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Statement of Deeana Jang, JD, Policy Director of the Asian & Pacific
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Testimony Before the Subcommittee on Health of the House Committee on
Ways and Means

June 10, 2008

Thank you, Chairman Stark, Ranking Member Camp, and members of the House Ways and Means Subcommittee on Health, for inviting me to testify on disparities in health and health care. I also want to thank Chairman Stark and members of this subcommittee for your leadership on health care reform and for your efforts to address health equity within the context of reform.

The Asian and Pacific Islander American Health Forum, or "Health Forum," is a national advocacy organization dedicated to improving the health and well-being of Asian American and Pacific Islander (AA and PI) communities through policy, programs, and research. We advocate on health issues that impact AA and PI communities, provide community-based technical assistance and training to address chronic diseases, HIV/AIDS, and domestic violence in AA and PI communities, and convene regional and national conferences on AA and PI health.

Health care reform, or expanding access to health care for uninsured and underinsured Asian Americans and Pacific Islanders (AAs and PIs), is one of five major policy priorities for the Health Forum. But, as you'll see from my testimony, even with health coverage, disparities in health and health care persist in our communities. My testimony will also cover some of the unique factors that make it difficult for AAs and PIs to access quality health care; such as disparities in health coverage due to poverty, and a significant percentage who work in or own small businesses and barriers due to language and culture.

Disparities in Health Coverage among AAs and PIs

As a group, Asian Americans and Pacific Islanders are more likely to be uninsured than non-Hispanic whites. Specific AA and PI groups face extremely high rates of uninsurance: from 2004-2006, 24 percent of Native Hawaiians and Pacific Islanders and 31 percent of Korean Americans were uninsured.¹

The high rate of uninsurance in several Asian American communities is related to their employment in small businesses that do not offer health

insurance benefits. For example, more than half of Korean Americans work in businesses with less than 25 employees. Yet, only half of employees in such firms are provided coverage through their employer. As a result, Korean Americans have one of the lowest rates of employer-sponsored health coverage among AAs and PIs, 49 percent, compared to South Asians who have the highest rate at 75 percent.² By providing small businesses with affordable options, health care reform efforts could significantly lower the number of uninsured AAs and PIs.

Public programs such as Medicaid and SCHIP also play an important role in reducing uninsurance in AA and PI communities. Gains in coverage by these programs, between 1997 and 2004-2006, helped protect AAs and PIs from declines in job-based coverage. This helped decrease the number of uninsured AAs and PIs from 21 percent to 19 percent over that same period.³ An expansion of public programs through health care reform efforts is critical for individuals who do not have access to affordable coverage through an employer or the private market.

Coverage of AAs and PIs in public programs grew in part due to federal and state efforts over the last decade to reduce barriers faced by minority and immigrant communities. Many AAs and PIs qualify for public programs but remain uninsured because of language and cultural barriers in the enrollment process, misinformation about eligibility, and other family hardships such as food and housing insecurity. There are others who do not qualify even if they are low-income and legal immigrants. Since 1996, legal immigrants in low-income families have been barred from receiving Medicaid or SCHIP during their first five years in this country, even if they meet all other requirements for the programs. Citizens of the Republic of the Marshall Islands (RMI), the Federated States of Micronesia (FSM), and the Republic of Palau are ineligible for public programs as well, even though they are allowed to work and travel in the US.

To address these disparities in coverage, many states developed strategies to help enroll individuals with limited English proficiency in Medicaid and SCHIP.⁴ States also took additional steps to simplify enrollment and renewal procedures for children.⁵ And, nearly half of states have continued to provide coverage for legal immigrants during their first five years in the country through state-funded programs.⁶ Ensuring that similar solutions are enacted through health care reform would help eliminate the health insurance disparities faced by AA and PI communities.

