RACE, ETHNICITY & HEALTH CARE

THE HENRY J. KAISER FAMILY FOUNDATION

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The Role of Health Coverage for Communities of Color

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Introduction

As 1 in 3 Americans self-identify as a member of a racial or ethnic minority group, and it is estimated that half of the U.S. population will be a person of color by 2045, there are significant health and economic consequences in eliminating, or failing to eliminate, disparities in access to health coverage and care.[1] People of color are disproportionately served by public programs like Medicaid, and are less likely than Whites to receive health coverage through their employer. In addition, of the 45.7 million nonelderly Americans who were uninsured in 2008, more than half (55%) are people of color. Furthermore, a recent report estimated that 30.6%, or $230 billion, of direct medical expenditures between 2003 and 2006 were excess costs due to health and health care inequalities incurred by racial and ethnic minorities.[2]

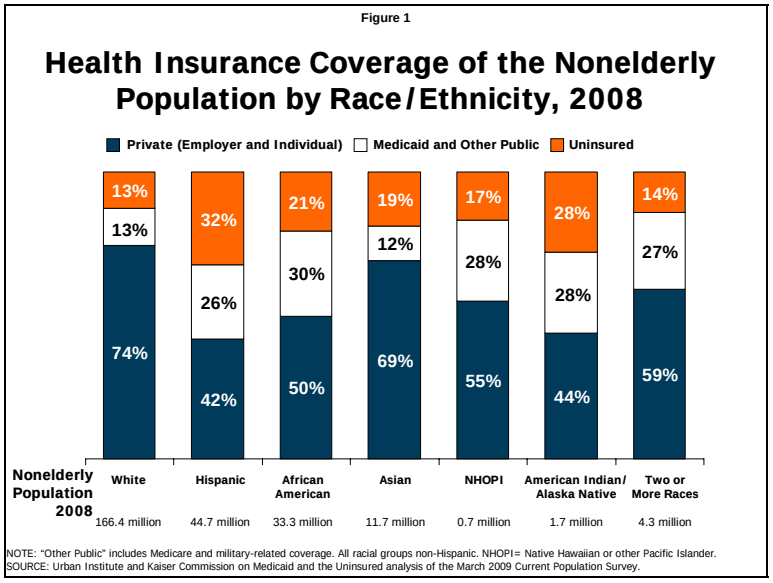
Lacking insurance can have negative impacts on an individual's health. Regardless of race or ethnicity, the uninsured are less likely to receive recommended preventive and primary care services, face significant barriers to care, and ultimately face worse health outcomes. People of color have the highest rates of a number of illnesses and conditions, including HIV/AIDS, diabetes, and heart disease, underscoring the importance of access to quality health coverage and care.[3]

The current health reform debate in this country focuses heavily on providing access to affordable health coverage for the millions of people who are uninsured. Proposals to expand public programs, including the introduction of a new public health insurance option, reforming the individual insurance market, and requiring all Americans to have health insurance, are all currently being explored. Any effort to expand coverage, alter current public programs, and/or create new public programs will have important consequences for the health of communities of color, who are more likely than Whites to be enrolled in public programs or to be uninsured.

This issue brief highlights variations in coverage by race and ethnicity and examines the role health coverage plays for communities of color. As the vast majority of elderly Americans receive their health coverage through the Medicare program, this brief focuses on the nonelderly population.

Health Insurance Status of Racial and Ethnic Groups

There is wide variation in the rates of health insurance coverage by race and ethnicity in the U.S. Among the nonelderly, Whites are the racial and ethnic group most likely to have health insurance (Figure 1). They are also more likely than any other racial or ethnic group to receive health coverage through the private insurance market. In contrast, with the exception of Asians, roughly 1 in 4 persons of each population of color receives coverage through Medicaid or other public programs.



