



IDENTIFYING AND EVALUATING EQUITY PROVISIONS IN STATE HEALTH CARE REFORM

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ABSTRACT: Millions of people in the United States—principally racial and ethnic minorities, immigrants, and those who lack proficiency in English—face barriers to high-quality health care. Such problems are largely due to high numbers of uninsured individuals among these groups, though it persists even when they are insured. By expanding health insurance coverage and addressing issues of access to care, quality of care, patient empowerment, infrastructural reforms, and social and community-level determinants of health, states have the potential to achieve equity. This report seeks to identify state policies that promote equitable health care access and quality and to evaluate existing laws, regulations, or reform proposals in five states—Massachusetts, Washington, Illinois, Pennsylvania, and California. These states’ initiatives, all of which move toward universal health insurance coverage, also address other innovative strategies such as improving health care provider diversity, distribution, and cultural competence.

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EXECUTIVE SUMMARY

Background

Rapidly escalating health care costs, a rising number of people without health insurance, inconsistent health care quality, and a paucity of federal action to address these problems have prompted legislatures and governors in nearly two dozen states to consider significantly changing their approaches to health insurance coverage and health system regulation. Few of these reforms, however, have focused on *inequality*. Millions of people in the United States—principally racial and ethnic minorities, immigrants, and those who lack proficiency in English—face barriers to high-quality health care.

Such problems derive largely from the high rates of uninsurance among these groups, but it persists among them even when they are insured. They simply tend to receive a lower quality of health care. But by expanding health insurance coverage and addressing issues of access, quality, and cost, state-level health care reforms have the potential to address inequality—that is, to achieve equity.

The analysis in this report seeks to:

1. Identify state-level policies that promote equitable health care access and quality for all populations (equity benchmarks).
2. Evaluate existing laws, regulations, or reform proposals in five states—Massachusetts and Washington, which have already enacted sweeping health care reform legislation; and California, Illinois, and Pennsylvania, where legislators are considering similar programs—to determine whether they address health care disparities relative to these equity benchmarks.

Several key findings emerge from this analysis:

1. *To promote health care equity, universal health insurance coverage is necessary but not sufficient.* States can and should attend to health care access, quality, and infrastructure, particularly in underserved communities, and help patients become educated and empowered—able to advocate for their needs. But states should also find ways to improve state health care planning and address social and community-level determinants of health.
2. *Several states are addressing health care inequality through innovative means.* All the states featured in this analysis have sought to make insurance and health

care more affordable, and many are taking steps to improve health care quality—for example, by collecting data and monitoring for disparities.

3. *More must be done.* None of the analyzed states are, for instance, implementing plans that would result in truly universal health insurance coverage or access. State policymakers should take advantage of the growing momentum for state health care reform to address such omissions.

Equity Benchmarks

Myriad factors contribute to health care inequality, and the lack of health insurance is one of the most important. Racial and ethnic minorities (“disparity populations”) in particular are more likely to lack health insurance coverage or to be underinsured compared to non-Hispanic whites; while people of color make up just one-third of the U.S. population, they comprise over half of the nation’s 47 million uninsured individuals. But insurance coverage alone does not eliminate health care gaps. The health-services research literature suggests that states can make health care more equitable for disparity populations by:

Improving access to health care. States can expand opportunities for low- and moderate-income families to purchase private insurance or enroll in publicly subsidized programs, and they can establish mechanisms that make it easier for people to find affordable insurance. But even when insured, minority and low-income individuals are less likely to access health care as out-of-pocket costs rise and more likely than are native-born white Americans to face cultural and linguistic barriers to care. States can address these problems by establishing limits on copayments and other out-of-pocket costs in public insurance, by studying and responding to potential unintended effects of cost-sharing on utilization, by taking steps to increase diversity among the state’s health care providers, and by providing incentives for health care systems to reduce cultural and linguistic barriers.

Improving the quality of care. States can provide incentives for strategies—such as pay-for-performance programs, performance measurement, and report cards—to reduce disparities in health care quality. In addition, states can promote the collection of data on health care access and quality by patients’ race, ethnicity, income or education level, and primary language—and publicly report this information.

Empowering patients. Patients, particularly racial and ethnic minority and immigrant patients, should be able to make decisions about their health care and to demand that care consistent with their needs, preferences, and values be delivered. These

goals can be pursued by developing and strengthening patient education and health literacy programs and by supporting training and reimbursement of community health workers, who can help patients navigate through the system.

Improving the state health care infrastructure. The relative lack of health insurance among racial and ethnic minorities is associated with lower levels of health care resources (e.g., practitioners, hospitals, and health care centers) in communities of color. Even if states achieved universal health insurance coverage, communities of color would still require investments to improve their health care infrastructure. States can address this situation by reducing the financial vulnerability of health care institutions serving poor and minority communities, by creating or broadening incentives for health care professionals to practice in underserved communities, and by requiring cultural-competency training for health care professional licensure.

Improving state program and policy infrastructure. States can better align health care resources with minority-community needs by gaining community input, by establishing or enhancing state offices of minority health (which increase the visibility and coordination of state health disparity-elimination programs), and by strengthening Certificate of Need (CON) policies as a tool for reducing geographic disparities.

Adopting or strengthening policies to address social and community-level determinants of health. State agencies that seek to reduce social and economic gaps are inherently engaging in health equity work. Almost all aspects of state policy in education, transportation, housing, commerce, and criminal justice influence the health of state residents and can have disproportionate impacts on marginalized communities. Thus states can address community-level and social determinants of health by coordinating the work of state agencies and by promoting the use of health impact-assessment tools, which evaluate the potential effects of government programs and initiatives both in and outside of the health care delivery sector.

Findings and Conclusions

Our analysis of five states' approaches to health insurance expansion finds that states are addressing disparities in several important ways. While no two of these states used the same approach, several policy strategies were common. These included:

- Expanding access to health insurance products by reducing financial barriers to coverage

- Improving and evaluating outreach and enrollment efforts
- Collecting data (often while building upon federally mandated Medicaid data- collection programs) on health care access and quality measures by patient demographics
- Supporting safety-net institutions
- Improving health care provider diversity, distribution, and cultural competence.

Our analysis also revealed several *missed opportunities* for states' promotion of equity. None of the five states are implementing plans that would result in truly universal health-insurance coverage or access. Many groups, such as single and childless low-income adults, undocumented immigrants, and even some legal immigrants are not eligible for new state public-insurance expansions. Community-empowerment strategies are also uncommon. Only one of the states, Pennsylvania, has sought to strengthen local community input and direct resources (in this case, those of nonprofit hospitals) to meet community needs. And only one state, Washington, has sought to strengthen state CON programs as a tool for regulating health care resources; it has linked CON approval with a statewide health-resources strategy.

Recommendations

Based on these findings, we offer a number of recommendations that should be considered by a range of stakeholders—including state policymakers, health professionals, health consumer and advocacy groups, health plans, and businesses—in their efforts to achieve equitable health care for all. These recommendations include:

Make universal health care a core goal. Uninsurance is not just a problem for those who lack coverage; it also contributes to escalating health care costs and access problems, even for those who do have insurance. Only by covering everyone in the population can states eliminate uncompensated costs and strengthen the health care infrastructures of underserved communities.

Assess how policies to expand coverage affect currently underserved groups. The states analyzed here have employed different strategies—mandates to purchase insurance, for example—in order to expand coverage. States that are considering such strategies should monitor their impact and take steps to correct them should they have a disproportionately negative impact on marginalized populations.

Be an agent for change. State government can leverage the power of other stakeholders, both public and private, to help in the battle to eliminate health care disparities.

Reach for low-hanging fruit. Many of the policy strategies examined here can be implemented through regulatory strategies or contractual requirements rather than through legislation. For example, states are required by federal law to identify the race, ethnicity, and primary language of Medicaid beneficiaries and to provide this information to managed care contractors. This information can be used to generate reports on how plans are faring with respect to health care equity.

Actively monitor the implementation of new health care expansion laws. Almost all of the equity-related policies examined in this study require ongoing monitoring to ensure that they are actually addressing disparities.

IDENTIFYING AND EVALUATING EQUITY PROVISIONS IN STATE HEALTH CARE REFORM

INTRODUCTION

Rapidly escalating health care costs, a rising number of people without health insurance, inconsistent health care quality, and a paucity of federal action to address these problems have prompted legislatures and governors in nearly two dozen states to consider significantly changing their approaches to health insurance coverage and health system regulation.¹ Few of these efforts, however, have focused on inequality—a pervasive and persistent problem that is central to overall health care reform.²

Health insurance coverage is the single most significant factor in determining the timeliness and quality of health care that patients receive.³ But inequality persists even when people *are* insured. For example, a large body of research shows that despite presenting with similar health problems and sources of health insurance, patients who are racial or ethnic minorities, are immigrants, lack proficiency in English, or have modest incomes tend to receive a lower quality of health care.⁴ Expanding insurance coverage, though necessary, is therefore not sufficient.

State-level health care reform proposals do, however, have the potential to address health care inequality as they deal with issues of access, quality, and cost.⁵ In that spirit, this study seeks to:

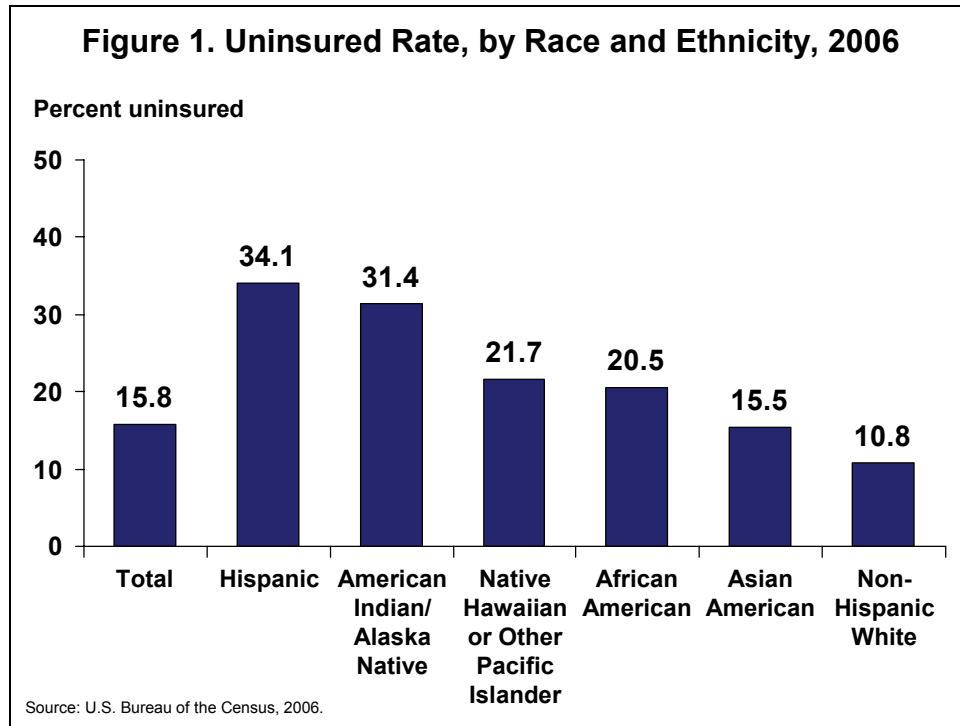
1. Identify elements of state-level health care policies and proposals that promote equitable health care access and quality for all populations (equity benchmarks).
2. Evaluate selected state health care reform proposals, or existing laws and regulations, to determine whether they address health care disparities relative to these equity benchmarks.

Our objectives are to raise awareness of health care inequality, inform discussion regarding health care equity policy principles, and assist state health care policymakers and advocates in their efforts to achieve equity.

STATE HEALTH CARE EQUITY BENCHMARKS: DEFINITIONS AND MEASUREMENT

Because racial and ethnic minority groups have higher rates of uninsurance than non-minorities, any state effort to expand access to health insurance will also improve access

to care for communities of color (Figure 1). But insurance-coverage expansion alone does not ensure that health care disparities will be eliminated. Systemic changes, such as steps to improve the health care infrastructure in minority and low-income communities, are also needed.



A growing body of literature identifies a number of strategies that can complement state insurance-coverage expansion in moving toward more equitable health care. These “equity benchmarks” include programs that strengthen: access to health care, quality of care, patient empowerment, state health care infrastructure, state program and policy infrastructure, and social and community-level determinants of health. These six policy types are discussed in turn below.

Access to Health Care

Myriad factors contribute to how and whether people can access needed health care, but the lack of health insurance is one of the most important.⁶ Individuals with affordable and comprehensive health insurance coverage have fewer barriers to health care, are more likely to see a physician on a regular basis, and enjoy the benefits of better health outcomes. Insurance coverage also reduces out-of-pocket costs and shields individuals and their families from the economic hardships that an unexpected injury or illness can create.⁷ But racial and ethnic minorities are more likely to lack health insurance coverage or to be underinsured compared to non-Hispanic whites; while people of color make up

just one-third of the U.S. population, they comprise over half of the nation's 47 million uninsured individuals.⁸

In addition to coverage barriers, racial and ethnic minority groups face other well-documented problems in accessing health care. Communities that are predominantly minority have fewer health care resources such as hospitals, primary care providers, outpatient clinics, and nursing home facilities. The health care services that *are* available to them are often of lower quality than those in more advantaged communities. And even among minorities who have insurance, many face cultural or linguistic barriers to accessing care.⁹

The literature suggests that states can expand health care access for disparity populations in the following ways:

Making health care affordable. Minorities and people with low incomes are more likely than whites and people with higher incomes to report an inability to access care when needed because of a lack of health insurance or high out-of-pocket costs. Insurance-coverage expansions and efforts to reduce out-of-pocket costs can therefore improve access to care.¹⁰ Strategies include public subsidies that enable those with low incomes to purchase health insurance, sliding fee scales for premiums, limits on copayments and other out-of-pocket costs (such that those at the lowest income levels will face only nominal charges), and efforts to study and respond to potential unintended effects of cost-sharing on utilization. State strategies to expand eligibility for public programs, however, may sometimes clash with federal guidelines to *limit* eligibility for public programs (see box on next page).

