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Closing the Gap: Past Performance of Health Insurance in Reducing Racial and Ethnic Disparities in Access to Care Could Be an Indication of Future Results

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Abstract This historical analysis shows that in the years just prior to the Affordable Care Act's expansion of health insurance coverage, black and Hispanic working-age adults were far more likely than whites to be uninsured, to lack a usual care provider, and to go without needed care because of cost. Among insured adults across all racial and ethnic groups, however, rates of access to a usual provider were much higher, and the proportion of adults going without needed care because of cost was much lower. Disparities between groups were narrower among the insured than the uninsured, even after adjusting for income, age, sex, and health status. With surveys pointing to a decline in uninsured rates among black and Hispanic adults in the past year, particularly in states extending Medicaid eligibility, the ACA's coverage expansions have the potential to reduce, though not eliminate, racial and ethnic disparities in access to care.

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OVERVIEW

Before the Affordable Care Act (ACA) spurred major expansions in health insurance coverage, black and Hispanic working-age adults were far more likely than whites to be uninsured.[1] While these minority groups still have higher uninsured rates than whites, the share of blacks and of Hispanics with coverage increased after the ACA's initial open enrollment period ended in the spring of 2014, with some of the biggest gains occurring in states that expanded eligibility for their Medicaid programs.[2] Early evidence also shows an overall increase in the likelihood of working-age adults with a personal health care provider, and a decrease in the percentage of adults who could not afford to pay their medical bills.[3]

To gauge the narrowing of racial and ethnic disparities in health care access and affordability that could result from insurance coverage expansion, we analyzed historical differences among white, black, and Hispanic adults. We analyzed two measures: not having a usual source of care, and going without needed care because of cost among adults ages 18

to 64 in 2012 and 2013—the two years leading up to major expansions in insurance coverage under the ACA. We looked at differences among the three racial and ethnic groups overall as well as differences by insurance status, taking into account income, age, sex, and health status. (For more information on our approach, see How We Conducted Our Study.)

Our analysis shows that having health insurance indeed reduces racial and ethnic disparities in key measures of health care access and affordability, even after adjusting for income and other factors. Still, even with coverage, Hispanics are less likely than both whites and blacks to have a usual source of care. Having health insurance makes it easier to gain access to and afford care,[4] but insurance alone is unlikely to eliminate differences in access among all groups.

Closing the gaps that remain among the insured will likely require efforts not only to connect Hispanics and other newly insured individuals to health services, but also to ensure that health plans provide enrollees with adequate benefits and that enrollees have protection from steep deductibles and other high out-of-pocket costs. Ensuring equitable access to health care, however, will likely be all the more difficult in the 22 states that, as of February 2015, have declined to expand Medicaid. Moreover, the gains already attained could be reversed if legal challenges succeed in eliminating premium subsidies for low- and middle-income adults in the 34 states with federally run insurance marketplaces.

RESEARCH FINDINGS IN DETAIL

Blacks and Hispanic Adults Less Likely to Have Insurance

Historically, uninsured rates within the working-age population have been much higher for blacks and Hispanics than for whites. In 2013, the year before the ACA's major coverage expansions took effect, more than one of five blacks ages 18 to 64 (22%) and one of three Hispanics (33%) did not have health insurance, compared with one of seven whites (14%) (Exhibit 1).

