Focus on Equity: Communities of Color in a Post-ACA California

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About CPEHN

The California Pan-Ethnic Health Network (CPEHN) is a multicultural health advocacy organization dedicated to improving the health of communities of color in California. CPEHN’s mission is to eliminate health disparities by advocating for public policies and sufficient resources to address the health needs of our communities.

Together we’re stronger!
Eliminating Health Disparities

6. What is this person’s race? **Mark X one or more races** to indicate what this person considers himself/herself to be.

- [ ] White
- [ ] Black, African Am., or Negro
- [ ] American Indian or Alaska Native — Print name of enrolled or principal tribe.
- [ ] Asian Indian
- [ ] Chinese
- [ ] Filipino
- [ ] Other Asian — Print race.
- [ ] Japanese
- [ ] Korean
- [ ] Vietnamese
- [ ] Native Hawaiian
- [ ] Guamanian or Chamorro
- [ ] Samoan
- [ ] Other Pacific Islander — Print race.
Overview

- Access to Care for Communities of Color
  - The Uninsured Pre- and Post-ACA
  - Impact of the ACA on Communities of Color
  - Remaining Uninsured
- Why Equity Matters: The Quadruple Aim
  - Quality Improvement Initiatives
- Mental Health Integration
- CPEHN’s Policy Solutions
Access to Health Coverage
Pre-ACA: 6.5 million Californians without health insurance in 2013

Individually Purchased All Year
5.5%
1,792,000

Medi-Cal or Healthy Families All Year
18.8%
6,078,000

Employment-Based Insurance All Year
50.5%
16,357,000

Uninsured All or Part Year
20.3%
6,582,000

Uninsured All Year
12.6%
4,082,000

Uninsured Part Year
7.7%
2,500,000

Communities of color are more likely to be uninsured

Communities of color make up 77% of the uninsured

- Latino: 59%
- White: 23%
- A&PI: 11%
- African American: 5%
- Other: 2%

Note: There is no break-out for the “Other” category so we do not have a percentage for AI/AN populations
Communities of color had most to gain from the ACA

**Medi-Cal Expansion**
- Latino: 48%
- White: 33%
- African American: 8%
- A&PI: 7%
- Other & Multiple Race: 4%

**Covered California**
- Latino: 47%
- White: 32%
- A&PI: 14%
- African American: 4%
- NA/AN & Multiple Race: 2%

CPEHN, Medi-Cal Expansion: What's at Stake for Communities of Color, 2013
2014-15 Medi-Cal Enrollment

Trend in Medi-Cal Enrollment and Month Over Month Growth
October 2012 Through September 2014

Certified Eligibles in Millions

Month-Over-Month Percent Change

Source: Medi-Cal eligibility data as of October 2014

Between October 2013 and September 2014, Medi-Cal enrollment grew by over 2.7 million.
2014-15 Medi-Cal Enrollment

• Medi-Cal enrollment grew from 7.6 million to 11.3 million between 2012-14
  • Approximately 1/3 of California’s population
  • Recent numbers indicate that over 12 million are now enrolled

• Enrollment of communities of color held steady
  • Latinos were 49% down from 54% before OE1
  • Black were 8% no change from 8% before OE1
  • API were 11% up from 10% in before OE1

• Better data needed to know how many are new enrollees versus renewals
2014-15 Covered California Enrollment

2014: 1.4 million enrolled in first open enrollment (OE1)

2015: 500,000 enrolled in second open enrollment
  • Latinos were 37% in 2015 up from 31% in OE1
  • African-Americans were 4% in 2015 up from 3% in OE1
  • APIs were 18% in 2015 down from 23% in OE 1
Without Health4All Disparities Will Persist!

Communities of color will make up 87% of the uninsured, 2019

- Latino, 74%
- White, 13%
- A&PI, 9%
- Other, 2%
- African American, 3%

Source: Laurel Lucia, Miranda Dietz, Ken Jacobs, Xiao Chen, and Gerald F. Kominski: Which Californians will Lack Health Insurance under the Affordable Care Act? January 2015
Remaining Uninsured in 2019
Uninsured Californians under age 65
Total: 3,380,000

- Eligible for Subsidies in Covered CA (14%)
- Eligible for Medi-Cal (28%)
- Non-subsidy Eligible Citizens and Legal Immigrants (14%)
- Not Eligible due to Immigration Status (44%)

Assumes lower take-up rates

Source: Laurel Lucia, Miranda Dietz, Ken Jacobs, Xiao Chen, and Gerald F. Kominski: Which Californians will Lack Health Insurance under the Affordable Care Act? January 2015
Who are the Remaining Uninsured?

