

Addressing Health Disparities Through the Marketplace

An Action Agenda for New York State of Health



PUBLIC POLICY AND EDUCATION FUND OF NEW YORK

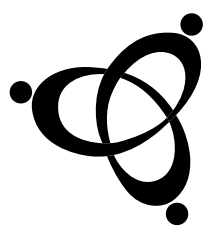
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INTRODUCTION

All things are not equal when it comes to health in the Empire State. Fortunately, the passage of national health reform has created numerous opportunities for addressing these disparities and improving the chances for all New Yorkers to live healthy lives.

Many mechanisms under the Affordable Care Act (ACA) aimed at health disparities depend on action on the state level. In New York, policymakers have taken advantage of a number of these opportunities, and they should be applauded for such decisions. Yet, there remains more that leaders in New York can do to promote health equity in our state.

This white paper recommends a number of steps the state can take in the coming years, primarily through the new state exchange formed under the ACA in 2012, which was named “NY State of Health: The Official Health Plan Marketplace” in August 2013. (We refer to it below as “New York State of Health,” “NYSOH” or “The Marketplace.”) The list in this white paper is by no means comprehensive. New York’s first year of Marketplace enrollment – which began in October 2013 – will provide extremely valuable information for determining what additional steps must be taken. New York should use all means to address health disparities and become a model for the nation.

HEALTH DISPARITIES PERSIST IN NEW YORK

New York is the most racially and ethnically diverse state in the country. In New York, people of color represent more than 40 percent of the state’s population, and one in three New Yorkers speaks a language other than English.¹ The state’s diversity is one of its strengths, yet the benefits of living in

New York are not shared equally, as is evident in the following health disparities:

- ▶ African American infants are more than twice as likely to die than white and Latino infants.
- ▶ Compared to whites, African Americans experience HIV/AIDS mortality rates that are 20 times higher, and Latinos face rates that are 11 times higher.
- ▶ The diabetes mortality rate is more than 50 percent higher for Latinos than for whites.²
- ▶ Twenty percent of lesbian and gay people and almost 24 percent of bisexual people in New York City lack insurance, compared to 15 percent of straight people.³
- ▶ Fifty-nine percent of New York State nonelderly residents without insurance coverage are non-white.⁴

These disparities reflect a number of factors, some of which – such as exposure to stress or reduced access to nutritious food – exist outside the health care system. But people of color also are less likely to have health insurance, have a regular source of health care, or receive the quality of care they need. Each of these disparities in access to quality health care must be addressed in order to reduce overall health inequities.

HEALTH REFORM PRESENTS OPPORTUNITIES TO ADDRESS DISPARITIES IN HEALTH CARE

The ACA includes a set of measures to reduce health disparities. The insurance expansion provisions, though not explicitly aimed at disparities, directly address the alarmingly low rates of coverage among people of color and other groups that face discrimination. The ACA does this through two primary mechanisms: by funding an expansion of Medicaid, and by lowering the cost of private

coverage through health insurance exchanges. The New York State Health Department, which houses the Marketplace, has called the establishment of a state exchange under the ACA “integral to helping reduce health disparities in New York State.”⁵

The success of these expansions depends on whether currently uninsured people will learn about their new coverage options and be able to enroll. Accordingly, the ACA requires state exchanges to take a number of steps to inform potential applicants of their options and creates a streamlined application process. Exchanges must create websites with information on benefits, rates, and other topics and operate toll-free call centers. They also are establishing navigator programs to assist residents with enrollment. Additionally, both federal and New York state law establish language access standards that the state exchange and participating insurers are required to meet.

In addition, the ACA establishes a single “No Wrong Door” system for processing applications and placing enrollees in the program for which they are eligible. This approach is intended both to simplify enrollment and to prevent temporary loss of coverage due to “churning” when an enrollee moves between Medicaid and exchange coverage because of changes in eligibility (such as those related to fluctuations in income).

Full implementation of the ACA’s disparities measures requires state action. This includes adopting expansions and supporting enrollment to reduce gaps in coverage that particularly affect people of color, immigrants, and others. It also includes taking steps to increase the availability and quality of care in communities where high-quality care historically has been limited. Finally, it includes monitoring disparities over the long-term and incorporating attention to disparities into ongoing health policy activities.

