

Gender and Race Differences in the Uninsured Population of the United States, 2013 – 2014

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Abstract

The aim of this paper is to (1) Determine the proportion of people that are uninsured by race and gender (2) Explain the differences in coverage between gender and race classifications. Data from the US Census Bureau showing health insurance coverage by race and gender for years 2013 and 2014 was analyzed and showed that a higher proportion of males compared to females were uninsured. In addition, Hispanic males and females had the highest proportion of the uninsured, closely followed by Blacks. Whites had the lowest proportion of uninsured people of any race.

Key words: Race; Gender; Ethnicity; Health Insurance; Uninsured; United States; Affordable Care Act.

1. Introduction

The Affordable Care Act (ACA), signed into law in March 2010 was enacted to decrease the number of uninsured people in the United States, decrease health costs and improve the quality of healthcare that patients receive. Amongst other things, it prohibits denial of insurance to individuals based on pre-existing conditions, establishes minimum standards for health insurance policies, and has an individual mandate that requires all individuals not covered by other government or employer sponsored plans to obtain a private insurance policy or face a penalty.

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Also, it led to the launch of public exchanges from which individuals can compare insurance policies and sign up for one that best suits their needs while giving subsidies to low-income individuals and families whose income are between 100%-400% of the federal poverty line, if they choose to shop for health insurance on the public exchange. Since the law was signed 5 years ago, nearly 17 million people have been covered under the ACA, with a Gallup study reporting in April 2015 that the uninsured rate among adults 18 and over fell from 18.0% in Q3 2013 to 11.9% by Q1 2015 [1] However, limited information exists about the differences in successful coverage amongst people of different gender, race and ethnic classifications.

Differences in gender is clear enough, but Race is a social classification based on phenotype and a marker for exposure to social factors that can influence health, including socioeconomic position, lifestyle habits, and use of health care [2]. Ethnicity is also a social construct referring to the sharing of a culture, including ancestry, language, religion, and traditions [3]. Ethnicity is thought to be separate from race, in this article as regards the US population the words are used interchangeably.

The major limitations of this paper are that (a) It does not consider that some individuals may have voluntarily decided to forego insurance, even though the number of people who fall into this category are most likely negligible (b) It does not consider the immigration status of individuals to determine whether they are eligible for insurance or not (c) Available data on the proportion of people that are uninsured since the implementation of the ACA cover only two periods, 2013 and 2014. It will be interesting to see what the numbers look like over the coming years.

The findings in this study will help policy makers identify gaps in the implementation of current policies aimed at reducing the number of uninsured people in the United States and possible solutions that can be implemented to narrow the differences in coverage amongst people of different genders and races.

2. Methodology and Data

Data from the US Census Bureau showing coverage rates and types of coverage for years 2013 and 2014 was analyzed. Data showing uninsured population by a combination of more than one race were excluded. Coverage by age groups and other factors were excluded from this research. A review of government publications, journal articles and reports was then conducted to find probable explanations for the disparities in coverage seen between different genders and races.

3. Results

Across all races, a larger proportion of males are uninsured than females: An analysis of the data from the US Census Bureau shows that in the year 2013, 14.4% of males were uninsured compared to 12.3% of females in the same year. By the year 2014 as the major provisions of the ACA kicked in, the percentage of males that were uninsured dropped to 11.3% vs 9.6% for females.

Hispanics have the highest proportion of people that are uninsured, followed by blacks: 24% of Hispanics

were uninsured in 2013 compared to 15.9% of blacks and 9.7% of whites. The gap was still considerable in 2014 despite implementation of the major provisions of the ACA. In 2014, 20% of Hispanics were still uninsured, more than double the proportion of Asians (9.3%) and Whites (7.6%), and nearly double the 11% of blacks that were not covered by any form of health insurance