Ensuring that all state residents have a medical home. Having a “medical home”—a health care setting that enhances access to providers and timely, well-organized care—is associated with better management of chronic conditions, regular preventive screenings, and improved primary care. Racial and ethnic minorities are less likely to report having a medical home, but when they do, their health care access gaps are significantly reduced.¹¹ States should promote the development of medical homes in community health centers and other state-supported health care institutions.

Federal Guidance that Dampens State Efforts

As of this writing, some state efforts to expand access to health insurance coverage may be dampened by new guidance, issued by the U.S. Department of Health and Human Services that would limit expansions of the State Child Health Insurance Program (SCHIP). This guidance requires any state that has already expanded or plans to expand SCHIP beyond 250 percent of the federal poverty level (FPL) to do the following: show that it has enrolled 95 percent of children below 200 percent of the FPL who are eligible for either Medicaid or SCHIP; charge premiums that approximate private coverage (or 5 percent of family income); impose a one-year waiting period during which children are uninsured (in order to prevent children from leaving private coverage); and show that the number of children in the target population who received coverage through private employers has not decreased by more than 2 percent over the past five years.¹ (Letter from Dennis Smith, Director, Center for Medicaid and State Operations, to State Health Officials, SHO #07-001, Aug. 17, 2007, available on <http://www.cms.hhs.gov/smdl/downloads/SHO081707.pdf>.)

At least 19 states have already set eligibility at 250 percent of the FPL or above, including several states that did so just this year (California, Massachusetts, and Washington, whose recent health care expansion efforts are analyzed in this report, were among them.) These states will have one year to comply with the new restrictions in order to maintain eligibility levels above 250 percent of the FPL. However, most states will find it virtually impossible to do so. New York, for example, which recently attempted to expand SCHIP to 400 percent of the FPL, was denied federal matching funds this past September for such an expansion .

Assessing how policies to expand insurance coverage—such as affordability standards and individual mandates to purchase insurance—may differentially affect communities of color, immigrants, and low-income populations. Several states are either examining whether to require individuals and families to purchase health insurance or are exploring standards of affordability to determine premium or cost-sharing contributions. The impact of an individual mandate, as well as definitions of affordability, may vary across racial and ethnic groups—even at the same income level—as these groups differ in their access to resources. In addition, the challenges of enforcing a mandate across different communities are significant. Some legal immigrants, for example, may be reluctant to apply for health insurance programs, even if eligible, as a result of anti-immigrant rhetoric and policies, and they might therefore be slower to comply with a mandate. States that are considering such strategies should monitor insurance take-up among the previously uninsured by race, ethnicity, and immigration status, and then take steps to correct policies that have disproportionate impacts.

Promoting cultural and linguistic competence in health care settings. Health care systems and providers must be culturally and linguistically competent if they are to help improve access and quality for an increasingly diverse U.S. population.¹² The federal

Culturally and Linguistically Appropriate Services (CLAS) standards identify over a dozen benchmarks that have been widely accepted, and increasingly adopted, by health care systems and providers.¹³ Federally funded health care organizations are mandated to meet four of the standards, but few states have yet taken steps to encourage more widespread adoption. When they do decide to act, states can promote cultural and linguistic competence through incentives that encourage and reward health care organizations that implement the CLAS standards.

Promoting diversity among health professionals. Racial and ethnic diversity among health care professionals is associated with improved access to care, and greater satisfaction with care, among patients of color.¹⁴ Federal programs have been stimulating heightened diversity among health care providers for over three decades, but congressional support for these programs is now waning. Nevertheless, states can develop or expand their own diversity efforts—for example, by forming tuition-for-service agreements with students whose race or ethnicity is underrepresented in the health care professions.

Reducing “fragmentation” of the health insurance market. A potentially significant cause of health care disparities among privately insured populations is minorities’ disproportionate enrollment in “lower-tier” health insurance plans. Such plans tend to limit services, offer fewer covered benefits, and maintain relatively small provider networks, all of which can reduce access to quality care.¹⁵ But states can take steps, as part of coverage-expansion programs, to promote equal access to the same kinds of health care products and services, regardless of coverage source.

Improving and streamlining enrollment procedures. Racial and ethnic minorities are underrepresented, relative to eligibility rates, in public health-insurance programs. States can increase minority participation in public programs, however, if they develop and sustain aggressive outreach mechanisms, with particular attention to the needs of cultural and language-minority groups.¹⁶

Consistently evaluating outreach and enrollment efforts. Measurement of public insurance take-up rates in communities of color or low income is essential to ensuring that health care expansion efforts actually reach underserved groups. States that regularly conduct such evaluations can expect to see improved coverage rates among eligible populations.¹⁷

Quality of Care

States can improve equity by promoting the collection of data—not only on health care access but also on quality of care—disaggregated according to patients’ race, ethnicity,

income or education level, and primary language, and by then publicly reporting this information. These evaluations should focus on reducing health care quality gaps, thereby approaching “quality equality.” In addition, states can provide incentives for quality improvement, such as pay-for-performance programs, performance measurement, and report cards. But quality-improvement efforts that fail to take into account the different challenges and needs of underserved communities, and of the health care institutions that serve them, can unintentionally worsen the quality gaps.¹⁸

States can establish mechanisms for quality equality in the following ways.

Requiring public and private health systems to collect and monitor health care disparities as a function of race/ethnicity, language status, and income. Current state data-collection efforts with regard to health care disparities are uneven. Some states require recipients of state funding (e.g., Medicaid managed care organizations) to collect and report health care access and quality data by patient demographic factors, but many other states fail to utilize their leverage as regulators, payers, and plan purchasers to encourage all health systems to collect and report data using consistent standards.¹⁹

Publicly reporting health care access and quality disparities. Once states have obtained health care access and quality data stratified by patient demographics, this information should be publicly reported. Such action will promote greater public accountability, allow consumers to make more informed decisions about where to seek care, and support state efforts to monitor disparities and take appropriate action to investigate potential violations of the law.²⁰

Encouraging the adoption of quality-improvement programs that take the health care challenges and needs of underserved communities into account. State quality-improvement efforts, such as pay-for-performance or performance measurement, are gaining increasing attention. But because patients from underserved communities are typically sicker, performance measurement can inadvertently dampen provider enthusiasm for treating them. Quality-improvement efforts should therefore reward efforts that reduce disparities and improve patient outcomes relative to baseline measures.²¹ In addition, states can target quality-improvement incentives to safety-net institutions and other providers that disproportionately serve communities of color.

Patient Empowerment

Patients should be empowered to make decisions about their health care and to insist that care consistent with their needs, preferences, and values be delivered. These issues,

which are particularly relevant for racial/ethnic minority and immigrant patients who face significant cultural gaps in U.S. health care settings,²² can be addressed in several ways.

Developing patient-education programs. These empowerment efforts teach patients how to effectively navigate health care systems, manage illness, participate fully in treatment plans, and generally ensure that their needs and preferences are being met. For example, patient-education programs have been found to be effective as a means of reducing racial and ethnic disparities in pain control.²³ They are most successful when designed in partnership with target populations and when language, culture, and other attributes of communities of color are fully addressed.²⁴

Supporting training and reimbursement for community health workers. Also known as lay health navigators or *promotoras*, community health workers function as liaisons between patients and health systems while endeavoring to improve local health outcomes. These individuals, typically members themselves of the medically underserved community, are trained to teach disease prevention, conduct simple assessments of health problems, and help their neighbors access appropriate health and human resources.²⁵ Community health worker models are rapidly spreading, as research and practice indicate that such services can improve patients' ability to receive care and manage illness. States can stimulate these programs by providing grants, seed funding, or other resources.

State Health Care Infrastructure

As noted earlier, the disproportionate lack of health insurance among racial and ethnic minorities is associated with fewer health care resources (e.g., practitioners, hospitals, and health care centers) in communities of color. Thus even if states achieved universal health insurance coverage, these communities would still require investments to improve their health care infrastructure. There are several ways in which states can ensure that such community needs are being met:

Supporting “safety net” institutions, such as public hospitals and community health centers, and reducing the financial vulnerability of health care institutions serving poor and minority communities. People of color and low-income individuals are more likely than other populations to access health care in safety-net institutions,²⁶ which in many cases face financial vulnerability—the result of low Medicaid reimbursement rates or of the institutions' provision of uncompensated care to uninsured individuals.²⁷ Safety-net institutions may fare better in states where health insurance expansions have been realized, but their survival depends on the manner in which the expansions are carried out. If the financing of these programs draws resources away from safety-net

institutions, they could suffer significant budget shortfalls. Therefore states should assess the impact of health insurance coverage expansion programs on these institutions, and if necessary should weigh provisions to provide them with additional financial resources or other support.

Creating or broadening incentives for health care professionals to practice in underserved communities. Low-income and minority communities often have the most pressing need for health care services, but they are served by a dwindling number of providers and institutions that usually lack resources to expand and improve their offerings.²⁸ States can address this imbalance by providing incentives—e.g., funds for graduate medical education programs that focus on underserved populations, tuition reimbursements, and loan-forgiveness programs that require service in areas short on health care professionals.

Requiring cultural-competency training for health care professional licensure. Many states are experiencing rapid growth in their populations of racial/ethnic minority and language minority residents. Already, four states and the District of Columbia are “majority minority,” and nearly one in two U.S. residents will be a person of color by mid-century. Given these demographic changes, the health professions will need to keep pace by training current and future providers to manage diversity in their practices.²⁹ Some states have already taken action to address this need. In 2005, New Jersey began requiring that all physicians practicing in the state attain minimal cultural-competency training as a condition of licensure.

State Program and Policy Infrastructure

States can adopt new policies or strengthen existing ones to help ensure that the health care needs of minority communities are being met.

Community health planning. This approach seeks to actively involve residents in their own communities’ planning, evaluation, and implementation of health activities. And as a means of gaining community input and better aligning health care resources with local needs, community health planning has a long history. But its promise as a tool to reduce health care disparities has yet to be fully realized. The National Health Planning and Resource Development Act of 1974 sought to create and support a network of community Health Systems Agencies (HSAs), but lack of funding, enforcement powers, and effective mechanisms for community input to shape health policy has led to a decline of HSA power and influence.³⁰ Some states, such as New York, are examining strategies

to reinvigorate HSAs and include disparity-reduction efforts as part of these planning agencies' mission.

Establishment or enhancement of state offices of minority health. Thirty states have established offices of minority health to stimulate and coordinate state programs that directly or indirectly address the health needs of racial and ethnic minority groups. Their existence has also helped to increase the visibility and coordination of state health disparity-elimination programs.³¹

Certificate of Need assessments, as a tool for reducing geographic disparities and the “fragmentation” of the health insurance market. Historically, the purpose of the Certificate of Need (CoN) process has been to control health care costs and ensure that investments in the health care industry reflect community needs. In most states that employ CoN, the process has required health care institutions seeking to establish or expand services to submit proposals; in that way, state boards may evaluate projects, eliminate unnecessary duplication of services, and ensure that investments are strategic. But CoN has met with significant resistance and criticism for its failure as a cost-containment measure. The process, however, has great potential to encourage a distribution of health care resources that better reflect community and statewide need.³² States should reevaluate, and in some cases reinvigorate, CoN through new policies that ensure accountability for the use of public funds.

Policies to Address Social and Community-Level Determinants of Health

While largely outside the purview of state health insurance-expansion programs, social and community-level determinants of health are powerful “upstream” predictors of who is healthy and who is ill. This study’s analysis is limited to two policy strategies germane to these determinants, but states can do much more (see box on next page).

Improve coordination of state agencies that should address determinants. Agencies that seek to reduce social and economic gaps are inherently engaging in health equity work. Almost all aspects of state policy in education, transportation, housing, commerce, and criminal justice influence the health of state residents, and they can have a disproportionate impact on marginalized communities. States that have taken steps to coordinate the work of such agencies are likely to reduce duplication of effort, increase efficiency, and more effectively address health outcome disparities.

Health impact assessment policies. The purpose of HIA is to ensure that all government programs and initiatives, whether in or outside the health care delivery

sector, are assessed to determine their potential impact on communities' health status.³³ HIA is widely used in Europe as a policy and planning tool, and it is gaining influence in the United States. The San Francisco Department of Public Health, for example, uses the Healthy Development Measurement Tool to identify and assess community health needs and to better understand how land use and development projects can complement public health goals.

