

## Senate HELP Committee Affordable Health Choices Act

Implications for Improving Access, Affordability and Quality of Health Care for America's Racial/Ethnic Minorities

Table 1. Expanding Access to Affordable Health Coverage

	Summary <sup>1</sup>	Implications for Racial/Ethnic Minorities
<b>Insurance Market Reforms</b>	<ul style="list-style-type: none"> <li>• Guaranteed availability and renewability of coverage.</li> <li>• Prohibit exclusions based on health status or pre-existing conditions.</li> <li>• Prohibit insurance rating variation by health status, gender, genetic information, disability, type of employment or claims history. Allow variation only by family structure, geography, actuarial value of health plan, and age (limited to 2:1 ratio).</li> <li>• Restrict co-payments and deductibles for preventive care to minimal amounts.</li> <li>• Expand dependent coverage for children up to age 26.</li> <li>• Create state and regional American Health Benefit Gateways through which individuals and small employers can compare and purchase health coverage through a standardized system.</li> <li>• Create a new public plan (details to be specified).</li> </ul>	<ul style="list-style-type: none"> <li>• Guaranteeing availability and renewability as well as prohibiting exclusions based on health status and pre-existing conditions is likely to help minorities with existing illnesses—particularly Black adults, nearly half of whom suffer from a chronic condition or disability—obtain health coverage.<sup>2</sup> Nearly 6 million Hispanic/Latino and 6 million racial minority (e.g., Black and Asian) young adults (ages 18-26) could gain coverage through parent's insurance policies.<sup>3</sup></li> <li>• Restricting out-of-pocket payments could help low-income and minority individuals, particularly the large proportion of Hispanics (54%), Asians (52%) and Blacks (44%) who often delay or forgo care, to obtain routine and preventive services.<sup>4</sup> Definition of "minimal amounts" however is critical given research suggesting higher out-of-pocket requirements often discourage care.<sup>5</sup></li> <li>• While implications of a new public plan option are still uncertain due to lack of specificity, a plan modeled after Medicare or Medicaid could offer affordable health coverage to many uninsured or underinsured low-income and minority adults, especially if premiums and out-of-pocket expenses are lower than private plans.</li> </ul>
<b>Individual Role</b>	<ul style="list-style-type: none"> <li>• Require all individuals to have health insurance coverage through an individual mandate. A tax penalty set by the Secretary of Treasury would be used to enforce the mandate. Exemptions include residents of states that have not yet established a Gateway, members of Indian tribes, those who do not meet affordability standards, and those who demonstrate financial hardship from the purchase of insurance.</li> </ul>	<ul style="list-style-type: none"> <li>• The impact of an individual mandate for minorities remains unknown. More data are needed on the impact of an individual mandate for minorities. Such information could be acquired by DHHS by monitoring compliance with the mandate among racial and ethnic minorities as well as barriers to obtaining coverage experienced by these communities.</li> <li>• An individual mandate would establish a "culture of insurance" that will likely require education and outreach that is culturally and linguistically appropriate, particularly to populations that may have limited experience with insurance coverage.</li> <li>• An individual mandate may increase demand for primary and specialty care among previously uninsured individuals, which would increase demand for culturally and linguistically competent providers.</li> <li>• Safety-net providers that have historically served minorities could face negative financial implications based on wider choice of providers accepting newly insured patients. At the same time, they may benefit from an increase in reimbursements from paying</li> </ul>

