Promoting Racial and Ethnic Health Equity through Exchanges

COMMUNITY CATALYST

Quynh Chi Nguyen and Alice Dembner

Community Catalyst, Inc.
30 Winter St. 10th Floor
Boston, MA 02108
617.338.6035
Fax: 617.451.5838
www.communitycatalyst.org

Executive Summary

Health disparities among racial and ethnic groups are persistent and drive up the cost of care for everyone. Despite national and local efforts to address disparities, people of color continue to experience poorer health than their white counterparts, including higher rates of infant mortality, lower life expectancy and increased prevalence of chronic diseases. Health Insurance Exchanges provide paths to advance racial and ethnic health equity. Below are six principles that will help the Exchanges better serve a diverse population.

1. **Ensure ongoing, diverse consumer input**
   - Guarantee consumers from diverse communities can meaningfully participate in governance
   - Establish a consumer advisory committee that reflects the diversity of the state
   - Develop a mechanism to receive consumer feedback

2. **Ensure effective language access services in all aspects of Exchanges**
   - Translate vital documents into all languages spoken by the lesser of 5 percent or 500 people in each Exchange service area
   - Include taglines indicating the availability of translated material or oral interpretation in the top 15 languages spoken in each Exchange service areas
   - Provide access to oral interpreters at all times
   - Hire multilingual staff for Exchange call centers

3. **Promote robust outreach programs targeting people of color and immigrants**
   - Establish and fund linguistically and culturally competent Navigators to help people sign up for health insurance
   - Conduct outreach programs tailored to specific communities
   - Require Navigators and outreach workers to provide on-going assistance beyond the enrollment period

4. **Simplify enrollment processes and protect privacy and confidentiality of information**
   - Provide opportunities to submit documentation of citizenship, immigration status and income, if such information is not available electronically
   - Eliminate questions that might discourage eligible members from applying for coverage
   - Comply with existing federal privacy and confidentiality standards
   - Connect people who are ineligible for Exchange plans to other state or local health programs

5. **Ensure robust networks of safety-net providers**
   - Require Exchange health plans to include in their network safety-net providers that have experience providing quality care to consumers from diverse backgrounds

6. **Develop quality strategies to reduce health disparities**
   - Include specific goals to reduce health disparities in every Exchanges' mission statement
   - Use the Exchange's authority to choose high-quality health plans that have robust strategies to reduce disparities and prohibit those without health disparity reduction strategies from selling in an Exchange.

Introduction

Health disparities among racial and ethnic groups are persistent and drive up the cost of care for everyone. Despite national and local efforts to reduce disparities, people of color continue to experience poorer health than their white counterparts, including higher rates of infant mortality, lower life expectancy and increased prevalence of chronic diseases. Low-income people of color, and immigrants with limited to no English language proficiency, are more likely to be uninsured and/or face significant barriers in accessing quality health care[1]. From 2003 to 2006, the cost of racial and ethnic health disparities and resulting premature deaths was $1.24 trillion nationally[2]. If nothing is done to address racial and ethnic health disparities, these problems are likely to worsen as the diversity of the population grows.

The U.S. Census Bureau projects that the U.S. population will rise from 311 million currently to 439 million in 2050. At that time, 54 percent of the population is expected to be comprised of people of color[3]. As the nation becomes increasingly diverse, the Affordable Care Act (ACA) presents a unique opportunity to advance health equity for racially and ethnically diverse populations. Health Insurance Exchanges provide paths to advance racial and ethnic health equity. These are competitive health insurance marketplaces where individuals, families and small businesses can access reliable information, compare different health insurance plans, and enroll in those that suit their needs. The ACA requires states to either create a state-run Exchange by 2014 or participate in a federal Exchange.

By 2019, about 29 million people will have enrolled in a health insurance plan through an Exchange[4]. A recent study[5] projects the majority of enrollees will be from low-income families and will receive subsidies, a tax credit to help make health insurance affordable. The study also suggests that the population using Exchanges will be more racially diverse than those who currently have private insurance: 58 percent of enrollees will be white, 11 percent black, and 25 percent Hispanic; 7 percent will be immigrants who have lived in the United States for less than five years; one in four enrollees will speak a language other than English at home. The table below compares the diversity of those expected to purchase insurance through Exchanges to those expected to purchase private insurance outside the Exchange in 2019.