State and Local Policies to Address Social and Community-Level Determinants of Health

Creating incentives for better food resources in underserved communities (e.g., major grocery chains, “farmer’s markets”). Several local jurisdictions have established public-private partnerships to bring supermarkets to underserved areas. For example, the city of Rochester, New York, which experienced an 80-percent decline in grocery stores in the 1970s and 1980s, used public resources (the Federal Enterprise Community Zone program, the Community Development Block Grant program, and other sources) to attract a major supermarket chain to the city. More recently, as part of a broader initiative to support the development of supermarkets and other food retailers in urban and rural communities that lack adequate access, Pennsylvania awarded a \$500,000 grant to help establish a supermarket in the Yorktown section of Philadelphia. Other states can make similar investments, and these programs should be determined by community health planning processes.

Developing policies and structural changes that support community-level interventions for health behavior promotion. Federal and state programs to promote healthy behaviors (e.g., smoking cessation, exercise) are increasingly recognizing the need to target community-level risk factors. Such programs can have significant impacts on low-income communities and communities of color, which have fewer local resources for exercise (such as safe public parks and recreation centers), effective nutrition, and reduction of individual health risks (e.g., these communities tend to have more public advertisement of tobacco products and greater availability of alcohol). Under the Healthy Arkansas initiative, for example, the state serves as a clearinghouse and advisor on best practices for worksite wellness programs, and it has expanded trail projects through the Arkansas Trails for Life Grant Program. Both programs were motivated by the state’s high obesity rates.

Addressing environmental health threats. Racial and ethnic minority communities are disproportionately harmed by toxic waste dumps and industrial hazards, which tend to be located in their “backyards.” But states can determine whether and how communities are affected by potentially polluting activity and then act to reduce any environmental health risks. For example, to assist communities in the redevelopment of “brownfield” sites—areas contaminated by hazardous substances—the Colorado Department of Health and Environment has developed local assessment tools, created state incentives, and established a revolving loan fund.

STATE HEALTH INSURANCE COVERAGE EXPANSION: RECENTLY ENACTED LAWS AND LEADING PROPOSALS

BACKGROUND

Selection of States for Analysis

We next examine how equity issues are addressed in selected states' efforts to expand health insurance coverage. As of September 2007, 15 states had recently enacted legislation or were in the process of implementing new coverage expansions, and another six were considering significant coverage expansion proposals.³⁴ Among states that had enacted comprehensive legislation intended to achieve near-universal coverage (Maine, Massachusetts, Vermont, and Washington), two of them—Massachusetts and Washington—have diverse populations and are therefore included in this analysis. Three other states—Illinois, Pennsylvania, and California—had significant health care bills before their legislatures that, as in Massachusetts and Washington, attempted to expand access to insurance coverage while addressing cost and quality problems. These pending bills also offered proposals for addressing health care disparities—particularly relevant given the racial and ethnic diversity of these states—and are therefore included in this analysis as well.

Because the Illinois, Pennsylvania, and California bills have not yet been enacted, they are of course subject to change. We include them here, however, because they reflect state policymakers' strategies at a time when the states are widely recognized as the leading edge of health care reform in the United States. And while these bills may not succeed in their current form—as was the case with A.B. 8, a bill that was passed by the California legislature in October 2007 but then vetoed by the governor—many of their elements will continue to be discussed in state capitals. For example, A.B. 8 will form the starting point for new negotiations between the state's executive and legislative branches. Similarly, by 2008, comprehensive reform proposals in Illinois and Pennsylvania had not been enacted, but some elements were implemented by the executive branch and others were moving forward through smaller legislative initiatives.

The demographic composition and insurance status of these five states' populations are summarized in Tables 1, 2, and 3 below.

Analysis of Laws and Pending Legislation

To assess how these five states' new insurance expansion laws or legislation address the equity benchmarks identified above, we analyzed each statute or the most recent version of a pending bill. Importantly, *we do not assess the likely or actual effect of legislation;*

rather, we describe whether and how each state explicitly approaches policy in each benchmark, according to the text. Because our equity benchmarks are not presumed to exhaust the universe of equity-related strategies that states may adopt, we also note where states employ other such strategies.

To check our work, in each state we contacted at least one state official (typically, in a state office of minority health) and at least one state policy analyst or advocate not affiliated with the state. We then asked them to review our analysis for accuracy and comprehensiveness.

Other Relevant Legislation, Contractual Requirements, or Regulation

Preexisting state laws, regulations, or contractual requirements can influence the means by which new state health coverage expansion laws are implemented. For this reason, we also searched the “books” in each state for rules that address the equity benchmarks identified above. Our findings, summarized in the state-by-state discussion below, are meant to illustrate the types of policies that states have already enacted to address our selected equity benchmarks. They are not a comprehensive review of each state’s disparities-related policies. As above, we asked at least one state employee and private sector analyst or advocate to review our work.

Table 1. Distribution of Race/Ethnicity, Age, Poverty, and Languages Other Than English Spoken at Home, Selected States, 2006

	MA	WA	CA	IL	PA
Distribution by Race and Ethnicity, 2006					
Non-Hispanic White	79.8	76.6	43.5	65.3	83.7
African American	6.4	3.2	6.1	14.8	9.9
Hispanic	6.7	8.3	36.1	13.1	3.9
American Indian/Alaska Native	0.3	0.6	0.4	0.1	*
Asian American	5.8	6.7	11.7	5.4	1.6
Native Hawaiian or Other Pacific Islander	*	0.4	0.6	0.1	*
Distribution by Age, 2006					
18 and under	23.2	24.0	26.4	25.2	22.5
19–64	63.6	64.8	63.1	63.4	63.1
65+	13.2	11.2	10.4	11.4	14.4
Poverty Rate by Race/Ethnicity, 2006					
Non-Hispanic White	8.6	6.1	7.1	6.6	8.1
African American	21.5	24.7	21.0	25.8	29.8
Hispanic	38.6	17.5	17.8	14.8	30.8
American Indian/Alaska Native	*	5.8	16.8	19.1	*
Asian American	16.8	9.0	9.7	6.7	16.5
Native Hawaiian or Other Pacific Islander	*	8.9	14.7	*	*
Language Other Than English Spoken at Home, Percent, Age 5+, 2006					
	20.2	16.6	42.5	21.8	9.2

* = Data not available or sample size too small to be represented here.

Source: U.S. Census Bureau, American Community Survey.

Table 2. Uninsured Rates by Race and Ethnicity for Selected States, Persons Under Age 65, 2006

	MA	WA	CA	IL	PA
Non-Hispanic White	10.0	10.1	10.1	9.2	8.7
African American	17.3	21.6	17.1	21.9	18.1
Hispanic	20.0	23.5	31.1	30.1	15.9
American Indian/Alaska Native	7.1	16.3	13.2	47.6	*
Asian American	10.3	11.1	14.7	13.9	17.6
Native Hawaiian or Other Pacific Islander	*	33.4	15.5	*	*

* = Data not available or sample size too small to be represented here.

Source: U.S. Census Bureau, Current Population Survey, 2007.

Table 3. Uninsured Rates, by Income-to-Poverty Ratio and Race and Ethnicity, 2006

	MA	WA	CA	IL	PA
Less than 100%					
Non-Hispanic White	15.8	24.9	23.2	24.0	23.3
African American	26.1	23.4	23.8	30.9	28.3
Hispanic	12.1	39.4	38.1	44.7	14.7
American Indian/Alaska Native	*	64.9	12.8	100.0	*
Asian American	31.0	16.0	30.2	42.0	19.8
Native Hawaiian or Other Pacific Islander	*	*	49.9	*	*
100%–200%					
Non-Hispanic White	13.1	18.5	15.6	16.9	14.5
African American	28.8	24.0	22.0	24.9	13.9
Hispanic	20.2	19.7	38.5	35.8	23.2
American Indian/Alaska Native	*	*	22.6	64.8	*
Asian American	3.4	21.8	27.2	25.9	51.5
Native Hawaiian or Other Pacific Islander	*	60.8	8.7	*	*
200%–300%					
Non-Hispanic White	16.8	14.7	10.7	13.5	11.5
African American	5.8	14.8	20.7	23.2	20.5
Hispanic	38.9	34.7	33.0	28.7	26.2
American Indian/Alaska Native	100.0	17.8	23.8	*	*
Asian American	3.6	8.0	17.0	13.4	18.8
Native Hawaiian or Other Pacific Islander	*	19.9	25.5	*	*
More than 300%					
Non-Hispanic White	6.2	5.3	7.4	4.8	4.4
African American	3.4	20.7	10.5	12.4	11.0
Hispanic	19.7	12.7	18.1	17.7	7.5
American Indian/Alaska Native	*	19.0	6.0	*	*
Asian American	7.0	6.0	9.1	9.7	3.1
Native Hawaiian or Other Pacific Islander	*	30.8	1.2	*	*

* = Data not available or sample size too small to be represented here.

Source: U.S. Census Bureau, Current Population Survey, 2007.

Note: A summary of findings for Massachusetts, Washington, Illinois, Pennsylvania, and California can be found in this report's [Appendix on page 51](#).

MASSACHUSETTS

Massachusetts captured national attention in 2006 when the state's legislature passed, and Governor Mitt Romney signed into law, a bill designed to achieve near-universal health insurance coverage while also addressing problems with health care costs and quality. Several provisions in the law directly or indirectly address health care disparities, particularly with regard to access and quality.

Best Practices from Massachusetts

The Chapter 58 law has several provisions that specifically address health care disparities—including the establishment, in the Office of Minority Health, of a Health Disparities Council, which is authorized to address diversity and cultural competence in the health care workforce. The council is required to develop health care quality-improvement goals to reduce disparities and to submit an annual report with recommendations toward those ends. The law also authorizes a study to assess the use and funding of community health workers. In addition, Massachusetts is considering an omnibus minority health bill that would address both health care disparities and broader social and community-level determinants of health.

Access to Care

The law, Chapter 58 of the Acts of 2006, expands eligibility for public health insurance coverage under Medicaid, SCHIP, and a state-funded program; it subsidizes premiums for residents with incomes under 300 percent of the federal poverty level (FPL); and it ensures that all state residents have affordable health insurance options that are considered “minimum creditable coverage.” While the law does not specifically direct authorities to focus on disparities in coverage for racial and ethnic minorities, the legislation's goal of creating near-universal insurance coverage will likely improve access to care for many currently uninsured people of color. Specific elements of the law that address such access are described below.

Make health care affordable. Chapter 58 includes numerous provisions to make coverage more affordable for the uninsured. It expands public coverage programs, creates a new subsidized coverage program, establishes a new state entity that negotiates with health insurers to provide more affordable unsubsidized coverage, and reforms health insurance regulations.

Section 26 of the law expands coverage under SCHIP to children in families with incomes up to 300 percent of the FPL. Section 107 raises the enrollment cap in a Medicaid waiver program that covers adults who have been unemployed for a long

period of time, and it allows more childless adults with incomes under 100 percent of the FPL to obtain coverage. Section 45, of the law (codified in Massachusetts General Laws at Chapter 118H) establishes a new program, the Commonwealth Care Health Insurance Program (“Commonwealth Care”), that provides coverage on a sliding-fee scale for people who do not qualify for other public programs but who have incomes under 300 percent of the FPL. A new state entity, the Commonwealth Care Health Insurance Connector Authority, administers this new program.

The Connector also negotiates with health plans that agree to provide affordable coverage to people over 300 percent of the FPL and helps both individuals and businesses enroll. These unsubsidized plans, called Commonwealth Choice plans, must offer a standardized set of benefits and follow quality standards and new rules about premium pricing and cost-sharing. For all private insurance, the law merges risk pools in the small-group and individual markets in order to determine rates. This is expected to lower premiums for individuals while raising them slightly for small groups.

The law includes two provisions designed to promote sharing of responsibility for the costs of health coverage. First, the law sets standards for what is a fair and reasonable contribution for employee coverage, and it requires businesses that do not provide it to pay the state a fee of \$295 per employee per year. This requirement applies to businesses with 10 or more employees. Second, the law requires residents to obtain health insurance coverage if they can afford to do so, thus sharing in the costs of health care. If they do not comply, residents pay a tax penalty. The Connector Board is responsible for setting standards about what is affordable coverage and what is the minimum amount of coverage a person must obtain. Although not required by the legislation, it will be important to continually evaluate the effect of the individual mandate on low- and moderate-income populations and on racial and ethnic minorities.

Chapter 58 does not, however, address the needs for subsidized health insurance of all people who live in Massachusetts. Eligibility for SCHIP, Medicaid, and subsidized Commonwealth Care coverage is limited to U.S. citizens, “qualified aliens” (as defined by the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996), or others permanently residing “under color of law.”

Promote cultural and linguistic competence and diversity among health care professionals. Section 160 of the law establishes a Health Disparities Council (see “State Program and Policy Infrastructure” below), which is authorized to, among other things, “address diversity and cultural competency in the health care workforce, including but not limited to doctors, nurses, and physician assistants.” The council is required to submit an annual report with recommendations for addressing these concerns.

Improve enrollment procedures for state health insurance programs. The creation of the Commonwealth Care Health Insurance Connector Authority provides a venue for helping people who do not qualify for MassHealth (Medicaid) and do not have employer-sponsored insurance to obtain affordable coverage. As noted above, the Connector markets both subsidized and unsubsidized private insurance for individuals and small businesses that meet certain standards, and it facilitates enrollment in those plans. It requires employers to set up a system for employees to pay their share of premiums with pretax dollars (that is, a Section 125 plan, also called a “cafeteria plan”). The law does not explicitly state that the Connector must aid racial and ethnic minority populations—for example, through language translation or other specific services. However, the creation of this body opens the possibility for such work to be emphasized.