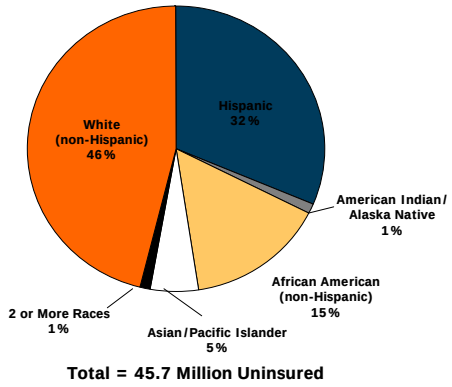
While most Americans receive health coverage through an employer, rates vary substantially by racial and ethnic group. Nearly three-quarters of nonelderly Whites and about 70% of Asians receive coverage through an employer compared with just over 40% of American Indians and Alaska Natives and Hispanics. Uninsured rates also vary by race and ethnicity. Thirty-two percent of Hispanics and 28% of American Indians and Alaska Natives are uninsured compared with 13% of Whites, 17% of Native Hawaiian or Other Pacific Islanders, and 14% of those who self-identify as two or more races.

Who are the Uninsured?

People of color comprise one-third of the U.S. population, but more than half of the uninsured. Of the 45.7 million nonelderly Americans lacking health insurance in 2008, more than half are racial and ethnic minorities. Though nearly half of the uninsured are White (Figure 2), their risk of being uninsured—along with individuals reporting two or more races—is below the national average (17%). In comparison, 1 in 4 people in the U.S. are either African American or Hispanic, but almost 1 in 2 uninsured individuals are African American or Hispanic. Nearly one-third of the nonelderly uninsured are Hispanic, and their risk of being uninsured is about three times that of Whites.

Figure 2

Distribution of the Nonelderly Uninsured by Race/Ethnicity, 2008

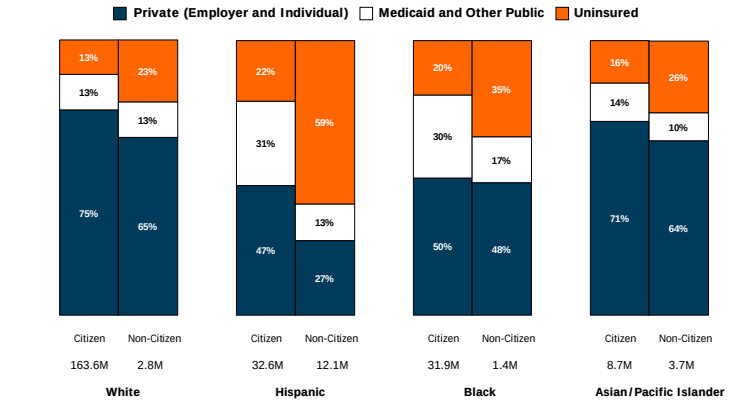


Total = 45.7 Million Uninsured

NOTE: American Indian group includes Aleutian Eskimos.
SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured analysis of the March 2009 Current Population Survey.

In the current health reform debate, there has been some focus on the insurance status of non-U.S. citizens, and the implications for the cost of health reform. Though there are differences in insurance coverage by citizenship status, the overall health insurance trends tend to mirror those of U.S. citizens, who constitute the majority of the U.S. population. For example, like the overall trend, both White and Asian American, Native Hawaiian and Other Pacific Islander citizens and non-citizens have the highest rates of private health insurance (Figure 3). With the exception of Asian American, Native Hawaiian and Other Pacific Islanders, about 1 in 3 U.S. citizens of color receives health coverage through Medicaid or other public programs. Additionally, Hispanic citizens have the highest uninsured rates (22%), followed closely by Blacks (20%). Among non-citizens, nearly 6 in 10 Hispanics, 1 in 3 Blacks, and about 1 in 4 Asian American, Native Hawaiian and Other Pacific Islanders and Whites lacked health insurance in 2008.

