



# Achieving Racial and Ethnic Equity in U.S. Health Care

## A Scorecard of State Performance

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### INTRODUCTION

Profound racial and ethnic disparities in health and well-being have long been the norm in the United States.

Black and American Indian/Alaska Native (AIAN) people live fewer years, on average, than white people.<sup>1</sup> They are also more likely to die from treatable conditions; more likely to die during or after pregnancy and to suffer serious pregnancy-related complications; and more likely to lose children in infancy.<sup>2</sup> Black and AIAN people are also at higher risk for many chronic health conditions, from diabetes to hypertension.<sup>3</sup> The COVID-19 pandemic has only made things worse, with average life expectancies for Black, Latinx/Hispanic, and, in all likelihood, AIAN people falling more sharply compared to white people.<sup>4</sup>

People's health also varies markedly across and within states, as does access to health services and overall quality of care.<sup>5</sup> Large racial and ethnic health inequities, driven by factors both inside and outside the health care delivery system, are common. In many communities of color, poverty rates are higher than average, residents tend to work in lower-paying industries, and residents are more likely to live in higher-risk environments — all contributors to COVID-19's disproportionate impact.<sup>6</sup>

Issues around cost, affordability, and access to care also contribute to inequities. Black, Latinx/Hispanic, and AIAN populations are less likely to have health insurance, more likely to face cost-related barriers to getting care, and more likely to incur medical debt.<sup>7</sup> It is also less common for individuals from these groups to have a usual source of care or to regularly receive preventive services like vaccinations.<sup>8</sup> In addition, many people of color contend with interpersonal racism and discrimination when dealing with clinicians and more often receive lower-value or suboptimal care.<sup>9</sup>



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Decades of policy choices made by federal, state, and local leaders have led to structural economic suppression, unequal educational access, and residential segregation, all of which have contributed in their own ways to worse health outcomes for many people of color.<sup>10</sup> The failure to ensure all Americans have reliable health coverage has paved the way to inequitable access to health care. Dramatic disparities in the quality of health care, meanwhile, are tolerated. And while the effects of structural racism persist in all states,<sup>11</sup> policy leaders in some states are reluctant to take actions that could mitigate health inequities, like expanding eligibility for Medicaid as provided for under federal law.<sup>12</sup>

The Commonwealth Fund's *State Scorecard on Health System Performance* has long tracked the functioning of each state's health care system, with the goal of motivating actions to improve their residents' health and health care. But assessing how well a state's health system performs on average can mask profound underlying inequities.

In this report, we evaluate health equity across race and ethnicity, both within and between states, to illuminate how state health systems perform for Black, white, Latinx/Hispanic, AIAN, and Asian American, Native Hawaiian, and Pacific Islander (AANHPI) populations. Our hope is that policymakers and health system leaders will use this tool to investigate the impact of past policies on health across racial and ethnic groups, and that they will begin to take steps to ensure an equitable, antiracist health care system for the future.

## How We Measure Performance of States' Health Care Systems for Racial and Ethnic Groups

Our measurement strategy was designed to produce a state health system performance score for each of five racial and ethnic groups in every state where direct comparisons are possible among those groups as well as among groups in other states.

We started by collecting data for 24 indicators of health system performance, stratified by state and by race and ethnicity. Indicators were grouped into three performance domains: 1) health outcomes, 2) health care access, and 3) quality and use of health care services.

**Scoring method.** For each of the 24 indicators, we calculate a standardized z-score for each state/population group with sufficient data. As an example, for adult uninsured rates, we calculate standardized scores using point estimates for 191 pairs of state racial and ethnic groups (51 white, 48 Latinx/Hispanic, 39 Black, 37 AANHPI, 16 AIAN) with sufficient data.

Within each performance domain, we combined indicator values to create a summary score. We then combined the domain summary scores to create a composite state health system performance score for each racial and ethnic group within a state — Black (non-Latinx/Hispanic), white (non-Latinx/Hispanic), AIAN (non-Latinx/Hispanic), AANHPI (non-Latinx/Hispanic), and Latinx/Hispanic (any race). The ability to generate these scores is dependent on having a sufficient population sample size for analysis.

Based on the overall composite scores, each racial/ethnic group within each state received a percentile score providing both national and state-level context on the performance of a state health system for that population. The percentile scoring, from 1 (worst) to 100 (best), reflects the observed distribution of health system performance for all groups measured in this report and enables comparisons within and across states. For example, a state health system score of 50 for Latinx individuals in California indicates that the health system is performing better for those residents than Latinx/Hispanic people in Florida, who have a score of 38, but worse than white residents in California, who have a score of 89. It is important to note that because scores are set relative to one another rather than to a predefined benchmark, there is still room for improvement in health system performance at or near the 100th percentile.

**Use of racial/ethnic data categories.** The five racial and ethnic data categories we include in this report often group together populations with different experiences, cultures, immigration barriers, and other socioeconomic factors. This includes a wide range of culturally distinct Latinx/Hispanic communities and Asian American communities. Such groupings are imperfect, as they mask significant and important differences. For example, past research has shown variability in health insurance coverage rates among Asian American subpopulations and between Asian Americans and Native Hawaiians or Pacific Islanders.<sup>13</sup>

Use of these categories is necessary to obtain sufficient sample sizes for analysis. But states and localities should interpret the findings within the context of their own communities, using them as a starting point to help guide more targeted research and policy solutions.

Refer to the [appendix](#) for complete study methods, list of indicators, and health system performance scores for each state's and racial and ethnic populations.

## FINDINGS

### Racial and ethnic inequities are pervasive across all state health systems.

Both across states and within states, health care system performance varies widely by race and ethnicity, as shown in Exhibit 1. Mirroring the nation as a whole, substantial health and health care disparities exist between white and Black, Latinx/Hispanic, and AIAN communities in nearly all states.

Even in states that achieve high performance overall, racial and ethnic disparities can be dramatic. For example, Minnesota, which ranked third in the Commonwealth Fund's most recent *State Scorecard on Health System Performance*, has some of the largest disparities between white and Black, Latinx/Hispanic, AANHPI, and AIAN communities.<sup>14</sup> Some states, like Mississippi, demonstrate relatively poor performance for all groups.

In the small number of U.S. states where AIAN communities represent a sizeable portion of the nonwhite population — such as South Dakota and Alaska — wide performance gaps are also apparent. While the health system in many states tends to perform better for AANHPI populations, performance is lower in New York and Texas, home to two of the country's largest AANHPI populations.

The overall health system score for each group within a state represents the aggregate performance across three dimensions: Health Outcomes, Health Care Access, and Quality and Use of Health Care Services. Below we describe findings for each of these domains.

### Health Outcomes

Health outcomes, as measured primarily by mortality rates and the prevalence of health-related problems, differ significantly by race and ethnicity. In most states, Black and AIAN populations tend to fare worse than white, Latinx/Hispanic, and AANHPI populations. While enduring lower life expectancies for Black and AIAN individuals in the U.S. can be attributed in large part to generations of structural racism, oppression, and other factors beyond health care delivery, the health care system nevertheless has a crucial and often unfulfilled role in mitigating disparities.<sup>15</sup>

Online viewers can use the interactive exhibits to see which states perform best and worst and to focus on specific racial and ethnic groups. State and group-specific profiles are available for download.



We can get a glimpse of the care delivery system's role in these unequal outcomes by looking at the frequency of deaths before age 75 from preventable and treatable conditions — a measure known as mortality amenable to health care that is highly correlated with life expectancy.<sup>16</sup> In nearly every state, Black people are more likely than white people to die early from preventable causes (Exhibit 2). Latinx/Hispanic individuals, however, generally have lower preventable mortality rates, despite their comparatively poor access to health care. These lower rates could be related to immigration factors, to a younger average age, or to lower rates of risky health behaviors like smoking.<sup>17</sup> Still, recent research shows increasing mortality and prevalence of chronic conditions for Latinx/Hispanic populations.<sup>18</sup> There are also differences in outcomes between different Latinx communities.<sup>19</sup>

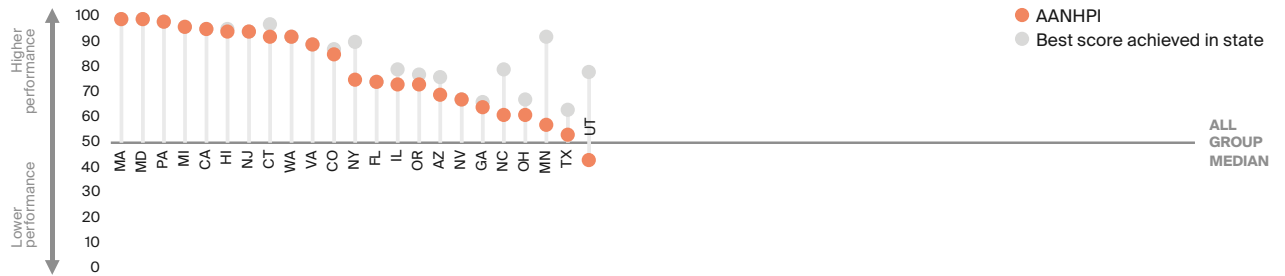
We also see distinct regional patterns. For example, preventable mortality rates are higher for both Black and white residents of many southeastern states compared to other parts of the country, while rates among AIAN people tend to be higher in the upper Midwest and northern Plains states. Among Latinx/Hispanic people, premature mortality rates are higher — and align more closely with rates among white people — in several southwestern and mountain states, including Arizona, Colorado, New Mexico, Oklahoma, Texas, and Wyoming.

Diabetes is an example of a disease that can often be effectively managed — for example, with consistent blood glucose monitoring and proven medications — but is nonetheless associated with profound racial and ethnic disparities in outcomes. Black and AIAN individuals are much more likely to die from diabetes-related complications (Exhibit 3) than people of other races and ethnicities. Health systems striving for equity should bolster disease management resources among these communities to achieve better outcomes.

### Exhibit 1. Profound racial and ethnic inequities in health and health care exist across and within states.

Health system performance scores, by state and race/ethnicity

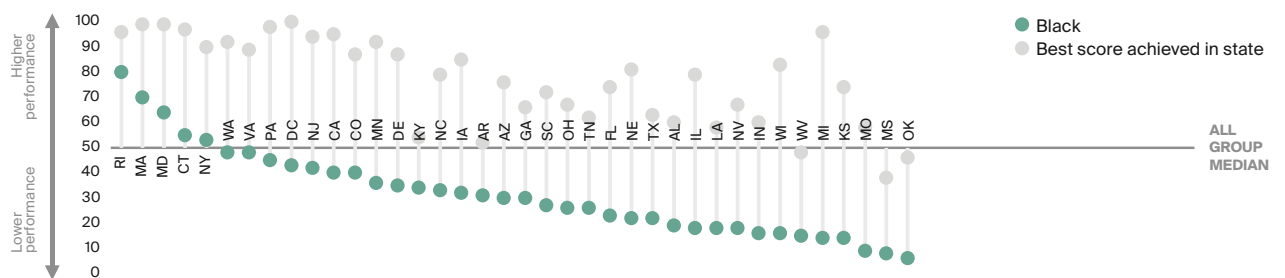
**Asian  
American,  
Native  
Hawaiian,  
and Pacific  
Islander**



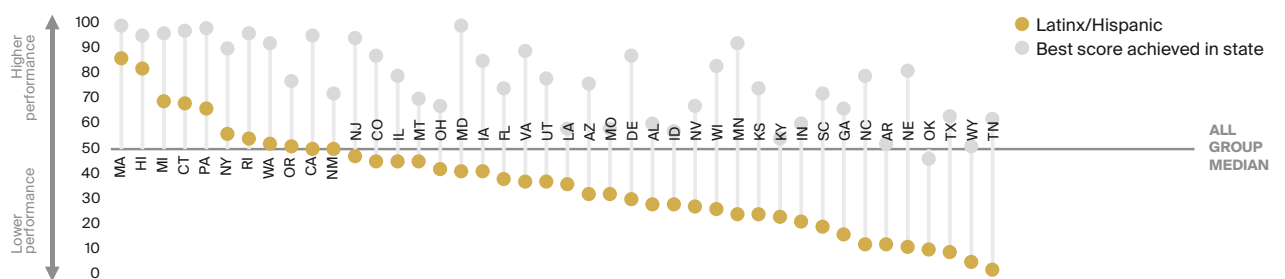
**American  
Indian/  
Alaska  
Native**



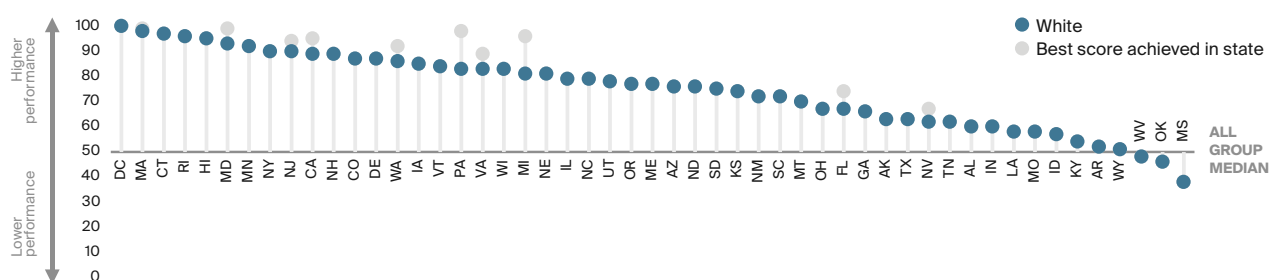
**Black**



**Latinx/  
Hispanic**



**White**

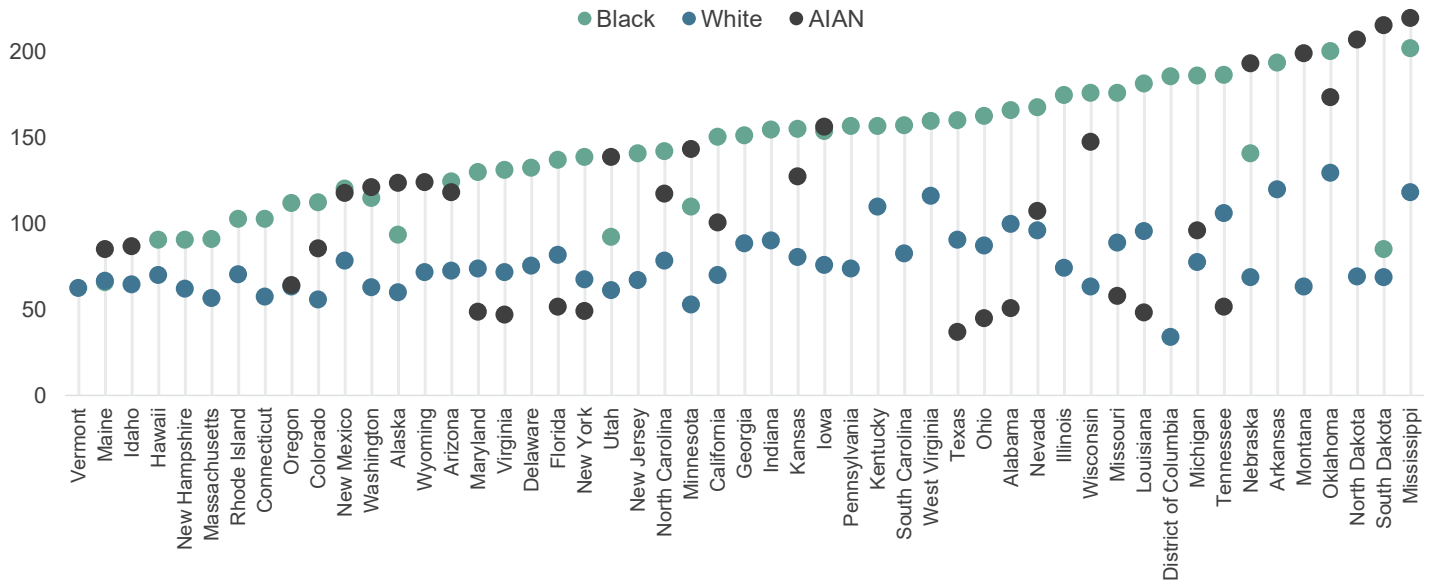


Notes: Scores are based on the percentile distribution of each group's final composite z-score across all indicators/dimensions; rank-ordered for each individual group. Grey dots represent the highest score achieved in each state by any of the five groups (if no grey dot is visible, the highlighted group has the top score). The 50th percentile represents the median health performance score among all the groups measured. Summary performance scores not available for all racial and ethnic groups in all states; states without group-specific scores not shown. AANHPI = Asian American, Native Hawaiian, and Pacific Islander; AIAN = American Indian/Alaska Native.

