

Medicaid Is an Important Driver of a Healthier North Carolina, But Not Enough to Dismantle Persistent Health Inequities

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Medicaid expansion has improved coverage for low-income North Carolinians, but persistent racial and geographic inequities limit its impact. Despite early gains and innovative social-care pilots, Black and Hispanic communities continue to face barriers to access, continuity, and outcomes. Lasting improvement will require sustained investment in primary care, navigation support, and the social factors that shape health.

North Carolina's Medicaid Program Has Undergone Several Major Shifts in Just a Few Years

In July 2021, North Carolina shifted 1.6 million beneficiaries to Managed Care, adding expectations for screening social needs, integrating behavioral health, and coordinating services. The state also launched the Healthy Opportunities Pilots (HOP), regional 1115 Medicaid waiver programs that pay for nonclinical support such as food, housing navigation, transportation, and safety services.^{1,2} The pilots were designed to test whether meeting basic social needs could improve outcomes and reduce avoidable spending. HOP operated only in 3 designated regions—each led by a Network Lead selected through a competitive process—covering rural and high-inequity communities but excluding large portions of the state. Specifically, Impact Health led the Western Region, serving many rural, mountainous counties with high poverty and limited services; Access East/Community Care of North Carolina Triad Health Project led the Piedmont Triad Region, serving a mix of urban and rural communities experiencing significant social vulnerability; and Community Care of the Lower Cape Fear led the Southeastern Region, serving coastal and rural counties with substantial food insecurity, housing instability, and transportation needs. These pilots did not operate statewide, and the North Carolina Department of Health and Human Services (NCDHHS) notes that the Pilot regions include rural communities and communities in which members experience health inequities at high rates. Interim findings show promising results: HOP participation was linked to 6 fewer emergency department visits per 1000 members, 2 fewer monthly inpatient admissions per 1000 non-pregnant adults, and lower overall health care expenditures compared with expected trends.¹⁻³

A 2nd major shift came in 2023, when North Carolina became the 41st state to expand Medicaid, extending coverage to low-income adults beginning on December 1, 2023. By April 2025, roughly 650,000 people had enrolled. The state-launched, publicly accessible Medicaid Expansion Enrollment Dashboard shows that early enrollment data revealed notable demographic patterns: Black residents were represented in enrollment at a higher share (38.1%) than their share of the state's population, while Hispanic residents enrolled at a rate roughly proportional to their population share (9.8%) even though Latinos represented 1 in 3 uninsured North Carolinians prior to expansion. Data from early in the expansion also show that nearly a quarter of new expansion enrollees live in rural counties, demonstrating meaningful inroads into areas long underserved by health coverage, and that the policy rapidly reached populations historically more likely to be uninsured. However, parts of the state's expansion population now face uncertainty due to provisions in the 119th Congress' House Resolution 1 (the One Big Beautiful Bill Act), signed into law on July 4, 2025. And despite reports demonstrating the effectiveness of the HOP program, the North Carolina General Assembly failed to include ongoing funding for the program, including the request submitted by advocates to explore the feasibility of expanding HOP statewide.⁴ However, notwithstanding the current political challenges and uncertainties around Medicaid expansion in North Carolina, it is hard to ignore and imprudent to dismiss the benefits—realized and emergent—directly linked to expanding health care coverage to poor and historically medically-underserved and vulnerable populations.

Medicaid expansion, paired with social service pilots, offered a pathway to reducing long-standing access gaps for Black and Hispanic communities. Yet despite evidence showing HOP's effectiveness, the North Carolina General Assembly did not fund its continuation, leading the NCDHHS to end the program on July 1, 2025.⁴ In this commentary, we examine how Medicaid expansion intersects with persistent racial, ethnic, and geographic inequities—focusing on Black maternal health, gaps in coverage and access for Latino communities, rural versus urban disparities, and ongoing challenges such as administrative churn and care fragmentation.

Gaps in Access Remain Obstinate Despite the Benefits of Expansion

Despite North Carolina's 2023 Medicaid expansion and strong initial enrollment, Black and Hispanic populations continue to face substantial barriers to care, including limited access to primary and preventive services, persistent disparities in mental health, opioid use disorder, maternal health, provider shortages, long wait times, transportation, administrative churn, coverage instability, and incomplete race/ethnicity data. Nationally, Hispanic adults with Medicaid are less likely than White Non-Hispanic adults to have

a usual source of care or receive regular checkups, and Non-Hispanic Black and Hispanic beneficiaries are less likely to receive treatment for depression, opioid use disorder, and postpartum care. While expansion improves access, gains are often smaller for Black and Hispanic adults, and durable health disparities remain.⁵⁻¹⁰ Insurance expansion must be coupled with system-level strategies that strengthen primary care, streamline treatment pathways, remove financial barriers, and ensure culturally and linguistically appropriate support.

