Preserving Medicaid & the Affordable Care Act for Adults with Disabilities

H. Stephen Kaye, PhD
Professor Emeritus

Disability Rights Education & Defense Fund DREDF

February 7, 2025

Statistics presented in this document are based on analyses I conducted of public use, person-level data from 3 nationally representative Federal surveys:

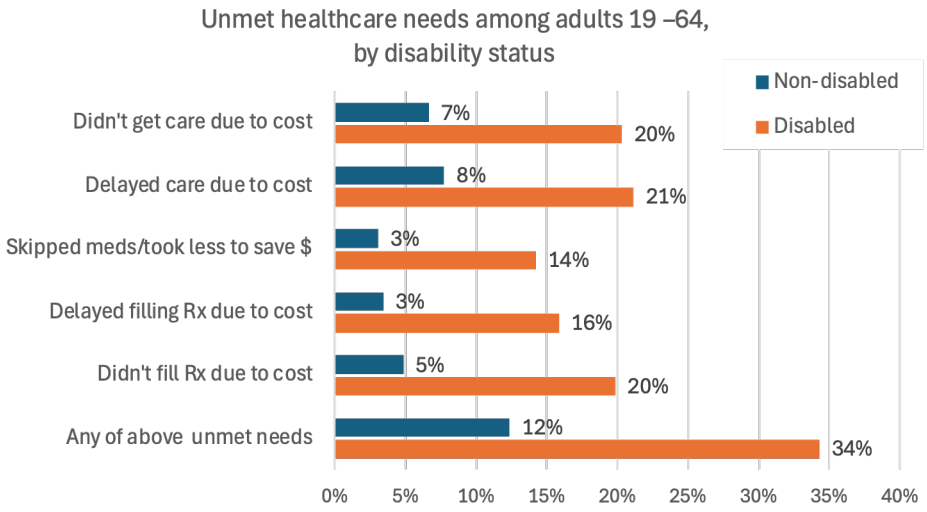
- The American Community Survey (ACS), 2010–2023
- The National Health Interview Survey (NHIS), 2010–2017 and 2019–2023
- The Medical Expenditure Panel Survey (MEPS), 2019–2022

I omitted 2020 data from all analyses due to the disruption caused by the COVID-19 pandemic. ACS is representative of the entire U.S. population. NHIS & MEPS are representative of the civilian, household-resident population. ACS & NHIS are conducted by the Census Bureau, the latter on behalf of the National Center for Health Statistics (NCHS). MEPS is conducted by Westat on behalf of the Agency for Healthcare Research and Quality (AHRQ) and NCHS.

The ACS, MEPS, and this analysis of years 2010–2017 of the NHIS use a standard 6-question definition of disability. Questions ask about "serious difficulty" hearing; seeing; concentrating, remembering, or making decisions; and walking or climbing steps; as well as difficulty dressing or bathing and doing errands alone outside the home. Respondents endorsing one or more of these questions were classified as having disabilities.

This analysis of years 2019–2023 of the NHIS uses an alternative disability measure, the Washington Group Short Set on Functioning – Enhanced (WG-SS Enhanced). The WG-SS (unenhanced version) asks about difficulty hearing, seeing, communicating, remembering or concentrating, walking or climbing steps, and washing or dressing. The Enhanced version fills in some of the gaps of the Short Set by including additional questions on upper body mobility, anxiety, and depression.

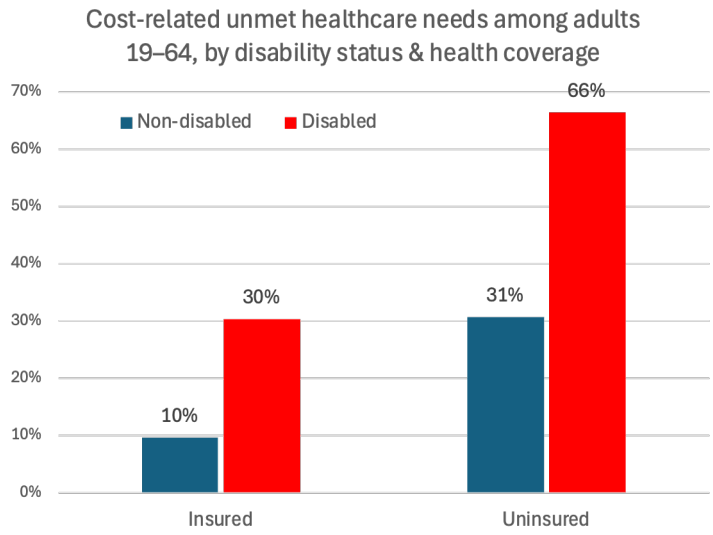
US healthcare system fails many disabled adults



Disabled working-age adults (shown in orange) are far more likely than their non-disabled counterparts to experience cost-related unmet needs for healthcare and prescription medications. One-third of disabled working-age adults experience such unmet needs (bar at bottom), compared to 12% of non-disabled working-age adults.

Source: DREDF analysis of data from the National Health Interview Survey, 2019–2023.

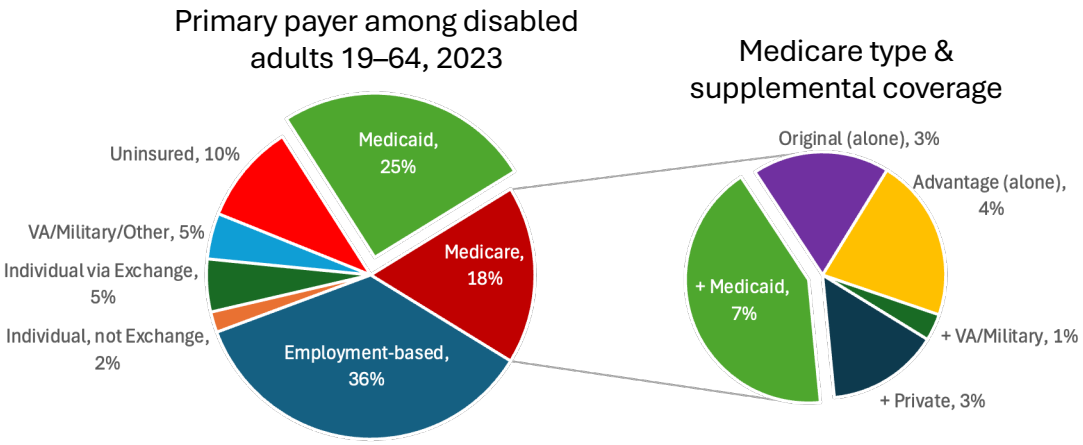
Health coverage is essential



About 2/3 of uninsured, disabled, working-age adults experience one or more unmet healthcare needs. In contrast, 90% of insured, non-disabled working-age adults have their healthcare needs met (only 10% have unmet needs). Note that the measures only address cost-related unmet needs, not unmet needs caused, for example, by inability to get to the provider's office, difficulty getting a referral, or providers who are not knowledgeable about the persons health condition or disability. Therefore, the true level of unmet need for healthcare is likely much larger than the statistics shown in the chart.

Source: DREDF analysis of data from the National Health Interview Survey, 2019–2023.

Medicaid covers 1/3 of working-age disabled adults



The pie on the left shows the primary healthcare payer (source of coverage that generally pays first) for disabled working-age adults.

- Private, employment-based group insurance, obtained from a current or former employer or union, is the most common, with more than 1/3 having such coverage.
- Next is Medicaid (light green), which provides coverage for 1/4 of disabled working-age adults.
- 17% have Medicare coverage.
- Individual, private insurance policies cover only 7% (5% purchased via Exchanges plus 2% obtained directly from insurer).
- Only 1/10 of disabled working-age adults are uninsured, down from about 1/5 before the Affordable Care Act took effect.

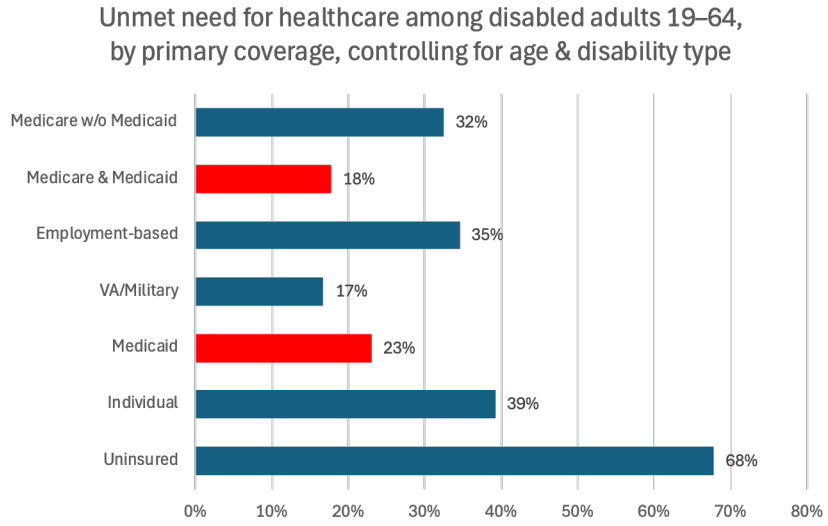
Details of Medicare coverage are shown in the pie on the right.