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	patients.	
<b>Employer Role</b>	<ul style="list-style-type: none"> <li>• “Shared responsibility” of employers in providing coverage (details to be specified).</li> </ul>	<ul style="list-style-type: none"> <li>• Expanded employer responsibility or mandate, with federal assistance to small businesses, could expand coverage for many employed low-income and minority individuals and their families. However, a mandate or “play or pay” provision could increase business costs and unintentionally reduce wages/salaries to the detriment of low-income and minority employees. Furthermore, if employers are asked to share responsibility for subsidizing public plans for low-income individuals, this may unintentionally discourage the hiring of low-income or minority individuals.<sup>6</sup></li> </ul>
<b>State Role</b>	<ul style="list-style-type: none"> <li>• Establish and administer American Health Benefit Gateways meeting federal standards and adopt individual and small group market regulation changes.</li> <li>• Create temporary Right Choices Programs through annual federal grants to provide uninsured adults with immediate access to preventive care and treatment for identified chronic conditions until a Gateway is established. Among others, eligibility requirements include US citizenship or legal immigrant status and family income below 350% FPL.</li> </ul>	<ul style="list-style-type: none"> <li>• The Gateways and Right Choices Programs would preclude undocumented immigrants which comprise a large proportion of the uninsured.</li> </ul>
<b>Federal Government Role</b>	<ul style="list-style-type: none"> <li>• Expand Medicaid to individuals with incomes up to 150% FPL. Expansion would be initially covered by the federal government, and between 2015 and 2020 the state share would be phased-in.</li> <li>• Individuals eligible for Children's Health Insurance Program (CHIP) have the option of enrolling in CHIP or a qualified health plan through a Gateway.</li> <li>• Prohibit undocumented immigrants from receiving federal insurance benefits.</li> <li>• Establish a Medical Advisory Council to make recommendations on essential health benefits, criteria for minimum coverage and affordability standards.</li> <li>• Create and administer Gateways in states that do not establish one in the allotted 4-year period.</li> </ul>	<ul style="list-style-type: none"> <li>• Expansion of Medicaid eligibility would extend coverage to over one-third of the nation's minorities living at or below 150% FPL.<sup>7</sup></li> <li>• Because many states with the lowest income thresholds for Medicaid eligibility have large proportions of low income minorities, expanding Medicaid eligibility at the federal level would expand access to Medicaid to many of the nation's lowest income minorities. A federal expansion of Medicaid would reduce the wide disparities in state uninsurance rates. However, it may be important to monitor states to assure those with historically low levels of coverage and with significant minority populations assume financial responsibility.</li> <li>• Federal insurance provisions preclude the nearly 12 million undocumented immigrants in the US, many of whom lack health insurance.<sup>8</sup></li> <li>• Essential that the Council composition and agenda work to promote and maintain equity across all populations.</li> </ul>
<b>Federal</b>	<ul style="list-style-type: none"> <li>• Provide credits on a sliding-scale basis to individuals and</li> </ul>	<ul style="list-style-type: none"> <li>• Minorities comprise 58% of uninsured adults below 200% FPL and</li> </ul>

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#### **Credits and Subsidies to Individuals**

- families with incomes up to 500% FPL to purchase coverage through a Gateway. Individuals are not eligible for credits through a Gateway if they have access to employer-based coverage that meets minimum qualifying criteria and affordability standards, or are eligible for Medicare, Medicaid, or other federal benefits.
- Limit maximum out-of-pocket costs for subsidized plans

an even larger proportion of uninsured at 500% FPL.<sup>9</sup> Therefore sliding-scale credits could assist individuals and families at different levels of poverty afford coverage.

- Medical debt is a leading cause of personal bankruptcy that disproportionately affects low income and minority families. For example, Blacks are more likely than whites (44% vs. 33%) to be unable to pay their medical bills, be contacted by a collection agency, and have outstanding medical debt.<sup>10</sup> Both provisions will help to limit the financial risks and potential exposure to medical debt for minority and poor families who were previously uninsured or underinsured.

#### **Federal Credits and Subsidies to Employers**

- Credits for small employers meeting the following eligibility criteria: (1) having up to 50 full-time employees; (2) paying an average wage of less than \$50,000 per employee; and (3) paying at least 60% of employee health benefits.
- Create temporary reinsurance program for employers providing health coverage to retirees ages 55 to 64 until the state Gateway program is established.

- Approximately 98% of minority-owned firms have fewer than 50 employees, the majority of which (70%) have less than 5.<sup>11</sup> Federal credits to small employers could assist minority-owned businesses expand coverage for themselves and their employees.
- The temporary reinsurance program can help to ensure continuity of coverage for minority retirees until Gateways are established.

#### **Financing**

- Not specified.

