

## Race, Ethnicity & Health Care Reform: Achieving Equity in Our Lifetime\*

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### Introduction:

The current health care reform proposals before Congress offer the potential for great progress in improving health care affordability, access and quality for Americans not seen for decades. While major provisions are intended to have a broad effect, they may have the most significant impact on minorities as they present the opportunity to redress longstanding inequities. Moreover, the leading bills which have emerged from House and Senate committees all explicitly recognize the need to reduce disparities as each includes provisions intended to support initiatives targeting racial/ethnic minorities and language access services. While all the bills offer solutions to reduce racial/ethnic disparities in health, each one differs in the level of its commitment and approach.

This issue brief identifies and analyzes provisions which explicitly address the health and health care needs of racial/ethnic minorities within the three leading Congressional health care reform proposals: the House Tri-Committee's *Affordable Health Choices Act of 2009* (H.R. 3200)<sup>§</sup>, the Senate Finance Committee's *America's Health Future Act* (S.1796), and Senate Committee on Health, Education, Labor, and Pensions' (HELP) *Affordable Health Choices Act* (S. 1697). Additionally, this issue brief explores the potential implications of broad legislative efforts to reform health care for racial/ethnic minorities. Through review of bill text, legislative analyses, published research and reports, this issue brief compares provisions within these bills on

the strengths of their diversity initiatives and other key provisions as they are likely to affect minorities. Final sections draw conclusions on the bills' support for decreasing disparities and improving minority health, identify related areas less fully developed that could further advance these goals, and discuss transitional challenges and questions for the future should health care reform legislation be enacted.

### Minority-Specific Provisions: Implications for Racially and Ethnically Diverse Patients and Communities

All three leading House and Senate bills directly integrate provisions intended to address racial/ethnic health inequalities and improve minority health. However, considerable differences exist in their scope, detail and focus along at least six dimensions.

- ***Data Collection and Reporting by Race, Ethnicity and Language.*** The lack of specificity, uniformity and quality of data collection and reporting procedures has been a significant limitation in identifying and monitoring efforts to reduce disparities.<sup>1</sup> As expressed in a report recently released by the Institute of Medicine (IOM), consistent methods for collecting and reporting health care data on racial and ethnic minorities are essential to informing evidence-based disparity reduction initiatives.<sup>2</sup> In addition to improving data collection across the broad Office of Budget and Management categories of race and ethnicity, information is needed on racial/ethnic sub-groups. Such data is critical to monitoring the health status and needs of immigrant populations and the approximately 100 different ethnic groups with populations over 100,000 living in the US.<sup>3</sup>

Both the House Tri-Committee and Senate HELP bills contain strong provisions to improve the depth and

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quality of data collected on health status, health care utilization and health outcomes by race, ethnicity and language (Table 1). The House Tri-Committee proposal includes a provision to establish a Bureau of Health Information which, in coordination with the Office of Minority Health (OMH), would develop standards for identifying, collecting, and reporting key health data by race, ethnicity, and language with the explicit goal of reducing health disparities. The Senate HELP bill would require all federally funded health care and public health programs to collect and report data on race, ethnicity, socioeconomic status, health literacy and primary language to the Department of Health and Human Services (DHHS). Efforts to improve data collection on minority health are less comprehensive in the Senate Finance bill; however the proposal does include a provision that would require the Centers for Medicare & Medicaid Services (CMS) to collect information on the primary language of Children’s Health Insurance Program (CHIP) enrollees and their parents.

All three bills propose to improve the collection of data on racial/ethnic sub-populations. The Senate Finance proposal includes a mandate which would require all federally-funded population surveys to collect information on these sub-groups sufficiently enough to produce statistically reliable results. The Senate HELP bill contains a similar provision on oversampling in federally-funded health programs, but only requires that such action be taken “if practicable.”

