Testimony submitted by
Samantha Artiga, Director, Disparities Policy Project,
The Henry J. Kaiser Family Foundation
for the House Subcommittee on Labor, Health, and Human Services, Education, and Related Agencies
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Chairman Cole, Ranking Member DeLauro, and other members of the subcommittee, thank you for this opportunity to testify on the status of health and health care disparities in our nation. It is a timely and important issue given the transformation of health care in recent years under the Affordable Care Act (ACA) and the changes being considered to health care by this Congress. In my comments today, I will address the following key points:

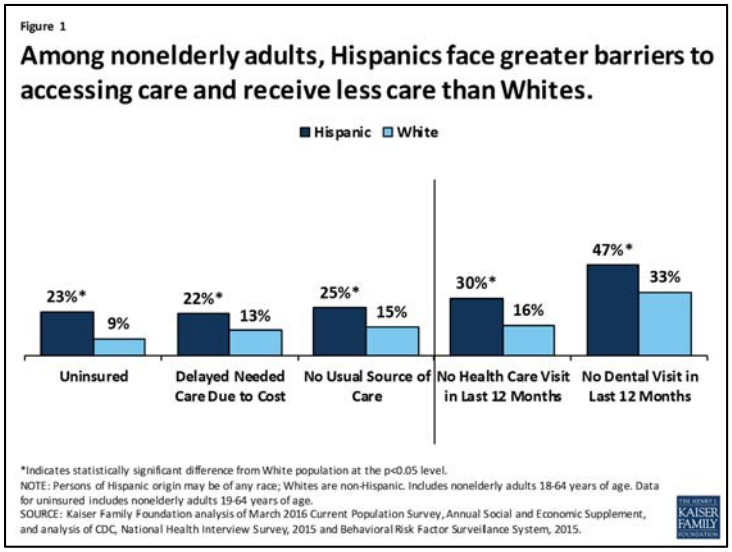
- **It is increasingly important to address disparities given our nation's growing diversity.** Health and health care disparities, which are differences between groups in their health status and their ability to access and use needed care, remain a persistent issue in the United States. Addressing disparities is not only important from a social justice standpoint, but also for improving our nation's health and reducing unnecessary costs.
- **Today, many groups face significant disparities in their health and health care.** People of color and low-income individuals face large disparities in access to and use of health care as well as health outcomes. Disparities also occur across other dimensions including language, location, and sexual orientation.
- **Maintaining gains in health insurance and support for public health and prevention, the health care workforce, and the delivery system are key for continuing advancements in reducing disparities.** The ACA health insurance expansions and investments in public health and prevention, the health care workforce, and the delivery system supported reductions of disparities. Changes being considered to repeal the ACA and restructure Medicaid, including capping federal financing, would disproportionately affect low-income individuals and people of color and negatively affect disparities.

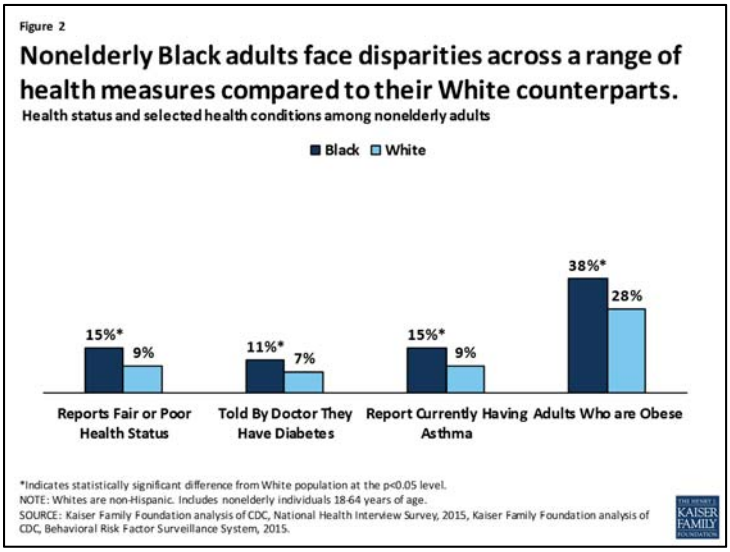
Health and health care disparities in the United States are a longstanding and persistent issue. Health and health care disparities refer to differences between groups in their health status and in their access to and use of needed health care.[1] While some health differences reflect genetics, disparities often refer to unnecessary differences that are driven by factors rooted in historic economic, social, and racial disadvantages. Research increasingly shows that race, class, and zip code play a larger role in determining health than genetics.[2] Although disparities have been documented for decades and there have been overall improvements in our nation's health, many disparities have persisted and, in some cases, widened over time.[3]

Addressing disparities is not only important from a social justice standpoint, but also for improving our nation's health and reducing unnecessary costs. Disparities in health and health care not only affect the groups facing disparities, but limit overall improvements in our nation's health. They also result in increased costs due to unnecessary medical expenditures and indirect costs associated with lost work productivity and premature death.[4] As our nation becomes increasingly diverse, with projections estimating that people of color will make up more than half of the population by 2044, it is increasingly important to address disparities.[5]

Today, many groups face significant disparities in their ability to access and use needed health care as well as in their health status and outcomes. There remain large disparities by race and ethnicity.[6] For example, Hispanics fare worse than Whites across measures of health access and use (Figure 1), and Blacks fare worse across a range of health measures compared to Whites (Figure 2).[7] There also are disparities by income, with lower income people facing greater barriers to accessing and using care and reporting worse health status than those with higher incomes.[8] Although disparities are often viewed through the frames of race and income, they also occur across other dimensions. For example, research shows increased barriers for

LGBT individuals, people with limited English proficiency, and individuals living in rural and inner city areas.[9] Further, it is important to recognize that these groups are not mutually exclusive and that there often are disparities among subgroups of populations.