- 7% of disabled working-age adults are on Medicare without any supplemental coverage: 4% on Medicare Advantage and 3% traditional Medicare.
- The rest have additional coverage, generally paying for the 20% of costs that Medicare typically doesn't pay: 7% of disabled working-age adults are duals, covered by both Medicaid and Medicare, and 3% have private coverage, mostly Medigap plans.

An additional 1.4% have Medicaid coverage neither as primary nor as supplementary to Medicare (not shown on chart), for a total of 34.1% of disabled working-age adults on Medicaid.

Source: DREDF analysis of data from the National Health Interview Survey, 2021–2023.

Medicaid meets disabled people's needs better!

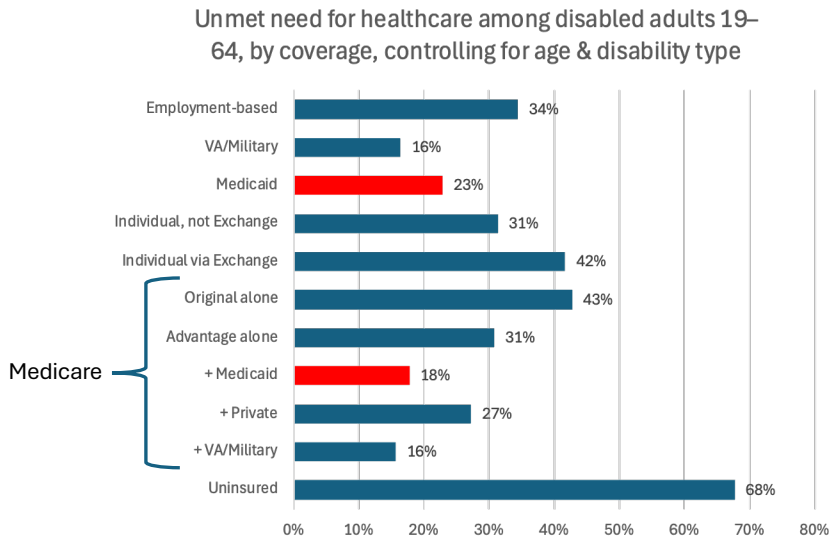


Dual Medicare-Medicaid beneficiaries (18%) and people on Medicaid alone (23%) are substantially less likely than those in the other coverage categories to have unmet healthcare needs: 32% among those on Medicare without Medicaid, 35% for those with employment-based coverage, and 39% for people with individual private coverage. Coverage from the VA or the military is about equivalent to dual coverage.

To make the comparisons across coverage categories more fair, I have controlled for differences in age and disability type and severity.

Source: DREDF analysis of data from the National Health Interview Survey, 2019–2023.

Medicaid meets disabled people's needs better!

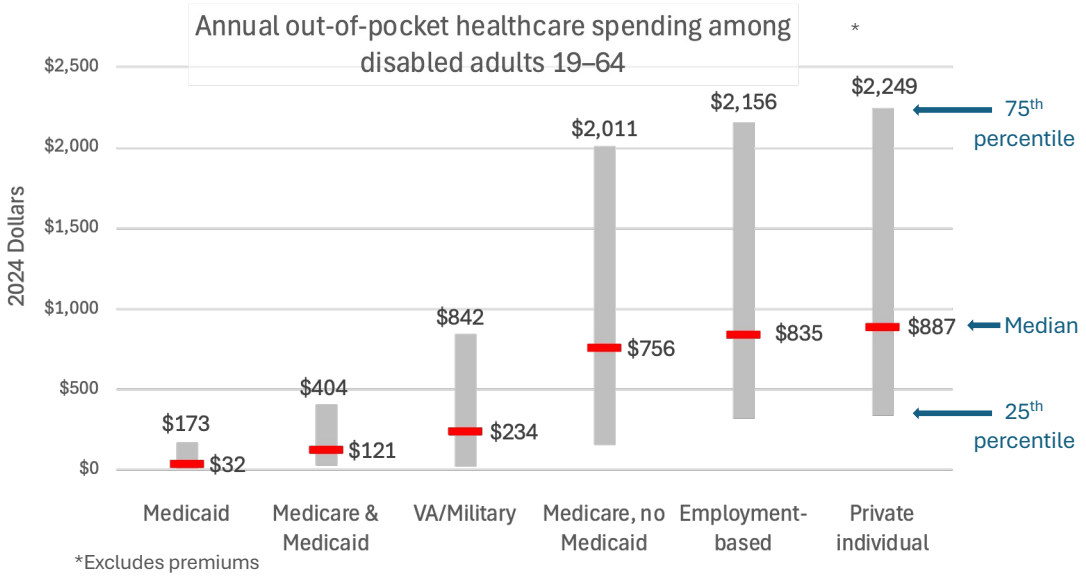


This chart is a more detailed comparison of the impact of different types of health coverage on unmet need for healthcare among disabled working-age adults. Again, people on Medicaid, whether alone or along with Medicare, do well compared to most of the other types of coverage, with the exception of VA & military coverage. People who have either employment-based coverage or individual coverage not obtained through Exchanges are more likely to have unmet needs, and people who have private coverage obtained through Exchanges are still worse off. As for people covered by Medicare, private coverage such as Medigap policies appear to reduce unmet need compared to Medicare alone. Disabled working-age adults with Medicare Advantage plans fare better than those on traditional Medicare, which generally requires the beneficiary to pay 20% of the cost. All types of coverage reduce unmet need substantially compared to no coverage.

To make the comparisons across coverage categories more fair, I have controlled for differences in age and disability type and severity.

Source: DREDF analysis of data from the National Health Interview Survey, 2019–2023.

Medicaid makes healthcare affordable



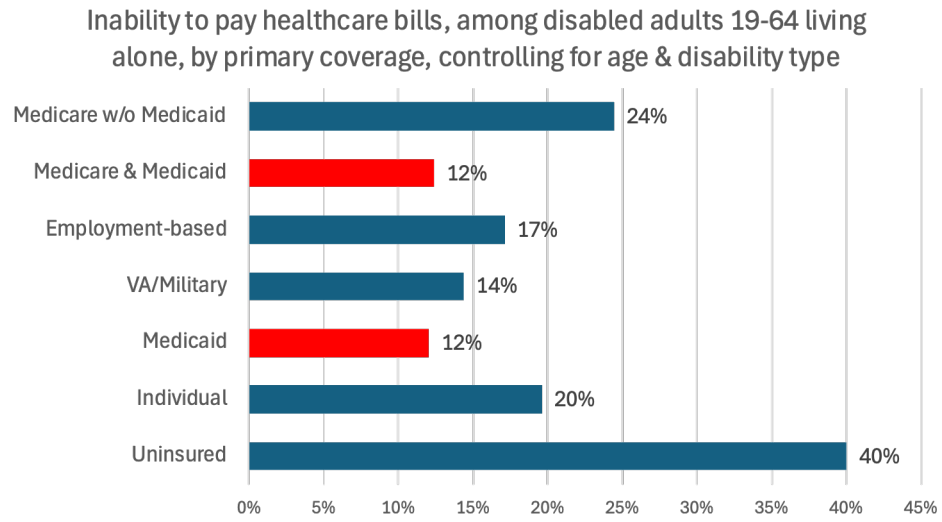
This chart illustrates the typical costs paid out-of-pocket by disabled working-age adults across primary coverage categories. The red lines indicate the median out-of-pocket spending for each coverage type; in other words, half of people in that group spend less than the median amount and half spend more. The grey bars indicate a typical range of out-of-pocket payment amounts: The top end of each bar represents the 75th percentile of out-of-pocket costs, meaning that 3/4 of people spend less than the amount and 1/4 spend more. The bottom of the gray bars represents the 25th percentile; 1/4 of people in that coverage category pay less and 3/4 pay more.

Among disabled working-age adults on Medicaid, median out-of-pocket costs are only $32 per year for people not covered by Medicare and $121 for duals. People with VA or military coverage pay a median amount of $234. All other categories are substantially higher: $756 for Medicare without Medicaid, $835 for employment-based coverage, and $887 for individual private coverage. The 75th percentile out-of-pocket amounts for Medicaid beneficiaries in either category are also fairly low, but the the amounts for Medicare without Medicaid and both types of private insurance are above $2,000. Again, this means that at least 1/4 of disabled working-age adults with those types of coverage must pay more than $2,000 in out-of-pocket costs per year.

Insurance premiums are not included in out-of-pocket costs. Dollar amounts were adjusted to 2024 dollars using the Consumer Price Index for Medical Care.

Source: DREDF analysis of data from the Medical Expenditures Panel Survey, 2019–2022.

