I

114TH CONGRESS
1ST SESSION

H. R. 3285

To provide for a study by the Institute of Medicine on health disparities, to direct the Secretary of Health and Human Services to develop guidelines on reducing health disparities, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JULY 29, 2015

Mr. PASCRELL (for himself, Mr. COHEN, Mr. CAPUANO, Ms. LINDA T. SÁNCHEZ of California, Mr. LARSON of Connecticut, Mr. DANNY K. DAVIS of Illinois, Mr. GRIJALVA, Ms. BROWN of Florida, Ms. MICHELLE LUJAN GRISHAM of New Mexico, Mr. BISHOP of Georgia, Mr. DAVID SCOTT of Georgia, Mr. HONDA, Mr. PAYNE, Ms. JUDY CHU of California, Mr. TAKAI, Mr. RANGEL, Mr. POCAN, Ms. LEE, Mr. GUTIÉRREZ, Mr. ELLISON, and Mr. THOMPSON of California) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

---

A BILL

To provide for a study by the Institute of Medicine on health disparities, to direct the Secretary of Health and Human Services to develop guidelines on reducing health disparities, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Reducing Disparities Using Care Models and Education Act of 2015''.

SEC. 2. FINDINGS.

The Congress finds as follows:

(1) The infant death rate among African-Americans is more than double that of Whites.

(2) The death rate for all cancers is 30-percent higher for African-Americans than for Whites; for prostate cancer, it is more than double that for Whites.

(3) Black women have a higher death rate from breast cancer despite having a mammography screening rate that is nearly the same as the rate for White women.

(4) In 2013, Asian-Americans and Pacific Islanders were the only racial group where cancer was the number one cause of death. Asian-Americans have the lowest screening rates for breast (64.1 percent), cervical (75.4 percent), and colorectal (46.9 percent) cancer, compared to all other racial groups; the cervical cancer rate for Vietnamese-American women is five times higher than for non-Hispanic Whites.

(5) Diabetes incidence is highest among Native Americans, at 15.9 percent, followed by 13.2 percent

for African-Americans, 12.8 percent for Hispanics, 9.0 percent for Asians, and 7.6 percent for Whites. In 2012, the percentage of Native Hawaiians and Pacific Islanders with diabetes was nearly two times higher than that of Whites.

(6) New cases of hepatitis and tuberculosis are higher in Asians and Pacific Islanders living in the United States than in Whites. Half of all persons living with hepatitis B in the United States are Asian-American.

(7) Individuals in same-sex couples were more likely than individuals in different-sex couples to report a delay in getting necessary prescriptions.

(8) Infants born to Black women are 1.5 to 3 times more likely to die than those born to women of other races or ethnicities, and American Indian and Alaska Native infants die from sudden infant death syndrome (SIDS) at nearly 2.5 times the rate of White infants.

(9) Low-income children have higher rates of mortality (even with the same condition), have higher rates of disability, and are more likely to have multiple conditions.

(10) White children are half as likely as Black and Latino children not to be in excellent or very good health.

(11) As of 2012, 38.9 percent of United States adults were obese, with the highest rate among African-Americans at 47.9 percent, followed by Hispanics at 42.5 percent, Whites at 32.6 percent, and Asians at 10.8 percent. Native Hawaiians and Pacific Islanders are 30-percent more likely to be obese than non-Hispanic Whites. Lack of disaggregated data among Asians can mask differences in the burden of obesity among ethnic groups.

(12) The risk of stroke is twice as high for African-Americans as for Whites, and African-Americans are more likely to die of stroke. Other ethnic minorities also have higher risk than Whites. Overall, strokes are most prevalent in the Southeast United States, and less so in the Northeast.

(13) African-Americans accounted for 44 percent of all those infected with HIV, despite being only 12 percent of the United States population.

(14) Black men who have sex with men (MSM) ages 13 to 24 had the most new infections among youth.

(15) Asian-Americans have the lowest rate of testing for HIV, with only four in 10 having ever been tested; Asian-American and Pacific Islander women have the lowest proportion (17.2 percent) of having ever been tested for HIV compared to other races.

(16) Globally, transgender women are 49 times more likely to acquire HIV than the general population; in the United States, transgender women are 34 times more likely than the general population.

(17) One study found that among heterosexuals living in the same urban community, those below the poverty line were twice as likely to contract human immunodeficiency virus (HIV).

(18) Persons with less than a high school diploma (6.7 percent) and high school graduates (4.0 percent) were more likely to report major depression than those with at least some college education (2.5 percent).

(19) Only about 10 percent of physicians practice in rural America despite the fact that nearly one-fourth of the population lives in these areas.