Disparities in Access to Care

Health insurance coverage is an important predictor of access to health care in AA and PI communities. From 2004 to 2006, uninsured Asian Americans were more than 4 times as likely as insured Asian Americans to lack a usual source of care.⁷

However, disparities in access to care remain regardless of health coverage. Nonelderly AAs and PIs were more likely to lack a usual source of care than non-Hispanic Whites (18 percent vs. 14 percent).⁸ Similarly, 52 percent of

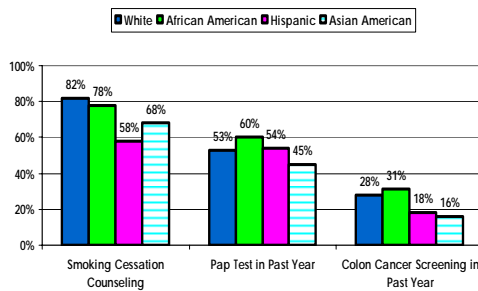
nonelderly uninsured AAs and PIs lacked a usual source of care, compared to 46 percent of non-Hispanic uninsured Whites. Factors such as language and cultural barriers prevent many AAs and PIs from accessing quality care.

Disparities in Quality of Care

Findings from the Commonwealth Fund's 2001 Health Care Quality Survey concluded that Asian Americans experience poor access to quality care on a range of measures.⁹ Asian Americans reported greater communication difficulties and lower levels of satisfaction during their health care visits.¹⁰ They were also "the least likely to feel that their doctor understands their background and values, to have confidence in their doctor, and to be as involved in decision-making as they would like to be."¹¹

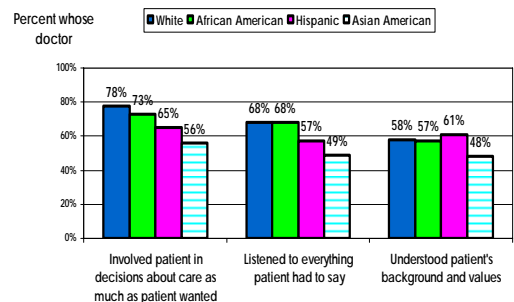
Despite having higher rates of certain health conditions, many AAs and PIs do not receive the recommended levels of prevention, counseling, or care they need. The 2001 and 2006 Health Care Quality Surveys revealed that Asian Americans were significantly less likely to receive preventive services such as cancer screenings or cholesterol checks, or counseling about smoking cessation, diet, weight, exercise, and mental health.¹² Less than half of Asian Americans with chronic conditions received the care they needed to manage their conditions.¹³

Figure 1: Preventive Care and Physician Counseling



SOURCE: The Commonwealth Fund 2001 Health Care Quality Survey

Figure 2: Asian Americans Experience Communication Problems with their Doctors



SOURCE: The Commonwealth Fund 2001 Health Care Quality Survey

Disparities in Health Outcomes and Disease Prevalence

The lack of health coverage, limited access to health care, and the lack of culturally and linguistically competent services can manifest in harmful, and even fatal ways:

- Cancer deaths are increasing at a faster rate among AAs and PIs than any other racial and ethnic population. For example, the risk of death for Asian American women with breast cancer is 1.5 to 1.7 times higher than that for white women.¹⁴ This is due in part to the relatively low screening rates and late stage diagnoses that occur among AA and PI women.
- Although statistics on the overall prevalence of diabetes in AA and PI communities are unavailable, it is the fifth leading cause of death among

AAs and PIs. In Hawaii, AAs and PIs aged 20 and over are more than 2 times as likely to have diagnosed diabetes as whites after adjusting for population age differences. In California, Asian Americans are 1.5 times as likely to have diagnosed diabetes as non-Hispanic whites. Despite the importance of managing diabetes, nearly half of AA and PI adults with diabetes in California had not received a foot exam in the past year, compared with less than 30 percent of Whites and African Americans.¹⁵

- Asian American women aged 15-24 and over 65 have the highest suicide rates across all racial and ethnic groups.¹⁶ Furthermore, Asian American girls have the highest rates of depression across both race/ethnicity and gender.¹⁷ The US Surgeon General noted in 2001 that nearly half of AAs and PIs have problems accessing mental health services because of the lack of providers with appropriate language skills.¹⁸

Strategies to address disparities in coverage, access and quality

There are two important strategies included in Subtitle D of H.R. 3162, the Children's Health and Medicare Protection Act of 2007 (CHAMP Act) that should be included in health care reform initiatives to address disparities in coverage, access and quality:

1. Standardizing the collection, analysis and reporting of data on race, ethnicity and primary language in an accurate and appropriate manner.
2. Ensuring that effective communication takes place between provider and patient through the provision of competent language assistance.