Medicaid makes healthcare affordable

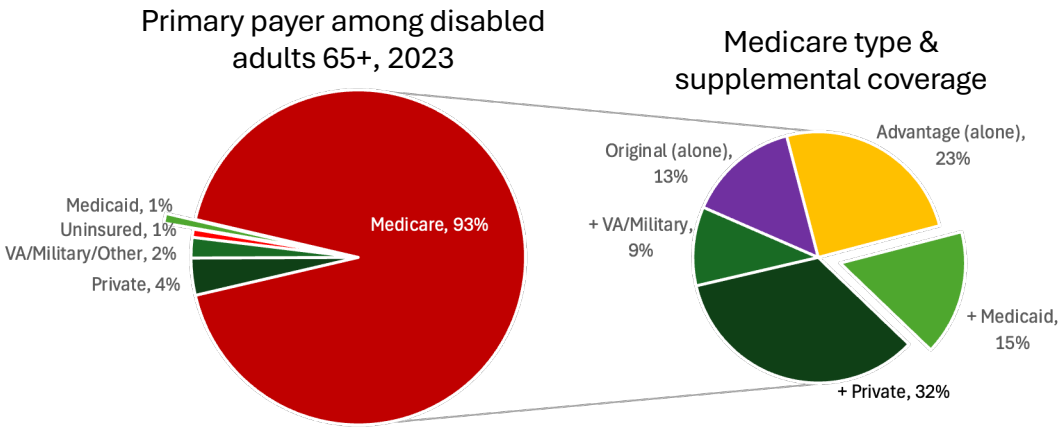


Another take on affordability is to ask people whether they can afford to pay their family's healthcare bills. Analyzing responses to such a measure, I've limited the sample to people living alone, so that their response is not complicated by the bills and health coverage of other household members.

Among such disabled working-age adults, 40% of those who are uninsured report inability to pay healthcare bills. At the opposite extreme are those on Medicaid, with or without Medicare, only 12% of whom say that they can't pay their healthcare bills. Other coverage types are in between: Medicare without Medicaid at 24%, individual private coverage at 20%, and employment-based coverage at 17%.

Source: DREDF analysis of data from the National Health Interview Survey, 2019–2023.

Medicaid covers 16% of older adults, mostly duals

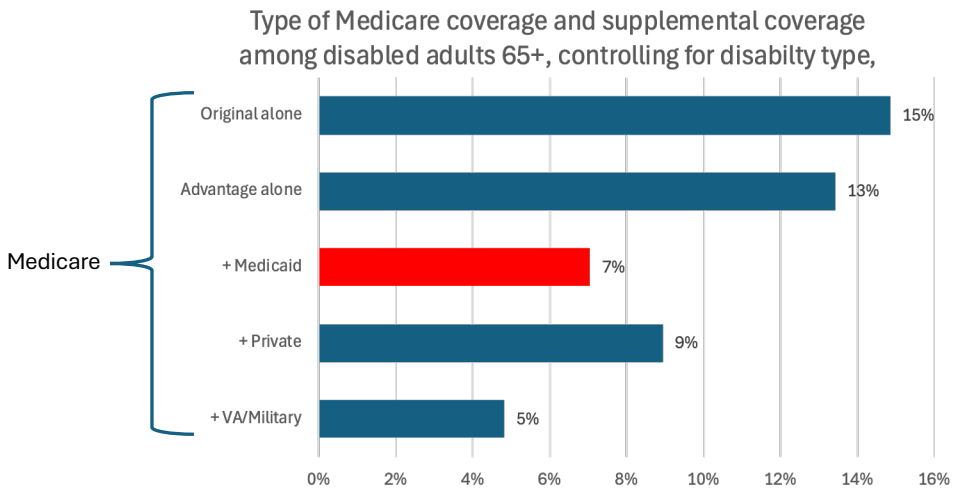


This pair of pie charts shows coverage for disabled older adults at least 65 years of age. Primary coverage, shown on the left, is mostly Medicare, at 93%. Of the remaining 7%, most have private coverage or get healthcare from the VA, military, or some other government program. Only 1% rely on Medicaid as their primary coverage, and 1% are uninsured.

On the right are the details of Medicare coverage. Of all disabled older adults, the largest group is people with Medicare plus private coverage, at 32%. This is mostly Medigap policies. Medicare Advantage plans, without supplementation, are next, at 23%; then dual Medicare plus Medicaid coverage, at 15%; original Medicare (13%); and finally Medicare plus the VA and/or military coverage (9%).

Source: DREDF analysis of data from the National Health Interview Survey, 2021–2023.

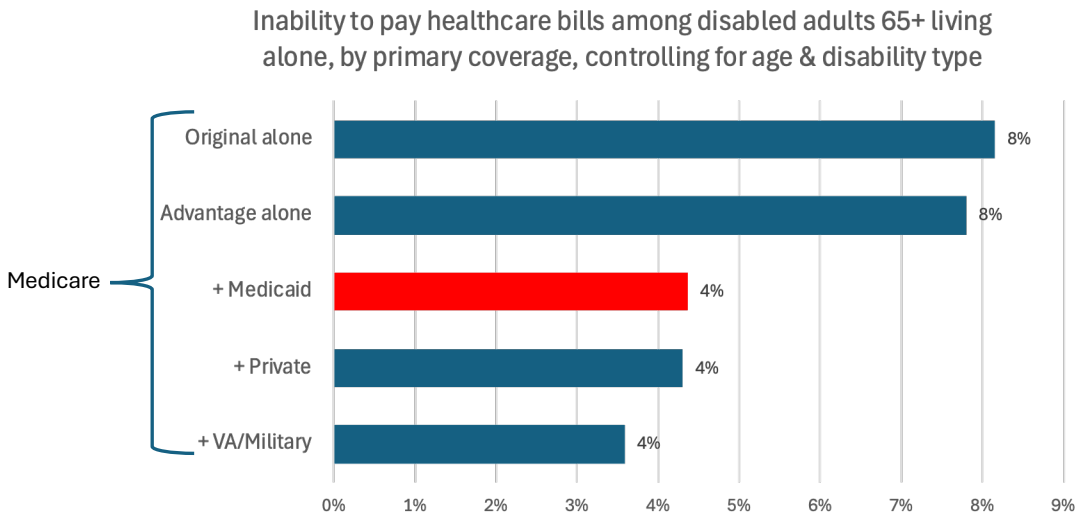
Duals more likely to have needs met



Unmet healthcare needs (any of the unmet needs for care or prescription medications) are less prevalent among disabled older adults (age 65+) than among their working-age counterparts. Among disabled older adults on Medicare alone, 13–15% have unmet needs. Supplemental coverage decreases that percentage. For dual Medicare-Medicaid beneficiaries, 7% have unmet need.

Source: DREDF analysis of data from the National Health Interview Survey, 2019–2023.

Medicaid makes healthcare affordable

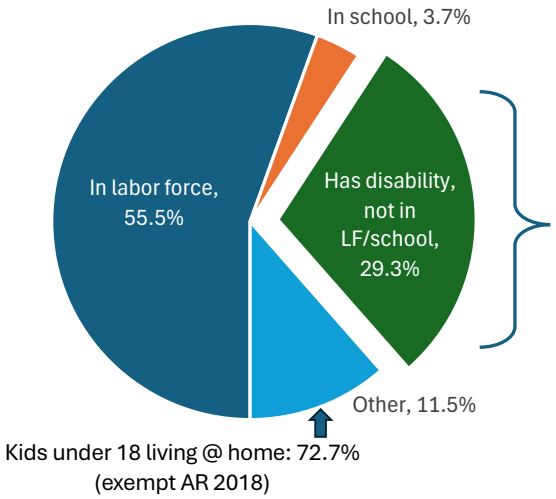


Among disabled older adults (age 65+), having any coverage to supplement Medicare reduces the likelihood of inability to pay healthcare bills from 8% to 4%.

Source: DREDF analysis of data from the National Health Interview Survey, 2019–2023.

Bad policy: Work requirements

Labor force & disability classification of Medicaid beneficiaries 19–64



Disability indicator	%
On SSI (exempted)	39.6
Of those not on SSI:	
On SSDI	35.9
Reports work limitation	84.4
Disability by ACS Qs	79.1

Need for healthcare	%
Poor health	25.3
Fair or poor health	60.7
Frequent provider visits	40.3
Hospitalized prior year	23.9
Median all-payer $/yr	$7,451

The pie chart represents working-age Medicaid beneficiaries divided into mutually exclusive categories according to labor force status, school attendance, and broadly defined disability status:

- 55.5% are in the labor force, meaning that they are either working or actively looking for work.
- 3.7% are not in the labor force but are attending school.
- 29.3% are in neither of the above categories but can be considered disabled (see table at upper right):
    - 36.6% receive Supplemental Security Income (SSI), and therefore become eligible for Medicaid benefits through the “disabled” pathway.
    - Of those not on SSI:
        - 35.9% receive Social Security Disability Insurance (SSDI) benefits, and therefore also (like SSI beneficiaries) meet the Social Security Administration definition of work disability.
        - 84.4% self-report a limitation in their ability to work due to “a physical, mental, or emotional problem.”
        - 79.1% are classified as disabled according to the standard 6-question ACS disability measure.
- Medicaid beneficiaries in this disabled category have high healthcare needs (table at bottom right): 25.3% report poor health and 60.7% report fair or poor

health; 40.3 percent are frequent healthcare users, seeing healthcare providers at least 10 times per year; and 23.9% had been hospitalized in the prior year. Median healthcare expenditures (from all payers, including public programs, private insurance, and out-of-pocket) for this group are $7,451 per year.

- The remaining 11.5% do not fall into any of the above categories.

Labor force participants and students generally meet proposed or existing Medicaid Work requirements, and people on Medicaid because of SSI recipiency are exempted. The remaining members of the disability category, those not on SSI, would typically not be automatically exempted, but would need to either meet the work requirements or file paperwork to prove that they were exempt by some other means, such as being "medically frail." As a population with high healthcare needs, their participation in Medicaid is essential to their well-being and survival.

