WRITTEN STATEMENT FOR THE RECORD

FOR THE HEARING ENTITLED "STRENGTHENING MEDICAID AND PRIORITIZING THE MOST VULNERABLE"

UNITED STATES HOUSE COMMITTEE ON ENERGY AND COMMERCE

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BY THE

ASIAN & PACIFIC ISLANDER AMERICAN HEALTH FORUM

The Asian & Pacific Islander American Health Forum (APIAHF) submits this written testimony for the record for the February 1, 2017 hearing before the House Committee on Energy and Commerce entitled "Strengthening Medicaid and Prioritizing the Most Vulnerable." APIAHF is a national health justice organization that influences policy, mobilizes communities, and strengthens programs and organizations to improve the health of the over 20 million Asian Americans and nearly 1 million Native Hawaiians and Pacific Islanders (AAs and NHPIs) in the United States. For over 30 years, APIAHF has worked at the federal, state, and local levels to advance sensible policies that reduce health disparities and promote health equity.

Congress is debating the importance of ensuring that Medicaid is available to our most vulnerable. Medicaid represents a vital piece of our country's health care system and is the sole source of health insurance for many AAs and NHPIs. Since 1965, it has served as the safety net for those in need of help, including persons with disabilities, those in poverty and older Americans. The Affordable Care Act (ACA) expanded Medicaid to cover poor, childless adults for the first time. In this testimony, APIAHF describes the importance of Medicaid to AA & NHPI communities, the value of the program and the current access immigrant populations have to Medicaid.

Medicaid Serves Our Most Vulnerable Members of Society

Access to health insurance is a critical part of ensuring a strong public health infrastructure. Medicaid and the Children's Health Insurance Program (CHIP) provide essential health coverage to 78 million people, about half of whom are children.[1] Medicaid also serves as a vital resource to seniors. As our country ages, many families struggle to find care for aging parents. Medicaid is the primary payer for

[1] Centers for Medicare and Medicaid Services (2016). Medicaid & CHIP: August 2016 Monthly Applications, Eligibility Determinations and Enrollment Report. https://www.medicaid.gov/medicaid/program-information/downloads/august-2016-enrollment-report.pdf.

more than half of long-term services and supports.[2] Medicaid is also critically important to providing reproductive and maternal healthcare to women. Together with CHIP, Medicaid covers nearly half of births across the country.[3]

Medicaid represents an important part of our country's ability to minimize harm at times of growing poverty rates and increasing need. Medicaid's recent growth as a share of insurance coverage represents this design. In addition to the eligibility expansion under the ACA, much of that growth is a reflection of greater need, corresponding with higher poverty rates for children, seniors and adults.[4]

Efforts to ensure Medicaid is accessible to the most vulnerable are important, but must be approached carefully. For example, fraud rates in Medicaid are comparable to the broader health care system.[5] Efforts to combat fraud must be focused on the true sources of misallocated funds, namely a small minority of providers, rather than targeting beneficiaries.[6] Providing for effective allocation of Medicaid involves targeted efforts that address the causes of fraud and must be carefully approached. Otherwise, eligible beneficiaries could face burdensome barriers to care.

Medicaid Plays an Important Role for AAs and NHPIs

AAs and NHPIs are among the fastest growing racial groups in the United States. Between 2014 and 2015, the AA population grew by 3.4 percent, more than any other group, while NHPIs grew 2.4 percent, following only mixed race individuals.[7] Planning for a successful Medicaid population in the future must take the needs of AA & NHPI communities into account. Like many Americans, health care ranks as one of the top issues of importance to AA families. This is reflected in polling showing that among AAs, healthcare was mentioned as the second most important issue affecting voters personally. In addition, 60 percent of AAs voters have said they support the Affordable Care Act.[8]

Medicaid provides coverage to racial and ethnic minorities, including AAs and NHPIs, who would otherwise have to go without essential health care and therefore plays a pivotal role in addressing health disparities.

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[2] ca L. Reaves & MaryBeth Musumeci (2015). Medicaid and Long-Term Services and Supports: A Primer. Kaiser Family Foundation. http://kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/.

