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Goldstein, Rachel, "The Rise of Health Disparities in the United States: An Investigation into Medicaid Expansionary Policies" (2020). *Social Impact Research Experience (SIRE)*. 82.
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Keywords

health care, Medicare, Medicaid, Connecticut, Texas, Medicaid expansion, health equality

Disciplines

Business | Community Health | Community Health and Preventive Medicine | Health Services Administration | Public Health Education and Promotion | Quality Improvement

**The Rise of Health Disparities in the
United States:
An Investigation into Medicaid
Expansionary Policies**

By Rachel Goldstein

The Wharton School

Professor Molly Candon

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Since the passage of the Affordable Care Act, the variations in health spending and health outcomes across states have further diverged. While some states have increased their overall funding of Medicaid, others, like Texas, have not increased Medicaid coverage nor have they kept funding equal to inflation levels. This research paper examines and compares the health outcomes of states with higher uninsured populations and the ability to meet UNESCO defined standards for social responsibility in the health care sector. Based on literature review and a case study of health outcomes for low-income patients and disabled individuals, this paper finds that non-expansion Medicaid states are not capable of meeting UNESCO defined standards, due to the barriers to mental health care and the likelihood of long-term disparities in health outcomes for low-income and disabled individuals.

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I. Introduction:

In 1965, President Lyndon B. Johnson worked to eliminate poverty and racial injustice through a series of initiatives called the Great Society. A cornerstone of the Great Society programs was the development of medical care programs called Medicaid and Medicare. Prior to the enactment of these initiatives, poor and uninsured Americans relied on savings, charity from hospitals, or funding from family members for coverage of hospital care. Today, Medicaid is the third largest domestic program in the federal budget, closely following Medicare and Social Security (Kaiser Family Foundation 2015).

Since 1965, Medicare and Medicaid health care programs have evolved to be more comprehensive. This includes developments that give coverage to broader age groups of people, increasing benefits like prescription drug coverage, and most significantly the overarching changes in marketplace structure brought about by the enactment of the Affordable Care Act. The Affordable Care Act was first federally enacted in 2010 and is a comprehensive health care reform law. The three primary goals of the act were (1) to make health insurance more affordable and accessible to more people via subsidies, (2) expand the eligibility of adults who were able to receive Medicaid due to poverty, and (3) support the development of lower cost, innovative medical care delivery methods.