• Approximately 2 million are:
  • Citizens or legal residents
    • Limited English Proficient (50%)
    • Latino (74%)
    • Residents of LA County (33%)
    • Lack of Affordable Coverage (14%)

• Approximately 1.5 million are undocumented immigrants:
  • Currently 20% of the uninsured, up to 50% by 2019

Source: Laurel Lucia, Miranda Dietz, Ken Jacobs, Xiao Chen, and Gerald F. Kominski: Which Californians will Lack Health Insurance under the Affordable Care Act? January 2015
Support Health4All!!!
Why Equity Matters: Implications for cost, quality, and access
Question: How much do we spend on health care?

How much does the U.S. spend per person on health care compared to the average of the other industrialized countries?

A. Three quarters (75%) of the average
B. The same
C. One and a half times (150%) as much
D. Two and a half times as much
E. Four times as much

Source: “Unnatural Causes…is inequality making us sick?” developed by California Newsreel based in part on a quiz developed by Stephen Bezruchka of Univ. of Wash. Population Health forum
Answer:

D. The U.S. spends more than two and a half times as much as other countries

- In 2011, the U.S. spent $8,508 on average per person compared to ~$3,000-$4,500 on average of OECD countries.
- Health care spending in the U.S. represented 17.7% GDP compared to just 9.3% GDP for OECD countries.

- *The U.S. is paying a lot more than most other countries.*

Source: Organization for Economic Cooperation and Development, Health at a Glance 2013
Per Capita Total Current Health Care Expenditures, U.S. and Selected Countries, 2009

<table>
<thead>
<tr>
<th>Country</th>
<th>Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austria</td>
<td>$4,045</td>
</tr>
<tr>
<td>Belgium</td>
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</tr>
<tr>
<td>Canada</td>
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<td>Luxembourg</td>
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<td>Netherlands^*</td>
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</tr>
<tr>
<td>United States</td>
<td>$7,598</td>
</tr>
</tbody>
</table>

^OECD estimate.

*Break in series.

Notes: Amounts in U.S. dollars, see [http://www.oecd.org/std/npp](http://www.oecd.org/std/npp); includes only countries over $2,500. OECD defines Total Current Expenditures on Health as the sum of expenditures on personal health care, preventive and public health services, and health administration and health insurance; it excludes investment.

Distribution of National Health Expenditures, by Type of Service (in Billions), 2010

- Hospital Care, $814.0 billion (31.4%)
- Physician/Clinical Services, $515.5 billion (19.9%)
- Prescription Drugs, $259.1 billion (10.0%)
- Other Personal Health Care, $384.2 billion (14.8%)
- Other Health Spending, $407.6 billion (15.7%)
- Nursing Care Facilities & Continuing Care Retirement Communities, $143.1 billion (5.5%)
- Home Health Care, $70.2 billion (2.7%)

NHE Total Expenditures: $2,593.6 billion

If we spend more we must live longer...right?

Q. How does U.S. life expectancy compare to other countries?

A. #1
B. in the top 5
C. in the top 10
D. 20th Place
E. 26th Place

Source: “Unnatural Causes...is inequality making us sick?” developed by California Newsreel based in part on a quiz developed by Stephen Bezruchka of Univ. of Wash. Population Health forum
Answer: We don’t!

E. The U.S. ranks 26\textsuperscript{th} place for life expectancy

- At 78.7 years, life expectancy is more than a year less than the average life expectancy of 80.1 years for OECD countries.
- Italy and France spend less than half as much as the U.S. on health care yet they rank 3\textsuperscript{rd} and 6\textsuperscript{th} in life expectancy

Source: Organization for Economic Cooperation and Development, Health at a Glance 2013
Life expectancy vs per-capita healthcare spending.

2013 National Healthcare Quality Report

Quality: Rated as Fair and improving

Access: Rated as Fair and worsening

Disparities: Rated as Poor with no change over time

- Quality improved for most of the National Quality Strategy priorities.
- Few disparities were eliminated most disparities persisted
  - Some disparities grew worse
- More data is needed to understand disparities among smaller groups such as Native Hawaiians, mixed race, and LGBT populations.
Health Care Pre- and Post-ACA

Pre-ACA

• Fee for Service/Volume based care
• Inpatient, hospital based care
• Serious data gaps
• Physician and hospital driven care

Post-ACA

• Value based care and payment reforms
• Population health and outpatient care settings
• Federal incentives for electronic health records
• Non-traditional providers and upstream, prevention interventions
The Triple Aim + Equity = Quadruple Aim

ACCESS

“EQUITY”

QUALITY

COST
Life Expectancy

In California, life expectancy can vary dramatically. White men (76.9 years) live about seven years longer than African American men (70.2 years).

