

**Health Consequences for Uninsured Americans
and Racial and Ethnic Disparities in Health Care**

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Invited Testimony
Subcommittee on Health
Committee on Ways and Means
United States House of Representatives
Hearing on "The Instability of Health Coverage in the United States"

April 15, 2008

Thank you, Chairman Stark, Representative Camp, and the members of the House Ways and Means Subcommittee on Health, for inviting me to testify on the health consequences for Americans who lack insurance and on the persistent problem of racial and ethnic disparities in the U.S. health care system. These topics are of vital importance to our nation. Too many Americans live in worse health and face an increased risk of death because effective medical care is not accessible and affordable without health insurance. Even when people are insured, the benefits of good health care are not consistently available to Americans of all racial and ethnic groups.

As a researcher and faculty member at Harvard Medical School over the past 16 years, I have studied with colleagues the adverse effects that Americans experience when they lack health insurance, as well as pervasive racial and ethnic disparities in health care and health outcomes across a wide range of medical conditions and services. From 2000 through 2004, I served on the Institute of Medicine Committee on the Consequences of Uninsurance. Our committee issued a series of six comprehensive reports on the cascade of medical, social and economic consequences of uninsurance for adults, children, families, communities, and our country.¹⁻⁶ As a physician at Brigham and Women's Hospital in Boston, I also care for patients with high blood pressure, heart disease, diabetes, cancer, and other serious conditions. I have seen first-hand how patients' lives are affected when they lose their insurance, causing them to miss appointments and forego treatments that could keep them in better health.

Health Consequences of Lacking Insurance

As you consider in this hearing the instability of health coverage in the United States, I would like to share insights from my research and clinical experience and from the findings of the Institute of Medicine. The financial challenge of achieving universal coverage may appear daunting, but the human and economic consequences of inaction are substantial. To put it bluntly, uninsured Americans "live sicker and die quicker" because they receive too little medical care that often comes too late to prevent avoidable complications and death.

Uninsured Americans are much more likely than insured Americans to avoid seeing a doctor because of the cost. Among those in poor health, 50 to 70 percent of uninsured adults go without needed medical care, compared with only about 20 percent of insured adults in poor health (Figure 1).⁷ Uninsured adults are less likely to receive high-quality primary care and important preventive services, such as cholesterol testing and mammograms. As a result, they

are often unaware of their major health risks, such as high blood pressure or high cholesterol,⁸ and those with curable cancers, such as breast cancer or colon cancer, are diagnosed at a more severe stage of disease.⁹⁻¹¹

Because of their unstable and sporadic medical care, uninsured adults have a much greater risk of dying at younger ages than insured adults.¹²⁻¹⁵ In 2002, the Institute of Medicine estimated that 18,000 Americans died prematurely in 2000 because they lacked health insurance.² A recent update from the Urban Institute estimated this number has risen to 22,000 to 27,000 excess deaths among uninsured adults in 2006.¹⁶ Sadly, many of these premature deaths occur among people with conditions that are readily treatable, including high blood pressure, HIV infection, and breast cancer.^{9, 17}

Uninsured Near-Elderly Adults: A Particularly High-Risk Group

The instability of insurance coverage in the United States has especially harsh effects for near-elderly adults who are uninsured or erratically insured between the ages of 55 and 64. About 4 million adults in this age group were uninsured in 2006.¹⁸ For those who have lost their insurance coverage because they've lost their job, become disabled, or had an older spouse retire, finding insurance in the individual market is often prohibitively expensive – if not impossible – when they have pre-existing medical conditions.

As a physician, I see that people who receive good medical care in their 50's and early 60's live longer and healthier lives. Medical advances over the past 40 years have done much to improve the outcomes of high blood pressure, heart disease, diabetes and cancer, particularly for middle-aged adults who have much to gain from early detection and effective treatment of these conditions. However, recent research by our group and others has shown that the health of uninsured middle-aged adults declines more rapidly than the health of comparable insured adults.^{19, 20} These declines in health are associated with a 40% greater risk of death for uninsured adults.¹⁴ This risk is concentrated among uninsured adults with high blood pressure, diabetes or heart disease (Figure 2), precisely the medical conditions for which we know good medical care makes a difference.

