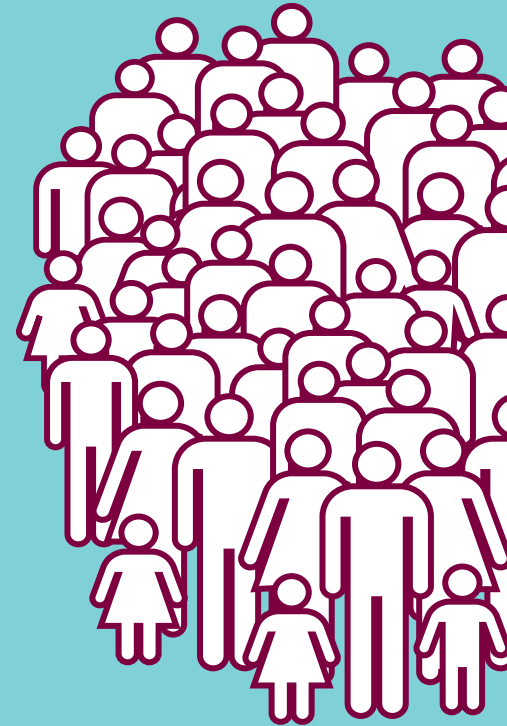




HEALTH CARE IN THE **TWO** **AMERICAS**



EXECUTIVE SUMMARY

Findings from the Scorecard on
State Health System Performance
for Low-Income Populations, 2013

Cathy Schoen, David Radley, Pamela Riley,
Jacob Lippa, Julia Berenson,
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ABSTRACT The Commonwealth Fund's *Scorecard on State Health System Performance for Low-Income Populations, 2013*, identifies opportunities for states to improve their health systems for economically disadvantaged populations and provides state benchmarks of achievement. Analyzing 30 indicators of access, prevention and quality, potentially avoidable hospital use, and health outcomes, the *Scorecard* documents sharp health care disparities among states. Between leading and lagging states, up to a fourfold disparity in performance exists on a range of key health care indicators for low-income populations. There are also wide differences within states by income. If all states could reach the benchmarks set by leading states, an estimated 86,000 fewer people would die prematurely and tens of millions more adults and children would receive timely preventive care. Moreover, many benchmarks for low-income populations in the top states were better than average and better than those for higher-income or more-educated individuals in the lagging states.

Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff. This and other Fund publications are available online at www.commonwealthfund.org. To learn more about new publications when they become available, visit the Fund's website and [register to receive email alerts](#).
Commonwealth Fund pub. no. 1700.

EXECUTIVE SUMMARY

Ensuring that all people have equal access to high-quality health care to help them live healthy and productive lives is a core goal of a high performance health system. In the United States, however, where you live matters, particularly if you have low income. In many states, there is a wide gulf in access to and quality of care between those with below-average income and the rest of society.

Recognizing the importance of families' economic status for affordable access to care and health status, The Commonwealth Fund's *Scorecard on State Health System Performance for Low-Income Populations, 2013*, aims to identify opportunities for states to improve how their health system serves their low-income populations and to provide benchmarks of achievement tied to the top-performing states. Based on its assessment of 30 indicators of access, prevention and quality, potentially avoidable hospital use, and health outcomes, the *Scorecard* documents sharp disparities among states in each of these areas.

The analysis finds that raising state health system performance to the top benchmark levels would make a critical difference for low-income populations. Between the leading and lagging states, there is often up to a fourfold disparity in performance on indicators of timely access to care, risk for potentially preventable medical complications, lower-quality health care, and premature death, affecting millions of Americans. If all states could reach the benchmarks set by leading states for more advantaged populations, an estimated 86,000 fewer people would die prematurely, with potential gains of 6.8 million years of life; 750,000

fewer low-income Medicare beneficiaries would be unnecessarily prescribed high-risk medications; and tens of millions of adults and children would receive timely preventive care necessary to lessen the impact of chronic disease and help avoid the need for hospitalization.

Notably, the *Scorecard* finds that having low income does not have to mean below-average access, quality, or health outcomes. In fact, in the top states, many of the health care benchmarks for low-income populations were better than average *and* better than those for higher-income or more-educated individuals in the lagging states. With new nationally funded expansions of health insurance and an array of new resources and tools, all states will have a historic opportunity to greatly improve health and health care for vulnerable populations across the country.

