Forum on Social Justice
Webinar Series

Racial Disparities in Public Health
Friday, April 29, 2022

Presented by the
Midwestern Legislative Conference
Forum on Social Justice
RACIAL DISPARITIES IN PUBLIC HEALTH

OVERVIEW

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Kaiser Family Foundation
An Overview of Health and Health Care Disparities and State Equity Efforts

Samantha Artiga
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Racial Equity and Health Policy
KFF (Kaiser Family Foundation)
KFF Racial Equity and Health Policy Program

- **KFF** (Kaiser Family Foundation) is a nonprofit organization focusing on national health issues, as well as the U.S. role in global health policy
  - Policy analysis
  - Polling/survey research
  - Journalism (Kaiser Health News)
  - Public health information campaigns (Greater Than COVID)
- The **KFF Racial Equity and Health Policy Program** focuses on the intersection of racism and discrimination, social and economic inequities, and health
  - Timely and reliable data and analysis of health and health care disparities
  - Education to increase awareness and understanding of disparities
  - Analysis of implications of policy changes on disparities and efforts to advance equity
What are health and health care disparities?

- Differences in health and health care between populations
  - Higher burden of illness, injury, disability, or mortality
  - Differences in insurance coverage, access to and use of care, and quality of care
  - Closely linked with social, economic, and/or environmental inequities
- Arise from a complex and interrelated set of individual, provider, health system, societal, and economic factors
- Occur across a broad range of dimensions: race/ethnicity; socioeconomic status; gender; age; disability; sexual orientation or gender identity; geographic location, etc.
- Remain a longstanding and persistent issue
Before COVID-19, people of color fared worse than their White counterparts across many measures of health.

Number of measures of health and health care for which group fared better, the same, or worse compared to White counterparts:

<table>
<thead>
<tr>
<th>Group</th>
<th>Better</th>
<th>No Difference</th>
<th>Worse</th>
<th>Data Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black</td>
<td>9</td>
<td>8</td>
<td>44</td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td>15</td>
<td>7</td>
<td>39</td>
<td></td>
</tr>
<tr>
<td>AIAN</td>
<td>9</td>
<td>13</td>
<td>33</td>
<td></td>
</tr>
<tr>
<td>NHOPPI</td>
<td>26</td>
<td>16</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td>2</td>
<td>37</td>
<td>13</td>
<td></td>
</tr>
</tbody>
</table>

Note: AIAN is American Indian or Alaska Native; NHOPPI is Native Hawaiian or Other Pacific Islander. Measures are for the most recent year for which data are available. "Better" or "Worse" indicates a statistically significant difference from White people at the p<0.05 level. No difference indicates no statistically significant difference. "Data limitation" indicates no separate data for a racial/ethnic group, insufficient data for a reliable estimate, or comparisons not possible due to overlapping samples. Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic.

Source: Key Facts on Health and Health Care by Race and Ethnicity, KFF January 2022
COVID-19 exposed and exacerbated underlying disparities in health and health care.

Risk of infection, hospitalization, and death compared to White people in the U.S., adjusted for age:

- **Cases:**
  - American Indian or Alaska Native: 1.6
  - Hispanic: 1.5
  - Black: 1.1
  - White: 1.0
  - Asian: 0.7

- **Hospitalizations:**
  - American Indian or Alaska Native: 3.1
  - Hispanic: 2.3
  - Black: 2.4
  - White: 1.0
  - Asian: 0.8

- **Deaths:**
  - American Indian or Alaska Native: 2.1
  - Hispanic: 1.8
  - Black: 1.7
  - White: 1.0
  - Asian: 0.8

NOTE: Persons of Hispanic origin may be of any race but are categorized as Hispanic; other groups are non-Hispanic; data for Native Hawaiian or Other Pacific Islander (NHOPI) people are not reported.

Health disparities are driven by social and economic inequities that are rooted in historic and ongoing racism.
The ACA helped narrow differences in health coverage, but disparities persist.

NOTE: Includes individuals ages 0 to 64. AIAN refers to American Indians and Alaska Natives, NHOPI refers to Native Hawaiians and Other Pacific Islanders. Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic.

Medicaid plays a disproportionately large role for people of color.

Health Coverage of the Nonelderly Population by Race and Ethnicity, 2020

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Uninsured</th>
<th>Medicaid/Other Public</th>
<th>Private</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian or Alaska Native</td>
<td>43%</td>
<td>35%</td>
<td>22%</td>
</tr>
<tr>
<td>Black</td>
<td>52%</td>
<td>36%</td>
<td>12%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>48%</td>
<td>33%</td>
<td>20%</td>
</tr>
<tr>
<td>Native Hawaiian or Other Pacific Islander</td>
<td>53%</td>
<td>35%</td>
<td>12%</td>
</tr>
<tr>
<td>White</td>
<td>74%</td>
<td>19%</td>
<td>7%</td>
</tr>
<tr>
<td>Asian</td>
<td>76%</td>
<td>18%</td>
<td>6%</td>
</tr>
</tbody>
</table>

NOTE: Includes individuals ages 0 to 64. Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic. Other public coverage includes Medicare (excluding Part A only) and military coverage. Totals may not sum to 100 percent due to rounding.

