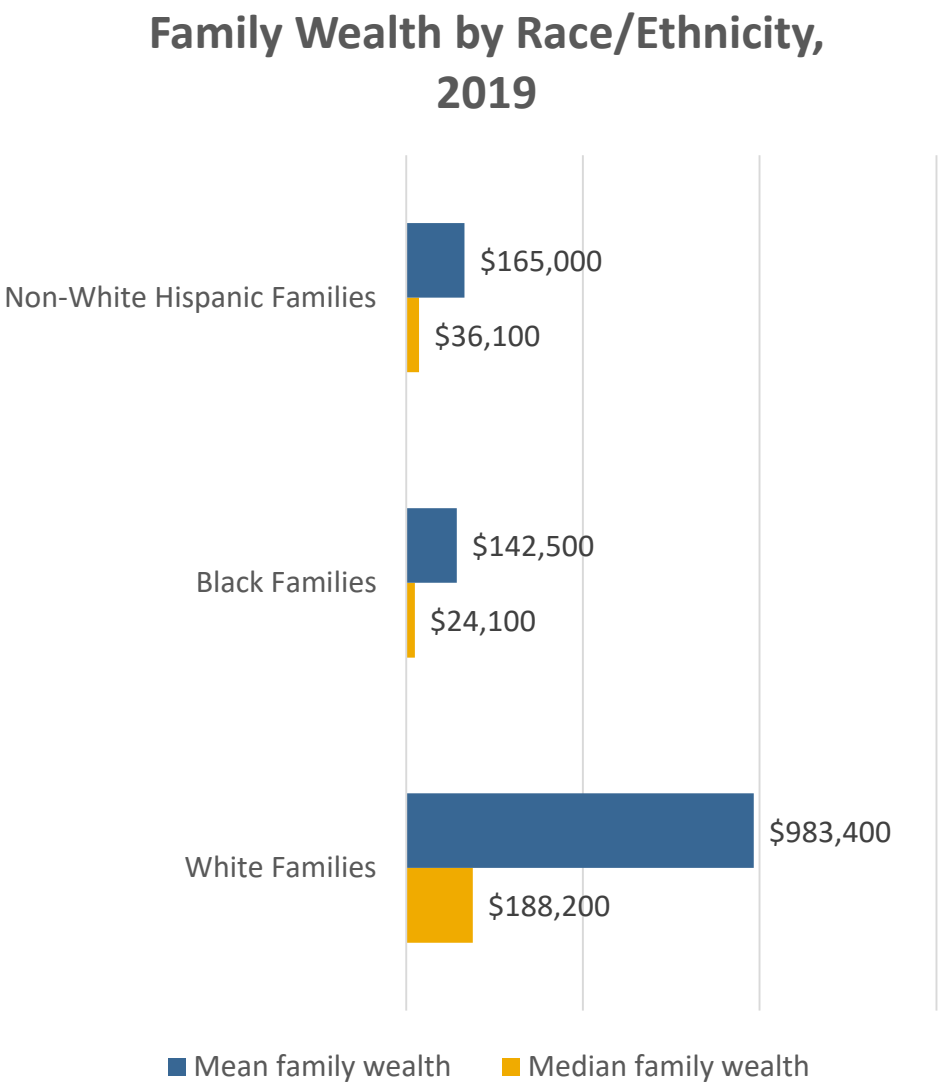


**The Biden Administration will need to make decisions on new and innovative Section 1115 demonstration requests submitted by states to date, including:**

- Improving health upon re-entry by covering (select) services for justice-involved populations pre-release and linking people to services post-release
- Establishing community-led equity councils to invest in initiatives that explicitly address racial/ethnic disparities
- Addressing Social Drivers of Health
- Adopting continuous coverage for children up to age 6 to eliminate churn
- Offering Traditional Healing and Natural Helper services
- Expansion of community-based treatment services for SUD and mental health conditions

See, Mann, Karl, Howard, Rethinking the Budget Neutrality Requirement for Medicaid 1115Demonstrations, *Health Affairs*, https://www.healthaffairs.org/do/10.1377/forefront.20220609.313905/

# Estate Recovery




## Medicaid Estate Recovery Has Inequitable Consequences

- Estate recovery affects the most important source of intergenerational family wealth for marginalized communities –their home.
- People with greater means often rely on estate planners
- Recovery results little recovery for states/federal government

Source: State Health & Value Strategies, Making Medicaid Estate Recovery Policies More Equitable: State Toolkit https://www.shvs.org/wp-content/uploads/2022/04/Medicaid-Estate-Recovery-State-Toolkit.pdf

# Thank you



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