There has been an elevated federal focus on eliminating disparities in recent years. In 2011, the Department of Health and Human Services (HHS) developed its first action plan to eliminate racial and ethnic disparities.[10] The plan builds on organizational changes made within HHS under the ACA to prioritize and better coordinate efforts to reduce disparities. The ACA also strengthened data collection and research efforts to allow for improved measurement and monitoring of disparities and provided new protections from discrimination in health care.

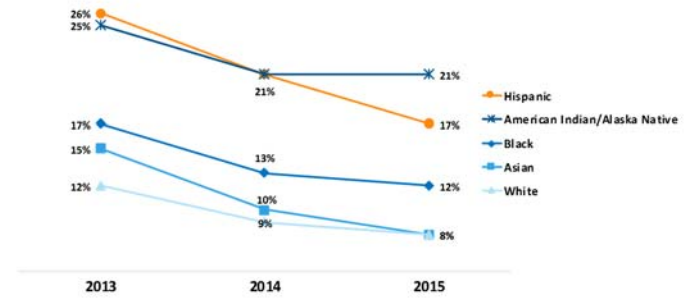
ACA initiatives and investments through discretionary programs to strengthen public health and prevention, the health care workforce, and the delivery system support reduction of disparities. For example, the ACA boosted funding for community health centers, which are a key source of care for low-income individuals and people of color.[11] It also contains provisions to increase the number of providers, particularly in underserved areas.[12] Moreover, it provided funding for and expanded initiatives to strengthen the public health workforce and infrastructure and prevention services, including the new Prevention and Public Health Fund.[13]

The ACA's broad health insurance coverage expansions through Medicaid and the Marketplaces also have played a central role in reducing health care disparities. Since implementation of these expansions, there have been large gains in coverage for low-income individuals and people of color, which helped narrow disparities in coverage (Figure 3).[14] The Medicaid expansion played a particularly important role in these coverage gains.

Figure 3

Racial and ethnic disparities in health insurance coverage have narrowed.

Uninsured Rate Among Nonelderly Individuals by Race/Ethnicity, 2013-2015



Note: Includes nonelderly individuals 0-64 years of age.
Source: Kaiser Family Foundation analysis of March 2014-2016 Current Population Survey, Annual Social and Economic Supplement.

These coverage gains are expected to reduce disparities in access to and use of health care as well as health outcomes over the long-term. Research shows that health insurance makes a key difference in whether and when people get medical care, where they get their care, and ultimately how healthy they are.[15] There also has been growing recognition that, although health insurance is key to health, social and environmental factors also influence health. An increasing number of initiatives within the health care system have emerged to address broader social determinants of health.[16] Further, there has been increased recognition of the need to increase diversity within the health care workforce, enhance providers' ability to deliver culturally and linguistically appropriate care, and increase provider access within rural and underserved areas.[17]

Despite nationwide gains in health insurance, differing state decisions to implement the ACA Medicaid expansion to low-income adults have widened disparities in coverage. In states that expanded, parents and childless adults with incomes up to 138% of the federal poverty level (FPL), which is about $28,200 for a family of three, are eligible for Medicaid. In contrast, among the 19 largely Southern states that have not expanded, the median Medicaid eligibility

limit for parents is 44% FPL, or less than $9,000 per year for a family of three, and other adults generally are not eligible. As a result of these eligibility differences, Medicaid expansion states have realized larger gains in coverage and access to care than states that have not expanded.[18] In particular, there are widening gaps between the South, which is home to many people of color and has high rates of chronic disease and poor health, and the rest of the nation.[19]

Further, although disparities in coverage have narrowed, low-income people and people of color still are more likely to be uninsured than those with higher incomes and Whites.[20] Hispanics and American Indians and Alaska Natives (AI/ANs) have the highest uninsured rates among racial and ethnic groups, and these disparities persist among children.[21] In 2015, Hispanic children were nearly twice as likely as White children to be uninsured (7% vs. 4%), and AI/AN children were nearly five times as likely as White children to be uninsured (19% vs. 4%).[22]

Maintaining gains in health insurance and support for public health and prevention, the health care workforce, and the delivery system are key for continuing advancements in reducing disparities. Changes being considered to health insurance through repeal of the ACA and restructuring of Medicaid, including capping federal financing, could have significant negative effects on disparities. People of color and low-income individuals would be disproportionately impacted by these changes since they had large coverage gains under the ACA and Medicaid is a central source of coverage for them. Reductions in health insurance and funding also would increase strains on other parts of the health care system, including community health centers and public health programs, which already face funding constraints and uncertainty regarding their future funding. Amid potential changes to health insurance, support for public health and prevention services and a health care workforce and delivery system that meets the needs of our increasingly diverse population is particularly important.

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