



# Addressing Health Disparities Through the Affordable Care Act

Studies show people of color tend to have poorer health care options and suffer from worse health outcomes than whites. For example:

- **Black and Latino New Yorkers** have a premature death rate nearly twice that of Whites .
- **Infant mortality among Blacks** is nearly 2.5 that of Whites.
- **Blacks suffer disproportionately** from cardiovascular disease.

Health disparities also exist by gender, language, disability status and sexual orientation. However, New York lacks a comprehensive strategy to reduce and eliminate health disparities.

## Health Disparities and the ACA

The Affordable Care Act (ACA) presents a unique opportunity to comprehensively address health disparities in New York. Under the new law, states must establish health insurance Exchanges by 2014, including passing legislation to do so. These Exchanges present several new provisions for states to reduce health disparities:

- **Data Collection:** Reliable data is key to identifying disparities and designing targeted quality improvement interventions. New York does not currently require all health care providers to collect and report quality of care data stratified by race, ethnicity, and other background information. While some providers do collect this data, it is not standardized throughout the state. This can make it difficult to compare across entities. In addition, while some health insurance & quality data is collected by race and ethnicity, this data is not regularly reported to the public.

Under the ACA, federally conducted or supported health care institutions and public health programs will be required to collect and report data on the race, ethnicity, gender, primary language and disability status of the people they serve beginning in 2012.

New York should follow suit and require uniform collection and public reporting of data stratified by race, ethnicity, disability status, gender, and language spoken throughout the state by all public and private health plans, hospitals, and other health care institutions

Like the “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. Advocates and policymakers should also have easy access to disparities data to develop policy solutions and to hold plans and providers accountable.

*We recommend that New York build an integrated system of health care data by race, ethnicity, gender, primary language, sexual orientation and disability and make it publicly available.*

- **Enrollment/“No Wrong Door”:** Today, hundreds of thousands of New Yorkers are eligible for public programs but remain unenrolled; many are people of color or who have limited proficiency in English.

Under the ACA, millions of federal dollars are available to establish an insurance Exchange—a virtual health insurance marketplace, along with consumer assistance programs, and “navigator” programs to help consumers select and enroll into health

plans, troubleshoot problems with their health care, and mediate conflicts.

The goal to achieve near-universal coverage can only be met if New York focuses its efforts on enrolling people in “hard to reach” communities, including communities where people of color, low-income people and immigrants predominate.

Come 2014, it is estimated that 50% of enrollees will flip between eligibility for public programs to private insurance and back each year as their financial circumstances change. Even members of the same family may be split between public and private coverage eligibility. We must have a “no wrong door” policy in which the Exchange can screen and enroll all those who contact it, regardless of the type of health insurance they seek or eligibility for public programs.

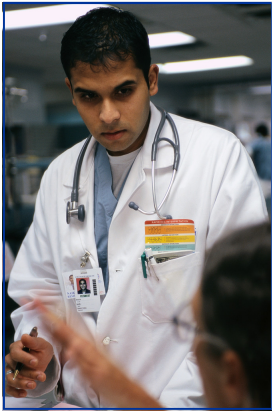
*We recommend that New York establish a “no wrong door” approach to enrollment by pursuing a comprehensive and diverse Exchange enrollment system paired with robust consumer assistance and navigator programs. Underserved communities must be targeted for enrollment and other services.*

(See reverse for more →)



**To be successful, enrollment efforts must target underserved communities.**

## Addressing Health Disparities Through the ACA



**Cultural competency training can help build relationships of trust between providers and patients, and lead to better health outcomes.**

- **Cultural Competency Training:**

A lack of culturally and linguistically appropriate services leads to poor quality of care and disparities in health outcomes. Cultural competency training for health providers is a well-recognized way of building relationships between providers and patients in underserved groups. By increasing levels of communication, mutual understanding, and trust between the patient and provider, quality of care can be greatly improved.

The ACA includes several provisions aimed at promoting cultural competency training, including the expansion of programs to support the development and dissemination of model cultural competency curricula.

New York should build on the ACA by facilitating the greater use of cultural competency training. Legislation should also be passed to mandate cultural competency training for all providers -- regardless of if they are affiliated with a health plan in the Exchange.

Consumer assistance and Navigator program staff should also be required to undergo training in cultural competency so that they can build relationships of trust with their clients.

*We recommend that cultural competency training be required for all health care providers as well as consumer assistance program staff and Navigator staff.*

- **Language Access:**

Roughly 2.3 million New Yorkers are limited English proficient (LEP) and need interpretation and translation services to effectively communicate with health care entities, providers, and information systems.

The ACA includes several provisions intended to make health insurance Exchanges accessible to people who are LEP. For example, qualified health plans are required to provide information in “plain language” that can readily be understood by intended audiences, including individuals who are LEP. It also encourages activities to reduce health disparities, including the use of language services and cultural competency trainings, by providing a quality incentive structure that rewards those types of activities. Navigator programs are also required to provide information in a manner that is cultural and linguistically appropriate to the targeted population.

To ensure that the highest level of health insurance enrollment is met and that LEP consumers are able to access the new health insurance Exchange, a

wide range of policies must be adopted, including: 1) hiring of bilingual staff, interpreters, and telephonic interpretation services; 2) translation of important consumer information provided by the Exchange into multiple languages; and 3) 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 sufficient bilingual staff and access to translation services to meet the needs of their clients.

*We recommend that the state take active steps to incorporate adequate language access and translation services into forthcoming health reform implementation efforts.*



**Language access must be fully incorporated into health reform implementation efforts.**

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