From Families USA Minority Health Initiatives

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# Moving toward Health Equity: Health Reform Creates a Foundation for Eliminating Disparities

Racial and ethnic health disparities continue to persist in our nation and our health care system. People of color in the United States are more likely than whites to lack health insurance, to receive lower-quality care, and to experience worse health outcomes. The causes of these disparities are broad and complex and include social, economic, and health system factors.

The Patient Protection and Affordable Care Act, the health reform law that was signed by President Obama in March, is designed to provide quality and affordable health care to all Americans by expanding health coverage, improving quality, and reducing costs. The new law also provides a critical foundation for addressing racial and ethnic health disparities through a number of key provisions—both those that will affect everyone but have a disproportionate impact on communities of color, as well as those that are designed specifically to eliminate health disparities. This brief provides a summary of those provisions.

## Improving Community-Based Prevention and Public Health

Where someone lives, works, and plays is central to his or her health and well-being. Preventive health care and public health efforts are therefore crucial for maintaining a healthy nation and reducing costs. But prevention efforts must be designed to improve not only individual health, but community health as well. People of color are more likely to encounter structural barriers to good health, including substandard housing; transportation difficulty; low job availability; less access to education; and limited geographic access to fresh, healthy foods and medical providers. Similarly, communities of color typically have higher rates of obesity, diabetes, and hypertension than their white counterparts.[1]

The health reform law calls for the development of a national prevention, health promotion, and public health strategy, which will include the establishment of a national prevention council, the formation of an advisory group, and the creation of a fund ($15 billion over 10 years) that will be devoted to these efforts. The law also establishes community transformation grants to promote community-based prevention initiatives aimed at addressing chronic diseases and reducing disparities. Grants will also be provided for several demonstration programs to test community-based prevention and disease management programs.

## Expanding Access to Health Care

### Expanding Health Coverage

The new health reform law will significantly expand access to affordable health coverage, which is especially important for communities of color. In 2008, people of color made up 35 percent of the U.S. population, but they accounted for 54 percent of the uninsured.[2] During the recent recession, communities of color have experienced higher rates of unemployment, and the number of people with job-based health coverage has decreased significantly.

Health reform will expand coverage by doing the following:

- Providing Medicaid to millions more low-income working families who currently fall through the cracks; and
- Creating new, regulated marketplaces known as exchanges where insurers will compete for customers and where consumers will have the opportunity to purchase the best plan at the best price.

- **Providing Medicaid**
  Under the new law, Medicaid coverage will be expanded to cover children and adults with incomes up to 133 percent of the federal poverty level—roughly $14,403 for an individual and $24,352 for a family of three in 2010.[3] This Medicaid expansion, which will go into effect in 2014, will provide coverage to many individuals and families who will otherwise go without quality, affordable health coverage, particularly adults without dependent children.

  Before the mandatory Medicaid expansion takes place in 2014, states now have the option to cover individuals with incomes up to 133 percent of poverty and receive federal funding for the new enrollees at the same rate as they receive in their current Medicaid programs (their current Federal Medical Assistance Percentage, or FMAP).

- **Creating New Marketplaces**
  The new law will expand coverage through the creation of state health exchanges for individuals who do not qualify for Medicaid or who do not have an offer of coverage from their employer. Beginning in 2014, these exchanges will serve as a gateway for individuals to easily compare coverage benefits and purchase insurance in the private market. To ensure that health insurance is affordable, the law subsidizes

premiums by providing tax credits to individuals and families whose incomes fall below 400 percent of poverty and who purchase coverage through an exchange.

These historic coverage expansions should have a significant impact on communities of color that are more likely to have low or moderate incomes. In 2008, about 80 percent of nonelderly blacks, Hispanics, and American Indians and Alaska Natives had incomes below 400 percent of poverty (the cutoff for premium subsidies), compared to 57 percent of whites.[4]

### Increasing Funding for Community Health Centers

Community health centers play a critical role in expanding access by serving as a trusted safety net, especially for communities of color. Typically located in medically underserved areas, community health centers provide culturally and linguistically appropriate care to all residents regardless of insurance status, citizenship status, or ability to pay.