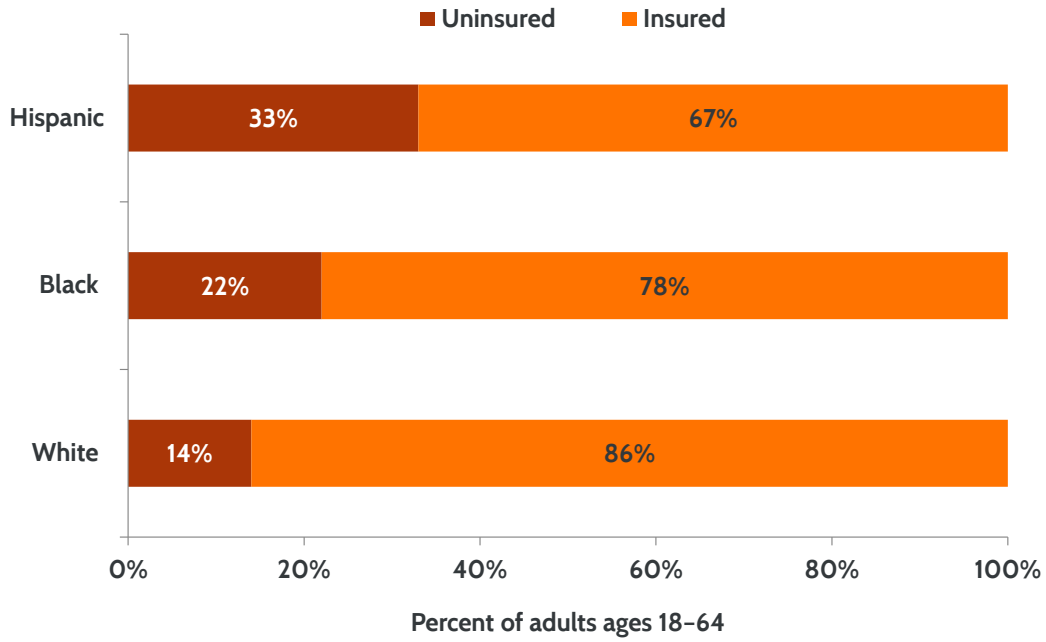
Before the ACA's coverage expansions, uninsured rates were also highest among adults with low incomes. And black and Hispanic adults are disproportionately more likely than whites to have low incomes. In 2013, among adults ages 18 to 64, nearly half of Hispanics and of blacks had incomes below 200 percent of poverty, compared with less than one-quarter of whites.[5]

Blacks and Hispanics More Likely to Lack Usual Source of Care and Go Without Care Because of Cost

Having a usual source of care—one or more people identified as one's personal doctor or health care provider—has been shown to be an important link to primary and preventive care services and better health outcomes.[6] Yet in 2012–13, more than one-quarter of black adults ages 18 to 64 (27%) and more than two-fifths of Hispanics (43%) reported not having a usual source of care, compared with just over one-fifth of whites (21%).

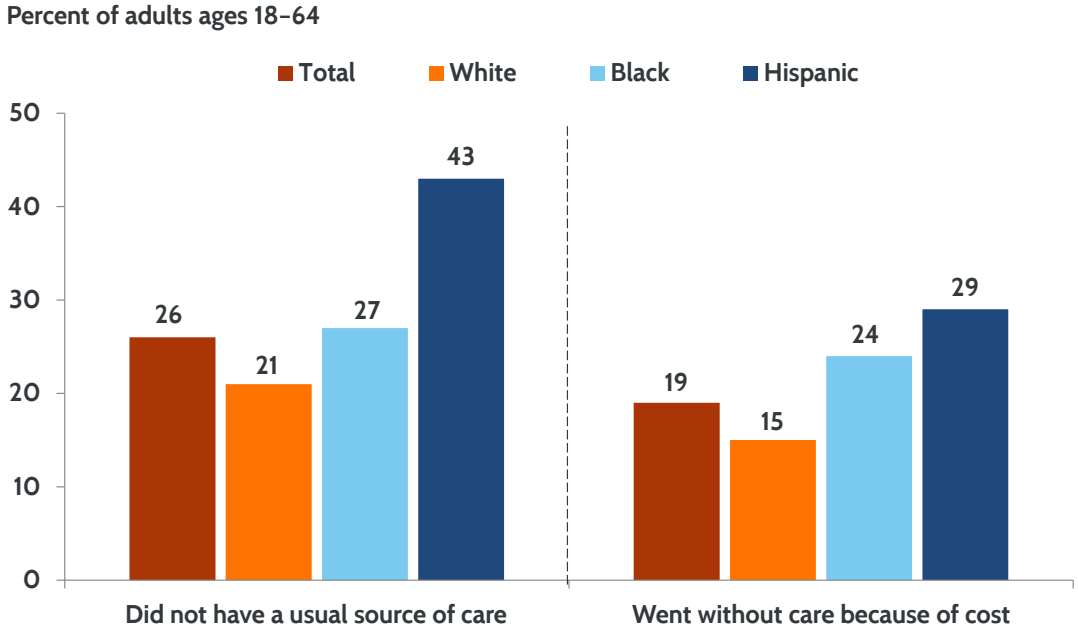
Black and Hispanic working-age adults also reported a time in the past year when they could not see a health care provider when needed because of cost at rates one-and-a-half to nearly two times as high as whites (Exhibit 2).

