Connecticut Health Care Survey

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TOP FINDINGS:

In Connecticut, Blacks and Hispanics are

- more likely than Whites to be in poor or fair health;
- more likely to lack health insurance, but also more likely to benefit from subsidized public insurance programs;
- somewhat less likely to have a usual source of care. The smaller disparity occurs largely because clinics and health centers are major sources of care for these groups.

TOP ISSUES FOR THE POLICY COMMUNITY:

- Better community education about both the availability of private and public insurance coverage, and how consumers should use such coverage.
- More approaches to ensure that those enrolled in public health insurance stay enrolled.
- Ongoing resources for safety-net providers that will be a leading source of care for those who benefit from expanded coverage and those who remain uninsured.
- Increased availability and retention of providers willing to practice in underserved areas.
- Greater service delivery coordination between the safety net and other components of the health care system like specialty care, hospitals, and behavioral and dental services.

Health Inequities in Connecticut and the Vital Role of the Safety Net

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Introduction

In 2011, the U.S. Department of Health and Human Services (HHS) observed that "the societal burden of health and health care disparities in America manifests itself in multiple and major ways," including lack of access to health care and poor outcomes.[1] The secretary of HHS committed in that report to a goal of "a nation free of disparities in health and health care" and put forth a five-year plan. A 2010 Connecticut Health Foundation policy brief observed that the 10-year trends at that time showed that Connecticut was far from eliminating racial and ethnic health disparities.[2]

Despite years of focus on these issues, statistics continue to show that "racial and ethnic minorities and poor people often face more barriers to care and receive poorer quality of care when they can get it."[3] The most recent national report in 2012 found that, on many measures, Blacks and Hispanics had worse access to care and received lower-quality care than non-Hispanic Whites. Although the report found improvement over the past decade on some quality measures (such as timely interventions after heart attacks) and process measures (such as screenings for appropriate vaccinations), there was little evidence that health care disparities were being reduced.

The Connecticut Health Care Survey (CTHCS) offers new insights into the

situation in Connecticut prior to the rollout of the expanded availability of health coverage and other reforms resulting from the Affordable Care Act (ACA). This brief highlights some baseline findings that can help the policy community hone in on disparities in order to expand health equity. It also features findings on the role of the health care safety net, which includes both public programs to make health insurance more available and affordable, and the system of service providers that exists to meet the needs of vulnerable populations. The baseline findings offer the means to monitor changes as more people of color experience improved access to health care and seek care from safety-net providers.

The health care safety net includes both public programs to make health insurance more available and affordable, and the system of service providers that exists to meet the needs of vulnerable populations.

Survey Findings: Racial and Ethnic Inequities in Health Status

Overall, according to the survey, 21 percent of Connecticut adults are Hispanic or Black. These racial and ethnic groups represent an even higher share among several demographic categories (Figure 1):

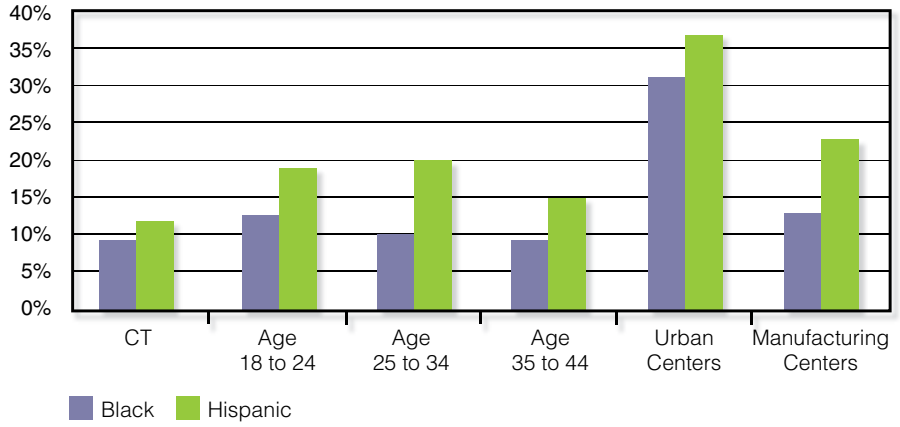
- Residents, ages 18 to 34 (31 percent)
- Residents, age 35 to 44 (24 percent)
- Residents of manufacturing centers (36 percent)
- Residents of urban centers (68 percent)

