



RACIAL  
EQUITY  
FRAMEWORK

**Filling in the Gaps:**

**A Racial Equity Framework for Successful  
Implementation of the Affordable Care Act**



## About the Greenlining Institute

The Greenlining Institute is a national policy, research, organizing, and leadership institute working for racial and economic justice. We ensure that grassroots leaders are participating in major policy debates by building diverse coalitions that work together to advance solutions to our nation's most pressing problems. Greenlining builds public awareness of issues facing communities of color, increases civic participation, and advocates for public and private policies that create opportunities for people and families to make the American Dream a reality.

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## Introduction

**B**elief in the American Dream – the idea that with hard work and perseverance, everyone has an equal opportunity to succeed – is a defining value of American culture. Often overlooked is the fact that good health is crucial to being able to achieve the American Dream. Disparities in health contribute to the challenges some groups experience as they strive to achieve America’s promise.

Numerous studies document disparities in the health status of people of color,<sup>1</sup> and many of the health conditions that disproportionately afflict people of color are preventable chronic illnesses. Trust for America’s Health, for example, reported that African Americans exhibit higher rates of diabetes, hypertension, and heart disease than other racial and ethnic groups.<sup>2</sup> Tuberculosis and Hepatitis B disproportionately afflict Asian Americans,<sup>3</sup> and Native Hawaiians and Pacific Islanders experience obesity at a rate that is 3.7 times higher than the overall Asian American population.<sup>4</sup> Furthermore, health disparities often become even more startling when examining vulnerable populations within racial and ethnic groups. Large gaps in the health status of people of color persisted over the last century, despite extensive improvements in overall health and life expectancy rates in the U.S.<sup>5</sup> These gaps also persisted despite evidence that disease prevention programs that do not require medical intervention and target at-risk communities are extremely cost effective: a \$10 investment per person per year in proven preventative community-based programs would save the country more than \$16 billion in five years.<sup>6</sup> **Thus, a commitment to eliminating disparities in health is an investment in the future of America and its citizens.**

Large gaps in the health status of people of color persisted over the last century, despite extensive improvements in overall health and life expectancy rates in the U.S.

### Why do Health Disparities Persist?

An individual’s health insurance coverage (or lack thereof) often determines his or her access to quality health care. A 2009 Harvard study estimated that every year, 45,000 deaths are associated with lack of health insurance.<sup>7</sup> People of color are less likely than whites to have health insurance, and rates of health insurance coverage differ across racial and ethnic groups. Nationally, within the non-elderly population, 36 percent of Latinos, 33 percent of American Indians/Alaska Natives, 22 percent of African Americans, and 17 percent of Asian and Pacific Islanders lack health insurance, as compared to 13 percent of whites.<sup>8</sup> Furthermore, a correlation exists between disparities in health insurance coverage and disparities in health status. Medical care is expensive, and individuals lacking insurance often receive irregular health care or forgo seeking medical treatment until a condition progresses to the point of needing emergency care. One report found that 46 percent of uninsured African Americans and Latinas lacked regular health care despite having one or more chronic health conditions.<sup>9</sup> Eliminating disparities in access to health insurance is essential to reducing racial and ethnic health disparities in the US.

Factors such as environment, social status, educational attainment, and accumulation of economic assets are closely linked to the health outcomes of individuals, families, and communities.<sup>10</sup> For example, multiple studies reveal that Americans at all income levels have inferior health outcomes compared to Americans of higher income, and the health of children is strongly linked to their parents’ level of educational attainment.<sup>11</sup>

Populations experiencing health disparities are also likely to experience other barriers as a result of social and economic condition. In America, people of color are disproportionately disadvantaged. Children of color, for example, are more likely than white children to attend elementary schools located in poor neighborhoods.<sup>12</sup> Furthermore, over half of African Americans live in areas characterized by overcrowding, inadequate housing, poor public education, and crime.<sup>13</sup> Similarly, Latinos are more likely than non-Latino whites to face unemployment and live in poverty, and employed Latinos earn less than non-Latino whites.<sup>14</sup> Addressing social and economic inequities based on race<sup>15</sup> and ethnicity is an important step in improving the overall health of Americans and building a healthy economy.

## How Can the Affordable Care Act Help Eliminate Health Disparities?

In March of 2010, President Obama signed The Patient Protection and Affordable Care Act (ACA) into law. This legislation marks a historic expansion of health care access and is a significant step in eliminating health disparities nationwide. The law makes health insurance more accessible and affordable for Americans by expanding Medicaid,<sup>16</sup> introducing new subsidies for the purchase of health insurance,<sup>17</sup> and creating Health Insurance Exchanges, which are marketplaces where consumers can purchase high quality and affordable health coverage. Approximately 32 million Americans who currently do not have health insurance will gain coverage in 2014 as a result of these expansions.<sup>18</sup> The success of health care reform, however, depends on the number of people who immediately enroll in its programs as they become available. Outreach specifically targeting populations eligible for the benefits of the ACA is imperative to achieving early maximum program enrollment. The populations that will most qualify for the benefits of health care reform will be healthy young people and people of color.<sup>19</sup>

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The populations that will most qualify for the benefits of health care reform will be healthy young people and people of color.

Even though people of color are the largest group that will be eligible to take advantage of the benefits of health care reform, social, environmental, and economic barriers could make it difficult for people of color to truly benefit from the ACA. Such barriers can complicate the ability of individuals of color to access information about health care reform, enroll in ACA programs and benefits, and maintain new insurance coverage. **Ensuring**



**Racial Equity** is the condition that would be achieved if one's racial or ethnic identity was no longer a determining factor in one's success. —*The Greenlining Institute*

**that people of color successfully enroll in and utilize these reforms will require targeted and strategic outreach to these communities, and successfully reaching these populations will require a thoughtful and well-coordinated effort between policymakers, advocates, and community stakeholders.** Utilizing a racial equity<sup>20</sup> framework throughout implementation of the Affordable Care Act will help policymakers, advocates, and community stakeholders successfully reach all communities of color.

This brief discusses and applies a framework for racially and ethnically equitable implementation of the Affordable Care Act. The purpose of this framework is to help policymakers, advocates, and community stakeholders (1) identify aspects of policies that may inadvertently create or perpetuate racial and ethnic disparities within communities, (2) identify barriers preventing communities of color from favorably and equitably benefitting from policy outcomes, and (3) develop policies and implementation strategies that will result in racially and ethnically equitable outcomes. Application of this framework is illustrated through examples from California’s health care reform implementation process.