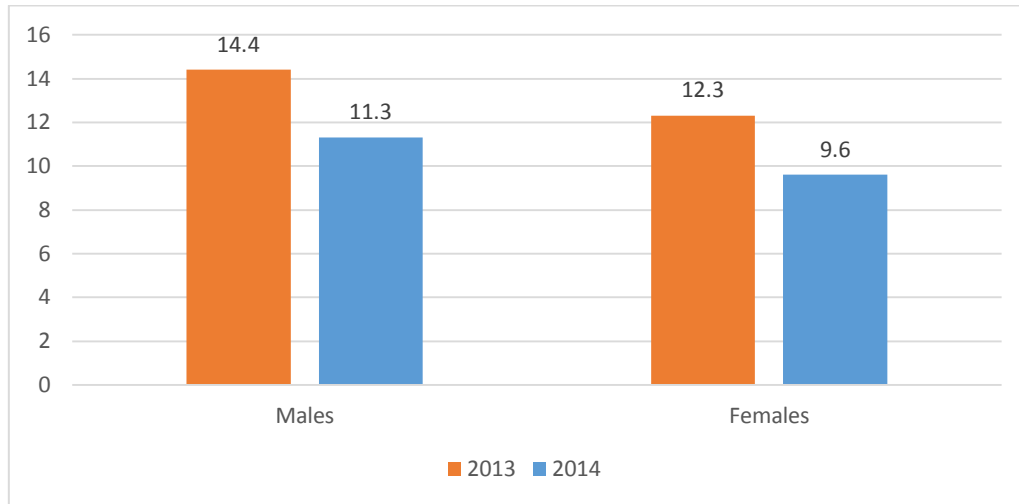


Figure 1: Percent of Males vs Females of all races without health insurance (2013 - 2014)

Source: US Census Bureau Table HIC-1. Health Insurance Coverage Status and Type of Coverage by Sex, Race and Hispanic Origin: 2013 – 2014

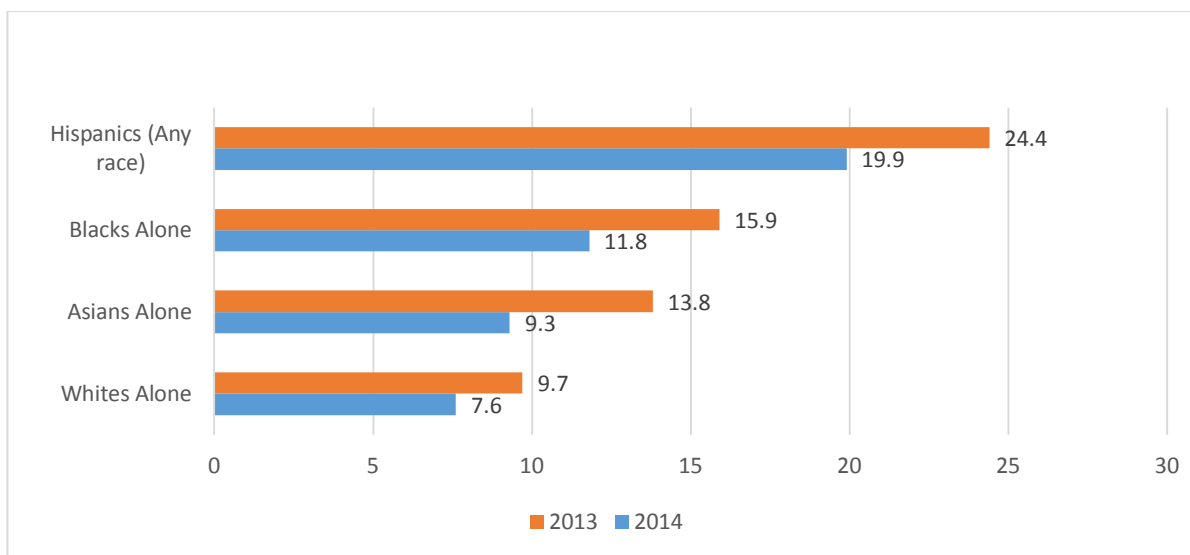


Figure 2: Uninsured population by Race (2013 - 2014)

Source: US Census Bureau Table HIC-1. Health Insurance Coverage Status and Type of Coverage by Sex, Race and Hispanic Origin: 2013 – 2014

In 2013, the biggest gap between the proportion of male and female uninsured was amongst Hispanics:

26.7% of Hispanic males were uninsured, compared to 22.1% of Hispanic females, representing a difference of 4.6 percentage points. This was closely followed by the 3.3 percentage point difference between uninsured Black males (17.6%) and females (14.3%). It is interesting to note that in 2013, the difference between the proportion of uninsured Asian males and females, and White males and females was 1.3 percentage points.

