Addressing Health Disparities Through the Marketplace

An Action Agenda for Washington State







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INTRODUCTION

Health disparities associated with race and ethnicity are a persistent problem in Washington State, as they are throughout the nation.\(^1\) The Affordable Care Act (ACA) at the national level has prompted a substantial expansion of health care coverage that will help improve access for all communities. Recognizing that, for some populations, insurance coverage will not be enough to maximize health outcomes, the ACA also includes new initiatives that can help to attack the disparities that bring less than optimal results for people of color populations, especially those that also are low-income.

This policy brief makes a series of recommendations about how Washington can attack disparities by making maximum use of the programs and requirements provided in the ACA. The recommendations are based on evidence that insurance coverage alone will not overcome the histories of neglect, poverty and discrimination that have embedded disparate outcomes into the structure of the health care system in America.²

HEALTH DISPARITIES PERSIST IN WASHINGTON

The presence of inferior health outcomes among people of color populations in the State has long been recognized. In 2001 the Washington State Board of Health issued a report on disparities in Washington.³ In 2006 the Legislature created the Governor's Interagency Council on Health Disparities.⁴ The role of this pioneering entity was and remains fairly limited – upon legislator request, it reviews legislative proposals to assess their impact on people of color populations as well as impact on gender. The Council is also required to develop a report on health disparities and to update it biennially.⁵

In addition to developing these reports, Washing-

ton decision makers and advocates have responded to the disparities problem. Washington has made a significant effort to expand coverage for children and low-income residents through the creation of Apple Health for Kids and the state funded Basic Health Plan. The State has maintained expansive coverage for Medicaid recipients. Undocumented children have been covered and interpretation and other language services have been provided for programs run by the government.

Nevertheless, disparities persist and health outcome statistics for Washington's people of color populations echo the dismal results found throughout the nation.

- ➤ Eighty-seven percent of those who identify as White report being in very good or excellent health, compared to 77% of Blacks, 73% of American Indian or Alaska Natives, and 69% of Hispanics.
- ▶ While the rates of overweight and obesity statewide are low, those who identify as American Indian or Alaska Native (79%), Black (76%), or Hispanic (69%) are more likely to be overweight or obese than those who identify as White (61%) or Asian, Native Hawaiian, or other Pacific Islander (42%).
- ► Those who identify as Black (44%) and White (42%) are more likely to report mental health issues, compared to those who identify as Asian, Native Hawaiian, or other Pacific Islander (33%), or Hispanic (26%).
- Rates of reported mental health issues in Washington are higher than national averages across people of color populations, except for Hispanics.
- ▶ While 75% of those who identify as White and 71% of those who identify as Asian, Native

Hawaiian, or other Pacific Islander report having a usual source of care, the rate is only 63% for Blacks and American Indians and Alaska Natives, and 46% for Hispanics.⁶

- Native Hawaiians and Pacific Islanders have higher rates of obesity, diabetes, and high blood pressure than the general Washington population.⁷
- ► Mortality rates among American Indian, Alaska Native and Asian and Pacific Island women in Washington have been steadily increasing since 1998, while the death rates for most other groups are declining.8

Additional documentation of these disparities is included in the biennial reports of the Governor's Interagency Council on Health Disparities. The Council has issued reports since 2008 and has made comprehensive recommendations to policy makers about ways to eliminate health disparities. The 2010 Council's report reached beyond the health delivery system to make recommendations about environmental causes of disparities and poverty.⁹

A series of studies by the State Department of Health also provides analyses of the extent and persistence of disparities in Washington. 10 In 2013 the Washington Health Alliance issued a report examining aspects of the disparities problem in Washington. 11

Even though these reports and analyses make it clear that Washington will have to go beyond insurance coverage in order to overcome health disparities, having insurance is critical for all populations because it is the portal through which consumers gain access to medical care and other important health services.