[3] Markus, A., Andres, E., West, K., Garro, N., & Pellegrini, C. (2013). Medicaid covered births, 2008 through 2010, in the context of the implementation of health reform. Women's Health Issues, *23*(5), e273-e280

[4] Bradley et al (2017). Strengthening Medicaid as a Critical Lever in Building a Culture of Health. National Academy of Social Insurance. https://www.nasi.org/sites/default/files/research/Strengthening_Medicaid_as_a_Critical_Lever_Low_Res.pdf

[5] Berwick, Donald and Andrew Hackbarth. (2012). Eliminating Waste in US Health Care. Journal of the American Medical Association. www.oregon.gov/oha/analytics/MetricsDocs/Eliminating_Waste_in_US_Health_Care.pdf

[6] The Challenge of Health Care Fraud. National health Care Anti-Fraud Association. https://www.nhcaa.org/resources/health-care-anti-fraud-resources/the-challenge-of-health-care-fraud.aspx

[7] Lam. Charles. (2016). Asians Remain Fastest-Growing US Group as Pacific Islanders, Mixed-Race Numbers Grow: Census. NBC News. http://www.nbcnews.com/news/asian-america/asians-remain-fastest-growing-us-group-pacific-islanders-mixed-race-n597711

The importance of Medicaid to AA & NHPI communities is emphasized by the 17 percent of AAs and 34 percent of NHPIs who are enrolled in its coverage.[9] NHPIs match American Indians as the racial community with the highest percent of its population on Medicaid. Twelve percent of AAs live in poverty, as do 17.3 percent of NHPIs.[10]

Through Medicaid, AA & NHPI populations can access treatment for conditions that disproportionately impact these communities, such as liver and stomach cancers, hepatitis and diabetes.[11] AAs and NHPIs have a higher likelihood of suffering from a number of chronic conditions requiring routine access to care and underscoring the importance of early prevention. AAs are 25 percent more likely to be diagnosed with diabetes than Whites, while NHPIs are 3 times more likely.[12] AAs and NHPIs are the only racial group for whom cancer is the leading cause of death.[13] Certain AA and NHPI subpopulations suffer from even greater health disparities. Fourteen percent of Indian Americans have diabetes, a rate higher than that of nearly all other racial groups.[14] Vietnamese women have cervical cancer rates five times higher than White women.[15]

Medicaid Expansion Covers the Vulnerable

Under the ACA, states were required to expand Medicaid to all individuals making under 138% of poverty. While the Supreme Court made that expansion optional in *NFIB v. Sebelius*, 32 states including Washington, DC, have chosen to make Medicaid available for that population, many for the first time and many on a bipartisan basis. Before the ACA, a childless adult could be penniless, yet not be eligible for subsidized health insurance and often struggled to stay healthy, even while working. The expansion of Medicaid has served as a critical part of the ACA's coverage expansion.

Many of those who are fortunate enough to live in states that expanded Medicaid gained health insurance for the first time, along with the ability to manage chronic diseases and access preventive services. Medicaid expansion has already been associated with reductions in preventable deaths and delayed care due to cost, as well as an increase in self-reported good health statuses.[16] For example, in

[9] National Health Interview Survey. (2015). United States Centers for Disease Control. ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/NHIS/SHS/2015_SHS_Table_P-11.pdf
[10] 2015 American Community Survey One Year Estimates. Table S0201.
[11] Asian American & Pacific Islander Health Disparities Compared to Non-Hispanic Whites. (2014). Families USA. http://familiesusa.org/product/asian-american-pacific-islander-health-disparities-compared-non-hispanic-whites
[12] Asian and Pacific Islander American Health Forum. (2010). Native Hawaiian and Pacific Islander Health Disparities. www.apiahf.org/sites/default/files/NHPI_Report08a_2010.pdf
[13] Heron, Melonie. (2016). Deaths: Leading Causes for 2014. National Vital Statistics Reports Volume 65, Number 5. United States Centers for Disease Control.
[14] Spanakis, Elias and Sherita Hill Golden. (2013). Race/Ethnic Difference in Diabetes and Diabetic Complications. Curr Diab Rep. 13(6) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3830901/
[15] Miller BA et al. (1996). Racial/Ethnic Patterns of Cancer in the United States, 1988-1992. https://seer.cancer.gov/archive/publications/ethnicity/
[16] Benjamin D. Sommers, Katherine Baicker, & Arnold M. Epstein (2012). Mortality and Access to Care among Adults after State Medicaid Expansions. New England Journal of Medicine, 367, 1025-1034. http://www.nejm.org/doi/pdf/10.1056/NEJMsa1202099.

expansion states, more people were able to access a diabetes diagnosis, a critical first step towards controlling the chronic condition often underdiagnosed in AA and NHPI communities.[17]

The Medicaid expansion filled a gap for low income workers whose employers did not offer health insurance. Of adults who would have become eligible in states that did not expand Medicaid in 2015, more than half were working.[18] Many of these workers are in industries that offer little to no paid sick leave, making health insurance an important part of promoting public health and safety.

