

Health disparities in Connecticut and what we can do about them

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Changing Systems, Improving Lives.



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Overview



On average, nearly 100 babies are born every day in Connecticut. Each one has the opportunity to grow up in one of the healthiest states in the U.S.

But a closer look at the data shows that they won't all have the same opportunities to be healthy. A Black child born in Connecticut is, on average, likely to die nearly five years earlier than a white child.[1] The Black child will be more likely to develop asthma, diabetes, and many forms of cancer.

More broadly, people of color in Connecticut face significantly more barriers to health and well-being than their white peers. Data shows they are more likely to endure sickness and disability, and to die younger.

These population-level disparities stem from a wide range of causes, including differences in opportunities, access to health care and other resources; disparate care; and the impact of racism on both individuals and the neighborhoods and systems that shape our experiences.

Health disparities carry steep costs to both individuals and society. On a personal level, individuals and families cope with sickness and premature death of loved ones. On an economic level, disparities result in lost earnings for families, a smaller and sicker workforce, and higher health care costs. A recent study estimated that racial and ethnic health disparities cost Connecticut $2.33 billion per year.[2]

Health disparities are not inevitable. Our state can make progress in eliminating gaps in health outcomes – and has, in recent years, taken steps to do so. There is more that we can do to remove the barriers that many state residents face to health and well-being.

Critically, the strategies that will help to close these gaps will benefit everyone by making the health care system fairer, improving the quality and responsiveness of care, and increasing affordability for everyone.

This report includes data on racial and ethnic health disparities in Connecticut, information on the causes and costs of these disparities, and recommendations for what our state can do to address them. The report also highlights promising practices and changes that have already taken place.

This document updates a report the Connecticut Health Foundation published in early 2020. Since then, the experience of the COVID-19 pandemic and the murder of George Floyd focused attention on the persistent inequities in our society and the impact of racism.

We have seen changes in law and attitudes related to health equity, toward a greater understanding of equity. More recently, the nation has experienced a backlash and crack-down on efforts to undo the harms of racism.

No matter what the political environment is, it remains critically important to the health of our residents, the state's economy, and all of our futures to ensure that the next generation of Connecticut residents does not face the same racial and ethnic health disparities that exist today. We hope this report will provide context and ideas for how our state can move forward to ensure that Connecticut can be the healthiest state for all of us.

Note on data and terminology: When citing data, we use the terms used by the data source. As a result, there will be some variation in terms used, such as Hispanic, Latino, and Latinx. Unless otherwise noted, racial groups listed in data sections only include people who did not identify as Hispanic. Some data sources include information on Asian American and Pacific Islanders, American Indian or Alaska Natives, and people who select multiple races, while others do not – in some cases because there is not enough data to report for certain groups.

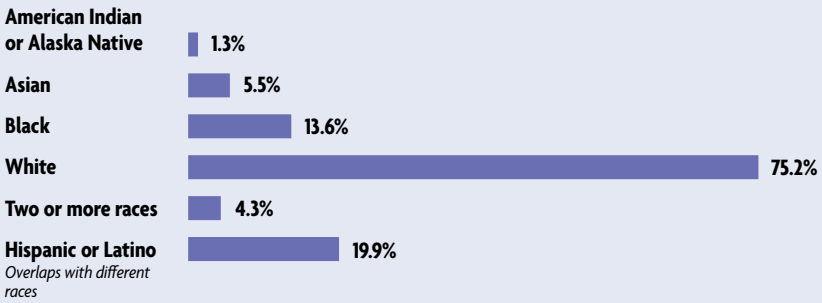
Health disparities in Connecticut

Not everyone in Connecticut has the same opportunity to be as healthy as possible. The results are disparities in health outcomes. These disparities affect people of all ages and income levels.

Differences in health outcomes at the population level are not the result of random luck or personal choices. Instead, they reflect a range of reasons, including those directly related to health care, things outside the health care system, and the impact of racism on people's health, the care they receive, and the opportunities available to them.



Connecticut's population, 2025[3]



Asthma



Asthma is a chronic condition that can be managed through medication, monitoring, and avoiding triggers. The condition disproportionately affects people of color in Connecticut.

Disparities start in childhood.

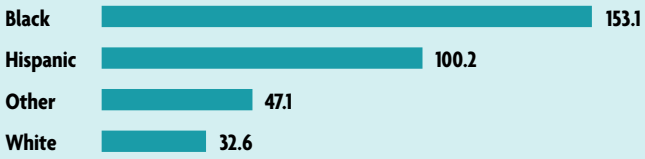
- Compared to white children and teens, Black children and teens are nearly **five times** as likely to go to the emergency room because of asthma. Hispanic children and teens are **more than three times** as likely.[4]
- Black youth are **more than five times** as likely to be hospitalized for asthma as white youth, and Hispanic youth are **more than three times** more likely to be hospitalized.[5]

These disparities continue into adulthood.

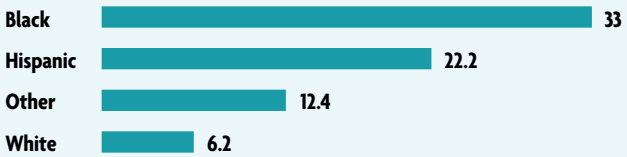
- Black adults are **nearly five times** as likely to go to the emergency room because of asthma as white adults, while the rate among Hispanic adults is **more than four times** as high.[6]
- Black and Hispanic adults are **four times** more likely to be hospitalized for asthma than white adults.[7]

Black Connecticut residents are **more than twice** as likely to die from asthma as white residents, while Hispanic residents are **nearly twice** as likely to die from it.[8]

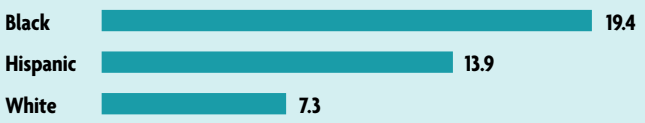
Asthma emergency department visits per 10,000 children under 18, Connecticut, 2023*



Asthma hospitalization rate per 10,000 children under 18, Connecticut, 2023*



Asthma annual death rate per 1 million people, Connecticut, 2018-2022*



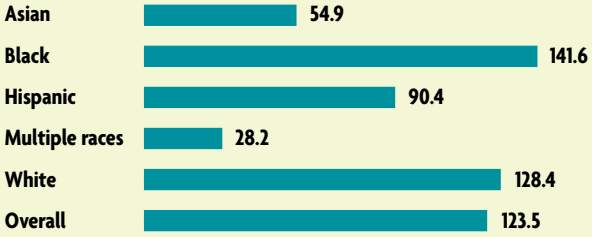
**Data is age adjusted*

Cancer



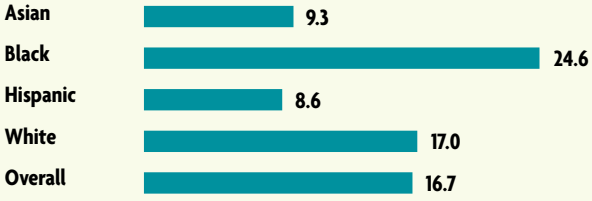
Black Connecticut residents are **nearly 15%** more likely to die from cancer than the population as a whole.[9]