MAXIMIZING ACCESS TO INSURANCE COVERAGE

RECOMMENDATION 1: Washington should Implement a plan under the ACA Basic Health Option and assure that it is affordable so that it can provide access for traditionally excluded communities, particularly immigrants.

Throughout the national recession, the State struggled to maintain a commitment to Medicaid, Basic

Health, and to Apple Health for Kids. ¹² When the ACA passed, Washington State moved aggressively to implement new coverage opportunities by expanding Medicaid and by creating the new Washington Health Benefits Exchange. However, the historic Basic Health Program was abandoned as the new programs were being implemented.

The ACA Basic Health Option (BHP) permits the State to receive 95 percent of premium tax credits and cost sharing reductions available to low-income consumers and use the funds to purchase a State-coordinated insurance plan In addition to reducing risk costs in the remaining exchange market, the program has the potential to charge low-income consumers less in premiums than the exchange would charge. Additionally, this option can provide access to coverage for immigrant populations who are lawfully present in the U.S. but ineligible for Medicaid.

Efforts to enact a BHP in Washington have not succeeded. A major political barrier has been that administrative costs for the program cannot be funded from aggregated subsidy and cost reduction funds and must be provided from other sources. In issuing its rules on this matter HHS has noted, "states have the option to establish sources of non-federal funding to help offset administrative costs associated with BHP. Nonfederal resources can include assessments imposed on BHP participating plans." ¹⁵ Washington should use this method to cover the needed administrative costs and proceed to implement a plan.

Even though it will largely be funded by the federal government, individuals enrolled in the Federal BHP are charged monthly premiums and are subject to cost sharing. It is critical that costs are controlled so that the program is a viable option for those it is intended to help.

DISPARITIES AND THE WASHINGTON HEALTH BENEFIT EXCHANGE

As the ACA itself recognizes, insurance coverage alone will not succeed in eliminating health disparities. Even if all of Washington's residents have insurance, disparities will continue among people of color populations.

Creation of the Washington Health Benefit Exchange (referred to as the Exchange or the WHBE) provides a new opportunity to broaden the assault on disparities. Because exchanges rely on private insurance companies to deliver coverage, it is critical that these com-

panies become strong partners in the effort to attack disparities. Doing this will be especially difficult for the Exchange as it struggles with the need to maximize enrollment and as it encounters private insurance systems that clamor for profits.

This White Paper will give special emphasis to the role that the Exchange can play in the State's overall attack on health disparities. The recommendations will suggest ways that the Exchange can use all the tools made available by the ACA to provide maximum impact on the challenge presented by health disparities.

Through the implementation of the ACA the WHBE has created a series of Technical Advisory Committees (TACs) to make recommendations to the Exchange Board of Directors and Staff. Two of the TACs have the potential to help the Exchange identify and address health disparities. These include the Navigator TAC and the Health Equity TAC. Updated recommendations concerning the work of the Disparities TAC were presented to the Exchange Board in September. 16 While this White Paper includes a number of matters that the TAC has worked on, many of the suggestions of the Health Equity TAC Committee have not been adopted. The work of this TAC and the WHBE could be strengthened by adoption of the recommendations included throughout this report.

There are several areas in which the Exchange needs to play a stronger role in order to become a leader in the efforts to attack health disparities in Washington. These include efforts to maximize people of color enrollments, the provision of comprehensive language access for consumers with Limited English Proficiency (LEP), and the development of quality improvement plans by insurance companies that work in tandem with other efforts to overcome health disparities.

OUTREACH AND ENROLLMENT

RECOMMENDATION 2: Target community outreach and enrollment efforts toward diverse communities, use a variety of communication methods, and reach people through one-on-one contacts.