Data: Commonwealth Fund 2021 Health System Performance Scores.

**Exhibit 2. In most states where data are available, Black people and AIAN people are more likely than white people to die early in life from conditions that are treatable with timely access to high-quality health care.**

Mortality amenable to health care, deaths per 100,000 population, by state and race/ethnicity



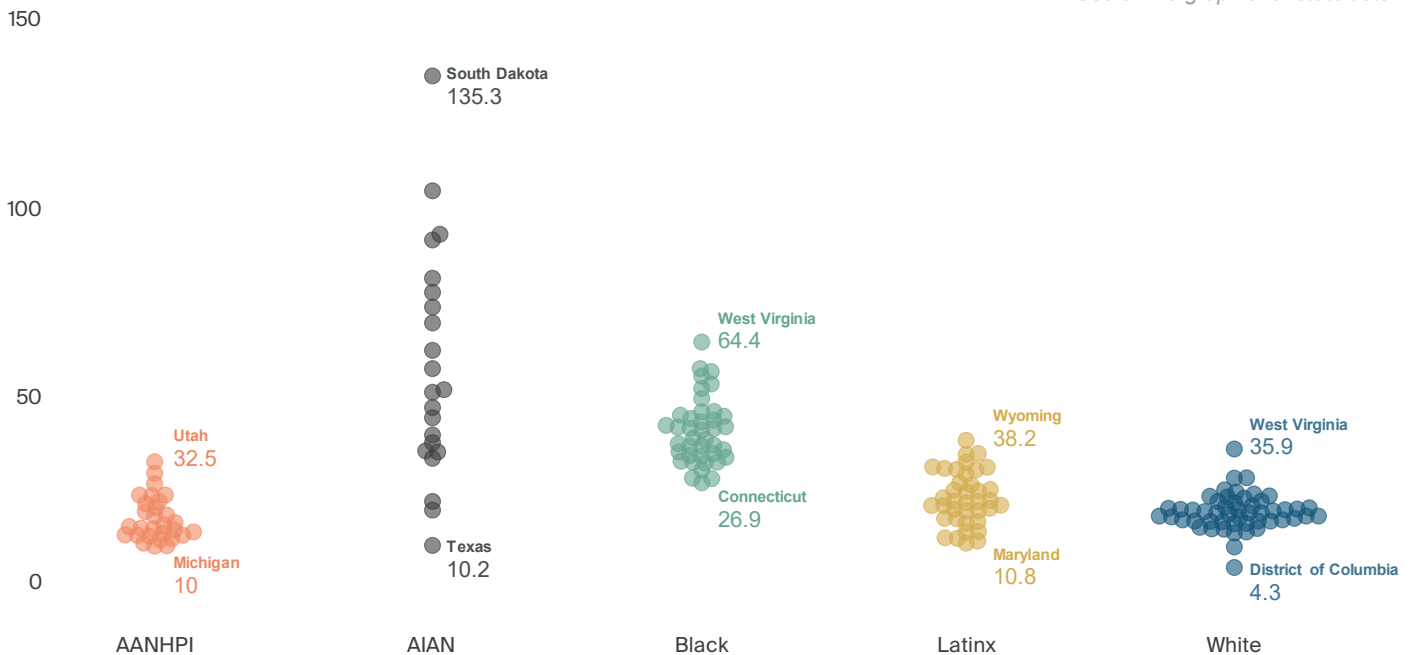
Notes: States arranged in rank order based on highest rate in each state. Missing dots for a particular group indicate that there are insufficient data for that state. Data for AANHPI and Latinx/Hispanic populations available in online exhibit and state profile documents. AIAN = American Indian/Alaska Native.

Data: CDC, 2018 and 2019 National Vital Statistics System (NVSS), All-County Micro Data, Restricted Use Files.

**Exhibit 3. In nearly all the states where data are available, Black people and AIAN people are more likely than AANHPI, Latinx/Hispanic, and white people to die from complications of diabetes.**

Diabetes-related age-adjusted deaths per 100,000 population, by state and race/ethnicity

Dots represent states  
See online graphic for state detail



Note: Dots represent states. Missing dots for a particular group indicate that there are insufficient data for that state. AANHPI = Asian American, Native Hawaiian, and Pacific Islander; AIAN = American Indian/Alaska Native.

Data: CDC, 2018 and 2019 National Vital Statistics System (NVSS).

We also see sizeable disparities when looking at mortality rates for other treatable conditions. Breast cancer, for example, is often considered treatable when detected early but is more likely to be diagnosed at later stages in Black women, who have much higher age-adjusted death rates for the disease across most states compared to other women (Exhibit 4).<sup>20</sup> Across all education levels, infant and maternal mortality rates are higher for Black and AIAN residents than for others.<sup>21</sup>

States can perpetuate disparities by not removing barriers to people receiving preventive services, getting effective treatment for chronic conditions like diabetes and high blood pressure, and receiving coordinated care. These barriers range from poor insurance coverage, lack of a usual source of care, and unaffordable medications, to clinicians who prescribe less-effective services or fail to provide timely care for a chronic disease.<sup>22</sup> Sometimes differential outcomes also can reflect unequal access to higher-performing providers, but disparities in care occur even within the same provider facilities.<sup>23</sup>

## Health Care Access

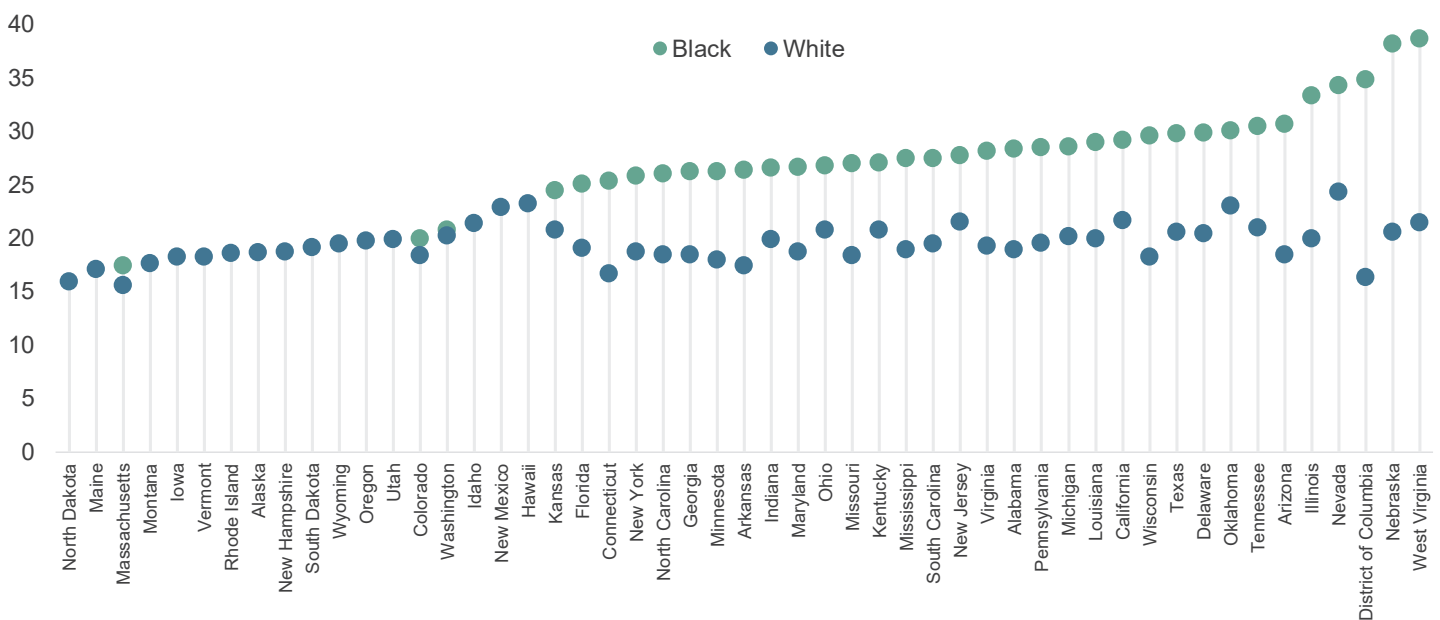
Large disparities in access to care between white and most nonwhite populations are apparent across states. Latinx/Hispanic people typically face the highest barriers to care, although, as noted above, they also tend to have better health outcomes than many other groups (despite variations by geographic region).

A key contributor to these access inequities is lack of comprehensive insurance coverage, or any coverage at all. Insurance alone cannot guarantee access, but it is necessary for getting needed health care without incurring substantial or even catastrophic financial risk.

Americans get their health coverage either from commercial insurance plans offered by employers or sold in the individual market, or from public insurance programs like Medicaid, Medicare, and the Children’s Health Insurance Program. Prior to the Affordable Care Act (ACA)’s major coverage expansions in 2014, limited access to employer health benefits, more restricted eligibility for Medicaid, and often unaffordable individual market plans created significant inequities in coverage among adults.

### Exhibit 4. Black women are more likely than white women to be diagnosed with breast cancer at later stages and to die, even though the disease is often considered treatable when detected early.

Breast cancer age-adjusted deaths per 100,000 female population, by state and race/ethnicity



Notes: States arranged in rank order based on highest rate in each state. Missing dots for a particular group indicates that there are insufficient data for that state. Data for AIAN, AANHPI and Latinx/Hispanic populations available in online exhibit and state profile documents.

Data: CDC, 2018 and 2019 National Vital Statistics System (NVSS).

After the health law’s coverage expansions, adult uninsured rates fell across all racial and ethnic groups. Still, in nearly all states, uninsured rates continue to be higher for Black, Latinx/Hispanic, and AIAN people than they are for whites (Exhibit 5).

Some Latinx/Hispanic and AANHPI populations continue to face immigration-related barriers to getting enrolled in coverage through Medicaid or the ACA marketplaces. While American Indians and Alaska Natives can obtain certain health care services through the Indian Health Service (IHS), lack of insurance coverage can hinder access to needed care outside of persistently underfunded IHS facilities.<sup>24</sup>

The ACA created a federal standard for comprehensive insurance and provides for subsidized coverage through marketplace plans and Medicaid. But 12 states have yet to take advantage of the law’s expansion of Medicaid eligibility,

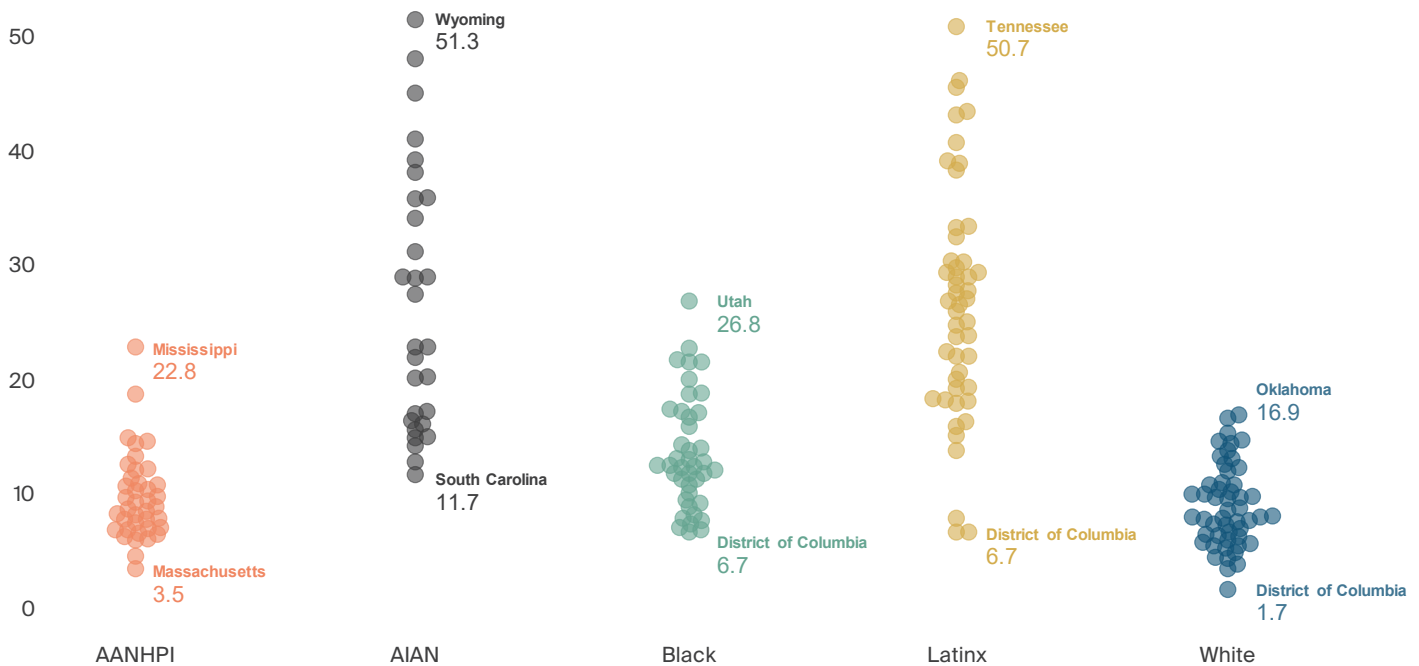
which has significantly improved equity in coverage and access and has helped health care facilities in underserved communities (including IHS providers) become more financially stable.<sup>25</sup> Further, Black and Latinx/Hispanic communities are disproportionately represented in states that have not expanded Medicaid: 43 percent of Black and 36 percent of Latinx people live in the 12 nonexpansion states.

When people are uninsured, experience gaps in coverage, or are in private plans that do not provide comprehensive coverage, they often avoid getting care when they need it or pay high out-of-pocket costs when they do seek care.<sup>26</sup> This is particularly burdensome for individuals with lower income and little wealth — disproportionately people of color.<sup>27</sup> Because of these costs, Black, Latinx/Hispanic, and AIAN people are more likely to avoid getting care when they need it, more often have higher out-of-pocket costs, and are more prone to incur medical debt at all income levels.<sup>28</sup>

**Exhibit 5. Although the ACA’s coverage expansion improved inequities, state uninsured rates are generally higher and more variable for Black, Latinx/Hispanic, and AIAN adults compared to AANHPI and white adults.**

Percent of adults ages 19–64 who are uninsured, by state and race/ethnicity

Dots represent states  
See online graphic for state detail



Note: Dots represent states. Missing dots for a particular group indicate there are insufficient data for that state. AANHPI = Asian American, Native Hawaiian, and Pacific Islander; AIAN = American Indian/Alaska Native. ACA = Affordable Care Act.

Data: American Community Survey Public Use Micro Sample (ACS-PUMS) 2019 1-year file.