Cancer deaths per 100,000 people, Connecticut, 2024*



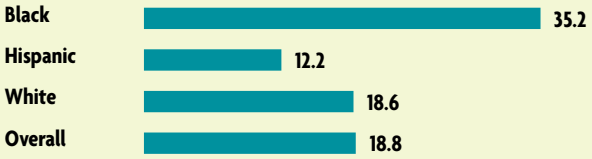
Black women in Connecticut **nearly 50%** more likely to die from breast cancer than the state average.[10]

Breast cancer deaths per 100,000 women, Connecticut, 2024*



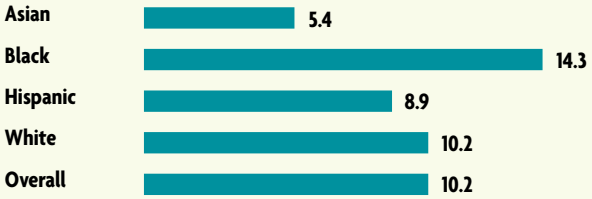
Black men are **nearly twice** as likely to die from prostate cancer as the overall population.[11]

Prostate cancer deaths per 100,000 men, Connecticut, 2020-2024*



Black Connecticut residents are significantly more likely to be diagnosed with colorectal cancer and to die from it.[12]

Colon and rectum cancer deaths per 100,000 residents, Connecticut, 2020-2024*



** Rates are age-adjusted*

Diabetes



Diabetes is a chronic condition that affects more than one in 10 adults in Connecticut.[13]

Black Connecticut residents are **more than twice** as likely as white residents to have diabetes,[14] and they are even more likely to suffer severe consequences from it.[15]

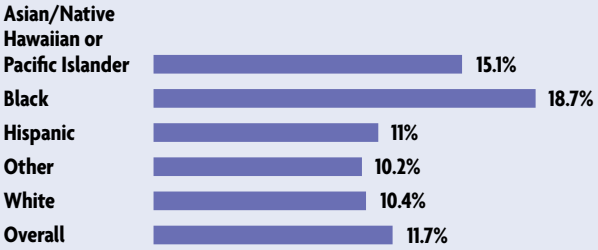
One complication of diabetes is having a leg or foot amputated. It is preventable, and experts say it should be unnecessary.[16] It occurs disproportionately among Black and Hispanic individuals.

- Black residents are **four times** as likely as white residents to be hospitalized for a diabetes-related lower extremity amputation.[17]
- Hispanic or Latino residents are **2.5 times** as likely as white residents to be hospitalized for a diabetes-related lower extremity amputation.[18]

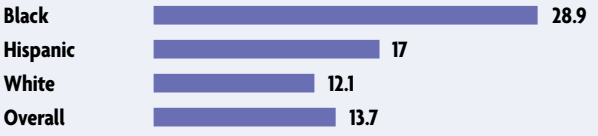
Compared to the full population of the state, Black Connecticut residents are **more than twice** as likely to die from diabetes.[19]

Adults who reported ever being told by a doctor they have diabetes, Connecticut, 2024[20]

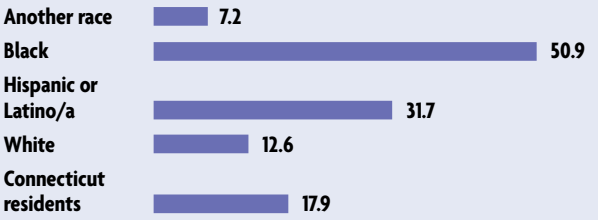
(Does not include pregnancy-related diabetes, borderline diabetes, or prediabetes)



Rate of diabetes deaths per 100,000 population, Connecticut, 2024[21]*



Hospitalizations for diabetes-related, nontraumatic lower-extremity amputations per 100,000 people, Connecticut, 2021[22]*



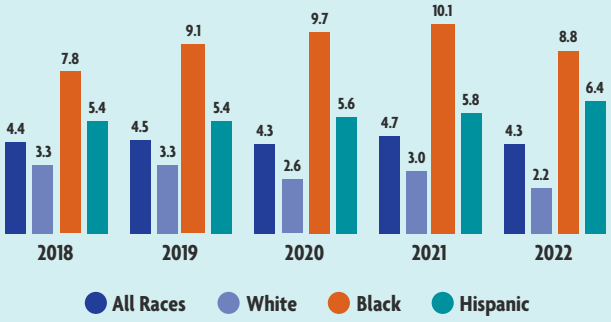
**Figures are age-adjusted*

Infant mortality



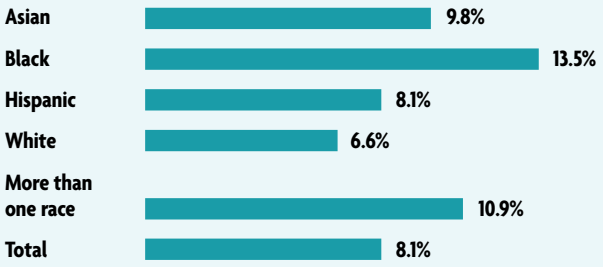
Connecticut has one of the nation's lowest infant mortality rates – defined as the death of a baby before turning one.[23] Yet there are significant gaps. Babies born to Black mothers in Connecticut are **two to four times** more likely to die before their first birthday than babies born to white mothers. Babies born to Hispanic mothers are also significantly more likely to die before turning one.[24]

Connecticut infant mortality rate

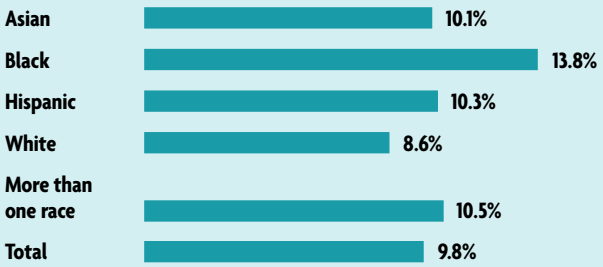


There are also significant gaps in the rate of low birthweight babies – those born weighing less than 5½ pounds. Among all babies born in Connecticut, Black babies are **1.7 times** more likely to have a low birthweight.

Births of low birthweight as a percentage of all births by race/ethnicity, 2024[25]
(Low birthweight is defined as less than 5 pounds, 8 ounces)



Preterm births as a percent of all births by race/ethnicity, 2024[26]
(Preterm is defined as before 37 weeks gestation)



Maternal mortality

Black women are more likely to die from pregnancy-related causes nationally and in Connecticut.

In Connecticut, Black pregnant people accounted for 12.8% of births, but 19% of pregnancy-related deaths from 2015 to 2020.[27]

19%

Severe maternal morbidity

Connecticut typically ranks among the top states in most health outcomes, when using data for the whole population. There's a big exception: severe maternal morbidity.

On this measure, Connecticut ranks **42nd in the nation.**[28]

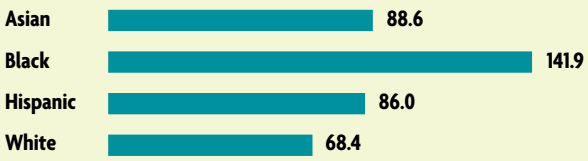
Severe maternal morbidity refers to potentially life-threatening complications of pregnancy or birth. These complications are often preventable and can have lasting consequences. Severe maternal morbidity can carry lifelong health consequences for the mother and can result in the death of the fetus or infant.[29]

Connecticut's low ranking is for the whole population – regardless of race or ethnicity.