NEW YORK HAS BEGUN IMPLEMENTING HEALTH REFORM AND ADDRESSING DISPARITIES

New York is now well into the process of health reform implementation. Governor Andrew Cuomo created a state exchange (then called the New York Health Benefits Exchange) by Executive Order in

April 2012, and the Governor and Legislature adopted the Medicaid expansion.⁶ Alongside health reform implementation, the state has engaged in redesigning its Medicaid program.

The Medicaid expansion under the ACA is a critical first step toward providing coverage for people of color in New York State. According to an Urban Institute estimate for New York State, 469,000 new Medicaid enrollees can be expected in New York State once reform is implemented.⁷ These new enrollees will be diverse: 27.3 percent Latino, 19.6 percent Black, and 9.4 percent other people of color. More than 40 percent are projected to be non-English speakers.⁸

More than a million people are expected to gain health coverage through New York State of Health after three years, with people of color representing more than 40 percent of these newly insured. Thirty-six percent will include speakers of languages other than English.⁹ While the initial figures for enrollment were extremely encouraging for the population as a whole – 285,164 had enrolled as of January 10, 2014, slightly more than half way through the first “open enrollment period,” ending on March 31 – the Marketplace did not provide a racial and ethnic breakdown for these figures.¹⁰ This was still true as of the end of open enrollment in April of 2014, when 908,572 had enrolled.¹¹ (This figure is increasing every day, as small businesses and some individuals and families may enroll year-round.)

In developing plans for health reform implementation, New York has taken important steps to reduce disparities. In September of 2012, the Marketplace brought together a variety of stakeholders to discuss strategies for addressing disparities. It then commissioned a report, prepared by the Center for Popular Democracy (CPD), compiling the recommendations of expert panelists and meeting participants. The recommendations fell into three categories: consumer assistance functions, network adequacy, and data collection.¹² Additionally, Regional Advisory Committees established to advise the Marketplace have provided opportunities for the public and advocates to raise concerns about disparities and to make recommendations.

As the state begins full implementation of health reform, it has adopted a number of important

measures that will contribute to better access to care for people of color and other historically marginalized groups. Among these positive initiatives are the following:

- ▶ *Creating a navigator program that relies on a diverse set of community-based organizations.* As previously stated, under the ACA, state exchanges have created navigator programs to assist enrollees with learning about coverage and signing up for it. New York has taken a positive step by creating a program that embraces a range of the state's ethnic and racial communities, with 48 languages represented among the selected entities.¹³
- ▶ *Protecting small business (SHOP) exchange applicants from additional verification requirements.* Requiring additional documentation and verification related to immigration status would both be unnecessary and present an obstacle to enrollment for employees of small businesses. New York has made the right decision to not require verification beyond that required under the federal law.
- ▶ *Adopting pre-authorization and one-year continuous eligibility for emergency Medicaid.*¹⁴ Although most New Yorkers will become eligible for health coverage under health reform, some will remain ineligible due to their immigration status. However, they will remain eligible for emergency Medicaid, and pre-authorization and one-year continuous eligibility will help them get needed health care.
- ▶ *Building on standards in the federal health reform law that requires insurers to establish adequate provider networks.* The ACA establishes standards for insurance companies with regard to their provider networks: the set of doctors' offices and other health facilities from which an enrollee may receive treatment. New York has expanded on these standards, such as limiting travel time to primary care providers to 30 minutes by public transit in metropolitan areas.
- ▶ *Actively participating in outreach and enrollment efforts with community-based organizations and other entities engaged in outreach.* At "Regional Outreach and Enrollment Summits" held in September 2013 in eight regions of the state, a

wide range of entities that conduct outreach (or were considering this step) joined with navigators to discuss ongoing coordination of outreach and enrollment, increasing the likelihood of enrollment among groups historically shut out of the insurance system. The Marketplace was extremely involved in organizing the Regional Summits, working closely with several major consumer health advocacy groups and other partners.¹⁵ It has also collaborated with community-based organizations and other stakeholders through a number of means, including joint sponsorship of events focused on education and enrollment.

NEW YORK CAN DO MUCH MORE TO ADDRESS DISPARITIES

Although the state has made a substantial start in addressing health disparities, much more needs to be done over the next few years. What follows is a set of basic recommendations that the New York State of Health and other state policymakers should consider adopting or implementing in a more robust manner.