In its October 2014 enrollment report the Exchange reported that it had enrolled 139,700 consumers

in Qualified Health Plans. Of these, 119,958 were eligible for subsidies, or 86 percent of the total. There also were 464,547 qualified adults enrolled in Medicaid. 17

The Exchange implemented an advertising program aimed at increasing awareness of the opportunities to acquire health coverage and to drive consumers to enroll. Recognizing that many consumers would have trouble accessing these improvements in access to health insurance, Washington tried to maximize its enrollments by developing programs that included an internet portal and community based outreach. Enrolment materials were provided in eight non-English languages.¹⁸

Surveys were conducted to assess the effectiveness of the marketing effort. The final survey, conducted in April 2014, includes only partial information about the effect of the advertising on Latino consumers and on various income groups.

Comprehensive information about enrollments by race and ethnicity is not being collected. Consequently, It is not clear how successful this effort has been in reaching people of color populations overall. 19 Based on voluntary, self-identification, the Exchange reports that, of the 152,753 individuals who selected a Marketplace plan through March 31, 2014, 6.8 percent were of Latino ethnicity, 27.1 percent were non-Latino, and 66 percent did not declare their ethnicity. Race was reported separately and, though 21.3 percent of enrollees did not provide information on race, those who did so indicate that enrollees included American Indian (0.6 percent of total), Asian (10.3 percent), African-American (2.4 percent), "Other" race (3.4 percent), Pacific Islander (1.7 percent), White (60.0 percent), Alaska Native (0.1 percent), and Hawaiian (0.1 percent).20

While this survey information has serious limitations, the numbers suggest a shortage of people of color participation in the Exchange. The Exchange itself has implicitly acknowledged a need for improved efforts to communicate with linguistic minorities in its Language Access Plan. 22

An even more extensive effort needs to be mounted in order to reach these populations. Special advertising efforts need to be designed to approach Hispanic, African American, and Asian populations in particular. Because it often is easier to reach people of color and low-income populations through direct contact, community based outreach efforts need to be increased and targeted.

RECOMMENDATION 3: Set targets for enrollment of various demographic groups.

Without specific goals targeting historically excluded groups, the Exchange runs the risk of reproducing or increasing disparities despite its commitment to enrolling all communities. Therefore, we recommend that, as open enrollment periods proceed, specific enrollment targets should be set for demographic groups that have historically had limited access to the health insurance marketplace, including people of color and immigrants. These targets should be discussed with the Technical Advisory Committees. Setting enrollment targets will help both the state and stakeholders measure progress.

Moreover, as health reform continues to be implemented, systems for enrolling applicants and ensuring retention of coverage will need to be refined based on experience. Accordingly, as we further explain in Recommendation 11, the Exchange should gather and make public a range of data broken down by race, ethnicity, and primary language. These data will shed light on the success of current strategies and how those strategies should be adjusted.

LANGUAGE ACCESS

RECOMMENDATION 4: Ensure competent interpretation and translation at all levels of the Health Benefits Exchange, in communications, media, and public information and by health plans.

Language should never present a barrier to obtaining health coverage and accessing care. Washington's population is linguistically diverse. According to the national census, approximately eight percent of the State's population identifies itself as having Limited English Proficiency (LEP).²³ As Washington's demographics continue to change, this population will increase.²⁴

In addition to the requirements set out in the ACA and federal civil rights law, Washington has its own provisions relating to language access. These include the 1991 $\it Reyes$ Consent Decree affecting medical assistance programs and the Washington Law Against Discrimination. ²⁵

The State has taken steps to provide LEP popula-

tions with interpretation and translation associated with services the State provides directly and for the health programs that it operates. The Exchange has added a component of language access to its enrollment and outreach efforts, including the translation of outreach materials and making interpretation available through its enrollment call centers.