Exhibit 1. Uninsured Rates for Blacks and Hispanics Are One-and-a-Half to Two Times Higher Than for Whites (2013)



Notes: Black and white refer to black and white non-Hispanic populations. Hispanics may identify as any race.
Source: U.S Census Bureau, Community Population Survey, Annual Social and Economic Supplement (CPS ASEC), collected in 2014.

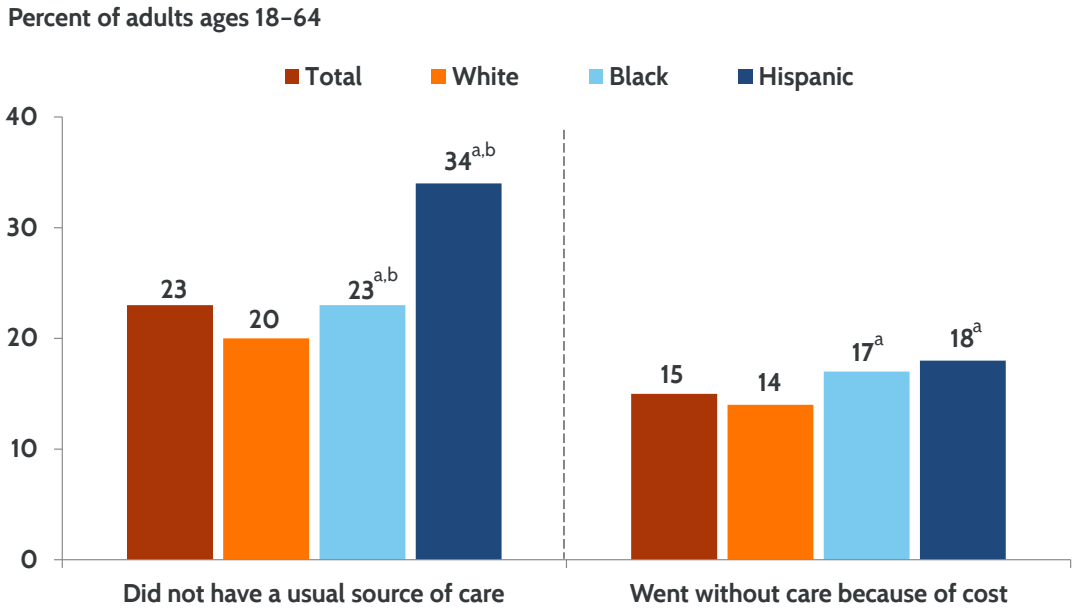
Exhibit 2. Blacks and Hispanics Are More Likely Than Whites to Lack a Usual Source of Care and Go Without Care Because of Cost (2012–13)



Notes: Black and white refer to black and white non-Hispanic populations. Hispanics may identify as any race.
Source: 2012 and 2013 Behavioral Risk Factor Surveillance Survey (BRFSS).

After we adjusted for respondents' income, age, sex, and health status, the gaps between white and minority adults on these two measures of health care access narrowed. However, the disparities persisted (Exhibit 3).

