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## The Role of Medicaid for People with Diabetes

### Introduction

Diabetes is one of the most prevalent chronic conditions and a leading cause of death in the United States.<sup>1</sup> Individuals with diabetes are at increased risk for serious health problems including heart disease and stroke, hypertension, blindness, kidney disease, and amputations. These complications are a major reason why the illness is very expensive, totaling \$116 billion in direct medical costs in 2007.<sup>2</sup> To manage their illness and reduce the risk of complications, individuals with diabetes may rely on a range of services, such as insulin or oral medication, regular preventive care, blood sugar monitoring, and diet and exercise programs. Diabetes disproportionately affects low-income populations.<sup>3</sup> As the nation's primary health insurance program for low-income people, Medicaid plays a key role in financing care for diabetes: Adults with diabetes are disproportionately covered by Medicaid,<sup>4</sup> and the program covered 15% of all individuals with diagnosed diabetes in 2003.<sup>5</sup> For these individuals, Medicaid helps cover the cost of treatment and services to manage their illness.

Beginning in 2014, the Affordable Care Act (ACA) enables states to expand Medicaid eligibility to cover all individuals up to 138% of poverty, including adults without children, a group that has historically been ineligible for the program. Many in the newly enrolled Medicaid population will likely have been uninsured and enter the program with undiagnosed or untreated diabetes. This brief examines Medicaid's role in providing care for adults with diabetes and the program's potential to expand access to a range of medical and community services and supports for these new beneficiaries. It compares low-income adults with Medicaid coverage to low-income adults who are uninsured with respect to prevalence of chronic diabetes and, within the population with diabetes, compares their health care spending, access to care, and utilization of services. [A more detailed description of the data and methods for the analysis in this brief is included in the Appendix at the end of the report.]

### Findings

#### *Prevalence & Health Status*

Among nonelderly adults with incomes at or below 138% of poverty, Medicaid beneficiaries were nearly twice as likely as the uninsured (9% versus 5%) to have diabetes (see Table 1). The higher prevalence rate among Medicaid enrollees reflects Medicaid eligibility rules that explicitly extend coverage to people in poor health, such as the medically needy and individuals with disabilities. Though lower, the prevalence rate among uninsured adults indicates that a notable share is living with chronic diabetes. The actual rate of disease may be even higher, as uninsured adults are more likely than those with coverage to have undiagnosed chronic illness.<sup>6</sup>

Individuals with diabetes have a high rate of comorbidity. Over four out of five Medicaid beneficiaries with diabetes also had a physical comorbidity, and over a third had a mental comorbidity—a reflection of this group's often complex health care needs. Considerable shares of the uninsured with diabetes also

had either a physical comorbidity (64%) or a mental comorbidity (27%). While the prevalence of other chronic conditions was lower among adults without diabetes, Medicaid beneficiaries in this group were more than twice as likely as uninsured adults to have another physical or mental condition.

**Table 1: Health Status of Medicaid and Uninsured Nonelderly Adults ≤138% FPL**

Prevalence of Diabetes	Medicaid		Uninsured	
	9% <sup>a</sup>		5%	
	With Diabetes	Without Diabetes	With Diabetes	Without Diabetes
<b>Had Other Chronic Condition</b>				
Other Physical Condition	82% <sup>ab</sup>	39% <sup>a</sup>	64%	15%
Chronic Mental Condition	38%	35% <sup>a</sup>	27%	13%
<b>Fair or Poor Health Status</b>	74% <sup>ab</sup>	33% <sup>a</sup>	51%	16%

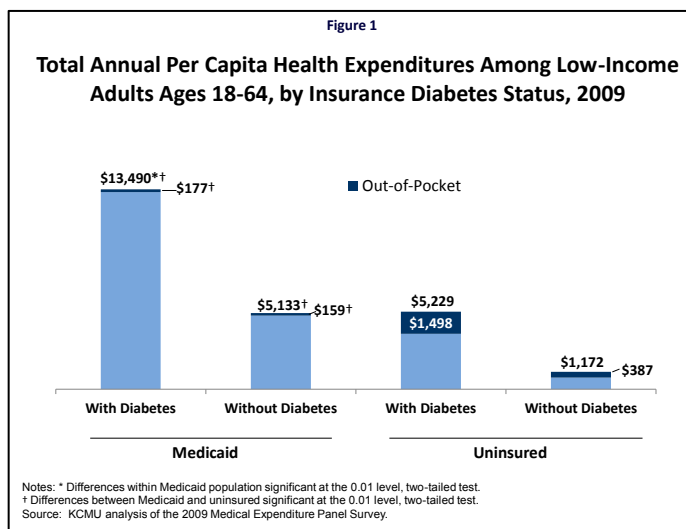
<sup>a</sup> Statistically significant difference from Uninsured population, p < .05  
<sup>b</sup> Statistically different from Medicaid population without diabetes, p < .05  
 SOURCE: Kaiser Family Foundation analysis of 2009 Medicaid Expenditure Panel Survey data.