Examining the data by race and ethnicity shows an even more concerning reality. Black Connecticut residents are **more than twice** as likely to experience severe maternal morbidity as their white counterparts.[30]

2x

Severe maternal morbidity per 10,000 deliveries, Connecticut, 2018-2020



In Connecticut, from 2018 to 2020, mothers who experienced severe maternal morbidity were **five times** more likely to have their fetus or infant die.[31]

Oral health



Connecticut ranked first in the nation in 2024 for the percentage of adults who visited a dentist or dental clinic in the past year. But that's not spread equally over the population. While 81% of white Connecticut adults had a dental visit, only 66% of Black residents and 61% of Hispanic residents did.[32]

Adults who visited a dentist or dental clinic in the past year, Connecticut, 2024



Life expectancy

Overall, life expectancy at birth for Connecticut residents was 81.1 years in 2024.

Life expectancy was close to the state average for white residents (81.4 years) and Hispanic residents (80.9 years), and higher for Asian residents (86.0 years).

For Black Connecticut residents, life expectancy was **almost five years shorter:** 76.5 years.[33]



Life expectancy, Connecticut, 2024

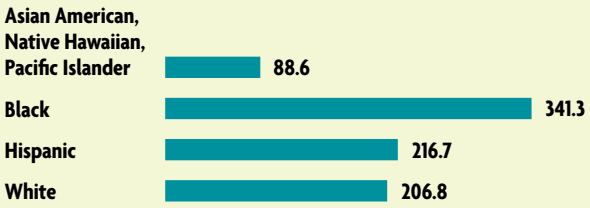


Premature deaths

"Premature deaths" refers to deaths before age 75 from preventable causes or treatable conditions such as appendicitis, diabetes, and some cancers.

In Connecticut, Black residents are significantly more likely to die prematurely from avoidable causes than other state residents.[34]

Premature deaths from avoidable causes per 100,000 people, Connecticut, 2022-2023



Disparities that intersect

Often, racial and ethnic disparities exist alongside other disparities.

People with disabilities often face worse health outcomes than those without disabilities, and people of color with disabilities have worse outcomes than their white peers.[35] For example, a recent study found that, on average, people with intellectual or developmental disabilities, Down syndrome, and cerebral palsy died more than a decade younger than people without intellectual or developmental disabilities. Disparities also existed among those with intellectual or developmental disabilities, Down syndrome, and cerebral palsy; people of color with those conditions died between five and 15 years younger than their white counterparts with the same conditions.[36]

People who identify as lesbian, gay, bisexual, or transgender (LGBT+) are more likely to report being in fair or poor health, having a chronic condition, or having a disability than their non-LGBT+ counterparts.[37]

Racial and ethnic health disparities also exist within the LGBTQ+ population. In a survey of Connecticut adults who identified as part of the LGBTQ+ community, Black and Hispanic adults were approximately five times more likely to have been refused health care services because of their sexual orientation or gender identity than white and multiracial survey respondents. Black and Hispanic/Latinx state residents were also significantly less likely than white and multiracial residents to say their needs were met all or most of the time when accessing health care.[38]



What causes disparities?

Disparities have many causes. Some exist within the health care system, while others are related to things outside the health care system. They include access to resources, differences in clinical care, and the effects of racism on health.

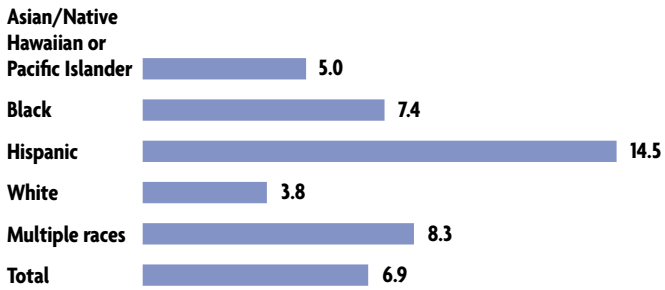
Coverage and access to care

Differences in insurance coverage

Research is clear: Having health care coverage is key to getting care and better health outcomes. Insurance alone won't keep someone healthy, but without health care coverage, people are less likely to get preventive care, more likely to have poor outcomes from chronic diseases, and more likely to die younger.[39] [40]

In Connecticut, Hispanic residents are nearly four times more likely to be uninsured than white residents. Black Connecticut residents are nearly twice as likely as white residents to be uninsured.

Uninsured rate for Connecticut residents under 65, 2024[41]

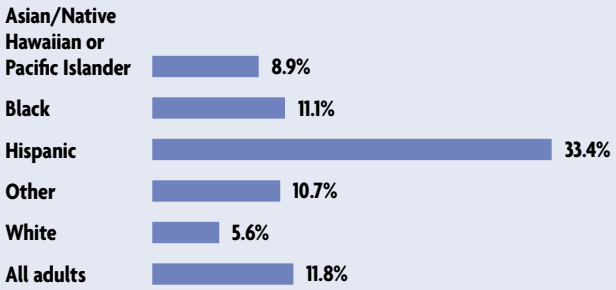


Access to a regular health care provider

Another key to good health is having a usual source of care – a regular health care provider to go to for preventive care or to address a problem. Building a relationship with a health care provider can be especially important for people who are wary of the health care system or have had bad experiences in the past.[42]

One in three Hispanic adults in Connecticut say they didn't have a person (or people) they considered a personal doctor or health care provider. By contrast, only one in 10 Black residents and one in 20 white residents say they don't have a personal doctor or health care provider.

Adults who say they don't have a personal doctor or health care provider, 2024[43]



The cost of care

The cost of health care is a major challenge for state residents, and it's an especially big burden on people of color.

In a 2025 poll of Connecticut residents, 77% of Black or African American adults and 78% of Hispanic or Latino adults reported that they had gone without care because of cost. Among white adults, 52% reported going without care because of the cost.[44]

Many people in the poll also reported rationing medication because of the cost – 37% of Black adults, 28% of Hispanic adults, and 18% of white adults.

Those who do get care can find themselves with significant debt. In the 2025 poll, 52% of Hispanic adults, 49% of Black adults, and 27% of white adults said they had experienced a financial burden from medical debt.

Connecticut adults who reported going without care because of the cost, within the past 12 months, 2025





Social needs that influence health

Much of what affects people's health happens outside the doctor's office. This includes having enough money to buy healthy food, a safe place to live, reliable transportation, and a safe neighborhood to walk around in.

The COVID-19 pandemic illustrated the link between meeting social needs and staying healthy. In the early days of the pandemic, it made a big difference to have a car rather than relying on public transportation, to be able to work remotely, to have the money to stock up on groceries, and to live in a home with enough space that someone could safely quarantine if he or she were exposed to the virus or got sick. Black and Hispanic residents were less likely to have access to these things, and the toll of the pandemic reflected it. By June 2022, Black Connecticut residents had nearly 2.5 times the rate of COVID-related deaths as white residents, while Latino residents had twice the death rate.[45] Nearly one in three Black or African American residents and one in four Hispanic residents said they had a close friend or relative who died from the virus. Among white residents, it was nearly one in six.[46]

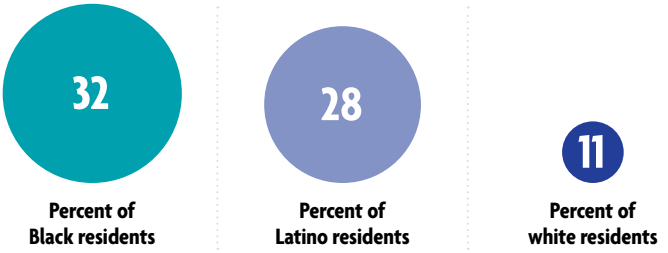
Even outside a pandemic, these gaps matter. They make a difference in how easy it is to take care of one's health and to get care when necessary.

