



**JOINT  
CENTER**  
— FOR —  
POLITICAL  
AND ECONOMIC  
STUDIES

---

***ISSUE BRIEF***

**RACE, ETHNICITY &  
HEALTH CARE REFORM:  
ACHIEVING EQUITY IN  
OUR LIFETIME**

**DECEMBER 2009**



## INTRODUCTION

Health care reform proposals before Congress offer potential for great progress in improving health care affordability, access and quality for all Americans—an opportunity not seen for decades. Little discussed, however, is that major provisions are likely to have a significant impact on minorities as they present opportunities to redress longstanding inequities. Moreover, the bills which have emerged from House and Senate committees explicitly recognize the need to reduce disparities; each includes provisions intended to support initiatives targeting racial and ethnic minorities and language access services. While both leading bills offer solutions to reduce racial and ethnic disparities in health, each one differs in the level of its commitment and approach.

This issue brief identifies, analyzes and compares provisions which explicitly address the health and health care needs of racial and ethnic minorities within the two leading Congressional health care reform proposals: The Affordable Health Choices Act of 2009 (H.R. 3962) passed in the House of Representatives on November 7, 2009; and The Patient Protection and Affordable Care Act of 2009 (H.R. 3590) introduced in the Senate on November 18, 2009, as a merged version of 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 health care reforms for racial and ethnic minorities. Also discussed is how each bill could decrease disparities and improve minority health, where each falls short in advancing these goals, as well as the 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

The leading House and Senate bills directly integrate provisions intended to address racial and 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 health disparities.<sup>1</sup> As expressed in a recent report 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 federal categories of race and ethnicity, information is needed on racial and 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 bills contain strong provisions to improve the depth and quality of data collected on health status, health care utilization and health outcomes by race, ethnicity and language (Table 1). The House proposal includes a provision to appoint an Assistant Secretary for Health Information whom, in coordination with the Directors of the Office of Minority Health and Office of Civil Rights, would develop standards for identifying, collecting, and

reporting key health data by primary language with the explicit goal of reducing health disparities (H.R. Sec. 2402). The Senate 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). In addition, the Senate bill includes a provision that would standardize the collection of data addressing health disparities in Medicaid and the Children's Health Insurance Program (CHIP) (S. Sec. 4302).

Both bills propose to improve the collection of data on racial and ethnic sub-populations. The Senate proposal includes a mandate which would require all federally-funded population surveys to collect information on these sub-groups to produce statistically reliable results that authorize where needed statistical over-samples of certain sub-populations (S. Sec. 3101). The House bill explicitly addresses the need to account for racial and ethnic sub-populations in Comparative Effectiveness Research (CER) (H.R. Sec. 1401).

**Workforce Diversity.** Racial and ethnic practitioner-patient concordance and greater medical workforce diversity have long been recognized as critical to improving the quality of patient care, yet efforts have fallen well short of goals. For example, the Association of American Medical Colleges' initiative, called "3,000 by 2000" (enrolling 3,000 underrepresented minorities in medical school by the year 2000) was less than fully achieved.<sup>4</sup> As a result, the proportion of minority physicians still falls well below their respective representation in the general population. 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> As the nation grows increasingly diverse, these workforce disparities are also likely to increase if left unaddressed.

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

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

Both the leading Congressional health care reform bills contain provisions intended to increase diversity in the health professions (Table 1). Title VII and Title VIII programs in the Public Health Services Act have great potential to increase diversity, cultural competency and the number of health care professionals practicing in underserved areas.<sup>6</sup> The House bill would provide grants to increase diversity among primary care providers and reauthorize Title VIII to increase diversity in the nursing professions (H.R. Sec. 2242). Similarly, the Senate proposal would increase workforce diversity through enhanced support for Title VII (S. Sec. 5303) and Title VIII (S. Sec. 5313) programs. Both the House and Senate bills propose to collect and publicly report data on the diversity of the health care workforce (H.R. Sec. 2271, S. Sec. 5001).

In addition, the Senate bill would provide grants and supportive services (e.g., child care) to train low-income individuals for health care occupations. At least three of such grants would be administered to Tribal entities (S. Sec. 2008).

**Cultural Competence Education and Training.** To improve quality of care for minority patients, schools of medicine, nursing, allied health and other health professions have turned to cultural competence education and training opportunities. Such efforts have great potential to improve the overall quality and safety of the delivery of health care to racial and ethnic minorities, as well as improve the patient care experience.<sup>7</sup> Racial and 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>

Both the House and Senate bills include proposals for expanding and improving cultural competence education and training (Table 2). The Senate bill includes provisions to develop, evaluate and disseminate model cultural competence curricula through a central Internet clearinghouse (S. Sec. 5307). The House bill also authorizes the evaluation of cultural competence curricula (H.R. Sec. 2251). While both bills support cultural competence training for health care professionals, the House bill is less specific (H.R. Sec. 2243) than the Senate Bill, which addresses cultural competence training in the context of primary care providers (S. Sec. 5301) and personal and home care aids (S. Sec. 5507).