Communities of color disproportionately use community health centers as their source of primary and preventive care. For example, of those who used community health centers in 2008, approximately two-thirds were racial or ethnic minorities: 33 percent were Latino, 28 percent were African American, 4 percent were Asian, and 2 percent were American Indian or Alaska Native.[5]

During the recent recession, with rising unemployment and health care costs, consumers are having an increasingly difficult time obtaining affordable, high-quality health care. It is therefore more important than ever that community health centers be properly funded so that they can adequately serve those who are medically underserved. Beginning in fiscal year 2011 and continuing through 2015, the health reform law will appropriate $11 billion to community health centers for the services they provide and for the construction and renovation of community health centers. The new law will also encourage other entities, such as state or local health departments, to collaborate with community health centers to improve prevention and primary care services.

### Community Health Centers Provide Essential Health Care

Community health centers will continue to play a critical role as the safety net for our most vulnerable populations, including those who will continue to lack access to care. Under the new health reform law, undocumented immigrants will remain ineligible for public benefits and will be barred from purchasing insurance through the exchanges. And legal immigrants who have been in the country for fewer than five years will also continue to face unfair barriers to obtaining coverage through Medicaid. However, legal immigrants *will* be eligible to purchase coverage through the exchanges and receive subsidies for that coverage without being subject to a waiting period.

## Addressing Disparities

The new health reform law contains several provisions that are specifically designed to reduce racial and ethnic health disparities.

### Improving Data Collection

It is well known that disparities in health exist across racial and ethnic minority groups, but there is limited coordination, documentation, and analysis of data that examine the nature of health disparities by race and ethnicity. Collecting and reporting these data are crucial for identifying and monitoring the problems that exist in communities of color, and for developing the proper solutions to eliminate disparities. The lack of consistent data on race, ethnicity, sex, or primary language makes it difficult for legislators, policy makers, and health professionals to identify and understand the problems that exist within minority communities and to create effective solutions.

By no later than 2012, the new health reform law will require that data be collected and reported by race, ethnicity, sex, and primary language for participants at the smallest geographic level possible for all federally conducted or supported health care or public health programs. This is so that reliable estimates of populations can be generated for surveillance, research, and analysis purposes. Data and analyses will also be available to agencies within the Department of Health and Human Services (HHS), as well as to other federal agencies, nongovernmental organizations, and the public.

### Expanding the Role of the Office of Minority Health

Currently, the Office of Minority Health, which is within the Department of Health and Human Services, is responsible for creating and funding programs, as well as for coordinating efforts, to help eliminate health disparities in communities of color. The health reform law gives official power to the Office of Minority Health, requiring the office to report directly to the Secretary of Health and Human Services and authorizing a Deputy Assistant Secretary for Minority Health. Funding is provided from 2011 through 2016.

The health reform legislation also makes permanent specific Offices of Minority Health within the following agencies:

- the Centers for Disease Control and Prevention (CDC),
- the Health Resources and Services Administration (HRSA),
- the Substance Abuse and Mental Health Services Administration (SAMHSA),
- the Agency for Healthcare Research and Quality (AHRQ),
- the Food and Drug Administration (FDA), and
- the Centers for Medicare and Medicaid Services (CMS).

These new offices will receive funding for their operations and staff and will gain more authority to address disparities. These offices will play a critical role in monitoring and improving minority health and the quality of health services that minority populations receive.

### Promoting Language Access Services

Effective communication among patients, health care providers, and insurance companies is essential to the delivery of quality health care in a timely manner. In order for proper care to be provided and received, it is critical that patients understand information—written and verbal—from physicians and insurance companies. Currently, states have the option to pay for language assistance services in Medicaid and the Children's Health Insurance Program (CHIP). Even though the federal government pays a portion of these costs, in 2009, only 13 states and the District of Columbia took up this option. With the reauthorization of CHIP in 2009, federal funding for translation and interpretation services under CHIP and Medicaid was increased.[6] These funds are for services in connection with the enrollment, retention, and use of services by children in Medicaid and all CHIP enrollees for whom English is not the primary language.