The CTHCS offers some clear evidence of racial and ethnic health inequities:

- A substantially higher share of Blacks and Hispanics (about 25 percent) is in poor or fair health compared to either non-Hispanic Whites (10 percent) or Asians (5 percent).
- Poorer health is also reflected in a higher prevalence of obesity.
- Poorer health is also shown by a somewhat higher prevalence of diabetes (although prevalence of other health conditions assessed in the survey is not clearly higher).

Whereas 94 percent of White adults had coverage at the time of the survey, only 84 percent of Blacks and 75 percent of Hispanics were insured.

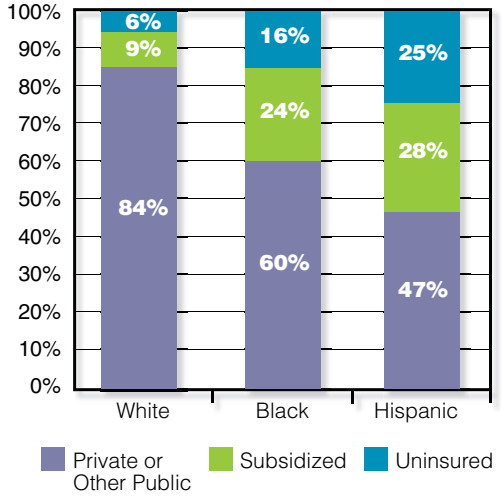
FIGURE 1: Share of Population in Different Subgroups that is Black or Hispanic



Closing the Gaps in Health Insurance Coverage through the ACA

The CTHCS showed that racial and ethnic populations were less likely to have health insurance. Whereas 94 percent of White adults had coverage at the time of the survey, only 84 percent of Blacks and 75 percent of Hispanics were insured.[4]

FIGURE 2: Pre-ACA Insurance Status by Racial or Ethnic Group*



*Categories may not sum to 100 due to rounding.

Disparities in coverage would likely be even greater in the absence of subsidized public insurance. Prior to ACA coverage expansions, about one-fourth of Blacks and Hispanics obtained coverage through Medicaid (also known as HUSKY in Connecticut) or similar subsidized public insurance programs, compared to 9 percent of Whites and 1 percent of Asians.

Medicaid is a key piece of the American health care safety net. Financed through both federal and state dollars, it provides medical assistance to many low-income individuals. States have had considerable flexibility to set Medicaid eligibility and benefit levels, including income eligibility limits. Because Connecticut had established higher income eligibility limits than most other states prior to the expansion funded by the ACA, it entered into health reform with a head start on health equity, reinforcing the role of safety-net coverage in reducing disparities and expanding health equity.

People with Medicaid are more likely to avoid financial distress and to obtain more care.[5] One study found that, compared to those without insurance, Medicaid beneficiaries were two and a half times less likely to delay or forgo medical care due to costs.[6] Another recent study showed that Medicaid can reduce adult mortality rates by 6 percent.[7]

Availability of insurance has grown in two ways since the CTHCS was completed. The ACA created new marketplaces through which private health insurance has become more widely available, and the law (as interpreted by the Supreme Court) created a state option for expanded Medicaid coverage. Through Access Health CT, the state's insurance marketplace, about 79,000 people enrolled in private insurance plans during the first open enrollment period. Over three-fourths of the new enrollees are taking advantage of federal subsidies.

The ACA allows states to expand Medicaid programs, with mostly federal dollars, for people up to 138 percent of the poverty level. For Connecticut, one of 26 states currently implementing this option, this meant adding coverage for adults without children, up to about $16,000 a year for single individuals and nearly $22,000 a year for couples. During round one of open enrollment, about 130,000 people enrolled in Medicaid.

