



NOVEMBER 2009

HEALTH REFORM AND COMMUNITIES OF COLOR: HOW MIGHT IT AFFECT RACIAL AND ETHNIC HEALTH DISPARITIES?

EXECUTIVE SUMMARY

By 2045, more than half of the population in the U.S. will be a person of color. People of color continue to experience worse access to health care and worse health outcomes than their white counterparts. The economic and opportunity costs associated with disparities are shared by everyone through money spent on preventable medical care, among other things. Health reform is a national priority, and Congress is considering several proposals that would expand coverage to many of the millions of individuals who currently lack coverage. Although the reduction of health disparities is not one of the main goals of health reform, there are provisions in each of the proposed bills that either directly or indirectly could have an impact.

People of color have much to gain from the health reform bills under consideration. Although they represent one-third of the total U.S. population, they comprise more than 50 percent of the uninsured. People of color are more likely to be low-income than whites, and they have lower employer coverage rates, in part because they are more likely to be unemployed, and when employed, they are more likely to work low-wage jobs, which are less likely to offer coverage. Many people of color would benefit from the proposed Medicaid expansions and the proposed financial aid for some of the individuals purchasing coverage through the health exchange. This issue brief discusses some of the key provisions of the proposed legislation that would expand health coverage and improve access to care for people of color, as well as some of the other provisions that would have either a direct or indirect impact on health disparities.

Expanding Health Coverage

Employer Mandate – People of color are more likely to work low-paying jobs, and have decreased access to employer sponsored coverage compared to non-Hispanic whites. Although there are exceptions, the proposed legislation would require employers to provide coverage to their employees. The employer mandate, along with the premium credits and cost-sharing subsidies would likely allow many people of color to obtain health coverage that would otherwise remain unaffordable.

Health Exchange – The House bill and Senate HELP Committee bill allow individuals with incomes above 150% FPL (133% for the Finance bill), to purchase coverage through a newly created health exchange if employer sponsored coverage is not available. To ensure that coverage would be affordable, premium credits and cost-sharing subsidies depending on the bill, would be available to people with incomes up to 400% FPL. Many people of color would be eligible for these premium credits and cost-sharing subsidies, as 4 out of 5 blacks, Hispanics and American Indians and Alaska Natives have incomes below 400% FPL.

Medicaid Expansions – Nearly 6 out of 10 of the 25 million nonelderly uninsured individuals with incomes below 150% FPL are a person of color. The House bill and the Senate HELP Committee bill would expand Medicaid eligibility to include individuals with incomes less than 150% FPL, including men and childless adults, while the Senate Finance Committee bill would expand eligibility to 133% FPL. The federal poverty level in 2009 is \$14,404 for individuals and \$29,327 for a family of four.

Improving Access to Care

Community Health Centers – Community health centers fill a critical need for communities of color, as half of the patients who receive care at a community health center are people of color. Each health reform proposal includes funding increases for community health centers, which would help them meet the needs of their patient population.

Workforce Development – Numerous reports indicate the health system is experiencing or will soon experience a shortage of health professionals. Many low-income individuals, rural residents, and people of color live in medically underserved areas, where the shortages already exist. Several of the health reform proposals contain provisions aimed at increasing the number of providers, particularly primary care providers, and increasing the number of providers in medically underserved areas.

Disparities-Specific Provisions

Each of the proposals contain provisions specific to health disparities. In the House bill much of the focus is on providing language services to individuals with limited English proficiency, while the Senate bills include provisions to improve the collection of data on race, ethnicity, primary language, geographic area, and disability. Other provisions in the proposals address cultural competency training for providers and ensuring services and information provided to individuals are culturally and linguistically appropriate, and the House bill would reauthorize the Indian Health Care Improvement Act.

Other Provisions Related to Disparities

Indian Health Care Improvement Act – Under the House bill, the Indian Health Care Improvement Act would be reauthorized for the first time since 2001. This is a comprehensive bill that addresses many of the needs of the American Indian and Alaska Native community, including provisions to improve health promotion and disease prevention services, provisions to improve access to care for urban Indians, and provisions to modernize facilities where American Indians and Alaska Natives receive care.

Immigrants – Legal immigrants would remain eligible for Medicaid. However, most legal immigrants would continue to be barred from enrolling in Medicaid during their first five years residing in the U.S. Legal immigrants without an offer of credible coverage from their employer, and those with credible coverage through their employer whose premiums exceed a specified percentage of their income would be eligible to receive premium credits and subsidies on the same basis as citizens. None of the proposed bills would allow undocumented immigrants to enroll in Medicaid or to receive premium credits or cost-sharing subsidies for coverage through the health insurance exchange.

