Health Disparities Policy Recommendations for Inclusion in National Health Care Reform

We believe health care is a right and everyone in America should have access to quality affordable health care. We believe health care reform legislation must address health inequities and ensure that the reduction and eventual elimination of health care disparities is a national priority. Communities of color and immigrant populations are disproportionately hurt by a lack of health insurance, high health care costs, poor quality treatment, service gaps and other barriers to care. Health care reform provides an important opportunity to make systemic improvements that can reduce these problems and move the nation toward providing equal access to affordable coverage and care. The following proposals represent a core set of recommendations for action now. They can form the framework for additional initiatives at both the state and national level.

- **Improve access to affordable care by setting income-based standards for premiums, co-payments, deductibles and all out-of-pocket health care costs, and by providing subsidies for people with low and moderate incomes.** Health care costs are a particular barrier for minority populations because they are more likely to live below the poverty line. Nationally, 32 percent of blacks and 28 percent of Hispanics live in poverty, compared to 11 percent of whites. Forty-eight percent of blacks and 51 percent of Hispanics live in households below 200 percent of the federal poverty level, compared with 28 percent of whites.[i]

- **Ensure that immigrants lawfully present in the United States face the same eligibility rules as citizens for public programs, including Medicaid, Medicare and CHIP, and that they have the same access as citizens to subsidies.** Many lawfully present immigrants work in sectors of the economy that are less likely to provide employer-sponsored health insurance, and many are categorically barred from public insurance programs. As a result, 24 percent of lawfully present immigrant adults are uninsured, compared to 14 percent of US-born citizens.[ii]

- **Maintain and expand funding for safety net and Medicaid providers, including public hospitals and community health centers, and reward other providers who increase comprehensive quality services to underserved populations.** Adequate reimbursement for providers will help ensure adequate networks of care. Currently, many low income, minority and immigrant communities have no options for care apart from the nation's health safety net. About 65 percent of individuals receiving inpatient care at safety net hospitals are black, Hispanic, Asian/Pacific Islander or other non-white races.[iii] Because safety net providers are often the only source of care in some urban and rural communities, these providers will continue to be the place where underserved and uninsured people seek medical care. It is essential to fund these providers and enhance financial incentives for those who expand or establish new facilities in underserved areas.

- **Support community-based outreach, health promotion and prevention efforts, including services of community health workers, with special attention to low-income, minority and immigrant communities.** This is essential to connect medically underserved individuals to cost-effective preventive and primary care, to address cultural barriers to care and to ensure those newly insured understand and efficiently access the services available.

- **Establish benchmarks for reducing disparities in health care by race, ethnicity and primary language, and provide financial incentives to institutions for progress.**[iv] This will help drive improved quality of care. Low income and minority populations now receive fewer health care services, lower quality services, and face impediments to optimal care, resulting in high rates of disease and death. For example, the infant mortality rate for blacks is 14 percent, compared to 6 percent for white babies, and the cancer death rate for blacks is 227 per 100,000, compared to 184 per 100,000 for whites.[v]

- **Strengthen incentives for primary care practices that can provide medical homes in underserved areas, especially for low-income, minority and immigrant populations.** Adults with medical homes have better health outcomes, and racial and ethnic health disparities are reduced and in some cases eliminated.[vi]

- **Require all health providers to meet all national standards on Culturally and Linguistically Appropriate Services (CLAS).** The government currently requires providers receiving federal funds to meet only four of the 14 CLAS standards.[vii] Expanding the requirement to all 14 standards and to all providers would help improve access and quality of care for diverse populations. The standards call for health care organizations to take a number of steps including providing culturally competent care, offering free language assistance and ensuring a diverse workforce that undergoes ongoing CLAS training. In addition, the federal government should provide explicit funding for language assistance services in all public programs.

