POLICY BRIEF
May 2009

Promoting Equity & Coverage in New York's Public Insurance Programs

Second in a Two-Part Series on Racial and Ethnic Disparities in Health

Community Service Society | Fighting Poverty Strengthening New York

NYS HEALTH FOUNDATION
Improving the state of New York's health

Support for this work was provided by the New York State Health Foundation (NYSHealth). The mission of NYSHealth is to expand health insurance coverage, increase access to high-quality health care services, and improve public and community health. The views presented here are those of the authors and not necessarily those of the New York State Health Foundation or its directors, officers, or staff.

POLICY BRIEF

PROMOTING EQUITY & COVERAGE IN NEW YORK'S PUBLIC INSURANCE PROGRAMS

By Elisabeth Ryden Benjamin, MSPH, JD & Arianne Garza, MPA



Photos by Dan Bigelow and Philip Greenberg

The Community Service Society of New York (CSS) is an informed, independent, and unwavering voice for positive action that serves the needs of low-income New Yorkers. CSS draws on a 160-year history of excellence in addressing the root causes of economic disparity through research, advocacy, and innovative program models that strengthen and benefit all New Yorkers.

David R. Jones, President & CEO

Steven L. Krause, Executive Vice President & COO

CSS's health policy work is generously supported by The Nathan Cummings Foundation, The New York Community Trust, the New York State Health Foundation, the Robert Wood Johnson Foundation, and the United Hospital Fund.

This report was made possible through a generous grant from the New York State Health Foundation; we would especially like to thank James Knickman, David Sandman, Melissa Seeley, and Amy Lee for their support and thoughtful comments.

We interviewed many people who provided us valuable feedback during our research process, more than can be acknowledged here. That being said, there are several people who deserve our recognition and thanks.

- At the New York State Department of Health: Deborah Bachrach, Jay Laudato, Foster Gesten, Patrick Roohan, Judy Arnold, Joseph Anarella, Anne Marie Costello, and Wilma Waithe.
- At Manatt Health Solutions: Melinda Dutton, Laura Braslow, Kalpana Bhandarkar, and Marianella Santiago.
- Colleagues in the field: Jacquie Anderson of Community Catalyst, Dr. Anne Beal of the Commonwealth Fund, and Dr. Brian Smedley of the Joint Center for Political and Economic Studies.
- Roundtable Reactors: Senator Thomas Duane, Assemblymember Richard Gottfried, Patricia Wang of Health First, James Tallon of the United Hospital Fund, and Department of Health Regional Director Celeste Johnson.
- CSS colleagues: David Jones, Christine Molnar, Francesca Mueller, Rosa Mendez, Robin Willig, Munira Khapra, and Alia Winters.

This report was written by Elisabeth Ryden Benjamin and Arianne Garza and all errors or omissions are ours alone.

Community Service Society | Fighting Poverty Strengthening New York

105 East 22nd Street
New York, NY 10010
PH 212.254.8900
www.cssny.org

Executive Summary

A crucial first step in addressing racial and ethnic disparities in health outcomes is getting and maintaining health insurance coverage. This Policy Brief finds that public health insurance has the equalizing effect of reducing coverage disparities among racial and ethnic minorities at very low income levels. However, more than 40 percent of publicly-insured enrollees in New York State are involuntarily disenrolled or "churned" from the public insurance plans each year, even though most remain eligible. This churning affects certain racial and ethnic groups—namely African Americans—to a greater degree than others. Three plans appear to be driving the racial disparity in retention. This Policy Brief recommends that the New York State Department of Health address racial and ethnic disparities in retention through: (1) implementing a two-year public insurance renewal and continuous coverage cycle; and (2) launching targeted initiatives with health plans.

I. Introduction

Serving 4.5 million beneficiaries, New York's public insurance programs are a vital source of coverage for the State's low-income families and racial and ethnic minorities.

Methodology

The findings in this Policy Brief are based on an original analysis of State retention data from New York's Medicaid Managed Care program. CSS analyzed data on managed care retention rates by enrollee race and ethnicity, health plan, enrollee age, aid category, and county, for the period June 2006 through July 2007. To supplement this analysis, CSS conducted interviews with State officials, representatives from health plans, health advocates and policy experts, and conducted a national review of literature concerning racial and ethnic disparities in health retention in public insurance programs. In addition, on February 27, 2009, CSS hosted a high-level roundtable with health care providers, State and City officials, health plan representatives, elected officials, and health advocates to present its analysis and gather feedback on its findings and recommendations.

Despite the significant role of publicly-funded health care, 2.1 million, or 18 percent of the State's adult population, are uninsured: nearly half of whom are below 200 percent of the federal poverty level and are disproportionately racial or ethnic minorities.[1]

Serving 4.5 million beneficiaries, New York's public insurance program has the potential to play a pivotal role in eliminating racial and ethnic disparities and promoting health equity for all State residents.

Public insurance has the potential to play a pivotal role in narrowing the gap in insurance coverage, eliminating health disparities, and improving the health of its residents. Despite significant enrollment in public health coverage, keeping eligible beneficiaries enrolled has been an ongoing challenge. "Churning," the cycle of involuntary disenrollment and re-enrollment, continues to plague the State's health insurance programs and leads to: disruptions in needed care; poor quality of care; administrative inefficiencies; and diminished revenue for safety net health care providers.

The purpose of this Policy Brief is to describe the State's performance in retaining enrollees in public insurance and to provide recommendations on how it can better leverage its purchasing and regulatory power to promote health equity. It begins by describing racial and ethnic disparities in insurance coverage in New York State. It then presents findings from a CSS analysis of retention data—stratified by racial and ethnic minority group—in New York State's public insurance programs. Finally, it concludes with a series of concrete recommendations aimed at reducing racial and ethnic disparities in public health insurance retention.