Exhibit 3. Disparities in Health Care Access by Race or Ethnicity Persist Even After Accounting for Income and Other Factors (2012–13)



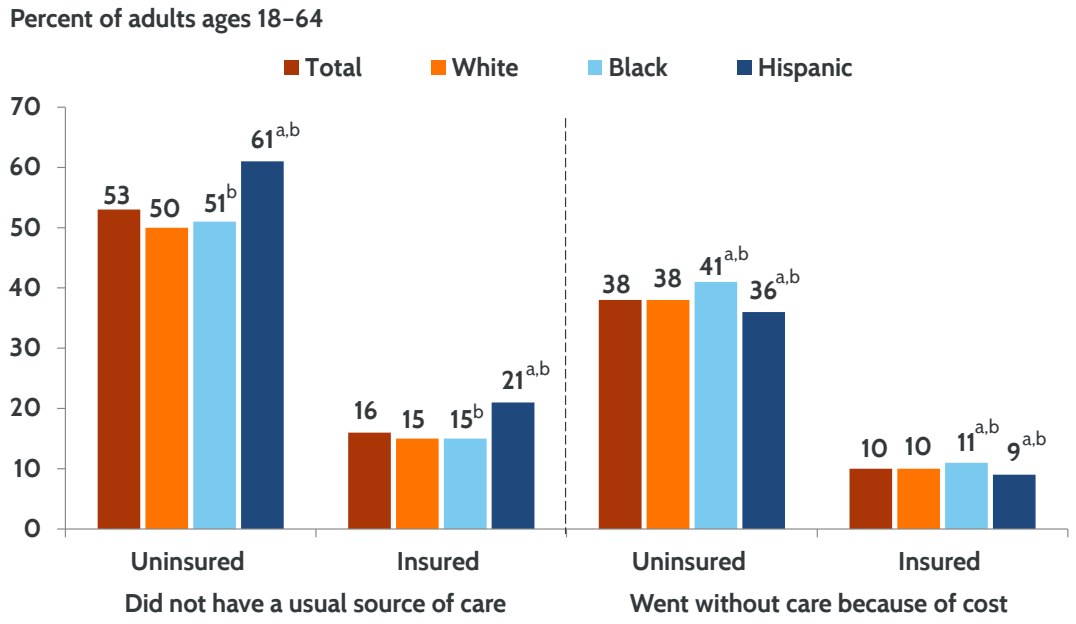
Notes: Black and white refer to black and white non-Hispanic populations. Hispanics may identify as any race. Adjusted means controlled for respondents' age, sex, health status, and income. Differences are statistically significant at the 0.05 level: (a) minority population compared with white; (b) black compared with Hispanic.
Source: 2012 and 2013 Behavioral Risk Factor Surveillance Survey (BRFSS).

Insurance Dramatically Improves Access to Care and Reduces Racial and Ethnic Disparities

We also measured the independent effect of insurance on disparities after adjusting for income, age, sex, and health status. Our results indicate that by itself, insurance had a large impact on whether working-age adults had a usual source of care and could afford care when needed in 2012–13. Within all racial and ethnic groups, uninsured adults reported not having a usual source of care and going without care because of cost at rates roughly three to four times higher than among insured adults.

Disparities between racial and ethnic groups were narrower among individuals with insurance compared to those without. However, despite being less connected to a usual care provider, Hispanics reported a lower rate of forgone care than whites and blacks (Exhibit 4).

Exhibit 4. Insurance Dramatically Improves Access to Care and Reduces Racial and Ethnic Disparities, Even After Accounting for Income and Other Factors (2012–13)



Notes: Black and white refer to black and white non-Hispanic populations. Hispanics may identify as any race. Adjusted means controlled for respondents' age, sex, health status, and income. Differences are statistically significant at the 0.05 level: (a) minority population compared with white; (b) black compared with Hispanic.
Source: 2012 and 2013 Behavioral Risk Factor Surveillance Survey (BRFSS).

