



The State of Urban Health

Eliminating Health Disparities to Save Lives and Cut Costs

Key Findings

In 2009, health disparities cost the U.S. economy \$82.2 billion. We estimated the economic burden of health disparities in the United States using two measures: (1) direct medical costs of health disparities, and (2) indirect costs of health disparities due to lower labor market productivity. Our analysis found:

- Health disparities increased health spending by \$59.9 billion.
- African Americans bore the most of the increased health care costs (\$45.3 billion), with those living in urban areas in the South and Midwest bearing most of these costs.
- For Hispanics, the costs of health disparities were largest in the West (\$5.3 billion) and Northeast (\$4.3 billion).
- The costs of health disparities for Asians were largest in the West (\$2 billion).
- African Americans in Midwestern urban areas bear a disproportionate share of health care spending – they are 6.5 percent of minority adults, but bear 15.5 percent of health care spending costs.
- For Hispanics, those living in the Northeast bear a disproportionate share of health care costs with 14.1 percent of the Hispanic population but 35 percent of the costs.
- Similarly, Asians in the West are 44.6 percent of the Asian population but bear 80 percent of the health care spending due to disparities.
- Private insurance plans paid 38.4 percent of the healthcare costs of health disparities. Individual and families through out-of-pocket payments paid 27.7 percent -- more than Medicare and Medicaid programs combined.
- Health disparities reduced labor market productivity by \$22.3 billion.
- Hispanics bore the highest costs due to lower productivity (\$9.8 billion) followed by African Americans (\$9.6 billion).
- The costs of lower productivity were highest in the South (\$8.8 billion) and West (\$6.8 billion).
- African Americans in all regions of the country and Hispanics in the Northeast and West bear a disproportionate share of the productivity loss.
- Education, Health and Social Services Industries (22.7%) followed by Leisure, Hospitality, and Other Services Industries (15.8%) had the highest shares of potential cost savings.

Policy Recommendations

The National Urban League believes that in addition to local and community strategies and partnerships, there are several federal policy levers that will help to eliminate disparities and help to realize the promise of the Affordable Care Act.

Medicare

1. ***Protect Medicare in the Budget.*** As the ACA is implemented and Congress seeks to address budget shortfalls, it is important to ensure that any proposed changes to Medicare will not impose burdensome costs on seniors with limited resources or weaken Medicare's ability to effectively negotiate prices and control costs.
2. ***Cost Controls Must Protect Dual Eligible Patients.*** Given the cost of caring for those low-income patients that are covered by both Medicare and Medicaid, policy makers are interested in approaches that will improve the quality and coordination of care. Currently, nine million low-income and elderly Americans are classified as "dual eligible", receiving their care from both Medicare and Medicaid and the cost for their care is about 1.8 times higher than for others on Medicare. As the Centers for Medicaid and Medicare Services (CMS) and federal policymakers continue to explore demonstration projects and approaches to coordinating the care for "dual eligibles", these approaches, innovations and attempts at deficit reduction must be balanced and avoid harming vulnerable low-income seniors and people with disabilities.

Medicaid

3. ***Incentivize Medicaid Expansion for All States.*** Medicaid is a major source of health care for African Americans. It is estimated that the 3.8 million African Americans who would otherwise be uninsured will gain coverage by 2016 through the expansion of Medicaid eligibility and the creation of Affordable Insurance Exchanges under the Affordable Care Act. As states seek to implement the expansion of Medicaid and other states resist expanding the program to 133% of the federal poverty level, it is important for the federal government to create incentives for expansion, guarantee the federal match or FMAP and continue to provide confidence to states about the Medicaid provider reimbursement rate as set out in the law. In turn for this confidence from the federal government, the states must guarantee that the expansion will cover single, childless adults, which is particularly important considering the high rates of unemployed African American males (17.8% for 2011).

Health Insurance Exchanges

4. ***Clear and Accessible Enrollment.*** Ensure implementation of strong health insurance exchanges, both in the states and federally. The HHS Center for Consumer Information and Insurance Oversight (CCIO) should issue guidance to facilitate successful adoption among underserved and vulnerable populations, such as meaningful access and plain language standards, processes for eligibility determination appeals, and navigator and other consumer assistance training standards.
5. ***Enrollment Campaigns Targeting Minorities.*** States seeking to develop enrollment plans or those states that have applied and receive funding from the HHS Exchange Establishment Grants to do enrollment work must develop strong outreach campaigns that include community-based organizations with credibility among targeted and vulnerable populations that are less likely to enroll. States must pursue meaningful engagement and community representation by stakeholder organizations that serve & represent low-income and minority populations in the development of state-based health exchanges and accountable care organizations.



6. ***Integration and Automatic Enrollment.*** States must ensure that new enrollment systems for state-based exchanges are comprehensive, culturally and linguistically appropriate and easily accessible. This includes exploring options for automatic enrollment when people apply for other social services and training social services staff or community health workers (CHWs) to aid individuals in using online exchanges (especially when no other viable enrollment options exist).

Engaging Community-Based Organizations

7. ***CBOs as Patient Navigators.*** Community based organizations, such as National Urban League and its affiliate community health worker programs, will benefit from the full funding of the ACA Patient Navigator provision - Section 3510 which reauthorizes Section 340a of the PHSA, the Patient Navigator and Chronic Disease Prevention grants, reauthorized through 2015.
8. ***Priority for CTG Grants with Racial and Ethnic Interventions.*** ACA Community Transformation Grants (Section 4201) supports evidence-based community-based activities to promote health and prevent chronic diseases. This discretionary program has received funding through the Prevention and Public Health Fund, appropriated at \$145 million in FY2011. NUL recommends clarifying guidance for the program's eligibility requirements that establishes a rating system that provides for balanced and equitable criteria for evaluating applications for CTG funding and that provides for racial and ethnic specific interventions at the community level.
9. ***Reducing Costs Through Integration of Services.*** Strategically integrate health care interventions with existing community-based interventions provided by local CBOs that connect local residents to services such as TANF, SNAP, job training and other programs.

Healthcare Workforce

10. ***Increasing Minority Health Professionals.*** An important component of addressing health disparities is to also ensure quality care provided by a diverse healthcare workforce. The National Urban League recommends strengthening and expanding critical health workforce programs aimed at increasing the pipeline of underserved and diverse populations in the health professions -- including the Health Careers Opportunities Program (HCOP), Area Health Education Centers (AHEC) and other Title VII and Title VIII Workforce programs.
11. ***Fully Fund Community Health Worker Programs.*** ACA Community Health Worker – Section 5313, 10501(c) authorizes a new grant program to award funding to states, health departments, health clinics, hospitals or community health centers that promote healthy behaviors in underserved communities through the use of community health workers. Such sums as necessary were authorized FY2010 – FY2014, however no funds have been appropriated to date. NUL recommends fully funding this program and encouraging funded entities to partner with existing community-based CHW programs.
12. ***Job Training Programs for Health Professions.*** Use unobligated Healthcare IT funds and realized Medicare savings resulting from ACA implementation to expand efforts to recruit, train and hire urban residents for good-paying health sector occupations, such as nurses and physician assistants. Develop a program similar to the Civilian Conservation Corps aimed at retraining qualified workers while addressing a critical national need in the shortage of trained medical personnel.

ⁱ "Medicare's Role for Dual Eligible" policy brief by the Kaiser Family Foundation, April 2012 publication #8138-02)

ⁱⁱ <http://aspe.hhs.gov/health/reports/2012/ACA&African-Americans/rb.shtml>