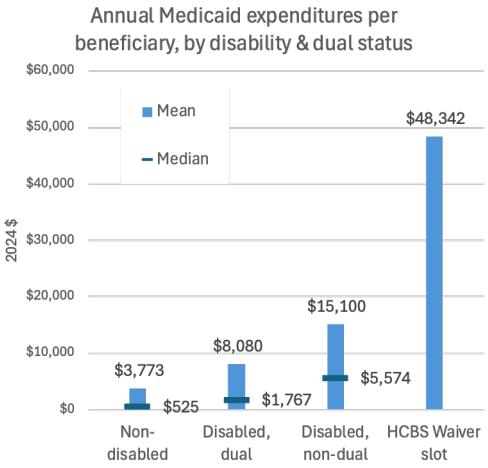
Note that, among the final category, 72.7% would have been exempted from the 2018 Arkansas work requirements because they had a child under 18 living at home with them. That fact alone would have made the beneficiary exempt from the 2018 Arkansas Medicaid work requirements. The 2025 Arkansas 1115 Waiver application does not feature exemptions per se, but mentions having a "dependent child is in the household" as a factor to be considered in whether the beneficiary meets the requirements.

It's hard to know which beneficiaries the authors of such work programs had in mind when designing them. A cynic might say that the goal was to kick some of the more costly (i.e., disabled) beneficiaries off of the program.

Source: DREDF analysis of data from the National Health Interview Survey, 2017 & Medical Expenditure Panel Survey, 2019–23 (for expenditures).

Bad policy: Per capita caps & block grants

- End of the guaranteed Federal match
  - Currently 50–77%, depending on state
  - 90–95% for expansion beneficiaries
- States get a fixed budget
  - Must pay 100% of any excess
  - 2 to 4 times normal share, or more
- Result: Target high-cost programs & beneficiaries
  - Cap/cut HCBS, DME, $$ treatments
  - Reduce HCBS financial eligibility (3xFPL)
  - Reverse LTSS rebalancing progress
  - Harms **disabled people, esp. LTSS users**



Whichever method they use, “per capita caps”* or block grants, the aim is to end the guaranteed Federal match of state Medicaid expenditures. The current Federal match (the Federal Medical Assistance Percentage, or FMAP) ranges from 50%, for the higher-income states, to 77%, for the lowest-income state. (Territories get an FMAP of 83%.) The FMAP can be even higher if Congress wants to give the states an incentive to change a policy or adopt a program. Medicaid expansion, for example, was originally matched at 90%, and that figure was raised even higher, to 95%, in the American Rescue Plan Act, to encourage states that had not already expanded to do so.

Without a guaranteed Federal match, states would get a fixed, pre-appropriated Medicaid budget from the Feds. If they go over, they have to pay 100%. That would be between twice and four times their ordinary share, or as much as 10 to 20 times if it’s for an incentivized program like the expansion. State Medicaid administrators will be quaking in their boots at the prospect of overspending. What will they do? They’ll take a close look at the high-cost programs and high-cost beneficiaries and institute caps and cuts.

Note the typical (median) annual Medicaid expenditures shown in the chart

(horizontal lines), which are much higher for disabled working-age beneficiaries (and especially disabled beneficiaries not also on Medicare) than for non-disabled. Mean expenditures (blue bars) are much greater in all categories; it's the mean expenditures, not the median, that determine program costs. Compare those means with the much greater mean (nearly $50K annually) for a 1915(c) HCBS Waiver slot. HCBS programs will be first on the chopping block!

Another likely program cut: States that allow people with incomes up to 300% of the Federal Poverty Level could reduce that to 100%, excluding a lot of more middle-class beneficiaries from coverage. Cuts, caps, and failure to launch new programs will halt and possibly reverse all the progress that has been made in rebalancing LTSS spending in favor of HCBS programs rather than institutions.

*Pet peeve: "Per capita" usually means per person in the general population. So a per capita cap would be an amount calculated based on the state population, not an amount based on the number of beneficiaries.

Sources: DREDF analysis of data from the Medical Expenditure Panel Survey 2019–23; CMS/Mathematica 2022 LTSS report.

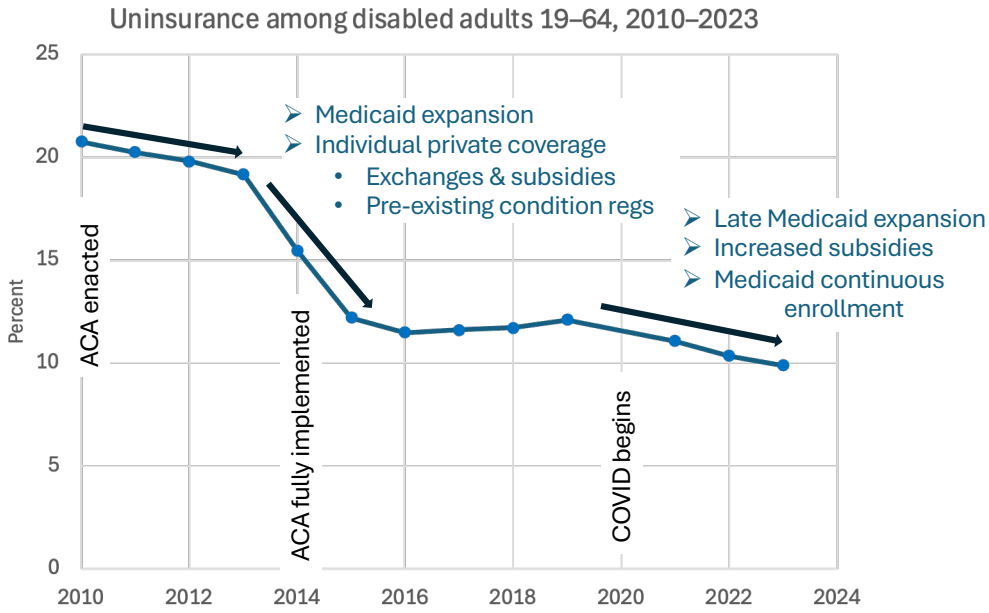
Bad policy: Block grants

- Indian Health Service
  - Funded by fixed appropriations, largely going to tribes in block grants
  - Not health coverage! Not an entitlement!
  - Services depend on facility, many operate beyond capacity
  - Pays for referrals "if the medical need is within the available funding at that time," prioritizing life-threatening illnesses or injuries.
  - IHS "denied and deferred an estimated $1.1 billion for approximately 265,785 services in FY 2020."
- Without a Federal guarantee, will states find ways to undermine Medicaid's status as an entitlement program?
- Block grants limit Congress's & CMS's ability to influence state Medicaid policy, which has been crucial to HCBS expansion and improvement

Aside from shifting to block grants, FMAP reductions are also being proposed, probably also entailing termination of enhanced-FMAP incentives. Enhanced matching percentages have been used repeatedly to encourage states to adopt HCBS programs. The ACA's Balancing Incentive Program was effective in incentivizing states to shift LTSS from institutional services to HCBS, according to a recent study (see https://academyhealth.confex.com/academyhealth/2024arm/meetingapp.cgi/Paper/67620).

Source: IHS website & ASPE Report HC-2022-21.

The ACA reduced uninsurance by half



The chart shows the proportion of disabled working-age adults who were uninsured, from the year the ACA was enacted, 2010, until the most recent year for which data are available, 2023. There is a sharp decline beginning in 2014, when the main provisions of the ACA went into effect.

- Medicaid expansion: In 2014, 27 states expanded Medicaid to working-age adults with incomes up to 138% of the Federal Poverty Level.
- Increased availability of individual private insurance coverage: Beginning in late 2013, private insurance policies, subsidized for people with low incomes, became available through Federal- or state-run Exchanges, providing coverage for calendar year 2014. Equally important, especially for people with disabilities, were the regulations preventing insurance companies from charging more or denying coverage to people with pre-existing conditions; for adults, these regulations took effect in 2014.

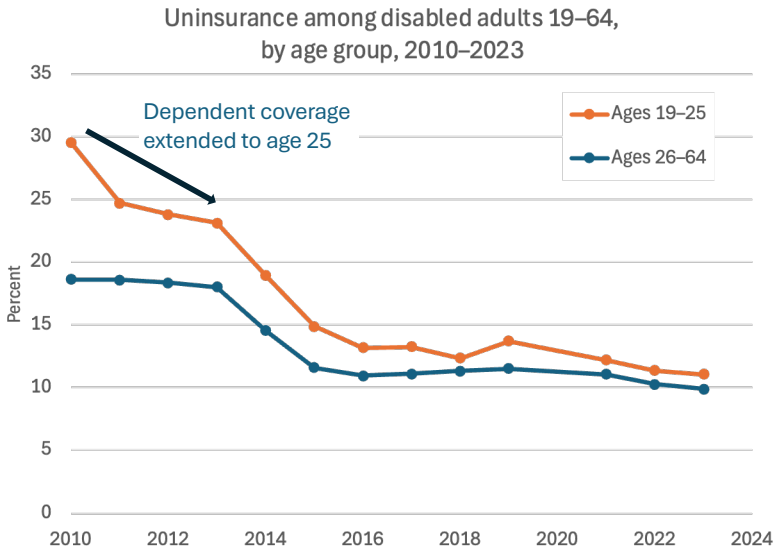
A further, smaller decline in the uninsurance rate took place between 2019 and 2023. There are 3 main explanations:

- Late Medicaid expansion: Following a lull, 7 states expanded Medicaid between 2018 and 2021, and 2 more did so in 2023.
- Increased subsidies: The American Rescue Plan Act of 2022, passed in response to the COVID epidemic, increased subsidies for Exchange policies.
- Medicaid continuous enrollment: The Families First Coronavirus Response Act of 2020 offered an enhanced Federal match for state Medicaid programs that kept all beneficiaries on the rolls, without rescreening for eligibility, until the end of the COVID-19 public health emergency. The declaration of emergency remained in force until May, 2023, after which states began rescreening during a gradual “unwinding” period.