Health Benefits of Gaining Insurance Coverage

The evidence on this topic is not all grim. Universal Medicare coverage at age 65 offers real benefits to individuals and society. If uninsured adults survive to age 65, Medicare provides improved access to physicians, appropriate medical tests, and effective treatments (Figure 3).²¹

In our most recent research, my colleagues and I have found that the differences in health between uninsured and insured adults with cardiovascular disease or diabetes at age 65 are reduced by half after 5 years of Medicare coverage (Figure 4).²⁰ Our research also shows that after these uninsured adults gain Medicare coverage, they experience fewer heart attacks, less heart failure, and less severe chest pain.

Hidden Costs When Uninsured Adults Enroll in Medicare

The status quo masks hidden costs to the Medicare program when millions of uninsured adults enroll in Medicare. Uninsured adults, particularly those with chronic medical conditions, have fewer visits to physicians and fewer hospitalizations than insured adults in similar health before age 65. After becoming eligible for Medicare, uninsured adults have a rapid increase in physician visits and hospitalizations that exceeds the use of services by insured adults and persists for at least 7 years after age 65 (Figure 5).²² Their care in the Medicare program is thus more costly because uninsured adults reach age 65 in worse health and have more immediate and expensive medical needs than if they had been insured and well treated in their 50's and early 60's. If all near-elderly adults had insurance coverage, the costs of covering this high-risk group could be offset by better health and potential savings for the Medicare program.

Racial and Ethnic Disparities in Health Care and Health Outcomes

To obtain high-quality care, Americans must overcome seven potential barriers: 1) having health insurance available; 2) getting enrolled in insurance; 3) having coverage for effective providers and appropriate services; 4) becoming well informed about treatment options; 5) having a consistent source of primary care; 6) getting referred for needed specialty care; and 7) having providers deliver high-quality care.²³ Disparities in medical care and health outcomes arise when people from disadvantaged racial, ethnic or socioeconomic groups experience barriers in any one of these seven steps.

The instability of health insurance coverage in the United States is an important factor contributing to racial and ethnic disparities in health care and health outcomes. Rates of coverage vary widely across racial and ethnic groups in the United States (Figure 6). Whereas 13 percent of white Americans under age 65 were uninsured in 2006, rates of uninsurance were considerably higher for other racial and ethnic groups: 17 percent for Asian Americans and Pacific Islanders, 22 percent for African Americans, 33 percent for American Indians and Alaska Natives, and 36 percent for Hispanic Americans.¹⁸ Without consistent insurance coverage, many

minority Americans receive fewer preventive services and less effective treatment for heart disease, high blood pressure, diabetes, cancer and other major conditions. In the latest National Healthcare Disparities Report, three key themes have emerged since 2001:

- “Overall, disparities in health care quality and access are not getting smaller.
- Progress is being made, but many of the biggest gaps in quality and access have not been reduced.
- The problem of persistent uninsurance is a major barrier to reducing disparities.”²⁴

Even when minority Americans have insurance coverage, the health system often does not perform as well for them as for white Americans. The landmark Institute of Medicine report, *Unequal Treatment*, has dissected the many ways in which the quality of health care is uneven across racial and ethnic groups.²⁵ Some disparities arise from biases and discrimination by health care providers, while other disparities occur because safety-net organizations that disproportionately serve poor minority patients are often underfunded and isolated from the best features of American health care.

Fragmented systems of care in the United States are a major contributor to disparities in care. Our health-care systems are complex and often difficult to navigate for all members of society. However, deficits related to fragmented care are most likely to affect patients who are disadvantaged because of their race, ethnicity, language, immigrant status, income, education, or lack of insurance coverage. These patients fall through the cracks in complex systems of care. In multi-step processes of evaluation and treatment, such as cardiac procedures, kidney transplants, or cancer care, small disparities at each step in the process can yield a moderate to large disparity in the overall pattern of care.²⁶

Racial and ethnic disparities in health outcomes have deep roots in American history. These disparities also result from persistent poverty, discrimination, and unequal opportunities in contemporary American society. Stable and affordable health insurance that provides access to high-quality primary and specialty care is an essential part of the foundation for eliminating these disparities and improving the health of all Americans.