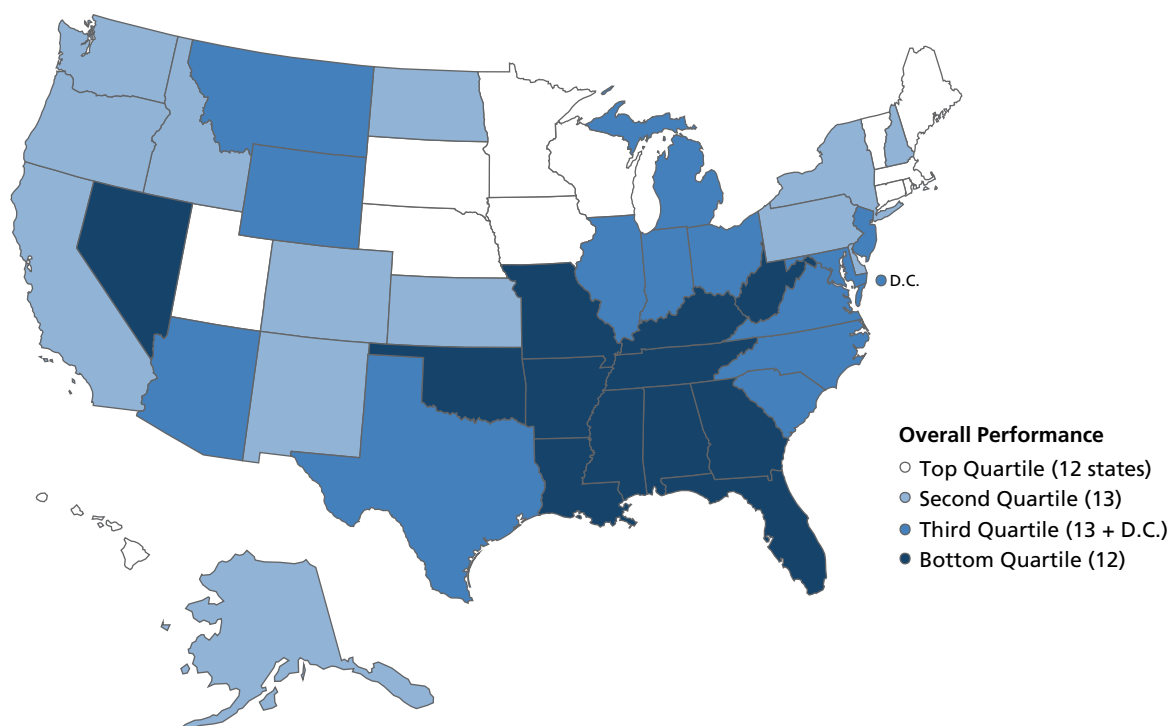
HIGHLIGHTS AND KEY FINDINGS

Where you live matters: For low-income populations, there are wide differences across states in access, quality and safety, and health outcomes.

Overall, the report finds that there are often two Americas when it comes to health care—divided by geography and income (Exhibit 1). Wide state differences in health care for low-income populations are particularly pronounced in the areas of affordable access to care, preventive care, dental disease, prescription drug safety, potentially preventable hospitalization, and premature death. Nationally, as of 2010–11, over half (55 percent) of the under-65 population with incomes below 200 percent of poverty—

In this *Scorecard*, we categorize individuals as low income if their annual income was under 200 percent of the federal poverty level. In 2013, this is \$22,980 for a single person or \$47,100 for family of four. Nationally, nearly 40 percent of the U.S. population meets this definition. Where income data were not available, we relied on education or community income as proxies for vulnerable socioeconomic status. On the Commonwealth Fund website, the [Health System Data Center](#) displays all data, compares each state to benchmarks set by the leading states, and provides analysis of the potential gains for each state if it were to improve its performance on selected indicators to the state benchmark levels attained for either low-income/less-educated or more-advantaged populations.

OVERALL HEALTH SYSTEM PERFORMANCE FOR LOW-INCOME POPULATIONS



Source: Commonwealth Fund Scorecard on State Health System Performance for Low-Income Populations, 2013.

nearly 57 million people—were either uninsured, or if insured, were spending a relatively high share of their incomes on medical care. This is sometimes referred to as being “underinsured.” The percentage uninsured or underinsured ranged from a low of 36 percent in Massachusetts to over 60 percent in 10 states (Alaska, Colo., Fla., Idaho, Mont., Nev., N.M., Texas, Utah, and Wyo.).