Enroll underserved groups. Section 45 of the law authorizes Commonwealth Care to “provide subsidies to assist eligible individuals in purchasing health insurance.” State authorities are required under this provision to “develop a plan for outreach and education that is designed to reach low-income uninsured residents and maximize their enrollment in the program.”

Quality of Care

Chapter 58 includes several provisions for improving health care quality in Massachusetts, with specific attention to health care disparities:

Data collection and monitoring of disparities. Section 16 of the law establishes, within the state Office of Health and Human Services, a Health Care Quality and Cost Council whose goal is “to promote high-quality, safe, effective, timely, efficient, equitable, and patient-centered health care.” The council is charged with reducing costs while “improving the quality of care, including reductions in racial and ethnic health disparities.” Further, the council will contract with an independent health organization to secure assistance in meeting quality goals and to “collect, analyze, and aggregate data related to costs and quality across the health care continuum.” The legislation, however, does not specifically require quality data to be disaggregated by patient race, ethnicity, or other demographic factors.

Public reporting of disparities. Section 16 of the statute further notes that “[t]o the extent possible, the independent organization shall collaborate with other organizations to develop, collect, and publicly report health care cost and quality measures.” The statute does not explicitly require that the information be disaggregated by demographic factors, but given the emphasis in the statute on addressing health care disparities, such reporting appears to be a possibility.

Encourage health systems to adopt guidelines and measure quality. Section 25 of the law mandates that hospital rate increases “be made contingent upon hospital adherence to quality standards and the achievement of performance benchmarks, including the reduction of racial and ethnic disparities in the provision of health care.”

Patient Empowerment

Promote the use of community health workers. Section 110 of Chapter 58 requires the Department of Public Health to undertake a study on the use and funding of community health workers by public and private entities, on increased access to health care (particularly Medicaid-funded health and public health services), and on elimination of health disparities among vulnerable populations. Such an investigation has the potential to drive and inform community health planning for specifically reducing health disparities and increasing the training and reimbursement of community health workers.

State Health Care Infrastructure

Support “safety net” hospitals and health centers. Section 56 of the law authorizes a Health Safety Net Office (within the Commonwealth’s Medicaid office), part of whose authority is to administer a Health Safety Net Trust Fund and an Essential Community Provider Trust Fund. These funds are established for the purpose of “improving and enhancing the ability of acute hospitals and community health centers to serve populations in need more efficiently and effectively.” Among the criteria for grants is addressing “the cultural and linguistic challenges presented by the populations served by the provider.” Section 128 of the law increases Medicaid rates for physicians and acute-care hospitals.

State Program and Policy Infrastructure

Establish or strengthen state offices of minority health. Section 160 of the law establishes a Health Disparities Council in the state Office of Health and Human Services. This council will “make recommendations regarding reduction and elimination of racial and ethnic disparities in health care and health outcomes within the Commonwealth.” The statute requires the council to submit an annual report to the governor and legislature, to provide recommendations for strategies to eliminate disparities in access to health care services, and to improve diversity and cultural competency in the health care workforce.

Other Legislation or Legislative Proposals

While Chapter 58 did include a number of disparities-specific provisions, minority health advocates in Massachusetts also felt that the time was right to more thoroughly address the host of issues that affect racial and ethnic health disparities. The Disparities Action

Network (DAN)—a group of advocates, researchers, providers, and others working to improve Massachusetts state policy on racial and ethnic health—drafted omnibus legislation for the 2007-08 state legislative session. On January 9, 2007, Representative Byron Rushing introduced the legislation, *An Act Eliminating Racial and Ethnic Health Disparities in the Commonwealth* (H. 2234), which includes the following provisions:

- Creation of a Health Equity Office to coordinate and lead state disparities-elimination efforts
- Development of innovative programs to address key disparities issues, including health literacy and workforce diversity
- Support for medical interpreter services, community health workers, and wellness education
- Development of a community health index to assist communities with disproportionate levels of morbidity and mortality.

A number of key activities created the momentum to get to this point. Soon after a well-publicized Institute of Medicine report on the persistence of health care disparities was released in 2002, the city of Boston embarked on related activities, including a mayor's task force on disparities and the implementation of a blueprint. Developed by the Boston Public Health Commission, this blueprint laid out 12 recommendations for eliminating disparities, including over \$1 million in new funding for community-based organizations. At the state level, a Special Legislative Commission on Racial and Ethnic Health Disparities was formed to investigate health disparities, develop recommendations, and lay out a statewide action plan.

Support from key political leaders at the state and local levels, a strong health research community, and an array of disparities-reduction campaigns helped move health disparities into the public eye. Perhaps more important, state legislators were hearing about health disparities around the same time that health reform was being discussed. This timing created a political climate favorable to the inclusion of provisions that addressed racial and ethnic health disparities in the new health reform legislation, as well as to building the momentum needed for developing disparities-specific legislation.

While H. 2234 was first heard in committee on May 16, 2007, it was redrafted and resubmitted in late November 2007, and currently remains in the Public Health Committee. However, the DAN remains active and submitted a budget request for a key provision in the legislation: the creation of an Office of Health Equity. In early 2008, the request was appropriated with \$1 million in Governor Patrick's 2009 budget.

WASHINGTON

In the spring of 2007, Washington’s legislature passed three bills that significantly moved the state toward universal coverage. Senate Bill 5930 “provid[es] high-quality, affordable health care to Washingtonians based on the recommendations of the blue ribbon commission on health care costs and access.” It includes measures for improving quality of care, for providing information about quality and cost to consumers and providers, for proposing changes in public programs that might make them more sustainable, and for altering Washington’s system for providing private insurance to high-risk pool as well as its program for public coverage of low-income childless adults. Senate Bill 5093 authorizes a new children’s health initiative. That bill includes provisions for increasing enrollment in Medicaid and SCHIP (starting in July 2007) and for expanding eligibility guidelines over the next two years.

In January 2009, the income-eligibility limit for SCHIP will be raised to 300 percent of the FPL, and all families with children and incomes above that level will be able to buy into the SCHIP program. In addition, premium assistance will be available to SCHIP-eligible families with employer-sponsored coverage. House Bill 1569 establishes the Washington Health Insurance Partnership, which aims to improve access to affordable health insurance by offering a variety of private plans to small employers and by providing premium subsidies to low-income employees. Washington is now studying several options for accomplishing those ends.

In 2008, Washington continues its work on health reform. A newly enacted law, SB 6333, creates a Citizens Working Group on Health Reform to develop further recommendations.

Best Practices from Washington

Washington’s package of health care expansion laws contains some provisions that address the needs of communities of color. They include: 1) better alignment between state health care resources and community need, particularly in the areas of community and migrant health clinics; and 2) the requirement of a “statewide health resources strategy” that will survey the demographics of the state, inventory existing health facilities, and assess health care needs in various geographic areas.

Washington also passed a package of four bills in 2006 that specifically address minority health through a governor’s interagency coordinating council on health disparities, biennial surveys of the race and ethnicity makeup of the health care provider workforce, and reviews to assess the health-disparities impact of pending laws.

Access to Care

All three of the Washington statutes aim to expand eligibility for comprehensive health coverage by:

Make health care affordable. Section 3 of SB 5093 expands insurance coverage for children. In 2007 it provided subsidized coverage, through SCHIP, for children in families at up to 250 percent of the FPL; and as of January 1, 2009, the law will provide subsidized coverage for children in families at up to 300 percent of the FPL. Families with incomes under 200 percent of the FPL will not be charged premiums; those with between 200 and 300 percent of the FPL will pay reduced premiums. The legislation also allows families above 300 percent of the FPL to buy policies for their children at full cost after January 1, 2009. When it is cost-effective to do so, the state may assist the families of SCHIP-eligible children in purchasing coverage through an employer, as opposed to providing coverage through the state-administered SCHIP program.

HB 1569 establishes the Washington Health Insurance Partnership for the purchase of small-employer-provided health insurance coverage. Small employers are eligible to participate if at least one employee has income below 200 percent of the FPL. Section 6 of the bill states that the Partnership will offer premium subsidies to eligible participants—when family income does not exceed 200 percent of the FPL. (The premium and subsidy scale have yet to be determined.) SB 5930, section 58, creates the board of the Partnership and specifies its goal to ensure affordable health insurance for individuals in small businesses.

Encourage the growth of “medical homes.” SB 5930 authorizes the state Department of Social and Health Services to develop medical homes for certain populations (aged, blind, or disabled clients, for example). While this provision does not specify that racial and ethnic minorities or other underserved populations must also benefit from special outreach, the state should consider how this effort could be expanded.

Encourage comprehensive benefit packages. SB 5930 requires that basic benefit packages for the health insurance pool must include hospital coverage, medical equipment, prescriptions, maternity care, and other services.

Enhance outreach to and enrollment of underserved groups. SB 5093 calls for a “proactive, targeted outreach and education effort” to enroll children in health coverage and improve the health literacy both of the children and their parents. These efforts will include a media campaign, community-based outreach, application assistance,

identification of potential enrollees through other systems (e.g., school-lunch or early-childhood-education programs), and simplified enrollment procedures. While state and local public health jurisdictions and others in the fields of health care and health education are urged to collaborate in designing the general outreach and education effort, the state is required to target “the populations least likely to be covered.”

Quality of Care

Although they do not explicitly mention disparities reduction as a goal, at least two provisions of SB 5930 directly or indirectly incorporate equity-related policies to improve quality of care:

Data collection and monitoring of disparities. Section 9 of SB 5930 authorizes the establishment of a state health care quality forum that will “produce an annual quality report detailing clinical practice patterns” and provide this information to “purchasers, providers, insurers, and policy makers.” However, no mention is made in the statute of disaggregating quality measures by patient race, ethnicity, or primary language.

Encourage health systems to adopt evidence-based guidelines. Section 1 of SB 5930 mandates that the state develop a five-year plan to “change reimbursement within state-purchased health care programs,” to require the use of evidence-based standards of care, and to “better support primary care and provide a medical home” to all enrollees. Section 6 authorizes a chronic care management program that “must be evidence-based, facilitating the use of information technology to improve quality of care, and must improve coordination of primary, acute, and long-term care for those clients with multiple chronic conditions.”

Encourage “medical homes.” SB 5093 seeks improvements in care for children and the establishment of effective “medical homes” for children. The state will measure: provider performance, and eventually tie provider rate increases to immunization rates; well-child care, including developmental, behavioral, and oral health screening; care management for children with chronic conditions; emergency room utilization; and preventive oral health utilization. The state will encourage primary care physicians participating in SCHIP to provide oral health screening, fluoride varnish, and other services to prevent dental disease in children and to refer them to dentists as needed.

Patient Empowerment

Patient education. Sections 2 and 3 of SB 5930 promote public and private programs to develop aids for decision-making, whether collaborative or by the patient alone. For example,

the health care authority will implement a demonstration program for improving shared-decision-making supports for care, such as elective surgery, that is sensitive to patient preferences. Section 5 directs the state to offer training to providers of patients with chronic conditions, particularly regarding “supports for patients managing their own conditions” and “community resources that are available in the community for patients and their families.” Similarly, Section 6 establishes patient-education programs for state employees with chronic conditions, and Section 41 establishes a demonstration health-promotion program (including patient education) for all state employees. However, no mention is made in these sections of the needs of racial and ethnic minority groups or of language minority groups.

State Health Care Infrastructure

Certificates of Need. Section 52 of SB 5930 requires a “statewide health resources strategy.” As part of this strategy, the state will survey the demographics of the state and its regions; inventory existing health facilities, health services, and availability of providers; and assess health care needs in various of geographic areas. Certificates of Need will be awarded consistent with this strategic planning effort.

Other Legislation or Legislative Proposals

In March 2006, Washington’s legislature passed and Governor Christine Gregoire signed a package of four bills based on recommendations of the Legislature’s Joint Select Committee on Health Disparities. This package included:

- SB 6193: Requires biennial surveys of licensed health professionals to determine many of their characteristics, including race and ethnicity
- SB 6194: Requires the development of an ongoing multicultural health awareness and education program.
- SB 6196: Adds a health official from a federally recognized tribe as a representative on the State Board of Health
- SB 6197: Creates the Governor’s Interagency Coordinating Council on Health Disparities to plan for the elimination of health disparities and to collaborate with the State Board of Health on health impact reviews.

The Governor’s Interagency Coordinating Council on Health Disparities was charged with the following tasks:

- *Action plan.* By 2012, create an action plan for eliminating health disparities in Washington. The plan will consider health disparities broadly and also explicitly address a number of diseases and conditions specified in the legislation.

- *Advisory committees.* The Council is required to establish advisory committees to help it address specific issues.
- *Language barriers.* The Council must, after holding hearings and conducting research, issue recommendations for improving the availability of culturally appropriate health literature and interpretive services in public and private health-related agencies.
- *Communication.* The Council is charged with promoting communication—among state agencies as well as between state agencies and communities of color, the public sector, and the private sector—to address health disparities.
- *Information gathering.* Through public hearings, inquiries, studies, and other efforts at information gathering, the Council will work to understand how the actions of state government ameliorate or contribute to health disparities.
- *Health impact reviews.* The Council will collaborate with the State Board of Health in the development of health impact reviews requested by the governor or the legislature.
- *Regular updates.* The Council must update the Legislature on its progress in 2008, 2010, and 2012.