- A preliminary Congressional Budget Office (CBO) report dated June 15, 2009 indicates that financing major provisions related to health insurance coverage would cost about \$1 trillion for 2010-2019 and result in a net decrease of 16 million uninsured.<sup>12</sup> These calculations, however, do not factor in provisions requiring additional specificity (e.g., new public plan option and employer mandate).

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Table 2. Expanding Access to Health and Medical Care		
	Summary <sup>1</sup>	Implications for Racial/Ethnic Minorities
<b>Expanding Availability of Care</b>	<ul style="list-style-type: none"> <li>• Implement workplace wellness programs to promote a culture of health and wellness.</li> <li>• Provide additional funding to expand school-based health clinics.</li> <li>• See also <i>Expansion of Health Care Safety Net</i> below.</li> </ul>	<ul style="list-style-type: none"> <li>• Utilizing non-medical settings such as workplaces and schools may help expand access to care for low-income and minority populations who often face access barriers beyond lack of health insurance (e.g., reliable transportation, time, distance, child care and limited English proficiency).<sup>13</sup></li> </ul>
<b>Public Health and Prevention</b>	<ul style="list-style-type: none"> <li>• Create a National Prevention, Health Promotion and Public Health Council to promote healthy policies across multiple sectors and agencies at the federal level.</li> <li>• Create a Prevention and Public Health Investment Fund to expand and sustain funding for prevention, public health programs and evidence-based public health and systems research.</li> <li>• Establish a temporary Right Choices Program to give low-income and uninsured adults access to preventive services, such as chronic disease risk assessment and referrals to community-based resources.</li> <li>• Require chain restaurants and food sold from vending machines to include nutrition labeling.</li> <li>• Award grants to implement school-based dental sealant programs, water fluoridation, and establish oral health leadership programs.</li> </ul>	<ul style="list-style-type: none"> <li>• Minorities face a disproportionate array of socio-economic and environmental barriers (e.g., poor housing, limited fresh produce in grocery stores, and lack of sidewalks or parks in neighborhoods) that contribute to higher rates of morbidity and mortality.<sup>14</sup> Greater funding for public health services, and policies that are better coordinated with other social programs could help to reduce health disparities and advance social equity.</li> <li>• The Right Choices Program, by excluding undocumented immigrants would not address existing access problems for this group of nearly 12 million individuals.<sup>15</sup></li> <li>• Mandatory nutrition labeling in chain restaurants could promote healthy choices in low-income minority neighborhoods where fast-food restaurants are disproportionately prevalent.<sup>16</sup></li> <li>• Oral health programs targeting youth could reduce disparities in tooth decay among children. Black (1.5 times), Latino (2.5 times), and American Indian/Alaska Native (5.8 times) children are more likely than white children to have tooth decay.<sup>17</sup></li> </ul>
<b>Expansion of Health Care Safety Net</b>	<ul style="list-style-type: none"> <li>• Provide additional funding to increase the number of community health centers (CHCs).</li> </ul>	<ul style="list-style-type: none"> <li>• CHCs are a major provider of primary care to low-income minority patients.<sup>18</sup> Their expansion in underserved communities could help improve access to primary and preventive care. However, safety-net support will need to extend beyond CHCs to improve access to specialty and tertiary care services to poor and minority patients.</li> <li>• Federal guidance to CHCs and other safety net providers is needed to facilitate implementation of health care reforms, given the role of these providers in serving poor and minority populations.</li> </ul>

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#### **Community Strategies**

- Provide grants to create community health teams to support a medical home model.
- Provide grants to promote evidence-based community preventive health activities to reduce chronic disease, racial/ethnic health disparities, and address social determinants of health.
- Acknowledges critical link to community for promoting health and effective health care. Providing grants to support community-based efforts has the potential to foster trust, understanding, and adherence to healthy behaviors and preventive health practices among low-income and minority communities.
- Represents significant, new potential to address long-standing lack of coordination and continuity of care for minorities.<sup>19</sup>
- Community support may work to facilitate understanding of transition to insurance (and insurance options) among minorities.