2019	Exchanges	Private Insurance
White	58%	84%
Black	11%	5%
Hispanic	25%	5%
Others	6%	6%
Immigrants in 5 year wait for Medicaid	7%	NA
Language spoken at home other than English	23%	NA

Source: Kaiser Family Foundation

Because of this diversity of customers, it is vital that Exchanges are designed to advance health equity and are responsive to culturally and linguistically diverse enrollees. Below we explore critical design elements that will help the Exchanges better serve a diverse population and reduce disparities. Many of these principles can be addressed in state Exchange legislation or Exchange policies.

Principles and strategies to promote racial and ethnic health equity in Exchanges

1. Ensure ongoing, diverse consumer input

To fulfill the promise of Exchanges to address racial and ethnic health disparities, people of color must have the opportunity to participate fully in developing and evaluating models for improving the quality and affordability of care. This will help ensure that their unique interests and concerns are addressed.

The ACA provides states with flexibility in establishing a governance structure for their Exchange. Proposed federal regulations support transparency in decision making by requiring Exchange boards to convene regular public meetings, to develop conflict-of-interest standards and to disclose financial conflicts of interest. The majority of board members must have relevant experience in health benefits and health policy. Exchanges are also required to regularly consult with stakeholders, including advocates, consumers, insurers and brokers. These requirements are good first steps toward consumer protection. However, to further ensure that decisions made by Exchanges benefit diverse consumers, Exchanges should:

- **Ensure meaningful participation of consumers from diverse communities in governance:** Ideally, state Exchange laws should require the Exchange board to reflect the racial and ethnic diversity of the state and include consumers, small business representatives and insurance experts who are not financially connected to the health insurance industry. The board should include at least one consumer advocate who is knowledgeable about racial and ethnic health disparities. To expand the influence of consumer representatives, they should work with a coalition that represents diverse consumer interests. Currently, California[6] and Maryland[7] have Exchange laws that go beyond the federal requirements, requiring the Exchange board to mirror the gender, cultural, ethnic and geographical diversity of the states.

- **Establish a consumer advisory committee:** To better serve people from all backgrounds, state Exchange laws should require Exchanges to establish a consumer advisory committee. This advisory committee should be comprised of consumer advocates and community based organizations that have experience assisting community members in navigating the local health care system. Ideally, the committee should reflect the racial and ethnic diversity of the state. The advisory committee should have a real ability to influence decisions. This is especially important for states that establish Exchanges inside existing state departments and do not establish a separate Exchange governing board.

- **Develop a mechanism to receive consumer feedback:** To help identify and address problems and track consumer satisfaction about the care they receive, Exchanges should develop a mechanism to collect feedback from culturally and linguistically diverse consumers. Examples include ombudsmen, consumer surveys and links to community run consumer hotlines. For instance, Massachusetts' Exchange, called the Connector, receives regular reports from a toll-free Helpline about trouble spots and consumers' concerns. Health Care for All, a non-profit state health advocacy organization, staffs the Helpline with counselors who are experts on the new health care programs and receive ongoing training. They take calls in English, Spanish and Portuguese to help people apply for coverage and navigate the health system. The Helpline receives about 3,500 calls each month.

What advocates can do:

At the state level:

- Advocate for the appointment of key leaders from communities of color as members of the Exchange governing board and the establishment of a consumer advisory committee that reflects the racial and ethnic diversity of the state population.
- Attend and testify at Exchange board meetings and provide comments on Exchange policies.
- Meet with state agencies to develop feedback mechanisms that include culturally diverse consumer groups.

2. Ensure effective language access services in all aspects of Exchanges

Language barriers impede access to health services[8]. Strong requirements on, and enforcement of, language access services would help improve care and reduce disparities.

Exchanges have the responsibility to provide appropriate language access services, including translation of documents (i.e. descriptions of health plan choices, grievance procedures) and interpreters to enrollees under the nondiscrimination protection of the ACA[9] as well as Title VI of the Civil Rights Act of 1964[10] prohibiting discrimination on the basis of race, color or national origin, gender and disability[11]. In addition, the section1311 of the ACA requires that all information distributed by Exchange health plans must be written in plain language that is clear and concise. The United States Department of Health and Human Services (HHS) and the Department of Labor (DOL) are required to jointly develop guidance and best practices for writing documents. Proposed federal regulations require Exchanges to monitor the use of plain language by Exchange health plans to ensure consistency with federal guidance.

