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Making Public Programs Work for Communities of Color:

An Action Kit for Community Leaders

About this Action Kit

The purpose of this Action Kit is to provide community leaders with the information, tools, and resources necessary to engage in health advocacy and improve the health and well-being of their communities. With an emphasis on the importance of public programs in reducing racial and ethnic health disparities, this kit contains sections that provide:

- A summary of racial and ethnic health disparities and of the role that public programs can play in reducing them;
- An overview of Medicaid (and SCHIP) and Medicare, including their importance to communities of color, as well as emerging issues pertaining to these programs (updated March 2006);
- Quick facts and statistics on disparities in health, health care, and access;
- Fact sheets on improving health coverage and access for African Americans, Asians and Pacific Islanders, and Latinos;
- Case studies on health advocacy efforts at the state and local level, including examples from the faith-based community and grassroots organizations;
- Strategies and tools for influencing Congress, the White House, communities, and the media, as well as an advocate's checklist on how to take action to improve minority health;
- A PowerPoint presentation for community leaders to use in talks and discussions about racial and ethnic health disparities and health policy; and
- Additional resources, including lists of organizations and publications that focus on minority health issues.

For more information on the issues discussed in this kit,
contact the Minority Health Initiatives Department at
Families USA by calling 202-628-3030 or by sending an e-mail to minorityhealth@familiesusa.org.

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Making
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of Color

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January 2006

Improve Public Programs, Improve Minority Health

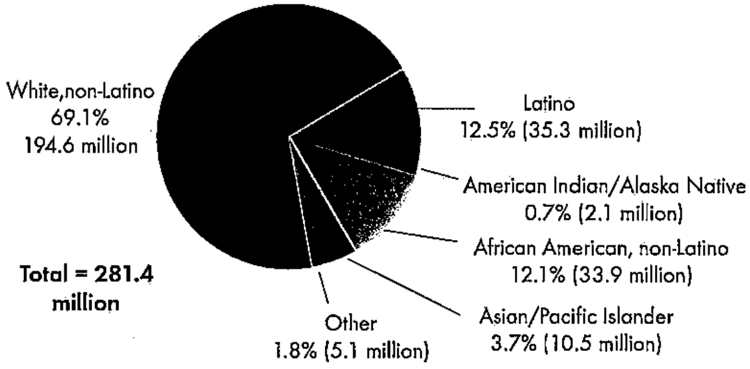
Background

The demographics of the nation are changing. People of color—African Americans, American Indians/Alaska Natives, Asian/Pacific Islanders, and Latinos—make up one-third of the U.S. population, and that proportion is expected to increase to half by 2050.[1] In many of America's major cities and urban areas, "minorities" now make up the majority.

Racial and Ethnic Health Disparities: An Overview

The problem of racial and ethnic disparities in access, coverage, treatment, and health outcomes has been well documented in recent years. In fact, the magnitude of this problem led the U.S. Department of Health and Human Services (HHS) to make eliminating health disparities by 2010 a national goal and has inspired members of Congress to introduce legislation to help achieve that goal. However, recent threats to public health programs such as Medicaid and SCHIP (the State Children's Health Insurance Program), changes in the Medicare program, and the growing number of racial and ethnic minorities who don't have health insurance coverage make reducing and ultimately eliminating these heath disparities a challenging task.

Figure 1:
Percent Distribution of U.S. Population by Race/Ethnicity, 2000



Source: U.S. Census, *Profile of General Demographic Characteristics: 2000*

The extent and breadth of racial and ethnic health disparities is staggering. People of color are less likely to have health insurance coverage, see a provider on a regular basis, and receive preventive screenings or routine health care services. At the same time, they are more likely to be diagnosed at a later stage of disease and be hospitalized for preventable conditions. For example:

- African-American men are 50 percent more likely to suffer from prostate cancer than white men, and they are more than twice as likely to die as a result of the cancer.[2]
- One-third of Latinos in fair or poor health had not visited a physician during the preceding year, a considerably higher rate than the rates for whites and African Americans.[3]
- Compared to the general U.S. population, American Indians are 638 percent more likely to suffer from alcoholism, 400 percent more likely to contract tuberculosis, 291 percent more likely to suffer from diabetes, 67 percent more likely to have pneumonia and influenza, and 20 percent more likely to suffer from heart disease.[4]
- Insurance rates among Asian American and Pacific Islander subgroups vary widely. Because of their likelihood to be self-employed or work in small businesses, one-third of Korean Americans remain uninsured, compared to only 13 percent of Japanese Americans.[5]
- African Americans and Latinos had higher rates of lower extremity amputations than non-Hispanic whites.[6]

Defining Disparities

The term "racial and ethnic health disparities" is an umbrella term that includes disparities in *health* and disparities in *health care*. Although these two terms are often incorrectly used interchangeably, they are two different concepts:

Disparities in health: Disparities in health refer to differences between two or more population groups in health outcomes and in the prevalence, incidence, or burden of disease, disability, injury, or death.

Disparities in health care: Disparities in health care refer to the differences between two or more population groups in health care access, coverage, and quality of care, including differences in preventive, diagnostic, and treatment services.

There is no one solution to eliminating racial and ethnic health disparities, because myriad sources contribute to this gap. These factors include:

- societal factors, such as racism, class differences, and poverty;
- environmental factors, such as hazardous air, unsafe neighborhoods, and lack of green space; and
- structural factors, such as health care delivery systems that may alienate people of color or discourage them from accessing needed care.

While a multi-pronged approach—including efforts from both the private and public sectors—is needed to address this issue, increasing access to coverage is key, and public programs provide the best chance for improving the health of communities of color.

Although the determinants of health disparities are complex and varied, we do not need to unravel every last piece of this puzzle to begin to take action.[7]

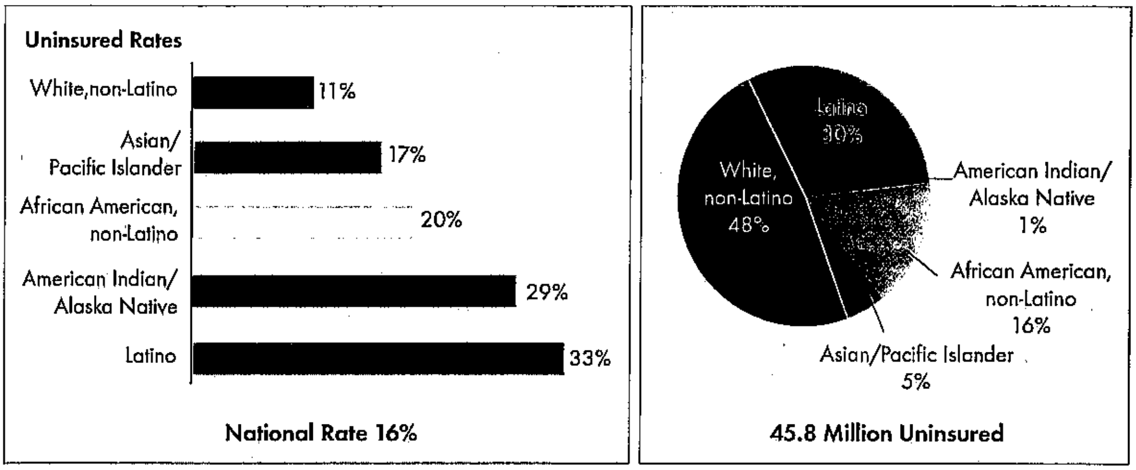
The Role of Coverage in Reducing Disparities

Of all the factors that contribute to health disparities, lack of health care coverage is the single most important factor.[8] Individuals with affordable and comprehensive health insurance coverage have fewer barriers to health care, are more likely to see a physician on a regular basis, and experience better health outcomes. Insurance coverage also reduces out-of-pocket costs and shields individuals and their families from the economic hardships that an unexpected injury or illness can create.[9]

Unfortunately, racial and ethnic minorities are much more likely to lack health insurance coverage or to be underinsured compared to non-Hispanic whites. While people of color make up just one-third of the U.S. population, they comprise over half of the 45.8 million uninsured. In 2004, 32.7 percent of Latinos (13.7 million) lacked coverage, as did 19.7 percent of African Americans (7.2 million) and 16.8 percent of Asian Americans/ Pacific Islanders (2.1 million), compared with 11.3 percent of non-Hispanic whites (22 million).

Figure 2:

People without Insurance by Race/Ethnicity, 2004



Source: U.S. Census Bureau, "Health Insurance Coverage: 2004," *Current Population Survey 2004*, available online at http://www.census.gov/hhes/www/hlthins/hlthin04.html.

Much of these disparities can be attributed to the fact that racial and ethnic minorities are more likely to be employed in industries that do not offer job-based health insurance, a source of coverage for most Americans (60 percent in 2004). Although 70 percent of whites are insured through an employer-sponsored health plan, less than half of African Americans and Hispanics—the two largest U.S. racial and ethnic minority groups—had such coverage in 2003 (Figure 3).[10] According to one study, as much as 80 percent of low-income Hispanics were uninsured during a four-year period, compared with 66 percent of low-income African Americans and 63 percent of low-income whites. Ironically, low-income Latinos were more likely than any other group to have stable employment over this same period.[11]

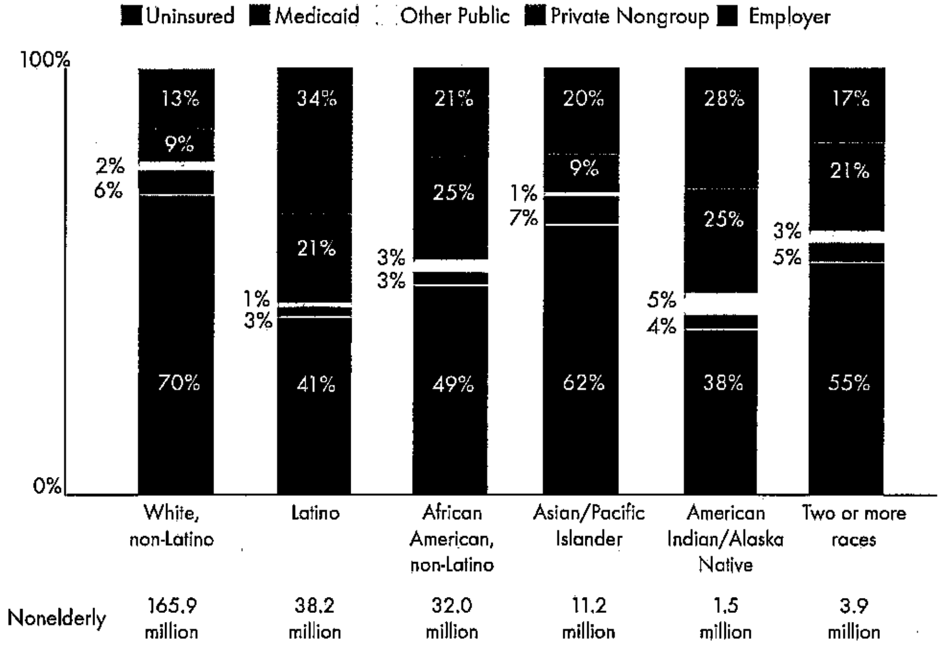
"Minority Americans in low-wage jobs work hard and play by the rules, but are too often shut out of the health care system because they are not offered coverage through work, or if coverage is offered it's unaffordable. Policy solutions to help low-income working families afford coverage would be an effective way to address these persistent inequities in health coverage and access to health care."

– Karen Davis, president of The Commonwealth Fund

The Role of Public Programs in Reducing Health Disparities

Racial and ethnic minorities are more likely to rely on public programs for insurance coverage. For example, 27.5 percent of African Americans, 22.3 percent of Latinos, and 29.9 percent of American Indians/Alaska Natives obtain care through public programs, compared with 11 percent of whites.[12] This is due to a variety of reasons, including higher rates of poverty, increased likelihood of employment in industries that lack employer-sponsored health care, and the inability to afford coverage even when it is offered.

Figure 3:
Health Insurance Coverage Among Nonelderly Americans, by Race/Ethnicity and Source of Coverage, 2003



Source: Marsha Lillie-Blanton and Catherine Hoffman, "The Role of Health Insurance Coverage In Reducing Racial/Ethnic Disparities In Health Care," *Health Affairs* 24(2): March-April 2005: pp. 398-408.

Overwhelming evidence indicates that the single most effective way to reduce racial and ethnic health disparities is through the expansion and preservation of public programs, which have a proven track record of serving low-income and minority Americans.[13] Medicaid and SCHIP have the administrative systems already in place to enroll beneficiaries and pay providers, and they have demonstrated how responsive they can be when unemployment increases and family incomes decrease. According to Lillie-Blanton and

Hoffman, several changes in public policy could have a sizable impact on the health coverage of communities of color. For example, an estimated 74 percent of the 23 million uninsured minority Americans could be covered by using Medicaid and SCHIP to:

1. expand outreach and enrollment efforts to assure that all children who are eligible—children in families with incomes less than 200 percent of poverty—are enrolled in these programs (approximately 4.6 million low-income minority children);
2. expand coverage to parents of children who are enrolled in these programs (approximately 5.0 million low-income minority parents); and
3. expand coverage to low-income adults without dependent children (approximately 7.5 million adults).[14]

Conclusion

The problem of racial and ethnic health disparities has been well documented. Although numerous sources contribute to these disparities, and several opportunities exist for addressing this issue, increasing access to insurance coverage is vital to closing the gap.

Public programs have a proven track record for increasing access and improving care for millions of racial and ethnic minorities. In fact, several models for treating minority patients and reducing disparities originated in public-sector programs, such as the collection of data on racial and ethnic minorities and making trained interpreters available for patients with limited English skills. Unfortunately, these programs are currently under threat, and conversations about scaling back have moved us in the direction of preservation rather than innovation.

Given the vital role that public programs play in the lives of racial and ethnic minorities, any efforts to restructure, scale back, or cut these programs must take into account the unique needs and inferior health status of minorities. At the state level, proposals to restructure or alter Medicaid programs must consider the proportion of racial and ethnic minorities enrolled and how these changes might affect existing health disparities. Similarly, proposed policy changes at the federal level must include an analysis of the impact these changes would have on minority populations, particularly if eliminating racial and ethnic health disparities is still the goal of the federal government.

Endnotes

[1] Kaiser Family Foundation, *Policy Challenges and Opportunities in Closing the Racial/Ethnic Divide in Health Care* (Menlo Park, CA: March 2005), available online at http://www.kff.org/minorityhealth/7293.cfm.

[2] American Cancer Society, *Cancer Facts and Figures, 2003* (Atlanta: American Cancer Society, 2003), available online at http://www.cancer.org/downloads/STT/CAFF2003PWSecured.pdf.

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[4] Indian Health Services, *Trends in Indian Health, 2000-2001* (Washington: Indian Health Services), p. 7, available online at http://www.ihs.gov/NonMedicalPrograms/IHS_Stats/Trends00.asp.

[5] Kaiser Commission on Medicaid and the Uninsured, *Health Insurance Coverage and Access to Care Among Asian Americans and Pacific Islanders* (Washington: Kaiser Family Foundation, June 2000).

[6] Andrew Karter, Assiamira Ferrara, Jennifer Liu, et al., "Ethnic Disparities in Diabetic Complications in an Insured Population, *Journal of the American Medical Association* 287 (19), pp. 2519-2527.

[7] Neil Calman, "Making Health Equality A Reality: The Bronx Takes Action," *Health Affairs* 24(2), March/April 2005, pp. 491-498.

[8] Kaiser Family Foundation, op. cit.

[9] Eugene Lewit, Courtney Bennet, and Richard Behrman, "Health Insurance for Children: Analysis and Recommendation," *The Future of Children* 13 (1), Spring 2003, pp. 5-29.

[10] Marsha Lillie-Blanton and Catherine Hoffman, "The Role of Health Insurance Coverage In Reducing Racial/Ethnic Disparities In Health Care," *Health Affairs* 24 (2), March/April 2005, pp. 398-408.

[11] Michelle M. Doty and Alyssa L. Holmgren, *Unequal Access: Insurance Instability among Low-Income Workers and Minorities* (New York: The Commonwealth Fund, April 2004).

[12] Kaiser Family Foundation, op. cit.

[13] Edward M. Kennedy, "The Role of the Federal Government in Eliminating Health Disparities," *Health Affairs* 24 (2), March/April 2005, pp. 452-458.

[14] Marsha Lillie-Blanton and Catherine Hoffman, op. cit.

For more information on Families USA's Minority Health Initiatives,
contact Rea Pañares, Director of Minority Health Initiatives
or Briana Webster-Patterson, Program Manager at
minorityhealth@familiesusa.org or 202-628-3030.

Making
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Communities
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◆

An Action
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January 2006

Medicaid:
A Vital Source of Coverage for Communities of Color

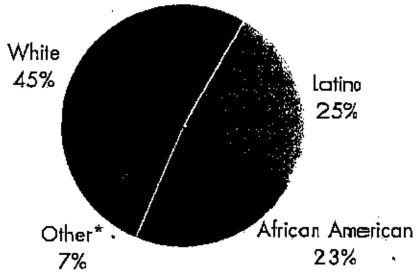
Medicaid Overview

Over the past 40 years, Medicaid has provided crucial, comprehensive health services and support for America's most vulnerable populations. Today, this important program provides primary and preventive health care services for over 53 million individuals, including low-income children, families, and seniors, and more than 8 million individuals with disabilities. It pays for nearly one in five health care dollars and one in two nursing home dollars. And it is the single largest source of financing for long-term care, accounting for nearly half (47.4 percent) of the nation's spending on long-term care services.[1]

Medicaid's Role in Communities of Color

Because the program's mission is to provide health coverage to low-income populations—and minority populations generally have lower incomes relative to whites[2]—Medicaid plays an especially important role in communities of color. For example, it provides health care coverage to 24.6 percent of African Americans, 24.9 percent of American Indians/Alaska Natives, 20.9 percent of Latinos, and 9.0 percent of Asian Americans/Pacific Islanders, compared with 8.7 percent of non-Latino whites.[3] Among children, roughly one in four low-income Latino and Asian American/Pacific Islander children, and one in five low-income African American children, rely on Medicaid for health care services.[4] Furthermore, while racial and ethnic minorities make up just one-third of the total U.S. population, they comprise more than half of those who get their health care through Medicaid (Figure 1).[5]

Figure 1:
Who's Covered by Medicaid?
Health Insurance Coverage of Non-elderly Medicaid Enrollees by Race/Ethnicity, 2003



* Other includes Asian-Americans, Pacific Islanders, American Indians, Aleutians, Eskimos, and persons of "two or more races."

Source: Kaiser Family Foundation, State Health Facts Online, *Health Insurance Coverage of Non-elderly Medicaid Enrollees by Race/Ethnicity, 2003*, accessed on November 11, 2005.

Medicaid Structure

Medicaid is jointly funded by the 50 states, the District of Columbia, and the federal government, requiring states to share the cost of providing health care programs and services with the federal government. The federal Medicaid match differs from state to state based on each state's per capita income. For instance, in fiscal year 2005, the rate of return for each dollar states invested in the Medicaid program ranged from $1.92 in Delaware to $6.22 in Mississippi.[6] It is important to note that Medicaid infuses state economies with money and jobs—every dollar a state spends on Medicaid pulls new federal dollars into the state—dollars that would not otherwise flow into state economies.

Although all 50 states and the District of Columbia participate in the Medicaid program, it is not mandatory and the program differs by state. While policies must fall within broad federal guidelines, each state enacts its own policies and procedures that govern its Medicaid program. In fact, states are given significant flexibility in how they run their programs; for example states set different program parameters, such as benefits covered, eligibility requirements, and provider payments. However, in order for states to receive federal matching funds for their Medicaid program, they must provide health coverage to certain "mandatory" enrollees. These mandatory individuals include the following:

- pregnant women and children under age six with household incomes below 133 percent of poverty;
- school-age children with family incomes below 100 percent of poverty;
- parents with incomes below their state's welfare eligibility levels; and
- most individuals with disabilities and seniors who receive cash assistance.

Beyond this group of mandatory individuals, there is another group of individuals that states may opt to cover at their discretion. This "optional" category of individuals includes the following:

- parents, children, and pregnant women with incomes above mandatory coverage levels;
- seniors and people with disabilities with incomes up to 100 percent of poverty;
- "medically needy" individuals who qualify for Medicaid because of high medical expenses; and
- individuals living in nursing facilities with incomes less than 300 percent of Supplemental Security income (SSI) standards.

Despite the distinctions noted above, in most cases, there is little difference between the health care needs of "mandatory" and "optional" enrollees. Both groups of Medicaid beneficiaries are low-income, have a tremendous need for medical care for catastrophic and chronic illnesses, and have no other source of health coverage. These groups make up 29 percent of all Medicaid beneficiaries and half of elderly Medicaid beneficiaries— a significant portion of the Medicaid population.[7]

States offer mandatory benefits (services that must be provided in order to participate in the Medicaid program) as well as optional benefits. States are allowed to cut select mandatory services if they get a waiver of the federal Medicaid rules. So, states, in effect, have the flexibility to determine what mandatory health services are covered—and to what extent—in their Medicaid programs. Some examples of mandatory benefits include: physician services, lab and x-ray services, nursing facility services for those 21 years and older, and midwife services. While considered optional, these services are no less essential for optimum patient care. These optional benefits include diagnostic screening, preventive and rehabilitation services, prosthetic devices, and specialist medical and remedial care. They also include some "optional" long-term care benefits, including case management, personal care, and home health care services. Many current proposals to reduce Medicaid spending focus on reducing optional acute care benefits.

Children's Health Coverage

Congress expanded children's public coverage in 1997 by creating the State Children's Health Insurance Program (SCHIP) which, together with Medicaid, provides a vital source of coverage for millions of children. SCHIP provides health coverage to low-income children who live in families with income or assets above Medicaid eligibility levels, yet whose parents cannot afford to purchase private insurance. In contrast to Medicaid, however, SCHIP's federal contribution is not an open-ended entitlement, but is capped (as a block grant) at $40 billion over 10 years.

SCHIP covers roughly 4 million children while Medicaid covers over 25 million children. Almost half of African American children and over a third of Latino children are covered by publicly funded insurance, compared to less than one-fifth of white children.[8] Evidence suggests that children insured through Medicaid or SCHIP are actually more likely to obtain medical care, preventive care, and dental care than similar low-income children with private insurance.[9] Publicly funded insurance programs can provide targeted care to children who might be underserved by traditional private insurance plans, including racial and ethnic minorities. For instance, current Medicaid regulations restrict states from introducing cost-sharing practices—such as requiring premiums, copayments and deductibles—that might discourage parents from providing their children with needed medical care. Parents whose children are privately insured, however, are more likely to face these sorts of financial barriers, possibly explaining the lower rate of medical use among low-income children with private coverage.

Uninsured children from minority families stand to benefit the most from enrolling in Medicaid or SCHIP. According to an extensive survey of children in New York's SCHIP program, African American and Hispanic children showed improved access, continuity, and quality of care following their enrollment in the program. In some cases, enrollment in SCHIP was followed by an almost complete reduction in racial and ethnic disparities in access to health care, including having a usual source of care.[10]

Given this evidence, expanding publicly funded health insurance programs by increasing enrollment in Medicaid and SCHIP offers an effective way to improve the health of minority children and reduce racial and ethnic health disparities.

Medicaid's Role in Expanding Access and Eliminating Health Disparities

> ***No single factor contributes more to disparities in health and health care than inadequate access to health care.*** [10]

Ensuring access to health care is critical to closing the gap between racial and ethnic minorities and whites in this country. Of the 45.8 million uninsured in 2004, over half were from communities of color: 13.7 million were Latinos, 7.2 million were African Americans, and 2.1 million were Asian Americans.[11] Without Medicaid, millions of Americans would join the ranks of the uninsured and the number of uninsured minorities would undoubtedly be higher. Because Medicaid provides crucial access to health care for millions of racial and ethnic minorities, any proposals to reduce or eliminate this vital program at either the state or the federal level will worsen existing health disparities and further widen the gap between minorities and whites.