Significant differences also existed between these groups of Medicaid and uninsured adults in self-reported health status. Nearly three-quarters of Medicaid beneficiaries with diabetes reported that their health status was fair or poor, while approximately half of the uninsured with these conditions had this view of their health. Moreover, one in three Medicaid adults without diabetes indicated that their health was fair or poor, while around half of that share of uninsured adults without these conditions gave that response.

**Spending**

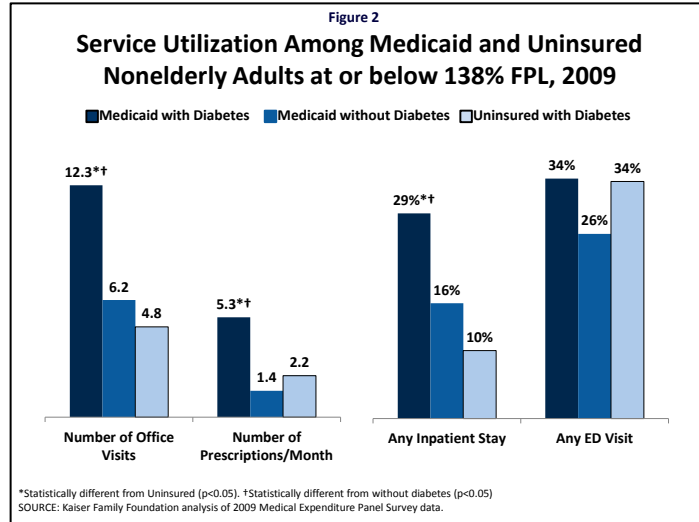
Among those with diabetes, average annual spending by Medicaid adults (\$13,490) was two and a half times the amount for uninsured adults (\$5,229) in 2009 (Figure 1). These spending figures include spending for all services, and the relatively high total reflects the substantial health care needs and high comorbidity rate among this population. Likewise, annual total spending among those without diabetes was more than four times greater for Medicaid adults than for the uninsured (\$5,133 versus \$1,172).

Despite lower overall spending, uninsured adults with diabetes faced average annual out-of-pocket costs for health care (\$1,498 per year) that were far greater than those for Medicaid adults with these conditions (\$177 per year). Among adults without diabetes, annual out-of-pocket spending was greater for the uninsured (\$387) than for Medicaid beneficiaries (\$159). The low out-of-pocket spending totals for Medicaid adults reflects program rules restricting cost-sharing to nominal amounts.



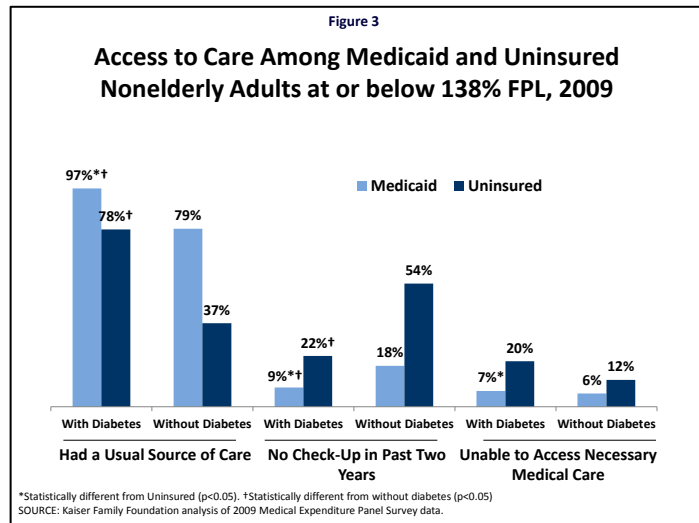
**Utilization**

The spending patterns above reflect differences in utilization by insurance coverage. Among low-income adults with diabetes, Medicaid beneficiaries had more provider office visits (12.3 vs. 4.8) and filled more prescriptions (5.3 vs. 2.2 per month) than the uninsured (Figure 2). Moreover, Medicaid adults with diabetes were nearly three times more likely than the corresponding group of the uninsured to have had an inpatient stay (29% versus 10%) in the previous year. Utilization of the emergency room was similar between the groups. As with spending, utilization was higher among Medicaid enrollees with diabetes than among those without, again with the exception of emergency department visits (which were statistically similar across the two groups).



**Access**

Despite their more complex health needs, low-income Medicaid beneficiaries with diabetes had greater access to care than the corresponding group of the uninsured (Figure 3). Among those covered by Medicaid, nearly all (97%) reported that they had a usual source of care, versus less than four out of five of the uninsured. Over 20 percent of uninsured adults with diabetes reported that they had not had a check-up in the past two years, a finding that is particularly notable given the ongoing care needs for people with this disease. Far fewer Medicaid enrollees reported not having a check-up, regardless of diabetes status. Further, the uninsured with diabetes were more likely than Medicaid beneficiaries with these conditions to be unable to get necessary medical care (20% versus 7%), a pattern that held even among those without diabetes (12% versus 6%).