ILLINOIS

The Illinois Covered Act (SB 5) was introduced into the state senate “to enable all Illinoisans to access affordable health insurance that provides comprehensive coverage and emphasizes preventive healthcare.”³⁵ As of this writing (summer of 2007), the bill was still undergoing major revision and compromises were being discussed. This section summarizes the May 2007 version, which included fairly comprehensive reforms. By spring 2008, SB 5 had neither passed nor been defeated, though some of the proposed coverage improvements were in fact implemented by the executive branch. Other aspects of the proposal will likely resurface in other bills and in budget proposals this year.

Best Practices from Illinois

The Illinois health care reform proposal has a number of provisions that address racial and ethnic health disparities. They include:

- The establishment of a state Healthcare Workforce Council to focus on, among other things, “the cultural competence and minority participation in health professions education.”
- Targeted community health center expansion grants, which include the hiring and training of community health workers.
- A loan-repayment program for physicians and dentists serving communities of color and underserved areas.

Access to Care

The Illinois Covered proposal (SB 5) is designed to expand coverage, through both public and private plans, to uninsured adults between the ages of 19 and 64. (Children in Illinois are already eligible for an “All Kids” coverage program; their families pay premiums based on household income.) While it makes no direct mention of increasing access for racial and ethnic minorities, SB 5 includes many provisions that would do so for certain groups, all of which include members of minority populations.

Make health care affordable. SB 5 includes a number of measures for making insurance affordable to state residents who were previously uninsured. It expands public coverage programs, establishes a new premium-assistance program for people buying private coverage individually or through small employers, and sets rules for a new standardized health plan— designed for affordability—to be offered by all managed care companies. In addition, the bill provides a new tax credit to encourage businesses to share in the costs of health care.

Section 5-2 expands public coverage programs. Parents and caretakers of children with incomes up to 400 percent of the FPL who do not have coverage through their jobs will be able to get Medicaid, SCHIP, or identical coverage that is funded by the state. Medicaid eligibility guidelines will expand to cover working people with disabilities who have incomes up to 350 percent of the FPL. Parents, caretakers, and the disabled will pay premiums on a sliding fee scale. Adults who do not have dependent children and who are not disabled are generally not eligible for federal Medicaid; but under the proposed legislation, those with incomes below 100 of the FPL will receive state-funded coverage similar to Medicaid.

Section 5-20 of the legislation calls for the Department of Healthcare and Family Services to provide premium assistance to other Illinois residents who have incomes under 400 percent of the FPL. For those with access to employer-sponsored insurance, the Department will provide premium assistance. For those lacking such access and who are ineligible for the public programs described above, the Department will provide premium assistance in a new Illinois “Covered Choices” program, described in Section 10-15 of the bill.

In addition, SB 5 includes a tax, of three percent of payroll expenditures, imposed on businesses with 10 or more employees. If a business incurs health care expenditures of at least four percent of payroll, such as by offering coverage to its workers, it receives a credit that fully offsets the new tax. The business tax and credit are designed to help

finance the new program and to provide incentives for employers to contribute to their workers' coverage.

The law's expansions will not meet the needs of all residents of Illinois who require subsidized coverage. To be eligible, people must be citizens, qualified immigrants, or documented non-immigrants. Legal residents are currently banned from receiving federal Medicaid coverage for a period of five years after their entry into the United States; if they meet the other eligibility criteria for Medicaid in Illinois, they can receive coverage that is similar to Medicaid but funded by the state.

Promote diversity among health care professionals. Section 20-10 of SB 5 establishes a state Healthcare Workforce Council to provide "an ongoing assessment of health care workforce trends, training issues, and financing policies, and to recommend appropriate state government and private sector efforts to address identified needs. The work of the Council shall focus on: health care workforce supply and distribution; cultural competence and minority participation in health professions education; primary care training and practice; and data evaluation and analysis." While this provision will improve knowledge of health care workforce needs, future policies and resources should be directed to addressing these needs.

Promote comprehensive health plan benefits. Section 10-15 (r) requires the Department of Healthcare and Family Services to establish the benefit package for Covered Choice plans by rulemaking. The legislation specifies that the plans include major medical benefits and mental health care but cannot include infertility treatment or long-term care. Article 18, section 370c requires all insurers operating in the state to cover "reasonable and necessary treatment and services for mental, emotional, or nervous disorders or conditions."

Improve enrollment procedures for state health insurance programs. Section 5-90 encourages coordination of eligibility, enrollment, and re-enrollment in public programs such as Children's Health Insurance Program and Cover All Kids Program. The bill states that state authorities "may exchange information with the Department of Healthcare and Family Services and the Department of Human Services for the purpose of determining eligibility for health benefit programs administered by those departments." In addition, Section 10-15 authorizes the state Department of Healthcare and Family Services to "conduct public education and outreach to facilitate enrollment" of eligible individuals in the Illinois Covered Choice program.

Evaluate outreach to and enrollment of underserved groups. In Section 10-30 the Division of Insurance, aided by the Department of Healthcare and Family Services, is instructed to order an evaluation of employer participation. This study, including an income profile of covered employees and individuals, analysis of claims experience, and assessed impacts of the Covered Choice program on the uninsured population, is to be submitted by October 2012. While not required to specifically address racial, ethnic, or language-status disparities, the evaluation could be an opportunity for the state to specifically investigate outreach among currently underserved populations.

Quality of Care

Data collection. Although SB 5 does not require public or private health care systems to collect quality data by race, ethnicity, language status, or income, in Article 33 it proposes additional quality measurements for the treatment of chronic illness. As part of its strategic plan for the prevention and management of chronic illness (discussed below), the state will “develop an appropriate payment methodology that aligns with and rewards health professionals who manage the care for individuals with or at risk for [chronic] conditions in order to improve outcomes and the quality of care.” Similarly, the Department of Healthcare and Family Services will develop performance measurements and a system to reward good performance in chronic care management in the programs that it administers. These policies provide opportunities for the state to monitor health care disparities in the area of chronic care.

Patient Empowerment

SB 5 establishes the Illinois Roadmap to Health, a state plan for the prevention of chronic illnesses, the strengthening of the chronic care infrastructure, and the development of “an integrated approach to patient self-management, community development, and healthcare system and professional practice change.” The Roadmap attempts to address patient-education needs in two ways:

Support patient-education programs. Section 33-5 authorizes chronic care management programs, including patient-education and communications programs to support “significant patient self-care efforts” and “patient empowerment,” as part of the Roadmap. However, the legislation does not specify that patient-education programs be tailored to the needs of diverse populations.

Promote the use of community health workers. The grants established in Section 30-10 (see below) provide for the hiring and training of workers in community health centers.

State Health Care Infrastructure

SB 5 includes provisions for expanding community health centers and increasing the presence of health care providers, particularly dentists, in underserved communities:

Support “safety net” hospitals and health care institutions that serve poor and minority communities. Section 30-10 of the legislation establishes grants to create new community health center sites, expand primary care services at existing sites, and add or expand specialty services at existing sites. Aside from providing medical care, community health center services can include outreach, language assistance to the population receiving care, patient education, and environmental health services. The targeted populations include the medically underserved, the uninsured, and people enrolled in a health care program administered by Illinois’ Department of Healthcare and Family Services.

Provide incentives for health care professionals to practice in underserved communities. Section 25-5 amends Illinois’ Loan Repayment Assistance for Physicians Act to include dentists (in addition to physicians) in this program, which seeks to increase the number of providers serving targeted populations (including communities of color). The program offers educational-loan repayment-assistance grants to providers who agree to work in underserved areas.

Establish minimum standards for culturally and linguistically competent services. As noted above, Section 20-10 creates a state Healthcare Workforce Council, part of whose mission is to make recommendations on strategies to improve cultural competence in the state’s health care systems.

State Program and Policy Infrastructure

Community health planning. Section 33-10 of SB 5 requires that consumer advocates and community leaders be represented on advisory groups and have opportunities for input in the development of the Roadmap to Health.

Other Legislation or Legislative Proposals

The Reduction of Racial and Ethnic Health Disparities Act. On August 4, 2005, Governor Rod Blagojevich signed HB 615, which:

- Requires the Department of Public Health to establish and administer a program of grants that stimulate development of community-based projects aimed at improving the health outcomes of racial and ethnic populations

- Requires the Department’s Office of Minority Health to reduce health disparities in certain priority areas, including asthma and infant mortality, through establishment of measurable outcomes
- Authorizes the Director of Public Health to appoint an ad hoc advisory committee to examine areas in which public awareness, public education, research, and coordination regarding racial and ethnic health outcome disparities are lacking. The committee will also make recommendations for closing these gaps.

Since HB 615 became law, Illinois has passed a number of bills that would further improve the health of racial and ethnic minorities but are awaiting the governor’s signature and are still subject to appropriations. These include:

SB 544, which amends the Language Assistance Act, specifies things that a health facility must do to ensure access to health care information and services by residents who are limited in their command of English or deaf. Specifically, it requires that a facility: adopt and annually review a policy for providing language-assistance services to patients with language or other communication barriers; develop and post notices that advise patients and their families of the availability of interpreters; and notify employees of the language services available and train them in making these services as useful as possible to patients.

SB 545 creates the Culturally Competent Healthcare Demonstration Program and further defines “culturally competent health care.” The bill specifies that the program shall establish models that reflect best practices in culturally competent health care and also provides guidelines for the program’s administration. The bill became law in September 2007 and the Department of Public Health is responsible for awarding the demonstration project grants.

PENNSYLVANIA

With the introduction of Governor Edward Rendell’s “Cover All Pennsylvanians” legislation on January 17, 2007, Pennsylvania was thrust into the national spotlight as one of several states considering significant health care insurance-expansion legislation. This bill, HB 700, was modified as the legislative session proceeded. Below we analyze the March 2007 version of HB 700, which contained all the initial components of the Governor’s proposal. As the legislative session proceeded, HB 700 was broken into smaller bills, and some of these were then modified and reintroduced in 2008. By spring 2008, a coverage expansion for low-income adults and increased regulation of private insurance had passed the House and were awaiting Senate action.

Best Practices from Pennsylvania

The state's health care reform proposal has a number of provisions that specifically address the needs of communities of color. They include:

- Establishment of the Pennsylvania Center for Health Careers, which is charged with, among other things, developing tools that health care facilities may use for increasing diversity and promoting cultural competency
- Requiring charitable hospitals to consult with community groups and conduct a needs assessment before determining how it will spend its community-benefit dollars.

Access to Care

HB 700 offers several provisions for increasing access to health care insurance. The legislation also addresses issues related to health care provider diversity and culturally appropriate care.

Make health care affordable. Section 7202 of HB 700 would create the Cover All Pennsylvanians (CAP) health insurance program, aimed at uninsured adults not eligible for Medicaid or Medicare and at small or low-wage businesses that do not currently provide coverage. Pennsylvania would contract with private insurance carriers to offer a state-designated benefit package, and the state would provide premium assistance to uninsured adults who directly purchased coverage through CAP. In addition, the state would help low-wage small businesses purchase CAP coverage for their workers by subsidizing both the employer's and the employee's share of premiums.

Small businesses would pay \$130/month per employee and employee premiums would vary from \$0 to \$70 a month depending on household incomes. Employers would set up systems (called Section 125 or cafeteria plans) so that employees could pay their share of premiums with pretax dollars. With the state's premium assistance, low-income individuals would be charged the same amounts for their coverage whether they purchased coverage directly or received it through their jobs.

The bill would increase regulation of insurance by prohibiting plans that insure small groups or individuals from charging higher premiums based on health, by limiting the amounts that plans could increase premiums based on other factors, and by requiring that plans insuring small groups spend at least 85 percent of premiums collected on medical claims, thereby limiting their administrative expenses and profits. These reforms should decrease the cost of private insurance, especially for individuals and small groups that are in poorer health, which would then increase access.

Although the bill originally proposed a Fair Share Tax paid by employers who do not provide health care coverage, because of opposition to any new business taxes Governor Rendell has proposed other revenue sources, including a 10-cent-per-pack cigarette tax and a tax on cigars and smokeless tobacco products. He is also asking the legislature to redirect surplus funds from a tobacco tax levied in 2003, to CAP.

Promote comprehensive health plan benefits. Section 7202 would mandate that basic benefit packages offered by insurance companies under CAP meet Department of Insurance guidelines. Among other services, the package would have to include maternity care, preventive care, and disease management.

Promote diversity among health care professionals. Section 7302 would establish the Pennsylvania Center for Health Careers. One of the Center's duties would be to develop "workplace tools that assist health care facilities to increase the diversity of their workforce and promote the delivery of culturally appropriate care."

Evaluate outreach to and enrollment of underserved groups. Under this bill, the Insurance Department of the Commonwealth would coordinate all aspects of an outreach plan to populations that might be eligible for CAP. Section 7202 specifies that the plan contain provisions for "reaching special populations, including nonwhite and non-English-speaking individuals and individuals with disabilities; and for reaching different geographic areas, including rural and inner-city areas." The Department would also monitor and evaluate the accessibility and availability of the services provided by CAP.

Quality of Care

Data collection. The bill does not mandate particular responsibilities for health plans to collect data on racial and ethnic disparities in the quality of care, but it does seek to use data collection to generally improve the quality of care and patient safety in hospitals and nursing homes. Under Section 7402, hospitals would report on hospital-acquired infections, medication errors, readmissions, patient-safety measures, and clinical improvements. Similarly, nursing homes would report on events that compromise patient safety. These data should be disaggregated by demographic factors in order to monitor for disparities in such settings.