The proportion of white people reporting cost as a barrier to receiving needed care ranges from 6 percent in the District of Columbia and Hawaii to 14 percent in Georgia, Oklahoma, Alabama, and Mississippi. But among Latinx/Hispanic people, state rates vary between 10 percent in Hawaii to a high of 30 percent in Tennessee (Exhibit 6).

Many people of color in the U.S. are also less likely to have a usual source of care, an important point of contact with the health system that can help people get treatment when they need it. Lack of a regular care provider often goes hand in hand with high uninsured rates and high patient cost sharing. But it also reflects low Medicaid payment rates that limit the network of participating providers and hospitals, a lower concentration of providers and health facilities in neighborhoods where people of color reside, and

language and cultural communication barriers.<sup>29</sup> For AIAN communities in rural areas, who are among the least likely to have a usual source care, geographic barriers can also be a key factor.<sup>30</sup>

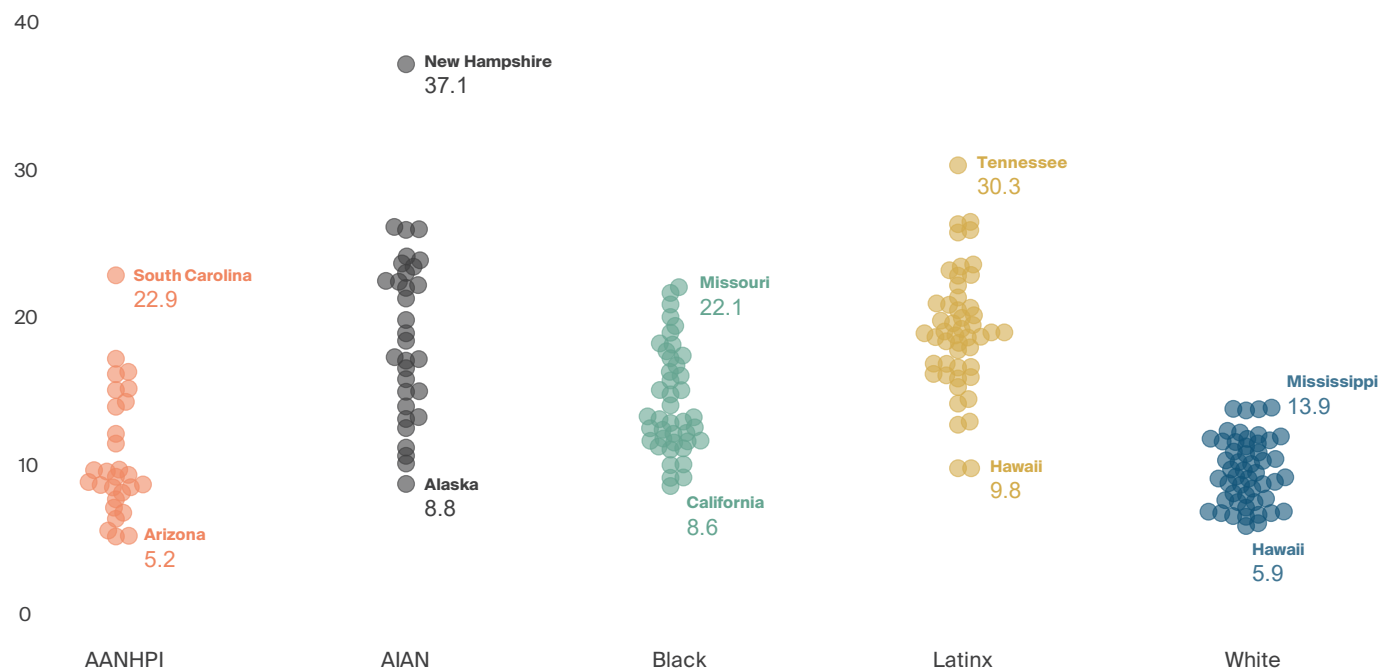
## Quality and Use of Health Care Services

Racial and ethnic disparities in the quality of care and the use of services have also been extensively documented. Across and within most states, white populations overall receive better care than Black, Latinx/Hispanic, American Indian/Alaska Native (AIAN), and, often, Asian American, Pacific Islander, and Native Hawaiian (AANHPI) individuals.

### Exhibit 6. White people are less likely than other population groups to face cost-related barriers in most states.

Percent of adults age 18 and older who went without care because of cost in the past year, by state and race/ethnicity

Dots represent states  
See online graphic for state detail



Note: Dots represent states. Missing dots for a particular group indicate there are insufficient data for that state. AANHPI = Asian American, Native Hawaiian, and Pacific Islander; AIAN = American Indian/Alaska Native.

Data: Behavioral Risk Factor Surveillance System (BRFSS), 2019–20.

Primary care clinicians play an especially critical role in providing people with high-value services, including preventive care like cancer screenings and vaccines, as well as chronic disease management. When there are barriers to obtaining primary care, people are more likely to get care in more intense and costly care settings, particularly an emergency department (ED).

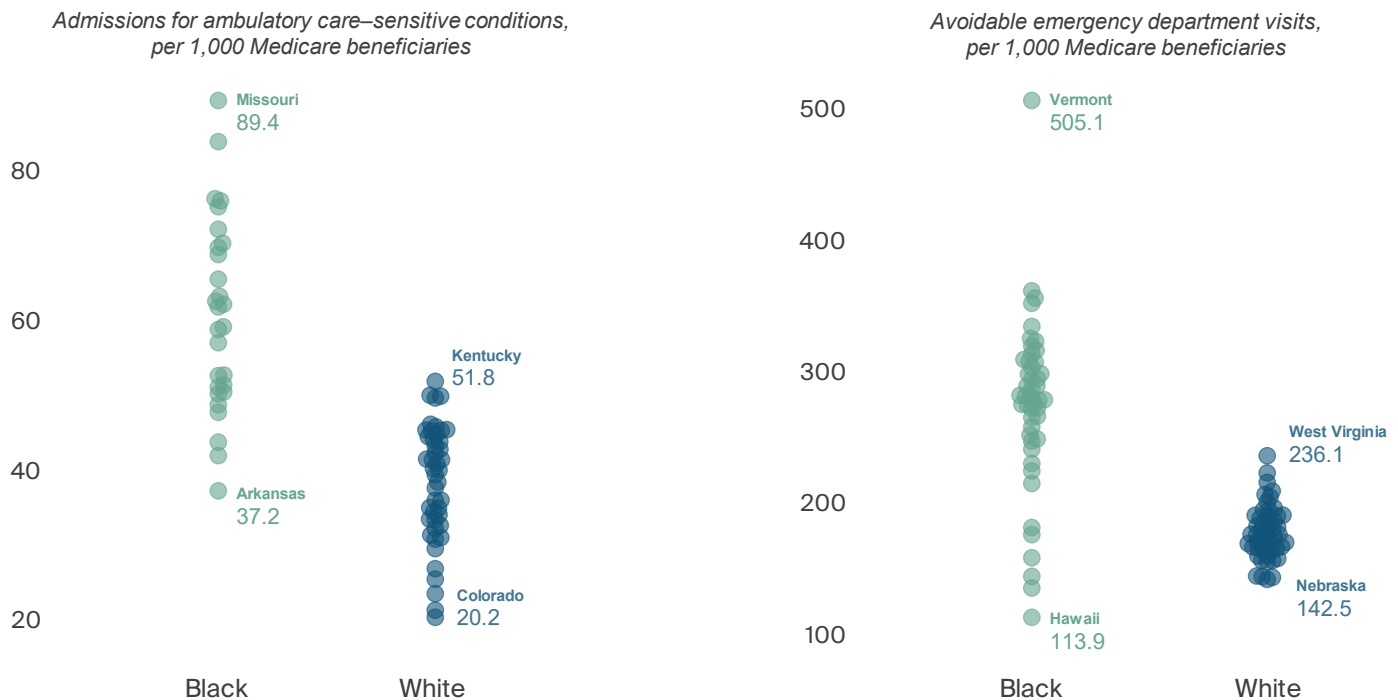
On two measures of primary care effectiveness, Black Medicare beneficiaries are more likely than white beneficiaries to be hospitalized for acute exacerbations of treatable and manageable chronic illnesses and to seek and receive care in an ED for conditions that are nonurgent or treatable by a primary care provider (Exhibit 7). For both Black and white Medicare beneficiaries, more primary care spending is associated with less use of the ED for treatable conditions and fewer hospital admissions.<sup>31</sup>

Primary care settings are also where the majority of vaccinations in the U.S. have taken place, and they play an important role in COVID-19 vaccination efforts. On average,

Black and Latinx people are less likely than white people to have received recommended vaccines. In 2019, Black and Latinx children were less likely than white children to have received all of seven key vaccines by age 35 months, but differences were relatively small. Conversely, less than half of all adults received an annual flu shot in 2019–20, and racial/ethnic inequities are apparent (Exhibit 8). Strong federal policy can help close these gaps. For example, the Vaccines for Children program run by the Centers for Disease Control and Prevention (CDC) promotes early childhood vaccination and makes vaccines available at no cost to a partner network of state and local health departments. This, along with state policies regulating vaccination, have proven successful for raising vaccination levels for all children.<sup>32</sup>

Expanded access to primary care improves health outcomes. And given the relatively lower use of primary care by Black, Latinx/Hispanic, and AIAN people, these groups in particular are likely to see a greater health impact from improved access and quality.

**Exhibit 7. Black Medicare beneficiaries are more likely than white beneficiaries to be admitted to a hospital or to seek care in an emergency department for conditions typically manageable through good primary care.**



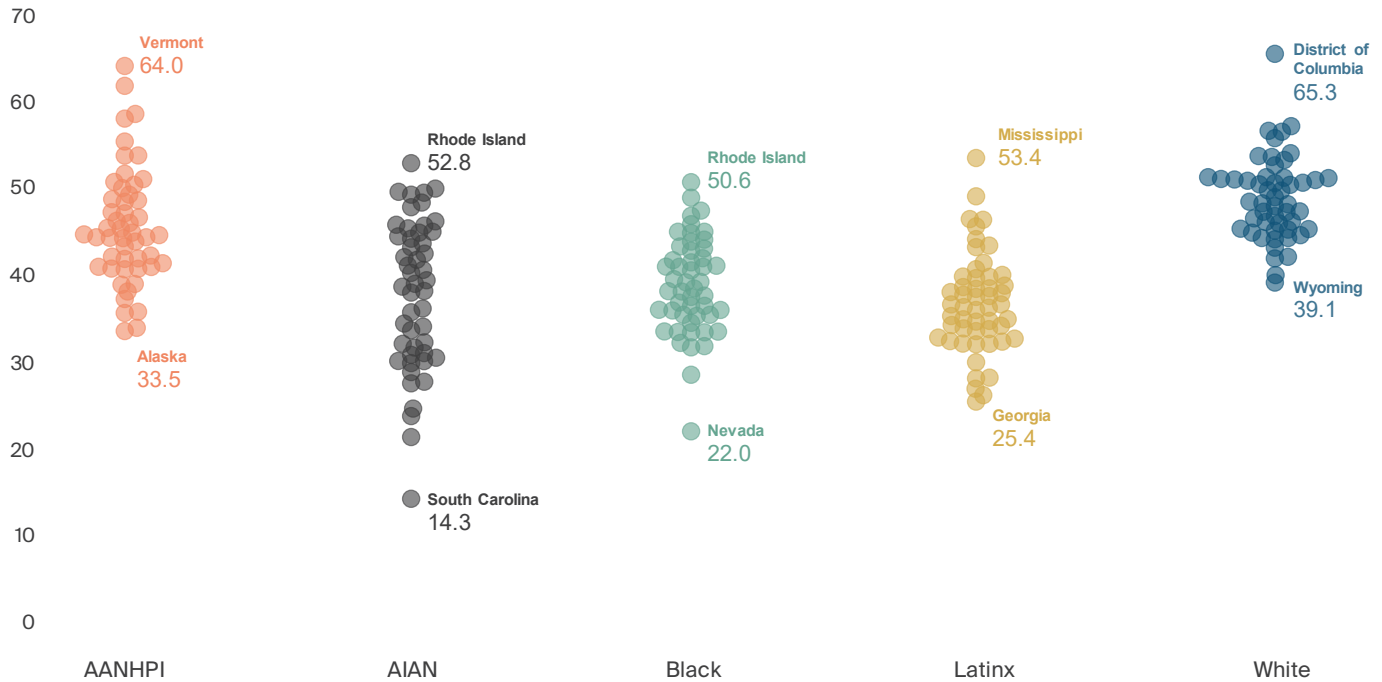
Notes: Dots represent states. Missing dots for a particular group indicates that there are insufficient data for that state. Race data only available for Black and white populations—ethnicity is unknown.

Data: Centers for Medicare and Medicaid Services, 2019 Limited Data Set (LDS) 5% sample. Analysis by Westat.

### Exhibit 8. Black, AIAN, and Latinx/Hispanic adults are less likely than AANHPI and white adults to receive an annual flu shot.

Percent of adults age 18 and older with a seasonal flu shot in the past year

Dots represent states  
See online graphic for state detail



Notes: Dots represent states. Missing dots for a particular group indicate that there are insufficient data for that state. AANHPI = Asian American, Native Hawaiian, and Pacific Islander; AIAN = American Indian/Alaska Native.

Data: Behavioral Risk Factor Surveillance System (BRFSS), 2019–20.

## DISCUSSION

Racial and ethnic disparities in health outcomes and health care are pervasive both across and within states. Transformative change will depend on policy and practice changes to make access to care more equitable and to ensure equal treatment in the delivery of care.

### What Policy Changes Are Needed to Bridge the Gap?

While health systems alone cannot address all the structural inequities that contribute to differential health outcomes, there are a number of policy options for addressing unequal access to care and unequal treatment within health care facilities.

We group these federal and state policy priorities into four areas:

#### **Ensuring universal, affordable, and equitable health coverage.**

Nearly 30 million people in the United States are still uninsured, and they are disproportionately people of color. Even those who have some coverage face rising levels of financial risk. Policy options include:

- *Make the marketplace premium subsidies provided by the American Rescue Plan Act (ARPA) permanent and close the Medicaid coverage gap in the 12 states that have not expanded eligibility for the program.* These two reforms, which are included in the Build Back Better bill currently before Congress, are estimated to reduce the number of uninsured people overall by 7 million,<sup>33</sup> the number of uninsured Black Americans under age 65 by 1.2 million, and the number of uninsured Latinx/Hispanic people under age 65 by 1.7 million.
- *Reduce deductibles and out-of-pocket costs for marketplace insurance plans.* The pending legislation would reduce cost-sharing to almost zero for people with incomes under 138 percent of poverty in the marketplaces, lowering household spending on health care and improving access to needed care. Another bill, currently in the Senate, would increase eligibility for marketplace subsidies and eliminate or reduce deductibles for some marketplace plan enrollees by as much as \$1,650.<sup>34</sup>
- *Allow more workers in expensive employer health plans to become eligible for subsidized marketplace plans.* Under current law, enrollees in employer coverage whose premiums exceed 9.8 percent of income are eligible for subsidized marketplace plans. The Build Back Better bill lowers that threshold to 8.5 percent of income.
- *Mount aggressive, targeted outreach and enrollment efforts to reach the remaining uninsured, most of whom are eligible for Medicaid or subsidized private insurance.*<sup>35</sup> Tracking low enrollment by demographic group, like California does, could help in targeting outreach efforts more effectively.
- *Lower immigration-related barriers to coverage.* An estimated 3 million uninsured cannot enroll in Medicaid or subsidized marketplace plans because of their immigration status.<sup>36</sup> The federal government could allow certain groups of undocumented, low-income immigrant adults and children to enroll in Medicaid or other affordable coverage, as several states already have done.<sup>37</sup>
- *Promote more equitable treatment of enrollees in commercial insurance plans.* Policymakers could require commercial insurers to: collect and report information on race and ethnicity during enrollment and make it linkable to claims data;<sup>38</sup> meet ACA requirements for including essential community providers in their networks;<sup>39</sup> and obtain health equity accreditation.