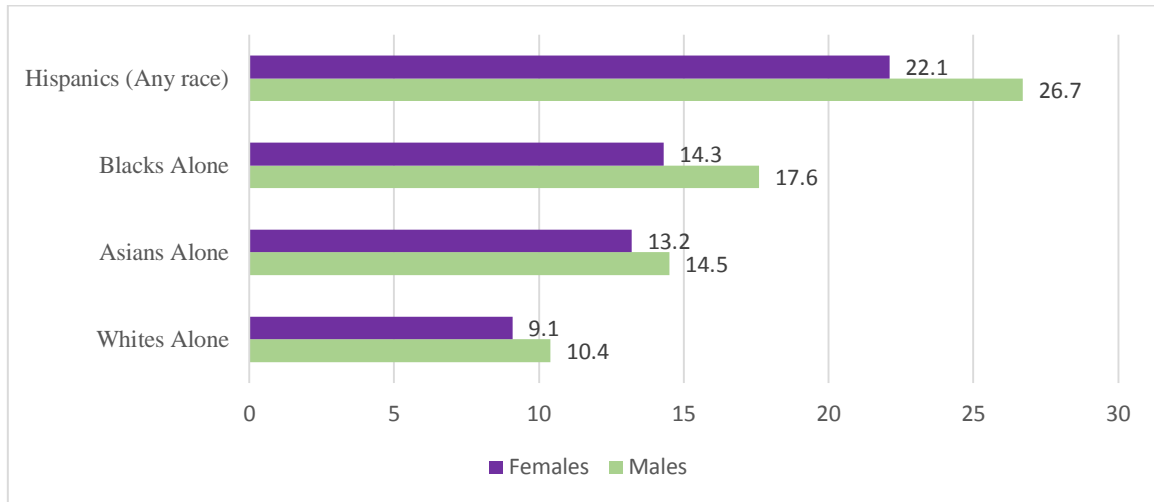


Figure 3: Uninsured population by race and gender (2013)

Source: US Census Bureau Table HIC-1. Health Insurance Coverage Status and Type of Coverage by Sex, Race and Hispanic Origin: 2013 – 2014

In 2014, the coverage gap between Asian males and females narrowed the most: Across the board, coverage gaps between males and females narrowed compared to 2013. However, Asians had the most gain with the coverage gap between uninsured males (9.5%) and females (9.1%) being only 0.4 percentage points. Whites had the least improvement in coverage gaps, with the coverage gap between uninsured males (8.2%) and females (7%) improving by only 0.1 percentage points over 2013 values. The coverage gap between uninsured Hispanics and Blacks remained high at 3.6 percentage points and 2.3 percentage points respectively.

4. Discussion

The disparities in the proportion of the uninsured along lines of race and gender have root causes that are multifaceted. These causes – outside of eligibility for health insurance coverage due to immigration status or other considerations – will be examined below.

Disparities by Gender: Firstly, is the age distribution between genders. Under the ACA children up to 26 years old can be covered by the health insurance of their parent after which they must personally obtain health insurance or pay a penalty. For both sexes, the uninsured rate peaks at age 26, an age when children lose their health insurance coverage provided by their parents' policies. The gap between men's and women's coverage rates appears to be entirely among people of working age, with the largest gaps among those in their late 20s and early 30s [4]. Most people of working age have private health insurance coverage, which they receive through

their employer or a family member's employer [4].