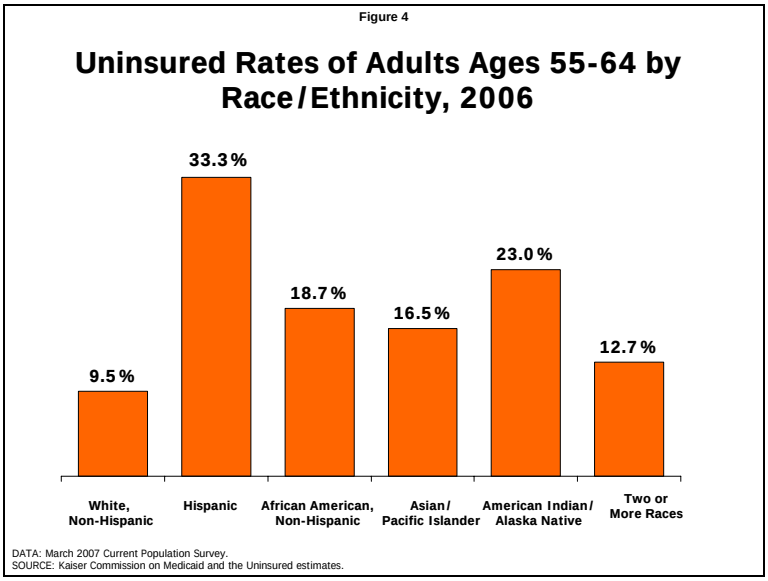
Figure 3



NOTE: "Other Public" includes Medicare and military-related coverage. All racial groups non-Hispanic. The sample sizes for American Indian/Alaska Native and individuals of two or more races were not large enough for reliable estimates.
SOURCE: Kaiser Family Foundation analysis of the March 2009 Current Population Survey.

Rates of health coverage vary across the age spectrum. In 2008, 4 million adults aged 55-64 were uninsured (13%) compared to about 7 million adults aged 19-24 (31%). While younger adults are more likely than older adults to be uninsured, older uninsured adults—especially the near-elderly (adults age 55-64)—are a particularly vulnerable group for incurring high medical costs or being unable to purchase insurance in the individual (non-group) market due to health status, as health problems tend to increase with age.[4] Among adults aged 55-64, people of color have higher rates of uninsurance than their White counterparts (Figure 4). Just over one-third of Hispanics aged 55-64 are uninsured compared to about 10% of Whites. These disparities have important consequences for the development and management of chronic conditions, and also for Medicare costs as many of the uninsured in this age group have unmet medical needs upon entering the Medicare program at age 65.[5]

Figure 4

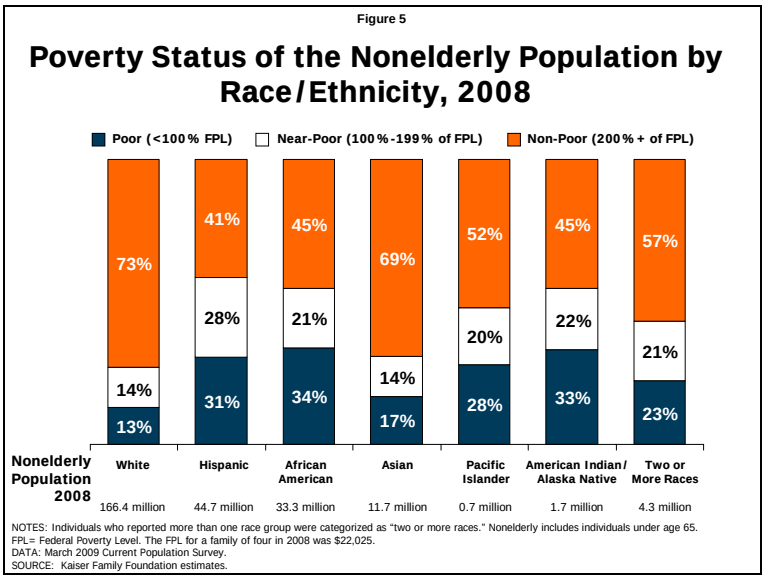


DATA: March 2007 Current Population Survey.
SOURCE: Kaiser Commission on Medicaid and the Uninsured estimates.

Why are Communities of Color at Higher Risk of Being Uninsured?

Rates of coverage vary substantially by income level, with poorer individuals less likely to have insurance. Individuals who have low-wage jobs are less likely to be offered coverage through their employers and less likely to take up coverage when offered. African Americans and Hispanics are more likely than Whites to work in low-wage jobs, and tend to have reduced access to employer-sponsored coverage relative to their higher-wage counterparts.[6] In 2008, over half of Hispanics, African Americans, and American Indians and Alaska Natives were poor or near poor compared with 27% of Whites and 31% of Asians (Figure 5). In 2008, the federal poverty level for a family of four was $22,025, and with the exception of Hawaii and Alaska, is the same regardless of the state of residence.[7]

Figure 5



NOTES: Individuals who reported more than one race group were categorized as "two or more races." Nonelderly includes individuals under age 65.
FPL= Federal Poverty Level. The FPL for a family of four in 2008 was $22,025.
DATA: March 2009 Current Population Survey.
SOURCE: Kaiser Family Foundation estimates.