> *"Medicaid extends access to care for millions of racial and ethnic minorities who otherwise would be uninsured. Cuts to the Medicaid program, therefore, will reduce access to health care and only exacerbate racial and ethnic disparities in health and in health care."*
>
> Congresswoman Donna M. Christensen, Chair of the Congressional Black Caucus Health Braintrust [4]

Only if Medicaid is preserved and expanded can it continue to serve as a safety net that provides timely access to health care for the nation's most vulnerable populations. Medicaid provides health care to many different groups, including individuals living in underserved and rural areas, low-income pregnant women, and those living with HIV/AIDS[12], a large proportion of which are racial and ethnic minorities However, several recent proposals would have a negative impact on communities of color, meaning that the health care of millions of Americans could be jeopardized, and racial and ethnic disparities in access, and consequently health outcomes, would be exacerbated.

Emerging Issues and Key Policy Concerns

While the Medicaid program has been a stable and reliable source of health care coverage for 40 years, recent debates have emerged about how to restructure and scale back the program. At the federal level, conversations are focused on ensuring financial accountability and future sustainability, as well as finding balance between the roles of the states and the federal government. As a result, much more responsibility is being put on the states that are requiring them to make very drastic and often devastating decisions that impact their Medicaid beneficiaries and state economies. States are still experiencing budget constraints that are forcing them to think of innovative ways to reduce their budget shortfalls—or at the very least dampen recent fiscal blows—with assistance from the federal government. These issues have created a challenging climate for advocates, with ample opportunity for community leaders to be engaged and active in current health policy debates.

The following sections provide a brief discussion of some of the most pressing issues and describe their impact on racial and ethnic minorities.

The 2005 Medicaid Commission

Because of the continuing budget debate among the state and federal government, the current Administration appointed a bipartisan committee to discuss the future of the Medicaid program. This commission, which has been debated since its inception, has been characterized as lacking credibility. Some argue that the commission was created to decide how to cut $10 billion dollars from the Medicaid program, rather than to discuss whether or not the cuts should be made in the first place. In fact, the agenda for the first commission meeting, which was held on July 27, 2005, included "options to achieve $10 billion in scorable Medicaid savings over five years while at the same time make progress toward meaningful longer-term program changes to better serve beneficiaries." Since then, commission meetings have focused on several challenges the Medicaid program is facing, such as quality of care, health information technology, the eligible population, long-term care, acute care delivery systems, fraud and abuse, and financing. Going forward, the commission will continue focusing on long-term care issues, improving the quality of care, and acute and preventive care, as well as system-wide administration, including financing issues. According to the Commission work plan, this includes state waiver reform.

Advocates will need to pay close attention to the recommendations of the commission as part of their effort to stay abreast of important health policy developments. In fact, it has been proposed that the Medicaid Commission meetings take place outside of Washington, DC, which would enable local community members to participate in these important meetings.

Hurricane Katrina and Its Aftermath

No one can ignore the disastrous effects Hurricane Katrina has had on Louisiana, Alabama, and Mississippi. Families were separated, jobs, homes, and lives were lost, and dreams were shattered. Often overlooked in the past, this hurricane exposed the extremely poor economic and health conditions that have long existed in the Gulf region. Prior to the storm, low-income minority residents of the Gulf region, especially Louisiana, suffered from a higher prevalence of many diseases such as diabetes and hypertension. For example, 11.9 percent of African Americans in Louisiana have diabetes, compared with 7.2 percent of whites, and approximately 15.8 percent of those who lived in households with income of less than $15,000 per year had diabetes[13]. Health officials predicted that most of the storm-related deaths resulted from complications that arose when individuals were not given access to needed medical care, rather than from drowning or trauma. Individuals with chronic illnesses, such as diabetes and hypertension, experienced massive disruptions in their health care and were unable to access necessary prescriptions and medical services. According to some health officials, health disparities that existed before the storm will only be exacerbated in the wake of the storm.[14] Individuals in the affected areas—the majority of whom are low-income African Americans— were in poorer health and had less access to medical care before the storm. Hurricane Katrina widened the gap between the "haves" and the "have-nots" even more.

As of late November 2005, Congress had not passed any type of Medicaid relief package for the survivors of Hurricane Katrina. Although the Senate did include some health relief provisions in their proposed budget package, these measures fell far short of what is needed. However, on November 2, 2005 all 42 members of the Congressional Black Caucus introduced H.R. 4197 (Hurricane Katrina Recovery, Reclamation, Restoration, Reconstruction and Reunion Act of 2005). This bill has two primary objectives: 1) to fully restore the Gulf Coast and 2) to see that all residents of the region are reunited with their families. H.R. 4197 contains a health provision that calls for assistance in closing disparities in health access and outcome that exist between racial and ethnic minorities and whites by providing Medicaid coverage for every survivor whose income is less than 100 percent of the federal poverty level. In order to fully recover from this terrible circumstance, hurricane survivors and the health care providers who are caring for them need to receive the health care and financial compensation they need as soon as possible.

Medicaid Waivers

The Department of Health and Human Services (HHS) has longstanding authorization under Section 1115 of the Social Security Act to waive provisions of the Medicaid law. States can apply for Section 1115 waivers, which allow them to operate their Medicaid programs outside of federal guidelines. In the past, states have used Section 1115 waivers to require beneficiaries to enroll in managed care, to expand coverage to people not otherwise eligible for Medicaid or SCHIP (the State Children's Health Insurance Program), and, in some cases, to change the benefits and cost-sharing allowed by the program. What's even worse, some of the states that have proposed the most disastrous waivers, such as South Carolina and Florida, have very large proportions of racial and ethnic minorities enrolled in Medicaid. Any restructuring that is accomplished through state Medicaid waivers will no doubt have a large impact on the health and well-being of the state's communities of color.

In August 2001, the Bush Administration announced a new approach to Section 1115 waivers called the Health Insurance Flexibility and Accountability (HIFA) Initiative. Because HIFA allows states to reduce coverage for people currently eligible for Medicaid, allows states to use waivers to undermine important beneficiary protections in the Medicaid program.

State Medicaid Cuts

The extreme fiscal challenges states across the country have had to deal with in recent years have left state lawmakers with few options regarding where to turn for financial relief. Unfortunately, many have chosen to cut benefits or beneficiaries (or both) from their Medicaid programs, leaving Medicaid enrollees to join the ranks of the uninsured.

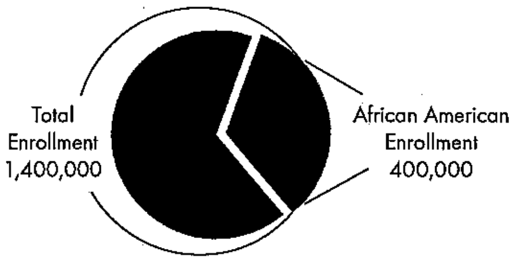
Two states that have made the most drastic Medicaid cuts in recent times are Missouri and Tennessee. An estimated 60,000 parents and 15,000 seniors with disabilities will lose coverage in Missouri. The situation in Tennessee is even worse. There, the recent cuts initiated by Tennessee's governor were actually the largest cuts in the program's 40-year history. More than 300,000 enrollees in TennCare, the state's Medicaid program, were to lose coverage for medical services and prescription drugs under the governor's original proposal. Currently, approximately 200,000 enrollees have been left with no medical or prescription drug coverage, and nearly 400,000 others are facing other benefit limits that are already costing them their health and lives.

These state efforts to control costs have left racial and ethnic minorities in the extremely difficult position of trying to find affordable health care in the midst of historic Medicaid coverage reductions. In Tennessee, African Americans in particular have been affected by reductions in the state's Medicaid program. While African Americans represent 16 percent of the total Tennessee population, prior to the 2005 TennCare cuts, they represented 33 percent of TennCare enrollees. In fact, TennCare provided coverage to two in every five African Americans in the state.[15] Now beneficiaries in Tennessee—like those in many other states (such as Florida, Mississippi, and Missouri)—will have to seek other sources of care. Many will turn to sources such as hospital emergency rooms, where the costs will be much higher.

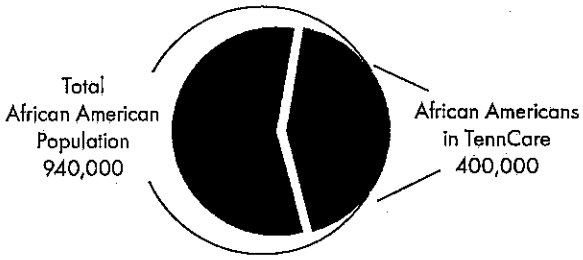
Figure 2:

TennCare and African Americans

Nearly 1 out of 3 TennCare Enrollees are African American



2 out of 5 African American Tennesseans are enrolled in TennCare



Source: Families USA, *The TennCare Waiver and African Americans: The Truth Behind the Rhetoric* (Washington: Families USA, September 2004).

Cuts to Optional Benefits

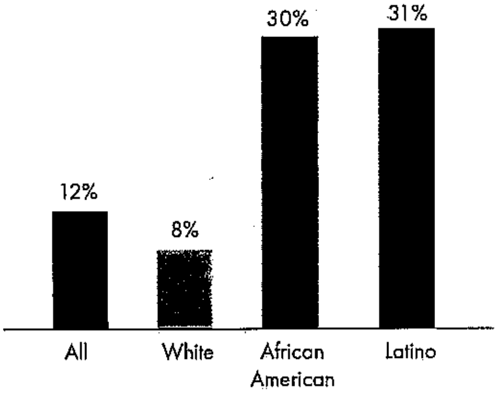
Racial and ethnic minorities are disproportionately represented among individuals that require "optional" benefits.[16] For example, numerous studies show that racial and ethnic minorities are disproportionately more likely to have chronic conditions that require specialty and long-term care—services that currently are considered "optional" benefits but could be taken away due to budget constraints. This is highly significant, since minorities traditionally have had less access to specialty health care, such as cardiac care and diagnostic and screening services. For example, Latino, Asian/Pacific Islander, African American, and American Indian/Alaska Native women are less likely to be screened for breast cancer than are non-Hispanic whites.[17] Any reduction in "optional" benefits within state Medicaid programs will have a tremendous impact on the health and welfare of large minority populations by diminishing access to regular and adequate health services, thus exacerbating racial and ethnic health disparities.[18]

The Medicare Modernization Act (MMA) and Implications for Dual Eligibles

Beginning in January 2006, full dual eligibles,[19] which currently comprise 6.2 million beneficiaries, will receive their prescription drug coverage through the new Medicare Part D drug benefit rather than through Medicaid. Part D will have two components—a basic benefit and an additional subsidy for low-income beneficiaries. Dual eligibles will need to enroll in both the new Medicare Part D prescription drug benefit and the low-income subsidy in order to maintain their prescription drug coverage.

Figure 3:

Percent of Americans 65 and Older Who Receive their Prescription Drug Coverage Through Medicaid, by Race/Ethnicity, 2002



Source: Kaiser Family Foundation, *A Profile of African Americans, Latinos, and Whites with Medicare: Implications for Outreach Efforts for the New Drug Benefit* (Washington: Kaiser Family Foundation, November 2005).

Implementing this new law will prove challenging, since it is important to ensure that all beneficiaries are well informed about upcoming changes and don't experience any gaps in coverage. The new law also presents states with new fiscal challenges. One such challenge is the "clawback" provision, which requires all states to pay back to the federal government a substantial portion of what they would have saved on Medicaid prescription drug coverage. Protecting other Medicaid benefits, such as long-term care, for dual eligibles will also be essential to maintaining the good health and well-being of our nation's low-income beneficiaries.

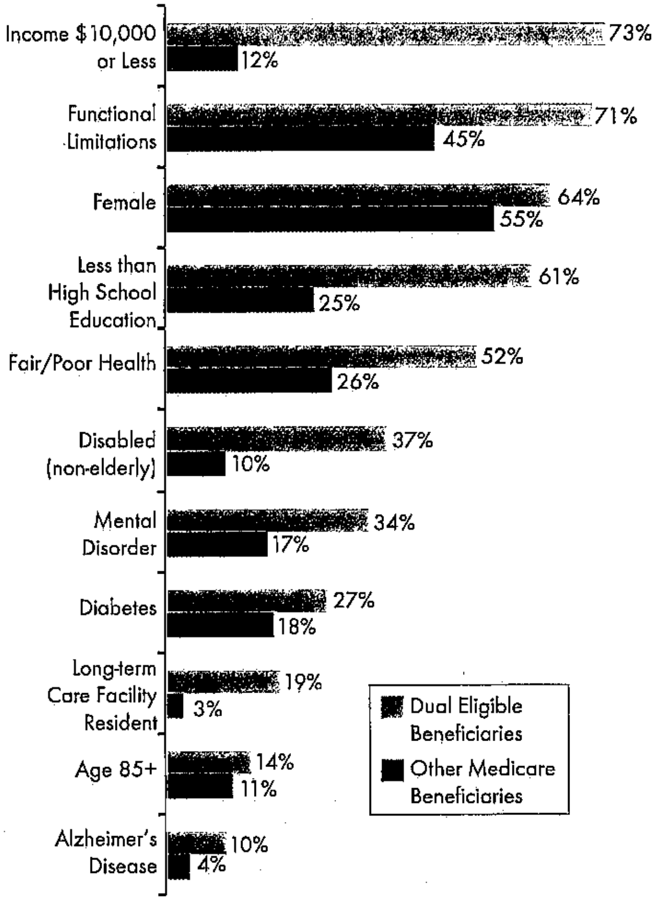
Aside from MMA implementation issues, there are other pre-existing concerns about health coverage for dual eligibles that will only complicate implementation of the new prescription drug benefit. Compared to other Medicare beneficiaries, dual eligibles are usually in fair or poor health, are non-elderly, are permanently disabled, are very poor, and live in long-term care facilities.[20] The multiple medical conditions of dual eligibles often mean that they require more health care services than others enrolled in Medicare. In fact, their health care costs are double those of other Medicare beneficiaries.[21]

The MMA also has particular importance for racial and ethnic minorities, since a significant proportion currently rely on Medicaid for their drug coverage. In fact, in 2002, 31 percent of Latino seniors relied on Medicaid to provide prescription drug coverage, as did 30 percent of African Americans, compared to only 8 percent of whites.[22]

November 2005 marked the beginning of the sign-up period for the drug benefit, and it is already proving to be very confusing and overwhelming for seniors[23]. What's clear is that there is a specific need for outreach to racial and ethnic minority seniors, especially those with limited English proficiency.

Figure 4:

Comparison of Dual Eligible and Other Medicare Beneficiaries, 2002



7.0 Million Dual Eligible Medicare Beneficiares in 2002

Source: Kaiser FamilyFoundation, *Medicare Chartbook*, Third edition (Washington: Kaiser, Summer 2005).

Notes: Functional limitation is defined as presence of a limitation in instrumental activities of daily living (ADLs) or one or more limitation in activities of daily living (ADLs).

Total number of dual eligibles includes beneficiaries eligible for full Medicaid benefits, along with other low-income beneficiaries eligible for assistance with Medicare premiums and cost-sharing requirements (the Medicare Savings Program).

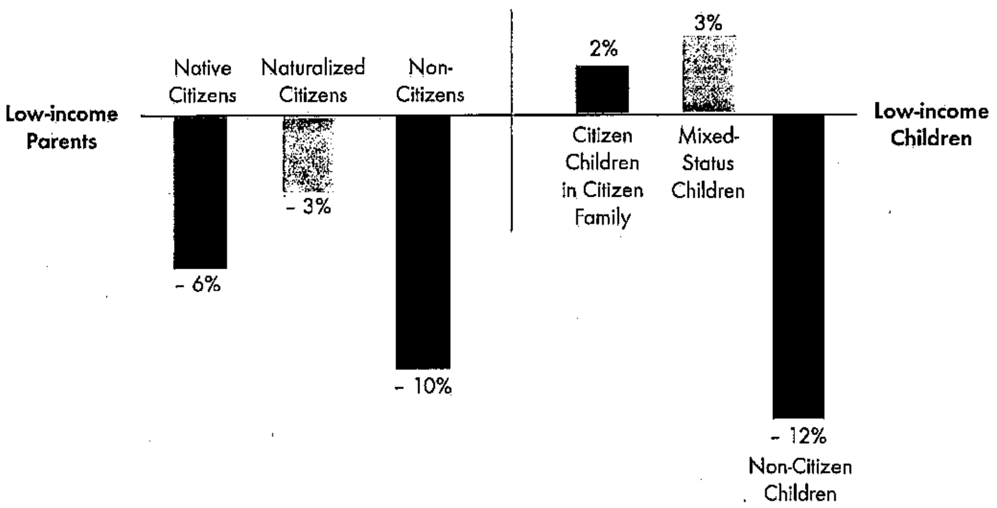
Medicaid Coverage for U.S. Immigrants

Since 1996, legal immigrants in low-income families have been barred from receiving Medicaid or SCHIP coverage during their first five years in this country (except for emergency care). This has left millions of legal, tax-paying individuals without a source of health care coverage. Before this law was passed, legally admitted immigrants were eligible for Medicaid and other benefits on the same terms as citizens. This and other discriminatory policy changes have caused a significant decline between 1995 and 2001 in the number of legal immigrant children and adults who receive Medicaid and SCHIP coverage. In fact, low-income, non-citizen enrollment in Medicaid and SCHIP has decreased much more rapidly than citizen enrollment. For children, non-citizen enrollment in Medicaid and SCHIP declined by 12 percent—versus an increase of 2 percent for citizen children—during the same period. Non-citizen enrollment for adults has also decreased, but not as rapidly as it has for non-citizen children.[24]

In 2003, a bill referred to as the Legal Immigrant Children's Health Improvement Act of 2003 (ICHIA) was introduced in Congress. This bill seeks to amend titles XIX and XXI of the Social Security Act to permit states to cover children and pregnant women who are legal immigrants under Medicaid and SCHIP. Unfortunately, this act has not been passed despite the support and hard work of health care and immigrant advocacy groups.

Figure 5:

Percentage Point Change in Medicaid Coverage for Low-Income Children and Parents, 1995-2001



Source: Shawn Fremstad and Laura Cox, *Covering New Americans: A Review of Federal and State Policies Related to Immigrants' Eligibility and Access to Publicly Funded Health Insurance* (Washington: Kaiser Family Foundation, 2004).

Conclusion

Although Medicaid has proven to be an excellent source of increasing access to health care among racial and ethnic minorities for more than four decades, within the past few years, budget debates and state fiscal crisis have created a climate of major debates about how to restructure and scale back the safety net program. States have put forth and implemented Medicaid waivers, which have reduced benefits to enrollees, or, in some instances, cut thousands of beneficiaries out of the program leaving them without any place to go for health care. Recently, on the federal level, a Medicaid Commission has been created to come up with ways to restructure the program on the federal level that may change the integrity of the program forever.

These emerging issues have presented unique ways that community leaders can get involved and engage their communities to be involved in the policy shaping debate within their local community, in their state, and in their country. Community leaders have a unique role to play in helping shape the lives of their community members by keeping abreast of recent health policy proposals and informing their constituents. Whether on the defense, or offense, there is a dier need for leaders to step up and get involved in preserving Medicaid for not only the present generation, but for the future generations to come.

Endnotes

[1] Kaiser Commission on Medicaid and the Uninsured, *Medicaid: A Primer* (Washington: Kaiser Family Foundation, July 2005).

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[14] Ibid.

[15] Families USA, *The TennCare Waiver and African Americans: The Truth Behind the Rhetoric* (Washington: Families USA, September 2004).

[16] Families USA, *Cut Medicaid—Increase Health Disparities: How Cuts to "Optional" Beneficiaries Will Affect Minority Health* (Washington: Families USA, February 2005).

[17] Marsha Lillie-Blanton, Osula Rushing, and Sonia Ruiz, *Key Facts: Race, Ethnicity and Medical Care, Update* (Washington: Kaiser Family Foundation, June 2003).

[18] Families USA, *Cut Medicaid—Increase Health Disparities: How Cuts to "Optional" Beneficiaries Will Affect Minority Health* (Washington: Families USA, February 2005).

[19] Medicaid dual eligibles are individuals who are covered by both Medicaid and Medicare.

[20] Juliette Cubanski, Molly Voris, Michelle Kitchman, et al., *Medicare Chartbook, Third Edition* (Washington: Kaiser Family Foundation, Summer 2005).

[21] Kaiser Commission on Medicaid and the Uninsured, *Dual Eligibles: Medicaid's Role for Low-Income Medicare Beneficiaries* (Washington: Kaiser Family Foundation, July 2005).

[22] Kaiser Family Foundation, *A Profile of African Americans, Latinos, and Whites with Medicare: Implications for Outreach Efforts for the New Drug Benefit* (Washington: Kaiser Family Foundation, November 2005).

[23] Kaiser Family Foundation, *The Medicare Drug Benefit: Beneficiary Perspectives Just Before Implementation* (Washington: Kaiser Family Foundation, November 2005).

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For more information on Families USA's Minority Health Initiatives,
contact Rea Pañares, Director of Minority Health Initiatives
or Briana Webster-Patterson, Program Manager at
minorityhealth@familiesusa.org or 202-628-3030.

Making
Public Programs
Work for
Communities
of Color

◆

An Action
Kit for
Community
Leaders

◆

January 2006

Medicare:
Improving Health for a Growing Minority Population

Medicare Overview

Medicare provides health insurance to nearly 42 million Americans, the vast majority of whom are seniors over age 65. Individuals are automatically considered eligible for Medicare if they or their spouse are eligible for Social Security payments and have made payroll tax contributions for at least 10 years. Medicare also covers roughly 6.3 million people under age 65 who have permanent disabilities and who qualify for Social Security Disability Insurance (SSDI).

Medicare's Role in Communities of Color

Today, Medicare covers 3.9 million African Americans, 3.1 million Latinos, and 1.7 million other racial and ethnic minorities, including Asian/Pacific Islanders and American Indians/Alaska Natives. Overall, communities of color constitute slightly more than 20 percent of the entire Medicare population.[1] This number, however, will grow dramatically as the minority population in the U.S. continues to age. It is estimated that by 2030, 26 percent of Medicare beneficiaries age 65 and older will be racial and ethnic minorities.[2] Furthermore, according to the most recent Census projections, racial and ethnic minorities are expected to make up almost 40 percent of the elderly population in 2050.[3]

Medicare Structure

Medicare was enacted in 1965 as a federal entitlement program for seniors. Unlike other public health insurance programs such as Medicaid, there are no income requirements to qualify for Medicare. Almost anyone who qualifies for Social Security payments—including most seniors over 65 and a number of younger individuals with permanent disabilities—can enroll in Medicare regardless of income. Today, the program consists of four distinct "parts," each of which offers different benefits and covers different types of medical services, as described below.

- **Medicare Part A (Hospital Insurance):** Almost anyone who has more than 10 years of Medicare-covered employment is entitled to Medicare Part A at no cost after they retire at age 65. Others can enroll, but they must pay a monthly premium that is calculated based on the number of years they made payroll tax contributions.

Medicare Part A helps pay for:

- hospital stays,
- skilled nursing home care,
- home health care, and
- hospice care.

Beneficiaries must pay a copayment or deductible when obtaining many of these services. The types of care beneficiaries need must also meet certain coverage criteria. For example, for hospital stays, the patient must need acute care that can be provided *only* in a hospital. In addition, the patient must pay a deductible ($952 in 2006) and copayments for stays of longer than 60 days ($238/day for days 61-90 and $476/day for days 91-150).

- **Medicare Part B (Medical Insurance):** Unlike Part A, Medicare beneficiaries are not automatically enrolled in Part B. Instead, they must choose to enroll and pay the monthly premium ($88.50 in 2006). However, 95 percent of eligible beneficiaries choose to enroll in the program, which pays for physician services, outpatient diagnostic tests, and certain medical supplies and equipment.

Similar to Part A, the medical insurance portion of Medicare also requires beneficiaries to pay deductibles and copayments for the services they use. In 2006, the annual deductible is $124, and the copayment is generally 20 percent of Medicare's approved charge for the service.

