Center for American Progress Action Fund

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Leaving Minorities Behind

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Executive Summary

Senator John McCain (R-AZ) has proposed a radical health care plan that could disproportionately harm insured racial and ethnic minorities. The McCain plan would make health care less affordable for minorities, cause some minorities with employer-based insurance to lose their coverage, and make health insurance less accessible for minorities with chronic or pre-existing conditions. Racial and ethnic minorities, on average, have lower incomes, higher rates of uninsurance, and poorer health than white Americans; the McCain plan would further marginalize them in the health care system.

The McCain health care plan would replace employer-based coverage with private, individual coverage. The plan would repeal the tax exclusion for employer-sponsored health insurance. As a substitute, individuals and families would receive a refundable tax credit—$2,500 for individuals and $5,000 for families—that could be used to purchase coverage in the employer or individual markets. The credit would not vary by health status, income, or family size. Individuals who are chronically ill or have pre-existing conditions would have fewer consumer protections and may not be able to afford or find coverage in the individual market.

By making health insurance less affordable and less accessible, the McCain health care plan would disproportionately affect racial and ethnic minority health for the worse. African-American and Hispanic family median income is roughly $40,000, which is 42 percent less than that of white families, putting health insurance even further out of their financial reach.[1] And by shifting from employer coverage to the individual market, the McCain plan would put more than 12 million chronically ill, non-elderly minority adults at risk of losing coverage in a market with fewer protections, higher costs, and less coverage.

Specifically, the McCain health care plan would have the following consequences:

The McCain plan would repeal the tax exclusion for employer contributions to health benefits, placing 43.3 million minorities in jeopardy of losing employer-based coverage. More than 43 million racial and ethnic minorities have health coverage through the employer-based coverage system. The McCain plan would repeal the tax exclusion for employer contributions to health benefits and replace it with a refundable tax credit, likely causing many employers to stop offering coverage. It would cause people to turn to the individual market, which comes with high cost-sharing and often limited benefits. Those with pre-existing conditions may not find coverage.

The McCain plan would place 12.2 million chronically ill, non-elderly, minority adults at risk of losing coverage. There are 24.4 million chronically ill, non-elderly, minority adults in the United States, and about half, or 12.2 million, currently have employer-based health insurance. The McCain health care plan would cause many to lose their employer-based coverage, but because of their chronic illness, it is unlikely that these individuals will be able to find affordable health insurance in the individual market—if they can find insurance that will cover them at all.

The McCain plan would disproportionately make health coverage even more unaffordable for many minority families. Even after the $5,000 tax credit, the average health insurance premium would comprise more than 21 percent of a black or Hispanic family's income, compared to about 12 percent of a white family's income. Black and Hispanic families in poverty would likely spend more than 40 percent of their gross income on a health insurance premium.

The McCain plan would weaken consumer protections, leaving many minorities in danger of being uninsured. Most of the 10 states and the District of Columbia with the highest black and Hispanic populations—Arizona, California, Georgia, Louisiana, Maryland, Mississippi, Nevada, New Mexico, South Carolina, and Texas—have weak consumer protections in the individual market. Insurers in these states can, for example, discriminate based on health status or pre-existing conditions and only insure those who are deemed "healthy." As such, the McCain plan would put blacks and Hispanics with pre-existing and chronic conditions at risk of not being able to find affordable coverage—if they can find coverage at all.

The McCain health care plan is a step in the wrong direction in reforming the American health care system for all, and it worsens racial and ethnic health disparities, leaving many minorities behind. In 2006 blacks and Hispanics were nearly 1.7 and 2.8 times, respectively, more likely to be uninsured than non-elderly whites.[2] These are statistics that we cannot afford to exacerbate, yet the McCain health care plan misses an opportunity to address this disparity in health coverage.

McCain's plan also fails to address inequities in the quality of care delivered to minority Americans, and the poorer health outcomes suffered by these populations.[3] His plan does not, for example, include any policies to reduce racial and ethnic health disparities such as increased cultural competency training for health care providers or investments in community healthy-living interventions.[4]

This paper is an analysis of the McCain health care plan and what happens to insured racial and ethnic minorities. It begins with a brief summary of current racial and ethnic health disparities and key components of the McCain health care plan. It will then discuss how the McCain policies would put minorities in jeopardy of losing employer-based coverage and how insufficient his proposed tax credits would be for minority families to purchase health coverage. The paper will close with an analysis of the plan's effect on chronically ill minority adults.

Racial and ethnic health disparities in the current system

Studies have documented the role the health care system plays in perpetuating racial and ethnic health disparities.[5] Health insurance status and the delivery of health care services both independently and jointly influence the quality of care minorities receive, and ultimately the health and well being of these populations.