POLICY IMPLICATIONS

Our analysis shows that while health insurance may not be the great equalizer, it does help reduce inequity. While black and Hispanic working-age adults faced much greater barriers to gaining access to and affording health care than their white counterparts in 2012–13, we found smaller differences among those with insurance coverage, even after we adjusted for income, age, sex, and health status.

These results highlight the potential for the ACA's major coverage expansions to improve access to a usual care provider among millions of black and Hispanic Americans, and reduce the likelihood that they will go without care because of cost. Gains in access may already be under way, as several key surveys have recorded a drop in the share of working-age blacks and Hispanics who were uninsured in 2014 compared with 2013.[7]

However, our findings also suggest that insurance coverage alone will not eliminate disparities in health care access. In the two years before the ACA's major coverage expansions, even insured Hispanic adults were more likely than insured white and black adults to lack a usual source of care.

Previous expansions of insurance coverage support the implications of our findings for the ACA's reforms. After Massachusetts achieved near-universal coverage, for example, the share of Hispanic adults with a personal provider rose—but still remained lower than the share of white adults with a personal provider.[8]

Historically, black and Hispanic adults also have been much more likely than whites to lack health insurance and to live in poverty, which puts these groups at risk of persistent health inequities. Even after insurance levels the playing field, other factors remain, including deep-seated historical inequities and pervasive cultural barriers, which the health care system alone cannot address. The slightly lower rates of forgone care because of cost among both uninsured and insured Hispanics

compared with blacks and whites, for example, could reflect different cultural perceptions as to when a doctor's visit is needed.[9]

Gaps in the ACA's coverage expansions—and differences in Medicaid expansion across states—also are leaving millions of very-low-income adults uninsured. The Commonwealth Fund Affordable Care Act Tracking Survey, conducted after the first open enrollment period, found the uninsured rate among Latinos statistically unchanged in states that had not expanded Medicaid.[10]

Uninsured blacks with incomes that would make them eligible for Medicaid under the law are more likely to live in the 22 states that have not yet chosen to expand their Medicaid programs.[11] What's more, several states with some of the largest black or Hispanic populations—Florida, Georgia, North Carolina, Texas, and Virginia—are also among the 34 states relying on the federal government to run their health insurance marketplace. This month, the Supreme Court heard oral arguments in *King v. Burwell,* a lawsuit challenging the legality of providing federal subsidies to low- and middle-income people who buy coverage in federally facilitated marketplaces. A ruling for the plaintiffs could put affordable coverage options at risk for large numbers of black and Hispanic adults.[12]

Despite the limitations of the ACA, maximizing its potential to narrow disparities in access to care among minority adults is important. Targeted culturally and linguistically appropriate programs that strive to ensure that coverage leads to better access to care could help. One example is the Centers for Medicare and Medicaid Services' Coverage to Care initiative, which offers outreach tools in Spanish and English to help newly insured people connect to the health care system and take full advantage of primary and preventive services.[13]

Ensuring that newly acquired coverage comes with adequate benefits and financial protection is also important. The ACA requires individual and small-group plans to cover essential health benefits, sets annual limits on out-of-pocket spending, and offers cost-sharing subsidies to people with low incomes who purchase silver-level plans in the marketplaces. However, the growing trend toward higher deductibles, copayments, and coinsurance puts even insured adults—especially those with low or moderate income—at risk of forgoing needed care because of cost.[14]

While insurance coverage holds tremendous potential to reduce disparities in access to care among blacks and Hispanics, much work needs to be done to ensure that coverage translates into improved access to care among these adults. Existing inequities suggest the need for additional efforts to maximize the contribution of insurance coverage to achieving equitable access to health care for all.

HOW WE CONDUCTED OUR STUDY

This brief draws on the 2012–2013 Behavioral Risk Factor Surveillance System (BRFSS), an annual survey conducted by the Centers for Disease Control and Prevention in partnership with state governments. The surveys included landline and cellular telephone interviews with more than 400,000 adults age 18 and older across all 50 states. In performing our analysis, we combined two years of data to ensure an adequate sample size in each of the socioeconomic strata, including income, race and ethnicity, and insurance status. We restricted our analysis to adults under age 65.