OUTREACH AND ENROLLMENT

RECOMMENDATION 1: *Target community outreach and enrollment efforts toward diverse communities, use a variety of communication methods, and reach people through one-on-one contacts.*

New York should implement comprehensive strategies that reach into communities whose members have been disproportionately excluded from the health insurance market. These strategies should involve ethnic media, trusted community institutions, presence at community events, and door-to-door canvassing, among other approaches. Additionally, these outreach strategies should be culturally and linguistically appropriate.

At the September 2013 Regional Summits and other public meetings, Marketplace staff and representatives of marketing firms retained by the state indicated an intention to target ethnic media

and use social media to target diverse communities. This pledge is highly commendable, but this work should be expanded in the future. NYSOH officials, in conjunction with community organizations and other entities concerned with health disparities, should carefully monitor these strategies and make adjustments, particularly if the state falls short on its targeted enrollment goals for traditionally excluded communities (see Recommendation 2).

We further recommend that NYSOH provide more information to stakeholders as to its future marketing and outreach plans now that the first year of open enrollment is completed, and provide detailed, timely updates as marketing plans are rolled out and changed. This information will be extremely helpful to navigators and stakeholders who are undertaking their own outreach and enrollment efforts. Timely information as to what community newspapers and ethnic media the Marketplace is placing advertisements in, for example, will enable stakeholders to effectively deploy their own limited outreach and advertising resources, amplifying the state's messaging and filling in gaps in the state's marketing and outreach efforts.

In addition to expanding outreach approaches and more effectively coordinating its outreach efforts with stakeholders, the Marketplace should reconsider some restrictions that have been placed on outreach by navigators. In particular, the Marketplace has prohibited navigators from conducting at-home enrollment and, arguably, even outreach, citing high-pressure or deceptive sales tactics carried out by health insurers in the past to enroll low-income people in public programs.¹⁶ These concerns are serious and merit further study.

At the same time, many potential enrollees are simply too isolated to be reached through outreach in public locations. This includes the homebound elderly, many people with disabilities, and many low-income people who lack the resources or information to attend community events. And particularly in rural locations, public events focused on providing information on health care options may simply be inadequate or not the most effective strategy to reach the vast majority of residents. Accordingly, after appropriate study and adoption of necessary safeguards (such as "cooling off" periods or other

enrollment cancellation options), the Marketplace should consider allowing home visits for the purpose of outreach and even enrollment in appropriate instances, particularly if first year enrollment figures fall short for certain traditionally excluded groups or for rural counties in the state.

Similarly, the Marketplace has banned navigators from "cold-calling" potential enrollees, although this term is not defined in the document inviting entities to apply for navigator funding. Narrowly interpreted, this prohibition could prevent navigator organizations from contacting members or supporters of organizations that they are affiliated with or in coalition with, even with the permission of the other organization. This unclear prohibition creates an air of uncertainty that potentially hampers outreach by community-based organizations receiving state navigator funds. We recommend that the Marketplace more carefully define its prohibition on "cold-calling," and reconsider this prohibition.

RECOMMENDATION 2: *Set targets for enrollment of various demographic groups.*

Increasing health coverage overall represents an important goal of health reform, but it is not sufficient, standing alone, to address disparities in coverage. Without goals targeting historically excluded groups, the Marketplace runs the risk of reproducing or increasing disparities despite its stated commitment to enrolling all New York's communities. Therefore, we recommend that by the second Marketplace open enrollment period, public enrollment targets should be set for each demographic group that has historically had limited access to the health insurance marketplace, including people of color, immigrants, people with disabilities, and LGBT people. These targets should be discussed with the Regional Advisory Committees and the health disparities stakeholder group proposed in Recommendation 11. Setting enrollment targets will help both the state and stakeholders measure progress.

Moreover, as health reform is implemented, systems for enrolling applicants and ensuring retention of coverage will need to be refined based on

experience. Accordingly, as we further explain in Recommendation 8, New York should gather and make public a range of data — broken down by race, ethnicity, primary language, gender, disability, and LGBT status — that shed light on the success of current strategies and how those strategies should be adjusted.