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

Congress proposes to continue support for, and advance the state of, health disparities research through health care reform (Table 2). Both chambers address at least two common sets of priorities, including an emphasis on CER and the development of national priorities and measures for quality improvement to reduce health disparities. Specifically, the House bill would establish a Center for CER within the Agency for Healthcare Research and Quality (H.R. Sec. 1401) and the Senate would create a non-profit Patient-Centered Outcomes Research Institute (S. Sec. 6301) to examine differences in health care service outcomes among racial and ethnic minorities, and to develop health disparities priorities. In addition, the House authorizes studies to examine the delivery of and reimbursement for culturally and linguistically appropriate services in health care, including a feasibility study on the development of Medicare payment systems for language services (H.R. Sec. 1222), and a broader IOM study on language access and services (H.R. Sec. 1223).

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

	House	Senate
<b>Cultural Competence Education &amp; Training</b>		
Cultural competence training for health professionals	✓	✓
Cultural competence education for personal & home care aides		✓
Develop and evaluate cultural competence curricula		✓
Online clearinghouse for model cultural competence curricula		✓
<b>Health Disparities Research</b>		
Develop quality measures for reducing racial and ethnic health disparities	✓	✓
Comparative Effective Research to examine differences by race/ethnicity	✓	✓
Collaborative efforts for examining health disparities	✓	✓
Epidemiological studies to examine disparities	✓	✓
Study on language access services provided by Medicare providers	✓	
IOM Study on impact of language access services on individuals with LEP	✓	

In addition to the House bill, the Senate bill provides support for collaborative research (S. Sec. 5307) and epidemiological studies to examine disparities in areas of disease such as post-partum depression (S. Sec. 2952).

**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>

Both the House and Senate bills have introduced common and distinct provisions intended to support public health and prevention (Table 3). Areas of commonality include: the establishment of national health disparities priorities; an emphasis on community-based strategies to reduce disparities; support for the Medical Home Model and its application to advancing health equity; and grants for preventive programs in Tribal communities.

The Senate bill is stronger than the House bill in this area, offering a number of unique initiatives important for the health and health care of minorities. These include, for example: a five-year national public health campaign on oral health, with an emphasis on racial and ethnic disparities (S. Sec. 4102); support for standardized drug labeling on risks and benefits developed in concert with health literacy and minority health experts (S. Sec. 3507); the strengthening of maternal and child home visiting programs for minorities (S. Sec. 2951); and grants for education about personal responsibility, such as culturally and linguistically appropriate teen pregnancy education in minority communities (S. Sec. 2953). In addition, the Senate bill differs from the House in its community-based proposals in that it creates Community Health Teams to support local primary care providers in delivering culturally appropriate and patient-centered care (S. Sec. 3502).

The House bill authorizes the active involvement of the Office of Minority Health in developing prevention initiatives (H.R. Sec. 2402) and supports community-based efforts, such as health empowerment zones, that attend directly to disparities reduction (H.R. Sec. 3151).

The House bill also supports a number of preventive programs which target Tribal communities through reauthorization of, and amendments to, the Indian Health Care Improvement Act (H.R. Division D). In fact, the House proposal contains over 125 distinct provisions which address the health and health care needs of American Indians and Alaska Natives (AI/AN). Examples of such preventive programs include those targeting substance abuse (e.g., H.R. Sec. 512 and Sec. 701), diabetes (H.R. Sec. 203 and Sec. 517), and suicide (H.R. Sec. 708)—all health-related issues which are disproportionately prevalent among the AI/AN population.<sup>11</sup>

**Addressing Disparities in Insurance Reforms.** Given the historic, disproportionate lack of participation in health insurance among minorities, facilitating improved access to health insurance for diverse populations is a critical ingredient to reducing health disparities. African Americans are nearly twice as likely to be uninsured than whites, while Hispanics are more than three times as likely to be uninsured.<sup>12</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; increases in reimbursement rates for language access services in Medicaid and (H.R. Sec. 1723); and a mandate for health insurance exchanges to provide culturally and linguistically appropriate outreach services. The House bill 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 proposal. The Senate 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) (S. Sec. 2901)—approximately 65% of the IA/AN population.