Looking across states, a lack of timely, affordable access to care—in particular, primary care—is undermining health outcomes and contributing to higher medical costs:

- Among low-income adults age 50 or older, just 22 percent to 42 percent received recommended preventive care. This means that even in the leading state, fewer than half of low-income older adults received recommended cancer screenings and vaccines for their age and gender.

- In 22 states, 30 percent or more of low-income Medicare beneficiaries were prescribed medications that are considered high-risk.
- Among adults from low-income communities, rates of hospital admissions for respiratory disease or diabetes complications were four times higher in the worst-performing states compared with the top performers. For children in low-income communities, there was a more than eightfold spread between the highest and lowest state rates of hospitalization for asthma.

The *Scorecard* also finds wide state differences in health outcomes for low-income and less-educated populations. There was a two- to threefold spread between leading and lagging states in premature death before age 75, infant mortality, smoking, obesity, and dental disease or tooth loss. States with the worst health outcomes on a single indicator tended to do poorly on multiple indicators.

Strikingly, the *Scorecard* finds much less state variation in health and health care experiences among people with higher incomes. The notable exception was unsafe prescribing: states with high rates of potentially unsafe prescribing were high for both higher- and lower-income Medicare beneficiaries.

Health system performance for low-income populations in leading states is often better than the national average and the high-income populations in other states.

The strong performance of leading states and the more positive experiences of low-income or less-educated populations in those states indicate having a low income does not have to mean worse care experiences or health. For all but six indicators, the experiences of low-income individuals in top-performing states exceeded the national average for all incomes. And for half the indicators, including receipt of medications that put health at risk, potentially preventable hospitalization, infant mortality, smoking, and obesity, the leading states' rates for their low-income populations was better than those of higher-income populations in other states.

States in the Upper Midwest and Northeast and Hawaii performed best overall for low-income populations.

The six leading states, Hawaii, Wisconsin, Vermont, Minnesota, Massachusetts, and Connecticut, did well across all four performance dimensions (Exhibit 2). Each ranked in the top half of states for the majority of the 30 indicators, particularly those related to access, prevention, and treatment. These leading states had among the lowest rates of uninsured adults, contributing to more positive health care and health outcomes.

At the other end of the spectrum, the Southern and South Central states often lagged other states (Exhibit 2). The 12 states in the lowest quartile performed below average for more than half of the available performance indicators. All these states have high

uninsured rates, low rates of preventive care, high rates of potentially avoidable hospital use from complications of disease, and significantly worse health outcomes on multiple indicators.

Notably, states at the bottom have among the highest poverty rates—with nearly half their total population having a low income (under 200% of poverty) or at most a high school education. With such a high share of the state population's health and well-being at risk, even modest gains would represent substantial gains for the entire state in healthier, more productive lives and potentially lower costs of health care. For such high-poverty states, federal resources to expand coverage and invest in local health systems offer significant new opportunities to improve their population's health and care experiences.