- **Workforce Diversity.** Racial and ethnic concordance between practitioners and patients as well as integrating diverse life experiences, knowledge and perspectives into health care have long been recognized as critical goals for improving patient care—yet efforts to increase diversity in the health care workforce have fallen short. For example, the plan of the Association of American Medical Colleges to take a major step forward, their “3,000 by 2000” (enrolling 3,000 underrepresented minorities in medical school by the year 2000) objective was less than fully achieved.<sup>4</sup> As a result, the proportion of minority physicians still falls well below their respective populations. For example, while Hispanics comprise approximately 12% of the US population, they account for less than 4% of all physicians. African Americans comprise a relatively similar

proportion of the nation’s population but only 5% of physicians in the health care workforce,<sup>5</sup> disparities which are likely to grow if left unattended as the nation grows increasingly diverse.

All three bills contain provisions intended to increase diversity in the health professions (Table 1). However, The House Tri-Committee and Senate HELP proposals contain robust provisions to increase diversity in all facets of the health care workforce, while initiatives proposed in the Senate Finance bill are limited to specific domains of care. In addition to reauthorizing the Centers of Excellence and Health Careers Opportunity Programs, the House Tri-Committee would provide grants to increase diversity in the primary care workforce and reauthorize Title VIII of the Public Health Services Act to increase diversity in the nursing professions. Similarly, the Senate HELP proposal would increase workforce diversity through reauthorization of Title VII and Title VIII programs. The Senate HELP bill is also the only one of the three proposals which would collect, and make publicly available, data on the diversity of the health care workforce.

Title VII and Title VIII programs have great potential to increase diversity, cultural competency and the number of health care professionals practicing in underserved areas<sup>6</sup>, yet the Senate Finance bill does not propose to reauthorize either of these programs.\* The Senate Finance bill would, however, provide grants and supportive services (e.g., childcare) to train low-income individuals for health care occupations. At-least three of such grants would be administered to Tribal entities.

**Table 1: Minority-Specific Provisions on Data Collection, Reporting and Workforce Diversity**

	House	HELP	Finance
<b>Data Collection &amp; Reporting by Race, Ethnicity and Language</b>			
Collect & report data by race, ethnicity, & language	✓	✓	
Collect data on racial/ethnic sub-populations	✓	✓	✓
Oversample racial/ethnic sub-populations		✓	✓
Collect data on primary language for CHIP Enrollees			✓
<b>Workforce Diversity</b>			
Expand diversity in the health care workforce overall	✓	✓	
Expand diversity in the nursing workforce	✓	✓	
Expand diversity among primary care providers	✓	✓	
Collect & report data on workforce diversity		✓	
Grants to support health care training in Tribal communities			✓

\* The Senate HELP Committee has jurisdiction over these programs; the Senate Finance Committee does not.

- **Cultural Competence Education and Training.** To improve quality of care for minority patients, health care and health profession education organizations have turned to cultural competence education and training opportunities. Such efforts have great potential to improve the overall quality of health care systems, care provided, and clinical experiences of racial/ethnic minorities.<sup>7</sup> Racial/ethnic minorities generally report experiencing poorer patient/provider interactions than whites, a disparity which is particularly pronounced among minorities who speak a primary language other than English.<sup>8</sup>

Significant differences exist between the Senate HELP bill and the other two legislative initiatives (Table 2). Specifically, the HELP bill excels by including provisions to: develop and evaluate cultural competence curricula; create an Internet clearinghouse for disseminating these resources; promote the use of cultural competence self-assessments; and provide related training for mental health providers. Each of the other bills identifies one initiative. The House Tri-Committee bill broadly proposes to support cultural competence training for health care professionals, while the Senate Finance Committee bill restricts cultural competence educational programs to personal and home care aids only.