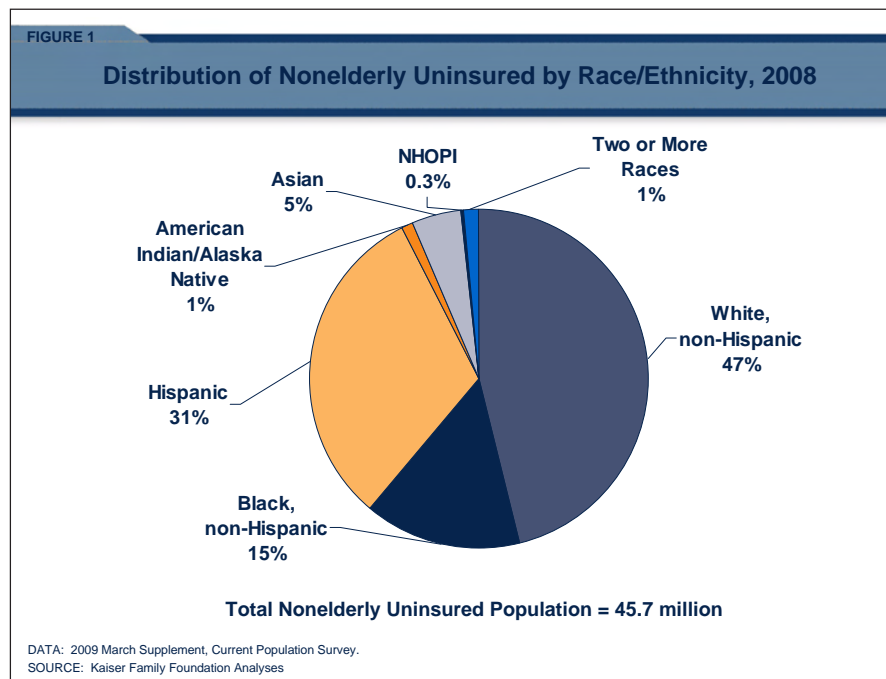
Prevention – People of color experience higher prevalence rates for many chronic conditions, as well as higher death rates from many of these conditions than whites, and the costs associated with these diseases are high. All of the bills contain provisions to improve the overall health of the population through improved access to proven preventive services.

BACKGROUND

People of color represent a growing proportion of the population in the U.S. By 2045, they will account for more than half of the population.¹ People of color tend to have worse access to health care, tend to receive lower quality care when they are able to access it, and tend to have worse health outcomes than non-Hispanic whites. It is hard to know the true cost of health disparities, but a recent report estimated that between 2003 and 2006, more than \$200 billion could have been saved in direct medical care expenditures if health disparities did not exist.² The direct and indirect costs attributed to health disparities contribute to the growth of health care costs in national health care expenditures, which is one of the reasons Congress has undertaken health reform.

Health reform has emerged as a priority for the President and Congress. Currently, Congress has before it three proposals for health reform, one from each of the authorizing committees. There are two Senate bills, one from the Health, Education, Labor and Pension (HELP) Committee (S. 1679, "Affordable Health Choices Act"), and one from the Finance Committee (S. 1796, "America's Healthy Future Act of 2009"). The House started with a single bill that was amended by each of the three authorizing committees, the Committee on Energy and Commerce, the Committee on Ways and Means Committee, and the Committee on Education and Labor. After being voted out of each committee, the bills were consolidated and H.R. 3962, Affordable Health Care for America Act was approved by the House. Meanwhile the leadership of the Senate continues to reconcile the bills for consideration before the end of the year.

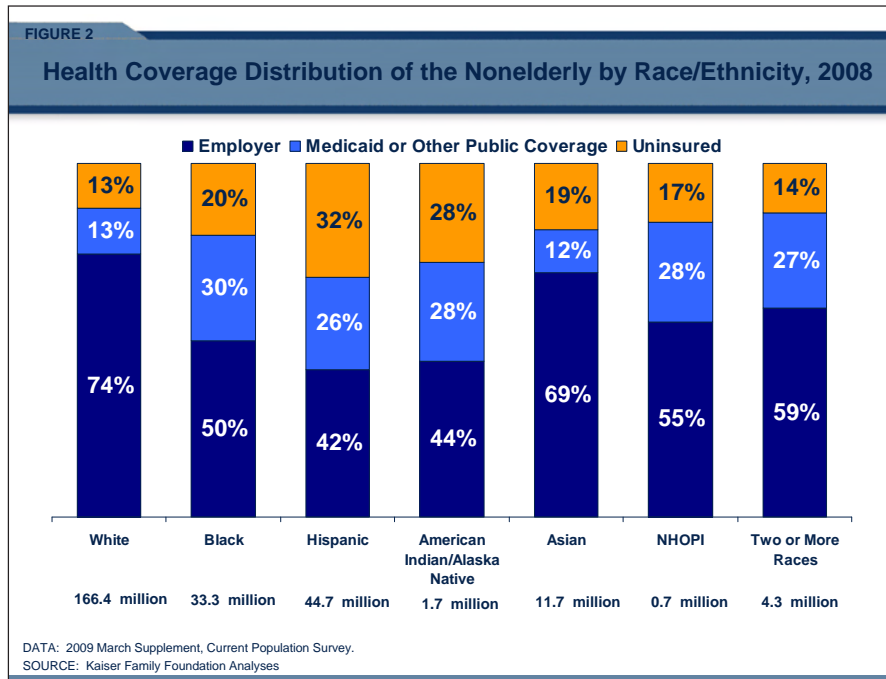
One of the main goals of health reform legislation is to expand health coverage to the more than 45 million nonelderly individuals who currently lack coverage. Other goals of the proposed legislation include improving the quality of care patients receive and reducing health care costs. Reducing and eliminating racial and ethnic health disparities is not a major goal of the proposed legislation, but each bill contains a few provisions specific to racial and ethnic health disparities, and there are other provisions not specific to disparities that have the potential to impact them, such as the coverage expansions proposed in each of the bills. Although people of color represent one-third of the U.S. population, they comprise more than half of the uninsured (Figure 1).