Approximately 25.6 million racial and ethnic minority Americans were uninsured in 2006—more than half of the total uninsured population.[6] Without health insurance, individuals are less likely to have a usual source of care, more likely to not receive care when needed, and more likely to delay care due to financial constraints.[7]

The quality of care delivered, on the whole, also varies depending on one's race. Consider chronic disease. The rising prevalence of chronic conditions in all racial and ethnic groups has made disease management a critical component of the current delivery system. Effective delivery requires many services, coordination of care between specialists, and aggressive follow-up. Yet inequities persist. The system does a relatively equitable job in delivering diabetes screenings, for example, to both whites and African Americans. But the rate of hospital admission for uncontrolled diabetes is 461 percent higher for African Americans than whites.[8] One factor that contributes to this startling disparity is the breakdown of disease-management services delivered to African Americans.

Not surprisingly, in view of the disparities in access and quality, racial and ethnic minorities suffer from poorer health outcomes. Again, consider some prevalent chronic diseases. At least one in five Americans, regardless of race, has hypertension. However, if the person is Hispanic the rate increases to one in three.[9] Cardiovascular disease is the leading cause of death in the United States, accounting for nearly 40 percent of deaths each year. While African Americans were 15 percent less likely than whites to suffer from cardiovascular disease in 2007, they were 31 percent more likely to die from it.[10]

These disparities have been documented for many decades.[11] Yet the McCain health care plan does little to nothing to remedy these racial inequities in health and health care. His plan does not, for example, include any policies to reduce racial and ethnic health disparities such as increased cultural competency training for health care providers or investments in community healthy-living interventions.[12] Instead it takes a leap backward in rectifying the inequities in the system.

Key aspects of the McCain health care plan

Health insurance coverage is the gateway for accessing the health care system.[13] Yet, the McCain health care plan would fundamentally alter employer-based coverage and potentially change Medicaid, two types of insurance on which racial and ethnic minorities depend.

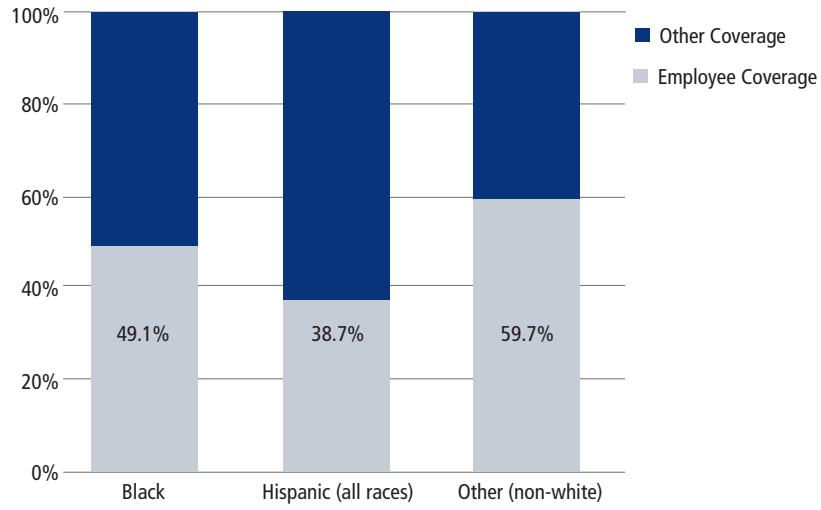
A clear goal of Senator McCain's health care plan is to replace employer-based coverage with private, individual coverage. His plan would repeal the current tax exclusion for employer-based health insurance and replace it with a new across-the-board, refundable tax credit of $2,500 for individuals and $5,000 for families. This credit would not vary by family size, health status, age, or income. The credit could be used to purchase coverage through an employer or in the individual market.[14] The value of the credit would be adjusted for general inflation annually, meaning it grows more slowly than the current tax break for employer-based insurance, which grows with health premiums. Since health insurance premium inflation is faster than general inflation—6.1 percent versus 2.6 percent from 2006 to 2007[15]—the value of the credit would diminish over time.

Under the guise of "state flexibility," the McCain health care plan could also fundamentally alter Medicaid. Medicaid is a state-federal public program serving more than 55 million low-income children, parents, seniors, and individuals with disability. The McCain plan would give states the option to use private insurance in Medicaid.[16] It is not clear how states will react to such an option, but moving low-income Americans to private coverage will likely cause them to face increased out-of-pocket costs and less coverage. Minority Americans would be disproportionately affected by this change. (Until the McCain campaign releases further details on this proposal, its true impact on low-income Americans and racial and ethnic minorities cannot be estimated.)