## The Racial Equity Framework

**I**n this framework we make the unique distinction between “racial equity” and “racial equality.” When policymakers address racial and ethnic disparities by allocating an equal amount of resources to each group, they are utilizing a “racial equality” strategy. Oftentimes, different racial and ethnic groups experience divergent community impacts as a result of implementation of a “racial equality” strategy, with some groups benefitting more than others and other groups experiencing outcomes that actually increase inequality within their communities. This outcome can also occur when policies are implemented “blindly,” or without any consideration to the impact on diverse racial and ethnic communities at all. In contrast, “racial equity” focuses on achieving comparable favorable outcomes across racial and ethnic groups, regardless of the resources and input allocated. Sometimes a greater volume of resources or different types of resources must be allocated to one

community in order for all groups to ultimately reap a net positive benefit. Variations in allocation of resources, however, are sometimes necessary to ultimately achieve equitable outcomes for all racial and ethnic communities.

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Members of households earning less than \$10,000 per year are over three times more likely to die prematurely than members of households earning more than \$100,000 per year.

The racial equity framework also uses an intersectional lens to recognize differences within and across communities impacted by racial and ethnic oppression. The theory of intersectionality describes the ways in which race,<sup>21</sup> ethnicity,<sup>22</sup> class,<sup>23</sup> sex,<sup>24</sup> gender identity,<sup>25</sup> sexual orientation,<sup>26</sup> ability,<sup>27</sup> nationality,<sup>28</sup> age,<sup>29</sup> geography,<sup>30</sup> and other markers of difference<sup>31</sup> intersect to explain and inform an individual’s life experiences.<sup>32</sup> Policymakers, racial justice advocates, and community leaders may inadvertently overlook the unique needs of individuals within racial or ethnic groups while working to remove barriers that prevent communities of color from reaching the American Dream and living healthy and prosperous lives.

Overlooking diversity within racial and/or ethnic groups can be problematic, as the existence of intersecting identities can change the degree to which members within and across racial and ethnic communities are able to access various programs and policies. For instance, marginalized individuals and groups within communities of color, including but not limited to youth, LGBTQ<sup>33</sup> individuals and women, may face limitations or experience discrimination when trying to access educational opportunities or when trying to access resources like health care services from government agencies. Marginalized people within racial and ethnic groups may also encounter



barriers when trying to garner political and community support against employment discrimination or neighborhood violence. Transgender African Americans, for example, are disproportionately victims of hate crimes, with 70 percent of transgender victims being African American.<sup>34</sup> A racial equity lens can aid policymakers, advocates, and social change leaders representing communities of color in reframing “traditional racial justice issues” and supporting policies that promote the well-being of all people.

The racial equity framework can also aid policymakers and advocates in understanding how social and economic issues impact all people differently, including people of color. For example, poverty and economic security are closely linked to health status, as members of households earning less than \$10,000 per year are over three times more likely to die prematurely than members of households earning more than \$100,000 per year.<sup>35</sup> Families across and within racial and ethnic groups, however, experience poverty in different ways and at different rates. For example, poverty rates vary considerably across Asian American ethnic groups: Between 2007 and 2009, the Hmong community experienced a 26 percent poverty rate - over three times the rate of poor (Asian) Indians in America. The poverty rate for the Hmong community actually exceeded the rate for poor Latinos (22 percent) and African Americans (25 percent) during the same time period.<sup>36</sup> Similarly, black and Hispanic single mothers experienced disproportionately higher poverty rates compared to married couples of the same racial and ethnic group.<sup>37</sup> In 2010, over 50 percent of Hispanic single mothers lived below the federal poverty line - twice the rate of Hispanic married couples with children.<sup>38</sup> A racial equity framework that uses an intersectional lens, thus, allows social change leaders to identify shared goals and tactics in promoting racial justice while also recognizing differences across and within communities of color. The political, economic, and institutional systems that uphold racial and ethnic inequality are the same systems used to uphold oppressive policies and practices based on gender, class, sexual orientation, and other markers of difference.<sup>39</sup> **Recognizing the diversity of experiences of *all* people, including people of color, is critical to creating effective policy.**

The racial equity framework consists of a set of Guiding Principles and a set of Guiding Questions. The Guiding Principles describe a vision of what equity could look like within policy implementation. Policymakers and advocates should strive to create policies whose results exhibit each of the principles. Passage of a federal or state law often requires lawmakers and policymakers at lower levels of government to create additional laws and policies in order to implement that law. The Guiding Questions help policymakers and change agents consider the social and environmental landscape of communities in which they will implement new policies and, thus, ensure equitable and positive impact of policies in all communities.



## Guiding Principles:<sup>40</sup>

**Diversity and Inclusion** – Recruit diverse community stakeholders – including but not limited to racial and ethnic minorities, women, youth, and LGBTQ individuals – and involve them as active participants in all stages of decision-making, policy-implementation, and program evaluation processes. Resulting programs and policies should be inclusive and representative of the needs of the communities that they will impact.

**Transparency and Accountability** – Maintain openness and fairness to diverse communities, such as low income communities, communities of color, and geographically isolated communities in all phases of planning, decision-making, program development, program implementation, documentation, program evaluation, and advocacy.

**Healthy Environments** – Pay active attention to eliminating existing disparities to achieve outcomes that maximize the health, safety and well-being of all individuals and communities.

**Equal Opportunity** - All individuals should have full and fair access to opportunities and benefits of resulting policies and programs without bias, unnecessary barriers or extra burden.

**Accessibility** – Ensure that all individuals receive the basic information, resources, and opportunities necessary to create healthy and prosperous futures for themselves and their children.

**Sustainability** – Implement equity-enhancing programs and policies with the support, protections, and enforcement necessary for long-term positive impact in diverse communities.



## Guiding Questions:<sup>41</sup>

### Step 1: Gathering Information

Review the purpose of the policy that will be implemented and begin identifying additional information needed to ensure equitable outcomes.

1. What specific issue(s) are we intending to address?
2. What is the purpose of the policy we are making and/or implementing?
3. What quantitative and qualitative evidence of inequity exists around the issue that this policy is supposed to address?
4. How might implementation play out differently in different communities?
5. What additional information is missing or needed?

### Step 2: Engaging Stakeholders

Assemble a team of stakeholders with diverse perspectives who can help policymakers holistically analyze the implementation process. Any policy-driven process should include robust stakeholder input and a program to ensure successful implementation in all communities.