For low-income workers who do not qualify for Medicaid or other public programs, the cost of premiums for employer-sponsored health insurance can be prohibitive. In 2008, for example, the average annual premium for family coverage was $12,680, and the average annual employee share of this premium was $3,354.[8] For a family of four earning an annual income of $22,025 per year (100% FPL), this equates to spending roughly 15% of income on health insurance premiums (Figure 6). This is on top of costs for housing, food and other household expenses. Additional wealth is also often necessary to pay out-of-pocket costs for medical expenses, including co-pays and prescription drugs.

Figure 6

Estimated Percent of Income Spent on Employee Share of Insurance Premiums by Poverty Status, 2008

FEDERAL POVERTY LEVEL	ANNUAL INCOME	AVERAGE ANNUAL WORKER PREMIUM* AS SHARE OF INCOME
100%	$22,025	15.2%
200%	$44,050	7.6%
300%	$66,075	5.1%

NOTE: *For covered workers. The average annual premium for family coverage was $12,680 in 2008; the average annual worker premium contribution paid by covered workers for family coverage was $3,354 in 2008. The federal poverty level for a family of four in 2008 was $22,025.
DATA: 2008 Poverty Thresholds. U.S. Census Bureau. Kaiser Family Foundation/HRET 2008 Employer Health Benefits Survey.
SOURCE: Kaiser Family Foundation estimates.

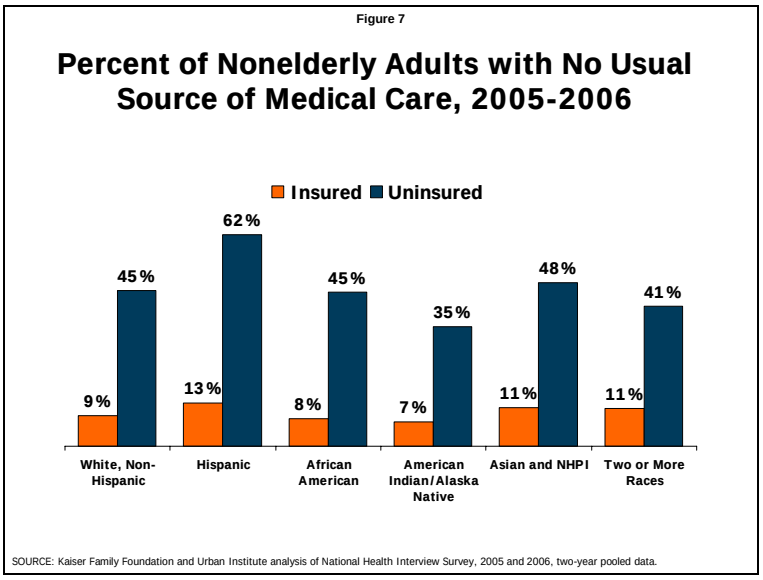
In addition, unemployment rates for many communities of color are higher than that of Whites, limiting access to employer-sponsored coverage for these communities.

Why Does Coverage Matter?

Health insurance coverage helps to facilitate timely access to health care, and having a usual source of medical care and regular doctor visits—two widely accepted measures of access to care—increases the likelihood that individuals receive recommended screening and preventive services.[9]