Importance of collection of data on race, ethnicity and primary language

Accurate, timely, disaggregated data by race, ethnicity, and primary language on Asian Americans and Pacific Islanders are vital to developing and monitoring programs and policies aimed at improving health equity.

In 1999, Congress requested that the Institute of Medicine (IOM) assess the extent of health disparities; explore factors that may contribute to inequities in care; and recommend policies and practices to eliminate them. Its report, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care," found significant disparities in the quality of health services received by minorities — even when insurance status, income, age, and severity of condition were comparable. The IOM study further revealed that minorities are less likely to be given appropriate cardiac medications, undergo bypass surgery, and receive kidney dialysis or transplants. Sadly, they are also more likely to receive last-resort procedures, such as lower limb amputations for diabetes. Subsequent research suggests that these disparities continue to this day for both minorities and women. For example, a recent study released by the Robert Wood Johnson Foundation found that the rate of leg amputation is four times greater in African American Medicare beneficiaries than in whites.¹⁹

To help close the disparity gap, the IOM recommended that the Federal government: (1) collect and report data on health care access and utilization by patients' race, ethnicity, and socioeconomic status; (2) include measures of disparities in performance measures; and, (3) monitor progress toward the elimination of health care disparities. In 2001, the Commonwealth Fund went a step further by recommending that quality measurement and reporting tools, such as the Health Plan Employer Data and Information Set collect and report health data by race, ethnicity, and primary language. However, no comprehensive action has been taken on these recommendations; it is long overdue.

A recent study published in *Health Affairs* found that, although there were some variations related to geography and socioeconomic status, overall, Asian Medicare beneficiaries were less likely than whites to receive mammography and colorectal cancer screening services and all three diabetic services.²⁰ The National Healthcare Disparities Report in 2006 found that Asians receive lower quality of care compared with whites for one-third of the core measures tracked in the report, and for 75 percent of those measures, the gaps in quality were not improving over time.²¹

Medicare data has provided a rich source of information about racial, ethnic, and socioeconomic disparities in health and health care among Medicare beneficiaries. And while there have been some improvements in the quality of data collected on race and ethnicity, there remain much more that needs to be done to improve the quality and accuracy of data. For example, an analysis of 2002 Medicare administrative data show that only 52 percent of Asian beneficiaries and 33 percent of both Hispanic and American Indian/Alaska Native beneficiaries were identified correctly.²²

Medicare's data on race and ethnicity come from Social Security's administrative records and are collected on a consistent basis when an individual applies for a Social Security number. The way the data is collected was not (and has not been) updated when the Office of Management and Budget revised the standards for collection of race and ethnicity data in 1997. In addition, since the late 1980's, most applications for Social Security numbers are made through the Enumeration at Birth process, and questions regarding race and ethnicity are not included. Finally, 12 percent of Medicare beneficiaries are enrolled by Medicare health plans that are not required to collect or report data on race, ethnicity or primary language.²³

APIAHF is part of the Out of Many, One (OMO) Data Task Force, a coalition of advocates working to eliminate racial and ethnic health disparities. At the request of OMO, the Congressional Tri-Caucus has sent a letter to the Social Security Administration requesting information on the status of its efforts to improve data collection on race, ethnicity and primary language. OMO and APIAHF are also supporting language in pending Medicare legislation in the Senate to grant authority to the Secretary of Health and Human Services to require Medicare plans and providers to report race, ethnicity, and gender-specific data as part of the quality measures they are currently required to collect and report. Such provisions would help identify

and eliminate disparities in the quality of health services that minorities and women enrolled in the program receive.