- **Increase support for recruitment and retention of underrepresented minorities and bilingual individuals in all health professions through funding for higher education (grants, loan forgiveness) and targeted pipeline and career ladder programs.** A health care workforce that reflects the diversity of the patient population can increase linguistic and cultural competence to improve quality of care. Hispanics and blacks comprise more than 25 percent of the U.S. population, but make up less than 6 percent of doctors and 9 percent of nurses.[viii] In addition, there are shortages of bilingual health workers across the nation.

- **Require and fund standardized collection of race, ethnicity and primary language data across all public and private health insurance plans and care settings. Fund use of data to set benchmarks for improvement.** Data collection is essential to track use and quality of care, document disparities and tailor interventions.[ix]

- **Require hospitals to identify and respond to the unmet health needs of the communities they serve by setting new conditions for Disproportionate Share Hospital payments and for community benefits required to maintain tax-exempt status.** Hospitals are an essential part of the safety net in many communities and can play a stronger role in other communities. To get DSH payments or maintain tax-exempt status, hospitals should be required to assess community needs regularly and devise ways to address them, involving representatives of underserved populations in this process. In addition, DSH funding should be available for all medically necessary services for vulnerable populations, such as interpreters, youth violence intervention programs and public health initiatives.

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[i] Estimates made by the Urban Institute and Kaiser Commission on Medicaid and the Uninsured, based on the U.S. Census Bureau March 2007 and 2008 Current Population Survey (CPS: Annual Social and Economic Supplements).

[ii] Jeffrey S. Passel and D'Vera Cohn. A Portrait of Unauthorized Immigrants in the United States. Pew Hispanic Center. April 2009.

[iii] National Association of Public Hospitals. Annual Survey of Members 2004. Based on 2002 data.

[iv] Pay for performance initiatives can be designed to reduce disparities by steps that include adjusting for patient risk, rewarding providers for improvements as well as reaching goals and rewarding facilities that increase access. David J. Satin, Paying Physicians and Protecting the Poor. Minnesota Medicine Commentary. April 2006. http://www.student.med.umn.edu/p4p/topic.php?catid=11. Lawrence P. Casalino, Arthur Elster, Andy Eisenberg, Evelyn Lewis, John Montgomery and Diana Ramos. Will Pay-for-Performance and Quality Reporting Affect Health Care Disparities? Health Affairs web exclusive April 10, 2007. http://content.healthaffairs.org/cgi/content/abstract/26/3/w405

[v] Marian F. MacDorman, Ph.D., and T.J. Mathews.M.S. Recent Trends in Infant Mortality in the United States, National Center for Health Statistics Data Brief, October 2008. Agency for Healthcare Research and Quality. 2007 National Healthcare Disparities Report. February 2008.

[vi] A. C. Beal, M. M. Doty, S. E. Hernandez, K. K. Shea, and K. Davis. Closing the Divide: How Medical Homes Promote Equity in Health Care: Results From The Commonwealth Fund 2006 Health Care Quality Survey. The Commonwealth Fund. June 2007.

[vii] U.S. Department of Health and Human Services Office of Minority Health. National Standards on Culturally and Linguistically Appropriate Services. http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=15

[viii] Lisa A. Cooper and Neil R. Powe. Disparities in Patient Experiences, Healthcare Processes and Outcomes: The Role of Patient-Provider Racial, Ethnic, and Language Concordance. The Commonwealth Fund, July 2004.

See language in S. 1576, Minority Health Improvement and Health Disparity Elimination Act, Title I, Section 102-104. Read twice and referred to the Committee on Health, Education, Labor, and Pensions 6/7/2007. *The Secretary shall make grants to, and enter into contracts with, public and nonprofit private health or educational entities, including designated health professions schools described in subsection (c), for the purpose of assisting the entities in supporting programs of excellence in health professions education for underrepresented minorities in health professions.*

[ix] **See language in H.R. 3014, Health Equity and Accountability Act.** Hearing held 6/24/2008. *Requires health-related programs of the Department of Health and Human Services (HHS) to collect data on race, ethnicity, and primary language.*