Also apparent is a modest decline between 2010 and 2014. See the next page for an explanation.

Source: DREDF analysis of data from the American Community Survey, age adjusted to the 2023 population.

Almost 20-point reduction for young adults

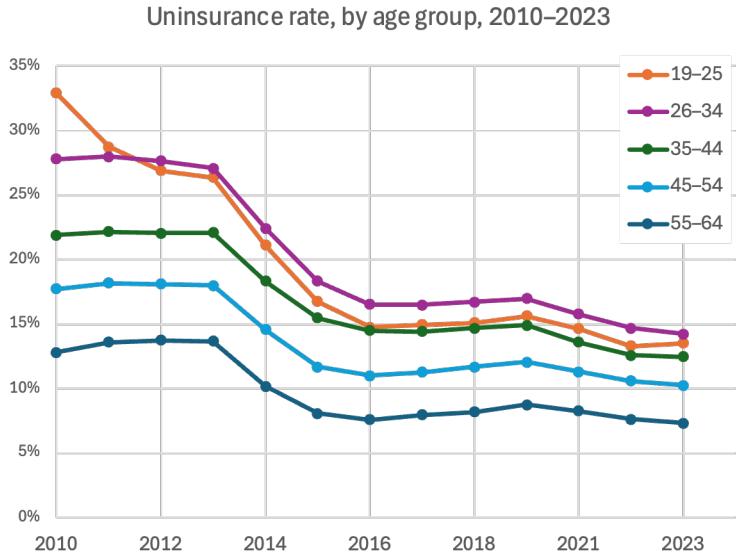


The graph shows the uninsurance trend for disabled young adults (19–25, orange) and for their older working-age counterparts (blue). Hardly any change is apparent for the older group, but a large decline took place for the young adults, beginning in 2011 and continuing until about 2016. One important ACA provision took place in late 2010, namely the requirement that insurance companies allow parents to include their dependent children on their policies through age 25. Before that, dependent coverage was only required up through age 19, and full-time students were generally also covered through age 23.

Disabled young adults, who had far higher uninsurance rates in 2010 than older disabled working-age adults, nearly reached parity with them by the early 2020s.

Source: DREDF analysis of data from the American Community Survey, age adjusted to the 2023 population.

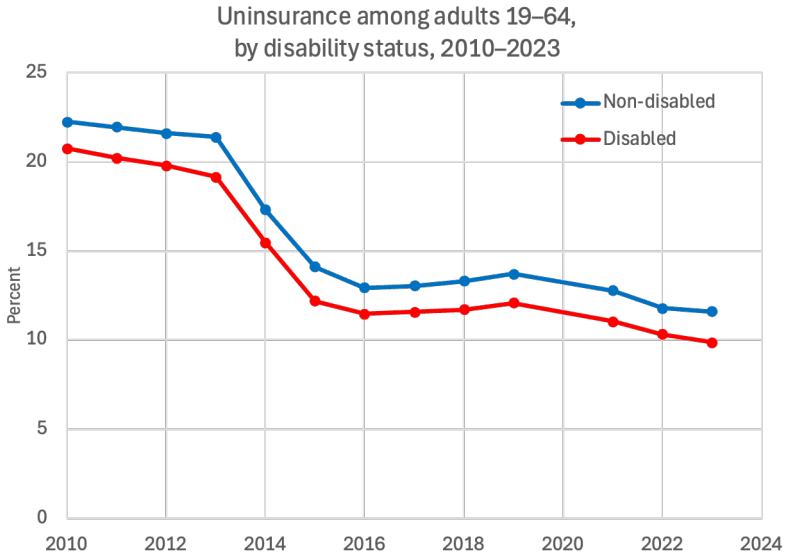
ACA reduced age-related disparities



The narrowing of disparities by age in insurance coverage is a major success of the ACA. The graph shows uninsurance rates for all working-age adults, by age group. The gap between the oldest and youngest group, nearly 20 percentage points in 2010, is reduced to 6 points by 2023.

Source: DREDF analysis of data from the American Community Survey, age adjusted to the 2023 population.

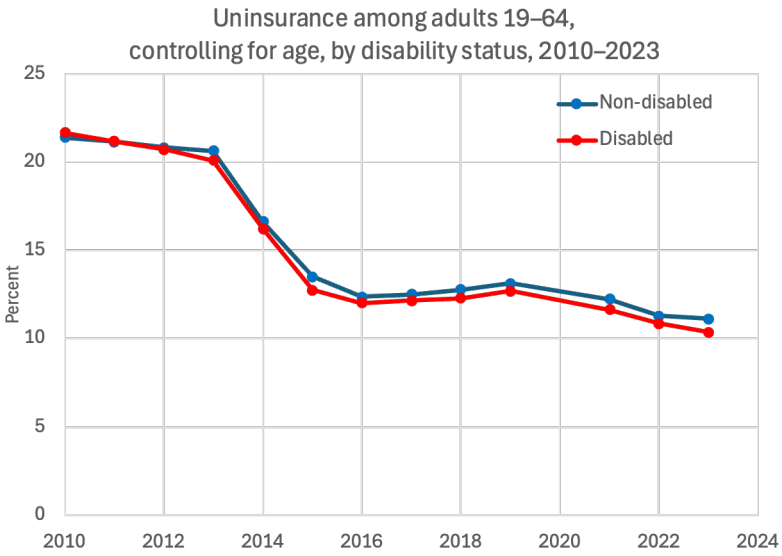
Equal improvements by disability status



Uninsurance rate trends for disabled (red) and non-disabled (blue) working-age adults are nearly identical, with the disabled group lower than the non-disabled group by 1.5 to 2.5 percentage points throughout. Does this fact imply that there was no disparity between disabled and non-disabled working-age adults in terms of health coverage? Only if the uninsurance rate is the sole measure.

Source: DREDF analysis of data from the American Community Survey, age adjusted to the 2023 population.

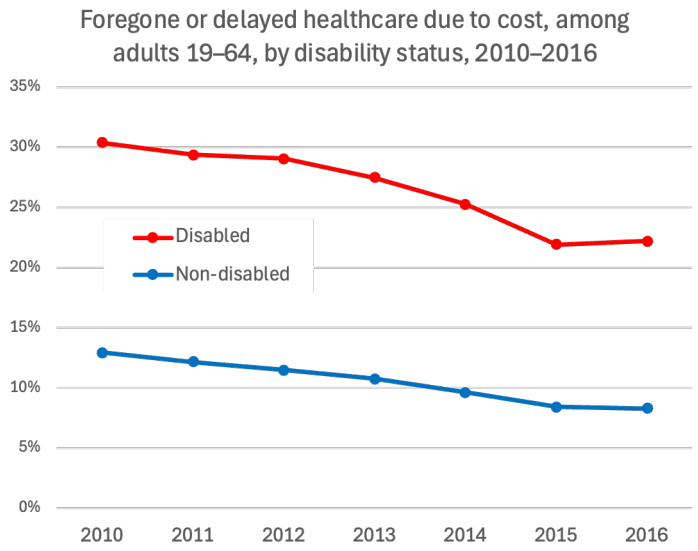
Controlling for age: Identical trends



The uninsurance gap between disabled and non-disabled working-age adults becomes even smaller when differences in the age distributions of the two populations are taken into account. In terms of coverage, the ACA was equally beneficial to disabled and non-disabled people.

Source: DREDF analysis of data from the American Community Survey, age adjusted to the 2023 population.

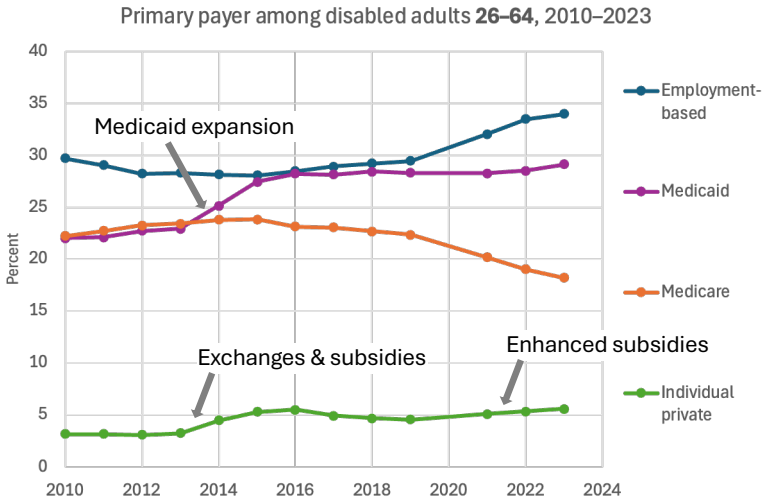
ACA reduced unmet need & narrowed the gap



Earlier charts showed a large disparity in unmet need between disabled and non-disabled working-age adults. This chart focuses on unmet need for care (excluding prescription medications). The ACA reduced unmet need for disabled working-age adults by 8.2 percentage points, versus 4.7 points for non-disabled working-age adults.