It is important to note that Part B is not a comprehensive benefit package. For example, although Medicare covers many preventive services, including mammograms, diabetes screening tests, and prostate cancer screening tests, Part B does **not** pay for:

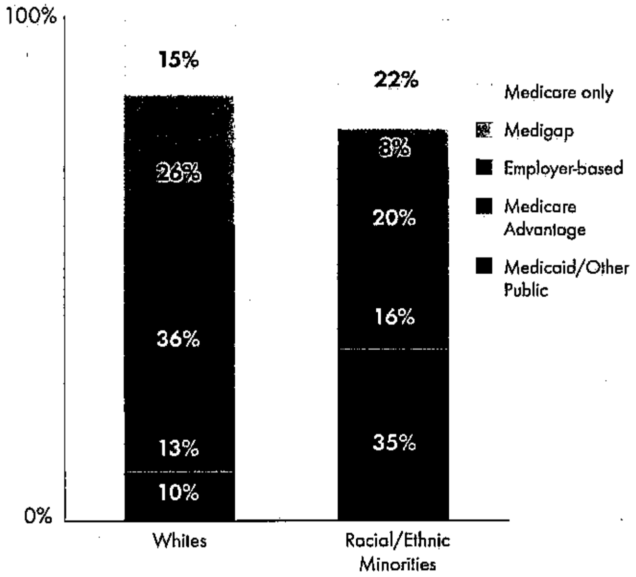
- routine checkups,
- eyeglasses or hearing aids,
- routine foot care, or
- most dental care.

Because there are notable gaps in coverage, many elderly individuals rely on additional insurance options to fill these gaps. Most beneficiaries receive supplemental coverage through private Medigap or employer-sponsored plans. Those with poverty-level incomes often can enroll in Medicaid, the public health insurance program for those with low incomes that provides much more comprehensive benefits than traditional Medicare, and with less cost-sharing.

The gaps in Medicare coverage hit racial and ethnic minorities the hardest. While only 12 percent of all beneficiaries rely entirely on Medicare for health insurance coverage, the percentage doubles for racial and ethnic minorities; for 23 percent of African Americans and 25 percent of Latinos, Medicare is their only source of coverage. What's more, African American and Latino beneficiaries are roughly three times as likely as whites to use Medicaid to supplement Medicare, making them among the most vulnerable Medicare beneficiaries.[4]

Figure 1:

Sources of Supplemental Coverage Among Medicare Beneficiaries, 2002



Source: America's Health Insurance Plans, *Low-Income and Minority Beneficiaries in Medicare Advantage Plans, 2002* (Washington: America's Health Insurance Plans, May 2005). Based on an analysis of the Medicare Current Beneficiary Survey Access to Care files, 2002 (CMS).

- **Medicare Part C (Managed Care Plans):** Also called "Medicare Advantage" (formerly Medicare+Choice), Medicare Part C was designed to restructure the options available to Medicare beneficiaries. Historically, these private plans (primarily HMOs) have provided Part A and B benefits to enrollees. Wth the introduction of Part D in 2006, the plans also have the option of including standard prescription drug coverage as part of their benefits package. Today, approximately 12 percent of beneficiaries are enrolled in Medicare Advantage plans.[5] The remaining 88 percent have traditional fee-for-service Medicare coverage in which Medicare pays for services as the costs are incurred by beneficiaries. Medicare Advantage is expected to play an increasingly important role in the next several years, with 16 to 30 percent of beneficiaries expected to enroll in such plans by 2013.[6]

- **Medicare Part D (Prescription Drug Benefit):** Beginning on January 1, 2006, beneficiaries who have enrolled in Part D have prescription drug coverage provided by private plans that contract with Medicare. Before this date, beneficiaries did not have access to prescription drugs through Medicare and either had to rely on other sources of coverage or had to pay all costs out of pocket. Like Part B, the drug benefit is optional for almost all Medicare beneficiaries, and it includes premiums and cost-sharing provisions. Those who wish to enroll must select either a stand-alone prescription drug plan (PDP) or a Medicare Advantage plan with a prescription drug benefit. Because Part D is still in its infancy, it is unclear how many beneficiaries have chosen to enroll and what impact the benefit has had on communities of color.

Medicare's Potential to Reduce Racial and Ethnic Health Disparities

As the single largest purchaser of health care in the U.S., Medicare has tremendous potential to reduce racial and ethnic disparities in health. In fact, the origins of the Medicare program are rooted in a federal effort to improve health care within the African-American community. By law, hospitals were required to comply with the Civil Rights Act of 1964 in order to receive payments for Medicare patients, a move that catalyzed the desegregation of hospitals during the 1960s. In the 40 years since then, however, an overwhelming body of evidence has shown that racial and ethnic minorities continue to receive lower quality care and suffer from worse health outcomes compared to whites. Because Medicare provides coverage for almost all racial and ethnic minorities over 65—as well as many individuals with permanent disabilities, regardless of age—it can play a powerful role in closing the health gaps that exist between minority populations and whites.

Despite having near-universal coverage for the elderly population under Medicare, numerous studies have shown that racial and ethnic elderly minorities are more likely to suffer from a greater number of illnesses and to report being in fair or poor health.[7] For example, according to a 2002 survey of Medicare beneficiaries:

- 30 percent of African Americans and 28 percent of Latinos on Medicare had diabetes, compared to 18 percent of non-Latino whites.
- 71 percent of African Americans on Medicare had hypertension, compared to 57 percent of Latinos and 59 percent of non-Latino whites.
- 32 percent of Latinos on Medicare had cognitive or mental impairments, compared to 25 of non-Latino whites and 20 percent of African Americans.[8]

These disparities may be due to the fact that compared to their white peers, African American and Latino beneficiaries are much less likely to have had insurance coverage before enrolling in Medicare. By the time they become eligible for and enroll in Medicare, certain conditions may have progressed and worsened.

Disparities in health care persist among Medicare beneficiaries despite the fact that the same standard Medicare benefits are supposed to be provided to all beneficiaries (unlike private health insurance plans and state Medicaid programs). While some evidence suggests that disparities might have narrowed among elderly Medicare beneficiaries in recent years, treatment gaps nevertheless persist.[9] For example:

- Less than half of African Americans and Latinos over 65 received a flu shot, and only about a third received a pneumonia vaccination in 2002. This compares with 68 percent of elderly whites who received the flu shot and 59 percent who received the pneumonia vaccination.[10]

- Elderly Latinos with Medicare coverage were roughly one-third as likely as whites the same age to undergo total hip replacement surgery, an operation that can reduce pain and improve physical function for patients with severe osteoarthritis.[11]
- Compared to white Medicare patients, elderly African Americans with early stage lung cancer were less likely to undergo surgery and more likely to die within five years of diagnosis.[12]
- Elderly African American, Latino, and Asian cancer patients living in nursing homes were less likely to receive pain treatment than their white peers.[13]
- Elderly African Americans, Latinos, and Asian and Pacific Islanders were more likely than elderly whites to suffer from infections that were caused by medical care.[14]

While modest efforts have emerged over the last few years to address these inequalities—for example, beginning in late 2003, health care plans started to receive race and ethnicity data on their Medicare enrollees with the requirement that they conduct at least one project on disparities—quality improvement has been uneven at best.[15]

> ***"... among persons enrolled in Medicare ... there have been no meaningful, consistent reductions in the gaps in care between black enrollees and white enrollees."[16]***

More can and needs to be done to reduce health disparities among the Medicare population. Since the program already reaches more than 7 million racial and ethnic minorities—and this number is only expected to grow—Medicare is uniquely positioned to address the problem of health care disparities by ensuring that all beneficiaries have access to high-quality care.

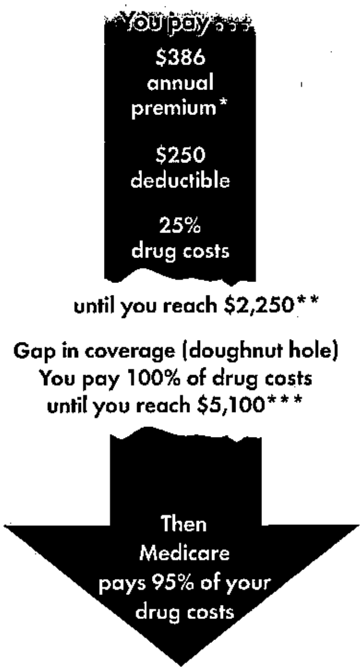
A Key Emerging Issue: The Prescription Drug Benefit

One of the most radical transformations to the Medicare program in its 40-year history took effect on January 1, 2006, with the implementation of the prescription drug benefit. Also called Medicare Part D, the benefit was enacted as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Beginning in November 2005, beneficiaries were given the option of enrolling in a private prescription drug plan or joining a Medicare Advantage plan that offered drug coverage.

Although the specific benefit design varies by plan and region, the standard benefit requires that Medicare enrollees pay a monthly premium, annual deductible, and copayment for their covered drugs. The standard benefit structure has three tiers of coverage: 1) partial coverage (which pays for 25 percent of the first $2,500 in drug costs); 2) no coverage (the coverage gap or so-called "doughnut hole," which is the $2,850 gap after the initial coverage limit when the beneficiary usually must pay all drug costs); and 3) catastrophic coverage (which covers 95 percent of all drug costs that exceed $5,100).

In 2006, the average premium for a private drug plan is $32.20. The maximum annual deductible is $250, after which point Medicare pays 25 percent of prescription drug costs until the beneficiary reaches the "doughnut hole." After the beneficiary pays a total of $3,600 in out-of-pocket drug expenses, Medicare pays 95 percent of all drug costs above the catastrophic threshold ($5,100 in 2006).[17]

Figure 2:
Standard Medicare Prescription Drug Benefit, 2006



* Annual amount based on $32.20 national average monthly beneficiary premium (CMS, August 2005).

** Equivalent to $750 in out-of-pocket spending.

*** Equivalent to $3,600 in out-of-pocket spending.

Medicare beneficiaries have an overwhelming number of choices to make when selecting a prescription drug plan. Most states offer between 40 and 49 plans, with a few offering more than 50. Each plan also has its own benefit structure—premiums, deductibles, drug prices, and the list of covered drugs can differ significantly from plan to plan. Beneficiaries who decide to enroll must choose a plan by May 15, 2006 or face a potentially substantial penalty for late enrollment.

While millions of Americans in Medicare now have to decide if the prescription drug benefit is right for them, that decision looms even larger for many racial and ethnic minorities. Among Medicare beneficiaries, 43 percent of African Americans and 37 percent of Latinos went without drug coverage for part or all of 2002. Many of them will have access to affordable drug coverage for the first time through the Medicare drug benefit.[18] The benefit structure, however, is extraordinarily complex. It is even more confusing for those who qualify for low-income assistance, a population that includes nearly two-thirds of all African-American and Latino Medicare beneficiaries.[19] Outreach is critically important for this population so that they understand the implications of the new benefit and how it will affect them if they enroll.

The following sections provide a brief discussion of some of the most pressing areas of concern with implementation of the Medicare prescription drug benefit and its impact on communities of color.

- Dual Eligibles

  More than 6 million Medicare beneficiaries have extremely low incomes that qualify them for Medicaid, the nation's public health insurance program for the poor. These individuals are often referred to as "full dual eligibles" because they qualify for both programs, meaning they have access to the additional benefits provided through Medicaid, such as long-term care. Medicaid also pays Medicare's premiums and cost-sharing for the dual eligible population.

  Racial and ethnic minorities make up a disproportionate percentage of dual eligibles. In fact, African Americans and Latinos are roughly six times more likely than whites to be dual eligibles.[20] Because of their disproportionate representation, any effort to reduce racial and ethnic disparities in health must also address the needs of this population. For example, the introduction of prescription drug coverage under Medicare Part D has important implications for Medicare beneficiaries who are also enrolled in Medicaid. More than a third of all African Americans and Latinos in Medicare received prescription drug coverage through Medicaid before January 2006, compared to one out of 10 white beneficiaries. As of January 1, 2006, however, Medicaid no longer pays for prescription drugs for dual eligibles. Instead, dual eligibles now must be enrolled in a private drug plan financed through Part D. Despite the fact that this change affects more than 2 million Medicare beneficiaries from communities of color, there has been relatively little outreach to minorities regarding the change in benefit.

- Low-income Beneficiaries

  Racial and ethnic minorities are disproportionately represented among low-income Medicare beneficiaries: 64 percent of African American and 62 percent of Latino beneficiaries have incomes below 150 percent of the federal poverty level ($19,245 for a family of two in 2005), compared to 32 percent of white beneficiaries.[21] Many of these individuals qualify for subsidies that will help them pay for premiums and cost-sharing, depending on their incomes and assets (see Table 1 on page 8). However, of the 8.1 million beneficiaries eligible for the low-income subsidy *who are not dual eligibles*, only 4.6 million are expected to receive the subsidy in 2006.[22] Many might not realize that they are eligible or, if they do think they are eligible, they might not know how to apply.

Table 1:

Medicare Prescription Drug Benefit Subsidies for Low-Income Beneficiaries, 2006

Low-Income Subsidy Level	Monthly Premium	Annual Deductible	Copayments
Full-benefit dual eligibles Income <100% of poverty ($9,570/individual; $12,830/couple)	$0	$0	$1/generic $3/brand-name; no copays after total drug spending reaches $5,100
Full-benefit dual eligibles Income ≥ 100% of poverty	$0	$0	$2/generic $5/brand-name; no copays after total drug spending reaches $5,100
Institutionalized full-benefit dual eligibles	$0	$0	No copays
Individuals with income <135% of poverty ($12,920/individual; $17,321/couple) and assets <$6,000/individual; $9,000/couple)	$0	$0	$2/generic $5/brand-name; no copays after total drug spending reaches $5,100
Individuals with income 135%-150% of poverty ($12,920-$14,355/individual; $17,321-$19,425/couple) and assets <$10,000/individual; $20,000/couple	sliding scale up to $32.50*	$50	15% of total costs up to 5,100; $2/eneric $5/brand-name thereafter

Note: *32.50 is the national monthly Part D base beneficiary premium for 2006. Poverty level dollar amounts are for 2005. Additional assets of up to $1,500/individual and $3,000/couple for funeral or burial expenses are permitted.

Source: Kaiser Family Foundation summary of Medicare prescription drug benefit low-income subsidies in 2006.

- Education and Outreach

  Without appropriate outreach to Medicare beneficiaries, particularly those from communities of color, the implementation of the prescription drug benefit will be a missed opportunity to reduce health disparities among the Medicare population. Unfortunately, in October 2005, more than 60 percent of seniors admitted that they did not understand the Medicare drug benefit well, and only 14 percent reported that they understood the benefit very well.[23]

  While the availability of Part D has become familiar to Americans, specific details about the benefit are available primarily through an online government-run Web site at www.medicare.gov. The site, which allows users to view detailed information about available drug plans, is designed to make choosing a plan simpler by offering side-by-side price comparisons. The Medicare Prescription Drug Plan Finder tool on the site even allows visitors to list the medications they are currently taking so that they can tailor their plan choices to their individual circumstances.

  The vast majority of seniors, however, do not use the Internet and probably never will see the tools available on the Web site. What's more, elderly African Americans are even less likely to use the Internet—according to a 2004 survey of seniors, only 11 percent of African Americans age 65 and over reported using the Internet, compared to 22 percent of non-Hispanic whites and 21 percent of English-speaking Hispanics.[24] As late as October 2005—one month before the sign-up period for Part D began—most Medicare beneficiaries said that they had never heard of www.medicare.gov, and barely one out of 20 reported that they had ever visited the site.[25]

Conclusion

Although racial and ethnic minorities in Medicare have access to the same coverage as whites, they continue to fare worse on measures of prevention, treatment, and overall health status. While much of the health gap can be attributed to disparities in income and education—factors that also have been shown to have a profound effect on health—the fact remains that Medicare can do more to improve health within communities of color.

The introduction of Medicare Part D in January presents a remarkable opportunity to address the problem of health disparities in minority communities. With increased attention being paid to the Medicare program, advocates and policymakers should seize the opportunity to focus attention on disparities while offering practical strategies to reduce them. The Part D benefit, for instance, provides significant financial assistance to low-income populations that could increase their access to prescription drugs. This assistance is particularly important to minorities who previously lacked drug coverage because of its high cost. Policymakers, advocates, and community leaders must make an organized effort to reach out to and educate communities of color about the drug benefit, particularly as the May 15 enrollment deadline rapidly approaches. Education efforts at both the national and community levels should include comprehensive and culturally sensitive materials that will reach populations that traditionally have been underserved by Medicare.

The Part D benefit has the potential to reduce disparities beyond expanding access to drug coverage. Currently, more than half of all beneficiaries who are eligible for Medicaid or other low-income assistance are not enrolled in these programs.[26] These programs help beneficiaries pay some or all of their Medicare premiums and deductibles, thus reducing two major barriers to access. By making a concentrated effort to inform minority groups about Medicare Part D and its associated low-income assistance, it is possible to further expand access to insurance coverage by encouraging eligible individuals to apply for help that is already available to them.

Because virtually all individuals over 65 are enrolled in Medicare—and because one out of five beneficiaries belongs to a racial or ethnic minority group—the Medicare program can use its significant stature as a federal insurance program to address the problem of health disparities. By reaching out to minority populations and making it much easier for low-income minorities to enroll in financial assistance programs, Medicare can begin to reduce the health gap among this population and pave the way for broader improvements.

Endnotes

[1] Kaiser Family Foundation, *A Profile of African Americans, Latinos, and Whites with Medicare: Implications for Outreach Efforts for the New Drug Benefit* (Washington: Kaiser Family Foundation, November 2005), available online at http://www.kff.org/minorityhealth/7435.cfm.

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QUICK FACTS: Disparities in Health

Disparities in Health: "Differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States."

Quick Facts on:

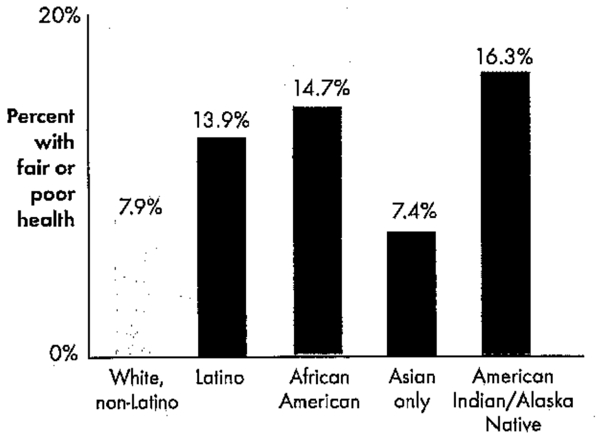
Overall Health

When viewed as a group, racial and ethnic minorities suffer from worse health compared to their white counterparts. For example:

- American Indians, African Americans, and Latinos are more likely to rate their health as fair or poor in comparison to whites (see Figure 1).[1]

Figure 1:

Fair or Poor Health, by Race/Ethnicity, 2003



Data: National Center for Health Statistics, National Health Interview Survey, 2000.

Source: Centers for Disease Conrol and Prevention, *Health, United States, 2005*, Table 60.

- Among adults, death rates for African Americans are approximately 55 percent higher than they are for whites.[2]
- Latinos are more likely to be employed in high-risk occupations than any other racial or ethnic group. For example, although they comprise only 14 percent of the population, Latinos account for 35 percent of all textile workers, 27 percent of building workers, 21 percent of construction workers, and 24 percent of all workers in the farming, forestry, and fishing industries.[3]
- In 2002, 71 percent of African Americans lived in counties that violated federal air pollution standards, compared with 58 percent of the white population.[4]
- African-American women have the highest death rates from heart disease, breast and lung cancer, stroke, and pregnancy among women of all racial and ethnic backgrounds.[5]
- Compared to the general U.S. population, American Indians are 638 percent more likely to suffer from alcoholism, 400 percent more likely to contract tuberculosis, 291 percent more likely to suffer from diabetes, 67 percent more likely to have pneumonia or influenza, and 20 percent more likely to suffer from heart disease.[6]
- The rate of Hepatitis B (HBV) in Asian Americans is more than two times the rate of HBV in whites (2.95 versus 1.31 cases per 100,000).[7]
- In 2001, Asian Americans and Pacific Islanders had the highest tuberculosis case rate of all racial and ethnic populations in the United States.[8]

Asthma

Racial and ethnic minorities are more likely to live in heavily polluted neighborhoods and work in high-risk occupations with lower air quality. Disparities in living and working conditions play a critical role in the incidence and burden of asthma in these populations. The effects of these conditions are evident in the adverse health outcomes experienced by children and adults in minority communities. For example:

- Although African Americans represent only 12.7 percent of the U.S. population, they account for 26 percent of all asthma deaths.[9]
- Age-adjusted asthma death rates are three times higher for African Americans than for whites.[10]

Cancer

Racial and ethnic minorities are not only more likely to be diagnosed with cancer, they are also more likely to receive less timely and effective treatment. Because of these disparities, cancer takes a greater toll on communities of color. For example:

- Cancer is the leading cause of death for Asians and Pacific Islanders, and it is the second leading cause of death among every other racial and ethnic minority group in the United States.[11]
- African-American men are 50 percent more likely to suffer from prostate cancer than white men, and they are more than twice as likely as white men to die as a result of the cancer.[12]
- Between 1982 and 1992, Vietnamese-American women had the highest age-adjusted rate of cervical cancer (43 per 100,000), more than five times the rate of non-Hispanic whites (7.5 per 100,000).[13]
- Lung cancer kills more African Americans and American Indians/Alaska Natives than any other type of cancer.[14]

Cardiovascular Disease

Minority populations suffer from cardiovascular disease at a higher rate and are more likely to die as a result. For example:

- In 2001, rates of death from heart disease were 30 percent higher among African Americans than among whites.[15]
- In 2001, death rates from stroke were 41 percent higher among African Americans than among whites.[16]
- Racial and ethnic minorities are more likely to posses the risk factors—such as obesity and high cholesterol—that lead to increased rates of cardiovascular disease.[17]

Diabetes

Diabetes strikes American Indian communities with far greater frequency and severity than any other racial or ethnic group. This has important implications for overall health: Individuals with diabetes face a much higher risk of heart disease, stroke, high blood pressure, and blindness. The disease disproportionately affects minorities and is one of many examples of disparities in health. For example:

- American Indians are more than twice as likely to suffer from diabetes as whites.[18]
- Diabetes is most prevalent among American Indians in the southeastern United States (27.8 percent) and southern Arizona (27.8 percent). Non-Hispanic blacks are also more likely to be affected by the disease than non-Hispanic whites (11.4 percent versus 8.4 percent).[19]

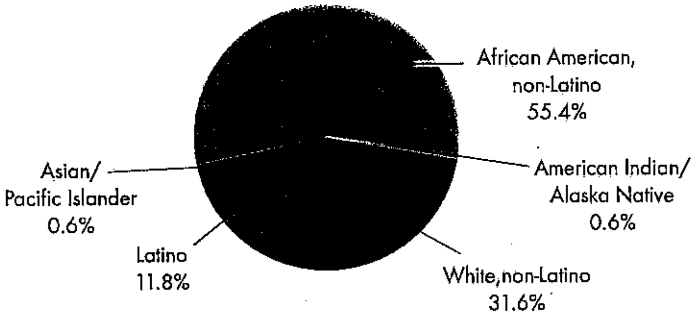
HIV/AIDS

HIV and AIDS pose a disproportionate threat to minority populations. For example:

- Although they made up only 26 percent of the U.S. population in 2001, African Americans and Latinos accounted for 67 percent of newly reported AIDS cases.[20]
- In 2003, HIV/AIDS was the leading cause of death for African-American women between 25 and 34 years of age. The rate of HIV diagnosis among African-American women was 25 times that of white women, and African-American men were eight times more likely than their white counterparts to be diagnosed with HIV.[21]

Figure 2:

Estimated Numbers of Diagnoses of HIV/AIDS by Race/Ethnicity, 2001



Source: Centers for Disease Control and Prevention, Cases of HIV Infection and AIDS in the United States, *HIV/AIDS Surveilance Report*, Vol. 14, Table 1.

Infant and Maternal Mortality

Infant mortality rates offer a vivid portrait of disparities in health. Even at birth, children from racial and ethnic minorities suffer worse health outcomes, including a notably higher rate of death. For example:

- Infant mortality is more than twice as high for African-American infants as it is for white, non-Hispanic infants (13.9 deaths per 1,000 live births versus 5.8 deaths per 1,000 live births).[22]
- The maternal mortality rate for African-American women is nearly five times the maternal mortality rate for white women.[23]
- American Indians and Alaska Natives have Sudden Infant Death Syndrome (SIDS) rates that are two times higher than the general U.S. population.[24]

Children

Children from racial and ethnic minority groups continue to lag behind their white peers on measures of health outcomes. Even among children of similar socioeconomic status, minority children fare worse overall. For example:

- Only 12 percent of white, non-Hispanic children are in less than very good or excellent health, compared to 25 percent of African-American children and 26 percent of Hispanic children.[25]
- African-American children are more than three times as likely as children of other races to develop sleep-disordered breathing.[26]

Endnotes

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QUICK FACTS: Disparities in Health Care

Disparities in Health Care: "Differences between two or more population groups in health care access, coverage, and quality of care not due to different health needs. This can include differences in preventive, diagnostic, and treatment services between population groups."