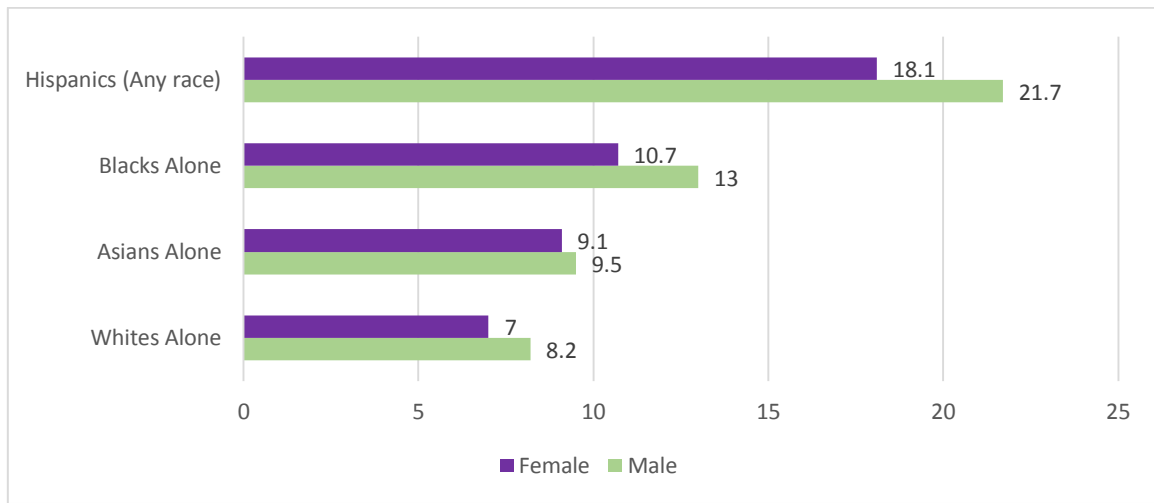


Figure 4: Uninsured population by Race and Gender (2014)

Source: US Census Bureau Table HIC-1. Health Insurance Coverage Status and Type of Coverage by Sex, Race and Hispanic Origin: 2013 – 2014

Secondly is the degree to which males and females are covered by government sponsored insurance. A lot of government insurance programs have provisions that enable women to be covered under them as opposed to men. It is in government-provided health insurance coverage where we see differences between men and women. At the younger ages, women have higher coverage rates than men [5]. This pattern reverses with age, as men in their later 50s and early 60s appear to have higher rates than women do [5]. Government-provided health insurance coverage is made up of several distinct programs. Women and men share similar coverage rates from Medicare (which benefits mostly people with disabilities and people 65 and older). However, far more women than men receive coverage under Medicaid (which mostly benefits people with lower incomes), with the largest gaps in coverage appearing among men and women in their 20s and 30s [5]. The difference between men's and women's insurance rates is mainly driven by government health insurance coverage, specifically Medicaid provided to young adults [4]. Lastly, women are more likely to search for health information and therefore obtain health insurance [6]. This voluntary behavior to seek out health services, health insurance inclusive, amongst other reasons contributes to many more women being covered by health insurance than men.

This is not however to discount the problems women face in obtaining health insurance, Data suggests that approximately 12.8 million women (13%) ages 19 to 64 were uninsured in 2014. These women often have inadequate access to care, get a lower standard of care when they are in the health system, and have poorer health outcomes [7]. Compared to women with insurance, uninsured women have lower use of important preventive services such as mammograms and Pap tests and are more likely to forgo medical services due to cost [8]. Although men are less likely than women to experience cost barriers to care, uninsured men are twice as

likely as all men to report cost barriers resulting in delayed care or reduced prescription medications. Men are also less likely to have seen a health care provider in the past two years and seek screening services or discuss their sexual health with providers [9].

Disparities by Race: Whether measured by income, education, or occupation, socioeconomic status (SES) is a strong predictor of variations in health [10]. Racial differences in SES contribute to reduced levels of health insurance coverage for many. Hispanics and Blacks disproportionately belong to lower SES compared to whites and Asians. This explains the lower degree of health insurance coverage amongst these group. In addition, a major reason that many Hispanics in the United States lack health insurance coverage is the unavailability of employer-based coverage for working-age Hispanic groups. Recently arrived immigrants often work in low-wage jobs with few fringe benefits [11].

5. Impact of being uninsured

Individuals by far bear the highest burden of being uninsured. However the effects of not having health insurance go beyond individuals to affect businesses, organizations, and the society as a whole.