- **Health Disparities Research.** Since the establishment of the Office of Minority Health in 1986 and the Office of Research on Minority Health in 1990, the Federal government has steadily increased resources to investigate health disparities causes and promote solutions. In 2003 National Institutes of Health (NIH) funding for minority health research exceeded \$2.13 billion, accounting for approximately 12% of the total NIH budget.<sup>9</sup>

Congress, especially the House Tri-Committee, proposes to continue support for, and advance the state of, health disparities research through health care reform (Table 2). In fact, the House bill contains at least five provisions addressing a range of priorities including: establishing a Comparative Effectiveness Research Commission that would focus on differences in health care service outcomes among racial/ethnic minorities; developing national priorities and measures for quality improvement to reduce health disparities (also in the Senate HELP bill); and sharing research with other federal agencies beyond DHHS to reduce health disparities. The House bill also proposes specific studies on language access

services among Medicare providers and a broader IOM study on language access.

The Senate HELP bill, while less expansive, proposes to enhance surveillance systems to track the prevalence of diseases related to environmental exposures with an explicit focus on minorities and to test cultural and language-sensitive patient navigation tools. The Senate Finance Committee identifies only an interagency collaboration initiative to share disparities research.

**Table 2: Minority-Specific Provisions on Cultural Competence Education and Health Disparities Research**

	House	HELP	Finance
<b>Cultural Competence Education &amp; Training</b>			
Cultural competence training for health professionals	✓		
Cultural competence training for mental health providers		✓	
Develop and evaluate cultural competence curricula		✓	
Central online clearinghouse on cultural competence curricula		✓	
Support for cultural competence self-assessment methods for providers		✓	
Cultural competence education for personal & home care aids			✓
<b>Health Disparities Research</b>			
Comparative Effective Research by race/ethnicity	✓		
Research on culturally & linguistically appropriate services in health care	✓		
Study on language access services provided by Medicare providers	✓		
Examine health disparities in collaboration with other federal agencies	✓		✓
Track disease prevalence associated with environmental exposures		✓	
Develop quality measures for reducing racial/ethnic health disparities	✓	✓	
IOM Study on impact of language access services on individuals with LEP	✓		
Test culturally and linguistically tailored patient navigation tools		✓	

- **Health Disparities Initiatives in Public Health and Prevention.** Addressing racial and ethnic disparities through public health and prevention offers the opportunity to intervene with large numbers of individuals and communities to stem the increase in acute and chronic diseases. Such initiatives offer the hope of reducing morbidity and mortality as well as reducing health care costs. Broad investments that foster a public health approach to reducing health disparities could yield positive results by addressing disparities within behavioral, social, economic, and environmental contexts.<sup>10</sup>

As with health disparities research, the House bill, and to a lesser extent the Senate HELP bill, have both introduced several provisions intended to support public health and prevention (Table 3). The House bill promotes establishing national priorities for reducing disparities, encourages active involvement of the

Office of Minority Health in developing prevention initiatives, includes a medical home pilot project focused on disparities reduction and supports community-based efforts such as health empowerment zones and other community-based strategies that attend directly to disparities reduction.

Like the House bill, the Senate HELP bill supports community-based preventive strategies. It is the only legislative proposal that targets oral health disparities, promotes the standardization of drug labeling through consultation with representatives of racial/ethnic minorities, and primary care Nurse-Managed Health Centers (NMHCs) directing specific attention to disparities reduction. The Senate Finance Committee includes only one provision—to establish national priorities for reducing disparities.

**Table 3: Minority-Specific Provisions on Health Disparities Initiatives in Public Health and Health Insurance Reform**

	House	HELP	Finance
<b>Health Disparities Initiatives in Public Health &amp; Prevention</b>			
Establish national priorities for reducing health disparities	✓		✓
Consult with OMH in establishing preventive priorities	✓		
Five-year national campaign on oral health & disparities		✓	
Fund Health Empowerment Zones, with emphasis on reducing disparities	✓		
Support for proven community-based strategies to reduce disparities	✓	✓	
Support for evaluation of Medical Home Pilot for reducing disparities	✓		
Standardize drug labeling in consultation with racial/ethnic minorities		✓	
Fund nurse-managed health centers to reduce primary care disparities		✓	
<b>Addressing Disparities in Health Insurance Reforms</b>			
Medicare payment systems for language services	✓		
Culturally & linguistically tailored outreach & enrollment services	✓		
Insurance exchange call centers with multilingual assistance			✓
Remove cost-sharing for Native Americans/Alaska Natives at 300% FPL			✓
Permit undocumented immigrants to purchase coverage through Exchanges	✓	✓	