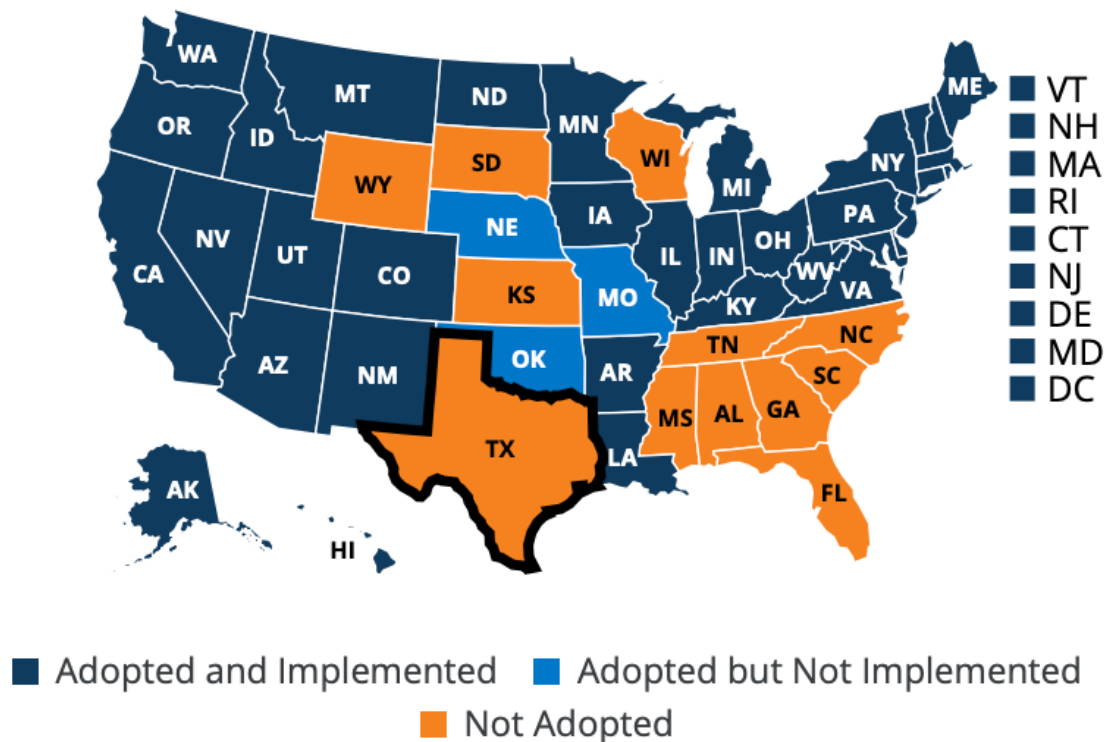


Figure 1: Map of states and decision to adopt Medicaid expansionary policy.
Source: Kaiser Family Foundation 2019

The Affordable Care Act, which is colloquially known as Obamacare, faced strong political opposition and calls for repeal. In 2012, the Supreme Court ruled in *National Federation of Independent Business v. Sebelius*, that the states could choose to not participate in the Medicaid

expansion (Pickert 2012). Due to this Supreme Court Act, only 38 states and the District of Columbia expanded Medicaid coverage to this low-income population. This reduced the ability of Medicaid to accomplish its second aforementioned goal. The Affordable Care Act's expansion of coverage has been associated with increases in coverage, service use, quality of care, and Medicaid spending across several studies (Health Affairs 2018). In the states that chose not to expand Medicaid following the Supreme Court ruling, it is estimated that 3.5 million non-elderly adults have been excluded from ACA Medicaid Expansions. Today, Medicaid accounts for \$1 out of every \$6 spent on health care in the United States (Kaiser Family Foundation 2015). The program is jointly funded by states and federal government, with a trend towards increasing payments by the states. Specifically, in 2020, the federal funding for the expansion of Medicaid has been scheduled to decrease from 100% to 90% (Gunn 2016). This 10% decrease in federal funding was the reason behind many states' lack of desire to expand Medicaid in 2012.

The Affordable Care Act has implications for both Medicare and Medicaid. There are several key differences in policy, funding, and beneficiaries between the two programs. Medicare is a federal program that provides standard benefit packages to all enrollees (Ball 1995). In total, Medicare serves over 34 million elderly adults. The majority, over 85.7%, of all Medicare beneficiaries are elderly with the remaining beneficiaries being disabled persons or having end stage renal disease (Kaiser Family Foundation 2018). Further, the distribution of Medicare beneficiaries is very uneven. Specifically, 35% of all beneficiaries live in California, Florida, New York, Pennsylvania, and Texas (Gage and Moon, 1999). The high rates of Medicare beneficiaries in these states greatly impact the economic policies for all residents of these states. The variations in population age result in these five states having the highest aggregate spending levels for nearly all types of Medicare covered services. Unlike Medicare, Medicaid is a state and federal program aimed at providing health coverage to very low-income adults. Some individuals are eligible for both Medicare and Medicaid, due to their age and income levels, or status as a disabled individual (Kaiser Family Foundation 2015). Medicaid beneficiaries receive care with only a small co-payment, if any payment is required. There are federal guidelines for coverage; however, Medicaid varies much more from state to state. Further, Medicaid is run by state and local governments.