(20) Rural residents are less likely to have employer-provided health care coverage or prescription drug coverage, and the rural poor are less likely to

be covered by Medicaid benefits than their urban counterparts.

(21) Twenty percent of nonmetropolitan counties lack mental health services versus 5 percent of metropolitan counties.

(22) Forty-one percent of transgender people have reported attempting suicide compared to 1.6 percent of the general population.

(23) Fifteen percent of persons with disabilities report not seeing a doctor due to cost in comparison to 6 percent of the general population.

(24) Nineteen percent of transgender people have been refused medical care because of their gender identity. Twenty-eight percent have been harassed in a doctor's office.

(25) More than 20 percent of the United States population speaks a language other than English at home. Among Asian-Americans, 32 percent are limited English proficient, meaning they speak English less than very well or not at all. Lack of linguistically accessible care presents health access challenges and can contribute to disparities for limited English speakers.

SEC. 3. INSTITUTE OF MEDICINE STUDY.

(a) IN GENERAL.—Not later than 60 days after the date of the enactment of this Act, the Secretary shall enter into an arrangement with the Institute of Medicine under which the Institute agrees to study—

(1) the extent of health disparities in the type and quality of preventive interventions, health services, and outcomes in all populations, including children, in the United States;

(2) the factors that may contribute to inequities in such disparities;

(3) existing programs and policies intended to reduce such disparities;

(4) best practices and successful strategies in programs that aim to reduce such disparities;

(5) priorities for successful intervention programs targeting such disparities; and

(6) potential opportunities for expanding or replicating such programs.

(b) REPORT.—The arrangement under subsection (a) shall provide for submission by the Institute of Medicine to the Secretary and Congress, not later than 20 months after the date of enactment of this Act, of a report on the results of the study.

SEC. 4. GUIDELINES FOR DEVELOPMENT AND IMPLEMENTATION OF HEALTH DISPARITIES REDUCTION PROGRAMS AND ACTIVITIES.

(a) GUIDELINES.—Not later than 90 days after the submission of the report described in section 3(b), and taking such report into consideration, the Secretary shall develop guidelines for entities to develop and implement programs and activities to reduce health disparities in all populations, including children.

(b) USE BY HHS.—The Secretary shall, where appropriate, incorporate the use of the guidelines developed under subsection (a) into the programs and activities of the Department of Health and Human Services.

(c) GRANTS FOR DISPARITIES REDUCTION ACTIVITIES.—

(1) IN GENERAL.—The Secretary may award grants to entities for the development and implementation of programs and activities to reduce health disparities in all populations, including children, in accordance with the guidelines described in subsection (a).

(2) APPLICATIONS.—To seek a grant under this subsection, an entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(3) MINIMUM CONTENTS.—The Secretary shall require that an application for a grant under this subsection contains at a minimum—

(A) a description of the population and public health concern the program will target and an outreach plan to ensure that the most in need populations will benefit;

(B) a description of the strategies the entity will use—

(i) to develop and implement its programs and activities in accordance with the guidelines developed under subsection (a); and

(ii) to make the interventions sustainable; and

(C) an agreement by the entities to periodically provide data with respect to—

(i) the population served;

(ii) improvements in reducing health disparities; and

(iii) effectiveness of the interventions used.

(d) APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated $5,000,000 for fis-

cal year 2017 and such sums as may be necessary for each of fiscal years 2018 through 2021.

SEC. 5. TESTING ALTERNATIVE PAYMENT AND DELIVERY MODELS TO REDUCE HEALTH DISPARITIES.

(a) IN GENERAL.—The Secretary acting through the Centers for Medicare and Medicaid Innovation under section 1115A of the Social Security Act (42 U.S.C. 1315a) shall provide for the testing of a payment and service delivery model that includes incentives for reducing health disparities in all populations, including children, consistent with the cost and quality criteria otherwise applicable to the testing of models under such section.

(b) DOCUMENTATION REQUIREMENT FOR MODEL TESTING.—In carrying out subsection (a), the Secretary shall require that an application to conduct such testing of such a model include at least—

(1) documentation of at least one health disparity targeted for reduction;

(2) a root-cause analysis of the health disparity targeted for reduction;

(3) identification and selection of performance targets for such reduction;

(4) a proposal to make payments in some way contingent on a reduction in health disparities; and

(5) a reliable method for monitoring progress in achieving such a reduction.

SEC. 6. DEFINITIONS.

In this Act:

(1) The term ''health disparity'' means significant disparity in the overall rate of disease incidence, prevalence, morbidity, mortality, or survival rates in a population as compared to the health status of the general population.

(2) The term ''intervention'' means an activity taken by an entity on behalf of individuals or populations to reduce health disparities.

(3) The term ''Secretary'' means the Secretary of Health and Human Services.

○