LINGUISTIC AND CULTURAL ACCESS

RECOMMENDATION 3: *Ensure competent interpretation and translation at all levels of the Marketplace, in Marketplace publicity and public information and by health plans.*

Language should never present a barrier to obtaining and navigating health coverage. In addition to language access requirements set out in the ACA and federal civil rights law, New York mandates language access for all state agencies that serve the public, including translation of all vital documents into the state's six most commonly spoken languages by Limited English Proficient (LEP) individuals.¹⁷

New York has taken some extremely positive steps toward the goal of enabling all New Yorkers, regardless of primary language, to obtain information about affordable health coverage through the Marketplace. For example, the Marketplace's call center makes assistance available in 170 languages, either through multilingual staff or oral interpretation services. Furthermore, as already noted, 48 different languages are offered through the navigators,¹⁸ although the availability of each language varies greatly by county.

As important as these steps are, additional progress is needed in order to ensure that non-English language speakers have access "at every point of contact with the Exchange, from enrollment to billing to appeals processes."¹⁹ At an absolute minimum, as suggested in the CPD report, the Marketplace should comply with the Governor's Executive Order No. 26 by translating all basic documents into the state's six non-English languages, which would cover 70 percent of the LEP population statewide. Finally, as further recommended by CPD, the Marketplace website

— and the most critical features in particular, such as the enrollment portal — should be translated into the six languages beginning with Spanish; presently, the website appears only in English. As of February of 2014, the Marketplace had placed several basic fact sheets in Spanish on the website, including publications on why consumers need health insurance and information pieces directed at small businesses, young adults and immigrants.²⁰ Fact sheets were also available in six non-English languages — including simplified Chinese, French, Haitian Creole, Italian, Korean, and Russian — in addition to Spanish, as of May.²¹ More detailed information should continue to be made available in these languages.

Strong language access standards should equally apply to insurers offering coverage through the Marketplace. In the 2014 invitation for health plans to participate in the New York State of Health, the Marketplace required insurers to "[m]ake available verbal interpretation services in any language to current or potential enrollees who speak a language other than English as a primary language."²² The invitation also required insurers to translate written and informational materials spoken by a least five percent of applicants and enrollees in a county, or instead use taglines in "common non-English languages" that indicate the "availability of written translation of materials in any language the process or current enrollees speaks."²³ Careful monitoring by NYSOH is necessary to ensure that insurers adhere to these requirements.

RECOMMENDATION 4: *Require insurers to cover interpretation and translation in the clinical setting.*

Language access is important not only for enrollment in coverage but also in the clinical setting. Accordingly, the Marketplace should develop standards that govern the circumstances under which health plans participating in the Marketplace cover interpretation and translation by health providers. Stakeholders have recommended that NYSOH mandate that insurers provide interpretation services for any language spoken by the lesser of 5 percent of 500 of any health plan's LEP enrollees, with a

minimum of six languages receiving translation by each plan.²⁴

The same rationale for LEP consumers' interaction with insurers also applies to their interactions with hospitals and other providers, as adequate health care requires that patients be able to understand and communicate effectively with their providers. Therefore, all insurers offering coverage through the Marketplace should be required to cover language services, including effective translation and interpretation, in the clinical setting, subject to standards established by the Marketplace. This recommendation is consistent with the existing state policy that covers medical language interpreter services in outpatient departments, hospital emergency rooms, diagnostic and treatment centers, federal qualified health centers and office-based practitioners for members with limited English proficiency enrolled in the Medicaid fee-for-service program.²⁵

RECOMMENDATION 5: *Ensure that the Marketplace meets the cultural needs of diverse New York communities.*

The Marketplace should use a number of mechanisms to ensure that diverse communities feel welcome and believe their needs will be met. Among other steps, the Marketplace should enhance its outreach efforts to increase its visibility among a diversity of New Yorkers, including members of communities that have experienced barriers to coverage and care based on race, language, income, disability, and other factors. Navigator organizations can be strong partners in this effort. Furthermore, the Marketplace should ensure that its website, outreach materials, and other materials reflect the diversity of the state. Broad publicity should be aimed at informing immigrant communities that NYSOH will not report the immigration status of applicants for coverage or family members to any outside entity. Finally, cultural and disability competency should be an important component in the training for navigators and others who interact with the public, including Marketplace call-center representatives.

Health advocates have reported that the Marketplace is aware of these concerns and has addressed them in a limited fashion. For example, a portion of the

navigator and Certified Application Counselor trainings focuses on “cultural competence,” “linguistic competence,” and “disability accessibility.”²⁶ However, ongoing attention is necessary, and the Marketplace regularly should conduct reviews of progress in this area, using the public input mechanisms recommended in this paper (see Recommendation 11). Use of surveys, focus groups, or public forums attended by diverse populations can help the Marketplace determine if it is perceived as welcoming to traditionally excluded groups and to solicit suggestions for improvements.