- **Addressing Disparities in Insurance Reforms.** Given the historic lack of participation among a disproportionate number of minorities, facilitating access to health insurance for these patients is a critical ingredient to reducing related disparities. African Americans are nearly twice as likely to be uninsured than whites, while Hispanics are more than three times more likely.<sup>11</sup>

The House bill includes three provisions intended to maximize health insurance access for minorities, including the development of Medicare payment systems for language access services and a mandate for health insurance exchanges to provide

culturally/linguistically appropriate outreach services. Both the House and Senate HELP bills would permit undocumented immigrants to purchase coverage, albeit without federal subsidies, through health insurance exchanges—this population would be prohibited from purchasing such coverage in the Senate Finance proposal. The Senate Finance bill would, however, remove all cost-sharing requirements for American Indians and Alaska Natives (IA/AN) at or below 300% of the federal poverty level (FPL)—approximately 65% of the IA/AN population.<sup>12</sup>

## General Provisions: Implications for Racially and Ethnically Diverse Patients and Communities

The three leading health care reform bills in the House and Senate offer a range of provisions on at least five key areas of priority: health insurance reform; actions to improve access to health care; quality improvement; cost containment and social determinants of health. While these provisions may vary in scope and detail, they collectively are likely to improve availability of coverage, access to care, affordability and quality of care for low-income racial/ethnic minorities.

- **Health Insurance Reform to Expand Coverage and Affordability.** Racial/ethnic minorities comprise about one-third of the nation’s population, however, they make up over half of the 47 million uninsured.<sup>13</sup> In 2005, nearly two-thirds of Hispanic adults (15 million) and one-third of African American adults (6 million) were uninsured compared with 20 percent of white adults.<sup>14</sup>

Proposed health insurance reforms included in the three leading House and Senate bills offer a range of promising actions to expand access to health insurance (Table 4). General areas of strength and common ground across the three bills include: prohibition of exclusions or rate variations based on pre-existing conditions; standard essential benefit package with no cost-sharing for preventive services; an individual mandate for coverage; federal subsidies and credits to individuals, families and small businesses; and creation of insurance exchanges. Recognizing the high uninsured rate and increased likelihood for being denied coverage due to poor health and disease, these initiatives hold significant potential for expanding coverage for racial/ethnic minorities.

Among important provisions for minorities is the expansion of income thresholds for Medicaid eligibility, 150% poverty in the House Tri-Committee bill and 133% poverty in Senate Finance Committee bill. Such proposed expansions would extend Medicaid to nearly one-quarter of the nation's poorest minorities, and importantly to those living in states with extremely restrictive income eligibility requirements. For example, Texas, Alabama and other Southern states, have set their income eligibility for Medicaid well below 20% FPL to qualify.<sup>15</sup> These are also states with large numbers of minorities and highest adult uninsured rates in the country.<sup>16</sup> This policy will be an important step toward eliminating geographic disparities in health care coverage by leveling the playing field for Medicaid eligibility nationally.

Other concrete actions that are likely to have a large positive impact on minorities include employer-based health insurance reforms. Whereas 71% of working-age whites had health insurance through their workplace in 2005, only one-third of working-age Hispanics and half of working-age African Americans had employer-sponsored coverage.<sup>17</sup> While all three bills include provisions to increase employer responsibility for providing coverage to their workers, only the House Tri-Committee and Senate HELP bills explicitly mandate this. All three bills, however, offer tax credits for employers with 25 employees or fewer to assist them in providing coverage for their employees. The Senate HELP bill is the most generous, in that it extends these credits to firms with 50 or fewer employees. Given that over 90% of minority-owned firms have fewer than 25 employees (and an even larger percentage have fewer than 50) and that minorities are more likely to be employed by a small firm, this policy has the potential to expand coverage for a sizeable low-income minority population.<sup>18</sup>