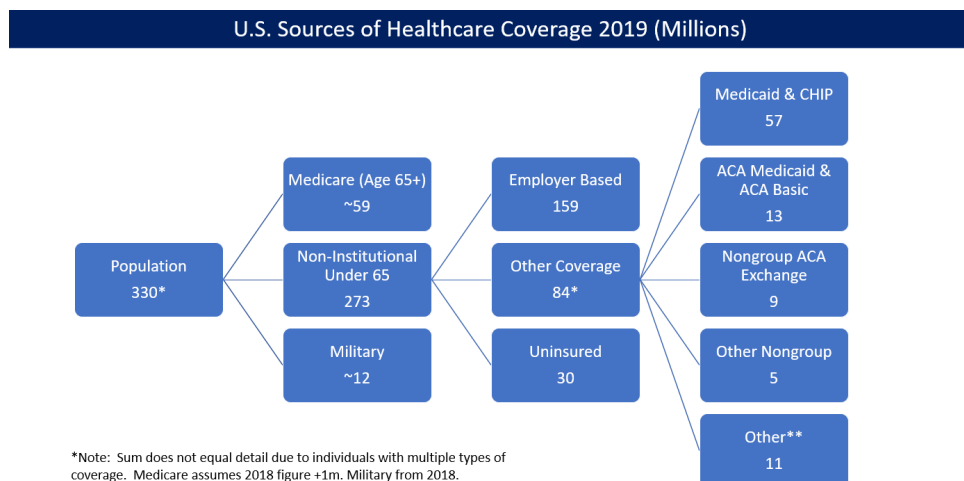


Figure 2: Data regarding current state of population health care coverage. Source: Census Bureau Health Insurance coverage United States 2018

II. Intentions and Goals:

It is important to examine how the variations in expansion of Medicaid affect the health outcomes of individuals, specifically for low-income patients. Texas and Connecticut operate under all of the same federal laws, but all states have a great deal of jurisdiction in their implementation of healthcare laws. For instance, Connecticut expanded its Medicaid spending in 2012, after the Supreme Court's ruling on the ACA. The state's expansion of Medicaid spending led to the consolidation of hospitals. Unlike Connecticut, Texas did not expand its Medicaid spending, nor has it experienced the trend of health care consolidation. The extreme differences in policy, structuring of practice, and demographics within these states create a unique mix of factors for research.

The United Nations Educational, Scientific, and Cultural Organization's (UNESCO's) International Bioethics Committee on Social Responsibility and Health defines social responsibility in the health care sector as "A task to be shared by the private sector and States and governments, which are called to meet specific obligations to the maximum of the available resources in order to implement and progressively achieve the full realization of this right." This paper aims to contribute to the literature on the impacts of Medicaid expansion for low-income individuals across the United States from qualitative and financial standards. It also aims to analyze and determine if a state that chose to not expand Medicaid coverage is capable of achieving this UNESCO-defined goal for social responsibility.

The information included in this paper is a result of analyzation of case studies, which highlight the performances and economic data from Connecticut and Texas. Ultimately, this paper focuses on researching how the expansion of Medicaid or a state's decision to not expand impacts patient well-being.

III. A History of Health Care in Connecticut and Texas

A. Connecticut State Health System History Pertaining to the Affordable Care Act

There are several differences in population health between Connecticut and Texas. These variations stem from both political and economic factors as well as demographic factors. These two states have differences across nearly every aspect of health-related issues and create an interesting juxtaposition for research.

One critical difference between Connecticut and Texas is that while Connecticut expanded its Medicaid spending, Texas chose not to do so following the Supreme Court's 2012 ACA ruling. Connecticut was the first state in the United States to expand Medicaid enrollment to low-income adults under the Affordable Care Act (Commonwealth Fund 2010). This expanded public health care coverage to an additional 45,000 adults. At the time of passage, Representative Rosa DeLauro stated that she was "so proud that after the long, uphill battle in getting the new health care reform law passed, Connecticut will be the first state to permanently expand coverage to some of our neediest residents" (CT Mirror 2010).

Since 2012, when Connecticut expanded its Medicaid spending, the state has seen a 33% increase in state spending on Medicaid, which is one of the highest increases in the nation and indicates an increase in the state's low-income population (Kaiser Family Foundation 2018). Further, one significant increase over the eight years has been the percentage of Connecticut's spending on Medicaid that has gone to Disproportionate Share Hospital payments. This type of payment is given to hospitals that serve more low-income and uninsured patients than other hospitals. Figure 5 outlines in detail comparisons in distribution of Medicaid funding. States have a considerable amount of discretion in determining the amount of DSH payments and which hospitals will receive them.

My previous research, *Evaluating the Impact of a Consolidated Health Care System on Low-Income Patients in Connecticut*, found that Connecticut, even after undergoing serious health system consolidation is still capable of meeting UNESCO defined standards.