Quick Facts on:

Amputation

Differences in amputation rates reveal one of the many treatment disparities that exist between racial and ethnic minorities and whites, suggesting that minorities tend to receive less appropriate care than their white counterparts. For example:

- In general, African Americans and Latinos had higher rates of lower extremity amputation than non-Hispanic whites.[1]
- Among Medicare beneficiaries, the rate of amputation of all or part of the lower limb was 6.7 per 1,000 for African Americans and 1.9 per 1,000 for whites.[2]

Asthma Care

Asthma rates are disproportionately high among racial and ethnic minorities, particularly within the African-American community. Moreover, disparities also appear to exist in how asthma is treated in minority populations, with racial and ethnic minorities often receiving inadequate asthma care.

- Insured African Americans with asthma are more likely than insured whites to be hospitalized for asthma-related health conditions and are less likely to be treated by an asthma specialist.[3]
- African-American children are about three times more likely to be hospitalized for asthma than their white peers and about five times more likely to seek care at an emergency room.[4]
- Among families in which parents lack any post-secondary education and do not have access to a primary care physician, African-American and Latino children with asthma are more likely than white children to underuse routine medications such as anti-inflammatory agents.[5]

Cancer Care

In many instances, racial and ethnic minorities are less likely to receive adequate screening for specific types of cancer. This often results in diagnosis at a later stage for minority populations and a worse prognosis for survival. Even after diagnosis, racial and ethnic minorities with cancer frequently fail to receive as high quality care as their white counterparts.

- African-American and Latino men are less likely to be screened for prostate cancer and are at greater risk of being at a more advanced stage of prostate cancer at the point of diagnosis than are white men.[6]

- All racial and ethnic minority women over 40 years old are less likely than white women to have undergone a mammogram to screen for breast cancer.[7]
- Latino, Asian, and American Indian women are less likely to be screened for cervical and breast cancer than white and African-American women. Latino men are least likely to be screened for colorectal cancer compared to all other ethnic groups.[8]
- African-American Medicare patients with early stage lung cancer are half as likely to undergo surgery in comparison to whites. They also have lower five-year survival rates.[9]
- African-American, Latino, and Asian cancer patients were more likely than whites to receive no analgesic agents for daily pain management.[10]

Cardiovascular Care

Repeated studies have shown that racial and ethnic minorities receive, on average, worse cardiac care than whites. Perhaps because of these treatment disparities, cardiovascular disease has had a disproportionate impact on minority communities, particularly African Americans.

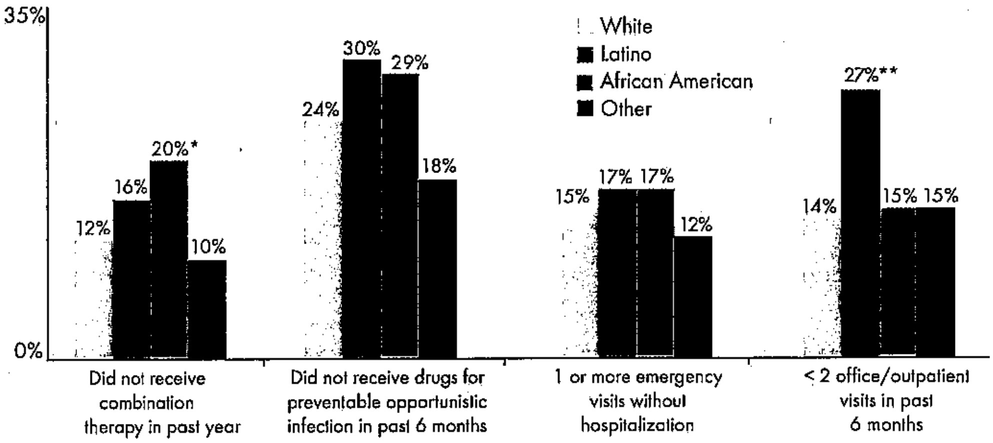
- Of 81 studies investigating racial and ethnic differences in cardiac care from 1984 to 2001, 68 studies (84 percent) found evidence suggesting that minorities received less appropriate care than their white counterparts.[11]
- Among the insured population, African Americans are less likely to undergo angiography than non-Hispanic whites, and African-American women are 40 percent less likely than whites to be recommended for cardiac catheterization.[12]
- African-American Medicare patients in California were less likely than whites to undergo catheterization, angioplasty, and bypass surgery, while Latino patients were less likely than whites to undergo catheterization and angioplasty.[13]
- In spite of their higher mortality and morbidity for cardiovascular disease, African Americans and Latinos are less likely to undergo treatment for their conditions and are especially less likely to receive high-technology cardiac procedures, such as cardiac catheterization and coronary revascularization.[14]

HIV Treatment

African Americans and Latinos make up the majority of HIV diagnoses in this country. Despite their overrepresentation among the HIV-positive population, however, racial and ethnic minorities continue to receive inferior treatment and care for the disease.

- African Americans and Latinos infected with HIV receive significantly less optimal health care compared to whites (see Figure 1).[15]
- African Americans with HIV are less likely to receive combination drug therapy, the accepted standard of care for the disease. Latinos with HIV are more likely than whites and African Americans to have had fewer than two outpatient visits in the past six months.[16]

Figure 1:
Health Services Use Among Persons with HIV/AIDS in Care, by Race/Ethnicity, 1998



* Results significantly different from whites ($p < .05$) after adjustment for CD4 count.

** Results significantly different from whites and African Americans ($p < .05$) after adjustment for CD4 count.

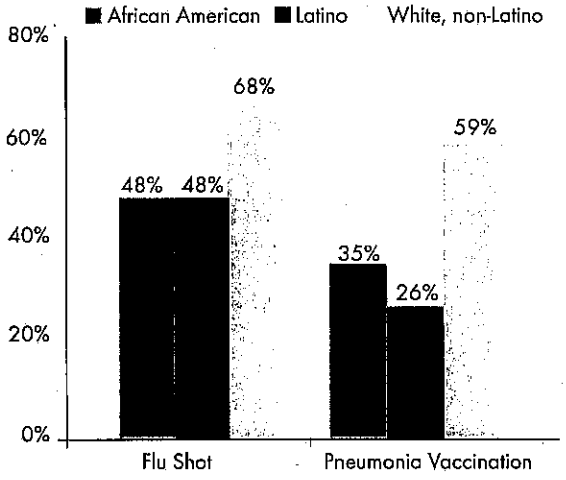
Source: Marsha Lillie-Blanton, Osula Evadne Rushing, and Sonia Ruiz, *Key Facts: Race, Ethnicity & Medical Care, Update June 2003* (Menlo Park, CA: Kaiser Family Foundation, 2003).

Immunizations

Preventive care is essential to ensuring good health outcomes. Racial and ethnic minorities, however, continue to lag behind their white peers in immunization rates, both in early childhood and later adulthood.

- In 2003, African-American children had the lowest rate of immunization, with 25 percent lacking one or more of the most current immunizations, compared to 21 percent of Latino children and 16 percent of white children.[17]
- Less than half of all African Americans over 65 received a flu shot, and only 35 percent received a pneumonia vaccination in 2002. Among Latinos, only 48 percent received a flu shot, and 26 percent received a pneumonia vaccination during the same time period. This compares with 68 percent of whites receiving the flu shot and 59 percent receiving the pneumonia vaccine.[18]

Figure 2:
Immunization Rate, by Race/Ethnicity, Age 65 and Over



Source: American Lung Association, *Lung Disease Data in Culturally Diverse Communities: 2005.*

Pain Management

The treatment of both acute and chronic pain varies between racial and ethnic groups. In general, minorities are less likely than whites to have their pain managed aggressively through the use of effective medications.

- Among children and adults hospitalized for serious limb fractures, Latinos receive the lowest average dose of pain medication of all racial or ethnic groups.[19]
- Among elderly nursing home residents with daily pain, African Americans were more likely than whites to receive no pain-relieving agent.[20]

Quality of Care

A thorough review of health quality data reveals that racial and ethnic minorities consistently receive lower-quality care than whites.

- Blacks had poorer quality of care than whites for about 60 percent of quality measures, including not receiving prenatal care and recommended childhood and adult immunizations.[21]
- Hispanics had poorer quality of care than non-Hispanic whites for about 40 percent of quality measures, including not receiving screening for cancer or cardiovascular risk factors.[22]
- American Indians and Alaska Natives had poorer quality of care than whites for about a quarter of quality measures, including lacking a usual source of care and having problems with patient-provider communication.[23]

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[5] Ibid.

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QUICK FACTS: Disparities in Access

Disparities in Access: "Differences between two or more population groups in rates of access to health care services and providers not due to differences in health needs. Disparities in access can include differences in insurance coverage rates, the number of primary or specialty care visits in a given time period, and the availability of a usual source of care."

Quick Facts on:

African Americans

- In 2004, 21.3 percent of nonelderly African Americans (7.15 million) were uninsured, compared to 13.1 percent of nonelderly whites.[1]
- Although more than 80 percent of African Americans live in working families, only 53 percent are covered by employer-sponsored health insurance, compared to 73 percent of whites.[2]
- Among uninsured African Americans, 80 percent live below 300 percent of the federal poverty level ($28,710 for an individual, $48,270 for a family of three in 2005), and 64.4 percent of uninsured non-Latino whites.[3]
- Compared to whites, African Americans had worse access to care for about 40 percent of access measures, including lacking health insurance or a usual source of care, having problems getting a referral to a specialist, and rating their health care poorly.[4]

American Indians and Alaska Natives

- In 2003, American Indians and Alaska Natives had worse access to care than whites for about a third of access measures, including lacking health insurance and having problems with patient-provider communication.[5]
- About a third of uninsured American Indians/Alaska Natives (35 percent) report that they do not have a usual source of care, more than three times the proportion of those who have some sort of health insurance coverage.[6]

Asians and Pacific Islanders

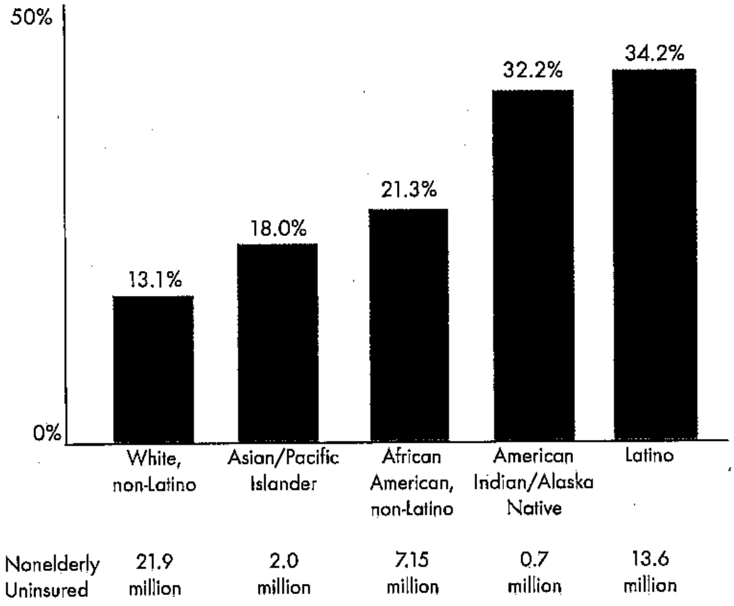
- In 2004, 18 percent of nonelderly Asian Americans and Pacific Islanders (2 million) were uninsured, compared to 13.1 percent of nonelderly whites.[7]
- Insurance rates among Asian American and Pacific Islander subgroups vary widely. For instance, as many as 34 percent of Korean Americans are uninsured, compared to only 13 percent of Japanese Americans.[8]
- Among Asian Americans and Pacific Islanders with incomes below 200 percent of the federal poverty level ($19,140 for an individual, $32,180 for a family of three in 2005), 32 percent were uninsured in 2004.[9]
- Asians had worse access to care than whites for about two-thirds of access measures, including lacking a usual source of care and having problems with patient-provider communication.[10]

- One-third of Asians and Pacific Islanders in fair or poor health had not visited a physician during the preceding year, a considerably higher rate than for whites and African Americans.[11]

Latinos

- In 2004, 34.2 percent of nonelderly Latinos (13.6 million) were uninsured, compared to 13.1 percent of nonelderly whites.[12]
- The number of uninsured Latinos increased from 10.8 million in 2000 to 13.7 million in 2004.[13]
- Roughly one-third of nonelderly Latinos are uninsured, the highest rate among all ethnic groups and almost three times the rate for non-Latino whites.[14]
- Among uninsured Latinos, 82.9 percent live below 300 percent of the federal poverty level ($28,710 for an individual, $48,270 for a family of three in 2005), 64.4 percent of uninsured non-Latino whites.[15]

Figure 1:
Nonelderly Uninsured Rates Among Racial/Ethnic Groups, 2004

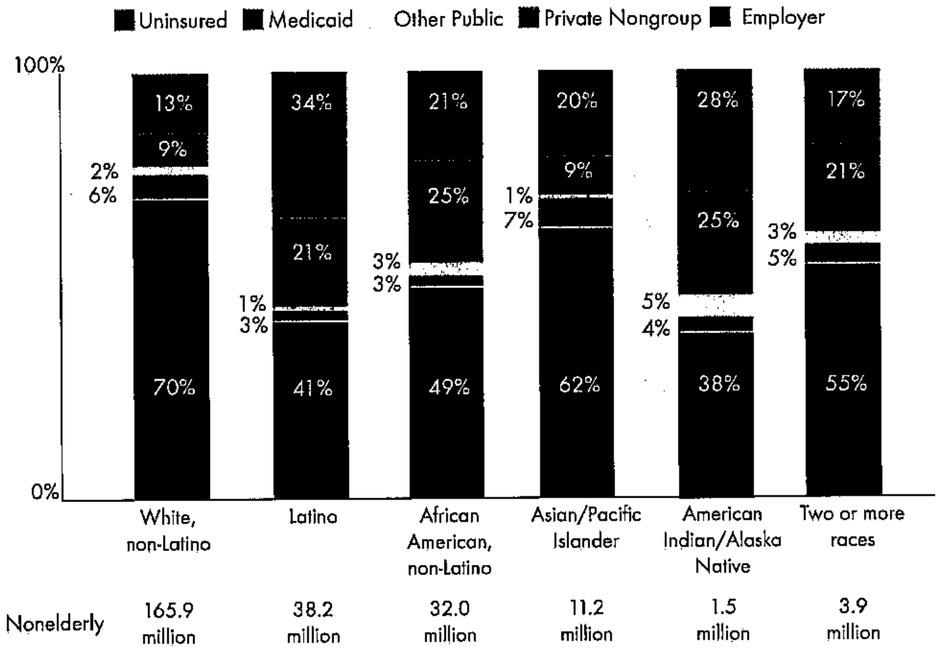


Source: Analysis of U.S. Census Bureau Current Population Reports, 2005.

- One-third of Latinos in fair or poor health had not visited a physician during the preceding year, a considerably higher rate than for whites and African Americans.[16]
- Latinos had worse access to care compared to non-Latino whites for about 90 percent of access measures, such as lacking a usual source of care, having problems getting a referral to a specialist, and rating their health care as poor.[17]
- While almost 9 out of 10 uninsured Latinos are workers or their dependents, Latinos are far less likely than whites to have job-based coverage—regardless of how much they work or the size of the firm or industry in which they work.[18]

- Even when compared to groups of similar income, Latinos were disproportionately less likely to have visited a doctor in the past year. For example, Latinos with incomes less than 100 percent of poverty ($9,570 for an individual, $16,090 for a family of three in 2005) were nearly 70 percent as likely not to have had a health care visit in the previous year as other racial/ethnic groups of the same income.[19]

Figure 2:
Health Insurance Coverage Among Nonelderly Americans, by Race/Ethnicity and Source of Coverage, 2003



Source: Marsha Lillie-Blanton and Catherine Hoffman, "The Role of Health Insurance Coverage In Reducing Racial/Ethnic Disparities In Health Care," *Health Affairs* 24(2), March-April 2005, pp. 398-408.

Note: Numbers may not add to 100 percent due to rounding.

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Improving Health Coverage and Access for African Americans

More than four decades after the passage of civil rights legislation in 1964, African Americans continue to face inequalities in health coverage, provider access, and overall health status. Uninsured African Americans are less likely to receive preventive care, screening services, and appropriate acute or chronic disease management, and they are more likely than insured individuals to have poorer overall health. In 1998, the federal government made eliminating racial and ethnic disparities in health a national priority. However, despite the increased attention that is now being paid to the problem of health disparities, African Americans continue to lag substantially behind their white peers on measures ranging from provider access to health status.

THE PROBLEM

Disparities in Coverage: The Source of the Problem

In 2004, one out of every five African Americans went without health insurance for the entire year, compared to one out of nine non-Latino whites. What's more, African Americans, who make up only 12.6 percent of the U.S. population, represent more than 15 percent of the nation's uninsured. And the problem continues to get worse: The number of uninsured African-American men and women in the country increased from 6.3 million in 2000 to 7.2 million in 2004.[1] While the majority of uninsured individuals belong to working families, African Americans are losing employment-based coverage at an alarming rate—between 2000 and 2003, African Americans experienced a 3.7 percentage point decline in employer-sponsored coverage.[2]

Disparities in Access: Too Little, Too Late

Health status and quality of care are compromised when people do not have access to a regular health care provider. Lack of insurance is the most significant barrier to obtaining health care, but other access limitations affect the health of minority communities as well. Among African Americans, 34 percent report having no regular doctor, compared to 24 percent of whites.[3] African Americans are also more likely than any other racial or ethnic group to use the emergency room as their usual source of care, and they are less likely to report being very satisfied with their care over time.

Not surprisingly, racial disparities in access are just as striking among the uninsured population. Only 42 percent of uninsured

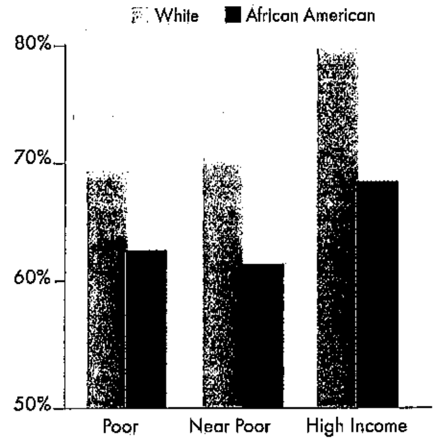
African Americans report having a regular doctor, compared to more than 50 percent of uninsured whites.[4] African Americans are also less likely than whites to visit a specialist, regardless of insurance status. Among insured African Americans, less than 20 percent had visited a specialist in 2003, compared to 27 percent of insured whites. Among the uninsured, 21 percent of African Americans had visited a specialist, compared to nearly 30 percent of whites.[5]

Having regular, affordable access to health care services is essential to maintaining good health. Conversely, not having access to regular health care can lead to poor health. For example, one out of four uninsured African-American men and one out of five uninsured African-American women who reported being in fair or poor health had not visited a physician during the preceding year. This compares to one out of six insured African-American men and one out of 15 insured African-American women.[6]

This disparity in access is likely responsible for many of the health disparities that exist between African Americans and whites. For example, perhaps as a consequence of lacking regular physician access, African Americans with asthma are twice as likely as whites to go to the emergency room for care. They are also much more likely to be hospitalized for asthma, and their mortality rate from the disease is three times higher than it is for whites. A similar trend exists for heart disease: Death rates from heart disease are almost twice as high among African-American adults as among white adults. Despite this health disparity, however, African Americans are less likely to receive adequate care for heart disease. For example, African Americans undergo bypass surgery at significantly lower rates than whites regardless of insurance status.[7]

Figure 1

People with an Office or Outpatient Visit in the Past Year by Race, 2001



Source: Agency for Healthcare Research and Quality, *2004 National Healthcare Disparities Report* (Rockville, MD: U. S. Department of Health and Human Services, March 2005). Data from Medical Expenditure Panel Survey, 2000-2001.

Lacking health insurance is a significant barrier to obtaining medical services—a barrier that invariably leads to less care and worse health outcomes for many African Americans in the United States.

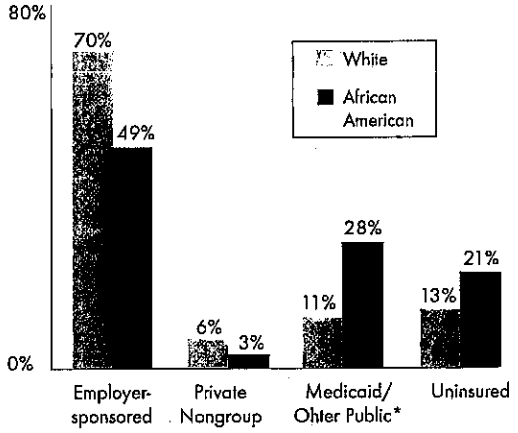
The Price of Work: Why Many Working Families Can't Afford Coverage

Health insurance is becoming increasingly expensive, and few Americans can afford to pay for it on their own. Employment related insurance is still the main source of coverage for most Americans, although every year more employers are dropping or scaling back the coverage they offer. As employers stop offering coverage, more families get priced out of the insurance market each year.

Contrary to popular belief, most people who lack health insurance actually belong to working families. In fact, just over 80 percent of uninsured adults and children live in families with at least one working family member.[8] Unfortunately, many African Americans work in nonstandard job environments, such as with temporary agencies or as independent contractors, which often means that they are less likely to receive insurance coverage through their employers.[9] What's more, African Americans are less likely to have steady employment—according to one survey, only 16 percent were employed full-time for more than 48 months, compared to 24 percent of whites during the same time period.[10]

Figure 2

Comparison of Nonelderly African Americans and Whites by Source of Coverage, 2003



Source: Kaiser Commission on Medicaid and the Uninsured, *Health Insurance Coverage in America: 2003 Data Update* (Washington: Kaiser Commission, November 2004).

* "Other" refers to public insurance other than Medicaid (mostly Medicare and military-related coverage). Medicaid includes the State Children's Health Insurance Program (SCHIP).

African Americans were among the hardest hit during the economic recession that gripped the nation from 2000 to 2003. Their employer-sponsored coverage decreased by 3.7 percentage points, with only a 2.9 percentage point increase in Medicaid coverage. Without the protection of Medicaid—the nation's health care safety net—the number of uninsured African Americans undoubtedly would have increased even more as a result of the economic downturn.

THE SOLUTION

Expanding Public Programs to Improve the Health of African Americans

Racial and ethnic disparities in health will continue to exist as long as minorities lack health insurance coverage and are unable to obtain affordable health care services. Access to health coverage is an issue of critical importance to the African American community because this community is disproportionately more likely than whites to be uninsured.

Advocates, policymakers, and community leaders all have a stake in improving the health of African-American communities. For example, nearly eight out of 10 uninsured African-American children appear to be eligible for Medicaid or SCHIP but are not enrolled.[11] To reach these underserved families, targeted, culturally sensitive outreach efforts are necessary to ensure that all children have adequate access to health care that will lead to a reduction in disparities.

Public health insurance programs have been remarkably effective at expanding coverage to low-income African-American families and their children, but the programs face serious financial threats at both the state and federal level. By making it easier to qualify and enroll in Medicaid and SCHIP, it is possible to make the U.S. health care system more accessible to African Americans and to help close the health disparities gap.

Improvements to public health programs must be coupled with increased access to job-based insurance. Because the vast majority of uninsured African Americans are members of working families, it is imperative that employers offer affordable health insurance to all of their workers. This is especially important for firms that employ low-wage, entry-level workers, where many African Americans find employment. Without affordable access to coverage, the problem of health disparities in African-American communities will continue to worsen.