**Table 4: General Provisions on Health Insurance Reform**

	House	HELP	Finance
Prohibit insurance exclusions or rate variations by pre-existing conditions	✓	✓	✓
Standard essential benefit package	✓	✓	✓
Individual mandate	✓	✓	✓
Subsidies/credits to individuals/families	✓	✓	✓
Insurance exchange for individuals and small businesses	✓	✓	✓
Subsidies/tax credits to small businesses	✓	✓	✓
Employer mandate and pay-or-play	✓	✓	
New public plan option	✓	✓	
Consumer Operated and Oriented Plan (CO-OP)	✓		✓
Medicaid expansion	✓		✓

Whereas both the House Tri-Committee and the Senate HELP bills propose to create a new public plan option, the Senate Finance Committee has no such provision. A new public plan would potentially offer an affordable health care coverage option for many uninsured and underinsured minorities as it is likely to have lower premiums and out-of-pocket expenses than private plans.<sup>19</sup>

- **Actions to Improve Access to Health Care.** Access to timely and needed health and medical care is a major challenge for minorities and their communities. A large body of research demonstrates the depth and breadth of these disparities throughout all aspects of care—from preventive and primary to specialty, inpatient and long term.

Embedded within all three bills are important actions for improving medical and health care access that would benefit minorities (Table 5). While specific strategies and details may vary, general areas of strengths and commonality across the three include: removing cost-sharing for preventive services; support for a Medical Home Model; and incentives/programs to expand primary care in underserved communities. Specifically, the House Tri-Committee would create monetary incentives through Medicare and Medicaid for providers in underserved areas, expand the National Health Service Corps to eliminate the shortfall in primary care providers, support primary care residency programs in community settings and establish a Medical Home Pilot Project to improve chronic disease management. Similarly, the Senate HELP Committee would expand primary care through funding for nurse-managed health centers and grants to create community health teams to support medical homes for patients. The Senate Finance Committee would redistribute unused Graduate Medical Education slots to primary care and general surgery in health profession shortage areas, establish Teaching Health Centers for residency programs in community settings, and create a medical home option for Medicaid enrollees with chronic conditions. Given that minorities are less likely to have a usual source of care or “medical home,” these initiatives have the potential to expand access to at least primary and preventive care.

Beyond these provisions, the House Tri-Committee and Senate HELP proposals include other concrete actions which are largely necessary to improving access for minorities. In particular, both offer explicit support for community health centers, which are a major

source of care for low-income and minority patients. Both also promote primary care and prevention in non-traditional community settings, another priority necessary for reaching poor and minority populations facing access barriers beyond health insurance (e.g., lack of transportation, cultural/linguistic barriers and availability of support services for child care).

Unique to the Senate HELP bills are two additional important initiatives with potential positive implications for minorities. First, given the frequent concentration of services in urban areas, the proposal to regionalize emergency and trauma care could significantly expand access to care for the nation’s growing poor and diverse communities in sprawling cities, suburbs and exurbs as well as in historically underserved rural areas with limited resources and capacity. Second, given that racial/ethnic minorities are more likely to have poor oral health and less likely to seek dental care, a five-year national oral health education campaign and school-based dental programs have the potential to reduce these disparities.