Millions of minorities are in jeopardy of losing employer-based coverage

Experts agree that the McCain health care plan would move some workers into the individual insurance market by removing incentives for employers to offer health benefits.[17] The individual market has few consumer protections and could leave the 43.3 million minorities who currently have employer-based coverage with no ability to purchase coverage on their own. Approximately 27.4 percent of people with employer-based health insurance are racial and ethnic, non-elderly,minorities—49.1 percent of

FIGURE 1. PERCENT OF NON-ELDERLY MINORITY POPULATIONS WITH EMPLOYER COVERAGE, 2006



Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2006 and 2007 Current Population Survey (CPS: Annual Social and Economic Supplements).

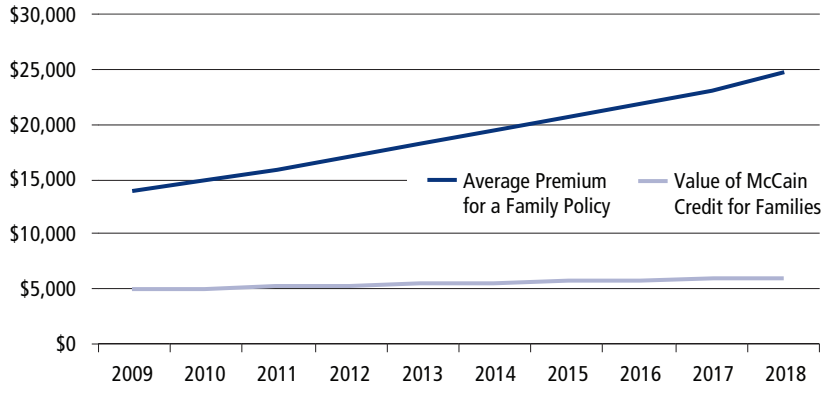
non-elderly blacks, 38.7 percent of non-elderly Hispanics, and 59.7 of additional non-white Americans have health coverage through the employer-based system (see Figure 1).[18]

By moving minority workers and their dependents to the individual market, the McCain health plan raises the likelihood of increased uninsurance for these populations. The pooling mechanism of employer-based insurance allows risks to be shared across enrollees, keeping health insurance premium costs down. State and federal laws governing the group insurance market ensure that anyone who applies for coverage cannot be turned down based on health status, pre-existing condition, age, or some other risk factor. The individual market does not have most of these protections, which also vary by state, and could cause many minorities to become uninsured—particularly those who are older or have pre-existing and chronic conditions that make them less desirable for insurance companies.

The McCain plan would make health care unaffordable for minority families

The McCain health care plan does little to make health care more affordable for minority families. The across-the-board $5,000 tax credit for families to purchase health insurance is woefully inadequate. This credit does not vary by family income level, premium costs, age, or family size. Estimates suggest that the average family insurance premium will be $13,800 in 2009 in the employer coverage market.[19] The tax credits in the McCain health care plan are set to rise with inflation at 2 percent, yet health care premiums are projected to rise at 7 percent (see figure 2).[20] Considering

FIGURE 2. MOST HOUSEHOLDS ARE WORSE OFF UNDER MCCAIN PLAN
Insurance premiums rapidly outstrip McCain's tax credit

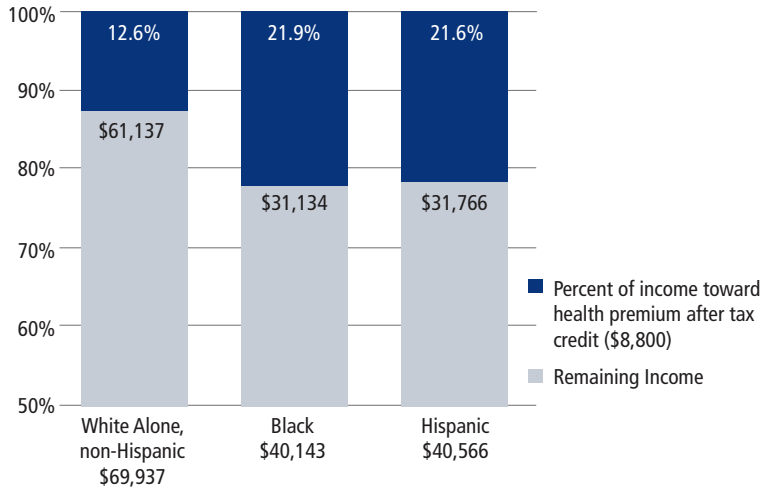


Source: Congressional Budget Office; Center for American Progress Action Fund.

cost trends and income statistics, the inadequacy of the McCain tax credits will disproportionately affect minorities; black and Hispanic families had median income levels of $40,143 and $40,566, respectively in 2007, while white families had a significantly higher median income of $69,937.[21]

After using the $5000 credit, the average health insurance premium would cost a family $8,800, which would comprise 21.9 percent of the median African-American family's income, and 21.6, percent of the median Hispanic family's income in 2007 dollars.[22] Yet the insurance premium would comprise only 12.6 percent of the median white family's income (see figure 3). Health care costs for all three racial groups would exceed the generally accepted affordability standard of 10 percent of income dedicated to total health care costs, including cost sharing and premiums.