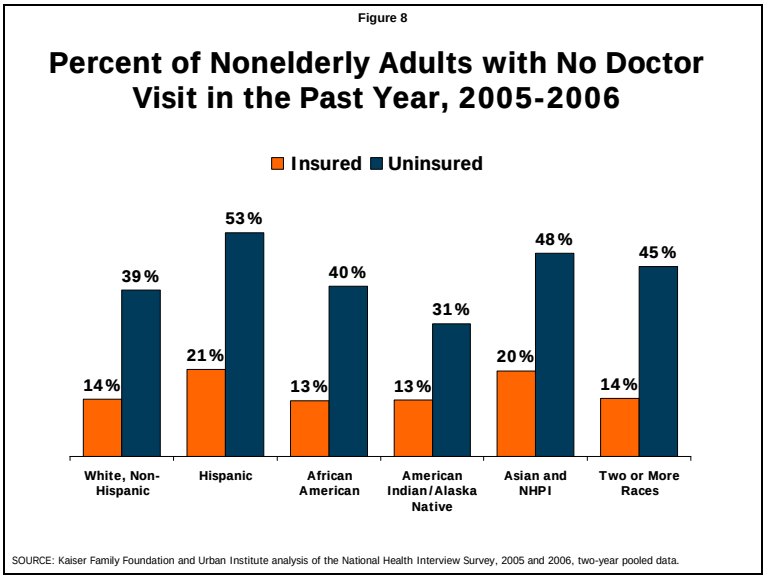
In 2005-2006, the rates of having no usual source of care among nonelderly uninsured adults across all racial and ethnic groups were at least 3 times higher than the rates for insured adults (Figure 7). The rates of having no usual source of care for insured African Americans (8%) and American Indian and Alaska Natives (7%) were slightly lower than the rate for Whites (9%). Additionally, uninsured adults of all racial and ethnic groups had rates of no doctor visits that were at least twice as high as the rates for insured adults (Figure 8). The largest difference in doctor visits between insured and uninsured populations was seen among African Americans and individuals of two or more races. Health insurance is a primary factor in explaining racial and ethnic disparities in whether an individual has a regular source of care.[10]

Figure 7



SOURCE: Kaiser Family Foundation and Urban Institute analysis of National Health Interview Survey, 2005 and 2006, two-year pooled data.

Figure 8



SOURCE: Kaiser Family Foundation and Urban Institute analysis of the National Health Interview Survey, 2005 and 2006, two-year pooled data.

The finding that nonelderly Hispanic adults were more likely than any other racial or ethnic group to have no usual source of care or to have gone without a doctor in the visit in the past year—whether insured or uninsured—highlights some of the particular challenges in access to care faced by this group.

Lacking health coverage can also translate to poorer health outcomes relative to those with insurance. Compared to the insured, a larger share of the uninsured report problems paying medical bills, relying on home remedies rather than seeking the care of a doctor, skipping dental care, and not filling a prescription due to cost.[11] Blacks and Hispanics compared to Whites are more likely to report experiencing these problems. For example, 35% of Hispanics compared to 24% of Whites reported having a problem paying medical bills in the past year, and more than half of Hispanics reported relying on home remedies in the past year instead of going to the doctor because of cost compared to almost one-third of Whites (Figure 9). In addition, about 1 in 3 Blacks and Hispanics reported not filling a prescription in the past year due to cost compared to about 1 in 4 Whites.

Figure 9

Percent of People who have Recently had a Problem with Health Care or Coverage

	White, non-Hispanic	Black, non-Hispanic	Hispanic
Paying medical bills in the past year	24%	30%	35%*
Relied on home remedies due to cost in the past year	32%	43%	53%*
Skipped dental care because of cost	33%	42%	48%*
Did not fill a prescription due to cost in past year	23%	34%*	35%*

NOTE: * Significantly different from White individuals
SOURCE: Kaiser Family Foundation. *The Effects of the Economic Recession on Communities of Color.* July 2009.

Why Addressing Health Coverage is Important for Communities of Color and the Health Reform Debate

Roughly 1 in 2 (53%) nonelderly persons of color in the U.S. are either publicly insured or uninsured (Figure 10). In 2008, for example, 12 million Hispanics were publicly insured, and over 14 million were uninsured, representing nearly 60% of the nonelderly Hispanic population. Given this, any effort to expand coverage and/or alter current public programs will have important consequences for the health of communities of color.