State Program and Policy Infrastructure

Community health planning. Section 7207 would require charitable hospitals to do a community needs assessment in order to determine how it should expend community benefit dollars—that is, what the hospital would do for the community in exchange for its

tax exemption. The hospital would be obliged to consult with community groups and local government officials in conducting its needs assessment, as well as to identify and prioritize community needs that the “hospital [could] address directly, in collaboration with others or through other organizational arrangements.” The resulting report would identify unmet needs, for each of the hospital’s primary service areas, particularly with respect to the uninsured, underinsured, or others eligible for public health programs. Section 7208 would require hospitals to adopt admission, billing, and collection practices that did not discriminate based on race and that protected uninsured residents lacking income or assets to meet their financial obligations.

Other Legislation or Legislative Proposals

Although Pennsylvania’s legislature has not enacted legislation to address racial and ethnic health disparities, Governor Rendell recently made efforts to do so by other means. In April 2006 the Governor signed an executive order that established the Office of Health Equity, under the state’s Department of Health, to “eradicate barriers to access and quality health care for all Pennsylvanians.”³⁶ The Office has since engaged in a media campaign to raise awareness about health disparities and has begun coordinating the state’s disparities-related activities across agencies and public and private partners.

In addition, the Department has released two reports, one in April 2002 (“Special Report on the Health Status of Minorities in Pennsylvania”) and another in June 2005 (a Strategic Plan to address health disparities), that serve as a blueprint for the Office’s disparities-reduction activities.

CALIFORNIA

California has been closely watched since Governor Arnold Schwarzenegger announced early in 2007 that he would propose a “Massachusetts-like” health insurance expansion law. Since then, state legislators have been working to craft a compromise bill aimed at surmounting the inevitable political hurdles. On June 20, 2007, Assembly Speaker Fabian Núñez and Senate President pro Tem Don Perata announced that they had reached agreement in principle on “unifying” the major provisions of their respective health care coverage reform measures, AB 8 and SB 48. The resulting AB 8 passed through both chambers of the state legislature, but it was vetoed by Governor Schwarzenegger on October 12, 2007. At the end of 2007, the General Assembly and the Governor agreed to compromise legislation, but in January 2008, the State Senate Health Committee defeated the proposal, partly because the state was facing a large deficit and budget cuts by that time. Here we analyze the bill’s September 2007 version.

Best Practices from California

As the most diverse state in this analysis, California has a number of existing laws that would help make health care reform legislation applicable to minority populations.

These include:

- AB 982, which establishes a loan-repayment program to extend providers' underserved areas. Priority is given to candidates who speak another language, have economically disadvantaged backgrounds, and have had significant training in culturally and linguistically appropriate service delivery.
- SB 853, which requires insurers to assess the language needs of enrollees and provide patients with translated materials and language assistance, when needed.

Access to Care

AB 8 improves access to care through three of our benchmarks. It expands public coverage through the Healthy Families program and implements private individual insurance market reforms. AB 8 also establishes a “pay or play” system, wherein both employees and employers have to pay their fair share of health costs.

Make health care affordable. The bill aims to expand public coverage. Children from families with incomes up to 300 percent of the FPL would be eligible for either Medicaid or SCHIP, regardless of immigration status. Parents and caretakers would be also eligible for Medicaid, though subject to federal approval (regarding immigration status) and state appropriation of its share of the funding. All California carriers that sell health plans to employers would be required to offer a plan that covered all Medicaid and SCHIP benefits at prices negotiated with a state-created board. Employees could thus choose to receive their Medicaid or SCHIP plans through their employer, and the state would provide premium assistance.

Section 22, part 6.45 of AB 8 would create the California Cooperative Health Insurance Purchasing Program (Cal-CHIPP)—a statewide purchasing pool designed to increase access to health care for many who were previously unable to afford it or who had encountered barriers trying to obtain it. This pool would be established and administered by the Managed Risk Medical Insurance Board. Employers would elect either to provide health coverage for employees or to contribute the equivalent of 7.5 percent of wages to the California Health Trust Fund for employees working 30 hours or more a week. If employers decided to contribute to the Fund, their workers could select a plan offered by Cal-CHIPP. Otherwise, the employers would have to set up a system (called a Section 125 or cafeteria plan) for employees to pay their share of premiums with

pretax dollars. Meanwhile, Cal-CHIP would have set premiums and would offer subsidies, on a sliding fee scale, for households at or below 300 percent of the FPL.

In addition, Article 4.1 would require California insurers to guarantee the availability and renewability of coverage to individuals; that is, unless a consumer had a listed serious condition, private insurers would have to offer them policies and could not charge higher premiums based on health status. Consumers with such a serious condition could instead purchase their coverage through California's high-risk pool.

Finally, Section 9 would require health plans to spend 85 percent of premiums on health care services, thus limiting their administrative costs and profits.

Encourage comprehensive benefits packages and reduce fragmentation. At least three uniform-benefit plan designs would be offered to Cal-CHIP enrollees, two of them based on preexisting state benchmark plans. All plans would include prescription drug benefits and be approved by the Insurance Commissioner. In the individual private insurance market, insurers would offer a choice of five standardized plans to individuals, thereby allowing them to comparison shop. The bill also proposes some restrictions on moving between coverage plans; these restrictions are designed to spread the risks and costs of health insurance and to discourage people from waiting until they are sick to buy comprehensive coverage.

Evaluate outreach to and enrollment of underserved groups. Section 5 would mandate that the state track and assess the effects of health reform by conducting an annual assessment of changes in availability of and access to health care throughout the state. This assessment would include examination of: cost and affordability of insurance, enrollment in the new Cal-CHIP program by income, availability of health care coverage (including in rural and underserved areas), adequacy of the health care delivery infrastructure to meet patients' needs, health-professions workforce capacity, and quality of care. Moreover, the assessment would include a "more in-depth review of areas of the state that were determined to be medically underserved in 2007."

Quality of Care

Data collection. Although AB 8 does not specifically address health care quality improvement for minority patients, it does mandate that the state develop provider-performance measures and move to a pay-for-performance system in all state-administered programs. Cal-CHIP plans would be required to use evidence-based practices for

preventive care, chronic disease management, and reduction of medical errors, as well as to include incentives for healthy lifestyles.

Other Legislation or Legislative Proposals

California has enacted legislation over the past five years aimed at achieving health equity, and these laws would affect the implementation of any new coverage-expansion law.

Assembly Bill 59, enacted in 2001, streamlines the eligibility process for children in Medi-Cal (the state's Medicaid program). Each county in California determines Medi-Cal eligibility for its residents and controls enrollment, but this bill established a state-mandated local program that improves procedures through the sharing of information between the federal Free School Lunch Program and the county Medi-Cal administrators.

The Community Healthcare Service Expansion Act of 2002 (AB 982) established the California Physician Corps, a loan-repayment program to increase the number of providers in underserved areas. Candidates who speak a Medi-Cal threshold language receive priority consideration, as do candidates with economically disadvantaged backgrounds and those with significant training in culturally and linguistically appropriate service delivery.

Assembly Bill 9 created the Urban Community Health Institute in 2003. Located in Los Angeles' Charles R. Drew University of Medicine and Science, the Institute assesses racial and ethnic disparities in health care and develops new solutions for eliminating them.

The Cultural and Linguistic Competency of Physicians Act of 2003 (AB 801) created a voluntary program for physicians that stresses foreign-language training and cultural-competency certification. The law also included a patient-satisfaction survey to evaluate physicians' treatments.

The Health Care Language Assistance Act of 2003 (SB 853) required that insurers assess the language needs of their enrollees and provide them with access to translated materials and language assistance, when needed. The law requires that contracts between providers and health plans be in compliance with Department of Managed Health Care standards of language assistance and translation standards.

STATE MEDICAID AND SCHIP CONTRACTUAL REQUIREMENTS

Looking beyond the five states in our above analysis, many state governments have addressed at least some expanded-coverage, cultural-competence, and quality issues in their contracts with Medicaid managed care organizations or SCHIP plans. In creating a new set of affordable health plans, they may wish to establish similar contractual provisions, in accordance with the federal requirements and other factor described below.

Access to Care

Federal law and regulations require that Medicaid managed care enrollees receive a choice of at least two health plans (or in rural areas, a choice of at least two physicians and case managers). The number of providers in a managed care plan's network must be enough to serve its members, and they must receive services on a timely basis. To determine the adequacy of a provider network, states must take into account, among other factors, the geographic locations of providers and the characteristics, health care needs, and service utilization of people expected to enroll in the plans.

States must identify the race, ethnicity, and primary language spoken by Medicaid beneficiaries and provide this information to managed care contractors. For its part, the managed care plans must make written materials available in languages that are prevalent in a state (states define "prevalence"). These written materials include member handbooks, enrollment packages, and other materials that help people understand how to use managed care and exercise their rights. In addition, plans and states must make translation services available to all enrollees.

Quality of Care

States must have a written strategy in place to measure, monitor, and improve the quality of care provided by their Medicaid managed care plans. They must specifically scrutinize the care provided to enrollees with "special health care needs," as defined by each state. To the extent that it is available, states must provide enrollees with comparative information about plans' performance on quality indicators.

States typically identify clinical and nonclinical areas in which they require plans to conduct studies and undertake quality-improvement efforts. Because all states must make racial and ethnic data available to managed care plans about their Medicaid enrollees, a particular area of study suggests itself: states could readily require monitoring of racial and ethnic disparities in treatment.

Patient Empowerment

As noted above, states must provide information about how patients can use a managed care system in locally prevalent languages. In addition, they may undertake patient education as a quality initiative, although they are not required to do so. For example, some states have established asthma or diabetes interventions that include patient education and support groups.

Health Care Infrastructure

States often require that a managed care plan's primary care providers and pharmacies be located within a defined distance from enrollees' residences. Moreover, a few states require a diverse provider network, and others have used their leverage to insist that managed care plans develop appropriate facilities, such as group treatment homes for people with mental illness, in underserved communities.

How Do Our Study States Measure Up?

California. Under AB 8, all health insurers that are licensed to sell plans to California businesses must offer, as one option for employees, a plan that includes all required benefits in the state's Medicaid program. When employees with low-enough incomes enroll in the plan, the state will pay all or a portion of the premiums. It is not clear, however, whether such plans will have to meet only the benefit requirements of current Medicaid programs or also the quality and access requirements.

Under California's Medicaid managed care contracts, plans must achieve specific ratios of providers to enrollees, include provider networks to "meet the ethnic, cultural, and linguistic needs" of plan members, and contract with a broad representation of traditional and safety-net providers. In addition, plans must assess and report on the linguistic capabilities of interpreters and employed and contracted staff, and they must provide 24-hour access to interpreters for all members. Groups that meet designated language thresholds (for example, over 1,500 members in two contiguous zip-code areas who speak a specific language) must provide corresponding language service at various designated "key points of contact."

Plans must also conduct an assessment of the cultural and linguistic needs of their members and forward any complaints about discrimination to the state for investigation. As part of their quality-assessment activities, plans must conduct a member-satisfaction survey of members, including those who are limited in their command of English. And in their quarterly reports to the state, plans must provide data on their provision of cultural and linguistic services and on the ethnic composition of providers in their networks.³⁷

Illinois. Illinois has already established an “All Kids” program under which children of all income levels can obtain care through the same managed care plans that serve SCHIP enrollees. Those families that are above the income limits for premium subsidies pay the full price of premiums. Under its proposed Covered Choices program, Illinois will also allow parents and caretakers to buy coverage from the same managed care contractors if they have no job-based coverage and their incomes are below 400 percent of the FPL. Adults with incomes over the FPL will pay for coverage on a sliding fee scale. Small businesses and their employees will be able to obtain coverage through a new set of managed care plans designed to be affordable, but it is not yet clear whether these new plans will have to meet requirements similar to those imposed on Medicaid managed care contractors.

Illinois’ contracts for managed care, both in Medicaid and All Kids, require that plans meet provider ratios, make services available within designated periods of time, and translate written materials into a language if more than five percent of households in a Human Services local office area speak it (and speak limited English). In addition, plans must furnish oral interpreters over age 18, free of charge, to all enrollees speaking another language who request the service. Moreover, plans cannot discriminate based on race and must comply both with Illinois laws and federal laws regarding nondiscrimination.

Massachusetts. Massachusetts has three different kinds of contracts with health plans: one for people who are eligible for Medicaid (called “MassHealth”); another for Commonwealth Care enrollees (people with incomes up to 300 percent of the FPL who pay premiums, on a sliding fee scale, to the same plans that serve Medicaid enrollees); and another for health plans that are marketed through the Connector but for which enrollees pay the full price.

The contracts for Medicaid and Commonwealth Care both contain standards for cultural competency and language access that are more protective than those of other plans marketed by the Connector. For example, plans’ provider networks must be responsive to the linguistic, cultural, and other unique needs of minority-population members, must meet provider-to-enrollee ratios and standards about waiting time for appointments and distance from enrollees’ homes, and must make multilingual providers and skilled medical interpreters available for the most commonly used languages in any particular geographic area in the plan’s service area. The network has to be sufficient so that all enrollees will have a choice between at least two providers who are accepting new patients and able to communicate with the enrollee in a linguistically and culturally appropriate manner, as long as such capacity exists within a service area.