To meet the cultural and linguistic needs of enrollees, states should require Exchanges to:

- **Translate written materials into languages spoken by those eligible to use Exchanges:** All vital documents should be translated into languages spoken by the lesser of 5 percent or 500 enrollees. This is a combination of the thresholds recommended in HHS's Revised Limited English Proficiency Guidance[12] and the DOL regulations on Limited English Proficiency[13].

- **Include notices on documents and websites** indicating the availability of translated material or oral interpretation in the top 15 languages spoken by people in an Exchange service area.

- **Provide access to oral interpretation services** at all times to any individual who requests them, regardless of whether thresholds for translating documents are met.

- **Hire multilingual staff for Exchange call centers and consumer assistance offices.**

What advocates can do:

At the federal level:
- Press for federal regulations and policies that require health plans to provide language access services.

At the state level:
- Advocate for state laws and regulations to require language access services in the Exchange.
- Monitor the implementation of language access services in the Exchange.

3. Promote robust outreach programs targeting people of color and immigrants

Due to lack of knowledge of the insurance system, language and cultural barriers and distrust of the government, people of color in general, and immigrants in particular, are less likely than whites to have insurance[14].

The ACA requires all state Exchanges to establish Navigator programs to help people sign up for insurance. Navigators are responsible for providing information about health insurance options that best fit the needs of enrollees and helping them enroll. Proposed federal regulations further require Navigators to demonstrate experience in conducting culturally and linguistically competent outreach to the uninsured and to populations with language barriers. In addition to Navigators, Exchanges are required to conduct separate outreach and education activities targeting hard-to-reach populations and populations experiencing health disparities.

To ensure eligible individuals and families have full access to Exchanges, they will need tailored information and help from trusted sources. Therefore, Exchanges should:

- **Establish and fund linguistically and culturally competent Navigators to help sign people up for health insurance:** At least one of the Navigators in a state should be a community based non-profit organization that serves communities of color and does not receive payments or subsidies from insurers to enroll people. Entities that serve people of color, immigrants and hard to reach populations such as community based organizations, community health workers, community health centers and family health clinics, should be considered as Navigators since many have been effective in increasing enrollment and reducing disparities in coverage. In Massachusetts, community based organizations were a key part of achieving the state's 97 percent insurance coverage rate[15].

- **Conduct specific outreach and education programs tailored to specific communities:** Exchanges should conduct a regional needs assessment to better determine the needs of low-income and diverse communities and use this assessment to create an effective outreach campaign. Outreach messages and materials should be developed in a way that resonates with underserved communities. Outreach and education activities should be conducted close to where people live. Potential outreach avenues include schools, food pantries, churches, ethnic restaurants, grocery stores carrying ethnic products, and ethnic radio and television channels.

- **Require Navigators and outreach workers to provide on-going assistance beyond the open enrollment period** to help newly insured people find providers and navigate the complex health care system, as well as help with renewal at yearly intervals[16]. In some instances, one-on-one assistance with individuals and families has been found to be the most effective outreach model in communities of color and immigrants[17].

What advocates can do:

At the state level:

- Advocate for Exchange policies that require the Navigator program to reflect the diversity of the state.
- Educate state and local funders about the importance of community engagement in outreach and enrollment and encourage them to provide funding to support this work.

4. Simplify enrollment processes and protect privacy and confidentiality of information

Confusing application processes, cumbersome documentation requirements and privacy violations are consistently identified as enrollment barriers, especially for immigrants[18]. Simple enrollment methods and strong privacy protection policies will help more eligible people sign up.

Under the ACA, states must develop a single and streamlined application for Exchanges and Medicaid programs to make it easy for people to get and keep coverage when they move from one state program to another, due to income fluctuations. Proposed federal regulations require Exchanges to develop a system to communicate with an HHS data service hub to verify information. The data service hub includes information from the Social Security Administration (SSA), Department of Homeland Security (DHS) and Internal Revenue Service (IRS). To protect privacy and confidentiality of information, the ACA reaffirms the Tri-Agency Guidance[19] on privacy protection and inquiries about citizenship and immigration status[20]. The Guidance prohibits states from denying benefits to an applicant if s/he refuses to disclose his/her social security number unless the disclosure is required by federal statute[21].