Source: DREDF analysis of data from the National Health Interview Survey.

ACA gains in Medicaid & individual coverage



The chart shows the primary payer, as defined below, for disabled working-age adults ages 26–64. The effects of the Medicaid expansion and the expansion of private coverage are readily apparent, as is a smaller effect of post-COVID enhanced subsidies.

For people with more than one type of coverage, and one payer acts as the primary payer and the other(s) pay for whatever is left over. Rules for which payer is primary are complex, depending, for example, on the size of the business buying employment-based coverage. These details are not available in the survey data; instead, I have constructed the most likely hierarchy:

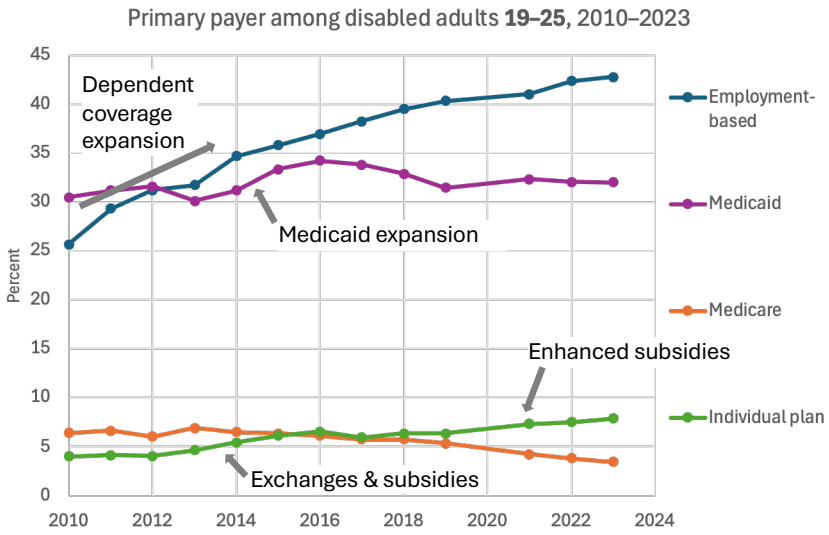
1. Medicare (includes duals)*
2. Employment-based group insurance
3. VA and/or military coverage (not shown)
4. Medicaid
5. Individual private insurance

Note that people using the Indian Health Service without other coverage count as uninsured, following the practice of the National Center for Health Statistics.

*Employment-based, VA, & military sometimes take precedence over Medicare.

Source: DREDF analysis of data from the American Community Survey, age adjusted to the 2023 population.

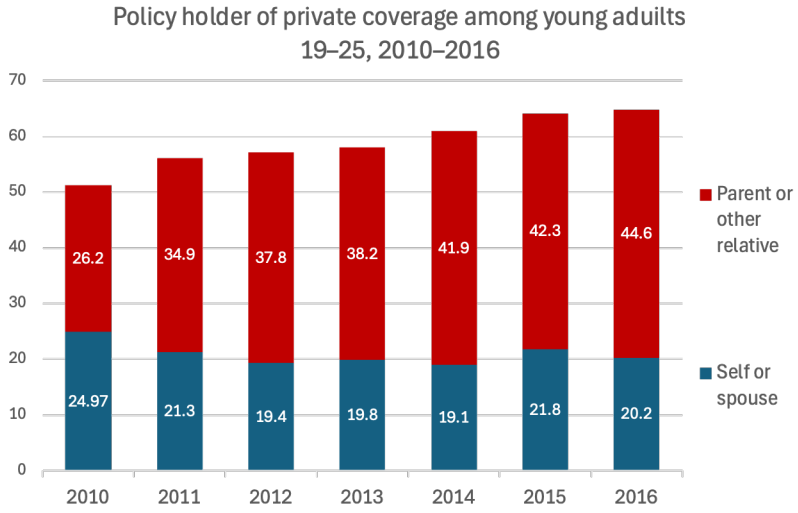
Young adults gained employment-based coverage



For disabled younger adults, the effects of both the Medicaid expansion (which appears to have been short-lived for this age group) and increased private coverage availability are less pronounced. In contrast, the expansion of dependent coverage to age 25 had a large effect beginning in 2011.

Source: DREDF analysis of data from the American Community Survey, age adjusted to the 2023 population.

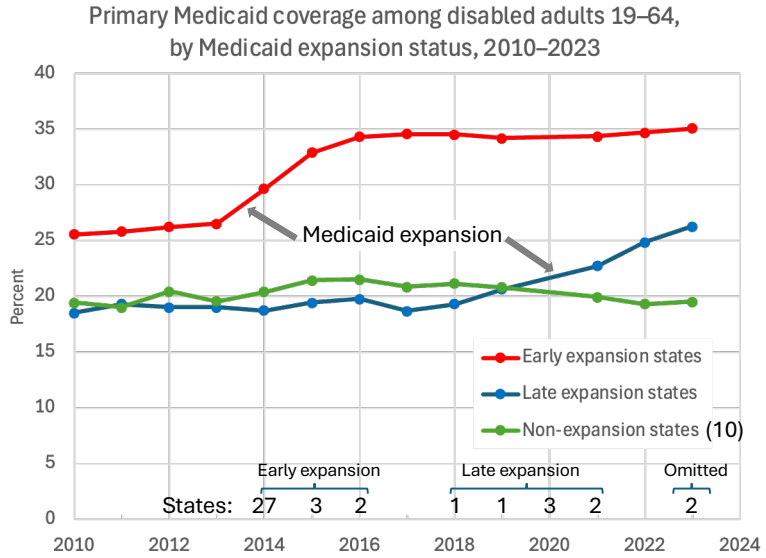
…as dependents on their parents' polices



We can confirm that the post-2010 increase in employment-based group coverage among disabled younger adults was not due to higher employment and therefore more coverage on policies of their own. Instead, there was a pronounced rise in the proportion who received coverage as dependents on their parents' policies.

Source: DREDF analysis of data from the National Health Interview Survey.

Medicaid gains limited to expansion states



I've divided the states into three groups:

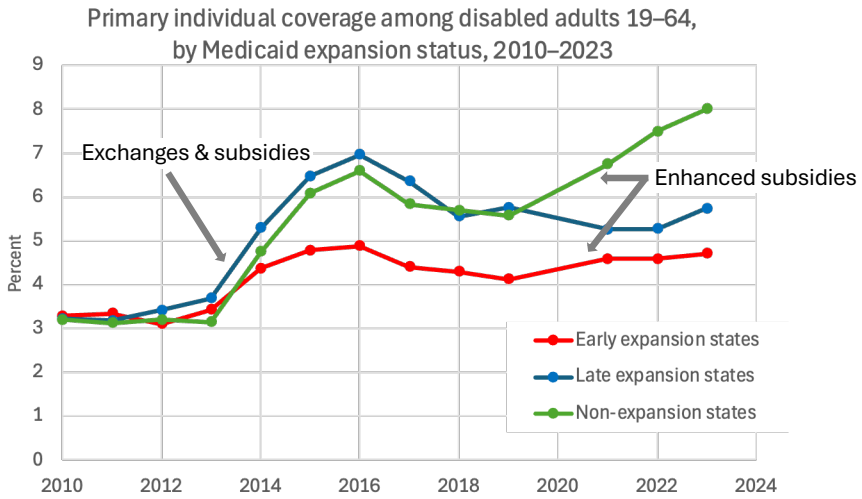
- Early expansion states, the 32 that adopted the Medicaid expansion between 2014 and 2016 (25 of them did so on January 1, 2014).
- Late expansion states, the 7 that expanded Medicaid between 2018 and 2021.
- Non-expansion states, the 10 that haven't yet expanded Medicaid.

The two states that expanded Medicaid in 2023 have been omitted from the analysis because the full effect would not yet be apparent in the data.

Large gains in Medicaid coverage among disabled working-age adults are apparent in the early expansion states from 2013 to 2016, and in the late expansion states between 2017 and 2023. The non-expansion states saw only a gradual rise in Medicaid participation followed by a gradual decline. Medicaid continuous enrollment, enacted in the Families First Coronavirus Response Act of 2020, is likely responsible for a 0.9 percentage-point rise in coverage between 2019 and 2023; its effect cannot be disentangled from Medicaid expansion in the late expansion states, and no effect is visible in the non-expansion states.

Source: DREDF analysis of data from the American Community Survey, age adjusted to the 2023 population.