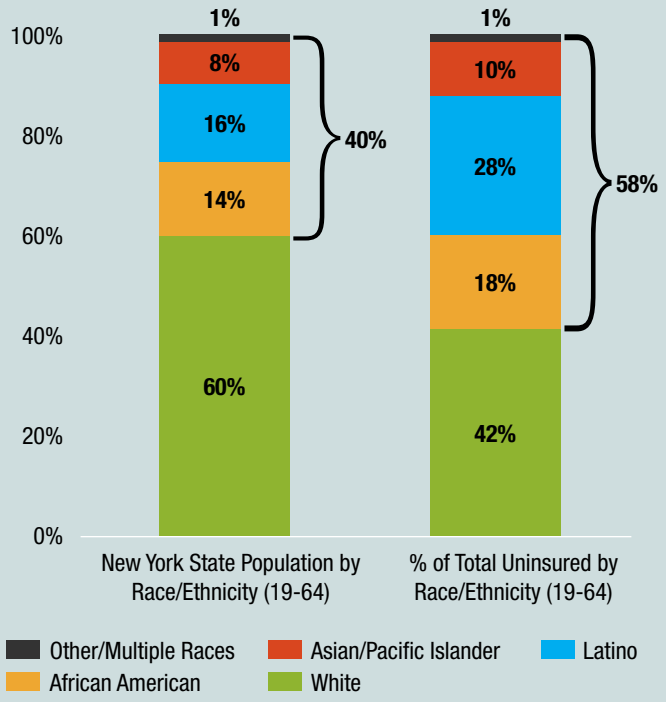
II. Racial and Ethnic Disparities in Coverage

In explaining health disparities between African Americans, Latinos, and Asian/Pacific Islanders as compared with Whites, uninsurance is the most significant determinant of disparities in health outcomes—surpassing income, education level, employment, citizenship, or availability of local health services.[2] Once individuals are insured and in receipt of care from a regular health care provider, racial and ethnic disparities are considerably reduced in childhood immunization rates, preventive screening rates, receipt of preventive care reminders, and receipt of quality care for heart attacks.[3] Thus, a crucial first step in addressing racial and ethnic disparities in health care outcomes is to ensure access to and enrollment in health insurance coverage.

New Yorkers without health insurance are disproportionately represented by racial and ethnic minorities. As described in the Table 1, below, 22 percent of African American adults, 31 percent of Latino adults, and 22 percent of Asian/Pacific Islanders living in New York are uninsured, compared with 13 percent of White adults.[4]

Overall, 58 percent of uninsured adult New Yorkers are members of racial or ethnic minority groups, but only 40 percent of total adult New Yorkers are members of racial

Figure 1
Racial and Ethnic Minorities Are Disproportionately Uninsured



Source: CSS Analysis of CPS Data, three-year blend 2006-2008.

Table 1
Number of Adult Uninsured by Race and Ethnic Group in New York State

Uninsurance by Race and Ethnic Group, New York State						
	White	**African American**	**Latino**	**Asian/Pacific Islander**	**Other/Multiple Races**	**Total**
Count and Percentage						
Number of people in New York by Race/Ethnicity (age 19-64)	7,161,553	1,713,933	1,927,881	979,441	102,316	**11,885,123**
Number of Uninsured in New York by Race/Ethnicity (age 19-64)	896,711	384,376	603,489	217,767	21,487	**2,122,474**
% of Race/Ethnicity who are Uninsured (age 19-64)	13%	22%	31%	22%	21%	**18%**
% of Total Uninsured by Race/Ethnicity (age 19-64)	42%	18%	28%	10%	1%	**100%**

Source: CSS Analysis of CPS Data, three year blend 2006-2008.

or ethnic minority groups.[5] Of the uninsured: 18 percent are African American; 28 percent are Latino; 10 percent are Asian and Pacific Islander; and 1 percent are members of another racial/ethnic group or are multi-racial. These results are graphically described in Figure 1.

Yet in New York, as shown in Table 2, below, the availability of public insurance has had an equalizing effect on improved health insurance coverage for racial minorities at the lowest income levels. New York offers public health insurance coverage for qualified adults below 150 percent of the Federal Poverty Level (FPL) for parents, and 100 percent of the FPL for childless adults. Currently, 30 percent of New York's African American population and 37 percent of the Latino population are enrolled in public insurance, compared to only 11 percent of the State's White population.[6]

As a result, despite having a higher total rate of overall uninsurance than the State's White population, African Americans below 150 percent of the FPL have slightly lower uninsurance rates than Whites (orange area in Table 2 below), and rates of uninsurance among Asian/Pacific Islanders and Latinos in this income bracket begin to approach that of Whites (yellow area in Table 2 below).

The equalizing effect of public insurance availability on disparities in coverage does not affect all racial and ethnic groups in the same way.[7] This difference is due, in part, to the cultural and legal factors associated with immigration, including eligibility restrictions, economic barriers, cultural and linguistic barriers, and both real and perceived immigration consequences to seeking enrollment in public programs.[8] Twenty-seven percent (3.2 million) of New York's adults are immigrants, of which half (1.6 million) have been naturalized.[9] While the majority of those who have not yet been naturalized are legal residents, these non-citizen immigrants are still nearly three times more likely to be uninsured than native-born New Yorkers.[10]

Uninsurance Hurts

According to the Institute of Medicine report *Care Without Coverage: Too Little, Too Late*, lack of health insurance is correlated with impeded access to health care, which can exacerbate disparities in delivery, treatment, and outcomes. Uninsured adults are less likely than insured adults to receive preventive health screenings, reducing the likelihood of disease prevention as well as early diagnosis and treatment of disease. Similarly, uninsured adults with chronic conditions experience significantly worse outcomes than their insured counterparts.