ADEQUATE PROVIDER NETWORKS

RECOMMENDATION 6: *Set network adequacy standards to meet the needs of diverse communities, conduct studies to assess the adequacy of these networks and whether standards are being met, and provide remedies to consumers for inadequate networks.*

Although New York overall has many health providers, there may be many parts of the state that will continue to be underserved. Significant parts of the state remain highly rural and, in many counties, providers in certain specialties may be few and far between. For instance, the ratio of primary care physicians per 100,000 consumers is 67.5 in Central New York. Contrary to popular myth, there are large pockets of people of color throughout upstate New York. The availability of providers for certain critical specialties also is an issue even in certain urban areas. For example, the ratio of primary care physicians is 145.6 to 100,000 patients in Manhattan but only 68.7 in the Bronx and 65.6 in Queens.²⁷ At a minimum, NYSOH should require health plans to disclose the number of physicians and hospitals in each plan on a county basis, so consumers can make informed decisions as to the plans they select.²⁸

Moreover, compliance with provider ratios, standing alone, does not guarantee access to care for members of many communities. Accordingly, the Marketplace should set additional standards for plans that address disparities. The standards should, for instance, require that plans have a sufficient number of providers that speak languages other than English

and can serve LEP patients; have examination rooms and other facilities that meet the needs of people with disabilities; offer the full range of reproductive health services; and, are clinically competent to meet the needs of LGBT community members.

The state should assess network adequacy against quality measures that go beyond provider ratios and distances, including measures assessing whether patients can obtain timely appointments or are received promptly in health facilities. Based on the results of these studies, the state should explore options in regard to supporting the placement of community clinics and expanding and diversifying the health care workforce.

There is still a significant amount NYSOH can do to ensure that the plans they purchase through the Marketplace are adequate and that consumers know what they are buying.

In 2014, the New York State Legislature created a new set of requirements for out-of-network charges that requires greater transparency for consumers and an arbitration process to resolve disputes between providers and insurance companies. In emergencies, consumers will be able to go out-of-network and not pay high out-of-network fees. The law also creates a new set of disclosures about the cost of going to providers that are not in a consumer's network. Consumers are also authorized to go out of network when a plan does not include a provider that meets their health care needs.²⁹

The new out-of-network provisions are particularly important for people with disabilities and others with specialized health care needs such as those with rare forms of cancer. These provisions should also hopefully put pressure on insurers to develop better networks.

NYSOH enrollees should also be given adequate information as to provider networks in each plan available through NYSOH, and remedies should be provided for changes to provider networks after consumers select an exchange plan. As Health Care for All New York (HCFANY), a major consumer advocacy organization, wrote to NYSOH in March: "Consumers report significant provider migration, confusing, unusable (e.g. non-searchable pdf) links

to provider networks, and in the case of several prominent plans, apparent wholesale changes of networks."³⁰ Changes in networks can potentially have disparate impacts on people of color, LEP populations, immigrants, people with disabilities and women, given their often specialized needs. Therefore, the provision in the 2015 plan invitation requiring insurers to report changes in their network on a monthly basis is a welcome change. HCFANY's recommendations to include adequate network search tools on the NYSOH web page should also be adopted by the Marketplace. Finally, to avoid the problem of consumers signing up for critical providers only to find that the provider leaves an insurer's network, NYSOH should either require plans to lock in their provider networks before the beginning of open enrollment or provide consumers with a "Special Enrollment Period" in the event that critical providers leave the plan during the plan year.³¹

QUALITY IMPROVEMENT AND SETTING STANDARDS FOR HEALTH PLANS SOLD THROUGH THE MARKETPLACE

RECOMMENDATION 7: *Create quality improvement standards and enforcement mechanisms to ensure that insurers promote quality care, with specific attention to disparities.*

Sections 2717 and 1311 of the ACA include various quality improvement requirements that health insurers must fulfill. Under Section 1311, in particular, all insurers participating in state exchanges must submit reports "demonstrating how they reward health care quality through market-based incentives in benefit design and provider reimbursement structures."³² One element of this strategy involves "activities to reduce health and health care disparities, including through the use of language services, community outreach, and cultural competency trainings ..."³³