To comply with the ACA and existing federal guidance, states should apply the following best practices for verification of information in Exchanges:

- **Provide opportunities to submit documentation of citizenship, immigration status and income, if such information is not available electronically or has changed, without disrupting the eligibility and enrollment process:** Because immigrant families are less likely to have information that can be verified electronically[22], Exchanges should not rely solely on electronic data sources.

- **Eliminate unnecessary questions from application forms** that might unintentionally discourage or prevent eligible members living in families with mixed immigration status from getting coverage (e.g. citizen children living with undocumented immigrant parents) [23].

- **Comply with existing privacy and security standards when verifying information on citizenship, immigration status and income data with SSA/DHS/IRS:** application forms should require verification only for the person requesting coverage. For example, a parent of a child should not be required to submit his/her documentation when applying for coverage for his/her child. Small Business Health Options Program (SHOP) and individual Exchanges must develop confidentiality policies to protect the privacy of enrollees. All information provided by applicants should be kept confidential and only shared with other government agencies for purposes of determining eligibility. SHOP Exchanges should not request additional verification from employed enrollees.

- **Link people who are ineligible for Exchange plans or Medicaid to other state or local health programs:** Although more than 30 million people will gain coverage with the implementation of the ACA, millions of people will remain uninsured. The uninsured will include people who still cannot afford to buy insurance, individuals who are eligible for an exemption from the requirement to have insurance, people who are eligible but have not yet enrolled, as well as some individuals who are not eligible because of their immigration status. Exchanges should refer these individuals to other state and local health programs including hospital community benefit and charity care programs and community health centers.

What advocates can do:

At the state level
- Encourage the Exchange board to require staff who review eligibility to make referrals to charity care and other programs for applicants who don't qualify for Exchange plans or Medicaid.
- Monitor the application and verification processes developed and used by the Exchange and bring civil rights violations to the attention of the Exchange staff and authorities.

5. Ensure robust networks of safety-net providers

All enrollees will benefit from providers who are responsive to their cultural and language needs. This is especially true of communities of color and immigrants that have faced discrimination and roadblocks to care.

The ACA requires health plans that participate in Exchanges to maintain a sufficient number of essential community providers that predominantly serve medically underserved and low-income populations. However, the law and HHS' proposed rules do not clarify what types of providers should be identified as "essential community providers." To ensure a sufficient number of providers to serve Exchange populations, especially medically underserved and low-income populations, Exchanges should:

- **Require Exchange health plans to include in their networks safety-net providers that have experience providing quality care to consumers from diverse backgrounds:** They should include federally qualified health centers, Indian health clinics and tribally operated programs, public hospitals, school-based clinics, community mental health centers, and other mental health and substance use disorder organizations that are licensed or certified by the state as providers[24]. These institutions have traditionally been the primary source of care for populations with unique health needs and many of them have worked to reduce health disparities. They are at the forefront of providing linguistic and culturally competent care and have worked to develop trust among the populations they serve.

What advocates can do:

At the state level

- Advocate for Exchange legislation or Exchange policy that requires participating health plans to include a broad cross-section of safety-net providers in their networks.

6. Develop quality strategies to reduce racial and ethnic disparities

The Healthy People 2010 Report released in October of 2011 laid out stark statistics on the persistence of racial and ethnic disparities: while about 15 percent of indicators showed an improvement, 15 percent showed disparities worsening and about 70 percent were unchanged[25]. While insurance coverage will help reduce racial and ethnic disparities, research shows that more is needed to tackle this persistent problem. Quality strategies specifically designed to reduce disparities are one avenue. The purchasing power of Exchanges creates an opportunity to extend the reach of these strategies.

The ACA empowers Exchanges to set quality criteria, including establishing a quality improvement strategy that aims to reduce disparities for the insurance plans sold through the Exchange. While HHS postponed the release of guidance on specific quality measures until 2014, the agency encourages states to develop metrics on quality data to be displayed on the Exchange website and explore ways to monitor the quality of care provided by Exchange health plans including complaints, appeals and network adequacy[26].