FIGURE 3. PREMIUM AS A PERCENTAGE OF FAMILY INCOME AFTER THE $5,000 TAX CREDIT IN 2007 DOLLARS



Source: U.S. Census Bureau median income data.

This policy will also do little to help families living in poverty—defined as at or below 100 percent of the federal poverty level—afford health coverage. A family of four living in poverty is projected to make $21,192 per year or less in 2009.[23] A low-income family would only be left with 58.5 percent of their gross income for all other needs after paying $8,800 in insurance premiums. Because more black and Hispanic families—roughly 30 percent—live in poverty than white families—roughly 10 percent—the McCain tax credit proposal would exacerbate current coverage disparities and leave more minority families behind.[24] Consequently, the McCain plan would provide little assistance to minority families trying to acquire coverage.

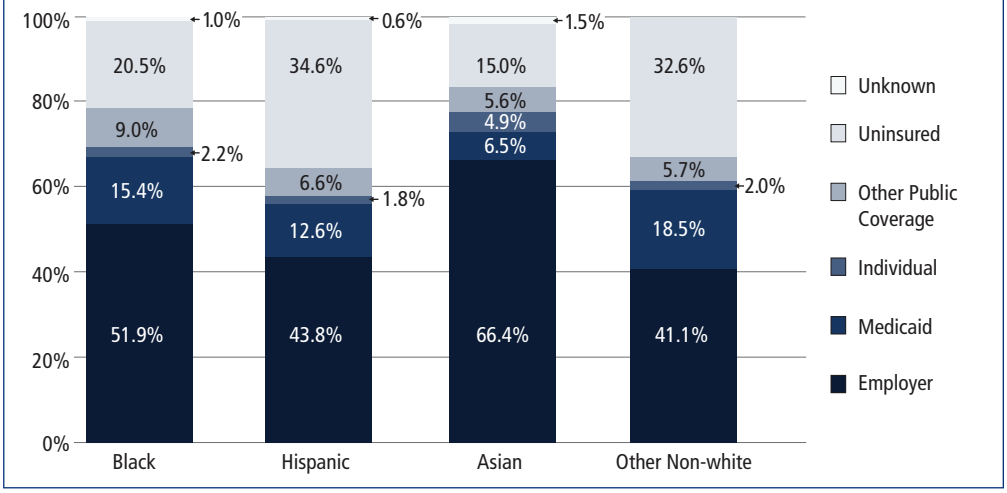
The McCain plan puts chronically ill minority adults at risk

According to an analysis of the National Health Interview Survey, more than 24.4 million non-elderly, minority adults have at least one chronic condition.[25] This includes approximately 11.4 million blacks, 9.5 million Hispanics, and 2.7 million Asians. Employer-based coverage ensures that nearly half, or 12.2 million, of all chronically ill, non-elderly, minority adults have health coverage. Medicaid and other public health coverage insures an additional 5.1 million, leaving the remaining either uninsured (6.3 million) or covered by the individual market (573,155) (see Figure 4).[26]

Insured chronically ill, non-elderly, minority adults

The McCain plan would put many insured, chronically ill, minority adults at risk of becoming uninsured because it emphasizes moving people away from employer-sponsored coverage and into the individual health insurance market. Furthermore, according to a recent survey report conducted by Families USA, many high-minority population states and the District of Columbia provide few consumer protections in the individual market.[27]

FIGURE 4. PERCENTAGE OF NON-ELDERLY MINORITY ADULTS WITH AT LEAST ONE CHRONIC CONDITION BY COVERAGE TYPE, 2006



Source: Data from the National Health Interview Survey and the Current Population Survey 2006. Computed by Katherine Arnold.
Note: Percents do not equal 100 due to rounding.

Mississippi, Louisiana, Georgia, South Carolina, Maryland, and the District of Columbia have the highest population of blacks. Arizona, California, Nevada, New Mexico, and Texas have the highest population of Hispanics.[28] And as Figure 5 shows, most of the 10 high-minority population states and the District of Columbia lack consumer protections in the individual market.