NYSOH required in its 2014 invitation for health plans to participate in the Marketplace that insurers establish and maintain quality strategies that include addressing disparities and insurers reporting on these strategies.³⁴ This requirement has been

retained in the 2015 plan invitation.³⁵ However, plan strategies to reduce disparities have not thus far been made public by NYSOH — a major impediment to evaluating whether qualified health plans are taking appropriate steps to address health disparities. In addition to disclosing the content of disparities-reduction strategies (with appropriate redaction of any sections that are not subject to disclosure under the state Freedom of Information Law or other legal provisions), the Marketplace should establish a monitoring system to track access to language services, cultural competency training for providers, and other measures intended to reduce disparities. The state should explore a range of mechanisms to enforce these requirements.

DATA COLLECTION

RECOMMENDATION 8: *In conjunction with the New York State Department of Health, collect and analyze data concerning health outcomes, broken down by factors like race, ethnicity, primary language, gender, disability, and LGBT status. As a first step, data should be made available on the demographics of Marketplace enrollees.*

Accurate data is a prerequisite for assessing progress on health disparities and improving the health of New Yorkers — and under the ACA, data collection is also a component of all federally supported health programs.³⁶ In 2012, a bill was introduced in the New York State Assembly (A.8278) with the support and input of HCFANY that would have required the state to establish a comprehensive system to collect and publicly disseminate data on a range of coverage, care, and health outcome indicators. Such a data collection system, presented in an easy-to-use format, would greatly assist consumers with making choices among health plans and providers, including health insurers offering qualified health plans (QHPs) through the Marketplace.

The state should move toward development of such a system. The state Education Department's school and school district report cards, which report student performance on various state-mandated tests and disaggregate the data based on demographic factors,

provides a useful model for a system focusing on health plans in New York State.³⁷

As part of this process, the state should continue to improve data efforts that are currently underway. The state Department of Health (DOH) received dedicated funding in the New York State Fiscal Year 2012-13 budget to review the various state databases that collect health data, including elements based on demographic factors, but the DOH has not sought significant public input on the design of such a system. DOH should establish a public input system for improving current health outcome databases and also for determining which additional data elements should be collected from plans and providers to make the ultimate system as valuable as possible for policymakers and consumers alike.

Once an effective system of data collection is in place, the Marketplace and the DOH can consider the development of incentives for health plans inside and outside the Marketplace that significantly exceed these standards.

An additional very short-term step should be taken directed at monitoring the effectiveness of outreach and enrollment in “hard to reach” communities. The enrollment data that has been released by the state as of May 2014 does not include data for applications or enrollments by race and ethnicity (i.e. Hispanic status), even though enrollment has been reported by, among other things, age and gender.³⁸ Providing application and enrollment data by race and ethnicity on a monthly basis would enable policymakers and the general public to know to what extent NYSOH is serving each of the state's diverse communities. And the release of timely data by NYSOH — ideally, broken down by county or region of the state — would enable navigators, certified application counselors and other private parties doing outreach and enrollment to adjust their efforts to address inadequate enrollment of particular demographic groups.

EXPANDING COVERAGE OPTIONS: MAKING HEALTH COVERAGE A REALITY FOR ALL NEW YORKERS

RECOMMENDATION 9: *Assure that cost-sharing in the new Basic Health Program is affordable and assure access by traditionally excluded communities, particularly immigrants.*

In a major advance for health plan affordability in the state, New York enacted a Basic Health Program (BHP) as part of the Fiscal Year 2014-15 state budget passed in March of 2014. Following consumer recommendations provided through a state BHP task force that met in 2013, the Governor proposed a BHP in his Executive Budget with very affordable rates: no premium payment for individuals with household incomes at or below 200 percent of the federal poverty level (FPL), and a monthly premium of up to \$20 monthly for those with household incomes of 150 percent to 200 percent of the FPL. Cost-sharing obligations by consumers will be set by DOH, subject to federal approval. These provisions were all incorporated in the final budget legislation.³⁹ DOH officials have pledged to keep cost-sharing as low as possible. It is critical that this goal be met to ensure broad access to the program by low income consumers.