The WHBE should be a leader of efforts to provide access for LEP populations. During the summer of 2014 the Exchange adopted a Language Access Policy. This policy sets standards for its communication with consumers and outlines how the Exchange will conduct further reviews of LEP services. This review will include surveys of LEP consumers and an effort to improve information about LEP consumers. Additionally, in order to improve the quality of its materials, the Exchange will utilize the services of the Washington State Written Translation Contract for all written translations. ²⁶

Advocates for LEP services have recommended that the Exchange go much further by improving its own communication with consumers, strengthening translation standards, appointing a coordinator for LEP services, and through improved data collection.²⁷ Many of these recommendations were proposed by the Health Equity Technical Advisory Committee but are not included in the final version of the Exchange Language Access Policy.²⁸

The Exchange should strengthen its language policies and the interpretation and translation services made available through its call centers. Because its review of these policies began in the summer of 2014 another enrolment period and another year will pass during which LEP populations will continue to experience problems communicating with the Exchange and with the insurance companies that sell plans on the Exchange.

In order to provide linguistically sensitive communication to a more substantial portion of the State's LEP population, standards for insurers should be increased in order to require that they translate materials into any language spoken by either 500 consumers or 5% of the population in any county in their service areas. ²⁹ These thresholds were developed by the National Health Law Program and are a combination of standards used by HHS and the Department of Labor. ³⁰

The Exchange web site should be translated into the 8 languages most commonly used by Washington's LEP population. In order to ensure that the language access services are both an important Exchange pri-

ority and to ensure the highest quality, the Exchange should appoint a coordinator for its LEP its programs.

RECOMMENDATION 5: Require insurers to cover interpretation and translation in clinical settings.

Communication about how to acquire and use insurance, important though it is, will not be enough to overcome health disparities for LEP populations. Being able to communicate clearly with health care providers is a critical problem for consumers with language issues that affect their access to health care.³¹

Private insurance companies are not presently required to reimburse providers for interpretation services in the medical setting, though some do. These services are available to Medicaid patients through a system coordinated by the Washington State Health Care Authority (HCA). They should be available to all LEP consumers regardless of the type of coverage they have. All insurers should be required to provide reimbursement for interpretation services for LEP consumers through contracting on behalf of providers in their networks with the HCA program or through programs that equal it in quality and accessibility.

QUALITY IMPROVEMENT AND SETTING STANDARDS FOR HEALTH PLANS SOLD THROUGH THE MARKETPLACE

RECOMMENDATION 6. The WHBE should create quality improvement standards and enforcement mechanisms to require that insurers promote quality care, with specific attention to disparities.

Section 1311 of the ACA requires insurance companies to develop quality assurance programs that include an emphasis on health disparities. It reads:

(1) IN GENERAL. — The Secretary shall, by regulation, establish criteria for the certification of health plans as qualified health plans. Such criteria shall require that, to be certified, a plan shall, at a minimum...implement a quality improvement strategy described in subsection (g). Subsection (g) is quite specific:

➤ REWARDING QUALITY THROUGH MAR-KET-BASED INCENTIVES — (1) STRATEGY DESCRIBED. — A strategy described in this paragraph is a payment structure that provides increased reimbursement or other incentives forthe implementation of activities to reduce health and health care disparities, including through the use of language services, community outreach, and cultural competency trainings.

Insurance companies who do not have such strategies are not supposed to be selling insurance in the exchanges. As required by the ACA, the Exchange does direct insurance companies to have quality programs, but has given little guidance about how they should comply with Subsection (g).

Plan responses to the 1311(g) mandate vary considerably. 32 Group Health is a health maintenance organization and employs its own health providers so its plan focuses on in-house disparity programs. Kaiser Permanente provides translation, cultural competency training and Centers of Excellence in a community setting. Molina establishes a Community Connector program and assists plan members with access to language services, income assistance, housing and other needs. Other plans are less specific. Premera Blue Cross provides telephonic translation in 160 languages, but makes no mention of community outreach or cultural competency training. Coordinated Care's plan refers to a program called "Ambetter" that is an effort to provide culturally appropriate care and to link linquistically sensitive providers with consumers. Community Health Plan of Washington tracks language, race and ethnicity among its membership and engages in "targeted" campaigns to reduce disparities.