#### **Strengthening primary care and improving the delivery of services.**

Communities that are predominantly Black and Latinx/Hispanic tend to have fewer primary care providers and lower-quality health care facilities than communities that are mostly white.<sup>40</sup> Federal and state policymakers could start to reverse these inequities by raising payment for primary care providers and transitioning primary care reimbursement to value-based payment that enables investment in health promotion, disease prevention, and chronic disease management.<sup>41</sup> For example, North Carolina now has a prospective Medicaid payment model that emphasizes primary care-based population health management, while Oregon and Washington are linking Medicaid payments to performance on equity measures.<sup>42</sup>

There are also opportunities to change how care is delivered and who delivers it:

- *Ensure that telemedicine remains an option.* The pandemic has already shown that telemedicine is an effective strategy for providing patients with convenient access to care.<sup>43</sup>
- *Modernize medical licensing.* Allow health care professionals to more easily practice across state lines.<sup>44</sup>
- *Develop community-based health care workforces focused on team care.* Offer financial assistance, such as loan repayment, to providers who serve in medically underserved communities. Expand community health worker programs to train individuals to provide basic health-related services and support within their communities.

**Reducing inequitable administrative burdens affecting patients and providers.** Americans seeking health care face far higher administrative hurdles than residents of other high-income nations.<sup>45</sup> Recent research points to the negative impact these barriers have on access to care for lower-income individuals, including many people of color.<sup>46</sup> Autoenrollment is one reform that could reduce the application burden associated with state Medicaid programs; it could help people get, and stay enrolled in, public coverage.<sup>47</sup> If poorly designed, the quality reporting, care management, utilization review, and prior authorization programs instituted by public and private insurers can create unnecessary red tape and even financial penalties for underresourced providers. Administrators could audit oversight and accountability programs for their disproportionate impact on providers serving communities of color.

**Investing in social services.** The U.S. spends less on economic and social supports for children and working-age adults than most other high-income countries, and the lack of adequate investment in this area likely contributes significantly to racial and ethnic inequities in health outcomes.<sup>48</sup> Federal and state policymakers could expand economic support for lower-income families by implementing unemployment compensation and Earned Income Tax Credit and child tax credit programs, as well as childcare, food security, and targeted wealth-building

programs.<sup>49</sup> Additional investments in affordable housing, public transportation, early childhood development, and affordable higher education also could help reduce racial and ethnic health inequities.<sup>50</sup>

## CONCLUSION

Racial and ethnic equity in health care should be a top priority of federal and state policymakers. A good start would be to identify policies and proposed legislation that impede progress toward health equity.

Given that structural racism has played a significant role in shaping those policies that have spawned widespread health inequities, leaders at the federal, state, and local levels should reexamine existing laws and regulations for their impact on people of color's access to quality care. And new reforms to ensure good insurance coverage and timely access to primary and specialty care need to target communities across the United States that have long been ignored.

Equally important is the development and use of equity-focused measures to monitor the progress of efforts intended to advance health equity and to engender accountability for achieving desired outcomes. And systems are needed to track whether states, health systems, and health plans are reducing racial disparities in clinical outcomes, coverage, access to clinicians, and a host of other health-related gaps.

Too often in the U.S., race and ethnicity are correlated with access to health care, quality of care, health outcomes, and overall well-being. This is a legacy of structural, institutional, and individual racism that predated the country's founding and that has persisted to the present day, in large part through federal and state policy. By pursuing new policies that center racial and ethnic equity, expand access to high-quality, affordable care, and bolster the primary care workforce, we as a nation can ensure that the health care system fulfills its mission to serve all Americans.

## NOTES

- Elizabeth Arias et al., *Provisional Life Expectancy Estimates for 2020* (NCHS Vital Statistics Rapid Release, July 2021); and Elizabeth Arias et al., “Mortality Profile of the Non-Hispanic American Indian or Alaska Native Population, 2019,” *National Vital Statistics Reports* 70, no. 12 (Nov. 2021).
- “Mortality amenable to health care,” Commonwealth Fund Health Systems Data Center and calculations from 2018–19 CDC National Vital Statistics System (NVSS); Eugene Declercq and Laurie Zephyrin, *Maternal Mortality in the United States: A Primer* (Commonwealth Fund, Dec. 2020); “Infant Mortality,” Commonwealth Fund Health Systems Data Center, n.d.; and “Infant Mortality,” CDC, 2021.
- Jesse C. Baumgartner et al., *Inequities in Health and Health Care in Black and Latinx/Hispanic Communities: 23 Charts* (Commonwealth Fund, June 2021); and “Disparities Fact Sheet,” Indian Health Service, Oct. 2019.
- Arias et al., *Provisional Life Expectancy*, 2021; Jessica Arrazola et al., “COVID-19 Mortality Among American Indian and Alaska Native Persons — 14 States, January–June 2020,” *Morbidity and Mortality Weekly Report (MMWR)* 69, no. 49 (Dec. 2020): 1853–56.
- David C. Radley, Sara R. Collins and Jesse C. Baumgartner, *2020 Scorecard on State Health System Performance* (Commonwealth Fund, Sept. 2020).
- Gina Kolata, “Social Inequities Explain Racial Gaps in Pandemic, Studies Find,” *New York Times*, Dec. 9, 2020; Samrachana Adhikari et al., “Assessment of Community-Level Disparities in Coronavirus Disease 2019 (COVID-19) Infections and Deaths in Large U.S. Metropolitan Areas,” *JAMA Network Open* 3, no. 7 (July 2020): e2016938; and Nancy Krieger, Pamela D. Waterman, and Jarvis T. Chen, “COVID-19 and Overall Mortality Inequities in the Surge in Death Rates by Zip Code Characteristics: Massachusetts, January 1 to May 19, 2020,” *American Journal of Public Health* 110, no. 12 (Dec. 2020): 1850–52.
- Shiwani Mahajan et al., “Trends in Differences in Health Status and Health Care Access and Affordability by Race and Ethnicity in the United States, 1999–2018,” *JAMA* 326, no. 7 (Aug. 17, 2021): 637–48; *Health Insurance Coverage and Access to Care for American Indians and Alaska Natives: Current Trends and Key Challenges* (ASPE, July 2021); and Sara R. Collins, Gabriella N. Aboulafia, and Munira Z. Gunja, *As the Pandemic Eases, What Is the State of Health Care Coverage and Affordability in the U.S.? Findings from the Commonwealth Fund Health Care Coverage and COVID-19 Survey, March–June 2021* (Commonwealth Fund, July 2021).
- Mahajan et al., “Trends in Differences,” 2021; Jesse C. Baumgartner, Sara R. Collins, and David C. Radley, *Racial and Ethnic Inequities in Health Care Coverage and Access, 2013–2019* (Commonwealth Fund, June 2021). See Appendix A2.
- Brian D. Smedley, Adrienne Y. Stith, and Alan R. Nelson, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Institute of Medicine, 2003); Kiran Clair et al., “Disparities by Race, Socioeconomic Status, and Insurance Type in the Receipt of NCCN Guideline-Concordant Care for Select Cancer Types in California,” *Journal of Clinical Oncology* 38, no. 15 suppl. (May 20, 2020): 7031; and William L. Schpero et al., “For Selected Services, Blacks and Hispanics More Likely to Receive Low-Value Care Than Whites,” *Health Affairs* 36, no. 6 (June 2017): 1065–69.
- Zinzi D. Bailey, Justin M. Feldman, and Mary T. Bassett, “How Structural Racism Works — Racist Policies as a Root Cause of U.S. Racial Health Inequities,” *New England Journal of Medicine* 384, no. 8 (Feb. 25, 2021): 768–73; and Jamila Taylor, *Racism, Inequality, and Health Care for African Americans* (Century Foundation, Dec. 2019).
- Bailey, Feldman, and Bassett, “How Structural Racism Works,” 2021.
- Jennifer Karas Montez et al., “U.S. State Policies, Politics, and Life Expectancy,” *Milbank Quarterly* 98, no. 3 (Sept. 2020): 668–99; and Jamila Michener, “Race, Politics, and the Affordable Care Act,” *Journal of Health Politics, Policy and Law* 45, no. 4 (Aug. 2020): 547–66.
- Munira Z. Gunja et al., *Gap Closed: The Affordable Care Act’s Impact on Asian Americans’ Health Coverage* (Commonwealth Fund, July 2020).
- Radley, Collins and Baumgartner, *2020 Scorecard*, 2020.

15. Elizabeth Arias and Jiaquan Xu, *United States Life Tables, 2018* (National Vital Statistics Reports, Nov. 2020); and “Disparities Fact Sheet,” 2019.
16. The state-level correlation between mortality amenable to health care and life expectancy holds for all racial and ethnic groups analyzed in this report. Commonwealth Fund analysis using 2018 and 2019 data from the CDC’s National Vital Statistics System (NVSS); and *2021 County Health Rankings: Data and Documentation* (University of Wisconsin Population Health Institute, n.d.). See also: Stephen C. Schoenbaum et al., “Mortality Amenable to Health Care in the United States: The Roles of Demographics and Health Systems Performance,” *Journal of Public Health Policy* 32, no. 4 (Nov. 2011): 407–29; and Margaret E. Kruk et al., “Mortality Due to Low-Quality Health Systems in the Universal Health Coverage Era: A Systematic Analysis of Amenable Deaths in 137 Countries,” *The Lancet* 392, no. 10160 (Nov. 17, 2018): 2203–12.
17. For discussion, see Eduardo Velasco-Mondragon et al., “Hispanic Health in the USA: A Scoping Review of the Literature,” *Public Health Reviews* 37 (Dec. 2016): 31.
18. Steven H. Woolf et al., “Changes in Midlife Death Rates Across Racial and Ethnic Groups in the United States: Systematic Analysis of Vital Statistics,” *BMJ* 362 (Aug. 2018): k3096.
19. Kimberly D. Miller et al., “Cancer Statistics for Hispanics/Latinos, 2018,” *CA: A Cancer Journal for Clinicians* 68, no. 6 (Nov./Dec. 2018): 425–45; and Velasco-Mondragon et al., “Hispanic Health,” 2016.
20. Carol E. DeSantis et al., “Cancer Statistics for African Americans, 2019,” *CA: A Cancer Journal for Clinicians* 69, no. 3 (May/June 2019): 211–33.
21. Declercq and Zephyrin, *Maternal Mortality Primer*, 2020; “Infant Mortality,” Commonwealth Fund Health Systems Data Center, n.d.; Danielle M. Ely and Anne K. Driscoll, “Infant Mortality in the United States, 2018: Data From the Period Linked Birth/Infant Death File,” *National Vital Statistics Reports*, 69, no. 7 (NVSS, July 2020); and Gopal K. Singh and Stella M. Yu, “Infant Mortality in the United States, 1915–2017: Large Social Inequalities Have Persisted for Over a Century,” *International Journal of Maternal and Child Health and AIDS* 8, no. 1 (2019): 19–31.
22. Sherry A. Glied and Benjamin Zhu, *Not So Sweet: Insulin Affordability over Time* (Commonwealth Fund, Sept. 2020); Clair et al., “Disparities by Race,” 2020; Schpero et al., “For Selected Services,” 2017; and Ziad Obermeyer et al., “Dissecting Racial Bias in an Algorithm Used to Manage the Health of Populations,” *Science* 366, no. 6464 (Oct. 25, 2019): 447–53.
23. Elizabeth A. Howell et al., “Black–White Differences in Severe Maternal Morbidity and Site of Care,” *American Journal of Obstetrics and Gynecology* 214, no. 1 (Aug. 2015): 122. e1–122.e7; and Elizabeth A. Howell et al., “Race and Ethnicity, Medical Insurance, and Within-Hospital Severe Maternal Morbidity Disparities,” *Obstetrics & Gynecology* 135, no. 2 (Feb. 2020): 285–93.
24. Mark Walker, “For Tribal Members in Oklahoma, Medicaid Expansion Improves Access to Specialty Care,” *New York Times*, Sept. 4, 2021; and Eric Whitney, “Native Americans Feel Invisible in U.S. Health Care System,” *NPR*, Dec. 12, 2017.
25. Baumgartner, Collins, and Radley, *Racial and Ethnic Inequities*, 2021; Walker, “For Tribal Members,” 2021; and Corinne Lewis et al., *The Role of Medicaid Expansion in Care Delivery at Community Health Centers* (Commonwealth Fund, Apr. 2019).
26. Sara R. Collins, Munira Z. Gunja, and Gabriella N. Aboulafia, *U.S. Health Insurance Coverage in 2020: A Looming Crisis in Affordability — Findings from the Commonwealth Fund Biennial Health Insurance Survey* (Commonwealth Fund, Aug. 2020).
27. William Darity Jr. et al., *What We Get Wrong About Closing the Racial Wealth Gap* (Duke University, Samuel Dubois Cook Center on Social Equity, Apr. 2018).
28. “Individuals with high out-of-pocket medical spending,” Commonwealth Fund Health Systems Data Center, n.d.; Collins, Aboulafia and Gunja, *As the Pandemic Eases*, 2021.