Medicaid expansion has furthered state's roles as policy laboratories. Medicaid's structure as a joint federal-state partnership includes flexibility that allows states to tailor their expansions to best suit the needs of their residents, while ensuring coverage and quality are maintained under existing law and guidance. Medicaid expansion states are using the flexibility that exists within the program to experiment in how to deliver better care, such as linking payment to performance for federally qualified health centers.[19]

Prior to the ACA, AAs and NHPIs faced major disparities in access to health care, in part because many lacked health insurance.[20] These communities, particularly certain subpopulations, faced higher uninsured rates in addition to cultural and language barriers. While the ACA has not eliminated health disparities, Medicaid expansion has played an important role in helping to reduce the number of AAs & NHPIs without insurance. States that expanded Medicaid had nearly twice as big a drop in uninsured than states that did not.[21] Since 2010, the uninsured rate for AAs has dropped from 15.1 to 7.5 percent. The percentage of NHPIs without insurance fell from 14.5 to 7.8 percent. These are among the biggest gains in health coverage among all racial and ethnic groups.[22]

If all states had expanded Medicaid, nearly 800,000 AAs and NHPIs would have become newly eligible for the program.[23] Currently, people in the coverage gap, those who make too little to qualify for ACA subsidies but are not in an expansion state, are disproportionately from communities of color.[24] In states

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[17] Kaufman, Chen, Fonseca, and McPhaul. (2015). Surge in Newly Identified Diabetes Among Medicaid Patients in 2014 Within Medicaid Expansion States Under the Affordable Care Act. Diabetes Care 38, no. 5: 833.
[18] Mahan, Dee. (2015). Medicaid Expansion Helps Low-Wage Workers: Non-Expansion States. Families USA. http://familiesusa.org/product/medicaid-expansion-helps-low-wage-workers
[19] Peter Shin, Jessica Sharac, Zoe Barber, & Sara Rosenbaum (2016). Community Health Centers and Medicaid Payment Reform: Emerging Lessons from Medicaid Expansion States. Geiger Gibson RCHN Community Health Foundation, Issue Brief #45. https://publichealth.gwu.edu/sites/default/files/downloads/GGRCHN/Community-Health-Centers-and-Medicaid-Payment-Reform-45.pdf
[20] Kim W, Keefe RH. (2010) Barriers to healthcare among Asian Americans. Soc Work Public Health. 25:286–95.
[21] Greater Drop in Uninsured Rate Among Adults in Medicaid Expansion States. (2016). Center on Budget and Policy Priorities. http://www.cbpp.org/greater-drop-in-uninsured-rate-among-adults-in-medicaid-expansion-states
[22] American Community Survey Table S2701. (2015 and 2010). United States Census.
[23] Wendt et al. (2014). Office of The Assistant Secretary for Planning and Evaluation. Eligible Uninsured Asian Americans, Native Hawaiians, And Pacific Islanders: 8 In 10 Could Receive Health Insurance Marketplace Tax Credits, Medicaid Or CHIP. https://aspe.hhs.gov/sites/default/files/pdf/180311/rb_UninsuredAANHPI.pdf
[24] Rachel Garfield & Anthony Damico (2016). The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid – An Update. The Kaiser Commission on Medicaid and the Uninsured; The Henry J. Kaiser Family Foundation, Issue Brief.

that expanded Medicaid, the gap between uninsured whites and people of color narrowed, while it expanded in non-expansion states.[25]

Medicaid is Good Care

Medicaid plays an important role in our healthcare system, promoting public health and ensuring vulnerable populations can access health care. Medicaid's entitlement nature and ability to cover all who are eligible is at the center of that role. Uninsured adults are more likely than those with insurance, including Medicaid, to die from a heart attack, be diagnosed with advanced cancer, have uncontrolled hypertension and have higher hospital mortality rates.[26] Medicaid beneficiaries access and use of care is comparable to people with employer sponsored insurance. If they lost access to Medicaid, beneficiaries would be more than four times as likely to have unmet needs for medical care.[27]

A study of the 2008 Oregon Medicaid lottery found that Medicaid beneficiaries were 25 percent more likely than the uninsured to report having good, very good or excellent health and 10 percent less likely to have depression. They had better access to preventive healthcare services and saw increased utilization of mammograms (60 percent), cholesterol tests (20 percent) and blood sugar or diabetes tests (15 percent).[28]

Medicaid provides the necessary federal support to allow states to respond to new and deepening health crises. For example, in response to the Flint water catastrophe, Michigan Governor Rick Snyder used a Medicaid waiver to ensure the city's population had access to care.[29] Because Medicaid is available to any eligible individual, if a city or state experiences a similar disaster, its residents can be assured access to care.