1. Who are the stakeholders (including community members and members of various racial/ethnic groups) who may be positively or negatively affected by this policy? How can we best inform them?
2. How can we engage potentially affected stakeholders as active participants in the decision-making, planning, and implementation processes in an impactful way?
3. Are we meaningfully considering the needs and concerns of stakeholders during final decision-making processes?
4. Who is missing and how can we engage them?

### Step 3: Identifying Policy Holes

Identify the positive and negative outcomes that a policy would have in diverse communities if implemented without recognizing the unique circumstances of various racial and ethnic groups. The input of diverse community stakeholders is extremely valuable during this step.

1. What adverse impacts or unintended consequences could result from this policy if enacted as written?
2. How would different racial and ethnic groups be impacted (either positively or negatively) if this policy were enacted or implemented as written?
3. What additional barriers might prevent individuals in certain racial/ethnic groups from benefitting fully if this policy were implemented as written?
  - a. Consider language, gender, SES, digital inequality, LGBTQ status, (dis)ability, employment status, immigration status, education level, geography, environment, religious beliefs, culture, history of incarceration, etc.

## Guiding Questions cont.:

### Step 4: Filling in the Holes

Identify additional steps policy-implementers and advocates should take to ensure that the policy will impact all communities positively and equitably.

1. What steps could we take to prevent or minimize adverse impacts or unintended consequences?
2. What steps could we take to address additional barriers that could prevent various racial/ethnic groups from accessing the policy fully?
3. Are there further ways to maximize equitable outcomes?

### Step 5: Examining Sustainability

Ensure that the implementation process and its equity framework are both transparent and sustainable.

1. Do this policy and additional equity-enhancing measures related to this policy have adequate funding? Are mechanisms in place to ensure successful implementation and enforcement?
2. Are there provisions to ensure ongoing stakeholder participation and public accountability of policy implementers and enforcers?

### Step 6: Evaluation

Measure the success of equitable policy implementation.

1. Are there provisions to ensure ongoing collection of data (that can be disaggregated by race/ethnicity) and public reporting of data?
2. Are there clear markers of short term and long term success as well as timelines for meeting markers of success?
3. What are the mechanisms we will utilize to ensure that goals are met?
4. What are the consequences if goals are not met?
5. Is there a process for those impacted by the policy to express grievances or satisfaction and to ensure that concerns are met?

## An Application of the Racial Equity Framework to California's Affordable Care Act Implementation Process

**T**he following case study applies the racial equity framework to California's ACA implementation process using a variety of resources to answer the guiding questions put forth in the racial equity framework. These resources include academic and scientific studies; reports created by community-based, statewide, and national policy and advocacy organizations; and reports sponsored by social justice and health-focused foundations. Primary data collected through needs assessments conducted in low-income communities and communities of color across California also informed this case study.

In order to collect primary data, The Greenlining Institute worked with diverse community partners to conduct a series of town halls across the state of California. These community events were held in October and November of 2011 and January of 2012 in six locations across the state: San Diego, Santa Ana, South Los Angeles, Thermal, South Sacramento, and Fresno. Greenlining staff educated community members about the ACA's benefits and provisions that may impact individuals, families, and ethnic small businesses. Greenlining staff also conducted needs assessments with community members participating in the town halls to identify barriers preventing access to health information and health care. Needs assessments were conducted under the premise that identified challenges may continue to prevent individuals from fully benefitting from the ACA unless policymakers, legislators, and advocates identify and account for these barriers throughout the implementation process.

During the town halls, Greenlining utilized Turning Technologies' live polling software along with guided open discussion questions. The goal of the survey was to understand the barriers to accessing quality health care that people face, and open discussions during town halls also enabled community members to provide feedback related to barriers to accessing health information and care. A Greenlining staff member recorded the responses of individuals who chose to participate during open discussion periods. The majority of community members opted to participate in town halls by submitting answers using TurningPoint remote controls; a minority of community members opted to participate during periods of open discussion.

A diverse group of community members participated in Greenlining's town halls. About 12 percent of participants identified as white, 12 percent identified as African American, 39 percent identified as Latino, 27 percent identified as Asian, three percent identified as Native American, and seven percent identified as other. Seventy-two percent of town hall participants were female. About 36 percent of participants were U.S. born. Twenty-nine percent of participants were born in Asia, and 32 percent were born in Mexico or Central America. Sixty percent of participants made less than \$30,000 annually.

We reference data and stories collected during Greenlining's town halls throughout the case study and recommendations.<sup>42</sup> Data from representative samples also provides additional context. The approach of gathering input from academic, policy, and organizational experts as well as community stakeholders represents a model that should be adapted widely in implementing various policies. Steps 1-3 in the following case study reflect the current status of ACA implementation in California, and steps 4-6 will be further developed as the implementation process continues and additional information becomes available.

## Case Study:

### Step 1: Gathering Information

- The California Health Benefit Exchange (HBEX)<sup>43</sup> is the body largely responsible for setting up California's health insurance Exchange and creating a web portal to determine eligibility into either the Exchange or Medi-Cal. The California Department of Health Care Services (DHCS) will oversee the expansion of Medi-Cal to cover individuals who earn up to 138 percent of the Federal Poverty Level.
- Approximately 4.7 million currently uninsured Californians will be able to obtain health coverage as a result of the ACA.<sup>44</sup>
- In 2010, the average private employer premium for family coverage in California was about \$13,871, and the average single-person deductible was just over \$1,025.<sup>45</sup>
- From 2009-2010, 19 percent of California's population was uninsured, and 59 percent of the nonelderly uninsured were Hispanic, while 25 percent were white, 11 percent were of other races, and five percent were African American.<sup>46, 47</sup>
- From 2009-2010, 61 percent of Medi-Cal enrollees were Hispanic, twenty percent were white, 10 percent were of other races/ethnicities, and nine percent were African Americans.<sup>48</sup>
- Approximately 66 percent of Californians eligible for Medi-Cal in 2014 will be people of color.<sup>49</sup>
- An estimated 64 percent of Californians eligible for premium tax credits in 2014 will be people of color.<sup>50</sup>
- Of those eligible for Medi-Cal expansions and tax credits in California in 2014, about 45 percent will be Latino, 35 percent will be white, 12.5 percent will be Asian, 6 percent will be African American and 2 percent will be American Indian, Alaska Native, Native Hawaiian or Other Pacific Islander.<sup>51</sup>
- Additional region-specific information describing racial and ethnic disparities in health conditions and insurance coverage is needed.