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

	House	Senate
<b>Health Disparities Initiatives in Public Health &amp; Prevention</b>		
Establish national priorities for reducing health disparities	✓	✓
Support for community-based strategies that reduce disparities	✓	✓
Support for Medical Home Model and its application to reducing disparities	✓	✓
Preventive programs targeting Tribal communities	✓	✓
Consult with OMH in establishing preventive priorities for minorities	✓	
Support Health Empowerment Zones, with emphasis on reducing disparities	✓	
Technical support for reducing disparities in care		✓
5-Year National Public Health Campaign on oral health & disparities		✓
Standardize drug labeling in consultation with racial and ethnic representatives		✓
Fund nurse-managed health centers to reduce disparities in primary care		✓
Strengthen Maternal and Child Home Visiting Programs for at-risk and minority populations		✓
Support teen pregnancy prevention in minority communities		✓
<b>Addressing Disparities in Health Insurance Reforms</b>		
Innovative payment methods for reducing disparities	✓	✓
Culturally & linguistically tailored outreach & enrollment services	✓	✓
Culturally & linguistically tailored appeals process		✓
Remove cost-sharing for American Indians & Alaska Natives at 300% FPL		✓
Permit undocumented immigrants to purchase coverage through Exchanges	✓	

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

General provisions in the House and Senate health care reform bills—concerning health insurance reform, improved access to health care, quality improvement, cost containment and social determinants of health— while varying in scope and detail, collectively are likely to benefit low-income racial and ethnic minorities.

### *Health Insurance Reform to Expand Coverage and Affordability.*

Racial and ethnic minorities comprise about one-third of the nation’s population; However, they make up over half of the 47 million uninsured.<sup>14</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>15</sup>

Proposed health insurance reforms included in the 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 include: prohibition of exclusions or rate variations based on pre-existing conditions; a 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 and ethnic minorities.

Among important provisions for minorities is the expansion of income thresholds for Medicaid eligibility, 150% of FPL in the House bill and 133% of FPL in the Senate 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 the most restrictive income eligibility requirements. For example, Texas, Alabama and other Southern states have set their income eligibility for Medicaid well below 20% of FPL to qualify.<sup>16</sup> These are also states with large numbers of minorities and among the highest adult uninsured rates in the country.<sup>17</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. Both bills also increase federal matching rates for Medicaid programs in U.S. territories (S. Sec. 2005, H.R. Sec. 1771).

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>18</sup> While both bills include provisions to increase employer responsibility for providing coverage to their workers, only the House bill explicitly mandates this. Both bills, however, offer tax credits for employers with 25 employees or fewer to assist them in providing coverage for their employees. Given that over 90% of minority-owned firms have fewer than 25 employees 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.

Both the House and Senate bills propose to create a new public plan option to compete with private insurers in exchanges. However, the Senate bill would allow states to opt-out and not offer the public plan.

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

	House	Senate
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	✓	✓
New public plan option	✓	✓
Consumer Operated and Oriented Plan (CO-OP)	✓	✓
Medicaid expansion	✓	✓
Increase Medicaid rates for US Territories	✓	✓
Immediate assistance for “uninsurable” individuals	✓	✓
Employer mandate and pay-or-play	✓	

A new public plan could potentially offer an affordable health care coverage option for many uninsured and underinsured minorities if it has lower premiums and out-of-pocket expenses than private plans. Both bills would also provide immediate assistance to individuals with pre-existing conditions, who have been unable to obtain coverage in the private market, through the creation of high-

risk insurance pools, until exchanges are operational (2014 in the Senate proposal and 2013 in the House).

**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 in both 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 strength and commonality include: removing cost-sharing for preventive services; support for a Medical Home Model; and incentives/programs to expand primary care in underserved communities, including schools. Specifically, the House bill would expand the National Health Service Corps to eliminate the shortfall in primary care providers (H.R. Sec. 2201), support primary care residency programs in community settings (H.R. Sec. 1502), establish a Medical Home Pilot Project to improve chronic disease management (H.R. Sec. 2528), and support a study on the effectiveness of programs which encourage primary care physicians to practice in underserved areas (H.R. Sec. 2217).