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/Pacific Islander	Total
<150% of FPL	31%	30%	34%	33%	**32%**
150-200% of FPL	24%	30%	41%	25%	**28%**
200-300% of FPL	16%	25%	37%	30%	**23%**
300-400% of FPL	13%	13%	31%	20%	**16%**
400-500% of FPL	8%	21%	21%	13%	**12%**
500%+ of FPL	6%	13%	16%	11%	**7%**

Source: CSS Analysis of CPS Data, three-year blend 2006-2008 (insufficient data for "Other/Multiple Races" group to represent accurately by income).

III. The Public Insurance Retention Problem

While access to public health insurance programs has the equalizing effect of significantly reducing coverage disparities among low-income populations, rates of uninsurance remain high across all racial and ethnic minorities. Indeed, nearly half of all uninsured New Yorkers are eligible but not enrolled in public insurance.[11] A significant first step in reducing the number of uninsured is to ensure that those who are currently eligible for coverage are enrolled and, once enrolled, retain coverage through successful completion of the annual renewal process.

More than 40 percent of publicly insured managed care enrollees are involuntarily disenrolled—or "churned"—every year, though the majority of them remain eligible for the program.[12] For some, this disenrollment leads to a permanent loss of public health insurance, despite continued eligibility.[13] For others, involuntary disenrollment at renewal results in temporary uninsurance, as many may find their way back to program enrollment.[14]

These disruptions diminish the quality of care received by patients and affect the continuity of care for beneficiaries. For example, recent focus groups held around New York State found many former beneficiaries to be suffering from serious medical conditions—such as diabetes, high-blood pressure, and cancer—that had gone untreated since losing coverage.[15]

Further, churning causes administrative inefficiencies and wastes resources. Beneficiaries must take the time to reapply for coverage, and eligibility workers at local government agencies, facilitated enrollment agencies, and health plans must process these applications—costs which could have been prevented if the beneficiary's coverage was retained. Churning also drains financial resources away from essential community-based healthcare providers that serve low-income and minority populations, as they may face long delays in reimbursement or even a lack of compensation for care delivered.

The Renewal Process

Public insurance beneficiaries must certify their eligibility annually with the State to establish their continued compliance with eligibility rules.

In early 2008, the State implemented a number of streamlining initiatives in the renewal process (e.g. allowing self-attestation of income and residency). State officials report some increased retention as a result of these steps.

Nonetheless, renewal remains a burdensome process for beneficiaries, the State, localities, plans, providers, and community-based enrollers.

In the future, the State plans to open a statewide enrollment center that will enable telephone and electronic renewals.

IV. Analysis of New York's Retention Data

With these public insurance retention challenges in mind, CSS conducted an analysis of Medicaid Managed Care retention data for the calendar year June 2006 to July 2007. Of the 2.4 million enrollees in Medicaid Managed Care, 61 percent remained enrolled in coverage at recertification. A more detailed analysis of this data reveals a complex picture of retention in the program with significant variation in retention rates by health plan, region, and aid category.

- **Health Plan Variation.** Amongst the 24 plans analyzed, the highest performing plan, from a retention perspective, had a 74 percent retention rate. The lowest performing plan experienced a 47 percent retention rate. Large plans, those with more than 100,000 members, had a higher retention rate than smaller plans, those with less than 25,000 members (63% and 56%, respectively). Much of this health plan variation may be driven by the next two factors.
- **Regional Variation.** Enrollees also experienced regional differences in retention rates, from a low of 21 percent (Schuyler County) to a high of 73

percent (Rockland County). Enrollees in New York City had a higher retention rate (63%) than the rest of the State (57%). Large enrollment counties—those with more than 20,000 Medicaid Managed Care enrollees—had higher retention rates (62%) than counties with fewer than 1,000 enrollees (40%). Finally, counties that have mandatory Medicaid Managed Care enrollment experienced higher retention rates (68%) than voluntary counties (48%).

- **Aid Category Variation.** The beneficiaries' Medicaid "aid category," or eligibility category under which they are receiving coverage, also influenced retention rates. This is because income for certain aid categories is automatically verified amongst government agencies and does not require beneficiaries to submit paperwork. For example, disabled individuals receiving Supplemental Security Insurance (or SSI) experienced the highest retention levels of 79 percent. The next highest retention levels were experienced by families on public assistance with children in the home, or TANF beneficiaries (63%), followed by people who have Family Health Plus and Safety Net Assistance (55% for both). Overall, children had higher retention rates (66%) than adults (57%).

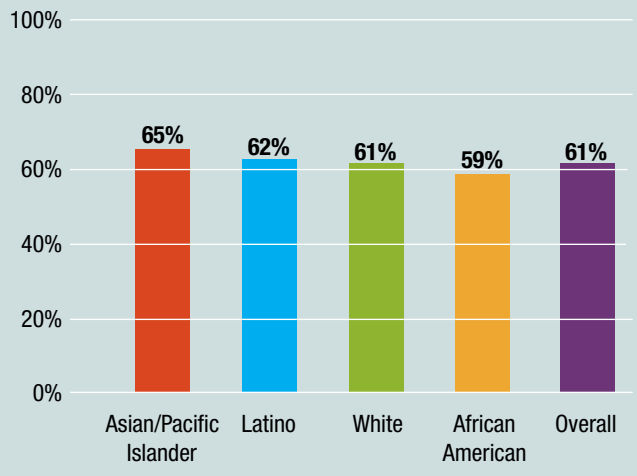
Racial and Ethnic Disparities in Retention

Variation in retention rates also occurs by race and ethnicity. As described in Figure 2, overall, African Americans experienced the lowest retention rate of 59 percent, followed by Whites (61%), Latinos (62%) and Asian/Pacific Islander enrollees (65%). Contrary to rates of insurance in the general population, Asian enrollees, and, to a lesser extent, Latino enrollees, many of whom may be immigrants and non-English speakers, appear to have higher rates of retention than their White or African American counterparts.