### Step 2: Engaging Stakeholders

- Legislation establishing the HBEX mandates that the racial and ethnic diversity of the board's members parallels the racial and ethnic diversity of the state of California. HBEX failed to meet this requirement, partially because of difficulty identifying qualified racially and ethnically diverse applicants who also did not have a conflict of interest.
- HBEX, the Office of the Patient Advocate, the Department of Managed Health Care, the California Department of Insurance, and legislators have convened or are in the process of convening a number of

different workgroups and stakeholder meetings made up of industry experts and consultants to assist in various aspects of the implementation process. Additionally, consumer advocates actively participate in public meetings and submit comments.

- AB 922 expands the duties of the Office of the Patient Advocate to include providing consumer education and outreach about how to find health care coverage and navigating the health care system.<sup>52</sup>
- Evidence from Greenlining’s town halls suggests that communities of color lack adequate information about the ACA: About 36 percent of individuals surveyed had never heard of health care reform. Furthermore, about 14 percent of individuals surveyed believed the ACA had been repealed, and nearly 33 percent were unsure whether the law was repealed or if it was still in effect.

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### Step 3: Identifying Policy Holes

Implementing the Affordable Care Act in California without consideration of social, environmental, and economic barriers will make it difficult for many Californians to take full advantage of the benefits of health care reform. Because about two-thirds of the population eligible to take advantage of expanded health coverage in California will be people of color, it is important to seriously examine and address the needs of communities

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of color during the implementation process.<sup>53</sup> Inappropriate and/or non-targeted outreach will result in under-enrollment, particularly in the Exchange and Medi-Cal, as eligible populations may not receive information explaining their eligibility or how to enroll. Community outreach efforts will need to begin well before January 1, 2014. Otherwise, the programs may suffer under-enrollment in those first months because eligible populations lack needed eligibility and enrollment information.

Policymakers and advocates should also address the following challenges impacting communities of color in California:

***Inaccessibility Due to Language and Literacy Level:*** Because 27 percent of Californians are foreign-born and 42 percent of Californians speak a language other than English at home, language accessibility is an important consideration.<sup>54</sup>

- 62.5 percent of those surveyed in Greenlining’s town halls spoke a language other than English most often at home.
- 26 percent of town hall participants did not speak English well, and about 19 percent of town hall participants did not speak English at all.

- Disparities in language access are particularly glaring within the Asian American population, as more than one third of all Asians living in California have limited English proficiency, and approximately 35 percent of Asian households live in complete linguistic isolation.<sup>55</sup> It is important to note that English proficiency varies greatly by age, with older Asian Americans tending to have more limited English proficiency than younger Asian Americans.
- Persons who have low English proficiency or low English literacy levels often have difficulty understanding important health forms and notices. Forty percent of individuals surveyed at Greenlining's town halls need help translating medical forms or communicating at doctor's appointments.
- There is a shortage of medical professionals who speak foreign languages (particularly Asian languages). One participant in Greenlining's town halls reported, *"I have to travel two hours to find a doctor that speaks my language."*
- Data from Greenlining's town halls suggest that individuals who primarily speak a language other than English at home are more likely to prefer purchasing health insurance in person, while those who report that they speak English well are more willing to purchase insurance over the Internet.
- Once enrolled in a health insurance plan, individuals with limited English proficiency may experience difficulty utilizing their insurance because of a lack of available translation services or shortage of health care professionals who speak their language.

**Cultural Competency:** Within the context of health, cultural competency refers to understanding and respecting the values, beliefs, social histories, and expectations of diverse ethnic groups, and appropriately and efficiently delivering health information and health care for specific ethnic groups based on this information. A lack of cultural competency creates barriers to the provision of appropriate health education and health care services in communities of color.

- Patients may not trust medical professionals, not follow medical advice, or forgo health services altogether because of fear or inability to communicate health care needs.<sup>56</sup>
- Physicians may not understand prevalent healthcare beliefs, expectations, or health conditions in diverse ethnic communities or run fewer diagnostic tests because of unfamiliarity with linguistic differences in descriptions of symptoms or conditions.<sup>57</sup> One participant at Greenlining's town halls described how a shortage of culturally competent doctors creates a barrier to accessing needed health care in her community: *"Many doctors don't understand the atrocities the older generation faced in our homeland. They don't believe the injuries and problems they have and won't give them the treatments they need."*
- Cultural incompetency could also prevent diverse ethnic communities from receiving relevant information about health care reform and make it difficult for individuals to successfully navigate through the enrollment process.

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*"Many doctors don't understand the atrocities the older generation faced in our homeland. They don't believe the injuries and problems they have and won't give them the treatments they need."*

**Digital Inequality:** Low income communities and communities of color have disproportionately low access to the Internet, use different devices to access the Internet, and use the Internet for different reasons.

- Eighty-one percent of whites have broadband at home, as opposed to 76 percent of Asians, 74 percent of African Americans, and 55 percent of Latinos, and these disparities are more pronounced amongst young adults of color.<sup>58</sup>
- Individuals who lack Internet access or with limited computer literacy may experience difficulty learning about and enrolling in public programs online, including the Exchange.
- Forty-two percent of young adults between the ages of 18-29 and 38 percent of African Americans and Hispanics primarily use a smartphone rather than a computer to access the Internet.<sup>59</sup>
- Whites are more likely to access government sites on the Internet than people of color, but people of color are more likely than whites to use social media networking sites such as Facebook and Twitter.<sup>60</sup>
- Almost 23 percent of respondents during Greenlining's town halls did not have access to a computer at home, and nearly 20 percent of individuals did not have any access to a computer.

**Socioeconomic Status:** Health status and socioeconomic status are inextricably linked, as living conditions and access to resources influence overall quality of life.

- Poverty is the biggest factor contributing to poor outcomes, and health outcomes worsen as the severity of poverty increases.<sup>61</sup>
- The socioeconomic status of an individual's family at birth is associated with higher death rates in adulthood.<sup>62</sup>
- Children raised in low-income families have rates of poor or fair health that are seven times higher than children of upper income families, and their poor health conditions persist into adulthood.<sup>63</sup>
- In California, 20 percent of African Americans make an income below poverty level, as well as 18 percent of Latinos, Native Americans, and Alaska Natives. Ten percent of Asians, Native Hawaiians and other Pacific Islanders make incomes below the poverty level.<sup>64</sup>
- Forty-one and a half percent of participants at Greenlining's town halls earned less than \$20,000 annually, and 18 percent earned between \$20,000 and \$30,000 annually. Low income individuals tended to prefer to purchase health insurance in person.

In California, 20 percent of African Americans make an income below poverty level, as well as 18 percent of Latinos, Native Americans, and Alaska Natives. Ten percent of Asians, Native Hawaiians and other Pacific Islanders make incomes below the poverty level.