The provisions included in Subtitle D of H.R. 3162, the Children's Health and Medicare Protection Act of 2007 (CHAMP Act) will substantially improve the collection of data on race, ethnicity and primary language. Specifically, we support:

- Collection of data on race, ethnicity, and primary language of each applicant for and recipient of Medicare benefits in conformity with the 1997 revised OMB standards and further disaggregation, where practicable, for additional population groups.
- Development of standards for collection of data on primary language spoken and written of Medicare beneficiaries.
- Technical assistance for health information technology improvements that will facilitate collection and analysis of racial, ethnic and primary language data; improving methods for collection and analysis of smaller populations and ethnic subgroups within the minimum OMB standards; and educating health care organizations, providers and health plans to raise awareness that collecting and reporting data on race, ethnicity and primary language are essential to eliminate disparities and is legal; and providing for the revision of the existing HIPAA claims-related code set to require collection of data on race and ethnicity and to provide a code set for the collection of primary language data.
- Identification of appropriate quality measures to monitor for disparities and to develop new quality measures related to racial and ethnic disparities in health and health care.

We also support the provision in ***H.R. 3014, the Health Equity and Accountability Act of 2007***, that requires the Social Security Administration to collect data on the race, ethnicity, and primary language of all applicants for social security numbers or benefits.

Ensuring that effective communication takes place between provider and patient through the provision of competent language assistance.

Language barriers can reduce access to health care, jeopardize the quality of care, lower patient satisfaction and adherence, increase the risk of medical errors and lead to other adverse outcomes. More than a third of Asian Americans and 12 percent of Pacific Islanders speak English less than very well. The rate of limited English proficiency is even higher for specific groups: more than half of Vietnamese, Hmong, Cambodian, Laotian, Bangladeshi, and Taiwanese are limited English proficient. Research indicates that the use of trained interpreters and especially the use of language concordant health providers can improve access to and quality of care for persons with limited English proficiency.²⁴ Research also shows that Medicare beneficiaries who are limited English proficient in English are less likely than those who are proficient in English to have access to a

consistent source of care and less likely to receive important preventive care, including cancer screening tests.²⁵ However, more research is needed to determine the impact of language services on the health and health care of limited English proficient populations. We support the provision in ***H.R. 3162*** that requires the Secretary of HHS to arrange for the Institute of Medicine to conduct a study of the effects of providing language access services on quality of health care, access to care and reduced medical error.

Medicare programs should be ensuring that meaningful access to enrollment and health care services is provided for persons with limited English proficiency.

Under Title VI of the Civil Rights Act of 1964, all recipients of Federal financial assistance are required to provide meaningful access to its programs, services and activities, including those that are not directly Federally funded, to persons with limited English proficiency. Not all Medicare programs are considered Federal financial assistance. While Medicare Part A providers are considered recipients of Federal financial assistance, providers (e.g. individual physicians, who only receive Medicare Part B and no other form of Federal financial assistance, e.g. Medicaid) are not obligated to comply with federal civil rights law.²⁶ This has caused some confusion as new Medicare programs have been initiated with a mixture of Part A and Part B funds, e.g. Part C, and other sources so that determining whether participants in some Medicare programs are required to comply has become more complex. We support the provision in ***H.R. 3162*** to require the HHS Inspector General to prepare and publish a report on the extent to which Medicare providers and plans are complying with Title VI and are providing culturally and linguistically appropriate services as described in the Office of Minority Health's Culturally and Linguistically Appropriate Services Standards in health care. In addition, we support requiring all Medicare providers to comply with Federal civil rights laws. This provision is included in Title I of ***H.R. 3014***.

Furthermore, Executive Order 13166 requires that all Federal agencies develop plans to ensure that programs conducted by the Federal government are accessible to persons with limited English proficiency.²⁷ Therefore, outreach and enrollment in the Medicare program conducted by the Centers for Medicare and Medicaid Services (CMS) should be accessible for persons with limited English proficiency. We are concerned that while CMS translated much of the outreach materials for enrollment in the Medicare Part D program, there remain issues of inaccessibility to telephone assistance and enrollment materials. We are also concerned that Medicare informational materials, applications and beneficiary notices are not available in languages other than English and Spanish.