To improve quality overall and reduce disparities, research is needed to understand how to make racial and ethnic disparity reduction a priority without initially driving up the costs of coverage. However, at a minimum, Exchanges should:

- **Develop specific goals to reduce health disparities:** These goals should be explicitly written in Exchanges’ mission statements. For instance, in its mission statement[27], the California Health Benefit Exchange recognizes the unique needs of its diverse consumers and sets movement toward health equity as one of the outcomes of its success.

- **Use the Exchanges’ authority to choose high-quality plans that have robust strategies to reduce disparities while prohibiting those without health disparity reduction strategies from the marketplace:** Exchanges should require participating health plans to develop disparity reduction strategies that are proven to be cost saving and increase quality. These include expanding the number of patient-centered medical homes, maintaining a diverse provider network and incorporating wellness and health promotion programs. Exchange health plans should report and publicly post their progress in improving health outcomes of enrollees by race, ethnicity, primary language, gender and disability. These reports should include data on complaints and appeals by race and ethnicity. This information will help consumers make decisions on plans that provide quality care and are making progress in addressing disparities.

If these measures result in increasing costs for Exchange health plans, and in turn lead to adverse selection[28], states should require all health plans inside and outside Exchanges to meet the same standards[29].

What advocates can do:

At the federal level:

- Urge HHS to develop regulations soon on quality measures that include standards and measures to reduce racial and ethnic health disparities.

At the state level:

- Advocate for state legislation that allows an Exchange to choose the highest quality health plans with robust strategies to reduce health disparities.

Conclusion

Racial and ethnic health disparities impose a steep toll on the U.S. economy and on the health of our residents. As the nation continues to become more diverse, these problems are likely to grow if left unaddressed. Since disparities are rooted in policies and institutions that govern how we live, work and play, advancing health equity requires a multifaceted approach at the federal, state and local levels.

Health Insurance Exchanges can be one strategy, providing leverage to close coverage gaps across the population and promote health equity by addressing governance, language access, outreach and enrollment, eligibility determinations, provider networks, and quality strategies. The guiding principles and strategies discussed in this paper are focused on state Exchanges, but most can also apply to federal Exchanges. To make progress, advocates must be persistent and work with other stakeholders to increase the involvement and impact of members of the vulnerable communities that have the most to gain from full implementation of the ACA. Exchanges will work better for everyone if people of color and immigrants are engaged fully in the creation, implementation and ongoing management of Exchanges. Underlying the work is the imperative to provide quality affordable care to millions of people.

---

[1] Department of Health and Human Services (April 2011). Action Plan to Reduce Racial and Ethnic Health Disparities: A Nation Free of Disparities in Health and Health Care. http://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[2] Joint Center for Political and Economic Studies (2009). The Economic Burden of Health Inequalities in the United States. http://www.jointcenter.org/hpi/sites/all/files/Burden_Of_Health_FINAL_0.pdf

[3] U.S. Census Bureau (May 2010). The Older Population in the United States: 2010 – 2050 – Population Estimates and Projections. http://www.census.gov/prod/2010pubs/p25-1138.pdf

[4] Congressional Budget Office (March 2010). http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf

[5] The Henry J. Kaiser Family Foundation (March 2011). A Profile of Health Insurance Exchange Enrollees. http://www.kff.org/healthreform/upload/8147.pdf

[6] California Health Benefit Exchange http://www.leginfo.ca.gov/pub/09-10/bill/sen/sb_0851-0900/sb_900_bill_20100930_chaptered.html

[7] Maryland Health Benefit Exchange Act of 2011http://dhmh.maryland.gov/healthreform/exchange/pdf/MHBEA_Enrolled.pdf

[8] Ku, Leighton and Flores, Glenn. Pay Now or Pay Later: Providing Interpreter Services in Health Care. *Health Affairs*, 24, No. 2 (2005): 435-444.