Given the extremely large number of enrollees statewide (there were 2.4 million individuals reflected in the data analyzed for this Policy Brief), all of the differences between groups and plans reported here are statistically significant. The findings reported here reflect a bivariate descriptive analysis based on race and health plan.[16] A multivariate analysis, which would have allowed for a comparison across racial and ethnic groups while simultaneously controlling for variation related to multiple other factors (for example, aid category and county), was not possible with the available data. Nonetheless, bivariate analyses yielded a number of interesting findings.

African American public insurance enrollees experience significantly lower retention rates than other racial and ethnic groups. Three health plans appear to be driving this disparity in retention.

Figure 2
Medicaid Managed Care Retention Rates by Race/Ethnicity (June 2006-July 2007).



Source: CSS Analysis of NYS DOH Data on Health Plan Retention for the Year 2006-2007.

Race & Ethnicity Variation by Region. Race data is not available by county of enrollee residence. In order to examine regional variation, CSS compared health plans operating in the Rest of the State (ROS) only, New York City only, and those operating statewide (in NYC and counties in the ROS).

As described in Table 3, below, in contrast to the overall finding that New York City plans had higher retention rates than ROS-only plans, when analyzed by race and ethnicity, a different pattern emerged. Specifically, African Americans experience lower retention rates in plans operating only in New York City than White enrollees, by nearly 14 percent. On the other hand in plans operating only in the ROS, African Americans were retained at a higher rate than their White counterparts (a difference of seven percentage points).

Latinos also experienced lower retention rates in plans operating only in New York City (64%) than Whites (72%), but higher retention rates (59%) than Whites (54%) in plans operating only in the ROS. Asian/Pacific Islanders experienced a similar pattern, with an 11 percent lower retention rate in New York City than Whites (61% vs. 72%); and a 4 percent higher retention rate (58%) in the ROS than Whites (54%).

Race & Ethnicity Variation by Plan Size. A similar experience is documented with plan size. African Americans had better retention rates than Whites in smaller plans. This pattern was also observed, with the exception of the very smallest plans, for Latinos. The experience of Asian/Pacific Islanders appeared to be mostly unaffected by plan size (see Table 3).

Race & Ethnicity Variation Within Plans

As indicated in Figure 2, on the previous page, African Americans had significantly lower retention rates than Whites. Latinos and Asian/Pacific Islanders had higher retention rates than Whites. In order to better understand the overall African American retention gap, CSS also analyzed race variation within plans.

Variation also exists in retention by race within plans, with

Table 3
Retention by Race & Ethnicity by Plan Size and Region of Operation

Retention by Race and Plan Size and Region of Operation, Statewide, June 2006–July 2007

	Race					White vs. African American Pct Point Diff
Plan Characteristics	**Asian**	**African American**	**Latino**	**White**	**Total**	
Plan Region of Operation						
NYC	61.3%	58.5%	63.6%	72.1%	63.2%	13.6%
Rest of State	58.1%	61.3%	58.5%	54.3%	57.0%	- 7.1%
Both	66.6%	58.1%	61.1%	61.1%	61.1%	3.0%
Plan Size						
>100K Members	66.0%	59.3%	62.7%	65.5%	62.7%	6.2%
50-100K Members	64.3%	56.7%	59.3%	56.4%	58.3%	-0.3%
25-50K Members	55.7%	56.4%	57.5%	53.2%	55.0%	-3.2%
<25K Members	54.0%	61.5%	52.5%	54.4%	55.9%	-7.2%
TOTAL	65.4%	58.7%	61.6%	61.2%	61.0%	2.6%

Source: CSS Analysis of New York State Department of Health Data on Health Plan Retention for the Year 2006-2007.

some plans showing significantly higher retention among African Americans than among other racial groups, and some plans showing significantly lower African American retention than among other racial groups. As shown in Figure 3, below, among the 24 plans, 11 have higher rates of retention among Whites than among African Americans.

