



Federal Health Care Reform and the Exchange: An Opportunity to Address Health Disparities

Studies have repeatedly shown that racial and ethnic minorities receive a lower level of care and have poorer health outcomes than whites. African American and Hispanic New Yorkers die prematurely at rates nearly twice that of whites; infant mortality among African Americans is nearly 2.5 times higher than whites; and cardiovascular disease is disproportionately prevalent among African-Americans. Health care disparities also exist by gender, primary language, disability status and sexual orientation. However, the state lacks a comprehensive strategy to eliminate health disparities.

The Affordable Care Act (ACA), the landmark federal health care law, presents a unique opportunity to comprehensively address health care disparities once and for all. Under the ACA, a new health care “exchange” -- a health insurance marketplace -- must be in operation by 2014, and legislation must be passed to establish the exchange in 2012 to make sure it’s ready by then. State leaders should ensure that our state exchange reduces health disparities so that *all* New Yorkers can enjoy the benefits of reform.

Data Collection: Build An Integrated System to Collect Health Care Data By Race, Ethnicity, Gender, Primary Language and Make the Data Available to the Public

Under the ACA, federally conducted or supported health care institutions and public health programs will have to report data on the race, ethnicity, gender, primary language and disability status of the people they serve beginning in 2012. New York already *collects* data by race and ethnicity on the records of public health care plans on certain measures of health care quality, but this data is not systematically released to the public. We should build on the ACA and existing state efforts to give consumers and policymakers a complete picture of the record of health care plans and institutions in reducing health disparities.

The State Department of Health (SDOH) should establish a system to require health care plans and health care institutions to report -- by race, ethnicity, gender, primary language, sexual orientation, gender identity and disability status -- the coverage or care provided to applicants, patients and subscribers, and the health outcomes of patients and subscribers based on existing state quality measures like asthma management and managing diabetes. Public insurance plans also should have to report their take up and retention rates by these factors. This information should be compiled in an easy to use fashion, so that the public can access disparities data by health care institution or health plan from the Internet and through the popular consumer guides to health insurers produced by the Department of Financial Services. Like the “school report cards” available today for schools and school districts, health care consumers should have access to data on health disparities to make informed health care decisions. Similarly, advocates and policymakers should have easy access to disparities data to develop policy solutions and to hold plans and providers accountable. (The FY 2012-2013 Executive Budget has \$1 million for the SDOH to begin the work of establishing a solid disparities data collection system.)

Enrollment and “No Wrong Door”: Enroll People in Underserved Communities and Build an Exchange That is Open to Those Eligible for Both Public and Private Insurance

The goal of the ACA to achieve nearly universal coverage can only be met if the New York exchange focuses its efforts on enrolling people in “hard to reach” communities, including communities where people of color, low-income people, and immigrants predominate. Today, hundreds of thousands of New Yorkers are eligible for public programs but remain unenrolled; many are people of color or limited English proficient.

Under the ACA, millions of federal dollars are becoming available to establish consumer assistance and navigator programs to help consumers enroll in the new exchanges and to select health plans that meet their needs. Consumer assistance and navigator programs must target underserved communities for enrollment and other services. Exchange advertising must also target these communities.

The ACA mandates that state exchanges enroll individuals and small businesses in *private* insurance. Yet, once ACA is fully implemented, millions of New Yorkers will continue to be eligible for public insurance programs like Medicaid, Family Health Plus and Child Health Plus. An estimated one-half of enrollees each year will flip from eligibility for public and private programs and back as their financial circumstances change. Even members of the same family may be split between public and private coverage. It makes no sense for people to lose their coverage because they cannot navigate the complex health care “maze”: we must have a “no wrong door” policy in which the exchange enrolls all those who contact it, irrespective of whether they are eligible for public or private insurance.

Cultural Competency Training: Require Cultural Competency Training for Health Care Providers, Consumer Assistance Programs and Navigators

Experts have found that some people of color and immigrants do not seek care due to mistrust of the health care system. Health care outcomes are better when patients and providers have relationships of communication and trust. Cultural competency training for health care providers is a well-recognized way of building relationships between providers and patients in underserved groups. The ACA includes several provisions aimed at promoting the greater use of cultural competency training, including the expansion of programs to support the development and dissemination of model cultural competency curricula. The New York exchange should build on the ACA by facilitating the greater use of cultural competency training in New York. Legislation should also be passed mandating cultural competency training for health care providers in the state -- whether or not affiliated with a health plan in the exchange. The staff of consumer assistance and navigation programs should also be required to be trained in cultural competency so that they can build relationships of trust with their clients.

Language Access: Address Language Access Disparities Through the Exchange

Roughly 2.3 million New Yorkers are limited English proficient (LEP), meaning these individuals need interpretation and translation services to communicate effectively with the exchange, health insurance plans and government agencies. A growing number of federal, state and local laws and policies mandate that LEP consumers receive free interpretation and translation services. In order to ensure that the ACA goal of universal coverage is met and that LEP consumers are able to access all health services available through the exchange, New York must adopt a wide range of policies, including: 1) ensuring that the exchange has bilingual staff, interpreters, and telephonic interpretation services; 2) ensuring that important consumer information provided by the exchange is translated; and 3) designating language access coordinators that are responsible for creating and implementing language access policies. The state should also mandate that

consumer assistance programs and navigators have similar policies, including bilingual staff and translation services.

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