Some of these plans are clearly deficient. Bridge Span's plan provides this:

▶ At Bridge Span we show our commitment to reducing health care disparities every day. This means providing special training in cultural competency to our employees who work most closely with members. We also train our care management staff to identify cultural groups that may be at greater risk for certain health conditions. They can provide those members with targeted information to

help care for their health. We even provide interpreters for certain kinds of doctor appointments. [Insert note.]

None of these plans appear to provide the kind of incentive system that the ACA contemplates. It must be noted that neither HHS at the federal level nor the WHBE have provided rules or guidance about the implementation of 1311(g).

Section 1311(g) is a critical component in efforts to reduce disparities, especially since it requires private insurance companies to become partners in this important effort. The Exchange guidance on this subject does not mention reimbursement systems or incentives. Current quality planning does not appear to include any details about the implementation of this requirement or any enforcement against plans that are deficient. The Exchange Board needs to direct the appropriate TACs to begin working on recommendations to improve the implementation of this requirement.

As the WHBE reviews the process for enforcing this important quality provision of the ACA, it must be aware that there is research that shows that payment systems alone may not be enough to overcome the problems of health disparities. To be successful these systems must be linked to data and research, they need to be widespread, and they need to be supported by the involvement of affected communities. They also need to be linked to the availability of interpretation and translation services.

ADEQUATE PROVIDER NETWORKS

RECOMMENDATION 7: The Office of the Insurance Commissioner's review of network adequacy standards should assure that the standards meet the needs of diverse communities and should provide remedies for inadequate networks.

One of the potential benefits of the ACA is improved access to medical care for previously uninsured populations. However, merely being insured does not guarantee that consumers will have adequate access to medical providers. Insurance regulatory systems commonly establish standards for insurance provider networks in order to assure consumers that insurance

companies are contracting with health care professionals in ways that permit ready access to care.³⁶

Because travel often is difficult for those in poor health or from low-income families, access is often a matter of proximity. Typically, health care providers have located facilities and practices where there are insured customers. ³⁷ Low-income, people of color areas experience proximity shortages. ³⁸ Because of expanded insurance coverage in Medicaid and benefit exchanges, it is important that networks expand to serve these new customers.

The network standards adopted by the U.S. Department of Health and Human Services pursuant to the ACA require that they include essential community providers (clinics) and sufficient numbers and types of providers, including providers that specialize in mental health and substance abuse services, and to ensure that all services will be accessible without unreasonable delay.³⁹

Recognizing that these federal standards might not provide sufficient access for consumers, Washington's Insurance Commissioner initiated a rulemaking to review and revise the State's provider network adequacy standards. In spite of industry opposition focused on the claim by insurance companies that narrower networks are needed in order to limit premium increases, the Insurance Commissioner adopted regulations that go beyond the HHS standards. 40

The new rules regulate such things as billing for out of network services and prior authorization requirements. The rules lay out requirements for the types of facilities that networks must provide, incorporate access to Indian Health Services, and include updated requirements for women's reproductive health. The rules also establish a requirement that most types of providers be located no further than thirty miles from their customer base for urban areas and sixty miles for rural areas. Service areas established by insurance companies "must not be created in a manner designed to discriminate or that results in discrimination against persons because of age, gender, gender identity, sexual orientation, disability, national origin, sex, family structure, ethnicity, race, health condition, employment status, or socioeconomic status."41

These are important improvements over the HHS standards. However, they may prove insufficient to meet the access needs of previously neglected populations and new, low-income enrollees. Recognizing the importance of these rules for consumers, the Insurance Commissioner is proceeding with a second

phase to the rulemaking process that includes a review of the network adequacy standards in practice. 42

The Insurance Commissioner should include in this review a special emphasis on Communities of Color. If the review of these standards reveals access gaps for people of color populations, the Office of the Insurance Commissioner should consider the following additional network requirements:

- Requiring a fifteen mile travel limit for lowincome, people of color communities;
- ► A time standard that limits travel time to access providers to 30 minutes.
- A required racial and ethnic health disparities analysis in order to prove that the access needs of people of color populations are being met.

