

PRINCIPLES FOR A HEALTHIER, MORE EQUITABLE NATION

Getting to Universal Coverage

At the Asian & Pacific Islander American Health Forum (APIAHF), **we believe in the right to health**. **Health is a human right** and as the primary means of accessing and financing care in the United States (U.S.), health coverage must be available to all persons residing in the country, *regardless of their race, ethnicity, immigration status, the language they speak, where they live, how they identify and how much money they make*. **Health equity** – the belief that everyone should have an opportunity at good health – drives our work and informs our values. Health equity is both a moral and economic imperative and critical to the U.S. being a nation with shared prosperity for all. As we look ahead to the next steps in coverage and access, **health equity must be the overarching goal** which any policy is benchmarked.

In order to achieve health equity, we must work toward a system of **universal coverage** in the U.S. Having over 27 million people without coverage and a usual source of care and an estimated 44 million underinsured is in opposition to our values and undermines our public health.¹ **But universal coverage is only the starting point, not the end goal**. Decades of work to identify and eliminate racial and ethnic health and health care disparities have made it clear that **access to coverage is not enough**. Policy proposals must tackle the multiple domains of health equity needed to create the conditions wherein every person lives a healthy life.

HOW TO EVALUATE UNIVERSAL COVERAGE PROPOSALS

APIAHF has developed this set of Principles against which to evaluate all proposals that aim to make a more just health care system. The Policy Options provide ways to determine if proposals align with our Principles and the needs of our families and communities. Decision makers, advocates, and community members should use these tools to determine if implementation were to occur, would the outcomes be different for Asian Americans, Native Hawaiians, and Pacific Islanders and other diverse populations?

¹ Sara R. Collins, Herman K. Bhupal, Michelle M. Doty, Health Insurance Coverage Eight Years After the Affordable Care Act, Commonwealth Fund, February 2019, available at: <https://www.commonwealthfund.org/publications/issue-briefs/2019/feb/health-insurance-coverage-eight-years-after-aca>.

APIAHF BELIEVES IN

Dignity of all people.

Universal right to health.

Values of respect, equity, fairness, compassion and kindness.

Importance of culture.

Expansive definitions of health, including what determines if one is healthy or not.

Health coverage eligibility must be available to all persons residing in the U.S, regardless of immigration status.

Why: The 1996 Personal Responsibility and Work Opportunity Reconciliation Act created arbitrary and inhumane restrictions on which immigrant groups are eligible for public health insurance. Since that time, Congress has expanded coverage in limited ways to certain immigrant groups, including through the Children’s Health Insurance Program Reauthorization Act in 2009 and the Affordable Care Act (ACA) in 2010. Yet progress has not been uniform. In addition to other factors, eligibility restrictions have led to immigration status being a social determinant of health, determining whether a person is eligible for coverage and able to afford and access a usual source of care. For example, the Obama administration made the decision that recipients of Deferred Action for Childhood Arrivals status would not be eligible for Affordable Care Act plans. Coverage for immigrants varies at the state and federal levels and is largely based on the notion of who is deserving of coverage. Universal coverage must be just that – universal for all persons, regardless of where they were born and their immigration status.

Policy Options

- ☐ Eligibility rules do not take into account immigration status.

Health coverage and care must adhere to civil rights protections for all persons regardless, of their race, color, national origin, sex (including gender identity, gender expression, sexual orientation, sex stereotyping, sex characteristics, pregnancy), age, disability or health status.

Why: No person should face barriers to accessing and utilizing quality health care based on the language they speak, how they identify, and where they come from. For over 55 years, nondiscrimination in health care has been a core part of legal and statutory precedent, yet too often patients still face discrimination in the doctor’s office, hospital waiting room or trying to enroll in insurance. The Health Care Civil Rights Law (Section 1557 of the Affordable Care Act) built upon existing civil rights protections in the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973 and the Age Discrimination Act of 1975. These civil rights protections must be maintained, strengthened and fully enforced.

Policy Options

- ☐ The Health Care Civil Rights Law (Section 1557 of the Affordable Care Act) is maintained and enforced, at a minimum, with adequate funding for enforcement purposes.
- ☐ Civil rights are tracked and enforced through strong and detailed data collection standards, through, at a minimum, the categories established by Section 4302 of the Affordable Care Act. Data is collected, analyzed and published.
- ☐ Enforcement is prioritized and funded, along with technical assistance for covered entities.

Health care services and infrastructure must be available to all persons, regardless of socioeconomic status and geography.

Why: Health care services are only accessible if they are actually available to persons with coverage within an area they can access. Individuals with public and private coverage currently experience barriers to accessing both primary and specialty care because health providers, facilities or services are not available in their geographical areas, including those in rural and medically underserved communities. In addition, patients should be able to access providers that are not only close in proximity, but are culturally competent, ideally providing services in the patient’s preferred language.