These two components of expanded coverage have the potential to improve health care access, especially for Blacks and Hispanics, who were far more likely than Whites to be uninsured in 2012. Although racial and ethnic breakdowns of new enrollments are not yet available, analysis conducted for Access Health CT found that, prior to 2014, about one-third of Connecticut's uninsured adults were Hispanic and about 15 percent were Black.[8] Still, the enrollment process remains challenging. A recent analysis showed that state implementation of a "No Wrong Door" policy – a work in progress that will allow consumers to apply through different channels and seamlessly route them to the programs for which they qualify – could increase enrollment 13 percent above implementation of the ACA alone, with people of color gaining the biggest boost.[9]

Survey Findings: Racial and Ethnic Differences in Access to Health Care Services

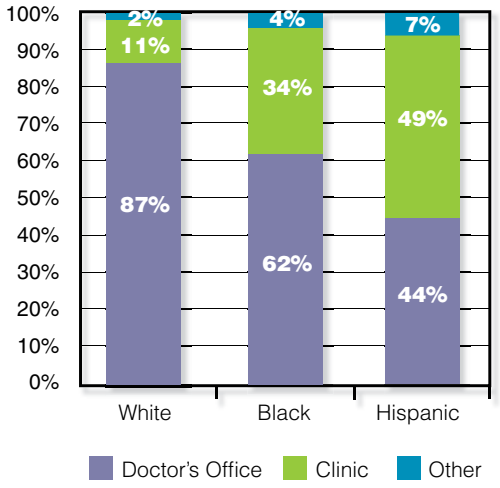
Racial and ethnic differences in access to health care services were not as great as those for overall health status. For example, only 11 percent of respondents said there were times when they did not get needed care, and 28 percent said they postponed getting care. For both questions, there was no statistical difference in responses across racial and ethnic groups.

During round one of open enrollment, about 130,000 people enrolled in Medicaid in Connecticut.

But not all health service areas showed the same results. For instance, 25 percent of Blacks and 26 percent of Hispanics, compared to 13 percent of Whites, did not obtain prescription medicines because of cost. While these differences were moderately less among those with health insurance, the disparity persisted.

Disparities in having a usual source of care were also smaller than on measures such as health status. Among White and Black respondents, 87 percent and 84 percent respectively had a usual place to go when they were sick or needed health advice. Among Hispanic respondents, the share was 76 percent.

FIGURE 3: Usual Source of Care by Racial or Ethnic Group



Racial and ethnic groups differed, however, in where they go for care: 34 percent of Blacks and 49 percent of Hispanics reported that clinics or health centers were their usual sources, compared to only 11 percent of Whites.

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These facilities constitute a major component of the health care safety net, providing those with limited resources places to obtain regular care. Most community health centers are nonprofit entities located in medically underserved areas. Throughout Connecticut, 14 centers serve 330,000 patients annually at over 100 sites.[10] In addition, free clinics, which rely mostly on volunteer medical personnel, serve other uninsured residents.[11] These clinics, which typically offer primary care while coordinating specialty care and other services, play a vital role in health equity. Because new enrollment is expected to come disproportionately from Blacks and Hispanics, who use safety-net clinics more than do Whites, the demand for safety-net providers is likely to increase.

CTHCS results revealed only modest differences by race and ethnicity among several measures of quality of health care services. Blacks and Hispanics were only slightly less likely than Whites to report seeing the same provider each time, or that the provider always spent enough time during the encounter. Similarly, they were just slightly less likely to say that the provider always considered their values, beliefs, and traditions in recommending treatments, or that the provider always discussed all prescription medicines. These findings are consistent with studies showing that safety-net clinics provide the same quality of medical encounters as private health care providers.[12]

Clinics, which typically offer primary care while coordinating specialty care and other services, play a vital role in health equity.

Survey Findings: Racial and Ethnic Inequities in Access to Prescriptions

As noted above, one persisting inequity identified by CTHCS respondents was that Blacks and Hispanics were more likely not to fill prescriptions because of cost. Financial obstacles may be harder to overcome when filling prescriptions than when getting other kinds of care. While clinics and emergency departments will treat patients who present for services and deal with payment later, pharmacies typically require payment at the point of service. Patients enrolled in Medicaid are

an exception since Connecticut does not require a co-payment. But other low-income Connecticut residents must make at least a co-payment at the pharmacy counter to get medications. Some patients for whom cost is a barrier may get free samples from their doctors; others may be eligible for programs offered by some manufacturers.[13]

Looking Forward: The Evolving Role of the Safety Net in Health Equity

Evidence from the CTHCS confirms that racial and ethnic health inequities remain despite many years of attention. But inequities would be much greater without the health care safety net. Subsidized health insurance, especially Medicaid, fills gaps in private coverage for Blacks and Hispanics. Similarly, community health centers and other clinics provide many with a usual source of care.