Policy Uncertainty

North Carolinians waited 13 years before the North Carolina General Assembly signed on as the 41st state to expand Medicaid coverage to uninsured low-income individuals. However, 2 years later (2025) the gains made through this sagacious action now face national and state policy uncertainties. Proposed federal actions, including efforts to condition Medicaid coverage on work requirements and lower the federal match rate for expansion populations, increase the risk that states could lose funding or be forced to scale back enrollment for some of the state's most medically fragile and vulnerable populations. At the same time, Affordable Care Act (ACA) Marketplace premiums are rising nationwide, increasing the cost of coverage for individuals who may not qualify for Medicaid or who experience coverage churn. Together, these pressures would strain states like North Carolina and could reverse recent gains in insurance coverage and access to care.

Medicaid Expansion and Coverage Gains for Hispanic and Black Populations

Before expansion, Hispanic individuals in North Carolina were disproportionately uninsured. Census and state data indicate that roughly 1 in 3 Hispanic adults lacked health insurance prior to expansion, compared with 1 in 11 Black adults and 1 in 17 White non-Hispanic adults, underscoring the depth of baseline inequities. National evidence shows that Medicaid expansion has led to substantial coverage gains for Hispanic and Black populations, with coverage among low-income adults in expansion states increasing by 16.2 percentage points for Hispanic adults and 11.2 percentage points for Black adults compared to non-expansion states.⁵ Although North Carolina has not yet released race- or ethnicity-specific pre/post expansion uninsured rates, early enrollment data show that Black adults enrolled at disproportionately high rates (38.1% of early enrollees), while Hispanic/Latino adults enrolled at rates roughly aligned with their population share (9.8%). Taken together, these patterns suggest meaningful—but uneven—progress in closing long-standing coverage gaps for communities of color. Beyond coverage gains, Medicaid expansion has improved access to routine and preventive care—more adults in expansion

Table 1. Key Health Disparities in North Carolina: Findings From the 2024 America’s Health Rankings Annual Report

Indicator	Key Findings
Maternal Mortality	American Indian/Alaska Native, Black, and Hawaiian/Pacific Islander women have mortality rates 2.5–4.5 times higher than other groups.
Infant Mortality Trends (2008–2011 to 2018–2021)	Infant mortality improved for infants born to White mothers (15% decrease), Black mothers (12% decrease), and Hispanic mothers (9% decrease).
Low Birth Weight	Infants born to Black mothers have 2.1 times higher rates of low birth weight compared to infants born to White mothers.
Severe Maternal Morbidity (2020)	Rates were 2.0 times higher for Black mothers compared with White mothers, and 1.5 times higher compared with Hispanic mothers.
Prevalence of two or more adverse childhood experiences (ACEs)	Black children (0-17) have 24.1% prevalence of two or more ACEs vs Asian children (1.5%). That is a 16.1-fold difference.
Uninsured	Black: 8.8%, Hispanic: 26.9%, White: 6.2%, Multi racial: 14.7%, Asian: 5.7%, American Indian/AK Native: 15.7%

Source: America’s Health Rankings¹⁵

states report having a usual source of care, delaying care less often due to cost, and receiving regular screenings and chronic disease management more reliably.^{5,7,8,11,12}

Medicaid expansion has led to over a 10% reduction in preventable hospitalizations and emergency department visits for Black adults compared to White adults. However, mortality reductions for Black populations occurred in urban, but not rural, communities, underscoring persistent place-based inequities despite coverage gains.^{7,13}

Maternal mortality and morbidity in North Carolina remain stubbornly high, reflecting deep social, economic, and structural inequities. The United Health Foundation’s America’s Health Rankings® Maternal and Infant Health Disparities Data Brief (2024) shows that Black, American Indian/Alaska Native, and other historically marginalized communities continue to experience disproportionate maternal and infant deaths and poor outcomes—even when they have health care coverage.¹⁴ (See findings in [Table 1](#)). Despite Medicaid expansion in North Carolina, recent data show little improvement in the health and well-being of Black mothers and their children. From 2014 to 2023, non-Hispanic Black and American Indian children consistently had higher mortality rates than other groups, and by 2023, Black infants were dying at 3 times the rate of White infants. While Black maternal mortality remains a critical concern, Medicaid programs still hold significant potential to advance racial equity in care and outcomes during pregnancy and the postpartum period.