BRFSS asks adults whether they did not visit a doctor when needed within the previous 12 months because of costs, and whether they have one or more than one person they think of as their personal doctor or health care provider.

Our analysis classifies respondents' socioeconomic (SES) characteristics as follows:

- Race/ethnicity: white (non-Hispanic), black (non-Hispanic), or Hispanic (any race).
- Income in three income groups:
    1. Low income: below 200 percent of the federal poverty level (income in 2012 of less than $22,340 if single, or less than $46,100 for a family of four).
    2. Middle income: 200 percent to 399 percent of poverty (income in 2012 of $22,340 up to $44,680 if single, or $46,100 to $92,200 for a family of four).
    3. Higher income: 400 percent of poverty or higher (income in 2012 at or above $44,680 if single, or $92,200 for a family of four).
- Insurance status: insured or not at the time of the questionnaire.

Exhibit 2 reports unadjusted point estimates, stratified by race/ethnicity. Exhibits 3 and 4 report adjusted means, to account for differences in respondents' age, sex, income, and health status. We adjusted estimates using survey-design adjusted logistic regressions in Stata (v.12.1).

Unadjusted point estimates were still subject to uncertainty because of the sample design. Each estimate has survey design–adjusted 95 percent confidence intervals of about 1 to 2 percentage points. Statistical significance associated with SES-adjusted point estimates is noted in Exhibits 3 and 4.

NOTES

[1] Authors' analysis of data from the Current Population Survey, prepared using the online CPS Table Creator tool. See also S. R. Collins, P. W. Rasmussen, M. M. Doty, and S. Beutel, *The Rise in Health Care Coverage and Affordability Since Health Reform Took Effect—Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2014* (New York: The Commonwealth Fund, Jan. 2015); S. R. Collins and P. W. Rasmussen, "New Federal Surveys Show Declines in Number of Uninsured Americans in Early 2014," *The Commonwealth Fund Blog,* Sept. 16, 2014; B. D. Sommers, T. Musco, K. Finegold et al., "Health Reform and Changes in Health Insurance Coverage in 2014," *New England Journal of Medicine,* Aug. 28, 2014 371(9):867–74; M. M. Doty, P. W. Rasmussen, and S. R. Collins, *Catching Up: Latino Health Coverage Gains and Challenges Under the Affordable Care Act—Results from the Commonwealth Fund Tracking Survey* (New York: The Commonwealth Fund, Sept. 2014); and S. R. Collins, P. W. Rasmussen, and M. M. Doty, *Gaining Ground: Americans' Health Insurance Coverage and Access to Care After the Affordable Care Act's First Open Enrollment Period* (New York: The Commonwealth Fund, July 2014).

[2] Collins, Rasmussen, Doty et al., *Rise in Health Care Coverage and Affordability,* 2015; Collins and Rasmussen, "New Federal Surveys Show Declines," 2014; Doty, Rasmussen, and Collins, *Catching Up: Latino Health Coverage Gains,* 2014; Sommers, Musco, Finegold et al., "Health Reform and Changes in Health Insurance Coverage," 2014; and Collins, Rasmussen, and Doty, *Gaining Ground: Americans' Health Insurance Coverage and Access,* 2014.

[3] Collins, Rasmussen, Doty et al., *Rise in Health Care Coverage and Affordability,* 2015; and Sommers, Musco, Finegold et al., "Health Reform and Changes in Health Insurance Coverage," 2014.

[4] National Research Council, *America's Uninsured Crisis: Consequences for Health and Health Care* (Washington, D.C.: National Academies Press, 2009).