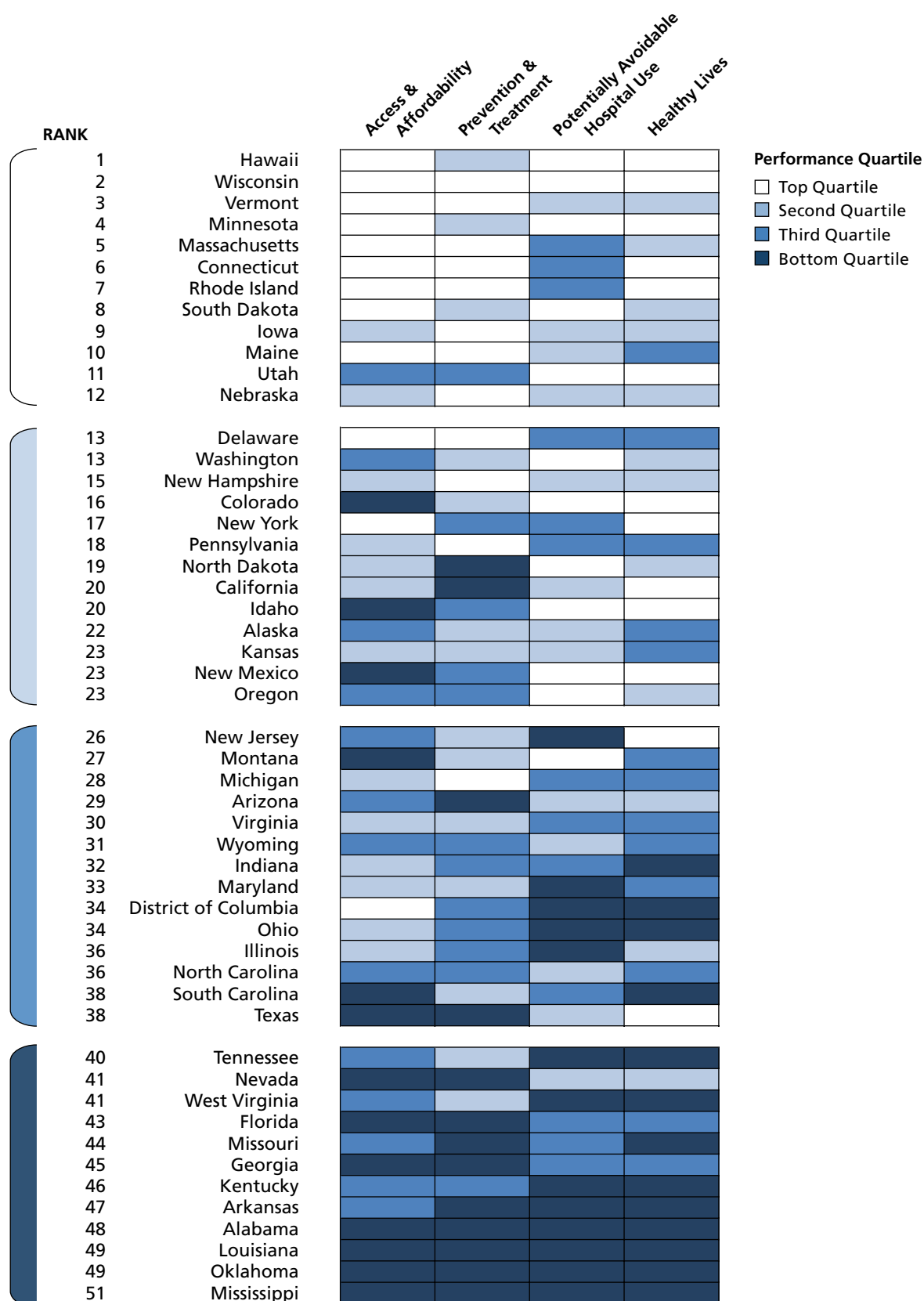
All states have room to improve. No state was in the top quartile or top half of the range of states for all 30 indicators, and nine of the 10 top-ranked states overall had at least four indicators in the bottom half of the state distribution.

Income-related health care disparities exist within states and across all areas of health system performance.

To establish benchmarks for performance, the *Scorecard* also compared experiences of low-income or less-educated populations in each state to those with higher income (i.e., above 400% of poverty) or more education (i.e., college degree or higher). Lower-income populations are at increased risk of experiencing worse access, lower-quality care—particularly in outpatient settings—and worse health outcomes compared to those with higher incomes in their home state. Income-related disparities were most pronounced on measures of access, prevention, potentially unsafe prescription medication, and health outcomes.

In all states, low-income adults age 50 or older were less likely to receive preventive care than were higher-income adults, reflecting, in part, the much

SUMMARY OF HEALTH SYSTEM PERFORMANCE FOR LOW-INCOME POPULATIONS



Source: Commonwealth Fund Scorecard on State Health System Performance for Low-Income Populations, 2013.

higher rates of low-income adults who are uninsured. In Kentucky, Idaho, and California, for example, rates of preventive care among higher-income older adults were double the levels reported by those with low incomes.

However, care patterns continue to differ by income even when adults are insured. The *Scorecard* reveals a pattern across all states, except Hawaii, of low-income Medicare beneficiaries being at greater risk than higher-income beneficiaries for receiving medications generally not recommended because of age or health.