Health Care Coverage Alone Is Not Enough

Health care coverage is essential, but coverage alone cannot eliminate longstanding health inequities. Even with Medicaid, Hispanic adults remain less likely than White adults to have a usual source of care, receive routine checkups, or have their blood pressure monitored, and Black and Hispanic beneficiaries are less likely to receive timely treatment for depression, opioid

use disorder, or postpartum needs.^{5,7,16,17} These gaps contribute to preventable crises in maternal health, mental health, and overdose. Many of these gaps stem from limited system capacity: Black and Hispanic communities often face clinician shortages, long waits, inadequate after-hours care, and transportation barriers—conditions especially pronounced in rural North Carolina and historically disinvested urban neighborhoods.^{3,5,14}

Administrative barriers also limit Medicaid’s ability to improve outcomes for Hispanic and Black populations. After North Carolina’s shift to Managed Care, many enrollees reported being automatically assigned to plans with little explanation or support: over 1 in 8 said they lacked enough information about plan options, and nearly 1 in 5 received no help choosing a plan.¹⁸ Early in the transition, new Medicaid Managed Care enrollees had 7% fewer primary care visits than privately insured patients, suggesting confusion or disengagement with a system intended to enhance access.¹⁸ Administrative churn remains a major problem, and Black and Hispanic enrollees are more likely to lose Medicaid when small income changes push them over eligibility thresholds—an “enrollment cliff” that leads to sudden loss of coverage, higher costs, and reduced use of outpatient care and prescriptions.¹⁷ This instability disrupts treatment for chronic disease, mental health conditions, and substance use. Finally, states—including North Carolina—still lack complete and accurate race and ethnicity data for Medicaid enrollees’ access to care.^{6,11,17} Without reliable data, it is difficult to identify where disparities are greatest or hold Managed Care plans accountable. These gaps show that while Medicaid expansion has increased coverage, further efforts are needed to strengthen primary care access, treatment pathways, and navigation support for Black and Hispanic communities.

Place-Based Inequities: Where People Live Shapes Access to Care

Across North Carolina, both rural isolation and urban disinvestment shape whether people can meaningfully access care, not only whether they are formally eligible for it. Where people live profoundly influences their ability to obtain needed services. Many rural counties, including those with large Black populations, continue to face severe primary care shortages, limited behavioral health services, and substantial transportation barriers.¹⁷ Children in these communities experience more frequent interruptions in Medicaid coverage, particularly in counties with lower high school graduation rates and higher social vulnerability.^{16,19,20}

During the COVID-19 pandemic, Medicaid enrollment rose most in counties with the greatest hardship, yet many eligible residents still did not enroll, reflecting persistent outreach and navigation barriers. In urban neighborhoods shaped by decades of segregation and redlining, Medicaid expansion reduced uninsurance, especially for Black adults, but coverage rates still lag behind those in better-resourced areas.²⁰

Taken together, both rural isolation and urban disinvestment continue to determine who can meaningfully use Medicaid, not just who qualifies for it.

Ongoing Barriers to Medicaid Enrollment Unique for Hispanic and Latino Communities

Despite Medicaid expansion, Hispanic and Latino individuals continue to face substantial barriers to enrolling and staying enrolled. In North Carolina, many eligible Latino residents remain unenrolled due to limited language access, lack of provider concordance, misinformation, and immigration-related fears—challenges that particularly affect mixed-status families and US-born children.²¹ Language barriers, immigration-related fears, mistrust, and complex paperwork keep many Hispanic residents who are eligible for Medicaid from enrolling, and similar administrative challenges contribute to coverage churn among Black adults.^{6,17,19,22-24}

Coverage disruptions are frequent among Hispanic children, even with 12-month continuous eligibility, as confusing reenrollment processes and limited language support lead to gaps in care.^{19,21-23} These breaks contribute to missed care and delayed diagnoses.