Every one of these 10 states and D.C. permits insurers to "cherry-pick," insuring those applicants who are healthier, less risky, and cost less, as well as charge higher premiums in the individual market based on health status. Every state except New Mexico allows insurers to exclude coverage of pre-existing conditions for more than 6 months after being enrolled in the insurance plan, and lets insurers look back more than six months in an individual's medical history to identify pre-existing conditions and deny coverage. And every state except three—New Mexico, Maryland, and California—does not have alternative coverage programs for those deemed uninsurable.

What is even more alarming is that these states have high rates of chronic disease, and a high risk factor of obesity for African Americans and Hispanics compared to whites. Due to data restrictions, asthma, diabetes, hypertension, and obesity are analyzed for African Americans and diabetes and obesity for Hispanics (see Figures 6-1 and 6-2).

Consider diabetes and obesity, twin escalating epidemics in the United States. The national diabetes rate is 50 to 80 percent higher among African Americans than it is among non-Hispanic whites.[29] Yet the difference between diabetes rates

FIGURE 5: LACK OF CONSUMER PROTECTIONS IN THE INDIVIDUAL MARKET IN HIGH-MINORITY POPULATION AREAS

BLACK/ AFRICAN AMERICAN	Permits insurers to "cherry pick" who they sell health insurance to	Doesn't have affordable coverage alternatives for uninsurable	Allows insurers to charge higher premiums based on health status	Allows insurers to exclude coverage of pre-existing conditions for more than six months	Permits look-back period for more than six months
D.C. (56%)	X	X	X	X	X
Mississippi (37%)	X	X	X	X	X
Louisiana (31%)	X	X	X	X	X
Georgia (29%)	X	X	X	X	X
S. Carolina (29%)	X	X	X	X	X
Maryland (29%)	X		X	X	X
HISPANIC					
New Mexico (42%)	X		X		
Texas (36%)	X	X	X	X	X
California (36%)	X		X	X	X
Arizona (32%)	X	X	X	X	X
Nevada (23%)	X	X	X	X	X
D.C. (9%)	X	X	X	X	X

Source: Modified from the Families USA report, "Failing Grades: State Consumer Protections in the Individual Health Insurance Market," June 2008.
Current Population Survey Data 2006.

FIGURE 6-1. AFRICAN-AMERICAN RATES AND PERCENT DIFFERENCE BETWEEN AFRICAN AMERICANS AND WHITES FOR SELECT HEALTH CONDITIONS BY HIGH-POPULATION STATE AND THE DISTRICT OF COLUMBIA

BLACK/AFRICAN AMERICAN	ASTHMA		DIABETES		HYPERTENSION		OBESITY	
	RATE (%)	% DIFF**	RATE (%)	% DIFF	RATE (%)	% DIFF	RATE (%)	% DIFF
Mississippi (37%)*	6.8	3.0	13.5	35.0	38.7	22.9	42.8	55.1
Louisiana (31%)	8.3	59.6	13.7	53.9	35.9	(15.8)	39.7	43.8
Georgia (29%)	6.9	(15.9)	12.5	34.4	34.9	17.5	35.5	36.5
S. Carolina (29%)	8.5	23.2	13	47.7	35.1	18.6	38.4	46.0
Maryland (29%)	8.6	--	11.2	41.8	36.9	29.0	34.4	37.1
D.C. (56%)	11.8	63.9	13.9	595.0	41	134.3	34.9	292.1

FIGURE 6-2. HISPANIC RATES AND PERCENT DIFFERENCE BETWEEN HISPANICS FOR SELECT HEALTH CONDITIONS BY HIGH-POPULATION STATE AND THE DISTRICT OF COLUMBIA

HISPANIC, NON-WHITE	DIABETES		OBESITY	
	RATE (%)	% DIFF	RATE (%)	% DIFF
New Mexico (42%)	9.2	50.8	30.2	47.3
Texas (36%)	12.3	48.2	32.7	28.2
California (36%)	7.7	8.5	29.4	39.3
Arizona (32%)	9.4	13.3	36.5	54.7
Nevada (23%)	4.4	(50.1)	27	12.0
District of Columbia (9%)	4.9	305.5	21.8	144.9

Data Source: Behavioral Risk Factor Surveillance System, Prevalence Data (2007), Centers for Disease Control and Prevention
Notes: * Percentages in parenthesis next to state denotes the percent of minority population in state or DC.
** (x) denotes the percent difference where the white rate is higher than the black rate in the state.

