Health Disparities in New York's Public Insurance Programs

Despite significant overall health spending and extensive public health insurance coverage, New York State experiences challenges in achieving a high-performing health care system. These challenges are particularly acute for underserved communities, which are disproportionately made up of low-income people and racial and ethnic minorities.

New York has a sophisticated quality assurance and monitoring program that tracks health outcomes in public and commercial insurance plans. However, to date, New York has not harnessed these systems with an eye to promoting health equity and addressing racial and ethnic disparities.

The Community Service Society (CSS) conducted an original data analysis to explore the possibility of utilizing New York's Quality Assurance Reporting Requirement (QARR) monitoring and surveillance data and New York's Quality Incentive (QI) pay-for-performance systems in order to reduce disparities in New York's public insurance programs.

CSS looked at existing QARR data and found that African Americans had worse outcomes than the total of all other racial and ethnic groups on 10 out of 12 measures (see Table 1).

Asian/Pacific Islander enrollees had better indicators than those for the total of all other racial and ethnic groups in every area except childhood immunization and nephropathy screening.

Latino enrollees showed better health indicators on a number of measures, and similar performance as the total of all other groups on other measures.

White enrollees had statistically significantly better outcomes on a number of indicators, but also significantly worse outcomes three measures.

To date, New York QARR data has been reported only by health plan and region, without indication of race and ethnicity. The absence of this data has prevented regular monitoring or tracking of changes over time in health outcomes and indicators for specific populations. As a result, the State's QARR and QI programs are major untapped resources in developing policy solutions to improve health outcomes and reduce disparities.

Based on our findings, CSS recommends that New York leverage existing resources to address this issue by doing the following:

1. Monitor health plan quality indicators by racial and ethnic categories.
2. Publicly disclose results of racial and ethnic disparities in health outcomes by health plan.
3. Leverage the State's purchasing power for health equity through pay-for-performance and monitoring. This could be accomplished in a number of ways:
   a. Adopt a competitive Quality Incentive program to reward plans with top-ranking outcomes for targeted disparities indicators.
   b. Adopt a benchmark scoring system that rewards all plans who meet specific goals.
   c. Surveillance, monitoring, and enforcement of plans with unacceptable health outcomes.
   d. Encourage quality improvement projects in existing managed care contracts.

Table 1: Selected 2007 QARR Measures Presented by Race & Ethnicity

Measure (age)	Race Group					
	Asian/ PI	African American	Latino	Other	White	Total
Prevent. Care/Care Mgmt						
Child Immunization	80%	78%	83%	78%	75%	79%
Dental Visit (2-21yo)	47%	36%	48%	43%	51%	45%
Child Asthma (5-17yo)	95%	90%	92%	92%	94%	92%
Adult Asthma (18-56yo)	95%	87%	89%	90%	91%	90%
Mammography (42-69yo)	68%	57%	71%	64%	57%	64%
Mgmt of Diabetes						
HbA1c Testing	90%	84%	87%	89%	86%	86%
Poor HbA1c Control	27%	41%	36%	33%	34%	35%
Lipid Profile	89%	78%	85%	87%	82%	83%
Lipids Controlled	46%	34%	42%	41%	39%	40%
BP Controlled	36%	25%	32%	32%	34%	31%
Dilated Eye Exam	72%	56%	62%	64%	61%	62%
Nephropathy Screening	83%	82%	83%	84%	80%	82%

Blue numbers indicate statistically significantly better performance when compared to all other racial groups, red numbers indicate statistically significant worse performance, and black numbers indicate no statistically significant difference.

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A crucial first step in addressing disparities in health outcomes is by making it possible for people to get and keep health insurance.