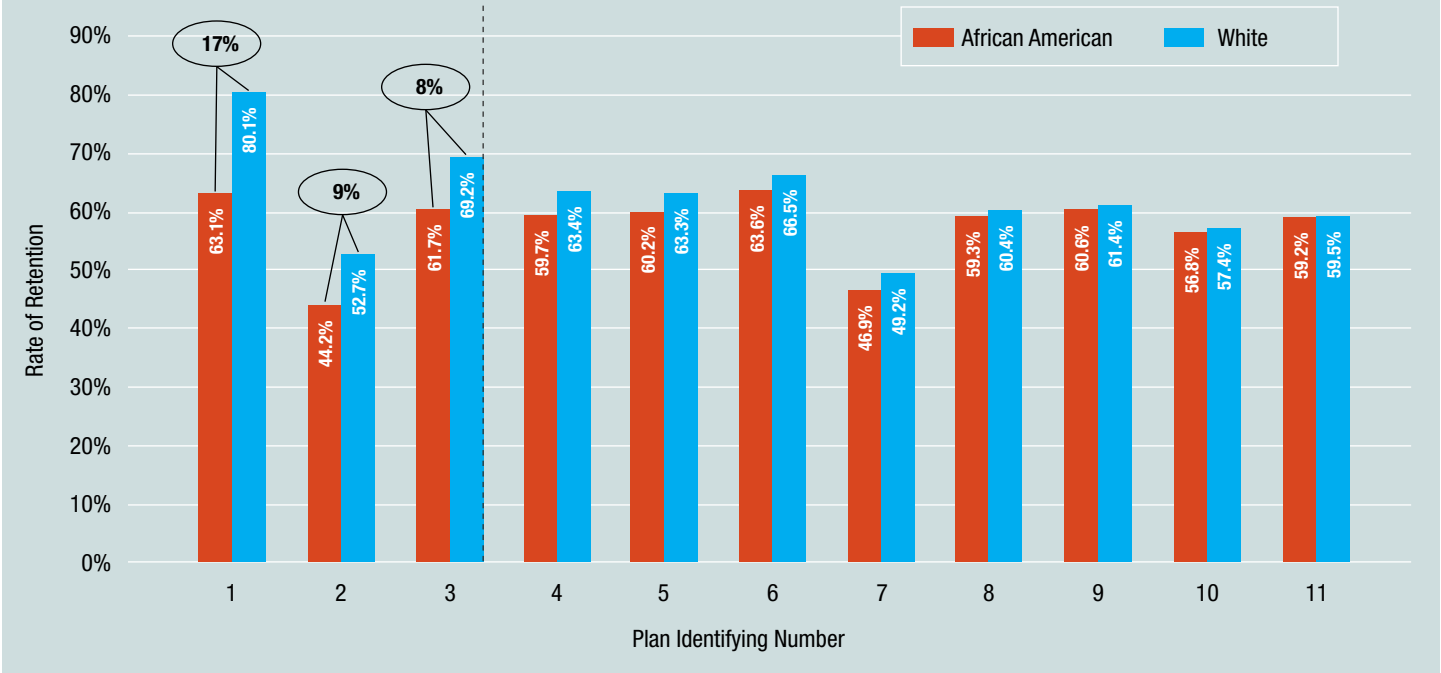
However, three plans had significantly higher retention of Whites than African Americans—and appear to be driving the overall disparity experienced between African American and White retention rates (see Figure 3). These three plans have nearly 450,000 members or 19 percent of all Medicaid managed care enrollment in New York State.

Their race-based retention rates are as follows:

- Plan 1 had an 80 percent White retention rate and a 63 percent African American retention rate;
- Plan 2 had a 53 percent White retention rate and a 44 percent African American retention rate;
- Plan 3 had a 69 percent White retention rate and a 62 percent African American retention rate.

When these plans are removed from the statewide retention totals, disparities between White retention and African American retention essentially disappear. Despite the disparity within these plans, two of these plans still have higher than average African American rates of retention (Plan 1 (63%) and Plan 3 (62%)). In fact, their African American retention rate is higher than the overall statewide average retention rate of 61 percent. So, while these plans are doing better with African Americans and with Whites, their rate of retention is much higher for their White enrollees than for their African American enrollees. On the other hand, Plan 2 had a lower than average retention rate for Whites, and an even lower than average retention rate for African Americans.

Figure 3
Three Health Plans Appear to be Driving the African American Disparity in Retention



Source: CSS Analysis of NYSDOH Data of NY Medicaid Managed Care, African-American and White Retention Rates By Plan, June 2006-July 2007.

V. Discussion and Recommendations—Addressing Retention Issues

Retention in public health insurance is critical to improving health outcomes and reducing racial and ethnic disparities in health care. Gaps in coverage and uninsurance in general are correlated with impeded access to health care, which can exacerbate disparities in delivery, treatment and outcomes.[17] New York State can best leverage its purchasing and regulatory power to both improve retention rates overall and to reduce racial disparities within retention by: (1) streamlining and improving the renewal process overall by implementing a two-year renewal and continuous coverage policy; and (2) involving health plans in targeted efforts to reduce racial and ethnic disparities in retention rates.

Recommendation: Streamline and Improve the Renewal Process By Implementing a Two-Year Renewal and Continuous Coverage Cycle

New York has made significant progress in streamlining its renewal process in recent years, such as limiting documentation requirements and permitting the self-attestation of income, residence, and child-care expenses. First time Medicaid Managed Care and Family Health Plus enrollees are provided a guaranteed six-month coverage period which has lessened some of the churning phenomena. At the CSS Roundtable in February 2009, one of the reactors stated that her health plan saw a significant drop-off of enrollment following the ending of this period—at approximately month eight.[18] In 2008, the New York State Department of Health (DOH) took the important first steps to address mid-year disruptions of coverage by filing a State Plan Amendment with the federal government that will assure continuous coverage throughout the year for all adult enrollees, a measure already in place for children. In March 2009, this request was re-filed in conjunction with New York's request to extend its Section 1115 Waiver.

In addition, DOH is in the process of setting up a statewide Enrollment Center which will share responsibility with local social service districts for expanding and managing the growth in the State's public insurance programs (Medicaid, Family Health Plus, Child Health Plus, and the Family Health Plus Employer Buy-In programs). By establishing a centralized (telephone, mail, and eventually web-based) renewal process for beneficiaries who can self-attest to their eligibility, this Enrollment Center should reduce churning and improve the currently cumbersome renewal process.[19] Telephone renewal in itself has the potential to reduce racial and ethnic disparities by providing assistance in multiple languages. Nonetheless, even with all these improvements, the renewal process will likely remain challenging for families, especially racial and ethnic minorities.

The single most important step to reducing the annual churn would be to lengthen the time span for the renewal period—and if possible the guaranteed coverage period—to two years. This step was taken briefly in the wake of the September 11, 2001 disaster with Disaster Relief Medicaid. While requiring a waiver of Medicaid rules from the federal government, a two-year continuous enrollment and coverage period would reduce disruptions in health care for Medicaid enrollees and roughly halve the costs and administrative burden of re-enrolling those who have been involuntarily disenrolled. Alternately, if the federal government demurs on an application of a two-year continuous enrollment and coverage period, the State could pursue "administrative renewal" or enhanced *ex parte* policies,

Renewal Process & Health Plans

In New York City, health plans regularly receive rosters from the City of plan members whose renewal dates are approaching, and generally reach out to enrollees by phone and/or mail in advance of the renewal date to remind them to complete the paperwork and resend it in to the City. As designated "facilitated enrollers," health plans employ eligibility specialists to assist members in completing the renewal application and gathering necessary paperwork. Elsewhere in the State, local districts do not provide plans with renewal rosters.