for African Americans and whites in the District of Columbia is 595 percent. Obesity contributes to a wide range of chronic conditions, from diabetes to heart disease to cancer. Obesity rates for both Hispanics and African Americans in all 10 states and the District of Columbia are much higher than rates of obesity for whites in those respective states. This will likely further exacerbate health coverage issues for these individuals, as many insurance companies are considering charging individuals considered obese higher premiums or denying them coverage outright in the individual market.[30]

The lack of consumer protections in the individual market in these and other states will mean that chronically -ill African Americans and Hispanics will have trouble finding affordable health insurance if they lose coverage through their employer. If an African American with hypertension in Washington, D.C. enrolls in an insurance plan in the individual market, for example, she may not have coverage for this condition for more than sic months after enrolling in a plan, causing unforeseen medical costs and health problems. If a Hispanic in New Mexico has diabetes, he or she will likely face higher health insurance premiums than someone without.

Uninsured chronically ill, non-elderly minority adults

The analysis of chronically ill, non-elderly adult minorities thus far has covered what happens to those with employer-sponsored insurance under the McCain plan. But what happens to the 6.3 million chronically ill minorities without insurance—the 1.8 million minority adults with hypertension, the 889,377 minority adults with diabetes, and the 784,337 minority adults with asthma without insurance, for example?[31] They are not more likely to become insured under the McCain plan.

Their health status will likely prevent them from finding health coverage in the individual market. And even if they could find coverage, the insurance is likely to be unaffordable. A tax credit of $2,500 or even $5,000 is simply insufficient in the individual market. The chronically ill can expect health care premiums two to four times the average in the individual market. For this reason, they are likely to delay or not get needed care due to cost.[32]

Conclusion

Senator John McCain's health care plan places minority health at risk. His plan is not a solution to the inequities in the current health care system, and would instead undermine the socioeconomic success of low-income families, disproportionately affecting minority families.[33] The plan emphasizes shifting away from employer-based coverage to the private, individual, health insurance market, which makes health coverage more expensive, particularly for low-income families, and jeopardizes the health coverage of the chronically ill by placing them in a market with few, if any, consumer protections. McCain's plan would negatively affect all Americans, but the plan especially has dire consequences for racial and ethnic minorities who, on average, have lower incomes than white Americans, and higher rates of many chronic diseases.

The McCain plan also misses an opportunity to rectify many of the disparities in the current system. His plan does not mention the need for constructive solutions to increase the number of minority health care providers, a proven strategy in improving the quality of care delivered to racial and ethnic minorities.[34] His plan does not mention the need for increased investments in community interventions that will not only improve the living conditions of many minorities, but will improve their health, as well.[35] And arguably most importantly, the McCain health care plan does not make health insurance coverage a priority by providing a clear policy that would increase minorities' access to the health care system. The McCain health care plan is a missed opportunity to implement key policies to decrease racial and ethnic health disparities and would leave many minorities behind.

Methodologies and assumptions

The analysis in this report used the following methodology and operated under the following assumptions to determine the effect that the McCain health care plan would have on minority populations.

Racial and ethnic categories

Because data is not available for all racial and ethnic groups, the analysis primarily focused on the black/African-American and Hispanic populations. For the analysis regarding the loss of employer-based coverage, the racial categories are those used in The Kaiser Family Foundation and Urban Institute evaluation of 2006 Current Population Survey Data. For the analysis on affordability, the racial categories used were those defined by the U.S. Census Bureau in the Current Population Survey data—the "white" category includes those who identified as "white alone, non-Hispanic" and the "black/African American" category includes those who identified as "black alone." The "Hispanic" category includes anyone, regardless of race, who identified "Hispanic" as their ethnicity. For this reason, the Hispanic statistics are likely inflated.

Loss of employer-based coverage

The analysis utilized Urban Institute and Kaiser Family Foundation computations of the March 2006 and 2007 Current Population Survey to calculate national number and rate of minorities with employer-based coverage and Medicaid coverage in 2006. From research conducted by the Center for American Progress Action Fund, the Center on Budget and Policy Priorities, and the Urban Institute, the analysis assumes that McCain's proposal to repeal the current tax exclusion for employer contributions to health benefits would cause a shift away from employer-based coverage.

Unaffordable coverage for minority families

The analysis calculated that after applying the $5,000 family tax credit in the McCain proposal, a family would have a premium balance of $8,800 by using the Congressional Budget Office's 2009 estimate of the average family insurance premium amount of $13,800. The analysis used the U.S. Census definition of black and Hispanic families

and their respective median income data found at www.census.gov to determine the percentage of black and Hispanic families' income that would be spent on the $8,800 insurance premium.