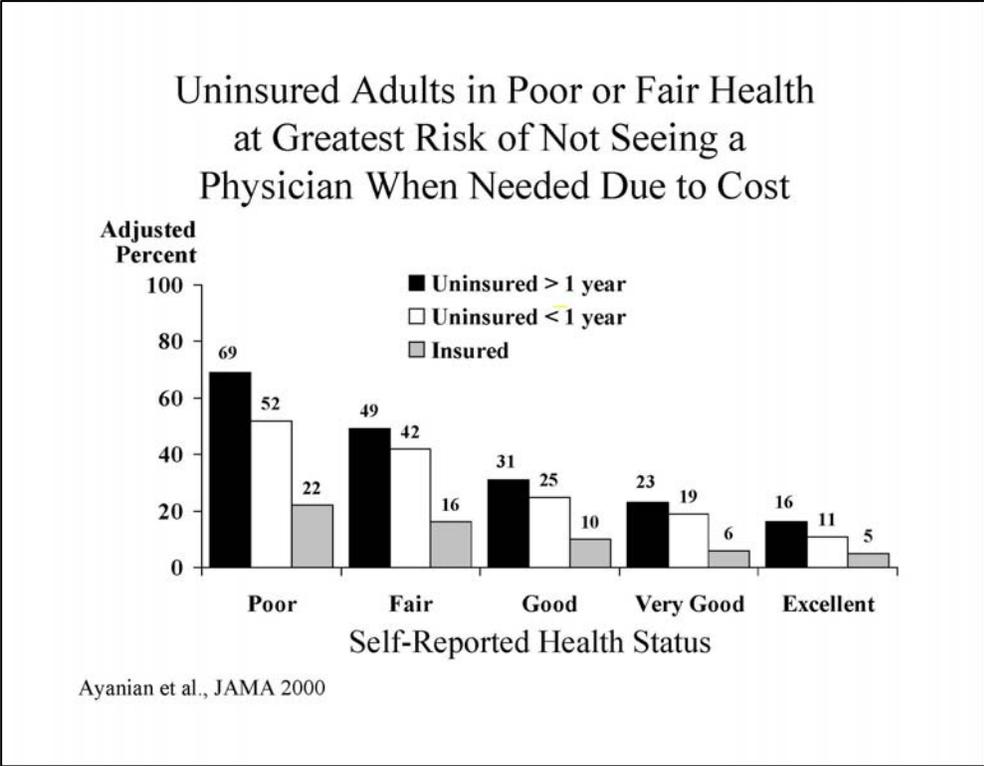


Figure 1

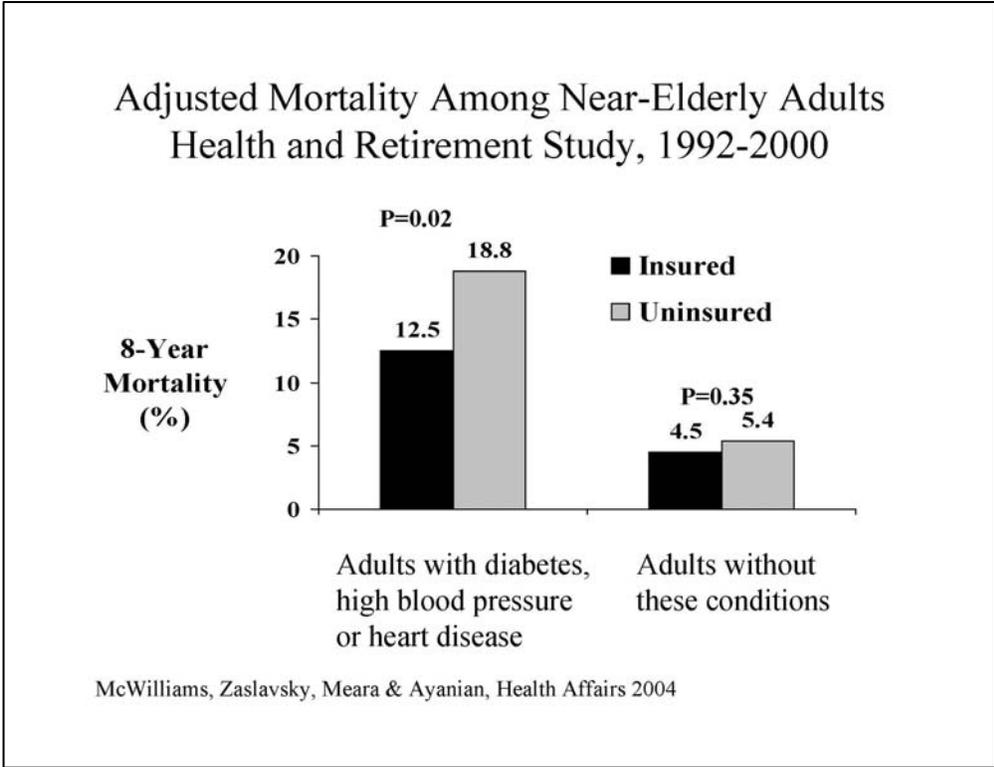
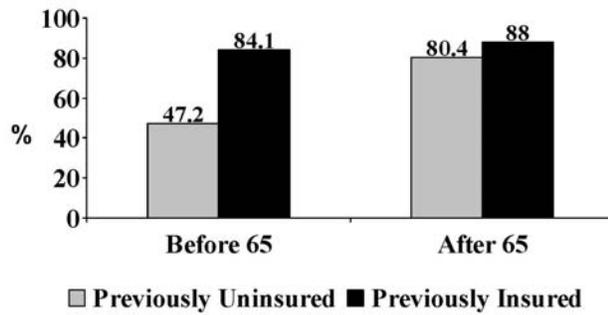