Even when insured, Hispanic adults are less likely than White adults to have a usual source of care and more likely to report unmet health needs, reflecting shortages of bilingual/bicultural providers, mistrust from prior discrimination, and transportation and access barriers in rural areas.^{5,19} For mental health specifically, the lack of language-matched services decreases service quality and discourages racial and ethnic minoritized populations from initiating and engaging in treatment. National studies consistently demonstrate lower mental health service use among Hispanic/Latino adolescents compared with White adolescents. A 2023 analysis identified significantly lower treatment use across provider types and settings, and subsequent 2022–2023 data indicate that only 25.6% of Hispanic adolescents received any mental health visit (versus 31.7% of non-Hispanic White adolescents), alongside lower telemental health utilization (12.0% versus 17.0%).^{20,24,25} El Futuro is recognized as an innovative community-based mental health organization serving Spanish-speaking, uninsured individuals in North Carolina with culturally responsive programming, but there are limited numbers of mental health practitioners who speak Spanish in the state and provide access to people on Medicaid.

The Role of Community Organizations and Community-Engaged Programs in Connecting People to Resources and Health Systems

Community-based organizations and community-engaged programs are essential to improving enrollment and navigation. In North Carolina, multisector coalitions like LATIN-19 and initiatives such as Salud (Hispanic Federation) strengthen language access, culturally informed communication,

and policy advocacy.²⁶ Duke's Fostering Insurance Enrollment among Latinos in North Carolina (FIEL-NC) program further supports Latino communities through culturally tailored, Spanish-language workshops delivered by community health workers, helping participants understand insurance options and make informed coverage decisions.

Community health worker and parent mentor programs are among the most effective strategies for improving Medicaid enrollment and care navigation, particularly for Hispanic and Black populations. They counter misinformation, address public charge fears, and increase satisfaction with care.^{5,6,21-23,27-29}

Navigator-led, Spanish-language education programs significantly improve health insurance literacy and are critical for accessing preventive care and reducing cost-related delays, while culturally concordant facilitators help build trust.^{30,31}

Public-private partnerships, health departments, and community-based organizations have expanded tailored outreach during the end of continuous coverage protections. Federally Qualified Health Centers embedding outreach workers or AmeriCorps members enroll nearly 3 in 4 uninsured children in Medicaid or CHIP, compared with about 1 in 4 under usual practice, demonstrating the impact of integrated case-management approaches.^{32,33}

As artificial intelligence (AI) tools become more embedded in health care and public health, some have suggested that technology could replace community engagement because it is cheaper, scalable, and always available. Yet this perspective misunderstands what engagement provides. Community engagement is rooted in trust, lived experience, cultural context, and accountability—qualities that no algorithm can replicate. AI systems, when developed without community input, often miss the realities of marginalized populations and risk amplifying existing inequities. Community health workers, promoters, navigators, and patient-family councils remain essential not only for enrollment and navigation but also for countering misinformation and addressing medical mistrust. Rather than replacing this workforce, AI should support it by reducing administrative burden and reinforcing human connection. Health systems that rely on technology without genuine engagement ultimately jeopardize trust and undermine the very goals AI aims to advance.³⁴

What North Carolina Should Do Next

North Carolina made great strides and took steps that many states are still debating. It has expanded Medicaid and temporarily linked Medicaid to social support through the HOP. In addition, it began to respond to language access and outreach needs through community partnerships. But to move from improvement to durability, the state will need to:

- Reassess discontinuation of HOP and, at minimum, apply lessons learned to build a statewide approach linking social needs to health outcomes.
- Invest in health navigators—Community Health Workers (CHWs), bilingual navigators, and parent mentors—as core components of Medicaid, recognizing that access requires active support, not just coverage.
- Stabilize coverage, especially in rural communities, by simplifying renewals, reducing administrative churn, and addressing the eligibility cliff that disproportionately affects Black and Hispanic adults.
- Build a system that incentivizes, stabilizes, and scales health care providers in rural communities that are health care deserts.
- Expand early prevention services, including doula and midwifery care, particularly in rural areas.
- Increase chronic disease education for pregnant people to help mitigate hypertension, diabetes, and other preexisting conditions.
- Strengthen primary care and behavioral health access by increasing primary care investment from 5% to 12% of total medical spending and by expanding capacity in rural and historically under-resourced urban areas, as recommended by the North Carolina Primary Care Payment Reform Task Force.
- Improve race and ethnicity data collection across Medicaid enrollment, renewals, and managed care plans, and routinely report plan- and region-level progress in closing gaps.
- Scale effective models, including culturally and linguistically aligned behavioral health services and integrated care approaches.

North Carolina has demonstrated that progress is possible; the next step is ensuring these gains are stable, measurable, and equitably shared across all communities.

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