#### **Regional Strategies**

- Provide grants to design and implement regional emergency care and trauma systems.
- Given frequent concentration of services, especially in urban areas, regionalizing emergency and trauma care could work to significantly expand access to care for the nation's growing poor and racially/ethnically diverse populations in sprawling cities, suburbs and exurbs, and in historically underserved rural areas with limited health care resources and capacity.<sup>20</sup>

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**Table 3. Cost Containment**

	Summary <sup>1</sup>	Implications for Racial/Ethnic Minorities
<b>Containing Drug Costs</b>	<ul style="list-style-type: none"> <li>Expand drug discount program to allow more hospitals to gain access to discounts.</li> <li>Strengthen Medicaid rebate program to reduce drug costs to state Medicaid programs.</li> <li>Standardize drug labeling and consult with stakeholders, including health literacy experts and racial/ethnic minorities, to assess the benefits of standardizing drug labels to improve clinician, patient, and consumer decision making.</li> <li>Support comparative effectiveness research (CER) on drugs, devices, medical and surgical procedures, screenings and other health interventions.</li> </ul>	<ul style="list-style-type: none"> <li>Drug discounts and Medicaid drug rebates may assist low income and minority families in obtaining needed medication. Monitoring effectiveness of drug access is important to assure adequate distribution/availability in low income and minority communities.<sup>21</sup></li> <li>Standardizing and tailoring drug labeling to low-literacy, LEP and minority populations can help these groups to better identify dosage information, risks and benefits of drugs and reduce medication errors.</li> <li>CER should target language and cultural issues with the potential to significantly impact effectiveness.</li> </ul>
<b>Malpractice Reform</b>	<ul style="list-style-type: none"> <li>Not specified.</li> </ul>	<ul style="list-style-type: none"> <li>Uncertain implications as details are not specified. Research suggests that malpractice reform could be important to improving patient safety by reducing medical errors and containing health care costs by limiting the practice of defensive medicine. These are critical goals for minorities whose rates of illness and disease are higher than whites for many conditions and thus may be at greater risk for errors.<sup>22</sup></li> </ul>
<b>Information Technology (IT)</b>	<ul style="list-style-type: none"> <li>Develop standardized IT to enroll individuals in public programs and provide grants to states and other governmental entities to adopt and implement enrollment technology.</li> </ul>	<ul style="list-style-type: none"> <li>A standardized electronic enrollment system may help individuals manage their eligibility information, compare health insurance options and make informed decisions. Without resources for enrollment assisters, however, the utility of this system will likely be limited for the estimated 24 million individuals with limited English proficiency (LEP)<sup>23</sup> if systems are only in English. The value of this system may also be limited for low-income individuals without access to a computer or the Internet and without skills to navigate websites. A recent study shows that only 25% of non-high school graduates, 44% of households with incomes below \$30,000, 44% of Hispanics and 50% of African Americans utilize the internet for health-related information needs.<sup>24</sup></li> </ul>

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Table 4. Quality Improvement		
	Summary <sup>1</sup>	Implications for Racial/Ethnic Minorities
<b>Data Collection and Public Reporting</b>	<ul style="list-style-type: none"> <li>Utilize a multi-stakeholder process to develop quality measures for health outcomes, continuity and coordination of care, safety, effectiveness and timeliness of care, health disparities and appropriate use of health care resources.</li> <li>Require public reporting on quality measures through a user-friendly website and an annual national health care quality report card.</li> <li>Collect data on the supply, demand, and diversity of the healthcare workforce to improve access and quality of health care services for low-income, underserved, uninsured, minority and rural populations.</li> <li>Develop reporting standards by gender, geographic location, socioeconomic status, primary language, and disability status.</li> <li>See also <i>Collecting Data on Disparities in Quality of Care</i> in Table 5.</li> </ul>	<ul style="list-style-type: none"> <li>Developing robust quality measures that span across multiple domains of care could help in identifying gaps in health care services in minority communities and in developing quality improvement strategies to reduce these disparities.</li> <li>Without adequate risk-based reimbursement, public reporting on quality measures could provide hospitals with incentives to “cherry pick” healthy patients and deter them from accepting high-risk patients whose outcomes might adversely affect their quality rating, and thus limit access for minorities with complex conditions.<sup>25</sup></li> <li>To maximize the potential of public reporting on quality measures to improve patients’ ability to seek the highest quality care, information must be made available at appropriate levels of literacy, in languages relevant for the communities served, and through means of communication that are appropriate for and available to individuals.</li> <li>Monitoring the diversity of the healthcare workforce, as well as availability and utilization of services, can help identify gaps in service and prompt efforts to improve quality and access in underserved areas.</li> <li>Standardized reporting mechanisms on primary language would help identify disparities in the quality of care received by specific sub-groups and identify language needs. Other indicators if assessed by race/ethnicity could offer new information on minority patient effectiveness.</li> </ul>
<b>Care Coordination and Disease Management</b>	<ul style="list-style-type: none"> <li>Develop quality measures to evaluate continuity and coordination of care.</li> <li>Provide grants for community programs to address chronic disease priorities, including screening of diabetes, cardiovascular disease, and stroke for individuals between the ages of 55-64 and for medication management services to reduce medical errors and improve patient adherence for chronic disease patients.</li> </ul>	<ul style="list-style-type: none"> <li>Medication management services may increase adherence to medication regimens for the disproportionately high number of minorities living with chronic disease if services are culturally and linguistically competent and if disease management integrates race/culture/language into related care, education and outreach.<sup>26</sup></li> </ul>