EXPANDING HEALTH COVERAGE

Expanding health coverage to many of the 46 million nonelderly uninsured is one of the major goals of the proposed health reform bills. People of color have higher uninsured rates than non-Hispanic whites, and Hispanics are the group with the highest uninsured rate (32%). Were it not for public coverage programs such as Medicaid, uninsured rates for all individuals, regardless of race would be higher. Having health coverage is an important determinant of access to health care. Fewer uninsured individuals have a usual source of care or receive preventive care screenings compared to insured individuals.³ The uninsured also have more preventable hospitalizations, and ultimately have worse health outcomes than those with insurance.⁴

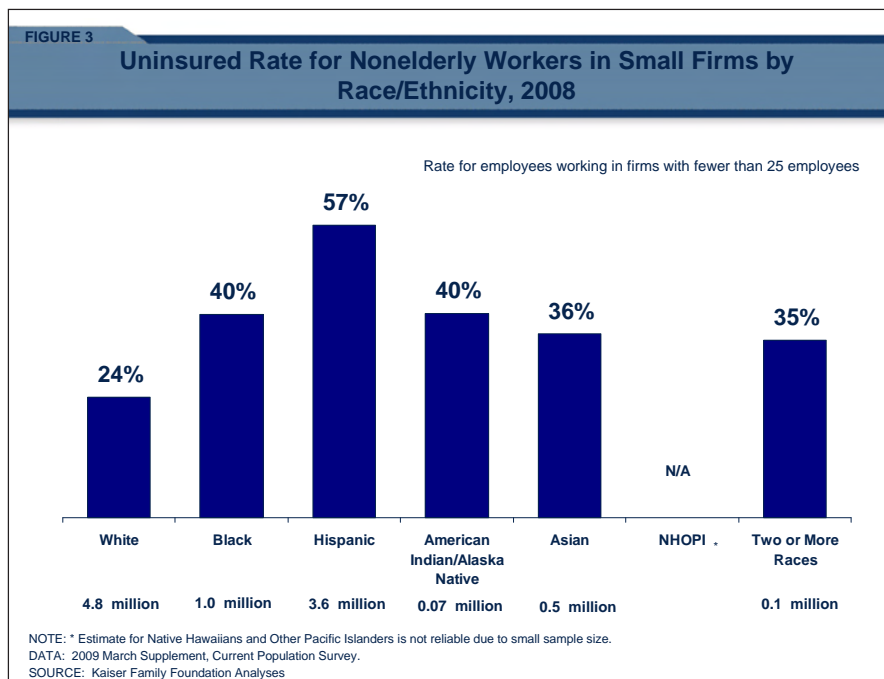
In the U.S., most individuals receive their health coverage through an employer. However, with the exception of Asians, employer coverage rates for people of color are much lower than those of non-Hispanic whites (Figure 2). Building on the current system, the proposed legislation would provide coverage to the uninsured through individual and employer mandates, expansions to Medicaid, and the creation of a health exchange for individuals who would otherwise remain uninsured.



Employer Mandate

People of color are more likely to work low wage jobs, and have decreased access to employer sponsored coverage compared with whites.⁵ Many people of color work for small employers, who compared with their larger counterparts, are less likely to offer health coverage to their employees.⁶ For various reasons, however, even among small employers, racial and ethnic disparities exist among those with health coverage (Figure 3). The House bill and the Senate HELP Committee bill include provisions that would require employers with a certain number of employees to provide coverage, or pay a penalty. In the Senate Finance Committee bill, there isn't a requirement, but should an employee purchase coverage through the health exchange because their employer does not offer coverage, then their employer would be required to pay a penalty. For smaller employers, the federal government would provide subsidies and tax credits to help make it more affordable to coverage. The Senate Finance Committee bill would allow employees whose coverage premiums exceed 10 percent of their income access to premium credits and coverage through the health insurance exchange. Under the House bill and the Senate HELP Committee bill, individuals whose premiums exceed 12 percent and 12.5 percent of their income respectively, would be eligible to receive premium credits to make coverage through the health exchange more affordable.

The employer mandate and access to premium credits for low wage workers and those for whom coverage remains unaffordable would likely lead to coverage expansions for minority workers and their families.