Similarly, the Senate bill would expand primary care through funding for nurse-managed health centers (S. Sec. 5208) and grants to create community health teams to support medical homes for patients (S. Sec. 3502). The Senate bill would also redistribute unused Graduate Medical Education slots to primary care in health profession shortage areas (S. Sec. 5503), establish Teaching Health Centers for residency programs in community settings (S. Sec. 5508), and create a medical home option for Medicaid enrollees with chronic conditions (S. Sec. 1722). 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, both House and Senate proposals include other concrete actions which are 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. The House bill broadly offers support for community health centers (H.R. Sec. 2101) while the Senate bill limits its support to Federally Qualified Health Centers (S. Sec. 5502). Both bills also promote primary care and prevention in non-traditional community settings (H.R. Sec. 2530, Sen. Sec. 4101), 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 bill are three additional initiatives with potentially positive implications for minorities. First, given the frequent concentration of services in urban areas, the proposal to regionalize emergency and trauma care (S. Sec. 3504) 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. Secondly, given that racial and ethnic minorities are more likely to have poor oral health and less likely to seek dental care,<sup>22</sup> oral health education campaigns and water fluoridation programs have the potential to reduce these disparities (S. Sec. 4102). Lastly, the Senate bill provides support for post-partum depression services (S. Sec. 2952), a condition which disproportionately affects African American and Hispanic women.<sup>23</sup>

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

	House	Senate
Remove cost-sharing for proven preventive services	✓	✓
Support for the Medical Home Model	✓	✓
Expand preventive/primary care in community settings—e.g., schools	✓	✓
Support for workplace wellness programs	✓	✓
Support for primary care residency programs in community settings	✓	✓
Increase funding for community health centers/Federally Qualified Health Centers	✓	✓
Programs to strengthen public health training and workforce	✓	✓
National public health and prevention strategy	✓	✓
Programs to expand primary care in underserved areas	✓	✓
Study on the effectiveness of programs to encourage primary care physicians to practice in underserved areas	✓	
Programs to expand primary care in underserved areas		✓
Support for regional emergency care & trauma systems		✓
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 and ethnic minorities receive often falls short on the dimensions of high quality.<sup>24</sup> Improving quality of care will require a range of actions that supports 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.

Both health care reform bills include a number of provisions to promote quality in the health care system (Table 6). Common areas of strength include an emphasis on CER, support for evidence-based community strategies, and increasing transparency in skilled nursing facilities (S. Sec. 6101, H.R. Sec. 1411).

Specifically, the House bill supports research on the effectiveness of health care services (H.R. Sec. 1401), would create a Center for Quality Improvement (H.R. Sec. 2401), and proposes to establish community-based collaborative care networks (H.R. Sec. 2543) to improve the quality and continuity of care for primary, acute and long term care services.

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

	House	Senate
Comparative Effectiveness Research	✓	✓
Evidence-based community strategies to improve 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	✓	✓
Increase transparency of skilled nursing facilities	✓	✓
Regional grants encouraging cooperative efforts to improve quality	✓	
Pilot incentive program to reward quality for Medicare providers		✓

Similarly, the Senate bill proposes to create a National Strategy for Quality Improvement in Health Care (S. Sec. 3011) and an Interagency Working Group on Health Care Quality (S. Sec. 3012) to develop and implement quality improvement initiatives. These initiatives would support efforts to improve patient safety, chronic disease management programs, and reduce health disparities. The Senate proposal also provides support for the development of quality measures (S. Sec. 3013), collecting data on health care

quality and making information available through standardized websites (S. Sec. 3015).

While provisions to improve health care quality in the House and Senate bills parallel each other in a number of respects, each contains at least one quality-related provision that is unique to that bill. The House bill would require ambulatory surgical centers to report quality data (H.R. Sec. 1144). The Senate proposal includes a provision to link Medicare hospital payments to quality outcomes (S. Sec. 3001).

**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-the-board socioeconomically and demographically, 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>25</sup>

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

	House	Senate
Financial incentives to providers for meeting performance & quality measures	✓	✓
Screen providers for fraud in public programs	✓	✓
Evaluate different payment mechanisms in public programs	✓	✓
Deny Medicaid reimbursement for health-care acquired conditions	✓	✓
Strengthen Medicaid drug rebate program	✓	✓
Develop IT to standardize enrollment, claims, and/or clinical data	✓	✓
Monitoring and reducing fraud & waste in health plans & claims		✓
Integrate the use of IT into medical residency programs		✓
Demonstration project on use of IT in nursing homes		✓

Both health care reform bills contain provisions to encourage the utilization of health information technology to improve efficiency, albeit in different ways (Table 7). The Senate proposal would develop national standards for interoperable systems of enrollment

for individuals in federal and state health-related programs (S. Sec. 1561) and support a demonstration project on the use of health information technology in nursing homes (S. Sec. 6114). The House bill would support a study on methods to increase the utilization of health information technology by small health care providers (H.R. Sec. 263) and promote the use of electronic health records in medical residency programs (H.R. Sec. 1505).