In addition, plans' written materials must be translated into prevalent languages as determined by the state—currently, English and Spanish—and plans must offer free oral interpretation in all languages. Written material must be accompanied by a statement in multiple languages instructing the enrollee to contact the plan for assistance with translation. The state provides data to the plan, to the extent available, about race, ethnicity, and language of enrollees.

The contract is less specific for unsubsidized plans that are marketed through the Connector. Plans prepare provider directories as required by law and regulation, but the contract does not require translation of written materials or that they contain information about languages spoken by providers. Plans must include an “adequate number” of providers that are accepting new patients in their networks, cannot discriminate against enrollees by race, color, national origin, personal appearance, and other factors, and cannot treat Commonwealth Choice enrollees differently from other enrollees (unless required to do so by other rules).

Pennsylvania. Under the proposed expansion, Pennsylvania would contract with health plans to serve adults in the Cover All Pennsylvanians program. People with incomes under 300 percent of the FPL would pay premiums on a sliding scale, and those with higher incomes but no other access to health insurance would pay the full cost of coverage. We do not yet know what standards the contractors will be required to meet.

Currently, Pennsylvania has two separate standard contracts for managed care plans that provide services to children. Its “Health Choices” agreement for Medicaid managed care enrollees contains a number of protections for racial and ethnic minorities. For children without access to other insurance who are above the income limits for the Medicaid program, Pennsylvania’s contract with health plans that serve children under the SCHIP and All Kids programs is somewhat less protective and leaves more discretion to the contractors.

Regarding adults, Pennsylvania’s “Health Choices” agreement for Medicaid managed care includes provisions that plans must meet provider ratios, make services available within designated periods of time, and use providers located within specified distances of enrollees’ homes. Each plan must also make written materials—including handbooks, education and outreach materials, provider directories, and written notices—available in prevalent languages as determined by the state, and the plan’s staffing should represent the cultural and ethnic diversity of the populations served.

In addition, plans must consider enrollees' language needs and cultural compatibility in assigning primary care providers to people who have not chosen their own, and plans and providers must demonstrate enough cultural competency that cultural differences cannot present a barrier to access or receipt of care. They must also demonstrate understanding of differences between traditional and nontraditional treatment methods (consistent with a member's cultural background) that may be equally effective. Moreover, plans and providers cannot deny service based on race, ethnicity, and other listed factors.³⁸

Pennsylvania's SCHIP contract is somewhat less stringent in its requirements—plans must have an adequate number of providers, but the contracts do not establish ratios of providers to enrollees or distance standards. Plans must set their own standards regarding waits for appointments in accordance with acceptable medical practice, and must make written materials available in Spanish and English. In addition, “health care initiatives, outreach, and educational activities should be sensitive to the health care needs of the culturally and ethnically diverse children served.” Plans are specifically required to provide parent education on the need for preventive care and to provide a list of languages spoken by network providers, and plans are encouraged to be culturally sensitive and to establish provider networks that represent the diversity of their enrollees.

Washington. The state contracts with managed care plans to serve both SCHIP and Medicaid enrollees. Under Washington's current SCHIP/“Healthy Options” contracts, the state must give the plans data about enrollees' race, ethnicity, and language. For their part, plans must consider this information in order to maintain an appropriate provider network, and they must ensure that there is equal access for enrollees who face communication barriers; toward that end, plans must arrange for free interpreters. Though the plan makes the arrangements, the state pays for interpreters used in outpatient medical services while hospitals pay for interpreters involved in inpatient services.

Plans must also ensure that there are providers within certain distance limits from enrollees' homes and that services will be available within designated periods of time. In addition, plans must monitor performance using HEDIS (standardized performance measures) and CAHPS (a nationally standardized survey of patient experience).

CONCLUSIONS

Our analysis of five states' approaches to health insurance expansion finds that they are addressing disparities, explicitly or implicitly, in several important ways. All are expanding public insurance programs or offering premium assistance to make private

insurance affordable to low- and moderate-income families—populations that disproportionately include people of color.

But all five states recognize that to equalize health care access and quality, improving access to insurance coverage—clearly the most important step for eliminating disparities—is necessary but not sufficient. As this report shows, states must do more. Additional steps can include monitoring for inequality, improving the health care infrastructure in low-income communities and communities of color, and addressing minorities’ cultural and linguistic needs.

While no two of these states used the same approach, several policy strategies were common. They included:

- Expanding access to health insurance products by reducing financial barriers to coverage
- Improving and evaluating outreach and enrollment efforts
- Collecting data (often while building upon federally mandated Medicaid data-collection programs) on health care access and quality measures by patient demographics
- Supporting safety-net institutions
- Improving health care provider diversity, distribution, and cultural competence.

These common strategies are discussed below:

Making health insurance affordable. Almost all approaches assessed in this study include expanding public insurance programs and implementing sliding scale fees for premiums based on income, both of which can help to reduce uninsurance rates among people of color. Massachusetts, for example, subsidizes premiums for families with incomes under 300 percent of the FPL and strives to ensure that all state residents have affordable health insurance options that are considered “minimum creditable coverage.” A new state entity, the Connector, administers this new program. The Connector also negotiates with health plans that agree to provide affordable coverage to people over 300 percent of the FPL, and it helps both individuals and businesses to enroll.

Similarly, Washington’s new Health Insurance Partnership was established to support health insurance coverage among small employers, which are eligible to participate if at least one employee has income below 200 percent of the FPL. Each

employee may choose among the benefit plans offered by the Partnership, which then collects premiums and administers subsidies. Employees' shares of premiums are paid with pretax dollars.

These states will face challenges, however. Because many state health insurance coverage programs include expansions of SCHIP eligibility, these states will have to grapple with recent guidance promulgated by the U.S. Department of Health and Human Services, which would require states to demonstrate that the poorest children are covered prior to expanding eligibility above 250 percent of the FPL. These new requirements also impose a waiting period for coverage, oblige state plans to charge premiums comparable to those of private plans for children in families above 250 percent of FPL, and demonstrate that the private market will not be "skimmed" by SCHIP expansions. Most states will have difficulty meeting these requirements, and unless the guidance is rescinded or overturned, states that have already expanded coverage stand to lose federal funds, and other states will be deterred from expanding.

Importantly, none of the states in this analysis can achieve truly universal health insurance coverage. Many groups are left out of even the most comprehensive plan studied, or they are ineligible for subsidized coverage even if they have very low incomes. These groups include childless adults who are not eligible for Medicaid and are subject to enrollment caps in state-funded programs, undocumented immigrants, and many legal immigrants. The failure to explicitly cover all residents makes it even more important that states support safety-net institutions and provide other means for uninsured residents to get the care they need, particularly primary care and health screenings.

Improving and evaluating outreach and enrollment efforts. At least two of the states in this analysis are aiming to better inform eligible populations of new insurance products or subsidies. Massachusetts' new Connector is required to develop an outreach and education plan designed to reach low-income uninsured residents and maximize their enrollment in the program. Similarly, Washington's new health insurance expansion statutes require a "proactive, targeted outreach and education effort" to enroll children in health coverage and improve the health literacy both of the children and their parents. These efforts will include a media campaign, community-based outreach and application assistance, identification of potential enrollees through other systems (such as school lunch and early-childhood education), and simplified enrollment systems. California's AB 8, still pending, would mandate that the state track the effects of health reform by conducting an annual assessment of changes in health care access. It would include an examination of the cost and affordability of insurance, enrollment in the new Cal-CHIP

program by income, availability of health care coverage (including in rural and underserved areas), and adequacy of the health care delivery infrastructure to meet community needs, achieve needed health-professions workforce capacity, and provide a high quality of care.

Collecting data and monitoring disparities. Several of the states in this review impose new data-collection requirements on health care plans and providers; most do so through regulation and contracting requirements, while others use legislation. Data collection is central to the disparities-reduction strategy being adopted by Massachusetts, whose law establishes a Health Care Quality and Cost Council within the state Office of Health and Human Services. The council is charged with developing and coordinating quality-improvement goals that aim to reduce not only costs but also racial and ethnic disparities. In addition, the law requires health care cost and quality data to be publicly reported, although it does not explicitly require that data be disaggregated by patient race, ethnicity, or other demographic factors. But given the emphasis in the statute on addressing health care disparities, public reporting of quality data by patient demographic factors appears to be a possibility.

Similarly, Washington's new law mandates the creation of a health care quality forum, charged with producing an annual report on clinical-practice patterns and with providing this information to purchasers, providers, insurers, and policymakers. The statute does not require, however, that data be disaggregated by patient race, ethnicity, or primary language, though advocates in the state may work to ensure that the report indeed addresses disparities and disparities-reduction measures.

Supporting safety-net institutions. Several of the states in this analysis are supporting safety-net institutions as a means of addressing the often-weaker health care infrastructures of poor and minority communities. Massachusetts' new law, for example, authorizes a Health Safety Net Office within the Commonwealth's Medicaid office, in part to administer a Health Safety Net Trust Fund and an Essential Community Provider Trust Fund. These funds are established for the purpose of "improving and enhancing the ability of acute hospitals and community health centers to serve populations in need more efficiently and effectively, including, but not limited to, the ability to provide community-based care, clinical support, care coordination services, disease management services, primary care services, and pharmacy management services through a grant program." Criteria for grants include "the cultural and linguistic challenges presented by the populations served by the provider."

Similarly, Washington established a grant program to create new community health center sites and expand existing health centers. And although the legislation is still pending as of this writing, the Illinois Covered Act (SB 5) establishes a grant program for establishing new community health center sites, expanding primary care services at existing sites, and adding or expanding specialty services at existing sites. The targeted populations include the medically underserved, the uninsured, and people enrolled in a health care program administered by Illinois' Department of Healthcare and Family Services.

Improving health care provider diversity and distribution. States in this analysis are also taking steps to increase the diversity of providers and to encourage them to work in underserved communities. Legislation pending in Illinois would create a state Healthcare Workforce Council to monitor health care workforce trends, particularly with respect to workforce supply and distribution; to provide assessments of cultural competence and minority participation in health professions education; and to recommend appropriate state-government and private-sector efforts for addressing identified needs.

Massachusetts' new law establishes a Health Disparities Council, which will address diversity and cultural competence in the health care workforce, in part through submission of an annual report with recommendations. Washington State's SB 5930 requires that Certificates of Need be awarded, consistent with a "statewide health resources strategy" that describes the demographics of the state and its regions; inventories health facilities, services, and the availability of providers; and assesses the health care needs of different geographic regions. SB 6194, enacted in Washington last year, requires multicultural training in health professionals' education curricula and in their continuing education. Legislation being considered in Pennsylvania would create a Center for Health Careers, with the expressed goal of increasing workforce diversity.

Our analysis also revealed several *missed* opportunities, which states could use to promote equity as they expand access to insurance coverage:

Patient empowerment. Some of our study states are seeking to strengthen patient-education programs through chronic-disease-management, consumer-education, and patient-safety initiatives. But their legislation does little to require that these patient-education programs be culturally sensitive or tailored to the needs of disparity populations. It will be important for states to be mindful of the educational needs of diverse patient populations as they implement these programs.

Community health workers. Of the five states in this analysis, only Massachusetts explicitly calls for the state public health department to study the potential of community health workers to improve access to health care and eliminate disparities. While other states may support community health workers through agency initiatives or through grants that enable community health centers to hire such workers, policymakers should also consider training and reimbursement for these services as part of statewide health care coverage expansion plans.

Community health planning. Community-empowerment programs were also uncommon among the coverage-expansion plans of the states examined here. Only one of them, Pennsylvania, sought to strengthen community input into health care policy and to direct resources to meet community needs. The Cover all Pennsylvanians proposal would require charitable hospitals, in consultation with community groups and local government officials, to produce a community needs assessment.

And only one state, Washington, sought to strengthen state Certificate of Need programs as a tool for regulating health care resources. CON approval would be linked with a statewide health resources strategy that described the demographics of the state and its regions; inventoried existing health facilities, services, and provider availability; and assessed health care needs in different geographic regions. Other states should look to these approaches as models of how to allow community input to meaningfully guide state health planning.

Cultural competence training and cultural/linguistic access standards. While Illinois is examining strategies to increase health care workforce cultural competence, none of the states in this analysis included mandates in legislation for providers' cultural competence training or established standards for cultural and linguistic access. Many states address these needs through contracts and regulation, but not all. State health care reform proposals should consider including these elements, which are increasingly important mechanisms for improving quality for diverse patient populations.

Reimbursement for language services. While the federal government allows states to include language services as an administrative or optional covered service in their Medicaid and SCHIP programs, only a handful of states are reimbursing providers for language services provided through these programs. In this report's analysis, Washington was the only state doing so.³⁹ State health care reform proposals provide a natural mechanism for adopting these services.

Health-impact assessment. None of the states in this analysis authorized the use of health-impact assessments to determine the health effects of state housing, transportation, environmental, or land-use projects on vulnerable communities. While some states—Washington, for example—have authorized such policies in legislation prior to enacting state coverage-expansion programs, most states should consider impact-assessment strategies as part of their comprehensive health care reform proposals.

Establishment or enhancement of state offices of minority health. None of the states in this analysis enhanced their existing offices of minority health as part of their coverage-expansion legislation. Massachusetts, however, established a Health Disparities Council to make recommendations “regarding reduction and elimination of racial and ethnic disparities in health care and health outcomes within the Commonwealth.”