Endnotes

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Improving Health Coverage and Access for Asians and Pacific Islanders

Asian and Pacific Islander (API) communities across the U.S. continue to face inequalities in health coverage, provider access, and overall health status. Uninsured API adults are less likely to receive preventive care, screening services, and appropriate acute or chronic disease management, and they are more likely than insured individuals to have poorer overall health. In 1998, the federal government made eliminating racial and ethnic disparities in health a national priority. However, despite the increased attention that is now being paid to the problem of health disparities, many Asians and Pacific Islanders continue to lag substantially behind their white peers on measures ranging from provider access to health status.

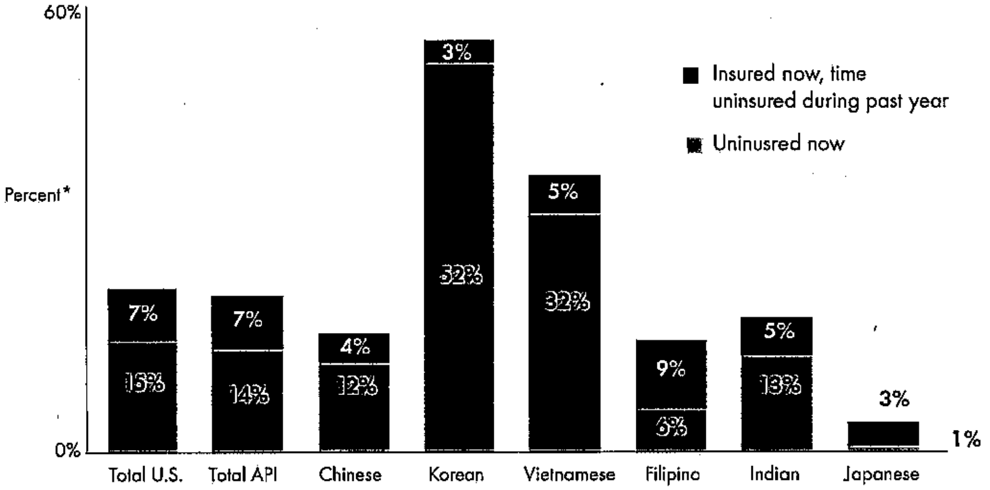
THE PROBLEM

Disparities in Coverage: The Source of the Problem

In 2004, one out of every six Asian Americans went without health insurance for the entire year, compared to one out of nine non-Latino whites. What's more, low-income Asian Americans were even more likely to be uninsured: Among individuals with incomes below the federal poverty level, 39 percent of Asian Americans were uninsured in 2004, compared to 25 percent of non-Latino whites.[1] Even within the broader API community, there are disparities between individual subgroups. Korean and Vietnamese adults and children, for example, are several times less likely to have insurance than Japanese, Filipino, and Chinese adults and children.[2]

Figure 1

Variation in Rates of the Uninsured in Six Asian-American Populations



* Percent of uninsured adults ages 18-64 uninsured now or uninsured during the past year.

Source: Dora Hughes, *Quality of Health Care for Asian Americans: Findings from The Commonwealth Fund 2001 Health Care Quality Survey* (New York: The Commonwealth Fund, March 2002).

Disparities in Access: Too Little, Too Late

Health status and quality of care are compromised when people do not have access to a regular health care provider. Lack of insurance is the most significant barrier to obtaining health care, but other access limitations affect the health of minority communities as well. According to one survey of Asians and Pacific Islanders, more than 30 percent reported having no regular doctor. And for many subpopulations, the problem of access was even worse: 54 percent of Korean and 41 percent of Vietnamese individuals reported that they did not have a regular doctor.[3]

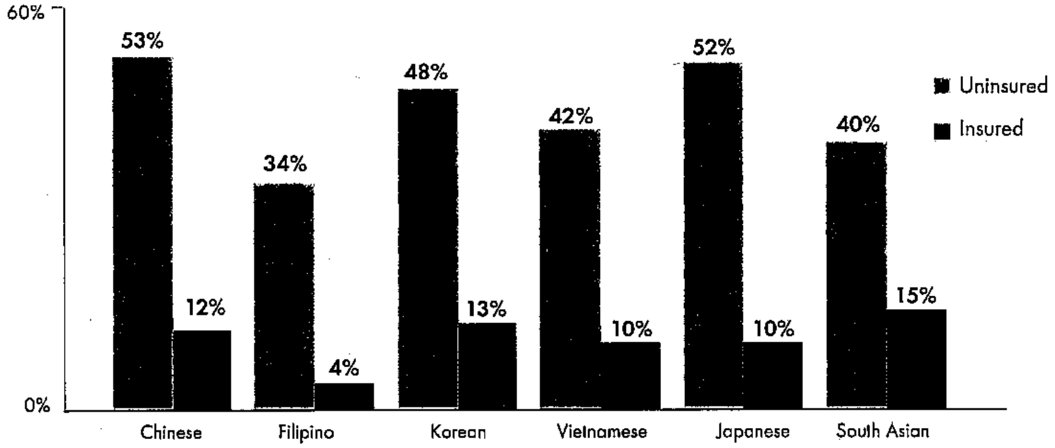
Having regular access to affordable health care services is essential to maintaining good health. Conversely, not having access to regular health care can lead to poor health. For example, more than half of all uninsured API adults reported that they had no usual source of care, compared to 36 percent of uninsured whites.[4] This disparity in access is likely responsible for many of the health disparities that exist between Asian and Pacific Islanders and whites. For example:

- Between 1982 and 1992, Vietnamese-American women had the highest age-adjusted rate of cervical cancer (43 per 100,000), more than five times the rate of non-Hispanic whites (7.5 per 100,000).[5]
- In 2001, Asians and Pacific Islanders had the highest rate of tuberculosis infection of all racial and ethnic populations in the United States.[6]
- Asians and Pacific Islanders are less likely than other racial and ethnic groups to undergo screening for breast cancer and cervical cancer. Perhaps as a result, cancer is the leading cause of death among API populations.[7]

Lacking health insurance is a significant barrier to obtaining medical services—a barrier that invariably leads to less care and worse health outcomes for many Asians and Pacific Islanders in the United States.

Figure 2

Percent with No Usual Source of Care by Health Insurance Status, Asian and Pacific Islander Subgroups (Ages 18-64), 1994-1995



Source: E. Richard Brown, Victoria D. Ojeda, Roberta Wyn, et al., *Racial and Ethnic Disparities in Access to Health Insurance and Health Care* (Los Angeles: UCLA Center for Health Policy Research and Kaiser Family Foundation, April 2000). Based on an analysis of the National Health Interview Survey, 1994 and 1995.

Asians and Pacific Islanders: Myths and Misperceptions

The term "Asian and Pacific Islander" encompasses a very diverse and heterogeneous population. While often lumped into a single category for statistical purposes, API ethnic subgroups vary tremendously. For example, variations in national origin frequently correspond to differences in language, cultural characteristics, socioeconomic background, and health care needs. In fact, the 12 million Asians and Pacific Islanders living in the United States can trace their origins to more than 20 different countries.

Because of the diversity of this loosely defined population, aggregate data on Asians and Pacific Islanders can be extremely misleading and mask many of the underlying health disparities that exist. For example, while the uninsured rate for APIs was around 21 percent in 1997, the figures ranged from a low of 13 percent among Japanese Americans to a high of 34 percent among Korean Americans.[8]

Another unintended consequence of grouping disparate ethnic subgroups under the broader API category has been the creation of what some refer to as the "model minority myth." Compared to other racial and ethnic minority groups, some Asian Americans have, on average, higher incomes and higher education levels. This leads to the misperception that APIs as a whole face fewer access barriers to obtaining health care. Research on health disparities frequently overlooks the unique problems facing API populations, and data collection methods frequently fail to explore disparities among ethnic subgroups.

In order to reduce health disparities in the Asian and Pacific Islander community, researchers and policymakers must focus on this often overlooked population. In particular, more attention needs to be paid to recent immigrants and low-income API populations, since these individuals are disproportionately represented among the uninsured.

Asian and Pacific Islander Immigrants: Living and Working without Coverage

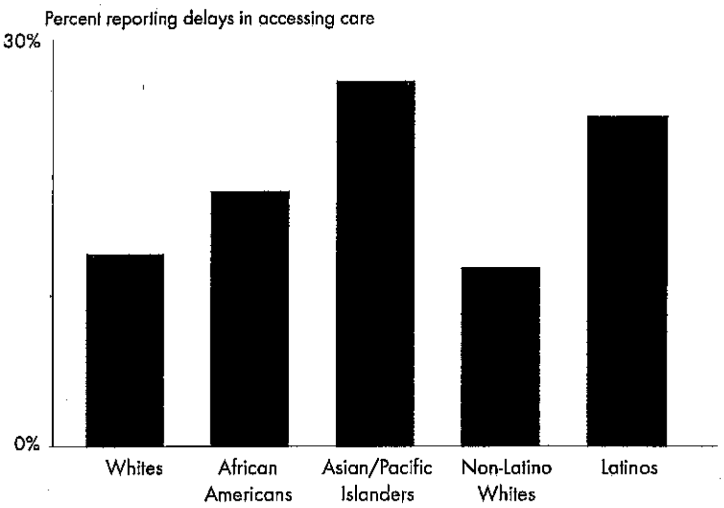
As a group, foreign-born Asians and Pacific Islanders are almost twice as likely to report being uninsured as those born in the United States (25 percent versus 13 percent). It is important to recognize that while foreign-born APIs constitute only a small fraction of the overall uninsured population (approximately 2 percent in 2004), almost one-fourth of all API immigrants went without health insurance for the entire year.[9] What's more, although many immigrant families work and pay taxes in the U.S., they are often excluded from public insurance programs and left with no options for affordable health care.

Contrary to popular belief, most people who lack health insurance actually belong to working families. In fact, just over 80 percent of uninsured adults and children live in families with at least one working family member.[10] Unfortunately, many uninsured Asians and Pacific Islanders are self-employed or work in small businesses, low-wage firms, or certain employment sectors that are less likely to offer coverage. And even when these families are offered coverage, it is often unaffordable. Immigrants are hit particularly hard by the dearth of affordable health insurance options. In 2004, only 56 percent of API immigrants received insurance through their employer (versus 65 percent of native-born APIs).[11]

Some disparities in access can also be attributed to language and cultural barriers that might prevent Asians and Pacific Islanders from obtaining the care that they need. Many of these problems persist even among insured populations. For example, compared to other racial and ethnic groups, Asians and Pacific Islanders are much more likely to report that they had difficulty obtaining care when they needed it, even after taking into account such factors as age, gender, income, education, and insurance status (see Figure 3).[12] These access barriers undoubtedly loom larger for recent immigrants, who may be less likely to speak English and to understand the intricacies of the U.S. health care system.

Figure 3

Adults Who Can Sometimes or Never Get Care for Illness or Injury as Soon as Wanted by Race/Ethnicity, 2001



Source: Agency for Healthcare Research and Quality, *2004 National Healthcare Disparities Report* (Rockville, MD: U.S. Department of Health and Human Services, March 2005). Data from Medical Expenditure Panel Survey, 2000-2001.

THE SOLUTION

Expanding Public Programs to Improve the Health of Asians and Pacific Islanders

Racial and ethnic disparities in health will continue to exist as long as minorities lack health insurance coverage and are unable to obtain affordable, culturally competent health care services. Access to health coverage is an issue of critical importance to the Asian and Pacific Islander community because this community is disproportionately more likely than whites to be uninsured.

Advocates, policymakers, and community leaders all have a stake in improving the health of API communities. Over the next 50 years, this population is expected to grow at a faster rate than all other racial and ethnic groups in the United States. According to the U.S. Census Bureau, the number of Asians and Pacific Islanders is expected to triple in the next 50 years, growing from 10.7 million in 2000 to 33.4 million in 2050.[13]

Public insurance programs have tremendous potential to reduce disparities in API communities and improve health. Many innovative models for health care delivery and practice have originated in public sector programs, such as interpreter services, cultural competence training, and data collection on race and ethnicity. However, more needs to be done to make the U.S. health care system more accessible to API communities. Compared to other racial and ethnic groups, public health insurance programs have had limited success in expanding coverage to low-income API families and their children. For example, only 13 percent of low-income Chinese have Medicaid coverage, compared to approximately 24 percent of low-income whites.[14] One solution is to make it easier to qualify and enroll in Medicaid and SCHIP, particularly for populations that may fear that enrolling in public programs could jeopardize their immigration status.

At the same time, improvements to public health programs must be coupled with increased access to job-based insurance. Because the vast majority of uninsured Asians and Pacific Islanders are members of working families, it is imperative that employers offer affordable health insurance to all their workers. This is especially important for firms that employ low-wage, entry-level workers, where many uninsured APIs find employment. Without affordable access to high-quality and culturally appropriate health services, the problem of health disparities in Asian and Pacific Islander communities will continue to worsen.

Endnotes

[1] Estimate based on the Census Bureau's March 2005 Current Population Survey. *Current Population Survey: Annual Social and Economic Supplements*, available online at http://pubdb3.census.gov/macro/032005/health/toc.htm, accessed on December 20, 2005.

[2] Dora L. Hughes, *Quality of Health Care for Asian Americans: Findings from The Commonwealth Fund 2001 Health Care Quality Survey* (New York: The Commonwealth Fund, March 2002).

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[6] Ibid.

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[9] Estimate based on the Census Bureau's March 2005 Current Population Survey, op. cit.

[10] Kaiser Commission on Medicaid and the Uninsured, *The Uninsured: A Primer, Key Facts About Americans Without Health Insurance* (Washington: Kaiser Family Foundation, December 2003).

[11] Estimate based on the Census Bureau's March 2005 Current Population Survey, op. cit.

[12] Agency for Healthcare Research and Quality, *2004 National Healthcare Disparities Report* (Rockville, MD: U.S. Department of Health and Human Services, March 2005), available online at www.qualitytools.ahrq.gov/disparitiesreport/.

[13] Estimate based on an analysis of the U.S. Census Bureau's "U.S. Interim Projections by Age, Sex, Race, and Hispanic Origin," available online at http://www.census.gov/ipc/www/usinterimproj/, accessed on December 21, 2005.

[14] Kaiser Commission on Medicaid and the Uninsured, *Key Facts: Health Insurance Coverage and Access to Care Among Asian Americans and Pacific Islanders*, op cit.

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Improving Health Coverage and Access for Latinos

Latino communities across the U.S. continue to face inequalities in health coverage, provider access, and overall health status. Uninsured Latino children and adults are less likely to receive preventive care, screening services, and appropriate acute or chronic disease management, and they are more likely than insured individuals to have poorer overall health. In 1998, the federal government made eliminating racial and ethnic disparities in health a national priority. However, despite the increased attention that is now being paid to the problem of health disparities, Latinos continue to lag substantially behind their white peers on measures ranging from provider access to health status.

THE PROBLEM

Disparities in Coverage: The Source of the Problem

In 2004, one out of every three Latinos went without health insurance for the entire year. What's more, Latinos, who make up only 14 percent of the U.S. population, represent nearly 30 percent of the nation's uninsured. And the problem continues to get worse: The number of uninsured Latino men and women in the country increased from 10.8 million in 2000 to 13.7 million in 2004.[1] Even within the broader Latino community, there are disparities between individual ethnic subgroups. Central Americans, South Americans, and Mexicans, for instance, are notably less likely to have insurance than Puerto Ricans and Cubans (see Figure 1).[2]

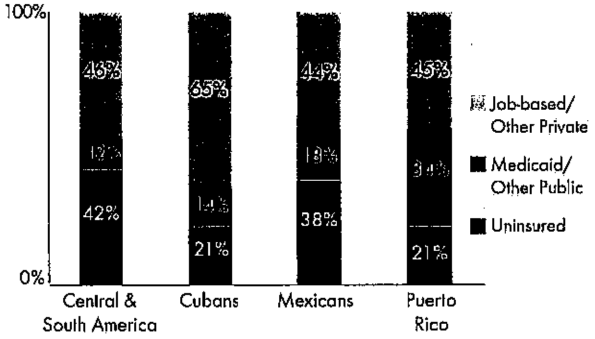
Disparities in Access: Too Little, Too Late

Health status and quality of care are compromised when people do not have access to a regular health care provider. Lack of insurance is the most significant barrier to obtaining health care, but other access limitations affect the health of minority communities as well. Among Latinos, 45 percent report having no regular doctor, compared to 24 percent of whites.[3] Latinos are more likely to use the emergency room as their usual source of care and are less likely to report being very satisfied with their care over time.

Not surprisingly, racial disparities in access are just as striking among the uninsured population. Only 34 percent of uninsured Latinos report having a regular doctor, compared to more than 50 percent of uninsured whites.[4]

Figure 1

Health Insurance Coverage Among Latino Subgroups (Ages 0-64), 1997

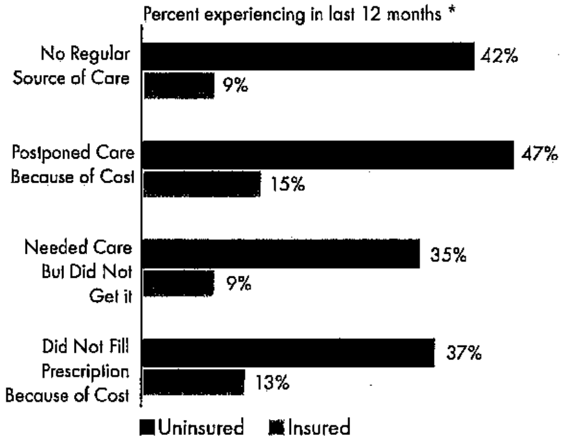


Source: Kaiser Commission on Medicaid and the Uninsured, *Health Insurance Coverage and Access to Care Among Latinos* (Washington: Kaiser Family Foundation, June 2000).

Even when compared to groups with similar incomes, Latinos are disproportionately less likely to have visited a doctor in the past year. For example, Latinos with incomes of less than 100 percent of poverty ($16,090 for a family of three in 2005) are nearly 70 percent as likely not to have had a health care visit in the previous year as other racial and ethnic groups with the same income.[5]

Figure 2

Barriers to Health Care by Insurance Status, 2003



* Experienced by the respondent or a member of their family; insured includes those covered by public or private insurance.

Source: Kaiser Commission on Medicaid and the Uninsured, *Health Insurance Coverage and Access to Care Among Latinos* (Washington: Kaiser Family Foundation, June 2000).

Having regular, affordable access to health care services is essential to maintaining good health. Conversely, not having access to regular health care can lead to poor health. For example, one out of four Latino men who reported being in fair or poor health had not visited a physician during the preceding year, compared to one out of seven white men.[6] This disparity in access is likely responsible for many of the health disparities that exist between Latinos and whites. For example, perhaps as a consequence of lacking regular physician access, Latino men are less likely to get screened for prostate cancer and are at greater risk of having a more advanced stage of prostate cancer at the point of diagnosis than are white men. Similarly, Latinas are less likely to be screened for cervical and breast cancer than white and African-American women.[7]

Lacking health insurance is a significant barrier to obtaining medical services—a barrier that invariably leads to less care and worse health outcomes for many Latinos in the United States.

Latino Children: The Need for Expanded Coverage

Among all racial and ethnic minority groups, Latino children are the most likely to be uninsured. Latino children in the United States are uninsured at a staggering rate–in 2004, 21 percent of all Latino children under 18 went without insurance.[8] The majority of these uninsured children actually qualify for public insurance, such as Medicaid or the State Children's Health Insurance Program (SCHIP), but enrollment barriers and a lack of effective outreach programs have left them behind.

Because they lack access to coverage, Latino children are disproportionately less likely to receive the health services they need. For example:

- Uninsured Latino children are twice as likely to lack a regular source of care as uninsured white children.
- Uninsured Latino children are significantly less likely to receive medical care than uninsured, non-Hispanic white children.[9]

And another likely result of not having adequate access to regular care is that Latino children are less likely than their white peers to be in very good or excellent health (74 percent versus 88 percent).[10]

The Price of Work: Why Many Working Families Can't Afford Coverage

Health insurance is becoming increasingly expensive, and few Americans can afford to pay for it on their own. Employment related insurance is still the main source of coverage for most Americans, although every year more employers are dropping or scaling back the coverage they offer. As employers stop offering coverage, more families become uninsured each year.

Contrary to popular belief, most people who lack health insurance actually belong to working families. In fact, just over 80 percent of uninsured adults and children live in families with at least one working family member.[11] Unfortunately, many Latinos work in small firms, low-wage firms, or certain employment sectors that are less likely to offer coverage. And even when these families are offered coverage, it is often unaffordable.

Young, working Latino families are disproportionately priced out of the insurance market. For example, among Latinos between ages 18 and 24 who worked full-time, more than 55 percent went without insurance coverage in 2004.[12] This is double the percentage for non-Latino whites in the same age group who worked full-time (27.6 percent). Moreover, there are lower rates of employment-based coverage among working Latinos regardless of firm size—whites who work in small firms are twice as likely as Latinos to be offered health insurance.[13]

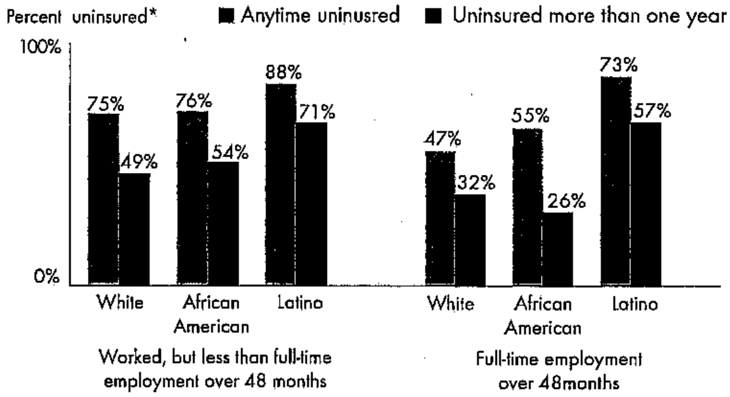
Latino Immigrants: Living and Working without Coverage

As a group, foreign-born Latinos are more likely to report being uninsured than those born in the United State (42 percent versus 25 percent). Likewise, Latinos who reported speaking Spanish as their primary language were nearly twice as likely as their English-speaking counterparts to go without health insurance (47 percent versus 25 percent).[14]

It is important to recognize that foreign-born Latinos constitute only a small fraction of the overall uninsured population (18 percent in 2004). At the same time, however, close to half of all Latino immigrants went without health insurance last year.[15] While Spanish-speaking Latinos are just as likely as whites to have at least one full-time worker in their family, they are more than twice as likely to have incomes below 200 percent of poverty ($32,180 for a family of three in 2005) and three times more likely to go without insurance.[16] What's more,

Figure 3

Low-Income Latinos are Less Likely to Have Insurance—Though More Likely to Be Steadily Employed



*Percent uninsured by employment of head of household among low-income adults (19-64), 1966-1999.

Source: Michelle M. Doty and Alyssa L. Holmgren, *Unequal Access: Insurance Instability among Low-Income Workers and Minorities* (New York: Commonwealth Fund, April 2004).

although many immigrant families work and pay taxes in the U.S., they are often excluded from public insurance programs and left with no options for affordable health care.

The children of Latino immigrants, particularly those children born outside the U.S., also experience disparities in access. While Latino children in citizen families are about as likely as white children to see a physician, non-citizen Latino children are less than half as likely as white children to visit the doctor (29 percent versus 71 percent).[17]

Compounding this problem, more than one-fifth of all uninsured children in the U.S. live in "mixed-citizenship" families.[18] In such families, although the children are citizens and eligible for coverage, one or both of their parents are non-citizens, and they erroneously fear that enrolling their children in public insurance programs might jeopardize their own immigration status or their chances of becoming citizens.

THE SOLUTION

Expanding Public Programs to Improve the Health of Latinos

Racial and ethnic disparities in health will continue to exist as long as minorities lack health insurance coverage and are unable to obtain affordable health care services. Access to health coverage is an issue of critical importance to the Latino community because this community is disproportionately more likely to be uninsured.

Advocates, policymakers, and community leaders all have a stake in improving the health of Latino communities. Latinos are expected to constitute 25 percent of the entire U.S. population by 2050, so it is imperative to address the insurance crisis facing this underserved population now.

Medicaid and SCHIP have been remarkably effective at expanding coverage to low-income Latino families and their children, but the programs face serious financial threats at both the state and federal level. By making it easier to qualify for and enroll in public health insurance programs, it is possible make the U.S. health care system more accessible to Latinos and to help close the health disparities gap.

