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AMERICAN HEALTH FORUM

THE IMPACT OF HEALTH CARE REFORM ON THE PREVENTION AND TREATMENT OF CANCER IN ASIAN AMERICAN, NATIVE HAWAIIAN, AND PACIFIC ISLANDER POPULATIONS

Overview

Addressing cancer within Asian American, Native Hawaiian, and Pacific Islander (AA and NHPI) populations raises many unique concerns. Lack of coverage and access, the high cost of treatment, lack of culturally competent care, insufficient data collection, and societal misconceptions complicate the diagnosis and treatment of cancer within the AA and NHPI community.

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (PPACA) into law. PPACA made several reforms to the nation's health care system, and contains numerous provisions that will improve the prevention and treatment of cancer within the AA and NHPI community. Improving access to health insurance coverage and preventive services, in combination with better management and coordination of care, will lead to better health outcomes and reduced rates of health care service utilization. These provisions offer AA and NHPI service providers opportunities for advocacy as the law moves into the implementation phase.

Increased Access to Coverage

PPACA expands both public and private insurance. Some of these provisions went into effect on September 23, 2010, offering consumers improved access to care. One of the most significant changes was the creation of the Pre-existing Condition Insurance Plan (also known as the High-Risk Pools) for persons newly diagnosed or being treated for cancer. Prior to the PPACA, insurance companies could deny health coverage to individuals with pre-existing conditions such as cancer. Now, insurance companies are prohibited from this type of discrimination, allowing individuals with cancer to access the life-saving testing and treatment services that have been inaccessible to them in the past.

Currently, individuals with chronic diseases can apply for coverage under the "Pre-existing Condition Insurance Plan." The requirements for eligibility are:

- United States citizenship or lawful presence in the country.
- Lack of insurance for past six months.
- Inability to obtain insurance because of a pre-existing condition.

All new plans must provide coverage, without cost-sharing, for mammograms (every 1-2 years for women over 40) and for all preventive services rated "A" or "B" by the United States Preventive Services Task Force (USPSTF), including:

- Genetic counseling and evaluation for women with family history and increased risk for mutations in breast cancer genes BRCA1 or BRCA2.
- Cervical cancer screening.
- Colorectal cancer screening (ages 50-75).

Beginning in 2014, consumer protections will increase. Private insurers will be prohibited from barring individuals or charging higher premiums because of their health status or pre-existing conditions, including cancer. Private insurers will only be able to rescind policies in the case of fraud or intentional misrepresentation. All new plans must provide coverage for cancer screening, treatment, and follow-up care. Insurers can no longer set lifetime limits on coverage and annual limits will be phased out by 2014.

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FEBRUARY 2011

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For 2010, all persons who hit or exceed the Medicare coverage gap will receive a one time $250 rebate to offset these expenses. For 2011, recipients will receive a 50% discount on covered brand-name drugs while in the donut hole. The Medicare "donut hole" will be closed by 2020. The gap in coverage will be closed by 2020.

Medicaid will be expanded to cover eligible individuals and families with incomes below 133% of Federal Poverty Level (FPL), including childless adults.

Each state will create its own Health Insurance Exchange (HIE), or the federal government will operate one for them. The HIE will serve as a one-stop marketplace for purchasing insurance coverage, with all plans containing an "Essential Benefits Package," setting forth the minimum benefits to be provided. These benefits will be defined by the Secretary of the Department of Health and Human Services and must include:

- Emergency services and hospitalization.
- Mental health services, including behavioral health treatment.
- Prescription drugs.
- Rehabilitative and habilitative services and devices.
- Laboratory services.
- Preventive care services and chronic disease treatment.

Recommendations for Service Providers

- Inform patients about the private and public healthcare expansion and assist them in the application process. Encourage eligible persons to enroll in the Pre-Existing Condition Insurance Plans.
- Work with patients to ensure continuity of care as they enter and transition into the public and private healthcare expansion.
- Inform patients about state consumer assistance programs, which can help them navigate the health care system, address grievances and report abuses.
- Play an active role in implementation in your state by working with state interagency committees and task forces. Work with your state insurance commissioner to ensure that any benefits not included in the federal essential benefits package are included in your state.
- Advocate that limits on out-of-pocket expenses be applicable to both group and individual insurance plans.