29. Nancy Beaulieu et al., “Primary Care Delivery Systems and Segregation in a Medicaid Population,” Harvard University, 2020; Roosa S. Tikkanen et al., “Hospital Payer and Racial/Ethnic Mix at Private Academic Medical Centers in Boston and New York City,” *International Journal of Health Services* 47, no. 3 (July 2017): 460–76; Elizabeth J. Brown et al., “Racial Disparities in Geographic Access to Primary Care in Philadelphia,” *Health Affairs* 35, no. 8 (Aug. 2016): 1374–81; Darrell J. Gaskin et al., “Residential Segregation and the Availability of Primary Care Physicians,” *Health Services Research* 47, no. 6 (Dec. 2012): 2353–76; and Emily P. Terlizzi et al., “Reported Importance and Access to Health Care Providers Who Understand or Share Cultural Characteristics with Their Patients Among Adults, by Race and Ethnicity,” *HHS National Health Statistics Reports* 130 (Oct. 2019).
30. *Medicaid’s Role in Health Care for American Indians and Alaska Natives* (Medicaid and CHIP Payment and Access Commission, Feb. 2021); “Profile: American Indian/Alaska Native,” U.S. HHS Office of Minority Health, Sept. 2021.
31. Correlation between primary care spending, expressed as a share of total per beneficiary spending, and hospital admissions for primary-care sensitive conditions was stronger among Black beneficiaries ( $r = -0.49$ ) than among white beneficiaries ( $r = -0.22$ ). Similarly, higher levels of primary care spending were associated with lower levels of emergency department use for nonemergent conditions, with a stronger correlation among Black beneficiaries ( $r = -0.40$ ) than white beneficiaries ( $r = -0.24$ ).
32. Cynthia G. Whitney et al., “Benefits from Immunization During the Vaccines for Children Program Era—United States, 1994–2013,” *Morbidity and Mortality Weekly Report (MMWR)* 63, no. 16 (Apr. 25, 2014): 352–55; Allison T. Walker, Philip J. Smith, and Maureen Kolasa, “Reduction of Racial/ Ethnic Disparities in Vaccination Coverage, 1995–2011,” *Morbidity and Mortality Weekly Report (MMWR)* 63, no. 1 (Apr. 18, 2014): 7–12.
33. Jessica S. Banthin, Michael Simpson, and Andrew Green, *The Coverage and Cost Effects of Key Health Insurance Reforms Being Considered by Congress* (Commonwealth Fund, Sept. 2021, updated Oct. 5, 2021).
34. Improving Health Insurance Affordability Act of 2021, S. 499, 117th Cong. (2021). See Linda J. Blumberg et al., *From Incremental to Comprehensive Health Insurance Reform: How Various Reform Options Compare on Coverage and Costs* (Urban Institute, Oct. 2019).
35. Sara R. Collins and Gabriella N. Aboulafia, “Will the American Rescue Plan Reduce the Number of Uninsured Americans?,” *To the Point* (blog), Commonwealth Fund, Mar. 22, 2021.
36. Collins and Aboulafia, “Will the American Rescue Plan?,” 2021.
37. Melody Gutierrez, “California Expands Medi-Cal, Offering Relief to Older Immigrants Without Legal Status,” *Los Angeles Times*, July 27, 2021; and Kelly Whitener, “COVID-19 and Immigrant Health,” *Say Ahhh!* (blog), Georgetown University Center for Children and Families, Apr. 10, 2020.
38. Kevin McAvey and Alisha Regional, *Unlocking Race and Ethnicity Data to Promote Health Equity in California* (Manatt Health, Apr. 2021).
39. Katie Keith, “How Insurers Can Advance Health Equity Under the Affordable Care Act,” *To the Point* (blog), Commonwealth Fund, Aug. 10, 2021.
40. Brown et al., “Racial Disparities,” 2016; Gaskin et al., “Residential Segregation,” 2012; and Howell et al., “Black–White,” 2015.
41. Diane Alexander and Molly Schnell, “The Impacts of Physician Payments on Patient Access, Use, and Health,” *NBER Working Paper* 26095 (July 2019); and Commonwealth Fund Task Force on Payment and Delivery System Reform, *Six Policy Imperatives to Improve Quality, Advance Equity, and Increase Affordability* (Commonwealth Fund, Nov. 2020).
42. Mandy Cohen et al., “Buying Health, Not Just Health Care: North Carolina’s Pilot Effort,” *To the Point* (blog), Commonwealth Fund, Jan. 27, 2020; and Sophia Tripoli et al., “To Advance Health Equity, Federal Policy Makers Should Build on Lessons from State Medicaid Experiments,” *Health Affairs Blog*, Apr. 14, 2021.
43. Brenda Gleason and Laurie Zephyrin, “Improving Access to Telematernity Services After the Pandemic,” *To the Point* (blog), Commonwealth Fund, Aug. 17, 2021.



44. Commonwealth Fund Task Force, *Six Policy Imperatives*, 2020; and Donnie L. Bell and Mitchell H. Katz, “Modernize Medical Licensing, and Credentialing, Too — Lessons From the COVID-19 Pandemic,” *JAMA Internal Medicine* 181, no. 3 (Jan. 2021):312–15.
45. Eric C. Schneider et al., *Mirror, Mirror 2021 — Reflecting Poorly: Health Care in the U.S. Compared to Other High-Income Countries* (Commonwealth Fund, Aug. 2021).
46. Michael Anne Kyle and Austin B. Frakt, “Patient Administrative Burden in the U.S. Health Care System,” *Health Services Research* 56, no. 5 (Oct. 2021): 755–65.
47. Linda J. Blumberg, John Holahan, and Jason Levis, *How Auto-Enrollment Can Achieve Near-Universal Coverage: Policy and Implementation Issues* (Commonwealth Fund, June 2021).
48. Roosa S. Tikkanen and Eric C. Schneider, “Social Spending to Improve Population Health — Does the United States Spend as Wisely as Other Countries?,” *New England Journal of Medicine* 382, no. 10 (Mar. 5, 2020): 885–87.
49. Montez et al., “U.S. State Policies,” 2020; Divya Amladi, *The Best and Worst States to Work in During COVID-19* (Oxfam America, Sept. 2020); Erica Williams, Samantha Waxman, and Julian Legendre, *States Can Adopt or Expand Earned Income Tax Credits to Build a Stronger Future Economy* (Center on Budget and Policy Priorities, Mar. 2020); and Shera Avi-Yonah and Danielle Moran, “NYC, Connecticut Start ‘Baby Bond’ Programs to Shrink Inequality,” *Bloomberg*, July 8, 2021.
50. Schneider et al., *Mirror, Mirror*, 2021.

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## STUDY METHODS

This report, modeled on the Commonwealth Fund's annual *Scorecard on State Health System Performance*,<sup>1</sup> evaluates state health system performance for five racial and ethnic groups on 24 indicators representing three dimensions:

- **Health Outcomes:** Eight indicators related to premature death, health status, and health risk behaviors.
- **Health Care Access:** Five indicators related to insurance coverage for children and adults, access to health care providers, out-of-pocket expenses for medical care, and cost-related barriers to receiving care.
- **Quality and Use of Health Care Services:** Eleven indicators related to receipt of preventive care, hospital and emergency department use that might have been reduced with timely and effective care, and estimates of spending on primary care as a share of total Medicare spending.

The racial and ethnic groups included in the analysis are: Black (non-Latinx/Hispanic); white (non-Latinx/Hispanic); Latinx/Hispanic (any race); Asian American, Native Hawaiian, or Pacific Islander (non-Latinx/Hispanic); and American Indian or Alaska Native (non-Latinx/Hispanic).

### Guiding Principles

*Performance metrics:* Nearly all 24 metrics in the report are those used for the *2020 Scorecard on State Health System Performance*. We selected them because they represent important dimensions and measurable aspects of health care system performance, and because they can be stratified by race and ethnicity within each state (see [Appendix C](#) for a full list of indicators and the available racial and ethnic groups within each data source).

*Data sources:* We selected the metrics from publicly available sources, including government-sponsored surveys, publicly reported quality indicators, vital statistics, mortality data, and administrative databases. The most current data available were used wherever possible. To increase the number of data points for different racial and

ethnic populations within states, we aggregated data across the two most recent years for 17 of the 24 indicators (e.g., 2019–20). [Appendix C](#) identifies the data source and time frame used for each indicator.

*Data inclusion:* Each data source used has its own guidance for suppressing estimates based on sample size. For example, guidance from the Centers for Disease Control and Prevention (CDC) for deriving estimates from the Behavioral Risk Factor Surveillance System (BRFSS) advises that subpopulation estimates be suppressed when the relative standard error (standard error divided by the estimate) is less than 30 percent. The CDC also advises that rates derived from the restricted-use detailed mortality files used for our preventable mortality measure be suppressed when there are fewer than 10 underlying deaths. In all instances, we followed each data source's suppression guidance; in some cases, we used even stricter suppression criteria to ensure the stability of our estimates (e.g., we suppressed preventable mortality rates if there were fewer than 20 deaths).

To further ensure data stability, we did not include any estimates for a state population group in our scoring calculations if: a) they did not make up at least 2 percent of the state's total population, and b) there were less than 40,000 people estimated to be in that group.

*Scoring methodology:* For each of the 24 performance indicators, we gather all available point estimates for the racial and ethnic populations in each state (including the District of Columbia as if it were a state) and calculated a standardized z-score for each state population group (e.g., all Texas residents who identify as Latinx/Hispanic). To illustrate, for adult uninsured rates, we have point estimates available for 191 state population groups (51 white, 48 Latinx/Hispanic, 39 Black, 37 AANHPI, 16 AIAN). For each group, we calculate the z-score by subtracting the average uninsured rate across all 191 groups from the uninsured rate for the specific group and then dividing by the standard deviation of all observed group rates. This approach is similar to the method used in our *Scorecard on State Health System Performance*, but it is applied to each population group within each state rather than to the full state population.

The standardized z-scores for each state population group were averaged across all indicators within the performance dimension (Outcomes, Access, Quality/Use), and then dimension scores were averaged to generate an overall health system performance score for that particular group. A group did not receive a dimension score (or scores for individual indicators within a dimension) if it was missing data for more than 50 percent of the indicators within that dimension. A group that was missing a dimension score did not receive a final overall health system performance score.

Finally, we took the overall composite z-scores for each state population group and assigned a 1–100 percentile score (we also assigned percentile scores for each of the three dimensions). The percentile scoring reflects the observed distribution of health system performance for all the groups measured. It enables users to make comparisons both across states (e.g., the health system performance for Black residents of Massachusetts compared to Black residents of Georgia) and within states (e.g., the gap in health system performance for Black and white Michigan residents).

It is important to note that because the scores are set relative to one another rather than to a predefined benchmark, groups at or near the 100th percentile still have room for improvement.

*Data limitations:* Not all data sources supported state-level estimates for all racial and ethnic groups featured in this report. For example, the Medicare LDS, used to create several utilization indicators, can reliably support estimates only for Black and white race but not for ethnicity.

For several populations (particularly AIAN and AANHPI), many states have insufficient data to produce an overall health system performance score or point estimates for many of the individual indicators. However, we do publish all point estimates meeting data-source suppression criteria within our individual state profiles.

Finally, it is important to note that the five racial and ethnic categories used for this report often group together populations with different experiences, cultures, immigration barriers, and other socioeconomic factors. For example, there is a wide range of culturally distinct Latinx/Hispanic communities and Asian American communities across the United States. Such groupings are imperfect and

can mask significant differences. For example, past research has shown variability in health insurance coverage rates among Asian American subpopulations and between Asian Americans and Native Hawaiians or Pacific Islanders.<sup>2</sup> While use of these categories is necessary to obtain sufficient data sample sizes, states and localities should interpret the findings within the context of their own communities, using them as a starting point to guide more targeted research and policy solutions.

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## NOTES TO METHODS

1. David C. Radley, Sara R. Collins, and Jesse C. Baumgartner, *2020 Scorecard on State Health System Performance* (Commonwealth Fund, Sept. 2020).
2. Munira Z. Gunja et al., *Gap Closed: The Affordable Care Act's Impact on Asian Americans' Health Coverage* (Commonwealth Fund, July 2020).
3. Dolores Acevedo-Garcia et al., "Racial and Ethnic Inequities in Children's Neighborhoods: Evidence from the New Child Opportunity Index 2.0," *Health Affairs* 39, no. 10 (Oct. 2020): 1693–1701; Denis Agniel et al., "Incentivizing Excellent Care to At-Risk Groups with a Health Equity Summary Score," *Journal of General Internal Medicine* 36, no. 7 (July 2021): 1847–57; and Cara V. James et al., *Putting Women's Health Care Disparities on the Map: Examining Racial and Ethnic Disparities at the State Level* (Henry J. Kaiser Family Foundation, June 2009).

## APPENDIX A1. State Equity Report Performance Indicators, Data Years, and Databases

Indicator	Data years	Database	
<b>Health Outcomes</b>			
1	Mortality amenable to health care, deaths per 100,000 population	2018–19	CDC National Vital Statistics System (NVSS): Restricted Use Mortality Microdata
2	Infant mortality, deaths per 1,000 live births	2017–18	CDC National Vital Statistics System (NVSS): WONDER
3	Breast cancer deaths per 100,000 female population	2018–19	CDC National Vital Statistics System (NVSS): WONDER
4	Colorectal cancer deaths per 100,000 population	2018–19	CDC National Vital Statistics System (NVSS): WONDER
5	30-day hospital readmissions, Medicare beneficiaries age 65 and older, per 1,000 beneficiaries	2019	CMS Limited Data Set (LDS)
6	Adults age 18 and older who smoke	2019–20	Behavioral Risk Factor Surveillance System (BRFSS)
7	Adults ages 18–64 who are obese (BMI >= 30)	2019–20	Behavioral Risk Factor Surveillance System (BRFSS)
8	Adults ages 18–64 who have lost six or more teeth because of tooth decay, infection, or gum disease	2018/20	Behavioral Risk Factor Surveillance System (BRFSS)
<b>Health Care Access</b>			
9	Adults ages 19–64 uninsured	2019	American Community Survey, Public Use Microdata Sample (ACS PUMS)
10	Children ages 0–18 uninsured	2019	American Community Survey, Public Use Microdata Sample (ACS PUMS)
11	Adults age 18 and older who went without care because of cost in past year	2019–20	Behavioral Risk Factor Surveillance System (BRFSS)
12	Individuals under age 65 with high out-of-pocket medical costs relative to their annual household income	2019–20	Current Population Survey Annual Social and Economic Supplement (CPS ASEC)
13	Adults age 18 and older with a usual source of care	2019–20	Behavioral Risk Factor Surveillance System (BRFSS)
<b>Quality and Use of Health Care Services</b>			
14	Hospital admissions for ambulatory care–sensitive conditions, Medicare beneficiaries age 65 and older, per 1,000 beneficiaries	2019	CMS Limited Data Set (LDS)
15	Potentially avoidable emergency department visits, Medicare beneficiaries age 65 and older, per 1,000 beneficiaries	2019	CMS Limited Data Set (LDS)
16	Adult women ages 50–74 who received a mammogram in the past two years	2018/20	Behavioral Risk Factor Surveillance System (BRFSS)
17	Adult women ages 25–64 who received a cervical cancer screening test in the past three years	2018/20	Behavioral Risk Factor Surveillance System (BRFSS)
18	Adults ages 50–74 with a recent colon cancer screening test	2018/20	Behavioral Risk Factor Surveillance System (BRFSS)
19	Adults age 18 and older who received a flu shot in the past year	2019–20	Behavioral Risk Factor Surveillance System (BRFSS)
20	Adults age 65 and older who have ever gotten a pneumonia vaccine	2019–20	Behavioral Risk Factor Surveillance System (BRFSS)
21	Children with age-appropriate medical and dental preventive care visits in the past year	2019–20	National Survey of Children’s Health (NSCH)
22	Children ages 19–35 months who received all recommended doses of seven key vaccines	2019	National Immunization Survey (NIS)
23	Adults age 18 and older without a dental visit in past year	2018/20	Behavioral Risk Factor Surveillance System (BRFSS)
24	Primary care spending as share of total health care spending, Medicare beneficiaries age 65 and older	2019	CMS Limited Data Set (LDS)