Both the House and Senate bills also propose numerous actions to strengthen Medicaid drug rebate programs (e.g., H.R. Sec. 1738, S. Sec. 2501). 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.<sup>26</sup>

Both bills also include provisions explicitly intended to reduce fraudulent claims in public programs, through enhanced screening requirements in the Senate bill (S. Sec. 6401) and by increasing penalties for fraudulent claims in the House bill (H.R. Sec. 1601). It is estimated that fraudulent billing accounts for 3% to 10% of total health care spending.<sup>27</sup>

**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—i.e., education, transportation, housing, and employment—impact health. To effectively implement such strategies, collaborative efforts are needed which span multiple sectors of the economy and federal government.

While both the House and Senate proposals contain provisions which encourage collaboration across federal agencies, the Senate 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 bill proposes to create a National Prevention, Health Promotion and Public Health Council to promote health-related policies across multiple sectors and agencies at the federal level—including health, agriculture, education, labor, and transportation (S. Sec. 4001). Additionally, the Senate bill promotes the use of health impact assessments (S. Sec. 4003); would provide community transformation grants for developing infrastructure that supports healthy lifestyles (S. Sec. 4201); and encourages primary care physicians to address social determinants of health through community-based efforts (S. Sec. 5405).



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

	House	Senate
Grants to support infrastructure to promote health lifestyles		✓
Develop evidence-based recommendations and interventions on social determinants of health		✓
Support community partnerships to address social determinants of health		✓
Promote health-related policies across federal agencies		✓

### Areas for Enhancement

Our review identified a range of common and distinct provisions in the leading Congressional health care reform bills for explicitly improving the health and health care of racial and ethnic minorities. The Senate bill, however, emerged as having a greater number of minority-specific provisions overall, and stresses considerably more than the House bill areas such as cultural competence education and training and public health and prevention for minorities. The House legislation, nonetheless, is stronger in the area of health disparities research initiatives, including provisions not mentioned in the Senate bill, such as authorizing DHHS and the IOM to evaluate language access services and their impact on individuals with limited English proficiency.

Our review of general health care reform provisions also identifies a range of common and distinct actions across the bills that are important for expanding access to health insurance and medical care as well as improving affordability and quality. While no obvious or consistent “leader” emerges in its strengths for minorities, Congressional Budget Office reports suggest the House legislation may be slightly stronger in that it will cover a greater number of uninsured, many of whom are disproportionately a racial or ethnic minority. Specifically, it is estimated that 36 million would gain coverage under the House bill whereas roughly 31 million would gain coverage under the Senate bill.

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 the current proposals in at least three areas will significantly strengthen the potential for positive change in achieving health equity and assuring 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 a new health care reform 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 mainstream and integrated role in health care. 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 or 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 resulting from delayed care; and safeguarding the public’s health.

**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 health care for minorities. These include, for example, DHHS/OMH’s National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care, the 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 proposals, a stronger emphasis and more explicit federal support is needed to promote programs that actively engage communities, through research and application of evidence-based strategies, greater support for community health workers, patient education and health literacy programs, and by involving 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 toward 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 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 through culturally and linguistically tailored outreach and enrollment services could be overwhelmed if there is insufficient capacity to meet demand. Of special importance will be tracking the financial burden on individuals 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 care reform enactment. Without them, abuses or avoidance of requirements could lead to “cherry-picking” of healthy individuals and exclusion of others, and to 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, since their capacity and history in assuming related responsibilities varies.

***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 expanding research, training and services to reduce health disparities will be linked to final appropriation levels. Assuring adequate funding levels for programs that demonstrate efficacy will determine the extent that they can contribute to this goal.

***Assisting diverse patients and communities during health care reform’s transition period.*** Without direct action, the time between enactment and implementation of health care reform is likely to 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% of FPL (through primarily federal financing) will have immediate impact on minorities in states with historically low levels. Eliminating health plan discrimination based on pre-existing conditions would help minorities with chronic disease find coverage. Also, research, data collection, and public health/prevention initiatives requiring lower funding levels and fewer systems changes could be implemented during the transition period.

## Conclusion

The recognition of health disparities as a critical priority in 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 the direction on improving minority health for years, if not decades, to come.

## Acknowledgements

The authors would like to thank Christie Y. Mun, Graduate Intern at the Center for Health Equality for her work on this project.

## Contact Information:

If you have questions or need additional information, please contact Dr. Dennis P. Andrulis at: [dpa28@drexel.edu](mailto:dpa28@drexel.edu).