The analysis defined a "family living in poverty" to be a family of four at or below 100 percent of the federal poverty level. This is a family with an income at or below $21,192 in annual income in 2009 according to Congressional Budget Office projections. The analysis utilized Current Population Survey data 2007 to find the rate of minority families living in poverty. Because data of minority household structure, including the number of workers, is not readily available, this report was unable to analyze the effect the tax credit would have on individual minorities.

Chronically ill and consumer protections in the individual market

The analysis used Katherine Arnold's evaluation of National Health Interview Survey data for chronic illness and minorities, which found that 24.4 million minority, non-elderly adults were chronically ill and 12.2 million had employer-based coverage in 2006. The chronically ill, for this paper, are defined as individuals with the following conditions included in the NHIS data: heart disease, diabetes, arthritis, cancer, stroke, emphysema, hypertension, asthma, bronchitis, liver condition, severe migraines, and anxiety/depression. This definition was also used in a recent report by the Urban Institute and the University of Maryland at Baltimore County, "Uninsured Americans with Chronic Health Conditions: Key Findings from the National Health Interview Survey." Percentages were applied to Census Bureau population estimates for 2006 to devise estimates.

This analysis does not count chronically ill children with employer coverage who would also be at risk of losing coverage under the McCain plan.

For figure 5, the analysis applied findings from a Families USA survey on state consumer protections in the individual health insurance market to the 10 high minority population states and the District of Columbia. The analysis determined the percentage of individuals with asthma, diabetes, hypertension, or obesity living in the 10 states or D.C. that would likely not be able to find and/or afford individual market insurance.

The analysis used Current Population Survey data from 2006 to determine the five states with the highest African-American population and the five states with the highest Hispanic population. Analyzing Behavioral Risk Factor Surveillance System prevalence data in the 10 high minority population states and the District of Columbia, Figures 6-1 and 6-2 were developed to illustrate the disproportionately high rate of sick or obese African Americans and Hispanics compared to whites in those states.

The Behavioral Risk Factor Surveillance System ascertains rates for specific health conditions by respondents answering "yes" to specific questions—for asthma, adults responded "yes" to having been told by a doctor that they currently have asthma; for diabetes, individuals responded "yes" to having been told by a doctor that they have non-pregnancy-related diabetes; and for hypertension, adults responded "yes" to having had their blood pressure checked and been told by a doctor that they have high blood pressure. Obesity was defined as an adult with a body mass index between 30.0 and 99.9.

Endnotes

1 U.S. Census Bureau, "Historical Income Tables—Table F-7 Type of Family (All Races) by Median and Mean Income: 1987 to 2007,," available at http://www.census.gov/hhes/www/income/histinc/incfamdet.html.

2 Urban Institute and KCMU, "Uninsured Rates for the Nonelderly by Race/Ethnicity, states (2005-2006), U.S. (2006), available at http://www.statehealthfacts.org/comparetable.jsp?ind=143&cat=3

3 See the Agency for Healthcare Research and Quality, "National Health Care Disparities Report, " (2007); and Centers for Disease Control and Prevention, "Health, United States"(2007).

4 See PolicyLink, "Healthy Food, Healthy Communities: Improving Access and Opportunities Through Food Retailing" (Fall 2005), available at http://www.policylink.org/Research/HealthyFood/.

5 Agency for Healthcare Research and Quality, "National Health Care Disparities Report, " (2005,), (2006,), (2007); and Centers for Disease Control and Prevention, "Health, United States,," series and data sources, (Hyattesville, MD).

6 Urban Institute and KCMU, "Uninsured Rates for the Nonelderly by Race/Ethnicity, states (2005-2006), U.S. (2006), available at http://www.statehealthfacts.org/comparetable.jsp?ind=143&cat=3

7 Lisa Dubay et al, "The Uninsured and the Affordability of Health Insurance Coverage," Health Affairs 26 (3) (2006).

8 Calculation conducted by Samantha Hong and referenced in Jamie D. Brooks and Meredith King, "Geneticizing Disease: Implications for Racial Health Disparities" (Washington, D.C.: Center for American Progress, January 2008), available at http://www.americanprogress.org/issues/2008/01/geneticizing_disease.html.

9 Centers for Disease Control and Prevention, "Health, United States, 2006" (Hyattsville, MD: 2006).

10 Ibid., 2007.

11 See B. Smedley, Unequal Treatment: Confronting Racial and Ethnic Disparities, (Institute of Medicine, 2002).

12 See PolicyLink, "Healthy Food, Healthy Communities: Improving Access and Opportunities Through Food Retailing."

13 Centers for Disease Control and Prevention, "Health, United States, 2006" (Hyattsville, MD: 2006).

14 John McCain for President, "Straight Talk on Health System Reform."

15 KFF/HRET, "Employer Health Benefits 2007 Annual Survey,," available at http://www.kff.org/insurance/7672/upload/76723.pdf.