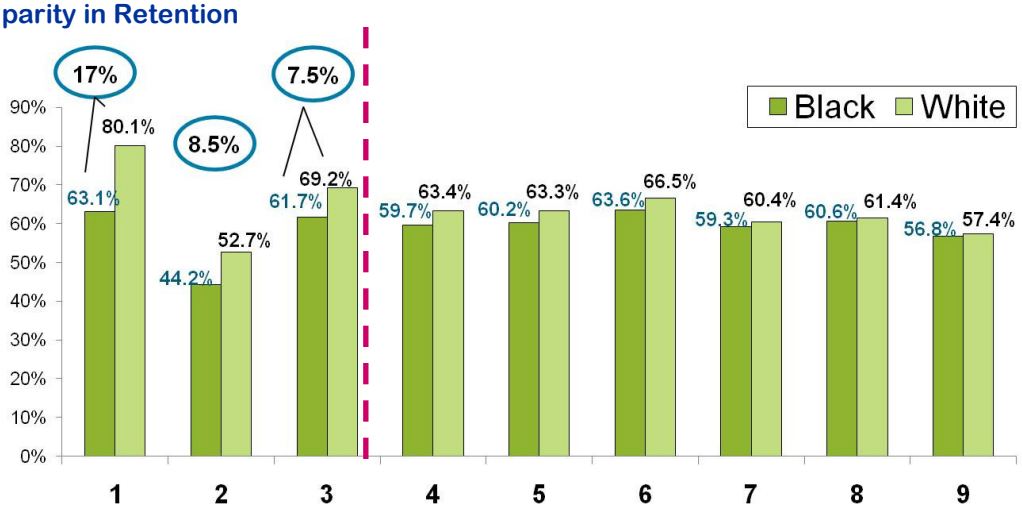
Overall, 22% of African-American adults, 31% of Latino adults and 22% of Asian/Pacific Islander adults are uninsured, compared to only 13% of Whites.

However, in New York the availability of public health insurance helps to equalize this disparity at the lowest income levels. As a result of the availability of this insurance, African Americans below 150% of FPL have slightly lower rates of uninsurance than Whites, and rates of Latinos and Asian/Pacific Islanders approach that of Whites (see Table 2, below).

But, in New York, more than 40% of publicly-insured enrollees are involuntarily dropped from their plans every year—even though most remain eligible.

CSS conducted an analysis of 2006-2007 Medicaid Managed Care retention data and found that African-Americans in New York experienced the lowest rate of retention compared to other groups. Moreover, this disparity appeared to be driven by only three health insurance plans (see Figure 1).

Figure 1: Three Health Plans Appear to be Driving the African American Disparity in Retention



*Thirteen out of 24 plans had higher African American than white retention rates.

Based on these results, and others, CSS developed the following recommendations to improve retention rates overall and reduce racial disparities:

1. Implement a two-year renewal and continuous coverage cycle.
2. Launch targeted initiatives with health plans through the following:
   a) Annually report an analysis of retention data to plans controlling for race, county, plan and aid category.
   b) Publicly disclose retention data by race/ethnicity, plan, and other meaningful categories in state reports.
   c) Share retention analyses with plans and use it to monitor plan participation in state public insurance programs.

To learn more, read the full reports titled, "Promoting Equity and Quality in New York's Public Insurance Programs" and "Promoting Equity and Coverage in New York's Public Insurance Programs," available at www.cssny.org

Table 2: Public Insurance has an equalizing effect on rates of uninsurance.

Percentage of Race/Ethnic Group Uninsured at Each Income Bracket				
	White	**African American**	**Latino**	**Asian/PI**
<150% of FPL	30.5%	29.9%	34.4%	32.8%
150-200% of FPL	23.8%	30.3%	41.2%	24.7%
200-300% of FPL	16.3%	25.2%	36.7%	29.7%
300-400% of FPL	12.5%	13.2%	30.7%	19.8%
400-500% of FPL	8.4%	21.4%	21.4%	12.8%
500%+ of FPL	5.5%	12.9%	15.8%	11.3%

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This fact sheet was prepared for Health Care For All New York by the Community Service Society of New York (CSS): www.cssny.org