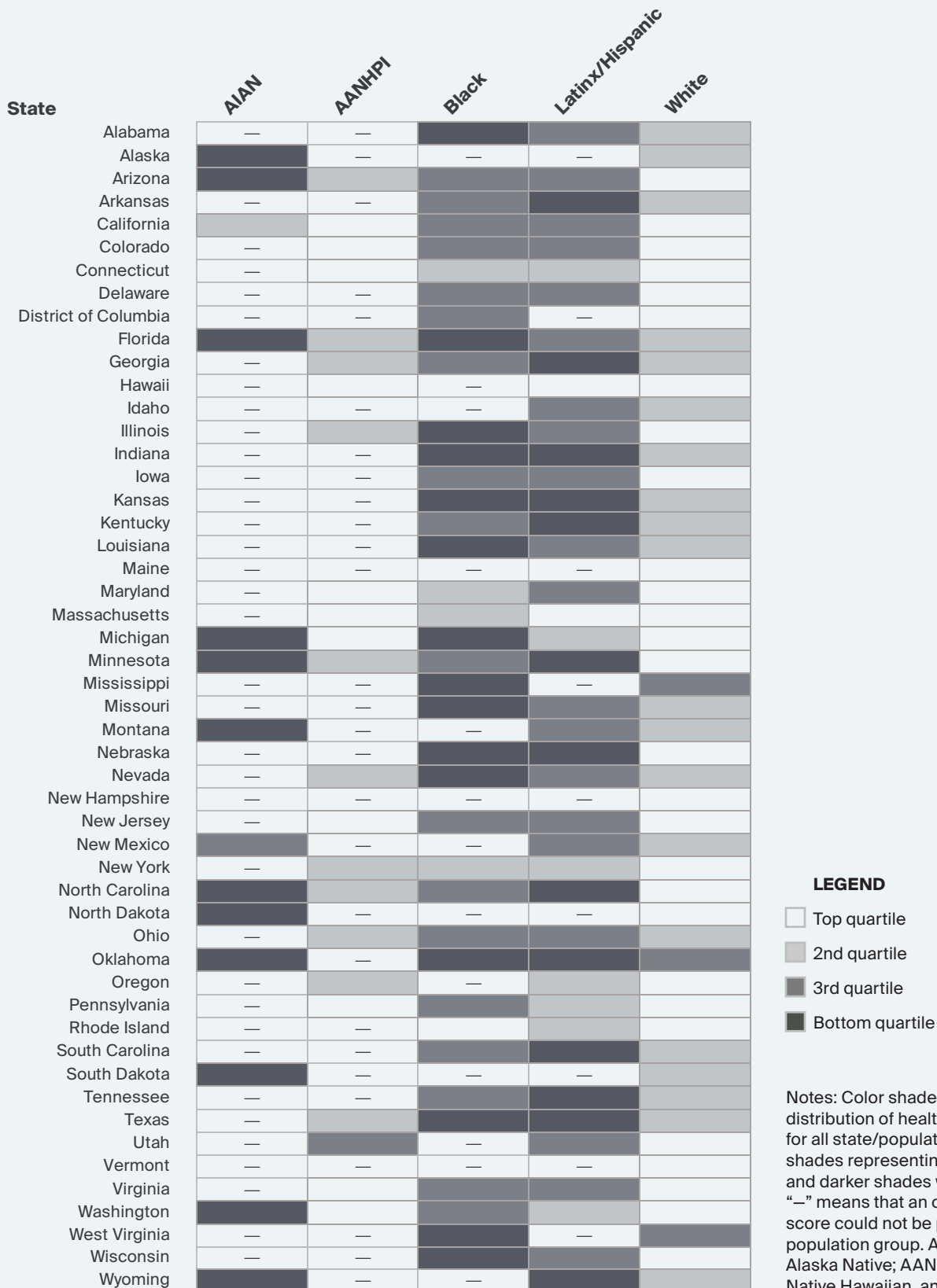
A downloadable Excel data file with all indicators for all state populations is available in the online version of the report. [>](#)

## APPENDIX A2. National Rates, by Race and Ethnicity, for State Equity Report Health System Performance Indicators

Indicator	Data year	U.S. average rate	AIAN rate	AANHPI rate	Black rate	Latinx/Hispanic rate	White rate	
<b>Health Outcomes</b>								
1	Mortality amenable to health care, deaths per 100,000 population	2018–19	<b>84.2</b>	107.6	49.3	153.1	66.9	78.2
2	Infant mortality, deaths per 1,000 live births	2017–18	<b>5.7</b>	8.7	3.9	10.9	5.0	4.7
3	Breast cancer deaths per 100,000 female population	2018–19	<b>19.6</b>	14.9	11.9	27.7	13.6	19.6
4	Colorectal cancer deaths per 100,000 population	2018–19	<b>13.2</b>	13.1	9.0	17.3	10.7	13.3
5	30-day hospital readmissions, Medicare beneficiaries age 65 and older, per 1,000 beneficiaries	2019	<b>37.6</b>	—	—	60.2	—	36.5
6	Adults age 18 and older who smoke	2019–20	<b>15%</b>	28%	8%	17%	12%	15%
7	Adults ages 18–64 who are obese (BMI >= 30)	2019–20	<b>32%</b>	40%	13%	42%	36%	31%
8	Adults ages 18–64 who have lost six or more teeth because of tooth decay, infection, or gum disease	2018/20	<b>9%</b>	18%	3%	11%	7%	10%
<b>Health Care Access</b>								
9	Adults ages 19–64 uninsured	2019	<b>13%</b>	25%	8%	14%	26%	9%
10	Children ages 0–18 uninsured	2019	<b>6%</b>	14%	4%	5%	9%	4%
11	Adults age 18 and older who went without care because of cost in past year	2019–20	<b>12%</b>	17%	9%	15%	19%	10%
12	Individuals under age 65 with high out-of-pocket medical costs relative to their annual household income	2019–20	<b>6%</b>	7%	5%	7%	6%	6%
13	Adults age 18 and older with a usual source of care	2019–20	<b>77%</b>	71%	75%	78%	60%	81%
<b>Quality and Use of Health Care Services</b>								
14	Hospital admissions for ambulatory care-sensitive conditions, Medicare beneficiaries age 65 and older, per 1,000 beneficiaries	2019	<b>39.4</b>	—	—	59.0	—	38.7
15	Potentially avoidable emergency department visits, Medicare beneficiaries age 65 and older, per 1,000 beneficiaries	2019	<b>185.3</b>	—	—	289.9	—	179.7
16	Adult women ages 50–74 who received a mammogram in the past two years	2018/20	<b>79%</b>	72%	76%	85%	79%	78%
17	Adult women ages 25–64 who received a cervical cancer screening test in the past three years	2018/20	<b>77%</b>	72%	72%	83%	79%	76%
18	Adults ages 50–74 with a recent colon cancer screening test	2018/20	<b>70%</b>	61%	63%	71%	59%	73%
19	Adults age 18 and older who received a flu shot in the past year	2019–20	<b>45%</b>	39%	47%	37%	35%	49%
20	Adults age 65 and older who have ever gotten a pneumonia vaccine	2019–20	<b>71%</b>	62%	67%	61%	55%	74%
21	Children with age-appropriate medical and dental preventive care visits in the past year	2019–20	<b>66%</b>	—	—	63%	61%	70%
22	Children ages 19–35 months who received all recommended doses of seven key vaccines	2019	<b>73%</b>	—	—	66%	70%	76%
23	Adults age 18 and older without a dental visit in past year	2018/20	<b>35%</b>	44%	33%	40%	43%	31%
24	Primary care spending as share of total health care spending, Medicare beneficiaries age 65 and older	2019	<b>6%</b>	—	—	5%	—	6%

Notes: “—” indicates stratification by race or ethnicity is not available. AIAN = American Indian/Alaska Native; AANHPI = Asian American, Native Hawaiian, and Pacific Islander.

**APPENDIX B1A. Summary of Overall State Health System Performance Across Populations**



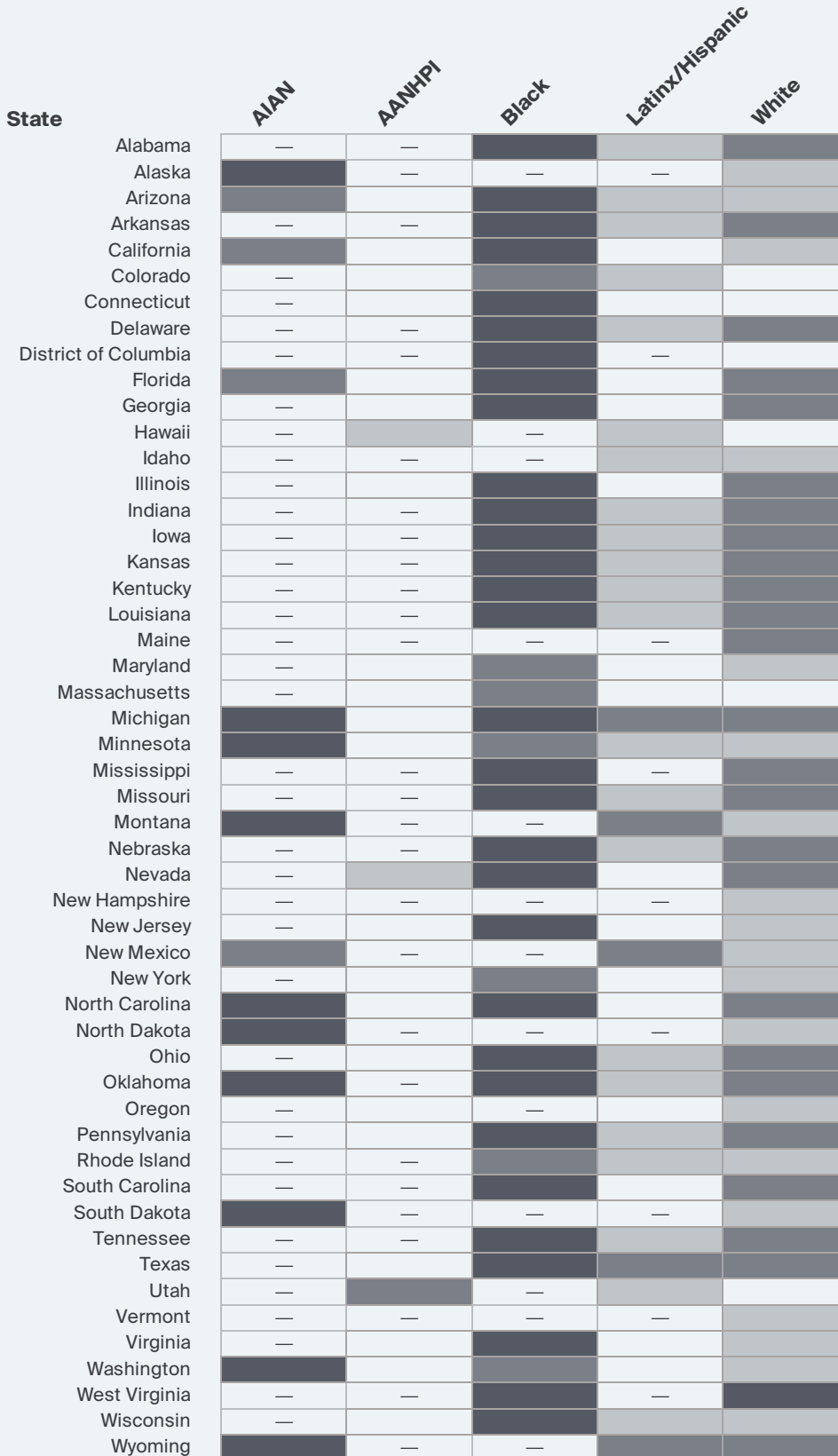
**LEGEND**

- Top quartile
- 2nd quartile
- 3rd quartile
- Bottom quartile

Notes: Color shades represent the quartile distribution of health system performance for all state/population groups, with lighter shades representing stronger performance and darker shades weaker performance. “—” means that an overall performance score could not be produced for that state/population group. AIAN = American Indian/Alaska Native; AANHPI = Asian American, Native Hawaiian, and Pacific Islander.