B. Texas State Health System History Pertaining to the Affordable Care Act

Juxtaposing this, since 2012, Texas has only increased its Medicaid spending from 24.6% to 30.6% of its state budget, not holding inflation constant (Kaiser Family Foundation 2019). This less than 6% increase is a result of Texas' refusal to expand Medicaid funding in 2012. Further, in Texas, Medicaid is only available to people with disabilities who have incomes below 75% of the federal poverty level (under \$9,000 a year for an individual); pregnant women with incomes less than 200 percent of poverty (about \$23,500 a year); and parents with incomes less than 19 percent of poverty, which is just under \$5,000 a year for a family of four (Kaiser Family Foundation 2014). Compared to average national rates and qualifications for coverage, Texas' policy is highly restrictive. Figure 3 shows the population demographics of Texas, which has a lot of young and middle aged individuals who would not qualify for other publically funded programs, like Medicare or CHIP, due to their age.

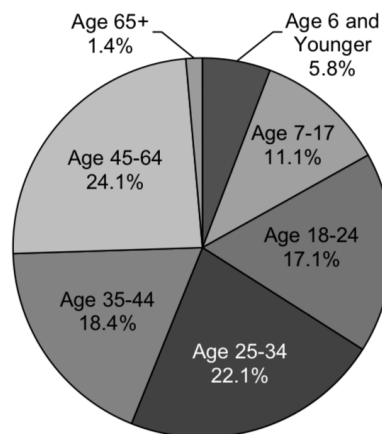


Figure 3: Data regarding current demographics of individuals residing in Texas.
Source: Census Bureau Texas Age Demographics 2013

C. Other State Comparisons

Across the country, there are vast disparities in the amount spent per capita on individuals who receive Medicaid. Figure 4 highlights the disparity. Other southern states, like Louisiana chose to expand Medicaid with the enactment of the Affordable Care Act. In these states, the rate of uninsured amongst low-income adults dropped by more than half (from 41% to 16%) (Kaiser Family Foundation 2015). In Texas, the rate only dropped from 39% to 27%. Today, Texas has the highest uninsured rate of any state in the country (Commonwealth Fund 2019). This equates to approximately 5 million people lacking health insurance within the state. This is nearly double the national average of 8.7% (US Census Bureau 2018). Further, Texas was one of only nine states in 2018 to have an increase in the recorded number of uninsured individuals. Texas was the only state to have an increase in uninsured and to have fewer individuals receiving insurance via Medicaid (Texas Tribune 2018). Specific to Medicaid, there are 1.1 million low-income Texans within the coverage gap who do not receive Medicaid or have access to another type of care, because of the lack of Medicaid expansion (Kaiser Family Foundation 2019).

For patients with disabilities, there are further differences. The average Medicaid annual payment to an individual with disabilities in Connecticut is \$24,798 compared to \$19,745 in Texas.