The ACA marked a significant broadening of the safety net by increasing the availability of both private insurance and Medicaid, and providing additional funding for community health centers. It is reasonable to expect further disparity reductions resulting from the increase in insurance enrollments. But expanded insurance and more support for safety-net providers may not be enough.

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All in a day's work (*)

One morning Daisy, a certified application counselor at a Bridgeport community health center, made her usual stop to grab a coffee at Dunkin' Donuts. She started chatting about her work with Marisol, who was behind the counter. Daisy learned that Marisol, 27, was studying for an associate's degree in early education to become a preschool teacher, and was interested in getting health care coverage. As she was leaving, Daisy encouraged Marisol to see her at the health center. When she came to see Daisy a few days later, Marisol left with the knowledge that she was eligible for HUSKY, and with an appointment for her first well-woman exam in years. With diabetes running in her family, Marisol was thrilled that she could both have health insurance and afford tuition, and relieved to have a place that would provide care, monitor her health, and help her focus on prevention.

(*) A true story, with identifying details changed.

To achieve improved health outcomes and disparity reduction, progress must continue in making insurance available and getting everyone signed up — including ongoing outreach and implementation of "No Wrong Door." However, because insurance coverage alone will not increase health equity, the policy community needs to address related issues that will help link coverage to improved outcomes.

Top Issues for the Policy Community

- Better community education about both the availability of private and public insurance coverage, and how consumers should use such coverage.
- More approaches to ensure that those enrolled in public health insurance stay enrolled.
- Ongoing resources for safety-net providers that will be a leading source of care for those who benefit from expanded coverage and those who remain uninsured.
- Increased availability and retention of health care providers, especially those willing to practice in underserved areas.
- Greater service delivery coordination in clinics and elsewhere, addressing issues such as:
  - connecting patients to specialty care when needed
  - providing better transitions between the hospital and follow-up care to reduce the likelihood of readmissions
  - reducing unnecessary use of emergency department services
  - improving coordination between medical, behavioral, and dental care

While none of these steps are easy, they are critical for improving health equity for all Connecticut residents, especially underserved racial and ethnic groups.

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Health Inequities in Connecticut and the Vital Role of the Safety Net

"Health Care Disparities in Connecticut and the Role of the Safety Net" was written by Jack Hoadley, Ph.D., of the Health Policy Institute of Georgetown University with support from the Connecticut Health Foundation. Data are from the Connecticut Health Care Survey, (CTHCS) a population-based assessment of the health and health care of Connecticut residents with a focus on patient perceptions. Survey funding was provided by Aetna Foundation, Children's Fund of Connecticut, Connecticut Health Foundation, the Foundation for Community Health, the Patrick and Catherine Weldon Donaghue Medical Research Foundation, and Universal Health Care Foundation of Connecticut. The survey was developed and conducted by the University of Massachusetts Medical School Center for Health Policy and Research. The views expressed in this brief are those of the author and supporting foundation and do not necessarily reflect those of all the funding partners. For more information, please contact the Connecticut Health Foundation.

How the Survey Was Conducted

The overarching goal of the CTHCS was to gather information relating to Connecticut residents' experiences and perspectives on their health and the health care system. The survey collected information using both landlines and cell phones from a sample of households across the state between June 2012 and February 2013. Adult residents of all ages were included; some adults were asked to report information on the children in their households. The Center for Health Policy and Research at the University of Massachusetts Medical School designed the survey, conducted the data collection, and did the initial analysis.

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[4] Because those age 65 and over have near-universal coverage through Medicare, coverage levels would be slightly lower if limited to adults below age 65.
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