Over 43 million Americans face some kind of mental health challenge, including 13 percent of AAs and 22 percent of NHPIs.[30] Over a quarter of mental health dollars come through Medicaid, a number that is expected to grow over time. Before the federal government took greater responsibility for improving mental health in recent decades, this burden fell on state and local governments (whose share of

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[25] Courtemanche, Marton, Ukert, Yelowitz, and Zapata. (2016). Impacts of the Affordable Care Act on Health Insurance Coverage in Medicaid Expansion and Non-Expansion States. he National Bureau of Economic Research. Working Paper No. 22182.

[26] America's Uninsured Crisis. (2009). Institute of Medicine of the National Academies. http://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2009/Americas-Uninsured-Crisis-Consequences-for-Health-and-Health-Care/Americas%20Uninsured%20Crisis%202009%20Report%20Brief.pdf

[27] Teresa A. Coughlin, Sharon K. Long, Lisa Clemans-Cope, & Dean Resnick (2013). What Difference Does Medicaid Make? Assessing Cost Effectiveness, Access, and Financial Protection under Medicaid for Low-Income Adults. The Kaiser Commission on Medicaid and the Uninsured; The Henry J. Kaiser Family Foundation. https://kaiserfamilyfoundation.files.wordpress.com/2013/05/8440-what-difference-does-medicaid-make2.pdf.

[28] What is the link between having health insurance and enjoying better health and finance? (2012) Robert Wood Johnson Foundation. http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf72145.

[29] Sara Rosenbaum (2016). Caring for Flint: Medicaid's Enduring Role in Public Health Crises. The Commonwealth Fund. http://www.commonwealthfund.org/publications/blog/2016/feb/caring-for-flint

[30] Any Mental Illness (AMI) Among U.S. Adults. (2014). National Institute of Mental Health. https://www.nimh.nih.gov/health/statistics/prevalence/any-mental-illness-ami-among-us-adults.shtml

spending on mental health has dropped 10 percentage points in the last 30 years). These states and local governments, with strapped budgets, would be unlikely make up the difference now.[31]

Federal Law Already Restricts Access to Medicaid for Immigrant Populations and Creates Burdens to Accessing Care

Since the passage of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, legal permanent residents are subject to a five-year bar for means-tested public benefit programs. Undocumented immigrants are barred from Medicaid, regardless of their tenure in the country. Some states, such as New York and California, have chosen to recognize the public health benefits of providing healthcare to immigrants and do so using state dollars. Thirty-two states have chosen a state option to waive the five-year bar for immigrant children and/or pregnant women, exercising the inherent flexibility in the program to tailor coverage to best meet the needs of state residents.

Many immigrants go without care because of existing restrictions on Medicaid eligibility, despite working hard, paying taxes and contributing financially to the same program. Restricting access to care limits the ability of immigrants to access routine care, including preventive services that can identify serious chronic conditions before they worsen. Given the existing barriers that immigrants, including those with lawful status, face in accessing care, additional restrictions targeting immigrant communities would move Medicaid in the wrong direction. The program's ability to help the most vulnerable, which includes many immigrants, would not be furthered by such proposals.

Notably, immigrants do not use a significant amount of public healthcare resources. The libertarian CATO institute found that immigrants use public benefit programs, including Medicaid, less than their native-born counterparts. Subsequently, according to the report, "the cost of public benefits to non-citizens is substantially less than the cost of equivalent benefits to the native-born."[32] Immigrants constitute 5% of the United States' population, but only constitute 1% of healthcare spending, as they tend to be younger and healthier than native born people.[33]

Medicaid Must Continue to Serve All Vulnerable Persons

APIAHF is committed to working to ensure Medicaid continues in its role as a source of health insurance for the most vulnerable Americans. As Congress debates the future of Medicaid and the health care system, we urge policy makers to take into consideration the needs of AA and NHPI communities, many of whom would have to forgo healthcare if Medicaid was cut or eligibility was further restricted.

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[31] Substance Abuse and Mental Health Services Administration (2014). Projections of National Expenditures for Treatment of Mental and Substance Use Disorders: 2010-2020. http://store.samhsa.gov/shin/content/SMA14-4883/SMA14-4883.pdf.

[32] Ku, Leighton and Brian Bruen. (2013). Poor Immigrants Use Public Benefits at a Lower Rate Than Poor Native-Born Citizens. Cato Institute.http://www.cato.org/publications/economic-development-bulletin/poor-immigrants-use-public-benefits-lower-rate-poor.

[33] Ku, Leighton. (2009). Health Insurance Coverage and Medical Expenditures of Immigrants and Native-Born Citizens in the United States," American Journal of Public Health, 99(7):1322-1328. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2696660/.