## Policy Implications

There is a relatively high prevalence of diabetes among low-income adults covered by Medicaid, and most have at least one additional chronic health condition. This prevalence is in part a result of Medicaid eligibility rules that explicitly extend coverage to people with substantial health needs. Reflecting these needs, Medicaid adults with diabetes have higher spending and utilization rates than enrollees without this illness. Despite their substantial need and complex health status, Medicaid enrollees with diabetes are not more likely to report a problem getting needed medical care than those without.

Medicaid adults with diabetes were more likely than low-income uninsured adults with this illness to have access to and utilize services; they also had lower out-of-pocket costs despite higher overall spending for their care. These findings indicate the important role Medicaid plays in supporting the health and well-being of these individuals by providing access to critical health care services with minimal financial burden.

Though low-income uninsured adults have a lower prevalence of diabetes and comorbidity than their Medicaid counterparts, there is still a substantial share of uninsured adults who live with this illness. Many of these individuals may become eligible for Medicaid in 2014 and are likely to present with substantial health needs. The analysis in this brief suggests that these individuals may see improved access to health care services and prescription drugs that may help them manage their illnesses, as well as reduced out-of-pocket costs.

The ACA also offers opportunities for states to improve the care that Medicaid beneficiaries with diabetes receive. The relatively high number of ED visits and hospital stays, as well as provider office visits and prescriptions filled, among Medicaid adults with diabetes indicates that there may be opportunities to better coordinate care or provide it more efficiently for beneficiaries with complex care needs. In addition, the high rate of mental health comorbidity among adults with diabetes presents opportunities for improved coordination of physical and mental health services. The Medicaid health homes option in the ACA presents an opportunity for states to coordinate care across providers to prevent duplicative or inappropriate care, especially for patients with multiple conditions and complex health needs.

While the ACA provides a number of opportunities to improve care for uninsured adults with chronic illness, it will be critical for states to ensure adequate provider capacity in their Medicaid programs so that these new enrollees have adequate access to the primary, preventive, and specialized care necessary to adequately treat their conditions. If states can meet these challenges, the results of this analysis suggest that enrollment in Medicaid may provide access to important services that would enable newly eligible adults with diabetes to better manage their conditions.

## Appendix

This analysis draws on data from the 2009 Medical Expenditure Panel Survey (MEPS) household component. The publicly-available MEPS-HC dataset is a nationally-representative survey of healthcare access, utilization, and expenditure among the United States civilian, non-institutionalized population. We restrict our analysis to low-income nonelderly adults who are either uninsured or covered by Medicaid for twelve consecutive months. We exclude those with coverage changes throughout the year to match the timing of insurance and access measures, which ask about all access and use over the past year. We define “low-income” as having family income at or below 138% of the federal poverty level. Medicaid beneficiaries with Medicare (“dual-eligibles”) are excluded.

To identify individuals with diabetes and comorbidities, we use the MEPS Medical Conditions file, which is based on self-reports of whether a person had been told by a health care provider that he or she had any “priority” condition,<sup>7</sup> self-reports of individuals taking a day or more of disability during the year for a condition and of a condition “bothering” a respondent, and ICD-9 codes, classified using Clinical Classification Codes, from the event files. We also use the HCUP Chronic Condition Indicator (CCI) to specify whether a condition was chronic; only chronic conditions are included in this analysis. Spending data include expenditures from all payers and on all health care services. All spending values are calculated as annual, per capita expenditures.

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<sup>1</sup> Centers for Disease Control and Prevention (CDC). National diabetes fact sheet: national estimates and general information on diabetes and prediabetes in the United States, 2011. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2011.

<sup>2</sup> CDC 2011.

<sup>3</sup> Brown AF, SL Ettner, J Piette, M. Weinberger, et al. Socioeconomic Position and Health among Persons with Diabetes Mellitus: A Conceptual Framework and Review of the Literature. *Epidemiol Rev.* 2004;26:63-77.

<sup>4</sup> Harris MI. Racial and Ethnic Differences in Health Insurance Coverage for Adults with Diabetes. *Diabetes Care*, October 1999, 22(10):1679-82.

<sup>5</sup> Cohen M. An Overview of Medicaid Enrollees with Diabetes in 2003. (Washington, DC: Kaiser Commission on Medicaid and the Uninsured), October 2007.

<sup>6</sup> Wilper AP, Woolhandler S, Lasser K, et al. A national study of chronic disease prevalence and access to care in uninsured U.S. adults. *Ann Intern Med.* 2008 August, 149(3):170-6.

<sup>7</sup> See MEPS documentation available at

[http://meps.ahrq.gov/mepsweb/data\\_stats/download\\_data/pufs/h128/h128doc.shtml#Appendix4](http://meps.ahrq.gov/mepsweb/data_stats/download_data/pufs/h128/h128doc.shtml#Appendix4) for a list of priority conditions.

This publication (#8383\_D) is available on the Kaiser Family Foundation’s website at [www.kff.org](http://www.kff.org).

The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid’s role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation’s Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission’s work is conducted by Foundation staff under the guidance of a bipartisan group of national leaders and experts in health care and public policy.