Policy Options

- ☐ Minimum time and distance standards are developed and codified to protect network adequacy.
- ☐ Networks include the full range of primary and specialty services that patients require, including pediatric and reproductive services, as well as essential community providers.
- ☐ Networks include providers who can provide qualified language services for patients.

QUALITY

Health care must be high quality, meaning it is patient-centered, responsive to cultural and linguistic needs and allows patients to receive the right care, at the right time and in the setting best suited for their needs.

Why: High quality care is based on the principle of delivering the right care at the right time and must be patient-centered, which requires engagement and collaboration with patients, families and their caregivers. The population of the U.S. continues to diversify in terms of racial and ethnic make-up and cultural backgrounds and practices, yet the way in which health care is provided has not kept up. The Census Bureau estimates that 25 million Americans are limited English proficient, meaning they speak little to no English, let alone enough to navigate a system as complex as health care.² Language barriers are known to interfere with the quality of care and can result in inappropriate care or at worst, death. The National Culturally and Linguistically Accessible Standards (CLAS) are designed to advance health equity, improve quality and help eliminate health disparities by establishing a blueprint for health and health care organizations and should serve as a starting point in all health care quality efforts.³

Policy Options

- ☐ Compliance with the CLAS standards is mandated, funded and enforced for all entities involved in the health system.
- ☐ Patients are empowered to participate in their health by making information available and accessible, including to persons with disabilities and who speak languages other than English.
- ☐ Existing federal and state requirements for provision of language services to patients are met or exceeded.
- ☐ Federal civil rights protections are strengthened to include numerical and percentage thresholds for required language services.
- ☐ Demographic data is collected, analyzed, standardized and reported to ensure compliance and enforcement at sufficient detail for race, ethnicity, preferred language, disability status, sex, gender identity, and sexual orientation at minimum, and for other social, psychological and behavioral data.

² APIAHF Analysis of 2017 American Community Survey Data.

³ National CLAS Standards, U.S. Department of Health and Human Services, available at: <https://www.thinkcultural-health.hhs.gov/clas>.

Health care must be comprehensive and include the full range of health care services and treatments that adults and children require.

Why: Health insurance provides little value if it does not provide coverage of the actual care a person needs to maintain their health. The Affordable Care Act's ten Essential Health Benefits made important strides by setting a floor, but even those have given space for harmful interpretation, such as limiting contraceptive coverage. Medicare and Medicaid each have benefit packages that are more extensive in other ways for the specific populations they serve, such as Medicaid's strong pediatrics requirements. Yet none of these programs require coverage of adult oral health or long-term care. In addition, all persons must have access to abortion services, regardless of where they live, the type of coverage they have, or their ability to pay.

Policy Options

- ☐ The Affordable Care Act's Essential Health Benefits are covered, at minimum for adults, while Medicaid's Early Periodic Screening, Diagnostic and Treatment benefits must be maintained for children.
- ☐ Coverage includes comprehensive sexual and reproductive care, including access to all contraceptive methods, infertility care, pre- and post-natal childbirth care, abortion care, STI-prevention and treatment. Includes gender-affirming care for trans people.
- ☐ Coverage includes pediatrics and measures to reduce infant mortality and promote the healthy development of infants and children.
- ☐ Coverage includes prescription drug coverage.
- ☐ Coverage includes mental health care and treatment for substance use disorders.
- ☐ Coverage includes vision and dental.
- ☐ Coverage includes long-term care.
- ☐ Coverage includes complementary, alternative and integrative medicine, such as acupuncture, to meet the needs of diverse populations.

PAYMENT

Health care must be affordable based on income.

Why: Health care costs, including premiums and other out-of-pocket expenses, must be grounded in equity and affordable to all. The cost of health care is a top expense for most individuals and families in the U.S. and a top issue for voters nationwide. Yet even with the historic expansions in coverage under the Affordable Care Act, an estimated 44 million Americans with coverage are underinsured due to high out-of-pocket costs and deductibles.⁴ This undermines the health and financial security of individuals and families who are forced to delay or skip needed health care and make choices between their health and basic necessities.

Policy Options

- ☐ Affordability is relative to income and takes into account costs for individuals and families.
- ☐ Premiums, cost sharing and any other out-of-pocket costs are not barriers to patients receiving the care they need.
- ☐ Low income patients should be held harmless from any costs.

⁴ Sara R. Collins, Herman K Bhupal, Michelle M. Doty, Health Insurance Coverage Eight Years After the Affordable Care Act, Commonwealth Fund, February 2019, available at: <https://www.commonwealthfund.org/publications/issue-briefs/2019/feb/health-insurance-coverage-eight-years-after-aca>.