Health plans also have an inherent financial incentive to ensure their members successfully complete the renewal process, as each member that fails to complete the renewal process represents an incremental loss in revenue for the health plan.

which does not require a federal waiver.[20] These actions reduce the burden on public-program enrollees by allowing DOH to use government databases to verify continued eligibility. Such state-based efforts were strongly encouraged in the recently enacted federal Children's Health Insurance Program Reauthorization Act (CHIPRA).[21]

Recommendation: Launch Targeted Initiatives with Health Plans

Health plans can play an important role in the renewal process. In New York State, public insurance plans coordinate recertification efforts with local departments of social services (LDSS), the local government agency charged with eligibility screening and enrollment of Medicaid beneficiaries. Sixty to 90 days in advance of a beneficiary's renewal date, the LDSS mails a renewal application to the beneficiary's home.[22] Beneficiaries are given a designated time frame within which they must respond (generally six weeks), after which they risk disenrollment.[23] The LDSS is responsible for making a final eligibility determination. The implementation of the new statewide Enrollment Center should significantly streamline the renewal process.

To promote health equity in retention, the State should annually analyze and report retention data by race and ethnicity, county of residence, plan, and aid category.

Health plans experience enormous variation in their beneficiaries' rates of success in completing the renewal process, and it is likely that targeted incentives to health plans would create a more focused effort among underperforming plans to improve their performance. To date, the DOH has not provided retention data to the plans broken down by their enrollees' race and ethnicity. Although the plans could generate retention data by race and ethnicity independently, it would not be viewed in comparison to other plans' retention statistics.

CSS's national research has found no state models for incentives for managed care plans to improve coverage of the eligible but uninsured (overall or for racial and ethnic minorities), or to promote retention of individuals enrolled (overall or for racial and ethnic minorities). This concept was briefly entertained in New York, where the DOH considered adding a member retention component to criteria for the Medicaid Managed Care plan Quality Incentive (QI) program. However, upon further review and analysis, the retention measure was not included because DOH officials determined that there were too many factors influencing retention that are out of the control of the plans. As described earlier, rates of retention vary widely because of the size of an enrollee's county, his or her aid category, and whether or not mandatory enrollment has been adopted in a specific region. Plans are unable to influence these retention factors. State officials have expressed optimism that the statewide Enrollment Center, through the use of telephone assistance and new technologies, will help reduce churning, facilitate greater consistency in renewal processing, and improve rates of retention.[24]

There are several concrete steps that can be taken in partnership with health plans to both address racial and ethnic disparities in retention and improve renewal rates overall.

1. Annually Analyze Retention Data and Report to Plans Regularly, Controlling for Race, County, Plan, and Aid Category.

While the State currently reports simple enrollment figures for its Medicaid Managed Care programs on a monthly basis, it is important that this data be analyzed by demographics on a regular basis. This would allow the State and the plans themselves to detect differences in retention patterns among both beneficiary and plan characteristics, which would in turn help target improvement efforts and improve the functioning of the statewide Enrollment Center, counties, renewal sites, and plan and community-based facilitated enrollers.

The new statewide Enrollment Center, in particular, could play a vital role in reducing disparities since it will be the first line of contact with the public insurance system for many beneficiaries. The Enrollment Center will be respon-

sible for renewing beneficiary eligibility, but also for educating and familiarizing beneficiaries with the programs. In this respect, it is important to include the statewide Enrollment Center in the data reporting and analysis process to identify and reduce disparities in retention.

2. Publicly Report and Disclose Stratified Retention Data by Race/Ethnicity, Plan, and Other Meaningful Categories in State Quality Reports.

The State publishes an annual Quality Assurance Reporting Requirements (QARR) report, which reports plan performance on a number of measures of plan performance and patient outcomes.[25] As an additional measure of plan performance, DOH should include stratified retention data by race and ethnicity and plan in the QARR reports.

The State Departments of Insurance and Health also regularly publish consumer guides on insurers and health maintenance organizations through which they provide a rank to each plan, based on consumer complaints and areas of customer service. The purpose of these guides is to inform consumer research on plans and their enrollment decisions. The Departments should include in these guides retention data, including data stratified by race and ethnicity and other meaningful categories, to facilitate transparency and further inform consumer enrollment decisions in plans. This would potentially create another incentive for plans to boost their retention rates short of adding an additional financial payment from the State.

3. Share Retention Analyses with Plans and Use it to Monitor Plan Participation in the State's Public Insurance Programs.

Following analyses of retention data, the DOH should meet with the plans that have racial and ethnic disparities in order to set up a performance improvement plan. A variety of interventions should be tested for plans with low overall retention. In addition, the DOH should consider using its standard enforcement procedures by issuing statements of deficiencies and developing corrective action plans for low-performing plans if they are unable to produce a positive change over time.

Conclusion

New York's public insurance programs are a fundamental source of coverage for racial and ethnic minorities. For low-income minorities, they are an important catalyst for achieving health equity in coverage. And yet, these programs are not without their flaws. Nearly 40 percent of their beneficiaries are "churned" off needlessly each year. This churn has a disparate impact on African American New Yorkers.