[5] Authors' analysis of data from the Current Population Survey, prepared using the online CPS Table Creator tool. Share of adult population ages 18 to 64 with incomes below 200 percent of poverty by race and ethnicity in 2013: Hispanics, 48 percent; non-Hispanic blacks, 45 percent; non-Hispanic whites, 23 percent.

[6] M. K. Abrams, R. Nuzum, S. Mika, and G. Lawlor, *Realizing Health Reform's Potential: How the Affordable Care Act Will Strengthen Primary Care and Benefit Patients, Providers, and Payers* (New York: The Commonwealth Fund, Jan. 2011); and J. Berenson, M. M. Doty, M. K. Abrams, and A. Shih, *Achieving Better Quality of Care for Low-Income Populations: The Role of Health Insurance and the Medical Home for Reducing Health Inequities* (New York: The Commonwealth Fund, May 2012).

[7] J. Levy, "In U.S., Uninsured Rate Sinks to 12.9%," (Washington, D.C.: Gallup, Jan. 7, 2015); Collins and Rasmussen, "New Federal Surveys Show Declines," 2014; Sommers, Musco, Finegold et al., "Health Reform and Changes in Health Insurance Coverage," 2014; and Collins, Rasmussen, and Doty, *Gaining Ground: Americans' Health Insurance Coverage and Access,* 2014.

[8] J. Maxwell, D. E. Cortes, K. L. Schneider et al., "Massachusetts' Health Care Reform Increased Access to Care for Hispanics, But Disparities Remain," *Health Affairs,* Aug. 2011 30(8):1451–60.

[9] A. Machado, "Why Many Latinos Dread Going to the Doctor: How Cultural Barriers Can Be More Important Than Income," *The Atlantic,* May 7, 2014; B. O'Hara and K. Caswell, *Health Status, Health Insurance, and Medical Services Utilization: 2010* (Washington, D.C.: Current Population Reports, U.S. Census Bureau, July 2013); and G. Livingston, S. Minushkin, and D. Cohn, *Hispanics and Health Care in the United States: Access, Information and Knowledge* (Washington, D.C., and Princeton, N.J.: Pew Hispanic Center and Robert Wood Johnson Foundation, Aug. 2008).

[10] Doty, Rasmussen, and Collins, *Catching Up: Latino Health Coverage Gains,* 2014; and Collins, Rasmussen, and Doty, *Gaining Ground: Americans' Health Insurance Coverage and Access,* 2014.

[11] L. Clemans-Cope, M. Buettgens, and H. Recht, *Racial/Ethnic Differences in Uninsurance Rates Under the ACA: Are Differences in Uninsurance Rates Projected to Narrow?* (Washington, D.C.: The Urban Institute, Dec. 2014); and Kaiser Commission on Medicaid and the Uninsured, *The Impact of Current State Medicaid Expansion Decisions on Coverage by Race and Ethnicity* (Washington, D.C.: Kaiser Family Foundation, July 2013).

[12] D. Blumenthal and S. R. Collins, "The Supreme Court Decides to Hear *King v. Burwell*: What Are the Implications?" *The Commonwealth Fund Blog,* Nov. 7, 2014.

[13] Centers for Medicare and Medicaid Services (CMS), press release: "CMS Initiative Helps People Make the Most of Their New Health Coverage," June 16, 2014.

[14] S. R. Collins, P. W. Rasmussen, M. M. Doty, and S. Beutel, *Too High a Price: Out-of-Pocket Health Care Costs in the United States—Findings from the Commonwealth Fund Health Care Affordability Tracking Survey, September–October 2014* (New York: The Commonwealth Fund, Nov. 2014); S. R. Collins, D. C. Radley, C. Schoen, and S. Beutel, *National Trends in the Cost of Employer Health Insurance Coverage, 2003–2013* (New York: The Commonwealth Fund, Dec. 2014); and C. Schoen, D. C. Radley, and S. R. Collins, *State Trends in the Cost of Employer Health Insurance Coverage, 2003–2013* (New York: The Commonwealth Fund, Jan. 2015).

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