[9] ACA Section 1557: Nondiscrimination Protection

[10] Title VI of the Civil Rights Act of 1964 http://www.justice.gov

[11] National Health Law Program (January 2011). The ACA and Application of § 1557 and Title VI of the Civil Rights Act of 1964 to the Health Insurance Exchanges.

http://www.healthlaw.org/images/stories/Short_Paper_6_The_ACA_and_Application_of_Section_1557_and_Title_VI.pdf

[12] HHS's Revised Limited English Proficiency Guidance
http://www.justice.gov/crt/about/cor/lep/hhsrevisedlepguidance.pdf

[13] National Health Law Program (October 2010). Comments in Response to OCIIO's Request for Comment for Planning and Establishment of State-Level Exchanges related to Language Access (Oct. 4, 2010)
http://www.healthlaw.org/images/stories/NHeLP_comments_OCCIO_language_access_Oct10.pdf
HHS' LEP Guidance recommends 5 percent or 1,000; DOL's regulations set 10 percent or 500 threshold for group health plans regarding summary plan descriptions. The National Health Law Program combined the two to take the "best" of both.

[14] The Henry J. Kaiser Family Foundation (2010). Health Reform and Communities of Color: Implications for Racial and Ethnic Health Disparities. http://www.kff.org/healthreform/upload/8016-02.pdf

[15] Stan Dorn, Ian Hill and Sara Hogan (2009). The Secret of Massachusetts' Success: Why 97 percent of State Residents Have Health Coverage. http://www.urban.org/uploadedpdf/411987_massachusetts_success.pdf

[16] James Maxwell, Dharma E. Cortés, Karen L. Schneider, Anna graves and Brian Rosman. Massachusetts' Health Care Reform Increased Access to Care For Hispanics, But Disparities Remain. *Health Affairs*, 30, no.8 (2011): 1451-1460

[17] The Henry J. Kaiser Family Foundation (2011). Connecting Eligible Immigrant Families to Health Coverage and Care: Key Lessons from Outreach and Enrollment Workers. http://www.kff.org/medicaid/upload/Connecting-Eligible-Immigrant-Families-to-Health-Coverage-and-Care-Key-Lessons-from-Outreach-and-Enrollment-Workers-pdf.pdf

[18] Ibid. as footnote 14

[19] Tri-Agency Guidance http://www.fns.usda.gov/SNAP/rules/Memo/pdfs/triagencyletter.pdf

[20] The Tri-Agency Guidance was issued in 2000 by three federal agencies, the Department of Health and Human Services, the Department of Agriculture and the Office of Civil Rights. Under this guidance, states should not require applicants to provide information about the citizenship or immigration status of non-applicant family or household members or deny benefits to applicants if family members who aren't applying for coverage do not submit their immigration and citizenship status.

[21] National Immigration Law Center (October 2011). Comments on Federal Funding for Medicaid Eligibility Determination and Enrollment Activities. File Code: CMS-2346-P http://www.nilc.org/immspbs/health/Comments-Medicaid-eligibility-enrollment-systems-funding-2011-01-07.pdf

[22] Examples of legal immigrant families whose information on income and immigration status may not be verified electronically include: (1) recently naturalized citizens; (2) people working in the informal economy, or not required to file taxes; or (3) someone who's circumstances have changed.
Source: NILC Comments on Proposed Exchange Rule – CMS 9974-P submitted on October 31, 2011

[23] Wiley, Dinah (September 2011). Let's Make the Exchanges More Welcoming to All Children and Families.
http://theccfblog.org/2011/09/lets-make-the-exchanges-more-welcoming-to-all-children-and-families.html

[24] Community Catalyst (October 2011). Supplemental Comments to the Department of Health and Human Services, Centers for Medicare & Medicaid Services re. Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans: Proposed Rule (CMS-9989-P).

[25] National Center for Health Statistics, Centers for Disease Control and Prevention (2011). Healthy People 2010: Final Review. http://www.cdc.gov/nchs/data/hpdata2010/hp2010_final_review.pdf

[26] Ibid. as footnote 16

[27] California Health Benefit Exchange's Mission Statements http://www.healthexchange.ca.gov/Documents/Meeting-Materials/21Oct2011/CA-HBEXVisionMissionValues10-21-11-Final.pdf

[28] Adverse selection is the situation where healthier people with lower health care costs would select plans outside Exchanges while sicker people with higher health care costs, who are more likely people of color, select plans within Exchanges. This would drive up the cost of plans in the Exchange.

[29] Center on Budget and Policy Priorities (2011). States Should Take Additional Steps to Limit Adverse Selection Among Health Plans in an Exchange. http://www.cbpp.org/files/6-28-11health.pdf