A BHP is an option for states under the ACA to provide more affordable coverage for low-income adults with incomes between 133 and 200 percent of the FPL than under traditional exchange plans. By one estimate — done in 2011, before the establishment of the NYSOH — the yearly cost of Marketplace plans would average up to \$2,330 a year for a family of three at the 200 percent of FPL, an improvement on the pre-reform private individual market, but still difficult to afford for many low income families. The exact cost to consumers depends on the ultimate program design adopted by the state.⁴⁰

The state is also likely to also reap significant benefits from creation of a BHP. Under the ACA, any state that establishes a BHP is eligible to receive federal funding linked to two groups: those at 133 to 200 percent of FPL who would have otherwise received coverage (and subsidies) through an exchange and noncitizens who have legal immigration status but

remain ineligible for Medicaid. In a 2011 report, the Community Service Society estimated that establishing a BHP in New York would save the state \$511 million annually, due to a number of factors, including the ability to shift the cost of providing coverage to over 86,000 legal immigrants who are now on Medicaid and funded solely with state funds to the federal government.⁴¹ A preliminary analysis by the Urban Institute projected significant savings to the state due to moving immigrants from state-funded coverage: \$597 million.⁴² According to one estimate, 466,700 adult New Yorkers would eventually enroll in the BHP when many of them previously uninsured, including a projected 30,000 immigrants.⁴³

Because many immigrant consumers will be shifted from Medicaid to the new BHP, it is important that both the state and advocacy communities monitor this transition to assure that consumers are transitioned into the new program successfully.

RECOMMENDATION 10: *Develop an insurance product that will cover undocumented immigrants not covered through health reform.*

Health reform will not achieve its full promise until all members of our communities have access to health insurance. Congress, in enacting the ACA, excluded undocumented immigrants from participation in exchanges and the premium tax credit provisions. An estimated 625,000 undocumented immigrants in New York are barred outright from the Marketplace under the ACA and are not eligible for most public coverage.

On top of this outright exclusion from the ACA, low-income undocumented New Yorkers have extremely limited alternatives for health care access: 1) hospital financial assistance (sometimes called “charity care”), which provides funds to pay for patients’ bills based on income; 2) income-based Emergency Medicaid, which is available for emergency care but not for preventive care; and 3) Child Health Plus.⁴⁴ With such limited options, New York’s immigrants often do not receive even the most basic level of health care, such as vaccinations.⁴⁵

Undocumented immigrants represent presently only 3.5 percent of the state’s population, but comprise

15 percent of the state's uninsured, a figure estimated to grow to 20 percent to 30 percent after health reform is implemented.⁴⁶ This troubling exclusion from the post-reform health care system presents a major challenge to the state's efforts to improve health outcomes. Therefore, New York should explore the development of a health insurance product to cover those excluded from federal health reform and current state programs, including undocumented immigrants.

ONGOING EFFORTS TO ADDRESS DISPARITIES AND ENFORCE CIVIL RIGHTS

RECOMMENDATION 11: *Create mechanisms for ongoing attention to disparities and enforcement of relevant civil rights laws.*

The reduction of disparities will require sustained attention and intervention. The Marketplace should set up permanent mechanisms for this purpose. One key step New York State of Health should take is establishing a stakeholder task force on disparities that meets frequently, perhaps monthly. The task force should monitor progress on disparities by health plans and the Marketplace and make recommendations, including those requiring administrative action or legislation. While the Regional Advisory Committees established by the Governor's executive order should also regularly address disparities, this issue is a sufficiently complex to merit an independent task force. The task force

should coordinate its efforts with the New York State Department of Health's Office of Minority Health and its Health Disparities Prevention Minority Health Council, two state entities whose scope is not restricted to the Marketplace but play important roles in coordinating disparities prevention efforts in state government.⁴⁷ Ultimately, other permanent or temporary task forces may be necessary to address the needs of specific demographic groups.⁴⁸

Additionally, NYSOH should create a unit responsible for investigating and enforcing civil rights laws and other requirements, such as the provisions of the ACA that address health disparities, the Americans With Disabilities Act and the prohibitions in the Marketplace's plan invitation on discrimination.⁴⁹ This unit too, should have the function of recommending any policy changes necessary to enable it to perform its investigatory and enforcement functions.

CONCLUSION

The implementation of health reform presents the state with many opportunities to close the persistent health gap that leaves New Yorkers of color and other traditionally excluded groups living sicker and dying younger. State policymakers have taken advantage of a number of these options and deserve credit for these important steps forward. Yet much work remains to be done. New York should not stop now. The state should use every opportunity to make the promise of quality health care a reality for all New Yorkers.

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