## References

- 1 Smedley, B. (June 23, 2009). Addressing racial and ethnic health inequities: Tri-Committee discussion draft for health care. House Energy and Commerce Committee, Health Subcommittee. Retrieved July 6, 2009, from <http://www.jointcenter.org/hpi/sites/all/files/Smedley%20testimony.pdf>.
- 2 Ulmer, C., McFadden, B., & Nerenz, D.R. (2009). Race, ethnicity, and language data: Standardization for health care quality improvement. Subcommittee on Standardized Collection of Race/Ethnicity Data for Healthcare Quality Improvement, Institute of Medicine. Retrieved October 2, 2009, from [http://www.nap.edu/catalog.php?record\\_id=12696](http://www.nap.edu/catalog.php?record_id=12696).
- 3 Brittingham, A. & de la Cruz, G.P. (2004). Ancestry: 2000. US Census Bureau. Retrieved June 23, 2009, from <http://www.census.gov/prod/2004pubs/c2kbr-35.pdf>.
- 4 Terrell, C. & Beaudreau, J. (2003). 3000 by 2000 and beyond: Next steps for promoting diversity in the health professions. *Journal of Dental Education*, 67(9): 1048-1052.
- 5 The Institute of Medicine. (2004). *The Nation's compelling interest: Ensuring diversity in the health care workforce*. Washington, D.C.: Institute of Medicine.
- 6 Green, A.R., et al. (2008). Providing culturally competent care: Residents in HRSA Title VII funded residency programs feel better prepared. *Academic Medicine*, 83(11): 1071-1079; Rittenhouse, D.R., et al. (2008). Impact of Title VII training programs on community health center staffing and National Health Service Corps participation. *Annals of Family Medicine*, 6(5): 397-405.
- 7 Office of Minority Health. (2002). National standards for culturally and linguistically appropriate services in health care. Washington, DC: US Department of Health and Human Services.
- 8 Mead, H., et al. (2008). *Racial and ethnic disparities in US health care: A chartbook*. New York: The Commonwealth Fund.
- 9 Thompson, G.E., Mitchell, F., & Williams, M.B., (2006). *Examining the Health Disparities Research Plan of the National Institutes of Health*. Washington, D.C.: Institute of Medicine.
- 10 Satcher, D. & Higginbotham, E. (2008). The public health approach to eliminating disparities in health. *American Journal of Public Health*, 98(3): 400-403.
- 11 Office of the General Counsel, US Commission on Civil Rights. (2004). Native American health care disparities briefing. Retrieved December 8, 2009, from <http://www.law.umaryland.edu/marshall/usccr/documents/nativeamericanhealthcare.pdf>.
- 12 Centers for Disease Control and Prevention. (2008). Behavioral Risk Factors Surveillance Systems. Adults aged 18-64 who have any kind of health care coverage. Retrieved October 30, 2009, from <http://apps.nccd.cdc.gov/BRFSS/race.asp?cat=HC&yr=2008&qkey=880&state=UB>.
- 13 James, C., Schwartz, K., & Berndt, J. (2009). A profile of American Indians and Alaska Natives and their health coverage. Kaiser Family Foundation. Retrieved October 2, 2009, from <http://www.kff.org/minorityhealth/upload/7977.pdf>.
- 14 Smedley, B.D. (2008). Moving beyond access: Achieving equity in state health care reform. *Health Affairs*, 27(2): 447-455.
- 15 Doty, M.M. & Holmgren, A.L. (2006). *Health Care Disconnect: Gaps in Coverage and Care for Minority Adults: Findings from the Commonwealth Fund Biennial Health Insurance Survey*. New York: Commonwealth Fund Issue Brief.
- 16 Kaiser Family Foundation. (2009). Medicaid and state funded coverage income eligibility limits for low-income adults, 2009. State Health Facts. Retrieved November 4, 2009, from <http://www.statehealthfacts.org/comparereport.jsp?rep=54&cat=4>.
- 17 Kaiser Family Foundation. (2009). Health insurance coverage of the total population, states (2007-2008), US (2008). State Health Facts. Retrieved November 4, 2009, from <http://www.statehealthfacts.org/comparereport.jsp?typ=2&ind=125&cat=3&sub=39&sortc=6&o=a>.
- 18 Doty, M.M. & Holmgren, A.L. (2006).
- 19 Lowrey, Y. (2007). Minorities in Business: A Demographic Review of Minority Business Ownership. Small Business Administration. Retrieved November 6, 2009, from <http://www.sba.gov/advo/research/rs298tot.pdf>.
- 20 Jaffe, S. "Health Policy Brief: A Public Health Insurance Plan," Health Affairs, June 19, 2009.
- 21 Mead, H., et al. (2008). *Racial and Ethnic Disparities in U.S. Health Care: A Chartbook*. New York: The Commonwealth Fund.
- 22 Children's Dental Health Project. *Racial and ethnic disparities in oral health*. Last retrieved June 24, 2009, from <http://www.cdhp.org/downloads/Disparityfactsheet.pdf>.