By June 2022, Black Connecticut residents had nearly 2.5 times the rate of COVID-related deaths as white residents.



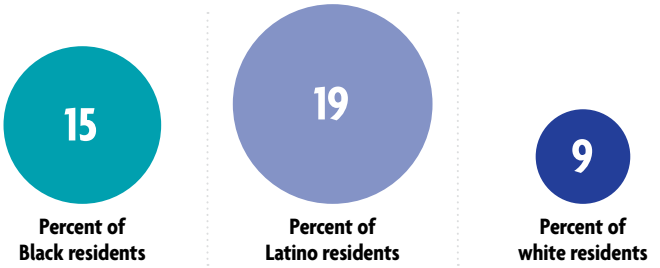
According to a 2025 survey of Connecticut residents:[47]

Lack of access to food



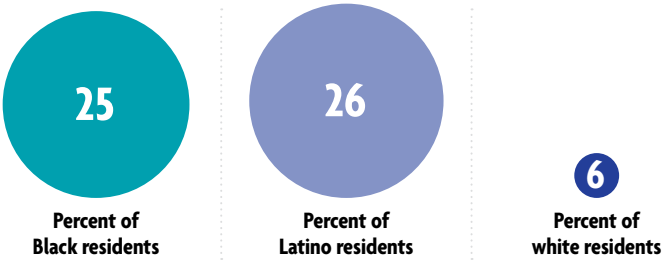
answered yes when asked if they did not have enough money to buy food that they or their family needed within the past 12 months.

Difficulty affording housing



answered yes when asked if they did not have enough money to provide adequate shelter or housing for themselves or their families within the past 12 months.

Lack of transportation



said they do not often have access to a car when needed.



Beyond socioeconomic status

Socioeconomic differences contribute to disparate outcomes, but research shows that health disparities exist even when controlling for education and income.[48] For example, nationwide, Black women with a college degree or higher were 1.6 times more likely to die from pregnancy-related causes than white women without a high school diploma.[49]

What accounts for these differences? The explanations include unequal treatment within health care; the physical effects of experiencing racism; and the ways racism has shaped people's experiences.

Disparate treatment

Research has found many examples of Black and Hispanic patients receiving less appropriate care than white patients.

- Black patients with heart issues were found to be significantly less likely than white patients to receive therapeutic interventions, including implanted defibrillator devices that can prolong long-term survival.[50]
- Among pediatric patients with appendicitis, Black patients were significantly less likely to be given opioids to treat pain than white patients.[51] The study was based on data of nearly 1 million patients.
- White children who came to the emergency department reporting certain types of headaches were more likely to be diagnosed with migraine. Black and Hispanic/Latino children who came to the emergency department reporting the same types of headaches were less likely to be diagnosed with migraines, received less testing – including brain MRI scans – and were less likely to be admitted as inpatients.[52] These findings were based on a study of 49 children's hospitals between 2016 and 2022.
- In a survey, 22% of Black patients who had given birth in the past decade said they were refused pain medication they thought they needed, more than twice the rate of white patients (10%).[53]

Black women with a college degree or higher were 1.6 times more likely to die from pregnancy-related causes than white women without a high school diploma.

How racism affects health

Research is clear: Racism affects people's health.[54]

This happens in a variety of ways.

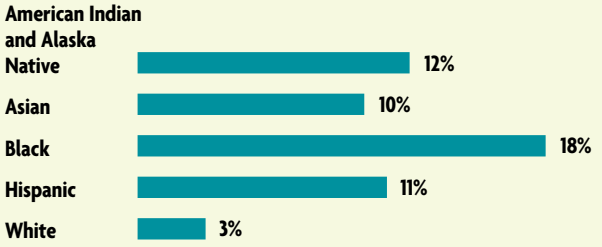
Many people think of racism as overt, interpersonal hatred. But there is also implicit bias, automatic judgments or biases that people might not even be aware of, which can lead even well-intentioned people to treat people differently because of their race or ethnicity.

A clinician who means well but has unconscious, implicit biases might be more likely to assume that a Black patient is seeking drugs for illicit purposes than a white patient or to assume that a Hispanic patient is less likely to take his medication as directed.

Health care workers themselves have identified racism against patients. A 2023 survey asked health care workers how big of an issue racism and discrimination based on race or ethnicity against patients is. Nineteen percent said it was a crisis; another 33% said it was a major problem. The rate was especially high among mental health care workers, 68% of whom said racism was a crisis or major problem.[55]

In a 2023 national survey, 18% of Black adults, 12% of American Indian and Alaska Native adults, 11% of Hispanic adults, and 10% of Asian adults said they had been treated unfairly or with disrespect by a health care provider in the past three years because of their race or ethnic background. By contrast, 3% of white adults said they had.[56]

Percent of adults who reported being treated unfairly or with disrespect by a doctor or other health care provider because of their race or ethnic background in the past three years, 2023



68% of mental health care workers said racism was a crisis or major problem.



The physiological effects of experiencing racism

Experiencing racism and discrimination can take a toll. Research has linked experiencing discrimination to outcomes including depression, anxiety,[57] hypertension,[58] breast cancer,[59] and giving birth preterm or having a baby with low birthweight.[60]

Experiencing racism and discrimination activate the body's stress response system. When that happens frequently, it can have long-term physiological and psychological effects.[61,62]

Researchers use the term "weathering" to refer to the physiological effects Black people in the United States can experience from facing adversity and marginalization repeatedly over long periods of time. These experiences can cause physiological deterioration, leading Black individuals to experience levels of illness and death at significantly earlier ages than their white counterparts would.[63]

"The stress inherent in living in a race-conscious society that stigmatizes and disadvantages Blacks may cause disproportionate physiological deterioration, such that a Black individual may show the morbidity and mortality typical of a White individual who is significantly older," wrote Arline Geronimus, the researcher who coined the term "weathering," and her colleagues. "Not only do Blacks experience poor health at earlier ages than do Whites, but this deterioration in health accumulates, producing ever-greater racial inequality in health with age through middle adulthood."[64]

Redlining and structural racism

Discrimination in housing is illegal today, but our society is still shaped by past policies that treated people differently by race. That has consequences for health.

One of the most prominent examples of the lasting footprint of racism stems from the practice known as redlining. Beginning in the 1930s, a federal agency developed "residential security" maps that classified neighborhoods into four categories, coded by color. The racial makeup of the neighborhood was among the factors in the categories, and the agency placed neighborhoods with more residents of color in the riskiest category ("hazardous"), identified on the maps in red. Banks and other lenders generally denied loans to people living in "redlined" neighborhoods, even if they could have qualified for credit. The result was that people of color were less able to obtain loans to buy houses.[65] [66]

This led to significantly lower homeownership rates among Black families and a persistent wealth gap, since homeownership is a major way families build wealth.