RECOMMENDATIONS

Based on these findings, we offer a number of recommendations that stakeholders should consider in their efforts to achieve equitable health care for all. The stakeholders include:

- State elected officials and policymakers, who are increasingly focused on eliminating health care disparities
- Health professionals, whose associations are also increasingly developing programs to eliminate disparities
- Consumer and advocacy groups, which have tended to focus on health insurance coverage and affordability issues but are now recognizing the need to achieve equity as well
- Health plans and insurers, which are increasingly recognizing the need to address disparities in order to compete for the business of communities of color (among the fastest-growing segments of the U.S. population)
- Private-sector entities, which have a strong interest in maintaining a healthy workforce—and whose workforce is becoming increasingly diverse with respect to race and ethnicity
- Affected communities.

Our recommendations are:

Make universal health care coverage a core goal. None of the states examined in this study offer truly universal health insurance, as all of them explicitly exclude or limit

the enrollment of many populations—such as low-income childless adults, undocumented immigrants, and even some legal immigrants. But uninsurance is not just a problem for those who lack coverage; it also contributes to escalating health care costs and access problems among those who do have insurance. Only by covering everyone in the population can states eliminate uncompensated costs and strengthen the health care infrastructures of underserved communities.

Assess how policies to expand coverage affect currently underserved groups. The states studied here have employed different strategies—mandates to purchase insurance, for example—in order to expand coverage. But none of these states required in legislation that these strategies be assessed in order to determine their actual effects. For example, the challenges of enforcing an individual insurance mandate across different communities are significant. Some legal immigrants (to cite just one group) may be reluctant to apply for public health insurance programs, even if eligible, as a result of anti-immigrant rhetoric and policies, and they might therefore be slower to comply with a mandate. States that are considering such strategies should monitor their progress and take steps to correct them should they have a disproportionately negative impact on particular populations.

Be an agent for change. State government can leverage the power of a range of public and private stakeholders to help in the effort to eliminate health care disparities. Health plans, providers, accrediting bodies, quality-improvement organizations, and health-professions educational institutions are obvious stakeholders, most of which share the goal of achieving “quality equality.” States can convene these groups, coordinate their activity, and offer incentives so that disparities-reduction efforts have maximal impact.

Reach for low-hanging fruit. Many of the policy strategies examined here can be implemented through regulatory strategies or contractual requirements, rather than through legislation. For example, states are required by federal law to identify the race, ethnicity, and primary language of Medicaid beneficiaries and to provide this information to managed care contractors. This information can be used to generate reports on how plans are faring with respect to health care equity.

Ride the health care reform wave. Stakeholders seeking to elevate the visibility of health care disparities issues and to advance disparities-reduction policies should take advantage of the growing interest in health care reform in state capitals. Advocates can offer two powerful reasons why any state health care reform legislation should address disparities: health care inequality carries a significant human and economic toll; and its persistence limits states’ ability to contain health care costs and improve overall quality

of care. In fact, such a strategy was successfully used in Massachusetts to lay the groundwork for legislative support of disparities-reduction efforts.

Actively monitor the implementation of new health care expansion laws. Almost all of the equity-related policies examined in this study require ongoing advocacy attention to ensure that they are actually working to reduce disparities. Policymakers and other stakeholders should make sure that laws, regulations, and contracts are explicitly addressing the unique needs of communities of color.

APPENDIX. EQUITY ELEMENTS OF STATE LAWS AND PROPOSALS ON HEALTH CARE COVERAGE EXPANSION

Policies that address:	MASSACHUSETTS (Chapter 58)	WASHINGTON (SB 5930/1569/5093)	CALIFORNIA (AB 8)	ILLINOIS (SB 5)	PENNSYLVANIA (HB 700)
<p>Access to Health Care</p> <p>Make health care affordable</p>	<ul style="list-style-type: none"> Subsidized care through the Connector for people with incomes under 300% FPL who are not eligible for Medicaid or SCHIP. They pay premiums to eligible plans on a sliding scale. Lifts enrollment caps on public coverage for childless adults under 100% FPL. These adults are not charged premiums. The state has negotiated with private plans to provide affordable standardized products through the Connector. These plans are available at full cost to individuals not eligible for subsidized coverage and to small businesses. Employer assessment Individuals who can afford coverage will be required to obtain policies or to pay a penalty, thus sharing in the costs of health care. Expansion of CHIP eligibility from 200% FPL to 300% FPL. By merging the risk pools for individual and small-group policies, the premiums for people buying individual policies are lowered. 	<ul style="list-style-type: none"> (5930) Creation of Washington Health Insurance Partnership to ensure affordable health insurance for individuals and small businesses. Sliding scale costs for eligible residents up to 300% FPL. A state agency can enroll eligible people regardless of open enrollment restrictions. (1569) Establishment of the Health Insurance Partnership, which offers premium subsidies to eligible participants and small businesses. Adjusted community rates will pool the medical experience of small groups purchasing coverage. (5093) Strengthening of private coverage and publicly supported CHIP. Public coverage in full up for children to 250% FPL. Premium assistance for children up to 300% FPL. Buy-in at full cost for children in families above 300% FPL. 	<ul style="list-style-type: none"> Creation of California Cooperative Health Insurance Purchasing Program (Cal-CHIPP), a statewide purchasing pool for health insurance to be administered by the Managed Risk Medical Insurance Board. Cal-CHIPP will offer premium assistance and subsidies for households up to 300% FPL. Households with income above 300% FPL will pay full cost for coverage through Cal-CHIPP. Employer election to either provide health insurance coverage for employees or to contribute 7.5% of wages to California Health Trust Fund. If employers pay the fee instead of providing coverage, their employees can obtain coverage through Cal-CHIPP. Ensures that all children, regardless of immigration status, will have access to affordable and comprehensive health care coverage. 	<ul style="list-style-type: none"> Creation of Illinois Covered Choices program, which will offer standardized plans to individuals and small businesses, with premium assistance for eligible people up to 400% FPL. Expands Medicaid, SCHIP, and a similar state-funded program to provide coverage to childless adults with incomes up to 100% FPL, parents up to 400% FPL, and working people with disabilities up to 350% FPL. Business tax (3% of payroll expenditures) imposed on businesses whose health care costs are less than 4% of their payroll expenditures. Offers Illinois Covered Choices eligibility to legal residents in the first five years of residence, despite federal regulations making them ineligible for Medicaid. Covered Choice plans cannot charge higher premiums to people based on their health status. 	<ul style="list-style-type: none"> Creation of Cover All Pennsylvanians (CAP) subsidized insurance program for previously uninsured adults and small businesses with low-wage workers. Sliding scale costs for eligible residents up to 300% FPL. Fair Share Tax for businesses that do not provide coverage for their employees will initially be 3% of their payroll expenditures. Restricts rates that private insurers are allowed to charge small businesses by requiring that 85 percent of premiums be used for medical care. Also prohibits insurers from charging increased premiums to businesses and individuals based on their health status. Requires insurers to issue some standardized plans.

			<ul style="list-style-type: none"> By 2011, insurers cannot charge higher premiums to people based on their health status. Guarantees availability and renewal of health coverage in the private market. 				
Assess how affordability policies and individual mandates affect uninsured populations							
Promote cultural and linguistic competence in health care settings						<ul style="list-style-type: none"> The state Healthcare Workforce Council will provide assessments and recommendations regarding cultural competence standards (see below). 	<ul style="list-style-type: none"> Creation of Pennsylvania Center for Health Careers, with expressed goal of increasing work force diversity.
Promote diversity among health care professionals						<ul style="list-style-type: none"> Health Disparities Council has been established, partly to address workforce diversity. 	<ul style="list-style-type: none"> The state Healthcare Workforce Council will provide assessments and recommendations regarding cultural competence and minority participation in the health care workforce.
Encourage comprehensive benefit packages and reduce fragmentation						<ul style="list-style-type: none"> Commonwealth Care provides low-income enrollees with dental and mental health benefits. 	<ul style="list-style-type: none"> Insurers must cover mental health services as an element of the benefits package provided. Basic benefits package offered by insurance companies under CAP must meet Department of Health guidelines. Among other services, the package must include maternity care, preventive care, and disease management.
Improve/streamline enrollment procedures for state health insurance programs							<ul style="list-style-type: none"> Allows for flexibility and information-sharing regarding eligibility, enrollment, and reenrollment among relevant state agencies.

Evaluate outreach to and enrollment of underserved groups	<ul style="list-style-type: none"> Connector must develop a plan for outreach and education that is designed to reach low-income uninsured residents and maximize their enrollment in the program. 	<ul style="list-style-type: none"> (5093) Targeted and community-based outreach and education efforts for enrollment of children and increased health literacy for parents and kids alike. 	<ul style="list-style-type: none"> Mandates annual assessment of the effects of reform—including quality of health care services, availability, and coverage to underserved areas—and their impact on safety-net system. 	<ul style="list-style-type: none"> Mandates evaluation and reporting of enrollment efforts and impact on uninsured populations. 	<ul style="list-style-type: none"> Evaluation and monitoring of outreach, including to special populations such as racial/ethnic minorities.
Encourage establishment of medical homes for patients.		<ul style="list-style-type: none"> Collaboration between Department of Health and Department of Social and Health Services to design evidence-based programs that ensure medical homes for vulnerable populations. Programs must show quality improvement. 			
Quality of Care					
Collect data and monitor health care disparities based on race/ethnicity, language status, and income.	<ul style="list-style-type: none"> Health Disparities Council will collect, analyze, and aggregate data related to disparities. 	<ul style="list-style-type: none"> Insurers must submit claims data to the state; demographic and member information will become state property. 	<ul style="list-style-type: none"> Mandates statewide data collection on quality and availability of care, health care costs, and outcomes. 	<ul style="list-style-type: none"> Proposes additional quality measurement regarding treatment of chronic diseases but does not address disparities. 	<ul style="list-style-type: none"> Requires data collection to improve patient safety and quality of care in hospitals and nursing homes but does not address disparities.
Publicly report health care access and quality disparities.	<ul style="list-style-type: none"> Establishes Website to publicly report health care cost and quality information. 		<ul style="list-style-type: none"> Above data collection is intended for public reporting. 		
Encourage health care systems to adopt guidelines and measure quality.	<ul style="list-style-type: none"> The Council will develop quality measures and implement solutions in health care systems. 		<ul style="list-style-type: none"> Develops health care provider performance measures and links provider pay to performance according to quality measures. 		

<p>Patient Empowerment</p> <p>Expand patient-education programs that are tailored to the needs of underserved communities.</p>		<ul style="list-style-type: none"> • SB 5930 promotes development of aids for decision-making, whether collaborative or by patient alone, but makes no mention of tailoring them to underserved communities. 	<ul style="list-style-type: none"> • Supports programs to improve patient self-management of chronic conditions, but does not address needs of underserved communities. • Community health center grant program can be used to support community health workers. 	
<p>Training and reimbursement for community health workers.</p>	<ul style="list-style-type: none"> • Community Health Worker Study, to be conducted by the Public Health Department, will determine the effectiveness of community health workers in reducing disparities. 			
<p>Health Care Infrastructure</p> <p>Support "safety net" hospitals and reduce the financial vulnerability of health care institutions serving poor and minority communities.</p>	<ul style="list-style-type: none"> • Establishment of Health Safety Net Office and Essential Community Provider Trust Fund to appropriately reimburse community health centers and institutions that provide eligible care. Section 128 increases Medicaid rates paid to physicians and acute-care hospitals. 	<ul style="list-style-type: none"> • Supports community health centers with targeted funds and data collection to ensure that care is in proportion to the needs of underserved populations. 	<ul style="list-style-type: none"> • Establishes a community health center grant program to create new health center sites and expand care at existing health centers. 	
<p>Incentives for health care professionals to practice in underserved communities.</p>			<ul style="list-style-type: none"> • Loan Repayment Assistance for Physicians Act provides incentives for physicians and dentists to serve underserved populations. 	
<p>Cultural-competence training for health care professional licensure.</p>			<ul style="list-style-type: none"> • Establishes a state Healthcare Workforce Council to make recommendations regarding cultural-competence training. 	

<p>Policy Infrastructure</p> <p>Utilize community health planning and other strategies that direct resources to community needs.</p>		<ul style="list-style-type: none"> Charitable hospitals' community needs assessments are done with help of community members (see below). 		<ul style="list-style-type: none"> Involve community in sustainability of Illinois Roadmap to Health. 	<ul style="list-style-type: none"> Community needs assessments for charitable hospitals involve community group meetings and are to be updated every three years. The assessment (Community Benefit Report) must be made available to the public by the hospital and state Department of Health.
<p>Establish or enhance state offices of minority health.</p>	<ul style="list-style-type: none"> Establishes a Health Disparities Council in the state Office of Health and Human Services to make recommendations regarding disparities elimination. 				
<p>Rejuvenate state Certificate of Need assessments.</p>		<ul style="list-style-type: none"> Section 52 of SB 5930 requires a "statewide health resources strategy." As part of this strategy, the state will describe its regions and demographics and will inventory existing health facilities, services, and the availability of providers. The state will also assess the health care needs in its geographic regions. Certificates of Need will be awarded consistent with this strategic planning effort. 			
Social and Community Determinants of Health					
<p>Coordinate relevant state agencies to address determinants.</p>	<ul style="list-style-type: none"> The Health Disparities Council can make recommendations on issues affecting health status that are not directly related to health care per se. 				
<p>Utilize Health Impact Assessment (HIA)</p>					

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