**APPENDIX B1B. Summary of State Health Outcomes Across Populations**

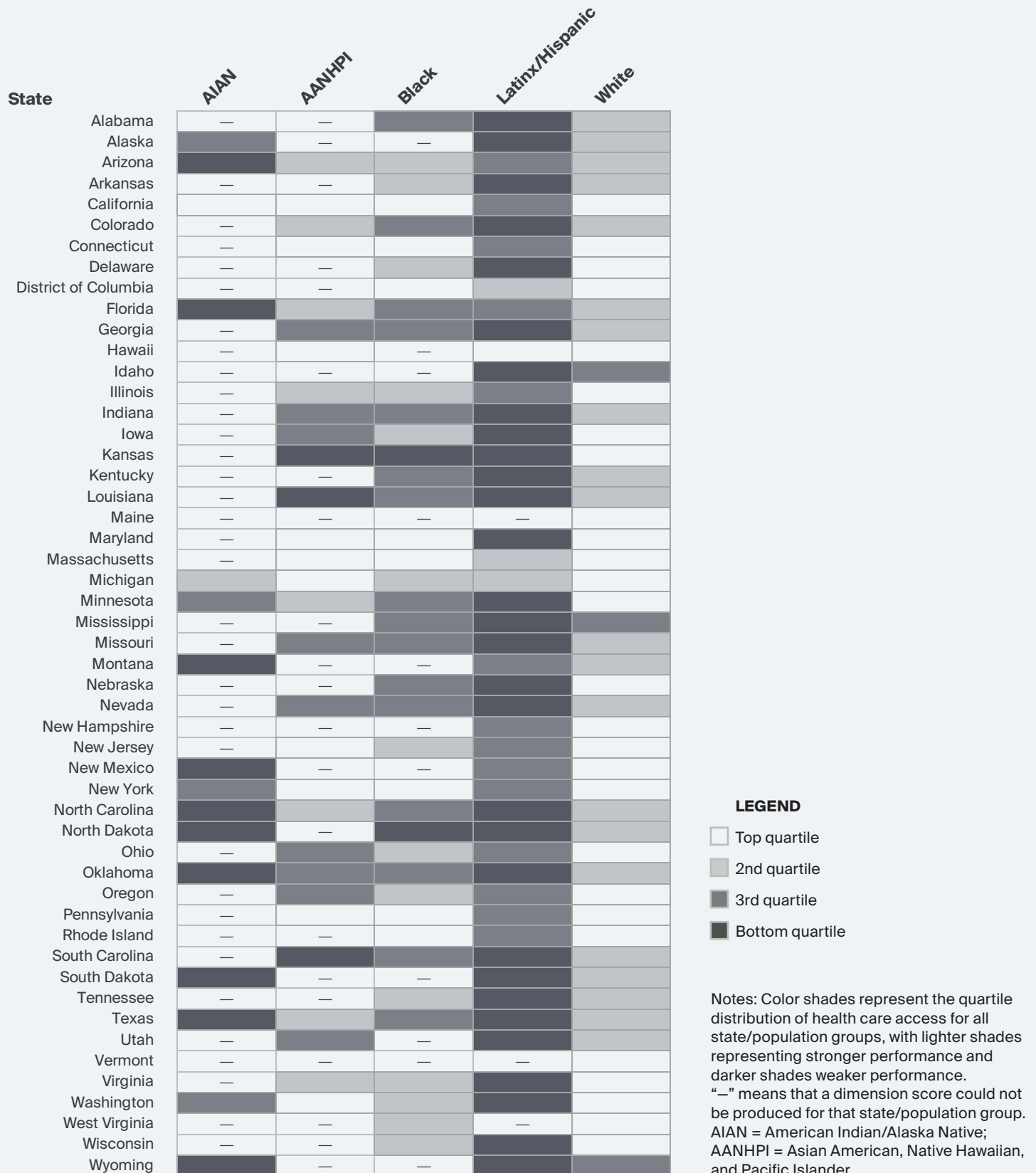


**LEGEND**

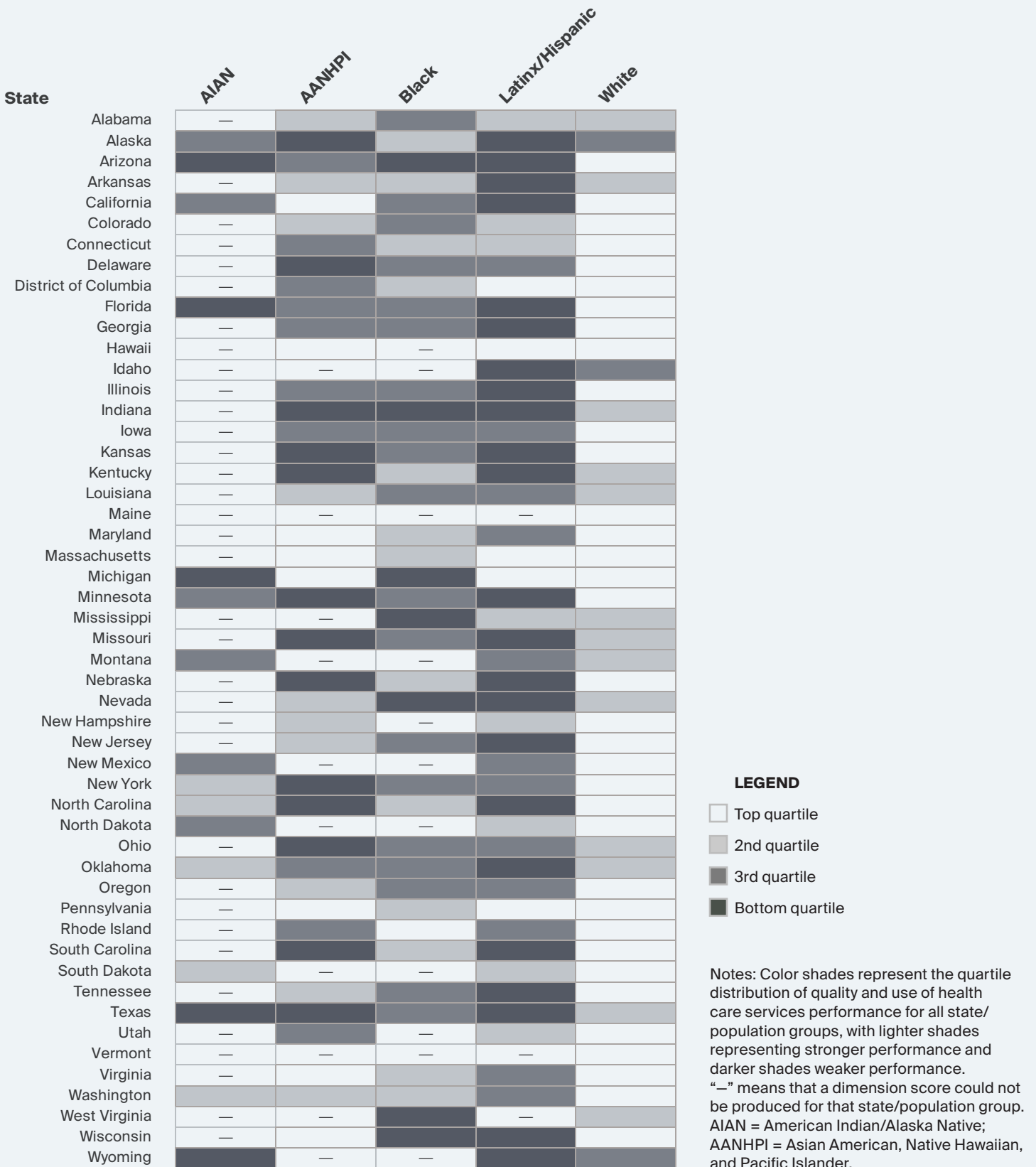
- Top quartile
- 2nd quartile
- 3rd quartile
- Bottom quartile

Notes: Color shades represent the quartile distribution of health care outcomes for all state/population groups, with lighter shades representing stronger performance and darker shades weaker performance. “—” means that a dimension score could not be produced for that state/population group. AIAN = American Indian/Alaska Native; AANHPI = Asian American, Native Hawaiian, and Pacific Islander.

**APPENDIX B1C. Summary of State Health Care Access Across Populations**



**APPENDIX B1D. Summary of State Quality and Use of Health Care Services Across Populations**



### APPENDIX B2A. Summary of State Health System Performance Rankings and Scores for American Indian/Alaska Native Populations

State	Overall		Outcomes		Access		Quality and Use	
	Percentile score (1-100)	Rank among AIAN populations (14 states)	Percentile score (1-100)	Rank among AIAN populations (14 states)	Percentile score (1-100)	Rank among AIAN populations (16 states)	Percentile score (1-100)	Rank among AIAN populations (16 states)
Alabama	—	—	—	—	—	—	—	—
Alaska	7	7	4	9	43	4	27	11
Arizona	5	9	29	4	13	13	3	15
Arkansas	—	—	—	—	—	—	—	—
California	56	1	41	1	76	1	37	7
Colorado	—	—	—	—	—	—	—	—
Connecticut	—	—	—	—	—	—	—	—
Delaware	—	—	—	—	—	—	—	—
District of Columbia	—	—	—	—	—	—	—	—
Florida	4	10	36	3	14	12	2	16
Georgia	—	—	—	—	—	—	—	—
Hawaii	—	—	—	—	—	—	—	—
Idaho	—	—	—	—	—	—	—	—
Illinois	—	—	—	—	—	—	—	—
Indiana	—	—	—	—	—	—	—	—
Iowa	—	—	—	—	—	—	—	—
Kansas	—	—	—	—	—	—	—	—
Kentucky	—	—	—	—	—	—	—	—
Louisiana	—	—	—	—	—	—	—	—
Maine	—	—	—	—	—	—	—	—
Maryland	—	—	—	—	—	—	—	—
Massachusetts	—	—	—	—	—	—	—	—
Michigan	8	6	8	8	51	2	9	12
Minnesota	6	8	3	11	49	3	34	8
Mississippi	—	—	—	—	—	—	—	—
Missouri	—	—	—	—	—	—	—	—
Montana	2	13	2	13	11	14	31	10
Nebraska	—	—	—	—	—	—	—	—
Nevada	—	—	—	—	—	—	—	—
New Hampshire	—	—	—	—	—	—	—	—
New Jersey	—	—	—	—	—	—	—	—
New Mexico	34	2	39	2	25	7	45	6
New York	—	—	—	—	32	6	58	3
North Carolina	14	4	9	7	20	9	71	1
North Dakota	3	12	1	14	18	11	33	9
Ohio	—	—	—	—	—	—	—	—
Oklahoma	12	5	12	6	20	9	64	2
Oregon	—	—	—	—	—	—	—	—
Pennsylvania	—	—	—	—	—	—	—	—
Rhode Island	—	—	—	—	—	—	—	—
South Carolina	—	—	—	—	—	—	—	—
South Dakota	3	11	3	10	9	15	58	3
Tennessee	—	—	—	—	—	—	—	—
Texas	—	—	—	—	24	8	4	14
Utah	—	—	—	—	—	—	—	—
Vermont	—	—	—	—	—	—	—	—
Virginia	—	—	—	—	—	—	—	—
Washington	21	3	14	5	33	5	54	5
West Virginia	—	—	—	—	—	—	—	—
Wisconsin	—	—	—	—	—	—	—	—
Wyoming	1	14	2	12	2	16	9	13

Notes: “—” indicates insufficient data to produce an overall or dimension-specific score. Groups missing at least one dimension score were not eligible for an overall performance score. “Percentile score” is the 1-100 percentile that the state/population group falls in among the full distribution of all groups with available data. Refer to [Study Methods](#) for methodological detail.

**APPENDIX B2B. Summary of State Health System Performance Rankings and Scores for Asian American, Native Hawaiian, and Pacific Islander Populations**

State	Overall		Outcomes		Access		Quality and Use	
	Percentile score (1-100)	Rank among AANHPI populations (23 states)	Percentile score (1-100)	Rank among AANHPI populations (24 states)	Percentile score (1-100)	Rank among AANHPI populations (30 states)	Percentile score (1-100)	Rank among AANHPI populations (41 states)
Alabama	—	—	—	—	—	—	68	12
Alaska	—	—	—	—	—	—	1	41
Arizona	69	16	86	19	63	14	43	22
Arkansas	—	—	—	—	—	—	55	17
California	95	5	93	11	92	6	77	8
Colorado	85	11	97	6	67	12	64	14
Connecticut	92	8	99	3	93	4	39	24
Delaware	—	—	—	—	—	—	16	34
District of Columbia	—	—	—	—	—	—	41	23
Florida	74	13	91	16	63	13	46	21
Georgia	64	18	89	18	42	22	37	25
Hawaii	94	6	72	22	96	2	96	1
Idaho	—	—	—	—	—	—	—	—
Illinois	73	14	94	10	62	15	30	27
Indiana	—	—	—	—	44	21	22	31
Iowa	—	—	—	—	34	25	49	19
Kansas	—	—	—	—	22	28	23	30
Kentucky	—	—	—	—	—	—	14	36
Louisiana	—	—	—	—	13	30	72	9
Maine	—	—	—	—	—	—	—	—
Maryland	99	2	95	8	93	4	88	3
Massachusetts	99	1	100	1	98	1	84	4
Michigan	96	4	98	5	81	9	84	4
Minnesota	57	21	85	20	55	18	21	32
Mississippi	—	—	—	—	—	—	—	—
Missouri	—	—	—	—	40	23	13	37
Montana	—	—	—	—	—	—	—	—
Nebraska	—	—	—	—	—	—	14	35
Nevada	67	17	72	22	49	19	70	10
New Hampshire	—	—	—	—	—	—	70	10
New Jersey	94	6	98	4	95	3	59	16
New Mexico	—	—	—	—	—	—	—	—
New York	75	12	95	8	77	10	19	33
North Carolina	61	19	91	15	56	16	8	39
North Dakota	—	—	—	—	—	—	—	—
Ohio	61	19	93	12	34	25	25	29
Oklahoma	—	—	—	—	38	24	33	26
Oregon	73	14	89	17	46	20	62	15
Pennsylvania	98	3	99	2	82	8	84	4
Rhode Island	—	—	—	—	—	—	26	28
South Carolina	—	—	—	—	18	29	9	38
South Dakota	—	—	—	—	—	—	—	—
Tennessee	—	—	—	—	—	—	55	17
Texas	53	22	92	13	56	16	3	40
Utah	43	23	46	24	28	27	48	20
Vermont	—	—	—	—	—	—	—	—
Virginia	89	10	92	13	70	11	79	7
Washington	92	8	96	7	82	7	65	13
West Virginia	—	—	—	—	—	—	—	—
Wisconsin	—	—	78	21	—	—	94	2
Wyoming	—	—	—	—	—	—	—	—

Notes: “—” indicates insufficient data to produce an overall or dimension-specific score. Groups missing at least one dimension score were not eligible for an overall performance score. “Percentile score” is the 1-100 percentile that the state/population group falls in among the full distribution of all groups with available data. Refer to [Study Methods](#) for methodological detail.

## APPENDIX B2C. Summary of State Health System Performance Rankings and Scores for Black Populations

State	Overall		Outcomes		Access		Quality and Use	
	Percentile score (1-100)	Rank among Black populations (38 states)	Percentile score (1-100)	Rank among Black populations (38 states)	Percentile score (1-100)	Rank among Black populations (40 states)	Percentile score (1-100)	Rank among Black populations (40 states)
Alabama	19	27	13	26	46	27	30	28
Alaska	—	—	—	—	—	—	53	12
Arizona	30	19	25	9	54	20	15	37
Arkansas	31	18	11	29	59	17	59	10
California	40	11	18	20	90	4	26	32
Colorado	40	11	38	1	39	29	35	25
Connecticut	55	4	25	8	84	6	59	9
Delaware	35	14	23	12	70	11	28	29
District of Columbia	43	9	13	27	83	7	60	8
Florida	23	24	23	12	31	35	38	24
Georgia	30	19	23	12	35	31	43	18
Hawaii	—	—	—	—	—	—	—	—
Idaho	—	—	—	—	—	—	—	—
Illinois	18	28	6	35	64	13	27	31
Indiana	16	31	16	23	48	23	11	39
Iowa	32	17	16	22	61	14	44	16
Kansas	14	34	20	16	19	39	48	15
Kentucky	34	15	18	20	47	25	67	5
Louisiana	18	29	9	32	47	24	28	29
Maine	—	—	—	—	—	—	—	—
Maryland	64	3	26	7	94	3	72	3
Massachusetts	70	2	33	2	95	2	74	2
Michigan	14	34	5	37	72	9	13	38
Minnesota	36	13	31	4	35	31	43	18
Mississippi	8	37	8	33	38	30	18	36
Missouri	9	36	10	31	31	35	31	26
Montana	—	—	—	—	—	—	—	—
Nebraska	22	25	19	17	28	37	54	11
Nevada	18	29	19	17	47	25	11	40
New Hampshire	—	—	—	—	—	—	—	—
New Jersey	42	10	23	11	72	9	43	18
New Mexico	—	—	—	—	—	—	—	—
New York	53	5	28	6	80	8	44	16
North Carolina	33	16	19	17	44	28	66	6
North Dakota	—	—	—	—	1	40	—	—
Ohio	26	22	11	30	57	19	39	23
Oklahoma	6	38	7	34	27	38	26	32
Oregon	—	—	—	—	61	14	39	22
Pennsylvania	45	8	15	25	87	5	53	13
Rhode Island	80	1	32	3	98	1	92	1
South Carolina	27	21	16	23	32	34	61	7
South Dakota	—	—	—	—	—	—	—	—
Tennessee	26	22	12	28	53	21	41	21
Texas	22	25	21	15	33	33	31	26
Utah	—	—	—	—	—	—	—	—
Vermont	—	—	—	—	—	—	—	—
Virginia	48	6	24	10	61	14	68	4
Washington	48	6	31	4	53	21	53	13
West Virginia	15	33	5	38	68	12	23	35
Wisconsin	16	32	6	35	58	18	24	34
Wyoming	—	—	—	—	—	—	—	—

Notes: “—” indicates insufficient data to produce an overall or dimension-specific score. Groups missing at least one dimension score were not eligible for an overall performance score. “Percentile score” is the 1-100 percentile that the state/population group falls in among the full distribution of all groups with available data. Refer to [Study Methods](#) for methodological detail.

## APPENDIX B2D. Summary of State Health System Performance Rankings and Scores for Latinx/Hispanic Populations

State	Overall		Outcomes		Access		Quality and Use	
	Percentile score (1-100)	Rank among Latinx/Hispanic populations (42 states)	Percentile score (1-100)	Rank among Latinx/Hispanic populations (42 states)	Percentile score (1-100)	Rank among Latinx/Hispanic populations (48 states)	Percentile score (1-100)	Rank among Latinx/Hispanic populations (48 states)
Alabama	28	26	53	36	8	37	57	10
Alaska	—	—	—	—	15	29	22	28
Arizona	32	23	55	34	26	17	21	29
Arkansas	12	36	74	17	7	39	6	44
California	50	10	76	14	42	5	15	36
Colorado	45	13	56	33	23	20	51	13
Connecticut	68	4	79	12	40	8	75	6
Delaware	30	25	74	17	10	35	30	25
District of Columbia	—	—	—	—	62	3	78	4
Florida	38	19	76	15	26	17	22	27
Georgia	16	35	81	10	4	45	16	35
Hawaii	82	2	52	37	87	1	86	2
Idaho	28	26	68	24	14	30	19	31
Illinois	45	13	82	8	30	13	14	37
Indiana	21	33	72	19	17	25	5	46
Iowa	41	17	67	25	23	20	37	20
Kansas	24	30	61	30	12	31	21	29
Kentucky	23	32	55	35	16	27	12	38
Louisiana	36	22	66	27	16	27	46	16
Maine	—	—	—	—	—	—	—	—
Maryland	41	17	90	1	12	32	34	23
Massachusetts	86	1	79	11	75	2	93	1
Michigan	69	3	45	39	59	4	80	3
Minnesota	24	30	75	16	17	25	7	42
Mississippi	—	—	—	—	7	38	51	12
Missouri	32	24	62	29	21	23	18	33
Montana	45	13	35	42	37	11	48	14
Nebraska	11	38	72	19	6	40	6	43
Nevada	27	28	86	5	19	24	4	47
New Hampshire	—	—	—	—	30	13	60	9
New Jersey	47	12	81	9	31	12	17	34
New Mexico	50	10	42	40	41	7	45	18
New York	56	6	79	12	39	9	46	17
North Carolina	12	36	88	3	3	47	8	41
North Dakota	—	—	—	—	22	22	71	7
Ohio	42	16	67	25	26	16	33	24
Oklahoma	10	39	72	19	4	44	11	39
Oregon	51	9	83	7	27	15	36	21
Pennsylvania	66	5	58	32	42	5	77	5
Rhode Island	54	7	64	28	37	10	48	14
South Carolina	19	34	84	6	5	42	19	31
South Dakota	—	—	—	—	3	46	57	10
Tennessee	2	42	68	23	2	48	2	48
Texas	9	40	48	38	6	40	10	40
Utah	37	20	72	19	11	33	62	8
Vermont	—	—	—	—	—	—	—	—
Virginia	37	20	88	2	9	36	40	19
Washington	52	8	87	4	24	19	36	21
West Virginia	—	—	—	—	—	—	—	—
Wisconsin	26	29	61	30	10	34	25	26
Wyoming	5	41	40	41	5	43	6	44

Notes: “—” indicates insufficient data to produce an overall or dimension-specific score. Groups missing at least one dimension score were not eligible for an overall performance score. “Percentile score” is the 1-100 percentile that the state/population group falls in among the full distribution of all groups with available data. Refer to [Study Methods](#) for methodological detail.