**Unemployment and Underemployment:** For each one percentage point rise in the national unemployment rate, the number of uninsured Americans rises by about 1.1 million.<sup>65</sup>

- The national annual unemployment rate for African Americans has been *double* the white unemployment rate for the past 38 years.<sup>66</sup> This pattern persists regardless of age or education level: In 2010, the unemployment rate for black male college graduates age 25 and older was almost double that of white male college graduates of the same age (7.8 percent and 4.4 percent, respectively). According to the Bureau of Labor Statistics, the black teen unemployment rate was 42.1 percent in December of 2011, while the white teen unemployment rate was 20.3 percent.<sup>67,68</sup>



- The unemployment rate in California is 11.3 percent.<sup>69</sup> This figure does not include the 165,062 individuals (many of whom are African American or Latino) who are currently incarcerated.<sup>70</sup>
- 38 percent of those surveyed during Greenlining's Town Halls were unemployed or underemployed.
- Many jobs that are part-time, hourly, or contractual do not include health benefits.
- In California, an individual must spend about 28.8 percent of unemployment benefits on COBRA<sup>71</sup> premiums in order to maintain single coverage. In order to maintain family coverage under COBRA, an individual would spend about 81.6% of total unemployment income on COBRA premiums.<sup>72</sup>
- Even though California offers COBRA as well as a state-sponsored COBRA-like supplemental insurance program, the costs of the coverage provided are usually prohibitively high, as most unemployed people cannot afford to pay even more for health coverage than they had been paying while employed.<sup>73</sup> As one participant at Greenlining's town hall explained, *"I don't qualify for Medi-Cal, but COBRA is too expensive. I need help now."*
- California's Pre-Existing Condition Insurance Plan<sup>74</sup> may soon reach its maximum enrollment level, limiting the number of newly uninsured who could gain health insurance through this program.<sup>75</sup>
- Medi-Cal is currently not available for many newly unemployed workers, as many unemployed workers are childless adults or do not have dependent children. (This will change in 2014).<sup>76</sup> Low Income Health Programs (LIHPs)<sup>77</sup>, however, are an option for low-income adults who do not qualify for Medi-Cal. LIHPs are currently up and running in 47 counties in California with 250,000 people enrolled, and the Department of Health Care Services expects for 55 of 58 counties to have operational LIHPs by June of 2012.<sup>78</sup>
- Many uninsured Americans delay or forgo needed medical care altogether, increasing the likelihood of illnesses being diagnosed later, at an advanced stage.<sup>79,80</sup>

The national annual unemployment rate for African Americans has been *double* the white unemployment rate for the past 38 years. This pattern persists regardless of age or education level.

*"I don't qualify for Medi-Cal, but COBRA is too expensive. I need help now."*

**Barriers Resulting from Immigration Status:** Over 10 million immigrants reside in California.<sup>81</sup> Almost

- half (46%) have become naturalized citizens, and an estimated 2.6 million are undocumented.<sup>82</sup>
- Under the ACA, naturalized citizens are eligible for Medi-Cal, can purchase coverage through the Exchange, and can receive tax credits on the same basis as U.S.-born citizens.<sup>83</sup>
- Lawfully residing immigrant families are able to purchase coverage through the Exchange and can receive health insurance tax credits but must wait five years before enrolling in Medi-Cal.<sup>84</sup>
- Barriers such as limited transportation options, language inaccessibility, low-literacy levels, and burdensome or confusing application processes and documentation requirements often prevent legally residing immigrants from accessing health information and health care.<sup>85</sup>
- Fear that participating in public programs could negatively affect U.S. immigration status may also prevent eligible individuals and families from enrolling in Medi-Cal.<sup>86</sup>

- Mixed-status families may refrain from enrolling legally residing family-members in public programs for fear of endangering unlawfully residing family members.<sup>87</sup> This fear will likely keep undocumented family members from purchasing insurance in the Exchange for legally residing family members as well.
- Undocumented immigrants are banned from enrolling in Medi-Cal, are ineligible for health insurance subsidies, and are not able to purchase insurance in the Exchange, even if they use their own money.<sup>88</sup>
- Twenty-three percent of Greenlining town hall participants were members of mixed-status households, and two percent reported that all members of their household are undocumented.
- Safety-net providers such as emergency rooms and community clinics will become the primary means of access to health care for these individuals.
- Thirty-three percent of Greenlining's town hall participants reported that they primarily go to community clinics or the emergency room when they are sick.

**History of Incarceration:** On May 23, 2011, the US Supreme Court ruled that California must release 30,000 inmates from the state penal system to reduce the prison population to 137.5% of system capacity.<sup>89</sup>

- The quality and availability of medical and mental health services in California prisons have declined as inmate populations ballooned.<sup>90</sup> As a result, many newly released individuals may have mental or physical health conditions that have not been fully diagnosed. Former inmates may need to quickly be connected to the health care system.
- Individuals with histories of incarceration often have difficulty finding employment, which can affect their ability to get job-based health insurance: While data on formerly incarcerated individuals is limited, one study of formerly incarcerated people in the District of Columbia (DC) found that the unemployment rate for this population is 45 percent. Additionally, employment rates for formerly incarcerated populations were found not to differ for those who earned a GED or a job certificate before or after they left prison.<sup>91</sup> Assuming that California's formerly incarcerated experience employment challenges that are similar to the formerly incarcerated in DC, many of California's formerly incarcerated will need to obtain health coverage through Medi-Cal<sup>92</sup> or, possibly, through the Exchange.
- Many individuals will require assistance navigating the public and private health care systems. One town hall participant stated, *"My younger brother is about to be released and has a liver condition. I'm trying to figure out how he can get health care. He's going to need health care."*

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More information is needed about the barriers to accessing health information and care experienced by women, LGBTQ individuals, individuals with a disability, individuals living in rural areas, individuals with low educational attainment, and individuals living in polluted or unsafe environments.

## Step 4: Filling in the Holes

The following steps can help address barriers to equitable implementation across ACA provisions:

### *Language and Literacy Level:*

- In order to ensure equity in the implementation process, agencies should produce health care reform outreach and application materials, including relevant websites and smart phone applications, in multiple languages. This must include translating to languages other than English and Spanish. California should use the existing Medi-Cal threshold language standards.<sup>93</sup>
- Make translation services available at any stakeholder meetings held by agencies involved in the implementation process to increase opportunities for feedback from advocates who do not primarily speak English. Meeting materials should also be made available in other languages.
- Make translators readily available in multiple languages to assist individuals in the enrollment and renewal processes, as well as in educating individuals about how to use their insurance.
- Increase the number of health care professionals who speak other languages, with special attention to health care professionals who speak Asian languages.