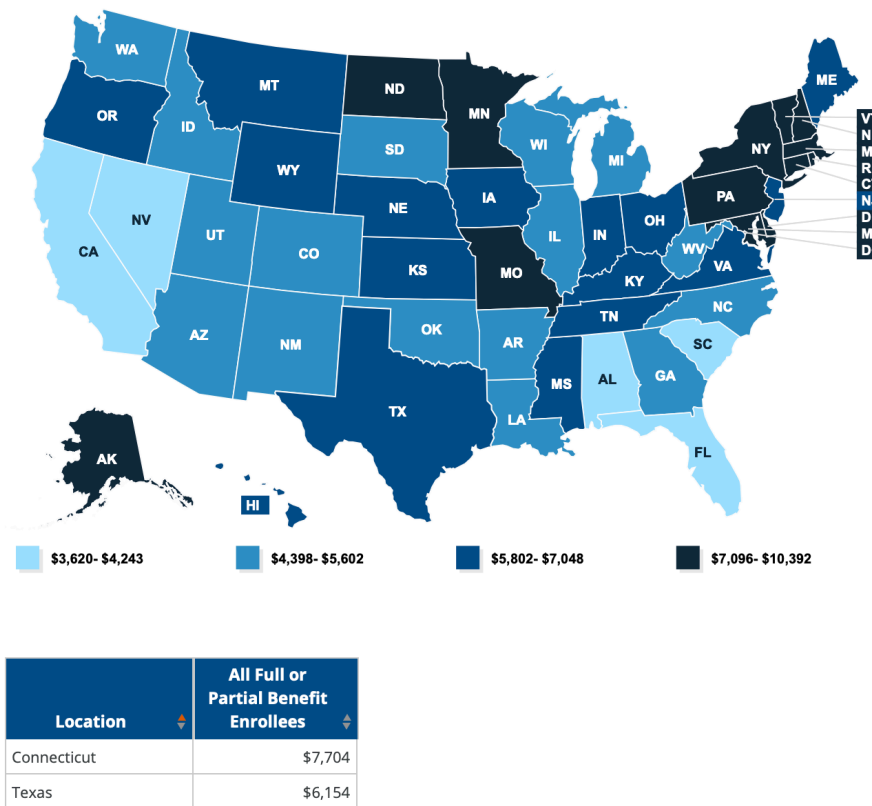


Figure 4: Comparison of Medicaid spending by state.
Source: Kaiser Family Foundation 2019

D. Further Health Policy Diversions

Since 2012, the differences in spending in the two states have further diverged. For example, the spending patterns in terms of Medicaid services covered is a clear diversion between the states. Figure 5 shows the key differences in spending patterns between the two states. One notable difference is the coverage of long-term care. To be able to get Texas's Medicaid program to pay for long-term care in 2019, a single person's monthly income cannot be higher than \$2,313 (Health and Human Services Texas 2019). In stark contrast, Connecticut provides Medicaid coverage for assisted living services through its 1915(c) Medicaid waiver program, the Connecticut Homecare Program for Elders (CHCPE).

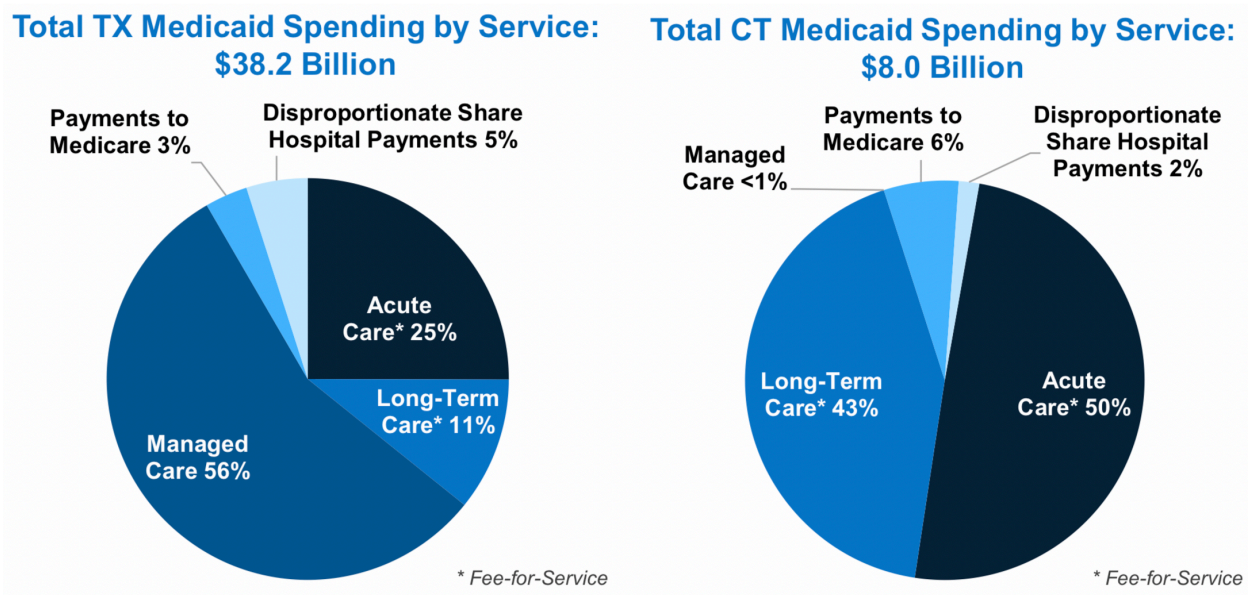


Figure 5: Detailed comparison of allocation of Medicaid spending at the state level.
Source: Kaiser Family Foundation 2019