Health care must be delivered and paid for in a way that promotes health equity. It must identify, address, and aim to ultimately eliminate racial and ethnic health and health care disparities.

Why: Efforts to address universal coverage must take into consideration the significant role that health care plays in the overall financial health of the country. In 2017, U.S. health care spending accounted for 17.9% of the nation's Gross Domestic Product.⁵ The complexity of the health insurance industry, as well as having both public and private sector coverage systems, contributes to a significant challenge in the success of any proposal. Continuity and smooth transitions in patient coverage will be required. In addition, despite decades of work to address health care disparities, racial and ethnic minorities, persons who are limited English proficient, persons with disabilities, LGBTQIA persons and those with low literacy or health literacy continue to experience barriers to care and receive and report lower quality care. These disparities take a significant human and economic toll and are estimated to cost \$93 billion in excess medical care costs and \$42 billion in lost productivity per year.⁶ At the same time, new payment models and frameworks of care as part of health care delivery system transformation efforts offer the ability to work to address health disparities. But these efforts will not be successful without an explicit strategy to achieve health equity.

Policy Options

- ☐ Financing proposals must, at a minimum, do no harm in terms of perpetuating health and health care inequities and must actively invest and reward advancements toward health equity.
- ☐ The needs of smaller, geographically isolated, diverse and safety-net providers who have traditionally served patients who are medically underserved must be addressed through payment systems, technical assistance and resources.
- ☐ There must be adequate transition periods to ensure that patients do not fall between the cracks. Sufficient time is needed to build out new systems and programs, otherwise the most vulnerable are most likely to experience the most direct consequences.
- ☐ We must recognize the contributions and innovations of public and private stakeholders in ensuring healthy lives and focus on the overall goal of ensuring there are no barriers for consumers to get the right care at the right time.
- ☐ Demographic data is collected, analyzed, standardized and reported at sufficient detail for race, ethnicity, preferred language, disability status, sex, gender identity, sexual orientation at minimum, and for other social, psychological and behavioral data.

Payment must adequately compensate a diverse and bilingual workforce that reflects the needs of the communities it serves.

Why: Research shows that patients are more likely to trust a health care provider that looks like them and language concordance between the clinician and patient promotes higher quality care. At the same time, bias in the treatment of people of color leads to unequal outcomes in health. We must have a health care workforce, made up of not only doctors, nurses and other health workers that come from communities of color, but also recognizes that we must utilize and fairly compensate mid-level and community-based health care workers and prioritize a bilingual workforce.

⁵ Centers for Medicare & Medicaid Services, available at: <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountshistorical.html>.

⁶ The Business Case for Racial Equity: A Strategy for Growth, W.K. Kellogg Foundation, 2018, available at: <https://altarum.org/RacialEquity2018>.

Policy Options

- ☐ Resources are directed towards increasing the diversity of the health care workforce, including ensuring cost and culture are not barriers to education.
- ☐ Community health workers and other providers that live and work in communities impacted by disparities are respected, fairly compensated and integrated into the health delivery system.

Payment must incentivize collaboration across stakeholders to work together to achieve the Triple Aim: better population health, lower costs and higher quality.

Why: The move from fee-for-service to value based care and payment offers an opportunity at moving the U.S. health care system from that of sick care to one that promotes health. Doing so, however, requires the recognition that all stakeholders, from regulators, policymakers, clinicians, payers and the social and community-based supports that serve as the pillar of communities are meaningfully involved and that payment supports and incentivizes collaboration. Complex problems like improving population health, while simultaneously lowering costs and improving quality for all populations, cannot be achieved without intentional collaboration that is supported by equitable payment models.

Policy Options

- ☐ Quality measures are stratified and publicly reported by demographic variables and social risk factors that align with payment.
- ☐ Disparities reduction is an explicit measure of success that impacts payment.
- ☐ Quality improvement includes investments and partnerships to address the social determinants of health, including policies that have made it difficult for communities of color to achieve health.

RESEARCH

Research addressing health must be actively shaped by and reflect the diversity of the country.

Why: Over 20 percent of the U.S. population is not white, with communities of color expected to be the majority in 2050. Yet the overwhelming majority of all clinical trials are still conducted only on white patients. While Asian Americans make up 6% of the U.S. population, they account for less than 2% of clinical trials.⁷ The National Institutes on Minority Health and Health Disparities estimates that less than 10% of participants in genetic studies were Hispanic or African American. Similarly, there continue to be serious data gaps for Asian Americans, Native Hawaiians and Pacific Islanders across all clinical trials.⁸ Communities of color bear the greatest burden for many conditions where cutting-edge research is critical, such as cancer. The evidence base must reflect the demographic diversity of the nation and move away from an assumption that research conducted on white males can be applied to everyone.