Concrete steps are within New York's grasp to address the troubling problem of racial and ethnic disparities in retention and to promote health equity in coverage. First, New York should take further steps to achieve continuous enrollment and coverage for low-income families, whether through a federal waiver or administrative renewals. Second, New York should address the disparities in retention with the managed care plans charged to provide coverage. Simple steps such as analyzing the data, sharing it with the new statewide Enrollment Center, the plans, community and health advocates, and beneficiaries could promote health equity significantly. Finally, for those plans that have low overall retention rates and even lower retention rates for racial and ethnic minorities, the State must use its purchasing and enforcement powers to monitor, and in certain cases intervene, with those plans that fail to achieve sufficient health equity.

Appendix I – List of CSS Roundtable Attendees & Interviewees

On February 27, 2009, Community Service Society of New York presented "A Roundtable on Reducing Racial & Ethnic Disparities in Health Coverage & Outcomes in Public Insurance Programs."

Attendees

Abena Abboa-Offei, Affinity Health Plan
Marilyn Aguirre-Molina, Health Sciences Doctoral Programs, The Graduate Center, CUNY
Jacquie Anderson, Community Catalyst
Deborah Bachrach, Office of Health Insurance Programs, NYS Department of Health
Elisabeth Benjamin, Community Service Society
Howard Berliner, SUNY Downstate Medical Center
Carolyn Berry, Center for Health Strategies, Inc.
Kalpana Bhandarkar, Manatt Health Solutions
Michael Birnbaum, United Hospital Fund
Laura Braslow, Manatt Health Solutions
Marjorie Cadogan, Office of Citywide Health Insurance Access
Neil Calman, MD, Institute for Family Health
Juan Cartegena, Community Service Society
Colin Casey, Office of NYS Senator Thomas Duane
Nora Chaves, MCCAP, Community Service Society
Andrea Cohen, Manatt Health Solutions
Louise Cohen, Division of Health Care Access and Improvement, NYC DOHMH
Bob Cohen, Citizen Action of New York
Anne Marie Costello, Office of Health Insurance Programs, NYS Department of Health
Honorable Thomas Duane, New York State Senate
Melinda Dutton, Manatt Health Solutions
Marianne Engelman Lado, New York Lawyers for the Public Interest
C. Virginia Fields, National Black Leadership Commission on AIDS
Tony Fiori, Manatt Health Solutions
Janeene Freeman, Community Service Society
Arianne Garza, Community Service Society
Foster Gesten, MD, Office of Health Insurance Programs, NYS Department of Health
Honorable Richard Gottfried, New York State Assembly
Mark Hannay, Metro New York Health Care for All Campaign
Dennis Johnson, Children's Health Fund
Celeste M. Johnson, NYS Department of Health
David R. Jones, Community Service Society
Jay Laudato, Office of Health Insurance Programs, NYS Department of Health
Priya Mendon, MCCAP, Community Service Society
Christine Molnar, Community Service Society
Francesca Mueller, Community Service Society
Wendy Negron, Division of Health Care Access and Improvement, NYC DOHMH
Beth Osthimer, NYS Department of Health

Appendix I (Cont.)

David Sandman, New York State Health Foundation
Rodolfo Santos, NYS Department of Health
Lisa Sbrana, Legal Aid Society
Magda Schaler-Haynes, NYS Insurance Department
Melissa Seeley, New York State Health Foundation
Joseph A. Stankaitis, Monroe Plan for Medical Care
James R. Tallon, Jr., United Hospital Fund of New York
Lois Uttley, The MergerWatch Project
Patricia Wang, HealthFirst
Lea Webb, Citizen Action of New York
Joyce Weinstein, Division of Health Care Access and Improvement, NYC DOHMH
Jessica Wisneski, Citizen Action of New York

List of Interviewees

Foster Gesten, MD, Medical Director, Office of Health Insurance Programs, NYS Department of Health
Patrick Roohan, Director, Bureau of Quality Management and Outcomes Research, Office of Managed Care, NYS Department of Health
Wilma E. Waithe, Director, Office of Minority Health, NYS Department of Health
Jay Laudato, Director, Division of Managed Care, Office of Health Insurance Programs, NYS Department of Health
Joe Anarella, Director, Quality Measurement and Improvement, NYS Department of Health
Deborah Bachrach, Deputy Commissioner, Office of Health Insurance Programs, NYS Department of Health
Lindsay Cogan, Division of Quality and Evaluation, NYS Department of Health
Paul Henfield, Director of Managed Care, IPRO
Brian D. Smedley, Vice President and Director of the Health Policy Institute, Joint Center for Political and Economic Studies
Anne Beal, MD, Associate Vice President, Program on Health Disparities, Commonwealth Fund
Deborah N. McNamara, Quality Coordinator, Bureau of Quality Management, Florida Agency for Health Care Administration
Janet (Jessie) Sullivan, MD, Chief Medical Officer, Hudson Health Plan
Mark Santiago, Senior Vice President of Marketing and Communications, Hudson Health Plan
Joe Stankaitis, MD, Chief Medical Officer, Monroe Plan for Medical Care
Lani Alison, Vice President of Quality, HealthFirst