"The current racial wealth gap is the consequence of many decades of racial inequality that imposed barriers to wealth accumulation either through explicit prohibition during slavery or unequal treatment after emancipation," economists at the Federal Reserve Bank of Cleveland wrote in 2019.[67]

Neighborhoods that were redlined faced decades of disinvestment, with lasting consequences, including higher levels of air pollution and lead in the soil decades later.

One recent study found that air pollution levels in 2010 corresponded to the way neighborhoods were classified in the 1930s; the neighborhoods deemed hazardous by redlining had the highest air pollution levels. Those neighborhoods were also most likely to have residents living near highways and industrial pollution sources.[68]

"Findings here highlight that present-day disparities in U.S. urban pollution levels reflect a legacy of structural racism in federal policy-making – and resulting investment flows and land use decisions – apparent in maps drawn more than 80 years ago," the researchers wrote.

Another study found that lead levels in the soil in Hartford neighborhoods corresponded with the way those neighborhoods were categorized through redlining, with significantly higher lead levels in neighborhoods in the two less-desirable categories. The result is that children are at greater risk of serious health complications in neighborhoods affected by redlining.[69]







"Nearly 90 years have passed since these maps were in effect, yet the soils have kept — and, indeed, perpetuated — that memory," the researchers wrote.

"The number one parameter that determines whether a block has a risk for high lead level is the historic redlining rate," Nico Perdrial, one of the study's authors and professor of geoscience at the University of Vermont, told Connecticut Public Radio.[70]



Algorithms and other tools

Some of the tools that have long been used in medicine were designed to treat people differently by race, leading to vastly different treatment and outcomes. Other tools have had the effect of producing different outcomes by race. Together, these point to the importance of measuring the impact of tools and clinical guidelines by race and ethnicity, to identify whether they are creating or exacerbating disparities.

When race is part of the equation: Algorithms that guide treatment

Assumptions about racial differences have been built into some of the tools that are still used to deliver care – even if those assumptions aren't based in fact.

Clinicians often use algorithms to help determine what treatment is right for a patient. Many of the algorithms used in medicine have used race as a factor.[71]

These have had huge effects.

An equation used to determine an indicator of kidney function (known as estimated glomerular filtration rate, or eGFR) took race into account and resulted in Black patients appearing to have higher kidney function than other patients. Because of this calculation, Black patients had to wait longer to be placed on waitlists for kidney transplants – a potentially life-and-death decision.[72,73]

In 2021, a task force of experts recommended changing the equation to one that did not adjust for a patient's race.[74] In 2023, the Organ Procurement and Transplantation Network required transplant programs to modify waiting times for Black patients affected by the earlier calculations.[75] Research found that the change resulted in more transplants among Black patients, without significant changes in transplant rates among other patients.[76]

Race and ethnicity were also factors in a calculator used to determine a patient's likelihood of successfully delivering a baby vaginally after having a cesarean section for a previous pregnancy. The calculator predicted significantly lower likelihood of success for Black and Hispanic patients, making it more likely that their clinicians would recommend another c-section, a more invasive procedure that can result in more complications. After years of work, researchers produced a new calculator that does not take race or ethnicity into account.[77]

Even if race itself is not part of the formula in an algorithm, using data on existing health care spending or care usage as inputs in an algorithm runs the risk of replicating disparities, rather than eliminating them. For example, an algorithm that used past health care costs as a proxy for health care needs recommended more resources for white patients, or assumed white patients had higher levels of need, because white patients tend to have higher health care expenses – something that likely reflects higher levels of access rather than differing levels of need.[78]

When rules affect groups differently: Lung cancer screenings

Lung cancer is the deadliest cancer in the U.S.[79] Black patients are less likely than their white counterparts to be diagnosed early, to receive treatment, and to survive five years after being diagnosed.[80]

Lung cancer is much more treatable if caught early. There is a screening available – a low-dose CT scan – that can detect early-stage lung cancer. The U.S. Preventive Services Task Force recommends that people with certain levels of smoking history receive the screening annually.[81] Because of the task force's recommendation, insurance plans must cover these screenings with no out-of-pocket costs for those who qualify.[82]

Those rules do not specify a person's race or ethnicity. However, research suggests that the rules have had the effect of making Black patients less likely to receive screening, even those who developed lung cancer.

To qualify for screening, a person needs to meet criteria that includes both the number of years smoked and the number of cigarettes smoked per day, a measure known as "pack years."

One recent study[83] of patients with lung cancer found that only 58% of Black patients with lung cancer would have been eligible for screening, compared to 74% of white patients with lung cancer. Both Black and white patients in the study had long smoking histories – the median for both groups was more than 40 years of smoking – but Black patients had smoked fewer cigarettes per day during that time. As a result, many did not qualify for screening – even though they all developed lung cancer.

The researchers recommended changing the screening criteria to focus on number of years smoked, rather than the years and intensity. Doing so would have allowed more than 80% of the patients in the study to have qualified for screening, eliminating the disparity and leading more people to potentially discover cancer at an earlier stage.



CT spotlight:

Examining algorithms to eliminate biases

In 2021, clinicians at Yale New Haven Health began investigating patient care decision tools that took race into account. They found 57 such tools and learned that the health system was using more than half of them. In some cases, the electronic health record system used the information it had on a patient to generate a risk level or recommendations, potentially leaving clinicians unaware that race was one of the variables used to make the recommendation.

"We've realized that these tools contribute to lower quality and safety because they propagate historical racial disparities as normative and biologically innate," said Dr. Louis Hart, MD, MBA, assistant professor of pediatrics, Yale School of Medicine, the lead investigator. "For example, a study shows that there was a race-based outcome difference in a population, it gets built into an algorithm, and then that algorithm expects that this racial difference should be fundamental in all populations moving forward."

Hart and his colleagues came up with a process for mitigating the risk of clinical bias for the tools that took race into account. If a validated alternative existed, the health system switched to use it instead. In total, they achieved updated clinical consensus for 45 of the 57 tools.

For tools that had no validated alternative, they considered whether a tool was necessary at all. If it was deemed clinically necessary, Hart and his colleagues established safeguards for using the tool, including showing how race changes the results, letting patients know about the use of race in the tool, and allowing for the use of alternative calculation methods.



The cost of disparities

There are many ways to measure the cost of health disparities: poorer health, lost limbs, time spent in the hospital, more people dying younger.

There are also high economic costs. These include higher health care spending, lost productivity, and costs stemming from premature death.

One measure is the cost of additional hospital care. A study of Connecticut data found that Black and Hispanic patients received more hospital services or services with higher intensity levels than white patients.[84] Based on data from 2014, the authors linked disparities to more than $384 million in excess hospital costs for Black or African American patients and more than $121 million for Hispanic or Latino patients. The authors noted that more health care services do not necessarily lead to better care, and that providers tend to rely more on tests and procedures "when cultural or linguistic barriers impede the understanding of patients' values, preferences and goals of care."

> "This analysis suggests that in order to address healthcare costs in Connecticut, there need to be specific strategies to identify and address health and healthcare disparities," the authors wrote.

A study published in 2023 attempted to quantify the cost of racial and ethnic health inequities through excess medical costs, lost labor market productivity, and the costs associated with premature death.[85] The study found that failing to achieve health equity cost the nation $1.03 trillion in 2018. In Connecticut, the cost was $2.33 billion.