The Federal government needs to provide reimbursement for the cost of language assistance and provide technical assistance to providers to ensure that high quality and effective language assistance is available in a timely manner.

Although CMS has clarified that states can get federal matching funds for

the provision of language services in its Medicaid and State Children's Health Insurance Programs, language services are currently not specifically reimbursable by the Medicare program. Although the regulations for Medicare Advantage require managed care plans to "ensure that services are provided in a culturally competent manner to all enrollees, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds,"²⁸ it is unclear whether and how Medicare Advantage plans are paying for language services and if they need or should have additional payments. Most managed care plans pass on the requirement to their contracted providers without specific funding or incentives. So while the managed care plans may have contractually agreed to provide language assistance, their payment policies may in fact create a disincentive for providers to participate and use language services.

Health care providers from across the country have reported inadequate funding of language services to be a major barrier to LEP individuals' access to health care and a serious threat to the quality of the care they receive.

- 63% of hospitals encounter patients with LEP daily or weekly; an additional 17% encounter LEP patients at least monthly.
- 65% of internal medicine physicians have active patients who are LEP.

Almost every major health organization (including the AMA, AHA, ANA, AAP, AAFP, ACP, ANA, APHA, APA, NACHC, NAPH, NASW, NMA and NHMA), **supports government payments for language services as necessary to ensuring quality healthcare.** Over 75 organizations have endorsed the Language Services in Healthcare Statement of Principles which supports funding mechanisms to ensure language services are available where and when they are needed.

- The American College of Physicians recommends that Medicare should pay for the added expense of language services and the additional time in providing clinical care.
- The American Hospital Association stated that resources should be targeted to improving language services for all patients with LEP.
- According to a recent article in *Pediatrics*, discussing results from a survey of pediatricians supported by the American Association of Pediatrics, reimbursement for language services is associated with greater use of professional interpreters.

We recognize that determining the best methodology and structure to provide reimbursement in the Medicare program is complex given the payment structure of the various providers, including in- and out-patient hospital care, physician care and managed care. Therefore, the approach taken by *H.R. 3162* to support a study and demonstration projects to examine the ways that Medicare should develop payment systems for language services is necessary to determine the most efficient, cost-effective way to ensure the provision of language services that includes incentives for providers and that result in effective communication between providers and LEP persons. The National Health Law Program together with the Center on Budget and Policy Priorities has already taken a preliminary look at this issue and we urge HHS to consider their report on "Paying for

Language Services in Medicare: Preliminary Options and Recommendations," October 2006. The major recommendations from the report are:

- Offer grants to hospitals, schools that train health professionals and community groups to increase the recruitment and training of bilingual and multilingual medical interpreters and clinicians.
- To improve language services in physician settings, provide Medicare reimbursements to in-person interpreters and develop a system of federal contracts for telephone interpretation firms.
- Improve monitoring and oversight of existing requirements to provide language services in Medicare managed care.
- Exempt language services from Medicare cost-sharing requirements.

Barriers to participation in Federal health care programs must be removed for immigrants and other noncitizens

In order to ensure coverage and access to health care for all, federal programs including Medicare, Medicaid and the State Children's Health Insurance Program (SCHIP) must remove barriers to eligibility for immigrants and other noncitizens.

We support the provisions in the CHAMP Act and H.R. 3014 to allow states to cover lawfully residing immigrant children and pregnant women in SCHIP and Medicaid. H.R. 3014 also provides eligibility for Medicaid and SCHIP for citizens of RMI, FSM and the Republic of Palau. In addition, other barriers such as excessive citizenship documentation must be repealed. We support these provisions in H.R. 3162 and H.R. 3014 as well.

Conclusion

We look forward to working with Congress and the new Administration to achieve our mutual goals of guaranteed, affordable, high quality care that is truly accessible and equitable to all.

*National Advocates for
Asian American,
Native Hawaiian &
Pacific Islander Health*

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