In all states, premature death rates were markedly higher among those with a high school education or less than they were for the college-educated. In 42 states, years of potential life lost before age 75 for college-educated residents age 25 and older were below 5,000 per 100,000 population. However, in all but three states, years lost for those with at most a high school degree were above 10,000 per 100,000.

Health insurance coverage expansions hold promise to begin closing gaps in primary care and prevention. Broader gains will require improvements to health care delivery and a greater focus on population health.

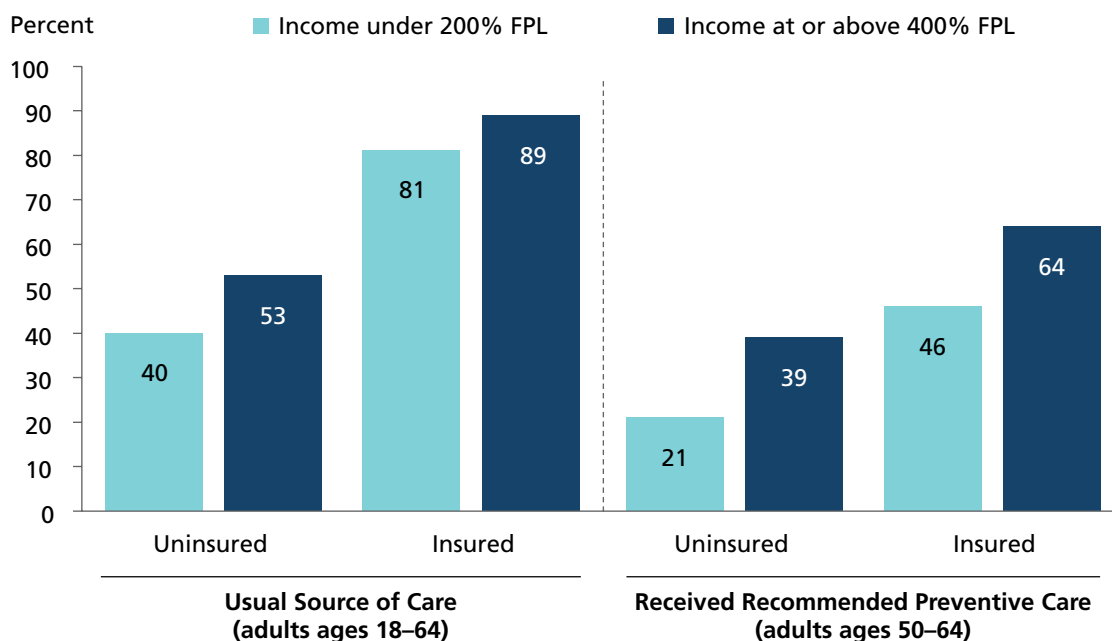
Our findings across states indicate that expanding insurance coverage will begin to close the income and geographic divide. In multiple states, insured low-income individuals report a similar rate of having a usual source of care and receiving recommended preventive care as high-income adults (Exhibit 3).

However, the care experiences of low-income Medicare beneficiaries, all of whom have insurance, show that there are additional opportunities to improve health system performance. For example, the *Scorecard* finds that one-third of all emergency department (ED) visits by low-income Medicare beneficiaries (i.e., those also receiving Medicaid) are potentially preventable with more accessible primary care. There is a more than twofold variation across states in the potentially avoidable ED use indicator (Exhibit

EXECUTIVE SUMMARY

EXHIBIT 3

HAVING A USUAL SOURCE OF CARE AND OLDER ADULTS WHO RECEIVED RECOMMENDED PREVENTIVE CARE, BY INCOME AND INSURANCE STATUS



Note: FPL denotes federal poverty level.

Data: Adults with a usual source of care—2011 BRFSS; Adults who received recommended preventive care—2010 BRFSS.

Source: Commonwealth Fund Scorecard on State Health System Performance for Low-Income Populations, 2013.

4). Efforts to improve health care delivery, particularly primary care, and public health could lower the need for emergency department visits and the risks of receiving an unsafe prescription drug, being admitted or readmitted to hospitals, and dying prematurely or having a disability.