"The costs and racial and ethnic health inequities to the U.S. economy are substantial and more than justify the societal investment in developing policies and programs to eliminate health inequities and larger data sets for smaller racial and ethnic subpopulations," the authors wrote. "Even a modest reduction in health inequalities can save the nation billions of dollars in medical spending and lost labor market productivity annually."

Cost of health disparities

Premature deaths, lost productivity, excess health care costs:

$2,330,000,000

(CT, 2018)

Excess hospital costs:

$505,000,000

(CT, 2014)



Progress in Connecticut and what we've learned

While disparities in health outcomes are the result of deeply rooted problems, they are not intractable. In fact, Connecticut has made progress in recent years in addressing some of the conditions that lead to disparities. Here are some examples.

Narrowing coverage gaps

Having health insurance is a critical step toward good health. In recent years, Connecticut has adopted policies to close some of the remaining gaps in coverage. This includes:

Creating state-funded HUSKY coverage for children up to age 16 and pregnant and post-partum people, regardless of immigration status. (Children covered before they turn 16 can remain covered until they turn 19.)

Allowing those who give birth while covered by Medicaid to stay covered for 12 months postpartum, helping to reduce coverage gaps at a critical time for new parents and babies. Previously, people who give birth were only eligible for six weeks postpartum without having to have their eligibility renewed.

Creating Covered Connecticut, which provides state-funded financial assistance to people with incomes below 175% of the federal poverty level who buy insurance through Access Health CT, the state's health insurance marketplace.

Getting closer to sustainable funding for community health workers

Community health workers are frontline workers who build trusting relationships with individuals and connect them to the care and services they need. They use many different job titles, including patient navigators, outreach workers, and health coaches. Research is clear that community health worker services improve health outcomes, save money, and reduce disparities.[86] [87] Although community health worker services are widely considered to be effective, they are often funded through short-term grants, limiting their potential.

In 2023, Connecticut adopted a law requiring Medicaid to pay for community health worker services – a major step forward in ensuring that these services could be funded in a sustainable way. However, this law has not yet been implemented, and lawmakers have not budgeted money to fund it. Because Medicaid covers close to 900,000 residents, having Medicaid cover community health worker services would make a big difference in ensuring that state residents have access to these important resources when they need them. The majority of other states already pay for community health worker services through Medicaid,[88] and Connecticut could make major strides by doing so.

In 2025, Medicare began paying for some community health worker services. Like Medicaid, Medicare is a major source of health coverage, insuring more than 742,000 state residents who are 65 or older or have a disability.[89]

There are other workforces that, like community health workers, center on building trust and relationships to improve health. These include doulas, recovery coaches, and peer support specialists. Each has a unique role. Connecticut has made progress in ensuring that these workforces can be available to state residents, including through certification and, in some cases, payment.[90]

There's still more to do to ensure each of these workforces has sustainable funding. In addition, there is more work to be done to ensure that these roles are incorporated into patient care teams so they can work collaboratively with all the providers involved in a person's care.

Data on patients' race, ethnicity, and language preference

It's hard to improve what you can't measure. That's why it's so important to have reliable data on patients' race, ethnicity, and language preference (also known as REL data).

Connecticut has taken major steps forward in recent years. In 2021, state lawmakers passed a law requiring health care providers to collect data from patients on their race, ethnicity, primary language, insurance status, and disability status. Patients can choose whether to answer or not.[91]

Since then, Connecticut health systems, community health centers, and other care providers have worked to standardize how they collect REL data. Some have launched campaigns for patients to explain the importance of sharing this data and many have trained staff and revised their procedures for gathering information from patients. Staff members from many of these organizations now meet regularly to share best practices and insights into how to use the data to identify and address disparities in care.

The state has released standards for the data, using more granular categories for ethnicity that are meant to help reflect people's identities and to allow for more detailed data analysis.[92] Using more granular categories can help identify disparities that might be masked by larger groups, such as issues that affect Puerto Ricans or Cambodians but would not show up in data for all Hispanic or Asian residents.

Early analysis of hospital data collection shows it's happening widely. Connie, the state's health information exchange and the entity where health care providers must report the data, found that in the fourth quarter of 2025, among 1 million records from hospitals, 98.2% of patient records included data on race, 73.7% had data on ethnicity, and 84.8% had data on language preference.

There is still work to be done to ensure that all health care providers are collecting and reporting data using the state's standards, particularly for the more granular categories.







Having the data has made a big difference. Many clinical care providers have embraced REL data as an opportunity to better understand gaps in care and to test solutions.[93] For example:

- Staff at one community health center reviewed data on patients using home test kits for colorectal screening. The data showed that Black and Latino patients had the lowest rates of completing the screening. To better understand the issue, the health center hosted focus groups and learned that many patients were confused about the kits, had concerns about self-collection, or needed reminders to complete the screening and return the sample. This led the health center to launch specific interventions intended to ensure that more patients complete the cancer screening.
- One clinical care provider found that white patients with diabetes were receiving more A1C tests – a measure of diabetes control – and follow-up visits than Black patients and patients with uncontrolled diabetes. The organization is now working to address the gap.
- Another care provider examined cervical cancer screening rates. Using broad categories, they found no differences in screening rates between Hispanic and non-Hispanic patients, or between Black patients and those in other racial groups. However, when they examined the data based on more granular categories, they found gaps: Dominican patients were much less likely to receive cervical cancer screening than other Hispanic patients, and patients who identified as West Indian, African, and Jamaican had lower screening rates than other patients. This led the organization to launch a quality improvement initiative to address the gaps, something made possible by having granular data.



CT spotlight:

Using REL data to improve mobile crisis response

Connecticut has a state-funded Mobile Crisis Intervention Service (MCIS) that provides an in-person response to children experiencing behavioral health crises. The service is available to any child in the state, free of charge, but data showed that there were gaps in how children and teens were getting access to it.

Using data as the starting point allowed those leading the program to make changes.

An analysis of data found that, compared to other youth served by mobile crisis, Black youth were 8% more likely to be referred by a school, 22% less likely to be referred by families, and 40% more likely to have a primary presenting problem of "disruptive behavior." The latter finding raised concerns that Black youth experiencing depression, hopelessness, and thoughts of suicide might be getting missed and not referred for services.[94]

The analysis was completed by the Child Health and Development Institute, in collaboration with the Department of Children and Families, 211, and providers.

The data provided a roadmap for improving the use of mobile crisis services in a way that would reduce gaps. One provider agency worked to strengthen relationships with family organizations and churches in communities with lower call rates. Several agencies worked with schools to emphasize that mobile crisis services can be used for a wide range of issues beyond disruptive behavior. In addition, clinicians received training on suicide prevention for Black youth.



Challenges

While Connecticut has made progress in addressing the causes of health disparities, our state also faces challenges that risk making health disparities worse. These issues affect all state residents and have particularly severe effects on people of color.

New threats to coverage and other assistance

While Connecticut's uninsured rate has been below 7.5% for the past decade,[95] federal policy changes could cause many state residents to lose their health care coverage.