16 Kaiser Family Foundation, "2008 Presidential Candidates Health Care Proposals: Side-by-Side Summary," available at http://www.health08.org/sidebyside_results.cfm?c=5&c=16.

17 J. Lambrew, "Conservative Health Reform: Why It Would Deepen Our Current Health System Crisis," (Washington, D.C.: Center for American Progress Action Fund, March 2008);. E. Park E. and J. Furman, "President's Health Care Tax Cut Proposals Are Likely to Weaken Employer-Based Health Insurance" (Washington, DC: Center on Budget and Policy Priorities, 2006); L. Burman and J. Gruber, "Tax Credits for Health Insurance," Tax Policy Center Discussion Paper No. 19. (Washington, DC: The Urban Institute, 2005).

18 Kaiser Family Foundation, Employer-Sponsored Coverage Rates for the Non-Elderly by Race/Ethnicity, US (2006), http://www.statehealthfacts.org/comparebar.jsp?ind=153&cat=3

19 Congressional Budget Office, "Taxes and Health Insurance: Presentation to the Tax Policy Center and the American Tax Policy Institute." (2008).

20 Karen Tumulty, "Update 4: The Great Health Care Debate," Swampland Blog, May 1, 2008, available at http://www.time-blog.com/swampland/2008/05/update4_the_great_health_care.html; Joint Committee on Taxation, "Estimating the Revenue Effects of the Administration's Fiscal Year 2008 Proposal Providing a Standard Deduction for Health Insurance: Modeling and Assumptions." (2007), available at http://www.house.gov/jct/x-17-07.pdf.

21 U.S. Census Bureau, "Historical Income Tables—Table F-7 Type of Family (All Races) by Median and Mean Income: 1987 to 2007."

22 Ibid.

23 Congressional Budget Office projections, available at http://www.cbo.gov/budget/data/econproj.shtml.

24 U.S. Census Bureau, "Historical Poverty Tables – Table 4 Poverty Status of Families, by Type of Family, Presence of Related Children, Race, and Hispanic Origin: 1959 -2007," available at http://www.census.gov/hhes/www/poverty/histpov/famindex.html.

25 National Health Interview Survey data and Current Population Survey data 2006. Computed by Katherine Arnold.

26 Ibid.

27 Families USA, "Failing Grades: State Consumer Protections in the Individual Health Insurance Market, " (June 2008).

28 Current Population Survey Data 2006., available at http://www.census.gov.

29 Centers for Disease Control and Prevention, "Diabetes at a glance" (Atlanta, GA. 2006).

30 D. Beyerle, "Obese May Pay More for Insurance," TuscaloosaNews.com, July 18, 2008, available at http://www.tuscaloosanews.com/article/20080718/NEWS/436467129; National Business Group on Health, Pressroom, "Most Workers Satisfied with Health Care Benefits, National Business Group on Health Survey Find," April 12, 2007, available at http://www.businessgrouphealth.org/pressrelease.cfm?ID=87; and "Being Overweight can reduce your chances for health insurance,," Insurance.com, 2003, available at http://www.insure.com/articles/healthinsurance/weight.html

31 National Health Interview Survey data and Current Population Survey data 2006. Computed by Katherine Arnold.

32 C. Hoffman et al., " Eroding Access Among Nonelderly U.S. Adults with Chronic Conditions: Ten Years Of Change," Health Affairs, July 22, 2008, web exclusive available at http://content.healthaffairs.org/cgi/reprint/hlthaff.27.5.w340v1; and N. Turnbull et al., "Insuring the Health or Insuring the Sick? The Dilemma of Regulating the Individual Health Insurance Market" (The Commonwealth Fund, February 2005).

33 See B. Furnas, "McCain's Education Plan Fails to Meet the Needs of Hispanics" Center for American Progress Action Fund, July 14, 2008, available at http://www.americanprogressaction.org/issues/2008/mccain_hispanic_ed.html; and Ben Furnas, Robert Gordon, and James Kvaal, "McCain Tax Plan Gives Nothing to Families in Poverty," The Wonk Room, April 24, 2008, available at http://thinkprogress.org/wonkroom/2008/04/24/mccain-poverty-part-2/.

34 Agency for Health Care Research and Quality, "Strategies for Improving Minority Health Care Quality,," January 2004 available at http://www.ahrq.gov/clinic/epcsums/minqusum.htm. XX LINK DOESN'T WORK XX

35 M. King, "Community Health Interventions: Preventions Role in Reducing Racial and Ethnic Health Disparities," (Washington, D.C.: Center for American Progress, February 2007).

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