- 23 Howell, E., et al. (2003). Racial differences in reported postpartum depression. *AcademyHealth Meeting Abstract*, 20(236). Retrieved October 2, 2009, from <http://gateway.nlm.nih.gov/MeetingAbstracts/ma?f=102275218.html>.
- 24 Smedley, B., Smith, A., & Nelson, A. (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Washington, DC: Institute of Medicine.
- 25 Doty, M.M. & Holmgren, A.L. (2006).
- 26 Reed, M.C., Hargrave, J.L., & Cassil, A. (2003). Unequal access: African American Medicare beneficiaries and the prescription drug gap. Center for Studying Health System Change. Retrieved July 6, 2009, from <http://www.hschange.org/CONTENT/586/>.
- 27 Morris, L. (2009). Combating fraud in health care: An essential component of any cost containment strategy. *Health Affairs*, 28(5): 1351-1356.
- 28 Congressional Budget Office. (October 29, 2009). Retrieved December 3, 2009, from <http://www.cbo.gov/ftpdocs/106xx/doc10688/hr3962Rangel.pdf>.
- 29 Congressional Budget Office. (November 18, 2009). Retrieved December 3, 2009, from [http://www.cbo.gov/ftpdocs/107xx/doc10731/Reid\\_letter\\_11\\_18\\_09.pdf](http://www.cbo.gov/ftpdocs/107xx/doc10731/Reid_letter_11_18_09.pdf).

## About the Joint Center and its Health Policy Institute

The Joint Center for Political and Economic Studies is one of the nation's leading research and public policy institutions and the only one whose work focuses primarily on issues of concern to African Americans and other people of color. For nearly 40 years, our research and policy analysis have informed and influenced public opinion and national policy, while contributing to a wider understanding of the role of black civic and political participation in making America a better place for all its citizens.

The Joint Center Health Policy Institute, one of its four “centers of excellence,” plays a leadership role in reframing policy debates on health and focusing attention on existing health disparities. Our ongoing research and analysis are helping to generate policy recommendations and solutions for longstanding health equity concerns. The Institute strives to identify the complex underlying causes of health disparities and to develop strategies to address them, with the understanding that targeting the social determinants of health can lead to positive changes in patterns of health and well-being.

**Ralph B. Everett, Esq.** is President and CEO of the Joint Center for Political and Economic Studies, widely acknowledged as the nation's leading think tank for policy analysis and research on issues of concern to African Americans and other people of color. A native of Orangeburg, South Carolina, he has a 30 year track record of pioneering leadership in the nation's capital, having served in the 1980s as Staff Director and Chief Counsel of the U.S. Senate Committee on Commerce, Science and Transportation, and subsequently for more than 17 years as a partner at the international law firm of Paul, Hastings, Janofsky & Walker, LLP. A Phi Beta Kappa graduate of Morehouse College, Mr. Everett earned his J.D. from Duke University Law School.

**Brian D. Smedley, Ph.D.** is Vice President and Director of the Health Policy Institute of the Joint Center for Political and Economic Studies in Washington, DC. Formerly, Smedley was Research Director and co-founder of a communications, research and policy organization, The Opportunity Agenda. Prior to helping launch The Opportunity Agenda, Smedley was a Senior Program Officer in the Division of Health Sciences Policy of the Institute of Medicine (IOM), where he served as Study Director for the IOM reports, *In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce* and *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, among other reports on diversity in the health professions and minority health research policy.

## About the Authors

**Dennis P. Andrulis, Ph.D., MPH**, is Associate Dean for Research of Drexel University's School of Public Health. He also directs the Center for Health Equality (CHE), a collaboration of the School of Public Health and the School of Nursing. Dr. Andrulis leads the development of initiatives on racial/ethnic disparities and cultural competence for CHE and the School, working at the community level, statewide, and nationally. He is a co-founder of the national, biennial conference on *Quality Health Care for Culturally Diverse Populations*.

**Nadia J. Siddiqui, MPH**, is a Senior Health Policy Analyst at CHE. Ms. Siddiqui conducts policy and evaluation research of national, state and local programs targeting the health and health care of racial/ethnic minority populations. She also leads research activities for CHE's initiatives on emergency preparedness for diverse communities and serves as Project Manager for the National Consensus Panel on Emergency Preparedness and Cultural Diversity. Ms. Siddiqui has written and presented on a range of topics including racial/ethnic disparities in health, health care and emergency preparedness, community-based participatory research and suburban health care.