### *Socioeconomic Status:*

- Invest in improving non-financial barriers to health, including transportation, child care, education (Pre-K through 12<sup>th</sup> grade), community spaces (such as parks and sidewalks), and safe housing.<sup>94</sup>
- Maintain full funding for social safety-net programs such as WIC, SNAP, and Medi-Cal.

### *Unemployment and Underemployment:*

- Create a meaningful COBRA subsidy and/or enable unemployed individuals to temporarily enroll in Medi-Cal.
- Invest in job creation programs, and target populations and communities with high levels of unemployment.

### *Digital Inequality:*

- Utilize social media in targeted outreach strategies to educate communities of color about health care reform (especially young adults of color).
- Utilize smartphone technologies to connect individuals to Medi-Cal or the Exchange and to remind people to enroll or renew their health insurance.
- Make linguistically and culturally competent assistance available and accessible for communities with low computer literacy.

### *Cultural Competency:*

- Utilize trusted individuals, organizations, and institutions within communities for health care reform education and outreach.

- Build a diverse health workforce (including workers involved in the health insurance enrollment process) that is culturally and linguistically competent by strengthening pipeline programs facilitating the entry of underrepresented groups into the health workforce.

#### *Immigration Status:*

- Advocates and policymakers should fully publicize that legally residing residents will be able to participate in the expansion of Medi-Cal and purchase in the Exchange without affecting legal status.
- Limit the amount of personal information collected from individuals who are purchasing for themselves.

#### *Identifying and addressing additional barriers:*

- Bodies overseeing implementation efforts should enlist individuals and organizations who specifically advocate on behalf of women, LGBTQ persons, persons with disabilities, persons with low educational attainment, and persons living in unsafe or polluted environments in order to better understand and address the needs of these groups throughout the process of ACA implementation.

### **Step 5: Examining Sustainability**

Contrary to popular belief, health care reform implementation should not have a negative impact on the state budget: Many programs, such as Medi-Cal, will receive federal matching dollars. Furthermore, the Exchange must be fully operational and self-sustaining by 2015. During this time of recession, individuals and families – now more than ever – are in need of health care services. It is absolutely imperative that the government not underfund or eliminate funding for provisions of the Affordable Care Act. Such cuts would cripple the success of health care reform implementation in California. California’s policymakers and advocates should lobby at the state level to maintain funding for provider fees and Medicaid reimbursement rates.

Bodies in charge of implementation and policy enforcement should put mechanisms into place that enable ongoing stakeholder participation throughout the implementation process, allowing those bodies to be held publicly accountable. Ongoing inclusion of diverse stakeholders throughout implementation and evaluation processes will help ensure that the policies that are put into place are equitable for all.

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## Step 6: Evaluation

The Affordable Care Act creates standards requiring any “federally conducted or supported health care or public health program, activity, or survey to collect and report data on race, ethnicity, sex, primary language, disability status...and other demographic data related to health disparities,” such as LGBTQ status.<sup>95</sup> Such information helps researchers, policymakers, health care providers, and advocates better identify and address health disparities within diverse communities. The proposed standards for collecting data include the following:

- Standards should be evidence-based and demonstrated to have worked well in practice for national survey data collection.
- Standards should represent a minimum data standard; agencies need to be able to aggregate additional information collected back to a minimum standard.<sup>96</sup>

It is extremely important that individuals and institutions in California that collect data take extra steps to ensure that the data collected can be disaggregated by race and ethnicity. Disaggregation of data is necessary to accurately study similarities and differences between and within ethnic groups, to prevent issues from hiding within aggregate data, and to identify and monitor specific needs within particular ethnic communities.<sup>97</sup> Disaggregated data can inform and influence the development of equitable programs and policies, help determine the appropriate allocation of resources to communities in need, and help researchers, policymakers, advocates, and health care providers develop, monitor, and improve programs and quality of services.<sup>98</sup> California could also take steps to collect data on marginalized populations that the ACA overlooks in its federal regulations. For example, the ACA requires that federally conducted or supported surveys ask individuals to designate whether they are male or female.<sup>99</sup> California could require that surveys also include broader options for individuals to designate their gender to adequately account for health disparities within transgender and intersex populations.<sup>100</sup>

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## Recommendations for Equitable Implementation of the Affordable Care Act

### INCLUDE INPUT FROM DIVERSE STAKEHOLDERS THROUGHOUT THE IMPLEMENTATION PROCESS

- *Bodies overseeing ACA implementation should take steps to ensure inclusion of racially and ethnically diverse viewpoints throughout remaining ACA decision-making and planning processes. They should also engage diverse stakeholders to gauge and enhance the effectiveness of implemented provisions.*
- *Make stakeholder input processes as accessible as possible.* Improvements in the stakeholder input process made by the California Health Benefit Exchange Board (HBEX) are a good example and should be replicated in other states. These improvements included podcasting HBEX Meetings online, providing a vehicle for advocates watching HBEX meetings online to submit comments and receive feedback in real time, providing time for public comment in person and on the phone after each agenda item, and providing translation services.
- *Bodies responsible for implementing the ACA should seek input from community members across the state in the form of town halls, listening sessions, and public forums. Feedback from state-wide community stakeholders should be sought throughout the process.* California's HBEX provides a good example through its plans to hold HBEX board meetings throughout California in 2012. HBEX and other policymakers should continue to travel to communities across California and provide a forum for community members to provide direct feedback about their needs throughout the implementation process.
- *Conduct a needs assessment in order to better understand the ethnic small business landscape before conducting outreach for and implementing the SHOP.<sup>101</sup>* This needs assessment should include questions that specifically address the challenges ethnic small businesses face with regard to purchasing health insurance.