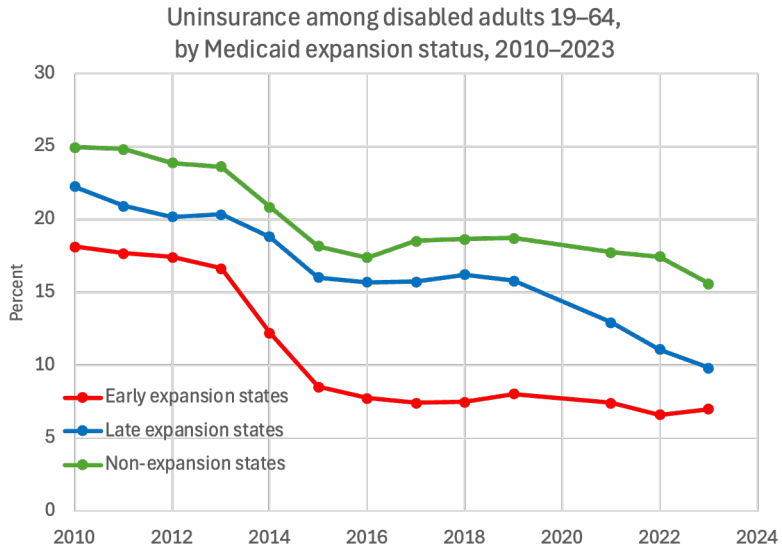
Individual coverage partly compensates for non-expansion



Note the difference in scale between this chart and the previous one. The impact of improved access to private coverage is greater in the late expansion and non-expansion states (3.3 and 3.5 percentage points, respectively, between 2013 and 2016) than in the early expansion states (1.5 points). The enhanced subsidies introduced in the American Rescue Plan Act of 2022 had a large impact in the non-expansion states (2.4 percentage points between 2019 and 2023), where Medicaid was not an option for many people. A smaller but notable effect is apparent in the early expansion states but not so apparent in the late expansion states.

Source: DREDF analysis of data from the American Community Survey, age adjusted to the 2023 population.

ACA achieved more in Medicaid-expansion states



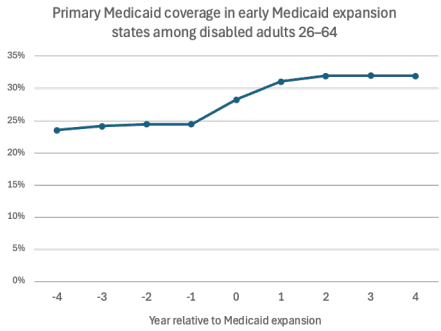
All the groups of states saw large declines in uninsurance once the ACA went into full effect, especially the early expansion states, which saw an 8.9 percentage point decline from 2013 to 2016, versus 6.2 points in the non-expansion states and 4.5 points in the late expansion states. Uninsurance fell by 5.1 percentage points in the late expansion states after 2018, when the first of those states expanded Medicaid, Overall, between 2010 and 2023, uninsurance declined by 12.5 percentage points in the late expansion states, 11.1 points in the late expansion states, and 9.4 points in the non-expansion states.

Source: DREDF analysis of data from the American Community Survey, age adjusted to the 2023 population.

The impact of each ACA component

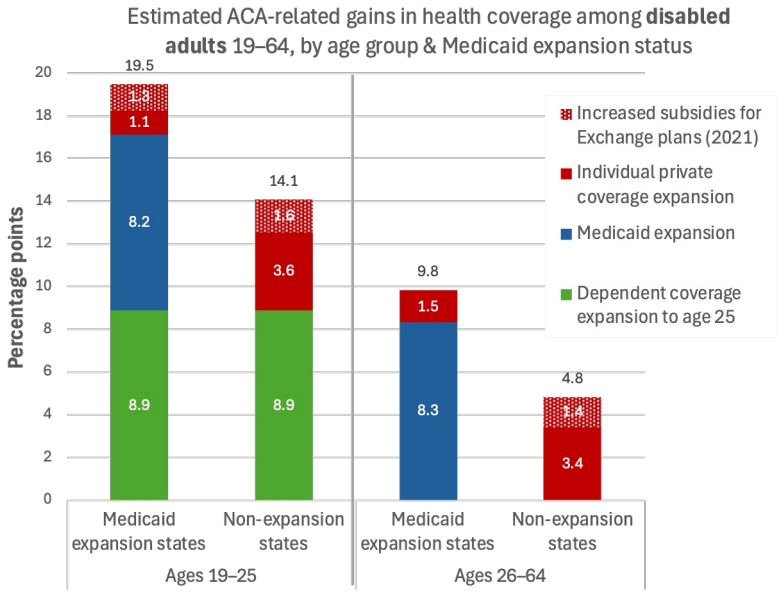
Methods

- Medicaid expansion: For early expansion states, compute change from 1 year pre-expansion to 2 years post-expansion.
- Individual private coverage expansion
  - Initial: Compute change from 2013 to 2016
  - Enhanced subsides: Compute additional increase from 2016 to 2023, if any.
- Dependent coverage expansion
  - Compute employment-based coverage change from 2010 to 2014 for ages 19–25
  - Compute change for unaffected comparison group, ages 17–18 & 26–27, and subtract



We can summarize these findings by calculating the separate effect of the various ACA components: Medicaid expansion, the expansion of individual private coverage (ACA plus ARPA enhanced subsidies), and the dependent coverage expansion.

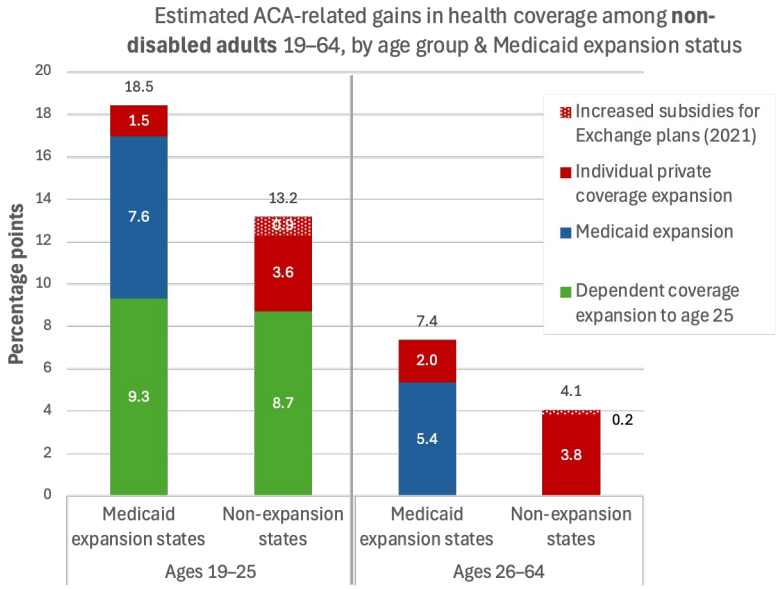
Largest gains from Medicaid & dependent coverage



The expansion of dependent coverage had a big impact on disabled young adults, with 8.9% gaining coverage (green bars). Medicaid expansion was also highly important, with a little over 8% gaining coverage in expansion states. The increased availability of individual private insurance, shown in solid red for the initial impact and dotted red for any additional impact from increased subsidies, had a smaller impact across categories, but it is larger in the non-expansion states, about 5 percentage points total for both age groups.

Source: DREDF analysis of data from the American Community Survey.

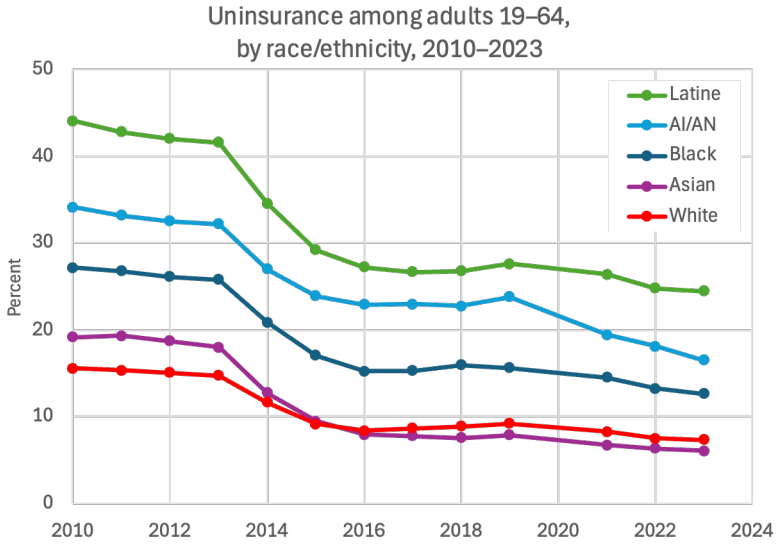
A slightly smaller increase for non-disabled adults



Impacts are similar for non-disabled working-age adults, with a bit less effect from the Medicaid expansion, especially in the older age group.

Source: DREDF analysis of data from the American Community Survey.