Figure 10

Nonelderly Publicly-Covered or Uninsured by Race/Ethnicity, 2008

INSURANCE COVERAGE	AFRICAN AMERICANS	HISPANICS	ASIANS/NATIVE HAWAIIANS & PACIFIC ISLANDERS	AMERICAN INDIANS/ALASKA NATIVES
U.S. Population, 2008	33.4 million	44.8 million	11.7 million	1.7 million
Public Coverage*	10.7 million	12.0 million	1.6 million	0.2 million
Medicaid	8.7 million	10.9 million	1.2 million	0.4 million
Medicare	1.6 million	0.9 million	0.2 million	0.1 million
Military (VA & DOD)	1.3 million	0.8 million	0.2 million	0.1 million
Uninsured	6.9 million	14.4 million	2.2 million	0.5 million
Total (Percent)	17.6 million (53% of U.S. nonelderly African American population)	26.4 million (59% of the U.S. nonelderly Hispanic population)	3.8 million (32% of the U.S. nonelderly Asian/NHPI population)	0.7 million (41% of the U.S. nonelderly AI/AN population)

NOTE: *Public coverage totals do not double count those enrolled in more than one public program and may not equal sum of Medicaid, Medicare, and military coverage.
SOURCE: Current Population Survey, Annual Social and Economic Supplement, 2009. U.S Census Bureau.

Expansions in coverage, while likely to increase costs in the short-run, can improve health and have the potential to reduce racial and ethnic disparities in the long-run.[12] In addition, expanding coverage to the uninsured or underinsured may also help to reduce the strain on hospitals, physicians, and other health care providers that serve as an important safety net for many of these populations.

Conclusion

Despite wide variation in the rates of health insurance coverage by race and ethnicity in the U.S., people of color—who make up one-third of the U.S. population—comprise over half of the 45.7 million nonelderly uninsured and are less likely to have health coverage than Whites. This is primarily due to the fact that people of color are more likely than Whites to be low-income and work for low-paying jobs that are less likely to offer health insurance. Low-wage jobs, along with higher unemployment rates, contribute to wealth gaps that can make coverage less affordable even when offered.

The current economic recession and the high levels of unemployment have impacted many individuals' access to job-based health coverage. Though the recession has affected many Americans, people of color are more likely to report difficulty affording and accessing health coverage as a result of the recession.[13] While public programs, like Medicaid, which disproportionately serve communities of color, can help fill in the gaps, these programs are not available to all persons in need. As a result, many people have become, or remain, uninsured.

As it is estimated that half of the U.S. population will be a person of color by 2045, all communities, but particularly communities of color, have much at stake in efforts to expand access to health coverage and/or alter public programs. As many of the health reform proposals currently being debated target low-income and uninsured populations, and a high proportion of racial and ethnic minorities are low-income and/or uninsured, the benefits would substantially assist people of color. For example, all of the health reform proposals currently before Congress include Medicaid eligibility expansions as well as specific measures to address racial and ethnic health disparities, like improvements in data collection and the provision of language appropriate services. The impact of expansions may be different for different racial and ethnic populations. While expansions in coverage are insufficient to eliminate racial and ethnic disparities in access to health care, health coverage is, at the very least, one important factor that helps to facilitate access to the health system thereby serving to reduce disparities in access to care.

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[1] Table 6. Percent of the Projected Population by Race and Hispanic Origin for the United States: 2010 to 2050 (NP2008-T6). Population Division, U.S. Census Bureau. August 14, 2008.
[2] LaVeist, T.A., D.J. Gaskin, and P. Richard. September 2009. *The Economic Burden of Health Inequalities in the United States*. Washington, DC: Joint Center for Political and Economic Studies.
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[4] Davis, K. "Uninsured in an Era of Managed Care." 1997. *Health Services Research.* 31(6):641-49.
[5] McWilliams, J.M., et al. 2009. "Differences in Control of Cardiovascular Disease and Diabetes by Race, Ethnicity, and Education: U.S. Trends from 1999 to 2006 and Effects of Medicare Coverage." *Annals of Internal Medicine*. 150(8):505-15.
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[11] Kaiser Family Foundation *Health Tracking Poll.* Unpublished data. (conducted June 1-8, 2009).
[12] McWilliams, J.M., et al. 2009. "Differences in Control of Cardiovascular Disease and Diabetes by Race, Ethnicity, and Education: U.S. Trends from 1999 to 2006 and Effects of Medicare Coverage." *Annals of Internal Medicine*. 150(8):505-15.
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