### COLLABORATE WITH TRUSTED COMMUNITY RESOURCES

- *Conduct community needs assessments to identify the trusted resources within diverse racial and ethnic communities.<sup>102</sup>* Pay particular attention to sub-communities within diverse communities.
- *Employ trusted community based organizations, institutions, and individuals who have shared backgrounds or experiences with the communities they are working in.<sup>103</sup>* Advocates should work with ethnic chambers of commerce, for example, to develop informational seminars about tax credits and with the Exchange to reach ethnic small business owners who may not trust insurance brokers or large small business associations.<sup>104</sup>
- *Leverage community based organizations, institutions, and individuals who have already established trust within diverse communities in community outreach and education strategies.* Such individuals and organizations often respect and understand language and cultural differences.<sup>105</sup> Individuals and organizations who already do community health education and outreach – such as *promotoras* – Latino/a [community members who promote health in their own communities](#) – could be excellent additions to the Navigator Program<sup>106</sup> or make excellent community assisters.<sup>107</sup>

## BUILD A DIVERSE HEALTHCARE WORKFORCE

- *As new offices are developed due to implementation, leadership and staff should include members who are representative of the state's diversity.*
- *Work towards increasing the diversity of members of the healthcare workforce by strengthening racial and ethnic diversity in health professions workforce pipeline programs.*<sup>108</sup> The shortage of racial and ethnic minorities within the health care profession is problematic.
- *Ensure that loan forgiveness is adequately distributed to students of color who are interested in medical and healthcare professions.*<sup>109</sup>
- *Government, private entities, and foundations should invest in and strategically fund programs that build and maintain medical and healthcare professions pipeline programs for minority students. Studies show that physicians of color are more likely to work in communities of color. African American physicians, for example, are more likely to care for poor patients and Medicaid patients, and Latino physicians are more likely to care for uninsured patients.*<sup>110</sup>

## IMPROVE LANGUAGE ACCESS AND CULTURAL COMPETENCY

- *Information discussed at stakeholder meetings open to the public should be accessible to advocates who do not primarily speak English or who work with communities that do not primarily speak English. Steps to improve language accessibility include providing interpretation services and translating documents to other languages.*
- *Individuals should be able to receive help in multiple languages while submitting applications, whether the process is done by phone, in person, or via the Internet.*
- *Make sure that organizations and individuals conducting education and outreach have adequate training and resources to provide assistance to community members.*<sup>111</sup> Also, establish standards for education and outreach to ensure that diverse communities receive comprehensive and accurate information.
- *Outreach campaigns should be linguistically and culturally competent and targeted to diverse communities. They should specifically take into account communities that face extra barriers in enrolling in health insurance programs.*
- *Utilize networking sites, such as Facebook and Twitter, and smartphone technologies to promote education and enrollment information about the ACA to young populations and communities of color.*<sup>112</sup> Seventy-one percent of people between the ages of 18 and 24 use social networking sites. Furthermore, 42 percent of young people and 38 percent of people of color primarily access the Internet using smartphones.
- *Utilize ethnic media outlets (newspapers, radio stations, TV channels) to publicize the availability of provisions in the ACA.*
- *All printed and electronic outreach and educational materials should be produced in multiple languages and at a literacy level that is easily comprehensible.*<sup>113</sup> Use Medi-Cal threshold languages as the standard.<sup>114</sup>



## CREATE A SYSTEM IN WHICH CITIZENS CAN EASILY ACCESS INFORMATION ABOUT HEALTH INSURANCE, ENROLLMENT, AND NEEDED HEALTH CARE

- *Use smartphone technologies to send reminders about health insurance enrollment and renewals.*<sup>115</sup>
- *Create streamlined notification processes for Health and Human Services programs and beyond.* For example, if an individual qualifies for the CARE program,<sup>116</sup> they should be notified that they may also qualify for a subsidy in the Exchange.
- *Create streamlined eligibility and application forms that only ask for information that is absolutely necessary to determine eligibility.* Research demonstrates that it is easier for families to enroll in programs when the same application is used to determine eligibility for multiple programs.<sup>117</sup>
- *Take advantage of already required interactions with the government to disseminate information about the ACA.* For example, inform small businesses about available tax credits and purchasing insurance through the SHOP during business license renewal periods, or inform families that they may qualify for expanded Medi-Cal or tax subsidies when they enroll their child in reduced-price lunch programs.
- *Promote 12 month eligibility periods, and make it easy for individuals who experience changes in circumstances that would affect their eligibility to move from one form of coverage to another without experiencing a lapse in coverage.* Such policies would make it easier for individuals to maintain access to health coverage while also reducing the cost of coverage.<sup>118</sup>
- *Begin targeted outreach to communities of color as soon as possible in order to ensure that community members are knowledgeable about the policy changes that are underway and prepared to take advantage of new benefits on January 1, 2014.* Educational community outreach should include the following information: (1) overview of the ACA and its specific provisions, (2) explanation of how individuals, families, and communities will benefit from the ACA and how they can enroll, and (3) explanation of ACA implementation efforts (and timeline). Implementing the Navigator Program by January 2013, for example, would help accomplish this goal, as part of the responsibility of Navigators is to conduct education, outreach, and enrollment assistance.
- *Conduct enrollment events in diverse locales (e.g. Community health centers, grocery stores, sporting events, places of worship, etc.) to reach diverse populations.*<sup>119</sup>
- *Publicize the availability of tax credits for small businesses in local ethnic newspapers/radio stations.* Many small business owners are unaware of the availability of small business tax credits.<sup>120</sup>
- *Find and utilize other systems, such as Telehealth and e-medicine, that can increase inadequate provider networks, especially for rural communities.*<sup>121</sup>

## ADVOCATE AT THE FEDERAL LEVEL FOR POLICIES THAT PROTECT IMPLEMENTATION AT THE STATE AND LOCAL LEVEL

- *State-level advocates should advocate at the federal level to protect and increase funds for community health centers.* Members of Congress attacked eleven billion dollars originally designated in the Affordable Care Act for the expansion of community clinics, resulting in a reduction of the number of new health centers that can be built.<sup>122</sup>

- *State-level policymakers and advocates should petition the federal government to keep funding for Community Transformation Grants intact.* Community Transformation Grants provide important resources for building up preventative health infrastructure in communities.<sup>123</sup>

## ENSURE SUSTAINABILITY

- *The compensation model for Navigators and community assisters should take into account the amount of time that it takes to enroll an individual or family. Work with current advocates working as assisters to determine a fair way to properly compensate Navigators and community assisters (e.g. grant, per head, etc.)*
- *Enroll people into the Low Income Health Programs (LIHP) now to help ensure that the safety net remains intact in counties after 2014.* Extending coverage to low-income adults through LIHPs will help assist California and its counties in implementing the expansion of Medi-Cal.<sup>124</sup>
- *States should require that non-federally conducted or supported health care or public health programs and surveys conducted within their states abide by the ACA's standards for data reporting, and this data should be able to be disaggregated by race and ethnicity.*<sup>125</sup>
- *Provide sustainable support and funding for community clinics, as individuals newly enrolled in Medi-Cal will use these centers, and they will also continue to be the primary service providers for persons who “fall through the cracks” of health insurance reform. Additionally, individuals and families who have an established relationship with a service provider at a community clinic and prefer to continue seeing that provider should be able to continue to see the medical professional with whom they have an established relationship.* Low-income people of color make up almost two-thirds of the people who receive health care at federally qualified health centers and community clinics.<sup>126</sup> A recent study, however, found that community health clinics offer patients reduced savings in annual overall medical and ambulatory expenditures.<sup>127</sup>
- *Ensure adequate funding for pipeline programs and community colleges who train students aspiring to enter medical or healthcare professions.*