Notes

1. CSS analysis of 2006-2008 Current Population Survey (CPS), Annual Social and Economic Supplement (ASEC), U.S. Bureau of the Census.
2. J.L. Hargraves and J. Hadley, "The Contribution of Insurance Coverage and Community Resources to Reducing Racial/Ethnic Disparities in Access to Care," *Health Services Research*, 38(3), June 2003. *See also* A.C. Beal, et al., "Closing the Divide: How Medical Homes Promote Equity in Health Care," Results from the Commonwealth Fund 2006 Health Care Quality Survey, Commonwealth Fund, June 2007; J. McDonough, et al. "A State Policy Agenda to Eliminate Racial and Ethnic Health Disparities," The Commonwealth Fund, June 2004; B. Smedley, et al. "Identifying and Evaluating Equity Provisions in State Health Care Reform," The Commonwealth Fund, April 2008; A.C. Beal, "Policies to Reduce Racial and Ethnic Disparities in Child Health and Health Care," *Health Affairs*, 23 (5), September 2004.
3. H. Mead, et al. "Racial and Ethnic Disparities in U.S. Health Care: A Chartbook," The Commonwealth Fund, Volume 27, March 2008.
4. CSS analysis of CPS, *supra* n. 1.
5. *Id.*
6. P.J. Roohan, "Race/Ethnicity Differences in the Quality of Care for Medicaid Managed Care Enrollees in New York State," Presentation at New York State Department of Health Minority Health Summit, January 13, 2009. Estimates are from NYS Medicaid Enrollment data and Census data. The percent of Asian/Pacific Islanders receiving Medicaid in New York is not listed.
7. Asian and Latino New Yorkers have the highest rates of non-naturalized immigrants relative to their populations (42% and 35%, respectively), followed by African Americans (16%) and Whites (4%). This can have a significant effect on uninsurance rates for Asian and Latino New Yorkers, despite the availability of public insurance programs. As Table 2 illustrates, both Asian and Latino rates of uninsurance remain higher than that of Whites even when income levels signify public insurance eligibility. This is likely due to higher rates of non-citizenship among these populations. CSS analysis of CPS, *supra* n.1.
8. M. Scherzer and J. Rejeske, "Analysis of New York State Coverage Expansion Proposals: Potential Impact on Immigrants," New Yorkers for Accessible Health Coverage and New York Immigration Coalition, February 2009.
9. CSS analysis of CPS, *supra* n.1.
10. 14% of native-born New Yorkers ages 19-64 are uninsured, compared to nearly 38% of non-citizens. *Id.*
11. United Hospital Fund, "Health Insurance Coverage in New York, 2005-2006," May 2008.
12. CSS analysis of New York Medicaid Managed Care retention data for calendar year June 2006 - July 2007, provided by the NYS DOH. In February 2008 (April 2008 in New York City), the State implemented two renewal simplification measures: the elimination of documentation for income and residency. As a result, State officials report a 10% reduction in churning. The current overall churn in Medicaid (managed care and fee-for-service) is approximately 30%; in Child Health Plus, it is approximately 25%. Personal communication between authors and DOH officials, April 29, 2009.
13. M. Perry, "Reducing Enrollee Churning in Medicaid, Child Health Plus, and Family Health Plus," NYS Health Foundation, February 2009; A.Cohen, et al., "Streamlining Renewal in Medicaid and SCHIP: Strategies from Other States and Lessons for New York," United Hospital Fund, 2008.
14. P.Boozang, et al., "Enrollment Churning in Medicaid: Coverage Gaps Undermine the Managed Care System and Continuity of Care for the Chronically Ill," New York State Coalition of Prepaid Health Services Plans, December 2006.
15. M. Perry, *supra* n.13.
16. While it appears from this descriptive analysis that there is regional variation and/or variation by plan size, these factors are highly correlated - plan size and region (or county) are correlated, as are, to a lesser extent, region and the racial make-up of the enrollee population. Individual plans are also correlated with region (or county), since each plan only operates in certain counties. Given the available data, it is not possible to isolate the effect of individual plans, plan size and region (or county). With access to observation-level data, it would be possible to use statistical models to attempt to isolate these variables and develop findings as to the causal relationships and degree of influence of each of these factors. The State began work on a related analysis as part of the exploration of the retention quality incentive - the key difference between their existing analysis and the analysis described above is the inclusion of plan in the statistical model as a variable. Barring the availability of observation-level data or willingness to conduct this analysis on the part of the State, the availability of a more detailed cross-tabulation of the data by county, race and plan could yield significant additional descriptive insights.
17. Institute of Medicine, "Care Without Coverage: Too Little Too Late," May 21, 2002.
18. Comment by Patricia Wang, President & CEO, Health First Managed Care Plan, at CSS Roundtable on Racial Disparities in New York's Public Insurance Programs, February 28, 2009.
19. New York State Department of Health, Division of Coverage and Enrollment, Office of Health Insurance Programs, "Request for Proposal for The Enrollment Center," RFP No. 0808040239, available at: http://www.health.state.ny.us/funding/rfp/0808040239/0808040239.pdf.
20. M. Dutton, et al., "Automated Renewal: Strategies to Maintain Coverage of Eligible Children in Medicaid and Child Health Plus," United Hospital Fund Medicaid Institute, December 2008.
21. H.R. Sec. 104 amending Title XXI of the Social Security Act Section 2105(a) by adding 4(E) Enrollment and Retention Provisions for Children; *see also* Center for Children and Families, Georgetown University Health Policy Institute, "The Children's Health Insurance Program Reauthorization Act of 2009," Overview and Summary, March 2009 at 10.
22. M. Dutton, et al., *supra* n. 20.
23. *Id.*
24. Deborah Bachrach, Deputy Commissioner of Health Insurance Programs, oral presentation at CSS Roundtable, February 28, 2009.
25. The New York State Quality Assurance Reporting Requirements (QARR) is a state-wide mechanism for monitoring managed care plan performance and improving quality of care. It is largely based on measures of quality published by the National Committee for Quality Assurance (NCQA) Health Care Information Data Set (HEDIS). QARR also includes information collected using a national satisfaction survey methodology called the Consumer Assessment of Health Care Providers and Systems (CAHPS). The data from these two surveys is received by the DOH separately and then merged to form the QARR.

Community Service Society
Fighting Poverty
Strengthening
New York

105 East 22nd Street
New York, NY 10010
PH 212.254.8900
www.cssny.org