More than 165,000 state residents are at risk of losing Medicaid coverage in the next 10 years under HR 1, the 2025 federal law also known as the "one big beautiful bill act."[96] Many adults under 65 will be required to prove that they work, attend school, or participate in community service activities, or qualify for an exemption (this requirement applies to people covered by HUSKY D in Connecticut). Although most adults under 65 with Medicaid already work,[97] many are at risk of losing coverage because of difficulties reporting their work hours or other administrative burdens.[98] Similarly, the law requires many adults to have their Medicaid eligibility reassessed every six months – up from the current once per year. When these eligibility assessments take place, people run the risk of losing coverage because of administrative glitches, even if they still qualify.[99] In addition, the law narrows the types of immigration status that would allow immigrants to qualify for Medicaid, causing many immigrants with legal status to lose coverage.[100]

The coverage losses are expected to hit people of color disproportionately. An analysis by DataHaven projected that 8% of all Connecticut Black residents and 9% of Latino residents would lose Medicaid coverage in the next 10 years under HR 1, compared to 3% of white residents. (Overall, more white people are projected to lose coverage than any other group, but it represents a smaller percentage because there are more white residents in the state.)[101]

HR 1 also made cuts to funding and eligibility for the Supplemental Nutritional Assistance Program, or SNAP, the nation's largest anti-hunger program. An estimated 58,000 Connecticut families are projected to lose some or all of their SNAP benefits under the changes in the law.[102]

Growing affordability challenges

Health care coverage makes a difference, but for many people with coverage, care is not affordable. Health care costs were tied with gasoline or other transportation costs as the top source of economic worries for adults in a national survey conducted in April 2026; 64% said they were very or somewhat worried about being able to afford each one.[103]

Connecticut has a tool known as the Connecticut Healthcare Affordability Index, or CHAI, which is designed to measure challenges paying for care. Under the CHAI, health care is considered affordable if a family can reliably get care without sacrificing the ability to meet all other basic needs or going into debilitating debt.[104]

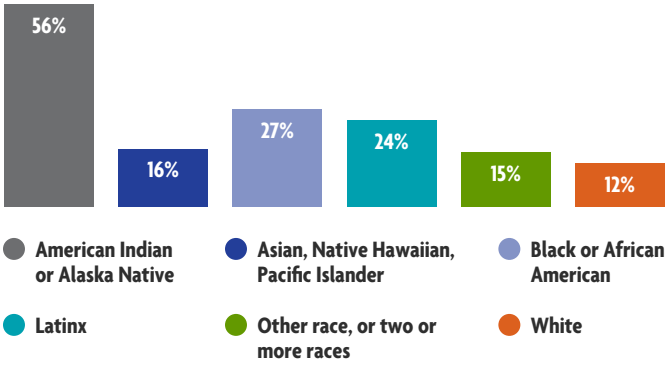
In 2022, about 13% of Connecticut households had unaffordable health care costs, according to the CHAI. The burden was particularly high for households that purchase insurance through the individual market.[105] Households headed by Black or African American, Latinx, and American Indian or Alaska Native residents were most likely to face unaffordable health care costs.[106]

Among households with employer-sponsored insurance in 2022, Black or African American and Latinx households were twice as likely as white households to have unaffordable health care costs. American Indian or Alaska Native households were the most likely to have unaffordable health care costs – 56%.[107]

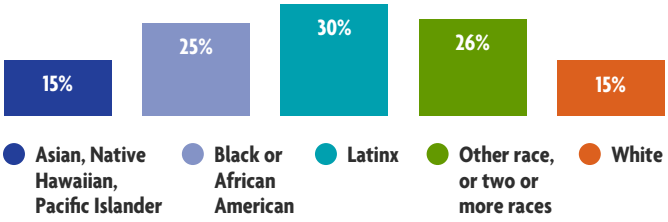
Similarly, among households who buy their own insurance through the individual market, Latinx households were twice as likely as white households to have unaffordable health care costs, and Black or African American households also had higher rates of unaffordable costs.[108]

The CHAI can also show the impact of policy changes on affordability. From 2019 to 2022, the rate of households buying individual market insurance that had unaffordable health care costs dropped from 68% to 20%.[109] During this time, federal financial aid to purchase insurance through the individual market increased dramatically. (These extra subsidies have since expired, although state policymakers allocated state dollars to help limit cost increases for many state residents.)

Connecticut households with employer-sponsored insurance that had unaffordable health care costs, 2022



Connecticut households with individual market insurance that had unaffordable health care costs, 2022





Health impacts of federal immigration policies

Federal policies targeting immigrants have created fear within Connecticut communities that could have lasting consequences for health. Immigrants are avoiding health care, forgoing services and benefits even if they qualify, and experiencing high levels of stress and anxiety.[110]

Health care providers who treat immigrant patients have reported having far fewer visits and that those who do come for care tend to wait until they are much sicker.[111] Patients reported the same thing; in a 2025 survey, 29% of immigrants said they had skipped or postponed care in the past 12 months, up from 22% who said the same thing in 2023. The increased rate of skipping care occurred for those with and without legal immigration status, including naturalized citizens.[112]

In a 2025 survey, 40% of immigrants said worries about their immigration status or that of a family member had led to health impacts including stress, anxiety or sadness, problems sleeping and eating, or worsening health conditions. Hispanic and Black immigrants reported these health impacts at nearly twice the rate of Asian and white immigrants.[113]

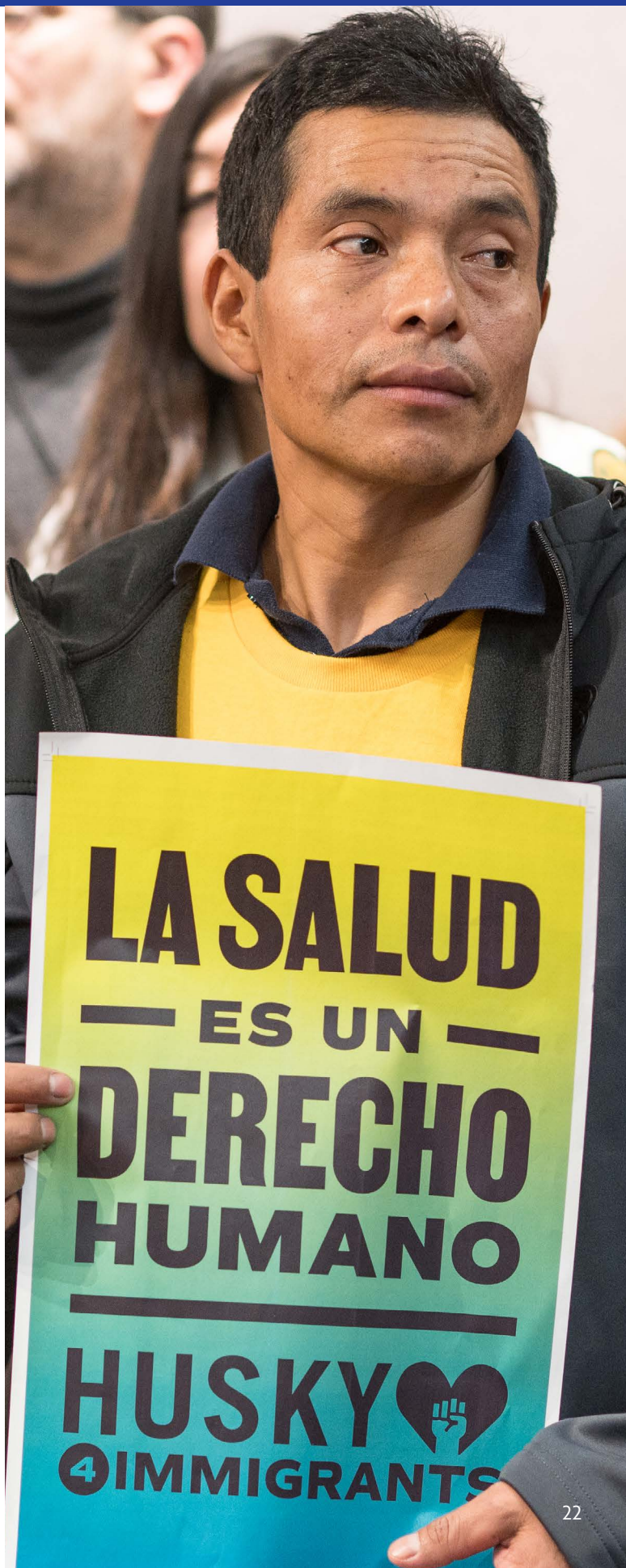
In July 2025, the U.S. Department of Health and Human Services announced a policy change that could prohibit people with certain immigration statuses from receiving care from community health centers.[114] Connecticut is one of more than 20 states that sued to stop this change, and legal action has stopped it for now.[115] Community health centers serve as a significant source of care for immigrants, and any change that affects their ability to serve immigrant patients could leave many people without access to primary care, behavioral health, and dental care.

