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An Action
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Leaders

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March 2006

Medicaid: A Vital Source of Coverage for Communities of Color

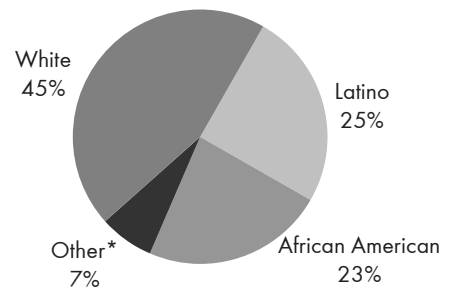
Medicaid Overview

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 whites²—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

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

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

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.

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/AIDS¹², 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.

"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 Braintrust⁴

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.

Budget Reconciliation

In February 2006, the Budget Reconciliation Spending Cuts Act (S. 1932) was passed by Congress and signed into law by the President. Also known as the Deficit Reduction Act (DRA), this new law will fundamentally alter the Medicaid program by reducing Medicaid spending (along with spending for other entitlement programs such as student loans) by nearly \$7 billion over five years.¹³ It contains both mandatory and optional provisions. Mandatory provisions include such measures as a citizenship documentation requirement and stricter regulations for asset transfer laws that affect Medicaid long-term care eligibility. Optional provisions would allow states to make changes to their Medicaid programs through state plan amendments. These changes could lead to increases in copayments, the implementation of premiums, changes to the benefit package, and the introduction of health savings account demonstrations.

A provision in the DRA that is particularly troubling to many racial and ethnic minorities—and to all those who care about fair access to necessary health care—is Section 6036, which requires states to obtain proof

of citizenship for all new Medicaid applicants and from current enrollees who renew their eligibility. According to the Center on Budget and Policy Priorities (CBPP), approximately 49 million U.S.-born citizens (and 2 million naturalized citizens) who are covered by Medicaid over the course of a year would be required to submit documents proving their citizenship or they would lose their health care coverage.¹⁴ A telephone survey conducted by the CBPP revealed that 3.2 to 4.6 million U.S.-born citizens could be at risk of losing their Medicaid coverage because they do not have these documents readily available.¹⁵ Groups at greater risk of losing Medicaid coverage for this reason include older African Americans (who may have never been issued a birth certificate due to racial segregation of hospitals), individuals living in rural areas, and families whose homes are destroyed by fire or other natural disasters, such as hurricane Katrina. This new provision, which will go into effect on July 1, 2006, is sure to create insurmountable barriers for many trying to enroll in Medicaid and decrease overall access to health care for those Americans who need it the most.

The 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. Some Medicaid Commission meetings will 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.¹⁶ 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.¹⁷ 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 early 2006, 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, Recon-

struction 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.

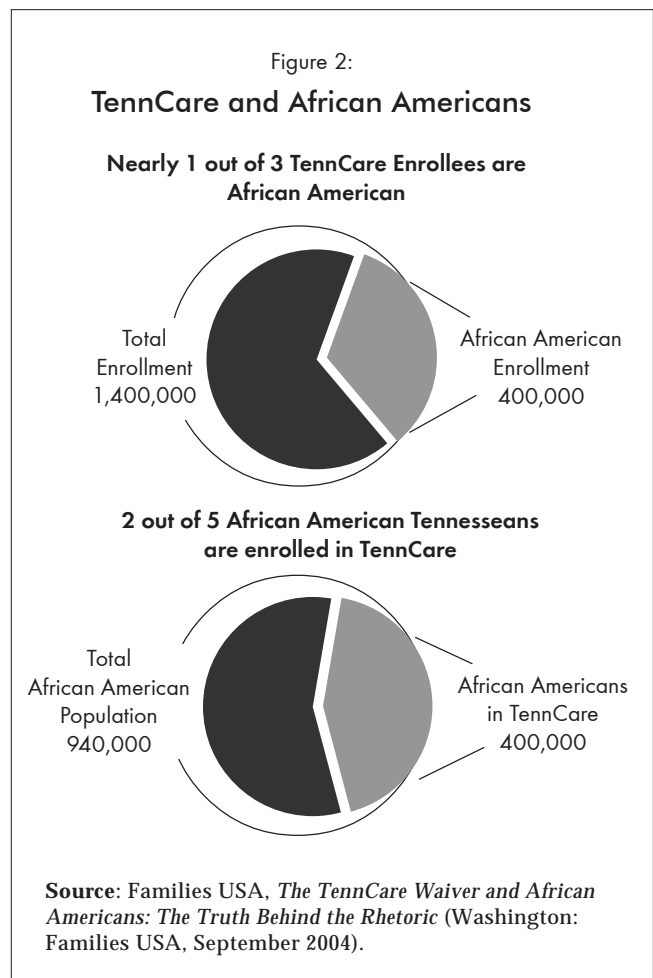
State Medicaid Cuts

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 per-

cent 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.¹⁸ 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.