WORKFORCE TRAINING

Recommendation 8. State funding for tuition support and loan forgiveness programs should be substantially expanded in order to help relieve provider shortages in low-income, people of color, and rural communities.

As Washington's health provider networks begin to expand to meet the needs of previously neglected communities, the challenge of overcoming shortages in the health care workforce will emerge as a major problem, especially for communities that have weak provider networks. These workforce challenges are particularly acute in the primary care sectors of the workforce, precisely the sectors that are most needed to help overcome health disparities.

The State of Washington has designed initiatives aimed at overcoming these shortages through loan forgiveness programs for providers who agree to practice in underserved areas. These programs provide assistance in the areas of primary care, physician assistants, dentistry, nursing and pharmacy. Similar programs are included in the ACA.

However, in 2010 Washington State reduced funding for the Health Professions Loan and Repayment program by only funding providers eligible for federal matching. Many of the federal programs designed to expand the health provider workforce also have not been funded. Without these programs, provider short-

ages will continue for all populations, but they will be particularly acute for previously underserved communities.

Governor Inslee has included a request to increase state funding for the state program by \$3 million in his biennial budget. The Legislature should approve this request.

Recommendation 9. The Washington State Legislature should initiate a comprehensive review of Washington's scope of practice laws and revise them in order to permit practitioners to provide the care that they are trained to provide.

Some of the anticipated shortages in the health care workforce could be overcome if the State reexamined its restrictive policies concerning the scope of practice by providers. The traditional dentist and physician lobbies have thwarted efforts to permit other fully-trained care providers to offer care in people of color and rural communities. While these narrow scope of practice laws are premised on the notion that the provision of therapies and treatments needs to be restricted to protect the safety of patients, they actually have the effect of denying badly needed care to low-income, rural, and people of color communities. These laws need to be reexamined and changed.

HOSPITALS

Recommendation 10. That the Department of Health reexamine the certificate of need process and make recommendations to the Governor and the Legislature to ensure that the certificate of need process include requirements that hospital expansions and acquisitions provide added access for underserved and people of color communities. This reexamination should include the involvement of consumer advocates and insurance carriers.

Access to hospitals is critical for all health care consumers but it is especially important to low-income,

people of color communities. Consumers in these populations need community hospitals that provide a broad array of medical services and are comprehensive and accessible. However, a trend toward hospital consolidation and specialization has caused hospitals to become both more expensive and less accessible to the poor and less useful to communities that need comprehensive services. $^{\rm 43}$

Non-profit hospitals enjoy special tax treatment at the federal level and special funding from Medicaid to help them cover the cost impacts of uninsured patients.⁴⁴ To retain non-profit status, the hospitals must show that they provide a community benefit.

The ACA strengthened the requirement that hospitals show how they meet the community obligations in order to qualify for non-profit tax status. Regular reviews are to include both an examination of how the hospital is meeting community needs and an implementation plan.⁴⁵

Additionally, In December of 2014 The IRS and the Treasury Department issued new rules governing charity care for non-profit hospitals. Under the new rules, non-profit hospitals have to offer discounts, free care or financial assistance to low-income patients. One of the most important provisions is a requirement that hospitals assess the financial needs of patients before referring cases to debt collectors. Furthermore, needy patients cannot be charged rates that are more than those charged insured patients, which normally are discounted. 46

These are important tools that need to be used in order to make hospitals accessible to people of color populations.