In a 2025 survey, 29% of immigrants said they had skipped or postponed care in the past 12 months.

Federal policies against equity

The Trump administration has taken steps to limit or eliminate efforts to address racial equity,[116] including cutting hundreds of millions of dollars in grant funding for research on minority health and health disparities.[117]

Disparities will exist whether or not they are measured, reported, and researched. To the extent that policy changes make it harder to identify gaps in care and outcomes by race and ethnicity, it will be harder to find solutions.





What Connecticut can do now

There are many things Connecticut can do to make progress in addressing health disparities and the conditions that cause them. This list is just a few of them. Each of these recommendations are likely to benefit Connecticut residents broadly, by expanding access to coverage or services, improving the quality of care, and addressing affordability and economic security.

Get and keep people covered

Federal policies helped to dramatically expand health care coverage in Connecticut in the past 15 years, and state policymakers took action to extend coverage even further, taking advantage of additional federal funds. The federal government's stance and funding availability has shifted, but health care coverage is just as critical for people in our state. State policymakers should explore options for extending state-funded coverage to more people and policies that can make existing coverage more affordable.

Fund community health worker services through Medicaid

Research is clear that community health worker services can improve people's health and well-being and narrow disparities. These services are cost-effective and often result in a positive return on investment. At a time when health misinformation is rampant and trust in traditional authorities has been diminished, community health workers' ability to build trusting relationships with their neighbors to ensure they get the care and services they need are especially valuable.

A 2023 Connecticut law requires Medicaid to cover community health worker services – something that the majority of other states already do. This law has never been funded or implemented. There are clear examples from other states[118] of how to structure this funding, and clear evidence that it will benefit Connecticut residents without a significant increase in costs.

Use data on race, ethnicity, and language preference to identify and fix gaps

Connecticut has made major strides in the collection of race, ethnicity, and language data in health care in the past five years.

Now that the data is being collected, it's important to use it to identify and address disparities in care and outcomes. Several health systems and community health centers have already started analyzing their data to see how they can deliver better care.

Beyond the opportunities for care improvement, this data will be especially important if the federal government changes what data it collects and reports.

There is more work to be done to ensure that health systems and other care providers are collecting data using the state's standards for granular categories. In some cases, this has been hindered by challenges with electronic records systems. Some large health systems are working to influence electronic medical record vendors, and having more voices to make the case could be helpful.

Focus on health care affordability

Health care affordability is a top economic worry nationwide. Policy changes can make a big difference. For example, when the federal government increased financial aid for people buying coverage through health insurance marketplaces, the rate of households with unaffordable health care in Connecticut dropped dramatically. Those enhanced subsidies expired at the end of 2025, but state funding has preserved some of the financial aid for Connecticut residents. Extending this funding could help keep more people from facing unaffordable costs.

While subsidizing the cost of coverage helps people pay for insurance, addressing the increasing cost of health care will require dealing with underlying cost drivers, including the price of care. Connecticut has taken some steps, such as the creation of a health care benchmark designed to measure and monitor increases in health care costs, but these have not yet been sufficient to ease the burden on Connecticut households.

Provide ways to report discrimination in health care

Whether intentional or not, discrimination and disparate treatment are realities for patients of color in Connecticut. Being able to identify and report it when it occurs is critical to addressing the problem. Confidential or anonymous reporting systems can allow health care workers and patients to report what they see or experience. The University of Pennsylvania's Penn Medicine now uses a system called Lift Every Voice in its departments of emergency medicine and obstetrics and gynecology.[119] Connecticut health systems could develop new models or test models that exist elsewhere. Policymakers could look to incorporate patient experience in required reports and other assessments of patient care, such as the maternal health report card for hospitals that is currently being developed.

Report on the impact of implicit bias training requirement

A 2021 law requires Connecticut hospitals to include training on implicit bias as part of its regular training to staff members who care for pregnant or postpartum patients.[120] It will be valuable to understand how uniformly this has been implemented and the impact of these trainings. An evaluation could help to identify how effective these trainings have been and pinpoint which trainings could be replicated or used in other settings. It would also be helpful to identify gaps or challenges to determine what additional training would be helpful.



Expand diversity in the health care workforce

A recent U.S. Supreme Court ruling limits the ability of medical schools to take race into account in admissions, but there are opportunities to encourage more diversity in medical education. The University of California, Davis offers an example of how to enroll a diverse student body even with restrictions on admissions policies.[121]

Ensure that artificial intelligence and algorithms are used to combat disparities, not reinforce them

Algorithms in health care can reduce disparities if they are designed to do so, but they can also perpetuate and worsen existing disparities.[122] As artificial intelligence tools become more common in health care and other settings, it is critical to understand how their use affects inequities that already exist. Like algorithms, AI tools carry the risk of replicating existing disparities and making them worse by making recommendations based on care or outcomes that are not equitable.

Support policies that address economic well-being

Longstanding disparities in wealth contribute to gaps in health outcomes. There are many promising practices that Connecticut can pursue or expand to improve economic security and mobility. These include ensuring the sustainability of CT Baby Bonds, reinstituting a child tax credit, and piloting basic income programs.



Conclusion

Connecticut is one of the healthiest states in the nation, but not everyone has the same opportunity to live their healthiest lives. A Black baby born in Connecticut is likely to live five fewer years than a white baby, and is more likely to face asthma, diabetes, cancer, and other health challenges throughout life. Racial and ethnic health disparities result from a combination of unequal access to health care and other resources, disparate treatment within health care, and the effects of racism on health.

Despite this, there are opportunities to make progress. Changes in recent years offer examples: Connecticut extended health care coverage to more residents, moved closer to sustainably funding community health worker services that can reduce disparities, and ensured that all health care providers ask patients for their race, ethnicity, and language preference. There is still more to do to ensure that these changes translate to better health and quality of life, and there are many other ways our state can make progress to reduce disparities and improve health and access to care for everyone in our state. The federal environment has made it more challenging to focus on equity, but Connecticut has the opportunity to stay on course and commit to prioritizing the well-being of all state residents in both policy and budgeting. We owe it to everyone in our state, especially those who make up our future, to ensure that everyone experiences the benefits of living in one of the healthiest states in the country.

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