Cuts to Optional Benefits

Racial and ethnic minorities are disproportionately represented among individuals that require “optional” benefits.¹⁹ 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 screen-

ing 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.²⁰ 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.²¹

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

Beginning in January 2006, full dual eligibles,²² which currently comprise 6.2 million beneficiaries, began receiving their prescription drug coverage through the new Medicare Part D drug benefit rather than through Medicaid. Part D has two components—a basic benefit and an additional subsidy for low-income beneficiaries. Dual eligibles have 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.

Implementing this new law has proven to be extremely challenging, since many beneficiaries were not well informed about upcoming changes in their drug 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.

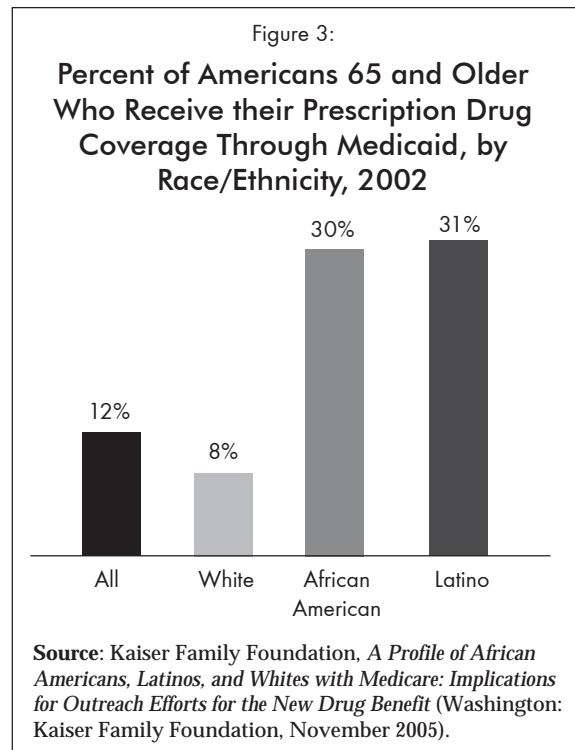
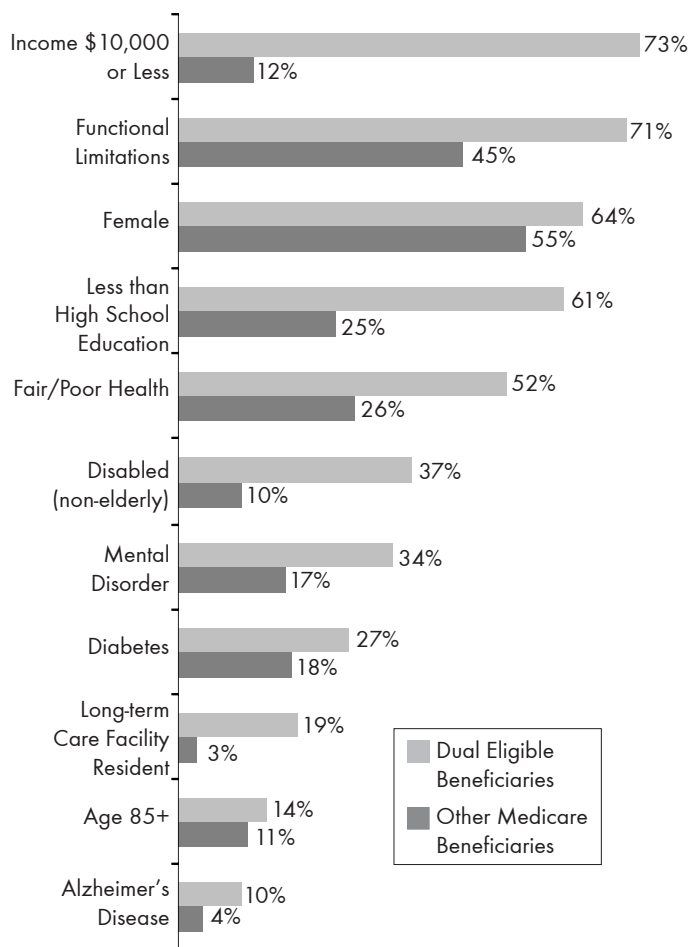


Figure 4:
Comparison of Dual Eligible and Other Medicare Beneficiaries, 2002



7.0 Million Dual Eligible Medicare Beneficiaries in 2002

Source: Kaiser Family Foundation, *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).