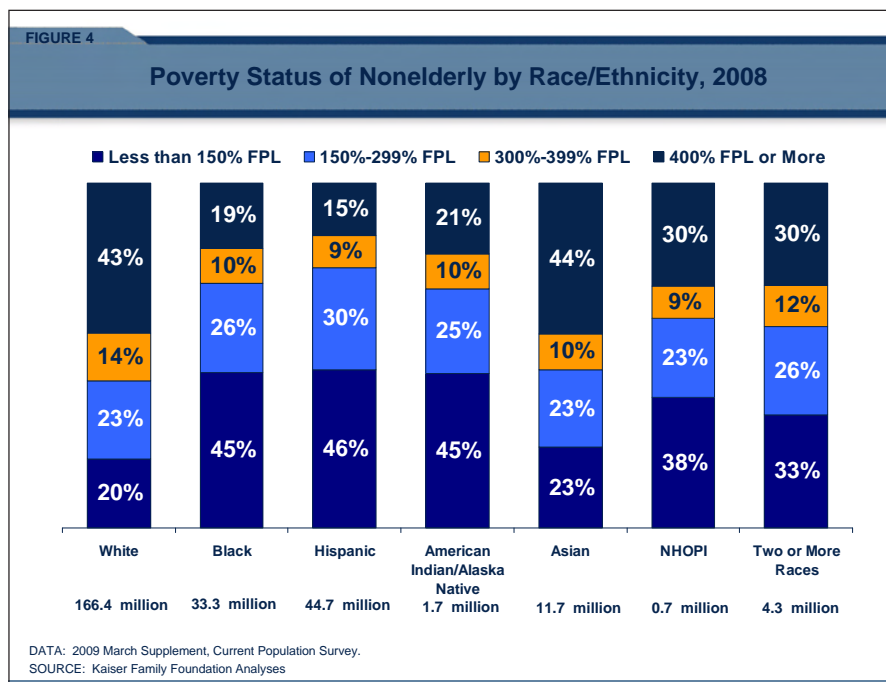


Health Exchange

The health reform bills seek to expand coverage for the uninsured with incomes above 150% FPL by creating a new marketplace – the health exchange – where people can compare health coverage policies. Individuals without an offer of credible coverage from their employer, those for whom their premiums would be deemed too costly, and depending on the bill, a small portion of individuals who qualify for Medicaid would be eligible to purchase health coverage through the health exchange.

To ensure that coverage in the health exchange will be affordable, premium credits will be available for many individuals. Each of the three bills includes premium credits for individuals and families up to 400% of the federal poverty level. All three bills also include subsidies to assist with cost-sharing. Cost-sharing subsidies in the Finance Committee bill would be available to individuals and families between 100% and 200% of FPL, while subsidies in the House bill and the Senate HELP Committee bill would be available for individuals and families with incomes up to 400 percent of FPL. These subsidies would help to limit the out-of-pocket expenditures for many individuals and families. Each of the three bills would require the Secretary of Health or an advisory panel to determine what benefits would be required of plans offering coverage.

Premium credits and cost-sharing subsidies would be particularly important to communities of color, as they comprise 50 percent of the 16 million nonelderly uninsured individuals with incomes between 150% FPL and 399% FPL. Additionally, individuals and families in these communities tend to have fewer economic resources at their disposal to pay for health coverage and out-of-pocket medical expenses. Nearly 4 in 5 nonelderly blacks, Hispanics, and American Indian and Alaska Natives have incomes below 400% of FPL (Figure 4), and before the start of the recession, there was a six-fold difference between the median net worth for White, non-Hispanic families (\$171,200) with holdings compared to families of people of color (\$28,300) with holdings.⁷ For these individuals in particular, the premium credits and subsidies as well as what the Secretary of Health defines as “affordable” coverage would have a significant impact on who is able to purchase health coverage. The timing of the credits and subsidies would also be critical in determining whether an individual is able to afford coverage. Each of the bills includes provisions to ensure that premium credits and cost-sharing subsidies are available to individuals and families at the time they purchase their health coverage. This would be important for many people of color, who, due to wealth differences between them and non-Hispanic whites, would be less able to afford the up-front expenditures associated with purchasing health coverage, and thus would be more likely remain uninsured.



Despite the efforts to limit cost sharing, affordability of health coverage is likely to remain an issue for some individuals, particularly the sick. For some individuals, the total cost of premiums, coinsurance, and the maximum amount cost-sharing would mean that they may still spend a significant amount of their income on health expenditures.

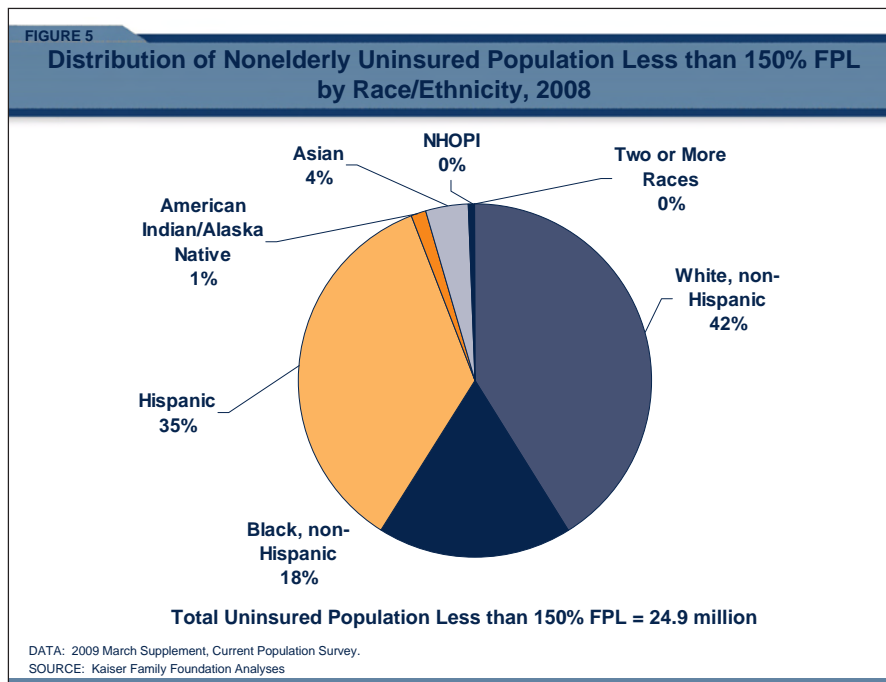
Nearly 40 million individuals residing in the U.S. are immigrants.⁸ More than one-third (36%) of them have become naturalized citizens, another third (34%) are legal immigrants, and the remaining 30% or 11.9 million are estimated to be undocumented. Among the nonelderly, non-citizens (including legal and undocumented immigrants) have a significantly higher uninsured rate compared with those who are citizens (46% vs. 15%), and despite similar employment levels, non-citizens have much lower rates of employer coverage than citizens (41% vs. 67%). Legal immigrants without an offer of credible coverage from their employer, and those with credible coverage through their employer whose premiums exceed a specified percentage of their income would be eligible to receive premium credits and subsidies on the same basis as citizens. None of the proposed bills would allow undocumented immigrants to receive premium credits or cost-sharing subsidies.