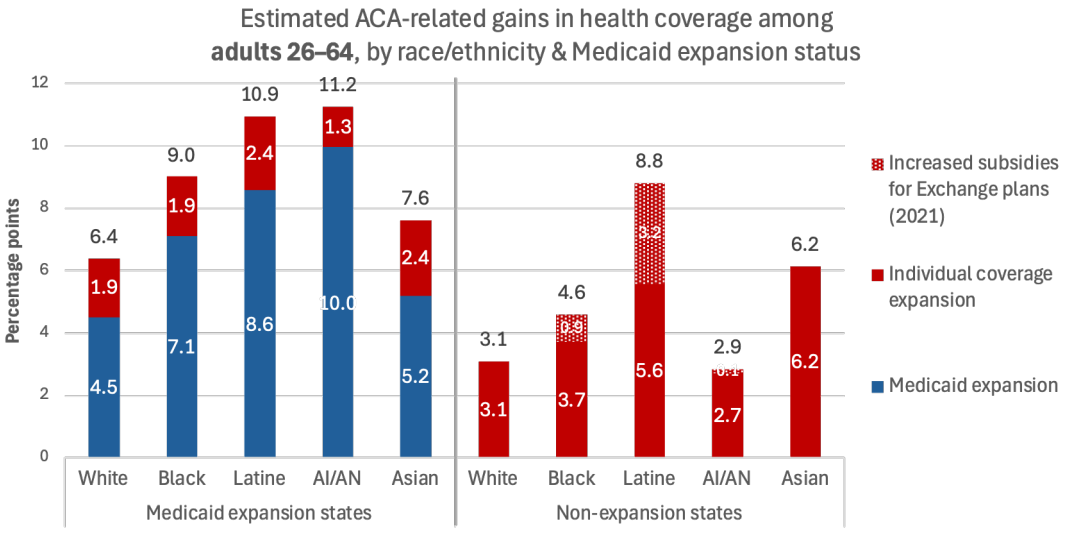
ACA reduced race/ethnicity disparities



The chart shows the trend in uninsurance for *all* working-age adults, by race and ethnicity. When the ACA was enacted, there were very large disparities in health coverage between racial/ethnic groups, with Latines highest and whites lowest. The gap stood at 28.5 percentage points. By the most recent year of data, it had shrunk to 17.2 points. A disparity remains, albeit substantially reduced.

Source: DREDF analysis of data from the American Community Survey, age adjusted to the 2023 population.

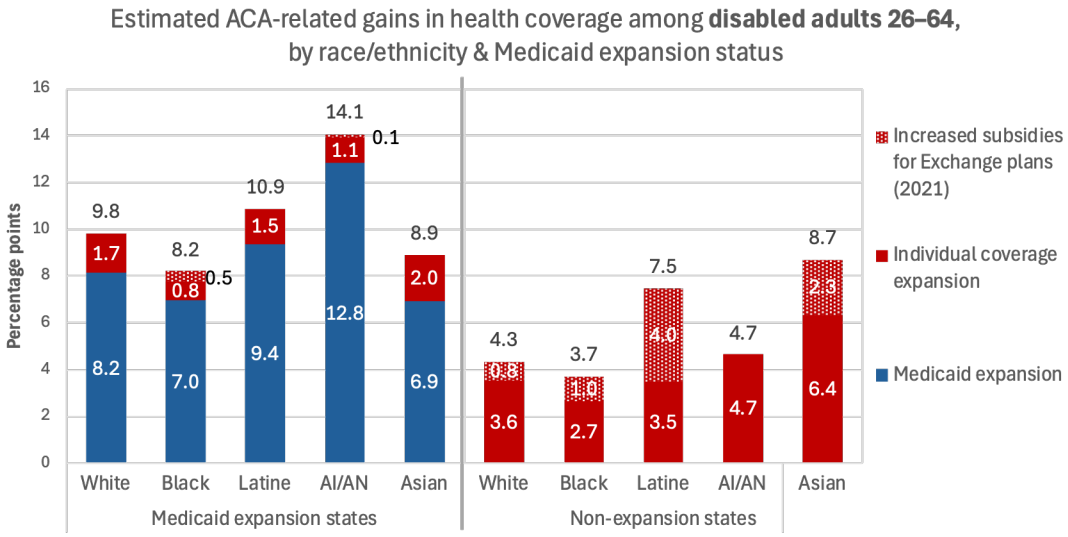
How much did the ACA increase coverage?



Among working-age adults (with or without disabilities) older than 25, Blacks and especially Latines and Natives made the largest gains in expansion states, substantially more than those of whites and Asian-Americans. Medicaid expansion was mostly responsible. In non-expansion states, Latines did best.

Source: DREDF analysis of data from the American Community Survey.

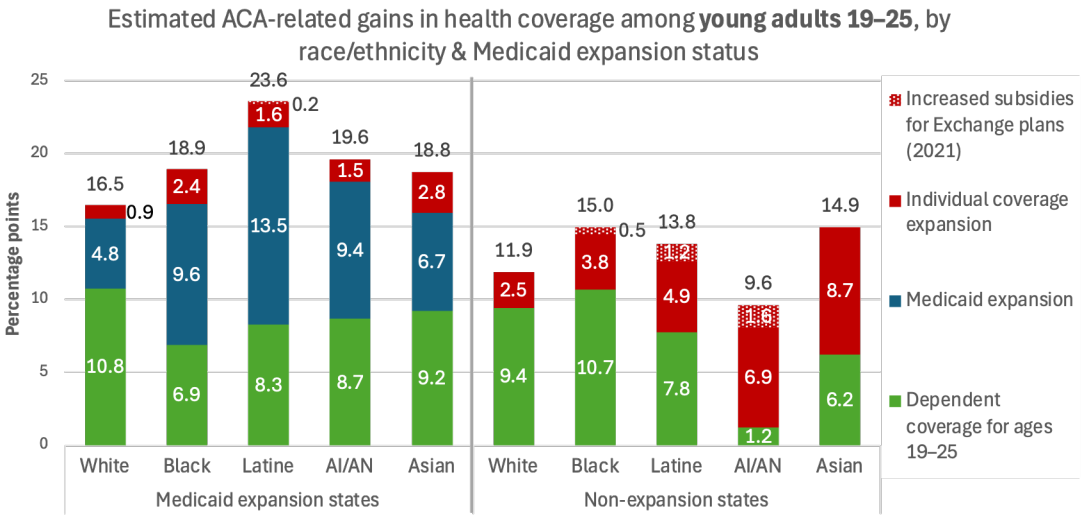
How much did the ACA increase coverage?



This chart is for *disabled* working-age adults 26 and over. Again, Latines and Natives fared best in expansion states. Latines and Asian-Americans fared best in non-expansion states.

Source: DREDF analysis of data from the American Community Survey.

How much did the ACA increase coverage?



Turning to younger adults 19–25, without regard to disability status, all of the BIPOC groups fared better than whites in expansion states, with Latines seeing the greatest increase. Dependent coverage drives most of the increase for whites, while Medicaid is a larger player for Blacks, Latines, and Natives.

The sample size is not sufficient to assess changes among disabled younger adults by race/ethnicity.

Source: DREDF analysis of data from the American Community Survey.

Bad policy: Gutting/weakening the ACA

- Deregulation of private insurance
  - Return of pre-existing condition exclusions & underwriting?
  - What about dependent coverage expansion?
- Reducing subsidies for Exchange policies
  - Enhanced subsidies sunset end of 2025
- Reducing Federal match incentive for Medicaid expansion
  - 12 states automatically end expansion if match reduced
  - Other states will likely consider ending expansion
- Narrowing & failing to enforce non-discrimination provisions

Project 2025 calls for "regulatory relief from the costly ACA regulatory mandates" for all non-subsidized health plans. A return of denial of coverage for people with so-called pre-existing conditions, and premium increases based on such conditions, would cause many disabled people to lose coverage or to forego coverage because they cannot afford it. Deregulation also introduces the possibility that insurers will reduce the age limit for dependent coverage, expansion of which has been crucial to the reduction in uninsurance for this group.

The enhanced subsidies for insurance policies purchased through the Exchanges, instituted in 2022, are set to expire at the end of 2025. Increasing the subsidies has led to an increase in health coverage, in particular for disabled people living in states that have not expanded Medicaid. If the subsidies return to their former levels, higher rates of uninsurance may well be the result.

The high Federal match rate for Medicaid expansion beneficiaries, as much as 95% for some states, motivated several reluctant states to participate. Policy proposals would lower that match. This change would result in automatic repeal of Medicaid expansion in 12 states; other states would likely follow suit. Medicaid expansion is the largest contributing factor to the increase in health coverage for disabled (and non-disabled) working adults, and especially benefitting Black, Latine, and Native adults.

Section 1557 of the ACA provides unprecedented civil rights protections in healthcare settings and programs on various bases including disability. Project 2025's goal of "Rolling Back Antidiscrimination Protections in Health Care" focuses mainly on narrowing the interpretation of sex discrimination to exclude sexual orientation and gender identity; there is also mention of applying disability non-discrimination protections to "protect… children born alive after abortions." An Administration that, upon entering office, immediately halts work of the Department of Justice Civil Rights Division would appear unlikely to enforce the non-discrimination provisions of the ACA in any meaningful way.

DREDF

Key points

- Medicaid is an essential public program for working-age adults with disabilities
  - Meets people's needs & makes healthcare affordable
  - Only source of paid LTSS for most people
  - Threats to Medicaid may lead to increased uninsurance & unmet need
- Despite flaws & legal setbacks, the ACA achieved a lot
  - Medicaid expansion is a godsend for many disabled people, and others
  - Greatly reduced age disparities in health coverage
  - Reduced racial/ethnic disparities
  - Pre-existing condition provisions open up private coverage for many
  - Subsidies make it more affordable
  - Non-discrimination provisions improve the healthcare system
- All of this is at risk!