**Jonathan Purtle, MSc**, is a Health Policy Analyst at CHE where he works on a number of projects which focus on eliminating racial/ethnic disparities in health and promoting cultural competence in health care. Mr. Purtle is the Content Manager for The National Resource Center on Advancing Emergency Preparedness for Culturally Diverse Communities, [www.DiversityPreparedness.org](http://www.DiversityPreparedness.org). He is also one of the co-investigators of a systematic review of California's state, local, and community efforts to integrate culturally diverse populations into public health preparedness and works with the National Consensus Panel on Emergency Preparedness and Cultural Diversity.

**Lisa Duchon, Ph.D., MPA**, is a Senior Consultant at Health Management Associates, one of the nation's leading health care research and consulting organizations. HMA specializes in analytic and technical services to health care safety-net organizations and publicly financed programs such as Medicaid and Medicare. Dr. Duchon conducts survey, evaluation and policy research on state health care reform and state and local health programs. She writes and speaks frequently on health care quality, performance measurement and medical home initiatives in public programs.

**JOINT CENTER FOR POLITICAL AND ECONOMIC STUDIES  
BOARD OF GOVERNORS**

*Chair*

**Roderick D. Gillum, Esq.**  
Former Vice President  
Corporate Responsibility & Diversity  
General Motors Corporation

*Vice Chair*

**William E. Kennard, Esq.**  
Managing Director  
The Carlyle Group

*Vice Chair*

**Dianne M. Pinderhughes, Ph.D.**  
Professor, Africana Studies and  
Political  
Science, Presidential Faculty Fellow  
University of Notre Dame

*Secretary*

**Jacquelyn C. Shropshire**  
President/Owner  
Momentum Unlimited

*Treasurer*

**David C. Chavern, Esq.**  
Chief Operating Officer and Executive  
Vice President  
United States Chamber of Commerce

*President*

**Ralph B. Everett, Esq.**  
President & CEO  
Joint Center for Political  
and Economic Studies

**Norma Ketay Asnes**  
President  
Ketay Asnes Productions

**Donna Brazile**  
Founder and Managing Director  
Brazile & Associates LLC

**Dwight L. Bush**  
Managing Director  
D.L. Bush & Associates

**Sanford Cloud, Jr., Esq.**  
Chairman and CEO  
The Cloud Company, LLC.

**John W. Franklin**  
Director of Partnerships  
and International Programs  
National Museum of African  
American History & Culture  
Smithsonian Institution

**Robert L. Mallett, Esq.**  
Former Senior Vice President,  
Worldwide Policy and Public  
Affairs, Pfizer, Inc.  
Former President of The Pfizer  
Foundation

**Cynthia G. Marshall**  
President  
AT&T North Carolina

**Marva Smalls**  
Executive Vice President  
of Global Inclusion Strategy,  
MTV Networks & Executive  
Vice President of Public Affairs,  
and Chief of Staff  
Nickelodeon/MTV Kids  
& Family Group

**Earl W. Stafford**  
Chief Executive Officer  
The Wentworth Group LLC

**Reed V. Tuckson, M.D., FACP**  
Executive Vice President  
and Chief of Medical Affairs  
UnitedHealth Group

**The Honorable Paul R. Webber, 3rd**  
Senior Judge  
D.C. Superior Court

**Robert L. Wright, O.D.**  
Chairman  
Flight Explorer

**Cynthia M. Bodrick**  
Assistant Secretary of the Corporation

**MEMBERS EMERITI**

**Dr. William B. Boyd**  
President Emeritus  
The Johnson Foundation

**Eddie N. Williams**  
Eddie Williams and Associates, LLC

**James D. Wolfensohn**  
President & CEO  
Wolfensohn and Company

**FOUNDERS**

**Dr. Kenneth B. Clark †**  
Served from 1970 to 2005

**Louis E. Martin †**  
Served from 1970 to 1997

† deceased

*The Joint Center Health Policy Institute is generously supported by a grant from the W.K. Kellogg Foundation.*



**JOINT  
CENTER**  
— FOR —  
POLITICAL  
AND ECONOMIC  
STUDIES

Joint Center for Political and Economic Studies  
1090 Vermont Avenue, NW, Suite 1100  
Washington, DC 20005  
[www.jointcenter.org](http://www.jointcenter.org)



This product is printed on paper that is 50% recycled, 25% post consumer, Elemental Chlorine Free (ECF), and acid free.