**Table 5: General Provisions to Improve Access to Medical Care**

	House	HELP	Finance
Remove cost-sharing for proven preventive services	✓	✓	✓
Support for the Medical Home Model	✓	✓	✓
Incentives/programs to expand primary care in underserved areas	✓	✓	✓
Support for primary care residency programs in community settings	✓		✓
Increase funding for community health centers	✓	✓	
Programs to strengthen public health training and workforce	✓	✓	
Support for workplace wellness programs		✓	✓
Expand preventive/primary care in community settings—e.g., schools	✓	✓	
Support for regional emergency care & trauma systems		✓	
National public health and prevention strategy	✓	✓	
Oral health campaign, dental sealant programs & water fluoridation		✓	
Support for post-partum depression services			✓

- **Quality Improvement.** It is well documented that the care that racial/ethnic minorities receive often falls short on the dimensions of high quality.<sup>20</sup> Improving quality of care will require a range of actions that support health care providers in the delivery of evidence-based medicine and services. These are likely to include establishing standard measures of quality, support for comparative effectiveness research on interventions and procedures, and transparency in reporting of quality data.

The three leading health care reform bills include a number of provisions to promote quality in the health care system (Table 6). Common areas of strengths include an emphasis on comparative effectiveness research and support for evidence-based community strategies. Specifically, the House Tri-Committee bill supports research on the effectiveness of health care services, establishes a Center for Quality Improvement, and proposes to establish Community Care Networks to improve the quality and continuity of care for primary, acute and long term care services. Similarly, the Senate HELP Committee proposes to create a Center for Health Outcomes Research and Evaluation to collect data and evaluate effectiveness and appropriateness of services and procedures. It would also support screening of community programs addressing chronic disease management to reduce medical errors and improve patient adherence. The Senate Finance bill also parallels the House and Senate HELP bills in that it proposes to create a Patient-Centered Outcomes Research Institute for comparative effectiveness research and also provides support for the evaluation of community-based services within Medicaid programs.

While not explicitly included in the Senate Finance bill, the House Tri-Committee and Senate HELP Committee both have a strong focus on the development of standard quality measures and public reporting. Nonetheless, the Senate Finance Committee, along with the House Tri-Committee, proposes to establish national priorities and strategies for quality improvement.

**Table 6: General Provisions on Quality Improvement**

	House	HELP	Finance
Comparative Effectiveness Research	✓	✓	✓
Evidence-based community strategies to quality of care	✓	✓	✓
Establish national quality improvement priorities and strategies	✓		✓
Establish a multi-stakeholder approach to develop quality measures	✓	✓	
Require public reporting of quality measures	✓	✓	
Establish a Center for Quality Improvement within AHRQ	✓		
Increase transparency of skilled nursing facilities	✓		
Regional grants encouraging cooperative efforts to improve quality	✓		
Pilot incentive program to reward quality for Medicare providers			✓

- **Cost Containment.** In addition to health insurance market reforms, improving efficiency and reducing fraud in the health care system is essential to curbing the growth of health care and prescription drug costs and making health care more affordable. While such improvements would benefit individuals across socioeconomic and demographic lines, the implications would be particularly profound for low-income minorities. For example, African Americans are more likely than whites (44% Vs 33%) to be unable to pay medical bills, be contacted by a collection agency, or have outstanding medical debt.<sup>21</sup>

All three health care reform bills contain provisions to encourage the utilization of health information technology to improve efficiency, albeit each in different ways (Table 7). The Senate Finance proposal would promote electronic reporting and sharing of health information, the House Tri-Committee would promote the use of health insurance cards and the development of infrastructure for electronic medical records, and the Senate HELP bill emphasizes the use of information technology (IT) to enroll individuals in public healthcare programs. While electronic enrollment strategies have the potential to help eligible individuals make informed decisions, their value may be limited for low-income minorities who utilize the Internet for health-related information at lower rates than whites.