Figure 2

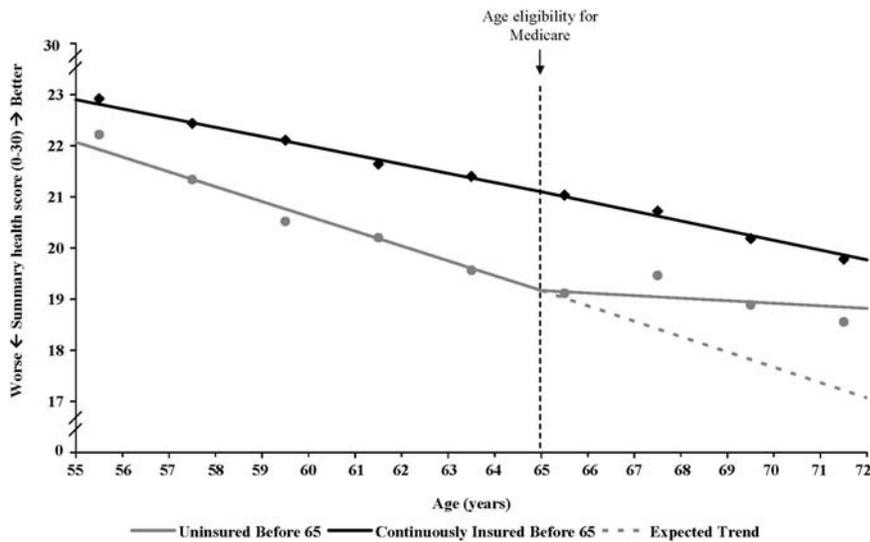
Improved Access to Effective Services With Medicare Coverage Cholesterol Testing for Adults with Diabetes or Hypertension