Improvements to public health programs must be coupled with increased access to job-based insurance. Because the vast majority of uninsured Latinos are members of working families, it is imperative that employers offer affordable health insurance to their workers. This is especially important in the service industries, where many Latinos find employment. Without affordable access to coverage, the problem of health disparities in the Latino population will continue to worsen.

Endnotes

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January 2006

Case Study: The Faith Community

Joining Together to Oppose Medicaid Cuts in Tennessee

Background

Created in 1994, TennCare, Tennessee's Medicaid program, was once looked to as a national model for expanding Medicaid coverage. In fact, up until 2002, all uninsured individuals—regardless of their income—were eligible to enroll in TennCare. This included two groups that usually have the hardest time buying insurance: low-income adults and individuals with pre-existing health conditions. At its peak, TennCare covered 1.4 million individuals, and by the late 1990s, only 14 percent of the state's population was uninsured (compared to 25 percent in states like California and Texas).[1]

The Problem

As of July 2005, the state cut nearly 200,000 beneficiaries from the Medicaid program completely, and it imposed strict benefit limits on 379,000 more enrollees. Under the leadership of democratic Governor Phil Bredeson, Tennessee's most vulnerable residents have been left without anywhere else to go for medical care. Many have been forced to make the ultimate sacrifice—their health and, in some instances, their lives. According to some estimates, TennCare cuts will result in the deaths of as many as 3,311 people over the next 15 years.[2] As of late 2005, the governor had not changed his course of action.

The Response

Many organizations, regardless of their members' racial and ethnic backgrounds or religious affiliations, have joined together in an effort to convince Governor Bredeson to reverse his Medicaid "reform" proposal. In particular, the faith community is one that has been quite vocal since the governor first announced his plans to restructure TennCare in January 2005. It is one of many communities that refuse to "go down without a fight," initiating and participating in numerous events to bring attention to TennCare cuts. Examples of these activities include:

- rallies at the state capitol in Nashville,
- statewide press events,
- nationwide petitions,
- meetings with state senators and other policymakers in Washington, D. C.,
- speeches about the cuts within their congregations and local community, and
- the longest sit-in at a state capitol in the history of our nation.

Ministers and other religious leaders in Tennessee feel a need for other faith leaders, as well as other community leaders, to speak up and do what they can to prevent future suffering. One such faith leader is Reverend Henry Blaze III, who serves as pastor at Progressive Baptist Church in Nashville and is co-convener of the TennCare Statewide Coalition. Rev. Blaze has been an outspoken leader on the TennCare issue. Although he had no prior knowledge about health care issues before he began working on TennCare, Rev. Blaze was very familiar with coalition building and grassroots organizing. He worked with other local organizations, such as the Tennessee Justice Center, the Tennessee Health Care Campaign, the Nashville Peace and Justice Center, the Tennessee Disability Coalition, and the National Association for the Advancement of Colored People (NAACP) to combine their expertise in health and organizing to build a bigger and stronger movement. His overall role has been to serve as the link between different individuals and organizations that are trying to engage others around this issue.

> ***"One of the high points of the TennCare campaign is that we have forged a coalition that has the potential of transcending issues of race and class."***
>
> – Rev. Henry Blaze III
> Pastor and Co-Convener of TennCare Statewide Coalition

Rev. Blaze has emphasized that in order to build a successful campaign, organizers must do the following:

- understand the interests that they are trying to bring together;
- identify values that will be the "glue" that holds everyone together;
- find people to get involved, recognizing that they do not necessarily have to know about health, but they need to know how to organize and be passionate about the issue;
- have a vision and framework for the campaign; and
- share the vision and framework with all the individuals and groups involved.

Another faith leader who has been instrumental in the efforts around TennCare is Reverend Dwight Montgomery, who serves as both the Pastor at Annesdale Cherokee Baptist Church in Memphis and the President of the Memphis chapter of the NAACP. After hearing of the governor's plan to restructure TennCare, Rev. Montgomery immediately wrote him a letter recommending that the state find alternative ways to make up budget shortfalls that would avoid cutting beneficiaries from TennCare. He also met with the governor personally, but neither tactic convinced the governor to change his mind. Rev. Montgomery then began working with other faith-based organizations, such as the African American Muslims, the Rainbow Push Coalition, the Memphis Baptist Ministers Association, and

> ***"The efforts around TennCare have brought the people of Tennessee together like never before."***
>
> Rev. Dwight Montgomery
> Pastor, Annesdale Cherokee Baptist Church
> and President, Memphis Chapter NAACP

even labor groups such as the American Federation of State and County Municipal Employees (AFSCME). He was easily able to bring people into the coalition in Memphis by picking up the phone and calling on people individually and asking for their support. Memphis is also unique, since the vast majority of the residents are African American, and many of them were cut from TennCare. Understandably, faith leaders in Memphis had a personal stake in the issue and wanted to get involved for the sake of their community.

By working with other groups on this issue, Rev. Montgomery and the Southern Christian Leadership Conference (SCLC) have been able to take on other health-related causes that they would not have gotten involved in had they not worked on TennCare. The SCLC is beginning to work on issues around mental illness, childhood obesity, infant mortality, and health disparities. They have also gotten a local radio station, WLOK Radio, to play a public service announcement that surveyed listeners on issues around TennCare.

The Fight Continues

Faith leaders play a unique role in their communities. They have the respect of their peers and congregations, are viewed as leaders in their communities, and have the ability to create change on a larger scale than the average community member. Even with varying levels of health expertise, there is a clear niche that faith leaders can fill in the health care advocacy arena. Getting and staying involved in health issues is essential for creating a more equitable and just society, especially with proposals emerging every day that have a disproportionate impact on racial and ethnic minorities. Regardless of whether or not Governor Bredeson reverses his Medicaid proposal, a new group of powerful health care advocates has been created in the state of Tennessee.

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[1] Trudy Lieberman "Mismanaged Care," *The Nation, posted November 22, 2005 (December 12, 2005 issue),* available online at www.thenation.com, accessed on November 29, 2005.

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Case Study: Local Grassroots Efforts

Advocating for Increased Access to Care in Northern Virginia

The Problem

In Alexandria, Virginia, a relatively wealthy suburb just outside of Washington, D. C., many of the low-wage workers in the hotel and restaurant industry lack health insurance coverage. What's more, there is no public hospital and, until recently, the area did not even have a federally qualified health center (FQHC).[1] It is estimated that 50 to 80 percent of the region's 150,000 or more African Americans and Latino, African, and Asian immigrants are uninsured or underinsured. Access to subsidized care for those who are ineligible for Medicaid is very limited, and in this metropolitan area with a large international community, there are still inexcusable linguistic and cultural barriers to health care.

The Response

The Tenants' and Workers' Support Committee (TWSC), a local advocacy group first organized in response to the mass evictions of 5,000 low-income Latinos and African Americans from local neighborhoods, had been hearing stories from community members about their experiences with a local for-profit hospital, Alexandria Inova Hospital. Problems included a lack of access to translation services for Latino patients (a growing population in Alexandria) and issues related to medical debt among low-income patients.

TWSC decided to bolster those anecdotes with research, and together with The Access Project in Boston, Massachusetts, TWSC surveyed 225 uninsured area residents. The survey was designed to paint a portrait of the experiences of the uninsured who had sought care at the hospital. TWSC also used telephone inquiries and site visits to determine the hospital's level of outreach, the quality of its public information, and staff familiarity with its free health care policies and practices.

The results of this survey revealed that of 225 respondents, 80 had incurred hospital medical debt. What's more, those in debt reported that debt was a barrier to follow-up or further care. The survey also identified lack of access to translation services and bilingual materials as another serious barrier to care for Latino residents. The investigation of hospital practices uncovered that Alexandria Inova Hospital failed to inform individuals who inquired about free hospital care 67 percent of the time. Moreover, TWSC found that the hospital lacked brochures containing information about public insurance programs or its free health care policies.

Armed with research, TWSC leaders brought 12 uninsured community members to tell their stories to top administrators, including the chief executive officer of Inova Health Systems, the parent company of Alexandria Inova Hospital. The research findings, coupled with the personal stories of hardship, provided the ammunition advocates needed to push for improvements to hospital policy, including the immediate freezing of 10 debtor accounts with the hospital, as well as a series of meetings among its staff to address the issues of debt relief and cultural competence.

The Fight Continues

TWSC is continuing to work with the community to advocate for improvements to hospital policy. While Inova Health Systems has implemented several changes to improve the cultural competence of its services, including increasing the availability of interpreters, progress has been much slower when it comes to improving the hospital's charity care policy and resolving debt. After repeated requests and suggestions, hospital administrators provided TWSC with its current charity care policy, which uses federal poverty level guidelines to determine eligibility for free or reduced-price care and is irrelevant to the actual cost of living in Alexandria, which is much higher than the national average.[2]

Moving Forward

Recognizing that negotiations with the hospital were just one part of the equation, TWSC also worked with city officials and community health coalitions to improve policies at the state and local levels for providing care to the uninsured. TWSC joined Alexandria's ad hoc Access to Care Coalition, whose mission is to expand the services and collaborative health planning effort in the city. This includes efforts to be designated as a medically underserved population by the Health Resources and Services Administration, a necessary step on the path to receiving federal funding for a federally qualified health center (FQHC).

In 2004, those efforts were rewarded when the Arlandria Health Center received a three-year, $1.95 million federal grant to become the first FQHC in northern Virginia. This designation allows it to receive federal money to provide care for the uninsured, and it is recognized by both Medicare and Medicaid. While it has been serving low-income residents of Alexandria for 12 years, this funding will allow the center to expand its services and capacity to serve this diverse population.[3]

Endnotes

[1] Federally qualified health centers (FQHCs) are nonprofit, consumer-directed facilities or programs that provide care to the underserved and the uninsured. Funding is provided by the federal government through grants under section 330 of the Public Health Service Act. FQHCs must provide "primary health services," which are defined as health services related to family medicine, internal medicine, pediatrics, obstetrics, or gynecology that are furnished by physicians and, where appropriate, physician assistants, nurse practitioners, and nurse midwives." Preventive services must include prenatal and perinatal services, screening for breast and cervical cancer, and voluntary family planning services.

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Strategies and Tools:
Influencing Congress, the White House, Your Community, and the Media

Community leaders can have a significant impact in their communities by taking a stand on health and health care issues. Below we list several tactics that leaders can use to engage and influence Congress, the White House, their communities, and the media.

Influencing Congress

The following is a list of tips to help community leaders communicate with members of Congress and learn how the lawmaking process works.

- **The Telephone Call**

  A phone call is a good way to let your legislator know how you or your organization feels about a particular issue. Congressional offices pay close attention to these calls as a measure of voters' sentiment. An outpouring of calls can sometimes change the vote of a legislator, but even a small number of calls can make a difference.

  Each member of Congress has a professional staff in Washington, DC. Some are assigned to the legislator's personal staff, others to a committee or subcommittee. Staff members schedule appointments, track legislation, and make recommendations concerning legislative issues. Because of the busy schedules legislators keep, it is important to develop and maintain a good working relationship with staff members responsible for health or related issues. When you call the Washington office, ask to speak with the staff person responsible for the legislation you are calling about. Don't be upset or take it personally if that staffer is not available. The average legislative assistant handles six or seven major subject areas and is under constant deadlines to help the member with speeches, hearings, etc.

  When you call, ask if your Senator or Representative could send you a written response. This will help ensure that your call gets counted. The volume of calls your member receives can make it hard to get through—you may get a busy signal, get a taped message, or be asked to leave a voicemail message. Remember—congressional staffs are surprisingly small, so don't give up! Please keep trying, or try a district office number in the member's state. This office is often less harried and will pass on the messages.

Where to call: Most Senators and Representatives maintain one or more offices in the state or congressional district they represent. You can find the phone number for that office in the U.S. government section of your telephone directory, by calling information, or by visiting the Web site for the Senate, for the House of Representatives, or for that specific member.

If you wish to call the Washington, DC office, you can reach your Senator or Representative through the Capitol switchboard. Simply dial 202-224-3121 and ask for your Representative or Senator's office.

• The Letter or E-mail

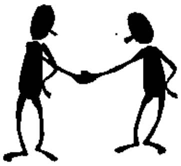
Your correspondence to Washington can make a difference. Legislators rely on letters and e-mail to find out what the people back home are thinking. And, for you, writing a letter or e-mail can be the first step in building an ongoing relationship with your legislators. All congressional offices are accessible by e-mail. Their addresses can be found at www.senate.gov or www.house.gov. Here are some guidelines to follow when writing a letter or e-mail.

- Spell your legislator's name correctly. If you know your legislator at all, use his or her first name—your correspondence will receive more attention.
- If not sending an e-mail, be sure to write legibly or type your letters.
- Address your legislator properly: For a salutation, use "Dear Representative (last name)" or "Dear Senator (last name)."
- Use your own words. Personal letters and e-mails are much more effective than postcards or petitions.
- In an e-mail, remember not to use "net jargon." Use full sentences and paragraphs—remember, it's just like a letter!
- Clearly state the topic you are writing about and your position on it in the opening sentences. For example: "I'm writing to oppose steep cuts in Medicaid."
- Refer to bills by name or number if you can, but don't delay your correspondence if you don't have the exact bill number.
- Stay on one topic. If you want to write about other issues, send another letter or e-mail later on.
- Give reasons for your position. As appropriate, use personal experience or a concrete example to make your case.
- Raise questions. A well-formulated question can get a personal response.
- Keep it short. One page is best! Use two pages only if necessary for clarity and completeness.

- Be polite, positive, and constructive. Don't plead, and never threaten or insult. You want to win a friend, if not now, then on other issues in the future.
- Be timely. Write before decisions are made and action is taken. But don't write too long beforehand—a letter six months before a vote will probably be forgotten.
- If writing a letter, be sure to use your name and address on both the envelope and the letter. This helps staff in replying, and it identifies you as a constituent. For e-mail, include your full name and address at the end of the e-mail.
- Write to thank your legislators when they take an action you agree with. It's surprising how few letters of thanks are received on Capitol Hill. If a staff member is particularly helpful, thank him or her, too—or mention your gratitude in your letter or e-mail to your legislator.
- Keep writing!

• Visiting Legislators In Their Home District

Most legislators travel to their home districts fairly often—on weekends, if possible, and when Congress is not in session. They go home, in part, to meet with constituents either individually or in town meetings. You can set up a meeting with your Representative or Senator during one of these visits or attend a town meeting forum to ask a question about your issues.



To prepare for the meeting:

- Arrange for a small group of people who share your concerns to participate in the meeting.
- Decide ahead of time what the group will say and who will speak on each issue.
- Limit your visit to one, or at most two, topics.
- Decide in advance what you hope to get out of the meeting—an agreement to sponsor a particular bill, for example. If you want press coverage of your meeting, clear it beforehand with the member. Don't "ambush" the member with surprise or unexpected press or tape the meeting without permission. In short, remember the Golden Rule—treat the member as you would like to be treated if you were in his or her shoes.

During the meeting:

- Present your case. Explain what you want your legislator to do and why.
- Give examples of the impact the proposed legislation will have on your home state or district.
- If you don't know the answer to a question, don't make it up. Offer to find out and send information back to the office later.

- Keep control of the visit. Don't be put off by smokescreens or long-winded answers.
- Don't confront, threaten, pressure, or beg.
- Leave a brief position paper or fact sheet with the member when you're done.
- Follow up your visit with a thank you note.

You can also invite your elected officials to participate in your organization's activities. You might ask them to address your group or present the legislator with an award. These events leave a lasting, positive impression about the organization and build a relationship with the legislator that can be useful.

How to Get Copies of Bills and Committee Reports

You can ask your legislator's office to get you information on pending legislation, copies of bills, and congressional schedules, but it is often faster to use Thomas, the congressional Web site, at http://thomas.loc.gov (named after Thomas Jefferson).

Identify the bill or committee report you want by name and number. In the House, bills are identified as H.R. _____. In the Senate, they are identified as S. _____.

Committee reports include the number of the Congress in their number: House committee reports issued during the 109th Congress will be identified as H.Rept. 109-_____; Senate reports, as S.Rept. 109-_____, etc.

How a Bill Becomes a Law

Being an effective advocate on legislative issues also means understanding how Congress works. The process of passing legislation is often complicated and very tedious. Here is an overview of how a bill becomes a law.

Introducing a Bill

Ideas for bills come from many sources: constituents, the President, lobbyists, or congressional staff. Any Senator or Representative may introduce a bill. After a bill has been written or "drafted," the member introduces it by formally presenting it to the House or Senate clerk when Congress is in session. In the House, the bill is placed in the "hopper" at the desk of the Clerk. The sponsor of the bill may or may not make a special statement about the bill when it is introduced. In the Senate, the bill may be presented to the Clerk, or the Senator may make a formal statement from the Senate floor to introduce it.

Once a bill is introduced, it is given a number: H.R. _________ if introduced in the House and S. _________ if introduced in the Senate. Bill numbers start with H.R. 1 and S. 1 at the beginning of each new Congress and continue in numerical order until the Congress ends two years later.

While a bill is the form used for most legislation, the House and the Senate can also originate resolutions. These are used for special purposes, such as budget resolutions or constitutional amendments. They are also numbered—for example, S. Con. Res. ________ (for Senate Concurrent Resolution) and H. J. Res. ________ (for House of Representatives Joint Resolution).

Cosponsoring a Bill

When a Senator or Representative introduces a bill, a "Dear Colleague" letter may be sent to other members. The letter explains the bill, what it would do, and why it is important, and it asks other members to cosponsor it. An effort to gain cosponsors by calling attention to a bill can help build pressure to move it through the legislative process. A bill has a much better chance of passage if the chair or members of the committee to which it will be referred introduce it.

Referring a Bill to Committee

Rules of the House and Senate provide general guidelines for which committee will consider which bill. For example, a bill to change Medicare hospital reimbursement would be referred to the Finance Committee in the Senate and the Ways and Means Committee in the House. Sometimes two committees will have responsibility (or jurisdiction) over subjects in the same bill. In that case, bills may be referred to both committees ("jointly referred").

Committees are the heart and soul of the legislative process. That's where the legislative work gets done. The House and Senate each have their own system of committees, and each committee has its own subcommittees, procedural rules, and committee chair. The committee chairs play a critical role in determining the fate of legislation. They control both the schedule (calendar) of when and if bills will be considered and the staffing of the committee.

Usually, work on a bill begins in a subcommittee. The subcommittee chair calls hearings to learn more about the effects of the proposed legislation and to find out who supports and opposes the bill. A record of the hearing is published (available to the public through the Government Printing Office and online at http://www.gpo.gov/). After hearings, the subcommittee will start "marking up" or rewriting the bill. If the subcommittee votes its approval, the "marked up" bill is sent to the full committee for its consideration. The full committee must then approve the bill, usually after marking it up again.

If a favorable vote is taken, the bill is "reported out" of committee. A written report, which explains the origins, purposes, content, and effect of the legislation, accompanies the bill. The committee report also must include information from the Congressional Budget Office on the bill's estimated cost and its impact on the federal budget.

The full House or Senate can now consider the reported bill. If the full committee does not approve the bill, it is usually dead for the rest of that Congress. Most bills die in committee. And even if hearings are held, the committee may fail to act. Once the two-year congressional term ends, all bills that have not become law must be re-introduced to be considered again.

Voting on a Bill

Bills that make it to the House or Senate calendar are not guaranteed to pass, but they have made it through the critical first phase.

The House and Senate have different rules about how bills are presented to their respective members for debate and voting. But in each case, a schedule is set up for consideration of the bill. The schedule allows for debate and, in some instances, the opportunity to offer amendments. In the House, the Rules Committee sets up the schedule. In the Senate, the leadership (headed by the Majority Leader) sets the schedule.

When a bill is passed by one house of Congress, it is then sent to the other. Usually, it will be referred to committee in the second house. More hearings may be held, and a favorable committee report issued, or the committee may decide to take no action at all. In some cases, the committee process on a given legislative issue occurs simultaneously in the House and the Senate. A bill may pass one house while a similar companion bill is moving forward in the other house at about the same time. A bill can also be placed directly on the calendar in the other house without being referred to any committee, where it will be promptly considered by the whole Senate or House.

Conference Committee

Even after both chambers approve a bill, the legislative process has not ended. If there are any differences between the House and Senate bills (and there usually are), a conference committee is set up to iron out these differences. The conference committee consists of members of both houses (called "conferees"), who are almost always members of the committees that sent the bill to the floor. On important bills like the budget or health care reform, representatives of the House and Senate leadership are likely to be included. Conferees are supposed to deal only with differences between the House and Senate bills—they are not supposed to delete provisions that are identical in both bills or to add new provisions that don't relate to the differences between the bills. Increasingly, however, they step over these boundaries to develop a compromise that resembles neither of the original bills.

When the conference committee reaches an agreement reconciling the differences between the two bills, a conference report and a final version of the bill are presented to both houses for a final vote. Only after the House and Senate both approve the compromise is the bill sent to the President.

Signing a Bill into Law

Once the President has received a bill passed by Congress, he may sign it into law or veto it within 10 days. He may also allow the bill to become law without a presidential signature by failing to act within 10 days (if Congress is in session). If he vetoes it, he returns it, along with a statement of his objections, to the house that originated the bill.

If the President vetoes a bill while Congress is in session, the members of the house that originated the legislation can vote to override the veto. If two-thirds of the members vote to override the veto, the bill then goes to the other house, where a two-thirds vote by the second house will turn the bill into law without the President's signature. If either house fails to override by a two-thirds majority, the veto stands.

Key Points in the Legislative Process

For advocates, there are a few steps to pay particular attention to:

- When bills are introduced and need cosponsors,
- When bills are being considered in committee, and
- When bills come to the floor of the House and Senate for voting.

At each of these points, advocates can make effective contacts with their elected representatives.

Influencing the White House

Sometimes you may want to call or write the White House to register your opinions. The Administration uses calls, e-mails, and letters to the White House as a gauge of public opinion. Communicating with the Executive Office can be as important as calls and letters to Congress.

To write an e-mail or letter to the White House, start with "Dear Mr. President." Send your e-mail to the White House at President@WhiteHouse.gov. If you are writing a letter, send it to the White House, 1600 Pennsylvania Avenue, NW, Washington, DC 20500.

If you would like to call the White House regarding a particular issue, you can call the White House comment line at 202-456-1111 to register your opinions on selected issues using a touch-tone phone. You may also choose to leave your message with an operator.

And finally, the White House fax number is 202-456-2461.

Many of the same pointers we listed for communicating with Congress apply to the White House as well—see "Influencing Congress" above.

Influencing Your Community

Below we list several action steps that advocates can take to improve minority health within their communities and at the federal level. Please also refer to the "Additional Resources" section of this action kit for a list of organizations that you can contact for up-to-date health policy information and resources.

1. **Leaders must be knowledgeable about—and stay abreast of—recent health policy developments and issues**, especially those that have a disproportionate impact on their racial and ethnic minority constituents. Such developments include, for example, any restructuring of state Medicaid programs that reduces benefits or cuts beneficiaries, as well as implementation of the new Medicare prescription drug benefit. Staying on top of health policy developments could include steps such as researching bills and committee reports online to keep current on pending legislation. (Find information on federal legislation online at http://thomas.loc.gov.)
2. **Organizations should identify a clear set of goals that will be used as a yardstick for determining success.** It is important to consider two kinds of goals: 1) external or policy goals and 2) internal or grassroots goals. Be aware that your goals can change over time and can be redefined and reevaluated.
3. **Building coalitions is key to having a successful initiative!** Building coalitions and strategic alliances with other minority health stakeholders, as well as other community stakeholders, is essential to leveraging expertise and vital resources. Being able to swap ideas and share "lessons learned" about effective outreach strategies will help strengthen and expand an organization's agenda and work. For example, groups could work to build consensus around particular health policies and legislative language that could be inserted into a bill. Then, they could submit policy recommendations and language to the proper state legislator or member of Congress. If your group does decide to participate in a coalition, it is important to plan your strategy around specific goals and develop messages that serve the entire coalition.
4. **Take part in legislative action!** Once you have built your coalition, you can begin to get involved in creating and influencing legislation. Here are a few legislative actions that community organizations can take part in:
    - Research and comment on proposed legislative changes. For example, if your governor or state legislators propose a Medicaid waiver to control state budget costs, write up and mail comments on why the proposed changes will be detrimental to your state's low-income community.
    - Contact state legislators and federal officials about key policy issues. Make recommendations to your state legislator about policies and state budget items that could reduce racial and ethnic health disparities.