Medicaid Expansions

All of the proposed health reform bills include a significant expansion of Medicaid. Under the proposals, all individuals, regardless of age, sex or parental status, would be eligible for Medicaid if they meet the income threshold. At a minimum, individuals with incomes below 133% FPL (the current poverty level is \$10,830 for an individual and \$22,050 for a family of four) would be eligible to receive Medicaid services. The House bill and the Senate HELP Committee's bill would make all individuals with incomes up to 150% FPL (\$16,245 for individuals and \$33,075 for a family of four) eligible for Medicaid, while the Senate Finance Committee's bill would make individuals up to 133% FPL eligible.

Of the 74 million nonelderly individuals with incomes below 150% FPL nearly 6 in 10 are people of color, and 24.9 million are uninsured. Some of these individuals are currently eligible for Medicaid, but for various reasons, are not enrolled. Increasing the Medicaid eligibility to 150% has the potential to significantly reduce the number of uninsured. The Congressional Budget Office estimates that raising the eligibility level to 133% would lead to 11 million new people receiving coverage through Medicaid over the course of the next 10 years,⁹ and raising the eligibility level to 150% would result in additional 4 million people receiving coverage.¹⁰ How many newly eligible individuals actually enroll in Medicaid will depend on the extent to which states simplify the enrollment process and coordinate with the exchanges in creating "no wrong door". Lessons from Medicaid and CHIP enrollment indicate that enrollment should be as simple as possible, and there should be coordination between the necessary agencies to help streamline the process and reduce delays.

Over 25 million uninsured nonelderly individuals have incomes less than 150% FPL, and more than half of them are people of color (Figure 5). Gender differences also exist among the uninsured, with men having a higher uninsured rate than women. This is largely the result of fewer men being eligible to receive coverage through Medicaid under the current eligibility requirements, which provides coverage to low-income adults with dependent children and the disabled. The proposed legislation would mean that poor men and poor women who meet the income threshold would have equal access to coverage through Medicaid.

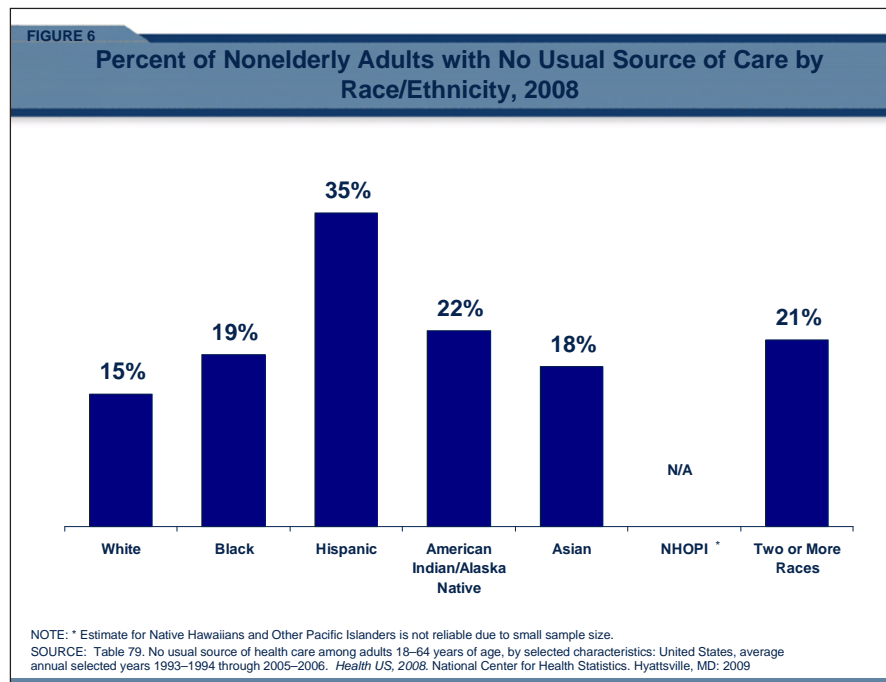


None of the proposed bills would allow undocumented immigrants to qualify for Medicaid. Legal immigrants would remain eligible for Medicaid. Most legal immigrants would continue to be barred from enrolling in Medicaid during their first five years residing in the U.S., although states now have the option to vacate this waiting period for otherwise eligible children and pregnant women.

Although Medicaid enrollees have better access to care compared to the uninsured, problems finding physicians exist in the program. Participation among providers had been low, and low provider participation in the Medicaid program has been attributed to the payment rates.¹¹ Payments to Medicaid providers have traditionally been lower than those of Medicare and private coverage. On average, for every dollar Medicare has paid a provider, Medicaid has paid \$0.72, and payment rates have varied substantially by state and for a given category of services (e.g. primary care vs. obstetric care).¹² Current health reform proposals include increases in Medicaid payments for primary care, but these increases would not eliminate the gap between Medicaid and Medicare completely. In the absence of an increase in the number of providers willing to treat patients with Medicaid coverage and an increase in the number of providers in medically underserved areas, the significant expansion of the program proposed in the health reform bills could exacerbate existing access problems, as well as health disparities.