All three bills also propose actions to strengthen Medicaid drug rebate programs. Such provisions could have positive implications for improving compliance with physician-recommended prescription drug regimens among low-income minorities with chronic diseases. In 2001, about 1 in 5 African American adults and 1 in 6 Hispanic adults did not purchase needed prescription medication due to cost. All three bills also include provisions explicitly intended to reduce fraudulent claims in public programs—through enhanced screening requirements in the House and Finance bills and through the establishment of a Health Care Program Integrity Coordinating Council in the HELP bill. It is estimated that fraudulent billing accounts for 3-10% of total health care spending.<sup>22</sup>

**Table 7: General Provisions on Cost Containment**

	House	HELP	Finance
Strengthen Medicare drug rebate program	√	√	√
Develop IT to standardize enrollment, claims and/or clinical data	√	√	√
Deny Medicaid reimbursement for health-care acquired conditions	√		√
Evaluate different payment mechanisms in public programs	√		√
Screen providers for fraud in public programs	√		
Financial incentives to providers for meeting performance & quality measures	√		√
Monitoring and reducing fraud & waste in health plans & claims		√	

- **Social Determinants of Health.** Disparities in health and health care are largely a product of social, economic, and environmental inequalities. Therefore, efforts to successfully reduce health disparities require an understanding of how policies beyond the traditional domains of health and health care—such as education, transportation, housing, and employment—impact health. To successfully implement such strategies, collaborative efforts are needed which span multiple sectors and federal agencies.

While both the House Tri-Committee and Senate Finance proposals contain provisions which encourage collaboration across federal agencies, the Senate HELP bill contains a number of provisions which are explicitly intended to improve population health and reduce disparities by addressing the social determinants of health (Table 8).

The Senate HELP bill proposes to create a National Health Council to promote health-related policies across multiple sectors and agencies at the federal level—including health, agriculture, education, labor, and transportation. Additionally, the HELP bill promotes the use of health impact assessments to examine the effect of the built environment on population and health and would provide grants for developing infrastructure which supports healthy lifestyles.

**Table 8: Provisions Addressing the Social Determinants of Health**

	House	HELP	Finance
Promote health-related policies across federal agencies		√	
Grants to assess impact of environment on population health		√	
Grants to support infrastructure to promote healthy lifestyles		√	

### Areas for Enhancement:

While our review identifies distinctions among the three major bills, no clearly consistent “leader” in terms of specific minority equity provision emerges from it. For example, the House Tri-Committee legislation contains the greatest number of health disparities research, public health/prevention and health insurance reform initiatives emphasizing race, culture and language. However, the Senate HELP bill has stressed cultural competence education and training considerably more than the other bills, while also overlapping with the House on several other provisions and including a few others not mentioned within that bill. The Senate Finance Committee has by far the fewest minority-specific provisions but yet still includes recommendations not included in the other two bills—such as attention to Tribal communities—that would enhance related efforts.

Our review of general health care reform provisions identifies a range of common and distinct actions across the three bills important for expanding access to health insurance and medical care as well as improving affordability and quality. While again no consistent “leader” emerges in its strengths for minorities, our review reveals a set of priorities beyond the common elements of all three bills that are necessary to achieving meaningful reform for minorities. These include: expanding Medicaid income eligibility to at least 133% of federal poverty; requiring employers to share in the responsibility of providing health care coverage; increasing funding for existing and new community health centers; establishing standard quality measures; and requiring public reporting of quality, overall and by race/ethnicity.

To varying degrees, the legislative proposals clearly recognize the need to address minority health directly and specifically. Nonetheless, there are areas less fully developed or emphasized that lessen the likelihood of greater impact. Building on and enhancing their initiatives in at least three areas will significantly

strengthen the potential for positive change in achieving health equity and assuring that access to care for all.

- ***Preserving and transitioning the health care safety net.*** Safety-net providers, such as community health centers and public hospitals, care disproportionately for low-income minorities, undocumented immigrants, and the uninsured. Many also serve vital roles in trauma and emergency care, specialty services such as burn and neonatal intensive care, and emergency response. For many, transitioning these providers into the new health care era may require targeted assistance. These providers may require help in adapting health information systems and other critical components of their infrastructure as they work to balance their continued safety net/essential community provider functions with a more mainstreamed and integrated role in health reform. These health care settings will also require direct support to continue their services for underserved populations, in particular the 12 million undocumented immigrants not covered through exchanges/gateways and public programs, as well as others who may not have health insurance. Assuming this responsibility, in turn, will be critical to: preventing inefficiencies in the health care system, such as crowded emergency departments; reducing costs associated with expensive treatments for delayed care; and safeguarding the health of all populations in the US.