IV. Case Study Regarding UNESCO Standards

A. Choice of Case Study

The next portion of this research paper will focus on recent studies that analyzed access and quality of care following the enactment of the Affordable Care Act. The first study was completed by the American Health Association. This group conducted an analysis of the ACA with a focus on veteran's access to primary care pre and post ACA enactment. The study, *Changes in Veterans' Coverage and Access to Care Following the Affordable Care Act*, utilized US Behavioral Risk Factor Surveillance System data to compare measures of veterans' coverage. The study hypothesized that health care access to primary care would improve and correlate with insurance coverage gain, which has been observed in the general population. Primary care is a good indicator of a region's ability to meet UNESCO defined standards, because primary care is an important factor

for improving average levels of public health. For this reason, one goal of the expansionary policies found in the Affordable Care Act was to increase access to this type of health care. Primary care utilization is associated with more access to preventative care, reductions in mortality, less overall spending, and reductions in health disparities across racial and sociodemographic groups. Two main themes in the current trends in primary care are (1) the increasing reliance on care from different types of providers and (2) a trend towards increasing access to primary care for both mental and physical health issues in an equitable manner. Lack of access to primary care is a market failure as access to primary care has positive externalities. The underprovided good here is access to primary care.

Professor Molly Candon of the Wharton School described a market failure as: “when the supply and or demand curves are wrong because some relevant information has not been incorporated into the market price.” Therefore, the equilibrium price and quantity are sub-optimal and the market allocation is not Pareto efficient. If the market is failing, one can use private and public policies to adjust the market to a better, more efficient outcome.

B. Case Study Methodology

The study measured coverage through pre-analysis and post analysis, and then conducted linear probabilities models from difference in differences approach. The rates examined Medicaid expansion and non-expansion states both before and after the ACA was enacted. The study adjusted for age, gender, race, marital status, employment, education and national employment by year. Additionally, the study was run with two separate subgroups. These groups were distinguished based on low socio-economic status and poor health status. The study used the SES definitions for each subgroup, which is defined as no high school diploma and self-reported poor health respectively.

C. Case Study Findings

This study reported that access to primary care for veterans has not improved since the implementation of the Affordable Care Act; however, there have been increases in insurance coverage (9.6% to 5.6% uninsured) among nonelderly veterans after the ACA coverage expansions. It is important to note that this increase in insurance rate did not consistently translate into improved access to primary care. The findings of the study were that there was no significant difference across the two different types of states in terms of “cost-related delays to care.” To summarize, the study found that for low socioeconomic and poor health subgroups of veterans that there was no significant improvement in terms of access to primary care following the enactment of the ACA.

This study found no improvements in access to primary or any other care outside of the VHA in both Medicaid expansion states and non-expansion states. For veterans who do not live near a VHA primary care facility, the problem of lack of access to primary care is still very prevalent. The study discusses the issues of trust in medical providers, social determinants of health, isolation and health literacy to be issues that “disproportionately” affect veteran’s access to care. All of these preferences could diminish the demand by veterans for health and primary care services. A secondary

finding of this study was the prevalence of veterans (compared to the general population) who live in rural areas, which may affect access to primary care.