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.²³ 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.²⁴

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.²⁵

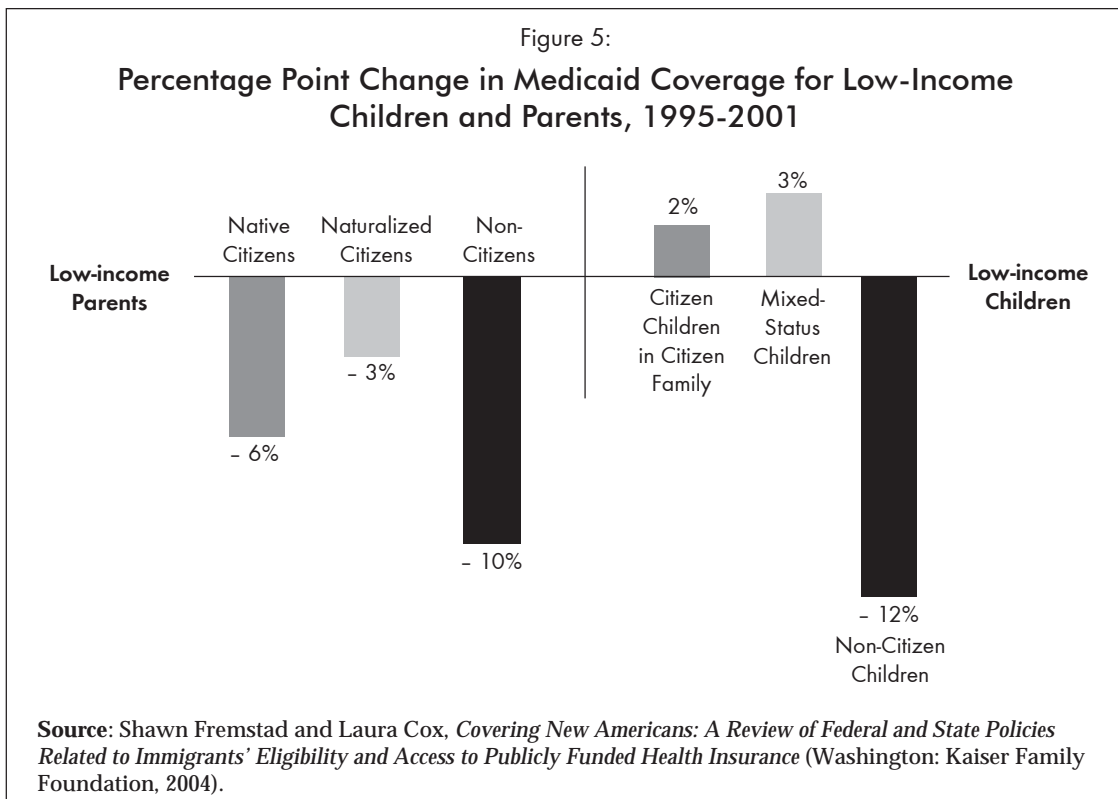
November 2005 marked the beginning of the sign-up period for the drug benefit, and it is already proving to be very confusing and overwhelming for seniors.²⁶ What's clear is that there is a specific need for outreach to racial and ethnic minority seniors, especially those with limited English proficiency.

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.²⁷

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.



Conclusion

Over the past four decades, Medicaid has proved to be an excellent source of increased access to health care for racial and ethnic minorities. Within the past few years, however, budget debates and state fiscal crises have led to major debates about whether-and how to-restructure and scale back this vital safety net program. States have implemented Medicaid waivers that have reduced benefits to enrollees or, in some instances, cut thousands of beneficiaries from the program altogether, leaving them without any place to go for health care. Recently, a Medicaid Commission has been created and tasked with restructuring the program at the federal level, a move that many fear will change the integrity of the program forever. What's more, the Deficit Reduction Act seeks to further alter Medicaid in ways that will decrease, not increase, access to health care for our most vulnerable citizens.

These emerging issues present unique opportunities for community leaders to get involved and engage their members in the policy-shaping debates within their local communities, their states, and 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 the offense, there is a dire need for leaders to step up and get involved in preserving Medicaid, not only for the present generation, but for future generations to come.

Endnotes

Endnotes

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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.