Figure 10

Studies generally find positive effects of the ACA Medicaid expansion across a range of outcomes.

Number of studies that find positive effects, no difference or mixed findings, and negative effects:

<table>
<thead>
<tr>
<th>Outcome</th>
<th># of studies that find positive effects</th>
<th># of studies that find no difference or mixed findings</th>
<th># of studies that find negative effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access &amp; Utilization of Care</td>
<td>184</td>
<td>79</td>
<td></td>
</tr>
<tr>
<td>Insurance Coverage</td>
<td>201</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Payer Mix</td>
<td>99</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Health Care Affordability &amp; Financial Security</td>
<td>66</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Provider Capacity</td>
<td>18</td>
<td>21</td>
<td>3</td>
</tr>
<tr>
<td>Self-Reported Health</td>
<td>20</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>State Economy</td>
<td>25</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive Health Outcomes</td>
<td>21</td>
<td>22</td>
<td>3</td>
</tr>
</tbody>
</table>

NOTES: Studies may have findings on multiple outcomes and be counted in multiple bars. "Insurance Coverage" includes coverage rates generally and for Medicaid.

The Medicaid coverage gap disproportionately affects people of color.

Share of the Nonelderly Population that is Black by Medicaid Expansion Status

Race/Ethnicity of Adults in the Coverage Gap

NOTE: Totals may not sum to 100% due to rounding. Nonelderly includes individuals ages 0 to 64. Other includes Asian, American Indian Alaska Native, and Native Hawaiian and Other Pacific Islander people, along with people of multiple races. Hispanic people may be of any race but are categorized as Hispanic; other groups are all non-Hispanic.

At least 36 states have taken steps to extend Medicaid postpartum coverage.

State actions as of 4/21/22:

- **12-month extension implemented** (13 states)
- **Planning to implement 12-month extension** (14 states & DC)
- **Limited coverage extension approved or proposed** (4 states)
- **Pending legislation to seek federal approval** (4 states)

NOTES: Pending legislation includes legislation that has passed one or both chambers.
Many states have taken up options to expand Medicaid/CHIP coverage to recent immigrants.

- Covers lawfully-residing immigrant children and pregnant people without 5-year waiting period (29 states)
- Covers lawfully-residing immigrant children without a 5-year waiting period (6 states)
- Covers lawfully-residing immigrant pregnant people without 5-year waiting period (1 state)
- State has not taken up option to cover lawfully residing immigrant children or pregnant people in the five-year waiting period (15 states)

NOTE: In addition, 18 states cover pregnant people regardless of immigration status through the unborn child option.

SOURCE: Based on results from a national survey conducted by KFF and the Georgetown University Center for Children and Families, 2022.
State Medicaid programs are increasingly linking financial incentives to health disparities metrics.

As of 7/1/21:

- 12 states report that health disparities are a performance measure focus area for financial quality incentives in Medicaid.

NOTES: Includes state-reported incentives across delivery systems including managed care organizations (MCOs), limited benefit prepaid health plans (PHPs), and/or primary care case management (PCCM) programs or fee-for-service (FFS).

SOURCE: KFF survey of Medicaid officials in 50 states and DC conducted by HMA, October 2021.
States are taking other broader actions to address racial health disparities.

- Health equity task forces, offices, cabinet positions
- Increasing data collection and reporting
- Establishing health equity metrics or conducting health equity impact assessments
- Training requirements for health care workers on bias, disparities, and/or equity
- Grants to providers and community based organizations
Addressing disparities is important for social justice and the nation’s overall health and economic prosperity.

- Underserved groups experience higher rates of illness and death that result in unnecessary costs and limit the overall health of the nation.
- As the population becomes more diverse it is increasingly important to address disparities.
- Addressing the disparate impacts of COVID-19 and ensuring equity in COVID-19 vaccinations is important for preventing against further widening of health disparities.
Now is a pivotal time for action to advance equity.

- Prioritizing equity and directing resources to address underlying inequities in structures and systems across sectors
- Increasing diversity of the health care workforce and diversity in research (e.g., clinical trials)
- Increasing availability of high-quality, disaggregated data and using data to inform actions and policies
- Establishing measurable goals for health equity and incentives and accountability to meet those goals
- Building on and supporting existing community resources and strengths