Improved Preventive Care

PPACA also makes significant investments in preventive care and public health initiatives including the creation of the Prevention and Public Health Fund, which received $500 million in fiscal year 2010. This money will go to programs such as the Community Transformation Grant Program, which provides grants to state and local agencies, and community based organizations (CBOs) that engage in evidence-based activities to promote chronic disease prevention. The program allows CBOs, especially those working with diverse populations, to apply for funding for their prevention initiatives.

In September, 2010, the Secretary of the Department of Health and Human Services announced grants to strengthen the public health infrastructure, support tobacco prevention and control, and combat obesity. Community health centers, which often serve as the primary preventive service provider for many vulnerable communities, also received increased funding for renovation, expansion and the development of new centers.

In addition, the PPACA increases Medicaid coverage of preventive care services by:

Covering comprehensive tobacco cessation programs for all pregnant women.
Preventing state programs from dropping coverage of breast and cervical cancer treatment before 2014.

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Starting in January, 2011 the PPACA increases Medicare coverage of preventative care services by:

- Covering one annual wellness visit.
- Covering preventive services, without cost-sharing, for interventions given an "A" or "B" rating by the United States Preventive Services Task Force.

Recommendations for Service Providers

- Educate patients about the expanded array of covered preventive services, such as cancer screening and laboratory services, and encourage use where appropriate.
- Continue and enhance efforts to adapt current CDC evidence-based cancer interventions for AA and NHPI cancer populations.
- Partner with your state health department and other CBOs to develop Community Transformation Grant proposals that provide culturally and linguistically appropriate strategies for chronic disease prevention.

New Measures to Improve the Quality of Care and Address Health Disparities

PPACA contains numerous provisions aimed at lessening racial, ethnic, socioeconomic, age, gender and geographical disparities in health and health care. The Act contains an emphasis on improving the quality of care through the creation of a National Quality Strategy and Plan and the National Prevention and Health Promotion Strategy and Plan. Both Plans will include strategies for improving the quality and delivery of health and addressing chronic disease prevention. In addition, Section 4302 of the Act requires federally funded health and health care programs and population surveys to collect and report data on race, ethnicity, sex, primary language, disability status and geography, and additional areas as required by the Secretary of Health and Human Services.

The new health reform law also makes investments in addressing disparities in the treatment and quality of care, particularly for racial and ethnic minorities and other underserved populations. These investments include:

- Providing grants for states to develop or partner with consumer assistance and patient navigator programs that use non-medical workers to assist patients in accessing the healthcare system and services, and provide health information in a culturally and linguistically appropriate manner.
- Improving administrative processes by requiring health plans to use "plain language" to explain health plans and patient rights. Plain language includes providing information in a manner accessible for persons with limited English proficiency.
- Establishing grant programs to educate health professionals on how to address chronic pain and treatment.
- Providing coverage for persons participating in clinical trials.

Recommendations for Service Providers

- Advocate for improved data collection and reporting to address health disparities in AA and NHPI communities. Track patient's primary language and the need for language assistance within your practice.
- Encourage your healthcare practice to recruit from your local community to ensure representation of patients' social and demographic characteristics.
- Provide patient-centered care by educating patients about their health status in plain language and involving patients, and family members when requested, in decision making about treatment.
- Educate patients on the use of patient navigators to promote improved access to healthcare.

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Definitions

Pre-existing condition: An injury, disease, or other medical illness that occurred before an individual applies for a health plan. Generally, the condition bars the individual from gaining health coverage, or raises the premium for coverage. The PPACA seeks to change this over time, through the Pre-existing Condition Insurance Plan.

Pre-existing Condition Insurance Plan: This is the government insurance plan that allows individuals with pre-existing conditions to gain coverage until 2014, when public and private plans will have to offer coverage to all individuals, regardless of health status.

Federal Poverty Level (FPL): Income levels set by federal agencies to determine whether individuals are eligible for federal benefits.

Essential Benefits Package (EBP): The minimum benefits an insurance plan within the state-based health insurance exchange must provide. The EBP will be defined by the Secretary of HHS in 2014.

Eligible individuals: The eligibility of an individual varies by program. Hence, the term "eligible individual" does not have one, fixed meaning.

Cost-sharing: The share of costs that an individual pays out-of-pocket, such as deductibles, coinsurance and copayments.

For more information about the health care reform law, please visit our Health Care Reform Resource Center at www.apiahf.org/hcr.

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