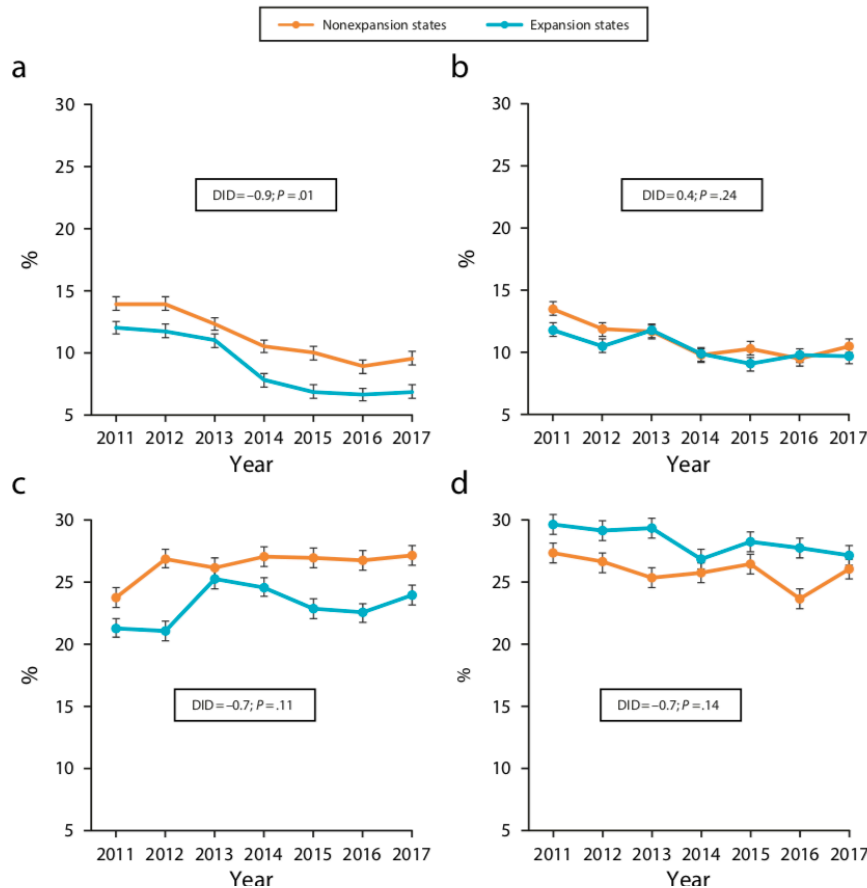


Figure 6: Annual analysis of access to primary care in expansion and non-expansion states. Source: Kaiser Family Foundation 2019

D. Limitations of Case Study for ACA Evaluation

There are several changes to understanding and evaluating the impact of policies like the ACA in real time. This study utilized quantitative data primarily to indicate changes in health.

Qualitative methods are used to understand people's beliefs, experiences, attitudes, behavior, and interactions. It generates non-numerical data. In healthcare related research there are three broad categories of qualitative data. These are: observational studies, textual analysis of written records, and interview studies. Qualitative research can lead to innovative ideas and solutions for health care policy makers.

Quantitative research, involves "explaining phenomena by collected numerical data that are analyzed using mathematically based methods" (Creswell 1994). The main advantages of quantitative research are that it can examine large populations, provide complicated results that can be condensed into numbers. It allows for statistical comparison between various groups. Quantitative data also allows for precise and standardized research that can be used to make predictions. In the past, health

economists have most heavily relied on natural experiments where select people are subject to a treatment that occur outside of a controlled experiment.

Since the benefits of insurance accrue over time, policy makers or health economists will not know the impact of the ACA for decades. It is also important to recognize that without a counterfactual, one can never know what the best policy solution is. One qualitative explanation is that when policies are politicized, (Obamacare vs Affordable Care Act) the policies and who they can help are impacted. The political tendencies of an individuals at any moment in time can affect their use and feelings about a policy. Politicization of the policy can destroy the impacts of public opinions, due to an individual's political views. For real time evaluations, the ACA is in the eye of the beholder at a certain moment when there are other political and economic factors at hand. Some people may not join due to the political implications and connotations of the policy. Differences in enrollment results of ACA is also partially due to ACA marketing depending on the state that an individual lived in. The information involved in the ACA roll out added to the politicization of this policy. In certain states, like Texas, individuals had no information at all regarding changes in Medicaid, because there were very few changes in the program (Kaiser Family Foundation 2015). Both of these factors make real time analysis very challenging.

One quantitative example of challenges to evaluating policies like the ACA in real time is that the benefits and outcomes of the policy take place over a period of time. One outcome that is commonly tracked is mortality, which will take more years and thus is not available in real time. Finding causation is difficult as there are so many other external factors. Quantitatively, policies are hard to evaluate and find correlation as researchers have difficulty in isolating any affect in real time due to external factors. For instance, a researcher has no direct information as to what is happening in hospitals, which makes it impossible to pin down causality or mortality. Further, one cannot observe patient population or understand confounding factors as so much is happening and changing constantly within healthcare. Additionally, with the Affordable Care Act's staggered implementation it is not possible to in real-time see and understand the variations in the long-term effects and outcomes in the insured rates since states implemented gradually over time.

