

Concurrent Session A2–4

**Collection and Use of Race and Ethnicity Data for Quality Improvement:  
2006 AHIP-RWJF Survey of Health Insurance Plans**

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**Aims:** To assess the extent to which health plans collect and use race, ethnicity, and primary language data; highlight barriers to the collection of these data, and identify any trends and major differences from the 2003 survey.

**Background:** Several studies across decades have demonstrated that quality of care for racial and ethnic diverse populations is lower and these populations are at greater risk for certain diseases. There is a widespread agreement that valid and reliable race and ethnicity data are fundamental building blocks to identifying disparities, to developing programs that close the gaps in care, and to ensuring a higher standard of care.

**Methods:** In 2006, America's Health Insurance Plans (AHIP) and the Robert Wood Johnson Foundation (RWJF) collaborated to conduct a web-based survey instrument, that consisted of 42 questions with a core set of questions consistent with 2003 to allow for comparisons. In 2006, 156 of 260 targeted health plans responded, resulting in a 60% response rate and representing 87 million covered lives.

**Results:** In 2006, 67% of enrollees were represented by health plans that collected race and ethnicity data, compared to 54% in 2003. Three major reasons why plans collect race and ethnicity data are to support language and culturally appropriate communications to enrollees, identify racial and ethnic disparities in health, and to implement or strengthen quality improvement efforts. Commercial plans are offering language access services at the same rates as Medicare and Medicaid plans; although 53% of Commercial plans are collecting data on their enrollees' primary language, as compared to 89% of Medicare and Medicaid plans. The lack of good or reliable method for data collection continues to be a major concern among respondents that do not collect these data.

**Conclusions:** Health plans have made significant progress in collecting race and ethnicity data to identify differences in treatment, medication adherence, and prevalence of enrollees' chronic conditions that can be improved and managed through preventive and educational measures. Additional research is needed to identify effective strategies and interventions to close the gaps in care. AHIP's series of tools to address disparities can assist plans with collecting data and strengthening quality initiatives that are culturally and linguistically appropriate for all Americans.