IMPROVING ACCESS TO CARE

Having insurance is critical to receiving timely health care. However, having health coverage is not enough to guarantee it. A common measure of access to care is whether an individual has a usual source of care. More people of color report not having a usual source of care and not having a personal health care provider than whites (Figure 6).¹³ Furthermore, regardless of whether Congress passes health reform, numerous reports indicate there will be a shortage of available health care professionals (e.g. doctors, nurses, dentists, and pharmacists) in the very near future, and that some areas such as nursing, pharmacy and public health are already experiencing a moderate shortage.¹⁴ To address these issues, the proposed bills include provisions to increase the health care workforce, and strengthen community health centers, which provide a substantial amount of care to people of color and low-income individuals.



Community Health Centers

By law, community health centers must be located in, medically underserved communities or communities that are designated primary care health professional shortage areas, or they must have as their target population communities that experience these circumstances. Community health centers play a critical role in providing care to people of color. Although people of color represent one-third of the U.S. population, half of the patients who receive care in community health centers are a person of color.¹⁵ Community health centers also play a critical role in the provision of care to migrant workers.

In each of the proposed health reform bills community health centers would receive a boost in funding. In the Senate Finance Committee bill, community health centers would receive a special payment from Medicaid. They would also receive an increased reimbursement rate from Medicare, which has typically under reimbursed community health centers for their services. The Finance Committee bill would also create teaching health centers. The House bill would provide grants to establish nurse-managed health centers to increase the provision of comprehensive primary care services and wellness services.

Workforce Development

The House bill contains provisions aimed at increasing the number of primary care providers, nurses, public health workers, including public health dentists and dental hygienists. This would be accomplished largely through loan repayment programs, scholarships, and expansions in the National Health Service Corps Program. Similar provisions are contained in the Senate HELP Committee bill, but the Senate Finance Committee bill does not include provisions for loan repayment programs or scholarship programs, although it does offer bonuses to primary care providers and general surgeons practicing in primary medical care health professional shortage areas.

Some of the proposed legislation also includes provisions to try to increase the number of providers in primary care, pediatrics, and geriatrics, but with the exception of reallocating unused residency positions, there is little to address the unequal distribution of providers that has left more than 4 in 10 women living in a primary care or mental health professional shortage area.¹⁶ Many low-income individuals, rural residents, and people of color live in medically underserved areas. Training programs will take many years to increase the primary care and public health workforce, but the need for these providers will be more immediate. These workforce expansions, should they work, would likely provide much need help to these communities, but it is likely that additional efforts will be needed to adequately address both the current health professional shortage, and the increased demand for services resulting from the newly insured individuals.

DISPARITIES-SPECIFIC PROVISIONS

Each of the three health reform proposals contain a section dedicated to the reduction of racial and ethnic health disparities. In the House bill, these efforts largely focus on the provision of language appropriate services to the millions of Americans with limited English proficiency (LEP), while the two bills in the Senate focus on data collection.

House Bill (H.R. 3962, Affordable Health Care for America Act)

The majority of the House bill's section on reducing health disparities addresses challenges associated with access to care for individuals with limited English proficiency. This would happen primarily through efforts directed towards the Medicare population. Specifically, the bill requests the Center for Medicare and Medicaid Services to conduct a study on the current availability and utilizations of language services, and the potential to provide incentives to providers to increase their use. The bill also asks the Institute of Medicine to produce a report on the impact of language access services on the health and health care of LEP individuals.

Over 24 million people ages 5 and older speak English less than very well, representing almost 9 percent of the population in that age group.¹⁷ The Congressional Budget Office estimates that more than 8 million people would be ineligible for new federal premium credits and cost-sharing subsidies or to enroll in Medicaid because they are undocumented immigrants.¹⁸ Many undocumented immigrants speak English less than very well. Data on the proportion of undocumented immigrants who speak English less than very well are not available, but looking at data for all non-citizens, regardless of documentation status, gives a glimpse of the situation. Nearly 9 in 10 non-citizens speak a language other than English at home,¹⁹ and more than 60 percent of foreign-born individuals who speak a language other than English at home, speak English less than very well. Undocumented immigrants would benefit from services provided in emergency rooms, as they will remain eligible for emergency services. However, unless the recommendations from the studies are implemented, the provisions specific to individuals with limited English proficiency included in the proposed bill, would likely have limited impact on health disparities experienced by people of color because without implementation the main beneficiaries of the provisions would be the Medicare study participants.

In addition to the provision of language services to the LEP population, the House bill requests the establishment of a demonstration project to promote reimbursement for culturally and linguistically appropriate services. The provision of culturally and linguistically appropriate services is important to ensure that patients receive quality health care. The House bill requests the Secretary take health disparities, among other things, into consideration when setting national priorities for performance improvement, when developing measures of quality improvement, when issuing grants for workforce development and community improvement, and when developing a national strategy for prevention and wellness.