Hospitals have begun to conform to the new ACA community benefit reviews and to the requirement that they have associated implementation plans. These plans typically deal with two subjects – how charity care is provided and how the hospital relates to the demographics of its surrounding community. The reviews often provide information on the health care disparities experienced in the populations that they serve. While the depth, scope and quality of these reviews varies, they seldom link any implementation plan to efforts to overcome the disparities that they identify.⁴⁷

In Washington state, one method for enforcing the

community benefit and charity care requirements comes from their inclusion in a Certificate of Need review (CON) through the Washington State Department of Health.⁴⁸ In 2007 the legislature strengthened the CON process to increase the scope of the review. In June of 2013, at the direction of Governor Inslee, the Department of Health undertook an analysis of these policies and issued rules expanding the process to require submission of hospital policies on admission and nondiscrimination, end-of-life care, and reproductive care. In June of 2014 the Thurston County District Court invalidated the portion of the law permitting these new requirements.⁴⁹

Given the decision by the court, the new ACA policies, and the general absence of implementation plans for community benefits, this entire process needs to be re-reviewed. These varied policies need to be drawn together into a systematic, coordinated assessment of the need for hospital expansions, charity care programs and community need. In addition to their exemptions from Federal taxation, Washington's non-profit hospitals are given dispensations from property taxes and access to tax-free municipal bonds for the construction of facilities. The State's tax policy and provision of access to bonds need to be drawn into the recommended review.

Given the importance of hospital location decisions, charity policies and community benefits to consumers, the review process should also include the involvement of consumer representatives and advocacy groups. In order to develop links to strong provider networks, insurance company representatives also should be included.

These hospital policies need to be revisited along with a reexamination of the community benefits that non-profit hospitals are supposed to provide. Community benefit plans should be linked to the development of adequate provider networks in ways that contribute to the elimination of health disparities. Barriers to hospital access caused by inadequate charity care policies need to be included in this review. The Governor, Health Benefit Exchange, Office of the Insurance Commissioner, Department of Health, and Washington Health Care Facilities Authority should develop a plan for hospital development in Washington and use their varied authorities to implement the plan.

DATA COLLECTION

RECOMMENDATION 11: The Office of Financial Management, in conjunction with the Office of the Insurance Commissioner, the Washington Department of Health, the Health Care Authority, the Health Benefit Exchange and the Department of Social and Health Services should collect and analyze data concerning health outcomes, broken down by factors such as race, ethnicity, and primary language. As a first step, data should be made available on the demographics of enrollees.

Collecting and sharing accurate data are prerequisites for assessing progress on health disparities and improving the health of all Washingtonians. Under the ACA, data collection is also a component of all federally supported health programs. State agencies should collaborate to establish a comprehensive system to collect and publicly disseminate data on a range of coverage, care, and health outcome indicators. Collection of race and ethnicity information through voluntary methods produce limited results. Other systems for data collection need to be developed. Comprehensive and detailed survey research about people of color populations, their health care needs, and their utilization of Washington health care programs need to be developed and implemented.

Such a data collection system, presented in an easy-to-use format, would greatly assist consumers with making choices among health plans and providers, including health insurers offering qualified health plans through the Exchange.⁵¹

In addition to developing comprehensive surveys of these populations, the state could accommodate additional data collections during the intake process. A method for doing this is included in recommendations made to the Exchange by Northwest Health Law Advocates and the Washington State Coalition for Language Access: "For example, in addition to the minimum race, ethnicity, and language data collection on the joint application for insurance affordability programs, the state could also offer open data fields to permit inclusion of groups and sub-groups that do not fit neatly into U.S. Census categories." 52

Beyond the ACA: Coverage for All Washingtonians

WOMEN'S HEALTH

Recommendation 12. The Governor's Interagency Council on Health Disparities should establish a special committee to review all aspects of women's health in Washington with a special emphasis on the health of women from people of color communities.

A recent report published by the Alliance for a Just Society gives Washington State only average marks regarding the State's treatment of women's health. 53 After an extensive analysis of women's health access, coverage, and outcomes, Washington got a C+ grade when compared to all other states.

Particularly troubling are the poor health outcomes for Black and Latina women.⁵⁴ Policy makers and advocates need both to understand why these disparities persist and to develop strategies to eliminate them.