## APPENDIX B2E. Summary of State Health System Performance Rankings and Scores for White Populations

State	Overall		Outcomes		Access		Quality and Use	
	Percentile score (1-100)	Rank among white populations (51 states)	Percentile score (1-100)	Rank among white populations (51 states)	Percentile score (1-100)	Rank among white populations (51 states)	Percentile score (1-100)	Rank among white populations (51 states)
Alabama	60	41	32	45	66	38	75	36
Alaska	63	37	75	7	54	45	50	49
Arizona	76	27	58	18	73	31	81	29
Arkansas	52	47	28	48	65	39	61	46
California	89	10	74	8	90	10	85	25
Colorado	87	12	85	2	74	29	90	17
Connecticut	97	3	80	5	96	6	99	3
Delaware	87	12	47	30	88	14	96	8
District of Columbia	100	1	96	1	99	2	100	1
Florida	67	34	44	33	55	44	78	34
Georgia	66	36	39	39	57	43	79	33
Hawaii	95	5	84	3	88	13	98	5
Idaho	57	45	61	16	48	49	50	49
Illinois	79	22	49	27	84	18	82	27
Indiana	60	41	33	44	75	28	67	42
Iowa	85	15	48	29	89	12	93	12
Kansas	74	30	40	38	80	21	82	27
Kentucky	54	46	26	50	74	29	63	44
Louisiana	58	43	34	43	71	32	65	43
Maine	77	25	46	31	80	21	85	25
Maryland	93	6	61	16	97	4	98	5
Massachusetts	98	2	77	6	99	3	99	2
Michigan	81	20	41	37	90	10	88	20
Minnesota	92	7	74	8	86	15	96	9
Mississippi	38	51	27	49	45	50	53	48
Missouri	58	43	37	40	57	42	70	41
Montana	70	33	65	11	68	35	71	40
Nebraska	81	20	50	26	77	25	95	10
Nevada	62	39	37	40	65	39	73	39
New Hampshire	89	11	58	19	91	9	91	15
New Jersey	90	8	63	12	94	7	90	17
New Mexico	72	31	51	24	76	26	77	35
New York	90	8	63	12	97	4	87	22
North Carolina	79	22	45	32	70	34	98	5
North Dakota	76	28	63	12	71	32	81	29
Ohio	67	34	35	42	78	23	73	38
Oklahoma	46	50	29	47	51	48	57	47
Oregon	77	25	62	15	78	24	80	31
Pennsylvania	83	17	42	36	92	8	92	13
Rhode Island	96	4	53	22	100	1	98	4
South Carolina	72	31	44	33	62	41	90	16
South Dakota	75	29	51	24	67	36	86	23
Tennessee	62	39	31	46	67	36	80	31
Texas	63	38	44	33	52	46	74	37
Utah	78	24	82	4	51	47	87	21
Vermont	84	16	55	21	86	15	90	17
Virginia	83	18	52	23	81	20	94	11
Washington	86	14	66	10	83	19	92	13
West Virginia	48	49	21	51	76	26	63	44
Wisconsin	83	18	56	20	85	17	86	23
Wyoming	51	48	49	27	36	51	49	51

Notes: “—” indicates insufficient data to produce an overall or dimension-specific score. Groups missing at least one dimension score were not eligible for an overall performance score. “Percentile score” is the 1-100 percentile that the state/population group falls in among the full distribution of all groups with available data. Refer to [Study Methods](#) for methodological detail.



## APPENDIX C. Indicator Descriptions and Source Notes

### ABBREVIATIONS

ACS PUMS = American Community Survey, Public Use Micro Sample

BRFSS = Behavioral Risk Factor Surveillance System

CDC = Centers for Disease Control and Prevention

CMS = Centers for Medicare and Medicaid Services

CPS ASEC = Current Population Survey, Annual Social and Economic Supplement

LDS = Limited Data Set

NCCDPHP = National Center for Chronic Disease Prevention and Health Promotion

NCHS = National Center for Health Statistics

NCIRD = National Center for Immunization and Respiratory Diseases

NIS-PUF = National Immunization Survey, Public Use Data File

NSCH = National Survey of Children's Health

NVSS-I = National Vital Statistics System-Linked Birth and Infant Death Data

NVSS-M = National Vital Statistics System-Mortality Data

WONDER = Wide-ranging Online Data for Epidemiologic Research

### Definitions for Indicators

#### HEALTH OUTCOMES

##### 1. Mortality amenable to health care, deaths per 100,000

**population:** Number of deaths before age 75 per 100,000 population that resulted from causes considered at least partly treatable or preventable with timely and appropriate medical care (see list), as described in Ellen Nolte and Martin McKee, "Measuring the Health of Nations: Analysis of Mortality Amenable to Health Care," *BMJ* 327, no. 7424 (Nov. 13, 2003): 1129-32. Authors' analysis of mortality data from CDC restricted-use Multiple Cause-of-Death file (NCHS) and U.S. Census Bureau population data, 2018-2019.

#### Causes of death (ages)

Intestinal infections (0-14)

Tuberculosis (0-74)

Other infections (diphtheria, tetanus, septicaemia, poliomyelitis) (0-74)

Whooping cough (0-14)

Measles (1-14)

Malignant neoplasm of colon and rectum (0-74)

Malignant neoplasm of skin (0-74)

Malignant neoplasm of breast (0-74)

Malignant neoplasm of cervix uteri (0-74)

Malignant neoplasm of cervix uteri and body of uterus (0-44)

Malignant neoplasm of testis (0-74)

Hodgkin's disease (0-74)

Leukemia (0-44)

Diseases of the thyroid (0-74)

Diabetes mellitus (0-49)

Epilepsy (0-74)

Chronic rheumatic heart disease (0-74)

Hypertensive disease (0-74)

Cerebrovascular disease (0-74)

All respiratory diseases (excluding pneumonia and influenza) (1-14)

Influenza (0-74)

Pneumonia (0-74)

## APPENDIX C. Indicator Descriptions and Source Notes (continued)

Peptic ulcer (0–74)

Appendicitis (0–74)

Abdominal hernia (0–74)

Cholelithiasis and cholecystitis (0–74)

Nephritis and nephrosis (0–74)

Benign prostatic hyperplasia (0–74)

Maternal death (all ages)

Congenital cardiovascular anomalies (0–74)

Perinatal deaths, all causes, excluding stillbirths (all ages)

Misadventures to patients during surgical and medical care (all ages)

Ischemic heart disease: 50% of mortality rates included (0–74)

2. **Infant mortality, deaths per 1,000 live births:** Authors' analysis of NVSS-I, 2017–2018 (NCHS), retrieved using CDC WONDER.
3. **Breast cancer age-adjusted deaths per 100,000 female population:** Authors' analysis of NVSS-M, 2018–19 (NCHS), retrieved using CDC WONDER.
4. **Colorectal cancer age-adjusted deaths per 100,000 population:** Authors' analysis of NVSS-M, 2018–19 (NCHS), retrieved using CDC WONDER.
5. **Thirty-day hospital readmissions for adults age 65 and older, per 1,000 Medicare beneficiaries:** All hospital admissions among fee-for-service Medicare beneficiaries age 65 and older who were readmitted within 30 days of an acute hospital stay for any cause. A correction was made to account for likely transfers between hospitals. Analysis of the 2019 LDS 5% sample of Medicare claims (CMS) by Angelina Lee and Kevin Neipp, Westat. Race data only available for Black and white populations—ethnicity is unknown.
6. **Adults who smoke:** Percent of adults ages 18 and older who ever smoked 100 or more cigarettes (five packs) and currently smoke every day or some days. Authors' analysis of 2019–20 BRFSS (CDC, NCCDPHP).
7. **Adults who are obese:** Percent of adults ages 18–64 who are obese (Body Mass Index [BMI]  $\geq$  30). BMI was calculated based on reported height and weight. Authors' analysis of 2019–20 BRFSS (CDC, NCCDPHP).
8. **Adults who have lost six or more teeth:** Percent of adults ages 18–64 who have lost 6 or more teeth due to tooth decay, infection, or gum disease. Authors' analysis of 2018 and 2020 BRFSS (CDC, NCCDPHP).

## HEALTH CARE ACCESS

9. **Adults ages 19–64 uninsured:** Percent of adults ages 19–64 without health insurance coverage. Authors' analysis of 2019 one-year ACS PUMS (U.S. Census Bureau).
10. **Children ages 0–18 uninsured:** Percent of children ages 0–18 without health insurance coverage. Authors' analysis of 2019 one-year ACS PUMS (U.S. Census Bureau).
11. **Adults who went without care because of cost in the past year:** Percent of adults age 18 and older who reported a time in the past 12 months when they needed to see a doctor but could not because of cost. Authors' analysis of 2019–20 BRFSS (CDC, NCCDPHP).
12. **Individuals with high out-of-pocket medical spending:** Percent of individuals residing in households where all residents are under age 65 with out-of-pocket medical spending that equaled 10 percent or more of income, or 5 percent or more of income if low-income (under 200% of federal poverty level), not including over-the-counter drug costs or health insurance premiums. This measure is limited to individuals who are insured and is different from a similar measure reported in the Commonwealth Fund State Scorecard that includes insured and uninsured individuals. Two years of data are combined to ensure adequate sample size for state-level estimation. Analysis of 2019 and 2020 CPS ASEC (U.S. Census Bureau) by Mikaela Springsteen, Robert F. Wagner School of Public Service, New York University.
13. **Adults with a usual source of care:** Percent of adults ages 18 and older who had one (or more) person they think of as their personal health care provider. Authors' analysis of 2019–20 BRFSS (CDC, NCCDPHP).

## QUALITY AND USE OF HEALTH CARE SERVICES

14. **Admissions for ambulatory care-sensitive conditions for adults age 65 and older, per 1,000 Medicare beneficiaries:** Hospital admissions for one of the following eight ambulatory care-sensitive (ACS) conditions: long-term diabetes complications, lower extremity amputation among patients with diabetes, asthma or chronic obstructive pulmonary disease, hypertension, congestive heart failure, dehydration, bacterial pneumonia, and urinary tract infection. Analysis of the 2019 LDS 5 percent sample of Medicare claims (CMS) by Angelina Lee and Kevin Neipp, Westat. Race data only available for Black and white populations—ethnicity is unknown.
15. **Potentially avoidable emergency department (ED) visits for adults age 65 and older, per 1,000 Medicare beneficiaries:** Potentially avoidable ED visits were those that, based on diagnoses recorded during the visit and the

## APPENDIX C. Indicator Descriptions and Source Notes (continued)

health care service the patient received, were considered to be either nonemergent (care was not needed within 12 hours), or emergent (care needed within 12 hours) but that could have been treated safely and effectively in a primary care setting. This definition excludes any ED visit that resulted in an admission, as well as ED visits where the level of care provided in the ED was clinically indicated. This approach uses the New York University Center for Health and Public Service Research emergency department algorithm developed by John Billings, Nina Parikh, and Tod Mijanovich (see: *Emergency Room Use—The New York Story*, Commonwealth Fund, Nov. 2000). Analysis of the 2019 LDS 5 percent sample of Medicare claims (CMS) by Angelina Lee and Kevin Neipp, Westat. Race data only available for Black and white populations—ethnicity is unknown.

- 16. Adult women who received a mammogram:** Percent of women ages 50–74 who received a mammogram in the past two years. Authors' analysis of 2018 and 2020 BRFSS (CDC, NCCDPHP).
- 17. Adult women who received a cervical cancer screening test:** Percent of women ages 25–64 who received a pap smear in the past three years. Authors' analysis of 2018 and 2020 BRFSS (CDC, NCCDPHP).
- 18. Adults who received a colon cancer screening test:** Percent of adults ages 50–74 who received a sigmoidoscopy or a colonoscopy in the past 10 years or a fecal occult blood test in the past two years. Authors' analysis of 2018 and 2020 BRFSS (CDC, NCCDPHP).
- 19. Adults who received a recent flu vaccine:** Percent of adults age 18 and older who received a flu shot in the past year. Authors' analysis of 2019–20 BRFSS (CDC, NCCDPHP).
- 20. Older adults who received the pneumonia vaccine:** Percent of adults age 65 and older who ever received a pneumonia vaccine. Authors' analysis of 2019–20 BRFSS (CDC, NCCDPHP).
- 21. Children with a medical and dental preventive care visit in the past year:** Percent of children ages 0–17 who had a preventive medical visit and, if ages 1–17, a preventive dental visit in the past year, according to parents' reports. For more information, see [www.childhealthdata.org](http://www.childhealthdata.org). Authors' analysis of 2019–20 NSCH (U.S. Census Bureau & Data Resource Center for Child and Adolescent Health). Race/ethnicity data available for this report for Black (non-Latinx/Hispanic), white (non-Latinx/Hispanic) and Latinx/Hispanic (any race) populations.
- 22. Children ages 19–35 months who received all recommended vaccines:** Percent of children ages 19–35 months who received at least 4 doses of diphtheria, tetanus, and acellular pertussis (DTaP/DT/DTP) vaccine; at least 3 doses of poliovirus vaccine; at least one dose of measles-containing vaccine (including measles-mumps-rubella (MMR) vaccine); the full series of Haemophilus influenzae type b (Hib) vaccine (three or four doses depending on product type); at least three doses of hepatitis B vaccine (HepB); at least one dose of varicella vaccine, and at least four doses of pneumococcal conjugate vaccine (PCV). Data from the 2019 NIS-PUF (CDC, NCIRD). Race/ethnicity data available for this report for Black (non-Latinx/Hispanic), white (non-Latinx/Hispanic) and Latinx/Hispanic (any race) populations.
- 23. Adults without a dental visit in past year:** Percent of adults age 18 and older who did not visit a dentist or dental clinic within the past year. Authors' analysis of 2018 and 2020 BRFSS (CDC, NCCDPHP).
- 24. Primary care as a share of total Medicare spending for adults age 65 and older, Medicare beneficiaries:** Share of Medicare fee-for-service health care spending attributed to primary care for each population group within a state. We based our approach on the method used by Reid, Damberg, and Friedberg (*JAMA* 2019) that characterizes a “broad” definition for primary care provider types and a “broad” definition of included services. Under this “broad/broad” definition, we include all professional services billed by physicians, physician assistants, and nurse practitioners in family medicine, internal medicine, general practice, geriatric medicine, and obstetrics and gynecology; hospitalists are excluded. Analysis of the 2019 LDS 5 percent sample of Medicare claims (CMS) by Angelina Lee and Kevin Neipp, Westat. Race data only available for Black and white populations—ethnicity is unknown.



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