Also required are targeted approaches for pockets of health care need across the country, such as communities with high rates of potentially avoidable hospital admissions among low-income children with asthma and adults with chronic lung disease. Successful intervention in these health care “hot spots” will likely require a combination of enhanced primary care and collaboration with community, social, and public health resources. The same is true for combatting higher state rates of smoking, obesity, infant mortality, and premature death in vulnerable populations. Acting early to reduce risks to health from unsafe workplaces, homes, communities, or behaviors would result in a healthier overall population and reduce health care costs over time.

Potential gains from raising the bar and bridging the income divide

If health care access and care experiences among vulnerable populations in all states were to attain state benchmarks for higher-income or otherwise more-advantaged populations, we might see the following gains:

- Over 30 million more low-income adults and children would have health insurance—reducing the number of uninsured by more than half.
- About 34 million fewer low-income individuals would face high out-of-pocket medical costs relative to their annual income and about 21 million fewer low-income adults would go without needed care because of cost.
- About 11 million additional low-income adults over age 50 would receive timely preventive care, including cancer screenings and immunizations.

- 750,000 fewer low-income Medicare beneficiaries would receive an unsafe prescription drug.
- There would be over 300,000 fewer readmissions within 30 days of hospital discharge among low-income Medicare beneficiaries.
- Fewer people would die prematurely, resulting in about 6.8 million potential years of life to work and participate in communities, or 86,000 fewer deaths each year assuming average life expectancy.
- 33,000 more infants born to mothers with a high school diploma or less would survive to see their first birthday.
- Nearly 9 million fewer low-income adults under age 65 would lose six or more teeth because of tooth decay, infection, or gum disease.

SUMMARY

Improving health system performance for vulnerable populations no matter where people live is within our grasp as a nation. By investing in improving the health of their most vulnerable, states would improve the overall health and economic well-being of their population. Healthier adults are less expensive to care for and have greater workforce productivity; healthier children are more likely to succeed in school and grow up to continue to participate in the workforce in the future. A healthy population is thus instrumental in maintaining strong local and state economies, as well as the nation’s economic health and well-being.

State and local care system action that leverages federal resources and builds on national initiatives will be critical to the success of efforts to improve access, health care, and health outcomes, particularly for those vulnerable because of low income. The *Scorecard’s* findings of high rates of uninsured, low rates of preventive and primary care, variable quality of care, and poor health outcomes for low-income populations underscore the potential gains from focused efforts to:

- Expand insurance, including Medicaid, and implement policies to hold insurance plans accountable for timely access to provider networks and quality care.
- Redesign care delivery systems, supported by payment reform, to provide enhanced, patient-centered primary care within care systems that provide effective, safe and coordinated care, with attention to population needs.
- Hold care delivery systems accountable for population health, including collaboration between health care, public health, and community-based services.

- Set targets or benchmarks to inform and guide strategic actions to improve.

When looking today at health care access, quality, and outcomes, we see two Americas, sharply defined by geography and income. As federal health reforms take hold and additional resources become available, state governments and local care delivery systems have a historic opportunity to address these inequities. By doing so, we will not only help close the gap, but we will improve the health system's performance for everyone in the U.S., regardless of geography or income.

ADDITIONAL SCORECARD HIGHLIGHTS

ACCESS AND AFFORDABILITY

- ♦ As of 2010–11, more than 32 million low-income adults and children were uninsured. Another 24.4 million were insured but in families with high out-of-pocket medical costs relative to their incomes.
- ♦ Uninsured rates among low-income adults vary fourfold across states, from a low of 12 percent in Massachusetts to 55 percent in Texas.

PREVENTION AND TREATMENT

- ♦ Just one-third (32%) of low-income older adults (age 50 or older) received appropriate preventive care screenings in 2010, ranging from 26 percent or less in the three lowest-rate states to just 42 percent in the top state—rates well below those for higher-income adults.
- ♦ The share of low-income children cared for by primary care practices that enable access and coordinate care (“medical homes”) ranged from 30 percent California to 60 percent in Vermont.
- ♦ The likelihood of a low-income Medicare beneficiary receiving medication that put their health at risk was nearly three times higher in Mississippi than in Massachusetts (45% vs. 17%). In eight states (Ala., Ark., Ga., La., Miss., Okla., S.C., Tenn.), 40 percent or more of low-income beneficiaries received potentially unsafe medications.