- ***Promoting the adoption of standards for culturally and linguistically appropriate services.*** Public and private agencies have developed a combination of recommended actions and requirements for improving the quality and safety of care for minorities. These include, for example, HHS/OMH’s National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care, National Committee for Quality Assurance’s standards for CLAS in health plans, and the Joint Commission’s proposed hospital accreditation requirements to advance effective communication, cultural competence and patient-centered care. Federal support in the form of grants, provider bonuses or other incentives, particularly in public programs, could assist health care agencies and providers in implementing and evaluating these actions to improve quality and safety as well as reduce inequities in care.

- ***Explicitly supporting the engagement and empowerment of communities.*** The full engagement and empowerment of communities is fundamental to

understanding inequities and overcoming barriers to health and health care for racial and ethnic minorities. While acknowledged in both reform proposals, a stronger emphasis and more explicit federal support is needed to promote programs that actively engage communities, support research and application of evidence-based strategies such as community health workers, patient education and health literacy programs, and involve communities in planning and policy development.

## Questions for the Future: Transition Challenges

Although considerable variation exists among the bills in their support for minority health, enactment of health care reform as currently proposed is at the very least likely to auger major change in affordability, accessibility and quality of care. Even given the differences in their comprehensiveness, each is likely to be a positive step in reducing disparities. Nonetheless, common concerns and questions about effectiveness in advancing health equity are likely to accompany any legislation that becomes law.

- ***Assuring maximum minority participation.*** The complexity of proposed changes to health insurance access and the fact that many minorities have been historically disenfranchised from mainstream health care will create significant challenges to enrollment and continuity of engagement of diverse patients. It will require outreach to minority communities, including involvement of community workers and organizations such as churches and schools. Efforts to facilitate access such as creating an ombudsman office and multi-language hotlines in Exchanges could be overwhelmed if there is insufficient capacity to meet demand. Of special importance will be tracking the financial burden on the individual in the form of penalties and fees; concerns around proof of citizenship and health literacy/language issues.
- ***Monitoring effective implementation of major provisions.*** Establishing strong mechanisms for monitoring and enforcement must accompany health reform enactment. Without them, abuses or avoidance of requirements could lead to “cherry-picking” healthy employees and excluding others, and efforts to circumvent areas with large numbers of

poor minorities or those with limited English proficiency. States’ roles in this process will need to be considered as well since their capacity and history in assuming related responsibilities will vary.

- ***Initial and continuing levels of appropriations for minority initiatives.*** The effectiveness of specific initiatives aimed at improving health equity such as increasing workforce diversity, facilitating health insurance access and health disparities research, training and services will be linked to final appropriations levels. Assuring adequate funding levels for programs that demonstrate efficacy will determine the extent that they can contribute to this goal.
- ***Assisting diverse patient/community needs during health care system transition.*** Without direct action, the time between enactment and implementation of health care reform is likely to simply perpetuate health disparities if not worsen them, especially during the continuing economic downturn. During this period Congress should consider accelerating at least selective provisions likely to stem losses and possibly improve health care access. For example, increasing Medicaid eligibility levels to 133% FPL will have immediate impact on minorities in states with historically low levels—which also tend to have large numbers of racially and ethnically diverse residents. Eliminating health plan discrimination based on pre-existing conditions would help minorities with chronic disease to enroll in care. Also, research, data collection, research and public health/prevention initiative requiring lower funding levels and less systems change could be implemented during the transition period.

## Conclusion:

The recognition of health disparities as a critical priority in the health care reform proposals illustrates how race, ethnicity and language have become inextricably linked to achieving health equity. How this priority is reflected in final legislative debates and discussions, and enactment into law, will set direction on improving minority health for years, if not decades, to come.

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