One of the most important issues that this review will need to confront is the shrinking access to reproductive health services as Washington's hospital markets are increasingly dominated by religious organizations that refuse to provide these services.

IMMIGRANTS

RECOMMENDATION 13: Develop an insurance product that will cover undocumented immigrants not covered through health reform.

Even after the coverage expansions in the ACA are implemented in Washington, undocumented immigrants remain uncovered. The ACA helps perpetuate immigrant exclusions from public programs and even limits their ability to purchase private coverage through the Exchange. What the ACA did not do the State of Washington can and should do. The states of California and New York are debating the possibility of providing a stand-alone insurance product that will provide the opportunity for the undocumented to

purchase health care coverage through an insurance plan organized by the state.⁵⁶ Washington should adopt similar policies and coverage options.

ENVIRONMENTAL DETERMINANTS

Recommendation 14. The Governor's Interagency Council on Health Disparities should be provided resources and the authority to develop initiatives to provide systematic responses to health problems associated with environmental causes.

Analysis done both by the Governor's Interagency Council on Health Disparities and the Washington Department of Health recognize that health disparities often are associated with problems that are not directly medical in nature. Data provided by the Washington Department of Health track environmental problems throughout the State.⁵⁷

Working to solve these non-medical causes is an important component of efforts to overcome disparities. In fact, disparities will not be overcome unless these associated problems are attacked.

Asthma presents a typical example of how environmental problems frequently are linked to health outcomes. A child who is treated for asthma returns to a home where roach dandruff triggers another asthma attack. No amount of medical care will help this child escape this chronic condition. The environment in the home also must change.

Early in 2014, HHS improved its reimbursement rules under Medicaid in order to permit payments to be made for community therapies for problems similar to the environmental causes of asthma. Washington State should mount a major effort to build on these new payment methods to develop an infrastructure for environmental intervention. At a minimum, this infrastructure needs to include health care providers, public health officials, housing regulators, and consumers. Community based organizations need to be involved in this system and training for practitioners, nurses, and clinics needs to be provided.

It is important that low-income consumers be protected from retaliation by property owners and landlords. Poor families will hesitate to use a system that might threaten their ability to keep their homes if they report environmental problems.

A PUBLIC INSURANCE OPTION FOR WASHINGTON

Recommendation 15. The Washington State Legislature should enact a public insurance option as an added choice for Washington health care consumers.

The role of private insurance in the delivery of health care access has long been debated in Washington and throughout the nation. Important priorities for consumers often clash with the insurance industry perception that its non-profit companies need profits. Insurers lobby for systems that provide them with less risky markets. Conversely, advocates for low income, people of color communities push for broadened coverage for groups that are seen as risky by insurers. The insurance industry advocates for "skinny" networks even though those networks make medical care less accessible.

Even if the provisions of the ACA are fully implemented in Washington some 8.27% of the population will remain uninsured. For some, insurance will be so unaffordable that they will not be required to buy it under the ACA mandate for individual coverage. Others, such as immigrants, will simply be unable to find insurance because they are excluded from subsidized coverage because of their immigration status. Some will fall into the "family glitch" and be forced to go uninsured. 60

Washington State should develop a public insurance instrument that offers affordable, accessible coverage to everyone. Vermont is trying to move to a single payer plan. Advocates in Connecticut are continuing efforts to broaden access to its public employee system in order to initiate a public option there. Proposals have been introduced in state legislatures in Colorado and California. A Medicare for All Plan is introduced in the U.S. Congress each session.

Washington State can draw on these examples to design its own program, and should do so.

Conclusion

The passage of the ACA ushers in a new era for health care in the United States. Even though there is an ongoing partisan debate about these reforms, it is likely that the coverage expansions made by the ACA will remain in place. States now have the responsibility to make these reforms work for everyone and to go beyond coverage to quality care. The implementation of the recommendations in this report will help assure that quality no longer is associated with skin color, language or ethnicity. The only thing standing in the way is the political will and determination to make it happen.

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