McWilliams, Zaslavsky, Meara, Ayanian, JAMA 2003

Figure 3

Health Trends for Adults with Cardiovascular Disease or Diabetes



McWilliams, Meara, Zaslavsky, Ayanian, JAMA 2007

Figure 4

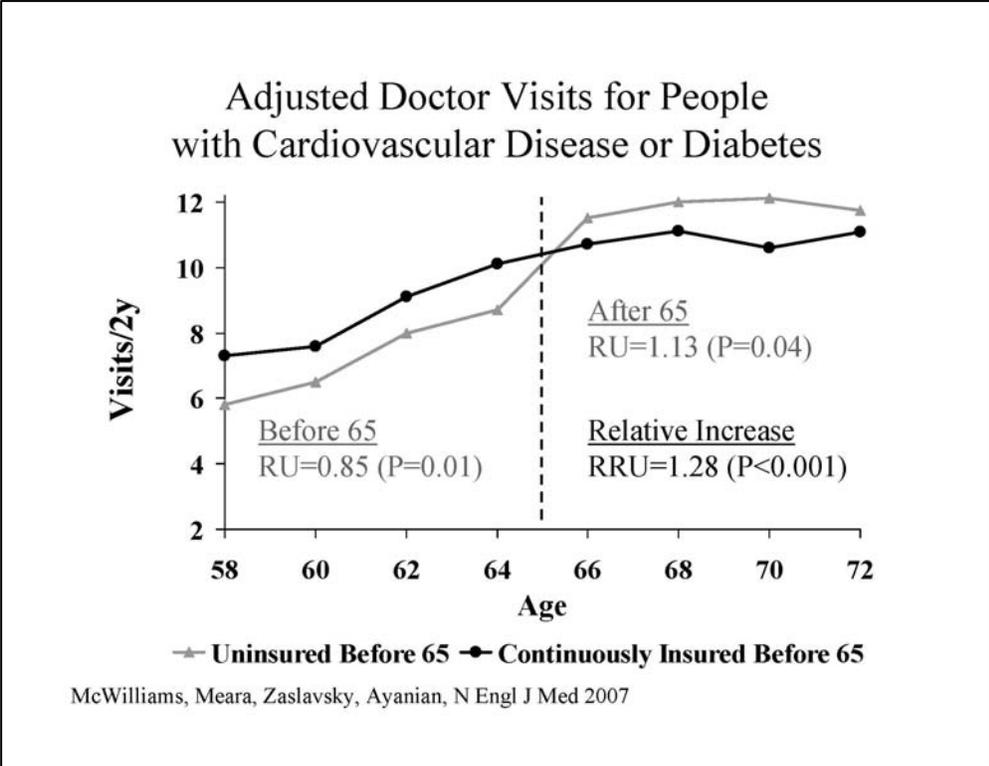


Figure 5

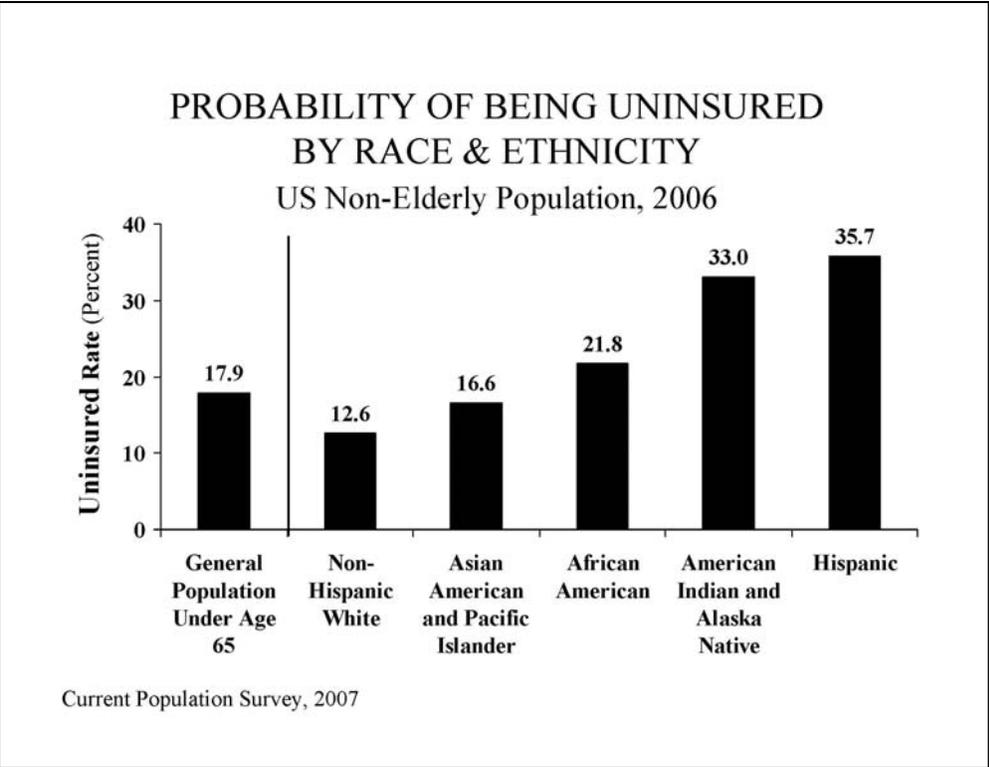


Figure 6

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