## Conclusion

**T**he Racial Equity Framework highlighted in this report is an example of the type of analysis that needs to be done in all health policy contexts. Because social and economic inequalities significantly impact health status and outcomes, policymakers and advocates should also use this type of analysis when implementing policies that indirectly impact health, such as education, environmental, and housing policies. A commitment by policymakers and advocates to utilize such a strategy when implementing policies will help improve the health of *all* Americans, facilitating increased achievement of the American Dream by individuals in all communities in the process.

## Racial Equity Framework Worksheet

### Step 1: Gathering Information

- What specific issue is this policy intending to address?
- What is the purpose of the policy we are making/implementing?
- What quantitative and qualitative evidence of inequity exists around the issue that this policy is supposed to address?
- How might implementation play out differently in different communities?
- What additional information is missing or needed?

### Step 2: Engaging Stakeholders

- Who are the stakeholders who may be positively or negatively affected by this policy? How can we best inform them?
- How can we engage potentially affected stakeholders as active participants in the decision-making, planning, and implementation processes in an impactful way?
- Are we meaningfully considering the needs and concerns of stakeholders during final decision-making processes?
- Who is missing and how can we engage them?

### Step 3: Identifying Policy Holes

- What adverse impacts or unintended consequences could result from this policy if enacted as written?
- How would different racial/ethnic groups be impacted if policy were enacted or implemented as written?
- What additional barriers might prevent individuals in certain racial/ethnic groups from benefitting fully if this policy were implemented as written?

### Step 4: Filling in the Holes

- What steps could we take to prevent or minimize adverse impacts or unintended consequences?
- What steps could we take to address additional barriers that could prevent various racial/ethnic groups from accessing the policy fully?
- Are there further ways to maximize equitable outcomes?

(cont. next page)



## Guiding Values

### Diversity and Inclusion

Recruit diverse community stakeholders, and involve them as active participants throughout process. Resulting programs and policies should be inclusive and representative of the needs of the communities that they will impact.

### Transparency and Accountability

Maintain openness and fairness to diverse communities in all phases of planning, decision-making, program development, program implementation, documentation, program evaluation, and advocacy.

### Healthy Environments

Active attention to eliminating existing disparities results in outcomes that maximize the health, safety and well-being of all individuals and communities.

### Equal Opportunity

All individuals should have full and fair access to opportunities and benefits of resulting policies and programs without bias, unnecessary barriers or extra burden.

### Accessibility

Ensure that all individuals receive the basic information, resources, and opportunities necessary to create healthy and prosperous futures for themselves and their children.

### Sustainability

Implement equity-enhancing programs and policies with the support, protections, and enforcement necessary for long-term positive impact in diverse communities.



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## Racial Equity Framework Worksheet

(cont. from previous page)

### Step 5: Examining Sustainability

- Do this policy and additional equity-enhancing measures related to this policy have adequate funding? Are mechanisms in place ensuring successful implementation and enforcement?
- Are there provisions to ensure ongoing stakeholder participation and public accountability of policy implementers and enforcers?

### Step 6: Evaluation

- Are there provisions to ensure ongoing collection of data (that can be disaggregated by race/ethnicity) and public reporting of data?
- Are there clear markers of short term and long term success as well as timelines for meeting markers of success?
- What are the mechanisms we will utilize to ensure that goals are met?
- What are the consequences if goals are not met?
- Is there a process for those impacted by the policy to express grievances or satisfaction and to ensure that concerns are met?

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- <sup>16</sup> Medicaid is the federal government's insurance program for low income families and children, the elderly, and people with disabilities. Under the Affordable Care Act, Medicaid will expand to cover individuals without children, and individuals and families making up to 133% of the Federal Poverty Level. For information, see: <http://www.healthcare.gov/using-insurance/low-cost-care/medicaid/index.html>.
- <sup>17</sup> Under the Affordable Care Act, new Small Business tax credits will subsidize employers who provide their employees with quality, affordable health insurance options. Additionally, new tax credits for individuals and families will subsidize families who make between 133% and 400% of the FPL in the purchase of health insurance through the exchanges. For more information about small business tax credits, see: <http://www.irs.gov/newsroom/article/0,,id=223666,00.html>. For more information about tax credits for individuals and families, see: <http://www.healthcare.gov/blog/2011/01/saving-money.html>.
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- <sup>21</sup> Race is a concept reflecting self-identification by people according to the race or races which they closely identify. Categories are sociopolitical constructs and not biological. See: Levy, B.S. and V. W. Sidel. (2006). Social Injustice and Public Health. *Oxford University Press*.
- <sup>22</sup> Ethnicity pertains to a people or group who share a common language, culture, or religion.
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- <sup>25</sup> Gender Identity pertains to how we see ourselves, some of us as women, some as men, some as a combination of both, or some as neither. See: Mason, C. N. (2010). Leading at the Intersections: an introduction to the intersectional approach model for policy and social change. *Women of Color Policy Network*. <http://wagner.nyu.edu/wocpn/publications/wcpn.intersections.pdf>.
- <sup>26</sup> Sexual orientation refers to a pattern of emotional, romantic, and/or sexual attractions to men, women, both genders, neither gender, or another gender. It also refers to a person's sense of personal and social identity based on those attractions, behaviors expressing them and membership in a community of others who share them. See: Mason, C. N. (2010). Leading at the Intersections: an introduction to the intersectional approach model for policy and social change. *Women of Color Policy Network*. <http://wagner.nyu.edu/wocpn/publications/wcpn.intersections.pdf>.



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1. What is your sex or gender? (Check ALL that apply)
- Female
  - Male
  - Transgender Male/Transman
  - Transgender Female/Transwoman
  - Genderqueer
  - Additional sex or gender (please specify)
  - Unknown or Question Not Asked
  - Declined to state
2. What sex were you assigned at birth? (check one)
- Female
  - Male
  - Unknown or Question Not Asked
  - Decline to state
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