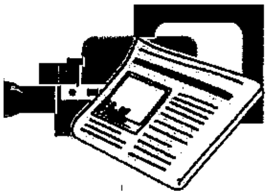
- Find out if there will be Medicaid Commission meetings in your area. If so, encourage community members to attend these meetings and make comments on how the commission's proposals will affect their communities.
- Set up a meeting with your Representative or Senator during one of his or her home visits to discuss your community or organization's minority health policy concerns. Be prepared to provide reasonable and actionable strategies for your Congressperson to consider.
- Advocates may also want to start petitions to get local citizens to support important policy recommendations and send them along to the appropriate Congressperson and local media outlets.

5. **Get the word out!** Informing constituents and colleagues about key policies and research findings is essential to empowering the community as a whole. Holding town hall meetings and organizing informal gatherings are just two ways to increase the knowledge base in a particular neighborhood or community. These need not be large-scale, formal events—they could be as simple as meeting at a local coffee shop to discuss health care issues that are affecting community members, or holding a town hall meeting in a local place of worship or senior center to inform seniors about the new Medicare law and how to pick out the plan that works best for them. The more people who know about the issues, the stronger the advocacy potential.

   In spreading the word, please remember to be aware of your constituents' unique language and cultural needs. Some materials may need to be translated for different populations. There are many national organizations, such as the National Alliance for Hispanic Health, that may be willing to assist in this effort.

6. **Get the faith community involved!** Religious leaders can raise awareness within their congregations about the importance of medical screenings for common health conditions, such as diabetes, high blood pressure, and breast cancer, as well as HIV/AIDS testing, prevention, and counseling. Congregations could also hold public health awareness events or health fairs. It is imperative that religious leaders promote health care screenings and other preventive measures in their congregations, especially since communities of color are disproportionately represented among the populations with the highest rates of several chronic conditions, and because those communities overall have worse health.
7. **Work with the media to get the most bang for your buck!** Building and maintaining relationships with local health care journalists is one way to ensure that issues that effect communities of color are addressed in the media. Writing letters to the editor and op-eds is also an effective way to inform the public about minority health issues.

Influencing the Media



In this section, we explain why your organization may want to develop a database of consumer stories and how you can use these stories to develop relationships with reporters and to get your message across effectively.

• The Story Bank

Reporters will sometimes seek out community-based organizations, especially those that work on health care issues, for real stories to use in their pieces. From personal testimonials in articles to on-camera interviews on the nightly news, personal stories are becoming more and more important in news reporting. This is especially true for health care stories. Reporters like to use "real life" examples to help simplify often-complex health care issues, to lend credibility to an issue, and to better illustrate the everyday struggles that Americans face concerning their health care. Your organization can collect consumer stories as a way to establish yourselves as a resource for reporters, as well as a means of getting your message out.

Building Relationships with Reporters through Stories

Real stories can be the hook to help you establish yourself as a resource for reporters. Once reporters hear that your organization can help them find real stories for their pieces, the phones will not stop ringing.

The Consumer Story Bank

Building a consumer story bank database will allow your organization to communicate through the media on a more personal level that can be much more compelling, but there are several issues that you must keep in mind when creating your story bank.

For example, it is important to remember to protect each individual's privacy. This means your organization must make sure that any public release of information does not happen until you get the specific consent of the person whose story you want to use. Individuals will also be more enthusiastic about getting involved in such a project if they know they can control when and with whom they share their story.

Handling a Reporter's Request for a Real Story

As with any media request, the trick to establishing yourself as a useful resource is to make sure that you get reporters the information they need quickly and efficiently. The first step in handling this request is to ask the reporter for all the information he or she is going to need. When talking with the reporter, you'll need to assess what kind of story the reporter is looking for, as well as what you will be asking of individuals in your story bank. Start the conversation by asking the reporter what kind of story he or she is working on. Usually, the reporter will give you very detailed information about the exact story he or she is envisioning. Make sure to get the following information from the reporter:

- The type of health care story the reporter is looking for—for example, an uninsured individual, a person with a compelling story about prescription drug needs, etc.
- The geographic requirements—this issue is especially important for TV reporters, who often need to speak to someone in a major media market so they can get a camera crew to the individual's home.

Get as much information as possible about what the reporter needs, but be wary about raising the reporter's expectations.

Picking the Right Story

When considering which story you will be giving a reporter, start by thinking about what kind of story will best communicate your message. You should also consider other elements of the story that will help explain your organization's position on an issue. For example, if a reporter is interested in interviewing a family that is uninsured, try to find a family where the kids are enrolled in the SCHIP program—but where the parents are uninsured. This way, the story shows the success of public programs at the same time that it fulfills the reporter's need for a story about the uninsured.

Pitching the Story

Once you have found a story that fits the reporter's criteria and that also communicates your message, your next step is to convince the reporter that this is the right story for his or her piece. Before you make that call, read through the story and make sure you have all the information you are going to need and that you are prepared to explain why your database story is the perfect fit for the reporter's needs.

Call the reporter and give him or her a brief description of the story. Finish by explaining how and why your story fits into the reporter's piece. If the reporter thinks you believe it will work, you have a better chance of convincing the reporter that this is the case. Do not call the individual whose story you have pitched until AFTER you have gotten the reporter to sign off on the story. Otherwise, you could dash the consumer's expectations and hurt his or her feelings if the reporter rejects the story.

Getting Permission from the Consumer

The next step is to call the consumer and get his or her permission. Explain what the piece is about and how he or she fits into the story. Make sure to give the person all the information about the interview.

Preparing Your Consumer for the Interview

After you have gotten permission from the consumer and have a reporter that is interested in speaking to him or her, make sure to prepare the individual for the interview.

You will find that many people are very nervous about telling their story to a reporter and will feel more at ease if you talk them through the process. Explain what the interview will be like, go over some potential questions that may come up in the interview, and assure the consumer that he or she should feel comfortable declining to answer any questions at any point during the interview.

After you have gotten the individual's permission and you have prepared him or her for the interview, you can then call the reporter with the contact information. Make sure you give the reporter instructions, such as specific times to call (if that has been discussed) or any updates you have learned through your conversation with the consumer.

Building Your Story Bank—Where to Find Stories

- Community health clinics can be a source of stories on the uninsured.
- Children's organizations will often have stories of families where the kids are enrolled in SCHIP and the parents are still uninsured.
- Senior centers can be a source of stories from seniors who are struggling to pay for prescription drugs.
- Local pharmacists are also a good source for prescription drug stories.
- Partner groups who work on your issues may be able to provide stories or leads.
- Web site—if your organization has the resources, you can create a section of your Web site where people can submit their stories online.
- Local unions can be a good source for uninsured stories.

More Sources:

- Small business owner/self-employed associations
- Calls from individuals to your organization
- Faith-based charities or organizations

A database of real stories is a resource you can use to further your relationships with reporters and to help get your message out through the media. Health care issues are often complex, and real stories help bring the issues down to a level that everyone can understand. Compelling stories can be powerful tools that will not only help you reach out to reporters, but they will also draw reporters to your organization. You'll probably find that many individuals will be interested in sharing their stories, and doing interviews with the press will allow them to do something about their current situation and become activists on the issue.

For more information on Families USA's Minority Health Initiatives,
contact Rea Pañares, Director of Minority Health Initiatives
or Briana Webster-Patterson, Program Manager at
minorityhealth@familiesusa.org or 202-628-3030.

DARE TO GET INVOLVED

How to Take Action to Improve Minority Health:

An Advocate's Checklist

Knowledge Is Power: Get Informed!

☑ **Stay abreast of recent health disparities research and policy developments.** Being informed about the issues is essential to becoming an effective minority health policy advocate.

☑ **Inform your constituents and colleagues** about key health policies and research findings. The more people who know about the issues, the stronger the advocacy potential.

☑ There is power in numbers—**build and maintain strong relationships** with other health advocates to leverage expertise and resources and share the benefits of "lessons learned."

☑ **Be innovative and culturally and linguistically appropriate** when you incorporate minority health into your organization's agenda and work.

☑ **Use Families USA as a resource** for all of your minority health policy needs. Look us up online at www.familiesusa.org. Contact us by e-mail at minorityhealth@ familiesusa.org or by telephone at (202) 628-3030.

Coalition Building and Community Development

Specific activities could include the following:

☑ **Build relationships** with other key health advocacy groups to leverage expertise and resources.

☑ **Swap strategy ideas** and share "lessons learned" about effective outreach strategies. Pool resources: Together, groups may be able to use more "high-tech" means of communicating, such as videos or video story banking.

☑ **Sponsor town hall meetings** about key health care issues (e.g., sponsor a meeting for senior citizens about the new Medicare law or a meeting for low-income mothers about Medicaid and SCHIP).

☑ **Start petitions** to get local citizens to support important policy recommendations and submit the petitions to the appropriate Congressperson and local media outlets.

Engaging the Faith Community

Specific activities could include the following:

- ☑ **Ask your pastor or minister to raise awareness** about the importance of screening for common health problems, such as diabetes, high blood pressure, and heart disease, as well as HIV/AIDS testing, prevention, and counseling.
- ☑ **Encourage fellow congregants to participate** in already-existing public heath awareness events, such as "take a family member to the doctor" day or "take a friend to have a mammogram" day.
- ☑ **Host a seminar about enrolling in public health programs** in your church and ensure that participants are educated about the importance of Medicaid and the State Children's Health Insurance Program (SCHIP) and the eligibility requirements for those programs.
- ☑ During weeknight events at your church, **invite a nutrition or health and wellness expert** to lead a lecture on health and wellness and the dangers of obesity.
- ☑ **Serve healthier foods** after church services and during church functions.

Media Outreach

Specific activities could include the following:

- ☑ **Help educate** both the minority and mainstream media about minority health policy issues so that these issues get timely and appropriate attention.
    - ✓ Figure out who your audience is and how best to reach it. What kinds of materials would be most likely to make your point, and what kinds of materials would be most useful to your audience?
    - ✓ Translate health care materials into Spanish or other languages spoken by the groups you want to reach, when appropriate. If your group doesn't have the resources to translate important materials, partnering with another organization might enable you to pool resources—and reach an even broader audience.
- ☑ **Build and maintain relationships** with health care journalists and talk to them on a regular basis.
- ☑ **Build a story bank**, which chronicles personal health care stories, to humanize your issues and more effectively get your story out to the public. (See the *ImPRESSive* newsletter article titled "The Art of Story Banking" on our Web site.)

☑ **Take a media training workshop** to learn how to get your messages out to reporters and share your acquired skills with fellow advocates so that many people can benefit from your newly gained knowledge.

☑ **Hold press conferences** to announce health policy news to a wide range of media outlets.

☑ **Write opinion-editorials** (op-eds) and **letters to the editor** for your local newspapers.

☑ **Call local radio talk shows** to discuss racial and ethnic health care issues.

☑ If your organization has a Web site, make sure that you **have a minority health policy Web page**, as well as a newsroom (or similar) page. If you cannot build such pages, link to another organization's Web site, such as Families USA's, which has a very informative minority health page and an extensive minority and mainstream media network.

☑ **Establish a health policy e-mail house list** that includes members of advocacy groups you want to keep in the loop.

Working with Appointed and Elected Officials

Specific activities could include the following:

☑ **Research bills and committee reports online** so that you are aware of pending legislation that could include language that addresses health disparities. (Find information on federal legislation online at http://thomas.loc.gov.)

☑ **Form strategic alliances** with other advocacy organizations, build consensus on particular health policies and legislative language that could be inserted into a bill, and submit the policy recommendation and language to your state legislator or member of Congress.

☑ **Contact your state legislator** about key health policy issues (i.e., make suggestions to your legislator about policies and state budgetary items that will reduce racial and ethnic health disparities).

☑ **Contact your federal officials** about key health policy issues. There are several ways to contact officials at the federal level:

- ✓ Write or call your members of Congress. The phone number for Washington, DC Capitol Hill offices is 202-224-3121.

- ✓ Set up a meeting with your Representative or Senator during one of his or her home visits to discuss your community or organization's minority health policy concerns. Be prepared to provide reasonable and actionable strategies for your Congressperson to consider.
- ✓ Develop lines of communication with congressional staff who oversee the office's health policy and public health initiatives.

For more information on Families USA's Minority Health Initiatives,
contact Rea Pañares, Director of Minority Health Initiatives
or Briana Webster-Patterson, Program Manager at
minorityhealth@familiesusa.org or 202-628-3030.

Additional Resources:
Organizations and Web Sites

The Arthur Ashe Institute for Urban Health
450 Clarkson Avenue, Box 1232
Brooklyn, NY 11203
Phone: (718) 270-3101
Web site: http://www.arthurasheinstitute.org/

The Arthur Ashe Institute for Urban Health works to reduce illness, injury, and death among the most vulnerable populations in urban areas through improved access to care and increased health knowledge. The organization's Web site features information on general health topics of interest to minority populations and also includes a listing of community programs that address health concerns.

California Pan-Ethnic Health Network (CPEHN)
654 13th Street
Oakland, CA 94612
Phone: (510) 832-1160
Fax: (510) 832-1175
E-mail: info@cpehn.org
Main Office Web site: http://www.cpehn.org/

CPEHN is dedicated to increasing access to health care and eliminating health disparities by advocating for public policies and sufficient resources to address the health needs of all Californians. The organization's Web site contains policy briefs, relevant publications, and a Listserv for advocates.

Center for Cultural and Linguistic Competence in Health Care
P.O. Box 37337
Washington, DC 20013
Phone: 1 (800) 444-6472
Fax: (301) 251-2160
Web site: http://www.omhrc.gov/cultural/

A division of the federal Office of Minority Health, the Center for Cultural and Linguistic Competence in Health Care develops and evaluates models, conducts research, and provides technical assistance on how to eliminate cultural and linguistic barriers to health care services. Their Web site includes information on the center's national standards for culturally and linguistically appropriate health services, as well as information on federal policies, initiatives, and laws.

Community Catalyst Physician Diversity Project
30 Winter Street, 10th Floor
Boston, MA 02108
Phone: (617) 338-6035
Web site: http://www.communitycatalyst.org/index.php?doc_id=29

The Physician Diversity Project seeks to increase the diversity of the medical profession to better reflect the increasing diversity of the patient population in the United States. The organization's Web site offers a searchable publications database, contact information for state-based advocacy organizations, and in-depth information on the organization's programs.

The Cross Cultural Health Care Program
270 South Hanford Street, Suite 100
Seattle, WA 98134
Phone: (206) 860-0329 or (206) 860-0331
Fax: (206) 860-0334
Web site: http://www.xculture.org/

The CCHCP addresses broad cultural issues that affect the health of individuals and families in ethnic minority communities in Seattle and nationwide. The mission of the Cross Cultural Health Care Program is to serve as a bridge between communities and health care institutions to ensure that patients have access to culturally appropriate, quality health care. The organization's Web site allows advocates to purchase relevant publications and videos, find out when cultural competence trainings are offered in their area, and learn more about providing culturally sensitive interpreting services.

Diversity RX
E-mail: rcchc@aol.com
Web site: http://www.diversityrx.org/

Diversity Rx is a clearinghouse of information on how to meet the language and cultural needs of minorities, immigrants, refugees, and other diverse populations seeking health care. The organization's Web site includes a Listserv and other networking tools for advocates.

Health Finder Just For You
Web site: http://healthfinder.gov/justforyou/

Health Finder is a site for consumers created by the U.S. Department of Health and Human Services (HHS). The Web site contains a collection of information organized by specific populations (e.g., parents, women, African Americans, Hispanics) and by specific health concerns (cancer, contraception, mental health, HIV/AIDS, diabetes, etc.).

Healthy People 2010
Web site: http://www.healthypeople.gov/

Healthy People 2010 is a national health promotion and disease prevention initiative created by a broad coalition of experts to improve the health of all Americans. Healthy People is designed to achieve two overarching goals, one of which is to eliminate health disparities among different segments of the population. Their Web site includes background information on the initiative; the complete text of *Healthy People 2010: Understanding and Improving Health*; data and statistics; a list of the Healthy People partners and related sites; and other Healthy People publications.

Kaiser Family Foundation
Web site: http://www.kff.org/

The Henry J. Kaiser Family Foundation is a nonprofit, private foundation that focuses on the major health care issues facing the nation. The foundation develops and runs its own research and communications programs, often in partnership with outside organizations. The organization's Web site has a section dedicated to minority health issues, including reports that specifically address racial disparities in health. Kaiser also offers a Listserv that focuses on various health care topics.

kaiserEDU
Web site: http://www.kaiseredu.org/

KaiserEDU.org is designed to provide easy access to the latest data, research, analysis, and developments in health policy to students, faculty, and others interested in learning about health policy. The site includes narrated slide tutorials; background reference libraries; and issue modules on current topics and policy debates, including a section on race, ethnicity, and health care.

National Center for Cultural Competence
Georgetown University Center for Child & Human Development
3307 M Street NW, Suite 401
Washington, DC 20007-3935
Phone: (202) 687-5387, 1 (800) 788-2066, (TTY) 202-687-5503
Fax: 202-687-8899
Web site: http://gucchd.georgetown.edu/nccc/index.html

The mission of the NCCC is to increase the capacity of health and mental health programs to design, implement, and evaluate culturally and linguistically competent service delivery systems. The center's Web site offers tools (such as individual and organizational assessment checklists) for advocates seeking to improve the cultural and linguistic competence of health systems.

National Center on Minority Health and Health Disparities
National Institutes of Health
6707 Democracy Blvd., Suite 800
MSC-5465
Bethesda, MD 20892
Phone: (301) 402-1366; TTY: (301) 451-9532
Fax: (301) 480-4049
Web site: http://www.ncmhd.nih.gov/

The mission of the National Center on Minority Health and Health Disparities (NCMHD) is to promote minority health and to lead, coordinate, support, and assess the NIH effort to reduce and ultimately eliminate health disparities. In this effort, the NCMHD conducts and supports basic, clinical, social, and behavioral research; promotes research infrastructure and training; fosters emerging programs; disseminates information; and reaches out to minority and other health disparity communities. Their Web site provides information on NIH programs that address health disparities, relevant conferences and meetings, and links to related government agencies.

National Immigration Law Center
3435 Wilshire Blvd., Suite 2850
Los Angeles, CA 90010
Phone: (213) 639-3900
Fax: (213) 639-3911
E-mail: info@nilc.org
Web site: http://www.nilc.org/

The NILC is a national support center whose mission is to protect and promote the rights and opportunities of low-income immigrants and their families. NILC staff specialize in immigration law and the employment and public benefits rights of immigrants. NILC conducts policy analysis and impact litigation and provides publications, technical advice, and trainings to a broad constituency of legal aid agencies, community groups, and *pro bono* attorneys. The organization's Web site allows advocates to download recently released articles and fact sheets, purchase publications on immigrant issues, and learn more about NILC conferences and trainings.

National Minority AIDS Council
1931 13th Street NW
Washington, DC 20009-4432
Phone: (202) 483-6622
Fax: (202) 483-1135; (202) 483-1127
Web site: http://www.nmac.org/home/

The National Minority AIDS Council is an organization dedicated to developing leadership within communities of color to address the challenges of HIV/AIDS. The organization's Web site includes publications, public policy information, an online action center, and an HIV/AIDS job bank.

Office of Minority Health (OMH) Resource Center
P.O. Box 37337
Washington, DC 20013-7337
Phone: 1 (800) 444-6472
Fax: (301) 251-2160
Web site: http://www.omhrc.gov/

The mission of the OMH is to improve the health of racial and ethnic populations through the development of effective health policies and programs that help eliminate disparities in health. The OMH Web site has a resource center that provides referrals, publications, reference information, and access to its resource person's network.

Resource Centers for Minority Aging Research
National Institute on Aging
Phone: (301) 496-1752
Web site: http://www.rcmar.ucla.edu/

The Resource Centers for Minority Aging Research were funded by the National Institutes of Health to decrease disparities in health and their social consequences for older people through research on health promotion, disease prevention, and disability prevention. The

Web site, run by a coordinating center at the University of California, Los Angeles, includes links to more information on the work of the centers, information on disparities that is available through the National Institute on Aging, and other resources.

Summit Health Institute for Research and Education, Inc. (SHIRE)
440 First Street NW, Suite 430
Washington, DC 20001
Phone: (202) 371-0277
Fax: (202) 371-0460
General inquiries: Shire@shireinc.org
Web site: http://www.shireinc.org/index.htm

SHIRE acts as a resource to communities, government agencies, corporations, educational institutions, and foundations seeking to address health disparities and expand access to health care. SHIRE works to build connections between stakeholders in communities of color that play a key role in creating and sustaining programs that will close health gaps and meet unique community needs.

United States Census Bureau—Minority Links
Web site: http://www.census.gov/pubinfo/www/hotlinks.html

This Web site presents links to the latest data on racial and ethnic populations in the United States, including profiles of the social and economic characteristics of the country's major minority populations.

University of North Carolina Minority Health Project
Department of Maternal and Child Health
Campus Box 7445
UNC School of Public Health
Chapel Hill, NC 27599-7445
Phone: (919) 843-6758
Fax: (919) 966-0458
E-mail: minority_health@unc.edu
Web site: http://www.minority.unc.edu/

The overall purpose of the Minority Health Project is to improve the quality of available data on racial and ethnic populations, to expand the capacity of minority health researchers to conduct statistical research and develop research proposals, and to foster a network of researchers in minority health. The MHP conducts educational programs, including the Annual Summer Public Health Research Institute and Videoconference on Minority Health. It also provides research and sources of data on minority health issues. The project's Web site includes useful links to relevant publications and webcasts of past conferences.

On American Indian and Native American Health

American Indian and Alaska Native Health
Web site: http://www.nlm.nih.gov/pubs/cbm/amindhlt.html

This Web site, compiled by the National Library of Medicine, provides a comprehensive bibliography of print resources on health topics related to American Indians and Alaska Natives in the United States. It includes basic background statistics on American Indian and Alaska Native health.

Association of American Indian Physicians
1225 Sovereign Row, Suite 103
Oklahoma City, OK 73108
Phone: (405) 946-7072
Fax: (405) 946-7651
E-mail: aaip@aaip.com
Web site: http://www.aaip.com/

The AAIP is dedicated to pursuing excellence in American Indian health. Its members are actively involved in medical education, cross-cultural training, and assisting Indian communities. The association's Web site provides a list of relevant resources for American Indian consumers and health care providers.

FASTATS: Health of American Indian or Alaska Native Population
Web site: http://www.cdc.gov/nchs/fastats/native_health.htm

This Web site includes data on health status, health risk factors, health care access, and mortality rates for the American Indian and Alaska Native populations in the United States. The information is provided by the National Center for Health Statistics.

Indian Health Service
The Reyes Building
801 Thompson Avenue, Suite 400
Rockville, MD 20852-1627
Web site: http://www.ihs.gov/

The Indian Health Service (IHS), an agency within the Department of Health and Human Services (HHS), is responsible for providing federal health services to American Indians and Alaska Natives. The IHS is the principal federal health care provider and health advocate for Indian people, and its goal is to raise their health status to the highest possible level. The agency's Web site provides a wealth of information on topics pertaining to American Indian and Alaska Native health.

Medline Plus—Native-American Health
Web site: http://www.nlm.nih.gov/medlineplus/nativeamericanhealth.html

This Web site provides links to recent news articles on health issues of particular importance to the Native-American population in the United States. It also contains links to relevant health organizations, statistics, and research studies.

National Council on Urban Indian Health
501 Capitol Court, Suite 100
Washington, DC 20002
Phone: (202) 544-0344
Web site: http://www.ncuih.org/

The mission of the NCUIH is to support and develop quality, accessible health care programs for all American Indian and Alaska Natives living in urban communities. It does this through advocacy, training, education, and leadership development. The organization's Web site also provides resources and tools for advocates interested in Indian urban health issues.