V. The Effects Of Medicaid Expansion Under The ACA: A Systematic Review

A. Choice of Case Study

While the American Health Association study found that the Affordable Care Act did not alone improve access to primary care, it does not indicate that a state that did not expand Medicaid is capable of meeting UNESCO defined standards. While primary care access may not change, other factors that indicate a certain lack of patient well-being or overall population health, which is found in states like Texas, shows concerning factors for further research.

One study accounting for other health factors and changes since the ACA enactment, is *The Effects Of Medicaid Expansion Under The ACA: A Systematic Review*. This was published by the Health Affairs Journal in 2019. This case study was included in this

research paper as it focuses on the qualitative aspects, such as patient's feelings towards quality of care rather than sheer access to care, as the previous study did.

B. Case Study Methodology

This study analyzed seventy-seven published studies that found key improvements for low-income patients made by the ACA in expansionary states. It utilized a systematic review approach of the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines. The studies were peer-reviewed empirical studies, that focused on the association between the ACA-related Medicaid expansion and the major goals of the Affordable Care Act. The goals of the Affordable Care Act are aligned with a region's ability to meet the UNESCO defined standards. The study did not include previous research that pre-dated the ACA, such as the Oregon Health Insurance Experiment. The study also utilized MEDLINE and the Cochrane Central Register of Controlled Trials to find studies that had data collected between January 2014 and September 2017. Finally, after data extraction, the authors utilized frequency analyses, chi-square tests, or both to determine whether key study characteristics were associated with the likelihood of a significant effect from Medicaid expansion.

C. Case Study Findings

The study indicates that the measures outlined in the Medicaid expansion, even just eight years after implementation have had a positive impact on patient-reported psychological distress, a reduction in days with poor mental health, and some evidence of increases in self-reported health status. The study found that in general, the Medicaid expansion was associated with several improvements in people's health. This included reductions in psychological distress and days of poor mental health. The study only found relatively limited evidence of Medicaid expansion systematically changing population health. This is because population health takes several years to study, due to it being a function of social, behavioral, environmental, genetic and medical factors it is too soon to be able to determine if the Medicaid expansion found in the Affordable Care Act will have tangible long-term benefits.

D. Case Study Long-Term Implications

The decision to not expand Medicaid leaves approximately 3.5 million people without any type of health care coverage throughout the United States. In these regions, this will likely create long-term disparities in health outcomes for low-income and disabled individuals depending. These health variations will likely be seen across mental health, physical health, and overall cost of care, as preventative care is typically the most cost-effective form of care.

VI. Comparing Recent Empirical Evidence

The data in the chart below indicates that although the spending in Texas is higher overall on Medicaid, that the percentage of individuals receiving coverage is lower and that the coverage they receive is more restrictive. Another key factor within this table, is the immense number of adults within the Texas coverage gap, who are currently eligible for no covered care.

	Connecticut	Texas
Annual GDP (2019)	\$285,640M	\$1,886,956M
GDP Per Capita (\$)	\$79,952	\$65,743
Unemployment Rate (2019)	10.2%	8.0%
% Risk of Poverty (2018)	10.2%	13.7%
Individuals Receiving Medicaid (2019)	17% of Population	22% of Population
Adults in Coverage Gap:	0	759,000-1.1M

Figure 7: Comparison of key health metrics between Connecticut and Texas.
Source: Kaiser Family Foundation 2019

VII. Conclusion:

The Affordable Care Act attempted to address many issues related to population health. As the goal of any health system should be to improve the long-term health status of the individuals within it, it is clear that at present, the non-expansionary states, like Texas, are not capable of meeting UNESCO health standards. This is because the UNESCO standard is defined as private and public entities meeting “obligations to the maximum of the available resources in order to implement and progressively achieve the full realization.” The lack of access to health insurance, for a large portion of the population does not maximize the health of 3.5 million Americans.

Through case studies, this research paper shows that even though access to primary health care has not changed in all expansionary regions, the states that did not have widespread access before the ACA’s enactment continue to lack access for large portions of the population. In conclusion, until 3.5 million Americans who do not have access to any form of health care, as a result of the decision to not expand Medicaid, begin to receive health care coverage, one cannot say that the non-expansionary states qualify as meeting UNESCO defined socially responsible standards for health.

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