Senate HELP Committee Bill (S. 1679 Affordable Health Choices Act)

In the Senate, the Health, Education, Labor, and Pensions (HELP) Committee and the Finance Committee bills take a different approach from that of the House bill. Both of the Senate health reform proposals have provisions that focus largely on data collection and reporting as a means to reduce health disparities. While mainly focused on racial and ethnic health disparities, the Senate HELP Committee's bill includes socioeconomic disparities and disparities among the disabled in some of its provisions. It would require the collection of data on race, ethnicity, language, geographic location, socioeconomic status (including income and education) and disability. It also asks the Secretary of Health to develop curricula for cultural competency for individuals with disabilities. In an attempt to develop a more diverse workforce, and to encourage providers to work in medically underserved communities, the HELP Committee bill includes funding for loan repayment programs for doctors in pediatrics and pediatric specialties, and public health, and grants for schools with a record or plan for training individuals for primary care, geriatrics, and public health dentistry, as well as individuals from underrepresented minority populations, disadvantaged backgrounds and rural backgrounds.

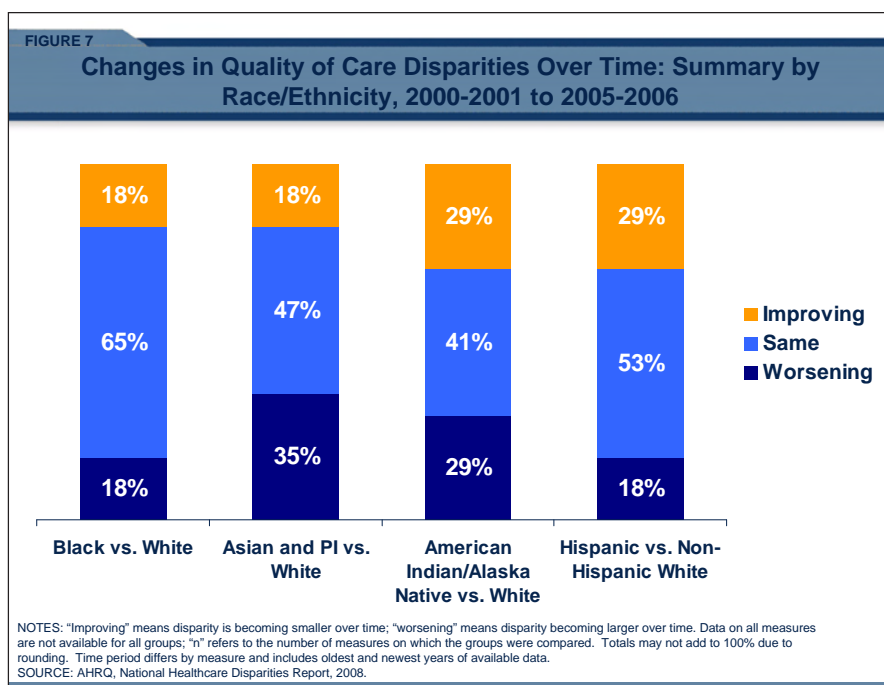
The Senate HELP Committee bill also includes provisions related to cultural competency. The provision of culturally and linguistically appropriate services is woven throughout many provisions of the bill. These provisions include grantmaking, the development of core training competencies, the dissemination of information through the health exchange, and the reimbursement definition for high quality health care.

Senate Finance Committee Bill (S. 1796, America's Healthy Future Act of 2009)

The Senate Finance Committee's bill also includes provisions to increase collection and reporting of data on race, ethnicity, and language. However, this bill would go a step beyond the provisions of the HELP bill to establish uniform categories to be used in the collection of race, ethnicity, sex, and primary language. This is timely, given the recent recommendation from the Institute of Medicine's (IOM) *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement* report. In it, the IOM recommended the collection of race and ethnicity using the OMB standard race and Hispanic ethnicity categories, collecting granular ethnicity data with categories specified by HHS, and collecting data on spoken language, including English proficiency and preferred language for medical encounters, using a standard set of categories provided by HHS. The IOM also encouraged the collection of data on language preference for written materials where possible. In addition to requiring data collection using standardized categories, the Finance Committee bill would require all federally-funded population surveys to collect enough data to allow for reliable reporting of racial and ethnic subgroups. These provisions would greatly improve our ability to document disparities, especially among some of the smaller populations who are typically either excluded from the reporting of survey findings, or grouped as "Other".

The Finance Committee's bill also includes a few provisions that are specific to American Indians and Alaska Natives. These provisions would exempt American Indians and Alaska Natives from the paying a penalty for not having health coverage. They would also exempt tribal benefits from gross income calculations, and prohibit cost-sharing for American Indians and Alaska Natives with incomes below 30 percent of the federal poverty level (FPL). In the absence of a financial penalty, it remains to be seen how many American Indians and Alaska Natives would obtain coverage.

While data collection is necessary to document the extent of the problem and to measure progress in remedying the situation, elimination of the problem does not necessarily follow. Evidence of this can be found in the *National Healthcare Disparities Report* (NHDR). Mandated by Congress in the Minority Health and Health Disparities Research and Education Act of 2000, the Agency for Healthcare Research and Quality has produced the NHDR every year since 2003. Yet, as the latest report shows, gaps in health care quality between whites and people of color remain unchanged, and in some cases are getting wider (Figure 7).²¹



OTHER PROVISIONS RELATED TO RACIAL AND ETHNIC HEALTH DISPARITIES

American Indians and Alaska Natives

American Indians and Alaska Natives experience some of the worst health outcomes and have some of the worst access to care of all racial and ethnic populations in the U.S. American Indian and Alaska Native women have some of the highest rates of diabetes, heart disease, and serious psychological distress. Similar to blacks and Hispanics, 1 in 3 nonelderly American Indians and Alaska Natives live in poverty, and the uninsured rate for nonelderly American Indians and Alaska Natives is the second highest of any racial or ethnic group in the U.S. at 28 percent. Many American Indians and Alaska Natives access care through the Indian Health Services, which, as a result of chronic underfunding, rations care based on a hierarchy of need.