National Indian Health Board
101 Constitution Ave. NW, Suite 8-B02
Washington, DC 20001
Phone: (202) 742-4262
Fax: (202) 742-4285
Web site: http://www.nihb.org/

A nonprofit advocacy organization, the NIHB conducts research; writes policy analyses; offers program assessment and development services; plans national and regional meetings, trainings, and technical assistance programs; and provides project management. These services are provided to tribes, Area Health Boards, tribal organizations, federal agencies, and private foundations. The organization's Web site includes legislative reports, information on specific health topics and illness categories, and links to health resources for those interested in becoming more involved.

On African-American Health

Black Women's Health Imperative
600 Pennsylvania Avenue SE, Suite 310
Washington, DC 20003
Phone: (202) 548-4000
Fax: (202) 543-9743
Web site: http://www.blackwomenshealth.org/site/PageServer

The Black Women's Health Imperative develops highly effective health information, products, and programs for African American women. The organization's aim is to deepen the public's commitment to investing in health prevention strategies and research that contribute to black women leading healthier, longer lives. The organization's Web site provides links to current research, upcoming events, and ways to become more involved in advocating for the health of black women.

The California Black Health Network
7840 Mission Center Court, Suite 200
San Diego, CA 92108
Phone: (619) 295-5413
Fax: (619) 295-5749
E-mail: cbhn@pacbell.net
Web site: http://www.cbhn.org/

The mission of the California Black Health Network is to improve the health status of people of African descent in California by influencing policies and programs that advance health promotion and disease prevention. The organization's Web site provides information on how to become more involved in the organization, including becoming a member or affiliate organization.

The Congressional Black Caucus Foundation
1720 Massachusetts Avenue NW
Washington, DC 20036
Phone: (202) 263-2800
Fax: (202) 775-0773
Web site: http://www.cbcfhealth.org/

This Web site, which is part of the Congressional Black Caucus Foundation's News Service, seeks to provide accurate information about public health issues that directly or indirectly affect people of African descent in America. It includes links to articles on HIV and AIDS, chronic illnesses, mental health issues, health disparities, current policy issues, and many other relevant topics.

FASTATS: Health of Black or African American Population
Web site: http://www.cdc.gov/nchs/fastats/black_health.htm

This Web site includes data on health status, health risk factors, health care access, and mortality rates for Americans of African descent. The information is provided by the National Center for Health Statistics.

Improving Cardiovascular Health in African Americans
Web site: http://www.nhlbi.nih.gov/health/public/heart/other/chdblack/index.htm

This Web site provides links to seven easy-to-read booklets on heart health designed for an African American audience. The booklets can be read online or purchased in bulk for distribution.

Joint Center for Political and Economic Studies, Health Policy Institute
1090 Vermont Ave., NW, Suite 1100
Washington, DC 20005
Phone: (202) 789-3500
Fax: (202) 789-6390
Web site: http://www.jointcenter.org/healthpolicy/

The mission of the Health Policy Institute is to ignite a "Fair Health" movement that gives people of color the inalienable right to equal opportunity for healthy lives. It aims to help communities of color identify short and long term policy objectives that can lead to improved health outcomes. Its Web site includes published reports, fact sheets, and Power Point presentations on health disparities.

Medline Plus—African American Health
Web site: http://www.nlm.nih.gov/medlineplus/africanamericanhealth.html

This Web site provides links to recent news articles on health issues of particular importance to the African American population. It also provides links to relevant health organizations, statistics, and research studies.

The National Association for the Advancement of Colored People (NAACP)—Health Division
4805 Mt. Hope Drive
Baltimore, MD 21215
Phone: (410) 580-5672
E-mail: health@naacpnet.org
Web site: http://www.naacp.org/departments/health/health_index.html

The Health Division seeks to inform and educate NAACP members and the broader community about health disparities, disease prevention, health care quality and access, health professions training, and youth health issues. The National Health Division staff works to create and implement initiatives and resources, evaluate and draft policy statements, and represent the NAACP at conferences, workshops, and advisory boards. The organization's Web site offers information about the Health Division, as well as tools for activists seeking to establish a health committee through their local NAACP branch.

National Medical Association (NMA)
1012 10th Street, NW
Washington, DC 20001
Phone: (202) 347-1895
Fax: (202) 898-2510
Web site: http://www.nmanet.org/

The National Medical Association represents and promotes the interests of African-American physicians and patients in the United States, focusing particularly on racial health disparities. NMA's Web site includes publications, policy statements, and a collection of links to other Web sites that address health issues.

On Asian and Pacific Islander Health

Asian and Pacific Islander American Health Forum
Main Office:
450 Sutter Street, Suite 600
San Francisco, CA 94108
Phone: (415) 954-9988
Fax: (415) 954-9999
E-mail: hforum@apiahf.org
Web site: http://www.apiahf.org/

Washington, DC office:
1001 Connecticut Avenue NW, Suite 835
Washington, DC 20036
Phone: (202) 466-7772
Fax: (202) 466-6444

The Health Forum is a national advocacy organization dedicated to promoting policy, program, and research efforts to improve the health and well-being of Asian American and Pacific Islander (AAPI) Communities. The organization's purpose is to create a network for disseminating and sharing health information, resources, and policy issues among individuals and organizations that provide health services to AAPI communities. Resources available through their Web site include fact sheets, bibliographies, newsletters, and links to other organizations.

Association of Asian Pacific Community Health Organizations (AAPCHO)
300 Frank H. Ogawa Plaza, Suite 620
Oakland, CA 94612
Phone: (510) 272-9536
Fax: (510) 272-0817
Web site: http://www.aapcho.org/site/aapcho/

The AAPCHO's mission is to promote advocacy, collaboration, and leadership in order to improve the health status of Asian Americans. The association's Web site has links to products, publications, programs, and other resources. AAPCHO also maintains an e-mail Listserv.

FASTATS: Health of Asian or Pacific Islander Population
Web site: http://www.cdc.gov/nchs/fastats/asian_health.htm

This Web site includes data on health status, health risk factors, health care access, and mortality rates for the Asian and Pacific Islander populations in the United States. The information is provided by the National Center for Health Statistics.

Medline Plus—Asian-American Health
Web site: http://www.nlm.nih.gov/medlineplus/asianamericanhealth.html

This Web site provides links to recent news articles on health issues of particular importance to the Asian American population in the United States. It also contains links to relevant health organizations, statistics, and research studies.

The National Asian Pacific Center on Aging
1511 Third Avenue, Suite 914
Seattle, WA 98101
Phone: (206) 624-1221
Fax: (206) 624-1023
Web site: http://www.napca.org/

The mission of the National Asian Pacific Center on Aging is to serve as the leading national advocacy organization committed to the dignity, well-being, and quality of life of Asian Pacific Americans (APA) in their senior years. Their Web site provides a variety of resources for advocates, including several translated articles.

National Asian Women's Health Organization
One Embarcadero Center, Suite 500
San Francisco, CA 94111
Phone: (415) 773.2838
Fax: (415) 773.2872
Web site: http://www.nawho.org/

The National Asian Women's Health Organization works to raise awareness about the health needs of Asian Americans through research and education. The organization's Web site includes publications, detailed information on current and past program initiatives, and a list of recent events and news headlines.

On Latino Health

Congressional Hispanic Caucus Institute (CHCI)
504 C Street NE
Washington, DC 20002
Phone: (202) 543-1771
Web site: http://www.chci.org/

The CHCI offers educational and leadership development programs, services, and activities that promote the growth of future Latino leaders. The group's Web site offers additional information on the organization and includes a listing of relevant conferences, reports, and policy recommendations.

FASTATS: Health of Hispanic-Latino Population
Web site: http://www.cdc.gov/nchs/fastats/hispanic_health.htm

This Web site includes data on the health status, health risk factors, health care access, and mortality rates for the Hispanic-Latino population in the United States. The information is provided by the National Center for Health Statistics.

FASTATS: Health of Mexican American Population
Web site: http://www.cdc.gov/nchs/fastats/mexican_health.htm

This Web site includes data on the health status, health risk factors, health care access, and mortality rates for Americans of Mexican descent. The information is provided by the National Center for Health Statistics.

Latino Cardiovascular Health Resources
Web site: http://www.nhlbi.nih.gov/health/prof/heart/latino/latin_pg.htm

This Web site includes materials published by the National Heart, Lung, and Blood Institute, including bilingual booklets on cardiovascular health risks and heart-healthy recipes. It also includes information about the Institute's most recent and comprehensive health promotion initiative, Salud para su Corazón (For the Health of Your Heart), a community-based heart disease initiative targeting Latinos living in the United States.

Latino Coalition for a Healthy California (LCHC)
1225 Eighth Street, Suite 500
Sacramento, CA 95814
Phone: (916) 448-3234
Fax: (916) 448-3248
Web site: http://www.lchc.org/

The LCHC focuses specifically on the public policies, services, and conditions that affect Latino health care, health disparities, and community health in California. The coalition's Web site provides additional information about the three major functions of the organization's work: public policy and advocacy, community education, and research.

Medline Plus—Hispanic-American Health
Web site: http://www.nlm.nih.gov/medlineplus/hispanicamericanhealth.html

This Web site provides links to recent news articles on health issues of particular importance to the Latino population in the United States. It also contains links to relevant health organizations, statistics, and research studies.

National Alliance for Hispanic Health
501 16th Street NW
Washington, DC 20036
Phone: (202) 387-5000
E-mail: alliance@hispanichealth.org
Web site: http://www.hispanichealth.org/

The National Alliance for Hispanic Health is the largest advocacy and research organization focused specifically on Hispanic health issues. Their Web site provides information for advocates, consumers, and others interested in learning more about important health issues facing Hispanic individuals in the United States. The site includes fact sheets, a list of helplines and hotlines, and some resources in Spanish.

National Association of Latino Elected and Appointed Officials Educational Fund (NALEO)
1122 West Washington Blvd., 3rd Floor
Los Angeles, CA 90015
Email: info@naleo.org
Web site: http://www.naleo.org/

NALEO is the leading organization that empowers Latinos to participate fully in the American political process, from citizenship to public service. The organization's work includes developing and implementing programs that promote the integration of Latino immigrants into American society, developing future leaders among Latino youth, providing assistance and training to the nation's Latino elected and appointed officials, and conducting research on issues important to the Latino population. NALEO also works to increase the understanding of local elected and appointed officials and community leaders about key health issues facing their constituents and effective strategies and successful policies for promoting access to health care.

Additional Resources:

Publications

Medicaid

Gail Christopher, "Medicaid's Larger Debate: What the Future Will Bring," Community Voices, available online at http://www.communityvoices.org/Article.aspx?ID=362.

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Kaiser Commission on Medicaid and the Uninsured, *The Medicaid Program at a Glance* (Washington: Kaiser Family Foundation, June 2005).

Courtney M. Perlino, *Medicaid, Prevention and Public Health: Invest Today for a Healthier Tomorrow* (Washington: American Public Health Association, 2005).

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Laura Shone, Andrew Dick, Jonathan Klein, et al., "Reduction in Racial and Ethnic Disparities After Enrollment in the State Children's Health Insurance Program," *Pediatrics* 115 (June 2005), pp. 697-705.

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June Eichner and Bruce C. Vladeck, "Medicare As a Catalyst for Reducing Health Disparities," *Health Affairs* 24 (March-April 2005), pp. 365-375.

Kaiser Family Foundation, *A Profile of African Americans, Latinos, and Whites with Medicare: Implications for Outreach Efforts for the New Drug Benefit* (Menlo Park, CA: Kaiser Family Foundation, November 2005).

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Maya Rockeymoore and Laura Hawkinson, *Structured Inefficiency: The Impact of Medicare Reform on*

African Americans (Washington: Congressional Black Caucus Foundation Center for Policy Analysis and Research, 2004).

Reginald D. Williams II, *Medicare and Communities of Color* (Washington: National Academy of Social Insurance, November 2004).

Access and Coverage

E. Richard Brown, Victoria D. Ojeda, Roberta Wyn, et al., *Racial and Ethnic Disparities in Access to Health Insurance and Health Care* (Los Angeles: UCLA Center for Health Policy Research and Kaiser Family Foundation, April 2000).

Michelle M. Doty, *Hispanic Patients' Double Burden: Lack of Health Insurance and Limited English* (New York: The Commonwealth Fund, February 2003).

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Joseph Harell and Olveen Carrasquillo, "The Latino Disparity in Health Coverage," *Journal of the American Medical Association* 289 (March 5, 2003), p. 1167.

J. Lee Hargraves, *Trends in Health Insurance Coverage and Access Among Black, Latino, and White Americans, 2001-2003* (Washington: Center for Studying Health System Change, October 2004).

Kaiser Family Foundation, *How Private Insurance Works: A Primer* (Menlo Park, CA: Kaiser Family Foundation, April 2002).

Kaiser Family Foundation, *Racial and Ethnic Disparities in Women's Health Coverage and Access to Care, Findings from the 2001 Kaiser Women's Health Survey* (Menlo Park, CA: Kaiser Family Foundation, March 2004).

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Kaiser Family Foundation, *Compendium of Cultural Competence Initiatives in Health Care* (Menlo Park, CA: Kaiser Family Foundation, June 2003).

Ruth T. Perot and Mara Youdelman, *Racial, Ethnic, and Primary Language Data Collection in the Health Care System: An Assessment of Federal Policies and Practices* (New York: The Commonwealth Fund, September 2001).

Summit Health Institute for Research and Education, *Giving Voice to the Voiceless: Language Barriers & Health Access Issues of Black Immigrants of African Descent* (Woodland Hills, CA: The California Endowment, March 2005).

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Agency for Healthcare Research and Quality, *2004 National Healthcare Disparities Report* (Rockville, MD: U.S. Department of Health and Human Services, December 2004).

Agency for Healthcare Research and Quality, *Health Care for Minority Women: Program Brief*, AHRQ Publication No. 03-P020 (Rockville, MD: U.S. Department of Health and Human Services, May 2002).

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Applied Research Center and Northwest Federation of Community Organizations, *Closing the Gap: Solutions to Race-Based Health Disparities* (Oakland, CA: Applied Research Center, July 2005).

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Kaiser Family Foundation/Pew Hispanic Center, *Health Care Experiences 2002 National Survey of Latinos: Survey Brief* (Menlo Park, CA: Kaiser Family Foundation and Pew Hispanic Center, 2004).

Edward M. Kennedy, "The Role of the Federal Government in Eliminating Health Disparities," *Health Affairs* 24 (March-April 2005), pp. 452-458.

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Wilhelmina Leigh and Maren Jimenez, *Women of Color Health Data Book, Second Edition* (Bethesda, MD: National Institutes of Health, 2002).

John E. McDonough, Brian K. Gibbs, Janet L. Scott-Harris, et al., *A State Policy Agenda to Eliminate Racial and Ethnic Disparities* (New York: The Commonwealth Fund, June 2004).

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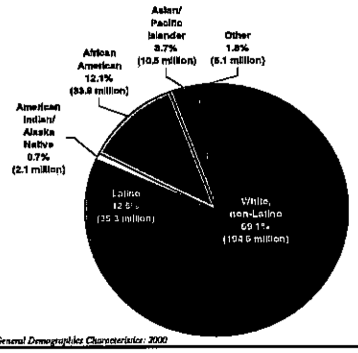
Making Public Programs Work for Communities of Color

Talking Points for Community Leaders
on Racial and Ethnic Health Disparities
and Public Programs

Changing Demographics

- The demographics of the nation are changing.
- People of color make up one-third of the U.S. population, and that proportion is expected to increase to half by 2050.

Percent Distribution of U.S. Population by Race/Ethnicity, 2000



Source: U.S. Census, *Profile of General Demographics Characteristics: 2000*

Racial and Ethnic Health Disparities

- The problem of racial and ethnic health disparities has been well documented, leading the U.S. Department of Health and Human Services (HHS) to make eliminating health disparities by 2010 a national goal.
- However, recent threats to public health programs such as Medicaid and SCHIP (the State Children's Health Insurance Program), changes in the Medicare program, and the growing number of uninsured racial and ethnic minorities make reducing and ultimately eliminating these disparities a challenging task.

The Extent and Breadth of Health Disparities

- People of color are less likely to have health insurance coverage, to see a provider on a regular basis, and to receive preventive screenings or routine health care services.
- At the same time, people of color are more likely to be diagnosed at a later stage of disease and to be hospitalized for preventable conditions.

Defining Disparities

The term "racial and ethnic health disparities" is an umbrella term that includes disparities in *health* and disparities in *health care.*

Disparities in health: differences between two or more population groups in health outcomes and in the prevalence, incidence, or burden of disease, disability, injury, or death.

Disparities in health care: differences between two or more population groups in health care access, coverage, and quality of care, including differences in preventive, diagnostic, and treatment services.

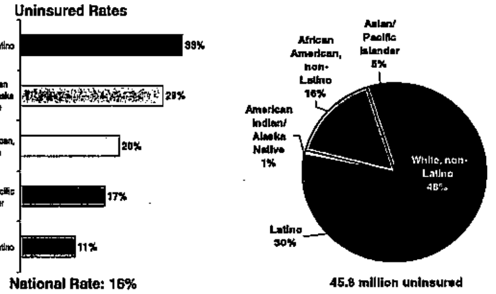
The Role of Health Coverage in Reducing Disparities

- Of all the factors that contribute to health disparities, lack of health care coverage is the single most important factor.
- Racial and ethnic minorities are much more likely to lack health insurance coverage or to be underinsured compared to non-Hispanic whites.

People of Color Disproportionately Uninsured

While people of color make up just one-third of the U.S. population, they comprise over half of the 45.8 million uninsured.

People without Insurance by Race/Ethnicity, 2004



Source: U.S. Census Bureau, "Health Insurance Coverage: 2004," *Current Population Survey 2004*, available online at http://www.census.gov/hhes/www/hlthin04.html.

The Importance of Public Programs

- Overwhelming evidence indicates that the single most effective way to reduce racial and ethnic health disparities is through the expansion and preservation of public programs.
- Innovative models for treating minority patients have often originated in public-sector programs such as Medicaid, SCHIP, and Medicare.
- Currently, these programs are under threat, moving us in the direction of preservation rather than innovation.

People of Color Disproportionately Rely on Public Programs

Racial and ethnic minorities are more likely to rely on public programs for insurance coverage. Consider that . . .

- 27.5 percent of African Americans,
- 22.3 percent of Latinos,
- 29.9 percent of American Indians/ Alaska Natives, and
- 11 percent of whites

. . . obtain care through public programs.

Medicaid: Background

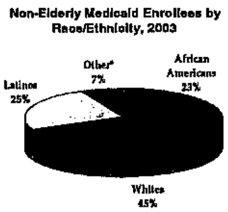
- Covers 53 million low-income Americans
  - *Who qualifies?* Pregnant women and children under age 6 with family incomes below 133 percent of poverty, older children with family incomes below 100 percent of poverty, parents with income below their state's welfare eligibility levels, and most elderly and people with disabilities who receive cash assistance
  - *What does it provide?* Health and long-term care services
- Jointly funded by states and federal government
- Program coverage differs from state to state

People of Color Disproportionately Rely on Medicaid

- 24.6 percent of African Americans,
- 20.9 percent of Latinos,
- 9.0 percent of Asian/Pacific Islanders, and
- 24.9 percent of American Indian/Alaska Natives have coverage through Medicaid.

Medicaid Essential to People of Color

- While racial and ethnic minorities make up just one-third of the total U.S. population, they comprise more than half of those who get their health care through Medicaid.
- Many minorities would be uninsured without the coverage that Medicaid provides.



Source: Kaiser Family Foundation, State Health Facts Online, available online at www.statehealthfacts.org, accessed on November 15, 2005.
* Note: Other includes Asian Americans, Pacific Islanders, American Indians, Aleutians, Eskimos, and people of "two or more races".

Threats to Medicaid

- Many proposals have been submitted by both states and the federal government that would radically restructure or cut the Medicaid program.
- Several states, such as Tennessee, Missouri, and now Florida and South Carolina, have submitted Medicaid waivers that have the potential to drastically reduce the number of racial and ethnic minorities who are covered under their programs. Some states have already made drastic cuts.
- Diverse advocacy efforts are needed to ensure that we can maintain and expand this very vital safety net.

The State Children's Health Insurance Program (SCHIP)

- SCHIP provides health insurance to roughly 4 million low-income children.
- SCHIP covers children who are uninsured, who are ineligible for Medicaid, and who are from families with low incomes (generally below 200 percent of poverty, depending on the state).

Children of Color Disproportionately Rely on Medicaid and SCHIP

- 46.9 percent of African American children and 38.3 percent of Latino children were covered only by either Medicaid or SCHIP in 2002, compared to 18.4 percent of white children.
- Latino children are twice as likely as African American and white children to be uninsured, but many actually qualify for Medicaid or SCHIP.

SCHIP Effective at Reducing Disparities

- Enrollment in SCHIP has been shown to increase minority children's use of health care services to the same level as white children.
- Although the SCHIP program is an effective tool for reducing racial and ethnic health care disparities, many states are making it harder to enroll and imposing additional barriers that invariably hurt minority children the most.

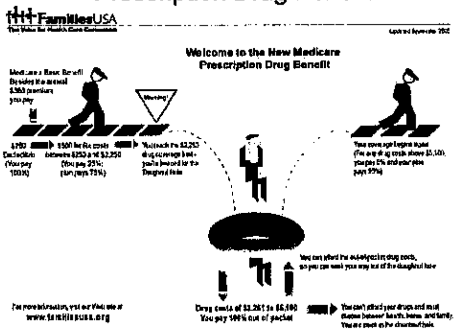
Medicare

- Provides health insurance to 42 million Americans:
  - Seniors over age 65
  - 6.3 million people with permanent disabilities
- Covers 3.9 million African Americans, 3.1 million Latinos, and 1.7 million other racial and ethnic minorities
- By 2030, 26 percent of Medicare enrollees are estimated to be from minority groups

The Medicare Prescription Drug Benefit

- Medicare Part D (the Medicare prescription drug benefit) began in January 2006.
- Part D provides optional drug coverage to all Medicare enrollees.
- The Part D benefit will still leave large gaps in coverage for individuals who do not qualify for low-income assistance.

The Structure of the Medicare Prescription Drug Benefit



People of Color and Medicare Part D

- Among Medicare beneficiaries, 43 percent of African Americans and 37 percent of Latinos went without drug coverage for part or all of 2002.
- Many of them will have access to affordable drug coverage through the Medicare drug benefit for the first time. However, because of the complexity of the program, outreach efforts will need to be expanded so that advocates don't miss this opportunity to reduce racial and ethnic health disparities.

Outreach to People of Color

- Details about the benefit are available primarily online through a government-run Web site at www.medicare.gov.
- However, only 11 percent of African Americans age 65 and over reported using the Internet, compared to 22 percent of non-Hispanic whites and 21 percent of English-speaking Hispanics.

Dual Eligibles

- With implementation of the new law, dual eligibles - those that qualify for both Medicaid and Medicare - will no longer receive prescription drug coverage through Medicaid. These low-income beneficiaries must be enrolled in Part D.
- Racial and ethnic minorities make up a disproportionate percentage of dual eligibles. More than a third of all African Americans and Latinos in Medicare received prescription drug coverage through Medicaid before January 2006, compared to one out of 10 white beneficiaries.
- Despite the fact that this change affects more than 2 million Medicare beneficiaries from communities of color, there has been relatively little outreach to minorities regarding the change in coverage.

Low-Income Medicare Beneficiaries

- 64 percent of African American and 62 percent of Latino beneficiaries have incomes below 150 percent of poverty -- which might qualify them for low-income subsidies.
- Only 4.6 million of the 8.1 million eligible low-income beneficiaries are expected to receive the financial help they qualify for. Minorities are disproportionately represented among the beneficiaries who are eligible for assistance.

What you can do!

Community leaders can have a significant impact in their communities by taking a stand on health and health care issues.

What you can do!

Engage and influence Congress, the White House, your communities, and the media.

Influencing Congress:
  - Make telephone calls
  - Send e-mails and letters
  - Visit state legislators in their home districts
  - Research bills and committee reports

- Influencing the White House:
  - Call, write, e-mail, or fax your comments and concerns to the White House

What you can do!

- Influencing your community:
  - Be knowledgeable about health policy developments
  - Set clear goals
  - Build coalitions
  - Take part in legislative action
  - Get the word out
  - Get your specific community involved
  - Work with your local media
- Influencing the media:
  - Build a consumer story bank

For more information contact:

Minority Health Initiatives
Families USA
Phone: 202-628-3030
E-mail: minorityhealth@familiesusa.org