⁷ Black Patients Miss Out on Promising Cancer Drugs: ProPublica, September 19, 2018, available at: <https://www.propublica.org/article/black-patients-miss-out-on-promising-cancer-drugs>.

⁸ Oh SS, Galanter J, Thakur N, Pino-Yanes M, Barcelo NE, White MJ, et al. Diversity in Clinical and Biomedical Research: A Promise Yet to be Fulfilled, PLoS Med 12(12): e1001918, available at: <https://doi.org/10.1371/journal.pmed.1001918>.

Policy Options

- ☐ Community based participatory research must be supported, including investments addressing the historical mistrust and fears in communities resulting from decades of harmful medical research on people of color.
- ☐ Clinical and biomedical research must reflect diversity in terms of researchers, participants and how research is conducted, taking into account the various demographic variables and how they impact health outcomes.
- ☐ Clinical trial diversity must be supported and funded.

Research must include a financial commitment to reducing disparities in health outcomes.

Why: Identifying and eliminating disparities requires a substantial change in how research is conducted and funded, with the goal of ultimately having an evidence-base that meets the needs of the diverse populations it seeks to serve. Efforts such as Precision Medicine, Patient-Centered Outcomes Research and Community-Based Participatory Research offer ways to improve the diversity of participation and relevance of research that can identify contributors to health inequities. These models seek to identify the genomic underpinnings of disease, research and outcomes that matter most to patients, and incorporation of community members into the research process, respectively. The ultimate success of these efforts, however, will be determined by the level of investments made in them.

Policy Options

- ☐ Demographic characteristics of participants in clinical trials, including race and ethnicity, should be publicly reported.
- ☐ Research should accurately address the intersections of people's lived experiences, including on the basis of race, ethnicity, sex, gender identity, national origin and disability status.

HEALTHY COMMUNITIES AND PARTNERSHIPS

Health care stakeholders must identify and incorporate the underlying social determinants of health, including where people are born, grow, live, work, age, and worship, and the societal and structural components that affect them, including structural racism.

Why: It is estimated that up to 80% of health care costs are attributed by factors outside of clinical care.⁹ The social determinants of health, which include access to food, housing, education, transportation, safety, and community supports play a critical role in determining individual and population health and associated disparities.¹⁰ These all influence the ability of a person to lead a healthy life and are necessary to supporting a healthy nation. New payment models and frameworks of care and collaboration across stakeholders offer opportunities to address whole person health in the health care system.

⁹ Hood, C.M., K. P. Gennuso, G. R. Swain, and B. B. Catlin, County Health Rankings: Relationships Between Determinant Factors and Health Outcomes, American Journal of Preventive Medicine 50(2): 129-136, 2016.

¹⁰ What Are The Social Determinants of Health? World Health Organization, available at: https://www.who.int/social_determinants/sdh_definition/en/.

Policy Options

- ☐ Provisions acknowledge and address systemic challenges including structural racism and other forms of discrimination.
- ☐ Health care services are directly integrated into the areas of a person's life that tie to social determinants, such as their housing, access to healthy food and access to safe spaces for physical activity that support them in achieving good health.

Health care resources must be equitably invested in racial and ethnic minority communities and other traditionally underserved groups and the organizations that serve them.

Why: The allocation of resources is a statement of values and as such, any proposal that aims to get us to universal coverage must have equity in investments. Despite continued and documented health and health care disparities amongst communities of color and other underserved groups, far too little funding is provided in health care, social services and community supports sectors.

Policy Options

- ☐ Resources are directed toward supporting enrollment, quality of care, health literacy and overall well-being of communities of color.
- ☐ At least 1% of the overall cost of coverage proposals must be earmarked towards resourcing community driven health improvements with cross-sector and community partners at the local and community levels.

Health care must be coordinated with public health efforts to prevent the spread of disease, ensure access to screening and improve health outcomes.

Why: Public health focuses on health promotion for the population overall and addresses both chronic and communicable disease, illness, protection and prevention. Health care must be coordinated with public health efforts if we are to truly achieve health equity by working to prevent sickness, support wellness and healthy behaviors. The integration of public health and health care requires equitable investments in public health funding for education, research, disease surveillance and response and community-led efforts. Furthermore, we will can never hope to address health care costs until we adequately address the public health interventions that can prevent unnecessary medical encounters and conditions.

Policy Options

- ☐ Public health funding and infrastructure is prioritized and adequately provided, including restoring and strengthening the Prevention and Public Health Fund.
- ☐ Investments in public health must be racially conscious, including interventions that are culturally and linguistically tailored.