POTENTIALLY AVOIDABLE HOSPITAL USE

- ♦ Asthma-related hospitalizations among children living in low-income zip codes were eight times higher in New York (477 per 100,000) than in Oregon (56 per 100,000).
- ♦ Among low-income Medicare beneficiaries who also qualified for Medicaid (i.e., those dually enrolled), hospital admissions for ambulatory care-sensitive conditions such as pneumonia, diabetes, and heart failure were nearly two times higher in the five highest-rate states (Ky., W.Va., Ark., Tenn., and Okla.) than in the five lowest-rate states.
- ♦ The rate of potentially avoidable emergency room visits among low-income Medicare beneficiaries was at least twice the rate for those with higher incomes in 32 states.

HEALTHY LIVES

- ♦ One of four or more low-income adults under age 65 in West Virginia, Tennessee, Alabama, Mississippi and Kentucky lost six or more teeth because of decay or disease, compared with fewer than 10 percent in Connecticut, Hawaii, and Utah.
- ♦ Years of potential life lost before age 75 for people age 25 and older with at most a high school education ranged from less than 10,000 per 100,000 in Minnesota, California, and New York to more than 15,000 per 100,000 in nine states.

LIST OF 30 INDICATORS IN SCORECARD ON STATE HEALTH SYSTEM PERFORMANCE FOR LOW-INCOME POPULATIONS, 2013

		Total Population			Vulnerable Population			
		All-State Median	Top State Rate	Bottom State Rate	All-State Median	Top State Rate	Bottom State Rate	Top Three States*
ACCESS & AFFORDABILITY								
1	Percent of adults ages 19–64 uninsured (a)	19	6	31	38	12	55	MA, HI, VT
2	Percent of children ages 0–18 uninsured (a)	8	3	19	13	5	27	VT, HI, DC
3	Percent of adults who went without care because of cost in the past year (a)	16	9	23	29	16	38	HI, ME, MA
4	Percent of individuals with high out-of-pocket medical spending relative to their annual household income (a)	16	10	22	35	25	46	DC, NY, CA
5	Percent of adults without a dentist, dental hygienist, or dental clinic visit in the past year (a)	30	19	42	46	30	60	MN, MA, CT
PREVENTION & TREATMENT								
6	Percent of adults age 50 and older who received recommended screening and preventive care (a)	44	54	36	32	42	22	MA, DE, ME
7	Percent of adults with a usual source of care (a)	79	88	64	75	88	57	VT, ME, MA
8	Percent of children with a medical home (a)	57	69	45	47	60	30	VT, IA, WI
9	Percent of children with both a medical and dental preventive care visit in the past year (a)	69	81	56	62	79	50	VT, DC, MA
10	Percent of Medicare beneficiaries who received at least one drug that should be avoided in the elderly (b)	24	15	39	28	17	45	MA, HI, NY
11	Percent of Medicare beneficiaries with dementia, hip/pelvic fracture, or chronic renal failure who received prescription in an ambulatory care setting that is contraindicated for that condition (b)	19	12	29	26	16	36	VT, AK, ME
12	Percent of patients hospitalized for heart failure or pneumonia who received recommended care (c)	96	98	91	96	98	85	NE, MT, DE
13	Percent of surgical patients who received appropriate care to prevent complications (c)	98	98	95	97	99	92	MT, NE, VT
14	Risk-adjusted 30-day mortality among Medicare beneficiaries hospitalized for heart attack, heart failure, or pneumonia (c)	13	11	13	12	11	15	DC, IL, CA, CT, MD
15	Percent of hospitalized patients given information about what to do during their recovery at home (c)	83	89	77	83	90	67	VT, ID, NE, NH, UT
16	Percent of patients who reported hospital staff always managed pain well, responded when needed help to get to bathroom or pressed call button, and explained medicines and side effects (c)	66	73	57	64	75	52	ID, AK, NH, UT

LIST OF 30 INDICATORS IN SCORECARD ON STATE HEALTH SYSTEM PERFORMANCE FOR LOW-INCOME POPULATIONS, 2013

(continued)