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#### **Promoting Evidence-Based Practices**

- Create a Patient Safety Research Center charged with identifying, evaluating and disseminating information on best practices to local providers and patients.
- Create a Center for Health Outcomes Research and Evaluation to collect, conduct, support, and synthesize research with respect to comparing health outcomes, effectiveness, and appropriateness of health care services and procedures.
- Expand efforts to review evidence of effectiveness of clinical preventive services and community/population-based preventive services.
- Identification and dissemination of best-practices can help improve quality by promoting evidence-based medicine in underserved areas, and thus could provide opportunities to systematically analyze disparities in safety and outcomes using national, standardized measures. Information for patients is liable to be most effective if it is culturally and linguistically appropriate.
- Community/population based review can assist in tailoring care to meet minority neighborhood/area concerns and needs.

#### **Civil Rights Enforcement and Legal Action**

- Non-discrimination in health care (details to be specified).
- Uncertain implications due to limited specificity on this provision. However, mandatory and standardized reporting procedures on race/ethnicity would allow for civil rights violations to be more readily identified.



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#### Health Workforce Diversity

- Amend current legislation (i.e. Title VII and Title VIII of the Public Health Services Act) to expand grants to support the training of primary care physicians, mental health service providers and other health professionals, giving preference to institutions with a record of training individuals from minority communities.
- See also *Data Collection and Public Reporting* in Table 4.

diverse/LEP populations given the high proportions with low health literacy.<sup>30</sup>

- Providing incentives for training health professionals from diverse backgrounds, with an emphasis on primary care, could help to increase workforce diversity and may improve quality of care and access to preventive services in underserved minority communities.
- Support for HBCUs to train African-Americans in the mental health professions will increase workforce diversity and has the potential to increase mental health service utilization and improve quality of care for African-Americans. However, this provision is likely to have minimal impact on increasing the low number of Hispanic/Latino and other minority mental health workers in the country.

#### Patient Navigation

- Create programs to develop, test and disseminate educational tools to help patients and caregivers understand treatment options in context of beliefs, preferences, options, scientific evidence and other circumstances.
- Support community health workers to educate underserved populations on CHIP, Medicare, and Medicaid and refer underserved populations to appropriate health care settings to increase service utilization and reduce duplicative care.

- Evidence-based patient education materials and tools can help both patients and physicians make more informed decisions within medical and socio-cultural contexts. Information and tools must be made available at a level of literacy and cultural sensitivity that is appropriate for LEP populations.
- Additional resources to support community health workers in assisting populations eligible for public programs obtain needed services could help to reduce health disparities. This could also be another resource to support individuals in accessing and understanding information provided through the proposed Gateways.

