

## Health Reform

### **Health Disparities and the Patient Protection and Affordable Care Act.**

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act, which is referred to as the Affordable Care Act (federal health reform), signed into law in March 2010 has provisions to improve the quality of care, reduce costs, increase access to care, fortify the health care workforce and make health coverage obtainable for all Americans all of which have the capacity to reduce disparities in health. Below are specific provisions in the Affordable Care Act (ACA) that have the potential to reduce health disparities:

### **Federal Infrastructures to Reduce Health Disparities**

Section 10334 establishes that the Office of Minority Health within the Department of Health and Human Services will be transferred to the Office of the Secretary. In addition, the National Center on Minority Health and Health Disparities will be re-designated as the "National Institute on Minority Health and Health Disparities." Six individual Offices of Minority Health will also be established within the Department of Health and Human Services. For example, The Centers for Disease Control and Prevention will create an Office of Minority Health, which along with a network of other offices within agencies will work with the Office of Office of Minority Health to improve the status of minority populations, monitor trends, and evaluate programs and initiatives. The agencies also include the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid, the U.S. Food and Drug Administration, the Health Resources and Services Administration, and Substance Abuse and Mental Health Services Administration. In addition, the Indian Health Care Improvement Act, which provides support to Indian Health Services, was permanently reauthorized. [Click here](#) for more information.

### **Data Collection, Quality Improvement, and Research**

Section 4302 of the ACA requires that population surveys and federally funded health and health care programs enhance their collection and reporting of data on race, ethnicity, sex, primary language, disability status, those living in rural and frontier areas and other characteristics identified by the Secretary of Health and Human Services. The Secretary is also required to lead efforts in analyzing and monitoring trends in health disparities from the data collected. States legislatures have been addressing health disparities in this capacity for some time. For example, Maryland's Health Disparities Data Program, which collects, analyzes, and reports data on health disparities, made data collection on race, ethnicity, and preferred language a priority to addressing health disparities in 2007 when they passed legislation to improve their data collection in those areas. The data collection, like that in the ACA, is based off of recommendations from the Institute of Medicine. Massachusetts and California are also among the states who have improved the data collection of minorities in an effort to address health disparities prior to the passage of the Affordable Care Act.

In addition, the law requires that a National Strategy for Quality Improvement be developed to improve the delivery of health care services, patient outcomes, and reduce health disparities. The ACA also increases funding to the Centers of Excellence to support health disparities research (Section 5401). It also creates the Patient-Centered Outcomes Research Institute to conduct comparative effectiveness research on health care service outcomes for minorities (section 6301). The National Center on Minority Health is elevated to the National Institute on Minority Health within the National Institutes of Health which allows them to plan, coordinate, and evaluate health disparities research. During the 2010 state legislative session, Connecticut enacted Public Act 10-104 which requires the University of Connecticut Health Center to include a health disparities institute to conduct research and evaluate models intended to improve care for minorities through evidence-based research.

### **Medicaid Expansion**

Medicaid serves as a vehicle for coverage for minority populations—it covers nearly 40 percent of African American and Latino children. Starting in January 2014, all individuals will be eligible for Medicaid up to 133 percent of federal poverty level (\$14,404 for an individual in 2009). Of the 46 million people currently uninsured, 47 percent of them are living in household incomes with incomes at or below 133 percent federal poverty guidelines. The federal government will cover most of the costs for this expansion at 100 percent FMAP in 2014 phasing down to 90 percent by 2020 and thereafter. [Click here](#) for more information on the ACA and Medicaid.

### **Insurance Regulation**

Beginning in 2014, the ACA prevents insurance companies from denying insurance coverage to people who have pre-existing conditions or charging higher premiums to those individuals. It also prohibits higher premiums based on gender and determining insurance rates and coverage according to race and ethnicity. Since minorities are disproportionately affected by chronic conditions including, diabetes, heart disease, and cancer, this will be a significant factor in obtaining health insurance coverage.

### **American Health Benefit Exchanges**

Health exchanges create a marketplace for health insurance. They are intended to provide choices to consumers in picking their health coverage and fill the gaps for people who do not qualify for Medicaid or have employer sponsored insurance. Premium assistance will be provided to individuals up to 400 percent of poverty to ensure they have affordable options. Hispanics and African Americans tend to have lower rates of employer sponsored coverage, making those groups more likely to take advantage of the new market created by health exchanges.

### **Health Care Workforce and Cultural Competence**

In 2008, African Americans and Latinos accounted for 14 percent of medical school graduates, a number that does not currently reflect the Nation's population. The ACA has multiple sections within the law that are aimed at increasing the diversity within the primary care, dental, mental health, and long-term care workforce. In addition, it requires the collection of workforce diversity data. Workforce diversity grants are expanded to include nurses. [Click here](#) for more information on workforce provisions in the ACA. Studies from the Commonwealth Fund and the Office of Minority Health show that providers who have participated in culturally competent training and education can improve the quality of care given to diverse populations. The ACA invests in the development and evaluation of culturally competent curricula in educational training over the next five years. Other support is also given for cultural competence training to primary care providers. In addition, loan repayment preference will be given to individuals who have cultural competency experience.

### **Community Health Centers (CHCs)**

In 2009, the majority of health center patients were racial and ethnic minorities; 34 percent of health center patients are Hispanic or Latino and 28 percent are African-American. CHCs will play a key role in providing primary care and preventive services to newly insured minorities and historically underserved populations. The new law provides \$11 billion over the next five years enabling health centers to double the number of patients to 40 million by 2019. [Click here](#) for more information on community health centers.

### **Prevention and Wellness**

The ACA has a major focus on prevention and wellness, but the details of those provisions are unclear as rules, regulations, and appropriations are still pending. The law requires private insurance plans to cover preventive services and prohibits co-payments and deductibles for preventive services, which can help eliminate cost barriers associated with those who don't seek preventive services because of out-of-pocket

costs. The ACA also invests in community health teams which can allow providers to offer more culturally appropriate care to patients in managing chronic diseases, which is significant for minority communities, including the nearly 50 percent of African Americans who suffer from a chronic disease. The ACA also includes prevention initiatives; section 4102 authorizes a five year national oral health campaign with an emphasis on disparities. African American and Hispanic children are more likely than white children to report having bad oral health. [Click here](#) to view meeting materials from NCSL's health summit session on prevention and wellness provisions in the ACA.

### **Maternal and Child Health**

The ACA provides funding—\$1.5 billion over five years—for the Maternal, Infant and Early Childhood Home Visiting Program. Regardless of whether a state plans to apply for this grant, each state must complete a needs assessment to identify at-risk communities to receive any Title V Maternal and Child Health Block Grant funds for FY 2011. Home visiting programs provide patient-centered support and education to individuals which can improve health literacy and ultimately, improve health outcomes. Click here to visit the [MCH health reform](#) webpage and for information on Home Visiting on that page, [click here](#).