While language access services in Medicaid and Medicare are not specifically addressed in the health reform law, it does include provisions pertaining to language services in the exchanges. The new law specifies that plans in the exchanges must develop uniform explanation and summary of coverage documents that are culturally and linguistically appropriate. The legislation also provides grants for training health care providers in culturally appropriate care and services.

### Increasing Workforce Diversity

It is projected that, within the next 32 years, people of color will make up the majority of the population.[7] As health reform expands coverage to all Americans, it will be increasingly important to make sure that the health care workforce is diverse and addresses the needs of all citizens. The health reform law takes a number of steps to increase diversity in our health care workforce.

One of the main approaches that the health reform law will use to create a diverse workforce is through the use of scholarships, grants, and loan repayment programs for health care professionals. The legislation will provide continuing education support for health professionals who serve minority and underserved populations. It also appropriates grants to improve health care services, increase retention, and increase the representation of minority faculty members and health professionals. These provisions will improve access to the health care system and enhance the practice environment by making sure that care is culturally appropriate.

Beginning no later than September 30, 2010, the health reform law also establishes a National Health Care Workforce Commission to provide comprehensive, objective information and recommendations to Congress and the Administration for aligning federal health care workforce resources with national needs.

### Supporting Community Health Workers

Often seen as a trusted source for information, community health workers are able to provide a unique link between members of the community and health care services. Their relationship with the community allows them to provide information and resources in a culturally appropriate manner. Currently, community health workers do not receive dedicated funding and are not provided sufficient support to carry out their work.

The health reform law provides additional support to community health workers through the appropriation of grants to divisions of a state, a public health department, a free health clinic, a hospital, or a federally qualified health center that hosts community health workers and promotes positive health behaviors and outcomes in medically underserved communities, especially communities of color. The legislation also provides funding for the training, supervision, and support of community health workers for fiscal years 2010 through 2014.

### Reauthorizing the Indian Health Care Improvement Act

American Indians and Alaska Natives are the only citizens of the United States who are born with a legal right to health care: There is a federal obligation to provide health services to members of federally recognized tribes that was established in 1787. Despite their legal right to health care, however, American Indians and Alaska Natives continue to face dire health conditions at higher rates than other racial and ethnic groups. According to recent data, nearly 30 percent of American Indians and Alaska Natives have no health coverage. American Indians and Alaska Natives are also disproportionately affected by a host of chronic conditions, such as diabetes, stroke, and heart disease.

The Indian Health Care Improvement Act,[8] which was enacted by Congress in 1976, dictates how the U.S. responsibility to provide health care to American Indians should be carried out. The new health reform law revises and permanently reauthorizes the Indian Health Care Improvement Act (The Act), which had not been comprehensively updated since 1992. These changes are critical to ensuring that the Indian Health Service (IHS) is properly funded and maintained so that it can provide culturally appropriate care to Indian Country.

The Act includes provisions that do the following:

- Authorize the appropriation of funds to support the IHS.
- Establish goals for addressing the health needs of Indian Country and eliminating health disparities.
- Seek to attract and increase the retention of qualified Indian health care professionals who provide services to the IHS and tribal health programs.
- Allow the IHS to develop and implement plans to repair and upgrade facilities, modernize equipment, and address other health facility maintenance issues.
- Revise and update the law to provide for modern methods of health care delivery in the Indian health care system.

## Conclusion

Although addressing disparities was not the primary focus of health reform, the legislation does take steps in the right direction to address disparities among communities of color. In addition to covering millions more people, reducing costs, and improving quality, health reform addresses widespread inequities that result in racial and ethnic health disparities. The coverage expansions, together with many other provisions, will significantly affect communities of color.

However, it will continue to be important to monitor and further address access to quality care and services for communities of color. Most importantly, we must continue to monitor how provisions are being implemented, and to provide public comment on federal regulations when possible. Only then can we ensure that communities are able to benefit from the new law and that we continue to build upon this critical foundation to advance health equity.

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[8] Sherice Perry and Jonay Foster, *Health Reform: Help for American Indians and Alaska Natives* (Washington: Families USA, May 2010), available online at http://www.familiesusa.org/assets/pdfs/health-reform/minority-health/help-for-american-indians-alaska-natives.pdf.

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