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**Table 6. Social Determinants of Health**

	Summary <sup>1</sup>	Implications for Racial/Ethnic Minorities
<b>Interagency Collaboration</b>	<ul style="list-style-type: none"> <li>• Create a National Health Council to promote healthy policies across multiple sectors and agencies at the federal level, including Health, Agriculture, Education, Labor, Transportation and others.</li> </ul>	<ul style="list-style-type: none"> <li>• Creation of a National Health Council with a purview that spans across multiple sectors will be critical to addressing social determinants as they affect minority communities (including immigrants)—such as housing, transportation, nutritional needs and access to nutritious foods, the built environment, education, and others— and enacting policies to improve population health. To be most effective will require specific actions that promote inter-sectoral cooperation and strategic program/service integration.</li> </ul>
<b>Infrastructure Support</b>	<ul style="list-style-type: none"> <li>• Provide grants to promote healthy lifestyles by developing infrastructure that supports physical activity and increasing access to nutritious foods.</li> </ul>	<ul style="list-style-type: none"> <li>• Innovations that enable healthy lifestyles, such as nutritious foods in schools and safe parks that promote exercise, may be particularly critical to reducing diabetes, obesity, and other chronic conditions prevalent in low-income minority communities.<sup>20</sup></li> </ul>
<b>Data Collection</b>	<ul style="list-style-type: none"> <li>• Conduct Health Impact Assessments (HIAs) to examine the effect of the built environment on population health.</li> <li>• See also <i>Collecting Data on Disparities in Quality of Care</i> in Table 5.</li> </ul>	<ul style="list-style-type: none"> <li>• HIAs can be valuable in evaluating adverse health consequences associated with living in close proximity to man-made structures, such as factories and highways, and promoting environmental justice. HIAs may be beneficial in informing policies that reduce exposure to environmental risk factors for asthma and other chronic diseases that afflict minorities living in low-income urban areas.<sup>31</sup></li> </ul>

### Notes

<sup>1</sup> Senate Health, Education, Labor and Pensions Committee. (9 June 2009). *Affordable Health Choices Act*, Last retrieved June 23, 2009, from [http://help.senate.gov/BAI09A84\\_xml.pdf](http://help.senate.gov/BAI09A84_xml.pdf); Kaiser Family Foundation. (22 June 2009). Side-by-Side Comparison of Major Health Reform Proposals, Last retrieved June 23, 2009, from [http://www.kff.org/healthreform/upload/healthreform\\_sbs\\_full.pdf](http://www.kff.org/healthreform/upload/healthreform_sbs_full.pdf); Community Catalyst. (15 June 2009). *Summary of Initial Draft of Health Reform Bill from Senate Health, Education, Labor and Pensions Committee*, Last retrieved June 23, 2009, from [http://www.communitycatalyst.org/doc\\_store/publications/help\\_full\\_summary.pdf](http://www.communitycatalyst.org/doc_store/publications/help_full_summary.pdf).

<sup>2</sup> Mead H. et al. (2008). *Racial and Ethnic Disparities in U.S. Health Care: A Chartbook*. New York: The Commonwealth Fund.

<sup>3</sup> U.S. Census Bureau, Current Population Survey. (2007) Poverty Tables. Last retrieved June 23, 2009, from <http://www.census.gov/hhes/www/macro/032008/pov/toc.htm>.

<sup>4</sup> Mead et al., *Racial and Ethnic Disparities in U.S. Health Care*.

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- <sup>10</sup> Doty, M.M. & Holmgren, A.L. (2006). *Health Care Disconnect: Gaps in Coverage and Care for Minority Adults: Findings from the Commonwealth Fund Biennial Health Insurance Survey*. New York: Commonwealth Fund Issue Brief.
- <sup>11</sup> Data obtained from Lowrey, Y. (2007). *Minorities in Business: A Demographic Review of Minority Business Ownership*. Small Business Administration.
- <sup>12</sup> Congressional Budget Office. (15 June 2009). *A Summary of the Key Provisions of the HELP Committee's Proposal*, Last retrieved June 23, 2009, from <http://www.cbo.gov/ftpdocs/103xx/doc10310/06-15-HealthChoicesAct.pdf>
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- <sup>14</sup> Smedley, B.D. (2006). Expanding the Frame of Understanding Health Disparities: From a Focus on Health Systems to Social and Economic Systems. *Health Education & Behavior*, 33(4): 538-541.
- <sup>15</sup> U.S. Census Bureau. Detailed Poverty Tabulations.
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