Impact on Individuals: The uninsured are less likely than the insured to have a regular source of care, less likely to receive preventive care, and less likely to benefit from early detection of medical problems. Furthermore, the uninsured are more likely to face burdensome medical bills [12]. Having no health insurance overall leads to poor health outcomes amongst the uninsured. The Institute of Medicine estimates that lack of health insurance leads to 18,000 deaths a year. That makes it the sixth leading cause of death among people ages 25 to 64—after cancer, heart disease, injuries, suicide, and cerebrovascular disease, but before HIV/AIDS or diabetes [12]. The impact of being uninsured disproportionately affects vulnerable groups such as children and the near elderly (55 – 64 years). Uninsured children are less likely to complete vaccinations or receive treatment for chronic conditions such as diabetes and asthma [13]. Parents of uninsured children are more likely to report unmet need for mental health services for their children [14]. Near-elderly (55 – 64yrs) people with low incomes or chronic illness typically face the greatest obstacles to obtaining private health insurance if they do not qualify for public coverage [15]. Based on adjusted eight-year mortality rates and an estimated 3.5 million uninsured people ages 55–64 in 2002, more than 105,000 excess deaths (more than 13,000 annually) may be attributable to the present lack of insurance coverage among the near-elderly [16]. This estimate would place un-insurance third on a list of leading causes of death for this age group, below only heart disease and cancer [17]. On the whole, uninsured persons have a much greater risk of health decline and death, with several studies showing them to be 1.2 to 1.5 times more likely to die than are insured persons [18].

Impact on businesses/enterprise: Health insurance may contribute to workers' and firms' productivity, as healthy workers are usually more productive than unhealthy workers. Since workers with health insurance may be more likely to seek regular preventive care and get needed treatment for illnesses and injuries, those with health insurance may be less likely to miss work and to miss fewer days of work when they do fall ill.¹⁹ One survey found that 16 percent of the uninsured were absent from work during the year because of a dental problem, compared with 8 percent of those with health insurance.¹² Workers' absences are expensive to

employers—finding temporary replacements is costly; the operation of production teams may suffer; and assets may be left idle—and sick employees may be less productive when they are at work. Unhealthy workers also may quit or retire early, creating a costly source of turnover. The benefits to employers of having healthier workers may also lower other labor costs, especially the cost of short-term and long-term disability insurance and workers' compensation [19].

Impact on society: The uninsured pay more for care—and get less—than those with insurance. But when the uninsured cannot pay, health care providers shift those costs to those who can pay—those who have insurance coverage. This “hidden tax” on health insurance arises from a failure to continuously cover all Americans and accounts for roughly 8 percent of the average health insurance premium [20]. This cost-shift amounted to \$1,100 per average family premium in 2009 and \$410 per average individual premium. By 2013, the cost shift was projected to be approximately \$480 for an individual policy and \$1,300 for a family policy [20]. Hospitals and physicians shoulder the financial burden for the uninsured by incurring billions of dollars in bad debt or “uncompensated care” each year [21]. Public subsidies to hospitals amounted to an estimated \$23.6 billion in 2001, closely matching the cost of uncompensated services that hospitals reported providing. Overall, public support from the federal, state, and local governments account for between 75 and 85 percent of the total value of uncompensated care estimated to be provided to uninsured people each year [22].

6. Policy Implications

As the other mandates of the affordable care act become implemented and more people get the opportunity to become covered, intentional efforts should be made to narrow the coverage gap between race and gender groups. Particular attention should be given to males of working ages that work in the informal sector or do part time work as this group is most likely not to have employer sponsored health insurance. They should be encouraged to purchase insurance on the exchanges. However, these set of people are more likely not to be educated or have regular access to the internet, therefore state governments and NGOs should make concerted efforts to reach to people that fall into these demographic group both where they work and where they live.

In the long run, programs should be put in place to narrow the socioeconomic gap between whites and other races in order to achieve equity in health insurance coverage. Such interventions may include programs to increase literacy rates, laws to increase the minimum wage and improve housing conditions for Blacks and Hispanics. If done properly, in the long run, the advantages of coverage under the ACA will be felt by all and sundry, rather than a disproportionate skew towards individuals that belong to a particular race or gender.

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