		Total Population			Vulnerable Population			
		All-State Median	Top State Rate	Bottom State Rate	All-State Median	Top State Rate	Bottom State Rate	Top Three States*
POTENTIALLY AVOIDABLE HOSPITAL USE								
17	Hospital admissions for pediatric asthma, per 100,000 children (d)	116	43	230	160	56	477	OR, UT, SD
18	Potentially avoidable hospitalizations from respiratory disease among adults, per 100,000 (d)	672	369	1,161	1,002	400	1,589	HI, UT, OR
19	Potentially avoidable hospitalizations from complications of diabetes among adults, per 100,000 (d)	187	101	268	300	149	559	SD, OR, ME
20	Hospital admissions among Medicare beneficiaries for ambulatory care-sensitive conditions, per 100,000 beneficiaries (e)	5,477	2,928	8,475	10,928	5,623	16,891	HI, CA, UT
21	Potentially avoidable emergency department visits among Medicare beneficiaries, per 1,000 beneficiaries (e)	183	129	263	337	218	466	UT, HI, MN
22	Medicare 30-day hospital readmissions as a percent of admissions (e)	18	13	22	21	15	25	ID, MT, ND
23	Percent of long-stay nursing home residents hospitalized within a six-month period (f)	19	7	31	19	7	31	MN, OR, AZ, RI, UT
24	Percent of short-stay nursing home residents readmitted within 30 days of hospital discharge to nursing home (f)	20	12	26	20	12	26	UT, SD, ID
HEALTHY LIVES								
25	Years of potential life lost before age 75 among adults age 25 and older (g)	7,916	5,931	12,090	12,725	9,465	21,635	MN, CA, NY
26	Infant mortality, deaths per 1,000 live births (g)	7	5	12	8	6	12	CA, UT, NM
27	Percent of adults who smoke (a)	21	12	29	30	17	40	UT, CA, NJ
28	Percent of adults ages 18–64 who are obese (BMI ≥ 30) (a)	28	21	36	34	26	44	HI, NV, AK
29	Percent of adults ages 18–64 who report fair/poor health, 14 or more bad mental health days, or activity limitations (a)	34	27	43	47	35	61	HI, WI, UT
30	Percent of adults ages 18–64 who have lost six or more teeth because of tooth decay, infection, or gum disease (a)	9	5	20	16	8	31	CT, UT, HI

* As a result of ties, more than three states may be listed.

Vulnerable group defined as (see [Appendix B](#) for more detail):

(a) under 200% of the federal poverty level.

(b) low-income Medicare beneficiaries who received a subsidy to pay for their prescription drug benefits.

(c) safety-net hospitals.

(d) residence in a low-income zip code.

(e) Medicare beneficiaries who also are enrolled in Medicaid.

(f) all short- and long-stay nursing home patients.

(g) high school diploma (or equivalent) or less.

Source: Commonwealth Fund Scorecard on State Health System Performance for Low-Income Populations, 2013.

SCORECARD METHODOLOGY

The Commonwealth Fund's *Scorecard on State Health System Performance for Low-Income Populations, 2013*, uses 30 key indicators to measure health system performance for economically vulnerable populations, primarily focusing on low-income populations. The *Scorecard* groups the indicators into four dimensions that capture key aspects of health system performance:

Access and Affordability—Two indicators that show rates of insurance coverage for children and adults and three other indicators of access and affordability.

Prevention and Treatment—Eleven indicators that measure the receipt of preventive care and the quality of care in ambulatory and hospital settings.

Potentially Avoidable Hospital Use—Eight indicators of hospital use that might have been prevented or reduced with timely and effective care and follow-up care.

Healthy Lives—Six indicators that measure premature death and health risk behaviors.

The following principles guided the development of the *Scorecard*:

Performance Metrics: The 30 performance metrics selected for this report span the health care system and represent important aspects of care. Where possible, indicators build on the data used in previous state and local scorecards. The report also includes new indicators, including a measure of premature death and a measure of out-of-pocket spending on medical care relative to income.

Data Sources: Indicators draw from publicly available data sources, including government-sponsored surveys, registries, publicly reported quality indicators, vital statistics, mortality data, and administrative databases. The most current data available were used in this report. They are generally from 2010–11, though this varied by indicator. [Appendix B](#) provides detail on the data sources and time frames.

Scoring and Ranking Methodology: The scoring method follows previous state scorecards. States are first ranked from best to worst on each of the 30 performance indicators based on experience of the low-income group in that state. We averaged rankings for indicators within each dimension to determine a state's dimension rank and then averaged dimension rankings to determine overall ranking on health system performance. This approach gives each dimension equal weight, and within dimensions weights indicators equally.