Life Expectancy at Birth

![Life Expectancy Chart]


Figure 1

California Population by Race/Ethnicity

![California Population Chart]

SOURCE: 2010 Census

Figure 3
Examples of Health Disparities

- Latinos and Asians in Medi-Cal are more likely to be overweight.

- Persons that speak English not well or at all are more likely to be diagnosed with heart disease.
Why Health Equity Matters...

• Income is a better predictor of poor health than health coverage

• Nationally and in California, institutional racism in the form of...
  • Housing segregation
  • Employment discrimination
  • Unequal wages and other discriminatory practices

...has created persistent inequalities that lead to poorer health outcomes and limit opportunities for communities of color in our state.
Income and Poverty

**Income**
- Latinos: $45,185
- African Americans: $42,441
- American Indians/Alaskan Native: $41,516
- Whites: $66,638

**Poverty**
- Latinos: 10%
- African Americans: 11%
- American Indians/Alaska Natives: 13%
- Whites: 7%

Source: Landscape of Opportunity: Cultivating Health Equity in California, June 2012
Why Health Equity Matters

• Health care quality and access are suboptimal
• Communities of color are the majority in California
• Health disparities are costly
  • 30% of direct medical costs for communities of color are excess costs due to health inequities
  • The U.S. economy loses an estimated $309 billion per year due to the direct and indirect costs of disparities
• Opportunities: The ACA provides various incentives for health care delivery systems to reduce costs and improve quality
Improving Health Care Quality and Efficiency Under the ACA

• **Prevention:**
  - Free Preventive Care
  - $15 billion Prevention and Public Health Fund
  - Free/low-cost preventive health coverage in Medicaid

• **Quality Care:**
  - Adoption of Electronic Health Records
  - Identifying and Fighting Health Disparities in federally funded programs

• **Others:**
  - Pay for performance proposal to focus on health disparities
  - 1115 Waiver: Whole person care, non-traditional providers, incentives for holistic services
  - All Payer Claims Database
Mental Health Parity & Integration
Mental Health Parity & Integration

- In California over 2 million adults (8%) of the adult population have mental health needs, however the majority reported receiving inadequate treatment or no treatment.

- Over 70% of youth with mental health needs do not have access to services, even if they have health insurance.

- Factors impacting mental health disparities include:
  - Age, gender, educational attainment, insurance status, race and ethnicity, sexual orientation, nativity, disability status and English proficiency.
Mental Health Parity & Integration

- The ACA added mental health and substance use coverage to individual and small group markets and extended parity law so benefits are comparable to coverage for medical and surgical care.

- In 2014, mental health and substance use benefits were added as part of Medi-Cal.

- **Challenge:** Behavioral health care delivery in Medi-Cal is fragmented.
  - Medi-Cal managed care plans responsible for providing care for mild-to-moderate conditions.
  - County mental health plans will continue to provide psychological services for severe mental health issues.
  - Drug and alcohol treatment services divided between Drug Medi-Cal program and fee-for-service Medi-Cal.

Source: “Medi-Cal Managed Care: Raising the Bar for Quality and Outcomes,” by Carolina Coleman & John Connolly, Insure the Uninsured Project, January 2015
Policy Solutions
CPEHN Policy Priorities

• **Expand Access to Health Care**
  • Expand health care for all
  • Maximize enrollment into health coverage programs for communities of color

• **Improve the Quality of Health Care**
  • Ensure delivery system reforms and payment incentive programs reduce health disparities and promote health equity
  • Collect, analyze and report health care quality measures by race, ethnicity, primary language, sexual orientation, gender identity and other factors
  • Ensuring timely access to health care services and translated vital documents for Limited English Proficient consumers
  • Ensure a diverse workforce that reflects communities of color

• **Promote Mental Health Equity**
  • Ensure equitable implementation of the new mental health benefit
  • Integrate behavioral health and primary care to ensure greater access to culturally and linguistically appropriate services

• **Create Healthy and Equitable Communities**
  • Ensure resources to develop transportation and neighborhood planning target historically underserved communities.
  • Create greater opportunities for healthy, fresh, and affordable food
CPEHN Policy Priorities

• **Expanding Access to Care**
  • SB 4 (Lara) Health4All

• **Strengthening Health Care Quality**
  • AB 389 (Chau) Hospital Language Assistance Act
  • SB 137 (Hernandez) Up-to-date Provider Directories
  • SB 388 (Mitchell) Translated Summary of Benefits and Coverage
  • AB 1073 (Ting) Translated Prescription Drug Labels

• **Promoting Healthy Environments**
  • SB 203/AB 1357 (Bloom) Soda Warning Labels/Soda Tax
  • SB 564 (Canella) School Zone Fines for Safe Routes to Schools
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