Both of the Senate bills would exempt members from tribes from the penalties associated with the individual mandate. In addition, the Senate Finance bill includes provisions to eliminate cost sharing for American Indians and Alaska Natives and individuals eligible for Medicaid, which may encourage them to enroll in coverage through the health exchange. Many American Indians and Alaska Natives are low-income, and therefore would meet the income threshold to qualify for Medicaid. It remains to be seen how many will enroll without the threat of paying a financial penalty. For American Indians and Alaska Natives who receive care through the Indian Health Services and who either enroll in Medicaid or enroll in a health care plan through the health exchange, the additional income to clinics through Medicaid and other health plan payments may help ease the financial strain, thereby leading to a decrease in the rationing of health care at these facilities, and an increase in the number of people receiving needed care in a timely manner.

The House bill also contains the Indian Health Care Improvement Act of 2009 (IHCIA). The IHCIA is a comprehensive bill aimed at addressing the myriad of health and access needs of the American Indian and Alaska Native population. Included in the IHCIA are provisions to increase the number of American Indian and Alaska Native health providers, provisions to increase and improve health promotion and disease prevention services, provisions to improve availability of behavioral health services, and provisions to improve access to care for urban Indians. There are also provisions to renovate health care facilities serving large populations of American Indians and Alaska Natives. In addition to the provisions included in the IHCIA, the House bill includes provisions to strengthen payments to providers treating American Indians and Alaska Natives, regardless of the location of that service, and provisions to increase outreach and streamline the enrollment of eligible American Indians and Alaska Natives into SCHIP and Medicaid.

Prevention

Primary and secondary prevention are important parts of maintaining a healthy population. People of color experience higher rates of diabetes, hypertension, obesity and serious psychological distress, and have higher death rates from heart disease than whites.²³ Direct medical costs for diabetes and heart disease were estimated to be more than \$100 billion and \$300 billion, respectively.²⁴

Each of the proposed bills contain provisions for prevention and wellness. Both the House bill and the Senate HELP Committee's bill include a provision to develop a national strategy for improving the nation's health through preventive efforts, and the HELP bill would establish an investment fund to help further prevention and public health programs. The HELP bill would also award grants to state, local and community-based organizations to implement efforts to reduce chronic disease rates and health disparities.

The House bill and the Senate Finance Committee bill would cover "proven" preventive services for Medicare and Medicaid enrollees, and both Senate bills would allow employers to offer financial rewards to employees participating in wellness programs. These rewards would cover up to 30 percent of the cost of coverage.

CONCLUSION

Although the elimination of racial and ethnic health disparities is not a major goal of health reform, each of the health reform bills contains provisions aimed at reducing health disparities, and others that will likely have an indirect impact on disparities. However, there are many factors within the health care system that contribute to health disparities that remain largely untouched by the current health reform proposals. In addition, the racial and ethnic disparities evident in the health care system today are the result of a myriad of factors, many of which are outside the traditional health care system such as poverty, education, and housing, and which are also not addressed as part of health reform.

Many of the provisions specific to racial and ethnic health disparities included in the health reform proposals rely on grants and demonstration projects. Due to fiscal constraints, it is likely that many people will be left out of the grantmaking process. Demonstration projects are helpful to gather knowledge where little exists, but unless the findings are implemented in existing programs or unless new programs are generated to put the new knowledge into practice, it is unlikely there will be a significant reduction in racial and ethnic health disparities.

Much remains to be seen regarding the implementation of the premium credit and cost-sharing subsidies, and the benefit design of health plans within the exchange. Many of the rules and regulations regarding implementation have yet to be written and will be critically important in determining many pieces of the remaining puzzle.

The passage of health reform legislation has the potential to significantly impact communities of color and their access to health care. It also has the potential to impact racial and ethnic health disparities. While the coverage expansions proposed in the health reform bills will not be sufficient to eliminate health disparities, they are a necessary first step.

People of color will likely benefit from many of the provisions in health reform, but these provisions are not likely to reduce the persistent racial and ethnic disparities evident in the U.S. The disparities-specific provisions in the proposed bills will likely have a very limited impact on the disparities in health and health care experienced by many people of color unless coupled with more comprehensive measures. Like the expansions in health coverage, the disparities-specific provisions in the proposed bills serve as an important first step in addressing racial and ethnic health disparities. Given the billions of dollars associated with health disparities and the goal of reducing health care expenditures through health reform, the exclusion of more comprehensive measures to address racial and ethnic health disparities represents a significant missed opportunity.

- ¹ Table 6. Percent of the Projected Population by Race and Hispanic Origin for the United States: 2010 to 2050 (NP2008-T6). Population Division, U.S. Census Bureau. August 14, 2008.
- ² LaVeist RA, Gaskin DJ, and Richard P. (2009). *The Economic Burden of Health Inequalities in the United States*. Washington, DC: Joint Center for Political and Economic Studies.
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